TECHNICAL REPORT

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Contents

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ASEAN	Association of Southeast Asian Nations
ASTRA	Astra Secretariat: Federation for Women and Family Planning
ART	Anti-retroviral Therapy
CEE	Central and Eastern European
EAHC	European Commission Executive Agency for Health and Consumers
ECCA	The European Cervical Cancer Association
EEA	European Economic Area
EHRN	Eurasian Harm Reduction Network
EMCDDA	European Monitoring Centre for Drugs and Drug Addictions
EN-HERA!	European Network for Promotion of Sexual and Reproductive Health and Rights of Refugees and Asylum-Seekers in Europe and Beyond
GIPA	Greater Involvement of People Living with HIV
GNP+	Global Network of People Living with HIV
GUMCAD	Genitourinary Medicine Clinic Activity Dataset
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
ICR	International Centre for Reproductive Health
ICW	International Community of Women Living with HIV/AIDS
IDU	Injecting Drug Use
IEC	Information, Education, and Communication
IOM	International Organization for Migration
IPPF	International Planned Parenthood Federation
LGV	Lymphogranuloma venereum
LSHTM	London School of Hygiene and Tropical Medicine
MTCT	Mother-to-child transmission
MSF	Médecins sans Frontieres
MSM	Men Who Have Sex with Men
NGO	Non-governmental Organisation
PID	Pelvic Inflammatory Disease
PLHIV	People Living with HIV
PWID	People Who Inject Drugs
SAFE	Sexual Awareness for Europe
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TAMPEP	Transnational AIDS/STI Prevention among Migrant Prostitutes in Europe Project
WHO	World Health Organization
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
VENICE	Vaccine European New Integrated Collaboration Effort

Glossary

Behavioural intervention	Action(s) aiming to change behaviour by motivating, empowering and/or persuading individuals, or groups of individuals [1].
Combination prevention	Combines behavioural, biomedical and structural interventions to address the immediate risks and underlying causes of vulnerability to adverse sexual health outcomes [1].
Gender:	Refers to the socially constructed roles, behaviour, activities, and attributes that a given society considers appropriate for men and women [2].
Generalisability	Extent to which the findings from a study can be extrapolated from the study population to the population at large [1].
Harm reduction	An approach which seeks to minimise avoidable harms associated with risky behaviour [1].
Incidence rate	Rate at which new infections occur in a population. The numerator is the number of new events occurring in a defined period; the denominator is the population at risk of experiencing the event during the chosen period (most commonly a year) [1].
Induced abortion	Refers to the intentional termination of a pregnancy [1].
Mobility:	Any form of geographical movement by individuals, communities, or whole populations, over short or long distances, within or across national or regional boundaries [1].
Migrant	Any person who either temporarily or permanently changes his or her country of usual residence [3].
Migration	General demographic term encompassing long-term resettlement involving emigration from one country and immigration to another, cyclical migration comprising several return trips often for seasonal or temporary work and forced migration, i.e. to avoid conflict or natural disasters [1].
Prevalence	Proportion of individuals in a population reporting a type of behaviour, or having an infection or disease at any one time [1].
Prophylaxis	Measures designed to preserve health and prevent the spread of disease: protective or preventive treatment against infection [1].
Risk	Likelihood that an individual is exposed to an adverse sexual health outcome (such as an STI, unintended pregnancy, dysfunction or sexual violence) [1].
Sex	Refers to the biological and physiological characteristics which define men and women [2].
Sexuality	A core human dimension which includes sex, gender, sexual identity and orientation, eroticism, attachment and reproduction, and is experienced or expressed in thoughts, fantasies, desires, beliefs, attitudes, values, practices, roles and relationships. Sexuality is a result of the interplay of biological, psychological, socio-economic, cultural, ethical and religious/spiritual factors [1].
Sexual health	A state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled [4].
Sexual violence:	Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work [5].
Sex worker	A person who sells sex for money, drugs or other material items [1].
Structural approaches	Action(s) that aim to change the broader context that influences risk behaviour and vulnerability, by altering social, political, economic and/or environmental factors [1].
Transgender	An individual whose gender identity differs from their sex assigned at birth [1].
Vulnerability	Degree to which an individual or group has control over the risk of being exposed to negative outcomes [1].
Young people	Men and women in the transition between childhood and adulthood, broadly aged 10–24 years [1].

Executive summary

This report highlights the benefits of a comprehensive approach to disease prevention, integrating HIV and STI control programming in Europe into broader public health strategies, whilst recognising the linkages between different sexual health outcomes and the overlap and synergy between the interventions required to address HIV/STI and other aspects of sexual health. Groups most vulnerable to infection, including young people, men who have sex with men (MSM), sex workers, migrants, people living with HIV (PLHIV), populations at risk of sexual violence, and people who inject drugs (PWID) experience a range of sexual health needs. Vulnerability among these individuals is determined not only by risk behaviour, such as unprotected sex, but by social structural determinants that can affect access to healthcare and education. As poor sexual health, including HIV and STIs, is a significant cause of morbidity and mortality in Europe, prevention efforts need to be strengthened.

The overall aim of this project was to increase the understanding of how HIV and STI can be prevented among vulnerable groups in the broader context of sexual health and health promotion. This aim was achieved by mapping past and current activities, key stakeholders, and potential data sources in the European Union and European Economic Area (EU/EEA).

Methodology

To assess the current state of sexual health in the EU/EEA, a mapping exercise of national sexual health data, programmes, activities and policies was conducted, with specific reference to the sexual health of the general population and key populations vulnerable to HIV and STI. Information was collected on a number of sexual health indicators relevant to these groups for each of the 30 countries:

- Contextual indicators – in addition to the epidemiological picture of each country, the existence of legislation, strategies, stakeholders and the national healthcare systems in place that could influence prevention efforts were examined.
- Research and surveillance indicators – a search was performed to determine the availability of surveillance data as well as the availability of information on sexual risk behaviour.
- Intervention indicators – the existence of public education campaigns, national HIV/STI prevention programming, provision of sexual education, national screening, vaccination programming and health service delivery were also examined for each country.

This mapping exercise allowed for identification of synergies and gaps in the availability of data and in policies and programmes at the national and EU/EEA level.

Results

A number of global publications, pan-European technical, surveillance, and guidance documents, European research projects, national policy documents and reports, and relevant academic papers were identified. Sexual health indicators are presented across EU/EEA and for countries separately in country profiles (see Appendix B and D). Synergies and gaps in data, policies, and programmes highlighted by the mapping exercise are described below.

- It is challenging to assess the overall burden of HIV/STI and other sexual health outcomes in Europe due to heterogeneity in data collection and differences in data quality across countries. There are gaps in country reporting of HIV and STI rates. National survey data on sexual health outcomes such as risk behaviour, teenage pregnancy, and abortion are often not available or comparable.
- Vulnerable groups have relatively high rates of HIV and STI and are at particular risk of poor sexual health. Prevention efforts targeting these vulnerable populations need to take a comprehensive approach: primary prevention in the form of information, education and behavioural interventions; secondary prevention including screening and vaccination programmes; and tertiary prevention to treat and care for those already infected. Services need to be accessible and acceptable and be provided in a non-stigmatising, non-discriminatory environment.
- This report reveals the variety of vertical programmes and projects in countries across Europe, as well as the wide discrepancies in the type and quality of interventions targeting vulnerable groups leading to difficulties in defining ‘good practice’.

- A major feature of this report is the extent to which wider social determinants have an impact on the sexual health of vulnerable populations, including HIV and STI rates. Contextual barriers, as well as factors at the individual level, prevent high-risk individuals from accessing services offering preventive interventions, testing, treatment, and care. Such barriers include: national legislation; current country-level political environments; economic policies; the structure and availability of service provision; failure to observe sexual rights; marginalisation and fear of stigma and discrimination. Social norms also need to be considered when developing national STI and HIV prevention programmes. The European Centre for Disease Prevention and Control (ECDC) has issued evidence syntheses and guidance in the form of technical reports to support interventions targeting not only individual behaviour but also social factors (*STI and HIV prevention in men who have sex with men in Europe* [89] and *HIV testing: Increasing uptake and effectiveness in the European Union* [66]).
- There is a need for further guidance on preventive efforts aimed at sex workers and people living with HIV (PLHIV). While there is an abundance of guidance documents and technical reports on disease prevention programming for MSM, young people, and migrants, international documentation on HIV/STI prevention among sex workers and PLHIV is sparse and outdated.
- There are a number of definitions of sexual health in circulation, which may result in inconsistencies and miscommunication at an international level when developing HIV/STI prevention in the context of sexual health.

Conclusions and recommendations

- Synergy between European bodies and NGOs needs to be promoted with regard to data collection, reporting and publication. The creation of a mechanism, in the form of a template or toolkit, to aid countries in gathering comparable data on a variety of sexual health indicators and outcomes of public health interest could be considered.
- Existing EU projects with a similar focus, such as on migrants or MSM, need to be brought together and international collaboration could be strengthened to develop initiatives focusing on STI/HIV prevention in the broader context of sexual health and health promotion among risk groups.
- International agencies could continue to develop evidence synthesis and guidance to support work with vulnerable groups and to inform the development of a strategy on the comprehensive disease prevention approach.
- The creation of a set of overarching guiding principles would aid countries in developing national HIV and STI prevention programmes in the broader context of sexual health. An evidence-based framework would allow countries to evaluate their programmes against ‘good practice’, develop innovative and effective sexual health interventions and identify areas for improvement.
- Existing European expert networks could be utilised to review current interventions targeting vulnerable groups and to provide guidance and recommendations for effective sexual health promotion and HIV/STI prevention.

1 Background

Sexually transmitted infections (STI), including HIV infection, remain a major public health challenge across Europe [6]. Improving prevention efforts is therefore a priority, not only in the general population, but among groups most vulnerable to infection, including young people, men who have sex with men (MSM), sex workers, people living with HIV (PLHIV), migrants, populations at risk of sexual violence, and people who inject drugs (PWID). As these groups experience a range of sexual health needs, there is considerable overlap and synergy between the interventions required to prevent HIV/STIs and promote sexual health among these groups.

The overall aim of this report is to increase the understanding of how STI and HIV can be prevented among vulnerable groups in the broader context of sexual health and health promotion.

1.1 HIV and STI among vulnerable populations

The surveillance of HIV and STI has been coordinated by ECDC since 2008 and 2009, respectively. Surveillance reports have been published annually and demonstrate heterogeneity in the epidemiology of STI and HIV across Europe due to differences in health services, testing practices and reporting systems. Completeness and comparability of surveillance data still has to be improved.

Reporting rates of STIs across Europe vary widely, with differences in national surveillance systems and considerable overall underreporting. Chlamydia is the most frequently reported STI in Europe and the number of reported cases is continuously increasing, with 346 911 cases reported by 25 EU/EEA countries in 2011. The true incidence is likely to be much higher than the rates reported due to the asymptomatic nature of the infection and amount of underreporting. The highest rates of chlamydia are reported among young people aged 15–24 years (73% of all reports), with the majority of cases being reported among females (male-to-female ratio is 0.7). Gonorrhoea and syphilis are less common, with 39 179 cases of gonorrhoea (reported by 28 countries) and 19 798 cases of syphilis (reported by 29 countries). MSM are particularly affected by these STI, 33% and 42% of all reported 2011 cases, respectively. Since 2008, gonorrhoea increased by more than 5% in 13 countries. Moreover, 42% of all gonorrhoea cases were reported in young people aged 15–24 years. Syphilis has increased in many western EU/EEA countries, mainly due to increases among MSM. [7] Only 19% of these cases were reported among young people.

The number of newly reported HIV diagnoses in Europe has increased over time and in 2011, 28 083 cases were reported by 28 countries in the EU/EEA. Sex between men is the most dominant mode of transmission (39%) in the EU/EEA, followed by heterosexual contact (36%). Overall, 11% of all HIV cases were reported among young people aged 15–24 years. In 2011, a third of heterosexually acquired infections were diagnosed in individuals from countries with a generalised HIV epidemic, mainly from sub-Saharan Africa. More than 60% of these were diagnosed late (defined as having CD4 cell count below 350 cells/mm^3) [8].

Among sex workers, available data indicate a relatively high HIV prevalence among male and transgender workers, people who inject drugs (PWID) and migrant sex workers from countries with high HIV prevalence [9].

1.2 Sexual and reproductive health

Sexual and reproductive health (SRH) rights include the right to make informed sexual and reproductive health choices. Access to SRH services that provide SRH information and counselling, effective contraceptives and safe abortion care are therefore crucial [4]. Although effective contraceptives are now widely available in the EU/EEA, use of contraceptives and access to SRH services varies widely across and within countries [10]. Lack of access to sexuality education, contraception and life skills education to manage sexual relationships in a safe and positive manner places young people at increased risk of poor sexual and reproductive health [11]. Yet across Europe, the availability and quality of sexuality education varies widely [12] and risk-taking behaviour in young people is often unaddressed or inadequately addressed [13].

1.3 Sexual health approaches

It is increasingly recognised that addressing STI/HIV prevention within an integrated and comprehensive approach within the broader context of sexual health is more effective than organising prevention and control efforts in vertical programmes [14-16]. A number of definitions of sexual health have been published [17]. WHO endorses the definition of sexual health as ‘a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity’. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled [4].

Some countries in Europe have moved towards adopting this broader approach in their national policies in recognition of the links between STI and other areas of sexual health, including unintended pregnancy and sexual violence. The United Kingdom for example, produced a ten-year sexual health and HIV strategy in 2001 which took an integrated approach [18]. There is variability between countries as to the extent to which this broader approach has influenced the sexual health concepts adopted and the approaches used. Reflecting and reinforcing this variability are national differences in relevant policy, legislation, healthcare provision and education, as well as in public knowledge, attitudes (including stigma) and behaviour (including sexual behaviour and health-seeking behaviour).

Policies and programmes which promote sexual health for all through education, health promotion and the provision of reproductive and sexual health services may assist in combating the stigma associated with HIV and STI. Stigma and discrimination can be particularly strong for people living with HIV (PLHIV) and other populations vulnerable to STI and HIV, inhibiting their ability to protect their sexual health [19].

Comprehensive sexual health approaches need to be complemented with appropriate prevention programmes and services targeted towards vulnerable groups, including MSM, sex workers and PWID. Services need to be accessible and targeted to the needs of such marginalised, hard-to-reach groups, as recommended by WHO [20]. In many cases, these individuals become even more vulnerable as a result of contextual and structural factors which limit the control they have over their sexual health. Examples include national legislation and policies that may restrict access to healthcare services, or being in prison where vulnerable groups are over-represented and at increased risk of poor sexual health [21].

1.4 Rationale

There is significant potential for greater sharing of knowledge and joint approaches to sexual health in Europe, supported by evidence-based policy and examples of effective programmes and initiatives. This provides a strong rationale for seeking to increase knowledge of past and current work across Europe, identifying key stakeholders and mapping potential data sources which could be used to identify gaps and support greater synergy at European level.

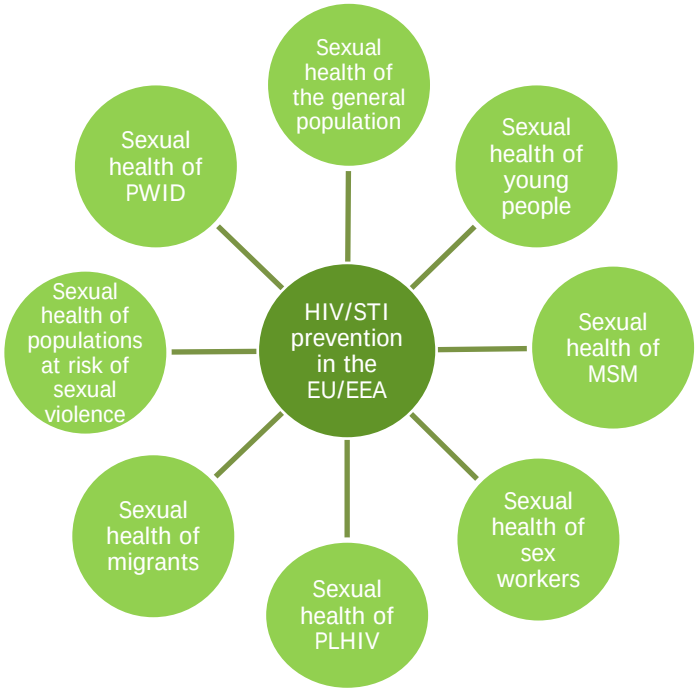
2 Methodology

The content of this report is based on information collected as part of a mapping exercise of sexual health activities in the EU/EEA, involving literature and internet searches and Member State surveys.

2.1 Sexual health domain framework

A sexual health domain framework reflecting the importance of addressing the sexual health of vulnerable groups in addition to the sexual health of the general population was developed and used to guide the search. The eight domains included in this report can be seen in the domain map (Figure 1).

Figure 1. Sexual health domain map



The report focuses on populations vulnerable to HIV and STI. Several considerations have guided the selection of these populations. A number of factors defy efforts to position individuals discretely into groups on the basis of sexual health risk, and this has prompted the view that, in a public health context, a focus on behaviour rather than groups may be more useful. For example, men and women behave in ways which may place them in more than one risk group. For instance, injecting drug users engage in unprotected sex with multiple sexual partners. In addition, individuals may not identify with groups characterised by certain risk behaviour, particularly where that behaviour is stigmatised. Similarly, men who have sex with men may not identify themselves as such. Furthermore, during the course of their life, individuals move into and out of groups identified epidemiologically as being at risk [16]. Nevertheless, a focus on population groups is valuable in the context of targeting interventions, and although STI can be contracted by people in all sections of society, some identifiable groups are more vulnerable than others.

Populations were selected not only because they are at greater risk of acquiring STI, but also because they may have particular communicational needs. Young people, for example, bear a disproportionate burden of disease and sexual ill health, but are also at a time of life when inculcation of skills and information is particularly important to lifelong sexual health. Furthermore, groups have been included, not simply on the basis of individual risk behaviour, but also vulnerability. For example, they may be more susceptible to social structural factors such as poverty, which may increase the likelihood of HIV and STI transmission. Individuals made vulnerable due to their setting, such as prisoners, are not separately addressed in this report. Finally, this report takes into account the fluidity of behaviour characterising groups; the fact that an individual's risk may depend not on their own, but on their partner's risk; and the fact that people do not necessarily identify themselves as belonging to a risk group, hence the decision to include a general population group.

2.2 Sexual health indicators

For each domain, relevant contextual, research and surveillance and implementation indicators were identified. It is important to note that the intervention indicators described do not necessarily reflect quality or coverage, as implementation monitoring and evaluation were beyond the scope of this study.

Contextual indicators

- Legislative aspects
- Political and structural context
- Economic systems
- Epidemiological context

Research and surveillance indicators

- Research data
- Surveillance and monitoring data

Intervention indicators

- National sexual health public education campaigns
- National prevention programmes
- Provision of sexuality education
- National screening and vaccination programmes
- Health services delivery.

2.3 Mapping exercise

Resources were identified through a literature and web search (Appendix A) that covered:

- Global publications from international organisations such as WHO, UNAIDS (UNGASS), the World Bank, Global Network of People living with HIV (GNP+), International Organisation for Migration (IOM), Amnesty International and International Planned Parenthood Federation (IPPF);
- Pan-European technical, surveillance and guidance reports from organisations such as ECDC, the European Cervical Cancer Association (ECCA), European Monitoring Centre for Drugs and Drug Addictions (EMCDDA) and the European Cancer Observatory.
- European research projects such as the SAFE Project, TAMPEP, Eurosupport, EMIS and EN-HERA!
- National policy documents and reports published by EU/EEA Member State government ministries, departments and public health institutes.

Relevant academic papers were gathered through searches of major online public health and medical databases such as PubMed, as well as more general search engines such as Google Scholar. No date restrictions were placed on the search.

2.4 Country feedback

Results of the mapping exercise were fitted to the framework and sent to the national contact point for STI/HIV prevention or the coordinator of the competent body for ECDC in the 30 EU/EEA countries. Appropriate country contacts were identified by ECDC competent bodies, a list of which can be found in Appendix C. These individuals were invited to validate the national country profile, allowing for changes according to the country-specific information provided. In all, 23 countries validated their country specific data. An overview of sexual health indicators in EU/EEA countries and a synopsis of references used to construct country profiles are presented in Appendix B, Tables 1-3 and a detailed characterisation of the sexual health domains for each country can be found in Appendix D – Country profiles.

3 Sexual health of the general population

To prevent the spread of HIV and STI in the general population, there is a need for a comprehensive strategy to address the broader topic of sexual health [22]. Untreated STI may not only facilitate transmission of HIV but can also cause long-term complications to sexual and reproductive health (SRH) [20,23]. The integration of STI and SRH services is beneficial, as utilising both family planning clinics and STI clinics to disseminate prevention material can reach a wider range of people and deal with problems of risk perception [22]. Population-level prevention strategies will benefit from a broad-spectrum approach, including primary education in the form of sexual health public education and awareness campaigns, comprehensive case management and community-level programming [22,23]. The 1998 United Nations publication 'Public health approach to STD control' [23] stressed the need for countries to adopt a more holistic public health package approach to HIV/STI control and prevention. The following components were recommended for inclusion: the promotion of safe sexual behaviour, condom use and health-seeking behaviour, the integration of STI services into primary care, effective case management, targeting those at high-risk, antenatal care service, and early case detection.

More recently, WHO's 'Global strategy for the prevention and control of STI: 2006-2015' [20] highlighted the increasing global burden of HIV/STI among 15–49 year olds and the cost-effectiveness of developing a strategy for prevention and control. Current efforts are not seen as sufficient and barriers that must be overcome include: the complexity of behaviour change, the availability of contraception and appropriate sexual health services. WHO recommended a unified innovative approach, consisting of components such as social marketing campaigns, user-friendly services, and male involvement initiatives for effective HIV/STI control. The report also provides a guide to collaborative implementation for HIV/STI control and prevention interventions.

Indicators used to monitor countries' progress in controlling the HIV epidemic are outlined in ECDC's 2010 progress report '*Implementing the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia*' [9]. Examples include national spending on HIV prevention, HIV-related knowledge, rates of testing, proportions of late diagnosis, condom use and qualitative measures to assess health promotion measures.

The reproductive health report 'State of sexual and reproductive health within the European Union 2011' commissioned by the European Union and the Portuguese Ministry of Health's High Commissariat for Health, assesses the current SRH of the general population [24]. This document was an output of the reproductive health project [25], which aimed to promote an integrated SRH strategy across the EU and to identify gaps and inequalities in public policy within the EU. The report provides in-depth profiles of all EU Member States covering the following topics: macro-economics, education, the national health care system, childbearing, contraceptive use, induced abortion, teenage SRH and management of infertility [24].

The state of SRH in Eastern Europe and the Baltic states is described in the 2006 'Federation for women and family planning' (ASTRA) report to the European Union[26]. The paper sets out recommendations to relevant EU commissioning bodies on ways to address SRH issues such as HIV/AIDS, abortion, family planning, and adolescent SRH. Examples include: adoption of a rights-based approach to SRH, collaboration between Member States, increased resource allocation to SRH and a focus on gender equality.

A regional report by the World Bank 'HIV epidemics of Europe: vulnerability and response' [27] examines the HIV epidemic in the European region, focusing primarily on high-risk populations such as sex workers, MSM and PWID. The report, a systematic review of both published data and grey literature, describes the epidemiological and behavioural trends of vulnerable groups, gaps in the HIV prevention response, challenges and examples of good practice in service provision, key country stakeholders in advocacy and health promotion and HIV prevention intervention coverage across the European region. The report offers recommendations as to how the gaps discovered should be addressed and the implications of the review findings.

The BORDERNETwork project (2010-2012) funded by the European Commission and the German Ministry of Health, works to scale up HIV/STI prevention, research, diagnosis and treatment in vulnerable groups through interdisciplinary cross-border networking in central, eastern and south-eastern Europe involving eight EU/EEA Members States [28]. The project has had a number of outputs including an expert workshop on improving the access of sex workers and PWID to HIV/STI testing services, the production of country-specific guidelines for the management of HIV co-infections, a training and good practice manual for HIV/STI prevention among migrants, and an online evaluation tool for HIV/STI prevention and SRH research programmes for young people.

3.1 Contextual factors

Legislative aspects

Several laws governing sexual conduct - and therefore relevant to control of STI - are in place in the majority of EU/EEA countries. One of them is the age of sexual consent – the minimum age at which a person is considered to be legally competent to consent to sexual acts. All EU/EEA countries have a legal age of consent in the range of

12–18 years old for both heterosexual and same-gender sex, with an average age of consent of 15 years old (Appendix D – Country profiles). Sex between men is legal in all EU/EEA countries, as is sex between women. There are regional variations in legislation relating to sex work in terms of where it is permitted, and whether the law relates to the buyer or seller. Sexual coercion, defined as rape, is illegal throughout the EU/EEA.

Several human rights declarations have a bearing on sexual health. These include declarations formulated by international organisations such as the United Nations at the International Conference on Population and Development (ICPD) in Cairo, 1994, where the right to 'Access to reproductive and sexual health services, including family planning' was one of four goals agreed by the conference. The International Planned Parenthood Federation (IPPF) has published two documents: 'Sexual Rights: an IPPF Declaration' [29] and 'Charter on sexual and reproductive health rights' [30], which set to guide countries on reinforcing their commitment to sexual rights. Progress in incorporating such statements of rights into internationally legally binding instruments has, however, been slow.

With respect to specific legislation that is relevant to the treatment of HIV/STI, these laws relate to partner notification and the mandatory notification of infections. Considerable heterogeneity exists in approaches to partner notification across the EU/EEA. Partner notification is mandatory by either the patient or the healthcare provider in ten countries (Appendix D – Country profiles). However, routine partner notification for HIV, gonorrhoea, syphilis, and chlamydia is carried out in the majority of the countries despite the lack of legislation [31]. Calls have been made for the setting of minimum standards for partner notification together with mechanisms for sharing best practice. Further research is needed to identify monitoring systems for inclusion in routine surveillance [32].

Political and structural context

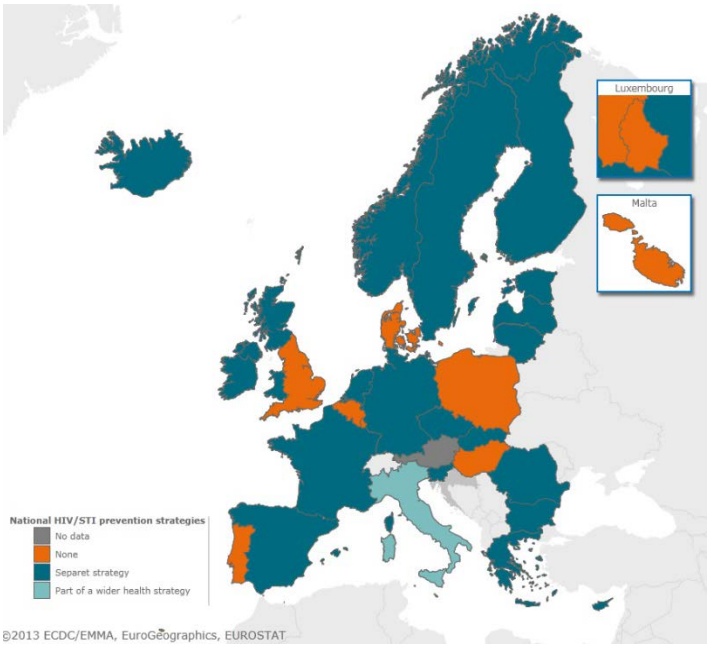
National sexual and reproductive health strategy

The purpose of a national SRH strategy is not only to reduce HIV/STI transmission in the population and reduce the prevalence of infections, but to achieve the benefits of synergy arising from a holistic approach to SRH, tackling these challenges alongside issues such as unintended pregnancy, abortion, contraceptive use, stigma, discrimination, and sexual violence. WHO Regional Office for Europe's regional strategy for sexual and reproductive health (2010) [33] acts as a framework by which Member States can design their national SRH policies, action plans for implementation, programme delivery and monitoring and evaluation strategy. Eleven EU/EEA countries (Finland, Greece, Latvia, Malta, Netherlands, Norway, Romania, Slovakia, Spain and UK) have adopted a national SRH strategy; information on national SRH strategies was not available for 10 countries (Appendix D – Country profiles).

