



## **HIV in Europe**

Working Together for Optimal  
Testing and Earlier Care

**Copenhagen 2012 Conference**

### **Programme and abstract book**



# **HIV in Europe** **Copenhagen 2012 Conference**

18 - 20 March 2012  
University of Copenhagen



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# Welcome to HIV in Europe Copenhagen 2012 Conference

**Dear Colleague,**

On behalf of the HIV in Europe Steering Committee we would like to welcome you to the **3<sup>rd</sup> HIV in Europe Conference, this year at the University of Copenhagen.**

The conference marks five years of the HIV in Europe Initiative, which seeks to ensure that people living with HIV enter care earlier than is currently the case. Today, 30-50% of people in Europe living with HIV are unaware of their status and approximately 50% of them present late for care. Entering early into care increases the quality and duration of life of the person living with HIV, it also reduces the risks of transmission.

The bi-annual conferences of HIV in Europe (Brussels 2007 and Stockholm 2009) have been an important step towards decreasing the number of people presenting late for care by creating a platform for national and innovative best practice initiatives on HIV testing around Europe and sharing knowledge and experiences across borders. The importance of having effective systems for testing in place and to work towards creating a positive perception of testing will be an important focus area of the conference.

The HIV in Europe initiative has influenced and in some cases guided the policy and normative discourse on testing and early access to care in Europe through the research projects it has initiated, the scientific conferences it has organized and its policy and advocacy work. The initiative has established itself as a pan-European platform for sharing ideas and knowledge, and is recognized as an important stakeholder in the fight against HIV and AIDS. It has generated numerous conference abstracts over the last three years. One of the strengths of the initiative is the joint participation from civil society, policy makers, health professionals and European public health institutions.

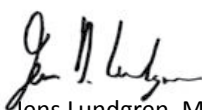
We are very pleased to see the enthusiasm across Europe for the Copenhagen Conference. Colleagues from more than 40 countries are present and the 124 abstracts that were submitted reflect the extent of the problem across Europe, the ongoing scientific research as well as the willingness and intent to urgently change the situation for the better.

We are confident that the initiative's projects will continue to inform political decision-making in the West and soon make an impact on early diagnosis and early care in Eastern Europe as well. We look forward to two days of lively discussion, innovative thinking and a renewed commitment of political action in Copenhagen.

On behalf of the Steering Committee of HIV in Europe,



Ton Coenen  
Executive Director AIDS Fonds  
& Soa AIDS Nederland  
Co-chair HIV in Europe



Jens Lundgren, MD, DMSc  
Professor, University of Copenhagen  
Director, Copenhagen HIV Programme  
Co-chair HIV in Europe





# HIV in Europe Steering Committee

## The Co-Chairs

|               |  |
|---------------|--|
| Ton Coenen    | AIDS Action Europe, Executive Director, Aids Fonds and STI Aids Netherlands, The Netherlands                       |
| Jens Lundgren | Professor & Chief Physician, University of Copenhagen & Rigshospitalet Director, Copenhagen HIV Programme, Denmark |

## Members

|                    |  |
|--------------------|--|
| Jordi Casabona     | Scientific Director, Center for HIV/STI Epidemiological Studies of Catalonia (CEEISCAT), Spain   |
| Nikos Dedes        | Past Chair of the Board of Directors European AIDS Treatment Group (EATG), Greece  |
| José Gatell        | Head, Infectious Diseases & AIDS Units, Clinical Institute of Medicine & Dermatology, Hospital Clinic. Professor of Medicine, University of Barcelona, Spain |
| Brian Gazzard      | Professor of Medicine, Imperial College School of Medicine. HIV Research Director, Chelsea & Westminster Hospital, United Kingdom                            |
| Igor Karpov        | Professor, Department of Infectious Diseases Belarus State Medical University, Belarus   |
| Jürgen Rockstroh   | Professor of Medicine, University of Bonn, and Head of an HIV outpatient clinic, Germany   |
| Anders Sönnernborg | MD, PhD, Professor, Department of Medicine Karolinska University Hospital, Sweden  |
| John de Wit        | Professor of Sociology, Utrecht University, The Netherlands  |

## Observers

|                    |  |
|--------------------|--|
| Vitaly Zhumagliev  | The Global Fund to Fight AIDS, Tuberculosis and Malaria, Switzerland |
| Lali Khotenashvili | WHO Regional Office for Europe, Denmark                              |
| Marita Van de Laar | European Centre for Disease Prevention and Control, Sweden           |
| Lucas Wiessing     | European Monitoring Centre for Drugs and Drug Addiction, Portugal    |
| Kevin Fenton       | Centers for Disease Control and Prevention (CDC), USA                |
| Jean-Elie Malkin   | UNAIDS RST/ECA, Russia   |



# HIV in Europe Copenhagen 2012 Conference – Organising Committee

All SC members and observers are part of the organising committee, please see page 6.

Jeffrey V Lazarus  
Ferenc Bagyinszky  
Ferran Pujol  
Henrik Arildsen  
Luis Mendao  
Miriam Sabin  
Ulrich Marcus  
Vincent Douris  
Yusef Azad  
Jan Fouchard  
Klaus Legau  
Anna Zakowicz  
Maryna Zelenskaya  
Igor Sobolev  
Alexey Yakovlev

Copenhagen HIV Programme, University of Copenhagen, Denmark  
Hungarian Civil Liberties Union, Hungary  
HISPANOSIDA, Spain  
HIVeurope, Denmark  
EATG, Portugal  
UNAIDS, Switzerland  
Robert Koch Institute, Germany  
Sidaction, France  
National AIDS Trust, United Kingdom  
Danish National Board of Health, Denmark  
STOP AIDS, Denmark  
European AIDS Treatment Group, Belgium  
Ministry of Health, Ukraine  
Estonia PLWHA Network, Estonia  
Botkin Hospital of Infectious Diseases in St. Petersburg, Russia



# HIV in Europe Copenhagen 2012

## Conference Objectives

The main objectives of the HIV in Europe Copenhagen Conference 2012 are to:

1. Provide an overview of European innovative initiatives and best practices on optimal testing and earlier care - how to get people tested;
2. Sustain and fuel the political discussion of the WHO Regional Office for Europe testing guidelines (2010), ECDC testing guidelines (2010) and ECDC-EMCDDA Guidance "Prevention and control of infections among people who inject drugs"(2011), the EU Communication on HIV/AIDS and EP Resolution adopted 1 Dec 2011 and their implementation at national levels;
3. Accompany the debate at European Union HIV/AIDS Civil Society Forum and Think Tank level on HIV testing;
4. Provide opportunities for multi-stakeholder dialogue to develop creative solutions to unresolved challenges in research and implementation of HIV policies and programmes to improve early diagnosis and care of HIV across Europe - which people are prevented from testing and treatment, which measures are needed to overcome these problems, which are the incentives for policy makers and people undiagnosed to become more active;
5. Discuss and take forward the strategy for implementation of changes based on the concrete outcomes of the projects and initiative;
6. Inform leaders, including key policy makers and donors, as to increase their commitment to ensure that people with HIV enter care earlier in the course of their infection than is currently the case;
7. Increase public awareness of the public health problems associated with late presentation for HIV care;
8. Present data available on temporal trends of late presenters and the undiagnosed population and data on the cost-effectiveness of HIV testing demonstrating how scaling up HIV testing can contribute to more sustainable health systems;
9. Discuss HIV testing and linkage to care and testing among key populations and the role of new HIV testing diagnostic technologies.





# Programme at a glance

| Time                  | Lundsgaard Auditorium  | Haderup Auditorium                        | Hannover Auditorium  |
|-----------------------|--|---|--|
| Monday 19 March 2012  |  |   |  |
| 9:00-10:30            | Opening plenary  |   |  |
| 11:00-12:30           | Plenary:<br>Access to earlier testing and care   |   |  |
| 13:30-15:15           | Parallel sessions: Testing programmes and strategies<br>HIV testing among key populations  | HIV testing and the continuum of HIV care | Lessons learned in novel HIV testing strategies and programmes |
| 15:15-16:15           | Poster session outside the auditorium  |   |  |
| 16:15-18:00           | Plenary:<br>Late presenters and the undiagnosed  |   |  |
| Tuesday 20 March 2012 |  |   |  |
| 8:15-10:30            | Plenary:<br>Discussing testing strategies  |   |  |
| 10:30-11:00           | Poster session outside the auditorium  |   |  |
| 11:00-12:30           | Parallel sessions: Challenges in optimal testing and earlier care<br>Characteristics of PLHIV who present late for care and missed opportunities for earlier diagnosis | New HIV testing diagnostic technologies   | Cost effectiveness of HIV testing                              |
| 13:30-15:00           | Closing session and Panel discussion:<br>HIV in Europe – the way forward   |   |  |

# Programme

**Sunday, 18 March 2012**

**Venue: Kong Arthur Hotel, Nørre Søgade 11**

**16.00-19.00** Registration, Kong Arthur Hotel

## Side events

**15.00-17.00** European Commission – Health Programme HIV/AIDS Projects

**17.00-18.45** HIVeurope Satellite meeting – The role of HIV workplace policies and programmes in addressing “barriers” to early HIV counselling, testing, treatment and care

**19.00-21.00** Welcome Reception, La Rocca, Vendersgade 23-25

**Monday, 19 March 2012**

**Venue: Panum Institute, Blegdamsvej 3, University of Copenhagen**

| Time               | Lundsgaard Auditorium  | Moderators and Speakers  |
|--------------------|--|--|
| <b>8.00-9.00</b>   | <b>Registration</b> – Coffee   |  |
| <b>9.00-10.30</b>  | <b>Opening plenary</b>   | Moderators: Jens Lundgren and Ton Coenen, Co-Chairs of HIV in Europe |
|                    | Welcome to HIV in Europe Copenhagen 2012 Conference / Objectives and expected outcomes                     | Jens Lundgren and Ton Coenen, Co-Chairs of HIV in Europe             |
|                    | Keynote speech: Danish Acting Minister of Health   | Pia Olsen Dyhr, Acting Minister of Health                            |
|                    | Keynote speech: European Commission  | Martin Seychell, DG Sanco  |
|                    | Earlier HIV testing and care on the European agenda  | Marisa Matias, European Parliament                                   |
|                    | The role of ECDC in optimal testing and earlier care   | Marc Sprenger, ECDC  |
|                    | The role of WHO in optimal testing and earlier care  | Guenael R.M. Rodier, WHO Europe                                      |
| <b>10.30-11.00</b> | Coffee Break   |  |
| <b>11.00-12.30</b> | <b>Plenary: Access to earlier testing and care</b>   | Moderators: Nikos Dedes, EATG and Marita van de Laar, ECDC           |
|                    | Welcome note from Copenhagen University  | Ulla Wewer, University of Copenhagen                                 |
|                    | Key issues for HIV testing in Europe   | Martin Donoghoe, WHO Europe  |
|                    | Challenges in earlier HIV testing and linkage to care among people who inject drugs                        | Roland Simon, EMCDDA   |
|                    | HIV testing guidelines in Europe and linkage to care: need for implementation - Western Europe perspective | Valerie Delpech, Health Protection Agency                            |
|                    | HIV testing and counselling in EECA: entry point for curbing the HIV epidemic                              | Nino Tsereteli, ECOM and EHRN  |
| <b>12.30-13.30</b> | Lunch  |  |

| Time               | Hannover Auditorium  | Haderup Auditorium   | Lundsgaard Auditorium   |
|--------------------|--|--|---|
| <b>13.30-15.15</b> | <b>Parallel sessions: Testing programmes and strategies</b>  |  |   |
|                    | <b>1. Lessons learned in novel HIV testing strategies and programmes</b><br>Moderators: Marita van de Laar, ECDC and Martin Fisher, Royal Sussex County Hospital   | <b>2. HIV testing and the continuum of HIV care</b><br>Moderators: Anders Sönnernborg, Karolinska Institutet and Jeffrey Lazarus, University of Copenhagen   | <b>3. HIV testing among key populations</b><br>Moderators: Julia del Amo, Institute of Health, Spain and Julian Hows, GNP+  |
|                    | PS1/01<br><u>Michael Rayment</u> , C Rae, S Finlay, M Atkins, P Roberts, A Sullivan<br><b>Routine HIV testing in the Emergency Department: tough lessons in sustainability, UK</b>   | PS2/01<br><u>Valerie Delpech</u> , Z Yin, M Kall, A Brown<br><b>Quality of care and clinical outcome of persons diagnosed with HIV in the UK</b>   | PS3/01<br><u>Oksana Savenko</u> , S Filippovych, Z Islam<br><b>Ukraine's experience in scaling-up HIV testing and further referral of high-risk population to health-care institutions Ukraine</b>  |
|                    | PS1/02<br>E Casalino, S Firmin, A Delobelle, B Bernot, C Choquet, G Der Sahakian, J Zundel, P Hausfater, YE Claessens, E Bouvet F Brun-Vezinet, <u>Dominique Costagliola</u><br><b>Routine HIV Screening in 6 EDs in Paris area: the ANRS URDEP Study, France</b>  | PS2/02<br><u>Michael Meulbroek</u> , E Ditzel, J Saz, H Taboada, G Font, A Perez, A Carrillo, F Perez, J Montilla, M Ingrams, V Gimenez, F Pujol<br><b>BCN Checkpoint: high efficiency in HIV detection and linkage to care, Spain</b> | PS3/02<br>Nino Tsereteli, I Chiqovani, K Gogvadze, N Rukhadze<br><b>Effectiveness of continuous prevention interventions for HIV testing uptake among high risk populations in Tbilisi, Georgia</b>   |
|                    | PS1/03<br><u>Fiona Burns</u> , S Edwards, J Woods, G Haidari, Y Calderon, J Leider, S Morris, R Tobin, J Cartledge, M Brown<br><b>Acceptability, feasibility and costs of universal offer of rapid point of care testing for HIV in an acute admissions unit: results of the RAPID project, UK</b>   | PS2/03<br><u>Maria José Campos</u> , E Teófilo, H Machado, J Brito, J Esteves, L Mendão, R Abrantes, R Furtos, T Rodrigues, N Pinto<br><b>CheckpointLX - MSM HIV testing and linkage to care in Lisbon, Portugal</b>                   | PS3/03<br><u>Lazare Manirankunda</u> , J Loos, C Nöestlinger<br><b>Translating research results into promotion of HIV testing among Sub-Saharan African migrants in Flanders, Belgium</b>   |
|                    | PS1/04<br>W Majewska, <u>Catherine Howland</u> , M Pakianathan<br><b>Increasing HIV testing in non-GUM settings – a new training resource, UK</b>  | PS2/04<br>Jean-Yves Le Talec, C Rouzioux, Nicolas Derche, C Taeron, A Guérin, G Sebbah, G Tellier, E Penel<br><b>Checkpoint: rapid HIV screening in community setting for a strong link to care, France</b>                            | PS3/04<br><u>Assel Terlikbayeva</u> , M Berry, V Ragoza, A Janayeva, C Berry, N El-Bassel<br><b>Using community-based rapid HIV screening among men who have sex with men in a behavioral sero-surveillance survey, Almaty, 2010, Kazakhstan</b>        |
|                    | PS1/05<br><u>Axel J Schmidt</u> , U Marcus, M Breveglieri, P Fernández-Dávila, L Ferrer, C Folch, M Furegato, F Hickson, HJ Hospers, D Reid, P Weatherburn.<br><b>The EMIS Network Individual level and country level predictors for recent HIV-testing and late HIV diagnosis among MSM in Europe - aspects to consider when planning interventions to increase HIV-testing. Results of the European MSM Internet Survey (EMIS)</b> | PS2/05<br>J Hows, <u>Elena Grigoryeva</u><br><b>PLHIV-Related Stigma in Belarus - impacts on quality of care and health outcomes, Belarus</b>  | PS3/05<br><u>Marta Vasylyev</u> , M Sluzhynska, O Sluzhynska, O Grushynska<br><b>Development of gender oriented services to increase the number of voluntary counseling and testing (VCT) among female drug users of Lviv region (Ukraine), Ukraine</b> |
|                    | PS1/06<br><u>Claudia Carvalho</u> R Furtos, R Lucas, MJ Campos, L Mendão, AJ Schmidt<br><b>HIV testing among Portuguese men who have sex with men- results from the EMIS Study, Portugal</b>   | PS2/06<br><u>Zoya Shabarova</u> , T Ford, I Sobolev, S Kulsis, R Kulchynska, A Podymova<br><b>Scaling-up community HIV rapid testing and linkage to care in Estonia, Lithuania, Russia and Ukraine: results and lessons learned</b>    | PS3/06<br>L Gios, M Breveglieri, M Furegato, <u>Massimo Mirandola</u><br><b>Socio-demographic factors predicting HIV test seeking behaviour among MSM in 6 EU cities. Results from the SIALON European Project (2008-2010), Italy</b>                   |
|                    | Discussion   | Discussion   | Discussion  |
| <b>15.15-16.15</b> | Poster Session and Coffee Break  |  |   |

| Time               | Lundsgaard Auditorium  | Moderators and Speakers   |
|--------------------|--|---|
| <b>16.15-18.00</b> | <b>Plenary: Late presenters and the undiagnosed</b>  | Moderators: Jean-Elie Malkin, Regional Support Team for Europe and Central Asia, UNAIDS and Brian Gazzard, Chelsea Westminster Hospital |
|                    | Characteristics of the epidemiology and temporal trends of late presenters in Europe         | Joanne Reekie, UCL  |
|                    | Estimating HIV prevalence in European countries  | Ard van Sighem, Stichting HIV Monitoring  |
|                    | An assessment of the approaches to evaluating cost-effectiveness of HIV screening strategies | Olivia Wu, University of Glasgow  |
|                    | Guidance on Indicator Condition-Guided HIV Testing: Presentation of draft guidance document  | Keith Radcliffe, IUSTI  |
|                    | Discussion   |   |
| <b>20.00</b>       | Conference dinner, Moltkes Palæ, Dronningens Tværgade 2                                      |   |

## Tuesday, 20 March 2011

| Time               | Lundsgaard Auditorium   | Moderators and Speakers   |
|--------------------|---|---|
| <b>8.45-10.30</b>  | <b>Plenary: Discussing testing strategies</b>   | Moderators: José Gatell, University of Barcelona and Lali Khotenashvili, WHO Europe |
|                    | Diagnostics/testing/regulations/incidence: US perspective   | Bernard Branson, CDC  |
|                    | A model of the MSM epidemic in the UK: implications for understanding the impact of condom use and ART in influencing incidence | Andrew Phillips, UCL  |
|                    | People living with HIV Stigma Index: Findings from Estonia  | Jekaterina Voinova, Estonian Network of PLWHIV and GNP+                             |
|                    | The COBATEST Project: Survey on Community-Based Testing Services in Europe  | Michele Breveglieri, Regional Centre for Health Promotion                           |
|                    | Report from Monday's plenary and parallel sessions  | Jens Lundgren and Ton Coenen, HIV in Europe   |
|                    | Discussion  |   |
| <b>10.30-11.00</b> | Poster Session and Coffee Break   |   |

| Time               | Hannover Auditorium   | Lundsgaard Auditorium  | Haderup Auditorium   |
|--------------------|---|--|--|
| <b>11.00-12.30</b> | <b>Parallel sessions: Challenges in optimal testing and earlier care</b>  |  |  |
|                    | <b>4. Cost effectiveness of HIV testing</b><br>Moderators: Raminta Stuikeyte, EATG and Valerie Delpech, HPa<br><br>PS4/01<br>Elena Pizzo, M Rayment, A Thornton, T Hartney, V Delpech, A Sullivan, The HINTS Study Group<br><b>Cost effectiveness of HIV testing in non-traditional settings – the HINTS Study, UK</b><br><br>PS4/02<br>Y Yazdanpanah, <u>Julian Perelman</u> , J Alves, K Mansinho, M Lorenzo, J-E Park, E Losina, RP Walensky, F Noubary, H Barros, K Freedberg, DA Paltiel<br><b>Routine HIV screening in Portugal: clinical impact and cost-effectiveness, Portugal</b><br><br>PS4/03<br>I Menacho, E Sequeira, M Muns, O Barba, T Clusa, L Leal, E Fernández, D Raben, J Lundgren, I Pérez, F García, <u>Agathe Leon</u><br><b>Comparison of “Opt-In” versus “Opt-Out” Strategies for early HIV detection, Spain</b><br><br>PS4/04<br><u>Oleksii Smirnov</u><br><b>Testing for HIV and syphilis in 4 cities of Ukraine: screening results, Ukraine</b><br><br>PS4/05<br>R Staub, <u>Steven Derendinger</u><br><b>“Test and Treat” is not the answer to the HIV-epidemic among gay men and other MSM in Switzerland</b> | <b>5. Characteristics of PLHIV who present late for care and missed opportunities for earlier diagnosis</b><br>Moderators: Yusef Azad, NAT and Henning Mikkelsen, UNAIDS<br><br>PS5/01<br>Tetiana Kiriazova, O Postnov, I Perehinets, O Neduzhko<br><b>Association of injection drug use and late enrollment in HIV medical care in Odessa Region, Ukraine</b><br><br>PS5/02<br><u>Karen Champenois</u> , A Cousien, L Cuzin, S Le Vu, E Lanoy, K Lacombe, O Patey, M Calvez, C Semaille, Y Yazdanpanah<br><b>Missed opportunities for HIV testing in newly diagnosed HIV-infected patients in France</b><br><br>PS5/03<br><u>Nikoloz Chkhartishvili</u> , N Rukhadze, L Sharavdze, P Gabunia, A Gamkrelidze, T Tsertsvadze<br><b>Factor associated with late HIV diagnosis in Georgia</b><br><br>PS5/04<br>M Perch, PH Andersen, <u>Axel Kok-Jensen</u><br><b>HIV testing among Tuberculosis patients in Denmark increased through the period from 2007 to 2009, Denmark</b><br><br>PS5/05<br>Murad Ruf, D Hsu, S O’Shea, S Costello, J Peck, W Tong<br><b>Diagnosing HIV infection in patients presenting with Glandular-fever-like illness in Primary care: are we missing primary HIV Infection?, UK</b><br><br>PS5/06<br><u>Percy Fernández Dávila</u> , C Folch, L Ferrer, R Soriano, M Díez, J Casabona<br><b>Profile and determinants of having never been tested for HIV amongst men who have sex with men in Spain</b> | <b>6. New HIV testing diagnostic technologies</b><br>Moderators: Igor Karpov, Minsk Medical Institute and Dominique Costagliola, INSERM Paris<br><br>PS6/01<br>Michael Rayment, E Doku, A Thornton, A Nardone, M Sudhanva, P Roberts, M Tenant-Flowers, J Anderson, A Sullivan, M Atkins<br><b>Automated laboratory-based oral fluid HIV testing in HIV screening programs – automatic for the people?, UK</b><br><br>PS6/02<br><u>Cristina Agustí</u> , L Fernández, J Mascort, R Carrillo, C Aguado, A Montoliu, X Puigdangolas, M De la Poza, B Rifà, J Casabona<br><b>Acceptability of rapid HIV diagnosis technology among primary health care practitioners in Spain</b><br><br>PS6/03<br><u>Anne-Francoise Gennotte</u> , P Semaille C Ellis, C Necsoi, M Abdulatif, N Rungen-Chellum, C Evaldre, D Gidiuta, F Laporte, M Mernier, S Sschellens, N Clumeck<br><b>Feasibility and acceptability of HIV screening through the use of rapid tests by GPs in a Brussels area with an important African community, Belgium</b><br><br>PS6/04<br><u>Liudmila Untura</u> , J Hows, I Chilcevskii<br><b>Stigma and discrimination on voluntary consultation and testing, Moldova</b><br><br>PS6/05<br><u>Virginie Supervie</u> , J Ndawinz, D Costagliola<br><b>How to estimate the size of the hidden HIV epidemic? The case of France</b> |
|                    | Discussion  | Discussion   | Discussion   |
| <b>12.30-13.30</b> | Lunch   |  |  |

| Time               | Lundsgaard Auditorium   | Moderators and Speakers   |
|--------------------|---|---|
| <b>13.30-15.00</b> | <b>Panel discussion: HIV in Europe – the way forward</b>  | Moderator: Jürgen Rockstroh, University of Bonn and Martin Donoghoe, WHO Europe   |
|                    | Report from Tuesday's plenary and parallel sessions   | Jens Lundgren and Ton Coenen, HIV in Europe   |
|                    | The impact and the outcome of the EP Resolution of 20 November 2008 - "HIV/AIDS: early diagnosis and early care" – Italy as a case  | Matteo Schwarz, NPS Italia Onlus  |
|                    | HIV testing and counseling services in Ukraine: what <i>else</i> should be done?  | Ihor Perehinets, WHO Ukraine  |
|                    | Panel discussion: <ul style="list-style-type: none"> <li>• Moving East: What are the challenges?</li> <li>• Political considerations: the way forward</li> <li>• From guidance to implementation</li> </ul> | Brian Gazzard, Chelsea Westminster Hospital<br>Elena Grigoryeva, Belarusian PLHIV Community<br>Nikos Dedes, EATG<br>Jean-Elie Malkin, UNAIDS Moscow |
|                    | HIV in Europe: Call to Action renewed   | Jens Lundgren and Ton Coenen, HIV in Europe   |
| <b>15.00-15.30</b> | Coffee break and End of conference  |   |

## Conference Venue: Store Mødesal

### Side events

**15.30-17.00** Teen Testing: Can Europe do better? Round Table discussion.  
Organized by UNICEF, WHO and UNAIDS with support from EU



# Scientific Programme

## Plenary Sessions

**Monday 19 March – Lundsgaard Auditorium**

**Simultaneous interpretation Russian/English**

## Opening Plenary

**9.00 – 10.30**

The opening plenary will consist of a number of key notes speeches by prominent representatives from leading European HIV/AIDS organisations. After a short introduction and outline of the objectives and expected outcomes of the conference, the Acting Danish Minister of Health, Pia Olsen Dyhr will give the welcome speech. The European Commission will present the 2<sup>nd</sup> Health programme and how the HIV in Europe initiative fits therein and the role of the commission in supporting EU member states to have effective systems for testing in place. European Parliament member, Marisa Matias will present the Resolution on HIV/AIDS adopted on 1 December 2011 on behalf of the involved members of the European Parliament and discuss what the European Union can do to broaden the response to HIV and encourage testing. The European Centre for Diseases Prevention and Control (ECDC) and the WHO Regional Office for Europe, will outline lessons learned from the implementation of the testing guidelines of the two organisations and the specific challenges in different European regions regarding access to earlier testing, diagnosis, care and treatment.

## Moderators:



### **Jens Lundgren, University of Copenhagen, Copenhagen HIV Programme**

Jens Lundgren is Professor of Viral Diseases. He founded and now heads the Center for Viral Diseases at the Department of Infectious Diseases at Rigshospitalet/Copenhagen University Hospital and the Copenhagen HIV Programme (CHIP), based at the University of Copenhagen, Faculty of Health Sciences. Dr. Lundgren is chairman of the Scientific Steering Committee of the NIH/NIAID funded INSIGHT network (International Network for Strategic

Initiatives in Global HIV Trials), a member of the INSIGHT Executive Committee, and co-chair of the START study. He is co-editor-in-chief of the journal *HIV Medicine*, chairs the Steering Committee for the D:A:D study, is co-chair the Steering Committee of the “HIV In Europe” initiative, and led the EuroSIDA study from 1994 to 2009.



### **Ton Coenen, AIDS Action Europe, Aids Fonds and STI Aids Netherlands**

Ton Coenen is executive director of the Aids Fonds and STI AIDS Netherlands since 2004. He is a member of the Steering Committee of the European HIV/AIDS Funders Group. He was a member of the steering committee of AIDS Action Europe and is board member of the International Council of AIDS Service Organisations (ICASO). For three years he was co chair of the EU civil society Forum on HIV/AIDS. He is also co-chair of the HIV in Europe Initiative. He started

as a public health worker in a Municipal Health Service, became vice-director of the National Association for Municipal Health Services and later director of the Netherlands' Foundation for STI-control. He has degrees in health sciences and public management.

## Speakers:



### **Keynote speech: Danish Acting Minister of Health**

#### **Pia Olsen Dyhr, Danish Acting Minister of Health**

Member of the Folketing for The Socialist People's Party in North Zealand greater constituency from November 13th 2007. Temporary Member of the Folketing for The Socialist People's Party in Frederiksborg County constituency, November 28th - December 15th 2006. The Socialist People's Party's candidate in Hillerød nomination district from 2007, in Fredensborg nomination district 2004-2006, and in Nyborg nomination district 1998-2004. Minister for Trade and Investments from October 3rd 2011. Member period: Parliamentary career MA (political science), University of Copenhagen 1992-2010. Political coordinator, CARE Danmark 2006-2007. International coordinator, Danish Society for the Conservation of Nature 2003-2006. Environmental policy staff member, Danish Society for the Conservation of Nature 2000-2003. Education and jobs: Chairwoman of the Young Socialist People's Party 1996-1998. Vice-chairwoman of the Danish Association for International Cooperation 2002-2004. Chairwoman of 92-gruppen Forum for Bæredygtig Udvikling (92 Group of the Forum for Sustainable Development) 2006-2007. Member of the Business Schools' think-tank Forum Europa 2006-2010. Member of Nævnet vedrørende EU Oplysning (EU Information Board) 2001-2005.



### **Keynote speech: European Commission**

#### **Martin Seychell, DG Sanco**

A graduate in chemistry and pharmaceutical technology, Mr. Seychell specialized in Chemical analysis. He has held important positions on several government boards and commissions in Malta, including the Food Safety Commission and the Pesticides Board. Mr. Seychell occupied the post of Head of Directorate at the Malta Standards Authority between 2001 and 2006. He has been responsible for the implementation of a number of EU directives in the areas of risk assessment, food safety, chemicals and cosmetic products legislation, and has actively participated in negotiations on major technical proposals such as the new chemicals legislation, REACH, and in screening processes in the areas of free movement of goods, environment and agriculture during the process leading to Malta's accession to the EU. He held the post of Director of Environment in Malta between 2006 and 2011. As Director, he was responsible for a broad range of functions arising from the Maltese Environment Protection Act. He was appointed Deputy Director General for Health and Consumers at the European Commission in March 2011.



### **Earlier HIV testing and care on the European agenda**

#### **Marisa Matias, European Parliament**

Doctorate in sociology from Coimbra University, Portugal, with the thesis 'Is nature sick of us? Health, environment and new forms of citizenship' (2009); MA in sociology in the field of social studies related to science and technology, Coimbra University, Portugal (2003); graduate in sociology, Coimbra University, Portugal (1998). Areas of specialisation: environmental health, sociology of science, sociology of health, political sociology. Has published scientific articles and chapters of books and other national and international publications on the relationship between the environment and public health, science and knowledge and democracy and citizenship. Has

participated as a trainer/teacher in post-graduate training programmes and courses (including masters and doctorate programmes). Researcher at Coimbra University's Centre for Social Studies, Portugal, since 2004; research assistant at Coimbra University's Centre for Social Studies, Portugal (2000-2004); teacher of sociology and other subjects at the ITAP and Profitecla schools (2000-2001); editorial secretary at Revista Crítica de Ciências Sociais (1998-2000). Member of the Bloco de Esquerda national directorate; member of the directorate of the Pro-Urbe Civic Association (Coimbra). National leader of the 'Citizenship and Responsibility sayYes' movement, within the context of the national referendum on the legalisation of abortion in Portugal. Headed the Bloco de Esquerda list in the Coimbra municipal elections (2005).



### **The role of ECDC in optimal testing and earlier care**

#### **Marc Sprenger, European Centre for Disease Prevention and Control**

Dr. Marc Sprenger, Director of the European Centre for Disease Prevention and Control, ECDC, since May 2010. Previously Director-General of the National Institute for Public Health and the Environment (RIVM) in Bilthoven (2003-2010). Medical microbiologist with a degree in medicine from the University of Maastricht (1988) and a PhD from Erasmus University, Rotterdam (1990).

Key international posts include Chairman of the ECDC Management Board (2004 – 2008) and member of the Executive Board of the International Association of Public Health Institutes (IANPHI) (2008-2010).



### **The role of WHO in optimal testing and earlier care**

#### **Guénael R.M. Rodier, WHO**

Dr Guénaël Rodier is Director, Communicable Diseases, Health Security, & Environment, at the World Health Organization (WHO), Regional Office for Europe, Copenhagen. From 2000 to 2010, he was Director, Communicable Disease Surveillance and Response, then Director, International Health Regulations Coordination, WHO, Geneva. Dr Rodier holds an MD from René

Descartes University, Paris, a MSc in Clinical Tropical Medicine from the London School of Hygiene and Tropical Medicine (recipient of the Frederick Murgatroyd Award), and a Public Health Certification from the French Ordre des Médecins, Paris. He has been actively involved in the development of new WHO strategies, tools and guidelines for communicable disease surveillance and response and supervised the successful revision of the International Health Regulations. He has coordinated numerous international disease surveillance initiatives, research projects and outbreak responses. Dr Rodier has specific experience in the international control of communicable diseases including influenza, SARS, drug-resistant tuberculosis, HIV infection, viral haemorrhagic fevers (Ebola, Marburg), arboviruses (Rift valley fever, dengue, yellow fever), malaria, plague, cholera, and Hantavirus. Dr Rodier started his career as Head and main clinician, private clinic, Republic of Djibouti, East Africa, from 1983 to 1989 before joining the International Health Programme of the University of Maryland at Baltimore where he was seconded to the U.S. Naval Medical Research Unit No. 3, Cairo, Egypt, from 1990 to 1994. He joined WHO, Geneva, in 1994. Dr Rodier has contributed to more than 80 peer reviewed publications and book chapters.

## Access to Earlier Testing and Care

11.00 – 12.30

The plenary session Access to Earlier Testing and Care, will provide an overview of the recent policy development and implementation on European and national level. After the welcome note by the Dean of the University of Copenhagen, WHO Europe will provide an epidemiological update of the HIV/AIDS epidemic in the region and present available testing guidelines, followed by the European Monitoring Centre for Drugs and Drug Addiction discussing challenges in earlier HIV testing and linkage to care among people who inject drugs. The last two presentations will examine access to testing and care – the need for implementation – from a Western European and an Eastern European perspective. The European AIDS Treatment Group and European Centre for Disease Prevention and Control will moderate the session.

### Moderators:



#### **Nikos Dedes, European AIDS Treatment Group**

Nikos Dedes has been involved in the HIV/AIDS field since 1997 as a member of the European AIDS Treatment Group (EATG). He is member of the EACS Treatment Guidelines and of the Steering Committee of the European Clinical Trials Network (NEAT) and of the HIV in Europe initiative. He participates to the advisory boards of the ECDC group to monitor the Dublin Declaration, the Collaborative HIV Resistance Network (CHAIN), the European Coordinating

Group of Observational Cohorts (EuroCoord), the DIA Advisory Council of Europe (ACE) and the WHO Strategic and Technical Advisory Committee for HIV/AIDS (STAC-HIV). He has held positions on scientific and organizing committees for international and European conferences, including, the Glasgow International Congress on Drug Therapy in HIV Infection, the European HIV Drug Resistance Workshop, the 12th European AIDS Conference, 5th Conference on Clinical and Social Research on AIDS and Drugs and others. He is former chair of the European AIDS Treatment Group (EATG) and co-chair of the Patients' and Consumers' Working Party (PCWP) at the EMA and co-chair of the EU HIV/AIDS Civil Society Forum of DG Sanco. Nikos advocates for universal access to health services and prevention tools for all and stresses the moral imperative for action to support those most severely affected by the HIV epidemic. He has initiated many projects promoting awareness, prevention and research on HIV in Greece and is a founding member and President of Positive Voice, the PLHIV association of Greece.



#### **Marita van der Laar, European Centre for Disease Prevention and Control**

Marita van de Laar is the coordinator for the programme on HIV/AIDS, sexually transmitted infections (STI) and hepatitis B and C in the European Centre for Disease Prevention and Control (ECDC) in Stockholm. Dr van de Laar joined ECDC in 2006 and has been leading the integration of HIV and STI enhanced surveillance in Europe. Before she joined ECDC, Dr van de Laar worked at the National Institute of Public health (RIVM) in the Netherlands and was responsible

for the national surveillance of STI, HIV and hepatitis. Dr van de Laar has carried out numerous epidemiological studies on HIV, STI and hepatitis, from population-base case control studies on hepatitis B, HIV studies in hard-to-reach populations as IDU and sex workers, to gonococcal resistance patterns in STI clinics the Netherlands. Marita van de Laar was trained as a population biologist (1984; with honours) and got a PhD in epidemiology at the medical faculty of the University of Amsterdam in 1996.

## Speakers:



### Welcome note from University of Copenhagen

#### **Ulla Wewer, University of Copenhagen**

Ulla Wewer is dean of the Faculty of Health and Medical Sciences, University of Copenhagen. Before becoming dean she was vice dean at the Faculty of Health Sciences, University of Copenhagen. She is professor in experimental pathology, University of Copenhagen. Currently she is a member of the Royal Danish Academy of Sciences and Letters, and until 2011 she was a member of the Danish Agency for Science, Technology and Innovation. She has received several prizes during her career, August Krogh Prize, Odd Fellow Ordenens Research Prize and Danish Cancer Society Young Investigators Research Award. In 2010 she was honored with the Royal Order of Dannebrog.



### Key issues for HIV testing in Europe

#### **Martin Donoghoe, WHO Europe**

Martin Donoghoe is the Programme Manager, HIV/AIDS, STIs and Viral Hepatitis, for the World Health Organization Regional Office for Europe's Division of Communicable Diseases, Health Security and Environment (Copenhagen, Denmark). The programme is committed to responding to the public health challenges of HIV/AIDS, STIs and Viral Hepatitis in all 53 Member States of the European Region. He is also the Senior Adviser on HIV/AIDS, Injecting Drug Use and Harm Reduction for the WHO European Region. Martin holds a B.A. in Social Research from the University of North London, a Master's degree in Public Health in Developing Countries and a Diploma in Hygiene and Tropical Medicine, both awarded by the London School of Hygiene and Tropical Medicine. He has extensive national and international experience in HIV/AIDS prevention, particularly for injecting drug users. His previous appointments include that of Research Fellow, at the Centre for Research on Drugs and Health Behaviour at Goldsmiths' (1987-1990) and later Imperial College, (London, UK) 1990-1994; Scientist, in the Programme on Substance Abuse, with the World Health Organization (Geneva, Switzerland) 1994-1999 and Associate Director for the Open Society Institute's International Harm Reduction Development Program (Budapest, Hungary) 2001-2002. He has published widely on HIV/AIDS prevention and injecting drug use.



### Challenges in earlier HIV testing and linkage to care among people who inject drugs

#### **Roland Simon, European Monitoring Centre for Drugs and Drug Addiction**

Roland Simon has a degree in Psychology from the University Trier and Tübingen. From 1984 he worked at the Max-Planck-Institute for Psychiatry, Research Group Addictions and from 1986-2006 at the IFT Institut für Therapieforschung in Munich and was Head of the German REITOX Focal Point. His main fields of work were: Setting up the national treatment monitoring system, National survey on use and misuse of addictive substances, National survey on misuse of pharmaceuticals, epidemiology and treatment of cannabis related disorders, Development of the EMCDDA National Focal Point (DBDD). From 2007-2010, Mr. Simon was Head of Unit Interventions, law and policy at the EMCDDA and is now (since January 2011) Head of Unit interventions, best practices and scientific partners at EMCDDA. His main fields of work are monitoring of treatment and harm reduction interventions, Best practice, the EMCDDA Scientific Committee, the EMCDDA Collaboration with the Scientific Community.



### **HIV testing guidelines in Europe and linkage to care: need for implementation - Western Europe perspective**

**Valerie Delpesch, Health Protection Agency**

Valerie oversees the national surveillance of HIV based at the Health Protection Agency, London, United Kingdom. She provides expert advice on a number of national and international committees and expert groups in relation to HIV surveillance, prevention and policy development and led on the production of the European Centre for Disease Control (ECDC) evidence and guidance to increase HIV testing across Europe. Her research interests and publications have focussed on better understanding and characterising the HIV epidemic and its impact on vulnerable populations. Valerie is an executive trustee of the National AIDS Trust (NAT), a charitable organisation that influences policy development and champion the rights of people living with HIV.



### **HIV testing and counselling in EECA: entry point for curbing the HIV epidemic** **Nino Tsereteli, Center for Information and Counseling on Reproductive Health – Tanadgoma**

Ms. Nino Tsereteli has been working in the field of HIV/AIDS for more than 12 years already. Being psychologist by background, she started working as a counselor at Medicines Sans Frontieres-Greece mission to Georgia. In 2000, together with the group of young professionals, she founded a Non-Governmental Organization “Center for Information and Counseling on Reproductive Health – Tanadgoma”, aiming at prevention of HIV and STIs and promoting reproductive health issues among Georgian population, especially among Most at Risk Populations. In 2007 Ms. Tsereteli was appointed as Executive Director of “Tanadgoma”. Ms. Tsereteli has been involved in different initiatives both at the country and regional levels. Since 2011 she is a member of Interim Board of the Eurasian Coalition on Male Health.

