



Ending the epidemic

An assessment of HIV policy in Spain, and recommendations to improve the lives of those living with and at risk of HIV



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The report was compiled by KPMG LLP UK (KPMG) and guided throughout by an independent Steering Group comprising of policy, clinical and patient experts in HIV. The Steering Group had editorial control of the report

01

Executive summary

The HIV epidemic in Spain is changing. The number of AIDS-related deaths and new AIDS diagnoses are declining, and there has been a modest but progressive decline in the number of new HIV infections ^[1]. Today, close to 71% of the approximately 140,000 people living with HIV are on anti-retroviral therapy and virally suppressed ^[2]. These are very good outcomes, but more must be done. New and continuing challenges must be tackled if Spain is to meet its ambition of ending the epidemic once and for all.

Today, around 25,000 (18%) of people are estimated to be living with undiagnosed HIV. Late¹ diagnosis, known to be associated with increased mortality and morbidity, is very high - estimated at 47.8% of all new HIV diagnoses in 2017. Changing demographics are creating new at-risk populations², for example the rate of late diagnosis is higher in women than in men, at 50.6% versus 47.2%. Social and institutional stigma continues, often creating barriers in accessing care. Finally, ensuring the long term health and well-being of the ageing population is another critical challenge, particularly given the estimated high proportion of people living with HIV who are 50 years or older ^[3].

Spain's current national strategy for HIV is detailed in the Plan Estratégico de Prevención y Control del VIH y otras ITS, 2017-2020, published in 2018 by the Ministry of Health, Consumption and Social Welfare (Ministry of Health) as an extension to the previous (2013-2016) plan ^{[4],[5]}. To understand its effectiveness in tackling the new and emerging challenges of the epidemic, the Steering Group³ undertook an assessment of Spanish HIV policy. Working step-by-step across the HIV care continuum of Awareness, Prevention, Testing and Screening, HIV-specific Clinical Treatment and Long Term Holistic Health, they identified areas of strength and those with room for improvement.

1. A 'late' diagnosis is made at a point in time at which HIV treatment should already have been started. Currently, a CD4 cell count below 350 cells/mm³ at the time of diagnosis is considered 'late'.

2. For list of high risk populations, see Methodology section, Table 2

3. For full list of Steering Group members, see Methodology section, Table 1

-  **Awareness** Limited commitment at national level is hampering efforts to educate high risk populations and reduce stigma. The lack of policy on sexual health education in schools is a key barrier to improving risk awareness among young people.
-  **Prevention** There is a general lack of focus on prevention, which is often not considered a priority and has no comprehensive, national level framework in place to unite efforts.
-  **Testing and Screening** While policy and guidelines exist, including universal screening in certain settings, they are not implemented consistently - particularly in primary care.
-  **HIV-specific clinical treatment** Immediate initiation on anti-retroviral (ART) therapy is recommended, and generally well implemented. Challenges remain in ensuring linkage to care and consistent medicine access across the regions.
-  **Long-term Holistic Care** Improvement is needed in clinical and non-clinical support services (e.g., mental health) and in developing indicators for the quality of life (QoL) of people living with HIV.



To drive greater improvements in the lives of those with or at risk of HIV, the steering group put forward a number of recommendations:

- **Strengthen the office of the National Plan on AIDS** - increase human and financial resources to dedicate sufficient effort to developing and implementing plans and policies in Spain.
- **Address low rates of testing in primary care** – generate greater awareness of existing guidelines on universal screening, combined with programmes to minimise missed opportunities, such as education of GPs, alert systems.
- **Develop a comprehensive, national level framework for combined prevention of HIV (or HIV and other STIs)** – bring together a framework of biomedical, behavioural, and structural prevention interventions at a national level, allowing for consistent and effective implementation at a regional level.
- **Implement more community based sexual health clinics** – create convenient and inclusive environments, improve links to care (e.g., establish direct referrals to HIV clinics) and develop cost effective means of delivering long term HIV and STI care and services.
- **Include sexual health education in the school curriculum** – mandate changes to school curriculums to ensure consistent programmes across the regions, with the aim of developing greater awareness of HIV and STIs among young populations.

02

HIV in Spain, the wider context

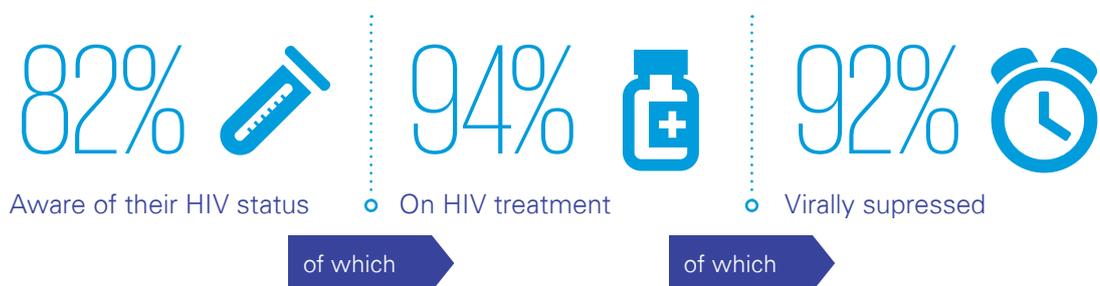
Brief epidemiology and 90-90-90 overview

Spain’s HIV response has delivered positive outcomes. There has been a continuous decline in the number of AIDS-related deaths and number of new AIDS diagnoses ^[1]. Of the estimated 140,000 people living with HIV in 2017, approximately 82% (115,000) knew their HIV status, of which 94% (108,000) were on anti-retroviral therapy (ART), of which 92% (99,000) were virally suppressed (see figure 1^[2] - indicating Spain is progressing well towards the UNAIDS 90-90-90 treatment targets ¹. This equates to approximately 71% of all people living with HIV being virally suppressed. Furthermore, national-level surveillance data have indicated a progressive overall decline in the number of new HIV infections, although this rate has slowed in recent years. In 2017, a total of 3,381 new HIV diagnoses were made, although this does not include late notifications - therefore the actual figure is likely to be higher ^[1].

These successes are to be celebrated, and as a result, the HIV epidemic in Spain has changed. However, new and continuing challenges remain, which must be overcome if Spain is to end the epidemic, once and for all.

While the overall number of new infections are declining, disaggregating the data indicates varying trends among high risk populations. Men who have sex with men (MSM) continue to form the largest at-risk group, with 54.3% new HIV diagnoses in 2017. Heterosexual transmission is the second largest (28.2%), and accounts for the largest mode of HIV infections among women (85%). The highest number of new infections by age-group are among the 30-39 year olds (33.9%), followed by those under 30 (29.3%) and over 50 (14.8%) years of age ^[1].

Figure 1. Performance towards the 90-90-90 targets



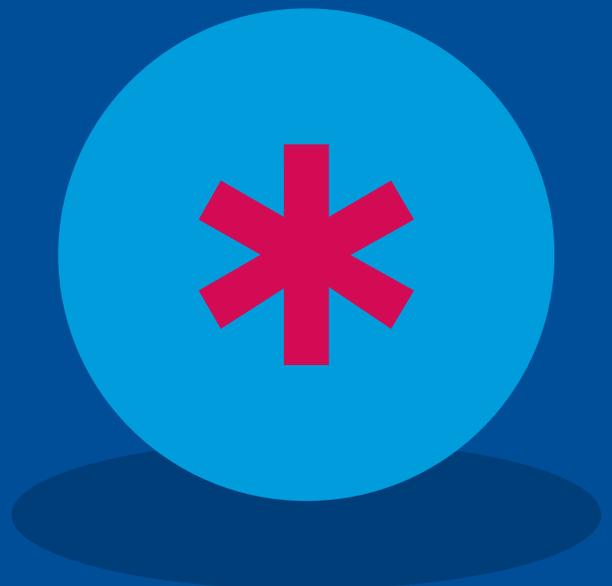
Source: GeSIDA ^[2]

1. The UNAIDS 90-90-90 targets set in 2014 are targets for the treatment of people with HIV – 90% of people with HIV will know their status, 90% of people diagnosed with HIV will be receiving ongoing antiretroviral therapy, and 90% of people with HIV on treatment will be virally suppressed by 2020. These targets are based on the assertion that it is not possible to end the HIV epidemic without treating all of those with HIV that need it. Source: UNAIDS

Linking people to care is another challenge. Currently, close to 25,000 people are estimated to be living with undiagnosed HIV. Late diagnosis continues to be high, estimated at 47.8% of all new HIV diagnoses in 2017. It is also worth noting variations among sub-populations, with a higher rate observed among women (50.6% versus 47.2%), and those who are older (65.2% of new HIV infections in those aged 50 years and older were considered late) ^[1]. Challenges in linkage to care is also exemplified by those diagnosed, but not in treatment – estimated at 6% (6,900).

