

ECDC Collection of models of good practices for improved testing, linkage to care and retention in care for migrant populations

28 September, 2026

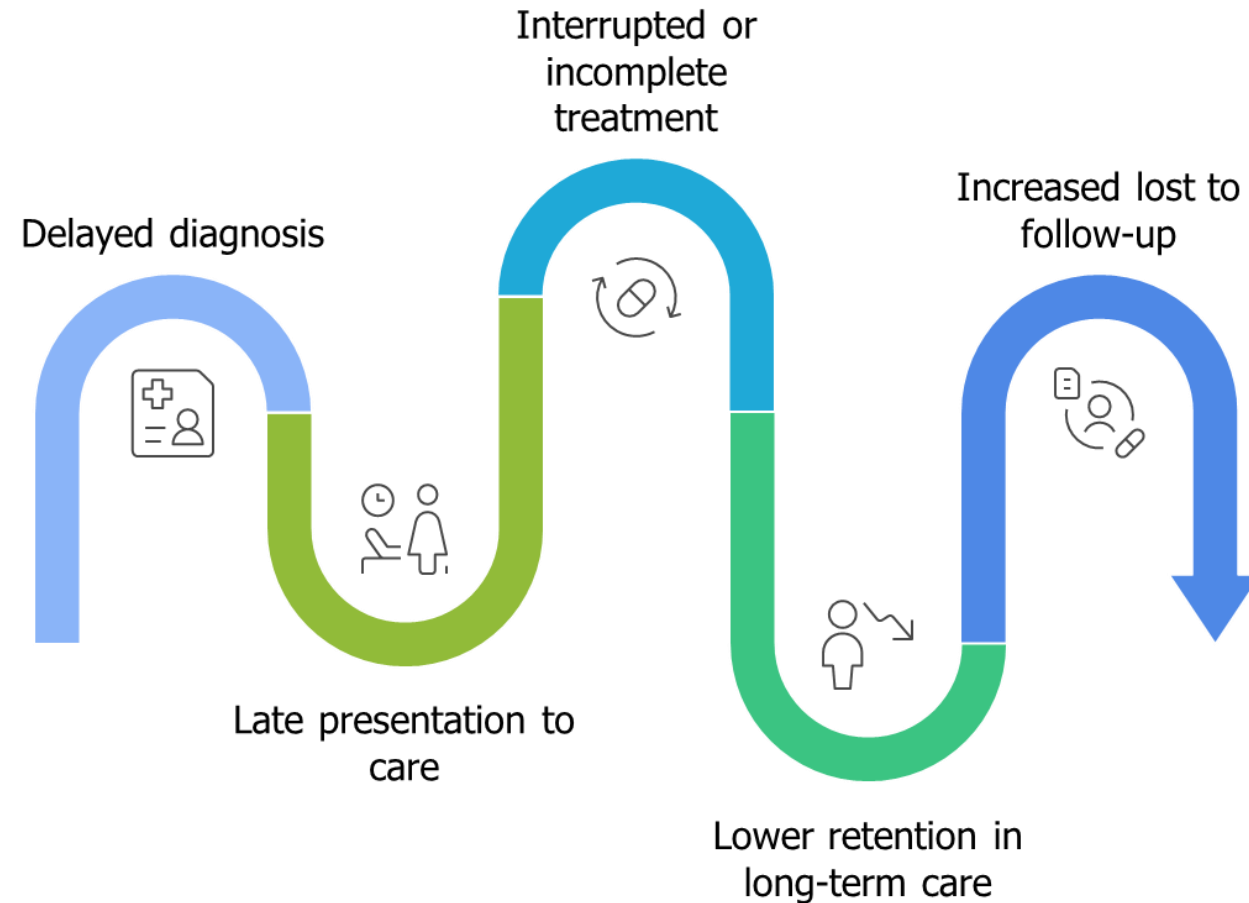
Ana Requena-Méndez, MD, PhD

Associate Research Professor

Barcelona Institute for Global Health (ISGlobal)

Background

- Migrant populations face **systemic and structural barriers** that disrupt continuity of care for HIV, viral hepatitis, STIs, and TB.
- Conventional healthcare delivery models may **not reach migrant populations effectively**.



