

INTEGRATE Joint Action First Regional Workshop

Hotel Puławska Residence, Warsaw, Poland
17-18 June 2019

Meeting Report

First Regional Workshop (Work Package 8 – Capacity Building – Project INTEGRATE): Testing in Community and in Healthcare Settings. Understanding needs and barriers for testing and linkage to care for people living with HIV, hepatitis and/or TB.

Background information:

INTEGRATE Joint Action (HP-JA-2016) 3rd Health Programme and 2016 Work Programme is a three-year project (2017-2020) receiving 80% co-funding under the third EU Health Programme. It brings together 29 partners from public health institutions, hospitals, NGOs and universities in Croatia, Denmark, Estonia, Greece, Hungary, Ireland, Italy, Lithuania, Malta, Poland, Romania, Slovakia, Slovenia, Spain, UK and Serbia. The main aim of the Joint Action is to integrate early diagnosis and linkage to prevention and care of HIV, viral hepatitis, TB and STIs in EU countries by 2020.

Total budget: 2,4 mill Euro (80% EU).

Overall objective:

To increase integrated early diagnosis and linkage to prevention and care of HIV, viral hepatitis, TB and STIs in EU member states by 2020. INTEGRATE builds on a number of previous and current EU-funded projects in which different INTEGRATE partners are also active (Quality Action, OptTEST, EuroHIVEDat, HA-REACT, HEPCARE).

The aim:

To improve the understanding and implementation of integrated activities related to early diagnosis of HIV, viral hepatitis, TB and/or STIs and linkage to prevention and care in partner countries.

- Work Package 8 should – like WP4 – be seen as a cross cutting WP aiming to identify training needs among partners and organize 3 regional workshops (in Poland, Italy and Estonia) during the project period. The meetings should enable a process of collaboration in the countries and should be successful in linking key stakeholders together.
- The regional workshops will include a national stakeholder meeting to bring together service providers and key actors at national level, based on the main needs of the hosting country. The meetings are unique opportunities for collaboration among representatives of public health,

clinicians and community and national decision makers. The goal is to facilitate national changes and improvements in testing and linkage to care.

First Regional Workshop has been divided into two parts:

- day 1 – June the 17th - international meeting of INTEGRATE partners
- day2 – June the 18th - national stakeholders meeting

REGIONAL WORKSHOP

17 June 2019

The main objective of the first day of the Warsaw meeting was:

- to strengthen the capacity of health professionals and service providers in implementing integrated testing and linkage-to-care for the newly diagnosed and living with: HIV, hepatitis and/or TB, as well as for members of key populations. The scientific basis for that were ECDC guidelines on HIV, hepatitis B and C testing in the EU/EEA countries and Dublin Declaration [European Centre for Disease Prevention and Control and Public health guidance on HIV, hepatitis B and C testing in the EU/EEA – An integrated approach. Stockholm: ECDC; 2018].

Day 1: Monday, 17 June 2019

Regional workshop for Integrate JA partners: Testing in community and healthcare settings. Understanding needs and barriers for testing and linkage to care for people living with HIV, hepatitis and/or TB.

08:00-08:30	Registration and coffee
08:30-09:00	<p>Welcome & Opening remarks – 15 min</p> <p>Anna Marzec-Bogusławska, Director of the National AIDS Centre Dorthe Raben, Centre of Excellence for Health, Immunity and Infections (CHIP/REGIONH), Coordinator of INTEGRATE project</p> <p>Introduction to the workshop aims and objectives – 15 min</p> <p>Iwona Wawer, National AIDS Centre, Co-Leader of Work Package 8 (<i>Capacity building</i>) Nadia Gasbarrini, Villa Maraini Foundation, Leader of Work Package 8</p>
09:00-09:30	<p>Theme 1: Introduction to Dublin Declaration and ECDC public health guidance on HIV, hepatitis B and C testing in the EU/EEA countries</p> <p>Anastasia Pharris, European Centre for Disease Prevention and Control (ECDC)</p>
09:30-10:30	<p>Theme 2: Overcoming barriers in integrated testing in community settings – the European perspective</p> <p>Overcoming legal, regulatory, practical and financial barriers in integrated testing in community settings – 30 min</p>

	<p>Daniel Simões, GAT Portugal</p> <p>Integrated community testing for key populations – the Italian experience – 15 min</p> <p>Elisabetta Teti, Villa Maraini Foundation</p> <p>Discussion – 15 min (moderator: Daniel Simões, GAT Portugal)</p>
10:30-11:00	Coffee break
11:00-12:30	<p>Theme 3: IC-guided testing in GP and clinical settings</p> <p>Indicator condition guided HIV testing in GP and clinical settings – 45 min</p> <p>Presentation: Ann Sullivan, Chelsea & Westminster Hospital, United Kingdom</p> <ul style="list-style-type: none"> • <i>What are Indicator Conditions</i> • <i>How can this be set-up in hospitals and general practice (Pathway tool)</i> • <i>Training for health care staff (online module)</i> <p>Implementing the Opt TEST project – country examples – 30 min</p> <p>Assoc. Prof. Justyna D. Kowalska, Advisory Board INTEGRATE, Poland – 10 min</p> <p>Raimonda Matulionyte, Lithuania – 10 min</p> <p>Greco Victor, Romania – 10 min</p> <p>Discussion – 15 min (moderator: Ann Sullivan, Chelsea & Westminster Hospital, UK)</p>
12:30-13:30	Lunch break
13:30-15:00	<p>Theme 4: Stigma as a barrier for testing and linkage to care and sustainability – focus on service provision and staff</p> <p>Barrie Dwyer, Programme Officer – Education & Training, ESTICOM</p> <ul style="list-style-type: none"> • Defining stigma • Building awareness of the drivers of stigma and discrimination and helping to create non-judgmental services • Engaging and involving the users of your services
15:00-15:15	Introduction to the group work
15:15-15:30	Coffee break
15:30-17:00	<p>Work in 2 Groups: on developing strategies to address the needs and barriers for testing and linkage to care faced by:</p> <ul style="list-style-type: none"> • Health care providers (group moderator Ann Sullivan) • Community-based services (group moderator Daniel Simões) • Cross cutting issues of Stigma (Barrie Dwyer)
17:00-17:45	<p>Feedback from Groups to Plenary – 35 min</p> <p>Wrap up of day 1 – 10 min</p>

Anne Raahauge, Centre of Excellence for Health, Immunity and Infections (CHIP/REGIONH)	
Iwona Wawer, National AIDS Centre, Co-Leader of Work Package 8	
18:30	Dinner

Opening Session

The meeting was opened by Anna Marzec-Bogusławska - the Director of the National AIDS Centre - who greeted the audience and underlined the importance of the Joint Action European projects and the implementation of the tasks planned. Dorte Raben - Centre of Excellence for Health, Immunity and Infections (CHIP/REGIONH), Coordinator of INTEGRATE project - made the introduction to the workshop aims and objectives. Iwona Wawer - National AIDS Centre, Co-Leader of Work Package 8 (Capacity building) Nadia Gasbarrini, Villa Maraini Foundation, Leader of Work Package 8 - made a short introduction to the meeting.

Theme 1: Introduction to Dublin Declaration and ECDC public health guidance on HIV, hepatitis B and C testing in the EU/EEA countries. Anastasia Pharris, European Centre for Disease Prevention and Control (ECDC).

Presentation entitled: "Introduction to Dublin Declaration and ECDC public health guidance on HIV, hepatitis B and C testing in the EU/EEA countries" encompassed the main objectives of integrated testing:

- reduction to zero of new HIV infection and AIDS-related deaths;
- in case of hepatitis B and C, 90% reduction in new cases and 65% reduction in mortality.

ECDC representative highlighted important issues that concern mentioned infectious diseases that emerged in the last few years: a large percentage of estimated undiagnosed people infected with HIV – 15%, HBV – 40-85% and for HCV – 20-91%; a vast percentage of new HIV infection as late diagnosis (49% cases, more common among women, older adults, people who inject drugs, heterosexuals and some migrants); a long time flow from HIV infection to diagnosis (mean 2.9 years); There is a lower percentage of patients who are linked to care within 12 months after the diagnosis due to a long confirmatory testing time period observed in some countries.

