ECDC EVIDENCE BRIEF

August 2015

HIV testing in Europe

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

Dublin Declaration

This ECDC evidence brief summarises key issues and priorities for action in Europe. It draws on country data reported to ECDC for Dublin Declaration monitoring and UNAIDS global reporting in 2012 and 2014 and surveillance data reported by countries to ECDC and WHO Europe since 2004.

Following ECDC's 2010 and 2012 progress reports, a new series of thematic reports and evidence briefs present the main findings, discuss key issues, and assess the progress made since 2012 in Europe's response to HIV.

Why is HIV testing so important?

Low rates of testing mean that many people who may need HIV treatment (antiretroviral therapy, ART) are not receiving it because they have not been diagnosed.

Early diagnosis enables people with HIV to start treatment at a more appropriate time, which increases their chances of living a long, healthy life and reduces the risk of transmitting HIV to other people.

More testing decreases the proportion of those who are infected but who may not be aware of their status, and who otherwise might transmit the virus unknowingly.

HIV testing is also critical for people who do not have HIV, because they can take steps to remain uninfected.

What are the main HIV testing challenges in Europe?

Many people at high risk of infection have not been tested for HIV in the last year. Testing rates are too low in those populations who are at the greatest risk of HIV infection. In the majority of countries, fewer than half of men who have sex with men – and fewer than half of people who inject drugs – were tested for HIV in the last year.

Low HIV testing:

Less than 50%

of members of key populations were tested last year.

Suggested citation: European Centre for Disease Prevention and Control. Evidence brief: HIV testing in Europe. Stockholm: ECDC; 2015.

Rates of testing in key populations are lower in non-EU/EEA countries than in EU/EEA countries. HIV testing rates are below 50% in men who have sex with men in 72% (16/22) of EU/EEA countries and in 88% (15/17) of non-EU/EEA countries.

HIV testing rates are below 50% in people who inject drugs in 36% (7/19) of EU/EEA countries and 76% (13/17) of non-EU/EEA countries.

HIV testing rates in sex workers are relatively high in the EU/EEA, at more than 50% in 92% (13/14) of countries, but are below 50% in 73% (11/15) of non-EU/EEA countries[1].

High number of cases with late diagnosis:

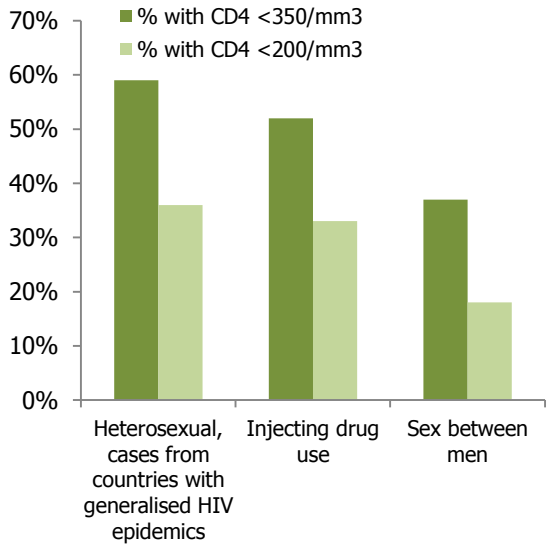
47%

of all HIV cases are diagnosed late.

Nearly half of all HIV cases are diagnosed late. Although the proportion of HIV cases diagnosed late (CD4 cell count of <350/mm^3) or with advanced HIV infection (CD4 cell count <200/mm^3) has fallen since 2004, current rates of late diagnosis in the region remain unacceptably high. In 2013, 47% of all HIV cases in EU/EEA countries were diagnosed late[2]. More than one in four (27%) had advanced HIV infection when they were diagnosed. In non-EU/EEA countries, 51% of all HIV cases were diagnosed late[3], and 27% had advanced HIV infection when they were diagnosed.

Populations most at risk of HIV are more likely to be diagnosed late. In the EU/EEA, the proportion of HIV cases diagnosed late is highest in people from countries with generalised epidemics who have heterosexually acquired infection (59%) and people who inject drugs (52%). More than one third of cases in men who have sex with men are diagnosed late. In nine EU/EEA countries, more than half of cases in people who inject drugs are diagnosed late, and in two countries more than half of cases in men who have sex with men are diagnosed late[4].

Figure 1: Late diagnosis by transmission mode, EU/EEA countries, 2013



Source: ECDC/WHO Regional Office for Europe[4]

Why are the rates of HIV testing so low? And why are the rates of late diagnosis so high?

