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TECHNICAL REPORT

HIV and men who have sex with men

Monitoring implementation of the Dublin Declaration on partnership to fight HIV/AIDS in Europe and Central Asia: 2018 progress report

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This report of the European Centre for Disease Prevention and Control (ECDC) was coordinated by Teymur Noori and Anastasia Pharris.

This report is one in a series of thematic reports based on information submitted by reporting countries in 2018 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: https://ecdc.europa.eu/en/infectious-diseases-public-health/hiv-infection-and-aids/prevention-and-control/monitoring-0.

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Abbreviations

EU/EEA	European Union/European Economic Area
EMIS	European men who have sex with men internet survey
GAM	Global AIDS monitoring
GBMSM	Gay, bisexual and other men who have sex with men
HAV	Hepatitis A virus
HBV	Hepatitis B virus
LGBT	Lesbian, Gay, Bisexual, Transgender
MSM	Men who have sex with men
NGO	Non-governmental organisation
PLHIV	People living with HIV
PrEP	Pre-exposure prophylaxis
STI	Sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS

Executive summary

This report is part of the 2018 progress reports monitoring the implementation of the Dublin Declaration. It presents the situation among men who have sex with men (MSM), a key group affected by HIV in the WHO European Region, and outlines priorities for action. In addition, case studies provided by health authorities highlight developments in public health policy and programme implementation, specific to MSM.

Men who have sex with men have been disproportionately affected by the HIV epidemic since its start in Europe in the 1980s. The burden of HIV on this group has been exacerbated by homophobia and HIV stigmatisation, which hampered the public health response and the availability and accessibility of prevention tools. Today, sex between men remains the main mode of transmission of HIV in Western Europe.

While some countries report a recent decline in HIV incidence among MSM as a result of successful combination prevention efforts, diagnoses have continued to rise in the majority of countries in Europe and Central Asia. In particular, there has been an eight-fold increase (710%) in diagnoses in the East sub-region since 2008.

In the 2018 reporting year, the ECDC survey was used to collect data to monitor implementation of the 2004 Dublin Declaration from the national health authorities in the Region. The survey contained specific questions in relation to the HIV epidemic among men who have sex with men, in addition to questions relating to current national prevention interventions, policies and barriers to the public health response to the epidemic.

Forty-six of the 52 reporting countries prioritise MSM as a key population in their HIV response, with 31 countries selecting MSM as their top priority (17 West; 13 Centre; 1 East). Findings are compared against the global 90-90-90 targets. The report also includes key findings from the European Men who have sex with Men Internet Survey 2017 (EMIS-2017).

The report presents the continuum of HIV care across the region and classifies results according to countries that provided data on: (a) all four stages, (b) no stages, and (c) at least two consecutive stages of the continuum of care nationally as well as disaggregated data, where available, for MSM. Only 19 countries, i.e. less than half of reporting countries, were able to submit two consecutive stages of data for the HIV continuum for MSM. It is hence difficult to gauge what is the real situation for this key population is across Europe and Central Asia.

Based on the findings, priorities for action to address the HIV epidemic among men who have sex with men are outlined in the report.

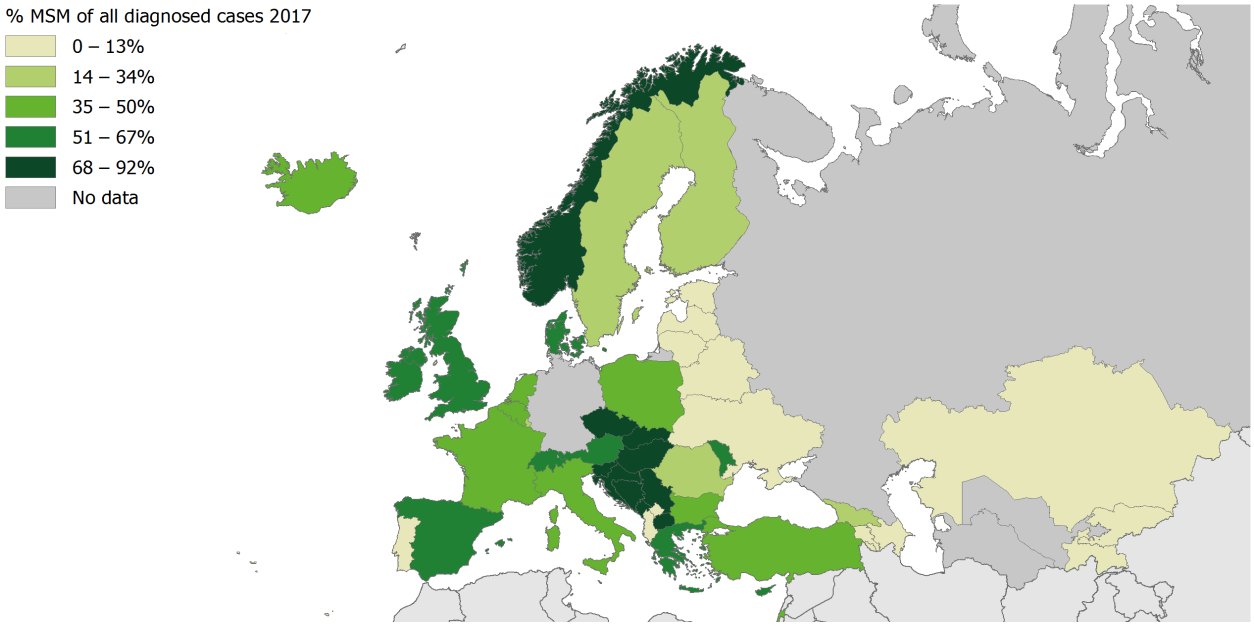
Why focus on men who have sex with men?

Men who have sex with men (MSM) have been disproportionately affected by the HIV epidemic since its start in Europe in the 1980s. The burden of HIV on this group has been exacerbated by homophobia and HIV stigmatisation, which hampered the public health response and the availability and accessibility of prevention tools.

Today, sex between men remains the main mode of transmission of HIV in the West sub-region of Europe and Central Asia. Forty-six of the 52 reporting countries prioritise MSM as a key population in their HIV response, with 31 countries selecting MSM as their top priority (17 West; 13 Centre; 1 East).

In 2017, 31% of all men and 25% of all persons newly diagnosed with HIV in Europe and Central Asia were MSM. In 31 countries, sex between men accounted for more than 35% of all diagnoses in 2017 (Figure 1). The proportion of MSM among all new diagnoses was highest in countries within the West and Centre of Europe and Central Asia, and much lower in the East sub-region. In part this is due to the epidemic being concentrated within people who inject drugs within the East sub-region. It may also be likely that HIV transmission due to sex between men may be poorly reported in the East sub-region due to societal and institutional homophobia preventing MSM from being open about their sexual orientation. This has resulted in an underestimation of the number of MSM living with HIV in the region by official authorities in the East [1].

Figure 1. Percentage of all new HIV diagnoses[1] reported in MSM in Europe and Central Asia, 2017



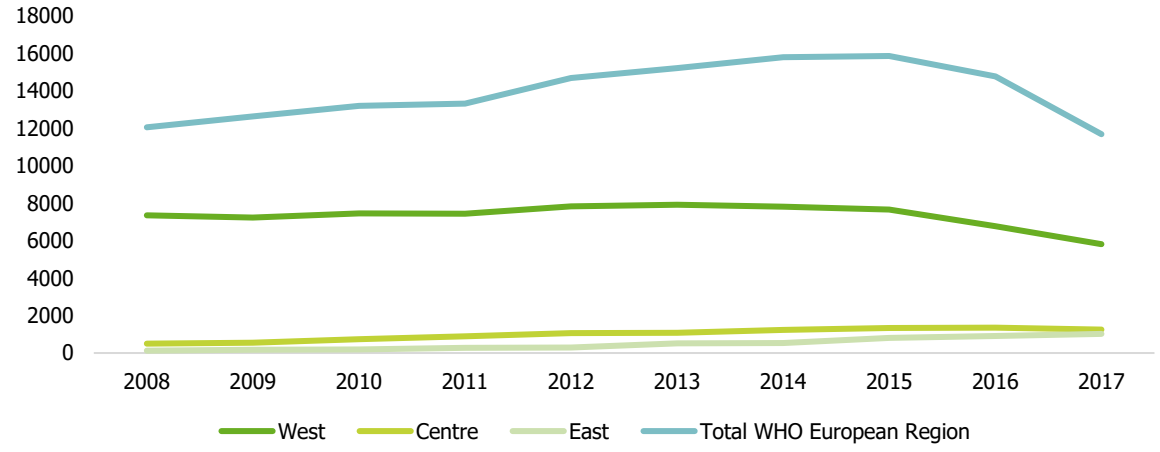
Source: ECDC/WHO (2018). HIV/AIDS Surveillance in Europe 2018 – 2017 data [2]

Trends in new HIV diagnoses

For the first time there has been a clear decline in new HIV diagnoses amongst MSM in the West sub-region. As depicted in Figure 2, there were 7 349 new diagnoses in the West sub-region in 2008 compared with 5 806 reported in 2017 (decrease of 21%).

This can be attributed to the performance of a small number of countries (see Figure 3). Between 2013 and 2015, eight countries – Belgium, Germany, Greece, Luxembourg, the Netherlands, Spain, Switzerland and the United Kingdom – observed a decline in new HIV diagnoses which persisted after adjustments for reporting delay, and in most instances occurred against a backdrop of increased HIV testing. This suggests that the decrease in new diagnoses most likely reflects a true decline in new infections (and therefore transmission of HIV) amongst MSM overall. The observed decline in new diagnoses in these countries is likely due to the successful implementation of prevention and test and treat strategies. This short report sets out the current situation in relation to HIV among MSM and outlines the progress towards replicating this success in different contexts.

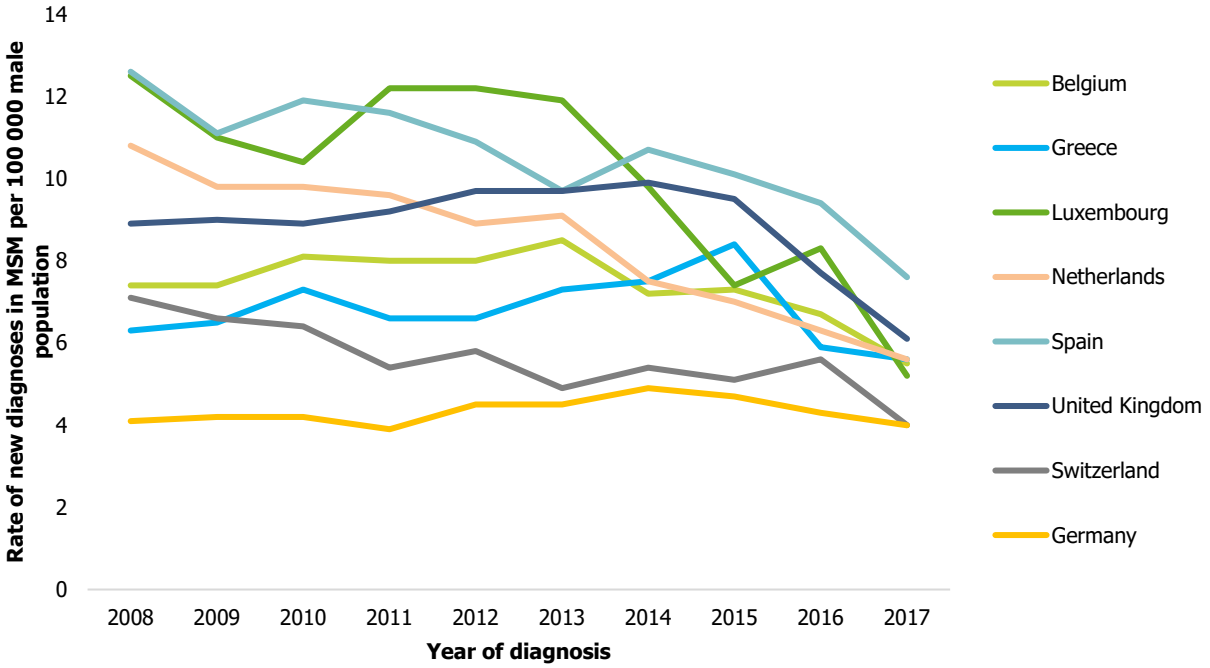
Figure 2. New HIV diagnoses reported in gay and bisexual men overall in Europe and Central Asia and by sub-region, 2008–2017



Source: ECDC/WHO (2018). HIV/AIDS Surveillance in Europe 2018–2017 data [2]

[1] Only includes diagnoses with known mode of transmission.