ECDC representative raised three main points:

1. Who should be tested?
2. How often?
3. Where?

Q1 and "Who should be tested?": ECDC guidelines mention several key populations who should be covered with testing e.g.: men who have sex with men (MSM), transgender people, sex workers (SW), people who inject drugs (PWID), inmates, migrants, homeless people, heterosexuals who show risky type of sexual behaviour or who are infected with other STIs (and thus are more prone to HIV infection), sexual partners of people of higher risk of infection, haemodialysis patients and those who underwent blood/surgery/transplant before 1992. Due to the risk of stigma related to HIV infection, in the guidelines ECDC suggested to elaborate a boarder strategy of HIV testing and to indicate various other ideas on who should be tested for HIV. Firstly, HIV testing should not be related with risky type of behaviour but should be focused on population risks for e.g. we can test people depending on their age – "birth cohort", we can

test high prevalence population (more than 1%) for such infections as HIV, HBV or HCV – we can create our “geographical cohort” of population who should be tested for HIV with intensified frequency (high prevalence > 1%). Pregnant women should be tested obligatory. It means all pregnant women no matter of risky type of behaviour or of higher risk of HIV infection. The second kind of HIV testing strategy is related to different clinical conditions which can be treated as symptoms of HIV infections named as “HIV indicator condition” (for e.g. if patient is diagnosed with mononucleosis, he/she should have HIV test done, because it was proved that this disease can be related with HIV infection). Other reason to provide an HIV test are clinical symptoms of hepatitis or co-infection with HBV or HCV.

Q2 and “How often testing should occur”: once in 12 months at least - depending on vaccination status and ongoing risks as well as health hazards taken up by a person interested in getting tested.

Q2 and “Where”: There are two possible approaches to do the test:

- in health care premises (primary health care, hospitals, emergency units, STI clinics, antenatal care, penitentiary institutions, pharmacies, drug treatment centres, tuberculosis (TB) services),
- in community settings (community-based testing facilities and venues, drug and harm-reduction units, streets, clubs). Testing at the community level is an excellent opportunity to reach hard-to-reach populations among which a lot of infections and high incidence of HIV/HBV/HCV are noted.

Core principles for efficient testing include: national testing strategy; normalised testing in health care settings; training and education for the providers.

ECDC representative underlined some good examples of self-sampling (self-collecting blood or saliva samples which are sent to a laboratory that issues the results by phone or online messages) as well as self-testing (patients collect the sample and perform a rapid test). The challenge is a low level of linkage-to-care in the group of self-tested clients, so the instruction /information on linkage-to-care should be included in the testing kits leaflet available in different languages.

ECDC representative admitted that the development of self-testing monitoring is needed in the near future. Regarding self-testing there is a lot of evidence coming from MSM group which indicates that this method is likely to be accepted and it increases HIV testing uptake. Moreover, this method is getting more and more popular in Europe due to the sale of CE kits in pharmacies.

Theme 2: Overcoming barriers in integrated testing in community settings – the European perspective **Daniel Simões, GAT Portugal.**

The expert emphasized the need to define country-specific barriers for integrated testing e.g.: legal, regulatory, financial or practical and to determine where they occur e.g.: among policy makers, sponsors, target populations, medical staff, lab personnel, public health professionals, community organisations or the society. The expert further stressed out the need to define the decision makers who could make a change and give response to the challenges.

Although community-based testing has been present during the latest twenty years, many countries lack regulations on it which means that most tests must be performed by medical personnel (as the only entitled group). Additionally, several non-governmental organisations face a financial barrier to employ medical staff to provide testing. As a result, Europe is left behind as far as innovative approaches are concerned.

In many countries HIV is the only infection that receives sustainable budgeting. It is much more difficult to secure sustainable financing in case of hepatitis, and especially in case of non-formal testing. The expert underlined the importance of innovative approaches to community testing, self-sampling, self-testing which unfortunately, are not yet implemented in many countries. The primordial role of checkpoints in Southern Europe was mentioned due to their contribution to testing key population members e.g. MSM and to reporting national data to ECDC. Many EU Member States experience lack of funds for prevention. It is perceived as the main barrier for integrated testing in community settings. Although each country has committed itself to comply with the Dublin Declaration, many MS indicate difficulties in renegotiating national budget especially for community-based disease prevention. According to the expert the major barrier in integrating testing is the lack of data on the continuum of care among key populations. For some key populations such as IDU the paucity of data may be linked with behavioural problem of addiction to psychoactive substances which means focusing on getting drugs rather than on seeking treatment and linkage-to-care as well as concentration of life energy of IDU and migrants on survival in difficult conditions rather than on health issues. The lack of data on the continuum of care concerns the group of migrants who remain a hard-to-reach group. The expert concluded that interventions targeting key populations do not only concern a test but should also be cover linkage-to-care as the most beneficial to the well-being of key population members. In order to be able to reach 90-90-90 all stakeholders (including the peers) have to work hand-in-hand and measure the results because cost-effective does not mean affordable. Integration of services really works because it overlaps key populations – there are no MSM, no IDU, etc just people.

Integrated community testing for key populations – the Italian experience – Elisabetta Teti, Villa Maraini Foundation

The Italian expert presented the experience of Villa Maraini Foundation in providing community testing for HIV and HCV through a mobile unit. The activity addresses hard-to-reach populations of drug users, LBGT and sex workers. Between 2015 and 2018 there were about 4500 rapid tests performed, 1651 of which concerned sex workers. Approximately 50% of them came from Eastern Europe, 23,8% from South America and around 21,9% from Africa.

The testing results indicates a 56,1% HCV Seroprevalence among PWUD, and a 4,3% HIV prevalence among sex workers.

All tests were anonymous and free-of-charge (at the testing level). Linkage-to-care was also provided, through referral of preliminary positive persons to a clinic centre for infectious diseases. A study was conducted by the clinic, to evaluate the HCV treatment adherence rates of PWUD. The study showed that treatment adherence rates are very high, even among active and problematic drug users, while retention in follow up still remains a challenge.

Implementation of the project enabled identifying several barriers concerning HIV and HCV testing among these group of clients such as: lack of knowledge, physical and psychological vulnerability, financial difficulties, lack of trust to the health system. According to the expert some barriers also exist among medical staff, these namely are: bureaucracy, stigmatization, changes or cancelations of appointments.

This kind of project represents an effective way to overcome some of these barriers, offering rapid tests in outreach settings and creating a fast track with infectious diseases clinic for linkage to care and enrolment in treatment. This approach represents a good example of ensuring HIV/HCV Continuum of care, from the diagnosis to linkage to care and retention in care, for most vulnerable and hard-to-reach populations.

Theme 3: IC-guided testing in GPs and clinical settings. Indicator condition guided HIV testing in GP and clinical settings – Ann Sullivan, Chelsea & Westminster Hospital, United Kingdom

The expert from Chelsea & Westminster Hospital gave an overview of the indicator condition-guided HIV testing implemented in primary care and other clinical setting. She referred to the definition of indicator condition and the evidence base for recommending IC-guided testing. Further to this topic she explained how to set up ICT in hospitals and in general practice and also provided examples of educational tools and training modules for health care staff delivering ICT. The expert recalled data drawn from HIDES 2 and OptTEST projects. HIDES 2 project covered indicator conditions associated with an excessive risk of being HIV positive. The results of audits carried out during HIDES 2 project and data embracing 9471 patients tested for HIV showed that of the patients, only 14% had ever had an HIV test. Further test results indicated 2,5% HIV prevalence and a high proportion of late presenters - 71.9%. For example, the correlation between HIV and patient with mononucleosis increased in positivity rate to 5.9%. The expert referred to the OptTEST project run in 2015-2017 in 7 EU MS: UK, France, Spain, Poland, Estonia, Greece and Czech Republic. The main aim of the project was to increase HIV testing and access to treatment and care using knowledge building tools (slides, interactive training modules, leaflets, checklists) for physicians on HIV Indicator Condition (IC) testing in case of infections like: hepatitis B and C, pneumonia and infectious Mononucleosis-like syndrome. The guidelines indicate some of these diseases as a co-infection with HIV. If they are diagnosed the HIV test should be obligatory. The evidence showed significant barriers for HIV testing e.g. limited knowledge of large group of medical staff on when to offer an HIV test. In order to build capacity in this area the online training modules were developed, and special emphasis was put on ways how to ask questions, how to offer the test and how to provide the result. Additionally, other information and materials on HIV epidemic were made available e.g. images used routinely by doctors, slides on HIV epidemiology and late diagnosis, as well as highlighting testing opportunities and barriers.

The expert emphasised the importance of having an effective strategy that would allow to identify the undiagnosed HIV positive people and those who are diagnosed but not linked to care.

