

Ways in which Legal and Regulatory Barriers Hinder the HIV Care Continuum and 90/90/90 Targets across Europe

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BACKGROUND

Recent survey data from the European Centre for Disease Control (ECDC) [1] shows of responding countries in the World Health Organization (WHO) European Region: 78% had significant gaps in their national continuum of care relating to getting PLHIV diagnosed; 41% had issues linking those diagnosed into care; 48% had break points in getting those in care on treatment. Break points involving care/treatment were found to be far greater in non-EEA countries but barriers exist across Europe. Two thirds of countries identified legal or policy issues as being contributory to these gaps (see **table 1**).

METHODS

A literature review undertaken between January and October 2015 for the OptTEST project [2] to identify legal and regulatory barriers to quality HIV care for PLHIV identified 54 salient documents, including academic and grey literature, describing a wide range of legal and regulatory barriers. A survey across Europe of the most common barriers identified in the review was undertaken by OptTEST in 2016 [3]. The database provided by this currently has responses from 31 countries and data compilation is ongoing.

Table 1: European and Central Asian countries are performing against the 90-90-90 targets [1]

| Country | Diagnosis | ART | Viral Suppression |
|------------------------|-----------|-----|-------------------|
| Albania | | | |
| Andorra | | | |
| Armenia | | | |
| Austria | | | |
| Azerbaijan | | | |
| Belarus | | | |
| Belgium | | | |
| Bosnia and Herzegovina | | | |
| Bulgaria | | | |
| Croatia | | | |
| Cyprus | | | |
| Czech Republic † | | | |
| Denmark | | | |
| Estonia | | | |
| Finland | | | |
| France | | | |
| Georgia | | | |
| Germany | | | |
| Greece | | | |
| Hungary | | | |
| Iceland | | | |
| Ireland | | | |
| Israel | | | |
| Italy | | | |
| Kazakhstan | | | |
| Kosovo | | | |
| Kyrgyzstan | | | |
| Latvia | | | |
| Liechtenstein | | | |
| Lithuania | | | |
| Luxembourg | | | |
| Macedonia | | | |
| Malta | | | |
| Moldova | | | |
| Monaco | | | |
| Montenegro | | | |
| Netherlands | | | |
| Norway | | | |
| Poland | | | |
| Portugal | | | |
| Romania † | | | |
| Russia | | | |
| San Marino | | | |
| Serbia | | | |
| Slovakia | | | |
| Slovenia | | | |
| Spain | | | |
| Sweden | | | |
| Switzerland | | | |
| Tajikistan | | | |
| Turkey | | | |
| Turkmenistan | | | |
| Ukraine | | | |
| UK | | | |
| Uzbekistan | | | |

Colour coding:

Red indicates an element was <70% of its predecessor; **amber** indicates an element which is 70-89% of its predecessor; **green** indicates an element which is ≥90% of its predecessor. **Green** indicates that a country is reaching the threshold of 90–90–90. Grey indicates no data available.

† Because of the specifics of HIV in Romania, more than half of the patients in treatment belong to a cohort of long-term survivors who have been in treatment for 20 years or longer. Given that adherence among this group may have been low and there have been multiple cases of drug resistance, a rate of 52% undetectable viral load among this group is considered to represent a success.

† Based on annual figures. In 2014, a total of 1228 people were on antiretroviral treatment. Of these, 1 118 (91.3%) had an undetectable viral load ≤50 copies per ml.

References:

- [1] Thematic Report on Continuum of Care, Monitoring Implementation of the Dublin Declaration, ECDC 2015 www.ecdc.europa.eu
- [2] Forthcoming online publication from OptTEST (Optimising testing and linkage to care for HIV across Europe), HIE/CHIP 2017
- [3] Barring The Way To Health, OptTEST, GNP+ 2016
- [4] Drug Decriminalization in Portugal: A Health Centered Approach, Drug Policy Alliance, 2015 www.drugpolicy.org

LITERATURE REVIEW RESULTS

Legal barriers identified include:

- Criminalisation of HIV transmission and perceived exposure (14 papers)
- Criminalisation of key populations e.g. drug users (6 papers), migrants (8 papers), transgender people (4 papers), sex workers (9 papers) and “gay propaganda” or other laws restrictive of MSM (5 papers)
- Failure to provide legal protections for these groups (4 papers)

These acted to deter access to HIV services and to impede disclosure of risk activities which might impact on testing, treatment and care. Examples of this are:

- Immigration law deterred many undocumented migrants and even some legal migrants from access to healthcare
- Denial of/poor access to ART existed in a number of prison and immigration detention systems
- Sex work laws requiring reporting, mandatory testing and/or special surveillance
- HIV testing and care hampered by inability to address MSM issues explicitly
- Drug laws in particular (including arresting people outside drug facilities) were shown to act to increase HIV transmission and deter access to care, whereas their reform can directly act to reduce HIV transmission (e.g. in Portugal) [4]

Regulatory barriers were less well documented but there was extensive coverage of testing. Outdated guidelines, alongside restrictive practices and regulations, acted to hinder proven new testing technologies and settings, including:

- Restrictions on who can administer tests (6 papers)
- Requirement of extensive pre/post test counselling (2 papers)
- Limited testing sites and restricted types of test (9 papers)

Wider regulatory behaviours cited as creating barriers to the continuum of care included:

- Separation of healthcare into vertical specialities e.g. drugs care separate from HIV and TB, necessitating multiple referrals (5 papers)
- Lengthy and complex referral and appointment systems (6 papers)
- Failure to integrate healthcare and social support (1 paper)
- Disruption of care between civil and detention authorities (7 papers)
- Complex regulations and charging systems which deterred migrants, including those entitled to free care (1 paper)

SURVEY RESULTS

The survey of country regulations provides further information on restrictions on types of test available. Only 17 of 31 countries said free HIV testing was widely available to all who needed it. Less than one in five (6/31) allowed and implemented self-testing while less than one in ten (3/31) currently operated postal sampling services, which have been shown to be cost effective and to reach some key populations better. And while only 4/31 responding countries did not allow any form of community-based testing, a wide range and variety of restrictions to how it can be implemented are documented in the literature, including:

- Only doctors allowed to interpret result
- Only medical personnel allowed to take blood (including blood spot testing)
- Doctor must be present in building that testing takes place in (actual presence at testing not required)
- Restrictions on disposal of waste (e.g. saliva kits)
- Social work qualification needed to do mandatory pre/post test counselling

While some restrictions are appropriately required for normal health and safety practices, other examples given appeared excessive and based on outdated concepts of risk or “custom and practice”

CONCLUSIONS

Findings suggest a need for:

- Consistent, updated evidence-based guidelines for HIV testing and care across Europe and attention to implementation of such guidelines in all facilities
- Use of the emerging database to compare and confront unnecessarily restrictive practices in individual countries
- Reform of laws where they are based on stigma rather than evidence and practices where they are based on custom rather than current knowledge
- Better dialogue between policymakers, clinicians, NGOs and people with HIV and those in key populations about the legal and regulatory barriers which continue to hinder the achievement of a 90/90/90 care continuum.