Aim of this collection

To understand models of practice reducing the fraction of undiagnosed and untreated SDG 3.3-related diseases (**HIV, viral hepatitis, STIs, and TB**) among high-risk migrant populations in the EU/EEA.



Call for submissions of models on testing, linkage to care and/or retention in care in migrants for HIV, viral hepatitis, TB and STIs.

Good practice model

Intervention or model of practice that reported indicators in at least one domain:

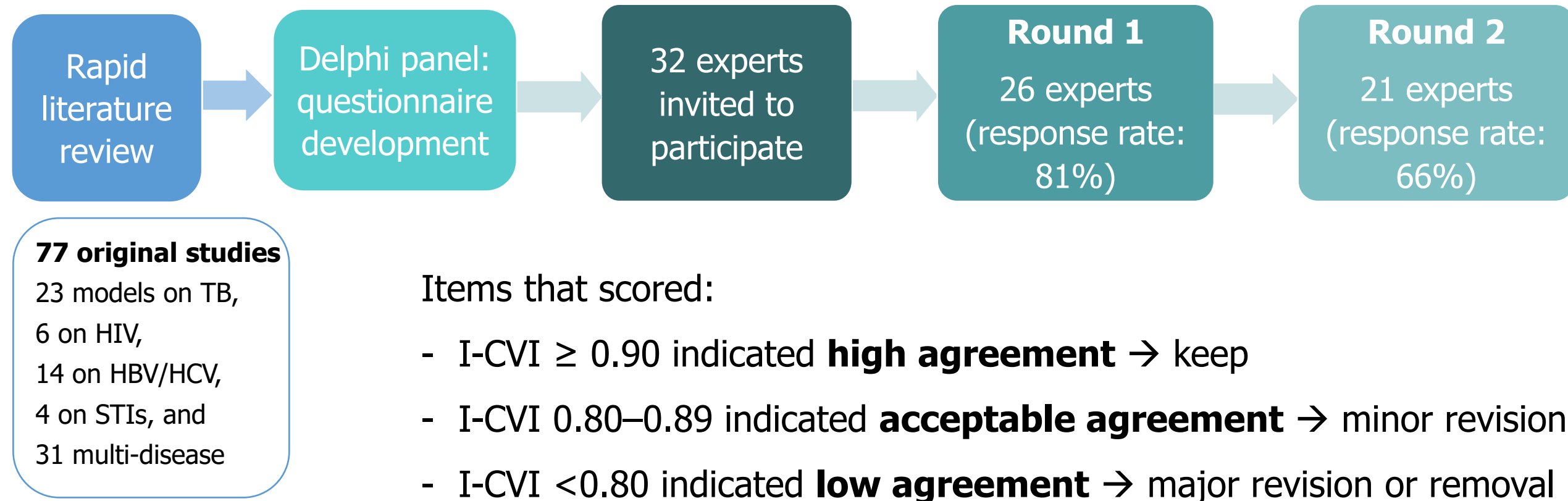
- Health impact & cost,
- Transferability and sustainability,
- Community and stakeholder engagement
- Additional relevant outcomes

