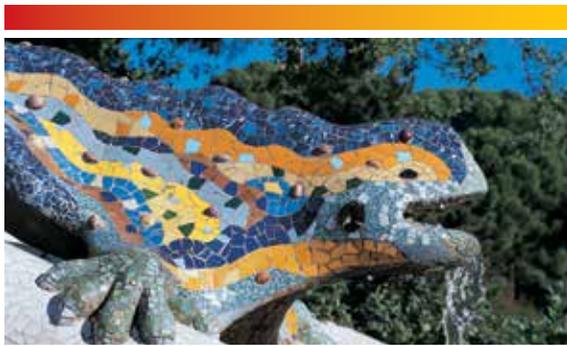


HepHIV 2014

5-7 OCTOBER BARCELONA

Conference proceedings



HepHIV2014 Conference

HIV and Viral Hepatitis:
Challenges of Timely Testing and Care

Barcelona, 5-7 October 2014

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HepHIV2014 organising committee

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Executive summary

HIV and viral hepatitis are both blood-borne diseases that are typically asymptomatic for years, and the response to both diseases involves many of the same stakeholders – and challenges, including stigma and late presentation. Though each kills 1.4 million people per year, HIV has been high on the public health agenda for 30 years, while hepatitis has been largely ignored. As the conference demonstrated, there is a great deal that the two fields can learn from each other's experiences, and a great deal of synergy to be had in working together to address the challenges of getting more people living with either disease into care earlier.

HIV incidence has remained stable in the EU in the last decade, decreasing among migrants and rising among MSM, in whom the epidemic is concentrated. In eastern Europe it continues to rise, fuelled by modest treatment levels and an almost complete lack of prevention. Surveillance data on viral hepatitis are patchy and poor, but modelling shows that the hepatitis C epidemic has apparently peaked in western Europe.

The good news is that in the last year, direct-acting antiretrovirals (DAAs) have given us a cure for HCV that is safe and effective with minimal side-effects, also for HIV-coinfected people. Unfortunately, current prices are prohibitive, topping €80 000 for a course of treatment with sofosbuvir, prompting a good deal of discussion about how negotiation and generics might make the drugs accessible to the millions of people who need them.

The new treatments also present a powerful argument for the scale-up of HCV testing. Several studies illustrated the cost-effectiveness of simultaneous testing for HBV, HCV and HIV. HIDES II confirmed the cost-effectiveness of 9 more indicator conditions for HIV testing, and a study of Dutch GPs found that 60% of new HIV patients had already been diagnosed with an indicator condition.

Late presentation levels for HIV have stagnated at around 50% in Europe and continue to be a major cause for concern, with many countries not testing the groups that their national plans commit them to testing. New definitions of late presentation and advanced disease in viral hepatitis were presented and met with broad support. Speakers shared numerous examples of the effectiveness of community-based rapid testing in key populations for both HIV and viral hepatitis, and pilot programmes used several methods to improve contact tracing and get physicians to increase testing. The UK is seeing success with home self-tests for HIV.

Intensified targeting of HIV and viral hepatitis interventions is needed across the European Region. Alliance Ukraine has demonstrated the power of community mobilization, but in eastern Europe it is an exception, and addressing the burgeoning epidemics in Russia poses formidable political challenges.

The conference concluded with the elaboration of a call for action, including greater integration of HIV and viral hepatitis efforts (see inside back cover).



HepHIV2014 Barcelona conference objectives

The main objectives of the HepHIV2014 Conference were to:

1. Provide the fields of HIV and viral hepatitis with the opportunity to learn from each other and to reflect on their experiences.
2. Provide an overview of European innovative initiatives and best practices on optimal testing and earlier care for HIV and viral hepatitis from different settings across Europe.
3. Highlight and discuss achievements and obstacles experienced in both fields, whilst maintaining focus on the lefthand side of the “treatment cascade,” with regards to undiagnosed cases, testing and initiation of care.
4. Sustain and fuel the political discussion of testing policies with the EU Commission and Parliament, the WHO Regional Office for Europe, ECDC and EMCDDA and the European Union HIV/AIDS Civil Society Forum and Think Tank and the implementation of testing policies at national levels.
5. Provide opportunities for multi-stakeholder dialogue to develop creative solutions to unresolved challenges in research and implementation of HIV and viral hepatitis policies and programmes to improve early diagnosis and care of HIV and hepatitis across Europe.
6. Inform leaders, including key policy makers and donors, as to increase their commitment to ensure that HIV and viral hepatitis infected patients enter care earlier in the course of their infection than is currently the case.
7. Increase public awareness of the public health problems associated with late presentation for HIV and viral hepatitis care.

Opening Session

Sunday, 5 October 2014

Welcome to the HepHIV2014 Conference: objectives and expected outcomes of the conference

The three HepHIV co-chairs opened the conference. **José Gatell** (University of Barcelona), the local conference chair, welcomed participants to Barcelona and thanked the local sponsors – the AIDS Working Group of the Spanish Society of Infectious Diseases (GeSIDA), the Spanish AIDS Research Network (RIS) and the University of Barcelona – as well as the funders of the HepHIV2014 Conference. **Brian West** (European AIDS Treatment Group (EATG)), Co-chair HIV in Europe, laid out the conference objectives (see p. 4), especially the goal of providing people who work in viral hepatitis and in HIV the opportunity to learn from each other. The nearly 250 participants hailed from 38 countries and included 34% community representatives, 25% clinicians, 10% policymakers, 8% media and industry representatives and 23% other, including social scientists, epidemiologists and statisticians. **Jens Lundgren** (Rigshospitalet, University of Copenhagen), the other co-chair of HIV in Europe, explained why the time was ripe for a joint hepatitis and HIV conference and thanked the many civil society groups and European bodies that made it possible. He sketched out two key outcomes: an overview of testing challenges, and a vision of how to integrate viral hepatitis and HIV activities.

HepHIV2014 Conference partners

Correlation Hepatitis C Initiative
European Liver Patients Association (ELPA)
European Association for the Study of the Liver (EASL)
European Centre for Disease Prevention and Control (ECDC)
Hepatitis B & C Public Policy Association (HEPBPPA)
HEPscreen Project
HIV in Europe Initiative
International HIV/AIDS Alliance in Ukraine (Alliance Ukraine)
WHO Regional Office for Europe
World Hepatitis Alliance

HepHIV2014 Conference local partners

AIDS Working Group of the Spanish Society of Infectious Diseases (GeSIDA)
Spanish AIDS Research Network (RIS)
University of Barcelona

Welcome address

Antoni Mateu (Catalan Ministry of Health) emphasized the importance of addressing HIV and hepatitis together from a public health point of view, including high prevalence in key populations. In Catalonia, HIV is primarily transmitted sexually, and community-based testing is responsible for 20% of new diagnoses. The Ministry of Health is focusing on testing in primary health care settings. It is committed to evidence-based prevention and recognizes the importance of multi-stakeholder collaboration.

