HIV and Hepatitis Surveillance trends in the EU/EEA

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HepHIV 2017
31 JANUARY-2 FEBRUARY, MALTA

Overview

- The latest EU surveillance data

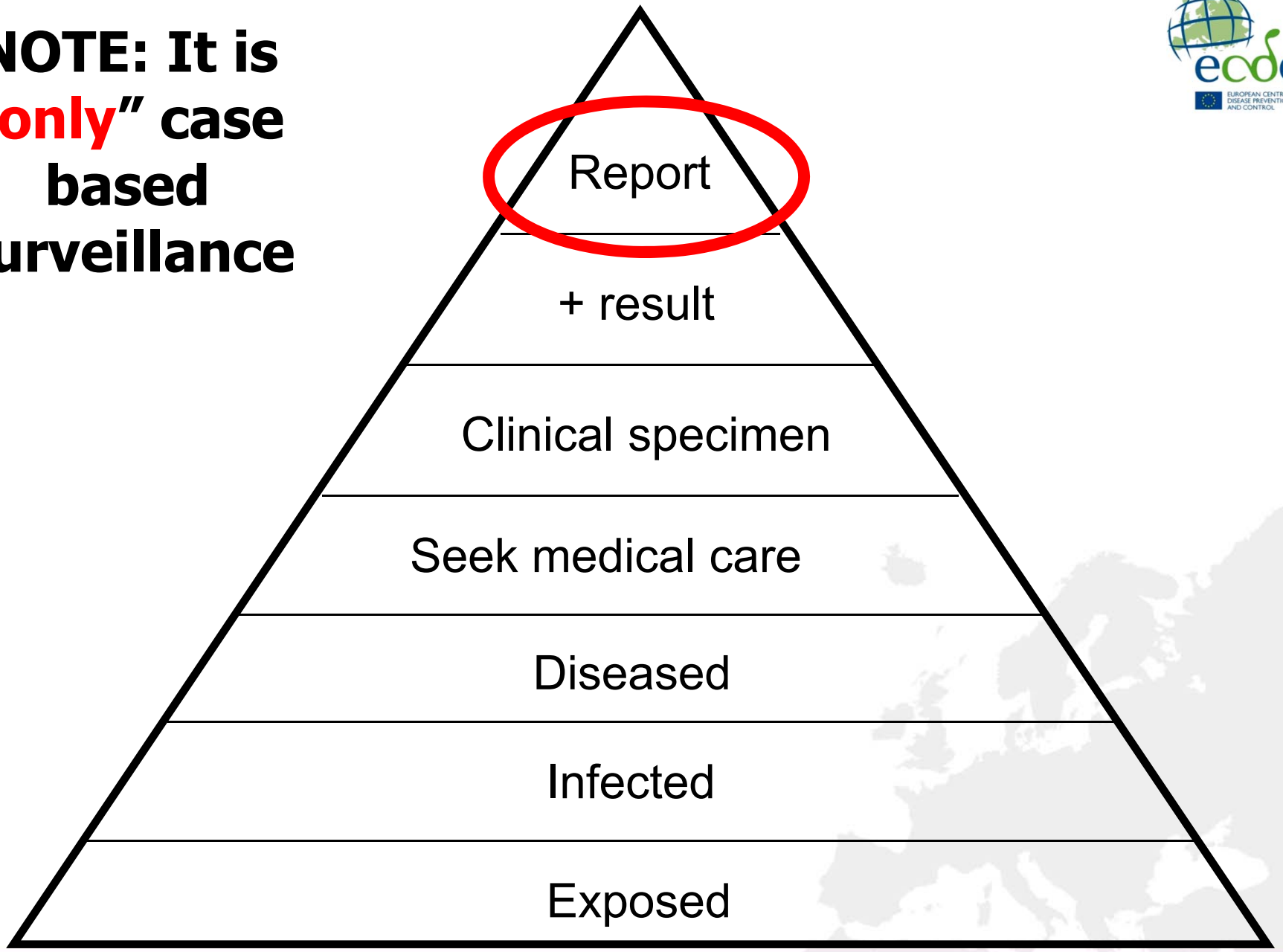
  HIV trends (2015 surveillance and 2016 Dublin Monitoring data)

  Hepatitis B and C trends (2015 surveillance and prevalence studies)

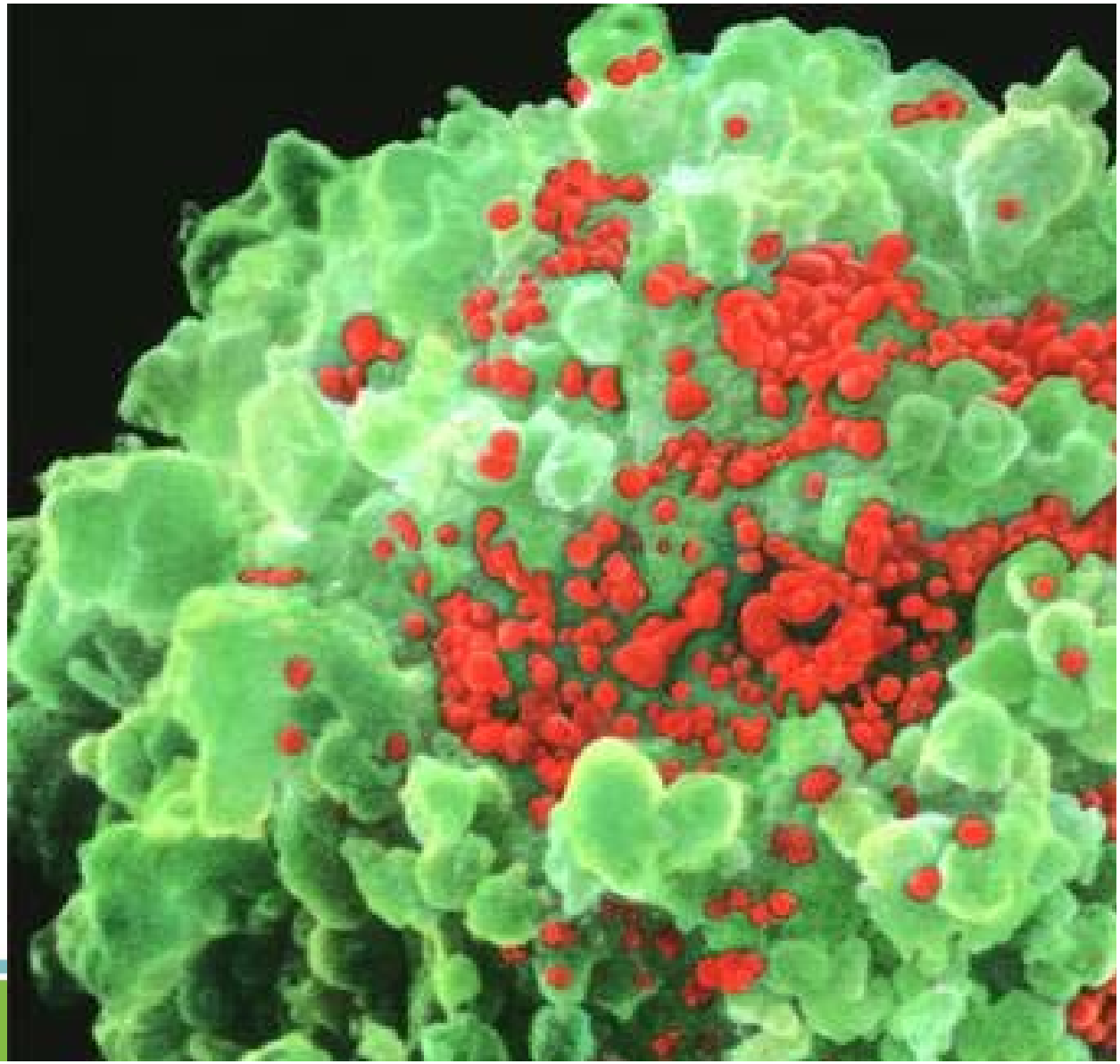
  Some conclusions

- Feedback from the Presidency conference

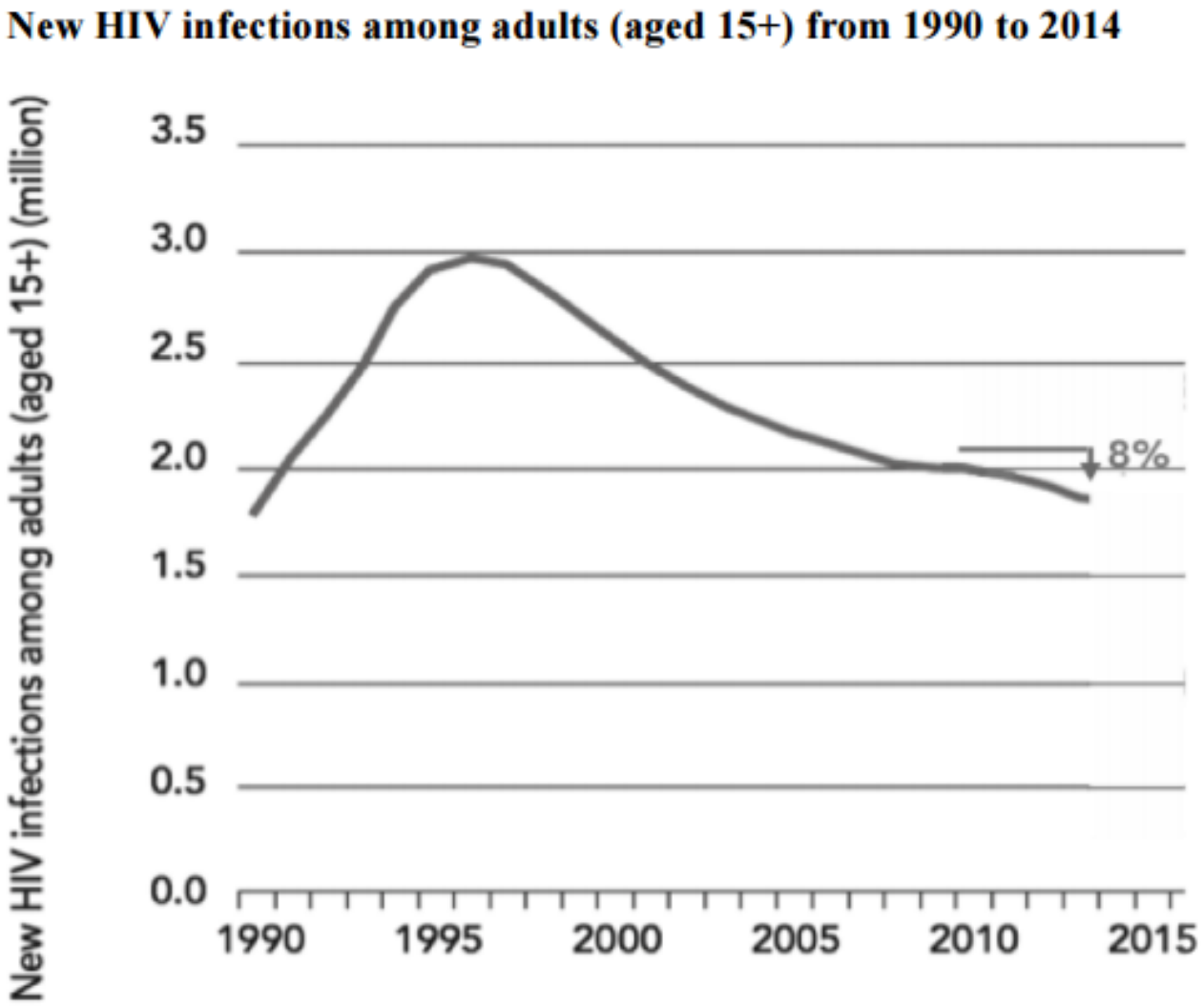
NOTE: It is "only" case based surveillance



