EACS HIV Summer School Report

Monday-Friday
9-13 September 2024
Prague, Czechia

EACS European AIDS Clinical Society

EACS | HIV Summer School

CONTENTS

1. Introduction and Event Summary

This document gives an overview of the European AIDS Clinical Society (EACS) HIV Summer School 2024. The HIV Summer School 2024 was designed for HIV physicians and clinical scientists to exchange ideas and practices with colleagues and faculty from all over the world. It also helped to create and reinforce the international network of young physicians engaged in the fight against HIV.

The event gathered 60 participants from 32 countries, for a five-day training programme on 9-13 September 2024 in Prague, Czechia. Accredited by the European Accreditation Council for Continuing Medical Education (EACCME®), attendees earned 27 European CME Credits (ECMEC®s) for time dedicated to education outside daily clinical practice.

The programme was developed by a Steering Committee, made up of six members from across Europe. The faculty consisted of 19 global experts in HIV clinical care and research. A full list of the Steering Committee members and expert faculty can be found on page (TBD).

DAY I

The first day opened with a welcome and faculty introduction, followed by three plenary sessions over two hours, before breaking up into afternoon working groups to discuss Research and Clinical practices and concluding with a presentation for afternoon discussion. The Day I working groups considered: **Study design, Treatment initiation, Identifying the research question and study design**, and **Management of long-term ART and comorbidities.**

In the first plenary session, **Nicola Mackie (United Kingdom)** considered **Antiretroviral Therapy (ART).** She explained principles of ART for the treatment of HIV and future perspectives for novel therapies, reflecting topics within the EACS core curriculum. This meant giving an overview of when to start ART, what to start, treatment optimisation including injectable antiretroviral therapy, and novel antiretroviral therapy and strategies. Her presentation ranged from the first description of AIDS in the early 1980s to the latest treatments available in the early 2020s. All major guidelines recommend ART for people living with HIV regardless of CD4 count, she reminded the audience, but the question of how quickly to start means considering the pros and cons of rapid ART. Patient factors, virus factors, and practical factors must all govern the decision about when to start. She then gave a detailed overview of existing guidelines, before summarising key trials and key messages. Treatment optimisation takes account of issues such as weight gain, age and the prevalence of co-morbidities. Changing ART was then also discussed, with a look at the different treatments available the best candidates for injectables. A novel ART summary was followed by thoughts on what is still needed, including new models of patient-centred care and global access to drugs.

Esteban Martinez (Spain) then gave a plenary presentation on **Co-morbidities.** This opened with the statement that persons with HIV can live longer with ART and a graph to illustrate the huge drop in deaths since ART became available. At the same time, co-morbidities - which increase with age even for HIV-negative people - are

more prevalent in HIV patients. Both the therapy and the infection itself will affect co-morbidities. A look at data from 2006-2014 found that age is the most important risk factor for co-morbidities, including cardiovascular disease and chronic kidney disease. He reminded the audience that smoking, with its associated health risks including cancers and chronic diseases, is twice as common among people living with HIV than the general population. This means, simply, that smoking is a major factor of co-morbidities in HIV patients. Weight gain is another risk factor but people with HIV are likely to weigh less than people without HIV, although weight gain is associated with some HIV treatments. There was a warning that ART discontinuation not only increases opportunistic diseases and fatalities but also major non-AIDS co-morbidities. He gave an overview of the toxicity profile of some antiretroviral drugs, and a reminder that renal injuries are not always reversible. He concluded with a look at the prevention and management of co-morbidities, including through smoking cessation, saying that treating co-morbidity is more effective than switching ART, but both interventions may be needed.

A third plenary session heard **Anders Boyd (Netherlands)** consider **Establishing a research question and choosing an appropriate study design.** This means it is important to have a clear question before starting to design a study. The question will allow appropriate decisions around topics such as study population and the primary outcome of interest. A PICO checklist, looking at Population, Intervention, Comparator, and Outcome, can help with this. He showed how to use PICO to move from a vague question such as "Do people who see more doctors end up with worse outcomes?" to the very clear "Do elderly (>70 years), female people with metabolic syndrome and first presentation of TIA who have standard, multi-specialist (endocrinology, cardiovascular, gerontology) care have higher one-year mortality compared to those receiving integrated (endocrinology, cardiovascular, gerontology) guideline-driven, single centre specialist care within a metabolic clinic?" For research, however, there is also a need to avoid being too focused, because the more focused a question is, the less the answer will mean to the wider patient population. A look at the main types of study design was followed by consideration of research topics such as brain-age gap between persons with and without HIV.

A brief history of the HIV epidemic and how our research studies have contributed to our knowledge provided the topic of an afternoon discussion for **Christine Katlama** and **Caroline Sabin.** This was "A brief history of HIV: viewed through the lens of a clinician and a cohort investigator," the two women explained. Their presentation was built around the HIV timeline, from the 1980s to today, beginning with early HIV trials and an overview of CD4 decline and the risk of AIDS and death. The second decade of the HIV timeline saw the introduction of protease inhibitors (PIs) and non-nucleoside reverse transcriptase inhibitors (NNRTIs), while the start of the 21st century, the third decade, saw improvements in ART drugs, although these were still associated viral load rebound and toxicities. There were also at this stage increased concerns about resistance development and cardiovascular, renal and liver toxicities. A graph was used to show dramatic increases in life expectancy from 1996 to 2008. The fourth decade, with its very effective ART drugs, meant that life expectancy was potentially normalised, leading to an increased focus on other age-related outcomes and mental health. Moving into the fifth decade and the

situation today, there are new drug modalities and an increased focus on non-virological outcomes. Questions to study today include how to ensure that everyone has good access to the best treatment, including those from underserved and marginalised populations. The discussion concluded that large cohort collaborations have been essential to our ability to address some questions - but that cohorts are expensive to run and cohort collaborations can only exist if funding continues.

DAY II

This second day took the same format as the first, with three morning plenaries and an afternoon discussion, held around afternoon working groups. Topics for the Research and Clinical working groups on this date were **Collecting data, Sexual and reproductive health, Developing the study protocol,** and **Management of unsuppressed viraemia/resistance.**

Romain Palich (France) gave the first presentation, on **Resistance & management of unsuppressed viraemia.** This began with a look at what to do in a case of confirmed virological failure. Discussion with the patient to understand, for instance, lifestyle as well as social and psychological difficulties, should lead to management of vulnerability. Overall, he said, the higher the level of precariousness among participants, the greater the probability of remaining in virological failure. Therapeutic drug management and hair drug measurement could be used to monitor drug concentrations. Virological and therapeutic history will help to understand available treatment options, particularly which drugs are still potentially effective. He then presented drugs of interest, before considering injectable ART for people living with HIV with detectable viral load and adherence challenges. Thoughts on how to proceed with people living with HIV with persistent low-level viremia was followed by advice to focus on resource-limited countries, using WHO guidelines.

Management of PrEP and prevention of STI was the subject of the next plenary from Ag**nès Libois (Belgium).** She cautioned that "Prevention is a lot more than the topic of this talk." Beginning with Oral Pre-Exposure Prophylaxis (PrEP), the talk looked at PrEP in cisgender men. Key messages included that PrEP efficacy is around 99% but compliance is essential, along with a reminder that PrEP is not effective against other STIs. Gaps in PrEP access and unmet need touched on the challenging fact that certain key populations, such as people who inject drugs, prisoners, and undocumented migrants, remain ineligible for PrEP in many countries in Europe. Research also shows compliance problems and poor efficacy among women in Africa with oral PrEP. Neisseria gonorrhoeae (NG) and Chlamydia trachomatis (CT) testing in asymptomatic men who have sex with men and transgender women is recommended every 3 to 6 months in PrEP guidelines but a reduction in asymptomatic infections has not so far been demonstrated. Screening resulted in a lower incidence of symptomatic Ct but not symptomatic Ng. She looked at problems of control and bias in Ng/Ct screening for the two target groups. The evidence and real-world data on Doxycycline Post-Exposure Prophylaxis (doxyPEP) was then presented, with the conclusion that it works but challenges include side effects, the risk of induced resistance, and that in men who have sex with men the majority of Ng and Ct infections are asymptomatic. The Belgian and UK public health services

do not endorse the use of doxyPEP for STI, saying that potential benefits will be outweighed by the considerable potential for antimicrobial resistance (AMR) to develop. There was a reminder that STIs are on the rise in Europe, including chlamydia, gonorrhoea and syphilis. Pending the results of ongoing trials, the evidence is low to recommend the use of the Meningococcal B vaccine against gonorrhoea.

Tracy Glass (Switzerland) then concluded the morning plenaries with a look at **Hypothesis testing, p-values and confidence intervals.** Her presentation opened by explaining "Hypothesis testing is the formal procedure and framework we use to answer questions." She gave an example in which a new drug for treating naive individuals with HIV is developed, and clinicians want to know if they should start future patients on this drug or on the current standard of care. An analysis plan must be based on stating the hypothesis, then developed around determinants such as the number of groups in the study and the outcome of interest. The data can then be analysed and the results interpreted in line with the analysis plan. However, although P-values are here helpful in deciding which effects are likely to be real, they suffer from several limitations and do not, for instance, allow findings to be put in a clinical context. Rather than just a P-value, the outcome of interest could be the 'treatment effect': the additional benefit that the new drug/regimen provides compared to the standard of care. A look at confidence intervals found that they can be more precise and therefore more meaningful than P-values alone.

The second day concluded with a **Focus on weight,** from **Esteban Martínez (Spain)** and **Tracy Glass (Switzerland).** Weight gain is now the norm in the adult general population, the speakers explained. In the US from 1990–2008 men could expect to gain 0.55 kg per year and women could expect to gain 0.52 kg per year. There are however several challenges to measuring weight in a useful way. The widely used Body Mass Index (BMI), for instance, does not account for race, age, sex or gender, and does not distinguish between a lot of muscle and a lot of fat. This can lead to healthy athletes being classed as obese. Patients with HIV in the Highly Active Antiretroviral Therapy (HAART) era, meanwhile, are commonly overweight or obese, showing rates similar to the general population. Obesity may however increase the risk of co-morbidities in people with HIV. Characterising weight gain is also problematic, as is simply knowing how often to measure weight. Small changes in weight can be statistically significant but not necessarily clinically relevant. Guidance on how to how to interpret the results of the studies included thoughts on trends in BMI, and weight gain during pregnancy, before moving onto "The weight and ART story." This included detailed consideration of changes in BMI by HIV status, looking at baseline BMI and first ART. One conclusion was that switching to Tenofovir alafenamide (TAF) is associated with greater weight gain than other ARVs in both randomised control trials and real-world cohorts.

DAY III

This third day of the Summer School again heard four presentations, but there were no working groups. Instead, participants were given a free afternoon.