Figure 3. Countries showing declines in the rates of new HIV diagnosis reported in MSM, 2008–2017



Source: ECDC/WHO (2018). HIV/AIDS Surveillance in Europe 2018–2017 data [2]

The recent success in declining HIV diagnoses is not apparent everywhere across the region. The number of new diagnoses continues to rise amongst MSM in two sub-regions (see Figure 2). In the Centre sub-region, there were 500 diagnoses in 2008 compared with 1 245 in 2017 (an increase of 149%).[2] In the East sub-region, there were 126 new diagnoses in 2008 compared with 1 020 in 2017 (an increase of 710%).[3]

Methodology

Between January and March 2018, a European Centre for Disease Prevention and Control (ECDC) survey was used to collect data to monitor implementation of the 2004 Dublin Declaration.[4] The monitoring questionnaire was disseminated online to the 53 countries in the WHO European Region, plus Kosovo[5] and Liechtenstein.

In the 2018 reporting year, ECDC further harmonised data collection with Joint United Nations Programme on HIV/AIDS (UNAIDS) to improve compatibility and reduce the reporting burden on health authorities. ECDC took the responsibility for collecting a core set of Global AIDS Monitoring (GAM) indicators through Dublin Declaration monitoring for European Union/European Economic Area (EU/EEA) Member States, meaning there was no separate GAM reporting for EU/EEA Member States. Non-EU/EEA Member States continued to report to GAM through UNAIDS and were therefore asked to complete a shortened ECDC Dublin Declaration questionnaire, with any GAM questions removed. The data collected through these processes were then combined and included in the analysis for this report.

National health authorities were requested to complete the Dublin Declaration survey between mid-February and the end of March 2018. In May 2018, the information reported by each country was cleaned up and returned for validation. Subsequent notifications of corrections were used to update the information reported. Validation of data collected through the GAM process was conducted by UNAIDS.

[2] Poland and Turkey were excluded from this calculation due to irregular reporting during the period 2008-2017.

[3] Estonia and Uzbekistan were excluded from this calculation due to irregular reporting during the period 2008-2017. Russia did not report cases by transmission mode during this period.

[4] Both the EU and non-EU versions (including Russian translation) can be accessed on ECDC's website at https://ecdc.europa.eu/en/infectious-diseases-public-health/hiv-infection-and-aids/prevention-and-control/monitoring-0

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

The survey contained specific questions in relation to the HIV epidemic among men who have sex with men (MSM), in addition to questions relating to current national prevention interventions, policies and barriers to the public health response to the epidemic.

This report presents the situation among MSM, a key group affected by HIV in the WHO European Region. As well as considering the picture for the overall European and Central Asian region, findings are presented by WHO sub-regions (West, Centre, and East) used in the joint ECDC/WHO report on HIV/AIDS surveillance in Europe [2] which broadly group areas of Europe and Central Asia by geography and epidemic type, as depicted in Figure 4. In addition, case studies provided by health authorities highlight developments in public health policy and programme implementation, specific to MSM.

The report presents the continuum of HIV care across the region and classifies results according to countries that reported: (a) all four stages[6], (b) no stages, and (c) at least two consecutive stages of the continuum of care nationally as well as disaggregated data, where available, for MSM. Findings are compared against the global 90-90-90 targets [3].

The report also includes key findings from the European Men who have sex with Men Internet Survey 2017 (EMIS-2017) [4]. EMIS-2017 was an online survey which collected self-reported data from MSM in 50 countries between 18 October 2017 and 31 January 2018. About 137,000 MSM in 50 countries responded to the survey – the data included in this report are from respondents from countries within the WHO European Region (47 out of 50 EMIS-2017 countries, see Annex 1). EMIS-2017 did not cover the following eight countries of the WHO European Region: Armenia, Azerbaijan, Georgia, Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan. When using EMIS figures, data from the four European microstates (Andorra, Liechtenstein, Monaco and San Marino) were merged with Spain, Switzerland, France, and Italy, respectively.

National focal points could decide whether to include EMIS figures in their reporting, or use other available data. Using EMIS data has the advantage of best possible comparability due to the same questions and the same sampling frame being used. Other national data sources, particularly data on MSM living with HIV, taken from existing cohorts, may be more up to date and reliable, for example, regarding viral load measures that are not self-reported.

Data for this report have also been supplemented with data from the European Surveillance System for the WHO European Region.

[6] See Table 1 of this report for definitions of each stage of the continuum of HIV care.

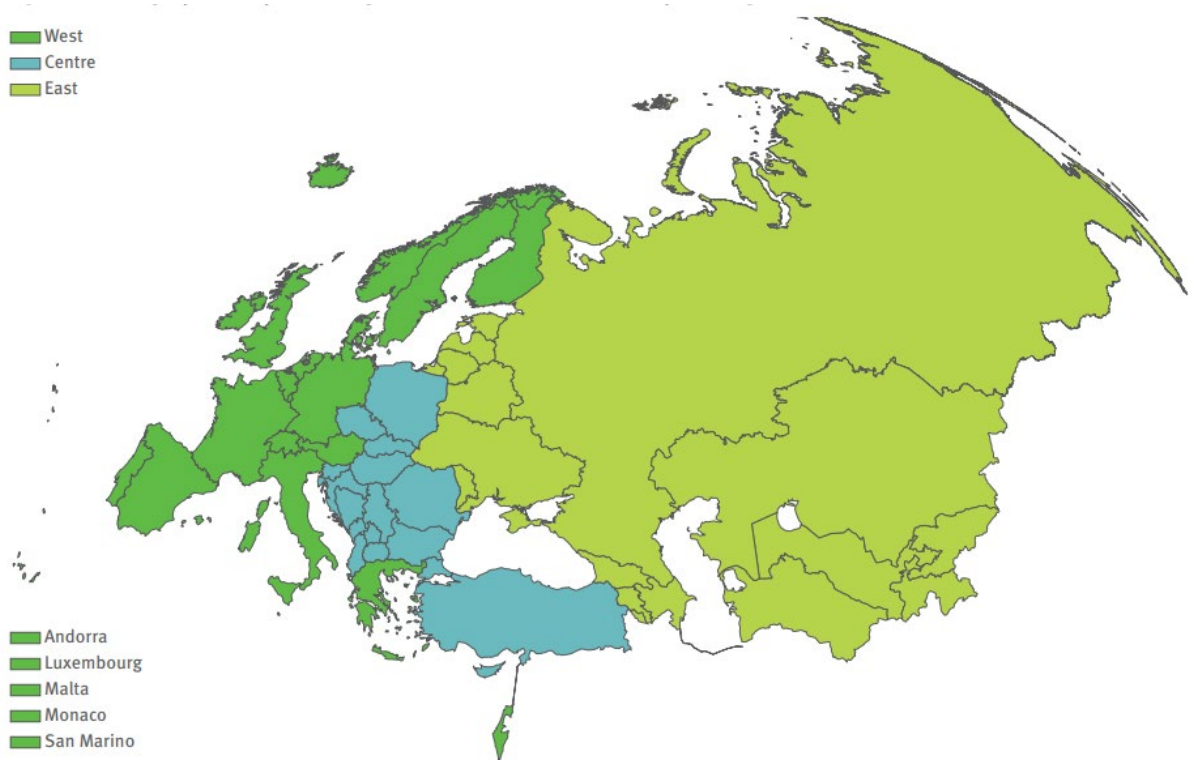
Grouping of countries covered by this report:

West, 24 countries: Andorra, Austria, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Liechtenstein, Malta, Monaco, Netherlands, Norway, Portugal, San Marino, Spain, Sweden, Switzerland, United Kingdom.

Centre, 16 countries: Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Hungary, Kosovo, North Macedonia, Montenegro, Poland, Romania, Serbia, Slovakia, Slovenia, Turkey.

East, 15 countries: Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Russia, Tajikistan, Turkmenistan, Ukraine, Uzbekistan.

Figure 4. Geographical/epidemiological division of the WHO European Region



Progress and remaining challenges

Continuum of HIV care

The continuum of HIV care is a conceptual framework that provides a snapshot of critical stages in achieving viral suppression among people living with HIV (PLHIV) [5]. It has become one of the central metrics through which the public health response to HIV is evaluated at the local, national and international level [6]. In 2014, the Joint United Nations Programme on HIV/AIDS (UNAIDS) established the 90-90-90 targets, the aim being that by 2020; 90% of all people living with HIV are diagnosed, 90% of those diagnosed receive treatment and 90% of those receiving treatment achieve viral suppression. This translates to a target of 73% viral suppression among all (PLHIV. To be able to report on each of the three '90' targets it is necessary to have data for the two relevant consecutive stages of the continuum of care. The definitions for each of the four stages of the continuum of care are provided in Table 1.

Table 1. Consensus definitions for monitoring the continuum of HIV care

Stage 1: Total estimated number of people living with HIV in the country
The total estimated number should be based on an empirical modelling approach, using the ECDC HIV Modelling Tool[7], Spectrum or any other empirical estimate. The estimate should include diagnosed and undiagnosed people.

Stage 2: Number/percentage of above (estimated number of people living with HIV in the country) ever having been diagnosed
The number should include all new HIV or AIDS diagnoses. It should also include those people who are in care and those who have not been linked to care.

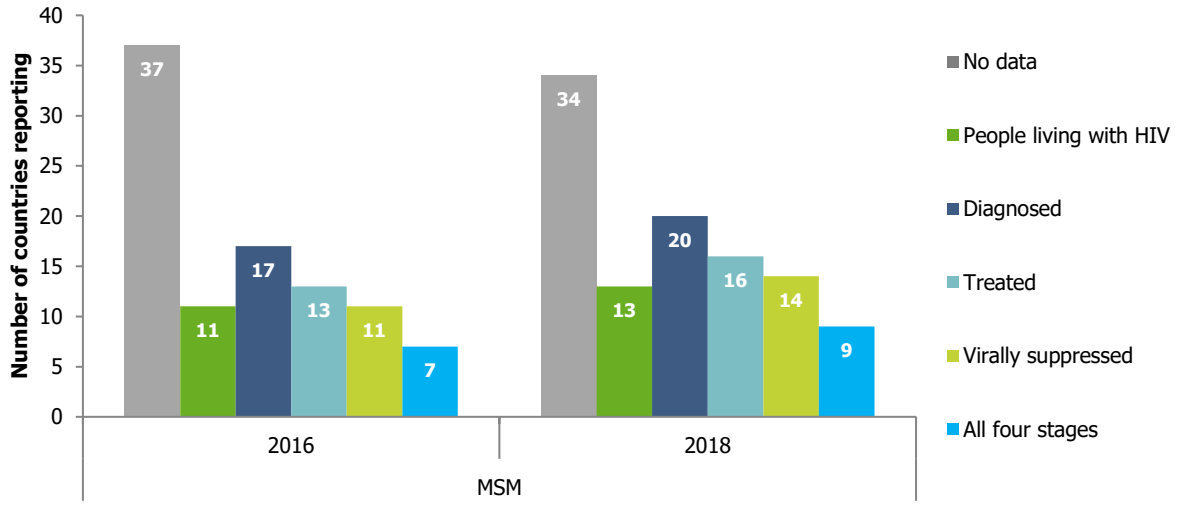
Stage 3: Number/percentage of above (estimated number of people living with HIV in the country, ever having been diagnosed) who are currently on antiretroviral treatment
The number should include all people currently on ART, regardless of treatment regimen or treatment interruptions/discontinuation.

Stage 4: Number/percentage of above (estimated number of people living with HIV in the country, ever having been diagnosed or having initiated antiretroviral treatment) who had viral load (VL) ≤200 copies/ml at last visit (virally suppressed)[8]
The number should include all those who have ever initiated ART, regardless of regimen or treatment interruptions/discontinuation.

Presenting the continuum of care by key population allows countries to measure outcomes for groups that are disproportionately affected by HIV. It also means that disparities between key populations that are hidden at the aggregate level can be revealed.

Few health authorities in Europe and Central Asia were able to submit data for all four stages of the continuum for MSM in 2018. This is despite an improvement from the data provided in 2016, particularly regarding the number of MSM receiving antiretroviral therapy and those who are virally suppressed, defined here as less than 200 copies/ml (see Figure 5).

Figure 5. Number of countries reporting data for different stages of the HIV continuum of care for MSM, Europe and Central Asia, reported in 2016 and 2018.



