Ending the epidemic

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

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01

Executive summary

France's response to the HIV epidemic has made a real impact. 156,000 people in France are estimated to be living with HIV. 90% who know their status are on anti-retroviral therapy (ART). 90% of this group are virally suppressed. HIV services are widely available, including free access to pre-exposure prophylaxis (PrEP) for at-risk populations. Until Germany makes PrEP available later this year, France is the only country currently doing so among the Europe5.

But the epidemic is far from over. Many challenges stand in the way. For example, while the number of new infections have broadly stabilised, it is not yet decreasing. Each year, approximately 5,000 new HIV diagnoses are made, with men who have sex with men (MSM) (43%) and foreign born heterosexuals (38%) among the two most affected groups. Worryingly, the number of new infections is not dropping among MSM, in contrast to other population groups [1]. The rate of late diagnosis[1] is still high, with a recent study indicating close to 48% of diagnoses were 'late', and close to 29% considered very late (CD4 < 200 cells/mm^3). 25,000 individuals are estimated to be living with undiagnosed HIV. Addressing the needs of the ageing cohort of people living with HIV is another challenge, given their changing long-term health and wellbeing requirements. Paying close attention to quality of life indicators and making sure services such as mental health are available is crucial. The wider legal landscape also continues to impact the HIV response and certain sub-populations. For example the 2016 changes criminalising the buying of sexual acts may have resulted in further marginalisation of sex workers.

France recently updated its strategy towards HIV and other STIs, producing The National Sexual Health Strategy 2017-2030 and its associated Three Year Implementation Road map. To understand their effectiveness in tackling the new and emerging challenges of the epidemic, the Steering Group[2] 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.

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1. A 'late' diagnosis is one which is made at a point in time after which HIV treatment should have been started. Currently, a CD4 cell count below 350 cells/mm3 at time of diagnosis is considered 'late'.
2. See Methodology section, Table 1

Awareness	Interventions are often limited to high prevalence areas, with regions and high risk populations[3] missing out. There is a persistent lack of awareness among the general population.
Prevention	A combined prevention approach is mandated through policy, and generally well implemented. However, there is a lack of easily accessible STI clinics, with only a few pilot community-based centres. Better understanding and addressing the changing patterns of risk is one area for improvement.
Testing and Screening	Improvements are needed in testing across various settings, including primary and community care, and better implementation of repeat testing.
HIV specific clinical treatment	This is conducted to an exceptionally high standard in France, meaning the majority of people living with HIV are on ART and virally supressed. Immediate initiation of ART is recommended, and newer and innovative medicines are accessible. Time to initiation of treatment from point of diagnosis may not be consistent across the country - there is limited national-level data however anecdotal evidence indicates this may be an area for improvement.
Long-term Holistic Care	Co-morbidities and ageing are generally well managed through specialists and community networks. However, more attention must be paid to long-term well being, such as the availability of mental health services.

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

- **Develop an understanding of the scale of chemsex[4] by mandating data collection –** creating evidence on patterns and risks to support policy development
- **Establish more detailed testing guidelines on repeat testing for high risk populations –** including guidance on roles and responsibilities for testing, and how to promote repeat testing behaviour
- **Formalise the assessment of mental health for people living with HIV –** including annual mental health checks with nurses during HIV check-ups
- **Expand HIV/STI community sexual health clinics** - providing easy and inclusive access to all populations for awareness, testing and prevention (e.g., PrEP programmes)

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3. See Methodology section for list of high risk populations
4. 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 [31]

02

HIV in France, the wider context

Brief epidemiology and 90-90-90 overview

France's HIV response has delivered good outcomes. The number of new HIV infections has broadly stabilised, and people with HIV who are diagnosed are on anti-retroviral therapy and virally supressed. As a result, France has made good progress towards international targets such as the UNAIDS 90-90-90, having achieved the 2nd and 3rd (see Figure 1).

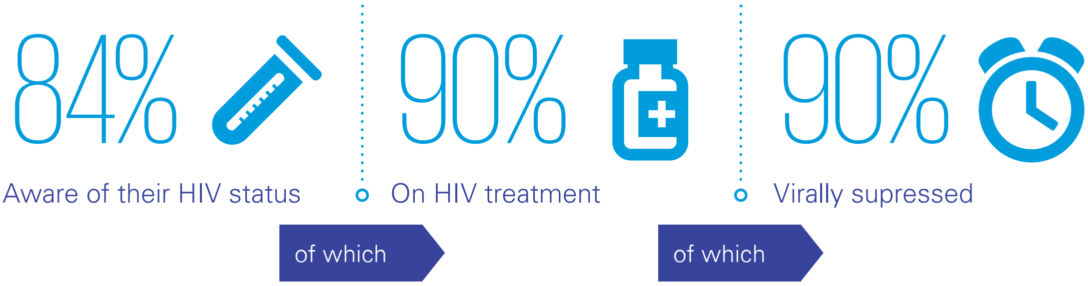
A number of key challenges remain. The number of new HIV diagnoses was approximately 6,000 in 2015 (rate of 7.7 per 100,000 residents). MSM and foreign born heterosexuals accounted for over 50% of these, representing 43% and 38% of new cases respectively. It is worth noting that while the overall number of HIV infections have stabilised, it is still not falling among MSM [1].

There is significant geographic variation, with a survey in 2014 indicating 42% of new infections from Ile-de-France and 14% in two regions in the south-east (Provence-Alpes-Côte d'Azur and Rhône-Alpes). Population heterogeneity is also seen, with 54% of new infections among heterosexuals, of which 35% were born abroad (high proportion of which were individuals from sub-Saharan Africa).

