Missed opportunities for testing in Portugal

INTEGRATE National Stakeholder meeting - Croatia

Daniel Simões, on behalf of the Community Based Screening Network team

Zagreb, 11 April 2019

PROMOTER

PARTNERS

GAT SPONSOR

FUNDING (from March 2015 to April 2016)

The Community Screening benefited from 278 000€ grant from Iceland, Liechtenstein and Norway through the EEA Grants, *Iniciativas em Saúde Pública* ("Public Health Initiatives") Program, operated by the Central Administration of the Health System.

What do we do?

Prevention, testing and linkage to care

INMOURARIA

INTENDENTE

MOVE-SE
UNIDADE MÓVEL DE SAÚDE

Some complementary projects

CENTRO ANTI-DISCRIMINAÇÃO VIH E SIDA

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The Network

Overview

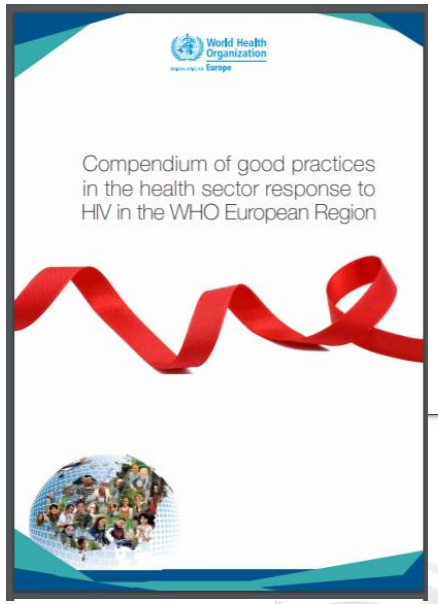
Community Screening Network

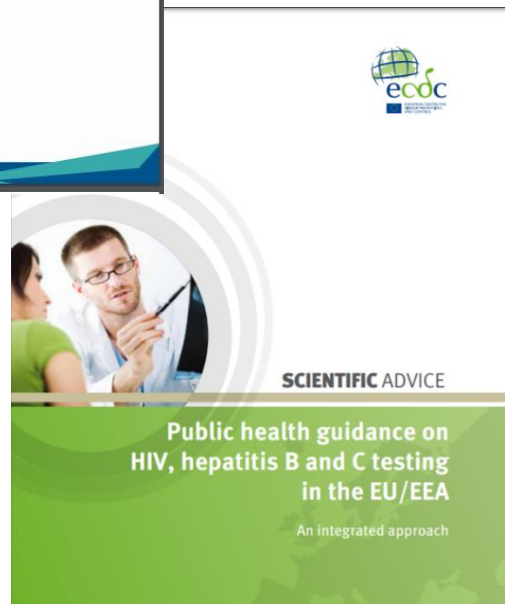
[Community-based screening of HIV, viral hepatitis and sexually transmitted infection in Portugal]

Based on community organizations that work with key groups

- People who Use Drugs (PUD),
- Sex Workers (SW)
- Men who have Sex with Men (MSM)
- Migrants

Objectives





To implement an additional and decentralized access to HIV, hepatitis B and C and syphilis testing

To ensure effective support and monitoring along the process of linkage to the Portuguese National Health Service (SNS) structures

To provide adequate conditions to cross-sectional evaluations and prospectively study the incidence of these infections, their predictors and test possible interventions

Second generation epidemiological surveillance

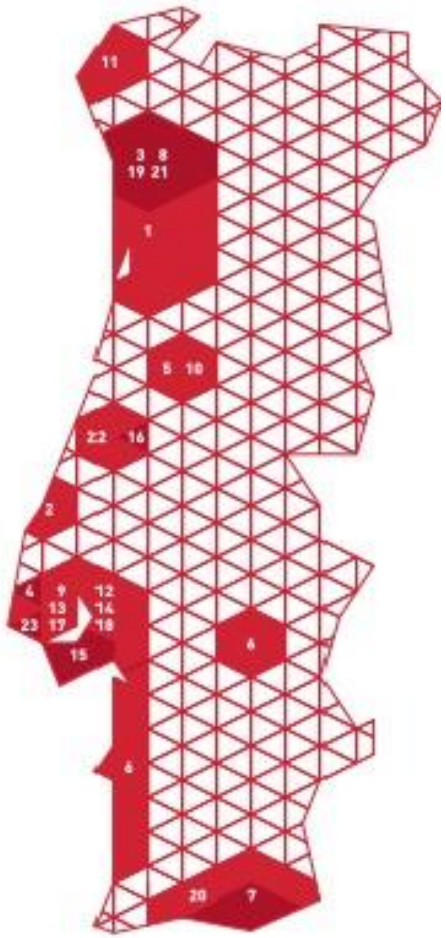
Prospective epidemiological surveillance

