

# Breaking Barriers: Implementing Status-Neutral HIV Screening and Prevention for All



## CMEO Podcast Transcript

### **Oni Blackstock, MD, MHS:**

Hello, and welcome. On behalf of CME Outfitters, I would like to thank you for joining us for this CME Outfitters (CMEO) Snack titled, *Breaking Barriers: Implementing Status-Neutral HIV Screening and Prevention for All*. This program has been supported by an independent educational grant from Gilead Sciences Inc. Today's activity may include discussions of products or devices that are not currently labeled for use by the U.S. Food and Drug Administration (FDA).

I'm Dr. Oni Blackstock, and I'm the Founder and Executive Director of Health Justice in New York, New York. I'm delighted to be joined by my colleagues who will help provide broad global perspectives as well as regional insights to this program. I'll let them introduce themselves, and then moving forward we'll use first names.

### **Cristina Mussini, MD:**

Thank you very much. I'm Cristina Mussini. I'm a Professor of Infectious Diseases at the University of Modena and Reggio Emilia, and I am a member of the International AIDS Society (IAS) Governing Council and I'm Vice Chair of the Anti-Retroviral Therapy European Guidelines.

### **Sunil Suhas Solomon, MBBS, PhD, MPH:**

Hello everyone. I'm Sunil Solomon. I'm a Professor of Medicine and Epidemiology. I'm also the Vice Chair for Research in the Department of Medicine at Johns Hopkins University in Baltimore.

### **Boghuma K. Titanji, MD, PhD, MSc, DTM&H:**

Hi everyone. I'm Boghuma Titanji. I am an Assistant Professor of Infectious Diseases and an HIV physician currently based at Emory University in Atlanta, Georgia.

### **Oni Blackstock, MD, MHS:**

Thank you all for your introductions. We have such an esteemed panel.

So, the learning objective for today's program is to adopt a status-neutral approach to HIV screening to effectively promote prevention strategies, including the initiation of pre-exposure prophylaxis (PrEP). Routine screening is a critical first step in the HIV prevention and care continuum, and we know that a healthcare practitioner recommendation for screening has a significant impact on a patient's decision to test.

With that said, let's briefly level set on an important distinction between HIV screening versus diagnostic testing before we dive in. HIV screening is routine HIV testing that we offer to all patients in a healthcare setting regardless of why they came in, whether that's for primary care, the emergency department, or an inpatient admission. Diagnostic testing is what we order when something about the clinical picture raises suspicion of HIV specifically. The status-neutral framework is built on screening, on offering this universally because every test result opens a pathway to care. We also know that this framework helps to reduce stigma and normalizes HIV testing.

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So, to start, I'd like each of you to briefly share one key factor in your region that influences how HIV screening is offered, whether that's stigma, cultural norms, health system structure, or patient perceptions. Cristina, let's start first with you.

## **Cristina Mussini, MD:**

Yeah, I have to say that in Italy, we wrote also guidelines and a document about testing. We can face two different barriers. One is to people level. The problem is that they don't perceive sometimes that they are at risk. They don't include HIV among the possible infection that people could acquire during unprotected sex, so they don't go and test for HIV. While the second one is about doctors, and I think that this is really the same. I mean, they think in an old way. They think that people who live with HIV have it written on their face, but it's not like this. Really everybody could have met HIV during their life.

So, I think that we really have a long way to go in order to overcome these two barriers, either in a healthcare practitioner or either in people who have to test themselves.

## **Oni Blackstock, MD, MHS:**

Sunil, why don't you share with us your perspective?

## **Sunil Suhas Solomon, MBBS, PhD, MPH:**

Thanks, Oni. I work across the world, but I'm going to try and focus more on India because it's a different setting altogether. So, in India, we actually end up having thousands and thousands of facility-based screening centers, but then they have to go for testing. And I think this is something that's common across the world where our primary focus has really been on the access side trying to make these tests available. But I think populations and their perceptions of risk has changed. The way people want services delivered has also changed with self-care and self-testing taking a bigger role.

So, I think one of the biggest barriers for me, the way I see it in India and many other settings is generating that demand among the populations that are vulnerable to HIV to actually seek out HIV testing.

