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OPERATIONAL SUPPORT

From evidence to practice – successful models for improved testing, linkage to and retention in care for migrant populations, related to HIV, TB, viral hepatitis and STIs in the EU/EEA

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This report was commissioned by the European Centre for Disease Prevention and Control (ECDC) through a service contract No. ECD. 18584. REF.250601, coordinated by Charlotte Deogan, with input from Otilia Mårdh and Teymur Noori and produced by the Barcelona Institute for Global Health (ISGlobal) with the collaboration of the University of Bari Aldo Moro, and City St George's, University of London.

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Acknowledgements

The authors are particularly grateful to Sally Hargreaves (City St George's, University of London) and Francesco Di Gennaro (University of Bari Aldo Moro) for supporting the development of this report and for their substantial contribution to the activities of the project. The authors would also like to thank the following individuals for supporting the rapid review on models of good practice targeting migrant populations residing in the EU/EEA: Jessica Carter (City St George's, University of London); Oumnia Bouaddi (Barcelona Institute for Global Health); Kathryn Mackey (City St George's, University of London, London School of Hygiene & Tropical Medicine); Alena Kamenschikova (Care and Public Health Research Institute – CAPHRI).

The authors and ECDC would like to thank all experts that contributed to the Delphi panel: Alena Menshchikova (Netherlands); Anca Vasiliu (Germany); Anna Maria Geretti (Italy/UK); Apostolos Veizis (Greece) ; Botond Lakatos (Hungary); Christian Morberg Wejse (Denmark); Christiana Noestlinger (Belgium); Cyriac Bouchet Maye (France); Denis Onyango (UK); Edoardo Occa (Italy); Ella van Landeghem (Belgium); Elisa Martro Catala (Spain); Felix Perez-Tejera (Spain); Heinke Kunst (UK); Ivan Solovic (Slovakia); Krista Stoycheva (Germany); Lorenzo Guglielmetti (Italy); Maider Arando Lasagabaster (Spain); Maria Buti (Spain); Mariantonietta Pisaturo (Italy); Marie Norredam (Denmark); Mariano Salazar (Sweden); Mojca Matičič (Slovenia); Olga Anagnostou (Greece); Sandra Dudareva (Germany/Latvia); Sofia Jordao (Portugal); Sonia Dias (Portugal); Takudzwa Mukiwa (UK); Thomas Vanwolleghem (Belgium); Valeska Padovese (Malta); Ville Holmberg (Finland).

The authors and ECDC would also like to thank the following organisations and institutions for disseminating the call for submissions: AIDS Action Europe (AAE); Coalition for Global Hepatitis Elimination (CGHE); Correlation Network; European AIDS Clinical Society (EACS); International Organization for Migration (IOM), and International Network on Health and Hepatitis in Substance Users (INHSU).

Suggested citation: European Centre for Disease Prevention and Control. From evidence to practice – successful models for improved testing, linkage to and retention in care for migrant populations, related to HIV, TB, viral hepatitis and STIs in the EU/EEA. Stockholm: ECDC; 2026.

Stockholm, September 2026

ISBN 978-92-9498-929-1
doi: 10.2900/8062966
Catalogue number TQ-01-26-074-EN-N

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Contents

Abbreviations iv
Executive summary 1
Introduction 3
Objectives 4
Methodology 5
Results 11
Discussion 24
Limitations 27
Conclusions 27
Recommendations 27
References 28
Annex 1. Rapid literature review 31
Annex 2. Summary of models of good practice 32

Tables

Table 1. Models of best practice for migrants with HIV, viral hepatitis, TB and/or STIs (in any of the evaluated domains) 12
Table 2. Best practice models for the 'health impact and cost' domain by care cascade step 14
Table 3. Effectiveness outcomes of best practice models for testing for HIV, viral hepatitis, TB and/or STIs among migrants. 15
Table 4. Effectiveness outcomes of best practice models for linkage to care of migrants with HIV, viral hepatitis, TB or other STIs. 17
Table 5. Effectiveness outcomes of best practice models for retention in care of migrants with HIV, viral hepatitis, TB or other STIs 18
Table 6. Best practice models in the domain of transferability and sustainability for migrants with HIV, viral hepatitis, TB or other STIs. 20
Table 7. Best practice models in the domain of community-based approaches and stakeholder engagement for migrants with HIV, viral hepatitis, TB or other STIs 21
Table 8. Outcomes reported by best practice models in the domain of 'additional relevant outcomes for migrants with HIV, viral hepatitis, TB or other STIs' 23

Abbreviations

ART	Antiretroviral therapy
AS	Asylum seeker
BBV	Blood borne viruses
CE	Cost-effectiveness
CEA	Cost-effectiveness analysis
CSO	Civil society organization
DOT	Directly observed therapy
EEA	European Economic Area
EU	European Union
EWRS	Early Warning and Response System
HAV	Hepatitis A Virus
HIV	Human immunodeficiency virus
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HPV	Human Papillomavirus
IOM	International Organization for Migration
NGO	Non-governmental organization
POCT	Point-of-care testing
PrEP	Pre-exposure prophylaxis
QALYs	Quality-Adjusted Life-Years
RDT	Rapid Diagnostic Test
STIs	Sexually Transmitted infections
SDG	Sustainable Development Goals
TB	Tuberculosis
TBI	Tuberculosis infection
TST	Tuberculin skin test
VH	Viral hepatitis

Executive summary

This report identifies practice-based evidence within models of care that improve testing, linkage to care, and/or retention in care for HIV, tuberculosis, viral hepatitis B and C and/or sexually transmitted infections among migrant populations[i] in the European Union (EU) and European Economic Area (EEA). It highlights approaches that have had an impact in real-world settings, especially those that address the specific needs and barriers faced by migrant populations.

Methods

Models of practice for testing, linkage to care, and/or retention in care for HIV, tuberculosis, viral hepatitis B and C and/or sexually transmitted infections among migrant populations were identified and assessed using a stepwise approach. First, a rapid literature review was conducted to synthesise existing evidence and identify documented models of good practice and key experts in the field across disease areas. Second, between June and August 2025, a Delphi process was carried out to reach consensus on the content of a structured questionnaire for collecting good practice models tailored to migrant populations and capturing information on how the models were implemented. Thirty-two experts from 17 European countries were invited to participate and the questionnaire was disseminated in the REDCap survey tool.

An open call for expressions of interest was launched in September 2025 and disseminated through professional networks and social media. This was followed by a second phase where people working on the identified models were invited to complete the questionnaire. To support data completeness and accuracy, the study team conducted individual interviews with submitting organisations between October 2025 and January 2026.

An assessment framework was developed based on the questionnaire to standardise the process. Submitted models were independently reviewed by two members of the study team against predefined criteria in the following evaluation domains:

- health impact and cost;
- transferability and sustainability;
- community-based approaches and stakeholder engagement;
- additional relevant outcomes (addressing social determinants and multidimensional support).

Discrepancies were resolved through consensus discussions involving the full study team. Models were scored and ranked according to the pre-defined criteria, and models in the top 20th percentile of scores in any of the evaluation domains were identified as models of best practice.

Good practice models identified

A total of 41 submissions were received, of which 37 models from 14 EU/EEA countries met the inclusion criteria and were evaluated. Most models focused on testing for at least one disease, followed by linkage to care and least commonly, on retention in care. The majority addressed multiple diseases (28/37; 75%), reflecting integration of service delivery, while a smaller proportion focused exclusively on viral hepatitis (4/37; 11%) or tuberculosis (4/37; 11%). For the purpose of this collection, all 37 initiatives are referred to as models of good practice.

Among these, 23 models were identified as best practice models in at least one of the evaluation domains. Best practice models were primarily identified in the 'health impact and cost' domain (n=10/23) and 'additional outcomes' domain (n=10/23), followed by 'transferability and sustainability' (n=8/23), and 'stakeholder and community engagement' (n=8/23). Ten of the 23 models were identified as best practice in more than one domain.

Twenty-one (91%) of the best practice models addressed several steps of the care cascade (testing, linkage to care and retention in care).

The ten models identified as best practice for the 'health impact and cost' domain (n=10/23) demonstrated sufficient evidence of health impact and data completeness. These models spanned the full care cascade, with the strongest representation in testing and linkage-to-care interventions.

Across the identified best-practice models for testing (n=7/10), approaches were predominantly focused on multiple infections, with point-of-care testing used in six out of seven (85%) models, enabling rapid results and reducing loss to follow-up. Three models incorporated dried blood spot testing to expand access in community and

[i] Migrants are defined as any person who changes his or her country of origin or usual residence, including migrants who move in a regular or documented manner, as well as migrants in irregular situations.

outreach settings. About 71% of models reported testing uptake (5/7), and almost all (6/7; 85%) included data on test positivity, demonstrating their effectiveness in reaching target populations.

Eight models of care were identified as best-practice for linkage to care (n=8/10), with half (n=4) addressing multiple infections and the others only focusing on viral hepatitis. Effective strategies included expedited referral pathways (7/8; 88%), follow-up support mechanisms (7/8; 88%), and immediate treatment initiation in some cases, particularly for sexually transmitted infections. The time between testing and first clinical follow-up varied by condition, ranging from approximately 1–7 days overall, around three days for HIV and STIs, 14–28 days for tuberculosis infection, and nearly 57 days for viral hepatitis.

Six models of care showed strong outcomes regarding retention in care (n=6/10) with five of these (83%) incorporating community health workers, including four that used peer navigators to address cultural and language barriers. Additional strategies such as SMS reminders, phone calls, video support, and home visits reinforced sustained engagement.

Eight models of care (n=8/23) demonstrated strong 'transferability and sustainability' and were identified as best practice for this domain. Sustainability was strongest among models integrated into existing health systems with dedicated funding or formal governance links, while NGO-led programmes were generally local but sometimes demonstrated national or international collaboration.

Eight models (n=8/23) were identified as best practice for the 'community-based approach and stakeholder engagement' domain. These demonstrated strong community engagement, involving participatory approaches such as focus groups and interviews to assess acceptability and guide cultural adaptations, including translated materials and safe spaces.

Ten models (n=10/23) were identified as best practice for the 'additional relevant outcomes' domain. These models addressed broader social and structural barriers while integrating prevention activities (such as condom distribution, vaccination, and contact tracing), alongside staff training and dedicated roles to support access and equity.

Common characteristics of good practice

Effective approaches to testing, linkage to care, and retention in care for HIV, TB, viral hepatitis, and STIs among migrant populations are both feasible and impactful when designed around the specific needs, lived realities and structural barriers of these communities. Distinguishing features of best-practice models identified in this collection show that:

- integrated, person-centred, multi-disease, low-threshold, and community-based testing strategies can improve testing, linkage to care, and retention in care;
- strong systems for rapid and coordinated linkage to care embedded within primary care and community settings are effective strategies;
- sustained retention support (often delivered through community or peer involvement which helps overcome barriers) can significantly improve engagement across the care cascade, not only improving health outcomes but also addressing broader social determinants of health.

Common positive enabling factors emerged across settings including stakeholder engagement, community based participatory approaches, intersectoral collaboration, and trust-building mechanisms through confidentiality, non-discriminatory and stigma free practices, the involvement of multidisciplinary teams and addressing social determinants of health.

However, several gaps limit comparability, implementation, and scale-up. Many models lack comprehensive monitoring and evaluation frameworks, including standardised indicators and data on costs or cost-effectiveness analyses, which constrains the ability to compare outcomes and support long-term planning and sustainability. In addition, sustainability and transferability depend on their integration within health systems, stable funding and supportive policy frameworks that ensure equitable access to healthcare.

Introduction

Definitions of the care cascade steps used for the project

Testing:

HIV: The process of detecting HIV antibodies, antigens, and/or HIV RNA through rapid diagnostic tests (including lateral flow tests in community or decentralised settings) or through standard laboratory-based serological or molecular methods, using blood or oral fluid samples.

Hepatitis B: The process of detecting HBsAg through a rapid diagnostic test, including rapid diagnostic tests in community or decentralised settings or through standard laboratory-based serological methods using blood samples.

Hepatitis C: The process of detecting HCV antibodies, antigens, and/or HCV-RNA through rapid diagnostic tests including lateral flow tests in community or decentralised settings or through standard laboratory-based serological or molecular methods, using blood or oral fluid samples. HCV-RNA confirmation can be carried out through portable molecular platforms at point of care or through standard laboratory-based methods.

Tuberculosis: The approach to testing for tuberculosis depends on whether the aim is to diagnose active disease or TB infection. For active TB, testing is defined as the process of identifying people with suspected active TB using tests, examinations, or other procedures that can be applied rapidly. These include symptom screens, chest radiography (chest X-ray or CXR), and molecular rapid diagnostic tests or molecular platforms that use blood or sputum samples.

Testing for TB infection is the identification of those at high risk of developing tuberculosis. The tuberculin skin test (TST) and the interferon-gamma release assay are the current screening methods for measuring adaptive host immune response.

STIs: The process of detecting sexually transmitted infections through serological, immunoassay, or molecular methods. Multiplex platforms allow for simultaneous detection of multiple pathogens, and testing can be performed using samples such as urine, genital swabs, or lesion swabs, in both laboratory and point-of-care settings.

Linkage to care:

HIV: Linked to care is defined as a person diagnosed with HIV who initiates antiretroviral therapy (ART) within 30 days of their HIV diagnosis and who has completed one HIV-related clinical visit to evaluate CD4 cell count.

Hepatitis B: Linked to care is defined as having had a documented first visit with a liver specialist or treating physician to evaluate liver staging and treatment eligibility.

Hepatitis C: Linked to care is defined as those who are HCV-RNA positive having initiated antiviral therapy.

Tuberculosis: Linked to TB care is defined as initiating TB treatment within 28 days of sputum submission among patients with a positive sputum test result.

STIs: Linkage to care is defined as those with a positive diagnosis for an STI referred for, asked to return for, or undergoing antibiotic therapy to treat the STI.

Retention in care:

HIV: Retention in care is defined as a person living with HIV who has had at least two HIV medical visits (or lab tests such as CD4 or viral load) at least 90 days apart within a 12-month period.

Hepatitis B: Retention in care is defined as a person who has had at least two visits with a liver specialist or treating physician within a 12-month period.

Hepatitis C: Those who have completed DAA therapy, irrespective of their sustained virologic response (SVR).

Tuberculosis: Those who have completed the full course of TB treatment.

STIs: Those who have completed treatment and follow-up to determine cure.

Global migration has been steadily increasing with an estimated 281 million people, or about 3.6% of the world's population, living outside their country of birth in 2020 [1]. In 2024, 94 million individuals born outside of the region resided in Europe [2].

Migrants living in European countries often face barriers in accessing healthcare. They may have limited access to preventive care and services and may be charged for treatment, limiting uptake and potentially resulting in worse health outcomes [6]. There may also be language and cultural barriers, as well as a lack of familiarity with the healthcare system in the host country [3]. Undocumented migrants in particular may avoid seeking medical help due to fear of detention or deportation, which exacerbates their health risks and delays necessary care [4]. The type of healthcare to which migrants are legally entitled to, particularly undocumented migrants, varies greatly between European countries [5].

Integrating migrants into healthcare systems requires substantial investment in training staff, increasing cultural competency, and promoting policies that ensure equitable access to healthcare services [7]. Addressing these challenges needs a coordinated effort between governments, civil society organisations, and local health authorities to ensure that structural barriers in accessing good healthcare are minimised for migrant populations [8].

Migrants and refugees to the EU/EEA are disproportionately affected by tuberculosis (TB) [9] human immunodeficiency virus (HIV) [10], hepatitis B and C viruses (HBV/HCV) [11,12], and other sexually transmitted infections (STIs) [13] compared with the general population. This may be because migrants from countries where these diseases are endemic are at increased risk of having these diseases [14] as they may not have received adequate preventive care or treatment due to limited access to healthcare and/or weak healthcare systems in their home countries [15]. Additionally, the arduous conditions endured by some refugees during their journey to the EU/EEA, including staying in environments with poor living conditions such as refugee camps or informal settlements, could have exposed them to these diseases [16,17]. Finally, some migrant populations are at higher risk of contracting infectious diseases in the host country due to risk factors such as poor living conditions and other social determinants of health [18], including risk of social exclusion.

Given these concerns, there is a clear need for tailored models of care in European countries to effectively test, link to care, and retain migrants in services for HIV, TB, viral hepatitis and STIs. Migrant populations often face unique and intersecting barriers that can delay diagnosis and interrupt continuity of care, including language differences, cultural and health literacy gaps, uncertain legal status, stigma, and limited familiarity with healthcare systems. Conventional healthcare delivery models may not adequately address these challenges, leading to missed opportunities for early detection and treatment [19]. Implementing adapted, person-centred models of care can help overcome these barriers [20]. These can include community-based outreach programs, migrant sensitive services, flexible service delivery, and integrated care pathways. Such approaches improve individual health outcomes but also reduce health inequities, prevent onward transmission, and ensure more inclusive and effective public health responses across the European region.

Objectives

The main objective of this report is to support countries in the EU/EEA in reducing the number of undiagnosed and untreated HIV, viral hepatitis, TB and STIs in migrant populations who are at high risk of contracting these diseases. By identifying and gathering models of good practice to increase testing and/or linkage to care and/or retention in care among migrant populations, this report provides a better understanding of the models implemented across the EU/EEA and highlights facilitators and barriers in addressing migrant populations.

This report summarises the methods of the call for models of good practice, describes the selection and evaluation process of submissions, presents the models of good practice as well as the results of which models qualified as best practice across the EU/EEA.

Methodology

Study design

A multi-phase, stepwise methodological approach was employed to ensure a comprehensive and systematic identification and assessment of relevant models of care across the EU/EEA.

For the purpose of this collection, **a good practice model** is defined as an intervention, strategy, or model of care that was submitted to the call, implemented and reported indicators in at least one of the following domains: 'health impact & cost', 'transferability and sustainability', 'community and stakeholder engagement', and/or 'additional relevant outcomes'. These models aim to improve health and broader social outcomes for migrant populations across one or more of the SDG 3.3 related diseases HIV, TB, viral hepatitis and STIs.

A **best practice model** is one that ranked in the top 20% percentile of evaluated models across any of the evaluation domains. These models demonstrated health impact and/or cost-effectiveness; and/or ensured transferability and sustainability; and/or strong community approach and stakeholder engagement; and/or addressed additional relevant outcomes, including social and structural determinants of health affecting migrant communities.

There is no universally accepted definition for the term 'migrant'. Nevertheless, migrant populations are defined according to the International Organization for Migration (IOM) as a person who moves away from his or her place of usual residence, whether within a country or across an international boarder, temporarily or permanently, and for a variety of reasons [21]. This report focuses on migrants referring to any person who changes his or her country of origin or usual residence including migrants who move in a regular or documented manner as well as migrants in irregular situations.

