

European AIDS Clinical Society

Standard of Care for HIV and Co-infections in Europe



Athens, Greece

16-17 October 2024



EACS European
AIDS Clinical Society



**EACS STANDARD
OF CARE**
for HIV and COINFECTIONS in Europe

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Introduction

The European AIDS Clinical Society (EACS) is the professional association of HIV doctors in Europe.

Since 2014, EACS has been holding biennial Standard of Care for HIV and Co-infections in Europe meetings (and workshops at their conferences in alternate years) with the aim of developing a common standard of HIV clinical care throughout Europe. Two years ago, EACS announced a collaboration with the European Centre for Disease Prevention and Control (ECDC) to create standards of care for Europe and to use auditing as a tool to make them a reality. EACS and ECDC met in Athens, Greece from 16 to 17 October 2024 to discuss the progress of the Standard of Care collaboration and also to discuss several issues that impact on achieving equitable standards – health system structures, migration and stigma.

ECDC's Teymur Noori told the meeting that the Standard of Care project was motivated by the fact that "large differences in delivery of HIV prevention, treatment and care exist across the WHO European region". (Although ECDC has no direct responsibility for non-EU countries, its advisory and supportive role enables EACS to extend the project to those countries.)

The project does not set guidelines. Guidelines recommend the best treatment and care, as determined by scientific data. The Standard of Care aims to be a consensus statement of the minimum standards that should be aimed for, given the socioeconomic, structural, legal and cultural inequities and constraints that exist across the region, and between and within individual countries.

Importantly, the Standard of Care is designed to be auditable. This means that it should be possible to collect data on the degree to which countries, regions and individual HIV services attain each auditable indicator (quantifiable target). This allows performance to be compared with other countries or services, or, when audits are repeated, to compare it with performance in previous years. In turn, the results from audits can be used to spur improvements in underperforming services and even suggest new approaches to care.

To be auditable, the standards need to be simple, succinct, achievable and, as much as possible, applicable to all countries. It has been a complex task to develop such simple indicators, and an important part of the meeting was devoted to how it is being done.

How the standards and audits work

The overall European Standard of Care covers 12 ‘modules’ or areas of care, and it was announced in 2022 that there should be time to develop and audit at least four of them by 2026. So far, two have been fully developed – testing and PrEP – and the aim is to start auditing them early next year.

Given varied national and project capacity, countries decide on which audits they participate in. For example, Poland, Italy, Croatia, Belgium and Spain have already undertaken an audit of, or have begun to audit, their PrEP services. France, Estonia and Greece have indicated they may join in, while Georgia, Germany, Hungary and Romania are gathering feedback from stakeholders on feasibility.

Work is ongoing to develop auditable standards of care for three other modules – HIV treatment and care, co-morbidity treatment and care, and antenatal screening for HIV and other conditions.

The other seven modules are ageing, mental health, PEP, stigma, linkage to care, person-centred practice and care and maintenance of viral suppression. Some of these subjects overlap. For instance, the standards on co-morbidities will include screening for depression and anxiety. And is following up people who are lost to care part of linkage to care, or of maintaining viral load suppression?

Much of the workshop was taken up with exploring such complexities, with reference to the experience of developing the five modules already being worked on. Former EACS President Professor Jürgen Rockstroh was optimistic that up to seven complete modules would be written by 2026.

He emphasised that audits were not only of clinical practice, and did not have to be conducted entirely or mainly by clinic staff. Audits could also cover national policies and guidelines, in which case the data source would be those documents. Other data sources might be national or international surveillance data, or the findings from surveys of local authorities, non-governmental organisations (NGOs) or community members. Even at a clinic level, the required data might simply require a binary yes/no answer (such as ‘do you provide the hepatitis B vaccine?’). So while some questions might need medical records and case notes to be reviewed, not all would.

The development process – testing and PrEP

Dr Miłosz Parczewski, EACS Vice President, outlined the painstaking process for the development of each quality statement and each standard.

ECDC provides advice on what can be codified as quality statements and acts as final reviewer. A core group, not formed from members of the writing group, helps the writing group co-ordinate its activities and provides ongoing support.

A researcher—often a PhD student—is commissioned to review the existing evidence base of government and health system policies, existing guidelines and statements. Meanwhile, the writing group decides which aspects of the module it aims to formulate as quality statements, which members of the writing group will work on which statements, and whether to bring in outside specialists for certain aspects of the module. This working process and methodology are presented to the advisory board.

Only after this does the writing group, splitting itself into different working parties, start drafting the quality statements and their associated auditable indicators. The whole writing group then decides on which standards to include, and also which not to include: some standards may be impractical to audit, may only apply to a few countries, or may duplicate standards in other modules.

The final consensus draft is then presented to ECDC's advisory and review board and then to the next Standard of Care meeting.