Yvonne Gilleece (United Kingdom) took the first morning presentation with consideration of **Conception, pregnancy, delivery, and breastfeeding.** This opened with a reminder that, around the world, 20.2 million women and girls are living with HIV. It is also important to remember that, globally, HIV is the leading cause of death among women of reproductive age. There is also the question of "subfertility" and HIV to be considered. Unexplained subfertility is the failure to conceive after one year of unprotected intercourse, and it is higher among women with HIV. She recommended that "all individuals diagnosed with HIV should have a discussion about their hopes and fears for having a family." Some basic principles of HIV in pregnancy include considerations when prescribing ART for pregnant women with HIV. Elective or emergency caesarean was the most common mode of delivery among women with HIV in England over the years 2000-2020 - but vaginal births now count for about 40% of the total, up from just over 10% in 2000. Complications of caesarean section, including infections, are higher in women with HIV. A look at Neonatal Post Exposure Prophylaxis set out high, low and very low risk categories for women's situations. Turning to breastfeeding, factors that increase the risk of breast milk HIV transmission when women are not on Combined Antiretroviral Therapy (cART) include the detectable viral load and the duration of breastfeeding. Overall, in the UK and other "resource rich" settings the safest way to feed infants born to mothers/people with HIV is with formula milk, as this eliminates on-going risk of HIV exposure after birth. But there are no data on the risk of HIV transmission via breast milk in resource rich settings. No guidelines currently recommend breastfeeding as a first line approach, but guidelines are changing. Above all, when it comes to conception, pregnancy, delivery, and breastfeeding, it is important to educate the obstetric team, educate and inform patients, and ensure equal access to PrEP.

The trend of non-AIDS-defining malignancies (NADM) is increasing, warned **Stéphane De Wit (Belgium)** in a presentation on **Cancers**. These include malignancies linked and not linked with viruses. AIDS-defining malignancies meanwhile include Kaposi's sarcoma, Non Hodgkin lymphoma, and cervical cancer. Trends in cancer incidence show declining rates but these remain, in most cases, high. Kaposi Sarcoma for instance remains a concern for ART-treated people with HIV, despite suppressed viral replication and recovered CD4. Risk factors associated with cancers in people living with HIV include but are not limited to ageing, drug abuse and opioids, and co-morbidities. The presentation included a look at HIV-1 provirus integration and cancer, as well as the oncogenic effects of HIV proteins and Hodgkin's lymphoma. The risk of Hodgkin's lymphoma, for instance, can be increased by 10 to 20 times in cases of immune suppression. Lung cancer, it was noted, remains elevated in people living with HIV even many years after smoking cessation. Colorectal cancer incidence is similar to the general population, but with diagnosis at a younger age and higher mortality. Similarly, breast cancer frequency is approaching that of the general female population but could occur at ages up to 20 years younger. Prostate cancer is the leading cancer diagnosis among men

with HIV. For oropharyngeal cancer, risk factors such as tobacco and alcohol are the same as in the general population, but the incidence is increased in people with HIV. Concluding recommendations included retiring the term "AIDS-defining" cancer, treating underlying health conditions that increase the risk of cancer for people with HIV, and expanding implementation and health services research.

In her presentation on **Getting it wrong, Caroline Sabin (United Kingdom)** looked at **Errors in statistical tests and why we need well powered studies.** She opened with an overview of hypothesis testing, and of errors in hypothesis testing. In this context, the P-value is the probability of obtaining the results by chance, known as the Type I error (a false positive signal). Every time a statistical test is performed, there is a risk that a Type I error will be made. Therefore, the probability that more than one result will be falsely significant increases exponentially along with the number of tests performed. Repetitions of a trial with no significant difference in outcomes would mean a P-value below 1. Interim analyses can also be used to control the P-value. Type 2 errors, meanwhile, occur if the researcher fails to reject a null hypothesis, even when there is a true difference (a false negative signal). Increasing the size of the study will reduce the Type 2 error rate. Type 1 errors matter because, for instance, "in a randomised trial, findings may erroneously suggest that a new treatment has a benefit that it doesn't have." Or, in cohort studies, unexpected findings, fuelled by the media, can create unnecessary panic. Type 2 errors meanwhile are important because for instance "In a randomised trial (researchers) may miss an important new treatment or diagnostic method." She concluded with reminders that statistical errors are pervasive in the literature, and to always apply caution.

The third day concluded with a lecture on **HIV cure** by **Asier Sáez-Cirión (France).** The introduction of HAART raised hope for HIV eradication, he said, but it soon became clear that "viral rebound occurs within days of treatment interruption." The search for an HIV cure now focuses on targeting HIV reservoirs. This will require a combined strategy to reduce and restrain reservoirs, steadily bringing down immune activation and chronic inflammation, along with strategies targeting the viral reservoir efforts to kill infected cells, and to repress or remove the provirus. New mechanisms to eliminate infected cells "tilt the balance" towards cell death. Strategies seeking to reinforce host barriers meanwhile include therapeutic vaccines, immune modulators, adoptive therapies, and inducing intrinsic resistance. This was followed by a look at stem cell transplant, potentially "as close to HIV cure as we may be." A dramatic reduction of viral reservoirs was observed in all cases of stem cell transplant. It is however not an infallible solution, with viral rebound observed in several cases. Markers and tools informing HIV cure research were then presented, as well as a move towards personalised medicine. He concluded that people maintaining undetectable viremia for decades without antiretroviral therapy show us than durable HIV remission/HIV cure is possible, and that "improving knowledge and technologies should help us to get to the finish line."

DAY IV

The fourth day of the Summer School hosted three morning presentations, followed by an afternoon of discussion. Research and clinical workshops on this date considered: **Sample size calculations and data analysis, Hepatology, Sample size calculations, Data analysis and completion of presentations,** and **Opportunistic infections.**

Opportunistic infections were the subject of the first presentation, by **Sanjay Pujari (India)**. This plenary session set out the problem itself, before focusing in on mycobacteria, fungi, viruses and protozoa. AIDS is at a crossroads, he warned, explaining that even through new HIV infections and AID-related deaths have been on a downward trend for about 20 years, "a person dies from AIDS-related causes every minute." The percentage change in the annual number of AIDS-related deaths has been negative since 2010 for every world region - except for Eastern Europe and Central Asia, which has seen a 34% increase over the period. The percentage of people who know their HIV status is also well below the UNAIDS target of 95% for most EU/EEA countries, as is the percentage of people on treatment. Trends in the estimated TB incidence rate show no signs of falling further since 2020. He gave a detailed overview of research and trails into TB among people with HIV. This was followed, for instance, by a close look at case of Cryptococcosis fungal infections in France, where there were 1,107 reported cases at 132 hospital centres between 2005 and 2020. Consideration was then given to treatments, including their side effects, acceptability, and cost. Annual incidence of Pneumocystis pneumonia in France 2013 to 2019 found an increase in the number of hospitalised cases, but HIV-infected patients had a lower mortality rate than non-HIV-infected patients. He turned to Latin America and Africa for data on the prevalence of Histoplasma antigenuria in people with HIV. The data helped identify populations that might benefit from systematic screening for histoplasmosis as part of an HIV package of care, suggesting that the "highest yield screening programme" would include people with advanced HIV disease. In summary, as well as welcoming "remarkable progress in TB therapeutics and prevention," it is vital to recall that early diagnosis and linking to care are key to prevent all opportunistic infections. "Opportunistic infections are forgotten, but not gone," he reminded participants.

A UK review of mortality in people with HIV in 2020 found that liver disease was the cause of death in 2% of cases, said **Sanjay Bhagani (United Kingdom),** in a presentation about **Management of liver disease in people living with HIV.** This compares with 3% for respiratory disease and 28% for non-AIDS infections, and was equal across men and women patients. He gave an overview of HIV-associated immune activation and liver disease, followed by key results of the START liver fibrosis study. The incidence of chronic hepatitis B (HBV) infection in children under five years of age had fallen from 4.7% to 1.3% by 2017, thanks to immunisation, but 257 million people were living with the disease in that same year. He looked at, for instance, the four phases of chronic HBV infection, and at the EACS Guidelines 2023 for HBV/HIV co-infection. Studies and research into drug resistance were presented in detail, alongside WHO guidelines from 2024, which recommend the treatment of all people aged over 12. HIV and HCV are "double trouble for the liver," contributing to multiple

organ dysfunction. WHO has set ambitious global targets to control viral hepatitis by 2030 and a first step for 'micro-elimination' is managing recently acquired HCV. There is compelling data that Treatment as Prevention (TasP) works, with a more than 50% reduction in the incidence of acute HCV infection, but incidence seems now to be plateauing out. Non-alcoholic fatty liver disease, also known as metabolic dysfunction-associated fatty liver disease, can be managed by a combination of approaches, including diet, exercise, and monitoring. In conclusion, although liver disease remains an important (but diminishing) cause of morbidity and mortality in people with HIV, there is a need for improved cascade of care and access to prescriptions, to make elimination possible.

Key sources of bias and tips on what to look for in a paper was the subject of the final plenary session heard at the Sumer School 2024. **Anders Boyd (Netherlands)** explained that "Many of the limitations of studies, particularly observational studies, are related to the potential for bias to occur." Bias, he added, occurs when there is a systematic difference between the results from a study and the true state of affairs. Bias is often, but not always, introduced at an early study stage, and cannot be completely removed by appropriate statistical methods or by increasing the sample size. Instead, he said, "we need to ensure that the sample we include in the study is representative of the population to which the results will be applied." In addition to this representative sample, it is important to consider the consequences of missing data, which are of more concern to cohort studies than to randomised control trials (RCTS). Missing data can introduce bias. Attrition bias, meanwhile, occurs when the people who are lost-to-follow-up in a longitudinal study differ in a systematic way from those who are not lost. This can be particularly difficult to deal with if the people who drop out of the study are the sickest patients. Confounding bias "occurs when a spurious association arises due to a failure to fully adjust for factors related to both the risk factor and outcome," and must be carefully dealt with through measured statistical methods. He also briefly touched on the importance of observer bias, under which for instance individuals change their behaviour because they know they are in a study, and survivorship bias, which is likely when people must survive to benefit from an intervention. He concluded with guidance on reporting and a reminder that "During analysis, it is important to question whether bias may have been introduced at any stage."

Finally, **Anders Boyd (Netherlands) and a panel of clinicians including Juan Ambrosioni (Spain), Stéphane De Wit (Belgium), and Nicola Mackie (United Kingdom),** looked at **Ageing and HIV.** This opened with a question of whether ageing is accelerated or accentuated for people with HIV. Improved treatments and increased life expectancy mean the population as a whole is ageing and the landscape of co-morbidities is changing, with a strong presence of "multimorbidity" in older individuals. They asked, however, if there is there a difference in multimorbidity between those with and without HIV, and if the earlier onset of co-morbidities among people with HIV would be evidence of 'premature' ageing. This raises broad research questions about the concept of ageing and how, or if, research here can be clinically useful. Panellists were asked to consider which elements, besides lifestyle, could play a role in ageing, and how to make patients aware of how to

improve the ageing process. This led to questions of how to study co-morbidities and the number of co-morbidities, such as diabetes, kidney disease, and osteoporosis, to be studied. Co-morbidities are also linked to one another, making the study of clusters of co-morbidities an interesting approach. Panellists were here asked to consider which factors they most insist on to improve an ageing patient's health. Consideration of biomarkers of co-morbidities led to questions on if and how adapt the model for HIV management. Overall conclusions included that multimorbidity is becoming more prevalent in people with HIV as they become older, making early diagnosis and prompt ART crucial. Similarly, model of attention, deprescribing and individualisation are essential.