Ensuring the health and wellbeing of the ageing population is another area requiring focus. An Economist Intelligence Unit publication indicated that as of 2015, 68,000 people living with HIV were aged 50+ years - which equals just under 50% of the total ^[3]. Ageing with HIV bring a significant number of challenges, resulting from treatment toxicity, impact of long term infections, co-morbidities and mental health issues.

Spain's current response to tackling the HIV epidemic along with the remaining key challenges are outlined in its new National Plan for HIV / AIDS (see chapter 3). The wider legal and policy environment also continue to influence the HIV response, impacting in turn the lives of those living with, at risk of and working in HIV (see Box 1).





Box 1. Laws and policies impacting the HIV response

As outlined in the Methodology section, a deep assessment of the wider legal and policy landscape and its impact on the HIV response is not within the scope of this project. However, we have indicated below Spain's current position on three common potential barriers to the HIV response:



1) Legal protection against stigma and discrimination:

A multitude of Spanish laws exist which in theory should protect people living with HIV from discrimination, including the Spanish Constitution, Health Laws, Work and Employment, Social Security, Insurance and the Prison System. However, as with all Western European countries, the extent to which these laws are useful depends on the willingness of people living with HIV to take action when they are discriminated against^[6], which often does not occur. Although uncommon, this issue is particularly disadvantageous to those with legal or social limitations, e.g., newly arrived migrants.

Although employment legislation stipulates the right to privacy and non-discriminatory treatment, up until recently people living with HIV may still have been excluded by regulations that govern entry to the Police, Military and Civil guard. Each of these bodies require a medical examination to join, which, although it does not mention or test for HIV specifically, has exclusions that cover HIV and other conditions (such as diabetes and coeliac disease - i.e., "Illnesses, physical defects or hereditary, constitutional or acquired anomalies that require some kind of specific and / or long-term treatment, or entail risk or rejection for social relations or coexistence within the Body.").^[9] While a study conducted by the Ministry of Health concluded that no specific instances of exclusion due to HIV had been documented, it was agreed in November 2018 by the Council of Ministers that the exclusion criteria for all public employment would be reviewed and updated to reflect the reality of HIV (and other diseases) in the era of viral suppression.^[10]



2) Free, non-discriminatory access to healthcare:

After removing the right to healthcare for certain groups in 2012^[11], the Spanish government is drafting legislation to bring back universal free healthcare coverage. This includes, from day 1, removing the 90-day period before which immigrants were eligible for services. As certain regions (including Catalonia and the Basque country), together with healthcare professionals and NGO's continue to provide treatment to undocumented migrants despite the 2012 law change, it is expected most regions will implement cover. However, variations may exist due to the freedom to choose appropriate levels of access for their region.



3) Decriminalisation of behaviours such as sex work and drug use:

While consumption or minor possession of illicit drugs in public places is a serious order offence, it is not punishable by incarceration, and can instead consist of fines ranging from EUR 601 to EUR 30,000 (Law on the Protection of Citizens' Security (2015), Article 36). The National Strategy on Addiction (2017-24) focuses on harm reduction and facilitating the social integration of drug users as key objectives^[12]. The rate of new infections among people who inject drugs (PWIDs) continues to decline, indicating effective harm reduction and prevention strategies among this population (see Chapter 2).

Regarding sex work, despite decriminalization in 1995, there are no public laws regarding the legal status of sex workers. Therefore it is mostly 'tolerated', i.e., not illegal, but not regulated. This means that in general no protection exists against exploitation and there are no government mandated benefits. While comprehensive data is scarce, ECDC have indicated an HIV prevalence of 2% among sex workers^[13], although this may be higher among male sex workers.



03

Assessment of HIV policy in Spain

This chapter outlines the Steering Group's assessment of the current HIV policy in Spain, and its effectiveness in tackling the new and continuing challenges of the epidemic. It is broken down by stages of the HIV care continuum, covering Awareness, Prevention, Testing and Screening, HIV-specific Clinical Treatment and Long Term Holistic Health. Recommendations for improving the lives of those with and at risk of HIV are outlined in the next chapter.

3.1 Overview of national HIV policy

Spain's national framework for tackling HIV / AIDS is detailed in *Plan Estratégico de Prevención y Control del VIH y otras Infecciones de Transmisión Sexual, 2017-2020*, published in 2018 by the Ministry of Health as an extension to the previous plan (2013-2016) ^{[4],[5]}. Due to the structure of the Spanish healthcare system (i.e., the devolution of power to the country's 17 autonomous regions), the plan provides only high level guidance. The regions are free to develop their own plans and implementation steps. For example, regions such as Catalonia (2016-2020) and Extremadura (2018-2021) have recently updated their plans, while many others such as Anadalusia (2010-2015), Castilla La-Mancha (2014-2017) and Galicia (2015-2018) also have active plans in place ^{[13][14][15][16][17]}.

The plan focuses on three populations: the general population, sexually active people at a higher risk of exposure HIV and / or STIs, and people living with HIV and / or STIs. It aims to tackle a number of existing challenges, including, achieving the first 90; evaluating the use of new detection modalities (e.g., self-testing) and combined prevention approaches (e.g., pre-exposure prophylaxis (PrEP); the promotion of sexual health among young children; and addressing stigma and discrimination.

Infrastructure exists for multi-stakeholder governance of the plan. At a national level, the inter-territorial council (Consejo Interterritorial del Servicio Nacional de Salud de España) aims to harmonise health services across the 17 autonomous regions. A committee specific to HIV (de Coordinación y Seguimiento de Programas de Prevención de Sida), which includes representatives from the Ministry of Health (e.g., Carlos III Health Institute), other Ministries (e.g., education), interior (prisons), representatives of the health authorities of the 17 regions, professional organisations (e.g., medicine, nursery and pharmacy) and NGOs aims to incorporate multiple viewpoints. While a meeting of this group has not been convened since 2014, the next meeting is scheduled for the first quarter of 2019.

