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ORAL ABSTRACTS

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1021 Learning from London's HIV Elimination Efforts to Improve Community Leadership and Partnership across Health Systems

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Introduction: London's ambition is to be the first global city to get to zero new HIV infections, zero preventable deaths from HIV, zero HIV stigma and 100% of people with HIV living well by 2030. In 2020, London launched an HIV Improvement Collaborative of 12 initiatives (between 9 NHS hospital trusts and 22 community organisations) to increase HIV testing, support HIV treatment, tackle stigma and improve quality of life for people living with HIV.

Description: The 12 partnerships are voluntary organisations-led, supported by Quality Improvement methodology, and share learning as an adaptive network. The partnerships address complex issues across micro, meso and macro levels: from individual health journeys (e.g., HIV care re-engagement, treatment adherence), to specific groups or needs (e.g., mothers with HIV and their babies, faith communities), to better coverage of HIV testing in the community (e.g., in homeless shelters, or with undocumented migrants), through to improving integration across the health system (e.g., between addiction and HIV services).

Lesson Learned: Along with quantifiable measures of success – 4,600 HIV tests, 750 people receiving post-HIV diagnosis psychosocial support, a 9-fold increase in referrals from clinics into peer support services, over £1m in welfare support for projects' clients – the Collaborative has produced ground-breaking learning. By building trust between the health service and the communities it serves, promoting an approach to collective expertise, and partnering to eliminate Hepatitis, the Collaborative has shown that working across boundaries has a sustainable impact.

Recommendations: This approach delivers better interventions to improve access to services that address unmet needs of frequently underserved communities. This way of working between the voluntary sector, public health and the NHS through an improvement community could be the blueprint for other long-term conditions to incorporate the third sector into treatment pathways.

1034 Combined Needle and Syringe Program and Opioid Agonist Therapy Reduce HIV And Hepatitis C Virus Acquisition among People who Inject Drugs in Different Settings: A Meta-Analysis of Emulated Trials

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Background: The Netherlands, Canada and Australia were early adopters of harm reduction programs for people who inject drugs (PWID). However, the current HIV and hepatitis C (HCV) epidemics in this group differ in these countries. We assessed the effect of needle and syringe program (NSP) and opioid agonist therapy (OAT) participation on HIV and HCV incidence in these settings.

Method: We included PWID at risk of infection from the Amsterdam Cohort Studies (ACS, 1985–2014), Vancouver Injection Drug Users Study (VIDUS, 1997-2009), and Melbourne Injecting Drug User Cohort Study (SuperMIX, 2010-2021). For each cohort, we emulated the design and statistical analysis of a target randomized trial. We compared the effect of complete harm reduction participation (on OAT and 100% NSP coverage, or on OAT if no recent injection drug use) versus no or partial harm reduction participation combined (no OAT and/or <100% NSP coverage) on HIV and HCV risk (only HCV in SuperMIX given low HIV transmission). Marginal structural models were used to analyze data for each cohort. Pooled hazard ratios (HR) and 95%CI were calculated using random-effect models to estimate combined effects across countries.

Results: During follow-up, there were 61/624 HIV seroconversions in ACS and 37/1,399 in VIDUS, and 34/122 HCV seroconversions in ACS, 30/216 in VIDUS, and 20/94 in SuperMIX. When combined across cohorts, complete harm reduction participation led to a 46% lower risk of HIV acquisition (pooled HR= 0.54, 95%CI=0.32-0.90, I^2=0%), and a 69% lower risk of HCV acquisition (pooled HR=0.31, 95%CI=0.16-0.60, I^2=0%), compared with no/partial harm reduction participation.

Conclusion: Complete NSP and OAT participation led to a substantial reduction of HIV and HCV acquisition compared to no/partial participation across all settings. These findings reinforce the crucial role of comprehensive access to harm reduction interventions in optimizing infection prevention.

1043 The Heat Syndemic: A New Status Neutral Framework of The HIV Epidemic among Transgender Women to Guide Prevention Efforts

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Background: The study sought to test a new biopsychosocial status-neutral framework, the Heat syndemic (HIV Epidemic Among Transgender women), based in Syndemic Theory and the Minority Stress Model, to conceptualize the complexities driving HIV acquisition and transmission risk among transwomen. The framework posited that interrelated psychosocial and structural problems experienced across marginalized communities (substance use, mental health, intimate partner violence, childhood abuse, incarceration, economic marginalization, i.e., "established" syndemic conditions) along with unique stressors due to gender ("unique" syndemic conditions), compound to drive biobehavioral HIV risk.

Method: A sample of mixed serostatus transwomen (*N*=81) in Miami, FL, an area with an uncontrolled HIV epidemic, completed a cross-sectional biopsychosocial assessment. Quantitative methods were used to empirically test the framework. Additionally, the mechanistic role of life chaos was explored post-hoc based on qualitative data.

Results: Findings support existence of the Heat syndemic. High prevalence of and correlations between syndemic conditions supported the appropriateness of constructs and that they co-occur and are interrelated. Nearly no differences in syndemic conditions between serostatus supported the status-neutral approach. Discriminatory power findings supported the appropriateness of considering established and unique syndemic conditions *together* in one model. There were significant relationships between higher number of syndemic conditions and HIV risk indicators (condomless sex and sex work not protected by PrEP/viral suppression). Life chaos had a direct effect on HIV risk and acted as a driver and product of experiencing multiple syndemic conditions.

Conclusion: Transwomen cannot benefit from HIV interventions if the context of their lives is not addressed. A multi-level, multi-faceted approach is necessary to address the complexity of gaps in the prevention and care cascade among transwomen. The Heat syndemic provides a potential blueprint for such efforts and the pursuit of health equity which is necessary for HIV prevention.

1051 Enabling Local Response to Build Bridges for Research with Communities Affected by Multidrug-Resistant Tuberculosis in Pakistan

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Introduction: Clinical trials produce critical evidence on efficacy and safety for health, however, due to rigorous protocols and resource limitations, may fail to include community voices in decision-making. This inhibits person-centered care, creates mistrust in communities, and hinders uptake of treatment following close of research. To address this, the end TB clinical trial in Karachi, Pakistan is collaborating with communities to foster ownership in research and tuberculosis (TB) service provision. This is a multi-country study (www.endTB.org) evaluating treatment regimens for multidrug-resistant TB. In Pakistan, it is being implemented at one urban and two peri-urban sites.

Description: January 2019 onwards, a novel Community Action Group (CAG) model was piloted across two districts in Karachi linked to the urban site. CAGs comprise local volunteers affected by TB (survivors, caregivers, and health providers), aiming to increase knowledge about screening, treatment, and research; advise on trial processes; and extend and embed services into the community.

Lesson Learned: While CAGs supported two-way communication between patients and the trial, its true success was in community action for TB care. CAGs have collectively held 34 meetings to-date, covering topics like TB, mental health, COVID-19, and hypertension, and have autonomously conducted 53 awareness sessions with 460+ residents.

Embedding this model in the trial has enabled trust, such that members referred 39 individuals for TB screening, of whom 6 (15%) were diagnosed with DS-TB and 2 (5%) with MDR-TB. They arranged 13 X-Ray camps – helping screen over 1,000 people for TB – and facilitated distribution of 154 ration bags to vulnerable families in their neighbourhoods.

Recommendations: The CAG model fosters inclusion of local voices and development of a sustainable decentralized model for TB care delivery. This highlights community engagement as a vital part of putting policy into practice and enabling access to care for the most vulnerable.

1059 Evaluation of a Peer Intervention Program in the Hospital Setting to Improve People Newly Diagnosed with HIV Health-Related Quality of Life

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Background: There is evidence supporting peer education effectiveness in health programs, and several institutional declarations recommend its use. However, there are few scientifically evaluated. This study aims to assess the impact of a peer intervention program in the hospital setting to improve the health-related quality of life (HRQoL) of people with a new HIV diagnosis.

Method: We conducted a quasi-experimental single-group design and pre-and post-measurements. An intermediate measure was also collected. The peer intervention program was conducted at three university hospitals in Seville, Spain. It consisted of four sessions that take place in 2 years. Three peers with HIV conducted the sessions. The dependent variables were HRQoL and psychological predictors of HRQoL. We analyzed the change in the dependent variables through repeated-measures variance analysis and covariance analysis.

Results: Forty-three people with HIV participated in the intervention. Most were MSM, with a mean age of slightly less than 40 years old. A significant positive evolution was found in all the predictors of HRQoL, except avoidant coping ($p<.05$). Also, we found a positive evolution in all HRQoL dimensions: overall health, physical health, psychological health, level of independence, social relations, environmental health, and spirituality ($p<.05$). We found changes between the three evaluation measures ($p<.05$). It was a significant increase in CD4 cell/mm3 lymphocytes ($p<.0001$) and in the CD4/CD8 ratio ($p<.001$). The positive differential scores in the psychological health and social relationship dimensions influenced the increase in CD4 cell/mm3 lymphocytes ($p=.012$, $p=0.13$). The increase in the social relations dimension score and overall health perception influenced the recovery of the CD4/CD8 ratio ($p=.044$; $p=0.68$).

Conclusion: Peer intervention improved the HRQoL of people recently HIV diagnosed. It was related to their immunological recovery. This study represents an essential advance in evaluating peer intervention programs for positive prevention in the hospital setting.

1073 Access Program to Health Care and Antiretroviral Treatment for People Living with HIV (PLWH) without Sufficient Health Insurance during the SARS-CoV2 Pandemic at Checkpoint BLN in Berlin, Germany

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Introduction: High administrative barriers make access to HIV care in Germany difficult for people without legal residence status or without sufficient health insurance coverage. This creates gaps in care that mainly affect people with low incomes: e.g., undocumented migrants, foreign students, foreign sex workers. These people rely on importing ARVs illegally from their countries of origin, if possible, by mail, or taking them personally to stock up for months. International travel restrictions during the pandemic left some HIV-infected people stranded in Berlin. The tightened customs restrictions led to a breakdown of personal self-sufficiency systems, putting these individuals at risk of interrupting their HIV treatment.

Description: We initiated a program at Checkpoint BLN (a community-led sexual health centre in Berlin) between 6/2020 and 12/2021to ensure access to free medical care. Patients were seen at least once by a social worker and a doctor. We clarified whether access to statutory health insurance was accessible or medical care could be covered by municipal funds.

Lesson Learned: 49 PLWH registered for the program. The average age: 34 years (24-68). Participants came from 33 countries. Some patients suffered from additional social problems (e.g., homelessness) and medical problems (e.g., HCV). At the end of the program: 19 (38.8%) had statutory health insurance, 13 (26.5%) were supported by municipal funds (Clearingstelle), 11 (22.4%) returned to their country of origin, 5 (10.2%) were lost to followed up and one died of a drug overdose.

Recommendations: We assume that this successful program only reached a small part of the people who did not have access to HIV care during the pandemic. Therefore, following this intervention, we have introduced a free universal HIV care program for undocumented migrants and other PLWH without sufficient insurance status at Checkpoint BLN in Berlin.

1074 High Burden of Blood-Borne Viral Infections (HCV, HIV, HBV) and Sexually Transmitted Infections among People Experiencing Homelessness (PEH): First Results from a Pilot Study in Berlin, Germany

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Background: There are about 417,000 people living in Germany who are affected by homelessness. Due to their precarious living conditions and associated factors (e.g., drug/alcohol use, sexual risk behaviour, imprisonment), they have an increased risk of contracting blood-borne viral infections (BBV) and sexually transmitted infections (STI). To determine the prevalence of BBV and STI in this population group, we conducted a pilot study in Berlin as a first step.

Method: A multicentre cross-sectional pilot study was conducted between April and June 2021. Data were collected by means of a questionnaire-based interview, serological tests for HIV, hepatitis B, hepatitis C (corresponding RNA determinations in case of seropositivity) and syphilis as well as nucleic acid amplification tests (NAAT) in urine for Neisseria gonorrhoeae and Chlamydia trachomatis.

Results: 216 participants were included in the analysis. Mean age: 41 years (range 19-68). Male: 191 (88.4 %), female: 24 (11.5 %) and gender diverse: 1 (0.5 %). 57 (26.8 %) participants were born in Germany. Reported homelessness <1 year was 29.4 %, for about 1-5 years: 42.5 %, more than 6 to over 10 years: 27.1 %. Drug use: 154 (71.6%) and 153 (71.5 %) were at least once incarcerated. 123 (56.9 %) had no health insurance. HCV-RNA was found in 34 (16.0%), 4 (1.9%) were HBsAg positive. HIV was detected in 6 (2.8%). Active syphilis was found in 3 (1.4%), while gonococcal infections were seen in 4 (2,0%) and chlamydial infections in 6 (3,0%).

Conclusion: PEH in Berlin have a high prevalence of BBV and STI. There is a need to improve awareness, access to treatment and care for this population and to include them in national elimination strategies for HCV, HBV and HIV. As more data is needed, a nationwide expansion of the POINT study is planned.

1081 Improving Quality and Equitable Access to Care through the Rollout of a User Fee Community-Led Monitoring Program

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Introduction: The HIV prevalence in Yaoundé is 4.4 % and higher than the national estimated at 2.7%. Users Fees possess a barrier to accessing quality services by the communities of People Living with HIV(PLHIV), consequently contributing to the delay in the attainment of the 95-95-95 UNAIDS targets. In response, the government enacted a policy to eliminate all Users Fee charged at health facilities for the provision of HIV care and treatment services. A Community Led Monitoring and Advocacy (CLM) which aims to monitor the implementation of this policy as well as the service quality for PLHIV is being rollout in the city of Yaoundé by the National Network of PLHIV in Cameroon (RECAP+), with support from USAID.

Description: The activity is conducted in 46 health facilities and involves 21 site mentors from 6 community-based Organisations. Key activities include periodic community sensitization on User fee policy, monthly site evaluations on 13 selected domains of care, development, and use of a mobile application for the anonymous denunciation of malpractices, presentation of results and advocacy for change at all levels of the health pyramid.

Lesson Learned: Preliminary findings from the semester evaluation indicate a decrease from 80% to 61% in the proportion of facilities implementing the User Fee policy irrespective of the 100% health workers awareness of the policy. There was an overall increase in the proportion of care domains accessed by PLHIV (65% to 87%). Recurrent commodity stockout was identified as a barrier to accessing care. Over 325 people were sensitized in the city of Yaoundé on the user fees policy

Recommendations: Rigorous monitoring and the sensitization of beneficiaries on policies favoring free access to HIV services is critical for success. CLM is a simplified model for ensuring community participation in policy formulation through prompt identification advocacy for change at all levels of the health pyramid, thus closing the gaps for healthcare access to PLHIV.

