Euro HIV EDAT Project

WP8. ACCESS TO HIV TESTING AND LINKAGE TO CARE FOR MIGRANT POPULATIONS IN EUROPE

SYNTHESIS OF THE NATIONAL REPORTS

2017 Edition

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ESSENTIALS ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
CBVCT	Community-Based Voluntary Counselling And Testing
ECDC	European Centre For Disease Prevention And Control
EEA	European Economic Area
EU	European Union
GP	General Practitioner
HIV	Human Immunodeficiency Virus
IDU	Injection Drug Users
LAC	Latin America and the Caribbean
MSM	Men Who Have Sex With Men
NGO	Non-Governmental Organization
SSA	Sub-Saharan Africa
STI	Sexually Transmitted Infection
VCT	Voluntary Counselling And Testing
WHO	World Health Organization

EXECUTIVE SUMMARY

This report provides a broad summary, a reflection, on the issues surrounding immigration and HIV among the 7 European countries involved in the WP8 study "access to HIV testing and linkage to care for migrant populations in Europe" of the EURO HIV-EDAT project (2014 – 2017).

This document summarizes information collected through individual national reports completed by each associated partner on the basis of scientific and grey literature, its own expertise, field knowledge and national surveillance data. The partners also depend on national stakeholders and key informant. This state-of-the art provides a basis for the following phases of the study which aims to describe HIV testing patterns among migrant populations in Europe. Therefore, we will in this study, identify the access and barriers for HIV testing and linkage to care among the main concerned migrant populations in community-based and classical health services.

Section 1 provides a brief presentation of the organizations participating in this study and provides an overview of their community-based activities. Section 2 reviews the different definitions of « migrant » in each participating country and identifies the relevant definition for the term migrant which will be used for this project. Section 3 defines the most HIV affected migrant groups in each participating country. Section 4 presents the legislative framework to access to health care for regular and irregular migrants in each participating country and thus with a special focus on prevention, testing and treatment of HIV. Finally, section 5 offers preliminary findings on obstacles and levers to the access to HIV testing, linkage to care and the continuity of care for migrants according to the different sources of information stated above.

Key findings:

- National reports show that legal definitions and representations vary greatly from one country to the other. The term "migrant" in this project will be associated to the definition provided by the Council of Europe: "any person who lives temporarily or permanently in a country where he or she was not born, and has acquired some significant social ties to this country".

- Sub-Saharan Africans (SSA) represent on a European scale the more vulnerable or most-at-risk migrant population for HIV, and Latin America and the Caribbean (LAC) the second most vulnerable. Indeed, in 2014, in Europe, four in ten people diagnosed with HIV were migrants and four in ten migrants were from Sub-Saharan Africa and one and a half were from Latin America. Thus, SSA migrants are a relevant target group for this project in all participating countries such as LAC migrants for Spain and Portugal.

- A significant diversity exists within the EU Member States regarding policy and legal frameworks for access to healthcare and HIV services. Among our panel countries, half of the country's associated partners (Denmark, Germany, Slovenia and Spain) provide for no more than emergency services for irregular migrants (with some exceptions regarding some specific categories of irregular migrants like pregnant women or under-18). Therefore, these countries does not provide access to anti-retroviral treatment for asylum seekers and irregular migrants except Spain which implemented a specific legislation regarding infectious disease. However the other half (Belgium, France and Portugal) entitled irregular migrants to access health care including anti-retroviral treatment on equal grounds as nationals. Regarding this last one, the associated partners report that administrative procedures can often constitute a barrier for migrants to enjoy their entitlements.

- Information provided by associated partners shows that the participating countries set up a variety of HIV testing offers: in medical laboratories, at the General Practitioners (GPs), at a pharmacy, at a hospital or clinic, on the premises or the mobile unit of an NGO or in community based organizations. It appears that in all participating countries, a free and anonymous testing offer exists. However, the proportion of late diagnosis´s or undiagnosed HIV among migrants is disproportionately high. This clearly reveals the reality of the issues surrounding migrant's access to HIV prevention. Associated partners highlighted many social and cultural factors (for example, low perceived risk, lack of knowledge on where to get tested, distrust in the medical system) preventing migrants to identify their healthcare needs and afterwards to seek and use the relevant healthcare service.

Phase 2 and 3 of the study will allow us to better understand the effective availability and accessibility to healthcare HIV services. A qualitative (phase 2) study will be conducted to identify the use of HIV testing services and perceived facilitators and barriers to HIV testing and linkage to care for migrants in the participating countries. This phase will be followed by a quantitative study (phase 3) with the use of a questionnaire collecting both socio-demographic and behavioural data. Research materials collected will allow us to describe HIV testing patterns and to identify the facilitators and barriers for HIV testing and linkage to care among the main concerned migrant populations and finally to develop a guide of better practices to improve earlier testing and linkage to care among migrant populations in Europe.

PURPOSES AND METHODS

- **EURO HIV EDAT project : Access to HIV testing and linkage to care for migrant populations in Europe (WP8)**

The **European HIV Early Diagnosis and Access to Treatment Project (Euro HIV EDAT) project** (co-funded by the Consumers, Health and Food Executive Agency (Chafea) under the European Union (EU) Public Health Programme for the period April 2014-September 2017, No. 2013 1101) aimed to generate operational knowledge to better understand the role and impact of Community Based Voluntary Counselling and Testing services (CBVCTs). It also aims to explore the use of innovative strategies based on new technologies and to increase early Human Immunodeficiency Virus/ Sexually Transmitted Infection (HIV/STI) diagnosis and treatment in Europe among the most affected groups. The Euro HIV EDAT ensures **continuity in the conduct of previous European projects on community-based HIV testing (e. g. the COBATEST Project)** and strengthens existing knowledge about vulnerable populations in Europe, such as men having sex with men (MSM) and migrant populations stemming from high endemic regions.

The project is divided into several work packages including the **work-package 8 (WP8) which aims to describe HIV testing patterns** as well as **identify the access and barriers for HIV testing and linkage to care among the main concerned migrant populations** in community-based and classical health services. Previous mobilization, awareness campaigns and different initiatives among MSM have already enabled us to gather data regarding this population and set up services and programs in several countries of the European Union.[1] Nevertheless, regarding other populations, like migrants, there is an evident lack of data and mobilization is still strongly needed. If some programs already exist, they are not well-known; and besides, access to classical health services is particularly difficult to reach for this population.

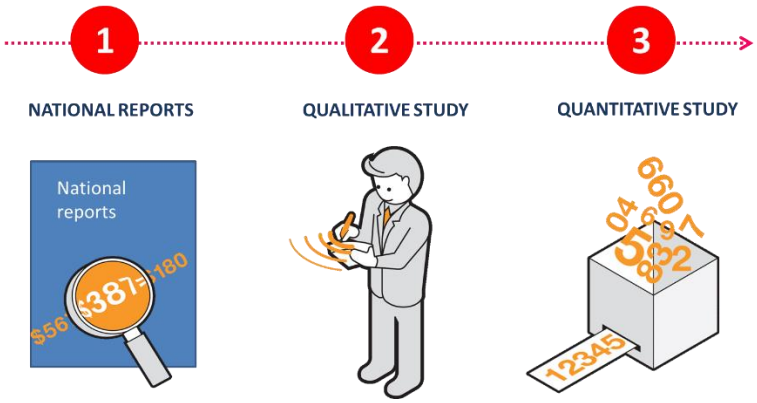
8 organizations among 7 countries are participating in this WP8 (in this document we will refer to them as **associated partners**):

- AIDS-Fondet (Denmark)
- AIDS-Hilfe NRW e.V. (Germany)
- Association AIDES (France)
- BCN Checkpoint-Hispanosida (Spain)
- ICO-CEEISCAT (Spain)
- Institute Tropical Medicine (Belgium)
- GAT-Grupo Português de Activistas sobre Tratamentos de VIH/SIDA (Portugal)
- Legebitra (Slovenia)

ICO-CEEISCAT (Spain) is the main partner of the Euro HIV EDAT project and Association AIDES (France) is the leader of the work-package 8.

[1] Such as: Community HIV testing for men who have sex with men: results of a pilot project and comparison of service users with those testing in genitourinary medicine clinics. Bailey A.C. et al., Sexually Transmitted Infections 2009; 85: 145–147,
EMIS Network. EMIS 2010: The European Men-Who-Have-Sex-With-Men Internet Survey. Findings from 38 countries. Stockholm: ECDC, 2013, available at : http://www.emis-project.eu/sites/default/files/public/publications/emis2010_european_msm_internet_survey_38_countries_v5.pdf

This study is divided into **3 successive phases: a state-of-the art which consist in this national reports synthesis, a qualitative study and a quantitative study.**



A **qualitative study** will be conducted and based on the results obtained in the synthesis of the national reports. This will allow us to identify the use of HIV testing services, perceived facilitators and barriers to HIV testing and linkage to care of migrants in the participating countries. Interviews with migrants and focus groups with key informant on the question of migration and HIV will be performed in all the participating countries. Then, a **quantitative study** will be conducted. A **questionnaire** collecting both socio-demographic and behavioural data will be presented to describe access, facilitators and barriers for HIV testing in CBVCT services and health care systems distributed among migrants in the participating countries (based on the national report, qualitative study and other sources of information). The questionnaire will be completed by migrants living in the participating countries and recruited through associated partners.

The data collected and analysed will allow us to produce **a "guide of better practices"**. This guide will provide a rationale for future decisions on how to improve access to HIV testing and linkage to care among migrant populations. It will be aimed at the European Non-Governmental Organization (NGO) of the Euro HIV EDAT network, but also to all NGOs, health institutions or organizations working with migrants.

- **National reports synthesis: methodology**

The purpose of this "Synthesis of the national report", first phase of the study, is to **guide the conception and conduct of the qualitative and quantitative study.** This document is based on the individual national report completed by the associated partners. Each associated partner, and thus on the basis of scientific and grey literature, its own expertise and field knowledge, national surveillance data, web research, information and indicators from the COBATEST network and with the involvement of national stakeholders and experts will in the end have to produce its "national report". The WP8 leader (association AIDES) centralized the data and produced this final version of this synthesis of the national reports.

These national reports concern several items (national report templates can be found in **Annex A**):

- The different definitions and representations of the terms migrants, foreigners and immigrants as well information on the main migrant population on their country

- Access to health for regular and irregular people
- Epidemiological HIV data regarding most affected migrant populations
- Access to HIV testing and linkage to care available and/or targeting migrants
- HIV community-based testing response in their country
- The migrant mobilization and identifying the migrants organizations, key informants regarding HIV in their country

The current document is partially based on the information collected through the individual national report of each country. This is a limited source of information, however, as data collection and quality varied from one associate partner to another depending on the availability and accessibility of the data, as well as the involvement of national stakeholders or key informants (experts on the issue of HIV and migration) to review and check the consistency and accuracy of all information provided. In addition, in some countries, during the time of report completion, some legislative changes occurred which could lead to data which is no longer up-to-date. An early draft of the synthesis was sent to the National Focal Points of the participating countries and the Project officer of Chafea. Belgian, German, Portuguese, Slovenian, Spanish National Focal Points and the Project officer of Chafea reviewed this document.

The individual National report (even when they are the results of a collaborative work) reflects mainly the vision, experience and expertise of associated partners. Moreover, the vision of associated partners can't reflect the different territorial specificities and diversity of migrants. Additionally, some breaches or difficulties presented do not aim to state a national reality on the issues regarding migrants and access to HIV services.

In line with the statement above, it must not be overlooked that this document presents preliminary research which afterwards needs to be deeply investigated in order to be validated (or not), which will be carried out during phase 2 and 3 of this project.

1. PRESENTATION OF INVOLVED ORGANIZATIONS AND THEIR COMMUNITY-BASED APPROACH

Objectives: Have a better understanding of the organizations participating in this study and an overview of their community-based activities

This project is based on a solid **partnership (the COBATEST network created during the HIV-COBATEST project -2010-2013)**. Partners represent the **variety of HIV and Aids stakeholders**. 2 partners are **research institutes** (Institute Tropical Medicine – Belgium and ICO-CEEISCAT - Spain) who have established longstanding working relationships with community organizations that offer voluntary counselling and testing. 6 others partners are **NGO´s working to fight HIV/AIDS** and support people concerned or affected by HIV/AIDS. These 6 organizations **provide community-based voluntary counselling and testing** (CBVCT). Among these 6, 5 are national NGO´s (AIDS-Fondet – Denmark, AIDS- Hilfe NRW e.V. – Germany, Association AIDES – France, GAT – Portugal, Legebitra – Slovenia) and 1 is a local NGO (BCN Checkpoint-Hispanosida – Spain).

These organizations do not cover the same geographical areas or for that matter the same target population. BCN Checkpoint – Spain is only addressed to MSM/trans populations (including MSM migrants) and sex workers. Legebitra – Slovenia mainly to LGBT population and Aidshlife – Germany mainly to MSM population but not only. Whereas, AIDS-Fondet – Denmark, Association AIDES – France and GAT – Portugal are dedicated to most-at-risk groups (including migrants).

The elements which can be found below present the organizations and their community-based activities or more broadly their actions targeting migrants. Prior to this, some elements regarding CBVCT are presented.

- **Community-based voluntary counselling and testing: definition and characteristics**

The definition of community-based voluntary counselling and testing (CBVCT) varies greatly from one national European context to the other and even in the same states from one organization to the other. In a previous project funded by the European Commission and also coordinated by the CEEISCAT – the HIV-COBATEST project – a network of CBVCT services targeting most affected populations (MSM, migrants and people who inject drugs) was implemented across Europe. The HIV-COBATEST project offers a **"large" definition of CBVCT**:

"CBVCT is **any program or service** that offers HIV counselling and testing on a voluntary basis **outside formal health facilities**. It has been designed to **target specific groups** within the most at-risk populations and is **clearly adapted and accessible to those communities**. Moreover, these services should ensure the **active participation of the community** with the involvement of community representatives either in planning or implementing HIV testing interventions and strategies"[2].

[2] Rios Guardiola L and al., HIV-COBATEST Project Steering Committee WP5 Working Group, *A guide to doing it better in our CBVCT centres. Core practices in some European CBVCT centres*, 2013

CBVCT programs and services are tools that help **improve early diagnosis and ensure timely access to adequate interventions for infected individuals**. These programs and services built on shared values and norms, belief systems, and social practices allow to shape and design **more effective, culturally tailored intervention approaches**. Thus, CBVCT programs and services scale up access to HIV testing and counselling services and **address many of the barriers regarding access to testing**[3]. It has been demonstrated that CBVCT enable to reach the most-at-risk populations and those who are less tested within the standard testing offer in clinical settings.