### **Late Presenters and the Undiagnosed** **16.15 – 18.00**

The plenary session “Late Presenters and the Undiagnosed” will consist of the presentation of the newest data from projects on late presenters. The Eurocood data on epidemiology and temporal trends of late presenters in Europe will be presented, as will the results from two ECDC supported projects on estimating HIV prevalence and cost-effectiveness of HIV testing. The outcome of the pan European panel under HIV in Europe developing “Guidance on indicator condition-guided HIV testing” will also be presented in this session.

### **Moderators:**



### **Jean-Elie Malkin, UNAIDS Regional Support Team for Europe and Central Asia**

Dr. Malkin, a citizen of France, is Senior advisor to the Executive Director of UNAIDS and since 2011 the Head of the UNAIDS Regional Support Team for Europe and Central Asia a.i. Dr. Malkin is a medical doctor specialised in infectious and tropical diseases, with over 25 years experience in care management of HIV-positive patients notably at the Medical centre of Pasteur Institute (Paris). Dr. Malkin is a member of several scientific and medical societies and during his career has been actively contributing to different committees and experts panels. He earned Post-Master's Diplomas in Public Health in developing countries. He holds a Master's degree in epidemiological statistics and Doctor of Medicine in the University of Paris.





### **Brian Gazzard, Chelsea and Westminster Hospital**

Professor Brian Gazzard started the HIV unit at the Chelsea and Westminster Hospital and is now its Clinical Research Director. This is one of the largest clinical units in Europe concentrating its research mainly on new algorithms of care Immunological and oncological manifestations of HIV disease and antiretroviral therapy. Brian Gazzard qualified at Cambridge and received his MD from that institution in 1983. He was awarded the Department of Health prize for distinguished achievement in 2002 and is the chairman of the Expert Group Advising Chief Medical Officer of Health on matters relating to HIV disease.

## **Speakers:**



### **Characteristics of the epidemiology and temporal trends of late presenters in Europe** **Joanne Reekie, Research Department of Infection and Population Health, UCL on behalf of the late presenters working group of the Collaboration of Observational HIV Epidemiological Research in Europe (COHERE) in EuroCoord**

Joanne Reekie is a Research Statistician within the HIV Epidemiology and Biostatistics Group, Research Department of Infection and Population Health at UCL. For the last five years she has been closely involved in the EuroSIDA study, a large prospective observational cohort study, where the main objective is to assess the impact of antiretroviral drugs on the outcome of the general population of HIV-positive patients living in Europe. More recently she has joined the late presenters working group within the Collaboration of Observational HIV Epidemiological Research Europe (COHERE) and the HIV Indicator Diseases across Europe Study (HIDES). Her main interests are in regional differences in patient care and outcomes, particularly related to non-AIDS events and late presentation for care. She has also just submitted her thesis for a PhD in Epidemiology.



### **Estimating HIV prevalence in European countries** **Ard van Sighem, Stichting HIV Monitoring**

Ard van Sighem is senior researcher at Stichting HIV Monitoring, which is the national executive organisation for the registration and monitoring of HIV-infected patients in the Netherlands. He is mainly working on the ATHENA national observational HIV cohort and has a major role in developing mathematical models describing the dynamics of HIV epidemics in European countries.



### **An assessment of the approaches to evaluating cost-effectiveness of HIV screening strategies** **Olivia Wu**

Dr Olivia Wu is a Reader in Health Economics and leads the Evidence Synthesis Programme within the Health Economics and Health Technology Assessment Unit at the University of Glasgow. Olivia has extensive experience in undertaking systematic reviews, performing complex meta-analysis, and conducting economic evaluations in a variety of clinical areas. Currently, she is leading an ECDC-funded project on the cost-effectiveness of screening for HIV, hepatitis B and C. In addition to her research, Olivia serves as a member of Technology Appraisal Committee for the UK National Institute for Health and Clinical Excellence (NICE) and the Health Service and Population Health Research Committee for the Chief Scientist Office Scotland, and is an advisor to the Scottish Intercollegiate Guidelines Network.



### **Guidance on Indicator Condition-Guided HIV Testing: Presentation of draft guidance document**

#### **Keith Radcliffe, International Union against Sexually Transmitted Infections on behalf of the Indicator Condition-Guided HIV Testing Panel**

Keith Radcliffe has been a specialist in genitourinary medicine (sexually transmitted infections) and HIV medicine working in Birmingham, UK since 1991. He has been the Regional Director of the European Branch of the International Union against

Sexually Transmitted infections (IUSTI Europe) since 2005, and was previously the Chair of its Scientific Board 2001–05. Since 1998 he has been the Editor-in-Chief of the European STI Guidelines Project which has produced the first comprehensive pan-European STI management guidelines. Between 2002–04 he led an international project to promote the production and adoption of evidence-based STI management guidelines in a number of former Soviet Union countries. Between 2010–12, he was President of the UK national specialty society, the British Association for Sexual Health and HIV (BASHH). He remains Chair of the BASHH Clinical Effectiveness Group which is responsible for the production of national STI management guidelines for the United Kingdom.

**Tuesday 20 March – Lundsgaard Auditorium**

**Discussing Testing Strategies**

**8.45 – 10.30**

**Simultaneous interpretation Russian/English**

The session “Discussing Testing Strategies” provides an overview of new technologies for HIV testing, including rapid HIV tests and tests for HIV incidence with experience from the US. A novel model of the MSM epidemic in the UK is under development and will be presented in this session. Furthermore, specific outcomes of two of the HIV in Europe supported projects will be presented: The people living with HIV Stigma Index with experience of implementation in Estonia and the effect of HIV related stigma on late testing and treatment, and the COBATEST Project and the country experience of community based testing services in Italy. Finally, conclusions from the first day of the conference will be presented.

### **Moderators:**



#### **José Gatell, Infectious Diseases & AIDS Units, Hospital Clinic**

Dr. José M. Gatell is Senior Consultant & Head of Infectious Diseases & AIDS Units at the Hospital Clinic, Professor of Medicine at the University of Barcelona and Co-director of the HIVACAT research program for the development of HIV vaccines. Dr. Gatell has been (1997–99) President of the Spanish Society for Infectious Diseases and Clinical Microbiology (SEIMC) is the past president of the European AIDS Clinical Society (EACS) and is Associate Editor of several Spanish and international

journals including Clinical Infectious Diseases, Antiviral Therapy, HIV Medicine, HIV Clinical Trials, J AIDS and Medicina Clinica. He has been the Co-Chair of the XIV International AIDS Conference in Barcelona in July, 2002, and of the X EACS Conference in Dublin in November 2005.

## Lali Khotenashvili, WHO

Dr Lali Khotenashvili is the testing and counselling focal point at the Communicable Diseases Unit, WHO Regional Office for Europe.

### Speakers:



#### **Diagnostics/testing/regulations/incidence: US perspective**

##### **Bernard Branson, Centers for Disease Control and Prevention**

Bernard Branson is currently Associate Director for Laboratory Diagnostics in the Division of HIV/AIDS Prevention in the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention at the CDC. Dr. Branson has been the chief architect for CDC's activities surrounding new technologies for HIV testing, including rapid HIV tests and tests for HIV incidence. He was the lead author for CDC's 2006 Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health Care Settings. Most recently Dr. Branson conceived and validated the new algorithm for supplemental testing to establish the diagnosis for HIV. Dr. Branson has authored more than 50 peer-reviewed articles on HIV diagnostics, HIV screening, and cost-effectiveness.



#### **A model of the MSM epidemic in the UK: implications for understanding the impact of condom use and ART in influencing incidence**

##### **Andrew Phillips, Research Department of Infection and Population Health, UCL**

Andrew Phillips is Professor of Epidemiology and Biostatistics at the Research Department of Infection and Population Health at UCL. Andrew Phillips is an epidemiologist from a statistical background who has worked in HIV research for many years. He has interests in clinical and public health issues relating to HIV. Mainly involved in collaborations, he has worked on observational cohorts of people with HIV, randomized trials, and on models of HIV progression, the effect of ART, and of HIV transmission.



#### **People living with HIV Stigma Index: Findings from Estonia**

##### **Jekaterina Voinova, Stigma Index project**

Jekaterina Voinova started in 2006 with the Needle Exchange Program as a counselor and then worked as project manager of consulting service at an infectious diseases hospital. Jekaterina Voinova was involved in the creation of psychosocial support services in North-East Estonia and coordinated this project for more than 2 years. At the same time, she worked in male and female prisons as consultant on chemical addiction treatment and HAART adherence. In 2010, together with a group of activists Jekaterina Voinova organized Estonian Community Board (ESTCAB). At the moment she is coordinating the Stigma Index project in Estonia and the opening of a clinic for testing and treatment of PLWH in Narva.



### **The COBATEST Project: Survey on Community-Based Testing Services in Europe** **Michele Breveglieri, Regional Program for Health Promotion of the Veneto Region**

Dr. Michele Breveglieri is a PhD in Sociology. Since 2008, he has been working as social researcher in the field of health promotion and HIV-STIs prevention at the Regional Program for Health Promotion of Veneto Region in Verona, Italy. He worked in SIALON, EMIS and COBATEST European projects. Before, he worked several years in the field of HIV and STIs prevention with sexual workers and trafficked women. He is president of Arcigay in Verona, member of the national Health Group of Arcigay – Italian Lesbian and Gay Association and member of the executive boards of GASP! Health and Aids Prevention Group (Verona - Italy) and of the National and recently founded PLUS – LGBT HIV+ People (Italy).

### **Panel discussion: HIV in Europe – the way forward** **13.30 – 15.00**

#### **Simultaneous interpretation Russian/English**

The final plenary session will consist of general feedback from the parallel sessions including highlights and commitments made during the conference which will be formulated into a renewed Call to Action for the partners and collaborators of the HIV in Europe Initiative. A panel discussion with key stakeholders from across Europe will discuss the way forward for HIV in Europe, included the challenges of moving East, lessons learned from guidance to implementation and political considerations on increasing HIV testing.

#### **Moderators:**



#### **Jürgen Rockstroh, Bonn University Clinic**

In addition to his clinical practice, Dr. Rockstroh is involved in HIV research on: antiretroviral therapy, including new drug classes; the course of HIV disease in haemophiliacs; and HIV and hepatitis co-infection. He has been an investigator in multiple clinical trials of antiretroviral agents and treatments for HIV and hepatitis co-infection. Dr. Rockstroh was the Chairman of the German Clinical AIDS Working Group (KAAD) from 1998 to 2007 and the president of the German AIDS Society (DAIG) from 2007-2011.



#### **Martin Donoghoe, WHO Europe**

Martin Donoghoe is the Programme Manager, HIV/AIDS, STIs and Viral Hepatitis, for the World Health Organization Regional Office for Europe's Division of Communicable Diseases, Health Security and Environment (Copenhagen, Denmark). The programme is committed to responding to the public health challenges of HIV/AIDS, STIs and Viral Hepatitis in all 53 Member States of the European Region. He is also the Senior Adviser on HIV/AIDS, Injecting Drug Use and Harm Reduction for the WHO European Region. Martin holds a B.A. in Social Research from the University of North London, a Master's degree in Public Health in Developing Countries and a Diploma in Hygiene and Tropical Medicine, both awarded by the London School of Hygiene and Tropical Medicine. He has extensive national and international

experience in HIV/AIDS prevention, particularly for injecting drug users. His previous appointments include that of Research Fellow, at the Centre for Research on Drugs and Health Behaviour at Goldsmiths' (1987-1990) and later Imperial College, (London, UK) 1990-1994; Scientist, in the Programme on Substance Abuse, with the World Health Organization (Geneva, Switzerland) 1994-1999 and Associate Director for the Open Society Institute's International Harm Reduction Development Program (Budapest, Hungary) 2001-2002. He has published widely on HIV/AIDS prevention and injecting drug use

## Speakers and panel members



### **The impact and the outcome of the EP Resolution of 20 November 2008 - "HIV/AIDS: early diagnosis and early care" – Italy as a case**

#### **Matteo Schwarz, NPS Italia**

Matteo Schwarz is a lawyer specialised in EU and Human Rights Law. Throughout his work experience, he had the opportunity to collaborate with International organizations and private law firms involved in the fight against human rights' violations as well as in the promotion of social rights, with a focus on the rights of patients. Since 2006 he is the head of the Legal Service at NPS Italia, an Italian NGO committed in the protection of the rights of People Living with HIV in Italy and in Europe. Thanks to the work of the legal department, NPS now plays a key role in the development of public policies concerning the fight against stigma affecting HIV+ people, access to care and treatments, national campaigns on the prevention of STDs.



### **HIV testing and counseling services in Ukraine: what else should be done?**

#### **Ihor Perehinets, WHO Ukraine**

Ihor Perehinets, MD, MPH, represents WHO Country Office in Ukraine where he serves as a National Professional Officer on Communicable Diseases and Capacity Building. In his capacity Ihor Perehinets provides technical assistance to the Government of Ukraine, national and international partners on HIV testing and counseling (HTC), health system strengthening in HIV and TB care, medicinal products and pharmacovigilance. Ihor has an extensive experience in public health field in Eastern Europe after working in Russian Federation and Ukraine for over ten years. His main interests lay in the field of health systems strengthening to insure quality of HIV and TB services delivery and capacity building of public HIV and TB services. He holds MD degree from Lviv State Medical University, Ukraine, and MPH from San Jose State University, USA.



#### **Elena Grigoryeva, Belarusian PLHIV Community**

Elena Grigoryeva, activist for PLHIV rights from Belarus. Chairperson of AIDS. Action.Europe Steering Committee. Member of Belarusian PLHIV Community, national coordinator of Belarus-PLHIV Communities Advisory Board. Member of EATG; ECAB; NGO Developing Countries Delegation of Global Fund for Fight with AIDS, TB and Malaria Board; UN Reference Group on IDU; ITPC.ru; ECUO. Over 10 years experience of activism in HIV-service NGOs, over 5 years of expertise in advocacy work, over 30 years experience of living in Belarus. Adherent to providing equal access to life for all.



### **Jean-Elie Malkin, UNAIDS Regional Support Team for Europe and Central Asia**

Dr. Malkin, a citizen of France, is Senior advisor to the Executive Director of UNAIDS and since 2011 the Head of the UNAIDS Regional Support Team for Europe and Central Asia a.i. Dr. Malkin is a medical doctor specialised in infectious and tropical diseases, with over 25 years experience in care management of HIV-positive patients notably at the Medical centre of Pasteur Institute (Paris). Dr. Malkin is a member of several scientific and medical

societies and during his carrier has been actively contributing to different committees and experts panels. He earned Post-Master's Diplomas in Public Health in developing countries. He holds a Master's degree in epidemiological statistics and Doctor of Medicine in the University of Paris.



### **Brian Gazzard, Chelsea and Westminster Hospital**

Professor Brian Gazzard started the HIV unit at the Chelsea and Westminster Hospital and is now its Clinical Research Director. This is one of the largest clinical units in Europe concentrating its research mainly on new algorithms of care Immunological and oncological manifestations of HIV disease and antiretroviral therapy. Brian Gazzard qualified at Cambridge and received his MD from that institution in 1983. He was awarded the Department of Health

prize for distinguished achievement in 2002 and is the chairman of the Expert Group Advising Chief Medical Officer of Health on matters relating to HIV disease.



### **Nikos Dedes, European AIDS Treatment Group**

Nikos Dedes has been involved in the HIV/AIDS field since 1997 as a member of the European AIDS Treatment Group (EATG). He is member of the EACS Treatment Guidelines and of the Steering Committee of the European Clinical Trials Network (NEAT) and of the HIV in Europe initiative. He participates to the advisory boards of the ECDC group to monitor the Dublin Declaration, the Collaborative HIV Resistance Network (CHAIN), the European Coordinating

Group of Observational Cohorts (EuroCoord), the DIA Advisory Council of Europe (ACE) and the WHO Strategic and Technical Advisory Committee for HIV/AIDS (STAC-HIV). He has held positions on scientific and organizing committees for international and European conferences, including, the Glasgow International Congress on Drug Therapy in HIV Infection, the European HIV Drug Resistance Workshop, the 12th European AIDS Conference, 5th Conference on Clinical and Social Research on AIDS and Drugs and others. He is former chair of the European AIDS Treatment Group (EATG) and co-chair of the Patients' and Consumers' Working Party (PCWP) at the EMA and co-chair of the EU HIV/AIDS Civil Society Forum of DG Sanco. Nikos advocates for universal access to health services and prevention tools for all and stresses the moral imperative for action to support those most severely affected by the HIV epidemic. He has initiated many projects promoting awareness, prevention and research on HIV in Greece and is a founding member and President of Positive Voice, the PLHIV association of Greece



## Parallel Session 1: Lessons Learned in Novel HIV Testing Strategies and Programmes

Monday 19 March 13:30 –15:15

Hannover Auditorium – Testing Programmes and Strategies

### Moderators:



#### **Marita van de Laar, European Centre for Disease Prevention and Control**

Marita van de Laar is the coordinator for the programme on HIV/AIDS, sexually transmitted infections (STI) and hepatitis B and C in the European Centre for Disease Prevention and Control (ECDC) in Stockholm. Dr van de Laar joined ECDC in 2006 and has been leading the integration of HIV and STI enhanced surveillance in Europe. Before she joined ECDC, Dr van de Laar worked at the National Institute of Public health (RIVM) in the Netherlands and was responsible

for the national surveillance of STI, HIV and hepatitis. Dr van de Laar has carried out numerous epidemiological studies on HIV, STI and hepatitis, from population-base case control studies on hepatitis B, HIV studies in hard-to-reach populations as IDU and sex workers, to gonococcal resistance patterns in STI clinics the Netherlands. Marita van de Laar was trained as a population biologist (1984; with honours) and got a PhD in epidemiology at the medical faculty of the University of Amsterdam in 1996.



#### **Martin Fisher, Brighton and Sussex University Hospitals NHS Trust.**

Martin Fisher is a Consultant in HIV/GUM at Brighton and Sussex University Hospitals NHS Trust. He is responsible for the outpatient and inpatient management of a large cohort of HIV infected individuals, and leads an active research team. He is currently an Executive Committee member of the British HIV Association, a member of the HIV Special Interest Group of the British Association for Sexual Health and HIV, and is an examiner and former Convenor

of the national Diploma in HIV Medicine. He was co-chair of the 2006 PEPSE guidelines, co-chair of the 2011 update, a co-author of the BASHH/BHIVA position statement on PrEP, and co-chair of the 2008 UK HIV Testing guidelines. His main clinical and research interests are in antiretroviral therapy, primary HIV infection, strategies to improve the diagnosis of HIV infection, HIV and hepatitis co-infection, and the interplay between HIV and other sexually transmitted infections.

### **Routine HIV testing in the Emergency Department: tough lessons in sustainability**

**Michael Rayment<sup>1</sup>**, C Rae<sup>1</sup>, S Finlay<sup>1</sup>, M Atkins<sup>2</sup>, P Roberts<sup>1</sup>, A Sullivan<sup>1</sup>

<sup>1</sup>Chelsea and Westminster NHS Foundation Trust, London, UK

<sup>2</sup>Imperial College London, UK

### **Routine HIV Screening in 6 EDs in Paris area: the ANRS URDEP Study**

E Casalino<sup>1</sup>, S Firmin<sup>2</sup>, A Delobelle<sup>2</sup>, B Bernot<sup>3</sup>, C Choquet<sup>1</sup>, G Der Sahakian<sup>4</sup>, J Zundel<sup>5</sup>, P Hausfater<sup>6</sup>, YE Claessens<sup>7</sup>, E Bouvet<sup>8</sup>, F Brun-Vezinet<sup>9</sup>, **Dominique Costagliola**<sup>2,10</sup>

<sup>1</sup>Hôpital Bichat, Service des Urgences, Paris, France

<sup>2</sup>U 943 INSERM et UPMC Paris Univ 6, Paris, France

<sup>3</sup>Hôpital, Avicenne, Service des Urgences, Bobigny, France

<sup>4</sup>Hôpital Hôtel Dieu, Service des Urgences, Paris, France

<sup>5</sup>Hôpital Bicêtre, Kremlin Bicêtre, France

<sup>6</sup>Hôpital La Pitié Salpêtrière, Service des Urgences, Paris, France

<sup>7</sup>Hôpital Cochin, Service des Urgences, Paris, France

<sup>8</sup>Hôpital Bichat-Claude Bernard, Service de Maladies Infectieuses, Paris France

<sup>9</sup>Hôpital Bichat-Claude Bernard, Service de Virologie, Paris, France

<sup>10</sup>Hôpital La Pitié Salpêtrière, Service de Maladies Infectieuses, Paris France

### **Acceptability, feasibility and costs of universal offer of rapid point of care testing for HIV in an acute admissions unit: results of the RAPID project**

**Fiona Burns**<sup>1</sup>, S Edwards<sup>2</sup>, J Woods<sup>2</sup>, G Haidari<sup>3</sup>, Y Calderon<sup>4</sup>, J Leider<sup>4</sup>, S Morris<sup>5</sup>, R Tobin<sup>2</sup>, J Cartledge<sup>2</sup>, M Brown<sup>6</sup>

<sup>1</sup>University College London, UK

<sup>2</sup>Central & North West London Foundation Trust, UK

<sup>3</sup>University College London Hospitals NHS Foundation Trust, London, UK

<sup>4</sup>Albert Einstein College of Medicine, Bronx, New York, USA

<sup>5</sup>UCL Centre for Applied Health Research, London, UK

<sup>6</sup>Department of Clinical Research, London School of Hygiene & Tropical Medicine, London, UK

### **Increasing HIV testing in non-GUM settings – a new training resource**

W Majewska<sup>1</sup>, **Catherine Howland**<sup>2</sup>, M Pakianathan<sup>1</sup>

<sup>1</sup>St George's Healthcare NHS Trust, London, UK

<sup>2</sup>Bristol-Myers Squibb Pharmaceuticals Ltd, Uxbridge, UK

### **Individual level and country level predictors for recent HIV-testing and late HIV diagnoses among MSM in Europe – aspects to consider when planning interventions to increase HIV-testing. Results of the European MSM Internet Survey (EMIS)**

**Axel J Schmidt**<sup>1</sup>, U Marcus<sup>1</sup>, M Breveglieri<sup>2</sup>, P Fernández-Dávila<sup>3</sup>, L Ferrer<sup>3</sup>, C Folch<sup>3</sup>, M Furegato<sup>2</sup>, F Hickson<sup>4</sup>, HJ Hospers<sup>5</sup>, D Reid<sup>4</sup>, P Weatherburn<sup>4</sup> The EMIS Network

<sup>1</sup>Robert Koch Institute, Department for Infectious Disease Epidemiology, Berlin, Germany

<sup>2</sup>Regional Centre for Health Promotion, ULSS 20 – Veneto Region, Verona, Italy

<sup>3</sup>Centre for Epidemiological Studies on HIV/AIDS in Catalonia (CEEISCAT), Barcelona, Spain

<sup>4</sup>Sigma Research, London School of Hygiene and Tropical Medicine, United Kingdom

<sup>5</sup>Maastricht University, University College Maastricht, The Netherlands

### **HIV testing among Portuguese men who have sex with men- results from the EMIS Study**

**Claudia Carvalho**<sup>1</sup>, R Furtres<sup>2</sup>, R Lucas<sup>1</sup>, MJ Campos<sup>2</sup>, L Mendão<sup>2</sup>, AJ Schmidt<sup>3</sup>

<sup>1</sup>University of Porto, Portugal

<sup>2</sup>Grupo Português de Activistas Sobre Tratamentos- GAT, Portugal

<sup>3</sup>Robert Koch Institute, Germany

## Parallel session 2: HIV Testing and the Continuum of HIV Care

**Monday 19 March 13:30–15:15**

**Haderup Auditorium – Testing Programmes and Strategies**

### Moderators:



#### **Anders Sönnernborg, Karolinska Institutet**

Professor Anders Sönnernborg is a specialist in infectious diseases and clinical virology. He has been involved in HIV care and research since 1984, and has published >250 articles. Presently, he is director of the Unit of Infectious Diseases, Karolinska Institutet, and director of the InfCare HIV cohort, including all HIV infected patients in Sweden. He is a consultant in infectious diseases, including HIV, to the Swedish Board of Health and Welfare, as well as a member in the

Scientific Advisory Group in Antivirals/HIV to the European Medicines Agency.



#### **Jeff Lazarus, Copenhagen HIV Programme, University of Copenhagen**

Jeffrey Victor Lazarus is a Professor of International Health Systems at University of Copenhagen and an Affiliated Professor at the Medical School in Porto University. He also works on strategy, performance and communicating results at the Global Fund to Fight AIDS, Tuberculosis and Malaria. Prior to joining the Fund he spent ten years at WHO Europe in Copenhagen where he worked as a health systems and communicable diseases expert. In his work around the world

he has always sought to bridge the “knowledge-action” gap through targeted communication and knowledge translation. Dr Lazarus is the author of more than 100 publications.

### **Quality of care and clinical outcome of persons diagnosed with HIV in the UK**

**Valerie Delpech, Z Yin, M Kall, A Brown**

Health Protection Agency, Colindale, London, UK

### **BCN Checkpoint: high efficiency in HIV detection and linkage to care**

**Michael Meulbroek, E Ditzel, J Saz, H Taboada, G Font, A Perez, A Carrillo, F Perez, J Montilla, M Ingrami, V Gimenez, F Pujol**

Projecte dels NOMS-Hispanosida, Barcelona, Spain

### **CheckpointLX - MSM HIV testing and linkage to care in Lisbon**

**Maria José Campos<sup>1</sup>, E Teófilo<sup>2</sup>, H Machado<sup>1</sup>, J Brito<sup>1</sup>, J Esteves<sup>1</sup>, L Mendão<sup>1</sup>, R Abrantes<sup>1</sup>, R Fuertes<sup>1</sup>, T Rodrigues<sup>1</sup>, N Pinto<sup>1</sup>**

<sup>1</sup>CheckpointLX, Portugal

<sup>2</sup>Centro Hospitalar de Lisboa Central, Portugal

### **Checkpoint: rapid HIV screening in community setting for a strong link to care**

**Jean-Yves Le Talec<sup>1</sup>, C Rouzioux<sup>2</sup>, Nicolas Derche<sup>3</sup>, C Taeron<sup>4</sup>, A Guérin<sup>5</sup>, G Sebbah<sup>5</sup>, G Tellier<sup>5</sup>, E Penel<sup>3</sup>**

<sup>1</sup>University of Toulouse 2, Toulouse, France

<sup>2</sup>Necker Hospital and Descartes University, Paris, France

<sup>3</sup>Le Kiosque Infos Sida & Toxicomanie, Paris, France

<sup>4</sup>Arcat, Paris, France

<sup>5</sup>Groupe SOS, Paris, France

## PLHIV-Related Stigma in Belarus - impacts on quality of care and health outcomes

J Hows<sup>1</sup>, Elena Grigoryeva<sup>2</sup>

<sup>1</sup>Global Network of People Living with HIV

<sup>2</sup>Belarusian PLHIV Community, Minsk, Belarus

## Scaling-up community HIV rapid testing and linkage to care in Estonia, Lithuania, Russia and Ukraine: results and lessons learned

Zoya Shabarova<sup>1</sup>, T Ford<sup>2</sup>, I Sobolev<sup>3</sup>, S Kulsis<sup>4</sup>, R Kulchynska<sup>5</sup>, A Podymova<sup>6</sup>

<sup>1</sup>AHF Global Immunity, Amsterdam, The Netherlands

<sup>2</sup>AIDS Healthcare Foundation, Los Angeles, USA

<sup>3</sup>Estonian Network of PLWH, Tallinn, Estonia

<sup>4</sup>NGO Demetra, Vilnius, Lithuania

<sup>5</sup>Ukrainian HIV Resource Center, Kiev, Ukraine

<sup>6</sup>Sverdlovsk Oblast AIDS Center, Yekaterinburg, Russian Federation

## Parallel session 3: HIV Testing among Key Populations

**Monday 19 March 13:30–15:15**

**Lundsgaard Auditorium– Testing Programmes and Strategies**

**Simultaneous interpretation Russian/English**

### Moderators:



#### **Julia del Amo, Institute of Health Carlos III**

Julia del Amo is a medical epidemiologist with an interest in how HIV impacts on migrant populations and ethnic minorities in Europe. She works at the National Center of Epidemiology at the Institute of Health Carlos III, in Madrid, Spain, and is involved in the scientific coordination of various cohort studies at national and international level. She is the co-lead of the work-package of HIV and Migrant Health within EuroCoord and has collaborated with ECDC in various projects on

HIV testing among migrant communities in Europe



#### **Julian Hows, GNP+**

Julian Hows has been working as programme officer with GNP+ ([www.gnpplus.net](http://www.gnpplus.net)) since April 2009. He has been involved in AIDS/HIV as a community activist, programme officer, outreach worker and CEO of several community based initiatives in the UK. His involvement in HIV has been since 1983 and in the Lesbian and Gay movement since the early 1970s. In recent years work has included “Criminalisation of HIV transmission in Europe: A rapid scan of the laws

and rates of prosecution for HIV transmission within signatory States of the European Convention of Human Rights” available at [www.gnpplus.net/criminalisation](http://www.gnpplus.net/criminalisation) as well as working on issues of service delivery and rights for migrants, refugees and asylum seekers and “substance” users within the UK as well as internationally. His current responsibilities at GNP+ include leading on work with the PLHIV Stigma Index.

## Ukraine's experience in scaling-up HIV testing and further referral of high-risk population to health-care institutions Ukraine

**Oksana Savenko, S Filippovych, Z Islam**

ICF “International HIV/AIDS Alliance in Ukraine”, Kyiv, Ukraine

## Effectiveness of continuous prevention interventions for HIV testing uptake among high risk populations in Tbilisi, Georgia

Nino Tsereteli<sup>1</sup>, I Chiqovani<sup>2</sup>, K Gogvadze<sup>2</sup>, N Rukhadze<sup>2</sup>

<sup>1</sup>NGO 'Center for Information and Counseling on Reproductive Health - Tanadgoma', Tbilisi, Georgia

<sup>2</sup>Curatio International Foundation, Tbilisi, Georgia

## Translating research results into promotion of HIV testing among Sub-Saharan African migrants in Flanders

Lazare Manirankunda, J Loos, C Nöestlinger

Institute of Tropical Medicine, Antwerp, Belgium

## Using community-based rapid HIV screening among men who have sex with men in a behavioral serosurveillance survey, Almaty, 2010

Assel Terlikbayeva<sup>1</sup>, M Berry<sup>2</sup>, V Ragoza<sup>3</sup>, A Janayeva<sup>3</sup>, C Berry<sup>2</sup>, N El-Bassel<sup>1</sup>

<sup>1</sup>Global Health Research Center of CA, Almaty, Republic of Kazakhstan

<sup>2</sup>Center for Public Health and Human Rights, John Hopkins Bloomberg School of Public Health, Baltimore, MD, USA

<sup>3</sup>'Amulet' Public Association, Republic of Kazakhstan

## Development of gender oriented services to increase the number of voluntary counseling and testing (VCT) among female drug users of Lviv region (Ukraine)

Marta Vasylyev, M Sluzhynska, O Sluzhynska, O Grushynska

Lviv Regional AIDS Center & Charitable Salus Foundation, Lviv, Ukraine

## Socio-demographic factors predicting HIV test seeking behaviour among MSM in 6 EU cities. Results from the SIALON European Project (2008-2010)

L Gios<sup>1</sup>, M Breveglieri<sup>2</sup>, M Furegato<sup>2</sup>, Massimo Mirandola<sup>1</sup>

<sup>1</sup>The Hospital Trust of Verona, Veneto Region, Italy

<sup>2</sup>ULSS20, Veneto Region, Verona, Italy

## Parallel session 4: Challenges in Optimal Testing and Earlier Care

Tuesday 20 March 11:00–12:30

Hannover Auditorium – Cost Effectiveness of HIV Testing

### Moderators:



#### Raminta Stuikyte, European AIDS Treatment Group, Eurasian Harm Reduction Network

Raminta Stuikyte is the Policy Working Group Chair of the European AIDS Treatment Group (EATG) where she focuses efforts on increasing access to essential medicines across the European and Central Asian continent and ensuring rights' protection. Until 2009 she was the Executive Director of the Eurasian Harm Reduction Network (EHRN), where she continues engagement

as Senior Advisor for advocacy and capacity building to reduce harm related to drug use in 27 countries in Central and Eastern Europe and the Commonwealth of Independent States. As Open Society Institute's Consultant she works on supporting transparency in decisions around access to medicines and on raising national and regional efforts for effective response to hidden hepatitis epidemics in Eurasia. Stuikyte completed her master's degree in Applied Mathematics from Vilnius

University in Lithuania. Stuikyte was elected as Deputy Chairperson and President of the Student Representation of Vilnius University, where she was responsible for initiating and organizing a variety of national and international study quality and social projects. Stuikyte co-authored the “The Impact of Drug Policy on Health and Human Rights in Eastern Europe” report, the “Sex Work, HIV/AIDS, and Human Rights in Central and Eastern Europe and Central Asia” analysis and has other publications related to drug related harm reduction, HIV/AIDS policies, civil society role and capacities in Central and Eastern Europe, as well as globally. In 2009 she received ‘Thank-You’ award from the East Europe & Central Asia Union of People Living with HIV Organisations. She serves in the UN Reference Group on HIV/AIDS and Human Rights.



### **Valerie Delpech, Health Protection Agency**

Valerie oversees the national surveillance of HIV based at the Health Protection Agency, London, United Kingdom. She provides expert advice on a number of national and international committees and expert groups in relation to HIV surveillance, prevention and policy development and led on the production of the European Centre for Disease Control (ECDC) evidence and guidance to increase HIV testing across Europe. Her research interests and publications have focussed on better understanding and characterising the HIV epidemic and its impact on vulnerable populations. Valerie is an executive trustee of the National AIDS Trust (NAT), a charitable organisation that influences policy development and champion the rights of people living with HIV.

### **Cost effectiveness of HIV testing in non-traditional settings – the HINTS Study**

**Elena Pizzo**<sup>1</sup>, M Rayment<sup>2</sup>, A Thornton<sup>3</sup>, T Hartney<sup>3</sup>, V Delpech<sup>3</sup>, A Sullivan<sup>2</sup>, The HINTS Study Group

<sup>1</sup>Imperial College Business School, London, UK

<sup>2</sup>Chelsea and Westminster NHS Foundation Trust, London, UK

<sup>3</sup>Health Protection Agency, UK

### **Routine HIV screening in Portugal: clinical impact and costeffectiveness**

Y Yazdanpanah<sup>1</sup>, **Julian Perelman**<sup>2</sup>, J Alves<sup>2</sup>, K Mansinho<sup>3</sup>, M Lorenzo<sup>4</sup>, J-E Park<sup>4</sup>, E Losina<sup>5,6,7</sup>, RP Walensky<sup>4,6</sup>, F Noubary<sup>4</sup>, H Barros<sup>8</sup>, K Freedberg<sup>4,6</sup>, DA Paltiel<sup>9</sup>

<sup>1</sup>Hospital Bichat Claude Bernard, Paris, France

<sup>2</sup>Universidade Nova de Lisboa, Lisbon, Portugal

<sup>3</sup>Hospital Center Lisboa Ocidental, Lisbon, Portugal

<sup>4</sup>Massachusetts General Hospital, Boston, USA

<sup>5</sup>Brigham and Women's Hospital, Boston, USA

<sup>6</sup>Harvard Medical School, Boston, USA

<sup>7</sup>Boston University School of Public Health, USA

<sup>8</sup>Institute of Public Health, Porto University, Portugal

<sup>9</sup>Yale University, New Haven, CT, USA

### **Comparison of “Opt-In” versus “Opt-Out” Strategies for early HIV detection**

I Menacho<sup>1</sup>, E Sequeira<sup>2</sup>, M Muns<sup>3</sup>, O Barba<sup>4</sup>, T Clusa<sup>3</sup>, L Leal<sup>5</sup>, E Fernández<sup>5</sup>, D Raben<sup>6</sup>, J Lundgren<sup>6</sup>, I Pérez<sup>5</sup>, F García<sup>5</sup>, **Agathe Leon**<sup>5</sup>

<sup>1</sup>GesClínic, Corporació Sanitària Clínic.

<sup>2</sup>Consorci d'Atenció Primària de Salut de l'Eixample Casanova

<sup>3</sup>Centre d'Atenció Primària de Drassanes

<sup>4</sup>Consorci d'Atenció Primària de Salut de l'Eixample Rosellon.

<sup>5</sup>Hospital Clinic, University of Barcelona, Barcelona

<sup>6</sup>HIV Indicator Diseases Across Europe Study Group



## Testing for HIV and syphilis in 4 cities of Ukraine: screening results

**Oleksii Smirnov**

International HIV/AIDS Alliance in Ukraine, Kyiv, Ukraine

## “Test and Treat” is not the answer to the HIV-epidemic among gay men and other MSM in Switzerland.

**R Staub, Steven Derendinger**

Federal Office of Public Health, Bern, Switzerland

## Parallel session 5: Characteristics of PLHIV who present late for care and missed opportunities for earlier diagnosis

**Tuesday 20 March 11:00–12:30**

**Lundsgaard Auditorium - Challenges in Optimal Testing and Earlier Care**

**Simultaneous interpretation Russian/English**

### Moderators:



#### **Yusef Azad, the National AIDS Trust**

Yusef Azad is Director of Policy and Campaigns at NAT (the National AIDS Trust) - the UK's HIV policy organisation - where he has been working since 2004. He has also just finished a three-year term as co-Chair of the European Union's HIV/AIDS Civil Society Forum, and is a member of the steering committee of AIDS Action Europe. Yusef engages in policy work across a wide range of issues, including HIV prevention and testing, migrant access to healthcare, criminalisation of HIV transmission, health

service reform, equality and human rights. He has provided expert advice to bodies such as ECDC, WHO Europe and UNAIDS. He previously worked in the United Kingdom Parliament.



#### **Henning Mikkelsen, UNAIDS**

Henning Mikkelsen is the Representative of UNAIDS to the European Union. He served as Policy Adviser on HIV/AIDS, Malaria and Tuberculosis for the Directorate for Development at the European Commission from 2007-2009, seconded by UNAIDS. He has more than twenty-five years experience in the international response to AIDS, with a particular focus on Europe and Central Asia. With a background in social sciences, he was among the founders of the

first national Danish NGO working on AIDS in 1986. He worked from 1988 at the WHO Global Programme on AIDS, and has worked since 1996 in UNAIDS. He is a Danish national.

## Association of injection drug use and late enrollment in HIV medical care in Odessa Region, Ukraine

**Tetiana Kiriazova<sup>1,2</sup>, O Postnov<sup>3</sup>, I Perehinets<sup>4</sup>, O Neduzhko<sup>2,3</sup>**

<sup>1</sup>Future Without AIDS Foundation, Ukraine

<sup>2</sup>Ukrainian Institute on Public Health Policy, Ukraine

<sup>3</sup>I.I.Mechnikov Anti-Plague Research Institute, Ukraine

<sup>4</sup>WHO CO in Ukraine

## Missed opportunities for HIV testing in newly diagnosed HIV-infected patients in France

**Karen Champenois**<sup>1</sup>, A Cousien<sup>2</sup>, L Cuzin<sup>3</sup>, S Le Vu<sup>4</sup>, E Lanoy<sup>5</sup>, K Lacombe<sup>6</sup>, O Patey<sup>7</sup>, M Calvez<sup>8</sup>, C Semaille<sup>4</sup>, Y Yazdanpanah<sup>1,9</sup>

<sup>1</sup>Inserm ATIP-Avenir, Lille/Paris, France

<sup>2</sup>Université Lille Nord de France, EA2694, Lille, France

<sup>3</sup>Service des maladies infectieuses, CHU de Toulouse, Toulouse, France

<sup>4</sup>Institut de Veille Sanitaire, Saint-Maurice, France

<sup>5</sup>Institut Gustave-Roussy, Service de Biostatistique et Epidémiologie, Villejuif, France

<sup>6</sup>AP-HP Hôpital Saint-Antoine, Paris, France

<sup>7</sup>Inserm, UMR-S707, Paris, France

<sup>8</sup>Service des maladies infectieuses et tropicales, CHI Villeneuve-Saint-Georges, Villeneuve-Saint-Georges, France

<sup>9</sup>Université européenne de Bretagne, université Rennes 2, France

<sup>10</sup>Service de maladies infectieuses et tropicales, AP-HP Hôpital Bichat Claude Bernard, Paris

## Factor associated with late HIV diagnosis in Georgia

**Nikoloz Chkhartishvili**<sup>1</sup>, N Rukhadze<sup>1</sup>, L Sharavdze<sup>1,2</sup>, P Gabunia<sup>1</sup>, A Gamkrelidze<sup>3</sup>, T Tsertsvadze<sup>1,2</sup>

<sup>1</sup>Infectious Diseases, AIDS and Clinical Immunology Research Center, Tbilisi, Georgia

<sup>2</sup>Tbilisi State University Faculty of Medicine, Georgia

<sup>3</sup>WHO Country Office in Georgia

## HIV testing among Tuberculosis patients in Denmark increased through the period from 2007 to 2009

**M Perch**<sup>1</sup>, PH Andersen<sup>2</sup>, **Axel Kok-Jensen**<sup>2</sup>

<sup>1</sup>Rigshospitalet, Department of Cardiology, Section for Lungtransplantation, Copenhagen, Denmark

<sup>2</sup>Statens Serum Institut, Department of Epidemiology, Copenhagen, Denmark

## Diagnosing HIV infection in patients presenting with Glandular-fever-like illness in Primary care: are we missing primary HIV Infection?

