

Legal Barriers for Providing HCV Community Testing in Europe

Report Telephone Survey 2018

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Overview

To successfully eliminate hepatitis C (HCV), it is critically important to reach people who have never tested before, people who do not attend clinical services, and members of key populations. Community HCV testing, offering testing in communities of key populations such as people who inject drugs, has proven to be an effective way to reach these individuals. To gain a better understanding of which barriers exist for providing community testing in various EU Member countries, Correlation European Harm Reduction Network conducted a telephone survey with representatives of harm reduction services and of NGOs that offer low-threshold services to drug users. During the months of September and October 2018, a total of twenty (20) organizations in 18 countries, participated in this survey and provided information on the state of affairs with regards to community testing in their country.

Study Description

Community-based testing refers to the provision of testing services within the community, provided by representatives of the community, non-medical workers, peer workers, or social workers, at venues frequented by affected and marginalized key populations. These settings include fixed venues, mobile testing units, outreach sites such as parks, peoples' homes and venues of community-based organizations such as churches and mosques, homeless shelters, needle and syringe programmes, schools, and workplaces.

Community testing has been recommended by the European Centre for Disease Prevention and Control (ECDC) and the World Health Organizations (WHO). However, access to community testing provided by non-medical workers and in non-medical settings is an ongoing major challenge throughout Europe today.

The primary objective of our survey was to find out how many organizations in how many countries do provide HCV community testing – and in what form. After all, each country has its own interpretation and understanding of what community testing is, or should be. For example, some organizations find it acceptable for medical workers to provide testing

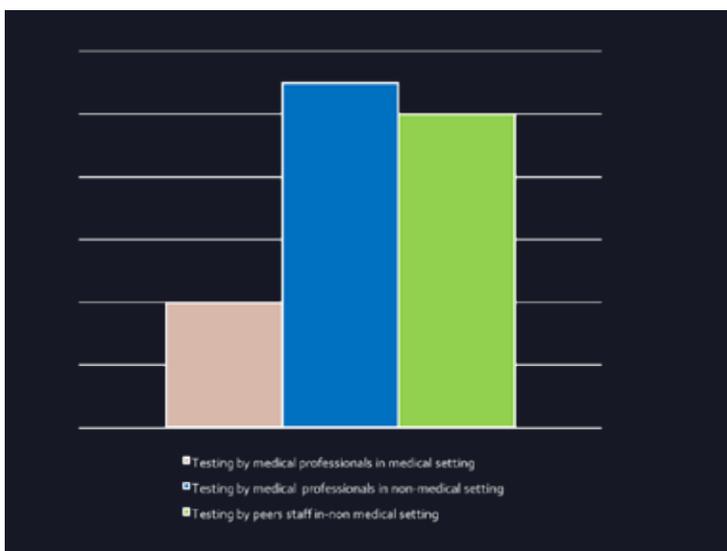
in the community, while others do not. Furthermore, all EU countries have legal and regulatory guidelines pertaining to the provision of HCV testing. These guidelines generally include that testing must be done by trained workers, test kits must be properly stored and accounted for, pre- and post-test counselling must be provided, consent to be tested must be provided, and a linkage to care must be established.

Our objective was to learn from each participating country who specifically is allowed to do the testing (a medical person and/or a non-medical person), where the testing takes place, and what types of tests are being used: rapid anti-body testing, venepuncture (blood), dry blood spot, or a combination of anti-body and PCR (polymerase chain reaction) tests.

Outcomes

Nine out of twenty (45%) of the organizations participating in the survey indicated that supervision by health professionals was required at all times when testing, while the rest stated that this was not necessary. This speaks to how stigma impacts policy and the organizations' culture associated with testing drug users.

Regarding the legal and/or regulatory issues, many organizations have reported that a growing number of medical workers are entering the community to conduct HCV tests themselves or to supervise peer workers who carry out these tests:



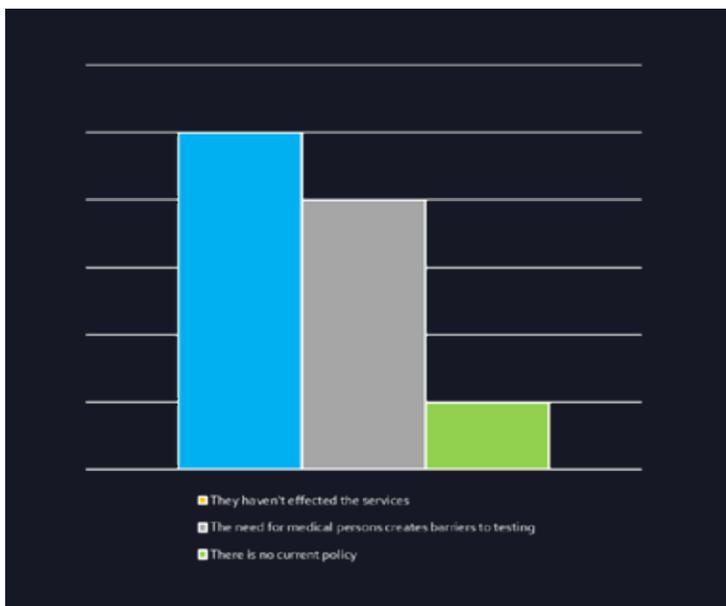
6% – Medical workers in medical settings

55% – Testing by medical workers in non-medical settings

85% – Testing by peers in non-medical settings

On the surface, the fact that 85% of organizations responded that peer workers perform HCV tests in non-medical settings appears good. However, if you look more closely, significant barriers to testing can be identified. One of the major barriers is that organizations need to have the resources to hire medical workers to supervise testing conducted by the peer workers. In many situations, the lack of staff limits the frequency with which testing services can be offered to a minimum.