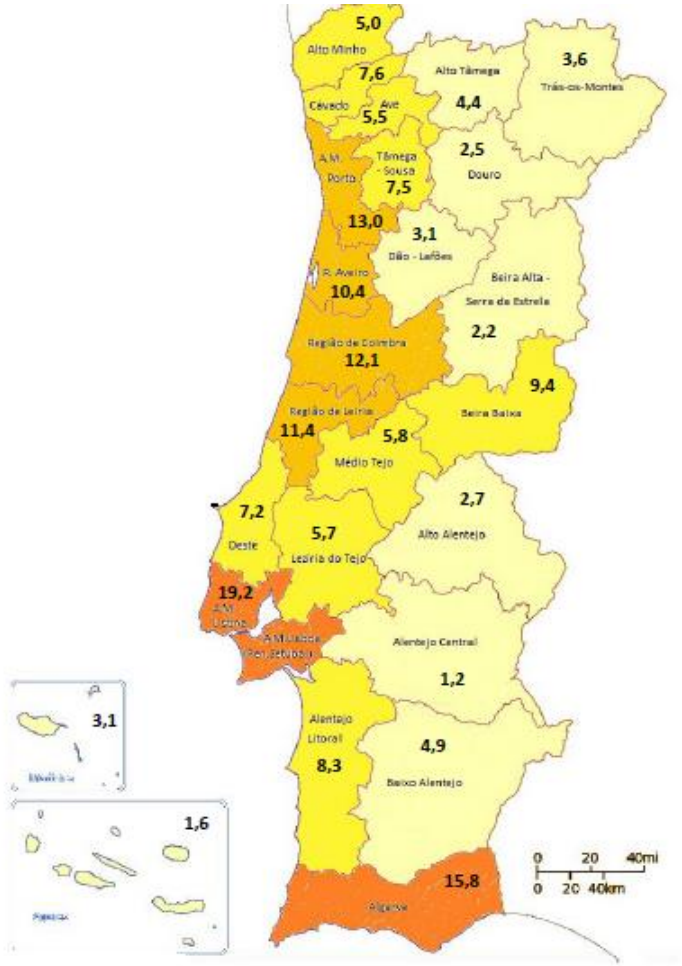
- 18 or more years old
- Sociodemographic and behavioral information collected on a structured questionnaire available online
- At least one rapid screening test — HIV, HCV, HBV or syphilis – referral to healthcare services

Allows for:

- cross-sectional characterization of users
- Temporal monitoring of second generation indicators within a dynamic cohort of hard-to-reach individuals.

The project – Upscaling and integrating community testing in Portugal





Instruments for implementation

Training

- Screening models for community-based testing centers and counselling
- Centers' licensing by Portuguese Health Regulation Authority (ERS)
- Sanitation and residues management plans for screening centers
- HIV, HCV, HBV and syphilis infection
- Data collection and communication

Rapid tests and consumables for HIV, HCV, HBV and Syphilis

External quality control (EQC)

- identification and assessment of the ability to perform screening tests
- guidance on amendable actions and improvement possibilities
- listing of training requirements
- evaluation of diagnostic methods

Online data collection form and centralized data analysis providing monthly access to a structured report on the screening activity and own database

Indicators of implementation (from March 2015 to December 2017)