Overall in 2018, the proportion of MSM living with HIV (diagnosed and undiagnosed) who are virally suppressed could only be estimated for nine countries. Estimates ranged from 10–82% (Figure 6), with five countries meeting or surpassing the target of 73% of all MSM living with HIV being virally suppressed (the United Kingdom, the Netherlands, France, Austria and Luxembourg).

It is notable that, with the exception of Belarus and the North Macedonia (who have both met or exceeded the target of 90% of MSM on HIV treatment who are virally suppressed), the countries that have met the targets for

[7] ECDC Modelling Tool. http://ecdc.europa.eu/en/healthtopics/aids/Pages/hiv-modelling-tool.aspx

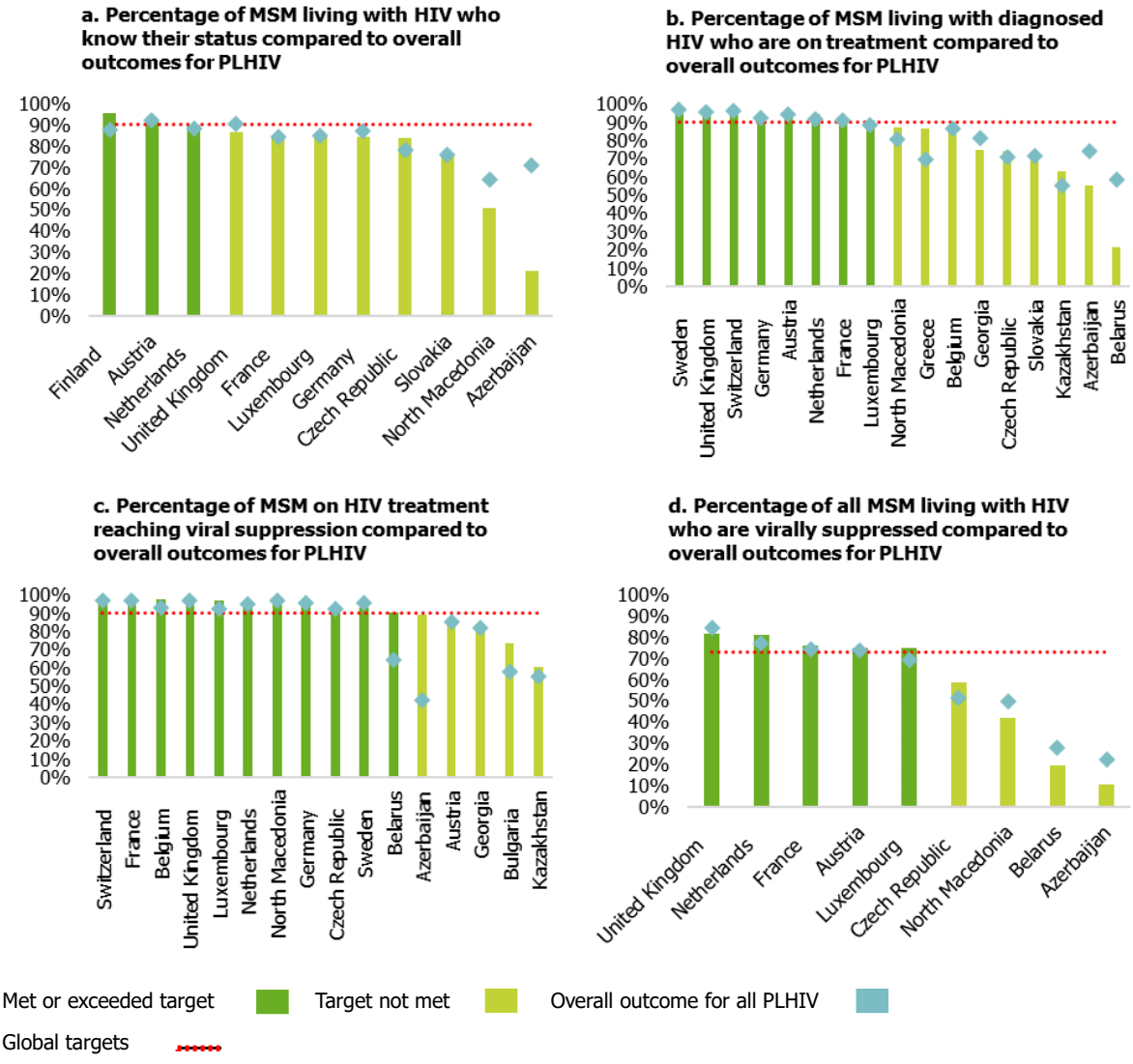
[8] A viral load threshold for viral suppression of <200 copies/mL was used to allow for changes over time in the lower detection limits of viral load assays. A threshold of 200 copies/mL for population-level monitoring is consistent with recommendations in a recent systematic review of guidelines produced by IAPAC - www.iapac.org/uploads/JIAPAC-IAPAC-Guidelines-for-Optimizing-the-HIV-Care-Continuum-Supplement-Nov-Dec-2015.pdf and the US Centers for Disease Control and Prevention - www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-care-continuum.pdf

the continuum of HIV care are entirely from the West sub-region. At the time of data collection, the Netherlands was the only country to have met all three 90-90-90 targets and the overall target of 73% for all MSM living with HIV who are virally suppressed.

When compared against overall outcomes for all people living with HIV, it is encouraging that MSM in most countries are achieving similar or better outcomes. The exceptions to this rule are North Macedonia (for first 90 and overall target), Azerbaijan (for first and second 90s and overall target), and Belarus (for overall target). As there are 34 countries for which there are no data specific to MSM, their overall continuum data may be obscuring significant inequalities in outcomes for MSM across Europe and Central Asia.

Amongst the countries who were able to submit data for the continuum, particular efforts are needed in reducing the proportion of MSM living with undiagnosed HIV through prevention of onward transmission and testing, and increasing the proportion of those who are diagnosed being on treatment (which will also have consequences for increasing viral suppression and accordingly reduce transmission). Implementing such an approach is beginning to bear fruit in some countries – it is significant that of the seven countries that are witnessing declines in HIV diagnoses among MSM, five are consistently high performers against the continuum of care targets (of the remaining two, Greece was only able to submit diagnosis and treatment data, whilst Spain did not submit any data).

Figure 6. Estimates provided for each stage of the continuum of care for MSM living with HIV in Europe and Central Asia, reported in 2018



Combination prevention

HIV combination prevention is an approach that brings together single prevention initiatives into one comprehensive programme. Importantly, the specific elements take effect across the life course of HIV infection and encompass primary prevention (preventing people without the virus from acquiring HIV infection), secondary prevention (preventing onward transmission from those living with HIV) and structural tertiary interventions (which improve health-related quality of life of those living with HIV). The effectiveness of these interventions increases when MSM are empowered to participate in the design, delivery and evaluation of services and when they are delivered in a non-discriminatory environment, where structural barriers such as criminalisation of same sex practices, sex work, societal stigma and hetero-normative policies have been removed..

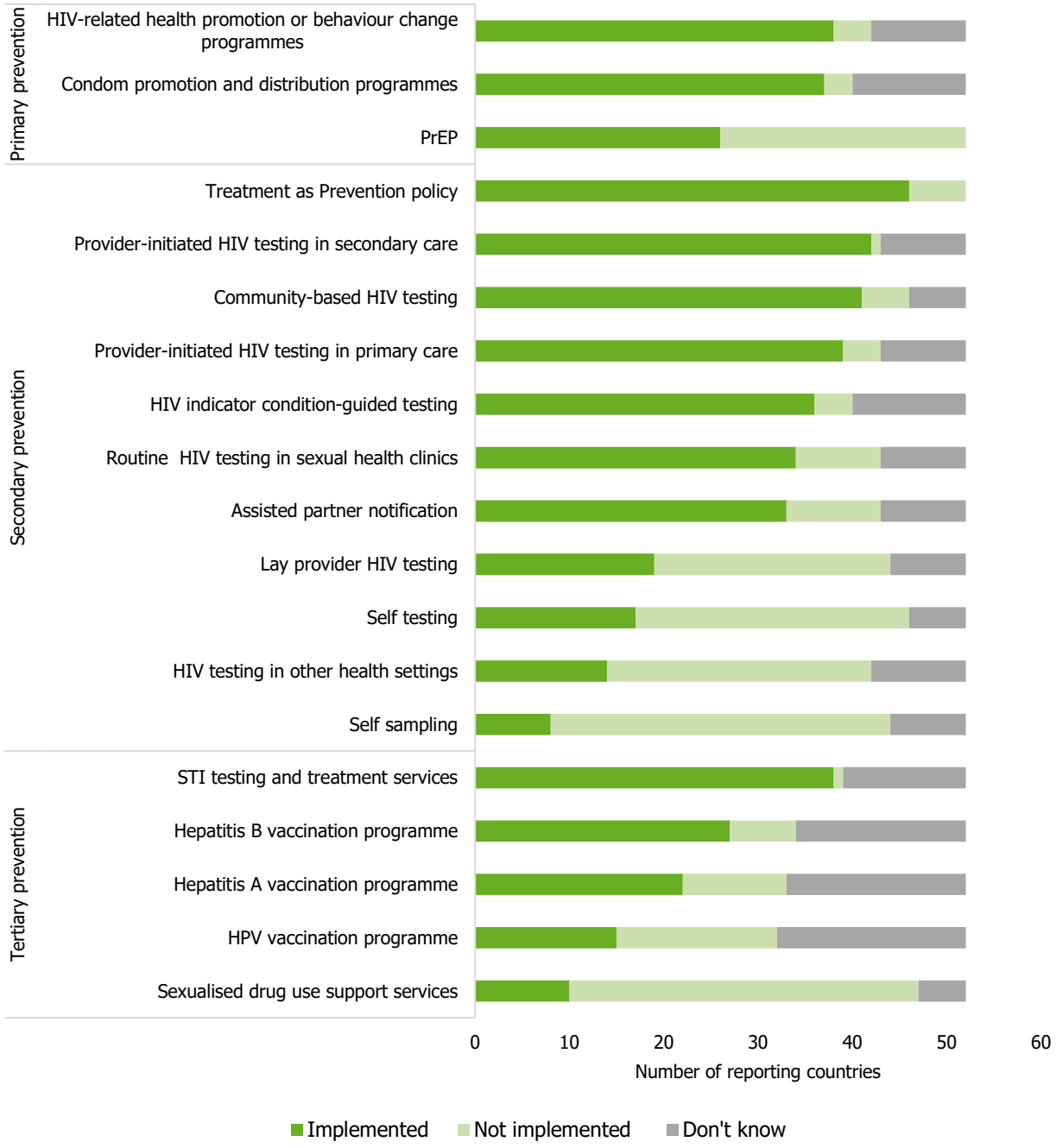
Guidance from ECDC in 2015 on HIV and STI prevention amongst MSM recommends seven key intervention components (listed in Table 2) to address infectious diseases, including HIV, among MSM [7].

Table 2. Key intervention components for a combination prevention approach for MSM

Vaccinations: Promote and deliver vaccination to protect against hepatitis A and B. Consider vaccination for HPV.
Condoms: Provide easily accessible condoms and condom-compatible lubricants and promote their effective use.
HIV and STI testing: Provide voluntary and confidential HIV counselling and testing via a variety of modalities that are easy to access for the target group including routine offering of tests in clinic, outreach and community-based settings. Offer STI screening including anal/penile inspection and adequate diagnostics (e.g. sampling of urethra, rectum, pharynx and blood). Voluntary partner referral can support the early diagnosis and treatment of contacts.
Treatment: Timely provision of antiviral treatment of HIV, hepatitis B and C according to individual needs and national or international clinical guidelines should be ensured. Provide targeted antibiotic treatment for other STIs. The preventive benefits of treatment are significant.
Health promotion: Provide accurate and accessible information that enables men to understand and assess sexual health-related risks and prevention efficacy, and that promotes awareness of one's own HIV status. Health promotion could take place in counselling sessions, peer support groups, and outreach interventions for MSM as well as by targeted information provision to promote sexual health among MSM.
MSM-competent health services: MSM-competent points of care offering a comprehensive sexual health programme including health promotion, counselling, peer support, prevention, adequate diagnostics and treatment will increase service uptake. Design and implementation of services should be organised with target group involvement. At any healthcare facility that targets sexual health there should be training for providers on how to offer comprehensive care for MSM.

Figure 7 describes the extent of implementation of the different strands of combination prevention and identifies progress made in specific prevention activities across Europe and Central Asia. Breakdown by country is seen in Annex 2.