Implementing the Opt TEST project and Indicator Condition-guided testing in hospital clinics– country examples – Assoc. Prof. Justyna D. Kowalska, Advisory Board INTEGRATE, Poland, Raimonda Matulionyte, Lithuania, Grecu Victor, Romania

The next presentations concerned the implementation of the OptTEST project and examples showing the introduction of Indicator Condition-guided Testing in hospital clinics in Poland, Lithuania and Romania. Professor Justyna Kowalska gave a presentation on implementation of OptTEST in Hospital for Infectious Diseases in Warsaw in 2014 and 2015. She referred to retrospective analysis showing continuum-of-care for mononucleosis like illness and characteristics of HIV positive patients. When presenting the implementation of the Opt TEST in Polish settings she referred to the routine testing for HIV in a group of patients with selected indicator conditions like mononucleosis-like illness, pneumonia and HCV (both forms acute and chronic). For example, data from prospective analysis of the routine HIV testing in patients with mononucleosis like syndrome showed 8 HIV infected patients out of 371 who were tested. The implementation of the OptTEST in Hospital for Infectious Diseases in Warsaw laid the ground for development of PDSA (Plan, Do, Study, Act) and for presentation of the results at the national and international level. For example, one of the PDSA assumptions was the introduction of IC testing in Poland and expanding this to other medical centers in the country. In 2016 the first Polish workshop on continuum of care in HIV took place in Warsaw. Workshop proceedings and action points were published in the official

journal of Polish Scientific AIDS Society (ref. Kowalska J.D. Grzeszczuk A., Pyziak-Kowalska K., Marzec-Bogusławska A., Rosińska M., Ankiersztejn-Bartczak M., Horban A. Shaping the HIV epidemic in Poland – proceedings from the first Polish workshop on cascade of care in HIV. HIV AIDS Rev 2017; 16; DOI: <https://doi.org/10.5114/hivar.2017.68804>)

Raimonda Matulionyte from Infectious Diseases Centre, Vilnius University Hospital Santaros Klinikos (VULSK); Department of Infectious Diseases and Dermatovenerology, Faculty of Medicine gave a brief overview of HIV epidemiological situation in Lithuania with particular focus on situation in VULSK, results of staff survey on knowledge about testing and barriers for testing in Lithuanian health-care institutions. She later referred to the implementation of INTEGRATE project in Lithuania. In 2018 an anonymous questionnaire-based survey was conducted among physicians and residents (internal GP and emergency/intensive care professionals) regarding knowledge on HIV testing and barriers. Two main conclusions from the survey indicated that only some doctors knew they should recommend HIV test to their patients (but 40.7% never did it). Information about risky type of behavior of the patient motivated doctors to recommend an HIV test (87%) which was not the case of other diseases mentioned in Indicator Condition-guidelines. There are some examples of changes for better in Lithuania. In the framework of INTEGRATE project the Dermatology Units took part in Work Package 5.2 pilot on testing. This pilot was conducted due to insufficient level of HIV testing in STI patients and because Lithuanian physicians do not consider dermatological conditions as HIV Indicator (as the survey outcome showed). HIV testing rates during the pilot project in VULSK Dermatovenerology centre increased from 11% to 66%. Some diseases were introduced to IC-guided for HIV testing in these units, also as integrated testing for HIV and HCV, especially for STI patients. In a summery, the expert admitted that the Indication Condition is still not the common way of HIV testing among physicians in Lithuania which to large extent can be attributed to the lack of knowledge. There is a gap among dermatological and venereal conditions to be considered as indicators for HIV testing.

Victor Ionel Greco from “Victor Babes” Clinical Hospital of Infectious Diseases and Pneumophtisiology in Craiova presented epidemiological situation of HIV/AIDS in Romania, where at the end of 2018 there were 590 HIV cases registered among whom approximately 60% had a TB episode during their lifetime. The expert pointed out existing gaps in information on the possible way of HIV infection as patients are not eager to disclose their risky type of sexual behavior. According to the National Programme for the Prevention, Surveillance and Control of Tuberculosis in Romania any tuberculosis patient should be tested for HIV but is obliged to sign an informed consent for HIV testing. HIV diagnosed patients undergo pulmonary X-ray and are tested for hepatitis B and C. Further to this topic the expert presented information leaflets for patients who test for HIV and referred to HIV patient survey that was carried out in the framework of the INTEGRATE project.

Theme 4: Stigma as a barrier for testing and linkage-to-care and sustainability – focus on service provision and staff - Barrie Dwyer, Programme Officer – Education & Training, ESTICOM

This interactive session led by Barrie Dwyer from ESTICOM began with a precise defining of the concept of stigma. That was necessary for the development of the further discussion on how/to what extent different aspects of stigma e.g. language, types of behaviour, cultural competence (awareness, attitude, knowledge, skills), social norms, values and beliefs affect the quality of health services addressed to key populations (e.g. MSM) and how particular aspects of stigma influence perception, approach, and treatment of key populations in health facilities. Stigma can have several dimensions e.g. external

(society's assessment of the disease as lethal, infectious, or a punishment for risky sexual type of behaviour) and internal (the infected blame themselves or blame people of the same sexual orientation for getting ill). The expert provided examples of key elements that can help reduce stigma in health facilities such as: building awareness of what stigma is and the benefits of reducing it, mitigating fears and clarifying misconceptions around HIV transmission, confronting the association of HIV and AIDS with assumed 'immoral' or 'improper' behaviours, developing and monitoring guidance and policies to challenge discriminatory behaviour. Non-judgemental services play very important role, but to achieve this you need the right knowledge about disease, treatment, transmission of infection, skills, commitment and active involvement of both healthcare workers and service recipients. The support of non-governmental organizations working with key populations and HIV + persons is the key here.

The workshop was divided into two groups. Group one focused on how to implement IC guided HIV testing strategy and Group 2 on how to address possible needs and barriers for testing and linkage-to-care, faced by health care providers and community-based services. (The concept of indicator condition guided HIV testing means that health care practitioners are encouraged to offer HIV tests to a bigger number of patients based on the increased likelihood of being HIV+).

Needs and barriers existing on different levels spotted by the two groups:

1. Strategy level - increased financial costs – high price of confirmatory tests like PCR or Western-blot, ART costs, perceived low probability of detecting new HIV cases, relying on existing services, limited access to health-care among some population members (e.g. for PWID – drug addiction reduces interest in health condition and frequent cancellations of medical visits; undocumented migrants – language difficulties and lack of health insurance were defined as the major barriers; female sex workers – if working in “organized services” are not able to see doctors without permission of their superior, so the access to primary or secondary health care is limited or even impossible, as for the inmates – doing an anonymous HIV test in penitentiary unit is not possible), for some countries the lack of recommendations on Indicator Condition-guided testing or not putting them into practice.
2. Policy level - in many countries only medical staff is entitled to provide an HIV test. In others, HIV testing is considered as a non-medical procedure, just an indication to further deep medical examination. That is why it is possible for lay providers who work with key populations to provide HIV testing. Inadequate referral procedures within the national system of health care – problems with integrated approach to testing and treatment of HIV/HBV/HCV/TB/STI co-infections, in many countries it is not possible to provide tests that are free-of-charge for different kind of diseases or only specific groups e.g. pregnant women can benefit from them; in many countries people infected with HCV need a referral from a general practitioner in order to visit a specialist which means long time-waiting and two different appointments. Another limitation is the lack of well-functioning linkage-to-care system for the diagnosed. However, the most important challenge is to organize an efficient linkage-to-care system, especially for those who are not eager to be covered with ART or any other treatment.
3. Service level - insufficient staff time; competing clinical priorities; burdensome consent process; pre-test counselling requirements that means asking about sexual orientation over and over again if testing is done on regular basis by the same client – for some people form big barriers; lack of knowledge and training; perceived lack of professionalism; patient not perceived to be at risk of infection; concern of the reaction of the patient; inadequate salary; stigma of HIV and HIV testing.

4. Individual level - fear of a positive test result and its consequences; fear of disclosure; denial; low risk perception; difficulty accessing services; stigma of HIV and HIV testing.

NATIONAL MEETING

18 June 2019

The main objectives of the second day of the Warsaw meeting were:

- to analyse difficulties (legal, regulatory, organizational and practical) at the individual, local and institutional levels in implementing testing in community and healthcare settings,
- to exchange good practices related to the provision of integrated testing services and to develop adequate strategies,
- to address needs and barriers of the implementation of integrated testing in Poland.