When we enquired how one's country's legal and regulatory system affected testing, we received very interesting answers describing a range of different policies, from the most restrictive to the most progressive. Examples of restrictive policy regulations, some written and others not, are those where people who inject drugs can only be tested if they are enrolled in OST (opioid substitution therapy), or when priority to be tested is given to people who are more likely to report for follow-up with the test counsellor for confirmation and treatment.

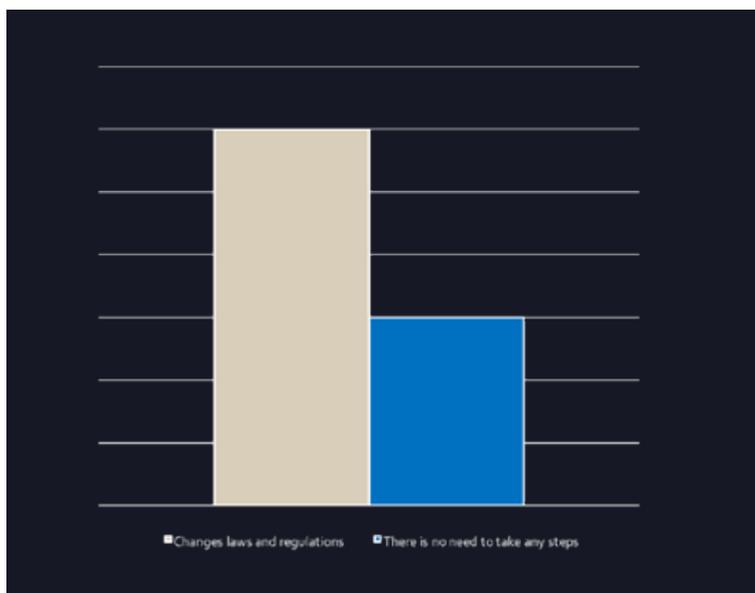


50% – No effect on services

40% – Need for medical supervision creates barriers

10% – No current policy

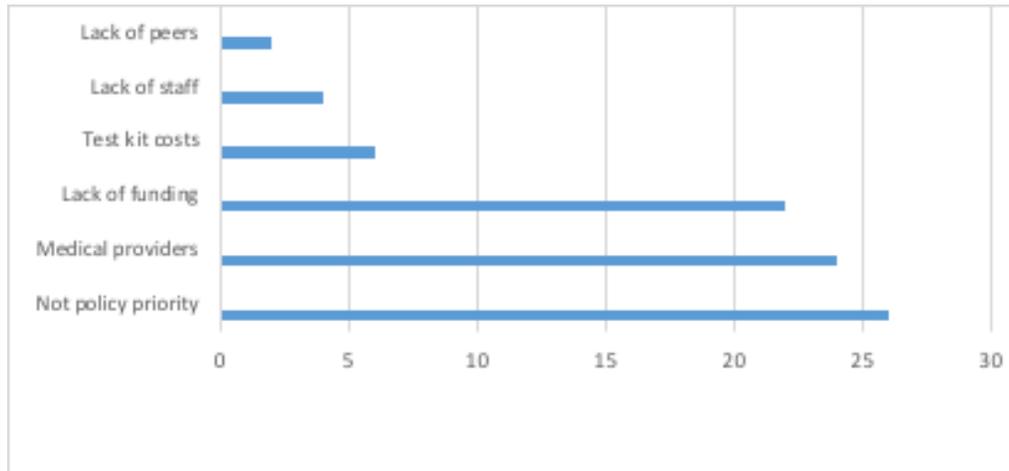
The most progressive policy that we have documented was the example where one country had no policy for community testing and the community took action to develop its own policy. Through community organizing, one organization was able to successfully lead the development and implementation of national policy guidelines. The efforts of collaboration and organizing among twenty organizations created leverage to establish a national policy on community testing. The network's success was named 'best practice' by WHO. As this example shows, the lack of a policy and/or the existence of a restrictive policy can actually stimulate the community to take innovative steps to overcome the legal and regulatory issues they face. When we asked what steps should be taken, the majority of organizations responded by saying their laws need to be changed.



74% – Need to change laws and regulations

16% – No need to take any steps

Ideally, testing services developed in collaboration with healthcare providers, legislators, community-based organizations and drug users themselves can ensure a solid continuum of care. What this survey has shown is that there is a wide variety of policy responses in the European Union. However, what we do see is organizations struggling to change the laws in their country that require medical workers to perform the testing. On the other hand, there is a country in Eastern Europe where the Ministry of Health pays healthcare providers for providing testing and care in harm reduction programmes. Nevertheless, this is a rare case and there are many obstacles to scaling up HCV community testing in the European region. Of all the barriers that we have documented, the following are considered the most problematic:



26% – HCV community testing not a priority among policy-makers

24% – Only medical professionals can carry out testing

22% – Lack of funding

6% – Costs of the test kits

4% – Lack of qualified staff

2% – Lack of peer workers