Figure 7. Implementation of HIV prevention interventions for MSM across Europe and Central Asia, 2018



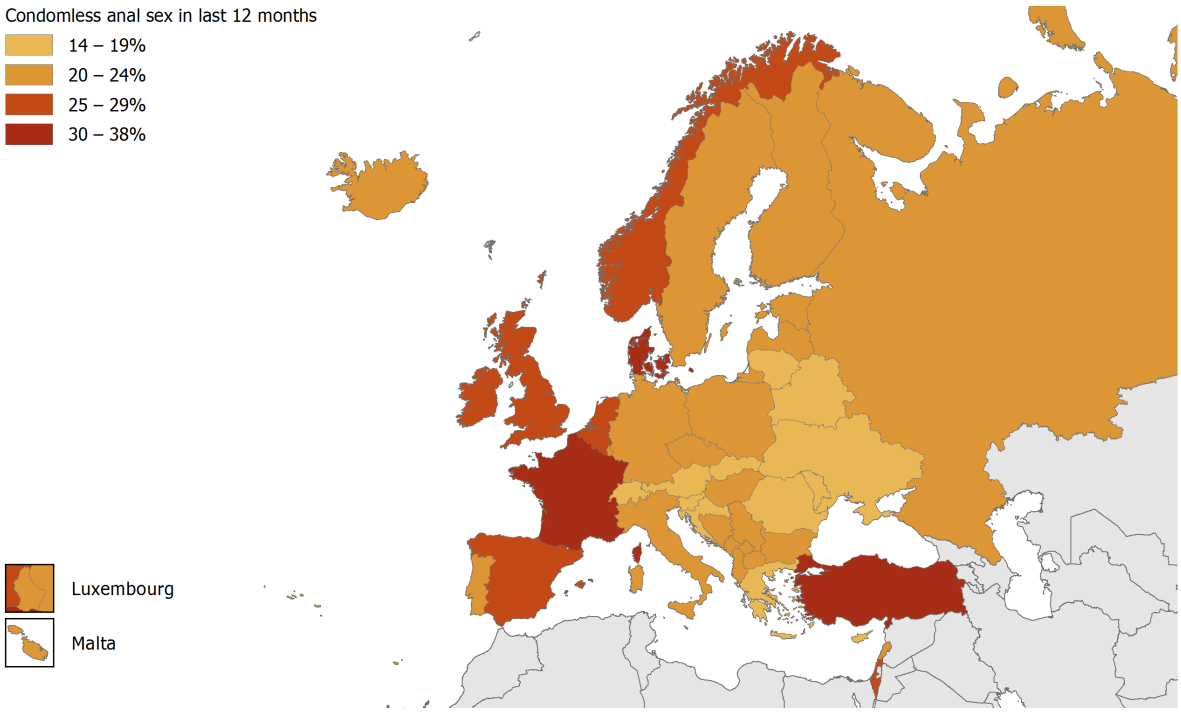
Primary HIV prevention

Understanding HIV risk behaviour

In 2018, 39 out of the 52 reporting countries had conducted behavioural surveillance amongst MSM between 2010 and 2017. Only 30 countries have data on condomless sex with at least one non-steady partner of unknown HIV serostatus. Available data suggest that high rates of sexual risk behaviour among MSM continue (see Figure 8). For countries that collected data on rates of condomless sex in the last 12 months, rates ranged from 20% to 77%. For countries that collected data on condomless sex at last sexual intercourse, rates ranged from 19% to 50%.

It should be noted that the introduction of pre-exposure prophylaxis (PrEP) and the concept of 'Undetectable=Untransmissible[9]' has changed understanding of HIV risk in relation to condomless sex; yet when asked about data collected on sexual risk behaviour, only nine out of the 29 countries with data on condomless sex amongst MSM asked research participants about their use of PrEP. It is important that future studies include questions about PrEP and treatment as prevention in order to get an accurate understanding of risk behaviours amongst MSM in their country.

Figure 8. Percentage of MSM who had condomless anal intercourse with non-steady partners of unknown HIV status, last 12 months (N=126 493)[10]



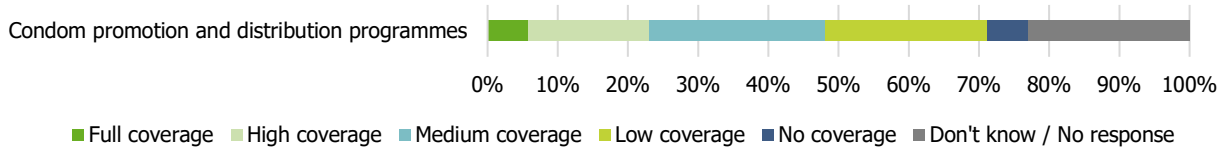
Source: EMIS-2017

Condom provision

Condoms have long formed a core component of HIV primary prevention. Condom promotion and distribution programmes aim to ensure that MSM have access to condoms when needed. However, Figure 9 indicates that condom promotion and distribution programmes are less well established across Europe and Central Asia than might be expected, with medium to full coverage in only 25 (48%) of the reporting countries.

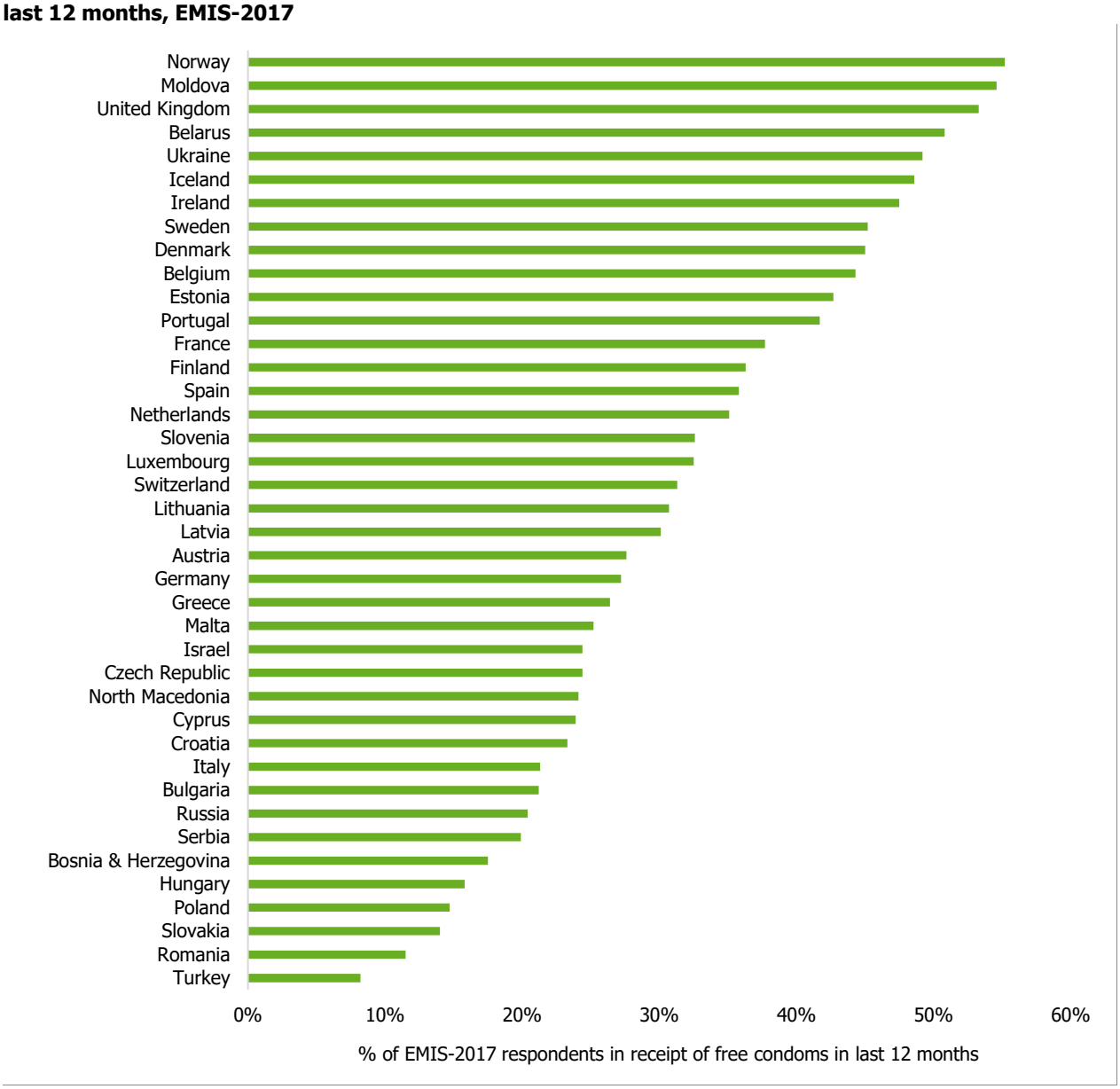
Figure 9. Estimated coverage of condom promotion and distribution programmes for MSM across Europe and Central Asia

[9] https://www.unaids.org/en/resources/presscentre/featurestories/2018/july/undetectable-untransmittable
[10] Data shown was collected between 2010 and 2017.



The picture is worse in Figure 10 which depicts self-reported data from MSM asked whether they have received free condoms from clinics, gay bars, saunas, or non-governmental organisations (NGOs). The largest proportion of MSM receiving condoms free is in Norway and Moldova (55%), and it is significantly less in most countries. Countries in both the West and East sub-regions perform particularly well in terms of condom provision, whilst countries from the Centre sub-region perform less well.

Figure 10. Proportion of MSM in receipt of free condoms from clinics, gay bars, saunas, or NGOs in last 12 months, EMIS-2017



Source: EMIS-2017 [4]

Pre-exposure prophylaxis

The availability of pre-exposure prophylaxis (PrEP) in Europe is fragmented, complex and in flux. Figure 11 provides information on where PrEP is made available within a country's health system. It does not take account of online PrEP access, usually of generic PrEP from abroad. Nor does it take account of access to PrEP through private healthcare, usually available at relatively costly patent prices. The three categories of availability are, nationally

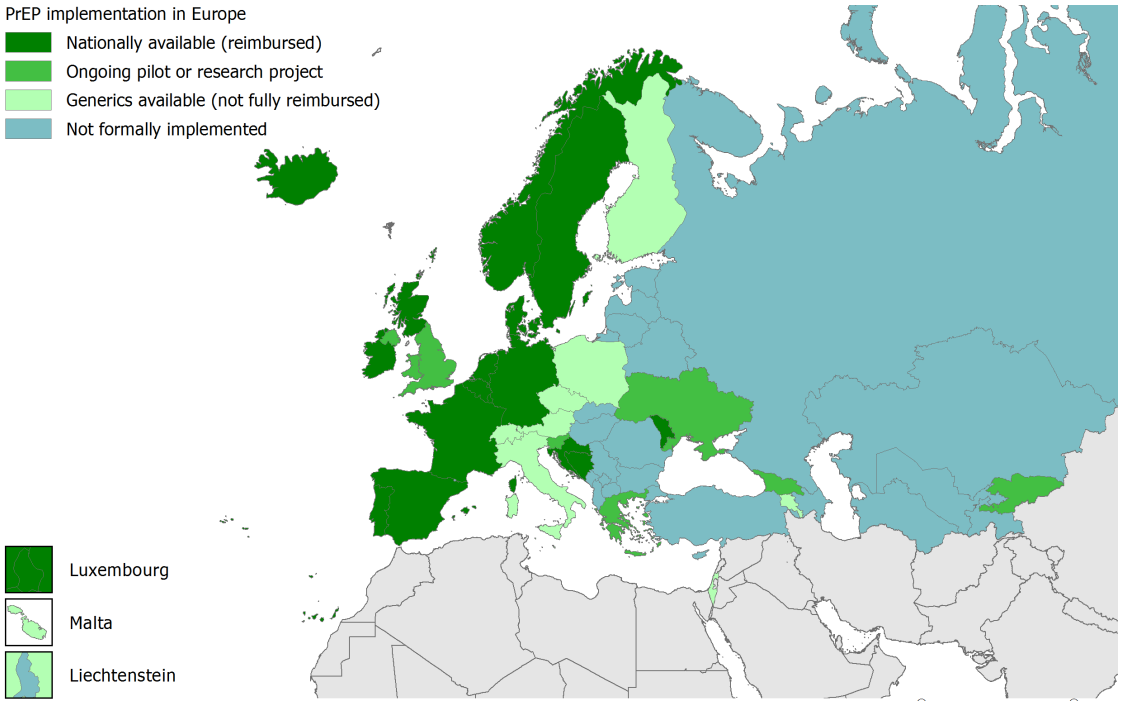
available (reimbursed), part of an ongoing pilot or research project (also reimbursed), and as generics available in healthcare settings but not reimbursed.