- **Presentation of the associated partners**

Institute Tropical Medicine – Belgium

The **Belgian Institute of Tropical Medicine (ITM)** is an autonomous institute for training, research and expert assistance in tropical medicine and public health. ITM houses a scientific department as well as a specialized outpatient clinic.

After revealing epidemiological data showing that the Sub-Saharan African migrants are the second most affected group by HIV in Belgium, the Institute of Tropical Medicine started the HIV-SAM Project in 1996. The project is funded by the Flemish Ministry of Health and Well-being. This **programme aims to promote sexual health and HIV prevention in the communities of sub-Saharan African migrants living in Flanders** (Belgium). The main objectives are: raising awareness on HIV and sexual health promotion, delivering culturally tailored information and education on the above topics, developing and testing interventions including the promotion of HIV testing. Linking people to care and promoting the wellbeing of people living with HIV. In order to reach these objectives, ITM offers HIV **testing services** in there low-threshold sexual health and HIV testing centre HelpCenter (Antwerp), and **produces specific communication tools for migrants** (brochures, posters, leaflets). They also **organize info sessions and group counselling** within the communities in order to promote HIV testing. Moreover, **community leaders and sometimes religious leaders** are involved in HIV prevention and promotion mobilization for HIV testing. ITM also collaborates closely with seven **key migrant community organizations** (mostly social or cultural organizations) that oversee and organize actions within their communities. ITM supports the members for their prevention and promotion work (training, transportation cost, supervision…). Through these networks, ITM mobilizes an effective community response to HIV in an environment free of HIV-related stigma and discrimination.

AIDS-Fondet – Denmark

The Danish associated partner – **AIDS-Fondet** – is a NGO working to build a world ´free of HIV´ and a world where sexual health is a right and a reality for all. The AIDS-Fondet works both in Denmark and internationally, focusing on the population groups that are particularly vulnerable and exposed to HIV. AIDS-Fondet works to ensure access to prevention, care and treatment for all, and to help people with HIV live free of prejudice and discrimination. Its main tasks are: prevent HIV among key audiences, provide support and advice to people with HIV who are most affected, support research on HIV and securing public and political support for the fight against HIV and AIDS.

[3] Ibid

Migrants are one of the targeted groups by AIDS-Fondet. AIDS-Fondet has three checkpoints that are primarily intended for: men who have sex with men and people with a different ethnic background than Danish. There, migrants can get free and anonymous counselling and HIV tests. Moreover, their checkpoints allow to target migrants through **outreach actions** in church settings, community settings such as local ethnic clubs, asylum centres or some residential areas with migrant concentrations. Volunteer migrants are involved in these activities**. Cooperation** with churches and religious leaders, as well as with migrant clubs, has also been developed. Finally, every month the AIDS Foundation hosts a number of **social events in English**: Educational Afternoon and Friday Social Night. Educational Afternoon are seminar style teaching on topics relevant to HIV/AIDS and STI while Friday Social Night are meeting specifically meant for people infected or affected by HIV

Association AIDES – France

AIDES is the leading HIV/Aids community-based organization in France. Set up in 1984, this NGO is represented in 70 cities throughout France. AIDES defends the idea that people infected and/or affected by HIV and hepatitis are directly concerned by the illness and are therefore in the best position to define their own needs and expectations. Therefore, at AIDES, they are the primary instigators behind our prevention, care and support services. AIDES actively contributes to progress made in prevention and access to care. They support the protection of HIV positive migrants, human rights for patients and the fight against all forms of discrimination and stigma.

Regarding migrants, AIDES provides support and counselling, prevention and information on STIs and hepatitis and offers TROD (Rapid test for diagnosis orientation) in the **70 AIDES' premises and through outreach interventions targeting migrants**. In 2013, 2107 actions targeting migrants were carried out (i.e. 55 376 contacts and 19457 interviews). AIDES also develops specific campaigns, leaflets to inform, and promotes HIV testing and treatment. The mobilization and integration of migrants (as volunteers or employees) is a strategic choice for AIDES. The organization also offers methodological and logistical support to the mobilization of several African and Caribbean communities (ex: RAAC). Finally, AIDES fights for human rights: access to healthcare and access to human care (advocacy) on a participatory and communitarian level.

AIDS-Hilfe NRW e.V. – Germany

AIDS-Hilfe NRW e.V. (Germany) is the **regional umbrella organization for AIDS service organizations in the region of North Rhine Westphalia**. It is a member of the national umbrella organization Deutsche AIDS-Hilfe. AIDS-Hilfe NRW e.V. is a NGO supporting **41 member organizations which provide information, prevention, testing, counselling and (social) care regarding HIV and STIs**. Their main target groups are MSM, IDU, women and people with HIV.

Some local AIDS-Hilfe **organizations are targeting migrants, mostly MSM,** through outreach actions. AIDS-Hilfe NRW e.V. also offers leaflets and brochures targeting migrants available in different languages.

GAT (Treatment Activist Group) - Portugal

GAT (Treatment Activist Group) is a NGO structure composed of i**ndividual membership of people affected by HIV, viral hepatitis and tuberculosis** who advocates for universal access to prevention, test, treatments and care. GAT

advocates and works (including participation in action/research) with other stakeholders for policy and legal changes that will positively affect the health, rights and quality of life of people living with HIV or associated diseases and from the most vulnerable key groups. Its main areas of Intervention: partnership in research on HIV/Hepatitis/TB, illnesses frequently associated with people with HIV, use of substances, risk reduction and drug policy reform and legal, human and health rights of groups more vulnerable to HIV.

GAT has **one specific project targeting migrants** for HIV and STI screening and a second one not specific to migrant but with a **special focus on migrant communities**. GAT provides counselling and testing for migrants, referral for health services with translated information in several languages. A **social worker** has been integrated in the team in order to make improve the structures referrals within and outside of the health system. A **cultural mediator** (native from Cape Verde) has also joined the team in order to facilitate contact with communities from former colonies. GAT is also in **contact with migrant organizations working** in other fields (such as culture or legal support for example). This organization, linked with GAT, promotes HIV testing in their communities. GAT produces targeted information for migrant population about screening and its importance and GAT's testing centre. The information is available in different languages.

BCN Checkpoint-Hispanosida - Spain

The **BCN Checkpoint (Spain)** is a community-based centre for the detection of HIV and other sexually transmitted infections, targeted at gay men, other men who have sex with men, and transgender women. It was created in 2006 by a patient based organization named Projecte dels NOMS-Hispanosida. BCN Checkpoint is a centre conceived and run by the community (all the members of the team are gay and some are HIV positive). BCN Checkpoint offers HIV testing free of prejudice, peer counselling and support, and linkage to medical care for people diagnosed with HIV infection. The centre also carries out community research studies, collaborates with the country's key scientific institutions and takes part in national and international research projects.

Migrants represent a large proportion of people getting tested for HIV and other STIs at BCN checkpoint. In 2014, 35% of people tested in BCN Checkpoint were not born in Spain (however some of them can be tourist). Migrants are not a target group for BCN Checkpoint as it's an organization dedicated to gay men and man who have sex with man however BCN checkpoint take in count the gay migrant community. BCN Checkpoints does not set up specific programmes for gay migrants but has made awareness campaigns for promoting HIV testing for gay migrants. Gay migrants, as other member of the community, are strongly involved in the organization. They participate in other non-testing interventions like individual/group counselling regarding treatments and side effects. They are also strongly involved in interventions focused in increasing awareness about risk of acquiring HIV in MSM.

ICO-CEEISCAT - Spain

The Centre for Epidemiological Studies on Sexually Transmitted Diseases and AIDS in Catalonia (CEEISCAT) was established in 1994 as a technical body to support the Spanish Department of Health (DS) regarding the prevention and control of HIV / AIDS and from 2006 also of Sexually Transmitted Infections (STIs). CEEISCAT is the public body responsible for **monitoring STI / HIV / AIDS** and also a **research centre of epidemiology**. The centre's research includes the study of natural history of HIV, mode of transmission, design and evaluation of preventive interventions, and determining the effectiveness of antiretroviral treatment and determinants of risk and access to health services.

LEGEBITRA - Slovenia

LEGEBITRA (Slovenia) is a cultural, informational and consultative centre mainly for the LGBT population in Slovenia. Its main activities include community-based testing, counselling and legal help for the LGBT community in the country. **Migrants are not a target group**. Thus, no specific actions targeting migrants, including a community-based approach have been developed.

All associated partners have **implement monitoring tool** (except AIDS-Hilfe NRW e.V.– Germany as stated in their national report). Institute Tropical Medicine – Belgium, Association AIDES – France, BCN Checkpoint – Spain and LEGEBITRA – Slovenia use intern monitoring tools, while AIDS Fondet – Denmark and GAT – Portugal use the COBATEST evaluation and data base.

These monitoring tools allow us to have a view on the **number of migrants that were HIV tested and counselled by the associated partners in 2014** (see table in annex B and C). In 2014, members of our study network have tested more than **14 000 migrants**. Among this migrants, 8 of 10 have been HIV tested in France by association AIDES. This can be explained by the great number of sub-Saharan migrants in France and by the great presence of association AIDES on the national territory through its 70 premises.

Highlights

CBVCT programs and services are **tools to improve access to HIV testing and counselling for hard-to-reach or more-at-risk populations such as migrants**. CBVCT can be defined as any program or service that offers HIV counselling and testing on a voluntary basis outside formal health facilities. More specifically, they are designed to target specific groups and hence designed to be **more adapted and accessible** to those communities. CBCVT should ensure **active participation** of the concerned community.

Associated partners to this project are either NGO´s offering community-based voluntary counselling and testing or research institutes who have established longstanding working relationships with community organizations that offer voluntary counselling and testing. The CBVCT structures involved in the project offer free of charge HIV testing and counselling. They develop specific communication in order to promote HIV testing and counselling towards migrants (campaign, partnership with community organization), and try to involve people who belong to the target community in the staff as workers or volunteer. They also develop outreach activities for promoting or offer HIV testing and counselling. Through our associated partners, **nearly 15 000 migrants have been tested for HIV and received counselling in 2014**.

2. OVERVIEW ON MIGRANT POPULATIONS IN THE PARTICIPATING COUNTRIES

Objectives:
- To review the different definitions of « migrant » in each participating country and asset the relevant definition of migrant in this project
- To have an overview of the migrant population in each participating country on migration history, migration flows and ethnic groups.

2.1 CONCEPTS

The following study focuses on a specific targeted population: migrants from endemic countries. On an international level, there is **not one accepted definition of the term "migrant"**[4]. Among our panel countries, the term "migrants" is also defined from an **administrative or legal point of view in numerous ways** along with the term "foreigners" and "immigrants". For example, in France an "immigrant" is a person born abroad (and born with another nationality than the French one) and living now in France[5]. An "immigrant" is not necessarily a foreigner as he/she can have obtained French nationality. In the same way, a foreigner is not necessarily an immigrant and may have been born in France (minors, in particular)[6]. On the contrary, in Portugal, the term "immigrant" defines a person that does not have the nationality of the country he/she is currently at. Thus, in Portugal all immigrants are inherently foreigners[7]. Also, some of this terms have in some countries no clear definition.

Besides the variety of legal definitions, the analysis of the national reports shows that there is also **different representations and images associated with the following terms** (see table in **annex D**). Representations associated to these terms are sometimes far off from the legal or administrative definition. Moreover, in some countries, a term will have a positive or neutral connotation while in another it will have a negative connotation. For example, in **Portugal,** the terms "foreigner" is mostly used to characterize tourists or higher status migrants whereas in other countries like **Belgium** or **France** it refers to demeaning representations along with "migrants" and "immigrants". Migrants often suffer from negative forms of perception and from anti-migrant sentiments which can lead to discrimination against them in sectors such as housing, education, work or health[8]. In this regards, associated partners reported that migrants often suffer from stigma and discrimination and are often subject to integration difficulties, social isolation. They also have higher prevalence poverty related diseases. By contrast, the terms of "refugee" or

[4] International Organization for Migration (IOM) portal, Termes clés de la migration [online], available at : http://www.iom.int/fr/termes-cles-de-la-migration, [Accessed 30 nov.2016]
[5] Institut national de la statistique et des études économiques (INSEE), Immigré – Définition, [online], available at : https://www.insee.fr/fr/metadonnees/definition/c1328 [Accessed 30 nov.2016]
[6] Ibid Insee
[7] José costa meireles e outros et al, Guia prático jurídico do cidadão imigrante, 2005
[8] United Nations High Commissioner for Human Rights, Combating Discrimination against Migrants [online], available at: http://www.ohchr.org/EN/Issues/Discrimination/Pages/discrimination_migrants.aspx, [Accessed 30 nov.2016]

"asylum seeker" refer generally in the panel countries to more positive representations by designating individuals who were forced to leave their country for political reasons.

Thus, it was important - in the framework of this European project to gather 8 organizations among 7 countries - to clearly define the term “migrant”. As Anderson and Blinder[9], succinctly put it “definitions affect data”, but there is no consensus regarding a single definition of who constitutes a migrant. Consequently, there are many different definitions and data sets and there is no agreed system for classifying migration, race, ethnicity, and culture, particularly across countries. The definition adopted for the project is the **Council of Europe** one. According to it, a “migrant” is "**any person who lives temporarily or permanently in a country where he or she was not born, and has acquired some significant social ties to this country[10]**".

2.2 Overview on migration flows

In 2011, in the EU-28, it was estimated at almost 51 million the number of people who had acquired residency, born outside of the Member State where they were living**. Europeans accounted for approximately half of all the foreign-born people** who were resident in an EU Member State. Indeed, 36,9% of the foreign born people were born in other EU Member States and 14,6% were born in other European Countries, however not EU members. People born **in Asia is the first largest group of the foreign-born people** (20,8%) **followed by people born in Africa** (16,9%). Residents born in the Caribbean, Central and South America estimated at 8.7 %.[11]

This data reflects the situation of the countries among our panel (see **table 1 below**). Migrants come mainly from Europe followed by migrants born in Asia (especially Turkey), in Africa (especially former colonies) and south and Central America for Spain and Portugal.

Table 1: Main region of origin or countries of the foreign-born population and reasons of migration within the participating countries

Country and data year	Main region of origin or countries of the foreign-born population[12]	Reasons of migration[13]
Belgium 2011	In 2011, European countries migrants were dominant: France (10.6%), Netherlands (7.8%), Romania (8.5%) and Poland (7.1%). There were also 8.6% of migrants from Morocco and it is the highest proportion of migrants from outside the EU, followed by the Turkish (6%) and Congolese (5%).[14]	Former economic agreements due to labour needs in the industry have facilitated the establishment of Italian, Turkish and Moroccan migrants. This immigration continued after the end of the agreements because of family reunification process. Sub-Saharan African migrants settled mainly through asylum or family reunification measures.

