Integrate

Joint Action on integrating prevention, testing and linkage to care strategies across HIV, viral hepatitis, TB and STIs in Europe

Joint Integrate, EuroTEST and European Testing Week National Stakeholder Meeting 3 June 2019, Vilnius, Lithuania

Meeting report

EuroTEST
Working together for integrated testing and earlier care
Addressing Hepatitis, HIV, STIs and TB

EUROPEAN TESTING WEEK
TEST.TREAT.PREVENT.
www.testingweek.eu

Co-funded by the Health Programme of the European Union

Co-funded by
the 3rd Health Programme
of the European Union under Grant
Agreement nº 761319

DATE	3 June 2019 09:00-17:00
VENUE	Artis Centrum Hotel, Vilnius, Lithuania
SUBJECT:	Joint INTEGRATE, EuroTEST and European Testing Week National Stakeholder Meeting

The National Stakeholder Meeting on current testing strategies for HIV, viral hepatitis and sexually transmitted infections was held in Vilnius, Lithuania on 3 June 2019. The meeting had diverse representation and was attended by approximately 35 people with representatives from the Ministry of Health, public health institutions, primary and specialised care, Center for Communicable Diseases and AIDS (ULAC), NGOs, Republican Centre for Addictive Diseases (RPLC) including regional representatives, the prison department, INTEGRATE partners from National Public Health Laboratory (NVSPL) and Vilnius University Hospital Santariškių Klinikos (VULSK) and international participants from The European Centre for Disease Prevention and Control (ECDC) and other organisations.

The main aim of the meeting was to bring together regional, national and local stakeholders to discuss current testing strategies for HIV, viral hepatitis and sexually transmitted infections in Lithuania and how to improve testing services with focus on the following key points:

- Current testing policy and practices in Lithuania;
- How to align with European and international testing guidelines;
- Gaps and barriers to testing for the individual, provider and institutional levels;
- Cost-effectiveness of testing;
- How to improve testing strategies including integrated testing, indicator condition (IC)-guided HIV testing and linkage to care.

1. Discussion and outcomes

Welcome

Jurgita Pakalniškienė (Ministry of Health, Public Health Department, Health Promotion Division) opened the meeting and welcomed all attendees.

Welcome remarks and introductions

Raimonda Matulionytė (Department of Infectious Diseases and Dermatovenerology, Faculty of Medicine, Vilnius University) welcomed all attendees to the meeting and introduced that the aim of the meeting was to showcase different integrated testing strategies in Europe, especially work done through the Integrate JA, which many partners in Lithuania are a part of.

Towards integrated testing

ECDC evidence-based public health guidance on HIV, hepatitis B and C testing in the EU/EEA—an overview

Lina Nerlander (European Centre for Disease Prevention and Control) provided an overview of the 2018 ECDC public health guidance on integrated hepatitis B, C and HIV testing in the EU/EEA. The guidance was developed through a systematic review and consensus decision making through an expert panel. Although the guidance was developed for the EU/EEA, it should be used in the context of the reader's local epidemic. Particularly, when developing national/local testing strategies, they should align with the core principles outlined in the guidance centring on the patient/person.

Regarding the recommended populations to test, the guidance recommends basing testing strategies aimed for high risk populations, people with clinical indications, as well as broader approaches (e.g. testing in high prevalence settings). Regarding how often to test, the guidance recommends testing to be determined by the local epidemiology, individual risk factors and behaviour. The guidance also provides an overview of how integrated testing could be implemented in different settings, including health care and community settings in addition to the latest evidence on self-sampling/testing. Lina concluded her presentation to emphasise, that no matter the setting, integrated testing is acceptable, and barriers are often at the provider-level but coverage could be improved with educational interventions and clinical decision-making tools. Additionally, partner notification is cost-effective and yields high positivity rates. With all testing strategies, linkage to care is key.

Discussion

- It was commented that the first 90 in Lithuania was acceptable, however, the second 90 (percentage on treatment) needs a lot of improvement.
- It was commented that if the guidance recommends GPs and primary health care (PHC) providers to do more testing, there is an issue in Lithuania of where the funding will come from to offer more HIV testing. Additionally, of those in PHC offering testing, occasionally linkage to care is weak.
- In Lithuania, HIV self-tests are available in pharmacies, but little is known about their use and linkage to care poses the biggest challenge.
- Concerns were raised that self-testing could be implemented with no support – e.g. no translated instructions or counselling.
- A comment was made on how more should be done to reduce the stigma, especially among health care professionals. More efforts must be made in emphasising the importance of establishing trust between the doctor and patient.

Situational assessment – Lithuania

Jurgita Pakalniškienė presented on the current strategies implemented in Lithuania since adopting the 2030 HIV goals in 2014. Currently in Lithuania, there is national legislation for HIV testing but in terms of combined testing or testing for more than one disease, there is limited legislation. Pakalniškienė provided a situational analysis on recommendations outlined in the latest ECDC guidance and how Lithuania is doing in meeting the recommendations. One of the strategies that helped to achieve the first 90 in

Lithuania was the implementation of routine testing of defined groups (pregnant women, blood donors, TB patients, those in substitution treatment and prisoners). However, only these groups are identified in legislation for routine and re-testing (only legislative things are compulsory and/or reimbursed); for all other risk-groups, there are some recommendations in place (thus not compulsory nor reimbursable). Additionally, a legislative decision is still under discussion regarding reimbursement of HIV testing in primary care. Additional barriers include no full list of HIV indicator conditions (ICs) included in legislation, lack of awareness of HIV ICs among health care professionals and the reimbursement for the consultation fee to offer HIV testing at the primary health care level is too low currently. Regarding community testing in Lithuania, rapid HIV testing is well-implemented in low threshold service sites but this is currently funded by international donors. In addition, lay providers are not allowed to perform rapid HIV testing. Regarding HIV self-testing/sampling, currently in Lithuania, self-tests are available for sale in pharmacies but little to no information is available. Partner notification in Lithuania is largely a passive responsibility placed on the patient and it is difficult to measure if the person who tested positive had been in contact with their partner. Monitoring and evaluation of testing services in Lithuania is well-implemented but their current system lacks funding for the implementation of web-based reporting system for the lab data reporting. Lastly, regarding combined testing for HIV, HCV and/or sexually transmitted infections (STIs), combined testing is implemented for pregnant women, blood donors, and for persons who test HIV positive. However, testing procedures for viral hepatitis in primary health care setting and in low threshold services are not described in legislation, while STIs are mainly tested in dermavenerology services where there is low coverage for HIV testing among STI patients. Pakalniškienė summarised that going forward, the Ministry of Health would revise the current legislation on testing strategies with consideration of results from INTEGRATE and recommendations with a focus on increasing knowledge of health care professionals and the community.

