SPECIAL REPORT

Thematic report: Migrants

Monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2012 progress

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Monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2012 progress report

This report of the European Centre for Disease Prevention and Control (ECDC) was coordinated by Teymur Noori and Anastasia Pharris, Programme for STIs, including HIV/AIDS and blood-borne infections.

This report is one in a series of thematic reports based on information submitted by reporting countries in 2012 on monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS. Other reports in the series can be found on the ECDC website at:
http://www.ecdc.europa.eu/en/activities/diseaseprogrammes/hash/Pages/dublin-declaration.aspx

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Contents

Abbreviations

ART	Antiretroviral therapy
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
EU/EFTA	European Union/European Free Trade Association
NCPI	National Commitment and Policies Instrument
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session

Executive summary

Key messages

Migration is an important issue for HIV programming in Europe and Central Asia. Migrants from countries with generalised HIV epidemics are particularly affected by HIV in many countries, particularly in the EU/EFTA.

There is evidence from some countries that migrants may be disproportionately represented among key affected populations, such as sex workers and people who inject drugs. Very few countries have data available on HIV prevalence among specific migrant populations.

Many countries throughout the region, particularly in the EU/EFTA, regard migrants as an important sub-population for their national response to HIV. Countries have many examples of different types of HIV programmes and services for migrants. However, very few countries have data available on the coverage of such services, for example, the rates of HIV testing among migrant populations.

Countries report qualitative data on the difficulties faced by some migrant populations in accessing certain HIV services in some countries. For example, undocumented migrants face difficulties in accessing antiretroviral therapy in a number of different countries. Many of these difficulties relate to ineligibility for access to free treatment, e.g. because of lack of health insurance.

There is evidence from a number of countries of higher rates of late HIV diagnosis among migrant populations. Countries provided examples of a wide range of services for different types of migrants. There are a number of good examples of active involvement of migrant communities in these programmes.

However, although a number of countries report that they are systematically monitoring the delivery of HIV programmes for migrants, the availability of data remains very limited. This is particularly true for the standard indicators for which ECDC requested data in this round of reporting. Countries are aware that migrants face a number of obstacles and difficulties in seeking to access HIV programmes and services. These include language barriers, cultural differences, lack of information, fear, stigma and discrimination. In some cases, there are policy or legal barriers to migrants receiving HIV services.

Background

The Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia, adopted in 2004, was the first in a series of regional declarations, which emphasise HIV as an important political priority for the countries of Europe and Central Asia.

Monitoring the progress in implementing this declaration began in 2007 with financial support from the German Ministry of Health. This resulted in the publication of a first progress report by the WHO Regional Office for Europe, UNAIDS and civil society organisations in August 2008. In late 2007, the European Commission requested that ECDC monitor the Dublin Declaration on a more systematic basis. The first country-driven, indicator-based progress report was published in 2010[i]. The objective was to harmonise indicators with existing monitoring frameworks, notably the United Nations General Assembly Special Session (UNGASS) and European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) indicators, and with the EU Communication and Action Plan[ii], using existing data and focusing on reporting that was relevant in the European and Central Asian context, to minimise the reporting burden for countries. In 2012, instead of producing one overall report, information provided by countries has been analysed to produce ten thematic reports.

Method

All 55 countries of the region were requested to submit data regarding their national responses to HIV (see Annex 1 for a list of the 55 countries). For this round of reporting, the process was further harmonised with Global AIDS Response Progress Reporting (formerly known as UNGASS reporting). As a result, countries submitted most of their responses through a joint online reporting tool hosted by UNAIDS. Responses were received from 51 of 55

[i] European Centre for Disease Prevention and Control. Implementing the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2010 progress report. Stockholm: ECDC; 2010. Available here: http://ecdc.europa.eu/en/publications/publications/1009_spr_dublin_declaration_progress_report.pdf

[ii] Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee, and the Committee of the regions. Combating HIV/AIDS in the European Union and neighbouring countries, 2009–2013. Available here: http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2009:0569:FIN:EN:PDF

countries (93%). This response rate was slightly higher than for 2010. More details of methods used are available in the Background and methods report[i].

In general, international reporting processes, such as Global AIDS Response Progress reporting, have had relatively little focus on migrants as a key population affected by HIV. There are a few questions within the National Commitment and Policies Instrument (NCPI) in which migrants and mobile populations are considered as one of a number of key affected populations. Countries were asked to respond to these questions.

In addition, a number of region-specific indicators were introduced into the UNAIDS reporting tool for Global AIDS Response Progress reporting. These included three indicators related to migrants – HIV prevalence among migrants and rates of condom use and HIV testing among migrants from high prevalence countries. Countries were asked to report data on these indicators. In addition, countries were asked to report disaggregated data for migrants in relation to coverage of antiretroviral therapy and late diagnosis.

A number of questions related to migrants were included in the European supplement to NCPI. These questions were asked of both government and civil society respondents. Respondents were offered the opportunity to submit any additional data that they wished to. A number of countries did so, particularly through their narrative reports.

A major challenge faced in dealing with this particular population is that there is no shared definition of the term 'migrant'. In addition, countries use a wide range of other terms. Some of these terms, e.g. immigrant, foreign citizen, appear to be used interchangeably with the term migrant in some countries. However, in other countries, there are clear distinctions between these terms. Other terms appear to be used to describe a sub-set of migrants, e.g. refugees and asylum seekers. Because of this, and because of the nature of available data, caution should be exercised in making comparisons between countries or generalising results beyond the area studied.

[i] European Centre for Disease Prevention and Control. Background and methods. Monitoringimplementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2012progress report. Stockholm: ECDC; 2013.

Introduction

The links between migration and HIV are complex and contested. It has been argued that people moving from countries with high HIV prevalence can result in HIV transmission in countries with lower prevalence. This has sometimes led to migrants being blamed and stigmatised for bringing HIV to a country. It has also been argued that migrants and mobile populations may be more vulnerable to HIV transmission because of behaviours adopted and more limited access to services than host populations. Issues relating to access to services are not only relevant with respect to prevention but also for treatment, care and support for migrants and mobile populations living with HIV.

Countries use the term migrants in quite different ways (see Annex 1). In general, most countries, particularly those in the EU/EFTA, use the term in relation to people coming into their country (see Box 1). A wide variety of other terms are used[i] and various categories of migrants are recognised, such as refugees and asylum seekers. In addition, some countries use the term to refer to internal mobile populations or ethnic minorities. Some countries use the term mainly to refer to their own citizens who migrate to other countries, particularly for work. This is an important social phenomenon in the eastern part of the region. Countries commenting on the importance of this form of migration included Armenia, Azerbaijan, Belarus, Moldova, Tajikistan, Ukraine and Uzbekistan. In the context of responses to HIV, countries refer to three main groups of migrants. These are:

- migrants from countries with generalised HIV epidemics, particularly in sub-Saharan Africa
- migrants from other countries who are part of particular sub-populations at increased risk of HIV infection, such as sex workers and people who inject drugs
- the group of labour migrants, particularly in the eastern part of the region.

There are large migrant populations in many countries of the region and, in some countries, e.g. Greece, these populations are reported to have increased over the last two years (see Annex 1). In addition, the number of labour migrants working in other countries is high from some countries. For example, the number of labour migrants outside the country is estimated by Moldova to be 300–600 000 and 750 000 to 1 million by Tajikistan.

In the 2010 Dublin progress report, strong evidence was presented that, in some countries, migrants from countries with high HIV prevalence were particularly affected by HIV. This is also confirmed by HIV surveillance results over the years. For this round of reporting, a number of indicators relevant to migrants were introduced and countries were asked to report on these to ECDC through the process of Global AIDS Response Progress reporting.

This report is divided into two main parts. The first part considers the HIV situation affecting migrants in Europe and Central Asia. The second part considers the nature of HIV responses for migrants in countries of Europe and Central Asia. The report then draws a number of conclusions, considers progress since the last round of Dublin reporting and presents a number of issues identified by ECDC for further action.

[i] In general, in this report, we have tried to avoid using terms other than migrant, such as 'foreigner'. However, we have retained such terms when they were used directly by countries in their responses.

Box 1. Migrants and HIV in EU/EFTA countries

In general, EU/EFTA countries consider migrants to be people born abroad now living in the country. However, there is no shared definition of the term migrant among EU/EFTA countries. Some consider people to be migrants only if they were born abroad of foreign parents. Countries vary in the amount of time someone has to be in a country before they are considered a migrant rather than a visitor.

Migrants constitute a sizable population in many EU/EFTA countries. Overall, the number of migrants within the EU/EFTA appears to have risen between 2008 and 2011. large increases have been reported in some countries during this period, e.g. in Greece.

Almost three quarters (71%) of the EU/EFTA countries that reported to the two rounds of Dublin reporting considered that they have evidence that migrants are disproportionately affected by HIV in their country. This compares to only one third (33%) of non-EU/EFTA countries.

In the context of HIV, most EU/EFTA countries are focused on those migrants coming from countries with high HIV prevalence as these are the sub-group of migrants particularly affected by HIV. Some EU/EFTA countries also report that migrants may be disproportionately represented among some key populations at increased risk of HIV infection, such as people who inject drugs, sex workers and prisoners. Overall, EU/EFTA countries do not consider the issue of labour migration as particularly related to HIV transmission.

Overall, more than three quarters (76%) of EU/EFTA countries and nearly two thirds (64%) of non-EU/EFTA countries that responded considered migrants an important sub-population in the national response to HIV.

In general, antiretroviral therapy (ART) is available to regular migrants in EU/EFTA countries. All government respondents that answered this question reported that ART is provided to migrants, in general, in their country.

However, ART is reported to be available to undocumented migrants in less than half of EU/EFTA countries responding to the question: 44% of government and 29% of civil society respondents from EU/EFTA countries answering the question reported that ART is available for undocumented migrants in their country. The figure was over half (54%) for both government and civil society respondents in non-EU/EFTA countries (see Figure 7). EU/EFTA countries that report they do provide ART for undocumented migrants are clustered in the south-west of the region (see Figure 8) whereas those that report they do not are clustered in the north, centre and east.

HIV and migrants in the region

Current situation

Migrants are disproportionately affected by HIV in their country

Based on all responses received in the two rounds of Dublin reporting, more than half (58%) of countries responding to this question reported that they had evidence that migrants are disproportionately affected by HIV in their country (see Figure 2).

Over the two rounds of reporting, almost three quarters (71%) of EU/EFTA countries who responded reported that they had evidence of migrants being disproportionately affected by HIV in their country. This was only the case in one third (33%) of non-EU/EFTA countries.

Migrants from countries with generalised HIV epidemics are particularly affected by HIV

Evidence from different countries relates to the different groups of migrants mentioned above. Many countries presented strong evidence that migrants from countries with generalised HIV epidemics are particularly affected by HIV (see Figure 2 Inset 1).

Migrants are disproportionately represented among key affected populations

In this round of reporting, the Czech Republic and Germany presented data that migrants from other European countries are particularly affected by HIV (see figure 2 inset 2). Germany referred specifically to injecting drug use and sex work. Germany also commented that migrants are disproportionately represented in both groups. The Czech government response commented that migrants were disproportionately represented among sex workers. There were similar reports from other countries (see Figure 1).

Figure 1. Number of countries reporting that migrants are disproportionately represented among key populations at increased risk of HIV infection