Data collected via Dublin Declaration monitoring provide a snapshot of a rapidly changing situation regarding state PrEP provision, with substantial diversity across the Region. However, results show that progress has been made since 2016, when only France reported that PrEP was nationally available and reimbursed [8]. By 2019, 16 out of 53 reporting countries reported reimbursed PrEP within their national health service, either through insurance or from the public sector (Belgium, Bosnia and Herzegovina, Croatia, Denmark, France, Germany, Iceland, Ireland, Luxembourg, Moldova, the Netherlands, Norway, Portugal, Spain, Sweden, and Scotland within the United Kingdom).

Nine countries report that generic PrEP is available in healthcare settings, but that it is not fully reimbursed (Armenia, Austria, the Czech Republic, Finland, Israel, Italy, Malta, Poland and Switzerland).

Five countries report PrEP availability only through pilot, research or demonstration projects at national or sub-national level (Georgia, Greece, Slovenia, Ukraine, and England, Northern Ireland and Wales within the United Kingdom). It is important to note that the degree of access to PrEP in such projects varies considerably. For example, the United Kingdom saw 6 000 people access PrEP in the 12 months prior to reporting in 2019, while Ukraine saw 125 people access PrEP in the same period.

Figure 11. Status of PrEP implementation in Europe and Central Asia, November 2019



Overcoming challenges to implementing PrEP

In Ukraine, a pilot project aimed at reducing the rate of HIV transmission among MSM (and trans people) by introducing PrEP as part of a combined prevention and care programme is being implemented in the country. Implementation challenges have included organisational issues related to harmonisation of the involved doctors' schedules due to competing demands on their time. This has been resolved by alerting the social workers' schedules to align with those of the doctors. Another challenge is the long delivery time of test results for HIV, hepatitis and STIs testing (which is required within seven days under the pilot project). This issue has been resolved by introducing time restrictions requiring that test results be returned to doctors on the same day as the test is taken.

Secondary HIV prevention

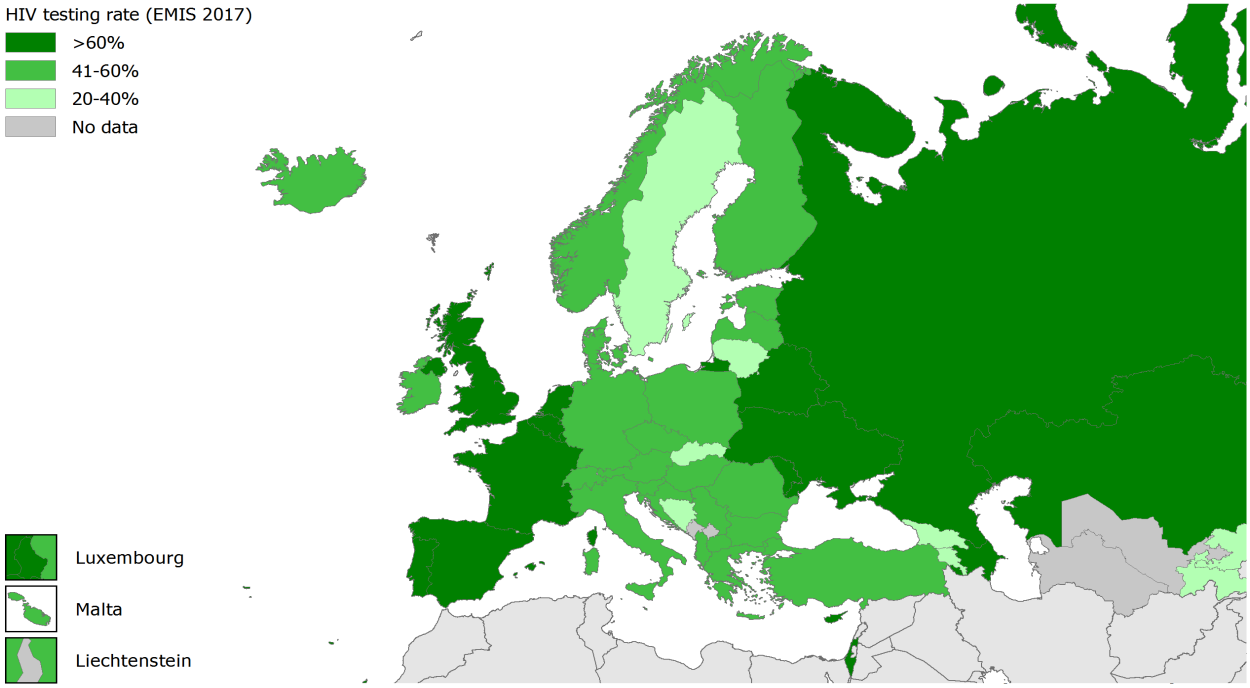
HIV testing

High levels of testing, combined with prompt treatment, are crucial for reducing HIV incidence amongst MSM [9]. Out of 40 countries with testing guidelines, 31 included content on specific key populations and 29 mentioned MSM. Twenty-eight countries had recommendations on testing frequency, with 24 countries recommending MSM test at least once a year (and most of these countries recommending more frequent testing in the context of high-risk sexual behaviour), as per ECDC guidance [10].

Data on HIV testing rates among MSM are limited, but indicate that rates remain low. In 2018, less than half (23) of reporting countries provided these data. The results range from 20.2% (Kyrgyzstan) to 98.5% (Bulgaria), with ten countries reporting testing rates of over 50%. Annex 3 provides a complete list of data on testing rates collected through the 2018 Dublin Declaration monitoring process.

EMIS-2017 data on testing rates are more comprehensive for the region, with rates estimated for 40 countries, and 28 out of 40 countries identified as having testing rates amongst MSM above 50% (see Figure 12) [4]. It also has greater comparability as all respondents were asked the same question. However, these data are self-reported and come from a self-selecting sample likely to be more engaged in sexual health promotion activities, so the results should be interpreted with caution.

Figure 12. HIV testing in the last 12 months amongst MSM, reported in 2018 (EMIS-2017 respondents N=96,132)



Source: EMIS-2017 [4] except for data from Albania, Armenia, Azerbaijan, Georgia, Kyrgyzstan, Kazakhstan, and Tajikistan which was reported via the Dublin Declaration questionnaire 2018.

Increasing access to HIV testing

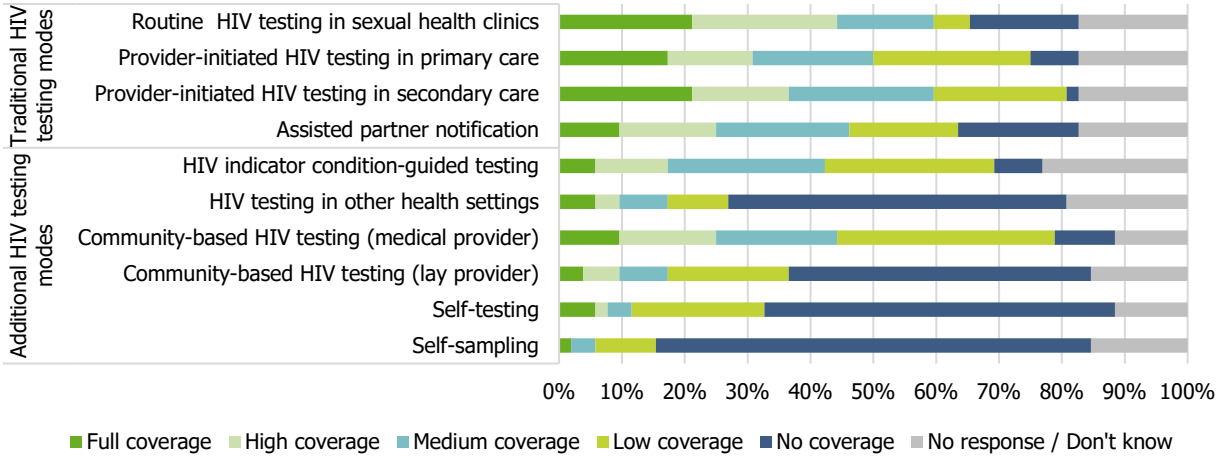
All large VCT centres and several clinics in Switzerland participated in the STAR trial, where asymptomatic sexually active men and women (with a focus on MSM and female sex workers) were comprehensively screened for STIs. This involved multi-site swabbing for seven bacterial STIs and blood tests for HIV, syphilis, hepatitis B, and hepatitis C. All staff in participating centres were trained to improve knowledge on asymptomatic STIs and to improve their performance in swabbing.

Implementation of different HIV testing modes

Even without taking into consideration the limitations to the EMIS-2017 data on testing rates, Figure 12 indicates that there is room for improvement in increasing HIV testing uptake among MSM. Adopting a range of testing interventions can overcome barriers to access and better target those who are at most risk. In particular, social network-based strategies, community-based testing, HIV self-testing, and modifications to the traditional clinic-based model have been found to be effective in reaching MSM [11].

Figure 13 highlights that testing strategies, such as HIV testing in other health settings, community-based testing by a lay provider, self-testing and self-sampling, are the least implemented of all the testing interventions. With only eight countries (16%) implementing self-sampling and 16 (33%) implementing self-testing, further exploration is required to understand what is limiting implementation of these interventions. While only 19 countries (37%) implement lay-provider HIV testing, a larger proportion of countries (79%) do implement some level of community-based testing administered by a trained medical professional, indicating that legal restrictions on who can administer HIV tests might be hindering wider implementation of lay-provider testing.

Figure 13. Level of implementation of different testing modes in Europe and Central Asia, reported in 2018[11]



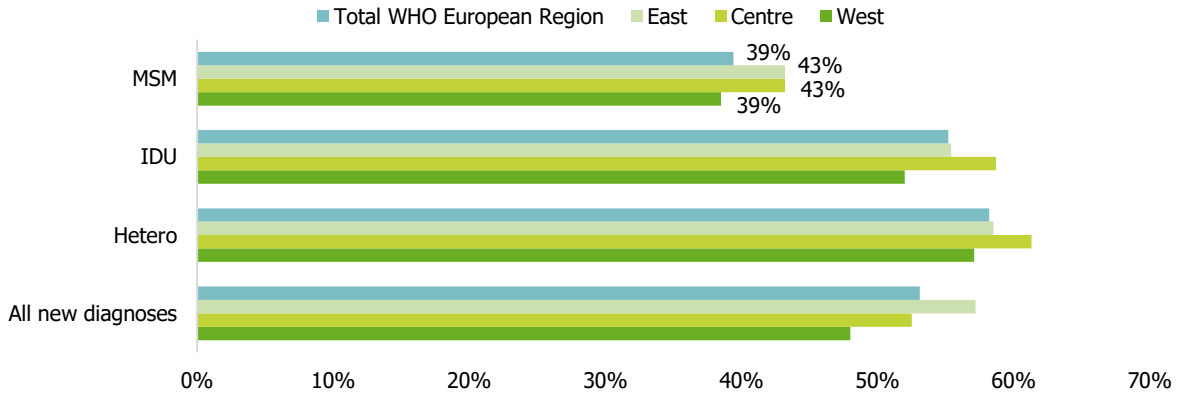
Late HIV diagnoses

Late diagnosis is associated with increased likelihood of mortality and morbidity, with most AIDS cases reported in the EU/EEA due to late diagnosis of HIV infection [2]. Late diagnosis also increases the risk of onward transmission of HIV. On average, people diagnosed late (with a CD4 <350 copies/mm^3) have been living with undiagnosed HIV infection for around three to four years [12]. If they are having condomless sex during this time, their sexual partners may have been at risk of acquiring HIV. Therefore, reducing late diagnosis is a key intervention for both improving health outcomes for people living with HIV and in preventing onward transmission.

In 2017, 39% of MSM were diagnosed late in Europe and Central Asia (Figure 14). When disaggregated by sub-region, this percentage remains the same for the West sub-region, but increases to 43% for both the Centre and East sub-regions. Whilst it is notable that late diagnosis rates are much higher amongst people who inject drugs and heterosexuals, rates amongst MSM are still far too high and undoubtedly contribute to the ongoing risk of HIV incidence in MSM and early death. Also of concern is that late diagnosis rates have worsened since 2016, when rates were 38%, 38%, and 41% for the West, Centre, and East, respectively and 38% for the overall WHO European Region.