Dr Parczewski talked about how auditable indicators can be 'reverse engineered' from a desired indicator which might not be easy to measure. The ultimate desired indicator for PrEP provision, for example, is a reduction in HIV incidence in the group taking it. But this data is rarely available for specific sub-groups and even if HIV incidence is falling, the causes are difficult to disentangle.



Dr Miłosz Parczewski. Photo by Bernard de Kayzer

An intermediate desired indicator might be the percentage of a specific key affected population – gay and bisexual men, or cisgender women in high-prevalence groups, for instance – taking PrEP. But this, to be audited meaningfully, might require adherence to PrEP to be audited as well as prescriptions for it, and that’s hard to measure.

More feasible to audit might be the proportion of each key affected population *offered* PrEP. This is classed as a ‘process outcome’ – one which is not dependent on user behaviours like adherence, but which in many settings can be derived directly from clinical records. It measures access, rather than the effect of that access.

In some situations, even this information may not be easy to obtain – as in a country where a significant amount of PrEP is obtained privately.

In such a setting one may only be able to measure a ‘structural outcome’ – namely, PrEP availability in the country, or whether it is reimbursed in local settings. This may be the easiest indicator to audit – but it is also the furthest away from the ultimate desired indicator.



EACS Co-Chairs **Dr Cristiana Oprea** (Romania) and **Dr Ann Sullivan** (United Kingdom). Photo by Alexandros Vetoulis

Dr Dorthe Raben of the **CHIP research collaboration** in Copenhagen explained that for each module, a set of quality statements are developed. An example from the testing module, for instance, is: “Everybody living with HIV should be aware of their status in order to access timely treatment and care.”

Statements like this imply auditable indicators which may, or may not, be auditable in practice, depending on the setting. This quality statement implies indicators such as:

- the proportion of people with HIV who know their status.
- the proportion who are diagnosed late (CD4 count below 350) and very late (CD4 count below 200).
- the average time taken from diagnosis to treatment provision.

These indicators are paired with targets established by the writing group. In the case of the first indicator, the target is 95%, in line with the UNAIDS 95-95-95 target – this can probably be obtained at country level by national surveillance systems.

The target for the second indicator is a 2% annual decrease in the proportions of people diagnosed late and very late. Note that this is a target that can only be established by means of at least two sequential audits. The data may be recorded nationally or may only be available at clinic level.

The third indicator is only likely to be auditable using clinic, rather than national, records. The indicator is “the proportion of newly diagnosed patients attending an HIV specialist appointment within two weeks of their initial HIV diagnosis” and the target is 90%.

The development process – treatment, prenatal screening and co-morbidities

There were also presentations of three modules that are in the process of development.

Dr Juan Ambrosioni of the Barcelona Hospital Clinic presented the work of the HIV treatment and care module. The writing group is made up of six clinicians, two public health experts and a community representative. The module was split into seven areas:

- Access to antiretroviral therapy (ART)
- Pre-ART assessment
- Initiating ART
- Key populations' access to ART
- Community services including peer support, mental health, social work, etc.
- Monitoring and support for people who are not virally suppressed
- Monitoring for virally suppressed people.

Within these seven areas there are 24 quality statements and their associated indicators, including whether demographics including HIV

risk group are collected, which pre-assessment tests are given and how often people who are not yet virally suppressed are seen.

It was particularly difficult in this module, Dr Ambrosioni said, to separate standards of care from guidelines, partly because in this case they are often closely aligned (e.g. in choice of first-line regimen). In other cases, however, practice differed from country to country and even from clinic to clinic (e.g. in how often people with stably undetectable viral loads should have a viral load test).

The module on antenatal screening hit an interesting problem. Dr Annette Haberl of the Frankfurt University HIV centre showed the meeting 'das Mutterpass', a booklet issued to expectant mothers in Germany and Austria, which contains all the screening tests they should expect. Other countries issue similar documents.

The monitoring of mother and baby in pregnancy is therefore already the subject of care standards and there are not that many additional screening tests that pregnant women with HIV need to have.

In addition, much antenatal testing is performed by obstetricians, not HIV doctors. This brings up the subject of whether other specialists can be asked to help complete an audit of HIV services.

This issue also arose in the module on co-morbidities, introduced by Jürgen Rockstroh. The co-morbidities section occupies 40% of the EACS guidelines and here, the main task of the writing group was to slim down these guidelines to a small number of auditable standards that are particularly important to monitor in people with HIV.

The writing group so far consists of six HIV physicians, one public health expert and two community representatives, though Professor Rockstroh said additional members would still be welcome. They had also invited non-HIV specialists in areas where outside expertise was particularly needed – one oncologist, one psychiatrist and two experts on ageing, one also with mental health/neurocognitive expertise.