DAY V

On this final day of the 2024 Summer School, participants took the stage to present their work. Those in the clinical module engaged in debates on key issues, discussing topics like "STI testing is redundant in asymptomatic patients," "All patients on a bPI regimen should switch to an alternative," and "Resistance testing has no role in routine clinical management." Each group presented opposing arguments on these subjects. Following the debates, participants from the research module showcased their project proposals, covering topics, methodologies, budgets, and more. Their presentations were followed by questions from peers and faculty members.

2. Key Statistics to Highlights from the Report

An evaluation questionnaire sent to participants at the end of the conference showed that the EACS HIV Summer School had once again been a success.

All respondents (100%) agreed that it was useful, with 76.5% even saying it was "extremely useful." Notably, by the end of the five-day event, 97% of participants said they would definitely recommend the HIV Summer School to colleagues. Even the remaining 3% said they would "probably" recommend it.

Overall, 91% of respondents said the event fully met **their educational goals and expected learning outcomes,** with the remaining 9% indicating it met them 'somewhat.' Additionally, 97% of respondents found the information **well-balanced and consistently supported by a valid scientific base**. Meanwhile, 82% "strongly agreed" that the content was **useful for their practice,** while the other 18% simply agreed.

Furthermore, 76.5% of respondents said the information from the conference would be "very much" implemented in their practice, with only one participant saying it would be "minimally" implemented. More than three-quarters of respondents believed their office, practice, and patients could accommodate these changes. Perhaps most notably, 10 % of respondents said the course would be "useful" for their professional activities, with 76.5% rated it "extremely useful." However, 41% agreed or strongly agreed that patient access to treatments could be a barrier to implementing changes.

Overall 98.5% of respondents said the EACS secretariat work was excellent, with even the remaining one participant (1.5%) opting for good. When it came to the overall programme, 100% of participants said their impression of the event was excellent or good.

Respondents were also given space to comment generally on the event,

Ideas for future activities and topics ranged from kidney and bone health, vertical transmission of HIV, substance abuse and HIV management, more about cross-sectional studies, and the management of HIV-associated neurological problems, to the creation of a Whatsapp/Telegram group for participants.

More social events and a sightseeing tour would be welcome, while one participant suggested having a welcome party, because "everybody wanted to keep hanging out with each other but some were too shy to do so."

Prague was appreciated as an event venue, with everyone describing it as excellent or good. Opinion was divided over whether it is a positive to share hotel rooms. Several participants were unhappy that people from Russia and Belarus were able to attend.

Overall however the conference was described as "a truly unique experience. "One respondent wrote "It was a wonderful experience for me. Interacting and learning from colleagues from across the world is an experience I will never take for granted. Thank you EACS." Another, asked if there were any potential improvements, simply replied "No. you just have to continue doing this because it is extremely useful."

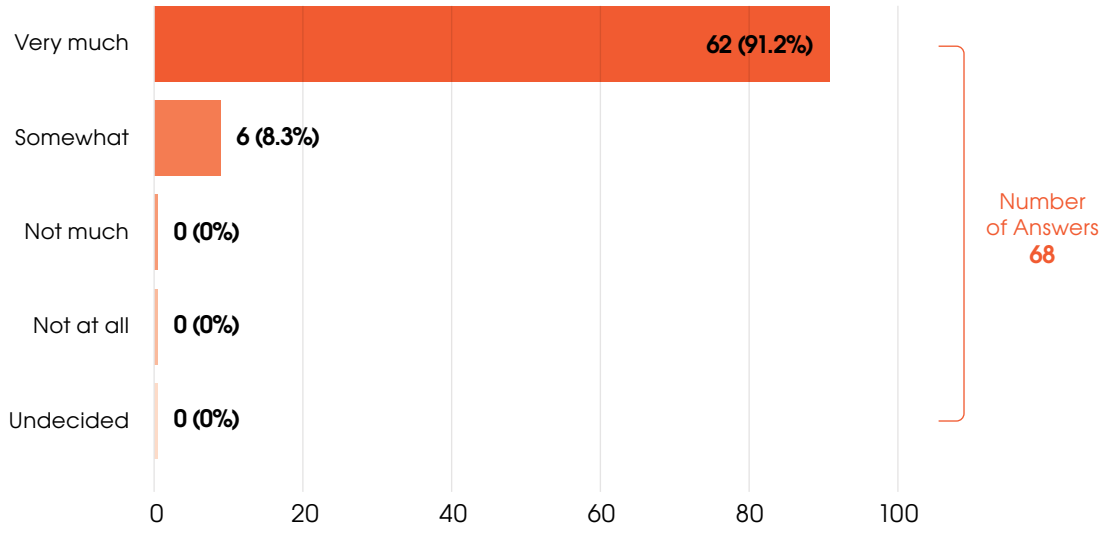
Overview of key statistics

Order or sections:

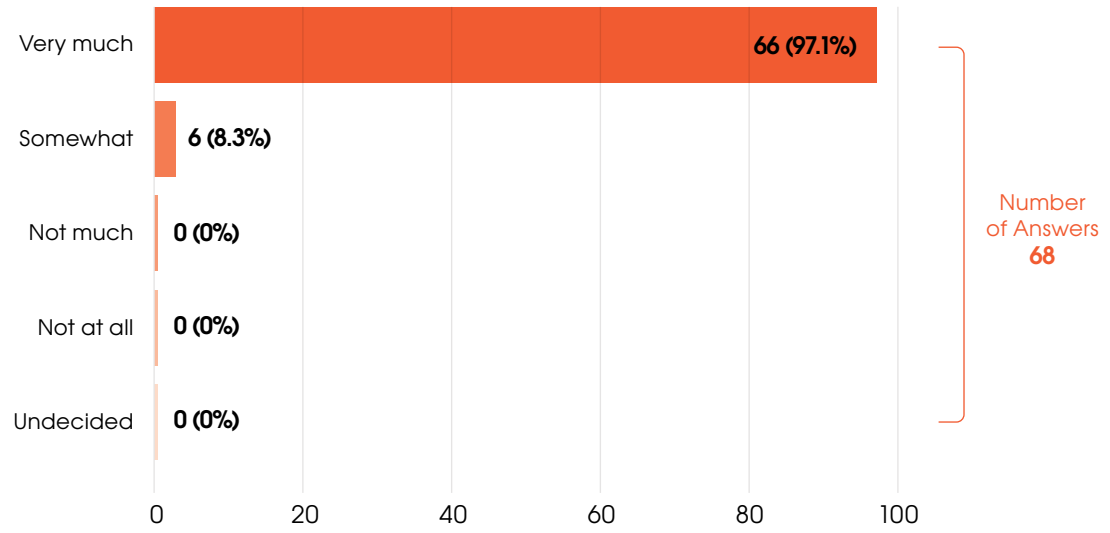
- Relevance of the event
- Impact
- Quality of the event
- Modules
- Commercial bias
- Additional questions

RELEVANCE OF THE EVENT

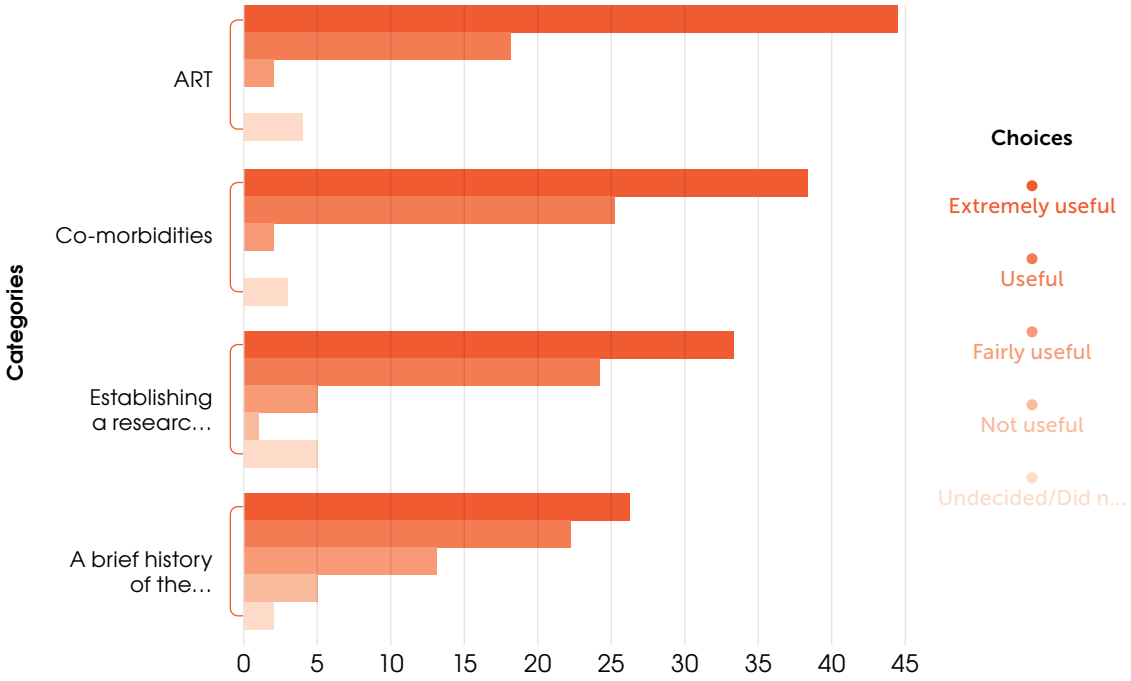
1. Did the event fulfil your educational goals and expected outcomes?



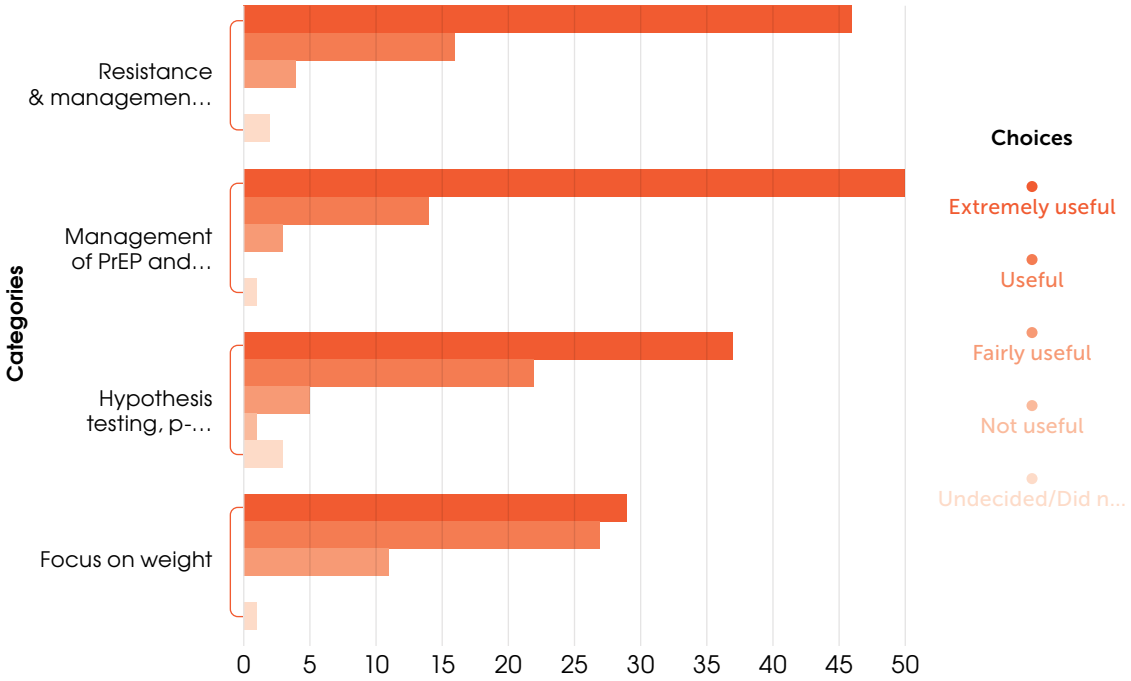
2. Was the presented information well-balanced and consistently supported by a valid scientific evidence base?