[9] Anderson B, Blinder S (2013) - Who counts as a migrant? Definitions and their consequences. Briefing, The Migration Observatory at the University of Oxford
[10] Council of Europe, Migration and Integration - some basic concepts
[11] Eurostat, People in the EU: who are we and how do we live?, 2015 edition
[12] The % are indicated when they were given to us by the associated partners
[13] Informations was provided by the associated partners
[14] Centre interfédéral pour l’égalité des chances et la lutte contre le racisme, Migrations et populations issues de l’immigration en Belgique - Rapport statistique et démographique 2013 (2011 data)

Denmark 2014	In 2014, the main migrant populations were from Turkey (6.8 %), Poland (6.8 %), Germany (6 %), Iraq (4.4 %), Bosnia-Herzegovina (3.6 %) and Romania (3.3 %).[15]	The main reason for migration is seeking employment.
France 2013	In 2013, migrants were mainly from European countries (36.5%) followed by migrants from Maghreb (Morocco, Algeria, Tunisia – 29.6%), from Asia (14.5%) and Sub-Saharan Africa (13.9% of migrants).[16]	The colonial past and traffic agreements with several European countries to meet the needs for labour (20th century) had a great influence on migration flows.
Germany 2014	Migrants come mainly from Turkey (1 506 113), Poland (1 256 000), Russian Federation (933 000), Kazakhstan (722 000), Romania (487 000), Italy (432 000) and Africa (not specified by country) (374 000).[17]	Polish, Turkish and Italian migrants have been invited to come as guest-workers to Germany. Migrants from Russia and Kazakhstan have German origins and come/came as resettlers to Germany. Germany possessed colonies in Africa only for a short period in Togo, Cameroon, Namibia and Tanzania, which were assigned to British and French possession after World War I. So there are, other than for France and Great Britain, barely any colonial ties and specific pull factors for migrants from Sub-Saharan Africa to Germany. Among ten most important regions of origin, most refugees from Sub-Saharan Africa come from Eritrea with 2,5 %, whereas 35,9 % of all refugees come from Syria.
Portugal 2011	In 2011, migrants come mainly from Brazil (27.8%), Cape Verde (9.9%), Ukraine (8.6%), Angola (6.8%), Romania (6.2%) and Guinea Bissau (4,10%).[18]	The impact of the colonial history is really strong on these migrations because of the use of a common language in Brazil, Cape Verde, Angola, Guinea-Bissau and S. Tome and Principe.
Slovenia	Migrants are mainly from Kosovo, Middle East and Africa.	They are mostly transitional and a part of the migration waves from the Middle East and Africa towards Western and Northern Europe.
Spain 2014	In 2014, the main migrant populations were from Romania (15.8%), the rest of Europe (22%) and Morocco (15.3%). There were also a large proportion of South and Central American migrants (Ecuador, Colombia, Bolivia, Argentina and Peru) who represent 13% of the migrant population.[19]	The main reason for migration is seeking employment. The colonial past had a great influence on migration flows in the case of Latin America.

[15] Statistics Denmark - Danish Statistical office (2014 data)
[16] Institut national de la statistique et des études économiques - French Statistical office - Fiches - Population : Insee Références, Édition 2016 (2013 data)
[17] Statistisches Bundesamt - German Statistical Office (2014 data)
[18] Instituto nacional de estatística - Portugal Statistical Office, Delgado et.all, (2011 data)
[19] Instituto Nacional de Estadistica - Spanish Statistical Office (2014 data)

Associated partners highlighted in their national report that migrants, even when they reside legally on the territories of these countries or that they have obtained nationality, are rarely treated as "national" by the locals. As stated below, migrants suffer sometimes from stigma and discrimination. An EU-wide survey on immigrants accounted experiences of discrimination, criminal victimization and policing was hosted in 2008. It states that an average one in three respondents experienced at least one incident of discrimination in the past year[20]. This is also valid for migrants who share a common colonial history with their adopted country (Portugal, France) and even for those who have always been citizens but who are from overseas territories (France). These perceptions are particularly accentuated through the prism of physical differences (especially skin colour).

Highlights

At an international level, there is not one accepted definition of the term “migrant”. Legal definitions and representations vary to a great extent among countries. The term **“migrant”** in this project will refer to: "any **person** who **lives temporarily or permanently in a country where he or she was not born**, and has acquired some **significant social ties** to this country" (definition of migrant provided by the Council of Europe).

In 2011, in the EU-28, it was estimated that almost **51 million people who are residents,** were born outside of the Member State where they were living in. Europeans are the largest group of foreign-born people followed by Asian, African and Caribbean, Central and South American. **Colonial and postcolonial history** remains crucial components in modern migrations flows. Indeed, former colonial links explain to some extent various migration flows.

[20] European Union Agency for fundamental right, EU-MIDIS: European Union minorities and discrimination survey [online], available at : http://fra.europa.eu/en/project/2011/eu-midis-european-union-minorities-and-discrimination-survey [Accessed 30 nov.2016]

3. EPIDEMIOLOGICAL DATA ON MIGRANT AND HIV

Objectives:
- To identify the most HIV affected migrant groups in each participating country
- To gather epidemiological HIV data regarding those groups

- **Migrants : a disproportionately affected group**

For 2014, **29 992 new HIV diagnoses were reported by the 31 EU/EEA countries**. The notification rate (per 100 000 population) was 5.9 for the EU/EEA overall. Variability can be observed between the EU/EEA countries, as this rate ranged from 1.6 in Slovakia to 22.1 in Estonia.[21] The number of people newly infected is unacceptably high, particularly since the rate of new infections has remained unchanged during the last decade.

New HIV diagnoses are concentrated in certain sub-populations namely men who have sex with men (MSM), migrants, injected drug users (IDU) and sex workers.

Dublin declaration' surveillance data for the EU/EEA in 2014 shows that **foreign-born people represented more than one third (37%) of all newly-diagnosed HIV** where information was known concerning the region or country of birth.[22] This data varies a lot between EU/EEA countries and the states organization participating in this study. In 2014, in Belgium, France and Denmark, migrants represented around half of the new HIV diagnoses out of all reported cases with known information and around one third for Germany, Spain and Portugal (see figure in Annex E).

- **Sub-Saharan Africans and Latinos : most affected sub-groups among migrants in Europe**

Sub-Saharan African (SSA) represents on a European scale **the most vulnerable or most-at-risk migrant population for HIV** infection and **Latin America and Caribbean (LAC) the second most.**

During 2007-2011, 40% of the 125 225 new HIV infection with known geographical origin in the EU/EEA countries were diagnosed among foreign-born individuals. Among them, 54.3% were from Sub-Saharan Africa, 12.2% from Latin America, 9.5% from Western Europe, 6.0% from central Europe, 5.0% from South and Southeast Asia, 4.1% from Eastern Europe, 4.0% from the Caribbean and 5.0% from countries in other regions[23].

The most recent data on the field is on the same track. **In 2014**, **Sub-Saharan Africans represented 43% of the new HIV infections among foreign-born individuals in EU/EEA and Latin America and Caribbean 16%**. This **proportion is slightly higher for the countries participating in this project**. In 2014, Sub-Saharan Africans represented near of half (48%) of the new HIV infections among these countries and Latin America and Caribbean 17% (see figure 1). This proportion ranged widely among the participating countries. SSA migrants accounted for 71% of the new HIV diagnoses among migrants in Portugal, 66% in France and 53% In Belgium, 40% in Denmark and 19% in Spain. Regarding LAC migrants, they accounted for half (52%) of the new HIV diagnosis among migrants in Spain and 21% in

[21] ECDC, WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2014. Stockholm: ECDC; 2015.

[22] Ibid

[23] ECDC. Assessing the burden of key infectious diseases affecting migrant populations in the EU/EEA. Stockholm: ECDC; 2014

Portugal. Not only **SSA and LAC represent a considerable part of new HIV diagnoses among foreign-born but also among all the new HIV diagnoses (native-born and foreign-born individuals).** For example, in 2014, in Belgium and in France, new HIV diagnoses among Sub-Saharan African migrants represented a third of all the new HIV diagnoses reported in the country (see figure 2).

Slovenia presents a specific situation among our panel countries. In 2014, 49 new HIV diagnoses were reported: 44 among native people, 4 among central & Eastern Europe, 1 among person born in LAC and 0 among SSA[24,25].

Figure 1: Proportion of individuals born in Sub-Saharan Africa or Latin America and Caribbean **among new HIV diagnoses in migrants** reported in the participating countries and in EU/EEA, 2014

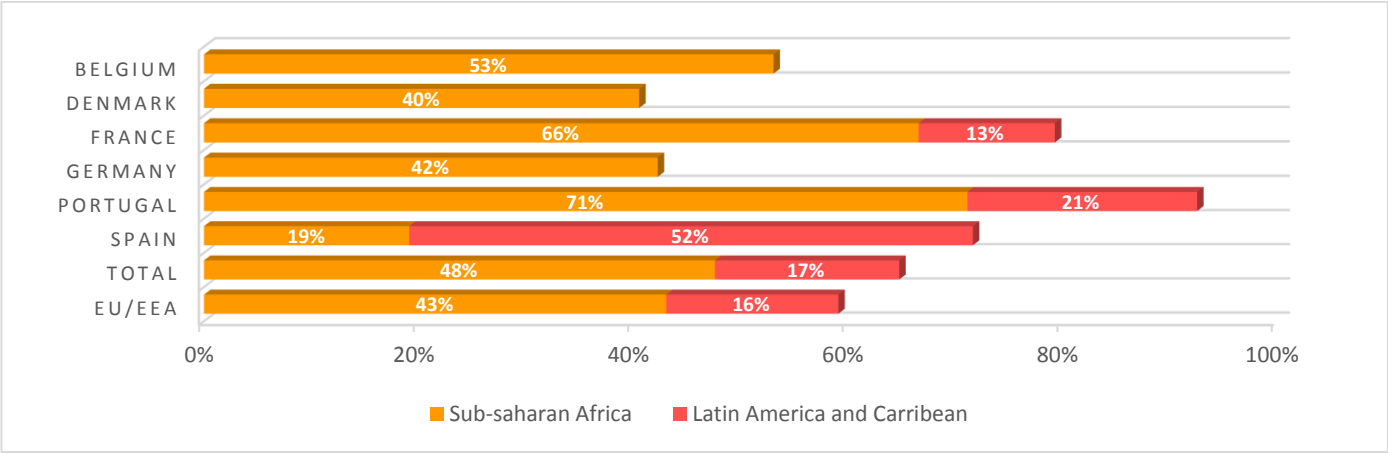
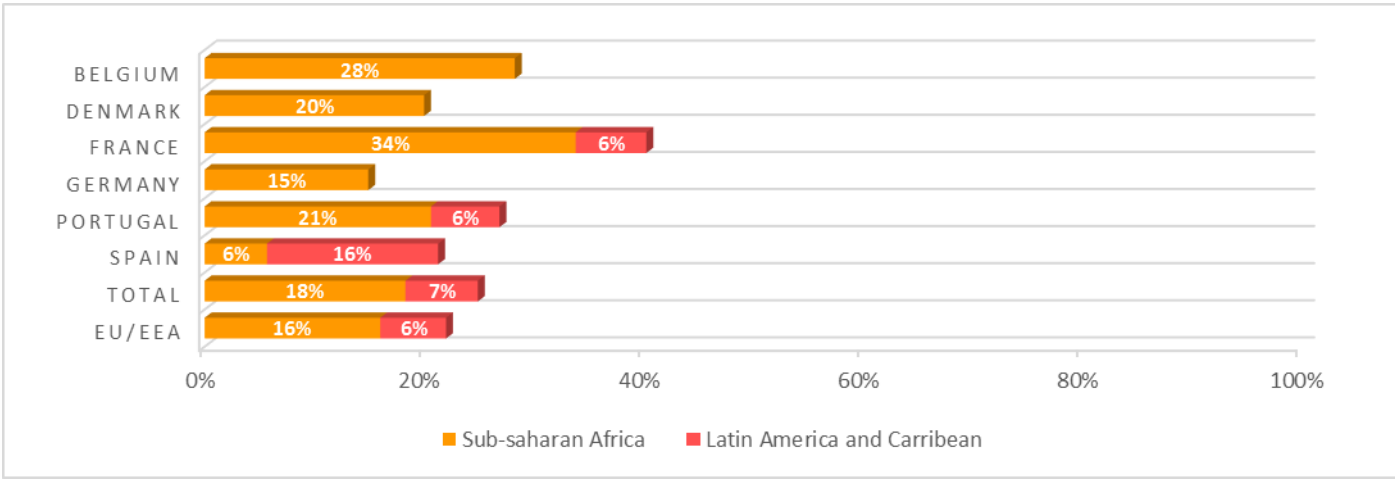


Figure 2: Proportion of individuals born in Sub-Saharan Africa or Latin America and Caribbean **among all new HIV diagnoses** (in **native-born and foreign-born groups**) reported in the participating countries and in EU/EEA, 2014



Source:
Data: European Centre for Disease Prevention and Control, WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2014. Data analysis: Mission Innovation Recherche Expériementation (MIRE), Association Aides, 2016.

[24] ECDC, WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2014. Stockholm: ECDC; 2015.
[25] Following a meeting between associated partners in 2015, it has been decided that Slovenia would not participate in the following phase of the study.

Based on these findings, **migrants from Sub-Saharan Africa (SSA) were identified as the targeted population** for this study by all the associated partners (except Slovenia). Portugal and Spain also identified migrants from LAC as the targeted population and thus have two targeted population for this study.

Among the 4139 **new HIV-diagnoses among SSA-born** in the EU/EEA region, **half of them were reported in our panel countries** (see figure 1 below and table in Annex F). The proportion of new HIV diagnoses among SSA-born individual is higher in France and Germany, as France counted for 23% of the new diagnoses and Germany 12% in 2014. Regarding **new HIV-diagnoses among LAC-born**, among the 1490 new HIV infection, **six in ten (57%) were reported in our panel countries.** Spain counted solely for 34% of the new HIV-diagnosis among LAC-born.

