

HepHIV 2017

31 JANUARY-2 FEBRUARY · MALTA

PROGRAMME AND ABSTRACT BOOK



HepHIV2017 CONFERENCE

HIV AND VIRAL HEPATITIS:
CHALLENGES OF TIMELY TESTING
AND CARE

MALTA, 31 JANUARY - 2 FEBRUARY, 2017



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WELCOME
TO THE
HEPHIV 2017
CONFERENCE
IN MALTA

WELCOME TO THE HEPHIV 2017 CONFERENCE IN MALTA

Dear Colleagues,

On behalf of the Organising Committee of the **HepHIV 2017 Conference: HIV and Viral Hepatitis: Challenges of Timely Testing and Care**, we would like to welcome you to this biennial conference on optimal testing and earlier care for HIV and viral hepatitis in Europe, in Malta, during the 2017 Maltese Presidency of the Council of the EU (www.eu2017.mt #EU2017MT). The presidency is hosting a technical meeting Fast-track the end of AIDS in the EU- practical evidence-based interventions from the 30st to the 31st January, 2017, in collaboration with ECDC, for Member States and other key actors. We are confident that important synergies will arise between the presidency meeting and the HepHIV 2017 Conference.

The need to address HIV and viral hepatitis continues to be a public health priority. Despite the current state of knowledge to prevent and manage these infections, the numbers of new infections continue to rise in Europe. Due to similarities in transmission routes and risk groups there is a public health benefit in exchanging knowledge, sharing good practices and performing dual testing.

This HepHIV 2017 Conference will for the second time bring together stakeholders working with HIV and viral hepatitis. The stakeholders range widely from local health practitioners to European level policy makers. The conference will provide stakeholders with the opportunity to learn from each other and to reflect on experiences, achievements and challenges.

The focus of the conference is on the left-hand side of the continuum of care; including testing of key populations and patients presenting with HIV indicator conditions; late presentation and reaching the undiagnosed; new testing technologies and cost-effectiveness; and new treatment paradigms and their impact on testing strategies.

The format of the conference includes a mix of plenary sessions, expert panel and roundtable discussions and moderated parallel sessions driven by submitted abstracts selected by the Conference Organising Committee based on a thorough review process. With participation from civil society, policymakers, health professionals and European public health institutions several different aspects and experiences will be presented and discussed.

Around 200 participants from across Europe take part in the HepHIV 2017 Conference in Malta to continue the discussions and pick up on where we left after the HepHIV 2014 Conference in Barcelona. All the abstracts submitted (66 abstracts and 13 late breakers) and the interest in the conference demonstrate the importance of this field, the ongoing scientific research and the willingness and urge to change the current situation by learning from each other and discussing across fields and professional groups.

Before the official opening of the conference, OptTEST, Euro HIV EDAT and Chafea have been hosting an open EU Health Projects' Symposium where projects and actions co-financed by the European Commission working on HIV, hepatitis, TB and STIs were invited to present and discuss main results of their work. All Symposium speakers have been invited to participate in the HepHIV 2017 Conference.

We look forward to three days in Malta of lively discussions, innovative thinking and a renewed commitment of political action.

On behalf of the HepHIV 2017 Conference Organising Committee,

Brian West

Board of Directors,
European AIDS Treatment
Group
Co-chair HepHIV 2017 and
HIV in Europe

Jürgen Rockstroh

MD, Professor of Medicine
and Head of the HIV Out-
patient Clinic, University of
Bonn. Co-chair HepHIV 2017
and HIV in Europe

Charmaine Gauci

Superintendent of Public
Health, Ministry for Health,
Malta. Local Co-chair
HepHIV 2017

THE HEPHIV 2017 CONFERENCE CONFERENCE CHAIRS

Brian West Board of Directors, European AIDS Treatment Group, EATG, Belgium
Jürgen Rockstroh MD, Professor of Medicine and Head of the HIV Outpatient Clinic,
University of Bonn, Germany
Charmaine Gauci Superintendent of Public Health, Ministry of Health, Malta

THE HEPHIV 2017 CONFERENCE ORGANISING COMMITTEE

Andrew Amato-Gauci European Centre for Disease and Prevention Control, ECDC, Sweden
Ann Sullivan Optimising testing and linkage to care for HIV across Europe,
OptTEST, Saint Stephen's AIDS Trust, United Kingdom
Ann-Isabelle von Lingen European AIDS Treatment Group, EATG, Belgium
Brian West European AIDS Treatment Group, EATG, Belgium (co-chair)
Charmaine Gauci Ministry of Health, Malta (local co-chair)
Eberhard Schatz Correlation Hepatitis C Initiative, the Netherlands
Fiona Godfrey European Association for the Study of the Liver, EASL, Switzerland
George Galea Ministry of Health, Malta
Jeffrey Lazarus CHIP, Rigshospitalet, University of Copenhagen, Denmark
Jens Lundgren CHIP, Rigshospitalet, University of Copenhagen, Denmark
John de Wit Utrecht University, the Netherlands
Jürgen Rockstroh HIV Outpatient Clinic, University of Bonn, Germany (co-chair)
Ludmila Maistat ICF, Alliance for Public Health, Ukraine
Martin Donoghoe WHO Regional Office for Europe, Denmark
Per Slaaen Kaye Euro HIV EDAT, AIDS-Fondet, Denmark
Pierre Van Damme Viral Hepatitis Prevention Board, Belgium
Stefan Mauss Center for HIV and Hepatogastroenterology, Germany
Tatjana Reic European Liver Patients Association, ELPA, Belgium
Tom Platteau Institute of Tropical Medicine, Belgium
Wim Zuilhof STI AIDS Netherlands, the Netherlands



THE HEPHIV 2017 CONFERENCE - OBJECTIVES

The many achievements that stemmed from the HepHIV 2014 conference have propelled the dialogue between HIV and viral hepatitis experts. At the conclusion of the HepHIV 2014 conference, the HIV in Europe Steering Committee and HepHIV2014 Scientific Committee developed a call to action for the health community to carry out within their field of work. From increasing testing services in community settings to addressing political barriers in health policies, the landscape of the HIV and viral hepatitis field has moved forward.

However, current progress with HIV and viral hepatitis research and practice, although significant, must be expanded. Therefore, the overall aim of the HepHIV 2017 conference is to further improve HIV and viral hepatitis testing and linkage to care by engaging stakeholders and to stimulate exchange of experiences and best practices, as well as present the latest evidence within the field. Developments since the 2014 conference have made improvements in practice, but there still exist significant gaps in service, policy and research. The HepHIV 2017 conference will address milestones achieved since 2014, follow up on the latest research and the future outlook of HIV and viral hepatitis.

HepHIV2014 Call to Action

1. Surveillance of viral hepatitis

Assess, nationally and regionally, how many people are infected with viral hepatitis (B and C, acute and chronic), their fibrosis stage, how many present late, and how many remain undiagnosed, over time and by key population, in order to monitor trends and to target interventions better.

2. Defining late diagnosis of viral hepatitis for medical care

Support further consultation to establish a simple and lasting consensus definition for late presentation of viral hepatitis to improve surveillance and enable monitoring of health systems and testing strategies.

3. Testing modalities and targeted testing and communication

Promote multiple testing platforms in community settings, healthcare facilities and the home, with special attention to cost and cost-effectiveness and the possibility of testing all three blood-borne viruses at the same time.

Involve key communities in the tailoring of testing and health promotion messages to their audiences.

4. Indicator-condition-guided testing

Implement indicator-condition-guided HIV testing broadly in healthcare settings, especially general practices. Develop the evidence to support the concept of indicator-condition-guided testing for viral hepatitis.

5. Health policy strategies

Correlate national health policy strategies with public health outcomes for viral hepatitis, HIV and TB, comparing the Eastern and Western European regions as well as the European Union and the rest of the European Region. Advocate for expansion and support the funding of successful harm-reduction models, such as that developed by Ukraine and adoption of international standards in national strategies.

6. Synergy of infectious disease efforts

Facilitate collaboration between HIV, HBV, HCV, STI and TB activities in research, policy, health promotion, surveillance, testing and education – at the regional, European Union and national levels and among civil society including representatives of key populations.

7. Continuum of care

Develop robust data to inform each component of the continuum of care for viral hepatitis and for HIV, including linkages to affordable state-of-the-art treatment and interventions for prevention and testing.

8. Affordability

Make HIV and viral hepatitis (HBV and HCV) treatment affordable by working to lower drug prices and ensuring that both domestic and international funders contribute to financing the treatment of both conditions.

9. Political leadership

Renewed political leadership of governments, the European Union and international agencies in the European Region is crucial to address the important challenges in viral hepatitis and HIV. Policies and public health interventions need to be based on existing scientific evidence and validated guidelines to inform viral hepatitis and HIV policies and programmes.

The EU co-financed project Optimising testing and linkage to care for HIV across Europe (OptTEST) is in its final year and will present results and outcomes from the three years of work within the four focus areas:

- Linkage to and retention in HIV care after diagnosis
- Indicator condition guided HIV testing
- The cost-effectiveness of HIV testing strategies in priority groups and regions
- Stigma and legal barriers to the provision and uptake of HIV testing services

The second day of the conference is sponsored by OptTEST and the plenary sessions, expert panel and roundtable discussions and moderated parallel sessions on this day are organised around the key themes of OptTEST.

Other HIV in Europe projects and collaborating partners profiled during the conference are the European HIV-Hepatitis Testing Week and the Euro HIV EDAT project.

**FOLLOW NEWS FROM THE CONFERENCE AND PROVIDE
FEEDBACK BY USING THE HASHTAG #HEPHIV2017**

PROGRAMME AT A GLANCE

TIME	ROOM: FORTRESS	ROOM: GARDJOLA
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TUESDAY, 31ST JANUARY 2017

17:00-19:00 Opening Session

WEDNESDAY, 1ST FEBRUARY 2017

8:45-10:30	PLE1: Surveillance and monitoring and evaluation of testing	
11:00-12:30	PLE2: Mixing testing strategies: Community and health care settings	
12:30-13:30	Poster session (Room: Bastion)	

PARALLEL SESSIONS

13:30-14:45	PS1: Monitoring for HIV and viral hepatitis	PS2: Testing strategies in key affected populations
14:50-15:35	Special session: PrEP: Influence of PrEP and new treatment paradigms on testing pathways	
15:35-16:05	Poster session (Room: Bastion)	
16:05-17:05	Round Table Discussion 1: Hepatitis C and unequal access to treatment in Europe	
17:10-18:10	Round Table Discussion 2: Role of stigma and criminalisation in discouraging testing	

THURSDAY, 2ND FEBRUARY 2017

OPTIMISING TESTING AND LINKAGE TO CARE FOR HIV IN EUROPE (OPTTEST SYMPOSIUM)

8:30-10:00	PLE3: Continuum of Care and improving linkage to care	
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PARALLEL SESSIONS

10:30-11:45	PS3: Challenges in health care settings: Testing and linkage to care	PS4: Community testing
11:45-12:45	Poster session (Room: Bastion)	
12:45-13:45	PLE4: New point of care diagnostics, affordability and cost-effectiveness	
14:15 -16:00	Closing session: European policies and strategies and their implications	

REGISTRATION OPENING HOURS

Tuesday, 31st January 12:30-19:30
 Wednesday, 1st February 08:30-18:15
 Thursday, 2nd February 08:15-16:15

For presentations including surveys please download the app VoxVote, vote on: live.voxvote.com or scan the QR code. **Use the PIN: 32638**



PROGRAMME

MONDAY 30TH JANUARY 8:00 - TUESDAY 31ST JANUARY 14:00

EU Presidency Conference: 'Fast-tracking the end of AIDS in Europe - practical evidence-based interventions' hosted by the Government of Malta, in collaboration with ECDC.

TUESDAY, 31ST JANUARY 2017

SIDE MEETINGS 09:00-17:00

TIME	ROOM	
9:00-12:00	OptTEST Partner Meetings	Terrace Suite
12:00-12:45	Chafea networking lunch (Open, registration required)	
12:45-17:00	Chafea HepHIV Symposium for EU co-financed projects and joint actions (Open, registration required)	Gardjola 2+3
15:00-16:00	PARTNER Meeting (Open, no registration)	Terrace Suite

TIME	ROOM - FORTRESS	MODERATORS AND SPEAKERS
17:00-19:00	OPENING SESSION	Moderators: Jürgen Rockstroh, Brian West and Charmaine Gauci
	Welcome to the HepHIV 2017 Conference in Malta: Objectives and expected outcomes of the Conference	Jürgen Rockstroh, Brian West and Charmaine Gauci
	Welcome Address	Minister for Health of Malta, Hon. Christopher Fearné
	The EU's contribution to ending the HIV and Hepatitis epidemics in Europe	Vytenis Andriukaitis, European Commissioner for Health and Food Safety
	HIV and Hepatitis Surveillance trends in the EU and feedback from the HIV Presidency conference	Andrew Amato-Gauci, ECDC
	HIV and Hepatitis in Europe, time to turn the tide	Masoud Dara, WHO Regional Office for Europe
	Do we have the right composition of testing strategies in Europe?	Michel Kazatchkine, UN Secretary-General's Special Envoy on HIV/AIDS in Eastern Europe and Central Asia
	Community perspective on whether we have the right testing strategies in Europe	Jackie Morton, EATG

19:30

RECEPTION (VENUE: Foyer at the Corinthia Hotel, Conference Venue)

WEDNESDAY 1ST FEBRUARY 2017

TIME	ROOM - FORTRESS	MODERATORS AND SPEAKERS
8:45-10:30	PLENARY SESSION 1: Surveillance and monitoring and evaluation of testing	Moderators: Teymur Noori and Tatjana Reic
8:45-9:00	HIV & Viral Hepatitis: What's Next?	Alfred Sant, European Parliament
9:00-9:30	10 years of HIV in Europe – what has been achieved, what remains as challenges	Jens Lundgren, CHIP Rigshospitalet and Ton Coenen, Rutgers
9:30-9:45	Test and link to care: How do we measure our success?	Valerie Delpech, PHE
9:45-10:00	Surveillance of hepatitis and hepatitis testing efforts among people who use drugs	Dagmar Hedrich, EMCDDA
10:00-10:30	Discussion	
10:30-11:00 COFFEE BREAK		

TIME	ROOM - FORTRESS	MODERATORS AND SPEAKERS
11:00-12:30	PLENARY SESSION 2: Mixing testing strategies: Community and health care settings	Moderators: Wim Zuilhof and Jackie Morton
11:00-11:15	Indicator Condition Guided HIV testing – progress and challenges	Ann Sullivan, SSAT
11:15-11:30	The Euro HIV EDAT Project. Monitoring and evaluation of community based testing: achievements and challenges	Jordi Casabona, Euro HIV EDAT
11:30-11:45	Home testing for HIV: Feasibility, acceptability, implementation, and applications	Aaron Siegler, Emory University
11:45-12:00	BCN Checkpoint: achievements, challenges and future plans of a community centre for MSM	Michael Meulbroek, BCN Checkpoint
12:00-12:30	Discussion	
12:30-13:30 LUNCH AND POSTERS (ROOM: BASTION) TESTING WEEK MEETING (ROOM: GARDJOLA)		

TIME	ROOM – FORTRESS	ROOM - GARDJOLA
13:30-14:45	PARALLEL SESSION 1: Monitoring for HIV and viral hepatitis Moderators: Antons Mozalevskis and Tom Platteau	PARALLEL SESSION 2: Testing strategies in key affected populations Moderators: Pierre van Damme and Lella Cosmaro
13:30-13:45	PS1/01 E. Aspinall, D. Goldberg, E. Duffell, S. Hutchinson, H. Valerio, L. Tavošchi Are EU/EEA countries ready to monitor progress on HCV programmes?	PS2/01 J. del Amo, I. Jarrin, V. Hernando, D. Alvarez Del Arco, B. Alejos, A. Amato, T. Noori, A. Pharris HIV diagnoses in migrants from Western, Central and Eastern Europe in the EU/EEA; emerging epidemics and J. Del Amo, I. Jarrin, V. Hernando, D. Alvarez Del Arco, B. Alejos, A. Amato, A. Pharris, T. Noori HIV diagnoses in migrants from Latin America & Caribbean in Europe; distinct epidemics
13:45-14:00	PS1/02 G. Ireland, D. Ogaz, P. Kirwan, S. Mandal, V. Delpech, N. Connor, R. Simmons HIV testing in persons diagnosed with hepatitis B and C and G. Ireland, V. Delpech, K. Balogun, P. Kirwan, S. Lattimore, S. Mandal, R. Simmons Diagnosed HIV infections in persons being tested for the hepatitis B virus: England, 2008-2014	PS2/02 J. Brännström, A. Sönnnerborg, V. Swedhem, U. Neogi, G. Marrone A high rate of HIV-1 acquisition post immigration among migrants in Sweden determined by a CD4+ T-cell decline trajectory model indicates missed opportunities for testing and primary prevention

WEDNESDAY 1ST FEBRUARY 2017, CONTINUED

14:00-14:15	PS1/03 M. Linnet, L. Peters, D. Raben, H. Petersen, J. Gerstoft, J. Lundgren Organizational barriers as an explanation for differences in offer and uptake rates for hepatitis B/C and HIV testing in three drug addiction centres in Copenhagen	PS2/03 J. Hoyos Miller, M.J. Belza, C. Agustí, S. Chanos, F. Pichon, M. Kuske, B. Cigan, R. Fuertes, L. Ooms, R. Stefanescu, C. Cabeza de Vaca, B. Arranz, L. de la Fuente Knowledge, and actual versus potential use of HIV self-testing and self-sampling testing kits in 8 European countries
14:15-14:30	PS1/04 K. Rützel, K. Kallavus, I. Tomera Monitoring anonymous HIV testing in Estonia in 2005-2015	PS2/04 A.J. Schmidt, D. Sander, T. Noori From HIV-testing to Gay Health Centres: A mapping of European "Checkpoints"
14:30-14:45	PS1/05 L. Fernández-López, J. Reyes-Urueña, C. Agustí, I. Klavs, T. Kustec, J. Casabona, COBATEST network The COBATEST network: A platform to perform monitoring and evaluation of HIV community-based testing practices in Europe	PS2/05 O. Anagnostou, A. Fotiou, E. Kanavou, A. Andaraki, T. Manina, C. Richardson, E. Kafetzopoulos, Drug Related Infectious Diseases (DRID) Medical Doctors Group of OKANA Factors associated with HCV test uptake in heroin users entering substitution treatment in Greece

14:45-14:50 TRANSITION

TIME	ROOM – FORTRESS	MODERATORS AND SPEAKERS
14:50-15:35	Special session on PrEP: Influence of PrEP and new treatment paradigms on testing pathways	Moderators: Gus Cairns and Anders Sönnnerborg
14:50-15:05	HIV testing in sexual health clinics – do they need to change for PrEP?	Sheel Patel, Chelsea and Westminster Hospital
15:05-15:20	PrEP implementation: Viral hepatitis C testing required?	Maria Prins, Academic Medical Center
15:20-15:35	Discussion	

15:35-16:05 COFFEE BREAK AND POSTERS (ROOM: BASTION)

16:05-17:05	Round Table Discussion 1: Hepatitis C and unequal access to treatment in Europe	Moderators: Jens Lundgren and Ludmila Maistat
16:05-16:20	Hepatitis C and unequal access to treatment in Europe	Daniel Simões, GAT
16:20-17:05	Should we treat those diagnosed or diagnose those who need treatment?	Panel Members: Daniel Simões, GAT Nikoloz Chkhartishvili, Infectious Diseases, AIDS and Clinical Immunology Research Center Tatjana Reic, ELPA Margaret Hellard, Burnet Institute Jürgen Rockstroh, University of Bonn Anton Basenko, Alliance for Public Health Philippa Easterbrook, WHO

17:05-17:10 TRANSITION

17:10-18:10	Round Table Discussion 2: Role of stigma and criminalisation in discouraging testing	Moderators: Nikos Dedes and Valerie Delpech
	Role of stigma and criminalisation barriers in discouraging testing	Panel Members: Julian Hows, GNP+ Lisa Power, OptTEST Alexandrina Iovita, UNAIDS Edwin Bernard, HIV Justice Network Raoul Fransen-dos Santos, International Civil Society Support

20:00 CONFERENCE DINNER (VENUE: The Casino Maltese)

THURSDAY, 2ND FEBRUARY 2017

OPTIMISING TESTING AND LINKAGE TO CARE FOR HIV IN EUROPE (OPTTEST SYMPOSIUM)

TIME	ROOM - FORTRESS	MODERATORS AND SPEAKERS
8:30-10:10	PLENARY SESSION 3: Continuum of Care and improving linkage to care	Moderators: Andrew Amato-Gauci and Jeffrey Lazarus
8:30-8:40	Short report from Conference Day 1	Conference chairs
8:40-8:55	Understanding and improving the HIV Continuum of Care in Europe	Anastasia Pharris, ECDC
8:55-9:10	The continuum of care and late presentation – implementing the consensus definition in HIV	Amanda Mcroft, UCL
9:10-9:25	The continuum of care and late presentation – hepatitis - implementing the consensus definition	Jürgen Rockstroh, University of Bonn
9:25-9:40	The role of civil society in successful testing and linkage to care	Tracy Swan, TAG
9:40-10:10	Discussion	
10:10-10:30 COFFEE BREAK		

TIME	ROOM – FORTRESS	ROOM - GARDJOLA
10:30-11:45	PARALLEL SESSION 3: Challenges in health care settings: Testing and linkage to care Moderators: Ann Sullivan and Fiona Godfrey	PARALLEL SESSION 4: Community testing Moderators: Per Slaaen Kaye and Ben Collins
10:30-10:45	PS3/01 G. Vourli , A. Pharris, F. Cazein, D. Costagliola, F. Dabis, J. Del Amo, V. Delpech, A. Díaz, E. Girardi, A. Gourlay, B. Gunsenheimer-Bartmeyer, V. Hernando, G. Nikolopoulos, K. Porter, M. Rosińska, C. Sabin, B. Suligoi, V. Supervie, F. Wit, G. Touloumi Assessing the representativeness of European HIV cohort participants as compared to HIV surveillance data	PS4/01 M. Kuske , C. Agusti, M. Meulbroek, D. Rojas Castro, F. Pinchon, P. Slaaen, M. Lobnik, B. Cigan, M. Wentzlauff-Eggebert, M. Alexandru, T. Platteau, D. Simões, S. Schanos, EURO HIV EDAT Study Group Development of a Toolkit for implementation and evaluation of Checkpoints for MSM
10:45-11:00	PS3/02 S. Croxford , F. Burns, A. Copas, A. Pharris, V. Delpech, OptTEST for HIV in Europe Factors for delayed linkage to care following HIV diagnosis in the WHO European Region	PS4/02 L. Power , J. Hows, S. Finne Jakobsen, A.-I. Von Lingen Barring the Way to Health: how legal and regulatory barriers hinder modernising HIV testing across Europe
11:00-11:15	PS3/03 D. Baliashvili , M. Tsereteli, M. Alkhashvili, K. Zakhshvili, A. Gamkrelidze Increased HIV case detection through Integration of HIV Testing in Georgian Hepatitis C Elimination Program Screening Activities	PS4/03 M. Meulbroek , F. Pérez, A. Dalmau-Bueno, F. Pujol, J. Saz, H. Taboada, G. Marazzi, A. Carrillo, A. Cabas, A. Gata, E. Aldabó, B. Roldán, P. Coll, F. Añez, J. Pantaleón, M. Mochales, O. Martín, V. Gómez, J.F. Mir, J. Decoca BCN Checkpoint: Same-day confirmation of reactive HIV rapid test with Point Of Care PCR test accelerates Linkage to Care and reduces anxiety

THURSDAY, 2ND FEBRUARY 2017, CONTINUED

OPTIMISING TESTING AND LINKAGE TO CARE FOR HIV IN EUROPE (OPTTEST SYMPOSIUM)

11:15-11:30	PS3/04 K. Rüütel, L. Lemsalu Monitoring HIV-indicator condition based HIV testing in Estonia	PS4/04 A.-M. Schweitzer , M. Bogdan, G. Ivanov, A. Corduneanu, I. Ciocea Impact of Pre-Test Counseling Sessions on Increasing Knowledge About HIV and Hepatitis Among the Beneficiaries of a Free of Charge, Voluntary Counseling and Testing Program (VCT) in Constanta, Romania
11:30-11:45	PS3/05 D. Bradshaw , C. Rae, G. Pickard, D. Patel, D. Rezende, P. Roberts, K. Pillay, M. Foxton, A. Sullivan Testing for blood borne viruses in the emergency department of a large London hospital	PS4/05 U. Marcus , S.B. Schink, M. Tappe, German Checkpoint Collaborative Group Monitoring test uptake and risk behaviour in community based HIV/STI testing sites in Germany, 2015/2016

11:45-12:45 LUNCH AND POSTERS (ROOM: BASTION)

TIME	ROOM – FORTRESS	MODERATORS AND SPEAKERS
12:45-13:45	PLENARY SESSION 4: New point of care diagnostics, affordability and cost-effectiveness	Moderators: Charles Gore and Mojca Matičič
12:45-13:00	New diagnostics for HIV and HCV testing	Emmanuel Fajardo, MSF
13:00-13:30	Cost-effectiveness of HIV testing: frequency and target groups	Yazdan Yazdanpanah, INSERM
13:30-13:45	Discussion	

13:45-14:15 COFFEE BREAK

TIME	ROOM – FORTRESS	MODERATORS AND SPEAKERS
14:15-16:00	CLOSING SESSION: European policies and strategies and their implications	Moderators: John de Wit and Nino Tsereteli
14:15-14:25	Short report from Conference Day 2	Conference chairs
14:25-14:45	Towards a realistic cure - the role of HIV testing	Brian Gazzard, Chelsea and Westminster Hospital
14:45-15:45	Panel discussion: Best practices: tailoring policies to specific epidemics, how do European policies translate into national reality? Implications of policies and indicators	Panel Members: Andrew Amato-Gauci, ECDC Lella Cosmaro, LILA Milano Charmaine Gauci, Ministry of Health, Malta Julia del Amo, Instituto de Salud Carlos III Brian Gazzard, Chelsea and Westminster Hospital Marcus Cronberg, EASL Andrej Senih, EATG Dagmar Hedrich, EMCDDA Antons Mozalevskis, WHO
15:45-16:00	Conference Call to Action	Conference chairs

TIME	MEETING	ROOM
16:30-17:00	HIV in Europe update meeting with sponsors	Terrace Suite
17:00-18:30	HIV in Europe steering committee meeting	Terrace Suite



SCIENTIFIC PROGRAMME PLENARY SESSIONS

TUESDAY, 31ST JANUARY 2017

Room: Fortress

OPENING SESSION

17:00 - 19:00

The opening plenary will consist of a number of key note speeches by prominent representatives from leading European organisations. After a short introduction and an outline of the objectives and expected outcomes of the conference, the Minister for Health of Malta, Hon. Christopher Fearnle will give the welcome address, followed by the European Commissioner for Health and Food Safety presenting on EU's contribution to ending the HIV and viral hepatitis epidemics in Europe. The European Centre for Disease Prevention and Control (ECDC) and the World Health Organization (WHO) will share updates on surveillance, feedback from the EU Presidency meeting on HIV and current action plans and strategies to address earlier testing, diagnoses, care and treatment. Michel Kazatchkine, UN Secretary-General's Special Envoy on HIV/AIDS in Eastern Europe and Central Asia will present on existing testing strategies in Europe and whether these are of the right composition and finally Jackie Morton, chair of the European AIDS Treatment Group, will discuss testing strategies from a community perspective.

MODERATORS:



Brian West, European AIDS Treatment Group, co-chair

Brian West is on the Board of Directors of the EATG, which is a European network of nationally-based volunteer activists comprising of more than 175 members from 47 countries in Europe. He also serves on the Steering Committee of AIDS Action Europe, a pan-European NGO. Closer to home, he is a trustee/director on the board of Waverley Care, Scotland's largest NGO provider of services for people living with HIV.



Jürgen Rockstroh, University of Bonn, co-chair

Jürgen Rockstroh is, in addition to his clinical practice, involved in HIV research on: antiretroviral therapy, including new drug classes; the course of HIV disease in haemophiliacs; and HIV and hepatitis co-infection. From 2007-2011 he was elected as the president of the German AIDS Society. He is also since 2009 a member of the executive committee of the European AIDS Clinical Society (EACS) and since 2011 member of the governing council of the International AIDS Society. He is also the chair of the National German AIDS Advisory Panel since 2011 and the EACS coinfection guidelines since 2008. In 2015, Jürgen Rockstroh was elected chair of the HIV in Europe Steering Committee.



Charmaine Gauci, Ministry for Health, Malta, local co-chair

Charmaine Gauci is the Superintendent of Public Health within the Ministry for Health in Malta with wide responsibility of public health to safeguard and enhance the health status of the people. Previous to this positions, she had occupied the position of Director of the Health Promotion and Disease Prevention Directorate for nine years. She graduated as a medical doctor in 1991. Over the years she has developed skills in the wide aspect of the public health specialty.

She pursued her studies with masters in public health and consequently followed the European Programme in Epidemiological Training. She has also specialized in fitness and nutrition. She attained her PhD Degree in epidemiology in 2006. Dr Gauci is also a Prince practitioner in project management. She is a fellow of the UK Royal Society for Public Health and a fellow of the UK Faculty of Public Health. Charmaine Gauci is a senior lecturer at the University of Malta and delivers lectures in the field of public health with special interest in Public Health, Epidemiology, Communicable Diseases, Health Promotion and Policy Development. She is active in the field of public health having served as secretary, vice president and also served as president with the Malta Association of Public Health Medicine for four years. Charmaine Gauci acts as a focal point for a number of bodies within the European Commission including HLG, ECDC and Health Security and for the World Health Organization and is project leader for a number of EU projects.

SPEAKERS

Welcome address



Hon. Christopher Fearne, Minister for Health of Malta

Hon. Christopher Fearne was born in Attard, Malta on 12 March 1963. In April 2016 he was appointed Minister for Health after holding the position of Parliamentary Secretary for Health since April 2014. Prior to this, Hon. Fearne worked as a Consultant Paediatric Surgeon and Clinical Chairman at Mater Dei Hospital. He is a Member of Parliament for the ruling Labour Party and was the

Chairman of the Foreign and European Affairs Committee at the Maltese House of Representatives. Hon. Fearne has worked as a doctor and surgeon for over 29 years. He received his formal education at St. Aloysius College and at the University of Malta graduating in Medicine and Surgery in 1987, becoming a Fellow of The Royal College of Surgeons of Edinburgh. He worked and studied in a number of children’s hospitals in England, including the Great Ormond Street Hospital in London. He also lectures students of medicine at the University of Malta. Hon. Fearne was a founding director of the Malta Institute for Medical Education and the chairperson of Celebrities for Kids, a voluntary NGO promoting children’s rights. As a student, Hon. Fearne was involved in a number of youth organizations. He has served as Secretary General of the Maltese Federation of Youth Organisations, officer within the University Students’ Council, KSU, and in the Malta Medical Students’ Association, MMSA.



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

Vytenis Andriukaitis, European Commissioner for Health and Food Safety

Vytenis Povilas Andriukaitis was appointed the European Commissioner for Health and Food Safety in November 2014. Vytenis Andriukaitis was born on 9 August 1951 in Kyusyur, Siberia, where his family was deported in 1941 from Lithuania. He returned to Lithuania in 1957 together with his mother and two

brothers. His father was permitted to return one year later. Vytenis Andriukaitis went on to graduate from medical school in 1975 and has been a practicing surgeon, gaining specialisation in cardiovascular surgery in 1989, for more than 20 years. He also holds a degree in History from Vilnius University acquired in 1984. From 1969 onwards the Commissioner was active in the anti-Soviet movement, and his political career began already in 1976. In 1990, Vytenis Andriukaitis was elected to the Supreme Council of the Republic of Lithuania which preceded Seimas (Lithuanian Parliament), and was a signatory of the Independence Act of Lithuania on 11 March 1990. Vytenis Andriukaitis was also one of the co-authors of the Constitution of the Republic of Lithuania adopted in 1992, and one of the founders of the Lithuanian Social Democratic Party. Andriukaitis has been a Member of the Lithuanian Parliament for six terms. During that time he served as a Deputy Chairman of the Committee on European Affairs, a member of the Foreign Affairs Committee and a Vice-President of the Social Democratic Party. The Commissioner was also the head of the Lithuanian delegation to the Convention on the Future of Europe. From 2012 to 2014 Vytenis Andriukaitis was a Minister for Health in the Lithuanian Government.



HIV and Hepatitis Surveillance trends in the EU and feedback from the HIV Presidency conference

Andrew Amato-Gauci, European Centre for Disease Prevention and Control

Andrew Amato-Gauci is an Epidemiologist and Family Medicine specialist. He studied Public Health and Epidemiology at the London School of Hygiene & Tropical Medicine and then set up the first national Communicable Disease Surveillance Unit in Malta and went on to become Malta’s national Director of

Public Health. He developed a keen interest in the prevention and control of Communicable Diseases, especially AIDS and HIV, and in the nineties worked with the WHO/GPA in Copenhagen and later with UNAIDS in Geneva. Over a period of about 15 years he has led or participated in almost a hundred missions in Eastern Europe and Central Asia, mainly focusing on strengthening HIV Programme Management and Planning, Surveillance and Monitoring and Evaluation, working for various international agencies. He is currently the head of the HIV, Sexually Transmitted Infections and Viral Hepatitis programme at the ECDC in Stockholm.

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HIV and Hepatitis in Europe, time to turn the tide

Masoud Dara, WHO Regional Office for Europe

Masoud Dara is a physician and public health expert from Belgium. In addition to his medical degree, he has accomplished several courses and postgraduate studies including courses at London School of Hygiene and Tropical Medicine and Harvard School of Public Health. Masoud Dara's professional career began as a clinician responsible for diagnosis and treating tuberculosis patients in rural and urban areas of Iran. Since 1998, Masoud Dara has been working with multiple national and international organizations implementing TB and TB/HIV control and care programmes, public health interventions and emergency response. He has worked as the Médecins Sans Frontières programme manager and medical coordinator in Central Asia from 1998 to 2001. From 2001 to 2003, Masoud Dara worked as a WHO Medical Officer in the Russian Federation providing technical assistance to national health authorities and TB and TB/HIV control services across the country. From 2003 to 2010, Masoud Dara worked as a senior consultant of KNCV Tuberculosis Foundation in different WHO Regions mainly in the fields of MDR-TB, TB/HIV and infection prevention and control. Since 2008, Masoud Dara has been appointed as the Chair of scientific working group of TB control in prisons of International Union Against Tuberculosis and Lung Diseases and since February 2015, Associate Editor of Journal of Tuberculosis and Lung Diseases. From 2010 to 2014, Masoud Dara led WHO Regional Office TB and MDR-TB programme, providing technical assistance to the Member States in prevention and control of drug resistant TB. From 2014 to 2016, based at WHO Office at European Union in Brussels, Masoud Dara worked as WHO Senior Advisor for communicable diseases and emergency and humanitarian response. Since October 2016, Masoud Dara has been coordinating communicable diseases and leading TB, HIV/AIDS and viral hepatitis programme at the WHO Regional Office for Europe.



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

Michel Kazatchkine, UN Secretary-General's Special Envoy on HIV/AIDS in Eastern Europe and Central Asia

Michel Kazatchkine has spent the last 30 years fighting AIDS as a leading physician, researcher, administrator, advocate, policymaker, and diplomat. He attended medical school at Hôpital Necker – Enfants Malades in Paris, studied immunology at the Pasteur Institute and completed postdoctoral fellowships at St. Mary's Hospital in London and Harvard Medical School. Professor Kazatchkine has played key roles in various organizations, including serving as Director of the National Agency for Research on AIDS (ANRS) in France (1998--2005) and Chair of the WHO's Strategic and Technical Committee on HIV/AIDS (2004--2007). From 2005 to 2007, Professor Kazatchkine served as French Ambassador for the fight against HIV/AIDS and Communicable Diseases. In 2007, he was elected Executive Director of the Global Fund, a position in which he served until March 2012. In July 2012, Professor Kazatchkine was appointed as the UN Secretary--General's Special Envoy on HIV/AIDS in Eastern Europe and Central Asia. He is a Senior Fellow with the Global Health Program of the Graduate Institute for International and Development Studies in Geneva, a member of the Global Commission on Drug Policy and serves as Chair of the Board of the Robert Carr Civil Society Networks Fund.



The patient perspective on whether we have the right testing strategies in Europe

Jackie Morton, European AIDS Treatment Group

Jackie Morton is a Registered Nurse, District nurse with a Master Degree in Business Administration. She is an active advocate for people living with HIV & comorbidities having been the Interim Chief Executive at Terrence Higgins Trust, Chair of HIV Scotland, Advisory panel member for the Blood Borne Virus Framework in Scotland 2011-15, advisory panel member of the UK Stigma Index 2015, lead on the BHIVA primary care project and is the Chair of the European Aids Treatment Group, Brussels.

WEDNESDAY, 1ST FEBRUARY, 2017

PLE1: SURVEILLANCE AND MONITORING AND EVALUATION OF TESTING

8:45-10:30

The aim of the session is first of all to provide an overview of the accomplishments and challenges of the HIV in Europe Initiative which was initiated 10 years ago in Brussels. Further, monitoring and surveillance of testing and linkage to care will be in focus, addressing how best to monitor progress and discuss challenges.

MODERATORS:



Teymur Noori, European Centre for Disease Prevention and Control

Teymur Noori works at the European Centre for Disease Prevention and Control, ECDC. He joined ECDC in 2007 and has been leading the work to monitor the HIV response in Europe and Central Asia (Dublin Declaration). Since 2007, he has also led ECDC's work on migrant health and infectious diseases.



Tatjana Reic, European Liver Patients Association

Tatjana Reic has been the President of European Liver Patients' Association (ELPA) since 2011. ELPA represents the collective voice of more than 100,000 people affected by liver disease. Established in 2005, it is an umbrella organization with 35 members in 27 countries involved in the fields of advocacy, scientific research and dissemination of information, aiming to highlight the heavy burden of liver disease in Europe. By raising awareness and by addressing the issue of prevention among healthcare professionals, policy-makers and the wider public ELPA is dedicated to promoting the interests of people with liver diseases across Europe and beyond. Prior to her tenure as President of the ELPA, back in the year 2000, she has founded "Hepatos", the first hepatitis patient association in Croatia. Today "Hepatos" is a leading civil society organization that has played a crucial role in ensuring that viral hepatitis is recognized and put on the policy agenda as a social problem. In 2005 it became a member of ELPA where Tatjana Reic took an active role as a member of the Steering and Advisory Committees, was the Vice President (2007 to 2011) before being elected the President in 2011. Tatjana Reic is a doctor of veterinary medicine and holds an MSci from the University of Zagreb, Croatia. A member of the Board of Advisors for the Viral Hepatitis Prevention Board, member of WHO Hepatitis Civil Society Reference Group, member of Hepatitis Technical Advisory Group for Georgia's Government Hepatitis C Elimination Program and several other expert organizations in the field of liver diseases well as a member of the Croatian National Committee for Viral Hepatitis and a founding member of the Croatian Alliance of Hepatitis Patients. Awarded, in 2010, by the Croatian Ministry of Health, the position of WHO focal point for Hepatitis she has held the position since then.

SPEAKERS



HIV & Viral Hepatitis: What's Next?

Alfred Sant, Member of the European Parliament

Alfred Sant studied physics and maths at the University of Malta, diplomacy at the Institut International d'Administration Publique (now amalgamated with the ENA) in Paris, and business administration at Boston and Harvard Universities. He worked as a diplomat at Malta's Mission to the then EEC in Brussels (1970 - 1975), as executive deputy chairman of the Malta Development Corporation (now Malta Enterprise) during the late seventies/early eighties, as a management consultant in between and later. He was chairman of the Labour Party's information department (1982 - 1984), President of the Party (1984 - 1988), a Labour M.P. (1987 - 2013), Labour Leader and Leader of the Opposition (1992 - 2008) and Prime Minister (1996 - 1998). Over the years Alfred Sant wrote plays for the theatre, radio and TV, as well as novels and short stories in the Maltese language; was editor of three magazines and for thirteen years a correspondent of the Economist Intelligence Unit; and he wrote extensively in English and Maltese for the political and economic press. Alfred Sant was elected Member of the European Parliament in May 2014.

10 years of HIV in Europe - what has been achieved, what remains as challenges



Jens Lundgren, CHIP, Rigshospitalet, University of Copenhagen

Jens Lundgren, MD, DMS.c. is Professor of Viral Diseases at the University of Copenhagen. In 1994 he established CHIP, Centre of Excellence for Health, Immunity and Infections, and has since been actively involved in international research in the field of infectious diseases, viral infections and HIV in particular. In 2010 CHIP was announced "Centre of Global Excellence" by the Capital Region of Copenhagen. The centre runs research activities in more than 35 countries and collaborates on clinical observational cohort studies as well as randomized controlled trials with more than 250 research institutions in Europe, USA, Canada, Australia and Latin America. Since 2015, Jens Lundgren is also center leader of the National Research Foundation Center of Excellence, PERSIMUNE. Jens Lundgren is author or co-author of more than 500 papers in scientific journals and book chapters. He has supervised 19 PhDs and six DMScs and has ongoing supervision for 12 PhDs and four DMScs. Co-chair of HIV in Europe Steering Committee from 2007 to 2013 and one of the founders of the initiative.



Ton Coenen, Rutgers

Ton Coenen is the Executive Director of Rutgers, centre of expertise on SRHR (Sexual and Reproductive Health and Rights) in the Netherlands and operating in 18 countries. Ton Coenen holds Master degrees in Public Health and Public Management. Before starting at Rutgers he was the executive director of Aids Fonds and STI/AIDS Netherlands for 17 years and worked in public health before that. He has been involved in strengthening civil society in many ways - among others: as the co-chair to the EU civil society Forum on HIV/AIDS, as co-chair to HIV in Europe, Board member to Icaso, as Board member to the Global Fund to Fight Aids, Tuberculosis and Malaria. Co-chair of HIV in Europe Steering Committee from 2007 to 2012 and one of the founders of the initiative.



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

Valerie Delpech, Public Health England

Valerie Delpech oversees the national surveillance of HIV based at Public Health England, 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.



Surveillance of Hepatitis and Hepatitis testing efforts among people who use drugs

Dagmar Hedrich, European Monitoring Centre for Drugs and Drug Addiction

Dagmar Hedrich is Head of the Health consequences and responses sector at the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in Lisbon, Portugal. She trained as a psychologist at Justus Liebig University in Giessen, Germany and gained a postgraduate qualification in the treatment of dependencies in 1986. Her work experience covers longitudinal research on outpatient treatment and self-recovery from heroin addiction, drug services planning and coordination at city level and, since 1991, European intergovernmental cooperation on drug demand reduction. At the EMCDDA, which she joined in 2001, she heads the Health consequences and responses sector, covering development and improvement of European data collection and analyses of drug-related health harms, drug treatment and harm reduction.

PLE2: MIXING TESTING STRATEGIES: COMMUNITY AND HEALTH CARE SETTINGS

11.00 - 12.30

The aim of the session is to provide an overview of ongoing testing activities in Europe in both health care and community settings. Examples of lessons learned from the two settings will be presented and how they complement each other in reaching the undiagnosed population.

MODERATORS



Wim Zuilhof, STI AIDS Netherlands

Wim Zuilhof works at STI AIDS Netherlands as manager of the National HIV and STI prevention programme for MSM and ethnic minorities in the Netherlands. He is involved in HIV, STI and Hepatitis prevention policies and strategies since 1988. Among other things he initiated and coordinated the current joint online strategy for MSM in the Netherlands, a series of online behavioral surveys among MSM and HIV testing campaigns for migrant communities and MSM. He contributed to the creation of the H-TEAM, a unique collaboration between all stakeholders involved in the prevention and care of HIV in Amsterdam, including key affected communities. In this consortium he coordinates the work package on early testing and direct treatment of MSM. He is one of the initiators of MCFree, a recently launched consortium working on the elimination of HCV among MSM in Amsterdam.



Jackie Morton, European AIDS Treatment Group

Jackie Morton is a Registered Nurse, District nurse with a Master Degree in Business Administration. She is an active advocate for people living with HIV & comorbidities having been the Interim Chief Executive at Terrence Higgins Trust, Chair of HIV Scotland, Advisory panel member for the Blood Borne Virus Framework in Scotland 2011-15, advisory panel member of the UK Stigma Index 2015, lead on the BHIVA primary care project and is the Chair of the European Aids Treatment Group, Brussels.

SPEAKERS



Indicator Condition Guided HIV testing - progress and challenges

Ann Sullivan, Saint Stephen's AIDS Trust

Ann Sullivan is a Consultant Physician and the Clinical Lead for the HIV Out-Patient Department at Chelsea and Westminster Hospital and Honorary Senior Lecturer, Imperial College, London. She trained in Hobart, Sydney and London and obtained her MD for her thesis: 'Immune reconstitution in HIV-1 infection: the effects of antiretroviral and immune therapy'. She has lead a number of HIV testing and prevention research studies, and is currently involved in OptTEST, a European-wide indicator condition-guided HIV testing project, and BEDS, a local blood-borne virus Emergency Department based opt out HIV testing programme. She has been involved in the development, writing and evaluation of a number of HIV testing guidelines both nationally and internationally.



The Euro HIV EDAT Project. Monitoring and evaluation of community based testing: achievements and challenges

Jordi Casabona, Euro HIV EDAT

Jordi Casabona is a medical epidemiologist, Scientific Director of CEEISCAT, President of the Fundació Sida i Societat and Associated Professor of Epidemiology and Preventive Medicine at the Autonomous University of Barcelona (UAB). He has been the Principal Investigator of the European Commission funded "HIV Community Based Testing Practices in Europe" project (COBATEST) and of the currently active European HIV Early Diagnosis and Treatment Project (Euro HIV EDAT). He was the co-President of the XIV International AIDS Conference in 2002 currently is member of the HIV in Europe Steering Committee.