1085 Ukraine's Model of Transition Plan as an Experience that can be Piloted in the EECA Region

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Introduction: Implementation of the Transition Plan 20-50-80 (TP) is one of objectives in the Global Fund grant for Ukraine for 2018-2020. To provide services in 2018 and implement the first phase of TP, centralized and decentralized models of service delivery have been developed. In 2018 20% of HIV prevention, care and support and TB support services for target groups were provided. The main tasks were to choose the optimal model and then implement it throughout Ukraine.

Description: In 2018, Poltava and Sumy regions were selected to pilot the models. Based on the results, our experts, together with Public Health Center and the main GF recipients, have created a model of TP for 2019-2020. In 2019, procurements of services were made through the ProZorro electronic system. The Strategic Group was set up to coordinate the process and deal with operational issues, respond to the challenges arising. About 100 million UAH has been allocated for the procurements of services in 2019. Regionals NGOs became winners of the tenders and started to provide services for state funding.

Lesson Learned: We managed to create the model of TP that is the most optimal for the HIV services area. The e-procurement mechanism is transparent and competitive, so we can get the best quality at a reasonable price. Participants in the process are all potential service providers – from municipal institutions to businesses and NGOs. This model is approved in normative acts (MoH orders, Cabinet of Ministers regulations) and can be the basis for adaptation and implementation in the EECA region.

Recommendations: The model of services procurements for TP encourages the state to optimize its financing – to buy the necessary services at a reasonable price from quality providers. We don't discriminate representatives of communities or other participants in the newly created market, since the criteria, standards and procedures are clear and approved in normative acts.

1094 Building Bridges: Use of HIV/STI Services and Gender-Affirming Care for Transgender and Gender Diverse Communities in Amsterdam at an NGO-Public Health Co-Led Clinic

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Background: Members of the transgender and gender diverse (TGD) community often face barriers to care due to discrimination or inexperience with TGD-specific health needs. Marginalized TGD persons who are homeless, active as sex worker, or have a migrant background, face additional barriers. High risk for HIV is an important health disparity experienced by this community.

Method: In 2021, a collaboration was started between the Centre for Sexual Health Amsterdam (CSHA) and Trans United Europe, a community-led organization. Through this collaboration, multidisciplinary services are offered to individuals who identify as TGD and who experienced barriers to care. Services include hormone therapy prescription, STI/HIV testing and counseling, and psychosocial support. Services are offered at community-based locations by a predominantly queer/TGD team. Descriptive statistics were used to summarize population characteristics, HIV/STI testing uptake and diagnoses.

Results: In 2021, 75 individuals visited the clinic at least once of whom 44 (59%) were tested for STI (table 1). Most visitors (76%, n=57) had not previously visited the CSHA; testing uptake in this group was56% (n=32). Testing uptake was 63% (37/58) among transfeminine visitors and 41% (7/17) among transmasculine visitors. Testing uptake was high among refugees (73%, 22/30) and those who reported sex work (69%, 18/25). Self-reported HIV prevalence was 13% among trans women and 0% among trans men. We found no new HIV, and 1 acute Hepatitis B infection. We found 15 bacterial STIs among 44 individuals during 77 visits.

Conclusion: Offering combined hormone therapy and sexual health services with strong community involvement seems a successful way to reach marginalized TGD communities for STI testing. The proportion of visitors diagnosed with an STI was substantial. Further insight into health needs of TGD people might help to improve sexual health outcomes through integrated care programs.

1099 Programmatic Mapping and Population Size Estimation (p-MPSE) of High-Risk Groups (HRGs) Operating through Networks in Delhi, India

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Background: Operational dynamics of HRGs among Female Sex Workers (FSWs), Men having sex with Men (MSM) &Transgender (TG) has shifted from hotspot based geographical locations to operator managed networking. In order to map people (Network Operator) with whom a group of HRGs are linked, for soliciting clients & sexual partners, a programmatic Mapping and Population Size Estimation (p-MPSE) of HRGs operating through networks was initiated in Delhi to understand operational aspects of Network operators & to provide HIV/AIDS prevention & treatment services to HRGs within these networks.

Method: Network mapping followed a multistage approach to identify and saturate networks. It followed sequential steps to identify an initial set of networks, profile them and identify further networks from each original network before profiling them. It adopted three stages, first identify initial starting points following discussions with different groups of HRGs and visible network operators, second meet identified network operators, established rapport with them and collect information about their network and other network operators and third consolidate the list of second level network operators. The mapping conducted during Nov. 2021 to Mar. 2022

Results: About 2968 network operators were mapped through Network mapping and around 92551 HRGs are associated with them. 94% of the Network operators deals with FSW followed by MSM (4%) and Transgender (2%). 80% of the Network operators are female, 17% Male and 3% TG. An average of 30 HRGs are associated in these networks. 10% of the HRGs are also associated with other networks and 3% of them also solicit at physical hotspot. However, significant variation observed among FSW, MSM, and TG population associated with other networks.

Conclusion: Network mapping and profiling have provided significant insights into the operational aspects of network operators and scope of reaching out to HRGs associated with them for providing HIV/AIDS prevention and treatment services.

1100 Implementation of a Municipal Strategy on HIV and Vulnerable Populations in a Municipality of Madrid Region 2021: Fast-Track Alcorcón

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Introduction: Alcorcón is a municipality of 170000 inhabitants, 14km outside Madrid city, and with 16 annual new HIV-diagnoses, among those with the highest incidence in Madrid-Region. Most public health competencies are regional and community resources are concentrated in Madrid city, making multisectoral work imperative for 95s targets.

Description: Alcorcón joined Fast Track Cities in 2021, in alliance with agents in Madrid-Region, establishing three priorities:

- Collaboration with Surveillance (Madrid-Region) and Hospital (only municipal hospital).
- Approach: "Zero New Infections, Zero Stigma," since intermediate 95s goals have a very high achievement rates in Spain.
- Coordinating resources:

Lesson Learned: *Baseline:* Since 2012, the incidence has fluctuated around 9.4/100000 inhabitants-years, 80.0% men, 43.0% 30-39 years old, 89.3% sexual transmission, late diagnosis rose from 33.3% to 63.6%. Of 410 PLHIV, 90.7% are monitored at Alcorcón-Hospital. *Zero Infections:* The high late diagnosis rate makes it essential to screen (HIV, hepatitis C, STIs). Two fixed care centers were enabled, plus campaigns. A rapid detection-referral circuit was created for vulnerable populations with low adherence. *Zero Stigma:* High participation of resources in weekly local radio program *Ganando Salud* (Memorial days, sexual health, discrimination, LGTB+, gender violence, mental health, addictions, social exclusion, disability) and street campaigns. Improvement in the Municipal Health School (Inclusive activities. Workshops on sexual, functional, cultural diversity).

Recommendations:

- Extrapolate 1º 95 from Madrid-Region (in process)
- Estimate 2nd-4th 95 from Alcorcón-Hospital
- To fix resources on vulnerability
- To collaborate with nearby municipalities

1104 Peer Mentoring Support for People Living with HIV: Addressing the Fourth 90

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Background: 'Better Together', a peer mentoring project in Greater Manchester (UK) for people living with HIV.

Method: George House Trust, Greater Manchester's HIV support organisation, with funding from the National Community Lottery Fund, launched 'Better Together' in 2017. A 5-year project providing high quality peer mentoring for people living with HIV. Mentors attended a three-day training course and provided support in the community and at HIV clinics. Time limited relationships focused on goal setting. Key outcomes focused on:

- Improved understanding of HIV, clinic engagement and medication adherence
- Improved confidence to talk about HIV
- Increased social connectivity and reducing stigma

Results: Since project inception:

- 415 people supported; 79 mentors trained; 200 community matches; 906 mentor sessions
- 87% reported improvement in ability to live confidently with HIV
- 87% reported improvement in ability to live healthily with HIV
- 78% reported feeling more confident talking about HIV
- 74% reported feeling more confident discussing HIV related medical issues with healthcare professionals
- *Gay man recently sought asylum* – living in shared accommodation, limited social connections, exploring sexuality. Regular meetings with mentor and activities including trips to gay district and cinema. Mentee reports greater confidence, now engages in volunteering.
- *Recently diagnosed African woman* – matched with woman from same community, explored HIV together, met in community settings. Reported less fear about HIV and told family about diagnosis.
- *Woman living with HIV for 10 years* – told nobody about status, outdated views about HIV and life expectancy. Became mentor, now helps lead a group for women living with HIV.

Conclusion:

- Tangible and long-lasting benefit to provision of peer-led support empowering people living with HIV
- People living with HIV should have access to peer mentoring through clinics, third sector organisations or remotely
- Addresses non-clinical needs and quality of life (4th 90) through provision of social interventions and peer conversations

1147 Despite the Obtainment of the 90-90-90 Cascade of HIV Care (CoC) Goal, Vulnerable Population Still Need Focused Interventions in Milan Metropolitan Area

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Background: Fast-Track City initiative has the goal to eliminate new HIV infections by 2030. Knowledge of critical issues at local level is the premise to support targeted campaigns. We aimed to define the Continuum of Care (ContC) and Cascade of Care (CoC) over calendar years in Milan.

Method: We evaluated ContC and CoC from 2012 to 2019 using data of Icona cohort from the 6 Infectious Diseaes centers of Milan and data of Italian Institute of Health Registry (ISS): in 2012, 44.5% of Lombardy residents were in Milan, equivalent to 13098 individuals. We determined: the ContC in Milan (% of PLWH on ART and on virological suppression (VS) over total estimated PLWH; 2012-2019); and the CoC, (% of PLWH on ART out of PLWH diagnosed and those on VS out of PLWH on ART). For the estimate of undiagnosed PLWH we used the adapted London Method2 (Mammone, 2016). PLWH on ART and those on VS were calculated using weighted data from Icona. We also calculated the Milan CoC in subpopulations (non-Italian; MSM vs Hetero vs IDU; females; age strata).

Results: Data on the ContC and of the CoC of Milan are shown in Table 1. Of note, the % of PLWH diagnosed, on ART and on virological suppression is increasing in more recent calendar years. UNAIDS targets of CoC were reached in 2016. Despite overall success, younger and non-hetero individuals reached later than 2016 the 2nd 90 (starting ART), and IDU did never pass it (Figure 1). Once on ART, non-Italians and IDU showed lower % VS (Figure 2).

Conclusion: These data underline that despite successful CoC, still vulnerable population such as younger, non-Italian and IDU need focused campaigns in Milan.

1191 More Hepatitis C Late Diagnosis Cases: An Aftermath of the COVID-19 Pandemic in Barcelona, Spain

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Background: In 2016 the World Health Organization advocated for elimination of viral hepatitis as a major health threat by 2030. However, COVID19 emergency caused an interruption of medical assistance. This study was designed to evaluate whether the profile of patients who visited the hospital for the first time have been changed after the pandemic.

Method: We collected all new HCV infection diagnosis that attended the outpatient hepatology consultation in four consecutive years (2108-2021) and analyzed their demographics and clinical characteristic before (2018-2019) and during COVID19 pandemic. Late presentation for care was defined as patients who enter care when substantial liver fibrosis is already present (Mauss et al. BMC. 2017) and established by non-invasive markers in most patients.

Results: A total of 376 patients with Hepatitis C were visited during this period: 229 before and 147 during COVID19 pandemic, representing a decrease by 35.81% of outpatients attended. Concerning to baseline characteristics, 55% were male with a mean age of 57.07 years before the pandemic and 50% with a mean age of 59.02 years after COVID19 emergence. Late presentation like advanced fibrosis or cirrhosis was recognized in 75 (32.75%) patients before and 52 (35.37%) after COVID19. However, when the latest group was evaluated, 21 (28%) patients in 2020 and 31 (43%) in 2021 had late presentation. The percentage of patients who received treatment with direct-acting antivirals (DAA) was 182 (76%) before COVID-19 and 136 (95%) during pandemic, this increase correlates with the restrictive use of DAA in 2018 in relation to the degree of fibrosis.

Conclusion: COVID19 pandemic caused a reduction of outpatient attendance at first hepatology consultation by 35.81%. The limited access to screening and diagnosis could have increased the percentage of patients with late presentation for care in 2021.

1192 Understanding Disengagement and Re-Engagement in Johannesburg's HIV Programme: An Analysis of Clients Re-Initiating ART

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Background: Long-term antiretroviral therapy (ART) adherence is needed to achieve and maintain viral suppression. Disengagement/re-engagement are increasingly recognised as a normal part of lifelong ART. Johannesburg District implemented *Welcome Back Campaign* activities, to encourage interupted ART clients to re-engage.

Method: Lay counsellors supported clients reinitiating ART at Johannesburg public health facilities. Demographics, duration of interruption, and reasons for interrupting and re-engaging with ART were collected during the re-initiation process. Data were entered into REDCap; Chi-squared tests identified differences between age/sex groups.

Results: Data were collected for 332 clients across 28 facilities August-December 2021. 192(58%) were women. 114(34%) had interrupted ART for <3 months, and 119(36%) for >12 months. The commonest reasons for interrupting ART were mobility/relocation (102; 31%), distance to the clinic (65, 20%), and difficulty getting time off work (62, 19%). The commonest reasons for re-engaging were worry about not taking ART (161, 48%), access to services improving (77, 23%), and feeling sick (73, 22%). Reasons for interrupting treatment differed by age/gender: women cited disclosure issues (p=0.04); anxiety about returning to care (p=0.04) more often; men cited changed employment (p=0.03); inability to get time off work (p= 0.01) more often; under 25 years cited treatment fatigue (p=0.05) and forgetting treatment (p=0.01); 25-44 years cited believing ART doesn't work (p=0.01) and >45 years cited waiting times (p=0.05).

Conclusion: Disengagement in Johannesburg is driven by shifting life circumstances and health systems barriers. Modifications to services must address the needs of different client groups to support long-term retention and quicker reengagement following interruption. Focus areas include increased flexibility and efficiency within HIV services, strengthening client support/education and positive staff attitudes.