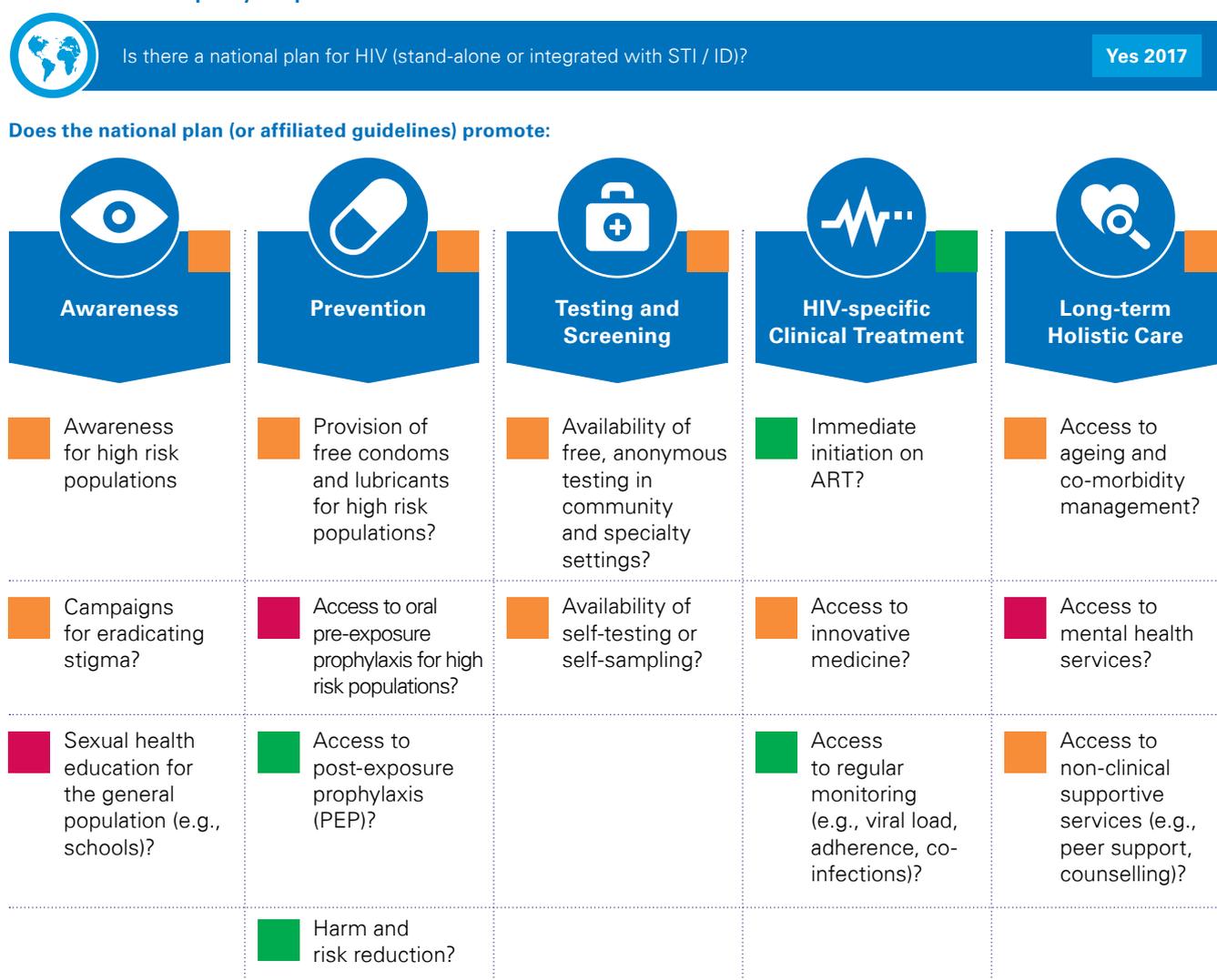
Recent progress is seen: a report evaluating the 2013-2016 National Plan for HIV and STIs was published in 2018, identifying achievements and areas for improvement [6]. Furthermore, the Social Pact [7], a document outlining a series of commitments aimed at tackling stigma and discrimination affecting those living with HIV was approved in also in 2018.

However, challenges in developing and implementing policy remain. Years of austerity measures have resulted in a gradual loss

of capacity and leadership at all levels of governance, impeding efforts at a national level and increasing regional discrepancies. Political, social and religious ideologies also continue to influence efforts concerning HIV, particularly issues such as sex education or the provision of PrEP (see below). As with other European countries, the political situation in Spain is fluid both at a national and regional level, which impacts the continuity of policy initiatives. Experts cite concern over political polarisation and instability, which will undoubtedly increase the discrepancy between regions. Additionally, there is a public perception that HIV is a 'problem solved', resulting in complacency and HIV dropping off the public agenda.

To understand the ability of Spain's HIV strategy to tackle the new and emerging challenges of the epidemic, the Steering Group undertook an assessment. Going step by step across the HIV care continuum of Awareness, Prevention, Testing and Screening, HIV-specific Clinical Treatment and Long Term Holistic Health, they identified areas of strength and those with room for improvement. Figure 2 summarises their findings, and further details on the policy position are available in chapter 5.

Assessment of HIV policy in Spain



Key

■ Policy available and effective

■ Room for improvement

■ Policy not available

Note on methodology: the assessment underlines the view of the Steering Group on current policy and its effectiveness, broken down by stage of the HIV care continuum. Additional in-country experts provided input, and findings were supplemented through secondary research. Full details of the policy, related to stages of the HIV care continuum, are available in section 5.



Awareness



- Interventions at a national level are sporadic and mostly limited to the MSM population
- Efforts to tackle stigma are similarly lacking, with only a few campaigns running intermittently. However, the recently signed Social Pact for non-discrimination does indicate increased attention in this area
- Regional policies do exist, but are variable subject to regional priorities and funding

What is the policy position?

The need to promote awareness in high risk populations is recognised by the national strategy, however there is little in the way of defined actions at a national level to support this.

The previous national strategy for 2013-2016 recognised the need to increase the knowledge of HIV and other STIs among high risk populations (young people, MSM, sex workers, PWID, migrants, and women) and outlines the policy to promote the dissemination of information adapted to each population ^[5]. As a continuation of the previous strategy, the 2017-2020 plan recognises this, however does not outline any specific actions targeting high risk populations ^[4].

Specifically regarding stigma, the 2017-2020 national strategy outlines a number of actions, including the intention to approve the Social Pact. The Social Pact was developed in 2011 with the aim of targeting stigma and discrimination against people living with HIV. It outlines a number of commitments: 1) favouring equality in treatment and opportunities of people living with HIV, 2) working in favour of social acceptance of HIV, and 3) reducing the impact of stigma on people living with HIV ^[7]. The Pact was approved in November 2018.

Regional plans for awareness are varied, but policy does exist, e.g., Catalonia includes policy on awareness for a number of high risk populations, including young people, MSM, sex workers, and PWIDs ^[15].

What happens in practice?

Campaigns for awareness in high risk populations and campaigns to address stigma are present in Spain, however they are typically limited to MSM populations and run intermittently. These include national-level campaigns run or funded by the Ministry of Health (e.g., € 2 million, unchanged from 2017, was made available for NGOs for interventions including but not limited to awareness in 2018 ^[20]) and the most recent campaign “Sin condón no hay vuelta atrás” (Without a condom there is no turning back) targeted the MSM population to encourage the use of condoms and testing ^[21].

The Ministry of Health also runs campaigns targeting stigma, often around key dates such as World AIDS Day. Recent examples include the #TransmiteRespecto campaign in 2017 and 2018, aimed at providing information on the low risk of HIV transmission through casual contact. Other national level campaigns include #yotrabajopositivo, run in 10 of the autonomous communities aimed at fighting discrimination in the workplace

Campaigns are also run by NGOs and Medical Societies, e.g., U=U by GeSIDA or Batalla a la Intolerancia a campaign by CESIDA. The latter aimed to combat intolerance suffered by people living with HIV - a collaboration with Arkano, a recognised Spanish rapper.

However the campaigns are not all widely publicised and often do not reach the wider population.



“Last year there was a campaign around December 1st, but there was not even any media presence covering it. There was no dissemination.”

Policy Stakeholder, Spain

What do the experts say?

Expert consensus is that awareness and action against stigma is generally poor, and point to a number of possible reasons:

- A lack of focus and funding on awareness activities, resulting in a lack of continuous, national-level interventions
- Regional discrepancies due to local funding, policies and priorities
- Limited focus on non-MSM high risk populations, particularly young people, sex workers, transgender individuals or those who fall at intersections (e.g., young transgender men)



“I saw a patient today, and we were talking about the differences between today and the start of the epidemic when there were many messages addressing HIV awareness. But now, there are no messages.”

HIV Clinician, Spain

Expert views are supported by studies indicating low levels of awareness across the HIV care continuum. Although dated, a representative sample surveyed in 2012 showed that 13.9% of people believed that HIV could be transmitted by sharing a glass, 13.9% through using public toilets, and 14.9% through coughing or sneezing ^[22].