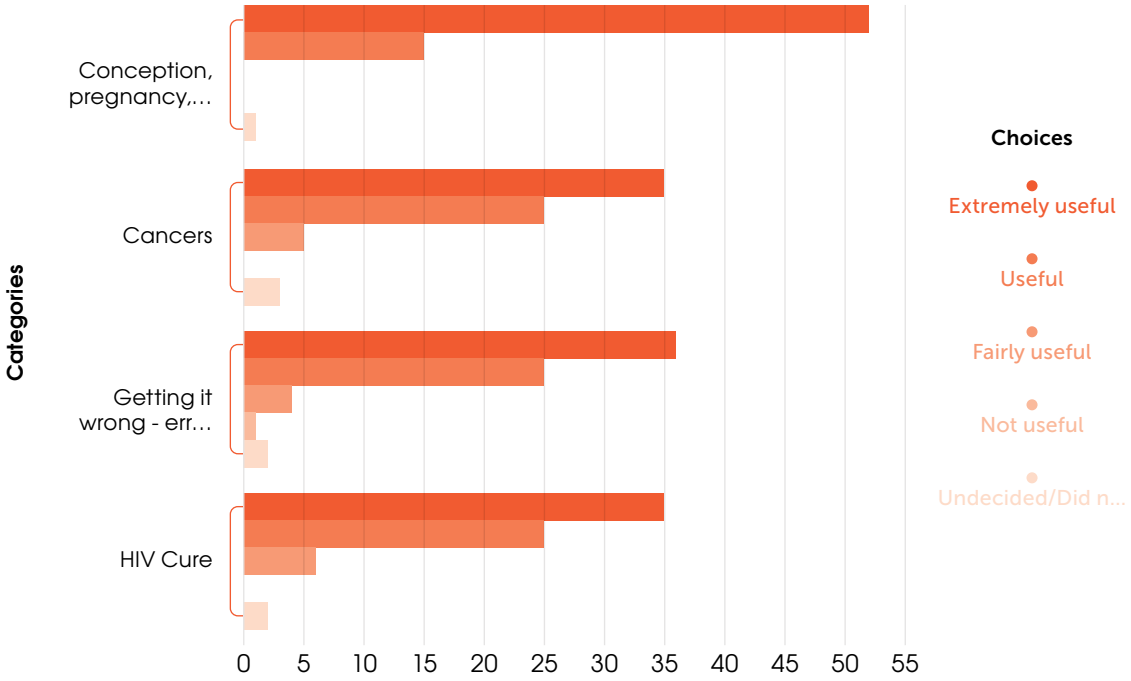
3. How useful to you personally was each session on Monday, 9 September?



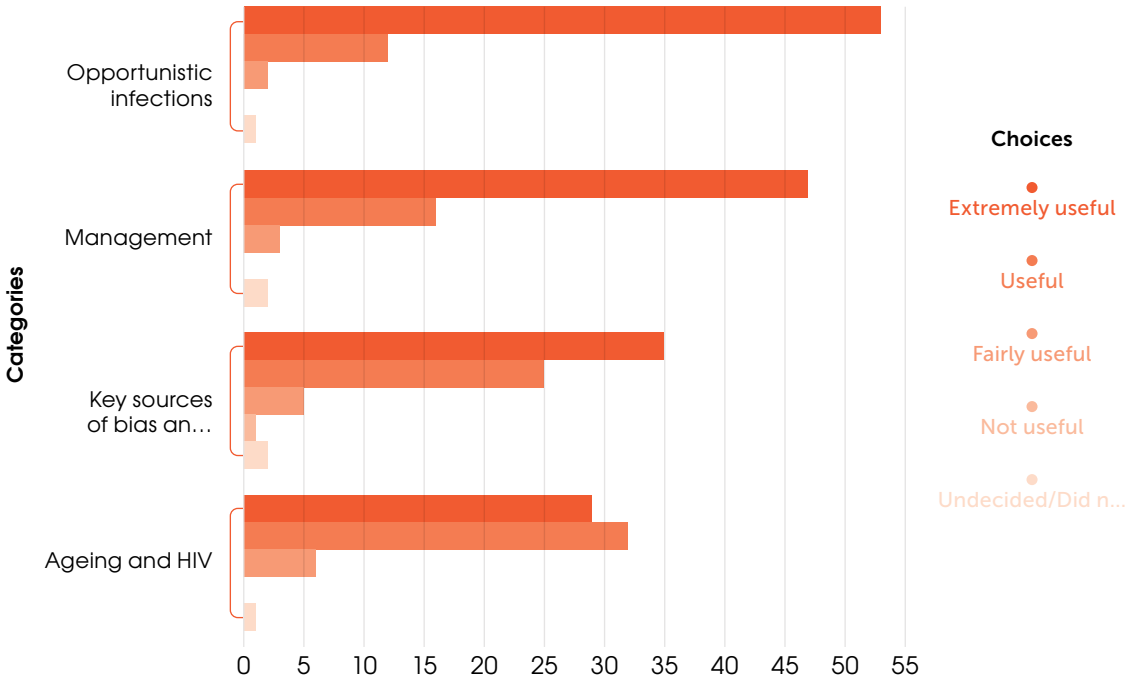
4. How useful to you personally was each session on Tuesday, 10 September



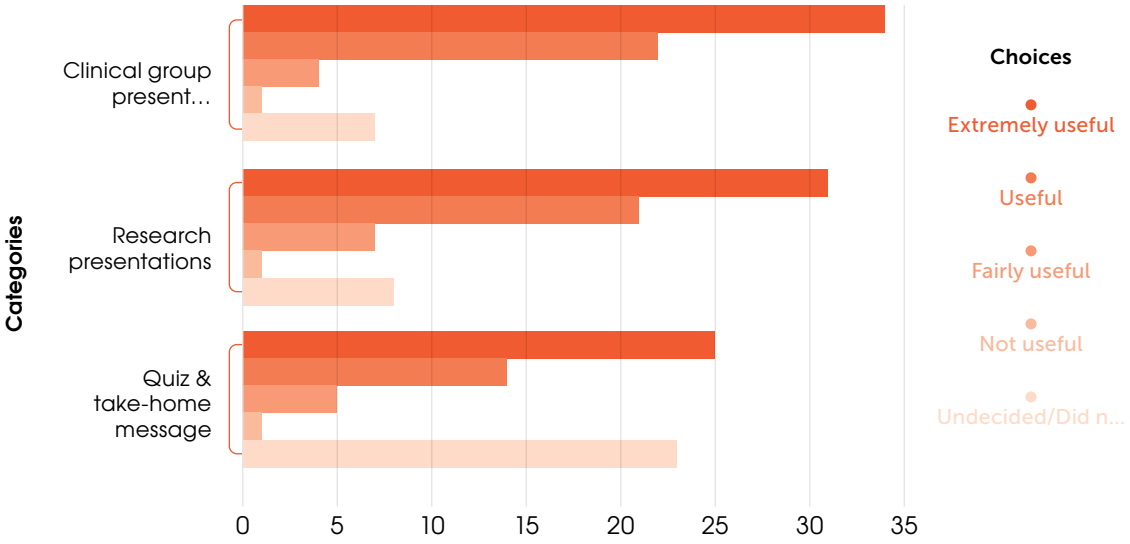
5. How useful to you personally was each session on Wednesday, 11 September



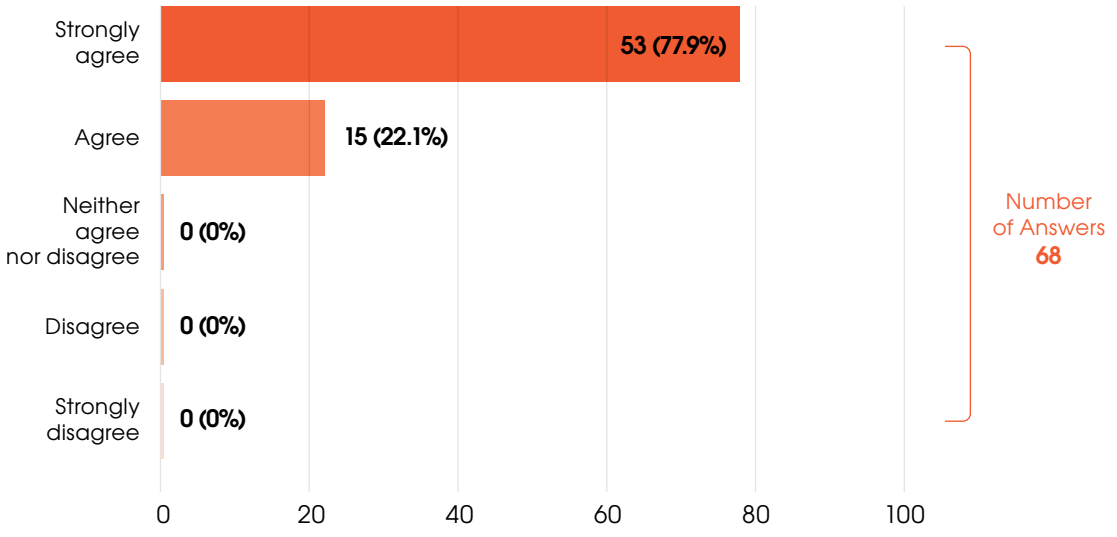
6. How useful to you personally was each session on Thursday, 12 September