**Murad Ruf**<sup>1</sup>, D Hsu<sup>1</sup>, S O'Shea<sup>2</sup>, S Costello<sup>3</sup>, J Peck<sup>1</sup>, W Tong<sup>3</sup>

<sup>1</sup>NHS Lambeth, Department of Public Health, London, UK

<sup>2</sup>St. Thomas' Hospital, GSTS Pathology, London, UK

<sup>3</sup>St. Thomas' Hospital, Department of Infectious Diseases, London, UK

## Profile and determinants of having never been tested for HIV amongst men who have sex with men in Spain

**Percy Fernández Dávila**<sup>1,2</sup>, C Folch<sup>1,3,4</sup>, L Ferrer<sup>1,3</sup>, R Soriano<sup>5</sup>, M Díez<sup>5</sup>, J Casabona<sup>1,3,4</sup>

<sup>1</sup>Centre d' Estudis Epidemiològics sobre les ITS i SIDA de Catalunya

<sup>2</sup>Stop Sida

<sup>3</sup>CIBERESP

<sup>4</sup>Universitat Autònoma de Barcelona

<sup>5</sup>Secretaría del Plan Nacional sobre el SIDA

## Parallel session 6: New HIV Testing Diagnostic Technologies

Tuesday 20 March 11:00–12:30

Haderup Auditorium - Challenges in Optimal Testing and Earlier Care

### Moderators:



#### **Dominique Costagliola, INSERM**

Dominique Costagliola, PhD, Senior Researcher at INSERM, heads the Unit on Clinical epidemiology, therapeutic strategies and virology in HIV infection at INSERM and Université Pierre et Marie Curie in Paris, France. She is the PI of the French Hospital Database on HIV ANRS CO4 and is deeply involved in collaboration of HIV cohorts. She is also Head of one of the monitoring and statistical data analysis centres for ANRS. Her main fields of competence include

biostatistics, epidemiology, clinical trials and modelling. She has studied the timing of mother-to-child HIV-1 transmission, incidence and the size of the HIV epidemic, the effects of ARVs, resistance to ARVs and AIDS and severe non-AIDS morbidity in HIV-infected patients, including cancers and myocardial infarction.



#### **Igor Karpov, Belarusian State Medical University**

Igor Karpov is Professor of Infectious Diseases and the Head of Infectious Disease Department at the Belarussian State Medical University. He is also the Chief Infectious Disease specialist at the Ministry of Health in Belarus. Dr. Karpov's main clinical and research interests include HIV-infection and opportunistic infections, as well as bacterial sepsis and meningitis. Dr. Karpov dedicates a lot of time to teaching of Medical students and postgraduate doctors. As Chief

Infectious Disease specialist he consults patients all over the country.

Dr. Karpov takes an active part in international research activities, he is a member of the Steering Committees of the EuroSIDA study and the HIV in Europe initiative, as well as member of ESCMID.

### **Automated laboratory-based oral fluid HIV testing in HIV screening programs – automatic for the people?**

**Michael Rayment<sup>1</sup>**, E Doku<sup>2</sup>, A Thornton<sup>3</sup>, A Nardone<sup>3</sup>, M Sudhanva<sup>4</sup>, P Roberts<sup>1</sup>, M Tenant-Flowers<sup>4</sup>, J Anderson<sup>5</sup>, A Sullivan<sup>1</sup>, M Atkins<sup>6</sup>

<sup>1</sup>Chelsea and Westminster NHS Foundation Trust, London, UK

<sup>2</sup>Imperial College Healthcare NHS Trust, London, UK

<sup>3</sup>Health Protection Agency, London, UK

<sup>4</sup>Kings College Hospital NHS Foundation Trust, London, UK

<sup>5</sup>Homerton University Hospital NHS Foundation Trust, London, UK

<sup>6</sup>Imperial College London, UK

### **Acceptability of rapid HIV diagnosis technology among primary health care practitioners in Spain**

**Cristina Agustí<sup>1,2</sup>**, L Fernández<sup>1,2</sup>, J Mascort<sup>3,4</sup>, R Carrillo<sup>3</sup>, C Aguado<sup>4</sup>, A Montoliu<sup>1,2</sup>, X Puigdangolas<sup>3</sup>, M De la Poza<sup>3</sup>, B Rifà<sup>5</sup>, J Casabona<sup>1,2</sup>

<sup>1</sup>Centre for Epidemiological Studies on HIV/STI in Catalonia - CEEISCAT - ICO, Badalona, Spain

<sup>2</sup>CIBERESP, Barcelona, Spain

<sup>3</sup>CAMFiC, Barcelona, Spain

<sup>4</sup>semFYC - Sociedad Española de Medicina Familiar y Comunitaria, Barcelona, Spain

<sup>5</sup>Departament de Salut Generalitat de Catalunya, Spain

## **Feasibility and acceptability of HIV screening through the use of rapid tests by GPs in a Brussels area with an important African community**

**Anne-Francoise Gennotte**<sup>1</sup>, P Semaille<sup>1,2</sup>, C Ellis<sup>2</sup>, C Necsoi<sup>1</sup>, M Abdulatif<sup>3</sup>, N Rungen-Chellum<sup>3</sup>, C Evaldre<sup>3</sup>, D Gidiuta<sup>4</sup>, F Laporte<sup>3</sup>, M Mernier<sup>3</sup>, S Sschellens<sup>3</sup>, N Clumeck<sup>1</sup>

<sup>1</sup>Division of Infectious Diseases, CHU ST Pierre, Belgium

<sup>2</sup>Department of General Medicine, Universite Libre de Bruxelles, Belgium

<sup>3</sup>Centre Free Clinic, Brussels, Belgium

<sup>4</sup>Centre Africain de Promotion de la Santé, C Brussels, Belgium

## **Stigma and discrimination on voluntary consultation and testing**

**Liudmila Untura**<sup>1</sup>, J Hows<sup>2</sup>, I Chilcevschii<sup>3</sup>

<sup>1</sup>A.O. Credinta, Childhood for All, Moldova

<sup>2</sup>GNP+, Holand

<sup>3</sup>League of People Living with HIV, Moldova

## **How to estimate the size of the hidden HIV epidemic? The case of France**

**Virginie Supervie**<sup>1,2</sup>, J Ndawinz<sup>1,2</sup>, D Costagliola<sup>1,2,3</sup>

<sup>1</sup>INSERM U943 Paris, France

<sup>2</sup>UPMC Univ-Paris 6, UMR S943, Paris, F75013, France

<sup>3</sup>APHP, Hôpital Pitié Salpêtrière, Service des maladies infectieuses et tropicales, Paris, France

# Poster sessions

Monday 19 March from 15:15-16:15 and Tuesday 20 March from 10:30-11:00

## Poster category 1: Characteristics of PLHIV who present late for HIV care

PO1/01

### **Psychosocial dynamics of HIV late presentation - results and recommendations from a qualitative study in Germany.**

PC Langer<sup>1</sup>, Peter Wiessner<sup>2</sup>

<sup>1</sup> Goethe University Frankfurt, Faculty of Social Sciences, Frankfurt, Germany

<sup>2</sup> Deutsche AIDS-Hilfe e.V., Cologne, Germany

PO1/02

### **Reduced proportion of peripheral CD4+ T-cells expressing IL-7 receptor (IL-7R, CD127) as peculiar feature of late presentation of HIV infection**

Francesca Bai, P Cicconi, C Tincati, T Bini, G Marchetti, A d'Arminio Monforte

Clinic of Infectious Diseases and Tropical Medicine, S.Paolo Hospital, Milan, Italy

PO1/03

### **What is hidden under the late enrollment in HIV care: illustrative example of Odessa Region, Ukraine**

Oleksandr Postnov<sup>1</sup>, T Kiriazova<sup>2,3</sup>, S Servetskiyy<sup>4</sup>, O Neduzhko<sup>1,3</sup>

<sup>1</sup>I.I.Mechnikov Anti-Plague Research Institute

<sup>2</sup>"Future without AIDS" Foundation

<sup>3</sup>Ukrainian Institute on Public Health Policy

<sup>4</sup>Odessa Regional AIDS Centre, Ukraine

PO1/04

### **High risk groups for late HIV diagnosis in Georgia**

Ketevan Goguadze, I Chikovani, N Rukhadze, G Gotsadze

Curatio International Foundation, Tbilisi, Georgia

PO1/06

### **Characteristics of PLHIV newly registered in Volga Federal District in 2008-2010**

Elena Kuzovatova, N Nosov

Nizhny Novgorod Scientific and Research Institute of Epidemiology & Microbiology after acad.I.N.Blokhina, Privolzhsky Okrug AIDS Center, Nizhny Novgorod, Russian Federation

PO1/07

### **Late presenters at the HIV/STI clinic in Antwerp, Belgium**

Ludwig Apers, O Koole, L Manirankunda, L Lynen, E Florence

Institute of Tropical Medicine, Department of Clinical Sciences, Antwerp, Belgium

PO1/08

### **Trends in the characteristics of HIV infected individuals at diagnosis in Portugal - 2000-2011**

Filipa Aragao<sup>1</sup>, A Alves<sup>2</sup>, L Mendao<sup>3</sup>, A Ferreira<sup>4</sup>, R Fernandes<sup>5</sup>, S Pinheiro<sup>6</sup>, E Teofilo<sup>6</sup>

<sup>1</sup>Escola Nacional de Saúde Pública UNL, Lisbon, Portugal

<sup>2</sup>Instituto de Marketing Research, Portugal

<sup>3</sup>GAT Grupo Portugues de Activistas sobre Tratamentos de VIH/SIDA, Portugal

<sup>4</sup>SER+ Associacao Portuguesa para a Prevencao e Desafio a SI, Portugal

<sup>5</sup>Associacao Positivo, Portugal

<sup>6</sup>Hospital St Antonio Capuchos CHLC

<sup>7</sup>Hospital St Antonio Capuchos CHLC

PO1/09

### **Recent infection and late diagnosis of HIV: a descriptive analysis of opposite ends of the spectrum**

Anne Gallois, A Esteve, C. Campbell, A Montoliu, J Csabona, AERI-VIH Study Group, PISCIS Study Group

Institut Català d'Oncologia - CEEISCAT, Barcelona, Spain

## **Poster category 2: Use and performance of new HIV testing diagnostic technologies**

PO2/01

### **Pilot study to analyze the feasibility of introducing rapid HIV testing in primary health care**

Laura Fernández<sup>1,2</sup>, C Agustí<sup>1,2</sup>, J Casbona<sup>1,2</sup>, Rapid testing in Primary Health Care Working Group

<sup>1</sup>Centre for Epidemiological Studies on HIV/STI in Catalonia - CEEISCAT - ICO, Badalona, Spain

<sup>2</sup>CIBERESP, Barcelona, Spain

PO2/02

### **Prevalence of HIV infection and acceptability of rapid HIV testing in patients attending emergency services**

Laura Fernández<sup>1,2</sup>, C Agustí<sup>1,2</sup>, L Force<sup>3</sup>, M Daza<sup>3</sup>, J Casabona<sup>1,2</sup>

<sup>1</sup>Centre for Epidemiological Studies on HIV/STI in Catalonia - CEEISCAT - ICO, Badalona, Spain

<sup>2</sup>CIBERESP, Barcelona, Spain

<sup>3</sup>Hospital de Mataró, Spain

PO2/03

### **Good practices in preventing AIDS—use of rapid HIV test in oral fluid**

Maria Meliou, A Kanakari

NGO Praksis, Athens, Greece

PO2/04

### **HIV rapid testing in a mobile unit in several urban settings in Spain: a strategy reaching a different population?**

Juan Hoyos<sup>1,2</sup>, L de la Fuente<sup>2,3</sup>, R Sánchez<sup>3</sup>, S Fernández-Balbuena<sup>3</sup>, J Gutiérrez<sup>4</sup>, M Ruiz<sup>3</sup>, J Álvarez<sup>4</sup>, C Figueroa<sup>1</sup>, MJ Belza<sup>1,2</sup>

<sup>1</sup>Escuela Nacional de Sanidad, Instituto de Salud Carlos III, Madrid, Spain

<sup>2</sup>Ciber de Epidemiología y Salud Pública, Barcelona, Spain

<sup>3</sup>Centro Nacional de Epidemiología, Instituto de Salud Carlos III, Madrid, Spain

<sup>4</sup>Asociación Madrid Positivo, Madrid, Spain

## Poster category 3: Implications of stigmatisation, criminalisation of HIV and other legal issues for the offer and uptake of HIV testing and earlier care

PO3/01

### **A focused response to HIV in Europe: policy recommendations from the Correlation Network II**

Koen Block

European AIDS Treatment Group, Brussels, Belgium

PO3/02

### **No NGO support for HIV-testing campaigns in prisons as long as rights of HIV-positive prisoners are not secured**

Peter Wiessner<sup>1,2</sup>, B Knorr<sup>1</sup>, F Bagyinszky<sup>2</sup>

<sup>1</sup>European AIDS Treatment Group, Cologne, Germany

<sup>2</sup>Deutsche AIDS-Hilfe e.V., Cologne, Germany

PO3/05

### **Stigmatization and Discrimination of People Living with HIV in Russia**

Sergey Smirnov

'Community of People Living with HIV'

## Poster category 4: Access to care and treatment for PLHIV

PO4/01

### **Providing universal access to services for people living with HIV in the Karaganda Region, Kazakhstan**

Yelena Bilokon

NGO "My House", Kazakhstan Network of Women HIV, Kazakhstan

PO4/02

### **Home visits as the way of providing early care and help to people living with HIV (PLHIV)**

Lilit Aleksanyan, A Abgaryan, Z Mayilyan

Real World, Real People NGO, Yerevan, Armenia

PO4/03

### **Overcoming barriers on the way of early HIV care provision for MARPs in Ukraine**

Hanna Shevchenko

All-Ukrainian network of PLWH, Kyiv, Ukraine

PO4/04

### **Cost-effectiveness and cost-utility of earlier initiation of first line treatment for HIV-infected people in Spain**

Antonio Antela<sup>1</sup>, JM Llibre<sup>2</sup>, JC López Bernaldo de Quirós<sup>3</sup>, J Portilla<sup>4</sup>, A Gallois<sup>5</sup>, C Campbell<sup>5</sup>, J Peñafiel<sup>5</sup>, A Brogan<sup>6</sup>, S Talbird<sup>6</sup>, L Lindner<sup>7</sup> A Vieta<sup>7</sup>

<sup>1</sup>Hospital Clínico de Santiago, Spain

<sup>2</sup>Hospital Universitari Germans Trias i Pujol, Fundació Lluita contra la SIDA, Spain

<sup>3</sup>Hospital Gregorio Marañón de Madrid, Spain

<sup>4</sup>Hospital General de Alicante, Spain

<sup>5</sup>Centre d'Estudis Epidemiològics sobre les Infeccions de Transmissió Sexual i Sida de Catalunya (CEEISCAT), Spain

<sup>6</sup>RTI Health Solutions, UK

<sup>7</sup>IMS Health, Spain



## Poster category 5: Scaling up HIV testing within health care settings

PO5/01

### **HIV/AIDS in Macedonia before 2004 and nowadays - how we made a step forward**

Rumena Krastovska, M Stevanovic, Z Ljubicic

Clinic for Infectious Diseases and Febrile Conditions, Skopje, FYR Macedonia

PO5/02

### **Approaches and results of youth HIV testing program**

Iatamze Verulashvili

Women's Center, Tbilisi, Georgia

PO5/03

### **HIV counselling and testing (HTC) in Estonia: policy implications based on data triangulation**

K Rüütel<sup>1</sup>, I Tomera<sup>1</sup>, K Tarien<sup>1</sup>, C Pervilhac<sup>2</sup>

<sup>1</sup>National Institute for Health Development, Tallinn, Estonia

<sup>2</sup>World Health Organization

PO5/04

### **HIV prevalence among pregnant women that were not tested during pregnancy (St.Petersburg, Russia)**

Ekaterina Musatova, D Niauri

St. Petersburg State University Medical Faculty, Department of Obstetrics & Gynecology, St. Petersburg, Russian Federation

PO5/05

### **Expanded HIV testing and community engagement: a strategic framework for scaling up HIV testing, engaging all sectors and changing the HIV response paradigm**

Marsha Martin<sup>1</sup>, G Edwards<sup>2</sup>

<sup>1</sup>Get Screened Oakland, Oakland, CA, USA

<sup>2</sup>Flowers Heritage Foundation, Oakland, CA, USA

PO5/06

### **HIV testing in Clinical Center of Vojvodina, Serbia**

Daniela Maric<sup>1</sup>, S Brkic<sup>1</sup>, J Nedic<sup>2</sup>, K Kiralj<sup>1</sup>, P Djuric<sup>3</sup>, V Turkulov<sup>1</sup>

<sup>1</sup>Infectious Diseases Clinic, University of Novi Sad, Republic of Serbia

<sup>2</sup>Medical School, University of Novi Sad, Republic of Serbia

<sup>3</sup>Center for Disease Control and Prevention, University of Novi Sad, Republic of Serbia

PO5/07

### **Determinants of HIV testing in the general population in Portugal**

Filipa Aragão<sup>1</sup>, PM Ferreira<sup>2</sup>

<sup>1</sup>Escola Nacional de Saúde Pública UNL, Lisbon, Portugal

<sup>2</sup>Instituto Ciências Sociais da Universidade de Lisboa, Lisbon, Portugal

PO5/08

### **Early HIV infection: demographic features and risk factors among individuals with early HIV infection in Ireland 2008-2011**

Joanne Moran, J Connell, D Burke, W Hall

National Virus Reference Laboratory, University College Dublin, Belfield, Dublin, Ireland

## Poster category 6: Results from the evaluation of VCT programmes

PO6/01

### **Approaches and results from the evaluation of VCT in the Pavlodar region of Kazakhstan**

Maiya Terekulova<sup>1</sup>, Z Kalmataeva<sup>1</sup>, A Pak<sup>2</sup>

<sup>1</sup>Kazakhstan School of Public Health, Almaty, Kazakhstan

<sup>2</sup>Kazakhstan union of PLHIV, Almaty, Kazakhstan

PO6/02

### **The role voluntary counselling and testing in early diagnosis of HIV infection**

Predrag Duric, S Ilic, S Rajcevic

Institute of Public Health of Vojvodina, Novi Sad, Republic of Serbia

PO6/03

### **Evolution in the number of tests performed and in the profile of people tested in VCT network of Catalonia, 1995-2010**

Laura Fernàndez<sup>1,2</sup>, J Casabona<sup>1,2</sup>, On behalf of HIV-DEVO Group

<sup>1</sup>Centre for Epidemiological Studies on HIV/STI in Catalonia - CEEISCAT - ICO, Badalona, Spain

<sup>2</sup>CIBERESP, Barcelona, Spain

PO6/04

### **HIV Testing and Counseling (HTC) in EECA: entry point for curbing the HIV epidemic**

Sergey Votyagov<sup>1</sup>, N Tsereteli<sup>2</sup>

<sup>1</sup>Eurasian Harm Reduction Network (EHRN). Vilnius, Lithuania

<sup>2</sup>Eurasian Coalition on Male Health (ECOM)

PO6/05

### **A non-healthcare HIV test clinic improving testing and linkage to care**

Peder Ahlin<sup>1</sup>, H Granholm<sup>1</sup>, L Lindborg<sup>2</sup>

<sup>1</sup>Noaks Ark, Stockholm, Sweden

<sup>2</sup>Stockholm South General Hospital, Sweden

PO6/06

### **Towards full coverage of HIV Counseling and Testing services in Rwanda, 2003 - June 2010**

Elise Mutunge, F Ndagije, JP Nyemazi, P Raghunathan, A Ahayo

Ministry of Health, HIV Prevention Department, Kigali, Rwanda

PO6/07

### **Possibility for improvement for counseling and testing for early diagnoses of HIV infection in Armenia**

Vardan Arzakanyan, S Grigoryan, A Papoyan

National AIDS Center, Yerevan, Armenia

PO6/08

### **Mental health care component in VCT services**

A Skonieczna<sup>1</sup>, Tomasz Malkuszcwski<sup>1</sup>, J Moskalewicz<sup>2</sup>, M Welbel<sup>2</sup>

<sup>1</sup>Association Social AIDS Committee - SKA, Warsaw, Poland

<sup>2</sup>Institute of Psychiatry and Neurology, Poland

PO6/09

### **Community Expanded Access to Test (CEAT): HIV testing project in Newham**

Wendy Hachmoller, J Tucker

NHS Newham, London, UK

## **Poster category 7: Lessons learned in the implementation of HIV testing strategies for migrants**

PO7/01

### **Copenhagen Central Station as HIV-testing site for migrant populations**

Kirsten Madsen, A Dahl, R Chandran, V Borré

Cross-Over, Copenhagen, Denmark

PO7/02

### **PARC-Project – prevention of AIDS with the resources of communities**

Sabine Lex

Aids Hilfe Wien, Department of Prevention, Vienna, Austria

PO7/03

### **Outreach project for HIV testing in an immigrant community**

L Domingos<sup>1</sup>, A Duarte<sup>1</sup>, Andreia Pinto Ferreira<sup>1</sup>, P Silvério Marques<sup>1</sup>, F Aragão<sup>2</sup>

<sup>1</sup>SER+ Associação Portuguesa para a Prevenção e Desafio à SIDA, Portugal

<sup>2</sup>Escola Nacional de Saúde Pública, Portugal

## **Poster category 8: Lessons learned in the implementation of HIV testing strategies for IDUs**

PO8/01

### **Low testing uptake and their determinants among IDUs in Georgia**

Ivdim Chikovanj, K Goguadze, N Rukhadze, G Gotsadze

Curatio International Foundation, Tbilisi, Georgia

PO8/02

### **Factors influencing HIV testing among injecting drug users in Lithuania**

Loreta Stoniene

Institute of Hygiene, Division of Public Health Research & UNODC Project Office for the Baltic States, Vilnius, Estonia

PO8/03

### **Results of piloting peer driven intervention – did we reach targeted population?**

Lile Batselashvili, M Sinjikashvili, M Chelidze, I Kirtadze, N Topuria

Addiction Research Center, Alternative Georgia, Tbilisi, Georgia

PO8/04

### **Immunochromatographic rapid tests in preventive work with injection drug users**

Tetyana Loginova

Kyiv Narcological Hospital 'Sociotherapy', Ukraine

PO8/05

### **Rapid HIV testing for drug users in low-threshold services**

Dirk Schäffer<sup>1</sup>, S Michel<sup>2</sup>, W Rensmann<sup>3</sup>, K Dettmer<sup>4</sup>, A Leicht<sup>4</sup>

<sup>1</sup>Deutsche AIDS-Hilfe, Germany

<sup>2</sup>Fachhochschule Dortmund, Germany

<sup>3</sup>AIDS Hilfe Dortmund, Germany

<sup>4</sup>Fixpunkt Berlin, Germany

PO8/06

### **HIV spread among different groups of IDUs and influence of awareness about HIV-status on safety of sexual and injection behaviors**

Polina Girchenko, S Dugin

Foundation of Medical and Social Programs 'Humanitarian Action', St Petersburg, Russian Federation

PO8/08

### **Maximizing reliance on IDUs to prevent HIV in Ukraine**

Oleksandra Datsenko<sup>1</sup>, P Smyrnov<sup>1</sup>, R Broadhead<sup>2</sup>

<sup>1</sup>International HIV/AIDS Alliance-Ukraine, Kyiv, Ukraine

<sup>2</sup>University of Connecticut, USA

## **Poster category 9: Lessons learned in the implementation of HIV testing strategies for MSM**

PO9/01

### **Activities directed to early testing and diagnostics of HIV among MSM in the Republic of Armenia**

Ruzanna Davtyan, S Stepanyan, R Ohanyan

'Education in the Name of Health' SO, Yerevan, Armenia

PO9/02

### **Check your status - first results from a MSM Outreach Prevention and VCT Project by Aids Hilfe Vienna**

Isabell Eibl, D Bozkurt, H Dopsch

Aids Hilfe Wien, Vienna, Austria

PO9/03

### **Scaling up HIV and STI testing of gay men and other MSM in Germany by community based testing campaigns**

Matthias Kuske<sup>1</sup>, P Wiessner<sup>1</sup>, J Drewes<sup>2</sup>, J Kuck<sup>2</sup>, D Kleiber<sup>2</sup>

<sup>1</sup>Deutsche AIDS-Hilfe e.V., Berlin, Germany

<sup>2</sup>Freie Universität Berlin, Department for Public Health, Berlin, Germany

PO9/04

### **Are gay men routinely testing for HIV? Findings from community surveys in The Netherlands and Australia**

John de Wit<sup>1,2</sup>, P Adam<sup>2,3</sup>

<sup>1</sup>Utrecht University, Department of Social and Organizational Psychology, Utrecht, The Netherlands

<sup>2</sup>University of New South Wales, Australia

<sup>3</sup>Institute for Prevention and Social Research, Australia

PO9/05

### **A participatory research on HIV and men who have sex with men: Uptake of HIV testing and its determinants**

Ana Gama<sup>1</sup>, L Mendão<sup>1</sup>, R Fuertes<sup>1</sup>, S Dias<sup>2</sup>

<sup>1</sup>GAT - Grupo Português de Ativistas sobre Tratamentos de VIH/Sida Pedro Santos, Portugal

<sup>2</sup>Instituto de Higiene e Medicina Tropical/Universidade Nova de Lisboa, Portugal

PO9/06

### **Results of 3 years outreach VCT for HIV/STI in gay venues in Antwerp, Belgium**

Tom Platteau, K Wouters, C Nöstlinger, A Ludwig, E Florence

Institute of Tropical Medicine, Department of Clinical Sciences, Antwerp, Belgium

PO9/07

### **HIV rapid testing in MSM venues (Estonia)**

Raul Lindemann<sup>1</sup>, I Sobolev<sup>1</sup>, Z Shabarova<sup>2</sup>

<sup>1</sup>Estonian Network of People Living with HIV, Tallinn, Estonia

<sup>2</sup>AIDS Healthcare Foundation, Estonia

PO9/08

### **Features of HIV testing prevention programs for MSM, implemented in the city of Kiev**

Andrii Chernyshev

Public organization 'Gay-Alliance', Kiev, Ukraine

PO9/09

### **Why are gay men testing late for HIV?**

Anders Dahl, MR Eiersted

Hiv-Danmark, Copenhagen, Denmark

PO9/10

### **Taking an HIV test in Slovenia: the situation for men who have sex with men**

Miran Solinc

SKUC, Ljubljana, Slovenia

PO9/11

### **Increasing HIV positive results in MSM group. Experience from VCT in Warsaw coordinated by Foundation of Social Education**

Magdalena Ankiersztejn-Bartczak

Foundation of Social Education, Warsaw, Poland

PO9/12

### **Expectations and perceptions of European men who have sex with men on voluntary testing and counselling**

Frank Michael Amort<sup>1,2</sup>, K Block<sup>1</sup>

<sup>1</sup>European Aids Treatment Group, Brussels, Belgium

<sup>2</sup>PEAC, Centro Nacional de Epidemiología, ISCIII, Madrid, Spain

## **Poster category 10: Lessons learned in the implementation of HIV testing strategies for sex workers**

PO10/01

### **HIV and commercial sex workers in Portugal: Are there missed opportunities to scaling up HIV testing and linkage to care?**

Sónia Dias<sup>1</sup>, L Mendão<sup>2</sup>, A Gama<sup>2</sup>, G Cohen<sup>2</sup>, S Trindade<sup>2</sup>, H Barros<sup>3</sup>

<sup>1</sup>Instituto de Higiene e Medicina Tropical/Universidade Nova de Lisboa, Portugal

<sup>2</sup>GAT – Grupo Português de Activistas sobre Tratamentos de VIH/Sida Pedro Santos, Portugal

<sup>3</sup>Instituto de Saúde Pública, Faculdade de Medicina da Universidade do Porto, Portugal

PO10/02

### **Combining VCT and STI testing and counselling as a factor increasing interest in VCT for high-risk groups**

Oksana Savenko, M Varban, S Filippovych, Z Islam

ICF "International HIV/AIDS Alliance in Ukraine", Kyiv, Ukraine

PO10/03

### **Barriers for early HIV testing among road and club-based female sex workers in Catalonia**

Meritxell Sabidó<sup>1,2</sup>, L Alonso<sup>1</sup>, MJ Blanco<sup>1</sup>, M Torrens<sup>1</sup>, C Alvarez<sup>1,3</sup>, D Faixó<sup>4</sup>, C Reina<sup>4</sup>, C Agustí<sup>2,5</sup>, J Casabona<sup>1,2,5,6</sup>

<sup>1</sup>Fundació Sida i Societat, Department of Public Health and Research, Barcelona, Spain

<sup>2</sup>CIBER de Epidemiología y Salud Pública (CIBERESP), Spain.

<sup>3</sup>Scholar of the Ministry of Foreign Affairs and Cooperation (Spain) and Fulbright Foreign Student Program

<sup>4</sup>Programa Carretera, Hospital St. Jaume de Calella - Corporació de Salut del Maresme i La Selva, Calella, Spain.

<sup>5</sup>Centre for Epidemiological Studies on HIV/AIDS and STI of Catalonia (CEEISCAT)/Institut Català d'Oncologia, Badalona, Spain

<sup>6</sup>Department of Paediatrics, Obstetrics, Gynaecology, and Preventive Medicine. Universitat Autònoma de Barcelona, Barcelona, Spain

PO10/04

### **BORDERNETwork's IBBS among Sex Workers (SWs) in 7 EU countries: bridging research to practice while scaling up HIV/STI testing**

Tzvetina Arsova Netzelmann<sup>1</sup>, E Steffan<sup>1</sup>, R Enke<sup>2</sup>, J Kalikov<sup>3</sup>, A Karnite<sup>4</sup>, A Leffers<sup>5</sup>, B Kucharova<sup>6</sup>, R Dimitrova<sup>7</sup>, C Fierbinteanu<sup>8</sup>

<sup>1</sup>SPI Forschung gGmbH, Berlin, Germany

<sup>2</sup>National Institute for Health Development, Tallinn, Estonia

<sup>3</sup>Aids Information and Support Centre, Tallinn, Estonia

<sup>4</sup>Latvia's Family Planning and Sexual Health Association, Riga, Latvia

<sup>5</sup>Aids Hilfe Potsdam, Potsdam, Germany

<sup>6</sup>C.A. Prima, Bratislava, Slovak Republic

<sup>7</sup>Health and Social Development Foundation, Sofia, Bulgaria

<sup>8</sup>Romanian Association Against AIDS, Bucharest, Romania

PO10/05

### **Results of peer-driven interventions for female sex workers in Ukraine**

Oksana Matiyash<sup>1</sup>, P Smyrnov<sup>1</sup>, R Broadhead<sup>2</sup>

<sup>1</sup>International HIV/AIDS Alliance-Ukraine, Kyiv, Ukraine

<sup>2</sup>University of Connecticut, USA

## **Parallel session 1 posters: Lessons Learned in Novel HIV Testing Strategies and Programmes**

PS1/01

### **Routine HIV testing in the Emergency Department: tough lessons in sustainability**

Michael Rayment<sup>1</sup>, C Rae<sup>1</sup>, S Finlay<sup>1</sup>, M Atkins<sup>2</sup>, P Roberts<sup>1</sup>, A Sullivan<sup>1</sup>

<sup>1</sup>Chelsea and Westminster NHS Foundation Trust, London, UK

<sup>2</sup>Imperial College London, UK

PS1/02

### **Routine HIV Screening in 6 EDs in Paris area: the ANRS URDEP Study**

E Casalino<sup>1</sup>, S Firmin<sup>2</sup>, A Delobelle<sup>2</sup>, B Bernot<sup>3</sup>, C Choquet<sup>1</sup>, G Der Sahakian<sup>4</sup>, J Zundel<sup>5</sup>, P Hausfater<sup>6</sup>, YE Claessens<sup>7</sup>, E Bouvet<sup>8</sup>, F Brun-Vezinet<sup>9</sup>, Dominique Costagliola<sup>2,10</sup>

<sup>1</sup>Hôpital Bichat, Service des Urgences, Paris, France

<sup>2</sup>U 943 INSERM et UPMC Paris Univ 6, Paris, France

<sup>3</sup>Hôpital, Avicenne, Service des Urgences, Bobigny, France

<sup>4</sup>Hôpital Hôtel Dieu, Service des Urgences, Paris, France

<sup>5</sup>Hôpital Bicêtre, Kremlin Bicêtre, France

<sup>6</sup>Hôpital La Pitié Salpêtrière, Service des Urgences, Paris, France

<sup>7</sup>Hôpital Cochin, Service des Urgences, Paris, France

<sup>8</sup>Hôpital Bichat-Claude Bernard, Service de Maladies Infectieuses, Paris France

<sup>9</sup>Hôpital Bichat-Claude Bernard, Service de Virologie, Paris, France

<sup>10</sup>Hôpital La Pitié Salpêtrière, Service de Maladies Infectieuses, Paris France

PS1/03

**Acceptability, feasibility and costs of universal offer of rapid point of care testing for HIV in an acute admissions unit: results of the RAPID project**

Fiona Burns<sup>1</sup>, S Edwards<sup>2</sup>, J Woods<sup>2</sup>, G Haidari<sup>3</sup>, Y Calderon<sup>4</sup>, J Leider<sup>4</sup>, S Morris<sup>5</sup>, R Tobin<sup>2</sup>, J Cartledge<sup>2</sup>, M Brown<sup>6</sup>

<sup>1</sup>University College London, UK

<sup>2</sup>Central & North West London Foundation Trust, UK

<sup>3</sup>University College London Hospitals NHS Foundation Trust, London, UK

<sup>4</sup>Albert Einstein College of Medicine, Bronx, New York, USA

<sup>5</sup>UCL Centre for Applied Health Research, London, UK

<sup>6</sup>Department of Clinical Research, London School of Hygiene & Tropical Medicine, London, UK

PS1/04

**Increasing HIV testing in non-GUM settings – a new training resource**

W Majewska<sup>1</sup>, Catherine Howland<sup>2</sup>, M Pakianathan<sup>1</sup>

<sup>1</sup>St George's Healthcare NHS Trust, London, UK

<sup>2</sup>Bristol-Myers Squibb Pharmaceuticals Ltd, Uxbridge, UK

PS1/05

**Individual level and country level predictors for recent HIV-testing and late HIV diagnoses among MSM in Europe – aspects to consider when planning interventions to increase HIV-testing. Results of the European MSM Internet Survey (EMIS)**

Axel J Schmidt<sup>1</sup>, U Marcus<sup>1</sup>, M Breveglieri<sup>2</sup>, P Fernández-Dávila<sup>3</sup>, L Ferrer<sup>3</sup>, C Folch<sup>3</sup>, M Furegato<sup>2</sup>, F Hickson<sup>4</sup>, HJ Hospers<sup>5</sup>, D Reid<sup>4</sup>, P Weatherburn<sup>4</sup> The EMIS Network

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<sup>2</sup>Regional Centre for Health Promotion, ULSS 20 – Veneto Region, Verona, Italy

<sup>3</sup>Centre for Epidemiological Studies on HIV/AIDS in Catalonia (CEEISCAT), Barcelona, Spain

<sup>4</sup>Sigma Research, London School of Hygiene and Tropical Medicine, United Kingdom

<sup>5</sup>Maastricht University, University College Maastricht, The Netherlands

PS1/06

**HIV testing among Portuguese men who have sex with men- results from the EMIS Study**

Claudia Carvalho<sup>1</sup>, R Fuertes<sup>2</sup>, R Lucas<sup>1</sup>, MJ Campos<sup>2</sup>, L Mendão<sup>2</sup>, AJ Schmidt<sup>3</sup>

<sup>1</sup>University of Porto, Portugal

<sup>2</sup>Grupo Português de Ativistas Sobre Tratamentos- GAT, Portugal

<sup>3</sup>Robert Koch Institute, Germany

**Parallel session 2 posters: HIV Testing and the Continuum of HIV Care**

PS2/01

**Quality of care and clinical outcome of persons diagnosed with HIV in the UK**

Valerie Delpech, Z Yin, M Kall, A Brown

Health Protection Agency, Colindale, London, UK

PS2/02

**BCN Checkpoint: high efficiency in HIV detection and linkage to care**

Michael Meulbroek, E Ditzel, J Saz, H Taboada, G Font, A Perez, A Carrillo, F Perez, J Montilla, M Ingrami, V Gimenez, F Pujol

Projecte dels NOMS-Hispanosida, Barcelona, Spain



PS2/03

### **CheckpointLX - MSM HIV testing and linkage to care in Lisbon**

Maria José Campos<sup>1</sup>, E Teófilo<sup>2</sup>, H Machado<sup>1</sup>, J Brito<sup>1</sup>, J Esteves<sup>1</sup>, L Mendão<sup>1</sup>, R Abrantes<sup>1</sup>, R Fuertes<sup>1</sup>, T Rodrigues<sup>1</sup>, N Pinto<sup>1</sup>

<sup>1</sup>CheckpointLX, Portugal

<sup>2</sup>Centro Hospitalar de Lisboa Central, Portugal

PS2/04

### **Checkpoint: rapid HIV screening in community setting for a strong link to care**

Jean-Yves Le Talec<sup>1</sup>, C Rouzioux<sup>2</sup>, Nicolas Derche<sup>3</sup>, C Taeron<sup>4</sup>, A Guérin<sup>5</sup>, G Sebbah<sup>5</sup>, G Tellier<sup>5</sup>, E Penel<sup>3</sup>

<sup>1</sup>University of Toulouse 2, Toulouse, France

<sup>2</sup>Necker Hospital and Descartes University, Paris, France

<sup>3</sup>Le Kiosque Infos Sida & Toxicomanie, Paris, France

<sup>4</sup>Arcat, Paris, France

<sup>5</sup>Groupe SOS, Paris, France

PS2/05

### **PLHIV-Related Stigma in Belarus - impacts on quality of care and health outcomes**

J Hows<sup>1</sup>, Elena Grigoryeva<sup>2</sup>

<sup>1</sup>Global Network of People Living with HIV

<sup>2</sup>Belarusian PLHIV Community, Minsk, Belarus

PS2/06

### **Scaling-up community HIV rapid testing and linkage to care in Estonia, Lithuania, Russia and Ukraine: results and lessons learned**

Zoya Shabarova<sup>1</sup>, T Ford<sup>2</sup>, I Sobolev<sup>3</sup>, S Kulsis<sup>4</sup>, R Kulchynska<sup>5</sup>, A Podymova<sup>6</sup>

<sup>1</sup>AHF Global Immunity, Amsterdam, The Netherlands

<sup>2</sup>AIDS Healthcare Foundation, Los Angeles, USA

<sup>3</sup>Estonian Network of PLWH, Tallinn, Estonia

<sup>4</sup>NGO Demetra, Vilnius, Lithuania

<sup>5</sup>Ukrainian HIV Resource Center, Kiev, Ukraine

<sup>6</sup>Sverdlovsk Oblast AIDS Center, Yekaterinburg, Russian Federation

## **Parallel session 3 posters: HIV Testing among Key Populations**

PS3/01

### **Ukraine's experience in scaling-up HIV testing and further referral of high-risk population to health-care institutions Ukraine**

Oksana Savenko, S Filippovych, Z Islam

ICF "International HIV/AIDS Alliance in Ukraine", Kyiv, Ukraine

PS3/02

### **Effectiveness of continuous prevention interventions for HIV testing uptake among high risk populations in Tbilisi, Georgia**

Nino Tsereteli<sup>1</sup>, I Chiqovani<sup>2</sup>, K Goguadze<sup>2</sup>, N Rukhadze<sup>2</sup>

<sup>1</sup>NGO 'Center for Information and Counseling on Reproductive Health - Tanadgoma', Tbilisi, Georgia

<sup>2</sup>Curatio International Foundation, Tbilisi, Georgia

PS3/03

### **Translating research results into promotion of HIV testing among Sub-Saharan African migrants in Flanders**

Lazare Manirankunda, J Loos, C Nöestlinger

Institute of Tropical Medicine, Antwerp, Belgium

PS3/04

### **Using community-based rapid HIV screening among men who have sex with men in a behavioral serosurveillance survey, Almaty, 2010**

Assel Terlikbayeva<sup>1</sup>, M Berry<sup>2</sup>, V Ragoza<sup>3</sup>, A Janayeva<sup>3</sup>, C Berry<sup>2</sup>, N El-Bassel<sup>1</sup>

<sup>1</sup>Global Health Research Center of CA, Almaty, Republic of Kazakhstan

<sup>2</sup>Center for Public Health and Human Rights, John Hopkins Bloomberg School of Public Health, Baltimore, MD, USA

<sup>3</sup>'Amulet' Public Association, Republic of Kazakhstan

PS3/05

### **Development of gender oriented services to increase the number of voluntary counseling and testing (VCT) among female drug users of Lviv region (Ukraine)**

Marta Vasylyev, M Sluzhynska, O Sluzhynska, O Grushynska

Lviv Regional AIDS Center & Charitable Salus Foundation, Lviv, Ukraine

PS3/06

### **Socio-demographic factors predicting HIV test seeking behaviour among MSM in 6 EU cities. Results from the SIALON European Project (2008-2010)**

L Gios<sup>1</sup>, M Breveglieri<sup>2</sup>, M Furegato<sup>2</sup>, Massimo Mirandola<sup>1</sup>

<sup>1</sup>The Hospital Trust of Verona, Veneto Region, Italy

<sup>2</sup>ULSS20, Veneto Region, Verona, Italy

## **Parallel session 4 posters: Cost Effectiveness of HIV Testing**

PS4/01

### **Cost effectiveness of HIV testing in non-traditional settings – the HINTS Study**

Elena Pizzo<sup>1</sup>, M Rayment<sup>2</sup>, A Thornton<sup>3</sup>, T Hartney<sup>3</sup>, V Delpech<sup>3</sup>, A Sullivan<sup>2</sup>, The HINTS Study Group

<sup>1</sup>Imperial College Business School, London, UK

<sup>2</sup>Chelsea and Westminster NHS Foundation Trust, London, UK

<sup>3</sup>Health Protection Agency, UK

PS4/2

### **Routine HIV screening in Portugal: clinical impact and costeffectiveness**

Y Yazdanpanah<sup>1</sup>, Julian Perelman<sup>2</sup>, J Alves<sup>2</sup>, K Mansinho<sup>3</sup>, M Lorenzo<sup>4</sup>, J-E Park<sup>4</sup>, E Losina<sup>5,6,7</sup>, RP Walensky<sup>4,6</sup>, F Noubary<sup>4</sup>, H Barros<sup>8</sup>, K Freedberg<sup>4,6</sup>, DA Paltiel<sup>9</sup>

<sup>1</sup>Hospital Bichat Claude Bernard, Paris, France

<sup>2</sup>Universidade Nova de Lisboa, Lisbon, Portugal

<sup>3</sup>Hospital Center Lisboa Ocidental, Lisbon, Portugal

<sup>4</sup>Massachusetts General Hospital, Boston, USA

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<sup>6</sup>Harvard Medical School, Boston, USA

<sup>7</sup>Boston University School of Public Health, USA

<sup>8</sup>Institute of Public Health, Porto University, Portugal

<sup>9</sup>Yale University, New Haven, CT, USA

PS4/03

### **Comparison of “Opt-In” versus “Opt-Out” Strategies for early HIV detection**

I Menacho<sup>1</sup>, E Sequeira<sup>2</sup>, M Muns<sup>3</sup>, O Barba<sup>4</sup>, T Clusa<sup>3</sup>, L Leal<sup>5</sup>, E Fernández<sup>5</sup>, D Raben<sup>6</sup>, J Lundgren<sup>6</sup>, I Pérez<sup>5</sup>, F García<sup>5</sup>, Agathe Leon<sup>5</sup>

<sup>1</sup>GesClínic, Corporació Sanitària Clínic.