Studies also indicate persistent levels of stigma, with a cross-sectional national survey (supported by SEISIDA) of 1,554 individuals in 2017 indicating persistent levels of stigma, with 25% of respondents concerned about exposure, and 43% concerned that a loved one will reject him / her after taking an HIV test ^[23]. The recent ratification of the Social Pact may be a key step in addressing some of these challenges, however it is yet to be implemented as operative plans and working groups are still being formed.

Lack of policy on sexual health education is a key barrier to awareness in the general population:

What is the policy position?

Sexual health education is not mandated in schools, with Ley Orgánica 8/2013 De 9 De Diciembre removing all content relating to sexuality in the Spanish academic curriculum ^[24]. The national strategy to date has collected information from the autonomous communities and NGOs about their programmes of effective sexual health education in both formal and extracurricular settings ^[4], and recognises the need for better promotion of effective sexual and reproductive health programs (especially among young people). Objectives for the period 2017-2020 include developing quality criteria and good practices for sexual education programmes, and collaborating with the Ministry of Education in order to promote sexual health in educational environments ^[4].



“This is a big problem for us. Some regions have programmes where nurses or trained people go to schools to talk to the pupils, but it’s voluntary for the school to agree to have this. This is a big fight in our country.”

Policy Stakeholder, Spain

What happens in practice?

While there is no national-level policy, the HIV (or STI) plans of some regional governments such as Catalonia and Extremadura offer outreach programmes providing sexual health education in schools ^{[15],[16]}. However, uptake of these by the schools remains optional.

There are also campaigns for the general population, such as the #túdecidesloquecompartes campaign in 2017. The Ministry of Health has also produced information sheets on STIs (syphilis, gonococcus, HPV, chlamydia, LGV genital herpes, trichomonas) ^[11] - an objective of the 2013-2016 national strategy ^[5].

What do the experts say?

The lack of sexual health education in schools is a critical gap, as it is an effective method of building a baseline knowledge of HIV and STIs in young people.



“There is not enough focus on prevention, e.g., having sexual education – we see a lot of young people with new infections and they do not have a feeling of risk, and therefore do not understand how or why they have HIV.”

HIV Clinician, Spain

Some barriers to the creation and implementation of an effective sexual health education policy derive from religious / ideological views, which at times make discussing sexual health education topics in schools difficult. Policy around sexual health education has been known to be a political issue, with policy repeatedly changing according to the government in power.



“There are a lot of ideological barriers. For example, it is difficult to talk about condoms in a Catholic school, even if it is state funded.”

HIV policy stakeholder, Spain

Where isolated activities do exist within schools or autonomous regions, they may lack impact as the key messages are delivered in isolated sessions by outside speakers, and not reinforced on an ongoing basis. Limitations in awareness among young people were evidenced by a recently concluded small scale study among young people, which indicated that over 50% do not use a condom during all sexual relations, and 15% admitted that they do not use condoms even if there is the possibility of contracting STIs or causing unwanted pregnancies ^[25].



Prevention



- Condoms and PEP are available, however implementation is inconsistent
- No policy exists for PrEP - despite a recent unanimous backing from the Health Commission of the Congress for its introduction
- Harm reduction is an area of success in Spain, with the incidence among PWIDs falling

What is the policy position?

The national strategy for 2017-2020 outlines the need for combined prevention, particularly targeting vulnerable populations^[4], but is limited in detail and in commitment from the government to implement it.

For example, no detail is provided on the provision of condoms or lubricants. Instead, the responsibility is devolved to the autonomous regions.

Similarly, details on biomedical interventions are limited. The strategy mandates PEP, however, with regards to PrEP it only outlines an intention to measure the impact of PrEP in the reduction of new HIV diagnoses in key populations^[4].

In spite of the lack of defined policy, GeSIDA developed a consensus document in 2016, recommending the development of a PrEP programme that not only includes the ability to prescribe PrEP, but also states that a prevention and training plan should be delivered alongside^[29]. Considering cost effectiveness, GeSIDA recommends to make PrEP available to groups where HIV infection incidence is greater than 2 cases per 100 person years. GeSIDA also make recommendations on who should be able to prescribe PrEP, and where, and also the length of time between follow-ups.

Harm and risk reduction policy (e.g., Estrategia nacional sobre adicciones 2017 – 2024) includes objectives to maintain and expand coverage of existing programmes. Policy does not yet fully address emerging trends, such as chemsex¹, which may indicate an increasing risk factor in the future.

What happens in practice?

Implementation of combined prevention is variable. PEP is generally available in hospital settings (e.g., HIV units and emergency rooms). While anecdotally there have been cases where individuals experience delays and barriers - for example as a result of emergency room clinicians being unfamiliar with guidelines on PEP -, this is not considered to be a common occurrence.

Harm reduction policy is also well implemented in Spain, scoring highly in evaluations of the policy coverage with many or most relevant locations being present for syringe exchange and opioid substitution.

Distribution of condoms is the responsibility of the autonomous regions, with funding for free condoms available only in some regions. For example, Plan Andaluz frente al VIH/sida y otras ITS 2010-2015 (Andalusian Plan for AIDS) indicates over 2 million free condoms and lubricants were distributed^[17]. Campaigns to distribute free condoms are also often run

1. Chemsex is the practice of consuming drugs recreationally in order to facilitate sexual activity – typically this refers to one or a combination of three drugs: methamphetamine (crystal meth), mephedrone (M-cat), and GHB/GBL (G). Consumption of these drugs reduces inhibitions and therefore increases risky behaviours, whilst also exacerbating an individual's mental health

around key dates at both regional and local levels e.g., Navarra’s “Love yourself, get tested, use condoms” campaign on World AIDS Day.

There is currently no defined policy on PrEP. While the Health Commission of the Spanish Congress recently unanimously approved the proposal to facilitate implementation of PrEP ^[26], details of the offering and its implementation are yet to be developed.

A limited clinical trial, initiated in 2017 to establish the feasibility of implementing PrEP is underway, with regions including Catalonia, Basque Country and Valencia participating ^{[27][28]}. On the ground support is available for the use of PrEP, through privately funded interventions such as the Barcelona Checkpoint (see case study), although these are limited to provision of counselling and support and not the drug itself.

“

“Although the position of the government has changed, we still don’t know what the position of the autonomous communities is on PrEP.”

Policy Stakeholder, Spain



What do the experts say?

Combined prevention activities are currently not well coordinated, a result of a lack of a cohesive national level framework which mandates policy and its consistent implementation.



“Prevention policy has not been effectively developed in Spain, there is no framework for prevention which means activities are fractured, scattered, and not well funded.”

HIV Clinician, Spain

PrEP remains a significant gap and the development and implementation of a policy may still face a number of challenges such as:

- strong ideological views which continue to influence the narrative
- a need for education and training among healthcare professionals, particularly primary care physicians, on the offer and use of PrEP
- lack of supportive infrastructure - for example community based sexual health clinics - which may mean limit access even if / when it is made available (as PrEP will be limited to hospitals)
- limited number of supportive services, for example counselling for risky behaviours, which are important for maximising the benefit of PrEP



“People view PrEP as something for greedy gay men who want to keep having sex. If you have people whose values are driven by ideology rather than public health evidence, you will also be in trouble.”

HIV clinician and policymaker, Spain

Experts note the success in harm reduction but caution that greater attention must be paid to emerging trends such as chemsex which may increase in prevalence over the coming years.



Case study: Barcelona Checkpoint ^[30]



What is it?

Barcelona (BCN) Checkpoint is a community based sexual health clinic targeting the MSM population. Services provided by the clinic are used by approximately 6,000 people per year. The clinic was set up and run by the NGO Projecte dels NOMS-Hispanosida.



What are the key features?

Alongside testing, vaccinations, psychological and chemsex advice, the checkpoint offers services for those taking PrEP independently:

- HIV testing before starting PrEP
- Regular medical check-ups
- Guidance on how to minimise the risks of taking PrEP
- Access to Psychosocial advice

The Checkpoint is also running a study on 150 people taking PrEP, and has performed research on PrEP in the past using their cohort to establish the cost effectiveness of implementing PrEP.