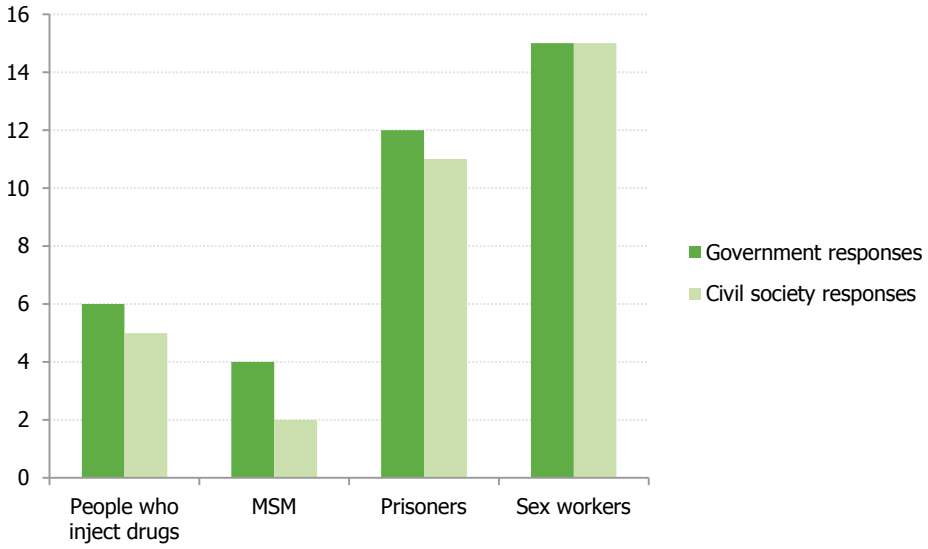
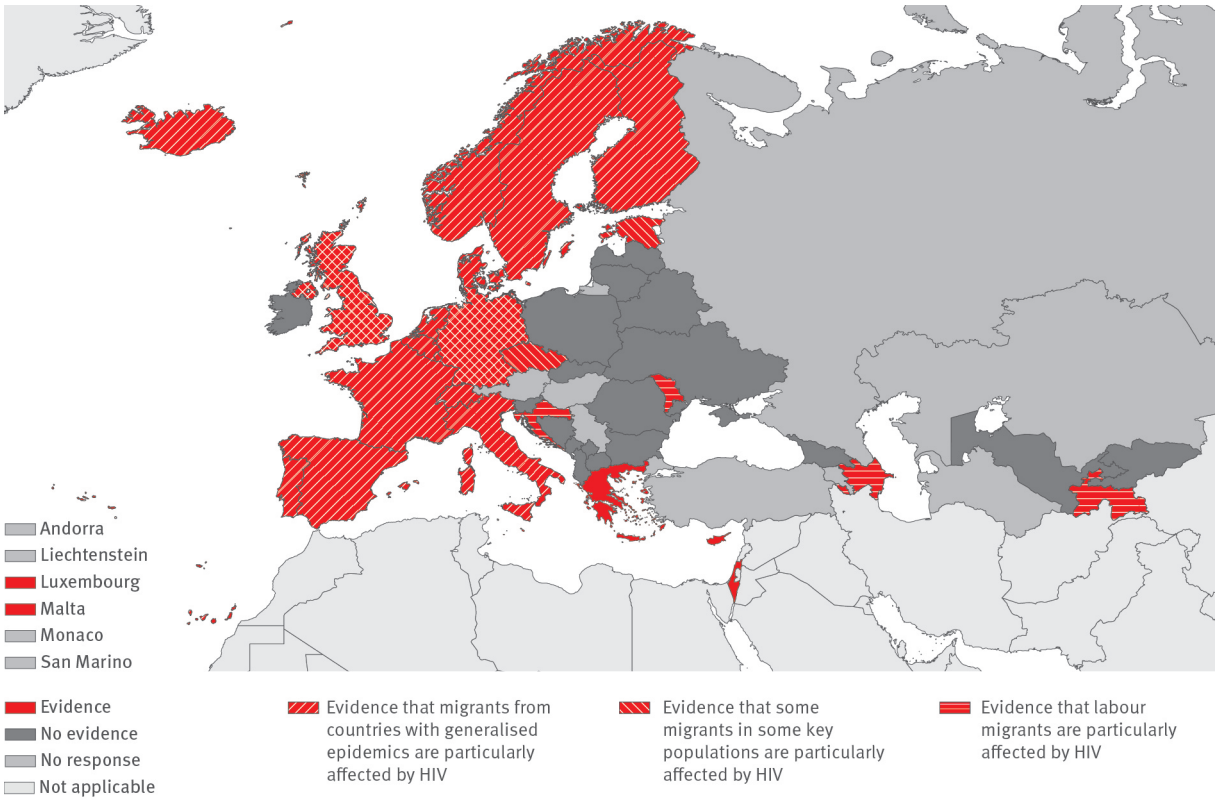


Figure 2. Evidence reported by European and Central Asian countries that migrants are particularly affected by HIV



There is limited evidence from countries of the region that labour migrants are disproportionately affected by HIV

In this round of reporting, Azerbaijan and Tajikistan reported data that migrant workers from their country are disproportionately affected by HIV (see figure 2 inset 3). However, in the case of Tajikistan, it appears that the increased risks relate to sexual and injecting behaviour in the country of destination rather than migration per se. In addition, although Moldova recognises that they have no biological data to constitute evidence of disproportionate risk for labour migrants, they report that 'an analysis of the PLHA database indicates that a larger share of them compared to the general population may have engaged in migration in the past. Many report that either themselves or their sexual partners may have been infected abroad.'

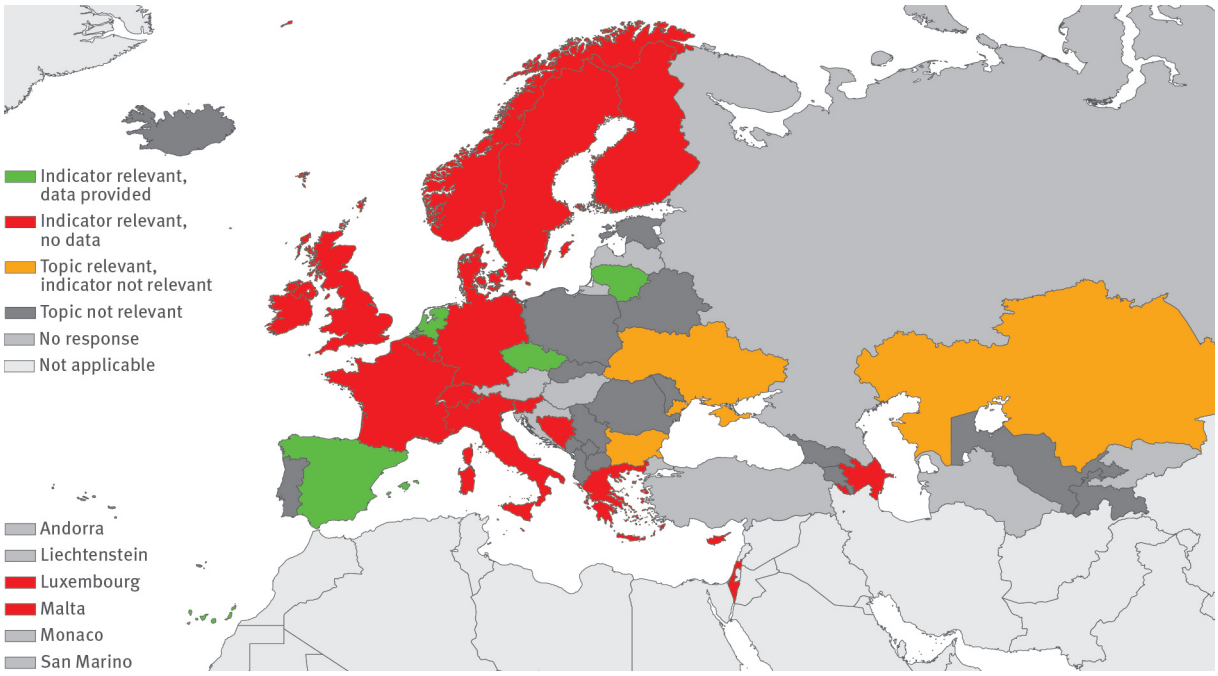
Very few countries had data available on the HIV prevalence among migrant populations

Countries were asked to report HIV prevalence among migrant populations. Very few, however, were able to report data (see Figure 3). Thirteen countries (light grey) did not respond to this indicator. Fifteen countries (black) reported that the topic was not relevant to them. Three countries (dark grey) reported that the topic was relevant but the indicator was not. Seventeen countries (red) commented that although both the topic and indicator were relevant to them, they had no data. Five countries (green) reported data on this indicator.

- The Czech Republic presented results of a survey conducted in 2011 using respondent-driven sampling. Fourteen of 7 081 migrants tested were found to be HIV positive, i.e. a prevalence of 0.2%.
- Lithuania presented their national HIV surveillance data from 2011. One of 25 migrants tested was found to be HIV positive.
- The Netherlands presented data from a mathematical model from projects conducted in 2007 and 2008. This resulted in an HIV prevalence among migrants of 3.1% overall, 3.4% among men and 2.8% among women.

- Spain reported on a behavioural surveillance survey conducted in 2010. One hundred and eighty seven of 4 641 migrants tested were found to be HIV positive, i.e. a prevalence of 4.03%. HIV prevalence was reported to be 7.91% among men and 0.95% among women. In addition, HIV prevalence was 4.47% among those aged over 25 and 2.88% among those under 25.
- The UK reported on a survey that had been conducted from October 2008 to January 2009 among Africans living in England. Among these, 12.1% (n=2542) of respondents had tested HIV positive at any time point prior to the survey[i]. The Health Protection Agency estimated that, in 2010, HIV prevalence among black African men and women in England and Wales was 47 per 1000 population. Among men, prevalence was 31 per 1000 population and among women it was 64/1000. HIV prevalence among African-born pregnant women in London was 21/1000 population[ii].

Figure 3. European and Central Asian countries reporting on HIV prevalence among migrants



Current responses

Many countries regard migrants as an important sub-population in their responses to HIV

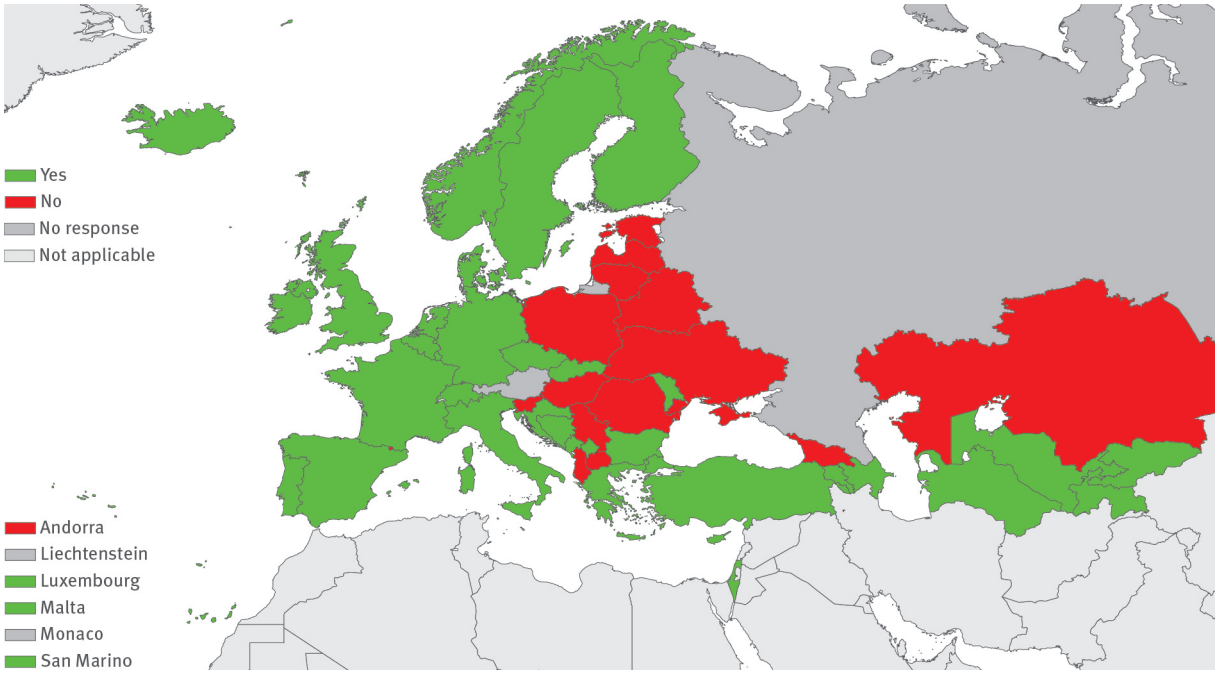
Based on all responses received in the two rounds of Dublin reporting, almost three quarters (71%) of countries responding to this question considered migrants an important sub-population in the national response to HIV. In this round of reporting, in three countries, the responses given by government and civil society respondents differed. In the case of Luxembourg, civil society considered migrants to be an important sub-population in the national response to HIV but the government did not. The reverse was true of Kyrgyzstan and Slovakia.

Over the two rounds of reporting, more than three quarters (76%) of EU/EFTA countries who responded considered migrants an important sub-population in the national response to HIV. In non-EU/EFTA countries nearly two thirds (64%) of countries responding considered migrants an important sub-population. Within the EU/EFTA, Estonia, Latvia, Lithuania, Poland, Romania, Slovakia and Slovenia (see Figure 4) reported that migrants are not an important sub-population in their national response to HIV.

[i] More information on the Bass Line survey can be found at: http://www.sigmaresearch.org.uk/files/report2009h.pdf

[ii] This information can be found in: http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317131685847

Figure 4. European and Central Asian countries that identify migrants as an important sub-population in the national response to HIV and AIDS



Countries are responding to HIV among migrants in a variety of ways

Countries report supporting and implementing a wide range of HIV-related programmes for migrants. Countries highlighted achievements and challenges relating to such programmes in a number of areas:

- Provision of government financing to HIV-related programmes for migrants, for example in Belgium and the UK. In the UK, civil society reported that the government continued to fund a nationally-coordinated prevention programme for black Africans. However, concerns were raised as to whether or not this would continue at the same level once plans to merge two national HIV prevention programmes into one are implemented. In the Netherlands, funding from the Ministry of Health was used to stimulate local cooperation between municipal health services and migrants' organisations.
- Provision of HIV-related programmes for particular sub-groups of migrants, e.g. those from Africa and African communities, for example in Germany and the UK. In Belgium, one of the challenges identified was delivering a coordinated response to the increasing health impact of HIV and STIs among sub-Saharan African migrants. Civil society reported the need to reach migrants from high-prevalence countries in a more effective manner
- Provision of HIV-related programmes as part of broader programmes of healthcare in migrants. For example, in Italy, special attention was paid to the diagnosis and care of migrants suffering from infectious diseases including HIV, human papillomavirus and tuberculosis.
- Provision of HIV-related programmes for migrants as part of broader programmes of healthcare in socially-marginalised groups. For example, in Greece, mobile medical units have operated in the centre of Athens providing health services not only to migrants but also to other socially-marginalised groups including people who inject drugs and sex workers.
- Continuation of services previously reported in the 2010 Dublin report. Examples include the work of the Finnish AIDS Council Multicultural HIV Programme; HIV checkpoints in Denmark; Afrimedia in Switzerland and the National African HIV Prevention Programme in the UK. For example, civil society in Switzerland reported further roll-out of peer-to-peer programmes for migrants through Afrimedia.