Keynote speech. New perspectives in early diagnosis and HIV coinfection: the Spanish Strategic Plan for Prevention and Control of HIV and STIs

Elena Andradas Aragonés (Spanish Ministry of Health, Social Services and Equality) outlined the HIV epidemic in Spain, where two thirds of new infections are transmitted among MSM and late presentation accounts for nearly 50% of new diagnoses. Hepatitis C remains the most important comorbidity for PLHIV, and Spain has been a leader in providing liver transplants for coinfecting patients. Andradas then summarized the latest national strategic plan for HIV and STIs, focusing on prevention and health promotion, particularly in encouraging early diagnosis. The Ministry has developed healthcare guidelines and is working on community guidelines for early testing and studying the feasibility of home testing.

Keynote speech. A Spanish MEP's perspective

Ernest Urtasun (European Parliament) decried the complacency of recent politicians, with budget cuts jeopardizing access to prevention and affordable treatment and care, and new laws threatening public health and human rights. He urged a renewal of national and regional political commitment to addressing screening and treatment gaps with expanded information campaigns, condom promotion and guarantees of universal access. The poorest and most vulnerable people are less visible than ever at the European level, he said, calling for a patient-centred approach. The new European Commission needs to develop a new action plan, which he assured participants that the new European Parliament would press for. He also called for increased efforts to assist neighbouring nations on HIV, viral hepatitis and multidrug-resistant TB, as well as increased support for the extraordinary efforts of civil society.

Looking at the last few years, there has been a tendency to complacency towards HIV and coinfections in Europe, ignoring public health evidence and ignoring the rights of people living with HIV and of people in the groups most at risk for infection.

—Ernest Urtasun, European Parliament

Progress on Dublin Declaration monitoring

Andrew Amato-Gauci (European Centre for Disease Control and Prevention (ECDC)) addressed progress on the 2004 Dublin Declaration and its framework for action in Europe, which the ECDC has been involved in implementing and monitoring. The new EU Commission is working on a new legal framework to link HIV efforts to hepatitis and likely to STIs and TB too. One key benefit of monitoring has been to increase national data collection, with 90% of countries now responding. MSM incidence in the EU increased after 2004, while migrant rates declined substantially and IDU rates have fallen until a recent spike in Greece and Romania due to reduced funding there. Data on HIV testing remain poor, especially among migrants, but testing rates are clearly too low. Access to care for undocumented migrants is a major problem, and condom use is going down among almost all risk groups, while opioid substitution therapy (OST) and needle exchange programmes are grossly inadequate in prisons. Amato-Gauci concluded by saying we need to get our political leaders to address difficult issues and provide more funding.

In EU countries, HIV infections have not gone away. In the last 10 years, if you want to be cynical, you could say nothing happened. There has been no change.

—Andrew Amato-Gauci, ECDC

WHO's response to HIV and viral hepatitis in the European Region

Gottfried Hirschall (WHO Regional Office for Europe) said that in early 2014, the hepatitis program moved in with the HIV program at WHO headquarters, as well as the European office. In Europe, both diseases present public health challenges, including late diagnosis and high cost, that make universal access prohibitive. Gains in ART coverage have been uneven in the European Region, being only about 30% in eastern Europe, leading to large increases in new infections. Less than 20% of all European PLHIV have achieved viral suppression. Hirschall said that with hepatitis C, a simple effective cure is now available, but it needs to be made affordable. A new World Health Assembly resolution asks countries to develop comprehensive hepatitis strategies and challenges WHO to explore the feasibility of eliminating hepatitis B and C. He noted that WHO has been developing treatment and screening guidelines for both viruses and established a new collaborating centre for HIV and viral hepatitis in Copenhagen.

The community perspective on access to testing and linkage to care

Luís Mendão (Portuguese Activists' Group for HIV Treatments (GAT) Checkpoint) lamented the years of unfulfilled obligations and wasted expenditures that followed the UNGASS and Dublin declarations. He described two major challenges that remain: prioritizing research into what we don't know and scaling up early diagnosis and treatment. The key issue is affordability – which is also true for hepatitis C. Since HCV drugs are easy and cheap to produce, Mendão said, we should commit to elimination. It's not acceptable to use outdated treatment options with numerous side-effects when quicker, more effective, less harmful options are available. We know what needs to be done, he said; where we're failing is implementation. Affected communities should play an important strategic role in addressing these diseases, but he believed they would have to take to the streets again to put pressure on politicians.

We cannot maintain health systems that invest 97% of their resources in treating preventable diseases – and almost nothing in prevention, early testing and linkage to care.

—Luís Mendão, GAT Checkpoint

Plenary Session 1. What is the status of the continuum of care for HIV and viral hepatitis?

Monday, 6 October 2014

The HIV and viral hepatitis epidemics in Europe: recent trends and regional differences

Jens Lundgren (Rigshospitalet, University of Copenhagen) began by describing overall infection figures for Europe, with prevalence for both HBV and HCV at about 2% and for HIV at 2.4%; two thirds of the cases for each infection are in eastern Europe. Poor data make it hard to get an accurate regional picture of viral hepatitis. Chronic HBV infections have increased markedly in EU countries – but does that mean a rise in infections or in diagnoses? Recent modelling of HCV trends in 12 western European countries indicates that the HCV epidemic has peaked in almost all of them, largely due to aging of the infected populations. However, the disease burden won't peak for most of them until sometime in the next 20 years. There are no solid data from eastern Europe, where the epidemic seems younger. For HIV, Lundgren observed that prevalence is increasing much more quickly in the east; Russia's failure to respond to the major IDU outbreak in 2000 has led to a much more mixed epidemic. Low diagnosis rates there are undermining the notion of treatment as prevention and needlessly increasing the disease burden.

The burden of care in mono- and coinfecting patients who are late presenters

Jürgen Rockstroh (University of Bonn) reminded the audience that HBV, HCV and HIV can all be asymptomatic infections for years. For HIV, the consensus definition of late presentation has helped policymakers formulate effective public health responses – which is why we need such definitions for HBV and HCV. He noted that late presentation increases mortality, medical costs and onward transmission of all three viruses, and called for innovative targeted testing approaches. Late presentation for HIV declined from 57% to 52% from 2000 to 2010. Recent treatment advances for viral hepatitis make it even more important to test people early. New non-invasive fibrosis screening methods make a fibrosis-based definition of late presentation more practicable while enabling better linkage to care, and he called for broad expansion of such testing.