Day 2: Tuesday, 18 June 2019	
National stakeholders meeting: Towards integrated testing in Poland	
09:00-09:20	<p>Summary of Day 1 and introduction to Day 2</p> <p>Anne Raahauge, Centre of Excellence for Health, Immunity and Infections (CHIP/REGIONH)</p> <p>Iwona Wawer, National AIDS Centre, Co-Leader of Work Package 8</p>
09:20-10:30	<p>Theme 1: Integrated testing and linkage to care in Poland in light of the Dublin Declaration data and the latest ECDC public health guidance on HIV, hepatitis B and C testing in the EU/EEA countries</p> <p>Dublin Declaration data and ECDC public health guidance, Polish context – 20 min Anastasia Pharris, ECDC</p> <p>Poland - Country situational analysis – 20 min Prof. Magdalena Rosińska, National Institute of Public Health</p> <p>Discussion — 30 min (moderator: Dorthe Raben, Centre of Excellence for Health, Immunity and Infections (CHIP/REGIONH))</p>
10:30-11:40	<p>Theme 2: HIV, HCV, HBV and TB in Poland – diagnostics and treatment</p> <p>Diagnostics and treatment of HIV patients and co-infected with HBV/HCV Recommendations of the Polish AIDS Scientific Society (PTN AIDS) – 20 min Prof. Miłosz Parczewski, President of the Polish AIDS Scientific Society</p> <p>Diagnosis and treatment of HIV patients co-infected with TB – 20 min</p>

	<p>Prof. Maria Korzeniewska-Koseła, Institute of Tuberculosis and Lung Diseases</p> <p>Discussion – 30 min (moderator: Assoc. Prof. Justyna D. Kowalska, Advisory Board INTEGRATE)</p>
11:40-12:10	Coffee break
12:10-13:20	<p>Theme 3: Integrated HIV, HBV, HCV testing services</p> <p>Needs, opportunities, good practices and barriers for integrated testing in healthcare and in community settings in Poland – 20 min Dr. Magdalena Ankiersztejn – Bartczak, Foundation for Social Education</p> <p>Opportunities and barriers to the integration of data coming from different sources and concerning various diseases – 20 min Dr. Marta Niedźwiedzka-Stadnik - National Institute of Public Health</p> <p>Discussion – 30 min (moderator: Anastasia Pharris, ECDC)</p>
13:20-14:20	Lunch break
14:20-15:30	<p>Theme 4: Integration of testing services in Poland – legal aspects</p> <p>Legal aspects of integrated approach to testing in Poland – 20 min Assoc. Prof. Dorota Karkowska, University of Łódź (since 2015), legal advisor, Assistant Prof. Collegium Medicum</p> <p>Overcoming legal barriers – best practices from Portugal – 20 min Daniel Simões, GAT Portugal</p> <p>Discussion – 30 min (moderator: Dr. Marta Niedźwiedzka-Stadnik - National Institute of Public Health)</p>
15:30-16:10	<p>Conclusions, development of final consensus on workshop recommendations</p> <p>National implementation of ECDC new integrated testing guidelines Road map: What are the next steps?</p> <p>Moderators: Dr. Magdalena Ankiersztejn – Bartczak, Foundation for Social Education Iwona Wawer, National AIDS Centre, Co-Leader of Work Package 8</p>
16:10-16:30	<p>Wrap up of the meeting and closing remarks</p> <p>Iwona Wawer, National AIDS Centre, Co-Leader of Work Package 8</p>

Theme 1: Integrated testing and linkage to care in Poland in light of the Dublin Declaration data and the latest ECDC public health guidance on HIV, hepatitis B and C testing in the EU/EEA countries.

Dublin Declaration data and ECDC public health guidance, Polish context –Anastasia Pharris, ECDC

First of all, a low range of HIV testing possibilities in Poland was mentioned. There was a suggestion of providing some revision of testing guidelines or ECDC recommendations in order to broaden the scope of testing in order to be able to fulfil the needs of all type of clients/patients (those who prefer counselling, those who prefer the intimacy of self-testing, etc). The importance of integrated testing for various groups of patients, (for e.g. those with liver inflammation should be offered HCV and HBV tests and HIV patients should have a possibility to do HCV, HBC, TB and other STI tests). Nowadays, it seems justified to broaden the access to testing for example for people undertaking risky types of sexual behavior. Such populations should be tested more frequently. Testing strategies should also consider epidemiological risks and situation of a particular region e.g. in countries and regions witnessing a large influx of migrants coming from different parts of the world who represent different risks of infections. Testing venues should meet testing preferences of different key populations.

Dublin Declaration monitoring report shows that there is a growing use of diverse testing models in Europe such as: community-based testing, HIV indicator condition-guided testing, self-testing and self-sampling. However, there was no change in community-based HIV testing (lay-provider) probably due to legal restrictions that allow only medical staff to do a blood test. ECDC expert pointed out that community testing should be available especially for populations who have limited contact with health care e.g. PWID, SW and who often present lack of concern about the health status, low adherence to treatment and who frequently do not come for medical appointments. A good solution to this would be a possibility to test in pharmacies (currently not available in Poland but practiced in other countries), where people can buy and do the test at home. It was emphasized that 90% WHO goal which determines percentage of people who know their HIV status can be reached only if good community-based testing has been introduced. Partner notification is also important (about 30% of partners can be infected).

Poland - country situational analysis –Prof. Magdalena Rosińska, National Institute of Public Health-National Institute of Hygiene (NIPH-NIH)

The expert from the NIPH presented the epidemiological situation on new infections and new diagnoses of HCV, HBV, HIV in Poland based on data coming from national surveillance and on mathematical estimation on new infections. For HCV the prevalence in general population is 0.5% and the proportion of diagnosed population is 22%. Its main transmission category was nosocomial infection (80%). HBV situation was presented based on data of immunization programme and the new case definition in surveillance in 2014 year. HBV the prevalence is 0.78% and the proportion of diagnosed cases is 46%. For HIV infection each year we have approximately 1500 new diagnosis but from the estimated prevalence the proportion on undiagnosed fraction is very wide. More cases with known transmission route are registered in MSM group. Treatment after diagnosis of both syphilis and gonorrhoea is mandatory and free-of-charge, but contracted by National Fund only in STI clinics which can be a barrier for some patients who are afraid of stigmatization during a medical visit in such clinics.

Professor Rosińska from the NIPH-NIH build the HIV cascade of care for main key populations. A fraction of undiagnosed cases, excluding PWID, is between 13-27% of all people living with HIV. The linkage-to-care

(treatment and viral suppression) has been satisfactory for more cases. Only for PWID group, even if they are well diagnosed, the adherence to treatment is the lowest. In this group there is the worst disproportion between diagnosed and treated cases. Also, for HCV treatment the main barrier for a lot of patients is the need of referral to a specialist issued by a general practitioner, the lack of health insurance in many cases, long waiting list to visit a specialist. But as it was indicated in the cross-sectional study from 2017 "Health of people who inject drugs in reference to infectious diseases transmitted through blood-borne infections and by sexual transmission. Prevalence. Knowledge. Behavior" if people who inject drug are linked to harm reduction services, although they have higher prevalence for all diseases, they do tests more frequently - three times more for HCV, two times more for HIV or HBV comparing to PWID who are not linked to harm reduction services.

Theme 2: HIV, HCV, HBV and TB in Poland – diagnostics and treatment

Diagnostics and treatment of HIV patients and co-infected with HBV/HCV

Recommendations of the Polish AIDS Scientific Society (PTN AIDS) – Prof. Miłosz Parczewski, President of the Polish AIDS Scientific Society

The content prepared by Profesor Miłosz Parczewski was presented by Profesor Justyna Kowalska (Hospital for Infectious Diseases, Medical University of Warsaw). The expert mentioned WHO targets to eliminate HBV and HCV as public health threats by 2030 such as: hepatitis B vaccination, blood safety (donations screened with quality assurance), injection safety (proportion of unsafe injection to be reduced to zero %), testing services, treatment (increase in percentage of diagnosed people in treatment) and harm reduction (the increase in number of syringes and needles distributed among PWID from 20 to 300 sets per person/year). The expert admitted that all these targets are very difficult to be achieved, however they are not impossible to be reached in the near future if adequate measures are taken. One of the main tasks is to increase the availability to testing and treatment across the European countries. The last year (2018) increase in number of people on the DAA treatment (Direct-acting antivirals in HIV/hepatitis C virus patients) was presented, however it was mentioned that there are many limitations to access this type of treatment e.g.: HCV testing is based on NGOs network which remains underfinanced, scarce national subsidies, the lack of integrated system and guidelines on preventing and giving response to HIV, hepatitis or STI. Additionally, PCR confirmation is available only within the health care, although waiting lists extend from 3-9 months which does not work for some populations, for example for PWID. Another problem that the guidelines on HIV/hep/STIs are neither integrated nor consolidated.