1193 Legal Drivers to Eradicate HIV-Related Discrimination in Spain

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Background: In 2018, the Social Pact for Non-Discrimination and Equal Treatment Associated with HIV was passed, including the analysis of legal regulations at the national, regional, and local levels to identify those with good practices towards people with HIV and those that discriminate against them.

Method: Through the cases received at the Legal Clinic of the University of Alcalá (1111 consultations between 2019-2021), keywords have been identified as search criteria in the main legal databases (vLex, Aranzadi, BOE). Once the legal norms were identified, they were analysed seeking whether there is discrimination against people with HIV or they constitute good practices.

Results: To date, 209 legal regulations could affect rights of people with HIV. Regarding good practices (highlights): at the state level the elimination of HIV as exclusion in access to state security forces; at regional level (Catalonia), the regulation of discrimination based on serological status; at the local level (Seville) grants to non-profit entities that develop projects for the prevention, promotion, and protection of HIV. Regarding discrimination based on HIV (highlights): at the state level, people with HIV are excluded from access to private security forces; at the regional level (Madrid) people who live with people with HIV are deferred as blood donors; at the local level (Seville) the requirement of infectious contagious disease in access to the profession of taxi driver.

Conclusion: Although since 2018 there is progress building a rights-based response to HIV, in the Spanish legal system, both at the state, regional and local levels, good practices have been identified at the state, regional and local levels, but legal regulations continue to be found that include some type of discrimination (direct, indirect, by association) towards people with HIV.

1194 Chicago's Housing Status Neutral Approach: Advancing Ending HIV Efforts

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Introduction: While shelter is one of the basic needs that support human being existence, it is often ignored in HIV prevention and care strategies. In the city of Chicago, between 2009 and 2016 new cases of HIV plateaued at ~1,000 cases per year. Black and Latino gay, bisexual, and other men who have sex with men between 18-29 years of age continue to account for most of the cases. These populations reported high need for housing services without supply meeting the demand from persons vulnerable to HIV. While the US Department of Housing and Urban Development (HUD) has Housing Opportunities for Persons with AIDS (HOPWA) for PLHIV since 1992, no HUD program provides housing assistance to individuals vulnerable to HIV.

Description: To respond to the population need and match its novel Status Neutral service approach, the city of Chicago invested local governmental resources to establish the first-of-its-kind in the U.S.A. housing program for individuals vulnerable to HIV who are PrEP adherent. This program provides housing subsidies and supportive services to Black and Latino gay, bisexual, and other men who have sex with men to promote the use of PrEP to prevent HIV infection.

Lesson Learned: After three years of Status Neutral Housing service delivery model implementation, the program has served 36 individuals each year and 100% of participants have remained HIV negative. This successful and novel program has contributed to reduce HIV infections in Chicago. approach continues being successful. New HIV infections have been recorded at its lowest since 1988 at 652 in 2019 and 627 in 2020.

Recommendations: To promote Status Neutral approaches and ease the implementation stress, national and international partners need to implement similar approaches to funding HIV services.

1202 Mobile App-Based Ordering of HIV Self-Test Kits and Associated Factors among Gay, Bisexual, and other Men who have Sex with Men

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Background: The Centers for Disease Control and Prevention recommends HIV screening at least annually among sexually active gay, bisexual, and other men who have sex with men (GBMSM), but in the United States (US) only half report being tested annually. As HIV self-test kits are offered around the US to address this gap via web and app-based interventions, it is important to understand who is willing and able to order.

Method: We used M-cubed baseline data from GBMSM in Atlanta, Detroit, and New York collected from January-October 2018. Behavioral, demographic, and other predictors of kit ordering were identified from theoretical underpinnings of the app and literature. Significant predictors in bivariate analyses were included in the empiric model. Variables chosen a priori were added back into the final model. Estimated risk ratios were calculated to reduce overestimation of odds ratios.

Results: Over half of 417 participants ordered an HIV self-test kit during the intervention. Ordering was associated with testing history, plans to test, and reported likelihood of getting tested. In the final model, participants who had not tested for HIV in the past three months were more likely to order (aRR=1.34, CI: 1.09-1.64). Those who reported plans to get tested in the next three months were 60% more likely to order (aRR=1.59, CI: 1.17-2.15). There was no difference in ordering by race, ethnicity, or age.

Conclusion: HIV testing is an important tool in ending the HIV epidemic, which will not happen unless testing is accessible and frequent for key populations. This study demonstrates the effectiveness of self-test kits in reaching undertested populations and shows that self-testing may supplement community and clinical testing while overcoming structural barriers that limit access to HIV prevention services.

1215 Scaling Viral Load Testing in Jakarta, Indonesia through Customization of the National HIV Cohort Platform

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Introduction: Indonesia's HIV information system (SIHA) does not include indicators that track viral load testing and suppression. Therefore, coverage of the third 95 of the UNAIDS 95-95-95 targets has not been recorded and reported, even in contexts where viral load testing is taking place.

Description: Jakarta Provincial Health Office (PHO) has been working with USAID EpiC project and partnered with Indonesia's Ministry of Health (MOH) to create the Cohort Recap Application *(Aplikasi Rekap Kohort,* or ARK*)* using Microsoft Excel and a MySQL software. ARK captures facility antiretroviral therapy (ART) register data and tracks people living with HIV (PLHIV) individual data across yearly ART cohorts. In addition to collecting data on ART initiation, outcomes (retention, death, loss to follow-up and re-engaged patients in treatment), and ART regimen, ARK identifies individuals who are eligible for viral load (VL) testing and records data on both viral load testing and suppression data.

Lesson Learned: Following the dissemination of the viral load testing acceleration policy in July 2018, ARK was introduced to 125 health facilities in Jakarta. Within one year, one hundred percent facilities are now regularly reporting VL testing and suppression data. Such improved data allowed us to find that over a three and a half-year period since July 2018, 18,894 VL tests were conducted, with an overall suppression rate of 93%. Approximately 78% of total eligible PLHIV in Jakarta had received at least one VL testing by March'22, up from only 3% reported in 2018. It is expected that by the end of 2022, VL testing coverage levels will exceed 85% among all PLHIV in Jakarta, it will exceed 45% of MOH targets

Recommendations: Jakarta PHO will continue to use ARK and expand it to more treatment facilities in order to build more accurate and comprehensive 95-95-95 HIV treatment cascades.

1225 Achieving Virological Control and Engagement through Tailored Peer Mentoring: A Collaborative Project Supported by the Fast-Track Cities Initiative

Jaime Sylla (presenting)[1], Harry Coleman[2], Jakub Krzyzynski[1], Joel Robinson[1], Elizabeth Dale[3], Elizabeth Hamlyn[3], Hannah Alexander[1], Kate Childs[3], Goli Haidari[1]

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Introduction: Incomplete adherence to antiretroviral therapy (ART) and difficulty engaging in care is a common cause of HIV related mortality and morbidity. Addressing barriers i.e., stigma, socioeconomic factors and patient empowerment may help to reduce these obstacles. We designed and implemented a peer mentor scheme, providing individualised support for people living with HIV (PLWH) with a viral load (VL) of >200 copies/ml.

Description: Aim: 60% of patients who engaged with the peer mentor to achieve a VL <200 copies/ml within 12 months. The FTC mentor was embedded in two clinics, with a NHS contract and email address. Prior to project initiation, promotional material, first contact script and referral pathway were agreed. The mentor had a series of discussions with clients, covering motivation, HIV knowledge, beliefs, and barriers to adherence – promoting patient agency. By month 20, 81 patients were referred. 40/81 (49%) patients were engaged. Median age was 40, 60% (24/40) black ethnicity, 63% (25/40) male, and 40% (16/40) heterosexual. 85% (34/40) achieved an undetectable VL. 75% had achieved virological suppression within 5 months of referral.

Lesson Learned: Case study: A 54 heterosexual black Caribbean female, living with HIV since 2006 was enrolled into the programme. She had advanced HIV with a nadir CD4 of 5 cls/uL and VL of >500,000 copies at referral. The mentor empowered her to ask for a smaller tablet to aid adherence and supported her holistically. As a result, she achieved a low VL for the first time in 10 years. Her positive experience has motivated her to train as a mentor.

Recommendations: We recommend embedding a peer mentor in all clinics to enable PLWH to achieve an undetectable VL. The project continues to accept new referrals and we are sharing out successful model with other clinics.

1239 Innovative Holistic Approaches to Improve Health Outcomes among Socially Vulnerable MSM Communities

David Nel (presenting)[1], Dorian Gule[1], Luiz De Barros[1], Paul Botha[1], Antonia Barnard[2]

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Introduction: OUT is a 28-year-old MSM-led South African NGO, currently in its fourth year of funding from the USAID/PEPFAR across the Continuum of HIV Services for Key Populations Affected by HIV (EpiC) Project. OUT established the Engage Men's Health (EMH) programme to improve HIV case finding, antiretroviral therapy (ART), and pre-exposure prophylaxis (PrEP) coverage for MSM in South Africa. Based on programmatic results, OUT expanded its data collection to evaluate housing, food, and employment insecurity amongst MSM to identify and address barriers to care.

Description: Covid-19 pandemic restrictions in South Africa broadened barriers to care and gaps in health programmes. OUT used its programmatic data results to advocate and collaborate with stakeholders to address these gaps. Responding to increasing unemployment and its impact on health, OUT launched initiatives to make shelters MSM-friendly and to develop skills and facilitate employment opportunities.

Lesson Learned: Self-reported employment statuses from programme beneficiaries have increased from an average of 58% unemployment in FY21 (Oct 2020 – Sept 2021) to 75% by month nine in FY22 (Oct 2021 – June 2022). Unemployment leads to food and housing insecurity and social vulnerabilities: homelessness, not having sustenance to take medication and remaining in abusive relationships. OUT engaged with the Department of Health in the City of Johannesburg to create MSM safe spaces in three shelters across the metro. Strategies have been adapted to accommodate unemployment by making home deliveries available for ART and PrEP, and providing travel reimbursements for visits to on-site services.

Recommendations: OUT designed programmes to link clients to skills development and job and learnership opportunities that should be made available to the wider MSM community. Health programmes need to address unemployment as a barrier to care. MSM specialised health providers need to collaborate with Government to offer crisis accommodation and facilitate access to opportunities.

1260 Experience of the Implementation of the "One Stop Shop" Strategy in Programs to Fight against HIV/AIDS among Young LGBTIQ people in the City of Yaoundé: Case of CAMFAIDS in Yaoundé 5th, Cameroon

Kamen Liwandi Mathias Nickel (presenting)[1]

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Introduction: Since 2009, CAMFAIDS has been implementing HIV services for LGBTIQ people. The strategy tested in 2019 is the One Stop Shop approach, which consists of offering clients complementary services to HIV services in one place. This strategy has boosted these indicators by 70% in the three UNAIDS 95s, for 19-25 year olds and by 50% for Hard to reach. The question answered by this experience was: How to improve the HIV service offer for young LGBTIQ and Hard to reach people in a Drop-in center?

Description: In 2020, the association led 04 focus groups. The results showed a need for diversification of activities, in particular: STI tests, legal support, emulation activities. A new service offer including: a community laboratory, a legal clinic, Gender Café activities, etc. After the adoption of this strategy, the staff were trained, the tools adapted, and the customers made aware. The contribution of the strategy has enabled the association to boost these results in prevention with 70% of the indicator, among 19-25 year olds with an improvement in retention of 70 to 85% and an increase in 40% of service request.

Lesson Learned: We have seen an increase in visits from young LGBTIQ and Hard to Reach people. Beneficiaries feel more comfortable participating in HIV services because they are combined with other services. The other services made it possible to reach 3,95. The Drop-in center saw the attendance of the other targets increase. The strategy can be duplicated with other targets.

Recommendations: This strategy made it possible to observe the effect of weariness of the HIV services centered on traditional methods of responding to HIV. The One Stop Shop approach has energized other departments.

1261 Linkb: A New Approach for Identification and Linkage to Care People Living with Chronic Hepatitis B

Anna Feliu-Prius (presenting)[1], Ana Barreira[1], Ariadna Rando[1], Francisco Rodríguez-Frías[1], Elena Vargas-Accarino[1], Judit Vico[1], Nieves Palomo[1], Adriana Palom[1], Mar Riveiro-Barciela[1], Rafael Esteban[1], María Butí[1]

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Background: Around 290 million people are infected by Hepatitis B worldwide, and HBsAg-positive prevalence is roughly 0.6% in Spain. In our setting, a large percentage of HBsAg carriers are not followed up. Our aim was to identify and characterize HBsAg-positive individuals and promote their linkage-to-care in an academic center.

Method: LinkB is a retrospective-prospective ongoing single-center study based on the search for all HBsAg-positive cases recorded in the laboratory of Vall d'Hebron University Hospital (Barcelona). The retrospective sampling included 2018 to 2020, and the prospective sampling went from 2021 to June 2022. Medical records were reviewed to identify those cases not linked to care, which were then contacted to offer follow-up.

Results: Until May 2022 our laboratory detected 2,657 HBsAg-positive cases (Figure 1). Overall, 946 individuals (35.6%) were not linked to care. LinkB referred 593 individuals to a hepatologist, and from them, 285 patients have been already visited. Individuals not linked to care (Table 1) were statistically younger (44 vs 49 years, $p<0.001$), with a higher proportion of males (66% vs 61%, $p=0.009$), higher HBV DNA levels (2.4 vs 2.2 log, $p=0.015$), though similar transaminases values. However, HBeAg-positive subjects or co-infected by hepatitis D or HIV were more likely to be properly linked to care ($p<0.001$, $p=0.001$ and $p=0.023$, respectively). Moreover, among patients contacted to be linked, those who did not attend the appointment differed in the ethnicity (41% Afroamerican).

Conclusion: LinkB study revealed that roughly one-third of HBsAg-positive carriers are not properly linked to care. This strategy allowed the retrieval of many individuals and identifies those persistently not linked to care as young middle-aged afroamerican males.

1289 Outcomes of a Nerve Centre Approach to Achieving the 90-90-90 HIV Targets in Johannesburg, South Africa

Mpefe Ketlhapile (presenting)[1], Nathene Morley[1], Antonia Barnard[1], Matlhodi Mogorosi[1], Prince Dulaze[1], Diana Mokoena[1], Moyahabo Mabitsi[1], Kate Rees[1]

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Introduction: er we share outcomes from interventions implemented to accelerate progress towards the UNAIDS 909090 HIV targets in Johannesburg Health District. There are an estimated 7,922,403 PLHIV in South Africa, 727,006 (9%) of which reside in Johannesburg.