Hepatitis C virus infection: a systemic infection with the possibility of a cure

Stanislas Pol (European Association for the Study of the Liver (EASL)) explained that it's important to treat HCV not only because of familiar problems like cirrhosis and lymphoma, but also because the virus can double mortality due to diabetes, cardiovascular and cerebrovascular problems, and non-liver cancers. The new DAA combinations provide an almost universal cure, achieving sustained virological response (SVR) in almost all patients. They reverse most HCV manifestations, and mortality afterwards is close to the general population's. The new treatments have rendered last year's treatment guidelines obsolete and have obliterated the concept of difficult-to-treat patients. The specific combination used should be tailored to the patient. Costs remains prohibitive – €80 000 for a treatment in France – but Egypt, for instance, was able to negotiate a price of €1000 with Gilead. Pol said we need to start by prioritizing transplant patients and patients with severe disease, but in the future we should treat everyone.

Linkage to hepatitis C care: how can challenges be overcome in eastern Europe?

Oksana Savenko (International HIV/AIDS Alliance in Ukraine (Alliance Ukraine)) enumerated the shortcomings in the Ukrainian hepatitis C response a couple of years ago: a lack of usable epidemiological data, prohibitive diagnosis and treatment costs, and minimal public funding and coordination. Yet HCV is rife among risk groups, especially IDUs (67%) and HIV-positive IDUs (95%). But rather than adopting a fatalistic attitude, Alliance Ukraine drew on international models for a focused, step-by-step approach. It tested 84 000 people in risk groups in 2010–2012, and this year it helped 87 NGOs provide rapid testing. It developed a treatment model based on community mobilization, working with the health ministry, health facilities, commercial labs and NGOs to provide social, psychological and adherence support. Alliance Ukraine also negotiated a 60% reduction in HCV drug price and a 50% cut in lab diagnostics for a small pilot treatment programme, catalysing national price reductions and the treatment of more than 7000 people within two years. Savenko anticipates universal access to treatment in the near future.

Key challenges in the cascade of care in the eastern European Region

Michel Kazatchine (UN) analysed the HIV epidemic in eastern Europe, where it continues to grow, driven largely by unsafe injecting drug use, especially in Russia. After exploring the challenges of stigma and the criminalization of key populations, the lack of cooperation between governments and civil society, the glaring lack of prevention (especially harm reduction) and the neglect of hepatitis C, he addressed the geopolitical dimensions of the HIV response. In eastern Europe, most of the work with key populations is funded by international organizations, but the Global Fund is pulling out of the region for reasons that Kazatchine does not understand. He said that regional responses to HIV are replacing the global response. Although Georgia, Moldova and Ukraine appear to be moving toward the EU, there's no guarantee that the EU will provide them with any more funding, while it's hard to know where central Asia will align itself. As Russia asserts itself in the region, HIV and harm reduction issues are becoming a political tool. It's difficult to find the right tone to engage with Russia, even for the UN. Kazatchine concluded by saying there will be no progress unless the countries implement legal and policy reforms, prioritize health in drug policies, and find ways to provide sustainable funding for the HIV and hepatitis response. The situation in Russia is untenable, but he does see cracks in the system.

The lack of effective prevention leading to very high infection levels, and the lack of critical analysis of the quite drastic drops seen along the continuum of care, are largely due to the fact that the epidemic in Russia and throughout the region is really about key populations.

—Michele Kazatchine, UN

Plenary Session 2. Public health challenges in the earlier diagnosis of HIV and viral hepatitis

Monday, 6 October 2014

Testing policies for HIV, HBV and HCV: missed opportunities and lessons learned

Kevin A. Fenton (Public Health England) described the responses to HIV and viral hepatitis as being in different phases. Key testing challenges are posed by hard-to-reach populations, stigma and a lack of provider awareness. He said that UK providers offer tests to clients of services with high prevalence rates, patients in risk groups and patients with indicator diseases. Routine HIV testing in high-prevalence areas has proven cost-effective and highly acceptable. Dried blood-spot self-tests, ordered online and submitted by post, have been especially effective in reaching young people and rural residents; they will soon be available in pharmacies too. Multiple venues and modalities also help in what Fenton called “democratizing testing”. For hepatitis, HIV has taught us the importance of voluntary patient-centred testing, community testing options, and provider and public education campaigns.

It isn't about groups being hard to reach, but services being hard to access.

—Charles Gore, World Hepatitis Alliance

Cost-effectiveness of screening strategies in HIV and viral hepatitis

Yazdan Yazdanpanah (French National Institute of Health and Medical Research (INSERM)) explored the factors involved in determining the cost-effectiveness (CE) of different testing strategies. WHO defines a cost-effective measure as one where the CE ratio is less than three times the GDP per capita. Good estimates for prevalence, transmission rates and disease burden for early and late presenters are necessary. He said it's also important to break the overall figures down for subgroups that might be useful to target, such as risk groups, age cohorts and residents of different locations to determine a cost-effective testing frequency for each. Accordingly, the US, the UK and France have all adopted different testing guidelines based on their particular epidemiological profiles. **Jason Farrell** (Correlation Network) noted that the CDC requires groups that receive HIV funding to offer rapid testing and use evidence-based interventions – an effective incentive structure not seen in Europe.

Quantifying the impact of increased HIV testing in MSM on future HIV incidence

Andrew Phillips (University College London) described a modelling exercise to determine how many PLHIV would need to be virally suppressed to reduce incidence from 5 per 1000 person-years to less than 1 per 1000 by 2030, using UK MSM as the sample population. The model also considered both testing increases and earlier initiation of ART. The exercise predicted that viral suppression would have to increase from 60% to 90% of infected MSM if levels of condomless sex remained constant; a relatively small decrease in condom use would double incidence rates by 2030, which would otherwise remain stable. Analysis showed that increased testing will be cost-

effective after about 20 years, assuming ARV prices remain constant. If generics reduced prices by 80%, increased testing becomes cost-effective relatively soon, and very cost-effective if ART is introduced at diagnosis.

Methods to estimate the number of people with viral hepatitis

Daniela De Angelis (UK Medical Research Council) said that to estimate hepatitis populations, we would ideally do a random cross-sectional sampling of the general population, an expensive approach that is still subject to response biases. More indirect methods are more realistic to use existing information: collecting longitudinal data on end-stage liver disease (based on natural history of the disease), linking of multiple registers such as lab reports and GP records (using capture-recapture methods used for hidden populations) and performing convenient cross-sectional prevalence surveys, which is De Angelis's own focus. These cross-sectional surveys draw on sources such as antenatal screening and anonymous IDU testing and combine them with group size estimates. Special care needs to be taken to acknowledge biases in extrapolating data from imperfect sources to a broader population, as we learned with HIV. **Charles Gore** said that the large discrepancy between such surveys and death data suggest that key groups of undiagnosed are being missed, or that disease progression estimates are off – a major problem, as the surveys are used to assess cost-effectiveness.