Discussion

- A question arose regarding time spent providing pre-test counselling. In practice in Lithuania, filling out forms and working with the current system is time consuming and physicians lack the time to provide counselling, including counselling for patients who test negative. The amount of time spent counselling scares off physicians from offering testing. It was agreed that counselling should be interpreted in different ways and be based on an individual basis following the WHO recommendation that extensive pre-test counselling is no longer necessary.
- A non-infectious disease specialist in the audience commented that if they were to offer HIV testing to their patients, it takes up a lot of time to counsel and educate on the reasoning behind the test creating barriers to offer testing.
- Questions arose on the incentives that GPs receive for testing of pregnant women for HIV. The incentives are not a substantial amount but is enough to motivate GPs to test. Additionally, the tests are covered by the National Health Insurance Fund.
- Additionally, in Lithuania, they are still implementing secondary HIV testing during pregnancy because there continues to be a few cases of mother to child transmission. It was suggested that testing partners could be more beneficial but doubts over the willingness of physicians to do so were expressed. Unfortunately, the issue is not in the current political agenda yet.

<u>Community perspective on national testing policies</u>

Kęstutis Rudaitis (Asociacija “Demetra“) provided a brief introduction on Association ‘Demetra’, which is a community centre that does rapid diagnostic HIV testing in a non-healthcare setting, targeting groups from different social layers. The centre is considered a low threshold service provider, providing

services such as transportation, testing (both on-site and mobile), linkage to care, harm reduction programmes, counselling and community advocacy. To improve testing coverage, the organisation developed an online system where staff can engage in one-on-one conversations with prospective patients, answering questions, as well as provide other online activities (lectures, social media awareness, etc). The centre functions within the country's legal framework by adhering that all clinical services, such as the testing and prescriptions, are conducted by medical staff only. Counselling services within the centre are offered by social workers, health professionals and other trained personnel meeting the Ministry of Health's requirements. Regarding current national testing strategies in Lithuania, in order to improve testing from the community perspective, the requirements for non-health care facilities to conduct rapid screening for HIV, viral hepatitis and STIs need to be simplified. Suggestions for simplification include allowing select rapid tests to be carried out by trained medical and health graduates (including public health, occupational therapy, physiotherapy) and/or allow trained psychologists, social workers, social worker assistants, clinical labs, medical students, peer-to-peer counsellors to also provide testing (as long as they attend training courses at least once a year). Additional barriers include: regulation is limited to only HIV; limited funding; inadequate staffing; internal stigma against HIV as well as for key populations; high costs of RDTs; lack of communication and cooperation between institutions, especially between public and non-governmental sectors; excessive data collection; and good practices from other countries and recommendations are not being adapted.

Discussion

- A comment was made suggesting that testing being conducted by non-medical staff could help meet the demand for human resources. However, according to the Lithuania legislation, testing is a medical procedure which can only be performed by licensed health care workers. In response, it was mentioned that in other countries, for example France, legislation also limited testing to health care professionals. However, to help gather the evidence to provide the rationale to change the law, a research project was developed where community health workers provided HIV testing, under the conditions of the research project. This project gathered the evidence that proved there was no patient harm caused by community health workers and that linkage to care was better than linkage from physicians. This evidence helped to support law reform which occurred in 2009.
- With the INTEGRATE project, the aim is to disseminate good practices and experiences, including cases where non-medical staff working together with medical staff and stakeholders to test patients.
- NGO representatives also emphasised that they were keen on working collaboratively with healthcare professionals to be more effective. NGOs do not want to test for the sake of testing, but they want health care professionals to learn from their experiences and vice versa.
- It was concluded that the best solution would be to provide services within in a comprehensive package and acknowledge what all stakeholders can bring to the table.

Cost-effectiveness of testing

Cost effectiveness of testing strategies – the OptTEST study

Yazdan Yazdanpanah (Service des Maladies Infectieuses et Tropicales Hôpital Bichat Claude Bernard, Inserm) Yazdanpanah presented the approaches healthcare providers, policy makers, developers of

evidence-based clinical guidelines and public health officials could take to decide how to utilise resources available, in situations of uncertainty and limited resources. Currently, there are two approaches:

1. Long term evaluation (cost effectiveness analysis): to estimate the additional value to society of a new intervention relative to the current ones.
2. Short term (budget impact analysis): to forecast the impact of new drugs/tech on health care budgets; cost effective doesn't mean cheap.

Yazdanpanah also discussed the various testing strategies and criteria used to target populations for HIV screening and pointed out that it was more effective to screen the general population – because it is difficult to determine if a patient is at-risk.

Yazdanpanah presented the evidence gathered through the OptTEST project, particularly through the work in Work Package 6 which aimed to determine the survival benefits, cost and cost-effectiveness of different HIV testing strategies in different settings, regions and priority groups in Europe. The project focused on 3 countries (Spain, France and Estonia) and used mathematical modelling which compared key parameters (key groups with main incidence, test acceptance of screening performance, cost of HIV and ART). Results from the analysis showed that it was cost effective to do a one-time screening of the general population. However, it was emphasised that general population testing has a high financial investment – if resources are limited, then testing should be increased for at-risk populations.

Discussion

- An audience member commented that offering integrated testing for HBV, HCV and HIV could be more cost-effective in the long term.
- Yazdanpanah also commented that he prefers to use "Chronic, viral and infectious disease testing" to account for multiple disease testing and providing more comprehensive care. For instance, if a person tests HBV negative then they should be offered HBV vaccination.
- It was commented that although cost-effectiveness provides ample evidence of the effectiveness of an intervention/programme, politicians and policy makers expect results in 2-3 years, whereas the results from cost-effectiveness analyses would only be proven over a longer period of time. Yazdanpanah emphasised that all testing/systems is cost-effective for public health but it is not cheap.
- Another audience member commented that funding is always being shifted from one organisation to another and the main challenge continues to be within capacity. For instance, for TB, all diagnosed with TB should be treated, and the TB treatment is covered from National Health Insurance Fund (like for HIV). However, in some cases providers lack the capacity to effectuate the stipulated treatment to all patients and do only treat as many as they can cope with.
- An important measure to also help examine cost-effectiveness is linkage to care, especially for key populations.
- When conducting a modelling of cost-effectiveness analysis, a key issue is that the data needs to be updated frequently, which many might not have the capacity to do, especially for longer periods of time.