Best practice model

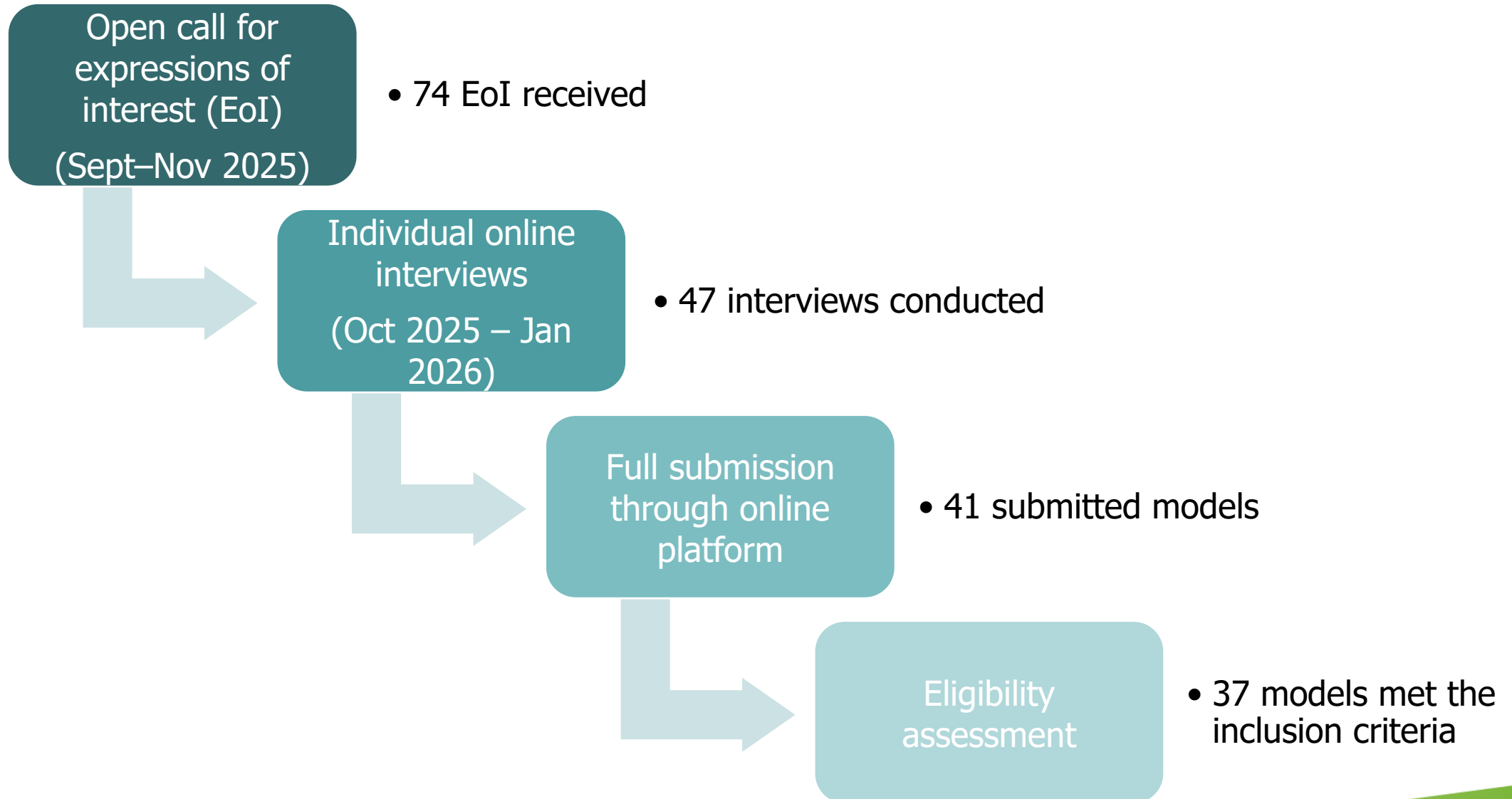
Model that ranked in the top 20% of evaluated models across any of the evaluation domains

Score questionnaire developed

Submission form developed through **Delphi methodology** (June – August 2025)