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

Aaron Siegler, Emory University

Aaron Siegler is a Research Assistant Professor in the Department of Epidemiology at the Rollins School of Public Health, Emory University, and serves as the Prevention Core Assistant Director in the Emory Center for AIDS Research (CFAR). His research addresses behavioral and biomedical approaches to HIV prevention, with a focus on sexual minority populations. His current work includes research to facilitate the scale up of HIV pre-exposure prophylaxis (PrEP), to increase condom use through innovating the condom itself, and to use mobile technology and home-based strategies to facilitate combination HIV prevention strategies that include PrEP.



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

Michael Meulbroek, Projecte dels NOMS-Hispanosida

Michael Meulbroek was born in Amsterdam in 1959, and has lived in Barcelona, Spain, since 1986, where he was diagnosed with HIV. In 1993 he co-founded Projecte dels NOMS-Hispanosida, one of Spain's most important HIV/AIDS community-based organizations. He is also a treatment counselor and educator within INFOTRAT, a peer focused information and education program for people living with HIV/AIDS. In 1998 co-founder of

ATOS (Association for Organ Transplants to persons living with HIV), an organization which promotes access for people with HIV and HCV co-infection to the Organ Transplant program, resulting in the first liver transplant in 2002. His latest project since 2006, has been the implementation of the BCN Checkpoint, a community based centre of HIV and STI detection for Men who have Sex with Men and development of community research. Michael Meulbroek is also member of the European AIDS Treatment Group, community member of the INSIGHT Network and HIVACAT.

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

14:50-15:35

The aim of the session is to provide an overview of new treatment paradigms, PrEP in particular, and highlight how these affect testing pathways. Not only will potential impact on HIV testing be addressed, but also what implementation of PrEP will mean for hepatitis C testing. The session will ensure that participants will get a greater understanding of PrEP implementation, also in sexual health clinics, and the consequences for both HIV and hepatitis C testing pathways.

MODERATORS



Gus Cairns, NAM

Fergus (Gus) Cairns is a prominent HIV treatment and prevention advocate and writer. With a background in mental health and social work, he was diagnosed with HIV in 1985. Following a recovery from AIDS-related illness, he became editor of the UK's magazine for people with HIV, Positive Nation, and then joined NAM / aidsmap.com as editor of their newsletter and a member of their news team. He has taken a keen interest in biomedical and public-health approaches to preventing HIV, and since the early 2000s has covered progress in the development of PrEP, microbicides, and treatment as prevention. He wrote two editions of *Preventing HIV* for NAM. His interest in prevention led him to being co-chair of the PROUD PrEP study and Prevention Co-ordinator for EATG. He is currently working with a team to develop PrEP in Europe, a pan-European information, training, advocacy and networking initiative which would perform a similar task in biomedical prevention that bodies like EATG do in treatment advocacy. He lives with his partner, a doctor, in north London.



Anders Sönnnerborg, Karolinska University Hospital

Anders Sönnnerborg is Professor of Infectious Diseases and Clinical Virology at Karolinska Institutet, Stockholm. He has been clinically and scientifically active in the field of HIV since 1983. He is director of the Swedish InfCare HIV cohort and of the Swedish Reference group for Antiviral Therapy.

SPEAKERS



PrEP and experiences with PreP

Sheel Patel, Chelsea and Westminster Hospital

Sheel Patel is a Consultant physician in HIV and STIs at 56 Dean Street, Chelsea and Westminster Hospital in London. She trained at Guys, Kings and St Thomas' Hospital in London from where she qualified in 2004. She was appointed as a Consultant physician in 2013.



PrEP implementation: Viral hepatitis C testing required?

Maria Prins, Academic Medical Center

Maria Prins is a Professor of Public Health and the Epidemiology of Infectious Diseases at the Academic Medical Center (AMC) in Amsterdam. She is a senior epidemiologist and she is the head of the Department of Infectious Diseases, Research and Prevention at the Public Health Service of Amsterdam. She is internationally acknowledged as a leading researcher on the epidemiology of sexually transmitted and bloodborne viruses in key populations. She has a highly productive research career and has an active role in several collaborative (inter-)national studies. She coordinates the long-standing Amsterdam Cohort Studies on HIV among people who use drugs and men who have sex with men (MSM), which are now in their 32nd year of follow-up, and the Infectious Diseases network of the Academic Collaborative for Public Health, the Sarphati Initiative. She is a highly successful grantee. Her most recent funding includes the continuations of the Amsterdam Cohort Studies and the MOSAIC study on acute HCV infection in HIV-infected MSM and the start of AmPREP in H-team demonstration project. This project evaluates the uptake of PrEP among HIV negative MSM and transgender people and is running at the Public Health Service of Amsterdam from June 2015 onwards. Participants can choose between daily and event-driven PrEP.

ROUND TABLE DISCUSSION 1: HEPATITIS C AND UNEQUAL ACCESS TO TREATMENT IN EUROPE

16:05-17:05

The session will start with a 15-minute overview addressing the unequal access to hepatitis C treatment in Europe followed by a roundtable discussion. The aim of the roundtable discussion is to:

- Understand and discuss testing strategies in light of new hepatitis C treatment
- Discuss whether it makes sense to treat everyone with hepatitis
- Understand what the investment is and what the impact of treatment is in terms of reduced transmission
- Discuss if it is sensible to implement elimination strategies when it is not yet known how many are required to be treated in order to halt the transmission rate
- Address whether there are lessons to be learned from the treatment as prevention (TasP) strategy in the HIV response
- Whether patients without severe liver disease should be treated when a large proportion of those with advanced liver disease is not receiving treatment
- How to improve hepatitis C testing coverage and uptake

MODERATORS



Jens Lundgren, CHIP, Rigshospitalet, University of Copenhagen

Jens Lundgren, MD, DMS.c. is Professor of Viral Diseases at the University of Copenhagen. In 1994 he established CHIP, Centre of Excellence for Health, Immunity and Infections, and has since been actively involved in international research in the field of infectious diseases, viral infections and HIV in particular. In 2010 CHIP was announced "Centre of Global Excellence" by the Capital Region of Copenhagen. The centre runs research activities in more than 35 countries and collaborates on clinical observational cohort studies as well as randomized controlled trials with more than 250 research institutions in Europe, USA, Canada, Australia and Latin America. Since 2015, Jens Lundgren is also center leader of the National Research Foundation Center of Excellence, PERSIMUNE. Jens Lundgren is author or co-author of more than 500 papers in scientific journals and book chapters. He has supervised 19 PhDs and six DMScs and has ongoing supervision for 12 PhDs and four DMScs. Co-chair of HIV in Europe Steering Committee from 2007 to 2013 and one of the founders of the initiative.



Ludmila Maistat, Alliance for Public Health

Ludmila Maistat possesses more than 10-years experience of working in HIV/AIDS area. As the Senior Program Advisor on Hepatitis Policy and Advocacy with Alliance for Public Health (International HIV/AIDS Alliance in Ukraine), she has been leading advocacy campaigns and projects aimed at expanding access to hepatitis C diagnostics and treatment with particular focus on co-infection with HIV and key populations in Ukraine and other countries where the International HIV/AIDS Alliance operates. She is actively involved in the hepatitis C advocacy work in the Eastern Europe and Central Asian region and internationally being part of the Global HepCoalition and other policy and advocacy groups, coordinates international hepatitis C projects of the Alliance Center for HIV, Hepatitis C and Drug Use, sits on a number of WHO groups and contributed to development of the WHO guidelines on HCV screening, care and treatment, WHO Global Health Sector Strategy on Viral Hepatitis, member of HIV in Europe Steering Committee, member of Expert Advisory Group of the Medicines Patent Pool, chairs the HepC group of the NGO delegation to UNITAID.

SPEAKER

Hepatitis C and unequal access to treatment in Europe

Daniel Simões, GAT

Daniel Simões is a Psychologist, with a Masters in Community Psychology, and 10 years of work in the third sector, having been involved in areas such as mental health, social housing and child protection.

For the last 5 and half years he has been working in GAT (Portugal) as a Project Manager and Policy Officer, and has been involved in the design and implementation of screening and linkage to care projects, as well as in both national and international advocacy activities in the several scopes of the organization.

Daniel is also a member of the EATG, and is part of the Policy Working Group.

ROUND TABLE DISCUSSION - SHOULD WE TREAT THOSE DIAGNOSED OR DIAGNOSE THOSE WHO NEED TREATMENT?

PANEL MEMBERS



Nikoloz Chkhartishvili, Infectious Diseases, AIDS and Clinical Immunology Research Center

Nikoloz Chkhartishvili graduated from Tbilisi Medical Institute with MD degree, he obtained MS degree in epidemiology from the State University of New York at Albany and PhD degree in infectious diseases from Tbilisi State University. Currently, he holds the position as Deputy Director for Research at the Infectious Diseases, AIDS and Clinical Immunology Research Center in Tbilisi, Georgia, which is the country's leading institution in the field of HIV, viral hepatitis and other infectious diseases (except TB). Nikoloz Chkhartishvili leads the National HIV/AIDS Treatment and Care Program, through which Georgia ensures universal access to antiretroviral therapy (ART) since 2004. He has been involved in the development and implementation of Georgia's national hepatitis C elimination program and serves as a member of the national scientific committee for this initiative. Nikoloz Chkhartishvili is actively engaged in research and leads nationwide HIV cohort studies. He has published a number of peer-reviewed papers on HIV and HCV infections and also co-authored several national and international guidelines.



Margaret Hellard, Burnet Institute

Margaret Hellard is the Head of the Centre for Population Health at the Burnet Institute, Head of Hepatitis Services in the Department of Infectious Disease at The Alfred Hospital and an Adjunct Professor of Infectious Diseases Epidemiology at Monash University in Melbourne, Australia. Margaret Hellard's principal research interests are in preventing the transmission and improving the management of blood borne viruses and sexually transmitted infections. She has considerable experience in undertaking multidisciplinary community based research involving people who inject drugs (PWID), gay and bisexual men (GBM) and other vulnerable populations. Margaret Hellard is a Principal Investigator of a number of world first studies including the TAP Study which is examining the efficacy hepatitis C treatment as prevention in PWID, using a community based social network approach. She leads two world first hepatitis C elimination projects in Australia, one focusing on PWID and the other on HIV positive GBM, with the aim to eliminate hepatitis C in Australia and to inform the elimination of hepatitis C transmission globally. Margaret Hellard is a member of numerous advisory committees and working groups on viral hepatitis and HIV within Australia and globally including Chairing the inaugural WHO Guideline Development Group for Viral Hepatitis. She has over 300 peer reviewed publications and has received over \$40 million in competitive research grants and tenders.



Tatjana Reic, European Liver Patients Association

Tatjana Reic has been the President of European Liver Patients' Association (ELPA) since 2011. ELPA represents the collective voice of more than 100,000 people affected by liver disease. Established in 2005, it is an umbrella organization with 35 members in 27 countries involved in the fields of advocacy, scientific research and dissemination of information, aiming to highlight the heavy burden of liver disease in Europe. By raising awareness and by addressing the issue of prevention among healthcare professionals, policy-makers and the wider public ELPA is dedicated to promoting the interests of people with liver diseases across Europe and beyond. Prior to her tenure as President of the ELPA, back in the year 2000, she has founded "Hepatos", the first hepatitis patient association in Croatia. Today "Hepatos" is a leading civil society organization that has played a crucial role in ensuring that viral hepatitis is recognized and put on the policy agenda as a social problem. In 2005 it became a member of ELPA where Tatjana Reic took an active role as a member of the Steering and Advisory Committees, was the Vice President (2007 to 2011) before being elected the President in 2011. Tatjana Reic is a doctor of veterinary medicine and holds an MSci from the University of Zagreb, Croatia. A member of the Board of Advisors for the Viral Hepatitis Prevention Board, member of WHO Hepatitis Civil Society Reference Group, member of Hepatitis Technical Advisory Group for Georgia's Government Hepatitis C Elimination Program and several other expert organizations in the field of liver diseases as well as a member of the Croatian National Committee for Viral Hepatitis and a founding member of the Croatian Alliance of Hepatitis Patients. Awarded, in 2010, by the Croatian Ministry of Health, the position of WHO focal point for Hepatitis she has held the position since then.



Jürgen Rockstroh, University of Bonn

Jürgen Rockstroh is, in addition to his clinical practice, involved in HIV research on: antiretroviral therapy, including new drug classes; the course of HIV disease in haemophiliacs; and HIV and hepatitis co-infection. From 2007-2011 he was elected as the president of the German AIDS Society. He is also since 2009 a member of the executive committee of the European AIDS Clinical Society (EACS) and since 2011 member of the governing council of the International AIDS Society. He is also the chair of the National German AIDS Advisory Panel since 2011 and the EACS coinfection guidelines since 2008. In 2015, Jürgen Rockstroh was elected chair of the HIV in Europe Steering Committee.



Anton Basenko, Alliance for Public Health

Anton Basenko has a master's degree in international economy, from Kyiv National. As an IDU, OST user and HIV+, Anton Basenko has worked since 2010 in the HIV-service and IDUs/OST advocacy field in local and national NGOs in Ukraine. He joined the Eurasian Network of People who Use Drugs (ENPUD) in 2012 consulting for access to treatment for PUD/PLHIV component. In January 2013 he became a Senior Program Officer for the Alliance for Public Health (aka International HIV/AIDS Alliance Ukraine), coordinating international and national harm reduction projects, responsible for collaboration with State Penitentiary Service, Centres of Social Services, pharmacies and participating in HIV, HCV, TB, OST and drug use consultations, conferences, working groups and campaigns at national, regional and international levels. As a person, whose life was astoundingly impacted by GF programs he joined the Global Fund Advocates Network Speakers Bureau to influence the Replenishment and other funding for GF processes in 2015. He has been a Board member of International Network of People who Use Drugs (INPUD) since November 2015. In January 2016, he was elected to the Communities Delegation of the Global Fund Board, a global advocate of access to hep C treatment and harm reduction services among PWID.



Philippa Easterbrook, WHO

Philippa Easterbrook is Senior Scientist in the Global Hepatitis Programme, HIV department at the World Health Organization Headquarters in Geneva. For the last five years, she has led and coordinated the scientific research and programmatic vision in the development and dissemination of global normative guidance first on the use of antiretroviral therapy in adult, pregnant women and children; diagnosis and management of cryptococcal infection – a major cause of mortality in HIV-infection; and more recently on the care and treatment of hepatitis B and C infection and just launched hepatitis testing in low and middle-income countries. She also provides technical leadership and guidance to country Ministries of Health on the implementation of hepatitis testing and treatment scale-up and access programmes to lower cost diagnostics and drugs worldwide. She serves as vice-chair of the WHO Guidelines Review Committee. Philippa Easterbrook has published more than 250 peer-reviewed articles, and three books, including a best seller “Basic Medical Sciences for MRCP”. In 1999, she was winner of the BUPA award for best young medical researcher in the UK, and in 2009, received a five year UK National Institute of Health Research (NIHR) Senior Investigator Award.

ROUND TABLE DISCUSSION 2: ROLE OF STIGMA AND CRIMINALISATION IN DISCOURAGING TESTING

17:10-18:10

The aim of this discussion is to:

- Understand and discuss the role of stigma and criminalization barriers and how they discourage testing.
- How and which barriers discourage testing?
- What can we do to overcome these?

MODERATORS



Nikos Dedes, European AIDS Treatment Group

Nikos Dedes is past Chair of the Board of Directors at EATG, a voluntary organisation with more than 90 members across 30 different European countries, founded in 1991. He is the founder of the NGO 'Synthesis', which aims to increase awareness, prevent and promote scientific research about HIV/AIDS in Greece. He is also Co-Chair of the HIV/AIDS Civil Society Forum.



Valerie Delpech, Public Health England

Valerie Delpech oversees the national surveillance of HIV based at Public Health England, London, United Kingdom. She provides expert advise 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.

ROUND TABLE DISCUSSION - ROLE OF STIGMA AND CRIMINALISATION BARRIERS IN DISCOURAGING TESTING

PANEL MEMBERS



Edwin Bernard, HIV Justice Network

Edwin J Bernard, 54, is the Global Co-ordinator of the HIV Justice Network, a global information and advocacy hub for individuals and organisations working to end the inappropriate use of the criminal law to regulate and punish people living with HIV. A former editor at NAM, he has been contributing to global knowledge of HIV criminalisation since his first book on the subject in 2007. His focus is not only the problems but also pragmatic solutions including combating ignorance and stigma through collaboration, rationality and science.



Julian Hows, GNP+

Julian Hows has been involved in community based activism and organisations since 1973. From 1983 he was involved in early responses to HIV. As a community activist and organiser he has set up and implemented many programmes and projects, as well involved in the implementation, monitoring, and evaluation of such programmes in the UK and internationally. For the past six years has been working at the Global Network of People Living with HIV.



Lisa Power, OptTEST

Lisa Power is a freelance sexual health policy consultant, currently working on legal and regulatory barriers to testing and treatment and on training new/emerging HIV & LGBT+ activists. She was previously the Policy Director of Terrence Higgins Trust, the UK's largest HIV NGO.



Alexandrina Iovita, UNAIDS

Alexandrina Iovita is a national of the Republic of Moldova. She holds a PhD in International Public Law and a Master of Public Health and works as a Human Rights and Law Adviser at UNAIDS Geneva. She has over 12 years of experience with the UN at country and global level, of them eight years with UNAIDS. She has been involved in generating strategic guidance and providing technical assistance to governments in a variety of areas, including rights-based and gender-sensitive HIV national responses, implementing, monitoring and evaluating key human rights programmes as part of such responses, knowledge transfer and legal research and analysis. She has also supported countries in Eastern Europe and Central Asia in pre-empting and responding to HIV-related human rights crises.

FOLLOW NEWS FROM THE CONFERENCE AND PROVIDE FEEDBACK BY USING THE HASHTAG #HEPHIV2017





Raoul Fransen-dos Santos, International Civil Society Support

Raoul Fransen-dos Santos is senior policy adviser at International Civil Society Support (ICSS) where he coordinates the Free Space Process, a partnership of key global civil society networking organisations with a focus on HIV, global health and human rights. This partnership aims to enhance the effectiveness and efficiency of civil society in its role in the response to HIV/AIDS. Raoul Fransen-dos Santos has been involved in a wide range of programs supporting people living with HIV and AIDS globally, since 1993. As one of the co-founders of Young Positives and the HIV Young Leaders Fund, he contributed to building new and sustainable leadership in the HIV response among young people most affected by HIV. He is a member of the Communities Delegation of the board of the Global Fund to Fight AIDS, Tuberculosis and Malaria. Raoul Fransen-dos Santos studied Medicine and Health Sciences at the Maastricht University and holds a Masters degree in Public Health. Before joining the ICSS team, he also worked at the Dutch NGOs Aids Fonds and STOP AIDS NOW! focusing on young people's issues and access to HIV treatment and care. At ICSS, he coordinates the Free Space Process, which fosters collaboration among leading global HIV and Key Population networks.

THURSDAY, 2ND FEBRUARY, 2017

PLE 3: CONTINUUM OF CARE AND IMPROVING LINKAGE TO CARE

8:30-10:10

The aim of the session is to provide an overview of the concept of continuum of care and how useful it is as monitoring tool as well as examples and ideas for how linkage to care can be improved. The late presentation definitions for HIV and viral hepatitis and their level of implementation and the role of civil society in successful testing and linkage to care will be discussed and addressed.

MODERATORS



Andrew Amato-Gauci, European Centre for Disease Prevention and Control

Andrew Amato-Gauci is an Epidemiologist and Family Medicine specialist. He studied Public Health and Epidemiology at the London School of Hygiene & Tropical Medicine (LSHTM) and then set up the first national Communicable Disease Surveillance Unit in Malta and went on to become Malta's national Director of Public Health. He developed a keen interest in the prevention and control of Communicable Diseases, especially AIDS and HIV, and in the nineties worked with the WHO/GPA in Copenhagen and later with UNAIDS in Geneva. Over a period of about 15 years he has led or participated in almost a hundred missions in Eastern Europe and Central Asia, mainly focusing on strengthening HIV Programme Management and Planning, Surveillance and Monitoring and Evaluation, working for various international agencies. He is currently the head of the HIV, Sexually Transmitted Infections and viral Hepatitis Programme at the ECDC in Stockholm.



Jeffrey Lazarus, CHIP, Rigshospitalet, University of Copenhagen

Jeffrey Lazarus is a senior researcher at CHIP, Rigshospitalet, University of Copenhagen, Chair of the Board of AFEW, on the board of the EASL International Liver Foundation, and Editor-in-Chief of Hepatology, Medicine and Policy.

SPEAKERS



Understanding and improving the HIV continuum of care in Europe

Anastasia Pharris, European Centre for Disease and Prevention Control

Anastasia Pharris is an Expert in HIV at the European Centre for Disease Prevention and Control (ECDC) in Stockholm, Sweden. She is a nurse with Masters degrees in public health and community health nursing and a PhD in public health. Since 1997 she has worked on clinical and public health aspects of HIV in the USA, Uganda, Zambia, Vietnam, Sweden and, now, at European-level. At ECDC she is responsible for HIV surveillance within the countries of the European Union, an ECDC project on the HIV continuum of care, and has led ECDC scientific guidance project on the prevention of infections among people who inject drugs and men who have sex with men.

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

Amanda Mocroft, University College London

Amanda Mocroft is a Professor of Epidemiology and Medical Statistics at University College London. She has been involved in HIV research since 1993, and has an interest in cohort studies and long term outcomes associated with HIV infection, as well as toxicities, morbidity and mortality and coinfection with hepatitis C, and late presentation with HIV. Amanda Mocroft has been co-project investigator of the EuroSIDA study since 2010 and is co-leading the Late Presenter working group in COHERE (Collaboration of Observational HIV Epidemiological Research Europe).



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

Jürgen Rockstroh, University of Bonn

Jürgen Rockstroh is, in addition to his clinical practice, involved in HIV research on: antiretroviral therapy, including new drug classes; the course of HIV disease in haemophiliacs; and HIV and hepatitis co-infection. From 2007-2011 he was elected as the president of the German AIDS Society. He is also since 2009 a member of the executive committee of the European AIDS Clinical Society (EACS) and since 2011 member of the governing council of the International AIDS Society. He is also the chair of the National German AIDS Advisory Panel since 2011 and the EACS coinfection guidelines since 2008. In 2015, Jürgen Rockstroh was elected chair of the HIV in Europe Steering Committee.



The role of civil society in successful testing and linkage to care

Tracy Swan, Treatment Action Group

Tracy Swan has been doing HIV-related work since 1990; she added hepatitis C virus (HCV) in 1998. She has worked at community health centers, hospitals, syringe exchange and addiction treatment programs, correctional facilities and homeless shelters. Tracy Swan was the Hepatitis/HIV project director at Treatment Action Group from 2003 until 2016, where she worked to improve research of and access to HCV treatment. She currently works at Medicines Sans Frontiers Access Campaign, as part of the communications team.

PLE 4: NEW POINT OF CARE DIAGNOSTICS, AFFORDABILITY AND COST-EFFECTIVENESS

12:45-13:45

The aim of the session is to provide an overview of recent developments within diagnostics. Further, cost-effectiveness will be addressed covering both testing frequency and target groups for testing.

MODERATORS



Charles Gore, World Hepatitis Alliance

Charles Gore was diagnosed with hepatitis C in 1995 and cirrhosis in 1998. In 2000 he set up The Hepatitis C Trust together with three friends who also had hepatitis C. In 2002 he did pegylated interferon and ribavirin treatment and successfully eradicated the virus. He has continued to run the Trust, working extensively with Government Departments and the National Health Service (NHS) in the UK, championing the patient perspective. He was closely involved in the creation of the European Liver Patients Association and was elected its first President in 2004. In 2007 he organised a meeting of hepatitis patient organisations from around the world to agree on co-ordinated global action. From this emerged the decision to hold an annual World Hepatitis Day and to create a new NGO, the World Hepatitis Alliance, of which Charles Gore is the President. As a result of advocacy by the Alliance and its members WHO adopted successive viral hepatitis resolutions in 2010 and 2014, making World Hepatitis Day an official day and mandating the creation of a global strategy to tackle viral hepatitis. Charles sits on a number of national and international advisory bodies including various WHO hepatitis guidelines development groups and the WHO Director-General's Strategic and Technical Advisory Committee for Viral Hepatitis.



Mojca Matičič, University Medical Centre Ljubljana

Mojca Matičič is Head of the Viral Hepatitis Department at the University Medical Centre in Ljubljana, Slovenia. She is also a Professor of Infectious Diseases and Epidemiology in the Medical Faculty at the University of Ljubljana. After gaining her medical degree, Mojca Maticic specialised in internal medicine and in infectious diseases at the University of Ljubljana, before completing a masters and PhD in HIV/AIDS and HCV. Subsequently, she undertook international postdoctoral training at the Middlesex Hospital and Royal Free Hospital in London, UK. Mojca Matičič's research interests focus on viral infections, primarily viral hepatitis, HIV and herpesviruses. A member of numerous professional societies including EASL (European Association for the Study of the Liver), INHSU (International Network for management of Hepatitis in Substance Users)

and ESCMID (European Society of Clinical Microbiology and Infectious Diseases) where she actively participates in the Study Group for Viral Hepatitis (ESGVH), she is an advisor for the Viral Hepatitis Prevention Board (VHPB), and an advisor for the World Health Organization HIV/Viral Hepatitis/STI Committee. Mojca Matičič is also a member of the HIV/AIDS Committee of the Slovene Ministry of Health and a co-author of the National strategy for the management of HCV infection in Slovenia (in 1997). She leads the Slovene National Viral Hepatitis Expert Group and co-authored the national clinical practice guidelines for the treatment of HCV and HBV. She was one of the founders of the National Healthcare Network for the management of HCV in PWID in Slovenia (in 2007). A Senior Clinical Editor for Hepatology, Medicine and Policy (HMAP), she has authored or co-authored more than 400 articles in national and international peer-reviewed journals.

SPEAKERS



New diagnostics for HIV and HCV testing

Emmanuel Fajardo, Médecins Sans Frontières

Emmanuel Fajardo is currently the HIV/HCV Diagnostics Advisor for MSF's Access Campaign based in Barcelona - Spain. He studied Microbiology and Laboratory Science (BSc Hons) at the Universidad de Antioquia in Medellin - Colombia and Epidemiology (MSc) at the at London School of Hygiene & Tropical Medicine. After having worked in Colombia in a transplantation laboratory and in a tertiary mycobacteriology laboratory hospital he decided to work in the medical humanitarian field. He joined MSF in 2005 as Laboratory Manager working in an HIV/TB/Malaria/Kala-Azar project in Ethiopia. He then worked in an MDR-TB programme in Nukus - Uzbekistan overseeing an MSF-supported project. From 2008 to 2015 he worked at the MSF Southern Africa Medical Unit (SAMU) in Cape Town - South Africa as regional HIV/TB Laboratory Advisor. His work focused on providing technical support to MSF projects in Southern Africa, particularly on the implementation of simplified HIV/TB diagnostics suitable for resource-limited settings. Since November 2016, he is HIV/HCV Diagnostic Advisor at MSF's Access Campaign to provide support on technical, access and advocacy issues pertaining to HCV and HIV diagnostics.



Cost-effectiveness of HIV testing: frequency and target groups

Yazdan Yazdanpanah, INSERM

Yazdan Yazdanpanah is currently the Head of Infectious Disease department at Bichat Claude Bernard Hospital and Professor of Medicine at Paris Diderot University, France. He is Director of the DeSCID team (Decision Science In Infectious Disease Prevention, Control and Care) within the the National Institute for Health and Medical Research, INSERM unit at Paris Diderot University. He is also the Coordinator of the REACTing network (REsearch and ACTION targeting emerging infectious diseases) of INSERM which aims to coordinate french research actions during infectious disease outbreaks. Yazdan Yazdanpanah became an MD from Lille School of Medicine, France in 1996. He qualified from the same institution first as a hepato- gastro-enterologist in 1996 and next an infectious disease specialist in 2002. He obtained a Master of Science degree in epidemiology from the Harvard School of Public Health, Boston, US in 2000, and a Ph.D degree in public health from the Bordeaux School of Public Health in 2002. In 2006, he became Professor of Infectious Disease. His research interests include the clinical epidemiology of HIV and viral hepatitis, and the pharmaco-economics of antimicrobial agents. Yazdan Yazdanpanah has published extensively in peer-reviewed journals and makes frequent presentations at numerous national and international meetings.

CLOSING SESSION - EUROPEAN POLICIES AND STRATEGIES AND THEIR IMPLICATIONS

14:15-16:00

The last panel discussion of the HepHIV Conference will address:

- The relationship between existing policies and implementation of these in order to improve testing in Europe
- What are the implications of existing policies and how are European level policies addressed and implemented nationally?
- What indicators do we have to measure the impact of European policies?

MODERATORS



John de Wit, Utrecht University

John de Wit, MSc, PhD, is professor and past director of the Centre for Social Research in Health, UNSW, Sydney, Australia, and professor of interdisciplinary social science at Utrecht University, The Netherlands. John de Wit has been a leader in social research regarding HIV, STI and sexual health for over 25 years, and his expertise and interest is with theory-informed research into individual, social and structural factors that shape prevention, diagnosis and treatment.

John de Wit has published widely across a range of topics and in a diversity of esteemed journals. He is actively involved in teaching, capacity building and advisory and organizing committees.



Nino Tsereteli, Center for Information and Counseling on Reproductive Health – Tanadgoma

Nino Tsereteli has been working in the field of HIV/AIDS for more than 16 years. 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. In 2007,

Nino Tsereteli was appointed as Executive Director of “Tanadgoma”.

SPEAKER



Towards a realistic cure - the role of HIV testing

Brian Gazzard, Chelsea and Westminster Hospital

Brian Gazzard, MD, professor, 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.

PANEL DISCUSSION: BEST PRACTICES: TAILORING POLICIES TO SPECIFIC EPIDEMICS, HOW DO EUROPEAN POLICIES TRANSLATE INTO NATIONAL REALITY? IMPLICATIONS OF POLICIES AND INDICATORS

PANEL MEMBERS:



Andrew Amato-Gauci, European Centre for Disease Prevention and Control

Andrew Amato-Gauci is an Epidemiologist and Family Medicine specialist. He studied Public Health and Epidemiology at the London School of Hygiene & Tropical Medicine and then set up the first national Communicable Disease Surveillance Unit in Malta and went on to become Malta's national Director of Public Health. He developed a keen interest in the prevention and control of Communicable Diseases, especially AIDS and HIV, and in the nineties worked with the WHO/GPA in Copenhagen and later with UNAIDS in Geneva. Over a period of about 15 years he has led or participated in almost a hundred missions in Eastern Europe and Central Asia, mainly focusing on strengthening HIV Programme Management and Planning, Surveillance and Monitoring and Evaluation, working for various international agencies. He is currently the head of the HIV, Sexually Transmitted Infections and viral Hepatitis Programme at the ECDC in Stockholm.



Julia del Amo, Institute of Health Carlos III

Julia del Amo is tenured Professor of Research in Biomedical Sciences in the National Center for Epidemiology, Institute of Health Carlos III in Madrid, Spain. She has a solid track in researching inequalities in HIV infection, with a particular interest in inequalities by race/ethnicity and migrant status. She has contributed to the understanding of HIV disease progression in migrants, ethnic minorities and women and to estimate the burden of disease of HIV in migrant populations in the European epidemiological data and their HIV testing patterns. She started her research career in London in 1994 and in 2006 established her own research group in the National Center for epidemiology, after obtaining tenure by the National Board of Scientist in 2005. She has had uninterrupted research funding through competitive grants for the last 12 years in the fields of HIV epidemiology and is/has been principal investigator of numerous grants at Spanish and European level. She has co-authored over 200 publications including articles in peer-reviewed journals, book chapters and technical reports.



Dagmar Hedrich, European Monitoring Centre for Drugs and Drug Addiction

Dagmar Hedrich is Head of the Health consequences and responses sector at the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in Lisbon, Portugal. She trained as a psychologist at Justus Liebig University in Giessen, Germany and gained a postgraduate qualification in the treatment of dependencies in 1986. Her work experience covers longitudinal research on outpatient treatment and self-recovery from heroin addiction, drug services planning and coordination at city level and, since 1991, European intergovernmental cooperation on drug demand reduction. At the EMCDDA, which she joined in 2001, she heads the Health consequences and responses sector, covering development and improvement of European data collection and analyses of drug-related health harms, drug treatment and harm reduction.



Charmaine Gauci, Ministry for Health, Malta

Charmaine Gauci is the Superintendent of Public Health within the Ministry for Health in Malta with wide responsibility of public health to safeguard and enhance the health status of the people. Previous to this positions, she had occupied the position of Director of the Health Promotion and Disease Prevention Directorate for nine years. She graduated as a medical doctor in 1991. Over the years she has developed skills in the wide aspect of the public health specialty.

She pursued her studies with masters in public health and consequently followed the European Programme in Epidemiological Training. She has also specialized in fitness and nutrition. She attained her PhD Degree in epidemiology in 2006. Dr Gauci is also a Prince practitioner in project management. She is a fellow of the UK Royal Society for Public Health and a fellow of the UK Faculty of Public Health. Charmaine Gauci is a senior lecturer at the University of Malta and delivers lectures in the field of public health with special interest in Public Health, Epidemiology, Communicable Diseases, Health Promotion and Policy development. She is active in the field of public health having served as secretary, vice president and also served as president with the Malta Association of Public Health Medicine for four years. Charmaine Gauci acts as a focal point for a number of bodies within the European Commission including HLG, ECDC and Health Security and for the World Health Organisation and is project leader for a number of EU projects.



Lella Cosmaro, Fondazione LILA Milano ONLUS

Lella Cosmaro has been working in the HIV field since 1993 in an Italian NGO, LILA - the Italian League for Fighting AIDS - one of the leading national organizations. Over the years, LILA has become more and more involved in European policies and networks: Lella Cosmaro is the Italian member of the HIV/AIDS Civil Society Forum, which she co-chaired for the period 2012-2015. She has been a Steering Committee member of AIDS Action Europe from 2011 thru 2016, is

one of the External Advisory Board Members of the EATG, has been the civil society expert in a number of WHO missions in the region and is involved in some of the ECDC advisory groups. LILA has been / is a partner of many European projects and Joint Actions and is also very involved in Italian projects, advocacy and policy issues.



Brian Gazzard, Chelsea and Westminster Hospital

Brian Gazzard, MD, professor, 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.



Andrej Senih, European AIDS Treatment Group

Andrej Senih started HIV activism in Macedonia in 2010, not long after having been diagnosed with HIV. He has done extensive work at the local level in a wide range of areas, such as establishing community based support mechanisms for people with HIV (peer, psycho-social and legal support), public awareness raising, as well as policy and advocacy. His policy and advocacy work has been largely related to community representation in the governance of the

national HIV and TB programs in Macedonia and in national HIV strategic planning and programming processes; structured advocacy for improved and affordable access to ARVs in Macedonia, and - more recently - acting as one of the leaders of the joint civil society advocacy in Macedonia aiming to ensure that the government financing of HIV programs and services for key affected populations after the phasing out of the country's Global Fund support. His international experience has largely been involved with the European AIDS Treatment Group, where has been largely focusing on the organization's policy work regarding access to and affordability of medicines.



Marcus Cornberg, European Association for the Study of the Liver

Markus Cornberg, MD is Professor of Medicine (Infectious Diseases) and attending physician in the Department of Gastroenterology, Hepatology and Endocrinology at Hannover Medical School responsible for the infectious disease ward and the hepatitis outpatient clinic. He is also the managing director of the German Competence Network for Viral Hepatitis (Hep-Net) and medical secretary of the German Liver Foundation. In 2006/7 and in 2010 he coordinated the

German consensus process for the management of hepatitis B. In 2012 he was the German representative in the panel for the EASL Practice Guidelines for Hepatitis B. He has published more than 150 scientific articles on viral hepatitis and serves as a reviewer for several journals such as the Lancet, Gastroenterology, Hepatology, GUT, and the Journal of Hepatology.



Antons Mozalevskis, WHO

Antons Mozalevskis has worked as the focal point for viral hepatitis at the WHO Regional Office for Europe in Copenhagen, Denmark since 2015. He coordinated the development of the Action Plan for the Health Sector Response in the WHO European Region, which was endorsed in 2016 and as well is responsible for providing technical support to the Member States in the Region. He completed his medical training and residency in Family Medicine at Riga Stradins University, Latvia. He worked as a clinician for seven years and was involved in a number of civil society, professional organisations and regional expert networks working in the field of HIV/viral hepatitis prevention and research. In 2012-2014, he completed the European Programme for Intervention Epidemiology Training (EPIET) and received a Master Degree in Applied Epidemiology from the National School of Public Health in Madrid, Spain. Over the last two years he has participated in the development of several global WHO guidelines on hepatitis, including viral hepatitis strategic information and testing for hepatitis B and C.

Antons Mozalevskis has worked as the focal point for viral hepatitis at the WHO Regional Office for Europe in Copenhagen, Denmark since 2015. He coordinated the development of the Action Plan for the Health Sector Response in the WHO European Region, which was endorsed in 2016 and as well is responsible for providing technical support to the Member States in the Region. He completed his medical training and residency in Family Medicine at Riga Stradins University, Latvia. He worked as a clinician for seven years and was involved in a number of civil society, professional organisations and regional expert networks working in the field of HIV/viral hepatitis prevention and research. In 2012-2014, he completed the European Programme for Intervention Epidemiology Training (EPIET) and received a Master Degree in Applied Epidemiology from the National School of Public Health in Madrid, Spain. Over the last two years he has participated in the development of several global WHO guidelines on hepatitis, including viral hepatitis strategic information and testing for hepatitis B and C.

CONFERENCE CALL TO ACTION



Brian West, European AIDS Treatment group, co-chair

Brian West is on the Board of Directors of the EATG - a voluntary organisation which has more than 175 members from 47 countries in Europe. He also serves on the Steering committee of AIDS Action Europe, a pan-European NGO. Closer to home, he is a trustee/director on the board of Waverley Care, Scotland's largest NGO provider of services for people living with HIV



Jürgen Rockstroh, University of Bonn, co-chair

Jürgen Rockstroh is, in addition to his clinical practice, involved in HIV research on: antiretroviral therapy, including new drug classes; the course of HIV disease in haemophiliacs; and HIV and hepatitis co-infection. From 2007-2011 he was elected as the president of the German AIDS Society. He is also since 2009 a member of the executive committee of the European AIDS Clinical Society (EACS) and since 2011 member of the governing council of the International

AIDS Society. He is also the chair of the National German AIDS Advisory Panel since 2011 and the EACS coinfection guidelines since 2008. In 2015, Jürgen Rockstroh was elected chair of the HIV in Europe Steering Committee.



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Charmaine Gauci is the Superintendent of Public Health within the Ministry for Health in Malta with wide responsibility of public health to safeguard and enhance the health status of the people. Previous to this positions, she had occupied the position of Director of the Health Promotion and Disease Prevention Directorate for nine years. She graduated as a medical doctor in 1991. Over the years she has developed skills in the wide aspect of the public health specialty.

She pursued her studies with masters in public health and consequently followed the European Programme in Epidemiological Training. She has also specialized in fitness and nutrition. She attained her PhD Degree in epidemiology in 2006. Dr Gauci is also a Prince practitioner in project management. She is a fellow of the UK Royal Society for Public Health and a fellow of the UK Faculty of Public Health. Charmaine Gauci is a senior lecturer at the University of Malta and delivers lectures in the field of public health with special interest in Public Health, Epidemiology, Communicable Diseases, Health Promotion and Policy development. She is active in the field of public health having served as secretary, vice president and also served as president with the Malta Association of Public Health Medicine for four years. Charmaine Gauci acts as a focal point for a number of bodies within the European Commission including HLG, ECDC and Health Security and for the World Health Organization and is project leader for a number of EU projects.

PARALLEL SESSIONS

WEDNESDAY, 1ST FEBRUARY, 2017

13:30-14:45

PS1: MONITORING FOR HIV AND VIRAL HEPATITIS

WEDNESDAY, 1ST FEBRUARY 13:30 - 14:45

Room: Fortress

MODERATORS



Antons Mozalevskis, WHO

Antons Mozalevskis has worked as the focal point for viral hepatitis at the WHO Regional Office for Europe in Copenhagen, Denmark since 2015. He coordinated the development of the Action Plan for the Health Sector Response in the WHO European Region, which was endorsed in 2016 and as well is responsible for providing technical support to the Member States in the Region. He completed his medical training and residency in Family Medicine at Riga Stradins University, Latvia. He worked as a clinician for seven years and was involved in a number of civil society, professional organisations and regional expert networks working in the field of HIV/viral hepatitis prevention and research. In 2012-2014, he completed the European Programme for Intervention Epidemiology Training (EPIET) and received a Master Degree in Applied Epidemiology from the National School of Public Health in Madrid, Spain. Over the last two years he has participated in the development of several global WHO guidelines on hepatitis, including viral hepatitis strategic information and testing for hepatitis B and C.



Tom Platteau, Institute of Tropical Medicine, Brussel

Tom Platteau is mental health scientist and sexologist. He works at the HIV/STI clinic of the Institute of Tropical Medicine in Antwerp, Belgium. Since 2007, he coordinates projects on the development and implementation of novel HIV/STI testing using outreach and online strategies.

PS1/01 Are EU/EEA Countries Ready to Monitor Progress on HCV Programmes?

E. Aspinall^{1,2}, D. Goldberg^{1,2}, E. Duffell³, S. Hutchinson^{1,2}, H. Valerio^{1,2}, L. Tavoschi³

¹Glasgow Caledonian University, School of Health and Life Sciences, Glasgow, United Kingdom,

²Health Protection Scotland, Glasgow, United Kingdom, ³European Centre for Disease Prevention and Control, Stockholm, Sweden

PS1/02 HIV Testing in Persons Diagnosed with Hepatitis B and C

G. Ireland¹, D. Ogaz¹, P. Kirwan¹, S. Mandal¹, V. Delpech¹, N. Connor¹, R. Simmons¹

¹Public Health England, London, United Kingdom

Diagnosed HIV Infections in Persons Being Tested for the Hepatitis B Virus: England, 2008-2014

G. Ireland^{1,2}, V. Delpech¹, K. Balogun¹, P. Kirwan¹, S. Lattimore¹, S. Mandal^{1,2}, R. Simmons¹

¹Public Health England, London, United Kingdom

²The National Institute for Health Research Health Protection Research Unit (NIHR HPRU) in Blood Borne and Sexually Transmitted Infections at University College London

PS1/03 Organizational barriers as an explanation for differences in offer and uptake rates for hepatitis B/C and HIV testing in three drug addiction centres in Copenhagen

M. Linnet^{1,2}, L. Peters², D. Raben², H. Petersen¹, J. Gerstoft³, J. Lundgren²

¹City of Copenhagen, Social Services Department, Copenhagen, Denmark, ²CHIP, Rigshospitalet, University of Copenhagen, Copenhagen, Denmark, ³Department of Infectious Diseases, Rigshospitalet, Copenhagen, Denmark

PS1/04 Monitoring Anonymous HIV Testing in Estonia in 2005-2015

K. Rüütel¹, K. Kallavus¹, I. Tomera¹

¹National Institute for Health Development, Tallinn, Estonia

PS1/05 The COBATEST Network: A Platform to Perform Monitoring and Evaluation of HIV Community-based Testing Practices in Europe

L. Fernández-López^{1,2}, J. Reyes-Urueña¹, C. Agusti^{1,2}, I. Klavs³, T. Kustec³, J. Casabona^{1,2}, COBATEST network

¹Centre for Epidemiological Studies on HIV/STI in Catalonia (CEEISCAT), Agència de Salut Pública de Catalunya (ASPC), Badalona, Spain, ²CIBER Epidemiología y Salud Pública (CIBERESP), Madrid, Spain, ³National Institute of Public Health (NIJZ), Ljubljana, Slovenia

PS2: TESTING STRATEGIES IN KEY AFFECTED POPULATIONS

WEDNESDAY, 1ST FEBRUARY 13:30 - 14:45

Room: Gardjola

MODERATORS



Pierre Van Damme, Faculty of Medicine & Health Sciences, University of Antwerp

Pierre Van Damme is full professor at the University of Antwerp, Faculty of Medicine and Health Sciences. He chairs the Vaccine & Infectious Disease Institute (VAXINFECTIO), University of Antwerp; VAXINFECTIO is a consortium of three research units within the university: the Laboratory of Medical Microbiology (LMM), the Laboratory of Experimental Hematology (LEH), and the Centre for the Evaluation of Vaccination (CEV). It is recognized as 'Centre of Excellence' of the University of Antwerp and functions as WHO Collaborating Centre for the WHO European Region for the control and prevention of infectious diseases. Since 1994, he has served as the executive secretary of the Viral Hepatitis Prevention Board, a group of international experts dealing with topics on prevention and control of viral hepatitis. In 2016 he participated in the creation of a second expert board on HPV, the HPV control and prevention board. His current research projects at the University are focused on the epidemiology and prevention of vaccine-preventable infectious diseases, such as hepatitis A, hepatitis B, diphtheria, pertussis, varicella, rotavirus, measles, HSV, influenza, Ebola, Chikungunya, HPV and polio (in collaboration with the Bill & Melinda Gates Foundation). His research also concerns public health, youth health and preventive health for sex workers. He has been for more than 10 years a regular advisor for national and international organizations, including the Flemish Vaccination Platform, the National Immunization Technical Advisory Group, and the World Health Organization (European Regional Office and Headquarters). He has been appointed as chairman of the European Technical Advisory Group of Experts on communicable diseases and vaccines for the WHO European Region (ETAGE) (2004-2014). He is a member of the Belgian Royal Academy of Medicine.