Figure 1: Country of report of new HIV-diagnoses among SSA-born in the EU/EEA region, 2014

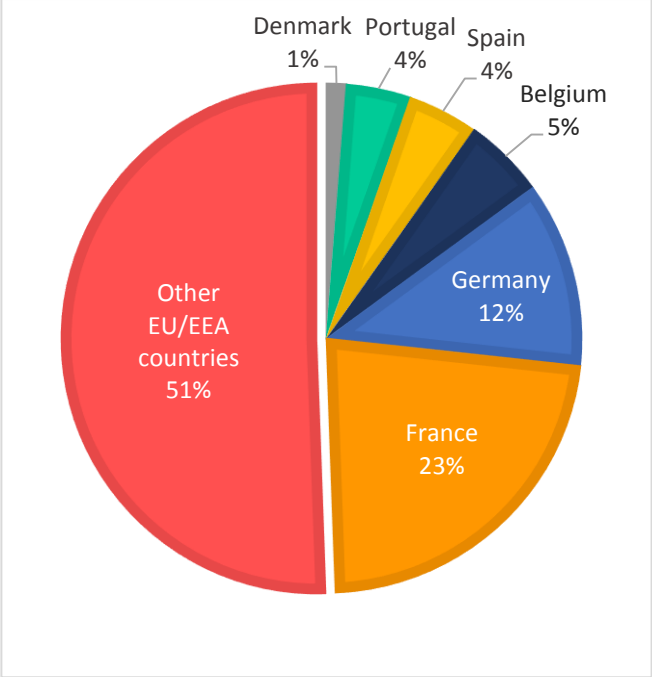
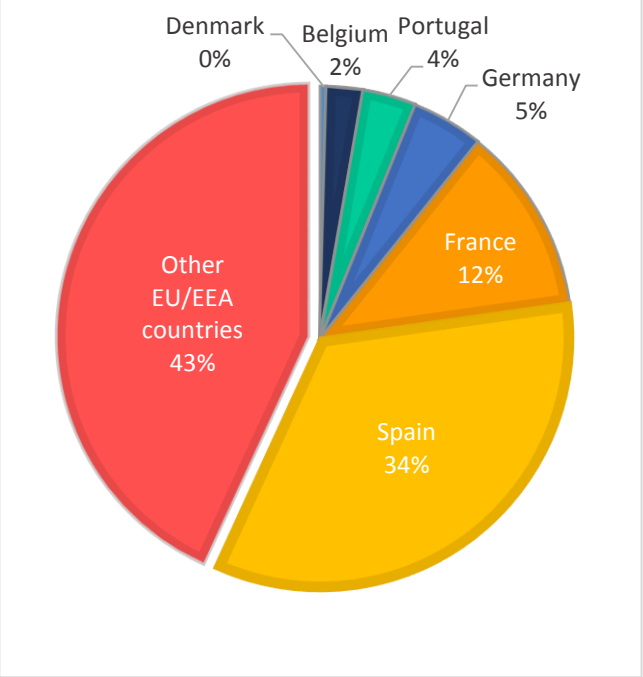


Figure 2: Country of report of new HIV-diagnoses among LAC-born in the EU/EEA region, 2014



Source:
Data: European Centre for Disease Prevention and Control, WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2014. Data analysis: MIRE, Association Aides, 2016.

Highlights

Migrants, especially Sub-Saharan African and Latin American born, are disproportionately affected by HIV. In 2014, **four in ten people diagnosed with HIV were migrants and four in ten migrants were from Sub-Saharan Africa and one and a half were from Latin America**. Sub-Saharan African represents on a European scale the more vulnerable or most-at-risk migrant population for HIV and Latin America and Caribbean the second one.

Thus, SSA migrants were designated as the target group for this project by all the associated partners (except Slovenia). LAC migrants were also defined as the target group by Spain and Portugal.

4. ACCESS TO HEALTH CARE AND HIV/AIDS SERVICES FOR MIGRANTS

Objectives: To describe and better understand the access to health care for regular and irregular migrants in each participating country with a special focus on prevention, testing and treatment of HIV

4.1 ACCESS TO HEALTH CARE FOR REGULAR AND IRREGULAR MIGRANTS

In all the participating countries, legal residents (regular migrants) benefit from the same access to health services as nationals. Their entitlements and conditions of access to health care depend on the national health system (see below table 2). For irregular migrants and asylum seekers, legal entitlements and administrative procedures regarding access to health care ranged widely from one country to another (see below table 3 and 4).

4.1.1 Review of regular migrants situation

Table 2: Legislative framework and access conditions to healthcare in the participating countries for regular migrants

Belgium	Belgium has a compulsory national health insurance system that covers the whole population and has a very broad benefits package. People who are documented and work are automatically affiliated to health insurance. Indeed, social security contributions are deducted automatically from salaries and these is in turn are distributed to health insurance companies (many private and one public one).[26] Nationals and authorized residents must pay in advance for the medical consultation fees charged by the doctor or hospital. Then, their health insurance companies reimburse in part these fees. In practice, patients are only responsible for small co-payment[27]. Some individuals, depending on their means, pay less for most medical services. Access to emergency care for residents is always assured.
Denmark	The Danish healthcare system is tax-financed and grants universal access to Danish residents. Denmark has an extensive public healthcare system that offers free consultation and treatment at doctor's office, emergency wards and public hospitals for legal resident.[28] All people legally residing in Denmark are entitled to healthcare. They need to register with the local authority and get a health insurance card. With this card, the consultation of a GP or specialist is free. The health insurance scheme partially covers the cost of other types of treatments according to the scale agreed between the scheme and practitioners' organizations. Access to emergency care is free without conditions in the case of an accident or acute illness[29].
France	The French health-care system is based on a national social insurance system complemented by elements of tax-based financing and complementary voluntary health insurance.[30] All residents are entitled to receive publicly financed health-care through statutory health insurance. This system covers approximately 65% of their health care expenses. Private health insurance can support the remaining costs. People whose incomes are below a certain threshold (721 euro/months for one person in 2016) have access to a complementary program (CMU-C)

[26] MDM International Network, Legal report on access to healthcare in 12 countries, 2015
[27] Ibid MDM.
[28] Danish public portal "Lifeindenmark", Healthcare, [online] available at: https://lifeindenmark.borger.dk/pages/healthcare.aspx [Accessed 29 nov.2016]
[29] European Commission, Your social security rights in Denmark, 2013
[30] PICUM, Access to Health care for Undocumented Migrants in Europe, 2007

	a scheme which provides full coverage of all health care expenses[31]. This complimentary program is accessible by request with proof of residency > 3 months on the territory, a resident permit and proof of income. Another system exists to help people with low income, but still slightly above the CMU-C threshold. Through this system, people receive financial assistance (between 100 and 500 euro) to finance their private insurance[32].
Germany	Health care for the majority of the German population is organized via a contribution-financed, compulsory health insurance system. It is compulsory for all German citizens and long-term residents to have health insurance. For those earning less than the threshold (54 900 euro by year in 2015), insurance is provided by the public statutory health insurance scheme. Those with a higher income, have the option to purchase a private health insurance plan. [33] Insurance payments are shared between employees and employers. For destitute nationals with welfare benefits, social welfare offices normally pay for (a part of) their compulsory insurance or directly for their medical treatment[34]. The health system does not cover all the costs related to medical services. In most cases, small co-payments must be made[35].
Portugal	The Portuguese constitution recognizes the right of provision to health-care for all. Foreign citizens who legally reside in Portugal are granted access in equal terms as other national health system beneficiaries for treatment, healthcare and co-payments of medication. Legal residents need, in order to have access to the health-care system, to obtain a free-of-charge health card. For each health check or service used (including diagnostic tests), the user must pay an amount known as a moderating fee, these fees are relatively low[36].
Slovenia	Slovenia has a compulsory national health insurance system which is fully regulated by national legislation and is based on a single insurer. This insurance is universal and based on a clear employment status or on a legally defined dependency status (such as minors, unemployed husband/spouses, registered unemployed people and individuals without source of income). Migrants who obtain temporary, permanent residency or citizenship have the same rights as other citizens. Health insurance contributions are shared between employee and employer. Patients are responsible for co-payments. They have the possibility to contract complementary insurance to cover that fee. Primary care is provided by public primary health care centres (including emergency medical aid and general practice), health stations and an increasing number of private GPs who participate in the public healthcare network and are reimbursed by the national health system.[37]
Spain	The universal right to enjoy health protection and care is laid down by the Spanish Constitution. Spain is a tax-based national health system[38]. Access to public health services is obtained through the Individual Health Care Card (IHC) issued by each health service. Workers as well as beneficiaries of social security services (unemployed) or spouses and descendants of an insured person can be covered by the National Health System. Foreign citizens and legal residents are granted access in equal terms than nationals. Regarding primary health care, a patient with health coverage does not have to pay doctors' fees in advance. However, each patient has to cover a part of the costs for medicine[39].

Among our panel countries, none show discrimination towards regular migrants regarding their access to healthcare. Regarding asylum seekers and irregular migrants, legal entitlements to access health care range a lot among our panel and are often very limited.

[31] French public portal devoted to CMU-C, Plafonds d'attribution de la CMU-C, de l'ACS et de l'AME, [online], avalaible at: www.cmu.fr/plafonds.php, [Accessed 29 nov. 2016]
[32] French public portal devoted to CMU-C, Aide au paiement d'une Complémentaire Santé, [online], avalaible at: http://www.cmu.fr/acs.php [Accessed 29 nov. 2016]
[33] MDM International Network, Legal report on access to healthcare in 12 countries, 2015
[34] PICUM, Access to Health Care for Undocumented Migrants in Europe, 2007
[35] Ibid MDM
[36] Ibid MDM
[37] Albreht T et al. Slovenia: Health system review. Health Systems in Transition . 2009; volume 11(3): 1-168
[38] Ibid PUCUM
[39] Ibid MDM

4.1.2 Review of irregular migrants and asylum seekers situation

Regarding **irregular migrants,** we can distinguish **3 degrees of access among the countries**[40]: countries providing **access to emergency services only** (Denmark); countries allowing **greater access to some services or for some categories of irregular migrants** (like Slovenia, Spain and Germany who allow a greater access to care for under-18 migrants and pregnant women, plus Germany who also provides recommended immunizations); finally, some countries allow **full access under specified conditions** (Belgium, France, Portugal).

Likewise, regarding asylum seekers, we can distinguish **two situations**. Some countries provide restricted **rights to access to healthcare** (Denmark who only allows urgent and pain-relieving treatment, Germany who only allows examination and treatments for acute diseases and pain and pregnancy during their first 15 months on German territory as well as in Slovenia) while some other countries will offer the **same rights to asylum seekers as legal or national residents** (Belgium, France, Portugal, Spain).

Table 3 and 4 present an overview of the legal entitlements and administrative procedures which allow access to health care for asylum seekers and irregular migrants. **Table 3** is focused on Denmark, Germany, Spain and Slovenia, four countries which provide limited or very limited rights of access to healthcare for irregular migrants and/or asylum seekers. **Table 4** presents asylum seekers and irregular migrants access to health care in Belgium, France and Portugal where migrants are entitled to benefit from extended rights.

Table 3: Access to health care in Denmark, Germany, Spain and Slovenia for asylum seekers and irregular migrants

	Asylum seekers	Irregular migrants
Denmark	Asylum seekers have very limited rights. Indeed, their healthcare expenses are covered only if it is necessary and/ or either urgent (treatment cannot be postponed) and/or pain-relieving.[41] There is an exception for the children of asylum seekers who are entitled to the same healthcare as children who are residents of Denmark. Health care expenses for asylum seekers are not covered by the national health insurance system but by the Danish Immigration Service[42].	Irregular migrants in Denmark have only access to emergency care. The Executive Order on the Right to Hospital Treatment notes that non-residents have the right to emergency treatment in cases of sudden illness, delivery, or aggravation of chronic illness[43]. Other care services and treatments are very restricted (for example, people without permanent residence may obtain non-emergency care if it is not reasonable to refer them for treatment in their home countries. These non-care emergency services may be subject to payment. For example, women can be charged for obstetric care. Moreover, if doctors have a duty to provide the best possible treatment in case of emergency care, this duty doesn't apply in case

[40] This categorization is based on the categorization proposed by Bradford H. Gray Ewout van Ginneken in Gray BH and van Ginneken E. Health care for undocumented migrants: European approaches, Commonwealth Fund pub. 1650 Vol. 33, 2012

[41] Danish public portal "The official portal for foreigners", Healthcare, [online], available at: https://www.nyidanmark.dk/en-us/coming_to_dk/asylum/conditions_for_asylum_applicants/healthcare.htm, [Accessed 29 nov. 2016]

[42] Ibid Danish public portal.

[43] Biswas D. et al, Access to health care for undocumented migrants from a human rights perspective: A comparative study of Denmark, Sweden, and the Netherlands, Health and Human rights, volume 14, number 2, December 2012

		of non-emergency cases (they can refuse to take care of the patient).[44] Finally, according to Danish legislation, irregular migrants in need of necessary care may also request treatment from the Danish Immigration Services. As Immigration Services are obliged to inform the police of the whereabouts of known irregular migrants, migrants don't call on immigration services[45].
Germany	Asylum seekers and refugees living in Germany do not have the same access to healthcare as nationals. For their first 15 months, asylum seekers have only the right to treatment for acute illnesses and severe pain; antenatal and postnatal care; recommended immunizations; preventive medical tests; and anonymous counselling and screening for infectious and sexually transmitted diseases.[46] After 15 month, they have access to health care system with the same conditions that apply to German citizens who receive welfare benefits. In some German states, asylum seekers will need a temporary treatment certificate before they are able to receive medical services; in others, they will receive an insurance card from a health insurance provider[47].	Irregular migrants are given by law the same access to health services as asylum seekers who have been in Germany for less than 15 months i.e., and have limited access to medical services[48]. See left Column. In theory, irregular pregnant women should have access to healthcare services in the same way as women seeking asylum. Children of irregular migrants should also have the same access to healthcare as the children of asylum seekers. For non-emergencies, irregular migrants seeking reimbursement or to get coverage for their treatment must themselves approach the social welfare office. Their staff then have a duty to report them to the administrative authorities and/or the police.[49] Indeed, according to German legislation "Public bodies [with the exception of schools and other educational and care establishments for young people] shall notify the competent foreign nationals' registration authority forthwith, if, in discharging their duties, they obtain knowledge of: the whereabouts of a foreign national who does not possess the required residence permit and whose expulsion has not been suspended". A latter instruction came back on this statement and bound hospital administrative, medical staff and social service departments to medical confidentiality in the hospital's emergency department. Hence, this restriction applies only to emergency department.[50]
Slovenia	Asylum seekers have limited entitlements to health care, they can only access free of charge "emergency medical care and essential treatment" and ante and postnatal care, family planning and assistance for abortion.[51]	Irregular migrants have the same rights as asylum seekers.[52]
Spain	Asylum seekers are entitled to access health care on equal grounds as Spanish nationals and authorized residents with regard to coverage and conditions[53].	The economic crisis and the austerity policies led in 2012 by the Spanish Government to exclude irregular migrants from the Spanish Health care system. Only under-18 migrants and pregnant women have since the right to health care system[54].