<sup>2</sup>Consorci d'Atenció Primària de Salut de l'Eixample Casanova

<sup>3</sup>Centre d'Atenció Primària de Drassanes

<sup>4</sup>Consorci d'Atenció Primària de Salut de l'Eixample Rosellon.

<sup>5</sup>Hospital Clínic, University of Barcelona, Barcelona

<sup>6</sup>HIV Indicator Diseases Across Europe Study Group

PS4/04

### **Testing for HIV and syphilis in 4 cities of Ukraine: screening results**

Oleksii Smirnov

International HIV/AIDS Alliance in Ukraine, Kyiv, Ukraine

PS4/05

### **“Test and Treat” is not the answer to the HIV-epidemic among gay men and other MSM in Switzerland.**

R Staub, Steven Derendinger

Federal Office of Public Health, Bern, Switzerland

## **Parallel session 5 posters: Characteristics of PLHIV who present late for care and missed opportunities for earlier diagnosis**

PS5/01

### **Association of injection drug use and late enrollment in HIV medical care in Odessa Region, Ukraine**

Tetiana Kiriazova<sup>1,2</sup>, O Postnov<sup>3</sup>, I Perehinets<sup>4</sup>, O Neduzhko<sup>2,3</sup>

<sup>1</sup>Future Without AIDS Foundation, Ukraine

<sup>2</sup>Ukrainian Institute on Public Health Policy, Ukraine

<sup>3</sup>I.I.Mechnikov Anti-Plague Research Institute, Ukraine

<sup>4</sup>WHO CO in Ukraine

PS5/02

### **Missed opportunities for HIV testing in newly diagnosed HIV-infected patients in France**

Karen Champenois<sup>1</sup>, A Cousien<sup>2</sup>, L Cuzin<sup>3</sup>, S Le Vu<sup>4</sup>, E Lanoy<sup>5</sup>, K Lacombe<sup>6</sup>, O Patey<sup>7</sup>, M Calvez<sup>8</sup>, C Semaille<sup>4</sup>, Y Yazdanpanah<sup>1,9</sup>

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<sup>3</sup>Service des maladies infectieuses, CHU de Toulouse, Toulouse, France

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<sup>9</sup>Université européenne de Bretagne, université Rennes 2, France

<sup>10</sup>Service de maladies infectieuses et tropicales, AP-HP Hôpital Bichat Claude Bernard, Paris

PS5/03

### **Factor associated with late HIV diagnosis in Georgia**

Nikoloz Chkhartishvili<sup>1</sup>, N Rukhadze<sup>1</sup>, L Sharavdze<sup>1,2</sup>, P Gabunia<sup>1</sup>, A Gamkrelidze<sup>3</sup>, T Tsertsvadze<sup>1,2</sup>

<sup>1</sup>Infectious Diseases, AIDS and Clinical Immunology Research Center, Tbilisi, Georgia

<sup>2</sup>Tbilisi State University Faculty of Medicine, Georgia

<sup>3</sup>WHO Country Office in Georgia

PS5/04

### **HIV testing among Tuberculosis patients in Denmark increased through the period from 2007 to 2009**

M Perch<sup>1</sup>, PH Andersen<sup>2</sup>, Axel Kok-Jensen<sup>2</sup>

<sup>1</sup>Rigshospitalet, Department of Cardiology, Section for Lung transplantation, Copenhagen, Denmark

<sup>2</sup>Statens Serum Institut, Department of Epidemiology, Copenhagen, Denmark

PS5/05

### **Diagnosing HIV infection in patients presenting with Glandular-fever-like illness in Primary care: are we missing primary HIV Infection?**

Murad Ruf<sup>1</sup>, D Hsu<sup>1</sup>, S O'Shea<sup>2</sup>, S Costello<sup>3</sup>, J Peck<sup>1</sup>, W Tong<sup>3</sup>

<sup>1</sup>NHS Lambeth, Department of Public Health, London, UK

<sup>2</sup>St. Thomas' Hospital, GSTS Pathology, London, UK

<sup>3</sup>St. Thomas' Hospital, Department of Infectious Diseases, London, UK

PS5/06

### **Profile and determinants of having never been tested for HIV amongst men who have sex with men in Spain**

Percy Fernández Dávila<sup>1,2</sup>, C Folch<sup>1,3,4</sup>, L Ferrer<sup>1,3</sup>, R Soriano<sup>5</sup>, M Díez<sup>5</sup>, J Casabona<sup>1,3,4</sup>

<sup>1</sup>Centre d' Estudis Epidemiològics sobre les ITS i SIDA de Catalunya

<sup>2</sup>Stop Sida

<sup>3</sup>CIBERESP

<sup>4</sup>Universitat Autònoma de Barcelona

<sup>5</sup>Secretaría del Plan Nacional sobre el SIDA

## **Parallel session 6 posters: New HIV Testing Diagnostic Technologies**

PS6/01

### **Automated laboratory-based oral fluid HIV testing in HIV screening programs – automatic for the people?**

Michael Rayment<sup>1</sup>, E Doku<sup>2</sup>, A Thornton<sup>3</sup>, A Nardone<sup>3</sup>, M Sudhanva<sup>4</sup>, P Roberts<sup>1</sup>, M Tenant-Flowers<sup>4</sup>, J Anderson<sup>5</sup>, A Sullivan<sup>1</sup>, M Atkins<sup>6</sup>

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<sup>2</sup>Imperial College Healthcare NHS Trust, London, UK

<sup>3</sup>Health Protection Agency, London, UK

<sup>4</sup>Kings College Hospital NHS Foundation Trust, London, UK

<sup>5</sup>Homerton University Hospital NHS Foundation Trust, London, UK

<sup>6</sup>Imperial College London, UK

PS6/02

### **Acceptability of rapid HIV diagnosis technology among primary health care practitioners in Spain**

Cristina Agustí<sup>1,2</sup>, L Fernández<sup>1,2</sup>, J Mascort<sup>3,4</sup>, R Carrillo<sup>3</sup>, C Aguado<sup>4</sup>, A Montoliu<sup>1,2</sup>, X Puigdangolas<sup>3</sup>, M De la Poza<sup>3</sup>, B Rifà<sup>5</sup>, J Casabona<sup>1,2</sup>

<sup>1</sup>Centre for Epidemiological Studies on HIV/STI in Catalonia - CEEISCAT - ICO, Badalona, Spain

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<sup>3</sup>CAMFiC, Barcelona, Spain

<sup>4</sup>semFYC - Sociedad Española de Medicina Familiar y Comunitaria, Barcelona, Spain

<sup>5</sup>Departament de Salut Generalitat de Catalunya, Spain

PS6/03

### **Feasability and acceptability of HIV screening through the use of rapid tests by GPs in a Brussels area with an important African community**

Anne-Francoise Gennotte<sup>1</sup>, P Semaille<sup>1,2</sup>, C Ellis<sup>2</sup>, C Necsoi<sup>1</sup>, M Abdulatif<sup>3</sup>, N Rungen-Chellum<sup>3</sup>, C Evaldre<sup>3</sup>, D Gidiuta<sup>4</sup>, F Laporte<sup>3</sup>, M Mernier<sup>3</sup>, S Sschellens<sup>3</sup>, N Clumeck<sup>1</sup>

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<sup>2</sup>Department of General Medicine, Universite Libre de Bruxelles, Belgium

<sup>3</sup>Centre Free Clinic, Brussels, Belgium

<sup>4</sup>Centre Africain de Promotion de la Santé, C Brussels, Belgium

PS6/04

### **Stigma and discrimination on voluntary consultation and testing**

Liudmila Untura<sup>1</sup>, J Hows<sup>2</sup>, I Chilcevschii<sup>3</sup>

<sup>1</sup>A.O. Credinta, Childhood for All, Moldova

<sup>2</sup>GNP+, The Netherlands

<sup>3</sup>League of People Living with HIV, Moldova

PS6/05

### **How to estimate the size of the hidden HIV epidemic? The case of France**

Virginie Supervie<sup>1,2</sup>, J Ndawinz<sup>1,2</sup>, D Costagliola<sup>1,2,3</sup>

<sup>1</sup>INSERM U943 Paris, France

<sup>2</sup>UPMC Univ-Paris 6, UMR S943, Paris, F75013, France

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# Side Events

## European Commission – Health Programme HIV/AIDS Projects Kong Arthur Hotel, Nørre Søgade 11, Sunday 18 March 15.00-17.00



EXECUTIVE AGENCY FOR HEALTH AND CONSUMERS

Health Unit

HIV in Europe Conference 2012 Conference, Copenhagen  
19-20 March 2012  
Health Programme HIV/AIDS projects  
Kong Arthur Hotel  
Pre meeting agenda for the 18 March 2012

### Priority groups:

**15.00 - 17.00** Special session on HIV/AIDS projects funded under EU programme 2008-2013 - 15 minutes presentations, Chair Cinthia Menel LEMOS EAHC

- (1) HIV-COBATEST project update on the Cross-national survey on the implementation of CBVCT programmes (WP4) and future developments by Jordi Casabona and Cristina Agusti, CEEISCAT
- (2) Scaling-up access to high-quality harm reduction, treatment and care for injecting drug users in the European region, Martin Donoghoe and Tim Rhodes, WHO EURO and LSHTM
  - (a) Access to hepatitis C treatment for people who inject drugs: A case study of successes and challenges in drug and alcohol settings. Magdalena Harris, Tim Rhodes, Anthea Martin, WHO EURO and LSHTM
  - (b) Accessing integrated TB, HIV and harm reduction services: A Rapid Assessment Among People Who Use Drugs in Portugal, Pippa Grenfell, Ana Cláudia Carvalho, Ana Martins, Dina Cosme, Henrique Barros, Tim Rhodes, WHO EURO and LSHTM
- (3) Capacity building in HIV/Syphilis prevalence estimation using non-invasive methods among MSM in Southern and Eastern Europe, SIALON project results and new action SIALON II, Massimo Mirandola, Veneto Region
- (4) HIV/TB testing among vulnerable populations, TUBIDU project - Aljona Kurbatova, National Institute for Health Development (NIHD), Estonia
- (5) Correlation HIV policy recommendations presented by Koen Block, EATG
- (6) Bordernet work target prevention among sex workers, Tzvetina Arsova Netzelmann and Elfriede Steffan,

**16:30 - 17:00 Discussion on how this initiatives contribute to the HIV/AIDS Communication 2009-2013 action plan on the intensification of the implementation of voluntary counselling and testing programs (VCT) among most at risk groups and the measurement of the indicators related to uptake of testing, gaps and priorities for the future.**

### Discussion session

- (1) Contribution of the Health Programme projects for the action aiming to intensify implementation of voluntary counselling and testing programs (VCT) among most at risk groups and the measurement of the following indicators:
  - Incidence of new HIV infections among most at risk groups
  - Rate of late diagnoses
  - HIV testing rates
  - Rate of unknown HIV status
  - Decrease of late diagnoses, timely start of treatment
  - Reduction in HIV transmission among most at risk groups
  -
- (2) Common planning of events, exchange of expertise, and other activities

# HIVeurope Satellite meeting

## HIV in Europe conference in Copenhagen

Sunday March 18<sup>th</sup> 17.00 - 18.45

Kong Arthur Hotel, Nørre Søgade 11, 1370 Copenhagen

The role of HIV workplace policies and programmes in addressing  
'barriers' to early HIV counselling, testing, treatment and care

*Do HIV and AIDS workplace policies counter Stigma and Isolation in the Workplace  
to ensure a trusting environment that improves access to testing, care and treatment.*



### Programme

- |             |   |
|-------------|---|
| 17.00-17.10 | Welcome to HIV in Workplace satellite meeting   |
| 17.10-17.30 | How does Protection of rights at work help in enhancing access to HIV services: - The ILO Recommendation on HIV and AIDS (no.200) and experiences in its implementation with a focus on Europe & the private sector |
| 17.30-17.50 | Workplace HIV/AIDS policies<br>Useful tools to combat Stigma and Discrimination in the Workplace?   |
| 17.50-18.10 | The People Living with HIV Stigma Index ; workplace findings from Europe  |
| 18.10-18.45 | Panel discussion  |
| 18.45       | Meeting closes  |

### Speakers

- |  |
|--|
| Henrik Arildsen, Chairman, HIVeurope   |
| Alice Ouedraogo, Director ILO/AIDS or<br>Afsar Syed Mohammad, Senior Technical Specialist ILO/AIDS (TBC)   |
| Nenad Petkovic, Chairman Q-Club<br>Belgarde, Serbia  |
| Elena Grigoryeva, Belarusian PLHIV<br>Community, Chairperson AIDS ACTION<br>EUROPE and co-speaker Vitaly Tkachuk, All-Ukrainian network of PLHIV |

Please indicate your interest [here](http://goo.gl/lq1qN)

<http://goo.gl/lq1qN>







# Teen Testing: Can Europe do better?

## Round Table discussion

Organized by UNICEF, WHO and UNAIDS with support from EU

On Tuesday, 20 March 2012

From 15:30 – 17:00 hours

Meeting Room: Store Mødesal at the Conference Venue (the Panum Institute)

**Risky behaviours that drive the HIV epidemic tend to start in adolescence.** Recent UNICEF studies show that in Eastern Europe the age of onset of risky behaviours is decreasing. The average age of start-up of drug injecting is estimated to be 17 in Moldova, and 16-17 in Romania. In Ukraine, adolescent girls comprise an estimated 20% of the female sex worker population, and over 30% reported starting to sell sex between the ages of 12 and 15. HIV prevalence among at-risk adolescents is high, particularly among those living and/or working on the streets.

Despite this alarming situation, data show that at-risk **adolescents systematically have poorer access** to HIV prevention and care, including to HIV testing and counselling, than their adult counterparts.

**Most adolescents at risk in the Region do not know their HIV status.** A number of barriers hinder the provision and uptake of testing and counselling by teenagers, including:

- legal obstacles such as parental consent requirements for minors to access HIV testing;
- lack of clear guidance and ethical dilemmas on appropriate services for at-risk adolescents
- inadequate provider skills to address adolescents in need
- mistrust of services by adolescents themselves, especially among those most vulnerable.

## What is your experience telling you about HIV testing for teenagers?

**This session will provide an open forum to exchange experiences and discuss how to tailor youth-friendly and age appropriate testing and counselling services for adolescents at risk of HIV and how to use them as an entry point for referring adolescents to related prevention, care, treatment, support and protection services.** The discussion will help inform the development of the WHO guidelines on HIV testing and counselling for adolescents.

**All interested colleagues are welcome!**

*Note: It is estimated that most adolescents at risk in the region do not know their HIV status. In Ukraine, almost 80% of IDU boys and girls could identify an HIV testing site but only 14% of them had taken an HIV test in the past 12 months and knew their results. Only 24% of adolescent MSM reported having been tested for HIV and knew their results. While over 50% of street children surveyed in Ukraine said they could identify testing sites, just 12% said they had tested for HIV and knew their results.*



Supported  
by EU Grant number  
DCI-SANTE/2011/260-351

# Scholarship grants for the HIV in Europe Copenhagen 2012 Conference

| EU FUNDING    |               |   |                        |
|---------------|---------------|---|------------------------|
| Name          | Organisation  |   | Country                |
| Lilit         | Aleksanyan    | "Real World, Real People" NGO, Yerevan, Armenia   | Armenia                |
| Irena         | Andrijevska   | Association of HIV affected women and their families  | Lithuania              |
| Vardan        | Arzakanyan    | Epidemiological Surveillance Department, National Center for AIDS Prevention                              | Armenia                |
| Veronica      | Baractari     | "League of people living with HIV"  | Moldova                |
| Lile          | Batselashvili | Addiction Research Center, Alternative Georgia  | Georgia                |
| Andrii        | Chernyshev    | Gay-alliance' NGO   | Ukraine                |
| Ivdiy         | Chikovani     | Curatio International Foundation  | Georgia                |
| Alexandr      | Curasov       | State Agrarian University of Moldova  | Moldova                |
| Ruzanna       | Davtyan       | 'Education in the Name of Health' SO  | Armenia                |
| Predrag       | Duric         | Institute of Public Health of Vojvodina   | Serbia                 |
| Ketevan       | Gogvadze      | Biological Threat Reduction Program, Republic of Georgia, Curatio International Foundation                | Georgia                |
| Elena         | Grigoryeva    | National NGO "Belarusian PLWH Community",   | Belarus                |
| Nino          | Gulua         | Georgia Health and Social Projects Implementation Centre  | Georgia                |
| Tatyana       | Khan          | ICO 'East Europe and Central Asia Union of PLWH'  | Ukraine                |
| Tetiana       | Kiriazova     | Future Without AIDS Foundation  | Ukraine                |
| Raul          | Lindemann     | Estonian Network of People Living with HIV  | Estonia                |
| Tetyana       | Loginova      | Kiev Narcological Hospital "Sociotherapy, Department for HIV-infected patients                            | Ukraine                |
| Hovhannes     | Madoyan       | The Advocacy group on AIDS  | Armenia                |
| Oksana        | Matiyash      | International HIV/AIDS Alliance in Ukraine  | Ukraine                |
| Antons        | Mozalevskis   | NGO Association of LGBT and their Friends MOZAIKA   | Latvia                 |
| Aliaksandr    | Paluyan       | Gay Alliance Belarus, National HIV/AIDS web-site AIDS.BY  | Belarus                |
| Oleksandr     | Postnov       | I.I. Mechnikov Ukrainian State Anti-Plague Research Institute, Laboratory of Slow infections and HIV/AIDS | Ukraine                |
| Oleksii       | Smirnov       | International HIV/AIDS Alliance in Ukraine  | Ukraine                |
| Miran         | Solinc        | DRUŠTVO ŠKUC  | Slovenia               |
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| Daniela       | Svarc Maric   | Clinical Center Novi Sad, Clinic for Infectious Diseases  | Serbia                 |
| Diana         | Tashkova      | Medical University of Sofia   | Bulgaria               |
| Aleksandre    | Tsereteli     | LGBT Georgia  | Georgia                |
| Liudmila      | Untura        | NGO "Childhood for All"   | Moldova                |
| Marta         | Vasylyev      | Charitable Salus Foundation; Lviv Regional AIDS Center  | Ukraine                |
| OTHER FUNDING |               |   |                        |
| Name          | Organisation  |   | Country                |
| Takhmina      | Alimamedova   | World Health Organization Country office in Tajikistan  | Tajikistan             |
| Viktoriya     | Ashirova      | NGO "Hope and Life",  | Uzbekistan             |
| Yelena        | Bilokon       | Kazakhstan Network of Women HIV   | Kazakhstan             |
| Polina        | Girchenko     | Humanitarian Action', Fund for Medical and Social Programs  | Russia                 |
| Elena         | Kouzovatova   | Privolzhsky Okrug Center for AIDS Prevention and Control  | Russia                 |
| Rumena        | Krastovska    | HERA – Association for health education and research  | Macedonia              |
| Srdjan        | Kukolj        | Action Against AIDS (AAA)   | Bosnia and Herzegovina |
| Ekaterina     | Musatova      | St. Petersburg State University medical faculty, Obstetrics, Gynecology and Reproductology department     | Russia                 |
| Sergey        | Smirnov       | Community of PLHIV, Positivenet   | Russia                 |
| Suzana        | Vasileva      | Ministry of Finance AND Health Education and Research Association   | Macedonia              |

## Social Events

### 3 Welcome reception

The welcome reception will take place at the **restaurant La Rocca** on **Sunday 18 March from 7 pm to 9 pm.**

La Rocca  
Vendersgade 23-25  
1370 Copenhagen  
Tel.: +45 33 14 66 55

### 2 Conference Dinner

A conference dinner will be held at **Moltkes Palæ** on **Monday 19 March from 8.00 pm.**

Moltkes Palæ  
Dronningens Tværgade 2  
1302 Copenhagen K  
Tel.: +45 33 14 80 66



## Transportation and Directions

Copenhagen has an extensive and reliable network of public transportation. It includes buses, trains, S-trains and metro, all of which use a common ticket with free transfer from one type of transportation to another.

### Airport - Hotel Kong Arthur and Ibsens Hotel

The Metro line M2 runs every 4 minutes between the airport and Nørreport Station and takes about 15 minutes.

Trains run every 10 minutes between the airport and the Nørreport Station and takes about 15 minutes.

Nørreport Station is located within walking distance to both hotels. The train or Metro fare is approximately DKK 36.

A typical taxi fare between the airport and the City Centre is approximately DKK 200-250.

### Airport – Cab Inn City

Trains run every 10 minutes between the airport and the Central Railway Station

(Hovedbanegården) and takes about 15 minutes. The Central Railway Station is located within walking distance to the hotel.

### **Hotel Kong Arthur and Ibsens hotel – Panum Institute (Conference Venue)**

You can either walk to the Panum Institute (20 minutes) or walk to Nørreport Station and take one of the busses: Bus 6A (direction Emdrup), Bus 184 (direction Holte), bus 185 (direction Klampenborg), bus 42 or 43 (direction Bagsværd, Værebroparken) or Bus 150 S (direction Kokkedal).

A typical taxi fare between the City Centre and the Panum Institute is approximately DKK 80-100.

### **Cab Inn City - Panum Institute (Conference Venue)**

Take Bus 5A (direction Husum Torv), the bus ride will take approximately 15 minutes.

### **Hotel Kong Arthur and Ibsens hotel – Moltkes Palæ (Conference Dinner)**

You can either walk to Moltkes Palæ (25 minutes) or take the Metro line M1 (direction Vestamager) or M2 (direction Lufthavnen) one stop to Kongens Nytorv.

### **Cab Inn City - Moltkes Palæ (Conference Dinner)**

Take bus 1A (direction Hellerup) or 15 (direction Østerbro, Ryparken).



### **Conference busses**

Transportation to and from the Conference venue (drop off and pick up at main entrance, Blegdamsvej) and the hotels, as well as to and from the hotels and the conference dinner will be available following this timetable:

| Date     | Departure time | From                             | To                |
|----------|----------------|----------------------------------|-------------------|
| 19 March | 08.00          | Kong Arthur Hotel (Ibsens hotel) | Conference venue  |
| 19 March | 08.00          | Cab Inn City                     | Conference venue  |
| 19 March | 18.00          | Conference venue                 | Kong Arthur Hotel |
| 19 March | 18.00          | Conference venue                 | Cab Inn City      |
| 19 March | 19.40          | Kong Arthur Hotel (Ibsens hotel) | Moltkes Palæ      |
| 19 March | 19.40          | Cab Inn City                     | Moltkes Palæ      |
| 19 March | 23.30          | Moltkes Palæ                     | Kong Arthur Hotel |
| 19 March | 23.30          | Moltkes Palæ                     | Cab Inn City      |
| 20 March | 08.00          | Kong Arthur Hotel (Ibsens hotel) | Conference venue  |
| 20 March | 08.00          | Cab Inn City                     | Conference venue  |

# Map of Copenhagen



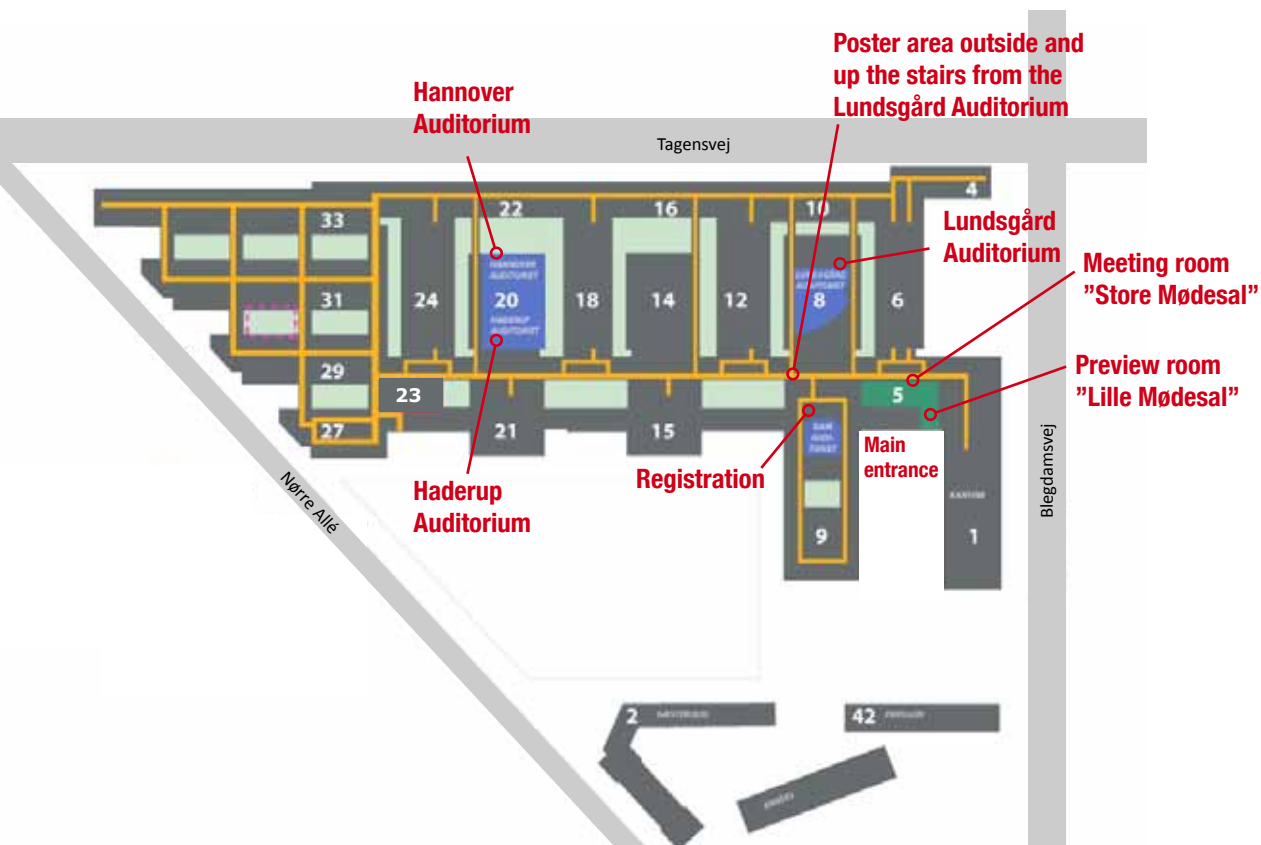
- |  |                            |
|--|----------------------------|
| <b>1</b> Conference Venue                | <b>A</b> Hotel Kong Arthur |
| <b>2</b> Moltkes Palæ, Conference Dinner | <b>B</b> Cab Inn           |
| <b>3</b> La Rocca, Welcome Reception     | <b>C</b> Ibsens Hotel      |



# Conference venue

**Panum Institute**  
**University of Copenhagen, Faculty of Health Sciences**  
**Blegdamsvej 3 B**  
**DK-2200 Copenhagen N, Denmark**

The Panum Institute at the University of Copenhagen houses the Faculty of Health Sciences, which includes the Dental and Medical schools. The Panum Institute is named after professor of physiology P.L. Panum (1820-1885) who, while still a medical student, worked on the cholera epidemics that culminated in 1853. P.L. Panum is also famous for his research into measles in connection with an epidemic of that disease in the Faroe Islands. The building was designed by a number of well-known Danish architects: Eva Koppel, Nils Koppel, Gert Edstrand and Erik Thyrring.



# Notes



Lined area for notes, consisting of multiple horizontal lines.



## Notes

# Notes







## **HIV in Europe**

Working Together for Optimal  
Testing and Earlier Care

**Copenhagen 2012 Conference**

### **Abstract book**



# **HIV in Europe**

## **Copenhagen 2012 Conference**

18 - 20 March 2012  
University of Copenhagen



[www.hivineurope.eu](http://www.hivineurope.eu)

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# Plenary Sessions

## Access to earlier testing and care

### **Martin Donoghoe, WHO Europe: Key issues for HIV testing in Europe**

HIV epidemic in Eastern Europe and Central Asia (EECA) the fastest growing in the world. Although globally the number of newly infected people is decreasing, in EECA it increased by 250% in the past decade. While diagnosed cases and AIDS mortality declined in WE, in EECA mortality from AIDS-related causes increased more than 10-fold between 2001 and 2010. Access to ART in many EECA is among the poorest in the world and coverage among the lowest. Only 23% of adults in need were receiving ART in 2010 (well below the global coverage of 47% for low/middle income countries and less than half that in sub Saharan Africa). Although accounting for the majority of PLHIV in EECA, IDU accounted for less than 25% of those receiving ART. Vulnerability and marginalization: HIV in EECA disproportionately affects IDU and their sexual partners; MSM; transgender people; SW, prisoners and migrants. In some EECA over 60% of new infections in 2009 were among IDU. The association between sex work and injecting drug use is accelerating HIV epidemic as is the incarceration. Low rates of testing – particularly in key populations: An estimated 26% of PLHIV are unaware of HIV status and up to 60% in some EECA are unaware of having been infected owing to their limited access to and low uptake of HTC. HTC quality requires further improvement. WHO HTC policy framework, other relevant documents including recently endorsed European Action Plan for HIV AIDS 2012-2015 guides Member States in their HTC scale up efforts.

### **Roland Simon, EMCDDA: Challenges in earlier HIV testing and linkage to care among people who inject drugs**

In the EU, the number of newly diagnosed HIV infections among injecting drug users (IDUs) has continuously been falling over the last decade. However, HIV continues to be a major public health concern in Europe. Timely detection of infections allows clients to seek healthcare to treat the infection, prevent complications, and reduce risks of further transmitting the disease. This presentation is using data from the EMCDDA key indicators and other sources to look into testing practice. The EMCDDA has issued guidelines on testing (EMCDDA 2010), as well as on prevention and control of infections (ECDC and EMCDDA, 2011) recommending annual testing for high risk drug users. Some findings indicate that this has not yet been reached in all countries. A recent expert survey in EU Member States suggested voluntary counselling and testing and provider-driven testing as mayor approaches. In order to increase the rate of early testing main options are increased accessibility and approaches to motivate the risk population to undergo test. Linked pre and post test counselling and treatment are discussed including related ethical considerations.

#### References:

EMCDDA (2010). Guidelines for testing HIV, viral hepatitis and other infections in injecting drug users. Luxembourg: The Publication Office of the European Union. ECDC and EMCDDA (2011). Prevention and control of infectious diseases among people who inject drugs. Stockholm: ECDC.



## **Valerie Delpech, Health Protection Agency: HIV testing guidelines in Europe and linkage to care: need for implementation - Western Europe perspective**

The individual and public health benefits of testing for and treatment HIV infection are well understood. Nevertheless despite widely availability ART for over a decade in Europe, deaths due to AIDS continue. The majority are persons who present late with advanced disease. It has been estimated that 30% of people infected with HIV in Europe are undiagnosed. Several countries, ECDC and WHO have produced testing guidelines. Successful implementation rely on adopting key core principles including: ensuring testing is voluntary, confidential and undertaken with informed consent (which can be verbal) and access to treatment, care and prevention services. Every effort should be made to reduce stigma and address the legal, structural and social barriers that discriminate and create vulnerable communities. There is good evidence that universal routine offer of an HIV test is both acceptable to patients and staff in a variety of settings (including STI clinics, antenatal care and harm reduction services). Monitoring and evaluation of programmes is critical to their success. Robust local and national surveillance systems – including the tracking of HIV previously undiagnosed prevalence in key groups, trends in testing uptakes and linkage into care - are the backbone.

## **Nino Tsereteli, Eurasian Harm Reduction Network (EHRN) and Eurasian Coalition on Male Health (ECOM): HIV testing and counselling in EECA: entry point for curbing the HIV Epidemic**

HTC is essential to increase access to and uptake of essential HIV services. There is evidence of a decreasing trend in HTC among key populations at greatest risk, hard-to-reach and inadequately served - 45% of IDU, 38% of MSM, 48% of SW coverage in 2009 in EECA. The increase in tests performed in health care settings in EECA does not result in improved access of key populations to HTC and other HIV services. 20-25 million tests are conducted in Russia each year. The number of HIV tests performed among IDUs was 277000 in 2009 despite the fact that 61% of HIV cases registered in 2009 were due to unsafe injection practices. Stigma, discrimination, human rights violations, repressive legislation against the key populations are barriers to HIV-prevention, treatment, care and support. Some countries criminalize homosexuality and in many countries the police abuse of sex workers and drug users. In the context of rampant police abuse, mandatory testing is used to extort or punish key populations. Migrants avoid HIV-testing out of fear of being deported. Governments must repeal laws that discriminate against key populations, eliminate mandatory testing and ensure their access to voluntary and confidential HIV-services and treatment. HTC must account for specific needs of hard-to-reach populations. HTC must expand beyond clinical settings and be community-based among hidden populations. Rapid testing must be universally available in community based and outreach programs. Individuals must be linked directly to prevention, treatment and care services at the time of testing.

## **Late presenters and the undiagnosed**

### **Joanne Reekie, UCL, on behalf of the late presenters working group of the Collaboration of Observational HIV Epidemiological Research in Europe (COHERE) in EuroCoord: Characteristics of the epidemiology and temporal trends of late presenters in Europe**

Background: This analysis aims to investigate temporal trends in the percentage of individuals who are presenting late for care and identify factors associated with late presentation.

Methods: Individuals enrolled in the Collaboration of Observational HIV Epidemiological Research Europe (COHERE), who presented for care for the first time after 1st January 2000 were included. Late presentation was defined, as a person presenting for care with a CD4 count <350 cells/μL or an AIDS defining event and presentation with advanced disease a person presenting for care with a CD4 count <200 cells/μL or an AIDS defining event.

Results: Of the 90,786 individuals presenting for care with a CD4 count available, 47,384 (52.2%) were classified as late presenters, of those 28,869 (60.9%) presented with advanced disease. The

table gives the characteristics of individuals presenting for care in 2000, 2005 and 2009. The odds of being a late presenter decreased over time (odds ratio [OR] 0.97 per year, 95% confidence-interval [CI] 0.97-0.98,  $p<.0001$ ). Individuals who were older (OR 1.35 per 10 years, 95% CI 1.37-1.41,  $p<0.0001$ ), whose mode of transmission was not MSM, and those originating from Africa (OR 1.67, 95% CI 1.59-1.75,  $p<.0001$ ), or other regions (OR 1.40, 95% CI 1.33-1.48,  $p<.0.0001$ ) compared to Europe, were more likely to present late.

Conclusions: Preliminary results indicate that around one half of HIV-1 positive individuals across Europe are presenting late for care. Individuals who are older, from regions other than Europe and where the transmission route is not MSM are more likely to present late. These populations need to be specifically targeted to reduce the number of individuals presenting late for care.

### **Ard van Sighem, Stichting HIV Monitoring: Estimating HIV prevalence in European countries**

Accurate estimates of the number of HIV-infected people in European countries are necessary for understanding the true burden of HIV, for estimating the corresponding need for treatment, and for intensifying testing for HIV. Two classes of methods have been used to estimate the number living with HIV, including methods based on prevalence surveys and estimates of the size of groups most at risk for HIV, and methods based on reported numbers of HIV and AIDS cases. Many countries in Europe, however, have no or only limited prevalence data, thus hampering the use of the first class of methods. Case report data, on the other hand, are often available, but methods using these data may involve complex mathematical models and are therefore not easy to use. In this presentation, first results will be shown of a project by the European Centre for Disease Prevention and Control on improving methods to estimate HIV prevalence in European countries. After a comprehensive review of existing methods, it was decided to further pursue two methods based on case report data. One method aims to reconstruct the HIV incidence curve using historical data on HIV and AIDS cases. The other method uses the relationship between CD4 counts and AIDS to estimate the total infected population, which is especially useful for countries with limited historical data. The methods are applied to a set of pilot countries in Europe representing a variety of different epidemiological situations and different levels of data availability.

### **Olivia Wu, University of Glasgow: An assessment of the approaches to evaluating cost-effectiveness of HIV screening strategies**

The European Centre for Disease Prevention and Control (ECDC) is currently working to improving the surveillance of viral infections including human immunodeficiency virus (HIV). This European wide initiative seeks to produce regionally relevant surveillance information to inform future prevention, control and intervention policies. In order to guide the development of such policies, it is not only important to study the clinical pathway and epidemiology of these infections, but also necessary to evaluate the potential health and economic impact of all available prevention and intervention strategies that may be adopted. A programme of work is currently underway to systematically review and evaluate the existing methods for cost-effectiveness analysis for HIV screening, and to propose the model(s) and tools that are the most relevant to be used at an EU-wide level to assess the impact of screening interventions. The preliminary findings of the first phase of this programme of work (systematic review of existing evidence) showed that existing evidence on the cost-effectiveness of HIV screening has been focused on: (1) evaluations of universal screening of unselected population and (2) of screening of women during pregnancy; these screening strategies were compared with no screening or screening of particular high-risk patient groups. Despite some heterogeneity in the economic modelling approaches and outcomes adopted in these evaluations, this systematic review has identified fundamental model structures, health states and parameter inputs that are of high importance and should be taken into consideration in designing future economic evaluations of HIV screening strategies.



## Keith Radcliffe, IUSTI on behalf of the Indicator Condition-Guided HIV Testing Panel: Guidance on Indicator Condition-Guided HIV Testing: Presentation of draft guidance document

The benefits of early diagnosis of HIV infection are well established. It results in reduced mortality and morbidity for the individual as a result of commencing antiretroviral therapy (ART). It is also likely to benefit the public health as a result of onward transmission being reduced by ART and by the adoption of safer sexual behaviour by the infected individual. Despite the recognition of the benefits of early diagnosis many HIV-infected persons in Europe continue to be diagnosed late (CD4 lymphocyte count below 350 cells/mm<sup>3</sup>) or very late (CD4 below 200). Reasons for this include barriers to patients requesting, and to healthcare workers offering, a test for HIV. Testing can be increased by identifying clinical situations where the offer of an HIV test is indicated and should be routinely offered irrespective of the individual's demography and without the need to ask about personal behaviour. This is termed 'indicator condition guided HIV testing' and *HIV in Europe* has produced guidance as to when this should be done.

There are 3 sets of conditions each with its own rationale for offering HIV testing:

1. In people diagnosed with AIDS-defining conditions (e.g. *Pneumocystis jiroveci* pneumonia) as correct clinical care involves the prompt initiation of ART;
2. Conditions which raise the pre-test probability of being HIV-infected to a level (i.e. greater than 1 in 1,000) where testing for HIV will be cost-effective (e.g. herpes zoster);
3. Situations where failure to diagnose HIV will have potentially catastrophic consequences for the individual or others (e.g. patients in whom potent immunosuppressive therapy is indicated).

Implementation of this guidance will help to reduce the late presentation of HIV disease but its adoption by professionals across Europe will require support through ongoing education and by its being embedded in clinical guidelines and healthcare policy.