Submissions of models across the EU/EEA



Assessment framework



Health impact and cost



Transferability and sustainability



Community and stakeholder engagement



Additional relevant outcomes contributing to wider societal benefits



Scoring rubric form

ESSENTIAL CRITERIA		Maximum points
1. Health impact & cost impact		10 points
Definition of outcomes	Effectiveness indicators are clearly defined and reported- 1 point <i>Note: 0.5 points is given for those who define how they report effectiveness and another 0.5 points is given for those who report the effectiveness outcomes</i>	
Reporting of outcomes <i>(1 point is given for each outcome reported)</i> <i>(If authors planned to estimate any of the effectiveness outcome in the next 12 months – 0.5 points per outcome.)</i>	Testing: • Testing uptake- 1 point • Testing coverage- 1 point: ○ If only absolute number of tests is reported- 0.5 points -OR- ○ If proportion of the total target population is reported- 1 point • Early diagnosis- 1 point • Other (e.g., number of diagnosis)- 1 point ○ <i>Note: Point awarded if other indicators are listed, even if reported qualitatively only.</i> (Maximum of 4 points)	
	Linkage to care • Number of referrals to primary care/specialized care- 1 point • Number of treatments initiated- 1 point • Number of lost-to-follow up- 1 point ○ If only the lost-to-follow up indicator is selected- 0.5 points -OR- ○ If lost-to-follow up data is reported- 1 point • Other- 1 point ○ <i>Note: Point awarded if other indicators are selected from the list.</i> (Maximum of 4 points)	
	Retention in care • Number of people lost to follow-up- 1 point • Number of people tested to evaluate cure/ infection control (i.e., SVR or viral suppression) - 1 point • Number of people with more than two documented visits in a defined time period / appointment adherence (%) - 1 point • Other- 1 point ○ <i>Note: Point awarded if other indicators are selected from the list.</i> (Maximum of 4 points)	

Comparison	A baseline estimate or comparator (control group/standard of care) is provided for any effectiveness outcome- 1 point	
Positive health impact	A positive health impact is documented and reported- 1 point if at least one of the following outcomes is reported: • Increase in the number of tests compared to control group, standard care or before the programme was implemented. • Test uptake >70% if there is no control group. • Decrease in late diagnosis. • Cost-effectiveness data with an ICER below the threshold. • Decrease in loss to follow-up compared to control group, standard of care, or previous programme in place. • Increased treatment adherence/completion compared to control group, standard of care, or previous programme in place. • Loss to follow-up ≤30% for linkage or retention in care. • If time for linkage to care is provided: ○ For HIV, linkage to care must be done within 30 days of diagnosis. ○ For TB, treatment initiation must be done within 28 days of sputum submission.	
Long-term outcomes	Long outcomes measured (i.e., incidence/morbidity /mortality reduction) were measured and reported- 1 point	
Cost	A cost analysis or cost-effectiveness analysis has been reported- 1 point ○ When evaluating the linkage to care and retention in care forms, award 0.5 points if the cost-analyses were done only for the testing part of the model- 0.5 points	
Funding	Total budget of the programme has been calculated and reported- 1 point ○ <i>Note: Award the full point in all forms if the total intervention budget is reported (even when, for example, costs relate only to testing because linkage and retention are part of routine care).</i>	
	SECTION SCORE	Testing: X/10 Linkage: X/10 Retention: X/10



2. Transferability & Sustainability		10 points
Setting described	The setting of the model of care is clearly described- 1 point	
Programmatic support documents	A manual, standard operating procedure (SOP), roadmap, or toolkit is available- 1 point	
Migrant legal access described	Access to health care for undocumented migrants in the programme/intervention is provided- 1 point	
Transparency of results' publication	Results have been published and publicly (e.g., peer-reviewed literature, grey literature, annual reports)- 1 point	
Replicability	The model has been implemented in another health system (national or international)- 2 points -OR- The model of care has been implemented in 2 or more settings within the region- 1 point (Maximum of 2 points)	
Funding mechanisms	- The funding mechanism is conducive to sustainability by being funded or integrated by the health authorities/health system- 3 points -OR- - The funding mechanism could be conducive to sustainability by being funded by a public and/or private source - 1 points -OR- - There is no current funding mechanism in place and the model is not ongoing at the time of completing this survey- 0 points (Maximum of 3 points)	
Institutional acceptance	The programme/intervention is adopted or included in local, national, or regional guidelines/clinical practice, irrespective of funding. - 1 point	
SECTION SCORE		X/10



