

BHIVA AUTUMN CONFERENCE 2014

Including CHIVA Parallel Sessions



Dr Valerie Delpech

Public Health England

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Dr Valerie Delpech

Public Health England

COMPETING INTEREST OF FINANCIAL VALUE \geq £1,000:	
Speaker Name	Statement
Dr. Valerie Delpech	None
Date	October 2014



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Primary infection Public health perspective

Dr Valerie Delpech
Head of HIV surveillance
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*We gratefully acknowledge
persons living with HIV,
clinicians, health advisors, nurses, microbiologists,
public health practitioners, data managers and other
colleagues who contribute to
the surveillance of HIV and STIs in the United Kingdom*



HIV in the UK: 2013 data

HIV diagnoses, AIDS & deaths

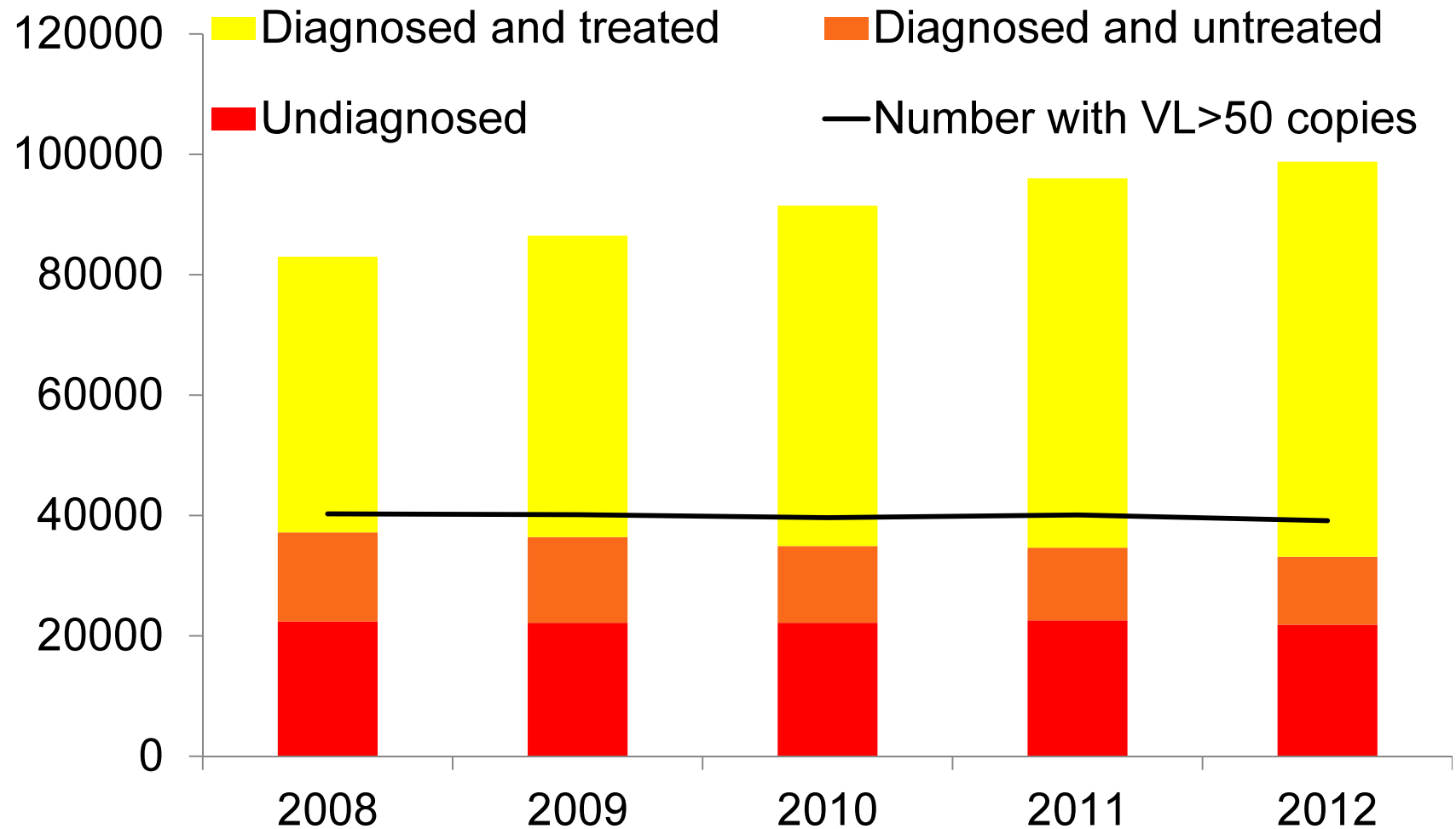
- 6,000 new HIV diagnoses
- 42% diagnosed late
- 319 reports of AIDS
- 577 deaths – 75% are late diagnosed