27 CBVCT structures from 18 NGOs involved and engaged

90 community-based workers trainned

Two rounds of supervision

External quality control (EQC) to all CBVCT structures

From January 2016 to December 2017

Over 90 000 rapid tests

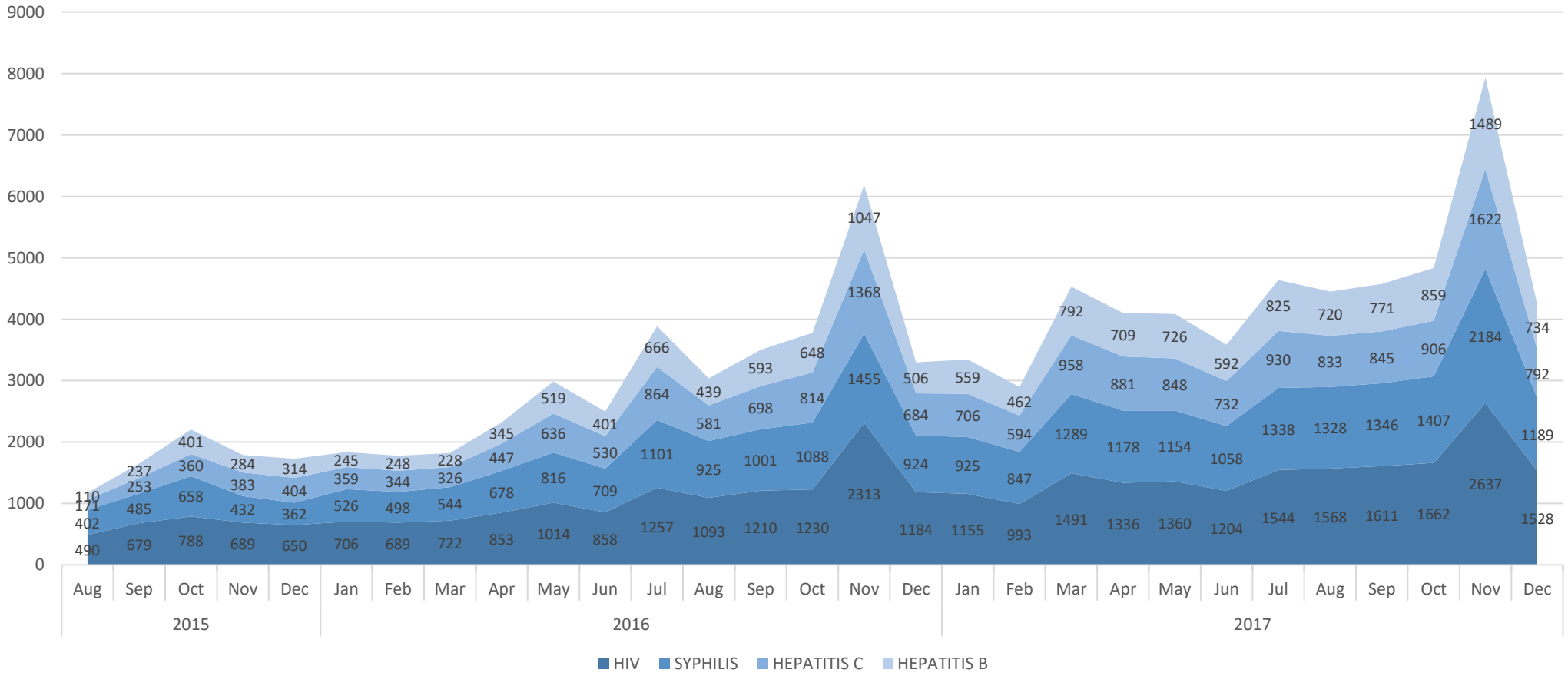
Over 28 000 people tested

2126 reactive results (76.2% referred to care)

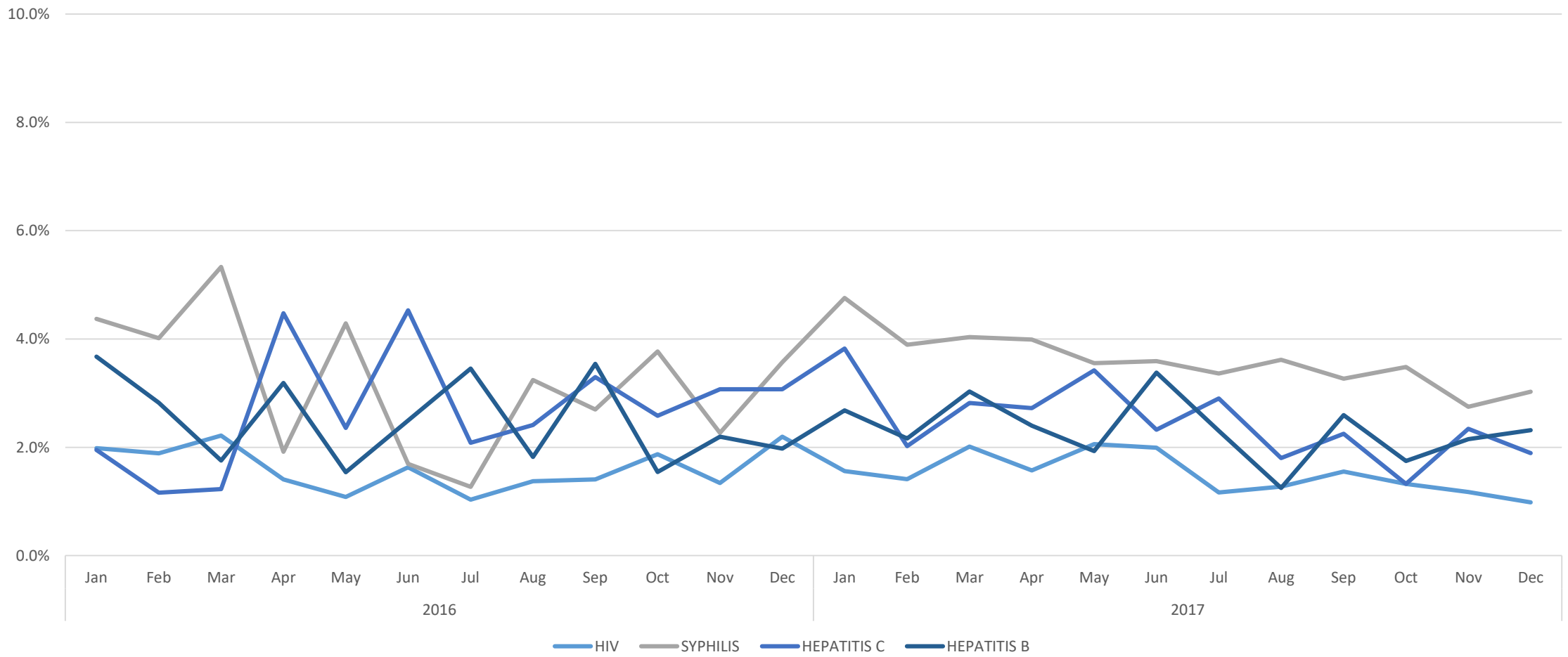
Overall results (Jan 2016- Dec 2017)