Phase 1: Rapid literature review

The first phase consisted of a rapid literature review which synthesised existing evidence on models of care focused on migrant populations for HIV, TB, viral hepatitis and STIs (Annex 1) This review served two primary purposes: (1) to identify and characterise models of good practice in the literature that report performance indicators, in order to invite authors to submit their models and (2) to map and identify key experts and stakeholders working in the fields of TB, HIV, STIs, and viral hepatitis across Europe and invite them to contribute to the development of the questionnaire. The combined searches yielded 77 original studies containing 78 models of practice; 23 models on TB, six on HIV, 14 on HBV/HCV, four on STIs, and 31 multi-disease models. Thirty-seven authors were contacted and invited to submit their models, of which seven (19%) responded to the call. The fact that no models were identified through institutional websites justified a broader call to experts across the EU/EEA to uncover unpublished but implemented models in Europe.

From the rapid literature review, 77 models reported outcomes on testing, 39 reported outcomes related to linkage to care models, and 21 reported outcomes around retention in care. Findings of the review suggested that increased testing uptake can be achieved through various models with some studies also showing successful linkage to care and treatment outcomes. However, ensuring continuity of care remains an ongoing challenge seen throughout the literature in respect to the care cascade. Conversely, the review also reported how migrant populations encounter significant structural and systemic barriers when accessing testing, linkage to care, and retention in care, in addition to language and gender-specific healthcare needs, cultural insensitivity, stigma, and migration challenges (such as insecure legal status, family separation, social isolation and unstable living conditions).. This work underscored the need for a more comprehensive evaluation framework beyond traditional performance indicators, particularly in relation to integrated service models (including infectious diseases testing and care with other essential services such as housing, employment support, or psychological care). Findings from the review informed subsequent stages of the study, particularly the development of the questionnaire and the assessment framework.

Phase 2: Delphi panel and questionnaire development

To refine the questionnaire, the study followed a two-round, anonymous Delphi methodology and an iterative process based on quantitative and qualitative feedback, involving a multidisciplinary expert panel. Experts were selected according to their experience in infectious diseases, public health, migrant health, and healthcare delivery and policy. A total of 32 experts from 17 countries were invited to participate between June and August 2025.

The primary objective of the Delphi panel was to achieve consensus on the key domains and questions to be included in the questionnaire for collecting the models of good practice. Through iterative rounds of consultation

and feedback, the panel agreed upon a comprehensive set of variables capturing key aspects of models of care, including design, implementation, outcomes, and scalability. This process resulted in the development of an expression of interest form (12 items), which collected general information about the model, and a subsequent structured questionnaire, implemented in the survey tool REDCap (Annex 3 in the supplementary document). The initial version of the structured questionnaire consisted of three sections: testing (46 items), linkage to care (44 items), and retention in care (43 items).

Of the 32 experts invited, 26 participated in the first Delphi round (response rate: 81%), with a high level of engagement also observed in the qualitative feedback. Overall, the first round demonstrated good content validity across all domains, with the majority of items achieving acceptable or high levels of agreement. Content validity was measured by Item-level Content Validity Index (I-CVI) which measures how much agreement there is among experts that a specific item is relevant or appropriate for the construct being measured. Thresholds for item retention, revision, or exclusion were applied according to established criteria as follows: I-CVI ≥ 0.90 indicated high agreement; I-CVI between 0.80 and 0.89 indicated acceptable agreement requiring minor revision; and I-CVI <0.80 indicated low agreement requiring major revision or removal.

In the expression of interest form, one item showed low agreement (I-CVI <0.80 meaning fewer than 80% of experts rated that item as relevant), five items showed acceptable agreement and required minor revision (I-CVI 0.80–0.89), and six items achieved high agreement (I-CVI ≥0.90). In the testing domain of the questionnaire, four items showed low agreement and were identified needing major revision or removal, while the majority of items fell within the acceptable (n=26) or high agreement categories (n=16). Similarly, in the linkage to care domain, two items showed low agreement, whereas 22 and 20 items achieved acceptable and high agreement, respectively. In the retention in care domain, two items showed low agreement and required major revision, while 20 and 21 items showed acceptable and high agreement, respectively.

Qualitative feedback collected during the first round highlighted several strengths of the questionnaire, including the high response rate, strong engagement from participants, and the relatively limited number of items requiring major revision. However, experts also identified key areas for improvement, particularly the overall length of the questionnaire, partial overlap between items in the expression of interest form and the questionnaire, and the limited acceptability of open-ended questions. Many participants suggested the use of predefined response options to improve usability and standardisation. Based on these findings, the questionnaire was substantially refined by reducing redundancy, simplifying item structure, and converting open-ended questions into closed-ended formats where appropriate.

In the second Delphi round, 21 experts participated (response rate: 66%). A marked improvement in consensus was observed across all domains, with no items scoring below the predefined acceptability threshold (I-CVI <0.80). In the expression of interest form, only one item required minor revision because it reached an I-CVI score below 0.90, while the remaining items achieved high agreement. In the testing domain of the questionnaire, four items fell within the acceptable range, and the large majority achieved high agreement. Similar patterns were observed in the linkage to care and retention in care domains, where only a small number of items required minor revisions because they had an I-CVI score below 0.90 (n=2 and n=5, respectively), and most items reached high agreement. The overall evaluation confirmed these findings, with no items below acceptable agreement threshold and the majority achieving high agreement.

Comparison between the two rounds demonstrated a clear progression, characterised by the elimination of poorly performing items, a reduction in items requiring minor revisions, and a substantial increase in items reaching high agreement (I-CVI ≥0.90). This iterative process resulted in a more coherent, concise, and widely accepted questionnaire.

Following the second round, all items met acceptable content validity criteria, and the questionnaire was therefore finalised. No additional Delphi rounds were required.

The final questionnaire was divided by steps of the care cascade (i.e. testing [37 items], linkage to care [33 items], and retention in care [31 items]) and, following experts' feedback, a separate domain was created ('General information', eight items), grouping together those questions that were common across the three domains of the care cascade, with the purpose to avoid unnecessary repetition and to facilitate the completion of the overall questionnaire. Ultimately, the final questionnaire aimed to understand the key characteristics of the models of care, capture their impact, their sustainability, and potential for scaling up and were applicable to any of the SDG 3.3 diseases.

Based on the finalised questionnaire, an assessment framework was subsequently developed by the project team to enable systematic scoring and comparison of submitted models. The final scoring rubric form was divided into four domains: health impact and cost, transferability and sustainability, community-based approaches and stakeholder engagement, and additional relevant outcomes (Annex 4 in the supplementary document)**.**

Phase 3: data collection

In September 2025, an open call for expressions of interest was disseminated broadly through the ECDC website, ECDC newsletter by the section on Sexually transmitted Infections, Blood-borne viruses and TB, scientific and professional networks, institutional partners, and social media platforms. It consisted of a brief form collecting general information about the models of practice such as contact persons, name of the model, brief qualitative description, country and dates of implementation, target population, diseases included, and the stages of the cascade of care addressed by the model. A preliminary mapping of the submitted initiatives was conducted to ensure varied representation of EU/EEA countries, targeted diseases and steps of the care cascade, and to identify potential gaps requiring increased dissemination efforts. In order to promote submissions from Central and Eastern Europe translation options were offered, and experts from these countries were contacted directly to encourage participation.

Authors submitting an expression of interest received the full submission questionnaire (Annex 3 in the supplementary document), through which detailed information about their model was collected. Subsequently, the MI-GOOD-CARE study team conducted individual online interviews with representatives of submitted expressions of interest to support the completion of the questionnaire and ensure its accuracy and completeness. These interviews were carried out between November 2025 and January 2026. Lastly, authors were requested to formally submit the completed questionnaire online to proceed to the next phase.

Phase 4: eligibility assessment and model evaluation

Following data collection, all submitted models underwent an eligibility screening process to ensure they met the collection's core criteria: implemented in an EU/EEA country; tailored to migrant populations; focused on HIV, TB, viral hepatitis, and/or other STIs; and addressed testing and/or linkage to care and/or retention in care. Eligible models (n=37) were then evaluated using the predefined assessment framework based on the questionnaire items evaluating the general description of the model of care, impact, sustainability, and scalability (Annex 4 in the supplementary document).

Each model was independently assessed by two reviewers from the MI-GOOD-CARE study team. Discrepancies between reviewers were resolved through a series of three consensus meetings involving the study team (seven people), with the support of one ECDC expert. Each meeting and consisted of in-depth discussions to ensure consistency and agreement in scoring.

Inclusion criteria:

Models must have been:

- implemented in the last 10 years;
- designed with the objective to address the unique needs of migrant populations;
- carried out in at least one EU country;
- address HIV, TB, STIs, and/or viral hepatitis;
- address at least one aspect of the care cascade for the respective diseases (testing, linkage to care, and/or retention in care).

Models were evaluated across four domains:

- health impact and cost (assessed independently for testing, linkage to care, and retention in care);
- transferability and sustainability;
- community-based approaches and stakeholder engagement;
- additional relevant outcomes.

The use of a multidimensional assessment framework based on four domains is draws on the understanding that models should be assessed beyond health impact alone. This approach recognises that strong performance in one domain may not necessarily translate into overall strength across multiple dimensions of good practice. Interventions may involve trade-offs between impact, cost-efficiency, transferability, sustainability, and community engagement. Applying a multidimensional framework therefore allows for a more comprehensive appraisal of models, ensuring that those identified as best practice are impactful in improving health outcomes and increasing testing, linkage to care, and/or retention in care, but are also feasible to implement, adaptable across different contexts, and capable of delivering sustained benefits over time.

Health impact and cost

The assessment of health impact and cost aimed to determine the extent to which models of care were able to demonstrate measurable improvements in health outcomes and/or provide evidence on their economic implications. Models were therefore scored according to the type of indicators provided, quality and comprehensiveness of data reported to substantiate their impact. This assessment was carried out by area of intervention (testing, linkage to care, and retention in care), resulting in an independent score and selection of best practice models for each area.

The following programme features were assessed for health impact and cost:

- The availability and completeness of quantitative indicators across the continuum of care:
  - number of individuals reached and tested;
  - testing uptake;
  - number of individuals linked to care;
  - number of individuals initiating treatment;
  - number of individuals completing treatment;
  - number of individuals lost to follow-up.

Models that reported indicators across multiple stages of the care cascade, and that were able to contextualise these findings using baseline estimates or comparator data, were considered to provide stronger evidence of impact. Demonstrated improvements such as an increase in testing volume compared to baseline or comparator, high testing uptake (e.g. >70%), or reductions in time to linkage to care were interpreted as indicators of positive health impact. Strengthened evidence included additional outcomes such as improved retention in care or reductions in loss to follow-up.

- Beyond immediate outputs, the evaluation also considered the extent to which models reported on longer-term health outcomes, including morbidity and mortality.
- Economic considerations formed an integral component of this section, with attention given to whether programmes conducted cost analyses or cost-effectiveness (CE) evaluations and whether they could provide total programme budget estimation.

Transferability and sustainability

Beyond supporting improved testing and continuity of care at local and national levels, models of care across EU/EEA countries present multiple delivery strategies that show great potential for transferability between settings. The funding mechanism of the models can influence their sustainability. In this regard, the integration of care initiatives within health system structures, including governance and funding, can facilitate sustainability.

The following model features were assessed for transferable and sustainable practices:

- a clear description of the setting, including the levels of care involved, organisational aspects and relevant policies;
- the explicit mention of migrant groups' entitlement to access or engage in the programme;
- the availability of a manual, standard operating procedure, roadmap or toolkit;
- the transparency and publication of results in peer-reviewed literature, grey literature, annual reports, or similar;
- the institutional acceptance of the programme through adoption in routine clinical practice or inclusion in local, national or regional guidelines;
- funding mechanisms that are conducive to sustainability, scalability and long-term viability (i.e. such as public, private, or donor-based financing and in particular models embedded in the budget line of health systems);
- evidence demonstrating replicability in multiple regional settings or in other health systems (either internationally or nationally in decentralised contexts).

Community-based approaches and stakeholder engagement

Community and stakeholder engagement are fundamental components of any strategy addressing groups at risk of acquiring HIV, TB, viral hepatitis, and/or other STIs and to achieve the intended health goals and SDG 3.3 targets [22]. This process spans involving community-based stakeholders and those communities in the exchange of information and perceptions, to the gradual development of longer-term partnerships with shared decision-making that can address a wider range of social, economic, political, and environmental issues relating to health [23]. Thus, for the assessment, the study team evaluated whether community members and key actors participated in the design and development of the programmes, as well as in their delivery and evaluation.

The following programme features were assessed under this section:

- the involvement of stakeholders in the design and/or evaluation of the programme;
- the employment of community-based participatory research methods;
- the use of focus group discussions, interviews or other methods with the target population and other key stakeholders to evaluate the programme's acceptability;
- the incorporation of cultural adaptations;
- the implementation of a dissemination strategy.

Additional relevant outcomes

The ECDC public health guidance on screening and vaccination for infectious diseases in newly arrived migrants within the EU/EEA [24] recommends that programmes address individual, community, and health system barriers to the uptake of screening and treatment. These include, for example, disease-related stigma, low risk perception, limited entitlement to (free) healthcare Immediate needs such as housing, employment or mental health may be prioritised over seeking preventative or curative healthcare, therefore considering broader determinants of health across the continuum of care can support improved uptake.

Peer navigators and interpretation services are recommended to support migrants in screening uptake, treatment initiation and adherence by supporting engagement with services and addressing language and cultural barriers [25]. Training for staff in delivering testing and related services in a non-judgmental and non-stigmatising manner should be offered, ensuring culturally sensitive health promotion and care [26]. In addition, prevention strategies such as hepatitis B vaccination, condom distribution or access to PrEP are encouraged towards the SDG 3.3 targets related to HIV, tuberculosis, viral hepatitis and STIs [27].

The following programme features were assessed under this section:

- the evaluation of behavioural changes (such as risk perception);
- stigma-reduction activities within the programme;
- the provision of training for professionals;
- the inclusion of prevention activities and contact tracing;
- the availability of dedicated staff to support testing, linkage to care and retention in care;
- the provision of transfer documents or information in case of migrants' mobility (i.e. relocation within or to a different host country);
- the provision of psychological support or referral to other health services;
- the provision of support to address social and legal barriers;
- and the use of innovative digital tools during the testing or continuum of care.

Phase 5. selection of best practice models

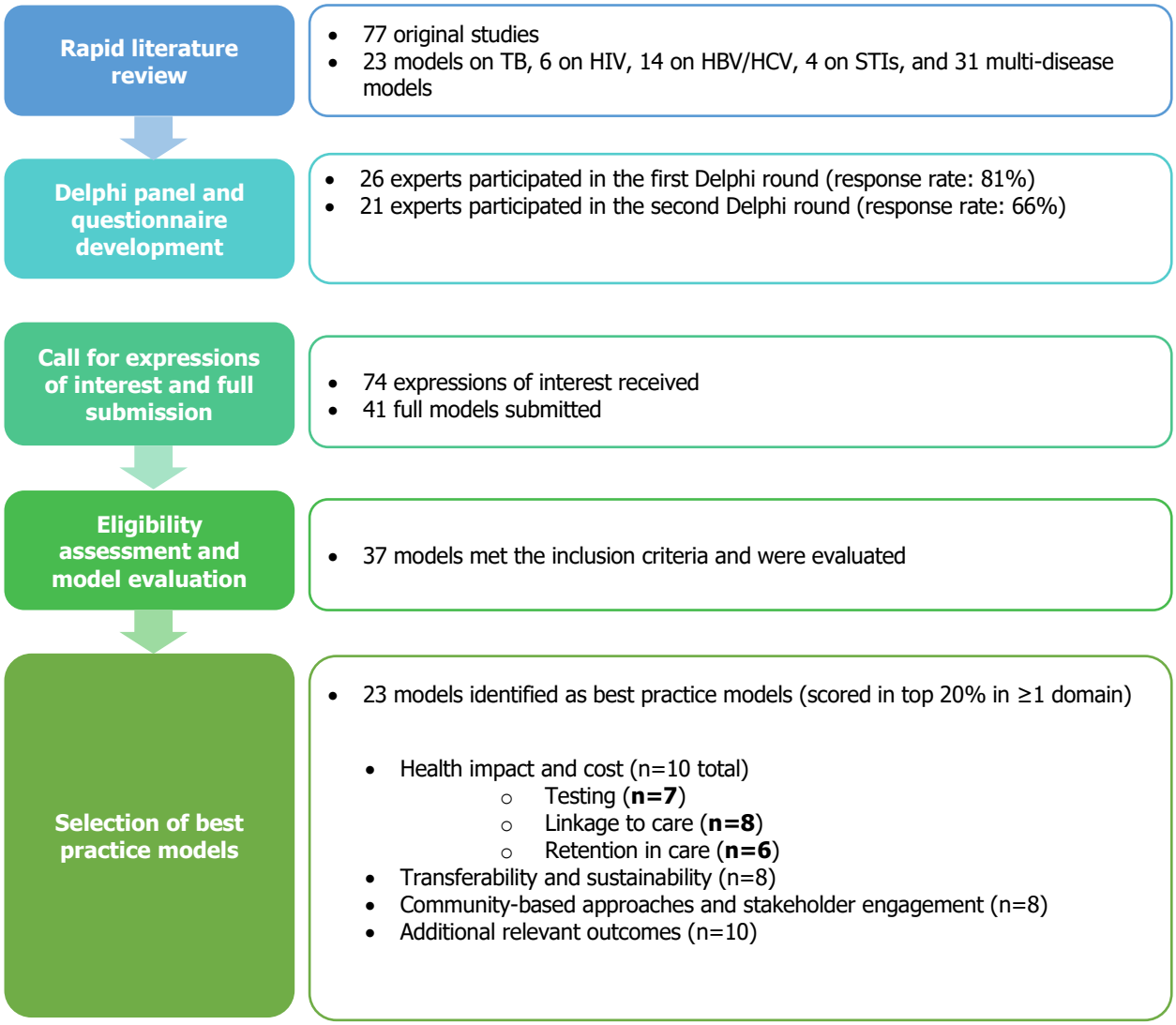
After evaluation and scoring, models were ranked within each of the four domains: (1) health impact and cost (health impact and cost regarding testing, health impact and cost regarding linkage to care, health impact and cost regarding retention in care); (2) transferability and sustainability; (3) community and stakeholder engagement; and (4) additional relevant outcomes (Figure 1).

The score distributions were assessed using descriptive statistics (percentiles, including the median, and quartiles) and a data-driven threshold was established at the top 20th percentile (relative to the scores of all submitted models for each domain). All models that reached this threshold were classified as best practice, provided that a minimum of 6 out of 10 points was obtained. If multiple models had equal scores at the cut-off, all were included.

This approach ensured that only the highest-performing models, those demonstrating strong performance in at least one of the domains, were retained for in-depth analysis. Using a percentile-based threshold also accounts for differences in the overall scoring distribution and provides a transparent, reproducible, and relative method for identifying best-practice models, regardless of whether the absolute scores are generally high or low.

Also, the top-performing 20% of models enabled a detailed examination of best practice while maintaining a manageable sample size for in-depth qualitative analysis. This approach balances methodological rigour with practicality and minimises the inclusion of models with only moderate performance that may not adequately represent exemplary practice.

