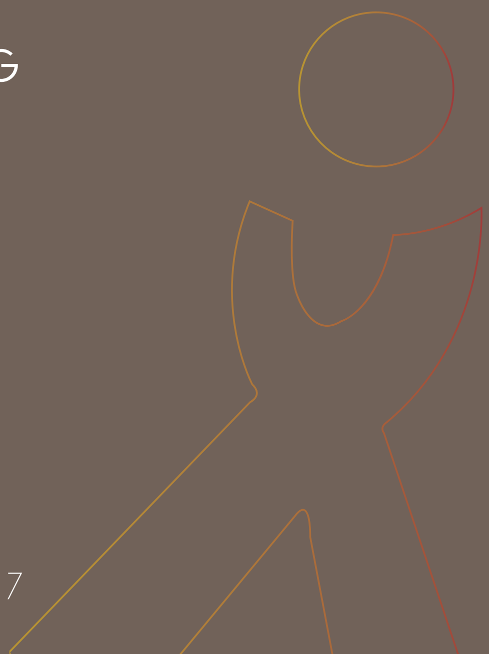
HepHIV2017
31 JANUARY-2 FEBRUARY · MALTA

CONFERENCE PROCEEDINGS

HepHIV2017 CONFERENCE

HIV AND VIRAL HEPATITIS: CHALLENGES OF TIMELY TESTING AND CARE



MALTA, 31 JANUARY – 2 FEBRUARY, 2017

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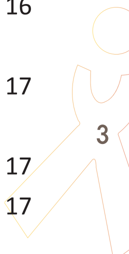

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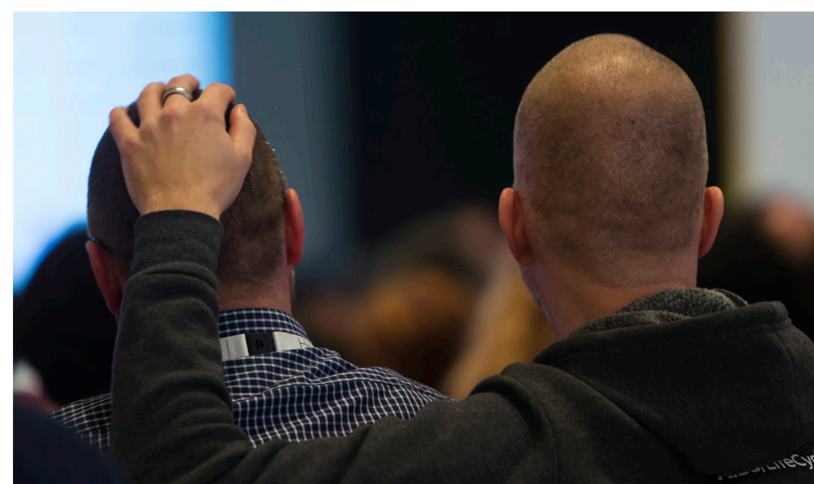
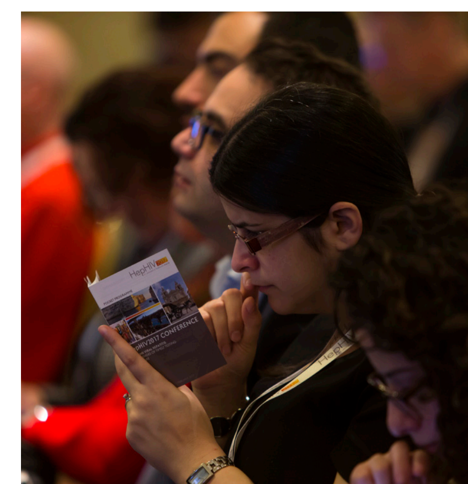
The proceedings of the HepHIV2017 Malta Conference were written by Misha Hoekstra, rapporteur.





HEPHIV2017 ORGANISING COMMITTEE

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HEPHIV 2017 CONFERENCE IN MALTA

EXECUTIVE SUMMARY

The epidemiological picture of Europe's viral hepatitis and HIV epidemics – and the urgency of the conference focus on early testing and treatment – remain largely unchanged from the first HepHIV conference, in 2014. Roughly 13 million people in the WHO European Region are chronically infected with hepatitis B and 14–15 million with hepatitis C; together the two viruses result in 125 000 deaths annually. Surveillance remains poor, however, and the vast majority of Europeans who have viral hepatitis do not realize they are infected.

With HIV, there are essentially two epidemics: a burgeoning epidemic in the eastern part of the region, driven by injecting drug use and exacerbated by a lack of targeted interventions and poor treatment coverage, and a stable epidemic in the EU, driven by sex between men.

A survey of legal and regulatory barriers to HIV testing methods (p. 25) identified several areas where testing policy has not caught up to the evidence of what works. Most European countries still do not allow self-testing, and most permit only medical personnel to perform tests. And while pre-exposure prophylaxis (PrEP) appears to be a key factor in last year's dramatic decline in HIV incidence among London MSM, only France and Norway have approved PrEP for broad distribution. Meanwhile, community testing continues to expand and to target key populations effectively.

Testing strategies that focus on key populations and indicator conditions will be critical to reducing the high rate of late presentation for care, which has stagnated at around 50%. Publicizing the effectiveness of antiretroviral therapy and interventions like PrEP – the 21st-century HIV story – would also improve testing and treatment uptake by helping to reduce stigma.

For hepatitis C, a roundtable was convened to debate how to prioritize costly treatment (p. 19). Participants rejected the question and agreed instead that countries should use Australia's approach: commit to treating everyone and negotiate well. Good negotiation requires knowing the size of the undiagnosed population – one of many good reasons to improve surveillance. Monitoring of hepatitis C testing and treatment also needs to be much better to achieve elimination.

Speakers also covered topics that were applicable to both hepatitis and HIV, including how surveillance data can strengthen cohort data, how to calculate cost-effective testing frequencies for key populations and the need for medical training on stigma. There were many examples of tandem testing, though much more integration of HIV and viral hepatitis efforts.

Finally, this conference marked the 10th year that the organizer, the HIV in Europe initiative, has been getting diverse stakeholders to collaborate on promoting early HIV testing and care. This milestone was celebrated in presentations by the original co-chairs, Ton Coenen and Jens Lundgren, and the publication of a history tracing the initiative's work (available at www.hiveurope.eu)

OPENING SESSION

TUESDAY, 31 JANUARY 2017

Welcome to the HepHIV 2017 Conference in Malta: objectives and expected outcomes of the conference

Co-chair **Brian West** (European AIDS Treatment Group (EATG)) described the purpose of the conference: to improve testing and linkage to care for HIV and viral hepatitis, specifically by following up on the call to action from the 2014 HepHIV conference in Barcelona. Although Malta is more out of the way, attendance was slightly up with 268 participants from 42 countries, including 33% community representatives; 17% clinicians; 17% policymakers and representatives of public health institutions; 16% social scientists, epidemiologists and statisticians; 13% industry representatives; and 4% media. The programme was designed to provide an update on European testing and linkage to care, and the challenges ahead; to improve surveillance and use it to impact policy and increase testing and treatment uptake; and to strengthen the links between HIV, viral hepatitis and other disease efforts.

Welcome address

On behalf of Minister of Health Christopher Fearne, co-chair **Charmaine Gauci** (Maltese Ministry of Health) conveyed the ministry's enthusiasm for the conference and noted that Malta has made HIV a priority for its presidency of the EU. Together with the European Centre for Disease Prevention and Control (ECDC), the presidency sponsored a conference of HIV experts just before this one, resulting in a technical declaration on HIV that Fearne is presenting to the other EU ministers of health in March. Gauci noted that HIV is a persistent problem in the EU, infecting 0.2% of the adult population. She said we need to scale up prevention efforts, especially those targeting MSM; expand early testing and linkage to care; and increase the number of people who are virally suppressed. While viral hepatitis has not received much attention in Europe, its disease burden is much higher than for HIV, TB and malaria combined.