Cost effectiveness of testing – Estonia as a case

Kristi Rüütel (National Institute for Health Development) presented on the results from OptTEST work package 6, which focused on determining the survival benefits, cost and cost-effectiveness of different HIV testing strategies in different settings, regions and priority groups in Estonia. The study looked at epidemiological parameters and testing performance, costs and utilities to determine what strategies would be cost-effective in HIV screening. Results showed the cost-effectiveness of frequency testing for MSM, PWID and the general population and provided the evidence for policy makers how their modelling could be used to develop a national testing strategy. After the results of the study were disseminated, the Ministry of Health decided that all medical guidance must be evidence-based.

Discussion

- Rüütel commented that although Estonia has experienced a reduction in HIV transmission, some high level stakeholders in the country are unaware of the importance of prioritising key populations. As a result, the Estonian testing guidance currently does not include testing for PWID.
- It was commented that the decrease in HIV transmission could also be attributed to the natural course of the infection and harm reduction efforts with more people getting on treatment. International organisations have also helped to influence change.
- A question arose regarding diagnosis and treatment of TB and HIV versus diagnosis and treatment of HIV and viral hepatitis. In Lithuania, the diagnosis and treatment of HIV and viral hepatitis is advanced and generally well implemented. In Lithuania patients undergoing TB treatment receive social support (food vouchers and compensation of travelling expenses) during the ambulatory treatment period, but none of the patients (hepatitis or TB) gets any specific social support after the treatment is completed. Few studies have examined social issues, especially providing support after the completion of treatment.
- Another question asked why the HIV incidence in Estonia for injecting drug users was still high even though harm reduction programmes are common. Additionally, what would be the most important elements to reduce the incidence for IDUs? Although its well know that harm reduction works, it still has a long way to go, especially regarding coverage. Some young drug users and even older users still are not aware of harm reduction services. Additionally, service providers in Estonia are not adhering to guidance recommendations on re-testing especially for PWIDs.
- Changing sexual behaviours for heterosexual transmission was commented as another challenge.
- It was discussed that there could possibly be underreporting of MSM and HIV in Lithuania. Data on MSM is fragmented in Lithuania and the actual number is still unknown due to underreporting. HIV positive MSM in Lithuania are sometimes statistically identified as heterosexual. It was suggested that there should be more MSM-friendly services due to the ongoing challenge of stigma and discrimination within the country.

Afternoon sessions

Summarisation of key points from morning presentations and discussion

In the opening remarks of the afternoon session, based on the discussions from the morning session, it was evident that in Lithuania testing is considered a "medical procedure," that only medical staff can perform and only in healthcare settings. It was then agreed that a meeting could be held in late 2019 with key stakeholders focusing on Lithuania, as well as a new EU project, focusing on testing in low threshold points.

Provider initiated testing

RPLC – scaling-up rapid testing at drug treatment facilities (INTEGRATE pilot project)

Loreta Stonienė (Respublikinis priklausomybės ligų centras, RPLC) provided a brief introduction on RPLC, its services and presented its pilot activities in the Integrate JA. RPLC is a drug addiction treatment facility in Lithuania that provides medical, psychological and social services to people prone to alcohol, tobacco, drugs and gambling and other dependencies. RPLC has five regional centres and online access to services nationwide. The typical patient profile at RPLC is a 50+ year old, alcohol-dependant male. In ECDC's overview, this group is classified as a high-risk group for undiagnosed HIV. Thusly, through the INTEGRATE JA, RPLC centres implemented a pilot project, beginning March 2019, on expanding testing for their clients. Under this pilot project, all patients visiting any of the 5 centres will be offered HCV and HIV testing using rapid point of care tests. All reactive tests would then be followed by a confirmatory antibody test and the patient will be linked to care for further tests and treatment. Since the inception of this pilot project, the centres have conducted 500 tests within a 3-month period. These results were relatively promising, and because of this, pilot programme coordinators are developing strategies to scale this project to other regional centres through staff trainings, knowledge sharing and securing funding for tools.

Discussion

- A recurring theme for discussion was on knowledge sharing and dissemination of information. One audience member highlighted that sharing evidence-based research on the benefits and outcomes had yielded positive results locally and could be widely publicised and used to garner the political support required to secure funds from the government. Another audience member also shared that by having open door events and information seminars explaining how alcohol abuse was a gateway to risky behaviour that exposed them to HIV and viral hepatitis, they managed to improve test uptake.
- An example of how promotion resulted in increased rates of testing was shown during European Testing Week when RPLC ran radio broadcast ads promoting their testing services. They saw a distinct increase in the number of tests, and even healthcare professionals were tested.
- To close of the discussion, an RPLC member stated that the next step would be to take key learnings from the pilot and integrate this as part of the standard care offered at RPLC.

Why indicator condition-guided HIV testing?

Ann Sullivan (Chelsea & Westminster Hospital/Integrate) presented an introduction on indicator condition (IC) guided testing, how the evidence was gathered through the HIDES 1 & 2 studies and results from work through the OptTEST project. HIV IC-guided testing is a provider-initiated approach to HIV testing. Indicator conditions are conditions associated with an excess risk of being HIV-positive and

as such is an opportunistic health care focused strategy. Studies have shown that routine HIV testing is cost effective when the undiagnosed HIV prevalence in the target group >0.1%. IC-guided HIV testing is included in several HIV testing guidelines but are implemented variably. To gather the evidence to support IC-guided testing, the HIV Indicator Diseases Across Europe Study – Phase 1 (HIDES I) was a piloted in 17 sites in 14 European countries. In the study, HIV testing was routinely offered to all patients aged 18-65 year olds of unknown HIV status presenting for care with an IC. The study explored the evidence for conditions associated with undiagnosed HIV prevalence. The results showed that IC testing detected an HIV prevalence of 1.8% and showing that IC-guided HIV testing is an acceptable, feasible and effective strategy to detect undiagnosed HIV infection, and potentially earlier detection. An analysis of the potential missed opportunities in the 5 years preceding HIV diagnosis identified that 20% of those patients had previous potentially HIV-related presentations to care, 23% had more than one presentation and of the 11% that had been hospitalised, 71% had an AIDS diagnosis or infection.