However, some countries, e.g. Moldova, reported that migrants were broadly overlooked and/or understudied in their programmes. Civil society in Ukraine commented that there are no activities targeting migrants.

Reported coverage of risk reduction programmes for migrants from high-prevalence countries remains low

Civil society respondents were asked their opinion of whether or not the majority of people in need in the country had access to risk reduction services for migrants from high-prevalence countries. Less than half (44%) of those who responded considered this to be the case.

Data on HIV testing among migrants are very limited

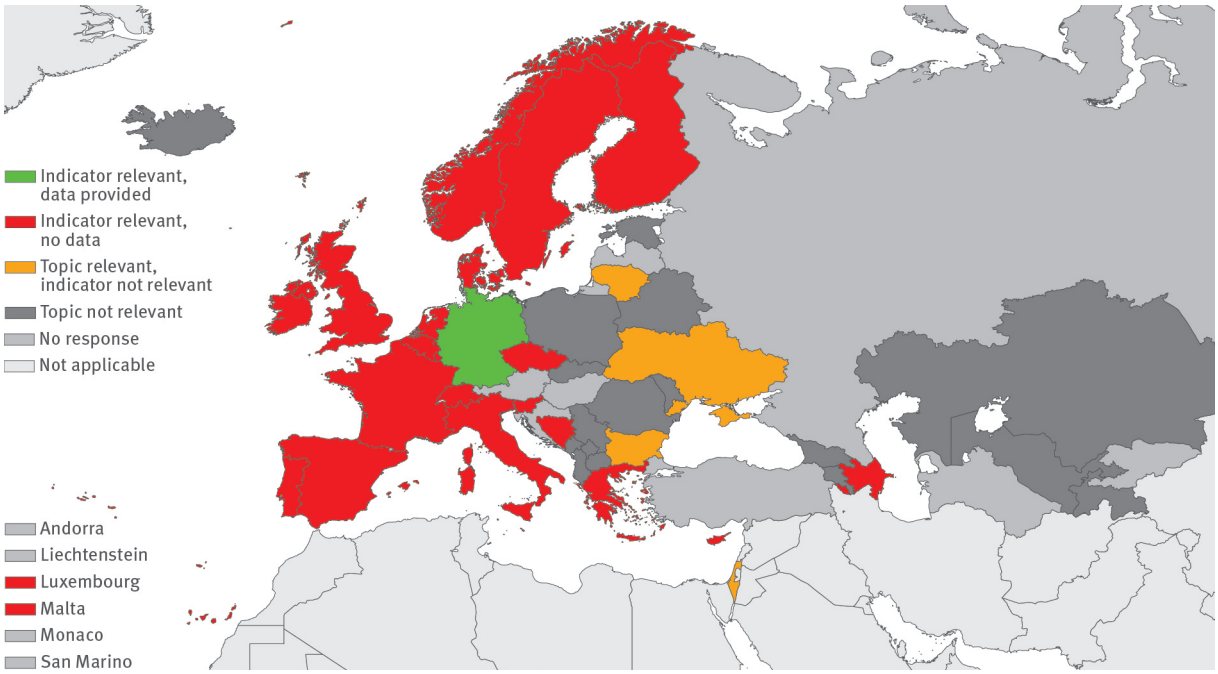
Countries were asked specifically to provide data about their HIV testing among migrants. Seven countries provided quantitative data (see Table 1). In five cases, countries reported the number of HIV tests conducted among different groups of migrants. Two countries, Germany and Portugal, reported results of a study that assessed what proportion of a group of migrants had ever received an HIV test. None of these countries previously reported quantitative data on HIV testing among migrants to the 2010 Dublin reporting process, although another eight did – Estonia, France, Moldova, the Netherlands, Romania, Serbia, Ukraine and the United Kingdom.

Table 1. Quantitative data on HIV testing among migrants

Country	Evidence
Azerbaijan	In 2010–2011, HIV tests were performed on 7 598 people entering the country and on 7 319 people leaving the country to travel abroad.
Germany	In 2010, a study was conducted in Hamburg among 176 males and 84 females from Cameroon, Togo, Ghana, Burkina Faso, Benin and Nigeria. Of these, 59% reported that they had been tested for HIV.
Greece	Of 1 271 HIV tests of non-Greek nationals in the centre of Athens, conducted in mobile units, during 2011 and 2012, 30 individuals (2.4%) were found positive.
Lithuania	In 2011 HIV tests were carried out on 25 migrants, of whom one was positive.
Portugal	In a survey of 1 513 migrants, more than half (51%) reported having been tested for HIV. Women were more likely to be tested than men.
Tajikistan	The number of migrant workers tested in Tajikistan, by year, was 2007 – 4 108; 2008 – 12 721; 2009 – 10 148; 2010 – 10 669 and 2011 – 76 080.
Uzbekistan	In 2010, about 55 000 people going abroad were tested for HIV.

Countries were also asked to provide data on the percentage of migrants who had been tested for HIV in the last year and who knew their results (see Figure 5). Twelve countries (light grey) did not respond to this indicator. Seventeen countries (black) reported that the topic was not relevant to them. Four countries (dark grey) reported that the topic was relevant but the indicator was not. Twenty-two countries (red) commented that although both the topic and indicator were relevant to them, they had no data[i]. Only one country, Germany (green) was able to report data for this indicator. In a 2010 survey in Hamburg of 261 migrants from West Africa, 59% reported that they had had an HIV test in the last year and knew the result.

Figure 5. European and Central Asian countries reporting on number of migrants who received an HIV test in the last year and received the results



[i] In one case, Germany, data were not available for the number of migrants tested for HIV in the last year but the number that reported ever having been tested for HIV was provided (see Table 1).

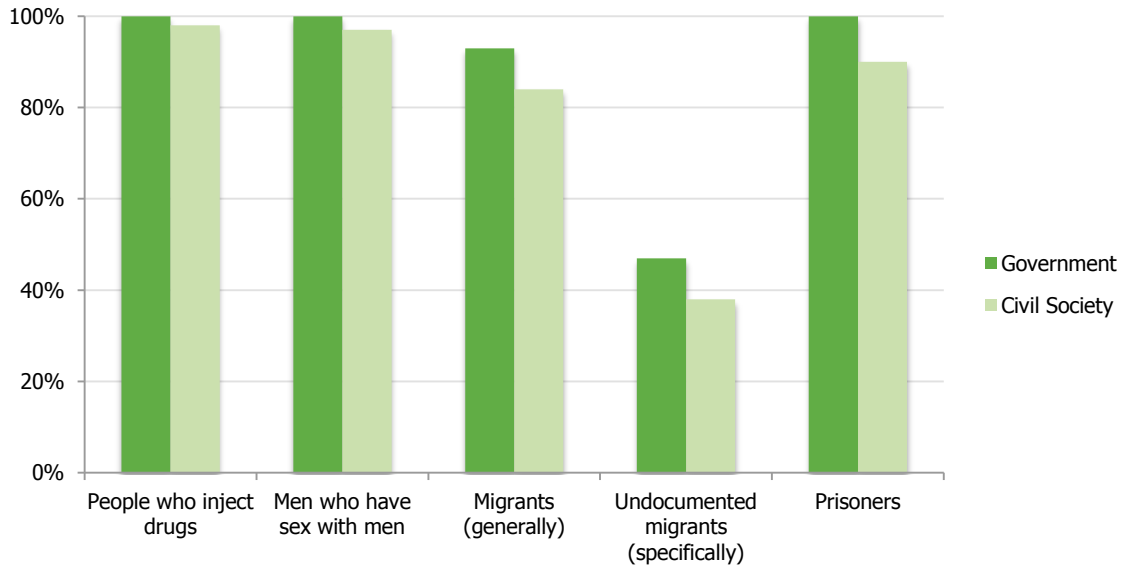
The civil society respondent from Belarus commented that no quantitative data on HIV testing were available although testing is available for legal migrants. Bulgaria commented that they have partial data available but there are plans to improve the national surveillance system to collect more complete data. Kyrgyzstan reported that they have data available for persons travelling abroad. Luxembourg also commented that their data were partial. The civil society respondent from Sweden commented that data are available for immigrants from non-EU countries. The UK commented that the Health Protection Agency has data on testing uptake by ethnicity for 2010 and that this is available on request.

A number of other countries provided qualitative data about their HIV testing among migrants. In Iceland, screening for HIV is provided to all migrants staying in the country for more than 12 months. In Luxembourg, rapid HIV testing and testing for hepatitis B and C is available in prisons and places where asylum seekers live through mobile units that promote sexual health.

Most countries report that antiretroviral therapy is available for migrants generally

Almost all government (93%) and civil society respondents (84%) to a question regarding availability of ART for different sub-populations reported that it is available for migrants, in general (see Figure 6).

Figure 6. Percentage of responding countries reporting that antiretroviral therapy is available for specific sub-populations



In most cases, additional data provided by countries were qualitative in nature including comments on access to ART for different types of migrants. Some countries commented on the availability of ART for all citizens including labour migrants, e.g. Armenia and Tajikistan.

Three countries provided quantitative data on the provision of ART for migrants (see Table 2). The data provided varied and included data on the proportion of migrants receiving ART compared to all those receiving ART in the country (Azerbaijan); data on the proportion of migrants receiving ART compared to all migrants known to be HIV positive (Spain) and data on the number of migrants receiving ART (Slovakia).

Table 2. Migrants' access to antiretroviral therapy

Country	Details	Comments
Percentage of migrants among all people receiving ART		
Azerbaijan	2%	At end 2011, 22/941 were foreigners.
Percentage of HIV-positive migrants receiving ART		
Spain	86%	For the period 2001–2010. In 2010, 14% of those attending with HIV were migrants. This compares with4% in 2001 and 10% in 2008.
Number of HIV-positive migrants receiving ART		
Slovakia	0	In 2011, two HIV-positive migrants were monitored but neither required ART.

Belgium commented that data on ART use disaggregated by nationality are available at AIDS reference centres but not nationally. The UK commented that data on ethnicity are published as part of the Survey of Prevalent HIV Infection Diagnosed but this does not include details of residency status. In addition, Denmark, France and Kyrgyzstan commented that they had data available on the uptake of ART among migrants but provided no details. Greece commented that data were available from special infection units. Iceland commented that data are available in a database at the University Hospital. Italy commented that data are available at regional level but not nationally. Luxembourg commented that their data were 'partial'. Malta commented that ART is prescribed by only one person so they have access to data for all patients. Uzbekistan commented that ART is provided to HIV-positive migrants. The Swiss civil society respondent commented that data are available in the Swiss HIV cohort study.

Some migrants, particularly those that are undocumented, face difficulties in accessing antiretroviral therapy in some countries.

Far fewer countries reported that ART was available to undocumented migrants (see Figure 6). Less than half (47%) of government respondents answering the question reported that ART is available for undocumented migrants in their country. The figure was lower (38%) among civil society respondents.

The proportion of EU/EFTA countries reporting that ART is available for undocumented migrants was lower than for non-EU/EFTA countries. In the case of EU/EFTA countries, 44% of government and 29% of civil society respondents answering the question reported that ART is available for undocumented migrants in their country. The figure was over half (54%) for both government and civil society respondents in non-EU/EFTA countries (see Figure 7).

