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Meeting Report

European
Roundtable
2026

**Commit to continuity:
targets that survive borders,
status changes, and displacement**

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Hosted by
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Co-organised by
European AIDS Clinical Society (EACS)



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Introduction

The European Roundtable 2026 brought together Members of the European Parliament, clinicians, public health experts, researchers, civil society advocates, community organisations, and international institutions to address one of the most pressing challenges in Europe's HIV response: how to maintain prevention, treatment and care when people move across borders, lose documentation, change legal status, or are displaced by war and crisis.

The meeting built on the 2025 European Roundtable, which called for renewed EU leadership, stronger political commitment, sustainable financing, expanded testing and PrEP, and investment in community-led services. The 2026 discussion focused more specifically on continuity: continuity of treatment, continuity of prevention, continuity of community support, and continuity of rights. The programme framed this through three main themes: mobility without disruption, community-based models that deliver, and parliamentary accountability for smart investment in health.

The discussions were situated within the Sustainable Development Goal 3.3 commitment to end AIDS as a public health threat by 2030, the UNAIDS 95-95-95 targets, and the WHO Global Health Sector Strategies on HIV, viral hepatitis and sexually transmitted infections for 2022–2030.^[1–3] WHO describes these strategies as a framework for ending AIDS and the epidemics of viral hepatitis and STIs through universal health coverage, primary healthcare, health security and people-centred services. ([World Health Organization](#))

Recent ECDC and WHO Europe surveillance data show that Europe remains off track. In 2024, 105,922 HIV diagnoses were reported across 49 countries of the WHO European Region, including 24,164 in the EU/EEA. Late diagnosis remains a major concern, with ECDC reporting that 48% of HIV diagnoses in the EU/EEA were late.^[4] ([ECDC](#))

The central message of the Roundtable was clear: Europe has the scientific tools to end HIV as a public health threat. What is still lacking is sufficient political visibility, sustainable financing, and health systems capable of ensuring that HIV care continues regardless of borders, displacement, stigma, poverty, incarceration, migration status, or legal uncertainty.



Continuity of HIV Care and Treatment Access

Professor Miłosz Parczewski, President of the European AIDS Clinical Society, underlined that antiretroviral therapy has transformed HIV care. People living with HIV who are diagnosed, linked to treatment and supported to maintain viral suppression can live long and healthy lives and do not transmit HIV sexually. However, this success depends on uninterrupted access to treatment, regular clinical monitoring, and sustained support.

Treatment interruption was repeatedly framed as both a clinical and public health risk. When care is disrupted, viral replication can return, immune status may worsen, the risk of opportunistic infections increases, and the prevention benefits of treatment as prevention are lost. The third “95” of the UNAIDS targets — viral suppression among people on treatment — is therefore directly dependent on continuity.

MEP Bartosz Arłukowicz and MEP Michalis Hadjipantela both reinforced the need for renewed political leadership. The Roundtable emphasised that late diagnosis is not simply a medical problem, but a sign that prevention, testing and access systems are failing to reach people in time. MEP Hadjipantela also highlighted the specific pressures faced by smaller and frontline Member States, including Cyprus, where migration pressures, incomplete medical documentation and treatment interruptions place additional demands on health services.

Participants agreed that Europe does not lack knowledge. The tools exist: testing, antiretroviral therapy, PrEP, harm reduction, community outreach, peer support and clinical standards. The challenge is to ensure that these tools reach people before they are diagnosed late, lost to follow-up, or excluded from care because their lives do not fit administrative systems.

Mobility Without Disruption

Mobility and migration were central to the Roundtable. Georgios Siakallis presented the Cyprus experience, showing how frontline health systems can adapt to changing migration patterns while avoiding simplistic narratives that blame migration for HIV transmission. Cyprus reported 218 HIV cases in 2022, with 72% among foreign-born people. However, molecular epidemiology data presented from Cyprus showed that transmission dynamics were more complex, with substantial acquisition occurring locally, including within identified transmission clusters.

This was an important advocacy point. Migration itself does not drive HIV transmission. Exclusion, delayed testing, fear of authorities, stigma, interrupted care and lack of access to prevention create risk.