In the second phase of the study (HIDES II), more centres and more diseases were included to pilot IC-guided testing. An audit of the routine offers of an HIV test to patients (18-65 years of age) presenting with an IC was also conducted on retrospective data from 100 patients or the previous 12 months. Of the 49 audits from 23 centres, the study found a HIV prevalence of 2.5% [95%CI 2.2 – 2.8] and that mononucleosis-like syndrome had the highest prevalence rates (almost 6%). HIDES 2 found that testing rates for HIV ICs remain low in some regions of Europe despite high prevalence rates, reflecting missed opportunities for earlier HIV diagnosis, treatment and care.

In order to address these missed opportunities for testing, the OptTEST project further piloted the impact and feasibility of IC-guided testing with three-select ICs in addition to developing learning tools specifically for health care staff in non-specialty settings on how to conduct IC-guided testing.

Discussion

- There was discussion on ways to overcome stigma amongst health care staff. Suggestions included education/training and implementation of provider-initiated testing supported by IC guided testing. In previous case examples, staff training and involvement in an HIV programme were shown to reduce perceived stigma.
- Some audience members added that adding HIV testing on top of already heavy workloads could be met with some reluctance. However, it was also emphasised that IC-guided HIV testing is a way to avoid any risk assessment and asking personal questions, and rather include HIV testing as routine activity.
- A push for more online training materials for staff, which also contain case studies, could show staff how routine HIV testing was beneficial.

<u>Introducing IC-guided testing at a hospital clinic (INTEGRATE pilot project)</u>

Raimonda Matulionytė (Department of Infectious Diseases and Dermatovenerology, Faculty of Medicine, Vilnius University) Of the partners in Lithuania, the Vilnius University Hospital Santaros Klinik (VULSK), is implementing a pilot following indicator-condition (IC) guided HIV testing of all patients at

both a STI and dermatovenerology clinic. Testing for HCV is also being implemented for all patients presenting with an STI. Interim pilot results have seen an increase in testing rates and that gaps exist among dermatological and venereal conditions in consideration as indicators for HIV testing. Additionally, as part of their work in Integrate, an anonymous physician survey on knowledge of HIV testing (including IC-guided testing) and barriers to testing was conducted amongst various health care institutions in Lithuania. A total of 371 physicians completed the survey. Results showed that IC-guided testing is still not a habitual method for Lithuanian physicians to offer HIV testing and lack of knowledge of ICs is one of the main barriers to provider-initiated testing.

Discussion

- One recurring point in the discussion was the need to expand the list of indicator conditions.
- Within the INTEGRATE network, research into national clinical guidelines revealed Lithuania had the lowest number of guidelines recommending or mentioning HIV, also showing that there was a barrier to reaching the first 90.
- Results from the survey show that doctors focus more on risky behaviour and situations and perceived no barriers to testing. Younger resident doctors appeared more aware of HIV education with a higher likelihood to conduct an HIV test on a patient presenting with an IC condition. On the other hand, GPs appeared to be more reluctant to conduct HIV testing, citing lack of financial incentives and high cost of tests as reasons for this.

HIV testing in Estonia – engaging health care

Kristi Rüütel (National Institute for Health Development) presented the experience of implementing HIV testing in health care settings in Estonia. In Estonia, national guidance on HIV testing was developed in 2012 and included regulation that HIV tests should be recommended for all patients regardless of age in case of indicator diseases and/or belonging to a risk group, especially within high prevalence areas in Estonia. The national guidance also states that HIV testing is free of charge for those with or without national health insurance and GPs have unlimited funds to test. However, a study on HIV testing among GPs found that in 2018, less than 1% of patients accessing care were tested. The study also measured barriers to HIV testing among GPs and found the biggest barriers were lack of awareness of the resources the government has made available for HIV testing and fear that GPs would not be able to answer patients' questions related to HIV. The National Health Insurance has formed a working group that aims to optimise HIV-testing among GPs to incentivise those who test and selecting ICs to be tested by GPs.

Conclusion and Wrap-up

Presentation of JA INTEGRATE

Stine Finne Jakobsen (CHIP/Integrate) provided an introduction to the INTEGRATE Joint Action. The overall objective of INTEGRATE, is to increase integrated early diagnosis and linkage to prevention and care of HIV, viral hepatitis, TB and STIs in EU member states by 2020. The method to achieve the objective is to examine existing tools for prevention, testing and linkage to care for HIV, viral hepatitis, TB and STIs and evaluate them to see if they can be adapted, extended and implemented for one or

more of the four diseases in selected pilot countries. The national stakeholder meeting is part of the proposed interventions in the pilot countries to help establish dialogue in improving testing strategies.

Challenges, proposed solutions and recommended next steps

As a wrap-up of the day, all participants introduced themselves and identified their main take-home message from the discussions.

All the participants' comments have been summarized, grouped into themes and merged with the areas identified throughout the meeting and discussions where actions are needed to move the HIV treatment and care field forward in Lithuania

Normalisation and Stigma:

- **Promote testing uptake among people at high risk:**
  (1) Conduct open door events, information seminars and radio broadcast advertisements – to promote testing services and inform about risky behavior and exposure
  (2) Implement education/training to reduce perceived stigma among health care professionals and to establishing trust between the doctor and patient
  (3) Establish more MSM-friendly services due to the ongoing challenge of stigma and discrimination within the country to facilitate more testing in this population