HIV

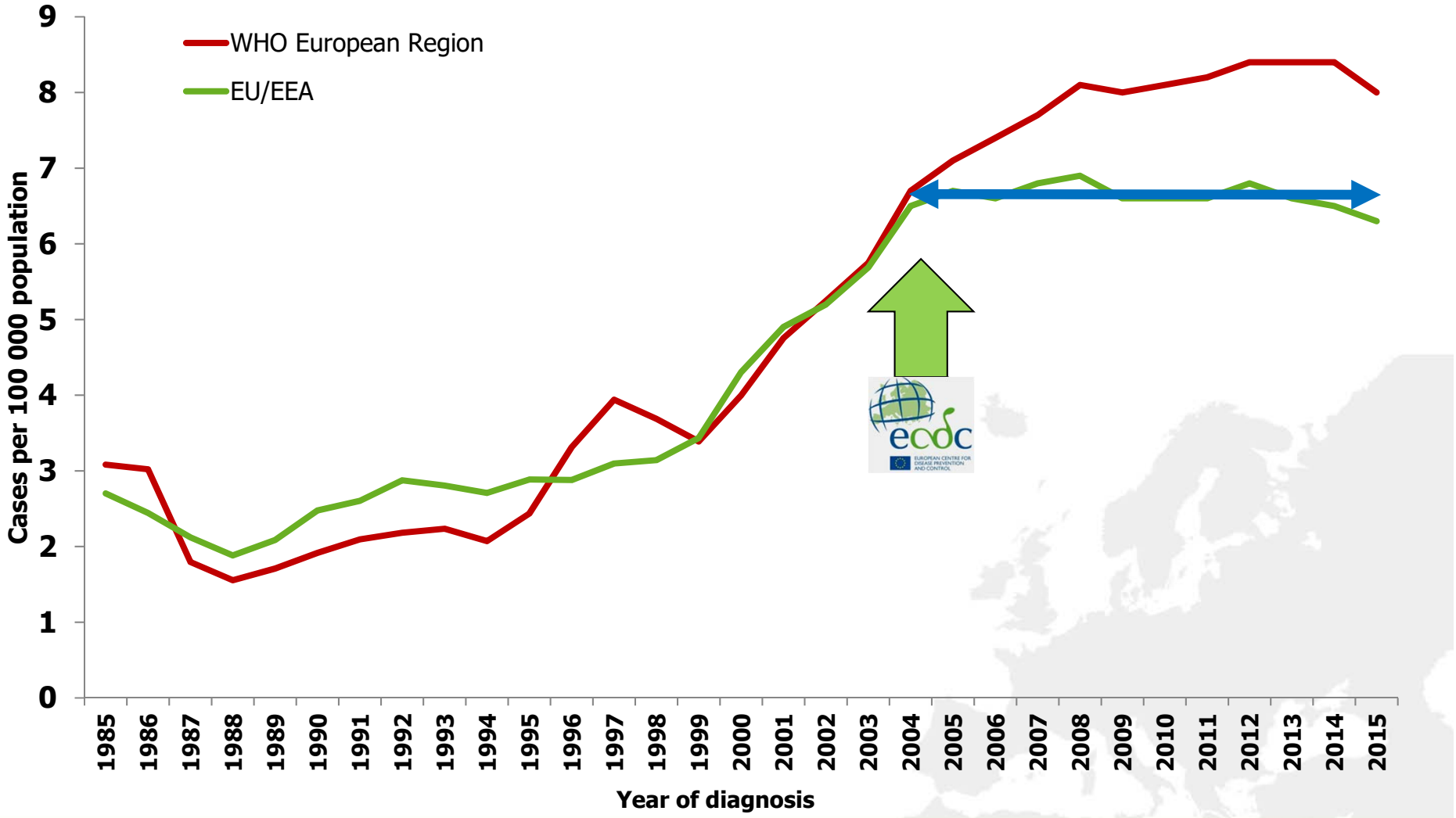


Global HIV trends



Source: On the fast track to ending the AIDS epidemic Report of the Secretary-General April 2016

HIV trends in Europe



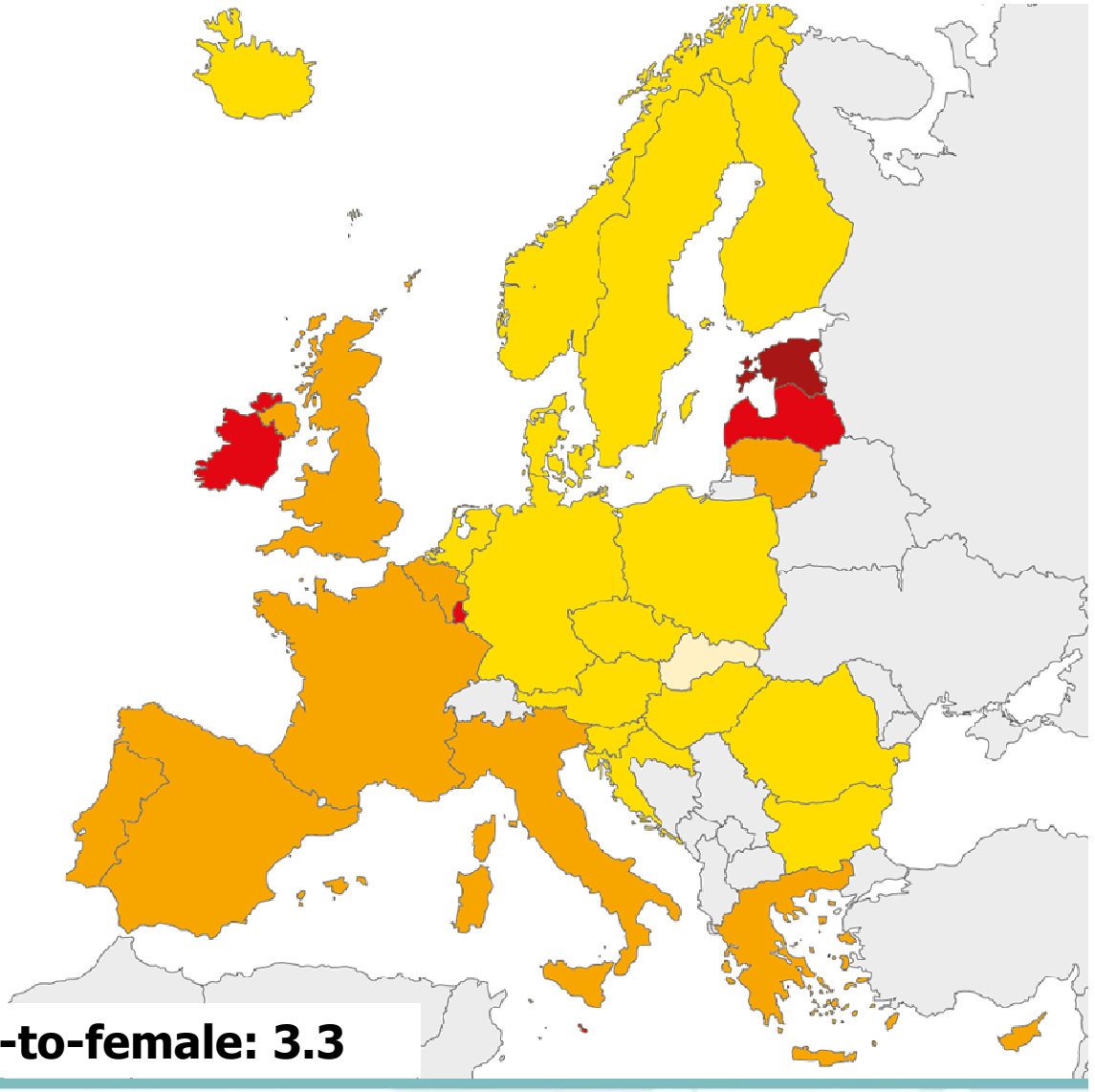
Source: ECDC/WHO (2016). HIV/AIDS Surveillance in Europe, 2015

29 747 new HIV diagnoses reported in EU/EEA, 2015

World Health Organization
REGIONAL OFFICE FOR Europe
ecdc
EUROPEAN CENTRE FOR DISEASE PREVENTION AND CONTROL