	#tests	#people	#reactive results	#referrals	% reactive/100 people	% referrals/100 reactive
HIV	31217	27412	471	362	1.7	76.9
HEPATITIS C	18298	16848	469	345	2.8	73.6
HEPATITIS B	15123	14089	348	280	2.5	80.5
SYPHILIS	25508	22485	838	634	3.7	75.7
Total	90146		2126	1621		76.2

Number of tests per month (from August 2015 to December 2017)



% of reactive test per month



Key populations - definition

Migrant

- user born in a country other than Portugal

Men who have Sex with Men (MSM)

- user assigned male at birth reporting having sex with another man over the past 12 months

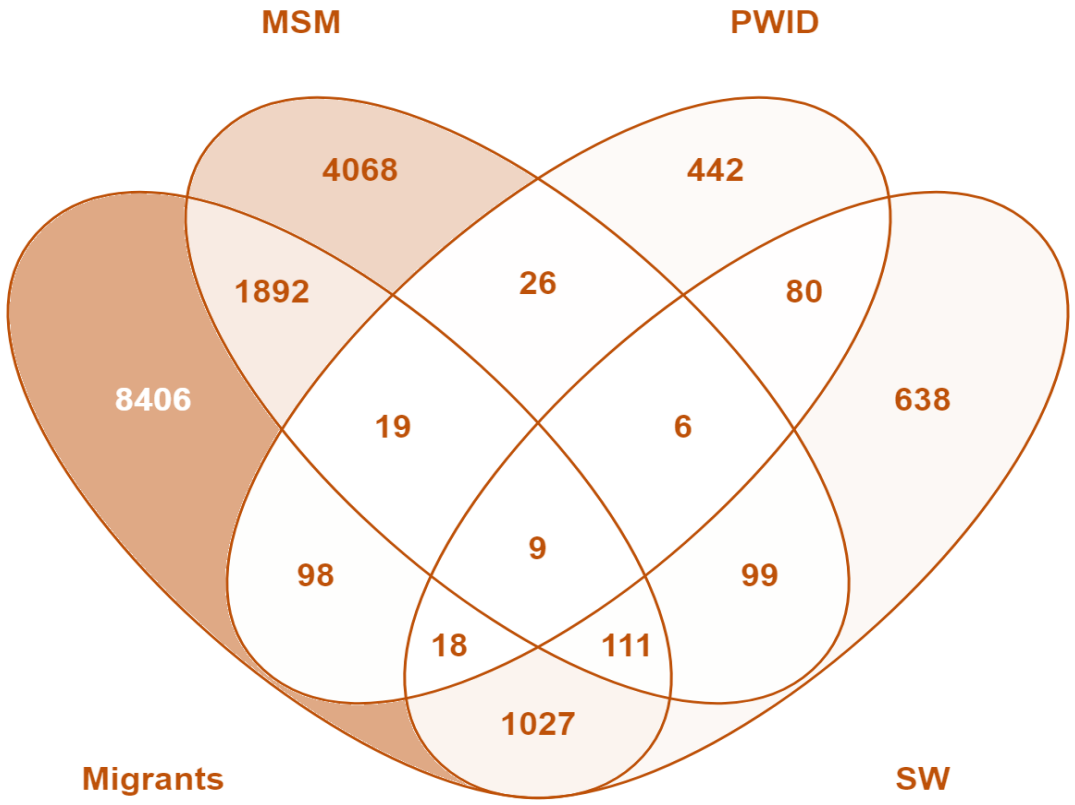
Injecting drug user (IDU)

- user that reports injecting drug use at least once in his/her lifetime

Sex Worker (SW)

- user that reports having had sex in exchange for money, drugs or goods, in the past 12 months.