[11] Countries were asked which testing modes were implemented and what level of coverage was implemented. Based on the WHO definition of universal health coverage, full coverage was defined as 'all who need the service can use it, that the service is of sufficient quality to be effective, and that use of the service will not expose the user to financial hardship'. Countries could choose from a scale of coverage, as follows: No coverage: The service is not provided; Low coverage: <30% of the population can use the effective, affordable service; Medium coverage: 30–60% of the population can use the effective, affordable service; High coverage: 61–95% of the population can use the effective, affordable service; Full coverage: 95-100% of the population can use the effective, affordable service.

Figure 14. Percentage of MSM diagnosed late (CD4 cell count < 350/mm³) overall and by sub-region, 2017



Source: ECDC/WHO (2018). HIV/AIDS Surveillance in Europe 2018 – 2017 data [2]

Tackling late diagnosis rates by increasing HIV knowledge amongst primary healthcare professionals

In Germany, training is being offered to physicians and medical students to learn how to address topics such as sexual health and sexually-transmitted infections during patient consultations, as well as how to offer HIV/STI tests when indicated. A booklet with information on late diagnosis of HIV, indicator diseases, how to address HIV in the doctor-patient interview and when to offer an HIV test has been developed and will soon be sent to 50 000 GP practices in Germany.

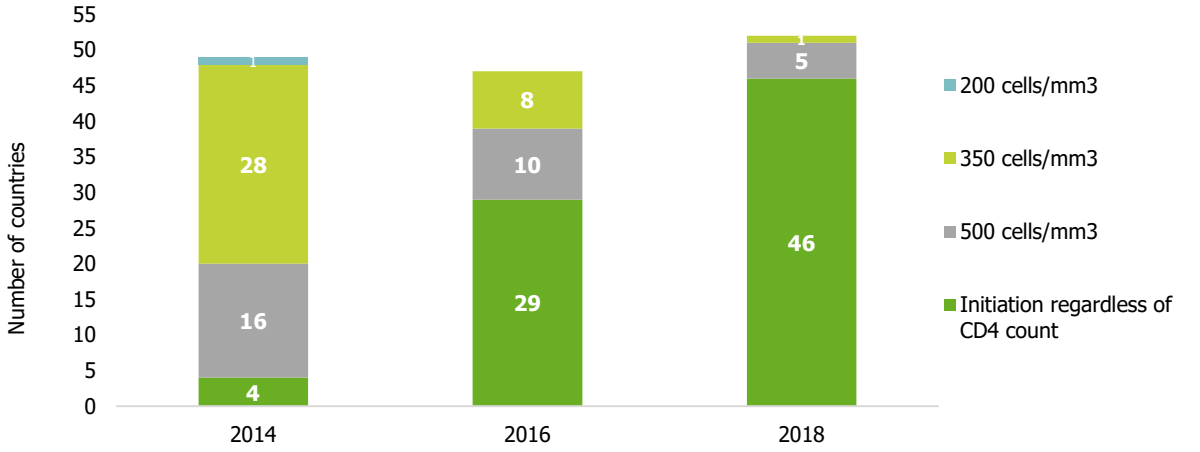
Treatment guidelines

Ensuring prompt access to treatment after diagnosis results in a near normal life span for PLHIV and reduces the risk of HIV transmission. Since 2014, there has been a significant increase in the number of countries in Europe and Central Asia with guidance advising prompt treatment following diagnosis, regardless of CD4 count (see Figure 15). In 2018, 46 countries had adopted this advice, in accordance with WHO [13] and EACS [14] clinical guidelines. Six countries, however, continue to maintain a CD4 threshold for initiating HIV treatment – Azerbaijan, Bosnia & Herzegovina[12], Latvia, Moldova, Tajikistan and Uzbekistan.

Whilst the adoption of test and treat policies indicates progress, it is less clear how these policies are being implemented in practice. As Figures 6 and 7b in the continuum of care section of this report show, disaggregated data on treatment coverage amongst MSM remain limited. Where data have been provided, there is significant variation in coverage ranging from 22–99%, and 9 out of the 17 countries that submitted data had not reached the target of 90% diagnosed MSM living with HIV receiving treatment. It is crucial that policies are fully implemented and treatment coverage data are available for all key populations, including MSM.

[12] Although Bosnia & Herzegovina did not officially submit data to the 2018 Dublin Declaration monitoring round, current treatment policy was confirmed via email by country focal point.

Figure 15. Changing policy on initiation of ART by CD4 count



Tertiary HIV prevention

Vaccination programmes

ECDC guidance promotes hepatitis A (HAV) and hepatitis B (HBV) vaccinations as a key component of public health programmes aimed at MSM. The guidance also states that countries should consider the provision of human papilloma virus (HPV) vaccines.

In 2018, 22 countries reported that a HAV vaccination programme is implemented nationally, with seven reporting high coverage, seven reporting medium coverage and eight reporting low coverage. No countries reported full coverage. Eleven countries reported no coverage, whilst 14 did not know the level of coverage and five did not respond. Data on uptake of hepatitis A vaccinations (Figure 16) indicate that there is significant variation across Europe and Central Asia (7.5–63.5%) [4]. Countries with higher rates of coverage (>40%) tend to be in the West sub-region, with the exception of the Czech Republic.

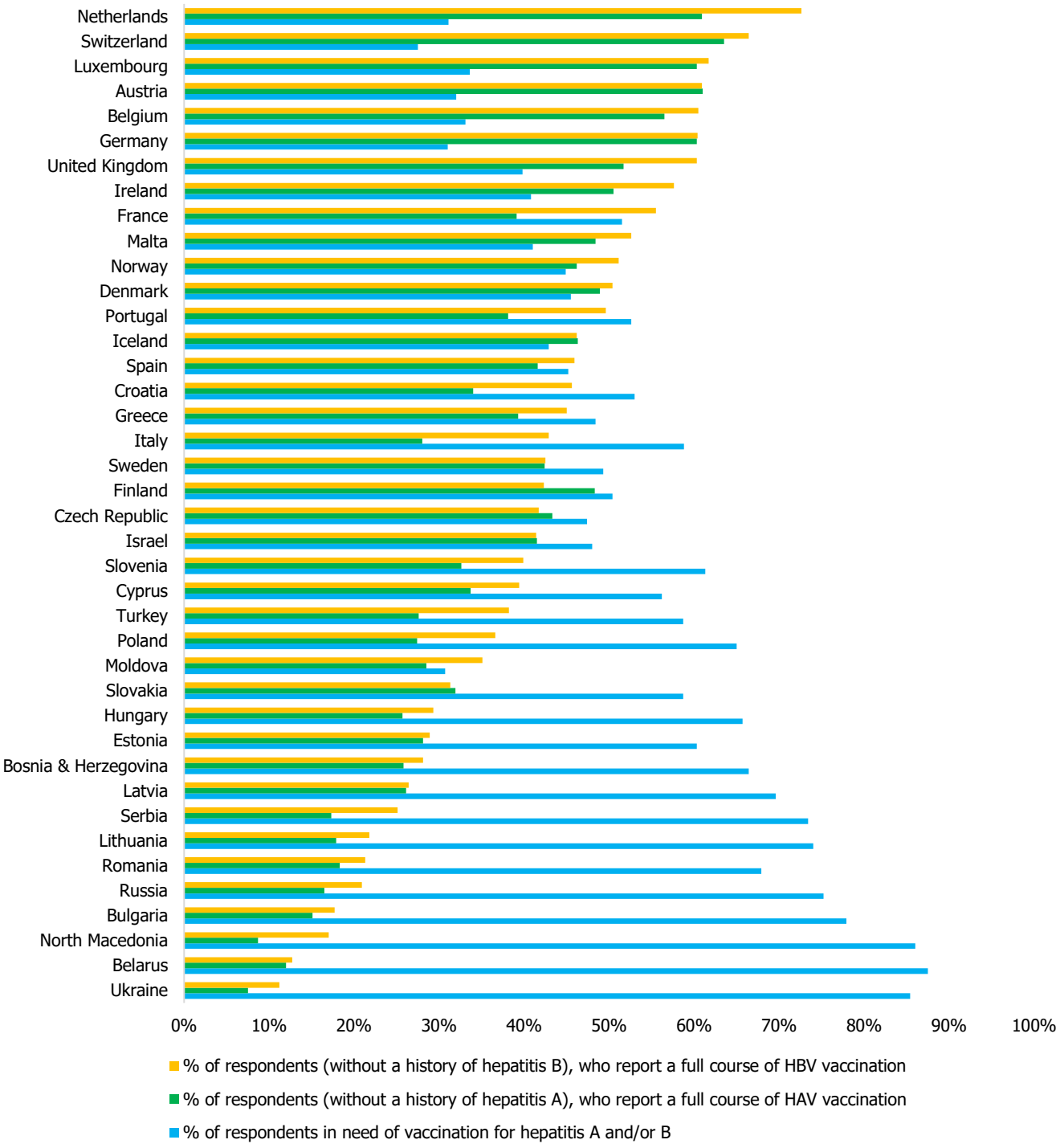
For hepatitis B (HBV), 27 countries reported implementation of a programme, with 14 reporting high or full coverage, nine reporting medium coverage and four reporting low coverage. Seven countries reported no coverage, whilst 13 did not know the level of coverage and five did not respond. Data on uptake of hepatitis B vaccinations (also Figure 16) indicate that coverage tends to be slightly higher compared to hepatitis A, although there is even greater variation across the overall region (11–73%).

There is significant need for hepatitis vaccination programmes amongst MSM, with 54% of EMIS-2017 respondents[13] in need of HAV or HBV vaccination. In some countries, this proportion is much higher and demand is associated with countries where provision is limited (see Figure 16).

Fifteen countries reported implementation of an HPV vaccination programme, with three reporting medium coverage and 12 reporting low coverage. Seventeen countries reported no coverage, whilst 15 countries did not know the level of coverage and five did not respond.

[13] This figure only includes EMIS countries that are part of the WHO European Region. See Appendix 1 for more details.

Figure 16. Proportion of MSM reporting having received a full course of hepatitis A and hepatitis B vaccination compared with proportion of MSM in need of vaccination

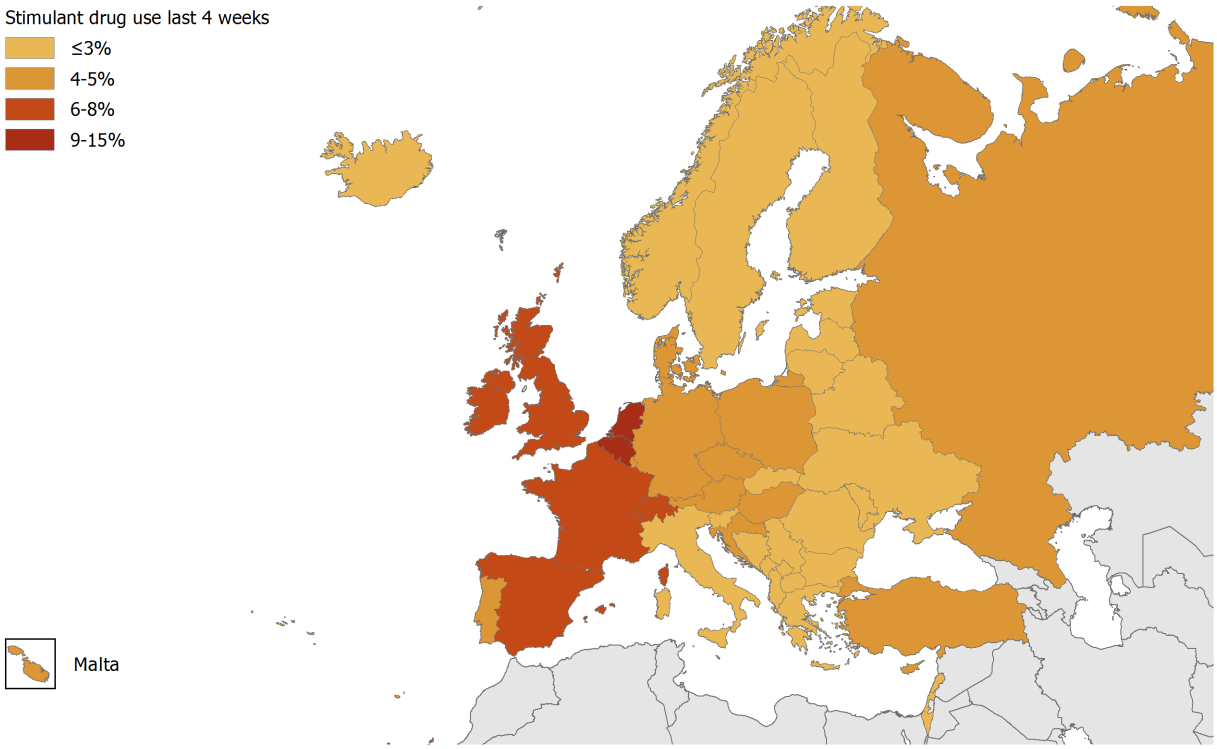


Source: EMIS-2017 [4]

Chemsex support services for MSM

Sexualised drug use, or more specifically 'chemsex', may increase HIV risk amongst MSM engaging in this practice [15]. In EMIS-2017, 'Chemsex' was defined as the use of stimulant drugs to make sex more intense or last longer [4]. Patterns of sexualised drug use vary across Europe and Central Asia, although the highest rates reported are largely in the West sub-region (Figure 17). Rates ranged from 1% (Belarus, Iceland, Moldova and North Macedonia) to 15% (the Netherlands).