National HIV/STI prevention strategies

National HIV/STI prevention strategies tend to have a narrower focus than national SRH strategies, and set out goals and objectives specific to reducing infection rates, increasing the use of HIV/STI services in terms of testing and treatment and increasing knowledge and awareness of HIV/STIs. Nineteen EU/EEA countries have a national strategy in place for the prevention of HIV/STIs and another 10 countries had strategies in place that had recently expired (within the last five years) (Appendix D – Country profiles) (Figure 2).

Figure 2. National HIV/STI prevention strategies implemented by EU/EEA, 2012



Data sources: literature and web review validated through country consultation (see Appendix D- Country profiles for details)

Many of these strategies were created in response to the 26th UN General Assembly Special Session (UNGASS) in 2001 that called on countries to declare their commitment to fight HIV/AIDS. Countries were encouraged to integrate HIV prevention, care, treatment, and support strategies into mainstream development planning and regularly report on their progress. The progress reports give a good overview of the national response to the HIV/AIDS epidemic, especially what is being done to target vulnerable groups such as MSM, sex workers and PWID. The progress report on the 2010 monitoring was published in 2011[9]; the 2012 monitoring report was published as ten individual thematic reports in 2013: leadership and financial resources [34], sex workers [35], civil society, men who have sex with men, people who inject drugs, migrants, treatment, care and support, stigma and discrimination, prisoners and combined reporting [35a–h].

In June 2011, the UN held a high-level meeting with the aim of encouraging countries to intensify efforts to eliminate HIV/AIDS by committing to the 2011 political declaration on HIV/AIDS and its new 2015 targets [36]. As a result of this meeting, UNAIDS has developed a revised set of indicators for country progress reporting, outlined in the document 'Global AIDS response progress reporting (GARP) 2012' [37]. UNGASS indicators have been adapted to be more relevant to the epidemiological context of individual EU/EEA Member States.

The role of non-governmental organisations

Non-governmental organisations (NGOs) dedicated to sexual and reproductive health play an important role in the control of HIV/STI among the general population. They work to enhance government services and provide additional support in areas such as SRH information, education and training, provision of family planning, advocacy for quality services, and community-based outreach.

The website EuroNGOs (European NGOs for Sexual and Reproductive Health and Rights, Population and Development) [38] is an online directory for NGOs based in European countries working to prevent HIV/STI worldwide. At least 28 countries in the EU/EEA have NGOs working to improve the sexual health of the general population (Appendix D – Country profiles). IPPF is an international NGO with a strong presence in Europe, acting as an umbrella organisation, with member associations in the majority of European countries.

Economic systems

The degree to which EU/EEA Member States can allocate resources to disease prevention in their countries is directly related to their national economic development and the political systems in place. A lack of public funding and the degree to which individuals are required to pay for their own care can affect coverage of healthcare services, limiting access to SRH services [39]. Healthcare provision systems in place in EU/EEA include: Bismarck (mandatory social insurance - 13 countries), Beveridge (social insurance system funded through taxation – nine countries), universal coverage funded by both the state and through taxation (seven countries), and private insurance (one country - Liechtenstein) (Appendix D – Country profiles).

3.2 Research and surveillance

Sexual health and behaviour of the general population

Comparable data on sexual health behaviour collected at a global level are not available. The only cross-national survey on the sexual attitudes and behaviour of the general population (the global sex survey) is carried out by a commercial company called the Durex Network. In 2005, survey participants numbered over 300 000 from more than 41 countries, 20 of which are part of the EU/EEA. Indicators examined include: age at first sex, number of sexual partners, unintended pregnancy, STI incidence and contraceptive use [40]. It is important to recognise that despite the large sample size, participants were recruited through the Durex website and through commercial advertising and the results are not necessarily representative of each country or of Europe as a whole.

Of the 30 countries in EU/EEA, 19 had a national survey to assess sexual knowledge, attitudes, and/or practices of the general population (Appendix D – Country profiles). National surveys for individual European countries, both nested and dedicated, are described in the 2009 ECDC report '*Mapping of HIV/STI behavioural surveillance in Europe*' [41].

HIV/STIs in the general population

The surveillance of HIV and STI has been coordinated by ECDC since 2008 and 2009, respectively. Surveillance reports have been published annually and demonstrate heterogeneity in the epidemiology of STI and HIV across Europe due to differences in health services, testing practices and reporting systems. Completeness and comparability of surveillance data still has to be improved.

STI reporting rates across Europe vary widely, with differences in national surveillance systems and considerable underreporting. Chlamydia is the most frequently reported STI in Europe and the number of reported cases is continuously increasing, with 346 911 cases in 2011. The true incidence is likely to be much higher than the rates reported due to the asymptomatic nature of the infection and amount of underreporting. The highest rates of chlamydia are reported among young people aged 15–24 (73% of all reports), with the majority of cases being reported among females (male-to-female ratio is 0.7). The burden of disease is yet to be confirmed in a number of countries which report low numbers of chlamydia. Gonorrhoea and syphilis are less common, with 39 179 cases of gonorrhoea and 19 798 cases of syphilis. MSM are particularly affected by these STI, 33% and 42% of all reported 2011 cases respectively. Since 2008, gonorrhoea has increased by more than 5% in 13/25 countries. 42% of all gonorrhoea cases were reported in young people aged 15–24 years. Syphilis has increased in many EU/EEA countries in the west of Europe, mainly due to increases among MSM [7].

The number of newly-reported HIV diagnoses in Europe has increased over time and, in 2011, 28 083 cases were reported in the EU/EEA. MSM is the most dominant mode of transmission (39%) in EU/EEA, followed by heterosexual transmission (36%). A total of 11% of all HIV cases were reported among young people aged 15–24 years. In 2011, a third of heterosexually acquired infections were diagnosed in individuals from sub-Saharan Africa [8].

HIV testing in the general population

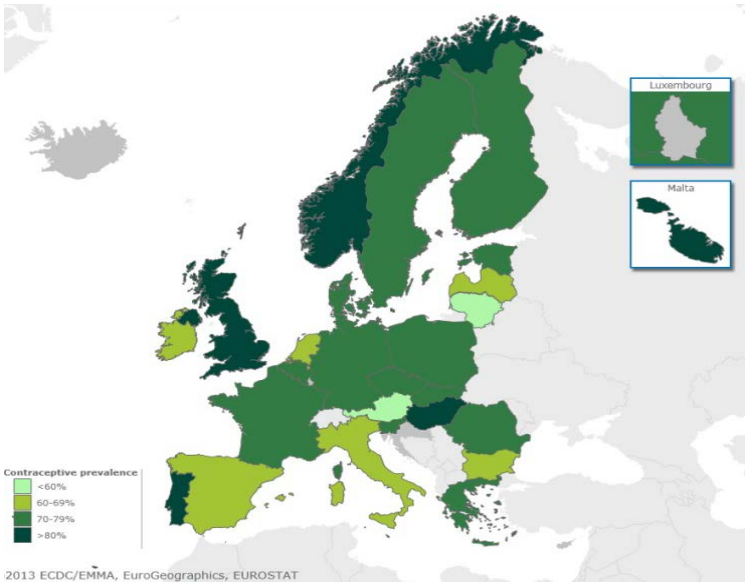
Data on HIV testing, excluding unlinked-anonymous testing and blood screening, are available in the HIV surveillance reports[8]. However, it is important to note that testing rates presented are likely to be overestimated, as the data are based on tests performed and not individuals tested and the numbers presented do not specify the populations being tested. Twenty-eight of the 30 EU/EEA countries routinely collect data on HIV testing in the general population (Appendix D – Country profiles).

WHO universal access progress reports [42] also provide data on HIV testing. Indicators reported by each country include number of health facilities providing HIV testing and counselling services; number and percentage of women and men aged 15 years and above who received HIV testing and counselling in the last 12 months and know their results and percentage of most-at-risk populations who received an HIV test in the last 12 months and who know their results.

Contraceptive use in the general population

The world contraceptive report [43], published annually by the UN Department of Economic and Social Affairs, provides routine worldwide data on contraceptive prevalence (percentage usage) 'among women aged 15–49 years in marriage or in union'. The data are obtained from national-level surveys with representative samples of women of reproductive age. As seen in Appendix D – Country profiles, 30 countries are covered by this report with only Iceland, Cyprus, Liechtenstein and Luxembourg missing (Figure 3).

Figure 3. Percentage of women of reproductive age (15–49 years) using methods of contraception among those who are 'married or in union' in EU/EEA



Source: United Nations Department of Economic and Social Affairs, Population Division
http://www.un.org/esa/population/publications/contraceptive2011/contraceptive2011.htm

3.3 Interventions

In 2010, WHO published 'Developing sexual health programmes: a framework for action' [14]. This report sets out a framework to aid decision-makers in assessing the current state of sexual health in their country and developing and implementing effective sexual health programmes. It emphasises the importance of taking a holistic approach to sexual health, focussing on five areas: laws, policies and human rights; economics; the health system; education; and society and culture. It also gives support for both population and community-based initiatives as part of an effective sexual health programme.

Public education campaigns

Public education campaigns utilise social marketing techniques and the media to disseminate health information and public health messages to the population. Effective information, education, and communication campaigns cover a wide range of activities and approaches including use of social networking sites, printed material, mass media, events to increase community awareness and giveaways, such as free condoms [44]. Studies have shown that mass media campaigns, utilising outreach tools such as television, radio, newspapers and billboards, may contribute to changing sexual risk behaviour [45,46].

HIV/AIDS awareness campaigns

HIV/AIDS awareness campaigns have been found to be effective in significantly reducing HIV transmission [47]. In 2003, a report 'Disease awareness campaigns guidelines' was published to provide information and promote good practice in the development of awareness campaigns. The report recommends that information presented in such campaigns be comprehensive, balanced and fair, readable/accessible, accurate, up-to-date and evidence-based. Subject matter should include general information on the disease; symptoms and risk factors; advice to patients; and sources for additional advice [48].

Twenty four countries in the EU/EEA have run at least one HIV/AIDS awareness campaign in the last five years (information was not available for Austria, Iceland, Italy and Liechtenstein). No information on such a campaign was retrievable from the bibliographic search for Finland or Italy (Appendix D – Country profiles). Production and distribution of a new interactive material (Health Education and HIV/AIDS & STI prevention) under the coordination of KEELPNO (Department of community interventions) was reported to be ongoing in Greece, designed to be distributed to schools.

Public education campaigns on STI

There is a lack of information on the existence of public education campaigns to prevent (specific) STI. Only eight EU/EEA countries – Belgium, UK, the Netherlands, Germany, Spain, Sweden, Slovenia and Slovakia – reported having had a specific STI prevention campaign in the last five years. However, information was not available for 18 countries (Appendix D – Country profiles). In Germany, a new multimedia campaign launched in early 2012 entitled 'Mediamix', aims to increase public awareness of both STI and HIV (personal communication).

Campaigns promoting condoms and/or contraceptive use

Nineteen countries (Belgium, Cyprus, Czech Republic, Denmark, Estonia, Germany, Hungary, Lithuania, Luxembourg, the Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and UK) reported having had at least one campaign to promote condom and/or contraceptive use in the last five years (Appendix D – Country profiles). Previous condom promotion campaigns in Europe have been found to have a positive effect on condom use among adolescents [49].

Vaccination programmes

Vaccination against human papilloma virus (HPV) aims to prevent disease associated with HPV infection (e.g. genital warts and cervical cancer). HPV vaccination has been shown to be effective against infection with oncogenic strains of HPV (types 16 and 18) and against cervical intraepithelial neoplasma, while also providing cross-protection for other non-oncogenic strains. Universal mass vaccination and catch-up campaigns are recommended for young women [50].

In 2009, the European Cervical Cancer Association (ECCA) published a report on current HPV vaccination policies and practices in the EU/EEA [51]. The report stresses the need for school-based provision, rather than on-demand provision that can miss minorities and those of low socioeconomic status. More current information on national and sub-national vaccination programmes, vaccination coverage and examples of good practice across the EU/EEA were collected as part of the Vaccine European New Integrated Collaboration Effort II (VENICE II) project, which ran from 2009-2011 [52]. The results of this project have yet to be released, but based on country feedback for this report an additional three countries offer a free HPV vaccination programme. At present, 16 countries (Belgium, Denmark, Germany, Greece, Iceland, Ireland, Italy, Latvia, Luxembourg, Malta, the Netherlands, Portugal, Slovenia, Spain, Sweden and UK) have a publically-funded vaccination policy against HPV, while vaccination is offered via co-payment in two more countries (Bulgaria and France) (Appendix D – Country profiles).

Screening programmes

An example of secondary prevention, screening involves the systematic application of a test with an aim to recognise disease or pre-disease conditions in apparently healthy individuals. Screening programmes can be applied to the general population as mass screening or only to those perceived to be at high-risk as selective or opportunistic screening [53].

The ten basic screening principles put forth by Wilson and Jungner in 1968 are as follows [54]: the condition must be an important health problem with a well-known natural history and a detectable early stage that can be treated; the test should be acceptable and able to detect the early stage, with recommended intervals for repeating; there should be staff and facilities necessary to carry out screening; and finally, the risks, both physical and psychological, and the costs, should be less than the benefits.

'Screening in Europe' [53], a policy brief released by the European Observatory on Health Systems and Policies, outlines current screening practices within the European Union. The document explores country policies on cancer screening (breast, colorectal and cervical), infectious disease screening (tuberculosis, chlamydia, and HIV) and antenatal screening (HIV, hepatitis B, rubella, and syphilis). Major challenges to screening in the EU include: the lack of regulation of screening in the private sector; inequitable access to screening services with the more affluent being more likely to accept screening invitations; bias to information provided about screening and misconceptions by the public and media as to the limitations of screening.

Chlamydia, antenatal and cervical cancer screening programmes are particularly relevant to a comprehensive strategy to prevent the spread of HIV/STIs in the EU/EEA, as well as to reduce the morbidity and mortality associated with HIV/STI.

Chlamydia screening

Evidence is limited as to the effectiveness of screening in the reduction of transmission and long-term complications of chlamydia. However, the short-term benefits in reducing pelvic inflammatory disease (PID) have been documented [55,56] and mathematical modelling has predicted that high uptake of continuous opportunistic screening could reduce the prevalence of chlamydia significantly in a number of years [55,57].

The ECDC report '*Review of chlamydia control activities in EU countries*' [39] outlines both opportunistic testing and national screening policies and practices in Europe, as well as country programming still in the planning phase. This overview is being updated in 2013 in collaboration with the European STI expert network. The guidance document 'Chlamydia control in Europe' [55] acts as a guide for policy-makers in developing and implementing national strategies for chlamydia control. It recommends a step-by-step approach to developing national screening programmes that can be adapted to the local epidemiological context and healthcare: primary prevention, case management, opportunistic testing and screening programmes. The report, however, does acknowledge that there is limited evidence that screening programmes reduce chlamydia transmission in the population over time. Eight of the 30 EU/EEA countries reported to have some form of screening programme for chlamydia currently in place (Appendix D – Country profiles).

Antenatal screening

Prevention of mother-to-child transmission (MTCT) of infections relies heavily on early detection and prompt treatment of the infected pregnant woman. Antenatal screening is therefore extremely important in the prevention of MTCT of infections such as HIV, hepatitis B and syphilis. Studies have shown that antiretroviral therapy (ART) can strongly reduce the risk of vertical HIV transmission from mother to child [58]. In addition, screening and treating mothers for syphilis is effective, safe and inexpensive for the prevention of congenital syphilis [59]. A paper published on AIDS in 2002 describes the European consensus statement and supports offering an antenatal HIV test to all pregnant women as the standard of care in Europe [60]. A review of antenatal HIV screening in Europe [61] was published in 2007 which assesses antenatal HIV screening policies for 25 European countries. Based on this paper and country feedback, twenty-four countries have antenatal screening policies for HIV in place. There was no information available for four countries (Appendix D – Country profiles).

Cervical cancer screening

Cervical cancer, a complication of infection among individuals with high-risk types of HPV, is an important area to address for the prevention of disease and the improvement of women's sexual and reproductive health across Europe. Secondary prevention in the form of cervical cancer screening complements the HPV vaccination strategies described above.

A summary of European country-level policy on cervical cancer screening is covered in 'Comparisons of cervical cancer screening programmes in the European Union' (2000) [62]. After researching the EU/EEA countries not mentioned in this paper, it was found that at least 26 EU/EEA countries have some form of cervical screening programme in place (Appendix D – Country profiles). Lack of programme evaluation due to non-systematic data collection is an obstacle to effective screening in Europe. The authors recommend standard practices and training be rolled out across the region to improve the comparability and evaluation of screening programmes at an international level, as well as to assess cost effectiveness of European resource allocation.

Health services delivery

It is well known that cost plays an important role in the utilisation of contraception, condoms and testing and treatment services by the general population. Provision of free oral contraception and condoms distributed by either health services or NGOs involved in family planning can influence the adoption of safer sex practices and the overall reduction in transmission of HIV/STI and unintended pregnancies [63]. However, provision can often be dependent on country-level political systems and is sometimes only available for married couples or young people.

Seven countries seem to provide some form of free contraception (Luxembourg, Norway, Portugal, Romania, Slovakia, Slovenia, and UK) and five countries have age restrictions on free provision or partial reimbursement (France, Germany, Norway, Spain and Sweden) [24,64]. Free condoms are provided by 17 countries, with partial reimbursement in Germany (Appendix D – Country profiles)

Barriers to HIV testing include both contextual and socio-medical aspects such as inadequate knowledge of services available and effective treatment; fear of a positive test result; unawareness of free/low cost services and low perceived risk of acquiring HIV [65]. HIV testing guidelines were published by ECDC in 2010 [66] along with an evidence synthesis on increasing uptake and effectiveness in Europe [67]. HIV and/or STI testing and treatment services are free of charge in 19 countries (Appendix D – Country profiles).

4 Sexual health of young people

Young people are especially vulnerable to poor SRH and are at increased risk of acquiring HIV/STI. Not only has this age group been found to be more biologically susceptible to STI, but they have been shown to have higher rates of partner change and engage in more high-risk sexual behaviour than the general population [68]. Those under 25 years of age are also less able to negotiate safer sex due to structural factors, such as limited access to contraception, SRH services and sexuality and relationship education [69]. As the future of our society, it is important to ensure that young people are provided with the support and guidance needed to make informed choices about their health [69].

A 2007 policy brief by IPPF as part of the Sexual Awareness for Europe (SAFE) Project entitled 'Developing Policies on the Sexual and Reproductive Health and Rights of Young People in Europe' [11], acts to inform policy-makers of the components necessary for a youth-friendly SRH policy. This document identifies the following five key policy areas to which improvements can be made: information, education and communication; health services for young people; access to contraception; prevention of HIV/STIs and unintended pregnancy and safe abortion.

Two very useful tools in assessing the SRH of young people in Europe include IPPF's 2011 SAFE II: Baseline youth SHRH policy assessment in Europe [70] and a report produced in 2007 by the Durex Network and Ogilvy Public Relations 'Safer sex for young people: review of information and data relating to sexual awareness and behaivour of European Youth' [71]. The SAFE II report acts as a policy assessment tool aiming to develop a methodology for cross-national comparison of young people's SRH, identify key decision-makers and relevant documents and summarise the current status of youth SRH in EU Member States. In comparison, the Durex report lists important surveys and academic papers on adolescent SRH at both the international and pan-European levels, describes best practices in education and awareness campaigns across Europe and, for each EU country comments on the availability of data and major findings in terms of youth sexual behaviour and education, and identifies gaps and common themes in SRH provision.

4.1 Contextual factors

Legislative aspects

The international policy environment plays a significant role in young people's SRH in Europe. The UN Convention on the Rights of the Child is an international treaty for the protection and assistance of all children without discrimination, recognising their human rights (<18 years of age). This agreement has been signed and ratified by all EU/EEA Member States, guaranteeing youth in Europe: access to education and healthcare, the opportunity to develop personal skills and talents and the chance to grow up in a healthy, happy environment [72]. This is significant since countries which have signed and ratified the agreement are held accountable for improving young people's SRH rights and are obliged to report on their progress [70].

Political systems and infrastructure

National strategies to reduce rates of teenage pregnancy

When devising ways to improve the SRH of young people in Europe, reducing unintended teenage pregnancy is a key objective. Teenage pregnancy is associated with an increased risk of negative social, economic and health outcomes, including an increased risk of HIV/STI, carrying significant private and public costs [73]. Thus, a comprehensive approach to HIV/STI prevention including national strategies to reduce rates of teenage pregnancy may be beneficial.

A review by the UK Health Development Agency published in 2003 (Teenage pregnancy and parenthood: A review of reviews) [74] is useful for policy makers in deciding the most important strategy components. The study found strong evidence to suggest that education linked to contraceptive services, youth development programmes and family outreach is effective in reducing teenage pregnancy. Evidence was found to support long-term interventions tailored to local needs, focussing on high risk groups and including interpersonal skill development.

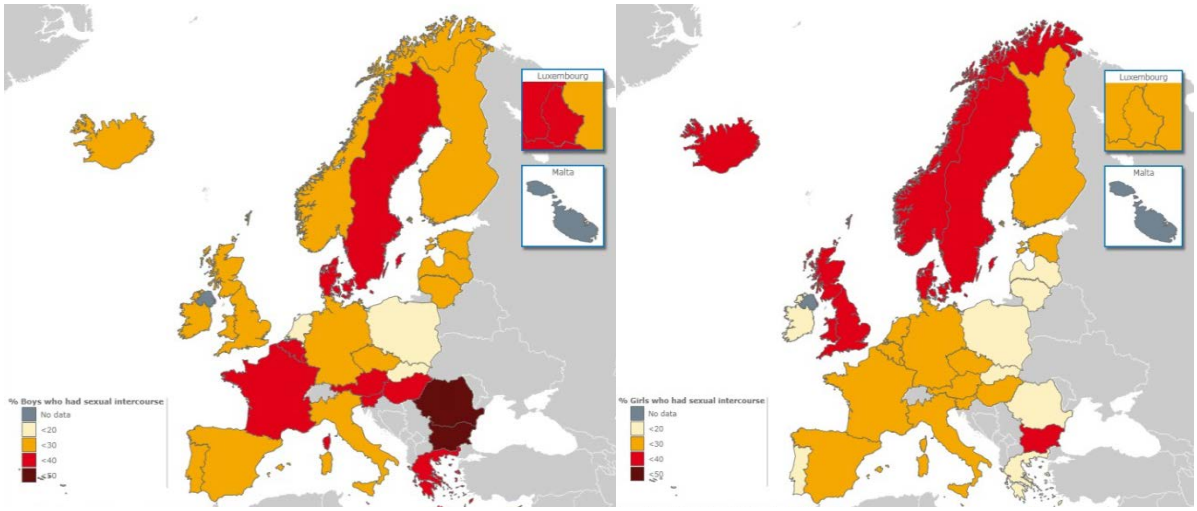
Eight of the 30 EU/EEA countries (Finland, Germany, Latvia, Netherlands, Norway, Slovakia, Spain and UK) currently have national strategies to reduce teenage pregnancy. Iceland had a strategy which ended in 2010 (Appendix D – Country profiles). One success story in the EU is the 'Teenage Pregnancy Strategy' for England, adopted in 1999 and carried out over 10 years. Implementation lowered the national under 18 conception rate by 13.3% and the number of births by over 25% [75]. The strategy was successful in reducing teenage pregnancies which continues to be a priority in England [75,76].

4.2 Research and surveillance

Sexual health and behaviour of young people

The most prominent survey on the health behaviour of young people is WHO Europe's 'Health behaviour in school-aged children survey' of 2009-2010. Indicators specific to sexual health behaviour, such as sexual activity, contraceptive use at last intercourse and condom use at last intercourse were nested within the survey questionnaire under the category of risk behaviour. The report breaks down the results by country and gender. Approximately 1 500 secondary students were targeted for the survey in each of the 41 countries participating [67], [77]. Of the 30 countries in the EU/EEA, 27 took part. Data on the indicators (e.g. percentage of 15-year old boys and girls sexually active and percentage of 15-year old boys and girls using a condom at last intercourse by country) are included in Appendix D – Country profiles. (Figure 4).

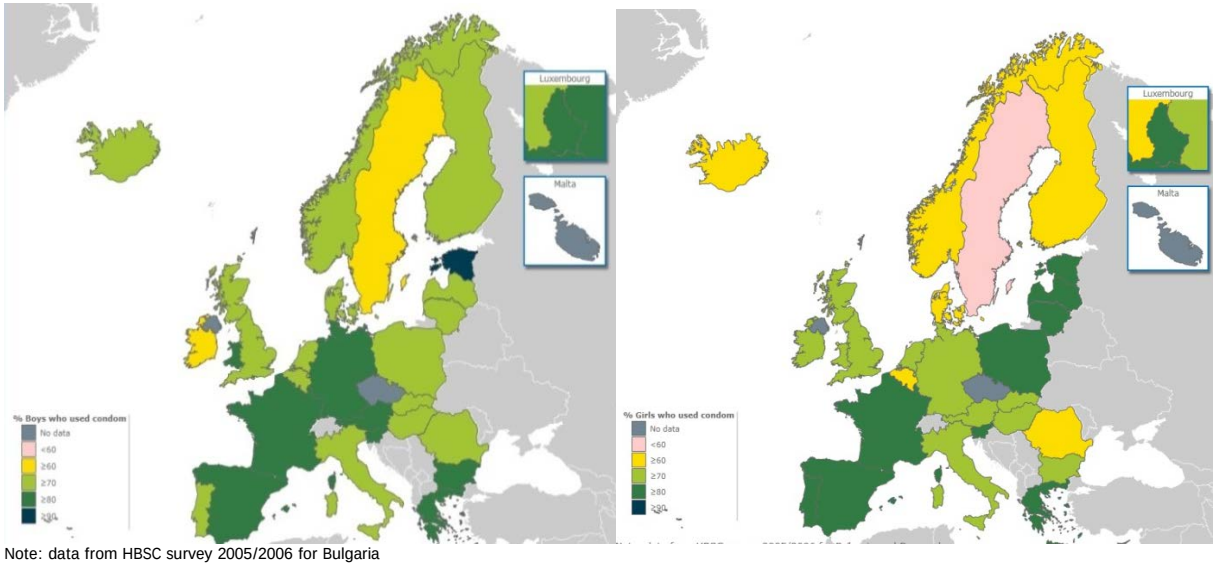
Figure 4a. 15-year-old boys and girls who have had sexual intercourse in EU/EEA countries



Note: data from HBSC survey 2005/2006 for Bulgaria
©2013 ECDC/EMMA, EuroGeographics, EUROSTAT

Source: WHO Europe, Health Behaviour in School-Aged Children (HBSC) study: international report from the 2009/2010 survey

Figure 4b. 15-year-old boys and girls who used a condom at last sexual intercourse in EU/EEA countries



Note: data from HBSC survey 2005/2006 for Bulgaria
©2013 ECDC/EMMA, EuroGeographics, EUROSTAT

Source: WHO Europe, Health Behaviour in School-Aged Children (HBSC) study: international report from the 2009/2010 survey

Information on availability of data from national surveys on the sexual health and behaviour of young people is included in Appendix D – Country profiles and in more detail in the ECDC report '*Mapping of HIV/STI behavioural surveillance in Europe*' [41].

HIV/STI among young people

HIV and STI surveillance results are published annually and data on young people aged 15–24 years is available for those countries that could report on age and gender [7,8]. A disproportionately large number of young people are affected by STI and account for a high proportion of all reported cases of chlamydia and gonorrhoea diagnosed: 73% and 42% respectively compared to only 16% for syphilis. Chlamydia is more often diagnosed among young women than young men. However, these results must be interpreted with caution as they could be affected by screening strategies targeting young people, and especially young women.

