



HIV
Ireland



FAST-TRACK
CITIES

TOWARDS A NATIONAL ACTION PLAN FOR HIV IN IRELAND

Autumn Conference, Dublin



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BY MAKING HIV TESTING ROUTINE, OPT-OUT TESTING REDUCES THE NEED FOR PATIENTS TO IDENTIFY THEMSELVES AS AT RISK, AND NORMALISES HIV TESTING AS PART OF MAINSTREAM HEALTHCARE.

EXECUTIVE SUMMARY

Ireland has committed to ending new HIV transmissions and HIV-related stigma by 2030. That commitment is reflected in the Paris Declaration, the Programme for Government 2025–2029, and the National Sexual Health Strategy 2025–2035. However, the central conclusion of the Fast Track Cities Dublin Autumn Conference is clear: Ireland will not meet the 2030 target without a fully resourced, stand-alone National HIV Action Plan that moves beyond ambition to funded, measurable, and accountable implementation.

On 29 and 30 September 2025, HIV Ireland, convened the conference *Towards a National Action Plan for HIV in Ireland* in Dublin. The conference brought together clinicians, public health specialists, policymakers, researchers, community organisations, advocates, and people living with HIV to examine what can be learnt from practice in Ireland, England, Wales, Scotland, and Northern Ireland. Across plenary sessions and workshops, participants identified the interventions that work, the gaps that remain, and the actions now required to place Ireland on a credible path to 2030.

A National HIV Action Plan for Ireland should set out what will be done, who will do it, how it will be funded, how progress will be measured, and how communities most affected by HIV will be involved at every stage. It should include named delivery leads, timelines, costs, workforce requirements, equity indicators, and annual public reporting. It should be governed through a national implementation structure involving people living with HIV and impacted communities, the Department of Health, HSE, HPSC, clinical services, public health, primary care, community organisations, researchers, and Fast Track Cities partners.



A key recommendation is the **national roll-out of routine opt-out HIV and blood-borne virus testing** in appropriate emergency department and acute healthcare settings. Evidence from England's Emergency Department Blood-Borne Virus Opt-Out Testing Programme shows the value of this approach. By making HIV testing part of routine blood testing, opt-out testing reduces the need for patients to identify themselves as at risk, reaches people who may not attend sexual health services, and normalises HIV testing as part of mainstream healthcare. For Ireland, opt-out testing should be treated as both a diagnostic intervention and an anti-stigma, health equity measure.

A second recommendation is the urgent and **equitable expansion of Pre-Exposure Prophylaxis (PrEP)**. PrEP access in Ireland remains constrained by waiting lists and regional variation.

Manchester's experience demonstrates the consequences of delayed access: between 2017 and 2019, 1,073 people were on a PrEP waiting list and fifteen acquired HIV during that period. Ireland's PrEP expansion must be designed around equity from the outset, with delivery through specialist, primary care, community, digital, and outreach models. Specific pathways are needed for women, migrants, asylum seekers, trans and non-binary people, people who sell sex, people who inject drugs, communities of colour, people outside major urban centres, and men who have sex with men who do not identify as gay or bisexual.

A third recommendation is the development of a **comprehensive Model of Care for people living with HIV**. This should cover the full pathway from diagnosis to linkage to treatment, access to advances in treatment e.g. long-acting injectables, retention in care, re-engagement, ageing with HIV, mental health, sexual health, reproductive health, migrant health, comorbidities, peer support, and psychosocial care. Clinical excellence is essential, but it is not sufficient. People living with HIV also need support to

live well, manage stigma, navigate services, and address the wider social determinants that shape health.

A fourth recommendation is that **HIV-related stigma must be treated as a measurable barrier to health**. The RISE Project showed significant gaps in HIV stigma training among healthcare workers and students. Public awareness campaigns alone will not solve this. HIV and stigma education should be embedded in undergraduate and postgraduate healthcare training, continuing professional development, clinical practice standards, workplace initiatives, and institutional culture. U=U should be mainstreamed across health and public information settings.

A fifth recommendation is sustained **investment in community and voluntary sector infrastructure**. Community organisations provide testing, prevention, outreach, peer support, psychosocial care, stigma reduction, education, advocacy, and policy innovation. They reach people statutory services often do not. The Action Plan should include multi-annual funding, full cost recovery, core funding, formal referral pathways, and structured involvement of community organisations in governance, delivery, and evaluation.

Finally, **Ireland's HIV response must be explicitly equity driven**. The Action Plan should address migration, structural racism, poverty, housing insecurity, regional inequality, homophobia, transphobia, drug-related stigma, sex work-related stigma and other social determinants affecting HIV prevention and care. Services must be designed around those most likely to be missed by existing systems.

Ireland has the clinical expertise, community infrastructure, research capacity, and international evidence required to end new HIV transmissions and HIV-related stigma by 2030. What is now required is political commitment, sustained investment, expert governance, and disciplined implementation. The goal remains achievable, but only if Ireland now moves from commitment to action.



FOREWORD

by Stephen O'Hare HIV Ireland

Ireland stands at a pivotal moment in its HIV response. We have made considerable progress over recent decades: HIV is now a manageable condition, effective treatment prevents onward transmission, pre and post exposure prophylaxes (PrEP and PEP) offer powerful prevention tools, and community-based testing and peer support are reaching people who might otherwise remain outside traditional services.

Yet progress is not the same as completion. New HIV diagnoses continue, late diagnosis remains a concern, stigma persists, and access to prevention, testing, care, and support remains uneven.

It was in this context that HIV Ireland, in partnership with Fast Track Cities UK & Ireland, convened the Fast Track Cities Dublin Autumn Conference, *Towards a National Action Plan for HIV in Ireland*, in September 2025. The timing of the conference was deliberate and urgent. Ireland has committed to ending new HIV transmissions and HIV-related stigma by 2030. These commitments are welcome and necessary, but they must now be translated into a fully resourced, measurable and accountable National Action Plan for HIV.

These proceedings are more than a record of presentations and discussions. They are intended as a practical contribution to national policy development. They set out evidence, examples of good practice, and recommendations that can help shape a National Action Plan for HIV that is ambitious but deliverable; clinically robust but community-led; national in scope but responsive to local need; and focused not only on preventing transmission, but on improving quality of life and ending stigma.

My hope is that this report will inform and influence the development of Ireland's National Action Plan for HIV and support a renewed partnership between people living with and impacted by HIV, Government, the HSE, clinical services, public health, researchers, and community organisations.

The goal of ending new HIV transmissions and HIV-related stigma by 2030 is achievable. To succeed it will require urgency, investment, leadership, collaboration, and trust. This report is offered in that spirit: as a call to action, and as a contribution to the shared work ahead.

Stephen O'Hare





INTRODUCTION

On 29 and 30 September 2025, HIV Ireland, in partnership with Fast Track Cities (FTC) UK & Ireland, convened the Fast Track Cities Dublin Autumn Conference at the Ashling Hotel, Dublin, under the title *Towards a National Action Plan for HIV in Ireland*. The conference brought together clinicians, community organisations, policymakers, public health leaders, researchers, advocates and colleagues from across Ireland, the UK and the FTC Celtic Nations group to share learning, examine innovation, and consider how evidence-based practice from neighbouring jurisdictions can inform Ireland's next phase of HIV prevention, treatment, care and support.



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The timing of the conference was significant. Ireland has renewed its commitment to ending new HIV transmissions and HIV-related stigma by 2030, including under the Paris Declaration, the Programme for Government 2025–2029, and the National Sexual Health Strategy 2025–2035. Against a backdrop of recent increases in newly notified HIV cases, continuing stigma, and ongoing challenges in access to prevention options such as PrEP, the conference provided an important opportunity to reflect on what is working elsewhere and how those lessons can be translated into an Irish context.

Across the two-day programme, participants explored the practical foundations of a robust and achievable National Action Plan for HIV in Ireland. Sessions focused on action planning and strategy implementation; learning from HIV action plans in England, Scotland and Wales; innovations in prevention including opt-out testing, self-testing, mobile testing and improved access to PrEP; and approaches to tackling HIV-related stigma in health-care, employment and wider society. The conference also placed a strong emphasis on community leadership, the mainstreaming of U=U (Undetectable equals Untransmittable), and the importance of ensuring that people living with HIV are central to policy development and implementation.

These proceedings document the key themes, discussions, and outcomes from the conference. It is intended to capture not only the content of individual sessions, but also the shared ambition that shaped the event: that Ireland can, and must, move decisively towards a coordinated, adequately resourced and measurable National Action Plan for HIV. The contributions gathered here demonstrate the value of collaboration across jurisdictions, the importance of partnership between clinical and community sectors, and the urgency of translating evidence, innovation and lived experience into policy and practice.

The conference made clear that ending new HIV transmissions and HIV-related stigma by 2030 is an achievable goal, but not an inevitable one. Without a change in trajectory and political commitment, sustained investment, data driven planning, community trust and a willingness to adopt proven interventions at scale, Ireland will fail to meet the 2030 target. This report therefore serves both as a record of the conference and as a call to action: to build on the learning shared in Dublin and to ensure that Ireland's National Action Plan for HIV is ambitious, inclusive, practical and fully realisable.





PLENARY SESSION 1

HIV IN IRELAND: A SNAPSHOT



1.1 Introduction

Plenary Session 1 provided the first substantive overview of the conference's central question: what evidence, experience and practical learning should inform the development of a National Action Plan for HIV in Ireland? The session brought together lived experience, national surveillance data, local Fast Track Cities learning, research innovation, and stigma expertise to establish a shared understanding of Ireland's current HIV landscape and the challenges that must be addressed on the road to 2030.

The session took place in the context of Ireland's renewed commitment to ending new HIV transmissions and HIV-related stigma by 2030. The wider conference framing, including the keynote contribution from **Professor Yvonne Gilleece**¹, Consultant in HIV Medicine at University Hospitals Sussex NHS Foundation Trust, underlined that a National HIV Action Plan is necessary not only to sustain progress towards UNAIDS targets, but also to improve quality of life, reduce stigma, expand testing, support PrEP access, and ensure that people living with HIV are central to policy and service design.



Prof Yvonne Gilleece

1.2 Lived experience and the need for person-centred action

The opening contribution from **Rebecca Tallon de Havilland**,² Trans Testing Coordinator at HIV Ireland, offered a personal perspective on Ireland and HIV. This contribution grounded the session in lived experience and reminded participants that the development of a National Action Plan must not be reduced to surveillance trends, service models, or policy commitments alone. It must also reflect the everyday realities of people living with HIV and those most affected by barriers to prevention, testing, care, and support.



Rebecca Tallon de Havilland

By beginning with a personal perspective, the session reinforced a core principle that recurred throughout the conference: effective HIV policy must be shaped by the voices of people with direct experience of HIV, stigma, healthcare access, community testing, and peer support. The inclusion of lived experience at the outset provided an important counterbalance to the data-led presentations that followed, ensuring that statistics were understood not as abstract indicators but as measures connected to people's lives, choices, and wellbeing.