Parallel Session 1. Late presentation

Monday, 6 October 2014

Continued late presentation for HIV care across Europe

Amanda Mocroft (University College London) presented COHERE cohort data from 35 countries, showing that levels of late HIV presentation (CD4 < 350) appear to have remained stable across Europe from 2010 to 2013, at around 50%. The levels had been decreasing in the previous decade. The lowest levels of late presentation were seen in MSM, at 39%, while IDU levels rose. Levels of very late presenters (CD4 < 200) and AIDS cases also remained stable, at 28% and 15% respectively. These results are supported by HIV surveillance data.

Challenges to the definition of late presentation to HIV testing

André Sasse (Belgian Scientific Institute of Public Health) presented a study examining whether some recent HIV infections might in fact be being misclassified as late presentations. The study examined Belgian case surveillance data that reported the clinical stage of HIV. If infection was known to occur within the past 6 months, the study defined it as recent and not late, regardless of CD4 count. It has been shown that transient low CD4 counts are not uncommon in recent infections. For MSM, 30% of the new diagnoses examined would be considered late presentations according to the HIV in Europe consensus definition, but only 15% of them according to the study definition.

Undiagnosed HIV and hepatitis C infection among people who inject drugs

Cinta Folch (Public Health Agency of Catalonia) shared a study estimating the proportion of Catalonian IDUs infected with HIV or HCV who are unaware of disease status and determining factors associated with undiagnosed infection. Undiagnosed HIV infections were associated with being male, never being in prison, not having accessed primary care recently, and not using a fixing room lately. Undiagnosed HCV infections were associated with migrants, being younger than 30, and never being in drug treatment.

The Sialon Project: undiagnosed HIV infection among MSM in 6 southern and eastern European Cities

Laia Ferrer (Center for Epidemiological Studies on STI and AIDS of Catalonia) presented a study of undiagnosed HIV among MSM in 2 southern and 4 eastern European cities (Barcelona, Verona, Bratislava, Bucharest, Ljubljana and Prague). It discovered that many HIV+ MSM remain undiagnosed, with the highest rates being in Bucharest (87%) and Ljubljana (85%) and the lowest in Barcelona (45%). The infected men who knew their status often persisted in practicing risky behaviours. Factors associated with undiagnosed infections included attending sex-focused venues, recent syphilis infections, recent popper use and a recent HIV test.

BCN Checkpoint: 31% of the new HIV cases detected in a community-based centre for MSM are recent infections

Michael Meulbroek (Hispanosida) reported that in Catalonia, fully 35% of all reported HIV cases among MSM are diagnosed at BCN Checkpoint in Barcelona. Data from 2006–2014 indicates that 31% of the new HIV cases detected are recent infections, meaning that they tested HIV negative within the previous 6 months, and another 25% tested negative 6 to 12 months previously. These findings suggest that this population should be tested every 3 months, including testing for HIV RNA to reduce false positives and examining for signs of acute infection.

Reaching the undiagnosed: a collaborative project

Magdalena Harris (London School of Hygiene and Tropical Medicine) presented findings from a project exploring the issue of late HCV diagnosis through interviews and focus groups with people who were diagnosed at least 15 years after infection. Reasons for delayed testing included lack of awareness, feeling well, GP inaction, and injecting-related stigma. Focus group participants also provided feedback on hepatitis C awareness materials, which they criticized as too generic and lacking in information on symptoms and risk behaviours.

Our dream of one world responding globally to the HIV and hepatitis epidemics is not being translated into reality. I see the HIV response splitting into regional entities, and I don't think this is a good thing.

—Michele Kazatchine, UN

Parallel Session 2. Testing in health care settings

Monday, 6 October 2014

European students planning to practice internal medicine are more likely to have condition-focused than behaviour-focused approaches to HIV testing

Justyna D. Kowalska (Medical University of Warsaw) presented of a study of the HIV knowledge of national and international fifth-year medical students, both Polish and international, at the beginning of their infectious disease training. They were asked basic questions on HIV characteristics, transmission risks and the indications for HIV testing. Only 41% listed pregnancy, sexual contacts or STIs as an indication for testing; most of the others listed only medical conditions. This suggests the need for earlier introduction of HIV testing in the medical curriculum and inclusion in other subjects such as obstetrics and internal medicine.

HIV diagnosis at time of STI diagnosis among MSM in Catalonia, 2011-2013

Rossie G. Lugo (Centre for Epidemiological Studies on STI/HIV/AIDS in Catalonia) described a study of 2600 MSM who were diagnosed with STIs in primary care centres, STI units and sexual health centres. Ten per cent of the MSM were not tested for HIV, though the circumstances of why they were not tested are not clear. Of those tested, 43% tested positive for HIV; 12% of this positive group (5% of the entire sample) were concomitant infections, defined as being diagnosed with HIV within the previous 3 months or subsequent 6 months of STI diagnosis.

Project PRO-test: pro-active HIV testing for prevention of late presentation

Ivo Joore (University of Amsterdam) presented an intriguing study examining the GP records of HIV patients in a high-prevalence district of Amsterdam. The authors identified 102 relevant cases, finding that nearly 60% of them had been diagnosed with HIV indicator conditions in the 5 years prior to their HIV diagnosis, including 24% who had been diagnosed with at least two indicator conditions, vs. 7% and 1% for a control group. The conditions were limited to those typically seen in general practices. The project group is developing interventions to promote indicator-condition testing in Dutch general practices, including a multilevel educational intervention for GPs.

Effectiveness of a pilot partner notification program for new HIV cases in Barcelona, 2012-2013

Patricia Garcia de Olalla (Public Health Agency of Barcelona) examined the successfulness of a pilot partner notification program for new HIV diagnoses in an HIV unit and an STI clinic. Trained public health workers interviewed the diagnosed patients, who were chiefly MSM, and followed up with the contacts identified. Of the 125 new diagnoses contacted, 109 agreed to contact tracing. A total of 199 contacts were identified (10% of the total contacts). Of these, 41 already knew their HIV status and 141 were tested for HIV, leading to 26 new diagnoses (18%).

We seem to have forgotten about condoms. Remember the condom?
It was one of our strongest tools in the olden days.

—Andrew Amato-Gauci, ECDC

Audit of HIV testing in patients diagnosed with an HIV indicator condition in primary care in Catalonia

Jordi Casabona (Centre for HIV/STI Epidemiologic Studies of Catalonia) presented a study examining how often patients presenting with an HIV indicator condition were screened for HIV and what their prevalence rate was. The authors found more than 74 000 patients who were diagnosed with an indicator condition (2% of all patients). Only 24% of the identified patients were tested for HIV within 4 months, of whom 1.5% tested positive, with the cost-effective threshold of 1% being exceeded for lymphadenopathy/lymphoma (8%), candidiasis, HCV, herpes zoster, syphilis and HBV.