Table 1. HIV and STIs among young people in EU/EEA countries, 2011

Indicators 2011	Chlamydia	Gonorrhoea	Syphilis	HIV
Rate per 100 000 population	175.0	12.6	4.9	5.7
Male-to-female ratio in reported cases	0.7	2.7	3.9	3.0
Percentage in young people of 15–24 years	73%	42%	19%	11%
Rate for 20–24 year olds per 100 000 population	731.0	36.0	5.7	7.7%

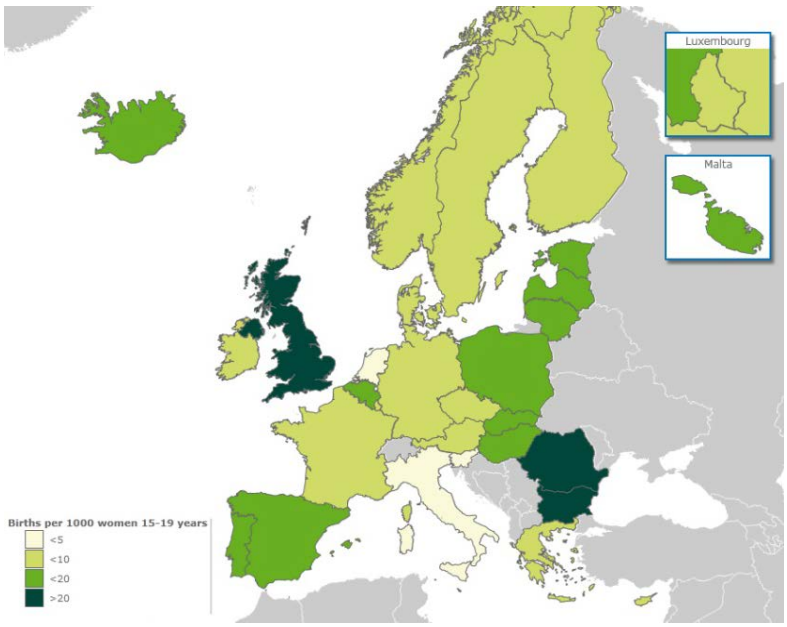
Source: HIV/AIDS surveillance in Europe 2011 [8]; STI 2011 report [7]

The national epidemiological context among young people in Europe is included in Appendix D – Country profiles.

Adolescent birth rates

Data on adolescent birth rates (15–19-year-olds) in the EU are presented in Appendix D – Country profiles (source: UN Statistics Division). Data in this report refer to the most recent year for which that information was available from 2000 to 2008. It appears that higher rates of teenage births are observed in eastern Europe and the Baltic states, while lower rates are seen in western Europe, especially Austria, Liechtenstein and the Netherlands [78] (see Figure. 5).

Figure 5. Adolescent birth rates in EU/EEA countries (per 1 000 women aged 15–19 years)

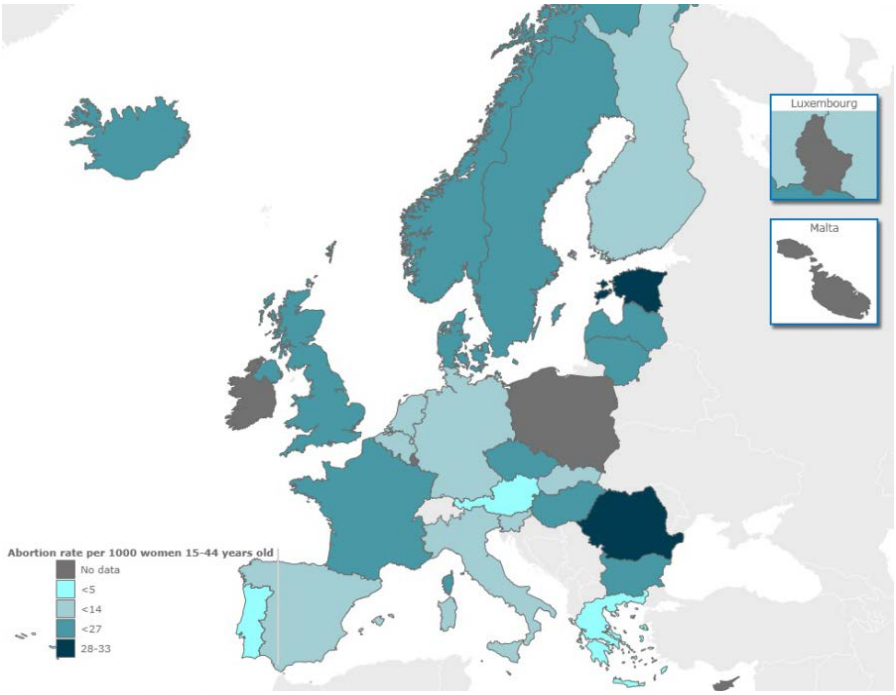


Source: United Nations Statistic Division; most recent data from the period 2000–2008

Abortion

Data on abortion were obtained from the same source as the data on adolescent birth rates, the UN Statistics Division. Rates displayed in Appendix D – Country profiles are per 1 000 women aged 15–44 years, using the most recent year available for the period 1996–2005. Similar to adolescent birth rates, the highest rates of abortion are observed in Eastern Europe and the Baltic States and the lowest rates in western Europe. It is important to note that access to abortion varies between countries [79] (Figure 6).

Figure 6. Abortion rates in EU/EEA countries (per 1 000 women 15–44 years)



Source: United Nations Statistic Division; most recent data from 1996–2005

4.3 Interventions

The systematic review of interventions to prevent the spread of STI, including HIV, among young people in Europe examined the effectiveness of health promotion and STI risk reduction interventions across the EU/EEA. The researchers found that peer-led interventions were better accepted by young people and more successful in improving sexual knowledge than those led by teachers. The paper suggests the following approaches in preventing HIV/STI among young people: involving families in behaviour-change initiatives, adopting a broader sexual education curriculum, providing condoms free of charge, developing interventions targeting same-sex groups and offering anonymous testing [80].

The EU-funded Sunflower consortium project, which ran from 2007–2011, worked to collect and disseminate data on HIV/AIDS among young people and recognise examples of good practice across Europe. The Sunflower handbook highlights innovative strategies to promote safer sex among adolescents, increase access to targeted services and improve awareness of HIV/STIs [81].

National prevention programmes targeting young people

National HIV/STI prevention programmes targeting young people are in place in 24 countries in the EU/EEA (Appendix D – Country profiles). Two examples of national prevention programmes targeting young people are given below.

In Estonia, the government adopted a national HIV prevention strategy which includes behaviour-change communication targeting youth and youth counselling services that offer HIV/STI testing and STI treatment. The services of youth counselling centres are coordinated by the Estonian Sexual Health Association and are available in all counties and major cities. The centres offer sexual and reproductive health lectures, individual counselling and HIV/STI testing for those up to 24 years of age [82].

In the Netherlands, prevention programming is multifaceted and integrates STI care with sexual health services. The relatively recent project, Sense, aims to provide youth-friendly services to people aged 15–24 using web-info, email, chat, a helpline and face-to-face consultation (personal communication).

Sexuality education

Sexuality education is perhaps one of the most important means of promoting the sexual well-being of young people and a key component of a comprehensive strategy for HIV/STI prevention in Europe. Sexuality education acts to inform young people in the physical, emotional and social elements of sexuality and has been included as a core aspect in WHO's sexual health strategies [33] [83].

Contradictory to claims that teaching youth about sex can encourage early onset of sexual activity or result in negative health outcomes, a recent literature review of over 80 studies in both developed and developing countries has found strong evidence to suggest that sexual education has a positive impact on the behaviour of young people, reducing sexual risk behaviour and consequently reducing the risk of acquiring HIV/STI [84]. Sexual education was found to be effective in: delaying sexual initiation, decreasing the number of sexual partners, increasing condom use, increasing knowledge and awareness of HIV/STI, increasing the ability to negotiate safer sex and avoid unwanted sexual activity and increasing communication with parents. It is important to note that this paper reviews the effectiveness of sexual education, a term which focuses on HIV/STI prevention and pregnancy, rather than the broader term sexuality education, which also encompasses aspects of sexual health such as gender roles and relationships.

The IPPF report 'Sexuality education in Europe: a reference guide to policy and practice' (2006) summarises the regulation, provision, quality and availability of sexuality education programming in each European country [12]. Major challenges in the provision of sexuality education in Europe include: insufficient coverage throughout countries with a discrepancy between rural and urban areas; a lack of adequate training for teachers and the fact that in some countries the quality of lessons is dependent on the attitudes of school administration and individual teachers. Another obstacle to the provision of sexuality education in schools is opposition from conservative and religious groups [12].

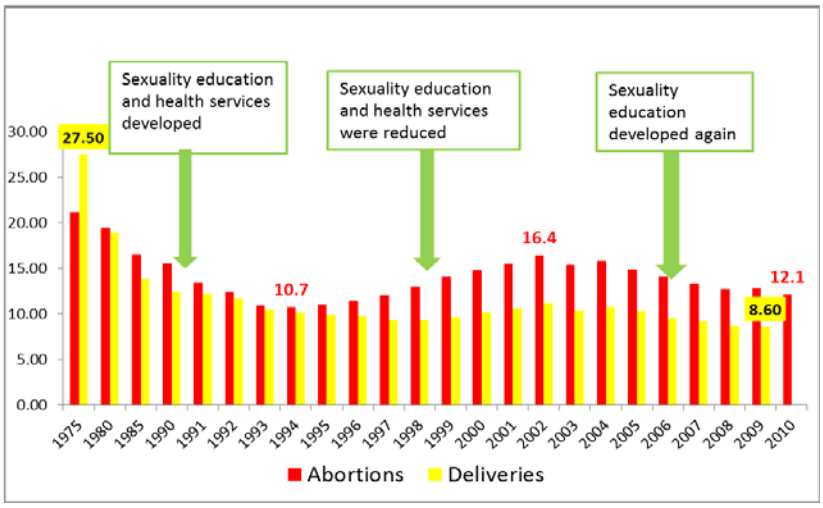
Sexuality education programming has many opportunities as it can be curriculum-based and implemented not only in traditional school settings by teachers, but in clinics and community settings, such as youth facilities, in faith centres, or through the internet (including social networking sites) and in juvenile detention centres by healthcare professionals and NGOs. The existence of NGOs dedicated to sexuality education is important, not only in terms of advocacy, but in the effort to reach at-risk youth and those not attending formal programmes [84].

Sexuality education was found to be mandatory in 20 countries; it is not mandatory in Bulgaria, Cyprus, Greece, Italy, Lithuania, Poland, Romania, Slovenia, Spain and United Kingdom. Minimum standards for sexuality education exist in 22 countries (Appendix D – Country profiles). In addition, eight countries, Finland, Germany, Latvia, Netherlands, Norway, Slovakia, Spain and the UK, have strategies to reduce teenage pregnancies.

In total, 26 countries have NGOs involved in the promotion of quality sexuality education with respect to activities such as the creation of education materials, the provision of training seminars for staff, peer education and supplementary sexual health lessons (Appendix D – Country profiles). No NGOs are involved in Italy and Slovenia and this information was missing for Liechtenstein and Malta.

In a 2012 country mission to Finland, ECDC reviewed the 2007–2011 Action Programme for Promotion of Sexual and Reproductive Health [85]. In Finland, sexual and reproductive health services are provided at municipal level. Sexual health counselling is integrated into the general services of the health centres, and every centre has a member of staff who is trained as a sexual counsellor. Sexual and reproductive health activities were established in the 1970s. Sexuality education also became obligatory in schools in 1970. In 1972, it became the duty of municipalities to provide counselling and contraception free of charge for the whole population. The development of sexual and health education services was followed by a decline in abortions and deliveries in young girls. This trend was reversed when the services were reduced during the recession experienced in Finland in the 1990s (Figure 7). These worrying observations have led to a re-launch of sexual and reproductive health services and the establishment of the Action Programme. The aim of the programme is to promote the sexual and reproductive health of the population, as well as to develop relevant methods, competencies and service structure. It establishes 14 themes with specific objectives, focussing on young people, i.e. sexual counselling, provision of knowledge and information, reorganisation of services, family planning, STI prevention and care, education and training, and research into sexual and reproductive health. An interim evaluation of the programme was carried out in 2009. The fact that the programme was initiated at ministerial level is considered to be a useful aid to its legitimacy and visibility, improving the potential for action in the field of sexual and reproductive health. One of the main achievements has been the establishment of a Unit for Sexual and Reproductive Health in the National Institute for Health and Welfare (THL) which improves national guidance and supports the municipalities in their activities. Sexual counselling has become a legal obligation in maternity and child health clinics, school and student healthcare. As a consequence, promotion of sexual health has continued in health centres and hospital districts and sexual counselling and therapy services have increased.

Figure 7. Number of abortions and deliveries per 1 000 in 15–19 year old girls, Finland, 1975–2010



Source: Family Federation of Finland

Sexuality education is increasingly being seen as a fundamental human right. There has been a shift from teaching sexual health from a strictly biological perspective, highlighting the negative consequences of sexual activity, such as unintended pregnancy and STIs, to working towards the empowerment of youth and the adoption of safer sexual behaviour [86]. In an effort to improve sexuality education, the Federal Centre for Health Education (BZgA) in Germany and WHO Europe published 'Standards for sexuality education in Europe – a framework for policy makers, educational and health authorities, and specialists' (2010). This report outlines a number of principles of sexuality education: it should be offered early, age-appropriate, empowering, it should focus on well-being as a whole and be based on a human-rights approach and scientifically accurate information [87].

Youth-friendly services

As access is a key determinant of young people's SRH, it is necessary for services and policies to be youth-friendly. Health systems can be made more responsive to the needs of young people by focussing on making services available, accessible and appropriate, generating resources in terms of staff and facilities and gaining the support of policy makers [88]. The report from WHO Europe [88] summarises the proceedings from an international conference that took place in Scotland in 2009, involving 35 representatives from European countries, young people and participants from the European Youth Forum. The report offers case studies and examples of best practice across Europe in terms of youth-friendly services. Portugal, Finland, Sweden and the UK were the only EU/EEA countries involved in this conference.

5 Sexual health of men who have sex with men

Men who have sex with men (MSM) in Europe are particularly vulnerable to poor sexual health and are disproportionally affected by HIV and STI. This risk is heightened by high levels of unprotected anal intercourse among MSM and extensive sexual networking, leading to outbreaks of syphilis, hepatitis C, and lymphogranuloma venereum (LGV) in MSM [89]. Barriers to HIV/STI testing and treatment and receiving quality care include societal stigma and discrimination based on sexual orientation, as well as ignorance, insensitivity and lack of awareness by healthcare providers [89-91].

In 2011, WHO produced guidance on the prevention and treatment of HIV and other STI among men who have sex with men and transgender people which outlined evidence-based recommendations on designing interventions tailored to the needs of these populations. Recommendations focus on prevention of sexual transmission, HIV testing and counselling, behavioural interventions, information, education and communication, substance abuse, HIV care and treatment, and prevention and care for other STIs. Guiding principles supported by WHO to reduce the spread of HIV and STIs include: a public health approach based on human rights principles, adopting a comprehensive health package and expanding the focus from just HIV and STIs to sexual health as a whole [90]. The report builds on the 2009 UNAIDS Action Framework: Universal Access for Men who have Sex with Men and Transgender People [92].

In 2009, ECDC released a technical report entitled '*Effectiveness of behavioural and psychosocial HIV/STI prevention interventions for men who have sex with men in Europe'* which identified both characteristics common to successful interventions and gaps in the evidence [93]. The majority of interventions among MSM are aimed at altering knowledge and attitudes related to the perception of risk in an effort to facilitate behaviour change. Internet-based interventions are becoming more popular to target hard-to-reach groups, such as MSM who do not openly identify themselves as homosexuals, while other interventions take place in gay venues and health facilities. Major gaps were identified in intervention outcome assessment, highlighting the need to implement new programmes with rigorous monitoring and evaluation.

The Sialon II Project [94], funded by the EU Commission under the 2008–2013 Public Health Programme, began in 2011. Sialon II aims to encourage and carry out targeted prevention and surveillance among MSM in Europe and Central Asia. The project is also working to build a network of institutions in an effort to support a comprehensive and integrated HIV/STI prevention strategy.

The Everywhere project, originally funded by the EU Commission and continued by the Terrence Higgins Trust (UK-based NGO), has worked to develop and implement a European model of good practice in the prevention of HIV among MSM[95]. The Everywhere project works across sectors with public health authorities, NGOs, academics and most importantly local businesses including sex venues, gay-friendly social spaces, hotels and gay dating websites, to ensure a set of sexual health standards are met. The project advocates the availability of condoms and lube, adequate lighting and sexual health promotion resources in venues where there may be sex on the premises. Businesses are audited and show compliance to these standards by displaying the 'Everywhere' logo. A similar project, Play Zone, is supported by local gay-friendly businesses in the UK [96].

5.1 Contextual factors

Political systems and infrastructure

The role of non-governmental organisations

Civil society plays a crucial role in the effort to prevent HIV/STIs and promote sexual health among MSM. NGOs can utilise non-traditional settings, such as the internet and popular gay venues, to access hard-to-reach groups. NGOs across Europe dedicated to the sexual health of MSM are involved in activities such as peer education, mass media dissemination, counselling and testing services and condom distribution [97]. The Global Forum on MSM and HIV is an example of an NGO that works worldwide with member organisations across Europe, to advocate for equitable access to HIV prevention, treatment and support services for MSM while promoting their human rights and health [98].

In 26 Member States there are NGOs dedicated to MSM (Appendix D – Country profiles). There are no NGOs dedicated to HIV/STI prevention and sexual health promotion among MSM in Luxembourg or Poland and this information is missing for Liechtenstein and Portugal.

5.2 Research and surveillance

Sexual health and behaviour of MSM

The 2010 European Men-Who-Have-Sex-With-Men Internet Survey (EMIS) is an internet-based cross-national research project in Europe on STI and sexual health among MSM [91]. Indicators examined include: self-reported STI testing practices, frequency of penile/anal inspection, number of sexual partners, venues where partners are found and possible HIV transmission risk assessed by the reporting of unprotected anal intercourse. With the exception of Liechtenstein and Iceland, MSM in all EU/EEA countries were covered by this survey (Appendix D – Country profiles).

Sexual behaviour according to EMIS

The EMIS chapter on sexual behaviour reveals that half of the respondents had had their first same-sex experience before the age of 18 (median) and their first experience of anal intercourse before they were 20 (with some variation between sub-regions). Overall, 58% of respondents reported having had a steady partner in the last 12 months and 67% of these had had unprotected anal intercourse (UAI) (i.e. 39% of all respondents reported UAI with a steady partner). Twenty-two per cent of men with a steady partner had non-concordant UAI, which is UAI with a partner of unknown or discordant HIV status, with that partner (i.e. 13% of all respondents). These results indicate that many men take their HIV status and that of their partner into account when deciding on the use of condoms for anal intercourse. It also suggests that prevention efforts to promote mutual HIV testing and disclosure of HIV status in steady relationships should be continued. Special attention is needed for young MSM (<25 years) and MSM with lower levels of education, as they reported significantly higher levels of non-concordant UAI with steady partners.

Overall, 67% of respondents reported having had one or more non-steady partners in the last 12 months and 39% of these reported having had UAI with at least one non-steady partner (i.e. 26% of all respondents reported UAI with a non-steady partner in the last 12 months). Twenty-five per cent of those with non-steady partners had non-concordant UAI with a non-steady partner (17% of all respondents).

After adjusting for seroconcordance in the multivariate analyses, age and settlement size were not related to non-concordant UAI with non-steady partners; educational level was related only when looking at unadjusted UAI. HIV status, on the other hand, was strongly related to non-concordant UAI suggesting that almost twice as many HIV-positive MSM reported UAI with non-steady sex partners as HIV negative and untested men. In addition, more than half of the MSM reported not having disclosed their HV status to their last non-steady partner when having UAI. HIV positive men were slightly more likely to have disclosed than HIV negative and untested men (47% vs. 42%). These figures do not necessarily imply high risks of HIV transmission, however, since most HIV positive MSM were receiving antiretroviral treatment, and reported having had an undetectable viral load. Nevertheless, these results do indicate that prevention strategies should be continued to address the promotion of less new sexual partners, non-penetrative sexual practices, condom use and focus on HIV testing and status disclosure.

Analysis of the results at sub-regional and country level indicated that MSM from Central-West Europe, France and Belgium reported the lowest rates of non-concordant UAI with any male partner while MSM from North East and South East Europe reported the highest rates. The results at country level are slightly different. Countries with a score below the 25th percentile were Austria, Belgium, Germany, Finland, France, Greece, Luxembourg, and Slovenia. Countries with a score above the 75th percentile were Bulgaria, Croatia, Lithuania, Latvia, Romania and Slovakia.

There appears to be a West-East divide in rates of UAI. The proportion of MSM who reported no condom at last anal intercourse, had any UAI in the past year, and reported non-concordant UAI with non-steady partners increased when moving from the west (EU/EEA countries) towards central European countries that joined the EU after 2004 (and further to non-EU countries). Further investigation is needed to ascertain whether access to HIV testing and healthcare, exposure to prevention activities, discrimination and social and gay community support had an impact on the frequency of UAI, as the findings will inform prevention intervention policies.

Source: EMIS 2010 [91]

In addition, 18 countries have a type of national survey to assess the sexual health of MSM (Appendix D – Country profiles). National surveys are described in more detail in the ECDC report on HIV/STI behavioural surveillance [41].

HIV testing among MSM

EMIS also describes self-reported HIV testing practices and knowledge of HIV testing among MSM [91].

HIV testing according to EMIS

Most respondents reported that they had access to free or affordable HIV testing, with exceptions in some countries. It may not be a coincidence that countries with lower perceived access to HIV testing ranked high in terms of gay-related stigmatisation and weak gay communities. Testing appeared to be more accessible in urban than in rural settings. Testing rates were lower among young MSM and MSM who did not visit gay social or sex venues and they were lower in rural than urban settings.

HIV testing varied widely between and within the regions, but the demographic associations were similar in all regions. It suggested that MSM with lower levels of education were both less likely to test for HIV and more likely to test positive. Migrants were more likely than non-migrants to test for HIV and to be diagnosed with HIV infection.

EMIS results suggest that only a minority of respondents were tested for HIV close to episodes of unprotected anal intercourse (UAI) with partners of unknown HIV status. However, results also suggest that men who had never been tested for HIV did not report more UAI with non-steady partners than men who had had a negative test. In contrast, within steady partnerships the proportion of men not using condoms was consistently higher, irrespective of HIV status knowledge. Thus, men should be encouraged to check and mutually disclose their HIV status with a steady partner before abandoning condoms.

Interventions such as skills building and risk reduction counselling in the context of HIV testing are underutilised. Hospitals and private practices not specialised in sexual health performed poorly when taking sexual histories and counselling specifically for MSM during testing. Counselling skills in these settings would need to be improved or alternative sites considered for testing or counselling with skilled staff.

Social discrimination and exclusion of gay men appears to be a major barrier to MSM taking an HIV test. Young MSM and men who are not out about their sexual preference may have particular difficulties overcoming this barrier. HIV-related stigma, which is expected not only from the general population but also from MSM, is another barrier to HIV testing.

Repeated HIV testing for people with continuous risk of infection should be promoted, and testing should be accompanied by the discussion of sexual practices, partner selection strategies and risk reduction counselling.

Source: EMIS 2010 [91]

HIV/STI among MSM

HIV and STI surveillance results are published annually and data on MSM are available for those countries that were able to report on possible mode of transmission [7,8].

Table 2. HIV and STIs among MSM in EU/EEA, 2011

Indicators 2011	Chlamydia	Gonorrhoea	Syphilis	HIV
Rate per 100 000 population	175.0	12.6	4.9	5.7
Male-to-female ratio in reported cases	0.7	2.7	3.9	3.0
Percentage among MSM	5%	33%	42%	39%

Source: HIV/AIDS surveillance in Europe 2011. [8]; STI 2011 report [7]

STIs and HIV are increasing among MSM in many countries, in particular in western and southern EU countries. Similarly, outbreaks of STI, HIV and hepatitis C are being reported among MSM indicating high levels of risk behaviour and extensive networking. More details on trends and outbreaks of STI/HIV can be found in the ECDC technical report '*STI and HIV prevention in men who have sex with men in Europe*' [89]. In eastern European EU Member States the situation is less clear, with low numbers being reported for MSM, possibly due to underreporting or non-disclosure of sexual orientation.

5.3 Interventions

National prevention programmes targeting MSM

The ECDC report *STI and HIV prevention in men who have sex with men in Europe* [89] updates current knowledge and identifies gaps in prevention programmes targeting MSM by reviewing the current state of the HIV/STI epidemic in the European region as well as reviewing existing interventions. Recommendations for national prevention programmes include: taking a broader sexual health focus for MSM, increased utilisation of

internet-based interventions to target hard-to-reach groups, improved HIV/STI surveillance among MSM and continued monitoring and evaluation of intervention programming.

In the EU/EEA, 22 countries currently have a national HIV/STI prevention programme targeting MSM (Appendix D – Country profiles). Programmes of this type are missing in Cyprus, Finland, Italy, Latvia and Malta and information was not available from Austria, France and Liechtenstein.

Examples of a national prevention programme targeting MSM

Norway has developed a comprehensive prevention programme to reach MSM. As outlined in the UNGASS progress report for Norway, the main strategies have been to: increase access to condoms and lubricants, disseminate information as to the importance of early testing, work to ensure services are MSM-friendly, implement innovative interventions aimed at behaviour change among MSM and increase awareness of the link between drug and alcohol abuse and risk of HIV infection [99].

6 Sexual health of sex workers

Sex workers are a key population to be addressed in a comprehensive HIV/STI control strategy, as they bear a particularly high burden of disease. Outbreaks of syphilis have been reported among female sex workers in London [100] and in migrant sex workers from eastern Europe [101]. In the UK, there has also been an increase in reporting of bacterial STIs among male sex workers [102].

Targeted prevention, testing, treatment and support interventions to sex workers can also reduce rates of STI/HIV transmission to their clients and thus into the broader population [103]. In seeking to strengthen HIV/STI prevention, it is necessary to address the health of sex workers and gain an understanding of the contextual and social determinants that leave this group at high risk of infection [104]. Sex workers are frequently threatened with violence from clients, police and procurers within the sex industry and consequently they have a limited ability to negotiate safe sex practices. The lack of legal protection for sex workers facilitates the violence they are exposed to [105]. A lack of control over working conditions and dependency on drugs and alcohol have led to poor SRH, including an epidemic of HIV/STIs among sex workers in Europe, the majority of whom are female [104,106]. Sex workers are also subject to social exclusion, stigma and discrimination and often lack protection in terms of law enforcement or respect of their labour rights. Many have limited access to healthcare services, including HIV/STI testing, treatment and support [104,106,107].

A UNAIDS technical update (2002) entitled 'Sex work and HIV/AIDS' highlights vulnerabilities such as limited access to information and means of prevention as well as to social and legal services, gender inequality, sexual exploitation and limited economic alternatives [108]. The report calls for a multifaceted approach to address the HIV/STI epidemic among sex workers and outlines the components of an effective response. Interventions should be carried out at the individual, community and policy-making levels and focus on preventing entry into sex work, protecting sex workers and assisting those sex workers that want to leave the sex industry. Key prevention strategies should actively involve the sex workers themselves and incorporate: education on condom use and negotiation skills, promotion of available HIV/STI testing and care services, legal and social services outreach, peer education training and advocacy for policy reform. An updated guidance 'Prevention and treatment of HIV and other sexually transmitted infections for sex workers in low- and middle-income countries' was published in December 2012 by WHO in collaboration with UNAIDS and UNFPA [109].

In 2009, the Transnational AIDS/STI Prevention among Migrant Prostitutes in Europe Project (TAMPEP), an EU-funded project dedicated to HIV/STI prevention and health promotion among migrant sex workers, released the report 'Sex work in Europe: a mapping of the prostitution scene in 25 European countries'. This report focuses on migrant as well as local female, male and transgender sex workers. It aims to highlight the changing trends in sex work across Europe, provide insight into how legal and policy frameworks can increase vulnerability and identify gaps in quality service provision and care for sex workers. Sample recommendations from the report include: sustainable funding for intervention programming, the adoption of harm reduction strategies, public education campaigns aimed at clients, community involvement, increased awareness of government and law enforcement, increased HIV/STI information availability on the internet and the encouragement of involvement from sex workers [104]. TAMPEP has also created an online directory for health and social support services for sex workers in Europe called Services4SexWorkers.eu [110].

The Eurasian Harm Reduction Network (EHRN) is also involved in sexual health of sex workers. EHRN is a regional NGO, with a geographical focus in Central and Eastern Europe and Central Asia that advocates and seeks to help implement non-discriminatory policies for vulnerable populations including PWID and sex workers. In 2005, EHRN published the report 'Sex work, HIV/AIDS, and human rights in Central and Eastern Europe and Central Asia' [111]. As well as characterising the issues that sex workers from this region face, the document gives an overview of the economic, political and social factors that influence national policies and attitudes towards this vulnerable group. The report makes a number of recommendations on removing barriers to healthcare services and upholding sex workers' human rights.