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1.3 National data: Current trends in HIV and BBVs

Stephen O'Hare,³ Executive Director, HIV Ireland, presented a data-focused overview of current trends in HIV and blood-borne viruses in Ireland. Drawing on provisional Health Protection Surveillance Centre data for weeks 1–35 of 2025, the presentation noted 545 HIV notifications compared with 704 notifications over the same period in 2024, representing a decrease of 22.6%. However, the presentation cautioned against interpreting this reduction as a straightforward fall in incidence, noting that changes in testing behaviour, reporting delays, access to testing, and testing strategy may all influence notification patterns.

The data also highlighted important regional and demographic patterns. Notifications were concentrated in the Dublin and North-East and Dublin and Midlands HSE regions, with 186 and 164 cases, respectively. Of the 545 notifications, 386 were among males and 159 among females, with the largest numbers occurring among adults aged 30–44. These figures underscored the need for both national coordination and regionally responsive interventions, particularly where notification patterns point to concentrated need or service pressure.

The presentation also situated HIV trends within a wider sexual health and BBV context. Comparative data showed decreases in chlamydia, gonorrhoea, and early infectious syphilis notifications in 2025 compared with 2024, while Mpox notifications increased from 6 to 46 over the same comparative period. This reinforced the importance of integrated surveillance and prevention approaches, particularly where overlapping risk contexts, testing pathways, and community engagement strategies may apply across HIV, STIs, Mpox and viral hepatitis.

A key distinction in the data was between first-time diagnoses and previous diagnoses. The most recently available full-year HPSC data for 2023 recorded 911 total HIV diagnoses, of which 61% were among people previously diagnosed outside Ireland, 19% were first-time diagnoses, and 20% were of unknown previous diagnosis status. Among first-time diagnoses, the presentation noted continuing concerns about late diagnosis, with 39% diagnosed late, alongside evidence of a declining trend in first-time diagnoses among gay, bisexual, and other men who have sex with men since 2015.

The implication for a National Action Plan is clear: Ireland requires a more nuanced response than headline notification figures alone can provide. Prevention policy must distinguish between new transmissions in Ireland, people already diagnosed abroad and now accessing care in Ireland, late presenters, underserved populations, and those who remain outside regular testing pathways. The data presented in this session therefore supported the case for stronger surveillance, better use of disaggregated data, and targeted interventions informed by both epidemiological trends and community experience.





1.4 Using data to inform local action: Learning from Cork and the South-West

The next contribution, delivered by **Tara Russell**⁴ of Cork Sexual Health Centre, **Alma Bermueller**⁵ of Department of Public Health and **Andrew Conroy**⁶ of Cork University Hospital, explored how locally available data can be used to inform practical action. The presentation focused on Fast Track South-West and Cork's experience since signing on to Fast Track Cities in 2019. Although the initial period was disrupted by COVID-19 and other constraints, local partners used the time to gather information, participate in national assessment and clinical audit processes, and learn from UK and international Fast Track Cities networks.

The presentation showed the value of examining local HIV trends in detail. A review of notifications in Cork and Kerry between 2012 and 2022 found a significant increase in HIV notifications in 2022, particularly among people aged 30–44 and among females. However, the review also found that the majority of those notified had been previously diagnosed and were already on antiretroviral treatment. On this basis, the presenters suggested that community transmission within Cork and Kerry was likely to be decreasing, even while service demand was increasing.

This finding is highly relevant to national planning. It demonstrates that increases in notifications may reflect changing migration patterns, changing service needs, and improved engagement with care, rather than increased local transmission alone. The presentation noted that many migrants arriving in Ireland with HIV already know their status and are on treatment. This creates both an opportunity and a responsibility: services must be equipped to provide accessible, culturally competent and appropriate, and continuous HIV care, while prevention programmes continue to focus on reducing undiagnosed infection and onward transmission.

The example also demonstrated how data can move from analysis to action. Local partners used evidence and consultation to support continued community-based programming, identify new venues for testing and outreach, and adapt information for wider language accessibility. Proposed or emerging actions included broader community testing, outreach in English language centres and regional locations, engagement in Cork Prison and night-time venues, public conversation initiatives such as “A Week of Pride in Sexual Health,” and peer-led workplace allyship training.

The presentation further highlighted the importance of patient experience as a data source. Cork University Hospital developed a new routine feedback survey for HIV clinical care, adapted from the HSE Inpatient Patient Experience Survey and informed by BHIVA (British HIV



Tara Russell



Alma Bermueller



Andrew Conroy



Association) guidelines, peer advocates, and community support workers. This approach was designed to allow comparison with broader health service indicators while also capturing issues specific to HIV care.

A further innovation was the development of a Power BI HIV dashboard by the Department of Public Health to support routine local data sharing with Fast Track Cities partners. The presentation noted that the proportion of people living with HIV in Cork North/South Lee had reduced from 77.4% in 2012–2015 to 58.0% in 2022, suggesting that more people accessing HIV care were living further from the main clinic. This type of information is important for planning outreach, transport-sensitive service models, regional access, and future resource allocation.

The case study offered a practical model for the National Action Plan: start with available data, enrich it through community consultation, take proportionate action within existing resources, and build the evidence base for more ambitious interventions. It also identified an important unresolved challenge: the need for community-informed agreement on how to measure progress towards “zero stigma.”



1.5 Research, innovation and patient participation

Professor Eoin Feeney,⁷ Consultant in Infectious Diseases at St Vincent's University Hospital addressed the role of research, innovation and patient engagement in HIV policy and practice. His presentation described CEPHR (Centre for Experimental Pathogen Host Research) as a platform for clinical, translational, statistical, and bio-medical research, with HIV remaining a core area of activity.

The presentation highlighted the All-Ireland Infectious Diseases cohort and biobank as a core research infrastructure, supporting the use of routine data and biological samples for infectious disease research. It also described the Infectious Diseases Clinical Trial Network Ireland (IDCTNI), funded by the Health Research Board, which aims to strengthen clinical trial infrastructure across six clinical sites, including St Vincent's University Hospital, the Mater Misericordiae University Hospital, St James's Hospital, Beaumont Hospital, Cork University Hospital and University Hospital Galway, with HIV Ireland as an additional collaborator.

A central message of the presentation was that public and patient involvement is not an optional add-on to HIV research. Examples included HIV Ireland's collaboration with CEPHR and ID-CTNI, PPI representation in studies such as SWIFT (Supporting Women with HIV Forum & Information), and community advisory structures in international Mpox vaccine research. The presentation argued that Ireland has the capacity to be at the forefront of patient-centred research in HIV and infectious diseases, supported by a population willing to contribute knowledge, lived experience, time, and samples to research.

For the National Action Plan, this contribution pointed to the need to embed research from the outset. Research infrastructure, community participation, clinical trials, biobanking, behavioural data, and implementation science can all help ensure that policy is evidence-led, responsive, and capable of adaptation over time. The session also made clear that Irish research can have significance beyond Ireland, contributing to European and global evidence on HIV, Mpox and other infectious diseases.

1.6 Internal stigma as a hidden barrier to health

The final presentation in the plenary was by **Deirdre Ní Cheallaigh**,⁸ Head of Programmes at Beyond Stigma, on internal stigma and HIV. It described internal stigma as a hidden barrier to health and framed it as a human rights issue: people may be eligible for care, treatment and support, but still not access those rights if they feel shame, guilt, self-loathing, contamination, low self-worth or fear of rejection.

The presentation defined internal stigma as a mindset of negative beliefs, thoughts and behaviours about HIV that can manifest in shame, guilt, self-rejection, and low self-esteem. It distinguished between stigma as thought, discrimination as action, and internal stigma as the process by which negative beliefs are turned inward. It also noted that a person can experience internal stigma even where external rejection is absent.

This contribution was particularly important because it challenged the conference to think beyond service availability alone. Internal stigma can affect whether people seek testing, remain engaged in care, disclose their status, adhere to treatment, pursue education or employment opportunities, and maintain mental wellbeing. The presentation identified links with depression, reduced quality of life, lower self-efficacy, anger, resentment, and withdrawal from services. The session overview identified stigma as one of the central challenges facing HIV policy in Ireland, particularly for groups who may be underrepresented in prevention and care efforts, including transgender people, migrants, sex workers, and people who use drugs. It also stressed the need to address stigma at individual, community, and structural levels.

The presentation concluded by identifying opportunities for leadership, collaboration, and practical action. The key message for a National Action Plan is that Ireland cannot meet its HIV prevention, treatment, or quality-of-life goals unless internal stigma is recognised, measured, and addressed. A credible plan must therefore include anti-stigma work not only in public awareness campaigns, but also in healthcare settings, peer support, community development, workplace inclusion, and the design of services.





TOWARDS A HIV ACTION PLAN FOR IRELAND

The opening plenary session established the evidence base and human context for the conference. It showed that Ireland has made progress in HIV care, prevention, and community partnership, but that this progress remains uneven and incomplete. The session identified several priorities for the development of a National Action Plan: earlier diagnosis; stronger and more accessible testing pathways; improved use of national and local data; regionally responsive service planning; better support for migrants and people previously diagnosed outside Ireland; meaningful patient and public involvement in research; and a direct, measurable response to HIV-related stigma.

The session also highlighted a recurring theme that would inform the wider conference: Ireland does not need to start from nothing. Existing evidence, Fast Track Cities learning, community-led practice, local data initiatives, research infrastructure, and international experience all provide a solid foundation. The task now is to connect these elements through a coordinated, funded, and accountable National Action Plan capable of delivering real change by 2030 and beyond.

In summary, Plenary Session 1 provided a clear snapshot of HIV in Ireland at a pivotal moment. It demonstrated the need for urgency, but also for precision i.e. understanding who is being diagnosed, where services are under pressure, where transmission may be changing, how stigma continues to operate, and how research and community participation can strengthen national policy. The session set the tone for the conference by making clear that a successful National Action Plan must be evidence-informed, community-centred, stigma-conscious, and capable of translating ambition into action.



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WORKSHOP 1

EQUITY AND WELLBEING IN HIV CARE

This workshop explored equity and wellbeing in HIV care, focusing on internal stigma, access to prevention through primary care, and experiences of community-based HIV testing. The discussion emphasised that effective HIV care must extend beyond clinical treatment to include psychosocial support, stigma reduction, peer leadership, and practical interventions that enable people to access prevention, testing, treatment, and care in safe, inclusive, and responsive settings.

Deirdre Ní Cheallaigh,⁹ Beyond Stigma, presented the Wakakosha case study, a peer-led intervention developed in Zimbabwe to address self-stigma among young people living with HIV. Using inquiry-based stress reduction, creativity and mindfulness, the programme supports self-worth, body positivity, improved relationships, and greater confidence.

Its emphasis on peer leadership and emotional wellbeing offers important learning for Ireland, particularly for young people, people newly diagnosed with HIV, and communities experiencing internalised stigma.