[44] Ibid Biswas D.
[45] Ibid Biswas D.
[46] Ibid MDM.
[47] Ibid MDM.
[48] MDM International Network, Legal report on access to healthcare in 12 countries, 2015
[49] PICUM, Access to Health Care for Undocumented Migrants in Europe, 2007
[50] Ibid MDM.
[51] Huma Network, Are undocumented migrants and asylum seekers entitled to access health care in the EU?, A comparative overview in 16 countries, 2010
[52] Ibid Huma Network.
[53] Ibid MDM.
[54] European Social Policy Network, Undocumented migrants in Spain to regain access to healthcare?, ESPN Flash Report 2016/39, july 2016

	Since September 2015 a proposal has been made by the Inter-territorial Council of the Spanish Healthcare System to extend primary care to irregular migrants, but no decision has been taken in that respect to-date[55].
	In case of emergency, irregular migrants have right to be attended for emergency care. But if a chronic disease is diagnosed they are left without care.

These four **countries present similar characteristics: asylum seekers and irregular migrants have limited or very limited rights to health care**. They can access free health care coverage mostly in case of emergency and/or pregnancy.

Among our panel, **Germany and Denmark** present specific legislations which have restricted access to these entitlements. In these two countries, public bodies which are in charge of processing demands for care services or covering expenses have also the duty to inform authorities of the whereabouts of known irregular migrants. These procedures constitute a breach to medical confidentiality.

Denmark is the only country where providing care for irregular migrants is technically prohibited. However, some private initiatives (physicians) or associations (Red Cross - clinic for migrants) bypass the legal system. In some cases, it can be possible to assign a temporary social security number (only possible at the hospital).

Spain also presents some specificities. Indeed, Spain suffers from a lack of homogeneity in terms of access to care because of its highly decentralized health system. Spanish Health system is largely decentralized to the 17 autonomous communities and their regional health authorities. Hence, whilst in 2012 the Central Government passed a decree excluding irregular migrants from the Healthcare system, Regional health Authorities have the power to decide how to implement it. Many Regions adopted legislative and administrative actions to void or limit its effects, while others decided to apply it.[56] In results, there is a huge difference in health care coverage for irregular migrants regarding their place of residency.

[55] Ibid ESPN.

[56] Cimas, Marta et al. Healthcare coverage for undocumented migrants in Spain: Regional differences after Royal Decree Law 16/2012, Health Policy , Volume 120 , Issue 4 , 384 - 395

Table 4: Access to health care in Belgium, France and Portugal for asylum seekers and irregular migrants

	Asylum seekers	Irregular migrants
Belgium	Asylum seekers are entitled to access a large range of preventive and curative care (some services such as orthodontics, infertility treatment are excluded)[57].	Irregular people can have access to health care by using the Urgent Medical Assistance (AMU) scheme. Any user of the Urgent Medical Assistance scheme can benefit from a consultation with a general practitioner as well as with a specialist.[58] This card doesn't only cover emergency or accurate cases but a wide variety of care provisions, such as medical examinations, operations, childbirth… The cost is covered by the social welfare office. In order to get this card, irregular migrants need to go to the social welfare office in the municipality where they live. This administrative authority then initiates a social inquiry to determine if the applicant is residing in their local area and if they are in a precarious economic situation. Then, if the decision is positive, the applicant can visit a health care provider. The health care provider will be paid by the social welfare service if an "urgent medical assistance certificate" is attached to the process.
France	Asylum seekers have the same access to care as legal residents in regards to coverage and conditions.[59]	Irregular migrants can access health care free of charge through the Medical State Aid (AME) scheme. Health care costs are fully covered except dental, optical and medically assisted reproduction. This aid is valid for one year.[60] To benefit from this medical state aid, irregular migrants must comply with two conditions: they must be and prove that they have resided for more than three months in France and that their income is below the threshold of 721 euros/months for one person in 2016 (8 653 euros by year for one person in 2016).[61] All other irregular migrants can access emergency care, and postnatal care, abortions and medical terminations of pregnancy as well as treatment for infectious diseases (tuberculosis, HIV) free of charge.[62]
Portugal	Asylum seekers are entitled to access health care on equal grounds as Portuguese nationals in regards to coverage and conditions.[63]	Migrants, residing for more than 90 days in Portugal must obtain a document called "temporary registration" in order to access to their healthcare right. They need to provide proof that they have been in Portugal for more than 90 days to obtain a residence certificate at the municipal council. The document can be obtained upon presentation of at least 2 witnesses that are also residents in the area to confirm the information. Thus, they can gain access to healthcare. For medical

[57] MDM International Network, Legal report on access to healthcare in 12 countries, 2015
[58] PICUM, Access to Health Care for Undocumented Migrants in Europe, 2007
[59] Huma Network, Are undocumented migrants and asylum seekers entitled to access health care in the EU?, A comparative overview in 16 countries, 2010
[60] Ibid Huma Network.
[61] French National Health Insurance website "Amelie", L'aide médicale de l'État, [online], avalaible at: http://www.ameli.fr/assures/droits-et-demarches/par-situation-personnelle/vous-avez-des-difficultes/l-8217-aide-medicale-de-l-8217-etat/les-conditions-pour-beneficier-de-l-ame_rhone.php, [Accessed 29 nov. 2016]
[62] MDM International Network, Legal report on access to healthcare in 12 countries, 2015
[63] Huma Network, is composed of undocumented migrants and asylum seekers entitled to access health care in the EU?, A comparative overview in 16 countries, 2010

	appointments or services provided, the person will pay the user fees applicable to health care according to what is officially established.[64]
	Migrants who don´t have "temporary registration" can access healthcare with the same terms that apply to the general population on the following conditions: urgent and vital healthcare, communicable diseases that represent danger to public health, maternal health and reproductive health, health care for minors residing in Portugal.[65] In other cases, they will have to pay the fee charges for the service.

Belgium, France and Portugal's migrants access to health care offers three similar set ups. Asylum seekers are entitled to access health care on equal grounds as national residents. Irregular migrants are also entitled to the same or similar healthcare benefits as national citizens and thus have the ability to access a large range of preventive and curative care. In order to enjoy these entitlements, **irregular migrants need to go through administrative procedures** which can be complex.

Many problems arise with the scheme set up in **Belgium**: many administrative steps must be followed[66]. Regarding homeless people or migrants who do not have a fixed address, difficulties are experienced to determine the competent social welfare office and following behind are difficulties to prove that they live in the territory. Also, like social welfare centres have a high degree of autonomy to manage the administrative procedure involved in obtaining the card, accessibility to health care varied widely from one municipality to another.

In **France**, similar difficulties arise. It can be difficult for irregular migrants to gather all the required documents therefore slowing down the procedure. For example: migrants have to prove their identity, but some do not possess an identity document. Therefore, they must provide a birth certificate document which will have to be translated by an official translator (this can represent an important cost). Migrants also have to prove that they have been resident in France for more than three months which can be tricky. Moreover, the local authorities who are competent to manage the administrative procedure (Caisses Primaire d'Assurance Maladie) have their own way of applying the regulation and can decide whether or not to accept certain documents. Some recognized the value of certificates delivered by NGOs and others not[67].

All the conditions and administrative procedures that migrants have to complete constitute **some major barriers and obstacles in their access to health**. The Médecins du Monde (MdM) NGO carried out a statistical survey among irregular migrants which identified **the gap between theoretical and effective access to health coverage** in 11 European countries (Belgium, France, Germany, Greece, Italy, Netherlands, Portugal, Spain, Sweden, Switzerland and the United Kingdom)[68]. In Belgium and France, **if theoretically respectively 98,2% and 88,9% of the respondents can**

[64] PICUM, Access to Health Care for Undocumented Migrants in Europe, 2007
[65] Ibid PICUM.
[66] MDM International Network, Legal report on access to healthcare in 12 countries, 2015
[67] MDM International Network, Legal report on access to healthcare in 12 countries, 2015
[68] Médecins du Monde European Observatory on Access to Healthcare, Access to healthcare for undocumented migrants in 11 European countries, 2009

benefit from health care coverage only 10% and 9,6% have effective health coverage[69]. The study shows that several barriers prevent irregular migrants to have effective access to healthcare coverage:

- ➢ Lack of knowledge of their right to access healthcare and/or the steps to access healthcare
- ➢ Difficulty to undertaken the necessary procedures to obtain these rights:
  - person even aware of their right don't try out to get health access
  - administrative procedures and problems (problems getting the documents which are required, abusive demands, unsuitable opening hours, being sent from one office to another)
  - language barriers

Medical tourism is not at the centre of the current political events. This topic has been discussed and / or debated in the media in **France**, however, data are scarce (or non-existent) and the phenomenon remains marginal.

4.2 ACCESS TO HIV/AIDS PREVENTION, TREATMENT AND CARE

4.2.1 Challenges for HIV/Aids prevention and control: Late diagnosis and undiagnosed HIV

Undiagnosed and late diagnosis constitute majors obstacles to control or to end HIV/Aids epidemic. Early diagnosis reduces the risk of transmitting HIV to other people. Also, it enables people with HIV to start treatment at a more appropriate time which improves patient outcomes, including quality of life and life expectancy. Early diagnosis of HIV is essential to decrease mortality, morbidity and transmission rates.

In the late 2000, there were an estimated 850,000 people living with HIV in Western and Central Europe and approximately **30% of these individuals living with HIV weren't diagnosed/ didn't know about their infection**.[70] In France, there were in 2013 an estimated number of 24 800 persons living with HIV and not diagnosed and among them 40% whom were non-French born[71],[72].

Regarding late diagnosis, in the **EEA countries**, **in 2013, nearly half (47%) of all HIV cases were diagnosed late (CD4 cell count of <350/mm3) and more than one in four (27%) cases were advanced HIV infection (CD4 cell count <200/mm3) when they were diagnosed.[73]**

SSA and Latin America were more likely to be diagnosed late in EEA countries than native-born or migrant originating from other countries of Europe as well North America, Australia and New Zealand. Indeed, while during the 2007-2011 period, 37% of native-born cases were diagnosed late, respectively **44% and 46% of migrants from Latin America and the Caribbean were diagnosed late. Half (51%) of SSA were diagnosed with CD4<350 cells/mm3 or AIDS[74].**

[69] Ibid Médecins du Monde European Observatory on Access to Healthcare
[70] ECDC. HIV testing: Increasing uptake and effectiveness in the European Union. Stockholm: ECDC; 2010
[71] Marty L. et al, Mapping the HIV epidemic to improve prevention and care: the case of France, Oral presentation at the 21th International AIDS Conference Durban, 19 July 2016, slides availables at: http://programme.aids2016.org/Programme/Session/975
[72] Supervie V, Données épidémiologiques VIH récentes en France, Oral presentation at the 17th SFLS conference, 6 and 7 October 2016, slides available at : http://sfls.aei.fr/ckfinder/userfiles/files/Formations/JourneesNationales/2016/presentations/VIRGINIE-SUPERVIE.pdf
[73] European Centre for Disease Prevention and Control. Thematic report: Migrants. Monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2014 progress report. Stockholm: ECDC; 2015.
[74] ECDC. Assessing the burden of key infectious diseases affecting migrant populations in the EU/EEA. Stockholm: ECDC; 2014

Overview on participating countries situation *(see table in Annex G)*

Proportion of late diagnosis of HIV among SSA migrants is particularly high for **Denmark and Germany** with respectively 66% in 2015 and 66.5% on the period 2001- 2015 of late diagnosis among the concerned group.

In **France,** in 2013, data are barely better: among migrants originated from SSA, 56.4% of the women were diagnosed late and 61.8% of the men. In 2013, the median time for heterosexual migrants between infection and diagnostic was 4.3 years while the global median time was 3.2 years[75]. In **Belgium**, half of the cases (50%) were diagnosed late.

This data indicates that greater efforts need to be made in order to improve uptake of testing especially among most concerned population such as migrants. Unfortunately, there is an evident lack of data on HIV testing and linkage to care among migrants. This lack of data can be explain by the fact that these data are not collected, data are not disaggregated by nationality or country of origin, data are incomplete or from a range of sources[76].

4.2.2 Access to HIV Testing and counselling

The following information aims to give a comprehensive approach of the HIV testing and counselling framework among our panel countries.

In **Belgium**, there is a number of referral centres offer STI screening. Screening is anonymous but some charges may apply depending the centre and/or the persons' situations[77]. NGO also offer free of charge testing. As our partner – the Institute of Tropical Medicine – reported outreach testing has been increasingly organized but it is currently only possible in the framework of research project on non-medicalized or decentralized testing. Rapid tests are one of the offered strategies but are not explicitly promoted as a testing strategy for specific groups.

In **Denmark**, HIV test can be offered by general practitioners, at some of the country's hospitals and by NGO´s. NGO´s such as Aids Fondet offer free and anonymous testing in its checkpoints or in the framework of outreach actions (in asylum centres; festival, train station…). Rapid tests are available and offered by hospitals and NGO´s[78].

In **France**, everybody, including irregular migrants have free access to anonymous testing, diagnosis of sexually transmitted infections and counselling through the Centre Gratuit d'Information Dépistage et de Diagnostic (CeGGID).[79] HIV testing is also available in private laboratories. This screening is entirely reimbursed by the health system for those who are insured and have prescriptions from their general practitioner[80]. NGO´s like Associations Aides, Médecins du Monde etc. offer free and community-based testing in their premises and through outreach interventions. Rapids test are used primarily in the framework of community-based testing[81].

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[75] Supervie V, Données épidémiologiques VIH récentes en France, Oral presentation at the 17th SFLS conference, 6 and 7 October 2016, slides available at : http://sfls.aei.fr/ckfinder/userfiles/files/Formations/JourneesNationales/2016/presentations/VIRGINIE-SUPERVIE.pdf

[76] ECDC. Thematic report: Migrants. Monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2014 progress report. Stockholm: ECDC; 2015.