Which conditions are indicators for HIV testing across Europe? Results from HIDES II

Galyna Kutsyna (Luhansk AIDS Centre) outlined the results from the second phase of the HIV Indicator Diseases Across Europe Study (HIDES), which collected data for conditions that expert opinion believed likely to be associated with HIV prevalence above 0.1%, indicating cost-effectiveness as HIV indicator conditions. HIDES II looked at 10 000 patients across Europe and found evidence to back up expert opinion for 9 conditions (in decreasing order of prevalence): simultaneous hepatitis B & C infection, ongoing mononucleosis-like illness, lymphadenopathy, leuko-/thrombocytopenia, pneumonia, HCV, seborrhoeic dermatitis/exanthema, HBV and cervical dysplasia/cancer. With nearly the highest coinfection rate and symptomatic similarity to acute HIV infection, mono-like illness provides an especially good opportunity for early diagnosis.

Good epidemiology drives and monitors good policy, prevention and interventions at all levels.
—Valerie Delpech, Public Health England

Parallel session 3. Key populations 1

Monday, 6 October 2014

Impact of immigration on diagnosis and prognosis of HIV in Catalonia and the Balearic Islands: the PISCIS Cohort

Manuel Fernández Quevedo (Public Health Agency of Barcelona) presented a study examining 4500 migrants and native inhabitants with HIV. While half of the study participants in both groups were MSM, there was less IDU transmission and more heterosexual transmission among migrants, with significant variation by region of origin. Spanish deaths were higher, but that might be due to greater numbers of migrants being lost to follow-up. Among migrants, late presenters were likelier to be heterosexuals or IDUs, older than 25 and less educated; those with advanced disease were also likelier to be unemployed.

Athens Checkpoint: reducing undiagnosed HIV infections despite crisis-affected public services in Greece

Sophocles Chanos (Athens Checkpoint) described the work of Athens Checkpoint in its first 18 months of operation. When the economic crisis struck Greece in 2010, it led to a severe disruption of HIV testing, with some testing facilities being shuttered and the introduction of a testing fee. The checkpoint provides free rapid testing and expects to diagnose one third of new MSM infections

in 2014, though 20% of the testing uptake is by heterosexuals. They also provide counselling and linkage to care; promote routine testing and safer sex; and battle stigma. Expert recommendations for the information and support needs of different population groups in preparation for the 2014 government approval of HIV self-testing in France. Karen Champenois (INSERM) presented the consensus recommendations of 72 experts on the access, information and support needs of different self-test user groups in France. Consultation occurred online, with each risk group including experts from policymaking, research, civil society, screening and care. A Delphi process generated 263 recommendations in 8 areas and resulted in broad agreement. There were casual disagreements on minors' access to self-tests and the provision of free self-tests, while MSM experts preferred blood-based tests (due to reliability) and youth experts favoured oral tests (due to acceptability).

Increase of sexually transmitted hepatitis C virus in HIV+ MSM in Barcelona, Spain: a problem linked to HIV infection?

Sandra Manzaneres-Laya (Public Health Agency of Barcelona) presented a study of HCV incidence in Barcelona from 2007 to 2013, which soared from 1.3 to 4.0/100 000 from 2012 to 2013. While 22 out of 29 cases in men in the first 4 years were due to nonsexual transmission, 34 of 39 were transmitted among MSM in 2012–2013, and 29 of them were HIV-positive, most of them infected with HIV first. Interviews found high levels of sexual transmission risk factors. Manzaneres-Laya called for increased transmission efforts, targeted screening and improved surveillance.

Hepatitis B: are at-risk individuals vaccinated if screened and found negative for HBV? Results of an online survey conducted in 6 EU countries

Miriam Levi (University of Florence) described the results of online surveying of experts from Germany, Hungary, Italy, the Netherlands, Spain and the UK. A total of 286 experts responded. Despite national guidelines recommending HBV vaccination or vaccination screening to IDUs and sex workers, large proportions of respondents indicated that vaccination is offered intermittently or not at all to IDUs in 4 countries and to sex workers in 4 countries. Results for PLHIV were somewhat better, and considerably worse for migrants and pregnant women.

Sociodemographic and behavioural characteristics of MSM attending a voluntary counselling and testing centre in Brussels

Anne-Françoise Gennotte (Saint-Pierre University Hospital) presented a survey of 3300 MSM in 2008–2012. HIV prevalence rose from 3.2% to 4.0% during this period, and most demographic characteristics remained stable. Few behaviours remained constant during this time, however; most notably, the proportion of HIV-positive MSM in Brussels who reported having recent unprotected sex due to alcohol or drug use soared from 24% to 69%. Levels of condom use were low for all sexual practices and in all meeting places. In 2011 and 2012, 66% of MSM never disclosed their sexual orientation to their GP.

Let's not forget primary prevention. The toolbox is full; let's take and adapt what works.

—Valerie Delpech, Public Health England

Plenary Session 3. Testing strategies in HIV and viral hepatitis: new innovative approaches, and a panel debate on the role of civil society

HIV testing: what works, and what are the implementation challenges?

Brian Gazzard (Chelsea and Westminster Hospital) covered a number of practical issues for making HIV testing more effective in health care settings. He hailed HIDES, which made clear for the first time how many diseases are useful indicators of HIV infection, but noted that a US study found that even with AIDS-defining conditions, as many as 50% of patients are not tested. Gazzard said that for casualty wards, the success of routine HIV tests depended on nurses. Ninety-five per cent of medical staff support increased HIV testing, yet only 54% say they're comfortable offering tests themselves. And to involve GPs, testing needs to be incentivized. He ended by saying that the problem with persuading decision-makers to invest in testing is democracy – politicians are more interested in short-term savings than long-term cost-effectiveness. **Andrew Amato-Gauci** (ECDC) suggested anonymous testing of test refusers who have blood work to obtain more data on the undiagnosed.

I'm not sure that post-test counselling helps anybody. You may be able to get them to be a bit safer, but of course the safest thing of all is to get them on treatment.

