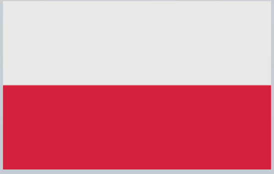
OptTEST
OPTIMISING TESTING AND LINKAGE
TO CARE FOR HIV ACROSS EUROPE

Country Report

Evidence on linkage to care after HIV diagnosis in Europe

Poland



August 2017

Authors:
Sara Croxford, Ifeoluwa Olowoniyi and Valerie Delpech
Public Health England (PHE), UK

www.OptTEST.eu

This country report is part of OptTEST by HiE Work Package 4 led by Public Health England (PHE), UK.

Acknowledgments
Thanks to the OptTEST project partners and the steering committee, and in particular to the national focal points that answered the survey.

OptTEST is co-funded by the 2nd Health Programme of the European Union.

Suggested citation:
Sara Croxford, Ifeoluwa Olowoniyi and Valerie Delpech. Country Report: Evidence on Linkage to care after HIV diagnosis in Europe. Poland. UK, October 2017

Contents

Background

Published data on linkage to HIV care from the European Union are lacking and few countries routinely monitor HIV quality of care measures locally or nationally. With successful expansion of HIV testing into a variety of settings (including hospital admissions, community testing and self-testing or self-sampling), prompt access to medical care must be ensured as linkage to care impacts subsequent treatment uptake and is essential for optimal patient outcomes. OptTEST is a three-year project, (2014-2017) co-funded by the European Commission and led by HIV in Europe, that aims to optimise HIV testing and linkage to care in Europe. Work package (WP4) of OptTEST looks to explore and document linkage to HIV care and access to therapy across Europe. Pilot countries involved in WP4 include: UK, France, Estonia, Spain, Poland, Portugal, Greece and Czech Republic.

In June 2015, a literature review carried out by WP4 found that a number of definitions of linkage to care following HIV diagnosis had been applied in the literature from Europe. The variety of settings, time periods, populations and definitions made it difficult to compare measurements between countries and studies, highlighting the necessity for a standardised definition to ensure consistent assessment of quality of HIV care and clinical outcomes.

The OptTEST project, in collaboration with the European Centre for Disease Prevention and Control (ECDC), hosted a workshop at an expert meeting in Stockholm in September 2015 at which such a standard definition for defining and measuring linkage to care for surveillance and monitoring purposes was developed. Linkage to care was defined as: the proportion of patients seen for HIV care after diagnosis (measured by first CD4 count and/or viral load and/or clinic attendance date and/or treatment start date), with prompt linkage defined as linkage within 3 months.

To pilot the agreed surveillance definition and explore current linkage to care at national-level, WP4 has undertaken analyses of the 2015 European HIV case-based dataset held at the ECDC. The aim of these analyses was to determine the feasibility of using these data to routinely monitor linkage to care. This report also presents data from an OptTEST WP4 survey of national HIV surveillance contact points to better understand what structural factors influence linkage to care and monitoring linkage to care in countries across Europe.

Methodology

Assessing linkage to care using routinely collected EU/EEA surveillance data

These analyses used case-based European HIV surveillance data held at the ECDC. Laboratory-confirmed cases of HIV are submitted annually by the 53 countries in the WHO European Region to a joint database using The European Surveillance System (TESSy) portal.

People were included if they were newly diagnosed with HIV between 2010 and 2014 and were reported to the ECDC/WHO in 2015 using the revised TESSy data template. Completeness of key variables over time was calculated to determine the appropriateness of using TESSy to monitor linkage to care.

Individuals were excluded if they had been previously diagnosed with HIV (HIVstatus variable=PREVPOS), previously been in HIV care (CD4 more than 14 days prior to diagnosis date) or died within three months of diagnosis. People were also excluded if they had no CD4 data reported, only the year of diagnosis/CD4 count reported or a CD4 count reported with no date. All partial dates, where the only month/quarter and year were provided, were defaulted to the middle of the month/quarter.