The writing group faced several challenges. One was to formulate simple and auditable quality statements and not simply repeat guidelines. The other was similar to the one faced by the writers of the antenatal screening module; would other specialists like oncologists or cardiologists be happy to engage in an audit of HIV services?

Another issue was that some co-morbidity screening tests are usually conducted as baseline tests after an HIV diagnosis. Should they be in the HIV treatment and care module instead?

Ultimately the group boiled the co-morbidities remit down to five topics:

- **Cardiovascular:** the quality statements here will cover baseline cardiovascular risk assessment, smoking assessment, and regular BMI and blood pressure testing.
- **Cancer:** here the quality statements cover screening for cervical cancer, anal cancer (in gay and bisexual men and trans people), bowel cancer (in people aged 50-80) and liver cancer (in people with cirrhosis).
- **Mental health:** these include annual depression and anxiety screening, sleep disorder monitoring, and drug and alcohol use assessment.
- **Ageing:** these include frailty assessment, neurocognitive assessment, and regular medication reviews to guard against polypharmacy and drug-drug interactions.
- **Other screening:** these include renal function, liver function, bone mineral density and fracture risk, and lung function testing in people presenting with respiratory symptoms.

The group decided that rather than trying to engage other specialists in audits of HIV services, an overarching quality statement and set of indicators will be developed that covers the establishment, maintenance and documentation of standard referral pathways to and from these other specialities.

Breakout groups and arising issues

The meeting then split into three breakout groups to discuss how different countries and regions might implement the standards.

One group consisted of members from Greece and Türkiye, the second from other countries in central and eastern Europe, and the third from countries in western Europe.

Despite regional differences, the feedback from the breakout groups was quite consistent and is consolidated here. Group members were asked how they would implement the standards in their country, what the barriers might be, and what they would do to overcome those barriers.

The following issues were prominent in the group discussions:

- **Health ministry liaison.** Members from most countries were reasonably confident that they could engage with government bodies who could contribute data on structural outcomes for the standards. The delegates from Türkiye thought that one-to-one meetings between EACS/ECDC representatives and government officials (many of whom are new after this year's election) might facilitate this process.
- **Government liaison.** Politicians, as opposed to civil servants, are harder to engage. "Politicians have no interest in this issue unless you can present their engagement as their achievement," commented one delegate.
- **Key affected population monitoring.** Many countries, including Türkiye, still do not collect data from service users on the affected population they belong to. This does not prevent good medical care post-diagnosis, but it means that it is difficult to establish how well these groups are being served. It may also detract from the effectiveness of NGOs and other civil society institutions that support key populations. These are the institutions that do most to support interest in testing and in prevention activities.
- **Private versus public sector.** In some countries, provision is split between monitoring public-sector clinics and private practices/pharmacies. Liaison with national pharmacy organisations might help, but the private sector does not collect the standardised data that national health systems do.
- **Legal constraints.** Outdated or over-protective attitudes towards confidentiality are a barrier to opt-out testing in some countries such as Germany. Delegates felt there was a need for strong advocacy to publicise the negative aspects of mandatory 'opt-in' consent in testing, especially where it applies solely to HIV. Concern with confidentiality, or with outdated methods of preserving confidentiality, may also limit the gathering of data on key affected populations. Many countries across Europe still only allow medically qualified people to administer HIV tests.

- **Regional differences.** These may arise because countries have a differently structured HIV service to their neighbours or because provinces have considerable autonomy on guidelines, reimbursement and reporting data. This can limit what can be audited – but it is also exactly the kind of inequality that an audit can highlight.
- **Undocumented migrants** and some other populations (see below) still do not have access to ART in many countries, which acts as a disincentive to testing.
- **Low awareness of HIV among non-HIV healthcare staff.** The ECDC/EACS ‘Stigma in Healthcare Settings’ survey, which was also presented at the meeting (see below), exposed considerable ignorance of quite basic HIV facts among many healthcare workers. This may be a barrier to collecting data from other specialists and GPs, but audit results could and should be used as an educational tool to overcome this.
- **Stigma and ignorance in the general population.** This is of course a huge problem, of particular importance in relation to prevention and testing. Audits could be used as a tool to suggest interventions in the community that might alleviate this.
- **Availability of PrEP.** The non-availability or limited availability of PrEP in some countries is not only harmful in itself but also represents a lost opportunity to engage members of key affected populations in their own sexual health before they acquire HIV.
- **Capacity and funding.** This was a big issue, both for clinicians in lower-income countries, especially in eastern Europe, who may not have the administrative support to help perform audits, and also for civil society organisations who need to be engaged in reporting certain indicators, e.g. of testing and demographics.
 - A number of ideas came up about how to resolve capacity and funding issues and enable participants to conduct audits. One person pointed out that the audit structure was a very flexible tool. While in one country it may be possible to call on all levels of the health system to contribute, in another even a single clinic with restricted administrative support could conduct clinical-note audits on some aspects of their service, and use it to engage community and NGO stakeholders in the exercise.
 - Where money is the chief issue, especially where there is no extra funding to pay administrative and research staff to help with an audit, it may be possible to source funding from the philanthropic and international sectors, at least for a pilot project. A good example from outside EACS was a pilot study of patients lost to care that was supported by the **Elton John AIDS Foundation**: three south London hospitals were able to conduct an exercise characterising, tracing and re-engaging patients who had been lost to care. This pilot project led to a **larger investigation by the UK Health Security Agency** (the government’s public health body) that led to the finding that there might be as many HIV-positive people lost to care in the UK as were left undiagnosed.

