were given to PWID with HIV and attitudes to PWID were highly intolerant and hostile. Over 80 percent of the total sample reported having no test for HIV, hepatitis C, or hepatitis B. When the health service facilities opened for other communicable diseases, HIV status was reported by 44 percent of the sample, whereas 18 percent reported being positive for hepatitis B and 12.5 percent for hepatitis C. The service providers and the key informant interviews identified the country's incompetent healthcare systems such as poor governance in the health sector.

Conclusions: The mass COVID-19 testing has shown that population-level screening is feasible, and these lessons can and should be applied in the context of HIV, and viral hepatitis and can be useful to design and strengthen strategies to scale up testing and treatment for HIV.

EACS2023: 31 | Comparison between patients who interrupted ART and those with late HIV diagnosis

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Abstract category: Cascade of care

Abstract body

Purpose: Early diagnosis of human immunodeficiency virus (HIV) and retention in care are cornerstones of better prognosis of people living with HIV (PLWH). The purpose of this study was to compare patients who discontinued antiretroviral treatment (ART) with those who were diagnosed late with HIV.

Method: In this retrospective analysis of PLWH under the care of one of the Infectious Diseases Clinics in Poland between 2020 and 2021, two sub-analyses were carried out. One comparing patients who relinked to care after treatment interruption ('Group A') with those who had late HIV diagnosis ('Group B'), another comparing group A to those who were adherent to ART ('Group C').

Results: 215 patients were included in this study (Group A = 47, Group B = 53, Group C = 115). Those who discontinued ART more often used actively drugs ($p = 0.001$) in comparison to those with late HIV diagnosis. In both bivariate and multivariable analysis migrants were more often diagnosed late with HIV than interrupted ART ($p = 0.004$ and 0.015 respectively). In the second analysis, in the multivariable analysis female sex was not associated with treatment interruption, whereas active drug usage was.

Conclusions: People using drugs have a higher risk of ART interruption. Migrants are more at risk of late HIV diagnosis. Adequate interventions should be made towards both groups.

EACS2023: 125 | Continuum of HIV care by key populations in Belgium: Cross-sectional and longitudinal views

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Abstract category: Cascade of care

Abstract body

Purpose: To obtain a comprehensive picture of HIV care in Belgium by combining cross-sectional and longitudinal analyses of the HIV continuum of care (CoC).

Method: National HIV surveillance data 01/01/2012-31/12/2021 were analyzed. Cross-sectional CoC (CsCoC) estimates were obtained by combining estimates of the number of undiagnosed PWHIV (ECDC-HIV-modelling-tool) and estimates of those not linked/retained in HIV care, with numbers of those in HIV care. Time-to-event for each transition in the Longitudinal CoC (LCoC) was visualized using non-parametric cumulative incidence curves and compared between key populations and time periods (2012-2016 vs. 2017-2021) by Cox proportional hazard models (infection to diagnosis) and Fine-and-Gray competing risk models (other transitions). The following populations were considered: Belgian MSM (BMSM), European MSM (EMSM), Belgian heterosexuals (BH), sub-Saharan heterosexuals (SSAH), people who inject drugs (PWID).

Results: At end of 2021, an estimated 17 873 PWHIV were living in Belgium, of whom 93.5% were diagnosed,

Figure 1: Trends in CsCoC results overall and by key populations, Belgium, 2012-2021.