Diagnosis and treatment of HIV patients co-infected with TB – Prof. Maria Korzeniewska-Koseła, National Institute of Tuberculosis and Lung Diseases, Research Institute

Professor Korzeniewska-Koseła presented an update on the epidemiology of TB/HIV coinfection. In 2017 there were an estimated 10.0 million TB cases in the world. 9% of TB cases were among the HIV positive. In 2017 TB caused an estimated 300 000 deaths among HIV- infected people. The risk of developing TB for the 37 million people living with HIV was 20 times higher than the risk for the rest of the global population. In 2017 in the European Union/European Economic Area countries HIV status was known in 25 583 (76.0%) of all 33 661 TB cases reported from these countries. 1006 (3.9%) cases were reported as HIV positive. The proportion of co-infected cases was the highest in Estonia, Latvia and Portugal (8.6-11.4%). Later in her

presentation the expert referred to EU/EEA standards for tuberculosis care. The International Standards for Tuberculosis (TB) Care define the essential level of care for managing patients that have or are suspected to have TB. These standards are in line with international principles and guidance outlined in the International Standards for Tuberculosis Care and the WHO Compendium of Tuberculosis Guidelines and Associated Standards. The goal of the standards is to help public health experts, clinicians and healthcare programmes in TB prevention and control, bridging current gaps in the case management of TB in the EU/EEA. The expert gave an overview of TB/HIV coinfection pointing out high risk of active tuberculosis among people infected with HIV. The risk of TB is also increased in patients covered by ART treatment. The most common form of active TB in HIV positive persons is pulmonary TB. Extrapulmonary and disseminated TB are more common among the HIV infected in particular among those with very low number of CD4 count. The expert added that immune reconstitution inflammatory syndrome is a potentially dangerous complication that occurs among HIV infected people who started ART in the early stage of TB treatment and especially among those who show advanced immunosuppression.

Theme 3: Integrated HIV, HBV, HCV testing services

Needs, opportunities, good practices and barriers for integrated testing in healthcare and in community settings in Poland – Dr. Magdalena Ankersztejn – Bartczak, Foundation for Social Education (FES)

The FES expert emphasized scarce financial resources that are allocated for HIV prevention. She added that the major portion of the national HIV/AIDS budget (95%) is dedicated on treatment and medical care for people living with HIV. There are no state strategies for infections other than HIV. The HIV legal age for testing is 18 years-of-age. Later in her presentation the expert pointed out barriers related to low uptake of HIV testing among the general public, e.g. only 9% of the Poles have ever done HIV test (data from the report prepared by Professor Izdebski & Polpharma “Polish sexuality 2011 Research”). The real time between considering and doing the HIV test was shorter than 6 months and concerned 67% of Poles who participated in the Stigma Index study. About 20% of people needed more time (7 months to 2 years) to decide to do the test, and 13% suspended the decision. The situation in Poland is very comparable with the outcomes coming from other countries that participated in Stigma Index study. Similar problem concerns the timespan between testing and linkage-to- health care system. 58% people declared less than 6 months, whereas 23% need more than 2 years.

The FES expert attempted to answer the question “Where we should do the testing?” drawn from ECDC public health guidance on HIV, hepatitis B and C testing in the EU/EEA. In the expert’s opinion, Poland offers limited access to testing venues e.g. in primary healthcare settings doctors are entitled to recommend an HIV test, but they rarely do so. The high cost of HCV or HBV test creates another barrier to recommend them to people. Hep patients have the possibility to consult a specialist but there are long waiting lists. In hospital settings tests are offered in case a patient undergoes a surgical procedure. STI clinics offer more possibilities to test other sexually transmitted diseases. In Poland it is not possible to test in pharmacies, self-sampling is not possible either. Tests are offered in penitentiary institutions and in harm-reduction services run by NGOs. Similar situation occurs in community testing run by NGOs, including some drug and harm reduction services. There are 30 VCT run by the National AIDS Centre all around the country but their opening hours are very limited, usually just one counsellor per VCT is employed. Only VCTs that operate in the biggest cities (Warsaw and Wrocław) are opened 5 days per week (4 hours per day) and employ two counsellors. In some VCTs there is a possibility to self-test, but this

concerns VCTs which receive additional funds from a local government and/or private donors. VCTs run by Foundation for Social Education offer tests for HIV, HCV and syphilis (also by means of a mobile unit) and collect data. VCTs have access to anonymous electronic data base that collects epi data, but it is not integrated into the surveillance data, therefore a lot of data is missing at both national and EU level of reporting. For example, in Warsaw there are only two VCTs that offer HCV and syphilis tests and HIV rapid tests. According to the expert there is a huge demand for such tests, members of key populations prefer lay-provided testing, even on the premises of VCTs and HIV clients are opened to be tested for other infections as well. In their case the best solution is the access to testing in a mobile unit. From 2017 to 2019 FES offered tests in such a venue financed by the National Bureau for Drug Prevention, local government and private companies. A big number of rapid tests was offered to PWID, among whom some were aware of being infected and some were newly diagnosed.

Opportunities and barriers to the integration of data coming from different sources and concerning various diseases – Dr Marta Niedźwiedzka-Stadnik – the National Institute of Public Health (NIPH-NIH)

The NIPH-NIH expert presented the outline of HIV case-based surveillance system launched in 1985. Its main characteristics are: cases diagnosed either by a clinician or in a laboratory; a name-based identifier including: the initials, the date of birth and gender. The expert discussed the problem of re-duplication that exist on a regional level (public health offices of the Sanitary Units) and reappears at the central level (Department of Infectious Disease Epidemiology and Surveillance of the NIPH – NIH). The main barriers concerning the data surveillance are related to the lack of identification (ID) to remove duplicates, the lack of Western-blot number to compare the cases (the number of laboratory test), reporting delay, laboratory reports missing epidemiological data like: the transmission group, CD4 count, previous testing, clinical stage. Later in her presentation the expert referred to possibilities and barriers in linkage between different databases e.g. the linkage between surveillance data and VCTs data. Linkage information from VCT and surveillance data can give us a better epidemiological overview of key population. Therefore, it will be possible to reduce the missing data related to HIV epidemic like the unknown transmission route of HIV infection, the nationality of a tested person or even the age or gender. Secondly, the linkage between the surveillance data and the Statistical Office Data on AIDS related deaths was presented. The underreporting of AIDS related deaths registered by the Sanitary Stations is the main problem compared to the data on causes of death identified as B20-B24 registered by the Statistical Office. This problem can be related to the anonymous data from HIV/AIDS surveillance, and to the fact that causes of death in surveillance were not verified in the past and only AIDS related deaths were collected. According to the expert, the integration of testing data into the surveillance data is possible but there are barriers to be addressed. Lack of the unique identifier for clients who are tested for HIV in VCTs can generate duplicates both in number of tests and HIV+ clients. Due to the sensitivity of data concerning the sexual orientation and risky sexual type of behaviour which clients have to provide in the questionnaire, it could be problematic to add the unique identifier to the existing questionnaire. However, adding a unique identifier to all clients entries would be helpful to estimate the real number of people tested for HIV in VCTs. On the other hand, such a questionnaire is also anonymous so all data on VCT clients are protected. At the same time the full anonymity would be maintained. Social campaigns on HIV testing launched by the National AIDS Centre target specific populations/groups e.g. pregnant women, MSM, people on the move. However, clients who do HIV test in VCTs after watching the campaign cannot be treated as representative group of clients who should be tested for HIV.

Integrated VCT data into the surveillance system may help to interpret epidemiological trends of different age groups depending upon the region and the kind of key populations and would help to understand the representativeness of data collected in the VCT system and identify the target population. Combining new diagnoses and analysis of the risk factor data from VCT system with surveillance may improve the understanding of the HIV transmission patterns. Another problem mentioned by the NIH-NIH expert was the legal status of the data sets (especially with respect to new data protection regulations) and data ownership. Legal analysis should consider both national and European legislation. Properly-designed indicators should take into account the coverage of different data collection systems in order to provide useful information.

Integrated electronic database systems are expensive not only in terms of launching but also maintaining. The expert mentioned an ongoing project embracing collection and presentation of the epidemiological data (EpiBaza) on infectious diseases aiming at efficient monitoring of the epidemiological situation as well as making the data publically available. Electronic data flow will come from clinicians, laboratories, sanitary stations.