Rate per 100 000 population

- < 2
- 2 to <5
- 5 to <10
- 10 to <20
- ≥ 20
- Not included or not reporting



EU/EEA rate 6.3 per 100 000*

Non-visible countries

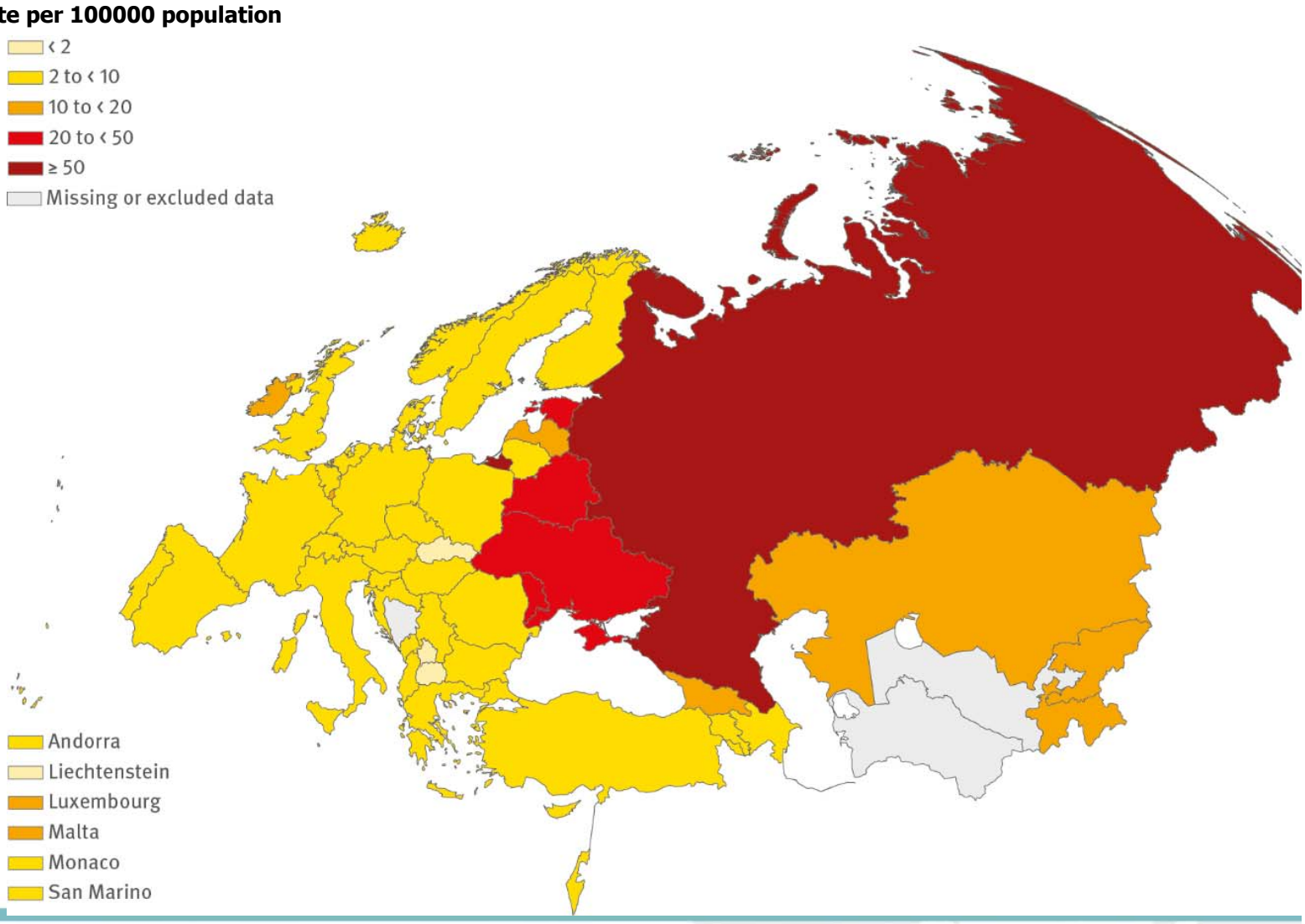
- Liechtenstein
- Luxembourg
- Malta

Male-to-female: 3.3

Source: ECDC/WHO (2016). HIV/AIDS Surveillance in Europe, 2015

* adjusted for reporting delay

153 000 New HIV diagnoses reported in the WHO Region, 2015

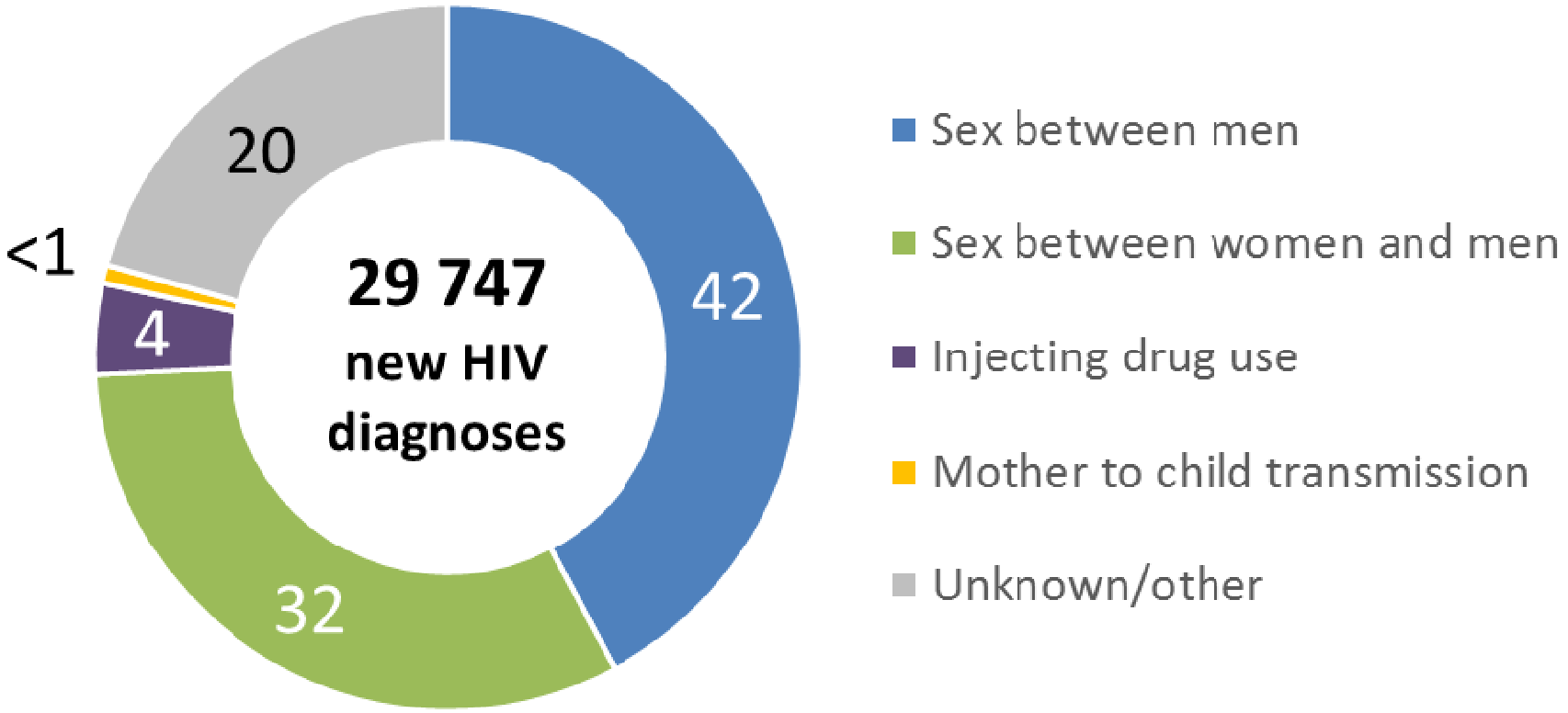


Rates per 100 000 pop.

West	**6.3**
Centre	**2.8**
East	**47.5**

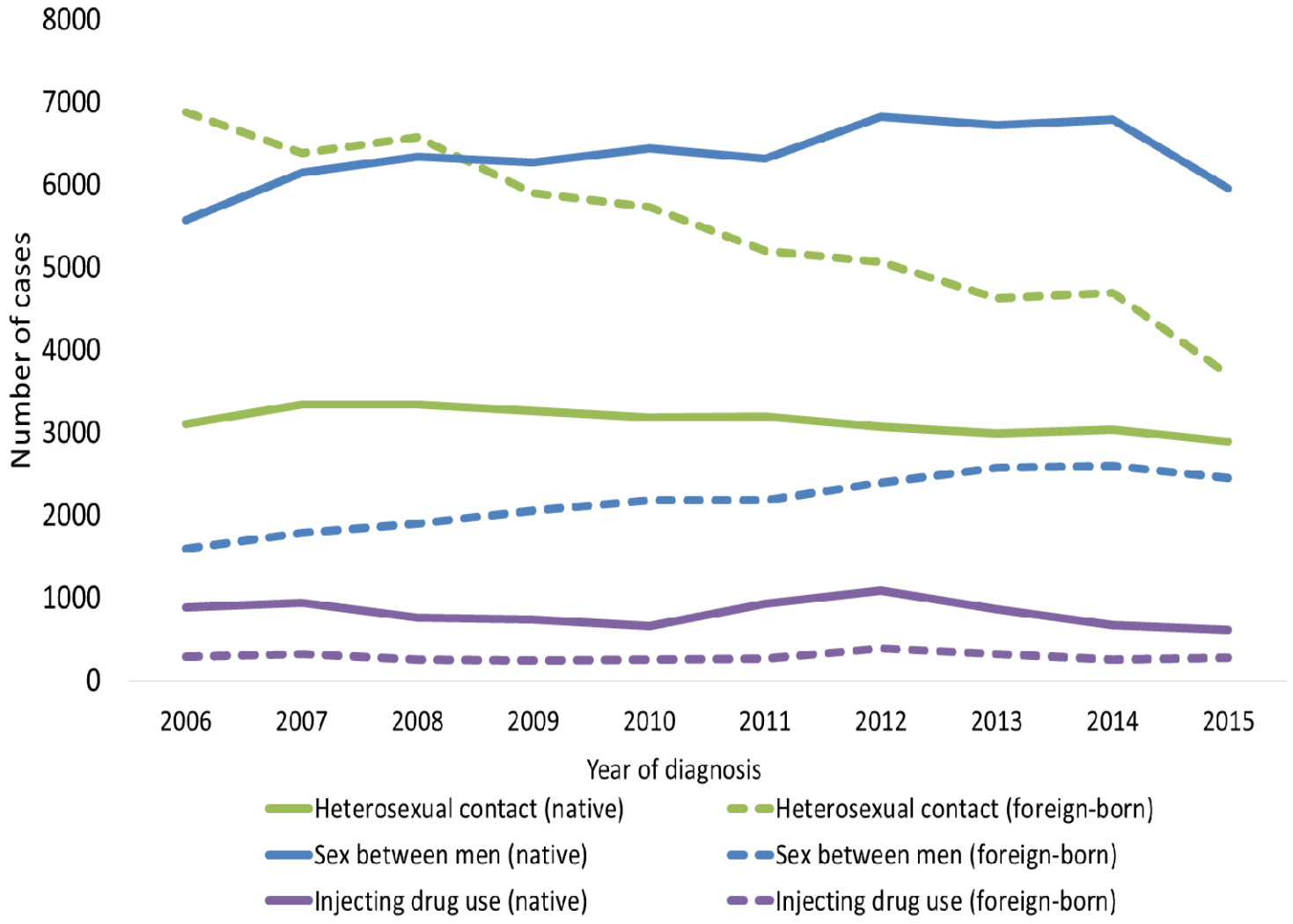
Source: ECDC/WHO (2014). HIV/AIDS Surveillance in Europe, 2013

Reported HIV by route of transmission, 2015, EU/EEA



Source: ECDC/WHO (2016). HIV/AIDS Surveillance in Europe, 2015

HIV diagnoses, by transmission mode and migration status, 2006-2015, EU/EEA



Source: ECDC/WHO (2016). HIV/AIDS Surveillance in Europe, 2015

Note: Data is adjusted for reporting delay. Cases from Estonia, Italy, Poland, Spain excluded due to inconsistent reporting over the period