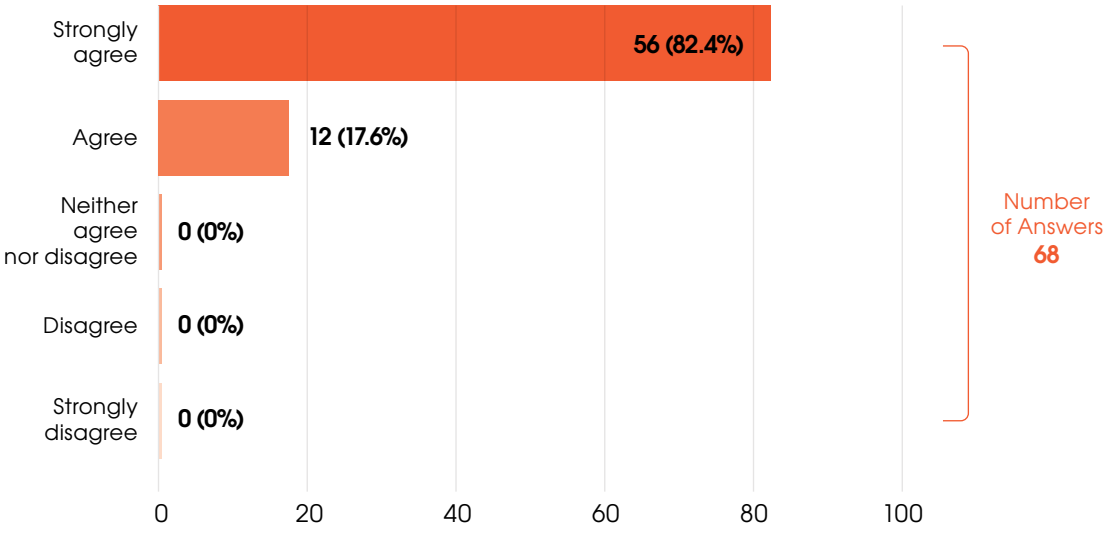
7. How useful to you personally was each session on Friday, 13 September



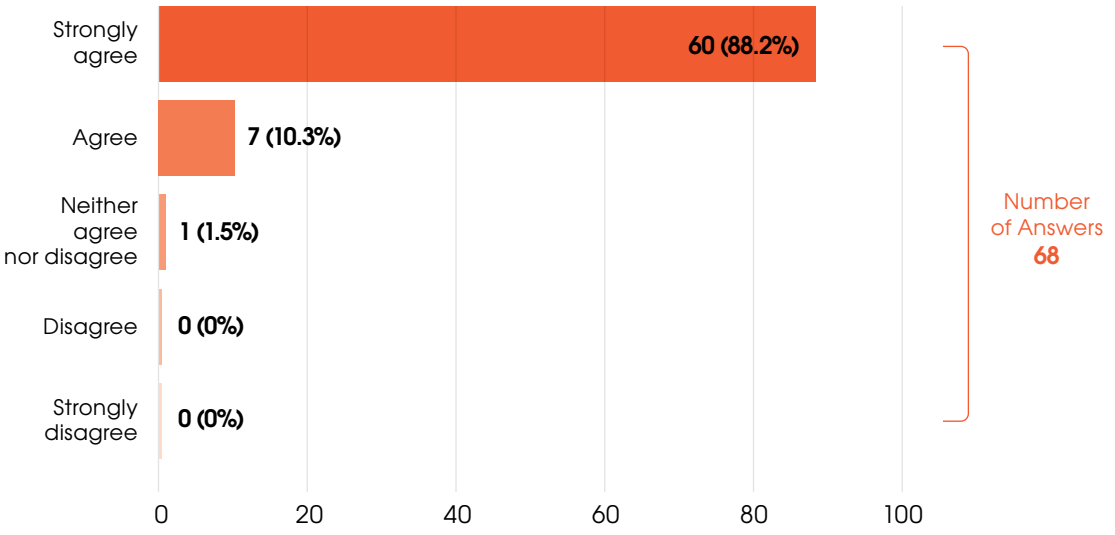
8. Was the content presented clearly?



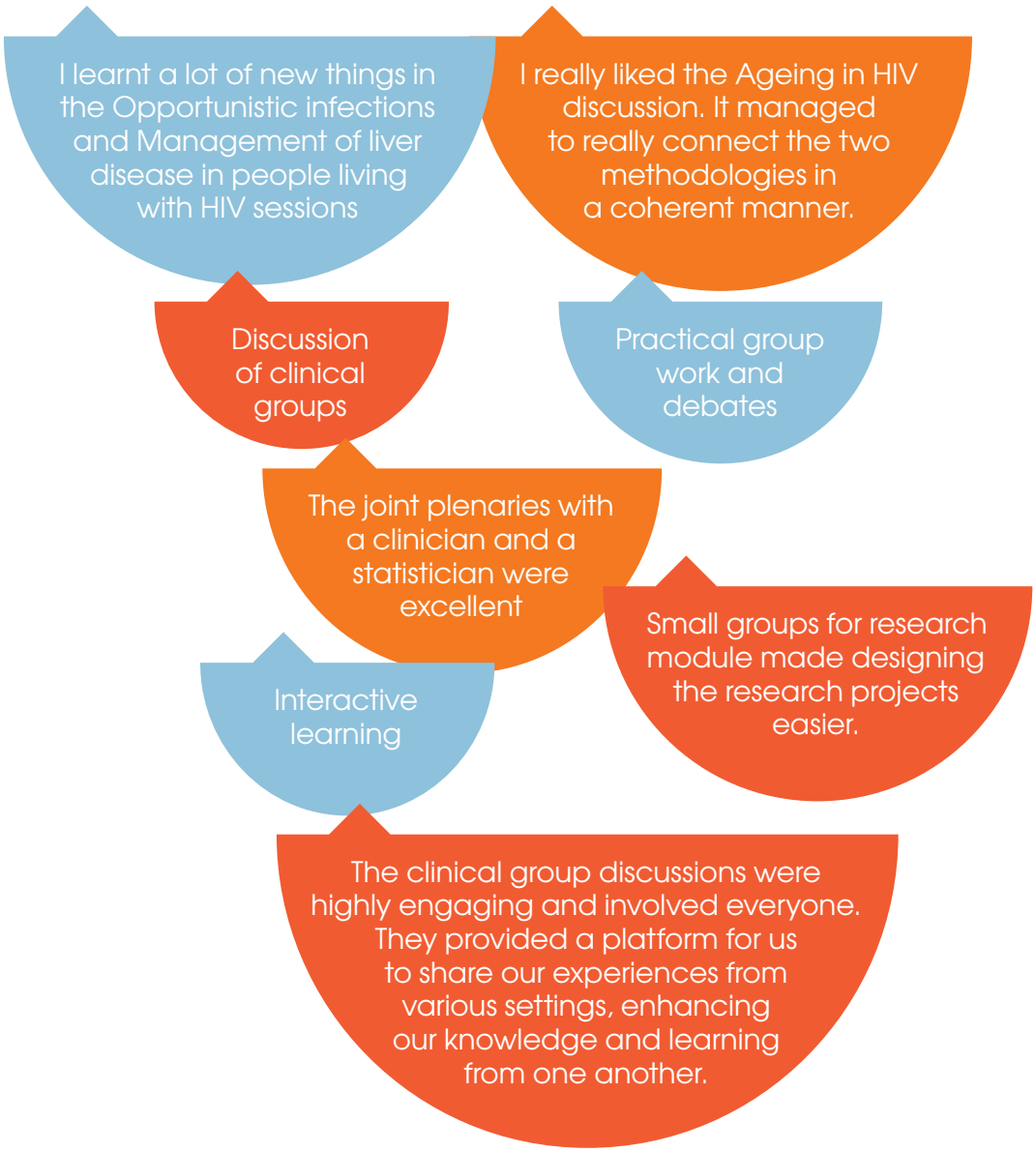
9. Was the content useful for your practice?



10. Was there adequate time available for discussions, questions & answers and learner engagement?

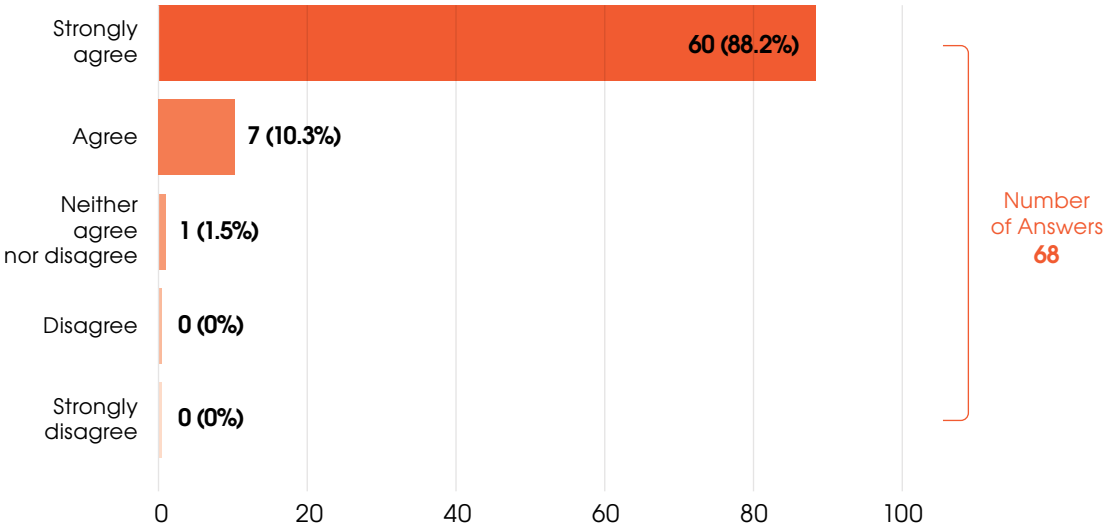


11. Can you indicate any innovative elements during the activity?



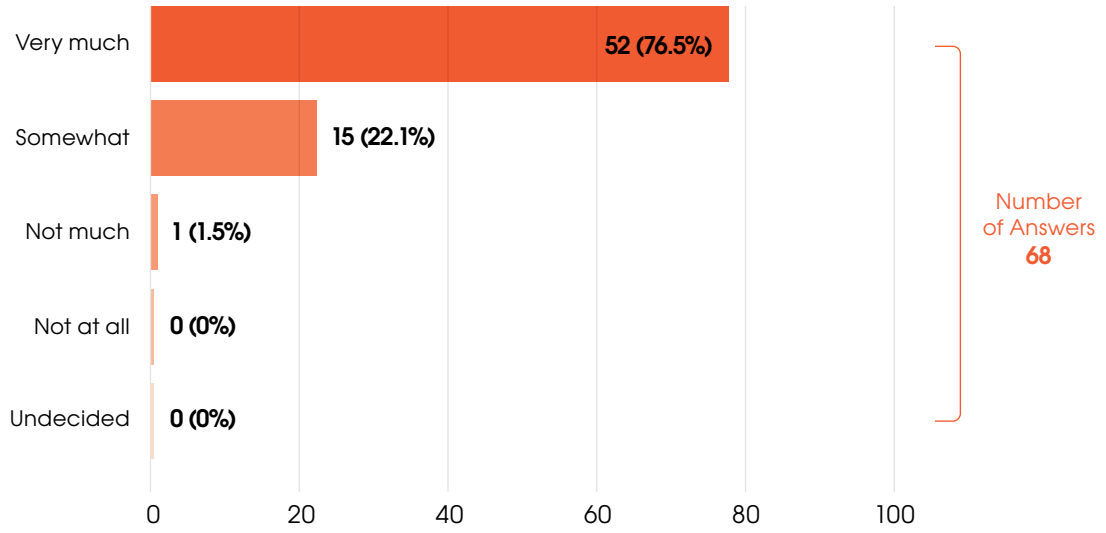
Total Responded **19**

12. Was this educational activity well planned and presented?



IMPACT

1. Will the information you learnt be implemented in your practice?



2. Can you provide one example how this event will influence your future practice?

I have greater understanding of data analysis plans and power calculations etc. This will be helpful in planning future research.

