Plenary presentations

PL01 WORKFORCE CONSIDERATIONS IN GETTING TO ZERO

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Ending the AIDS epidemic as a public health threat and eliminating new HIV infections by 2030 is a global target. For this ambition to be realised there will need to be an effective comprehensive approach to HIV testing and treatment situated within strong strategic frameworks and supported by robust infrastructure including the appropriate workforce. As undiagnosed prevalence falls, approaches to case finding need to become more tailored and sophisticated. As implementation of early and effective therapy reduces infectiousness, so it increases longevity for people living with HIV. For success health systems and services must keep pace with the epidemiological and demographic changes through a whole system approach. An integrated outcomes focused patient centred approach to long-term care will be required. Working in partnership with key populations and communities to coproduce and deliver services along with multiagency and cross boundary collaboration will help define the skills and competencies required. Maintaining progress will require effective monitoring across the key domains of HIV prevention and care including comorbidities, psychosocial services alongside monitoring of stigma and discrimination within health systems. Maintaining focus on the development and delivery of tailored interventions that are consistently within the reach of those most likely to be left behind will be essential.

PL02 BEHAVIOURAL ECONOMICS EXAMPLES FOR STI CONTROL

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Human behavior sits on the final common pathway to health. Our best medical advances often require a clinician to prescribe them and our best health or health care promoting measures require a patient to accept them. Yet, the dominant approach to improving health behaviors not only starts with educating clinicians and patients, but ends there. Can we improve on that?

We would like patients and clinicians to behave rationally—weighing the risks and benefits of their behaviors toward choices most likely to lead to the health outcomes they seek. But that thinking seems to ignore the substantial evidence we have that humans don't always behave rationally. Our decisions are subject to emotion, and framing, and social context. Behavioral economics has helped develop new approaches to improving patient outcomes by seeing past the rational ways we would like people to behave and toward the ways we actually behave much of the time. Once we understand how people are irrational, we are in a much better position to help them.

PL03 PARTNER MANAGEMENT IN THE ERA OF ANTIMICROBIAL RESISTANCE: HOW TO PREVENT TRANSMISSION WHILST USING ANTIBIOTICS RESPONSIBLY

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Epidemiologic treatment – the practice of empirically treating the sexual contacts of infected persons – has been a mainstay of STD control for nearly 100 years. It was developed originally for syphilis prevention due to diagnostic limitations and high morbidity of infection, and was later expanded to include 'epi treatment' for gonorrhea and chlamydia. However, now in 2021 we are in a new era. Antimicrobial resistance is common both in STIs such as *Neisseria gonorrhoeae* and *Mycoplasma genitalium* as well as other pathogens, and there are few antibiotic treatment options currently available or in development. At the same time, diagnostic tests for gonorrhea and chlamydia have greatly improved, and electronic medical record technology now allows for near instantaneous reporting of results directly to patients. In light of these developments, the time has come to reexamine the practice of epidemiologic treatment.

PL04 PRIORITIZING NON-HIV -STI INTERVENTIONS IN LOW RESOURCE SETTINGS

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The HIV pandemic has impacted Sub Saharan Africa- more than other regions, and has had priority focus for the last 40 odd years rendering other STI into near oblivion. Challenges of accurate diagnosis and the use of syndromic management did not necessarily improve treatment outcomes for non HIV-STI. As treatment and prevention options for HIV have become more prevalent and are more widely implemented, concerns have emerged about incidences of other non HIV STI. This is especially among younger at risk populations and in particular for young women and adolescent girls (YWAG). This is not only because both HIV and other STI have some common transmission routes but the synergistic pathways described for STI facilitation for HIV transmission.

This talk will describe the current trends of non HIV-STI in SSA and explore why this should be prioritised as a public health concern.

PL05 SEX AND SEXUALLY TRANSMITTED INFECTIONS IN THE TIME OF COVID

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The World Health Organization declared the coronavirus disease 2019 (COVID-19) as a pandemic on 11 March 2020.

Since then, many countries have introduced national responses to the COVID-19 pandemic and these include the closure of international borders, stay at home orders, restrictions of movement, curfews, physical distancing and wearing face masks. This talk will discuss how these restrictions have impacted sexual practices among individuals, access to health-care seeking as well as the diagnoses of sexually transmitted infections globally.