Description: Through the national project Operation Phuthuma, a centralised, structured and standardised Nerve Centre and Project Management approach allowed for rapid scale of effective interventions. The approach was started in April 2019 as "War Rooms" and augmented in 2021 as the Nerve Center Approach using a phased strategy to closely monitor program achievements through Quality Improvement and data-driven activities at public-sector primary care facilities. Methods consisted of analysing routine program data, applying weekly monitoring tools, analysing processes to identify service delivery gaps, and redesigning service delivery through systems strengthening e.g., re-allocation of staff and resources. Interventions were monitored weekly for outcomes.

Lesson Learned: An annual evaluation in early 2022 showed achievement of the first UNAIDS 90, with 91% of PLHIV in the city knowing their HIV status, 70% with a known status on ART and 85% retention in care. The number of people on ART grew from 77% of the annual target of 514,115 in April 2021 to 438,749 (85%) at the end of the financial year (March 2022). The core NCA elements consisted of identifying interventions that drive outcomes, implementing, monitoring, and disseminating lessons rapidly. Training of managers ensured facility teams accountability through huddle meetings using standardized tools to identify non-performing indicators.

Recommendations: We recommend this approach is expanded; it allowed stakeholder engagement, enhanced accountability for rapid identification and management of health system factors impeding performance, leading to overall service delivery improvements.

1301 Impact of the War in Ukraine on Sustainability of HIV Prevention Services for Key Groups in Fast-Track Cities

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Introduction: Ukraine remains a region with a high level of HIV prevalence and a concentrated epidemic among the key population (KP): men who have sex with men (MSM), sex workers (SW), people who inject drugs (PWID). Access to HIV prevention programs is provided by legislation and financed from the state budget. The Russian-Ukrainian war led to a humanitarian crisis, which can affect the spread of HIV. We analyzed the impact of the war on the sustainability state prevention program in Fast-Track Cities.

Description: HIV prevention programs for KP in Ukraine are coordinated at the state level and financed from the state budget. Since 2019, the state has gradually transferred HIV prevention programs from donor funding to the state budget according to the formula of 20%-50%-80% by the end of 2020. In 2021, prevention services were fully financed from the state budget. The state provides a basic package of HIV preventive services.

Lesson Learned: The war in Ukraine has begun in February 2022. To analyze the impact of the war on the provision of HIV prevention services, it was compared data for February-May 2021 to the same period in 2022. The presented results demonstrate the stability of the system of preventive services, even in a period of crisis for the country. In Fast-Track Cities, it was possible not only to maintain services at the pre-war level, but also to expand the number of service clients. In Kyiv and Odesa, the number of PWID increased by 85% and 12%, respectively. In Odesa, the number of SW increased by 73%. Only in Mariupol, where active military operations took place, the number of service clients decreased by 79% PWID, 65% SW.

Recommendations: The systemic approach and state coordination of prevention programs ensured the stability of the HIV response system even in the conditions of armed conflict. This approach will ensure a reduction in new HIV infection among key groups in the future.

1312 Low-Threshold Housing as a Powerful Strategy for Ending HIV Epidemics

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Introduction: Despite ample evidence that housing status is among the strongest predictors of HIV health outcomes, housing supports fall far short of need in most settings. Lack of housing resources is exacerbated by barriers to existing programs posed by admission criteria that bar people with HIV (PWH) based on active substance use and/or untreated mental health issues. Low-threshold, harm reduction housing models, also described as housing first, are not employed at scale because behavioral health objectives are conflated with and elevated above ending the epidemic goals.

Description: A New York City HIV services organization employs a low-threshold, harm reduction approach to housing assistance, with neither admission nor retention in housing conditioned on abstinence from substance use or behavioral treatment compliance. Residents are entitled to privacy within their own homes, have access to a range of optional supportive services, and are encouraged to share behavioral health concerns and questions as one aspect of a toolkit of strategies to promote viral load suppression and optimal health. Over 400 units of supportive housing target underserved PWH who face the challenges of extreme poverty, homelessness, mental health issues, substance use disorder, and incarceration, including housing programs for youth and people of trans experience.

Lesson Learned: As of May 1, 2022, 80% of 432 residents identified as Black (54%) or Latinx (26%), 23% as LGBTQ+, and 19% as age 18-24. Approximately 77% had a mental illness diagnosis, 57% were current alcohol and/or substance users, and over 60% were experiencing homelessness upon program entry. Despite multiple demonstrated barriers to antiretroviral adherence, 86% of residents were virally suppressed, and viral suppression among all residents had not fallen below 80% in the prior 12 months.

Recommendations: Low-threshold housing assistance provides a powerful tool for ending HIV epidemics and addressing persistent health inequities.

1375 Mental Health Morbidities among PLHIVs in Mumbai, India: The Need for an Integrated Response

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Background: Studies have documented higher rates of mental health disorders among people living with HIV (PLHIV). Common mental disorders can be a substantial barrier in engagement and retention in HIV care. Mental health morbidities contribute to poorer health care behaviours across the HIV care continuum with poor health outcomes. We designed a mobile application 'Samvaad' (dialogue) for counsellors at ART centres to screen for mental health issues among PLHIVs during their routine care at ART centres.

Method: All PLHIVs were screened with a simple tool seeking their symptoms suggestive of depression, anxiety and mood disorders in the preceding two weeks. Common behaviours associated with these morbidities were included in the app to identify PLHIVs in need of mental health counselling and were provided referral to specialist services.

Results: Among 9497 PLHIVs screened, 1033 (10.8%) had a mental health co-morbidity: Anxiety (754 [7.9%]) was the most common, followed by depression (429 [4.5%]) and mood disorders (344 [3.6%]). 701 (7.4%) people had a single co-morbidity, 170 (1.8%) had two & 162 (1.7%) had all three co-morbidities. Among people with mental health co-morbidities, 57.7% were male, 41.3% were female and 1.1% were male-to-female transgendered people. Anxiety was more common in middle age (median 37 years) compared to depression and mood disorder (median 35 years). There was no association between gender and any mental health morbidity. Patients with depressive symptoms were more likely to be virally un-suppressed (70% vs 62%; $p=0.058$). Depression (65% vs 36%; $p<0.001$) and mood disorders (47% vs 30%; $p<0.001$) were more common among patients on treatment for < 2 years while anxiety did not differ significantly.

Conclusion: There is an urgent need for universal mental health screening for PLHIVs in routine HIV care through ART centres and integrated management of mental health morbidities for successful treatment outcomes.

1380 What Happened to Tuberculosis Diagnostic Delay during the COVID-19 Pandemic? Sevilla Experience

Valme del Río García (presenting)[1], Sofia Villalobos Herrera[2], Eduardo Briones Perez de la Blanca[2], Elena Baños Alvarez[1], Nicola Lorusso[3]

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Background: According to 2020 WHO Global Tuberculosis Report, the COVID-19 pandemic threatens to undermine the progress that had been made in reducing the global burden of tuberculosis. Negative effects for essential tuberculosis services include that in many cases human and financial resources have been reallocated to respond to COVID-19. In many countries, data collection and reporting systems have also suffered.

Method: Cross-sectional analysis of tuberculosis cases reported in Sevilla District (2010-2021), based on data obtained from the Andalusian surveillance system, spatial analysis in disadvantaged areas (DAs).

Results: The average number of total cases reported in 2010-2019 was 113 cases p/y. In 2020-2021, it was 76 cases p/y, registering a historical minimum value of 74 cases in 2021. The cases reported in 2019-2021 represent 25.74% of the tuberculosis cases in the Andalusian DAs. In 2019, 38% of tuberculosis cases were in DAs; in 2020, 30% and in 2021, 35%. Diagnostic Delay (DD) is considered if there is a delay of more than 30 days diagnosing tuberculosis. The mean total DD in 2019-2021 was 80 days in DAs and 77 days in NO-DAs. In 2020, the shortest DD for both DAs (69 days) and NO-DAs (73 days) was found.

Conclusion: For 2020-2021, the incidence of tuberculosis decreased compared to previous years, especially in 2020. Although we suspect that the main reason for these decreases is related to underdiagnosis during the COVID-19 alert state, we must also consider the role that anti-COVID-19 measures may have had delaying tuberculosis transmission. Also, according to DD definition, the average DD found was more than twice and even higher in DAs. In the current situation, allocating resources for the evaluation, intervention and surveillance of tuberculosis, especially in DAs, is essential.

1423 HIV Stigma and Punitive Laws and Policies as Barriers to HIV Care in Five African Fast-Track Cities

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Background: Policy environments can either mitigate or exacerbate stigma and discrimination experienced by people living with HIV (PLHIV) seeking, accessing, and utilizing healthcare. The Joint United Nations Programme on HIV/AIDS (UNAIDS) Global AIDS Strategy, 2021-2026, calls for a reduction to less than 10% of stigma and discrimination experienced by PLHIV and/or members of key populations.

Method: The International Association of Providers of AIDS Care (IAPAC) conducted a survey of PLHIV in Fast-Track Cities to assess quality of care, including experienced stigma and sense of inclusion in healthcare settings. Separately, IAPAC conducted assessments of national and municipal policies relating to HIV and key populations and fielded a survey of key informants.

Results: Respondents included 421 PLHIV from Kigali, 487 from Lusaka, 422 from Maputo, 582 from Lagos, and 408 from Yaoundé. More than 10% in each city said that they felt unwelcome at their HIV care facility, ranging from 12% in Lusaka to 23% in Yaoundé. Four of five cities also had more than 10% of respondents indicate fear of having their HIV status disclosed to others, ranging from 21% in Lusaka to 78% in Lagos. No city had laws preventing HIV criminalization, legalizing sex work, or prohibiting LGBTQ discrimination. Thirteen key informants found issues such as illegality of sex work, police treatment of LGBTQ people, and LGBTQ discrimination to be even more problematic than HIV discrimination or criminalization.

Conclusion: All five cities had indications of not reaching the global target that less than 10% of people living with HIV and/or members of key populations would experience stigma or discrimination. Given that all lacked policies to address such issues, advocating and enacting legal changes where they originate may aid these and other cities in reaching this critical goal in relation to punitive laws and policies.

1424 Community Influence on EHE Plans in US Fast-Track Cities

Kalvin Pugh (presenting)[1], Corey Prachniak-Rincón[1], José M. Zuniga[1,2]

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Background: The Ending the HIV Epidemic (EHE) initiative was launched by the US Department of Health and Human Services (HHS) in 2019 with a goal of reducing new HIV infections by 90% by 2030. EHE prioritizes 57 jurisdictions, 21 of which overlap the U.S. Fast-Track Cities (FTC) network. Selected for having high HIV incidence rates, each jurisdiction was required to meaningfully engage communities to develop a locally tailored plan for EHE-funded work.

Method: From January-March 2022, IAPAC conducted a study of people living with HIV in EHE priority jurisdictions to gauge community engagement in the development of EHE plans and community perceptions of EHE's success to date. An online survey utilized Likert scale options plus three open response questions to gauge opinions of the EHE community awareness.

Results: Of the 121 participants included in the study, 54% lived in a jurisdiction overlapping with the FTC network. 57% identified as Black or Latinx, 72% had been living with HIV for more than 10 years. 62% of respondents were involved in HIV advocacy. 73% of respondents were aware of the EHE initiative, and 63% were aware of the requirement for jurisdictions to have individual plans. Only 32% of respondents attended local EHE planning sessions. Only 56% of respondents felt they had influence in their local plan. While 59% felt their community was meaningfully engaged, only 41% felt current plans would meet their community's needs.

Conclusion: Despite the respondent group being more inclined to participate in HIV advocacy and likely to have stronger ties to local planning groups, they did not feel that their influence on current plans met the needs of their communities. The results suggest that a deeper understanding of community concerns is needed to strengthen stakeholder's confidence and EHE effectiveness to address the needs of FTC communities.

1425 Association between Discrimination and Quality of HIV and Primary Care in 50 Fast-Track Cities

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Background: Discrimination against people living with HIV and LGBTQ individuals impact health and well-being. The Joint United Nations Programme on HIV/AIDS (UNAIDS) Global AIDS Strategy, 2021-2026, calls for a reduction to less than 10% of stigma and discrimination experienced by people living with HIV and/or members of key populations, including sexual minority men and transgender individuals.

Method: In 2021, the International Association of Providers of AIDS Care (IAPAC) fielded a survey of 275 key informants who are involved in addressing LGBTQ issues across 50 Fast-Track Cities worldwide. Questions utilized Likert scales to assess expert opinion on topics such as quality of care, discrimination, and other facets of well-being among LGBTQ populations.

Results: Discrimination based on sexual orientation, gender identity, HIV status, and multiple forms of marginalization were all associated with quality of both primary and HIV-related care. Sexual orientation discrimination had the strongest association with HIV care quality; those who reported that sexual orientation discrimination was "not a problem" in their city rated HIV care quality at 4.6 on a scale of 1 ("poor") to 5 ("excellent"), while those who said sexual orientation discrimination was a "major problem" gave just a 3.0 HIV care rating. The strongest association between discrimination and primary LGBTQ care was HIV discrimination; those who reported HIV discrimination was "not a problem" rated LGBTQ primary care at 4.0, while those who rated it a "major problem" rated LGBTQ primary care at 2.5.

Conclusion: The association of LGBTQ- and HIV-related discrimination with quality of care highlights the importance of reducing discrimination to facilitate the goal of ending AIDS as a public health threat by 2030. Holistically addressing the needs of key populations, including LGBTQ individuals, can close critical gaps across HIV prevention and care continua.

1426 Assessing Health Facility HIV-Related Stigma in the City Of Lagos

Helen Olowofeso (presenting)[1], Imane Sidibé[2], Sindhu Ravishankar[1], José M. Zuniga[1,2]

1 Fast-Track Cities Institute, Washington, DC, USA
2 International Association of Providers of AIDS Care, Washington, DC, USA

Background: Fast-Track Cities around the world are working towards achieving the Zero Stigma and Discrimination goal outlined in the Paris Declaration to End AIDS in Fast-Track Cities. As part of these efforts, IAPAC has been working with select Fast-Track Cities, including Lagos, to implement a stigma assessment tool in health facilities which informs an autogenerated action plan to address gaps.