—*Brian Gazzard, Chelsea and Westminster Hospital*

Testing of hepatitis: global and European perspectives

Charles Gore (World Hepatitis Alliance) said it is difficult to estimate the prevalence of viral hepatitis, and few countries have diagnosed more than 50% of HCV infections, while global diagnosis of HBV is probably less than 20%. The upshot: low monitoring and treatment levels and high mortality, with global mortality now about the same as for HIV. Where national screening exists, it's generally to exclude people rather than to link them to care. Fortunately, WHO is committing now to more than just control, and Gore says cancer prevention may help to mobilize support. Patient advocacy will take root as diagnosis and treatment expand. Diagnosis without treatment can still enable people to reduce risk behaviour and stop drinking to slow progression. Gore maintained that to increase diagnosis, the way forward is to increase screening: involve civil society, combine with other tests, target high-prevalence groups and institute non-stigmatized testing, e.g. by age.

Panel debate: what is the role of civil society and what are the major challenges in access to testing and care?

Ton Coenen (AIDS Action Europe) began by asking if civil society's role in addressing viral hepatitis is really the same as with HIV. **Danny Morris** (Royal College of General Practitioners) compared the situation for hepatitis to that for HIV in the late 1980s – clinicians and infected people educating each other. In the UK, people with hepatitis are suffering a lot of stigma and isolation that PLHIV no longer suffer. **Nenad Petkovic** (Q-Club) said that in Serbia, his group brings different groups of stigmatized people together to combat stigma based on health status. **Ferran Pujol** (Hispanosida)

and **Nikos Dedes** (EATG) both noted that HIV groups began HCV efforts a long time ago. **Andriy Klepikov** (Alliance Ukraine) distinguished between an established HIV response in his country and a hepatitis response that's in its infancy. He urged people to lobby the Global Fund as it considers whether to fund hepatitis as a major disease. **Ton Coenen** noted that most countries represented at the conference aren't eligible for Global Fund support. He wondered whether, at the same time that civil society was taking on new initiatives, its struggle for funding were getting worse. **Nikos Dedes** observed that in Greece, all sorts of services are no longer free; civil society must ensure that its activities are cost-effective and sustainable. **Ferran Pujol** drew attention to politicians who throw money at ineffective programmes year after year; *they're* the ones who need to prioritize and invest wisely. **Nenad Petkovic** noted that the Global Fund and other UN agencies, which have been providing most civil society funding in eastern Europe, have been withdrawing from the region. Closer collaboration with local or state bodies is one answer; social enterprises another.

What should HIV in Europe concentrate on in the next two years? **Andriy Klepikov** called for increasing the focus on access to treatment, while **Nikos Dedes** wanted to concentrate on surveillance to provide better data to lobby policymakers. He added that we should also embrace integration of national HIV and hepatitis plans. **Danny Morris** called for a renewed emphasis on prevention, particularly harm reduction for IDUs. **Nenad Petkovic** reminded listeners of the need to distinguish between the differing situations in different countries and parts of the region. **Ferran Pujol** noted that HIV in Europe has had a strong emphasis on late presentation; in his experience, the main problem is addressing acute infections, and he called for debate on and implementation of pre-exposure prophylaxis (PrEP) in Europe. **Andriy Klepikov** said that treatment isn't just a matter of pills; civil society needs to be involved in delivering treatment and should be included in guidelines.

Plenary Session 4. Linkage to care and economic consequences: bridging lessons learned in viral hepatitis and HIV

Tuesday, 7 October 2014

The Euro Hepatitis Care Index: a project of the European Liver Patients Association (ELPA)

Lilyana Chavdarova (ELPA) guided the audience through the Euro Hepatitis Care Index 2012, which covers the 28 EU member states plus Norway and Switzerland. Developed through literature review and stakeholder consultation, it facilitates ready comparison of different countries' response to hepatitis and identifies gaps in care; for instance, it shows that in 2012, only France and Scotland had effective national plans in place. The Index is limited by a lack of pan-European data collection procedures. Chavdarova urged the establishment of national registries, awareness campaigns, and equal access to testing and treatment, and she stressed the importance of patient empowerment.

Unaffordable medicines: public health and economic consequences

Sergey Golovin (International Treatment Preparedness Coalition) decried the lack of progress on drug prices; after 25 years, patients are still protesting the price of drugs containing AZT. The

cost of a sofosbuvir cure is as much as \$84 000; a price of \$177 would be affordable – and is actually feasible. Golovin pointed out that unfortunately, key populations are hit much harder by high prices. Competition is the key to slashing prices; for generic lamivudine, the prices dropped more than 90%. By banding together, civil society and governments can exert more leverage on negotiations with pharmaceutical companies. Price monitoring is also critical for keeping prices in check.

Voluntary licensing of patent drugs is a market segmentation strategy, not an access strategy.

—Sergey Golovin, *International Treatment Preparedness Coalition*

Are the UNAIDS 90-90-90 targets achievable? Will they result in the end of HIV/AIDS?

Valerie Delpuch (Public Health England) drew on experiences in the UK to address the ambitious 90-90-90 targets of UNAIDS – that by 2020, 90% of all PLHIV would know their serostatus, 90% of those diagnosed would be on ART, and 90% of those treated would achieve viral suppression. The UK is actually quite close, with figures of 78%, 87% and 95%, respectively. Though the UK guideline is to treat people with CD4 counts under 350, many others have taken up the offer of free treatment as prevention. Yet even as diagnosis rates increase and more people go on treatment, incidence is remaining constant and the PLHIV population is rising; contrary to UNAIDS claims, achieving the 90-90-90 targets will not eliminate AIDS and make transmission rare. Delpuch advocating focusing on primary prevention and adopting a whole systems approach – for instance, tackling sexual risk behaviours by also addressing depression, substance abuse, homelessness, etc.

Late presentation of viral hepatitis for medical care: a consensus definition

Maria Buti (Hepatitis B and C Public Policy Association (HEPBCPPA)) made the case for a consensus definition of late presentation for viral hepatitis, which will help standardize and harmonize surveillance across Europe and facilitate the scale-up of treatment. On behalf of the European Consensus Working Group on Late Presentation for Viral Hepatitis Care, she presented definitions for both late presentation and presentation with advanced disease (see box). Both definitions received nearly 80% support from conference participants, followed by some debate on the definitions and their use. The working group will now consult further with stakeholders.

Late presentation: persons presenting for care with F3 or F4 fibrosis.

Presentation with advanced disease: persons presenting with symptoms related to liver disease (hepatocellular carcinoma or cirrhosis presenting with significant biochemical evidence of chronically impaired liver function or symptomatic portal hypertension).

—draft consensus definitions

Parallel Session 4. Key populations 2

Tuesday, 7 October 2014

HIV testing trends and reasons for not testing among MSM in Croatia: review of surveys conducted from 2005 to 2012

Zoran Dominković (Iskorak) reviewed bio-behavioural surveys of HIV testing among MSM in Croatia, where they represent 84% of new HIV diagnoses. Several repeated surveys all indicated an increase in uptake, though the testing rate of about 25% remains under the European median for MSM. By far the most common reason given for not testing is no perceived risk of infection.