> *We need to reach out to the poorest, the most vulnerable, including people who use drugs; to combine health instruments with social instruments; and to promote health as a human right across all political sectors.*
>
> *—Vytenis Andriukaitis, European Commissioner for Health and Food Safety*

The EU's contribution to ending the HIV and hepatitis epidemics in Europe

Vytenis Andriukaitis (European Commission) stressed the need to address the underlying determinants of HIV and viral hepatitis, as well as their public health consequences. He called for a stronger focus on social determinants and inequality, which he said is growing in the EU. While noting that the EU Health Programme, which has invested more than €20 million in HIV efforts during the past decade, is his main tool for supporting public health action, he urged member states to use EU structural funds too, including the European Social Fund. The Commission recently approved a second joint action to build on the success of Optimising Testing and Linkage to Care for HIV Across Europe (OptTEST) and to run in parallel to joint actions on hepatitis and TB. In addition, it is now expanding the remit of the HIV/AIDS Think Tank and the HIV/AIDS Civil Society Forum to address hepatitis and TB.

HIV and hepatitis surveillance trends in the EU and feedback from the EU presidency conference on HIV

Andrew Amato-Gauci (ECDC) said that while HIV incidence has been declining globally, it's held steady in the EU/European Economic Area (EEA) and is rising in the European Region as a whole, while the situation in Russia is very worrying. In the EU, harm reduction is working, and most newly diagnosed HIV cases are sexually transmitted, with MSM accounting for 42% of new cases in 2015. HIV incidence among migrants is declining but still accounts for 37% of new diagnoses. Reported cases present late 47% of the time. Data on viral hepatitis are much patchier, due to its largely asymptomatic nature and to incomplete and non-standardized reporting. As a result, hepatitis B and C notification rates appear to be much higher in the UK and Scandinavia, but that's simply because they test more effectively. Based on prevalence studies, the ECDC estimates that in the EU/EAA, 4.1 million people are infected with hepatitis B and 5.6 million with hepatitis C.

Amato-Gauci also summarized some key points from the Maltese presidency meeting on HIV: more community involvement is needed in prevention activities and expansion of PrEP; most migrants with HIV acquire it after arriving in the EU; more diversified and tailored approaches to HIV testing need to be implemented, in particular by strengthening community-based service delivery, though legal frameworks will also have be developed; late diagnosis is a major barrier for all groups, especially migrants; and the EU is getting close to achieving the 90-90-90 goals, but the affordability and pricing of medicines are a major barrier and must be addressed at EU level.

> *Unlike in other regions globally, HIV incidence in the European Region has not declined; on the contrary, it's getting worse. Many parts of Africa are doing better than we are.*
>
> *—Andrew Amato-Gauci, ECDC*

HIV and viral hepatitis in Europe: time to turn the tide

Masoud Dara (WHO Regional Office for Europe) provided more context for the European Region: 125 000 annual deaths from viral hepatitis, a near doubling of HIV coinfection among TB patients between 2011 and 2015 (to 9%), and an HIV epidemic in the east that is fuelled by injecting drug use and low antiretroviral therapy (ART) coverage (21%, vs. 72% for Western and Central Europe). Dara said the regional goal of ending AIDS by 2030 will require a "test early and treat all" approach focusing on key populations; political will and sustainable financing; expansion of harm reduction in the east; and effective interventions for MSM. The goal of eliminating viral hepatitis will demand some of the same things, plus major price reductions in medicines, much better surveillance and greater integration of hepatitis services and interventions into broader health programmes.

Do we have the right composition of testing strategies in Europe?

Michel Kazatchkine (UN) highlighted two examples of the testing mix, one from the epidemic in Eastern Europe and one from the epidemic in Western and Central Europe. In Russia, perhaps 60% of PLHIV don't know their status. Late diagnosis averages 73%. Though 20 million Russians were tested in 2015, only 5% of them identified with a key population – largely thanks to testing campaigns aimed at the general population. Paris, by contrast, provides ready access to anonymous testing, self-testing, PrEP and treatment. Yet the epidemic there isn't abating, due to insufficient community-based testing and physicians' reluctance to test. Kazatchkine said hepatitis C testing

faces additional problems in Europe: RNA testing, which is required for treatment, is only available through healthcare systems, and testing is not linked to primary prevention. He concluded by calling for more of a public-health approach to testing and less of a health-system one.

There is no shortage of guidelines on testing. The problem is whether they're implemented.

—Michel Kazatchkine, UN

Community perspective on whether we have the right testing strategies in Europe

Jackie Morton (EATG) highlighted the OptTEST survey of legal barriers to community-based HIV testing in 43 countries (see p. 25). Thirty-one restrict who can do HIV testing, and 11 don't allow it in community settings at all. Only 9 permitted self-testing, and just 3 had postal sampling projects. An OptTEST literature review in 2015 found that sex workers were the group most likely to face legal or regulatory barriers to testing, but in fact all key populations face similar barriers in parts of Europe – and they are the groups that benefit most from community testing. Other obstacles to community testing include financial barriers, regulations that hinder anonymity, and a lack of relevant best practice guidelines. She stressed the importance of challenging every law and policy that restricts testing, and said community organizations need to become better at collaborating with government facilities and collecting data to show effectiveness.

PLENARY SESSION 1. SURVEILLANCE AND MONITORING AND EVALUATION OF TESTING

WEDNESDAY, 1 FEBRUARY 2017

HIV and viral hepatitis: what's next?

Alfred Sant (European Parliament) noted that almost 30 000 new HIV cases were reported in the EU/EEA in 2015 – the same incidence as during the previous decade – while an estimated 122 000 were infected without realizing it. He said fear still keeps many people from being tested, even though effective treatment no longer makes a positive test result a death sentence but instead, a path to better future. Sant called on countries to fight stigma, including self-stigma; to scale up testing in a variety of settings, especially for risk groups; and to honour their commitments in order to meet the UN goal of eliminating HIV as a public health threat by 2030. Finally, he described viral hepatitis as a silent epidemic that may prove more daunting to address than HIV.

Ten years of the HIV in Europe initiative: what we have achieved, and the challenges that remain

Ton Coenen (Rutgers), founding co-chair of HIV in Europe, said its success was not preordained; it was risky convening such diverse stakeholders, some of them rivals. He singled out Gilead Sciences for making the first conference in Brussels possible and giving the steering committee a free hand. Despite the tremendous success of Brussels, it was a real challenge to take ownership of the initiative and focus on a broad mix of concrete initiatives – but doing so is why HIV in Europe has flourished. Coenen highlighted the initiative's effect on policy, its work with the Stigma Index, its analysis of testing guidelines and practices and its creation of European Testing Week. In addition, the biennial conferences were critical in bringing different stakeholders together and creating a shared vision. Challenges now include integrating HIV and hepatitis efforts even more, keeping early testing and treatment on the political agenda, and supporting key populations, especially in today's climate of rising nationalism.

Jens Lundgren (CHIP, Department of Infectious Diseases, Rigshospitalet), HIV in Europe's other founding co-chair, contrasted the clinician's experience of HIV in 2007 and 2017, noting how rarely doctors engage directly with public health issues. He paid tribute to John Bartlett, whose many initiatives with the US Centers for Disease Control and Prevention (CDC) helped inspire HIV in Europe, and to the initiative's other founders, Ton Coenen, Nikos Dedes, Jeff Lazarus and Brian Gazzard. Major accomplishments included the consensus definition of late presentation for HIV care, which the ECDC then adopted; a modelling tool for estimating undiagnosed populations; and evidence for indicator conditions that should trigger an HIV test in the healthcare system. Lundgren closed by challenging participants to stay humble, to let science and data guide public health, to normalize our approach to HIV and to listen and learn from each other, including those working with other diseases.

*The majority of migrants with HIV acquire it after they come to the EU. Our lack of action makes **us** the key risk factor for migrants.*

—Andrew Amato-Gauci, ECDC

Test and link to care: how do we measure our success?