## Discussing testing strategies

### Bernard Branson, Centers for Disease Control and Prevention: Diagnostics/testing/regulations/incidence: US perspective

Technologies for HIV testing have proceeded along two paths: one for screening donors of blood and blood products, and the second for establishing the diagnosis of HIV infection, monitoring progress of HIV disease, and evaluating response to therapy. Both applications encompass serologic and molecular techniques. In the U.S., adoption of more sensitive technologies for diagnostic testing has proceeded slowly, in part due to regulatory requirements of the FDA. Point of care testing with rapid HIV tests, which now play a large role in diagnostic testing, was dependent on additional regulatory requirements CLIA waiver, which engendered considerable controversy. Acute HIV infection – the initial phase when infectious RNA is present before antibodies develop – accounts for a substantial proportion of onward transmission. Efforts to improve HIV diagnostics have narrowed the “window period” between infection with HIV and the detection of laboratory markers from 56 days (with early viral lysate assays) to 15 days (with Ag/Ab combination assays) or 10 days (with RNA assays). The costs and logistics of screening with RNA have heretofore limited acute infection screening to specific populations and programs, but the advent of combination Ag/Ab immunoassays presents new opportunities. However, screening with these more sensitive assays demands new supplemental testing strategies poised for implementation in the U.S. Finally, several promising opportunities now exist to reliably estimate HIV incidence by differentiating a specified interval of early infection from the majority of prevalent cases with longstanding HIV infection.



### **Andrew Phillips, UCL: A model of the MSM epidemic in the UK: implications for understanding the impact of condom use and ART in influencing incidence**

Numbers of new diagnoses in MSM have been increasing in several countries, including the UK, which is leading to renewed focus on prevention policy and a number of issues arise. (i) HIV prevention approaches until now have been based largely on promotion of appropriate condom use and it has been suggested that continued rises in new diagnoses of HIV indicates that such approaches have failed. In considering new policies it is important that we have a correct analysis of the impact of the existing approach of condom promotion. (ii) Increases in rates of HIV testing are likely to lead to reductions in condom-less anal sex in people with HIV as there is evidence that diagnosis of HIV infection leads to some reductions in condom-less sex, which indicates that increased testing – even amongst those with CD4 counts are such that ART is not yet indicated - will lead to reductions in HIV incidence. However, it remains unclear in what proportion of men reductions of given magnitudes and duration occur and some studies do not provide encouragement that there are large and sustained reductions in condomless sex in most diagnosed men. This is an important area of uncertainty in understanding the magnitude of the impact of increased HIV testing on HIV incidence. (iii) Linked to this, there is interest in considering initiating ART in all people with HIV in order to limit incidence of new infections, but numbers of new infections have not decreased as ART coverage and success have increased over the past 15 years, which has led some to question how great could be the benefit of further expansion of ART use. This talk will describe the development and use of a stochastic computer simulation transmission model to reconstruct the extensively documented MSM epidemic in the UK in order to try to understand these issues further.

### **Jekaterina Voinova, Estonian Network of PLWHIV and GNP+: People living with HIV Stigma Index: Findings from Estonia**

Objectives: To gather evidence of PLHIV related stigma and discrimination in Estonia as stigma is widely recognized as a barrier to accessing HIV prevention, treatment, care and support. Research concentrated on the perceptions, experiences, and opinions of PLHIV. Methods: The PLHIV Stigma Index, an existing survey instrument, was amended to include additional questions about barriers to uptake of HIV testing and treatment was used to conduct the study. Interviews undertaken using a participatory research process, including 'side by side' interviewing. Interviews conducted between Dec 2010 - Jan 2011 in 4 different regions and 2 prisons. 300 PLHIV participated in the study. Results: results show stigma and discrimination are prevalent toward PLHIV in Estonia. This included respondents reporting experiencing psychological and physical violence (23%) due, in part to their HIV status, breaches of confidentiality, fears surrounding possible breaches. Internalized stigma also reported resulting in wishing to give up living, studying, career opportunities, sexual intimacy, and/or not accessing necessary medical help, making choices not to have a full family life including having children. Conclusions: From being diagnosed PLHIV need psychosocial support. Medical workers need training to ensure confidentiality/ being unprejudiced towards PLHIV. The data and the process used are being utilized by Estonian PLHIV for advocacy, empowerment, and training. Initial results of this step will be available at the conference.

## **Michele Breveglieri and the COBATEST group: The COBATEST Project: Survey on Community-Based Testing Services in Europe**

**Objective:** Overall objective of the study is to gain understanding of Community Based Voluntary Counselling and Testing (CBVCT) programmes and services in European countries through a survey to ascertain how CBVCT programmes are implemented. Study is part of COBATEST, a project co-funded by EU Commission under the Public Health Programme 2008-2013.

**Methods:** A study definition of CBVCT was proposed for the purpose of the survey. HIV national/regional focal points (NFP) and CBVCT services in 31 EU/EFTA countries were contacted. Preliminary results from 25 NFP in 22 countries and 39 CBVCT in 18 countries are presented. Descriptive analysis was performed.

**Results:** 19 NFP (76%) reported that a definition of CBVCT in their country doesn't exist, 14 of which agreed with the study definition, 2 didn't agree and 3 didn't know. 23 NFP responded that CBVCT are available in their country. 15 NFP (60%) reported governmental/regional regulation covering HIV testing in CBVCT, 12 (48%) a strategic plan for the implementation of CBVCT, 14 (58%) that HIV rapid test on blood is accepted and 5 (22%) that oral fluid rapid test is accepted in their country.

According to CBVCT experience, rapid tests on blood are performed in 13 on 18 countries (72%), while none used oral fluid rapid tests. COBATEST Project will address test issues in the coming WPs.

**Conclusions:** Lack of common definitions, strategies, regulations and procedures on CBVCT services emerged at European and often even at country level. Common good practices and strategies in the implementation of CBVCTs should be identified.

## **Panel discussion: HIV in Europe – the way forward**

### **Matteo Schwarz, NPS Italia Onlus: Impact and outcome of the European Parliament Resolution of 20 November 2008 - "HIV/AIDS: early diagnosis and early care" – at Member State level, with a focus on Italy as a case study**

Impact and outcome of the European Parliament Resolution of 20 November 2008 - "HIV/AIDS: early diagnosis and early care" – at Member State level, with a focus on Italy as a case study of the opportunity to use European political initiatives to drive improvements in HIV testing strategies and guidelines at MS level. Lessons learned in obtaining the adoption of a National Consensus Document on Testing, identifying its relevance for coordinated actions across the EU in response to the EP Resolution 2011- "EU Response to HIV/AIDS in the EU and neighbouring countries, mid-term review of Commission Communication COM(2009)569". Considerations including: 1) EU-national institutional dynamic, strategic approach given the public health system, critical factors enabling the swift approval of Agreement on the Consensus Document; 2) Recommendation for an active offer of testing with assessment of the understanding and attitudes towards this methodology, and identifying barriers and facilitators to testing; 3) Engagement with key players involved in promoting risk-reduction counselling and offering HIV testing in the prevention and control of HIV; 4) Available data on current practices on testing in key regions and how the impact of the Document will be measured; 5) Relevance of political and multi-stakeholder engagement for the implementation of the recommendations at Regional level; 6) Barriers (procedural, political and cultural) and key learnings on overcoming them. Conclusions will highlight issues which remain to be tackled and summarise the tools and tactics to disseminate best practice, and stimulating similar actions in the field of HIV in other Member States.



## **Ihor Perehinets, WHO Ukraine: HIV testing and counseling services in Ukraine: what else should be done?**

HIV testing and counselling (HTC) services in Ukraine are delivered through three domains: a network of regional AIDS Centers and their “satellites” – Trust Offices (HIV testing points), other state health care facilities and community based organizations. Trust Offices, of which there are over 761 around the country, remain the main public facilities to provide HTC services and ensure linkage to care. Despite increased number of tests performed (3.3 millions tests) and relatively high coverage in 2011, only 60 % of those tested positive are seen for treatment and care. In addition, close to 60% of all tests in 2011 were among pregnant women and blood donors. Most at risk populations remain under tested, especially through the public health care facilities. Issues of linkage to care, strengthening capacity of public health facilities and MARPs’ coverage increase remains a systemic issue. The paradigm of HTC services needs to be shifted from referral approach that often is far from optimal to efficient linkages to actual follow up services needed including antiretroviral therapy and care. WHO Country Office in Ukraine coordinate number of activates to strengthen HTC services from health systems point of view. Resent assessment of legal and financial functioning of HTC services in Zakarpattia Oblast and operational researches on linkage to care in Odessa oblast will inform the revision of the National HTC Protocol. The European Action Plan for HIV AIDS 2012-2015, endorsed by WHO Europe Members States in 2011, guides Ukraine in these efforts.

# Parallel Sessions

## Parallel Session 1: Lessons Learned in Novel HIV Testing Strategies and Programmes

### PS1/01 Routine HIV testing in the Emergency Department: tough lessons in sustainability

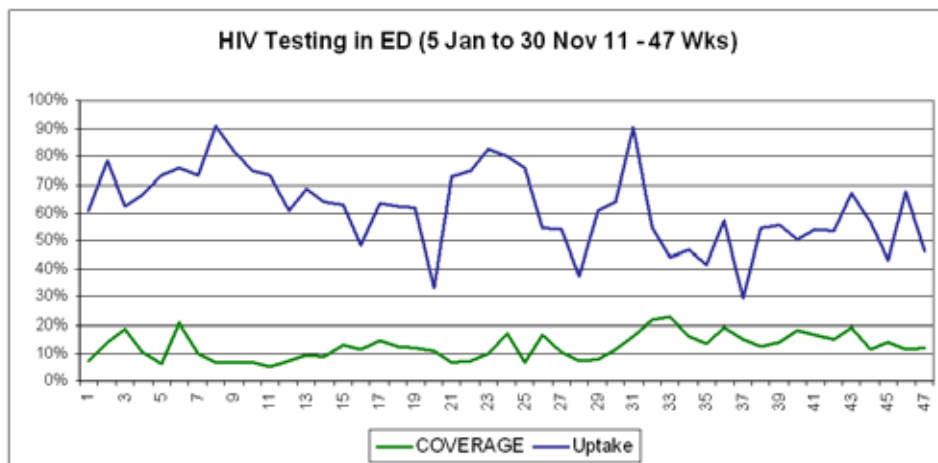
Michael Rayment<sup>1</sup>, C Rae<sup>1</sup>, S Finlay<sup>1</sup>, M Atkins<sup>2</sup>, P Roberts<sup>1</sup>, A Sullivan<sup>1</sup>

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Objectives: Routine HIV testing in non-specialist settings has been shown to be acceptable to patients and staff in pilot studies. How to embed and sustain HIV testing in routine care remains to be answered. Methods: We established a service of oral fluid-based HIV testing in an Emergency Department (ED) in London. Testing was delivered by ED doctors as part of routine clinical care. All patients aged 16 to 65 years were offered an HIV test. Meetings were held weekly and two outcome measures examined: test offer rate (coverage) and test uptake. Sustainability methodology (process mapping; Plan Do Study Act (PDSA) cycles) was applied to maximise these outcome measures. Results: Over eleven months, 17,125 age-eligible patients attended the ED. Of these, 930 were ineligible. Of 1,938 patients offered an HIV test (Coverage: 12%) 1,161 accepted (Uptake: 60%). Two patients have been diagnosed with HIV infection. Marked variation in the two outcome measures has occurred over the course of the programme. Mean weekly coverage ranged from 5% to 23%, and uptake from 30% to 91%. PDSA cycles having the most positive and sustained effect on coverage and uptake have included in-house training delivered by ED doctors, an IT solution prompting the offer of a test, and the production of a periodic newsletter. Conclusion: HIV testing can be delivered in the ED, but constant innovation and attention has been required to maintain this over eleven months. Patient uptake remains high, but true embedding in routine clinical practice has yet to be achieved.

“Routine HIV Testing in Emergency Departments: Tough Lessons in Sustainability”



## PS1/02 Routine HIV Screening in 6 EDs in Paris area: the ANRS URDEP Study

E Casalino<sup>1</sup>, S Firmin<sup>2</sup>, A Delobelle<sup>2</sup>, B Bernot<sup>3</sup>, C Choquet<sup>1</sup>, G Der Sahakian<sup>4</sup>, J Zundel<sup>5</sup>, P Hausfater<sup>6</sup>, YE Claessens<sup>7</sup>, E Bouvet<sup>8</sup>, F Brun-Vezinet<sup>9</sup>, Dominique Costagliola<sup>2,10</sup>

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**Objectives:** Our objectives were to determine whether routine HIV screening using a rapid test in the EDs was feasible without extra-personnel and whether newly diagnosed HIV individuals could be linked with care. **Methods:** The study was conducted for one year from December 2009 in 6 EDs from Paris area, using the INSTITM test. Eligible individuals were 18 to 70 years old, not presenting with vital emergency nor for HIV blood, sexual exposure or screening, providing written inform consent. **Results:** During the study period, 183,957 individuals were eligible, 11,401 were offered HIV testing (6.3%), 7,936 accepted it (69.6%), and 7215 (90.9%) were tested. In addition, 1,857 not eligible individuals were also tested. Overall, 55 individuals were confirmed as newly diagnosed HIV positive using WB (0.55% of eligible and 0.81% of non-eligible patients,  $p=0.210$ ), and one individual was a false positive. Among the newly diagnosed patients, 48 (87%) were linked with care, of whom 36 were not lost at month 6 (75%), 40% were MSM, 46% were from sub-Saharan-Africa, 44% had never been tested and the median CD4 count was 241/mm<sup>3</sup> (IQR: 52-423/mm<sup>3</sup>). **Conclusion:** Acceptance rates were similar to those reported in studies with no dedicated personnel. The rate of newly diagnosed HIV positive people was 0.61% (95% CI: 0.46-0.79), a rate similar to those observed in free anonymous testing centres in Paris area, well above 0.1%, a prevalence for which testing has been shown to be cost-effective illustrating the value of routine HIV screening with rapid test in this setting.

### **PS1/03 Acceptability, feasibility and costs of universal offer of rapid point of care testing for HIV in an acute admissions unit: results of the RAPID project**

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Background: UK guidance recommend acute medical admissions are offered an HIV test. Our aim was to determine whether a dedicated staff member using a multimedia tool, a model found effective in the USA, is an acceptable, feasible, and cost-effective model when translated to a UK setting. Design: Over four months in 2010, a Health advisor (HA) approached 19-65 year olds at a central London acute medical admissions unit (AAU) and offered a rapid HIV point of care test (POCT) with the aid of an educational video. Feasibility and acceptability were assessed through surveys and uptake rates. Costs per case of HIV identified were established. Results: Of the 606 eligible people admitted during the pilot, 324 (53.5%) could not be approached or testing was deemed inappropriate. In total 23.0% of eligible admissions had an HIV-POCT. Of the patients who watched the video and had not recently tested for HIV, 93.6% (131/140) agreed to an HIV test; four further patients had an HIV test but did not watch the video. Three tests (2.2%, 3/135) were reactive and all were confirmed HIV positive on laboratory testing. 97.5% felt HIV testing in this setting was appropriate. The cost per patient of the intervention was £21. Conclusions: Universal POCT HIV testing in an acute medical setting, facilitated by an educational video and dedicated staff appears acceptable, feasible, effective, and low cost. These findings support the recommendation of HIV testing all medical admissions in high prevalence settings, although with this model a significant proportion remained untested.

### **PS1/04 Increasing HIV testing in non-GUM settings – a new training resource**

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<sup>2</sup>Bristol-Myers Squibb Pharmaceuticals Ltd, Uxbridge, UK

Objective: Late diagnosis of HIV remains a challenge in the UK. National guidelines set out criteria for testing outside the genitourinary medicine(GUM) setting. Despite this, testing in other specialties remains low. A training resource was developed with the aim of increasing testing in non-GUM secondary care settings. Methods: A collaborative project between the GUM and respiratory departments at St George's Healthcare NHS Trust (supported by Bristol-Myers Squibb), this hospital-level plan comprised a training slide deck and supportive materials, including a survey for assessing the impact of the training. The resource was developed to enable HIV specialists and non-GUM colleagues to jointly deliver HIV testing training to non-HIV specialists. Training can be delivered in 45-60 minutes and is designed to integrate into departmental training time. The content is applicable to all centres, but key slides allow tailoring of the training deck to specific localities. Results: The training resource supports doctors in offering HIV testing to patients, and alerts them to their centre's care pathway. Piloted to the respiratory department at St George's Hospital in October 2011, it has since been taken up by 15 further centres, with very positive feedback: "Not only did it generate interest and discussion during training but it also helped identify unexpected barriers to testing, leading to practical changes and solutions." Based on feedback, we are now seeking to develop this for the primary care setting. Conclusion: Preliminary results suggest that delivery of the training resource is feasible and well received, with plans for continued roll out.

## **PS1/05 Individual level and country level predictors for recent HIV-testing and late HIV diagnoses among MSM in Europe – aspects to consider when planning interventions to increase HIV-testing. Results of the European MSM Internet Survey (EMIS)**

Axel J Schmidt<sup>1</sup>, U Marcus<sup>1</sup>, M Breveglieri<sup>2</sup>, P Fernández-Dávila<sup>3</sup>, L Ferrer<sup>3</sup>, C Folch<sup>3</sup>, M Furegato<sup>2</sup>, F Hickson<sup>4</sup>, HJ Hospers<sup>5</sup>, D Reid<sup>4</sup>, P Weatherburn<sup>4</sup> The EMIS Network

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Objectives: HIV testing is being promoted as a preventive intervention. Early diagnosis of HIV - if resulting in effective antiretroviral treatment - can decrease infectiousness and prevent disease progression. The European MSM Internet Survey (EMIS) allows for comparing self-reported data across EU countries and beyond, on MSM's protective and risk behaviour, unmet prevention needs, and intervention performance. Methods: In June-August 2010, the European MSM Internet Survey (EMIS) was completed by more than 180,000 men who have sex with men from 38 European countries in one of 25 languages. Data were collected on access to HIV-testing and knowledge about its benefits, on the recency of HIV testing, last test result, and current HIV status respondents assumed to have when filling in the survey. Men who tested positive for HIV between 2001 and 2010 were asked about their CD4 count at diagnosis. Results: EMIS results show large differences across Europe in HIV testing rates, and large differences in HIV transmission risk (non-concordant unprotected anal intercourse). In all European sub-regions, men with recent HIV transmission risk were less likely to be (recently) tested for HIV. Among MSM diagnosed with HIV, substantial proportions were diagnosed late, confirming the magnitude of previous estimates based on clinical data. Conclusion: The presentation will discuss individual and country level associations with recent testing as with late diagnosis, consider the impact of knowledge on testing benefits, structural country level differences, key barriers to uptake of risk-adequate testing behaviour. Rates of self-reported late presentation will be compared with existing surveillance data.

## **PS1/06 HIV testing among Portuguese men who have sex with men- results from the EMIS Study**

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<sup>2</sup>Grupo Português de Activistas Sobre Tratamentos- GAT, Portugal

<sup>3</sup>Robert Koch Institute, Germany

Introduction: Information about HIV testing among Portuguese MSM is scarce. Objectives: To identify factors associated to lower frequency of HIV testing among MSM. Methods: EMIS survey took place in 2010. An anonymous questionnaire was provided online in 38 European countries. A total of 4584 participants living in Portugal were included in the analysis (SPSS19). Results: 4546 men answered the question about previous HIV testing. 3281 (72%) had ever received a test result and 350 (7.7%) reported a positive test. After excluding men with positive result, 71.7% of those ever tested had received a result in the previous year. Ever testing was most frequent among men aged 35-44 and least frequent among those under 25 (81.3% vs. 50.9%,  $p<0.001$ ). Ever testing was more common among participants with higher education (76.2% vs. 61.3%,  $p<0.001$ ) and in those living in big cities (76.4% vs. 60.0%). Previous year testing was more common in men born in Brazil (77.8%). Men who identified themselves as homosexual reported more frequent ever testing (74.2% vs. 60.3%,  $p<0.001$ ). Those "out" reported ever and previous year testing more commonly (ever: 78.3% vs. 65.1%,  $p<0.001$ ; previous year: 74.0% vs. 70.1%,  $p=0.026$ ). Ever testing was more frequent among participants living with a male partner. Previous year testing was more commonly reported by men who had UAI in the same period (73.7% vs. 68.0%,  $p=0.002$ ). Conclusions: The large adherence of the MSM community provided valuable information about HIV testing among MSM in Portugal. That is useful for future monitoring and comparisons.

## Parallel Session 2: HIV Testing and the Continuum of HIV Care

### PS2/01 Quality of care and clinical outcome of persons diagnosed with HIV in the UK

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Objective: Improvements in life expectancy rely on early diagnosis of HIV and prompt access to antiretroviral therapy (ART). We assess the quality of care and clinical outcomes of adults diagnosed with HIV in the United Kingdom. Methods: Analyses of new diagnoses data linked to a national cohort of adults receiving HIV care at NHS specialized clinics. Deaths were obtained from the Office for National Statistics. Completeness of case reporting and data fields is high (>95% and >85% respectively). Data outputs are adjusted for missing data. Results: In 2010, 50% of the 6 600 adults diagnosed in the UK were late presenters (CD4<350 per mm<sup>3</sup>) (including 28% with CD4<200); Late presenters accounted for >80% of 640 reported AIDS. Overall 89% of adults diagnosed were linked into care within 14 days and 98% within 3 months (based on date of first CD4 test). The uptake of ART among 14,700 adults with a CD4<350 in HIV care was 87%. Among the 6040 adults who started therapy in 2009, 85% had viral suppression within a year. Late presenters had 10 fold increased risk of dying within a year of diagnosis compared to those diagnosed with CD4 ≥ 350 (4% vs 0.4%). Conclusion: Access to HIV care in the UK is excellent and standard of care is high. The majority of AIDS cases and deaths are associated with late diagnosis. Efforts to implement expanded routine and universal testing should be prioritized.

### PS2/02 BCN Checkpoint: high efficiency in HIV detection and linkage to care

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Projecte dels NOMS-Hispanosida, Barcelona, Spain

BCN Checkpoint is a Community-Based Centre (CBC) for MSM in Barcelona that offers HIV rapid testing, peer counseling/support and linkage to care. Objective: To assess the efficiency of BCN Checkpoint in HIV detection and linkage to care. Methods: The annual HIV prevalence, the capacity of detection in BCN Checkpoint regarding reported cases in Catalonia, the linkage to care rate, and the proportion of recent infections were analyzed. Linkage to care rate: proportion of cases referred to an HIV Unit within 1 week. Recent infections: HIV cases tested negative within the last 18 months of the diagnosis. Results: The cases detected in BCN Checkpoint raised progressively and represented around 40% of all HIV cases in MSM reported in Catalonia in 2010. Of all HIV cases in our CBC that had been tested negative at least 1 time, 61,39% declared a negative result within the last 18 months, and were considered an early HIV infection. Of all cases detected 95,11% were referred to care. Conclusions: BCN Checkpoint shows a high efficiency in HIV detection, as 1) in 2010, out of 3.500 tests, detected 4,49% prevalence (compared to Catalonia: over 300.000 tests, prevalence: 0,80%); 2) an increase in absolute number of HIV detections was obtained; 3) the proportion of cases detected regarding the reported cases in MSM in Catalonia raised progressively. Moreover, BCN Checkpoint also has shown efficiency in detecting recent HIV infections, and in linking cases to care. Therefore a community-based approach should be an essential part of an HIV prevention strategy.

## PS2/03 CheckpointLX - MSM HIV testing and linkage to care in Lisbon

Maria José Campos<sup>1</sup>, E Teófilo<sup>2</sup>, H Machado<sup>1</sup>, J Brito<sup>1</sup>, J Esteves<sup>1</sup>, L Mendão<sup>1</sup>, R Abrantes<sup>1</sup>, R Furtos<sup>1</sup>, T Rodrigues<sup>1</sup>, N Pinto<sup>1</sup>

<sup>1</sup>CheckpointLX, Portugal

<sup>2</sup>Centro Hospitalar de Lisboa Central, Portugal

Introduction: CheckpointLX offers anonymous, confidential and free rapid HIV screening for MSM. Counselling is offered by trained MSM on a peer approach. Objectives: Early HIV detection in MSM, to provide HIV/STI's information, and to refer to NHS the MSM with reactive result. Methods: The centre offers testing and counselling in a community setting and is promoted in gay venues. MSM with reactive result are offered referral to HIV clinic and a member of staff is available to accompany to the appointment. Results: From April to November 2011, 780 tests were performed: 677 (86.8%) in MSM. Among MSM, the median age was 30 years (std deviation 9.47). 84.7% of MSM had been tested before, 61.3% of them in the previous 12 months. The median age of MSM with previous testing was 31 and for those being tested for the first time was 22. There were 35 (5.17%) reactive results, of which 27 (77%) accepted reference to the HIV clinic and 13 the company of a counsellor. We're presenting the first immunological evaluation of 21 MSM referred to HIV clinic. The median CD4 cell count was 455/mm<sup>3</sup>. The mean VL was 86901 copies/ml (4,93log<sub>10</sub>). Half patients started anti-retroviral medication. Conclusions: The percentage of reactive results was high (5.68%). 77% of MSM with reactive result were successfully referred to care and half of these with the company of a counsellor. Half of MSM referred needed HART which reinforce the importance of early detection and referral to care.

## PS2/04 Checkpoint: rapid HIV screening in community setting for a strong link to care

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Objectives: Checkpoint (implemented by a non profit organization) was set up (at the beginning of) in 2010 within a biomedical research program aiming to evaluate the acceptability of a medicalized HIV screening site amongst MSMs, and its efficiency in ensuring link to care for positive patients. Methods: The MSMs are received by a doctor and a nurse (pre-test counselling - test -post-test counselling). All positive results of rapid HIV tests are confirmed by two ELISA and one Western-blot. Positive patients receive immediately appropriate medical support and are encouraged to initiate specific HIV care in the following days. Results: In 2010, 2 343 MSMs received counselling on HIV/STIs prevention, were screened for HIV and got their results. The 52 HIV-1 positive diagnostics were all confirmed (2,22%, IC95 : 1,62-2,80%). WB analysis identified 29 recent infections, including 17 primo-infections. All patients came to confirmation appointments. 92% initiated medical care (at) : doctors offices (37%), healthcare centres (19%), or hospitals (15%). 8% received information about medical follow-up and referral (patients living abroad or the greater Paris area). Out of the 32 CD4-documented cases, 12 had an indication for HAART (CD4 < 500/mm<sup>3</sup>). Conclusion : Checkpoint succeeded in detecting recent infection and primo-infection cases among MSMs, and in establishing an effective link between test and care. This service is a good answer to MSMs' medical needs by providing clinical exam, rapid HIV tests, proper counselling and, for patients tested positive, an immediate medical support and facilitated access to care.



## **PS2/05 PLHIV-Related Stigma in Belarus - impacts on quality of care and health outcomes**

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Study AIM and Methods: Conducted in 2010/11 PLHIV researchers surveyed 370 PLHIV residing in all regions ofn Belarus using a tool and process developed by GNP+, ICW, IPPF, and UNAIDS. Some 75 questions covered - including perceptions of stigma experienced in family, community, work, healthcare, religious and other settings was analysed using SPSS. Results: PLHIV regularly encounter stigma and discrimination: gossip (reported by 66.8% of respondents, insults (41.6%) physical harassment, threats and violence. Internalised stigma is common (feelings of guilt, shame, loss of self-esteem, etc.), as well as related decisions and actions: not to have children (45.9%), not to get married (20.0%), not to go to school (17.8%), not to apply for a job (15.9%), not to visit a local clinic (34.6%), or to access healthcare etc. 50% of respondents face problems about treatment issues ("the doctors provided little information," "I do not clear understanding what it is," "I know little about side effects," etc.) as well as reporting disruptions in the supply of ARVs and diagnostic materials, directly affecting adherence to treatment. Internalised stigma particularly prevalent amongst women.. 47% of respondents reported health care professionals advising them not to have children (35.9% of men and 61% of women), 11.4% of respondents reported being coerced into sterilisation - 1.9% of men and 23.2% of women. Conclusion: Since study advocacy and programmes have been put into place to try and address some of these issues. Results will be available at the time of the conference detailing challenges encountered.

## PS2/06 Scaling-up community HIV rapid testing and linkage to care in Estonia, Lithuania, Russia and Ukraine: results and lessons learned

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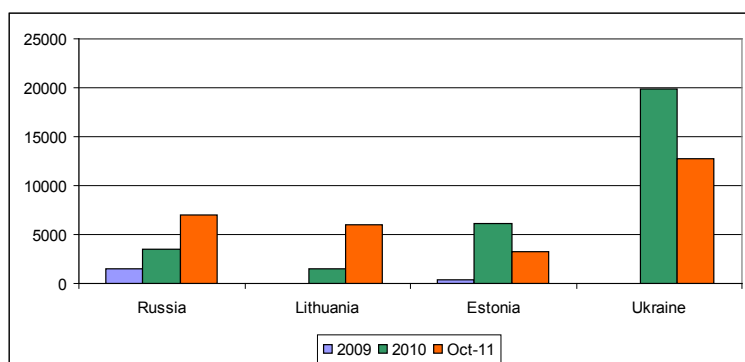
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Problem: According to WHO data nearly 60% of HIV infected people in WHO European region do not know their positive status. Considerable proportion of the patients diagnosed late which is missed opportunity for timely access to treatment and care (Ukraine: 23% of HIV newly diagnosed has late stage of infection and 9% dies during first year of ART). Access to HIV testing among vulnerable groups is very low: Among those tested in European region less than 1% were tested in TB clinics; in drug treatment settings and in STI facilities. Only 12% of all HIV testing performed in the region is rapid. Objective: AIDS Healthcare Foundation (AHF) in partnership with governmental and NGOs from Estonia, Lithuania, Russia and Ukraine initiated community based rapid HIV testing initiative in 2009 to provide easy and free access to rapid testing for vulnerable groups and links those who tested positive to care and treatment. Results: Total 61,823 people learned their HIV status using rapid tests, provided by AHF in four European countries in 2009-2011. The dynamic provided in the chart below.



The seropositivity rate:

| Country   | 2010 | 2011 |
|-----------|------|------|
| Russia    | 3.6  | 3.5  |
| Lithuania | 2.4  | 0.9  |
| Estonia   | 1.9  | 2.2  |
| Ukraine   | 3.8  | 4.1  |

Lessons learned: Continuous growth of people tested proved that people do want to know their HIV status; Linkage to care became a measurable component of rapid testing program; Cooperation between community settings and HIV/AIDS treatment sites is critical for effective linkage.

## Parallel Session 3: HIV Testing among Key Populations

### PS3/01 Ukraine's experience in scaling-up HIV testing and further referral of high-risk population to health-care institutions Ukraine

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Objectives: Ukraine is in the top three in terms of spreading of HIV infection in Europe. Epidemic is concentrated in high-risk groups. Estimated size of risk groups is the following: IDU-290 000, FSW-78 000, MSM-95 000. Only 25% of PLHA were tested and are aware of their status in Ukraine. The major task is scaling-up of HIV detection among high-risk population particularly. Methods: 1. Development of a comprehensive package of services for high-risk groups. Conduction of joint testing on HIV/STI/Viral Hepatitis and introduction of combi tests. 2. Testing in mobile clinic. 3. Training on testing and VCT for physicians of different specialties, working with high risk groups. 4. Development of unified base of rapid testing points and placement of information on the website of Alliance and partner organizations. Results: 140 points of HIV rapid testing were created. 366 618 HIV tests were conducted. 442 379 tests on STI/Viral Hepatitis were done. There are 15 mobile vans. More than 100 health-care institutions conduct diagnose and follow-up treatment of HIV/STI for high risk groups. Conclusions: The following has contributed greatly to increase in the number of HIV tests in Ukraine: Development of a comprehensive package of services, introduction of combi tests: Conduction of testing in the mobile van. Involvement and mandatory training on testing and VCT for physicians of different specialties. Possibility to obtain information on testing points' locations in each region through the Internet.

### PS3/02 Effectiveness of continuous prevention interventions for HIV testing uptake among high risk populations in Tbilisi, Georgia

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The study aimed to evaluate HIV testing and related data based on two rounds of BioBehavioral Surveillance Surveys conducted among Men who have Sex with Men (2007 and 2010) and Female Sex Workers (2006 and 2009) in Tbilisi, Georgia. Recruitment was done through respondent driven sampling for MSM and time-location sampling for FSWs. Interviews were conducted using standardized behavior questionnaires. Data were analyzed with SPSS. The study protocols and questionnaires were approved by Ethical Committee of the HIV/AIDS Patients Support Foundation. As a result of prevention interventions targeting these groups with the same intensity and frequency, knowledge about availability of HIV testing among MSM has increased from 32.9% in 2007 to 58.7% in 2010 ( $p < 0.05$ ). HIV testing uptake in both groups during the last year and during the last 1-2 years did not demonstrate any change over the two years period. In 2010 MSM who considered themselves at no risk of HIV acquisition, were less likely to be ever tested on HIV (OR 0.3; 95% CI 0.1–0.7). Less than ¼ of MSM participated in previous BSS, compared to 43.1% of FSW. Continuous interventions increase knowledge about availability of HIV testing services, but do not influence testing behavior. There are barriers to testing needing further investigation. Other factors such as low personal risk assessment and higher intensity of new recruits in the MSM population should also be considered. This will enable to undertake targeted preventive interventions aiming at increased testing among high risk populations and specifically among MSM.

| Indicator                               | MSM 2007       | MSM 2010        | FSWs 2006       | FSWs 2009       |
|---|----------------|-----------------|-----------------|-----------------|
| Tested on HIV during the last year      | 22.6% (32/140) | 26.3% (73/278)  | 38.8% (62/160)  | 36.3% (58/160)  |
| Tested on HIV during the last 1-2 years | 11.4% (16/140) | 5.0% (14/278)   | 17.5% (28/160)  | 18.8% (30/160)  |
| Knows where to go for HIV testing       | 32.9% (46/140) | 58.7% (163/278) | 83.8% (129/160) | 81.3% (130/160) |
| Participated in previous BSS            |                | 23.7% (66/278)  |                 | 43.1% (69/160)  |

### **PS3/03 Translating research results into promotion of HIV testing among Sub-Saharan African migrants in Flanders**

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Background: Sub-Saharan African migrants (SAM) in Belgium are highly affected by HIV and often diagnosed late. In order to improve uptake of HIV testing, we developed combined interventions targeting various levels based on formative research. Methods: In 2007, a qualitative study using focus group discussions revealed target group-specific barriers to voluntary HIV counseling and testing (VCT): fear of consequences of HIV diagnosis, low perceived risk, lack of knowledge about the health system, lack of preventive behaviour. Provider-initiated HIV testing and counseling (PITC), free testing and outreach testing were identified as facilitators. Culturally sensitive tools promoting VCT were developed to refer SAM to a low threshold sexual health centre offering free HIV/STI tests. Using a participatory approach, 6 outreach testing sessions were organized in the community in 2009/10. A complementary qualitative study assessed barriers to implement PITC among physicians. Based on barriers identified and on existing WHO VCT guidelines, culturally sensitive testing guidelines were developed. Between 09-11/2011, 80 GPs were recruited for their implementation and evaluation. Results: The program showed acceptability of culturally sensitive information tools. Outreach testing was feasible: 56/645 individuals (8.7%) were tested for HIV/STI. There is indication that HIV testing uptake increased at the sexual health centre: 77 (2006-2008), 148 (2009) and 181 SAM (2010) respectively. Conclusions: Implementing a multi-level approach comprising community participation, sensitization and training of physicians, outreach testing, and improved access to low threshold HIV testing services including PITC is feasible and should be encouraged and sustained.

### **PS3/04 Using community-based rapid HIV screening among men who have sex with men in a behavioral serosurveillance survey, Almaty, 2010**

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<sup>3</sup>'Amulet' Public Association, Republic of Kazakhstan

Objectives: To better understand the demographics, risk factors associated with poor health outcomes, human rights experiences, and to update HIV prevalence among men who have sex with men (MSM) in Almaty, Kazakhstan. Methods: Using respondent-driven sampling to recruit, interview and screen for HIV using rapid test assays among 400 MSM in Almaty, Kazakhstan from March to August 2010. The analysis was weighted to adjust for the probability of people recruiting people who are similar to themselves. Results: HIV prevalence among MSM surveyed was 20%. All participants were referred to designated city HIV testing centers for HIV testing. About 13% reported unprotected anal sex with two or more male partners in the last 12 months and more than 60% noted having been afraid to tell their health care provider about their sexual orientation, as a proxy for barriers to accessing appropriately MSM targeted health care. 87% of MSM said their access to free condoms was "very difficult," and 38% found their access to water- or silicone-based lubricants "very difficult." Conclusion: The results found high levels of risk behavior and human rights concerns among MSM in Almaty. Anonymous, community-based rapid screening for HIV was a motivation to participate. The results will be used to inform prevention activities and innovative outreach programs with access to community-based rapid testing with the same day results for MSM to ensure smooth linkages to care and treatment.

### **PS3/05 Development of gender oriented services to increase the number of voluntary counseling and testing (VCT) among female drug users of Lviv region (Ukraine)**

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Objectives: HIV voluntary testing and counseling (VCT) is key element for behavior change, entry to treatment, care, support. Gender oriented approach in HIV prevention programs for female drug users (FDU) is very important factor for the success of the intervention. According to the Lviv Regional AIDS Center (LRAC) data in 2010 only 27% from all drug users who made VCT were females. Aim of initiative was to increase the number of HIV VCT among FDU of Lviv region. Methods: Specially equipped mobile clinic was used for the intervention. FDU had an opportunity to pass gynecological examination, express testing for STI's along with HIV testing. Condoms, femidoms, shampoos, lipsticks, hand creams were distributed among FDU as a motivation for those clients who passed HIV test. Results: During October 2010 – October 2011 189 FDU 16-47 years old passed VCT and HIV express test. All FDU were tested in mobile clinic in out reach routs. 29 HIV positive results of express tests were detected, 23 positive results of HIV express test were confirmed by LRAC lab. 91% of women mainly were interested in gynecological check up, free distribution materials and in process of medical consultations made a decision to pass HIV test. Conclusions: Gender oriented programs for FDU are different comparing to unisex approach widely used in Ukraine. Multisectoral services consisting of social medical and psychological parts, cost effective, specially developed for the target group are needed and should be implemented in Lviv region for increasing the HIV VCT rate among FDU.

### **PS3/06 Socio-demographic factors predicting HIV test seeking behaviour among MSM in 6 EU cities. Results from the SIALON European Project (2008-2010)**

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<sup>2</sup>ULSS20, Veneto Region, Verona, Italy

Objectives The aim of the project is to obtain valid and reliable data on HIV prevalence in MSM in Southern and Eastern Europe. Methods: The SIALON project is a descriptive multi-centre bio-behavioural cross-sectional survey and it was carried out in six cities: Barcelona, Bratislava, Bucharest, Ljubljana, Prague and Verona. Time-location sampling was used to recruit a representative sample of MSM visiting the gay scene in each city. Both oral fluid sample and questionnaires with UNGASS indicators were collected. Results: Almost half of respondents on the overall sample had been tested in the last year. Southern European cities (Barcelona, Verona) had the highest percentage of tested people who received their HIV test result, while the Eastern European cities had the lowest percentages. After the introduction of age and sexual orientation at city level, multilevel multivariate logistic modelling showed that test seeking behaviour is influenced by several social factors: MSM who are older (OR: 1.01), have a university degree (OR: 1.31), live alone or with a male partner (OR: 1.64), live in big cities (OR: 1.96), self-define as gay or homosexual (OR: 1.77), have been reached with prevention programs (OR: 1.53) and perceive positive interpersonal attitudes toward gays/bisexuals (OR: 1.07) are more likely to have had access to HIV test. Conclusion Testing seeking behaviour seems to be influenced by age, education, living conditions, perceived homonegativity. Sexual orientation/identity plays an important role in predicting testing seeking behaviour. A major effort to promote test seeking behaviour in Eastern-EU countries is needed.

## Parallel Session 4: Cost Effectiveness of HIV Testing

### PS4/01 Cost effectiveness of HIV testing in non-traditional settings – the HINTS Study

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**Objectives:** This prospective study assessed the costs of routine HIV testing in non-specialist settings in areas of high HIV prevalence in the UK. **Methods:** As part of the HIV Testing in Non-traditional Settings (HINTS) study, HIV tests were offered to patients aged 16-65 over three months in four settings: Emergency Department, Acute Care Unit, Dermatology Outpatients and Primary Care Centre in London. We assessed the costs of screening in terms of costs per newly diagnosed HIV-infected patient using the data derived from the study. Additionally, national data from the Survey of Prevalent HIV Infections Diagnosed (SOPHID) was used to estimate the number of undiagnosed individuals attending each setting over one year. A sensitivity analysis was run using the SOPHID data to simulate the costs and cost-effectiveness of HIV screening in different scenarios, changing the prevalence, and test offer and uptake rates. **Results:** Testing as per the HINTS Study cost £19,056 per newly diagnosed patient. Assuming all undiagnosed persons had been offered a test and applying the same test uptake rate as the study (67%), the cost per newly diagnosed patient becomes £4,460. In the best scenario, assuming 100% coverage and 100% uptake, the cost will decrease to £2,940 per patient. **Conclusions:** The results of the study are encouraging and suggest that a screening programme in a high prevalence area could identify HIV-infected patients at a low cost per test. Earlier diagnosis of HIV infection may subsequently have further cost benefits in terms of early treatment and aversion of incident infections.