Serving the underserved: an HIV testing program for populations reluctant to use public health services

Ramón Esteso (Institute of Health Carlos III) presented a study of people tested for HIV by Médecins du Monde in Spain. The majority of those tested were sex workers, drug users and irregular migrants, chiefly from Latin America. Seventy per cent of those tested were women and 3% transsexuals. Positive tests were higher among men and transsexuals (both 5%) than women (1%). Esteso noted that the NGO has seen more irregular migrants since the study period, since although they can receive HIV care from public health facilities, they can no longer be tested there.

Results of a disease awareness programme offering Chinese migrants on-site testing for chronic hepatitis B and C virus infection in 6 urban areas in the Netherlands

Irene Veldhuijzen (Public Health Service Rotterdam-Rijnmond) related that while HBV is highly endemic in China, there is no hepatitis screening in the Netherlands for migrants, including its large Chinese population. An outreach programme was set up with the Chinese community to test for HBV and HCV, vaccinate for HBV, heighten awareness of both viruses and refer positive cases to care. The programme found that 6% of those tested were infected with HBV and 0.3% with HCV.

Determinants of having never been tested for HIV among migrant MSM in Spain

Percy Fernández-Dávila (Stop Sida) described a study of migrant MSM in Spain conducted utilizing the 2010 European MSM Internet Survey (EMIS). It identified 2900 foreign-born MSM respondents; 13% reported being HIV-positive and 17% had never been tested. Factors associated with non-testing included being younger than 25, being “out” to no one or few people, having less than 3 casual partners in the previous year and non-testing for STIs. Twenty-eight per cent felt they had no access to testing.

Characteristics of foreign-born patients in the Swiss Hepatitis C Cohort Study: implications for national screening recommendations

Barbara Bertisch (University of Bern) described a study of hepatitis C that discovered a large reservoir of older migrants from Italy and Spain who were infected by re-used needles in clinical settings between 1950 and 1970. IDU targeting would have missed them. Before this population is screened, however, she recommended a cost-effectiveness analysis, considering that the average age of the infected group is 72, with a high rate of early-stage cirrhosis.

Parallel Session 5. The treatment cascade

Tuesday, 7 October 2014

Continuum of care of the patients diagnosed with HIV in Belgium according to region of origin

Dominique Van Beckhoven (Belgian Scientific Institute of Public Health) analysed the HIV continuum of care in Belgium by region of origin. There was low attrition between each stage, though non-nationals were somewhat less linked to and retained in care than native Belgians; however, some of the migrants lost at these stages may have left the country. The losses at each stage were fairly similar among sub-Saharan Africans, Europeans and other migrants.

Peer education at infectious disease units as a mechanism to optimize the left side of the HIV treatment cascade

Antonio RG Susperregui (Adhara HIV/AIDS Association) presented a study comparing the impact of peer educators performing rapid testing at infectious disease clinics, at an NGO and on the street. Testing in the clinics found much higher rates of infection and enabled same-day results and next-day appointments with a doctor; when a person testing at the NGO or on the street was from a different health district, it often involved redundant testing at a family doctor and an infectious disease unit, inevitably losing people to follow-up.

Regional differences in hepatitis testing, vaccination and treatment in the EuroSIDA study

Jeffrey V Lazarus (University of Copenhagen) described the results of a 2014 study of active EuroSIDA clinics. Simple HBV and HCV scores were developed for quality of care based on screening, vaccination and treatment, and linked to the fibrosis staging in the clinical database. As expected, lower HBV care scores were associated with a greater risk of fibrosis, suggesting concrete steps to improve care in clinics with low scores. However, the association was not observed for HCV care.

Exploring how commonly diagnosing services refer newly diagnosed chronic hepatitis B and C patients to specialist secondary care: the views of hepatologists, gastroenterologists and infectious disease specialists in 6 EU countries

Miriam Levi (University of Florence) presented a study examining referral patterns for chronic hepatitis patients through an online survey sent to specialists in Germany, Hungary, Italy, the Netherlands, Spain and the UK. Despite some common practices, there was a great deal of disparity in how frequently patients were received from the services most involved in screening. Specialists in some countries reported rarely or never receiving patients from antenatal, sexual health or IDU clinics, suggesting a lack of effective screening and referral practices.

Evidence for the cost-effectiveness of screening for chronic hepatitis B and C among migrants

Susan Hahné (Dutch Centre for Infectious Disease Control) reviewed 7 studies on the cost-effectiveness of screening migrants in developed countries for hepatitis B or C in 2000–2013. Cost-effectiveness estimates varied among studies and were most influenced by the assumptions of prevalence and disease progression rates. The evidence showed that screening of migrants for chronic viral hepatitis is (relatively) cost-effective. Notably, however, HBV vaccination after screening was not found to be cost-effective. Future studies should investigate combination screening for more than one disease.

Parallel Session 6. Alternative approaches

Home-delivered dried blood spot testing for hepatitis B screening of the household contacts of infected pregnant women

Philip Keel (Public Health England) described a home-based initiative in London that used a nurse to visit households and provide dried blood spot tests to household members of pregnant women infected with hepatitis B, as well as to offer vaccination to children in the household. Uptake of screening and vaccination increased dramatically in comparison to clinic referrals, to nearly 100%, and detected infection in about 60% of adult contacts.

A pilot HCV rapid testing project among MSM: the CheckList Project, Lisbon

Miguel Rocha (GAT) described a peer-led program for targeted HCV screening of MSM. During HIV or STI counselling, a client would be given a list of risk behaviours for HCV transmission – fisting, anal group sex, the presence of blood during sex and sharing of drug-snorting or injecting equipment. The client could then indicate eligibility for screening without specifying qualifying behaviours. The positive test rate was 2%.

Feasibility of joint HIV, HBV and HCV testing offered routinely by GPs during one week in two French counties in 2012

Catherine Fagard (University of Bordeaux) described an initiative that recruited and trained 66 French GPs to offer HIV, HBV and HCV tests to a large portion of their patients for one week, in accordance with certain criteria. Two thirds of the patients met the test criteria; tests were offered to one half. Afterwards, the participating GPs reported being more willing to propose tests; e.g. 42% reported frequently proposing an HCV test to patients with a new tattoo before the initiative, and 61% after.

Screening for viral hepatitis among immigrants in Barcelona: comparison of two recruitment strategies

Manuel Fernández Quevedo (Public Health Agency of Barcelona) compared the results of two different strategies to recruit Latin American and eastern European migrants for HBV and HCV screening. The active approach used health workers who were migrants and involved an educational session; the passive strategy involved opportunistic recruitment at health centres. While the demographic profiles were fairly similar, the active strategy was more successful in reaching socially vulnerable migrants.