BCN Checkpoint is partially funded by public contributions from the government of Catalonia, also taking charitable donations.



Why is it a good practice?

- PrEP policy must extend beyond simply approving the drug to include development of a full implementation model in order to be effective. BCN Checkpoint demonstrates how the supportive services around PrEP could be implemented in a community sexual health clinic setting.



Testing and screening



- Offer and uptake of testing in primary care settings is low, despite existence of guidelines recommending universal screening in areas of high prevalence
- Self-tests are available but limited awareness may be resulting in low uptake
- Limitations in data (e.g., number and locations of tests done) means a lack of visibility of interventions that are most effective

What is the policy position?

The national strategy addresses testing in healthcare and community settings, highlighting the need to improve both the offering and the uptake. In particular, it outlines a number of actions to improve testing in the community and notes the need to update guidelines on early diagnosis in healthcare settings^[4]. Recognising the lack of reliable data on the number of tests, the strategy outlines actions to implement a new system, called RedCo-HIV, to track testing and diagnosis of HIV in the community^[4]. This programme will include developing common procedures and tools for collecting information, collection of evaluation indicators, and promotion of the exchange of good practice between NGOs^[31].

The national strategy further promotes early diagnosis of HIV and STIs through strategies such as self-testing. Self-testing was made available in Spain in 2017, with a Royal Decree from 2000 restricting sale of medical devices for “in vitro” diagnosis being reversed to allow sale and advertising to the public^[32]. Sale is currently restricted to pharmacies.

Recommendations by the Ministry of Health to improve early diagnosis include routine testing of sexually active 20-59 year olds residing in

provinces where the rates of new HIV diagnoses are above the the 75th percentile in this age group, who are getting a blood test. Antenatal screening, screening of prisoners and testing performed according to exposure and risk factors are also recommended^[33].

Some regions have issued their own testing policies. For Example, the Department of Health in Galicia has issued testing recommendations for early diagnosis of HIV. These are also covered in Galicia regional plan for HIV^[34].

What happens in practice?

Testing is available through primary care and specialty care settings, e.g., HIV clinics in hospitals. Given a GP referral is needed to attend a specialty clinic, primary care is a common site of testing in Spain. However, experts note a lack of awareness among GPs, particularly of latest testing guidelines, which may result in missed opportunities.



“We have guidelines on testing and screening, and when we ask GPs and nurses if they knew the guidelines to improve early diagnosis are available, they do not know! Only 20-30% are aware.”

HIV Specialist Physician, Spain

Testing is also available in the community, with a range of interventions including NGO offices (Ministry of Health has published around 150 NGO sites on their testing map ^[35]) and mobile units offering rapid tests. In-pharmacy testing programmes are also available, with a recent study indicating success in reaching non high-risk populations, such as heterosexual men who had no previous HIV tests. There is a requirement for someone qualified to administer the tests, and also for referral for further confirmatory tests at a public health centre or primary care centre prior to link to an infectious disease specialist.

Self-tests are also available without a prescription, and can be found in pharmacies across Spain ^[35].

Specific actions focused on improving the current testing offer are underway, including a study on the implementation of HIV testing in primary care in 8 autonomous communities with the aim of providing evidence to promote a routine test offer. Steps have also been taken to better implement self-testing in pharmacies, with a Pharmacy Action Guide for dispensing HIV self-tests produced, covering information on how to interpret results, what advice to give, and recommendations for engaging customers on the reliability of tests and alternative testing modes ^[36].

What do the experts say?

Experts note the need to improve the offer, uptake of testing and linkage to care, and point to a few challenges that need to be tackled as a priority:

- Improving rates of testing among GPs. This would require improving awareness of guidelines and providing education to tackle stigma. The collaboration between GeSIDa and semFYC is a step towards this ^[37].
- Removing the requirements for a qualified person to administer tests in community settings, which limits capacity and may even deter marginalised groups from engaging with care.
- Improving linkage to care following testing in community, ensuring inconvenience for the individual is minimised
- Collating comprehensive data on testing, including testing sites, positive results, uptake among sub-populations etc.
- Providing wider awareness among the population of the use and linkage to care following the use of self-tests.



“Self-tests are available in almost every community pharmacy in Spain. However in pharmacies, they are not very visible so more promotion is needed of this option of testing.”

Policy Stakeholder, Spain



HIV specific clinical treatment



- Immediate initiation on ART is recommended, and generally well implemented once people are linked to care - although improvements may be made in time to initiation
- Access to new and innovative medicine, although available, may face delays due to lengthy approval processes and restrictions due to budget constraints
- Linkage to care may vary, particularly due to need for referral from GP to access to HIV clinic

What is the policy position?

The national strategy together with detailed guidelines from GeSIDA recommend immediate initiation on ART, irrespective of CD4 cell count^[45]. It also outlines 2nd and 3rd line regimes and wider clinical management, e.g., identification of co-infections and regular screening. The GeSIDA guidelines are updated annually.

With regards to access to medicine, following marketing authorisation by the European Medicines Agency (EMA) and Spanish Medicines Agency (AEMPS), Pricing & Reimbursement decisions are made by the Ministry of Health (MSC). Further approval is then required by each of the 17 autonomous regions, which can make their own reimbursement decisions. Finally, at times certain hospitals may also negotiate on pricing.

What happens in practice?

In Spain, people living with HIV continue to be managed in hospital clinics, by HIV specialists acting as reference doctors. ART is currently only available from hospital pharmacies.

Immediate initiation on ART is recommended, and generally well implemented. However, time to initiation of therapy may vary - while there is limited national data, anecdotal evidence indicates delays may occur. Once on ART,

patients are generally well monitored for viral suppression. Certain regions such as Catalonia and Valencia are indicated as being particularly effective at sharing medical records between hospitals and primary care, therefore ensuring close monitoring and continuity of care.



“Monitoring is well implemented in Spain; it’s one of the things done consistently everywhere.”

Policy Stakeholder, Spain

While some good practice examples exist, linkage to care at times may be ineffective due to current requirement of a GP referral in order to see an HIV specialist. This has been known to introduce delays, as waiting times can be long. It can also result in the loss of individuals from care. The multi-step linkage process may disproportionately affect the more vulnerable populations (e.g., migrants -especially those unable to speak Spanish or those with legal, economic or social limitations), who are more likely to be reluctant to engage with healthcare professionals or miss appointments.

Time for access to new medicines can vary between six to eighteen months, in part due to the multi step process for pricing /

reimbursement decisions. Variations in access across the country may also arise due devolution of responsibility to the autonomous regions, which are able to impose caps and restrictions. This contrasts with other Europe5 countries such as Germany and France, where consistent access is available following EMA approval.

What do the experts say?

Experts concur HIV-specific clinical treatment is delivered effectively in Spain, with policy and supporting guidelines regularly adapted and well implemented. Recent data indicates Spain has achieved the 2nd (94%) and 3rd (92%) of the UNAIDS 90-90-90 treatment targets ^[5].

Time to treatment initiation is an area for improvement. As noted above, national-level data is not currently available, however, experts believe time lines are not consistent across the country. Other areas for improvement include the the current process for linkage to care which introduces delays and may cause the loss of individuals from the health system. More convenient routes for linking people, especially those most vulnerable and hard to reach, are required. Experts also note closer collaboration between management of co-infections would be beneficial, for example through integration of HIV guidelines with those for other common co-infections such as tuberculosis. Finally, a more consistent approval process for new medicines could enable more equal access, thereby limiting the 'zip code lottery' that can currently be found.



Case study: Centro Sanitario Sandoval



What is it?

Centro Sanitario Sandoval is a STI centre integrated in the San Carlos Clinical Hospital in Madrid that has been serving the community for approx. 90 years.



What are the key features?