Figure 1. Overview of the stepwise methodological approach and selection of models of best practice



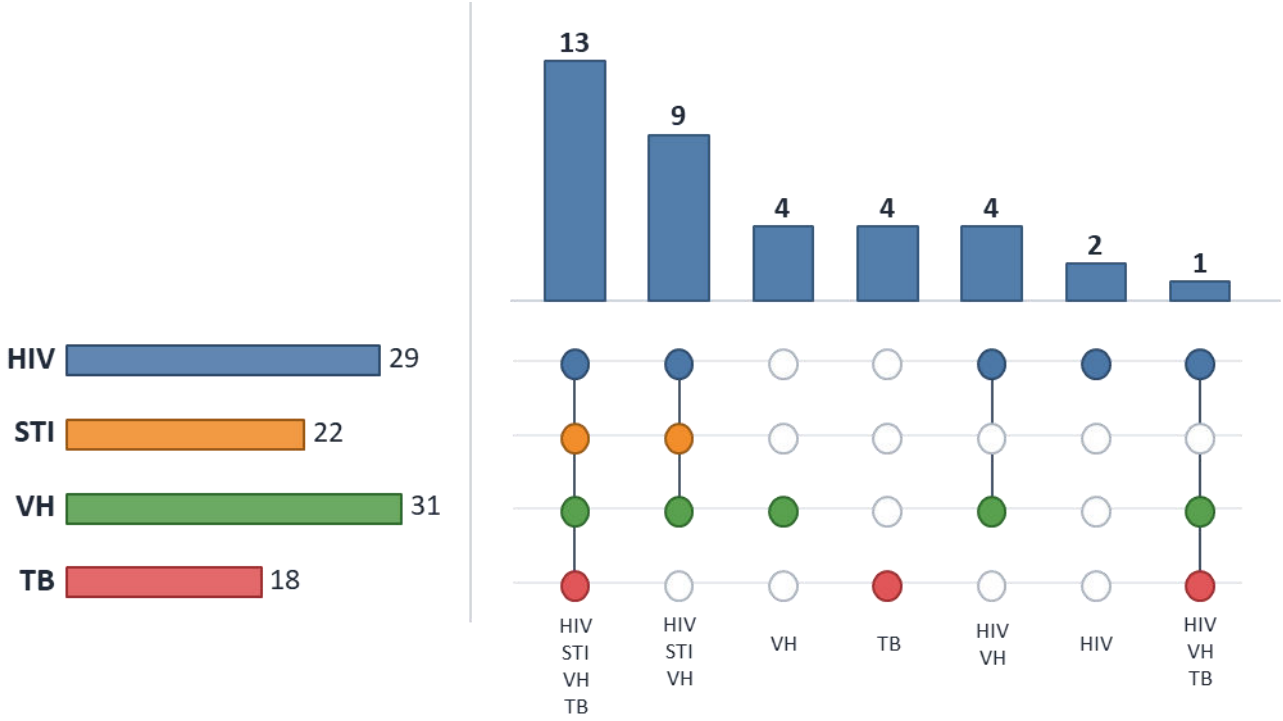
Results

Between November 2025 and January 2026, a total of 74 expressions of interest were received of which six were from non-EU/EEA countries and were excluded. The remaining 68 were invited to submit full questionnaires and invited to perform individual online interviews; of these four authors denied our invitation to follow the process and 17 did not respond. A total of 47 interviews were conducted with representatives of submitted models; 41 submissions were received and 37 were eligible and included in the assessment, all of which are considered 'good models of practice' in this report. Of note, there were six authors with whom interviews were conducted that did not finalise the formal submission of the questionnaires through the online platform.

Most models addressed testing for at least one of the diseases (n=35), followed by linkage to care (n=30) and fewer models focused on retention in care (n=25).

A substantial number of the submissions focused on more than one of the diseases (n=27; 73%), (Figure 2); two models only covered HIV (n=2; 5%) and four models, were single-disease focused on viral hepatitis (n=4; 11%) and TB (n=4; 11%) respectively.

Figure 2. Models of good practice by disease area (n=37)



HIV=human immunodeficiency virus; STI=sexually transmitted infections; VH=viral hepatitis; TB=tuberculosis

Models were submitted from 14 EU/EEA countries, primarily originating from Western and Central Europe. Details for each model, including the title of the programme, contact person and a summary of the main features are described in Annex 2. Thirty-six of the 37 models provided consent for inclusion in this report, including all the models of best practice.

Twenty-three (out of 37) models were identified as 'best practices' across the domains evaluated, scoring in the top 20th percentile in at least one of the evaluation domains (Table 1). Best practice models were primarily identified in the 'health impact and cost' domain (10/23) and 'additional relevant outcomes' domain (10/23).

Eight models each demonstrated strong outcomes in the domains of 'sustainability and transferability' (8/23) and 'stakeholder and community engagement' (8/23) and were identified as best practice. Ten models were identified as best practice models within more than one of the evaluation domains, of which three models were identified as best practice in three of the four domains.

Table 1. Models of best practice for migrants with HIV, viral hepatitis, TB and/or STIs (in any of the evaluated domains)

Model*	N[ii]	Country	Disease	Approach	Best practice			
					Health impact & cost	Transferability & sustainability	Community engagement	Additional outcomes
Integrated Migrant Care – Negrar	1	Italy	HIV/VH/ STIs/TB	Integrated clinic and outreach model, combining targeted testing, treatment/referral, and strong community partnerships. Accessible, culturally sensitive screening and care for migrants, including undocumented people.	✓			
Health Screening of Forced Migrants	5	Ireland	HIV/VH/ STIs/TB	On-site, opt-out health screening and support for asylum seekers to detect communicable diseases and other serious conditions.		✓		
Salud Entre Culturas	8	Spain	HIV/VH	Community-based, culturally adapted screening, education, prevention, and mediation support for HIV and viral hepatitis among migrant communities, linking individuals to care.		✓	✓	
Checkpoint BLN	9	Germany	HIV/VH/ STIs	Low-threshold, community-based sexual health clinic providing integrated, multilingual counselling, testing, treatment, and prevention services for under-served populations at high-risk of contracting these diseases.			✓	
Choices@AZC	10	Netherlands	HIV/VH/ STIs	Accessible mental health counselling and prevention services for LGBTQ+ asylum seekers, combining risk assessment, supported self-testing, linkage to care, and practical case management.				✓
MICATC	11	Spain	VH	Community-based hepatitis B/C education and rapid screening with peer and healthcare teams to improve detection and linkage to care for migrants.	✓			
LINK - Ares do Pinhal	13	Portugal	HIV/VH/ STIs/TB	Coordinated, person-centred pathway for homeless people, including migrants, combining outreach, harm reduction, shelter, healthcare access, and supported housing transitions to promote stability and reintegration.	✓			
HepBC-link model of care	14	Spain	VH	Community-led education, rapid hepatitis B/C screening, and simplified referral pathways to improve cost-effective detection and treatment access for migrant communities.	✓		✓	
Screening of communicable diseases	15	Finland	HIV/VH/ STIs/TB	Voluntary initial health screening and follow-up care for asylum seekers, with nurse-led coordination and medical referral systems.		✓		✓
Noaks Ark Mosaik	16	Sweden	HIV/VH/ STIs	Community-based HIV and STI prevention, testing, and care support for migrants through outreach and partnerships.		✓	✓	✓
WIR-Walk In Ruhr	19	Germany	HIV/VH/ STIs	Walk-in sexual health centre that combines prevention, testing, treatment, counselling, and outreach to deliver accessible, migrant-sensitive care for diverse communities.			✓	✓
PLUS Project in WIR (Bochum)	20	Germany	VH	Outreach and close community partnerships to provide low-threshold hepatitis C testing, education, and linkage to care for migrants and refugees.	✓			✓

[ii] All 37 models were assigned numbers and are referred to by name and number in this report.

Model*	N[ii]	Country	Disease	Approach	Best practice			
					Health impact & cost	Transferability & sustainability	Community engagement	Additional outcomes
BBV Rapid Test & Treat	21	Ireland	HIV/VH	Client-centred rapid testing approach using oral swabs and minimal blood sampling to efficiently identify and link refugees and protection applicants to care for blood-borne viruses.	✓	✓	✓	
MACIP-TB	25	Spain	TB	Integrated surveillance, clinical care, and community-based support to strengthen tuberculosis prevention and ensure equitable continuity of care for migrant populations.		✓		✓
Sexual Health Center Berlin	26	Germany	HIV/VH/ STIs	Integrated sexual health and family planning services with social and translation support, prioritising migrants excluded from regular healthcare.				✓
ISMiHealth	28	Spain	HIV/VH/ STIs/TB	Clinical decision support tool that enhances screening and referral for infectious diseases and other health needs among migrants in primary care.	✓			
Screen to act on TB	29	Malta	TB	Targeted tuberculosis screening for individuals from high-risk countries to enable early diagnosis and timely treatment of active cases.		✓		
SAUDE + PERTO TB	30	Portugal	HIV/VH/ STIs/TB	Integrated, community-based screening, clinical care, and psychosocial support through mobile and outreach services for vulnerable populations.	✓	✓		✓
HEALTH4MIGRA SCREEN-AGRI	31	Italy	HIV/VH/ STIs/TB	Integrated infectious disease screening and follow-up for migrants in informal settlements through multi-partner collaboration and active community engagement.			✓	✓
ProSPIRo	32	Malta	HIV/VH/ STIs/TB	Programme that combines a whole-system approach to STI rapid testing with coordinated outreach and awareness strategies for HIV, TB, and sexual health among populations vulnerable to contracting these diseases.			✓	
MIDMIP	33	Italy	HIV/VH/ STIs/TB	Outreach-based, low-threshold infectious disease screening and integrated follow-up care for undocumented migrants, including diagnosis, treatment pathways, and prevention.	✓			
VH-COMSAVAC	35	Spain/Italy/Greece	VH	Decentralised, community-based hepatitis B/C screening, vaccination, and linkage to care for migrants, using rapid testing, culturally tailored education, and peer-supported referral pathways.	✓			
CCM HIV Services	36	Norway	HIV/VH/ STIs	Low-threshold HIV/STI testing, prevention, and psychosocial support for migrant populations and populations vulnerable to contracting these diseases, integrating peer support, outreach, and fast-track linkage to specialist care within a trauma-sensitive, community-based model.				✓

**A summary of models are provided in Annex 2.*
HIV: Human immunodeficiency virus; TB: Tuberculosis; VH: Viral hepatitis; STIs: Sexually transmitted infections

Health impact and cost

In the domain of health impact and cost, a total of 10 out of 23 best practice models were identified. Seven (70%) of these models showed impact on testing, eight (80%) showed impact on linkage to care, and six (60%) on retention in care (Table 2). Most of the models addressed more than one of the steps of the care cascade (n=8, 80%). Most (n=6; 60%) were models of care addressing more than one disease, followed by viral hepatitis-specific models of care (n=4; 40%).

Table 2. Best practice models for the 'health impact and cost' domain by care cascade step

Model	[iii]N.	Country	Infections	Testing	Linkage to care	Retention in care
Integrated Migrant Care – Negrar	1	ITALY	HIV/VH/ TB/STIs	✓		
MICATC	11	SPAIN	VH	✓	✓	✓
LINK - Ares do Pinhal	13	PORTUGAL	HIV/VH/ TB/STIs		✓	✓
HepBC-link model of care	14	SPAIN	VH	✓	✓	✓
PLUS Project in WIR (Bochum)	20	GERMANY	VH		✓	✓
BBV Rapid Test & Treat	21	IRELAND	HIV/VH	✓	✓	
ISMiHealth	28	SPAIN	HIV/VH/ TB/STIs	✓	✓	
SAUDE + PERTO TB	30	PORTUGAL	HIV/VH/ TB/STIs		✓	✓
MIDMIP	33	ITALY	HIV/VH/ TB/STIs	✓		
VH-COMSAVAC	35	GREECE/ITALY/SPAIN	VH	✓	✓	✓

Best practice models for testing

Ten models were considered best practice in the domain of health impact and cost and demonstrated impact across the care cascade, showing clear advantages over standard care or comparator approaches. For example, high testing uptake, often exceeding 90%, was reported among models 1, 11, 14, and 21.

Seven out of 10 models were identified as best practice models for testing. Almost all (n=6; 86%) (models 1, 11, 14, 21, 33, 35) used point of care testing (POCT) as part of the testing strategies. One model (model 21) explored the acceptability of offering multiple POCT tests and ended up offering two rapid oral swab POCTs and one capillary whole blood rapid test after feedback from the migrant communities. As a result, 94% of users reported their experience as 'excellent'. Three models also used dried blood spot (DBS) testing to collect additional blood samples (models 11, 14, 35) for further testing. One best practice implemented an innovative primary care-based alert system to prompt GPs to offer and carry out testing for multiple infectious diseases, including HIV and viral hepatitis (model 28). The centres where the alert system was implemented, raised their overall monthly diagnosis of HIV, hepatitis B and C, and active TB to 2.72 (95% CI 0.43-5.00, p=0.02) extra diagnoses compared with the control centres.

Testing uptake or the number of tests performed were reported by all the included best models of practice with the test positivity indicator being reported among five (71%).(Table 3).

Two models used an interactive education tool for viral hepatitis (*HEPARJOC*) to promote the testing and subsequent linkage to care of migrants living with viral hepatitis. Three of the models for viral hepatitis testing were carried out in Catalonia (Spain) (models 11, 14, 35) and the protocol of the *HepBC-link model of care* (model 14) was shared with the Public Health Agency of Catalonia (Spain), and served as the basis for the *MICATC* (model 11) pilot study carried out in three different regions in Catalonia to assess the model's scale up, showing institutional acceptance and scale.

[iii] All 37 models were assigned numbers and are referred to by name and number in this report.

Four models incorporated a community-based component within the testing phase (models 11, 14, 21, 35) with two combining it with other settings, including detention centres or prisons (model 35), migrant health or refugees' reception centres (model 21), and citizenship or integration classes (model 35). One of the community-based models also offered their services through mobile clinics (model 21), whereas the testing phase of the *ISMiHealth* model was carried only out at the primary care level (model 28). A model implemented in Catalonia (Spain) (model 28), to increase testing of HIV, viral hepatitis, and active TB, demonstrated improved testing uptake across multiple infections when compared to standard care. In the 2018 pilot, uptake in the intervention group was consistently higher than in the control group: HIV testing reached 15% compared to 8.9% in the control group, HBV 12% versus 9%, HCV 13% versus 9%, and active tuberculosis screening 5% versus 3%.

Another model of care currently being implemented in Ireland (model 21) that uses RDTs for blood-borne virus (BBV) showed both high acceptability and greater demand compared to conventional phlebotomy-based testing. Following refinement of the sampling approach, 94% of service users rated their experience as excellent, and providers described the intervention as quicker, less invasive, and easier to deliver when comparing with standard of care. Importantly, comparative data from the initial rollout demonstrated higher engagement with the RDT model, with 26 participants attending testing across two settings compared to only 13 participants across 34 community settings offering standard laboratory-based testing during the same period (zero people testing in more than half of the community settings).

Table 3. Effectiveness outcomes of best practice models for testing for HIV, viral hepatitis, TB and/or STIs among migrants.

Model	N[iv]	Country	Infection	Effectiveness outcomes								
				Testing uptake	Testing coverage	Number of tests performed	Test positivity	Early diagnosis	No. of people with results communicated	No. of people with referrals provided	No. of people with additional testing	No. of people lost to follow-up
Integrated Migrant Care – Negrar	1	Italy	HIV/VH/ TB /STIs	✓		✓	✓	✓			✓	
MICATC	11	Spain	VH	✓		✓	✓	✓	✓	✓	✓	✓
HepBC-link model of care	14	Spain	VH	✓		✓	✓	✓	✓	✓	✓	✓
BBV Rapid Test & Treat	21	Ireland	HIV/VH	✓		✓	✓	✓	✓	✓	✓	
ISMiHealth	28	Spain	HIV/VH/ TB /STIs		✓		✓	*		✓		✓
MIDMIP	33	Italy	HIV/VH/ TB/STIs	✓				✓				
VH-COMSAVAC	35	Spain	VH			✓	✓	✓	✓	✓	✓	✓

*HIV: Human immunodeficiency virus; STIs: Sexually transmitted infections; TB: Tuberculosis; VH: Viral hepatitis. *Analysis of early diagnosis planned to be completed during 2026.*

[iv] All 37 models were assigned numbers and are referred to by name and number in this report.

Linkage to care

Eight out of the 10 models were classified as best practice models for linkage to care (Table 4). Of these models, one was implemented in several countries (Spain, Greece and Italy), three (38%) were implemented in Spain, two (25%) in Portugal, one in Germany and one in Ireland. Half of the models integrated multiple infectious diseases, while the other half focused on viral hepatitis alone. Notably, the community-based and primary care initiatives of some of the models facilitated migrants' integration and linkage to other levels of care (e.g. primary and specialised care). For example, in the *PLUS Project in WIR (Germany)* (model 20) implemented in a walk-in outpatient clinic for sexual health, the follow-up care of migrants who are HCV positive was offered within their clinic which also combined multiple services, including primary and specialised care; while for the *VH-COMSAVAC* model (model 35) researchers collaborated with tertiary level hospitals to expedite and facilitate referrals of reactive RDT results.

Overall, seven of the models established an expedited referral pathway with specialised care (models 11, 13, 14, 20, 21, 30, 35), four models undertook additional measures to integrate follow-up phone calls with expedited referral as part of their linkage to care efforts (models 14, 20, 21, 30) and two incorporated drop-in clinics (models 20, 21). Three models, the community-based model entitled *LINK - Ares do Pinhal* (model 13), the *PLUS Project in WIR (Bochum)* (model 20) and the *SAUDE + PERTO TB* (model 30) where testing was carried out at various sites (community, primary care and hospital level) (model 30), reported a well-established referral system with primary care and specialised care; while the *ISMiHealth* model (model 28), implemented at primary care, also reported a well-established referral system to specialised care following routine clinical practices. Of note, three multi-infection models reported offering immediate treatment initiation at the testing site, mostly for STIs (models 13, 28, 30), and the *VH-COMSAVAC* model (model 35) reported offering the first dose of HBV vaccination to migrants testing negative for HBV in community settings and then referring them to primary care for subsequent doses.

Seven of the models integrated dedicated staff and resources to ensure follow-up and linkage to care. Such efforts included informing migrants about follow-up care, assisting with appointment scheduling, offering transportation to the care facility, providing accompaniment to appointments, interpretation and mediation (models 11, 13, 14, 20, 21, 30, 35) (for further details see Section 4. Additional relevant outcomes). The average time between testing and the first follow-up clinical appointment varied by model and disease, from one to seven days (model 20) days (model 35) for viral hepatitis, around three days for HIV and other STIs (model 30), and from 14-28 days for TBI (model 30). The multi-disease model *LINK - Ares do Pinhal* reported an average time of 15-30 days for all positive cases (HIV, viral hepatitis, TB and STIs) (model 13). The model *VH-COMSAVAC* (model 35), which was implemented in Greece, Italy, and Spain reported varying average times between testing and first clinical appointments. Mean times for HBV ranged from 20 to 83 days and for HCV from 13 to 83 days. As a result of well-established expedited referral pathways with the different reference hospitals, all settings achieved a reduction in waiting time compared to the standard of care, from five days in Athens, to a reduction of 76 days in Catalonia (Spain). In the context of Catalonia, during the pilot phase, the study achieved a successful linkage to care rate of 72% for all participants, with secondary care appointments arranged within 16 days (i.e. time from testing to first documented visit).