Lella Cosmaro, Fondazione LILA Milano ONLUS

Lella Cosmaro has been working in the HIV field since 1993 in an Italian NGO, LILA - the Italian League for Fighting AIDS - one of the leading national organizations. Over the years, LILA has become more and more involved in European policies and networks: Lella Cosmaro is the Italian member of the HIV/AIDS Civil Society Forum, which she co-chaired for the period 2012-2015. She has been a Steering Committee member of AIDS Action Europe from 2011 thru 2016, is

one of the External Advisory Board Members of the EATG, has been the civil society expert in a number of WHO missions in the region and is involved in some of the ECDC advisory groups. LILA has been / is a partner of many European projects and Joint Actions and is also very involved in Italian projects, advocacy and policy issues.

PS2/01 HIV Diagnoses in Migrants from Western, Central and Eastern Europe in the EU/EEA; Emerging Epidemics

J. del Amo¹, I. Jarrin¹, V. Hernando¹, D. Alvarez Del Arco¹, B. Alejos¹, A. Amato², T. Noori², A. Pharris²

¹Institute of Health Carlos III, Madrid, Spain, ²ECDC, Stockholm, Sweden

HIV Diagnoses in Migrants from Latin America & Caribbean in Europe; Distinct Epidemics

J. Del Amo¹, I. Jarrin², V. Hernando², D. Alvarez Del Arco², B. Alejos², A. Amato³, A. Pharris³, T. Noori³

¹Institute of Health Carlos III, National Center for Epidemiology, Madrid, Spain, ²Institute of Health Carlos III, Madrid, Spain, ³ECDC, Stockholm, Sweden

PS2/02 A High Rate of HIV-1 Acquisition Post Immigration among Migrants in Sweden Determined by a CD4+ T-cell Decline Trajectory Model Indicates Missed Opportunities for Testing and Primary Prevention

J. Brännström¹, A. Sönnernborg^{1,2}, V. Swedhem¹, U. Neogi², G. Marrone¹

¹Karolinska Institutet and Karolinska University Hospital, Department of Medicine, Unit of Infectious Diseases and Department of Infectious Diseases, Stockholm, Sweden, ²Karolinska Institutet and Karolinska University Hospital, Division of Clinical Microbiology, Department of Laboratory Medicine, Stockholm, Sweden

PS2/03 Knowledge, and Actual Versus Potential Use of HIV Self-testing and Self-sampling Testing Kits in 8 European Countries

J. Hoyos Miller¹, M.J. Belza^{1,2}, C. Agustí^{1,3}, S. Chanos⁴, F. Pichon⁵, M. Kuske⁶, B. Cigan⁷, R. Fuertes⁸, L. Ooms⁹, R. Stefanescu¹⁰, C. Cabeza de Vaca², B. Arranz¹¹, L. de la Fuente^{1,11}

¹CIBER Epidemiología y Salud Pública (CIBERESP), Madrid, Spain, ²Institute of Health Carlos III, Escuela Nacional de Sanidad, Madrid, Spain, ³Centre Estudis Epidemiològics sobre les Infeccions de Transmissió Sexual i Sida de Catalunya (CEEISCAT), Departament de Salut, Generalitat de Catalunya,, Badalona, Spain, ⁴Checkpoint Athens, Athens, Greece, ⁵AIDS Fondet, Copenhagen, Denmark, ⁶AIDS Hilfe NRW e.V., Berlin, Germany, ⁷Legebitra, Ljubljana, Slovenia, ⁸GAT-Grupo de Ativistas em Tratamentos, Lisboa, Portugal, ⁹Institute Tropical Medicine, Antwerp, Belgium, ¹⁰ARAS-Asociația Romana Anti-SIDA, Bucharest, Romania, ¹¹Institute of Health Carlos III, Centro Nacional de Epidemiología, Madrid, Spain

PS2/04 From HIV-testing to Gay Health Centres: A mapping of European "Check-points"

A.J. Schmidt^{1,2}, D. Sander³, T. Noori⁴

¹London School of Hygiene and Tropical Medicine, Sigma Research, London, United Kingdom, ²Swiss Federal Office of Public Health FOPH, Infectious Diseases Division, Bern, Switzerland, ³Deutsche AIDS-Hilfe, Berlin, Germany, ⁴European Centre for Disease Prevention and Control (ECDC), Stockholm, Sweden

PS2/05 Factors Associated with HCV Test Uptake in Heroin Users Entering Substitution Treatment in Greece

O. Anagnostou¹, A. Fotiou², E. Kanavou², A. Andaraki², T. Manina², C. Richardson³, E. Kafetzopoulos¹, Drug Related Infectious Diseases (DRID) Medical Doctors Group of OKANA

¹Greek Organisation Against Drugs (OKANA), Athens, Greece, ²Greek Reitox Focal Point of the EMCDDA, Athens University Mental Health Research Institute (UMHRI), Athens, Greece, ³Panteion University of Social and Political Sciences, ATHENS, Greece

44 **THURSDAY, 2ND FEBRUARY, 2017**

10:15-11:30

PS3: CHALLENGES IN HEALTH CARE SETTINGS: TESTING AND LINKAGE TO CARE

THURSDAY, 2ND FEBRUARY 10:15-11:30

Room: Fortress

MODERATORS



Fiona Godfrey, European Association for the Study of the Liver

Fiona Godfrey is the Director of Policy and Public Affairs at the European Association for the Study of the Liver. Originally from the UK she is a law graduate and worked as a litigation solicitor in England before moving to Luxembourg in 1995. She has worked in EU and international public health for 20 years, starting off in the EU Commission Europe Against Cancer unit before moving to work for the UICC, ERS, the IUATLD and finally EASL in 2013. She has drafted

EU health legislation and worked on the WHO FCTC for 12 years, during which time she served as an expert observer and as an advisor to several health ministries around the world. In 2011 she was awarded the WHO World No Tobacco Day individual award for Europe. She has served on the boards of several health NGOs and will shortly be taking up a position as a Trustee at the UK human rights charity, Statewatch. She is also the alternate member for health on the EU Commission TTIP Advisory Group. In her work at EASL she focusses on viral hepatitis and alcohol policy. After 25 years of full on campaigning and international travel she would like to take things a little easier but suspects the political developments of 2016 will make that dream unattainable for quite some time.



Indicator Condition Guided HIV testing - progress and challenges

Ann Sullivan, Saint Stephen's AIDS Trust

Ann Sullivan is a Consultant Physician and the Clinical Lead for the HIV Out-Patient Department at Chelsea and Westminster Hospital and Honorary Senior Lecturer, Imperial College, London. She trained in Hobart, Sydney and London and obtained her MD for her thesis: 'Immune reconstitution in HIV-1 infection: the effects of antiretroviral and immune therapy'. She has lead a number of HIV testing

and prevention research studies, and is currently involved in OptTEST, a European-wide indicator condition-guided HIV testing project, and BEDS, a local blood-borne virus Emergency Department based opt out HIV testing programme. She has been involved in the development, writing and evaluation of a number of HIV testing guidelines both nationally and internationally.

PS3/01 Assessing the Representativeness of European HIV Cohort Participants as Compared to HIV Surveillance Data

G. Vourli¹, A. Pharris², F. Cazein³, D. Costagliola⁴, F. Dabis⁵, J. Del Amo⁶, V. Delpech⁷, A. Díaz⁶, E. Girardi⁸, A. Gourlay⁹, B. Gunsenheimer-Bartmeyer¹⁰, V. Hernando⁶, G. Nikolopoulos^{11,12}, K. Porter⁹, M. Rosińska¹⁵, C. Sabin⁹, B. Suligoj¹³, V. Supervie⁴, F. Wit¹⁴, G. Touloumi¹

¹Medical School, National and Kapodistrian University of Athens, Department of Hygiene, Epidemiology and Medical Statistics, Athens, Greece, ²European Centre for Disease Prevention and Control, Stockholm, Sweden, ³Institut National de Santé Publique, Saint-Maurice, France, ⁴Sorbonne Universités, UPMC Univ Paris 06, INSERM, Institut Pierre Louis d'Epidémiologie et de Santé Publique (IPLESP UMR_S 1136), Paris, France, ⁵Université Bordeaux, ISPED, Centre INSERM U1219 - Bordeaux Population Health, Bordeaux, France, ⁶Instituto de Salud Carlos III, National Center of Epidemiology, Madrid, Spain, ⁷Public Health England, London, United Kingdom, ⁸Clinical Epidemiology Unit, National Institute for Infectious Diseases, Rome, Italy, ⁹University College London, Department of Infection and Population Health, London, United Kingdom, ¹⁰Robert Koch Institute, Department of Infectious Disease Epidemiology HIV/AIDS, STI, Berlin, Germany, ¹¹Hellenic Centre for Disease Control and Prevention, Amarousio, Greece, ¹²University of Cyprus, Medical School, Nicosia, Cyprus, ¹³Istituto Superiore di Sanità, Centro Operativo AIDS, Rome, Italy, ¹⁴Stichting HIV Monitoring, Amsterdam, Netherlands, Department of Epidemiology, National Institute of Public Health – National, Institute of Hygiene, Warsaw, Poland¹⁵

PS3/02 Factors for Delayed Linkage to Care Following HIV Diagnosis in the WHO European Region

S. Croxford¹, F. Burns², A. Copas², A. Pharris³, V. Delpech¹, OptTEST for HIV in Europe

¹Public Health England, London, United Kingdom, ²University College London, Department of Infection and Population Health, London, United Kingdom, ³European Centre for Disease Prevention and Control, Stockholm, Sweden

PS3/03 Increased HIV Case Detection through Integration of HIV Testing in Georgian Hepatitis C Elimination Program Screening Activities

D. Baliashvili¹, M. Tsereteli¹, M. Alkhazashvili², K. Zakhshvili³, A. Gamkrelidze⁴

¹National Center for Disease Control and Public health, HIV/AIDS, Hepatitis, Tuberculosis and STIs, Tbilisi, Georgia, ²National Center for Disease Control and Public health, Regional Public Health, Tbilisi, Georgia, ³National Center for Disease Control and Public health, Communicable Diseases, Tbilisi, Georgia, ⁴National Center for Disease Control and Public health, Tbilisi, Georgia

PS3/04 Monitoring HIV-indicator Condition Based HIV Testing in Estonia

K. Rüütel¹, L. Lemsalu¹

¹National Institute for Health Development, Infectious Diseases and Drug Monitoring Department, Tallinn, Estonia

PS3/05 Testing for Blood Borne Viruses in the Emergency Department of a Large London Hospital

D. Bradshaw^{1,2}, C. Rae¹, G. Pickard³, D. Patel³, D. Rezende³, P. Roberts¹, K. Pillay¹, M. Foxton¹, A. Sullivan¹

¹Chelsea and Westminster Hospital NHS Foundation Trust, London, United Kingdom, ²Brighton and Sussex University Hospitals NHS Trust, Brighton, United Kingdom, ³Imperial College Healthcare NHS Trust, London, United Kingdom

PS4: COMMUNITY TESTING

THURSDAY, 2ND FEBRUARY 10:15-11:30

Room: Gardjola

MODERATORS



Per Slaaen Kaye, Euro HIV EDAT

Per Slaaen Kaye has worked with the Danish AIDS-Foundation for 10 years and he is the Manager of Checkpoints in three cities in Denmark. He has been part of the EU COBATEST and the Euro HIV EDAT projects, and he is currently in charge of a working group looking at linkage to care in six countries under the Euro HIV EDAT project.



Ben Collins, International HIV Partnerships

Ben Collins is director of International HIV Partnerships, a resource consultancy and activist platform, which works with local partners across Europe and the Middle East, especially low HIV prevalence countries, for successful responses to HIV and HCV. He is a founder of Network of Low HIV Prevalence Countries (NeLP), an EATG member, serves on the EACS education committee and the European HIV-HCV Testing Week work group. Ben Collins is the convenor of

ReShape, an emerging London-based think tank to reshape the response to HIV, HCV and related sexual and mental health concerns. Ben Collins has been HIV+ since 1982 and undetectable since 1998.

PS4/01 Development of a Toolkit for Implementation and Evaluation of Checkpoints for MSM

M. Kuske¹, C. Agusti², M. Meulbroek³, D. Rojas Castro⁴, F. Pinchon⁵, P. Slaaen⁵, M. Lobnik⁶, B. Cigan⁶, M. Wentzlaff-Eggebert¹, M. Alexandru⁷, T. Platteau⁸, D. Simões⁹, S. Schanos¹⁰, EURO HIV EDAT Study Group

¹AIDS Hilfe NRW e.V., Köln, Germany, ²CEEISCAT, Badalona, Spain, ³BCN Checkpoint Hispanosida, Barcelona, Spain, ⁴Association AIDES, Paris, France, ⁵AIDS Fondet, Copenhagen, Denmark, ⁶Legebitra, Ljubljana, Slovenia, ⁷ARAS, Bucarest, Romania, ⁸Institute Tropical Medicine, Brussels, Belgium, ⁹GAT-Grupo Português de Activistas sobre Tratamentos de VIH/SIDA, Lisboa, Portugal, ¹⁰Check-point Athens, Athens, Greece

PS4/02 Barring the Way to Health: How Legal and Regulatory Barriers Hinder Modernising HIV Testing across Europe

L. Power¹, J. Hows^{2,3}, S. Finne Jakobsen^{3,4}, A.-I. Von Lingen^{3,5}

¹OptTEST by HIV in Europe, Cardiff, United Kingdom, ²GNP+, Amsterdam, Netherlands, ³OptTEST by HIV in Europe, Copenhagen, Denmark, ⁴University of Copenhagen, Region H, Copenhagen, Denmark, ⁵European AIDS Treatment Group, Brussels, Belgium

PS4/03 BCN Checkpoint: Same-day Confirmation of Reactive HIV Rapid Test with Point Of Care PCR Test Accelerates Linkage to Care and Reduces Anxiety

M. Meulbroek¹, F. Pérez¹, A. Dalmau-Bueno², F. Pujol¹, J. Saz¹, H. Taboada¹, G. Marazzi¹, A. Carrillo¹, A. Cabas¹, A. Gata¹, E. Aldabó², B. Roldán², P. Coll², F. Añez², J. Pantaleón², M. Mochales², O. Martín², V. Gómez², J.F. Mir², J. Decoca²

¹Projecte dels NOMS-Hispanosida, Barcelona, Spain, ²BCN Checkpoint, Barcelona, Spain

PS4/04 Impact of Pre-Test Counseling Sessions on Increasing Knowledge About HIV and Hepatitis Among the Beneficiaries of a Free of Charge, Voluntary Counseling and Testing Program (VCT) in Constanta, Romania

A.-M. Schweitzer¹, M. Bogdan¹, G. Ivanov¹, A. Corduneanu¹, I. Ciocca¹

¹Fundatia Baylor Marea Neagra, Infectious Diseases, Constanta, Romania

PS4/05 Monitoring test uptake and risk behaviour in community based HIV/STI testing sites in Germany, 2015/2016

U. Marcus¹, S.B. Schink², M. Tappe³, German Checkpoint Collaborative Group

¹Robert Koch-Institut, Infectious Disease Epidemiology, Berlin, Germany, ²Charite Universitätsmedizin Berlin, Berlin, Germany, ³Deutsche AIDS-Hilfe, Berlin, Germany

FOLLOW NEWS FROM THE CONFERENCE AND PROVIDE FEEDBACK BY USING THE HASHTAG #HEPHIV2017

POSTER SESSIONS

WEDNESDAY, 1ST FEBRUARY, 2017

FROM 12:30-13:30 AND FROM 15:35-16:05 AND

THURSDAY, 2ND FEBRUARY, 2017

FROM 11:45-12:45

Poster category 1: Monitoring for HIV and Viral Hepatitis

PO1/01 Reflex RNA Testing on Hepatitis C Antibody Positive Samples: Is it Being Adopted?

G. Ireland¹, R. Simmons¹, S. Ijaz¹, S. Lattimore¹, M. Ramsay¹, S. Mandal¹

¹Public Health England, London, United Kingdom

PO1/02 Increasing Trend of New HIV Diagnoses among Older Adults in the EU/EEA: Missed Opportunities and Barriers to Testing

L. Tavošchi¹, J. Gomes¹, A. Pharris¹

¹European Centre for Disease Prevention and Control, Stockholm, Sweden

PO1/03 Monitoring HIV Testing Guidance Implementation in Estonia

K. Rüütel¹, L. Lemsalu¹

¹National Institute for Health Development, Infectious Diseases and Drug Monitoring Department, Tallinn, Estonia

PO1/04 Core Indicators for Monitoring and Evaluation of Community based Voluntary Counseling and Testing (CBVCT) for HIV in the COBATEST Network, 1st Half 2015 Data

I. Klavs¹, T. Kustec², L. Fernandez Lopez³, J. Casabona³, C. Agusti Benito³, J.M. Reyes Urena³, D. Rojas Castro⁴, F. Pichon⁵, P. Slaaen Kaye⁶, B. Cigan⁷, M. Kuske⁸, M. Dan⁹, G. Musat⁹, T. Platteau¹⁰, D. Simoes¹¹, L. Fugon⁴, COBATEST Network

¹National Institute of Public Health, Ljubljana, Slovenia, ²NIJZ, Ljubljana, Slovenia, ³CEEISCAT, Barcelona, Spain, ⁴AIDES, PANTIN Cedex, France, ⁵STOP-AIDS, AIDS-Foundation, Copenhagen, Denmark, ⁶STOP AIDS, AIDS-Foundation, Copenhagen, Denmark, ⁷LEGEBITRA, Ljubljana, Slovenia, ⁸AIDS-Hilfe NRW e.V., Berlin, Germany, ⁹Romanian association against AIDS - ARAS, Bucharest, Romania, ¹⁰ITM, Antwerpen, Belgium, ¹¹GAT-Grupo Português de Activistas sobre Tratamentos de VIH/SIDA, Lisbon, Portugal

PO1/05 HIV: Are we Testing Appropriately?

J.L. Hulley¹, K.S. Nurse¹

¹Northern Deanery, Newcastle Upon Tyne, United Kingdom

PO1/06 Mind the Gap: Exploring Continuum of Care for HIV in Slovenia

M. Solinc¹

¹Association SKUC, Ljubljana, Slovenia

PO1/07 Accessibility of HCV Diagnostics and Treatment Services in Eastern Europe and Central Asia (EECA)

L. Maistat¹, N. Kravchenko¹, P. Skala¹

¹ICF Alliance for Public Health, Policy and Advocacy, Kiev, Ukraine

PO1/08 Review of Specialty Guidelines on HIV Testing Recommendations for HIV Indicator Conditions in Spain

F.J. Manzanares¹, M. Gamarra¹, M.J. Pérez-Elías², J. Del Amo¹, V. Hernando¹, OptTEST Research Group

¹Institute of Health Carlos III, Madrid, Spain, ²Hospital Ramon y Cajal, Madrid, Spain

PO1/09 Prevalence and Risk of Hepatitis E Virus Infection in the HIV Population of Nepal

B.P. Gupta¹

¹Tribhuvan University, Kirtipur, Kathmandu, Nepal

PO1/11 Alternative Routes to HCV DAA Access in Europe

T. Bereczky^{1,2}, G.M. Corbelli¹

¹European AIDS Treatment Group, Brussels, Belgium, ²ELTE University of Budapest, Budapest, Hungary

PO1/12 Has Increased Rollout of DAA Therapy Decreased the Burden of Late Presentation and Advanced Liver Disease in Patients Starting HCV Therapy in Germany?

C. Boesecke¹, J. Rockstroh¹, P. Ingiliz², F. Berger³, K.-G. Simon⁴, T. Lutz⁵, K. Schewe⁶, J. Schulze zur Wiesch⁷, D. Hueppe⁸, S. Christensen⁹, S. Mauss³, GECCO study group

¹Bonn University Hospital, Bonn, Germany, ²Center for Infectiology Berlin, Berlin, Germany, ³Center for HIV and Hepatogastroenterology, Düsseldorf, Germany, ⁴Practice for Gastroenterology Leverkusen, Leverkusen, Germany, ⁵Infektologikum, Frankfurt, Germany, ⁶Infektionsmedizinisches Centrum Hamburg, Hamburg, Germany, ⁷University Medical Center Hamburg-Eppendorf, Hamburg, Germany, ⁸Practice for Gastroenterology Herne, Herne, Germany, ⁹CIM Infectious Diseases, Münster, Germany

PO1/13 Availability of HIV Testing in Health Care, Community-based and Home-based Settings in the EU/EEA Member States

E. Filatova¹, D. Raben², T. Platteau³, A.-I. von Lingen⁴, S. Croxford⁵, L. Tavošchi⁶, J. Casabona⁷, I. Sperle²

¹Individual Consultant, 'HIV in Europe' Initiatives, Barcelona, Spain, ²CHIP, Rigshospitalet, University of Copenhagen, Copenhagen, Denmark, Denmark, ³Institute of Tropical Medicine, Antwerp, Belgium, ⁴European AIDS Treatment Group, Brussels, Belgium, ⁵Public Health England, London, United Kingdom, ⁶European Centre for Disease Prevention and Control, Stockholm, Sweden, ⁷CEEISCAT, Spain

PO1/14 Variation in ART-coverage and Virological Suppression among HIV Key Populations

K. Laut¹, L. Shepherd², M. Gottfredsson³, D. Sedlacek⁴, B. Knysz⁵, J. Begovac⁶, R. Radoi⁷, N. Chkhar-tishvili⁸, E. Florence⁹, M. Ristola¹⁰, G. Fätkenheuer¹¹, P. Schmid¹², E. Kutzovatova¹³, D. Paduta¹⁴, P. Domingo¹⁵, J. Szilávik¹⁶, J. Lundgren¹, A. Mocroft², O. Kirk¹, on behalf of the EuroSIDA study group

¹CHIP, Department of Infectious Diseases, Finsencentret, Rigshospitalet, Copenhagen University, Copenhagen N, Denmark, ²University College London, Department of infection and population health, London, United Kingdom, ³University of Iceland and Landspítali University Hospital, Dept of Infectious Diseases, Reykjavik, Iceland, ⁴Charles University Hospital Plzen, AIDS Centre, Plzen, Czech Republic, ⁵Medical University, Wrocław, Poland, ⁶University Hospital of Infectious Diseases, Zagreb, Croatia, ⁷Clinical Hospital of Infectious Diseases Dr Victor Babes, Bucharest, Romania, ⁸Infectious Diseases, AIDS & Clinical Immunology Research Center, Tbilisi, Georgia, ⁹Institute of Tropical Medicine, Antwerp, Belgium, ¹⁰Helsinki University Hospital, Helsinki, Finland, ¹¹University Hospital Cologne, Cologne, Germany, ¹²Kantonsspital St Gallen, St Gallen, Switzerland, ¹³Nizhny

Novgorod Scientific and Research Institute of Epidemiology and Microbiology named after Academician I.N. Blokhina, Nizhny Novgorod, Russian Federation, ¹⁴Regional AIDS Centre, Svetlogorsk, Belarus, ¹⁵Hospital Clínic Sant Pau, Barcelona, Spain, ¹⁶United Szent István and Szent László Hospital, Budapest, Hungary

PO1/15 Improving Cascade of Care in Challenging Conditions: Experience from Eastern Siberia

A. Chuykov¹, A. Boyko², I. Tirikova², A. Zakowicz³, Z. Shabarova³

¹AHF Europe, Yekaterinburg, Russian Federation, ²Krasnoyarsk Regional AIDS Center, Krasnoyarsk, Russian Federation, ³AHF Europe, Amsterdam, Netherlands

PO1/16 Regional Differences across Europe in Advanced Fibrosis and Cirrhosis among HIV/HCV Co-infected Persons between 2010-2015

S. Amele¹, L. Peters², J.D. Lundgren^{2,3}, J.K. Rockstroh⁴, H. Sambatakou⁵, T. Staub⁶, F. Maltez⁷, C. Leen⁸, C. Pedersen⁹, J.M.G. Artigas¹⁰, S. Moreno¹¹, R. Matulionyte¹², G. Kyselyova¹³, I. Karpov¹⁴, D. Jilich¹⁵, M. Parczewski¹⁶, K. Zilmer¹⁷, H. Elinav¹⁸, K. Lacombe¹⁹, M. Cavassini²⁰, J. Tomazic²¹, A. Mocroft¹, EuroSIDA ¹UCL, Research Department of Infection & Population Health, LONDON, United Kingdom, ²University of Copenhagen, Faculty of Health Science, Copenhagen HIV Programme, Copenhagen, Denmark, ³Rigshospitalet, Department of Infectious Diseases, Copenhagen, Denmark, ⁴Universitäts Klinik Bonn, Bonn, Germany, ⁵Hippokraton General Hospital, Athens, Greece, ⁶Centre Hospitalier de Luxembourg, Luxembourg, Luxembourg, ⁷Hospital Curry Cabral, Lisbon, Portugal, ⁸Western General Hospital, Edinburgh, United Kingdom, ⁹Odense Universitetshospital, Odense, Denmark, ¹⁰Hospital Clínic, Barcelona, Spain, ¹¹Hospital Ramon y Cajal, Madrid, Spain, ¹²Vilnius University Hospital, Department of Infectious, Chest diseases, Dermatovenerology and Allergology, Vilnius, Lithuania, ¹³Crimean Republican AIDS centre, Simferopol, Ukraine, ¹⁴Belarus State Medical University, Minsk, Belarus, ¹⁵Faculty Hospital Bulovka, Prague, Czech Republic, ¹⁶Pomeranian Academy of Medicine (PAM), Szczecin, Poland, ¹⁷West-Tallinn Central Hospital, Tallinn, Estonia, ¹⁸Hadassah Hospital, Jerusalem, Israel, ¹⁹Hospital Saint Antoine, Paris, France, ²⁰Centre hospitalier Universitaire Vaudois, Lausanne, Switzerland, ²¹University Clinical Centre Ljubljana, Ljubljana, Slovenia

PS1/01 Are EU/EEA Countries Ready to Monitor Progress on HCV Programmes?

E. Aspinall^{1,2}, D. Goldberg^{1,2}, E. Duffell³, S. Hutchinson^{1,2}, H. Valerio^{1,2}, L. Tavoschi³

¹Glasgow Caledonian University, School of Health and Life Sciences, Glasgow, United Kingdom, ²Health Protection Scotland, Glasgow, United Kingdom, ³European Centre for Disease Prevention and Control, Stockholm, Sweden

PS1/02 HIV Testing in Persons Diagnosed with Hepatitis B and C

G. Ireland¹, D. Ogaz¹, P. Kirwan¹, S. Mandal¹, V. Delpech¹, N. Connor¹, R. Simmons¹

¹Public Health England, London, United Kingdom

Diagnosed HIV Infections in Persons Being Tested for the Hepatitis B Virus: England, 2008-2014

G. Ireland¹, V. Delpech¹, K. Balogun¹, P. Kirwan¹, S. Lattimore¹, S. Mandal¹, R. Simmons¹

¹Public Health England, London, United Kingdom

PS1/03 Organizational barriers as an explanation for differences in offer and uptake rates for hepatitis B/C and HIV testing in three drug addiction centres in Copenhagen

M. Linnet^{1,2}, L. Peters², D. Raben², H. Petersen¹, J. Gerstoft³, J. Lundgren²

¹City of Copenhagen, Social Services Department, Copenhagen, Denmark, ²CHIP, Rigshospitalet, University of Copenhagen, Copenhagen, Denmark, ³Department of Infectious Diseases, Rigshospitalet, Copenhagen, Denmark

PS1/04 Monitoring Anonymous HIV Testing in Estonia in 2005-2015

K. Rüütel¹, K. Kallavus¹, I. Tomera¹

¹National Institute for Health Development, Tallinn, Estonia

PS1/05 The COBATEST Network: A Platform to Perform Monitoring and Evaluation of HIV Community-based Testing Practices in Europe

L. Fernández-López^{1,2}, J. Reyes-Urueña¹, C. Agusti^{1,2}, I. Klavs³, T. Kustec³, J. Casabona^{1,2}, COBATEST network

¹Centre for Epidemiological Studies on HIV/STI in Catalonia (CEEISCAT), Agència de Salut Pública de Catalunya (ASPC), Badalona, Spain, ²CIBER Epidemiología y Salud Pública (CIBERESP), Madrid, Spain, ³National Institute of Public Health (NIJZ), Ljubljana, Slovenia

Poster category 2: Testing Strategies in Key Affected Populations

PO2/01 Missed Opportunities for Diagnosing Viral Hepatitis Testing in Europe: a 25-country Analysis

J. Lazarus^{1,2}, S.R. Stumo², K.L. Hetherington², J. Tallada³, M. Harris⁴, T. Reic⁵, K. Safreed-Harmon², on behalf of the Hep-CORE Study Group

¹CHIP, Department of Infectious Diseases, Rigshospitalet, Copenhagen, Denmark, ²ISGlobal, Hospital Clinic, University of Barcelona, Barcelona, Spain, ³European AIDS Treatment Group, Brussels, Belgium, ⁴Department of Social and Environmental Health Research, London School of Hygiene and Tropical Medicine, London, United Kingdom; ⁵European Liver Patients Association, Belgium

PO2/02 Hepatitis B, C and HIV Testing Uptake in the General, Migrant and Roma Populations in Greece: Results from the Health Examination Survey Hprolipsis

G. Touloumi¹, A. Kalpourtzi¹, O. Anagnostou¹, I.S. Petraki², A. Karakosta¹, S. Kaskafetou¹, A. Vantarakis³, P. Voulgari⁴, G. Rachiotis⁵, G. Chlouverakis⁶, G. Trypsianis⁷, I. Alamanos⁸, T. Mimikou⁹, T. Antypas¹⁰, M. Gavana¹¹

¹Medical School, National and Kapodistrian University of Athens, Department of Hygiene, Epidemiology & Medical Statistics, Athens, Greece, ²Medical School, National and Kapodistrian University of Athens, MSc International Medicine - Health Crisis Management, Athens, Greece, ³Medical School, University of Patra, Environmental Microbiology Unit, Department of Public Health, Patra, Greece, ⁴Medical School, University of Ioannina, Rheumatology Clinic, Department of Internal Medicine, Ioannina, Greece, ⁵Medical Faculty, University of Thessaly, Department of Hygiene & Epidemiology, Larissa, Greece, ⁶School of Medicine, University of Crete, Division of Biostatistics, Heraklion, Greece, ⁷Medical Faculty, Democritus University of Thrace, Department of Medical Statistics, Alexandroupolis, Greece, ⁸Institute of Epidemiology, Preventive Medicine and Public Health, Corfu, Greece, ⁹Medecins Du Monde (MDM), Athens, Greece, ¹⁰PRAKSIS NGO, Athens, Greece, ¹¹Medical School, Aristotle University of Thessaloniki, Department of Primary Care, General Practice and Health Services Research, Athens, Greece

PO2/03 Targeting HIV-stigma within the MSM Community in Italy: Results from a National Survey

R. Lelleri¹, G.M. Corbelli^{2,3}, S. Mattioli⁴, M. Degli Esposti⁴

¹Independent researcher, Bologna, Italy, ²Plus onlus, Rome, Italy, ³European AIDS Treatment Group, Bruxelles, Belgium, ⁴Plus onlus, Bologna, Italy

PO2/04 Increasing the Impact of Harm Reduction Programs in Response to HIV and HCV Epidemics through Integrated Approach of Testing with Linkage to Care and Treatment

N. Kravchenko¹, L. Maistat², P. Skala²

¹ICF Alliance for Public Health, Policy and advocacy, Kiev, Ukraine, ²ICF Alliance for Public Health, Policy and Advocacy, Kiev, Ukraine

PO2/06 Get Test Project: an Innovative Approach in Attraction of Customers to the Continuum of Services for MSM

A. Chernyshev¹, A. Radetsky², R. Marchenko³

¹Public organization 'GAY-ALLIANCE', Head of external communication and advocacy, Kyiv, Ukraine,

²Public organization 'GAY-ALLIANCE', Outreach Department, Kyiv, Ukraine, ³Public organization 'GAY-ALLIANCE', Program Director, Head of Get Test Project, Kyiv, Ukraine

PO2/07 Missing Opportunities: Systematic Review on Testing for HCV in Prison Settings

G. Madeddu¹, H. Vroiling², A. Oordt², M. Vonk Noordegraaf-Schouten², R. Monarca³, S. Babudieri¹, L. Tavošchi⁴

¹University of Sassari, Department of Clinical and Experimental Medicine, Unit of Infectious Diseases, Sassari, Italy, ²Pallas Health Research and Consultancy, Rotterdam, Netherlands, ³Health Without Barriers - European Federation for Prison Health, Viterbo, Italy, ⁴European Centre for Disease Prevention and Control, Stockholm, Sweden

PO2/08 The Role of PWID Community in Increasing Importance of Testing for Harm Reduction Services in Ukraine

A. Basenko¹

¹INPUD, APH, Kyiv, Ukraine

PO2/09 Strategies to Expand Access to Treatment for Hepatitis C and Promote Adherence to HIV Treatment: the Role of Peer Work in a Harm Reduction Centre in Lisbon, Portugal

R. Pinto¹, J. Santa Maria¹, M. Ferreira²

¹GAT, IN-Mouraria, Lisboa, Portugal, ²GAT, IN-Mouraria, Lisbon, Portugal

PO2/10 The "Red Umbrella Athens" Initiative: Presentation of the First Sex Workers' Drop-In Centre in Athens, Greece.

A. Poulis¹, S. Chanos², A. Christopoulos¹, M. Xanthaki², N. Kakantousis², N. Fitsialos², A. Kouroukou², L. Polychronopoulou², G. Papadopetrakis², A. Papatrechas², C. Sagredos²

¹National and Kapodestrian University of Athens, Psychology Dpt., Athens, Greece, ²Positive Voice, Greek Association of PLWHA, Athens, Greece

PS2/01

HIV Diagnoses in Migrants from Western, Central and Eastern Europe in the EU/EEA; Emerging Epidemics

J. del Amo¹, I. Jarrin¹, V. Hernando¹, D. Alvarez Del Arco¹, B. Alejos¹, A. Amato², T. Noori², A. Pharris²

¹Institute of Health Carlos III, Madrid, Spain, ²ECDC, Stockholm, Sweden

HIV Diagnoses in Migrants from Latin America & Caribbean in Europe; Distinct Epidemics

J. Del Amo¹, I. Jarrin², V. Hernando², D. Alvarez Del Arco², B. Alejos², A. Amato³, A. Pharris³, T. Noori³

¹Institute of Health Carlos III, National Center for Epidemiology, Madrid, Spain, ²Institute of Health Carlos III, Madrid, Spain, ³ECDC, Stockholm, Sweden

PS2/02 A High Rate of HIV-1 Acquisition Post Immigration among Migrants in Sweden Determined by a CD4+ T-cell Decline Trajectory Model Indicates Missed Opportunities for Testing and Primary Prevention

J. Brännström¹, A. Sönnernborg^{1,2}, V. Swedhem¹, U. Neogi², G. Marrone¹

¹Karolinska Institutet and Karolinska University Hospital, Department of Medicine, Unit of Infectious Diseases and Department of Infectious Diseases, Stockholm, Sweden, ²Karolinska Institutet and Karolinska University Hospital, Division of Clinical Microbiology, Department of Laboratory Medicine, Stockholm, Sweden

PS2/03 Knowledge, and Actual Versus Potential Use of HIV Self-testing and Self-sampling Testing Kits in 8 European Countries

J. Hoyos Miller¹, M.J. Belza^{1,2}, C. Agustí^{1,3}, S. Chanos⁴, F. Pichon⁵, M. Kuske⁶, B. Cigan⁷, R. Fuertes⁸, L. Ooms⁹, R. Stefanescu¹⁰, C. Cabeza de Vaca², B. Arranz¹¹, L. de la Fuente^{1,11}

¹CIBER Epidemiologia y Salud Publica (CIBERESP), Madrid, Spain, ²Institute of Health Carlos III, Escuela Nacional de Sanidad, Madrid, Spain, ³Centre Estudis Epidemiològics sobre les Infeccions de Transmissió Sexual i Sida de Catalunya (CEEISCAT), Departament de Salut, Generalitat de Catalunya, Badalona, Spain, ⁴Checkpoint Athens, Athens, Greece, ⁵AIDS Fondet, Copenhagen, Denmark, ⁶AIDS Hilfe NRW e.V., Berlin, Germany, ⁷Legebitra, Ljubljana, Slovenia, ⁸GAT-Grupo de Ativistas em Tratamentos, Lisboa, Portugal, ⁹Institute Tropical Medicine, Antwerp, Belgium, ¹⁰ARAS-Asociatia Romana Anti-SIDA, Bucharest, Romania, ¹¹Institute of Health Carlos III, Centro Nacional de Epidemiología, Madrid, Spain

PS2/04 From HIV-testing to Gay Health Centres: A mapping of European "Checkpoints"

A.J. Schmidt^{1,2}, D. Sander³, T. Noori⁴

¹London School of Hygiene and Tropical Medicine, Sigma Research, London, United Kingdom, ²Swiss Federal Office of Public Health FOPH, Infectious Diseases Division, Bern, Switzerland, ³Deutsche AIDS-Hilfe, Berlin, Germany, ⁴European Centre for Disease Prevention and Control (ECDC), Stockholm, Sweden

PS2/05 Factors Associated with HCV Test Uptake in Heroin Users Entering Substitution Treatment in Greece

O. Anagnostou¹, A. Fotiou², E. Kanavou², A. Andaraki², T. Manina², C. Richardson³, E. Kafetzopoulos¹, Drug Related Infectious Diseases (DRID) Medical Doctors Group of OKANA

¹Greek Organisation Against Drugs (OKANA), Athens, Greece, ²Greek Reitox Focal Point of the EMCDDA, Athens University Mental Health Research Institute (UMHRI), Athens, Greece, ³Panteion University of Social and Political Sciences, ATHENS, Greece

Poster category 3: Challenges in Health Care Settings and Linkage to Care

PO3/01 Delays in Starting HIV Treatment as Prevention: ART Initiation in the UK

A. Brown¹, Z. Yin¹, C. Chau¹, P. Kirwan¹, N. Gill¹, V. Delpech¹

¹Public Health England, London, United Kingdom

PO3/02 Promotion of HIV Testing in Primary Care in East London through a Research Programme is Effective. An MRC Phase IV Implementation Study

W. Leber¹, J. Anderson², J. Figueroa³, F. Naomi⁴, C. Estcourt⁵, M. Shahmanesh⁴, J. Hutchinson⁵, L. Beresford¹, C. Nightingale¹, F. El-Shogri¹, K. Boomla¹, S. Creighton², D. Millett², H. McMullen¹, C. Griffiths¹, HIV-CLAHRC

¹Queen Mary University of London, London, United Kingdom, ²Homerton University Hospital NHS Foundation Trust, London, United Kingdom, ³NHS City and Hackney, London, United Kingdom, ⁴University College London, London, United Kingdom, ⁵Barts Health NHS Trust, London, United Kingdom

PO3/03 Is the Emergency Department (ED) a Suitable Environment to Offer Hepatitis Screening?

L. Hunter¹, G. Nebbia², S. Douthwaite²

¹Guy's & St Thomas NHS Foundation Trust, Emergency Department, London, United Kingdom,

²Guy's & St Thomas NHS Foundation Trust, Infectious Diseases, London, United Kingdom

PO3/04 Routine HIV Testing in an Inner City Emergency Department- Avoiding Missed Opportunities for Testing

L. Hunter¹, N. Larbalestier², J. Paparello²

¹Guy's & St Thomas NHS Foundation Trust, Emergency, London, United Kingdom, ²Guy's & St

Thomas NHS Foundation Trust, Sexual Health, London, United Kingdom

PO3/05 HIV Testing Improvement in Primary Care through Opt-TEST's Indicator Condition Guided Testing: The Tool-1 and Plan-Do-Study-Act Experience in Catalonia, 2016

R. Lugo^{1,2}, A. Sullivan³, C. Rae³, D. Lacasta^{4,5}, J. Casabona^{1,2}, D. Raben⁶, Opt-TEST Study group

¹Centre for Epidemiological Studies on HIV/STI in Catalonia (CEEISCAT), Agència de Salut Pública de Catalunya (ASPC), Departament de Salut de Catalunya, Badalona, Spain, ²CIBER Epidemiología y Salud Pública (CIBERESP), Badalona, Spain, ³Chelsea and Westminster Hospital NHS Foundation Trust, London, United Kingdom, ⁴Institut Català de la Salut (ICS), CAP Gran Sol, Badalona, Spain, ⁵Unitat de Recerca Atenció Primària Jordi Gol, Badalona, Spain, ⁶CHIP, Rigshospitalet, University of Copenhagen, Copenhagen, Denmark

PO3/06 One Year after their Commercialization in France, who Use HIV Self-tests?