- Provides free HIV prevention, detection, treatment and care
- Provides complete anonymity
- Available to patients both with, or without a medical card
- HIV test results obtainable within 20 minutes

In addition, the centre provides services such as counselling for serodiscordant couples who are looking to reproduce.



Why is it a good practice?

- The centre provides an inclusive environment where free testing, counselling, and support is available. It is recognised for its ability to reach vulnerable populations as well as providing good practice examples of rapid testing and linkage to care.



Long-term holistic care



- Guidelines on managing co-morbidities are comprehensive and frequently updated, but more could be done to ensure smooth linkage across specialties
- There is no specific policy tackling mental health of people living with HIV living in Spain, representing a significant gap
- Policy on other supportive services is limited, and could be better emphasised in the national strategy and implemented more consistently

What is the policy position?

Policy encourages a multidisciplinary approach to care for people living with HIV, promoting early diagnosis of co-morbidities, and continuous training of HCPs who care for people living with HIV ^[18]. GeSIDA clinical guidelines, updated every 2-3 years, also cover recommendations on the management of common HIV related co-morbidities, covering renal issues, cardiovascular comorbidities and bone related issues. Vaccinations for certain viruses are also recommended including Hepatitis A and B ^[38].

With the average age of people living with HIV in Spain approaching 50 years ^[39], addressing the issue of ageing is becoming more important. While HIV-specific policy does not currently exist, the 2017-2020 national strategy sets out the intention to promote studies to evaluate the impact of ageing on the health of people living with HIV ^[4].

Mental health services for people living with HIV are currently a gap in policy, and not a focus for the National Plan or the general mental health strategy. The national strategy does outline the intention to define measures to monitor quality of life ^[4], which may include monitoring of mental health. An agreement was made to update the wider mental health strategy in 2017 ^[40] and this is currently being prepared by the Ministry of Health, however, it is unlikely to include specific provisions for HIV. In an attempt to address this gap, GeSIDA produced guidelines on mental health for people living with HIV including screening at initial diagnosis as well as ongoing management ^{[38] [41]}.

What happens in practice?

In practice co-morbidity management is considered to be of a good standard, while other aspects of holistic health such as mental health and supportive services are generally sub-optimal.

In most regions, primary care physicians remain gatekeepers of co-morbidity management. Specialists are unable to make referrals, which may create delays and inconvenience for the patient.



“I’d like to know what percentage of people living with HIV actually go back to their GP to get that referral to go back to their cardiologist or whichever specialist.”

HIV policymaker, Spain

Current provision of mental health services is in line with that for the general population, and faces a number of wider challenges - such as continued austerity which has resulted in a lack of capacity and capability across the country. In some isolated instances NGOs provide services in some hospital clinics. Other supportive services are also limited, e.g., peer-support programmes, and provision is again heavily dependent on NGOs.



“There are some hospitals which have specific psychologists for people living with HIV, but they’re paid by NGOs.”

Policy stakeholder, Spain

What do the experts say?

There is wider recognition that the current provision of long-term health services for people living with HIV are not sufficient, and that a fundamental shift in the current care model is required. Cost-effective management of long-term health of people living with HIV requires a move out of specialty HIV clinics into the community, ensuring closer collaboration of co-morbidity and other psychological and behavioural support services (e.g., mental health, peer-support). Effective implementation requires better communication and referral routes, as well as addressing awareness among GPs. Currently, people living with HIV indicate a reluctance to move into care of GPs.



“Now we see the patients once or twice a year, and so then it is impossible to control co-morbidities such as diabetes or blood pressure. So we need to share this management with community / family care.”

HIV Clinician, Spain

Current GeSIDA guidelines and educational tools on psychological and psychiatric conditions are considered comprehensive ^{[38] [41]}, however experts concur there is not sufficient capacity in the system to provide mental health services specifically tailored to people living with HIV. For example the provision of services within HIV clinics is in line with that for the general population. Mental health for the general population is not well integrated into the health system and relies on existing networks of clinics within regions.

There is a need for greater monitoring of indicators of holistic health and collection of real world evidence, for example quality of life among people living with HIV, which are currently missing. A better evidence base of needs beyond viral suppression would enable targeted effective policies to be developed.



“We need to assess the needs of people who are virally suppressed and where care can best be provided to them. This is more about QoL, symptoms of discomfort and health related issues they face even though they are virally suppressed (anxiety, insomnia, and other issues in addition to clinical guidelines).”

HIV policymaker



Case study: Telemedicine for HIV patient follow up ^{[42] [43]}



What is it?

A study conducted in Hospital Clinic Barcelona showed that using a ‘virtual hospital’ model for follow up was a satisfactory and safe way to provide care to clinically stable HIV patients.



What are the key features?

- Consultations with physicians were provided via video conferences, and other HCPs were also available via digital communications
- Medications were dispatched via couriers
- 85% of the sample in the study thought that the virtual hospital improved their access to clinical data, and were comfortable with video conferencing as a method of communicating with their HIV doctor.
- Overall satisfaction was 69% of patients.



Why is it a good practice?

- The virtual hospital model provides an alternative to routine HIV care in the longer term, which in the current system can be inconvenient for patients. The study showed that telemedicine was feasible, and cut down average consultation times for patients to 10 minutes, compared to 60-90 minutes needed to visit the clinic.

04

Recommendations



4.1 Strengthen the office of the National Plan on AIDS

What is the issue?

Since the 2011, the political polarisation and economic instability in Spain has resulted in resources of the National Plan on AIDS being steadily depleted – in terms of both human resources and budget. This has meant the scale, scope and speed of HIV policy development and implementation in Spain has reduced, resulting in further loss of attention to HIV and increasing reliance on non-governmental bodies and activists to apply pressure to drive change.

What is the recommendation?

The office of the National Plan for AIDS should be strengthened in terms of budget and human resource in order to be able to dedicate sufficient effort to developing and implementing plans and policies in Spain, both at national and regional level. Additional resources should be considered to further develop data analysis, co-ordination and collaboration between autonomous regions and building an updated strategy for the 2020+. This should include an evaluation of the current national strategy as well as improvements needed to tackle the changing epidemic in an era beyond viral suppression.



4.2 Include sexual health education in the school curriculum

What is the issue?

Since 2013, sexual health education has not been mandated in the school curriculum, meaning that coverage is variable across regions with no standardised objectives, information, or audit. Some regions do perform outreach activities (e.g., with nurses), however this remains insufficient to address the issue of awareness of HIV and STIs in young people. Underlying moral, ideological and religious factors also present a challenge in implementing sexual health education in schools.

What is the recommendation?

Reintroduce sexual health education into the curriculum in Spain, mandating it in law. To support this, a program for sexual health education in schools, integrating sexual health education transversally through the curriculum should be developed to ensure consistency of implementation across the country. There is an option to also extend coverage to wider health and wellbeing issues, and “citizenship” issues such as health, nutrition, smoking, drugs, bullying, etc.

The program should make young people fully aware of the risks of HIV and other STIs, and methods of prevention, contraception, as well as stigma and discrimination issues around HIV and STIs. Objectives should be developed and outcomes audited in order to track the impact of the education.

Collaboration between diverse stakeholders from the Ministry of Health, Ministry of Education, social services and the autonomous communities will be required in order to develop and implement an effective program. Given the politicised nature of education curriculums, consensus should be sought from different political parties to ensure that sexual health education will remain in the curriculum irrespective of which government is in power.

4.3 Address low rates of testing in primary care

What is the issue?

Reaching the undiagnosed population and addressing the rate of late diagnosis remains a challenge in Spain, driven in part by the low application of GeSIDA guidelines in primary care settings. Although the guidelines indicate universal screening in all of those getting blood tests in high prevalence areas and screening in at risk populations, expert consensus is that knowledge and application of these is low.

What is the recommendation?

Update and re-launch HIV testing guidelines for healthcare settings in order to increase awareness of the guidelines. Updates could be made to simplify policy and make it easier to implement, for example switching to a 'lifetime test' policy where every patient should receive at least one HIV test in their life (in addition to regular testing in high risk populations) as is the policy in France.