6.1 Contextual factors

Legislative aspects

The legality of sex work affects sex workers' vulnerability to HIV/STIs and other SRH hazards. Criminalisation can result in a reluctance among sex workers to access healthcare and support services, the deterioration of working conditions, limited protection from law enforcement and limited legal rights [104]. Legislation explicitly criminalising sex work is currently in place in four EU/EEA Member States: Romania, Malta, Lithuania and Liechtenstein. Of the 26 countries in which sex work is not criminalised, brothel ownership is only legal in five (Austria, Belgium, Greece, Germany, Netherlands). Sex work has limited legality in three Member States – Iceland, Norway and Sweden – where it is illegal to buy sex but not to sell sex. (Appendix D – Country Profiles).

Legislation on sex work in EU/EEA countries is by no means straightforward and easy to interpret. In several EU/EEA countries, there is no law legalising or criminalising sex work, instead there are many laws and regulations in place making sex work difficult (e.g. criminalisation of soliciting, 'curb crawling' and 'companion activities') and regulations on where and when sex work is allowed. In several EU/EEA countries, even though sex work is not recognised as a trade, sex workers have to register at the local municipality, have mandatory, regular health check-ups and sometimes even pay taxes as self-employed workers [112]. It is important to note that these findings do not take into account the fact that anti-trafficking legislation is often used by law enforcement agencies to target prostitution and remove sex workers from the streets [110,112] .

6.2 Research and surveillance

Sexual health and behaviour of sex workers

Apart from the national studies listed in the ECDC report on HIV/STI behavioural surveillance [41], there are currently only a handful of cross-national surveys to assess the sexual health and behaviour of sex workers (Appendix D – Country profiles). One such survey is part of the aforementioned BORDERNETwork project which integrates biological and behavioural surveillance of sex workers in seven countries (Germany, Slovakia, Romania, Latvia, Poland, Bulgaria and Estonia) [113]. Data have been collected on a number of sexual health indicators including: condom use, knowledge and attitudes to HIV/STIs, access to and uptake of HIV/STI services and self-reported STI diagnosis. As well as collecting behavioural data on sex workers, the BORDERNETwork project was involved in the testing of blood specimens from male and female sex workers for HIV, syphilis, HCV, HBV, chlamydia, gonorrhoea and herpes simplex II.

HIV/STIs among sex workers

HIV and STI surveillance results are published annually and data on sex workers is collected in only a small number of countries (Estonia, Greece, Lithuania, Malta, Slovakia and Spain). Data on STIs among sex workers are collected at EU level as part of the enhanced surveillance of STIs; however at present the completeness of reporting varies significantly [7,8].

6.3 Interventions

National prevention programme targeting sex workers

The 2009 TAMPEP report [114] acts as a European manual on good practices in work with and for sex workers. The manual focuses on seven areas in prevention programming for sex workers: outreach programming, campaigns for clients, advocacy campaigns, peer education, training, information materials and drop-in centres utilising a variety of intervention examples from countries across Europe.

In addition to the local work done by NGOs, 19 of the 30 EU/EEA countries currently have a national HIV/STI prevention programme for sex workers in place (Appendix D – Country profiles).

Examples of a national prevention programme targeted at sex workers

The strategy adopted by Italy, as outlined in the 2010 UNGASS country progress report, takes a two-pronged approach involving condom promotion and increased access to HIV testing and counselling services [115]. In Portugal, outreach projects also distribute condoms and provide tailored information to sex workers on STI transmission, the legal, social and counselling services available and health promotion.*

* Observation made during an ECDC country mission to Portugal in 2008.

7 Sexual health of people living with HIV

People living with HIV (PLHIV) are among those most vulnerable to sexual health problems, however their needs and rights are often not considered, and due to fear of stigma and discrimination, PLHIV often have limited access to healthcare services [116]. A 2010 systematic review aiming to determine the prevalence of STI co-infection among PLHIV by looking at 37 studies from both developed and developing countries, found a mean overall STI prevalence of 16.3%, syphilis 9.5%, gonorrhoea 9.5%, chlamydia 5%, and trichomoniasis 18.8% [117]. Another study examining STIs in a sample of 490 HIV-positive men and women, found that 14% had been diagnosed with a new STI in a six-month period. Participants with a new STI diagnosis had significantly more sexual partners during this time period, including HIV-negative partners, compared to those who had not contracted a STI. Participants with a new STI diagnosis were also more likely to have detectable viral loads and to be unaware of their viral loads compared to those without a new STI [118]. This research highlights the importance of addressing the sexual health of PLHIV in order to control the HIV epidemic in Europe and reduce transmission of STIs.

The term 'positive prevention' has been used to support empowerment and the right of HIV positive individuals to maintain good sexual health with access to education and information, non-judgemental HIV/STI treatment and care services and prevention programming [116]. PLHIV are also in need of counselling and support for disclosure and access to condoms, contraceptive methods and other reproductive health services such as antenatal care [119]. A paper entitled 'Sexual health for people living with HIV' [116], published in 2007, argues for a rights-based approach to addressing the sexual health of PLHIV and the need for appropriate health services, advocacy for policies supporting positive prevention, sensitivity training for health workers and targeted education to ensure disease prevention among PLHIV.

The guidance document 'Advancing the sexual and reproductive health and human rights of people living with HIV' [120], published in 2009 by The Global Network of People Living with HIV (GNP+), was designed for decision makers, programme managers and healthcare professionals to aid in understanding the sexual and reproductive health and rights of PLHIV. The report outlines cross-cutting recommendations to improve the SRH of PLHIV including the necessity of confidential voluntary HIV testing; legislation banning discrimination; increased access to HIV treatment and care; support information dissemination to marginalised groups and the benefit of involving PLHIV in programme planning and implementation.

This call to involve PLHIV began with the 2007 UNAIDS policy brief entitled 'Greater Involvement of People Living with HIV' (GIPA) [121]. GIPA is a principle based around the idea that personal experiences of PLHIV should shape HIV/AIDS response. PLHIV can be involved in advocacy; campaigns and public speaking; treatment roll-out and preparedness; the policy-making process, programme development and implementation; leadership and support and group networking and sharing.

One particular initiative targeting PLHIV in Europe, the Eurosupport 6 project [122] which ran from 2009 to 2012, involved the development of a training and resource package for improving the sexual and reproductive health of PLHIV. Its main objectives included the implementation and evaluation of evidence and theory-based interventions to improve the SRH of PLHIV; the creation of a resource manual for service providers and policy-makers on the integration of HIV and sexual health services and the creation of a European network of HIV and SRH experts.

Apart from the Eurosupport 6 project, there is currently a lack of guidance or technical reports from international organisations on disease prevention programming for PLHIV in Europe.

7.1 Contextual factors

Legislative aspects

Criminalising HIV transmission

In 2002, UNAIDS produced a policy options paper entitled 'Criminal law, public health and HIV transmission' [123]. The paper outlines the legal, human rights and public health consequences of the application of HIV/AIDS criminal legislation. Furthermore, it lists considerations that should be taken into account by Member States and recommends that criminal law should only be used in certain cases and as a last resort.

A paper produced in collaboration between GNP+ Europe and the Terrence Higgins Trust entitled 'Criminalisation of HIV Transmission in Europe' [124], outlines laws and HIV transmission prosecution rates within those countries that have signed the European Convention on Human Rights. In total, 23 EU/EEA Member States have legislation criminalising HIV transmission (Appendix D – Country profiles). There is no legislation in Bulgaria, Hungary, Ireland, Luxembourg, Slovenia or Spain and information was missing for Poland.

Criminalisation of HIV transmission has been widely criticised as going directly against the 2006 Political Declaration on HIV/AIDS, according to which governments committed to 'promote a social and legal environment that is supportive of and safe for voluntary disclosure of HIV status' [36,120,125].

Protection of PLHIV

It is known that fear of discrimination can prevent PLHIV from accessing testing and treatment services [125]. Therefore legislation that bans discrimination based on HIV status and ensures the protection of the rights of PLHIV is crucial to the effective prevention of HIV spread in Europe. In all, 22 countries in the EU/EEA have some form of legislative protection to prevent discrimination against PLHIV (Appendix D – Country profiles). However, there is little evidence as to whether laws are being properly enforced or whether PLHIV experiencing discrimination can effectively seek justice. Chapter 5 of the 2010 edition of the UNAIDS report on the global AIDS epidemic ('Human rights and gender equality') summarises legislation affecting PLHIV worldwide by country [125].

7.2 Research and surveillance

Sexual health and behaviour of PLHIV

According to the 2011 UNAIDS report 'How to Get to Zero' there were 840 000 PLHIV in Europe at the end of 2010 [126]. The sexual health and behaviour of this population is examined in the cross-national research project, 'Eurosupport V' [127]. The research was funded by the European Commission with the aim of reducing onward HIV transmission by understanding behaviour. Data were collected using an anonymous, self-reported, standardised questionnaire from 1 212 respondents at 16 HIV clinics in 13 EU countries

National surveys are described in the ECDC HIV/STI behavioural surveillance report [41]. Only nine of the 30 countries in the EU/EEA have country-level surveys of PLHIV, covering a variety of sexual health subjects such as quality of life, personal experiences, attitudes and contraceptive use (Appendix D – Country profiles). Public Health England is in the process of developing a national survey to look at sexual health, risk behaviour, patterns of care access, ART uptake and chronic disease among PLHIV accessing HIV care.

Stigma experienced by PLHIV

The 'PLWH Stigma Index' [128] is an initiative supported by IPPF, UNAIDS, GNP+, and International Community of Women Living with HIV/AIDS (ICW). The project aims to collect research data on the experiences of PLHIV related to stigma, discrimination and human rights in countries worldwide. This user guide acts as a guidance document for researchers, giving background to the project, introducing the questionnaire, offering direct training on data collection and interviewing and providing tips for communicating findings and advocacy. The UK, Estonia and Poland are currently the only countries in the EU/EEA to have carried out research as part of this project.

STI among PLHIV

Reports on co-infections among PLHIV provide significant information. The ECDC surveillance report *Sexually Transmitted Infections in Europe* [7] shows the proportion of co-infections with HIV at time of diagnosis for syphilis, gonorrhoea and chlamydia. Several Member States have included co-infections as part of their national surveillance systems, but as yet the picture is far from complete.

7.3 Interventions

Interventions to prevent HIV/STIs and improve sexual health among PLHIV can focus on a number of areas. PLHIV need sexuality education and support, access to condoms and non-discriminatory STI services. The reduction of stigma and discrimination related to HIV/AIDS can increase the uptake of testing and status disclosure to partners and HIV counselling after a positive HIV test can increase condom use among discordant couples [116]. Increasing emphasis is being placed on the effectiveness of antiretroviral treatment to prevent HIV transmission, which is why access to HIV testing and treatment services is so important. However, it is also important to consider the impact of initiating ART treatment early on in terms of side effects and development of drug resistance, both for the individual and for society as a whole [58].

Reduce stigma experienced by PLHIV

The paper 'Interventions to reduce stigma: what have we learnt?' [129] aims to review interventions aimed at decreasing HIV/AIDS stigma felt by PLHIV and describe common characteristics of successful interventions. The key findings of this report highlight the need for rigorous monitoring and evaluation of interventions to reduce stigma; research on the effectiveness of national-level mass media campaigns to combat stigma and interventions targeting young people.

8 Sexual health of migrants

The impact of increased international mobility and migration on the spread of HIV/STIs has been well described [130-132]. In 2008, there were an estimated 2.6–6.4 million migrants of irregular status in the EU, with an additional 7.6% of the EU population born outside of Europe [133]. A migrant is described by the UN as 'any person who lives temporarily or permanently in a country where he or she was not born, and has acquired significant social ties to this country' [3]. However, the term 'migrant' has no universally accepted definition and in EU/EEA countries different definitions are applied, limiting comparability between countries [134]. Migrant populations differ between EU/EEA Member States, but can be made up of individuals that have relocated to another country to improve their social or economic situation; asylum seekers; displaced persons; refugees and/or internal migrants [135].

In 2011, 34% of all HIV diagnoses reported in the EU/EEA were among individuals from a country with a generalised HIV epidemic, mainly from sub-Saharan Africa [8]. Migrants from Eastern Europe, sub-Saharan Africa and Asia have been found to be the most relevant targets for prevention efforts in the majority of European countries [135]. A report from the UK presenting national data from 2010, found migrant heterosexuals more likely to be diagnosed with HIV late, compared to UK-born heterosexuals (63% to 50%), with the highest percentage of late diagnoses among those originating from Asia (67%) and Africa (64%) [136]. Since limited access to HIV/STI prevention, testing and treatment services leaves individuals vulnerable to poor sexual health, migrant sub-groups at increased risk of HIV/STIs include persons without proper documentation, sex workers, MSM and trafficking victims [135,137].

In 2009, evidence from the UK suggested that the proportion of migrants originating from countries with generalised epidemics who acquired HIV after arrival in the UK was substantially higher than had previously been estimated. According to this study, somewhere between 25–33% of HIV-positive African residents in the UK, and approximately 50% of HIV-positive African MSM, were thought to have acquired HIV in the UK [138]. These findings have important implications for the programmatic response to HIV in countries where HIV in migrant populations accounts for a substantial proportion of newly-diagnosed HIV infections and may require countries to divert their prevention spending to those prevention strategies that are likely to have the most effect on curbing the epidemic.

During 2012–2013, ECDC has been carrying out a project on the sexual transmission of HIV among migrants and implications for prevention. This project aims to gather and analyse the evidence for sexual transmission of HIV among persons from countries with generalised HIV epidemics after they have arrived in the EU/EEA in order to inform HIV prevention planning and programmes.

Limited access to quality healthcare is perhaps the most significant barrier facing the welfare of migrants in the EU [133,139,140]. The following factors have been identified in contributing to migrants' lack of access to healthcare and testing services: legal obstacles, policies aimed at migrant dispersal, language barriers, different cultural perceptions of disease, religion, poverty, social exclusion and marginalisation, fear of stigma and discrimination, lack of awareness of local services, inequitable service provision and available health systems being unresponsive to migrant needs [133,135,139,141,142]. As part of the migrant health series, in 2011 ECDC published a report on HIV testing and counselling in migrant populations and ethnic minorities in EU/EEA Member States. A key finding of the report is the need to address HIV testing within the broader context of inequalities and migrant health [142].

The report 'Health and migration in the EU: Challenges for health in the age of migration' [143], published in 2007 by the Portuguese Ministry of Health, provides a comprehensive picture of the features, trends and vulnerabilities of migrants in the EU. The report highlights the importance of cooperation between Member States, transit states, and regions of migrant origin and outlines the benefits of integrating health into all applicable national policies.

The ECDC report '*Migrant health: Access to HIV prevention, treatment and care for migrant populations in EU/EEA countries*' [135] highlights the following major challenges: lack of a clear legal framework for migrant rights; legal, cultural and administrative barriers; discrimination exacerbated by the media and inconsistent data collection across countries.

The International Organization for Migration (IOM), a key stakeholder in promoting the health of migrants worldwide, was responsible for managing the 'Assisting Migrants and Communities' (AMAC): analysis of social determinants of health and inequalities project. The aims of the project were to provide guidance, involve experts and engage the international community in vital issues associated with migrant health. The final project report outlines the main areas for action: migration impact assessment; effectiveness evaluation of successful interventions targeting migrants; increased access to health information and services; inter-sectoral collaboration and quality care tailored to migrant needs [140].

The focus of international efforts have been on migrant health as a whole or HIV specifically rather than on improving SRH in this population. However, the International Centre for Reproductive Health (ICR) has initiated a project entitled European Network for Promotion of Sexual and Reproductive Health and Rights of Refugees and

Asylum-Seekers in Europe and Beyond (EN-HERA!). The aim of this project is to create a European network of relevant stakeholders in an effort to specifically promote the SRH of migrants. A framework has been published to identify good practice in terms of service provision, participatory approach and policy development ('Sexual and reproductive health and rights of refugees, asylum seekers and undocumented migrants') [144]. At the time of publication, 27 Member States had joined EN-HERA!

In addition, the TAMPEP report [104] describes the prostitution situation in 25 European countries. In 2008, 47% of females, 32% of males, and 47% of transgender sex workers were migrants. The most frequently reported countries of origin include Bulgaria, Romania, Russia, Nigeria, Ukraine and Brazil, many of which are countries with a relatively high HIV/STI prevalence.

There are also implications for migrants that originate from countries with low HIV/STI prevalence and travel to areas of high HIV/STI prevalence. A paper published in 2010 looked at the sexual risk of central and eastern European (CEE) migrant MSM travelling to the UK. As HIV prevalence among central and eastern European MSM is lower than among MSM in the UK, migrant central and eastern European MSM are at risk of acquiring HIV and STIs from sexual contact with men from the host country, as high rates of unprotected anal intercourse have been reported. These findings are significant in terms of cross-national transmission, as central and eastern European MSM may travel back to their home countries after becoming infected [145].

8.1 Contextual factors

Legislative aspects

There are a variety of legislative aspects associated with migration and migrant rights, and among EU Member States there is a significant diversity with regard to legal frameworks. The IOM report 'Migration and the right to health: A Review of European Community Law and Council of Europe Instruments' [146] (2007) describes all European legislation relating to migrants, specifically laws on equal treatment, international protection of asylum seekers, social security and patient mobility, victims of trafficking and sexual and reproductive health needs. Current EU legislation calls for Member States to provide free SRH services and contraception to migrant populations. The extent to which this has been implemented is unknown.

It is important to focus on implementing legislation in Europe to criminalise human trafficking as 'invisible' female migrants are at high-risk of sexual abuse and exploitation, leaving them vulnerable to poor physical and mental health [141]. Trafficking is illegal in all 30 EU/EEA Member States (Appendix D – Country profiles).

Political systems and infrastructure

The role of non-governmental organisations

A variety of NGOs are working to promote sexual health and prevent HIV and STIs among migrants in 26 Member States in the EU/EEA (Appendix D – Country profiles). NGOs dedicated to HIV/STI prevention and sexual health promotion among migrants do not exist in Estonia and Latvia and the information is missing for Iceland and Liechtenstein.

IOM has a global programme on HIV among migrants focussing on service delivery, capacity building, advocacy for policy development and data and research dissemination, with projects in Portugal, Italy and Belgium [147]. Médecins sans Frontieres (MSF) is also involved in improving migrant SRH, working in southern Europe (Italy, Malta and Greece) to provide medical care for pregnant asylum seekers and prevent disease in migrant camps [148].

8.2 Research and surveillance

Sexual health and behaviour of migrants

To date, there have been no cross-national surveys dedicated to the sexual health of migrants. However, the results of the 'EuroCoord' work package 14 survey on HIV among migrants will be available in 2014–2015 [149]. EU/EEA countries involved in this project include Germany, France, Belgium, Spain, Portugal, Greece, the Netherlands, Italy and the UK.

Furthermore, Médecins du Monde, an international NGO providing medical care and support to vulnerable populations in collaboration with the European Observatory, carried out a small qualitative statistical survey in 2008 looking at undocumented migrants attending healthcare services in 11 European countries. The survey was two-fold, examining health-seeking behaviour in migrants, as well as difficulties experienced by migrants when trying to access care for their children [150].

According to ECDC's HIV/STI behavioural surveillance report [41], only six EU/EEA Member States have carried out national surveys regarding sexual health among migrant populations.

HIV/STIs among migrants

HIV and STI surveillance results are published annually and data on migrants is collected through a variety of variables (i.e. country of birth, country of nationality, probable country of infection, and for HIV in heterosexually acquired cases, country of partner). For HIV, the majority of heterosexually acquired cases were reported in individuals originating from countries with a high HIV prevalence, mainly sub-Saharan Africa. For STI, data on country of infection are collected at EU level as part of the enhanced surveillance of STIs, however the completeness of reporting needs to be improved [7,8].

In 2011, ECDC published a report entitled '*Migrant health: Epidemiology of HIV and AIDS in migrant communities and ethnic minorities in EU/EEA countries*' [151]. This report characterises the HIV epidemic among migrants in Europe, estimating the number of migrants and the proportion infected with HIV and/or diagnosed with AIDS in each Member State. The ECDC report '*Improving HIV data comparability in migrant populations and ethnic minorities in EU/EEA/EFTA countries: findings from a literature review and expert panel*' [134] highlights the difficulty in estimating the size of the HIV epidemic among migrants with no standard definition for the term 'migrant'. This report recommends that steps should be taken to harmonise data collection to improve data comparability, but recognises that, given migration patterns and the cultural diversity across Europe, surveillance of migrants cannot be standardised. A paper published in AIDS [137], describes in more detail the information currently collected in Europe to monitor HIV/AIDS among migrants and the limitations of the variables used to characterise HIV/AIDS in this population.

ECDC is in the process of revising data collection procedures to accommodate the increasing need to correctly describe the source of infection and possible country of infection. The revision includes adapting the current data collection and carrying out a study assessing heterosexual transmission among migrants.

8.3 Interventions

Examples of good practice aimed at improving health among migrants across Europe can be found in 'Good practices on health and migration in the EU' [152], published in 2007 following the conference supported by the EU Portuguese Presidency. The EUGATE project [153] coordinated by various bodies under the University of London umbrella and funded by the EU Directorate General for Health and Consumer Affairs, looks at best practice in health services for immigrants in Europe. This project aims to prevent illness; improve services; reduce inequalities; exchange models of best practice; provide quality data and develop a harmonised EU strategy to improve migrant health.

Started in 1992 at the Netherlands Institute for Health Promotion and Disease Prevention, the European AIDS and Mobility Project [154], aims to reduce the vulnerability of migrants and mobile populations to HIV, with a special focus on young migrants between the ages of 16 and 25. Areas of work include: health education, mediator training, HIV prevention through collaboration and network building, project evaluation, result dissemination, and advocacy. Though the project is now run by the Ethno-medical Centre in Germany, it continues to be funded by the European Commission Executive Agency for Health and Consumers (EAHC).

National prevention programmes targeting migrants

National HIV/STI prevention programmes targeting migrants exist in 20 countries within the EU/EEA (Appendix D – Country profiles). Information on these programmes was obtained from both UNGASS country progress reports, the National Composite Policy Index questionnaires submitted by countries to UNAIDS, and through country feedback. No programmes were in place in Cyprus, Denmark, Finland, Germany, Latvia and Malta and information was missing for Austria, France, Iceland and Liechtenstein.

Examples of a national prevention programme targeting migrants

The UNGASS report submitted by Germany describes prevention efforts to target migrants such as the use of a culturally sensitive approach to implement pilot projects and operational research tailored to the needs of migrant subgroups [155].

Swedish prevention efforts focus on the provision of voluntary health check-ups for migrants to identify HIV-infected individuals in need of support, treatment and care [156].

Bulgaria utilises community outreach and behaviour-change communications to target young migrants at high-risk of HIV/STIs [157].

9. Sexual health of populations at risk of sexual violence

Sexual violence is defined by WHO as 'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim in any setting, including but not limited to home and work'. Population groups at high risk of sexual violence can include women, young people, sex workers, previous victims of sexual violence, substance abusers, prisoners and people living in poverty [158].

In addition to physical injury and mental trauma, sexual violence is associated with a number of sexual and reproductive health (SRH) problems [158]. Victims can suffer immediate and long-term consequences and are at risk of not only HIV and STIs, but also of unintended pregnancies, gynaecological complications, death from HIV/AIDS, suicide and murder [158,159]. There is also research suggesting that women with experience of childhood sexual abuse are less likely to use contraceptives, are younger at first sexual encounter and are more likely to become teenage mothers, compared to women without experience of childhood sexual abuse [160,161]. The myriad of issues surrounding populations at high risk of being exposed to sexual violence reinforces the argument for a comprehensive strategy addressing SRH health as a whole, rather than focussing entirely on HIV/STI prevention.

Chapter 6 of the 'World report on violence and health' [158], published in 2002 by WHO, deals with sexual violence. This chapter describes the issues associated with sexual violence, settings in which it can occur and the extent of the problem worldwide. It recommends that prevention efforts focus on psychological support, life skills and education programming for victims, training of healthcare staff, HIV prophylaxis for victims, public awareness campaigns and school-based programming.

The joint 2010 WHO and London School of Hygiene and Tropical Medicine (LSHTM) report 'Prevention of Intimate Partner and Sexual Violence against Women: Taking Action and Generating Evidence' builds on previous work in the development of data-driven prevention programming for those at risk of sexual violence. Aimed at policy makers, the document outlines the step-wise process required to implement such a programme at national level and recommends the involvement of the community, NGOs, local governments and the criminal justice sector. Evidence is emerging of the effectiveness of primary prevention of sexual violence including the utilisation of social norms theory to change gender norms and childhood school-based programming on the recognition and avoidance of situations that may be sexually abusive [162]. It is important to note that though sexual violence can be directed at both men and women, prevention efforts often focus on women as they are considered at higher risk [158].

The proceedings of the conference 'Sexual Violence Issues and Responses across Europe' [163], hosted in Dublin by the Rape Crisis Network Europe, provides insight into issues related to sexual violence that are relevant in the European context. Specifically, the conference focussed on campaigns to prevent sexual violence and increase awareness, trends in attrition rates for rape cases, sexual violence and trafficking and the sexual abuse of sex workers.

9.1 Contextual factors

Legislative aspects

Legislation criminalising sexual violence exists in all 30 of the Member States of the EU/EEA (Appendix D - Country profiles). The sexual violence legal frameworks of each country are listed in the UN Secretary-General's Database on Violence against Women [164]. Though the scope is broader than sexual violence, the Handbook for Legislation on Violence against Women [165] by the UN Department of Economic and Social Affairs is a constructive tool for stakeholders on the adoption of laws preventing violence, guaranteeing survivor rights and punishing perpetrators.

Political systems and infrastructure

National strategy to prevent sexual violence and increase awareness

Currently, 19 countries in the EU/EEA have adopted national strategies in an effort to prevent sexual violence (Appendix D - Country profiles). The development of national strategies is important in the coordination of a sustainable response across Europe. The UN Handbook for National Action Plans on Violence against Women, produced as part of the UN Secretary-General's UNiTE Campaign to End Violence against Women, is a useful guide to designing strategies focussing on primary prevention and the implementation, monitoring, evaluation and reporting of such national plans [166].

9.2 Research and surveillance

The UN Secretary-General's Database on Violence against Women [164] is a useful tool when researching EU/EEA country legislative frameworks, policies, strategies, programmes, institutional mechanisms, services for victims and survivors, national preventive measures, training and research- and statistical data related to sexual violence. Information is listed by country and though not specified in the title of the database, covers the different types of sexual violence.

9.3 Interventions

Campaigns to prevent sexual violence and increase awareness

In addition to a variety of national campaigns designed to prevent sexual violence and increase awareness, there have been a number of pan-European campaigns carried out in the last five years. All 30 countries in the EU/EEA have had a sexual violence awareness-campaign in the last five years (Appendix D – Country profiles). However, there is limited evidence of the effectiveness of such large-scale campaigns due to a lack of monitoring and evaluation initiatives [167].

The most recent campaign, One in Five [168,169], was initiated in early 2011 by the Council of Europe after the entry into force of the Convention on the Protection of Children against Sexual Exploitation and Sexual Abuse. The campaign encourages countries to sign the convention, the first international treaty to criminalise sexual abuse of children, and aims to empower governments, NGOs, parents and children in the prevention of sexual violence. Materials developed in the campaign include an awareness-raising tool for parents – 'The Underwear Rule'; handbooks and brochures for advocacy and reports describing good practice and the current state of research.

Between 2006 and 2008 the Council of Europe also instigated the Campaign to Combat Violence against Women, including Domestic Violence [170]. The campaign aimed to raise awareness of violence against women as a human rights issue, promote the implementation of national legislation and prevention plans and encourage Member States to allocate resources to the issue of domestic violence. According to a review of the campaign, over half of all European Member States implemented national awareness-raising campaigns. Member States were also involved in policy and legislation review, bringing the issue of domestic violence onto the political agenda.

Another important resource in terms of campaigns to prevent sexual violence and increase awareness is the Daphne Toolkit [171]. This is a database of all projects associated with the Council of Europe's Daphne Programme to prevent and combat violence against children, young people and women and protect victims and groups at risk.