Respondents' distribution per key group



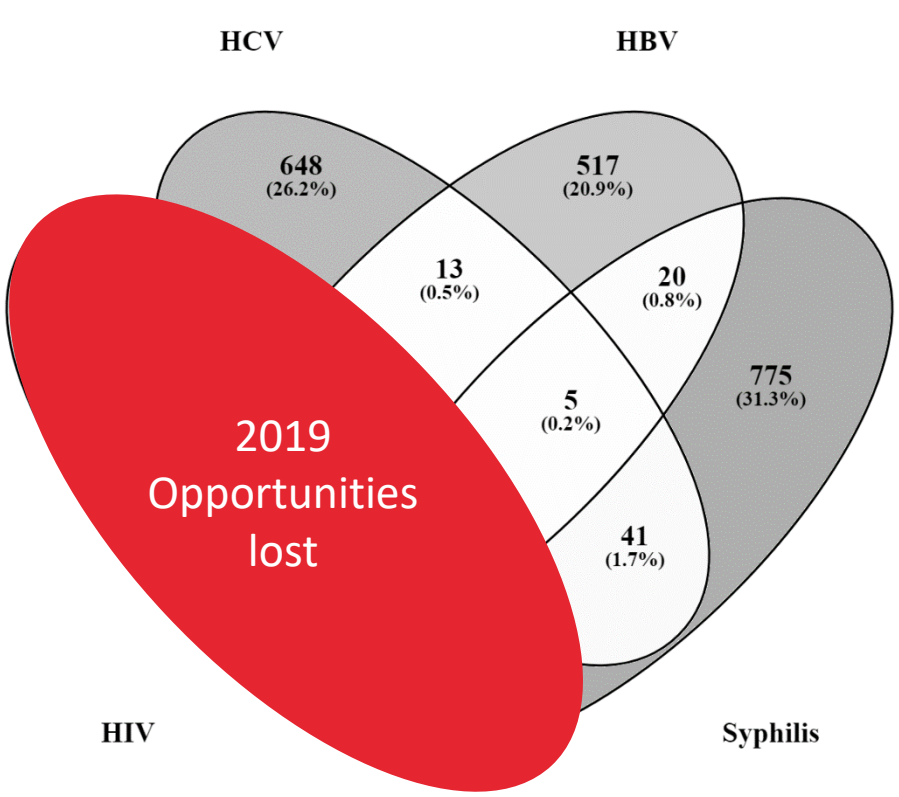
Of the 28 127 people tested (in 2016 and 2017)

- 3396 (12.1%) did not provide information that could be used to classify for a KP
- 6988 (24.8%) provided information and were not classified in any KP

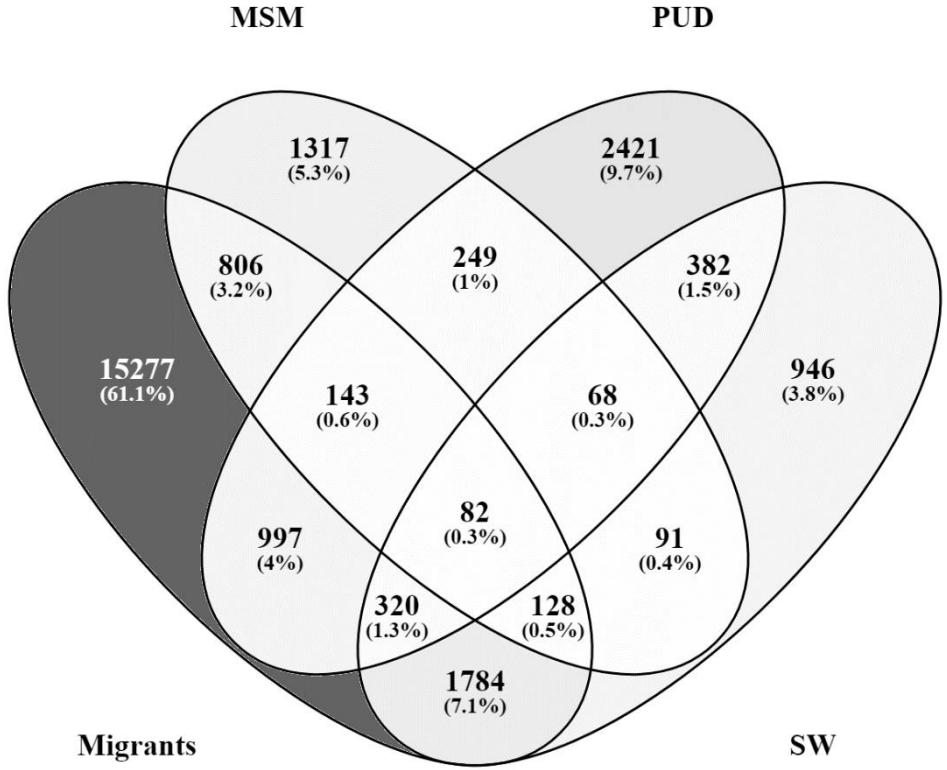
Results and implications for testing projects and strategies

(does not include CheckpointLX data on MSM)

Co-infections (2015-2018)