Method: A 10-question stigma index scorecard was rolled out on WebApp to 74 healthcare facilities (75 providers) in Lagos, Nigeria as part of a stigma elimination training program. The scorecard included question on staff training (3 questions), labelling of HIV service locations in the facility (1 question), essential supplied for safety and infection control (1 question), existing relevant procedural guidance/policies (4 questions), and community engagement in promoting stigma free HIV prevention and care services (1 question). The scorecard generated a score between 1-31 with a score of 22 (~70%) or higher indicating *near stigma-free status*.

Results: 19% (14/74) of health facilities (all PEPFAR-funded) achieved near stigma-free status (score of 22/31). 45% of the facilities reported that more than 50% of core HIV staff were trained on the delivery of HIV services at the facility but only 23% of the facilities had more than 50% of all staff trained on the delivery of HIV services. 64% reported having access to essential supplies for safety and infection control. 12% of facilities reported having policies or procedures in place to registering and address complaints related to stigma and discrimination and 12% of the facilities reported evidence of community engagement in promoting stigma free HIV prevention and care services.

Conclusion: Inclusion of the stigma assessment toolkit in routine facility Quality Improvement SOPs could be useful in creating avenues for self-reflection among facility teams and might prove useful in useful in the stigma elimination process at facility level. Further assessment using the stigma index score card at end-line to assess any improvements in the core measures of stigma since baseline is necessary to document improvements in stigma free service delivery. Given the small percentage of facilities achieving near stigma-free.

1433 Quality of Care for PLHIV across 7 Fast-Track Cities: Assessing Interpersonal Communication in Health Facilities

Imane Sidibé (presenting)[1], Helen Olowofeso[2], Karen Chale[1], Mariam Diallo[1], Chris Duncombe[1], José M. Zuniga[1,2]

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Background: Interpersonal communication (IPC) in health facilities affects the quality of care (QoC) for people living with HIV (PLHIV) and has a powerful effect on their well_being and quality of life. Negative IPC leads to PLHIV feeling unwelcome in health facilities, which directly impacts PLHIV engagement and retention in the care pathway.

Method: A cross-sectional study was conducted among 3206 PLHIV, across 175 health facilities, to investigate QoC perceptions in 7 FTCs: Lagos, Yaoundé, Kinshasa (WCA), Kigali, Lusaka, Maputo (ESA), and Jakarta from 2020 to 2021. Data was collected using a 36-Question questionnaire covering 8 QoC domains including interpersonal communication.

Results: Across all 7 FTCs surveyed, between 12% to 28% of PLHIV reported feeling unwelcome in their respective health facilities, with higher percentages in WCA compared to ESA. In WCA, 28% of respondents reported feeling unwelcome in Kinshasa, 23% in Yaoundé, and 13% in Lagos; compared to ESA's, 15% in Kigali, 12% in Lusaka, and 14% in Maputo alongside Jakarta's 17%. Disaggregated by gender, rates were higher among men in WCA with 28% indicating feeling unwelcome in Kinshasa, 24% in Yaoundé, and 14% in Lagos. In ESA, men and women in Lusaka recorded similar rates: 13% and 12% respectively. However more women in Kigali (16%) and Maputo (15%) reported feeling unwelcome. The highest age-range of respondents indicating feeling unwelcome is 25-29 in Yaoundé (30%) and Kinshasa (22%). Disaggregated by age, 25-29-years-old were more in Kigali (25%) and Maputo (17%); and 18-24-year-olds, more in Lusaka (19%) and Jakarta (29%).19% of respondents were over 60 years in Lagos.

Conclusion: The results emphasize the urgent need to improve healthcare providers' verbal and non-verbal interactions in healthcare facilities. Mapping IPC approaches and practices and identifying gaps on each step of care continuum would benefit stigma and discrimination policies and interventions to improve the QoC in PLHIV healthcare settings.

1438 HIV Treatment Burden among Key Populations in Five Fast-Track Cities

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Background: Fast-Track Cities around the world are committed to attaining 95-95-95 targets by 2025, including the target that 95% of PLHIV diagnosed with HIV are on antiretroviral therapy. While many cities have made progress against these targets in the last few years, closing the gaps to reach these targets requires understating sub-population epidemics, particularly among key and vulnerable populations that may have fallen through the cracks.

Method: This study assessed treatment coverage data in five Fast-Track Cities (Amsterdam, eThekwini, Johannesburg, London, Nairobi) that reported aggregate city and key population burden (proportion of PLHIV attributed to each total PLHIV) and proportion of PLHIV on and not on treatment. City-level estimates were reported directly from Fast-Track Cities between 2019-2021. Key Population estimates were either reported by Fast-Track Cities or were sourced from UNAIDS AIDSinfo and were from 2017-2020.

Results: In Nairobi: 15% of PLHIV are sex workers and sex workers living with HIV contribute to 43.97% of all PLHIV not on treatment; 5.24% of PLHIV are MSM and MSM living with HIV contribute to 15.68% of all PLHIV not on treatment; 3.25% of PLHIV are PWID and PWID living with HIV contribute to 11.85% of all PLHIV not on treatment. In eThekwini 1.07% on PLHIV are sex workers and sex workers living with HIV contribute to 2% of all PLHIV not on treatment. In Johannesburg, 77.3% if PLHIV are sex workers living with HIV contribute to 70.99% of all PLHIV not on treatment. In Amsterdam, 72.9% of PLHIV are MSM and MSM living with HIV contribute 52.71% of all PLHIV not on treatment. In London, 52.59% of PLHIV are MSM and MSM living with HIV contribute 51.85% of all PLHIV not on treatment.

Conclusion: Key populations attribute for large portions of people living with HIV in many cities. However, in some cities, Key Populations are significantly falling between the cracks, with large proportions not on treatment. Achieving 95-95-95 targets and ultimately zero new HIV infections and HIV-related deaths necessitates disaggregated data that can strategically inform HIV programming to close the gaps.

1440 Impact on Municipal HIV Funding Due to COVID-19 and National Funding Constraints

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Background: Cities in the Global North have historically relied on the commitment from federal governments for HIV program funding in coordination with municipal funding to build and maintain sustained responses to HIV. The COVID-19 pandemic and resulting shock to health systems impacted financing mechanisms for national and municipal COVID-19 responses.

Method: An HIV Policy Barometer Survey was fielded among Fast-Track Cities in seven countries: Canada (1), France (7), Germany (2), Italy (7), Spain (5), the United Kingdom (8), and the United States27).The survey's aim was to gain a multidisciplinary view of opinions and perspectives regarding: 1) effect of COVID-19 on city HIV responses; 2) COVID-19's impact on city health budgets; and 3) ongoing commitment to funding city HIV responses. The survey collected Likert scale responses from local stakeholders connected to funding and/or implementing city HIV responses, including public health officials, community-based organizations, clinical and service providers, and patient-advocates.

Results: More than two thirds of respondents indicated that the probability of decreased national HIV funding would precipitate increased HIV Infections and AIDS-related mortality as either somewhat probable (35%) or probable (28%) (Figure 1). 66% of respondents indicated that social support services would be at risk due to COVID-19 related budget cuts. HIV research (43%), HIV prevention (42%), key population outreach (42%), and mental health services (42%) were also identified as services at highest risk due to COVID-19 healthcare budget constraints (Figure 2). When asked about the impact COVID-19 had on municipal funding for HIV programming, 23% of respondents indicated the impact was significant; with 26% reporting that this impact would be short-term, lasting no more than 1-2 years (Figure 3). In contrast, a plurality of respondents believed COVID-19 would have a somewhat significant or significant impact on commitment towards HIV funding, with the USA demonstrating the greatest concern with 36% reporting somewhat significant and 19% reporting significant impact on municipal commitment to HIV funding due to COVID-19 (Figure 4).

Conclusions: The data from this survey demonstrated that covid-19 fueled budget constraints are having and may continue to have a negative impact on municipal HIV responses. Strategies to minimize the impact covid-19 has had on municipal responses, such as reallocating resources or leveraging existing resources, should be further explored.

1442 Poor HCV Literacy among Men who have Sex with Men as a Barrier to HCV Elimination

Sindhu Ravishankar (presenting)[1], Jessica Hicks[2], Cary James[2], José M. Zuniga[1,3]

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2 World Hepatitis Alliance, London, United Kingdom
3 International Association of Providers of AIDS Care, Washington, DC, USA

Background: An estimated 58 million people have chronic hepatitis C virus (HCV) infection, and an estimated 1.5 million new HCV infections occur annually. Although direct-acting antiviral regimens lead to sustained viral suppression (cure), the world is off-track to meet the World Health Organization (WHO) goal of eliminating HCV by 2030, particularly among key populations, including men who have sex with men (MSM).

Method: An online survey was fielded in six countries to gauge MSM perceptions about HCV and literacy regarding HCV testing and treatment (N=1,400). Respondents self-declared as MSM and were aged ≥18 years of age. Analyses were conducted with data from 47 Fast-Track Cities (FTCs) across the six countries (Canada [3], France [3], Germany [4], Italy [2], Spain [4], the United Kingdom [3], and the United States [28]). City data were aggregated by country.

Results: More than half (53%) of global respondents said they lack information about HCV and how to prevent infection, with respondents from French FTCs citing having the least access to such information (65%). Although successful HCV treatment can lead to cure, 18% and 26% of global respondents do not believe it is possible to cure HCV or are not sure whether HCV can be cured, respectively. The percentage of respondents who do not believe a cure for HCV is possible ranged from a high of 23% in Canadian FTCs to a low of 6% in Italian FTCs. Almost half (49%) of global respondents confirmed they have been tested for HCV, and of those 22% reported a positive diagnosis. In this key population for which HCV testing is recommended by global and most national HCV clinical management guidelines, testing ranged from a high of 60% in Spanish FTCs to 33% in US FTCs. Of the 294 respondents who believe they are at risk of HCV infection, only 50% said they are "very likely" to get tested if they thought they had been exposed to HCV. Despite acknowledging risk for HCV infection, the percentage of respondents who reported they would "very likely" seek testing if exposed to HCV ranged from a high of 59% in Spanish FTCs to 27% in Italian FTCs.

Conclusions: Poor HCV literacy among MSM is contributing to suboptimal levels of testing and treatment among this key population of people vulnerable to HCV infection. The WHO targets for diagnosing 90% of people living with HCV and treating 80% of those by 2030 cannot be met without closing gaps across the HCV care continuum for MSM.

1448 Stigma Indicators in 25 European Fast-Track Cities – what are we (not) measuring?

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2 International Association of Providers of AIDS Care, Washington, DC, USA

Background: HIV-related stigma and discrimination pose a barrier to seek healthcare and to achieving the epidemic control. Both the UNAIDS' Global AIDS Strategy 2021-2026 and the WHO's Global Health Sector Strategies on, respectively, HIV, viral hepatitis, and sexually transmitted infections for the period 2022-2030 outline a target that <10% of people living with HIV experience stigma and discrimination by 2025.

Method: An exploratory online survey with a convenience sample was conducted from mid-May 2022 to mid-July 2022. The purpose of the survey was to understand if and how cities measure different domains of HIV-related stigma and discrimination, and what the key barriers are. The 13-question survey was administered on the Qualtrics platform to the network of European Fast-Track Cities and responses were received from municipal health department and community stakeholders in 25 cities. 37% of the respondents were from the municipal health department followed closely by 26% from 'other' including NGOs, community-based testing centres, and public hospitals. The following stigma domains were analyzed: structural stigma; experienced stigma and discrimination; perceived stigma; and internalized stigma.

Results: Nearly half of the respondents answered that their city has a policy prohibiting HIV-related stigma and discrimination, but only 26% measure the impact and 41% the enforcement of these policies. Only 14% measure the representation of PLHIV and/or key populations. In all stigma domains, the majority of respondents reported their jurisdiction does not measure stigma indicators: 59% reported not measuring HIV-related stigma in healthcare settings; 71% reported not measuring perceived stigma towards PLHIV; 63% reported not measuring internalized stigma by PLHIV. Key barriers to measuring stigma included: the lack of organisational capacity, of human resources, and of validated and standardised indicators. 81% of the respondents agreed that it is important to have standardized and validated stigma indicators developed and adopted across the FTC-network to measure progress.

Conclusion: Fast-Track Cities are committed to attaining the target of <10% of PLHIV experiencing stigma and discrimination by 2025. However, based on our assessment, validated metrics to report against this target are scarce in European Fast-Track Cities. Findings can be leveraged to inform the development such metrics and to engage in organizational capacity-building at city-level to utilize these indicators.

1451 Assessing the HIV 95-95-95 Targets for Pediatric Populations in Five Fast-Track Cities

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Background: Children living with HIV (CLHIV) globally fare worse off across the HIV care continua and 95-95-95 treatment targets compared to adult populations. In 2021, 75% of all PLHIV living with HIV globally were accessing antiretroviral therapy (ART); but for children under the age of 15 only 52% were on ART (UNAIDS 2022).

Method: This study assessed the second and third 95 targets (% on ART among diagnosed PLHIV and %virally suppressed among those on ART, respectively) among CHLIV compared to all PLHIV in five Fast-Track Cities: Bangkok, eThekwini (Durban), Kingston, Nairobi, and São Paulo. City aggregate and CHLIV data were reported directly from Fast-Track Cities between 2018-2021. Two cities (Bangkok and São Paulo) had trend data from 2015-2020 and 2015-2021 respectively. In Kingston and Bangkok, linked to care was used as a proxy for diagnosed PLHIV/CLHIV. In eThekwini the 3rd 95 (viral suppression) target for PLHIV and CLHIV is defined as those virally suppressed among those who have access to viral load tests.

Results: When considering the 2nd 95 treatment target, compared to all PLHIV, CHLIV fared better in one city by 35 percentage points (Kingston), worse in three cities (Bangkok, eThekwini, São Paulo) with the difference between PLHIV and CLHIV ranging from 17-23 percentage points; and approximately the same in one city (Nairobi). When considering the 3rd 95 viral suppression target CHLIV fared worse compared to all PLHIV in all five cities with the difference between PLHIV and CLHIV ranging from 11-44 percentage points. When considering trend data in Bangkok (2015-2020) and São Paulo (2015-2021), not only did CLHIV consistently fare worse compared to all PLHIV across the years; but improvements across the years were marginally less or worse compared to all PLHIV. In Bangkok the 2nd and 3rd 95 targets for PLHIV increased by 25 percentage points and 20 percentage points from baseline (2015) to 2020, respectively. Among CHLIV the 2nd and 3rd 95 targets decreased by 17 percentage points and 14 percentage points from baseline (2015) to 2020, respectively. In São Paulo, 2nd and 3rd 95 targets for PLHIV increased by 8 percentage points and 7 percentage points from baseline (2015) to 2021, respectively. Among CHLIV the 2nd and 3rd 95 targets **increased** by 0 percentage points and 5 percentage points from baseline (2015) to 2021, respectively.