Late diagnosis of HIV is still commonly reported

In the EU/EEA

47%

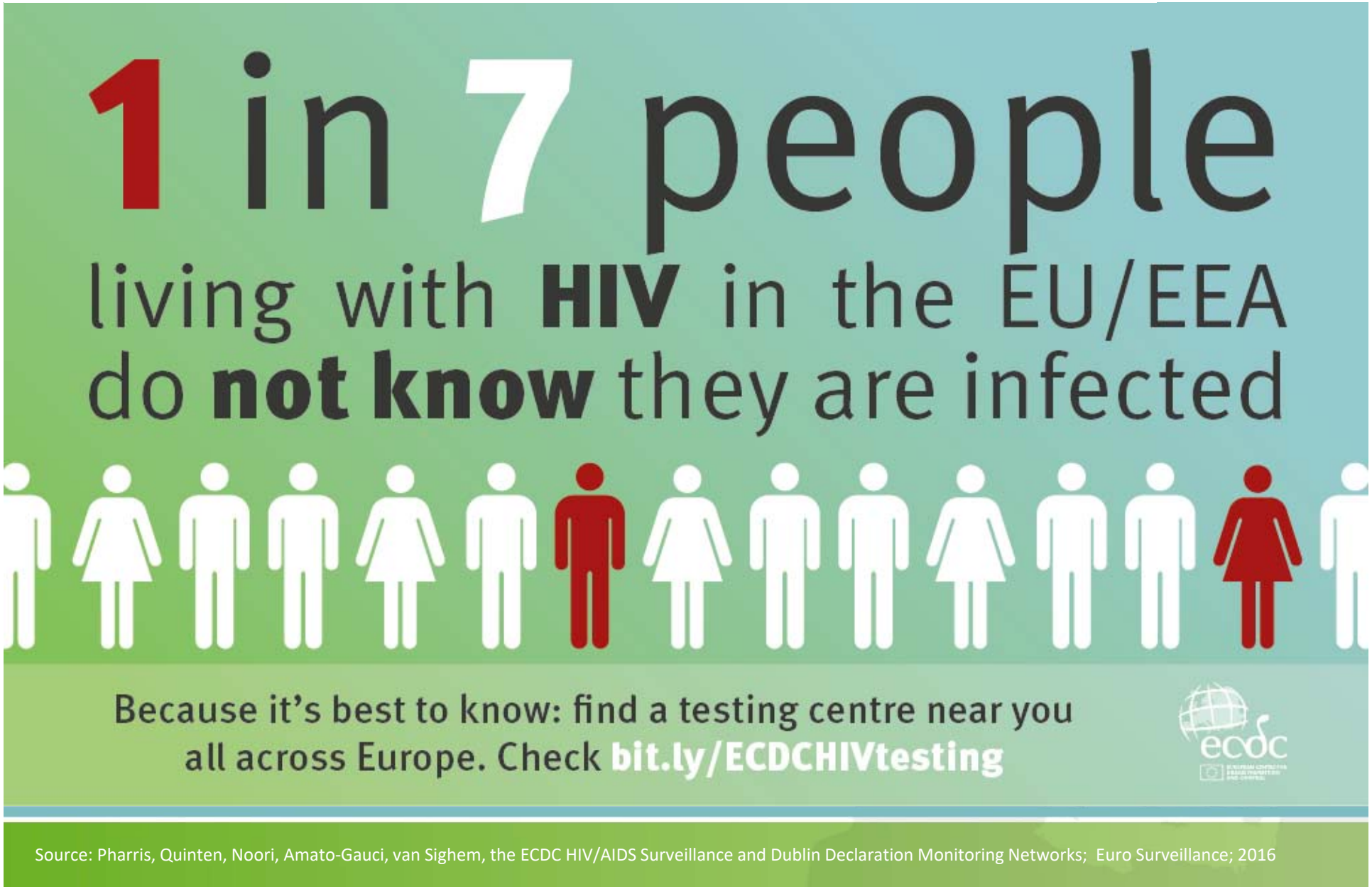
of those with a CD4 count reported are diagnosed late

Source: ECDC/WHO (2016). HIV/AIDS Surveillance in Europe, 2015

*CD4<350 at diagnosis

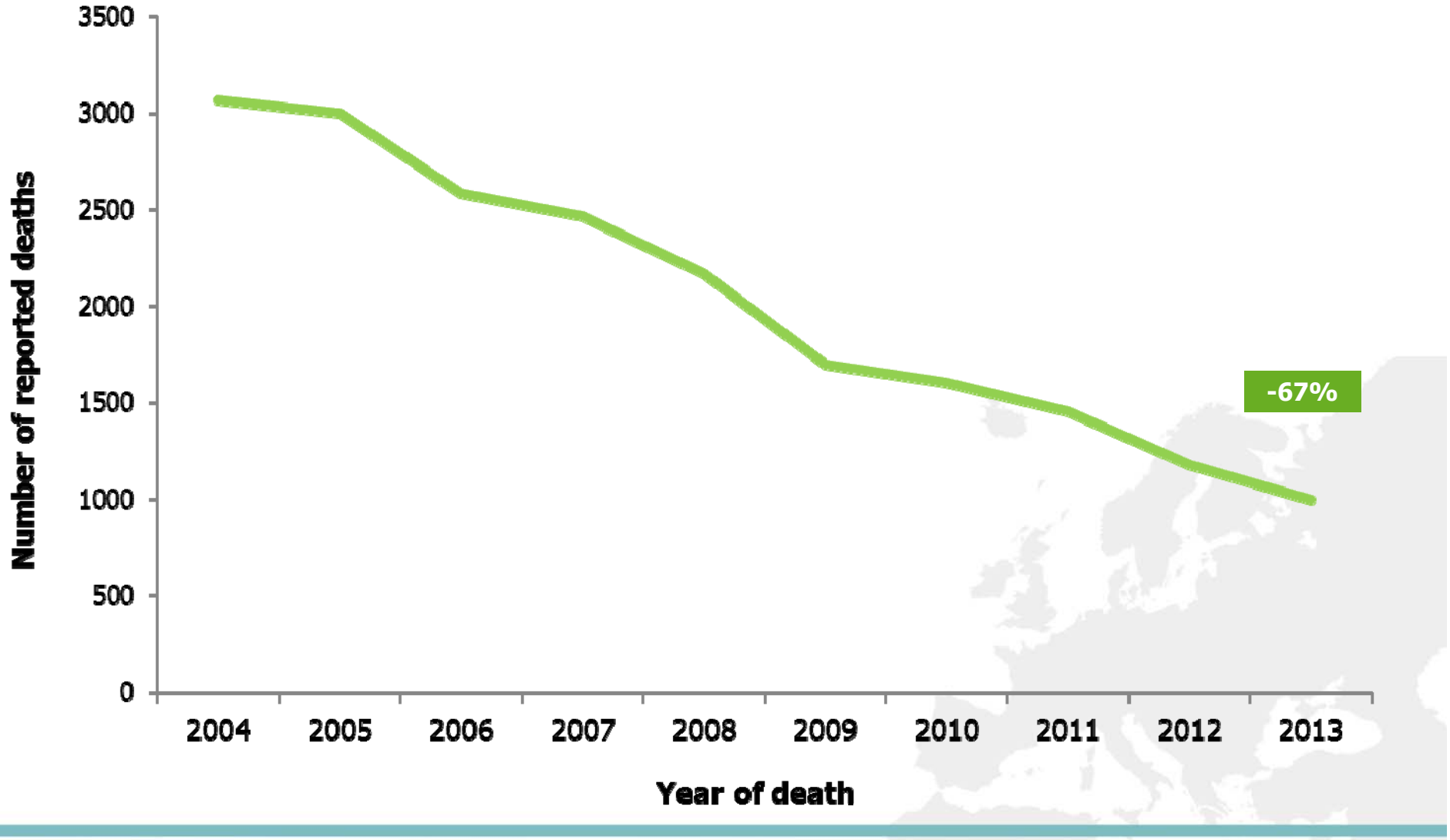
ECDC HIV Modelling Tool findings:

'Incidence Method', a CD4 cell count-based back-calculation



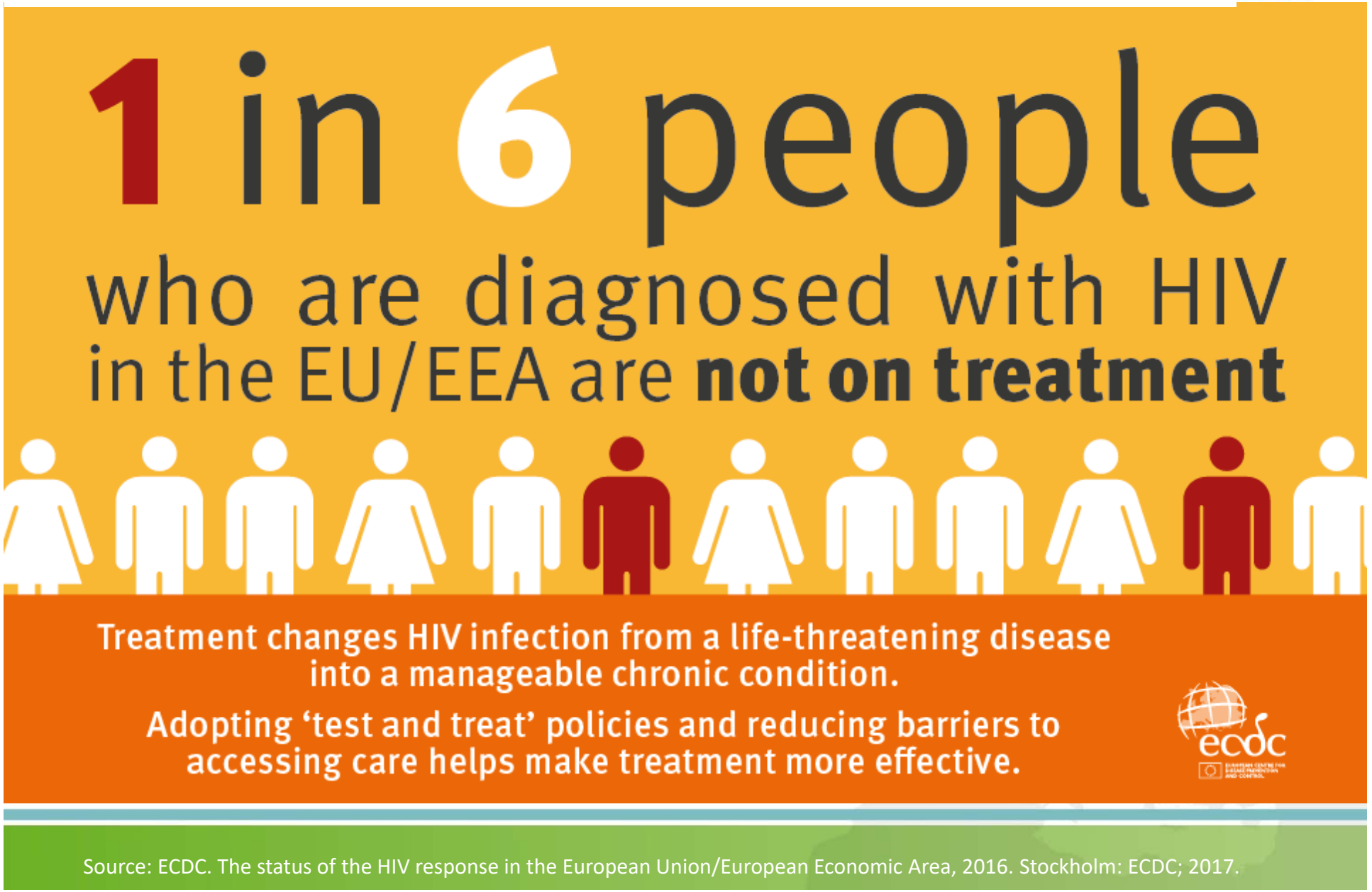
Source: Pharris, Quinten, Noori, Amato-Gauci, van Sighem, the ECDC HIV/AIDS Surveillance and Dublin Declaration Monitoring Networks; Euro Surveillance; 2016