81,512 people receiving HIV care

- 97% linked to care within 3 months
- 95% retained in care annually
- 92% in need of treatment are on treatment (87% of all diagnosed)
- 95% on treatment achieve VL<200 copies/ml

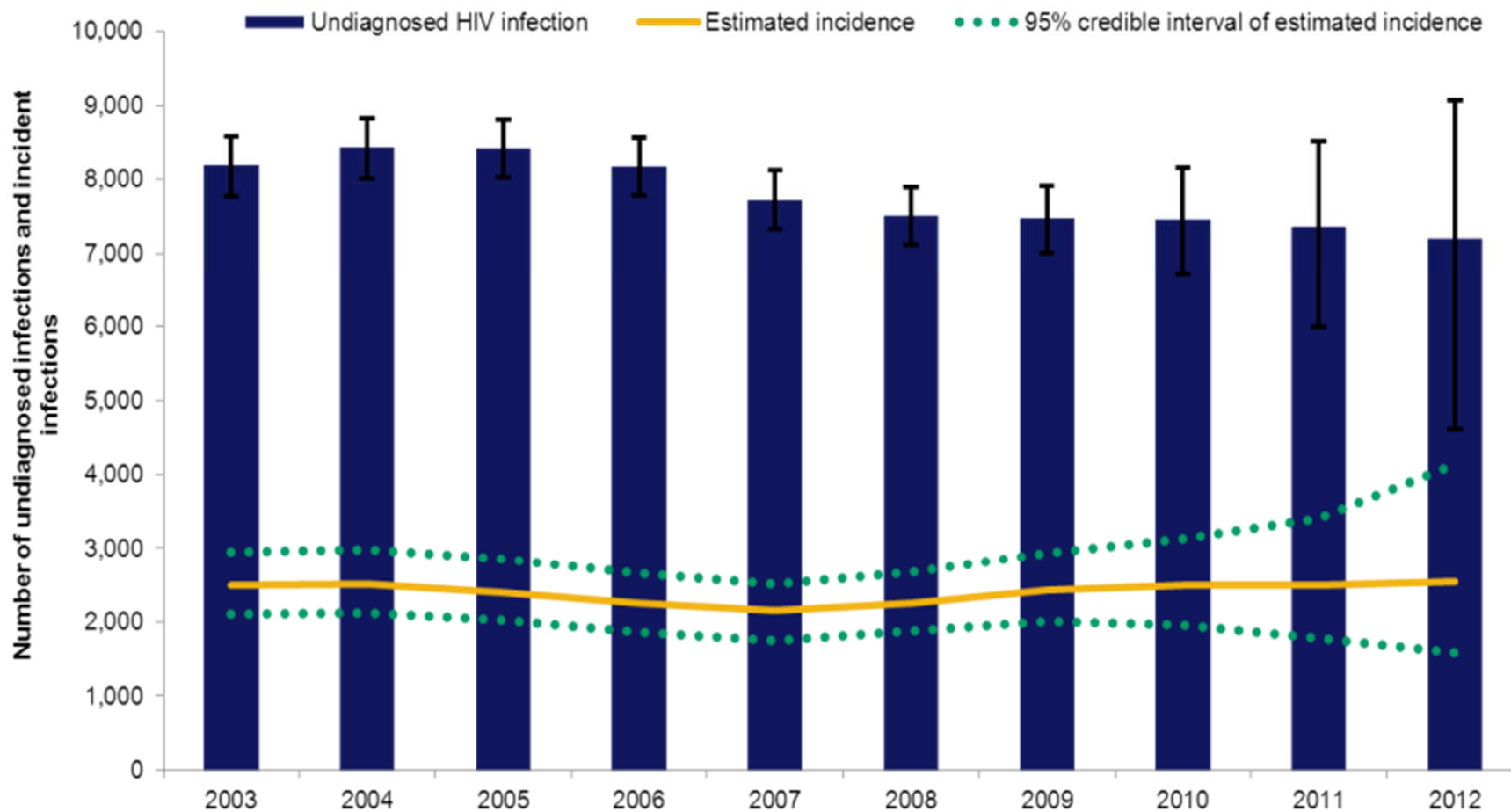


People living with HIV by diagnostic and treatment status, and number with detectable viral load, UK, 2006-2012