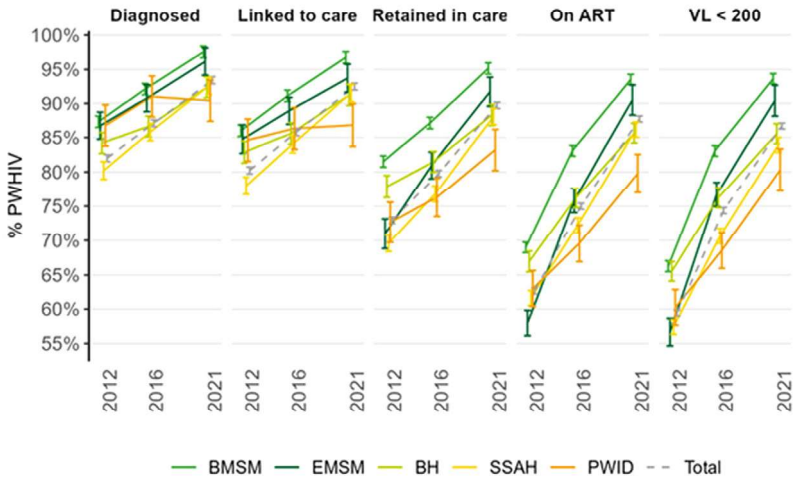

Figure 2: Cumulative incidence curves for all transitions in the LCoC by key population and periods of diagnosis (first 2 transitions), of entry in care (3rd transition) and of ART initiation (4th transition).

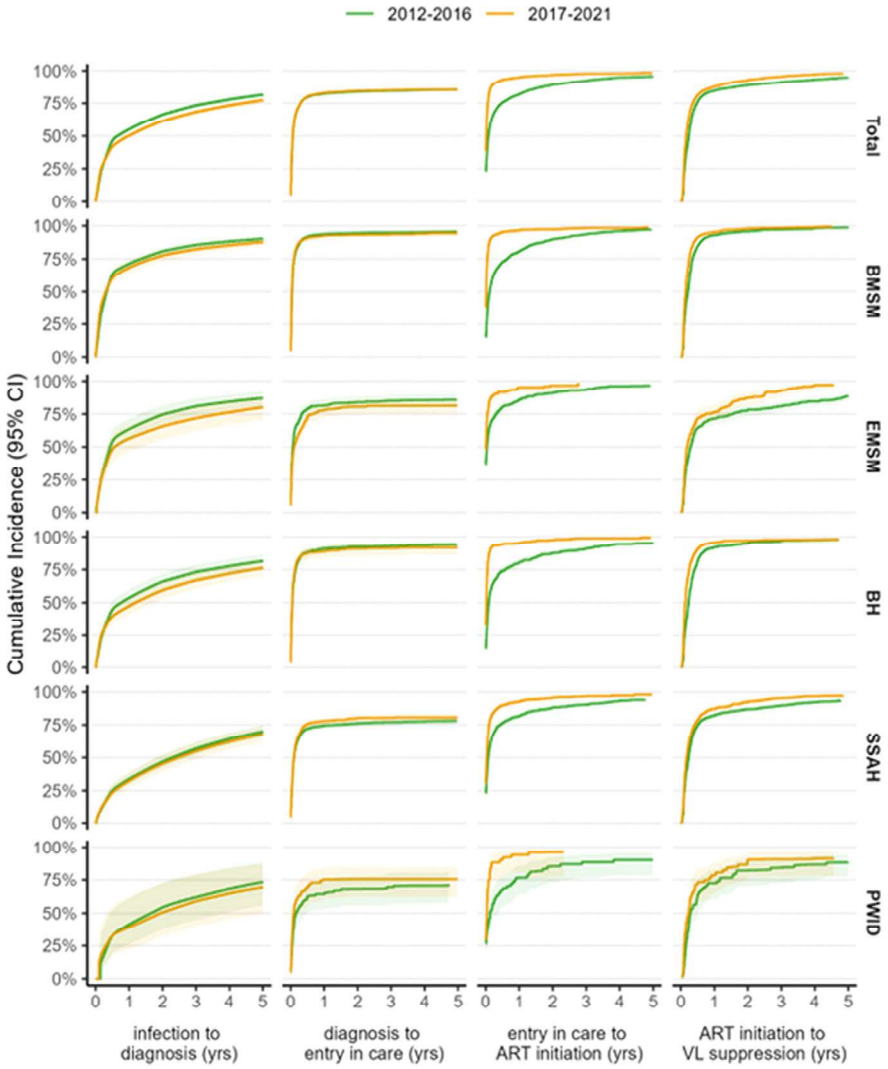

Table 1: (Subdistribution) Hazard ratios (HR, [95% CI]) (for the events of interest).