Very informative conference. I clarified for myself the issue of managing patients on dialysis and transplant patients with HIV infection

The research tract was exceptionally helpful, the lectures summarized some great points too. I plan to implement a change in my clinic by trying to make it a multidisciplinary clinic instead of referring the patient for any needed speciality by having psychiatry, dermatology and possible gynecologists with me to assist my patients in a timely manner

The knowledge I got there will contribute in planning new research projects with more quality.

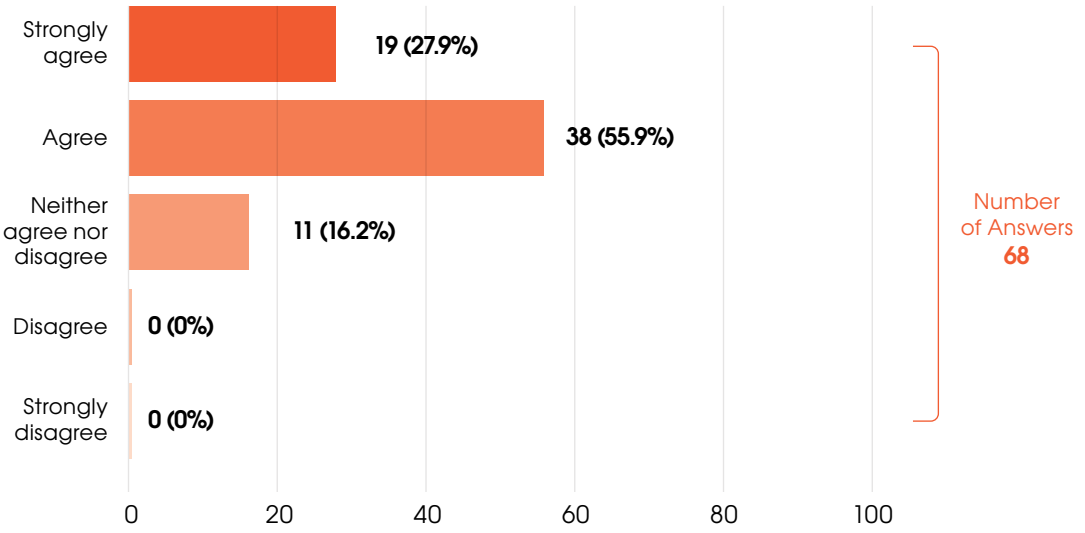
It has increased my awareness about issues in the ageing population, especially regarding menopause-related health problems.

Much increased understanding and confidence in critically appraising HIV literature as well as increased context for this

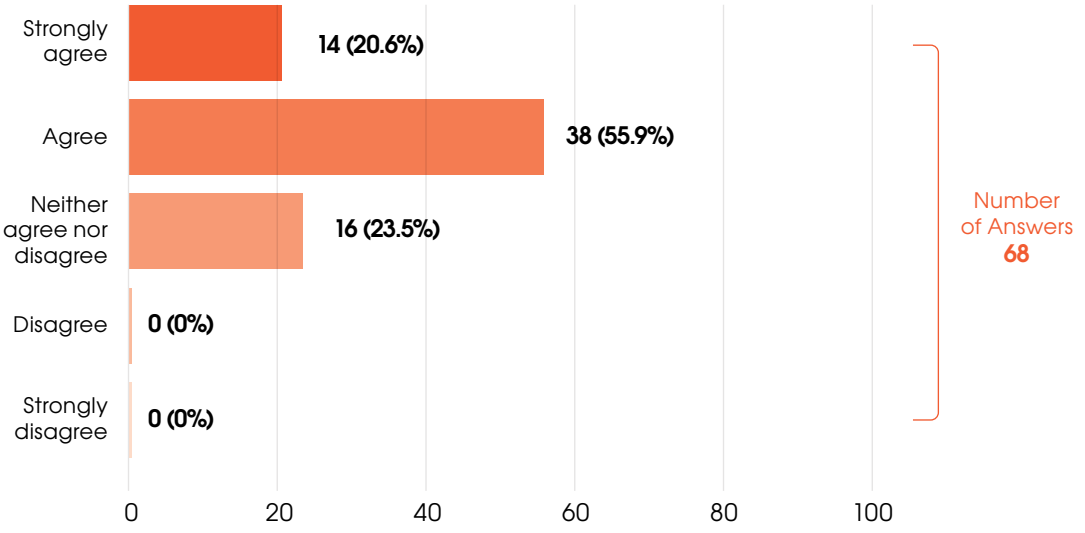
Combining theory with implementtion as discussed at the Summer School

Total Responded **46**

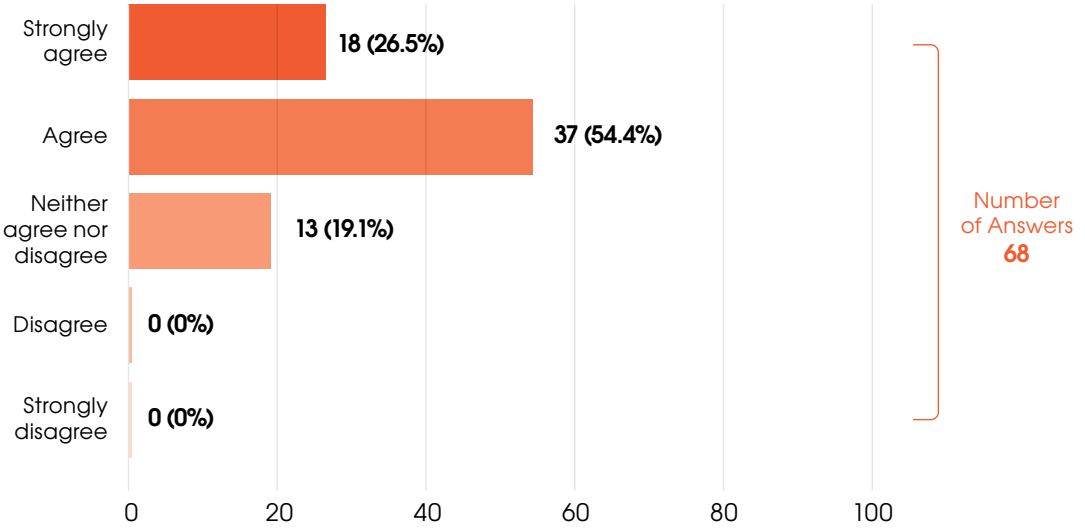
3. Do you intend to modify/change your clinical practice based on this educational activity?



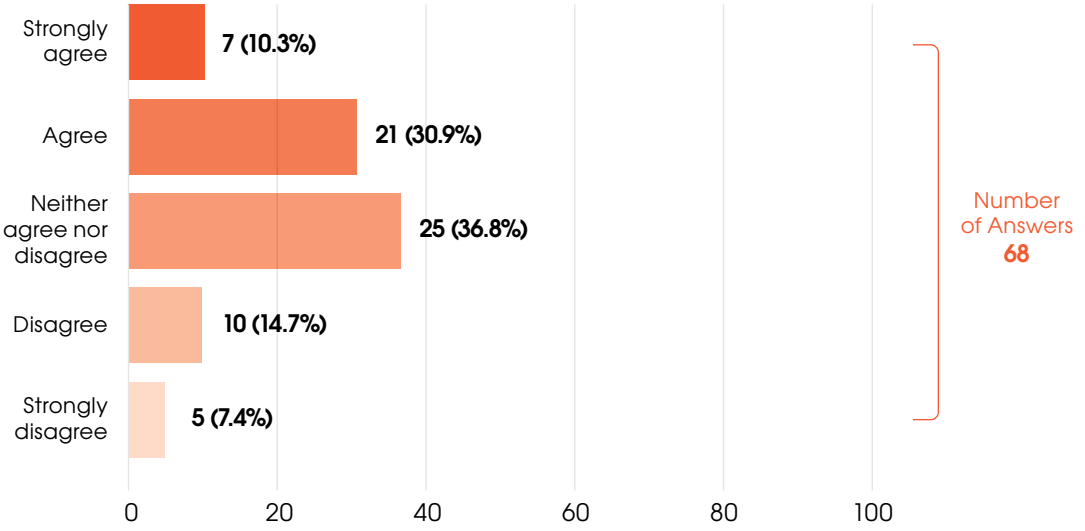
4. Can your office and practice systems accommodate these changes?



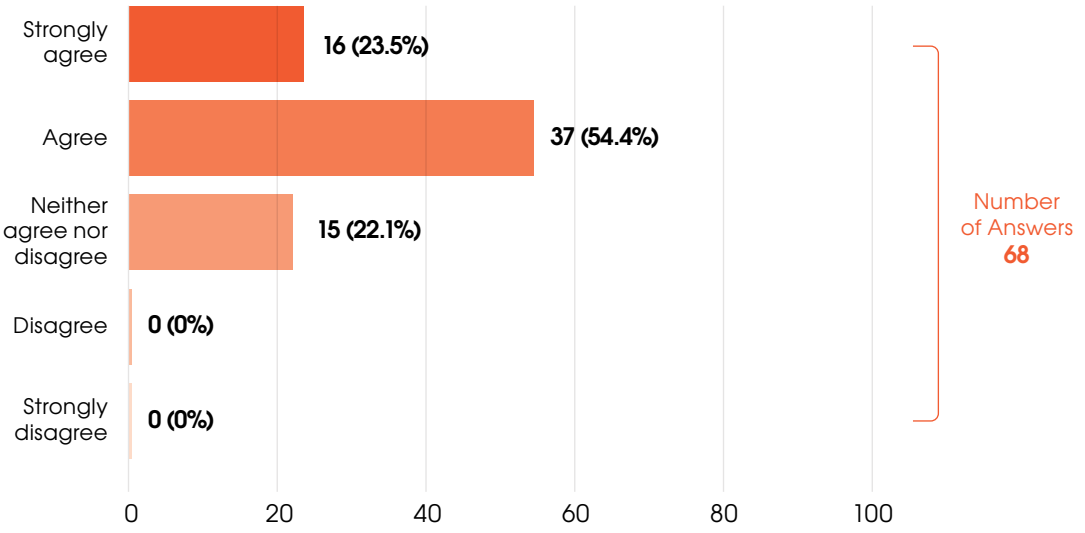
5. Can your patients accommodate these changes?