To support the updated or re-launched guidelines, campaigns aimed at GPs including educational outreach from HIV clinicians could be utilised to encourage adherence. Systems updates could also be used to encourage adherence to the policy, such as automated reminders in EMRs to remind HCPs on when to test patients who meet the criteria.

Tracking data on testing will be a critical to understanding impact. This should include data on number of tests and outcome (i.e., positive or negative) and settings of care to develop a view on effective practices.

Collaboration between the Ministry of Health, GeSIDA, the autonomous communities and GPs will be required in order to develop and implement an effective program that is practical and effective.



4.4 Develop a comprehensive, national level framework for combined prevention of HIV (or HIV and other STIs)

What is the issue?

Prevention continues to be underfunded and deprioritised, with no national-level framework within which to develop and implement policy. The result of this is that whilst policy exists for elements of prevention, it is not comprehensive or co-ordinated, leaving gaps in biomedical, behavioural, and structural interventions.

What is the recommendation?

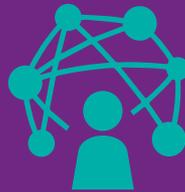
Develop a national framework on combined prevention to address the current HIV epidemic. Key considerations should include:

- Addressing the changing epidemiology of HIV, e.g., targeting women, older heterosexuals or those who fall at intersections of high risk populations such as young transgender people or newly arrived migrants
- Assessing and targeting changing risk patterns (e.g., chemsex and other emerging risk behaviours)
- Integrating latest evidence-based strategies (e.g., U=U, biomedical interventions)
- Engaging targeted and effective communication channels for high risk populations (e.g., Apps, social

media)

The national framework should provide detailed interventions encompassing biomedical (e.g., PrEP), behavioural (e.g., condoms, harm and risk reduction behaviours, stigma eradication, sexual health awareness), structural (e.g., sexual health infrastructure) and integrate closely the policy and legal landscape.

To develop the prevention framework, input needs to be sought from multiple stakeholders, including policymakers, healthcare professionals, community and civil society. Commitment from the National Plan, allocated funding and a roadmap to ensure development and implementation of the framework will be required.



4.5 Implement more community-based sexual health clinics

What is the issue?

Currently, GPs have responsibility for provision of sexual health services in Spain, including testing and treatment of STIs, advice on contraception, and testing and advice for communicable diseases such as HIV, HCV or HPV. They are also relied upon to provide advice on safe sex (e.g., contraception) and risky behaviours (e.g., chemsex). Sexual health services are available in alternative channels from a handful of sexual health clinics, or government or privately-funded NGOs, however these are primarily found in the larger cities.

The GP-led delivery model faces a number of challenges, especially with regards to HIV: lack of knowledge on testing and screening guidelines, and fear of real or perceived stigma in engaging with people living with HIV. NGOs and other community providers often face funding and capacity challenges, resulting in inability to deliver a holistic set of services. Good practice examples do exist, such as Barcelona Checkpoint. Finally, marginalised populations (e.g., sex workers, PWIDS or newly arrived migrants) are often reluctant to engage with public services, thereby creating a challenge in offer and uptake.

What is the recommendation?

Increase the capacity and number of existing community-based sexual health clinics, to enable greater provision of services close to the population. Community based services could cover (among others) testing and linkage to care (e.g., implementing direct referrals to HIV clinics, by-passing the need to visit GPs). In the future, such centres can also be used to implement biomedical preventative interventions, such as PrEP and PEP, and act as centres of knowledge for local communities (e.g., on contraception, chemsex).

Lessons can be learnt from good practice examples from Spain (e.g., Center d'Atenció Primària Drassanes and Barcelona Checkpoint) and abroad (e.g., Dean Street Clinic, Soho, London, UK) on the most cost effective models of care delivery, which can be scaled up across the country.

05

Policy Assessment

Is there a national plan for HIV? Yes

The national strategy (Plan Estratégico de Prevención y Control de la infección por el VIH y otras infecciones de transmisión sexual 2017-2020), developed by the Plan Nacional Sobre el SIDA (National Plan) which is part of the Ministry of Health, Consumption and Social Welfare was updated in 2018 to cover the period 2017-2020. This is an extension of the previous 2013-2016 strategy, meaning that the structure of the plan along axes of intervention and objectives has been maintained, with the 2017-2020 plan representing a roadmap of actions.

The axes of intervention are: (1) the general population, (2) sexually active people with a higher risk of exposure to HIV and STIs, and (3) people with HIV and / or STIs.

The strategic objectives are organised along four lines, as detailed below ^[4]:

- Coordination of the response
 - Promotion of national and international coordination
 - Adapting information systems to best coordinate the response
- Promotion of health, and prevention
 - Increase knowledge about HIV infection and other STIs
 - Reduce the incidence of HIV infection and other STIs
 - Promote the early diagnosis of HIV infection and other STIs

- Improving health outcomes
 - Prevention limitation of functional capacity and comorbidities
 - Improve early access to treatment for people with HIV and other STIs
 - Guarantee the correct follow-up of the patient and the continuity of care between levels of care
- Guaranteeing egalitarian access
 - Promote equal treatment and non-discrimination of people with HIV and STIs
 - Ensure equal access to prevention and socio-sanitary care for people with HIV and STIs

In total, 15 actions aligned to these objectives were achieved during the 2013 to 2016 term, ranging from the integration of new information systems on HIV diagnoses, to the creation of a map of online testing centres, and the design and implementation of a work situation survey in collaboration with NGOs and unions. However there still remains a longer list of 37 actions to be implemented as part of the 2017 to 2020 strategy ^[4].

Although a national plan is produced centrally, the responsibility for health and public health has been devolved to the autonomous regions, which means that plans are also developed at a regional level (e.g., Catalonia, Extremadura have recently developed strategic plans in 2016 and 2018 respectively, whilst other regions such as Andalusia last updated their plan in 2010).

Does the national plan (or affiliate guidelines) promote?



Awareness



Campaigns for key populations? ■

The national strategy for 2013-2016 recognized the need to increase the knowledge of HIV and other STIs among high risk populations (young people, MSM, sex workers, PWID, migrants, and women) and outlines the policy to promote the dissemination of information adapted to each population.

As a continuation of the previous strategy, the 2017-2020 plan continues to recognize this need to promote awareness, however does not outline any specific actions targeting high risk populations.

Regional plans are varied, but policy does exist, e.g., Catalonia includes policy on awareness for a number of high risk populations, including young people, MSM, sex workers, and PWIDs ^[15].



Campaigns for eradicating stigma? ■

The original 2013-2016 national strategy includes the objective to promote equal treatment and non-discrimination of people with HIV and STIs. Included under this objective are several actions, including: (a) creating a Social Pact for equal treatment and non-discrimination, (b)empowering people living with HIV to avoid self-exclusion, fostering skills that help address possible stigma and discrimination and (c) including the objective to reduce stigma and discrimination in all prevention and care programmes for people living with HIV and STIs ^[7].

The 2017-2020 continuation of the strategy includes specific actions relating to addressing stigma and discrimination, including the intention to approve the Social Pact, and the intention to study the magnitude of discrimination against people living with HIV in all areas of daily life ^[4].

The Social Pact includes a range of commitments under the headings of favouring equality in treatment and opportunities of people living with HIV, working in favour of social acceptance of HIV and reducing the impact of stigma on people living with HIV. ^[7]



Sexual health education in schools? ■

Sexual health education in schools is not mandated, with Ley Orgánica 8/2013 De 9 De Diciembre removing all content relating to sexuality in the Spanish academic curriculum ^[24].

The national strategy for HIV states that to date they have collected information from the autonomous communities and NGOs about their programmes of effective sexual health education in both formal and extracurricular settings ^[4], however no suggestions or objectives are put forward in the updated strategy for the use of this information.