As one delegate remarked: “Even if you have an ‘action plan’, the problem now is its implementation.” The next EACS Standard of Care meeting will be an opportunity to explore to what degree the standards have been implemented.

Greece and Türkiye – pivotal countries in the global fight to defeat HIV

EACS' decision to hold the 2024 meeting in Athens, Greece and to invite healthcare and community representatives from Türkiye and Greece to help organise it was timely. This region – the bridge between western and eastern worlds for millennia – has also become the world's hotspot for HIV in terms of new infections.

The world's annual total of HIV diagnoses fell by 39% between 2010 and 2023, [UNAIDS reported](#) at the AIDS 2024 conference in July, and by 59% in eastern and southern Africa. In contrast, in eastern Europe and central Asia, diagnoses rose by 20%, and they more than doubled in the Middle East and north Africa. In eastern Europe AIDS-related deaths increased by 35% – showing that treatment is not reaching those who need it most. Greece and Türkiye are respectively classed as being in western and central Europe by the World Health Organization – but what is happening on their borders is key to the future of the HIV epidemic.

People with HIV in Greece and Türkiye face barriers to a better standard of care that are both external, in terms of global events, and internal, in terms of structures in the healthcare system, and stigma within it. We will look at stigma below.

The way HIV services are structured within the Greek and Turkish healthcare systems are very different and have differing results. In Greece, testing is free (though explicit consent is needed) and available in a variety of community settings, but Greece has only 16 HIV treatment centres, 11 of them located in Athens. If you have HIV and are living on a remote island, your HIV clinic may be a day's journey away.

In contrast, Türkiye has a network of over 100 HIV care clinics, and HIV testing services are widely available in hospitals, primary care centres, and via private labs. But there are only six specialist voluntary counselling and testing centres in the country, all in the big cities. As a result, people don't seem to be coming forward for testing.

Barriers to care in Greece

The UNAIDS 95-95-95 target requires that 95% of people with HIV know they have it, 95% of those people are taking ART and 95% of them are virally suppressed, meaning 86% of all people with HIV are virally suppressed. Professor Antonios Papadopoulos and Dr Konstantinos Protopapas, both of Attikon University Hospital in Athens, compared this target with the situation in Greece.

Approximately 85% of people with HIV in Greece know their status and of those, 82% are linked to care and on ART. This process may take some time, though. In Greece, 55% of people start treatment within a month of diagnosis, while 26% have still not started treatment after three months (in the UK, for example, the corresponding figures are 75% and 12%).

Where Greece *appears* to fall behind the UNAIDS target most badly is in the proportion of people with HIV who have an undetectable viral load. This is 56% if we only count the proportion of people on ART with documented viral suppression, implying that the proportion of all people with HIV who are virally suppressed is only 39%.

But Dr Protopapas told the meeting the true proportion is nearer 86%, which is the number on ART who would be suppressed if it is assumed that people with undocumented viral load test results are also undetectable. This would imply that 61% of all people with HIV in Greece are virally suppressed. He said: "According to the National Guidelines, viral loads should be done twice a year. The problem occurred during a five-year period, 2016-2021, when we could not perform the test, but since 2021 this has been resolved. We have had incomplete data entry during the past couple of years, but we believe the 86% figure is accurate."

He emphasised that the people left unsuppressed are mostly immigrants and people who inject drugs. On the second day of the conference, Dr Giota Lourida of Evangelismos Hospital in Athens

presented an overview of HIV healthcare stigma in Greece and the challenges of HIV care in Greece, including staff shortages, HIV services not being provided at facilities for people who inject drugs, and a lack of support services for migrants within the Greek healthcare system. She identified these as significant problems affecting HIV care.

A high proportion of new diagnoses in Greece are in key affected populations other than gay and bisexual men. In 2012, there was an HIV epidemic in people who inject drugs in Athens, with more than half of all diagnoses in Greece in this group that year. Swift action included setting up harm reduction services that quickly reduced onward HIV transmissions, and diagnoses in people who inject drugs were down to their previous level of 120-160 a year within two years.