## **Boghuma K. Titanji, MD, PhD, MSc, DTM&H:**

Yeah. I currently practice in the U.S., and one of the biggest barriers that we see particularly here is still a lot of, perception of risk is quite different. And again, there are so many people who don't feel that they are at risk for HIV because a lot of the population still particularly feels that it's isolated to certain communities like men who have sex with men (MSM) or people who are coming from overseas. And you might find that it's just not intuitive for people who are not in these demographics to seek out testing or even understand why you might be recommending that they get tested for HIV and know their status.

On the side of the provider who actually offer HIV testing, you also see another barrier in the context particularly in the hospital where there's always the question of who is then going to discuss the result with the patient. And people sort of turf this to the outpatient setting with your primary care provider as being the person that should be offering you HIV testing. And so, there are missed opportunities, particularly for people who may not have health insurance and maybe getting their care primarily through the emergency rooms if there's not that proactive approach to offering testing.

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## **Oni Blackstock, MD, MHS:**

So, that's really helpful. So, we heard some individual level similarities in terms of low perceived risk. Providers maybe not thinking that patients are at risk and therefore not offering testing. Providers not wanting to have to deal with what happens if someone tests positive and having to have that conversation and then also access and building demand for screening.

So, Sunil, you work across multiple global contexts, and I'm wondering if you could walk us through where the guidelines align and where you see the biggest disconnect between what's actually recommended and then what's happening on the ground.

## **Sunil Suhas Solomon, MBBS, PhD, MPH:**

So, I think we have several guidelines. For example, we have the Centers for Disease Control and Prevention (CDC) guidelines, we have the World Health Organization (WHO) guidelines, we have the European testing guidelines, and then several countries have their own national guidelines, but most of them sort of align with the WHO guidelines themselves. And I think the one similarity across all these guidelines is they all normalize HIV testing. They all suggest that we should be screening everyone for HIV. It should be routine. And there's also a very strong emphasis on linkage beyond the testing. So, once you screen, if they screen positive, then the linkage to diagnostic testing and then whether it's PrEP or whether it's antiretroviral therapy (ART), that pathway needs to be continued. And I think these are sort of recommendations across all the guidelines.

The biggest disconnect I would say is these guidelines generally tend to be focused on the general population, versus like when you start going outside of Sub-Saharan Africa, the majority of infections seem to be happening in either key populations or their partners. And these are populations that face several challenges accessing HIV testing, whether it's stigma, whether it's logistics, or whether it's just distance. And I think that's something that hasn't really been addressed on how do you access, or how do you improve access to HIV testing to populations that are not able to come to the traditional testing venues like the testing center, like the integrated counseling and testing centers or the laboratories that are established, whether it's part of the President's Emergency Plan for AIDS Relief (PEPFAR) or part of government programs or CDC.

And this is extraordinarily clear when you start looking at the HIV care continuum and the HIV care cascade. When you start splitting it, even in countries that have great cascades, when you split the cascade by population at risk, you tend to see large drop-offs the minute you go to populations like trans people or cisgender men who have sex with men, especially in Sub-Saharan and Africa where it's criminalized in many settings. Or if you go to India, people who inject drugs, they're significantly lower. And I think that's where the guidelines need to modify or give us examples of what strategies work in these populations. But other than that, I would say most of the guidelines are in alignment with each other, really recommending and normalizing HIV testing.

## **Oni Blackstock, MD, MHS:**

Okay, that's really great. So, it sounds like, again, you said they are all promoting routine testing, normalizing it, but it sounds like in terms of reach, reaching those communities or those groups that are most vulnerable and giving examples of how to do that.

Cristina, I'm wondering ... so the status-neutral framework in many ways changes the question from what is your status to what do you need. And I'm wondering if you could walk us through how this works in practice.

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## **Cristina Mussini, MD:**

Yeah, I really think that is the way to put in practice all the development, all the different approaches that we have found along these 30 years or 40 years of the epidemic. I mean, I think that we have had so many progresses in treatment, and more recently, so many achievements in PrEP that this kind of model really put the person at the center and provide the person who test with the two option. That is if your test is positive, so you will have the best treatment. If your test is negative, you can have access to the prevention. That could be prevention with the drug, but also the counseling with safe sex, whatever, it's just something. It's a model that provides people who test with not just a test, but just at the beginning of a pathway, either of treatment or of prevention. And I think that this is something that is in a way, new, because we are used to say the person look at the result of the test and that's it. But with these incredible achievements that we had in treatment and in prevention, it would be terrible not to share it.