As shown in Table 4, eight models reported the collection of seven or more of the nine effectiveness outcomes considered for linkage to care including number of referrals to primary care or specialised care, and treatments initiated and lost to follow-up. The proportion of migrants lost to follow-up between testing and treatment initiation varied by model and disease. Models exclusively comprising viral hepatitis testing and follow-up care reported a heterogeneous proportion of migrants lost to follow-up, from 10% (model 20) to 60% (model 14) with higher proportions observed in exclusively community-based models (models 11, 14, 35). Notably, the *MICATC* model (model 11) reported relatively low lost to follow-up rates for linkage to care (81% of positive cases for HCV and 66% of positive cases for HBV were linked to specialised care), and outstanding performance in treatment initiation (100%) for HCV. Case-manager nurses coordinated appointments, ensured follow-up, and facilitated navigation of the health system, including fast-track referral to specialist care. Participants without a health card were supported in obtaining one, ensuring entitlement to public healthcare regardless of legal status. Peer educators and community health agents supported attendance by accompanying participants with language barriers to medical visits and helped bridge gaps between the health system and migrant communities. Their continuous presence played a key role in trust building, and effective linkage to care.

Regarding multi-infection models, the *BBV Rapid Test & Treat* model in Ireland (implemented in late September 2025) reported 0% lost to follow-up, where all four diagnosed HIV and/or viral hepatitis cases were linked to care (model 21); the *SAUDE + PERTO TB* model in Portugal (model 30) reported a range of lost to follow-up between 2% and 5% of the patients with at least one diagnosed infection, none of them with TB infection or active TB (0% lost to follow-up for TB); the *LINK - Ares do Pinhal* model in Portugal (model 13) reported 15% lost to follow-up for any of the included infections; and the last multi-infection model did not provide lost to follow-up data (model 28).

Table 4. Effectiveness outcomes of best practice models for linkage to care of migrants with HIV, viral hepatitis, TB or other STIs

Model	#[v]	Country	Infections	Effectiveness outcomes								
				No. of people with results communicated	Referrals to secondary care	No. of people with a first visit	No. of people with a follow-up visit	No. of people with confirmed diagnosis	No. of people eligible for treatment	No. of people initiating treatment	No. of people receiving vaccination	No. of people lost to follow-up
MiCatC	11	Spain	VH	✓	✓	✓	✓	✓	✓	✓		✓
LINK - Ares do Pinhal	13	Portugal	HIV/VH/ TB/STIs	✓	✓	✓	✓	✓	✓	✓	✓	✓
HepBC-link model of care	14	Spain	VH	✓	✓	✓	✓	✓	✓	✓		✓
PLUS Project in WIR (Bochum)	20	Germany	VH	✓	✓	✓	✓	✓	✓	✓	✓	✓
BBV Rapid Test & Treat	21	Ireland	HIV/VH	✓	✓	✓	✓	✓			✓	✓
ISMiHealth	28	Spain	HIV/VH/ TB/STIs		✓	✓	✓	✓	✓	✓	✓	✓
SAUDE + PERTO TB	30	Portugal	HIV/VH/ TB/STIs		✓	✓	✓	✓	✓	✓	✓	✓
VH-COMSAVAC	35	Spain Greece Italy	VH		✓	✓		✓	✓	✓	✓	✓

HIV: Human Immunodeficiency Virus; STIs: Sexually Transmitted Infections; TB: Tuberculosis; VH: Viral Hepatitis.

Retention in care

Of the 10 models, six reported particularly strong health impact and cost effectiveness outcomes associated with retention in care (Table 5). These models also reported strong effectiveness outcomes for the linkage to care component (see Linkage to care section). Of these six models, one was implemented in several countries (Spain, Greece and Italy), two (33%) were implemented exclusively in Spain, two (33%) in Portugal and one in Germany.

Three of the models implemented community screening of viral hepatitis, complemented by linking and retaining migrants who tested positive with the appropriate specialised care (models 11, 13, 35), and one model carried out viral hepatitis testing across different settings, including community-based settings, detention centres or prisons, migrant health or refugees' reception centres, mobile clinics, and the WIR clinic, where follow-up care was offered within the latter (model 20). The other two models integrated testing multiple infections (HIV, viral hepatitis, TB and other STIs) at the community level (models 11, 30), where the *SAUDE + PERTO TB* model (model 30) also carried out testing initiatives at the primary care and specialised care level.

Five models reported having a specific protocol in place for migrant patients with infections that required follow-up after treatment initiation (models 11, 13, 14, 30, 35). All five reported inclusion of community health workers in their model to promote follow-up, four of these incorporated peer navigators (models 11, 13, 30, 35), with one also including peer educators (model 11). Their roles encompassed, but were not limited to, providing tailored explanations about the infections, addressing misconceptions, reducing stigma, coordinating appointments and ensuring follow-up, and interpreting and mediating interactions between the healthcare professionals and patients. Therefore, the inclusion of these figures in the models was key to reduce cultural and language barriers usually faced by migrant populations, facilitating their retention.

Other tools for the follow-up of patients under treatment were digital tools, reported by two models (models 13, 30); the *SAUDE + PERTO TB* model (model 30) reported using electronic reminders via text messages and carrying out home visits as well. The *VH-COMSAVAC* model (model 35), where one of the implementation's sites was a prison setting in Greece, incorporated the prison's staff for the follow-up of viral hepatitis cases. Treatment adherence support was also reported by four models (models 11, 13, 20, 30) using telephone calls or text messages to foster follow-up, three relied on peer support (models 11, 20, 30), the two multi-infection models incorporated directly observed therapy (DOT) or video supported therapy (models 13, 30), mostly for TB, and the *LINK - Ares do Pinhal* model (model 13) also allocated resources to support treatment adherence by conducting home visits.

[v] All 37 models were assigned numbers and are referred to by name and number in this report

The identified best practice models reported the collection of three or more effectiveness outcomes for retention in care including the number of people with more than two visits in a defined time period, appointment adherence, number of people tested to evaluate cure or infection control, and those lost to follow-up (Table 5). For instance, *MICATC* (model 11) and *VH-COMSAVAC* (model 35) reported that around 0-7% of migrants were lost to follow-up after initiating treatment for viral hepatitis until treatment completion or, at the point where HBV treatment was not recommended). The *MICATC* model (model 11) reported 92% of treatment completion for HCV. In *VH-COMSAVAC* (model 35) data on retention in care were available for Greece, where all patients with active HCV infections who had access to public healthcare services (12 individuals) started and completed DAA treatment, while four patients awaited temporary access to begin treatment. For HBV infection, three individuals required and started treatment and two did not, but all five remained under care.

These findings illustrate how integrated, multi-infection screening approaches can enhance coverage beyond routine practices. Together, such evidence highlights that models combining high acceptability with demonstrable improvements over conventional care can significantly increase testing uptake and overall programme effectiveness.

Cost of models of care

Six models reported assessing the total cost of their implementation (models 11, 13, 14, 28, 30, 35) and three viral hepatitis models conducted cost effectiveness evaluations (models 11, 14, 35). Another model, the *Integrated Migrant Care – Negrar* model (model 2), reported that a cost effectiveness evaluation is currently ongoing. The community integrated screening of HBV and HCV infections, including testing and linkage to care, implemented by the *HepBC-link model of care* (model 14) and later scaled-up in three other Catalan regions (Spain) as part of the *MICATC* model (model 11), achieved a health gain of 312 Quality-Adjusted Life-Years (QALYs) per 100 individuals screened and an Incremental Cost-Utility Ratio (ICUR) of €4 692 per QALY (cost-efficient). Moreover, the *VH-COMSAVAC* model (model 35) achieved a health gain of 6 100 incremental QALYs per 1 000 individuals screened and an Incremental Cost-Effectiveness Ratio (ICER) of €2 118 per QALY for HBV, and of 2 032 incremental QALYs per 1 000 individuals screened and €187 per QALY for HCV (cost-effective).

Table 5. Effectiveness outcomes of best practice models for retention in care of migrants with HIV, viral hepatitis, TB or other STIs

Model	#[vi]	Country	Infections	Effectiveness outcomes						
				No. of people completing treatment	No. of people with >2 documented visits	Appointment adherence	Re-engagement in care	No. of people tested to evaluate cure/ infection control	No. of people lost to follow-up	Other retention in care outcomes
MICATC	11	Spain	VH	✓	✓			✓	✓	
LINK - Ares do Pinhal	13	Portugal	HIV/VH/ TB/STIs	✓	✓	✓	✓	✓	✓	
HepBC-link model of care	14	Spain	VH	✓			✓	✓	✓	
PLUS Project in WIR (Bochum)	20	Germany	VH	✓	✓	✓		✓	✓	
SAUDE + PERTO TB	30	Portugal	HIV/VH/ TB/STIs	✓	✓	✓	✓	✓	✓	
VH-COMSAVAC	35	Spain Greece Italy	VH	✓					✓	✓

HIV: Human Immunodeficiency Virus; STIs: Sexually Transmitted Infections; TB: Tuberculosis; VH: Viral Hepatitis.

Transferability and sustainability

Eight models were identified as best practice for their strong performance on transferability and sustainability (Table 6, see further information in Annex 3 in the supplementary document). Of these, two models also demonstrated positive health impact: *BBV Rapid Test & Treat* for testing and linkage to care (model 21), and *SAUDE + PERTO TB* for linkage to care and retention in care (model 30). All eight models included undocumented migrants in service provision, with six models explicitly identifying them as the focus population (models 8, 15, 16,

[vi] All 37 models were assigned numbers and are referred to by name and number in this report

25, 29, 30). The remaining two models, both from Ireland, mainly focused on International Protection Applicants (models 5, 21).

The sustainability of the models was reinforced through institutional acceptance and structural integration, including their incorporation into health system frameworks via epidemiological or surveillance programmes (models 16, 25, 29), embedded within routine care (models 5, 15, 21), or adopted within local (model 5) and national strategic plans (models 15, 21, 25, 30). The majority of the identified models were funded through a budget line from the health systems (models 15, 16, 21, 29, 30), ensuring long-term sustainability. Alternatively, models received public funding at local (models 5, 8, 16), national (models 5, 8, 16) or European levels (models 8, 16, 25).

Programmes embedded into health system structures included testing services in migrant or refugee reception centres (models 5, 15, 21), primary care (model 15), as well as community-based locations through mobile clinics (model 21). The model *Screen to act on TB*, a national surveillance programme in Malta, integrated TB testing across different levels of care, including primary care, hospital-based, antenatal care, and migrant health or refugee reception centres (model 29) for migrants coming from countries where there is a high or very high-risk of contracting TB. The programme *Screening of communicable diseases* showcases the implementation of national screening protocols for refugees and asylum seekers in Finland by the Ministry for Social Affairs and Health, based on an individual risk assessment (model 15). The intervention is implemented locally at reception centres and contracted clinics, with guidance and supervision provided at the national level. Importantly, reception centre nurses assist in linkage to care, psychosocial support, and treatment support (e.g. DOT) for diagnosed cases. *MACIP-TB*, a regional TB-focused programme in Spain, used a community-based approach to support retention in care, led by community health workers and integrated with public health policies and epidemiological surveillance (model 25).

These programmes were implemented locally (model 15), regionally (model 25), in multiple regions within the country (model 21), or broadly at a national level (model 5, 29). The model *BBV Rapid Test & Treat*, an innovative approach for blood borne viruses RDT in Ireland, required a multidisciplinary approach across health services (public health, infectious disease services, and general practitioners) to reach buy-in across the system for regional programme rollout, with potential for scale-up at a national level (model 21). In the context of decentralised healthcare systems in some EU/EEA countries, implementation across multiple regions might highlight the models' potential for replication and scalability.

Civil-society organization (CSO)-based programmes were mainly implemented at a local or regional level (models 8, 16, 30), with testing delivered through community-based approaches, including mobile clinics (models 16, 30), as well as in migrant or refugee reception centres (model 8), citizenship or integration classes (models 8, 16), and food shelters (model 16). Nonetheless, some models demonstrated successful collaborations at a national or international level, fostering the transferability of best practices. The CSO-based model *Noaks Ark Mosaik* in Sweden has shared their integrated testing approach with partner organisations within the region (e.g. delivering on-site testing during community activities), has taken part in transnational projects (COmmunity REsponse to End Inequalities, and Mi-Health HIV Partnership initiative) to increase their reach and impact in service provision, and has established a collaboration with a patient-led HIV/AIDS organization in Ukraine to promote knowledge transfer (model 16). The *Mobile Screening Unit "Saúde + Perto"* was the first mobile unit in Portugal to perform screening tests for HIV, viral hepatitis and other STIs. Since then, their model has been adopted by other local organisations, creating a network of mobile units across the country with shared pathways to care (model 30).

Programmatic support documents such as implementation manuals or standard operating procedures were not consistently available across models of good practice. Comprehensive guides for implementation were reported by model users in Finland (model 15), Ireland (model 21), Spain (model 8) and Malta (model 29). This highlights the need for the systematic development of manuals to facilitate transferability, reproducibility of practices across different settings, and comprehensive guidance for programme implementation. Publicly available results and outcomes of programmes can be found in the scientific literature (models 15, 25) as well as in institutional or programme websites and reports (models 8, 15, 16, 21, 30) (Annex 5 in the supplementary document).

Table 6. Best practice models in the domain of transferability and sustainability for migrants with HIV, viral hepatitis, TB or other STIs

Model	#[vii]	Country	Infections	Programmatic support documents	Undocumented migrants included	Results publication		Replicability		Funding mechanisms			Institutional acceptance
						Website/ News	Scientific publication	National	International	Budget line from health system	Public funding	Private funding	
Health Screening of Forced Migrants	5	Ireland	HIV/VH/ STIs/TB	✓	✓			✓			✓		✓
Salud Entre Culturas	8	Spain	HIV/VH	✓	✓	✓		✓			✓	✓	✓
Screening of communicable diseases	15	Finland	HIV/VH/ STIs/TB	✓	✓		✓	✓		✓			✓
Noaks Ark Mosaik	16	Sweden	HIV/VH/ STIs	✓	✓	✓		✓		✓			✓
BBV Rapid Test & Treat	21	Ireland	HIV/VH	✓	✓		✓	✓		✓			
MACIP-TB	25	Spain	TB		✓		✓	✓			✓		✓
Screen to act on TB	29	Malta	TB	✓	✓			✓		✓			
SAUDE + PERTO TB	30	Portugal	HIV/VH/ STIs/TB		✓	✓		✓		✓			✓

HIV: Human Immunodeficiency Virus; STIs: Sexually Transmitted Infections; TB: Tuberculosis; VH: Viral Hepatitis.

Community-based approaches and stakeholder engagement

Eight models presented remarkable outcomes on community-based participatory approaches and stakeholder engagement (Table 7, and further information in Annex 4 in the supplementary document). Of these, two models also demonstrated positive health impact: *HepBC-link model of care* for testing, linkage to care and retention in care (model 14), and *BBV Rapid Test & Treat* for testing and linkage to care (model 21). As anticipated, for good practice initiatives targeting migrant populations, the community and stakeholder engagement component stood out among the four evaluation domains, with a considerable number of models scoring high and reporting relevant involvement of multiple actors in the design, delivery and evaluation of interventions.

Strong inter-sectoral collaboration was a common feature of successfully implemented models across countries. The involvement of health authorities (namely local administrations, public health services or government departments) and healthcare providers was typically coordinated (models 14, 19, 21, 32). Importantly, community involvement through migrant representatives and organisations serving migrant populations was central to programme development and implementation, directly enhancing intervention acceptability and uptake.

First, within several models, meaningful collaboration during the planning phase, including needs assessments and the co-creation of interventions through community-based participatory actions, led by or including migrant community members or representatives (models 8, 9, 14, 16, 19, 31, 32), as well as pilot programmes for preliminary assessment before broader implementation (model 21) were reported. The active involvement of community representatives enabled valuable cultural considerations and adaptations, including the translation and cultural adaptation of dissemination and educational materials (models 8, 9, 14, 21, 31), the creation of safe spaces[viii] by gender and age during awareness-raising sessions (models 16, 19) and testing activities (model 31), the incorporation of intercultural mediators or interpreters during testing activities (models 9, 20, 32), as well as staff who identify as LGBTQI+ (model 9).

[vii] All 37 models were assigned numbers and are referred to by name and number in this report.

[viii] Safe spaces refer to community care environments designed to be inclusive, confidential, and free from discrimination, enabling individuals to safely access services and support.

The *HepBC-link model of care* co-created educational tools for health promotion and strategies with health professionals and the community, and adapted them to the social and cultural aspects of the different migrant populations, following the methodological "eSPiCTools-ACTUA!" guidelines (model 14). The establishment of *Checkpoint BLN* involved extensive participation from NGOs (Schwulenberatung Berlin gGmbH, Berliner AIDS Hilfe e.V., Fixpunkt e.V., and Paritätischer Verband, a major umbrella organisation representing over 10 000 social and health service organisations in Germany) and the Senate Department for Health, Care and Equality (model 9).

Salud Entre Culturas engaged intercultural mediators and community leaders in project design, materials validation, and evaluation (model 8), similarly to *HEALTH4MIGRA SCREEN-AGRI*, where community leaders were involved in the co-design and feasibility assessment of the programme (model 31). The model *BBV Rapid Test & Treat* stemmed from a pilot program to determine of the most appropriate testing format for the target communities (model 21).

Second, strong dissemination strategies were fundamental to reaching target populations and underserved groups. These included the distribution of leaflets and physical information materials (models 9, 16, 19, 21, 31, 32); website, social media or TV campaigns (models 9, 16, 19, 32); outreach activities and community meetings (models 8, 9, 14, 19, 21, 31); through collaborating organisations and partners (models 9, 16); peer-led dissemination and referrals from primary care providers (model 32).

BBV Rapid Test & Treat used a dissemination strategy through communication apps such as WhatsApp and Telegram, physical leaflets and flyers, as well as an animated video in 11 different languages (model 21). *WIR-Walk In Ruhr* used social media videos, flyers in community centres, as well as outreach activities at festivals, sex work premises, youth centres, refugee reception centres and homeless shelters (model 19). Acceptability of the programmes was most frequently assessed through qualitative feedback gathered via structured interviews, focus group discussions (models 8, 19, 21, 32), and informal group exchanges involving migrant communities and a range of stakeholders (models 9, 16, 31, 32). In addition, self-reported questionnaires after service use and satisfaction surveys (models 9, 16, 21) informed the adaptation and refinement of delivery strategies.