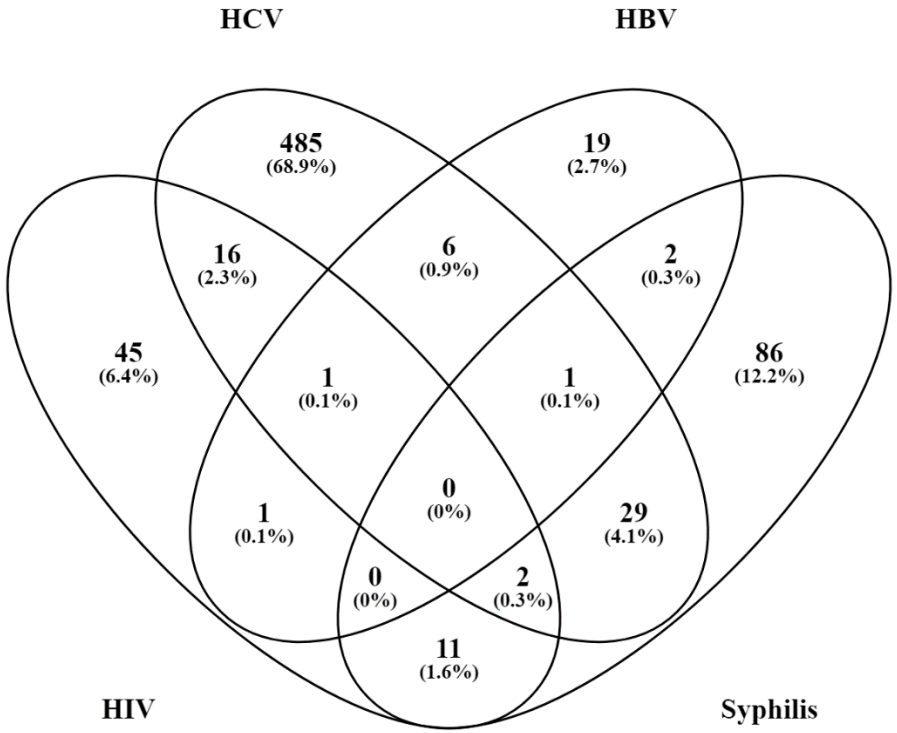


Key populations reached (2015-2018)

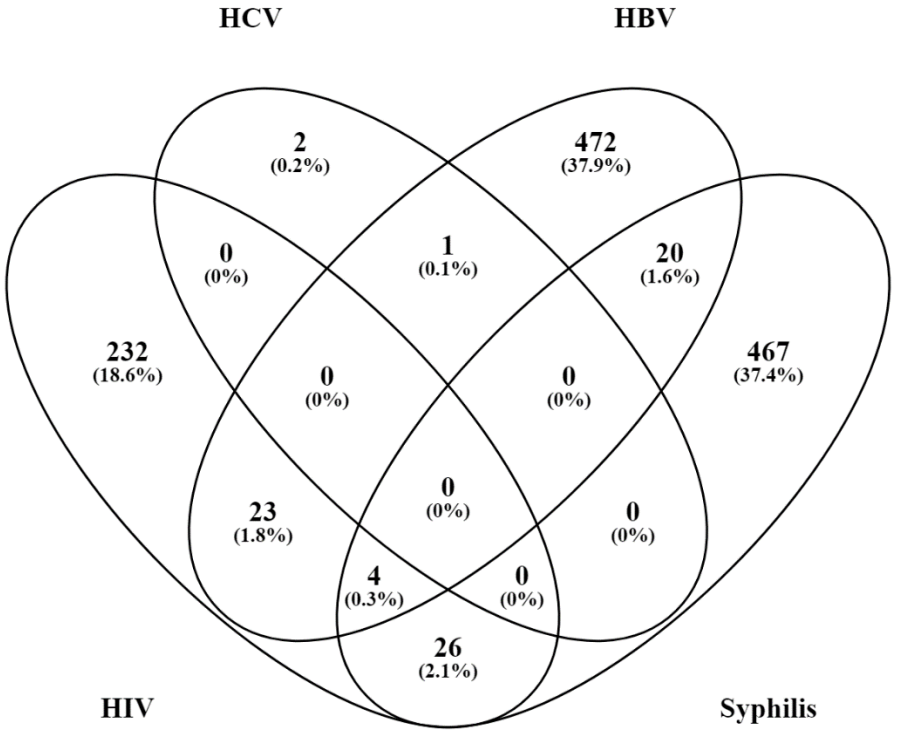


Results and implications for testing projects and strategies

Co-infections among PUD (2015-2018)



Co-infections among Migrants (2015-2018)



New HIV infections (2018)

Data from ECDC/WHO HIV surveillance in Europe 2019 (2018 data)