[77] HIV Belgium Plan 2014-2019, available at: http://www.breach-hiv.be/media/docs/HIVPLan/NationalPlanEng.pdf

[78] AidsFondet webportal, Here you can get an HIV test, [online], available at: https://aidsfondet.dk/hiv-test, [Accessed 29 nov. 2016]

[79]European HIV Legal Forum – Aids actions Europe, Accessing HIV prevention, testing, treatment care and support in Europe as a migrant with irregular status in Europe: A comparative 10-country legal survey, 2016

[80] French Health authority webportal "Haute Autorité de santé", Questions générales sur le dépistage du VIH, [online], available at: http://www.has-sante.fr/portail/jcms/c_2023281/fr/questions-generales-sur-le-depistage-du-vih [Accessed 29 nov. 2016]

[81] Ibid French Health authority webportal

In **Germany,** HIV tests are on offer at a local public health centre "Gesundheitsamt", doctor's offices, AIDS service organizations like AIDS-Hilfe NRW e.V. and service organizations for gay men. Public health centres provide the test free of charge for some (for example, for students, the unemployed…) or for a small fee (about 10 – 15 euros). At the local public health department, HIV testing is totally anonymous. However, HIV tests completed in doctor's offices are not and are normally added to the patient's medical record.[82] Other testing options include community-based testing services offered by AIDS support organizations.

In **Portugal**, HIV testing is possible at hospitals, centres for HIV detection "Centros de Detecção do VIH (CAD)", primary healthcare services and in some CBVCT organizations. CBVCT organizations CAD offers free and anonymous HIV testing. There are no official orientations for CBVCT but the Directorate of Health, who finances these projects. There are also no legal barriers to community-based testing actions as they are supervised by a reference laboratory. Rapid HIV tests are used. They are mainly offered at CBVCT services and centres for HIV detection (CAD) such as associated partners GAT.

In **Slovenia,** anyone who has a health card can get tested for HIV for free at their primary health care practitioner. Across the country, there are several voluntary counselling and testing centres such as Legebitra (sometimes free of charge and sometimes on a self-payment basis)[83]. The infection clinic in Ljubljana offers free and anonymous testing to everyone.

In **Spain**, HIV testing is offered free of charge in the Spanish Health system. CBVCTs also provided anonymous and free of charge HIV screening (using rapid tests -blood or oral tests)[84]. Several pharmacies of 6 ACs of Spain (Catalonia, Basque Country, Ceuta, Castile and León, Cantabria and the Balearic Islands) are also offering HIV rapid tests, these tests are not free of charge.

4.2.3 Access to treatment

Standard **antiretroviral therapy (ART)** consists of the combination of antiretroviral (ARV) drugs to maximally suppress the HIV virus. ART does not cure HIV infection but **controls viral replication** within a person's body and **allows an individual's immune system to strengthen and regain the capacity to fight off infections**. ART also prevents onward transmission of HIV.[85]

Before focusing on migrant's access to treatment, it must be highlighted that **in Europe, HIV-positive people do not have access to HIV treatment in the same conditions** because of their countries policy. Previously, the World Health Organization (WHO) recommended to provide ART to all people with a confirmed HIV diagnosis with **a CD4 count of 500 cells/mm or less** and to give priority to initiating ART among those with severe/advanced HIV disease or a CD4 count of 350 cells/mm or less[86]. In 2014, at the time of this study, France was the only country to provide ART regardless of CD4 cell count. Belgium and Spain use a CD4 count of <500 cells/mm3 as the threshold for starting ART.

[82] Deutshe Aids-hilfe web portal, FAQs about HIV testing [online], available at: https://en.aidshilfe.de/faqs-hiv-testing#acc-906764, [Accessed 29 nov. 2016]
[83] NELP, Testing Country Profile in 2015 – Slovenia, [online], available at http://www.nelp-hiv.org/countries/SI [Accessed 29 nov. 2016]
[84] Fernàndez-Lopez L et al, Impact of the introduction of rapid HIV testing in the Voluntary Counselling and Testing sites network of Catalonia, Spain, Int J STD AIDS. 2010 Jun;21(6):388-91
[85] WHO, HIV/AIDS, [online], available at: http://www.who.int/mediacentre/factsheets/fs360/en/, [Accessed 29 nov. 2016]
[86] WHO, Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection, Recommendations for a public health approach, june 2013

While Denmark, Germany, Portugal and Slovenia use a <350 cells/mm3 threshold.[87] **In 2016,** WHO released **new recommendations** including the recommendation to provide lifelong ART to all **regardless of CD4 cell count**.[88]

- **Access to treatment for regular and irregular migrant**

Among our panel countries, national policies ensure **free access to antiretroviral treatment for legal residents** including regular migrants. However, national policies regarding the **provision of ART to irregular migrants ranged a lot from one country to another that was part of our panel**.

In Denmark and Slovenia there is no access to ARVs for HIV-positive irregular migrants[89]. Aids Fondet in Denmark reports that some hospitals and/or general practitioners still provide treatments in some instances.

Germany constitutes a particular case. The **German** Law on Preventing and Combating infectious diseases in humans of July 20th 2000 provides for free HIV/AIDS treatment if the patient cannot bear the costs. However, as many reports on access to healthcare for irregular migrants state, the duty to report irregular migrants of public bodies override completely this entitlement[9091]. Also, German associated partners explained that in the case of lack of health insurance and /or residence permit, associations and activists can negotiate with insurance companies as well as the authorities to allow migrants to have access to treatment.

As stated earlier, in 2012 the **Spanish** Government decided to revise its principle of universal coverage and excluded irregular migrants from health care system. However, in 2014, the Ministry of Health, Social Services and Equality decided to create an exception for infectious disease. Indeed, it was established individuals have the right to healthcare (preventative, follow-up and monitoring) whenever an infectious disease subject to epidemiological control and/or elimination at a national or international level is suspected[92]. Also, as explained previously many autonomous communities adopted legislative and administrative actions to void or limit effects of the 2012 reform. Consequently, many of the autonomous community still provide HIV testing, diagnosis (test and confirmatory test) and treatment.

Portugal offers free access to antiretroviral treatment for all including HIV-positive migrants in an irregular situation[93]. However, GAT – associated partner to his study – notes that due to the budget cutbacks, previous existing administrative barriers have been increasing. Denial of access to ARV due to not having the correct documentation has been reported. Also, in principle HIV-positive people have the right to choose the hospital where he/she wants to receive treatment, however these last years it has not always been possible. Moreover, HIV-positive patients have to go to the Hospital pharmacy once a month to pick up ARVs. Reports of Hospitals providing ARVs for lower periods have been noted over the last year.

[87] ECDC. HIV testing: Increasing uptake and effectiveness in the European Union. Stockholm: ECDC; 2010
[88] WHO, Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection, Recommendations for a public health approach - Second edition, June 2016
[89] Huma Network, Are undocumented migrants and asylum seekers entitled to access health care in the EU?, A comparative overview in 16 countries, 2010
[90] Ibid Huma Network.
[91] MDM International Network, Legal report on access to healthcare in 12 countries, 2015
[92] European HIV Legal Forum – Aids actions Europe, Accessing HIV prevention, testing, treatment care and support in Europe as a migrant with irregular status in Europe: A comparative 10-country legal survey, 2016
[93] Huma Network, Are undocumented migrants and asylum seekers entitled to access health care in the EU?, A comparative overview in 16 countries, 2010

In **France**, irregular migrants who benefit from the State Medical Aid (AME)[94] will benefit in theory, as legal residents, from free treatment. If irregular migrants have no health coverage (application for AME has not been done yet or is ongoing), the patient will be treated in the hospital and the cost will be covered by the PASS services (All-Day Healthcare Centres)[95]. In **Belgium,** irregular migrants can have access to free HIV ART only through the Urgent Medical Assistance (AMU). Irregular migrants needs to pass through the AMU complex administrative procedures[96]. As our associated partners explained, first migrants have to contact a caregiver in order to obtain a certificate confirming their care needs. Then they should contact their local social welfare office who will apply for them. Being regular is not mandatory, but in practice documents are required most of the times. Addresses are verified by social workers. For people without a fixed home, the situation becomes much more complicated as they first have to obtain proof of their current situation. Conflicts have been reported between municipalities that do not want to take over homeless migrants living in train stations (Brussels region).

Thus, if in these three countries, legislative framework guarantees free access to ART for irregular migrants, this right has not the same extent. While Belgium links access to ART to entitlement (Urgent Medical Assistance) and restricts access to treatment to a certain groups of migrants, Portugal provides access to treatment for all. France presents an intermediate situation, in theory ART is available for irregular migrants with healthcare (State Medical Aid) and through the PASS services for irregular for those they do not have healthcare. It must be highlighted that in these countries, associated partners reported some breaches to these legal entitlements. Next phase of the study will allow us to explore the gap between the theoretical and practical access.

Our panel countries reflected the overall situation in Europe, where in 2014, half (15) of the EU/EEA countries reported that ART was provided for irregular migrants and another half (14) that it was not[97] (see figure 3 below).

[94] See 4.1
[95] MDM International Network, Legal report on access to healthcare in 12 countries, 2015
[96] Ibid MDM.
[97] ECDC. Thematic report: Migrants. Monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2014 progress report. Stockholm: ECDC; 2015.

Figure 3: Provision of ART for irregular migrants, EU/EEA countries, 2014

Source: ECDC. Thematic report: Migrants. Monitoring implementation of the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and Central Asia: 2014 progress report. Stockholm: ECDC; 2015.

- **Protection of seriously ill irregular migrants**

Some countries have set up **legal mechanisms protecting seriously ill irregular migrants against expulsion**. In most countries, these people can be granted specific residence permits for "medical" or "humanitarian" reasons. Some countries have also developed other types of legal mechanisms temporarily preventing people from deportation.[98]

Among our country panel, in **Belgium, France, Germany, Portugal, Spain[99] and Denmark[100]** irregular migrants may apply for residence permits unlike in **Slovenia[101]**. Legal provisions attached to these permits varied among countries.

[98] Ibid Huma Network.
[99] Ibid Huma Network.
[100] Danish Immigration Service and the Danish Agency for International Recruitment and Integration's official web portal, Instructions for asylum seekers about the possibility for applying for humanitarian residence permit, [online], available at : https://www.nyidanmark.dk/en-us/coming_to_dk/humanitarian_residence_permit/instructions_about_possibility_for_applying_for_humanitarian_residence.htm, [Accessed 29 nov. 2016]
[101] Ibid Huma Network.

Highlights

Access to healthcare is a complex process. To a great extent it depends on the legal entitlements which are recognized. Among half of the participating countries (Denmark, Germany, Slovenia and Spain), irregular migrants are entitled to access health care on equal grounds as nationals, the other half (Belgium, France and Portugal) provide to irregular migrants for no more than emergency services (with some exceptions regarding some specific categories of irregular migrants). Indeed, if regular migrants are entitled to the same rights than nationals, the situation of irregular migrants and asylum seekers varied greatly among the countries. Access to antiretroviral therapy among our panel countries presents a similar set. National policies ensure free access to antiretroviral treatment for legal residents including regular migrants. Regarding access to ART for HIV-positive irregular migrants, Denmark, Slovenia and Germany denied access to ART while in France, Portugal, Belgium and Spain policies guarantee free access to ART.

Effective access to healthcare including ART depends also on the administrative conditions and procedures required along with the intelligibility of the system. A huge gap can be observed between a theoretical and an effective access to healthcare. Phase 2 and 3 of the study will allow to better appreciate the effective availability and accessibility of healthcare services and ART.

Regarding access to HIV testing, information provided shows that participating countries have set up a variety of HIV testing offers: in a medical laboratory, at the GP, at a pharmacy, at a hospital or clinic, on the premises or the mobile unit of an NGO or community based organization…

Also, it appears that in all participating countries, a free and anonymous testing offer exists. However the proportion of late diagnosis´s or undiagnosed HIV among migrants reveals that there are real issues regarding access to quality HIV testing for migrants. Following work, we allow us to identify the use of HIV testing services, perceived facilitators and barriers to HIV testing of migrants in the participating countries.

5. BARRIERS AND LEVERS TO ACCESS HIV TESTING, LINKAGE TO CARE AND CONTINUITY OF CARE

Objectives: To make a preliminary research on the obstacles and levers to access to HIV testing, linkage to care and continuity of care.

Access to health care literature is rich and offers a **large range of definitions of access and categorization**. In this report, we will use the following definition: "Access is the **opportunity or ease with which consumers or communities are able to use appropriate services in proportion of their needs**"[102].

5.1 OBSTACLES TO HIV TESTING, LINKAGE TO CARE AND CONTINUITY OF CARE

As seen previously, access to health care policies for migrants - especially for irregular migrants – ranged from one country to another. While, in some countries, irregular migrants are theoretically entitled to the same rights as legal residents, in others countries, they only have access to emergency care. Also, administrative procedures can constitute an obstacle to the benefit of his/her rights. Legislative framework and administrative procedures aren't the only components of access to health care. **Numerous factors or characteristics influence the use of health care services**.

Several studies focused on barriers to HIV testing especially on barriers regarding migrant population. Numerous studies have shown that barriers exist on **a patient and community level, on the health-care provider level and on the policy or structural level**. Regarding HIV testing, the following barriers have been identified[103][104]:

- *On a patient and community level*: low-risk perception, fear of HIV disease, fear of disclosure and breaches of confidentiality, lack of information on where and how to get tested , cultural and gender norms
- *On a healthcare and structural level*: communication, language problems and lack of cultural sensitivity and underinvestment in culturally competent services,
- *On a structural/policy level*: legal and administrative status (fear of deportation), discrimination, low social status, unemployment and poor living conditions, lack of clarity among health-care providers on migrant's rights to health

For this study, we decided to use the conceptual framework offered by Levesque JF et al.[105] Within this framework, access is defined as the **possibility to identify healthcare needs, to seek healthcare services, to reach the healthcare resources, to obtain or use health care services, and to actually be offered services appropriate to the needs for care**. Access to healthcare is viewed as resulting from the **interface between on one hand the characteristics of people, social and physical environments and on the other hand the characteristics of health systems, organizations and providers**. Thus, the framework is comprised of **five dimensions of accessibility** of care services: approachability

[102] Levesque JF et al., Patient-centred access to health care: conceptualising access at the interface of health systems and populations, International Journal for Equity in Health, 12:18, 2013
[103] Alvarez-del Arco D. et al, HIV testing and counselling for migrant populations living in high-income countries: a systematic review, European Journal of Public Health, December 2013
[104] Deblonde J. et al, Barriers to HIV testing in Europe: a systematic review, European Journal of Public Health, Vol 20, No 4, 422-432, 2010
[105] Levesque JF et al., Patient-centred access to health care: conceptualising access at the interface of health systems and populations, International Journal for Equity in Health, 12:18, 2013

(i), acceptability (ii), availability and accommodation (iii), affordability (iv), appropriateness (v) and **five corresponding abilities of patients and populations** to access of care ability to perceive (i), ability to seek (ii), ability to reach (iii), ability to pay (iv), ability to engage (v). Table 5 below presents the characteristics of these five "paired dimensions" of accessibility.