Figure 7. Percentage of responding countries reporting that antiretroviral therapy is available for undocumented migrants

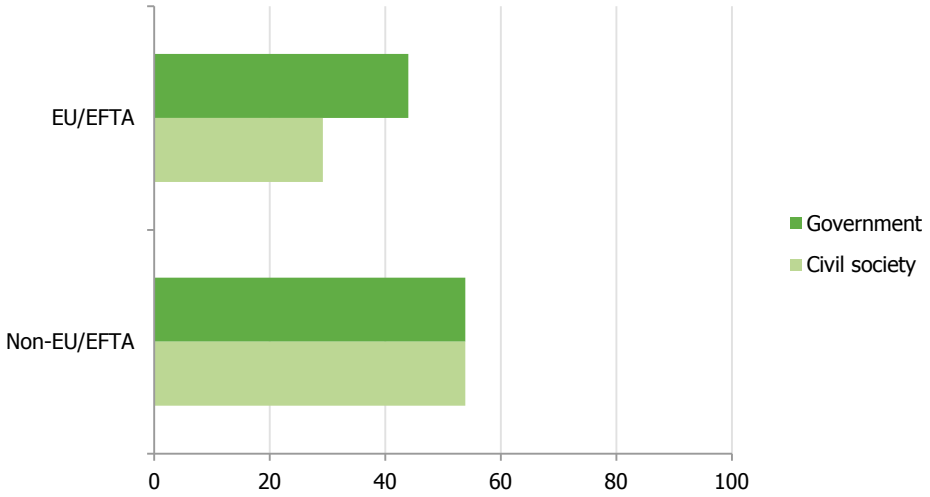
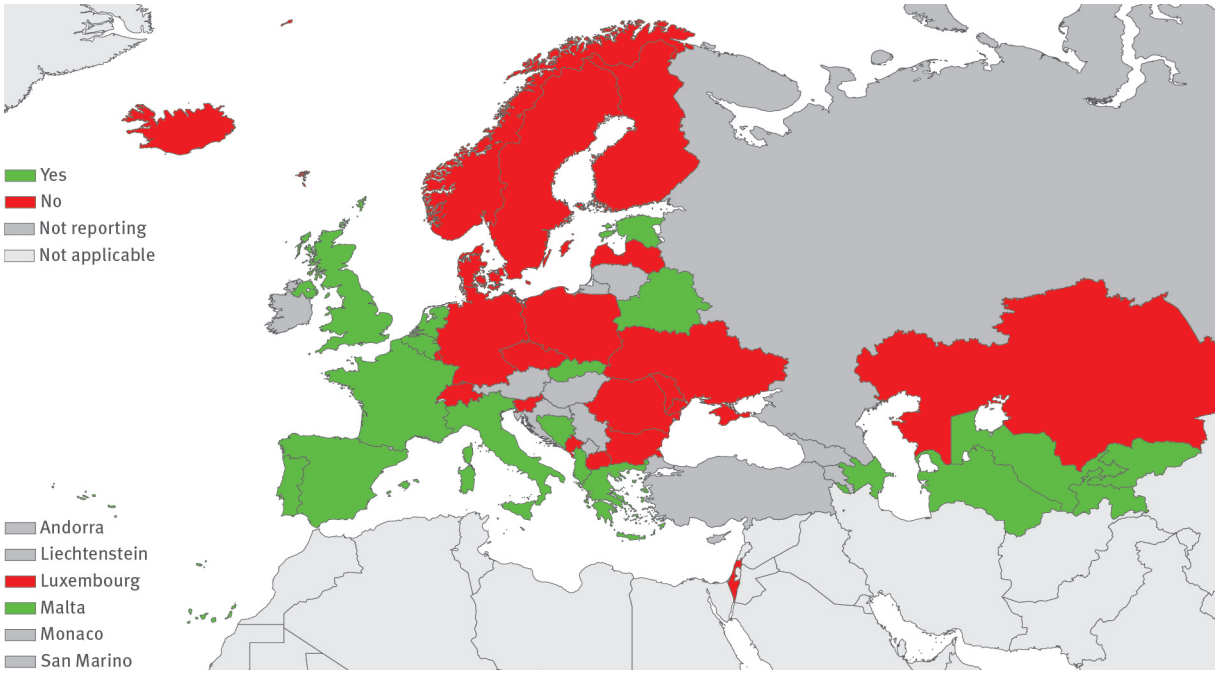


Figure 8 shows the countries which reported whether ART is available or unavailable for undocumented migrants[i].

[i] Where government and civil society respondents expressed the same opinion this opinion was used. Also, where either respondent expressed an opinion and the other sector did not respond, the response given was used. In five cases, divergent views were expressed between civil society and government respondents. In four cases (Greece, Kyrgyzstan, Slovakia and the UK), the government respondent expressed the view that ART is available for undocumented migrants while the civil society respondent expressed the contrary view. The situation was reversed in Moldova.

Figure 8. European and Central Asian countries reporting whether antiretroviral therapy is available for undocumented migrants



Countries reported a number of reasons why ART is not available for undocumented migrants. Many of these reasons relate to the way ART for undocumented migrants is financed, e.g. in Germany and Israel. Although several respondents assumed that undocumented migrants would not be able to access ART unless it was provided free of charge, two countries – the Netherlands and the UK – distinguished between availability of treatment and who was expected to pay for it. In the case of the UK[i], the government respondent commented that 'a small number of overseas visitors are currently excluded from free HIV treatment but in practice there is no evidence treatment is refused although it may be chargeable.' In the case of the Netherlands, the civil society respondent commented that 'persons who are illegally present in the Netherlands have to pay their own health care expenses. They are not covered by the Health Insurance Act. If undocumented persons can prove that they are not able to pay for the cost of medical care, then the health care provider can claim part of his costs from a special national budget.'

Countries reported a variety of reasons why undocumented migrants are unable to receive ART free of charge:

- In many countries, this is because ART is provided on the basis of health insurance and most undocumented migrants are uninsured. This is the case in the Czech Republic, Finland, Hungary, Israel, Montenegro, Poland and Slovakia. In Israel, women are able to receive ART while pregnant and for six months afterwards irrespective of whether or not they have health insurance. In Switzerland, undocumented migrants are reportedly able to have health insurance but, in most cases, are unable to afford the premiums.
- In some countries, e.g. Denmark and Luxembourg, ART is provided on the basis of being eligible for social security. In Denmark, this is linked to permanent residence and in Luxembourg this requires a fixed address.
- In some countries, e.g. Georgia, Romania and Ukraine, ART is provided on the basis of citizenship. In Romania, this is assessed on the basis of identity papers.
- In some countries, e.g. Bulgaria and Latvia, ART provision requires some form of registration with HIV services.

Other reasons why undocumented migrants may not access ART include difficulties in reaching them as they are a marginalised group, e.g. in Switzerland. In Slovakia, there are no specific services focused on undocumented migrants. In Spain, it is reported that undocumented migrants are afraid of accessing health services for fear that their immigration status will become known to the police.

[i] The United Kingdom also reported that from October 2012, the practice of charging people with no 'leave to remain' for HIV treatment will be stopped.

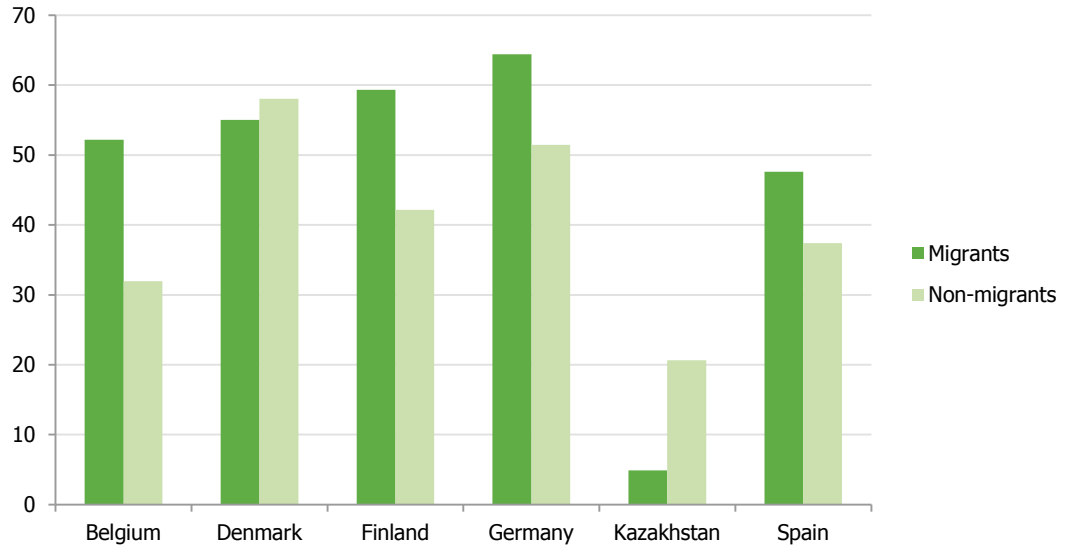
In some countries, e.g. Sweden and the UK[i], it is reported that ART may be provided free of charge informally to undocumented migrants by individual doctors/infection clinics despite rules or restrictions which should prevent this.

Other groups of migrants who are reported to face difficulties accessing services include older male migrants in Denmark; migrant sex workers in France and Switzerland; migrant transsexuals in France; migrants from high-prevalence countries in Germany and Sweden; non-nationals in Italy; those from African communities in the UK; asylum seekers in Israel and the Netherlands; migrant workers in Kazakhstan; undocumented children who have never been in the asylum process in Sweden and trafficked women in Denmark and Israel. In Belarus, foreign citizens and stateless persons can be subjected to compulsory medical examination if they are suspected of having a 'dangerous disease'. Finland reported that it was using the same criteria for HIV treatment among refugees and asylum seekers as among citizens. The Swedish civil society respondent[i] commented that migrants face particular problems in accessing HIV services outside the main urban centres.

Rates of late diagnosis are higher among migrants from high-prevalence countries than among non-migrants in some countries

Eleven countries reported rates of late diagnosis disaggregated for migrants from high-prevalence countries. In five countries the numbers were very small (<10). Data for the other six countries are shown in Figure 9. In four of these countries (Belgium, Finland, Germany and Spain), rates of late diagnosis were higher among migrants from countries with high HIV prevalence than among non-migrants. This was not the case in Denmark or Kazakhstan. A number of other countries commented that late diagnosis was a particular issue among migrants from high-prevalence countries. These included Austria, Belgium, Germany, Italy, the Netherlands and the UK (see Box 2).

Figure 9. Percentage of people already needing antiretroviral therapy at time of HIV diagnosis: migrants from high-prevalence countries vs non-migrants



[i] The difficulties reported to be faced by migrants in relation to accessing antiretroviral therapy in Sweden were reported by the civil society respondent. In commenting on these points, the government respondent stated that 'It should be clearly stated what has been reported from the civil society and the government respectively. The Swedish government reported that migrants face *no major barriers accessing HIV prevention, treatment and care services.* From government NCPI*:*

No major barriers. The National Strategy states that people seeking asylum or newly arrived due to family reunion immigration are to be offered a health examination, including VCT, within two months of arrival. The National Strategy emphasizes the systematic health examination as a tool to access prevention, testing, treatment and support. The Health and Medical Service for Asylum Seekers and Some Others Act (SFS 2008:344)11 states that county councils are to offer a health examination to individuals newly arrived in Sweden who are covered by this law. All people living in Sweden diagnosed with HIV have equal access to ART, except undocumented migrants. However, in practice all patients in need of HIV treatment are offered treatment regardless of migration status. A governmental inquiry (SOU 2011:48) proposed in May 2011 that all undocumented migrants in Sweden should get access to subsidized health care on the same terms as Swedish citizens. However, the government also reports the problem that not all asylum seekers and other migrants are reached with an offer of health examination and SRHR information at the time of arrival in Sweden. There is ongoing work to improve this situation.'

Box 2. Late presentation for HIV diagnosis and care: country examples related to migrants

In Austria, a distinction is made between late (CD4 <350) and advanced diagnosis (CD4 <200). Among 3 061 new HIV infections diagnosed from 2001 to 2010, 50.2% were classified as late and 30.0% as advanced. Increased risk of late and advanced diagnosis was found among those infected heterosexually and among those originating from high-prevalence countries. No change in the rate of late or advanced diagnosis was reported over time.

In Germany[1], data from the national surveillance database for 2001 to 2010 showed that almost half (49.5%) of 22 925 eligible patients were found to have a CD4 count <350 cells/mJ at the time of diagnosis. From 1999 to 2010, more than half (58.1%) of 6 897 treatment-naive patients in the ClinSurv cohort study were found to have a CD4 count <350 cells/mJ at the time of diagnosis. Late presentation was associated with older age (median 42 vs 39 years for early presenters) and was more likely among migrants and heterosexuals than among men who have sex with men. The probability of late presentation among men who have sex with men declined from 1999 to 2010. However, the authors conclude that, in Germany, the numbers of late presenters for HIV diagnosis and care remain high. The probability of late presentation for HIV diagnosis seems to be particularly high for migrants. Late presentation for care seems to be an additional problem after HIV diagnosis.

[1] Zoufaly A, An der Heiden M, Marcus U, Hoffmann C, Stellbrink HJ, Voss L, Van Lunzen J, Hamouda O and the ClinSurv Study Group (2012). Late Presentation for HIV Diagnosis and Care in Germany HIV Medicine 13, 172-181.

Countries are implementing a wide range of other HIV-related programmes for migrants

Programmes provide a wide range of other services, including:

HIV prevention education and provision of information materials, e.g. in France, Finland, Luxembourg, the Netherlands, Spain and Switzerland. In France, there is a special programme providing translation by telephone in health facilities for infectious diseases. In Luxembourg, HIV-related information is available in prisons and places where asylum seekers live through mobile units to promote sexual health. In the Netherlands, kitchen tea parties are used to provide HIV/STI education at baby shower meetings of African migrants. Uma Tori is a group education method on sexuality and safe sex for Surinam and Antillean women. In Spain, there is a programme for Latin American people, which offers materials, with messages about condoms and the role of alcohol in reducing risk perceptions of sex, in bathrooms of bars frequented by this group. In Switzerland, there is a 'prevention among migrants' project designed to facilitate access to prevention for all migrants regardless of their origin or residence status. The civil society respondent in Portugal expressed the need for urgent efforts to reach migrants through outreach interventions.

Promotion of sexual and reproductive health, e.g. in Portugal and Sweden. In Portugal, this includes work through sexual and reproductive health for ethnic minorities. In Sweden, RFSU[i] provides information on sexual and reproductive health and rights in Swedish classes for immigrants.

Use of the internet for HIV prevention, e.g. in the Netherlands where existing internet communities of migrant youth have been utilised for education on sexual health, STI and HIV.

Services provided through peers, e.g. in France, Ireland, Germany, the Netherlands, Spain and Switzerland. In France, there is a longstanding programme of mediation/facilitators and a 'big sisters' programme through which HIV-positive African women provide support to each other. In Ireland, the Dublin AIDS Alliance has a volunteer programme for ethnic minorities through which volunteers provide sexual health information in their own communities. In the Netherlands, Sense provides education on STI, HIV and sexual/reproductive health to asylum seekers through peer educators. In Spain, members of migrant communities serve as health agents and provide health messages. In addition, some programmes have cultural mediators who know the language and cultural codes of a particular group. These cultural mediators take part in HIV prevention workshops, e.g. for people from sub-Saharan Africa.