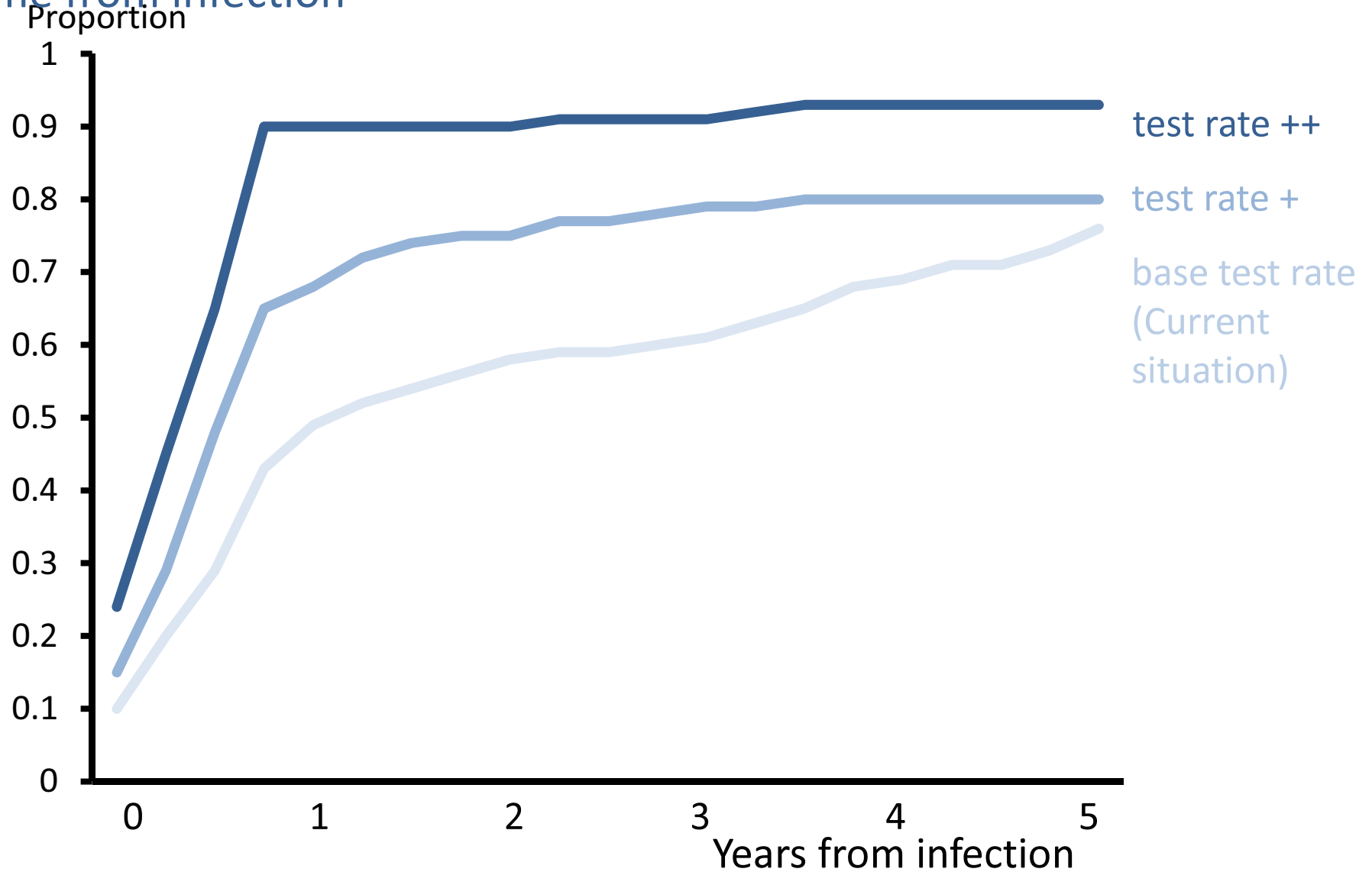


Back-calculation estimate of HIV incidence and prevalence of undiagnosed infection among MSM: UK, 2003-2012