Figure 17. Rate of self-reported sexualised use of stimulant drugs (´Chemsex´) in the last four weeks among MSM (%), EMIS-2017 (N=119 252)



Source EMIS-2017 [4]

Specialist sexualised drug use services for MSM remain limited with only 10 countries providing these services in 2018, mostly from the West sub-region (see Table 3). Six countries stated that they have plans to introduce specialist sexualised drug use services for MSM within the next two years – two of whom are from the West sub-region, three from the Centre sub-region and one from the East sub-region. Where countries did not implement sexualised drug services, 38% reported that this was due to a lack of evidence of sexualised drug use, 35% cited a lack of technical expertise and capacity and 25% a lack of funding.

Table 3. Provision of specialist sexualised drug use services for MSM across Europe and Central Asia [14]

Service provided	Countries
Yes	**West**: Austria, France, Germany, Ireland, Italy, Netherlands, Spain, Switzerland, the United Kingdom; **Centre:** Slovenia.
Plans to introduce in the next two years	**West:** Finland, Portugal; **Centre:** Czech Republic, Romania, Serbia; **East:** Ukraine.
No plans to introduce	**West:** Andorra, Belgium, Denmark, Greece, Iceland, Israel, Luxembourg, Malta, Norway, Sweden; **Centre:** Albania, Bulgaria, Croatia, Cyprus, Hungary, Kosovo*, Montenegro, North Macedonia, Poland, Slovakia, Turkey; **East:** Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Tajikistan.

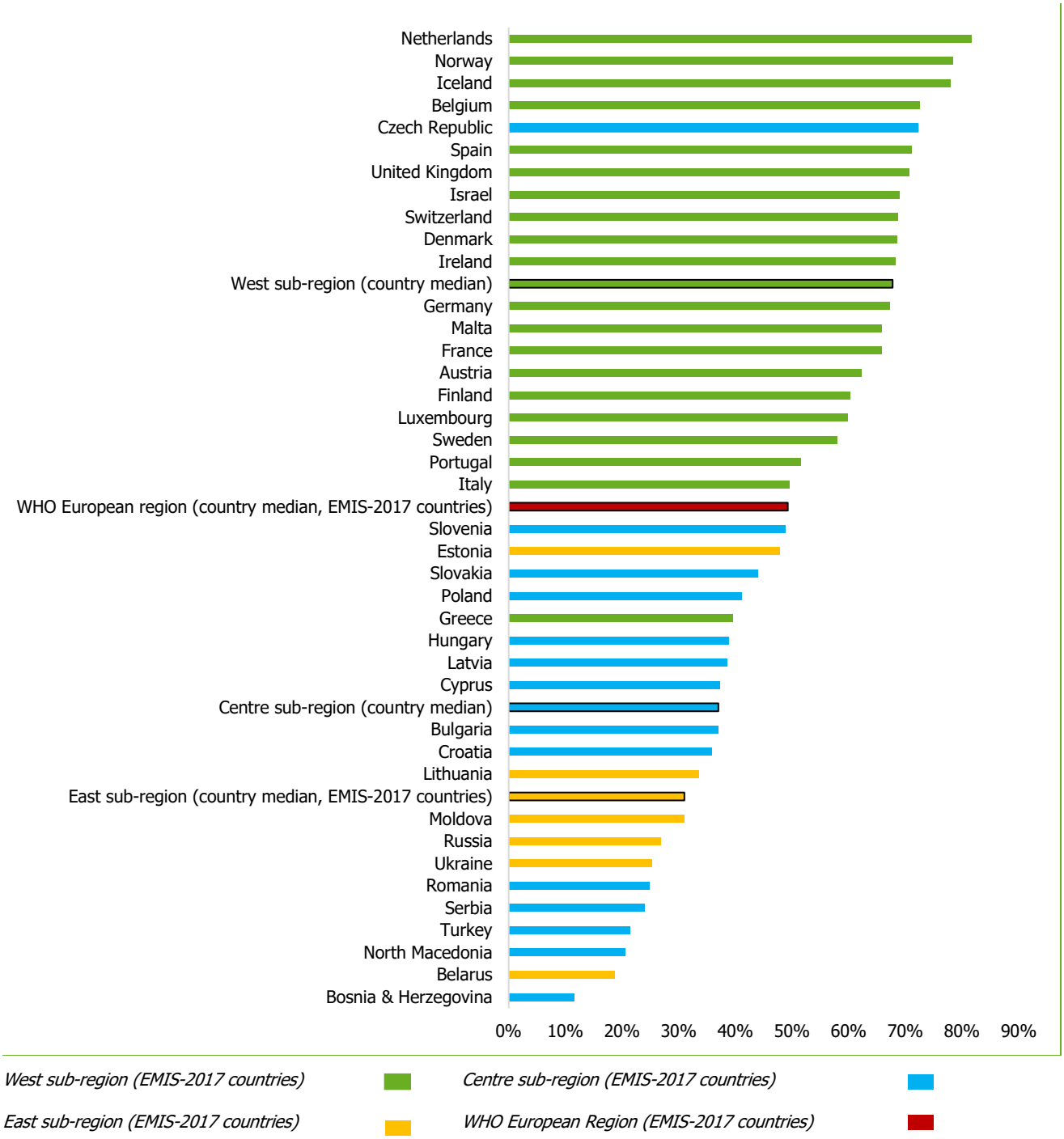
[14] The four countries that did not provide data for this question were Liechtenstein, Monaco, Russia, and Uzbekistan.

Addressing barriers to services

In 2016, countries reported that persistent barriers to services remain for MSM. Barriers to testing included stigma and discrimination amongst MSM; a lack of community-based testing services, stigma and discrimination amongst health professionals; a lack of confidentiality; lack of testing services in general; a lack of support or buy-in to HIV testing amongst MSM and laws or policies [16]. The following two measures are not indicators collected within the Dublin Declaration monitoring framework, and instead come from EMIS-2017, but are useful to include as they add further insight into the structural barriers that can limit MSM's ability to access services.

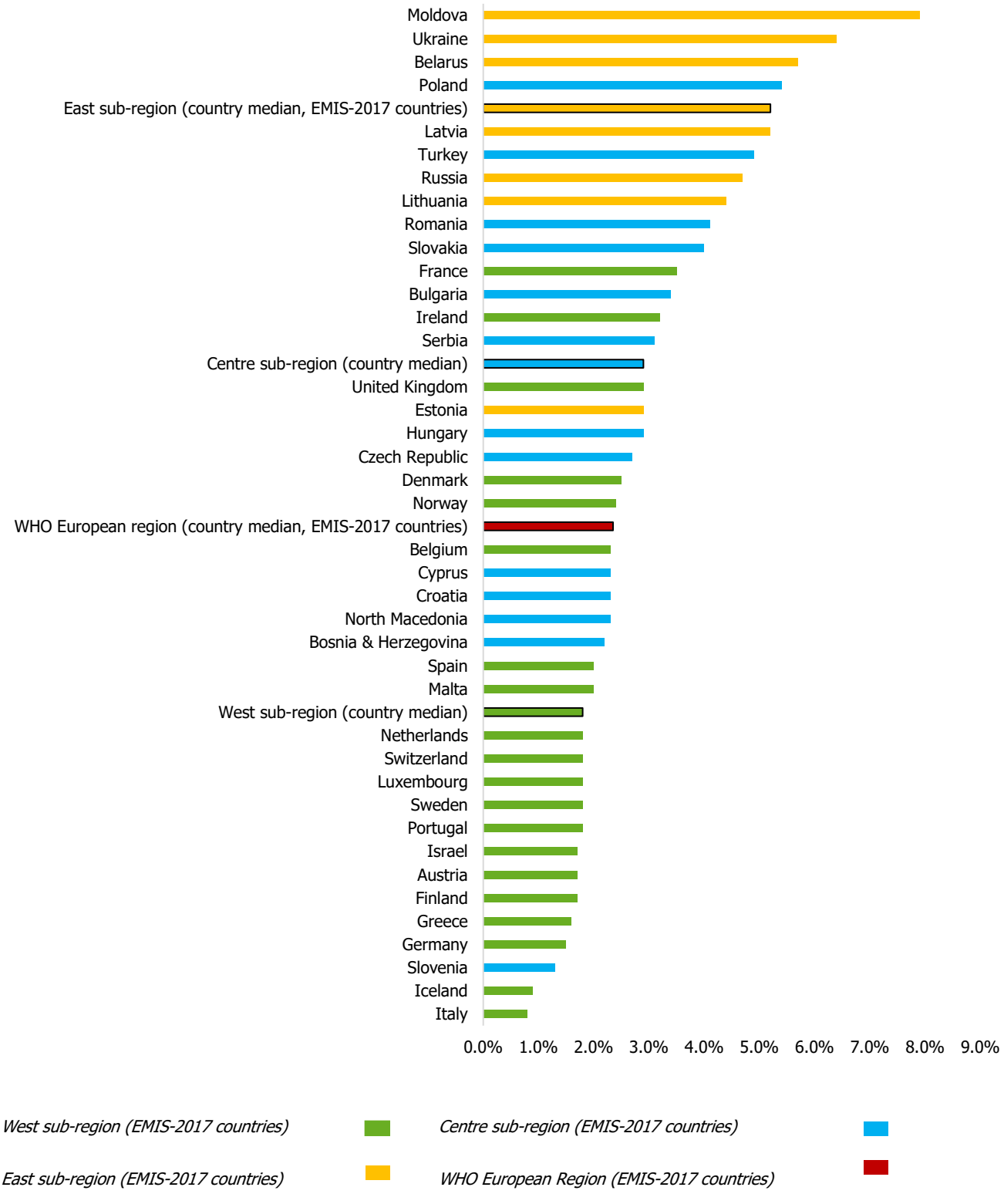
Homonegativity (both external and internalised, often called homophobia) is also a particular issue for MSM when accessing prevention and testing services [17]. In EMIS-2017, 58% of respondents living in the WHO European Region were 'out' to more than half of their family, friends, and work/study colleagues (Figure 18). However, when using the country median, this measure dropped to 49%. There is reason to assume that the country median for all countries of the WHO European Region, including central Asian countries, is even lower. There is an association between being open about sexual orientation and living in the West sub-region and on average, 65% of gay, bisexual and other MSM (GBMSM) living in the West are out to more than half their family and friends. The Czech Republic, however, is an outlier for the Centre sub-region with higher rates of openness (72%). GBMSM are generally less likely to be open about their sexual orientation if they are living in the Centre or East sub-regions, with the proportion of GBMSM being out to more than half of their family and friends at 35% and 32%, respectively.