PL06 A TRIBUTE TO JULIUS SCHACHTER, CHLAMYDIA CHAMPION

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This presentation will honor the distinguished career of Julius Schachter, PhD, whose untimely passing due to COVID-19 in December 2020 left a major gap in the STD/HIV field. We will review the career highlights of our eminent colleague in the field of chlamydia microbiology, novel diagnostics, epidemiology, and their application to national and international program policies for chlamydia prevention.

PL07 (RE-)EMERGING STIS, A CHALLENGE FOR PUBLIC HEALTH

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In the early eighties HIV/aids emerged among men who have sex with men (MSM), this new virus was originally transmitted from chimpanzees in Central Africa to humans about 100 years ago. In the beginning no one foresaw that HIV/aids would spread all over the world through sexual transmission. In the past decades hundreds of infectious diseases (re-) emerged including other sexually transmitted infections (STIs). Among MSM outbreaks occurred of enteric pathogens through oro-anal transmission like Hepatitis A virus, Shigella, Campylobacter and Entamoeba histolytica. Also among MSM, clusters of invasive meningococcal disease were seen while the same pathogen, the N meningitidis, a colonizer of the nasopharynx, was found to cause urethritis in heterosexual men. Other examples of (re-)emerging STIs among MSM are lymphogranuloma venereum (LGV) and Hepatitis C among HIV-positive MSM and HIV-negative MSM using PrEP. In 2015 Zikavirus, a flavivirus transmitted through the mosquito Aedes Aegypti, broke out in South America and unexpectedly was found to be sexually transmitted especially from men to women. During the Ebola outbreak in West-Africa in 2013–2016, reports strongly suggested sexual transmission of this filovirus from men to women. In 2021 Ebola Virus re-emerged in Guinea and genomic analysis made it likely that this outbreak started through sexual transmission of the virus by a survivor of the West African epidemic 5 years earlier. In the future new and re-emerging STIs will surface and cause limited outbreaks, epidemics and possibly even a pandemic, a major challenge for public health.

PL08 CHLAMYDIA CONTROL IN WOMEN AND MEN WHO HAVE SEX WITH MEN: CONTROVERSIES AND EVIDENCE ON (EXTRA)GENITAL TESTING AND TREATMENT

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Background Chlamydia trachomatis (CT) is the most common bacterial sexually transmitted infection worldwide. In CT-control, testing and treatment is considered key to prevent transmission and complications. Testing and treatment is not without controversy, expressing opposing views on what are best test-and-treat strategies in women and men who have sex with men (MSM). Views in urogenital testing include promoting testing in [key]populations versus reluctance to testing asymptomatics. Views in extragenital testing include promoting testing versus reluctance to rectal testing in women and pharyngeal CT testing overall. Views in CT treatment involve using azithromycin versus using doxycycline. Controversies are here explored by state-of-the-art scientific insights, in order to provide guidance in CT control.

Discussion Recent studies provided updates on CT prevalence, complication risks, and new evidence on CT bacterial load and viability of urogenital, rectal, and pharyngeal CT detection by nucleic acid amplification assays (NAATs). Recent evaluations confirmed high numbers of extragenital CT missed in MSM and women, and high accuracy of NAATs for testing on self-collected samples, adding to the feasibility of (extra) genital testing. Recent controlled trial results in MSM provide evidence on treatment effectiveness in rectal CT, stressing concerns on azithromycin use in both MSM and women. Evidence also accumulates on the downsides of testing and treatment, i.e. difficulty to reduce prevalence, and inducing of harms (e.g. antimicrobial resistance). Calls were observed for a renewed focus on comprehensive case-management and prevention of morbidity, rather than on testing asymptomatics.

Summary and Conclusions The controversies on testing and treatment appear to be grounded in judgements of ‘relevance’ (infectiousness, pathogenicity) of CT at a certain anatomic site and a certain population, and in weighing benefits and harms to test-and-treat these infections. The scientific insights presented provide further guidance for care professionals and policy makers to make these trade-offs for CT control.

PL09 DIGITAL SEXUAL HEALTH: WHAT WE KNOW AND WHAT WE NEED TO KNOW FOR EFFECTIVE SERVICES

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Many countries’ health strategies promote a large scale shift to digital and self-managed care to meet the population’s health needs. Sexual health services have been at the forefront in some countries, offering an increasing proportion of care remotely through a variety of mixed online and in person clinical care pathways. This shift has probably accelerated during the Covid-19 pandemic when face-to-face care has been actively discouraged, and digital care is at the heart of many countries’ recovery plans.