I'll give you an example. In my hospital, people who came to infectious diseases were receiving this kind of approach. While people went to sexually transmitted disease clinic, they just tested and they received the treatment for sexually transmitted diseases, but they were not counseled about PrEP. So, we change it, we just train the dermatologist on PrEP, and in this way we could reach the status-neutral HIV prevention and care model. And I think that this is very important.

## **Oni Blackstock, MD, MHS:**

Thank you, Cristina. I love the example of the dermatologist integrating the screening into their practice.

I'm wondering if Boghuma or Sunil have any reflections around whether this framework resonates with how testing is done in the settings that you work in?

## **Boghuma K. Titanji, MD, PhD, MSc, DTM&H:**

I think that the framework and the setting that I work in, there's still a lot of room for improvement because there are lots of providers who don't yet have the reflex of thinking ahead, "I'm offering testing. What would I do with the test result when the test is here?" There's still a great perception that anything related to HIV should be relegated to sexual health doctors and infectious diseases doctors. Which means that even when you have an individual who has an HIV negative test who ought to be offered PrEP, that reflex is not immediately there. What we are still seeing a lot in practice is, "Okay, your HIV test is negative and that's it."

So, currently at our large county hospital where we work, we are currently piloting ... sort of the status-neutral approach where every HIV negative test automatically reflexes to engaging with offering that individual PrEP and providing them with the resources if they want to go to the PrEP clinic and learn more. Or for those who want a prescription before they leave the hospital, being able to get that prescription before they get discharged. And what that does is, again, it emphasizes that linkage to care piece. You're not deferring it to sometime down the line where there's more of a risk for loss, so that person being lost to follow up. So, it's going to be very exciting to see if that is the thing that our providers need to kind of fill that gap where they're thinking more proactively about, negative tests, I offer PrEP, positive tests, I link the patient to care and start treatment.

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## **Sunil Suhas Solomon, MBBS, PhD, MPH:**

The only thing I would probably add to the discussion is, I think in terms of status-neutral HIV prevention and care, I would also go one step further back and say status-neutral person-centered HIV prevention and care. Because I think for many people infected and affected by HIV, HIV testing is not their priority. And I think we've seen this in many settings in the U.S. and globally where access to services like gender-affirming care or access to services like laser hair removal or food and showers are what draw populations who are really vulnerable into these facilities. And once they're in the platform of status-neutral, HIV care can begin.

So, you get them their access to gender-affirming care and when they're there, say, "Hey, can we also screen you for HIV?" And if they're positive, then you go down the positive pathway or the negative, you go down the negative pathway. But I think we also had to start thinking about what people want versus what we think people want.

## **Oni Blackstock, MD, MHS:**

Totally. Yes. I think bundling the screening with things that people care about, services that people actually want, definitely helps to increase uptake.

So, Boghuma, I'm wondering if you can tell me about or walk us through, you mentioned a little bit earlier about these two pathways and the benefits of acting on both. So, whether someone has a reactive screening test or a negative test.

## **Boghuma K. Titanji, MD, PhD, MSc, DTM&H:**

Yeah, I think I can draw from my practice quite readily, in the sense because I'm teaching about this all the time. That whole pathway as we've talked about before is in the context of someone having an HIV negative test, the next conversation that I'm engaging that person with is understanding what a negative test means, and also the fact that a negative test at that time point is not a static thing. Based on your exposures and your sexual health behaviors, you may be exposed to HIV down the line and that status could change. And there are ways that you can ensure that your test remains negative by considering PrEP. And then I have the conversation about offering them PrEP, talking about what PrEP is and what the options we have for PrEP are, and then directing them towards one direction of where they can actually access these services.

Now in the back of my mind also, we always know that it's not everyone who would show up with a negative test. For those individuals that have a positive test, we are also accelerating linkage to care. So, again, providing counseling immediately about what it means to live with HIV currently, emphasizing on the fact that putting people on treatment as soon as possible after diagnosis leads to better outcomes and you can go on to have a very normal healthy life if you are treated. And then providing those resources to connect them to care so that they can start treatment promptly and stay engaged in their care.