Table 7. Best practice models in the domain of community-based approaches and stakeholder engagement for migrants with HIV, viral hepatitis, TB or other STIs

Model	#[ix]	Country	Infections	Inter-sectoral collaboration						Acceptability		Community engagement		Dissemination		
				NGOs	National health authorities	Other healt authorities	Healthcare providers	Migrant representatives	Others	Migrants	Other stakeholders	CBPR approach	Cultural adaptations	Flyers/ leaflets	Social media	Others
Salud Entre Culturas	8	Spain	HIV/VH	✓		✓		✓	✓	✓	✓	✓	✓		✓	✓
Checkpoint BLN	9	Germany	HIV/VH /STIs	✓		✓	✓			✓	✓	✓	✓	✓	✓	✓
HepBC-link model of care	14	Spain	VH	✓		✓	✓	✓	✓	✓	✓	✓	✓			✓
Noaks Ark Mosaik	16	Sweden	HIV/VH /STIs	✓		✓		✓	✓	✓	✓	✓	✓	✓	✓	✓
WIR-Walk In Ruhr	19	Germany	HIV/VH /STIs	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
BBV Rapid Test & Treat	21	Ireland	HIV/VH	✓	✓	✓	✓		✓	✓		✓	✓	✓	✓	✓
HEALTH4MIGRA SCREEN-AGRI	31	Italy	HIV/VH/TB/STIs	✓		✓			✓	✓	✓	✓	✓	✓		✓
ProSPIRo	32	Malta	HIV/VH/TB/STIs	✓		✓	✓	✓		✓	✓	✓	✓	✓	✓	✓

CBPR: Community-based Participatory Research; HIV: Human Immunodeficiency Virus; NGOs: Non-governmental Organizations; STIs: Sexually Transmitted Infections; TB: Tuberculosis; VH: Viral Hepatitis.

[ix] All 37 models were assigned numbers and are referred to by name and number in this report.

Additional relevant outcomes

Ten models scored highest on additional relevant outcomes (Table 8, and further information in Annex 4 in the supplementary document) and were identified as best practice for this domain. Of these, two models also demonstrated positive health impact: *PLUS Project in WIR (Bochum)* (model 20), and *SAUDE + PERTO TB* (model 30), both for linkage to care and retention in care.

The submitted models of care implicitly aimed to promote stigma-free testing environments while ensuring continuity of care. As a further step, a number of initiatives actively addressed stigma-related barriers to care through culturally-mediated counselling and empowerment (models 7, 10, 31), and educational and awareness raising activities among migrants and healthcare professionals (models 16, 19, 20, 25), and Risk perception and behaviour changes were formally assessed in community-based initiatives through questionnaires before and after testing (models 16, 30) and counselling sessions (model 10). The latter, *Choices@AZC*, a model based on psychological support services in the Netherlands, includes individualised prevention plans that identify risk behaviours to be minimised or eliminated, and established behaviour change targets as core programme goals (model 10).

The inclusion of prevention activities was a common element among the identified best-practice models, encompassing free condom distribution (models 10, 16, 19, 24, 26, 30, 31, 36), HBV vaccination (models 10, 15, 26), HPV vaccination (model 26) or information on vaccination programmes (model 20), provision of information and education on the targeted diseases and preventive measures (models 16, 19, 25, 26, 30, 36). Additionally, contact tracing of sexual partners (models 10, 16, 30), as well as TB contacts (models 25, 30) was carried out by phone, through SMS or email notification (model 20), or according to standard public health procedures and guidelines (models 15, 31). However, some programmes may face limitations in directly reaching contacts due to legal data protection barriers, highlighting in such cases the importance of partner notification, in which users are encouraged to personally reach out to their sexual partners (model 26). An online partner notification tool was used in a viral hepatitis-focused model, allowing patients to send standardised SMS or email messages to their sexual partners using the institutional *Walk-In Ruhr* address (models 19, 20).

Models of good practice promoted strengthening professionals' capacities through skill-building activities delivered in various formats, such as continuous training or attending conferences and workshops. This included training of medical and non-medical staff (peer navigators, intercultural mediators, community health workers, social workers or psychologists) on testing procedures, treatment standards, transmission and prevention mechanisms, surveillance and contact tracing, operational referral pathways, intercultural competence, and social needs provision.

Incorporating dedicated staff in specific tasks, such as accompanying patients to healthcare visits or actively following up with them, was identified as an essential component for providing guidance and support throughout testing and continuity of care processes. In this context, peer navigators were reported to offer both physical and emotional accompaniment (models 10, 16), helping patients overcome structural barriers to testing and treatment. Three models included psychologists in their service provision (models 10, 19, 20).

Other models included support provided by a range of professionals, including intercultural mediators (model 30), dedicated healthcare professionals or social workers (models 15, 26, 36), community leaders (model 31), sexual health advisors (models 19, 20), or community health workers (model 25). They played a key role in addressing social determinants of health, such as housing, legal status, work integration, healthcare access, and cultural or language barriers. In-house social workers, along with collaborations with social services and specialised organisations, facilitated legal guidance and residency applications (processes closely linked to healthcare entitlements in many EU/EEA countries) (models 10, 15, 16, 19, 26, 30). These partnerships also addressed housing difficulties (models 16, 26, 30, 31, 36), promoted work integration (models 16, 26, 30, 36), provided language classes (models 16, 30), and helped navigate services and overcome healthcare access or treatment barriers (models 10, 15, 16, 20, 25, 26, 30, 31). One model focused on specific populations such as refugees or sex workers (model 19). In the Netherlands, *Choices@AZC*, a social integration initiative for LGBTQ+ asylum seekers aimed to promote healthy behaviour and safe sex practices also included a free buddy support helpline (model 10). Some models also provided financial support or transportation tickets to facilitate mobility and ensure linkage and retention in care (models 15, 26, 31).

To ensure continuity of care and adherence to treatment among patients who moved between locations or countries, several models included mechanisms to facilitate successful transfer of care between healthcare providers. Two models (models 30, 31) included providing patients with written documentation of their diagnosis, treatment and follow-up needs, which could be shared with healthcare providers in their new location. In addition, four models (models 15, 16, 25 and 36) included communication and information-sharing between healthcare providers within the same country, while two models (models 25 and 36) included facilitated communication across EU/EEA countries. These measures aimed to ensure continuity of treatment and follow-up despite patient mobility. A national initiative *Screening of communicable diseases* in Finland used electronic patient information systems, phone and/or paper records for information transfer within the country, as well as the Early Warning and Response

System (EWRS) if patients relocated to another European country (model 15). The EWRS is a cross-border communication platform for alert and risk management, with its information system operated by the ECDC [27].

A range of interesting innovations that enhance the provision of services were reported. The *Choices 4 Better Living* app includes online videos to support self-testing and connects users to stigma free and queer-friendly healthcare and social support services (model 10). The online tool *Zanzu* provides comprehensive information on sexual and reproductive health and rights in seven different languages (model 36). The *Health Survey System* enables real-time recording of community actions (case follow-up, contact tracing or education actions) and communication with public health teams, integrating data collected at the community level with epidemiological and clinical data (model 25).

Overall, models of best practice highlight that integrating testing and treatment services for SDG 3.3 diseases with a range of complementary initiatives (such as educational actions for target populations and professionals, the promotion of prevention and contact tracing strategies, stigma reduction, social integration and the provision of psychosocial support, among others) contributes to early healthcare seeking and sustained continuity of care.

Table 8. Outcomes reported by best practice models in the domain of 'additional relevant outcomes for migrants with HIV, viral hepatitis, TB or other STIs'

Model	#	Country	Disease	Additional relevant outcomes									
				Behavioural changes	Stigma reduction	Training healthcare providers	Prevention activities	Contact tracing	Dedicated staff	Transfer of healthcare	Support/referral to psychological and/or other health programs	Support to address social and/or legal barriers	Integration of digital tools
Choices@AZC	10	Netherlands	HIV/VH	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Screening of communicable diseases	15	Finland	HIV/VH/ TB/STIs		✓	✓	✓	✓	✓	✓	✓	✓	✓
Noaks Ark Mosaik	16	Sweden	HIV/VH/ STIs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
WIR-Walk In Ruhr	19	Germany	HIV/VH/ STIs		✓	✓	✓	✓	✓	✓	✓	✓	✓
PLUS Project in WIR (Bochum)	20	Germany	VH		✓	✓	✓	✓	✓		✓	✓	✓
MACIP-TB	25	Spain	TB		✓	✓	✓	✓	✓	✓		✓	✓
Sexual Health Center Berlin	26	Germany	HIV/VH/ STIs		✓	✓	✓	✓	✓	✓	✓	✓	
SAUDE + PERTO TB	30	Portugal	HIV/VH/ TB/STIs	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HEALTH4MIGRA SCREEN-AGRI	31	Italy	HIV/VH/ TB/STIs		✓	✓	✓	✓	✓	✓	✓	✓	
CCM HIV Services	36	Norway	HIV/VH/ STIs		✓	✓	✓		✓	✓	✓	✓	✓

HIV: Human Immunodeficiency Virus; STIs: Sexually Transmitted Infections; TB: Tuberculosis; VH: Viral Hepatitis.

[x] All 37 models were assigned numbers and are referred to by name and number in this report.

Discussion

The identified models show effective, sustainable, and transferable models of care that extend beyond standard healthcare delivery to include integrated, culturally competent, and person-centred approaches tailored to the complex realities for migrants in Europe.

Common characteristics of good practice

The assessment of 37 models implemented across 14 EU/EEA countries reflect the heterogeneity of health systems, which has been documented in the literature as a key determinant of intervention success and transferability [28]. Differences in governance (centralised vs. decentralised systems), financing mechanisms, and legal entitlements create varying conditions for implementation. However, common enabling factors emerged across settings, including stakeholder engagement, intersectoral collaboration, and trust-building mechanisms through confidentiality, non-discriminatory and stigma free practices, the involvement of multidisciplinary teams and links to broader social services. In this sense, the establishment of strong, multidisciplinary networks across services has been repeatedly identified as a cornerstone for improving service uptake among migrants, who may otherwise avoid healthcare due to fear of stigma or legal repercussions. This is key to ensuring continuity of care and to addressing intersecting barriers to care [29].

An important finding of this collection is the performance of integrated, multi-disease testing approaches. Models that combine screening for HIV, viral hepatitis, TB, and STIs in a single encounter show increased uptake and are consistent with prior implementation science research [15,30-32]. This approach reduces missed opportunities for diagnosis and the need for multiple healthcare visits, which can be particularly challenging for individuals in precarious living or working conditions. The high proportion of included models (75%) adopting multi-disease testing suggests a positive shift toward alignment with international guidelines for integration [24-26,33,34]. However, further evaluation is needed as integration may increase complexity in service delivery and pose challenges for workforce and diagnostic pathways.

A consistent theme across the models is low-threshold and community-based testing strategies, such as mobile clinics, outreach testing, and partnerships with CSOs and other stakeholders, which have consistently shown an increase in early diagnosis and engagement in care [35] and in reducing structural barriers, including legal insecurity, language difficulties, stigma, or low health literacy that migrants often encounter [36-38].

An important, good practice component increasingly recognised in health interventions is the community-based participatory approach. Programmes developed in collaboration with migrant communities are more likely to be acceptable, accessible, and effective by ensuring that services are relevant and responsive to the needs of this population [20].

Another finding confirms the central role of addressing social determinants of health. Health outcomes for migrants are closely linked to broader issues such as housing, employment, legal status, and social inclusion. Programmes that integrate health services with social support, legal assistance, housing support, or mental health care show improved engagement in care and have a positive effect on both linkage and retention in care [39].

Improved testing and screening

Most of the models reported varying strategies to increase the screening and testing uptake of migrants. For example, a high number of models included POCT as part of the testing strategy, which provide rapid results and reduce loss to follow-up [40-42]. Several models showed innovative ways to integrate testing in non-traditional settings, including community settings, prisons (models 27, 35), reception centres or mental health services (model 10). The latter was a mental health counselling programme primarily focused on addressing psychosocial migrant needs that incorporated risk assessment and testing for infectious diseases. This reflects an emerging trend in public health practice toward opportunistic and cross-sectoral screening, which has been recently suggested as an effective strategy to reach underserved populations [43]. Similarly, the use of clinical decision support systems based on routine clinical data can be used to identify migrants at higher risk who should be prioritised for screening [44]. These systems provide individualised recommendations to physicians, representing a promising data-driven approach, consistent with broader trends in precision public health.

Improved linkage to care

Despite improvements in testing strategies, the literature consistently emphasises that linkage to care remains a critical gap, corroborated by the findings of this report. The literature highlights that delays between diagnosis and treatment initiation and people lost to follow-up are common challenges [45,46]. Effective models address these gaps through patient navigation, case management, and peer support systems. Community health workers, peer navigators, and cultural mediators play a significant role in guiding individuals through complex healthcare systems [47,48], as they facilitate communication and assist with administrative procedures in addition to ensuring the understanding of diagnosis and treatment options. This is especially valuable in contexts where health systems are fragmented or difficult to access. Overall, the findings of this report strongly align with evidence showing that culturally adapted support mechanisms significantly improve linkage outcomes for migrants.

Improved retention in care

Retention in care emerges as one of the most challenging components of the care cascade across all diseases. Migrants often experience frequent mobility, unstable housing [18], cross-border continuity barriers and changing legal or employment circumstances, all of which disrupt continuity of care [49,50]. Models of good practice therefore emphasise flexibility, including decentralised treatment services (models 1, 13, 15, 17, 19, 20, 21, 23, 30, 31, 35, 36), multi-month dispensing of medications (model 7), digital follow-ups, and cross-border continuity mechanisms where possible. For example, from best practice models that included a retention in care component, the majority (4 out of 6; 66%) supported treatment adherence and follow-up by using telephone calls or text message reminders. Interestingly, the shift from directly observed therapy (DOT) programmes to more flexible approaches, such as video-DOT offered by the model *SAUDE+PERTO TB* (model 30) or the *Low-threshold Integrated Network of Care* (model 13) in Portugal, which support treatment adherence through home visits, may substantially reduce the costs of treatment adherence for TB monitoring. This transition reflects evolving evidence that emphasises patient autonomy while maintaining adherence. In addition, few models such as the *Checkpoint BLN* (model 9) offered decentralised treatment (outside hospital settings), which is particularly important for diseases requiring chronic treatment.

Around 50% of the submitted models addressed and supported the entire care cascade. While this shows progress toward coordinated approaches that ensure continuity of care, some gaps remain, particularly in ensuring adherence to treatment and long-term retention in care for chronic infections such as hepatitis B or HIV. This is consistent with broader evidence indicating that while testing and diagnosis have improved in many settings, sustaining engagement in care remains a major challenge, particularly for marginalised populations [51].

A broader assessment of effectiveness in addressing migrant needs

Good practice models in this collection were assessed according to a broad and practice-oriented assessment framework encompassing four key domains, and not only on measures of effectiveness on health impact [52,53]. This approach places value on interventions which holistically focused on migrants, a population which often operates in complex, resource-variable, and context-specific settings, where success depends not only on clinical outcomes but also on feasibility, being culturally appropriate, and long-term integration into health systems. By also including these domains, the evaluation aims to identify models that are not only impactful but also adaptable, inclusive, and capable of being sustained and scaled across diverse contexts, thereby offering more meaningful guidance for policy and practice.

No model ranked in the top 20th percentile for all four domains, and only three models were classified in the top 20th percentile in three of the domains. Interestingly, among the 10 models that scored highest in the health impact and cost domain, five were not classified in the top 20th percentile in any other domain. These findings suggest that high performance in one domain does not necessarily translate into overall strength across multiple dimensions of good practice. The absence of any model in the top 20th percentile across all four domains highlights the inherent complexity of designing interventions that are simultaneously impactful, cost-efficient, transferable, sustainable, and strongly grounded in community engagement. It also points to potential trade-offs in programme design, where optimising for health impact alone may come at the expense of broader system-level considerations.

Health impact and cost

While most best practice models for testing reported indicators related to number of tests performed or testing uptake, fewer assessed coverage, early diagnosis, or long-term outcomes, largely due to methodological and practical challenges in estimating the size of migrant populations and following individuals over time. All best practice models except one (model 35) reported testing uptake, but the testing coverage was only assessed by one model. This may be due to the difficulty in estimating the size of the population at risk that could benefit from the programme within catchment areas. The positivity rate and early diagnosis have been assessed by >60% of the best practice models, whereas other health impact indicators, (i.e. individuals with results communicated or lost-to-follow up before referral to specialist), were less registered. In the linkage to care component, all best practice models reported the number of individuals with confirmed diagnosis, referrals to specialists, first visits and number of lost to follow-up.

A key gap identified across the reviewed models is the limited number of models reporting cost-analyses or cost-effectiveness analyses. While the majority of interventions reported collecting overall programme cost or funding sources, only a small proportion conducted structured economic evaluations assessing indicators such as cost per test performed, cost per diagnosis, cost per individual linked to care, cost per patient retained in care, index of ICER or quality adjusted life years (QALYs). Performing cost-effectiveness analyses can be challenging, as it requires identifying direct costs, health outcomes/impact as well as related indirect costs from disease prevention and control. Therefore, the absence of robust CE data represents a significant challenge for evidence-informed decision-making and resource allocation, particularly in the context of constrained public health budgets.

Importantly, several models incorporated components that are likely to be cost-effective based on existing evidence, even if a formal evaluation was not conducted (i.e. multi-disease integrated testing approaches [34], POCT [54], task-shifting to community health workers [55], and decentralised or community-based service delivery [56]). Such interventions can reduce downstream healthcare costs by enabling earlier diagnosis, preventing disease transmission, and avoiding complications associated with late-stage presentation.

Limitations

This selection of good and best practice models is subject to the following limitations. First, participation was based on self-selection. Although the call for models was disseminated broadly through multiple professional and stakeholder networks, only authors that expressed interest and submitted their models could be considered for inclusion. As a result, initiatives where staff did not respond to the call and subsequently did not spend the necessary time filling out the survey and participating in the interview, are not included in the collection.

In addition, the geographical representation of models was uneven. While submissions were received from a range of countries and settings, no models from Eastern Europe were included, limiting the regional representativeness of the findings and potentially overlooking context-specific practices and challenges.

Conclusions

These models of good practice describe interventions and approaches used successfully across the EU/EEA to address the care cascade for SDG 3.3 diseases HIV, TB, viral hepatitis and STIs among migrant populations. They illustrate how integrated and tailored interventions (combining convenient testing, rapid linkage and tailored retention support) improve engagement across the care cascade for migrants.

Effective approaches to testing, linkage to care, and retention in care for HIV, viral hepatitis, TB, and STIs among migrant populations are both feasible and impactful when designed around the specific needs, lived realities and structural barriers of these communities. Distinguishing features of the best-practice models identified in this collection demonstrate that:

- Integrated, person-centred, multi-disease, low-threshold, and community-based testing strategies can result in increased testing, linkage to care, and/or retention in care;
- Strong systems for rapid and coordinated linkage to care embedded within primary care and community settings are effective strategies;
- Sustained retention support (often delivered through community or with peer involvement that help overcome barriers) can significantly improve engagement across the care cascade and improve health outcomes but also address broader social determinants of health.

However, several gaps limit comparability, implementation, and scale-up. Many models lack comprehensive monitoring and evaluation frameworks, including standardised indicators and data on costs or cost-effectiveness analyses, which constrains the ability to compare outcomes and support long-term planning and sustainability. In addition, the sustainability and transferability depend on their integration within health systems, stable funding and supportive policy frameworks that ensure equitable access to healthcare.

Recommendations

Testing, linkage to care and retention in care

- Expand low-threshold and community-based testing approaches including mobile clinics and outreach;
- Strengthen systems for rapid and coordinated linkage to care and retention in care adapted to migrant populations through tailored support mechanisms such as patient navigation, case management, and culturally adapted support services;
- Strengthen integration of multi-disease, person-centred service delivery.