Valerie Delpech (Public Health England) reviewed the ECDC's *FACTS* checklist for evaluating whether a testing strategy is working: assess whether it's *feasible, acceptable, cost-effective, targeted* and *sustainable*. It's also important to involve the community in assessment efforts. In the UK, such assessments have shown the value of implementing strategies such as home sampling and postal testing. In estimating the size of undiagnosed populations, Delpech said it's important to use a variety of models. Health systems should also collect data on patient satisfaction and on stigma and discrimination in healthcare settings, looking not only at systemic trends, but also geographic and clinic-level trends. The latter helped determine that the recent dramatic drop in new HIV diagnoses among London MSM is due largely to the successful combination approach of a single clinic, Dean Street.

No one should be dying of AIDS in 2017.

—Valerie Delpech, Public Health England

Surveillance of hepatitis C and hepatitis C testing efforts among people who inject drugs (PWID)

Dagmar Hedrich (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)) said that in the EU/EEA, injecting drug use is responsible for 78% of hepatitis C notifications with a known transmission route, and prevalence among PWID is 40%–80% in most countries. The large population of infected former injectors, many of them asymptomatic, are extremely hard to reach with services, and they need to be included in prevalence estimates. Models show that both harm reduction and treatment are needed to reduce prevalence. Most EU countries don't have accurate estimates of their PWID populations, which are critical to programme planning, so the EMCDDA is training countries how to estimate them. The agency also collects data on the cascade of care and evidence-based interventions, including syringe distribution and opioid substitution therapy (OST). Hedrich noted that EU countries have agreed on common minimum standards for demand reduction, standards that promote making voluntary testing of blood-borne diseases available at drug treatment services.

It makes no sense to separate medical care and drug counselling.

—Dagmar Hedrich, EMCDDA

Discussion

Andreas Berglöf (Swedish Association for Sexuality Education (RFSU)) asked the speaker panel, "How do we address stigma and discrimination, especially in healthcare settings?" **Valerie Delpech** stated that such settings should address stigma head on. We need to develop more interventions and work harder to raise awareness and monitor stigma. **Ton Coenen** called for the community and healthcare systems to collaborate on fighting stigma. **Dagmar Hedrich** said that despite progress, discrimination and criminalization of PWID is still widespread. She also stressed that health workers need more training and options to help PWID access HCV testing in contexts where drug use is criminalized. **Jens Lundgren** said that stigmatization is a continuum and urged the development of an instrument to quantify stigma.

Julian Hows (Global Network of People Living with HIV (GNP+)) asked, "How, with the political right ascendant in Europe, do we restore the political will to reach all undiagnosed PLHIV?" **Ton Coenen** championed the importance of continuing to present evidence in this post-factual era. **Jens Lundgren** stressed the need for all stakeholders – civil society, policymakers, clinicians – to keep working together and speaking out with one voice.

Most of the barriers to getting tested for HIV are driven by attitudes and opinions.

—Valerie Delpech, Public Health England

PLENARY SESSION 2. MIXING TESTING STRATEGIES: COMMUNITY AND HEALTHCARE SETTINGS

Indicator condition-guided testing: progress and challenges

Ann Sullivan (Saint Stephen's AIDS Trust) outlined the development of indication condition-guided testing over the past decade, notably the development of evidence for 17 indicator conditions in the HIV Indicator Diseases Across Europe Study (HIDES). HIDES also identified several clinician barriers to implementation: lack of motivation in non-HIV specialities, time pressure on service delivery and a lack of skills. She then described the tools and training materials developed in OptTEST to address these obstacles and help health systems implement routine testing of people presenting with hepatitis B and C, pneumonia and infectious mononucleosis-like syndrome. These materials include a strategic pack for health policymakers, an interactive service-design module, a staff training module, and a resource pack. The project is also developing targeted materials to raise key population awareness so they know to be tested if they have symptoms of mononucleosis-like illness.

am an IDU, and OST gave me life. It enabled me to be treated for HIV and finally, after 13 years, hepatitis C.

—Anton Basenko, Alliance for Public Health

Monitoring and evaluation of community-based testing in the European HIV Early Diagnosis and Treatment Project (Euro HIV EDAT): achievements and challenges

Jordi Casabona (Euro HIV EDAT) presented preliminary results from Euro HIV EDAT and its 11 core work packages, which build on the success of HIV Community-Based Counselling and Testing (CBVCT) Practices in Europe (HIV-COBATEST). The COBATEST Network is gathering information on European community-based testing and developing standardized monitoring and evaluation procedures. During 2015, data from more than 95 000 testing clients were collected, with the overall prevalence at each site ranging from 0.3% to 3.4%. Data from those sites using the common web-based app showed that almost 90% of the tests were performed at site offices, rather than through outreach. Overall linkage to care was 65.5%, and among MSM tested at checkpoints it ranged from 53% to 100%. In collaboration with the ECDC, spine projects have assessed cost and quality assurance of CBVCT. By providing better data to policymakers, Euro HIV DAT is promoting greater awareness of the critical role that community testing plays and the importance of integrating its data into formal surveillance systems – two things that the next joint action on integrating prevention, testing and link to care strategies across HIV, viral hepatitis, TB and STIs in Europe, (INTEGRATE), will address.

Home testing for HIV: feasibility, acceptability, implementation and applications

Aaron Siegler (Emory University) described two methods of home testing: an oral swab with immediate results and a mail-in dried blood spot (DBS) test. Other possibilities to explore are telemedicine and delivering testing kits to local pickup points. An internet survey of American MSM found 75% were willing to home test, 84% if they received a $10 incentive. Another such survey found that overall, oral swab testing was clearly preferred over physician testing and other testing situations. When DBS kits were mailed to 900 MSM, 84% returned them, with a 3.4% positivity rate; half of those testing positive were then linked remotely to care. He also described a pilot of an MSM health app in which more than half of the users ordered free home tests – and two thirds of those ordering had not intended to test. For oral tests, one way to verify testing is to urge participants to submit mobile phone photos of their used tests.

BCN Checkpoint: achievements, challenges and future plans of a community centre for MSM

Michael Meulbroek (Projecte dels NOMS–Hispanosida) presented the work of BCN Checkpoint, which offers a suite of HIV, viral hepatitis and STI services to MSM. In 2006 it was the first community centre in Europe to offer rapid HIV testing. In 2016 it performed 7700 HIV tests on 5500 people. The positive results – nearly 200 – accounted for 15% of all new HIV diagnoses in Catalonia and more than 40% of those among MSM. BCN Checkpoint also linked 85% of the new cases to care, usually within one week. In the last five years, the percentage of recent infections among new cases rose from 15% to 60%, thanks partly to its test-often campaign. Given the tremendous effectiveness of European checkpoints in diagnosing PLHIV and linking them to care, why, asked Meulbroek, can they not access EU grants or obtain significant funding from national HIV budgets? He closed by announcing the launch of BCN PrEP-Point in June to offer PrEP services.

PARALLEL SESSION 1. MONITORING FOR HIV AND VIRAL HEPATITIS

Are EU/EEA countries ready to monitor progress on HCV programmes?

Erika Duffell (ECDC) presented a survey of 31 EU/EEA focal points on viral hepatitis. Based on the WHO monitoring framework, the survey asked about data collection for 9 core indicators on hepatitis C, focusing on epidemiology and the continuum of care. The 21 responses showed widespread gaps: less than half of the countries had national HCV testing guidance, only 13 reported testing policies targeting PWID, and only 8 reported offering testing routinely to all prisoners. Only Scotland reported data collection across the entire care continuum. A separate ECDC review found prevalence studies in 19 countries since 2005, many with weak methodologies.

HIV testing in persons diagnosed with hepatitis B and C and Diagnosed HIV infections in persons being tested for HBV: England, 2008-2014

Georgina Ireland (Public Health England) noted that UK guidelines recommend an HIV test after a hepatitis B or C diagnosis. Yet an audit of 48 000 adults who tested positive for hepatitis B or C found that only 45% of each cohort were tested for HIV within 6 months of diagnosis, mostly on the same day. A second study examined HIV infection among 2 million people testing for hepatitis B surface antigen (HBsAg). Overall, 1.5% either had been diagnosed with HIV or would be within 6 months. For those testing positive for hepatitis B, the diagnosed HIV coinfection rate was 3.9%.