3. Community/stakeholder engagement		10 points
Inter-sectoral collaboration	- At least three stakeholders were consulted in the design and/or evaluation of the programme/intervention- 4 points -OR- - Two stakeholders were consulted in the design and/or evaluation of the programme/intervention- 2 points -OR- - No stakeholders were consulted in the design and/or evaluation of the programme/intervention- 0 points (Maximum of 4 points)	
Acceptability	- Community-based participatory research methods were employed in the design of the programme/ intervention- 2 points - FGDs and/or interviews were carried out to measure acceptability of the programme/intervention- 2 points: <u>With target populations</u> – 1 point <u>With other stakeholders</u> – 1 point <i>Note: Ensure that qualitative methodology was employed when scoring this item.</i> - No measures were taken into consideration to measure acceptability- 0 points (Maximum of 4 points)	
Cultural adaptation	Cultural adaptations have been considered in the planning, development or evaluation of the programme/intervention- 1 point	
Dissemination	Was there a dissemination strategy in place? - 1 point	
SECTION SCORE		X/10



4. Additional relevant outcomes		10 points
Behavioural changes	Behavioural changes are evaluated and reported (i.e., Risk perception)- 1 point	
Stigma	A reduction in stigma is considered in the programme/intervention- 1 point	
Training health professionals	Training of health care professionals is provided- 1 point	
Prevention activities	Prevention activities (i.e., condom distribution) is included and reported- 1 point	
Contact tracing	Contact tracing is included and reported- 1 point	
Dedicated staff	Dedicated staff (i.e., peer navigators) are available to enhance testing/linkage to care/retention in care through navigation or cultural/language support- 1 point	
Transfer of healthcare <i>Collected in the linkage and retention forms</i>	Transfer documents or information are provided for migrants' mobility (i.e., relocation within or to a different host country) during linkage/retention in care- 1 point	
Additional support <i>Collected in the linkage and retention forms</i>	• Support and referral to other psychological or health programmes is provided- 1 point • Support to address other social barriers/legal status is provided- 1 point (Maximum of 2 points)	
Innovation	Are digital tool(s) used during the testing approach? (i.e., app, alert system, reminders) - 1 point <i>Note: the use of electronic health records is not considered an innovation.</i>	
SECTION SCORE		X/10

Results

37 models from 14 EU/EEA countries

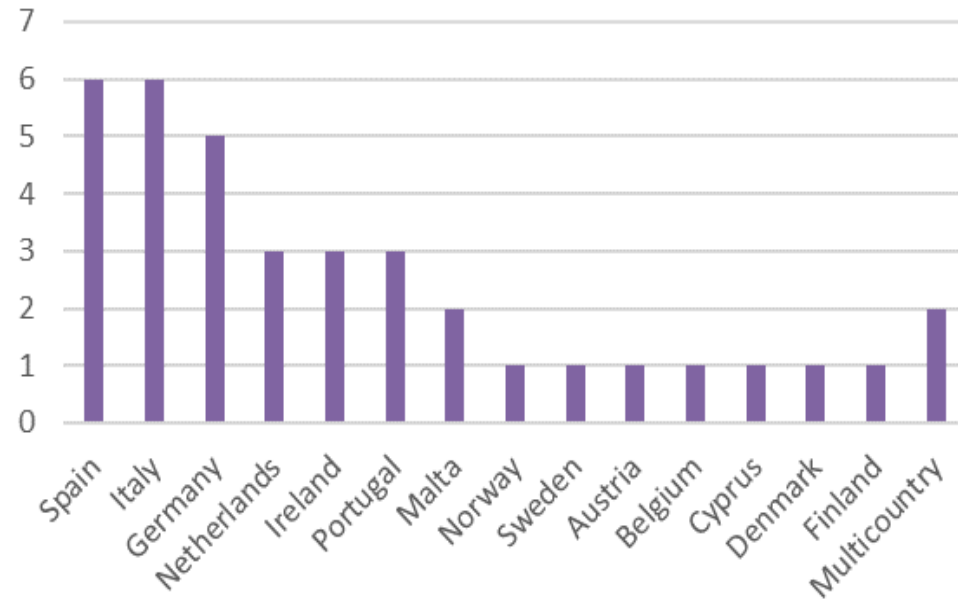


Figure 1. Number of submitted models per country across the EU/EEA.