Community engagement and collaboration

- Ensure meaningful community engagement and co-creation strategies of interventions with migrant populations;
- Develop culturally and linguistically adapted health promotion materials and communication efforts to improve awareness and health literacy across the care cascades;
- Address broader social and structural barriers affecting access to care by establishing links to general health and social services, including mental health, sexual and reproductive health, legal aid, and housing support with HIV, viral hepatitis, TB, and STI services;
- Foster multisectoral partnerships involving public health authorities, civil society and migrant communities.

Sustainability and transferability

- Improve monitoring, evaluation and comparability of service models;
- Support sustainability and transferability through system integration and stable funding mechanisms;
- Address broader social determinants of health;
- Support long-term project funding and institutionalised financing mechanisms for effective models.

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Annex 1. Rapid literature review

There is particularly limited up-to-date evidence on effective, transferable and sustainable approaches for testing, linkage to care, and retention in care for human immunodeficiency virus (HIV), viral hepatitis, tuberculosis (TB), and sexually transmitted infections (STIs) among high-risk migrant populations in the European Union and the European Economic Area (EU/EEA) context.

A rapid literature review was conducted that comprised three different searches on: (i) testing and screening programmes for HIV, TB, hepatitis B (HBV) and C virus (HCV) for migrant populations in high-income countries (May 2024), (ii) screening programmes for infectious diseases in primary care and community settings targeting migrant populations in high-income countries (July 2024), and (iii) testing, linkage to care, and retention in care interventions for STIs in migrants living in the EU/EEA (May 2025). One reviewer sifted and searched through the titles, abstracts, and full texts of articles using the inclusion criteria, and consulted a second reviewer for any papers of uncertainty. A narrative synthesis was conducted.

The combined searches yielded 77 original studies containing 78 models of practice, with one article describing two models. The studies covered nine countries including Italy (n=26), Spain (n=14), the Netherlands (n=10), France (n=9), Germany (n=4), Sweden (n=3), Belgium (n=3), Finland (n=2), Denmark (n=2), Greece (n=1), and three were in multiple EU/EEA countries. There were 23 models on TB, six on HIV, 14 on HBV/HCV, four on STIs, and 31 multi-disease models. Models targeted different migrant groups (e.g., asylum seekers, refugees) or other minority groups (e.g., sex workers), and were implemented across community and healthcare settings. Seventy-seven models reported outcomes on testing, 39 reported outcomes related to linkage to care models, and 21 reported outcomes around retainment in care.

These findings demonstrate that increased testing uptake can be achieved through various models and some studies showed successful linkage to care and treatment outcomes; yet, trial evidence was limited and when available it focused on diagnosis rather than clinical outcomes, restricting the assessment of effectiveness. Overall, ensuring continuity of care remains an ongoing challenge throughout the treatment cascades in majority of the reported literature. Migrant populations encounter significant structural and systemic barriers when accessing testing, linkage to care, and retention in care, in addition to language and gender-related barriers, cultural insensitivity, stigma, and migration stressors. An integrated approach combining multiple models is necessary to achieve comprehensive coverage. Community-based testing models appear particularly effective for initial engagement and reaching marginalised subgroups of migrants, while primary care integration shows promise for ensuring continuity of treatment. Hospital-based approaches may serve as important access points for populations with limited healthcare rights. Crucially, evidence underscores that for the successful implementation of any model, meaningful community engagement is needed throughout the entire process.

To conclude, addressing the barriers migrants face in accessing infectious disease testing and care requires adaptable, multi-setting, and multi-disease strategies, combining community outreach, primary care integration, and adapting services in the hospital setting with flexible entry points and rapid testing.

Annex 2. Summary of models of good practice

1	Integrated Hospital- and Community-Based Screening Programme for Infectious and Tropical Diseases among Migrants in Negrar, Verona, Italy		
	Italy	HIV/VH/STIs/TB	Testing / Linkage / Retention
Tamara Ursini, Department of Infectious - Tropical Diseases and Microbiology, IRCCS Sacro Cuore don Calabria Hospital, Negrar, Verona, Italy; Dora Buonfrate, Department of Infectious - Tropical Diseases and Microbiology, IRCCS Sacro Cuore don Calabria Hospital, Negrar, Verona, Italy;			
The Migrant Outpatient Service was established over 30 years ago as a dedicated facility providing screening and care for migrants, including undocumented individuals. Initially focused on neglected tropical diseases (NTDs) and major non-communicable diseases (NCDs), the programme has progressively expanded its scope and diagnostic capacity. Since its inception, it has consistently worked in close collaboration with CESAIM, a volunteer-based medical assistance organisation in Verona, ensuring strong links with hard-to-reach migrant communities, particularly those without entitlement to healthcare. Over the last decade, systematic screening for tuberculosis infection and disease, HIV, syphilis, hepatitis B and C has been implemented, with additional testing for other sexually transmitted infections in high-risk cases. Screening for NTDs (i.e. schistosomiasis, strongyloidiasis, filariasis, and soil-transmitted helminthiases) is offered based on migrants' geographical origin. Tuberculosis, syphilis, and helminthic infections are managed within the service; HIV and viral hepatitis cases are referred to specialised Infectious Diseases Units within the Verona network. Women's health is a specific focus, with particular attention to infectious disease screening in pregnancy. A key feature is the involvement of cultural mediators throughout the care pathway, supporting communication, helping to reduce stigma, and promoting a migrant-sensitive approach to care, with benefits for both individual outcomes and public health. A recent innovation is a pilot integrated outreach screening project conducted directly in reception centres for asylum seekers and newly arrived migrants. Implemented in collaboration with social workers, reception centre staff, and cultural mediators, it complements the hospital-based service by improving accessibility, continuity, and coordination of care. The team would like to acknowledge Dr Geraldo Badona Monteiro for his pivotal role in developing and strengthening the Migrant Outpatient Service over the years.			
2	General Heath Assessment of refugees		
	Denmark	HIV/VH/STIs/TB	Testing
Marie Louise Nørredam, Hvidovre Hospital, Denmark Ida Glode Helmuth, Hvidovre Hospital, Denmark			
In Denmark, all newly arrived refugees (UNHCR-quota) are by law systematically offered voluntary general health assessments (GHAs). Municipalities may also offer GHAs to selected refugees with asylum seeking history or family reunification background. The GHA includes a comprehensive evaluation and examination of physical and mental health status and is conducted, with regional variance, either by a general practitioner (GP) at a department of social medicine, or at a specialised migrant health outpatient clinic (MHOC). In the Capital Region, the MHOC Hvidovre, Department of Infectious Disease, carry out the GHA including tests for HIV, hepatitis, syphilis and tuberculosis as part of standard care. After getting a blood test done, migrants attend the MHOC for a one-time medical visit, where they receive the test results and the necessary follow-up information. Positive patients are referred to the Infectious Diseases Unit at the hospital, and if needed, to other specialized units for other medical conditions.			
3	Active and latent TB screening in unaccompanied foreign minors (UFMs)		
	Italy	TB	Testing / Linkage
Francesca Pennati, MD, Infectious and tropical disease specialist; AAST Spedali Civili of Brescia, Italy Paola Zanotti, MD, Infectious and tropical disease specialist; AAST Spedali Civili of Brescia, Italy			
Since August 2023, thanks to a collaboration between the public hospital Spedali Civili and the Municipality of Brescia (Italy), a systematic health assessment of all unaccompanied foreign minors (UFMs) is carried out in reception centres. During the visit, the child's migration and health history is investigated, a general clinical assessment is conducted and evaluation for active tuberculosis and ectoparasitosis signs is performed. Finally, all patients are screened for tuberculosis infection. Those who test positive are sent to evaluation to decide if treatment for LTBI is required. UFMs are also vaccinated according to national indications.			

4	Screening for HIV, viral hepatitis and STI in undocumented adult migrants in a migrant health clinic in Brescia, Italy		
	Italy	HIV/VH/STIs	Testing / Linkage
Francesca Pennati, MD, Infectious and tropical disease specialist; AAST Spedali Civili of Brescia, Italy Paola Zanotti, MD, Infectious and tropical disease specialist; AAST Spedali Civili of Brescia, Italy			
The screening takes place within the migrant health clinic of the largest public hospital in Brescia, Italy. It is a free access clinic for the screening, diagnosis and treatment of the main STIs. Migrants who visit the clinic are offered infectious disease screening tests for HIV, viral hepatitis and STI, which are carried out on site, free of charge. All migrants can have a test, counselling, medical examination and treatment, including undocumented migrants. Those who are diagnosed with HIV, TB, TB infection or viral hepatitis are referred to a second level Clinic while treatment and follow-up for other STIs is directly provided, including scabies. All STI diagnosis are regularly notified and epidemiological data are collected. The migrant clinic offers vaccination for high-risk individuals including HBV, HAV, HPV and MPX vaccines. It also offers free primary care to undocumented migrants (replacing the general practitioner, who is not provided for this population by current Italian legislation) and, where necessary, refers them to hospital or secondary care. It also provides guidance on local community health and social services.			
5	Health Screening Service for International Protection Applicants		
	Ireland	HIV/VH/STIs/TB	Testing
Dr Sabrina Vassia, Health Service Executive South West, Ireland;			
The aim of the service is to identify communicable diseases such as TB, HIV, HBV/HCV and STIs through screening, timely specialist referral, tracing of contacts, immunisation of patients and of contacts, health education. The service also screens for other serious illnesses and serious mental health issues, particularly in relation to trauma. The target population are International Protection Applicants (otherwise known as 'Asylum Seekers') who have been resettled in Direct Provision Centres (hotel-like accommodation centres) in County Cork, Ireland. The opt-out service is offered on-site through regular clinics in accommodation centres run by doctors and nurses, with the assistance of centre staff, reception officers and community workers / peer support workers.			
6	INTEGREAT-study		
	Netherlands	HIV/VH/TB	Testing / Linkage
Chrissy Moonen, Elfi Brouwers, elfi.brouwers@ggdzl.nl 1. Department of Health Policy and Development, Living Lab Public Health Mosa (AWPG Mosa), South Limburg Public Health Service, Heerlen, the Netherlands 2. Department of Social Medicine, Care and Public Health Research Institute (CAPHRI), Maastricht University, the Netherlands			
The INTEGREAT-study assessed the feasibility and acceptability of integrating HBV, HCV and HIV testing into mandatory TB screening for migrants from high-prevalence countries (>50 cases per 100,000) intending to stay over three months. This mixed-methods study offered point-of-care testing (POCT) using finger-prick blood for HBV, HCV, and HIV alongside a brief medical history questionnaire during TB screening at the Public Health Service. Four focus groups with executive healthcare workers assessed implementation. Of 293 eligible individuals, 231 (78.8%) participated. Participants (51.1% male, mean age 31.9 years) originated from India (27.7%), South Africa (24.7%), Pakistan (7.4%), and other countries (40.2%). Three participants (1.3%) tested positive for HIV Ag/Ab or HBsAg and were referred to care if appropriate. Most participants (90%) preferred finger-prick testing over venipuncture. Focus groups highlighted the importance for clear protocols and skilled staff for successful implementation. The study demonstrated the feasibility and acceptability of integrating POCT into TB screening.			
7	Testing, linkage and retention in HIV care and prevention for migrant populations in the Republic of Cyprus		
	Cyprus	HIV/VH/STIs/TB	Testing / Linkage / Retention
Georgios Siakallis, MD, MSc, HIV National Focal Point, Gregorios HIV Reference Clinic, Larnaca General Hospital. Cyprus Fani Theophanous, BSc, MSc, Unit for Surveillance and Control of Communicable Diseases, Ministry of Health. Cyprus			
Universal testing is provided for all migrant populations entering the country at hospitality centres as an opt out approach. This includes TST for tuberculosis and serology for HIV, viral hepatitis, and syphilis. Reactive results are directly linked to specialised care to ensure fully reimbursed treatment and medical follow up. Following release from hospitality centres to the community, opt in testing is provided at various sites, which are fully reimbursed and anonymous. Among others, these include public hospitals, community-based rapid testing, community-led mobile clinics in collaboration with medical schools, free provision of self-tests and community-performed rapid tests at gatherings like Pride, PrEP outpatient services, etc. The Republic of Cyprus provides full reimbursed ART and medical follow up for people living with HIV, regardless of NHS/migration/or residency status. The holistic provision of HIV-related care follows an anonymous coding system to limit barriers associated with fear of deportation and strengthen linkage to care. Furthermore, as of October 2025 Cyprus has included migrant and moving populations amongst the beneficiaries of the recently implemented PrEP services. Provision of PrEP is also fully reimbursed and linked to fast-track vaccination centres to offer vaccination against HBV, HAV, HPV, N. meningitidis, and *S. pneumoniae* as per national guidelines.			

8	Salud Entre Culturas: Community-based model working with intercultural mediators for infectious disease prevention, testing, and linkage to care among migrant and mobile communities in Spain		
	Spain	HIV/VH	Testing / Linkage / Retention
Cristina Arcas Noguera, Health Area Coordinator;Salud Entre Culturas, Spain Ignacio Peña Ruiz, Coordinator; Salud Entre Culturas, Spain			
Salud Entre Culturas is an NGO-led programme that promotes early diagnosis, linkage to care, and retention in care for HIV, viral hepatitis (B and C), and other infectious diseases among migrant populations in Spain. The programme combines community-based screening campaigns with culturally and linguistically adapted health education, counselling, and referral pathways. A key component is the involvement of trained intercultural mediators who facilitate communication, build trust, and support individuals throughout the care continuum. This approach reduces structural, linguistic, and cultural barriers to access, while addressing stigma and misinformation. The programme also strengthens system capacity by training NGO staff, volunteers, and healthcare professionals in culturally competent communication and the management of diversity. It further supports the provision of intercultural mediation and interpretation services within healthcare settings. The main objectives are: (1) to improve access to testing and early diagnosis among migrant and mobile communities; (2) to enhance health literacy and promote preventive behaviours; (3) to ensure effective and equitable linkage to and continuity of care; and (4) to foster more inclusive and responsive healthcare services.			
9	Checkpoint BLN		
	Germany	HIV/VH/STIs	Testing / Linkage / Retention
Jacques Kohl, Checkpoint Berlin, Germany Bornice Biomndo, Checkpoint Berlin, Germany			
Checkpoint BLN is a sexual health clinic that integrates community-based approaches with clinical service provision. It operates under two NGOs: Schwulenberatung Berlin gGmbH, which provides support and counselling for gay, bisexual, trans*, and inter* individuals on issues of health, substance use, identity, and discrimination; and Berliner AIDS Hilfe e.V., which focuses on HIV and AIDS prevention, testing and care, sexually transmitted infections (STIs) and hepatitis, as well as combating stigma and discrimination. Established as a low-threshold hub, the clinic offers free or subsidised anonymous and confidential counselling, testing, and treatment for HIV (including PrEP and PEP), STIs, and Hepatitis C, along with vaccinations for hepatitis A and B, HPV, and MPX. Counselling is also provided on sexuality, substance use, and access to health insurance for individuals with limited coverage. Services are delivered on-site and through outreach by a multilingual, multidisciplinary team reflecting diverse ethnic, sexual, and gender identities. The clinic includes counselling rooms, a medical examination room, and a laboratory, enabling faster, seamless testing and treatment initiation, and also provides space for self-help groups and research activities. Checkpoint BLN facilitates early diagnosis and timely management of HIV, hepatitis, and STIs among high-risk populations, contributing to reducing undiagnosed infections in line with SDG 3.3. Most clients are first-generation migrants, with a focus on gender minorities, undocumented migrants, sex workers, and people who use drugs. Collaboration with community organisations and public health services supports referrals and continuity of care, further strengthened by on-site specialised general practitioners.			
10	Choices Support Center: Testing and Prevention Interventions for LGBTQ+ Migrants		
	Netherlands	HIV/VH/STIs	Testing / Linkage / Retention
Ivanesa Borisova, NIP psychologist; Choices Support Center, the Netherlands			
Choices Support Center (Choices) has developed a national community-based initiative for prevention and mental health counselling for LGBTQ+ asylum seekers. Choices prevention counselling, that is available on site in asylum seekers centers (AZCs), our office and online via video consultations helps people with trauma, depression, PTSD and anxiety disorders to remain stable in the AZC during the long, uncertain asylum procedure. During our intake assessments we conduct a risk assessment and determine if testing for HIV, HCV and STIs should be offered. Our psychologists offer a combination of supervised and supported self-testing through online video support when the client is ready to test or in our office. Linkage to care is offered on a needed basis when testing or PrEP is requested at the health department, and after a positive self-test result. Our community services coordinator is responsible for assisting clients resolve non mental health issues, support counselling and case management tasks such as connecting clients to external services (i.e., city health department for confirmation testing, treatment and HIV support / advocacy organisations).			

