Short report from the conference: Day 1+2

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Madrid

Day 1 – opening session

Key points

- Europe is not on track to reach the UNAIDS and SDG targets
- Late diagnosis remains a key challenge, and lack of diagnosis particularly for hepatitis B and C where huge proportions are unaware of their infection (keep?)
- There is documented HIV-related stigma in healthcare settings with clinicians experiencing the consequences of people not accessing services. The stigma data gap is being addressed via surveys and studies at European & national levels.
- Importance of political support to take action to address HIV-related stigma – example of review and update of national legislation to remove HIV-related discriminatory laws and regulations
- The conference focus on stigma and removal of barriers for migrants is aligned with the vision of the MoH of Spain

Implications/next steps

- Need to address HIV-related stigma and discrimination as a key structural barrier preventing Europe from meeting the SDG and UNAIDS targets

Day 2 – Side meeting: Testing Week Working Group meeting

Challenges and opportunities

- Peer driven, community-level and self-testing interventions are effective to reach key populations who have never tested before and may not be already accessing other biomedical interventions such as PrEP.
- Community-level services are trustworthy for community as CBOs provide a safe environment
- Sustainable funding is necessary for CBO testing programmes
- Enabling legal environment is needed for lay provider testing, and ETW can be used to push for lay provider testing
- A holistic public health approach to testing is needed – also factoring in mental health
- Collaboration with epidemiologists would be valuable for ETW organisations, to calculate CoC and better understand which communities are diagnosed late
- ETW provides a good opportunity to foster new collaborations with other stakeholders
- ETW is a useful platform for advocacy – to demonstrate how community interventions are effective and valuable

"We need to cure the stigma to end the virus"

– Jorge Garrido Apoyo Positivo, Spain

Day 2 – plenary session 1: Overcoming stigma and discrimination in accessing testing services

Key points

- Stigma towards people living with HIV and key populations in healthcare and community (family/friends) settings is highly prevalent and must be addressed for improved access to testing, retention in care, health seeking behaviours, quality of life and to reach global health targets
- Missed opportunities to diagnose individuals who don't appear to be "at risk" for HIV, stigma is among one of the reasons why people aren't offered tests. HCPs need to offer HIV testing more often
- Lack of HCP knowledge of sexual health (delayed mpox diagnosis example in Turkey), communication about HIV testing (1/3 of PLHIV in PT were tested for HIV without giving consent) and HIV transmission (not understanding U=U, pregnancy & HIV) contributing to stigma and providing ppl with incorrect information leading to poor health outcomes and impacting quality of life (telling PLHIV they can't have sex and/or give birth to an HIV-negative baby)
- Importance of language: Use of person-centred language to avoid contributing to stigma (Peoples First Charter). Also consider how "self-stigma" is alienating and perceived as blaming to PLHIV

Lessons learned…

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- WHO July 2023 policy brief on The Role of HIV Viral Suppression in Improving Individual Health and Reducing Transmission can be useful for HCPs, laboratory staff, policy makers and clinical diagnostic partners to better understand HIV VL measurements and testing approaches

Next steps

- Look out for and help to promote the ECDC/EACS survey of healthcare providers on HIV stigma
- WHA will present findings from ECDC/WHA survey on viral hepatitis stigma at the world hepatitis summit in April 2024
- There is a need for increased meaningful inclusion and visibility of trans people in efforts to address stigma and discrimination and participate in local/regional initiatives and responses to HIV
- NGO peer workers need help from researchers to develop/implement effective research methodology and interventions on intersectional stigma

Day 2 – plenary session 2: Status of integrated testing and integrated services

Key points

- Multiple models of good practice (e.g. London, Portugal, France, Australia, Spain)
- Fast Track City initiatives good model for enhancing cross-programme and cross-sector collaborations
- Situation very diverse across WHO European Region – requiring diversification and tailoring of testing approaches to local context

Progress and challenges

- The closer we get to elimination, the harder and more costly to find remaining cases and secure funding and political commitment.
- Lack of simple point-of-care TB tests for community settings AND good models of integrating tuberculosis testing into other integrated testing programmes
- Silo-based programmes (planning, delivery, funding) and competing clinical priorities
- National policies not updated
- Criminalization

Day 2 – plenary session 2: Status of integrated testing and integrated services

Next steps

- Maintain political advocacy to sustain commitment as we progress towards elimination: Understand geography and place, be agile and adapt responses in low prevalence areas, sell story of ending HIV and demonstrate value for money – infections averted, results for money invested, reduced mortality
- Address stigma, remove legal barriers review legislation, enhance sexuality education also for clinicians
- Normalise HIV, HBV and HCV testing and decentralise also to primary care
- Measure late diagnosis in absolute numbers and not solely as a proportion of newly diagnosed
- Strengthen leadership, cross-sector and programmatic collaboration and coordination
- Realign investments and priorities (ED opt-out testing; London FTC…)
- Prioritise prevention, health promotion with focus on cultural competence, equity and stigma
- Deepen community-centred approaches *(Orange = from Fenton, maybe too much)*