Diversification of Testing Strategies

- **Scale-up HIV testing by GPs and primary health care (PHC):**
  (1) Simplify the reporting system and pre-test counselling requirements for physicians providing HIV testing to save time and resources
  (2) Implement a funding model similar to the existing model for pregnant women where GPs receive incentives for testing and for referring pregnant women to treatment and the tests are covered by the National Health Insurance Fund.
- **Changing the legislation to de-medicalize testing and allow non-clinical providers to conduct point of care tests – possible steps:**
  (1) Work to (re)define point of care testing as screening
  (2) Consider launching a pilot project – like in France - where community health workers provide HIV testing to help gather the evidence to provide the rationale to change the law and show that no patient harm is caused by community health workers and that linkage to care may even be better than linkage from physicians.
- **Broaden implementation of provider-initiated testing – routine and HIV IC guided testing - in hospitals and clinics**
  (1) Organize training for staff at hospitals to disseminate information on routine and IC-guided testing (Use conducted staff survey to improve results), e.g. online training materials and case examples showing how routine HIV testing is beneficial.
  (2) Expand the offer of multiple disease testing for HBV, HCV and HIV and the provision of comprehensive care. For instance, if a person tests HBV negative then they should be offered HBV vaccination
  (3) Advocate for including recommendations for HIV testing in relevant medical speciality guidelines

- **Focus testing on high risk populations:**

(1) Strengthen coordination/cooperation between NGOs and healthcare on active outreach testing activities, to reach populations not attending health care facilities, e.g. Roma camps
(2) Introduce a peer-to-peer approach to get more people tested
(3) Focus on testing in low threshold service sites
(4) Explore the possibility to enhance testing of partners of PLHIV
(5) Support self-testing as a way to overturn barriers for some hard to reach groups
(6) Closely follow and map harm reduction coverage and service providers' adherence to guidance recommendations e.g. on re-testing especially for PWIDs

- **Assess Cost-effectiveness of testing strategies:**

(1) Conduct a cost-effectiveness analysis in Lithuania on the availability and accessibility of testing to identify the optimal testing strategies
(2) Assess the cost-effectiveness of conducting a second HIV test during pregnancy
(3) Explore the relevance of geographical based testing strategies based on prevalence rates as implemented in Estonia

Linkage to care and treatment rates:

- **Strengthen the health system's focus on linkage to care rates to raise the percentage on treatment:**
  (1) Speed up lab work and shorten turn over time for testing results
  (2) Address the issue of capacity to ensure that national standards are in fact implemented across the country
  (3) Support linkage to care from decentralised testing sites, General Practitioners, Primary Health Care and self-testing
  (4) Make sure that health care providers in the regions are focused on improving linkage to care, have up-to-date information and provide treatment of high quality equally to the capital region
- **Support patients to be linked to care and continue in treatment:**
  (1) Focus on the challenge of how to motivate people to link to care and continue in treatment
  (2) Address the social issues of vulnerable groups, e.g. homeless TB or hepatitis patients, that makes linkage to care complicated and secure adequate social support during and after completion of treatment

Surveillance and collaborations

- **Strengthen documentation and data:**
  (1) Produce solid national data and statistics to support making an argument for testing and for surveillance
  (2) Work to facilitate improved sharing of data
  (3) Strengthen documentation and dissemination of local results and outcomes for information and knowledge sharing purposes and to garner the political support and desired funding
- **Cross sector collaboration:**

(1) Strengthen the collaboration between NGOs and healthcare professionals to be able to provide services within in a comprehensive package and take advantage of what stakeholders can bring to the table.
(2) Use the existing foras, e.g. Coordination Council, Action Plans, Laws – and a new in the MoH with stakeholders
(3) Prioritize intercommunication between organisations and settings, e.g. building bridges between prison system-health care system,

Funding

- **Secure effective use of existing funds**

(1) MoH must target the use of funding to achieve most effective outcome
(2) Focus on funding to low threshold sites in the countryside to secure better operation
(3) Focus on funding/incentives for GPs to test more patients (linked with training and information)
(4) Secure funding for HIV testing of all TB patients (now 80%)
(5) Keep need needle and syringe exchange programmes in place to maintain prevention high
(6) Scale up staff training and education on prevention

National stakeholder collaboration - the way forward

The National Stakeholder Meeting on current testing strategies for HIV, viral hepatitis and sexually transmitted infections in Lithuania brought a range of issues, barrier and possible solutions to the fore as the participants engaged in discussions. A main outcome of this was complete agreement of the importance of strong stakeholder collaboration to pursues the same goals without barriers.

Jurgita Pakalniskiene from the Division of Health Promotion in the Ministry of Health's Department of Public Health committed to arranging a meeting with key stakeholders to get together once more and continue the discussions and start implementations for change.

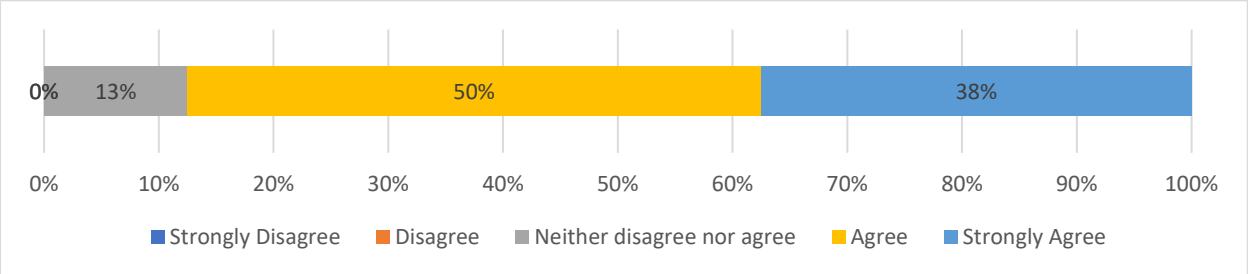
2. Meeting Evaluation

At the conclusion of the meeting, a short paper questionnaire was distributed to all audience members to provide feedback on the meeting. In total, 16 attendees completed the evaluation. Of the respondents, 44% were health care professionals, 13% were community health workers, 19% included social workers, psychologists and public health experts, 25% were other health-related occupations including government workers. In terms of occupational setting, 56% worked in a hospital/clinic,19% worked in a public health institution as well as in community-based organisations, 6% worked in other health-related setting and 19% worked in the government setting.