Organizational barriers as an explanation for differences in offer and uptake rates for hepatitis B/C and HIV testing in three drug-addiction centres in Copenhagen

Marianne Linnet (Social Services Department, City of Copenhagen and CHIP, Department of Infectious Diseases, Rigshospitalet) said that while Copenhagen drug centres are obligated to offer HIV and viral hepatitis tests to all newly referred users of cannabis and cocaine, testing rates are low. She presented a study examining possible reasons for differences in testing rates. It found that, compared to social workers, healthcare workers were much likelier to offer HIV and viral hepatitis

tests to people who use party drugs – and much likelier to get an offer accepted. Rates were even lower at the centre where social workers offering the tests worked on a different floor than the healthcare workers who performed them.

Monitoring anonymous HIV testing in Estonia, 2005-2015

Kadi Kallavus (Estonian National Institute for Health Development) described how the number of anonymous HIV tests in Estonia has more than doubled since 2005, comprising roughly 5% of all HIV tests but accounting for more than 20% of new diagnoses. At the same time, the number of new cases identified anonymously has fallen, while the proportion of PWID among them has dropped from 54% to 24% – likely due in part to testing campaigns targeting the general population. As a result, the cost of detecting one new case through anonymous testing has increased more than fourfold, to about €3400.

The COBATEST network: a platform to perform monitoring and evaluation of HIV community-based testing practices in Europe

Laura Fernàndez-López (Centre for Epidemiological Studies on STIs and HIV/AIDS in Catalonia (CEEISCAT)) presented the ongoing work of the COBATEST network, which connects 40 community-based voluntary counselling and testing (CBVCT) centres located in 19 European countries. Besides sharing good practices and advocating for more supportive public policies, the network has been monitoring and evaluating its members' HIV testing services for the Euro HIV EDAT project (p. 8). In 2015, centres performed anywhere from 8 to 43 000 tests; 45% of those tested were MSM, 32% migrants and 10% sex workers. Among 13 sites providing complete data, 11 linked 100% of the confirmed positives to care.

Obviously, community-based testing is efficient. It's effective. It has good penetration. Yet should it be so much cheaper than health system testing? Is that sustainable? Is that fair? Is that equitable?

—Julian Hows, GNP+

PARALLEL SESSION 2. TESTING STRATEGIES IN KEY AFFECTED POPULATIONS

HIV diagnoses in migrants from Western, Central and Eastern Europe in the EU/EEA: emerging epidemics and HIV diagnoses in migrants from Latin America and the Caribbean in the EU/EEA: distinct epidemics

Julia del Amo (Institute of Health Carlos III (ISCIII)) described HIV trends among migrants to the EEA from Latin American, Caribbean and European subregions in 2004–2013. In migrant groups with large proportion of MSM – South and Andean America and Western Europe – numbers have risen. New cases also increased among migrant men and women from Central and Eastern Europe, while reported HIV diagnosis in migrant women from the Caribbean experienced a drop. CD4 counts upon diagnosis increased for most groups, though the data are incomplete. She concluded that migrants from different subregions have distinct epidemics, each requiring its own response.

A high rate of HIV-1 acquisition post-immigration among migrants in Sweden: missed opportunities for testing and primary prevention

Anders Sönnerborg – presenting for Johanna Brännström (Karolinska Institute) showed how a model of the CD4 cell decline trajectory was used to estimate infection dates for migrants diagnosed with HIV-1 between 1983 and 2013. According to this model, 19% of the migrants were infected after arriving in Sweden, vs. 12% according to doctor estimates. A phylogenetic analysis performed on a subset of the HIV+ migrants favoured the CD4 model with a concordance of 36%, compared to 13% for the physician estimates. The higher rate of post-migration infection underscores the need for stronger primary prevention measures among migrants.

Knowledge and actual vs. potential use of HIV self-testing and self-sampling kits in 8 EU countries

Cristina Agusti (Biomedical Research Networking Centre for Epidemiology and Public Health (CIBERESP)) described an online survey of 11 700 MSM in the EU. Fewer than half of the respondents had been tested for HIV in the previous year. She said 25% had heard of self-sampling and 19% self-testing, but 66% would have used self-sampling if available and 76% self-testing. Less than 3% had actually tried either method. For self-sampling, 70% said they'd prefer to receive results without a face-to-face interaction, e.g. by email or phone – but when asked how they'd like to receive a positive result, the percentage dropped to 42%.

Unless we tell the story about 21st-century HIV, we aren't going to get anywhere.

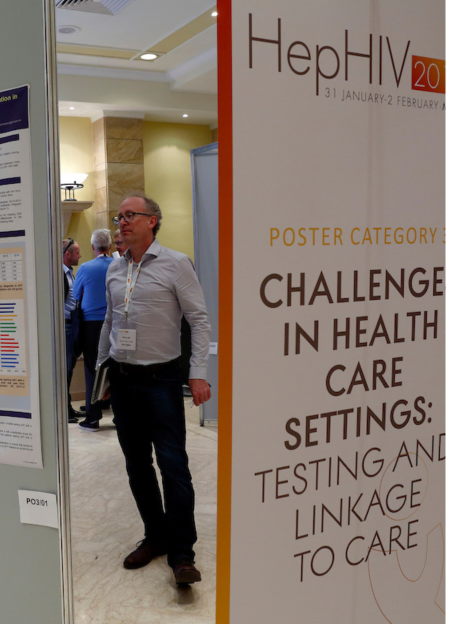
—Ben Collins, International HIV Partnerships

From HIV testing to gay health centres: a mapping of European checkpoints

Axel J. Schmidt (London School of Hygiene and Tropical Medicine) presented two "maps" providing an overview of MSM sexual health centres that have opened across Europe since 2002: a geographical map (http://goo.gl/OVjdnf) with 56 centres, and a diagram of service levels. Forty-four community-based checkpoints and 10 more traditional clinics provided information. All centres provide rapid HIV testing, while majorities offer outreach work, MSM-related research, syphilis testing and counselling for mental health, transgender health and drug use (chem sex). The geographical map can be integrated with location-based apps to send MSM push notifications when they're near a centre.

Factors associated with HCV test uptake in heroin users entering substitution treatment in Greece

Olga Anagnostou (Greek Organisation Against Drugs (OKANA)) presented a study of factors associated with HCV testing history among PWID. In the study population of 2300 heroin users who were beginning OST, 61% had been tested recently for HCV (within the past year), while 22% had last been tested more than a year previous and 17% had never been tested. Analysis suggested that HCV testing efforts should target young PWID, unemployed PWID, and people who have shared syringes in the past two years or whose injecting history is less than two years.



HepHIV20
31 JANUARY-2 FEBRUARY
POSTER CATEGORY
CHALLENGE
IN HEALTH
CARE
SETTINGS:
TESTING AND
LINKAGE
TO CARE

HepHIV 2017
31 JANUARY-2 FEBRUARY · MALTA

The majority of HIV+ migrants are
estimated to have aquired HIV
before immigration*

HepHIV 2017

HepHIV 2017
31 JANUARY-2 FEBRUARY · MALTA
HepHIV 2017

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HepHIV 2017
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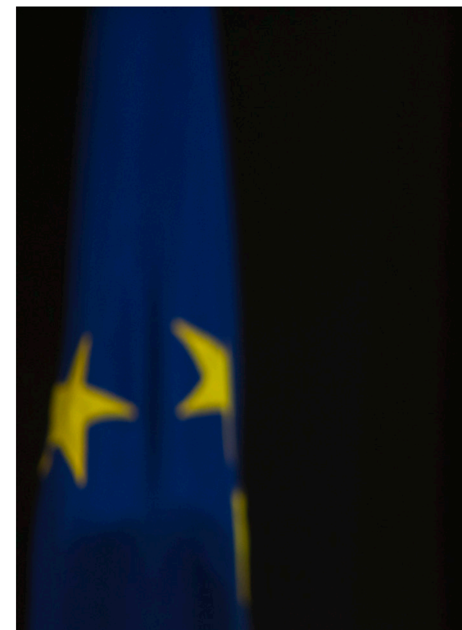


SPECIAL SESSION ON PREP. INFLUENCE OF PREP AND NEW TREATMENT PARADIGMS ON TESTING PATHWAYS

HIV testing in sexual health clinics: do they need to change for PrEP?

