Author's response to reviews

Title: A systematic review of post-migration acquisition of HIV among migrants from countries with generalised HIV epidemics living in Europe: implications for effectively managing HIV prevention programs and policy

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Author's response to reviews:

Dear Victorino Silvestre,

Thank you for this further opportunity to revise our paper. We are very pleased that our previous revisions have been well received. Below we have responded to each of the new comments in turn.

Thank you for your extensive revisions to your re-submitted manuscript. We feel that you have adequately addressed the majority of comments and concerns raised by authors and we appreciate your attention to detail in terms of your responses. There are a few outstanding issues, as detailed below. I would also note that authors should carefully proofread the manuscript again for language and grammar (e.g., Abstract, first sentence of methods has two periods; last sentence of methods has no period; some spelling mistakes throughout).

Thank you for identifying these typos, we have proofread the manuscript again and apologies if any grammatical errors remain.

1) The introduction has been expanded on, as per the reviewers' request - however, the first paragraph in the introduction is long and recommend breaking into two.

As suggested we have split this paragraph in two.

2) More information on the relevance of Type B is required in the Introduction for readers to understand the importance of the Results on sexual mixing later on. Right now it is still unclear why sexual mixing was included in the review. It would
be helpful to clarify this again in the discussion for non-medical audiences.

The introduction has been changed to include the following:

Often these estimates do not take into account additional factors. For example, it has been reported that CD4 cell counts close to seroconversion are considerably lower among those living with non-B HIV-1 viral subtypes, which are most common among migrants from outside Europe, particularly in Sub-Saharan Africa. [3, 5, 6]. Consequently, a lower CD4 cell value at diagnosis in those with non-B sub-types may wrongly suggest that individuals have been living with HIV for longer than they have; leading to the conclusion that HIV was acquired before migration. The presence of non-B subtypes among Europe-born populations may also be interpreted as evidence of sexual mixing between migrants and non-migrants.

3) Clarify if the studies included in the review were peer-reviewed (Results, first paragraph)

This line is now included in the results:

Twenty-seven peer-reviewed papers (representing 26 studies) were found to fulfil the inclusion and quality assessment criteria and were therefore included in the final review

4) Discussion - Implications for policy: what is an 'irregular migrant'? In what way are they not provided with ART (for free? at all?).

We have now changed the discussion to include the following:

Approximately half of the EU/EEA countries surveyed report that they do not provide ART to irregular/undocumented migrants, that is, to persons that cannot legally reside in the country [34]. Treatment as a means of reducing sexual transmission of HIV now forms a key part of the prevention paradigm, like other conditions of paramount public health importance such as tuberculosis [35]. Improving access to HIV treatment for all infected persons, regardless of their administrative and or immigration status, could positively impact on reducing incident infections both within and beyond migrant communities.

I think another key implication for policy that could be addressed here is related to the importance of providing ART or increasing access to migrants living with HIV during their transit and arrival - even 48 hours without ART can cause a spike in viral load that can heightened the probability of HIV transmission - this could go here or in Implications for Prevention Programming, with reference to Treatment as Prevention (Julio Montaner from Vancouver, Canada is a good person to cite here)

We thank the reviewer for this comment. However, we do not agree that we should include this implication in our paper. We appreciate that this may be an important clinical issue but current evidence suggests that the only policy response to this would be mandatory screening on arrival. Any form of mandatory testing contravenes WHO's policy framework for HIV testing in Europe which states mandatory HIV testing for migrants and asylum seekers upon arrival violates basic rights and ethical principles and cannot be justified on public health grounds (World Health Authority, 2010). In the UK, calls for the mandatory
screening of migrants for HIV were not acted upon due to fears such a policy would further stigmatise at-risk groups and dissuade people from testing (All-Party Parliamentary Group on AIDS, 2003; Coker, 2004).

5) In Prevention Programming (Discussion) authors mention that programs should be tailored to migrants - here it could be important to make a note about culture specifically and the challenges with tailoring specific interventions for diverse cultures

We thank the reviewer for this comment. We have changed the discussion to include the following:

This awareness will require additional attention and resources to improve primary prevention programmes targeted to the specific (culturally appropriate) needs of various migrant communities.