Table 5: **Definitions of the five dimensions of access as conceptualized by Levesque JF et al.**

Supply-side dimensions of accessibility of services	Definitions	Demand-side abilities of patients to access services	Definitions
Approachability	Approachability of services relates to the fact that people facing health care needs can identify that some form of services exist, can be reached, and have an impact on their health.	**Ability to perceive**	Ability to perceive translates into the ability of people to identify their needs for care.
Acceptability	Acceptability of services relates to social and cultural factors determining the possibility for people to accept the aspects of a service.	**Ability to seek**	Ability to seek healthcare relates to factors that would determine expressing the intention to obtain healthcare.
Availability and accommodation	Availability and accommodation refers to the fact that health services (either the physical space or those working in healthcare roles) can be reached both physically and in a timely manner.	**Ability to reach**	Ability to reach healthcare relates to factors that would enable one person to physically reach service providers.
Affordability	Affordability reflects the economic capacity for people to spend resources and time to use appropriate services.	**Ability to pay**	Ability to pay for healthcare is described as the capacity to generate economic resources to pay for healthcare services without catastrophic expenditure of resources required for basic necessities.
Appropriateness	Appropriateness denotes the fit between services and clients' needs, its timeliness, the amount of care spent in assessing health problems and determining the correct treatment and the technical and interpersonal quality of the services provided.	**Ability to engage**	Ability to engage in health care relates to the participation and involvement of the client in decision-making and treatment decisions. This is in turn strongly determined by the capacity and motivation to participate in care and commit to its completion.

Source:

- Levesque JF et al., Patient-centred access to health care: conceptualising access at the interface of health systems and populations, International Journal for Equity in Health, 12:18, 2013
- Richard L. et al., Equity of access to primary healthcare for vulnerable populations: the IMPACT international online survey of innovations, International Journal for Equity in Health, 15:64, 2016

In their national reports, associated partners reported some components or barriers to HIV testing and care. These insights are extracts from literature and/or field reports. Many of these items are identical to the items listed above from the literature review. These items have been classified following the Levesque JF et al. conceptual framework (see table 6 below).

Table 6: Components or barriers to HIV testing and care identified by associated partners

Dimensions of accessibility	Components or barriers
Approachability **Opportunity to identify healthcare needs and relevant healthcare services**	Low perceived risk/ ignorance of HIV and modes of transmissions Low priority given to HIV/health and lack of preventive behaviour/ ignorance of the existence of treatment Cultural health beliefs (Religious dimensions of the disease, different understanding of masculinity or blood) Fears of social consequences of being HIV positive (reject, discrimination, stigma, and loss of social status…) Fear of being deported if HIV positive Lack of knowledge about health services and HIV testing Language barriers Poverty, modest social status, unemployment
Acceptability **Opportunity to seek healthcare services**	Cultural barriers and language barriers Lack of information on the right and on the conditions to access to health care and testing Lack of opportunity for men contrarily to women Distrust in the social and medical system/ Fear of lack of confidentiality and the community finding out Regarding health care givers: Lack of cultural sensitivity, assumptions about migrants, lack of understanding of context of different migrant and ethnic communities
Availability **Opportunity to reach**	Lack of knowledge on getting tested and where to get tested Language barriers
Affordability **Opportunity to obtain/ use**	Economic difficulties Lack of knowledge on conditions of access to testing/ language barriers
Appropriateness **Opportunity to engage**	Incorrect information/ considering traditional medicines effectiveness No access to free HIV treatment (for irregular migrants) Lack of knowledge of their rights Deny of test results (fear of stigma…) / Psychosocial barriers (depression) Lack of telephone number, physical or e-mail address to contact patient Language and cultural barriers Discriminatory attitudes among health professionals

In order to conduct this study, we will also employ the Health Promotion Approach (see the Ottawa Chart[106]). This approach has been defined by the World Health Organization's (WHO) as "*the process of enabling people to increase control over their health and its determinants, and thereby improve their health*". Social determinants of access don't easily fit in this conceptual framework, hence this conceptual framework will be refined in order to take better account of social inequalities and determinant.

[106] WHO, The Ottawa charter for health promotion, First International Conference on Health Promotion, Ottawa, 21 November 1986

5.2 FACILITATORS HIV TESTING, LINKAGE TO CARE AND CONTINUITY OF CARE

In their national reports, each **associated partner** pointed out facilitators to improve access to HIV treatment and care for migrants. These facilitators relate mostly to policy and HIV testing and care strategy or to health-care service settings. These items are presented in the **table 7 below.** Phases 2 and 3 of this study will allow us to investigate these facilitators.

Table 7: Facilitators to improve access to HIV treatment and care for migrants pointed out by the associated partners

Access to testing - Linkage to- Continuity of care		
Provide **information and counselling in multiple languages** Have **interpreters and cultural mediators present** Have a **culturally sensitive approach** and empathy (for caregivers) Ensure patients **knowledge on their rights to access to care** and on the procedure to follow		
Access to testing	**Linkage to care**	**Continuity of care**
Implement following policy/ HIV testing strategy: -Providers initiated HIV testing Outreach HIV testing -Community-based testing or with participation of migrant community -Free of charge testing -Rapid testing -For women, coupling prenatal visits to an HIV test **Promote testing services** (through outreach actions notably) **Inform** of the importance of HIV testing and on the advantages to knowing his/her HIV status.	Provide **free antiretroviral treatment** Ensure **support** towards linkage to care and during administrative procedures Ensure **patient´s knowledge on their rights to access to care**/ patient's rights Provide **counselling adapted to cultural specificities** Have a **medical team with a migration background**	Provide **support groups for patients** or buddy programs Facilitate **acceptance of the diagnosis** by the patient (like a chronic disease) Offer presence and accompaniment by **interpreters / cultural mediators.** Have **moral and social support from family and partner**

Highlights

Access to healthcare can be defined as the opportunity or ease with which consumers or communities are able to use appropriate services to meet the level of their needs. Access to healthcare depends on the character of people and health systems and providers. Within the conceptual framework proposed by Levesque JF et al. and in use in this study, access is defined as the possibility to identify healthcare needs, to seek healthcare services, to reach the healthcare resources, to obtain or use health care services, and to actually be offered services adapted to the needs for care.

Through their national reports, associated partners highlighted many social and cultural factors (for example, low perceived risk or fear or distrust in the medical system) preventing migrants to identify and afterwards to seek their healthcare needs and the relevant healthcare service. Phase 2 and phase 3 of this study allows us to obtain information regarding the dynamics for receiving (or not) testing for HIV in CBVCT and/or in classical health systems and to deepen our understanding of facilitators and barriers to HIV testing and linkage to care of migrants in the participating countries.

ANNEX

Annex A: National report - template

Please, respect the following instructions:

1. Indicate the source of data provided (scientific/grey literature).
2. Fill in the document in English.
3. Provide as much detailed information as possible. There is no limit extension for answering this document.
4. Fill in all the questions. If there are no data, please indicate it.
5. Send the document to drojas@aides.org and sbenayoun@aides.org when completed.
   Deadline: March 20th, 2015

0. INTRODUCE YOURSELF

1. Name and contact of the person responsible for filling in the current national report:

This national report can be completed by different people (WP leaders, experts, etc.) but there will be only one referent person in charge of filling in and sending out the national report.

2. Structure/organization where the person responsible for filling in this national report works:

3. Country where the structure/organization is based:

4. Names of all the people and structures/organizations contributing to this document:

5. Please, provide a short description of your structure/organization (history, main activities, and places of intervention…):

1. LET'S TALK ABOUT CONCEPTS

1.1. Which words/terms are used in your country to designate those who are not considered as "nationals"/"citizens"? If no adequate translation exists, please mention them in the original language and give a description of their meaning/connotation.

1.2. In your country, what are the representations/images associated with the following terms?

- Foreigner:
- Migrant:
- Immigrant:
- The other words/terms mentioned in the question 1 (if no adequate translation exists, you can mention them in the original language and explain their cultural definition in English)

1.3. From a legal point of view, in your country, what is the definition of?

- Foreigner:
- Migrant:
- Immigrant:
- The other words/terms mentioned in the question 1 (if no adequate translation exists, you can mention them in the original language and explain their legal definition in English)

1.4. What are the criteria used to categorize people attending your organization as migrants (or other term used in question 1, please specify)?

To make this document easier to read and fill in, we will use the term “migrant” in the following sections to categorize people who are not considered as “nationals”/”citizens”?

2. LET’S MAKE AN OVERVIEW OF MIGRANT POPULATIONS

2.1. Who are the main “migrant” populations in your country?

2.2. Could you briefly describe the historical background concerning these populations (ex: colonial past, migration waves etc.)?

2.3. Has your country ever had territories other than those on the mainland? If yes, please describe the legal status of the people living in these territories.

2.3.1. How are they seen by the mainlanders (as nationals/migrants/other)?

2.3.2. Is their situation similar to that of “migrants”? Please add any information you consider relevant regarding integration issues in the mainland (e.g. cultural/linguistic/religious differences, issues in terms of access to health or other services)

3. ACCESS TO HEALTH FOR REGULAR AND IRREGULAR MIGRANTS

3.1. What are the legal frameworks for migrants to have access to health services and/or obtain a medical card?

Documented:
Undocumented:

3.2. Describe the administrative procedures to gain access to health services and/or obtain a medical card for migrants.

Documented:
Undocumented:

3.3. What are the legal frameworks for migrants to gain access to emergency care services?

Documented:
Undocumented:

3.4. Describe the administrative procedures to gain access to emergency care services for migrants.

Documented:

Undocumented:

3.5. What are the national guidelines regarding access to HIV antiretroviral treatment for undocumented migrants in your country?

3.6. In your country, it is illegal to provide care to undocumented people?

3.6.1. If yes, do you know if there are cases of medical staff providing care to undocumented people despite the legal framework? Please describe a "typical" situation.

3.7. Is there any legislation in your country which guarantees medical confidentiality for migrants? If yes, please describe it.

3.7.1. Are you aware of any breach of medical confidentiality regarding undocumented people in your country?

3.8. Do monitoring committees or other data collection tools on HIV and migration exist?

3.8.1. If so, what are their objectives?

3.8.2. Do you participate in this data collection?

3.8.3. Why?

3.9. Is there any data available regarding medical tourism in your country in relation to HIV (If yes, can you provide us with this information)?

3.9.1. Even if there are no data, is there a political discourse regarding the existence of medical tourism? What is your experience regarding this issue?

4. LET'S HAVE A LOOK AT HIV EPIDEMIOLOGICAL DATA

4.1. Please give here the most recent HIV epidemiological data for the most affected migrant(s) population(s) in your country?

Please, indicate the year of the data source. Include National Data.

Table 1: Migrant population 1 (numbers or population)

Epidemiological data (if available)	Women	Men	Total	Sources and date
HIV incidence (%)				
HIV prevalence (%)				
Late diagnosis (%)				
Linkage to care (%)				
Access to treatment (%)				
Viral load at the moment of diagnosis				

(median and/or average, if both available please indicate)				
CD4 counts at the moment of diagnosis (median and/or average, if both available please indicate)				
Age (median) of PLWHIV				
Region of birth of PLWHIV				
Probable region of HIV Infection				
Modes of transmission (name and % when possible)				

Table 2: Migrant population 2 (if that is the case)

Epidemiological data (if available)	Women	Men	**Total**	**Sources and date**
HIV incidence (%)				
HIV prevalence (%)				
Late diagnosis (%)				
Linkage to care (%)				
Access to treatment (%)				
Viral load at the moment of diagnosis (median and/or average, if both available please indicate)				
CD4 counts at the moment of diagnosis (median and/or average, if both available please indicate)				
Age (median) of PLWHIV				
Region of birth of PLWHIV				
Probable region of HIV Infection				
Modes of transmission (name and % when possible)				

4.2. Is there a national/regional HIV health plan? If so, does it specify recommendations for migrants? (Please, describe them). Please include links to websites where official documents are available, if any:

5. HIV TESTING AND LINKAGE TO CARE FOR MIGRANTS

5.1. Please describe the HIV testing frameworks for migrants in your country (CBVCT and classical health services).

5.1.1. Are rapid HIV tests used in your country to target high-risk population such as migrants? If so, please describe the framework.

5.2. Regarding HIV testing and linkage to care among migrants, please describe the following issues:

5.2.1 Obstacles and facilitators to HIV testing (CBVCT and classical health services).

5.2.2 Obstacles and facilitators to linkage to care. Specify the linkage to care procedure in your country.

5.2.3 Obstacles and facilitators to continuity of care. Specify the continuity of care procedure in your country.

5.3. Do migrants have access to translation services in your CBVCT? If so, please describe.

5.4. Do migrants have access to translation services in classical health services? If so, please describe.

5.5. Are the translation services available for all migrants or only for those with a positive result?

5.6. In your country, if there are other services/tools to facilitate testing and linkage to care among migrants, please describe them.

6. HIV COMMUNITY-BASED TESTING: THE CBVCTs RESPONSE

6.1. Are there HIV testing services, classical or community-based, targeting migrants? Please, name them and/or indicate how many of each kind.

6.2. In your country, is there a specific communication regarding HIV testing in CBVCT targeted to migrants (brochures, leaflets etc.)?

6.3. Regarding your CBVCT or health institution, are migrants a target group? Please, describe the interventions conducted.

6.3.2. Is there any specific cultural/religious/community-based approach for migrants? If so, please describe.

6.4. In your CBVCT or health institution, if there are no interventions specifically targeting migrants, do the migrants come to your organization? If so, please describe in what kind of interventions they come for.

6.5. What is the proportion of women among the migrants coming to your CBVCT?

6.6. What is the proportion of MSM among the migrants coming to your CBVCT?

6.7. Is there a system for monitoring and evaluating the impact of actions targeting migrants in your CBVCT?

If so, please provide the following data and indicate for what period this information is available:

Number of migrants coming to the CBVCT

Satisfaction with testing

Proportion of HIV positive results among those tested

Proportion of linkage to care among those tested positive

If not, please explain why your CBVCT has no monitoring and evaluation system:

If not, please indicate if you have some information regarding testing and linkage to care among migrants coming to your CBVCT:

7. INVOLVEMENT, ORGANIZATIONS AND KEY INFORMANTS

7.1. Would you say that migrant communities are involved in associative experiences in your country (whatever their objective)?