N	% of total
106	
101	95,28
5	4,72
97	91,51
0	0,00
8	7,55

New HIV infections (2018)
Men
Women
MSM
IDU
Heterosexual

N	% of total
1068	
768	71,91
300	28,09
391	36,61
18	1,69
612	57,30

82,1% national

30-39 and 40-49 as main age ranges

13.2% non national from C/E Europe

64,8% national

Main ages distributed from 30+

18,5% SSAfrica; 10,3% South America

AIDS cases (2018)

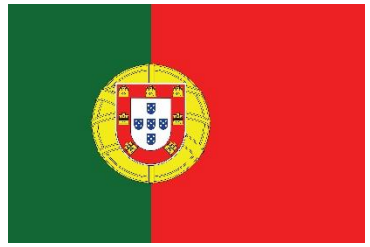
Data from ECDC/WHO HIV surveillance in Europe 2019 (2018 data)

18,87 %

N	% of total
20	100
19	95
17	85
2	10
1	

% of AIDS cases (of all reported HIV infections)

# of AIDS cases
Men
MSM
IDU
Hetero

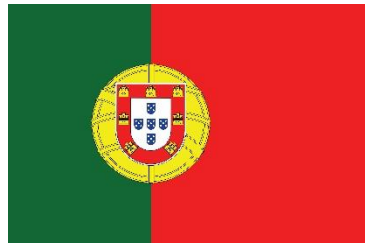


21,91%

N	% of total
234	100
170	72,65
43	18,38
24	10,26
150	64,10

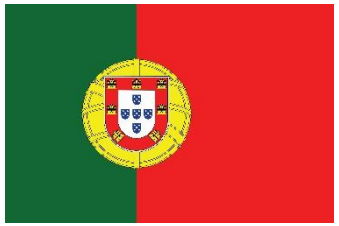
Late presentation (2018)

Data from ECDC/WHO HIV surveillance in Europe 2019 (2018 data)



96%	% with CD4 cell count (reported)	84,7%
38 (37,3%)	Under 200 CD4	280 (31,1%)
59 (57,8%)	Under 350 CD4	464 (51,5%)

90-90-90 and the missing steps to ending HIV



4105493	Population	10291027
70%	Diagnosed	92%
85%	In treatment	87%
89%	Virally Supressed	90%

Missing for 100%

Missing for 100%

1533	Estimated PLHIV	38959
456	Diagnosed	3250
614	In treatment	7950
711	Virally Supressed	10952

Hepatitis B and C

Hepatitis B and C are still a significant public health burden with an estimated 25,000 persons chronically infected with HBV and about 40,000 persons chronically infected with HCV in Croatia

Acta medica Croatica, Vol. 67 No. 4, 2013.

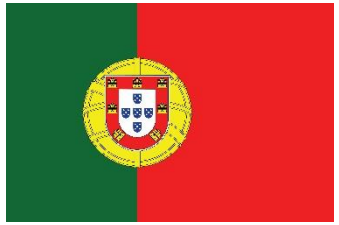
Injecting drug users (IDUs) still represent a group with the highest risk for HCV infection with prevalence ranging from 29% to 65%. Compared to the prevalence in the Croatian general population (0.9%), higher prevalence rates were found in prison populations (8.3%-44%), human immunodeficiency virus-infected patients (15%), persons with high-risk sexual behavior (4.6%) and alcohol abusers (2.4%).

World J Gastroenterol. 2015 Aug 28;21(32):9476-93

Syphilis

newly diagnosed syphilis was present in 23 of 447 persons (5.5% [95% CI, 3.4G7.6%]). All persons with current syphilis (n=35) were males and 33 (94%) were MSM.
The prevalence of syphilis in HIV infected patients entering care in Croatia was high. All newly diagnosed HIV infected patients should be tested for syphilis and HIV testing is also important for all patients with a new diagnosis of syphilis

1st Croatian Congress on Travel, Tropical, Migration Medicine & HIV with International Participation - Book of Abstracts, 2015



Syphilis associated with HIV aquisition in Portugal as well (among MSM).
Early diagnosis and treatment of syphilis can contribute to further decrease new HIV infections.
Proximity sexual health counselling and testing can be an effective strategy to reach at risk MSM and promote early diagnosis and linkage to care

Topics for discussion

With current epidemiological data, integrated testing of key populations for one of the infections may contribute for early diagnosis of all 4 infections

Testing is only one part of the response! Prevention, linkage to care and support are critical.

MSM seem to be the main driver of the HIV epidemic. What responses are in place?

Reaching key populations may require non standard approaches. People will get tested where they feel comfortable. Lay provider testing has been proven effective to reach key populations in Europe (we have data on this being prepared for publication) – enabling environments, stigma and discrimination and "allergy" to health facilities/doctors.