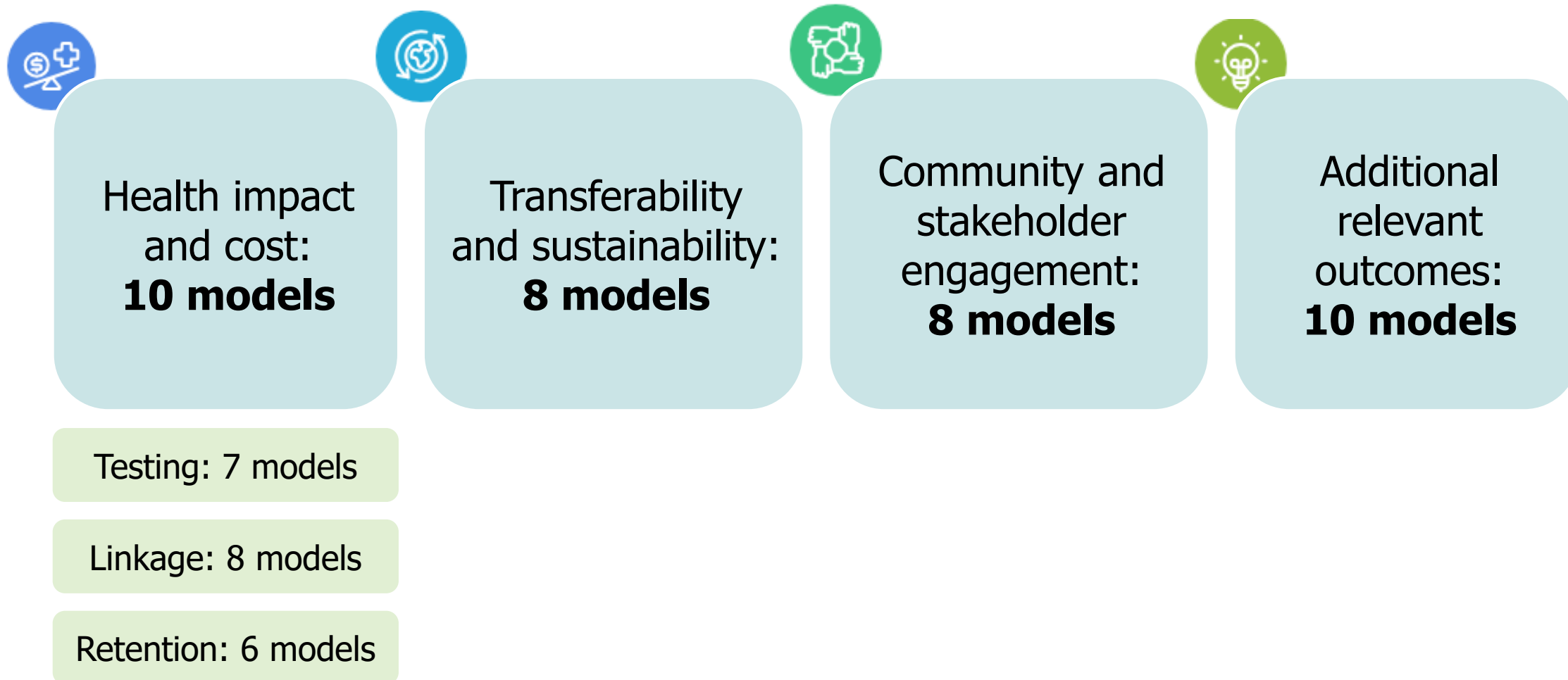
27 submissions (73%) focused >1 disease.
10 models (27%) were single-disease.