Dr Daniela Brawley,¹⁰ NHS Grampian in Scotland, discussed expanding PrEP access through primary care, highlighting the need for inclusive and community-based delivery models. The discussion reflected a wider conference theme: PrEP must move beyond specialist sexual health settings if it is to reach all those who could benefit.

Primary care, community services, outreach settings, and trusted local providers all have a role in normalising HIV prevention and reducing barriers to access.



Stephen O'Hare,¹¹ HIV Ireland, presented findings from HIV Ireland's MPOWER programme, including rapid testing, peer-led outreach, and self-testing initiatives. In 2024, more than 2,400 self-tests were distributed, with strong uptake and satisfaction among gay, bisexual, and other men who have sex with men and Latin American communities.

Ongoing challenges included limited responses to some outreach activity, the need for sustained resourcing, and capacity constraints in supporting chemsex-related needs.



The workshop concluded that equity and wellbeing must be central to Ireland's National HIV Action Plan. Stigma reduction, peer support, accessible prevention, expanded testing venues, and age-appropriate support for young people transitioning to adult services should be embedded as essential components of Ireland's pathway to 2030.



PLENARY SESSION 2

PLANNING FOR 2030: FROM STRATEGY TO SUCCESS



2.1 Introduction

Plenary Session 2 opened the second day of the conference and shifted the focus from understanding Ireland's HIV landscape to examining how national ambition can be translated into practical, funded, and accountable implementation.



Robbie Currie

The session chaired by **Robbie Currie**,¹² Executive Director of the National AIDS Trust, brought together perspectives from Ireland, England, London and Sussex to consider what Ireland can learn from jurisdictions already working through formal HIV action plans, Fast Track Cities structures, PrEP expansion models and integrated approaches to prevention, care and stigma reduction.

The session was particularly relevant to Ireland's emerging policy context. Ireland's National Sexual Health Strategy 2025–2035 includes a renewed commitment to eliminating new HIV transmissions by 2030 and provides an important foundation for a stand-alone National HIV Action Plan.

Plenary Session 2 explored what such a plan must contain if it is to move beyond aspiration: clear targets, measurable actions, investment, governance, community partnership, service innovation, and a strong equity focus.





2.2 Focus on HIV: National Sexual Health Strategy 2025-2035 priorities

Stephen O'Hare, Executive Director of HIV Ireland, delivered the opening presentation of Session 2¹³ and focused on HIV priorities in Ireland's National Sexual Health Strategy 2025–2035. The presentation situated HIV as a continuing public health priority in Ireland, noting first-time diagnoses, late presentation, the specific epidemiology of HIV as it pertained to vulnerable groups in Ireland, and the national goal of eliminating new transmissions by 2030.

The presentation identified several strategic commitments that should form the backbone of Ireland's HIV response. These included the development of a stand-alone HIV elimination plan, a comprehensive Model of Care for people living with HIV, updated standards, guidelines and KPIs, expanded access to PrEP and improved delivery models, stronger surveillance and monitoring, and a direct outcome-led response to HIV-related stigma.

Five priority areas were outlined.

1. Ireland must expand HIV prevention, including scaling up PrEP access, reducing waiting lists, widening delivery through primary care and digital models, exploring long-acting PrEP medication options, enhancing outreach and self-testing, and strengthening linkage-to-care pathways.
2. Ireland must improve diagnosis and linkage to care by reducing late diagnosis, ensuring rapid connection to care after diagnosis, and monitoring time from diagnosis to treatment as a key performance indicator.
3. A comprehensive Model of Care must be developed, supported by updated clinical standards, multi-disciplinary practice, workforce planning, and proper resourcing.
4. Surveillance and research must be strengthened through better data collection, disaggregation by key population, routine monitoring of outcome indicators, and the establishment of feedback loops that allow policy to adapt to emerging evidence.
5. Stigma, equity and social determinants must be addressed through public campaigns, community empowerment, and specific attention to migrants, underserved regions, access to housing, the impact of poverty, and mental health.

The central message for Ireland was that the National Sexual Health Strategy provides an enabling framework, but implementation will depend on whether the HIV commitments are resourced and operationalised. The proposed next steps included resourcing the HIV elimination plan for 2025–2030, accelerating PrEP expansion, establishing monitoring frameworks, engaging marginalised communities, and conducting annual progress reviews.



Ministers for Health publish the National Sexual Health Strategy, 2025-2035





2.3 England's HIV Action Plan: Prioritisation for impact

Professor **Kevin Fenton**,¹⁴ Director of the Office of Inequalities and Disparities, presented to the conference on the HIV Action Plan in England 2025–2030 and the importance of prioritisation for impact. His presentation described England's commitment, first made in 2019, to end new HIV transmissions, AIDS diagnoses, and HIV-related deaths by 2030. The 2021 HIV Action Plan set an interim ambition of reducing new HIV infections in England by 80% by 2025, alongside reductions in AIDS diagnoses and HIV-related deaths.

The English plan was structured around four core objectives: equitable access to prevention, scaling up testing, optimising rapid access to treatment and retention in care, and improving quality of life while addressing stigma. Professor Fenton identified several strengths of the first phase of the plan: clear numerical targets, strong surveillance and published monitoring, national leadership, cross-system collaboration, and investment in evidence-based interventions such as emergency department opt-out testing, national prevention programming, and routinely available PrEP.

However, the presentation also stressed that England's epidemic is changing. Total HIV diagnoses rose in 2023 compared with 2022; inequalities widened among heterosexual populations, women, and some ethnic minority communities; late diagnoses increased, particularly among Black African populations; and a growing proportion of diagnoses were among people previously diagnosed abroad. Professor Fenton also noted that significant numbers of



people were not linked to care, retained in care, or virally suppressed, reinforcing the need to strengthen the full HIV care pathway rather than focusing only on diagnosis.

The implications for Ireland are highly relevant. As HIV incidence declines in some populations, new infections may become increasingly concentrated among people with poorer access to services, marginalised communities, and groups affected by wider social determinants. This requires a shift from broad, generalised approaches to more targeted, culturally competent, community-centred, and participatory interventions. It also requires surveillance systems capable of identifying outbreaks, changing transmission patterns and new populations at risk.

Professor Fenton's presentation also highlighted the governance challenges that can arise even where a national plan exists. Stakeholders in England identified insufficient progress outside emergency department opt-out testing, including PrEP provision beyond sexual health clinics, retention, and re-engagement in care, testing in primary care and secure settings, HIV stigma among healthcare workers and the public, and partner notification. Questions of local and regional accountability were also raised.

For Ireland, the lesson is that a National HIV Action Plan must not only set out ambitions; it must specify who is responsible for delivery, at what level, with what resources, and against what measures. Collaboration, Professor Fenton stressed, must be structured, not assumed. Community involvement, local ownership, data infrastructure, regulation, policy alignment, and branding around the 2030 goal all emerged as important considerations.





2.4 London's Fast Track Cities experience: Getting to Zero

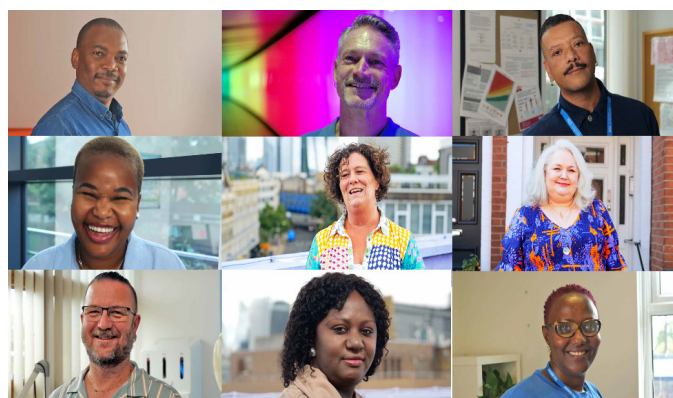
Professor Jane Anderson,¹⁵ Co-Chair of Fast Track Cities London, presented London's experience under the theme *Getting to Zero*. London's context is complex: an estimated 37,300 Londoners live with HIV, representing around 40% of people living with diagnosed HIV in England. The city's response involves multiple layers of governance and delivery, including local boroughs, acute hospitals, HIV clinical centres, voluntary organisations, primary care providers, Integrated Care Boards, community trusts, NHS England, London Councils, UK Health Security Agency (UKHSA), Office for Health Improvement and Disparities (OHID) and the Mayor of London.

The London experience demonstrated the value of partnership infrastructure. Through the *Delivering Together* programme, community organisations, the NHS and other partners tested novel approaches to HIV challenges across the city. The programme involved voluntary sector leadership, funding over three years, increased testing, psychosocial support and stronger links between clinics and peer support.

A major theme of the London presentation was stigma and quality of life. The programme included background research, empowerment work, an HIV Ambassadors Programme, and the HIV Confident Charter Mark. The *Getting to Zero* Collaborative also embedded advice, support, re-engagement in care and peer support across London clinics, with services addressing psychological support, welfare benefits, housing, chemsex support, nutrition, mentor mother support, and migrant community engagement.

This model is significant for Ireland because it demonstrates how HIV care can be expanded beyond a narrow biomedical frame. London's approach recognises that retention in care, viral suppression and quality of life is shaped by housing, immigration status, poverty, welfare access, mental health, drug and alcohol use, stigma, and isolation. The integration of voluntary sector services into primary and secondary care through peer support and social prescribing offers a practical example of how a National Action Plan can address the social determinants of HIV outcomes.

Professor Anderson also described London's investment in HIV GP Champions, designed to strengthen links between primary and secondary care, increase testing, improve engagement in care, explore PrEP access, and support a long-term condition model for HIV. The pilot involved 16 GP champions and was associated with a 25–30% increase in HIV testing across the region, as well



as improved holistic care indicators such as increased statin prescribing for people living with HIV aged over forty.

London's next phase includes continued commitment to Fast Track Cities London, STG£1.25 million in funding from London Integrated Care Boards for 2025–2028, an active programme board, programme evaluation through 2026/27, additional partnership investment, and alignment with the national HIV Action Plan. For Ireland, the London example shows that Fast Track Cities can operate as both a political commitment and a practical delivery mechanism when supported by funding, partnership structures, and evaluation.



2.5 PrEP lessons from the UK: PrEP eMERGE and wider access models

The final presentation was delivered by **Professor Yvonne Gilleece**,¹⁶ who focused on PrEP lessons from the UK, including the PrEP eMERGE model. The presentation traced the development of PrEP evidence and implementation in the UK, including the PROUD study, which demonstrated an 86% reduction in HIV transmission, and the PrEP Impact Trial, designed to inform the costs and delivery of PrEP within specialist sexual health services.

Professor Gilleece also highlighted the role of Brighton as the first UK Fast Track City in 2017, where clear time-bound targets, opt-out HIV testing, funded emergency department testing, mandatory healthcare staff training, and the treatment of late diagnoses as serious incidents contributed to a focused city-wide response. This provided the foundation for later innovations in PrEP delivery and digital care.