Sheel Patel (Chelsea and Westminster Hospital) observed that while MSM demand for PrEP has skyrocketed, cost has been the key barrier to adoption outside France and Norway. In the UK, there's been a surge in MSM obtaining generic PrEP cheaply, legally and safely through iwantprepnow.co.uk. Dean Street, a sexual health clinic serving London MSM, responded by offering PrEP support, including counselling, HBV and HIV testing, sexual health screens, renal monitoring and therapeutic drug monitoring. They've found no evidence of fake generics, no kidney problems – and no new HIV cases. Once PrEP becomes available through the healthcare system, they expect an influx of new patients. To reduce service costs, Patel suggested exploring options like Skype clinics, home testing and focused engagement of high-risk patients.

PrEP implementation: hepatitis C testing required?

Maria Prins (Public Health Service of Amsterdam) pointed out that a dozen years ago, the CDC considered the risk of HCV transmission between sexual partners low and did not recommend testing, even for people with infected partners. While prevalence has risen among MSM since, it's concentrated among those with HIV. PrEP, however, gives MSM less incentive to serosort for HIV and use condoms. She described a recent study in Amsterdam that found a higher than expected baseline prevalence (4.8%) of HCV among MSM starting PrEP. Genotypic analysis suggested that high-risk HIV-negative men might serve as a bridge population, spreading HCV from HIV-positive men to the rest of the HIV-negative men. Prins concluded that yes, we should offer routine HCV screening to MSM on PrEP. **Jürgen Rockstroh** (University of Bonn) asked whether, given a recent study showing that HCV is shed into the rectal fluid, we shouldn't screen *all* MSM for HCV. **Prins** agreed that yearly monitoring makes sense.

> *We need to decide what good HIV and STI prevention should look like in the PrEP era.*
>
> *—Gus Cairns, NAM*

ROUNDTABLE 1. HEPATITIS C AND UNEQUAL ACCESS TO TREATMENT IN EUROPE

Hepatitis C and unequal access to treatment in Europe

Daniel Simões (Treatment Activist Group (GAT)) discussed four interrelated drivers of inequitable access to hepatitis C treatment in the European Region. *Stigma and discrimination* directed against PWID and people in prisons remain enormous barriers. After decades of debate, we still lack the tools to deal with them effectively. *Provision of care* is not tailored to the specific needs of those most affected by HCV. *Lack of capacity to pay for effective treatment* condemns millions to unnecessary suffering. Nations like Portugal have demonstrated that money can be found to treat everyone. Finally, *a lack of political will and commitment* make it impossible to overcome the other three causes of inequity. All of us, Simões said – activists and academics, clinicians and policymakers – must unite our voices and scream for change.

> *We have treatments now that can cure everyone of hepatitis C – and yet every day, 400 people in the European Region die from it. I call that murder.*
>
> *—Daniel Simões, GAT*

Hepatitis C: treatment indications across Europe

Jürgen Rockstroh (University of Bonn) recounted that when DAs became available, the question was, *Where on the disease continuum do we treat?* Now the guidelines from the European Association for the Study of the Liver (EASL) state clearly that everyone who has replicating virus should be treated. Yet every European country has its own treatment guidelines for when to treat, and testing strategies vary wildly too, resulting in what Rockstroh called a controversial way of handling clear European guidelines – and a sure recipe for not achieving elimination.

Should we treat those who are diagnosed, or diagnose those who need treatment?

After some initial comments on prioritizing people for treatment, **Margaret Hellard** (Burnet Institute) refuted the premise of the roundtable question and refocused discussion on how to negotiate with pharma so everyone can be treated. Companies have shown that they'll negotiate; Australia sent them away and used licensed generics from abroad until they came with an acceptable offer. **Jürgen Rockstroh** said that the vast difference in prices – €4000 in Italy vs. €55 000 in Germany – shows how a commitment to universal treatment can lower prices dramatically. German physicians are personally liable for misprescribed medications, which keeps both testing and treatment levels artificially low. **Anton Basenko** (Alliance for Public Health, Ukraine) spoke passionately about the need to test and treat members of key populations – and involve them in policy decisions. **Philippa Easterbrook** (WHO) advocated scaling up diagnosis so that more people can be treated. "Champion" countries like Egypt often skip clinical assessment – they keep it simple and just treat everyone. **Nikoloz Chkhartishvili** (Infectious Diseases, AIDS and Clinical Immunology Research Center) said that strong pressure from all Georgian stakeholders created government commitment. This commitment translated into the implementation of treatment programmes, including programmes for prisoners, and culminated in the HCV elimination program supported by Gilead Sciences.

Daniel Simões said the breakthrough in Portugal came when the negotiating team stopped haggling over the price per treatment and said, *We want to treat everyone, and here's what we can pay.* Politicians need our expert help to negotiate well. **Anton Basenko** described how the government excluded the Ukrainian community from a mediocre deal – which led to activists negotiating a much better price for the community. That then became the benchmark for government procurement. **Philippa Easterbrook** said that high-burden countries with good prevalence data have lots of negotiating power. WHO advises countries to make short-term agreements because innovation is rapid and prices can fall quickly. She argued for using the existing infrastructure of community-based HIV testing to scale up HCV testing. **Tatjana Reic** (European Liver Patients' Association (ELPA)) closed by calling for Europe to develop a Dublin Declaration for hepatitis C to commit countries to action.

ROUNDTABLE 2. THE ROLE OF STIGMA AND CRIMINALIZATION IN DISCOURAGING TESTING

The role of stigma and criminalization barriers in discouraging testing

Edwin Bernard (HIV Justice Network) stated that although we don't know how much HIV criminalization actually deters testing, we do know that it increases stigma. Punitive laws and policies make health workers into agents of the state and damage trust. He urged care in using the term surveillance, which has negative connotations outside public health. Lisa Power added that governments perpetuate stigma when they don't support peer interventions and make the community a full partner. Raoul Fransen-dos Santos (International Civil Society Support) worried that advances in testing and treatment options are translated into coerced uptake of these services without paying sufficient attention to quality counseling. Recommendations to test more and start treatment earlier should not be based on clinical advantages or to addressing logistical challenges alone, but also take into account individual needs to ensure effective long-term treatment. Alexandrina Iovita (UNAIDS) asserted the importance of incorporating human rights standards in public health and healthcare delivery. She called for making human rights part of the medical curriculum and for monitoring and addressing stigma and discrimination in healthcare settings. Julian Hows suggested that many governments have a vested interest in not addressing stigma and discrimination, as doing so would expand the number of people utilizing services.

Raoul Fransen-dos Santos said that the most important way to empower communities was to invest in them directly. Lisa Power reminded the audience that self-stigma is also a major problem. It blocks people from trying things – from talking to their GPs, from returning to work after they realize they're going to live. Julian Hows recalled showing a self-testing kit to PLHIV in Poland. The older ones, who had watched friends die and still thought of HIV as a death sentence, found self-testing a terrible idea because without counselling, a positive result might lead to suicide. Yet the younger PLHIV were all for it. Ben Collins (International HIV Partnerships) said that we did a great job of publicizing the horrors of 20th-century HIV. HIV in the 21st century has been an amazing success, but if you ask most people to tell you about HIV, they'll tell you the 20th-century story.

Nikos Dedes described a vicious circle of invisibility – where for instance, MSM don't appear in epidemiological figures in Eastern Europe, leading to a lack of investment, which exacerbates stigma and drives MSM further underground. Deploring the lack of good training in public health, Valerie Delpech said we have to be better at showing our colleagues how to address stigma and discrimination – how to collect data sensitively, for instance. Edwin Bernard stated that punitive laws won't end without science and evidence. Raoul Fransen-dos Santos observed that because the HIV experience today is more varied, our approaches need to be too. We can't just cater to the people who are happy to be diagnosed today and treated tomorrow; we also have to cater to those who have issues about having HIV and not push them too hard. Alexandrina Iovita reminded participants that the Eastern European story is still a long way from the EU's 21st-century success story.

The best results come when public health and healthcare meet human rights standards.