11	MiCatC: A community strategy for screening for Hepatitis B and C, and early access to treatment, among migrant populations from high-prevalence countries		
	Spain	VH	Testing / Linkage / Retention
Venus Forero, Sandra Manzanares-Laya, Subdirectorate General of Addictions, HIV, STI and Viral Hepatitis, Public Health Agency of Catalonia (ASPCAT); Spain			
The main goal of the MiCatC intervention was to design and implement a community-based strategy to improve the detection and linkage to care for hepatitis B (HBV) and hepatitis C (HCV) among migrant populations from high-prevalence countries living in Catalonia, Spain. Recognising barriers to healthcare access, the project aimed to bring screening and education directly into community settings, fostering trust and accessibility. Activities were carried out in collaboration with religious leaders and centres, migrant and community organisations, emphasising participatory approaches. A multidisciplinary team—composed of peer educators, community health agents, and primary care nurses—ensured both cultural sensitivity and clinical rigor. The intervention included educational workshops on viral hepatitis transmission and prevention, followed by on-site rapid testing for HBsAg and anti-HCV, with immediate communication of results. Individuals testing anti-HCV positive provided dried blood spot samples for HCV RNA confirmation. Sociodemographic, clinical, and risk factor information was collected, and participants testing positive were referred for hepatology consultation, follow-up, and treatment initiation. Implementation took place over 10 months, screening 1,505 people, predominantly men (71%) and of Pakistani origin (68%), most of whom were long-term residents in Catalonia. The project identified active HBV and HCV infections and ensured linkage to care for a proportion of cases. MiCatC highlights the need for coordination between primary and hospital care in community interventions. It demonstrates that culturally adapted screening can effectively detect, link, and treat viral hepatitis, while emphasising the importance of strengthening community-based approaches to improve retention in care and long-term outcomes.			
12	PaKoMi - Partizipation und Kooperation in der HIV-Prävention mit Migrantinnen und Migranten		
	Germany	HIV	Testing / Linkage
Dr. Laila Prager, Deutsche Aidshilfe e.V. (German Aids Federation); Germany			
PaKoMi stands for participation (Pa) and cooperation (Ko) in HIV prevention with migrants (Mi). It aimed to identify existing needs in the development and implementation of HIV primary prevention strategies. The project is a research initiative of the non-governmental organisation Deutsche AIDS-Hilfe e.V. (DAH), which was scientifically supported and supervised by Prof. Dr. Hella von Unger (LMU Munich) and Prof. Dr. Michael T. Wright from the Social Science Research Center Berlin (WZB). The project targeted communities by engaging peer researchers within these groups. PaKoMi is a participatory and empowerment-based project, meaning that all partners collaborate throughout every phase in order to better understand the living conditions and needs of migrants. The project had multiple components and goals: • A survey of 90 AIDS service organizations • Case studies in four German cities (Berlin, Hamburg, Dortmund, and Osnabrück) • A series of workshops for capacity building • On-site evaluation of the case studies and workshops The cross-case analysis of the overall project led to a range of findings that were later adapted in other cities and presented at conferences and workshops across Europe. The project's advisory board included community experts on living conditions as well as practitioners (e.g., employees of AIDS organizations, prevention projects, counselling centres, public health authorities, and scientists).			
13	Low-threshold Integrated Network of Care		
	Portugal	HIV/VH/STIs/TB	Testing / Linkage / Retention
Hugo Faria; Ares Do Pinhal, Portugal Claudia Pereira; Ares Do Pinhal, Portugal			
The Integrated Care Pathway (LINK) is a low-threshold, person-centred intervention designed for people experiencing homelessness and other situations of severe social and health vulnerability, including migrants and people who use drugs (PWUD). It delivers an integrated continuum of care through outreach, harm reduction, communicable disease screening, emergency accommodation, supervised consumption, case management, and supported transitions to more stable living situations. Through regular outreach and other proximity-based responses, multidisciplinary teams engage individuals who are often underserved and face significant barriers to accessing mainstream health and social services, including administrative, linguistic, cultural, and structural barriers. The model is grounded in low-threshold access, trust-building, and sustained engagement, enabling early identification of unmet health and social needs. A core component of the pathway is integrated health assessment and referral, including screening for HIV, hepatitis B, hepatitis C, syphilis, other sexually transmitted infections, and tuberculosis, alongside basic clinical support, psychosocial assessment, harm reduction interventions, and overdose prevention. Particular emphasis is placed on linkage to care and continuity of care, ensuring active referral, care navigation, and follow-up from screening to confirmatory diagnosis, treatment initiation, specialist care, and ongoing support. By combining immediate protection and stabilisation with medium- and longer-term support, the model strengthens access to healthcare, social and legal support services, and housing pathways. Overall, LINK promotes safer service engagement, improves retention in care, and supports progressive pathways towards health improvement, social inclusion, and greater autonomy.			

14	HepBC-link: Hepatitis B and C screening and linkage to care and treatment in migrants from endemic countries in Barcelona through a community action.		
	Spain	VH	Testing / Linkage / Retention
Elisa Martró; emartro@igtp.cat 1.Pathogen Diagnostics and Genomic Epidemiology Group, Microbiology Department (LCMN), Germans Trias i Pujol Institute and Hospital (IGTP), Can Ruti Campus, Badalona, Spain. 2. Biomedical Research Networking Centers in Epidemiology and Public Health (CIBERESP), Instituto de Salud Carlos III, Madrid, Spain. Jordi Gómez i Prat; 1. Public Health and Community Team (eSPiC), Drassanes-Vall d'Hebron International Health Unit (USIDVH), Department of Infectious Diseases, Vall d'Hebron University Hospital, Barcelona, Spain. 2. International Health Program of the Catalan Institute of Health (PROSICS), Barcelona, Spain.			
HepBC-link aimed to pilot and assess the feasibility and outcomes of a community action combining education, screening, and simplified access to care for hepatitis B and C among migrants from Pakistan, Romania, and Senegal living in the Barcelona province. The project was based on a previously developed and evaluated methodology for HCV community screening in Pakistani migrants. From 2021 to 2023, participants were recruited through community actions targeting these populations. The intervention included education on viral hepatitis using an interactive tool (Heparjoc), an epidemiological questionnaire, and rapid testing for HBV surface antigen (HBsAg) and HCV antibodies. Positive cases provided dried blood spot samples for laboratory confirmation of HCV RNA and HBV DNA. Recruitment, education, and testing were carried out within single events in diverse settings. Activities were coordinated by the International Health Unit (IHU) Community and Public Health Team, including a physician specialised in infectious diseases and public health, a public health nurse, and Community Health Workers (CHWs) from each country of origin. CHWs were trained in testing, DBS collection, and counselling, and conducted activities in participants' native languages. Participants testing negative were advised to attend primary care or the IHU for further health checks, including HBV vaccination if needed. Viremic cases were referred for clinical assessment and antiviral treatment through a simplified pathway. The strategy was evaluated using quality indicators and informed a similar pilot by the Public Health Agency of Catalonia (MiCatC). Combined analysis showed that this new model of care is cost-effective compared to a non-intervention scenario.			
15	Screening and early detection of communicable diseases among asylum seekers in Finland		
	Finland	HIV/VH/STIs/TB	Testing / Linkage / Retention
Kaisa Kontunen, Finnish Institute for Health and Welfare; Finland			
The main goal of the programme is early detection, prevention and treatment of communicable diseases among asylum seekers. Initial health examination including screening for HIV, hepatitis B, hepatitis C and syphilis (based on incidence/prevalence in country of origin and individual risk factors) is offered to all asylum seekers. Screening for TB is offered to all asylum seekers regardless of country of origin. The initial health examination and screening tests are voluntary (however, TB screening is mandatory for migrants from high TB incidence countries who work in health care settings or care for young children, as well as for anyone who presents with TB symptoms). Nurses working at the reception centres implement the initial health examination and refer asylum seekers to the closest contracted private medical clinic for screening tests. Doctors working at the clinic interpret the test results, conduct additional diagnostics, provide treatment for diagnosed cases and/or refer patients to tertiary care as needed. Reception centre nurses provide assistance in linkage to care, psychosocial support, and treatment support (e.g., DOT) for diagnosed cases.			
16	Noaks Ark Mosaik's HIV Response		
	Sweden	HIV/VH/STIs	Testing / Linkage / Retention
Povi Foly Lawson, Executive Manager, Noaks Ark Mosaik, Malmö, Sweden; Dr. Abimbola Ajomale, Community Health Specialist, Noaks Ark Mosaik, Malmö, Sweden;			
Noaks Ark Mosaik works in the HIV response to reduce late diagnoses and improve access to prevention, testing, and care for migrants and mobile populations in southern Sweden. The organisation provides a full package of community-driven services: multilingual health education, psychosocial support (for people living with HIV and their families), rapid HIV/STI testing, and advocacy for equitable sexual and reproductive health and rights. Activities take place in safe, familiar environments such as language schools, cultural events, religious centres, and community gatherings, ensuring services are accessible, respectful, and stigma-free. Since January 2023, Noaks Ark Mosaik has been a partner in the EU-funded CORE (Community Response to End Inequality) project, led by Deutsche Aidshilfe, which has strengthened its testing interventions. Through CORE, services have expanded beyond HIV to include hepatitis B and C and syphilis testing, increased outreach personnel, and broader participation in community events. These additions enhance visibility, cultural relevance, and responsiveness to migrants and key populations, including LGBTQ+ individuals facing language barriers and limited health literacy. A central element of the work is ensuring that individuals who test positive, or require further assessment, are supported throughout the care pathway. This includes early counselling, personal follow-up, and referrals to infectious disease clinics. Individuals are assisted in preparing for appointments, understanding their rights, and maintaining engagement in long-term care. Overall, the programme combines community-led outreach, practical support, and strong partnerships to ensure continuity of care and improve equitable access to sexual health services.			

17	Unidad de Salud Internacional Vall d'Hebron-Drassanes		
	Spain	HIV/VH/STIs/TB	Testing / Linkage / Retention
Núria Serre Delcor, Tropical Medicine Unit Vall d'Hebron-Drassanes Hospital; Spain Maria Luisa Aznar, Tropical Medicine Unit Vall d'Hebron-Drassanes Hospital; , Spain			
Our unit provides systematic screening and clinical evaluation for imported diseases in individuals recently arrived from other countries, whether due to migration or international travel. Access to our services is free of charge, and people may attend either on their own initiative or through referrals from organisations with which they are affiliated. This includes, for example, asylum seekers referred by CEAR, individuals residing in reception centres, or persons linked to other social and humanitarian institutions. The care pathway begins with an initial visit, during which all newly arrived individuals are offered comprehensive, free-of-cost screening for imported infectious diseases. This includes testing for sexually transmitted infections, tuberculosis, and parasitic infections commonly acquired abroad. Based on epidemiological risk factors, clinical presentation, and country of origin, additional diagnostic tests may be performed. Following the initial assessment, patients receive counselling, preventive guidance, and appropriate management according to the findings. When necessary, they are referred for further specialised care within our centre or to other healthcare services. Our model aims to ensure early identification and treatment of travel-related and migration-related infectious diseases, improving both individual and public health outcomes.			
18	**Cool and Safe: a project to enhance sexual health for migrant communities in Belgium**		
	Belgium	**HIV/VH/STIs**	**Testing**
Thierry Martin, Plateforme Prevention Sida; Belgium Doucoure Saharou, Plateforme Prevention Sida; Belgium			
Plateform Prevention Sida is a community-based organization working on the enhance of sexual health of general population but also some key population as migrant communities, young people, people living with HIV, migrants LGBTQIA+, etc. The project "Cool and Safe" aims to enhance knowledge of migrant communities on HIV/STI prevention and improve their sexual health. This is done through the implementation of diverse activities like: - The production of HIV/STI prevention campaigns to increase awareness on HIV/STI prevention and specific topics like PrEP, condom use, PEP, etc. - Sensibilization and training in asylum seekers centres and in community associations. - Free distribution of condoms, flyers, lubricants in specific sites like barber shops, restaurants, bars, etc. - Prevention stands during communities' events as music festivals, football tournaments, etc. - Training activities for professionals and community organisation - Support for people living with HIV. - Free testing activities. For testing activities, we propose free access to HIV, Hep B and C, Syphilis rapid test in our office and also in the offices of some partners. We have a mobile unit (a van) for outreach testing. For rapid test we work closely with HIV reference centre and hepatologist to facilitate the linkage to care. We also perform chlamydia/gonorrhoea testing in our office (PCR testing with diverse samples: urine, vaginal/anal and throat) and we deliver free treatment for undocumented migrant with a positive test. Our testing services target migrants' communities but we are open for the general population.			
19	**WIR-Walk In Ruhr, Center for Sexual Health and Medicine, Bochum (Germany)**		
	Germany	**HIV/VH/STIs**	**Testing / Linkage / Retention**
PD Dr. Adriane Skaletz-Rorowski; Dr. Anja Potthoff; WIR-Walk In Ruhr, Center for Sexual Health and Medicine, Bochum, Department of Dermatology, Venerology und Allergology, Ruhr-University Bochum, Germany			
WIR-Walk In Ruhr, Center for Sexual Health and Medicine in Bochum (Germany), was opened in 2015 and combines an outpatient clinic (Interdisciplinary Immunological Outpatient Clinic, Center for Sexual Health and Medicine, Department of Dermatology, Venerology und Allergology, Ruhr-University Bochum), the communal public health service of the city of Bochum, as well as various NGOs (Aidshilfe Bochum e.V., Madonna e.V., profamilia e.V. and Rosa Strippe e.V.) "in one place", offering key group-oriented information, primary prevention, diagnosis, therapy, psychosocial and psychotherapeutic care, research and evaluation. WIR works on topics of sexual, reproductive and psychosexual health and wellbeing. While WIR is open for everyone and tries to cover a variety of needs by offering programs, initiatives and projects for different communities, it has focused on the realities of migrant communities from the beginning. For almost ten years, the WIR has initiated various projects that were also directed at migrant communities and focused on the needs of these target groups (e.g., determining barriers of accessing HIV-PrEP). Other initiatives are sex education-workshops in schools with high numbers of migrant students, outreach projects with refugee homes and homeless shelters as well as target-group specific collaboration with NGOs who support queer refugees and migrants with risk-related counselling, confidential STI-testing, treatment and psychosocial support. The Center itself was evaluated by the German Ministry of Health (BMG) between 2017 and 2019. The report was published in 2020 and can be accessed on the official BMG-Website. About 30% of the WIR clients are migrants.			

20	PLUS Project in WIR-Walk In Ruhr (Bochum) in Germany		
	Germany	VH	Testing / Linkage / Retention
PD Dr. Adriane Skaletz-Rorowski; WIR-Walk In Ruhr, Center for Sexual Health and Medicine, Bochum, Department of Dermatology, Venerology und Allergology, Ruhr-University Bochum, Germany			
PLUS Project in WIR-Walk In Ruhr (Bochum): The WIR - Walk In Ruhr, Center for Sexual Health and Medicine in Bochum (Germany) was opened in 2015 and combines an outpatient clinic (Interdisciplinary Immunological Outpatient Clinic, Center for Sexual Health and Medicine, Department of Dermatology, Venerology und Allergology, Ruhr-University Bochum), the communal public health service of the city of Bochum as well as various NGOs (Aidshilfe Bochum e.V., Madonna e.V., profamilia e.V. and Rosa Strippe e.V.). One big nationwide project that regularly includes migrant communities in Germany is the so-called PLUS-Project. WIR is participating in this project. It aims to eliminate Hepatitis C (among HIV) and contains outreach work implemented by sexual health advisers and close cooperation with migrant communities to support low-threshold testing, linkage to care and education of the target group and of the employees of facilities that care for migrants and refugees.			
21	Migrant Rapid BBV Testing and Linking to Care Programme		
	Ireland	HIV/VH	Testing / Linkage
Douglas Hamilton, Consultant in Public Health Medicine, HSE Dublin and North-East; Dublin, Ireland Sarah Murray, Senior Medical Officer, Balseskin Health Screening Centre Dublin; Ireland			
Approximately 7 000 Refugees and Applicants Seeking Protection (RASPs) in the Dublin and Northeast (DNE) region in Ireland have not been tested for blood-borne viruses (BBVs), as the current system of phlebotomised samples and standard laboratory testing has been overwhelmed since February 2022. This prompted a pilot to assess Rapid Diagnostic Testing (RDT) as an alternative for a test-and-treat programme. Pilot (02–11/2024; n=227). Aim: To assess the accuracy and feasibility of RDTs. - Phase 1: A three-fingerprick approach for collecting blood samples proved not feasible. - Phase 2: Using oral gum swabs for HIV and HCV, and a single fingerprick blood sample for HBV, proved highly accurate, acceptable, quick, and straightforward. This approach was less invasive and likely more impactful than phlebotomy, based on feedback from service users and providers. DNE Programme Roll-out. Aim: To implement an end-to-end multidisciplinary approach to identifying and treating RASPs, reducing morbidity, mortality, transmission, and costs. Testing the backlog of 7 000 individuals is projected to identify 31 people living with HIV, 109 with hepatitis B, and 121 with hepatitis C, all linked to care. Effective treatment could prevent, on average, €1 million in healthcare costs per 300 tested for HIV alone. Implementation began on 30 September 2025, with ongoing data collection to guide programme development and potential adaptation to other regions. This programme represents the first large-scale use of combined oral and fingerprick RDT sampling, offering an innovative, integrated, client-centred, multidisciplinary model for BBV case-finding and linkage to care among migrant populations.			
22	Integrating hepatitis B virus, hepatitis C virus and human immunodeficiency virus screening for migrants from endemic countries into travel-related and sexual health care in Amsterdam, the Netherlands		
	Netherlands	HIV/VH	Testing
Ellen Generaal, Department of Infectious Diseases, Public Health Service of Amsterdam, Amsterdam, the Netherlands; Evelien Siedenburg, Department of Infectious Diseases, Public Health Service of Amsterdam, Amsterdam, the Netherlands;			
The Health Council of the Netherlands recommends screening for hepatitis B (HBV), hepatitis C (HCV), and HIV among migrants from endemic countries. We investigated the operational feasibility, test uptake, and outcomes of integrating HBV/HCV/HIV screening into routine care at the Public Health Service (PHS) of Amsterdam. In 2022–2023, visitors (≥18 years) from endemic countries were offered free HBV, HCV, and HIV testing at the Travel and Vaccination Center (TVC). In 2021–2022, 1,172 visitors (≥16 years) were offered free HCV testing at the Center for Sexual Health (CSH), alongside routine HBV/HIV testing. Endemic countries were defined as having ≥2.0% prevalence or ranking among the top 10 in the Netherlands. Feasibility required inclusion within six months and ≥25% (TVC) or ≥50% (CSH) uptake within one year. Positive HBV/HCV cases were referred for care; HIV-positive individuals were referred to CSH. Staff were trained, and standard protocols were followed. Data collection was limited to feasibility, uptake, and demographics. At the TVC, 298 visitors participated in testing; at the CSH, 1,023 underwent HCV testing. Inclusion targets were met, with 87% uptake at CSH. At the TVC, five new chronic HBV cases were identified (2.0%), with no new HCV or HIV cases. At the CSH, one chronic HCV case was identified (0.1%). Integrating HBV, HCV, and HIV screening into routine travel and sexual health care is operationally feasible. HBV screening showed a higher yield, while HCV and HIV yields were low. Routine HBV screening in similar migrant settings warrants further evaluation.			