The PrEP eMERGE model built on the wider EmERGE mHealth platform, which was co-developed with community involvement and designed to reduce unnecessary face-to-face appointments while maintaining quality of care. The PrEP eMERGE pathway is an integrated digital pathway for PrEP, co-designed by community and clinical partners, piloted in 2020, and fully implemented in April 2021. Its features include access to results, medication tracking and reminders, appointment details, clinic notifications, two-way messaging, health promotion information, and integration with the clinic electronic health record.

By May 2025, 811 of 2,968 PrEP users in Brighton and Hove were using the PrEP eMERGE app, representing 27% of PrEP users. The pathway has reduced clinic visits, enabled postal STI screening every six months, and helped manage clinic capacity. The evaluation found that 233 users completed a satisfaction survey, with 87% saying they would recommend the app pathway to a friend. However, the evaluation also showed that digital delivery should not be assumed to replace in-person care: 96% of respondents wanted to visit the clinic for some or all their PrEP pathway and routine testing.

Lessons for Ireland include the impact of digital models which can increase efficiency, reduce unnecessary appointments, and support self-management. In her evaluation, Professor Gilleece cautioned that such models must also be designed around user preference, clinical need, and equity. Some users require additional monitoring, adherence support, or face-to-face engagement. Home sampling also presents practical barriers, including difficulty with blood collection, forgetfulness, and preference for in-clinic testing.

The presentation also described outreach and alternative access models, including the THT PrEP2U model, PrEP



provision in nightclub settings, delivery through services for trans and non-binary people, and outreach nurse teams supporting vulnerable patients in homes and community settings. These examples reinforce the principle that PrEP access must extend beyond traditional clinic-based models if underserved populations are to be reached.

Professor Gilleece also presented emerging UK PrEP pilots supported by the Elton John AIDS Foundation. The ExPAND-NEL pilot, launched in May 2025, aims to expand PrEP access across eight North East London local authorities through digital and non-specialist settings, community engagement, and evaluation. A further bundled pathways project in Liverpool, West Sussex and Brighton and Hove focuses on integrating PrEP into women's health hubs, asylum, refugee and migrant health pathways, clinic-based digital pathways, and wider sexual health service adaptations.

The use of "PrEP to Need" ratios in these projects highlighted significant inequities in PrEP access, particularly for women and non-UK-born populations compared with gay, bisexual, and other men who have sex with men. For Ireland, this is a critical planning lesson: expanding PrEP is not only about increasing overall numbers but ensuring that provision matches epidemiological need and reaches groups currently underserved by existing pathways.



TOWARDS A HIV ACTION PLAN FOR IRELAND

Plenary Session 2 provided a clear set of implementation lessons for Ireland. First, Ireland's National HIV Action Plan should be built around explicit targets, measurable outcomes, and annual review. England's experience demonstrates the value of numerical targets and structured monitoring but also shows that targets alone are insufficient unless supported by delivery mechanisms, accountability, and investment.

Second, prevention must be equitable. PrEP expansion should include clinic-based, digital, primary care, community, and outreach models, with specific pathways for women, migrants, asylum seekers, transgender people, people who experience stigma in clinical settings, and those who may not identify themselves as PrEP candidates. The experience in Brighton & Hove suggests that digital pathways can release capacity, but community-based and face-to-face options remain essential.

Third, Ireland must strengthen the whole HIV care pathway. Testing, diagnosis, linkage to care, retention, viral suppression, quality of life, and stigma reduction should be treated as connected elements of one system. A National Action Plan should therefore include indicators not only for new diagnoses or PrEP uptake, but also for time to treatment, retention in care, re-engagement, patient experience, and stigma.

Fourth, Fast Track Cities structures can provide a practical platform for implementation. London's experience shows how city-wide collaboration can connect political leadership, statutory services, voluntary organisations, clinical care, peer support, and quality improvement. For Ireland, Fast Track Cities can help translate national goals into local action, provided roles, funding, and governance are clear.

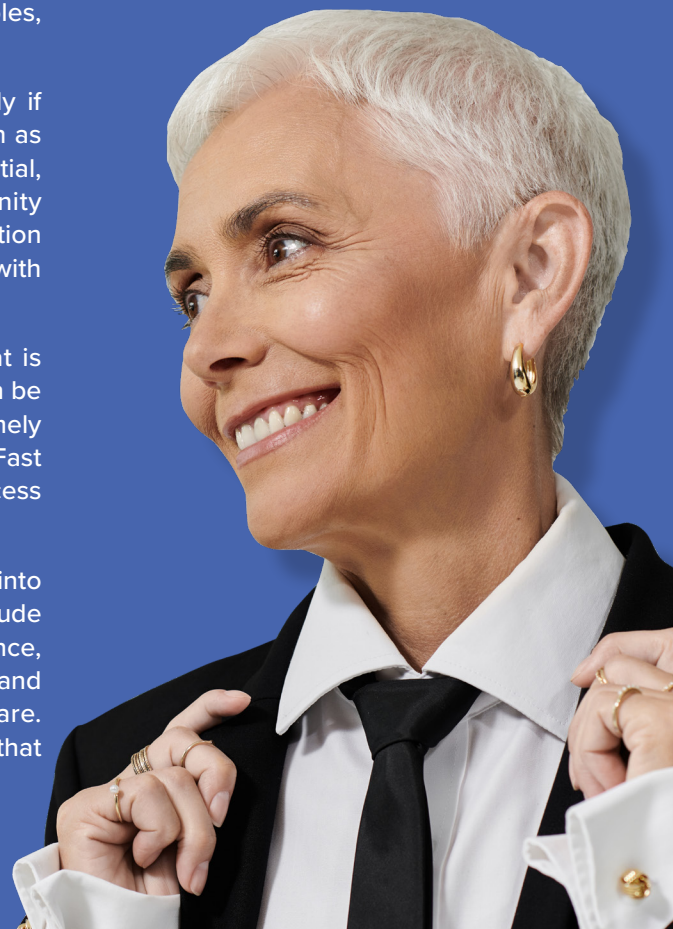
Finally, the session made clear that the 2030 goal is achievable only if HIV is treated as both a clinical and social issue. Biomedical tools such as PrEP, treatment as prevention, testing and viral suppression are essential, but their impact depends on access, trust, stigma reduction, community leadership, and attention to social determinants. The National HIV Action Plan must therefore be ambitious, practical, and rooted in partnership with people living with and affected by HIV.

Plenary Session 2 moved the conference from the question of what is happening in Ireland's HIV response to the question of how change can be delivered. The presentations collectively showed that Ireland has a timely opportunity to learn from England's national action planning, London's Fast Track Cities infrastructure, and Brighton/Sussex innovations in PrEP access and digital care.

The session's central message was that strategy must be converted into implementation. A successful Irish National HIV Action Plan should include clear targets, funded actions, accountability structures, strong surveillance, annual review, meaningful community involvement, expanded PrEP and testing pathways, stigma reduction, and a comprehensive Model of Care. It should also anticipate inequalities rather than react to them, ensuring that services are designed for those least well served by existing systems.



**A SUCCESSFUL
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WORKSHOP 2

BUILDING SUPPORTIVE COMMUNITIES ACROSS THE HIV JOURNEY

Workshop 2 focused on community-building, peer support, and culturally responsive outreach across the HIV journey. The discussion emphasised that HIV services are most effective when they are rooted in trust, sustained relationships, and a strong understanding of the communities they seek to serve.

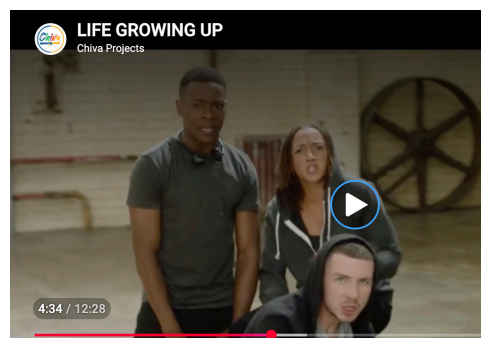
Dr Erin Nugent,¹⁷ HIV Ireland, shared a 20-year account of street outreach and migrant engagement in Dublin, tracing the development of community-based HIV and STI testing from early outreach work to structured service delivery. Initial engagement identified significant demand among migrant communities, leading to pilot testing sessions in which 73% of participants were migrants. By 2019, 568 service users had accessed the programme, 62% of whom were migrants, with 39% attending through word of mouth.

This demonstrated both the need for accessible community testing and the value of trust-based referral within communities. A volunteer-led model was subsequently developed through focus groups, training, and action research.



Ashling McCormack,¹⁸ AIDS Care Education and Training (ACET Ireland) presented the *Positive Youth Project*, which supports young people growing up with HIV in Ireland. The presentation identified key challenges, including the Dublin-centric nature of children's HIV care, limited age-appropriate peer support, and gaps in transition from paediatric or youth services to adult HIV care.

Recommendations included building trust with young people, providing targeted support during the late teenage years, improving transition planning, and increasing sectoral awareness of young people's needs.



Darren Knight,¹⁹ George House Trust, shared learning from Manchester's *Living Well with HIV* project, emphasising holistic care, peer support, and the importance of addressing wellbeing alongside clinical outcomes.

His contribution reinforced the wider workshop theme that people living with HIV need services that support quality of life, connection, confidence, and long-term engagement in care.



The workshop concluded that Ireland's National HIV Action Plan should invest in community infrastructure, inclusive testing, youth-focused services, peer support, and partnerships with migrant-run businesses, local organisations, and trusted community networks.



Tara Russell, Sexual Health Centre Cork; Verena Tarpey, GOSHH; Joe McDonagh, Sexual Health West; with Youssef Youssef and Helen O'Dwyer, ViiV x GSK, Stephen O'Hare, HIV Ireland.



Why are we here?

- A National HIV Action Plan is key to achieving the goal of eliminating new transmissions by 2030 and to support the estimated 10,000 people living with HIV in Ireland.
 - Showing Collaboration: Involvement of all stakeholders
 - Ireland has shown it can make significant progress in HIV care, testing and prevention
 - Sexual Health Strategy has been published
 - There is a commitment in the Programme for Government for such a plan
 - Acceleration of this momentum is essential
- In 2021, the HIV Action Plan was launched to ensure UNAIDS 95-95-95 commitment to be achieved but also to:
 - Reduce HIV incidence across through education, expanded PrEP testing and PrEP provision
 - Find those individuals living with undiagnosed HIV
 - Reduce HIV transmission through effective treatment of individuals identified as living with HIV
 - Reduce HIV related illness and death
 - Improve QoL and reduce stigma
 - Our next testing drive led to over 1,400 new HIV diagnoses in the UK
 - 42 EU in the England new funding to allow opt-out ED testing



Mark Lewis,
Conference Rapporteur

PLENARY SESSION 3

INNOVATION AND COLLABORATION

3.1 Introduction

Plenary Session 3 explored how practical innovation, cross-sector partnership, and targeted implementation can accelerate progress towards ending new HIV transmissions and HIV-related stigma.