K. Champenois¹, V. Coquelin², D. Rahib-Kersaudy³, V. Supervie⁴, A. Velter³, D. Rojas-Castro², J. Ghosn⁴, N. Lydié³, T. Greacen¹

¹EPS Maison Blanche, Laboratoire de recherche, Paris, France, ²AIDES (MIRE-Mission Innovation Recherche Expérimentation), Pantin, France, ³Santé Publique France, Saint-Denis, France, ⁴Inserm U1136, Paris, France

PO3/07 Population-based Modeling as the First Step in Optimization of HIV Interventions in Ukraine

S. Soloviov^{1,2}, A. Symchuk¹, O. Bulakh²

¹Shupyk National Medical academy of postgraduate education, Virology Department, Central research laboratory, Kyiv, Ukraine, ²The National Technical University of Ukraine 'Igor Sikorsky Kyiv Polytechnic Institute', Department of Applied Mathematics, Kyiv, Ukraine

PO3/08 Psychiatric Symptomatology among Patients with HIV and Hepatitis C - the Experience of a Romanian Clinic

A.-M. Schweitzer¹, M. Bogdan¹, L.S. Vlahopol¹, I. Radulescu¹, S.I. Stanciu¹, C. Pop¹, D. Craciun¹

¹Fundatia Baylor Marea Neagra, Infectious Diseases, Constanta, Romania

PO3/10 Incidence and Risk Factors for Medical Care Interruption in HIV-Infected Patients

A. Fournier¹, K. Champenois², E. Papot², E. Bouvet², R. Landman², R. Verdon¹, Y. Yazdanpanah²

¹CHU de Caen, Maladies infectieuses, Caen, France, ²Hôpital Bichat; AP-HP, Paris, France

PO3/11 Collaboration with Primary Healthcare Network Significantly Improves Retention in Care and Viral Load Suppression in Ukraine

A. Chuykov¹, Y. Lopatina², L. Sikailo³, S. Zhmynda³, V. Zadorozhnia³, A. Zakowicz⁴, Z. Shabarova^{4,1}AHF Europe, Yekaterinburg, Russian Federation, ²AHF Ukraine, Kiev, Ukraine, ³Voznesensk Regional Hospital, Voznesensk, Ukraine, ⁴AHF Europe, Amsterdam, Netherlands

PS3/01 Assessing the Representativeness of European HIV Cohort Participants as Compared to HIV Surveillance Data

G. Vourli¹, A. Pharris², F. Cazein³, D. Costagliola⁴, F. Dabis⁵, J. Del Amo⁶, V. Delpech⁷, A. Díaz⁶, E. Girardi⁸, A. Gourlay⁹, B. Gunesheimer-Bartmeyer¹⁰, V. Hernando⁶, G. Nikolopoulos^{11,12}, K. Porter⁹, M. Rosińska¹⁵, C. Sabin⁹, B. Suligoj¹³, V. Supervie⁴, F. Wit¹⁴, G. Touloumi¹

¹Medical School, National and Kapodistrian University of Athens, Department of Hygiene, Epidemiology and Medical Statistics, Athens, Greece, ²European Centre for Disease Prevention and Control, Stockholm, Sweden, ³Institut National de Santé Publique, Saint-Maurice, France, ⁴Sorbonne Universités, UPMC Univ Paris 06, INSERM, Institut Pierre Louis d'Epidémiologie et de Santé Publique (IPLESP UMR_S 1136), Paris, France, ⁵Université Bordeaux, ISPED, Centre INSERM U1219 - Bordeaux Population Health, Bordeaux, France, ⁶Instituto de Salud Carlos III, National Center of Epidemiology, Madrid, Spain, ⁷Public Health England, London, United Kingdom, ⁸Clinical Epidemiology Unit, National Institute for Infectious Diseases, Rome, Italy, ⁹University College London, Department of Infection and Population Health, London, United Kingdom, ¹⁰Robert Koch Institute, Department of Infectious Disease Epidemiology HIV/AIDS, STI, Berlin, Germany, ¹¹Hellenic Centre for Disease Control and Prevention, Amarousio, Greece, ¹²University of Cyprus, Medical School, Nicosia, Cyprus, ¹³Istituto Superiore di Sanità, Centro Operativo AIDS, Rome, Italy, ¹⁴Stichting HIV Monitoring, Amsterdam, Netherlands, Department of Epidemiology, National Institute of Public Health – National, Institute of Hygiene, Warsaw, Poland¹⁵

PS3/02 Factors for Delayed Linkage to Care Following HIV Diagnosis in the WHO European Region

S. Croxford¹, F. Burns², A. Copas², A. Pharris³, V. Delpech¹, OptTEST for HIV in Europe

¹Public Health England, London, United Kingdom, ²University College London, Department of Infection and Population Health, London, United Kingdom, ³European Centre for Disease Prevention and Control, Stockholm, Sweden

PS3/03 Increased HIV Case Detection through Integration of HIV Testing in Georgian Hepatitis C Elimination Program Screening Activities

D. Baliashvili¹, M. Tsereteli¹, M. Alkhazashvili², K. Zakhshvili³, A. Gamkrelidze⁴

¹National Center for Disease Control and Public health, HIV/AIDS, Hepatitis, Tuberculosis and STIs, Tbilisi, Georgia, ²National Center for Disease Control and Public health, Regional Public Health, Tbilisi, Georgia, ³National Center for Disease Control and Public health, Communicable Diseases, Tbilisi, Georgia, ⁴National Center for Disease Control and Public health, Tbilisi, Georgia

PS3/04 Monitoring HIV-indicator Condition Based HIV Testing in Estonia

K. Rütel¹, L. Lemsalu¹

¹National Institute for Health Development, Infectious Diseases and Drug Monitoring Department, Tallinn, Estonia

PS3/05 Testing for Blood Borne Viruses in the Emergency Department of a Large London Hospital

D. Bradshaw^{1,2}, C. Rae¹, G. Pickard³, D. Patel³, D. Rezende³, P. Roberts¹, K. Pillay¹, M. Foxton¹, A. Sullivan¹

¹Chelsea and Westminster Hospital NHS Foundation Trust, London, United Kingdom, ²Brighton and Sussex University Hospitals NHS Trust, Brighton, United Kingdom, ³Imperial College Healthcare NHS Trust, London, United Kingdom

Poster category 4: Community Testing

PO4/01 Euro HIV EDAT Project (WP9/2): HIV-testing Using Oral Fluid Samples and Online Communication of Test Results (Swab2know)

T. Platteau¹, C. Agusti², E. Florence¹, M. Lixandru³, L. Ooms¹, T. Vermoesen¹, L. Fernández-López², K. Fransen¹, V. González², J. Casabona², EURO HIV EDAT Project study group

¹Institute of Tropical Medicine, Clinical Sciences, Antwerp, Belgium, ²Centre d'Estudis Epidemiològics sobre les ITS i SIDA de Catalunya (CEEISCAT), Barcelona, Spain, ³Romanian association against AIDS - ARAS, Bucarest, Romania

PO4/02 Community Based Screening Network: Combined HIV, Hepatitis and syphilis testing and monitoring - A Community Led Partnership in Portugal

S. Daniel¹, R. Freitas¹, M. Rocha¹, P. Meireles², A. Aguiar², H. Barros²

¹GAT-Grupo de Ativistas em Tratamentos, Lisbon, Portugal, ²EPIUnit - Institute of Public Health, University of Porto, Porto, Portugal

PO4/03 Monitoring and Evaluation of AHF "Test and Treat" Programme in Lithuania

L. Stoniene¹, S. Kulsis¹, Z. Shabarova²

¹Association of HIV affected women and their families "Demetra", Vilnius, Lithuania, ²AHF Europe, Amsterdam, Netherlands

PO4/04 Euro HIV EDAT Project (WP8): A Qualitative Study to Better Understand the Barriers and Facilitators to Early HIV Testing and Linkage to Care among Migrant Populations in Europe (Belgium, Denmark, France, Spain, Portugal)

S. Benayoun¹, D. Rojas Castro^{1,2,3}, C. Nöstlinger⁴, L. Manirankunda⁴, F. Pichon⁵, P. Slaaen Kaye⁵, M. Meulbroek⁶, D. Simoes⁷, C. Agusti^{8,9}, L. Fernández-López^{8,9}, J. Casabona^{8,9}, EURO HIV EDAT Project study group

¹AIDES, Pantin, France, ²Université Lyon 2, GREPS EA4163, Lyon, France, ³Inserm, UMR912 (SESS-TIM), Marseille, France, ⁴Institute of Tropical Medicine, Antwerp, Belgium, ⁵AIDS Fondet, Copenhagen, Denmark, ⁶BCN Checkpoint Hispanosida, Barcelona, Spain, ⁷GAT - Grupo Português de Activistas sobre Tratamentos de VIH/SIDA, Lisbon, Portugal, ⁸Centre d'Estudis Epidemiològics sobre les ITS i SIDA de Catalunya (CEEISCAT), ICO/Agència de Salut Pública de Catalunya, Barcelona, Spain, ⁹CIBER Epidemiologia y Salud Publica (CIBERESP), Barcelona, Spain

PO4/05 COBA-Cohort: Preliminary Results of a Pan-European Cohort of HIV Negative MSM in Community-based Voluntary Counselling and Testing Services

N. Lorente^{1,2}, R. Fuertes³, P. Meireles⁴, R. Lucas^{4,5}, F. Pichon⁶, P. Slaaen Kaye⁶, B. Cigan⁷, M. Lobnik⁷, S. Chanos⁸, N. Dedes⁸, S. Morel⁹, D. Rojas Castro^{9,10,11}, C. Agusti^{1,2,12}, L. Fernández-López^{1,2,12}, J. Casabona^{1,2,12}, Euro HIV EDAT Study group

¹Centre Estudis Epidemiològics sobre les Infeccions de Transmissió Sexual i Sida de Catalunya (CEEISCAT), Departament de Salut, Generalitat de Catalunya,, Badalona, Spain, ²Institut Investigació Germans Trias i Pujol (IGTP), Badalona, Spain, ³GAT-Grupo de Ativistas em Tratamentos, Lisbon,

Portugal, ⁴EPIUnit—Institute of Public Health, University of Porto, Porto, Portugal, ⁵Department of Clinical Epidemiology, Predictive Medicine and Public Health, University of Porto Medical School, Porto, Portugal, ⁶AIDS-Fondet, Copenhagen, Denmark, ⁷Drustvo informacijski center Legebitra, Ljubljana, Slovenia, ⁸Ath Checkpoint, Athens, Greece, ⁹AIDES (MIRE-Mission Innovation Recherche Expérimentation), Pantin, France, ¹⁰Groupe de Recherche en Psychologie Sociale (GRePS) EA4163. Université de Lyon 2, Bron, France, ¹¹INSERM, UMR912 (SESSTIM), Marseille, France, ¹²CIBER Epidemiologia y Salud Publica (CIBERESP), Madrid, Spain

PO4/06 HepC Testing in the Community, for the Community, by the Community

L. Wylie¹

¹Hepatitis Scotland, Glasgow, United Kingdom

PO4/07 CD4 Point-of-care Testing as Intervention Improving Linkage to Care - Lessons Learned from Poland

M. Ankiersztejn-Bartczak¹, J.D. Kowalska²

¹Foundation for Social Education, Warsaw, Poland, ²Hospital for Infectious Diseases, HIV Out-Patient Clinic, Medical University of Warsaw, Department for Adult's Infectious Diseases, Warsaw, Poland

PO4/08 Euro HIV EDAT (WP4T1): Development of a Self-evaluation Tool in Order to Improve the Impact of the "A Guide to do it Better in our Community Based Voluntary Counselling and Testing (CBVCTs) Centers"

E. Ricard¹, V. Laporte¹, L. Rios¹, S. Morel², D. Rojas Castro^{2,3,4}, C. Agustí Benito^{5,6}, L. Fernandez Lopez^{5,6}, J. Casabona^{5,6}, B. Cigan⁷, M. Wurm⁸, F. Pichon⁹, G. Musat¹⁰, M. Meulbroek¹¹, R. Fuertes¹², EURO HIV EDAT Project study group

¹AIDES, Pantin, France, ²AIDES (MIRE-Mission Innovation Recherche Expérimentation), Pantin, France, ³Université Lyon 2, GREPS EA4163, Lyon, France, ⁴INSERM, UMR912 (SESSTIM), Marseille, France, ⁵Centre d'Estudis Epidemiològics sobre les ITS i SIDA de Catalunya (CEEISCAT), ICO/Agència de Salut Pública de Catalunya, Badalona, Spain, ⁶CIBER Epidemiologia y Salud Pública (CIBERESP), Badalona, Spain, ⁷Legebitra, Ljubljana, Slovenia, ⁸AIDS-Hilfe NRW e.V., Köln, Germany, ⁹AIDS-Fondet, Copenhagen, Denmark, ¹⁰ARAS - Romanian Association Against, Bucarest, Romania, ¹¹Projecte dels NOMS-Hispanosida, Barcelona, Spain, ¹²GAT - Grupo Português de Activistas sobre Tratamentos de VIH/SIDA, Lisboa, Portugal

PO4/09 The COBATEST Network: Opportunities and Challenges of a European Network of Community-based Voluntary Counselling and Testing Services for HIV

L. Fernández-López^{1,2}, J. Reyes-Urueña¹, C. Agusti^{1,2}, I. Klavs³, T. Kustec³, J. Casabona^{1,2}, COBATEST network

¹(CEEISCAT), Agència de Salut Pública de Catalunya (ASPC), Badalona, Spain, ²CIBER Epidemiologia y Salud Pública (CIBERESP), Madrid, Spain, ³National Institute of Public Health (NIJZ), Ljubljana, Slovenia

PO4/11 A Difference. Specific (and Different) Needs of Clients in Two VCT Centres in Southern Poland (Krakow and Rzeszow)

M. Brodzikowska^{1,2}

¹The University of Physical Education in Krakow, Department of Humanities, Section of Pedagogy, Krakow, Poland, ²Association for HIV/AIDS Prevention and Social Support "One World", Krakow, Poland

PO4/12 HIV Community Testing Monitoring in Spain

G. Fagúndez Machaín¹, A. Díaz Franco², E. García Carrasco¹, O. Castillo Soria¹

¹Ministry of Health, Social Services and Equality, National AIDS Strategy, Madrid, Spain, ²Health Institute Carlos III, National Center of Epidemiology, Madrid, Spain

PS4/01 Development of a Toolkit for Implementation and Evaluation of Checkpoints for MSM

M. Kuske¹, C. Agusti², M. Meulbroek³, D. Rojas Castro⁴, F. Pinchon⁵, P. Slaaen⁵, M. Lobnik⁶, B.

Cigan⁶, M. Wentzlaff-Eggebert¹, M. Alexandru⁷, T. Platteau⁸, D. Simões⁹, S. Schanos¹⁰, EURO HIV EDAT Study Group

¹AIDS Hilfe NRW e.V., Köln, Germany, ²CEEISCAT, Badalona, Spain, ³BCN Checkpoint Hispanosida, Barcelona, Spain, ⁴Association AIDES, Paris, France, ⁵AIDS Fondet, Copenhagen, Denmark, ⁶Legebitra, Ljubljana, Slovenia, ⁷ARAS, Bucarest, Romania, ⁸Institute Tropical Medicine, Brussels, Belgium, ⁹GAT-Grupo Português de Ativistas sobre Tratamentos de VIH/SIDA, Lisboa, Portugal, ¹⁰Checkpoint Athens, Athens, Greece

PS4/02 Barring the Way to Health: How Legal and Regulatory Barriers Hinder Modernising HIV Testing across Europe

L. Power¹, J. Hows^{2,3}, S. Finne Jakobsen^{3,4}, A.-I. Von Lingen^{3,5}

¹OptTEST by HIV in Europe, Cardiff, United Kingdom, ²GNP+, Amsterdam, Netherlands, ³OptTEST by HIV in Europe, Copenhagen, Denmark, ⁴University of Copenhagen, Region H, Copenhagen, Denmark, ⁵European AIDS Treatment Group, Brussels, Belgium

PS4/03 BCN Checkpoint: Same-day Confirmation of Reactive HIV Rapid Test with Point Of Care PCR Test Accelerates Linkage to Care and Reduces Anxiety

M. Meulbroek¹, F. Pérez¹, A. Dalmau-Bueno², F. Pujol¹, J. Saz¹, H. Taboada¹, G. Marazzi¹, A. Carrillo¹, A. Cabas¹, A. Gata¹, E. Aldabó², B. Roldán², P. Coll², F. Añez², J. Pantaleón², M. Mochales², O. Martín², V. Gómez², J.F. Mir², J. Decoca²

¹Projecte dels NOMS-Hispanosida, Barcelona, Spain, ²BCN Checkpoint, Barcelona, Spain

PS4/04 Impact of Pre-Test Counseling Sessions on Increasing Knowledge About HIV and Hepatitis Among the Beneficiaries of a Free of Charge, Voluntary Counseling and Testing Program (VCT) in Constanta, Romania

A.-M. Schweitzer¹, M. Bogdan¹, G. Ivanov¹, A. Corduneanu¹, I. Ciocea¹

¹Fundatia Baylor Marea Neagra, Infectious Diseases, Constanta, Romania

PS4/05 Monitoring test uptake and risk behaviour in community based HIV/STI testing sites in Germany, 2015/2016

U. Marcus¹, S.B. Schink², M. Tappe³, German Checkpoint Collaborative Group

¹Robert Koch-Institut, Infectious Disease Epidemiology, Berlin, Germany, ²Charite Universitätsmedizin Berlin, Berlin, Germany, ³Deutsche AIDS-Hilfe, Berlin, Germany

SIDE EVENTS



European HIV-Hepatitis Testing Week Meeting

Date: 1 February 2017, 12:30-13:30

Venue: Corinthia Hotel, meeting room Gardjola

Meeting content:

European HIV-Hepatitis Testing Week (ETW) took place from 18-26 November 2016. This was the fourth testing week, and the second to include both HIV and viral hepatitis. A total of 519 participants from 49 countries took part and implemented a wide range of activities to increase awareness of testing.

The following will be presented:

12.30-12.40	The Test Finder and collaboration with App Owners	Cary James (THT) and Teymur Noori (ECDC)
12.40-12.50	Key populations collaboration	Ben Collins (NeLP)
12.50-13.05	Preliminary results from the evaluation of the 2016 ETW	Valerie Delpech (PHE)
13.05-13.15	Experiences and challenges as 2016 ETW participant	Adam Shanley (KnowNow)
13.15-13.30	Discussion	



EU Health Programme Projects' Symposium

Time: Tuesday, 31 January 12-16:45h

Venue: Gardjola Meeting Room, Corinthia Hotel (the HepHIV Conference venue)

Participants: Open to HepHIV Conference participants, registration required

Meeting objectives: The aim of this Symposium is to foster dialogue, discussion and collaboration among EU co-financed projects and actions within the field of HIV, Hepatitis and TB. All speakers are invited to reflect on and present their take on these questions:

- Which are the areas of work of your project/action where there is most potential/need for further work?
- What is the perspective for establishing/continuing working relations with other EU co-financed projects/actions?

Agenda

Time	Symposium	Chairs and speakers
12:00-12:45	Networking lunch	
12:45-12:50	Welcome and introduction by the co-chairs	Co-chairs: Wolfgang Philipp, DG SANTE Olivia Castillo Soria, Head of Area of HIV Prevention, MoH, Spain Olivia Castillo Soria, Head of Area of HIV Prevention, MoH, Spain
12:50-13:00	HIV Pre-Exposure Prophylaxis in Spain	Olivia Castillo Soria, Head of Area of HIV Prevention, MoH, Spain
13:00-14:30	Session I: Prevention, early diagnosis (in CBVCTs and health care settings) and linkage to care	Moderators: Massimo Mirandola, Verona University Hospital, Italy (SIALON II) Jack Lambert, UCD, Ireland (HEPCARE Europe)
13:00-13:10	New prevention efforts	Michael Krone, Executive Coordinator, Germany (AIDS Action Europe)
13:10-13:20	Collecting data on prevention needs by a Europe-wide MSM online survey	Ulrich Marcus, Robert Koch Institute, Germany (ESTICOM)
13:20-13:30	Improving practice in health care settings	Ann Sullivan, SSAT, UK (OptTEST)
13:30-13:40	Monitoring and evaluation of CB-VCT: data to improve practice	Jordi Casabona, CEEISCAT, Spain (Euro HIV EDAT)
13:40-13:50	Advocacy to raise awareness about TB	Anete Cook, Results, UK (TB Europe Coalition)
13:50-14:30	Discussion	
14:30-15:00	Coffee break	
15:00-16:30	Session II: Risk groups and co-infections: prevention, early testing and linkage to care	Moderators: Jeffrey Lazarus, CHIP, DK (HA-REACT) Jordi Casabona, CEEISCAT, Spain (Euro HIV EDAT)
15:00-15:10	Hepatitis infection among MSM	Massimo Mirandola, Verona University Hospital, Italy (SIALON II)
15:10-15:20	Preventing HIV and co-infections in Europe through strengthened harm reduction	Outi Karvonen, Institute for Health and Welfare, Finland & Jeffrey Lazarus, CHIP, Denmark (HA-REACT)
15:20-15:30	Outreach for early TB diagnosis	Alistair Story, UCL, UK (E-DETECT TB)
15:30-15:40	Integration of Testing and Linkage to Care for HIV, Viral Hepatitis, STIs & TB in Europe	Dorthe Raben, CHIP, DK (Link2Care)
15:40-15:50	How to reach the risk groups	Jack Lambert, UCD, Ireland (HEPCARE Europe)
15:50-16:30	Discussion	
16:30-16:45	Wrap-up and close	Co-chairs: Olivia Castillo Soria, Head of Area of HIV Prevention, MoH, Spain Cinthia Menel Lemos, Project Officer, CHAFEA Wolfgang Philipp, DG SANTE



PARTNER Meeting

The PARTNER study is an observational study of serodifferent couples, heterosexual and men who have sex with men (MSM), in which the HIV-positive partner is taking ART. PARTNER began enrolling couples in 2010 and finished the 1st phase of the study in June 2014. The study continues in a 2nd phase with only MSM couples included.

2016 were the year PARTNER had the highest enrollment of MSM couples and the study is still enrolling MSM couples in 2017.

In 2016 the result from the 1st phase PARTNER was published in JAMA: *Sexual Activity Without Condoms and Risk of HIV Transmission in Serodifferent Couples When the HIV-Positive Partner Is Using Suppressive Antiretroviral Therapy.*

We would like to invite all to a PARTNER meeting Tuesday, 31 January 2017 from 15:00-16:00. The meeting takes place in the Terrace Suite (Level 0).

Agenda:

1. Update from PARTNER
2. The result from the 1st phase of PARTNER
3. Community involvement: Michael Meulbroek: Counsel gay men about the risk of transmission.

SCHOLARSHIP GRANTS FOR THE HEPHIV 2017 CONFERENCE

Name	Organisation	Country
Adam Shanley	KnowNow	Ireland
Andrii Chernyshev	Public Organization "Gay-alliance"	Ukraine
Artem Symchuk	Shupyk National medical academy of postgraduate education	Ukraine
Davit Baliashvili	National Center for Disease Control and Public Health	Georgia
Giulio Maria Corbelli	Plus-onlus	Italy
Ivo Prochazka	Czech AIDS Help Society	Czech Republic
Magdalena Ankiersztejn-Bartczak	Foundation for Social Education	Poland
Maia Tsereteli	National Centre for Disease Control & Public Health	Georgia
Michele Degli Esposti	Plus-onlus	Italy
Miran Solinc	SKUC	Slovenia
Sophocles Chanos	Athens Checkpoint	Greece
Tamás Bereczky	European AIDS Treatment Group	Hungary

PRACTICAL INFORMATION

REGISTRATION OPENING HOURS

Tuesday, 31st January 12:30-19:30
 Wednesday, 1st February 08:30-18:15
 Thursday, 2nd February 08:15-16:15

For presentations including surveys please download the app VoxVote, vote on: live.voxvote.com or scan the QR code. **Use the PIN: 32638**



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SOCIAL EVENTS

Welcome Reception

Tuesday, 31 January 19:30-22:00

Corinthia Hotel

St. Julians, STJ 3301

Malta

Tel: +356 2137 4114 – Fax: +356 2137 4039

Website: http://www.corinthia.com/hotels/malta/malta_stgeorgesbay/



Conference Dinner

Wednesday, 1 February 20:00

The Casino Maltese

247 Republic St, Valletta, Malta

Tel. +356 2133 0539

Website: <http://www.thecasinomaltese.com/index.html>



TRANSPORTATION AND DIRECTIONS

Welcome reception

The welcome reception will take place at the conference venue, the Corinthia Hotel

Conference dinner - Transportation from the Corinthia Hotel to the Casino Maltese

Wednesday, 1st February 2017

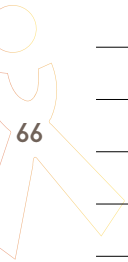
Bus schedule:

19:40 Departure from hotel

20:00 Conference dinner

22:00 Transport back to hotel

NOTES



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NOTES



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HepHIV 2017
31 JANUARY-2 FEBRUARY · MALTA

ABSTRACT BOOK



HepHIV2017 CONFERENCE

HIV AND VIRAL HEPATITIS:
CHALLENGES OF TIMELY TESTING
AND CARE

MALTA, 31 JANUARY - 2 FEBRUARY, 2017



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WELCOME
TO THE
HEPHIV 2017
CONFERENCE
IN MALTA



PLENARY SESSIONS

Plenary Session 1: Surveillance and Monitoring and Evaluation of Testing

Jens Lundgren, CHIP, Rigshospitalet, University of Copenhagen and Ton Coenen, Rutger: 10 years of HIV in Europe – what has been achieved, what remains as challenges

The year 2017 marks the 10 year anniversary of the HIV in Europe initiative. This presentation will present the main achievements during the past 10 years as well as what remains as the most important challenges.

The HIV in Europe initiative was established in June 2007. At that time, even though combination therapy had been making an enormous difference for patients for more than a decade, HIV research was still focused on what to do with people once they entered the clinic, and HIV testing sessions were not included in scientific conferences on HIV. And even though early treatment was known to be beneficial testlevels were very low throughout Europe. The idea in the beginning was not to found anything long-term, but to organize a conference on overcoming the obstacles to early testing and care. The first conference was held in Brussels in November 2007, involving multiple stakeholders and with the aim of getting early testing and care on the political agenda. And this is where it all started as a unique partnership between civil society, clinicians and policy makers.

Since then, the HIV in Europe initiative has continued to work towards improving earlier testing and linkage to care. Five biennial conferences have been held focusing on testing and earlier care, the latest two, HepHIV2014 and HepHIV2017, also including viral hepatitis. The initiative has been influencing the political agenda and trying to ensure that improving testing remains a European political priority in the EU and in the European countries.

The initiative and its dedicated steering committee members have also conducted research and initiated and carried out projects on testing and linkage to care. Some important achievements of the initiative include developing draft definitions for late presentation for HIV (2009) and viral hepatitis (2015), HIDES 1 and 2, European HIV-Hepatitis Testing Week and the EU funded project OptTEST. While the achievements are many, important challenges remain. These include keeping testing and linkage to care at the top of the political agenda, further improving the relationship and collaboration with viral hepatitis experts and organizations and exploring a broader remit by including STIs and TB.

Valerie Delpech, Public Health England: Monitoring HIV testing in Europe: how do we know if we are succeeding?

Early detection and prompt linkage to care and treatment following diagnosis is critical in ensuring a long and high quality of life. This presentation will present the evidence and rationale for expanding HIV testing and prompt linkage to care and treatment as well as provide examples of useful markers to measure the successes of testing initiatives. European and country specific testing guidelines recommend testing based on the local epidemiology and settings where testing should be part of routine care. Testing strategies should be delivered using a human rights approach (voluntary, confidential, consent, linkage to care and treatment following diagnosis, and access to prevention services for those who are negative). Successful implementation may be evaluated using the FACTS criteria (Feasibility, Acceptability, Cost-effectiveness, Target population reached and Sustainability of the intervention) with regular feedback to key stakeholders. Testing activities should reduce persons unaware of their status – but these figure are difficult to estimate and track over time. Most countries therefore rely on epidemiological trend data to measure the impact of testing efforts, such as the rise or fall of new and/or late diagnoses, which are also subject to a variety of interpretations. New diagnoses through self-testing will further challenge routine surveillance systems. Once diagnosed, targets can be set at the local (eg clinic) and geo-



graphical (regional/national) level to promote prompt linkage to HIV care and high retention in care and treatment uptake rates in all population groups. Regular feedback of clinical outcome to service providers, planners and commissioners ensure engagement and targets can be linked to incentives to further improve the quality of services. Furthermore, barriers to testing and access to services including levels of stigma and discrimination experience by most affected communities should be routine and involve a wide range of community members at every stage. Ultimately testing programmes must be evaluated as part a wider prevention agenda to reduce HIV incidence and AIDS related deaths. No one should die of AIDS in 2017.

Dagmar Hedrich, European Monitoring Centre for Drugs and Drug Addiction
Surveillance of hepatitis and hepatitis testing efforts among people who use drugs

Viral hepatitis, particularly infection caused by the hepatitis C virus (HCV), is highly prevalent among injecting drug users across Europe. HCV antibody levels among national samples of injecting drug users in 2014-15 varied from 15.7 to 83.5 with 5 out of the 13 countries with national data reporting a prevalence rate in excess of 50%. Among the countries with national trend data for the period 2010-2015, increasing HCV prevalence in injecting drug users was reported in 3 countries. HCV infection, often worsened by heavy alcohol use, is likely to account for increasing numbers of cases of liver disease, including cirrhosis and liver cancer, among an ageing population of high-risk drug users. There are now new opportunities for effective treatment and prevention that, if scaled up sufficiently in Europe, could contribute to a significant reduction in the health harms associated with this disease. Many people with an injecting history, however brief, as well as current injection drug users, are still unaware of their infection status. Considering high prevalence and long history of infection among many PWID, effective approaches to better target testing and identify those in need of treatment are required. Minimum quality standards agreed at EU level include a call for making voluntary testing for blood-borne infectious diseases, counselling against risky behaviours and assistance to manage illness available at drug treatment facilities (Council of the European Union, 2015). Strategies to improve hepatitis C care and to enhance treatment uptake and adherence among people who inject drugs as well as new developments in community-based testing approaches to extend testing opportunities and adapt the offer to the needs of people who use drugs from different European countries are presented

Plenary Session 2: Mixing Testing Strategies: Community and Health Care Settings

Ann Sullivan, Saint Stephen's AIDS Trust: Indicator Condition Guided HIV testing – progress and challenges

Indicator Condition guided HIV testing has convincingly been shown to be a highly effective way of identifying individuals with undiagnosed HIV infection. Furthermore this strategy is deemed to be cost effective when the HIV prevalence is at least one per thousand tests. Not only is this approach effective it also works to normalise HIV testing for individual patients, healthcare workers and society in general. There are European and numerous National guidelines recommending this approach, however application of these guidelines overall is extremely low and highly variable. This talk will review the available data on HIV Indicator Condition testing in Europe and examine potential barriers to explain the poor coverage and how these may be overcome. One example is OptTEST, a European wide programme which is designed to support and improve the implementation of Indicator Condition guided HIV testing guidelines, providing practical advice and tools, staff training modules and resources. Using three representative indicator conditions and Qualitative Improvement methodology the programme is developing the tools, evaluating effective interventions to begin to overcome the barriers which exist to this testing strategy, and identifying successful sustainability factors. The tools and modules will be demonstrated and data on testing coverage and outcome reported. Whilst the majority of data and focus with this strategy is in relation to healthcare workers, professional bodies and policy makers, the role of civil society and relevant NGOs will also be considered.

Jordi Casabona, Euro HIV EDAT: The Euro HIV EDAT Project. Monitoring and evaluation of community based testing: achievements and challenges

CBVCT programs and services in Europe have been expanding during last years and preliminary data shows they can be effective in both reaching the right target populations and facilitating periodical testing to high risk groups. Nevertheless, there is a huge heterogeneity in terms of organization, stability, size of reached population, observed prevalence and coordination with the formal system. The EURO-HIV-EDAT project, co-financed by the European Commission (CHAFEA) (2014-2017) (Grant Agreement No. 20131101), is aimed to generate harmonized monitoring and evaluation data from CBVCTs across Europe using the Indicators and Data Collections Instruments developed by the COBATEST Project and to explore the acceptability, feasibility and effectiveness of innovative strategies, like Point of Care technologies for HIV and STI diagnosis, HIV self-testing and web based outreach and counselling approaches. Overall, the project outcomes will provide operational data and implementation manuals and guidelines to improve the effectiveness and scale up of testing and linkage to care programs, as well as some new tools to increase access to them. For the moment, all the WPs of the project are still ongoing, but some quantitative results can be shown: Regarding the M&E of community based testing, 32 CBVCT services/networks from the COBATEST network have sent their data for the whole year of 2015, a total of 95,493 clients were tested for HIV on those CBVCT services and the proportion of clients with a HIV reactive test was 1.3%; the MSM seronegative cohort established in the WP5 (COBA-Cohort) is collecting common data among HIV-negative MSM attending 17 community-based voluntary counselling and testing (CBVCT) services in 6 countries and on February 29th, the last data censorship, 2295 participants were enrolled in the cohort.

Several challenges have to be faced in order to improve the M&E of community based testing: to improve the quality assurance of the services; to improve the coordination with the overall health care system; to improve the capacity of systematically collecting good quality data and its technical integration with formal surveillance systems; to strengthen the collaboration between the different sectors.

Aaron Siegler, Emory University: Home testing for HIV: Feasibility, acceptability, implementation, and applications

A substantial proportion of those who are HIV-positive remain undiagnosed, resulting in late entry to care and missed community prevention benefits. HIV home testing can lower barriers to testing, such as fear of healthcare stigma or transportation difficulties, and can moreover facilitate testing for key populations. This presentation describes current methods for home testing and provides data from numerous research projects conducted by PRISM Health at Emory University on acceptability and usage. The life cycle of HIV home testing will be explored, including recruitment, return of results, counseling options, and linkage to care. The advantages and optimal settings for different options for home test programs will be explored, including couples or individual testing, instant home result or specimen mail-in, video or telephone counseling, and app or online recruitment. Across different models of provision, HIV home testing is shown to be feasible, acceptable, and have high rates of use

Michael Meulbroeck, Projecte dels NOMS-Hispanosida. Barcelona, Catalonia: BCN Checkpoint: achievements, challenges and future plans of a community centre for MSM

The HIV care continuum is a model that is used to identify issues and opportunities related to improving the delivery of services to people living with HIV across the entire continuum of care and basis for the UNAIDS fast track to reach the 90-90-90 objectives. Examination of each of the five stages of the HIV care continuum showed that the biggest gap and challenge is to detect those infected with HIV and unaware of their status, and to reduce the new infections that are happening every day and increase the number of people living with HIV. Epidemiological data show that in general population the reported HIV cases have been stable and low during the last years. Nevertheless, MSM is the only group where reported HIV cases are increasing, representing the majority of new cases. On the other side new HIV infections are more probably replicated in metropolitan than in rural areas. The Cohort Barcelona Checkpoint study showed an overall HIV incidence rate of 2.34 per 100 person-years (95%CI: 2.11-2.58). Although around 70% of persons present symptoms after an infection, just few are aware of this process and during this period of time is when more new infections are produced. For these reasons, although more new diagnostics are made, we must search for new tools and methods to stop the HIV transmission chain in MSM and Transgender Women. The EU Fundamental Rights Agency states that many LGBT people fear stigma and prejudice from health-care providers. To overcome the “hard-to-reach-facility” barrier, BCN Checkpoint was established in 2006 as a community centre for MSM for detection of HIV. During the 10-year-experience the centre has been able to detect a significant part of the reported HIV cases, to detect HIV in earlier stages of the infection, to link to care almost all cases, to reduce the time of linkage-to-care and, to give peer support and treatment information to recent diagnosed individuals. In Europe, other Checkpoints have been created with similar results and show the capacity to reach clearly the population most affected by HIV, to work on each and every level of the HIV care continuum and contribute significantly to the objectives to end HIV.

Special Session on PrEP: Influence of PrEP and New Treatment Paradigms on Testing Pathways

Sheel Patel, Chelsea and Westminster Hospital: HIV testing in sexual health clinics – do they need to change for PrEP?

Pre-exposure prophylaxis (PrEP) is not currently available on the National Health Service (NHS) in England. Despite this, large numbers of men who have sex with men (MSM) are accessing this from internet-based pharmacies without monitoring or regular HIV testing.

UK national guidelines recommend annual HIV testing in men who have sex with men (MSM) and 3-monthly testing in individuals at highest risk; this includes people on PrEP.

Support for individuals at high risk of HIV acquisition (diagnosis of rectal bacterial sexually transmitted infection (STI) or syphilis, attendance for HIV post-exposure prophylaxis (PEP) or unprotected receptive anal intercourse with >1 partner) is crucial, and at 56 Dean Street, we have implemented strategies such as Dean Street PRIME to encourage and facilitate regular testing as well as enable high risk MSM to choose and adhere to risk reduction interventions that suit them. For these interventions to be successful, it is extremely important that clinic staff are able to incorporate discussions about the importance of regular testing for HIV, STIs and hepatitis C testing into consultations with MSM attending for sexual health care alongside hepatitis/HPV vaccination and support for psychological issues or recreational drug use if needed. At our clinic staff have been trained to recognise high risk individuals and to help them to access appropriate support.

Once PrEP becomes available on the NHS, the number of individuals presenting to services for HIV testing is likely to significantly increase. It is therefore imperative that clinics are able to cope with the pressures that this might create. Several initiatives currently exist to encourage testing in high risk individuals such as outreach testing in saunas and clubs and the use of home testing kits. Strategies such as this, alongside the provision of innovative models of support are essential to the success of HIV testing programmes.

Maria Prins, Academic Medical Center: PrEP implementation: Viral hepatitis C testing required?

Undiagnosed hepatitis C virus (HCV) infections may be spread and lead to morbidity decades after HCV infection. HCV is transmitted primarily by blood-to-blood contact and around the world people who inject drugs account for the vast majority of new HCV infections. However, since 2000 HCV incidence has increased among HIV-positive men who have sex with men (MSM). Although data on the spread of HCV among HIV-negative MSM are limited, available data suggest that HCV prevalence was stable and HCV incidence low in HIV-negative MSM in the past decade, indicating that these men remained largely unaffected by this outbreak of HCV. Moreover, studies suggest that HIV infection preceded HCV infection in MSM and HCV was transmitted sexually in the majority of the cases. The recent introduction of pre-exposure prophylaxis (PrEP) as HIV prevention strategy has raised concern that its use may increase STI incidence because of risk compensation based on perceived HIV protection. Findings from ongoing PrEP demonstration projects indeed show an increase in risk behavior, but do not observe an increase in bacterial STI in MSM on PrEP. An increase in condomless anal sex with HIV-positive MSM may fuel HCV spread from HIV-positive to HIV-negative MSM. Hence, monitoring HCV infections among the HIV-negative population using PrEP is essential. An overview of studies assessing HCV infections in HIV-negative MSM, in particular in those starting and using PrEP, will be presented and the findings will be synthesized. The focus will also be on recommendations for HCV testing in PrEP guidelines.

Plenary Session 3: Continuum of Care and Improving Linkage to Care

Anastasia Pharris, European Centre for Prevention and Disease Control: Understanding and improving the HIV Continuum of Care in Europe

The concept of the continuum of HIV care is increasingly used to monitor HIV programmes in Europe and beyond. The continuum of care measures HIV services which people living with HIV (PLHIV) need including HIV diagnosis and linkage to care to antiretroviral treatment (ART) with the goal of achieving viral suppression. UNAIDS 90-90-90 targets which envision 90% of PLHIV diagnosed, 90% of those diagnosed on ART, and 90% of those on ART virally suppressed by 2020, have increased interest in construction of regional and national HIV continuums of care. In the 31 countries of the European Union and European Economic Area, modelled estimates indicate that 85% of persons living with HIV in 2015 had been diagnosed, although the proportion of persons remaining undiagnosed varies across countries and between key populations within countries. Preliminary data from countries in Europe and Central Asia who reported Dublin Declaration Monitoring data to the European Centre for Disease Prevention and Control in 2016, indicated that 75% of diagnosed PLHIV were receiving ART and that 87% of those on ART were virally suppressed. There is significant variation between countries on all steps of the HIV continuum of care; this may be partially due to limited consistency in terms of methods used to construct estimates. The HIV continuum of care can be strengthened as a concept for public health monitoring and clinical quality improvement through greater standardisation of definitions; increased collaboration between clinical and public health bodies on data generation, extraction and analysis; and disaggregation of data by key population and/or country sub-region.

Amanda Mocroft, University College of London: The continuum of care and late presentation – implementing the consensus definition in HIV

Late presentation for HIV diagnosis, defined as a CD4 cell count less than 350/mm³ or an AIDS diagnosis regardless of CD4 count, continues to be a significant problem across the European continent with poorer survival, increased healthcare costs and increased risks of onward HIV transmission among those who are undiagnosed. While many European countries have published data on late presentation from cohort studies, there is a lack of common definitions used, and scarce data from countries in Eastern Europe, where surveillance of HIV infection may be more complex. The European Centre for Disease Control (ECDC) publishes an annual summary of HIV across Europe which may be more complete than data from an individual cohort, but lacks information on outcomes after HIV diagnosis, as well as issues with incomplete reporting. Comparisons across studies are limited due to different approaches to data collection, a lack of standard definitions for the elements of the continuum and significant gaps in data in many countries. Large gaps in knowledge remain and it is essential moving forward that a closer collaboration is established between clinicians and experts from across a range of countries in Europe (including Eastern Europe) and ECDC to better understand differences in the continuum of care in different settings and regions. The aim of this presentation is to review the available cohort data and how to link it to surveillance data, in order to be able to better understand the right hand side of the continuum of care, including late presentation, the country specific burden and the potential impact of late presentation on morbidity and mortality across Europe.

Jürgen Rockstroh, University of Bonn: The continuum of care and late presentation – hepatitis - implementing the consensus definition

The development of the HIV treatment cascade as well as the definition and subsequent identification of late presenters has been a valuable tool set to help clinicians, public health officials and advocates visualize the state of HIV testing, linkage to care and treatment. With the >95% cure rates achievable with modern direct acting antiviral (DAA) all oral combination HCV therapy, increased interest has been generated to also create a hepatitis C treatment cascade which then can provide a framework for evaluating the delivery of HCV care over time and within subgroups, and also can be useful in monitoring the impact of new screening efforts and advances in antiviral therapy. Most cascade of care analysis so far however, show that less than 10% of HCV patients have been successfully treated so far which underlines the slow uptake of treatment mostly because of the high cost burden associated with HCV therapy and the various treatment restrictions in place. Introducing a consensus definition of late presentation with viral hepatitis is important to create a homogenous, easy to use reference for public health authorities in Europe and elsewhere to better assess the clinical situation on a population basis. In line with recommendations from clinical guidelines first real life data confirm that initially DAA therapy was prioritized to HCV patients with advanced liver disease. As a consequence the proportion of patients initiating DAA-based therapy with no or minimal HCV related liver disease has increased in recent years. The use of a consensus definition for advanced liver disease will contribute to both improving the epidemiological understanding of viral hepatitis and other liver diseases as well as testing policies and linkage to care.

Tracy Swan, Treatment Action Group: The role of civil society in successful testing and linkage to care

A little kindness costs nothing.

The HIV experience demonstrated that civil society engagement is essential to fighting epidemics. Civil society - also known as 'community' - has worked locally, at country-level, regionally, and globally to raise awareness, demand and secure resources, and change policies – and played a strong role in programme development, implementation and oversight. Unlike HIV, hepatitis C is now easily cured. Building a community around a curable disease is challenging, especially when epidemics are both generalized and concentrated among marginalized and vulnerable populations. People who inject drugs face numerous structural barriers – and have had unpleasant experiences with medical providers; former injectors may be reluctant to disclose their history. Migrants face numerous challenges to health care access, including language barriers and stigma. Other high-risk and high-prevalence populations may need services specifically adapted to their needs. A successful approach to testing and linkage to care must be based on, and work to meet the needs of different populations, yet be cost-effective and efficient. Pragmatic and technical solutions such as rapid diagnostics, portable screening devices, better treatment and more convenient services are helpful, but not sufficient to overcome significant barriers to healthcare access. The mainstay of harm reduction philosophy, "meeting people where they are", is relevant to hepatitis C testing and linkage to care; low threshold, peer-based services are far more likely to engage people than simply waiting for them to show up for health care. Healthcare systems can build partnerships with civil society and trusted community-based organizations (where they exist) to welcome people into hepatitis C testing, care and treatment. If we are to eliminate hepatitis C, our efforts must recognize – and seek to change - the social, economic, legal and other barriers that people face.

Plenary Session 4: New Point of Care Diagnostics, Affordability and Cost-effectiveness

Emmanuel Fajardo, Médecins Sans Frontières: New diagnostics for HIV and HCV testing

To achieve the UNAIDS' 90-90-90 targets by 2020 will require a substantive increase in HIV testing, uptake of test-and-treat approach, and scaling-up viral load (VL) monitoring. The availability of prequalified oral HIV self-tests (i.e. OraQuick) along with recent policy recommendations from the WHO will hopefully foster uptake of HIV testing. Expanding access to dried-blood-spots and novel point-of-care (POC) technologies will be instrumental to further simplify, decentralize and scale-up VL testing in resource-constrained settings. Similarly, the recent prequalification of POC tests for Early Infant Diagnosis (EID) (i.e. Xpert HIV-1 Qualitative and AlereQ) will increase uptake of testing and, hopefully, will lead to more HIV-infected infants put on treatment. In the field of HCV diagnostics, the advent of all-oral pan-genotypic direct-acting antivirals (DAAs) holds the potential to further simplify the diagnosis and clinical management of HCV infection. Access to affordable and prequalified rapid diagnostic tests for the serological diagnosis of HCV infection (e.g. SD Bioline HCV) is crucial as the first step in the treatment cascade. Novel and simpler POC VL technologies will soon become commercially available and will stand as useful tools to complement conventional VL laboratory-based testing. The detection of Hepatitis C Core Antigen (HCVcAg) as a less expensive alternative to RNA-based testing could be particularly useful in settings with already access to it. New molecular POC technologies both for HCVcAg and RNA detection will facilitate further decentralization and quicker clinical decision-making. Despite the availability of pan-genotypic regimens, HCV genotyping will continue to play an important role to tailor treatment selection and duration. Nevertheless, having the test won't be enough. There's also a need to concurrently develop comprehensive packages which include case finding strategies, new models of care, effective referral systems and linkage to care to realize the potential of new diagnostics.

Yazdan Yazdanpanah, INSERM: Cost-effectiveness of HIV testing: frequency and target groups

Objective: We evaluated the clinical impact, costs, and cost-effectiveness of alternative testing strategies for both high-risk individuals and the general population in three European countries with different epidemic profiles.

Methods: We used the Cost-Effectiveness of Preventing AIDS Complications (CEPAC) Model, with country-specific clinical and economic data including: HIV prevalence, incidence, mean CD4 at diagnosis (Table), screening performance, costs for ART, HIV tests, and HIV care, to project life expectancy, cost and incremental cost-effectiveness ratios (ICERs) of alternative screening strategies in Estonia, France and Spain, that we compared to current HIV testing practices among Men who have Sex with Men (MSM); People Who Inject Drugs (PWID); and the general population. Strategies were "cost-effective" if their ICER in 2015€ per year of life saved (YLS) was less than the annual GDP/capita of the country (20,000€/29,000€/24,300€).

Results: Frequent HIV testing increased life expectancy in each risk-groups. Among MSM, the most cost-effective strategies were: testing every 12 months in Estonia (16,200€/YLS) and France (23,900€/YLS); every 3 years in Spain (25,400€/YLS). Among PWID, the most cost-effective strategies were: testing every month in Estonia (11,000€/YLS); every 3 years in France (27,700€/YLS); every 6 months in Spain (18,300€/YLS). In the general population, one additional lifetime test had ICERs of 37,100€/YLS in France; 28,100€/YLS in Spain; testing every 3 years was cost-effective in Estonia (13,000€/YLS). Findings were most sensitive to HIV incidence and costs of HIV tests.

Conclusions: MSM must be tested every 12 months in France and Estonia, and every 36 months in Spain. PWID must be tested as frequently as possible in Estonia, every 6 months in Spain, and every 36 months in France. The general population must be tested every three years in Estonia, and maintained in France and Spain. For optimal value, HIV screening strategies in Europe should be tailored to each country's epidemic.

Keywords: Cost-effectiveness; HIV testing strategies; Economic modelling, Men who have sex with men (MSM); People who inject drugs.

Table

Testing strategies: ¹	Estonia			France			Spain		
	Costs in PLWH (€)	LE ² in PLWH	ICER (€/YLS) ³	Costs in PLWH (€)	LE ² in PLWH	ICER (€/YLS) ³	Costs in PLWH (€)	LE ² in PLWH	ICER (€/YLS) ³
MSM	PRE=3.0; INC=0.08; CD4=289			PRE=17.0; INC=1.0; CD4=465			PRE=6.2; INC=0.6; CD4=450		
Current strategy	52,240	315.2	--	238,780	443.2	--	189,440	482.4	--
Every 3 years	62,930	334.0	8,900	249,940	449.3	dominated	205,050	492.7	25,300
Every year	67,330	342.0	16,200	259,410	453.7	23,900	213,460	498.2	31,200
Every 6 months	70,130	346.8	30,000	266,090	457.0	33,100	218,770	501.3	32,500
PWID	PRE=55.0; INC=6.0; CD4=289			PRE=17.5; INC=0.1; CD4=316			PRE=33.1; INC=1.5; CD4=275		
Current strategy	58,250	341.4	--	190,440	448.2	--	157,150	404.3	--
Every 3 years	68,010	358.5	dominated	235,080	470.3	27,700	204,960	435.8	dominated
Every 6 months	77,910	376.9	6,500	267,660	486.8	97,000	224,840	448.3	18,300
Every month	83,620	386.1	11,000	286,180	493.6	1,138,300	233,990	452.5	101,700

¹Only the most cost-effective strategies (bold) for each group are presented in the table, but the set of strategies tested included more testing frequencies; the current strategy (background testing) was included in each strategy, so each testing frequency was in addition to current practice; PLWH: People Living With HIV; MSM: Men who have Sex with Men; PWID: People Who Inject Drugs; PRE: HIV prevalence (%); INC: Annual incidence (per 100 person-years); CD4: CD4 counts at ART initiation (cells/ μ L)

²LE: Life Expectancy in months

³ICER: Incremental Cost-Effectiveness Ratio in Euros per Year of Life Saved (YLS): calculated from the 3% discounted outcomes in the total cohort (i.e. PLWH or not) when accounting for secondary transmission in Estonia and Spain (in France we used a 4% discount rate); the comparator strategy is always the next lowest, non-dominated, alternative; the 2015 GDP per capita was 20,000€ in Estonia, 29,000€ in France, and 24,300€ in Spain.