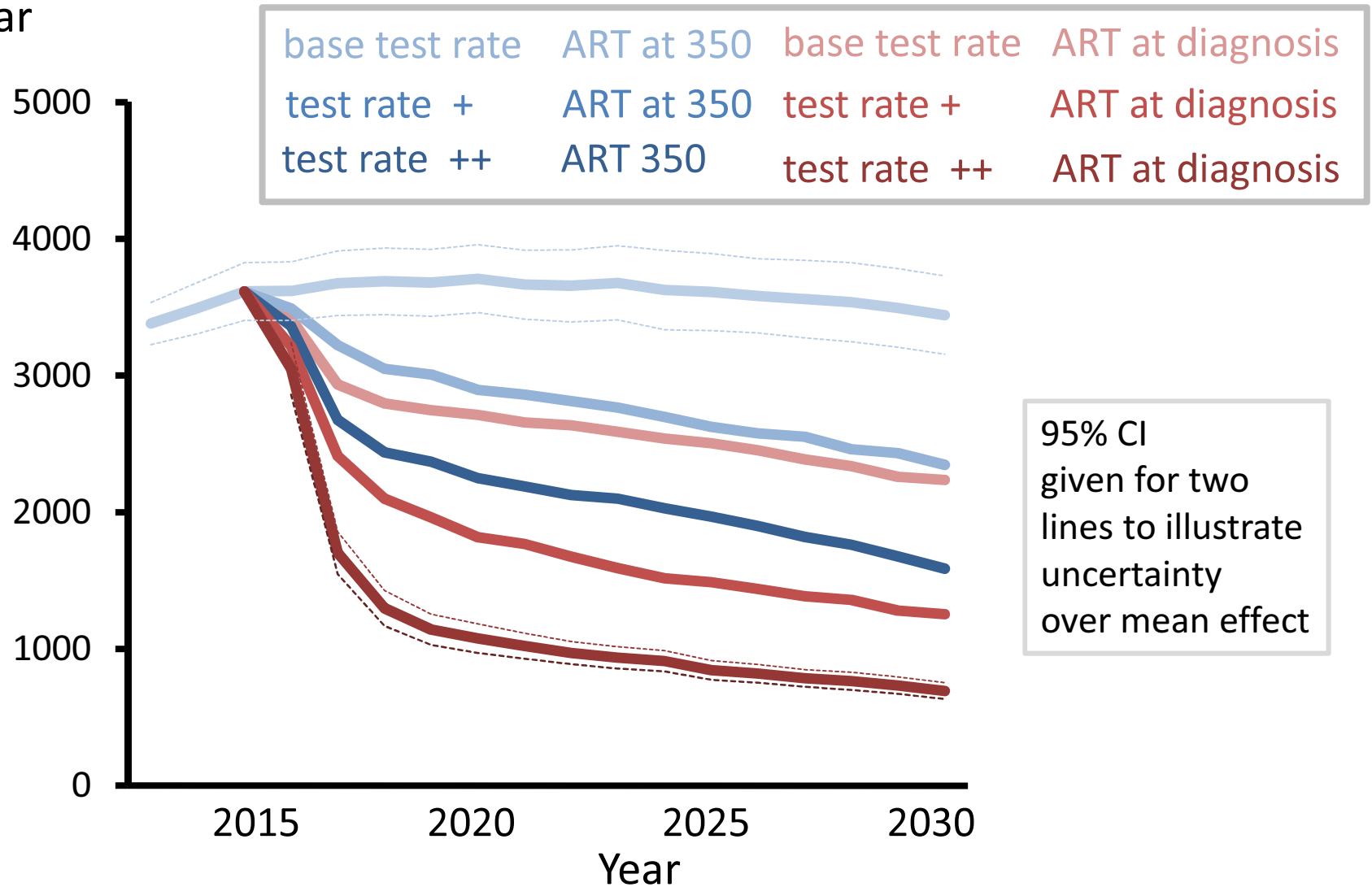
Phillips model of MSM in the UK

Potential increases in testing: probability of diagnosis by time from infection



HIV incidence among MSM, Phillips model

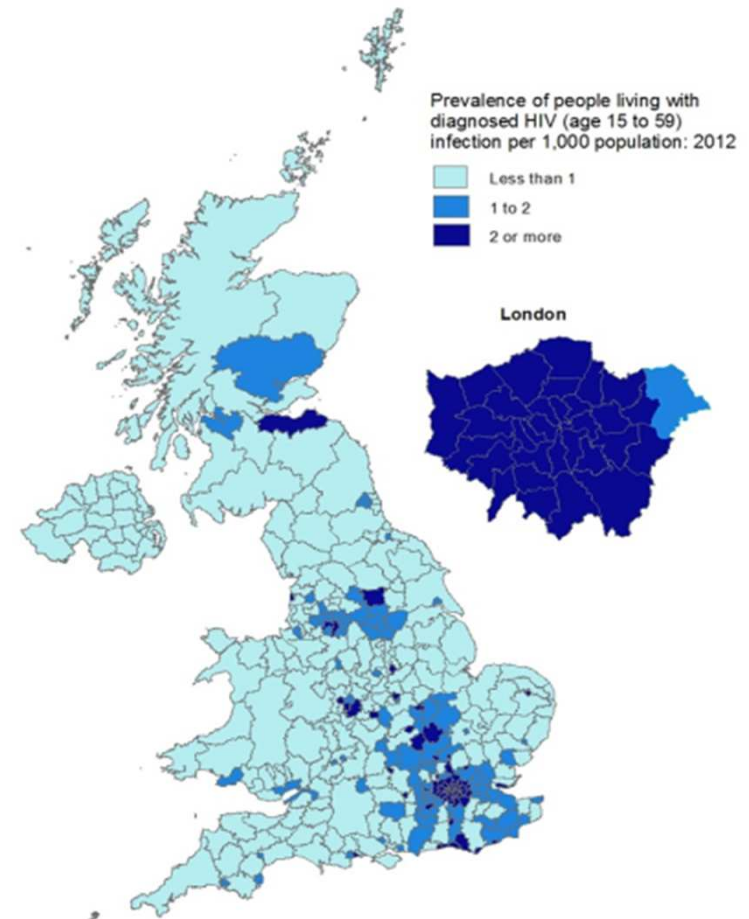
Number of new infections
per year





So why can we not eliminate HIV in the UK?

- Undiagnosed remain too high
- Failure to implement testing guidelines
 - low uptake in key populations despite new technologies
 - geographical testing not working – is 2/1,000 threshold still relevant?
- how frequent does testing need to be?
- primary infection substantially contribute to onward transmission





Primary infection

- Different definitions of primary infection – variation in duration, microbiological vs clinical (6 weeks) vs epidemiological definition (recently infected – RITA 4-6months) modelling (3 months)
- Primary infection is likely to substantially contribute to onward transmission
- Models and phylogenetics work show considerable variability however (15-50% of new infections are acquired from a person unaware of their infection in primary infection)
- Targeting persons in primary infection for early treatment and partner notification is likely to have a substantive impact on transmission
- The challenge is identifying persons in early infection



Identifying persons in primary infection

Clinical symptoms

- screening of men with the acute symptoms (*Fisher triad*)
- screening of men with IMN and other HIV indicator conditions
- Increase awareness among gay men to present and seek test

Targeting high risk persons

- Promotion of 3 monthly HIV screening among MSM with new partner/UAI
- Recall of STI attendees – MSM with previous STI and/or history of UAI
- New diagnostics (home sampling/testing) and outreach (eg Dean St)

Partner notification of recently infected (RITA recent, neg test previous 6 months)



Why is HIV transmission among MSM remaining high

- Role primary infection likely to be substantive 30%- 60% of all infections

Other factors

- High rates of STIs and other co-infections
- Low investment in primary prevention
 - Condom uptake remains too low – serosorting is not safe
- Changing social networks with wide use of apps to find casual partners
- Increase in chemsex
- Insufficient uptake of Treatment as Prevention
- Failure of partner notification policies
- Low uptake of TasP



What should we do?

- Primary prevention remains important – holistic approach
- Prep
- Tasp
- Partner notification
- Improve culture of testing
- Recall of high risk STI attendees
- Greater emphasis on combination of identifying persons in primary infection+ early treatment/TasP + intense PN