Figure 2. Number of submitted models per disease.

Selection of best practice models

23 models identified as best practice models (scored in top 20% in ≥ 1 domain)



Health and cost impact

10 models demonstrated health impact and cost across the care cascade.

6 models assessed the total cost of implementation.

3 models (viral hepatitis) conducted cost-effectiveness evaluations.

Country	Disease	Testing	Linkage to care	Retention in care
ITALY	HIV/VH/TB/STIs	✓		
SPAIN	VH	✓	✓	✓
PORTUGAL	HIV/VH/TB/STIs	✓	✓	✓
SPAIN	VH	✓	✓	✓
GERMANY	VH	✓	✓	✓
IRELAND	HIV/VH	✓	✓	
SPAIN	HIV/VH/TB/STIs	✓	✓	
PORTUGAL	HIV/VH/TB STIs		✓	✓
ITALY	HIV/VH/TB/STIs	✓		
GR/IT/ES	VH	✓	✓	✓

Health and cost impact



Testing

- Mean time: viral hepatitis (1-57 days), HIV/STIs (3 days), LTBI (14-28 days).
- **Support:** Community workers, peer navigators...
- **Flexibility:** Treatment initiation, vaccination or health card application at testing site.

- Integrated multi-disease approach (60%).
- Point-of-care testing (86%).
- **Flexibility:** Testing in non-traditional settings.
- **Innovation:** CDSS, interactive education tool.

Linkage to care



Retention in care

- **Support:** Community workers, peer navigators...
- **Flexibility:** Decentralized treatment, multi-month drug supply, digital and cross-border follow-up.
- **Innovation:** Phone calls/text messages, DOT or video supported therapy, home visits.

Transferability and sustainability

Models reporting **high transferability / sustainability**:

Sustainability

- **Integration** in health system (surveillance programs, routine care, local/national strategic plans.
- Dedicated health system **budget line** implies long-term stability.

Transferability

- Implementation multiple regions (potential **replication / scalability**)
- <60% of models reported to have **implementation toolkits**, which constrains replication efforts.

Funding Mechanisms

Stable funding
Resource allocation



Structural
integration



Institutional Acceptance

Alignment with clinical
guidelines
Embedding within existing
systems

Community and stakeholder engagement

Models of best practice:

Strong intersectoral collaboration (multiple actors)

CSOs

Health care
providers

Academia

Migrant
representatives

Health
authorities

Reported meaningful collaborations
during planning phases of programmes



- Adaptations to migrant changing needs
- Engage community /
- Health workers and peer navigators
- Offer culturally competent services
- Promote multidisciplinary collaborations

Community involvement



Additional relevant outcomes

Reduction of stigma

Educational activities
Culturally-mediated counselling
Empowerment

Contact tracing

By phone, SMS, or email
Encourage partner notification

Psychosocial support

Counselling, legal guidance,
housing, work integration,
health system navigation

Prevention activities

Condom distribution
Vaccination programs
Awareness and education

Training for professionals

Testing procedures,
surveillance, referral pathways,
intercultural competence,
social needs provision

Support transfer of healthcare

Information on paper,
communication between
healthcare providers

Support

Dedicated staff - accompany patients to visits or follow up.

Psychological support: mental health service - counselling and prevention -risk reduction measures