¹Only the most cost-effective strategies (bold) for each group are presented in the table, but the set of strategies tested included more testing frequencies; the current strategy (background testing) was included in each strategy, so each testing frequency was in addition to current practice; PLWH: People Living With HIV; MSM: Men who have Sex with Men; PWID: People Who Inject Drugs; PRE: HIV prevalence (%); INC: Annual incidence (per 100 person-years); CD4: CD4 counts at ART initiation (cells/ μ L)

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Closing Session: European policies and strategies and their implications

Brian Gazzard, Chelsea and Westminster Hospital: Towards a realistic cure - the role of HIV testing

Cure agenda for HIV infection has largely been stimulated by one extremely unusual case where eradication of HIV infection was accompanied by a bone marrow transplantation with a CCR5 deleted donor, and perhaps in retrospect more importantly by the immune changes introduced by 2 severe episodes of graft versus host rejection. This has stimulated enormous worldwide interest in research designed to cure patients and understandable patient excitement in such a potential outcome. There are disadvantages to such a cure agenda which include potential cost and widespread applicability of some of the treatments being investigated, a very long time scale that patients would need to be observed for to ensure that cure had indeed occurred and finally the whole problem of re-infection; important in hepatitis C for example where up to 28% of patients that we are currently treating in our HIV unit have been infected with Hep C previously but cured "with therapy". For a number of years now the EU have been supporting a less dramatic and "sexy" approach to the control of HIV with a long-term objective of reducing the reproductive rate of the epidemic to less than one in which case it would peter out. To enable such an outcome to occur we would need to use a combination of education, pre-exposure prophylaxis and treatment as prevention in patients having an HIV test. The most important single variable to reduce the reproductive rate to less than one would be that the vast majority of cases of HIV were ascertained. When the HIV testing in Europe was first set up of course PrEP had not been proved to work and the effects of TASP on long term outcome remained highly controversial. Nevertheless, HIV in Europe had an important influence on placing HIV testing and treatment and care high on the political agenda throughout Europe. It was instrumental in introducing targeted testing as a way of case ascertaining the majority of HIV infected individuals, of exploring HIV testing in alternative venues and exploring important reasons such as stigma, why potentially HIV positive patients may not be willing to undergo a test. In many of these areas HIV in Europe has achieved outstanding success, the major ongoing issue is the patchy nature of HIV testing in certain countries particularly in Eastern Europe, the variable access to treatment which goes hand in hand with the low level of testing. HIV in Europe continues to flourish and wishes to gather together the expertise gained in HIV testing so that this can be applied to hepatitis C where many of the problems of unknown infections are similar to those of HIV but with the advantage that hep C is now an entirely curable condition, although pressure continues to need to be applied to allow such cures to be available at an affordable cost around Europe.

PARALLEL SESSIONS

Parallel Session 1: Monitoring for HIV and Viral Hepatitis

PS1/01 Are EU/EEA Countries Ready to Monitor Progress on HCV Programmes?

E. Aspinall^{1,2}, D. Goldberg^{1,2}, E. Duffell³, S. Hutchinson^{1,2}, H. Valerio^{1,2}, L. Tavoschi³

¹Glasgow Caledonian University, School of Health and Life Sciences, Glasgow, United Kingdom,

²Health Protection Scotland, Glasgow, United Kingdom, ³European Centre for Disease Prevention and Control, Stockholm, Sweden

Introduction: Hepatitis C virus (HCV) is associated with a large burden of disease in Europe, with an estimated 5 million people living with the infection. Public health interventions targeting HCV are being scaled-up and appropriate monitoring is crucial to effectively inform service development and assess progress. Recently WHO endorsed a Regional Action Plan for viral hepatitis and

related monitoring framework to guide the collection and analysis of standardised data on HCV testing, treatment and care. We explored the availability of relevant data in European Union/European Economic Area (EU/EEA) countries.

Methods: The European Centre for Disease Prevention and Control (ECDC) conducted a survey among National Focal Points for viral hepatitis in EU/EEA countries on testing policy, practice and monitoring. The questionnaire explored data collection on nine indicators relating to HCV testing, treatment and mortality data pathway. Surveys were distributed via email in March 2016, and two reminders sent.

Results: Responses were received from 20/31 (68%) EU/EEA countries. Eleven countries (55%) monitored at least one indicator for HCV testing and diagnosis, with majority (10/20, 50%) monitoring positive cases. Whilst only three (15%) countries reported monitoring the undiagnosed fraction, five countries reported national estimates of the HCV undiagnosed fraction, ranging from 20% to 78%, obtained with a range of methods. Thirteen (65%) countries monitored treatment, with number treated being the preferred indicator (12/20, 60%). Five (25%) countries monitored indicators of HCV related mortality.

Conclusions: Our data show that monitoring of HCV programmes is limited in the EU/EEA. Diagnosis and mortality indicators are the least ones to be monitored. While primary data may be available in countries, challenges in collating them at central level may be a major obstacle. More efforts are needed to implement effective monitoring systems to ultimately inform action and maximise public health gains.

PS1/02

HIV Testing in Persons Diagnosed with Hepatitis B and C

G. Ireland¹, D. Ogaz¹, P. Kirwan¹, S. Mandal¹, V. Delpech¹, N. Connor¹, R. Simmons¹

¹Public Health England, London, United Kingdom

Introduction: UK HIV-testing guidelines recommend an HIV-test following a diagnosis of hepatitis B or C. We investigate to what extent these guidelines are being followed using PHE Sentinel Surveillance of Blood Borne Virus Testing (SSBBV) and national HIV databases.

Method: HIV-testing information was extracted from SSBBV for all adults (≥15 years) testing positive for HCV antibodies (HCV), indicative of being ever infected and at increased risk of HIV, or hepatitis B surface antigen (HBV) between 2010-2014. Persons diagnosed with HIV prior to their hepatitis diagnosis, identified following data linkage with the national HIV database, were excluded. CD4 at HIV diagnosis was used to estimate date of HIV-infection.

Results: Among persons positive for HCV (36,576), 48.8% with an active infection, 34.1% (12,471) were tested for HIV on the same day as their HCV test, 6.0% (2,192) were tested for HIV within six months and 59.9% (21,913) had no record of an HIV test in the six months following their positive HCV test. Among persons who tested positive for HBV (21,352), the corresponding figures were 32.2% (6,617), 8.6% (1,840) and 59.9% (12,642). There was no difference by sex, with older individuals less likely to test within the six month period. Of the remaining persons with no record of a HIV test within six months of their hepatitis diagnosis (HCV: 21,913, HBV:12,642), 23 (0.1%) and 15 (0.1%) persons were diagnosed with HIV after the six month period respectively. Three-quarters (74%) of whom were diagnosed more than 12 months after their hepatitis diagnosis. Among those diagnosed with HIV after six months, 22% and 33% were estimated to have been infected with HIV at the time of their hepatitis diagnosis.

Discussion: HIV-testing following a positive test for hepatitis is sub-optimal in England and highlights missed opportunities to diagnose persons co-infected with HIV.

Diagnosed HIV Infections in Persons Being Tested for the Hepatitis B Virus: England, 2008-2014

G. Ireland^{1,2}, V. Delpech¹, K. Balogun¹, P. Kirwan¹, S. Lattimore¹, S. Mandal^{1,2}, R. Simmons¹

¹Public Health England, London, United Kingdom

²The National Institute for Health Research Health Protection Research Unit (NIHR HPRU) in Blood Borne and Sexually Transmitted Infections at University College London

Introduction: A limited number of studies have estimated the UK burden of HIV in persons with HBV. We estimate HIV prevalence among those being tested for HBV and examine associated risk factors.

Methods: Persons with a hepatitis B surface antigen (HBsAg) test, reported to the PHE sentinel surveillance of blood borne viruses, were linked to the PHE national HIV database. All persons aged ≥ 15 yrs, presenting for an HBsAg test between 2008 and 2014 were included. Persons were identified as co-infected if they had a HIV-diagnosis before their positive HBsAg test, or in the 6 months following.

Results: Between 2008 and 2014, 1.3% (28,789/2,150,143) of persons tested for HBsAg were positive, of whom 3.9% (1,129) were co-infected with HIV. Co-infection rates were highest in persons aged 34-44 years (5.7%), of white ethnicity (7.0%), tested in primary care services (4.3%), and in males (5.1%). Significant predictors of co-infection included increased age (aOR 1.1) and co-infection was more likely to have been diagnosed in sexual health (aOR 49.2), A&E (aOR 5), specialist liver (aOR 6.2) and renal services (aOR 2.5) compared to GPs. Being of black ethnicity or a male of white ethnicity was a predictor when compared to white females. Among persons of black ethnicity, 72.9% had probable region of HIV-acquisition reported as Africa. In co-infected persons, probable route of HIV-infection was reported as heterosexual contact in 48.6% and sex between men in 42.0%. Most persons (60.4%) had a HIV-diagnosis more than 6-months before their HBV.

Conclusions: High levels of HIV-HBV co-infection among persons of black ethnicity reflects the high prevalence of HBV and HIV in certain African countries. In many cases, it is likely that both infections were acquired prior to migration to the UK. These findings highlight the ongoing need to increase vaccine coverage among the MSM population.

PS1/03 Organizational barriers as an explanation for differences in offer and uptake rates for hepatitis B/C and HIV testing in three drug addiction centres in Copenhagen

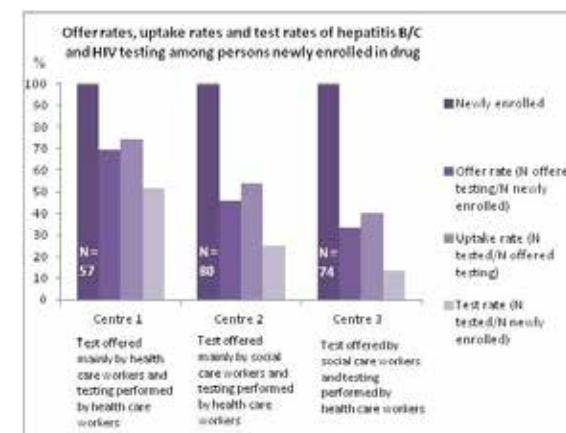
M. Linnet^{1,2}, L. Peters², D. Raben², H. Petersen¹, J. Gerstoft³, J. Lundgren²

¹City of Copenhagen, Social Services Department, Copenhagen, Denmark, ²CHIP, Rigshospitalet, University of Copenhagen, Copenhagen, Denmark, ³Department of Infectious Diseases, Rigshospitalet, Copenhagen, Denmark

Objectives: The drug addiction centres in the City of Copenhagen have an obligation to offer testing for viral hepatitis and HIV to all newly referred cocaine and cannabis users, but testing rates have been low (~20%). The aim was to explore organizational barriers to hepatitis B/C and HIV testing in three centres serving the same type of drug users.

Methods: Offer and uptake rates (definitions in figure) of HIV and hepatitis testing among all newly referred drug users were registered between June and October 2016 in three drug addiction centres. Information on potential barriers for both offering and accepting testing was obtained by a semi-structured interview with the persons in charge of registering offer and uptake rates.

Results: The three centres enrolled 57, 80 and 74 drug users, respectively. In centre 1, 2 and 3 the offer rates were 69%, 46% and 33%, respectively, while uptake rates were 74%, 54% and 40% and test rates were 52%, 25% and 13% (figure).



The interviews showed that in centre 1 testing was offered mainly by health care workers and performed by health care workers, while testing in centre 2 was mainly offered by social care workers and performed by health care workers. In these centres the two professions worked side-by-side. In centre 3 testing was offered by social care workers and performed by health care workers, working on a different floor of the building.

Conclusions: Among newly referred drug users, both offer and uptake rates for hepatitis B/C and HIV testing were markedly higher when the test was offered by a health care professional instead of a social care worker. Physical separation of those offering and performing the test within a drug addiction centre might further impair uptake and test rates.

PS1/04 Monitoring Anonymous HIV Testing in Estonia in 2005-2015

K. Rütel¹, K. Kallavus¹, I. Tomera¹

¹National Institute for Health Development, Tallinn, Estonia

Objectives: In Estonia, network of anonymous HIV testing sites is operating since 1988. Services are provided by health care organizations and financed by National Institute for Health Development (NIHD) from the state budget. Since 2009, testing for viral hepatitis markers (HCV-antibodies and HBsAg) is also available. The objective of this analysis is to assess anonymous HIV testing in Estonia in 2005-2015.

Methods: We used data from NIHD annual activity and financial reports and National Health Board. Results: In Estonia, annually more than 200,000 HIV-tests are performed, with approximately 5-6% of them in anonymous HIV testing sites. Figure 1 shows the number of people counselled and tested in 2005-2015. Figure 2 shows the number and percentage of new HIV cases, including injecting drug users among them, 2005-2015. Figure 3 shows cost of detection of one new positive HIV case and positivity rate (proportion of new HIV cases among all people tested). Figure 4 shows the proportion of new HIV cases diagnosed in anonymous testing sites compared to all new HIV cases in Estonia. Figure 5 shows the number of people tested for viral hepatitis markers and the percentage positive.

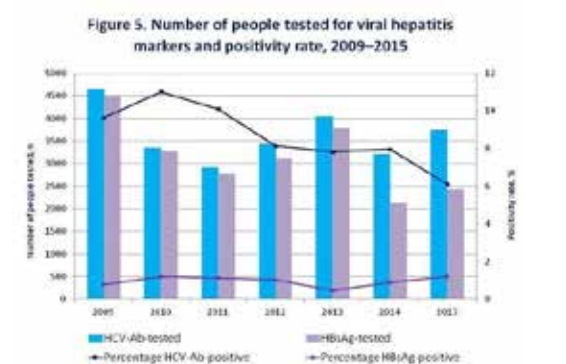
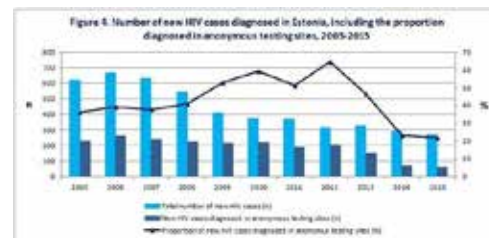
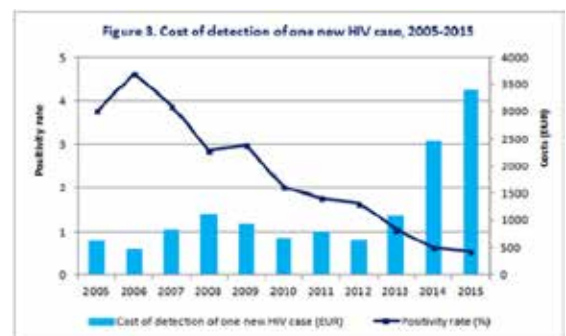
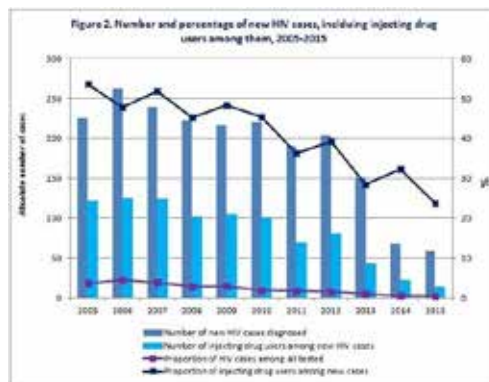
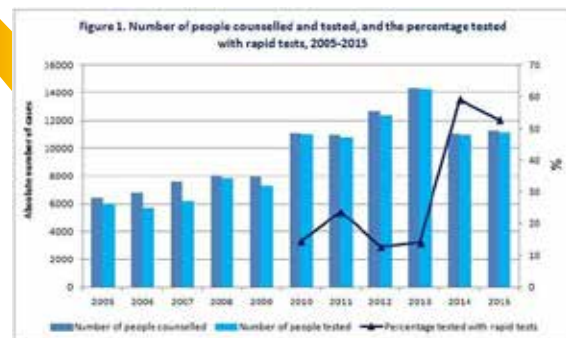
Conclusions: Considerable proportion of all new HIV cases in Estonia have been diagnosed in anonymous HIV testing sites. Since 2005, the number of new positive cases and the positivity rate among all tested has decreased. Simultaneously the cost of detection of one new HIV case has increased. This may in part be related to testing campaigns targeting more of general population with low HIV risk. In the future, more attention should be paid to people with higher HIV risk and increasing access to testing in community based organizations.

PS1/05 The COBATEST Network: A Platform to Perform Monitoring and Evaluation of HIV Community-based Testing Practices in Europe

L. Fernández-López^{1,2}, J. Reyes-Urueña¹, C. Agustí^{1,2}, I. Klavs³, T. Kustec³, J. Casabona^{1,2}, COBATEST network

¹Centre for Epidemiological Studies on HIV/STI in Catalonia (CEEISCAT), Agència de Salut Pública de Catalunya (ASPC), Badalona, Spain, ²CIBER Epidemiología y Salud Pública (CIBERESP), Madrid, Spain, ³National Institute of Public Health (NIJZ), Ljubljana, Slovenia

Objectives: The COBATEST network is a European network of Community-based Voluntary Counselling and Testing (CBVCT) centres, established in the framework of HIV-COBATEST project, which monitors and evaluates HIV testing activity. The objectives of the network are: 1) To use standard-



ized questionnaires and procedures for monitoring and evaluation (M&E) of CBVCT activity; 2) To evaluate the potential impact of CBVCTs in the improvement of HIV early diagnosis and access to treatment.

Methods: Currently, 40 CBVCTs of 18 European countries participate in the network. For M&E of CBVCT activities of the participating centres, a standardized protocol with core indicators was de-

veloped. CBVCT centres, members of the network, share common instruments for data collection and data entry. The network has a common database that allows global data analysis and comparisons between centres. Alternatively, those CBVCTs that do not use these common tools send aggregated data on core M&E indicators.

Results: According to the preliminary analysis of data centres using common data entry tools (24 centres) for the period 2014-2015, a total of 9,676 HIV tests have been performed in 9,006 individuals (46.8% men who have sex with men (MSM), 10.4% sex workers (SW), 1.3% people who inject drugs (PWID), 28.3% migrants). 1.9% were reactive (3.4% MSM, 4.5 male SW, 0.2% female SW, 9.7% transgender SW, 1.9% PWID, 2.3% migrants). 71.8% of the cases with a reactive result had a confirmatory test performed and 89.0% of the confirmed positive individuals were successfully linked to healthcare. In 33.4% of cases, the clients were tested for the first time.

Conclusions: The COBATEST network contributes to standardize information about the activity, procedures and results of CBVCT centres in Europe. This information and standardized tools can help improve these services and inform the responsible politicians to better integrate these interventions within their national HIV prevention and control programs.

Parallel Session 2: Testing strategies in key affected populations

PS2/01 HIV Diagnoses in Migrants from Western, Central and Eastern Europe in the EU/EEA; Emerging Epidemics

J. del Amo¹, I. Jarrin¹, V. Hernando¹, D. Alvarez Del Arco¹, B. Alejos¹, A. Amato², T. Noori², A. Pharris²

¹Institute of Health Carlos III, Madrid, Spain, ²ECDC, Stockholm, Sweden

Background: We describe characteristics and trends of new HIV reports in migrants from UN-defined regions of Western (WE), Central (CE) and Eastern Europe (EE) in the European Union/Economic Area (EU/EEA).

Methods: HIV reports to European Surveillance System (TESSy) during 2004-2013 from 30 EU/EEA countries were analysed. Migrants were defined as people whose geographical origin was different to reporting countries. Differences in CD4 counts at HIV diagnosis for each region were used as a measure of HIV testing delay and were analyzed using median regression adjusting for transmission category, age and sex.

Results: Of 252,609 reports, 19,452 (8%) were from other European countries; 49% were migrants from WE, 30% from CE and 21% from EE. The countries which reported the largest numbers of cases were UK (33%), Germany (13%), Spain (10%) and France (7%). Male/Female ratios were 7 for WE, 3.3 for CE and 1.7 for EE. The proportion of Men who have sex with men (MSM) was 73%, 55% and 24% in WE, CE and EE, respectively, corresponding proportions of heterosexually transmitted cases were 14%, 21% and 22%, and 7%, 10% and 37% for injecting drug use. From 2004 till 2013 HIV reports in men from WE, CE and EE increased by 35%, 77% and 57%, respectively. In the same period, HIV reports in women from WE declined by 38% and in CE and EE increased by 70% and 66%, respectively. CD4 counts were available in 63% of cases and improved overtime. Median CD4 counts showed statistically significant increases overtime in migrants from WE, non-statistically significant increases in migrants from CE, and statistically significant decreases in migrants from EE. Findings were similar in sensitivity analyses of subsets with stable CD4 count reporting. Conclusions: HIV reports in migrants from WE, CE and EE in the EU/EEA conform distinct and emerging epidemics.

HIV Diagnoses in Migrants from Latin America & Caribbean in Europe; Distinct Epidemics

J. del Amo¹, I. Jarrin², V. Hernando², D. Alvarez Del Arco², B. Alejos², A. Amato³, A. Pharris³, T. Noori³

¹Institute of Health Carlos III, National Center for Epidemiology, Madrid, Spain, ²Institute of Health Carlos III, Madrid, Spain, ³ECDC, Stockholm, Sweden

Background: We describe characteristics, CD4 counts at diagnosis and trends overtime of new HIV reports in migrants from UN-defined regions of Central America (CA), Caribbean (Cb), Andean (AA) and South America (SA) in the European Union/Economic Area (EU/EEA).

Methods: HIV reports to European Surveillance System (TESSy) during 2004-2013 from 30 EU/EEA countries were analysed. Migrants were defined as people whose geographical origin was different to the reporting country. Differences in CD4 counts at HIV diagnosis over time for each region were used as a measure of HIV testing delay and were analyzed using median regression adjusting for transmission category, age and sex.

Results: Of 252,609 reports, 14,621 (6%) were from LAC; 4% in 2004, 7% in 2010 and 5% in 2013. The countries which reported the largest numbers of cases were Spain (37%), UK (20%), France (18%), Portugal (7%) and Italy (6%). Of the 14,621 cases, 35% were from SA, 27% from each Cb and AA, respectively, and 9% from CA. Male/Female ratios were 1.4 and 2.5 for Cb and CA and 5 for SA and AA. The proportion of Men who have sex with men (MSM) was 81%, 75% in SA and AA and 56% in CA and 41% in Cb. HIV reports in men and women from SA and AA increased till 2010 to decline thereafter; whereas cases from Cb and CA showed stable trends. Median CD4 counts at HIV diagnosis increased steadily overtime; 308 cells/mm³ in 2004 and 377 cells/mm³, were higher in migrants from SA and Cb and increases were only statistically significant in Cb. Findings were similar in sensitivity analyses of subsets with stable CD4 count reporting.

Conclusions: HIV reports in migrants from LAC in the EU/EEA conform distinct epidemics - thus requiring different responses -are unevenly distributed within the different EU/EEA countries.

PS2/02 A High Rate of HIV-1 Acquisition Post Immigration among Migrants in Sweden Determined by a CD4+ T-cell Decline Trajectory Model Indicates Missed Opportunities for Testing and Primary Prevention

J. Brännström¹, A. Sönnnerborg^{1,2}, V. Swedhem¹, U. Neogi², G. Marrone¹

¹Karolinska Institutet and Karolinska University Hospital, Department of Medicine, Unit of Infectious Diseases and Department of Infectious Diseases, Stockholm, Sweden, ²Karolinska Institutet and Karolinska University Hospital, Division of Clinical Microbiology, Department of Laboratory Medicine, Stockholm, Sweden

Objectives: Migrants constitute a substantial proportion of the HIV-1 positive population in Europe and represent a vulnerable group with increased risk of late presentation. With increasing evidence that HIV acquisition post immigration is underestimated there is a need of more thorough assessments. The objective of this study was to assess to which extent migrants acquire HIV after arrival to Sweden using a CD4+ T-cell decline trajectory model.

Methods: All migrants (n=2,268), ≥ 15 years, diagnosed with HIV-1 1983-2013, without mother-to-child transmission or primary HIV infection, with a known year of arrival were included. The CD4+ T-cell decline trajectory model was applied and estimates of HIV acquisition compared with what was clinically reported. A multinomial logistic regression model assessed characteristics of patients with discordant results. Finally phylogenetic analysis was performed in a subset of the patients to explore whether this would favor the model or the doctor's estimate.

Results: The model estimated 19% to have acquired their HIV infection after arrival to Sweden, compared to a doctor estimate of 12%. In 79% of cases the estimates agreed. Discordance was predominantly seen when the model estimated HIV acquisition after arrival to Sweden while the doctor's estimate suggested the opposite and occurred in 10% of all patients. The probability of a discordance increased with a high first CD4+ T-cell count and age, while it was lower for men who have sex with men and people who inject drugs compared to those heterosexually infected. The phylogenetic analysis favored the CD4 model with a concordance of 36% vs 13%.

Conclusions: A substantially higher proportion of migrants are infected after arrival to Sweden than what is estimated by clinical routine reports. Emphasis on initial health examinations as well as strengthening of primary prevention measures is equally important for migrants establishing themselves in their new country.

PS2/03 Knowledge, and Actual Versus Potential Use of HIV Self-testing and Self-sampling Testing Kits in 8 European Countries

J. Hoyos Miller¹, M.J. Belza^{1,2}, C. Agustí^{1,3}, S. Chanos⁴, F. Pichon⁵, M. Kuske⁶, B. Cigan⁷, R. Fuertes⁸, L. Ooms⁹, R. Stefanescu¹⁰, C. Cabeza de Vaca², B. Arranz¹¹, L. de la Fuente^{4,11}

¹CIBER Epidemiología y Salud Pública (CIBERESP), Madrid, Spain, ²Institute of Health Carlos III, Escuela Nacional de Sanidad, Madrid, Spain, ³Centre Estudis Epidemiològics sobre les Infeccions de Transmissió Sexual i Sida de Catalunya (CEEISCAT), Departament de Salut, Generalitat de Catalunya,, Badalona, Spain, ⁴Checkpoint Athens, Athens, Greece, ⁵AIDS Fondet, Copenhagen, Denmark, ⁶AIDS Hilfe NRW e.V., Berlin, Germany, ⁷Legebitra, Ljubljana, Slovenia, ⁸GAT-Grupo de Ativistas em Tratamentos, Lisboa, Portugal, ⁹Institute Tropical Medicine, Antwerp, Belgium, ¹⁰ARAS-Asociatia Romana Anti-SIDA, Bucharest, Romania, ¹¹Institute of Health Carlos III, Centro Nacional de Epidemiología, Madrid, Spain

Aim: To assess the acceptability and potential use of several innovative strategies among men who have sex with men recruited online in eight European countries.

Methods: We analyze data from an online survey carried out in the context of the EURO HIV EDAT project. The survey was conducted in 8 countries (Spain, Germany, Greece, Romania, Denmark, Slovenia, Portugal and Belgium) between April and August 2016. It was advertised mainly through banners and mailing lists in a number of transnational and national level gay dating websites. We conduct a descriptive analysis of the main characteristics of the participants who agreed to participate, and present preliminary data on indicators of knowledge, use and potential use of two innovative testing options: HIV self-sampling and HIV self-testing.

Results: We analyze 10.656 individuals that agreed to participate. The number of individuals recruited per country ranged from 149 to 5103. Overall, 39.4% were ≥40 years of age, 11.4% were born abroad and 49.3% had a university education. Approximately 24.0% reported that they kept their sexual life hidden or in total secrecy. Regarding testing history, 27.6% had never been tested (Range: minimum 6.5%- maximum 49.5%).The proportion of participants who knew about self-sampling and self-testing was of 24.2%(min 21.0% max 48.8%) and 18.9% (min 11.8%- max 29.3%) respectively but the use of both testing methods was anecdotic (0.7% and 2.1% respectively.) Potential use of both methods is high, with 75.2% and 68.0% of participants answering that they would have used a self-testing and/or a self-sampling kit in the past if it was available.

Conclusion: Even though knowledge and use are low, both self-testing and self-sampling have the potential of increasing testing rates in MSM of the 8 countries analyzed if approved in the future. Financial support: CHAFAEA: 20131101 AESI: PI14CIII/00009

PS2/04 From HIV-testing to Gay Health Centres: A mapping of European "Checkpoints"

A.J. Schmidt^{1,2}, D. Sander³, T. Noori⁴

¹London School of Hygiene and Tropical Medicine, Sigma Research, London, United Kingdom, ²Swiss Federal Office of Public Health FOPH, Infectious Diseases Division, Bern, Switzerland, ³Deutsche AIDS-Hilfe, Berlin, Germany, ⁴European Centre for Disease Prevention and Control (ECDC), Stockholm, Sweden

Background: In Europe, HIV/STIs are concentrated in vulnerable groups, above all, men who have sex with men (MSM). Since the early 2000s, the concept of community-based centres (CBCs) for HIV-testing and other sexual health services has spread and many such centres ("Checkpoints") have been established. Our aim was to map MSM sexual health centres in Europe.

Methods: In preparation of the second round of the European-MSM-Internet-Survey (EMIS-2017), the EMIS-Network (including more than 80 academic, governmental, and non-governmental organisations) was contacted to identify MSM sexual health centres. Service features were queried with 16 questions. We used Google Maps for geographical visual representation. We calculated two 7-point-scores for testing-and-(prophylactic)-treatment and counselling-and-community-involvement.

Results: 56 centres were identified and 54 responded. CBCs (N=44) were distinguished from tra-

ditional clinics (N=10). All centres offered rapid HIV-testing, most (66% of CBCs) syphilis-testing, some (39%) also featured anal/pharyngeal swabbing. STI treatment was offered by 18% of CBCs, 69% had a standard referral organised. Vaccination against hepatitis A/B (18%), HIV-post-exposure-prophylaxis (11%), HIV-treatment (7%) were rarely offered by CBCs. Clinics ranked high on testing-and-(prophylactic)-treatment, reaching a score of 5 or higher. Among CBCs, only the Swiss Checkpoints Geneva, Lausanne and Zurich; Checkpoint Barcelona, and GMHS-Dublin reached a high score. 75% of CBCs and 80% of clinics reported counselling for mental health, transgender health (59%; 50%, respectively), and drug use/addiction (57%; 60%). Nearly all CBCs (95%) and half (50%) of the clinics did outreach work, while 50% and 80%, respectively, organised MSM-related research.

Conclusions: The added value of maintaining up-to-date listing of CBCs is their use in online mapping services and integration in geo-location-based dating-apps targeting MSM. Experience with European HIV-Testing-Week has shown that reaching out to MSM through push notifications with a spectrum of HIV services and opening times of Checkpoints is both cost-effective and accepted by the community.

PS2/05 Factors Associated with HCV Test Uptake in Heroin Users Entering Substitution Treatment in Greece

O. Anagnostou¹, A. Fotiou², E. Kanavou², A. Andaraki², T. Manina², C. Richardson³, E. Kafetzopoulos¹, Drug Related Infectious Diseases (DRID) Medical Doctors Group of OKANA

¹Greek Organisation Against Drugs (OKANA), Athens, Greece, ²Greek Reitox Focal Point of the EMCDDA, Athens University Mental Health Research Institute (UMHRI), Athens, Greece, ³Panteion University of Social and Political Sciences, ATHENS, Greece

Background: International guidelines suggest regular HCV testing for PWID as one of the main prevention measures. Implementation of guidelines varies significantly due to individual and structural-level factors impeding access to testing. We examined history of HCV testing and its determinants among people entering opioid substitution treatment in Greece.

Methods: Anonymous behavioural data were collected from heroin users upon entering substitution treatment in Greece (2013-2015). Three groups were defined based on self-reported past HCV test uptake: Group A never tested, Group B tested 12 months ago, and Group C tested >12 months ago. Multinomial logistic regression analyses identified differences between groups according to several characteristics.

Results: Data from 2747 persons were analyzed [median age 36 years (31, 43), 83.9% males, 88.3% Greeks]. Drug injecting history was reported by 79.7% and syringe sharing by 56.9% (last 30 days 34.9% and 7.2% respectively). Groups A, B, and C represent 16.5%, 61.2% and 22.3%, respectively of those with complete HCV testing uptake data (N=2299).

In multivariable analyses, age group(25-34 years), previous addiction treatment attempts, injecting history ≥5 years, and syringe sharing history were positively associated with any past HCV testing. Female gender (relative risk ratio[RRR]=2.6, 95% confidence interval[CI]:1.7-4.0, p<0.001) and polydrug use (RRR=1.6, 95%CI: 1.0-2.3, p=0.029) were positively associated with recent HCV testing. Living in Athens Metropolitan Area (RRR=0.7, 95%CI: 0.5-1.0, p=0.029) was negatively associated with past, but not recent testing. Having stable job (RRR=1.8, 95%CI:1.2-2.9, p=0.010) and 2-4years injecting history (RRR=2.1, 95%CI: 1.1-4.3, p=0.033) were positively associated with past, but not recent, testing.

Conclusion: The majority of people entering an opioid substitution programme in Greece mention HCV testing in the past, although a considerable proportion were never tested or tested with inadequate frequency. Prevention efforts should emphasize on offering convenient and continuous opportunities for testing, especially to those living under vulnerable conditions.

Parallel Session 3: Challenges in Health care settings: testing and linkage to care

PS3/01 Assessing the Representativeness of European HIV Cohort Participants as Compared to HIV Surveillance Data

G. Vourli¹, A. Pharris², F. Cazein³, D. Costagliola⁴, F. Dabis⁵, J. Del Amo⁶, V. Delpech⁷, A. Díaz⁶, E. Girard⁸, A. Gourlay⁹, B. Gunesheimer-Bartmeyer¹⁰, V. Hernando⁶, G. Nikolopoulos^{11,12}, K. Porter⁹, M. Rosińska¹⁵, C. Sabin⁹, B. Suligoi¹³, V. Supervie⁴, F. Wit¹⁴, G. Touloumi¹

¹Medical School, National and Kapodistrian University of Athens, Department of Hygiene, Epidemiology and Medical Statistics, Athens, Greece, ²European Centre for Disease Prevention and Control, Stockholm, Sweden, ³Institut National de Santé Publique, Saint-Maurice, France, ⁴Sorbonne Universités, UPMC Univ Paris 06, INSERM, Institut Pierre Louis d'Epidémiologie et de Santé Publique (IPLESP UMR_S 1136), Paris, France, ⁵Université Bordeaux, ISPED, Centre INSERM U1219 - Bordeaux Population Health, Bordeaux, France, ⁶Instituto de Salud Carlos III, National Center of Epidemiology, Madrid, Spain, ⁷Public Health England, London, United Kingdom, ⁸Clinical Epidemiology Unit, National Institute for Infectious Diseases, Rome, Italy, ⁹University College London, Department of Infection and Population Health, London, United Kingdom, ¹⁰Robert Koch Institute, Department of Infectious Disease Epidemiology HIV/AIDS, STI, Berlin, Germany, ¹¹Hellenic Centre for Disease Control and Prevention, Amarousio, Greece, ¹²University of Cyprus, Medical School, Nicosia, Cyprus, ¹³Istituto Superiore di Sanità, Centro Operativo AIDS, Rome, Italy, ¹⁴Stichting HIV Monitoring, Amsterdam, Netherlands, Department of Epidemiology, National Institute of Public Health – National, Institute of Hygiene, Warsaw, Poland¹⁵

Background: European Surveillance System (TESSy) collects case-based surveillance data on new HIV diagnoses through national surveillance systems. However, clinical and follow-up data are often lacking. HIV cohorts are an ideal source of these data and can be used to supplement surveillance data if cohorts are representative of the diagnosed populations. This study assessed the representativeness of HIV cohorts within EuroCoord by comparing characteristics of cohort participants to TESSy data.

Methods: France, Germany, Greece, Italy, Spain and the UK provided cohort data. Comparisons of distributions of demographics (age, gender, transmission route, origin country and CD4 count at diagnosis, where available) were made between cohorts and TESSy, after stratification for year of diagnosis (2000-2004, 2005-2009, 2010-2013) to allow for temporal changes in the coverage of cohorts and/or surveillance systems. Logistic regression models were fitted to estimate the probability of being included in the cohort given demographic characteristics, and weights generated which can be applied when using cohort data to supplement surveillance data.

Results: We demonstrate that these cohorts were generally representative of the diagnosed population in each country based on TESSy data. However, people injecting drugs (range of ORs for inclusion: 0.24-0.78), those born in another country (ORs: 0.26-0.83) and those with low CD4 counts at diagnosis (ORs: 0.62-0.75) were less likely to be included in cohorts (Table). The generated inclusion weights can be used to compensate for these imbalances in a weighted analysis.

	Drug injectors vs. Men who have sex with men	Born in another country vs. reporting country	<200 vs. >200 CD4 cell count/ml
UK	0.36 (0.29-0.44)	Data not available	0.69 (0.65-0.74)
France	0.43 (0.34-0.54)	0.28 (0.25-0.30)	0.75 (0.70-0.81)
Italy	0.78 (0.66-0.93)	1.09 (0.98-1.21)	0.62 (0.57-0.68)
Germany	1.22 (0.97-1.52)	Data not available	Data not available
Spain	0.38 (0.31-0.46)	0.83 (0.77-0.90)	0.62 (0.57-0.69)
Greece	0.24 (0.20-0.29)	0.26 (0.22-0.32)	0.62 (0.53-0.74)

[ORs for inclusion in the cohort (2010-2013)]

Conclusions: European cohorts included here capture a representative sample of HIV diagnosed individuals and can be used to supplement surveillance data. Application of the weights derived here to any such analyses, may further improve reliability of findings. Notably, while TESSy data were considered the gold standard against which cohort data were compared, surveillance data may also suffer from high rates of missing data, under-reporting and reporting delays.

PS3/02 Factors for Delayed Linkage to Care Following HIV Diagnosis in the WHO European Region

S. Croxford¹, F. Burns², A. Copas², A. Pharris³, V. Delpech¹, OptTEST for HIV in Europe
¹Public Health England, London, United Kingdom, ²University College London, Department of Infection and Population Health, London, United Kingdom, ³European Centre for Disease Prevention and Control, Stockholm, Sweden

Objectives: To describe linkage to HIV care following diagnosis in the World Health Organization (WHO) European Region and to identify factors associated with delayed linkage

Methods: Analyses were carried out using data on new HIV diagnoses reported to the European Surveillance System (TESSy) in 2014. Data were included for countries that reported using the revised template (n=33). Analyses were restricted to adults (aged ≥15 years) diagnosed between 2010 and 2014. Individuals were excluded if they had been previously diagnosed or in care, died within 3 months of diagnosis and/or had no CD4 data reported. Linkage to care was calculated using the time between the HIV diagnosis date and first CD4 count date. Linkage was considered delayed if the CD4 count was taken more than 3 months (91 days) after diagnosis. Logistic regression was used to determine factors for delayed linkage.

Results: Of the 127,703 adults diagnosed from 2010-2014, 4,612 people were diagnosed previously, 820 had died within 3 months of diagnosis and 61,680 people were missing CD4 data. Among the 60,591 people included in these analyses, linkage to care within 3 months was 95.5%. In multivariable analysis (Table 1), delayed linkage to care was associated with: being infected by injecting drug use (IDU) or heterosexual transmission, being diagnosed in Central or Eastern Europe and having a first CD4 count >200 cells/mm³. Older age at diagnosis and being diagnosed after 2011 were associated with faster linkage to care. Sex and region of birth were not associated with linkage delays.

Conclusions:

Overall, linkage to care in Europe is prompt, though estimates may be lower than reported due to incomplete CD4 data. Our findings show improvements are needed in linkage to care for those diagnosed in Central and Eastern Europe and people infected through heterosexual contact and IDU.

PS3/03 Increased HIV Case Detection through Integration of HIV Testing in Georgian Hepatitis C Elimination Program Screening Activities

D. Baliashvili¹, M. Tsereteli¹, M. Alkhazashvili², K. Zakhshvili³, A. Gamkrelidze⁴

¹National Center for Disease Control and Public health, HIV/AIDS, Hepatitis, Tuberculosis and STIs, Tbilisi, Georgia, ²National Center for Disease Control and Public health, Regional Public Health,

Table 1: Linkage to HIV care and risk factors for delayed linkage after diagnosis: Europe, 2010-2014

		Linked within 3 months		Risk factors for delayed linkage		
		n	%	Adjusted Odds Ratio (OR)		
				adjOR	95% CI	p value
Sex	Men	42,924	95.8%	1.00	-	-
	Women	14,611	95.4%	0.98	0.87 - 1.11	0.806
Age at diagnosis	15-24	7,070	94.3%	1.00	-	-
	25-34	19,173	95.2%	0.93	0.81 - 1.07	0.299
	35-44	16,540	96.1%	0.89	0.77 - 1.03	0.117
	45-54	9,791	96.4%	0.92	0.78 - 1.09	0.359
	55-64	3,800	97.3%	0.75	0.59 - 0.96	0.021
	65+	1,187	97.5%	0.58	0.36 - 0.92	0.022
Diagnosis year	2010	10,894	95.5%	1.00	-	-
	2011	11,257	94.9%	1.04	0.90 - 1.19	0.602
	2012	11,760	95.8%	0.81	0.70 - 0.93	0.004
	2013	11,729	96.6%	0.61	0.53 - 0.71	<0.001
	2014	11,925	95.8%	0.74	0.64 - 0.85	<0.001
Exposure	Sex between men	26,955	96.6%	1.00	-	-
	Heterosexual contact	24,484	95.9%	1.16	1.02 - 1.32	0.027
	Injecting drug use	2,790	89.9%	1.74	1.48 - 2.05	<0.001
	Other	382	91.2%	2.53	1.69 - 3.78	<0.001
Region of diagnosis	West	50,804	96.7%	1.00	-	-
	Centre	4,469	88.3%	3.80	3.35 - 4.31	<0.001
	East	2,292	91.4%	2.97	2.48 - 3.55	<0.001
Region of origin	Reporting country	27,508	95.3%	1.00	-	-
	Other Europe	6,121	95.2%	1.13	0.98 - 1.29	0.083
	Africa and the Middle East	12,105	96.4%	1.15	1.00 - 1.32	0.058
	Latin America & the Caribbean	2,076	96.2%	1.21	0.95 - 1.54	0.132
	Asia	1,455	96.2%	1.24	0.93 - 1.64	0.143
	Other	545	97.5%	0.82	0.48 - 1.41	0.476
First CD4 count after diagnosis (cells/mm ³)	<200	15,528	96.4%	1.00	-	-
	200-349	11,857	95.6%	1.23	1.08 - 1.41	0.003
	350-499	12,020	95.6%	1.35	1.18 - 1.55	<0.001
	≥500	18,360	95.3%	1.46	1.29 - 1.65	<0.001

Completeness: sex (99.9%), age at diagnosis (99.9%), year of diagnosis (100%), exposure (94.8%), region of diagnosis (100%), region of origin (86.7%) and CD4 count (100%)

Tbilisi, Georgia, ³National Center for Disease Control and Public health, Communicable Diseases, Tbilisi, Georgia, ⁴National Center for Disease Control and Public health, Tbilisi, Georgia

Objective: The objective of this programmatic approach was to increase HCV and HIV detection in general population by combined testing strategy.

Methods: In 2015 Georgia launched unprecedented National Hepatitis C Elimination Program, aiming to dramatically decrease HCV prevalence in the country by 2020 (currently seroprevalence of HCV in Georgia is 7.7%). Starting from November, 2015, any citizen of Georgia can obtain free

HCV testing at the National Center for Disease Control and Public Health (NCDC) including its regional branches. In addition, every person willing to be tested for HCV is offered free HIV test as well. Both HIV and HCV testing are performed by rapid immunochromatographic method. RT-PCR for viral load was used for confirmation of active HCV infection and Immunoblot was used for HIV confirmation.

Results: Through September, 2016, 56,646 voluntary HCV testing and 29,150 HIV testing were performed at NCDC laboratory network. Rate of positive HCV test result was 17%. All positive cases were referred to HCV treatment component of National Elimination Program. Rate of positive HIV test result was 0.3% (83 out of 29,150). Out of 83 volunteers who tested positive, further diagnostic procedures confirmed HIV in 42 and are enrolled in the HIV treatment program.

Conclusions: Until 2015, free of charge HIV testing was offered only for high-risk groups. Preliminary results from combined testing indicates that HIV prevalence in general population remains low. Considering the low prevalence of HIV in Georgia, extra cases found by the combined screening approach was significant contributing factor for early detection of HIV cases. Nationwide HCV elimination program appears to be an effective mechanism that can be used to increase case detection of HIV in country and integration of HIV testing within HCV screening should be maintained and further expanded.

PS3/04 Monitoring HIV-indicator Condition Based HIV Testing in Estonia

K. Rütel¹, L. Lemsalu¹

¹National Institute for Health Development, Infectious Diseases and Drug Monitoring Department, Tallinn, Estonia

Objectives: Assess HIV-indicator condition (IC) based HIV testing in Estonia using data from Estonian Health Insurance Fund (EHIF).

Methods: EHIF is the core purchaser of health care services in Estonia, covering health care costs for insured people (94% of the total population). After health care services' provision, the provider sends a bill to EHIF, which includes patient information (e.g. age, gender, diagnoses based on ICD-10) and services provided (e.g. what tests were performed). We derived cumulative data on people aged 15-49 years for 2012-2015 to assess the proportion of people tested for HIV among those diagnosed with any of the following:

- 1) Sexually transmitted infections (STI): A51-A52 (syphilis); A54 (gonorrhoea); A56 (Chlamydia); A59 (trichomoniasis); A60 (herpes simplex);
- 2) B02 (herpes zoster);
- 3) B27 (infectious mononucleosis);
- 4) B16-B18 (acute and chronic viral hepatitis);
- 5) J12-J18 (pneumonia).

Data included both in- and out-patient, primary and specialist care (excluding palliative care and dentistry) services in 2012-2015.