Figure 18. Proportion of MSM who are out to more than half of their family and friends, EMIS 2017



Source: EMIS-2017 [4]

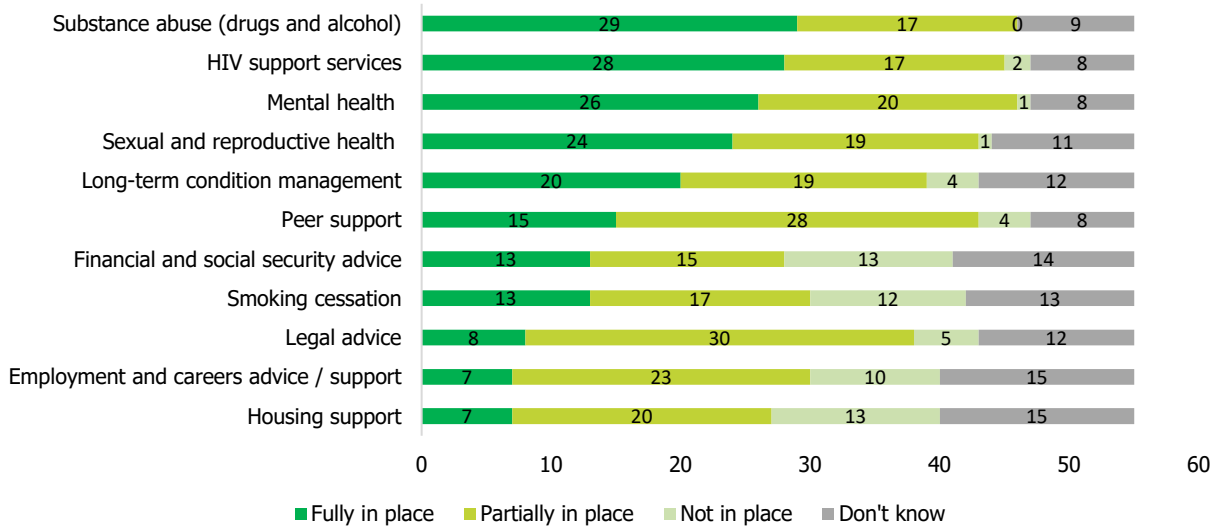
Figure 19. Proportion of MSM who in the last 12 months were punched, hit, kicked, or beaten because someone knew or presumed they were attracted to men, EMIS-2017.



Source: EMIS-2017 [4]

The Dublin Declaration questionnaire 2018 asked whether there are systems in place to ensure that people living with HIV who are on treatment are linked to other care programmes and services which can improve their quality of life of living with HIV. Figure 20 indicates that health-related services such as substance abuse (drugs and alcohol) support, mental health services, and long-term condition management are better integrated than services focused on wider social issues such as peer support, employment and housing.

Figure 20. Linkage to other support services for people receiving HIV care



Tackling stigma and discrimination through peer support

In Slovenia, MSM NGO LEGEBITRA offers psychosocial peer support to those newly diagnosed with HIV. It is available 365 days per year and is continuously developing based on monitoring relevant policy and legislation implementation as well as the needs of PLHIV. Legal support is also provided in cases where discrimination is identified.

Conclusions and priorities for action

Overall progress

The recent decline in HIV incidence amongst MSM in some European countries is a positive development and sends a clear message that we have the tools available to halt the HIV epidemic. It appears that strong performance against the 90-90-90 targets through the adoption of a combination prevention approach, focused on reducing the numbers of people living with undiagnosed HIV and reducing onward transmission through prompt access to treatment, is key to this success.

It is important to recognise, however, that diagnoses have continued to rise in the majority of countries in Europe and Central Asia. In particular, there has been an eight-fold increase (710%) in diagnoses in the East sub-region since 2008 (and this is without the inclusion of Russia which, based on recently released data, is facing a rapidly growing epidemic [5]).

In spite of progress made, it is of concern that so few countries are able to provide continuum of care data disaggregated by key population. With only 19 countries able to submit two consecutive stages of data for the HIV continuum for MSM (less than half of reporting countries), it is difficult to gauge what is the real situation for MSM across Europe and Central Asia. Aggregate data can mask inequalities experienced by key populations at risk of HIV, and identifying these disparities is a first crucial step to knowing how best to address them.

Further exploration is needed into why accessibility and use of condoms appears to be limited even in countries which state there is high coverage of condom programmes.

Countries should consider ensuring PrEP is available to those who need it by formally implementing programmes which are accessible and affordable. Significant progress has been made since 2016, with 27 countries now with some form of formal implementation of PrEP, of which 12 have a national policy to provide PrEP free at the point of delivery. However, a significant number of countries are not providing PrEP at scale to meet the demand of those at risk for acquiring HIV. Availability and access to PrEP is an important target for countries implementing such programmes. Countries which still do not provide PrEP should explore options for overcoming barriers to implementation, especially since the cost of the drugs have reduced significantly.

Increasing testing frequency amongst MSM is a key tool to reducing the proportion of MSM living with undiagnosed HIV and reducing late diagnosis. Late diagnosis remains a significant issue, with 39% of MSM diagnosed late across Europe and Central Asia (rising to 43% for the Centre and East when broken down by sub-region). Broadening access to testing by adopting different testing modes will be essential to addressing this.

It is encouraging that most countries across Europe and Central Asia have adopted a policy of prompt treatment regardless of CD4 count, with 88% of reporting countries having done so. It is important though that practice reflects policy, and it will only be possible to ascertain this through the collection of disaggregated data on treatment coverage. Only 17 countries were able to provide data on treatment coverage, and of these eight had met or surpassed the target of 90% of people diagnosed with HIV on treatment.

In addition to prompt treatment, it is also important that services that support the broader wellbeing of MSM are implemented to reduce their risk of acquiring HIV and improve the health outcomes of those living with HIV. This should include addressing risk behaviours such as sexualised drug use. Current service provision remains limited to a handful of countries, despite rates of sexualised drug use among MSM as high as 11% elsewhere. It also means ensuring good coverage of HAV, HBV and HPV vaccination programmes – EMIS-2017 data indicate that there is significant need amongst MSM for vaccination which is not being met.

Finally, without concurrent efforts to decrease discrimination and homophobia in the political, legal, social, cultural and religious environment, the actions being suggested will be of limited effect. Less than half of MSM across all countries the WHO European Region are 'out' about their sexual orientation, and this proportion is much lower in countries in the Centre or East sub-regions of the WHO European Region. Physical assault and abuse remains a reality for many MSM; 3% of MSM living in EMIS-2017 countries in the WHO European Region have experienced physical assault in the last 12 months due to their sexual orientation, with country rates in ranging between 1 and 8% (Figure 19).

Limitations

Data submitted to the Dublin Declaration monitoring process are self-reported by national health authorities, which may compromise accuracy where measures are more subjective (for example, coverage questions which ask the respondent to answer 'high, medium or low').

Data comparability has its limitations. Although accompanying definitions were provided alongside questions as much as possible, in practice some countries use slightly different definitions, so caution is required when making comparisons. There are also variations in data sources, sample sizes, timeframes, analysis and quality, which limit the scope for directly comparing data between countries.

There are still considerable levels of missing data which makes it difficult to generalise findings for the entire European and Central Asian region.

Priorities for action

- In countries which are experiencing a confirmed decline in HIV incidence among MSM, it is crucial that governments sustain their efforts and continue to identify opportunities for further improvements.
- Countries with no indication of a decline in HIV incidence among MSM should consider implementing a combination prevention approach which incorporates the seven key interventions outlined in ECDC guidance, with effective monitoring in place to determine impact and identify any barriers to effectiveness.
- Countries should see how best to disaggregate their data for the continuum of care and may request ECDC technical support if needed.
- Countries should consider developing national testing guidelines which explicitly mention MSM and make recommendations on frequency of testing for MSM, ensuring these recommendations are communicated to clinicians and MSM themselves.
- A wider range of testing interventions can be implemented to improve uptake and frequency of testing among MSM [10], with effective monitoring of these interventions put in place to measure their impact.
- Countries that do not currently recommend prompt treatment following diagnosis, regardless of CD4 count, should consider updating their guidance as soon as possible. Where countries have adopted this guidance, they should consider introducing monitoring systems to ensure that clinical practice reflects policy.

- Countries should consider more closely what barriers prevent MSM from accessing testing services and contributing to late diagnosis rates and how to address them. Stigma and discrimination towards MSM and people living with HIV in particular should be addressed. Where innovations to address barriers to testing have been successful, countries should share their learning with their regional neighbours.
- Countries need to consider what wider legal, political and social changes need to be made to tackle homophobia and promote the rights of lesbian, gay, bisexual and transgender (LGBT) people.

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Annex 1. EMIS-2017 respondent countries [4]

Country	Sample size
Austria	2 705
Belarus	440
Belgium	3 038
Bosnia & Herzegovina	232
Bulgaria	1 177
Croatia	1 015
Cyprus	307
Czech Republic	1 897
Denmark*	1 698
Estonia	212
Finland	1 409
France*	10 996
Germany	23 107
Greece	2 909
Hungary	2 177
Iceland	111
Ireland	2 083
Italy*	11 025
Israel	1 274
Latvia	251
Lithuania	370
Luxembourg	169
Malta	299
Moldova	498
Netherlands	3 851
North Macedonia	175
Norway	2 957
Poland	4 025
Portugal*	2 555
Romania	2 002
Russia	6 247
Serbia	1 041
Slovakia	1 003
Slovenia	685
Spain*	10 652
Sweden	4 443
Switzerland*	3 383
Turkey	1 855
Ukraine	1 201
United Kingdom*	11 889

**includes microstate(s) and/or overseas territory*

EMIS-2017 countries not included in this report are Lebanon, Canada and the Philippines. Sample sizes were too small for national estimates in Albania, Montenegro, and Kosovo (this designation is without prejudice to positions on status and is in line with UNSC 1244 and the ICJ Opinion on the Kosovo Declaration of Independence).

Annex 2. Combination prevention for MSM by country

- C – Condoms
- P – PrEP
- BC – HIV-related health promotion or behaviour change programmes
- CBT – Community-based HIV testing
- SS – Self sampling
- ST – Self testing
- LPT – Lay provider testing
- RSH – Routine HIV testing in sexual health clinics
- PIPC – Provider-initiated HIV testing in primary care
- PISC - Provider-initiated HIV testing in secondary care
- TOS – HIV testing in other settings
- TASP – Treatment as Prevention
- HAV – Hepatitis A vaccination programme
- HBV – Hepatitis B vaccination programme
- HPV – HPV vaccination programme
- STITT – STI testing and treatment
- SDS – Sexualised drug service

This table is based on responses reported via the Dublin Declaration Questionnaire 2018. There may be some difference in responses when compared with data from EMIS-2017.

Reported as high to full coverage | Reported as low to medium coverage | Reported as not implemented

	Primary prevention			Secondary prevention									Tertiary prevention				
Country	**C**	**P**[15]	**BC**	**CBT**	**SS**	**ST**	**LPT**	**RSH**	**PIPC**	**PISC**	**TOS**	**TASP**[16]	**HAV**	**HBV**	**HPV**	**STITT**	**SDS**[17]
Albania																	
Andorra																	
Armenia																	
Austria																	
Azerbaijan																	
Belarus																	
Belgium																	
Bosnia & Herzegovina																	
Bulgaria																	
Croatia																	
Cyprus																	
Czech Republic																	
Denmark																	
Estonia																	
Finland																	
France																	
Georgia																	
Germany																	
Greece																	
Hungary																	
Iceland																	
Ireland																	
Israel																	

[15] In the case of PrEP, countries were given the options of responding 'Nationally available (reimbursed)' (categorised as green), 'Generics available in healthcare settings (not reimbursed)', 'Ongoing research or pilot projects' (both categorised as orange), or 'Not formally implemented' (categorised as red).
[16] When asked whether they implemented a policy of treatment as prevention, countries were only given the option of yes (categorised as green) or no (categorised as red).
[17] When asked whether sexualised drug services were available, countries were only given the option of yes (categorised as green) or no (categorised as red).

	Primary prevention			Secondary prevention									Tertiary prevention				
Country	C	P[15]	BC	CBT	SS	ST	LPT	RSH	PIPC	PISC	TOS	TASP[16]	HAV	HBV	HPV	STITT	SDS[17]
Italy																	
Kazakhstan																	
Kosovo																	
Kyrgyzstan																	
Latvia																	
Liechtenstein																	
Lithuania																	
Luxembourg																	
Malta																	
Moldova																	
Monaco																	
Montenegro																	
Netherlands																	
North Macedonia																	
Norway																	
Poland																	
Portugal																	
Romania																	
Russia																	
San Marino																	
Serbia																	
Slovakia																	
Slovenia																	
Spain																	
Sweden																	
Switzerland																	
Tajikistan																	
Turkey																	
Turkmenistan																	
Ukraine																	
United Kingdom																	
Uzbekistan																	

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European Centre for Disease Prevention and Control (ECDC)

Gustav III:s Boulevard 40, 16973 Solna, Sweden

Tel. +46 858601000
Fax +46 858601001
www.ecdc.europa.eu

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