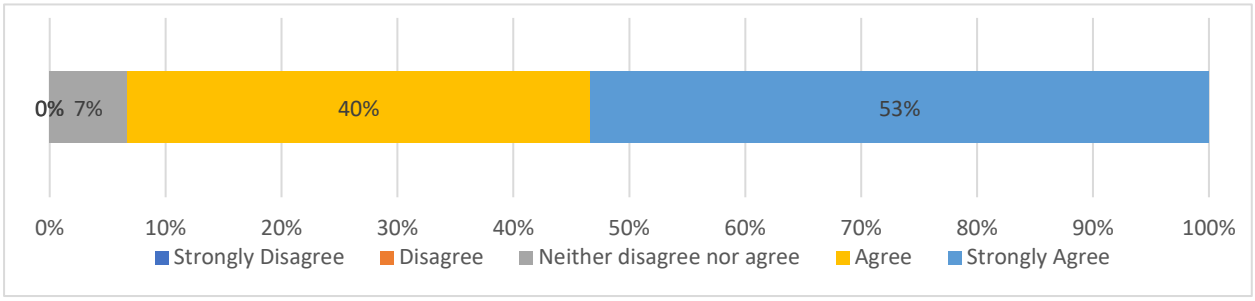
Attendees were asked to provide overall feedback on the meeting by grading their agreement based on a 5-point scale on eight statements: a score of 1 meaning they Strongly Disagreed with the statement to 5 meaning they Strongly Agreed with the presented statement.

Generally, 88% of the respondents agreed that the meeting met their expectations with 38% of all respondents strongly agreeing. Over half of the respondents strongly agreed that the topics and presentations chosen were appropriate. 94% of the respondents agreed that the sequence of topics was well arranged, with half strongly agreeing and only 6% disagreeing. 94% agreed that the presenters were engaging and well prepared, with 56% strongly agreeing to this. The majority (88%) agreed that the moderated discussions were useful and relevant, and all respondents reported that there was good opportunity to discuss and network during breaks. Although a large number of respondents agreed (81%) that there was a good representation of national stakeholders, 13% reported neither disagreeing or agreeing and 6% reported disagreeing with the statement. The majority of the respondents (75%) agreed that decisions/action points were made on how to move forward, with 47% strongly agreeing.

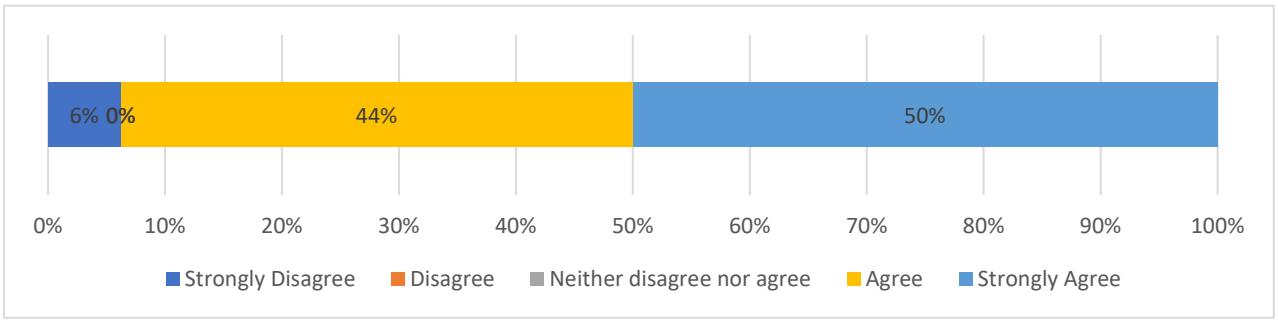
1. **The meeting met my expectations.**



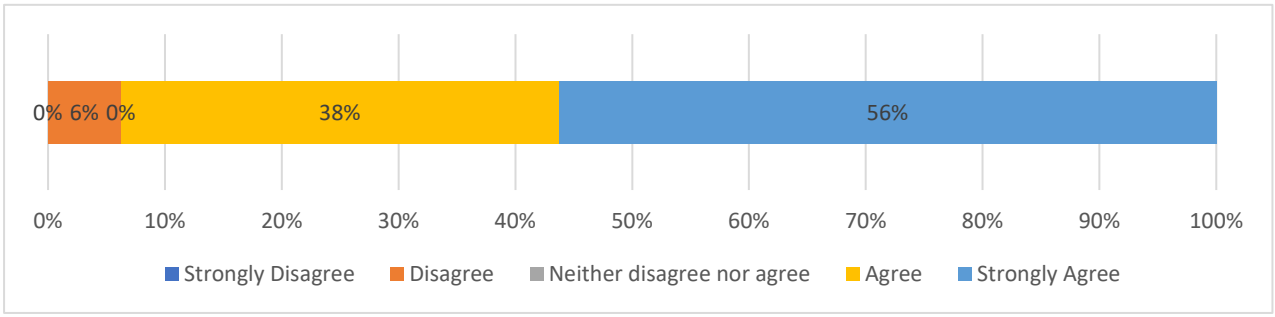
2. **The topics and presentations chosen were appropriate and useful.**



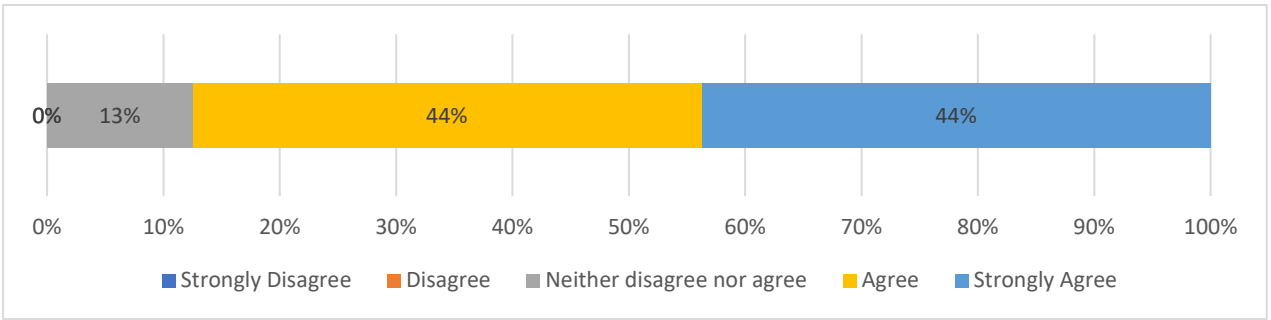
3. The sequence of topics has been well arranged.