Results: Figure 1 shows the proportion of patients tested for HIV among those with HIV ICs. Figure 2 shows HIV-testing rates among STI patients by gender, and Figures 3-4 among male and female STI patients by age-groups.

Conclusions: Our data show that HIV IC based HIV-testing rates are low in Estonia and have not changed in the last four years. Testing rates are higher for ICs which are managed mostly in specialist care, among men and younger age-groups. Almost a third of patients with infectious mononucleosis and viral hepatitis are tested for HIV. More attention is needed in educating health care

personnel and ensuring adequate funds for HIV testing. Despite several limitations (e.g. no data on un-insured people, possible misclassification of diagnoses and tests), EHIF data can be used to monitor HIV testing trends in patients with HIV ICs.

Figure 1. Percentage of 15-49 year old patients diagnosed with HIV indicator conditions tested for HIV, 2012-2015

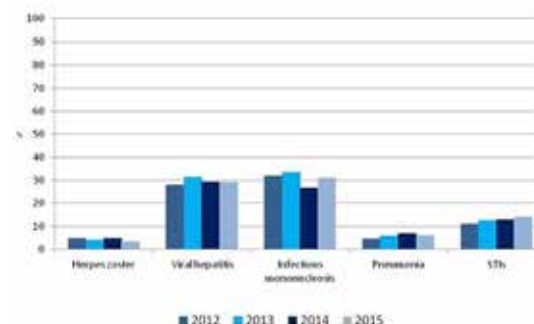


Figure 2. STI cases aged 15-49 years tested for HIV by gender, 2012-2015

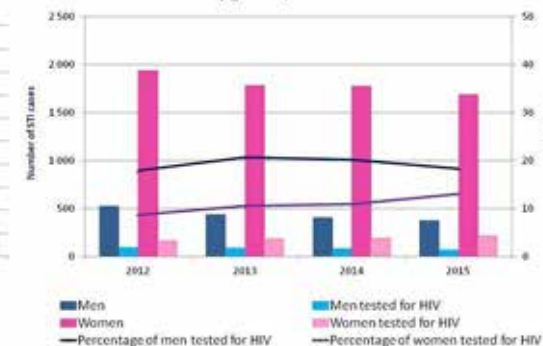


Figure 3. Percentage of STI cases among women tested for HIV by age groups, 2012-2015

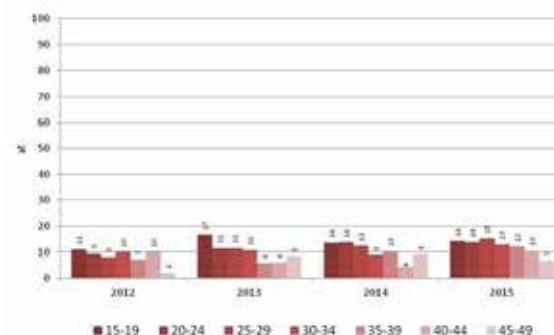
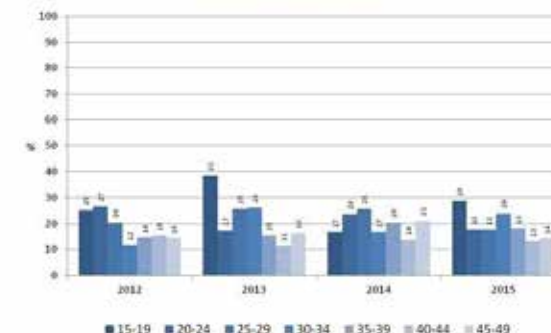


Figure 4. Percentage of STI cases among men tested for HIV by age groups, 2012-2015



PS3/05 Testing for Blood Borne Viruses in the Emergency Department of a Large London Hospital

D. Bradshaw^{1,2}, C. Rae¹, G. Pickard³, D. Patel³, D. Rezende³, P. Roberts¹, K. Pillay¹, M. Foxton¹, A. Sullivan¹

¹Chelsea and Westminster Hospital NHS Foundation Trust, London, United Kingdom, ²Brighton and Sussex University Hospitals NHS Trust, Brighton, United Kingdom, ³Imperial College Healthcare NHS Trust, London, United Kingdom

Objectives: Novel therapies against hepatitis C virus (HCV) have recently been licensed but access to treatment may be limited due to a high proportion of undiagnosed infection. UK national HCV and hepatitis B virus (HBV) seroprevalence is estimated at 0.4% and 0.3% respectively but this conceals hotspots of high seroprevalence and local data are lacking. This study aimed to identify local blood borne virus (BBV) seroprevalence.

Methods: This was an opt-out BBV testing program in the emergency department (ED) of a large London hospital. Individuals of age 16-65 years accepted either routine BBV testing (HCV, HBV, HIV) or a standalone HIV test. Assays were performed for anti-HCV IgG and HBV surface antigen (HBsAg), costing £3.50 and £3.60 respectively, and HIV-1/-2 antibody/antigen.

Results: Of 18,419 individuals attending the ED over a 40 week period, 4367 (23.7%) accepted BBV screening; 1191 (6.5%) accepted a standalone HIV test; 5558 (30.2%) therefore tested for HIV. Numbers positive for anti-HCV, HBsAg and HIV are shown in the Table. Seroprevalence (%) for HCV, HIV and HBV was 1.5, 1.2 and 0.5. The positive test cost for anti-HCV and HBsAg was £232 and £714, respectively.

	Anti-HCV	HBsAg	HIV
Total no. of positive tests	66 (100)	22 (100)	66 (100)
Previously known diagnosis	43 (65.2)	9 (40.9)	54 (81.8)
Confirmed new diagnosis	9 (13.6)	7 (31.8)	11 (16.7)
Other eg patient not contactable	13 (19.7)	6 (27.3)	1 (1.5)
Negative on repeat testing	1 (1.5)	0	0
Seroprevalence*, %	1.5	0.5	1.2

Notes: Brackets denote %. * Denominator is 4367 (HCV, HBV) or 5558 (HIV) attendees.

Conclusions: Local seroprevalence of HIV, HCV and HBV infection was 4.0, 3.8 and 1.7 times the national average, respectively. Overall uptake of BBV testing was low at 23.7%; this could have been due to low uptake and/or offer of testing. Further work is required on the cost effectiveness of universal screening for BBV in the ED and other non-traditional settings.

Parallel Session 4: Community testing

PS4/01 Development of a Toolkit for Implementation and Evaluation of Checkpoints for MSM

M. Kuske¹, C. Agusti², M. Meulbroek³, D. Rojas Castro⁴, F. Pinchon⁵, P. Slaaen⁵, M. Lobnik⁶, B. Cigan⁶, M. Wentzlaff-Eggebert¹, M. Alexandru⁷, T. Platteau⁸, D. Simões⁹, S. Schanos¹⁰, EURO HIV EDAT Study Group

¹AIDS Hilfe NRW e.V., Köln, Germany, ²CEEISCAT, Badalona, Spain, ³BCN Checkpoint Hispanosida, Barcelona, Spain, ⁴Association AIDES, Paris, France, ⁵AIDS Fondet, Copenhagen, Denmark, ⁶Legebitra, Ljubljana, Slovenia, ⁷ARAS, Bucarest, Romania, ⁸Institute Tropical Medicine, Brussels, Belgium, ⁹GAT-Grupo Português de Activistas sobre Tratamentos de VIH/SIDA, Lisboa, Portugal, ¹⁰Checkpoint Athens, Athens, Greece

Background: In the last years in many European countries low-threshold Communitybased Voluntary Counselling and Testing (CBVCT) centres (Checkpoints) for MSM have been established. To support recently opened Checkpoints, we developed an online-based Toolkit.

Methods: A working group with Checkpoints from all over Europe was established. In November 2015 a workshop with experts and working group members developed the main content and structure of the toolkit. The toolkit content was afterwards elaborated by an expert in close collaboration with the working group. The toolkit was tested in a workshop in Ljubljana in October 2016. The final version of the Toolkit will be published in June 2017.

Outcome: The toolkit is an online guidance that provides the main information needed to plan, run and optimize the quality of a CBVCT service (Checkpoint) that address MSM. This is mainly performed by checklists that enable the user to develop his own strategies according to his needs. The Toolkit is split in five main chapters that cover all main aspects for running a quality based service:

Chapter 1: Operating a CBVCT targeting MSM, 1A: Regulatory and Legal Frameworks, 1B: Key population and community involvement, 1C: Collaboration, 1D: Infrastructure and materials, 1E: Human Resources, 1F: Monitoring and evaluation, 1G: Funding viability and sustainability, Chapter 2: Counselling and linkage to care, Chapter 3: Communication, Chapter 4: Accountability, advocacy and empowerment, Chapter 5: Quality improvement and innovation. The Toolkit is enriched by content from other work packages of the Euro HIV EDAT project and other European wide Projects, especially HIV quality action (www.qualityaction.eu).

Conclusion: Thanks to the collaboration of many experienced partners and experts a useful and practical toolkit was developed that enables Checkpoints to optimize and develop their services and helps to provide low-threshold, quality based access to test and treatment for the group most at risk.

PS4/02 Barring the Way to Health: How Legal and Regulatory Barriers Hinder Modernising HIV Testing across Europe

L. Power¹, J. Hows^{2,3}, S. Finne Jakobsen^{3,4}, A.-I. Von Lingen^{3,5}

¹OptTEST by HIV in Europe, Cardiff, United Kingdom, ²GNP+, Amsterdam, Netherlands, ³OptTEST by HIV in Europe, Copenhagen, Denmark, ⁴University of Copenhagen, Region H, Copenhagen, Denmark, ⁵European AIDS Treatment Group, Brussels, Belgium

HIV testing rates across Europe need to be improved in order to benefit from treatment and new prevention tools. Trials of new testing technologies like community, postal and self-testing show increased uptake and cost-effectiveness. Outdated guidelines and legal and regulatory barriers are cited as reasons for failure to adopt

In 2016 participants in the OptTEST programme (GNP+, EATG and an independent contractor) surveyed legal and regulatory barriers across Europe. Country respondents and a literature review identified which testing technologies were in use and what barriers existed locally.

HIV Testing in European Countries

European countries surveyed	31
Countries restricting who can legally administer HIV test	20
Countries with legal testing in NGO/community settings	26
Countries with legal testing in outreach settings	24
Countries where self-testing (home testing) is legally done	6
Countries with postal testing schemes/pilots	3

Two thirds of European countries surveyed (data on 31/53 currently, full data expected by January 2017) legally restricted who can administer HIV tests; in most cases specialist clinicians must either administer the test themselves or supervise administration by others. In one notable case, the physician must be in the same building (not necessarily the same room). This hinders the adoption of self-testing technologies (less than 1 in 5 countries) including postal sampling (less than 1 in 10 countries) and discourages community testing by increasing costs and decreasing NGOs ability to do targeted outreach testing with those who are reluctant to attend hospitals. Reasons given include failure to update guidance linked to old methods of testing; prohibition of/ lack of rapid testing; compulsory intensive pre-test counselling; prohibitions on where testing can take place; clinician resistance to non-clinic based forms of testing.



There need to be intensified efforts across Europe to demonstrate the benefits of increasing access to HIV testing and challenge costly, outdated custom and practice in HIV testing systems. European-wide best practice guidelines would be helpful in this. Country health systems should be encouraged to learn from successful pilots elsewhere in Europe and understand the cost-benefit implications of better targeted, simpler HIV testing taking full advantage of new technologies and scientific advances.

PS4/03 BCN Checkpoint: Same-day Confirmation of Reactive HIV Rapid Test with Point Of Care PCR Test Accelerates Linkage to Care and Reduces Anxiety

M. Meulbroek¹, F. Pérez¹, A. Dalmau-Bueno², F. Pujol¹, J. Saz¹, H. Taboada¹, G. Marazzi¹, A. Carrillo¹, A. Cabas¹, A. Gata¹, E. Aldabó², B. Roldán², P. Coll², F. Añez², J. Pantaleón², M. Mochales², O. Martín², V. Gómez², J.F. Mir², J. Decoca²

¹Projecte dels NOMS-Hispanosida, Barcelona, Spain, ²BCN Checkpoint, Barcelona, Spain

Objectives: The introduction in 2006 of the rapid HIV test by BCN Checkpoint, a community-based HIV testing center for MSM, has been a successful step forwards in the uptake of testing. Nevertheless, HIV serostatus should be reported as HIV positive only when a reactive result has been tested again using a different assay (WHO guidelines 2015). The standard confirmation test has been the Western Blot test, but results take around 7 days to come back. This study explores the possibility of Point of Care PCR testing for a same-day confirmation.

Methods: Between March 2015 and September 2016 a POC PCR test (Xpert[®] HIV-1 Qual, LOD on WHO standards is 278cp/ml, 95%IC: 253-304 cp/ml) was performed in parallel to the Western Blot test after a reactive HIV rapid test (Alere Determine[™] HIV-1/2 Ag/Ab Combo and Alere[™] HIV Combo). HIV confirmed positive cases received emotional support by peers, were informed and prepared for treatment initiation and linked to HIV hospital in less than 15 days (75%).

Results: During the study period 11,455 tests were performed to 7,163 clients. A total of 249 reactive rapid HIV tests were found. For analysis a total of 33 cases were excluded due to the lack of PCR and/or WB test. Results of comparison of the 216 cases are shown in table 1.

Results	n	%	Sero-status HIV	Interpretation
PCR positive; WB positive	194	89.8%	+	Confirmed positive results
PCR negative; WB negative or indeterminate	14	6.5%	-	Confirmed false positive results
PCR positive; WB negative or indeterminate	3	1.4%	+	Confirmed positive results: recent infections
PCR negative; WB positive	5	2.3%	+	Confirmed positive results: HIV controllers
Total	216	100%		

Conclusions: The POC PCR assay is easy to use and feasible in a community-based center. Reducing time for confirmation to 90 minutes has been possible in 91.2% (197/216) of cases with positive PCR result. In cases of a negative PCR result an additional test (WB, Elisa or PCR quantitative) was needed to distinguish false positive results (6.5%) from viral load results below level of detection (2.3%). Clients expressed satisfaction with same-day confirmation and less anxiety.

PS4/04 Impact of Pre-Test Counseling Sessions on Increasing Knowledge About HIV and Hepatitis Among the Beneficiaries of a Free of Charge, Voluntary Counseling and Testing Program (VCT) in Constanta, Romania

A.-M. Schweitzer¹, M. Bogdan¹, G. Ivanov¹, A. Corduneanu¹, I. Ciocea¹

¹Fundatia Baylor Marea Neagra, Infectious Diseases, Constanta, Romania

Objectives: To identify the utility of the pre-test counseling sessions in increasing the level of knowledge regarding HIV and viral hepatitis B and hepatitis C for the clients attending a free of charge VCT program. To check if the content of the pre-test counselling session is relevant for the group served in the community where the VCT program is unfolded.

Methods: A standardized content of pre-test counseling was defined and counselors were trained

regarding the correct delivery of the information during the session. Clients that attended the VCT program since September 2015 to August 2016 have been asked to fill a questionnaire after the pre-test counseling session, regarding how much the clients themselves assess that their level of knowledge regarding HIV and viral hepatitis has increased as a result of the information presented by the counselor. A 6 point interval scale was used for the answer (0% increase, 20%, 40%, 60%, 80%, 100%). Data was analyzed in order to identify increase was estimated by clients, as well as if there was any higher gain between the 2 components (HIV and hepatitis).

Results: 3065 clients accepted to fill in the questionnaire (average age 44.9 years, 59% women and 64% with urban residence). 78% of attendees considered that their knowledge regarding HIV and viral hepatitis has increased with more than 60%; more information was gained about hepatitis compared with HIV ($P < 0.0001$).

Conclusion: Pre-test counseling is a noteworthy activity and it is appreciated by clients as significantly improving their knowledge about the tests they are going to take. In our community, people that attend VCT are more knowledgeable about HIV than about viral hepatitis. Hepatitis pre-test counseling is not compulsory by law, but our data shows the information about prevention, transmission and vaccination of infectious diseases is relevant.

PS4/05 Monitoring test uptake and risk behaviour in community based HIV/STI testing sites in Germany, 2015/2016

U. Marcus¹, S.B. Schink², M. Tappe³, German Checkpoint Collaborative Group

¹Robert Koch-Institut, Infectious Disease Epidemiology, Berlin, Germany, ²Charite Universitätsmedizin Berlin, Berlin, Germany, ³Deutsche AIDS-Hilfe, Berlin, Germany

NGO-Checkpoints offering anonymous HIV and STI testing for groups at increased risk for HIV infection have been established in larger cities across Germany since 2004. In 2015 larger checkpoints started to collect standardized anonymous self-administered pre-counseling questionnaires from clients about testing history, risks and protective behaviours. Paper questionnaires and test results were sent to the national public health institute, scanned, entered into a database, and analyzed with Stata. Descriptive statistics were used to describe the sample. Factors associated with reactive/positive HIV test results were identified using bivariate and multivariate logistic regression (MLR) analysis after stratification by self-declared sexual orientation.

From 01/2015 through 10/2016 ten checkpoints contributed questionnaire and test data from 16,375 clients. Eighty-four percent were male, 16% female. Fifty-one percent self-identified as gay, 12% as bisexual, and 36% as heterosexual. Twenty-nine percent were born abroad, an additional 9% had a migrant background, and 62% were of German origin. Overall prevalence of reactive/positive HIV test results was 1.1%, with 0.4% among self-identified heterosexual clients and 1.5% among self-identified male gay/bisexual clients. Self-attributed medium or high infection risk among gay/bisexual men significantly increased odds for a reactive HIV test result (OR 3.6-11.0). In MLR, reactive/positive HIV test results among gay/bisexual men were positively associated with substance use other than alcohol or cannabis in the context of sex (OR 1.7), reported condomless anal intercourse with two or three or more partners in the previous 6 months (OR 2.1-2.8), and with a transmission risk within 15 days to 6 weeks before testing (OR 1.9). Clients accept standardized anonymous data collection. Data informs counselling, risk assessment and targeting of testing services. Reasons for not using condoms and risks associated with substance use need to be addressed by counselling; re-testing of clients with recent (< 6weeks) infection risks and non-reactive test results should be recommended.

POSTER SESSIONS

Poster category 1: Monitoring for HIV and Viral Hepatitis

PO1/01 Reflex RNA Testing on Hepatitis C Antibody Positive Samples: Is it Being Adopted?

G. Ireland¹, R. Simmons¹, S. Ijaz¹, S. Lattimore¹, M. Ramsay¹, S. Mandal¹

¹Public Health England, London, United Kingdom

Introduction: Diagnosis of current hepatitis C (HCV) infection requires testing for HCV RNA following a positive test for HCV antibodies (anti-HCV). Guidance recommends RNA testing on the same serum sample (reflex testing).

Method: All anti-HCV and RNA tests between 2008 and 2014 were extracted from Sentinel Surveillance of Blood Borne Virus Testing. Persons testing anti-HCV positive were identified, along with their first subsequent RNA test. Reflex testing was defined as an RNA test within seven days of a positive anti-HCV test. Persons were linked to a validated PHE treatment algorithm dataset, which uses sequential PCR tests to ascertain treatment rates and outcomes, and a cost analysis of testing strategies was done using 2013 testing data.

Results: Between 2008 and 2013 52.7% of persons anti-HCV positive were reflex tested, 18.3% were RNA tested between one week and six months, 2.8% between six and 12 months and 26.5% had no RNA test within 12 months. One year RNA testing rates were lower in DBS compared to serum samples (55.0% vs 67.6%) and 13.1% of persons had multiple anti-HCV tests. The main predictor of reflex testing was laboratory of anti-HCV test. Persons reflex tested received treatment quicker (167.5 vs 282.5 days, $p < 0.0001$) but a lower proportion received treatment and achieved sustained virological response (treatment: 20.6% vs 31.1%; SVR: 65.4% vs 74.9%; both: $p < 0.001$). The estimated annual savings gained from reflex testing was £166,500.

Conclusions: Variations in reflex testing remain, which appear to be a function of individual laboratory commissioning. Reflex testing saves money and ensures only those with a current HCV infection are referred to specialists. Poorer treatment outcomes in reflex tested persons need further investigation

PO1/02 Increasing Trend of New HIV Diagnoses among Older Adults in the EU/EEA: Missed Opportunities and Barriers to Testing

L. Tavoschi¹, J. Gomes¹, A. Pharris¹

¹European Centre for Disease Prevention and Control, Stockholm, Sweden

Background: HIV burden among older adults in the European Union/European Economic area (EU/EEA) is increasing. We described factors associated with HIV infection, diagnosis and health seeking behaviour among older adults in the EU/EEA.

Methods: We defined older and younger adults as ≥ 50 and 15-49 years old, respectively. We analysed new HIV diagnoses reported annually to The European Surveillance System during 2004-2014, for the 31 EU/EEA countries by age, gender, migration status, transmission route and CD4 count using χ^2 test for difference and linear regression of rates or proportions. We searched Embase and PubMed to identify studies reporting factors influencing provision and uptake of HIV testing among older adults in high-income countries.

Results: The rate of reported new HIV diagnoses among older adults in the EU/EEA significantly increased over time with an annual average change of 2.3% (95%CI 1.3%-3.2%; $p=0.0003$). In 2014 the rate was 2.6 per 100 000 population (range 0.2-6.1 per 100 000), with majority of the cases attributed to heterosexual transmission (2083, 40.8%) and sex between men (1614, 31.6%). Migration status and late diagnosis (CD4 < 350cell/ml) were significantly associated with older age ($p <$

0.0001 and $p < 0.0001$, respectively). Published evidence indicated lower likelihood of HIV testing among older adults as compared to younger age groups, with great variation between studies. HIV test uptake was influenced by several patient and provider factors. Conclusions: In the EU/EEA the rate of reported new HIV diagnoses among older adults is steadily increasing. Distinctive socio-demographic factors characterise this population sub-group. Increasing opportunities for provider-initiated HIV testing among older adults is a critical public health intervention.

PO1/03 Monitoring HIV Testing Guidance Implementation in Estonia

K. Rütel¹, L. Lemsalu¹

¹National Institute for Health Development, Infectious Diseases and Drug Monitoring Department, Tallinn, Estonia

Objectives: In 2012, national HIV testing guidance was issued, which recommends HIV-indicator condition and risk-behaviour based testing. In two HIV epidemic regions (Harju county (capital region) and Ida-Viru county in North-Eastern Estonia) HIV testing is recommended to all patients aged 16-49 years. The aim of this analysis was to assess HIV testing in epidemic regions using data from Estonian Health Insurance Fund (EHIF) database.

Methods: EHIF is the core purchaser of health care services in Estonia, covering health care costs for insured people (94% of the total population). After health care services' provision, the provider sends a bill to EHIF, which includes patient information (e.g. age, gender) and services provided (which tests were performed). We derived cumulative data on people aged 15-49 years to assess the proportion of people tested for HIV among those using in- and out-patient primary (general practitioner) and specialist care (excluding palliative care and dentistry) services in 2012-2015.

Results: Tables 1 and 2 show HIV testing rates by gender and year in Harju and Ida-Viru counties. Figures 1-3 show HIV testing rates among men and women accessing primary and specialist in- and out-patient care in the two counties.

Harju county (population size in 2015: 575,00)		2012	2013	2014	2015
Male	Number of people receiving health care services	88,646	86,437	87,193	89,973
	Number of people tested for HIV	3142	3853	3694	3490
	Percentage tested for HIV	3.5	4.5	4.2	3.9
Female	Number of people receiving health care services	122,613	118,041	117,519	118,466
	Number of people tested for HIV	15,008	16,888	16,713	17,488
	Percentage tested for HIV	12.2	14.3	14.2	14.8

[Table 1. HIV testing rates in Harju county]

Ida-Viru county (North-Eastern Estonia) (population size in 2015: 147,000)		2012	2013	2014	2015
Male	Number of people receiving health care services	22,474	22,707	22,303	22,061
	Number of people tested for HIV	1120	1629	1376	1404
	Percentage tested for HIV	5.0	7.2	6.2	6.4
Female	Number of people receiving health care services	26,241	29,206	25,460	24,590
	Number of people tested for HIV	3632	4592	4643	4361
	Percentage tested for HIV	13.8	15.7	18.2	17.7

[Table 2. HIV testing rates in Ida-Viru county]

Figure 1. HIV testing in primary care (out-patient services), according to gender in different counties

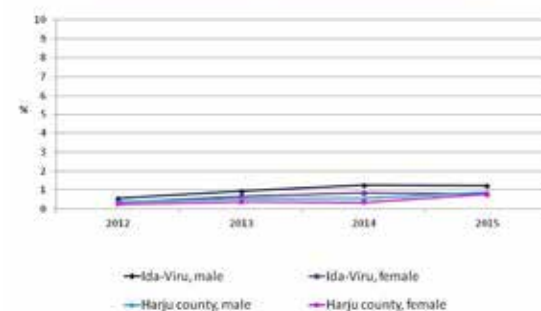


Figure 2. HIV testing in specialist care services, out-patient care, according to gender in different counties

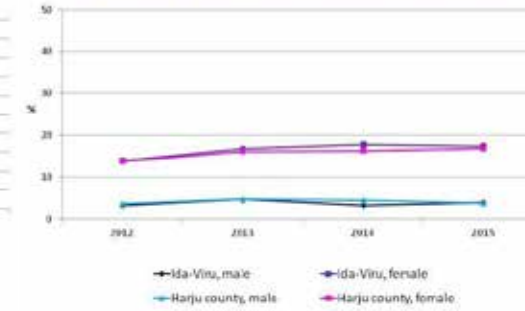
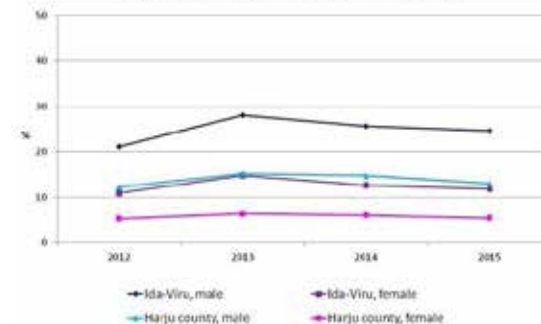


Figure 3. HIV testing in specialist care services, in-patient care, according to gender in different counties



Conclusions: HIV-testing rates in HIV epidemic regions are low and have not increased much in the last four years. Rates are somewhat higher in the county with highest burden of HIV (Ida-Viru county). Testing rates are especially low in primary care. Out-patient specialist care HIV-testing rates are higher among women, most likely because of screening among pregnant women. Despite several limitations (e.g. no data on un-insured people, possible misclassification of diagnoses and tests), EHIF data can be used to monitor HIV testing trends.

PO1/04 Core Indicators for Monitoring and Evaluation of Community based Voluntary Counselling and Testing (CBVCT) for HIV in the COBATEST Network, 1st Half 2015 Data

I. Klavs¹, T. Kustec², L. Fernandez Lopez³, J. Casabona³, C. Agusti Benito³, J.M. Reyes Urena³, D. Rojas Castro⁴, F. Pichon⁵, P. Slaaen Kaye⁶, B. Cigan⁷, M. Kuske⁸, M. Dan⁹, G. Musat⁹, T. Platteau¹⁰, D. Simoes¹¹, L. Fugon⁴, COBATEST Network

¹National Institute of Public Health, Ljubljana, Slovenia, ²NIJZ, Ljubljana, Slovenia, ³CEEISCAT, Barcelona, Spain, ⁴AIDES, PANTIN Cedex, France, ⁵STOP-AIDS, AIDS-Foundation, Copenhagen, Denmark, ⁶STOP AIDS, AIDS-Foundation, Copenhagen, Denmark, ⁷LEGEBITRA, Ljubljana, Slovenia, ⁸AIDS-Hilfe NRW e.V., Berlin, Germany, ⁹Romanian association against AIDS - ARAS, Bucharest, Romania, ¹⁰ITM, Antwerpen, Belgium, ¹¹GAT-Grupo Português de Activistas sobre Tratamentos de VIH/SIDA, Lisbon, Portugal

Background: Community based voluntary counselling and testing (CBVCT) improves access to early HIV diagnosis for key populations at higher risk of HIV infection. The objective was to present the estimates for core indicators for monitoring and evaluation (M&E) of individual CBVCT services/networks for the first half of 2015.

Methods: The COBATEST network of CBVCTs operates within Euro HIV EDAT project (co-funded by Chafea, Grant Agreement N° 2013 11 01). Guidelines for data collection for M&E had been developed (<https://eurohivedat.eu/>). Descriptive analysis of data collected was conducted.

Results: Data were submitted by 33 CBVCTs from 12 countries (Denmark, Czech Republic, Poland, France, Slovenia, Croatia, Portugal, Latvia, Ukraine, Austria, Italy and Spain). Total number of clients tested with a screening test was 47,237 and varied between individual CBVCTs (9-20,815). The proportion of clients with HIV reactive screening test result varied from 0% to 10.2% (mean: 1.9%; median: 1.6%). Among 12 CBVCTs without missing information, the proportion of clients with reactive HIV screening test result with HIV confirmatory test varied from 42% to 100%. Among 4 CBVCTs with complete information on HIV confirmatory testing results, the positivity rate varied between 0.3% and 2.7%. Among 9 CBVCTs that submitted complete information about the proportion of clients with confirmed HIV infections linked to health care, 7 reported 100% linkage and the other two 92% and 95%.

Conclusions: The estimates for core CBVCT M&E indicators for the first half of 2015 vary between CBVCTs. For individual CBVCTs collating such estimates on European level provides opportunity for comparing their own performance to that of others within the COBATEST network. This may contribute to the improvement of such services.

PO1/05 HIV: Are we Testing Appropriately?

J.L. Hulley¹, K.S. Nurse¹

¹Northern Deanery, Newcastle Upon Tyne, United Kingdom

Objectives: An audit by the British HIV Association (BHIVA) in 2006 found that over half of HIV deaths were a direct consequence of late diagnosis. In 2008, BHIVA created National Guidelines for HIV testing, defining clinical indicator conditions in which doctors should offer an HIV test. An audit was conducted at a District General Hospital in December 2014 to assess whether HIV testing is offered in appropriate conditions.

Method: 50 patient notes were analysed on a general medical ward using a proforma; a re-audit was performed in August 2015.

Results: HIV testing in accordance with BHIVA guidelines was poor. 52% of patients required an HIV test; only 15% were offered testing. 30% required an HIV in their PMH; only 7% had been tested. These results are comparable to a previous audit conducted within the region. Following an education session, a further 50 patients were analysed. Despite this intervention, results failed to improve; 20% of patients required an HIV test, yet only 10% of those were offered testing. A survey to explore the reasons for poor testing took place in September 2015 and highlighted a number of issues. 20% of respondents were unaware of the BHIVA guidelines, and 28% were unaware of which conditions should prompt testing. 40% felt there was a stigma amongst medical professionals regarding HIV testing and 36% cited fear of causing upset as a reason for not testing. Over a third claimed the likelihood of HIV was low and cited this as a reason for not testing.

Conclusion: Late diagnosis of HIV has significant implications for patients and society. Despite education and awareness, there is a failure amongst doctors' to test for HIV. More research is required to further understand the resistance to testing amongst health care professionals and to explore new approaches to education and training.

PO1/06 Mind the Gap: Exploring Continuum of Care for HIV in Slovenia

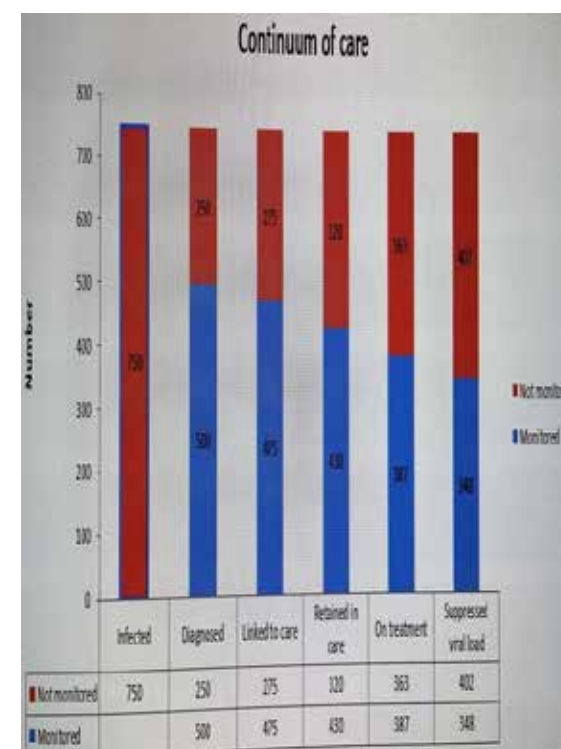
M. Solinc¹

¹Association SKUC, Ljubljana, Slovenia

Objectives: Slovenia is a low-level HIV epidemic country. Less than one individual per 1000 inhabitants is living with HIV. Late presenters are a big concern. The aim was to find out gaps along the process in continuum of care to be able to follow and reach the goal 90-90-90 in near future.

Methods: The research was conducted during 2016 and consisted of data collection from different resources for 2014. Analysis for treatment cascade construction with six columns was made. We used ECDC modelling tool for calculation of the first column - number of infected with HIV.

Results: the analysis has shown that 34% of infected (N=750) is undiagnosed (N=250). This gives the biggest gap, a breakpoint in the continuum of care between first two columns. The main reasons for that are stigma and other barriers to testing which needs further research. All other gaps between columns are much smaller and quite exemplary. Number of diagnosed is 500 and number of linked to care is 475 which gives the 5% drop between second and third column. Number of retained in care is 430 which gives 10% drop. Number of people on treatment is 387, which gives 10% drop. And finally the number of people with suppressed viral load is 348, which gives 10% drop. We lose 54% patients from the beginning to the end of the care, from being infected to the stage having suppressed viral load.



Conclusions: the first treatment cascade for Slovenia was developed with help of the ECDC modelling tool. More attention is needed to minimize the first gap with testing more people and with more testing options. With these efforts we estimate that the goal 90-90-90 could be reached in next five years. With focused and combined prevention tools we have to continue preventing new infections.

PO1/07 Accessibility of HCV Diagnostics and Treatment Services in Eastern Europe and Central Asia (EECA)

L. Maistat¹, N. Kravchenko¹, P. Skala¹

¹ICF Alliance for Public Health, Policy and Advocacy, Kiev, Ukraine

Objectives: Alliance for Public Health in collaboration with ITPCru conducted a survey aimed to identify key hurdles in HCV response and provide recommendations to increase access to diagnostics and treatment addressing key stakeholders (drug registration and prices, national HCV guidelines and treatment program coverage) and civil society organizations in EECA countries.

Methods: The survey conducted by Alliance in 11 countries of EECA region, 17 CSOs surveyed.

Survey instruments: questionnaire covering country-level HCV epidemiology data, access to HCV testing and diagnostics services for KPs, availability and content of HCV testing and treatment guidelines, government and donor-funded HCV program coverage and CSO activities; the tables to be filled in were included for collections of epidemiology data, testing, care and prevention strategies, drug registration and prices.

Results: reported anti-HCV prevalence ranged from 1.5% to 7.5% for the general population, 22.7% to 70%-95% for PWID and 18% to 80% for PLHIV. HCV treatment guidelines are available in nine countries (82%). 10 countries (91% of the sample) have registered one or more 2nd generation DAAs for potential interferon-free treatment. State and donor-funded treatment programs covered less than 1% of estimated need.

Conclusions: access to HCV testing and treatment is very limited in EECA countries. Key barriers: absence or lack of state epidemiologic surveillance, lack of awareness, low testing and treatment demand, exorbitant prices for diagnostics and treatment, late registration of DAAs, low or no access to generics, extremely limited or no access to testing and treatment for key populations (criminalization and prosecution of KPs, discrimination, stigma and self-stigmatization), underfunded national programs, low treatment coverage, obsolete national HCV testing, treatment and care guidelines. In EECA CSOs play one of the key roles in increasing access to HCV testing and treatment. Governments and other stakeholders should undertake appropriate measures to overcome the epidemic as listed in survey.

PO1/08 Review of Specialty Guidelines on HIV Testing Recommendations for HIV Indicator Conditions in Spain

F.J. Manzanares¹, M. Gamarra¹, M.J. Pérez-Elías², J. Del Amo¹, V. Hernando¹, OptTEST Research Group

¹Institute of Health Carlos III, Madrid, Spain, ²Hospital Ramon y Cajal, Madrid, Spain

Background: Implementation of the routine HIV testing in AIDS defining conditions (ADC) and other indicator conditions (IC) can help increase early diagnosis of persons with HIV infection so that these can benefit from antiretroviral treatment. Our aim was to review the Spanish specialty guidelines for ADC and IC regarding HIV testing recommendations in Spain.

Methods: The Spanish specialty guidelines for ADC and IC were identified using Specialty Society, Association, National Agencies or College websites, Google. Each guideline was reviewed by two independent researchers to check if (1) HIV infection was discussed; (2) HIV testing was recommended and that recommendation was according to "Guide Recommendations for early diagnosis of HIV in the health sector", Ministry of Health 2014. The conditions reviewed were those recognized by the HIDES project; 25 ADC's and 48 IC's.

Results: A total 104 guidelines were identified, 21 for ADC, 75 for IC and 8 for both. At least one guideline for 15 (60%) ADC's and 33 (69%) IC's was identified (range 1-15). Tuberculosis was an ADC with more guidelines (8) and sexually transmitted infections had 15 for IC. A 67.3% (70) of the guidelines was found using Specialty Society and Government webpage and a 28.8% (30) using FISTERRA webpage for General Practitioners. A 54% of the reviewed guidelines had been

updated in the last 6 years; only 3 guidelines are from before 2000. HIV infection was discussed in 91/104 (87.5%) and HIV testing was recommended in 38/104 (36.5%) guidelines. Of the 21 ADC specific guidelines, 90.5% (19) of them mentioned HIV infection but only 19.0% (4) recommended HIV testing. Regarding the 75 IC guidelines, 86.7% (65) mentioned HIV infection and 44.0% (33) recommended HIV testing.

Conclusion: Most of the guidelines pertaining ADC and IC in Spain discuss HIV infection but, recommendation on HIV testing is scarce

PO1/09 Prevalence and Risk of Hepatitis E Virus Infection in the HIV Population of Nepal

B.P. Gupta¹

¹Tribhuvan University, Kirtipur, Kathmandu, Nepal

Objectives: Infection with the hepatitis E virus (HEV) can cause acute hepatitis in endemic areas in immune-competent hosts, as well as chronic infection in immune-compromised subjects in non-endemic areas. Most studies assessing HEV infection in HIV-infected populations have been performed in developed countries that are usually affected by HEV genotype 3. The objective of this study is to measure the prevalence and risk of acquiring HEV among HIV-infected individuals in Nepal.

Methods: We prospectively evaluated 459 Human Immunodeficiency Virus (HIV)-positive individuals from Nepal, an endemic country for HEV, for seroprevalence of HEV and assessed risk factors associated with HEV infection. All individuals were on antiretroviral therapy and healthy blood donors were used as controls.

Results: We found a high prevalence of HEV IgG (39.4%) and HEV IgM (15.3%) in HIV-positive subjects when compared to controls: 9.5% and 4.4%, respectively (OR: 6.17, 95% CI 4.42-8.61, p< 0.001 and OR: 3.7, 95% CI 2.35 -5.92, p< 0.001, respectively). Individuals residing in the Kathmandu area showed a significantly higher HEV IgG seroprevalence compared to individuals residing outside of Kathmandu (77.8% vs 20.3%, OR: 30.33, 95% CI 18.02-51.04, p=0.001). Mean CD4 counts, HIV viral load and presence of hepatitis B surface antigen correlated with higher HEV IgM rate, while presence of hepatitis C antibody correlated with higher rate of HEV IgG in serum. Overall, individuals with HEV IgM positivity had higher levels of alanine aminotransferase (ALT) than IgM negative subjects, suggesting active acute infection. However, no specific symptoms for hepatitis were identified.

Conclusions: HIV-positive subjects living in Kathmandu are at higher risk of acquiring HEV infection as compared to the general population and to HIV-positive subjects living outside Kathmandu.

PO1/11 Alternative Routes to HCV DAA Access in Europe

T. Berczky^{1,2}, G.M. Corbelli¹

¹European AIDS Treatment Group, Brussels, Belgium, ²ELTE University of Budapest, Budapest, Hungary

The advent of direct acting agents (DAA) in the treatment of hepatitis C (HCV) infection offers the possibility to stop and reverse the HCV epidemic within foreseeable future. However, the current pricing policies of pharmaceutical manufacturers, the complex non-transparent reimbursement schemes of health care systems in the European Union, and the opaque system of global intellectual property regulations render access to these medicines difficult and expensive.

This study looks at certain alternative routes of access to DAA medicines in Europe from the patients' perspective. A general epidemiological situation analysis is given, followed by the description how health care professionals, patients and their organisations, activists and even entrepreneurs are exploring various legal, illegal and semi-legal options for accessing medicine outside of the official health care systems where medicine is difficult to access for pricing or other reasons. Legal limitations existing across EU Member States and their inherent conflict with the basic hu-

man right to health is discussed. Alternative routes to access are described and illustrated through short case studies. Recommendations are made for health care policy makers and pharmaceutical companies on how access to DAAs can be improved.

Wider and earlier access to DAAs in HCV care in combination with consistent testing and prevention efforts can lead to significant reductions in the number of new infections; and the volume and severity of complications can be effectively prevented. The use of illegal and unclear access routes causes unnecessary stress to the patients and exposes them to pharmacovigilance risks, which should be avoided.

PO1/12 Has Increased Rollout of DAA Therapy Decreased the Burden of Late Presentation and Advanced Liver Disease in Patients Starting HCV Therapy in Germany?

C. Boesecke¹, J. Rockstroh¹, P. Ingiliz², F. Berger³, K.-G. Simon⁴, T. Lutz⁵, K. Schewe⁶, J. Schulze zur Wiesch⁷, D. Hueppe⁸, S. Christensen⁹, S. Mauss³, GECCO study group

¹Bonn University Hospital, Bonn, Germany, ²Center for Infectiology Berlin, Berlin, Germany, ³Center for HIV and Hepatogastroenterology, Düsseldorf, Germany, ⁴Practice for Gastroenterology Leverkusen, Leverkusen, Germany, ⁵Infektiologikum, Frankfurt, Germany, ⁶Infektionsmedizinisches Centrum Hamburg, Hamburg, Germany, ⁷University Medical Center Hamburg-Eppendorf, Hamburg, Germany, ⁸Practice for Gastroenterology Herne, Herne, Germany, ⁹CIM Infectious Diseases, Münster, Germany

Background: To date, it remains unclear if wide-spread DAA usage has already led to a reduction in HCV-positive patients presenting with advanced liver disease. More recently, a consensus definition has been developed which defines advanced liver disease due to chronic viral hepatitis as a treatment-naïve patient with chronic hepatitis B, C or D who shows significant fibrosis (assessed by APRI score >1.5 or transient elastography (FibroScan) >9.5 kPa).

Methods: The GECCO cohort is a multicenter cohort from 9 German sites. All treatment-naïve HCV mono- (n=822) and coinfecting (n=197) patients (n=1019) initiating DAA-based treatment since 2014 were analysed. Advanced liver disease was considered a liver stiffness >9.5 kPa in transient elastography (n=718) or APRI score >1.5 (n=301).

Results: 651/1019 (64%) patients were male, median age 50 years (IQR:41-57). HCV genotype (GT) distribution: GT1 60%, GT2 5%, GT3 30%, GT4 5%. 129/416 (31%) had IL28B C/C GT polymorphism. Median baseline HCV RNA: 1.000.000 Mio IU/mL (288.327-2.933.105). Median baseline ALT: 69 U/l (43-121). Liver cirrhosis was present in 219/1019 (22%). Median baseline CD4 was 585/ul (398-768). 254/1019 (25%) were on opiate substitution therapy (OST). Overall SVR rate was 87.9%.

In 2014 44% (115/264) of all patients presented with advanced liver disease. In the following years that proportion decreased to 25% (147/586) in 2015 and 30% (50/169) in 2016 (p< 0.001).

Conclusions: In line with recommendations from clinical guidelines our real life data confirm that initially DAA therapy was prioritized to HCV patients with advanced liver disease. As a consequence the proportion of patients initiating DAA-based therapy with no or minimal HCV related liver disease has increased in recent years. The use of a consensus definition for advanced liver disease will contribute to both improving the epidemiological understanding of viral hepatitis and other liver diseases as well as testing policies and linkage to care.

PO1/13 Availability of HIV Testing in Health Care, Community-based and Home-based Settings in the EU/EEA Member States

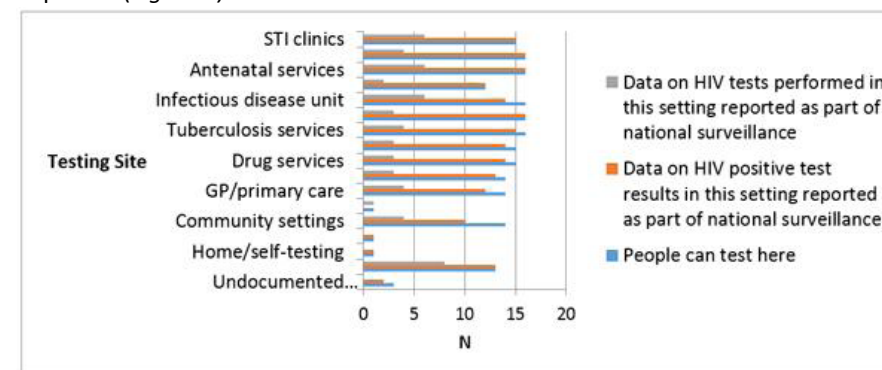
E. Filatova¹, D. Raben², T. Platteau³, A.-I. von Lingen⁴, S. Croxford⁵, L. Tavoschi⁶, J. Casabona⁷, I. Sperle²

¹Individual Consultant, 'HIV in Europe' Initiatives, Barcelona, Spain, ²CHIP, Rigshospitalet, University of Copenhagen, Copenhagen, Denmark, Denmark, ³Institute of Tropical Medicine, Antwerp, Belgium, ⁴European AIDS Treatment Group, Brussels, Belgium, ⁵Public Health England, London, United Kingdom, ⁶European Centre for Disease Prevention and Control, Stockholm, Sweden, ⁷CEE-ISCAT, Spain

Objectives. Recent introduction of HIV rapid tests and self-tests in EU/EAA provides opportunity for expansion of HIV testing for health care (HC), community-based (CB) and home-based (HB) settings. Information on existing national practices of HIV testing in the three settings and use of data by National Surveillance (NS) systems in EU countries was collected.