Factor	Level	Unadjusted HR	Adjusted HR*
Time between infection and diagnosis			
Subpopulation (ref. = BMSM)	EMSM	0.79 [0.68; 0.92]	0.84 [0.73; 0.97]
	BH	0.67 [0.60; 0.75]	0.62 [0.55; 0.70]
	SSAH	0.51 [0.46; 0.56]	0.51 [0.45; 0.58]
	PWID	0.54 [0.41; 0.72]	0.57 [0.43; 0.75]
Year (ref. = 2012-2016)	2017-2021	0.91 [0.85; 0.98]	0.90 [0.84; 0.97]
Time between diagnosis and entry in care			
Subpopulation (ref. = BMSM)	EMSM	0.61 [0.55; 0.68]	0.65 [0.59; 0.73]
	BH	0.88 [0.81; 0.96]	0.89 [0.82; 0.98]
	SSAH	0.53 [0.50; 0.57]	0.55 [0.51; 0.60]
	PWID	0.45 [0.36; 0.56]	0.46 [0.37; 0.57]
Year (ref. = 2012-2016)	2017-2021	1.03 [0.98; 1.08]	1.07 [1.02; 1.13]
Time between entry in care and ART initiation (HRC patients only)			
Subpopulation (ref. = BMSM)	EMSM	0.95 [0.81; 1.06]	0.93 [0.80; 1.08]
	BH	0.94 [0.87; 1.04]	0.92 [0.80; 1.06]
	SSAH	0.79 [0.72; 0.87]	0.76 [0.65; 0.82]
	PWID	0.80 [0.63; 1.02]	0.77 [0.54; 1.10]
Year (ref. = 2012-2016)	2017-2021	2.45 [2.33; 2.60]	2.35 [2.19; 2.46]
Time between ART initiation and VL < 200 (HRC patients only)			
Subpopulation (ref. = BMSM)	EMSM	0.92 [0.80; 1.09]	0.95 [0.90; 1.06]
	BH	0.99 [0.91; 1.10]	0.95 [0.82; 1.06]
	SSAH	0.95 [0.87; 1.06]	0.82 [0.73; 0.93]
	PWID	0.65 [0.48; 0.82]	0.55 [0.40; 0.76]
Year (ref. = 2012-2016)	2017-2021	1.33 [1.25; 1.40]	1.29 [1.20; 1.35]
**The models for the adjusted HR contain population and year of diagnosis as factors of interest and sex, age, CD4 at baseline (categorical), VL at baseline (categorical) as covariates (the latter two are not included for the infection-to-diagnosis transition as these are not known at baseline).*			

92.6% linked to HIV care, 90.6% retained in HIV care, 88.4% on cART, 87.5% virally suppressed. Viral suppression was reached for 93.6% of BMSM [92.9%-94.4%], 90.4% of EMSM [88.1%-92.7%], 85.5% of BH [84.1%-87.0%], 83.9% of SSAH [82.8%-85.0%] and 80.3% of PWID [77.2%-83.3%] (Figure 1). Time from infection to diagnosis increased in 2017-2021 (Adjusted Hazard Ratio (AHR): 0.90 [0.84-0.97]) but times from diagnosis to entry in HIV care, from entry in HIV care to cART initiation and from cART initiation to VL suppression decreased over time (AHR: 1.07 [1.02; 1.13]), 2.35 [2.19; 2.46], 1.29 [1.20; 1.35] respectively) (Figure 2 & Table 1).

Conclusions: The steady improvement observed in all stages of the CsCoC over the years are highly influenced by the increasing number of PWHIV in care for long, mostly virally suppressed. The LCoC outputs nuances the interpretation: no improvement observed in time from infection to diagnosis in recent years, whilst substantial progresses in times to cART initiation and VL suppression.

EACS2023: 305 | Intervention to implement continuum of care monitoring of people living with HIV/AIDS in public health services in São Paulo, Brazil

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Abstract category: Cascade of care

Abstract body

Purpose: In Brazil, 731 thousand people living with HIV/AIDS (PLHA) are in treatment and monitoring their continuous care (CCM) in public health services (PHS) can be supported by an electronic database called the Clinical Monitoring System (SIMC), which identifies PLHA in the