And I also use that discussion about the test result to also have a discussion around just sexual health in general. And that still involves kind of having conversations about other aspects of harm reduction, talking about condom use and looking for other behaviors that may be adding or kind of a component of an individual's particular risk profile. So, is that person using injection drugs and are there opportunities to connect them to a needle exchange program and other things that would optimize their health and make sure that they're staying

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negative if they tested negative. Or if they're HIV positive, making sure they're connected to care and have the right resources to take care of their health.

## **Oni Blackstock, MD, MHS:**

No, that's wonderful. And I think so much of what you talked about was around also education and identifying resources for folks, regardless if they have a reactive test or a test negative. And the education part I think addresses some of the sort of misinformation and misconceptions that people can have that can often be barriers to effective HIV screening. So, from your experiences, what misconceptions among patients or clinicians most often interfere with a status-neutral approach in your region? And you can pick one misconception and share that with us, and we'll start, Cristina, with you.

## **Cristina Mussini, MD:**

Yeah, as I said before, I think that the most important, the most relevant is the one that you could see HIV from the face of someone. I can tell you that I was an expert in a trial of a lady who died of HIV, unfortunately. And she was a lawyer, so nobody tested her because she was a lawyer. So, that's the problem. And it was something that explains I think more than a thousand words. After all these years, there is still this misconception. So, either in the people who say maybe, "I'm a lawyer, I don't test." "Because I think that my husband is faithful." So, the information is something that is absolutely crucial to improve, because the other possibility is to test really everybody and to normalize the testing like cholesterol. You test for cholesterol, you test for HIV, and this would be the most important thing. But until then, we really have to fight about these misconceptions and the risk perception, I think,

## **Sunil Suhas Solomon, MBBS, PhD, MPH:**

And I can go next, and I think from a patient's side, fear of judgment, fear of being thought of as a bad person or someone who engage in a bad behavior is one of the biggest barriers. And from a provider perspective, I would say the biggest barrier is we think people want an HIV test, but most people don't.

## **Boghuma K. Titanji, MD, PhD, MSc, DTM&H:**

And I would round it out by saying stigma is still pretty huge. I've encountered so many patients for whom you might offer screening and they would say, "I've not been screened, but I would rather not know." And when you try to probe a little bit, you find out that the reason why they are not interested in getting an HIV test is because they don't want to have the conversation that comes after the test. To the point where the stigma is so strong that even the possibility of having a negative test is still not something they want to engage with. And that in itself leads the patient to reject the test when it's offered.

## **Cristina Mussini, MD:**

Yeah, I would say that we have a long way to go, for example, with Undetectable = Untransmittable (U = U). Because this fear of being tested, it's something that dates back in the early time, early year of the epidemic when it was like HIV equals death. And still today that we have active drugs, so tolerated drugs, and if you have fear of being tested, even if you... Maybe you don't realize that it's not a death sentence anymore since a long time ago. So, it's just the many messages that are very clear for the healthcare providers, at least infectious

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disease specialist, I would say. They're not being so received by the so-called general population, whatever it means.

## **Oni Blackstock, MD, MHS:**

Cristina, and you mentioned U = U. Can you just spell that out with the whole entire phrase is and what it refers to for our audience?

## **Cristina Mussini, MD:**

Yeah, it's undetectable equals untransmittable. It means that if your plasma viral load is undetectable, you cannot transmit HIV. And this is something that is really revolutionary for me, and it is the first thing that I say when I counsel someone who tested positive, because I think that the stigma and especially the self-stigma, it's something that we have to fight.

## **Oni Blackstock, MD, MHS:**

Thank you, Cristina. You all shared, you shared that stigma plays a role, assumptions about one's own risk or the assumptions that we make as clinicians, the assumptions that we make around whether screening is a priority for our patients, discomfort that we might have as practitioners having these conversations, these all weigh in, all those play a role. And you may have answered some of this already. We know that sometimes these barriers can show up differently depending on local context, and so wondering if each of you could briefly highlight one specific regional barrier that most strongly affects testing in your specific setting.