Methods: A quantitative survey among national surveillance contacts of the European Centre for Disease Prevention and Control in EU/EEA countries was performed in September 2016. The respondents were requested a) to identify HC, CB and HB settings where HIV testing is available and b) to inform if the data on HIV positive test results and size of tested population is reported to NS in their country.

Results: 17 EU/EEA Member States submitted the survey. Of the respondents, 15 reported that HIV testing is available in STI clinics, infectious disease units, emergency departments, antenatal care, drug treatment, TB, and other outpatient and inpatient services; and 14 of the 17 reported that CB testing is available, while HB testing is available only in France and United Kingdom (UK). HIV positive test results from CB settings are reported to NS in 10 countries, while HIV positive test results in HB settings are only reported in UK. Data on number of HIV tests performed in HC are collected in 5 countries (UK, Poland, France, Lithuania and Czech Republic) and tests in CB in 4 countries (Czech Republic France, Greece, Luxemburg); number of tests in HB settings are not reported (Figure 1).



[Figure 1: HIV Testing settings in Europe (N=17)]

Conclusions: While HIV testing have expanded beyond HC setting in the majority of the EU countries, HIV testing data from CB, non-HIV HC and HB settings is not widely reported into NS. Reporting of data collected by NS from these three settings need to be improved.

PO1/14 Variation in ART-coverage and Virological Suppression among HIV Key Populations

K. Laut¹, L. Shepherd², M. Gottfredsson³, D. Sedlacek⁴, B. Knysz⁵, J. Begovac⁶, R. Radoi⁷, N. Chkhar-tishvili⁸, E. Florence⁹, M. Ristola¹⁰, G. Fätkenheuer¹¹, P. Schmid¹², E. Kutzovatova¹³, D. Paduta¹⁴, P. Domingo¹⁵, J. Szlávik¹⁶, J. Lundgren¹, A. Mocroft², O. Kirk¹, on behalf of the EuroSIDA study group ¹CHIP, Department of Infectious Diseases, Finsencentret, Rigshospitalet, Copenhagen University, Copenhagen N, Denmark, ²University College London, Department of infection and population health, London, United Kingdom, ³University of Iceland and Landspítali University Hospital, Dept

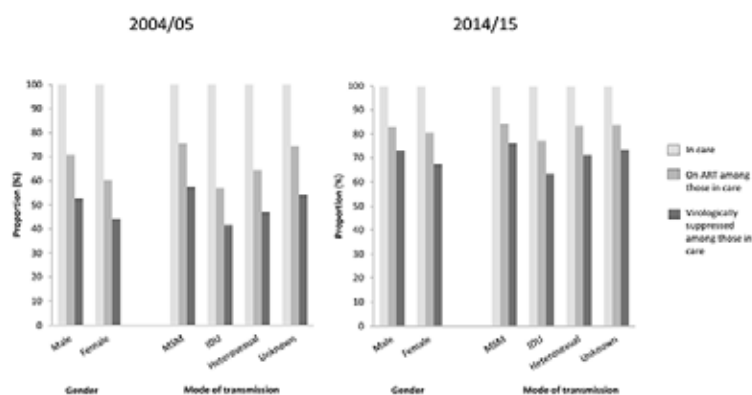
of Infectious Diseases, Reykjavik, Iceland, ⁴Charles University Hospital Plzen, AIDS Centre, Plzen, Czech Republic, ⁵Medical University, Wroclaw, Poland, ⁶University Hospital of Infectious Diseases, Zagreb, Croatia, ⁷Clinical Hospital of Infectious Diseases Dr Victor Babes, Bucharest, Romania, ⁸Infectious Diseases, AIDS & Clinical Immunology Research Center, Tbilisi, Georgia, ⁹Institute of Tropical Medicine, Antwerp, Belgium, ¹⁰Helsinki University Hospital, Helsinki, Finland, ¹¹University Hospital Cologne, Cologne, Germany, ¹²Kantonsspital St Gallen, St Gallen, Switzerland, ¹³Nizhny Novgorod Scientific and Research Institute of Epidemiology and Microbiology named after Academician I.N. Blokhina, Nizhny Novgorod, Russian Federation, ¹⁴Regional AIDS Centre, Svetlogorsk, Belarus, ¹⁵Hospital Clínic Sant Pau, Barcelona, Spain, ¹⁶United Szent István and Szent László Hospital, Budapest, Hungary

Objectives: EuroSIDA has recently reported increasing proportions of ART-coverage and virological suppression across Europe over time, but these improvements may be unevenly distributed across patient groups. We explored differences in ART-coverage and ART-induced virological suppression by gender and by HIV transmission category over time.

Methods: EuroSIDA participants under follow-up in the periods 01/01/2004-31/12/2005 and 01/01/2014-31/12/2015 were included. In cross-sectional analyses we assessed proportions of people on ART (≥ 3 antiretrovirals) and the proportion virologically suppressed (< 500 copies/mL) among those on ART in EuroSIDA. Missing HIV-RNA was considered unsuppressed.

Results: Of 11,975 people under follow-up in EuroSIDA in 2014/15, 27.8% were women. The predominant mode of transmission was MSM (38.2%), followed by heterosexual intercourse (31.8%) and injection drug use (IDU) (22.9%). Overall, levels of ART-coverage and virological suppression among those on ART increased significantly over time, for males as well as females, and across all risk groups ($p < 0.01$ for all categories). In 2014/15, there were small but statistically significant gender-differences in the levels of ART-coverage (men:83.1%, women:80.5%, $p < 0.001$), and ART-induced virological suppression (men:88.0%, women:83.8%, $p < 0.001$). Within transmission categories, levels of ART coverage in 2014/2015 remained lower among IDU (77.2%) compared with MSM (84.2%), heterosexual (83.5%), and unknown (83.7%) ($p < 0.001$). The differences were also pronounced for levels of virological suppression among those on ART: 82.1%, 90.5%, 85.3% and 88.1% respectively ($p < 0.001$).

Conclusions: Small, but persistent, differences in levels of ART-coverage and virological suppression among those on ART were observed between gender- and transmission categories, although improvements were noted across all categories over time. Performance indicators of HIV care remain significantly lower among people infected by IDU. The results underline the need for a special focus and support for this patient group. The influence of regional differences in key populations is currently under investigation.



Proportions on ART and proportion virologically suppressed among those in care in EuroSIDA, by gender and mode of transmission in two different time periods. Number of people included in each risk group by year (2004/05; 2014/15): males (n=7539; 8,649), females (n=2,790; 3,326), MSM (n=3761; 4,571), IDU (n=2,090; 2,744), heterosexual (n=2,556; 3,808), unknown (n=571; 852). MSM = men who have sex with men. IDU = injection drug use.

PO1/15 Improving Cascade of Care in Challenging Conditions: Experience from Eastern Siberia

A. Chuykov¹, A. Boyko², I. Tirikova², A. Zakowicz³, Z. Shabarova³

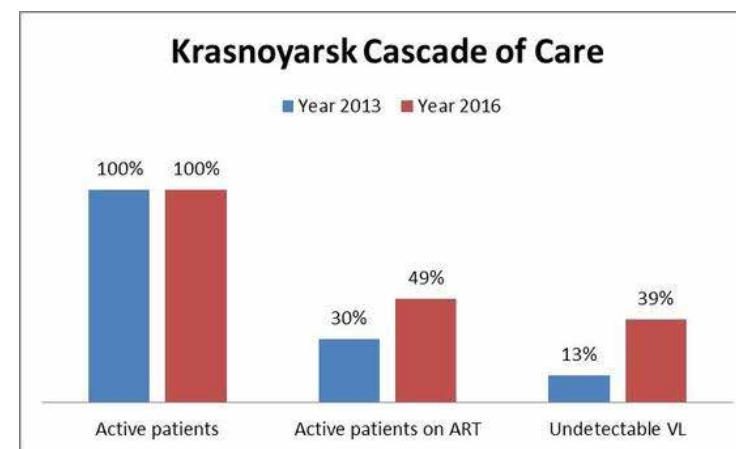
¹AHF Europe, Yekaterinburg, Russian Federation, ²Krasnoyarsk Regional AIDS Center, Krasnoyarsk, Russian Federation, ³AHF Europe, Amsterdam, Netherlands

Objectives: Krasnoyarsk is one of leading cities in Russia in terms of growing of HIV epidemics. Number of new cases enormously grows every year. Currently there are 6196 active patients. Almost 60% of PLWH acquired HIV through intravenous drug use. According to Russian national clinical guidelines antiretroviral therapy should be prescribed to a patient with clinical symptoms of opportunistic diseases or if CD4 account is less than 350 cell/mcl. In such conditions it is crucial to maintain patients in HIV care.

Methods: In 2013 Krasnoyarsk Regional AIDS Center started a collaboration with AHF and a department of medical and social care was organized to bring HIV (including medical and psychosocial) care closer to those clients who cannot attend the clinic or need additional assistance, e.g. patients with low adherence, pregnant women, disabled and severely ill patients. Main activities included outreach visits, providing HIV care (including medical, psychosocial), seeking lost patients, assistance in documents recovery, intensive adherence counselling.

Results: Since 2013, 3785 patients in different periods of time were clients of the department. Specialists of department returned to regular HIV care 2066 patients, who in other circumstances would be lost-to follow-up. Proportion of patients on antiretroviral therapy increased from 30% in 2013 to 49% in 2016. At the same time proportion of patients with suppressed viral load increased from 13% in 2013 until 39% in 2016.

Conclusions: In countries, where majority of PLWH acquired HIV infection through intravenous-drug use, current model of HIV care might be not sufficient to maintain patients in care. Krasnoyarsk experience shows positive results in improvement of retention in care in such conditions resulting in improvement of cascade of care. However revision of current guidelines and improving access to antiretroviral therapy are necessary to maintain shown success.



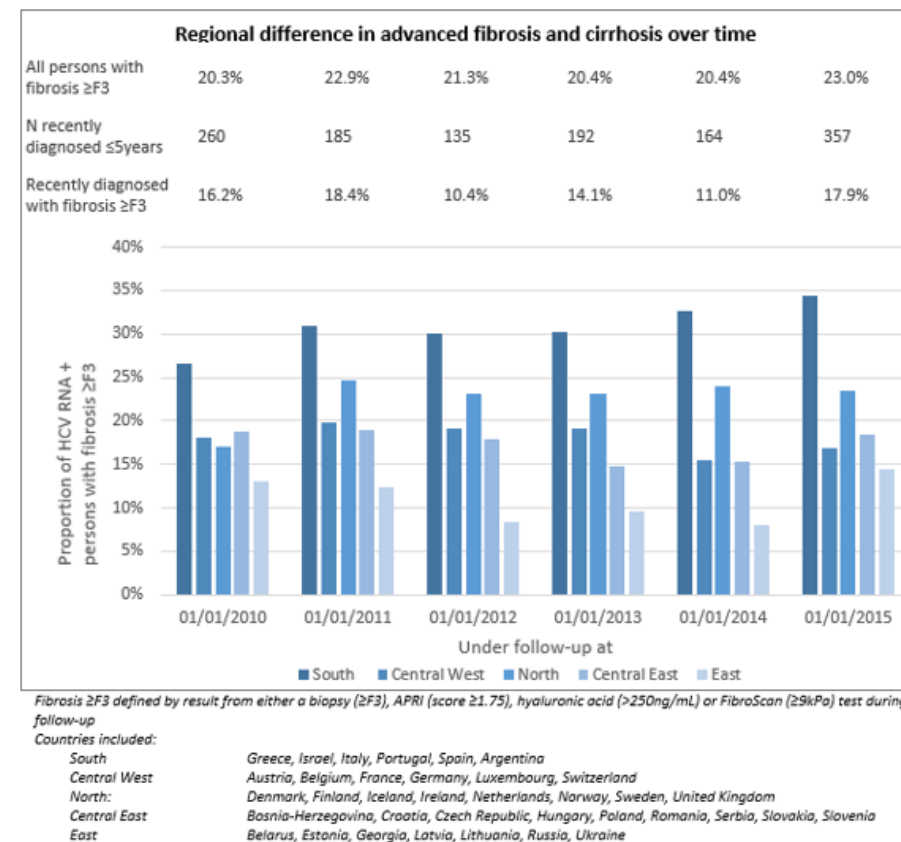
PO1/16 Regional Differences across Europe in Advanced Fibrosis and Cirrhosis among HIV/HCV Co-infected Persons between 2010-2015

S. Amele¹, L. Peters², J.D. Lundgren^{2,3}, J.K. Rockstroh⁴, H. Sambatakou⁵, T. Staub⁶, F. Maltez⁷, C. Leen⁸, C. Pedersen⁹, J.M.G. Artigas¹⁰, S. Moreno¹¹, R. Matulionyte¹², G. Kyselyova¹³, I. Karpov¹⁴, D. Jilich¹⁵, M. Parczewski¹⁶, K. Zilmer¹⁷, H. Elinav¹⁸, K. Lacombe¹⁹, M. Cavassini²⁰, J. Tomazic²¹, A. Mocroft¹, EuroSIDA

¹UCL, Research Department of Infection & Population Health, LONDON, United Kingdom, ²University of Copenhagen, Faculty of Health Science, Copenhagen HIV Programme, Copenhagen, Denmark, ³Rigshospitalet, Department of Infectious Diseases, Copenhagen, Denmark, ⁴Universitäts Klinik Bonn, Bonn, Germany, ⁵Hippokration General Hospital, Athens, Greece, ⁶Centre Hospitalier de Luxembourg, Luxembourg, Luxembourg, ⁷Hospital Curry Cabral, Lisbon, Portugal, ⁸Western General Hospital, Edinburgh, United Kingdom, ⁹Odense Universitetshospital, Odense, Denmark, ¹⁰Hospital Clínic, Barcelona, Spain, ¹¹Hospital Ramon y Cajal, Madrid, Spain, ¹²Vilnius University Hospital, Department of Infectious, Chest diseases, Dermatovenerology and Allergology, Vilnius, Lithuania, ¹³Crimean Republican AIDS centre, Simferopol, Ukraine, ¹⁴Belarus State Medical University, Minsk, Belarus, ¹⁵Faculty Hospital Bulovka, Prague, Czech Republic, ¹⁶Pomeranian Academy of Medicine (PAM), Szczecin, Poland, ¹⁷West-Tallinn Central Hospital, Tallinn, Estonia, ¹⁸Hadassah Hospital, Jerusalem, Israel, ¹⁹Hospital Saint Antoine, Paris, France, ²⁰Centre hospitalier Universitaire Vaudois, Lausanne, Switzerland, ²¹University Clinical Centre Ljubljana, Ljubljana, Slovenia

Objectives: To investigate regional differences in prevalence of \geq F3 fibrosis/liver-related outcomes in persons co-infected with HIV/HCV under follow-up in EuroSIDA on January 1st each year, 2010-2015. **Methods:** The proportion of HCV-RNA+ patients with fibrosis METAVIR \geq F3 or liver events (hepatic decompensation, hepatocellular carcinoma) was compared between regions over time. The odds of \geq F3 fibrosis in 2015 was assessed using logistic regression.

Results: There were 1508, 1443, 1375, 1445, 1407 and 2214 persons with chronic HCV at 1/1/2010-2015 respectively. The proportion with \geq F3 fibrosis was 20.3% in 2010 and 23.0% in 2015 (Figure); with significant differences between regions each year ($p < 0.0001$). The greatest increase over time was in Northern and Southern Europe (17.0% to 23.5%, 26.5% to 34.5%). The proportion with a liver-related event decreased from 4.8% to 2.8%; small numbers precluded regional comparisons. The proportion reporting testing HCV+ recently (< 5 years) was low, and significantly differed between regions ($p < 0.0001$), as did the median duration of HCV infection, 14 and 7 years in Southern/Eastern Europe respectively ($p < 0.0001$); 15% had \geq F3 fibrosis (Figure). After adjustment, non-MSM had higher odds of fibrosis \geq F3 at 1/1/2015 compared to MSM [adjusted odds ratio [aOR] 1.74; 1.19-2.55] as did individuals aged >50 compared to those aged 30-40 [aOR 1.67; 1.16-2.39]. Compared to Southern Europe, all regions had lower odds of fibrosis \geq F3 [aOR 0.34; 0.24-0.47; 0.56; 0.39-0.81; 0.50; 0.36-0.71; and 0.38; 0.26-0.58] in Central-West, North, Central-East and East], as did those with CD4 count $>200/\text{mm}^3$ [aOR 0.42; 0.30-0.58].



Conclusions: 20% of individuals with HIV/HCV had fibrosis \geq F3, with significant differences between regions likely attributable to duration of HCV infection. Recent HCV diagnoses were uncommon, but still with significant fibrosis \geq F3 levels. The prevalence of fibrosis \geq F3 and the relationship between CD4 and fibrosis \geq F3 highlights the need to prioritise HIV and HCV treatment across Europe.

Poster category 2: Testing strategies in key affected populations

PO2/01 Missed Opportunities for Viral Hepatitis Testing in Europe: a 25-Country Analysis

J. V. Lazarus^{1,2}, S.R. Stumo², K.L. Hetherington², J. Tallada³, M. Harris⁴, T. Reic⁵, K.

Safreed-Harmon², on behalf of the Hep-CORE Study Group

¹CHIP, Department of Infectious Diseases, Rigshospitalet, Copenhagen Oe, Denmark, ²ISGlobal Hospital Clínic, University of Barcelona, Barcelona, Spain, ³European AIDS Treatment Group, Brussels, Belgium, ⁴Department of Social and Environmental Health Research, London School of Hygiene and Tropical Medicine, London, United Kingdom; ⁵European Liver Patients Association, Brussels, Belgium

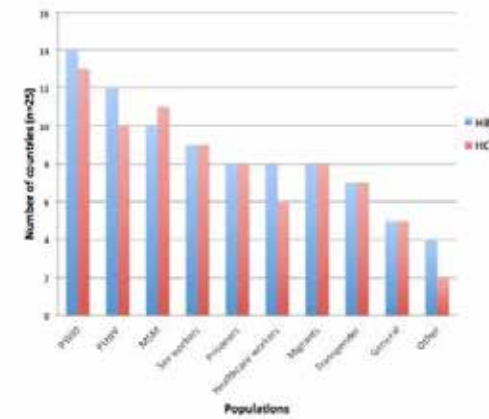
Objectives: The 2016 approval of the WHO Global Health Sector Strategy on Hepatitis, coupled with the advent of better antiviral medications, has underscored the importance of hepatitis B virus (HBV) and hepatitis C virus (HCV) testing. The European Liver Patients Association (ELPA) carried out the Hep-CORE study to collect information regarding numerous aspects of national HBV and HCV policies, including testing-related policies.

Methods: In 2016, we asked patient groups in 27 countries to participate in a cross-sectional survey that asked about their countries' policy responses to HBV and HCV. The 39-item English-language survey, administered online to one patient group or coalition of patient groups per country, included questions about testing/screening sites outside of hospitals, screening of pregnant women, notification of blood donors, risk assessment during routine medical check-ups, and the existence of free and/or anonymous testing services. We present a descriptive analysis of findings from the 25 European countries represented in the study (Table 1).

Results: Patient groups in many study countries reported an absence of HBV/HCV testing sites outside of hospitals for people who inject drugs and other high-risk populations (Figure 1). There was reported to be routine HBV/HCV screening for pregnant women in 88% and 44% of countries, respectively (Table 1). In 23 countries (92%), blood donors were said to be notified if screening indicated infection with HBV/HCV (Table 2). According to survey respondents, 17 countries (68%) include liver enzyme tests in routine medical check-ups, whereas only five (20%) include HBV/HCV risk assessment (Table 3). Less than half of countries were reported to have widespread free and anonymous HBV/HCV testing services targeting high-risk populations (Table 4).

Conclusions: European countries must act to reduce missed opportunities to diagnose HBV and HCV, giving particular attention to testing accessibility for high-risk populations and to risk assessment during routine medical check-ups.

Figure 1. Number of countries reported to have hepatitis B virus (HBV)/hepatitis C virus (HCV) testing/screening sites outside of hospitals for high-risk populations.*



Notes: PWID = people who inject drugs, PLHIV = people living with HIV, MSM = men who have sex with men
* For this survey question, respondents were told that testing/screening sites outside of hospitals should be understood as "sites that are not within either inpatient or outpatient hospital facilities"

Table 1: Pregnant women routinely screened for hepatitis B virus (HBV) and hepatitis C virus (HCV)?

	HBV	HCV
Austria	yes	yes
Belgium	yes	yes
Bosnia & Herzegovina	no	no
Bulgaria	yes	no
Croatia	yes	no
Denmark	yes	no
Finland	yes	no
France	yes	no
Germany	yes	no
Greece	yes	yes
Hungary	yes	no
Italy	yes	yes
Macedonia	yes	yes
Netherlands	yes	no
Poland	no	yes
Portugal	yes	no
Romania	yes	yes
Serbia	yes	no
Slovakia	yes	yes
Slovenia	yes	no
Spain	yes	yes
Sweden	no	no
Turkey	yes	yes
United Kingdom	yes	no
Ukraine	yes	yes
Total (yes)	22	11
% (yes)	88%	44%

Table 4: Proportions of participating countries where respondents reported the existence of free/anonymous hepatitis B virus (HBV)/hepatitis C virus (HCV) testing services targeting high-risk populations (n=25)

	Free HBV testing N (%)	Anonymous HBV testing N (%)	Free HCV testing N (%)	Anonymous HCV testing N (%)
PWID	14 (56%)	10 (40%)	13 (52%)	9 (36%)
MSM	12 (48%)	9 (36%)	11 (44%)	7 (28%)
Transgender people	11 (44%)	7 (28%)	10 (40%)	6 (24%)
Sex workers	10 (40%)	7 (28%)	9 (36%)	5 (20%)
Prisoners	14 (56%)	7 (28%)	13 (52%)	7 (28%)
Migrants	6 (24%)	6 (24%)	6 (24%)	6 (24%)
PLHIV	13 (52%)	10 (40%)	12 (48%)	9 (36%)
Other	1 (4%)	0 (0%)	1 (4%)	0 (0%)

Notes: PWID = people who inject drugs, MSM = men who have sex with men, PLHIV = people living with HIV

Table 2: Responses to survey questions asking if blood donors in the respondent's country are informed and referred to medical care when screening of their blood indicates that they have been infected with hepatitis B virus (HBV) or hepatitis C virus (HCV)

	Informed of HBV/HCV infection (n=25)	Referred to medical care (n=22)
Austria	yes	yes
Belgium	yes	yes
Bosnia & Herzegovina	yes	yes
Bulgaria	no	no
Croatia	yes	yes
Denmark	yes	yes
Finland	yes	yes
France	yes	yes
Germany	yes	yes
Greece	yes	no
Hungary	yes	yes
Italy	yes	no
Macedonia	yes	yes
Netherlands	yes	yes
Poland	yes	no
Portugal	yes	yes
Romania	yes	yes
Serbia	yes	no
Slovakia	yes	yes
Slovenia	yes	yes
Spain	yes	yes
Sweden	yes	yes
Turkey	yes	yes
United Kingdom	yes	yes
Ukraine	no	no
Total (yes)	23	19
% (yes)	92%	86%

Table 3: Responses to survey questions asking if liver enzyme testing and/or risk assessment for the hepatitis B virus (HBV) and hepatitis C virus (HCV) are included in routine medical check-ups in the respondent's country

	Liver enzyme testing included in routine medical check-ups?	Risk assessment for HBV/HCV included in routine medical check-ups?
Austria	yes	yes
Belgium	yes	no
Bosnia & Herzegovina	yes	no
Bulgaria	no	no
Croatia	yes	no
Denmark	yes	yes
Finland	yes	no
France	yes	no
Germany	no	no
Greece	yes	no
Hungary	yes	yes
Italy	yes	yes
Macedonia	yes	no
Netherlands	no	no
Poland	no	no
Portugal	no	no
Romania	yes	no
Serbia	no	no
Slovakia	yes	no
Slovenia	yes	no
Spain	no	no
Sweden	no	no
Turkey	yes	yes
United Kingdom	yes	no
Ukraine	yes	no
Total yes	17	5
% (yes)	68%	20%



PO2/02 Hepatitis B, C and HIV Testing Uptake in the General, Migrant and Roma Populations in Greece: Results from the Health Examination Survey Hprolipsis

G. Touloumi¹, A. Kalpourtzi¹, O. Anagnostou¹, I.S. Petraki², A. Karakosta¹, S. Kaskafetou¹, A. Vantarakis³, P. Voulgari⁴, G. Rachiotis⁵, G. Chlouverakis⁶, G. Trypsianis⁷, I. Alamanos⁸, T. Mimikou⁹, T. Antypas¹⁰, M. Gavana¹¹

¹Medical School, National and Kapodistrian University of Athens, Department of Hygiene, Epidemiology & Medical Statistics, Athens, Greece, ²Medical School, National and Kapodistrian University of Athens, MSc International Medicine - Health Crisis Management, Athens, Greece, ³Medical School, University of Patra, Environmental Microbiology Unit, Department of Public Health, Patra, Greece, ⁴Medical School, University of Ioannina, Rheumatology Clinic, Department of Internal Medicine, Ioannina, Greece, ⁵Medical Faculty, University of Thessaly, Department of Hygiene & Epidemiology, Larissa, Greece, ⁶School of Medicine, University of Crete, Division of Biostatistics, Heraklion, Greece, ⁷Medical Faculty, Democritus University of Thrace, Department of Medical Statistics, Alexandroupolis, Greece, ⁸Institute of Epidemiology, Preventive Medicine and Public Health, Corfu, Greece, ⁹Medecins Du Monde (MDM), Athens, Greece, ¹⁰PRAKSIS NGO, Athens, Greece, ¹¹Medical School, Aristotle University of Thessaloniki, Department of Primary Care, General Practice and Health Services Research, Athens, Greece

Background: Delayed hepatitis B (HBV), C (HCV) and HIV diagnosis has important negative clinical and public health implications; yet most infected are unaware of their disease. We aimed to estimate prevalence of HBV, HCV and HIV testing uptake and identify significant predictors in the general, migrant and Roma adult (≥18 years) populations in Greece.

Methods: Data derived from the Greek Health Examination Survey Hprolipsis, funded by European Social Fund and National funds. Samples selection: multistage stratified random sampling (general population); non-probability multistage quota sampling (migrants/Roma). Trained interviewers and physicians made home (general population) or community (Roma/migrants) visits; standardized questionnaires were administered; blood samples were collected. Knowledge score calculated based on 17 questions and risk behavior level on 9 questions. General population prevalence rates were age/sex standardized and corrected for study design.

Results: 5951, 505 and 536 individuals from the general population, migrants and Roma respectively, were enrolled. Descriptive characteristics and prevalence of HBV, HCV and HIV testing uptake are presented in Table. 2.8%, 4.6% and 6.2% of the general, migrant and Roma populations respectively had reported high risk behavior. Corresponding percentages with high knowledge score were 27.6%, 15.6% and 5.0% and for being tested for at least one infection 33.6%, 39% and 20%. Younger age, higher educational level, higher income, being married, higher knowledge and high risk behavior were independent predictors for testing in the general population; educational level and income were not significant predictors among Roma; among migrants educational and knowledge level and high risk behavior were significant predictors.

Conclusions: HBV, HCV and HIV testing rates were limited for studied populations, particularly among Roma. The very low comprehensive knowledge contributed substantially to these low rates. There is urgent need for large scale awareness interventions, especially among most vulnerable populations, to increase population engagement in prevention practices and testing.

	General population (N=5951)	Migrants (N=505)	Roma (N=536)
Male [N(%)]	2527 (48.4%)	278 (55.1)	247(46.1)
Age [Mean (SD)] years	47.9 (34,64)	36.4 (29.9,46.3)	35.0(25,48)
Educational level			
No/up to primary school [N(%)]	2110 (29.3)	129 (26.1)	473 (90.8)
Secondary school [N(%)]	2569(46.8)	301 (60.9)	48 (9.2)
Higher education [N(%)]	1221 (23.9)	64 (13.0)	-
HBV testing uptake [N(%)]	1657(30.7)	123(24.4)	102 (19.1)
HCV testing uptake [N(%)]	1180(22.5)	82(16.2)	30 (5.6)
HIV testing uptake [N(%)]	1006 (19.6)	129(25.5)	23 (4.3)

[Descriptive characteristics and prevalence of hepa]

PO2/03 Targeting HIV-stigma within the MSM Community in Italy: Results from a National Survey

R. Lelleri¹, G.M. Corbelli^{2,3}, S. Mattioli⁴, M. Degli Esposti⁴

¹Independent researcher, Bologna, Italy, ²Plus onlus, Rome, Italy, ³European AIDS Treatment Group, Bruxelles, Belgium, ⁴Plus onlus, Bologna, Italy

Background: Studies show impact of HIV-stigma on HIV interventions. Data are needed to show if visibility of HIV-positive people can be an effective tool against HIV-stigma: can role-models help breaking the silence about HIV in affected communities?

Methods: We run a project to evaluate Italian situation regarding visibility of HIV-positive MSM within their community. We analysed scientific literature about similar previous researches. A survey was developed based on these results. The survey was disseminated in April-May 2016 and responses collected using Qualtrics and elaborated using SPSS.

Results: 2,463 responses were included in final analysis: 27.7% were HIV-positive, 62.9% had last HIV test with negative result, 9.4% never tested for HIV (13.0% of all non-HIV-positive). 64.2% say all or almost all of their friends know they are gay. Only 8.7% of HIV-positive say all or almost all of their friends know they are HIV-positive (15.1% among gay friends). 94.6% of those visibly HIV-positive say relationship remained the same or improved after telling them, compared to 36.5% of those not-visible thinking relationship would remain the same or improve. 51.0% of all responders do not have anyone they can talk about HIV with. As per sexual relations, 86.6% of HIV-negative responders say they never had sex with someone known to be HIV-positive in the last year compared to 57.7% among HIV-positive responders. Experience of discrimination is not so common (45% of HIV-positive never experienced discrimination from HIV-negative, 80% of total responders from HIV-positive) but expectations are higher (55.5% HIV-positive, 66.5% HIV-negative).

Conclusions: HIV is present in MSM community, but it is not a visible topic. Visibility of MSM living with HIV within the community is poor but fear of discrimination is higher than actual experience. Strategies aiming at supporting visibility of MSM living with HIV may improve HIV-related interventions outcomes within the community.

PO2/04 Increasing the Impact of Harm Reduction Programs in Response to HIV and HCV Epidemics through Integrated Approach of Testing with Linkage to Care and Treatment

N. Kravchenko¹, L. Maistat², P. Skala²

¹ICF Alliance for Public Health, Policy and advocacy, Kiev, Ukraine, ²ICF Alliance for Public Health, Policy and Advocacy, Kiev, Ukraine

Background: Alliance for Public Health implements awareness/advocacy campaign to generate demand for HIV/HCV testing and treatment among general/key populations (KPs), including HCV component in harm reduction (HR) programs and national health care strategy, scaling up access to diagnostics and treatment with a focus on HIV/HCV co-infection. In 2015, Alliance conducted a study to identify behavioral and other issues of PWIDs and their partners.

Description: Alliance implements large-scale HR program (covering >250,000 people). In 2015, Alliance changed testing approach to assisted testing, increasing the number of people tested for HIV by 147%. During public advocacy events, Alliance conducted over 18,000 screening tests for HCV/HIV among general population raising awareness and advocating for expanding access to diagnostics and treatment.

Methods: 1) awareness-raising/advocacy campaigns: large-scale testing programs for general and KPs; public events with HIV and/or HCV testing and counselling of general population, involving key stakeholders, wide media coverage at national and regional levels; 2) providing testing as an

entry point to getting cured: testing for HIV (>202,800 people), HCV and HBV (>38,000) among KPs and case management (increasing the number of people receiving treatment two-fold); pushing stakeholders to reduce prices for diagnostics and DAAs; pushing national authorities to allocate funds, prioritizing KPs for treatment; launch of demonstration HR/treatment programs with innovative testing, diagnostic and treatment approaches.

Results: high testing demand and coverage, raised awareness and better knowledge about hepatitis transmission, diagnostics, treatment and re-infection prevention among KPs and NGOs. In Ukraine 88% of PWIDs know where to test for HIV, 72% were tested at least once. Alliance HR/advocacy campaign serves as a best practice model in EECA.

Conclusions: Integration of testing in advocacy/awareness campaign, HR programs with integrated HIV/Hepatitis/STI services proved to be efficient in raising demand and scaling up access to diagnostics and treatment.

PO2/06 Get Test Project: an Innovative Approach in Attraction of Customers to the Continuum of Services for MSM

A. Chernyshev¹, A. Radetsky², R. Marchenko³

¹Public organization 'GAY-ALLIANCE', Head of external communication and advocacy, Kyiv, Ukraine,

²Public organization 'GAY-ALLIANCE', Outreach Department, Kyiv, Ukraine, ³Public organization 'GAY-ALLIANCE', Program Director, Head of Get Test Project, Kyiv, Ukraine

Objectives: GET TEST is an innovative project for Ukraine that started in January 2016, the main objectives of which is output to hard to reach and still not reached by programs MSM, involving them to rapid diagnosis for HIV/STIs/hepatitis; detection the new cases of HIV/STIs/HBV/HCV; linkage to care and support; assistance in obtaining of ARVs.

Methods: The involvement of MSM for testing takes place in two cities (Kyiv/Odessa) in two ways: 1) clients register on testing at the www.gettest.com.ua, about which learn through advertising, which we place on dating sites for MSM, mobile smartphone applications and social networks; 2) a social worker chooses web resources where singly comes to online communication with MSM, invites them to pass the rapid diagnosis and provides consultation "peer to peer". The social worker acts as a case manager and accompanies the client during take on the dispensary registration and motivates to use of ARVs.

Results: For the period from January to September 2016, rapid testing for HIV in general passed 1160 MSM, starting with 18, of which 57 persons received a positive HIV test result (5%). At the dispensary registration in the AIDS centers became 45 MSM (79% of detected), ARV therapy began to receive 8 persons (18% of those who were took on register). Also, for the period July-August 2016, were involved 58 partners of MSM who a previously have been tested in the GET TEST, of which the HIV-positive status was detected in 5 MSM (8.6%).

Conclusions: GET TEST showed itself as an effective model to attract hard to reach MSM category among Internet users. As a result of a successful advertising campaign has been involved a sufficient number of MSM who never received services in our NGO. For even more coverage of services should increase the amount of advertising on Internet resources, improve the procedure providing a full cascade of services for each client and increasing the commitment to ARVs.

PO2/07 Missing Opportunities: Systematic Review on Testing for HCV in Prison Settings

G. Madeddu¹, H. Vroiling², A. Oordt², M. Vonk Noordegraaf-Schouten², R. Monarca³, S. Babudieri¹, L. Tavoschi⁴

¹University of Sassari, Department of Clinical and Experimental Medicine, Unit of Infectious Diseases, Sassari, Italy, ²Pallas Health Research and Consultancy, Rotterdam, Netherlands, ³Health Without Barriers - European Federation for Prison Health, Viterbo, Italy, ⁴European Centre for Disease Prevention and Control, Stockholm, Sweden

Introduction: Hepatitis C virus (HCV) infection is an important public health problem. With the availability of highly effective treatment and elimination target within reach, early diagnosis is crucial. Across the European Union/European Economic Area (EU/EEA) HCV prevalence in prison populations is much higher than in the community. Therefore prison settings offer a key opportunity for active case finding. The objective was to systematically review data on HCV testing in EU/EEA correctional facilities.

Methods: A systematic review of the literature (Pubmed, Embase, Cochrane Library) published from 1990 onwards was performed, and complemented with searches for conference abstracts and unpublished research reports.

Results: Five primary studies and one systematic review (including two relevant studies) were found that reported on uptake of and positivity rate after HCV testing in France, Italy, United Kingdom. Testing was mostly offered as opt-in at entry to the correctional facility. The uptake and positivity rate ranges were 9%-92% and 5%-30%, respectively. In one study opt-in testing was offered during imprisonment with uptake and positivity rate of 65% and 23%. The figures were 63% and 37%, respectively, in one study not specifying testing offer and timing. Three conference abstracts and one unpublished research report from Italy on opt-in testing found uptake and positivity rates within the above ranges.

Two comparative studies reported on the introduction of dried blood spot testing, with contradictory results. Another study found an increased uptake following peer-to-peer education (no p-values given). Out of three cost-effectiveness studies, two concluded opt-in HCV testing at entry to be more cost-effective than symptom-based screening.

Conclusions: The evidence on HCV testing in correctional facilities is limited. Positivity rates among tested inmates are variable and generally high. Active case finding for HCV chronic infections in prison settings could contribute to prevent onward transmission and lower the undiagnosed fraction in the EU/EEA.

PO2/08 The Role of PWID Community in Increasing Importance of Testing for Harm Reduction Services in Ukraine

A. Basenko¹

¹INPUD, APH, Kyiv, Ukraine

Generally, HCV transmission among people who inject drugs in low and middle-income countries is certainly important from a public health perspective. The risk of newly acquiring HCV infection is high among people who inject drugs who are often denied access to harm reduction services, and less experienced injecting drug users who may not yet have learned about safe injecting techniques and harm reduction practices. PWIDs are prioritized group for treatment according to EASL2015. The estimate number of PWIDs in Ukraine - 345 000. Ukraine were able to develop the biggest harm reduction program in EECA region (212 000 PWID). It was impossible without the involvement of peer community out-reach workers providing the sincere and trustee relationship with the PWID clients on the street. The same success we found out when the testing approach was changed from rapid testing providing by medical staff to the rapid testing assisted by community outreach worker or case-manager. The results improved 8 times more. Finally Ukraine (APH) provided the first DAA free of charge treatment for more than 1500 PWID. But to provide access

to treatment and to raise awareness among PWID mean to attract and scale up testing. Conclusion is that the peer workers from the same community could be the key increaser of testing and advocate for changes concerning their health.

PO2/09 Strategies to Expand Access to Treatment for Hepatitis C and Promote Adherence to HIV Treatment: the Role of Peer Work in a Harm Reduction Centre in Lisbon, Portugal

R. Pinto¹, J. Santa Maria¹, M. Ferreira²

¹GAT, IN-Mouraria, Lisboa, Portugal, ²GAT, IN-Mouraria, Lisbon, Portugal

Objectives: HCV and HIV infection disproportionately affect people who inject drugs (PWID). Our experience as peer workers suggests that obstacles on access and adherence to care and treatment for PWID persist, although there is few national data on this subject. This case study describes the importance of integrating testing services, social work and peer work to overcome barriers to access health services and increase adherence to treatment for HIV and hepatitis C among PWID.

Methods: Three individual cases based in the project records are presented to describe our work as peer workers in a harm reduction centre in Lisbon and document the strategies in place to promote access to prevention, testing and treatment for hepatitis C and HIV among PWID.

Results: The centre offers diversified and tailored peer driven interventions related to hepatitis C and HIV: needle exchange, rapid testing, targeted information, case management, accompaniment to hospital, and advocacy for treatments.

Conclusion: Barriers to access HCV treatment and mainting adherence to HIV tretament among PWID are a reality. Therefore strategies to complement the ones already available in the national health system should be discussed. Peer work in harm reduction settings can have a key role in all phases of the process - prevention, testing and access to care - due to our proximity and knowledge of PWID difficulties and needs. It is also very important the ability of peer workers to share information, increase awareness and promote political participation of PWID.

PO2/10 The “Red Umbrella Athens” Initiative: Presentation of the First Sex Workers’ Drop-In Centre in Athens, Greece.

A. Poulivos¹, S. Chanos², A. Christopoulos¹, M. Xanthaki², N. Kakantousis², N. Fitsialos², A. Kouroupou², L. Polychronopoulou², G. Papadopetrakis², A. Papatrechas², C. Sagredos²

¹National and Kapodestrian University of Athens, Psychology Dpt., Athens, Greece, ²Positive Voice, Greek Association of PLWHA, Athens, Greece

“Red Umbrella Athens” is a prevention and empowerment center for sex workers, located in the center of Athens. It was established in the framework of the streetwork activities of the Greek Association of People Living With HIV/AIDS “Positive Voice” and the Greek Liver Patients Association “Prometheus”. The objectives of the project are:

1. Empowerment and psychological first aid provision to the sex workers; 2. Raising awareness and prevention regarding Sexually Transmitted Infections (STIs); 3. Harm reduction concerning substance use; 4. Advocating for sex workers’ rights; 5. Research.

Data is collected through health diaries (WHO, 2013) and questionnaires regarding sex workers (Abel, Fitzgerald & Brunton, 2007, AIDS information & support centre, 2002).

The center operates once a week for 4 hours, employing 4 employees and 19 volunteers. The way in which the structures and the services are organized, are presented along with the first findings emerging from the analysis of the questionnaires concerning socio-demographics and sex working practices. Preliminary findings reveal that the majority of the beneficiaries feel insecure when working while a great number of them also report having undergone violence (both verbal and physical) as well as being addicted to substances. “Red Umbrella Athens” aims to constitute a best practice for linkage to further health care services for the target group, for which the

existing information is too little while, sex workers’ access to mental health services is far too limited. Finally, the efficiency of the day center as a community based initiative is attempted to be evaluated, focusing on the extent to which it can provide information about this target group, as well as on the level of adaptation of its counselling services to the needs of the target group and finally on the amount of successful referrals and networking initiatives with the state authorities and institutions.

Poster category 3: Challenges in Health care settings: testing and linkage to care

PO3/01 Delays in Starting HIV Treatment as Prevention: ART Initiation in the UK

A. Brown¹, Z. Yin¹, C. Chau¹, P. Kirwan¹, N. Gill¹, V. Delpech¹

¹Public Health England, London, United Kingdom

In the UK, treatment coverage is 96%. Antiretroviral therapy (ART) at diagnosis is now considered best practice for both clinical and public health purposes. We present national trends in ART initiation by CD4 count and explore median time from diagnosis to starting treatment. The UK has a comprehensive open cohort of people with HIV from the point of diagnosis onwards, with annual updates from every clinic nationally. We analysed data on all persons starting ART (40,965) between 2010-2015 where ART start dates and CD4 counts were available (63%). Those pregnant at ART initiation were excluded. The number starting ART remained around 5,500 annually between 2010-2014, but rose to 6,000 in 2015. Among all persons starting treatment, the proportion with CD4>350 rose from 34% in 2010 to 66% in 2015 (14% to 41% with CD4>500, respectively). In 2015, 75% of MSM starting ART had CD4>350 (CD4>500:50%) compared to 51% among heterosexuals (CD4>500:27%). Among those starting ART with CD4>350, the median time from diagnosis to ART was 80 days (IQR:19-288); reducing from 130 (IQR:32-373) in 2010 to 54 (IQR:15-261) in 2015. The equivalent figure was 59 days (IQR:13-236) among those starting at CD4>500; 77 in 2010 (IQR:15-289) to 49 in 2015 (IQR:13-203). Between 2010-2015, the median time from diagnosis to starting ART among those with CD4 >350 was 108 (IQR:24-341) among MSM and 71 (IQR:18-266) among heterosexuals. The median was 42 days (IQR:21-134) among those starting ART with CD4< 350. Trends in CD4 at ART initiation reflect the evolution of national treatment guidelines. The higher proportion of MSM starting ART with CD4>350 reflects elevated late HIV diagnoses among heterosexuals. On average, those starting ART with CD4>350 take twice as long to start treatment compared to those with CD4< 350, with MSM particularly delayed. Delays in treatment initiation may reduce effectiveness of treatment as prevention.

PO3/02 Promotion of HIV Testing in Primary Care in East London through a Research Programme is Effective. An MRC Phase IV Implementation Study

W. Leber¹, J. Anderson², J. Figueroa³, F. Naomi⁴, C. Estcourt⁵, M. Shahmanesh⁴, J. Hutchinson⁵, L. Beresford⁴, C. Nightingale¹, F. El-Shogri¹, K. Boomla¹, S. Creighton², D. Millett², H. McMullen¹, C. Griffiths¹, HIV-CLAHRC

¹Queen Mary University of London, London, United Kingdom, ²Homerton University Hospital NHS Foundation Trust, London, United Kingdom, ³NHS City and Hackney, London, United Kingdom, ⁴University College London, London, United Kingdom, ⁵Barts Health NHS Trust, London, United Kingdom

Objectives: We aimed to determine the effectiveness of a pragmatic cluster randomized controlled trial (RHIVA2) in promoting point of care HIV testing at general practice new-patient registration when implemented as part of a routine clinical service outside a trial setting.

Methods: RHIVA2 was conducted in the London borough of Hackney (2010-12) and comprised initial education and training sessions, nomination of a practice lead nurse, external quality

assurance, practice support and a rapid referral pathway of any newly diagnosed patient to the local HIV clinic. Following the trial, all Hackney practices were offered additional intervention training, a service evaluation of antiretroviral prescribing and an audit of missed opportunities of HIV diagnosis (2012-15). Monthly computerised HIV testing data were remotely extracted by the clinical effectiveness group and analysed using interrupted time series analysis.