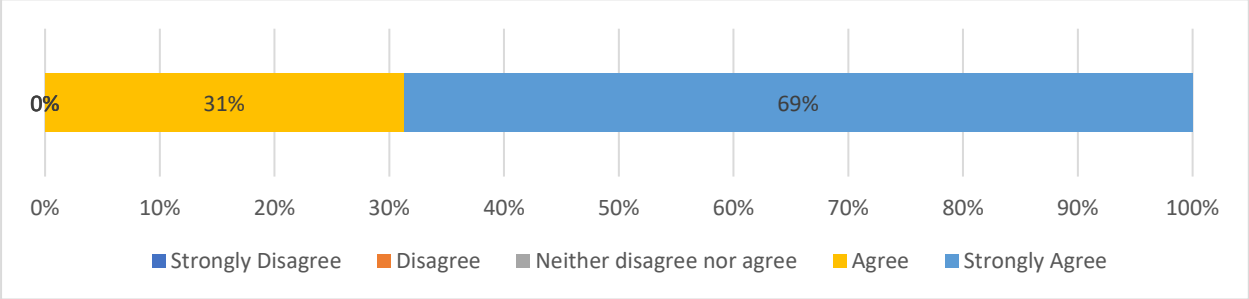
4. The presenters were engaging and well prepared.



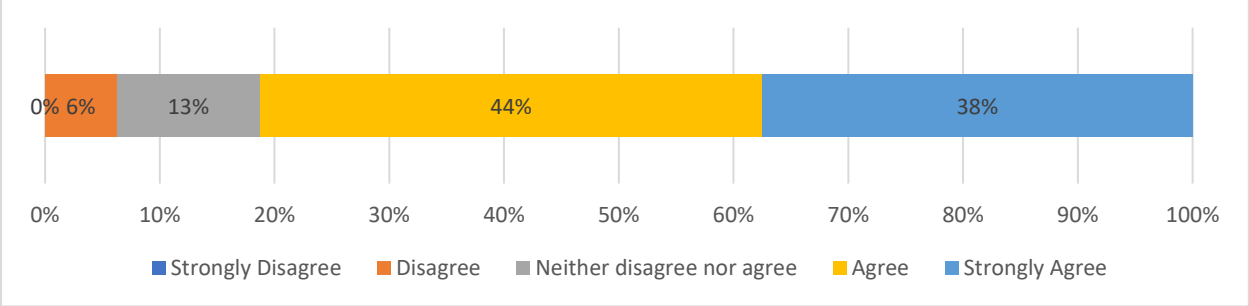
5. The moderated discussions were useful and relevant



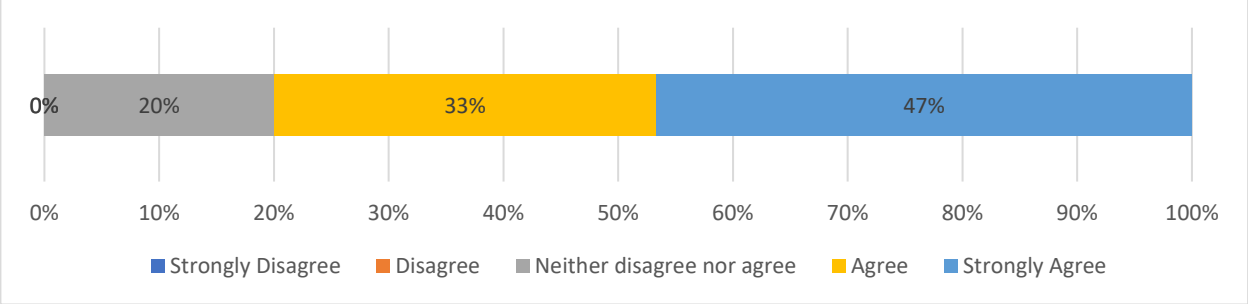
6. There was a good opportunity to discuss and network during breaks.



7. There was a good representation of all National Stakeholders (NGOs/clinics/policy makers/experts etc). at the meeting.



8. Decisions/action points were made on how to move forward.



Respondents could also provide comments on topics that they would have liked to see and general comments on the meeting.

One audience member commented: "*Only one NGO from LT presented, the other[s] were missed.*"

Report topics missing included:

"Other good practice examples from other countries"
"A lot about linkage to care"
"Not only about testing HIV, HBV, and etc, but linkage to care"

"Latvian situation"
"Diagnostic advantages. All topics were relevant and couldn't make exception, but maybe it would be useful to discuss more financial opportunities of country..."
"Financing of the discussed (best practice - only Estonia)"
"Combined testing of CBO as if possible."

Reported 'best aspects' of the meeting included:

"Good presenters"
"Possibility to share about evidence based methods"
"NGO including the national stakeholder meeting discuss"
"Showing expectations of different countries"
"The idea of starting one testing for more infections"
"Statistics"
"Knowledge"
"HIV testing of health care. Other projects and results"

Reported ways to improve the meeting included:

"More microphones, longer break in the first half of the marketing, introduce [INTEGRATE] project at the beginning"
"More discussions"
"Situation timing according to program"
"More specialist in order to have a broader discussion"

Appendix A. Agenda

Time	Agenda	Presenter/Moderator
9.00-9.05	**Welcome note by representative of Ministry of Health of the Republic of Lithuania**	Jurgita Pakalniskiene, MoH, Department of Public Health, Division of Health Promotion
9.05-9.10	**Welcome remarks and introductions**	Raimonda Matulionytė, VULSK/Integrate (Lithuania)
	Towards Integrated Testing	Moderators: 1) Ann Sullivan, ChelWest/Integrate (United Kingdom) 2) ULAC -TBC
9:10-9:30	**ECDC evidence-based public health guidance on HIV, hepatitis B and C testing in the EU/EEA-- an overview:** • Main topics and guidance *5 minutes for questions*	Lina Nerlander, European Centre for Disease Prevention and Control (Sweden)
9:30-9.50	**Situational assessment - Lithuania:** • Current national testing policy on HIV, viral hepatitis and STIs • Current testing practices in specific settings • Planned policy updates *5 minutes for questions*	Jurgita Pakalniskiene, MoH (Lithuania)
9:50-10:10	**Community perspective on national testing policies:** • Demetra - case example • Experiences implementing national policy in community settings • Limitations and barriers to providing services *5 minutes for questions*	Kestutis Rudaitis, Demetra (Lithuania)
10.10-11.00	**Discussion of testing policies and practices in Lithuania** • How can multi disease testing be scaled-up? • What are the barriers? • What needs to be changed? • How far is the reality from the ECDC guidance?	
	Cost effectiveness of testing	Moderators: 1) Stine Jakobsen, CHIP/Integrate (Denmark)