Services in a range of different languages, e.g. in Germany and Italy.

Condom distribution, e.g. in Belgium and Ireland. In Ireland, 89% of service users of the Dublin AIDS Alliance are migrants.

[i] Swedish Association for Sexuality Education http://www.rfsu.se/

Counselling services, e.g. in Italy and Sweden. In Italy, the AIDS and STI helpline of the Istituto Superiore di Sanità provides services in Italian, English, French and Portuguese. More than a quarter of those using the services of the helpline from 1995 to 2011 were from Africa.

Training of health professionals, e.g. in Belgium and Finland.

Activities to tackle stigma and discrimination, e.g. in Belgium and Portugal. In Portugal, the national labour platform against AIDS was founded in 2004. This platform was created to decrease discrimination and support equity among men and women, including migrants.

Community and individual empowerment, e.g. in Belgium, Portugal and Sweden. In Portugal, there is a programme entitled Project of Community Intervention among Migrants in Amadora Region (AJPAS). In Sweden, the Somali health team works on HIV within the Somali community, through meetings to discuss health issues.

Providing legal services, e.g. in English in Italy.

Promoting civil and human rights, e.g. in Finland, Germany and Sweden. The civil society respondent from Sweden commented that there is a need to reach migrants from high-prevalence countries in a more effective manner and to do more work with the rights of migrants and other minority groups.

Advocacy activities, e.g. in Belgium and Germany.

Promoting access to HIV prevention, care and treatment, e.g. in Germany.

Support services for people from migrant communities living with HIV, e.g. in Finland, Germany, Iceland, Israel, Luxembourg and Portugal. In Germany, Deutsche AIDS Hilfe supports a national network of immigrants living with HIV – AfroLebenPlus. In Iceland, there is a societal bonding programme for HIV-positive migrants according to language. In Israel, the Ministry of Health has a special team of HIV coordinators for the Ethiopian community. They assist HIV-positive Ethiopian patients from the time of diagnosis throughout their course of treatment, acting as a culturally-sensitised bridge between the Ethiopian community and the medical and social/welfare establishments. In Portugal, the Living with HIV/AIDS project offers care at home, treatment, psychological support, rehabilitation and legal support for migrants living with HIV and their families. The project also seeks to support migrants affected by HIV to be socially integrated. Key features of this project are that it links clinical and care services, and has been developed with the active involvement of migrant communities.

Through migrant/immigrant NGOs, e.g. in France and Sweden. In Sweden, around ten national immigrant NGOs receive funding from the national HIV grant directed to HIV prevention activities. There are other similar arrangements at local level.

Some countries have documented their experience of working with migrants

In addition, some countries have documented their experience of working with migrants on issues of health and HIV (see Box 3).

Box 3. Examples of documentary evidence of countries' work with migrants on health and HIV

Finland recently produced comprehensive, updated national guidance on best practice for initial voluntary health examination for refugees and asylum seekers. The objective of the examination is to identify all possible health problems in order to offer the best available treatment and care to the person. This treatment and care is provided free of charge as long as the person maintains his/her refugee/asylum seeker status. The aim of such treatment and care is to provide the individual with the same opportunity for a healthy life as for any other resident of the country.

In Germany, Deutsche AIDS Hilfe produced the PaKoMi handbook which is focused on HIV prevention among migrants.

In the Netherlands, the Municipal Health Service in Amsterdam has produced a manual for community-based work on HIV, STI and sexual health in migrant communities, including a manual for the training of religious leaders.

In the UK, the National African HIV Prevention Programme resulted in the development of a strategic prevention framework for African communities in England. This is called 'The Knowledge, the Will and the Power.'

Some countries have conducted research on issues relating to HIV and migrants

Some countries reported research in this field. For example:

- In Finland, there is an ongoing study of migrant health and wellbeing (Maamu). The Maamu study is gathering information on 3 000 adults of Russian, Somali and Kurdish origin, in six cities of Finland. Its objective is to produce information on health and wellbeing, work ability and need for services, as well as the factors that influence them. Information from the study will be used to promote the health and wellbeing of ethnic minorities, improve the quality of services for migrants and their access to services, and promote the labour market potential of people of migrant origin.
- In Germany, the PaKoMi project of Deutsche AIDS Hilfe included participatory research with immigrant communities in four cities. This work led to the development of HIV prevention services for different migrant groups
- In Italy, there is a longstanding body called the Italian National Focal Point – Infectious Diseases and Migrant[i] which is formed from experts from public institutions and non-governmental organisations from different regions of Italy. The group's focus is on studying the phenomenon of migrant flows associated with the health needs of foreign populations.

Some countries provide particular services for specific key sub-populations within migrant communities

Box 4. Examples of HIV programmes for key sub-populations within migrant communities

In Azerbaijan, harm reduction programmes, in part supported by the Global Fund, provide migrants with information materials, health products, legal consultations, medical aid and psychological support.

In Bulgaria, services provided under the national programme include NGO outreach services among migrant sex workers. Such services are also available for people who inject drugs, men who have sex with men and the Roma community. HIV testing and counselling are also available through a network of 19 fixed centres, 12 mobile medical units, and five low-threshold centres for people who inject drugs. In addition, services are provided in prisons including for migrants.

In Finland, Pro Centre Finland has low-threshold health and social services for sex workers, of whom approximately 80% are migrants. In addition, the Saphaan project works among sex workers in Thai massage parlours.

In Germany, the model project 'Health Promotion and HIV Prevention for People from Eastern Europe' (GEMO) developed and tested methods to improve access to HIV services for migrants. This project was funded by the Federal Ministry of Health and was implemented by Red Cross, AIDS-Help Freiburg and the Catholic University of Fribourg.

In Greece, KEELPNO mobile medical units provide services to marginalised groups including migrants, people who inject drugs and sex workers. In addition, KEELPNO teams conduct street-based outreach work among these groups. Services include provision of condoms and information materials in a range of languages. Five mobile medical units provide a range of services including general health checks, vaccinations and HIV testing. The medical units are staffed by health professionals and cultural mediators. These services are not only provided in Athens and Piraeus but also in the borders of Evros.

In Malta, NGOs provide HIV prevention programmes for migrants in immigration detention facilities. Groups of doctors regularly visit these centres to provide services.

In Moldova, the Soros Foundation implements a harm reduction programme which aims to reduce the negative medical, social and economic effects of injecting drug use and unprotected sex practices. Vulnerable groups targeted by these activities include people who inject drugs, sex workers, men who have sex with men and migrants.

In some cases, these programmes were explicitly focused on key sub-populations at increased risk of HIV infection, such as sex workers. In others, they were targeted at migrants from a particular region, e.g. Eastern Europe, among which members of key sub-populations are represented.

[i] Please see http://www.iss.it/urcf/emer/cont.php?id=16&lang=1&tipo=11

Some countries provide particular services for labour migrants and ethnic minorities

Box 5. Examples of HIV programmes for labour migrants

Armenia and neighbouring southern Caucasus countries are participating in a programme of cross-border cooperation on HIV prevention among labour migrants. This includes various channels for communicating about HIV and building the capacity of providers of HIV testing and counselling services. In addition, there is a programme to reduce the risk of HIV, STIs and tuberculosis in rural communities in five regions of the country. This programme includes increasing access to preventive and clinical services and condoms for migrants and their families through mobile medical teams.

In Azerbaijan, there are a number of HIV prevention programmes focused on migrant workers. These include a programme focused on those arriving from other countries and another focused on internal migrants from among internally-displaced immigrants. The Azerbaijani Youth Organization of Russia (AMOR) provides educational activities for students and the diaspora as a whole. Activities focus on promoting a healthy lifestyle and raising HIV awareness among young people.

In Georgia, a number of donor-funded projects, e.g. through World Vision, provide HIV-related services to labour migrants in particular regions. However, the national response to HIV in Georgia is more focused on other key populations, such as people living with HIV, people who inject drugs, sex workers and men who have sex with men. In addition, Georgia is part of a multi-country World Vision project which is focused on reducing the vulnerability of migrants to HIV and STIs, and strengthening human rights. Other countries involved in this project are Armenia and Azerbaijan.

In Kyrgyzstan, three organisations, Danish Church Aid, Dutch Inter Church Cooperation for Development Organisation and Christian Aid, have been supporting a project to improve the access of migrant workers to basic services.

In Tajikistan, migrant-friendly clinics have been established for migrant workers and their families

Box 6. Examples of HIV programmes for ethnic minorities in two countries

In Bulgaria, HIV testing and counselling are available through a network of different centres including eight Roma health centres.

In Montenegro, it is reported that 4% of the population are refugees or displaced persons, mainly from Kosovo, Bosnia and Herzegovina and Croatia. A significant number of these are of Roma, Ashkali or Egyptian (RAE) ethnicity. The Montenegrin Association against AIDS (CAZAS) provides HIV prevention services to young RAE through 30 young RAE peer educators.

Some counties provided examples of ways in which they involve migrants in programmes which affect them

A number of countries provided information about the ways in which migrant communities are involved in programmes and activities which include them (see Box 7)[i]. These ways include:

- involving members of migrant communities in programmes as peer educators, health agents and cultural mediators, e.g. in Israel, Montenegro, Spain and Switzerland;
- involving community representatives in structures and processes involved in delivering the national response to HIV, e.g. in Armenia, Belgium, France, Germany, the Netherlands and Sweden;
- working with and funding NGOs and networks working with and formed from migrant communities, e.g. in Germany, Portugal and the UK.

[i] Some activities had previously been reported to the Dublin reporting process in 2010 and are not repeated here, e.g. in Bulgaria.

Box 7. Examples of ways in which countries involve migrant populations in HIV programmes which affect them

In Armenia, it is reported that labour migrants and their families are involved in programme design, implementation and evaluation. This involves planning key activities, giving insight on problems and obstacles faced by labour migrants, and taking on some roles in programme implementation.

In Belgium, strategies, situation analyses and logical frameworks are defined in participatory workshops with professionals and communities.

In France, migrant NGOs are involved in committees and working groups. They were also involved in the preparation of the fifth HIV plan of action.

Although in Germany, the involvement of representatives from migrant communities has been relatively low, progress has been made in recent years through:

- involvement of individual representatives from African communities in developing local, community-based responses
- involving representatives from migrant communities in the PaKoMi project to develop local responses and to improve participation and cooperation in HIV prevention nationally
- establishing a national network of African community representatives engaged in HIV prevention – the first meeting is planned for September 2012
- community participation in various HIV and health programmes

In Greece, there has been some cooperation between KEELPNO and migrant communities, particularly over the last year. However, this is mostly focused on providing information, e.g. in a variety of different languages.

In Israel, HIV coordinators for HIV health education and prevention among the Ethiopian community help to plan and update the HIV prevention programme conducted by the Ministry of Health.

In Montenegro, NGOs have created a network of HIV peer educators among the RAE populations.

In the Netherlands, migrant communities are represented on the independent advisory platform STI and Sexual Health. Local migrant communities are involved in developing and implementing HIV prevention activities at local and regional levels.

In Portugal, NGOs that work with migrants participate in the Civil Society Forum and the High Commissariat for Immigration and Intercultural Dialogue. These NGOs were involved in the preparation of the National Programme for HIV Infection.

In Spain, the most useful programmes for migrant populations are reported to be characterised by the participation of the target population in their design and implementation. This includes involving members of the migrant communities in programmes as key informants, health agents and as cultural mediators. The working group of experts on HIV prevention among migrants took part in planning the Multisectoral Strategic Plan against HIV Infection and AIDS. In 2009, this group designed and conducted the campaign 'Let's talk about HIV'. This focused on the migrant population in Spain and was translated into 14 languages.

In Sweden, although an NGO working for immigrants [it's not the NGO that is an immigrant]is represented in the National HIV Council, civil society respondents commented that the involvement of migrant populations was limited.

In Switzerland, HIV prevention projects for migrants are usually based on a peer-to-peer approach using mediators, e.g. the Afrimedia project.

In Tajikistan, migrant workers and other groups were involved in broad discussions of goals, objectives, priorities and activities of the National Programme on HIV/AIDS. An NGO working among migrant workers is represented on the National Coordination Committee.