Cyprus' response showed the value of building networks between the Ministry of Health, Ministry of Interior, public hospitals and NGOs, alongside culturally sensitive approaches, satellite primary care services, PrEP introduction and fast-track vaccination linkage. Services were described as fully reimbursed and unconditionally accessible, regardless of residency or national health system status.

Stela Bivol of WHO Europe placed these national experiences within the wider regional picture. She highlighted that migrants represented 29.6% of reported HIV diagnoses across the WHO European Region in 2024, and 57.5% in the western part of the Region. Her presentation stressed that migrant-inclusive services are essential to reaching the 95-95-95 targets and disease elimination.

WHO Europe also highlighted poorer outcomes among migrants, including late diagnosis, later treatment start, loss to follow-up and virological failure. These are not biological differences. They are the consequence of structural barriers: language, legal uncertainty, stigma, discrimination, fear of deportation, mistrust of authorities and lack of universal access to testing, ART and PrEP.



Alena Kamenshchikova of Maastricht University drew attention to labour migration as an often overlooked part of HIV care continuity. Many mobile workers in Europe are employed through temporary contracts, zero-hours contracts, employment agencies or subcontracting chains. Her presentation noted that, in 2024, around 7.2 million working-age intra-EU migrants were employed or looking for work, alongside more than 3.3 million third-country nationals. In the Netherlands, only 12% of workers born in another EU Member State and 10% of workers born outside the EU had permanent contracts.

This instability can make HIV care fragile. People may be recruited in one country, legally employed through another, and physically working in a third. If access to healthcare depends on formal residence, insurance status or stable employment, continuity of care becomes vulnerable. Dr Kamenshchikova also noted that re-testing and re-diagnosis requirements can delay care for people already diagnosed and on treatment in another country. Better recognition of HIV diagnosis and testing across borders was therefore identified as a practical priority.



Community Leadership and Models That Deliver

As in the 2025 Roundtable, community leadership was a central theme. Denis Onyango of the Africa Advocacy Foundation stressed that access to services on paper is not the same as access in practice. Migrants may arrive with urgent needs for shelter, food, legal advice, income, safety and trauma support. HIV care becomes reachable only when people trust the system and are supported to navigate it.

Community organisations were described as essential infrastructure. They provide peer support, translation, cultural mediation, legal orientation, psychosocial support, accompaniment and linkage to care. They are often the first trusted point of contact for people who are undocumented, newly arrived, displaced, LGBTQI+, using drugs, selling sex, homeless, traumatised or afraid of authorities.

Camila Picchio of ISGlobal presented findings from MI-GOOD-CARE, which collected models of good practice to improve testing, linkage to care and retention in care for HIV, tuberculosis, viral hepatitis B and C, and STIs among migrant populations.

The models that delivered outcomes were commonly community-based or decentralised, integrated across multiple diseases, culturally relevant, supported by peers or community health workers, and able to provide psychosocial and legal navigation. They were also more likely to be co-developed with affected communities.

A recurring concern was that effective community models are often funded as short-term projects, evaluated by activity rather than outcomes, and not properly integrated into health systems. When pilot funding ends, successful interventions disappear, while health systems continue to bear the costs of late diagnosis, untreated infections and loss to follow-up.

The Roundtable therefore echoed one of the strongest messages of the 2025 report: communities must be involved from the planning stage, not only during implementation.

Community-led work is not an optional add-on. It is one of the most effective and cost-efficient ways to reach people whom formal health systems routinely miss.

Integrated Prevention, Testing and Care

Dorthe Raben, representing SHIELD and EuroTEST, presented the case for integration. SHIELD — Strategies for Health Interventions to Eliminate Infection-related Cancers — is a Joint Action running from 2025 to 2028, with 69 partners across 25 countries and an overall budget of EUR 25 million. Its aim is to prevent infections from causing cancer by strengthening prevention, vaccination, testing and linkage to care for HBV, HCV, HPV, HIV and TB.