Health service-based HIV testing and counselling: a review of European guidelines

Stephen Bell (University of New South Wales) compared 5 European regional and 2 global guidelines for HIV testing and counselling. Analysis revealed conflicting guidance related to pretest information and post-test counselling, as well as a number of gaps in individual guidelines. The guidelines rely heavily on expert opinion, and reference to published evidence is limited; the evidence that is used is largely more than 10 years old and predominantly stems from the US and UK. Bell called for the guidelines to be reviewed using more up-to-date evidence from a broader spectrum of European settings.

Plenary Session 5. Testing and linkages to care in key populations

Tuesday, 7 October 2014

Barriers to accessing testing, treatment and care for key populations

Ramón Estesó (Institute of Health Carlos III) detailed a broad variety of barriers that prevent the people who need them most from accessing health and social services, including financial, legal and administrative barriers. Often those at risk do not understand how to access services or their basic right to them. Stigmatization and scapegoating only make the problem worse, and restrictive laws and policies need to be overturned. Estesó called for increased investment in the interventions that reach these populations, such as rapid testing and non-invasive liver elastometry, needle exchange, peer education and targeted materials in visual form. Better access also requires addressing social determinants and making drugs affordable.

Challenges of HCV testing in people who inject drugs

Jason Farrell (Correlation Network) noted that despite guidelines discouraging the treatment of active injectors for HCV, evidence shows that it's one of the best ways to reduce burden of disease and reduce transmission – and it starts with testing. He focused on the need for community-based testing, saying it's at least as important for IDUs as for other vulnerable groups, yet harm-reduction programmes, which would be the natural place to conduct it, are not funded to test for HCV, and so HCV testing is almost never provided at European needle exchange sites or safe injecting rooms. Instead, it's usually located in drug treatment programs and prisons. Similarly, Farrell lamented policies that require rapid tests to be conducted by medical personnel, preventing peer testers from going out into the community.

Why is that we can buy home-pregnancy and HIV tests at the pharmacy, but trained peers cannot go into the community and conduct rapid testing for HCV?

—Jason Farrell, Correlation Network

Migrants in Europe: a growing epidemic of the undiagnosed?

Manuel Carballo (International Centre for Migration, Health and Development) contrasted the HIV response and the viral hepatitis response in migrant populations. With HIV, though many small NGOs quickly took up the issue of migrants, tremendous unsubstantiated assumptions were made on sexual risk behaviour, a one-size-fits-all model prevailed, and action was often poorly planned, targeted and executed. While NGOs learned from their efforts, national governments have failed to. The same scenario is unfolding with hepatitis B and C – but much more slowly and dramatically. Carballo challenged policy-makers to look more closely at seasonal workers, refugees and illegal migrants; at trafficked people and sex workers, the homeless; at people we fear and want to send back. We don't even count them, he said.

Key institutions such as WHO took up the issue of HIV – but have not done so until very recently, or done so forcefully, in the case of hepatitis B and C.

—Manuel Carballo, International Centre for Migration, Health and Development

Increasing incidence of HIV and HCV among MSM across Europe

Ulrich Marcus (Robert Koch Institute) said that while HIV incidence among MSM has stabilized in western Europe since 2006, it has increased dramatically in central Europe and is largely unknown in eastern Europe. Marcus proposed a primary reason for the increase in MSM incidence after 2000: due to a broad expansion in the use of the Internet and smartphone apps, many MSM who were previously not very well connected to urban core groups of MSM – including MSM living in rural areas and younger and older MSM who visit MSM venues infrequently – have now been integrated into enlarged MSM sexual networks and now contribute a larger proportion of new HIV and STI infections. This broadening of the epidemic is reflected in large rises in incidence rates among these MSM subpopulations, subpopulations that are also less often out to their GPs and are less well served by MSM-focused testing and prevention services. The HCV epidemic in Europe is concentrated among HIV+ MSM, who have many HCV risk factors, including rectal STIs, rectal trauma and nasal party drugs. With the advent of effective hepatitis C therapy, a test-and-treat approach seems promising.

Closing Session

Tuesday, 7 October 2014

The HepHIV2014 Call to Action

A multi-stakeholder panel discussed a draft call to action, with audience members helping to identify gaps and to articulate the individual action points. With respect to the consensus definitions on late presentation and advanced disease for viral hepatitis, **Margaret Walker** (ELPA) noted that the working group just began work a month previous, saying that there needs to be further consultation, particularly with patient groups; **Angelos Hatzakis** (HEPBCCPA) stressed the need to enlist broad stakeholder support. Discussion of the considerable challenges in Eastern Europe focused on the need for political action. **Nikos Dedes** (EATG) suggested adding a separate point on political leadership generally, as it's needed throughout Europe, and a new action point was duly drafted. Several people pointed out that it doesn't always make sense to integrate HIV and hepatitis efforts, depending for instance on the nature of national and regional epidemics. Concerning the need for better data on the continuum of care for both diseases, particularly hepatitis, **Brian West** (EATG) noted the importance of addressing the affordability of treatment and **Martin Donoghoe** (WHO Regional Office for Europe) the affordability of diagnostics. **Ton Coenen** (AIDS Action Europe) suggested developing a separate action to address affordability, a suggestion that was subsequently implemented in the final document.

The core principle behind self-tests is to “democratize” testing – to get testing technologies out into the communities and mobilize them to take up the offer. It’s better for people to know – and it’s better to let them know when they’re ready to do so. What is key is to provide multiple venues for people to be aware of their status throughout the course of their life, using as many different modalities as possible.

—Kevin Fenton, Public Health England



HepHIV2014 Call to Action

The **HepHIV2014: Challenges of Timely Testing and Care** held in Barcelona 5-7 October, co-organized by leading stakeholders in the fields of HIV and viral hepatitis, was the first European conference to bring the two fields together. The conference closed with a Call for Action addressed to policy makers and other stakeholders.

The **Call for Action** has been developed by the HIV in Europe Steering Committee and the HepHIV2014 Scientific Committee based on input at the conference.

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 better target interventions.

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, health care facilities and in the home (self-testing), with special attention to cost and cost-effectiveness and the possibility of testing all three blood-borne diseases – HIV, HBV and HCV – at the same time. Involve key communities in the tailoring of testing and health promotion messages to their audiences.

4. Indicator-condition-guided testing

Broadly implement indicator-condition-guided HIV testing in health care 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 eastern and western European regions, as well as the European Union and the rest of the WHO European Region. Advocate for expansion and support the funding of successful harm-reduction models, such as those 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 – and at regional, European Union and national levels and in civil society, including organizations representing 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 are needed to inform viral hepatitis and HIV policies and programmes.

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