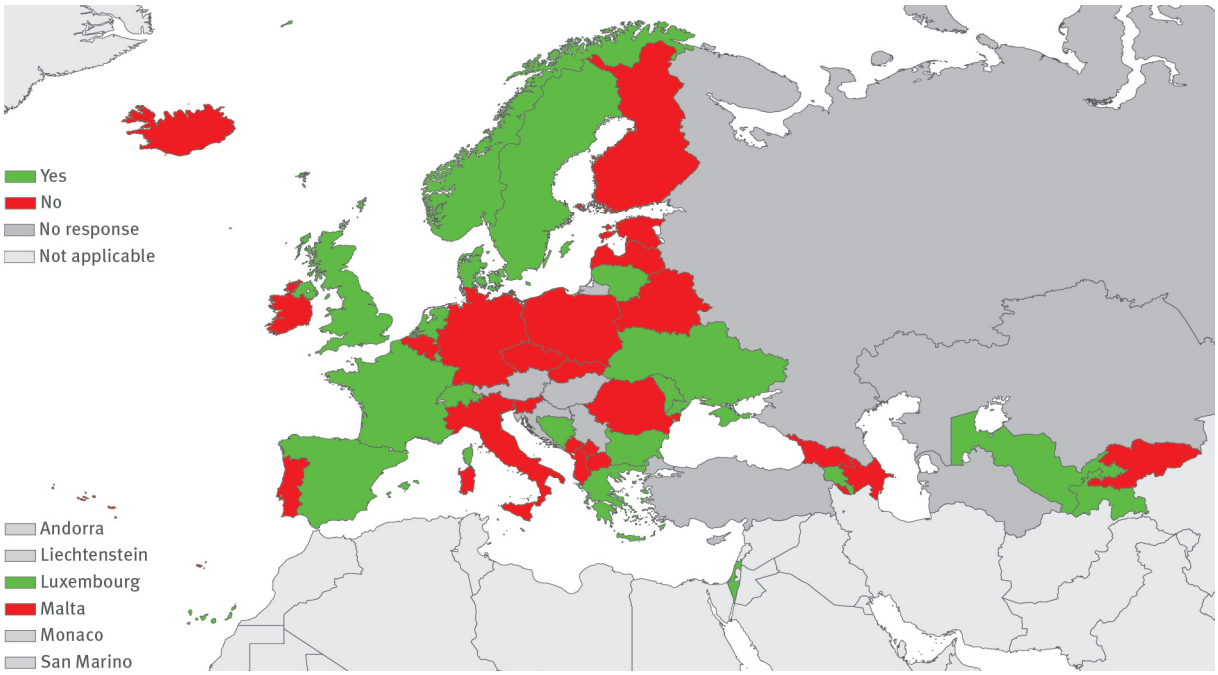
In the UK, the Department of Health and other UK Health departments work with and fund a range of HIV NGOs including those working with black and ethnic minority groups. The national HIV prevention programme for black Africans is coordinated by an African-led organisation, the African Health Policy Network.

Some countries are systematically monitoring their HIV programmes for migrants

Nineteen countries report that they monitor their response to HIV among migrants (see Figure 10). Countries report monitoring responses among migrants in a wide variety of different ways, including through various forms of surveillance. Forms of surveillance include:

- HIV testing/screening among migrant workers, e.g. in Tajikistan
- HIV case reporting with data disaggregation for migrants, e.g. in Slovakia, Spain, Switzerland and the UK
- Periodic bio-behavioural surveillance among key populations, including migrants, e.g. in Armenia, Bulgaria, Ukraine and Uzbekistan.

Figure 10. European and Central Asian countries that report monitoring HIV responses among migrants



In addition, several countries reported conducting special studies or surveys among migrants including in Israel, Moldova, Switzerland and the UK. These included:

- Moldovan Migrant Health: Impact of the Socio-Economic Welfare 2010
- a Swiss study in 2011 entitled 'HIV/AIDS and other sexually transmitted infections among migrant populations: An inventory'
- two studies in the UK – BASSLINE conducted in 2008–2009 and a study of newly-diagnosed HIV among Africans in London (SONHIA) in 2009.

Switzerland reported that there is currently important European research targeting migrants (the aMASE project). Switzerland is planning a migrants survey for 2013 focused on sexual health among sub-Saharan African migrants. Bosnia and Herzegovina reported that it would be carrying out a survey among migrants in 2012 with support from the International Organization for Migration (IOM) and the Global Fund.

Other sources of monitoring data reported included:

- routine data, e.g. from the State Agency for Refugees in Bulgaria
- national HIV, AIDS or HIV care registers in Bulgaria, the Netherlands and Spain
- data from clinical services including HIV testing services in Bulgaria, Lithuania and the Netherlands; STI clinics in the Netherlands and Spain; mobile medical units in Greece; public hospitals in Spain; and ART services in Bulgaria
- NGO programme data in Bulgaria
- project data in Moldova
- NGO evaluations in Denmark.

Bulgaria reported that it had taken steps to strengthen monitoring of HIV services for migrants including improving surveillance as recommended by ECDC; conducting a situation analysis of migrants' needs; developing indicators for work with migrants; and monitoring both the National Programme for Integration of Refugees and the National Demographic Strategy.

Several countries reported on the type of indicators they use for tracking HIV responses among migrants. Several countries, e.g. Bulgaria, France, Luxembourg, Spain and the UK, report that they track numbers of newly-registered HIV infections among migrant populations. Spain also tracks the prevalence of HIV among migrants attending STI clinics. Bulgaria and Luxembourg track the number of migrants living with HIV that receive clinical follow up and/or antiretroviral therapy.

Several countries, including France, Luxembourg, Spain and the UK also report that they track rates of late diagnosis among migrants with HIV.

Other indicators that countries track include:

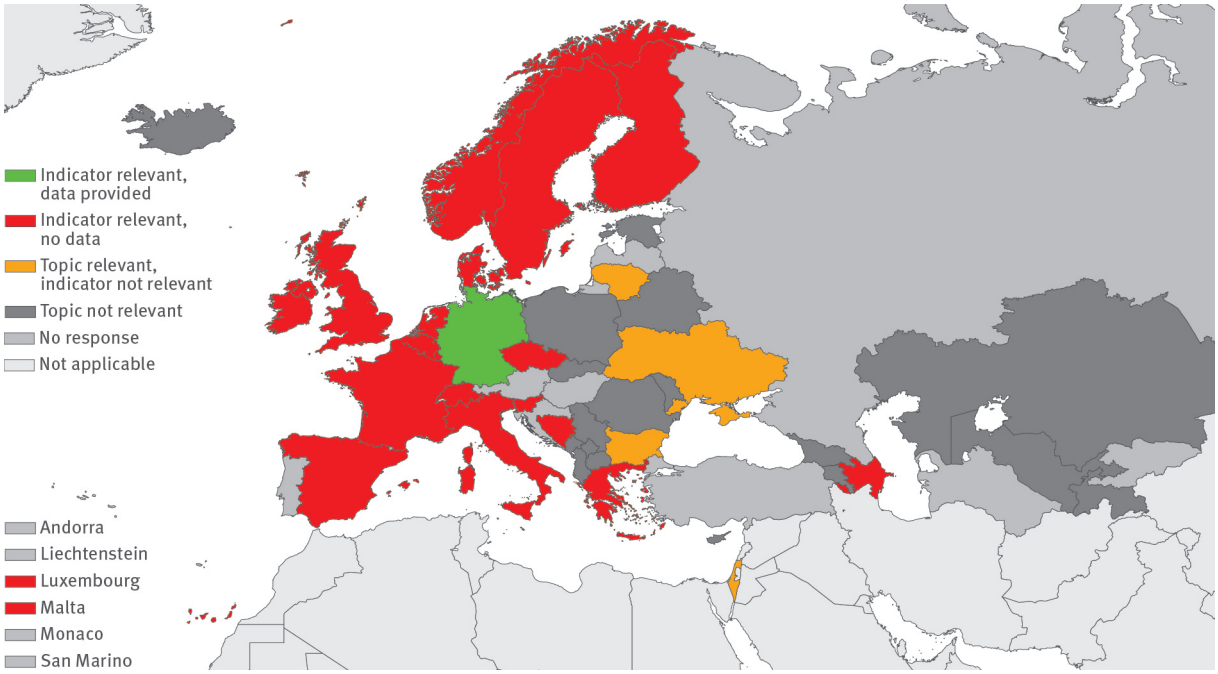
- number and percentage of sex workers in Bulgaria who have worked or plan to work abroad
- number and percentage of MSM in Bulgaria who have been abroad
- a range of modified Global AIDS Response Progress indicators among labour migrants in Armenia and Moldova
- correct and consistent condom use in the Netherlands
- prevalence of syphilis in Bulgaria and Tajikistan.

Since the 2010 Dublin progress report, ECDC and the Dublin advisory group have been working to develop harmonised indicators for tracking HIV responses among migrants across the region. This has not been easy, partly due to the very wide variation in understanding of the term 'migrant' in different countries of the region. Nevertheless, several indicators were identified and these were included in the indicator set that countries were invited to report on to UNAIDS during this round of Global AIDS Response Progress reporting. The indicators were:

- percentage of migrants who were HIV-infected
- percentage of migrants from high-prevalence countries that have received an HIV test in the last 12 months and know the results
- percentage of migrants from high-prevalence countries who report the use of a condom during their last high-risk sexual intercourse
- percentage of migrants diagnosed with HIV infection with a CD4 count <350 at time of diagnosis.

Overall, availability of data for these indicators was very limited (see Figures 3, 5 and 11). Figure 11 shows country reports related to the indicator on use of condom at the last high-risk sexual intercourse by migrants from countries with generalised HIV epidemics. Thirteen countries (light grey) did not respond to this indicator. Eighteen countries (black) reported that the topic was not relevant to them. Four countries (dark grey) reported that the topic was relevant but the indicator was not. Nineteen countries (red) commented that although both the topic and indicator were relevant to them, they had no data. Overall, there was a good match between the countries which reported that this indicator was relevant to them and those countries that considered migrants to be particularly affected by HIV in their country (see Figure 2). Only one country, Germany (green) was able to report data on this indicator. In a 2010 survey in Bremen of 236 migrants from West Africa, 62% of men and 32% of women reported condom use at their last high-risk sexual encounter.

Figure 11. European and Central Asian countries reporting on condom use at the last high-risk sex among migrants



Overall, the amount of data provided when countries are asked to report to standardised indicators is lower than when more open questions are asked. One argument for standard indicators is that they aid data comparison. However, it is unclear if this is possible, e.g. for the countries reporting HIV prevalence, because of differences in sampling method and sample size. It is unclear if the same definitions of migrants were used in each country.

Migrants face a number of barriers and obstacles in receiving HIV-related services in countries

The barriers and obstacles related to delivering HIV-related services to migrants are similar to those documented in the 2010 Dublin progress report. These include:

- language barriers (12 government respondents; 14 civil society)
- cultural differences and taboos (nine government respondents; eight civil society)
- lack of information about health services and rights of access (11 government respondents; 11 civil society)
- fear, including fear of deportation (six government respondents; seven civil society)
- various forms of stigma and discrimination (three government respondents; five civil society). According to the civil society respondent from Spain, 70% of migrants responding to a survey reported that they face difficulties in accessing 'sanitary assistance' because of fear of being arrested or discriminated against.

A few countries commented on specific issues related to migrants from specific key sub-populations. For example, people who inject drugs coming from countries of the former Soviet Union find it difficult to access services in Israel. In Portugal migrant sex workers face fear of deportation. In Finland, civil society commented that it had become more difficult to reach foreign sex workers with services because of intensified activities of the police who were reported to be using possession of condoms as proof of selling sexual services. In the Netherlands, civil society commented that there were cultural taboos about homosexuality in some migrant communities.

Civil society respondents highlighted a number of barriers and obstacles which were less frequently reported by government respondents. These included:

- lack of education (4);
- poverty and lack of money (3);
- isolation (2);
- racism and xenophobia (2);
- lack of trust in services (1);
- need to focus on other priorities such as obtaining legal documents, housing and food (1);
- lack of migrant-friendly services (1); and
- oversaturation of HIV messages in some countries of origin.

In Spain, reluctance to use HIV services was considered to be contributing to 'migrant invisibility'.

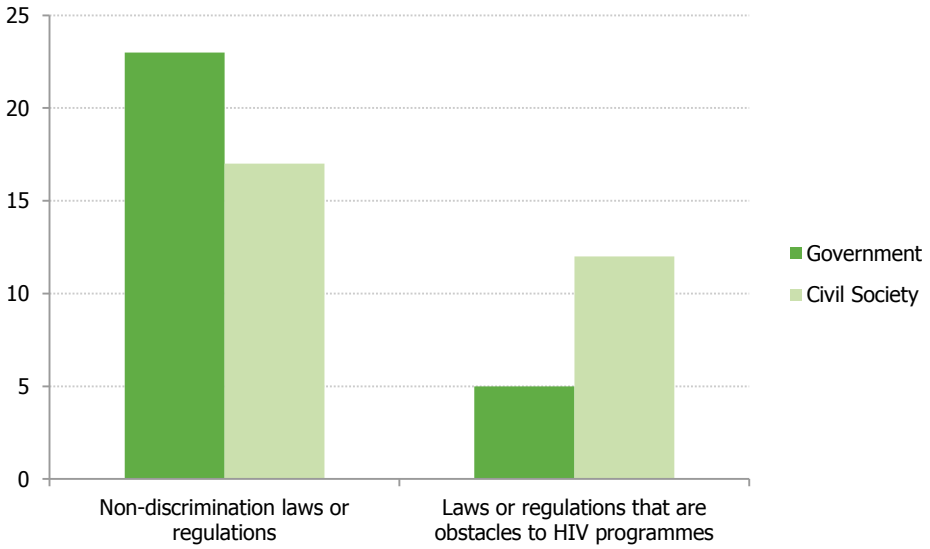
Five government respondents and 12 civil society respondents reported that their country has laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support for migrants/mobile populations (see Figure 12). In many cases, e.g. the Czech Republic, Finland, Greece, Kyrgyzstan, the Netherlands, Serbia, Slovakia, Spain, Sweden and the UK[i], these laws relate to categories of migrants eligible to receive health services, in general, and ART, in particular.