But since then, there has been a smaller but significant increase in infections in people who inject drugs in Greece's second-largest city, Thessaloniki, and injecting drug users still comprise 20 to 30% of all new diagnoses. The number increased somewhat to a total of 535 last year; in a country with the population of the UK or France that diagnosis rate would equal more than 3700 cases.

Migrants used to form about 10% of those diagnosed with HIV in Greece, but 40% of new HIV cases were in people not born there last year. The majority of migrants acquire HIV after they have arrived in Greece.

The meeting heard a very moving testimony from a young west African woman (who asked not to

be named) who had ended up in Greece after being trafficked from Türkiye. She gave an account of initially understanding she had tested HIV negative, getting shuttled between her HIV clinic and the medical service at her migrant centre, and constantly struggling to travel between one and the other. People with HIV in Greece are, unusually, entitled to a monthly benefit close to the national minimum wage regardless of their actual state of health, but undocumented migrants are not eligible.

In terms of the figures, although there has been international publicity about migrants flooding into Greece from Türkiye, most of them are Afghans, Syrians and Iranians – currently countries with low HIV prevalence. Most foreign-born people with HIV in Greece are from sub-Saharan Africa (30%, and over 50% of them women), central Europe (22%) and eastern Europe and central Asia (18%). People from north Africa and the Middle East only account for 6.1% of migrants with HIV.

As for the treatment cascade, even if as many people on ART with undocumented viral load results are undetectable as people with documented viral loads, still only 47% of HIV-positive people who inject drugs and 42% of migrants are virally suppressed.

If we can't rely on viral load suppression (Undetectable equals Untransmittable; U=U) to bring down onward HIV infections in Greece as yet, how about PrEP? The answer is, there is almost none. The Greek Health Ministry **approved the use of PrEP** in September 2022 – but in practice it is not yet available.



Dr Konstantinos Protopapas. Photo by Alexandros Vetoulis



Professor Antonios Papadopoulos. Photo by Alexandros Vetoulis

Barriers to care in Türkiye

Dr Deniz Gökengin of the Ege University School of Medicine in Izmir presented the situation in Türkiye.

In 2010, about 500 people a year were being diagnosed with HIV. Diagnoses then started to rise exponentially, and in 2022 new cases reached 5200, meaning that for the first time, the rate of new diagnoses in Türkiye outstripped the population rate in Greece, which has 12% of its population. Data from cohort studies found that 55% of cases were acquired via heterosexual sex and 27% via sex between men; Türkiye has not seen an epidemic in people who inject drugs like Greece.

“A local survey of men who have sex with men found that 41% were aware of PrEP, but only 1.7% were using it.”

While models show that, globally, HIV incidence – the rates of new HIV infections, regardless of diagnosis rates – halved between 2000 and 2020, incidence in Türkiye rose sixfold in men and fourfold in women, albeit from a much lower base, with the rate in women catching up in recent years.

In terms of the 95-95-95 targets, once people are diagnosed 88% are linked to care and of them, 87% are virally suppressed. But it is estimated that only 41% of people with HIV in Türkiye know their status. This is strongly linked firstly to the lack of community-friendly voluntary counselling and testing services and secondly to stigma, especially for key populations.

PrEP is in theory available in Türkiye but it is not reimbursed and unfavourable price negotiations and exchange rates make even generic PrEP four times as expensive in Türkiye as in western Europe (the Lira has lost 83% of its value against the Euro since 2019).

A local survey of men who have sex with men found that 41% were aware of PrEP, but only 1.7% were using it. Dr Gökengin’s centre opened a clinic for PrEP but found no takers for it. “No-one is using PrEP because the high price to be paid out of the pocket precludes its sustainability in the long term,” she says.

While much of the data to confirm it is missing, one factor or potential factor in the increase of HIV cases in Türkiye is the large number of migrants and refugees. Türkiye hosted the largest number of refugees and displaced persons in the world up until last year, when Iran, with a huge influx of Afghans, overtook it. Most of them are some 3.7 million Syrians fleeing civil war and who are “under temporary protection” (meaning that the Turkish government regulates their right to stay). Another 330,000 are refugees under international UN law. The Syrian civil war doubled the number of refugees in Türkiye, to 4.4% of the population. Overall, 16% of people with HIV living in Türkiye were born abroad.

The refugees are a young population – average age 22 – and 71% are women. Contrary to the images in the news, only 1.3% actually live in refugee camps – the others live in towns, cities or ‘informal housing’. They are concentrated in nine southern provinces close to the Syrian border where they form 12.3% of the population as opposed to less than 5% in the other 91 provinces.

Significantly, only one in every 12,500 refugees has obtained a Turkish work permit, so most work illegally. It is unknown how many resort to sex work, as there have only been small surveys of this population. A study of 26 Syrian sex workers who were under temporary protection (14 trans women, eight cis women, four gay men) found that 81% had sex work as their sole source of income, 42% were using various drugs and 77% used alcohol.

