

## Case Study 9

# Meeting the challenge of restrictive testing regulations in the Ukraine

### What was the issue?

Since 2007 the International HIV/AIDS Alliance in Ukraine (now the [Alliance for Public Health](#)) has operated community-based rapid testing for HIV, supported by the [Global Fund for AIDS, Tuberculosis and Malaria](#) (GFATM). They successfully target key populations otherwise underserved by state clinics, such as gay men, drug users and sex workers. A Health Ministry protocol required licensed medical professionals to administer HIV tests, which were defined as a clinical procedure. The doctors were paid from GFATM money, but this was due to stop in 2014 as cutbacks were made in GFATM assistance to the Ukraine.

### Why was change needed?

*“The Fund said additional payments that doctors required for out-of-hours working should be covered by the Government and not them. The government wouldn't pay it because the doctors were already on government salaries, and the doctors wouldn't provide services outside the hospital without incentives. They said people would have to test in hospitals, but many people won't go there, so we had to reconfigure the way services were provided. We only had a third of the income we needed for the services we were providing.”* (Pavlo Smyrnov, Alliance).

All the Alliance's prevention programmes were cut to the bare essentials, but alarming levels of HIV amongst drug users in particular, and the success of their prevention services in reaching key populations, meant the Alliance was very reluctant to reduce their outreach testing.

### How could access be maintained?

The Alliance needed to reduce the cost of specialist staffing while maintaining testing and linkage to care. They realised that it would help towards this if they were able to use their rapid testing kits with trained peer support workers, instead of expensive clinicians. Peer support would not require the additional payments expected by doctors for outreach and unusual working hours.

### What were the barriers to change?

The Alliance were advised that any change to the Government testing protocol to allow non-clinical staff to test for HIV could take several years, which was unacceptable. Additionally, with the solution that was eventually found, there were complaints from some laboratory specialists who insisted that testing was a complex procedure requiring a specialised setting and staff. Some of these barriers echoed those they had earlier faced from clinicians in introducing rapid testing but, in effect, once the solution was found there was little opposition.

### How long did change take and who was involved in making the change?

In hopes of finding a legal way to change the protocol more swiftly, in 2013 the Alliance consulted a lawyer already working on HIV issues. The lawyer, in reviewing the legislation, realised that the Government protocol only covered testing when administered by a second party. Self-administered HIV testing had not been thought of when the law was drawn up and thus was not subject to Government regulation. In 2015, when the Global Fund reduced their support, the Alliance

replaced the existing testing service with a new self-testing protocol using rapid testing kits delivered by peer support staff to people in the setting of their choice, including homes and outreach settings. The peer supporters arranged further diagnostic testing and linkage to care for anyone with a positive result. In 2015, as a result of this change, the Alliance was able to support more than 200,000 tests and diagnose over 4,000 people with HIV.

### How was change made?

**Don't assume that things must be done as they always have:** Flexibility was key to the Alliance being able to survive a major funding cut, which made them think about what was really necessary to ensure a safe, accessible service. Too often funding cuts are met by shrinking a service rather than finding a way to reconfigure; the first question asked should be “how else could we do this?”.

**Think creatively about how services should be delivered:** NGOs don't have to mimic the state, but often regulatory requirements are set up to mirror existing statutory services. As treatments and technologies advance, we should demand that such regulations are reviewed by a body that includes both clinicians and patients. The Alliance also thought creatively about how self-testing technology could be enhanced with human input. The peer support worker brings the test in a small anonymous looking backpack to wherever the person wants to test and talks them through its use, helping them read the result correctly and making whatever referrals are needed.

**Check what the law does and doesn't say:** Without creative legal advice, the service might well have been heavily cut. It is always helpful to have a good legal mind on your side, or on the Board of your organisation.

**Take advantage of new technology advances:** While the Alliance had been very quick to pick up on rapid testing, they had not yet grasped its potential for self-testing. New treatment and testing technologies may well allow services to be improved or streamlined. The Alliance now does three times more tests than before, with peer workers from the key populations, at venues and times that suit their clients, at lower cost.

**Get support from global bodies on best practice:** The Ukraine Alliance were fortunate in their existing links to a strong global body, the [International HIV/AIDS Alliance](#). This also meant that once they were aware of the potential of self-testing, they were able to link in to best practice and advice on it from UNAIDS and WHO, which helped to convince the authorities of the safety of the new proposals.

**Don't assume all key populations need the same service:** Though changing the system meant that the Alliance reduced their costs considerably, they still had to make some savings. This was partly done by looking at the different needs of the key populations they served. People who injected drugs had higher levels of need and much lower levels of successful linkage to care without support (20% without, but 70% with support), so case management systems were continued with drug users but not other groups like gay men, who were found to be more likely to self-refer.

### Are there any ongoing issues?

There have been some complaints, mainly from laboratories, about the wastefulness of testing twice because all positive results require a confirmatory test in the traditional setting, but the changed system is actually more cost-efficient while diagnosing more people. The service itself is

working well and has been rolled out in a number of different settings and populations. The Alliance are now seeking to improve case-finding but budget constraints continue.

#### **What lessons have been learnt?**

*“Everything is possible if you try. There are many obstacles and risks, but they can be overcome, especially by NGOs because we are not part of the system. You cannot wait for people to come in to a hospital to test for something they don't want to have, you need to go out to them” (Pavlo Smyrnov).*

It's also unhelpful, with a condition such as HIV where advances are being constantly made in treatment and technologies, to codify things into law which is hard to change, rather than regulations which can be amended as the situation demands. But if law is what you have, get a lawyer and check the small print.

#### **Links**

The Alliance's own website [www.aph.org.ua](http://www.aph.org.ua)

[http://ecuo.org/media/filer\\_public/2015/11/18/eng\\_htc-current-practices-in-eeca\\_report\\_final.pdf](http://ecuo.org/media/filer_public/2015/11/18/eng_htc-current-practices-in-eeca_report_final.pdf)  
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