6. Will patient access to the treatments provided be a barrier to implementing these changes?

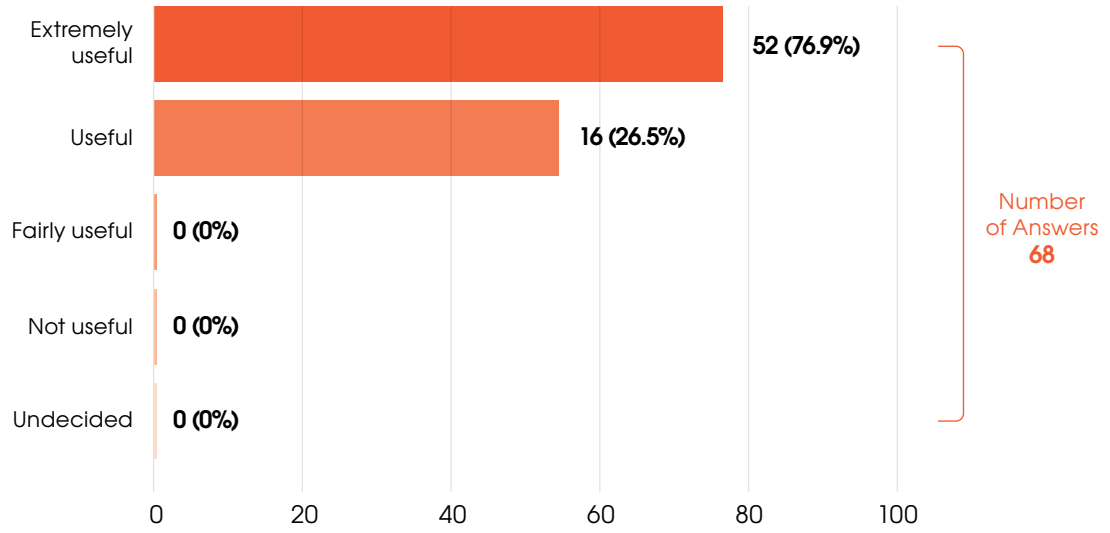


7. On average, how did you utilise the patient treatment strategies described in this educational activity prior to your participation?

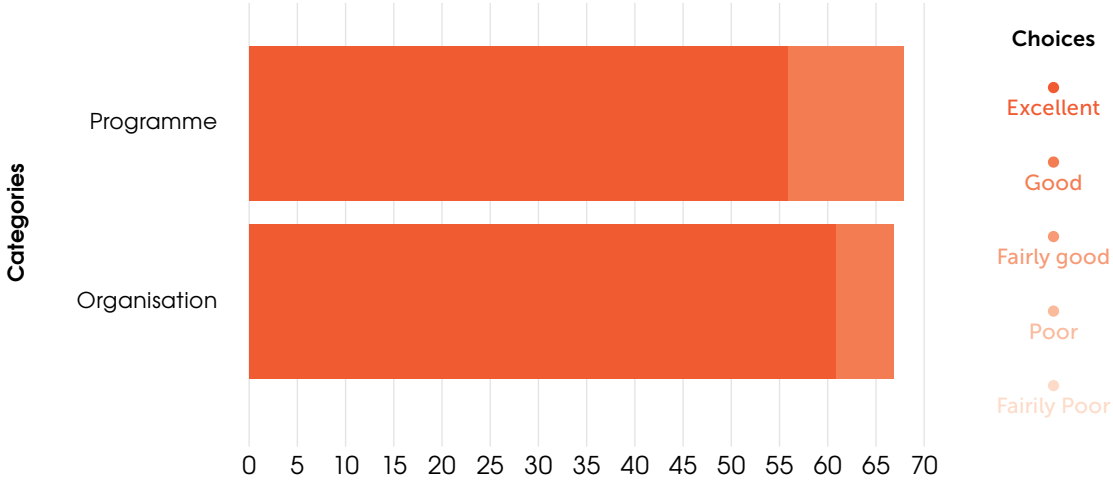


QUALITY OF THE EVENT

1. How useful for your professional activity did you find this event?



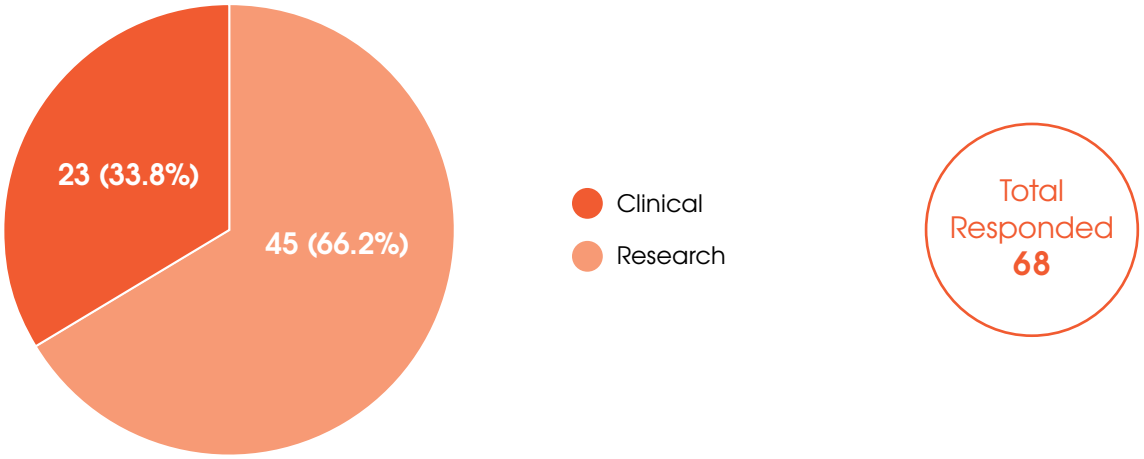
2. What was your overall impression of this event?



3. What was the best aspect of this event? What did you find most useful for your professional activity? Why?

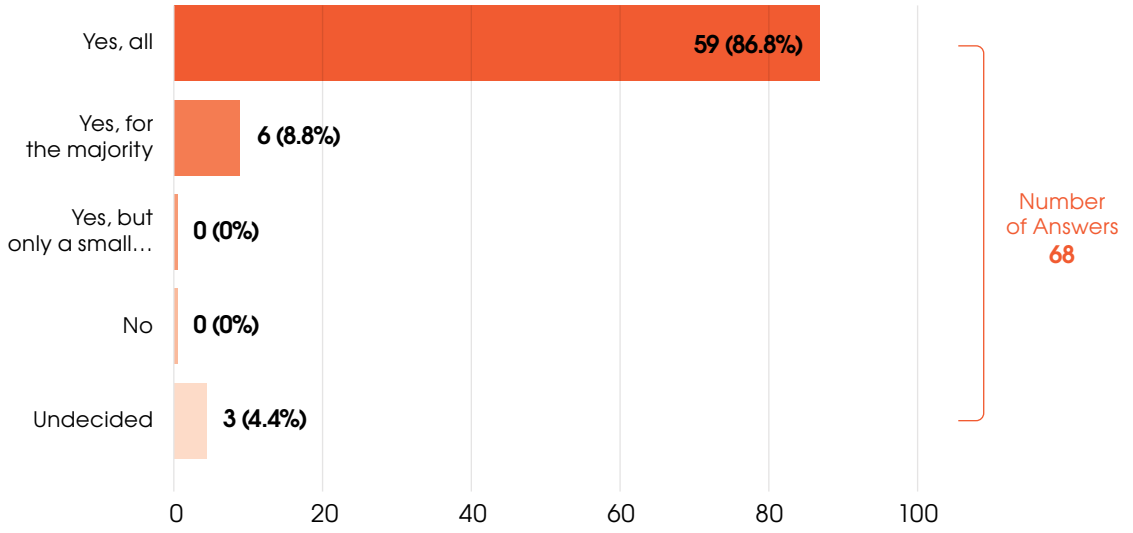
MODULES

Which module did you follow?

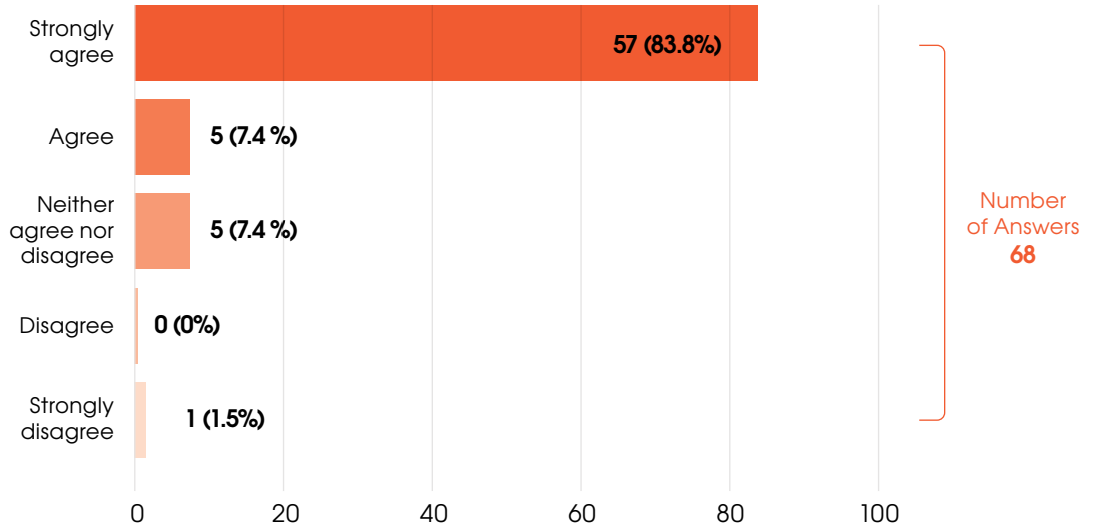


COMMERCIAL BIAS

1. Did all the faculty members provide their potential conflict of interest declaration with the sponsor(s) as a second slide of their presentation?



2. Was this activity free of commercial bias for or against any product?



ADDITIONAL QUESTIONS

1. Do you have any anecdotes or stories you would like to share about your time at the HIV Summer School?

Thanks a lot. I learned many recent studies. And also, I discussed with many doctors all over the world. This was my first experience and it was very interesting

So inspiring to hear from HIV clinicians across Europe.

The experience was truly unique. The combination of clinical module sessions with integrated research discussions was particularly engaging. While focusing on research is important, having a solid understanding of the clinical aspects of the current HIV/AIDS landscape and ongoing clinical trials is equally crucial. It was fascinating to witness a diverse group of experts, including Professor Christine Katlama, Estebane Martinez, Stephane, and others, share their invaluable knowledge with us.

Made some good friends

Loved meeting everyone such friendly people and a great opportunity to meet with people from all over the world

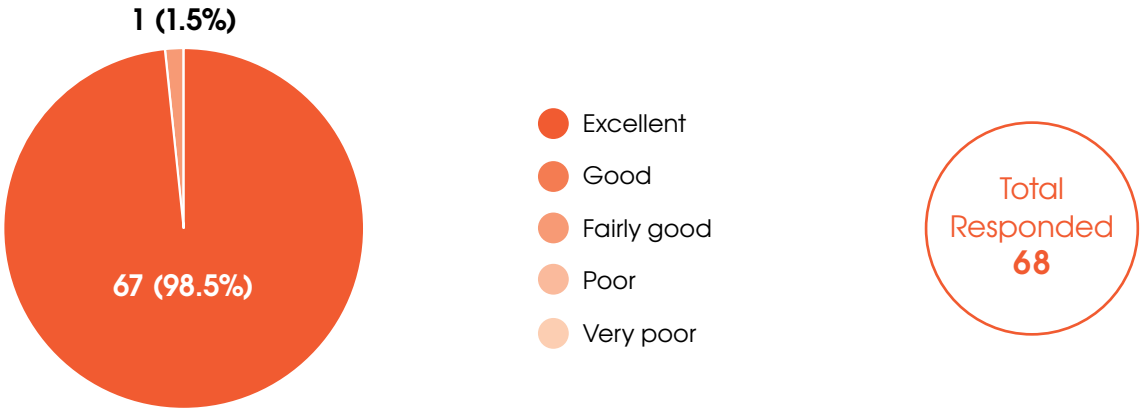
It was a wonderful experience for me. Interacting and learning from colleagues drom across the world. Its an experience I will never take for granted. Thank you EACS.