There may be high rates of HIV and associated infections in this population, although this is unclear due to lack of testing. One survey of Syrian migrants in Istanbul found that 0.2% were HIV positive, which is similar to the general population. However, a scoping review of several studies of Syrian refugee women attending outpatient clinics nearer the border found that on average 2% had HIV, 2% hepatitis C and 4% chronic hepatitis B.

One piece of data suggested that investing in better testing and reporting could pay dividends. A model has shown that if the testing rate in Türkiye was increased to 70%, there would be a subsequent decline of 85% in HIV incidence, solely due to the higher proportion of people with viral suppression. EACS hopes to help Greece and Türkiye develop better services for people with HIV in these two countries that are pivotal in the fight to defeat HIV.



Dr Deniz Gökengin. Photo by Alexandros Vetoulis

Towards more co-ordinated sexual health services

The way sexual health services are organised can act as a barrier to co-ordinated care. Dr Josip Begovac of the University Hospital for Infectious Diseases in Zagreb, Croatia used his country as an example.

Referring to the World Health Organization definition of sexual health as “a state of physical, emotional, mental and social well-being in relation to sexuality, and not just not absence of disease”, he said that sexual health required a positive and respectful approach to sexuality and sexual relationships (without coercion, stigma or violence).

In practice, different aspects of sexual health are treated at different care levels, and may be the professional concern of a variety of specialists: GPs, dermato-venerologists, infectious disease physicians, gynaecologists, and so on.

In Croatia, and former Yugoslavia generally, the ‘classical’ bacterial STIs are treated by dermato-venerologists. They do not treat HIV or hepatitis B or C, and in everyday practice rarely test patients for these diseases.

“In real life,” Dr Begovac said, “there is almost no service that can test in due time for all STIs, especially for the MSM [men who have sex with men] population, and provide treatment when necessary at one place.”

In order to see a dermato-venerologist, the patient needs to get a referral from their GP, which involves disclosing why they need the referral. After examination and tests, they need to come back to the GP for the prescription for treatment and then go to a pharmacy to get the drug. All this takes time, involves more people and can be stigmatising. The result is that people pay for a private service or attempt self-treatment.

What is needed, he said, are STI services people don’t need a referral for, with on-site diagnosis and treatment. They should adopt efficient methods such as self-testing and be targeted to specific populations with good liaison with NGOs and social support. And they should be staffed by skilled, informed and community-friendly healthcare workers.



Dr Josip Begovac. Photo by Alexandros Vetoulis

Many healthcare workers in Europe don't know basic HIV facts, survey reveals

In contrast, a large survey of healthcare workers across Europe has revealed, there is widespread ignorance about HIV transmission and prevention among healthcare workers.

A large minority were unaware that a person with an undetectable viral load cannot pass on HIV, while a majority were unaware of PrEP. Although doctors were on the whole better informed than other healthcare workers, 51% of the physicians who answered the survey were either unaware of PrEP or had inaccurate knowledge of it.

The survey, jointly conducted by EACS and ECDC, also found that a minority of healthcare workers were reluctant to treat people with HIV. This was often due to lack of training or outdated views on transmission, but was also at times due to stigmatising attitudes.

A previous survey of the experience of stigma among people living with HIV was presented at the 2022 Standard of Care meeting in Brussels ([see this report for the full findings](#)). In that survey, 23% of respondents had said that they "worried about being treated differently" if they disclosed their HIV status to healthcare staff, and 12% said they had avoided healthcare appointments in the last year because of that worry.

Teymur Noori from ECDC presented the new survey's findings. It was distributed to 54 countries in Europe and central Asia between September and December 2023 and 18,430 people replied, a large number for this sort of survey.

Nearly three-quarters (74%) of respondents were female. Forty-four per cent of respondents were doctors and 22% were nurses. The other one-third ranged from other specialists such as radiographers and dentists to admin workers and students. Fifty-eight per cent said they worked in a hospital and 17% in a primary care centre.

Only 7% worked in a dedicated HIV department. Thirty per cent were located in an infectious disease department or other in-patient hospital facility, while 13% worked in surgery or in an A&E department. A quarter worked in primary care or another out-patient facility.

Perhaps the most revealing results were of respondents' basic knowledge of HIV facts. The survey asked respondents whether they agreed with, disagreed with or didn't know the answer to three statements about U=U, PEP, and PrEP. They were:

- U=U: People living with HIV who are on effective treatment and have an undetectable viral load cannot transmit the virus sexually.
- PEP: Taking a short course of HIV medicines after a possible exposure to HIV prevents the virus from taking hold in your body.
- PrEP: Someone who does not have HIV can take HIV medicines to prevent them from getting HIV.

"I disagree" and "I don't know" were both classed as incorrect answers.

A quarter of respondents gave no correct answers to the three questions – not many fewer than the 31% who gave three correct answers.