Results: Following RHIVA2 (20 intervention and 20 control practices), an additional 12 practices (11 former trial control and one former non-participating) received the intervention, and training was reinforced in 6 former trial intervention practices; a total of 31 practices (13 former trial intervention, 15 former trial control, and 3 former non-participating) completed the service evaluation. Combined point of care and serology HIV testing rates in intervention practices (trial or post-trial) increased immediately following the intervention by 85% (IRR = 1.8505, 95% CI 1.7218 to 1.9887), and a similar effect (IRR 1.8241, 95% CI 1.7238 to 1.9303) was observed when including comparator practices that didn't receive the intervention at any point. The change in the effect of the intervention during the three years following the intervention decreased significantly (IRR = 0.9935, 95% CI 0.9905 to 0.9966).

Conclusions: Promotion of HIV testing in primary care through research significantly increased testing activity but regular refresher training and support may be required to make it sustainable long-term.

PO3/03 Is the Emergency Department (ED) a Suitable Environment to Offer Hepatitis Screening?

L. Hunter¹, G. Nebbia², S. Douthwaite²

¹Guy's & St Thomas NHS Foundation Trust, Emergency Department, London, United Kingdom,

²Guy's & St Thomas NHS Foundation Trust, Infectious Diseases, London, United Kingdom

Objectives: Initial infection with Hepatitis B and Hepatitis C may be accompanied by only a mild illness or be completely asymptomatic. Chronic infection may result in liver fibrosis, cirrhosis, decompensated liver disease or hepatocellular carcinoma if left untreated. We aimed to determine if the Emergency Department screening offers a suitable environment for Hepatitis screening in areas of high local prevalence.

Methods: Patients aged 16 years and over were offered HepBsAg and HepC IgGabs testing if they required venepuncture during their ED attendance over a 6 week period from February 15th - March 27th 2016. Test were ordered utilising a pre-configured order set that included pre-selected HepBsAg and HepC IgGabs. Patients were informed of the intention to test all attendances and were able to opt out if desired. Positive test results were followed up at a rapid access one stop clinic.

Results :3073 (49%) and 2982 (47%) accepted testing for Hepatitis B and Hepatitis C respectively. 1.1% (n=35) tested positive for Hepatitis B surface antigen, indicating acute or chronic infection. 2.2% (n=66) =tested positive for Hep C antibodies, indicating current or previous HCV infection. Reflex antigen testing was positive in 1.2% (n=35) indicating current HCV infection. Two newly diagnosed patients were eligible to be commenced on direct acting anti-virals. One patient had evidence of cirrhosis on initial fibroscan.

Conclusions: Consider the ED for opportunistic blood borne virus testing in areas of high prevalence. We achieved testing rates of approximately 50% by use of a pre-configured blood order set and opt out policy. This resulted in identification of new diagnoses and lost to follow-up patients. Use of a one-stop clinic provides rapid entry to care for positive patients and reduces burden of follow-up for ED.

PO3/04 Routine HIV Testing in an Inner City Emergency Department- Avoiding Missed Opportunities for Testing

L. Hunter¹, N. LARBalestier², J. Paparello²

¹Guy's & St Thomas NHS Foundation Trust, Emergency, London, United Kingdom, ²Guy's & St Thomas NHS Foundation Trust, Sexual Health, London, United Kingdom

Objectives: In July 2015 our Emergency Department commenced a pilot project to assess the feasibility of routine HIV testing within a busy inner city ED.

Method: Patients over the age of 16 had an HIV test performed if they required venepuncture during their emergency department attendance. Tests were ordered using a pre-configured blood order set that included a pre-selected HIV test. Patients were informed of the intention to test all attendances and were able to opt out if desired. Positive or equivocal tests were followed up by our HIV team.

Results: During the first year, 66.4% of our ED attendances (27,632/41,615) had been tested for HIV. Our prevalence was 0.9% (n=244) and 0.3% were not aware of their HIV diagnosis (n=76). Thirteen patients were not currently engaged in services, although aware of their diagnosis. Median age was 36. Patients who tested positive were predominantly male (81%) and Caucasian (61%) (BME 36%, Asian 3%). 51% of patients who tested positive self-identified as heterosexual and 49% MSM (men who have sex with men). 87% of patients who tested positive had previously attended our Emergency Department, on one or more occasions, prior to the implementation of routine testing. Approximately 1/5th of new diagnosis were seroconverting at the time of testing.

Conclusion: The Emergency Department provides a suitable environment for opportunistic HIV testing in areas of high prevalence. We have maintained testing rates of > 65% of our ED attendance and achieved early diagnosis and treatment engagement in patients who were unaware of their HIV status. We have also identified patients who had been lost to follow up and have now re-engaged in care. Use of pre-configured blood order sets, regular staff education and feedback on results improves testing rates.

PO3/05 HIV Testing Improvement in Primary Care through Opt-TEST's Indicator Condition Guided Testing: The Tool-1 and Plan-Do-Study-Act Experience in Catalonia, 2016

R. Lugo^{1,2}, A. Sullivan³, C. Rae³, D. Lacasta^{4,5}, J. Casabona^{1,2}, D. Raben⁶, Opt-TEST Study group

¹Centre for Epidemiological Studies on HIV/STI in Catalonia (CEEISCAT), Agència de Salut Pública de Catalunya (ASPC), Departament de Salut de Catalunya, Badalona, Spain, ²CIBER Epidemiología y Salud Pública (CIBERESP), Badalona, Spain, ³Chelsea and Westminster Hospital NHS Foundation Trust, London, United Kingdom, ⁴Institut Català de la Salut (ICS), CAP Gran Sol, Badalona, Spain, ⁵Unitat de Recerca Atenció Primària Jordi Gol, Badalona, Spain, ⁶CHIP, Rigshospitalet, University of Copenhagen, Copenhagen, Denmark

Background: In 2013, the EU 2nd Health Programme co-funded the Optimising testing and linkage to care for HIV across Europe Project (Opt-TEST) to provide tools and assessment methods to reduce HIV infection late diagnosis and timely linkage to care/treatment throughout Europe. Out of the seven work packages (WP), WP5 will develop and implement four tools for HIV indicator conditions (IC) guided HIV testing at healthcare settings. Catalonia participates in WP5 with three primary care sites. The aim of this communication is to describe the Catalan experience using Tool-1 through the Plan-Do-Study-Act (PDSA) methodology.

Methods: Tool-1 is a strategic presentation tool developed by WP5 group and used at the Catalan site of Badalona-Gran Sol during June 2016. This centre is participating in the IC guided HIV testing of severe/recurrent pneumonia and hepatitis B/C since July 2015. Intervention was planned using PDSA methodology: 1) Plan a talk using Tool-1 adapted to the Catalan region, 2) Do or perform adapted Tool-1 talk during a staff's continuing education session, 3) Study what we learned and needed to improve or modify, 4) Actions planned: measurement of impact in testing; follow-up

meeting if testing is not achieved to 90% by October 2016; modify Tool-1 to include information on barrier and; to find alternative to data collection to increase quality of testing. Lessons learned: Standardized Tool-1 with capability to be adapted to country/public's profile. Tool-1 increased family physicians' (FP) willingness to increase quality of IC guided HIV testing to reduce late diagnosis and linkage to care. Tool-1 had added value to FP by receiving talk during continuing education session. Further actions: sites' training in 6 months; FP personal incentive and; calculation of quality indicator. The PDSA methodology helped to plan and carry out a small intervention which can be easily modified to improve quality of HIV testing.

PO3/06 One Year after their Commercialization in France, who Use HIV Self-tests?

K. Champenois¹, V. Coquelin², D. Rahib-Kersaudy³, V. Supervie⁴, A. Velter³, D. Rojas-Castro², J. Ghosn⁴, N. Lydié³, T. Greacen¹

¹EPS Maison Blanche, Laboratoire de recherche, Paris, France, ²AIDES (MIRE-Mission Innovation Recherche Expérimentation), Pantin, France, ³Santé Publique France, Saint-Denis, France, ⁴Inserm U1136, Paris, France

Objectives: In France, HIV self-tests are available over the counter in pharmacies since September 2015. One year after, we aim to describe self-testing knowledge, attitudes and use, particularly in men who have sex with men (MSM) and migrants from sub-Saharan Africa.

Methods: An online survey will be launched in the middle of October 2016 for 8 weeks. Questions address the knowledge, interest and use of HIV self-tests, habits of HIV testing, sexual behaviour and other HIV risks, health care use and sociodemographic data.

People aged ≥ 18 living in France and French overseas departments (where HIV prevalence and stigmatisation are high) will be informed about the study by banners on community and meeting websites and community NGOs Facebook pages, and flyers in community venues. The information campaign will target mainly MSM and migrants from Sub-Saharan Africa but no one are excluded. **Results:** We will describe the population groups who participated in the survey and how the recruitment process worked for every group. Participants will be described in terms of socio-demographic profile, at-risk behaviour, and testing habits according to their interest in and their use of HIV self-tests. Barriers and difficulties met to access and use HIV self-tests and access to confirmation test and care will be addressed and bring knowledge on needs of information and support on HIV self-testing.

PO3/07 Population-based Modeling as the First Step in Optimization of HIV Interventions in Ukraine

S. Soloviov^{1,2}, A. Symchuk¹, O. Bulakh²

¹Shupyk National Medical academy of postgraduate education, Virology Department, Central research laboratory, Kyiv, Ukraine, ²The National Technical University of Ukraine 'Igor Sikorsky Kyiv Polytechnic Institute', Department of Applied Mathematics, Kyiv, Ukraine

Background. Recent advances in HIV prevention and treatment have decreased number of new HIV infections in regions of the world that have traditionally been the source of highest concern, such as countries in sub-Saharan Africa. Despite these encouraging results, in other parts of the world the HIV epidemic continues to grow. In particular, the HIV epidemics in Eastern Europe and Central Asia have been rapidly growing over the past decade. Among the countries in the region, Ukraine's situation has raised serious concerns, since it has one of the fastest growing HIV epidemics in the world, which makes it an important case study for HIV interventions.

Methods. It has been used open source statistical data (time series) of HIV/AIDS monthly incidence and prevalence in Ukraine. As the modeling approach we chose flow-chart compartment model, widely used in formal description of infectious disease epidemic process. The proposed model had three compartments, describing three subgroups of Ukrainian population: susceptible persons, HIV-infected persons, patients with AIDS.

Results. With the use of statistical data and mathematical approaches, we have determined the transition rates between different population subgroups. We have found that these rates are time-dependent. For example, the rate of HIV acquisition in Ukrainian population has been decreasing during decade of years from $3E-10$ to $5E-11$, and transition rate from HIV to AIDS has oscillatory nature varying from 0.002 to 0.006.

Conclusions. In the field of HIV prevention, analytic models become necessary for analysis of recent epidemiological data and simulation of impact of different intervention strategies on HIV prevalence among Ukrainian population. The health officials can use the developed model within identification of key socio-economic parameters associated with these strategies.

PO3/08 Psychiatric Symptomatology among Patients with HIV and Hepatitis C - the Experience of a Romanian Clinic

A.-M. Schweitzer¹, M. Bogdan¹, L.S. Vlahopol¹, I. Radulescu¹, S.I. Stanciu¹, C. Pop¹, D. Craciun¹

¹Fundatia Baylor Marea Neagra, Infectious Diseases, Constanta, Romania

Objectives: To identify the prevalence of depressive symptomatology among long term survivors living with HIV (PLWHA) and among the patients recently diagnosed with hepatitis C virus (PCHC) enrolled for medical and psycho-social services at the foundation during the year 2015; and to assess the need for mental health care services (psychological support, psychiatric care) among those at risk for depression.

Methods: The Hamilton Depression Inventory (HDI), Romanian version was used in order to screen 349 adult PLWHA (average age 26.7 years old) and 128 PCHC (average age 54.5 years old) that were in the care of the clinic psycho-social team at the time of the assessment. Patients were dichotomized on whether they had high HDI scores and needed referral for a psychiatric evaluation or low scores and were not referred.

Results: PLWHA have been in care for an average of 9.8 years, while PCHC were generally new cases (average since enrollment: 2 months). 29% (37) PCHC and 4% PLWHA (13) were referred for further psychiatric evaluation. As a result of the assessment, 12 PCHC were diagnosed with adjustment disorder with depressed mood, or with depressive episode, and received treatment, while 25 PCHC were recommended psychological support; all PLWHA referred were diagnosed with various psychiatric disorders and 10 received medication.

Conclusion: HDI is a convenient screening tool. Mental health screening should be included in standard care procedures. Newly enrolled PCHC might be at higher risk due to both challenges associated with adjustment to a new diagnosis and the linkages reported in the literature about the effect of hepatitis C virus on the brain. PLWHA who had been diagnosed a decade ago have significantly lower rates of depressive symptomatology. A liaison psychiatrist is a valuable addition to the multidisciplinary team that cares for patients with HIV and chronic hepatitis.

PO3/10 Incidence and Risk Factors for Medical Care Interruption in HIV-Infected Patients

A. Fournier¹, K. Champenois², E. Papot², E. Bouvet², R. Landman², R. Verdon¹, Y. Yazdanpanah²

¹CHU de Caen, Maladies infectieuses, Caen, France, ²Hôpital Bichat; AP-HP, Paris, France

Objectives: The aim of our study was to identify HIV-infected patients at risk of medical care interruption (MCI) in a high income country.

Methods: We estimated the incidence rate of MCI in 4,796 individuals followed in a HIV clinical cohort in Paris between January 2010 and May 2016. We enrolled patients over 18 years old who were seen at the clinic at least twice between January 2010 and October 2014. Patients were considered in MCI if they did not attend care in or outside the clinic for at least 18 months, regardless of whether or not they came back after interruption. For each case of MCI, we actively searched for any medical contact or blood test, by reaching their infectious diseases specialist or primary care physician. We investigated sociodemographic, clinical and immuno-virological characteristics at HIV diagnosis and during follow-up through a Cox model analysis.

Results: The incidence rate of MCI was estimated to be 2.5 per 100 persons-years (95% confidence interval [CI] 2.3-2.7). The independent risk factors for MCI were a time period between diagnosis of HIV and linkage to care >6 months (hazard ratio [HR] =1.05; 95%CI=1.02-1.08 vs. ≤6 months), not having a primary care physician (HR=2.23; 95%CI=1.88-2.65) and a viral load ≤1,000 when the patient has initiated care (HR=1.13; 95%CI=0.89-1.43 vs. >100,000 copies/mL). People born in Sub-Saharan Africa interrupted less likely medical care (HR=0.74; 95%CI=0.61-0.90 vs. when born in France). During follow-up, the risk of MCI increased when CD4 count was ≤350 (HR=2.86 95%CI=2.01-4.07 vs. >500 cells/mm³) and when the patient was not under antiretroviral therapy (HR=2.81 95%CI=2.15-3.68).

	Multivariate OR (95%CI)	p
Country of birth: France	1	-
Sub-Saharan Africa	0.74 (0.61-0.90)	0.003
Other countries	0.81 (0.65-1.03)	0.081
Having a primary care physician	1	-
Not having a primary care physician	2.23 (1.88-2.65)	<0.001
Time before first visit ^a ≤ 6 months	1	-
Time before first visit ^a > 6 months	1.05 (1.02-1.08)	0.002

^aTime period before first visit: time between HIV diagnosis and first medical visit.

All results were adjusted for first viral load, CD4-T cells count and number of ART line during follow-up.

[Factors associated with medical care interruption]

Conclusions: The incidence rate of MCI in this Northern country clinical cohort shows the need to implement interventions to improve the patient retention into care. Our findings may help clinicians to identify patients who are at risk of interrupting care.

PO3/11 Collaboration with Primary Healthcare Network Significantly Improves Retention in Care and Viral Load Suppression in Ukraine

A. Chuykov¹, Y. Lopatina², L. Sikailo³, S. Zhmynda³, V. Zadorozhnia³, A. Zakowicz⁴, Z. Shabarova⁴

¹AHF Europe, Yekaterinburg, Russian Federation, ²AHF Ukraine, Kiev, Ukraine, ³Voznesensk Regional Hospital, Voznesensk, Ukraine, ⁴AHF Europe, Amsterdam, Netherlands

Objectives: Decentralization of HIV care is known to be one of key conditions for successful patient management. HIV care clinical site in Voznesensk was created in 2010 and since that time it has been providing HIV care and support to more than 500 patients living in the area of 537 square miles in the center of Mykolaiv Region of Ukraine, where half of population live in rural conditions. In 2013 only 60% of patients were on antiretroviral therapy and 25% of patients were virally suppressed

Methods: In order to improve performance, in 2014 AHF suggested a plan to address poor patient retention. Collaboration with primary healthcare network was initiated. Site staff conducted a series of educational trainings on medical, psychosocial aspects and counseling for primary healthcare providers (doctors, nurses, feldshers), working in Voznesensk area. Since November 2014 patients are reminded about appointment through SMS. If client misses an appointment, social worker calls him several times within a week after the appointment is missed. If it is not successful, social worker contacts patient's GP or feldsher who visits this patient in his/her house and provides an adherence counselling.

Results: In 2014 before this model of collaboration was in place only 5% of clients who missed their appointment returned to HIV care within a month, while in 2016 this number increased to 40%. Number of patients on antiretroviral therapy increased from 64 to 90%, at the same time viral load suppression increased from 55% in 2014 to 74% in 2016.

Conclusions: Collaboration with primary healthcare network shows positive results in terms of HIV retention in HIV care in Ukraine. We recommend this model as an effective tool to improve patient outcomes in rural areas of Eastern Europe.

Poster category 4: Community testing

PO4/01 Euro HIV EDAT Project (WP9/2): HIV-testing Using Oral Fluid Samples and Online Communication of Test Results (Swab2know)

T. Platteau¹, C. Agusti², E. Florence¹, M. Lixandru³, L. Ooms¹, T. Vermoesen¹, L. Fernández-López², K. Franssen¹, V. González², J. Casabona², EURO HIV EDAT Project study group

¹Institute of Tropical Medicine, Clinical Sciences, Antwerp, Belgium, ²Centre d'Estudis Epidemiològics sobre les ITS i SIDA de Catalunya (CEEISCAT), Barcelona, Spain, ³Romanian association against AIDS - ARAS, Bucarest, Romania

Background: Targeted HIV-testing in Europe is crucial in reducing the numbers of infections in Europe. In our swab2know-project, we aim to assess the feasibility of outreach and online HIV testing on oral fluid samples as well as web based delivery of test results via www.swab2know.eu. **Methods:** Within the Euro HIV EDAT consortium, 3 partners implemented the strategy in 2016: Institute of Tropical Medicine (Belgium), CEEISCAT (Spain), and ARAS (Romania). Targeted populations are men who have sex with men (MSM), migrant populations (MIG), female sex workers (FSW) and male sex workers (M\$M). Samples are collected via outreach and online sampling. HIV-test is executed in the laboratory. Test results are communicated through a secured website. Each reactive sample needs confirmation using state-of-the-art procedures on a blood sample.

Results: Between 01/01/2016 and 30/09/2016, 829 HIV-tests are executed. Most samples were collected in Belgium (558; 67.3%), followed by Spain (189; 22.8%) and Romania (82; 9.9%). Half of the samples were collected during outreach activities (411; 49.6%), and half via online orders

(418; 50.4%). The vast majority of samples were collected among MSM (645; 77.8%). The other samples were collected among migrants (116; 14.0%), MSM (39; 4.7%) and FSW (29; 3.5%). Most samples were tested HIV-negative (792; 95.5%). Eighteen samples (2.2%) were tested reactive, and 19 (2.3%) weakly reactive. Positivity rate was highest in Romania (7.3% reactive test results), followed by Belgium (1.8%) and Spain (1.1%).

Conclusions: Despite a high workload for outreach activities and a considerable number of false reactive results, final positivity rate in all participating centers remains above 0.1%, the consensus for cost-effectiveness of HIV-testing programs. The project helped us to reach target populations, in numbers of tests executed and in newly diagnosed HIV infections. In 2017, 3 additional sites (Aids Fondet Denmark, Legebitra Slovenia, GAT Portugal) will implement the project's strategy.

PO4/02 Community Based Screening Network: Combined HIV, Hepatitis and syphilis testing and monitoring - A Community Led Partnership in Portugal

D. Simões¹, R. Freitas¹, M. Rocha¹, P. Meireles², A. Aguiar², H. Barros²

¹GAT-Grupo de Ativistas em Tratamentos, Lisbon, Portugal, ²EPIUnit - Institute of Public Health, University of Porto, Porto, Portugal

Objective: Since May 2015, 18 NGOs are providing combined screening of HIV, HBV, HCV and syphilis, in a joint effort led by GAT, in a partnership with the Institute of Public Health of the University of Porto (ISPUP) and São João Hospital Center (CHSJ): the Community-based Screening Network.

Methods: All NGOs involved received training, test kits and consumables and provide free, rapid and anonymous testing for HIV, viral hepatitis and syphilis. Everyone with a reactive result is offered linkage to care and escort to the first appointment. Users aged 18 or older were invited to be followed-up prospectively and to complete a structured questionnaire in a computer assisted personal interview. Data collected is anonymous and each participant has a unique identifier to allow for data linkage during follow-up, enabling a multi-site cohort of people from key groups. This allows generation of national and group specific data. In addition, all NGOs have a quality assurance protocol and laboratorial supervision from CHSJ.

Results: From January to September 2016, a total of 22 016 tests were performed, with 515 reactive results of which over three quarters accepted to be linked to care. Of the tests performed, 7 779 were for HIV (121 reactive), 4 433 for HCV (114 reactive), 3 373 for HBV (86 reactive) and 6 431 for syphilis (194 reactive). Less than 20% of people had a reactive result for more than one infection.

Conclusions: The community-based screening network is a pioneer project in Portugal that allowed us so far to successfully reach the subgroups of the population for whom little was known, to identify a substantial number of infections and successfully link to care over three quarters of them. Results show the added value of both a combined testing strategy, and the meaningful involvement of the different stakeholders.

PO4/03 Monitoring and Evaluation of AHF "Test and Treat" Programme in Lithuania

L. Stoniene¹, S. Kulsis¹, Z. Shabarova²

¹Association of HIV affected women and their families "Demetra", Vilnius, Lithuania, ²AHF Europe, Amsterdam, Netherlands

Background: Association "Demetra" in Lithuania are implementing AIDS Healthcare foundation (AHF) project "Test and Treat". The aim is to increase access to rapid, anonymous and free HIV testing and to link to medical care those with positive HIV test result. In the project are involved 28 national project partners.

Method: Activities were monitored using evaluation forms for HIV testing monitoring (age, gender, testing reason, lifetime testing and last test result) and positive HIV test result (in addition date of positive test result approval, last CD4 count and transmission mode) monitoring. All partners submitted fulfilled forms for analysis monthly.

Results: During 2011-2015 period 57,429 rapid tests was performed. 719 test results (1.25%) were positive, of them 623(87%) was integrated to health care system.

Analysis showed that portion of those who first lifetime test were positive increased 1.8 times from 19% in 2012 till 34% in 2015, those who reported the last test result negative portion increased from 6% in 2012 up to 16-19% in 2014-15. This demonstrates that high-risk behaviour after negative HIV test result wasn't changed. Data showed that among positive test results 63 cases in 2013, 77 in 2014 and 79 in 2015 were new or unregistered to national HIV/AIDS epidemiological register. Laboratory testing proved low CD4 test result median 422, 259, and 287 respectively.

Conclusions: During the project implementation period about 60000 learnt about HIV status.

More than 85% of those with positive HIV test results were integrated to health care system.

Monitoring and evaluation revealed that every year percentage of first HIV testers and late presenters increased. Also was found that up to half of new HIV cases in the country during last 3y were diagnosed with rapid HIV testing approach. Monthly data analysis allows timely and in flexible manner to improve programme performance.

PO4/04 Euro HIV EDAT Project (WP8): A Qualitative Study to Better Understand the Barriers and Facilitators to Early HIV Testing and Linkage to Care among Migrant Populations in Europe (Belgium, Denmark, France, Spain, Portugal)

S. Benayoun¹, D. Rojas Castro^{1,2,3}, C. Nöstlinger⁴, L. Manirankunda⁴, F. Pichon⁵, P. Slaaen Kaye⁵, M. Meulbroek⁶, D. Simoes⁷, C. Agustí^{8,9}, L. Fernández-López^{8,9}, J. Casabona^{8,9}, EURO HIV EDAT Project study group

¹AIDES, Pantin, France, ²Université Lyon 2, GREPS EA4163, Lyon, France, ³Inserm, UMR912 (SESS-TIM), Marseille, France, ⁴Institute of Tropical Medicine, Antwerp, Belgium, ⁵AIDS Fondet, Copenhagen, Denmark, ⁶BCN Checkpoint Hispanosida, Barcelona, Spain, ⁷GAT - Grupo Português de Ativistas sobre Tratamentos de VIH/SIDA, Lisbon, Portugal, ⁸Centre d'Estudis Epidemiològics sobre les ITS i SIDA de Catalunya (CEEISCAT), ICO/Agència de Salut Pública de Catalunya, Barcelona, Spain, ⁹CIBER Epidemiologia y Salud Publica (CIBERESP), Barcelona, Spain

Objectives: The number of new HIV diagnosis continues to rise in many European countries, especially among migrant populations. Current data show that access to HIV testing services is particularly difficult for migrant populations. To better understand the barriers and facilitators to HIV testing and linkage to care among migrants in classical healthcare system and Community-Based Voluntary Counselling and Testing (CBVCT) centres, a qualitative study has been conducted in 5 European countries.

Methods: This qualitative study was based on 5 focus groups conducted with experts in the participating countries and 48 semi-structured interviews conducted among first generation HIV-/HIV+ migrants from endemic region (Sub-Saharan Africa and Latin America).

Results: For most of the participants, the HIV testing offer is available in their country of residence

but not always accessible for migrants. A large number of social, financial, cultural, psychosocial and linguistic barriers are identified. The lack of information about where to get tested (especially in CBVCT centres) and the administrative barriers constitute major obstacles to HIV testing for migrants.

Participants stress the importance to diversify the HIV testing offer, although CBVCT centres are often described as more confidential and non-discriminatory. For undocumented migrants, CBVCT centres appear to be a significant facilitator to reduce administrative barriers and facilitate access to treatment.

Regarding linkage to care, we find that good cooperation between classical healthcare system and CBVCT centres decreases the rate of patients lost to follow-up. Several participants are in favour of the implementation of dedicated places offering comprehensive sexual health services (HIV and STIs care, PrEP delivery).

Conclusion: The results of the qualitative study give some insights to improve early HIV diagnosis and linkage to care for migrants populations. A questionnaire is distributed among migrants in the participating countries in order to shed some light on the data obtained during the qualitative study.

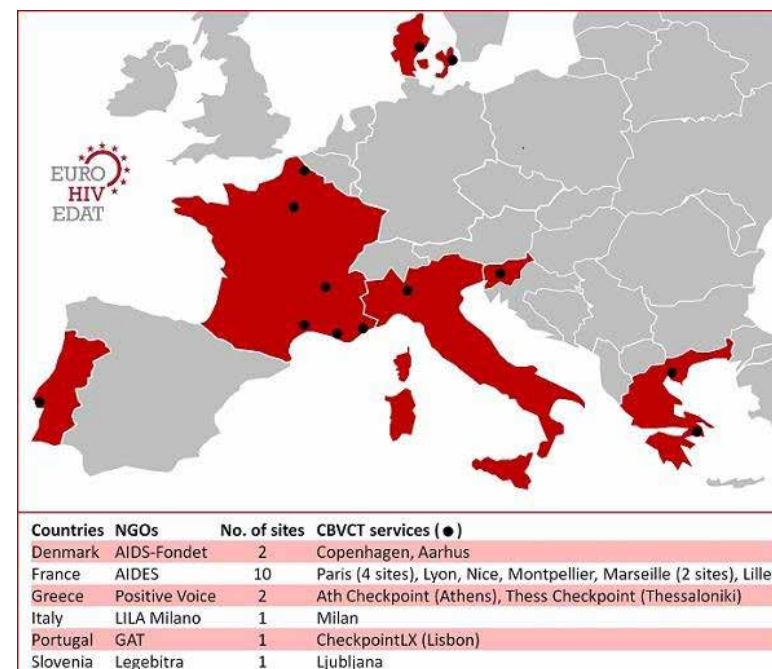
PO4/05 COBA-Cohort: Preliminary Results of a Pan-European Cohort of HIV Negative MSM in Community-based Voluntary Counselling and Testing Services

N. Lorente^{1,2}, R. Fuertes³, P. Meireles⁴, R. Lucas^{4,5}, F. Pichon⁶, P. Slaaen Kaye⁶, B. Cigan⁷, M. Lobnik⁷, S. Chanos⁸, N. Dedes⁸, S. Morel⁹, D. Rojas Castro^{9,10,11}, C. Agusti^{11,2,12}, L. Fernández-López^{1,2,12}, J. Casabona^{1,2,12}, Euro HIV EDAT Study group

¹Centre Estudis Epidemiològics sobre les Infeccions de Transmissió Sexual i Sida de Catalunya (CEE-ISCAT), Departament de Salut, Generalitat de Catalunya,, Badalona, Spain, ²Institut Investigació Germans Trias i Pujol (IGTP), Badalona, Spain, ³GAT-Grupo de Ativistas em Tratamentos, Lisbon, Portugal, ⁴EPIUnit—Institute of Public Health, University of Porto, Porto, Portugal, ⁵Department of Clinical Epidemiology, Predictive Medicine and Public Health, University of Porto Medical School, Porto, Portugal, ⁶AIDS-Fondet, Copenhagen, Denmark, ⁷Drustvo informacijski center Legebitra, Ljubljana, Slovenia, ⁸Ath Checkpoint, Athens, Greece, ⁹AIDES (MIRE-Mission Innovation Recherche Expérimentation), Pantin, France, ¹⁰Groupe de Recherche en Psychologie Sociale (GRePS) EA4163. Université de Lyon 2, Bron, France, ¹¹INSERM, UMR912 (SESSTIM), Marseille, France, ¹²CIBER Epidemiología y Salud Pública (CIBERESP), Madrid, Spain

Background: Longitudinal data on HIV-testing and behaviour of HIV-negative MSM are scarce in Europe. The pan-European COmmunity-BAsed Cohort (COBA-Cohort), implemented in the framework of the Euro HIV EDAT project, aims to overcome this gap by collecting common data among HIV-negative MSM attending community-based voluntary counselling and testing (CBVCT) services in 6 countries, and possibly more (project still open to new partners).

Methods: All MSM older than 18 attending one of the 17 participating CBVCT services (figure 1) and who had a negative HIV test result are invited to participate in COBA-Cohort. The first site started enrolling in January 2015, the last one in October 2016. Recruitment is due to last at least 12 months at each study site. Follow-up frequency is not pre-determined: it depends on the CBVCT service testing recommendations and the participant's willingness. The biggest challenge was to reach a consensus regarding a common questionnaire and to adapt existing ones. Sociodemographic data are collected at baseline; baseline and follow-up questionnaires both gather data on attitudes and perceptions, discrimination, HIV/STI testing history, sexual behaviour, condom use, and pre-/post-exposure prophylaxis.



[Fig.1. CBVCT services participating in COBA-Cohort]

Results: From commencement to 06/30/2016, 3071 HIV-negative MSM were enrolled in COBA-Cohort (table 1) and 667 (21.7%) had at least 1 follow-up visit (range [1-6]). Among these latter, the mean time between visit is 7.1 months (STD: 4.01). Median age of the sample is 29 (IQR=[24-38]), 59.8% had university education. Overall, 15.8% reported having never been tested for HIV while 28.6% reported more than 5 previous tests. Among those ever tested, the median delay between current and last test was 8.8 months (IQR=[5.2-17.1]).

NGOs	Start dates	Participants enrolled	At least one follow-up visit	No. of follow-up visits	Age (years)	Never tested for HIV	Delay since last HIV test (months)
	mm/dd/yyyy	n(%)	n(%)	median[IQR]	median[IQR]	n(%)	median[IQR]
Gat/CheckpointLX	01/02/2015	1521	339(22.3)	1[1-2]	28[23-36]	308(20.3)	10.6[5.6-19.9]
AIDS-Fondet	04/13/2015	833	232(27.9)	1[1-2]	33[26-42]	85(10.2)	9.0[5.4-17.2]
Legebitra	02/09/2015	319	77(24.1)	1[1-2]	28[24-37]	66(20.7)	10.1[6.5-17.9]
AIDES	01/05/2016	207	12(5.8)	1[1-1]	31[24-39]	13(6.3)	6.2[3.6-10.5]
Positive Voice/Ath Checkpoint	02/15/2016	191	7(3.7)	1[1-1]	27[20-35]	14(7.3)	5.2[4.5-8.8]
Total	01/02/2015	3071	667(21,7)	1[1-2]	29[24-38]	486(15.8)	8.8[5.2-17.1]

Conclusion: The prospective design of COBA-Cohort and the common data collected in a large number of MSM is a unique opportunity to track possible changes regarding HIV incidence, testing patterns and sexual behaviour across Europe

PO4/06 HepC Testing in the Community, for the Community, by the Community

L. Wylie¹

¹Hepatitis Scotland, Glasgow, United Kingdom

In Scotland most HCV testing is restricted to specialist or traditional treatment settings, be that GP surgeries, sexual health clinics, addiction services, admission to prisons. A current programme is also assessing the dried blood spot (DBS) test in community pharmacy settings. While these settings are relevant for a particular group who may have been affected by Hepatitis C, the central tenet of this pilot study is that most testing is carried out by professionals or workers/volunteers closely linked to opioid based services, or based on risk factors related to opioid use. In Scotland 15-20 per cent of current injecting use also includes novel psychoactive substances (NPS), cocaine and other stimulants. There is also a significant proportion of former PWUD who do not have any interest in accessing opioid based treatment services nor are willing to disclose the risk factor of past injecting drug use to their GP. This study will investigate home-based and/or peer supported testing, using DBS, that will enable those currently or previously at risk to carry out a test in a safe and comfortable environment, while at the same time maintaining personal control over the process. The study will provide self-administered DBS kits through a web-based ordering system, at needle exchange (NSP) points and through encouraging persons diagnosed with HCV to distribute home-testing kits to members of former injecting networks they may still know. A publicity campaign will accompany the pilot. Easy to use online and paper based materials to ensure the test is administered correctly are being adapted. The proposed freepost method of easily returning the sample, while ascertaining sufficient contact or follow-up details for disclosing results, is currently successfully used for HIV testing. The programme is being tested for acceptability amongst the target population.

PO4/07 CD4 Point-of-care Testing as Intervention Improving Linkage to Care - Lessons Learned from Poland

M. Ankiersztejn-Bartczak¹, J.D. Kowalska²

¹Foundation for Social Education, Warsaw, Poland, ²Hospital for Infectious Diseases, HIV Out-Patient Clinic, Medical University of Warsaw, Department for Adult's Infectious Diseases, Warsaw, Poland

Background: Point-of-care CD4 T-cells testing has been proposed as method to shorten the time from HIV diagnosis to antiretroviral therapy (cART) initiation thus improve clinical outcomes. Here we investigate its impact on linkage to care in community-based voluntary counselling and testing (CBVCT) in central Poland.

Methods: All clients who presented at two CBVCT in Warsaw and had positive ELISA test has been offered a CD4 count testing simultaneously with WB test, however as an extra blood sample.

According to CBVCT standards all tests were anonymous. The CD4 test results has been given at the same time as WB result. Additional counselling was provided to explain the meaning of CD4 count result. Data collected in 2010-2013 in CBVCTs were linked with HIV clinics records using WB test number as unique identifiers. Individuals were followed from the day of CBVCTs visit until first clinical visit or 4/06/2014. Persons registered in HIV clinics were considered linked to care.

Results: In total 123 clients were tested HIV-positive in CBVCT in 2012-2013. Of these 30 had CD4 count tested. 42 (65.8%) clients were linked to HIV care. Linkage rate did not differ between CD4 testing groups (66.7% of tested vs 65.6% of not tested for CD4; p=0.91). There was no significance difference in time to linkage, p=0.52. In total 81 (65,8%) clients started cART. 19 (28,8) in CD4 group and 47 (71,2) in others (p=0,07). There was significant difference in time to starting cART, p=0.005. Table1.

Characteristic	All N=123	CD4 tested at CBVCT N=30	CD4 not tested in CBVCT N=93	P value
Age in years <i>Median (IQR)</i>	30.0 (26.2-35.2)	30.2 (25.4-36.3)	30.0 (26.4-34.2)	0.84
MSM <i>N (%)</i>	98 (79.7)	24 (80.0)	74 (79.6)	0.96
Higher education <i>N (%)</i>	94 (76.4)	26 (86.7)	68 (73.1)	0.27
HIV-positive partner <i>N (%)</i>	25 (20.3)	5 (16.7)	20 (21.5)	0.57
Never tested for HIV before <i>N (%)</i>	38 (30.9)	14 (46.7)	24 (25.8)	0.041
Time to first visit at HIV care in months <i>Median (IQR)</i>	0 (0-14)	0 (0-8)	1 (0-15)	0.52
Time to starting ARV in months (for those who started) <i>Median (IQR)</i>	3 (1-14)	1 (0-2.5)	6 (1-16)	0.005
First CD4 at HIV clinic <i>Median (IQR)</i>	389 (284-509)	363 (163-496)	391 (310-509)	0.17
First HIV RNA at HIV clinic <i>Median (IQR)</i>	25344 (5324-117082)	23023 (11656-92293)	25344 (4238-117082)	0.66

Conclusions: In Poland, a resource rich country, CD4 point of care testing had no effect on linkage to care, but positive impact on time to starting cART. This may reflect increased patients awareness regarding treatment benefit received from additional consultation with CBVCT counsellors. But people who had never HIV test before decided for CD4 test more often.

PO4/08 Euro HIV EDAT (WP4T1): Development of a Self-evaluation Tool in Order to Improve the Impact of the "A Guide to do it Better in our Community Based Voluntary Counselling and Testing (CBVCTs) Centers"

E. Ricard¹, V. Laporte¹, L. Rios¹, S. Morel², D. Rojas Castro^{2,3,4}, C. Agustí Benito^{5,6}, L. Fernandez Lopez^{5,6}, J. Casabona^{5,6}, B. Cigan⁷, M. Wurm⁸, F. Pichon⁹, G. Musat¹⁰, M. Meulbroek¹¹, R. Fuertes¹², EURO HIV EDAT Project study group

¹AIDES, Pantin, France, ²AIDES (MIRE-Mission Innovation Recherche Expérimentation), Pantin, France, ³Université Lyon 2, GREPS EA4163, Lyon, France, ⁴INSERM, UMR912 (SESSTIM), Marseille, France, ⁵Centre d'Estudis Epidemiològics sobre les ITS i SIDA de Catalunya (CEEISCAT), ICO/Agència de Salut Pública de Catalunya, Badalona, Spain, ⁶CIBER Epidemiología y Salud Pública (CIBERESP), Badalona, Spain, ⁷Legebitra, Ljubljana, Slovenia, ⁸AIDS-Hilfe NRW e.V., Köln, Germany, ⁹AIDS-Fondet, Copenhagen, Denmark, ¹⁰ARAS - Romanian Association Against, Bucarest, Romania, ¹¹Projecte dels NOMS-Hispanosida, Barcelona, Spain, ¹²GAT - Grupo Português de Activistas sobre Tratamentos de VIH/SIDA, Lisboa, Portugal

Objectives: The Work package (WP) 4 Task 1 of the Euro HIV EDAT project is a qualitative and quantitative study implemented to describe the impact of the guide "to doing it better in our Community Based Voluntary Counselling and Testing services (CBVCTs) centres" developed by the HIV-COBATEST project. The aim of this WP is to identify barriers and facilitators for the implementation of good practices in the participating CBVCT and to improve the guide: either by actualizing its content or by adding new elements such as a Self-evaluation tool.

Methods: To conduct the assessment of the quality of practices in CBVCTs, a tool has been developed and implemented. It includes a short guidance on how to implement a self-assessment and a series of grids to conduct it based on the main quality criteria of the guide. These self-evaluation grids have been tested in focus groups by each WP4T1 associated partner (AIDS-Hilfe NRW e.V., ARAS, AIDS-Fondet, GAT, Projecte dels NOMS-Hispanosida, Legebitra and AIDES) in a subset of CBVCTs centres.

Two others questionnaires were used to collect data from this CBVCTs: one to describe the barriers and facilitators of the self-evaluation process and the other one to describe how the guide has been disseminated in each country.

Results: The self-evaluation grids of the tool were validated by the associated partners. The grids will be improved with the suggestions of the WP4 T1 associated partners. The questionnaire to evaluate the dissemination of the guide has allowed identifying a lack in the diffusion of the guide in the participating CBVCTs.

Conclusions: The tool of self-evaluation will be inserted in the Guide "To doing it better ...". Two paragraphs will be added in the guide in order to present a method to improve the dissemination and to describe the self-evaluation process.

PO4/09 The COBATEST Network: Opportunities and Challenges of a European Network of Community-based Voluntary Counselling and Testing Services for HIV

L. Fernández-López^{1,2}, J. Reyes-Urueña¹, C. Agustí^{1,2}, I. Klavs³, T. Kustec³, J. Casabona^{1,2}, COBATEST network

¹(CEEISCAT), Agència de Salut Pública de Catalunya (ASPC), Badalona, Spain, ²CIBER Epidemiología y Salud Pública (CIBERESP), Madrid, Spain, ³National Institute of Public Health (NIJZ), Ljubljana, Slovenia

Background: The COBATEST network is a European network of Community-based Voluntary Counselling and Testing (CBVCT) centres established in the framework of the HIV-COBATEST project and currently comprised of 40 CBVCTs from 18 European countries. For Monitoring and Evaluation (M&E) of CBVCT activities basic indicators developed in HIV-COBATEST project are used. The CBVCT centres, members of the network, share common instruments for data collection and data entry. Alternatively, they can send disaggregated data according data file specifications or aggregated data with the M&E indicators calculated.

Strengths: HIV testing data collected through the COBATEST network can be a source of strategic HIV-related evidence for the need to strengthen community-based service delivery models as an integral part of HIV interventions. Also such data might lead to a deeper understanding of the context of the epidemic, and can be used for advocacy and for the empowerment of the different stakeholders. Public health institutions have to take into account the community and to work closely with them.

Limitations: Several important limitations have been detected regarding the usefulness of data collected in the network: quality of the data submitted; representativeness of the data collected; integration of data collected into national surveillance systems.

Actions for improvement: Several actions are being considered in order to overcome these limitations: 1) a project for validation and analysis of the quality of HIV testing data collected in the COBATEST network will be implemented with ECDC; 2) a specific Logo and Website will be developed and the common tools will be improved, in order to increase the visibility of the network and to reach new CBVCT services to be included in the network (Grant from Gilead); 3) a new Joint Action is planned, which is going to address the integration of HIV testing data collected at CBVCT level into national surveillance systems.

PO4/11 A Difference. Specific (and Different) Needs of Clients in Two VCT Centres in Southern Poland (Krakow and Rzeszow)

M. Brodzikowska^{1,2}

¹The University of Physical Education in Krakow, Department of Humanities, Section of Pedagogy, Krakow, Poland, ²Association for HIV/AIDS Prevention and Social Support "One World", Krakow, Poland

Two VCT centers in southern Poland (placed in two different voivodeships) are led by the same organization with the same staff. It creates a chance to observe how such variables as a type of clients, number of clients, reaching key populations, circumstances and opportunities in environment as well as mentality of local community can influence on needs and possibilities of counselling and testing (HIV and HCV). The two centers differ completely (although the distance between them can be estimated as only 170 km). For example in Krakow a huge number of clients is observed when in Rzeszow there are still less people who would like to get tested. It gives a possibility to provide more emotional and educational support for clients in Rzeszow but on the other hand in consequence of low account of tests there are still too less people diagnosed with HIV compared to the actual amount of people living with HIV in podkarpackie voivodeship. In Krakow much more MSM use the opportunity of anonymous and free of charge testing than in Rzeszow (it is caused probably by highest stigma of LGBT+ people in this area) but in Rzeszow there are more women (especially pregnant women) coming to the center than in Krakow. Average age of clients is higher in Rzeszow than in Krakow and in Krakow there are more serodiscordant couples visiting the centre. All of those circumstances create different needs and barriers dependent on the variables mentioned before.

PO4/12 HIV Community Testing Monitoring in Spain

G. Fagúndez Machaín¹, A. Díaz Franco², E. García Carrasco¹, O. Castillo Soria¹

¹Ministry of Health, Social Services and Equality, National AIDS Strategy, Madrid, Spain, ²Health Institute Carlos III, National Center of Epidemiology, Madrid, Spain

Introduction: Approximately 150,000 people are estimated to be living with HIV in Spain, 25% of them are unaware of their serostatus. This situation does not allow them to benefit from early treatment and increases the risk of transmission. Community-based voluntary counseling and testing (CBVCT) allows scaling up of the offer of the test, especially in outreach programmes, providing information and advice and enabling the linkage to care.

Objectives: 1. Develop a tool to localize CBVCT in Spain that facilitates access to the test. (Mapping Project);

2. Develop a network to monitor community HIV diagnosis programmes, develop common procedures and tools for collecting information, obtain assessment indicators, and promote the exchange of good practices. (RedCoVIH Project)

Materials and Methods: Mapping Project: a form was created with the variables: name, address and telephone. An active research of internet data was carried out and subsequently validated by the Autonomous Regions and the NGO Advisory Committee. Finally, GPS localization software for georeferencing was applied. RedCoVIH Project: CBVCT programmes were identified. An online application was developed with the following variables: programme type, socio-demographic data of the users, previous tests, reasons for testing and usual sexual practices. A minimum set of data was defined and the evaluation indicators of the Cobatest project were selected.

Results: 448 centers were identified: 257 pharmacies, 136 NGOs, 15 STI / HIV Centers and 40 others, (Youth Centers, Town Health Centers and Primary Care Centers with community testing programmes). The RedCoVIH on-line tool is in pre-production phase.

Conclusions: These tools will contribute to improve the accessibility of CBVCTs and provide test performance information monitoring. Also, will promote the implementation of good practices and help to a better contextualization of the interventions in the community HIV prevention programmes.

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