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Sexual Health Messages

PHE advice for MSM

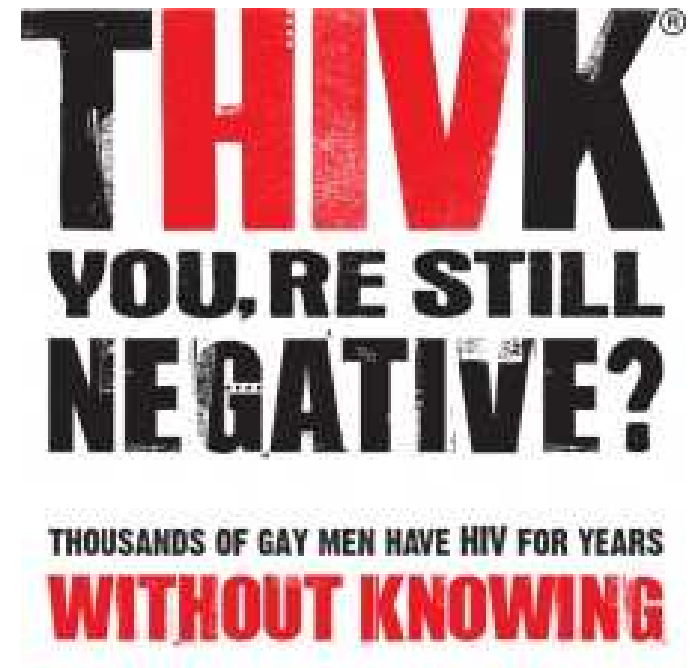
Have an HIV/STI screen at least annually, and every three months if having unprotected sex with new or casual partners.

Unprotected sex with casual and new partners who are believed to be of the same HIV status (serosorting) is unsafe.

For HIV positive men, serosorting poses a risk of acquiring other STIs and hepatitis with serious treatment implications.

For HIV negative MSM it carries the risk of HIV transmission (as a quarter of HIV positive MSM are unaware of their infection), as well as acquiring STIs

Need for tailored messaging for individuals based on risk assessment



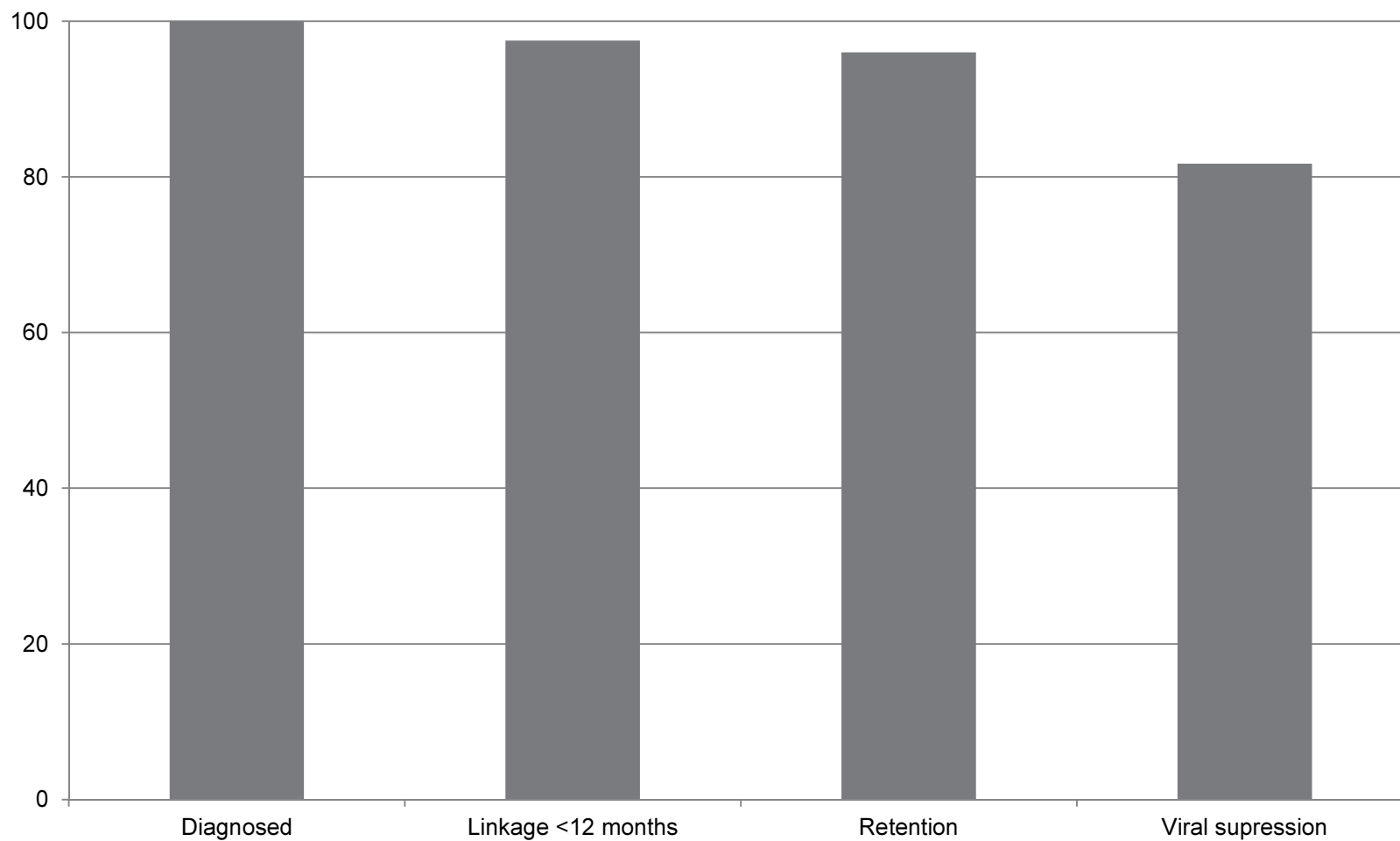
THINK, TEST, TAKE CONTROL
Go to www.thinkhiv.co.uk to find your nearest clinic.