The European Commission has described SHIELD as a project to prevent infections that can lead to cancer by making vaccination, testing and treatment easier to access. ^[5] ([European Commission](#)) The Roundtable highlighted this as a relevant model for HIV advocacy, because HIV, viral hepatitis, STIs, HPV and TB often affect overlapping populations and share structural barriers.

Integrated approaches were presented as a way to reduce missed opportunities. People do not experience health risks in separate policy categories. They may need HIV testing, hepatitis testing, STI services, TB screening, vaccination, PrEP, condoms, harm reduction, mental health support and legal assistance at the same time. Health systems should be designed accordingly.

EuroTEST experience also showed increasing movement from single-disease testing towards integrated testing. SHIELD survey data further indicated that migrants, undocumented people and ethnic minority groups are among the hardest populations to reach for HPV and HBV vaccination.

The Roundtable therefore supported integration not as a way of diluting HIV, but as a way of strengthening prevention, increasing efficiency and reaching populations facing multiple barriers.





Sustaining Financing and Strengthening Political Commitment

Robert Hejzák, speaking for the Coalition for a European HIV Response, warned that Europe's HIV response is losing momentum. His presentation identified funding pressures affecting community-led responses at national, regional and global levels, and called for three concrete priorities: renewal of the EU HIV and communicable diseases Action Plan, sustainable funding for community-led services, and restoration of EU global leadership on HIV.

This message is closely aligned with the European Parliament's 2017 resolution on the EU response to HIV/AIDS, tuberculosis and hepatitis C, which called for a comprehensive and integrated EU policy framework. ^[6] (Eur-Lex) It is also consistent with the ECDC/EACS Standards of HIV Prevention and Care, which provide practical standards on testing, PrEP, ART initiation and HIV-related comorbidities. ^[7]

MEP Tomislav Sokol reflected on the role of Parliament and the changing position of health within EU policy. He noted that health was historically treated as a marginal EU competence, but that COVID-19 and the European Health Union have changed expectations. While healthcare delivery remains largely a Member State responsibility, the EU can set targets, support best practice, fund programmes, stimulate research and innovation, and provide political direction.

The Multiannual Financial Framework was identified as a decisive advocacy arena.

Participants stressed that HIV must remain visible in budget negotiations and must not be lost among competing priorities. Political attention is not symbolic; it shapes funding, accountability and implementation.

MEP Sokol's practical advice to civil society was direct: HIV advocates must remain visible, persistent and active, using parliamentary questions, meetings, events, amendments, national pressure and media engagement to ensure that HIV does not disappear from the political agenda.



Ukraine, Displacement and Continuity of Care

The discussion on Ukraine showed why continuity must be treated as a European priority. Community representatives described how Russia's full-scale invasion displaced millions of people, including people living with HIV, people who use drugs, people on opioid agonist therapy, women, LGBTQI+ people and internally displaced people.

The EU Temporary Protection Directive was recognised as an important and unprecedented response. Temporary protection for people fleeing Ukraine has been extended until March 2027.^[8,9] However, participants warned that March 2027 is close in policy terms. People living with HIV need clarity well before any legal transition so that treatment, housing, employment, family decisions and possible return to Ukraine can be planned safely.

The Roundtable also highlighted transnational realities. Some Ukrainians may remain in host countries, some may return to Ukraine, and others may move back and forth. Some continue to rely on clinicians in Ukraine because of trust, language and continuity of chronic care. This should not be interpreted as misuse of systems. It reflects the realities of displacement and long-term health management.

A major unresolved issue is safe clinical data transfer. Ukraine has a degree of centralised HIV documentation, while many European countries lack interoperable systems to transfer HIV treatment records securely. Informal professional networks have helped, but they cannot replace rights-based mechanisms to transfer essential information, including ART regimens, resistance data where available, TB history and comorbidities.

United Against Stigma, Exclusion and Gaps in Care

The Roundtable made clear that a renewed European HIV response must explicitly include populations that are too often left out of policy planning.

Participants working on harm reduction and drug policy stressed that continuity of HIV care must include continuity of harm reduction. This means sterile injecting equipment, opioid agonist therapy, naloxone, overdose prevention, community outreach and access to services without fear of punishment, deportation or loss of protection.