Conclusion: Achieving 95-95-95 targets and ultimately zero new HIV infections and HIV related deaths requires ensuring that no population, including children, are falling between the cracks. Additional 95-95-95 and care continua data disaggregated by age across the network of Fast-Track Cities can strategically inform HIV programming to close the gaps.

1455 HIV Provider Perceptions of COVID-19 Disruptions in HIV Service Access in Lagos State

Imane Sidibé (presenting)[1], Helen Olowofeso[2], Chris Duncombe[1], José M. Zuniga[1,2]

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[2] Fast-Track Cities Institute, Washington, DC, USA

Background: Health system resilience is the ability to prepare for, manage (absorb, adapt, and transform), and learn from shocks. Multiple surveys conducted during the COVID-19 pandemic have documented the pandemic's variable impact on the disruption of HIV prevention, care, and treatment services and the provision of related services.

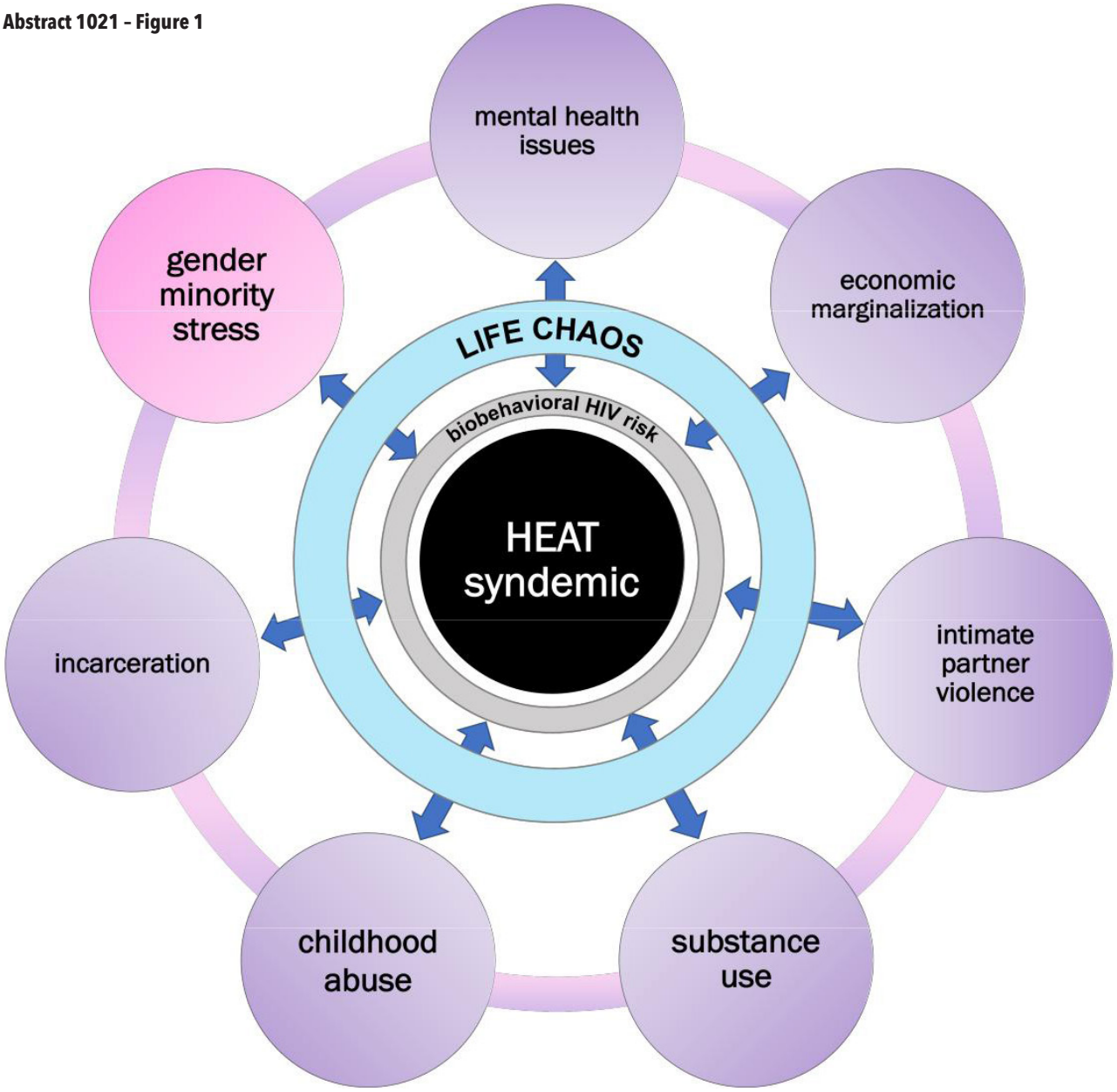
Method: A cross-sectional study was conducted in Lagos State in 2022 among 85 HIV care providers to assess perceptions of HIV and related service disruptions during the COVID-19 pandemic. The survey examined perceptions on the impact of COVID-19 on health systems and health system preparedness and planning in response to future crises, including pandemics. Data was collected using a 22-question, Likert Scale questionnaire.

Results: Of the 85 respondents in Lagos State, 58% were HIV physicians, 24% nurses, 10% pharmacists, and 6% community health workers. When asked about disruptions to essential HIV services by COVID-19, moderate to severe disruptions were perceived across the care continuum. Eighty percent reported a moderate or severe disruption to HIV testing services; 70% to HIV linkage to care; 58% indicated moderate to severe disruptions to ART initiation; 54% to retention on ART; 46% reported disruptions to adherence; and 60% indicated disruptions to access to viral load testing. The top causes cited for the observed disruptions during the pandemic included staff shortages due to illness or quarantine (83%), clinic/hospital closures (88%), and staff reassignment from HIV services toward COVID-19 emergency response (82%). In exploring perceptions regarding preparedness of the health systems for future crises, HIV care providers reported further planning and improvements needed on 1) differentiated care delivery (78%), 2) reporting of inventory and stockouts control (73%); and 3) community delivered health services (72%).

Conclusion: The ability of health systems to plan for and provide differentiated care solutions and further engage communities in provision of health services will alleviate the burden on healthcare services as those experienced during the COVID-19 pandemic. Understanding the impact of COVID-19 on the delivery of HIV care and treatment is key to urban response preparedness for future crises and ensuring health systems remain resilient.

FIGURES

Oral Abstract 1021 - Figure 1



Oral Abstract 1094 - Table 1

Table 1. Baseline characteristics of 75 transgender persons experiencing barriers to care, who visited the trans clinic (Amsterdam, The Netherlands) in 2021

	Total N=75	Transfeminine [a] N=58	Transmasculine [b] N=17
Age in years, median (IQR)	29.6 (23.5-36.9)	29.8 (23.5-37.7)	28.3 (25.0-32.0)
Region of birth			
Netherlands	9 (12%)	5 (8.6%)	4 (24%)
Western & Central Europe and North America	13 (17%)	10 (17%)	3 (18%)
Eastern Europe and Central Asia	5 (6.7%)	4 (6.9%)	1 (5.9%)
Middle East and North Africa	13 (17%)	11 (19%)	2 (12%)
Latin America and the Caribbean	27 (36%)	23 (40%)	4 (24%)
Asia and the Pacific	6 (8%)	4 (6.9%)	2 (12%)
Sub-Saharan Africa	1 (1.3%)	1 (1.7%)	0 (0%)
Did not disclose	1 (1.3%)	0 (0%)	1 (5.9%)
Reported barriers to care			
Status as refugee/asylum seeker	30 (40.0%)	25 (43.1%)	5 (29.4%)
Undocumented or denied residency	8 (11%)	7 (12%)	1 (5.9%)
Not proficient in English and Dutch[c]	17 (23%)	14 (24%)	3 (18%)
House- or homeless (incl. crisis centre)	12 (16%)	10 (17%)	2 (12%)
Self-reported history of sex work	25 (33%)	25 (43%)	0 (0%)
Had a CSHA visit prior to first trans clinic visit (2017-2021)			
Yes	18 (24%)	17 (29%)	1 (5.9%)

Abbreviations: N, number; CSHA, Centre for Sexual Health Amsterdam;
[a] Including trans women and non-binary persons assigned male at birth; [b] Including trans men and non-binary persons assigned female at birth; [c] unable to have their clinic consultations in English or Dutch

Oral Abstract 1100 - Table 1

	Administration	Civil	Acaemic
National	HIV-Plan (Ministry)	Community Coordinator	Scientific Society
		CESIDA	SEISIDA
Regional	HIV-Prevention	Associations: Apoyo+, LGTB+ Madrid, Imagina+, Unidad Móvil	University Rey Juan
	HIV-Surveillance		
Local	Hospital: Infectiology, Gastroenterology, Psychiatry	Red Cross	
	Primary Care		
	Social services		
	Addictions Centre		
	Public Health		

Oral Abstract 1147 – Table 1, Figure 1, Figure 2

Table - HIV continuum of care (A) and Cascade of Care (B) in Milan area according to calendar year

A) Continuum of Care (ContC)			
Year	Diagnosed (% PLWH)	ART started (% PLWH)	VS (% PLWH)
2012	91.2%	64.8%	58.1%
2013	93.4%	71.2%	65.4%
2014	94.7%	75.8%	70.4%
2015	95.4%	80.8%	76.0%
2016	96.0%	86.6%	82.1%
2017	96.0%	88.3%	83.7%
2018	95.5%	89.5%	84.7%
2019	96.6%	91.1%	86.1%

B) Cascade of Care (CoC)			
Year	Diagnosed (% tot PLWH)	ART started (% tot diagnosed)	VS (% on ART)
2012	91.2%	71.1%	89.7%
2013	93.4%	76.2%	91.9%
2014	94.7%	80.0%	92.9%
2015	95.4%	84.7%	94.1%
2016	96.0%	90.2%	94.8%
2017	96.0%	92.0%	94.8%
2018	95.5%	93.7%	94.7%
2019	96.6%	94.2%	94.6%

Figure1. Estimated % of diagnosed PLWH on ART by calendar year in different subpopulation in Milan area

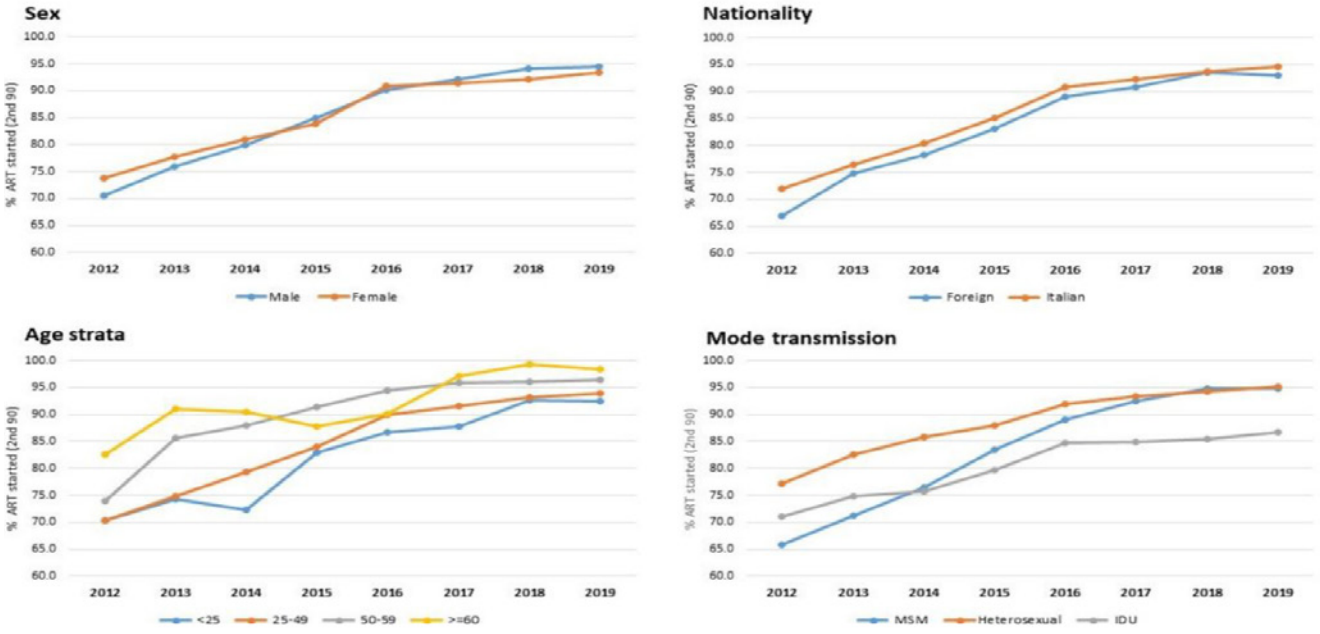
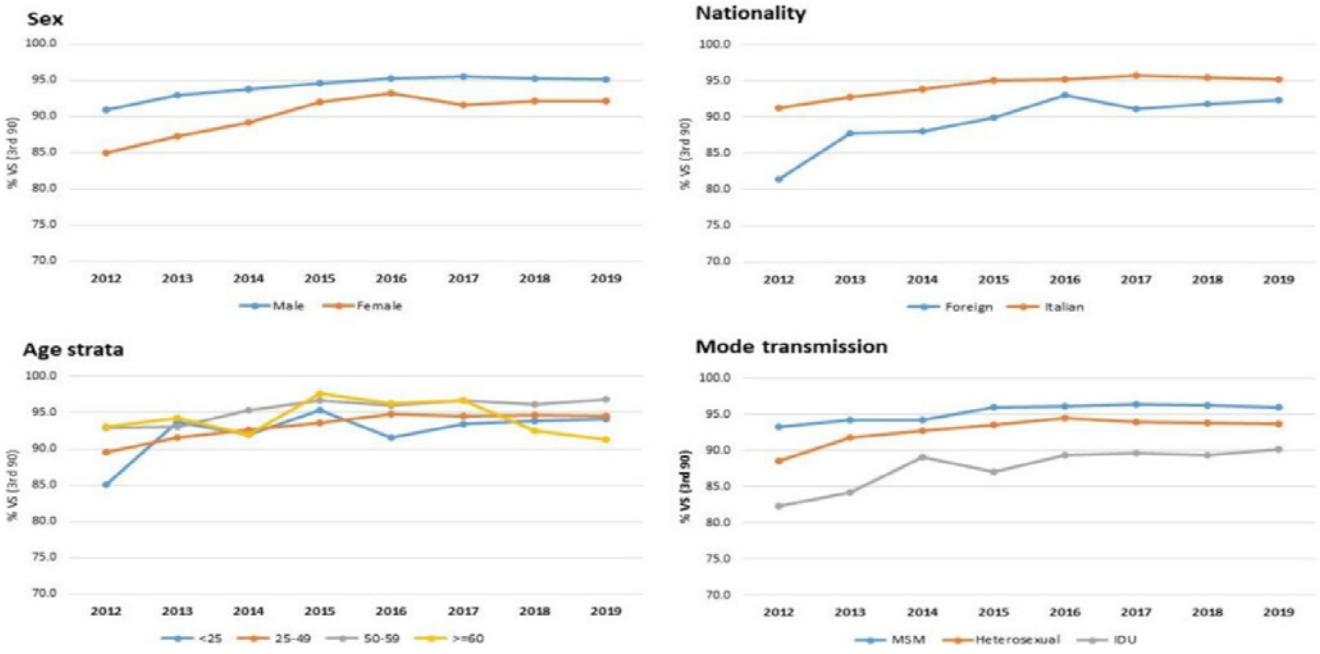