AIDS related deaths, EU/EEA, 2004-2013



Source: ECDC/WHO. HIV/AIDS Surveillance in Europe, 2014;
Note: Data from Italy and Sweden excluded due to incomplete reporting on death during the period

ECDC Dublin Monitoring findings:
Estimates of EU/EEA PLHA not on treatment, 2016



Source: ECDC. The status of the HIV response in the European Union/European Economic Area, 2016. Stockholm: ECDC; 2017.

Conclusions

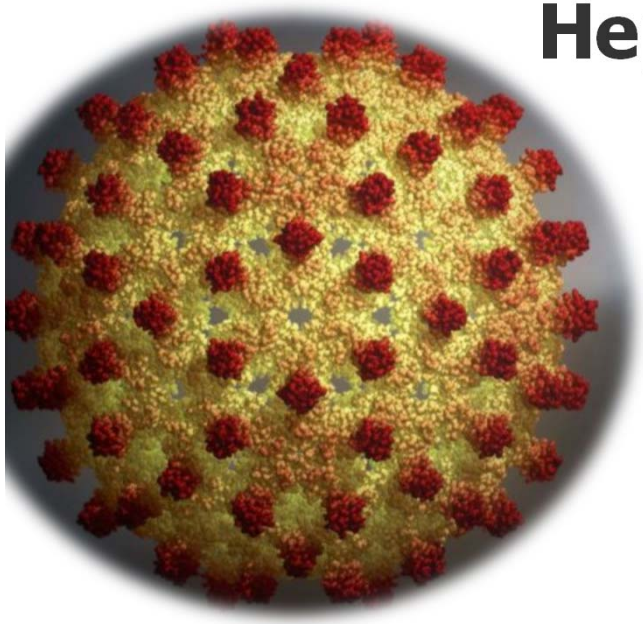
Although preventable through public health measures, significant HIV transmission continues in the EU/EEA

- During the past decade (2006-2015) in the EU/EEA:

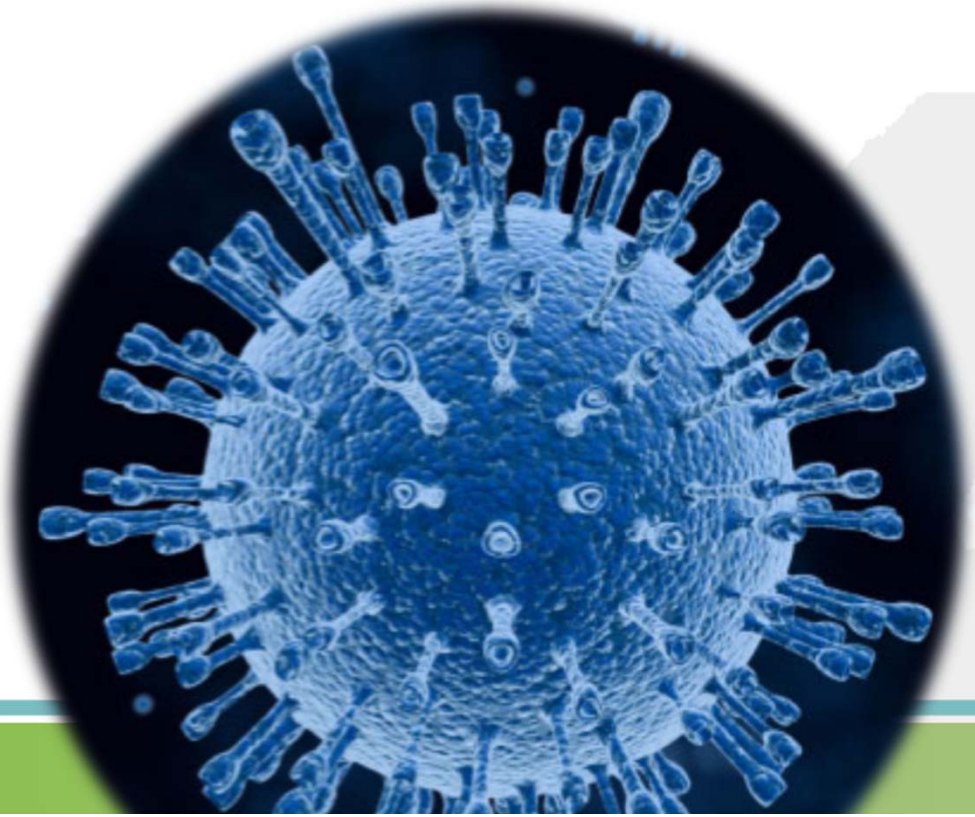
  - Sex between men accounted for the majority of cases diagnosed in 2015 (42%) and is the only group where HIV infections have increased
  - Heterosexual cases declined, driven by a decline among those from countries with generalised HIV epidemics
  - Still, 37% of HIV diagnoses in 2015 were among people originating from outside the reporting country
  - HIV cases attributed to injecting drug use continued to decline over the last decade, despite some localised outbreaks
  - Testing opportunities need to improve - nearly half (47%) of those diagnosed in 2015 were diagnosed late (CD4 cell count of <350/mm3 at diagnosis).

Source: ECDC/WHO (2016). HIV/AIDS Surveillance in Europe, 2015

Hepatitis B



Hepatitis C



Limitations of the data

- Due to the largely **asymptomatic** nature of hepatitis infections, data are strongly correlated to local testing practices

- Challenges remain implementing **standard case definitions** - different case definitions used by countries (despite there being an official EU definition)

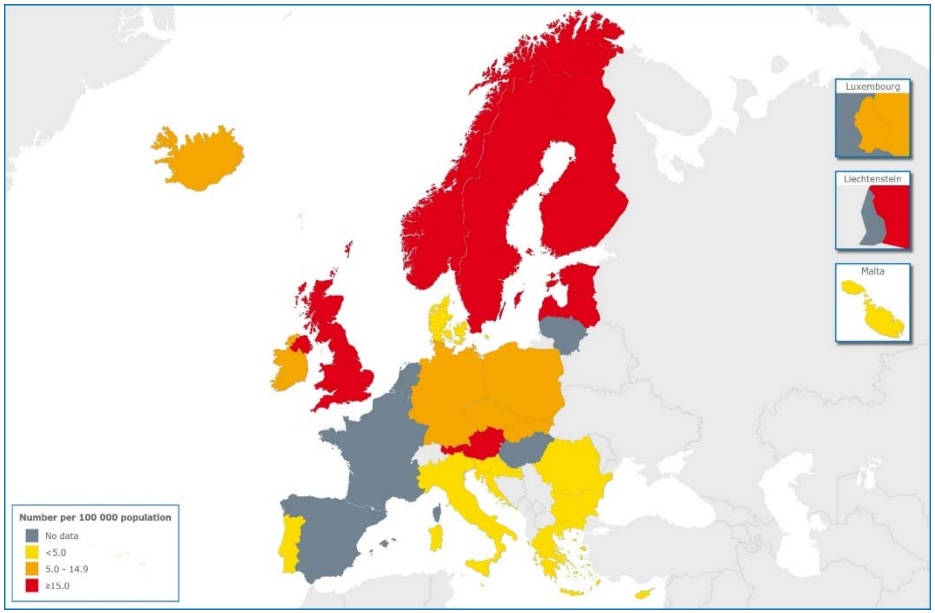
- Data **completeness** low for many variables:

  Transmission, genotype, complications, country of nationality, Co-infection (HCV status for HBV cases and vice-versa), HIV status, Occupational hazard (sex worker, healthcare worker, etc)

- **Under-reporting major issue** for some countries

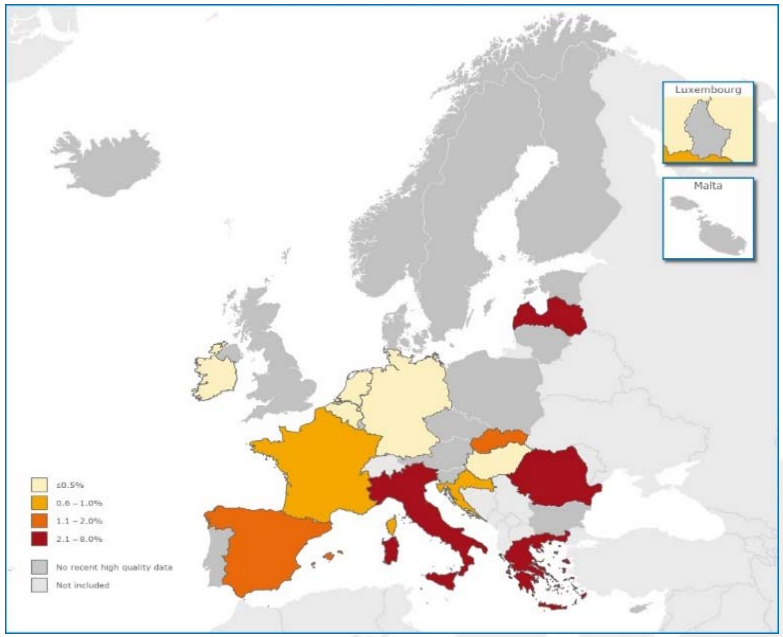
Notification rate and prevalence of chronic HCV infection, EU/EEA

Rate of reported HCV cases*, 2015



*Countries included if their surveillance systems captured data on both acute and chronic cases.