## **Sunil Suhas Solomon, MBBS, PhD, MPH:**

I can go first in terms of, I'm going to focus on India and Asia because it's different from the U.S., who I'll talk about. But I think in terms of, so the populations, like I said, have shifted. The way they're seeking out partners and everything has changed. There's a lot of virtual networking, especially looking for partners through platforms like Grindr and Tinder and Blued. So, this is a population that's not showing up in physical venues to take HIV testing. So, we've actually transformed our programs in India to go online. So, we're actually offering HIV services completely online where we have counselors that talk to people. So, I think this goes back to the point of meeting people where they're at. And if people, we need to make sure our programs are adaptable and flexible and nimble to change as people's requirements and people's needs are also changing.

So, in India, we're actually looking at all these other approaches like, can we go into virtual platforms? Can we integrate HIV testing into places where people come to find food? Can we integrate... Which are not traditional venues where we are offering HIV testing. So, I think if we want to get to that last group of people who haven't been reached, we need to stop with our routine and start thinking outside the box on what could work in these populations.

## **Boghuma K. Titanji, MD, PhD, MSc, DTM&H:**

Yeah, and I would say kind of just to add for the U.S., the other thing that is a specific challenge is how people perceive HIV currently in the U.S. In the general population in the manner of speaking, there's a perception that HIV is over and done with, it's no longer a problem. And what that leads to is that getting tested for HIV is not at

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the fore or it's not something that people are necessarily thinking about as a component of their care. And we also see that not only in the patient populations that engage with the healthcare system, even in the healthcare providers. For healthcare providers who may not be working in the Southeastern U.S. where the epidemic is currently concentrated, people are not necessarily thinking that I should be offering HIV testing routinely to every adult at least once a year as part of their healthcare.

And I think that we have to change those perceptions to really encourage people, providers to actively offer testing and to remind the population that, for example, in the case of the U.S., 13% of people with HIV do not know their HIV status. And the only way we are able to reach that 13% and make sure that they are tested and connected to care is by being proactive in getting people to recognize there's a need to know your status as an individual. And on the provider side, really reminding providers that HIV testing is an integral part of the care that we provide to people we have the privilege of looking after.

## **Oni Blackstock, MD, MHS:**

So, let's shift from barriers to implementation. Can each of you share one practical example of a challenge you've encountered and how a regional approach has helped to operationalize the status-neutral approach?

## **Cristina Mussini, MD:**

I think that our problem is that the possibility to provide the test with the opt-out is not on the table. Still we are changing the law. The law on HIV dates back in 1990. And with all the stigma, it carries all the stigma that was there when people were dying. So, now the situation is completely different. We wanted to have the opt-out, but it was very, very complicated. So, we have maintained obviously the consensus. Imagine it in the law now it is written that they have to sign to do the test, imagine the barrier to sign for the test. We don't do it, but we are against the law, I have to say.

So, we have to inform people, but we cannot prescribe the testing, HIV testing like this. You have to explain that you're doing the test. And this creates stigma, I think, because it should be absolutely in the status-neutral approach. It should be very natural. While if you put a lot of pressure on it with the counseling, with everything, it's more difficult. It's more difficult.

## **Sunil Suhas Solomon, MBBS, PhD, MPH:**

I think to use an example from India, in 2020, 2021, we were trying to establish the status-neutral HIV centers for the trans community. So, we ended up doing a bunch of focus groups with them and we said, "Which of these services," and we provided like PrEP, ART, HIV testing, sexually transmitted infections (STI) screening, which would really be a draw. And they essentially said, "If you can do laser hair removal, then you will get the community to come in." So, we actually built the model around laser hair removal. And what we found was we were able to get a lot of people who were coming in who were not engaged in... It was almost 6,000 trans people who used these services in a 2 year period, and 70% of them had never been to one of the HIV programs before.

But they all came in for the gender-affirming care. And while they were there, we offered them HIV screening. Anyone who was positive was linked to antiretroviral therapy and anyone who was negative was linked on PrEP

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if they were eligible and wanted to be on PrEP. So, I think we need to start taking community perspectives into the way we design programs. And that's probably a lesson from India, but probably a lesson for the world.