10 Sexual health of people who inject drugs

People who inject drugs (PWID) are vulnerable to infection, not only through their injecting practices but also through their sexual behaviour [172,173]. PWID have been found to be more likely to report a recent STI than non-injecting drug users [174], to have low rates of consistent condom use; to frequently report multiple sexual partners and to face barriers to accessing HIV/STI testing and treatment services [172]. Infections, such as HIV and hepatitis B and C virus infections, acquired through unsafe injecting, can then be spread into the wider population through risky sexual behaviour [173]. Although the sexual health of PWID may be overshadowed by the more obvious parenteral risk of infection with blood-borne viruses through the sharing of contaminated equipment, it is important to address sexual and reproductive (SRH) health among PWID in a comprehensive HIV/STI prevention strategy [172,173,175].

PWID are vulnerable to sexual exploitation and sexual violence by partners, drug dealers and the police. Limited access to quality SRH services and/or effective contraception can leave female drug users with little control over their reproductive health. Long-term infection with certain STIs can lead to reproductive complications such as infertility, pelvic inflammatory disease and ectopic pregnancy [172].

In 2010, the Global Network for People Living with HIV (GNP+) released a policy brief on advancing the sexual and reproductive health and human rights of PWID [176]. This policy brief aims to explore the main SRH needs and rights of PWID. Issues identified that can contribute to poor SRH in PWID include legislation criminalising drugs; societal stigma and discrimination, lack of harm reduction service; lack of access to contraception; fear of legal repercussions when accessing SRH services and a lack of information on pregnancy and drug use. The report makes recommendations to policy-makers to integrate SRH into drug treatment and HIV care and treatment services, provide publically funded testing and treatment and sensitivity training for healthcare workers and involve PWID in decision-making.

In collaboration with the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), in 2011 ECDC released a guidance document for the development of national strategies to prevent infection among PWID [177]. Recommendations include provision of free clean injecting equipment; vaccination for hepatitis B; voluntary confidential testing and antiretroviral treatment for HIV; health promotion focussed on sexual health; injecting behaviour and testing and treatment and targeted delivery of services.

10.1 Contextual factors

The report published in 2007 by the Association of Southeast Asian Nations (ASEAN) [172] highlights the importance of addressing the sexual health of PWID and structural barriers that contribute to poor sexual health. Barriers include the cultural and legal environment, police harassment, stigma and discrimination against PWID by service providers and restrictive government policies. The report also promotes harm reduction initiatives such as condom promotion, regular STI check-ups and prompt treatment of STIs. Despite the fact that this document comes from ASEAN the report makes no reference to PWID in Asia specifically. All barriers identified are relevant to the European context as well as the recommendations which are broad and cross-cutting. This document was used for the report in the absence of European publications.

10.2 Research and surveillance

Sexual health and behaviour of PWID

Though injecting practices are beyond the scope of this report, the 2009 HIV/STI behavioural surveillance report provides information on the risk behaviour of PWID. Fifteen EU/EEA countries have surveys in place [41]. The EMCDDA also plays an important role in collecting data on the sexual health and behaviour of PWID. Country reports, released each year, present data on condom use at last intercourse.

HIV/STI among PWID

Data on HIV among PWID is routinely collected across Europe and can be found in HIV/AIDS Surveillance in Europe 2010 [8]. Data can also be found on the EMCDDA website and is published annually [178].

10.3 Interventions

In 2011, EMCDDA and ECDC published two evidence-based reports looking at the evidence for effectiveness of interventions to prevent infections among PWID [179,180], one on needle and syringe programmes and one on drug treatment. Both reports provide guidance on how to prevent and control infectious disease among PWID. The evidence presented in these reports focuses on the evidence of drug treatment and other harm reduction interventions designed to prevent transmission of infection resulting from high-risk injecting behaviour.

One example of an organisation involved in planning interventions for PWID in Europe is the Eurasian Harm Reduction Network-EHRN. As previously mentioned, EHRN is heavily involved in sexual health and HIV/AIDS among vulnerable groups, especially PWID. In the organisation's strategic plan for 2010–2014, EHRN's current goals include the improvement of harm reduction services for PWID and the expansion of evidence-based interventions targeted to PWID across Central and Eastern Europe and Central Asia [181].

Another NGO, Foundation the Rainbow Group, coordinates the EU-funded project Correlation – European Network Social Inclusion and Health, which was initiated in 2005 and targets marginalised populations [182]. The most recent network project, Correlation II (2009-2012), focuses on blood-borne infections including HIV and hepatitis C in PWID and aims to improve services providing prevention, care and treatment.

National prevention programme targeting PWID

WHO's Regional Office for Europe recommends intervention programmes delivered through local NGOs and community-based organisations, with peer and professional outreach, utilisation of PWID networks and PWID involvement in organisation. WHO also recognises the reluctance of governments to invest in PWID services and thus the need for continued advocacy to ensure government commitment [183].

Since injecting drug use is associated with high-risk sexual behaviour, USAID encourages the use of a combined approach for interventions targeting PWID. The organisation recommends that harm reduction interventions such as needle and exchange programmes should be combined with community-based outreach; HIV counselling and testing; condom promotion programmes and information, education and communication campaigns for PWID [184].

There are national HIV/STI prevention programmes targeting PWID in place in 24 EU/EEA countries (Appendix D – Country profiles) and these cover a wide range of initiatives. No such programme was in place in Germany or the United Kingdom and information was missing for Austria, France, Iceland and Liechtenstein.

Examples of a national prevention programme targeted at PWID

The national HIV/STI prevention programme in Poland focuses not only on drug prevention, but also the promotion of health and prevention of social harm. The programme includes prophylaxis, treatment, rehabilitation, harm reduction and reintegration into society[2].

In Finland, where harm reduction and health promotion services reach over 60% of PWID, the national prevention programme includes street outreach programmes in the form of mobile, low-threshold service centre units and pharmacy needle exchanges [9].

Observation made during an ECDC country mission to Poland in 2008.

11. Discussion and conclusions

This report highlights the benefits of linking HIV/STI control programmes in Europe to broader public health strategies including sexual and reproductive health. Evidence is growing that there is are links between different aspects of sexual ill health and the independent predictors of risk for a range of sexual health outcomes including HIV and STIs, not only in the general population but also in vulnerable populations.

Different sexual health outcomes, such as unintended pregnancy and STIs, have in common both individual-level determinants, such as unsafe sex, and social structural determinants, such as access to healthcare services, educational programmes, poverty and gender. STIs are not only co-factors for HIV, but can cause long-term consequences if untreated, such as pain during intercourse, pelvic inflammatory disease, ectopic pregnancy and infertility. Sexual violence is a strong, independent risk factor for HIV acquisition. A strong case can be made, therefore, for the adoption of a public health approach which takes account of these linkages and offers efficiencies by promoting all aspects of sexual health and well-being, integrating HIV/STI prevention into broader sexual health education and healthcare provision. Adopting a comprehensive and holistic approach to sexual health and enhancing synergy between Member States and international organisations in data collection and prevention programming, is not only sensible on economic grounds, but also facilitates a reduction in the burden of HIV and STIs in the European community.

Sexual health and health promotion in the context of a comprehensive approach to disease prevention remain major public health challenges across Europe. While there are many areas of synergy, this mapping exercise has uncovered a number of gaps in the availability of data and in policies and programmes at a country and EU/EEA level, offering several possibilities for future work.

- In order to address the prevention of HIV and STIs in the broader context of sexual health, it is necessary to be able to accurately assess the burden of HIV and STIs and other sexual health outcomes in vulnerable groups, such as MSM, young people, migrants, sex workers and PWID. As illustrated through this mapping exercise, there are gaps, not only in country reporting of HIV/STI infection rates, but in the collection and availability of data on sexual risk behaviour and other sexual health outcomes, such as adolescent birth rates and abortion rates. Data published from these surveys are often not comparable and therefore there is a need for greater synergy between European bodies and NGOs with regard to data collection, reporting, and publication. One option might be the creation of a mechanism in the form of a template or toolkit, to aid countries in gathering comparable data on a variety of sexual health indicators and outcomes of public health interest.
- Vulnerable groups have relatively high rates of HIV and STIs and are particularly likely to suffer poor sexual health. Prevention efforts targeting these vulnerable populations need to take a holistic approach: primary prevention in the form of information; education and behavioural interventions; secondary prevention including screening and vaccination programmes; and tertiary prevention to treat and care for those already infected. Services need to be practically accessible as well as provided in a non-stigmatising, non-discriminatory environment so as to be acceptable to these vulnerable, marginalised populations. Existing EU projects with a similar focus, such as on migrants or MSM, need to be brought together and collaboration among EU agencies should be strengthened to develop initiatives with a focus on sexual health for high-risk groups.
- This report reveals the variety of vertical programmes and projects operating in countries across Europe, as well as the wide discrepancies in the type and quality of interventions targeting vulnerable groups. This makes it difficult to define 'good practice'. The creation of a set of overarching guiding principles would aid countries in developing national HIV/STI prevention programmes in the broader context of sexual health and health promotion. In addition, an evidence-based framework would allow countries to evaluate their programmes against 'good practice', develop innovative and effective sexual health interventions and identify areas for improvement.
- A major feature of this report is the extent to which wider social determinants have an impact on the sexual health of vulnerable populations, including their rates of HIV and STIs. Contextual barriers as well as individual-level factors prevent high-risk individuals from accessing services offering preventive interventions, testing, treatment and care. Such barriers include: national legislation; current country-level political environments, economic policies, the structure and availability of service provision, failure to observe sexual rights, marginalisation and fear of stigma and discrimination. Social norms also need to be considered when developing national HIV/STI prevention programmes. ECDC has issued evidence syntheses and guidance to support interventions targeting not only individual behaviour but also social factors (see ECDC reports '*STI and HIV prevention in men who have sex with men in Europe*', '*HIV testing: increasing uptake and effectiveness in the European Union*' and '*Prevention and control of infectious diseases among people who inject drugs*'). International agencies should continue to develop evidence synthesis and guidance to support work with vulnerable groups and inform the development of a strategy for a comprehensive disease prevention approach.

- There is a particular need for support and guidance from European agencies for preventive efforts aimed at sex workers and PLHIV. While there is an abundance of guidance documents and technical reports on disease prevention programming for MSM, young people, PWID and migrants, international documentation on HIV/STI prevention among sex workers and PLHIV is sparse and outdated. Existing European expert networks could contribute to reviewing current interventions targeting these vulnerable groups and provide guidance and recommendations for effective sexual health promotion and HIV/STI prevention.
- In order to integrate disease prevention within a broader sexual health improvement agenda, it is important to situate HIV and STIs within a holistic definition of sexual health. Edward and Coleman describe eight alternative definitions of sexual health, some broader than others [17]. The definition endorsed by WHO [4] is comprehensive and is the most widely used in the international community. To avoid confusion and ensure consistency in communication at the international level, WHO's definition of sexual health could be adopted by ECDC, directing its focus to those sections of the definition more relevant to ECDC's specific remit.

ECDC has initiated two projects on disease prevention in the broader context of sexual and reproductive health. First, the production of evidence-based guidance for a comprehensive approach to STI/HIV prevention among MSM in the context of sexual health is ongoing and follows a framework accommodating the heterogeneity observed in EU/EEA countries. Stigma, discrimination and service delivery will be included in the guidance and communication strategy that will be published early 2014. The second project deals with the effectiveness of antenatal screening programmes in EU/EEA as it has been observed that in a number of countries transmission from mother to child of HIV, syphilis and hepatitis B is ongoing. Mother-to-child transmission is preventable and cost-effective with an effective screening programme for pregnant women, enabling substantial gains in health. The guidance for strengthening antenatal screening programmes will be based on an evidence-based review and the results of an EU-wide survey on policies, strategies and outcomes of individual programmes.

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Appendix A – Search methods

References were identified through a comprehensive internet search using the Google search engine. For country-level information, search terms and phrases were translated using the Google Translate function into national languages, or alternatively, the country name was added to the string of terms/phrases.

Search terms and phrases included:

EU sexual and reproductive health, sexuality education Europe, national HIV/AIDS prevention strategy, sexual and reproductive health strategy, sex work legislation EU, NGOs, men who have sex with men, MSM, migrant sexual health, sexual health young people, chlamydia control Europe, chlamydia screening in Europe, antenatal screening HIV Europe, cervical cancer screening Europe, HPV vaccination Europe, reproductive health, national prevention programme HIV STIs, HIV testing treatment policy Europe, criminalisation of HIV in the EU, partner notification legislation Europe, HIV/AIDS awareness campaigns Europe, national strategy to prevent sexual violence, sexual health and reproductive rights, youth-friendly SRH services, MSM-friendly SRH services, sexual health promotion, sexual health sex workers, people living with HIV sexual health, sexual health MSM, HIV/STI prevention Europe, human trafficking legislation EU, PLHIV legal protection, sexual violence legislation EU, sexual health IDUs, etc.

In addition, the websites of international organisations such as WHO, UNAIDS (UNGASS), the World Bank, ECDC, EMCDDA, the European Commission, European Cancer Observatory, ECCA, GNP+, IOM, Amnesty International, and IPPF were examined. The Ministry of Health websites for individual European countries were also examined for relevant information regarding national policy/ strategies for HIV/STI prevention. Relevant academic papers were collected through a non-systematic literature search using PubMed and Google Scholar. No date restrictions were placed on the search. Search terms were similar to those listed above. However, the search was only run using English terms/phrases with no translations. Papers were also identified by searching the bibliographies of the grey literature already accumulated.

Appendix B – Synopsis for country profiles and references

Table 1. Contextual indicators

	Austria	Belgium	Bulgaria	Cyprus	Czech Republic	Demark	Estonia	Finland	France	Germany	Greece	Hungary	Iceland	Ireland	Italy	Latvia	Liechtenstein	Lithuania	Luxembourg	Malta	Netherlands	Norway	Poland	Portugal	Romania	Slovakia	Slovenia	Spain	Sweden	United Kingdom
Legislative aspects																														
Age of consent (heterosexual sex)	14	16	14	17	15	15	14	16	15	14	15‡	14	15	17	14	16	14	16	16	18	12	16	15	14	15	15	15	13	15	16
Age of consent (homosexual sex)	14	16	14	17	15	15	14	16	15	14	15‡	14	15	17	14	16	14	18	16	18	12	16	15	16	15	15	15	13	15	16
Legislation legalising sex work	SB	SB	S	S	S	S	S	S	S	SB	SB	S	LL	S	S	S	SC	SC	S	SC	SB	LL	S	S	SC	S	S	S	LL	S
Legislation criminalising sexual violence	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Legislation criminalising human trafficking	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Legislative protection of people living with HIV	No	Yes	Yes	No	Yes	No	Yes	Yes	No	Yes	Yes§	Yes	No	Yes	No	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Legislation criminalising HIV transmission	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes◊	No#	Yes	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	-	Yes	Yes	Yes	No	No	Yes	Yes
Legislation on mandatory partner notification	No	No	No	No	Yes	No	Yes£	Yes	No	No	No ±	Yes	Yes	No	Yes	Yes	No	Yes	No	No	No	Yes	No	-	Yes	No	No	No	Yes	No
Political and structural context																														
Current national sexual & reproductive health strategy	No	No	No	No	Yes 2008-12	No	-	No 2007-11‡	-	-	Yes 2008-12	-	-	No	-	Yes*** 2011-17	-	No	-	Yes 2010	Yes 2010	Yes 2010-15	-	-	No 2003-06	Yes 2008-12	No	Yes 2011	No	Yes
Current national HIV/AIDS/STI prevention strategy	-	No	Yes 2008-15	Yes 2011-14	Yes 2008-12	No 2006-09	Yes 2006-15	Yes	Yes 2010-14	Yes	Yes 2008-12	No 2004-10	Yes	Yes 2008-12	Yes*** 2011-13	Yes 2009-13	No	Yes 2011-12***	No 2006-10	No	Yes 2011	Yes 2009-14	No 2007-11	No 2007-10	Yes 2008-13	Yes 2009-12	Yes 2010-15	Yes 2008-12	Yes 2006-16	Yes
National strategy to prevent teenage/adolescent pregnancy	-	-	-	-	-	No	-	No 2007-11‡	-	Yes	-	-	No 2004-10	-	-	Yes***2011-17	-	-	-	-	Yes 2010	Yes 2010-15	-	-	-	Yes	No	Yes***	No	ϕ
National strategy to prevent sexual violence and increase awareness	Yes	Yes	No	-	No	Yes	Yes	Yes	Yes	Yes	-	-	Yes	Yes	Yes	Yes	-	Yes	-	Yes	Yes 2010	Yes 2012-14	-	-	-	Yes	-	Yes	Yes	Yes
Existence of NGO dedicated to:																														
i. Sexual & reproductive health of the general population	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	-	Yes	Yes	-	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
ii. Sexuality education	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	-	Yes	Yes	-	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	-	Yes	No	-	Yes	Yes	No	-	Yes	Yes	Yes	Yes	Yes	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	-	Yes	Yes	No	-	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Economic systems																														
Healthcare systems	M	M	UC	UC	M	SI	M	SI	M	M	M	SI	SI	M	M	UC	PI	SI	M	M	M	SI	UC	SI	UC	UC	M	UC	SI	SI
Epidemiological context (2011)																														
HIV (new diagnoses per 100 000):																														
i. General population	3.5	10.7	2.7	6.4	1.5	4.8	27.3	3.3	6.3	3.5	7.4	1.6	7.2	7.2	5.8*	13.4	-	5.1	8.6	5.0	6.1	5.5	2.5	8.5	1.8	0.9	2.7	8.4*	3.9	10.0
ii. Young people (15-24 year olds)	5.3	9.1	4.7	3.7	2.6	2.2	35.5	3.5	4.7	3.4	8.6	1.5	4.3	4.8	5.2*	15.1		3.9	14.7	0.0	5.1	3.0	3.1	7.6	5.0	1.5	2.6	6.6*	3.4	7.9
iii. MSM (rate per 100 000 males)	3.5	7.3	1.3	6.6	2.2	4.1	-	1.4	3.2	3.9	5.1	2.3	0.0	6.0	3.9*	2.1	-	0.5	9.0	1.9	8.0	3.9	1.3	4.9	0.7	1.2	3.4	6.5*	1.9	9.0
Chlamydia (diagnoses per 100 000):																														
i. General population	-	-	0.7	0.7	-	478.7	128.3	254.3	-	-	4.4	-	656.6	143.0	-	69.6	-	10.6	0.2	35.0	-	457.9	0.8	-	0.6	5.6	11.3	-	396.0	341.4
ii. Young people (15-24 year olds)	-	-	1.3	-	-	2676.7	531.5	1356.2	-	-	2.2	-	3207.3	-	-	215.0	-	14.3	-	106.0	-	2386.1	1.7	-	1.8	13.3	33.5	-	2089.0	2032.9
iii. MSM (rate per 100 000 males)	-	-	-	-	-	-	-	-	-	-	0.2	-	-	-	-	0.1	-	-	-	13.5	-	-	-	-	-	-	0.6	-	12.2	24.3
Gonorrhoea (diagnoses per 100 000):																														
i. General population	-	-	2.6	-	6.7	9.0	12.4	5.4	-	-	3.3	-	10.0	18.6	-	24.4	-	7.6	0.4	11.0	-	7.5	0.8	1.1	2.4	3.6	1.2	5.0	10.0	37.1
ii. Young people (15-24 year olds)	-	-	-	3.7	19.8	23.3	31.1	13.5	-	-	3.7	-	21.4	-	1.3	56.6	-	17.9	-	22.6	-	14.2	1.2	3.6	7.2	8.8	2.2	-	30.5	124.7
iii. MSM (rate per 100 000 males)	-	-	-	-	2.9	6.8	-	2.3	-	-	0.6	-	-	-	-	1.0	-	0.2	0.4	8.2	-	7.2	-	0.1	0.0	-	0.8	-	5.6	25.0
Syphilis (diagnoses per 100 000):																														
i. General population	-	-	4.2	-	3.4	7.7	4.9	3.3	-	4.5	2.4	-	0.6	3.1	-	6.4	-	8.4	5.5	10.8	-	2.6	2.5	1.5	11.0	7.0	3.9	6.8	2.2	5.2
ii. Young people (15-24 years old)	-	-	-	1.5	4.6	10.5	2.2	0.9	-	3.9	2.1	-	2.1	4.8	1.3	10.3	-	17.2	4.9	7.0	-	1.6	3.5	2.8	20.5	12.5	4.8	-	1.7	6.2
iii. MSM (rate per 100 000 males)	-	-	-	-	2.6	11.7	-	1.1	-	-	2.3	-	-	5.2	-	1.0	-	0.3	1.2	9.2	-	4.4	-	0.2	0.3	0.2	4.4	-	2.4	6.4
Adolescent birth rate per 1 000 women (15-19 year olds)	9.7	11.2	36.2	5.5	9.2	5.1	17.2	9.3	6.0	6.8	9.6	13.6	11.6	8.8	4.0	12.8	2.8	16.1	8.4	11.8	4.3	7.4	12.2	12.5	28.8	16.7	4.5	10.7	6.5	29.7
Abortion rate per 1 000 women (15-44 year olds)	1.3	7.5	21.3	-	17.9	14.3	33.3	10.4	16.9	7.8	5.0	16.9	14.53	-	10.6	22.6	-	16.4	-	-	10.4	15.2	-	0.2	27.8	11.7	10.6	8.3	20.2	17.0
% 15-year-old girls who have had sexual intercourse	28	28	31 (2005-06)	(2.5)	26	38	23	24	23	24	18	24	30	17	22	18	-	12	24	-	22	30	13	18	17	10	24	20	32	∫
% 15-year-old boys who have had sexual intercourse	36	35	47 (2005-	(13.0)	22	38	21	20	32	20	39	37	28	27	26	27	-	26	36	-	19	26	19	27	48	15	31	23	31	□

			06)																											
% 15-year-old girls who used a condom at last sexual intercourse	77	69	76 (2005-06)	-	-	63 (2005-06)	89	63	82	75	86	74	64	77	78	84	-	84	84	-	75	63	83	84	61	76	82	85	58	●
% 15-year-old boys who used a condom at last sexual intercourse	86	79	86 (2005-06)	-	-	74 (2005-06)	91	76	90	84	87	79	71	70	78	77	-	77	90	-	75	75	78	80	79	77	85	81	69	∩

Explanatory notes for tables

(-)	Information not available
Y	Yes
N	No
SC	sex work criminalised
M	Mandatory health and social insurance
SI	Social insurance
UC	Universal coverage
PI	Private insurance
S	Sex work legalised
SB	Sex work and brothels legalised
()	Data produced independently by each country and may not be directly comparable
*	Subnational: adjusted population, according to the coverage, see HIV surveillance report 2011
**	Underestimation due to low ascertainment of cases
***	Incorporated into a wider national health strategy
^	National sexual and reproductive health strategy 2012-2020 to be published

Austria and Liechtenstein did not provide HIV data to TESSy

Country comments

Greece	ǂ	1 Art. 339 Penal code (PC)
	§	There is state benefit for HIV seropositivity, disabled persons (HIV individuals are generally considered as disabled persons) and for people living below the poverty line.
	◇	No specific legislation but the contamination with HIV virus from one HIV seropositive person to another (non HIV seropositive) is considered as wounding, or causing grievous bodily harm with intent) (Art. 310 PC). The HIV-positive person is considered to have attempted to injure because he/she did not inform his/her sexual partner or take the appropriate measures to avoid contamination. Public prosecutors recently ruled that sex workers had attempted to expose their clients to grievous bodily harm with intent/put their lives at risk (Art.306 PC), even though the clients had consented to the act, because they had had sexual intercourse without taking precautions. The penalty for grievous bodily harm is imprisonment for up to ten years. The penalty for attempted grievous bodily harm is one to six years imprisonment (Art. 42 PC, Art.83 PC).
	±	N specific legislation, though non notification to a partner is seen as severe bodily harm (Art. 310 PC) under Greek legislation (see also op. cit. 306 PC).
Estonia	ℓ	Partner notification mandatory for healthcare provider but not for the patient to report names of sexual partners
Hungary	#	Intentional HIV transmission can be subject to prosecution under civil law
Finland	↕	National strategy for 2012-2020 is expected to be adopted soon
UK	ɷ	England: Yes (2013-2016); Scotland: Yes (2011-2015); Wales Yes (2010-2015)
	∫	England:32, Scotland: 35, Wales: 39
	□	England:26, Scotland: 27, Wales: 29
	●	England:73, Scotland: 78, Wales: 70
	∩	England:74, Scotland: 83, Wales: 73

Table 2. Research and surveillance indicators

	Austria	Belgium	Bulgaria	Cyprus	Czech Republic	Demark	Estonia	Finland	France	Germany	Greece	Hungary	Iceland	Ireland	Italy	Latvia	Liechtenstein	Lithuania	Luxembourg	Malta	Netherlands	Norway	Poland	Portugal	Romania	Slovakia	Slovenia	Spain	Sweden	United Kingdom
Research data																														
Survey of sexual health of:																														
i. General population	C	N	NC	N	C	N	N	C	NC	NC	NC	-	C	NC	C	N	-	N	-	N	NC	NC	NC	C	-	NC	N	NC	C	NC
ii. Young people	C	N	C	NC	C	N	NC	NC	NC	NC	NC	C	NC	NC	C	NC	-	NC	C	NC	NC	C	NC	C	C	C	C	NC	NC	NC
iii. MSM	C	NC	C	C	C	NC	NC	NC	NC	NC	NC	C	-	NC	NC	NC	-	NC	C	C	NC	NC	NC	C	C	C	NC	NC	NC	NC
iv. Sex workers	-	N	C	-	-	N	NC	-	-	N	C	-	-	-	-	NC	-	N	N	No	NC	-	N	-	-	C	No	N	-	N
v. PLHIV	C	N	-	-	C	N	N	-	N	NC	C	C	C	-	C	C	-	-	-	No	NC	NC	C	C	-	C	No	NC	C	NC
vi. Migrants	-	N	-	-	-	-	-	-	N	N	-	-	-	-	-	-	-	-	-	C	NC	-	-	-	-	C	No	N	-	N
Surveillance and monitoring data																														
Availability of routinely collected case-based data on HIV/STI (at least one STI - chlamydia/gonorrhoea/syphilis) in:																														
i. General population	S	HS	HS	HS	HS	HS	HS	HS	HS	HS	HS	HS	HS	HS	HS	HS	-	HS	HS	HS	HS	HS	HS	HS	HS	HS	HS	HS	HS	HS
ii. Young people	S	HS	HS	HS	HS	HS	HS	HS	HS	HS	HS	HS	HS	HS	HS	HS	-	HS	HS	HS	HS	HS	HS	HS	HS	HS	HS	HS	HS	HS
iii. MSM	S	H	HS	HS	HS	HS	H	HS	HS	HS	HS	HS	H	HS	HS	HS	-	HS	HS	HS	HS	HS	HS	HS	HS	HS	HS	HS	HS	HS
iv. Sex workers	-	-	-	-	-	No	HS	-	-	-	S	-	-	-	-	-	-	HS	-	-	HS	-	-	-	-	H	-	HS	-	-
v. PLHIV	H	H	H	H	H	H	H	HS	H	H	HS	H	H	-	H	H	H	H	H	H	HS	H	H	H	H	H	H	HS	HS	H
vi. Migrants	-	H	-	HS	-	HS	-	HS	-	-	HS	-	-	-	-	-	-	HS	-	-	HS	-	-	-	-	H	-	HS	HS	-
vii. IDUs	-	H	H	-	H	H	HS	H	H	H	HS	H	H	H	H	HS	-	H	H	H	HS	H	H	H	H	H	H	H	HS	H
Availability of routinely collected data on HIV testing:																														
i. General population	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	-	Yes	-	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
iii. MSM	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	-	No	Yes	Yes	-	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	-	Yes
Availability of routinely collected data on teenage pregnancy	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	-	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Availability of routinely collected data on abortion	Yes§	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No ‡	Yes	Yes	-	Yes	-	No ◊	Yes	Yes	-	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Availability of routinely collected data on contraceptive use	Yes§	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	-	Yes	-	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Country comments

Austria	§	Based on consulted references, data not available at Ministry of Health level
Ireland	‡	Induced abortion is illegal
Malta	◊	Induced abortion is illegal

Footnotes

(-)	Information not available
N	National
C	Cross-national
NC	National and cross-national
H	HIV
S	STIs