Topics for discussion

Funding is always an issue – different models for different objectives - project vs pay per task;

oral vs blood – test costs and quality (oral has many more flaws in terms of results)

Reccomendations, regulation, training, monitoring and evaluation – models and national objectives/priorities

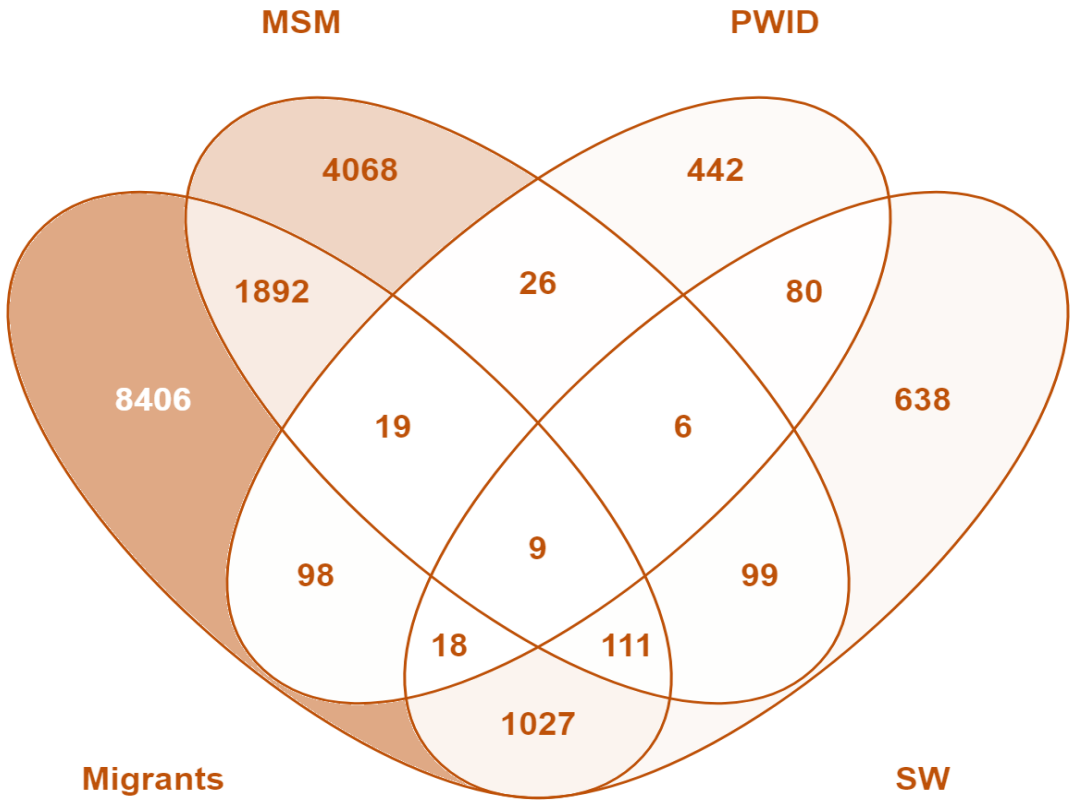
Sex workers and PWID specific responses

Geographical distribution of the epidemics and the response – uncovered areas?

Molecular PoC technology allows for even further progress/innovation on testing strategies/pathways

Thank you!

Respondents' distribution per key group



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HIV test results in selected subsamples (Jan 2016 – Dec 2018) (does not include CheckpointLX data)

HIV results: key populations vs "general population"				
		Reported criteria to be classified as a key population?		Total
		Yes	No	
HIV test result	Non reactive	23672	18291	41963
	Reactive	364 (1,53%)	86 (0,47%)	450 (1,07)
	invalid	82	78	160
Total		24118	18455	42573

HIV in People who report drug use					
		No drug use reported	Drug use reported	Missing	Total
HIV test result	Non Reactive	31699	4363	5901	41963
	Reactive	271	76	103	450
	Invalid	89	14	57	160
Total		32059	4453	6061	42573

HBV test result per country of birth (selected countries)
Jan 2016 – Dec 2018

Country of birth	Test result				Total
	Non reactive	Reactive (%)	Invalid	Not offered	
Angola	1815	74 (4%)	34	656	2579
Brasil	2730	16 (0,58)	34	1966	4746
Cabo Verde	3412	119 (3,48%)	51	646	4228
China	46	12 (26%)	1	9	68
França	163	0 (0%)	2	267	432
Georgia	2	2 (100%)	0	1	5
Gambia	15	2 (13,3%)	0	2	19
Guiné	156	9 (5,77%)	6	53	224
Moçambique	373	9 (2,41%)	5	183	570
Nigéria	65	3 (4,61%)	0	8	76
Portugal	11323	60 (0,52%)	164	11958	23505
Guiné-Bissau	1495	170 (11,37%)	16	187	1868
Timor Leste	6	0 (0%)	1	5	12
Roménia	166	7 (4,21%)	4	80	257
São Tomé e Príncipe	1204	62 (5,14%)	26	265	1557
Senegal	69	9 (13,04%)	7	8	93
Overall total	24578	572 (2,32%)	377	17515	43042