I was able to talk to people from different countries and we had a group chat, so I hope we can continue to connect, and we are talking about sharing and discussing interesting things about HIV care and other diseases.

The programme and lectures were SO intense my friend and I couldn't help but going out for a bit of fresh air as soon as we were free and when we realised we'd walked all along the way to Prague Castle in like 20min :D

Total Responded **16**

2. How do you evaluate the work of the EACS Secretariat in charge of your participation in the course?



3. How do you evaluate information provided about your travel and accommodation?

4. Would you recommend the HIV Summer School to your colleagues?

3. Programme Agenda

Sunday, 8 September 2024	
All day	**Arrival participants and faculty**
19:30	**Arrival dinner**

Monday, 9 September 2024			
Morning			
Time	**Session**	**Type**	**Title & speaker**
8:00 - 8:30	Opening		**Welcome & faculty introduction**
8:30 - 9:10	Morning Plenary 1 + Q&A	**Clinical**	**ART** *Nicola Mackie (United Kingdom)*
9:10 - 9:50	Morning Plenary 2 + Q&A	**Clinical**	**Co-morbidities** *Esteban Martinez (Spain)*
9:50 - 10:30	Morning Plenary 3 + Q&A	**Research**	**Establishing a research question and choosing an appropriate study design** *Anders Boyd (Netherlands)*
10:30 – 11:00	**Coffee break**		
11:00 - 13:00	Module A	**Research**	**Study design** *Anders Boyd (Netherlands)* *Tracy Glass (Switzerland)* *Caroline Sabin (United Kingdom)*
	Module B	**Clinical**	Working groups (3 groups) **Treatment initiation** *Sanjay Bhagani (United Kingdom)* *Stéphane De Wit (Belgium)* *Agnès Libois (Belgium)* *Nicola Mackie (United Kingdom)* *Romain Palich (France)*
13:00 - 14:00	**Lunch break**		

14:00 - 16:00	Module A	**Research**	Working groups (3 groups) **Identifying the research question and study design**
			Anders Boyd (Netherlands) *Tracy Glass (Switzerland)* *Caroline Sabin (United Kingdom)* *Juan Ambrosioni (Spain)* *Maxime Hentzien (France)* *Romain Palich (France)*
	Module B	**Clinical**	Working groups (3 groups) **Management of long-term ART and co-morbidities**
			Sanjay Bhagani (United Kingdom) *Stéphane De Wit (Belgium)* *Yvonne Gilleece (United Kingdom)* *Christine Katlama (France)* *Nicola Mackie (United Kingdom)*
16:00-16:30	**Coffee break**		
Time	**Session**	**Title & speaker**	
16:30 - 17:30	Afternoon discussion session 1	**A brief history of the HIV epidemic and how our research studies have contributed to our knowledge**	
		Christine Katlama (France) *Caroline Sabin (United Kingdom)*	
19:00 - 22:00	**Poster walk**		

Tuesday, 10 September 2024			
Morning			
Time	**Session**	**Type**	**Title & speaker**
8:30 - 9:10	Morning Plenary 4 + Q&A	**Clinical**	**Resistance & management of unsuppressed viraemia** *Romain Palich (France)*
9:10 - 9:50	Morning Plenary 5 + Q&A	**Clinical**	**Management of PrEP and prevention of STI** *Agnès Libois (Belgium)*
9:50 - 10:30	Morning Plenary 6 + Q&A	**Research**	**Hypothesis testing, p-values and confidence intervals** *Tracy Glass (Switzerland)*
10:30 - 11:00	**Coffee break**		
11:00 - 13:00	Module A	**Research**	**Collecting data** *Anders Boyd (Netherlands)* *Tracy Glass (Switzerland)* *Caroline Sabin (United Kingdom)*
	Module B	**Clinical**	Working groups (3 groups) **Sexual and reproductive health** *Jose Bernardino (Spain)* *Yvonne Gilleece (United Kingdom)* *Maxime Hentzien (France)* *Agnès Libois (Belgium)* *Romain Palich (France)* *Hannah Pintilie (United Kingdom)*
13:00 - 14:00	**Lunch break**		

14:00 - 16:00	Module A	**Research**	Working groups (3 groups) **Developing the study protocol** *Anders Boyd (Netherlands)* *Tracy Glass (Switzerland)* *Caroline Sabin (United Kingdom)* *Juan Ambrosioni (Spain)* *Maxime Hentzien (France)* *Romain Palich (France)*
	Module B	**Clinical**	Working groups (3 groups) **Management of unsuppressed viraemia/resistance** *Sanjay Bhagani (United Kingdom)* *Jose Bernardino (Spain)* *Yvonne Gilleece (United Kingdom)* *Christine Katlama (France)* *Nicola Mackie (United Kingdom)* *Sanjay Pujari (India)*
16:00-16:30	**Coffee break**		
Time	**Session**	**Title & speaker**	
16:30 - 17:30	Afternoon discussion session 2	**Focus on weight** *Esteban Martínez (Spain)* *Tracy Glass (Switzerland)*	

Wednesday, 11 September 2024			
Morning			
Time	**Session**	**Type**	**Title & speaker**
8:30 - 9:10	Morning Plenary 7 + Q&A	**Clinical**	**Conception, pregnancy, delivery, and breastfeeding** *Yvonne Gilleece (United Kingdom*
9:10 - 9:50	Morning Plenary 8 + Q&A	**Clinical**	**Cancers** *Stéphane de Wit (Belgium)*
9:50 - 10:30	Morning Plenary 9 + Q&A	**Research**	**Getting it wrong – errors in statistical tests and why do we need well powered studies** *Caroline Sabin (United Kingdom)*
10:30 - 11:00	**Coffee break**		
9:10 - 9:50	Lecture	**HIV Cure** *Asier Sáez-Cirión (France)*	
12:00 - 13:00	**Lunch break**		

Thursday, 12 September 2024			
Morning			
Time	**Session**	**Type**	**Title & speaker**
8:30 - 9:10	Morning Plenary 10 + Q&A	**Clinical**	**Opportunistic infections** *Sanjay Pujari (India)*
9:10 - 9:50	Morning Plenary 11 + Q&A	**Clinical**	**Management of liver disease in people living with HIV** *Sanjay Bhagani (United Kingdom)*
9:50 - 10:30	Morning Plenary 12 + Q&A	**Research**	**Key sources of bias and tips on what to look for in a paper** *Anders Boyd (Netherlands)*
10:30 - 11:00	**Coffee break**		

11:00 - 13:00	Module A	**Research**	**Sample size calculations and data analysis** *Anders Boyd (Netherlands)* *Tracy Glass (Switzerland)* *Caroline Sabin (United Kingdom)*
	Module A	**Research**	Working groups (3 groups) **Hepatology** *Juan Ambrosioni (Spain)* *Jose Bernardino (Spain)* *Sanjay Bhagani (United Kingdom)* *Yvonne Gilleece (United Kingdom)* *Sanjay Pujari (India)*
13:00 - 14:00	**Lunch break**		
14:00 - 16:00	Module A	**Research**	Working groups (3 groups) **Sample size calculations, data analysis and completion of presentations** *Anders Boyd (Netherlands)* *Tracy Glass (Switzerland)* *Caroline Sabin (United Kingdom)* *Juan Ambrosioni (Spain)* *Maxime Hentzien (France)*
	Module B	**Clinical**	Working groups (3 groups) **Opportunistic infections** *Sanjay Bhagani (United Kingdom)* *Yvonne Gilleece (United Kingdom)* *Agnès Libois (Belgium)* *Nicola Mackie (United Kingdom)* *Sanjay Pujari (India)* *Stephane de Wit (Belgium)*
16:00-16:30	**Coffee break**		
16:30 - 17:30	Afternoon discussion session 3	**Ageing and HIV – including a section on what we have learnt from ageing studies about accelerated/accentuated ageing and the potential mechanisms that might be involved** *Stéphane de Wit (Belgium)* *Anders Boyd (Netherlands)*	
19:00 - 22:00	**EACS Dinner**		

Friday, 13 September 2024		
Morning		
Time	Type	Title & speaker
09:00 - 10:30	Debates	Clinical groups presentations
10:30 - 10:45	Break	
10:45-12:15	Presentations	Research presentations (6 groups) *The participants from the research module present their research study*
12:15 - 13:15	Clinical & Research	Quiz & take-home messages *Sanjay Bhagani (United Kingdom)*
13:15 - 13:30		Closing remarks
13:30 - 14:30		Lunch and departure

4. Steering Committee Members and the Expert Faculty

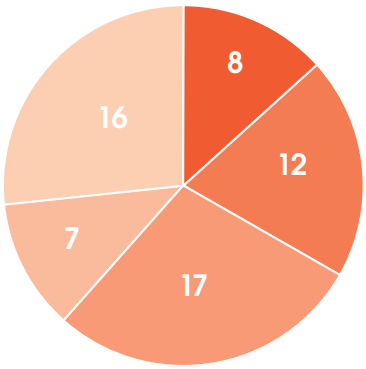
Steering Committee

Sanjay Bhagani	United Kingdom
Stéphane De Wit	Belgium
Tracy Glass	Switzerland
Christine Katlama	France
Nicky Mackie	United Kingdom
CarolineSabin	United Kingdom

Faculty

Juan Ambrosioni	Spain
Jose Bernardino	Spain
Anders Boyd	Netherlands
Yvonne Gilleece	United Kingdom
Maxime Hentzien	France
Agnès Libois	Belgium
Paddy Mallon	Ireland
Esteban Martinez	Spain
Romain Palich	France
Hannah Pintilie	United Kingdom
Sanjay Pujari	India
Asier Sáez-Cirión	France
Kenji Uno	Japan

5. Global Spread of Attendees



- Europe East
- Europe North
- Europe South
- Europe West
- Rest of the World

60

1	Albania
5	Argentina
1	Belarus
1	Bulgaria
1	Cameroon
1	Czechia
2	Denmark
2	France
1	Greece
2	Ireland
7	Italy
1	Japan
1	Lithuania
2	Malawi
2	Mexico
3	Netherlands
1	North Macedonia
2	Poland
2	Portugal
1	Romania
1	Russian Federation
1	Saudi Arabia
1	Serbia
1	South Africa
2	Spain
1	Sri Lanka
2	Sweden
1	Tanzania
2	Turkiye
1	Uganda
3	Ukraine
5	United Kingdom

6. Acknowledgements

The European AIDS Clinical Society would like to thank Gilead Europe, and ViiV Healthcare for their support in part by an unrestricted educational grant. They have no influence on the programme and the organisation of the HIV Summer School.

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