Legal¹ aspects of integrated approach to testing in Poland – Assoc. Prof. Dorota Karkowska, University of Łódź (since 2015), the legal advisor, Assistant Prof. Collegium Medicum

The expert carried out a detailed analysis of the law in terms of integrated approach to testing. After the analysis of the Polish legal system it was concluded that there are no legal barriers to integrate testing procedures, if such barriers exist they stem from non-statutory standards. The difficulties observed in the integration of testing in Poland are based on the fact that HIV was given a privileged status of the protection of the anonymity of the client. Upon the example of oncological diseases and nutrition the expert said that testing was possible in the non-medical setting. Therefore, there are no barriers to HIV testing in the communities e.g. inside mobile units, in clubs, etc. According to the expert there is a problem with blood testing due to injection procedures, however rapid tests (finger pricks) or oral testing are not considered as medical procedures and can be performed by a client himself/herself. The usage of proper and exact terminology was emphasized such as: *patients* meaning people tested in medical settings and *clients* meaning people tested in non-medical settings Testing may not equal a medical service.

As far the integration of data is concerned the expert emphasized the need for the absolute security of the data base due to the sensitive data that enters to the system. It is recommended to lower the legal testing age from 18 to 16 years-of-age.

Overcoming legal barriers – best practices from Portugal – Daniel Simões, GAT Portugal

The expert mentioned late HIV diagnosis present in Europe stressing the importance of giving choices and comfort to people who want to get tested. He emphasized the phenomenon of co-existence of HIV and other infections such as: syphilis, HCV, HBV in key populations such as MSM, IDU, sex workers and

¹ Information added by NAC on 2nd September 2019: according to some experts the applicable laws on laboratory diagnostics (Law of 27 July 2001 on laboratory diagnostic (Dz. U of 2014, poz. 1384, with amendments), and infectious diseases (Act of 5 December 2008 on preventing and combating infections and infectious diseases in humans) do not include the terms such as a screening test. The lack of terminology in the official government documents creates a legal gap that needs to be filled. Apart from that, in Poland it is possible to test for HIV both anonymously or by name. In case of syphilis the client has to give his/her personal details in case she/he tests positively. That conflicts with the idea of anonymous testing policy in vcts.

migrants. The expert recalled epidemiological trends and modes of HIV transmission in key populations in Portugal. The expert highlighted the fact that first it should be established what, where and who is the barrier to integration of services and then solving these issues should be present on the agenda until the aim has been reached. It also should be noted that any change requires effort and very often mean a conflict.

The expert mentioned issues that hamper programme/policy development in HIV and viral hepatitis such as: fear, discomfort associated with speaking about sex and sexual orientation, drug use, lack of financial and human resources, lack of information and expertise on implementing effective strategies, protectionism concerning medical and laboratorial approach to diagnostics, lack of political will and interest. Referring to legal, regulatory, financial and practical barriers, the expert pointed out in which group barriers may exist e.g. in policy makers, sponsors, in key populations, among medical personnel, lab staff, in public health experts, community organizations and in the society. He stressed the lack of regulations regarding community testing, restrictions of the right to provide testing to medical personnel only, providing HIV tests only (no integrated testing).

Discussion

The following description provides information on the course of discussion and key topics raised by experts during the first and second day of the workshop:

Primary health care, emergency rooms are proper venues for HIV testing as they are visited by masses of people. These places constitute the basis for the testing strategy and should be accessible to everyone. In some countries HIV tests are refunded by the government. However, in many countries patients must pay themselves for HIV/HBV/HCV tests done in medical settings.

Testing in primary health care should be treated as normal procedure not related to any risky type of behavior. It should be based on the indicator condition guided HIV testing (IC) that is related to higher risk of HIV infections (see IC- guidelines). The knowledge on IC should be provided to all medical students as part of the study program. For doctors who treat patient with IC, HIV testing should become a *standard procedure*. However, for many of them it is not a priority during treatment. They often do not consider the need for an HIV test and seek the cause of the disease somewhere else. Sometimes it is more probable that this health conditions are related to HIV infection, therefore primary care physicians should offer more HIV tests.

Early diagnosis and linkage to care results in decreased HIV transmission and decreased mortality due to early initiated ART and opportunistic infection prophylaxis. Decreased cost of care is another factor supporting early and integrated approach to diagnosis and linkage to care for patients suffering from HIV and co-infections.

During the workshop some experts admitted that HIV tests should be offered free-of-charge at a primary care level, and they should not be related to any risky type of behavior.

Experts raised a **behavioral problem that exists among the medical personnel when attending people during an HIV test**. It concerns asking patients sensitive questions related to their sexual habits, risky types of behavior, sexual orientation. For some personnel it is problematic, but this kind of conversation should be practiced during the medical studies in order to make it standardized.

People who may feel stigmatized because of their HIV infection or because of any other reason should have a possibility to do the test out of the health-care settings (in a community settings). The existing network of VCTs is a key for community-based testing but it should be kept in mind that VCTs are often visited by populations where the level of risky type of behavior is elevated, which is proved by the percentage of HIV positive cases detected among PWID and MSM.

In many countries an HIV test performed in VCT requires client's consent and it is accompanied by a pre-test counselling. This kind of procedures should be available to everyone but should be not obligatory. VCT clients should be able to come to do the test on regular basis, even twice a year and they should be provided with information materials (e.g. leaflet). In many European countries self-testing is available and widely used. In some countries it is not legal yet.

The experts concluded that self-testing should not be treated as a diagnostic test but as a screening one (as in the case of diabetes and glucose monitoring). Such test provided by non-medical personnel should be treated just as an indicator for further diagnosis. This issue does not require any legislative changes but rather a re-interpretation of the existing rules. The danger of false negative and positive results was mentioned but if tests are certified such a risk is low. The problem of false negative or positive results can be balanced by a higher percentage of the diagnosed. It should be underlined on every level of the self-testing procedure that the results should be confirmed by a specialist in a medical setting. However, in that case an extensive waiting time may be a barrier. There is also a big problem with linkage-to-care in this case. On the other hand, there is also the lack of legal possibilities to receive a screening test result without the confirmatory one.

For some people, the necessity to repeat the test in clinical setting could be a barrier in case if they want to be seen by a specialist.

In Poland it is rather common to do the full ID named test for HIV (PCR test) rather than queue and wait for the confirmatory WB done by a VCT, even if anonymity is lost. It was noted that there is a problem with access to a VCT (short working hours, localization of VCTs in the big cities, recommended a pre-test consultation with a counsellor or a doctor), long waiting time for WB confirmation. Sometimes if we establish specific places just for the purpose of HIV testing, people are unwilling to come because of the fear of being recognized.

A limited access to integrated testing offered in VCTs forms another barrier. Most VCTs can only provide HIV tests. Integrated testing for other infections such as HCV/HBV/STI is not possible. However, blood testing offers tests for these diseases.

Some VCT clients fall out of the health system because it takes them more than 2-3 years to decide on visiting a doctor. In the meantime, if such clients are not tested for other diseases, they transmit them to others. It is also cost-effective to do various tests during one visit (considering doctors' fees, and lab costs). There is also a problem of separated diagnosis and treatment for HCV/HBV/STI. In Poland there are different clinics for HIV patients, HCV patients and STI patients.

Moreover, there are separate guidelines concerning different diseases e.g. for HIV recommendations of the Polish AIDS Society, for hepatitis C/B treatment recommendations published by the Polish Group of HCV/HBV Experts from Polish Association for Study of Liver, and recommendations on gonorrhoea, syphilis, and chlamydia issued by Polish Association for Dermatology.

Another problem that was raised during the meeting concerned access to HIV testing which should be equal for everybody. Quite often it is not the case e.g. due to difficulties in convincing hard to reach populations e.g. injecting drug users, sex workers or men who have sex with men to go and do HIV test, especially in medical settings or even in VCTs. Some countries offer the possibility to test for key populations in places and venues where they gather (streets, clubs, etc.). The screening testing is done by lay providers. For some people it is hard to talk with medical staff and they prefer to meet their peers. For e.g. there is a problem with harm reduction program in Poland, there are no procedures on street-provided pharmacological treatment. The main question is who should take care of the clients. According to the law, only medical staff is entitled to this but sometimes they tend to refuse. In such a case the task should be transferred to harm reduction activist (s) who is an important link in the process of linkage-to-care.