Chaired by **Dr Aoife Cotter**,²⁰ Consultant in Infectious Diseases at the Mater Misericordiae University Hospital, Dublin, the session brought together perspectives from NHS England, emergency medicine, PrEP delivery, medical education, and health economics. Across the presentations, a consistent message emerged: Ireland's National HIV Action Plan must be ambitious, but it must also be operational, equitable, and capable of reaching people who are not well served by traditional models of care.



The session focused on interventions that are already changing practice across neighbouring jurisdictions, including emergency department opt-out testing, targeted PrEP delivery, online and outreach models, institutional stigma education, and economic evidence on the consequences of delayed action.

The session overview emphasised that progress remains possible, but only through decisive action, inclusive strategies, and sustained investment in prevention, education, and care.





3.2 Emergency department BBV opt-out testing: Normalising access and finding undiagnosed infection

The first presentation, delivered by **Ian Jackson**,²¹ Director for Specialised Commissioning at NHS London, focused on the NHS Emergency Department Blood-Borne Virus Opt-Out Testing Programme.



The programme was launched in April 2022 and aligns with the ambition to eliminate HIV, hepatitis B, and hepatitis C as public health threats by 2030. Its central principle is simple but transformative: where blood is already being taken in emergency departments, testing for HIV, hepatitis B, and hepatitis C can be normalised as part of routine care.

The scale of the programme is significant. It began in 34 high-prevalence emergency departments and had expanded to 79 live sites, with a further 11 sites in development. Between April 2022 and June 2025, the programme reported more than 10.6 million tests across HIV, hepatitis B, and hepatitis C. These included 3,977,365 HIV tests, 3,104,758 hepatitis B surface antigen tests, and 3,522,857 hepatitis C antibody/RNA-related tests. Across all three infections, the programme identified 10,354 new diagnoses, 2,984 people previously diagnosed but not in care, and 26,140 people previously diagnosed and already in care.

For HIV specifically, the programme reported 1,401 new HIV diagnoses, 835 people previously diagnosed but not in care, and 18,443 people previously diagnosed and in care. These figures demonstrate the dual value of opt-out testing: it identifies people who are undiagnosed, and it also helps reconnect people who have fallen out of care. The presentation noted that data are drawn from the NHS England ED BBV opt-out testing dashboard, are aggregate rather than patient-linked, are not routinely deduplicated, and remain subject to verification.

The programme's success was attributed not merely to the testing model itself, but to collaborative governance involving integrated care systems, NHS trusts, community organisations, and clinical teams.

The presentation highlighted strong clinical and non-clinical buy-in, high uptake rates, cost-effectiveness, and



the spread of innovation between sites. However, it also identified areas requiring further work, particularly the need to strengthen hepatitis B pathways so that linkage to treatment matches the success achieved in HIV.

A particularly important theme for Ireland was the role of opt-out testing in reducing stigma and health inequalities. Emergency departments reach people who may not attend sexual health clinics, primary care, or community testing services.

By normalising BBV testing, the programme reduces the need for individuals to identify themselves as “at risk” before being offered a test. This can help identify infections among people without typical risk markers and among underserved communities who face stigma, language barriers, unstable housing, migration-related barriers, or poor access to routine healthcare.

For an Irish National HIV Action Plan, the implications are clear: opt-out testing should be considered not simply as a testing intervention, but as a mainstreaming, anti-stigma, and health equity measure.

The experience from England suggests that implementation requires clear guidance, funding, care pathways, monitoring systems, and collaboration between hospitals, public health, laboratories, community organisations, and specialist services.





3.3 Implementing opt-out testing in Newham: Public health in practice in emergency medicine

Dr **Emma Young**,²² Consultant in Emergency Medicine at Newham Hospital, provided a frontline clinical perspective on implementing opt-out BBV testing in an emergency department. Her presentation grounded the programme in everyday emergency care, describing the reality of crowded departments, undifferentiated patients, and missed opportunities for diagnosis.



A central case example described an older Portuguese-speaking woman, originally from Brazil, who had attended emergency and urgent care services several times with non-specific symptoms before HIV was detected through routine emergency department blood testing. She was subsequently linked to treatment and achieved an undetectable viral load.

The example illustrated how people may live with undiagnosed HIV for many years and may not be diagnosed through conventional sexual health routes, particularly where they are not perceived, by themselves or others, as being at risk.

Dr Young addressed common concerns raised during implementation, including workload, consent, pre-test counselling, and follow-up. Her argument was that emergency departments are precisely the right place for this intervention because they see people who may not access healthcare elsewhere, and because blood tests are already being taken as part of routine care. In this framing, opt-out BBV testing is not an additional burden disconnected from emergency medicine, it is public health in practice.

The presentation also highlighted why the timing of this intervention matters. COVID-19 exposed health inequalities and helped normalise broader infectious disease testing. The experience of pandemic-era testing helped challenge assumptions about HIV exceptionalism and pre-test counselling, creating conditions in which routine BBV testing could be better understood as a practical, ethical, and life-saving intervention.

For Ireland, the Newham Hospital experience reinforces that implementation will need clinical leadership, practical workflow design, and clear follow-up arrangements. It also suggests that resistance can be addressed by demonstrating that opt-out testing saves lives, prevents onward transmission, and reaches people who would otherwise remain undiagnosed until serious illness occurs.





3.4 PrEP delivery and equity: The Manchester experience

The third presentation, delivered by **Dr Orla McQuillan**,²³ Consultant Physician in Genitourinary Medicine at Manchester University NHS Foundation Trust, examined the Manchester experience of PrEP delivery. Manchester's context is one of high HIV diagnosed prevalence, with Manchester itself recorded at 6.20 per 1,000 population aged 15–59, and several Greater Manchester areas above or near high-prevalence thresholds.



The presentation demonstrated both the effectiveness and the limitations of PrEP scale-up. Between 2017 and 2019, Manchester had 1,073 people on a waiting list for PrEP, during which 15 people acquired HIV. The estimated cost associated with these preventable infections was presented as STG£5.412 million, underscoring the human and financial consequences of delayed PrEP access.

In 2024, Greater Manchester recorded 11,800 people eligible for PrEP, of whom 8,300 received PrEP. However, the distribution of PrEP use showed clear inequity: 97% of those eligible were men and 3% women, while 98.5% of those who received PrEP were men and only 1.5% were women.

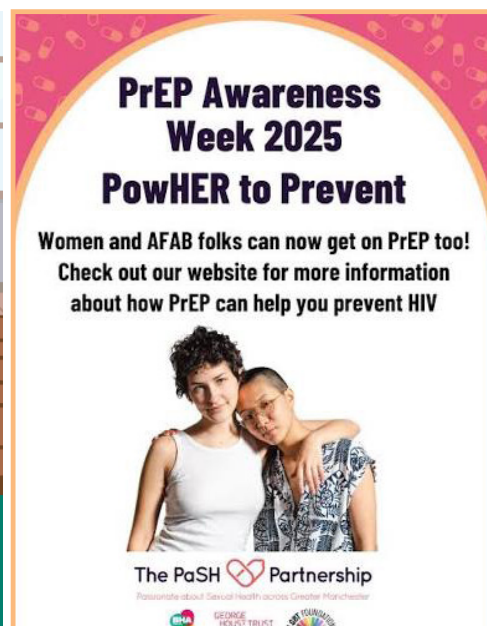
The presentation identified several underrepresented groups, including Black African and Black Caribbean communities, queer communities of colour, migrant communities, transgender and non-binary people, people who inject drugs, people who sell sex, young gay and bisexual men, heterosexual women at risk of HIV, and men who have sex with men who do not identify as gay or bisexual.

Manchester's response has included targeted interventions in partnership with community organisations and non-traditional settings. These included work with MASH, who work with women who sell sex, Black Health Agency for Equality to increase PrEP use among women and heterosexual men, outreach in venues such as G-A-Y and Basement sauna, GP-based PrEP provision, and outreach models designed to meet people where they are. In one example, 241 individuals were receiving PrEP through GP settings.

The presentation also addressed practical approaches to managing demand. Manchester has used different prescription lengths, with the vast majority receiving 90-tablet prescriptions in 2024, but the lesson drawn was that six-month prescriptions should become more normal where clinically appropriate. Dr McQuillan also emphasised that online access is essential and that novel outreach and delivery methods are particularly important for reaching underrepresented populations.

For Ireland, the Manchester experience offers several lessons. PrEP expansion must be designed around equity from the outset. It is not enough to increase overall uptake if women, migrants, trans and non-binary people, people who sell sex, people who inject drugs and communities of colour remain underrepresented.

Ireland's National HIV Action Plan should therefore include explicit PrEP equity indicators, community delivery models, GP and primary care pathways, digital access, outreach provision, and mechanisms to prevent waiting lists from becoming a driver of avoidable HIV acquisition.





3.5 Redefining institutional stigma education: The RISE Project

Dr Amir Bachari²⁴ of the Royal College of Surgeons in Ireland presented the RISE Project - Redefining Institutional Stigma Education. RISE is an educational initiative designed for healthcare students and healthcare workers in Ireland and beyond. Its purpose is to address gaps in stigma education within third-level institutions and postgraduate training systems.



The project was informed by a needs assessment survey of healthcare workers and students. Participants identified multiple settings in which people living with HIV experience stigma, including dating, self-image and self-esteem, healthcare spaces, family and friends, school or workplace, media, and social media.

The survey found that 78–82% of healthcare workers and students reported witnessing stigmatising or prejudiced comments from a colleague about a person living with an infectious disease. Two-thirds believed that a person living with HIV may have difficulty sharing their status with healthcare professionals.

The survey also revealed significant training gaps. One quarter of healthcare workers and nearly half of students had not received training in Post-exposure Prophylaxis (PEP) and Pre Exposure Prophylaxis (PrEP). More strikingly, 58% of healthcare workers and 73% of students had not received training in HIV stigma and discrimination. Among healthcare workers who had not completed further HIV-related training since qualifying, a majority indicated that they would like such training if available.

RISE was launched in June 2024 as a three-part module covering HIV basics and tools, stigma, and applied learning through real-life stories from people living with HIV and those working with them. The presentation placed particular emphasis on the importance of hearing directly from people living with HIV, using their experiences to



disrupt didactic teaching, and making stigma education more human, practical, and memorable.

The project has already reached more than 400 healthcare professionals and students, with participants receiving certification. It has achieved RCPI CPD accreditation, has been integrated into the University of Galway and RCSI medical curricula, and has led to the development of a shorter “lunch and learn” model. Sixty-one per cent of participants reported feeling more prepared to communicate accurate information about HIV to combat stigma.