## **Boghuma K. Titanji, MD, PhD, MSc, DTM&H:**

Yeah, I would say that in the U.S., I'll take again the example of our site. We have done several things over the years and continued to build on these to remove the barriers. The first thing I mentioned was the opt-in testing that automatically is offered to everybody who comes in contact with our healthcare system. And it serves both as a reminder to the healthcare providers to offer the test and also provides the patient with an opportunity to be counseled about the importance of testing and to get tested and know their status.

We have had, in terms of people who test positive, we have a rapid start and rapid engagement to care programs. So, we have patient coordinators that immediately, and counselors that immediately engage with anyone who has a new test. And they are offered resources on counseling immediately to understand what it means to test positive. Reflexively, they get a consult from an HIV physician and there is rapid start for most of these individuals in the hospital at the time of diagnosis unless they have, say, for instance, a contraindication to starting ART rapidly.

And now we are piloting the connection to care for PrEP. So, that's the other exciting and final component of us removing the barrier to being able to engage people in PrEP in the hospital. I'll take an example of a recent individual that we saw who was offered HIV screening and because of his hospitalization was HIV negative, but had tested positive for other STIs. And then when we engaged with him, we offered him PrEP, and he initially refused. And when we probed, his reason was, "I don't want a PrEP bottle in my house because it's HIV medication and someone's going to ask me about it, and I don't want to be having that conversation with my roommates." But when we said, "Actually, there's injectable PrEP that we could connect you to," he left with an appointment to get his first shot, and that was the first time he was hearing about PrEP.

So, again, that pilot is already yielding fruit with us being able to connect people who would not otherwise consider PrEP as an option for them because they have questions around stigma. They may not want oral PrEP for reasons that just their understanding that they may not, they don't know what options are open to them. Being able to engage them in this manner has really taken away a significant barrier.

## **Oni Blackstock, MD, MHS:**

It follows with some really innovative approaches to overcoming some of the barriers that you all mentioned earlier.

So, moving on, we know that all the different approaches that you've shared also depend on how clinicians or staff open the conversation around HIV screening. So, Boghuma, I'm going to ask you, what language or strategies have you found helped to normalize testing and prevention discussions?

## **Boghuma K. Titanji, MD, PhD, MSc, DTM&H:**

Yeah, I like leading my conversations with individuals really from a point of being completely non-judgmental. So, I start usually by telling people, "Okay, so yay, your HIV test result has come back negative." And then just kind of having a conversation about their understanding of what an HIV negative test is and what is their understanding of HIV prevention in general. I think that starting out with open questions really allows me to get

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an understanding of where the person is at in terms of their knowledge around HIV prevention and what options are available to them.

And that immediately also allows me to have the conversation of risk perception, because I think that one of the biggest barriers is that a lot of people think when you start talking about PrEP or if you jump straight into PrEP, they're like, "Oh, PrEP is not for me. I'm not a person who has, a man who has sex with other men. I'm a Black woman. That's not something that I should be considering." So, approaching it from a very neutral and non-judgmental way allows you to have a conversation with people that meets them where they are, and you are able to provide a lot more information and counseling that removes some of those misconceptions.

And then I move on to kind of also asking them, telling them that my role is to basically make them understand what is available to them, and I go over the options and then ask them what speaks to them and what is most likely to fit into their lifestyle and what they think they would need more information about. And I think that approaching it in this way really helps folks to arrive to a point where they're making the decision that's best aligned with what their goals are, and it really allows a lot of patients to feel that you're not judging them and that you are on their side in optimizing their health.

## **Oni Blackstock, MD, MHS:**

Definitely. And I'm wondering from your experience doing work in Cameroon in West Africa, if there's anything that you can share around, for instance, engaging men in HIV testing?

## **Boghuma K. Titanji, MD, PhD, MSc, DTM&H:**

Yeah, I think that in those settings in particular, it can be quite different in terms of the approach to how you engage men, particularly in terms of their HIV care. There's a lot of taboo around talking about sex in general, and people already approach it kind of like from a place of weariness when you start asking them questions about, "Okay, what type of sex you're having and what kind of exposures you may be having." You have to be very culturally sensitive in these settings. And again, emphasizing the fact that this is about finding something that aligns with the individual. It's not about me as a healthcare provider telling that individual what to do. It's about them being able to know what options are available to them to best preserve their health. And I think that when you approach it in that manner, people are a lot more receptive.