There is also a problem with linkage-to-care of the clients due to their life concerns like a place to live, food to eat, etc. E.g. PWID have limited access to HCV treatment, sometimes due to personal reasons or because they are not able to go and see the doctor. Sometimes the reason and barriers concern medical staff, some doctors admit they don't want to treat people who injected drugs. Migrants mention the language barrier as a big challenge to visit a place where they can do the test. Some participants admitted the lack of partner notification system. Disease symptoms are motivating factor to do the test. The situation gets worse if there are no HIV signs perceived by the client.

Future steps:

Integration of testing in Poland has not yet been fully implemented but during the workshop a lot of opportunities were discussed. There are steps to make a full use of them:

- Rapid testing in VCTs should be treated as a non-medical procedure but as an indicator to future diagnosis in medical settings (a screening test). All people who are tested in VCTs are called clients, not patients.
- Western-blot test is too costly and needs more time to show the results. It will be more efficient to do Elisa tests which is cheaper but have good sensitivity and specificity rates.
- Confirmatory tests should be moved from VCTs to medical health settings. It is fine to get a confirmatory result in a VCT but maybe it is time to change the procedure to screening test for VCT clients emphasizing that the fact that the result has to be confirmed by a doctor. In this way the rate of the linkage-to-care will be higher as well.
- Epidemiological data do not indicate the key population that should be targeted. It would be helpful to integrate the data from VCTs into the national surveillance system.

- Pre-test counselling should not be obligatory in VCTs.² It should depend on the client wish and there should be such a possibility especially in case of on a diagnostic window. But in general, it should be enough to present prevention materials on TV or leaflets in the waiting room. For some people personal contact with a stranger (a counsellor) and the obligation to talk about sensitive issues may be seen a barrier. It should be enough to have just a self-filled in questionnaire on the main statistical data instead of a lengthy and time-consuming questionnaire.
- Integrated testing is important especially for key population members who do not come to see help very often.
- The way of VCT operation should be adjusted to the real conditions: extensive waiting time for a confirmatory test, lengthy questionnaire to be filled in, to short or uncomfortable opening hours.
- There are some barriers concerning test providers. Sometimes doctors admit that they do not know how to recommend the test to their patients. There is a big need for education in that area (e.g. a guidance on how to offer testing for different STI).
- Pathways for confirmatory testing in community testing should be established as well as clear pathways for linkage to care. For example, the referral for HCV treatment should be removed from the general practitioner.
- There is no consolidation of current guidelines in terms of HIV/HCV/HBV/STI screening and treatment. Cooperation between different stakeholders, experts, institutions and government should be strengthened.

² In Polish VCTs run by the National AIDS Centre pre- and post- test counselling is offered to all clients on regular basis and serves as information tool to/from a client and as epi data.

Evaluation Report from Regional Workshop on 17-06-2019

The number of evaluation forms collected after the meeting was 19.

The professional category of respondents was: 8 medical doctors, 1 nurse, 4 social workers and 6 project managers.

The kind of organizations represented were: 7 NGOs, 5 governmental organizations, 6 clinics and hospitals, 1 community centre.

The evaluations were all positive, with an average grade of 4. Only in 1 form the rates are all 3 and 2 for the sequence of topics, but no clear motivation is given.

The best aspects of the workshop were considered the group work and the possibility to share experiences and best practices from other countries. Also, the selection of topics was considered good.

The suggestions for improvement were: share in advance the list of participants, do not have parallel sessions so that everyone can attend everything, have smaller groups, provide participants with some more practical material/tools, have representatives of different key populations (PWUDs, sex workers, etc.). A doctor suggested to prepare recommendations for stakeholders and discuss more in detail how INTEGRATE can improve the situation in EU countries.

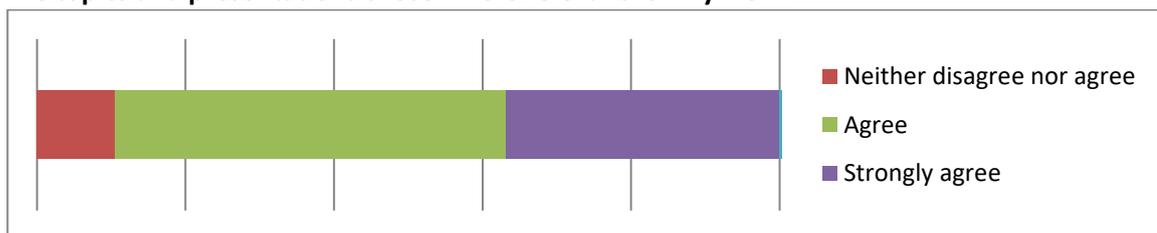
Overall, both the organization and the content of the workshop were considered good.

1. The meeting met my expectations.



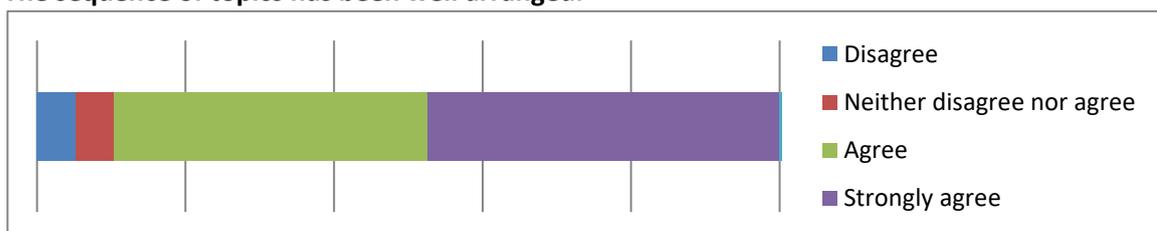
15,8% neither disagree nor agree; 63,1% agree; 21,1% strongly agree

2. The topics and presentations chosen were relevant for my work.



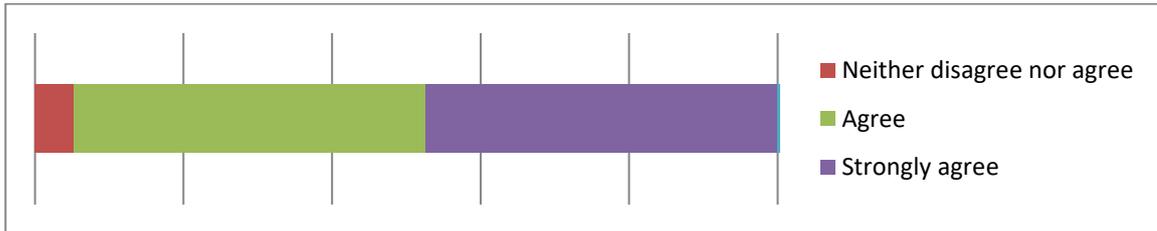
10,5% neither disagree nor agree; 52,6% agree; 36,9% strongly agree

3. The sequence of topics has been well arranged.



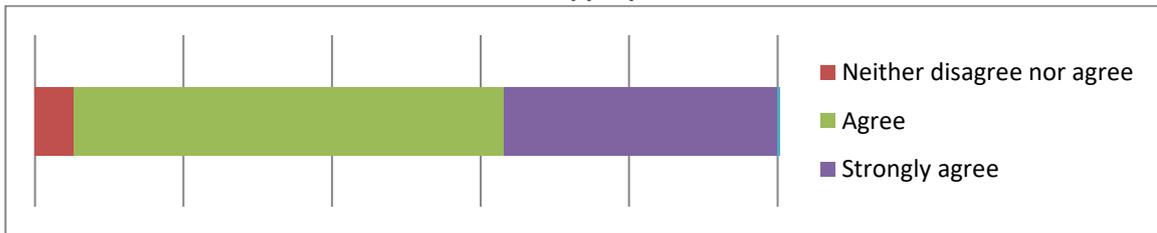
5,2% disagree; 5,2% neither disagree nor agree; 42,2% agree; 47,4% strongly agree

4. The presenters were engaging and well prepared.



5,2% neither disagree nor agree; 47,4% agree; 47,4% strongly agree

5. The level of discussions and interactions was appropriate.



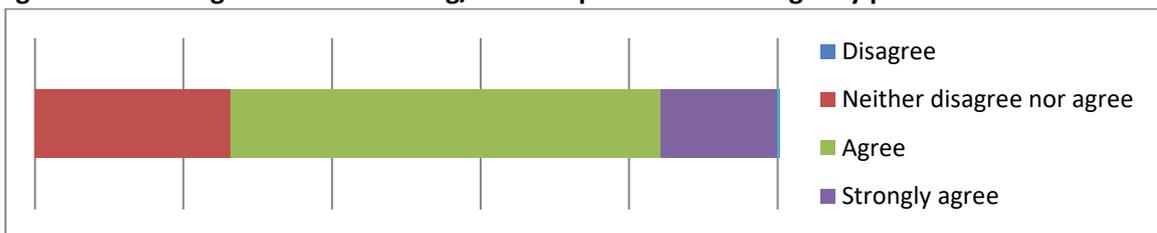
5,2% neither disagree nor agree; 57,9% agree; 36,9% strongly agree