Day 2 – parallel abstract session 1: Improving BBV testing strategies in Emergency Departments

Key points

- ED screening is highly effective, feasible and cost-effective in high prevalence areas
- Tends to identify people of older age, more ethnically diverse and at later stages of infection
- Political will and funding crucial to implement and sustain a national programme
- Partner notification was highly effective and can successfully amplify reach of opt-out ED testing – but pathways and numbers of partners tested need improvement

Progress and challenges

- Need to optimize pathways and improve linkage to care and retain motivation of ED doctors with competing clinical priorities. Automated ordering of tests can support process
- Re-engaging people previously diagnosed and lost to follow-up
- Collaboration with laboratories and clinics to improve capture and sharing of data

Next steps

- Improve linkage, manage positive results where people are being seen for care (e.g.in drug dependence centres) and using peer support → implement decentralised models of care.

Day 2 – parallel abstract session 2: Combination Prevention: Optimizing Implementation of Testing and PrEP

Key points

- Causes and factors associated with discontinuation of PrEP: side effects, perceived low risk of HIV, young age, female, STIs,, follow up difficulties, being in exclusive/stable relations, not judging PrEP useul, poor tolerance, medical issues, Covid 19, being in a stable relationship
- Barriers to PrEP uptake: lack of awareness and knowledge among non MSM. *"PreP access does not start with a referral, it starts with PrEP knowledge."* Out of pocket cost, waiting time for first consultation, lack of information sharing between referring community organisations and hospitals.
- Data quality remains a key issue for proper surveillance
- Community has valuable role to play for development of practical models for PrEP referrals as hospital setting can be a barrier for effective initiation of treatment.
- Enabling factors for PrEP uptake and retainment: Digital tools
- Clear increase in use of chemsex drugs
- Chemsex highly prevalent among GBMSM and transgender individuals, migration, sex work, IDU.
- More research needed on chemsex among transgender individuals
- A community validated checklist for combination prevention can be used to identify gaps in health service delivery.
- Community networks well positioned to provide counselling for key populations engaged in Chemsex. Clear association between Chemsex and HIV aquisition behaviours, HCV, STIs and mental health.

Next steps

- New WHO PrEP guidelines from 2022: De-medicalised PrEP provision recommended. Public health expert opinion can support advocacy for changing national guidelines
- Need for innovative and de-medicalised community based PrEP provision as great dfference across Europe for provision of drugs outside medical settings. → Expansion of low threshold services needed.
- Strengthening of data quality for continous analysis and surveillance needed across Europe

Day 2 – plenary session 3: Migrants and Mobile Populations – Testing and Linkage to Care

Key points

- Stigma, discrimination and racism are the primary barriers to healthcare access for migrants
- Among migrants living with HIV in Europe and Central Asia, there is significantly higher prevalence among transgender migrants
- Migrants account for a significant proportion of those newly diagnosed with HIV in Europe - and have acquired infection post-migration

Lessons learned

- Community-based testing is an effective strategy as community-led organisations create trustworthy, culturally sensitive environments for migrants to engage
- NGOs in Ukraine and Poland have played a major role in testing and treatment access for Ukranian refugees
- Providing service delivery and awareness raising messaging in different languages is key to engaging migrant populations

Next steps

- Urgent need for inclusive health policies and scale up of strategies for delivering HIV testing, prevention and treatment tailored to migrant populations
- Healthcare policy must take into account the need for earlier testing and treatment for migrants during the full migration process (pre, during, post)
- Anti-migration attitudes towards those from and outside of Europe must be acknolwedged and addressed
- There is willingness and interest to collaborate across the region, however sustainable funding for European NGO testing and linkage to care as well as initiatives (such as COBATEST) are integral to bring stakeholders together
- There is a need to address linkage to care data gaps with national public health institutes and NGO testing sites

"Migrants are willing to engage in HIV testing…. it is the services that are hard for them to reach"
Denis Onyango, Africa Advocacy Foundation

Day 2 – Side meeting: BBV testing in Emergency Departments

Key points

- BBV testing in ED can reach people who might not have tested otherwise.
- BBV testing ED was possible to implement due to funding, political will, stakeholder willingness/readiness, pre-developed protocols with examples of good practice, national guidelines, trained clinicians and collaboration with NGOs.
- Routine reporting on data from collaborating ED testing sites allows for sharing of real-time data with feedback from colleagues at conferences and regular meetings.
- **Health systems are adaptable**: Now there is earlier BBV treatment initiation than previously which has resulted in:
    - reduced re-admission rates, mortality and HIV-related health complications
    - prompt and effective partner notification

Next steps

- There is a need to leverage the success of this initiative to have new sites participate.
- Sharing stories of how this intervention has positively impacted individuals is powerful to demonstrate impact.
- UK colleagues happy to continue the conversation with other countries on implementing BBV testing in ED – get into contact with them!