Innovation

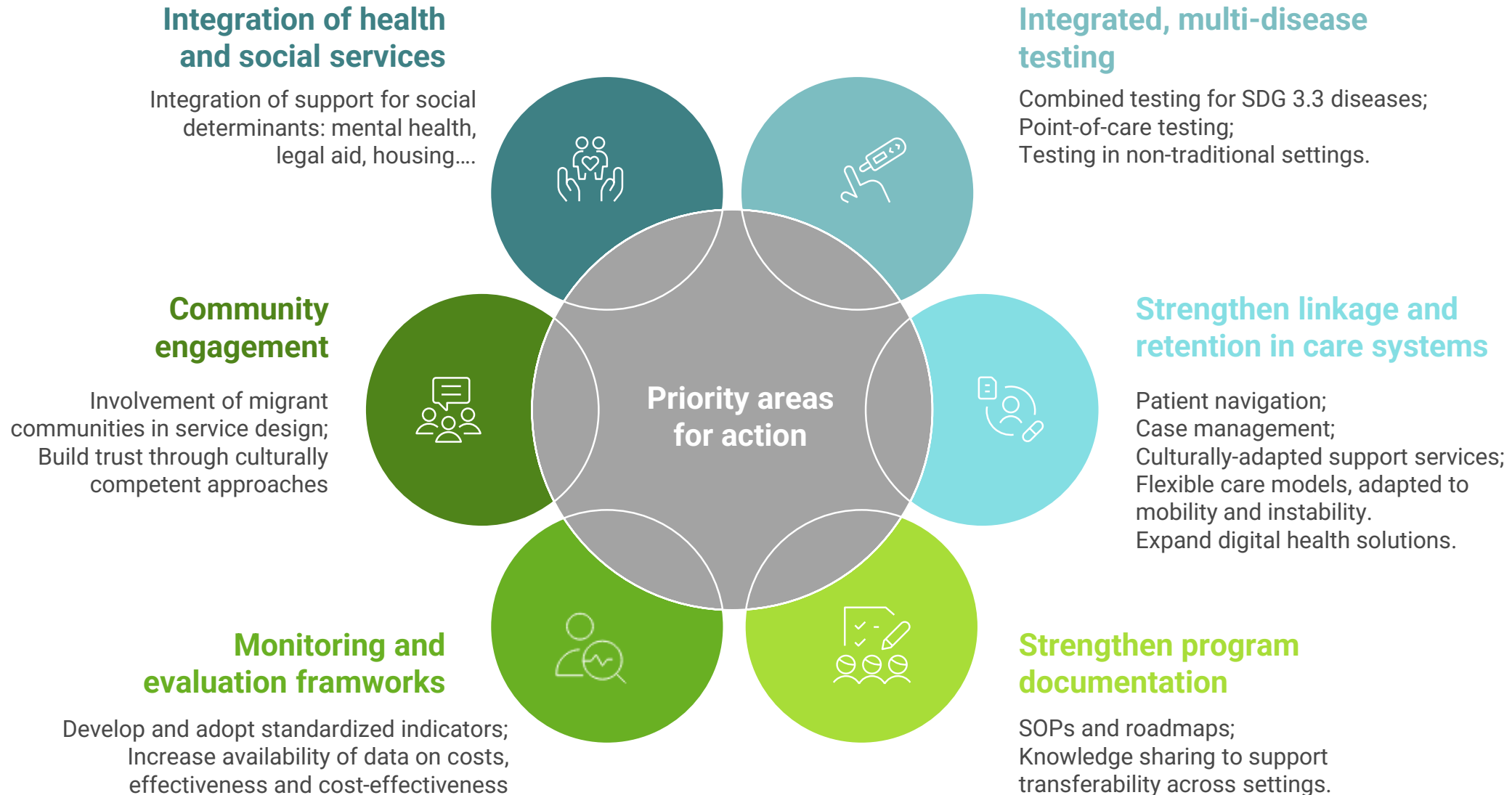
Mobile app - online videos supporting self-testing and connect with health/social services.

Online tool info on SRH rights in several languages.

Real-time recording system for community-based actions (case follow-up, contact tracing).

Integration epidemiological/clinical data.

Priority areas for action



Key messages

- **Integrated, tailored, community-based models** combining convenient testing, rapid linkage and tailored retention support – effectively improve engagement across the care cascade.
- **Enabling factors** common to best practices include: strong stakeholder engagement, intersectoral collaboration, and trust-building approaches such as confidentiality, non-discriminatory practices, and the use of multidisciplinary teams.
- **Key gaps persist**, including a lack comprehensive monitoring, integration of models within health systems, stable funding and supportive policy frameworks that ensure equitable access to healthcare

Thank you