—Alexandrina Iovita, UNAIDS

PLENARY SESSION 3. THE CONTINUUM OF CARE AND IMPROVING LINKAGE TO CARE

THURSDAY, 2 FEBRUARY 2017

Understanding and improving the HIV continuum of care in Europe

Anastasia Pharris (ECDC) summarized the ECDC's monitoring of the HIV continuum of care in 2014 and 2016, which comprises part of its monitoring of the Dublin Declaration for the 53 countries in the European Region. In 2014, only 13 countries reported on all six indicators. Reporting was simplified to four indicators in 2016, which still permitted monitoring of "the three 90s," and 27 countries reported on all four indicators in 2016. Denmark, Sweden and the UK reached the overall goal of 73% of all PLHIV being virally suppressed, with the average being about 58% for reporting countries. Notably, Russia did not report data. Pharris emphasized that the real purpose of the data is to stimulate action in countries, and they need to disaggregate data by key population to target their efforts. Finally, the focus on the continuum of care shouldn't let countries forget about the importance of prevention or quality of life.

Staging and genotyping aren't important for promoting access. When we look at the "champion" countries for hepatitis C, we don't see them prioritizing patients based on clinical criteria. They streamline and keep it simple.

—Philippa Easterbrook, WHO

The HIV continuum of care and late presentation: implementing the consensus definition

Amanda Mocroft (University College London) explained how the high rate of late presentation in the European Region undermines the effectiveness of the HIV response. Data from the Collaboration of Observational HIV Epidemiological Research Europe (COHERE), a group of more than 30 HIV cohorts from across the EU, shows a gradual decline in overall late presentation from 57% in 2000 to a plateau of 48% in 2010–2013. Mocroft described how ECDC surveillance data was used to weight cohort data from COHERE and EuroSIDA to make them more representative. Clinical event rates were then calculated, giving an estimated 2500 excess deaths in Western Europe and 9000 in Eastern Europe due to late presentation in 2010–2014. Data were only available for three countries outside the EU, however, where the HIV burden and late presentation are much higher. She called for concerted efforts to reduce late presentation, particularly by scaling up indicator disease-guided testing and community-based testing.

*Let's recognize that some people are hard to reach because they **want** to be hard to reach.*

—Julian Hows, GNP+

The hepatitis C continuum of care and late presentation: implementing the consensus definition

Jürgen Rockstroh (University of Bonn) described the continuum of care model for hepatitis C and gave some initial estimates for individual components. The continuum provides a framework for monitoring the effect of HCV screening and treatment efforts; the definition of late presentation for liver disease is also useful. Roughly 110 million people are infected with HCV worldwide; just 5% of them know it. While European rates vary widely, the highest national treatment rate is only 7% of the infected population, well under the WHO target of 80%, chiefly due to the high cost of direct-acting antivirals (DAAs). Because people with advanced liver disease are prioritized for treatment, DAAs are reducing late presentation rates. **Anastasia Pharris** said that the late presentation definitions for viral hepatitis seem to refer to late initiation of treatment, rather than the late diagnosis concept that is used for HIV. **Jürgen** agreed that ideally data would be collected at diagnosis too, but using the definitions at treatment start is the best way to start understanding the urgency of national epidemics.

> *The whole issue of HIV testing is revolutionized by access to care. Bog-standard treatment would transform areas of Europe that are being decimated by untreated HIV.*
>
> *—Brian Gazzard, Chelsea and Westminster Hospital*

The role of civil society in successful testing and linkage to care: a little kindness costs nothing

Tracy Swan discussed the importance of meeting people from vulnerable populations *where they are*, broadly understood. She focused on the structural barriers that PWID living with HCV encounter in healthcare settings. Involving members of the PWID community is crucial to identifying and overcoming these barriers, which include long waiting times, inflexible opening hours, the separation of drug services from hepatitis services, and the nature of hospital settings. Swan drew attention to the fact that active drug users, the very people who are at the highest risk for onward transmission, are generally excluded from treatment. The EASL HCV guidelines have much stricter treatment criteria for PWID, including "integrated management of their substance abuse," than for people with any other medical or psychiatric condition. She cited several studies showing that active drug use does not affect treatment completion, adherence, number of adverse events or cure rate.

> *The cure agenda impedes research on much more important matters, i.e., how do we translate what we know into action?* **Cure** *in the real sense of the word is within our grasp at meetings such as this.*
>
> *—Brian Gazzard, Chelsea and Westminster Hospital*

DISCUSSION

Lamenting the lack of continuum of care data from the Baltic states, **Loreta Stonienė** (Demetra) asked the ECDC, EMDCCA and WHO to be less diplomatic in dealing with countries. **Susan Cowan** (Statens Serum Institut) asked about amending the HIV definition for late presentation to prevent misclassifying acute infection. **Anastasia Pharris** answered that the ECDC has begun removing infections reported as acute from calculations of cases diagnosed late, but information on acute infection is often not available or not reported. **Amanda Mocroft** speculated that acute infections might affect 10%–15% of the cohort data on late presentation.

PARALLEL SESSION 3. CHALLENGES IN HEALTHCARE SETTINGS: TESTING AND LINKAGE TO CARE

Assessing the representativeness of European HIV cohort participants in comparison to surveillance data

Georgia Vourli (National and Kapodistrian University of Athens) explored how well data from 6 EU cohorts reflects ECDC surveillance data for HIV, and described how to make cohort data more representative of the national diagnosed population. Each cohort individual is weighted according to the inverse of the proportion of individuals in the national surveillance data who have matching demographic characteristics and route of transmission. Since the cohorts contain clinical outcome information that is often lacking in the surveillance data, weighting allows this information to be extrapolated more accurately for the entire country. PWID, migrants and people with low CD4 counts tend to be underrepresented in the cohorts.

> *Where's the evidence base for restricting hepatitis C treatment based on drug use?*
>
> *—Tracy Swan*

Factors for delayed linkage to care following HIV diagnosis in the WHO European Region

Sara Croxford (Public Health England) presented a study of how quickly Europeans are linked to care after HIV diagnosis. National comparisons are tricky due to varied definitions of linkage to care. The study examined the time between diagnosis and first CD4 count, finding that 95% of people were linked to care within 3 months. Delays in linkage to care were most likely for diagnoses of people infected through heterosexual contact and injecting drug use, as well as those in Central and Eastern Europe. Actual delays in linkage are probably much more common, as the study excluded people without CD4 counts.

Increased HIV case detection through integration of HIV testing in the Georgian Hepatitis C Elimination Program screening activities

Davit Baliashvili (Georgian Center for Disease Control and Public Health) said that while HCV

seroprevalence in Georgia is 7.7%, HIV prevalence is quite low, with an incidence of less than 0.03%. To detect additional cases, the country started offering HIV tests to everyone who took an HCV test as part of its effort to eliminate hepatitis C by 2020. Out of 29 000 HIV tests, 83 were positive (0.3%); 42 of them were confirmed new cases and enrolled in treatment. It appears to be an effective case-finding mechanism for the general population, and the programme is being expanded.

Monitoring HIV indicator condition-guided testing in Estonia

Liis Lemsalu (Estonian National Institute for Health Development) presented an audit of HIV testing among Estonians who present with an STI, infectious mononucleosis, viral hepatitis, pneumonia or herpes zoster. HIV testing rates for these indicator conditions were low, though substantially higher (about 30%) for infectious mononucleosis and viral hepatitis. Testing was lower among women and older patients. No change was observed after the national HIV testing guidelines were introduced in 2012, though they recommend testing for these conditions.

Testing for blood-borne viruses in the emergency department of a large London hospital

Daniel Bradshaw (Chelsea and Westminster Hospital) described an initiative to offer a combination test for HIV, HBV and HCV to people attending the emergency department at his hospital. To improve uptake, it was implemented as an opt-out test, and patients were only informed of positive results. Resulting seroprevalences were significantly higher than the national rates. Despite staff incentives and an electronic prompt, uptake was just 27% of eligible patients; since the offer rate was not recorded, it is unclear where the barriers lay.

The HIV in Europe initiative has been one of the most important forces for good in the history of European AIDS.