23	GAT Par a Par (Peer Navigation Programme)		
	Portugal	HIV/VH/STIs	Linkage / Retention
Mariana Vicente, GAT – Grupo de Ativistas em Tratamentos; Portugal Willian Gomes, GAT – Grupo de Ativistas em Tratamentos; Portugal			
Par a Par is a peer navigation programme created by GAT in 2018 to ensure that migrants in Portugal, especially undocumented migrants, can access treatment for HIV, viral hepatitis, and other STIs without fear or unnecessary obstacles. It operates as a national response for linkage and retention in healthcare, supporting migrants in accessing, navigating, and remaining engaged with the National Health System, while promoting health literacy. The programme is integrated within GAT, a community-led organisation delivering comprehensive responses to HIV, viral hepatitis, and STIs. GAT operates six sexual health and harm reduction centres and three mobile units providing integrated screening for HIV, HCV, HBV, and syphilis across the Greater Lisbon area. Services include rapid testing, medical and nursing consultations, an anti-discrimination centre, and social support. Par a Par is a cross-cutting initiative embedded across these services, supporting linkage to and retention in care. Migrants, particularly undocumented individuals, face language barriers, administrative challenges, economic hardship, stigma, and self-stigma. Par a Par offers personalised support to reduce these barriers, improving access to care and understanding of rights. In the past three years, the programme has supported over 1,000 people in obtaining a National Health Number, mainly undocumented migrants. Each year, more than 1,500 accompaniments are provided, about 70% involving undocumented migrants. The model is based on three pillars: multilingual digital support, trained peer navigators providing case management and accompaniment, and health literacy tools such as community sessions and the Kit Migrante platform.			
24	Simply testing. Low-threshold testing among migrant populations		
	Austria	HIV/VH/STIs	Testing / Linkage / Retention
Sabine Lex, Andrea Brunner, Aids Hilfe Wien, Austria			
Simply Testing is a project of Aids Hilfe Wien (Aids Help Vienna) that aims to raise awareness among migrants from high- and low-prevalence countries about sexually transmitted infections and facilitate their access to testing. The Austrian HIV Cohort Study shows that 40% of all people living with HIV in Austria are migrants. Simply Testing aims to specifically target migrants from sub-Saharan Africa and Southeast European countries, as well as Roma and Sinti, and sex workers. To this end, Aids Hilfe Wien (Aids Help Vienna) collaborates with organizations of major social service providers such as Caritas, Diakonie, Volkshilfe, and community leaders and churches within the sub-Saharan African community. Peer educators are trained to inform their communities about sexually transmitted infections and testing options through workshops, on-site work, and peer-to-peer discussions. They also distribute brochures with vouchers for free tests. Furthermore, training courses are offered for staff of organizations like Caritas, Diakonie, etc. as well workshops for their clients. Aids Hilfe Wien has been operating since 1985, and its services include HIV-related counselling, social work, and prevention. Over the past 40 years, it has continuously expanded its expertise in sexual health, offering information, counselling, and testing for HIV, hepatitis B and C, chlamydia, gonorrhea, and syphilis. From June 1, 2026, AIDS Hilfe Wien will operate a sexual health clinic called magnus* in addition to its existing services. magnus* offers testing, counselling and treatment for various sexually transmitted infections through a multidisciplinary team, thus ensuring a direct link to care.			
25	Community and Public Health Action Model for Tuberculosis Prevention and Control in Migrant Communities in Catalonia (MACIP Programme)		
	Spain	TB	Retention
Laura Gavaldà Mestre, Head of the Tuberculosis Prevention and Control Service and Specific Programmes, Sub-Directorate for Public Health Surveillance and Emergencies Response, Public Health Agency of Catalonia, Department of Health, Government of Catalonia; Jordi Gómez i Prat, Public Health and Community Team (eSPiC), Unit of Tropical Medicine and International Health Drassanes-Vall d'Hebron (UTMIHD-VH), PROSICS, Barcelona, Spain;			
The MACIP programme aims to strengthen tuberculosis (TB) prevention and control among migrant populations living in vulnerable contexts through an integrated public health and community-based approach. It is implemented by the Public Health Agency of Catalonia and the eSPiC team (equip de Salut Pública i Comunitària) of the Drassanes International Health Unit–Vall d'Hebron, and operates across Catalonia, excluding the Barcelona Metropolitan area. It is coordinated by the Service for Tuberculosis Prevention and Control and is embedded within regional TB control policies. MACIP provides a tailored response to vulnerabilities linked to migration and broader social and epidemiological risks. The model integrates a community-based strategy within routine epidemiological surveillance. It combines clinical and epidemiological follow-up with structured community actions led by Community Health Workers (CHWs). A dedicated digital platform enables systematic collection of community and social data linked to epidemiological information, supporting retention in care both in healthcare settings and at community level. CHWs—sharing language and cultural backgrounds with target populations—provide follow-up, outreach, and support to ensure continuity of care. Patients enter the programme through a four-step pathway: detection in healthcare, notification to surveillance services, vulnerability assessment, and referral to eSPiC for CHW-led interventions. These include health education, phone support (calls and WhatsApp), in-person visits, accompaniment, and guidance on administrative and legal procedures. By linking surveillance, clinical care, and community support, MACIP strengthens TB prevention and promotes equitable continuity of care among migrant populations in Catalonia.			

26	Zentrum für sexuelle Gesundheit und Familienplanung in Berlin - Sexual Health Center Berlin		
	Germany	HIV/VH/STIs	Testing / Linkage / Retention
Tessa Winkel Sexual Health Center Berlin, Germany			
The Center of Sexual Health and Family Planning Berlin is a community-based clinic run by the City of Berlin. It has two main, integrated focuses: 1. Family planning: In five locations across Berlin, the centre provides family planning services, including medical check-ups for undocumented pregnant migrants, free contraception, gynaecological check-ups, and pre-abortion counselling. 2. HIV/STI services: The focus of this report is HIV/STI care. The centre runs four clinics across Berlin providing HIV/STI counselling, testing, and treatment, open to the general public. Patients who test positive and have health insurance are referred to specialists in the regular healthcare system. For those without insurance, treatment and follow-up are provided within the clinics or through associated services. A key target group is migrants without access to regular healthcare in Germany due to lack of papers, insurance, or financial means. This includes migrant sex workers and undocumented pregnant migrants living in Berlin. In addition to medical services, social workers provide counselling on housing, legalisation processes, birth registration, and other social needs. Depending on requirements, translation services in multiple languages are available. Services are free of charge, anonymous (if desired), and fully confidential. To understand the context, it is important to note that in Germany, individuals without public or private health insurance have very limited access to healthcare, including prevention, testing, and treatment. This particularly affects undocumented migrants and other marginalised groups.			
27	INMI Mobile Population Clinic- Rome		
	Italy	HIV/VH/STIs/TB	Testing / Linkage
Dimitra Kontogiannis, MD- IRCCS Instituto Nazionale Malattie Infettive (INMI), L.Spallanzani Rome,Italy Francesca Faraglia, MD- IRCCS INMI L.Spallanzani Rome, Italy			
In response to the growing need for accessible healthcare services among migrant populations, a dedicated Infectious Diseases Outpatient Clinic was established on 7 February 2024 at INMI L. Spallanzani Hospital in Rome. The outpatient clinic, specifically dedicated to migrant populations, is located inside the hospital. Thanks to collaboration with Médecins Sans Frontières (MSF), a cultural mediation service is provided, adopting a context-sensitive approach that considers health conditions in countries of origin, exposures during transit, and challenges upon arrival. Patients attend the clinic from migrant reception centres, other hospital departments, or spontaneously. A central feature of the clinic is the provision of STP (Straniero Temporaneamente Presente) codes, enabling undocumented migrants to access care within the Italian National Health Service. During the initial visit, a comprehensive medical and social assessment is conducted, focusing on migration route, imprisonment, sexual exploitation, stays in refugee camps, and comorbidities, including chronic and mental health conditions. Based on country of origin, migration trajectory, and risk profile, a targeted infectious disease screening protocol is applied, including HIV and syphilis, hepatitis B and C, asymptomatic malaria, and tuberculosis infection. All participants are also screened for Schistosoma spp. and Strongyloides stercoralis, with confirmatory PCR and stool/urine testing when indicated. Protocols are updated according to epidemiological data and international and national guidelines. Basic laboratory tests include full blood count and urinalysis. After assessment, patients are followed up to review results and develop individualized care plans, including treatment initiation, further diagnostics, specialist referral, or hospital admission when needed.			
28	Delivering an innovative multi-disease screening tool to high-risk migrant populations (ISMiHealth)		
	Spain	HIV/VH/STIs/TB	Testing / Linkage
Ana Requena Méndez, Barcelona Institute for Global Health (ISGlobal); Spain Angeline Cruz, Barcelona Institute for Global Health (ISGlobal); Spain Alba Cuxart Graell, Barcelona Institute for Global Health (ISGlobal); Spain			
ISMiHealth is a clinical decision support system integrated into the electronic health record system of primary care (PC), aimed at improving screening for infectious diseases, mental health, and female genital mutilation/cutting (FGM/C) in migrants presenting in PC for any reason. The objective was to assess the tool's health impact and evaluate its feasibility and acceptability at PC level of two Spanish settings, Catalonia and Almería. A pilot cluster randomised controlled trial (RCT) was conducted in eight PC centres in Catalonia (March–December 2018) to assess preliminary effectiveness (Phase 1). This was followed by a larger cluster RCT in 35 PC centres in Catalonia (October 2023–December 2024) to validate the tool, and a pilot cluster RCT in seven PC centres in Almería (October 2023–September 2024) to assess preliminary effectiveness in a different healthcare system (Phase 2). The conditions and screening criteria were defined in independent consensus workshops with experts, based on current clinical guidelines. Catalonia and Almería both included HIV, viral hepatitis, and active TB; Almería also included syphilis, and TB infection. Healthcare professionals were trained in migrant health, mental health, and/or FGM/C. In the intervention centres, ISMiHealth provided electronic prompts with screening recommendations based on individual risk assessment. Control centres followed routine clinical practice. Positive cases were referred to secondary care or managed in PC according to standard pathways. In Phase 1, ISMiHealth showed improved diagnoses and was feasible and acceptable for implementation in PC. In Phase 2, the tool's acceptability, feasibility and health impact are being evaluated.			

29	TB Screening for those coming from high/very high-risk TB countries (screen to act on TB)		
	Malta	**TB**	**Testing / Linkage / Retention**
Tanya Melillo, Antoinette Attard, Ministry of Health, Malta			
To proactively diagnose and treat Active TB cases from those coming from high and very high-risk TB countries according to WHO rates of 40 per 100,000 TB cases.			
30	**Programa "Saúde + Perto"**		
	Portugal	**HIV/VH/STIs/TB**	**Testing / Linkage / Retention**
Maria Eugénia Saraiva, Liga Portuguesa Contra a SIDA; Portugal Margarida Trindade Figueiredo Torres, Unidade Local de Saúde (ULS) São José ; Portugal			
This intervention model is based on an integrated health programme combining community-based screening, clinical referral, and psychosocial support, with strong focus on populations facing barriers to accessing healthcare. Mobile Screening Unit (MSU) “Saúde + Perto”, developed by Liga Portuguesa Contra a SIDA (LPCS), facilitates access to testing, counselling, diagnosis, care, and treatment for HIV, viral hepatitis, and other STIs. It targets populations identified as vulnerable, (sex workers, men who have sex with men, people who use drugs, migrants, and people experiencing homelessness). Screenings are free of charge and confidential, with pre and post-test counselling provided by a psychologist. Team includes a doctor for clinical supervision and treatment initiation, a psychologist, a clinical laboratory technician, community mediators ensuring culturally sensitive communication. Building on this approach, outreach and inreach project “Saúde + Perto TB”, also developed by LPCS, focuses on active screening and early identification of TB infection and active tuberculosis. It targets people living in refugee reception centres, migrants from high-incidence countries, people using psychoactive substances, and people living with HIV. Interventions include symptom and risk assessment, referral for diagnostic testing (IGRA or medical evaluation), support for treatment initiation and adherence (including DOT/video-DOT), and TB literacy. Activities are implemented across municipalities including Lisbon, Loures, Odivelas, Amadora, Sintra, and Almada, in collaboration with Centro de Diagnóstico Pneumológico Dr. Ribeiro Sanches, which ensures clinical assessment, diagnosis, treatment and follow-up. Finally, Integrated Support Center (Espaço Liga-te) provides social, psychological, nutritional, legal support, ensuring multidisciplinary care, improved access to services, continuity of care, and social integration.			
31	**HEALTH4MIGRA SCREEN-AGRI (Screening for Communicable and Emerging Diseases in Agricultural Migrants in Apulia, Italy)**		
	Italy	**HIV/VH/STIs/TB**	**Testing / Linkage / Retention**
Francesco Di Gennaro, Clinic of Infectious Diseases, Department of Precision and Regenerative Medicine and Ionian Area - (DiMePRe-J), University of Bari "Aldo Moro" Giacomo Guido, Clinic of Infectious Diseases, Department of Precision and Regenerative Medicine and Ionian Area - (DiMePRe-J), University of Bari "Aldo Moro" Italy			
The programme is part of a broader project aimed at assessing the prevalence of parasitic diseases, integrated with screening activities aligned with the Sustainable Development Goals, and designed to facilitate engagement with and access to the healthcare system for underserved migrant populations. Led by the Clinic of Infectious Diseases of University of Bari (UniBa), the programme aims to strengthen infectious disease prevention, early diagnosis, and clinical management among migrants and refugees living in informal settlements ("ghettos") in Apulia, Italy, with a particular focus on agricultural workers. Activities include screening and clinical follow-up for HIV, HBV, HCV, TB, STIs, parasitosis, malaria, and antimicrobial resistance (AMR) through rectal and nasal swabs. The initiative is implemented in collaboration with multiple partners: Istituto Superiore di Sanità (ISS): malaria diagnosis and entomological surveillance, including vector capture (mosquitoes, ticks, and sandflies); Istituto Zooprofilattico Sperimentale (IZS): vector monitoring and identification; Sacro Cuore Don Calabria Hospital - Negrar: microbiological analysis of stool and urine samples; Clinic of Infectious Diseases (DiMePre-J) and Apulian Region Reference Parasitology Laboratory of UniBa (lead institution): coordination, and screening and management of HIV, HBV, HCV, TB and parasitosis; CUAMM Doctor with Africa (NGO): provision of basic healthcare services and community outreach. Migrants are actively engaged throughout the process —participating in preparatory training, helping to schedule activities, and serving as community health leaders, thus promoting peer involvement and health awareness within their communities.			

32	Implementation of the whole system programme model for STI point-of-care testing and outreach community clinics in Malta (PROSPIRO)		
	Malta	HIV/VH/STIs/TB	Testing / Linkage / Retention
Valeska Padovese, Genitourinary Clinic, Mater Dei Hospital, Malta; Isotta Rossoni, Project Officer Reach out Europe; Malta			
The overarching aim is to improve access to sexually transmitted infection (STI) testing and treatment across diverse populations and healthcare settings, while generating evidence on the acceptability, feasibility, and suitability of a collaborative whole system programme model supporting implementation of STI point of care tests (POCTs). The protocol is delivered through structured, stakeholder-led workshops that co-design locally appropriate implementation plans and clinical pathways. Participating sites include sexual health services implementing POCTs for Chlamydia trachomatis, Neisseria gonorrhoeae, and/or HIV/syphilis. A mixed methods evaluation assesses patient outcomes, health system capacity, economic costs, and acceptability among patients, healthcare professionals, and policymakers. Quantitative data are collected pre and post-implementation, complemented by qualitative data from workshops, focus groups, and interviews. A realist case study comparison explores reach, fidelity, and contextual mechanisms influencing implementation success. In parallel, the REACH OUT project aims to strengthen and harmonise outreach initiatives for migrants, refugees, and other socially disadvantaged populations across Europe, focusing on groups at increased risk based on country of origin and/or specific vulnerabilities. The project promotes early testing, timely access to care, and consistent, evidence-based awareness raising on HIV, tuberculosis, and sexual health. Using participatory outreach methodologies involving communities, health institutions, authorities, and NGOs, REACH OUT develops culturally sensitive and sustainable health promotion models. It also leverages digital platforms and large-scale awareness campaigns to expand reach, build capacity, foster cross-sector collaboration, and generate evidence to inform future interventions and policy development.			
33	Integrated Program of Infectious Disease in Migrants (MIDMIP)		
	Italy	HIV/VH/STIs/TB	Testing / Linkage / Retention
Francesca Bonvicini, Centro per la Salute della Famiglia Straniera, Azienda USL-IRCCS di Reggio Emilia, Reggio Emilia, Italy; Marco Vinceti, Department of Biomedical, Metabolic and Neural Sciences, University of Modena and Reggio Emilia, Modena Italy;			
The Centre for Foreign Family - CFF of Reggio Emilia is an outpatient clinic located in the city centre. It is devoted mainly to immigrants without a valid residence permit, who are not entitled to choose a general practitioner, to detect, prevent and control infectious diseases. Our main goals and activities are: reaching out to the target migrant population; implementing screening programs; management of 'positive' tested individuals with specific and integrated pathways; contact tracing and management; follow-up; preventive measure implementation.			
34			
	Ireland	TB	Testing / Linkage / Retention
35	Viral Hepatitis COMmunity Screening, Vaccination, and Care (VH-COMSAVAC)		
	Greece, Italy, Portugal, Spain	VH	Testing / Linkage / Retention
Camila Picchio, Barcelona Institute for Global Health; Barcelona, Spain Aina Nicolàs, Barcelona Institute for Global Health; Barcelona, Spain			
The VH-COMSAVAC project (October 2022-January 2025) implemented decentralised HBV and HCV testing, HBV vaccination, and linkage-to-care interventions targeting migrants and refugees in Greece, Italy and Spain. While the models share common principles, each country tailored the model of care to the local migrant population and in accordance with their legal, operational, and health system feasibility. Screening activities were decentralised and conducted in community spaces, which could include faith-based venues, NGOs, community centres, and prisons. Central to the activities, which were community-based in nature, was the use of rapid diagnostic tools to facilitate access to viral hepatitis testing. Educational components were integrated to increase health literacy regarding viral hepatitis, liver cancer, and its prevention. Communication strategies were tailored to the cultural and linguistic context of the target populations. To ensure timely access to specialist care, expedited referral pathways were established with collaborating tertiary level hospitals, enabling direct linkage to specialist care and reducing potential loss to follow-up. In Spain, outreach efforts were further strengthened through the engagement of community health workers and intercultural mediators, who played a key role in supporting engagement across the entire viral hepatitis care cascade for migrant and refugees participating in the project.			

36	The Church City Mission Norway: Integrated HIV and STI Prevention, Testing, and Care		
	Norway	HIV/VH/STIs	Testing / Retention
Thea Indahl Mæhlum; Aksept - National health and social service centre for anyone affected by HIV, Norway Øyvind Jørgensen, Aksept - National health and social service centre for anyone affected by HIV, Norway			
Testing The Church City Mission Norway delivers low-threshold HIV and STI prevention, testing, and follow-up services through a national programme. Funded by the Norwegian Directorate of Health and implemented across seven departments—including Aksept (people living with HIV), Nadheim (sex workers), PMV (multicultural centre), and the Health Centre for Undocumented Migrants—the programme targets people affected by HIV and vulnerable migrant populations. Services are provided in Oslo, Bergen, Stavanger, and Trondheim. The programme offers free, anonymous, and low-threshold HIV and STI testing in-house and through outreach in migrant communities. Approximately 8,300 HIV tests and 6,000 STI tests have been conducted, identifying 50 HIV-positive cases. Everyone was linked to specialist care through fast-track hospital referral pathways and offered psychosocial follow-up via Aksept. Prevention efforts include targeted condom distribution (1.8 million condoms) and 700 culturally adapted outreach and education activities. Retention in Care Aksept is Norway's only dedicated health and social care service for people affected by HIV. With a national mandate from Oslo and local services in Bergen and Trondheim, Aksept strengthens life skills, promotes health literacy, and supports equal access to good health. Services include low-threshold HIV and STI prevention, combined with health and social care follow-up in collaboration with the public healthcare system. Aksept functions as a meeting place and empowerment arena, offering counselling, peer support, courses, and group activities aimed at retention in care and improved long-term health outcomes. With nearly 40 years of experience, our trauma-sensitive, evidence-based approach integrates professional expertise, lived experience, strong user involvement, and cultural competence.			
37	Mi-Health HIV Partnership		
	Belgium, Cyprus, France, Germany, Greece, Ireland, Italy, Netherlands, Portugal, Spain, Sweden	HIV	Testing
Denis Onyango, Mi-Health Europe / Africa Advocacy Foundation; Anne Flaherty-Gupta, Mi-Health Europe / Africa Advocacy Foundation;			
The Mi-Health HIV Partnership is a community-led initiative that seeks to address gaps in the HIV care continuum in 11 European countries with a high prevalence of HIV amongst migrants by developing co-designed educational materials, building capacity and conducting targeted HIV testing. These efforts have resulted in the generation of first-of-its-kind data on undocumented migrants, refugees and asylum seekers (disaggregated by key population) after testing 4,000+ migrants for HIV.			

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of the European Union