The need to include people in prisons was also strongly raised. Incarcerated populations are disproportionately affected by HIV and other blood-borne infections, yet are often absent from HIV strategies and stakeholder consultations. Any action plan that excludes prisons leaves a major gap in the care continuum.

Trans inclusion was identified as another non-negotiable element of a credible HIV response. Rising anti-trans rhetoric, barriers to gender-affirming care, stigma in health-care settings and exclusion from sexual health services all undermine prevention and care. Participants stressed that HIV policy must remain grounded in human rights and must not allow vulnerable communities to be pushed out of the response.

The Roundtable also warned against treating Europe as synonymous with the European Union. Non-EU countries, particularly in eastern Europe and central Asia, continue to face serious gaps in access to PrEP, testing, harm reduction, surveillance and treatment continuity. WHO Europe's regional action plans provide a framework for a wider regional response, but EU leadership remains essential.^[3]



Political Reflections and the Role of Parliamentarians

The final political reflections focused on the need to translate evidence into oversight and funding. Participants acknowledged that despite major scientific advances, implementation still lags behind. Parliamentarians were urged to act as conduits between communities, clinicians, researchers and EU institutions.

There was broad agreement that technical evidence must be accompanied by clear political demands. The Roundtable identified the renewal of an EU HIV and communicable diseases action plan, sustainable community funding, cross-border care continuity, and explicit inclusion of key populations as priority advocacy objectives.

Christoph Boesecke of EACS closed the discussion by recalling that Europe has the tools to achieve the targets, but that responsibility is shared. Communities, clinicians, policymakers, international organisations and industry all have a role in sustaining HIV care and prevention. The meeting concluded with a strong call to maintain pressure and to ensure that HIV remains a visible European public health priority.

Ways Forward

- **Renew and Strengthen EU Leadership on HIV:**

Develop a renewed EU HIV and communicable diseases action plan, building on the 2017 European Parliament resolution, WHO 2022–2030 strategies, the ECDC/EACS standards, and the SDG 3.3 commitment.

- **Protect Continuity of Care Across Borders:**

Create mechanisms for rapid linkage and re-linkage to HIV care when people move, including recognition of prior diagnosis, safe transfer of essential clinical information, multilingual navigation and access pathways for people without documents.

- **Invest in Community-Led and Inclusive Programmes:**

Provide sustainable funding for community-led services, including peer navigation, testing, counselling, harm reduction, psychosocial support, legal orientation and linkage to care.

- **Prepare Now for Ukraine Beyond March 2027:**

Ensure that people living with HIV, people who use drugs and other key populations are not exposed to treatment interruption during any transition out of temporary protection.

- **Scale Up Integrated Prevention, Testing and Care:**

Integrate HIV testing, PrEP, hepatitis testing, STI services, TB screening, HPV and hepatitis B vaccination, and harm reduction where this improves access and outcomes.

- **Combat Stigma Through Policy, Training and Community Leadership:**

Address stigma in healthcare and society, protect trans people and other key populations, include prisons in HIV strategies, and ensure that services are rights-based and free from discrimination.

- **Use the Multiannual Financial Framework Strategically:**

Secure predictable funding for HIV prevention, testing, treatment, community systems, research, health security and cross-border cooperation.



Conclusion

The Roundtable concluded with a clear message: Europe has the tools to end HIV as a public health threat, but only if political will aligns with community leadership, sustained investment and practical mechanisms for continuity of care.

Achieving the 95-95-95 targets requires more than treatment availability. It requires early diagnosis, rapid linkage to care, uninterrupted treatment, stigma-free services, harm reduction, PrEP access, community engagement and systems that work for people whose lives cross borders.

The EU Parliament, the European Commission and Member States were called upon to act now: to protect the gains already made, to restore political visibility, and to ensure that no one is left behind because of migration, displacement, legal status, incarceration, drug use, gender identity, poverty or stigma.

Targets will only be meaningful if they survive borders, status changes and displacement.

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