—Brian Gazzard, Chelsea and Westminster Hospital

PARALLEL SESSION 4. COMMUNITY TESTING

Development of a toolkit for implementation and evaluation of MSM checkpoints

Matthias Kuske (AIDS-Hilfe North Rhine-Westphalia) described the development of an online toolkit to help NGOs establish, run and improve MSM checkpoints. Drawing on the experience of existing checkpoints across Europe, the toolkit addresses the operating environment, testing and counselling services, communications, advocacy and quality improvement. An effort was made to accommodate a great variety of checkpoint services, structures and local conditions. The toolkit can be readily modified to create toolkits for community testing sites that target other key populations. It will launch in June 2017 at msm-checkpoints.eu and eurohivedat.eu.

To address hepatitis C in Europe, we have to address people who inject drugs.

—Dagmar Hedrich, EMCDDA

Barring the way to health: how legal and regulatory barriers hinder the modernization of HIV testing in Europe

Lisa Power (OptTEST) summarized a survey of legal and regulatory testing barriers. In 49 European countries, at least 37 restrict who can perform HIV tests, usually limiting it to medical personnel only. While most countries allow community-based testing and outreach, only 11 permit self-testing. At least 7 countries don't offer free testing to some key populations, with migrants being the least well served. Even more don't target key populations, such as MSM and PWID, while pregnant women are often tested multiple times. Power called to modernize testing guidelines, publicize successes and challenge misguided testing policies.

BCN Checkpoint: same-day confirmation of reactive HIV rapid tests with point-of-care PCR tests accelerates linkage to care and reduces anxiety

Michael Meulbroek (Projecte dels NOMS-Hispanosida) reminded people that rapid tests are usually confirmed by sending a western blot test to a lab, which takes at least a week for results. BCN Checkpoint in Barcelona began using a polymerase chain reaction (PCR) test, which gives results in 90 minutes, for confirmation. In 91% of the cases, a positive PCR result provided quick confirmation, including 3 cases (of 219) where a subsequent western blot didn't detect a recent infection. For negative PCR results, a PCR assay now provides confirmation of whether it was a false positive in another 90 minutes. The rapid confirmations have reduced anxiety and improved linkage to care.

Impact of pretest counselling sessions on increasing knowledge about HIV and hepatitis among the beneficiaries of a free voluntary counselling and testing programme in Constanta, Romania

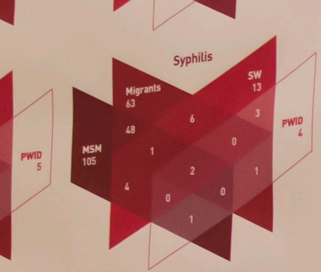
Ana-Maria Schweitzer (Baylor Black Sea Foundation) described the pretest counselling sessions provided at a Romanian clinical centre to people who tested for HIV, HBV or HCV. The vast majority had not been tested before. Clients later assessed how much they had learned, with 54% and 67%, respectively, of the HIV and hepatitis test clients saying their knowledge had increased 80%–100%, suggesting greater public familiarity with HIV than viral hepatitis.

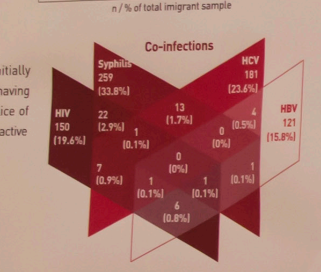
Monitoring test uptake and risk behaviour in community-based HIV/STI testing sites in Germany, 2015-2016

Ulrich Marcus (Robert Koch Institute) presented the results of 15 000 anonymous surveys of people taking HIV tests at 10 German checkpoints. Most respondents were aged 20–39, and more than half were MSM. MSM were much likelier than heterosexuals to have reactive test results (1.4% vs. 0.4%). Reactive results were more common among MSM who assessed their infection risk as moderate or high, especially if they used chem sex drugs or had condomless anal sex with multiple partners. Marcus also urged lab tests for those reporting recent risks, as rapid tests can miss acute infections.

We have all the evidence. Now we need to make sure that all these strategies don't just sit on a shelf, but that we find the resources to put them into action so that no one – whether infected or at risk for infection – is left behind.

—Charmaine Gauci, Maltese Ministry of Health


Syphilis
Migrants
63
SW
13
MSM
105
PWID
4
PWID
5


Co-infections
Syphilis
259
(33.8%)
HCV
181
(23.6%)
HIV
150
(19.6%)
HBV
121
(15.8%)

PLENARY SESSION 4. NEW POINT-OF-CARE DIAGNOSTICS AND COST-EFFECTIVENESS OF DIFFERENT TESTING FREQUENCIES

New point-of-care diagnostics for HIV and HCV

Emmanuel Fajardo (MSF) started with point-of-care HIV diagnostics that enable early infant screening, oral self-testing, CD4 counts and viral load monitoring. OraQuick offers the only oral self-tests right now. Viral loads can now be monitored with dried blood spots, which perform a little worse than plasma-based tests but are very easy to use. For hepatitis C, dozens of rapid tests exist, but quality varies tremendously, and Fajardo stressed the importance of quality assurance. In general, countries should base their tender systems on performance as well as price. The new DAAs are starting to simplify diagnosis and treatment monitoring. Right now there's only one point-of-care RNA test. Testing costs in general are quite variable – Ukraine pays $5 for viral load genotyping and Switzerland $180. Scaling up will drive prices down, but meanwhile, pooled procurement can help reduce costs.

Cost-effectiveness of HIV testing: frequency and target groups

Yazdan Yazdanpanah (French National Institute of Health and Medical Research (Inserm)) presented a study that calculated cost-effective testing frequencies for MSM, PWID and the general population in three countries. The study team deemed a testing frequency to be cost-effective if the savings per year of life gained was less than the annual gross domestic product (GDP) per capita. Their findings were most sensitive to incidence rate and testing costs, but they also took into account such factors as size of the undiagnosed population, CD4 count at diagnosis, linkage to care and treatment costs. For PWID, for instance, they concluded that in Estonia, it would be cost-effective to at least monthly; in Spain, every 3–12 months; and in France, every 1–3 years. Yazdanpanah stressed, however, that testing approaches should not be based on cost-effectiveness alone.

CLOSING SESSION. EUROPEAN POLICIES AND STRATEGIES AND THEIR IMPLEMENTATION

Towards a realistic cure: the role of HIV testing

Brian Gazzard (Chelsea and Westminster Hospital) characterized HIV cure efforts as misguided at best, with many potential cures being expensive, difficult to implement widely, susceptible to re-infection and requiring extended follow-up. At worst, he said, they divert money and energy away from meaningful research into the application of existing knowledge. Instead, he described what he called "a realistic cure." It consists of identifying the infected, guaranteeing that they have access to treatment and making sure that testing and treating remains a government priority. The long-term goal is to reduce the reproductive rate of the epidemic to less than one, so that it peters out. Gazzard said that the EU has embraced this cure, thanks to HIV in Europe's advocacy for targeted testing, alternate testing venues, the use of indicator conditions, stigma research and now PrEP.

How do we tailor policies to specific epidemics - and translate European policy into national reality?

Charmaine Gauci reminded listeners that we're dealing with people, not viruses, and we must address their needs, especially as they age and become more at risk for comorbidities. **Antons Mozalevskis** (WHO Regional Office for Europe) noted that all 53 countries in the European Region have endorsed the new European action plans on HIV and viral hepatitis. Now they need to revise their national plans and targets accordingly. **Markus Cornberg** (EASL) said that with hepatitis C, the focus should now be treatment uptake. He argued that high reinfection rates make elimination very difficult for high-prevalence groups – which is why we should still invest in vaccine development. **Charles Gore** (World Hepatitis Alliance) was unconvinced, saying it was more important to develop better-targeted strategies. For instance, reinfection among PWID is very low when harm reduction is well implemented.