The call to action from RISE was clear: stigma education must begin early, must include the voices of people living with HIV, and must be scaled across healthcare education and professional development. For Ireland’s National HIV Action Plan, this suggests that anti-stigma commitments should not be limited to public awareness campaigns. They should include mandatory or incentivised healthcare worker education, undergraduate curriculum integration, CPD-accredited training, and evaluation of changes in knowledge, attitudes, and practice.





3.6 Altering the trajectory of HIV: The cost of complacency

The final presentation, delivered by **Youssef Youssef**,²⁵ Business Unit Head at ViiV Healthcare Ireland, focused on altering the trajectory of HIV. Drawing on research commissioned by ViiV Healthcare and conducted by the Office of Health Economics, the presentation examined the potential health and financial consequences of failing to meet 2030 HIV targets in Europe.

The presentation framed the issue as the “cost of complacency.” It argued that if current efforts remain unchanged, or if investment deteriorates in the context of geopolitical instability and funding pressures, Europe risks falling significantly short of global HIV targets by 2030. The analysis considered prevalence, diagnosis projections, healthcare system costs, and wider barriers to progress across several European countries, including Ireland.

For Ireland, the projections were stark. The analysis estimated that the number of people living with HIV in Ireland could reach 10,320 by 2030, with an estimated cost of care for people living with HIV between 2025 and 2030 of €694.47 million. It also projected 5,587 new diagnoses between 2025 and 2030 under the 2014–2023 trend, with additional costs of new diagnoses incurred during that period estimated at €228 million, and additional lifetime costs estimated at €2.02 billion.

The presentation noted that Ireland, while having the lowest absolute numbers among some comparator countries, had the highest diagnosis rates per 100,000 population in the analysis and showed concerning recent trends. It also emphasised that no country examined was on track to



reach zero new diagnoses by 2030 on current trajectories. Even where modelled incidence is gradually declining, rising diagnosis rates create immediate pressures for health systems through increased treatment costs and service demand.

The analysis identified barriers at individual, societal, healthcare, policy, and research levels. These included limited knowledge and awareness of HIV, stigma, insufficient community involvement, healthcare professional knowledge gaps, limited access to testing and treatment outside traditional settings, inadequate surveillance, inconsistent government commitment, and inequitable access to services.

The proposed solutions closely aligned with the wider themes of the conference:

- Expand care beyond traditional clinical settings
- Increase access to varied testing methods, including home and community testing
- Strengthen collaboration with disproportionately affected communities; increase funding for community-based organisations
- Diversify prevention and treatment options
- Improve stigma-related data collection
- Use targeted campaigns to reduce misconceptions

For Ireland’s National HIV Action Plan, the presentation provided a financial and policy rationale for urgency. Delayed action should not be viewed as cost neutral. Failure to invest in prevention, testing, treatment, stigma reduction, and data systems risks higher long-term expenditure, preventable diagnoses, and avoidable health inequities.

**POLITICO**

The cost of complacency: Why Europe must act now to end HIV

Europe’s current trajectory means the UNAIDS’s 2030 HIV target won’t be met. Rising infections, late diagnoses and growing healthcare costs demand urgent action to avoid long-term financial and societal burdens.





ENDING NEW HIV TRANSMISSIONS BY 2030 IS NOT SIMPLY A MATTER OF AMBITION. IT REQUIRES THE COURAGE TO CHANGE SYSTEMS, THE DISCIPLINE TO MEASURE OUTCOMES, AND THE COMMITMENT TO REACH PEOPLE WHO ARE CURRENTLY MISSED.



TOWARDS A HIV ACTION PLAN FOR IRELAND

Plenary Session 3 demonstrated that innovation in HIV policy is not confined to new medicines or technologies. It also includes new settings for testing, new models of PrEP delivery, novel approaches to healthcare education, new uses of data, and new forms of partnership between statutory services, clinicians, communities, and industry.

Several cross-cutting themes emerged. The first of these is that mainstreaming matters. Opt-out BBV testing in emergency departments reduces stigma by making testing routine and non-exceptional. Secondly, access must be brought closer to people's lives. PrEP, testing and care cannot rely solely on specialist clinic attendance if the goal is to reach underserved populations. Thirdly, stigma must be treated as a practical barrier to healthcare, not only as a social attitude. The RISE Project showed that healthcare institutions themselves must be part of the anti-stigma response. The fourth theme to emerge highlighted how investment must be understood as prevention of future cost, not simply current expenditure.

The session also reinforced the importance of implementation detail. Each innovation presented required more than a promising idea. For example, opt-out testing required laboratory pathways, clinical buy-in, governance and linkage to care. PrEP outreach required partnerships and demand management. Stigma education required curriculum space and accreditation. Economic modelling required better data. All these lessons are directly relevant to Ireland's National HIV Action Plan, which must be designed for delivery from the outset.

Plenary Session 3 made clear that the tools to accelerate progress already exist, but they must be scaled, adapted, and properly resourced. Emergency department opt-out testing can identify undiagnosed infection and reconnect people to care. PrEP can prevent HIV acquisition, but only if access is timely, equitable and available through varied pathways. Stigma can be reduced, but only if healthcare education and institutional practice change. Data and economic evidence can support action, but only if surveillance systems are strong and policymakers are willing to act on the findings.

In summary, Plenary Session 3 showed that ending new HIV transmissions by 2030 is not simply a matter of ambition. It requires the courage to change systems, the discipline to measure outcomes, and the commitment to reach people who are currently missed. The innovations presented in this session offer Ireland concrete models that can be adapted, implemented, and scaled as part of a National Action Plan for HIV for Ireland.





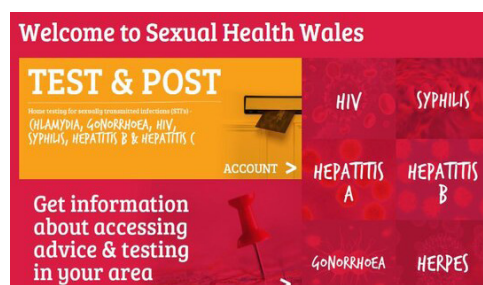
WORKSHOP 3

COMMUNITY-CENTRED TESTING: LESSONS FROM HIV AND HEPATITIS PROJECTS

The third workshop focused on community-centred approaches to HIV and hepatitis testing, highlighting the importance of accessibility, trust, lived experience, and rapid linkage to care. Led by Sarah Maslen-Roberts of Fast Track Cities Cymru, the session brought together examples from Wales, Ireland, and England to show how testing programmes can be strengthened when designed around community needs rather than traditional service settings.

Zoe Couzens²⁶ of Public Health Wales introduced the *Test and Post* model, which supports rapid testing and timely connection to care. The presentation emphasised the value of simple and accessible testing pathways that reduce barriers for people who may not attend conventional clinical services.

Postal and community-based approaches were presented as important tools for extending reach, normalising testing, and supporting earlier diagnosis.

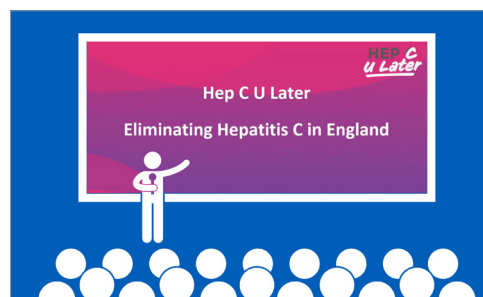


Ann Piercy²⁷ presented HIV Ireland's *Equal: Check + Chat* initiative, a mobile and outreach-based testing service that brings rapid HIV and STI testing directly into communities. The project works with groups who may experience barriers to clinic-based services, including refugees, migrants, sex workers, gay, bisexual, and other men who have sex with men, trans people and people who use substances.

By offering confidential, stigma-free testing in trusted community settings, Equal: Check + Chat demonstrates how mobile outreach can improve access, build relationships, and support onward referral. Since its launch, the initiative has delivered more than 1,000 tests and has been supported by 32 trained community volunteers.



Dr Mark Gillyon-Powell²⁸ NHS England, presented England's hepatitis C elimination strategy, which has been built around peer-led outreach, integrated care, and targeted engagement with underserved groups. Since 2015, the programme has treated more than 110,000 people, contributing to a 57% reduction in prevalence and a 52% reduction in liver transplants. Peer workers, many with lived experience, are embedded in clinical teams, prisons, and community vans, helping to ensure equitable access, continuity of care and trust among people who may otherwise remain outside treatment pathways.



The workshop concluded that Ireland's National HIV Action Plan should expand community-powered testing, strengthen peer-led models, simplify care pathways, and invest in trusted local partnerships rooted in health equity.



PLENARY SESSION 4

TURNING PLANNING INTO ACTION



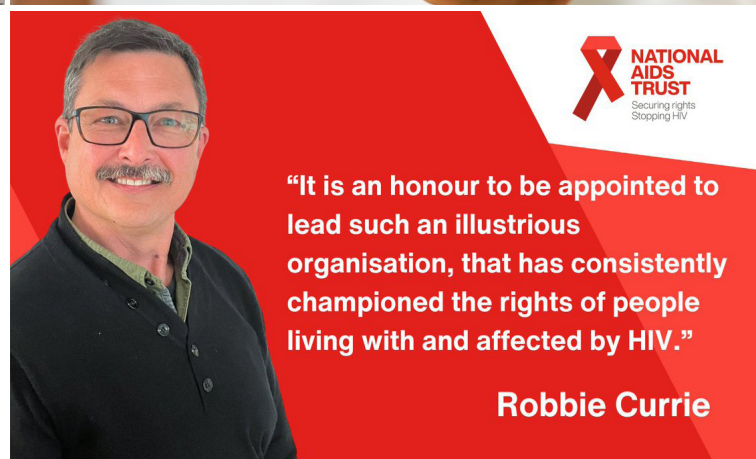
4.1 Introduction

Plenary Session 4 brought the conference to its central implementation question: how can Ireland move from policy commitment and strategic ambition to a practical, equitable and accountable National Action Plan for HIV?

Chaired by Professor **Jane Anderson**, Co-Chair of Fast Track Cities London, the session focused on the conditions required to turn the 2030 goal into reality: a clear understanding of who is affected by HIV in Ireland, meaningful community leadership, sustainable funding, strong voluntary sector infrastructure, honest public language, and delivery mechanisms rooted in justice, solidarity and lived experience.

The session featured contributions from **Richard Carson**, Executive Director of ACET (Aids Care Education and Training) Ireland; **Robbie Currie**, Executive Director of the National AIDS Trust; and **Richard Angell**, Executive Director of the Terrence Higgins Trust.

It concluded with a panel discussion on Ireland's roadmap to 2030, involving perspectives from Fast Track Cities, HIV Ireland, the Mater Misericordiae University Hospital, Fast Track Cymru, the National AIDS Trust and the Terrence Higgins Trust.



“It is an honour to be appointed to lead such an illustrious organisation, that has consistently championed the rights of people living with and affected by HIV.”