Table 3. Programmatic and intervention indicators

	Austria	Belgium	Bulgaria	Cyprus	Czech Republic	Demark	Estonia	Finland	France	Germany	Greece	Hungary	Iceland	Ireland	Italy	Latvia	Liechtenstein	Lithuania	Luxembourg	Malta	Netherlands	Norway	Poland	Portugal	Romania	Slovakia	Slovenia	Spain	Sweden	United Kingdom
Sexual health public education campaigns at a national level (in the last five years)																														
HIV/AIDS awareness campaign	-	Yes	Yes	No	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	-	Yes	-	Yes	-	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Public education campaign on STIs	-	Yes	-	No	-	Yes	-	No	-	Yes	Yes	-	-	-	-	-	-	-	-	-	Yes	-	No	-	-	Yes	Yes	Yes	Yes	Yes
Sexual violence awareness campaign	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Campaign promoting condom and/or contraceptive use	-	Yes	-	Yes	Yes	Yes	Yes	No	-	Yes	Yes	Yes	-	-	-	No	-	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
National HIV/STI prevention programmes																														
National HIV/STI prevention programme for:																														
i. Young people	-	Yes	Yes	Yes	Yes	Yes	Yes	No	-	Yes	Yes	Yes	Yes	Yes	Yes	Yes	-	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
ii. MSM	-	Yes	Yes	No	Yes	Yes	Yes	No	-	Yes	Yes	Yes	Yes	Yes	No	No	-	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
iii. Sex workers	-	Yes	Yes	-	Yes	Yes	Yes	No	-	No	Yes	Yes	-	Yes	No	No	-	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
iv. Migrants	-	Yes	Yes	No	Yes	No	Yes	No	-	No	Yes	Yes	-	Yes	Yes	No	-	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
v. PWID	-	Yes	Yes	Yes	Yes	Yes	Yes	Yes	-	No	Yes	Yes	Yes	Yes	Yes	Yes	-	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No
Provision of sexual education																														
Sexuality education mandatory	Yes §	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	No ●	Yes	Yes	Yes	No	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes	No	Yes	No	No	Yes	No
Minimum standards for sexuality education	Yes §	Yes	No	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes	-	-	Yes	Yes	Yes	Yes	Yes	Yes	-	Yes	No	No	Yes	Yes ↕

National screening and vaccination programmes																														
Chlamydia screening programme (country self-assessment)	No	No	No	No	No	Yes □	Yes	No	Yes	Yes	No	No	No	No	Yes	No	-	No	No	No	Yes	Yes	No	Yes	No	No	No	No	No	Yes ∫
Antenatal screening programme for HIV	Yes	No	-	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes Φ	No	Yes	Yes	No	Yes	-	Yes	-	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Cervical cancer screening programme	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	-	Yes	Yes	No	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Publically-funded HPV vaccination programme	No	Yes	No ~	No	No	Yes	No	No	No ~	Yes	Yes #	No	Yes	Yes	Yes	Yes	-	No	Yes	Yes ^	Yes	No	No	Yes	No	No	Yes	Yes	Yes	Yes
Health service delivery																														
Provision of free contraception	No	Yes ǂ	No	No	No	No	No	No	Yes *	Yes *	No	No	No	No	No	No	-	No	Yes	No	-	Yes ◊	No	Yes	Yes	Yes	Yes	Yes *	Yes *	Yes
Provision of free condoms	-	Yes	Yes	Yes	Yes	No	Yes	No	-	Yes *	Yes	Yes	No	Yes	No	No	-	Yes	Yes	No	-	Yes	-	Yes	Yes	Yes	Yes	Yes	No	Yes
Availability of free testing/treatment for HIV and/or STIs	-	Yes	Yes	-	Yes	Yes ∩	Yes	Yes	-	Yes *	Yes	Yes	Yes	Yes	Yes	Yes ~	-	Yes	-	Yes	Yes	-	Yes	Yes	Yes	Yes	Yes	Yes *	Yes	Yes

Footnotes

(-) Information not available

~ Co-payment rather than publically funded

* Either partially reimbursed or conditions on free provision

Country comments

Austria	§	Based on consulted references, data not available at Ministry of Health level
Belgium	ǂ	Free contraceptives are provided for girls/women < 21 years of age
Denmark	□	Opportunistic screening addressing young people attending general practice, with or without identified risk behaviour
	∩	Treatment is not free for gonorrhoea and chlamydia
Greece	●	Ministry of Education Data reported for Global AIDS Reporting 2012. The sexual education programs 'Diafilikes sexseis' is included in the school curriculum as an optional module in the section of health Promotion. It has to be chosen by the school authorities and students might not attend if they choose not. In this program there is a minimum of standards including training of the trainees, collaboration with relevant organisations such as KEELPNO and B' Gynaecology Clinic of Athens University
	Φ	According to Greek legislation, adopted in 1990, HIV testing should be voluntary, confidential and anonymous; free of charge in every public hospital and AIDS reference centre; accompanied by written informed consent and by pre- and post-test counselling. Targeted HIV testing is recommended to a wide range of people, including pregnant women who are known to be injecting drug users, sex workers and victims of sexual assault, and persons diagnosed with another STI. These guidelines are under revision. Changes include recommendation for testing all pregnant women at least once in an opt-out base.
	#	The Ministry of Health in collaboration with primary care facilities initiated a cervical screening programme in 2011. (http://www.anticancer.gov.gr/). KEELPNO is responsible for the National cancer registry and the communication campaign.
Malta	^	Launched in 2012, offered to girls 12 years olds
Norway	◊	Contraceptives subsidised for women 16-20 years of age; free provision to sex workers.
UK	↕	No minimum sexuality education standards in Northern Ireland
	∫	No chlamydia screening programme in Scotland or Wales

References for tables

Legislative aspects

Age of consent (heterosexual sex) [12,185]
Age of consent (homosexual sex) [12,185]
Legislation legalising sex work [110,112]
Legislation criminalising sexual violence [164,186]
Legislation criminalising human trafficking [187-190]
Legislative protection PLHIV [125]
Legislation criminalising HIV transmission [124]
Legislation on mandatory partner notification [31]

Political and structural context

Current national SRH strategy [18,24,70,191-199]
Current nation HIV/STI prevention strategy [155-157,195,197-219]
National strategy to prevent adolescent/teenage pregnancy [76,209,220]
National strategy to prevent sexual violence and increase awareness [11,164,166,186,216,221-227]
NGO dedicated to the sexual health of the general population [38,54,228]
NGO dedicated to sexual education [12,229,230]
NGO dedicated to HIV/STI prevention/sexual health promotion among MSM [64,98,99,194,201,203,206,211,231-234]
NGO dedicated to HIV/STI prevention/sexual health promotion among migrants [99,135,148,201,203,206,211,231,232,235]

Economic systems

Healthcare systems [39]

Epidemiological context

Teenage fertility rates [78]
Abortion rates [79]
% 15 year olds girls who have had sexual intercourse [12,77]
% 15 year olds boys who have had sexual intercourse - [12,77]
% 15 year olds girls who used a condom at last sexual intercourse - [12,77]
% 15 year olds boys who used a condom at last sexual intercourse - [12,77]

Research data

Survey of sexual health of the general population [40,41,55]
Survey of sexual health of young people [41,55,77]
Survey of sexual health of MSM [41,55,236]
Survey of sexual health of sex workers [28,41,55,113]
Survey of sexual health of PLHIV [41,55,127]
Survey of sexual health of migrants [41,55]

Surveillance and monitoring

Data on general population [7,8]
Data on young people [7,8]
Data on MSM [7,8]
Data on IDUs [8]
Data on HIV testing in the general population [8]
Data on HIV testing among MSM [91]
Data on teenage fertility [78]
Data on abortion [79]
Data on contraceptive use [43]
Survey of sexual health of migrants [41,55]

Sexual health public education campaigns

HIV/AIDS awareness campaign [99,156,194,200,231,237-251]
Sexual violence awareness campaign [99,168,187,252]
Campaign on condom/contraceptive use [99,238-244,246,248-251,253-258]

National prevention programmes

Young People [64,99,115,156,157,194,200,201,203,211,238,240,242-245,247,249,250,253,257]
MSM [64,99,115,155-157,200,201,203,211,238,240,243-245,247,250,257,259,260]
Sex Workers [64,99,115,156,157,194,201,203,211,231,238,240,242-245,247,250,254,259,260]
Migrants [99,115,155-157,201,203,211,231,238,240,243-245,247,250,254,259]
IDUs [64,99,115,156,157,194,200,201,203,211,231,238,240,242,243,245,247,250,259,260]

Provision of sexuality education

Sexual education mandatory [12,26,70,229,261-264]
Minimum standards for sexuality education [12, 26, 70, 229, 261-264]

National screening and vaccination programmes

Chlamydia screening programme [39,53,55]
Antenatal screening programme for HIV and/or syphilis [61,99,265]
Cervical cancer screening programme [53,62,266,267]
Publically funded HPV vaccination programme [51]

Health services delivery

Provision of free contraception [24,64]
Provision of free condoms [64,99,156,157,200,201,203,231,234,238,239,242-244,249,250,253,259]
Availability of free testing and treatment [64,115,155-157,200,201,203,211,231,233,234,238,253,261,268]

Appendix C - List of country respondents

Country	Respondent	Affiliation
Austria	Gabriela El Belazi, Reinhild Strauss	Ministry of Health
Belgium	André Sasse	Scientific Institute of Public Health
Bulgaria		
Cyprus	Chrystalla Chadjianastassiou	Ministry of Health
Czech Republic	Hana Zákoucká	National Institute of Public Health
Denmark	Jan Fouchard	Danish National Board of Health
Estonia	Kristi Rüütel	National Institute for Health Development
Finland	Kirsi Liitsola, Kristiina Poikajärvi	National Institute for Health and Welfare
France		
Germany	Gerit Solveig Korr	Federal Ministry of Health
Greece	Vasileia Konte, Chryssa Tsiara, Magda Pylli, Dimitra Paraskeva, Chryssoula Botsi, Christos Chryssomalis, Ioanna Pavlopoulou, Harris Politis	Hellenic Centre for Disease Control and Prevention
Hungary	Mária Dudás	National Center for Epidemiology
Iceland		
Ireland	Aiden O'Hora	Health Protection Surveillance Centre
Italy		
Latvia	Anda Karnite/ Ingrida Sniedze	Department of Public Health and Epidemiology, Riga Stradins University/ Centre for Disease Prevention and Control
Liechtenstein		
Lithuania	Agne Simkunaite-Zazecke	HIV/AIDS, STI and Hepatitis Epidemiological Surveillance Department, Centre for Communicable Diseases and AIDS
Luxembourg	Charlé Norbert	Ministry of Health
Malta	Jackie Maistre Melillo	Health Promotion and Disease Prevention Directorate
Netherlands	Marianne van der Sande, Eline Op de Coul	RIVM - Centre for Infectious Disease Control
Norway	Lennart Lee Lock	Norwegian Directorate of Health
Poland		
Portugal		
Romania	Mariana Mardarescu, Mioara Predescu/Viorica Gheroghiu	National Institute of Infectious Diseases National Institute of Infectious Diseases/National Institute of Public Health
Slovakia	Alexandra Žampachová	Public Health Authority of the Slovak Republic
Slovenia	Irena Klavs, Barbara Mihevc	National Institute of Public Health
Spain	Manuel Alberto Martin-Perez, Mercedes Diez	National Epidemiology Centre
Sweden	Frida Hansdotter	Institute for Communicable Disease Control
United Kingdom	Ian Simms/ Lesley Wallace/ Daniel Thomas	Health Protection Agency/ NHS National Services Scotland/ Public Health Wales

Appendix D – Country profiles

Austria

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	14
Age of consent (homosexual sex)	14
Legality of sex work	SB
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	No
Legislation criminalising HIV transmission	Yes
Legislation on mandatory partner notification	No

Political and structural context	
Current national sexual and reproductive health strategy	No
Current national HIV/AIDS/STIs prevention strategy	-
National strategy to prevent teenage/adolescent pregnancy	-
National strategy to prevent sexual violence and increase awareness	Yes
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	M

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	3.5
ii. Young people (per 100 000 population 15-24 years)	5.3
iii. MSM (per 100 000 male population)	3.5
Chlamydia (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Gonorrhoea (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Syphilis (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Adolescent birth rate per 1 000 women (15-19 year old)	9.7
Abortion rate per 1 000 women (15-44 year old)	1.3
% 15 year old girls who have had sexual intercourse	28
% 15 year old boys who have had sexual intercourse	36
% 15 year old girls who used a condom at last sexual intercourse	77
% 15 year old boys who used a condom at last sexual intercourse	86

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	C
ii. Young people	C
iii. MSM	C
iv. Sex workers	-
v. PLHIV	C
vi. Migrants	-
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	S
ii. Young people	S
iii. MSM	S
iv. Sex workers	-
v. PLHIV	H
vi. Migrants	-
vii. IDUs	-
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	Yes
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	Yes*
Availability of routinely collected data on contraceptive use	Yes*

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	-
Public education campaign on STIs	-
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	-
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	-
ii. MSM	-
iii. Sex workers	-
iv. Migrants	-
v. IDUs	-
Provision of sexual education	
Sexuality education mandatory	Yes*
Minimum standards for sexuality education	Yes*
National screening and vaccination programmes	
Chlamydia screening programme	No
Antenatal screening programme for HIV	Yes
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	No
Health service delivery	
Provision of free contraceptives	No
Provision of free condoms	-
Availability of free testing/treatment for HIV and/or STIs	-

Footnotes

(-) Information not available

SB = Sex work and brothels legalised

M= Mandatory health and social insurance

C = Cross-national

H = HIV

S = STIs

Country comments

* Based on consulted references, data not available at Ministry of Health level

Belgium

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	16
Age of consent (homosexual sex)	16
Legality of sex work	SB
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	Yes
Legislation criminalising HIV transmission	Yes
Legislation on mandatory partner notification	No

Political and structural context	
Current national sexual and reproductive health strategy	No
Current national HIV/AIDS/STIs prevention strategy	No
National strategy to prevent teenage/adolescent pregnancy	-
National strategy to prevent sexual violence and increase awareness	Yes
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	M

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	10.7
ii. Young people (per 100 000 population 15-24 years)	9.1
iii. MSM (per 100 000 male population)	7.3
Chlamydia (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Gonorrhoea (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Syphilis (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Adolescent birth rate per 1 000 women (15-19 year old)	11.2
Abortion rate per 1 000 women (15-44 year old)	7.5
% 15 year old girls who have had sexual intercourse	28
% 15 year old boys who have had sexual intercourse	35
% 15 year old girls who used a condom at last sexual intercourse	69
% 15 year old boys who used a condom at last sexual intercourse	79

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	N
ii. Young people	N
iii. MSM	NC
iv. Sex workers	N
v. PLHIV	N
vi. Migrants	N
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	H
iv. Sex workers	-
v. PLHIV	H
vi. Migrants	H
vii. IDUs	H
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	Yes
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	Yes
Availability of routinely collected data on contraceptive use	Yes

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	Yes
Public education campaign on STIs	Yes
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	Yes
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	Yes
iii. Sex workers	Yes
iv. Migrants	Yes
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	Yes
Minimum standards for sexuality education	Yes
National screening and vaccination programmes	
Chlamydia screening programme	No
Antenatal screening programme for HIV	No
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	Yes
Health service delivery	
Provision of free contraceptives	Yes*
Provision of free condoms	Yes
Availability of free testing/treatment for HIV and/or STIs	Yes

Footnotes

(-) Information not available
SB = Sex work and brothels legalised
M= Mandatory health and social insurance
N = National
NC = National and cross-national
H = HIV
S = STIs

Comments

* Free contraceptives are provided for girls/women < 21 years of age

Bulgaria

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	14
Age of consent (homosexual sex)	14
Legality of sex work	S
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	Yes
Legislation criminalising HIV transmission	No
Legislation on mandatory partner notification	No

Political and structural context	
Current national sexual and reproductive health strategy	No
Current national HIV/AIDS/STIs prevention strategy	Yes (2008-2015)
National strategy to prevent teenage/adolescent pregnancy	-
National strategy to prevent sexual violence and increase awareness	No
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	UC

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	2.7
ii. Young people (per 100 000 population 15-24 years)	4.7
iii. MSM (per 100 000 male population)	1.3
Chlamydia (diagnoses per 100 000):	
i. General population	0.7
ii. Young people (per 100 000 population 15-24 years)	1.3
iii. MSM (per 100 000 male population)	-
Gonorrhoea (diagnoses per 100 000):	
i. General population	2.6
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Syphilis (diagnoses per 100 000):	
i. General population	4.2
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Adolescent birth rate per 1 000 women (15-19 year old)	36.2
Abortion rate per 1 000 women (15-44 year old)	21.3
% 15 year old girls who have had sexual intercourse	31
% 15 year old boys who have had sexual intercourse	47
% 15 year old girls who used a condom at last sexual intercourse	76
% 15 year old boys who used a condom at last sexual intercourse	86

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	NC
ii. Young people	C
iii. MSM	C
iv. Sex workers	-
v. PLHIV	-
vi. Migrants	-
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	-
v. PLHIV	H
vi. Migrants	-
vii. IDUs	H
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	Yes
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	Yes
Availability of routinely collected data on contraceptive use	Yes

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	Yes
Public education campaign on STIs	-
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	-
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	Yes
iii. Sex workers	Yes
iv. Migrants	Yes
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	No
Minimum standards for sexuality education	No
National screening and vaccination programmes	
Chlamydia screening programme	No
Antenatal screening programme for HIV	-
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	No ~
Health service delivery	
Provision of free contraceptives	No
Provision of free condoms	Yes
Availability of free testing/treatment for HIV and/or STIs	Yes

Footnotes

(-) Information not available
S = Sex work legal
UC = Universal coverage
C = Cross-national
NC = National and cross-national
H = HIV
S = STIs

Comments

~ Co-payment rather than publically funded

Cyprus

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	17
Age of consent (homosexual sex)	17
Legality of sex work	S
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	No
Legislation criminalising HIV transmission	Yes
Legislation on mandatory partner notification	No

Political and structural context	
Current national sexual and reproductive health strategy	No
Current national HIV/AIDS/STIs prevention strategy	Yes (2011-2014)
National strategy to prevent teenage/adolescent pregnancy	-
National strategy to prevent sexual violence and increase awareness	-
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	UC

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	6.4
ii. Young people (per 100 000 population 15-24 years)	3.7
iii. MSM (per 100 000 male population)	6.6
Chlamydia (diagnoses per 100 000):	
i. General population	0.7
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Gonorrhoea (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	3.7
iii. MSM (per 100 000 male population)	-
Syphilis (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	1.5
iii. MSM (per 100 000 male population)	-
Adolescent birth rate per 1 000 women (15-19 year old)	5.5
Abortion rate per 1 000 women (15-44 year old)	-
% 15 year old girls who have had sexual intercourse	(2.5)
% 15 year old boys who have had sexual intercourse	(13.0)
% 15 year old girls who used a condom at last sexual intercourse	-
% 15 year old boys who used a condom at last sexual intercourse	-

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	N
ii. Young people	NC
iii. MSM	C
iv. Sex workers	-
v. PLHIV	-
vi. Migrants	-
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	-
v. PLHIV	H
vi. Migrants	HS
vii. IDUs	-
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	No
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	No
Availability of routinely collected data on contraceptive use	No

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	No
Public education campaign on STIs	No
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	Yes
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	No
iii. Sex workers	-
iv. Migrants	No
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	No
Minimum standards for sexuality education	No
National screening and vaccination programmes	
Chlamydia screening programme	No
Antenatal screening programme for HIV	Yes
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	No
Health service delivery	
Provision of free contraceptives	No
Provision of free condoms	Yes
Availability of free testing/treatment for HIV and/or STIs	-

Footnotes

(-) Information not available
S = Sex work legal
UC = Universal coverage
N = National
C = Cross-national
NC = National and cross-national
H = HIV
S = STIs

Comments

() = Data produced independently by each country and may not be directly comparable

Czech Republic

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	15
Age of consent (homosexual sex)	15
Legality of sex work	S
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	Yes
Legislation criminalising HIV transmission	Yes
Legislation on mandatory partner notification	Yes

Political and structural context	
Current national sexual and reproductive health strategy	Yes (2008-2012)
Current national HIV/AIDS/STIs prevention strategy	Yes (2008-2012)
National strategy to prevent teenage/adolescent pregnancy	-
National strategy to prevent sexual violence and increase awareness	No
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	M

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	1.5
ii. Young people (per 100 000 population 15-24 years)	2.6
iii. MSM (per 100 000 male population)	2.2
Chlamydia (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Gonorrhoea (diagnoses per 100 000):	
i. General population	6.7
ii. Young people (per 100 000 population 15-24 years)	19.8
iii. MSM (per 100 000 male population)	2.9
Syphilis (diagnoses per 100 000):	
i. General population	3.4
ii. Young people (per 100 000 population 15-24 years)	4.6
iii. MSM (per 100 000 male population)	2.6
Adolescent birth rate per 1 000 women (15-19 year old)	9.2
Abortion rate per 1 000 women (15-44 year old)	17.9
% 15 year old girls who have had sexual intercourse	26
% 15 year old boys who have had sexual intercourse	22
% 15 year old girls who used a condom at last sexual intercourse	-
% 15 year old boys who used a condom at last sexual intercourse	-

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	C
ii. Young people	C
iii. MSM	C
iv. Sex workers	-
v. PLHIV	C
vi. Migrants	-
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	-
v. PLHIV	H
vi. Migrants	-
vii. IDUs	H
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	Yes
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	Yes
Availability of routinely collected data on contraceptive use	Yes

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	Yes
Public education campaign on STIs	-
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	Yes
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	Yes
iii. Sex workers	Yes
iv. Migrants	Yes
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	Yes
Minimum standards for sexuality education	Yes
National screening and vaccination programmes	
Chlamydia screening programme	No
Antenatal screening programme for HIV	Yes
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	No
Health service delivery	
Provision of free contraceptives	No
Provision of free condoms	Yes
Availability of free testing/treatment for HIV and/or STIs	Yes

Footnotes

(-) Information not available

S = Sex work legal

M= Mandatory health and social insurance

C = Cross-national

H = HIV

S = STIs

Denmark

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	15
Age of consent (homosexual sex)	15
Legality of sex work	S
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	No
Legislation criminalising HIV transmission	Yes
Legislation on mandatory partner notification	No

Political and structural context	
Current national sexual and reproductive health strategy	No
Current national HIV/AIDS/STIs prevention strategy	No (2006-2009)
National strategy to prevent teenage/adolescent pregnancy	No
National strategy to prevent sexual violence and increase awareness	Yes
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	SI

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	4.8
ii. Young people (per 100 000 population 15-24 years)	2.2
iii. MSM (per 100 000 male population)	4.1
Chlamydia (diagnoses per 100 000):	
i. General population	478.7
ii. Young people (per 100 000 population 15-24 years)	2676.7
iii. MSM (per 100 000 male population)	-
Gonorrhoea (diagnoses per 100 000):	
i. General population	9.0
ii. Young people (per 100 000 population 15-24 years)	23.3
iii. MSM (per 100 000 male population)	6.8
Syphilis (diagnoses per 100 000):	
i. General population	7.7
ii. Young people (per 100 000 population 15-24 years)	10.5
iii. MSM (per 100 000 male population)	11.7
Adolescent birth rate per 1 000 women (15-19 year old)	5.1
Abortion rate per 1 000 women (15-44 year old)	14.3
% 15 year old girls who have had sexual intercourse	38
% 15 year old boys who have had sexual intercourse	38
% 15 year old girls who used a condom at last sexual intercourse	63
% 15 year old boys who used a condom at last sexual intercourse	74

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	N
ii. Young people	N
iii. MSM	NC
iv. Sex workers	N
v. PLHIV	N
vi. Migrants	-
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	No
v. PLHIV	H
vi. Migrants	HS
vii. IDUs	H
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	Yes
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	Yes
Availability of routinely collected data on contraceptive use	Yes

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	Yes
Public education campaign on STIs	Yes
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	Yes
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	Yes
iii. Sex workers	Yes
iv. Migrants	No
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	Yes
Minimum standards for sexuality education	Yes
National screening and vaccination programmes	
Chlamydia screening programme	Yes*
Antenatal screening programme for HIV	Yes
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	Yes
Health service delivery	
Provision of free contraceptives	No
Provision of free condoms	No
Availability of free testing/treatment for HIV and/or STIs	Yes§

Footnotes

(-) Information not available

S = Sex work legal
SI = Social insurance
C = Cross-national
NC = National and cross-national
H = HIV
S = STIs

Comments

* Opportunistic screening of young people attending general practice, with or without identified risk behaviour

§ Treatment is not free for gonorrhoea and chlamydia

Estonia

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	14
Age of consent (homosexual sex)	14
Legality of sex work	S
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	Yes
Legislation criminalising HIV transmission	Yes
Legislation on mandatory partner notification	Yes*

Political and structural context	
Current national sexual and reproductive health strategy	-
Current national HIV/AIDS/STIs prevention strategy	Yes (2006-2015)
National strategy to prevent teenage/adolescent pregnancy	-
National strategy to prevent sexual violence and increase awareness	Yes
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	No

Economic systems	
Healthcare systems	M

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	27.3
ii. Young people (per 100 000 population 15-24 years)	35.5
iii. MSM (per 100 000 male population)	-
Chlamydia (diagnoses per 100 000):	
i. General population	128.3
ii. Young people (per 100 000 population 15-24 years)	531.5
iii. MSM (per 100 000 male population)	-
Gonorrhoea (diagnoses per 100 000):	
i. General population	12.4
ii. Young people (per 100 000 population 15-24 years)	31.1
iii. MSM (per 100 000 male population)	-
Syphilis (diagnoses per 100 000):	
i. General population	4.9
ii. Young people (per 100 000 population 15-24 years)	2.2
iii. MSM (per 100 000 male population)	-
Adolescent birth rate per 1 000 women (15-19 year old)	17.2
Abortion rate per 1 000 women (15-44 year old)	33.3
% 15 year old girls who have had sexual intercourse	23
% 15 year old boys who have had sexual intercourse	21
% 15 year old girls who used a condom at last sexual intercourse	89
% 15 year old boys who used a condom at last sexual intercourse	91

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	N
ii. Young people	NC
iii. MSM	NC
iv. Sex workers	N
v. PLHIV	N
vi. Migrants	-
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	H
iv. Sex workers	HS
v. PLHIV	H
vi. Migrants	-
vii. IDUs	H
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	Yes
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	Yes
Availability of routinely collected data on contraceptive use	Yes

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	Yes
Public education campaign on STIs	-
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	Yes
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	Yes
iii. Sex workers	Yes
iv. Migrants	Yes
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	Yes
Minimum standards for sexuality education	Yes
National screening and vaccination programmes	
Chlamydia screening programme	Yes
Antenatal screening programme for HIV	Yes
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	No
Health service delivery	
Provision of free contraceptives	No
Provision of free condoms	Yes
Availability of free testing/treatment for HIV and/or STIs	Yes

Footnotes

(-) Information not available

S = Sex work legal
M= Mandatory health and social insurance
N = National
NC = National and cross-national
H = HIV
S = STIs

Comments

* Partner notification mandatory for healthcare provider but not for the patient to report names of sexual partners.