### PS4/02 Routine HIV screening in Portugal: clinical impact and costeffectiveness

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**Background:** We sought to forecast the clinical impact and cost-effectiveness of routine HIV screening in Portugal, where the burden of disease remains high. **Methods:** We used a computer model of HIV detection and treatment, coupled with Portuguese national clinical and economic data, to estimate life expectancy (LE), cost, and cost-effectiveness of alternative HIV screening strategies. We compared current HIV detection practices in Portugal to routine HIV screening in adults aged 18-69. We considered a variety of target populations with differing levels of HIV risk and a variety of testing strategies including the current strategy, one-time screening, screening every five years, and annual screening (Table 1). Baseline input values included: mean age of population (42.61 years), mean CD4 at care initiation (292 cells/ $\mu$ L), test acceptance (63%), linkage to care (81%), HIV test cost (€5.40), and an annual discount rate (5%). We conducted extensive sensitivity analyses on these base case values. **Results:** Switching from current detection practices to a one-time test increased undiscounted HIV-infected LE from 36.05 to 36.58 LYs, resulting in a discounted, incremental cost-effectiveness ratio of €38,600/QALY. More favorable survival and cost-effectiveness results were observed in regions with greater HIV risk (Table 1). **Conclusions:** One-time, routine, voluntary HIV screening in the Portuguese general population meets accepted international standards of cost-effectiveness. More frequent screening is justified in regions with higher undiagnosed HIV prevalence and with higher incidence rates.

### PS4/03 Comparison of “Opt-In” versus “Opt-Out” Strategies for early HIV detection

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<sup>6</sup>HIV Indicator Diseases Across Europe Study Group

Objectives: Compare prospectively an “opt-in testing” (OI) versus an “opt-out testing” (OU) strategies in 4 primary care centers in Barcelona. Patients included in the OI strategy are also included in an international pilot study (HIDES I) of HIV in Europe. Methods: Patients (18-65 years) consulting for a new Herpes Zoster, Seborrheic Eczema, Mononucleosis Syndrome and Lymphopenia/Thrombopenia were included in OI and patients (1 of every 10) unselected patients consulting for other reasons, in OU. Those who participate perform a blood HIV rapid test (1 test has a cost of 6€). Results: 85 patients were included in OI strategy and 304 in OU. 4 [4.7% (95%CI: 1.3-11.6)] in OI and 1 patient [0.3% (95%CI: 0.01-1.82)] in OU respectively, were HIV infected. Total population (18-65 years) attended in the 4 centers during follow-up were 775 patients in OI and 66043 persons in OU strategy. If we have performed an HIV test to every person visited, we would have spent 4,650€ in OI and 396,258€ in OU strategy, respectively. According with HIV prevalence obtained, 36 persons (95%CI: 10-90) would be diagnosed of HIV in OI strategy and 198 persons (95%CI: 7-1,201) in OU one. The cost of a new HIV diagnose would be 129€ (95%CI: 52-465) in OI and 2,001€ (95%CI: 329-56,608) in OU strategies. Conclusions: Opt-in seems to be feasible and a more cost-effective strategy to improve early diagnose of HIV infection than opt-out in our environment. HIV prevalence in indicator diseases should be confirmed in other more extensive studies.

### PS4/04 Testing for HIV and syphilis in 4 cities of Ukraine: screening results

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Objectives: Study was aimed to detect HIV and syphilis prevalence among street children in 4 cities of Ukraine. Methods: A screening testing of street children aged 14-18 has been conducted by social patrols in streets of Kyiv, Odessa, Mykolaiv and Donetsk. Altogether 1399 persons were tested with rapid tests for HIV and 1089 for syphilis from August 2010 to September 2011. Positive results were verified with laboratory tests. Results: In Mykolaiv 350 street children were tested for both infections; 12 (3.4%) tested positive for HIV and 3 (0.9%) tested positive for syphilis. In Donetsk 358 street children were tested for both infections; 14 (3.9%) and 3 (0.8%) tested positive for HIV and syphilis respectively. In Odessa 27 (8.5%) out of 316 street children tested positive for HIV and 25 (7.9%) out of 315 tested positive for syphilis. In Kyiv 29 (7.7%) out of 375 and 28 (7.5%) out of 376 tested positive for HIV and syphilis respectively. Conclusion: A 14 month screening for HIV and syphilis among street children has been conducted for the first time in Ukraine; it shows high prevalence of HIV in all 4 cities of Ukraine, particularly in Odessa and Kyiv. High prevalence of syphilis in Kyiv and Odessa is alarming. Screening results give the evidence that both HIV and syphilis among Ukrainian street children are underdiagnosed. Having neither documents nor registration street children fall through the net of the public health system.



## **PS4/05 “Test and Treat” is not the answer to the HIV-epidemic among gay men and other MSM in Switzerland.**

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**Objectives:** Despite the highly improbable HIV transmission when one is under an efficient ART, the preventive effect of ART seems to be offset by the continuous raise of risky behaviour among MSM in Switzerland. In order to evaluate how efficient early testing and treatment (T&T) is to alter incidence, the Swiss Federal Office of Public Health (SFOPH) has commissioned the development of a mathematical model. **Method:** Data coming from the Swiss Gay Survey, the Swiss HIV Cohort and the SFOPH surveillance system have been used in order to do a remodelling of the HIV epidemic among MSM from 1980 to 2010, and see how the epidemic could develop in the future according to different scenarios. **Results:** The model shows that T&T is not effective to break the chains of new infections during Primary HIV Infection. Even if one reaches an undetectable viral load one month after the diagnosis, the number of new infections would sustain to a high level. Only the combination of behavioural change with T&T could drastically diminish incidence of HIV. **Conclusions:** “Test and treat” is a good additional answer to the HIV epidemic. Yet, the key factor to alter incidence is behavioural change. New approaches are needed. According to the model, the combination of effective behaviour change with early T&T could prevent approximately two thousand MSM needing ART until 2020 and, thus, heavy health care costs.

## Parallel Session 5: Characteristics of PLHIV who present late for care and missed opportunities for earlier diagnosis

### PS5/01 Association of injection drug use and late enrollment in HIV medical care in Odessa Region, Ukraine

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Late enrollment of PLWH in specialized care is a significant challenge to limiting the spread of HIV epidemic in Ukraine. Thus, in 2008-2010, only 54% of 108,116 persons who tested HIV positive enrolled in care at AIDS Centers in Ukraine; in 2010, 45% of new AIDS cases were diagnosed in patients tested for HIV for the first time. The objective of the study was to identify factors associated with late enrollment in HIV medical care in Odessa Region, Ukraine. We conducted retrospective data analysis of two cohorts of PLWH (aged 15+) who enrolled into HIV care in 1995-2010, depending on reported possible way of HIV transmission. Non-parametric statistics (Kruskal-Wallis test) was used to compare the groups. We found that a delayed enrollment in HIV care among PWIDs in Odessa Region was higher than in the sexually infected with HIV group (1140 days vs 336 days in 2010) (see Table). During the analyzed period, the mean delay in enrollment in care among PWIDs increased for both men and women; the mean age of PWIDs at the time of enrollment in care also showed gradual increase. Urban residents account for the majority of PWIDs enrolled in HIV care, with some growth in proportion of rural residents. People who had acquired HIV via IDU, demonstrated later enrollment in AIDS Centers compared to the second group. There is therefore an urgent need to improve efficiency of HIV counselling and referral, taking into account differences in behavior of drug using and non-drug using populations.

Time (days) between being tested HIV(+) and enrolled in HIV care for people with different ways of HIV transmission in Odessa Region, Ukraine (1995-2010)

| Year      | Transmission through IDU |       |      |         |         | Sexual transmission |       |      |        |        |
|-----------|--------------------------|-------|------|---------|---------|---------------------|-------|------|--------|--------|
|           | # cases                  | Range |      | Mean    | SD      | # cases             | Range |      | Mean   | SD     |
|           |                          | min   | max  |         |         |                     | min   | max  |        |        |
| 1995      | 41                       | 0     | 125  | 21,95   | 23,78   | 29                  | 0     | 2653 | 754,79 | 921,1  |
| 1996      | 1082                     | 0     | 591  | 80,88   | 94,62   | 246                 | 0     | 1611 | 101,22 | 142,81 |
| 1997      | 687                      | 4     | 759  | 149,57  | 191,46  | 197                 | 3     | 2225 | 192,09 | 235,9  |
| 1998      | 306                      | 0     | 1441 | 422,35  | 348,76  | 228                 | 0     | 1105 | 217,07 | 254,15 |
| 1999      | 441                      | 0     | 1561 | 603,17  | 488,14  | 309                 | 9     | 3497 | 335,27 | 465,8  |
| 2000      | 439                      | 2     | 2143 | 597,37  | 618,09  | 288                 | 12    | 2149 | 383,13 | 483,49 |
| 2001      | 407                      | 0     | 2200 | 857,61  | 762,08  | 297                 | 0     | 2503 | 486,75 | 600,03 |
| 2002      | 556                      | 0     | 2644 | 844,69  | 880,72  | 420                 | 0     | 4888 | 535,96 | 740,45 |
| 2003      | 659                      | 0     | 3193 | 1018,54 | 1061,7  | 449                 | 0     | 2948 | 635,57 | 845,88 |
| 2004      | 724                      | 0     | 4637 | 858,14  | 1133,38 | 540                 | 0     | 3139 | 578,02 | 877,71 |
| 2005      | 483                      | 0     | 3697 | 1138,89 | 1262,88 | 505                 | 0     | 3548 | 523,8  | 898,41 |
| 2006      | 516                      | 0     | 3998 | 946,63  | 1317,39 | 685                 | 3     | 3938 | 466,5  | 916,87 |
| 2007      | 432                      | 9     | 4368 | 719,22  | 1156,33 | 614                 | 7     | 4399 | 268,21 | 652,39 |
| 2008      | 398                      | 7     | 4741 | 852,3   | 1326,57 | 762                 | 8     | 4348 | 211,53 | 479,55 |
| 2009      | 435                      | 9     | 5099 | 807,56  | 1344,51 | 813                 | 8     | 4919 | 264,53 | 620,88 |
| 2010      | 491                      | 14    | 5811 | 1139,5  | 1593,77 | 955                 | 11    | 4672 | 335,6  | 668,29 |
| 1995-2010 | 8097                     | 0     | 5811 | 686,5   | 1034,24 | 7337                | 0     | 4672 | 329,2  | 620,93 |

## **P55/02 Missed opportunities for HIV testing in newly diagnosed HIV-infected patients in France**

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**Objectives:** In France, around 1/3 of HIV-infected patients are diagnosed at advanced stages of the disease. We describe missed opportunities for earlier HIV-testing in MSM and patients with HIV-related symptoms. **Methods:** Adults living in France for  $\geq 1$  year, HIV-diagnosed for  $\geq 6$  months were included from 06/2009 to 10/2010. We collected information on patients' characteristics at diagnosis, and within the 3-year period prior to HIV-diagnosis: history of HIV-testing, contacts with healthcare settings, HIV-related events occurrence, and HIV-testing proposition at the first contact with healthcare settings when patients notified to the care provider their HIV-risk group or HIV-related symptoms. Patients were considered probably HIV-infected at the contact if no HIV-test was performed after this contact and they were not diagnosed at acute HIV-infection stage. **Results:** 69 HIV-care centers enrolled 1,008 newly HIV-diagnosed patients: mean age 39 years, 79% male, 53% MSM, and 16% with an AIDS-defining event. At their first contact with a healthcare setting, 91/191 MSM (48%) who had not HIV-related symptoms mentioned they belonged to this risk group; 50/91 (55%) had a missed opportunity for HIV-testing proposition; 22/50 (44%) were probably HIV-infected. Likewise, 299/364 patients (82%) who sought care for HIV-related symptoms had a missed opportunity for HIV testing proposition in the three years before HIV-diagnosis; 233/299 (78%) were probably HIV-infected (CD4 at diagnosis=210 vs. 432 cells/mm<sup>3</sup> in patients with a test proposition;  $p < 0.0001$ ). **Conclusion:** Missed opportunities for HIV testing remain unacceptably high in HIV-infected patients with the current practiced screening policies. This argues in favor of routine HIV-testing strategies.

### **PS5/03 Factor associated with late HIV diagnosis in Georgia**

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Objectives: Georgian had universal access to antiretroviral therapy (ART). However, substantial proportion of HIV patients in Georgia are diagnosed late, compromising benefits of ART. The objective of this study was to identify risk factors for late HIV diagnosis. Methods: Study enrolled 300 adult patients newly diagnosed with HIV between 01/06/ 2010-03/012011. Patients were interviewed between 03/11/2011-01/03/2011. Clinical data were abstracted from medical records. Risk factors for late diagnosis were evaluated in multivariate logistic regression. Results: Of 300 patients enrolled 64.0% were males and median age was 36 years. 69.7% were unemployed and 50.3% reported history of living abroad primarily as temporary labour migrants. 43.0% had history of injection drug use (IDU). 18.0% patients had ever been tested for HIV prior to diagnosis. 47.7% reported referral to healthcare facility for conditions possibly indicative of HIV. The median time from first medical encounter to HIV diagnosis was 26 months. 67.0% had CD4 count <350 cells/mm<sup>3</sup> and 41.3% had AIDS-defining illness. In multivariate regression factors significantly associated with late diagnosis were: increasing age (OR: 3.6, 95% CI: 1.7-7.6), unemployment (OR: 2.7, 95% CI: 1.5-4.9), history of living abroad (OR: 2.5, 95% CI: 1.29-4.7), history of IDU (OR: 2.1, 95% CI: 1.0-4.7), history of referral to healthcare facility (OR: 5.4, 95% CI: 3.0-9.5). Conclusion: The findings suggest that current HIV testing practices in the country fail to identify a substantial proportion of HIV patients earlier in the course of their disease. Our findings support implementation of proactive approach to HIV testing especially among IDUs.

### **PS5/04 HIV testing among Tuberculosis patients in Denmark increased through the period from 2007 to 2009**

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Background: It is generally accepted that any individual diagnosed with Tuberculosis (TB) should undergo testing for Human Immunodeficiency Virus (HIV) to rule out co-infection. TB disease as well as HIV infection is notifiable in Denmark. All TB cases are registered in the Danish national TB registry but information on HIV co-infection is in-constant. We examined whether patients notified with TB in Denmark were tested for co-infection with HIV during a 3 year period from 2007 to 2009. Methods: We used the Danish national TB registry to identify patients diagnosed with TB and locate the relevant clinical departments in charge of treatment. We contacted the departments and requested the results of HIV testing in all TB patients. Results: A total of 1085 persons were diagnosed with TB in Denmark during the three year period from 2007 to 2009. We were able to obtain HIV test status for 95%. The percentage of patients examined for HIV infection, increased from 43% in 2007, to 50% in 2008, and 63% in 2009. HIV infection prevalence was 3% among the total number of TB patients, and it was 6% in the 521 patients tested for HIV co-infection. Discussion: HIV prevalence among tested TB patients in Denmark is much higher than the estimated 0.1% in the average population. The true prevalence of HIV infection in all TB patients in Denmark is likely to be 3-4%. It seems there is an increasing aware-ness in Denmark towards testing TB cases for HIV co-infection.

## **PS5/05 Diagnosing HIV infection in patients presenting with Glandular-fever-like illness in Primary care: are we missing primary HIV Infection?**

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**Objectives:** To examine the prevalence of HIV in patients presenting in primary care with Glandular-fever-like illness. **Methods:** Samples from primary care submitted for a GF screen between April 2009 and June 2010 were identified. Samples without an HIV request were anonymised and retrospectively tested using a 4th generation HIV antigen/antibody screening test. Reactive samples were further confirmed by an HIV antibody only test, with or without a p24 antigen assay. Antibody avidity testing based on the Recent HIV Infection Testing Algorithm (RITA) was used to identify individuals with evidence of recent acquisition (within 4 - 5 months). **Results:** Of 1046 primary care GF screening requests, concomitant HIV requests were made in 11% (119/1,046) patients. Excluding one known positive patient, 2.5% (3/118) tested HIV positive. 45 (4.3%) had a subsequent HIV test through another consultation within 1 year; of these 4.4% (2/45) tested positive. Of the remaining 882 patients, 694 (78.7%) had samples available for unlinked anonymous HIV testing; of which 6 (0.9%) tested positive. Overall screen detected HIV prevalence was 1.3% (11/857); with 72.7% (8/11) of cases missed at initial primary care presentation. 4 of the 9 (44%) available positive samples had evidence of recent acquisition, with 3 (75%) missed at initial primary care presentation. **Conclusion:** Low levels of HIV testing in patients presenting in primary care with GF-like illness is resulting in a significant number of missed HIV and PHI diagnoses. Local policy should consider adopting an opt-out strategy to include HIV test routinely within the GF-screening investigation panel. This approach represents an easily implementable and cost-effective testing strategy.

## **PS5/06 Profile and determinants of having never been tested for HIV amongst men who have sex with men in Spain**

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**Objectives:** To describe the socio-demographic profile of MSM who have never been tested for HIV and to analyse factors associated with never HIV testing. **Methods:** The European MSM Internet Survey (EMIS) was implemented in 2010 in 38 European countries on websites for MSM and collected data on socio-demographics, sexual behaviour, and other sexual health variables. A logistic regression analysis was conducted to assess variables associated with never HIV testing. **Results:** Out of the 13,111 respondents residing in Spain, 26% had never been tested for HIV. Never testers were significantly more likely to: live in a city with less than 100,000 inhabitants, be less than 25 years old, have a lower educational level, be a student, and identify themselves as bisexual. In the multivariate analysis, to have never been tested for HIV was associated with being born in Spain (OR: 1.46; 95%CI: 1.290–1.656), being less than 25 years old (OR: 3.00; 95%CI: 2.577–3.501), being out to no-one or only few people (OR: 2.17; 95% CI: 1.951–2.404), having had none non-steady partner in last 12 months (OR: 2.46; 95%CI: 1.813–3.337), being not at all confident to get a test for HIV (OR: 3.94; 95%CI: 2.377–6.525), and not having any knowledge about HIV/STI/PEP (OR: 3.87; 95%CI: 1.094–13.681). **Conclusions:** The profile of the MSM who had never been tested for HIV indicates that most of them are men hard to reach (young, bisexual men, being in the closet) and therefore they may not have access to prevention programs.

## Parallel Session 6: New HIV Testing Diagnostic Technologies

### PS6/01 Automated laboratory-based oral fluid HIV testing in HIV screening programs – automatic for the people?

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Objectives: UK guidelines recommend routine HIV testing in general clinical settings when the local HIV prevalence >0.2%. During pilot programs evaluating this, we used laboratory-based testing of oral fluid samples from patients accepting tests. Samples were tested manually using the Bio-Rad Genscreen Ultra HIV Ag-Ab test (n=3800). This was a methodologically robust but labour intensive method. A validation study was later performed to ascertain whether automation of oral fluid HIV testing using the 4th generation HIV test on the Abbott Architect platform was possible. Methods: Oral fluid was collected from 143 patients (56 known HIV+ volunteers and 87 other participants having HIV serological testing) using the OraC+ device (Malvern Medicals PLC, UK). Samples were tested concurrently: manually using the Genscreen Ultra test and automatically on the Abbott Architect. Results: For oral fluid, the level of agreement of results between the platforms was 100%. All results agreed with HIV serology. The use of the OraC+ device produced high quality samples. Questionnaires administered during the initial pilot programs showed oral fluid sampling with laboratory testing to be acceptable to 96% of 528 respondents. Conclusions: Laboratory-based HIV testing of oral fluid requires less training of local staff, with fewer demands on clinical time and space than near-patient testing. It is acceptable to patients. The validation exercise suggests automation is possible with test performance preserved. This reduces laboratory workload and quickens releasing of results. Automated oral fluid testing is therefore a viable option for large scale HIV screening programs.

### PS6/02 Acceptability of rapid HIV diagnosis technology among primary health care practitioners in Spain

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Objective: To study the acceptability of rapid HIV testing among general practitioners and to identify perceived barriers and needs in order to implement rapid testing in primary care settings. Methods: An anonymous questionnaire was distributed online to all members of two largest Spanish scientific medical societies for family and community medicine. The study took place between 15th June and 31st October 2010. Results: Completed questionnaires were returned by 1308 participants. The majority (90.8%) of respondents were General Practitioners (GP). Among all respondents, 70.4% were aware of the existence of rapid tests for the diagnosis of HIV but were unaware of their use. Nearly 80% of participants would be willing to offer rapid HIV testing in their practices and 74.7% would be confident of the result obtained by these tests. The barriers most commonly identified by respondents were a lack of time and a need for training, both in the use of

rapid tests (44.3% and 56.4%, respectively) and associated pre and post test counselling (59.2% and 34.5%, respectively). Conclusions: This study reveals a high level of acceptance and willingness on the part of GPs to offer rapid testing in their practices. An adaptation of counselling and improved training in the use of rapid tests would facilitate the implementation of rapid HIV testing in primary care.

### **PS6/03 Feasibility and acceptability of HIV screening through the use of rapid tests by GPs in a Brussels area with an important African community**

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**Objectives:** To assess: 1) if HIV screening with rapid tests in neighbourhoods with an important African community is feasible and acceptable among GPs and patients 2) HIV incidence. **Method:** multicentric prospective study among trained physicians. Use of HIV standard test and INSTI Ultrarapid test. **Inclusion criteria:** MSM, sex worker, multiple sexual partners, returning/coming from an HIV endemic country, IVDU, Indicator's conditions as defined by HIV in Europe Pilot study: IST, HBV, HCV, lympho/neutropenia, dermatitis, herpes zoster, anal or cervical dysplasia/cancer, lymphoma, mononucleosis like illness. **Results:** From August 2010 to August 2011, 10 trained GPs proposed an HIV test to 224 patients: 51% ♀, 48% ♂, 43% Caucasians, 45% Africans. **Inclusion criteria:** 32% "high risk group, 9% returning from an endemic country, 29% with an indicator's condition 12 patients (6%) refused the standard test. The INSTI was proposed to 217 (97%), 197 achieved with 2 reactive rapid tests confirmed. **Incidence:** 1.8% (2.25% among Africans) 1.5% among patients with an indicator's condition 1087 consecutive consultations of the same GPs were recorded: 42% patients had ≥ 1 inclusion criteria among which 41% of proposed tests, that is to say 59% of "missed opportunities". The reasons for not proposing the test as recorded for 55% of patients: "not indicated" 44.5%, "no time" 33%, "impossible to propose" 15%, test completed previously 11%, known HIV+ 4%. **Conclusion:** standard and rapid tests are well received by patients but are rarely prescribed by doctors who have been trained.

## PS6/04 Stigma and discrimination on voluntary consultation and testing

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The purpose of the study was to outline the areas, which need to be strengthened, related to stigma and discrimination, when the testing and treatment is required by the patient. It is a quantitative and qualitative study based on: questionnaires, interviews, which proves that is based on facts, rather than probabilities. Main results: • 9 of 10 people of the general population of Moldova have low tolerance toward HIV-positive people • Each second HIV positive person was unemployed during the interview (52,9%) and 8 out of 10 (83,5%) had only graduated the school or have less education. • Each fifth of the questioned HIV-positive (18,5%), that required medical services within the last 12 months, were rejected because of their status. • 44,4% are sure there is a lack of confidentiality of diagnosis • Each second (50,4%) admitted that the medical workers revealed their status without their consent • More than a half of the questioned (53,8) admitted they have access and receive ART therapy • 90,7% evaluated the ART therapy being very accessible Conclusion: ' Low tolerance toward the people living with HIV, generates social tension among this group ' 42,7% of the questioned that follow the ART therapy live with HIV less than 5 years, which proves the late diagnosis of the infection ' Poverty, stigma and discrimination, the lack of confidentiality or the fear related to it, limits the access to medical services and negatively influences at the quality life of people living with HIV in Moldova

## PS6/05 How to estimate the size of the hidden HIV epidemic? The case of France

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Objectives: To estimate the size of French hidden epidemic. Methods: We estimated the size of French hidden epidemic using three methods: the direct method and two back-calculation models, an "historical" model using data on AIDS cases and a new model using data on HIV cases. The direct method combines estimates of undiagnosed HIV prevalence among one or several risk groups together with estimates of the size of these groups to obtain estimates of the hidden epidemic. Historical back-calculation model estimates HIV prevalence at a given time from which HIV incidence is extrapolated. Then removal of deaths and diagnosed cases allows obtaining the size of the hidden epidemic. New back-calculation model allows estimating not only incidence but also time interval between infection and diagnosis, therefore facilitating the estimation of the hidden epidemic. Results: Recently, undiagnosed HIV prevalence was found to be 0.14% (CI:0.08%-0.22%) in Ile-de-France (IDF) region. By multiplying this estimate by the population size of IDF, we estimated that 10700 (CI:6100-16700) individuals remain undiagnosed in IDF. Since 44% of HIV/AIDS cases are diagnosed in IDF, we then deduced that 24300 (CI:13800-37900) individuals live with undiagnosed HIV in France. Historical back-calculation estimated the size of the hidden epidemic at 25900 (CI:0-84900). Using the new back-calculation model, we estimated that 28800 (CI:19100-36700) individuals remain undiagnosed, 31% are MSM, 33% non French-national heterosexuals, 34% French-national heterosexuals and 2% IDUs. Conclusion: The three methods gave similar results: between 24000 and 29000 individuals remain undiagnosed in France. Increasing HIV testing opportunities is thus essential.



# Poster Sessions

## Poster category 1: Characteristics of PLHIV who present late for HIV care

### **PO1/01 Psychosocial dynamics of HIV late presentation - results and recommendations from a qualitative study in Germany**

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Objectives: Over 30 percent of new HIV diagnoses are currently characterized as “late” in Germany, posing challenges for treatment, counselling and prevention. The community-based research project aimed at identifying psychosocial backgrounds and dynamics that lead to late presentation. Methods: Based on a comprehensive review on medical and social science literature on late presentation a qualitative research design was developed. 32 interviews with medical, psychological and prevention experts and people recently diagnosed with AIDS-related diseases were carried out in 2009/10. The interviews were analysed using content and psychoanalytic approaches. Results: The analysis hint at heterosexual women, migrants and older MSM as those groups being most affected by late presentation in Germany and reveal different psychosocial dynamics in these groups. While a conjuncture of practitioner’s non-testing and a lack of patient’s concernment – both due to risk-group perception of HIV infections – could be found in heterosexual women, pre-conscious defence mechanisms of repression and projection due to internalized representations of “old AIDS” led to an avoidance of testing among MSM. These dynamics are essentially stigma-driven. In migrants knowledge deficits concerning transmission risks and care options play a decisive role in late presentation dynamics. Conclusion: The results demonstrate the inappropriateness of ‘test-and-treat’-strategies to counteract HIV late presentation in Germany. Low-threshold target-group and community-based counselling and testing should be accompanied with de-stigmatizing approaches, enabling rational test decisions by the individual. The supporting role of general practitioners in this process should be strengthened by developing symptom-based manuals; trainings for communication skill enhancement are needed.

## **PO1/02 Reduced proportion of peripheral CD4+ T-cells expressing IL-7 receptor (IL-7R, CD127) as peculiar feature of late presentation of HIV infection**

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Objective: We aimed to identify a broader immunological characterization of newly HIV-diagnoses with different degrees of immune depletion. Methods: We enrolled newly diagnosed HIV-positive patients at our Clinic in 2007-2011. Patients were stratified by initial CD4+: late presenters (LP, CD4+<350/mm<sup>3</sup> and/or AIDS)-intermediate presenters (IP, CD4+=350-500/mm<sup>3</sup>)-early presenters (EP, CD4+>500/mm<sup>3</sup>). Peripheral immune phenotypes (CD8+%, CD127+CD4+/CD8+%, CD95+CD4+/CD8+%, CD38+CD8+%, CD45RO+CD38+CD8+%) were evaluated (flow-cytometry). The groups were compared by ANOVA-Dunnett's test. Factors associated with LP were assessed by two logistic regressions (model-1 conducted on EP-LP, excluding IP; model-2 conducted on IP-LP, excluding EP). Given the recommendation to start cART with CD4+=350-500/mm<sup>3</sup>, we evaluated characteristics associated with IP by a third logistic regression conducted on IP-EP. Parameters with p<0.05 in univariate analyses entered the multivariate models. Results: The majority of the new HIV-diagnoses resulted LP (144/260, 55%), 36/260 (14%) were IP and 80/260 (31%) EP. Table 1 shows baseline characteristics of patients. In the model-1 of logistic regression (LP-EP), LP resulted associated with heterosexual contacts and lower CD127+CD4+%. The model-2 (LP-IP) confirmed lower CD127+CD4+% the only parameter associated with LP. Interestingly, lower CD127+CD4+% resulted associated with a trend toward statistical significance with IP (model-3, IP-EP), (Table 2). Conclusion: LP displayed an exhausted peripheral immune pattern, characterized by reduced IL-7R-expressing CD4+ proportions. Dysregulation of IL-7/IL-7R system should be further investigated as LP hallmark. A similar contraction of central memory CD4+ in IP suggests an exhaustion of the T-cell compartment despite relatively conserved CD4+, further strengthening the rationale of an early cART start.

## PO1/03 What is hidden under the late enrollment in HIV care: illustrative example of Odessa Region, Ukraine

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Objectives: HIV incidence is calculated in Ukraine based on a number of people with confirmed HIV (+) test result enrolled in care at specialized AIDS Centers. A high proportion of people tested HIV (+) and not enrolled in HIV care is not included in HIV incidence calculations. We aimed to examine effect of existing HIV incidence surveillance system on perception of leading routes of HIV transmission in Odessa region, Ukraine. Methods: We retrospectively compared annual HIV incidence among the cohort of residents of Odessa Region tested HIV (+) and enrolled in care aged 15-49 in 1995-2010, calculated by two methods: 1) number of HIV (+) testing results; 2) number of enrolled in care. Several stratifications were made, including 1) by the time of enrollment after being tested HIV (+)(same year vs. next years); 2) by sexual vs. injection way of transmission. Results: 31.9% of PLWH were enrolled in care after the first year following HIV (+) testing (more among PWIDs,  $p < 0.0001$ ). The epidemiological picture of the main ways of HIV transmission differs depending on the system of HIV incidence reporting (see Figure). The average difference in HIV incidence was 27,57% (IDU - 37,28% vs. sexual way -17,42%). Conclusion: Current HIV incidence surveillance in Ukraine deforms the picture of HIV epidemic and the role of different ways of transmission. HIV incidence may be calculated based on a number of HIV (+) test results; registration of new HIV cases at the time of confirmed HIV (+) testing should be recommended.

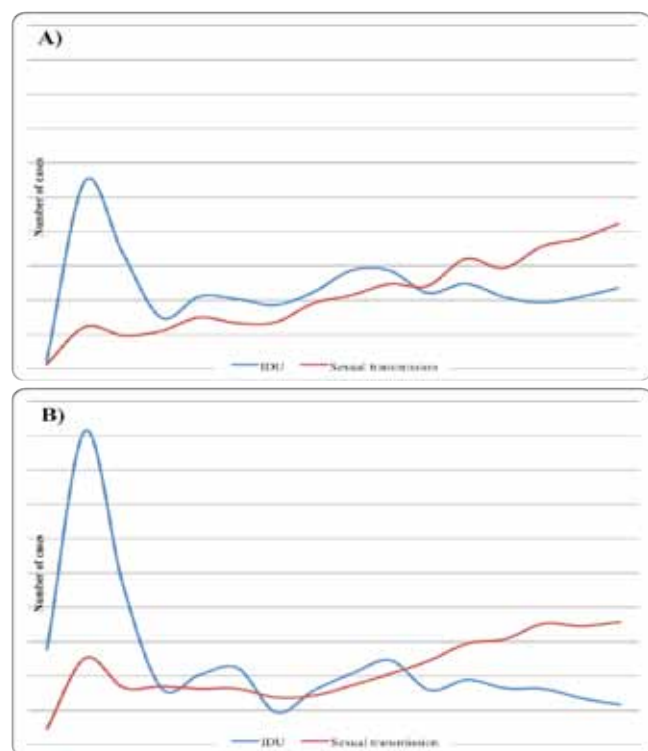


Figure 1. HIV incidence (PLWH enrolled in care) by the way of transmission in Odessa Region, Ukraine (aged 15-49; 1995-2010) calculated by: A) number of people enrolled in care (official statistic) B) number of people with HIV (+) testing results

## PO1/04 High risk groups for late HIV diagnosis in Georgia

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The study aims to identify high risk groups for late HIV diagnoses in Georgia to develop programmatic recommendations for the national program. Data on 2502 HIV positive individuals who were registered by the national HIV surveillance system and sought care at HIV treatment services during 2000-2010 were analyzed. Late diagnosis was defined by CD4 cell counts <200 cells/mm<sup>3</sup> or presentation with clinical AIDS symptoms at the time of diagnoses. A multivariate analysis in SPSS was conducted to evaluate characteristics related to late HIV detection. Administrative surveillance data for 2000-2010 shows that more than half of the newly registered HIV cases are detected late, which negatively affects treatment outcomes due to late entry into anti-retroviral care. Also due to late diagnosis more than a quarter of detected HIV+ patients have died. In a univariate analysis males and people older than 30 years have higher odds of being diagnosed late. Odds of detecting HIV among IDU are higher compared to other population groups. In a multivariate model IDUs and 30 years older have higher odds of presenting late for HIV diagnosis. Delayed diagnosis of HIV infection and related morbidity negatively affects HIV treatment outcomes. Although preventive and treatment interventions have been scaled up significantly, outcomes of the national response have not improved significantly over the past decade. The analysis shows need to focus more on IDU population to assure yearly detection and treatment initiation, which offers potential for improved treatment outcomes and higher survival rates for PLIVH.

Table. Characteristics of 2502 HIV infected people who present late for HIV care in Georgia (2000-2010)

|                  | N (2502) |       | Determinants of late diagnoses |                              |
|------------------|----------|-------|--------------------------------|------------------------------|
|                  | n        | %     | Unadjusted Odds Ratio (95% CI) | Adjusted Odds Ratio (95% CI) |
| Late diagnoses   | 1435     | 57.4% |                                |                              |
| Died             | 460      | 18.4% |                                |                              |
| Age              |          |       | P < 0.001                      | P < 0.001                    |
| < 30 years       | 739      | 29.5  | 1                              | 1                            |
| 31-40            | 1057     | 42.2  | 1.77 (1.47-2.14)               | 1.69 (1.39-2.05)             |
| 41 and more      | 706      | 28.2  | 1.86 (1.51-2.29)               | 1.76 (1.42-2.18)             |
| Gender           |          |       | P < 0.05                       | P = 0.553                    |
| Female           | 672      | 26.9  | 1                              | 1                            |
| Male             | 1830     | 73.1  | 1.33 (1.11-1.58)               | 1.08 (0.84-1.37)             |
| Risk group       |          |       | P = 0.001                      | P = 0.332                    |
| No risk group    | 916      | 36.6  | 1                              | 1                            |
| IDU              | 1432     | 57.2  | 1.34 (1.14-1.59)               | 1.14 (0.9-1.43)              |
| Other (CSW, MSM) | 154      | 6.2   | 0.53 (0.64-1.26)               | 0.89 (0.64-1.27)             |

## **PO1/06 Characteristics of PLHIV newly registered in Volga Federal District in 2008-2010**

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The aim of study is to describe population of newly registered HIV-positive people for the last three years in PFO. Data are obtained from the annual statistical form and elaborated mortality form. The number of initial HIV cases showed yearly increase with about half of them being IDUs. At the moment of registration considerable part of patients in 2008-2010 were diagnosed with the late stages of disease (4-5 according to the Russian classification of HIV-infection) - 22.5%, 23.9%, and 20.3% respectively. It contributes to the high hospitalization rate in the first year of follow-up (9.1% in 2010, tenth of hospitalized patients were admitted to the hospital at least twice). Goodly proportion of patients had to begin ART in the year of registration (9.8%, 11.5%, and 11.4% respectively). Because of low cell count these patients often required prophylaxis and treatment of opportunistic infections. In 2010 10.2% of newly registered patients received TB treatment, 5.7% - PCP chemoprophylaxis. Late presentation and low adherence to HIV care resulted in late ART start up. 49% of more than 5.000 patients started HAART in 2010 had CD4+ count less than 200, quarter of them less than 50. As a result lethality rate among intent-to-treat patients in 2010 was 3.8%. Annual lethality rates in patients registered in 2008-2010 were 3.6%, 3.5%, and 4.2% respectively. We might conclude that implementation of new testing strategies especially in main population groups with increased risk of HIV contracting allows improving quality and results of medical care for HIV-positive patients.

## **PO1/07 Late presenters at the HIV/STI clinic in Antwerp, Belgium**

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Objectives: To quantify the proportion of patients that presented late at the HIV/STI clinic in Antwerp over the period 1997-2010 and to document the risk factors for late presentation as a consequence of late testing, over the last two years. Methods: A retrospective analysis of the database of the HIV patients in follow-up at the clinic since 1997 was performed. To study risk factors for late presentation a prospective case control study was used. A case was defined as a patient who was diagnosed at our clinic with a CD4 lymphocyte count of less than 200/mm<sup>3</sup>. All participants were subjected to an anonymous structured questionnaire. Results: On average, 21.9% (range: 15%-30.8%) of the total annual number of new patients presented late, with a significant decreasing trend over the past 14 years ( $p < 0.001$ ). In 2009-2010, 42 cases and 59 controls were selected. In multivariable analysis, being heterosexual (AOR: 6.6 [95% CI: 2.5-17.2],  $p < 0.001$ ) and having complaints (AOR: 5.1 [95% CI: 1.9-13.6],  $p = 0.001$ ) were independent risk factors for late diagnosis. Nationality was not withheld in the final model ( $p = 0.100$ ), however non-African (AOR: 2.7 [95% CI: 0.9-8.6] and African migrants (AOR: 3.2 [95% CI: 0.9-11.9]) tended to present late compared to residents. Conclusion: Although we observed a significant decrease in the number of patients that presented late over more than a decade at our clinic, the statistically significant risk factors for being diagnosed late (being heterosexual, migrant, and having complaints), remain fairly constant. More efforts are needed to promote testing in those risk groups.

## **PO1/08 Trends in the characteristics of HIV infected individuals at diagnosis in Portugal - 2000-2011**

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**Objectives:** Early diagnosis of HIV infected individuals generates significant clinical and economic benefits not only to the individual, but also from a public health perspective. We aimed at evaluating the socio-demographic and clinical characteristics of HIV infected individuals at the time of diagnosis in the last decade. **Methods:** 1,073 patient records of individuals currently on antiretroviral therapy, followed at 20 hospital units in Portugal, were randomly selected and retrospectively reviewed. 28% were women, mean (SD) age at diagnosis was 37.7(11.7) years-old and a total of 62% were late presenters (CD4<350 cells/mm<sup>3</sup>). Comparisons of groups of patients by year of diagnosis were performed using Anova for continuous variables, Pearson's  $\chi^2$  test for categorical variables and Mann-Whitney U test for detection of tendencies/trends. **Results:** At diagnosis, data suggests a statistically significant decrease of CD4 cells/mm<sup>3</sup> ( $p<0.001$ ), time from diagnosis to ART initiation ( $p<0.001$ ), and HCV Co-infection ( $p<0.001$ ) over time. Data also suggests a statistically significant increase in log10HIV RNA copies/mL ( $p<0.001$ ), females ( $p=0.011$ ), age ( $p<0.001$ ), Africans ( $p=0.018$ ), homosexuals/bisexuals ( $p<0.001$ ) and late presenters ( $p<0.001$ ) over time. All results, namely the increase in the proportion of late diagnosis, remained statistically significant even when considering only the 2007-2009 versus 2010-2011 periods. **Conclusion:** While the sample may be biased by the fact that those diagnosed with a higher CD4 cell count are less likely to have died, the data available suggests that early diagnosis remains a challenge.

## **PO1/09 Recent infection and late diagnosis of HIV: a descriptive analysis of opposite ends of the spectrum**

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**Objectives:** In order to increase the early diagnosis of HIV, we need to understand both the characteristics of late presentation and recent infection. This study aims to describe characteristics of patients with recent infection (RI) and late diagnosis among a cohort of HIV infected people. **Methods:** The PISCIS Cohort is a prospective, open, multicenter cohort study of HIV infected patients aged over 16 and enrolled from January 1998 in 12 hospitals in Catalonia and the Balearic Islands. In order to identify RI, a Serological Testing Algorithm for Recent HIV Seroconversion (STARHS) was performed in adult patients newly diagnosed with HIV between 2006 and 2009; patients with cd4 count< 200 or presenting an AIDS-defining disease on enrolment were excluded. Late presentation (LP) was defined as a cd4 count< 350 on enrolment among patients newly diagnosed during the same period. **Results:** Of the 215 patients with RI and 827 with LP identified in the cohort, respectively 10 and 19% were female ( $p=0.003$ ); median age was 32.9 years -IQR=27.8-39.00- and 38.1 years -IQR=31.8-45.4 ( $p<0.0001$ ). Patients with RI reported sexual transmission in 93.0% and intravenous drug user (IVDU) in 1.9% while these proportions were 83.5% and 7.4% in LP ( $p<0.0001$ ). 34.8% of RI and 41.4% of LP were immigrants ( $p=0.19$ ). HCV and HBV co-infections were respectively 10.6 and 9.5% in RI and 15.5 and 6.0% in LP ( $p>0.05$ ). **Conclusion:** LP were more likely to be older, female and IVDU in comparison to patients with RI. Emphasis must be done on this targeted population.