Coverage of testing services is too low. Although most countries report that HIV testing services are delivered at scale for key populations, low rates of testing and high rates of late diagnosis suggest that coverage is still too low.

Uptake of testing services is low. Too few countries have programmes to increase availability and encourage uptake of testing for key populations. Only eight EU/EEA countries and one non-EU/EEA country report that they have specific programmes that aim to increase HIV testing availability and uptake for men who have sex with men.

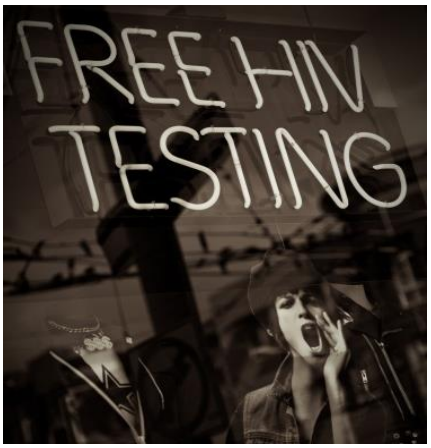


Photo: Jeremy Brooks/flickr.com, Creative Commons license

Provision and uptake of testing services is limited by unfavourable laws and policies. Although laws and policies are generally supportive of HIV testing in the region, they are a barrier in a

[1] Data reported in 2014 or 2012 by 15 non-EU/EEA countries.

[2] In 2013, 21 EU/EEA countries provided information on CD4 cell count at the time of HIV diagnosis; information was available for 61% of newly-diagnosed cases reported.

[3] Based on data reported to ECDC/WHO by 14 countries.

[4] European Centre for Disease Prevention and Control/WHO Regional Office for Europe. HIV/AIDS surveillance in Europe 2013. Stockholm: European Centre for Disease Prevention and Control; 2014.

number of countries. The most frequently mentioned barrier is criminalisation of drug use and sex work and discrimination against men who have sex with men, which makes it difficult to reach these populations and discourages uptake of services.

Uptake of testing is also influenced by stigma and discrimination, accessibility and confidentiality. Governments in 23 countries and civil society in 26 countries in the region report that HIV-related stigma and discrimination has an adverse effect on uptake of HIV testing. The characteristics of services, e.g. location, opening hours, staff attitudes and the type of test offered, also have a significant impact on uptake of HIV testing. Confidentiality is a concern in some countries, in particular where certain sexual and drug-related behaviours are criminalised.

Testing programmes are not targeted. Few countries target HIV testing programmes to those who are most at risk. In most cases this is due to lack of data about subgroups of key populations who are at increased risk of HIV and about whether the right people are being reached with testing services. For example, most countries do not have data on testing uptake among migrants from countries with generalised HIV epidemics or subgroups of men who have sex with men.

Migrants face additional barriers to accessing HIV testing services. These include lack of information about health services and rights, culture, language and religion, health worker attitudes, stigma and discrimination and fear of the consequences of a positive HIV test result including deportation. Undocumented migrants face particular barriers to accessing HIV testing and other health services, due to lack of legal status and health insurance.

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What needs to be done?

Greater efforts to improve uptake of testing and encouraging earlier testing are vital to reduce the proportion of people with HIV who do not know their HIV status or who are diagnosed late. Low rates of testing and high rates of late diagnosis among key populations suggest that HIV testing programmes are not being delivered at scale and where they are most needed. Programmes fail to reach a sizeable proportion of key populations, and there are several factors which prevent uptake of testing. Higher priority must be given to addressing low rates of HIV testing, high rates of late HIV diagnosis, and undiagnosed HIV infection among the most affected populations.

Key options for action

Allocate resources to planning and promoting **testing services** throughout the country and focus on better accessibility and user-friendly services.

Implement **targeted programmes to promote HIV testing**, including earlier testing, especially for men who have sex with men, people from countries with generalised HIV epidemics, and people who inject drugs.

Improve **data on HIV testing coverage and uptake**, late diagnosis and barriers to testing for subgroups of migrants and men who have sex with men who are at increased risk of HIV.

Expand **community-based and outreach testing services** (including expanding services through approaches such as postal testing) that increase availability, accessibility and uptake of HIV testing for those who are most at risk and who are most likely to have undiagnosed infection.

Develop and evaluate new and **more effective approaches to increase uptake and frequency of HIV testing** (i.e. self-testing and home-testing).

Address barriers to testing, for example laws and policies that limit the provision and uptake of testing, and stigma and discrimination in healthcare settings.