Finland

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	16
Age of consent (homosexual sex)	16
Legality of sex work	S
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	Yes
Legislation criminalising HIV transmission	Yes
Legislation on mandatory partner notification	Yes

Political and structural context	
Current national sexual and reproductive health strategy	No (2007-2011)*
Current national HIV/AIDS/STIs prevention strategy	Yes
National strategy to prevent teenage/adolescent pregnancy	No (2007-2011)*
National strategy to prevent sexual violence and increase awareness	Yes
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	SI

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	3.3
ii. Young people (per 100 000 population 15-24 years)	3.5
iii. MSM (per 100 000 male population)	1.4
Chlamydia (diagnoses per 100 000):	
i. General population	254.3
ii. Young people (per 100 000 population 15-24 years)	1356.2
iii. MSM (per 100 000 male population)	-
Gonorrhoea (diagnoses per 100 000):	
i. General population	5.4
ii. Young people (per 100 000 population 15-24 years)	13.5
iii. MSM (per 100 000 male population)	2.3
Syphilis (diagnoses per 100 000):	
i. General population	3.3
ii. Young people (per 100 000 population 15-24 years)	0.9
iii. MSM (per 100 000 male population)	1.1
Adolescent birth rate per 1 000 women (15-19 year old)	9.3
Abortion rate per 1 000 women (15-44 year old)	10.4
% 15 year old girls who have had sexual intercourse	24
% 15 year old boys who have had sexual intercourse	20
% 15 year old girls who used a condom at last sexual intercourse	63
% 15 year old boys who used a condom at last sexual intercourse	76

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	C
ii. Young people	NC
iii. MSM	C
iv. Sex workers	-
v. PLHIV	-
vi. Migrants	-
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	-
v. PLHIV	HS
vi. Migrants	HS
vii. IDUs	H
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	No
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	Yes
Availability of routinely collected data on contraceptive use	No

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	No
Public education campaign on STIs	No
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	No
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	No
ii. MSM	No
iii. Sex workers	No
iv. Migrants	No
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	Yes
Minimum standards for sexuality education	Yes
National screening and vaccination programmes	
Chlamydia screening programme	No
Antenatal screening programme for HIV	Yes
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	No
Health service delivery	
Provision of free contraceptives	No
Provision of free condoms	No
Availability of free testing/treatment for HIV and/or STIs	Yes

Footnotes

(-) Information not available
S = Sex work legal
SI = Social insurance
C = Cross-national
NC = National and cross-national
H = HIV
S = STIs

Comments

* National strategy for 2012-2020 is expected to be adopted soon

France

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	15
Age of consent (homosexual sex)	15
Legality of sex work	S
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	No
Legislation criminalising HIV transmission	Yes
Legislation on mandatory partner notification	No

Political and structural context	
Current national sexual and reproductive health strategy	-
Current national HIV/AIDS/STIs prevention strategy	Yes (2010-2014)
National strategy to prevent teenage/adolescent pregnancy	-
National strategy to prevent sexual violence and increase awareness	Yes
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	M

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	6.3
ii. Young people (per 100 000 population 15-24 years)	4.7
iii. MSM (per 100 000 male population)	3.2
Chlamydia (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Gonorrhoea (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Syphilis (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Adolescent birth rate per 1 000 women (15-19 year old)	6
Abortion rate per 1 000 women (15-44 year old)	16.9
% 15 year old girls who have had sexual intercourse	23
% 15 year old boys who have had sexual intercourse	32
% 15 year old girls who used a condom at last sexual intercourse	82
% 15 year old boys who used a condom at last sexual intercourse	90

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	NC
ii. Young people	NC
iii. MSM	NC
iv. Sex workers	-
v. PLHIV	N
vi. Migrants	N
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	-
v. PLHIV	H
vi. Migrants	-
vii. IDUs	H
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	Yes
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	Yes
Availability of routinely collected data on contraceptive use	Yes

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	Yes
Public education campaign on STIs	-
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	-
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	-
ii. MSM	-
iii. Sex workers	-
iv. Migrants	-
v. IDUs	-
Provision of sexual education	
Sexuality education mandatory	Yes
Minimum standards for sexuality education	Yes
National screening and vaccination programmes	
Chlamydia screening programme	Yes
Antenatal screening programme for HIV	Yes
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	No ~
Health service delivery	
Provision of free contraceptives	Yes*
Provision of free condoms	-
Availability of free testing/treatment for HIV and/or STIs	-

Footnotes

(-) Information not available
S = Sex work legal
M= Mandatory health and social insurance
N = National
NC = National and cross-national
H = HIV
S = STIs

Comments

~ Co-payment rather than publically funded
* Either partially reimbursed or conditions on free provision

Germany

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	14
Age of consent (homosexual sex)	14
Legality of sex work	SB
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	Yes
Legislation criminalising HIV transmission	Yes
Legislation on mandatory partner notification	No

Political and structural context	
Current national sexual and reproductive health strategy	-
Current national HIV/AIDS/STIs prevention strategy	Yes
National strategy to prevent teenage/adolescent pregnancy	Yes
National strategy to prevent sexual violence and increase awareness	Yes
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	M

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	3.5
ii. Young people (per 100 000 population 15-24 years)	3.4
iii. MSM (per 100 000 male population)	3.9
Chlamydia (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Gonorrhoea (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Syphilis (diagnoses per 100 000):	
i. General population	4.5
ii. Young people (per 100 000 population 15-24 years)	3.9
iii. MSM (per 100 000 male population)	-
Adolescent birth rate per 1 000 women (15-19 year old)	6.8
Abortion rate per 1 000 women (15-44 year old)	7.8
% 15 year old girls who have had sexual intercourse	24
% 15 year old boys who have had sexual intercourse	20
% 15 year old girls who used a condom at last sexual intercourse	75
% 15 year old boys who used a condom at last sexual intercourse	84

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	NC
ii. Young people	NC
iii. MSM	NC
iv. Sex workers	N
v. PLHIV	NC
vi. Migrants	N
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	-
v. PLHIV	H
vi. Migrants	-
vii. IDUs	H
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	Yes
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	Yes
Availability of routinely collected data on contraceptive use	Yes

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	Yes
Public education campaign on STIs	Yes
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	Yes
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	Yes
iii. Sex workers	No
iv. Migrants	No
v. IDUs	No
Provision of sexual education	
Sexuality education mandatory	Yes
Minimum standards for sexuality education	Yes
National screening and vaccination programmes	
Chlamydia screening programme	Yes
Antenatal screening programme for HIV	Yes
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	Yes
Health service delivery	
Provision of free contraceptives	Yes*
Provision of free condoms	Yes*
Availability of free testing/treatment for HIV and/or STIs	Yes*

Footnotes

(-) Information not available
SB = Sex work and brothels legalised
M= Mandatory health and social insurance
N = National
NC = National and cross-national
H = HIV
S = STIs

Comments

* Either partially reimbursed or conditions on free provision

Greece

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	15*
Age of consent (homosexual sex)	15*
Legality of sex work	SB
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	Yes§
Legislation criminalising HIV transmission	Yes‡
Legislation on mandatory partner notification	No¤

Political and structural context	
Current national sexual and reproductive health strategy	Yes (2008-2012)
Current national HIV/AIDS/STIs prevention strategy	Yes (2008-2012)
National strategy to prevent teenage/adolescent pregnancy	-
National strategy to prevent sexual violence and increase awareness	-
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	M

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	7.4
ii. Young people (per 100 000 population 15-24 years)	8.6
iii. MSM (per 100 000 male population)	5.1
Chlamydia (diagnoses per 100 000):	
i. General population	4.4
ii. Young people (per 100 000 population 15-24 years)	2.2
iii. MSM (per 100 000 male population)	0.2
Gonorrhoea (diagnoses per 100 000):	
i. General population	3.3
ii. Young people (per 100 000 population 15-24 years)	3.7
iii. MSM (per 100 000 male population)	0.6
Syphilis (diagnoses per 100 000):	
i. General population	2.4
ii. Young people (per 100 000 population 15-24 years)	2.1
iii. MSM (per 100 000 male population)	2.3
Adolescent birth rate per 1 000 women (15-19 year old)	9.6
Abortion rate per 1 000 women (15-44 year old)	5
% 15 year old girls who have had sexual intercourse	18
% 15 year old boys who have had sexual intercourse	39
% 15 year old girls who used a condom at last sexual intercourse	86
% 15 year old boys who used a condom at last sexual intercourse	87

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	NC
ii. Young people	NC
iii. MSM	NC
iv. Sex workers	C
v. PLHIV	C
vi. Migrants	-
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	S
v. PLHIV	HS
vi. Migrants	HS
vii. IDUs	HS
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	Yes
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	Yes
Availability of routinely collected data on contraceptive use	Yes

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	Yes
Public education campaign on STIs	Yes
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	Yes
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	Yes
iii. Sex workers	Yes
iv. Migrants	Yes
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	No ◇
Minimum standards for sexuality education	Yes
National screening and vaccination programmes	
Chlamydia screening programme	No
Antenatal screening programme for HIV	Yes±
Cervical cancer screening programme	Yes^
Publically-funded HPV vaccination programme	Yes
Health service delivery	
Provision of free contraceptives	No
Provision of free condoms	Yes
Availability of free testing/treatment for HIV and/or STIs	Yes

Footnotes

(-) Information not available

SB = Sex work and brothels legalised

M= Mandatory health and social insurance

C = Cross-national NC = National and cross-national

H = HIV S = STI

Country comments

* 1 Art. 339 Penal code (PC)

§ There is state benefit for HIV seropositivity for disabled persons (HIV individuals are considered in general as disabled persons) and for people living below the poverty line.

‡ There is no specific legislation but contamination of HIV virus from one HIV-positive person to another (non-HIV-positive) person is considered as wounding, or causing grievous bodily harm with intent) (Art. 310 PC). It is considered that the HIV-positive person has attempted injury because he/she did not inform his/her sexual partner or did not take the appropriate measures to avoid contamination. Public prosecutors recently argued that sex workers had attempted to commit exposure to risk of life/grievous bodily harm with intent (Art.306 PC) to their clients who had consented to the sexual act because they had had sexual intercourse without taking precautions. The penalty for grievous bodily harm is imprisonment for up to ten years. The penalty for attempt to cause grievous bodily harm is from one to six years imprisonment (Art. 42 PC, Art.83 PC).

¤ No specific legislation, though omission of partner notification is recognised as severe bodily harm (Art. 310 PC) under Greek legislation (see also op. cit. 306 PC).

◇ Ministry of Education data reported for Global AIDS Reporting 2012. The sexual education programme “Diafilikes sexseis” is included in the school curriculum as an optional module in the section on health promotion. It has to be chosen by the school authorities and students do not have to attend if they choose not to.

In this programme there are minimum standards including training of trainees and collaboration with relevant organisations such as KEELPNO and the B’ Gynecology Clinic of Athens University.

± According to Greek legislation adopted in 1990, HIV testing should be voluntary, confidential and anonymous; free of charge in every public hospital and AIDS Reference Centre; accompanied by written informed consent and by pre- and post-test counselling. Targeted HIV testing is recommended to a wide range of people, including pregnant women who are known to be injecting drug users, sex workers and victims of sexual assault, and persons diagnosed with another STI. These guidelines are under revision. Changes include recommendations to test all pregnant women at least once on an opt-out basis.

^ The Ministry of Health in collaboration with primary care facilities initiated a cervical screening programme in 2011 (http://www.anticancer.gov.gr/). KEELPNO is responsible for the national cancer registry and the communication campaign.

Hungary

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	14
Age of consent (homosexual sex)	14
Legality of sex work	S
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	Yes
Legislation criminalising HIV transmission	No*
Legislation on mandatory partner notification	Yes

Political and structural context	
Current national sexual and reproductive health strategy	-
Current national HIV/AIDS/STIs prevention strategy	No (2004-2010)
National strategy to prevent teenage/adolescent pregnancy	-
National strategy to prevent sexual violence and increase awareness	-
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	SI

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	1.6
ii. Young people (per 100 000 population 15-24 years)	1.5
iii. MSM (per 100 000 male population)	2.3
Chlamydia (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Gonorrhoea (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Syphilis (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Adolescent birth rate per 1 000 women (15-19 year old)	13.6
Abortion rate per 1 000 women (15-49 year old)	16.9
% 15 year old girls who have had sexual intercourse	24
% 15 year old boys who have had sexual intercourse	37
% 15 year old girls who used a condom at last sexual intercourse	74
% 15 year old boys who used a condom at last sexual intercourse	79

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	-
ii. Young people	C
iii. MSM	C
iv. Sex workers	-
v. PLHIV	C
vi. Migrants	-
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	-
v. PLHIV	H
vi. Migrants	-
vii. IDUs	H
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	Yes
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	Yes
Availability of routinely collected data on contraceptive use	Yes

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	Yes
Public education campaign on STIs	-
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	Yes
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	Yes
iii. Sex workers	Yes
iv. Migrants	Yes
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	Yes
Minimum standards for sexuality education	No
National screening and vaccination programmes	
Chlamydia screening programme	No
Antenatal screening programme for HIV	No
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	No
Health service delivery	
Provision of free contraceptives	No
Provision of free condoms	Yes
Availability of free testing/treatment for HIV and/or STIs	Yes

Footnotes

(-) Information not available
S = Sex work legal
SI= Social insurance
C = Cross-national
H = HIV
S = STIs

Country coments

* Intentional HIV transmission can be subject to prosecution under civil law

Iceland

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	15
Age of consent (homosexual sex)	15
Legality of sex work	LL
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	No
Legislation criminalising HIV transmission	Yes
Legislation on mandatory partner notification	Yes

Political and structural context	
Current national sexual and reproductive health strategy	-
Current national HIV/AIDS/STIs prevention strategy	Yes
National strategy to prevent teenage/adolescent pregnancy	No (2004-2010)
National strategy to prevent sexual violence and increase awareness	Yes
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	-

Economic systems	
Healthcare systems	SI

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	7.2
ii. Young people (per 100 000 population 15-24 years)	4.3
iii. MSM (per 100 000 male population)	0.0
Chlamydia (diagnoses per 100 000):	
i. General population	656.6
ii. Young people (per 100 000 population 15-24 years)	3207.3
iii. MSM (per 100 000 male population)	-
Gonorrhoea (diagnoses per 100 000):	
i. General population	10.0
ii. Young people (per 100 000 population 15-24 years)	21.4
iii. MSM (per 100 000 male population)	-
Syphilis (diagnoses per 100 000):	
i. General population	0.6
ii. Young people (per 100 000 population 15-24 years)	2.1
iii. MSM (per 100 000 male population)	-
Adolescent birth rate per 1 000 women (15-19 year old)	11.6
Abortion rate per 1 000 women (15-44 year old)	14.53
% 15 year old girls who have had sexual intercourse	30
% 15 year old boys who have had sexual intercourse	28
% 15 year old girls who used a condom at last sexual intercourse	64
% 15 year old boys who used a condom at last sexual intercourse	71

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	C
ii. Young people	NC
iii. MSM	-
iv. Sex workers	-
v. PLHIV	C
vi. Migrants	-
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	H
iv. Sex workers	-
v. PLHIV	H
vi. Migrants	-
vii. IDUs	H
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	-
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	Yes
Availability of routinely collected data on contraceptive use	Yes

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	-
Public education campaign on STIs	-
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	-
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	Yes
iii. Sex workers	-
iv. Migrants	-
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	Yes
Minimum standards for sexuality education	Yes
National screening and vaccination programmes	
Chlamydia screening programme	no
Antenatal screening programme for HIV	Yes
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	Yes
Health service delivery	
Provision of free contraceptives	No
Provision of free condoms	No
Availability of free testing/treatment for HIV and/or STIs	Yes

Footnotes

(-) Information not available

LL= Limited legality, purchasing of sexual services is criminalised

SI= Social insurance

C = Cross-national

NC = National and cross-national

H = HIV

S = STIs

Ireland

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	17
Age of consent (homosexual sex)	17
Legality of sex work	S
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	Yes
Legislation criminalising HIV transmission	No
Legislation on mandatory partner notification	No

Political and structural context	
Current national sexual and reproductive health strategy	No
Current national HIV/AIDS/STIs prevention strategy	Yes (2008-2012)
National strategy to prevent teenage/adolescent pregnancy	-
National strategy to prevent sexual violence and increase awareness	Yes
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	M

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	7.2
ii. Young people (per 100 000 population 15-24 years)	4.8
iii. MSM (per 100 000 male population)	6.0
Chlamydia (diagnoses per 100 000):	
i. General population	143.0
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Gonorrhoea (diagnoses per 100 000):	
i. General population	18.6
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Syphilis (diagnoses per 100 000):	
i. General population	3.1
ii. Young people (per 100 000 population 15-24 years)	4.8
iii. MSM (per 100 000 male population)	5.2
Adolescent birth rate per 1 000 women (15-19 year old)	8.8
Abortion rate per 1 000 women (15-44 year old)	-
% 15 year old girls who have had sexual intercourse	17
% 15 year old boys who have had sexual intercourse	27
% 15 year old girls who used a condom at last sexual intercourse	77
% 15 year old boys who used a condom at last sexual intercourse	70

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	NC
ii. Young people	NC
iii. MSM	NC
iv. Sex workers	-
v. PLHIV	-
vi. Migrants	-
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	-
v. PLHIV	-
vi. Migrants	-
vii. IDUs	H
Availability of routinely collected data on HIV testing:	
i. General population	No
iii. MSM	No
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	No*
Availability of routinely collected data on contraceptive use	Yes

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	Yes
Public education campaign on STIs	-
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	-
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	Yes
iii. Sex workers	Yes
iv. Migrants	Yes
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	Yes
Minimum standards for sexuality education	Yes
National screening and vaccination programmes	
Chlamydia screening programme	No
Antenatal screening programme for HIV	Yes
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	Yes
Health service delivery	
Provision of free contraceptives	No
Provision of free condoms	Yes
Availability of free testing/treatment for HIV and/or STIs	Yes

Footnotes

(-) Information not available

S = Sex work legal

M= Mandatory health and social insurance

NC = National and cross-national

H = HIV

S = STIs

* Induced abortion is illegal

Italy

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	14
Age of consent (homosexual sex)	14
Legality of sex work	S
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	No
Legislation criminalising HIV transmission	Yes
Legislation on mandatory partner notification	Yes

Political and structural context	
Current national sexual and reproductive health strategy	-
Current national HIV/AIDS/STIs prevention strategy	Yes (2011-2013)§
National strategy to prevent teenage/adolescent pregnancy	-
National strategy to prevent sexual violence and increase awareness	Yes
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	No
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	M

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	5.8*
ii. Young people (per 100 000 population 15-24 years)	5.2
iii. MSM (per 100 000 male population)	3.9*
Chlamydia (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Gonorrhoea (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	1.3
iii. MSM (per 100 000 male population)	-
Syphilis (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	1.3
iii. MSM (per 100 000 male population)	-
Adolescent birth rate per 1 000 women (15-19 year old)	4
Abortion rate per 1 000 women (15-44 year old)	10.6
% 15 year old girls who have had sexual intercourse	22
% 15 year old boys who have had sexual intercourse	26
% 15 year old girls who used a condom at last sexual intercourse	78
% 15 year old boys who used a condom at last sexual intercourse	78

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	C
ii. Young people	C
iii. MSM	NC
iv. Sex workers	-
v. PLHIV	C
vi. Migrants	-
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	-
v. PLHIV	H
vi. Migrants	-
vii. IDUs	H
Availability of routinely collected data on HIV testing:	
i. General population	-
iii. MSM	Yes
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	Yes
Availability of routinely collected data on contraceptive use	Yes

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	-
Public education campaign on STIs	-
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	-
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	No
iii. Sex workers	No
iv. Migrants	Yes
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	No
Minimum standards for sexuality education	No
National screening and vaccination programmes	
Chlamydia screening programme	Yes
Antenatal screening programme for HIV	No
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	Yes
Health service delivery	
Provision of free contraceptives	No
Provision of free condoms	No
Availability of free testing/treatment for HIV and/or STIs	Yes

Footnotes

(-) Information not available
S = Sex work legal
M= Mandatory health and social insurance
C = Cross-national
NC = National and cross-national
H = HIV
S = STIs

Comments

* Sub-national: adjusted population, according to the coverage
§ Incorporated into a wider national health strategy

Latvia

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	16
Age of consent (homosexual sex)	16
Legality of sex work	S
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	Yes
Legislation criminalising HIV transmission	Yes
Legislation on mandatory partner notification	Yes

Political and structural context	
Current national sexual and reproductive health strategy	Yes (2011-2017)*
Current national HIV/AIDS prevention strategy	Yes (2009-2013)
National strategy to prevent teenage/adolescent pregnancy	Yes (2011-2017)*
National strategy to prevent sexual violence and increase awareness	Yes
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	No

Economic systems	
Healthcare systems	UC

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	13.4
ii. Young people (per 100 000 population 15-24 years)	15.1
iii. MSM (per 100 000 male population)	2.1
Chlamydia (diagnoses per 100 000):	
i. General population	69.6
ii. Young people (per 100 000 population 15-24 years)	215.0
iii. MSM (per 100 000 male population)	0.1
Gonorrhoea (diagnoses per 100 000):	
i. General population	24.4
ii. Young people (per 100 000 population 15-24 years)	56.6
iii. MSM (per 100 000 male population)	1.0
Syphilis (diagnoses per 100 000):	
i. General population	6.4
ii. Young people (per 100 000 population 15-24 years)	10.3
iii. MSM (per 100 000 male population)	1.0
Adolescent birth rate per 1 000 women (15-19 year old)	12.8
Abortion rate per 1 000 women (15-44 year old)	22.6
% 15 year old girls who have had sexual intercourse	18
% 15 year old boys who have had sexual intercourse	27
% 15 year old girls who used a condom at last sexual intercourse	84
% 15 year old boys who used a condom at last sexual intercourse	77

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	N
ii. Young people	NC
iii. MSM	NC
iv. Sex workers	NC
v. PLHIV	C
vi. Migrants	-
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	-
v. PLHIV	H
vi. Migrants	-
vii. IDUs	HS
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	Yes
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	Yes
Availability of routinely collected data on contraceptive use	No

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	Yes
Public education campaign on STIs	-
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	No
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	No
iii. Sex workers	No
iv. Migrants	No
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	Yes
Minimum standards for sexuality education	Yes
National screening and vaccination programmes	
Chlamydia screening programme	No
Antenatal screening programme for HIV	Yes
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	Yes
Health service delivery	
Provision of free contraceptives	No
Provision of free condoms	No
Availability of free testing/treatment for HIV and/or STIs	Yes~

Footnotes

(-) Information not available
S = Sex work legal
UC = Universal coverage
N = National
C = Cross-national
NC = National and cross-national
H = HIV
S = STIs

Comments

~ Co-payment rather than publically funded
* Incorporated into a wider national health strategy.

Liechtenstein

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	14
Age of consent (homosexual sex)	14
Legality of sex work	SC
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	No
Legislation criminalising HIV transmission	Yes
Legislation on mandatory partner notification	No

Political and structural context	
Current national sexual and reproductive health strategy	-
Current national HIV/AIDS/STIs prevention strategy	No
National strategy to prevent teenage/adolescent pregnancy	-
National strategy to prevent sexual violence and increase awareness	-
Existence of NGO dedicated to:	-
i. Sexual and reproductive health of the general population	-
ii. Sexuality education	-
iii. HIV/STI prevention/sexual health promotion among MSM	-
iv. HIV/STI prevention/sexual health promotion among migrants	-

Economic systems	
Healthcare systems	PI

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Chlamydia (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Gonorrhoea (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Syphilis (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Adolescent birth rate per 1 000 women (15-19 year old)	2.8
Abortion rate per 1 000 women (15-44 year old)	-
% 15 year old girls who have had sexual intercourse	-
% 15 year old boys who have had sexual intercourse	-
% 15 year old girls who used a condom at last sexual intercourse	-
% 15 year old boys who used a condom at last sexual intercourse	-

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	-
ii. Young people	-
iii. MSM	-
iv. Sex workers	-
v. PLHIV	-
vi. Migrants	-
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	-
ii. Young people	-
iii. MSM	-
iv. Sex workers	-
v. PLHIV	H
vi. Migrants	-
vii. IDUs	-
Availability of routinely collected data on HIV testing:	
i. General population	-
iii. MSM	-
Availability of routinely collected data on teenage pregnancy	-
Availabilityof routinely collected data on abortion	-
Availability of routinely collected data on contraceptive use	-

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	-
Public education campaign on STIs	-
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	-
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	-
ii. MSM	-
iii. Sex workers	-
iv. Migrants	-
v. IDUs	-
Provision of sexual education	
Sexuality education mandatory	Yes
Minimum standards for sexuality education	-
National screening and vaccination programmes	
Chlamydia screening programme	-
Antenatal screening programme for HIV	-
Cervical cancer screening programme	-
Publically-funded HPV vaccination programme	-
Health service delivery	
Provision of free contraceptives	-
Provision of free condoms	-
Availability of free testing/treatment for HIV and/or STIs	-

Footnotes

(-) Information not available

SC = Sex work criminalised

PI = Private Insurance

H = HIV

Lithuania

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	16
Age of consent (homosexual sex)	18
Legality of sex work	SC
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	Yes
Legislation criminalising HIV transmission	Yes
Legislation on mandatory partner notification	Yes

Political and structural context	
Current national sexual and reproductive health strategy	No
Current national HIV/AIDS/STIs prevention strategy	Yes (2010-2012)*
National strategy to prevent teenage/adolescent pregnancy	-
National strategy to prevent sexual violence and increase awareness	Yes
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	SI

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	5.1
ii. Young people (per 100 000 population 15-24 years)	3.9
iii. MSM (per 100 000 male population)	0.5
Chlamydia (diagnoses per 100 000):	
i. General population	10.6
ii. Young people (per 100 000 population 15-24 years)	14.3
iii. MSM (per 100 000 male population)	-
Gonorrhoea (diagnoses per 100 000):	
i. General population	7.6
ii. Young people (per 100 000 population 15-24 years)	17.9
iii. MSM (per 100 000 male population)	0.2
Syphilis (diagnoses per 100 000):	
i. General population	8.4
ii. Young people (per 100 000 population 15-24 years)	17.2
iii. MSM (per 100 000 male population)	0.3
Adolescent birth rate per 1 000 women (15-19 year old)	19
Abortion rate per 1 000 women (15-44 year old)	16.1
% 15 year old girls who have had sexual intercourse	12
% 15 year old boys who have had sexual intercourse	26
% 15 year old girls who used a condom at last sexual intercourse	84
% 15 year old boys who used a condom at last sexual intercourse	77

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	N
ii. Young people	NC
iii. MSM	NC
iv. Sex workers	N
v. PLHIV	-
vi. Migrants	-
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	HS
v. PLHIV	H
vi. Migrants	HS
vii. IDUs	H
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	Yes
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	Yes
Availability of routinely collected data on contraceptive use	Yes

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	Yes
Public education campaign on STIs	-
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	Yes
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	Yes
iii. Sex workers	Yes
iv. Migrants	Yes
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	No
Minimum standards for sexuality education	-
National screening and vaccination programmes	
Chlamydia screening programme	No
Antenatal screening programme for HIV	Yes
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	No
Health service delivery	
Provision of free contraceptives	No
Provision of free condoms	Yes
Availability of free testing/treatment for HIV and/or STIs	Yes

Footnotes

(-) Information not available
SC = Sex work criminalised
SI= Social insurance
N = National
NC = National and cross-national
H = HIV
S = STIs

Comments

* Incorporated into a wider national health strategy

Luxembourg

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	16
Age of consent (homosexual sex)	16
Legality of sex work	S
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	Yes
Legislation criminalising HIV transmission	No
Legislation on mandatory partner notification	No

Political and structural context	
Current national sexual and reproductive health strategy	-
Current national HIV/AIDS/STIs prevention strategy	No (2006-2010)
National strategy to prevent teenage/adolescent pregnancy	-
National strategy to prevent sexual violence and increase awareness	-
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	No
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	M

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	8.6
ii. Young people (per 100 000 population 15-24 years)	14.7
iii. MSM (per 100 000 male population)	9.0
Chlamydia (diagnoses per 100 000):	
i. General population	0.2
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Gonorrhoea (diagnoses per 100 000):	
i. General population	0.4
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	0.4
Syphilis (diagnoses per 100 000):	
i. General population	5.5
ii. Young people (per 100 000 population 15-24 years)	4.9
iii. MSM (per 100 000 male population)	1.2
Adolescent birth rate per 1 000 women (15-19 year old)	8.4
Abortion rate per 1 000 women (15-44 year old)	-
% 15 year old girls who have had sexual intercourse	24
% 15 year old boys who have had sexual intercourse	36
% 15 year old girls who used a condom at last sexual intercourse	84
% 15 year old boys who used a condom at last sexual intercourse	90

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	-
ii. Young people	C
iii. MSM	C
iv. Sex workers	N
v. PLHIV	-
vi. Migrants	-
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	-
v. PLHIV	H
vi. Migrants	-
vii. IDUs	H
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	Yes
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	-
Availability of routinely collected data on contraceptive use	-

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	Yes
Public education campaign on STIs	-
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	Yes
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	Yes
iii. Sex workers	Yes
iv. Migrants	Yes
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	Yes
Minimum standards for sexuality education	Yes
National screening and vaccination programmes	
Chlamydia screening programme	No
Antenatal screening programme for HIV	-
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	Yes
Health service delivery	
Provision of free contraceptives	Yes
Provision of free condoms	Yes
Availability of free testing/treatment for HIV and/or STIs	-

Footnotes

(-) Information not available

S = Sex work legal

M= Mandatory health and social insurance

N = National

C = Cross-national

H = HIV

S = STIs

Malta

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	18
Age of consent (homosexual sex)	18
Legality of sex work	SC
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	Yes
Legislation criminalising HIV transmission	Yes
Legislation on mandatory partner notification	No