Figure 2. Estimated % of VS for PLWH on ART by calendar year in different subpopulation in Milan area



Oral Abstract 1225 - Figure 1

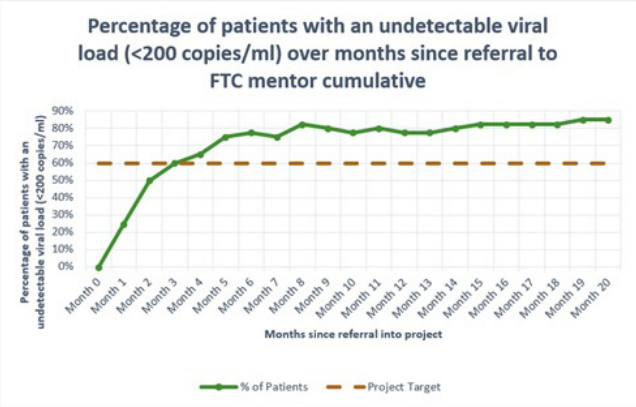
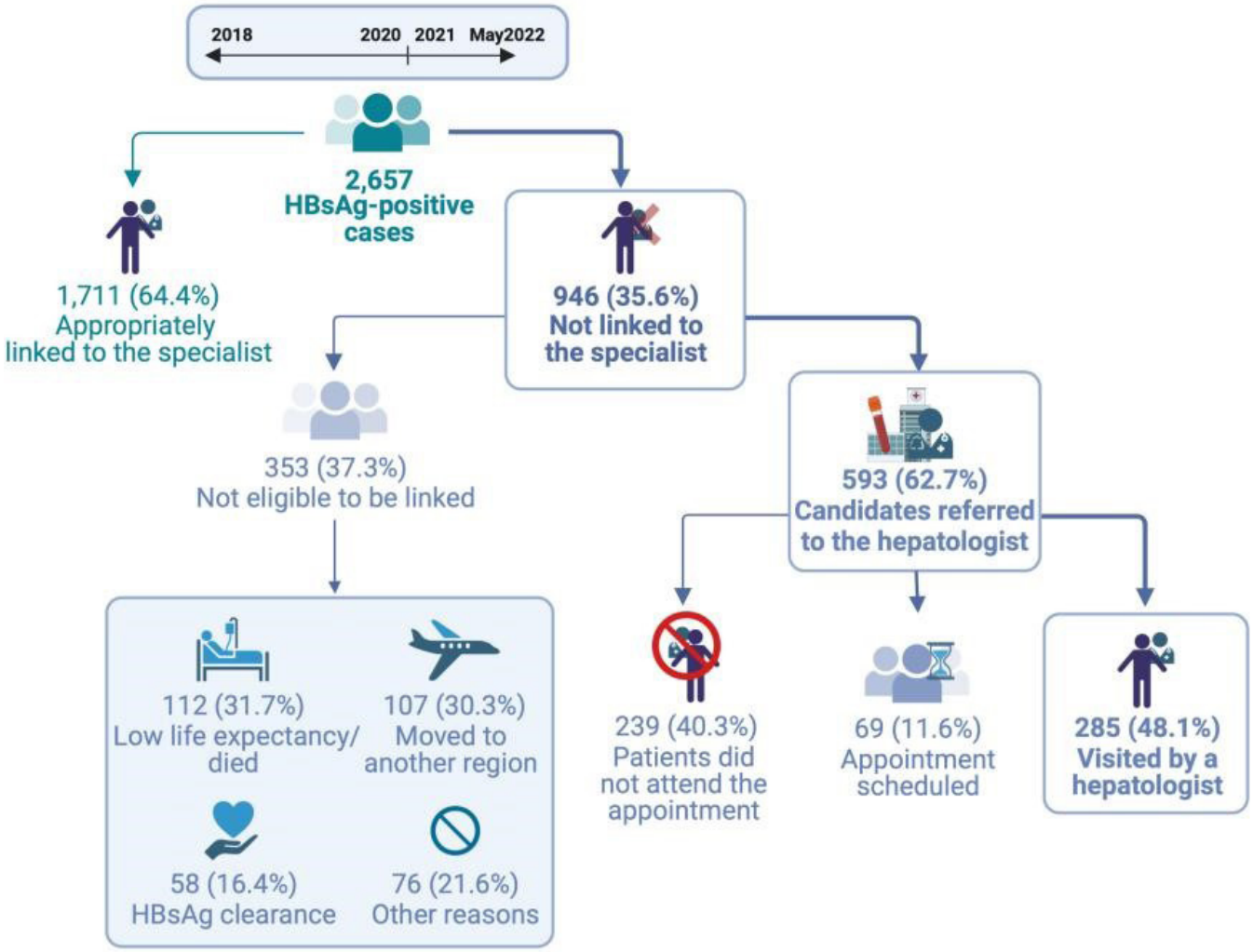


Figure 1: Percentage of patients with an undetectable viral load (<200 copies/ml) over months since referral to FTC mentor

Oral Abstract 1261 - Table 1

Clinical characteristics	Not linked to the specialist (N= 946)	Appropriately linked (N=1,711)	p-value
Age (years), Md (IQR)	44.7 (34.3-59.1)	49.1 (37.5-60.1)	**0.000**
Male sex, n (%)	625 (66.1)	1050 (61.4)	**0.009**
Platelet count (x10E9/L) mean±SD	237.1±76.5	228.0±69.5	**0.003**
AST			
AST (UI/mL), Md (IQR)	26.0 (21.8-35.3)	27.0 (22.0-35.0)	0.905
Subjects with increased AST, n (%)	93 (14.2)	194 (13.9)	0.437
ALT			
ALT (UI/mL), Md (IQR)	26.0 (17.0-37.0)	25.0 (18.0-37.0)	0.538
Subjects with increased ALT, n (%)	136 (15.9)	272 (17.1)	0.234
HBV DNA (logIU/mL), Md (IQR)	2.4 (1.3-3.3)	2.2 (1.2-3.2)	**0.015**
HBsAg (logIU/mL), Md (IQR)	2.8 (1.3-3.6)	3.2 (2.4-3.9)	**0.000**
HBeAg+, n (%)	56 (7.3)	164 (12.4)	**0.000**
anti-HCV+, n (%)	22 (3.0)	45 (4.5)	0.071
anti-HDV+, n (%)	8 (4.5)	59 (12.5)	**0.001**
anti-HIV+, n (%)	4 (0.8)	17 (2.5)	**0.023**

Oral Abstract 1261 - Figure 1



Oral Abstract 1301 - Table 1

	The number of key population clients of HIV prevention services in Fast-track Cities					
	PWID February-May 2021	PWID February-May 2022	SW February-May 2021	SW February-May 2022	MSM February-May 2021	MSM February-May 2022
Kyiv	12316	22796	2598	2375	4573	5803
Odesa	11549	13000	3588	6225	4524	4962
Mariupol	1144	244	317	113	0	0
Kryvyi Rih	11150	10135	1780	1754	0	0
Dnipro	4126	3884	2420	2651	1387	600

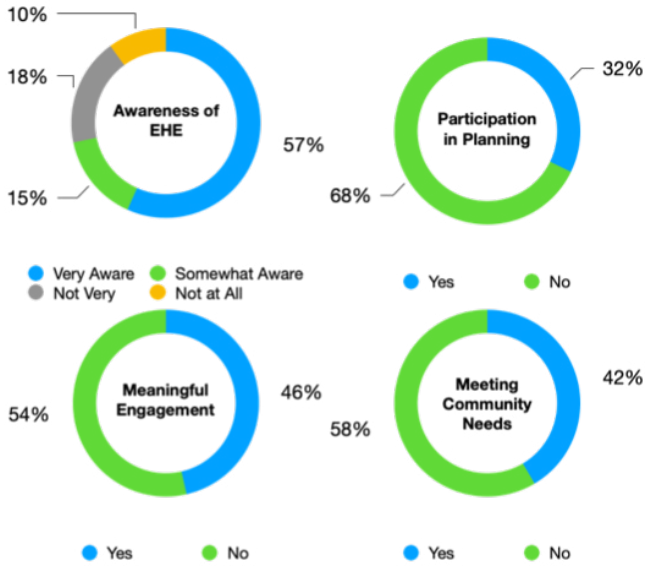
Oral Abstract 1423 - Table 1

Patient Experiences with Stigma and Inclusion in Healthcare Settings					
	Lusaka	Lagos	Yaoundé	Maputo	Kigali
Percent feeling unwelcome at facility where they access HIV care	12%	13%	23%	14%	15%
Percent afraid someone at health facility will disclose their HIV status to others	21%	78%	41%	1%	77%

How Significant of Problems Are Various Issues According to Key Informants	
Laws criminalizing HIV exposure and/or nondisclosure of status	2.1
Discrimination based on HIV status	2.7
Targeting of or arrests of LGBTQ people because of their identity	2.8
Criminalization of sex work and/or mistreatment of sex workers	3.0
Discrimination based on sexual orientation	3.0
Discrimination based on gender identity	3.0
Discrimination based on LGBTQ people with other marginalized identities	3.0
Mistreatment of LGBTQ people by law enforcements	3.2

On a scale of 1 ("not a problem") to 4 ("serious problem")

Oral Abstract 1424 - Figure 1



Oral Abstract 1425 - Tables 1-4

How big of a problem is sexual orientation discrimination in your city?		
	Primary LGBTQ Care Score*	HIV Care Score*
Not a problem	3.9	4.6
Somewhat of a problem	3.4	4.1
Moderate problem	2.9	3.7
Major problem	2.6	3.0

*1-5 scale in which 1 is "poor" and 5 is "excellent"

How big of a problem is HIV-related discrimination in your city?		
	Primary LGBTQ Care Score*	HIV Care Score*
Not a problem	4.0	4.4
Somewhat of a problem	3.3	4.0
Moderate problem	3.1	3.9
Major problem	2.5	3.3

*1-5 scale in which 1 is "poor" and 5 is "excellent"

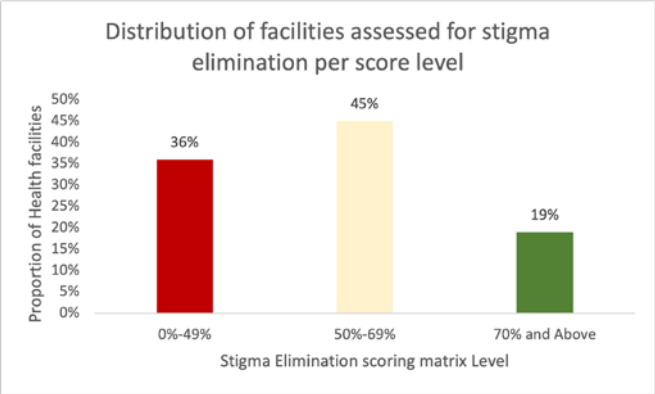
How big of a problem is gender identity discrimination in your city?		
	Primary LGBTQ Care Score*	HIV Care Score*
Not a problem	3.9	4.6
Somewhat of a problem	3.4	4.1
Moderate problem	3.2	3.9
Major problem	2.6	3.3

*1-5 scale in which 1 is "poor" and 5 is "excellent"

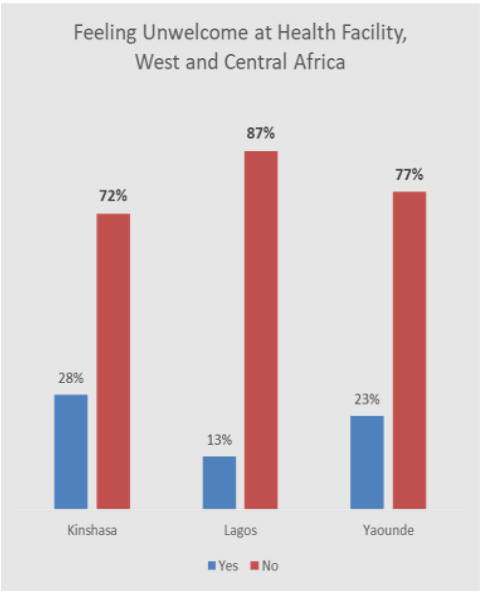
How big of a problem is discrimination against LGBTQ people with multiple forms of marginalization in your city?		
	Primary LGBTQ Care Score*	HIV Care Score*
Not a problem	4.0	4.4
Somewhat of a problem	3.3	4.0
Moderate problem	3.1	3.9
Major problem	2.5	3.3