Now, kind of talking outside of the group of men, I would highlight that women as well in that particular setting can be challenging to engage where PrEP is concerned. Because there's the whole notion that if you are a woman and you're using PrEP, that automatically means that you're promiscuous. You're using it because you're having so much sex that you need to prevent HIV.

So, again, turning the conversation to be from the angle of, what are you doing for your health that best aligns with your objectives of staying healthy and putting it in a non-judgmental way enables you to engage people better regardless of their gender in these particular settings.

## **Oni Blackstock, MD, MHS:**

Yes, I agree. I always like the saying, it's not about what's the matter with the person which pathologizes them, but what matters to them, what are their priorities and needs.

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## **Sunil Suhas Solomon, MBBS, PhD, MPH:**

I have nothing to add. I think Boghuma summed it up beautifully.

## **Oni Blackstock, MD, MHS:**

Yes, yes, agreed.

Okay. So, moving on to this sort of general approach to universal screening. Again, regardless of the results, how we communicate, it matters. We want to make sure we deliver the test results in person if possible, and understanding that negative results can be delivered virtually or via phone, ensuring that the results are delivered in a confidential manner that we deliver the results using as best possible and empathic yet direct tone of voice with our patients or our clients. And then of course, use non-judgmental approach. And again, showing empathy when addressing our patient's responses to their testing results and being flexible with patient's reactions and the needs they may have in the moment, what may need to be explained to them and their ability to make decisions in that moment may vary.

Also, a key takeaway here is that clinicians don't need to do everything themselves. If you're not ready to prescribe today, whether it's PrEP or treatment, knowing who and where to refer patients to is a really important step to make.

In the U.S., guidelines support initiating antiretroviral treatment while confirmatory testing is pending. So, the question for us as healthcare practitioners is not whether to act, but how to communicate clearly with the patient about why we're starting treatment now and what the confirmatory process looks like, how long it may take. And we realize that this may differ in different settings, but recognizing that in certain countries and settings, same-day treatment and same-day PrEP are also the goal.

Before we close, we'll briefly touch on key considerations for PrEP initiation following a negative test and appropriate follow-up. So, Sunil, starting with you, walk us through the pre-initiation steps.

## **Sunil Suhas Solomon, MBBS, PhD, MPH:**

Sure. I think to just make clear to everyone, PrEP is only for people who are HIV negative. So, I think probably the most important thing you want to do is confirm the HIV negative status with 4th-generation antibody antigen test. For people who have recently been exposed to a behavior or a practice which may have placed them at risk for HIV, you could consider doing a nucleic acid test, either an RNA PCR. If you're outside of the U.S., you have point-of-care machines that you can use this. This will help to identify people in the window period and prevent persistence.

But I think the two other things that are not HIV related, I would also suggest, especially in many countries where tenofovir disoproxil fumarate (TDF) and tenofovir alafenamide fumarate (TAF) are still used, is definitely do a hepatitis B surface antigen test and also get a renal function test done. Because both these medications can, will actually impact hepatitis B treatment outcomes as well, and so you want to be very careful if the person you are starting on PrEP is also coinfecting with hepatitis B.

## **Oni Blackstock, MD, MHS:**

Great. Thank you, Sunil. Boghuma, do you have anything to add in terms of linkage?

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## **Boghuma K. Titanji, MD, PhD, MSc, DTM&H:**

Yeah, I would say once you've ascertained all the things that Sunil has so very clearly laid out, it's important to have the conversation about what the options are for the individual who is considering PrEP for themselves. And once you make the options known to them, also encourage them to think about what best fits their lifestyle and what best fits what they're able to take as PrEP. And then the next thing would be having a conversation about how you direct them to get access to what they've decided on. And I think one key piece of information that I think a lot of providers miss when they're having conversations about PrEP is reminding people who are considering PrEP for their own health that it is completely normal to cycle on and off PrEP because your risk profile or your exposure profile doesn't stay static.

And I think that there's still the perception amongst a lot of patients that, "Oh, is PrEP like a medication now that I have to take every day for the rest of my life?" No, you have a conversation of if at some point your exposure profile has changed, if you are going through a period of abstinence or if you're going through a period where you feel that you may not need PrEP, it is totally okay to come off of it. And if that changes, it is again totally okay to be able to go back on PrEP. I think that that usually is something that patients don't realize, and it really helps a lot of people over the hump in feeling very comfortable about making that decision for their health.