Political and structural context	
Current national sexual and reproductive health strategy	Yes
Current national HIV/AIDS/STIs prevention strategy	No
National strategy to prevent teenage/adolescent pregnancy	-
National strategy to prevent sexual violence and increase awareness	Yes
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	-
ii. Sexuality education	-
iii. HIV/STI prevention/sexual health promotion among MSM	-
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	M

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	5.0
ii. Young people (per 100 000 population 15-24 years)	0.0
iii. MSM (per 100 000 male population)	1.9
Chlamydia (diagnoses per 100 000):	
i. General population	35.0
ii. Young people (per 100 000 population 15-24 years)	106.0
iii. MSM (per 100 000 male population)	13.5
Gonorrhoea (diagnoses per 100 000):	
i. General population	11.0
ii. Young people (per 100 000 population 15-24 years)	22.6
iii. MSM (per 100 000 male population)	8.2
Syphilis (diagnoses per 100 000):	
i. General population	10.8
ii. Young people (per 100 000 population 15-24 years)	7.0
iii. MSM (per 100 000 male population)	9.2
Adolescent birth rate per 1 000 women (15-19 year old)	11.8
Abortion rate per 1 000 women (15-44 year old)	-
% 15 year old girls who have had sexual intercourse	-
% 15 year old boys who have had sexual intercourse	-
% 15 year old girls who used a condom at last sexual intercourse	-
% 15 year old boys who used a condom at last sexual intercourse	-

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	N
ii. Young people	NC
iii. MSM	C
iv. Sex workers	No
v. PLHIV	No
vi. Migrants	C
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	-
v. PLHIV	H
vi. Migrants	-
vii. IDUs	H
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	Yes
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	No*
Availability of routinely collected data on contraceptive use	Yes

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	Yes
Public education campaign on STIs	-
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	No
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	No
iii. Sex workers	No
iv. Migrants	No
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	Yes
Minimum standards for sexuality education	Yes
National screening and vaccination programmes	
Chlamydia screening programme	No
Antenatal screening programme for HIV	Yes
Cervical cancer screening programme	No
Publically-funded HPV vaccination programme	Yes§
Health service delivery	
Provision of free contraceptives	No
Provision of free condoms	No
Availability of free testing/treatment for HIV and/or STIs	Yes

Footnotes

(-) Information not available
SC = Sex work criminalised
M= Mandatory health and social insurance
N = National
C = Cross-national
NC = National and cross-national
H = HIV
S = STIs

Comments

* Induced abortion is illegal
§ Launched in 2012, offered to 12-year-old girls

Netherlands

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	12
Age of consent (homosexual sex)	12
Legality of sex work	SB
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	Yes
Legislation criminalising HIV transmission	Yes
Legislation on mandatory partner notification	No

Political and structural context	
Current national sexual and reproductive health strategy	Yes
Current national HIV/AIDS/STIs prevention strategy	Yes
National strategy to prevent teenage/adolescent pregnancy	Yes
National strategy to prevent sexual violence and increase awareness	Yes
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	M

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	6.1
ii. Young people (per 100 000 population 15-24 years)	5.1
iii. MSM (per 100 000 male population)	8.0
Chlamydia (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Gonorrhoea (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Syphilis (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Adolescent birth rate per 1 000 women (15-19 year old)	4
Abortion rate per 1 000 women (15-44 year old)	4.3
% 15 year old girls who have had sexual intercourse	22
% 15 year old boys who have had sexual intercourse	19
% 15 year old girls who used a condom at last sexual intercourse	75
% 15 year old boys who used a condom at last sexual intercourse	75

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	NC
ii. Young people	NC
iii. MSM	NC
iv. Sex workers	NC
v. PLHIV	NC
vi. Migrants	NC
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	HS
v. PLHIV	HS
vi. Migrants	HS
vii. IDUs	HS
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	Yes
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	Yes
Availability of routinely collected data on contraceptive use	Yes

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	Yes
Public education campaign on STIs	Yes
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	Yes
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	Yes
iii. Sex workers	Yes
iv. Migrants	Yes
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	Yes
Minimum standards for sexuality education	Yes
National screening and vaccination programmes	
Chlamydia screening programme	Yes
Antenatal screening programme for HIV	Yes
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	Yes
Health service delivery	
Provision of free contraceptives	-
Provision of free condoms	-
Availability of free testing/treatment for HIV and/or STIs	Yes

Footnotes

(-) Information not available

SB = Sex work and brothels legalised

M= Mandatory health and social insurance

NC = National and cross-national

H = HIV

S = STIs

Norway

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	16
Age of consent (homosexual sex)	16
Legality of sex work	LL
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	Yes
Legislation criminalising HIV transmission	Yes
Legislation on mandatory partner notification	Yes

Political and structural context	
Current national sexual and reproductive health strategy	Yes (2012-2015)
Current national HIV/AIDS/STIs prevention strategy	Yes (2009-2014)
National strategy to prevent teenage/adolescent pregnancy	Yes (2010-2015)
National strategy to prevent sexual violence and increase awareness	Yes (2012-2014)
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	SI

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	5.5
ii. Young people (per 100 000 population 15-24 years)	3.0
iii. MSM (per 100 000 male population)	3.9
Chlamydia (diagnoses per 100 000):	
i. General population	457.9
ii. Young people (per 100 000 population 15-24 years)	2386.1
iii. MSM (per 100 000 male population)	-
Gonorrhoea (diagnoses per 100 000):	
i. General population	7.5
ii. Young people (per 100 000 population 15-24 years)	14.2
iii. MSM (per 100 000 male population)	7.2
Syphilis (diagnoses per 100 000):	
i. General population	2.6
ii. Young people (per 100 000 population 15-24 years)	1.6
iii. MSM (per 100 000 male population)	4.4
Adolescent birth rate per 1 000 women (15-19 year old)	7.4
Abortion rate per 1 000 women (15-44 year old)	15.2
% 15 year old girls who have had sexual intercourse	30
% 15 year old boys who have had sexual intercourse	26
% 15 year old girls who used a condom at last sexual intercourse	63
% 15 year old boys who used a condom at last sexual intercourse	75

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	NC
ii. Young people	C
iii. MSM	NC
iv. Sex workers	-
v. PLHIV	NC
vi. Migrants	-
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	-
v. PLHIV	H
vi. Migrants	-
vii. IDUs	H
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	Yes
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	Yes
Availability of routinely collected data on contraceptive use	Yes

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	Yes
Public education campaign on STIs	-
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	Yes
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	Yes
iii. Sex workers	Yes
iv. Migrants	Yes
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	Yes
Minimum standards for sexuality education	Yes
National screening and vaccination programmes	
Chlamydia screening programme	Yes
Antenatal screening programme for HIV	Yes
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	No
Health service delivery	
Provision of free contraceptives	Yes*
Provision of free condoms	Yes
Availability of free testing/treatment for HIV and/or STIs	-

Footnotes

(-) Information not available

LL= Limited legality, purchasing sexual services is criminalised
SI= Social insurance
C = Cross-national
NC = National and cross-national
H = HIV
S = STIs

Comments

* Contraceptives subsidised for women aged 16-20 years; free provision to sex workers.

Poland

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	15
Age of consent (homosexual sex)	15
Legality of sex work	S
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	Yes
Legislation criminalising HIV transmission	-
Legislation on mandatory partner notification	No

Political and structural context	
Current national sexual and reproductive health strategy	-
Current national HIV/AIDS/STIs prevention strategy	No (2007-2011)
National strategy to prevent teenage/adolescent pregnancy	-
National strategy to prevent sexual violence and increase awareness	-
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	No
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	UC

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	2.5
ii. Young people (per 100 000 population 15-24 years)	3.1
iii. MSM (per 100 000 male population)	1.3
Chlamydia (diagnoses per 100 000):	
i. General population	0.8
ii. Young people (per 100 000 population 15-24 years)	1.7
iii. MSM (per 100 000 male population)	-
Gonorrhoea (diagnoses per 100 000):	
i. General population	0.8
ii. Young people (per 100 000 population 15-24 years)	1.2
iii. MSM (per 100 000 male population)	-
Syphilis (diagnoses per 100 000):	
i. General population	2.5
ii. Young people (per 100 000 population 15-24 years)	3.5
iii. MSM (per 100 000 male population)	-
Adolescent birth rate per 1 000 women (15-19 year old)	12.2
Abortion rate per 1 000 women (15-44 year old)	-
% 15 year old girls who have had sexual intercourse	13
% 15 year old boys who have had sexual intercourse	19
% 15 year old girls who used a condom at last sexual intercourse	83
% 15 year old boys who used a condom at last sexual intercourse	78

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	NC
ii. Young people	NC
iii. MSM	NC
iv. Sex workers	N
v. PLHIV	C
vi. Migrants	-
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	-
v. PLHIV	H
vi. Migrants	-
vii. IDUs	H
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	Yes
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	-
Availability of routinely collected data on contraceptive use	Yes

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	Yes
Public education campaign on STIs	No
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	Yes
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	Yes
iii. Sex workers	Yes
iv. Migrants	Yes
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	No
Minimum standards for sexuality education	Yes
National screening and vaccination programmes	
Chlamydia screening programme	No
Antenatal screening programme for HIV	Yes
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	No
Health service delivery	
Provision of free contraceptives	No
Provision of free condoms	-
Availability of free testing/treatment for HIV and/or STIs	Yes

Footnotes

(-) Information not available

S = Sex work legal

UC = Universal coverage

N = National

C = Cross-national

NC = National and cross-national

H = HIV

S = STIs

Portugal

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	14
Age of consent (homosexual sex)	16
Legality of sex work	S
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	Yes
Legislation criminalising HIV transmission	Yes
Legislation on mandatory partner notification	-

Political and structural context	
Current national sexual and reproductive health strategy	-
Current national HIV/AIDS/STIs prevention strategy	No (2007-2010)
National strategy to prevent teenage/adolescent pregnancy	-
National strategy to prevent sexual violence and increase awareness	-
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	-
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	SI

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	8.5
ii. Young people (per 100 000 population 15-24 years)	7.6
iii. MSM (per 100 000 male population)	4.9
Chlamydia (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Gonorrhoea (diagnoses per 100 000):	
i. General population	1.1
ii. Young people (per 100 000 population 15-24 years)	3.6
iii. MSM (per 100 000 male population)	0.1
Syphilis (diagnoses per 100 000):	
i. General population	1.5
ii. Young people (per 100 000 population 15-24 years)	2.8
iii. MSM (per 100 000 male population)	0.2
Adolescent birth rate per 1 000 women (15-19 year old)	12.5
Abortion rate per 1 000 women (15-44 year old)	0.2
% 15 year old girls who have had sexual intercourse	18
% 15 year old boys who have had sexual intercourse	27
% 15 year old girls who used a condom at last sexual intercourse	84
% 15 year old boys who used a condom at last sexual intercourse	80

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	C
ii. Young people	C
iii. MSM	C
iv. Sex workers	-
v. PLHIV	C
vi. Migrants	-
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	-
v. PLHIV	H
vi. Migrants	-
vii. IDUs	H
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	Yes
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	Yes
Availability of routinely collected data on contraceptive use	Yes

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	Yes
Public education campaign on STIs	-
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	Yes
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	Yes
iii. Sex workers	Yes
iv. Migrants	Yes
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	Yes
Minimum standards for sexuality education	Yes
National screening and vaccination programmes	
Chlamydia screening programme	Yes
Antenatal screening programme for HIV	Yes
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	Yes
Health service delivery	
Provision of free contraceptives	Yes
Provision of free condoms	Yes
Availability of free testing/treatment for HIV and/or STIs	Yes

Footnotes

(-) Information not available
S = Sex work legal
SI = Social insurance
C = Cross-national
H = HIV
S = STIs

Romania

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	15
Age of consent (homosexual sex)	15
Legality of sex work	SC
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	Yes
Legislation criminalising HIV transmission	Yes
Legislation on mandatory partner notification	Yes

Political and structural context	
Current national sexual and reproductive health strategy	No (2003-2006)
Current national HIV/AIDS/STIs prevention strategy	Yes (2008-2013)
National strategy to prevent teenage/adolescent pregnancy	-
National strategy to prevent sexual violence and increase awareness	-
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	UC

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	1.8
ii. Young people (per 100 000 population 15-24 years)	5.0
iii. MSM (per 100 000 male population)	0.7
Chlamydia (diagnoses per 100 000):	
i. General population	0.6
ii. Young people (per 100 000 population 15-24 years)	1.8
iii. MSM (per 100 000 male population)	-
Gonorrhoea (diagnoses per 100 000):	
i. General population	2.4
ii. Young people (per 100 000 population 15-24 years)	7.2
iii. MSM (per 100 000 male population)	0.02
Syphilis (diagnoses per 100 000):	
i. General population	11.0
ii. Young people (per 100 000 population 15-24 years)	20.5
iii. MSM (per 100 000 male population)	0.3
Adolescent birth rate per 1 000 women (15-19 year old)	28.8
Abortion rate per 1 000 women (15-44 year old)	27.8
% 15 year old girls who have had sexual intercourse	17
% 15 year old boys who have had sexual intercourse	48
% 15 year old girls who used a condom at last sexual intercourse	61
% 15 year old boys who used a condom at last sexual intercourse	79

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	-
ii. Young people	C
iii. MSM	C
iv. Sex workers	-
v. PLHIV	-
vi. Migrants	-
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	-
v. PLHIV	H
vi. Migrants	-
vii. IDUs	H
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	Yes
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	Yes
Availability of routinely collected data on contraceptive use	Yes

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	Yes
Public education campaign on STIs	-
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	Yes
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	Yes
iii. Sex workers	Yes
iv. Migrants	Yes
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	No
Minimum standards for sexuality education	-
National screening and vaccination programmes	
Chlamydia screening programme	No
Antenatal screening programme for HIV	Yes
Cervical cancer screening programme	No
Publically-funded HPV vaccination programme	No
Health service delivery	
Provision of free contraceptives	Yes
Provision of free condoms	Yes
Availability of free testing/treatment for HIV and/or STIs	Yes

Footnotes

(-) Information not available

SC = Sex work criminalised

UC = Universal coverage

C = Cross-national

H = HIV

S = STIs

Slovakia

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	15
Age of consent (homosexual sex)	15
Legality of sex work	S
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	No
Legislation criminalising HIV transmission	Yes
Legislation on mandatory partner notification	No

Political and structural context	
Current national sexual and reproductive health strategy	Yes (2008-2012)
Current national HIV/AIDS/STIs prevention strategy	Yes (2009-2012)
National strategy to prevent teenage/adolescent pregnancy	Yes
National strategy to prevent sexual violence and increase awareness	Yes
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	UC

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	0.9
ii. Young people (per 100 000 population 15-24 years)	1.5
iii. MSM (per 100 000 male population)	1.2
Chlamydia (diagnoses per 100 000):	
i. General population	5.6
ii. Young people (per 100 000 population 15-24 years)	13.3
iii. MSM (per 100 000 male population)	-
Gonorrhoea (diagnoses per 100 000):	
i. General population	3.6
ii. Young people (per 100 000 population 15-24 years)	8.8
iii. MSM (per 100 000 male population)	-
Syphilis (diagnoses per 100 000):	
i. General population	7.0
ii. Young people (per 100 000 population 15-24 years)	12.5
iii. MSM (per 100 000 male population)	0.2
Adolescent birth rate per 1 000 women (15-19 year old)	16.7
Abortion rate per 1 000 women (15-44 year old)	11.7
% 15 year old girls who have had sexual intercourse	10
% 15 year old boys who have had sexual intercourse	15
% 15 year old girls who used a condom at last sexual intercourse	76
% 15 year old boys who used a condom at last sexual intercourse	77

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	NC
ii. Young people	C
iii. MSM	C
iv. Sex workers	C
v. PLHIV	C
vi. Migrants	C
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	H
v. PLHIV	H
vi. Migrants	H
vii. IDUs	H
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	Yes
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	Yes
Availability of routinely collected data on contraceptive use	Yes

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	Yes
Public education campaign on STIs	Yes
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	Yes
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	Yes
iii. Sex workers	Yes
iv. Migrants	Yes
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	Yes
Minimum standards for sexuality education	Yes
National screening and vaccination programmes	
Chlamydia screening programme	No
Antenatal screening programme for HIV	Yes
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	No
Health service delivery	
Provision of free contraceptives	Yes
Provision of free condoms	Yes
Availability of free testing/treatment for HIV and/or STIs	Yes

Footnotes

(-) Information not available

S = Sex work legal

UC = Universal coverage

C = Cross-national

NC = National and cross-national

H = HIV

S = STIs

Slovenia

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	15
Age of consent (homosexual sex)	15
Legality of sex work	S
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	Yes
Legislation criminalising HIV transmission	No
Legislation on mandatory partner notification	No

Political and structural context	
Current national sexual and reproductive health strategy	No
Current national HIV/AIDS/STIs prevention strategy	Yes (2010-2015)
National strategy to prevent teenage/adolescent pregnancy	No
National strategy to prevent sexual violence and increase awareness	-
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	No
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	M

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	2.7
ii. Young people (per 100 000 population 15-24 years)	2.6
iii. MSM (per 100 000 male population)	3.4
Chlamydia (diagnoses per 100 000):	
i. General population	11.3
ii. Young people (per 100 000 population 15-24 years)	33.5
iii. MSM (per 100 000 male population)	0.6
Gonorrhoea (diagnoses per 100 000):	
i. General population	1.2
ii. Young people (per 100 000 population 15-24 years)	2.2
iii. MSM (per 100 000 male population)	0.8
Syphilis (diagnoses per 100 000):	
i. General population	3.9
ii. Young people (per 100 000 population 15-24 years)	4.8
iii. MSM (per 100 000 male population)	4.4
Adolescent birth rate per 1 000 women (15-19 year old)	4.5
Abortion rate per 1 000 women (15-44 year old)	10.6
% 15 year old girls who have had sexual intercourse	24
% 15 year old boys who have had sexual intercourse	31
% 15 year old girls who used a condom at last sexual intercourse	82
% 15 year old boys who used a condom at last sexual intercourse	85

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	N
ii. Young people	C
iii. MSM	NC
iv. Sex workers	No
v. PLHIV	No
vi. Migrants	No
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	-
v. PLHIV	H
vi. Migrants	-
vii. IDUs	H
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	Yes
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	Yes
Availability of routinely collected data on contraceptive use	Yes

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	Yes
Public education campaign on STIs	Yes
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	Yes
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	Yes
iii. Sex workers	Yes
iv. Migrants	Yes
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	No
Minimum standards for sexuality education	No
National screening and vaccination programmes	
Chlamydia screening programme	No
Antenatal screening programme for HIV	Yes
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	Yes
Health service delivery	
Provision of free contraceptives	Yes
Provision of free condoms	Yes
Availability of free testing/treatment for HIV and/or STIs	Yes

Footnotes

(-) Information not available
S = Sex work legal
M= Mandatory health and social insurance
N = National
C = Cross-national
NC = National and cross-national
H = HIV
S = STIs

Spain

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	13
Age of consent (homosexual sex)	13
Legality of sex work	S
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	Yes
Legislation criminalising HIV transmission	No
Legislation on mandatory partner notification	No

Political and structural context	
Current national sexual and reproductive health strategy	Yes
Current national HIV/AIDS/STIs prevention strategy	Yes (2008-2012)
National strategy to prevent teenage/adolescent pregnancy	Yes[§]
National strategy to prevent sexual violence and increase awareness	Yes
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	UC

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	8.4*
ii. Young people (per 100 000 population 15-24years)	6.6
iii. MSM (per 100 000 male population)	6.5*
Chlamydia (diagnoses per 100 000):	
i. General population	-
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Gonorrhoea (diagnoses per 100 000):	
i. General population	5.0
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Syphilis (diagnoses per 100 000):	
i. General population	6.8
ii. Young people (per 100 000 population 15-24 years)	-
iii. MSM (per 100 000 male population)	-
Adolescent birth rate per 1 000 women (15-19 year old)	10.7
Abortion rate per 1 000 women (15-44 year old)	8.3
% 15 year old girls who have had sexual intercourse	20
% 15 year old boys who have had sexual intercourse	23
% 15 year old girls who used a condom at last sexual intercourse	85
% 15 year old boys who used a condom at last sexual intercourse	81

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	NC
ii. Young people	NC
iii. MSM	NC
iv. Sex workers	N
v. PLHIV	NC
vi. Migrants	N
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	HS
v. PLHIV	HS
vi. Migrants	HS
vii. IDUs	H
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	Yes
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	Yes
Availability of routinely collected data on contraceptive use	Yes

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	Yes
Public education campaign on STIs	Yes
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	Yes
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	Yes
iii. Sex workers	Yes
iv. Migrants	Yes
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	No
Minimum standards for sexuality education	No
National screening and vaccination programmes	
Chlamydia screening programme	No
Antenatal screening programme for HIV	Yes
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	Yes
Health service delivery	
Provision of free contraceptives	Yes[ǂ]
Provision of free condoms	Yes
Availability of free testing/treatment for HIV and/or STIs	Yes[ǂ]

Footnotes

(-) Information not available
S = Sex work legal
UC = Universal coverage
N = National
NC = National and cross-national
H = HIV
S = STIs

Comments

* Subnational: adjusted population, according to the coverage, see HIV Surveillance Report 2011

§ Incorporated into a wider national health strategy

ǂ Either partially reimbursed or conditions on free provision

Sweden

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	15
Age of consent (homosexual sex)	15
Legality of sex work	LL
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	Yes
Legislation criminalising HIV transmission	Yes
Legislation on mandatory partner notification	Yes

Political and structural context	
Current national sexual and reproductive health strategy	No
Current national HIV/AIDS/STIs prevention strategy	Yes (2006-2016)
National strategy to prevent teenage/adolescent pregnancy	No
National strategy to prevent sexual violence and increase awareness	Yes
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	SI

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	3.9
ii. Young people (per 100 000 population 15-24 years)	3.4
iii. MSM (per 100 000 male population)	1.9
Chlamydia (diagnoses per 100 000):	
i. General population	396.0
ii. Young people (per 100 000 population 15-24 years)	2089.0
iii. MSM (per 100 000 male population)	12.2
Gonorrhoea (diagnoses per 100 000):	
i. General population	10.0
ii. Young people (per 100 000 population 15-24 years)	30.5
iii. MSM (per 100 000 male population)	5.6
Syphilis (diagnoses per 100 000):	
i. General population	2.2
ii. Young people (per 100 000 population 15-24 years)	1.7
iii. MSM (per 100 000 male population)	2.4
Adolescent birth rate per 1 000 women (15-19 year old)	6.5
Abortion rate per 1 000 women (15-44 year old)	20.2
% 15 year old girls who have had sexual intercourse	32
% 15 year old boys who have had sexual intercourse	31
% 15 year old girls who used a condom at last sexual intercourse	58
% 15 year old boys who used a condom at last sexual intercourse	69

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	C
ii. Young people	NC
iii. MSM	NC
iv. Sex workers	-
v. PLHIV	C
vi. Migrants	-
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	-
v. PLHIV	HS
vi. Migrants	HS
vii. IDUs	HS
Availability of routinely collected data on HIV testing:	
i. General population	No
iii. MSM	-
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	Yes
Availability of routinely collected data on contraceptive use	Yes

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	Yes
Public education campaign on STIs	Yes
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	Yes
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	Yes
ii. MSM	Yes
iii. Sex workers	Yes
iv. Migrants	Yes
v. IDUs	Yes
Provision of sexual education	
Sexuality education mandatory	Yes
Minimum standards for sexuality education	Yes
National screening and vaccination programmes	
Chlamydia screening programme	No
Antenatal screening programme for HIV	Yes
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	Yes
Health service delivery	
Provision of free contraceptives	Yes*
Provision of free condoms	No
Availability of free testing/treatment for HIV and/or STIs	Yes

Footnotes

(-) Information not available
LL= Limited legality, purchasing sexual services is criminalised
SI= Social insurance
C = Cross-national
NC = National and cross-national
H = HIV
S = STIs

Comments

* Either partially reimbursed or conditions on free provision

United Kingdom

Contextual indicators

Legislative aspects	
Age of consent (heterosexual sex)	16
Age of consent (homosexual sex)	16
Legality of sex work	S
Legislation criminalising sexual violence	Yes
Legislation criminalising human trafficking	Yes
Legislative protection of people living with HIV	Yes
Legislation criminalising HIV transmission	Yes
Legislation on mandatory partner notification	No

Political and structural context	
Current national sexual and reproductive health strategy	Yes
Current national HIV/AIDS/STIs prevention strategy	Yes
National strategy to prevent teenage/adolescent pregnancy	‡
National strategy to prevent sexual violence and increase awareness	Yes
Existence of NGO dedicated to:	
i. Sexual and reproductive health of the general population	Yes
ii. Sexuality education	Yes
iii. HIV/STI prevention/sexual health promotion among MSM	Yes
iv. HIV/STI prevention/sexual health promotion among migrants	Yes

Economic systems	
Healthcare systems	SI

Epidemiological context (2011)	
HIV (new diagnoses per 100 000):	
i. General population	10.0
ii. Young people (per 100 000 population 15-24 years)	7.9
iii. MSM (per 100 000 male population)	9.0
Chlamydia (diagnoses per 100 000):	
i. General population	341.4
ii. Young people (per 100 000 population 15-24 years)	2032.9
iii. MSM (per 100 000 male population)	24.3
Gonorrhoea (diagnoses per 100 000):	
i. General population	37.1
ii. Young people (per 100 000 population 15-24 years)	124.7
iii. MSM (per 100 000 male population)	25.0
Syphilis (diagnoses per 100 000):	
i. General population	5.2
ii. Young people (per 100 000 population 15-24 years)	6.2
iii. MSM (per 100 000 male population)	6.4
Adolescent birth rate per 1 000 women (15-19 year old)	29.7
Abortion rate per 1 000 women (15-44 year old)	17
% 15 year old girls who have had sexual intercourse	§
% 15 year old boys who have had sexual intercourse	◇
% 15 year old girls who used a condom at last sexual intercourse	¤
% 15 year old boys who used a condom at last sexual intercourse	^

Research and surveillance indicators

Research data	
Survey of sexual health of:	
i. General population	NC
ii. Young people	NC
iii. MSM	NC
iv. Sex workers	N
v. PLHIV	NC
vi. Migrants	N
Surveillance and monitoring data	
Availability of routinely collected case-based surveillance data on HIV and STIs (at least one STI - chlamydia/gonorrhoea/syphilis) in:	
i. General population	HS
ii. Young people	HS
iii. MSM	HS
iv. Sex workers	-
v. PLHIV	H
vi. Migrants	-
vii. IDUs	H
Availability of routinely collected data on HIV testing:	
i. General population	Yes
iii. MSM	Yes
Availability of routinely collected data on teenage pregnancy	Yes
Availabilityof routinely collected data on abortion	Yes
Availability of routinely collected data on contraceptive use	Yes

Programmatic and intervention indicators

Sexual health public education campaigns at a national level (in the last five years)	
HIV/AIDS awareness campaign	Yes
Public education campaign on STIs	Yes
Sexual violence awareness campaign	Yes
Campaign promoting condom and/or contraceptive use	Yes
National HIV/STI prevention programmes	
National HIV/STI prevention programme for:	
i. Young people	No
ii. MSM	Yes
iii. Sex workers	No
iv. Migrants	Yes
v. IDUs	No
Provision of sexual education	
Sexuality education mandatory	No
Minimum standards for sexuality education	Yes*
National screening and vaccination programmes	
Chlamydia screening programme	Yes**
Antenatal screening programme for HIV	Yes
Cervical cancer screening programme	Yes
Publically-funded HPV vaccination programme	Yes
Health service delivery	
Provision of free contraceptives	Yes
Provision of free condoms	Yes
Availability of free testing/treatment for HIV and/or STIs	Yes

Footnotes

(-) Information not available
S = Sex work legal
SI = Social insurance
N = National
NC = National and cross-national
H = HIV
S = STIs

Country comments

‡ England: Yes (2013-2016); Scotland: Yes (2011-2015); Wales Yes (2010-2015)
§ England: 32, Scotland: 35, Wales: 39
◇ England: 26, Scotland: 27, Wales: 29
¤ England: 73, Scotland: 78, Wales: 70
^ England: 74, Scotland: 83, Wales: 73
* No minimum sexuality education standards in Northern Ireland
** No chlamydia screening programme in Scotland or Wales