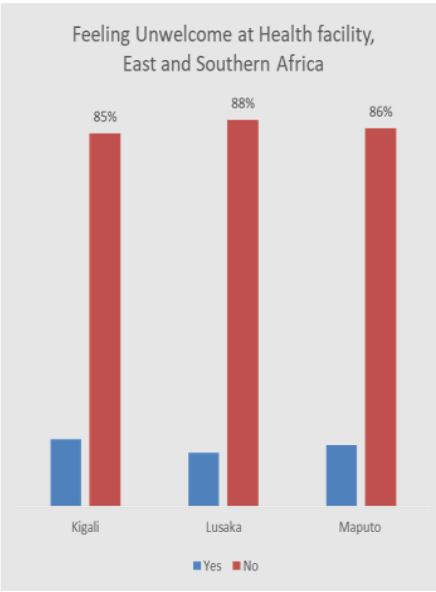
*1-5 scale in which 1 is "poor" and 5 is "excellent"

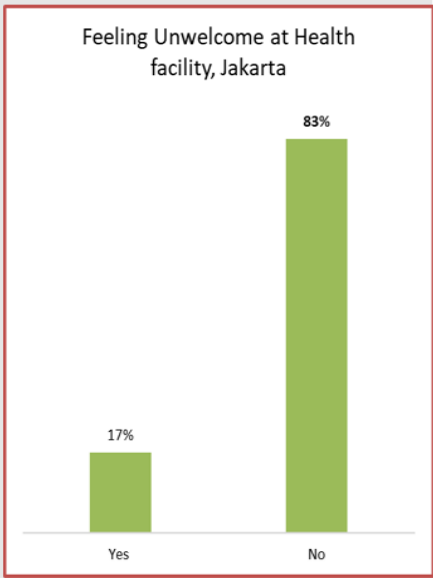
Oral Abstract 1426 - Figure 1



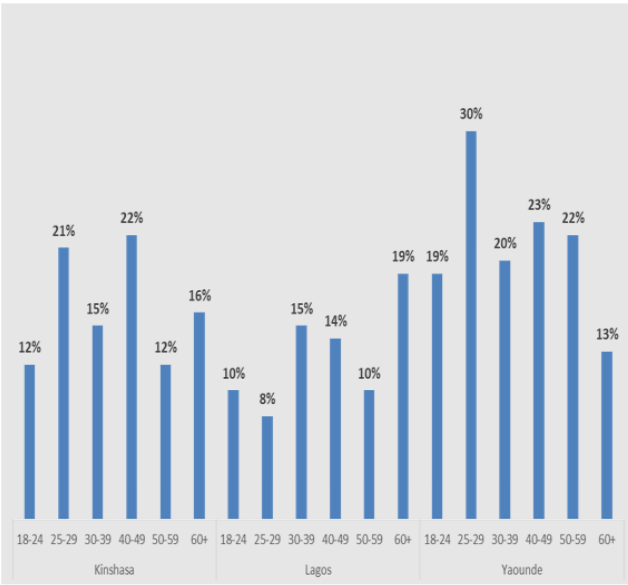
Oral Abstract 1433 - Figures 1-4



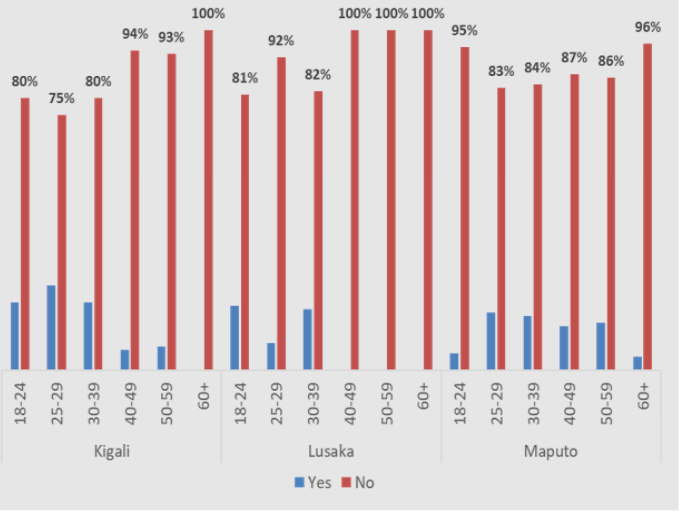




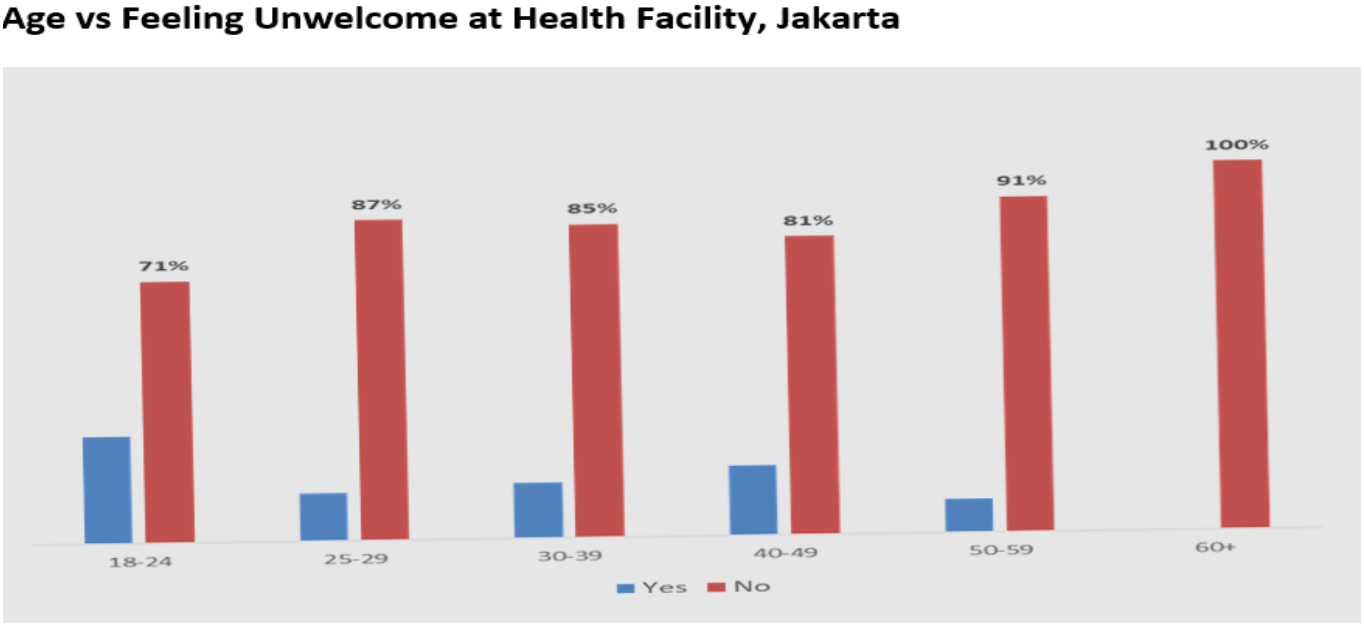
Age vs Feeling Unwelcome at Health Facility, WCA

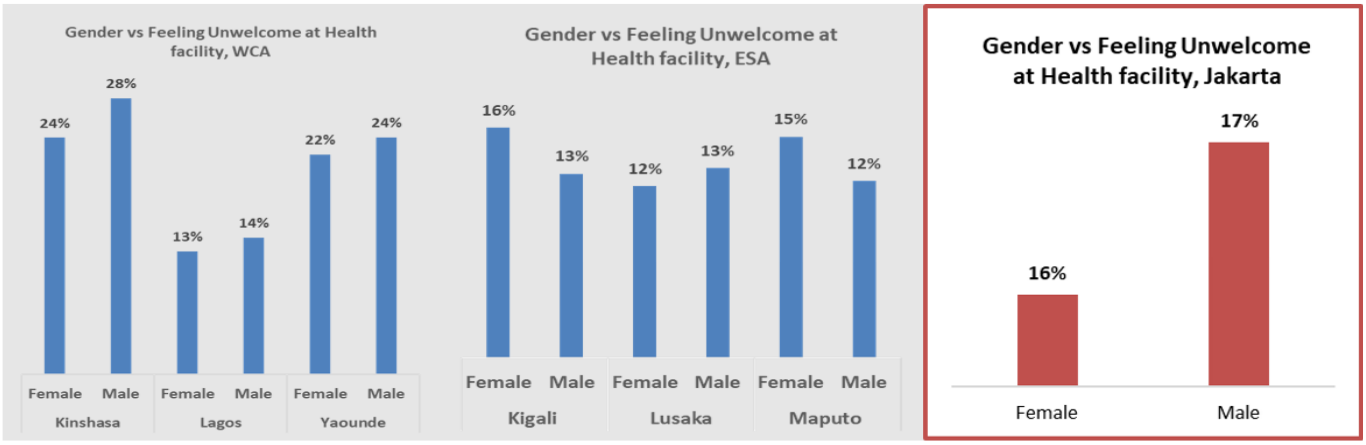


Age vs Feeling Unwelcome at Health Facility, WCA



Oral Abstract 1433 - Figures 1-4 (continued)





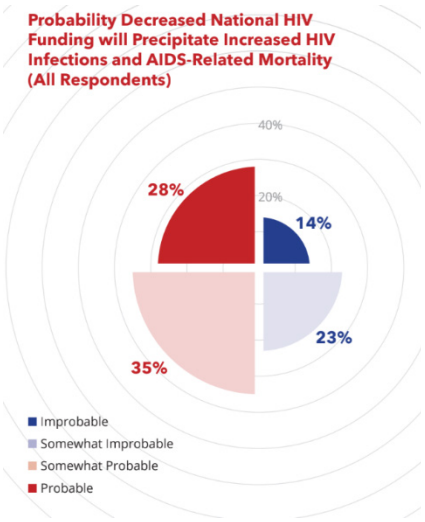
Data Source: IAPAC FTC QoC Survey–Preliminary Data (7 Cities)

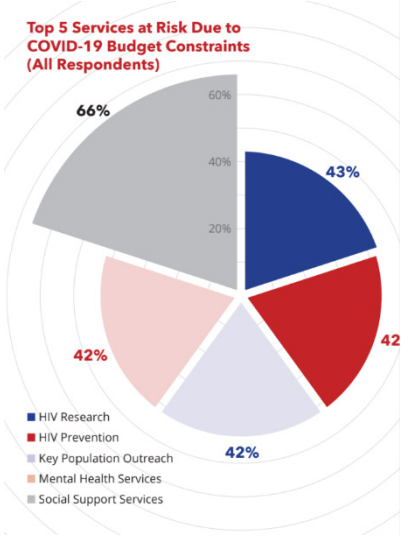
Oral Abstract 1438 - Table 1

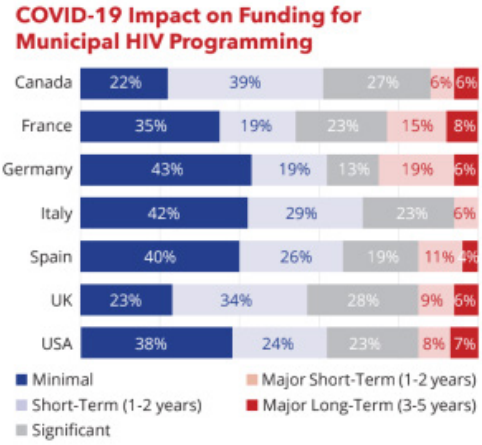
	Aggregate City		Sex Worker				MSM				PWID			
City	% on ART	% not on ART	Prop of PLHIV	% on ART	% not on ART	Not on Treatment burden	Prop of PLHIV	% on ART	% not on ART	Not on Treatment burden	Prop of PLHIV	% on ART	% not on ART	Not on Treatment burden
Nairobi	77.67%	22.33%	15.44%	36.40%	63.60%	43.97%	5.24%	33.10%	66.90%	15.68%	3.25%	18.70%	81.30%	11.85%
eThekwini	70.05%	29.95%	1.07%	44.20%	55.80%	2.00%								
Johannesburg	58.43%	41.57%	72.33%	59.20%	40.80%	70.99%								
Amsterdam	89.95%	10.05%					72.90%	92.74%	7.26%	52.71%				
London	93.01%	6.99%					52.59%	93.10%	6.90%	51.85%				

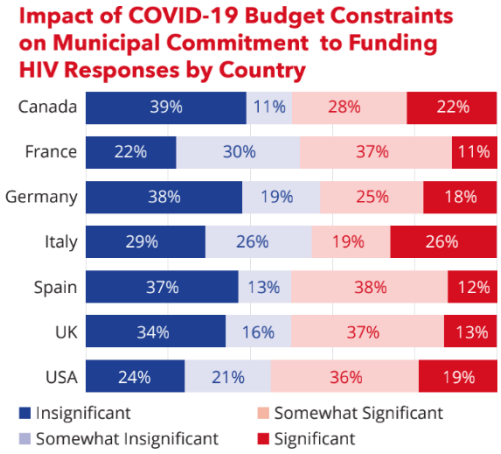
*Not on treatment burden is the proportion of sub-population not on treatment out of all PLHIV not on treatment

Oral Abstract 1440 – Figures 1-4









Oral Abstract 1451 – Tables 1-3

	Nairobi City County, 2018		Bangkok, 2020		Kingston, 2019		Sao Paulo, 2021		eThekwini, 2021	
	Children	Total Population	Children	Total Population	Children	Total Population	Children	Total Population	Children	Total Population
Second 95	100%	99%	54%	77%	89%	54%	71%	88%	58%	80%
Third 95	77%	92%	70%	98%	29%	72%	55%	66%	62%	84%

Target	Bangkok Total Population						Bangkok Children					
	2015	2016	2017	2018	2019	2020	2015	2016	2017	2018	2019	2020
Second 95	52%	57%	58%	60%	62%	77%	71%	69%	66%	63%	61%	54%
Third 95	78%	79%	80%	97%	98%	98%	84%	83%	82%	74%	85%	70%

Target	Sao Paulo Total Population 95-95-95							Sao Paulo Children						
	2015	2016	2017	2018	2019	2020	2021	2015	2016	2017	2018	2019	2020	2021
Second 95	80%	81%	83%	83%	84%	88%	88%	71%	70%	72%	70%	69%	70%	71%
Third 95	59%	62%	60%	65%	66%	62%	66%	50%	50%	49%	53%	55%	60%	55%

SEVILLA
FAST-TRACK CITIES 2022

Fast-Track Cities 2022 is sponsored by the International Association of Providers of AIDS Care (IAPAC) in partnership with the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Fast-Track Cities Institute (FTCi). We wish to express our deepest gratitude to the institutional and commercial supporters whose generosity is making this conference possible.

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