6. The balance between presentation and group work was appropriate.



15,7% neither disagree nor agree; 63,2% agree; 21,1% strongly agree

7. I gained knowledge from this training/workshop which will change my practice.



26,3% neither disagree nor agree; 57,9% agree; 15,8% strongly agree

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

Best aspects of the meeting:

“Hearing experience from different countries”

“Knowledge about HIV indicator conditions”

“Different perspective”

“Work with groups”

“Other countries disclose how they provide services + health promotion”

“To engage ideas for future projects”

“Update on pilot action; they give examples of application in real life”

“Topics of the themes”

“Presentation for best practices”

“Exchange of experiences and barriers between countries and discussion on some very common issues”

“The exchange of best practices and knowledge with different stakeholder”

What to improve:

“A list of attended affiliates would be helpful”

“To prepare recommendations to stakeholders”

“More discussion for linkage to care (needs and barriers); Inclusion of suggestions”

“More time for discussion”

“More open circle discussion groups”

What to change for next meetings:

“To discuss practical issues, how could integrate improve situation in EU countries”

“I think the group should be smaller”

“Have representatives of other key populations present: PWID, sex workers, transgender”

“Not to have parallel sessions”

“Provide participants with some practical material”

“could be interesting trying to establish group discussion and participants in each group prior to departure, in order to allow organizations to better organize material and information useful to the discussion”

General comments included:

“Relevant and useful for communication among the partners”

“Very well organized and topic is well chosen and actual for all countries”

“More representation from healthcare system and decision makers”

“Lack of people from different part of Europe”

Evaluation Report National Meeting 18-06-2019

The number of evaluation forms collected after the meeting was 13.

The professional category of respondents was: 7 health workers, 4 government workers and 2 community workers.

The kind of organizations represented were: 3 NGOs, 5 governmental organizations, 5 clinics and hospitals.

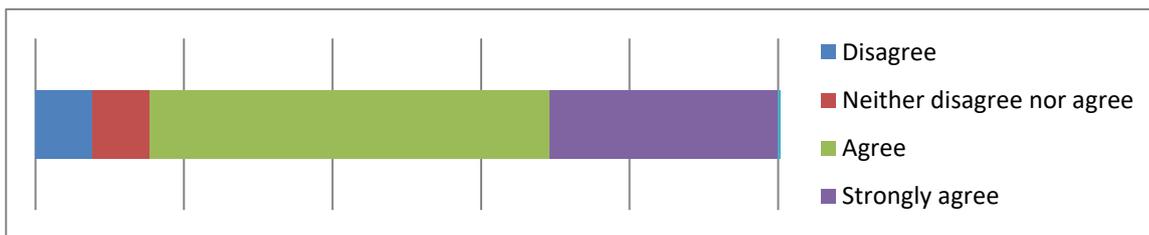
The evaluations were all positive (excluding the last two points) with an average grade of 4 tending to 5. The last two points (there was a good representation of all national stakeholders and decisions/action points were made on how to move forward received 3x1 and were supported by written comments like: lack of participation from policy level.

The best aspects of the workshop were the analysis of opportunities and barriers, the best practice from Portugal, discussions as well as good organization.

The suggestions for improvement were: the very required presence of national decision makers so new decisions could have been made.

Overall, both the organization and the content of the workshop were considered good.

1.The meeting met my expectations.



7,6% disagree, 7,6% neither disagree nor agree; 53,8% agree; 30,7% strongly agree

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



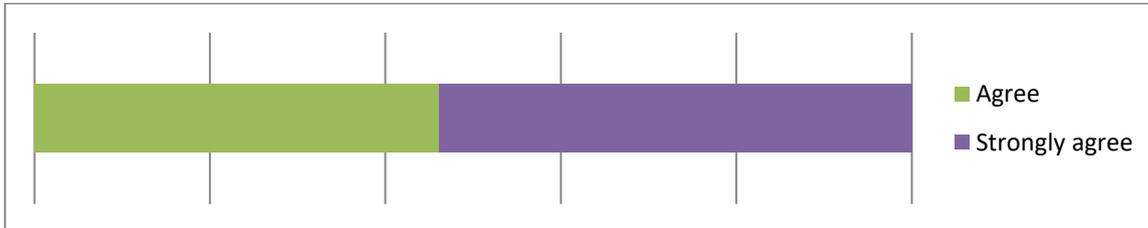
7,6% % neither disagree nor agree; 38,4% agree; 53,8% strongly agree

3.The sequence of topics has been well arranged.



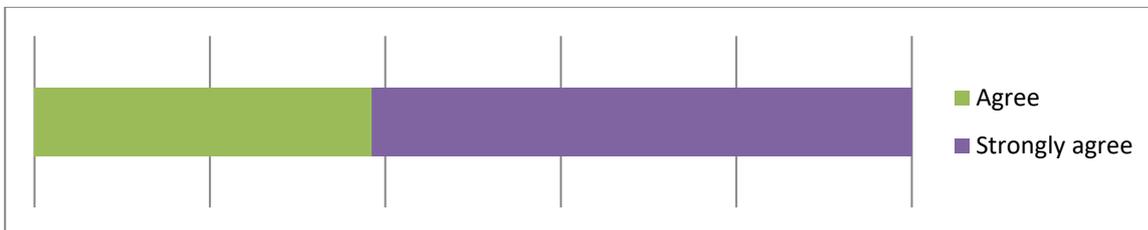
7,6% neither disagree nor agree; 46,1% agree; 46,1% strongly agree

4.The presenters were engaging and well prepared.



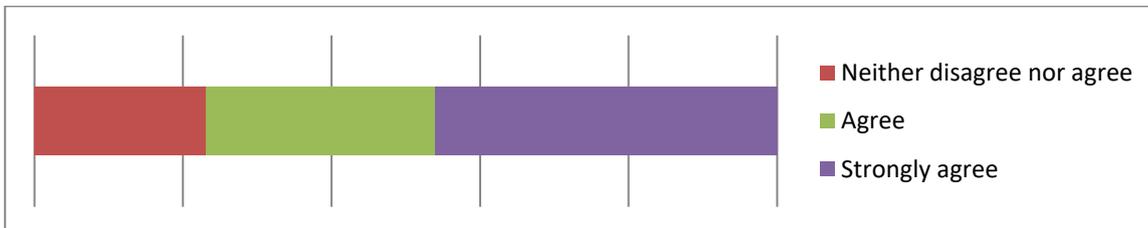
46,1% agree; 53,8% strongly agree

5.The moderated discussions were useful and relevant.



38,4% agree; 61,5% strongly agree

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



23% neither disagree nor agree; 30,7% agree; 46,1% strongly agree

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



23% strongly disagree, 7,6% neither disagree nor agree; 30,7% agree; 38,4% strongly agree

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



15,3% strongly disagree, 7,6% disagree, 15,3% neither disagree nor agree; 30,7% agree; 30,7% strongly agree

Appendix 1

Attendance list of the Regional Workshop 17th – 18th of June 2019:

INTEGRATE Partners			
#	Name	Organisation	Country
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5	Dorthe Raben	CHIP	Denmark
7	Anne Raahauge	CHIP	Denmark
8	Stine Finne Jakobsen	CHIP	Denmark
9	Sophie Nash	Public Health England	UK
10	Werner Leber	Queen Mary University of London	UK
11	Katerina Isari	KEELPNO	Greece
12	Manuel Maffeo	ARCIGAY	Italy
13	Maria Axisa	Ministry of Health	Malta
14	Elisabetta Teti	FVM	Italy
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16	Raimonda Matulionyte	VULSK	Lithuania
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6	Magdalena Ankiersztejn-Bartczak	FES NGO
7	Magdalena Rosińska	NIZP-PZH
8	Marta Niedźwiecka-Stadnik	NIZP-PZH
9	Robert Kowalczyk	Sexuologist
10	Justyna Kopeć	Women Against Viruses in Europe
11	Dorota Karkowska	A layer
12	Łukasz Łapiński	Podwale 7 NGO

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2	Daniel Simoes	GAT
3	Anastasia Pharris	ECDC
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