## **Oni Blackstock, MD, MHS:**

Great. Thank you both for highlighting those important steps after a negative test result. And so, detailed PrEP prescribing will be covered more deeply in later activities in this series, so stay tuned.

So, this visual highlights different staff who may be involved in PrEP delivery, and we understand that team structures may vary based on region and healthcare setting. And so, I'd like you all to name the top three, or maybe each person can name one, but top three essential roles in PrEP delivery in your region in terms of team members. Roles may be clinical, community-based, or system level, and try to focus on who is essential versus full workflows. We'll start with you, Cristina.

## **Cristina Mussini, MD:**

Yeah, I have to say that the reimbursement of PrEP was based on the fact that delivery should be made only by doctors. And this is an infectious disease specialist. So, this is just something that... But we were among the last countries that obtained reimbursement because we obtained it in 2023, so very, very recently. And we don't have injectable PrEP because of cost, as in all European countries. So, our only choice is between every day or on demand. That is the only choice.

But what we do, we collaborate with the pharmacist and we have some checkpoints where the PrEP is delivered by peers. So, I think that this is the, and the most important for now by law is the infectious disease specialist. We are trying to enlarge the possibility to prescribe PrEP with Agenzia Italiana del Farmaco (AIFA – Italian Medicines Agency), but it takes some time, I think, because it was just reimbursed. They're not ready to change everything now.

## **Sunil Suhas Solomon, MBBS, PhD, MPH:**

If I needed to pick, I would say for oral PrEP it would either be counselors or social workers, one of those two positions, and someone who could prescribe, depending on which setting you're in. Just those two positions,

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you should be able to design an effective oral PrEP program. And for an injectable, I would use those same two positions and include someone who could also deliver the injectable. And I think with those three positions, you should be able to pull off a PrEP program.

## **Boghuma K. Titanji, MD, PhD, MSc, DTM&H:**

I would just add one third important person. I think that our linkage to care coordinators do a fantastic job because they're able to have a lot more longer conversations and more detailed counseling conversations with folks that are considering PrEP. Which is always a challenge, particularly in a hospital setting where a lot of the healthcare providers are very busy and may not take the time to actually answer all the questions. So, I would say the linkage to care coordinators are an important piece for our program.

## **Oni Blackstock, MD, MHS:**

Great. Thank you so much. And so, this seems like there's some variation in terms of whether oral PrEP or injection PrEP is available, what the resources are. But the unifying, I think, point is that successful PrEP delivery almost always depends on clear roles and referral pathways and communication, not necessarily on having a perfect or complete team. So, also want to emphasize that even when only one provider is available, PrEP can still be delivered effectively with simple tools like handouts or counseling scripts, mobile or virtual follow-ups, and support doesn't always have to be specialized. The goal is really about continuity, trust, and actionable steps.

So, to close, we want to leave you with three practical goals you can take back to your healthcare setting. The first is to normalize screening for all patients by using a status-neutral approach to HIV screening. Second, use results to connect people to prevention or treatment based on what's available in your setting. And third, make communication and team collaboration the backbone of that work. No matter your role or region, adopting a status-neutral approach helps to normalize testing, reduce stigma, and ensures that every patient has a clear next step.

Thank you to our wonderful faculty for sharing your perspectives, and thank you to our audience for joining us. We encourage you to explore the additional resources linked with this activity and to continue the conversation in your own practice. We invite you to visit the CME Outfitters Infectious Disease Hub, which includes free evidence-based resources for both healthcare professionals and patients. These tools are designed to support practical implementation of concepts discussed today, including status-neutral HIV screening and prevention.

This activity is part of a broader HIV prevention education series. Additional programs will explore topics including long-acting injectable PrEP, patient engagement and adherence strategies, and expanding access to newer prevention options. We encourage you to explore these programs and to continue building on today's discussion. Before we wrap up, just a quick reminder that to receive CME or CE credit for this activity, you'll need to complete the post-test and evaluation online. Once completed, you'll be able to download and print your certificate immediately. Thank you.