Robbie Currie





4.2 “What’s the story?”: Memory, narrative, and prevalence in Ireland’s HIV response

The opening presentation by **Richard Carson** challenged participants to think about HIV policy not only as a matter of epidemiology, but also as a matter of story, memory, identity, and place. His central provocation was direct: We do not know who is living with HIV in Ireland. This proposition pointed to a significant challenge for national planning. If Ireland does not have a sufficiently clear, current, and nuanced understanding of who is living with HIV, where people are located, what communities are most affected, and what structural barriers shape their lives, then any National Action Plan risks being incomplete from the outset.



Richard Carson

Conference participants were invited to consider how Ireland’s HIV response is shaped by the stories it tells about itself. A National Action Plan cannot be built solely on aggregate numbers or generic commitments. It must be attentive to the lived realities of people living with HIV including migrants, racialised communities, people affected by poverty and exclusion and those whose experiences are not adequately represented in existing data systems. The presentation therefore linked prevalence and surveillance with deeper questions of memory, belonging, and social context.

A key theme was the need to confront structural racism as part of Ireland’s HIV response. The presentation drew on the National Action Plan Against Racism, which defines racism as a structurally embedded phenomenon of domination and power, reproduced through institutional arrangements and experienced by groups and individuals. This framing is important for HIV policy because patterns of diagnosis, access to care, stigma, migration, housing insecurity, and healthcare engagement are not individual issues. They are shaped by systems, institutions, and histories.

The presentation also drew on ideas of place as both local and global. Referencing Doreen Massey’s understanding of places as shaped by flows, movements and interdependencies, Richard Carson suggested that Ireland’s HIV response must be place-based without being parochial. Local responses matter, but HIV in Ireland is also shaped by migration, global inequalities, international health systems, cultural memory, and transnational experience. This has practical implications for a National Action Plan: local services must be designed around the people who live in and move through those places, rather than around fixed assumptions about who is “at risk” or who belongs.

The presentation’s emphasis on memory and narrative also has consequences for stigma reduction. HIV stigma is sustained not only by misinformation, but also by silence, shame, and selective forgetting. By bringing history, identity and lived experience into policy design, Ireland can develop a response that is more honest, more inclusive, and more capable of reaching those who have been missed by conventional approaches. In this sense, the contribution reframed “planning into action” as a moral and cultural task as well as a technical one.





4.3 HIV at the crossroads: The role and sustainability of the voluntary and community sector

The second presentation was delivered by **Robbie Currie**²⁹, Executive Director of the National AIDS Trust. Drawing on research by HIV Outcomes UK, the presentation examined the state of HIV voluntary, community and social enterprise organisations, referred to as HIV VCSEs, and their critical role in sustaining the HIV response. The presentation began from a clear premise: HIV VCSEs have been central to the global HIV response since the start of the epidemic, but their ability to continue this work is under serious threat.

This extensive research was co-designed with a research advisory group and included a survey of 51 HIV voluntary sector organisations, a survey of 332 people living with HIV, 12 focus groups and community engagement sessions across the UK, and interviews with key stakeholders. The purpose was to understand community needs, the value of HIV services, the challenges organisations are facing, and how commissioning, policy and partnerships can be improved.

The research found that two-thirds of organisations had either reduced staff numbers, closed services, merged with other organisations or used cash reserves to cover operating costs in the previous three years. Only three out of 50 organisations felt they had been completely able to meet demand over the previous five years.

More than a third of organisations were somewhat or very concerned that they would not be able to continue delivering services over the next three years. The research also identified significant regional inequalities in access to HIV support.

Despite these pressures, the presentation showed that HIV VCSEs deliver substantial value across the HIV pathway. Four in five respondents reported increased wellbeing after accessing voluntary sector services, and peer support was described in the research as the difference between merely surviving with HIV and thriving with good quality of life. HIV VCSEs also play a central role in outreach, community testing, prevention, PrEP access, innovation, and engagement with people who may not access traditional clinical services.

A major theme was the role of the voluntary sector in addressing the social determinants of health. HIV outcomes are shaped by far more than clinical care alone. Housing, poverty, immigration status, food security,



loneliness, mental health, stigma, and access to culturally competent support all influence whether people can engage with treatment and live well.

The presentation argued that HIV VCSEs address many of these non-clinical determinants through hardship support, housing and benefits advice, nutrition support, advocacy, peer support, and community connection.

The presentation also highlighted the importance of strong partnerships between healthcare providers and HIV VCSEs. Effective referral pathways, opt-out approaches to support, embedded peer support and honorary contracts were identified as mechanisms that allow people living with HIV to access holistic, person-centred care. These partnership models are particularly relevant to Ireland, where a National Action Plan will need to connect clinical services, public health, community organisations, and peer-led support in a structured and sustainable way.

Financial sustainability was identified as one of the most serious barriers. One third of HIV VCSEs had closed services in the previous three years. Short-term contracts, lack of full cost recovery, complex procurement processes and the absence of inflationary uplifts were identified as commissioning practices that undermine the sector's stability. The presentation made clear that innovation may be cost-effective, but it is not free. Community organisations cannot be expected to deliver increasing demand, expanded prevention, testing, anti-stigma programmes, and psychosocial support without adequate core funding.

The recommendations presented included renewed partnership between governments and HIV VCSEs in the delivery of HIV Action Plans; expanded access to psychosocial and peer support; sustainable funding for HIV testing, prevention and anti-stigma programmes; full cost recovery; increased core and unrestricted funding; meaningful involvement of VCSEs and communities in funding decisions; strengthened partnerships between healthcare providers and HIV VCSEs; and continued leadership by people living with HIV.

For Ireland, Robbie Currie's presentation offered a clear warning and a clear opportunity. A National HIV Action Plan cannot treat the community and voluntary sector as an optional delivery partner. It must recognise community organisations as essential infrastructure. This requires multi-annual funding, formal partnership arrangements, referral pathways, peer support integration, and recognition of the sector's role in tackling inequality, stigma, and unmet need.



4.4 “Saying what we mean and meaning what we say”: Clarity, accountability, and trust

The third presentation was delivered by **Richard Angell OBE**,³⁰ Executive Director of the Terrence Higgins Trust. The presentation was focused on the need for clear communication and accountability in HIV policy, warning that vague language and lack of transparency can undermine progress towards the 2030 goal.



This contribution was particularly important in the context of Ireland’s emerging National HIV Action Plan. Strategic documents can easily become diluted by general language, broad commitments, and poorly defined responsibilities. Richard Angell’s message was that policy language matters because it shapes expectations, accountability, and public trust. If commitments are unclear, it becomes difficult for communities, clinicians, advocates, and policymakers to know what has been promised, who is responsible, and whether progress is being made.

The presentation called for direct, inclusive messaging that reflects the lived realities of people affected by HIV. This includes speaking plainly about HIV transmission, stigma, PrEP, testing, treatment, U=U, inequalities and the barriers faced by specific communities. Clear communication is not simply a communications exercise; it is part of implementation. It helps reduce stigma, build trust, support uptake of services and ensure that people can understand and claim their rights.

Participants also heard how accountability must go beyond metrics alone. Targets and indicators are necessary, but they are not sufficient if they are not accompanied by sustainable funding, meaningful partnerships with community organisations, and peer-led support. This aligns closely with the wider themes of Session 4: words must be matched by resourcing, governance, transparency, and action.

The implication for Ireland is that the National HIV Action Plan should use clear language, assign responsibility, set measurable goals, and provide transparent progress reporting. It should also be honest about the barriers to delivery, including workforce constraints, stigma, regional inequality, funding gaps, and unmet community need. The credibility of the plan will depend not only on what it promises, but on whether those promises can be tracked, tested, and delivered.

4.5 Roadmap to 2030 in Ireland: Panel discussion

The session concluded with a panel discussion chaired by **Dr Aoife Cotter**³¹ of the Mater Misericordiae University Hospital and included **Lisa Power**³³ of Fast Track Cymru, **Richard Angell** of the Terrence Higgins Trust and **Robbie Currie** of the National AIDS Trust. The discussion brought together clinical, community, advocacy, and Fast Track Cities perspectives on how Ireland can translate the learning from the conference into a workable national roadmap.

The panel reinforced several recurring themes from across the conference. First, sustainable funding is essential. Ireland cannot deliver expanded testing, PrEP access, stigma reduction, community support, peer-led services, surveillance, and integrated care through short-term or insecure funding arrangements. Second, integrated care pathways are required to ensure that people can move smoothly between testing, diagnosis, treatment, psycho-social support, peer support, and long-term care. Third, people living with HIV must be meaningfully involved in the design, delivery, and evaluation of the National Action Plan.

The discussion also emphasised peer support as a core component of HIV care, not a peripheral service. Peer support can improve wellbeing, reduce isolation, support engagement with treatment, help people navigate services, and challenge internalised and institutional stigma. The UK evidence presented earlier in the session showed that community-led and peer-led services are often the bridge between clinical care and the realities of people’s lives.

The panel’s focus on justice and solidarity was also significant. Ending new HIV transmissions by 2030 is not only a public health target; it is a commitment to equity. Ireland’s roadmap must therefore attend to those most likely to be missed by existing services, including migrants, minority ethnic communities, people outside major urban centres, people experiencing poverty or homelessness, people who use drugs, sex workers, trans and non-binary people, and people who experience stigma in healthcare or community settings.





TOWARDS A HIV ACTION PLAN FOR IRELAND

Plenary Session 4 provided a set of practical tests for Ireland's National HIV Action Plan. First, the plan must be built on a clear understanding of who is living with HIV in Ireland. This requires improved data, better community insight, attention to migration and structural racism, and a willingness to listen to stories that may not be visible in surveillance alone.

Second, the plan must treat the voluntary and community sector as essential delivery infrastructure. Community organisations are not simply advocates for better services; they are providers of testing, prevention, peer support, psychosocial care, stigma reduction, outreach, education, and policy innovation. A credible National HIV Action Plan should include multi-annual funding, full cost recovery, core funding, formal referral pathways, and structured community involvement in governance and delivery.

Third, the plan must use clear language and create real accountability. Commitments should be specific enough to be measured, funded, and evaluated. Public reporting should show progress against targets, but also describe what is not working and what corrective action will be taken. Communities affected by HIV should be able to see themselves in the plan and hold decision-makers to account for delivery.

Fourth, the plan must embed peer support and psychosocial care into the HIV pathway. Clinical excellence is essential, but it is not sufficient. People living with HIV need support to live well, manage stigma, navigate services, maintain treatment, and address the wider social determinants that shape health. This requires genuine partnership between hospitals, community organisations, primary care, public health, and peer-led services.

Finally, the session made clear that implementation is an ethical question as well as a technical one. The language of solidarity, responsibility, equity, and justice was not rhetorical. It reflected the reality that the people most affected by weak systems are often those already facing the greatest exclusion. A National HIV Action Plan must therefore be designed not only to reduce transmissions, but to reduce inequity.