The national charity **thinkhiv**





MSM in HIV care, UK, 2012





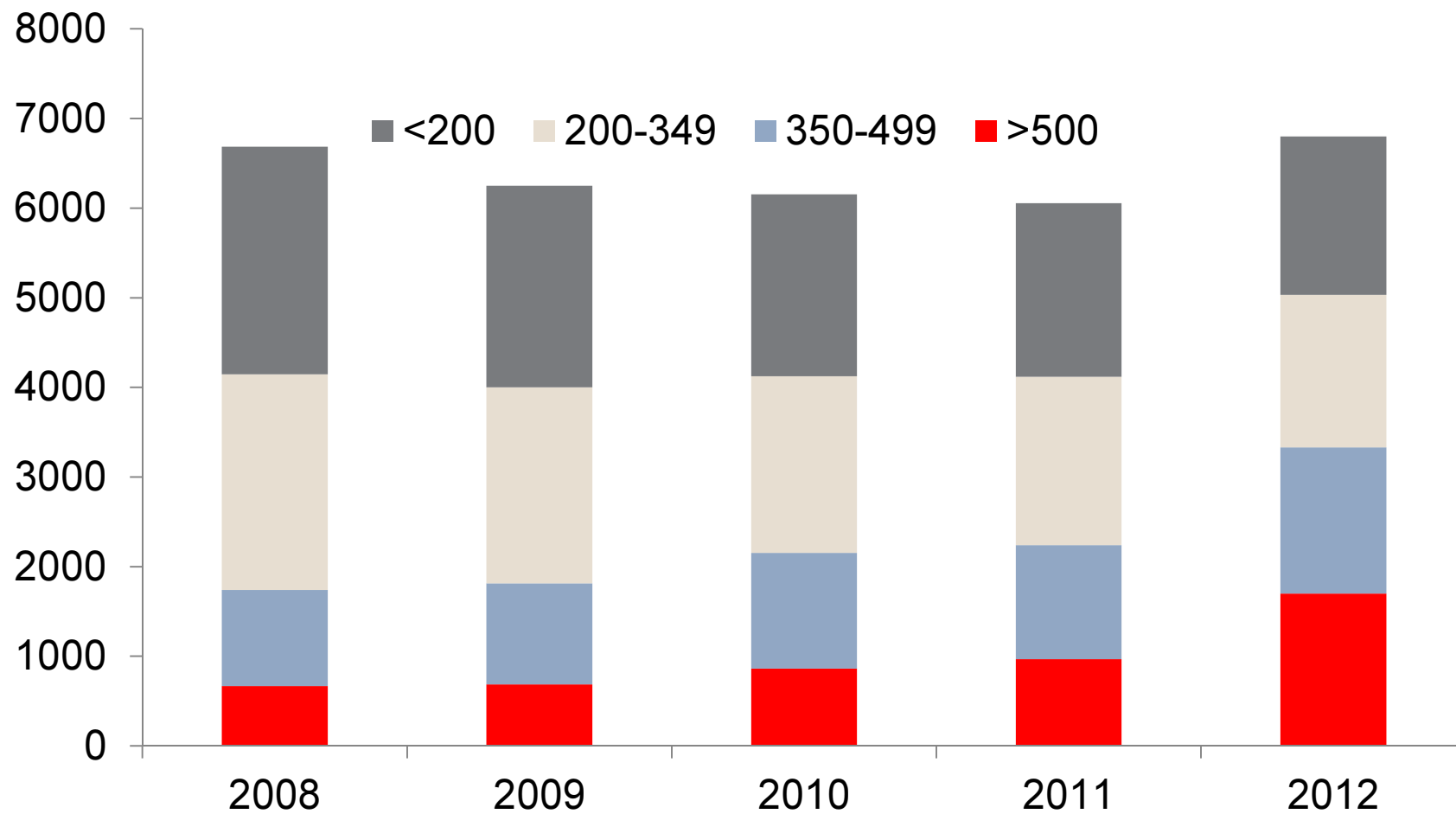
Breakdown of patients on ART, UK, 2008-2012