Prevalence of HCV infection*, 2005-2015



*HCV infection was defined as presence of anti-HCV antibodies in serum, blood or saliva

34 651 cases (8.6 cases per 100 000)

- 346 (1%) Acute
- 4 394 (13%) Chronic
- 24 087 (70%) Unknown/unspecified

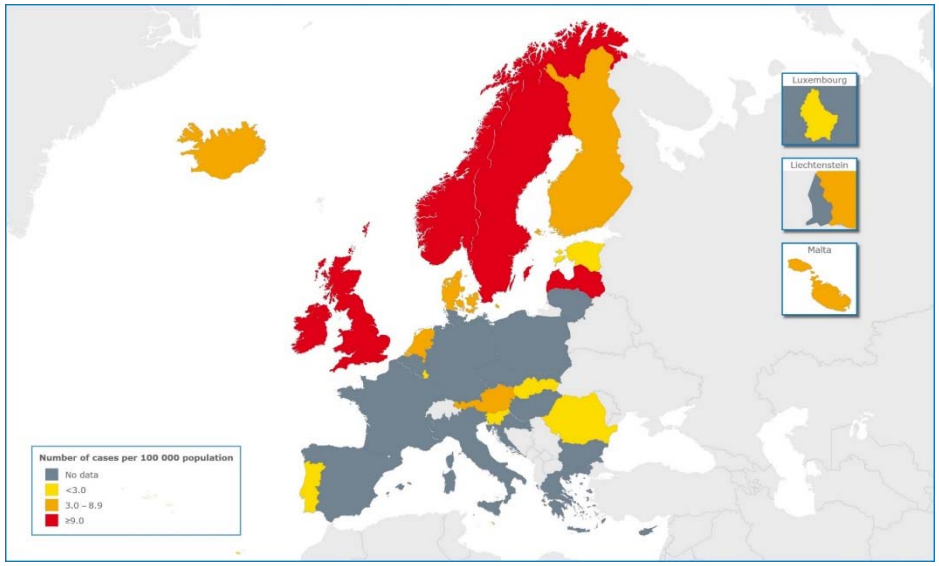
1.1% (95% CI: 0.9–1.4),

5.6 million anti-HCV positive individuals

Source: ECDC. Systematic review on hepatitis B and C prevalence in the EU/EEA. 2016.
ECDC. Surveillance of hepatitis B and C in the EU/EEA, 2015. 2016

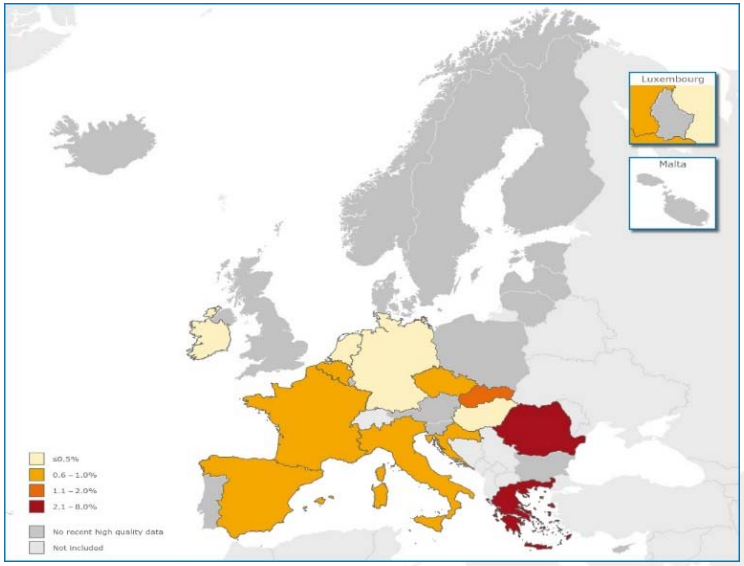
Notification rate and prevalence of chronic HBV infection, EU/EEA

Rate of reported chronic HBV cases*, 2015



*Data for UK exclude Scotland

Prevalence of chronic HBV infection*, 2005-2015



* Chronic HBV infection was defined as presence of HBsAg in serum or blood

24 573 cases (4.7 cases per 100 000)

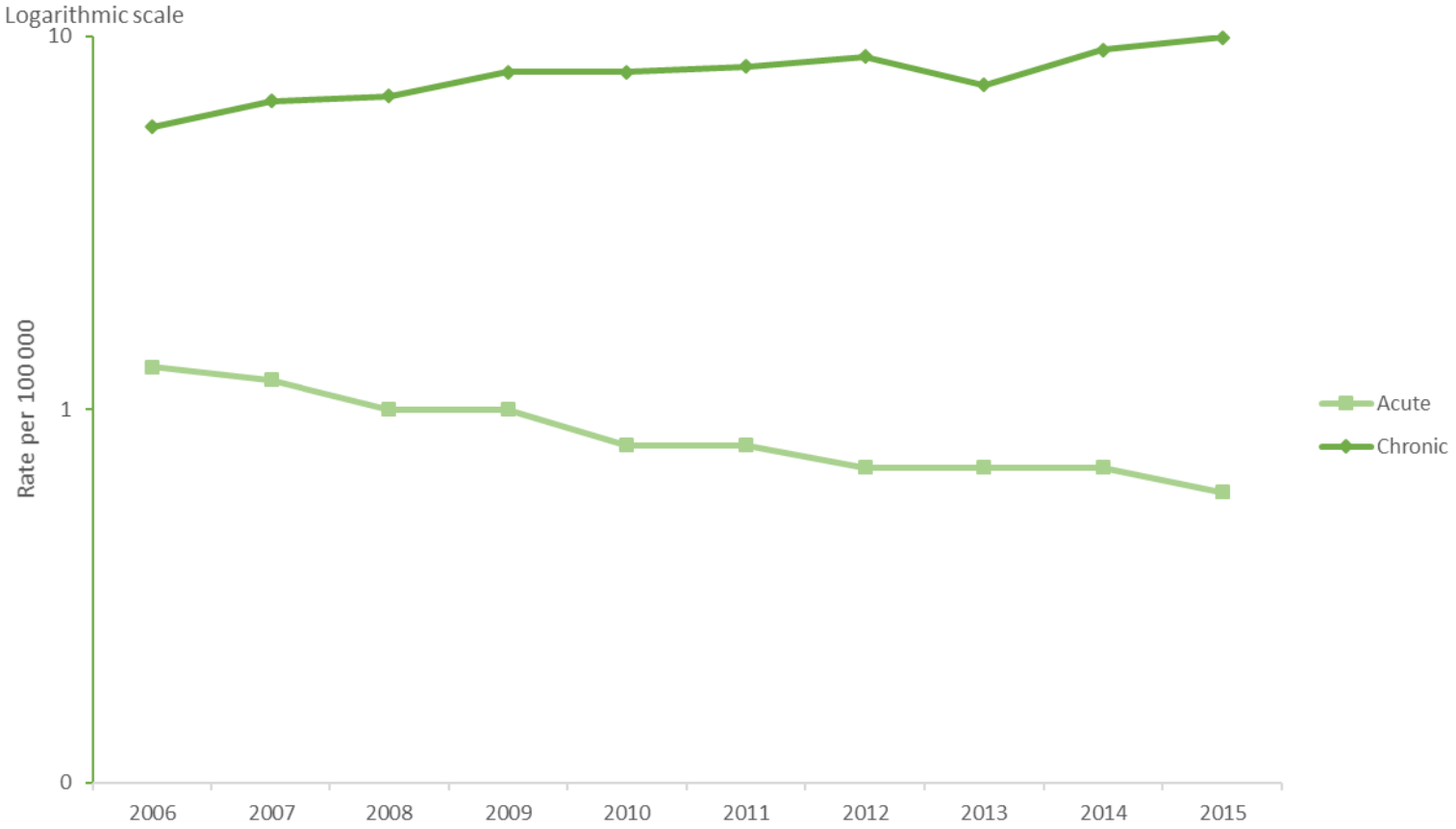
- Acute: 2 505 (10%)
- Chronic: 15 595 (64%)
- Unknown: 4 777 (20%)

0.9% (95% CI: 0.7–1.2)

4.7 million HBsAg positive individuals

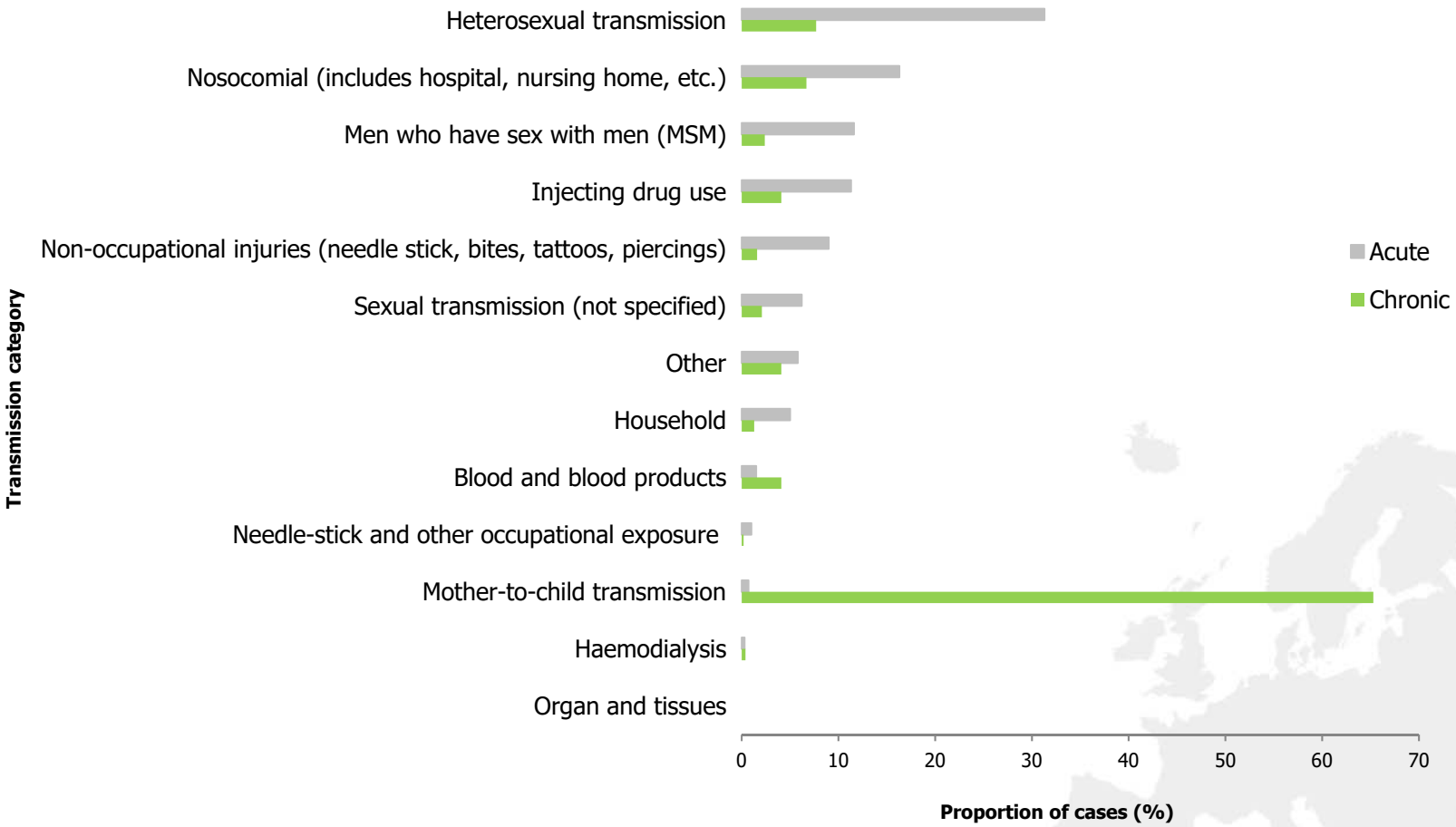
Source: ECDC. Systematic review on hepatitis B and C prevalence in the EU/EEA. 2016.
ECDC. Surveillance of hepatitis B and C in the EU/EEA, 2015. 2016