People tended to give more correct answers to the U=U and PEP questions. Sixty-one per cent answered the U=U question correctly (69% of doctors), and 56% the PEP question (67% of doctors). But levels of knowledge of PrEP were considerably lower, with only a minority of 41% knowing about PrEP, and even a minority of doctors (49%).

The only workplace setting where more people knew about PrEP than not was community centres, where 53% knew and replied correctly about it. Only 46% of hospital workers were aware of PrEP, and only a third of people working in primary care. In contrast, two-thirds of hospital workers answered the U=U question correctly, and a bare majority (52%) of workers in primary care.

“Twenty-six per cent said they still used double gloves when working with a person with the virus.”

Understandably, those who cared for more people with HIV were more likely to have correct knowledge. Of healthcare workers who were not aware of having cared for any HIV-positive patients or clients in the last year, 23% answered the PrEP question correctly, versus 89% of those who had seen more than 100 people with HIV.

The survey asked about incorrect or out-of-date knowledge of HIV transmission, especially during medical procedures. About a quarter of respondents (23%) were “worried” dressing wounds of a person with HIV, and 27% when drawing blood. Twenty-six per cent said they still used double gloves when working with a person with the virus.

The survey also asked whether people “preferred not to” provide services for four different key populations with HIV: transgender women and men, sex workers, men who have sex with men and people who inject drugs. This varied by geographical region, with scarcely any respondents in western Europe not wanting to work with the first three categories and 6% preferring not to work with people who inject drugs, whereas in eastern Europe 15% preferred not to work with the first three categories and 21% not with drug users.

Among the people expressing aversion to working with HIV-positive patients or clients, the reasons for these preferences ranged from the practical (“I haven’t had training”, with 50% of respondents giving this reason for not working with drug users and 49% with transgender people), through outdated or exaggerated risk perception (“They put me at risk”, with 43% giving this reason not to work with drug users and 38% with sex workers) to straightforward disapproval (“This group engages in immoral behaviour”, with 50% giving this as the reason not to work with men who have sex with men and 45% with sex workers).

When asked if they had *observed* stigmatising behaviour in other healthcare workers, 30% said they had heard discriminatory remarks, 22% had witnessed reluctance to care, and 19% said they had witnessed non-consensual disclosure of a person’s HIV status to a third party.

Teymur Noori concluded: “This study underscores the importance of implementing targeted interventions, aimed at different healthcare facilities and healthcare professions, to combat HIV-related stigma and discrimination.”

The full report of the ECDC/EACS survey, *HIV Stigma in the Healthcare Setting*, can be accessed here: www.ecdc.europa.eu/en/publications-data/hiv-stigma-healthcare-setting-monitoring-implementation-dublin-declaration

More on migrants in Europe

Returning to the challenge of caring for migrants with and at risk of HIV, Dr Asuman Inan of the University of Health Science in Istanbul told the meeting that 50 million people in the world were refugees or asylum seekers in 2023.

Three-quarters of them came from just five countries – Afghanistan, Syria, Venezuela, Ukraine and South Sudan – and nearly 40% were hosted by just five countries: Iran, Türkiye, Colombia, Germany and Pakistan.

Though people not born in their home country form 14% of the population of the European Union/European Economic Area (EE/EEA), 48% of new HIV diagnoses were in this group in 2022. Across the region, the number of people diagnosed with HIV in their home country has been decreasing in all sub-groups since 2014, whereas diagnoses in migrants have increased since 2014, except during COVID in 2020-2021, and increased sharply in 2022. There are now more diagnoses in heterosexual migrants than any other group. People over 50, migrants from south and southeast Asia and heterosexual men (in general) are also more likely to be diagnosed late than other populations; while 50% overall are diagnosed with CD4 counts lower than 350, in these three groups 68%, 64% and 63% respectively were diagnosed late.

The cascade of care in migrants is greatly under-reported. In 2022, a third of countries in Europe and central Asia reported no data for any step of the 95-95-95 cascade when it came to migrants. Of those who did, 11 reported on the proportion of migrants with HIV who were diagnosed, nine reported on the proportion of those on ART, and seven on the proportion of those who were virally suppressed. Only four countries – the UK, Austria, Luxembourg and Czechia – were able to report on all three stages and only the UK achieved the

95-95-95 target (though the UK is the only country in western Europe that does not specifically mention migrants as a key affected population in its national HIV strategy).

Talking specifically about Türkiye, Dr Inan said that the majority of the 10 million HIV tests in Türkiye last year were taken by Turkish citizens, who have access to free testing; they are often taken by people at relatively low risk for reasons such as employment requirements and pre-nuptial agreements. HIV tests are not free for non-citizens.



Dr Asuman Inan. Photo by Alexandros Vetoulis

Ukrainians in Poland

Dr Bartosz Szetela of the HIV clinic in Wroclaw, Poland updated the meeting on the way that refugees from Ukraine had transformed the delivery of HIV care in that country.