Julia del Amo displayed a map of European countries that deny HIV treatment to undocumented migrants. Such policies make achieving the 90-90-90 targets impossible. **Dagmar Hedrich** said that meetings like this one are critical because they promote the spread of good strategies that can then feed into policy. She pointed out that we lack data and strategies especially for prisons. **Andrew Amato-Gauci** pleaded for ideas on how to monitor implementation of testing programmes. He praised WHO and other actors for pushing countries to stop basing treatment on CD4 counts and just test and treat everyone – up from 4 countries in 2014 to 24 in 2016. He questioned whether the emphasis on the three 90s have made us forget about cheap, reliable prevention methods like condom promotion. **Nikos Dedes** stated that while condom promotion and use is still quite high among gay men, it will never return to its 1990s peak. We must be pragmatic and use a combination of tools.

Brian Gazzard maintained that the real game-changer for HIV is access to care. Yet translating testing into care has been disturbingly poor – and we're all to blame. We succumb to the blandishments of pharma and their shiny new drugs, when cheap alternatives are efficacious and have virtually no side-effects. **Andrej Senih** (EATG) depicted the Dublin Declaration as a very effective policy instrument that remains relevant, despite major gaps. He said it's time now for a new regional policy dialogue – and he proposed that it focus on public health as the best way to bring governments and other stakeholders together. On behalf of civil society, **Lella Cosmaro** (Italian League for Fighting AIDS (LILA)) called for stronger EU leadership in pressuring national governments to implement European policy, and requested better monitoring of national efforts to fight stigma and discrimination. She also said that countries should help fund community based-testing and integrate it into their national strategies.

Conference call to action

Co-chair **Jürgen Rockstroh** presented a draft call to action prepared by the conference organizing committee. He added a point about challenging policies that restrict undocumented migrants' access to testing and treatment, and the draft was accepted by acclamation. It will be sent out to participants for further comment and finalization and then formally shared with the European commissioner for health and food safety. Co-chair **Charmaine Gauci** closed the conference by reiterating the Maltese government's strong commitment to the conference agenda and challenging participants to implement what they had learned.

HEPHIV 2017 CALL FOR ACTION

All of us – people living with HIV and with viral hepatitis, civil society representatives, health professionals, public health officers and decision-makers, policymakers, representatives from European and national institutions, and researchers – need to keep collaborating closely to decrease the number of people initiating HIV and HCV treatment late, in order to improve long-term health outcomes and reduce onward transmission.

The year 2016 saw the adoption of the very first global health sector strategy on viral hepatitis, a turning point in efforts to fight the disease, and of a corresponding strategy on HIV. The participants in the HepHIV 2017 Conference call on all stakeholders to work together to achieve the targets and goals in these strategies, and to exceed them when possible, by implementing the following actions.

1. Improve surveillance of viral hepatitis and the late presentation of viral hepatitis, and support ECDC efforts in this area.
2. Improve the monitoring and evaluation of programmes and services with respect to testing and linkage to care for HIV, viral hepatitis and sexually transmitted infections, (STIs), and promote the sharing of their best practices.
3. Improve HIV and viral hepatitis testing strategies:
    - tailor HIV and viral hepatitis screening strategies to each country's epidemics, including at the subnational level;
    - expand and support community-based testing for HIV and viral hepatitis by trained laypeople;
    - make self-testing and self-sampling an integral part of the testing toolkit;
    - educate general practitioners and other healthcare providers about testing strategies, including the importance of prompt referral to specialist care, and facilitate the implementation of indicator condition-guided testing;
    - develop new, affordable testing diagnostics, and utilize them; and
    - increase testing frequency and testing at early stages of infection when cost-effective, particularly in high-risk populations.
4. Create synergies between efforts to tackle communicable and non-communicable diseases by encouraging partnerships and collaborations, including tandem testing, among people working with HIV, viral hepatitis, TB and STIs.
5. Advocate for stronger political leadership in implementing evidence-based public health interventions by the EU and its member states, as well as by other governments and international agencies in the WHO European Region.
6. Remove all restrictions on direct-acting antiviral (DAA) therapy for hepatitis C, and make it immediately available for all people living with active hepatitis C.
7. Drawing on the support and involvement of all stakeholders, urge governments to negotiate effectively to ensure universal access to DAA therapy.
8. Make pre-exposure prophylaxis (PrEP) available to everyone who needs it, as an integral part of HIV prevention.
9. Scale up efforts to combat stigma and discrimination by:
    - telling the 21st century HIV and viral hepatitis story – that diagnosis and treatment can ensure a long and healthy life and stop onward transmission;
    - normalizing and expanding HIV and viral hepatitis testing;
    - promoting national and regional monitoring of stigma, discrimination and unjust criminalization; and
    - developing more effective interventions to combat stigma, discrimination and unjust criminalization.
10. Challenge policies that prevent undocumented migrants from accessing HIV and viral hepatitis prevention, testing, treatment and care.

PRESS AND MEDIA COVERAGE

INTERNATIONAL ONLINE NEWSPAPERS

gozonews.com, 14 February 2017
122,000 people in Europe unaware of HIV infection
Former Prime Minister Alfred Sant has said that it is estimated that there are some 122 000 people in Europe living with HIV who are currently unaware of their infection …

tvm.com, 14 February 2017
122,000 infected with HIV in Europe without their knowing – Sant
MEP Alfred Sant said it is estimated that around 122 000 people in Europe are unaware that they are infected by HIV and are therefore …

gscene.com, 5 February 2017
New HIV infections in gay men in England drop by a third
New Scientist reveals that new HIV infections in gay men have fallen by nearly a third since 2015 across the country. This data was presented at the recent HepHIV conference in Malta by Valerie Delpech from Public Health England, who told …

gaystarnews.com, 4 February 2017
New HIV infections in gay men drops by one third in England
HIV infection rates in gay and bisexual men dropped by almost one third since 2015 in England. This may be due to people buying preventative medicines online, reports *New Scientist*. The results offer a nationwide snapshot of the state of new HIV transmissions in England. During the HepHIV conference in Malta on Wednesday (1 February), Valerie Delpech of Public Health England revealed the results …

trueviralnews.com, 4 February 2017
New HIV infections of men in England have dropped by a third
The number of gay men in England who have contracted new HIV infections has fallen by a third since 2015, according to preliminary data presented on Wednesday at the HepHIV conference in Malta.

newnownext.com, 3 February 2017
New HIV cases in England drop by a third The rate of new HIV infections among gay men have fallen drastically in England, according to a new study. On Wednesday, a report presented at the HepHIV conference in Malta revealed diagnoses among gay men have dropped nearly a third …

MALTESE ONLINE NEWSPAPERS

maltatoday.com.mt, 14 February 2017
HIV: 122,000 Europeans are unaware they are infected
Almost 30 000 newly diagnosed HIV infections have been reported across Europe with viral hepatitis emerging as a silent epidemic …

SOCIAL MEDIA COVERAGE

Facebook and Twitter
The HepHIV 2017 Conference was featured on several social media channels. The hashtag #HepHIV2017 was used ahead of and throughout the conference. From 30 January to 2 February, the hashtag generated 17.2K impressions, with an average of 50 retweets and 13 link clicks per day. There were also a number of Facebook posts on the HIV in Europe, OptTEST and EATG pages. Some of our favorite posts and tweets have been gathered in a story on Storify that you can access here.

YouTube
One blog report and five interviews were conducted during the HepHIV 2017 Conference covering questions about HIV and HCV testing.

Blog report, Tamás Bereczky: https://youtu.be/JORpLDICFxg

Edwin Bernard interview: https://youtu.be/ggVt-43ICHg

Gus Cairns interview: https://youtu.be/-SZ0SCd2hg8

Jackie Morton interview: https://youtu.be/N9rsu_Wykp4

Jeffrey Lazarus interview: https://youtu.be/MZ4ind7-78M

Ulrich Marcus interview: https://youtu.be/63Kvrk5JtKM

THE HEPHIV 2017 CONFERENCE: HIV AND VIRAL HEPATITIS: CHALLENGES OF TIMELY TESTING AND CARE IS HELD IN CONJUNCTION WITH THE MALTESE PRESIDENCY OF THE COUNCIL OF THE EU

THE HEPHIV 2017 CONFERENCE IS FUNDED BY THE HIV IN EUROPE INITIATIVE

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