Rates of acute plus chronic hepatitis B in EU/EEA countries, 2006-2015



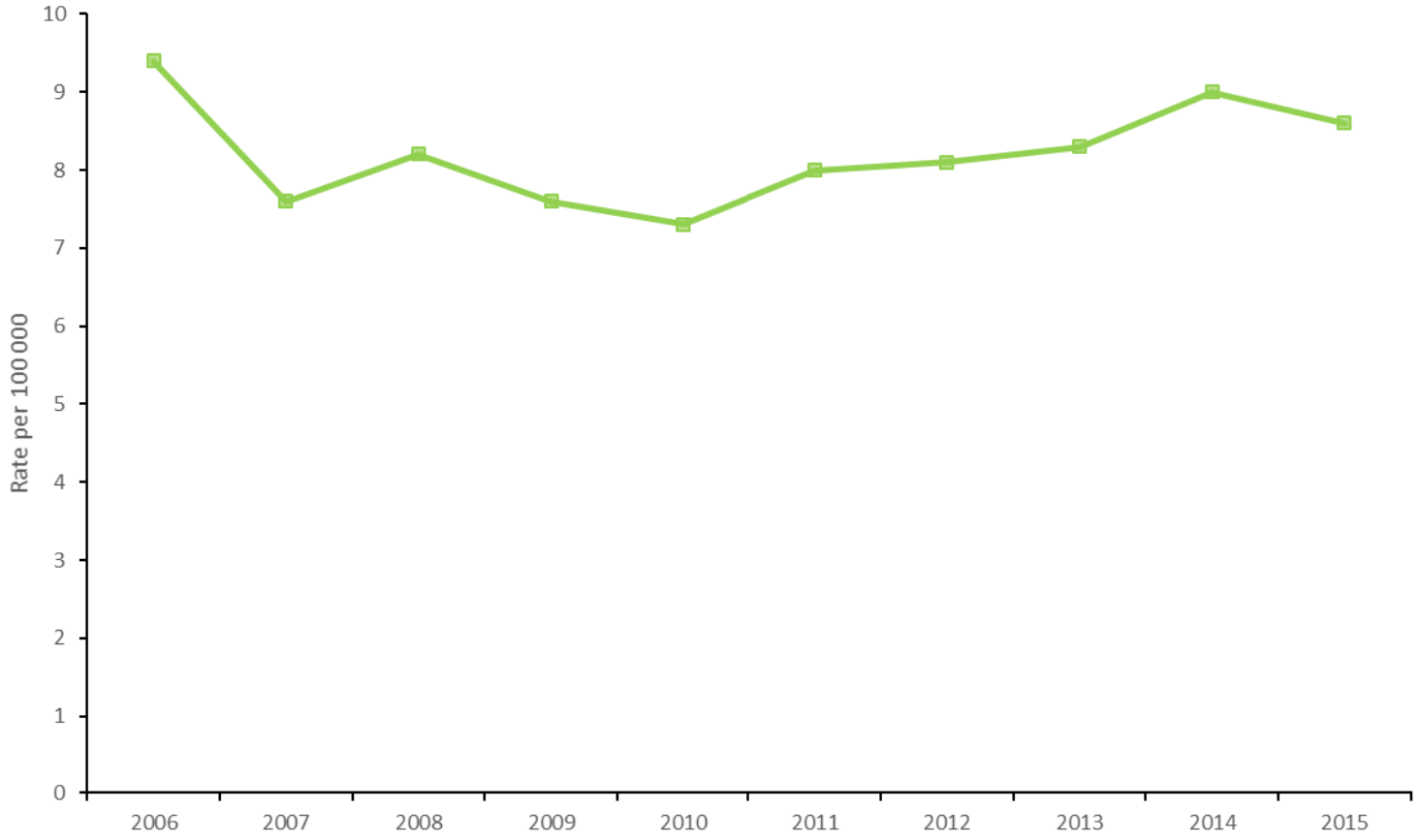
Source: Country reports from: Austria, Bulgaria, Cyprus, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, and the United Kingdom (Note that UK data exclude Scotland).

Reported transmission category for acute and chronic hepatitis B cases, 2015



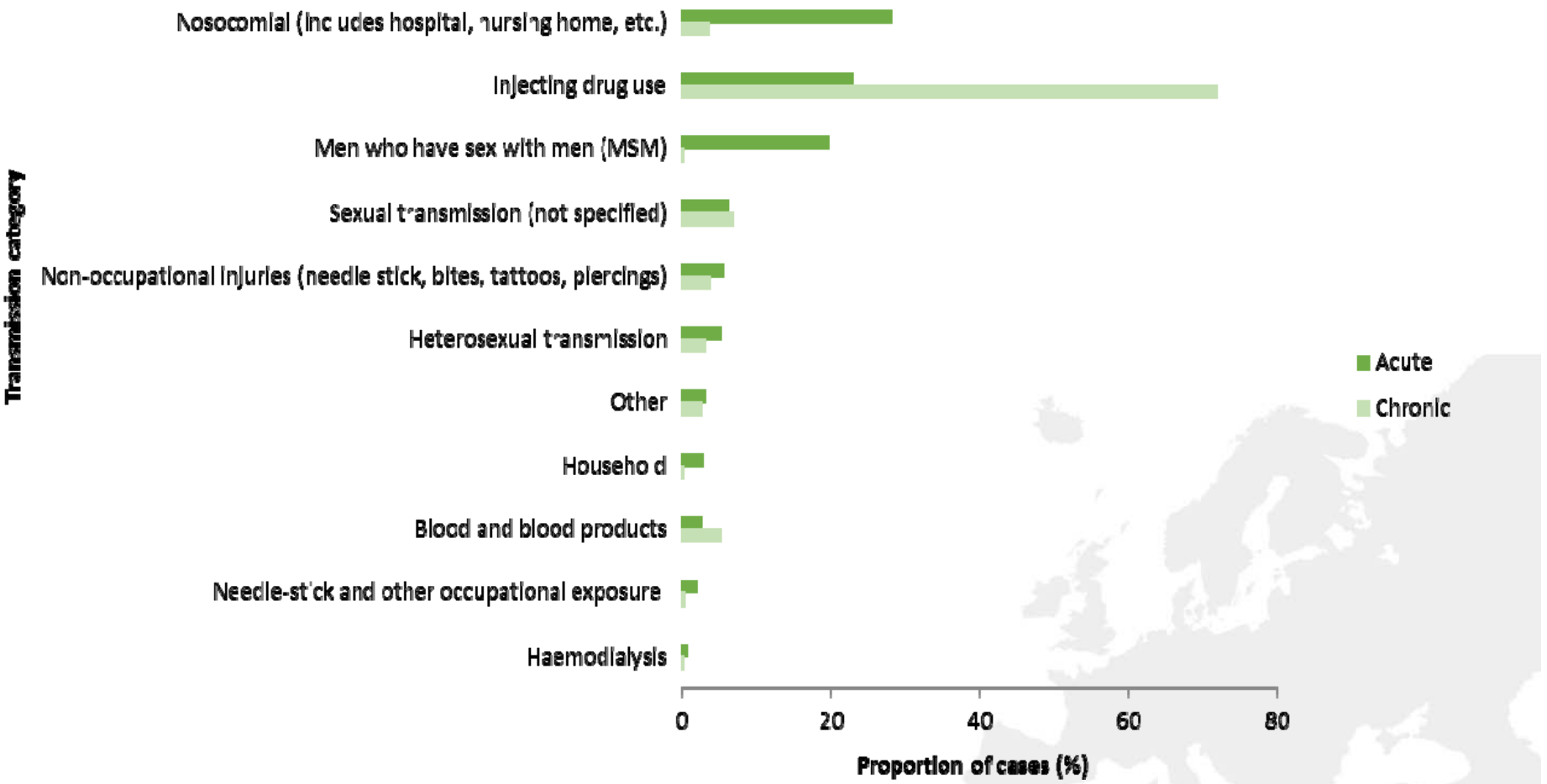
Source: Country reports from: Austria, Denmark, Estonia, Finland, France, Germany, Hungary, Ireland, Italy, Latvia, Lithuania, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Sweden, and the United Kingdom (UK data exclude Scotland).

