



**Abstract OC19 Figure 1** Kaplan-Meier estimates of time to loss to follow-up among migrant people living with HIV, stratified by gender identity

**Methods** This retrospective study included all migrants living with HIV taken into care at the Infectious and Tropical Diseases Unit of a tertiary teaching hospital in Florence, Italy, between 1 January 2014 and 1 March 2025, with data censored on 28 February 2026. Time to linkage to care was defined as the interval from arrival in Italy to linkage for ART-experienced individuals, and from first HIV-positive test to linkage for ART-naïve individuals. Early linkage was defined as linkage within 3 months, while LTFU was defined as absence from care for  $\geq 12$  months without documented transfer.

Determinants of linkage to care and LTFU were assessed using Cox regression models.

**Results** Among 308 migrants (217 CM, 91 TM), TM were almost exclusively Latin American transgender women (98.9%), with higher out-of-status rates than CM (82.4% vs 23.9%,  $p < 0.001$ ) and sex work prevalence increasing from pre- to post-migration (47.2% to 75.8%,  $p < 0.001$ ) (table 1) TM consistently accounted for nearly one third of new linkages to care over the study period.

In multivariable analysis with an interaction between ART experience and administrative status, out-of-status condition was associated with earlier linkage to care among ART-naïve migrants (HR 1.65, 95% CI 1.01–2.69;  $p = 0.048$ ), while ART-experienced migrants with regular status were less likely to link early (HR 0.26, 95% CI 0.14–0.47;  $p < 0.001$ ). This effect was attenuated among ART-experienced out-of-status individuals (HR 0.60, 95% CI 0.35–1.02;  $p = 0.057$ ).

Transgender identity and age were not associated with linkage timing (table 2).

During 2101.7 person-years of follow-up, the incidence rate of LTFU was 4.1 per 100 person-years (95% CI 3.3–5.1), with no differences between TM and CM (figure 1). In multivariable analysis, administrative vulnerability was the only factor independently associated with LTFU (HR 2.25, 95% CI 1.28–3.94) (table 3).

**Conclusions** In our setting HIV care trajectories among migrants appear to be shaped primarily by structural and legal vulnerability rather than gender identity. Administrative vulnerability facilitates early linkage mainly at diagnosis and represents the main driver of loss to follow-up regardless of prior ART experience, highlighting the potential role of integrated community–healthcare models in mitigating HIV care disparities.

OC20

### 'NARRATING TO TRANSFORM': STIGMA, COPING, AND THE RESHAPING OF LIFE TRAJECTORIES FROM DIAGNOSIS TO DISCLOSURE AMONG WOMEN WITH HIV

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**Background** Despite biomedical advances, women with HIV (WWH) still face stigma, moralised guilty narratives, and structural inequalities. Diagnosis and disclosure may represent critical biographical turning points that disrupt identity and relations, but could also activate processes of agency, coping, and identity reconstruction that impact well-being. However, how women negotiate diagnosis and disclosure in everyday life and how these processes shape patient-reported outcomes (PROs) is poorly explored, especially from a sociological perspective.

**Material and Methods** We conducted a qualitative study based on semi-structured interviews with WWH. Using a participatory research perspective, clinicians and people with HIV (PWH) were involved in the study design, recruitment, and interpretation of results. The project involved LILA Como, the Infectious Diseases Unit of IRCCS San Gerardo (Monza), and the Department of Sociology and Social Research of the University of Milano-Bicocca. Participants were recruited through clinical and community networks. Interviews, lasting approximately 1 hour each, explored diagnosis, disclosure, stigma, relationships, coping strategies, and healthcare experiences. The study received Ethics Committee approval.

**Results** Fifteen WWH, aged 35 to 75, were interviewed. Thematic analysis showed that diagnosis is narrated as a biographical rupture of taken-for-granted identities and future imaginaries. Through biographical reconstruction and agency-oriented coping, participants engaged in active meaning-making to restore continuity. Strategies included cognitive reframing of HIV as a chronic and manageable condition, emotional regulation, information-seeking, and reorganisation of life priorities. Disclosure emerged as a relational practice rather than a single event: WWH calibrated timing, audience, and narrative framing according to anticipated stigma, gender norms, and power asymmetries. Boundary-setting in intimate and family relationships acted as protection, while selective openness preserved social belonging. Peer networks fostered collective coping, reinforcing self-efficacy and resilience. Although stigma—often moralised around sexuality and responsibility—affected self-perception and mental well-being, coping practices mitigated its impact by supporting identity renegotiation, empowerment, and perceived control over life trajectories. Supportive clinical relationships further enhanced adherence and positively influenced self-reported quality of life.

**Conclusions** Women's experiences of HIV highlight the dynamic interplay between stigma and agency, showing how diagnosis and disclosure function as socially embedded turning points that require active processes of biographical and identity reconstruction. Integrating PROs into HIV care from a social sciences perspective could empower women as active agents in their health trajectories, thus complementing biomedical advances.