Linkage to care was calculated as the time between the HIV diagnosis date and first CD4 count date. Linkage was considered prompt if the first CD4 count was taken up to three months (91 days) after diagnosis. In a sensitivity analysis, to assess the worst case scenario, those with no CD4 count reported after diagnosis were considered not linked to care.

Understanding the linkage to care context: a survey of national HIV surveillance focal points

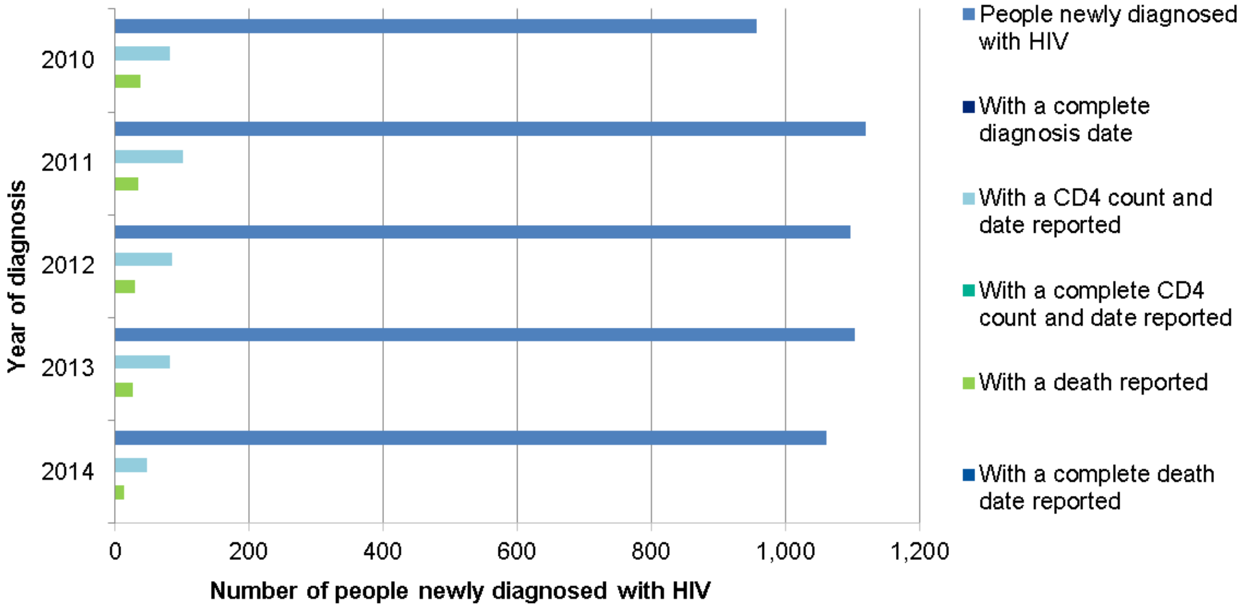
In September 2016, a short survey was sent to the 30 EU/EEA national contact points to better understand what structural factors influence linkage to care and monitoring linkage to care in countries across Europe. In the EU/EEA, competent bodies for surveillance in each Member State nominate a national contact point for HIV/AIDS. These contact points work with the ECDC and WHO Regional Office for Europe on the reporting of new HIV cases to TESSy. The questionnaire was developed in collaboration with international experts, including: the ECDC, the WHO Regional Office for Europe, OptTEST partner organisations, the HIV/AIDS Civil Society Forum, the EURO HIV EDAT project, AIDS Fondet in Denmark and the European AIDS Treatment Group (EATG). Topics covered included: where people can be tested for HIV, HIV care structure, data collection mechanisms, linkage definitions and data caveats. In section two of the survey, respondents were asked to provide data on CD4, viral load, care attendance and treatment initiation after diagnosis to better understand the sensitivity of the linkage to care definition.

Results

Assessing linkage to care using routinely collected surveillance data

There were 5,339 new diagnoses of HIV between 2010 and 2014 in Poland reported to TESSy. Of these, 0% had a complete diagnosis date reported and 7% had a CD4 count and CD4 date reported. For those diagnoses with CD4 data reported, 0% had complete information provided. 0% of people diagnosed over the five years that died had a complete death date. Trends in the completeness of these key fields over time can be seen in the graph below (Figure 1).