## Poster category 2: Use and performance of new HIV testing diagnostic technologies

### PO2/01 Pilot study to analyze the feasibility of introducing rapid HIV testing in primary health care

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**Objective:** To analyze feasibility of HIV oral rapid test introduction in Primary Health Care (PHC). **Methods:** 1450 rapid oral tests were distributed among 77 General Practitioners (GP) volunteers of the Catalanian ITS sentinel network. GPs offered HIV rapid oral test (OraQuick ADVANCE) to patients with HIV risk criteria. After the study period, a feasibility questionnaire was distributed among all the participating GPs. The study took place between September and November 2010. **Results:** 665 rapid oral tests were performed and 3 reactivities were found (0.45%). According to the survey distributed after the study period, 100% of GPs found the rapid test performing and interpretation of results easy or very easy, and 86.1% rely plenty on the test results. The main barriers identified to offer rapid test were the cultural and language barriers with the patient and the lack of time to perform the test and the counselling. 86.1% considered that it would be desirable to have this tool in Primary Health care settings. 38.2% consider that the test should be performed by the physician, this percentage increases to 44.4% for the pre-test counseling, and increases to 61.8% for the post-test counseling in the case of a positive result. **Conclusions:** These results show a high acceptance of GPs to offer rapid HIV tests, and feasibility of rapid testing implementation in PHC. An adaptation of counselling to the different patient needs and more training in rapid testing technologies would help to facilitate the implementation of this test in primary care settings.

### PO2/02 Prevalence of HIV infection and acceptability of rapid HIV testing in patients attending emergency services

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**Objective:** To study the acceptability of rapid testing among patients attending emergency services and to estimate the HIV infection prevalence in that population. **Methods:** Two nurses offered oral rapid HIV test to patients aged 18 to 64 years attending the emergency department (ED) of Hospital de Mataró, who were able to provide consent for HIV testing. Exclusion criteria were self-reported HIV infection and inability to provide consent. The recruitment of participants was performed by a nurse after the patient triage. The sample calculated was 3,000 patients tested. **Results:** During the first 4 months of the pilot program, 1189 patients were offered the test. Of those, 89 refused (7.5%) and 1100 were tested. None of them obtained a reactive result. One patient, who was in the window period at the moment of testing, repeated the test 3 months later in the hospital HIV service, obtaining a positive result. Almost the half of people tested was men (49.4%), the median age was 38.5, 9.0% were immigrants and 33.4% had a previous HIV test. 74.1% thought rapid test is more comfortable than conventional test, and 68.5% preferred rapid test with oral fluid than with finger stick. 94.2% would recommend the test to a friend, and 96.4% thought that offer HIV testing in ED is appropriate. **Conclusions:** The preliminary results obtained show that rapid HIV screening in ED is acceptable and feasible, but hasn't detected any positive. Therefore, these preliminary results do not support the implementation of HIV screening in emergency services.

## PO2/03 Good practices in preventing AIDS—use of rapid HIV test in oral fluid

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Objectives: HIV/AIDS is a fast growing phenomenon in Greece. The stigma following the syndrome, fear and psychological burden of waiting the results creates the need of a rapid, accurate, anonymous test. The purpose of this study is the evaluation of the rapid HIV testing as a tool in secondary prevention. At the same time, the public level of awareness was examined and indirectly the efficacy of primary prevention actions until today. The study did not intend to focus only on native population but also to touch the migration flow that has affected the country during the latest years. Method: 1332 individuals were tested through the use of rapid HIV1,2 antibodies test in oral fluid. All individuals were between 18-61 years old and participated voluntarily. The following parameters were examined: sex, country of origin, previous dangerous behaviour, previous testing for HIV and outcome. Results: 67,11% of people tested were male. The great majority (88,28%) were Greeks Half (50,7%) had shown some sort of dangerous behaviour in the past and 48,2% had previously been tested. Finally, 3,2 % showed detection of HIV antibodies. Conclusion: Individuals with dangerous behaviour have higher relative risk to be infected. Men have fewer hesitations to being tested. Even though half have already been tested in the past, very high percentage continues to show dangerous behaviour. The number of positive results doesn't seem to reduce, fact that makes necessary the continuance for primary and secondary prevention since the benefit on social, economical and medical level cannot be ignored.

## PO2/04 HIV rapid testing in a mobile unit in several urban settings in Spain: a strategy reaching a different population?

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Objective: To evaluate a street-based rapid HIV-testing programme and its capacity of reaching populations who might find it difficult to access already existing diagnostic services. Methodology: 7860 individuals underwent rapid testing between 2008 and 2011 mainly in the city of Madrid. After taking the test, participants completed a self-administered questionnaire. Those with a reactive result were referred to public centres for confirmation. We compared the profile of the new diagnoses to the one shown at 20 free and anonymous Spanish Genito-urinary medicine clinics (GUM). Results: Of the 120 reactive tests, confirmatory result is known for 106 of them. Three were false positives. 90,7% of the new diagnoses were MSM (prev=3.9%), 44,3% immigrants (prev=2.1%) and 43.4% had a university degree (prev=1.3%). CD4 counts were available for 71.2%, 80.3% had >350 CD4. We had a slightly higher presence of immigrants than in GUM's (35.9%) a higher educational level and virtually the same percentage of MSM. 80.4% had been tested previously (48.8% in the previous 12 months). Aspects related to low risk perception were the main reason given by those with no previous test (55.6%). Conclusion: The programme showed a good capacity of detecting new diagnoses within heavily affected subgroups (MSM, Immigrants) in an early stage of infection, having little impact in subgroups with a lower prevalence but with a higher presence of late diagnosis (Women, heterosexual men). Sociodemographic and behavioural characteristics are similar to the ones in GUM's and, given their high educational level and testing history, they would have probably sought testing in normalized services more sooner than later.



## Poster category 3: Implications of stigmatisation, criminalisation of HIV and other legal issues for the offer and uptake of HIV testing and earlier care

### PO3/01 A focused response to HIV in Europe: policy recommendations from the Correlation Network II

Koen Block

European AIDS Treatment Group, Brussels, Belgium

Concerned about a resurgent HIV epidemic concentrated among key populations in the European Union and EFTA countries, service providers and community leaders from across Europe decided to develop policy recommendations to inform policy making in Europe, both at national level and at EU level, with a view to reducing existing HIV/AIDS-related health inequalities. Within the context of the Correlation Network II (CNII), a project funded by the European Commission, a set of 10 policy recommendations was created based on a survey and a literature review that focus on the HIV epidemiology affecting the four risk groups, the adequacy of current policies and programmes, and the implications and recommendations for policy makers at the national and EU levels. EU/EFTA States should ensure universal access to HIV services. They should scale up efforts to reach key populations, and ensure equitable access to services by removing barriers faced by MSM, people who inject drugs, migrants, sex workers and prisoners. They should ensure timely diagnosis, full ART coverage, and TB and hepatitis services to all PLHIV. The critical issue of late diagnosis of HIV infection should be addressed and the proportion of PLHIV who are delayed in starting ART because of late diagnosis should be reduced. These recommendations should become a tool to be used by community representatives at local, national and international level. The recommendations should support civil society, their advocates, policy makers and other actors to review and improve their policies.

### PO3/02 No NGO support for HIV-testing campaigns in prisons as long as rights of HIV-positive prisoners are not secured

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Objective: HIV-prevalence in Germany's prisons is in average 16 to 24-fold higher than in the general population. 14,3 to 17,6 % of prisoners are infected with Hepatitis C, a high percentage belongs to most-at-risk populations (IDUs, migrants). It would be important to initiate VCT-services in prison. Community-based testing campaigns are available outside prisons. Methods: Many NGOs working in prison record legal abuses related to an HIV-status. Germany is a federal state, uniting 16 states with own laws. Prisons are governed at state level, resulting into 16 different laws/practises. HIV-tests, as part of the medical examination at entry are organised differently, very often with complete disrespect of VCT standards and confidentiality. Results: Prisoners with HIV are often excluded from certain job options, like kitchen, bakery or laundry, with negative impact on income and training. To preclude HIV-transmissions prisoners are sometimes excluded from recreational-activities. Violations of confidentiality are recorded. In North-Rhine Westphalia prisoners with HIV are forced to out themselves, in case they want to participate in social activities. Such Practices prisoners' rights, they foster stigma and discrimination. Conclusion: Outside prison community-based testing campaigns are nation-wide promoted. Similar campaigns in prisons cannot get supported, as long as an HIV-status results into legal abuses and violations of fundamental rights. Measures against discrimination need to get established to secure the well-being of HIV-positive prisoners. Deutsche AIDS-Hilfe will not promote testing campaigns in prisons, as long as HIV-test results have negative and unforeseeable consequences. HIV-Testing must be accompanied with the promotion of human rights.

### **PO3/05 Stigmatization and Discrimination of People Living with HIV in Russia**

Sergey Smirnov

'Community of People Living with HIV'

Introduction: 'Community of People Living with HIV' with support from UNFPA and in cooperation with 'Levada Analytical Centre' and 11 Russian NGOs in 2010 conducted a survey on HIV related stigma and discrimination in Russia. Objectives: 1. Collect data regarding HIV-related stigma and discrimination; 2. Provide evidence based data for policy change interventions; 3. Build capacity and involve HIV+ people in the survey and follow-up advocacy activities. Methods: 1. Stigma Index original methodology was adapted to the Russian context. 2. Project participants/interviewers were selected from 11 NGOs in 11 cities. Each NGO-partner was represented by 3 HIV+ persons – survey coordinator, 1 male and 1 female interviewer. 3. Personal interviews 'side by side' were conducted by trained interviewers among 660 HIV+ respondents (50% men/50% women) in 11 cities. Period of data collection: March-April 2010. Results: •52% of respondents faced stigma and discrimination for their HIV status. 35% - for the past 12 months. •17% of those who referred to medical institutions, were refused in providing medical help. •78% experienced negative attitude toward themselves. Suicide ideas were experienced by 13%. •12% mentioned facts of violation of rights for the past 12 months. Only 18% took protective measures. •78% say that they do not have any influence on policy-making towards HIV+ people. •23% of female respondents at least once were advised by medical workers to avoid pregnancy. 4% of women were forced to sterilization. 21% of pregnant women were forced to terminate pregnancy. Conclusions: Full report: [http://positivenet.ru/files/stigma\\_index.pdf](http://positivenet.ru/files/stigma_index.pdf)

### **Poster category 4: Access to care and treatment for PLHIV**

#### **PO4/01 Providing universal access to services for people living with HIV in the Karaganda Region, Kazakhstan**

Yelena Bilokon

NGO "My House", Kazakhstan Network of Women HIV, Kazakhstan

Questions: At the beginning of 2010 in Kazakhstan, 13 784 cumulative reported HIV cases. More than 75% of them were unemployed person, 65% - injecting drug users (IDUs). Diagnosed with AIDS put 989 patients, most of whom live in the Karaganda region. To improve the social status of people living with HIV and to minimize the impact of the epidemic in the Karaganda region is taking steps to provide people living with HIV complex medical and social services. Description: In order to increase the availability, scope and effectiveness of NGO "My Home" implements social projects focus on prevention, care, treatment and social support for people living with HIV, injecting drug users and their families. The project - the interface between HIV prevention, strengthening of strategic partnerships, raising awareness of the target groups through workshops and training sessions. A key element of efforts to ensure the care of PLHA is a team of doctors, nurses, social workers and peer educators, who works in close cooperation with all organizations (medical, psychological, social) that provide services to PLHIV.

Total 735 customers have become parties to the social support. Counseling received 396 clients. Consultation in palliative care provided to 286 people. Created two self-help groups of PLHIV and their families. The key point is to create an initiative group network for women living with HIV in Kazakhstan. Lessons learned: The close cooperation and strong partnerships with government agencies has yielded good results when redirecting clients to obtain services. Creating a self-help groups was a good incentive to attract new members, to reduce stigma and discrimination, the formation of a tolerant attitude towards people with HIV. Next Steps: A model of multi-disciplinary team in a new format designed to enhance the access of target groups to the existing medical, social, legal, information and education services for people with HIV. The work of this model has allowed to establish sustainable partnerships of public and private structures.

#### **PO4/02 Home visits as the way of providing early care and help to people living with HIV (PLHIV)**

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Real World, Real People NGO, Yerevan, Armenia

Objective: Increase the availability of social, psychological and legal services for PLHIV. Methods: Many of PLHIV are diagnosed at a very late stage, when health condition is worse and they need to be admitted to hospital for inpatient care. Therefore, the full and timely provision of social-psychological assistance is only possible in home and hospitals through multidisciplinary team visits. Real World, Real People NGO created a mobile team consisted of social workers, peer-counselors, physiologist to provide social-physiological support to PLHIV through visits in home and medical institutions countrywide. The analysis of the dynamic of numbers of home visits was done. Result: From October 2010 till April 2011 42 home visits were implemented by the team to provide support to beneficiaries in general, 19 of them were in regions, 8 of them were in different medical institutions. From April 2011 till October 2011 77 home visits were implemented, 26 of them were in regions, 41 of them were in medical and other institutions. As a result of home visits PLHIV received social-psychological support, as well as their social activity, life quality and self-interest in their problems had increased. Conclusion: The doubled number of home visits during last six months and five fold increased number of visits to hospitals, in comparison with previous half-year, shows increased demand on these services, especially in hospitals. To make this service more effective we need to cooperate with all possible medical institutions where PLHIV may be admitted after they were tested HIV positive.

#### **PO4/03 Overcoming barriers on the way of early HIV care provision for MARPs in Ukraine**

Hanna Shevchenko

All-Ukrainian network of PLWH, Kyiv, Ukraine

A significant progress is observed in ART provision for HIV+ patients over the last years in Ukraine. Nevertheless the access of most at risk population to ARVs remains rather limited. Out of the general number of PLWH receiving ART (25 865 as of Oct 01, 2011) the active IDUs make only 7% though injecting drug use way of transmission makes 35% of the new infections registered annually. Key barriers • lack of awareness about HIV and benefits HIV treatment • drug use • lack of risk perception • discrimination by health care provider • unfriendly administrative procedures • presence of criminal laws against these marginalized groups Prevention and harm reduction programs for MARPs are usually the first and only point of entry into the public health care system. Compared to prevention programs implemented by NGOs, state medical facilities are high threshold institutions and often it turns out to be impossible to make it from the needle exchange point or mobile clinic to the AIDS center for ART and lab testing. It is crucial to establish effective liaisons between the point of entry of clients into the system of care to the , where they can receive medical care. Finding a way out • training programs for outreach workers of prevention programs on treatment literacy • connecting harm reduction programs with health services provision • development and implementation of a referral model tailored to client's need • addressing legal/ policy barriers

#### **PO4/04 Cost-effectiveness and cost-utility of earlier initiation of first line treatment for HIV-infected people in Spain**

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**Objective:** To assess the cost-effectiveness of initiating highly active Antiretroviral treatment (HAART) at CD4<500 cells/mm<sup>3</sup> ('early'-treatment) compared to initiating at CD4<350 cells/mm<sup>3</sup> ('late'-treatment) in HIV-positive Spanish patients. **Methods:** A Markov model was used to project lifetime costs and outcomes in HIV-positive patients over 6 health states defined by CD4 cell-count. Model inputs were obtained from literature and from a Spanish cohort of HIV-infected subjects and were validated in a Delphi panel meeting. All resources were estimated at 2011 prices from the perspective of Spanish National Health System (NHS). Uncertainty in the model's parameters was examined by one-way sensitivity analysis. **Results:** Total lifetime costs for 'early'-treatment were €350,062 compared to €343,820 for 'late'-treatment. 'Early'-treatment achieves a mean of 18.35 QALYs over patients' lifetimes compared to 17.99 QALYs for 'late'-treatment. Initiating treatment at CD4<500 cells/mm<sup>3</sup> resulted in an incremental cost-effectiveness ratio (ICER) per life year (LY) gained of €16,060 and per QALY gained of €14,543 over patients' lifetime. Sensitivity analysis showed that, under the assumption that earlier treatment would not avoid any new cases of HIV infection, the ICER of the 'early'-treatment would be €32,742 per LY gained and €32,309 per QALY gained. Reducing the time horizon to 20 years resulted in a lower ICER for 'early'-treatment of €6,476 per LY and €5,316 per QALY gained. **Conclusions:** Initiating HAART at CD4≤500 cells/mm<sup>3</sup> is a cost-effective option for the Spanish SNS compared to starting HAART at CD4<350 cells/mm<sup>3</sup>, especially when the public health benefits of reduced rates of transmission are taken into account.

## Poster category 5: Scaling up HIV testing within health care settings

### PO5/01 HIV/AIDS in Macedonia before 2004 and nowadays - how we made a step forward

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Objectives: - To examine the scaling up of HIV testing and the effects of earlier care and treatment among most-at-risk- population, as well as the introduction of ART for PLHIV in Macedonia. To correlate HIV/AIDS aspect defined prior to the first AIDS strategy and today's situation. Methods: - A descriptive analysis of progress in responding to HIV/AIDS had been conducted from 2004 to 2010, and had been compared with condition before 2004.-A preventive program for HIV testing and the number of PLHIV had been evaluated during this period. Results: Till the end of 2004, there had been no available ART and only 68 people in total had been diagnosed with HIV/AIDS. Out of these, 55 were AIDS cases and 85% of the cases had lethal outcome. For 17 years (1986-2003) only 49 589 HIV tests have been made. In 2003 the Country Coordinating Mechanism was established, as body that provides assistance in developing of the first coordinated program for HIV respond. By launching the HIV program through the GF and the introduction of ART, many people were encouraged for early diagnose and timely initiation of treatment. From 2004-2010 there had been 64 new cases of HIV/AIDS, of which only 16 had lethal outcome and more than 79 500 HIV tests have been made. Conclusions: Investment in access to VCT services, capacity and coordination mechanisms for providing a comprehensive response to HIV/AIDS must be kept and innovative approaches to services delivery must be developed in future.

### PO5/02 Approaches and results of youth HIV testing program

Iatamze Verulashvili

Women's Center, Tbilisi, Georgia

Objectives: Youth living with HIV and doesn't know about it . Country doesn't practice sexuality education programs at school, universities Student often unaware of the serious risk of infection and there is still stigma associated with seeking out HIV testing. Women's Center work on HIV/AIDS prevention program among youth , pregnant women which includes risk-reduction counseling, education ,hot-line, e-mail, face to face consultation, confidential HIV testing. Methods Using both qualitative and quantitative methods, the study gathered information on result of confidential free rapid ANTI-HIV test and interview 954 student respondents. Results: After 92 group discussion at 10 faculty of university , was organize rapid test by used ANTI-HIV strip. 467 student tested in confidential rooms at university and 97 practice home-based HIV-testing .487 student refuse testing as they feared the results of an HIV test. Result of interview show that Non-testers were significantly more likely than testers to agree that they are risk for HIV infection ( $p < 0.6$ ), to fear test result ( $p < 0.002$ ), to fear to lost family, friends as result of an HIV-positive diagnose ( $p < 0.3$ ). Majority of both group agreed that they were at risk for HIV infection and that they feared the results of an HIV testing.98, 8 % of respondents were being testing for the first time. 57% noted that they are sexual active. No new infections were diagnosed. Conclusions: The growing incidence of HIV infection has engendered and urgent needs for comprehensive education on a large scale among student

## **PO5/03 HIV counselling and testing (HTC) in Estonia: policy implications based on data triangulation**

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Objectives. The assessment aimed to analyze HCT trends in Estonia in order to provide direction for optimizing testing in health care and for vulnerable populations, as part of a larger triangulation project to analyse the course of the HIV epidemic. Methods. In-depth retrospective secondary data analyses were conducted (2010–11) applying data triangulation principles, using data from national databases and registries, study reports, articles, and programmes. Results. The highest burden of HIV is born in capital city Tallinn and north-east Estonia (90% of all HIV cases; 8–20 times higher incidence than in other regions). The number of people tested and of HIV tests has increased since early 2000s in all regions and among routine screening groups (e.g. pregnant women, TB patients, prisoners) and high risk groups (injecting drug users, sex workers). Still, many people engaging in high-risk behaviour do not access HCT. For example, 20% of IDUs report no lifetime HCT and more than 30% of HIV-infected IDUs are unaware of their status. Late diagnosis was estimated to be around 40% and more than half of diagnosed cases were not followed up. Conclusions. More vigorous HCT among vulnerable groups across the country and 18–49-years clients accessing health care in Tallinn and the north-east is needed. Risk-assessment and clinical indications-based HCT is recommended in other geographical locations. Because many people testing positive do not reach the health care system afterwards, referral needs improvement. Data triangulation is applicable for comprehensive data documentation and analysis to improve policy and programmatic guidance.

## **PO5/04 HIV prevalence among pregnant women that were not tested during pregnancy (St. Petersburg, Russia)**

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In Russia antenatal centres provide free dual HIV testing for every pregnant woman. However there are some women who either do not visit centres or not take HIV-tests. Objectives: Determine HIV prevalence, clinical and demographical characteristics of women not tested for HIV during pregnancy. Methods: In 2010 in first aid department of Botkin Hospital 75 rapid tests for pregnant women were done. Rapid test Determine® (Abbott) was used, positive results were confirmed by ELISA and Western Blott. Results: Of the 75 women 62 were in II-III trimesters, including 28 had not done HIV-test instead of recommendation and 34 were admitted to the hospital without contact with medical service earlier. Among 75 women 21 (28.0%) HIV(+) cases were detected. Characteristics of HIV(+) women: average age - 26,7±4,5 yrs, majority - jobless (20), single (19), IVUD (14), no contact with antenatal centre (19). Clinical categories - A1 (6), A2 (6), B1 (3), B2 (6). Obstetric/gynecology anamnesis: gynecological disorders - 11 cases, not-first pregnancy - 18, including 10 abortions. 19 women were delivered: 5 caesarean sections, 14 vaginal deliveries (labour activity before testing). In postpartum period 10 children were abandoned. Conclusion: Extremely high level of HIV prevalence among pregnant women without contact with antenatal centre were detected 28.0%. Majority of HIV(+) pregnant women, who were rapid tested for HIV, had had no contact with medical service until III trimester or labour. In spite of using rapid tests, HIV detection after labour has started affects caesarean section as a prevention of mother-to-child transmission.

## **PO5/05 Expanded HIV testing and community engagement: a strategic framework for scaling up HIV testing, engaging all sectors and changing the HIV response paradigm**

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Municipalities worldwide are scaling up HIV screening/testing. Several North American, European and African cities have experiences in launching and managing large scale public health HIV testing campaigns and implementing HIV testing routinization strategies. Utilizing a mixed method approach, the scale up initiatives and expanding HIV screening/testing efforts undertaken have combined print and media campaigns, think tanks and focus groups, celebrity and physician ambassadors, philanthropic and corporate leaders, pharmaceutical representatives, persons living with HIV, community health centers, emergency and trauma centers, community-based AIDS service and faith-based organizations with special concerts, public venue testing, high profile community/civic and religious leaders to garner attention and support broad-based HIV screening/testing implementation. These HIV screening/testing programs have been effective in reaching HIV positive individuals and linking them to care. Expanded HIV screening/testing programs that utilize a municipal model have been successful in identifying traditional and non-traditional partners. Municipal HIV screening/testing initiatives reach those who would not 'normally' think HIV is anything to be concerned about, thereby helping to expand awareness and address stigma. HIV testing is for everyone.

## **PO5/06 HIV testing in Clinical Center of Vojvodina, Serbia**

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Introduction: Serbia is a low prevalence country, but also a country with poor testing rates of only 7.7 tested per 100000 population. This causes late presentations and hospitalizations in different clinics before the HIV positive status is established. Material and methods: A short survey on physicians in Clinical center of Vojvodina done during November 2011. Results: A total of 123 physicians were surveyed, medium age 43,5, mainly female (70%). The main reason for offering HIV test was an assessment of risky behavior (77.2%), less frequently symptoms (31.7%) or routine testing (6.5%). Half of the doctors see mandatory patients' consent as an obstacle to test (48,8%). Fifth of the doctors in this survey have never asked for an HIV test (19.2%) or at least didn't ask for it the last 12 months (44.7%). When asked for specific reasons the main argument for not testing was patients' unwillingness to test (Graph 1.). In dermatology, neurology, internal medicine and psychiatric clinic the chief reason for not testing was physicians' perception of low risk population of patients (50%, 32%, 27%, 35% respectively). Gynecology and obstetrics clinic doctors admitted they don't prioritize HIV testing in their everyday work (29%) and rarely think of testing (24%). Compared to older physicians younger physicians (39 and younger) were more likely to blame the lack of time and believe HIV is not their responsibility ( $p<0.001$ ;  $p<0.05$ ). Conclusion: More education for pretest counseling and about HIV is needed, especially for young physicians.



## **PO5/07 Determinants of HIV testing in the general population in Portugal**

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Among HIV infected individuals in Portugal, illness/hospitalization has been identified as a major reason for being tested for HIV and perception of low risk pointed as the main reason for not having been tested prior to diagnosis (Carvalho 2009). We aimed at understanding whether these results are observed in the general population. Data were collected within a study of sexual patterns of behavior and the HIV/AIDS infection in Portugal evolving 3,643 randomly selected individuals, aged 16 or older, nationwide. Logit regression was used to evaluate the determinants of HIV testing. Mean (SD) age was 36 (13) years-old. 19% had been tested in the previous 12 months. 38% answered correctly to 100% of HIV knowledge questions. 4% classified their own health status as bad/very bad and 16% had been diagnosed with chronic disease or disability. 29% of men and 10% of women had more than one partner last year. 31% of men stated to have paid for sex (lifetime). Younger women are more likely to have been tested than those above 46 years old. Among males, determinants were “currently having multiple partners” (OR=1.7 p=0.03) and “the lifetime number of conjugalities” (OR=1.2, p=0.001). The number of partners last year, having unprotected sexual relations and ever having paid for sex were not found to be statistically significant. In this analysis, health indicators do not show as a determinant of testing. Among men, not among women, some but not all sexual risk factors are found to influence the probability of being tested.

## **PO5/08 Early HIV infection: Demographic features and risk factors among individuals with early HIV infection in Ireland 2008-2011**

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Acute HIV infection may account for up to half of all HIV transmissions. Identification of acute HIV infection provides an opportunity to target interventions to prevent further transmission. Although half to three quarters of acute infections may be symptomatic, many infections are unrecognised. This study highlights the value of serology testing in guiding Public Health interventions.

We reviewed all confirmed HIV diagnoses in Ireland between 2008 and 2011 (n=1,404). Acute HIV diagnosis is defined as;

Evidence of an HIV negative test in the previous twelve months.

Detection of HIV p24 antigen on first diagnosis.

Application of the INNO-LIA HIV confirmatory assay banding pattern (Schupbach et al, 2007).

Acute infection was identified in 17% of the cohort (n=239). Risk factor data were available for 91% (n=218), of whom 61% (n=134) were men who have sex with men (MSM), 28% (n=62) were heterosexual and 10% (n=22) were injecting drug users. Over time, the proportion of recent HIV infections attributed to MSMs increased steadily (38% in 2008 to 69% in 2011). A number had detectable p24 antigen suggestive of primary or acute HIV infection (n=52). Of these 71% were among MSM. Irish MSM more frequently test for HIV than other risk group populations and are therefore more likely to present early in the course of their illness. In conclusion, early diagnosis, effective counselling and behaviour modification can prevent onward transmission of HIV. This study demonstrates that laboratory testing for early infection can help to target effective Public Health interventions.



## Poster category 6: Results from the evaluation of VCT programmes

### PO6/01 Approaches and results from the evaluation of VCT in the Pavlodar region of Kazakhstan

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VCT is an effective and economical method of HIV prevention. Pavlodar is the leader of the republic on the frequency of infection, it is region of concentrated epidemic. The purpose of the research is evaluation of the implementation of VCT in the region. A qualitative study of focus PLH group provided the basis for develop a methodology for the research. Was conducted a mixed research: qualitative and quantitative analysis. Carried out: 1.observation for counseling in 16 points, were evaluated 24 specialists (the finite population). 2.Interviewing 24 consultants, 16 managers VCT. 3.interviewing 80 PLHIV 4.Questioning 80 PLHIV, assess the level of awareness of HIV, mental and emotional status by the Beck depression score. For statistical analysis we used the method of multidimensional groups. In a research: 1.Satisfactory availability of VCT 2.Unsatisfactory quality of counseling. 2.1.The level of knowledge of counselors is high, level of HIV awareness of PLHIV is middling. 2.2.Level of emotional burnout of counselors is high, level of depression PLHIV is high. 3.Level of stigma in society is high, Level of risk behavior among people PLHIV is high. Conclusion: inefficiency of HIV counseling associated with the underestimation of the importance of the process for addressing the HIV epidemic; low empathy, psychological aloofness health workers, formalization of the counseling process. The recommendations on ways to reduce these phenomena are presented in the Department of Health and Republican AIDS Center. Was published manuals for consultants.

The work was done by KSPH in conjunction with KazUnionPLHIV

### PO6/02 The role voluntary counselling and testing in early diagnosis of HIV infection

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Objectives: to describe results of voluntary counselling and testing (VCT) in Autonomous Province of Vojvodina, Serbia (APV) in 2002-2011. Methods: analysis of surveillance data from all VCT centres in APV, including public health institutions, prisons, outreach activities and drop-in centres. In 2002 VCT program in APV is expanded, followed by surveillance system of VCT uptake and outcomes. Data about age, gender, sexual orientation, drug use, sexual work, presence of other sexually transmitted infections and HIV, HBV and HCV test results are collected. Results: Significant increasing in VCT uptake is observed, with maximum in 2006, following Global fund project as a resource for HIV tests with the rate 143.2 per 100,000 population and declining in 2007, when Global fund project was temporarily interrupted. Most of the clients are 20-39 years old and about 60% of clients are males. The significant increasing of the most vulnerable population covered by VCT is observed, especially in men having sex with men. Most of HIV cases in this period were diagnosed in VCT centres, compared to patients tested in health care facilities. HIV cases diagnosed in VCT centres are more often presented in early stage of HIV infection than HIV cases diagnosed in health care facilities. Large regional differences were observed in VCT uptake in APV. Conclusion: VCT could be the most important tool for early HIV diagnosis, but it depends on organisational capacities of VCT centres, procurement procedures, sustainability of programmes and promotion of VCT.

## **PO6/03 Evolution in the number of tests performed and in the profile of people tested in VCT network of Catalonia, 1995-2010**

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Objective: To analyze the evolution over 15 years in the number of test performed and in the profile of people tested in the VCT network of Catalonia. Methods: Descriptive analysis of data collected in VCT network (currently comprising 12 centers) for 15 years. Results: The yearly evolution of the number of tests performed in VCT centres was relatively small until 2006, oscillating between 716 in 1995 to 1,849 in 2006. At the end of 2006 rapid HIV test was introduced into VCT centres, increasing the demand for HIV test. Comparing the number of tests performed in 2007 with respect to those performed in 2006, an increase of 102.9% is seen. The number of tests performed has continued increasing yearly, reaching the 7,822 tests in 2010 (an increase of 323.04% over 2006). Despite this increase in the number of tests performed, the percentage of positive tests detected has not varied significantly. The proportion of MSM tested in these centres has been increasing, and at the same time the proportion of IDU has been decreasing. Regarding positive tests, from 1996 until 2004 the largest group was IDU, but from 2005 the proportion of IDU was decreasing and MSM was increasing, reaching 85% of the total of positives detected in 2010. The risk group with the highest percentage of positive results over the whole period was IDU. Conclusions: Rapid HIV testing can help increase access to testing, but it should be complemented with specific outreach programs aimed at the most vulnerable subgroups.

## **PO6/04 HIV Testing and Counseling (HTC) in EECA: entry point for curbing the HIV epidemic**

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HTC is essential to increase access to and uptake of essential HIV services. There is evidence of a decreasing trend in HTC among key populations at greatest risk, hard-to-reach and inadequately served - 45% of IDU, 38% of MSM, 48% of SW coverage in 2009 in EECA. The increase in tests performed in health care settings in EECA does not result in improved access of key populations to HTC and other HIV services. 20-25 million tests are conducted in Russia each year. The number of HIV tests performed among IDUs was 277000 in 2009 despite the fact that 61% of HIV cases registered in 2009 were due to unsafe injection practices. Stigma, discrimination, human rights violations, repressive legislation against the key populations are barriers to HIV-prevention, treatment, care and support. Some countries criminalize homosexuality and in many countries the police abuse of sex workers and drug users. In the context of rampant police abuse, mandatory testing is used to extort or punish key populations. Migrants avoid HIV-testing out of fear of being deported. Governments must repeal laws that discriminate against key populations, eliminate mandatory testing and ensure their access to voluntary and confidential HIV-services and treatment. HTC must account for specific needs of hard-to-reach populations. HTC must expand beyond clinical settings and be community-based among hidden populations. Rapid testing must be universally available in community based and outreach programs. Individuals must be linked directly to prevention, treatment and care services at the time of testing.

## **PO6/05 A non-healthcare HIV test clinic improving testing and linkage to care**

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Background and objectives: In Sweden, migrants are overrepresented among those newly diagnosed with HIV, however The Swedish Institute for Communicable Diseases estimated in 2009 that only 38 % of migrants seeking asylum were actively offered an HIV test suggesting the need for further efforts, beyond regular health care, to reach this population. The project explores an alternative approach to target difficult-to-reach groups and provide linkage to care. Method: An HIV test clinic was established in Stockholm offering quick-test (Alere Determine HIV-1/2 Ag/Ab Combo) on a “drop-in”, free-of-charge basis in a non-healthcare setting. Target groups are migrants, other vulnerable groups and individuals worrying over their HIV-status. Individuals testing positive are rapidly referred to a General Hospital for further care. Results: From 04 November 2009 until 08 December 2011, 1764 (1106 men, 658 women) individuals were tested. 457 (28%) were migrants, 270 (15%) men who have sex with men and 8 (0.5%) were injection drug users. 12 tests were positive. The most common reasons for testing where: “wish to know status” (47%), new relation (16%), HIV related anxiety (6%), own infidelity (6%). The leading cause for choosing this setting was the quick-test (61%). Conclusions: A drop-in, free-of-charge test clinic in a non-healthcare setting using the quick-test method has attracted a significant number of individuals to take a test and 12 HIV infections have been detected over ~ 2 years. Among difficult-to-reach groups, migrants constituted approx ¼ of testers while IDU’s have not been reached. The outcome warrants further development of the concept.

## **PO6/06 Towards full coverage of HIV Counseling and Testing services in Rwanda, 2003 - June 2010**

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Background: HIV Counseling and Testing is an important cornerstone for comprehensive prevention, Care and Treatment. The national HIV prevention program has set as a priority to test and provide HIV results to 50% of the Rwandan population by 2012. Methods: Monthly reports of aggregate HCT client’s demographic data are collected from all health facilities offering HCT session in Rwanda. These findings are derived from secondary analysis of 18,569 HCT from January 2003 to 2010. Results: HCT services have increased from 44 in 2003 to 419 in June 2010. The proportion of HCT services are 72% North, 81% South, 77% West, 82 % East and 90 % Kigali City. Between 2003-June 2010, 5,110, 565 tests were performed, peaking in 2010 with 140,064 tests/month for an estimate of 1,600,000 tests in 2010. Females had higher uptake of VCT (54%) compared to males. Of people tested, 20 % were aged ≤ 18 years, 33% aged 18-25 years, and 47% aged > 25 years. Overall HIV positivity rate was 5.9% in population >25 years, 2.8% in 18-25 years and 1.9% in those ≤ 18 years. Overall HIV positivity by sex was 4.5% in female and 3.7% in male clients. As HCT programs scaled up to rural areas, HIV positivity decreased from 11 % in 2004 to 2.3 % in 2010. Lessons Learnt: The scale up of HCT services in Rwanda has been successful. The target set by National HIV Prevention Strategy to test and provide results to at least half of Rwandan population is feasible.

## **PO6/07 Possibility for improvement for counseling and testing for early diagnoses of HIV infection in Armenia**

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Objective: To evaluate the importance of HIV TC in HIV early detection. Methodology: Some data of conducted HIV tests and of HIV patients diagnosed in 2007-2010 were studied. Patients were divided into two groups: I - CD4+<350, II - CD4+>350. Results: 279,090 people underwent HIV testing, whereof 542 received HIV diagnosis. Though the increase in HIV testing is insignificant, (2007 - 64,242, 2010 - 71,882), the number of detected cases increased - 109 and 148 respectively. 70.5% of diagnosed people underwent CD4 tests. As a result, 59% made up I group, 41% - II group. Comparison shows that the ratio practically has not changed (57% in 2007 and 61% in 2010 belonged to I group). First group were those mostly tested according to clinical presentations - 48%, patients' partners - 14%, HIV positive returnees - 12%, PWID - 8%. Second group were those undergone client-initiated testing - 32%, patients' partners - 20%, pregnant women 14%, PWID - 8%, prisoners - 4%, etc. 84% of 128 patients tested due to their clinical presentations belonged to I group. Conclusions: HIV in Armenia is mostly diagnosed at late stages. Increase in HIV testing has not resulted in increase in HIV early detection, because PLHIV present lately to health care facilities. The study shows that HIV at early stages is detected mostly in clients initiating HIV testing, pregnant women, prisoners. It is necessary to promote client-initiated TC and to motivate, through outreach workers, the key populations at higher risk to use HIV TC services.

## **PO6/08 Mental health care component in VCT services**

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The study was conducted as part of the project "Developing HIV/AIDS & Mental Health Programs in EU countries - MAIDS" co-financed by EAHC in 10 countries (BU, CZ, EST, HU, LV, LT, PL, RO, SL, SI). The study was aimed at the identification of mental health related services accessible in three types of facilities providing care for PLHA (Centers for HIV counselling & testing; ARV therapy Centres and other organizations providing mental health care and support for PLHA); description of structural and organisational issues of provided services, i.e. their accessibility, scope, financing etc. with a stress on provided mental health care. The research was based on a questionnaire distributed among 340 facilities out of which 146 responded. Among them 105 facilities (72%) reported providing HIV testing, 110 (75%) - HIV pre-test counselling, 103 (71%) - HIV post-counselling. Around 50% reported having established procedures of referrals to mental health care: only for people with HIV - 78 (53%) and for all patients and clients with emotional and psychological problems - 70 (48%). Consecutive study is currently implemented in Poland, verifying the need for the extension of the scope of VCT services. The study is based on a anonymous questionnaire for VCT center clients in which they may name additional services they would like to be offered at VCT center, including consultation of a psychologist (not in connection with HIV-testing), psychiatrist etc. and self-assess their state of mental health. Final results will be available in the middle of February.

## **PO6/09 Community Expanded Access to Test (CEATt): HIV testing project in Newham**

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NHS Newham, London, UK

Background: HIV/AIDS present a major Public Health problem in Newham, London. By 2010 a total of 1401 people were reported to be living with HIV/AIDS. Black African population are disproportionately affected, even though they represent only 9.5% of the population in Newham, they account for over 60% of HIV/AIDS cases. In addition, black Africans are at the greatest risk of having their HIV positive serostatus diagnosed very late with over 40% diagnosed with a CD4 count less than 200cells/mm. In order to address the problem of HIV among black Africans, NHS Newham implemented the Community Access to Test (CEATt) project in 2008.

Objectives:

- Promote the benefits of HIV testing
- Increase the number of people who know their HIV status
- Increase availability and range of HIV testing services

Methods: The project had three components: community mobilisation; rapid testing in non-clinical settings; and rapid testing in Primary care and Pharmacies. Implementation was in two phase.

Phase (1) testing in non – clinical community venues delivered by voluntary sector providers (October 2008 – July 2011). Phase (2) testing in primary care (GPs) and community pharmacies (September 2010 - )

Results: From October 2008 July 2011 the project carried out 2188 tests. There were 31 reactive results of which 4 already knew of their HIV positive status and 1 false reactive result. Conclusion: The project was able to reach many people who were unaware of the HIV status previously. Community mobilisation activities helped generate awareness and improve acceptability of testing.

## **Poster category 7: Lessons learned in the implementation of HIV testing strategies for migrants**

### **PO7/01 Copenhagen Central Station as HIV-testing site for migrant populations**

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Cross-Over, Copenhagen, Denmark

Objectives: To compare HIV-test offered on a daily basis from Cross-Over (CO), a discrete counselling service for migrants, with a HIV-testing site from tent at Copenhagen Central Station (CCS) to see which test-site are most popular, with special focus on the African group. Methods: To test whether an offer for HIV-test can be utilized in more public and visible environments, HIV-test was offered from a tent at CCS once a month since November 2010. As the African population is known to be highly affected by HIV it was important to see if we reached this group at CCS. Surveyed period: 1 November 2010 – 31 November 2011. Results: The tent at CCS was operating 12 times, 12-18 pm (72 hours). The CO testing was open on a daily basis, with walk-in service once a week, 4 and 7 PM (168 hours). 93 people have been tested at CCS, 160 people at CO. 3 out of 4 testers at both test-places were men. The African group represented 24 % at CCS, 31 % at CO. First-time testers: CCS, all 46 %; African group 23 %; CO, all 27 %, African group 32 %. No positive tests found. Conclusion: A highly visible site at CCS turned out comparatively to reach more people than the more discreet and stationary offer at CO; the African group however to a lesser extent than at CO. In general more first-time testers were reached at CSS than CO. Among the African group more first-time testers visited CO.