7.2. Please provide information here regarding the main organizations interested in "HIV".

Name of the organization	Brief description (History, missions, local/regional, size of the organization)	Indicate the migrant group concerned and the language(s) spoken	Specify if the organization was created by migrants or if migrants are only the target population	Indicate the name and contact details of a referent person

7.3. Indicate who are the people who could be considered as "key informants" (advocacy, health system and association representatives) and who should be interviewed regarding HIV testing access and linkage to care among migrants.

Key informants' names	Key informants' contact details	Which organization they belong to?	Why should we conduct an interview with him/her?

Annex B: Data on migrants getting tested (number, satisfaction, proportion of positive, monitoring)

	Data year and monitoring tool	Number of migrants tested for HIV	Number and proportion[107] of migrants tested positive among those tested		Satisfaction after getting tested	Proportion of linkage to care among migrants tested positive
			Nb	%		
Institute Tropical Medicine - Belgium	2014 Intern monitoring tool	259*	New infections: 6 persons Known infections: 4 persons	New infections: 2.3% Known infections: 1,5%	Data not available	Data not available
AIDS Fondet - Denmark	2014 COBATEST evaluation and data base	738	10	1.4%	Data not available	100%
Association AIDES - France	2014 Intern monitoring tool: DOLORES	11 559	New infections: 78 persons Known infections: 14 persons	0.7%	83% very satisfied and 97% of them would recommend it	60%
AIDS- Hilfe NRW e.V. - Germany	*No monitoring tool*					
GAT - Portugal	2014 COBATEST evaluation and data base	437	9	2.06%	Data not available	Confirmed for 44%[108]
LEGEBITRA - Slovenia	2014 Intern monitoring tool with very limited items	13	1	7.7%	Data not available	100% (1 person)
BCN Checkpoint-Hispanosida - Spain	2014 Intern monitoring tool	1527	66	4.3%	Data not available	Data not available
Total		14 533				

* This number concerned only migrants originating from Sub-Saharan Africa

[107] Only revelant proportion are specified

[108] The proportion might be higher since some people have been referred by other health services (for example, by their family doctor).

Annex C: Number or proportion of women and men who have sex with man among the migrants tested for HIV through the VCT's associated partners

	Data year and monitoring tool	Number and/or proportion of women		Number and/or proportion of MSM	
		Number	**%**	**Number**	**%**
Institute Tropical Medicine - Belgium	2014 Intern monitoring tool	234*	42%*	20	8.5%
AIDS Fondet - Denmark	2014 COBATEST evaluation and data base	X	22%	X	50%
Association AIDES - France	2013 Intern monitoring tool: DOLORES	3493	29%		
GAT - Portugal	2014 COBATEST evaluation and data base	X	36%	X	10%

*This number and proportion not concerned migrant women but specifically Sub-Saharan women

N.B:

- **BCN Checkpoint (Spain)** and **Legebitra (Slovenia)** are only addressed to MSM population.
- No data where furnished by **Aidshlife NRW (Germany).** Aidshlife NRW is mostly dedicated for MSM and a very small amount of women come to the organization. Men migrants coming to the organization are mostly MSM (exceptions for male sexworkers or some heterosexual mean who rely more on the CBVCT services than other services).

Annex D: Different representations and images associated with the terms "migrants, foreigners and immigrants" among participating country

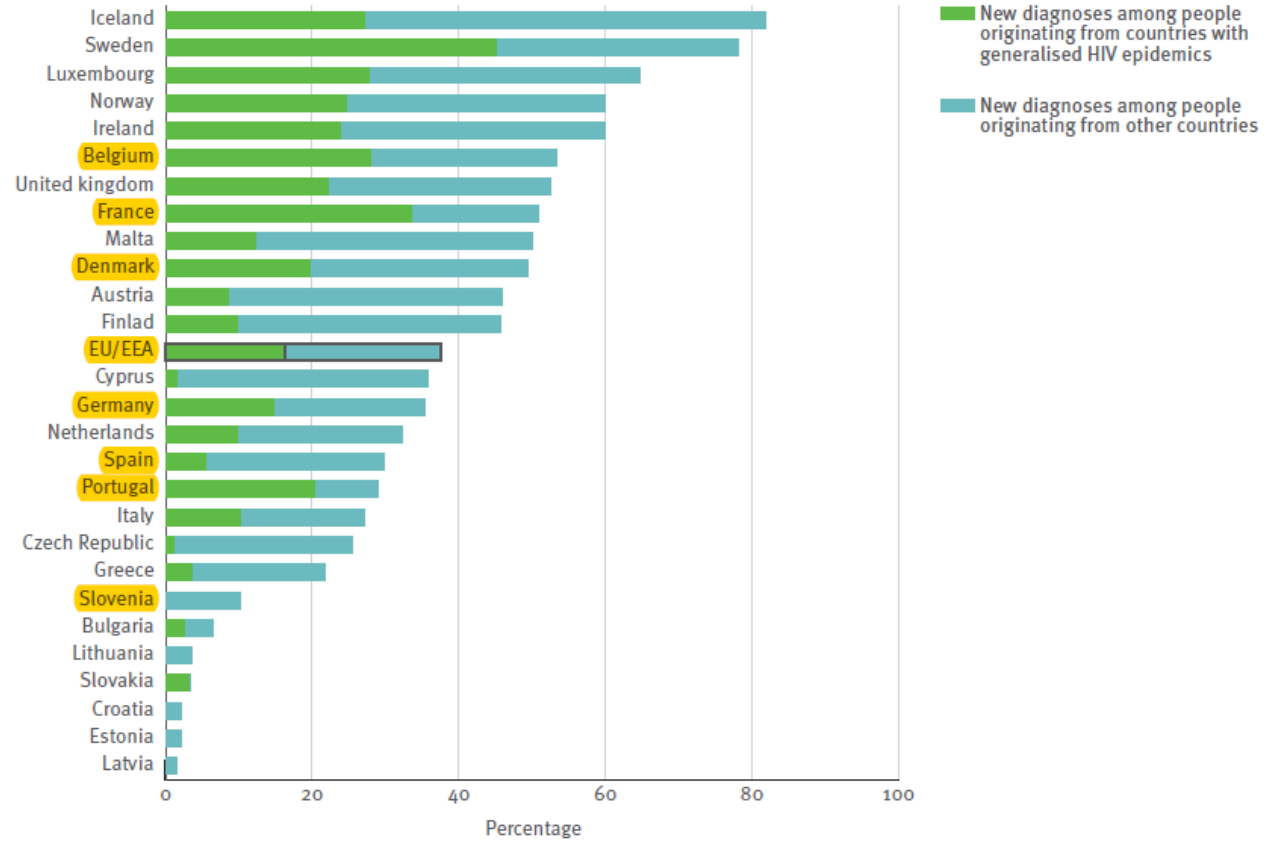
	''Migrants''	''Foreigners''	''Immigrant''	Exceptions
Belgium	Non national voluntary migration	Non national voluntary migration	Non national voluntary migration	**Undocumented** : illegal migrants **Allochtones** : people with foreign origin
Denmark	Voluntary migration (work, marriage, etc…) or to get married, 2nd generation migrants	Non national	Non national people which do not look like West European people	The Danish language has a lot of words to describe migrants. "Ethnic minority" is largely used.
France	Non national (academical dimension), voluntary migration	Non national voluntary migration	Non national voluntary migration (or illegal)	**Refugee/exile** : involuntary migration due to political issues in the country of origin **Undocumented** : illegal migrants
Germany	Non national, voluntary migration (work)	Non national	Rarely used	**Refugee/exile** : involuntary migration due to political issues in the country of origin **Undocumented**: Persons who enter undocumented or further stay in Germany if their papers run out ***« People with migration background »***: (social sciences) people born abroad or with at least one parent born abroad
Portugal	Non national (academical dimension)	Tourists, migrants with high social status non-national workers	Non national, voluntary migration or illegal coming from countries in development	Refugees and asylum seekers are considered a different kind of migrants, but with no prejudice attached.
Slovenia	Non national, voluntary migration provisional)	Person who visit the country for a short period of time	Non national, voluntary migration (definitive)	The Slovene language has a lot of words to describe migrants: "Priseljenci" (immigrants), "migranti" (migrants), "begunci" (migrants)…
Spain	Non national (academical dimension)	Tourists or migrants with high social status	Non national, voluntary migration or illegal	

Source: Nationals reports

- **Blue**: positive/neutral connotation
- **Red** : negative connotation

Annex E: New HIV diagnoses among migrants on EU/EEA countries

Figure 1.6: Percentage of new HIV diagnoses among migrants out of all reported cases with known information on region of origin, by country of report, EU/EEA, 2014 (n=25 525)



One or no cases were reported in 2014 among people born abroad by Hungary, Liechtenstein, Poland and Romania.

Source: European Centre for Disease Prevention and Control, WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2014.

Annex F: HIV cases diagnoses in 2014 in partners countries by country of report and region of origin

Country partners	Country of report		Sub-saharan African		Latin America and Carribean		Other region[109]		Unknown		Total	
	Nb	%	Nb	%	Nb	%	Nb	%	Nb	%	Nb	%
Belgium	353	34%	214	**21%**	34	**3%**	156	15%	282	27%	1039	100%
Denmark	129	50%	51	**20%**	6	**2%**	69	27%	1	0%	256	100%
France	1366	32%	940	**22%**	179	**4%**	295	7%	1547	36%	4327	100%
Germany	2111	60%	487	**14%**	69	**2%**	598	17%	260	7%	3525	100%
Portugal	581	63%	169	**18%**	51	**6%**	18	2%	101	11%	920	100%
Spain	2287	68%	185	**6%**	508	**15%**	276	8%	110	3%	3366	100%
Slovenia	44	90%	0	**0%**	1	**2%**	4	8%	0	0%	49	100%
Total	6871	51%	2046	**15%**	848	**6%**	1416	11%	2301	17%	13482	100%
EU/EEA	15945	53%	4139	**14%**	1490	**5%**	3951	13%	4467	15%	29992	100%

Source: ECDC, WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2014

[109] Other region refers to among others to Western Europe, Central and Eastern Europe, South and South-East Asia. Data specific to this region can be founded in the HIV/Aids surveillance 2014 report.

Annex G: Table: Epidemiology and clinical characteristics of the most affected migrant population among participating country

	France			Belgium			Denmark			Spain		Germany		
Date sources	**2011**			**2013**			**2015**			**2013 if not specified otherwise**		**2015 if not specified otherwise**		
Groups	**Sub Saharan Africa**			**Sub Saharan Africa**			**Sub Saharan Africa**			**Sub Saharan Africa**	**Latino-American**	**Sub Saharan Africa**		
Characteristics	**F**	**M**	**Total**	F	M	**Total**	**F**	**M**	**Total**	**Total**	**Total**	**F**	**M**	**Total**
Number of new cases among SSA and/or Incidence VIH (%)	X	X	0.27% (270 pour 100 000)	X	X	X	27 0.02%	16 0.01%	43 0.02%			328	236	565
Prevalence VIH (%)	X	X	X	3%	6.1%	4.75%	7.3%	3.6%	5.5 %	5.4% (2000-2010) 3.9% (2010)	3.2% (2000-2010) 4.9% (2010)	3127	2265	5502
Late diagnosis (%)	56.4%	61.8%	X	X	X	50%	66%	67%	66%	51.9%	49.4%	No gender-specific data : 66.5% (cumulative data 2001-2015)		
Viral load at the moment of diagnosis (median and/or average)	X	X	X	X	X	X	Md : 37000 Avg : 204000	Md : 78000 Avg : 400000	Md : 47000 Avg : 270000	X	X	Md: 28590 Avg : 261446.76	Md: 67794.50 Avg : 542031.33	Md: 40000 Avg : 381866.33
												(cumulative data 1993-2015)		
CD4 counts at the moment of diagnosis (median and/or average)	<200 : 5.1% 200-349 : 16% 350-499 : 26.6% >500 : 52.3%	<200 : 4.9% 200-349 : 24.7% 350-499 : 35.6% >500 : 34.8%	X	X	X	X	Md : 280 Avg : 310	Md : 260 Avg : 290	Md : 270 Avg: 305	X	X	Md: 250 Avg : 333.73	Md: 240.50 Avg : 282.06	Md: 246.50 Avg : 311.29
												(cumulative data 1993-2015)		
Age (median) of PLWHIV	33 [28-38]	38 [32-45]	X	X	X	X	29	36	32	X	X	31 (cumulative data 2001-2015)		
Probable region of HIV Infection	Region of origin : 59.5% France : 20% Inconnu: 20.5%	Region of origin : 54.5% France : 19.1% Inconnu: 26.4.	X	No gender specifi data: Africa: 50% Belgium: 10% Europe (excluding Belgium): 2% Unknown: 32%			X	X	X	Region of origin: 41% Spain: 14% (2003 – 2004)	Region of origin: 18% Spain: 39% (2003 – 2004)	No gender specifi data: Region of origin: 82,1 % North Africa/Middle East: 1,65 % Germany: 13,79 % Western Europe: 2,47 %		

Modes of transmission (%):						*No gender specific data*
Heterosexual	90%	75%	85%	87.4%	28.1%	94.8%
MSM	NC	10%	3%	1.1%	62.2%	2.7%
Vertical transmission	0.4%	0.4%	0.4%	1.6%	0%	X
IDU				0%	0.4%	0.2%
Others	9.6%	14.6%	11.6%	0.5%	0.2%	X
Unknown				9.3%	9.1%	X

Sources:

France: Agence nationale de santé publique (InVS) BEH n°26-27 7 juillet 2013(2013)

Belgium: Institute Public Health (2013), Loos et al. (2014): HIV prevalence among sub-Saharan African migrants in Antwerp City. Oral presentation at the 3rd BREACH symposium, Brussels, 21/11/2014.

Denmark: National surveillance, National statistics bureau (2015)

Spain: EPI-VIH studies (2000-2010), National Information system of new HIV diagnoses (2013), National register of AIDS cases.

Germany: Statutory HIV surveillance data by Robert-Koch-Institute (2015)

Focus on Portugal:

In 2014, 17% of HIV infection new cases are in migrants, 67% of which are from Sub-Saharan Africa. 79% of new infections in migrants were in the Lisbon area and Setúbal.

Data is not desegregated by country, gender or stage of the disease. There are samples showing that heterosexual man tend to arrive with late diagnosis, more than women, probably due to the universal screening among pregnant women