In 2021, just 1.2% of new diagnoses in the EU/EEA were in people born in Ukraine, jumping to 10.2% in the following year, with the majority in Poland. Until the war in Ukraine, Poland's HIV epidemic had been a relatively low-prevalence one primarily in gay and bisexual men: three-quarters were men who have sex with men, 20% heterosexual and 5% people who injected drugs.

In contrast, among Ukrainians in Poland, 60% were heterosexual (of whom 70% were women), less than 5% were men who have sex with men, and over 35% were people who inject drugs. The majority are still people already diagnosed in Ukraine, but the proportion diagnosed in Poland (either as newly diagnosed or people returning to care) has now increased to 11%.

No less than 70% of these Ukrainians diagnosed in Poland are either diagnosed late or had dropped out of care in Ukraine and re-present with low CD4 counts. Forty per cent had an HIV-related illness at diagnosis. This included *Pneumocystis jirovecii* pneumonia in 19%, toxoplasmosis in 12%, and *Mycobacterium avium* in 7%. By far the most common was tuberculosis, in 40%, of whom 30% (86 cases) had multi-drug resistant TB.

Dr Szetela said that regular attendance for care was difficult for many Ukrainian refugees, whether newly diagnosed or not. He urged clinicians to plan for patients who might struggle to attend as often or as regularly as guidelines recommend.

He said that peer support and assistance with the bureaucratic aspects of health care could greatly assist retention in care. This included some simple and not necessarily expensive measures such as providing travel cards or arranging ride-shares among people with no extra money for transport. People with stable viral suppression could be offered telehealth appointments as had happened during COVID, rather than expecting them to attend all appointments in person.

“Regular attendance for care was difficult for many Ukrainian refugees, whether newly diagnosed or not.”

He proposed a list of recommendations for migrant populations in Europe generally, some of which could form auditable quality standards for a module on migrant populations:

- All countries should improve monitoring and surveillance of their migrant populations.
- All countries should disaggregate their data on the continuum of HIV care by population group.
- HIV testing and treatment should be available and accessible, regardless of residential and migration status.
- Services should reflect on how to best engage with and provide information to migrants on HIV testing and treatment as early as possible upon arrival.

- As 30-40% of HIV among migrant populations is acquired after arrival, screening newly arrived migrants at point of entry alone may not be enough to tackle rising incidence in this key population.
- Information campaigns for migrants which provide information about accessing the healthcare system and address barriers to HIV care should be considered.
- Primary prevention services, including condom provision and PrEP, should be expanded whilst ensuring they are accessible for migrants.
- Holistic approaches to testing and treating HIV that integrate links between HIV support services and other services (i.e. housing, mental health, financial, legal) are necessary to address psychosocial factors such as poverty and homelessness.
- We must reflect on how general attitudes and legislation around migrants, especially undocumented migrants, may impact their willingness to seek out medical support.



Dr Bartosz Szetela. Photo by Alexandros Vetoulis

Will things get worse for European migrants?

Finally, Denis Onyango of London's Africa Advocacy Foundation reminded the meeting that health services for migrants could be cut, rather than expanded, in the future.

He concentrated on the position of so-called 'undocumented migrants' but emphasised that only a minority of them had arrived on the boats that are so prominent in the headlines. The majority were people whose permission to reside in a host country via work or study visas or similar had lapsed, and they were often trying very hard to regularise their status.

He laid emphasis on the worse physical health of being a migrant but also on the mental health toll: for instance, one French study found that one in six migrants in France had symptoms of post-traumatic stress disorder – a rate at least eight times that in the French-born population.

There are currently 15 countries in western Europe that allow free testing for undocumented migrants but of these, only 10 allow free access to ART: countries not providing ART include Germany, the western European country with the highest migrant population.

Even these entitlements could be withdrawn under the proposed EU Pact on Migration and Asylum, which reflects a general move in Europe towards restricting migrant numbers and entitlement. This strengthens legal sanctions not only against people arriving 'illegally' such as on boats, but also among people who assist them, or civil servants who fail to report them.

It provides for mandatory health screening, not just at borders but of people found to be undocumented, and swifter deportation. Most

importantly, while European countries including Belgium, Italy, France and Portugal have had legislation in place to ensure that undocumented migrants residing in their countries can access necessary preventative and curative health care, these changes can be reversed at any time.

In this climate, a clear demonstration of why better care for everyone with or at risk of HIV in Europe will benefit public health in general is not only desirable, but also necessary.



Denis Onyango. Photo by Alexandros Vetoulis

Report by Gus Cairns, editing by Amelia Jones and Roger Pebody,
and design by Beth Tunncliffe for the European AIDS Clinical Society.



Photo by Alexandros Vetoulis