		2) National Health Insurance Fund - TBC
11.00-11:20	**Cost effectiveness of testing strategies – the OptTEST study:** • What is a modelling approach and what key data is required? • What results were found in Estonia, France and Spain *5 minutes for questions*	Yazdan Yazdanpanah, Inserm (France)
11.20-11.40	**Cost effectiveness of testing - Estonia as a case:** • The OptTEST experience (data collection, calculations, results) • Application of results, policy process in Estonia *5 minutes for questions*	Kristi Rüütel, TAI (Estonia)
11:40-12:30	**Discussion:** • Cost-effectiveness of testing in Lithuania	
12.30-13.30	***Lunch***	
13:30-13:40	**Summarisation of key points from morning presentations and discussion**	Morning moderators
	Provider Initiated testing	Moderators: 1) Yazdan Yazdanpanah, Inserm (France) 2) Raimonda Matulionyte, VULSK/INTEGRATE (Lithuania)
13.40-14.00	**RPLC - scaling-up rapid testing at drug treatment facilities – (Integrate pilot project)** • HIV rapid tests for clients • Hepatitis rapid tests *5 minutes for questions*	Loreta Stoniene, RPLC/Integrate (Lithuania)
14.00-14.20	**Why Indicator Condition-guided HIV testing?** • Evidence of cost-effectiveness • The OptTEST training module *5 minutes for questions*	Ann Sullivan, ChelWest/Integrate (United Kingdom)
14.20-14.40	**Introducing IC-guided testing at a hospital clinic (Integrate pilot project)** • HIV testing at a dermatovenerology Clinic • Hepatis testing of STI patients *5 minutes for questions*	Raimonda Matulionytė, VULSK/Integrate (Lithuania)
14.40-15:00	**Estonian case example:**	Kristi Rüttel, TAI (Estonia)

	• HIV testing in General Practitioners • Engaging professional societies • Changes in payment system *5 minutes for questions*	
15:00-15.30	***Coffee break***	
15:30-17.30	**Discussion of main points of the day – Conclusions and Wrap-up**	Moderators: 1) Ann Sullivan, ChelWest/Integrate (United Kingdom) 2) Jurgita Pakalniskiene, MoH (Lithuania)
15:30-15:45	**Presentation of JA Integrate -** Joint Action on integrating prevention, testing and linkage to care strategies across HIV, viral hepatitis, TB and STIs in Europe	Stine Jakobsen, Integrate/CHIP (Denmark)
15:45-17:00	**Discussion of main points of the day** • Conclusions • Consensus on national priorities • Main action points and next steps	Moderators of the day
17:00	**Wrap-up and goodbye**	Raimonda Matulionytė, VULSK/Integrate (Lithuania)

Appendix B. List of Participants

INTEGRATE Partners	
Agne Simkuuaite-Lazecke	Centre for Communicable Diseases and AIDS
Algirdas Šumila	Vilnius University Hospital Santaros Klinikos, Centre of Dermatovenerelogy/ INTEGRATE
Ann Sullivan	Chelsea Westminister/ INTEGRATE
Arūnas Petkevičus	Hospital of Lithuanian University of Health Sciences, Department of Skin and Venereal Diseases
Ausra Širvinskienė	Republic Centre for Addictive Diseases, Klaipeda branch/ INTEGRATE
Birute Semenaite	Prison Department Under the Ministry of Justice of the Republic of Lithuania
Dovile Mačiulyte	Republic Centre for Addictive Diseases, Department of Methodical Guidance and Monitoring/ INTEGRATE
Edita Davidavičienė	Lithuanian Tuberculosis Registry; Vilnius University Hospital Santaros Klinikos
Eglė Lydeikaite	Republic Centre for Addictive Diseases, Klaipeda branch/ INTEGRATE
Girvydas Guoblys	Association ”I can live” Coalition
Grazina Aleksaitiene	Support Fund ”Rigra”
Ilona Kušlevičiutė	National Public Health Surveillance Laboratory/ INTEGRATE
Jurgita Pakalniškienė	Ministry of Health of the Republic of Lithuania, Department of Public Health, Division of Health Promotion, senior specialist
Justina Šimanauskaite	Republic Centre for Addictive Diseases, Klaipeda branch/ INTEGRATE
Kestutis Rudaitis	Association of Women and Their Families Affected by HIV and AIDS ”Demetra”
Kristi Rűttel	TAI
Lauren Combs	CHIP/ INTEGRATE
Likatoućius Giedei	Demetra
Lina Kotoviene	Central Policlinic, Department of Contagious diseases and Dermatovenerology
Lina Nerlander	ECDC
Loreta Stoniene	Republic Centre for Addictive Diseases, Klaipeda branch/ INTEGRATE
Meaghan Kall	Public Health England/ INTEGRATE
Raimonda Matulionyté	Vilnius University Hospital Santaros Klinikos, INTEGRATE
Saulius Ćaplinskas	Centre for Communicable Diseases and AIDS/Integrate
Snaigė Kokanauskienė	Hospital of Lithuanian University of Health Sciences Kauno Klinikos, Romainiai Tuberculosis Hospital
Sonata Varvuolytė	The Society of Lithuanian General Practitioners
Sophie Nash	Public Health England/ INTEGRATE
Stine Finne Jakobsen	CHIP/ INTEGRATE
Tadas Raudonis	Vilnius University Hospital Santaros Klinikos, Centre of Dermatovenerelogy/ INTEGRATE
Vaida Kirulaitiene	Republic Centre for Addictive Diseases, Klaipeda branch/ INTEGRATE
Vilma Pocienė	Republic Klaipeda Hospital, Department of Dermatovenerology
Vilma Uždaviniene	National Health Insurance Fund Under the Ministry of Health
Vitalija Gelzinyte	Central Policlinic, Department of Internal Audit
Yazdan Yazdanpanah	Inserm
Ždrunė Baigiene	National Health Insurance Fund Under the Ministry of Health