## **PO7/02 PARC-Project – prevention of AIDS with the resources of communities**

Sabine Lex

Aids Hilfe Wien, Department of Prevention, Vienna, Austria

Background: Sub-Saharan African migrants (SAM) are one of the MARP in Vienna. They are about five times more at risk to get a late diagnosis. Goal: To reach SAM with prevention messages including knowing ones HIV status. Method: Based on the participatory quality development model an outreach peer project was implemented. Peer educators from different sub-Saharan countries defined in a participatory approach prevention messages and settings (e.g. African shops, hairdressers, churches, bars, nightclubs, parties, other events) for prevention work. Five key messages ' HIV/AIDS is not a death sentence! ' Know your status - get tested! ' Using a condom prevents you from getting HIV! ' Social contacts with HIV+ people don't put you at any risk! ' Hepatitis B is a viral infection of the liver - get vaccinated! were communicated by the peer educators to their communities handing out information materials, male and female condoms as well as vouchers for free HIV rapid testing and Hepatitis B and C screening at Aids Hilfe Wien. Outcome: During the three-month project period, 5.195 people were reached through nine peer educators. Though feedback from SAM communities was generally positive there are still barriers to VCT highly related to stigma. Nevertheless, the approach of Peer Education brings lot of advantages: ' Peer Educators (PE) are experts in their communities ' PE bring in their experiences and are a communication channel ' PE act as role models ' Bridging the gap between organization and communities

## **PO7/03 Outreach project for HIV testing in an immigrant community**

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Objectives: Data on HIV infection in Portugal shows that a very high – between 70 and 80 - percentage of diagnosed and notified AIDS cases had the very first HIV test performed in the same year. This may indicate that an AIDS clinical diagnose was, at least simultaneous with the laboratorial diagnose. Methods: Starting January 2012, counseling and testing facility will be located within an immigrant community (mainly from Guinea-Bissau, where HIV prevalence is estimated at 2.5%). This intervention will involve about 400 individuals. "Pears", will be trained to assist in spreading the message during and after the project. Expected Results: It is expected that 70% of people will (i) acquire basic knowledge about HIV, HCV, HBV and other STDs; (ii) reveal an attitude of acceptance and non-discrimination of people infected with HIV/AIDS, (iii) demonstrate a positive attitude and intention to use condoms. Expected that 50% of residents will be tested for HIV, HCV, HBV, syphilis and that all new diagnosis will be adequately referred to care according to national recommendations. The project will also allow for the Characterization of knowledge, attitudes, drug use, sexual practices related to HIV, and access to health services. It will also provide estimates of (i) the number of diagnostic cases with CD4 + counts <200 cells/mm3 avoided, (ii) the prevalence of infection in this community and (iii) the cost per additional case of HIV, HBCV, HBC and syphilis infection linked to care.

## Poster category 8: Lessons learned in the implementation of HIV testing strategies for IDUs

### PO8/01 Low testing uptake and their determinants among IDUs in Georgia

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The study aimed to evaluate HIV testing uptake among Injecting Drug Users (IDUs) through Bio-Behavioral Surveys in five cities of Georgia. Study used data from Bio-Behavioral surveys conducted in 2008-2009 among IDUs in five cities of Georgia. Recruitment was done through respondent driven sampling. Interviews were conducted using standardized behavior questionnaires. The study protocols and questionnaires were approved by Ethical Committee of the HIV/AIDS Patients Support Foundation. Data of 1,112 IDUs was analyzed in SPSS. Majority of IDUs (71.2%) were never tested on HIV during their lifetime. IDUs older than 30 years were more likely not to be tested on HIV. Those who injected Ephedrine and Buprenorphine during last month had higher odds of not been tested compared to heroin users. IDUs from Gori and Telavi were more likely not undergo test, while not testing was significantly lower among Batumi IDUs compared to the capital city residents. Not knowing of HIV testing possibility in the neighborhood was significantly associated with never being tested. After adjustment the young age (<30 years), residency in Gori and Telavi and lack of awareness about HIV testing possibilities remained significantly associated with never testing for HIV among IDUs. Despite intensive preventive interventions HIV testing uptake is very low, specifically among young IDUs. Awareness about HIV testing capabilities in the community should be increased especially in certain geographical locations. Focusing on individuals injecting Ephedrine and Buprenorphine and being younger than 30 years is important to increase HIV testing rates among IDUs.

Table: Univariate and Multivariate analyses of no testing on HIV among IDUs in 5 cities of Georgia

| Indicator   | N=1112 | Never tested on HIV            |                              |
|---|--------|--------------------------------|------------------------------|
|   |        | Unadjusted Odds Ratio (95% CI) | Adjusted Odds Ratio (95% CI) |
| Never tested on HIV   | 71.2%  |                                |                              |
| Age groups  |        | p<0.005                        | p<0.005                      |
| <30 years   | 31.2%  | 1.0                            | 1.0                          |
| 31 - 40   | 35.3%  | 0.58 (0.42-0.80)               | 0.59 (0.42-0.83)             |
| 41 and more   | 33.5%  | 0.96 (0.50 – 0.98)             | 0.76 (0.53-1.09)             |
| Types of drugs injected in the past month (single drug):        |        | p<0.0001                       |                              |
| Heroin  | 33.6   | 1.0                            |                              |
| Ephedrine   | 9.2%   | 2.6 (1.50-4.52)                |                              |
| Buprenorphine   | 17.7%  | 2.19 (1.46-3.29)               |                              |
| Multiple/ Other   | 39.5%  | 1.35 (1.01 – 1.82)             |                              |
| City of residence   |        | p<0.0001                       | p<0.0001                     |
| Tbilisi   | 27.3%  | 1.0                            | 1.0                          |
| Gori  | 18.0%  | 2.02 (1.32-3.09)               | 1.76 (1.12-2.77)             |
| Telavi  | 18.4%  | 3.69 (2.26-6.02)               | 3.21 (1.91-5.39)             |
| Zugdidi   | 18.3%  | 1.04 (0.71-1.52)               | 1.05 (0.69-1.58)             |
| Batumi  | 18.0%  | 0.57 (0.39-0.83)               | 0.64 (0.41 -1.0)             |
| Awareness about possibility to get HIV testing in the community |        | P<0.01                         | P<0.01                       |
| yes   | 81.9%  | 1.0                            | 1.0                          |
| no  | 18.1%  | 2.16 (1.46-3.19)               | 1.72 (1.14-2.60)             |



## **PO8/02 Factors influencing HIV testing among injecting drug users in Lithuania**

Loreta Stoniene

Institute of Hygiene, Division of Public Health Research & UNODC Project Office for the Baltic States, Vilnius, Estonia

Objectives: The purpose was to investigate HIV testing coverage and related factors of better access to testing among injecting drug users (IDUs) in Lithuania. Methods: Using peer-driven intervention (PDI) model 367 IDUs were reached in six needle/syringe programs (NSPs) in Alytus, Druskininkai, Kaunas, Mazeikiai, Visaginas and Vilnius. 324 (88.3 %) of them were new clients who were selected for further analysis. Sample consists of 85.4% heroin and 14.6% amphetamine injectors, 10.2% were younger than 20 years, and 29.6% belongs to 20-25 years age group. 35.5% injected drugs less than 5 years. 259 (79.9%) respondents were male, 62.9% of male and 35.4 % of female have been in prison. Results: Results showed that 68.8% of new clients (71.4% male and 58.5% female) reported that they have been tested for HIV during life time. The main reasons were imprisonment (48.0%), 26.7% by own volition, 12.5% in drug treatment institution. During 12 month have been tested for HIV and know result 43.8% of clients (46.3% male and 33.8% female). The main factors influenced better access to testing was age, gender, injection time and imprisonment ( $p<0.01$ ). Those who are younger; had shorter injection history and women are less tested for HIV. Conclusions: Majority of respondents are never reached by NSPs. The biggest problem is that younger injectors with less injections history and female missed opportunity to information/education/counseling and ARV treatment, care and support on time and to mother to child transmission prevention.

## **PO8/03 Results of piloting peer driven intervention – did we reach targeted population?**

Lile Batselashvili, M Sinjikashvili, M Chelidze, I Kirtadze, N Topuria

Addiction Research Center, Alternative Georgia, Tbilisi, Georgia

Objective: Estimated number of injecting drug users (IDU) in Georgia is considered to be 40 000. In 2010, 9 combined centers consisted of Needle and Syringe Programmes and Voluntary Counseling and Testing. The traditional way of outreach work does not recruit some sub-population of IDU. The enrollment of young (aged 18-25) injectors and women IDU in harm reduction services has been very low. Method: The peer driven intervention (PDI) has been developed in response to the problems with traditional outreach. PDI includes both a health education component and a recruitment component. In 2010 Georgia Harm Reduction Network piloted PDI model among IDUs. This intervention was done in 5 cities of Georgia by 6 harm reduction centers. Results: during the 4 months intervention the total sample size of recruited IDUs were 815, while in 2009 the number of newly recruited IDUs consisted of 2168. The age range of covered IDU population was 18-65 (Mean-28.7; Median-24; Mode-24;). The number of recruited women IDU was 17, while in 2009 their number was 22. Regarding health education component and the following testing, the average indicator of right answers were 6 out 8. Conclusion: The PDI was able to recruit significantly more IDUs to receive HIV information and testing rather than traditional outreach. With this intervention it is possible to reach the desired target population in a short period of time as well as implement educational intervention for which drug users themselves are involved.



## **PO8/04 Immunochromatographic rapid tests in preventive work with injection drug users**

Tetyana Loginova

Kyiv Narcological Hospital 'Sociotherapy', Ukraine

Problem: Kyiv is rated as 7th city in Ukraine based on the HIV expansion. The injection drug users (IDUs) are the driving force of epidemic process of HIV infection in Kyiv. Objectives: Thank to Global Fund financial support, National program for HIV prevention aims to cover 60% of vulnerable groups of population, including harm reduction programs also including Opioid Substitution Therapy (OST). To improve the IDUs access to OST has been the main prevention task. Methods: On the basis of 'Sociotherapy', the first Cabinet of Trust for drug addicts was founded. Voluntary Counseling and Testing (VCT) is available here. Since 2005, in 'Sociotherapy' was launched implementation of OST for IDUs. Immunochromatographic Rapid Tests (RT) were provided by the Global Fond Grant. The program was carried out in places of IDUs accumulation (outpatient narcological clinics and departments of criminal inspection for IDUs). This work included VCT on HIV and viral hepatitis with RT. All examinations, consultations, and tests provided are free of charge. Results: RT has increased the VCT importance as the tool of HIV prevention; the approach of VCT to the places of IDUs accumulation has allowed involving patients into OST. Larger number of HIV-positive persons has been identified for appropriate treatment and social support. Conclusion: RT has increased amount of consulted people up to 3 times; during last year, 300 IDUs were involved in OST: they have changed their lifestyle to a safer behavior; IDUs are enrolled into intervention programs (e.g., Harm Reduction, ARV treatment).

## **PO8/05 Rapid HIV testing for drug users in low-threshold services**

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<sup>4</sup>Fixpunkt Berlin, Germany

Intravenous drug users are still at risk of HIV. The project 'test it' offered drug users access to rapid HIV and HCV testing with a low threshold. The aim was to raise HIV and HCV awareness and to support the development of individual protection strategies. The task was to check whether rapid HIV testing can be used in low-threshold drug support agencies. Selected results: ' 240 drug users (201D,39B) were tested ' Seven were reactive (2.9%). ' 28 drug users in Berlin took a HCV Test(25% pos.) ' The individual risk situations underlying the wish for testing result both from drug use (unsafe use) and (unsafe sex). ' Alcohol consumption is one of the main indicators for an increased readiness to assume risks during sex. ' The fact that rapid HIV testing is 'straightforward' largely contributes to the good rate of take-up (quick, no venous blood, uncomplicated). Conclusion Offering rapid HIV and HCV testing can indeed enable low-threshold access for drug users. The short duration between the test and the result is very attractive. ' Drug users have a strong need to reflect on their 'risk management' and a high level of health awareness. ' Low-threshold service centres can provide an adequate setting to offer HIV/ HCV rapid testing.

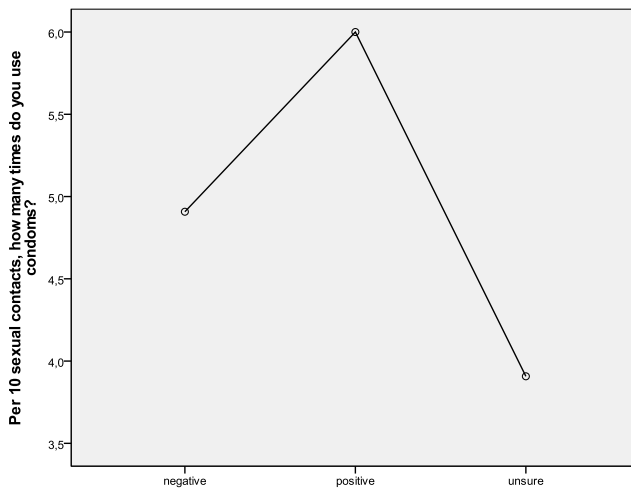
## PO8/06 HIV spread among different groups of IDUs and influence of awareness about HIV-status on safety of sexual and injection behaviors

Polina Girchenko, S Dugin

Foundation of Medical and Social Programs 'Humanitarian Action', St Petersburg, Russian Federation

Objectives: Objectives of the study were to assess the levels of HIV spread among different categories of IDUs in Saint Petersburg, to identify major factors contributing to and preventing HIV-infection among different IDUs groups, to assess current behavioral risks, and to estimate influence of awareness about HIV status to safety of sexual and injection behaviors. Methods: Study was conducted in Saint Petersburg on the base of mobile harm reduction stations of "Humanitarian Action" (buses for IDUs and for CSW IDUs). Each participant was interviewed (semi-structured questionnaire) and tested for HIV (express blood test). Sample size - 1006 IDUs. Data were entered to SPSS database and analyzed using methods of descriptive and correlation analysis. Results: 50,9% of respondents were tested HIV-positive (54,7% - women, 47,5% - men (sign.=0,0024)). Among IDUs using drugs for less than 5 years level of HIV-infection was 28%, among IDUs using drugs for 6 to 10 years it was 46%, for IDUs using drugs for more than 11 years the level of HIV was 58% (sign.=0,000). 26% of HIV-positive IDUs didn't know they were HIV-positive. Knowledge of HIV-status positively influences the safety of sexual and injection behaviors (see diagrams). Conclusion: Harm reduction programs should scale up testing for HIV to prevent new cases of HIV. Harm reduction programs should use differentiated approaches to different types of IDUs clients (men or women, CSW or not CSW, clients with different periods of drug use) as the objectives and methods of work with different groups of IDUs should be different.

Average number of condom use per 10 sexual contacts in relation to awarness about HIV status (IDU not doing commercial sex work) (sign.=0,001)



Aptitude to share used syringes in relation to awareness about HIV status (sign.=0,000)

## **PO8/08 Maximizing reliance on IDUs to prevent HIV in Ukraine**

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Objectives: Conventional harm reduction (HR) projects overlook IDUs' capabilities by offering them services but no active roles to play. In contrast, "peer-driven interventions" (PDIs) offer IDUs rewards to educate and recruit peers for services. All IDU-recruits receive the opportunity to play both roles. Methods: In 2010, PDIs were implemented in 12 Ukrainian cities that relied entirely on IDUs to access and teach IDUs who had never received HR services vs. former PDI-respondents eligible for a one-year follow-up (FU) intervention. IDU-recruiters were trained to administer two completely different bodies of prevention information: one to new recruits, the other to FU-recruits. Recruits from both groups were administered an 8-point knowledge test (KT) at their appointment that measured how well their recruiters educated them. Results: In 6 months of operation: 1) The 12 PDIs recruited 8,115 IDUs: 2,782 (34%) new recruits and 5,333 (66%) PDI-FU-recruits. 2) Among new recruits, 87% scored 7 or higher on the first KT. The PDI-FU-recruits were administered both KT's at the follow-up appointment. 3) On the first KT: 86.4% of the FUs scored 7 or higher. (As new recruits one year earlier, 81.5% of the group scored 7 or higher, which underscores how the PDI's repetitive features improved respondents' retention rate). 4) On the second KT: 89.6% of the FUs scored 7 or higher. Conclusion: The PDIs documented that IDUs can play active roles in preventing HIV by carrying-out complicated tasks of recruiting and educating IDUs who have never received HR services, or IDUs eligible for FU intervention

## **Poster category 9: Lessons learned in the implementation of HIV testing strategies for MSM**

### **PO9/01 Activities directed to early testing and diagnostics of HIV among MSM in the Republic of Armenia**

Ruzanna Davtyan, S Stepanyan, R Ohanyan

'Education in the Name of Health' SO, Yerevan, Armenia

Objectives: "Education in the Name of Health" SO is currently conducting HIV/AIDS preventive activities among MSM within the frameworks of the "National Programme on the Response to HIV Epidemic in Armenia". Preventive activities on HIV/AIDS among MSM are carried out by outreach workers via method of peer education. Another significant process is reasoning and organization of early testing on HIV among the beneficiaries which ensures early identification of HIV status. Methods: A study has been carried out to reveal the comparative data (analysis) of the beneficiaries undergone testing on HIV due to the counseling work of the program's specialist-counselors on one side and the outreach workers' on the other. Results: The majority of beneficiaries who received counseling on HIV by specialist counselors consequently took testing on HIV, unlike the beneficiaries who received counseling by the outreach workers. Correspondingly, in the period of 2010 - 2011 1432 beneficiaries have been referred to testing on HIV, out of which 522 have been referred to HIV testing by the program specialist counselors. As a result 452 beneficiaries have been tested. Meanwhile, only 15 beneficiaries out of 910, who have been referred to testing by the program outreach workers, have undergone testing. Conclusion: For early organization of HIV testing it is vital to develop the outreach workers' capacities of information provision and interpersonal communication which will enable them to formulate and raise the cognizance of healthy lifestyle among program beneficiaries which will serve them as basis and motivation for testing on HIV.

## **PO9/02 Check your status - first results from a MSM Outreach Prevention and VCT Project by Aids Hilfe Vienna**

Isabell Eibl, D Bozkurt, H Dopsch  
Aids Hilfe Wien, Vienna, Austria

Goal: Decrease number of MSM unaware of their HIV status with focus on: Young MSM, MSM with migration background (Turkish and Serbo-Croatian), MSM with higher risk behavior, MSM not present in the gay scene, MSM who haven't been tested before or within the last three years. Method: VCT was offered to MSM in a gay fetish club during the Vienna Pride in June 2011 for four days, from July till November every Wednesday and for seven days in a gay sauna. HIV laboratory -, HIV rapid-, Syphilis testing was offered cost-free and anonymous. The VCT offers were promoted by the prevention department by distribution of flyers in the gay scene and cruising areas, peers reaching young MSM, promotion on internet platforms and social networks and in gay magazines and newsletters. The VCT Team consisted of two counselors, one doctor and one administrator. Outcome: VCT promotion worked and it was offered to 209 clients on 31 days between June 14th and November 30th 2011. 35 Young MSM, 4 MSM with defined migration background, 35 MSM with higher risk behavior, 34 MSM not present in the gay scene. All goals set were reached over expectations. Compared to the in house services the project had an increase of 2,5 MSM/testing day. 61 HIV laboratory -, 143 HIV rapid -, 180 Syphilis tests were made. For 28 it was the first test and for 37 the last test was more than three years ago. 2 HIV tests and 4 Syphilis tests were positive.

## **PO9/03 Scaling up HIV and STI testing of gay men and other MSM in Germany by community based testing campaigns**

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<sup>2</sup>Freie Universität Berlin, Department for Public Health, Berlin, Germany

Objective: In 2009 and 2010 HIV and STI testing campaigns for MSM were conducted in Germany. The campaigns were embedded under the umbrella of the nationwide community based MSM campaign (IWWIT: I KNOW WHAT I'M DOING). Objective of the campaigns was to highlight the importance of HIV and STI counselling and screening in primary and secondary prevention, to lower the increasing number of new HIV infections and to strengthen the prevention capacities of the gay community. The study aimed to evaluate the impact of the campaign to scale up willingness and testing behaviour among gay men and other MSM. Methods: Both testing campaigns were embedded in two online-questionnaires, primarily using gay dating portals. 6.399 /21.928 people participated. Results: The results demonstrate that the campaign helped to raise the willingness to conduct HIV-tests for gay men & MSM in Germany. The willingness to scale up STI-testing could only be identified among sexually active men with high-risk contacts. Men with high risks contacts demonstrate in general a higher test-behaviour, whereas the test-behaviour of younger men is lower. "User" of the IWWIT-campaign demonstrate a significantly higher test-behaviour and – willingness. Conclusion: The results underline the importance of community based counselling and testing campaigns and programs for gay men and other MSM. Better communication is needed to highlight awareness and importance of regular STI screening for men with risk contacts. New public health approaches and a better cooperation between community based programs, public health authorities and local physicians might help to achieve even better outcomes.

## **PO9/04 Are gay men routinely testing for HIV? Findings from community surveys in The Netherlands and Australia**

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<sup>2</sup>University of New South Wales, Australia

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Objective: To assess the extent to which HIV/STI testing has become routine for gay men and explore characteristics of routine and non-routine testers. Method: Data are taken from online community surveys conducted in two countries, at two points in time (The Netherlands, 2004; New South Wales, Australia, 2011). Almost all participants were sexually active, were predominantly white and well educated. Both surveys included questions to assess whether gay men regularly tested for HIV as part of a sexual health routine. Results: Despite historically different policies and practices regarding HIV testing, comparable minorities of men (NL 31%; AU 41%), regularly tested for HIV. Routine testers were significantly more likely than non-routine testers to have tested recently and more frequently, and to have tested out of their own initiative. Routine testers also had higher numbers of sexual partners and, in The Netherlands only, were more likely to have engaged in unprotected anal intercourse. Conclusion: HIV testing plays a critical role in HIV testing, and current guidelines recommend regular testing, in particular for gay men with higher numbers of partners and for men who engage in unprotected anal sex. Our findings show that, while men who are more sexually active are more likely to routinely test for HIV/STI, only a minority of men routinely test for HIV. Furthermore, findings regarding the association between sexual risk-taking and routine testing are mixed. It remains important to understand and address the factors that shape gay men's testing practices, including in countries with strong HIV prevention traditions.

## **PO9/05 A participatory research on HIV and men who have sex with men: Uptake of HIV testing and its determinants**

Ana Gama<sup>1</sup>, L Mendão<sup>1</sup>, R Fuertes<sup>1</sup>, S Dias<sup>2</sup>

<sup>1</sup>GAT - Grupo Português de Ativistas sobre Tratamentos de VIH/Sida Pedro Santos, Portugal

<sup>2</sup>Instituto de Higiene e Medicina Tropical/Universidade Nova de Lisboa, Portugal

This study aims to describe HIV testing among MSM and its demographic and behavioural correlates. It also aims to provide information on self-reported HIV infection. A participatory cross-sectional study was conducted with a snowball sample of 1046 MSM (mean age 31.9±9.9 years). A structured questionnaire was used to collect data on sociodemographics and HIV testing. A multiple logistic regression analysis was performed. The magnitude of associations was estimated by means of odds ratios with 95% confidence intervals. Of the total sample, 88.3% reported having ever been tested for HIV; 60.6% had a traditional laboratory test and 35% were tested in a VCT centre. Reasons for having never been tested included no engagement in risk behaviours (34.4%), low self-risk perception (27%) and fear of the test result (18.9%). Of those ever tested for HIV, 71.4% had a test during the previous year. Having been tested in the previous year was positively associated with increasing number of sexual partners, having searched for HIV-related information at health services and organizations and having been reached with prevention programs, and was negatively associated with increasing age. Of participants ever tested, 10.3% reported to be seropositive and 7.2% reported not to know their serostatus. The results highlight that targeted health education and information strategies may be important to scaling up HIV testing and should be supported.

## **PO9/06 Results of 3 years outreach VCT for HIV/STI in gay venues in Antwerp, Belgium**

Tom Platteau, K Wouters, C Nöstlinger, A Ludwig, E Florence

Institute of Tropical Medicine, Department of Clinical Sciences, Antwerp, Belgium

Introduction: HIV-incidence in Belgium is among the highest in Europe. MSM are one of the most affected groups, and highly responsible for the increasing incidence. Outreach HIV-testing may scale up the number of MSM getting tested, and thereby knowing their HIV-status. Awareness of one's status is a prerequisite for behavioral change. Methods: Helpcenter, a low-threshold screening center for HIV/STI, offered outreach VCT test sessions for HIV, Syphilis, and Hepatitis in a fetish club and two gay bathhouses. Sessions were announced two weeks prior to the sessions, and lasted three hours. Results were communicated through standardized cell phone messages. Results: Between 2008 and 2010, 21 test sessions were organized. During these sessions, 293 men were tested (mean 14 per session; range 4-24). Thirty-eight men (13%) received a message that "at least 1 result was positive". Of them, 7 were newly HIV-diagnosed; 6 (5%) of participants in the fetish club, 1 (0.6%) in bathhouses ( $p=0.005$ ). The venue was the only significant difference between STI-infectious participants and their STI-negative counterparts. All but one participants received their result (he provided the wrong phone number). Conclusions: Thorough preparation is a prerequisite for succeeding, both long term (contacts and arrangements with owners) and for each session (test kits, material). Outreach activities result in a high yield compared to other screening programs. Nevertheless, costs remain high (3 staff members, nightly hours during weekends). Next steps to increase efficiency to reach this target group need to be studied. Saliva tests, and community based testing are currently in development.

## **PO9/07 HIV rapid testing in MSM venues (Estonia)**

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<sup>1</sup>Estonian Network of People Living with HIV, Tallinn, Estonia

<sup>2</sup>AIDS Healthcare Foundation, Estonia

Problem: There is no clear statistics about HIV-positive cases in MSM community in Estonia. Statistics like that have proven remarkably difficult to produce due to the understandable anxiety associated homophobia and discrimination. As a result MSM may not have access to healthcare services, prevention, treatment and care. According to studies up to 50% of MSM have never tested for HIV in Estonia. Objective: To increase access to HCT in non-clinical settings to reduce HIV incidence through earlier detection of new cases and faster linkages to medical care. Method: EHPV offers HIV rapid testing and counseling in convenient places for MSM at nighttime (MSM clubs, bars and saunas) Results: Starting from May 2010 at the gay nightclub in Tallinn 3 HIV-rapid testing events for MSM were held. All together 108 club visitors were tested, 3 positive cases were discovered. All newly diagnosed HIV positive clients received psychological support and were referred to care. Many people came to gay club only because of HIV-testing and not for entertainment. The owners of MSM venues are interested with partnership with us. Clients have given very positive feedback about described testing events in MSM clubs. Conclusions: It's important to increase rapid testing opportunities in MSM community. Constantly evaluating the prevalence of high-risk sexual behavior among gay and bisexual men and tailoring services accordingly. To improve current efforts to prevent HIV. To expand outreach activities in locations frequented by high-risk groups. To provide continual access to condoms and lubricant to those in high-risk groups.

## **PO9/08 Features of HIV testing prevention programs for MSM, implemented in the city of Kiev**

Andrii Chernyshev

Public organization 'Gay-Alliance', Kiev, Ukraine

NGO 'Gay Alliance' was established in October 2002 to protect the health, rights of the MSM. From 2003 to the present, 'Gay Alliance', with funding from the Global Fund, implement projects for the prevention of HIV and STIs among MSM in Kiev. Our organization provides the following medical services: rapid testing for HIV, STI, medical consultations, vaccination against hepatitis B etc. All these activities help to reduce risky sexual behavior. Our organization is trying to attract to test many different groups of MSM (gay, bisexual, sex workers etc.), so it takes place in the organization of the community center, a mobile clinic in the gathering place of MSM, in health care settings. Each year increases the number of persons who are diagnosed. For example, in 2010 an HIV test were more than 2500 MSM, in 2011 almost 2900. These figures were obtained due to the effectiveness of street and club outreach, works the community center, distribution of information materials, the work of the volunteer department and so on. Next year we plan to develop the online consultation and improve the personal website of institution to attract even more testing for MSM. Also, in recent years has increased awareness of the problem and the number of people who know their HIV status. We are confident that in the near future we will be able to stop the AIDS epidemic in our country.

## **PO9/09 Why are gay men testing late for HIV?**

Anders Dahl, MR Eiersted

Hiv-Danmark, Copenhagen, Denmark

Objectives: To compare personal reasons for late testing among late testing HIV-positive MSM with reasons for not testing among a cohort of non-tested MSM. Methods: All known cases of HIV in Denmark are registered in The Danish HIV Cohort Study. In this cohort all PLHIV diagnosed with CD4 count less than 200 from January 2003 to June 2009 was selected to receive a questionnaire at out-patient clinics from 15 September 2009 until 31 March 2010. The questionnaire had 43 questions asking about personal, social and structural reasons for late-testing. Selected personal reasons for late testing among HIV-positive MSM are compared with data from a Sex Life Survey 2009 carried out among non-tested MSM in spring 2009. Results: 63 % of MSM found as late testers indicated that one of the reasons for not testing earlier was "afraid to find out, that I had HIV"; among MSM not having tested for HIV only 13 % indicated this answer. "Avoiding negative reaction from other people" was of some or great importance for 67 % of late testing MSM for not testing earlier; among MSM not having tested for HIV only 8 % indicated this answer. Conclusion: There is a notable difference in these responses. It seems that late testing MSM are much more afraid of the stigma associated with HIV - and that this could be a significant explanation for not testing. Considering future activities in promoting HIV-test it is worth considering how this group - that actively opts out HIV-testing - can be reached.

## **PO9/10 Taking an HIV test in Slovenia: the situation for men who have sex with men**

Miran Solinc

SKUC, Ljubljana, Slovenia

This study collected in-depth information on health-seeking behaviour and assessed men who have sex with men's perception of the service offered by public HIV testing centres in Ljubljana, Slovenia, in September 2009. We used a convenience sample of 20 MSM who participated in face-to-face, semi-structured in-depth interviews to gather information on their health-seeking behaviour. The analysis focused on MSM's perception of testing services. The data gathered revealed respondents testing history (previous experience in HIV testing or previous STIs), sociodemographic information and knowledge about the screening centre procedures. The interviews focused on existing testing procedures (prescription, appointment or drop-in, anonymity, free-of-charge tests), procedures while having a test (pre-test counselling, result collecting, post-test counselling), legislation and rights at the moment of the disclosure of the result (either positive or negative), and awareness of PEP and HAART. The research also addressed reasons to go (or not to go) for an HIV test, personal barriers affecting testing as well as the experience and perception of having an HIV test. The results indicated that the respondents were well informed about testing possibilities. Some MSM reported using alternative testing locations in order to avoid public services. The data also revealed the respondents' lack of knowledge on legislation and rights and show that heteronormativity still represents a major barrier when counselling MSM. These findings can help improve the accessibility of HIV testing by encouraging the sensitization of the health system to the needs of men who have sex with men.

## **PO9/11 Increasing HIV positive results in MSM group. Experience from VCT in Warsaw coordinated by Foundation of Social Education**

Magdalena Ankiersztejn-Bartczak

Foundation of Social Education, Warsaw, Poland

**Objectives:** The aim of this study was to verify newly detected infections in VCT centers coordinated by the Foundation of Social Education. What was the detection of HIV infection in 2011? Who and how they infected? Did they do before the test? **Methods:** Studies based on comparative analysis of VCT clients 2011 with previous years. It will be used for the analysis of the National Institutes of Health National Institute of Hygiene to compare the situation in Warsaw with the epidemiological situation in Poland in 2011 compared to previous years. **Results:** In 2011, the VCT in Warsaw was detected 68 new HIV infections in 4704 performed the tests. 53 infections involved MSM. Only 7 of them it was the first test in life. For comparison, in 2010 on the 3922 tests 37 were positive, of which 23 are MSM, for most was another test in life. Epidemiological reports show a huge increase in reported HIV cases in 2011. Just to October 1113 recorded infections, where in previous years, an average of about 800 infections were coming. Not noted in the declaration of the more tests in VCT. **Conclusion:** Studies show a twofold increase detection of HIV infection at a similar number of tests performed. Worried about a significant increase in infections detected among MSM who regularly performs HIV tests. Also concerned almost twofold increase in reported HIV cases in 2011, which is the highest since the beginning of HIV in Poland.



## **PO9/12 Expectations and perceptions of European men who have sex with men on voluntary testing and counselling**

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Objective: HIV infections rise among men who have sex with men (MSM) in Europe and still many MSM are diagnosed late. The objective of this study is to determine perceptions of MSM regarding voluntary testing and counselling (VCT) available at present in countries belonging to the WHO Europe region and identifying characteristics MSM expect from VCT. Method: Rapid assessment directed to key contacts (KC) in NGOs of types, quality and main characteristics of VCT with a semi-structured online questionnaire, including lists of potential attributes of VCT which participants could evaluate regarding their significance. Results: Nineteen KC from 14 countries participated and included 10/27 European Union countries and Russia, Serbia, Tajikistan and Turkey. For 12 countries the presence of VCT is reported with 6 defined as MSM exclusive. VCT services are well valued by 10/19 KC. Poor quality of counselling (8/19) and anonymity threatening settings (7/19) are the major criticism. The voluntary character (15/19), gay friendly attitude (14/19), access to counselling (13/19) and anonymity (12/19) are identified as vital characteristics for service acceptance. Items such as counsellors being MSM themselves, the possibility of prior risk assessment on the Internet or testing in bars show no clear tendency of relevance. Conclusions: Despite an overall positive perception of VCT services, main criticisms include deficits in counselling and doubts about anonymity. These results might serve as basis for an extended in depth analysis of counsellor trainings and VCT service quality in Europe.

## Poster category 10: Lessons learned in the implementation of HIV testing strategies for sex workers

### PO10/01 HIV and commercial sex workers in Portugal: Are there missed opportunities to scaling up HIV testing and linkage to care?

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This study aims to examine HIV testing and associated factors among female CSW and describe the proportion of reported HIV infection. Based on a participatory approach, a cross-sectional study was conducted with a snowball sample of 846 female CSW (mean age 35.9±10.7 years; 56.3% Portuguese). A structured questionnaire was used with items on sociodemographics, sexual practices, preventive measures and HIV testing. Odds ratios with corresponding 95% confidence intervals were calculated through logistic regression analysis. Overall, 90.5% of participants reported having ever been tested for HIV; among these, 72.7% had been tested during previous year, with no significant differences between nationals and foreigners. Approximately 91% of participants reported having always used condom with clients during previous month and 31.1% with non-client sexual partners during previous year. HIV testing during last year was more frequent among those reporting consistent condom use with clients (72.8% vs. sometimes: 60% and never: 33.3%,  $p=0.013$ ). HIV testing during last year was more likely among participants who had contacted with prevention programs and who knew that HIV testing in Portugal is free and confidential. Lower odds of having been tested were associated with being older and doing sexual work in indoor settings, compared to those working in street. Of participants ever tested, 7.4% reported being HIV positive. Although most HIV-infected participants referred being in treatment, barriers to treatment remains. The results indicate that integrative efforts comprising HIV prevention campaigns and test promotion among female CSW are valued. Heterogeneity within CSW and subgroups' specific needs must be addressed.

### PO10/02 Combining VCT and STI testing and counselling as a factor increasing interest in VCT for high-risk groups

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Background: Ukrainian high-risk groups still remain the driving power of epidemics growth in Ukraine. Under the estimated data there are 290,000 IDUs, 78,000 FSWs and 95,000 MSMs in the country. 55% of FSWs were covered by NGO services. 1, 1% out of them are regular clients. Increasing of coverage (including VCT) of FSWs in HR projects is first priority action points. Methods: Operational research covered 1414 clients of NGO's in 17 cities of Ukraine. Comprehensive approach was used during the study including qualitative, quantitative and desk research methods. Results: Among the risk groups the biggest percentage of new clients (10%) was in FSWs group. Also FSWs (37%) and IDUs (31%) were most regular clients of HR projects (37%). STI-testing (81%) and doctors counselling (76%) are the main services involving and keeping clients in HR projects. 31%-79% of FSWs received medical and social services in combination with HIV counselling and testing using rapid tests. Conclusions: Further development of the range of medical services in HR projects provided by NGO will increase client's retention in the NGO's projects and enhance receiving of services by risk groups regularly. Adding STI testing and counselling to VCT will increase the number of clients which will be covered by VCT. Further increase in the number of dermatologists and gynecologists trained to conduct VCT is needed.

## **PO10/03 Barriers for early HIV testing among road and club-based female sex workers in Catalonia**

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**Objectives:** To identify potential barriers to early HIV testing and to elucidate approaches in order to improve HIV screening among female sex workers (FSWs) that operate along roads and clubs between Barcelona and Girona, Catalonia. **Methods:** From August 2009-April 2010, a qualitative study was undertaken using observation, mapping, key informant interviews and semi-structured interviews of 35 FSWs at commercial sex sites and at reference gynaecological services. **Results:** Nineteen (54.3%) women were club-based and 12(34.3%) road-based.. Mean age was of 27.7 years and they were mainly from Eastern Europe (51.0%) and Latin America (36.0%). Only 54.0% had ever tested for HIV. The following themes emerged as HIV testing barriers: (1) perceived low HIV risk despite reporting unprotected sex and insufficient knowledge on condom breakage management. Most believed that they could tell whether clients were HIV-positive by their appearance; (2) transport difficulties and inconvenient hours; (3) stigma both internalized by FSWs and projected by health workers; (4) concerns about lack of confidentiality of test results; and (5) lack of registration to the health system since most were undocumented migrants and were highly mobile. **Conclusions:** FSWs, in particular those standing along the road, have specific needs and encounter specific challenges for testing. Effective HIV testing approaches for this group might include offering point-of-care tests combined with education and legal services for FSWs, and addressing stigmas of FSWs by providing education and information to health professionals. FSWs testing coverage should be incorporated in national AIDS Action Plans, as a separate and specific action point.

## **PO10/04 BORDERNETwork's IBBS among Sex Workers (SWs) in 7 EU countries: bridging research to practice while scaling up HIV/STI testing**

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Objectives: Epidemiologically sex workers are not considered a key population at higher risk of HIV exposure Europe wide. Nonetheless overlap of risks (ID use, young age) and high mobility (particularly since the last EU-extension) are important HIV risk predictors insufficiently studied in cross-country comparison. Alongside in many countries SW suffer double vulnerability, belonging to migrant or marginalised minority community, often lacking legal papers and health insurance. Services' access is additionally hampered by harsh stigmatization and criminalising or abolitionist prostitution legislation. The EU- project BORDERNETwork addresses these through integrated bio-behavioural survey in 7 EU countries, adopting ethics of research and human rights with the aim of scaling-up HIV/STI testing and outlining comparable behaviour change indicators in SWs. Methods: Face-to-face interviews (85 behavioural items) combined with blood tests (HIV, Syphilis, HCV, HBV) among 923 female SWs (respondents- and service-driven sample) in 6 capital cities and a border region. Results: 1) Enhanced evidence of HIV/STIs prevalence in SWs, analysis of the co-links between epidemiological and social risk determinants; 2) Intersections of risks in prostitution and drug use closely studied; 3) Comparative analysis of 6 UNGASS and 5 additional indicators, evidence of stigma and tabooisation of sex work; Conclusions: From the perspective of combination HIV prevention the surveillance benefits for the target communities have a paramount priority, leading to scaled-up tailored prevention, diagnostic and care. BORDERNETwork will formulate recommendations for improved early access to services for SWs, rights- and equity-based approaches against stigmatization and empowerment of SWs for participation in behaviour and social change.

## **PO10/05 Results of peer-driven interventions for female sex workers in Ukraine**

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**Objectives:** In 2010, Peer Driven Interventions (PDIs) for female sex workers (FSWs) were tested in harm reduction projects in two Ukrainian city-sites. The goal was to recruit 500 FSWs in 6 months who had never received services before, and to measure how well peer-recruiters educated their recruits in a body of fresh HIV prevention information. Finally, the efficacy of a lottery was tested for rewarding FSWs for their efforts in place of nominal cash rewards to individuals. **Methods:** The PDI relies on respondents to educate and recruit peers for intervention. All recruits also serve as peer educators/recruiters earning tickets to participate in a project-sponsored lottery. The recruits' scores on an 8-item knowledge test (KT) (measuring how well their recruiters educated them) determine how many lottery tickets the recruiters earn. Each PDI-site conducted a weekly drawing offering prizes for 4 lucky winners: cosmetic kits, appliances, and gift-certificates redeemable at local stores. **Results:** Within 6 months, the two PDIs recruited 532 and 437 FSWs never seen before by the projects. In comparison, 6 months prior to the PDIs' start-up, 311 and 102 new FSWs were recruited via traditional outreach methods. Both projects held 23 lotteries with an average attendance of 8 FSWs. **Conclusion:** The respondents responded enthusiastically to the PDI, by serving as peer educators/recruiters. The lottery reward system also proved to be a cost-saving alternative to nominal cash reward to individuals. The study indicates that harm reduction projects have an entirely new outreach model to use for accessing and educating FSWs.

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# Main Sponsor



The conference has received funding from the European Commission under the Health Programme 2008-2013. However, the sole responsibility for the study lies with the author and the European Commission is not responsible for any use that may be made of the information contained therein

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