Rate of (all) reported hepatitis C cases EU/EEA, 2006-2015



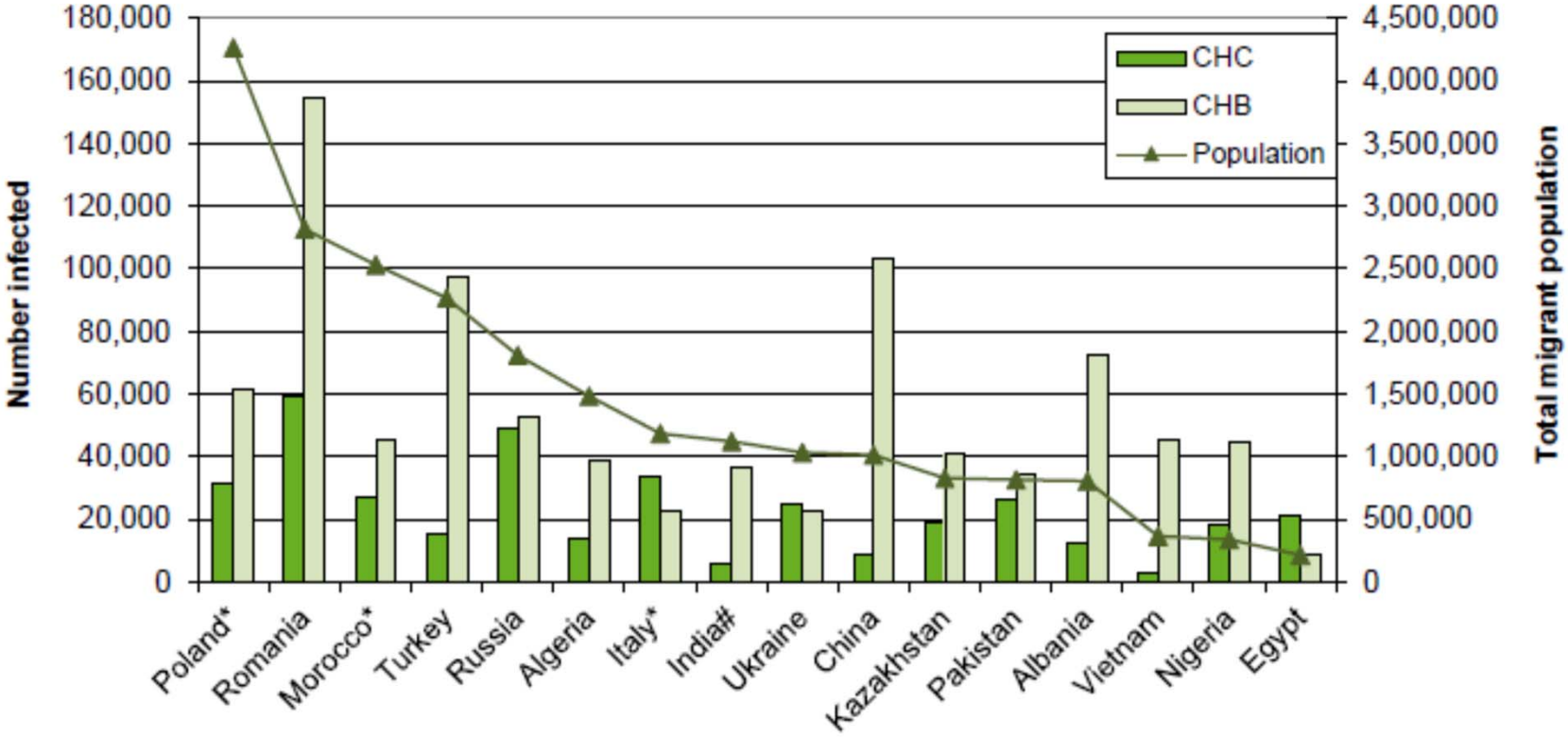
Source: Country reports from: Austria, Bulgaria, Croatia, Cyprus, Czech Republic, Denmark, Estonia, Finland, Germany, Greece, Hungary, Iceland, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Norway, Poland, Portugal, Romania, Slovakia, Slovenia, Sweden, and the United Kingdom.

Reported transmission category for acute and chronic hepatitis C cases, 2015



Source: Country reports from: Austria, Denmark, Estonia, Hungary, Ireland, Italy, Latvia, Malta, Netherlands, Portugal, Romania, Slovakia, Slovenia, and the United Kingdom.

Estimated numbers of chronic HBV and HCV cases among migrant communities, EU/EEA

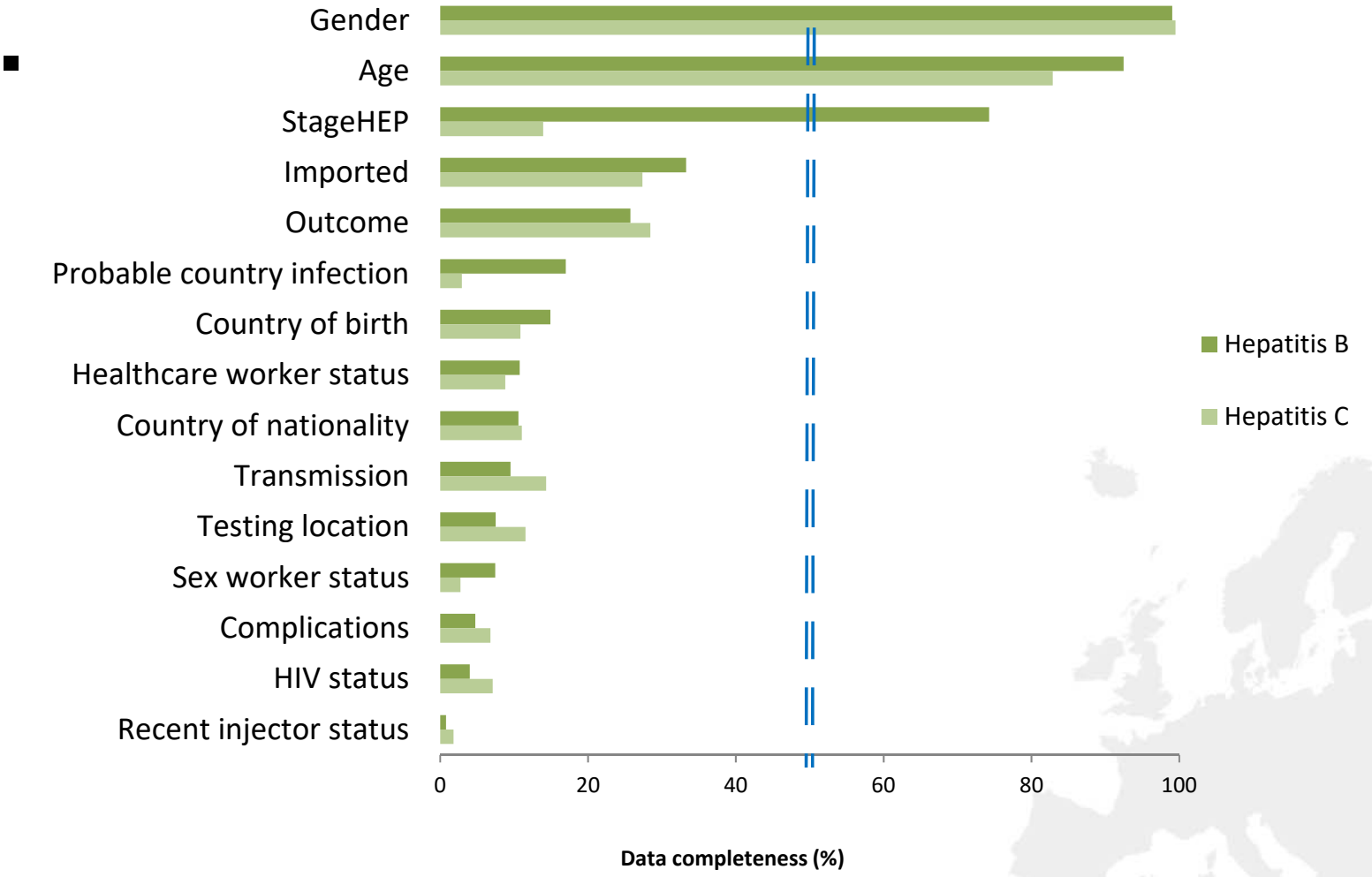


Migrant defined as person born outside of the country of residence

* low-endemic country for HBV (HBsAg prevalence <2%)
\# low-endemic country for HCV (anti-HCV prevalence <1%)

Source: ECDC. Epidemiological assessment of hepatitis B and C among migrants in the EU/EEA. Stockholm: ECDC; 2016.

EU surveillance of hepatitis B and C: data completeness in 2015



Source: ECDC. Surveillance of hepatitis B and C in the EU/EEA, 2015. 2016

Conclusions

High numbers of newly diagnosed hepatitis B and C cases still being notified in EU/EEA

- Hepatitis C notification rate twice the hepatitis B notification rate
- Chronic cases dominate across both diseases – acute 'hard to catch'?
- Marked variation between countries in rates and quality of data
- Imported cases are significant, especially for hepatitis B
- Surveillance data still has many limitations – time for a new approach?

Source: ECDC/WHO (2016). HIV/AIDS Surveillance in Europe, 2015

Fast-track the end of AIDS in the EU practical evidence-based interventions

MALTAEU2017

St. Julians, 30-31 January 2016

Scope of the meeting:

- Expert discussion on how the EU can improve its response to HIV using evidence based strategies

- Focus on:
  - **HIV prevention**, both in terms of coverage and uptake, especially those targeting men who have sex with men, migrants and people who inject drugs;
  - **HIV testing**, to reduce the undiagnosed fraction and ensure early linkage to care for people living with HIV (PLHIV);
  - **HIV treatment**, to ensure that the proportion of PLHIV with an undetectable viral load is increased, both for their personal benefit as well as to reduce future HIV transmission.

Key conclusions - HIV prevention

- Effectiveness of combination prevention interventions targeting populations at risk but 2 out of 3 countries in the region do not have a comprehensive package to scale

- Benefit of community engagement at all levels, including community-based service delivery and community led interventions, essential to reach populations at risk

- Expanding epidemics among men who have sex with men: increase the uptake and funding for the range of proven and effective interventions such as condom programming and sexual health education across the region

- PrEP as part of comprehensive sexual health care and combined with other prevention interventions (eg condoms) a "must" - strong evidence, but only two countries provide national access for at risk populations. Main barriers: pricing and service delivery

- Up to two thirds of HIV infections among migrant populations acquired post-migration. Need for prevention tailored to the diverse needs of the heterogeneous migrant populations, including MSM migrants.

- Great progress on harm reduction for people who inject drugs, but high prevalence and challenge of new stimulants requires sustainable long term programmes. Joint action works well to overcome barriers through sharing of lessons learnt.

Key conclusions - HIV testing

- Overwhelming evidence of early diagnosis and treatment to enable normal life, increase life expectancy and prevent transmission
- Major gaps in access and uptake of HIV testing for key populations
- Needs for diversified and tailored approaches to HIV testing, in particular strengthening community based service delivery (check points), self testing, home sampling and sensitization of health care providers.
- Lack of legal framework for rapid and de-medicalised testing, stigma and discrimination, price of test kits, distance and other barriers must be addressed.
- Community based testing a bridge to provide a comprehensive sexual health package, including access to PrEP, condom promotion, STI screening, linkage to care

Key conclusions - HIV treatment

- Effectiveness of (early) treatment to improve health outcomes for the patient and effectively block transmission - need for clear and strong message
- Late diagnosis still a major problem for all groups, and particularly for migrants
- Data availability on continuum of care greatly improved, but gaps in estimates of PLHIV, viral suppression.
- Europe getting close to 90-90-90, but more ambition required to fast track the end of HIV as a problem. Should consider moving to 90% viral suppression for all people living with HIV, and look at 90-90-90 for specific locations and key populations.
- Affordability and pricing of medicines, including PrEP, a major barrier and must be addressed at EU level – possibly through joint procurement or multicountry negotiation with pharmaceutical industry

Next steps

The Government of Malta will take the main points,

summerised in the form of a technical declaration and

raise these issues at the next Health Council (March 2017)

A brief meeting report will also be published

Acknowledgements

Special thank you to the national experts and surveillance contact points in the EU HIV and Hepatitis networks, the Dublin Monitoring contact points and to the Malta Presidency HIV conference organisation team.

Thank you also to
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and

Annemarie Stengaard, Masoud Dara and
Martin Donohoe (WHO Regional Office for Europe)

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