Figure 1: Trends in completeness of key fields used to calculate linkage to care in TESSy, 2010-2014



Given that in Poland, CD4 data are only reported for people with an AIDS diagnosis, no further analysis was undertaken.

Understanding the linkage to care context: a survey of national HIV surveillance focal points

The survey response from Poland was received by a representative from the National Institute of Public Health – National Institute of Hygiene, Warsaw.

HIV testing and diagnosis

Available settings for HIV testing:

STI clinics	Yes
Emergency departments	Yes
Antenatal services	Yes
Labour wards	No
Infectious disease unit	Yes
Other inpatient admissions	Yes
Tuberculosis services	Yes
Other outpatient services	Yes
Drug services	Yes
Prisons	Yes
General practice/primary	Yes
Pharmacies	No
Community settings	No
Self-sampling	No
Home/self-testing	No
Laboratories	Yes
Other setting	No

Data on both negative and positive HIV tests these settings are reported as part of national surveillance; this does not include data on reactive tests. The date of confirmatory assay is used as the date of diagnosis. HIV notification data is collected from laboratories performing the confirmatory assay and from clinicians. There is no infrastructure and no unique ID to extract individual level data on positive tests from laboratories or to link them to the surveillance databases. The laboratories are not allowed to collect additional information from the patients.

HIV clinical care pathway

Routine HIV clinical care is provided in 24 dedicated HIV clinics and infectious disease units. Care is also provided in penitentiary units. Baseline assessments carried out at initial entry into care include: confirmatory HIV test, CD4 count, viral load measurement, a complete sexual history, partner notification and a complete medical history. Other assessments include HIV genotyping, tests for syphilis, toxoplasma, hepatitis A, B and C, tuberculosis, a gynecological exam, and if appropriate – human papilloma virus, varicella zoster and herpes simplex virus.

HIV data capture:

	Local level	National level
Date of first reactive test	No	No
Site of first reactive test	No	No
Confirmatory diagnosis date	Yes	Yes

Site of confirmatory diagnosis	Yes	Yes
HIV care attendance date	Yes	No
First CD4 count	Yes	Yes
First CD4 date	Yes	No
First viral load	Yes	No
First viral load date	Yes	No
HIV treatment start date	Yes	No

There are currently no guidelines in place for linkage to care after diagnosis and current definition for linkage to care in Poland.

Data and estimates

No data were provided on CD4, viral load, care attendance and treatment initiation after diagnosis.

Data provision

There were a number of difficulties reported by Portugal in providing the data used in the calculations for linkage to care. A high proportion of CD4 and death data are missing as the data source for these two measures covers only a subset of cases. Viral load, attendance date, treatment start date and death data are not collected routinely, not reported centrally and lack the legal framework for collection. Finally, there is significant delay in notification of the subset of deaths reported.

Linkage to care definition and interpretation of estimates

The most appropriate measure used to monitor linkage to care after diagnosis in Poland is CD4 count. CD 4 count is collected and this test occurs at admission to HIV care. Treatment initiation is collected at a central clinic level (outside of the surveillance system). There are currently plans to increase coordination between these two data sources is planned so this could be another option. Significant reporting delay and underreporting of new cases, especially by clinicians, must be considered when interpreting any estimates.

OpTEST PARTNERS

chip
Centre for
Health & Infectious
Disease Research

REGION H Rigshospitalet

Aids Fonds

EATG European AIDS Treatment Group

GNP+ GLOBAL NETWORK OF PEOPLE LIVING WITH HIV

MEDFASH

Public Health England

Tervise Arengu Instituut
National Institute for Health Development

Inserm

SSAT
ST STEPHEN'S AIDS TRUST

MINISTERIO DE ECONOMÍA Y COMPETITIVIDAD

isciii
Instituto de Salud Carlos III

Co-funded by the 2nd Health Programme of the European Union