Moving forwards, the national strategy highlights that promoting effective sexual and reproductive health programs (especially among young people) is an important challenge to be addressed. Objectives for the period 2017-2020 include developing quality criteria and good practices for sexual education programmes, and collaborating with the Ministry of Education in order to promote sexual health in educational environments ^[4].

Key

■ Policy available and effective

■ Room for improvement

■ Policy not available



Prevention



Free condoms for high risk populations?



No specific policy on provision of condoms and lubricants exists in the national strategy document, however it does outline the intention to address combined prevention strategies to assist vulnerable populations ^[4].

Free distribution is the responsibility of the autonomous regions, with only some regions providing money for free condom distribution. For example, Plan Andaluz frente al VIH/sida y otras ITS 2010-2015 (Andalusian Plan for AIDS) indicates over 2m free condoms and lubricants were distributed ^[17]



PrEP for high risk populations?



No policy position currently exists on implementing PrEP, or the pricing of PrEP.

The national strategy for 2017-2020 outlines the intention to measure the impact of PrEP in the reduction of new HIV diagnoses in high risk populations ^[4]. This trial was confirmed in July 2017, using PrEP donated by a pharmaceutical company to establish the feasibility of implementing PrEP in Spain ^[27]. This trial was originally intended to last 1 year (run across a number of regions including Catalonia and Basque Country), however was extended to October 2019 due to the Valencian community requesting to join the study ^[28].

In November 2018, The Health Commission of the congress in Spain unanimously approved the proposal to facilitate the implementation of PrEP, however specific policy on the details of the PrEP offering and implementation are yet to be finalised ^[26].



Occupational and non-occupational access to PEP?



As with all antiretroviral drugs in Spain PEP is only available from hospitals, including emergency medicine settings and infectious disease clinics.

Guidelines are produced by GeSIDA for the use of PEP in both occupational and non-occupational settings, and outline the recommendations for when to use PEP along with risk reduction practices for occupational settings such as training and protection measures ^[44].

Key

Policy available and effective

Room for improvement

Policy not available



Harm and risk reduction (e.g., needle and syringe programmes (NSP), opioid substitution therapy (OST), chemsex) ■

Spain has an up to date strategy on drugs (Estrategia Nacional sobre Adicciones 2017 – 2024), which includes detail on their objectives to maintain and expand coverage of existing harm reduction and expand programs to new consumption profiles. It includes specific actions such as:

- Expand the support of opiate replacement medication
- Expand the supply and coverage of overdose prevention programs
- Improve syringe exchange programs, expanding into primary care
- Work on the social incorporation of excluded people with addictions in harm reduction programs

- Promote harm reduction in places of traffic and consumption
- Extend this methodology to young people and adolescents
- Maintain harm reduction measures in prison

Although other areas such as chemsex are an increasing trend, they are not covered by the risk reduction policy. The national strategy for HIV does not mention chemsex, and whilst the national strategy for addiction highlights that apps such as Wapo, Tinder and Grindr are promoting new patterns for drug use including chemsex and slamming, it does not suggest any policy to address this ^[10].



Testing and screening



Free anonymous testing through specialty / community settings?

The national strategy addresses testing in a number of ways:

- Outlines a number of actions to improve testing in community settings, such as: publishing recommendations on early diagnosis of HIV in community settings, and increasing the offer of HIV testing at all levels and specialties of care, with a focus on primary care ^[4]
- Highlights the need to update guidelines for recommendations on early diagnosis (the previous document 'Guía de Recomendaciones para el diagnóstico Precoz del VIH en el ámbito sanitaria' from 2014 is otherwise the most recent) ^[4]
- Outlines actions to implement a new system for collecting more reliable data on number of tests conducted in community settings. The system, called RedCo-HIV, will track testing and diagnosis of HIV in NGOs in the community [4]. This programme will include developing common procedures and tools for collecting information, collection of evaluation indicators, and promotion of the exchange of good practice between NGOs ^[31].

Ministry of Health state that testing should be offered in two ways: routine offering and directed offering:

Routine – tests should be offered to those in the general population if they are sexually active, are having a blood test requested by a primary care centre, and reside in regions where the rate of new diagnoses in the 20-59 age group is above the 75th percentile for the last three years at a national level. Antenatal screening and screening of new prisoners is also recommended.

Directed – the test is offered due to exposure to HIV or clinical symptoms require eliminating the possibility of an HIV infection. Reasons for a directed test include: sexual partners infected with HIV, current or previous STIs, engaging in sex work, MSM and their sexual partners, people suffering sexual assault, and people from countries with a high prevalence (>1%) and their sexual partners ^[34].

Certain regions have issued their own guidelines. For example, the Department of Health in Galicia has issued their own guidelines for early diagnosis of HIV, recommending routine testing among pregnant women, people in penitentiary institutes and users of primary care who are sexually active and come for a blood test, as well as testing performed according to exposure and risk factors ^[34].



Self-testing / sampling?

A Royal Decree from 2000 on medical devices for "in vitro" diagnostics that restricted sale was reversed in 2017 to allow for sale and advertising to the public HIV self-testing devices. In spite of this, however, sale and distribution remains limited to pharmacies and websites of authorized pharmacies ^[32].

As the national strategy indicates a commitment to promote early diagnosis of STIs through use of strategies such as self-testing for HIV, it is expected that the current offering will be maintained ^[4].

Key

■ Policy available and effective

■ Room for improvement

■ Policy not available



HIV-specific clinical treatment



Immediate initiation on ART? ■

GeSIDA guidelines recommend immediate access to ART, irrespective of CD4 cell count ^[45]



Access to innovative medicines? ■

GeSIDA guidelines are up to date in recommending 2nd and 3rd line therapies ^[45].



Access to regular monitoring (e.g., viral load, adherence, co-infections)? ■

The 2013-2016 national strategy included the objective of ensuring proper patient monitoring and continuity of care through coordination of shared medical records, and promoted the monitoring of patient retention in hospital clinics ^[18].

The national strategy for 2017-2020 continues with this, including the objectives of promoting adherence monitoring and patient retention monitoring, and strengthening coordination with penitentiary institutions ^[4].

GeSIDA guidelines are up to date with the latest recommendations on managing patients with HIV covering all aspects beyond ART. It is recommended that all patients are screened for TB, viral hepatitis and STIs at the time of their initial diagnosis and visit, then ongoing screening is recommended if risk factors are present ^[38].

Key

■ Policy available and effective

■ Room for improvement

■ Policy not available



Long-term holistic care



Ageing and co-morbidity care?

Comorbidity management was one of the objectives of the 2013-2016 national strategy, and it outlined the intention to encourage a multidisciplinary approach, promote the early diagnosis of co-morbidities and the continuous training of HCPs who care for people living with HIV.

The 2017-2020 national strategy continues with this objective and sets out the intention to promote studies that evaluate the impact of ageing on the health of people living with HIV.

GeSIDA clinical guidelines also cover recommendations on the management of common HIV related co-morbidities such as renal issues, cardiovascular comorbidities and bone related issues. Vaccinations for certain viruses are also recommended including Hepatitis A and B ^[38].



Mental health services?

The national strategy does not explicitly outline any policy on mental health services for people living with HIV. Policy does outline the intention to define measures to monitor quality of life ^[4], which may include monitoring of mental health.

Mental health for people living with HIV is treated in the same way as for the general population. An agreement was made to update the wider mental health strategy in 2017 ^[40] and this is currently being prepared by the Ministry of Health. It is unlikely to include specific provisions for HIV.

GeSIDA produce guidelines on mental health in people living with HIV including screening at initial diagnosis as well as ongoing management ^[38].



Supportive services?

The national strategy places little attention on supportive services such as counselling and peer support, instead focusing on clinical aspects of support, as shown by the lack of inclusion in the objectives or strategic lines.

The national strategy document does however outline one action; the intention to improve patient care for HIV through integration with peer support programmes ^[4].

In practice, although not well documented, both regional and the central government provide funding for services such as counselling which are delivered by NGOs.

Key

■ Policy available and effective

■ Room for improvement

■ Policy not available



06

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