Plenary Session 4 concluded the conference by focusing attention on the practical and political conditions required for success. Ireland has the opportunity to develop a National HIV Action Plan that is evidence-informed, community-led, adequately funded, and accountable. However, the session made clear that this will not happen automatically. It will require honest data, clear language, meaningful partnership, sustainable voluntary sector infrastructure, peer support, anti-racism, and a commitment to address the social determinants of HIV outcomes.

The session's central message was that planning must now become action. Ireland must know who is living with HIV, understand who is being missed, fund the organisations that reach people, speak clearly about the barriers to progress, and build systems that are accountable to the communities most affected.

The path to 2030 must be practical, measurable, and just.



IRELAND MUST KNOW WHO IS LIVING WITH HIV, UNDERSTAND WHO IS BEING MISSED, FUND THE ORGANISATIONS THAT REACH PEOPLE, SPEAK CLEARLY ABOUT THE BARRIERS TO PROGRESS, AND BUILD SYSTEMS THAT ARE ACCOUNTABLE TO THE COMMUNITIES MOST AFFECTED.





WORKSHOP 4

CHAMPIONING CHANGE: TRAINING, AWARENESS AND LEADERSHIP

Workshop 4 explored how training, awareness, and leadership can drive systemic change in HIV care, reduce stigma, and strengthen confidence among healthcare professionals and wider communities. Led by Maria Vidal-Reade of Fast Track Cities London, the session featured contributions from Dr Aneesha Noonan of NHS England, George Potts of Belfast Health and Social Care Trust, and Tara Russell and Will Kennedy of Sexual Health Centre Cork.

Dr Aneesha Noonan³³ discussed strategies for engaging primary care in HIV and hepatitis C elimination, emphasising collaboration, education, and shared ownership across the health system.

Her contribution highlighted the key role of primary care in prevention, testing, diagnosis, linkage to care, and long-term support, while also noting that this role must be enabled through training, clear pathways, and practical engagement with general practice and community-based services.



George Potts³⁴ presented the *Ignorance is Not Bliss* HIV Awareness Training Project, a long-running initiative in Northern Ireland. Established in 1989, the programme has trained more than 1,600 healthcare staff, improving knowledge, reducing stigma, and increasing confidence in working with people living with HIV.

Evaluation findings show that 92% of participants reported increased awareness, while 84% reported improved understanding of HIV-related stigma.



Tara Russell³⁵ and **Will Kennedy**³⁶ shared peer-led work in Cork to challenge stigma and promote allyship. Inspired by learning from the FTC Celtic Nations Conference 2024, their training programme combines story-telling, science-based education, and practical skill-building.

It addresses misconceptions, supports disclosure, promotes understanding of U=U and PrEP, and encourages participants to consider how workplaces can become safer and more supportive for people living with HIV.



The workshop concluded that Ireland's National HIV Action Plan should embed HIV awareness in healthcare culture, expand peer-led training, support primary care engagement, and sustain change through partnership, education, and leadership.



CONFERENCE RECOMMENDATIONS

The Fast Track Cities UK & Ireland Conference held in Dublin on 29 and 30 September 2025 demonstrated that Ireland has both the opportunity and the obligation to move decisively towards a stand-alone, funded, and accountable National Action Plan for HIV. These proceedings show that Ireland's commitment to ending new HIV transmissions and HIV-related stigma by 2030 is now firmly reflected in national policy ambition, including the Programme for Government and the National Sexual Health Strategy 2025–2035.

However, the central conclusion of the conference is that ambition alone will not deliver change. Ireland now requires a detailed strategy and implementation plan that sets out the rationale for action including what will be done, who will do it, how it will be funded, how progress will be measured, and how communities most affected by HIV will be involved at every stage.

1: Establish an inclusive, evidence-based, expert-led, consultative mechanism to develop a national Action Plan for HIV in Ireland

The National Action Plan should be developed through a time-limited, independently chaired, national co-design process, led by the Department of Health and HSE but jointly owned. People living with HIV, including migrants, women, trans and non-binary people, gay and bisexual men, people who use drugs, people who sell sex, and people diagnosed outside Ireland must be centrally involved, not as consultees only, but as equal partners in design, governance, implementation, and evaluation.

In addition, broad representation across health and community-based providers should include clinical, primary care, public health, research, and community partners. This means engaging with HIV and infectious disease consultants, sexual health clinicians, emergency medicine leads, maternity and reproductive health specialists, nurses, pharmacists, laboratory and surveillance experts, HPSC/public health representatives, GP and primary care leaders, practice nurses, community pharmacy representatives, industry, Fast Track Cities partners, researchers, and voluntary and community organisations working in HIV prevention, testing, peer support, migrant health, LGBTQ+ health, drug services, sex worker support, homelessness, mental health, and anti-stigma work.

Themed working groups could include prevention, testing, PrEP and PEP, treatment and care, stigma, surveillance, research, community infrastructure, and funding. The final plan should set clear actions, named delivery leads, timelines, costs, workforce requirements, equity indicators, and annual reporting arrangements, ensuring that Ireland's response is evidence-informed, clinically robust, community-led, and accountable.

2: Publish a four-year National Action Plan for HIV 2027-2030

Government should publish a stand-alone National HIV Action Plan for the remaining four years, up to and including 2030, with clear national targets aligned to the goal of ending new HIV transmissions and HIV-related stigma by the target date. This plan should not be a general statement of intent within a broader sexual health framework.

It should be a specific, time-bound, costed, and measurable action plan, with named responsibilities across the Department of Health, HSE, HPSC, clinical services, public health teams, community organisations, research bodies, and Fast Track Cities partners. It should include annual public reporting and a formal mid-point review so that progress can be assessed and corrective action taken where implementation is falling short.





3: Establish a HIV Action Plan Implementation Group

The Action Plan should establish a strong governance and accountability structure. Learning from England's HIV Action Plan and London's Fast Track Cities experience, the proceedings make clear that collaboration must be structured rather than assumed.

Ireland should therefore create a national HIV implementation group with representation from government, HSE leadership, public health, clinicians, community organisations, researchers, Fast Track Cities, and people living with HIV. This group should be responsible for overseeing delivery, monitoring indicators, advising on emerging trends, and ensuring that the plan remains responsive to communities and changing epidemiology.

4: Strengthen HIV surveillance, data use, and research

The Action Plan should commit to a major strengthening of HIV surveillance, data use, and research infrastructure. Enhanced data gathering must be able to distinguish clearly between first-time diagnoses, people previously diagnosed outside Ireland, late diagnoses, people not linked to care, people lost to follow-up, and those experiencing barriers to prevention or treatment. Data should be disaggregated by geography, gender, age, ethnicity, country of birth, route of transmission where available, and key population, while fully respecting privacy and data protection requirements.

The plan should support local dashboards and should embed research, implementation science, patient experience measures, and public and patient involvement (PPI) in research as core components of the national response.

5: Expand and improve HIV testing including opt-out, mobile and self-testing availability

Ireland should scale up HIV testing as a core national prevention strategy. The Action Plan should include routine opt-out HIV and blood-borne virus testing in appropriate emergency department and acute healthcare settings, supported by clear clinical pathways, laboratory capacity, consent protocols, linkage-to-care arrangements, and evaluation. It should also expand community-based testing, self-testing, mobile testing, outreach testing, testing in prisons, and other secure settings, and testing linked to indicator conditions.

Testing should be normalised, accessible and stigma-free. The evidence presented on emergency department opt-out testing in England shows that routine testing can identify undiagnosed infection, reconnect people to care, and reach individuals who may never attend sexual health services.

6: Enhance access to and availability of PrEP and PEP

The Action Plan should deliver equitable, barrier free, and timely access to PrEP and PEP. The proceedings show that PrEP expansion is essential, but also that uptake must be measured against need rather than overall numbers alone. Ireland should eliminate PrEP waiting lists, broaden criteria for access, widen delivery beyond specialist sexual health clinics, and develop pathways through primary care, community services, digital models, pharmacies, mobile outreach, and targeted services.

Specific PrEP access strategies should be developed for women, migrants, asylum seekers, trans and non-binary people, people who sell sex, people who inject drugs, people from minority ethnic communities, people outside major urban centres, and men who have sex with men who do not identify as gay or bisexual. Ireland should also explore long-acting injectable PrEP options together with other emerging prevention options as part of a forward-looking prevention strategy. Similarly, artificial and/or administrative barriers to PEP access including regional disparities, out-of-hours access, and the impact of hospital ED charges as a financial barrier should be addressed.





7: Develop and fund a Model of Care that is patient centred

The Action Plan should include the development and funding of a comprehensive Model of Care for people living with HIV in Ireland. This model should cover the full pathway from diagnosis to linkage to treatment, retention in care, re-engagement where people are lost to follow-up, treatment adherence e.g. choice of daily oral vs long-acting injectable medication, ageing with HIV, mental health, sexual health, comorbidities, maternity and reproductive health, migrant health, and psychosocial support.

It should include measurable standards for time from diagnosis to treatment, retention in care, viral suppression, patient experience, and quality of life. HIV should be treated both as a highly manageable long-term condition and as a condition shaped by stigma, inequality, and social determinants.

8: Make meaningful progress towards elimination of HIV-related stigma

Stigma was one of the strongest themes across the proceedings: internal stigma, public stigma, institutional stigma, and healthcare-based stigma all continue to affect testing, disclosure, treatment adherence, mental health, and quality of life. The Action Plan should make HIV-related stigma reduction a measurable national objective.

The plan should include a national anti-stigma programme, mainstream U=U, support peer-led education, develop workplace and healthcare campaigns, and create agreed indicators to measure progress towards zero stigma. The RISE Project demonstrates that stigma education should be embedded in undergraduate healthcare education, postgraduate training, and CPD, with people living with HIV directly involved in the design and delivery of learning.

9: Resource and enhance the role of community organisations through funding, partnership, and inclusion

The Action Plan should recognise the community and voluntary sector as essential HIV infrastructure. Community organisations are not ancillary to the HIV response; they provide testing, prevention, outreach, peer support, psychosocial care, advocacy, stigma reduction, education, and policy innovation.

The proceedings show that where community organisations are properly integrated into care pathways, they improve wellbeing, reach underserved groups, and address social determinants that clinical services alone cannot resolve. Ireland should therefore provide multi-annual funding, full cost recovery, core funding, formal referral pathways, embedded peer support, and structured involvement of community organisations in governance and implementation.

10: Ground the Action Plan in equity, anti-racism, and social justice

Finally, the Action Plan must be explicitly grounded in equity, anti-racism, and social justice. Ireland's HIV response must address the realities of migration, structural racism, poverty, housing insecurity, regional inequality, gender inequality, transphobia, homophobia, drug-related stigma, and the criminalisation or marginalisation of particular communities.

The plan should be designed around those most likely to be missed by existing systems. This means combining national standards with place-based implementation, ensuring that services reflect the actual communities impacted by HIV rather than outdated assumptions about risk or identity.



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