Year	Total ¹	On ART No. (%)	Started ART		Number untreated
			< report year	In report year	
2008	59,657	45,167 (76)	38,394	6,686	14,490
2009	63,605	49,615 (78)	43,316	6,250	13,990
2010	67,709	55,358 (82)	49,162	6,154	12,351
2011	72,559	60,668 (84)	54,580	6,055	11,891
2012	76,705	65,487 (85)	58,662	6,800	11,218



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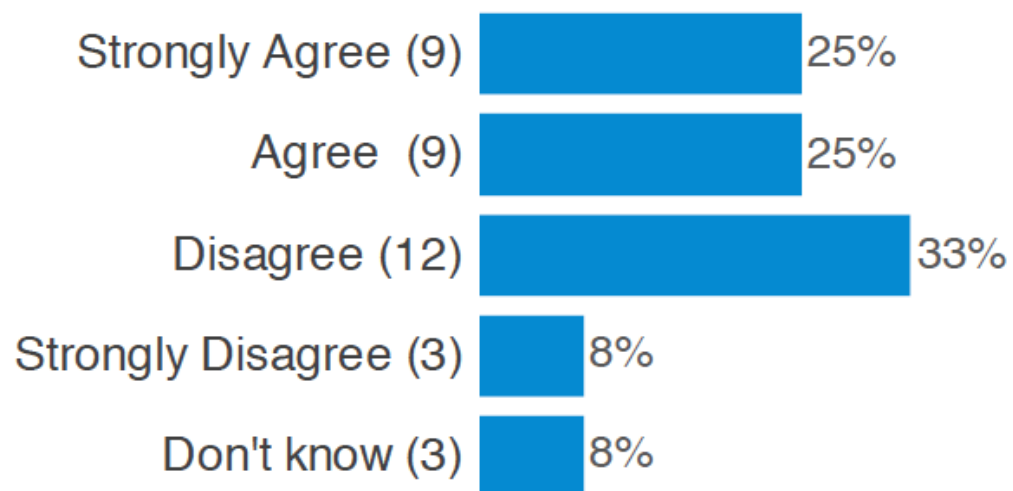
Number of persons initiating ART by CD4 count at initiation, UK, 2008-2012





Positive Voices (n=660) Survey among PLHIV, UK

I would prefer to start HIV drugs now, in order to make me less infectious to a sexual partner





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Proportion of patients with VL <200 copies 12 months after ART initiation, by CD4 at ART start, UK





Conclusion

Two-thirds of HIV positive people with detectable viral loads are unaware of their infection and those in early infection are most likely to transmit their infection to others

Expanded and targeted testing with novel diagnostics must be scale up.

Efforts to Identify persons in primary infection is critical. Once diagnosed, they should be offered earlier treatment and prioritise for partner notification.

Novel interventions are underway. What works needs scaling up.

Other prevention strategies including condom use, PREP, reduced partners, treatment of STIs, and improvements in sexual wellbeing, mental health and non-harmful use of drugs and alcohol remain critical in the control of HIV and other STIs epidemic.



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Recently diagnosed young man, UK

From the year 2014 as i became hiv, my life just changed. my mum does not want to know me or to see as i told her about my sexuality and her last word was to me that, because i am a muslim and a gay men that's why i am paying for my sins. she also told me that i have chose hell here in this world and also after i will die.



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THANK YOU



Dr Alison Brown and the HIV team at Colindale, PHE

MPES team, Andrew Phillips

Persons living with HIV,

Clinicians, health advisors, nurses, microbiologists, public health practitioners, data managers and other colleagues who contribute to the surveillance of HIV and STIs in the UK