Twenty-three government respondents and 17 civil society respondents reported that their country has non-discrimination laws or regulations which specify protection for migrants/mobile populations (see Figure 12). In general, most countries report that their laws and policies are based on the principle of providing services equitably to all in need of them. In some cases, service provision extends to all migrants regardless of status. For example, three Spanish regions are reported to have introduced solidarity cards which allow undocumented migrants to access health services. Other countries reporting positive legal developments/changes since 2010 included:

- Sweden – in May 2011, a governmental inquiry proposed that all undocumented migrants should have access to subsidised healthcare on the same terms as Swedish citizens.
- The United Kingdom – from October 2012, the practice of charging people with no 'leave to remain' for HIV treatment will be stopped.
- Moldova reported that, in 2010, the expulsion of people living with HIV was made unlawful.

However, some countries reported negative legal changes since 2010. For example, France commented that a change to immigration regulations in June 2011, which imposed more difficult conditions, increased the fear of undocumented migrants going to healthcare facilities.

Figure 12. Countries reporting the existence of non-discrimination laws or regulations which specify protections for migrants



Box 8 documents a number of civil society perspectives on the legal and policy barriers facing migrants in relation to receiving HIV services.

[i] The United Kingdom also reported that from October 2012, the practice of charging people with no 'leave to remain' for HIV treatment will be stopped.

Box 8. Examples of legal and policy barriers affecting migrants seeking HIV-related services: reports from civil society

In Belgium, it is reported that there is a difference between theory and practice, even for documented migrants who may experience an interruption in services if they move city or change job.

In Germany, concern was expressed over the 'duty to denounce' which requires public officials to report undocumented migrants. This requirement was considered to deter such migrants from seeking healthcare services. Both civil society and government respondents commented on 'residenzpflicht' which limits rights to treatment and care to one geographical location.

In Italy, it was reported that people from newer EU countries can only access services if they have a job or private health insurance.

In Spain, it was reported to be difficult to access a public health sanitary card. It was also claimed that some migrants in detention centres are being tested for HIV without being provided with the results.

In Switzerland, it was reported that stricter immigration policies have resulted in a situation where people with HIV can be more easily deported.

In the UK, concerns were raised about the lack of HIV care in centres for asylum seekers and the continued deportation of failed asylum seekers with HIV to countries where it was considered they would not receive the treatment they need.

Conclusions

Overall, it is clear that migration is an important issue for HIV programming in Europe and Central Asia. Many countries, particularly those in the EU/EFTA, reported evidence that migrants are particularly affected by HIV in their countries. As in the 2010 Dublin progress report, strong evidence is presented from many countries that migrants from countries with generalised HIV epidemics are particularly affected by HIV. There is evidence from some countries that migrants may be disproportionately represented among some key affected populations, such as sex workers and people who inject drugs. Evidence that labour migrants are particularly affected by HIV is very limited.

Very few countries have data available on HIV prevalence among specific migrant populations.

Many countries, particularly in the EU/EFTA, regard migrants as an important sub-population for their national response to HIV. Countries have many examples of different types of HIV programmes and services for migrants. However, very few countries have data available on the coverage of such services, for example, the rates of HIV testing among migrant populations. Less than half (44%) of the civil society respondents replying considered that the majority of migrants from high-prevalence countries had access to HIV risk reduction services in the host country.

Almost all countries provide antiretroviral therapy to migrants generally who require this treatment. But, this is not the case for undocumented migrants in many countries. Less than half (47%) of government respondents and only just over one third (38%) of civil society respondents reported that ART is available for undocumented migrants in their country. The main issue relates to financing the treatment for this group of migrants. In many countries, undocumented migrants are not eligible to receive free ART. This may be because they lack health insurance, because they are ineligible for social security services, because they are not a citizen of the host country or because they are not able to register with HIV clinical services.

There is evidence from a number of countries of higher rates of late HIV diagnosis among migrant populations.

Countries provided examples of a wide range of services for different types of migrants. There are a number of good examples of active involvement of migrant communities in these programmes. However, although the number of countries that report they are systematically monitoring the delivery of HIV programmes for migrants, the availability of data remains very limited. This is particularly true for the standard indicators for which data were requested in this round of reporting.

Countries are aware that migrants face a number of obstacles and difficulties in seeking to access HIV programmes and services. These include language barriers, cultural differences, lack of information, fear, stigma and discrimination. In some cases, there are policy or legal barriers to migrants receiving HIV services.

In 2010, the ECDC report on monitoring the implementation of the Dublin Declaration identified a number of key issues needing further action. Progress on addressing these is summarised here:

Issue identified as needing further action in previous report	Progress Shading indicates amount of progress since last reporting round; ranked from limited to good.	Comment
There is a need for selected standard definitions of categories of migrants in relation to HIV in Europe. There is a strong argument for one of these categories to be someone born in a country with a generalised HIV epidemic.	Limited progress / **Good progress**	Overall, there has been little progress in coming up with standard definitions of categories of migrants, although there has been growing consensus among EU countries about focusing on those born in a country with a generalised HIV epidemic. However, this definition and focus is not that relevant for countries in the eastern part of the region who have little inward migration from such countries and are more focused on their own citizens who are labour migrants.
There is a need for EU/EFTA countries to develop and expand programmes for migrants from countries with generalised HIV epidemics. There is also need to develop ways of monitoring whether these programmes are being delivered at sufficient scale.	Limited progress / **Good progress**	There is significant anecdotal evidence of existing programmes being maintained and new programmes being developed. However, there are currently no agreed methods for tracking the scale of these programmes.
There is a need to ensure that programmes focused on other key populations, for example, sex workers, MSM and IDU, provide equitable access to services, including to those born in other countries or having a particular nationality or ethnicity, regardless of legal status.	Limited progress / **Good progress**	In this reporting round, a number of countries included elements of their reporting on activities focused on key sub-populations within the migrant community. However, the scale and extent of these are not clear.
There is a need to develop a standard set of HIV indicators for inclusion in a regional European monitoring and evaluation system	Limited progress / **Good progress**	ECDC has made significant strides in this area by identifying possible indicators and negotiating with UNAIDS for their inclusion in the Global AIDS Response Progress Reporting set. This was the first time that this process was regionalised in this way. It is encouraging that these indicators were seen as relevant by almost all countries for whom migrants from countries with generalised HIV epidemics are a significant population in terms of the national response to HIV. However, it was disappointing that so few countries have data to report for these indicators.

Issues needing further action:

- There is a need for those countries in Europe and Central Asia who identify migrants as an important sub-population in their national response to HIV to improve the monitoring of key services provided to those migrants disproportionally affected by HIV.
- Countries in Europe and Central Asia need to provide equitable access to prevention and treatment services to all categories of migrants, including undocumented migrants.
- There is a need for countries, especially in the EU/EFTA, to address the high rates of late HIV diagnosis among migrant populations.
- There is a need for countries of Europe and Central Asia to generate more evidence on the HIV prevalence among particular migrant communities.
- There is a need to identify effective measures for coverage of HIV programmes among migrant populations.
- There is a need for countries of Europe and Central Asia to identify ways of overcoming the obstacles and difficulties faced by some migrant communities in accessing some HIV services, particularly HIV diagnosis and treatment. Ensuring ways of financing such services will be a key element of this.

Annex 1. Countries included in Dublin Declaration monitoring

Nr	Country	Nr	Country	Nr	Country
1	Albania	20	Greece	39	Poland
2	Andorra	21	Hungary	40	Portugal
3	Armenia	22	Iceland	41	Romania
4	Austria	23	Ireland	42	Russia Federation
5	Azerbaijan	24	Israel	43	San Marino
6	Belarus	25	Italy	44	Serbia
7	Belgium	26	Kazakhstan	45	Slovak Republic
8	Bosnia and Herzegovina	27	Kosovo	46	Slovenia
9	Bulgaria	28	Kyrgyzstan	47	Spain
10	Croatia	29	Latvia	48	Sweden
11	Cyprus	30	Liechtenstein	49	Switzerland
12	Czech Republic	31	Lithuania	50	Tajikistan
13	Denmark	32	Luxembourg	51	Turkey
14	Estonia	33	Malta	52	Turkmenistan
15	Finland	34	Moldova	53	Ukraine
16	the former Yugoslav Republic of Macedonia	35	Monaco	54	United Kingdom
17	France	36	Montenegro	55	Uzbekistan
18	Georgia	37	Netherlands		
19	Germany	38	Norway		

Annex 2. Reported number of migrants in European and Central Asian countries

(These figures are as reported to the Dublin monitoring process. For other figures, please see Eurostat - http://epp.eurostat.ec.europa.eu/portal/page/portal/population/data/database)

	2010 Dublin reporting		2012 Dublin reporting	
Country	**Number**	**Comment**	**Number**	**Comment**
Albania		No data		No data
Andorra		No data		No data
Armenia		No data		No data
Austria		No data		No data
Azerbaijan		No data	53 017	According to the State Migration Service of Azerbaijan, the number of people that applied officially to the State Migration Service in 2011.
Belarus		No data	19 982	According to the National Statistics Committee, the number of people who came to the country as permanent residents. Most migrants were from CIS countries, including Russia, Ukraine, Kazakhstan and Turkmenistan.
Belgium	971 448	Non-Belgians in 2008	1 057 666	This includes all persons of non Belgian nationality residing in Belgium in 2010
Bosnia and Herzegovina		No data		No data
Bulgaria	55 684	2006 figures for foreigners as permanent residents		There are partial data on sub-groups identified by the National HIV/STIs Programme, i.e. official data on refugees, asylum seekers, foreigners with granted stay, work and residence permits. No official data on migrants illegally present in Bulgaria, except for those detained.
Croatia	30 000	2009 figures for immigrants. Also figures for seafarers, construction workers and truck drivers		No data
Cyprus		No data		No data
Czech Republic	438 000	2008 figures. 4% of population. Estimated 50 000–200 000 undocumented migrants	42 4291	Circa 4 % of population of which 189 000 foreigners with permanent residence. Undocumented migrants: 50 000 – 200 000 (estimated).
Denmark	450 000	Estimated 8% of population	542 738	Migrants and descendants living in Denmark in 2010 (newest numbers). This is 9.8% of the population.
Estonia		26% of population were ethnic Russians[i, ii] in 2008		Regarding asylum seekers: 288 people sought asylum in Estonia in 1997–2011 (of those, 67 in 2011). Countries from where more than 10 people have sought asylum in Estonia include: Armenia, Congo, Russia, Iraq, Turkey, Georgia, Belorussia, and Afghanistan (see Citizenship and Migration Board; http://www.politsei.ee/dotAsset/218156.pdf).

[i] Where countries reported percentages only, it would be possible to calculate the absolute number from population statistics. However, as these tables contain only data reported by countries, this has not been done. Similarly, percentages are only given where they have been supplied by countries.

[ii] It should be noted that ethnic Russians are not considered migrants in Estonia. More details of this issue are provided in the previous Dublin report (Box 11.1).

	2010 Dublin reporting		2012 Dublin reporting	
Country	**Number**	**Comment**	**Number**	**Comment**
Finland	143 256	2008 figures[i]	167 954	The number of foreign citizens in Finland was 155 705 (2.9%) in 2009, and 167 954 (3.1%) in 2010. Around 40% of them are from neighbouring countries (Russia, Estonia, Sweden).
The former Yugoslav Republic of Macedonia	1 670	Asylum seekers from Bosnia and Kosovo. Also figures for internally displaced people		No data
France	4 959 000	2005 figures. 8.1% of total population	5 400 000	2009 figures. 8.4% of total population
Georgia		No data		No data
Germany	15 411 000	People with a migrant background live in Germany - total population 82 257 000	15 700 000	According to Federal Office for Statistics 7.2m (based on nationality) or 15.7m (based on migration background) (source: Statistisches Bundesamt 2011)
Greece	563 625	Legal migrants	1 500 000	Source: Ministry of Interior[ii] Official estimates coming from the HCDCP in co-operation with the Ministry of Interior, the Ministry of Citizen Protection and the Immigration Directorate indicate that almost 1.5m migrants (documented and undocumented) lived in Greece by October 2011.
Hungary		No data		No data
Iceland		No data		No data
Ireland	420 000	Foreign nationals		No data
Israel	150 000	Work immigrants - in addition about 35% of the Israeli population was born elsewhere		Detailed data are available for migrants who are documented. Israel being a country of migration - many Israeli citizens are migrants (28% of Jewish population were born abroad). In addition, undocumented migrants and asylum seekers are estimated to be around 200 000
Italy	3 891 295	Out of population of 60 045 068		In 2010, the undocumented migrants intercepted were about 47 000 people (European Migration Network, Italy, 2011). OECD 2009 report estimates the number of uncontrolled migrants in Italy varying between 500 000 and 750 000 people.
Kazakhstan		No data		No data
Kosovo (UNSCR 1244)		No data		No data
Kyrgyzstan		No data		No data
Latvia	33 055	Permanent residents at end 2007[iii]. Also figures for temporary residents and for end 2006		No data
Liechtenstein		No data		No data
Lithuania		No data		According to the State Department of Statistics, the number of foreigners immigrating to Lithuania was 1 700 in 2011. Most immigrants originate from Russia, Belarus, Ukraine and Latvia. Between 1997 and 2012, a total of 7 000 foreigners were accommodated in the Foreigners' Registration Centre (Centre) Pabrade, including 173 to date in 2012. Most of these were from Georgia and Russia.

[i] 2007 – 132 708

[ii] These are estimates from the Ministry of the Interior presented in a meeting in July 2012 and can be found in the website of the Ministry http://www.ypes.gr/el/MediaCenter/Minister/Speeches/?id=d280961b-241b-4f6d-8ab7-84adef3916cd

[iii] Over three quarters of these (78%) are Russian.

	2010 Dublin reporting		2012 Dublin reporting	
Country	**Number**	**Comment**	**Number**	**Comment**
Luxembourg	16 675	2007 figures. Also figures for emigration	2 100	
Malta	3 489	Asylum seekers in open and closed centres	6 000	
Moldova	13 973	Also figures for emigrants, national truck drivers and trafficked women	318 300	The most recent data provided by the National Statistics Department of Moldova (The Study 'Labour migration in Moldova', conducted in 2008), reports 318 300 labour migrants from the Republic of Moldova, i.e. people who in the last 12 months have worked or sought work abroad. Please note that different definitions have been used in the 2010 and 2012 rounds of reporting, hence data are not comparable. The data for 2010 reflect the number of immigrants only. The data in the 2012 round of reporting refer to Moldovan citizens that have worked abroad in the last 12 months, i.e. emigrants.
Monaco		No data		No data
Montenegro		No data		About 4% of the population are refugees or displaced persons. Of the displaced persons, most are from Kosovo, Bosnia and Herzegovina and Croatia. The total number of internally displaced persons was 16 196 at the end of 2006. Almost one fifth (17%) of displaced persons are of Roma, Ashkali or Egyptian (RAE) ethnicity. During the summer season, the number of migrants increases several times.
Netherlands	approx 3 100 000	2007 figures. 1.7m are non-western mainly from Surinam and Dutch Antilles		About 20% of the population are migrants (western and non-western migrants); more information on the website of the Bureau for Statistics (http://statline.cbs.nl/statweb/)
Norway	508 000	Includes immigrants and people with migrant background	460 000	2009. Approximately 460 000 persons who have migrated to the country or born in Norway, but have migrant parents.
Poland	15 300	Increasing inflow of illegal migrants but no data available on numbers		No data
Portugal	approx 500 000	4% of Portuguese population	457 306	In 2010 – 457 306 registered migrants Source: Eurostat (http://epp.eurostat.ec.europa.eu/portal/page/portal/population/data/database)
Romania	133 441	Legally registered migrants		No data
Russia		No data		No data
San Marino		No data		No data
Serbia		No data		No data
Slovakia		No data	67 976	There were a total number of 67 976 foreigners with officially registered residence as of the end of the year 2010.
Slovenia		At the end of 2006, 2.7% of people had the status of foreigners, while 11.3% of the population was born abroad		11.1% of the population living in Slovenia on 1 January 2011 were born in other countries.
Spain		2008 figures - 11.4% of population		12.2% of total population in Spain (Year: 2011). Source: Municipal Register 2011. http://www.ine.es/jaxi/menu.do?type=pcaxis&path=/t20/e245/&file=inebase
Sweden	1 200 000	1.2m of 9m inhabitants born outside Sweden. In addition, 3% of the population have two parents born abroad and 6 % have one parent born abroad.	1 400 000	Sweden has 9.5 million inhabitants and approximately 1.4 million (15%) were born outside of Sweden.

	2010 Dublin reporting		2012 Dublin reporting	
Country	**Number**	**Comment**	**Number**	**Comment**
Switzerland		21% of population does not have Swiss passport	1 500 000	Out of a total population of 8m in Switzerland, more than 1.5m are foreigners. Most of them are from EU countries. We therefore restrict the definition of migrants as a key population to people from high-prevalence countries. The estimation of this population varies between 50 000 and over 100 000.
Tajikistan		No data		According to estimates of the Migration Service and the International Organization for Migration, about 750 000 to 1 million citizens of Tajikistan are labour migrants, i.e. travel to other countries for employment.
Turkey		No data		No data
Turkmenistan		No data		No data
Ukraine	160 000	Permanent residents in Ukraine		Statistical recording of external migration processes is performed. For example, in 2011, the external migration growth rate made 17 096 persons (with the total of 31 674 arriving in, and 14 588 leaving the country); the 2010 increase was at 16 133 persons (33 810 arrived in, and 14 667 left the country).
United Kingdom	577 000	2007 figures	583 000	For the year ending June 2011, estimated net long-term migration to the UK was 250 000. Estimated long-term immigration to the UK was 583 000. Data are published electronically: http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=International+Mig
Uzbekistan		No data		There is evidence in public institutions of legal migrants. Such data are available in the police department and its divisions, the Health Department and its units, management of labour and social security and its units as well as local government.

Annex 3. Evidence that HIV disproportionately affects migrants in Europe and Central Asia

Country	Dublin reporting 2010	Dublin reporting 2012
	Evidence	Evidence
Albania	No data	No data
Andorra	No data	No data
Armenia	No data	No data
Austria	No data	No data
Azerbaijan	No data	As of 1st January 2012, 690 of 3,154 Azeri citizens with HIV were reported to have been infected abroad, particularly in Russia. However, in quoting the same data, the civil society respondent concluded that this did not provide evidence that labour migrants were disproportionately affected by HIV.
Belarus	No data	No data
Belgium	To 2007, of 14804 people diagnosed with HIV with known nationality, 60.1% were non-Belgian. From 2005-7, of 1 350 non-Belgians with reported nationality, 70% were from sub-Saharan Africa.	59.5% of people diagnosed with HIV (to 31.12.10) with known nationality were non-Belgian. Of 1,364 non-Belgians diagnosed between 2008 and 2010, 62.3% were from sub-Saharan Africa
Bosnia and Herzegovina	No data	No data
Bulgaria	No data	No data
Croatia	54% of documented HIV infections occurred abroad	No data
Cyprus	No data	No data
Czech Republic	Foreigners, especially those from Eastern Europe, account for 21% of PLHIV	Foreigners are particularly affected by HIV. 35% of PLHIV in the Czech Republic are immigrants especially from Russia, Ukraine, Moldova and sub Saharan Africa.
Denmark	The rate of HIV infection among immigrants (1 in 400) is higher than ethnic Danes (1 in 1250).	Rates of HIV are higher among some migrant groups than among Danes
Estonia	One third of general population is Russian-speaking yet Russian speakers account for 75% of IDUs. HIV prevalence among IDUs is high (48-60%). Although ethnicity of newly-diagnosed PLHIV is not recorded, 89% of newly-diagnosed PLHIV were counselled in Russian[i].	No data
Finland	In 2007, foreign citizens accounted for 30% of newly-diagnosed PLHIV and, in 2008, this figure was 42%. Foreign citizens accounted for 2.5% of the population in 2007 and 2.6% in 2008.	The percentage of foreign citizens among new HIV diagnoses was 44.1% in 2009 and 44.2% in 2010. Foreign citizens comprised 2.9% of Finland's population in 2009 and 3.1% in 2010.
The former Yugoslav Republic of Macedonia	No data	No data
France	In 2008, 48% of newly-diagnosed PLHIV were born outside France. This percentage was higher for women (75%) than men (35%). The rate of new diagnoses was 6 per 100 000 in the population born in France, 62 per 100 000 in the population born outside France and 372 per 100 000 in the population born in sub-Saharan Africa.	In 2011, 47% of newly diagnosed PLHIV were born outside France (68% for men and 32% for women). Rates of new HIV diagnoses in 2011 in France are 10 times higher in migrants than in non-migrants (respectively 53 per 100 000 and 5 per 100 000).

[i] It should be noted that ethnic Russians are not considered migrants in Estonia. More details of this issue are provided in the previous Dublin report (Box 11.1).

Country	Dublin reporting 2010	Dublin reporting 2012
	Evidence	Evidence
Georgia	No data	No data
Germany	People from high prevalence regions count for 0.3 % of the population but for approximately 13 % of the HIV diagnoses.	A large proportion of heterosexually acquired HIV is diagnosed in migrants from sub-Saharan Africa and to a lesser extent from South East Asia, particularly Thailand. Injecting drug users from Eastern Europe are particularly affected by HIV. Some of these are ethnic German immigrants from the former Soviet Union who migrated to Germany in the 1990s. The majority of sex workers in Germany originate from central and eastern Europe, e.g. Bulgaria, Hungary, Poland, Romania and Ukraine.
Greece	Of 2 118 people infected through heterosexual contact, 35.2% were persons who lived in or originate from countries with a generalised epidemic.	Source: KEELPNO In 2012, non-Greek nationals comprise: 21% of cases of HIV among people who inject drugs reported (an increase from 16% in 2011); 7% of MSM cases; 24% of cases with unknown route of transmission (increase from 15% in 2011); and 50% of cases classified as heterosexual transmission. Of the heterosexual cases, 24% are from countries with a generalised HIV epidemic in 2012 (an increase from 17% in 2007
Hungary	No data	No data
Iceland	No data	Approximately half of all new HIV infections in the last ten years were among migrants.
Ireland	No data	No data
Israel	People originating from 'endemic' countries, particularly Ethiopia, contribute 50% of all people living with HIV/AIDS in Israel.	70% of PLHIV are foreign born; this is true of only 28% of Israeli population overall
Italy	In 2007 the HIV incidence[i] among migrants was 11 times higher than among Italians.	Incidence of HIV in 2010 was five times higher among non-nationals than among Italians
Kazakhstan	No data	No data
Kosovo	No data	No data
Kyrgyzstan	No data	No data
Latvia	No data	No data
Liechtenstein	No data	No data
Lithuania	No data	No data
Luxembourg	In 2008, 21 of 68 newly-diagnosed PLHIV originated from sub-Saharan Africa.	No data
Malta	The majority of new HIV cases are being recorded among migrants from areas of high prevalence for HIV.	Numbers of HIV diagnoses in Maltese persons is still relatively low. Migrants mainly come from countries with high prevalence of HIV so there are a disproportionate number of cases in migrants when compared to Maltese persons.
Moldova	In 2007, the proportion of those leaving the country and having an HIV test that were HIV positive was 0.09%. Of those returning who had an HIV test the proportion positive was 1.4%.	No data
Monaco	No data	No data
Montenegro	No data	No data

[i] Based on HIV case reporting

Country	Dublin reporting 2010	Dublin reporting 2012
	Evidence	Evidence
Netherlands	Women from sub-Saharan Africa (456) constituted 60% of all newly-diagnosed women with HIV in 2008.	HIV prevalence among migrants from sub Saharan Africa is 3.1% as compared to 0.4% among migrants from the Caribbean and 0.02% among the general Dutch population.
Norway	Out of all infections reported in Norway, around one third have migrant backgrounds. In 2008, there were 139 newly-diagnosed cases among people infected prior to arriving in Norway. Of these, 92 were women and 47 were men. 108 of 139 originated in Africa. Of these, most originated from East Africa. Another vulnerable group is Thai women entering Norway through marriage with Norwegian men. This group accounted for 14 new cases in 2008.	No data
Poland	No data	No data
Portugal	No data	The civil society respondent reported that data that is not publicly available shows that 20% of heterosexual transmission of HIV in Portugal is occurring among migrants. Studies carried out in health centres with high concentrations of migrant populations or ethnic minorities have higher rates of HIV among pregnant women (1.4%) than the national average (0.3%)
Romania	No data	No data
Russia	No data	No data
San Marino	No data	No data
Serbia	No data	No data
Slovakia	No data	No data
Slovenia	No data	No data
Spain	For the period 2003-2007, 35% of new HIV diagnoses in 8 autonomous Regions in Spain. There was an increasing trend from 29.4% in 2003 to 36.9% in 2007.	The proportion of new HIV diagnoses in nine Spanish Regions among migrants rose from 31% in 2004 to 36.3% in 2009. However, the civil society respondent argued that sexually transmitted infections experienced by migrants are largely due to poverty and isolation. '*Most of the migrant population were healthy in their origin countries, poor life conditions in their new country favour this and other diseases.*'
Sweden	New diagnoses per year – approximately 120 among migrants and 59 among non-migrants.	Foreign born people are over-represented among people infected with HIV among MSM and heterosexuals
Switzerland	Yes for those originating from Sub-Saharan Africa	Migrants from sub-Saharan Africa have accounted for between 16 and 23% of the newly diagnosed cases of HIV in Switzerland; the main transmission route in this group is via heterosexual contacts. The civil society respondent also commented that migrants are more often diagnosed late; face higher morbidity and mortality; and face other problems related to work situation and discrimination.
Tajikistan	No data	8.9% of HIV infected people are migrant workers although it is stated that most report risk injecting or sexual behaviour
Turkey	No data	No data
Turkmenistan	No data	No data
Ukraine	No data	No data

Country	Dublin reporting 2010	Dublin reporting 2012
	Evidence	Evidence
United Kingdom	Sentinel surveillance among GUM clinic attenders showed HIV prevalence of 2.4% among heterosexuals born in sub-Sahara Africa compared to 0.2% among those born in the UK. Among women giving birth, HIV prevalence was 0.05% for women born in the UK, 0.53% for those born in Central America and the Caribbean and 2.4% among those born in sub-Saharan Africa. In 2007, among IDUs diagnosed with HIV, 61% were from outside the UK, particularly Southern and Eastern Europe.	The Health Protection Agency estimated that in 2010, HIV prevalence among black African men and women in the UK was 47/1000 population (England and Wales). Among men prevalence was 31/1000 population and among women it was 64/1000. HIV prevalence among African-born pregnant women in London was 21/1000 population.
Uzbekistan	No data	No data