Late diagnosis continues to persist, with an Agence nationale de recherches sur le Sida et les hépatites virales (ANRS) study of a cross-sectional national survey indicating close to 48% late diagnosis (CD4 < 350cells/mm^3), and 29% with advanced disease (CD4 < 200cells/mm^3). The number of people living with HIV was estimated at 156,000 in 2017. MSM comprising the majority, followed by people who inject drugs (PWID), with a prevalence of 14% and 10% respectively. A 2014 national survey estimated 25,000 people were living with undiagnosed HIV [1][2][3].

The challenges are recognised, and France's new strategy for HIV, included within the *French National Strategy for Sexual Health 2017 to 2030*, attempts to address these (see next Chapter). The wider legal and policy environment also continues to impact the current response, contributing towards the quality of life of people living with HIV and efforts to limit the epidemic (see Box 1).

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



Source: Ministère des affaires sociales et de la Santé, "Stratégie nationale de santé sexuelle," 2017
Note: 90:90:90 figures from 2013

Box 1. The wider legal and regulatory landscape

As outlined in the Methodology section, a deep assessment of the wider legal and regulatory landscape and its impact on the HIV response is not within the scope of this project, however, indicated below are Italy's current position on three common potential barriers to the HIV response:

1) Legal protection against stigma and discrimination:

in 1990, France passed a law prohibiting discrimination on the grounds of 'health status or handicap', which covers people living with HIV [4], which was further adapted in 2005 to strengthen equality rights and social participation of people with disabilities [4]. However, a national representative survey, conducted in 2011, found that discrimination is experienced frequently by people living with HIV (26%), and particularly when applying for a job (24%) [5], suggesting implementation of these laws may not be widespread. Further, a study of over 3,000 people living with HIV indicated barrier- and refusal- related renunciation of healthcare, with 17% reporting a healthcare renunciation in the preceding year. 42% had a high level of social insecurity [6].

2) Free, non-discriminatory access to healthcare:

France has universal health coverage, largely funded by public health insurance, providing access regardless of age, income or status [7]. Migrants are covered under Protection Universelle MAladie (PUMA), brought into effect in 2016, which allows all people residing in France in a regular, stable manner for over three months to have access to healthcare, regardless of their working status [7]. Undocumented migrants, or those with irregular status, are covered under State Medical Support (AME), which qualifies individuals to receive free care for up to one year. A seropositive status is considered a medical emergency, and treatment is covered under the PASS system (a system to provide anyone access to free outpatient hospital care) or the Fund for Vital and Urgent Care (FSVU) [8]. However, despite these efforts, 2014 data from Médecins du Monde indicated only 10.2% of undocumented migrants accessed AME [9]. Reasons may include social and economic concerns which may bar this population from accessing care, as well as difficulties in producing the documentation (e.g., proof of residence) required. Finally, reports have indicated some healthcare professionals may be refusing to provide care for migrants, with people living with HIV facing an increased risk of being denied access [10].

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

While it is legal for individuals to sell sexual acts, buying of sexual acts was outlawed in 2016. Studies have since indicated a detrimental effect on safety, health and overall living conditions in general [11]. Specific to HIV, research presented at AIDS2018 conference indicated a decrease in condom use and increased difficulty in negotiated safe-sex practices following implementation of the law [12].

The Government Plan for Combating Drugs and Addictive Behaviours 2013-2017, developed by the inter-ministerial Mission for Combating Drugs and Addictive Behaviours, addresses the use of illicit and licit substances. The use and possession of illicit drugs remains a criminal offense in France, evidenced by the recent adoption of a fixed-amount fine ('amende forfaitaire') for the illegal use of drugs [13]. While the law itself does not distinguish between possession and intent to supply, prosecutors will in practice opt for an appropriate charge depending on the quantity of the drug found and the context of the case [14]. Multiple harm reduction policies are in place (see Chapter 2) and latest data indicate only 49 cases of newly diagnosed HIV infections were related to injecting drug use in 2016, which constituted less than 2% of all new HIV diagnoses that year.

03

Assessment of HIV policy in France

This chapter outlines the Steering Groups assessment of the current HIV policy in France, 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

The French strategy for HIV is included within *The French National Strategy for Sexual Health 2017 to 2030*, developed by the Ministry of Health, aimed at providing a comprehensive approach towards sexual and reproductive health. It sets out ambitious goals for HIV, including ending the AIDS epidemic by 2030 and ensuring that 95% of people living with HIV are aware of their status, 95% of people who know they are HIV positive have access to treatment, and 95% of people being treated are virally supressed. It outlines six priorities:

- invest in the promotion of sexual health, in particular among young people;
- improve health care pathways to STIs, including HIV: prevention, screening and treatment;
- improve reproductive health;
- meet specific needs of vulnerable populations;
- promote research and innovation and
- support specific characteristics of Overseas Territories.

A key strength of the French strategy is the regular monitoring and evaluation of its policies for cost-effectiveness, providing a source of data for assessing impact. This has included monitoring of specific interventions such as the impact of the national mass screening policy on HIV testing [15], testing policies for specific populations [16], and the provision of PrEP (the IPERGAY trial was not considered to be a full cost-effectiveness model, however, it provided an indication on the number of individuals on PrEP needed to avoid HIV infections and the associated costs) [17], [18].

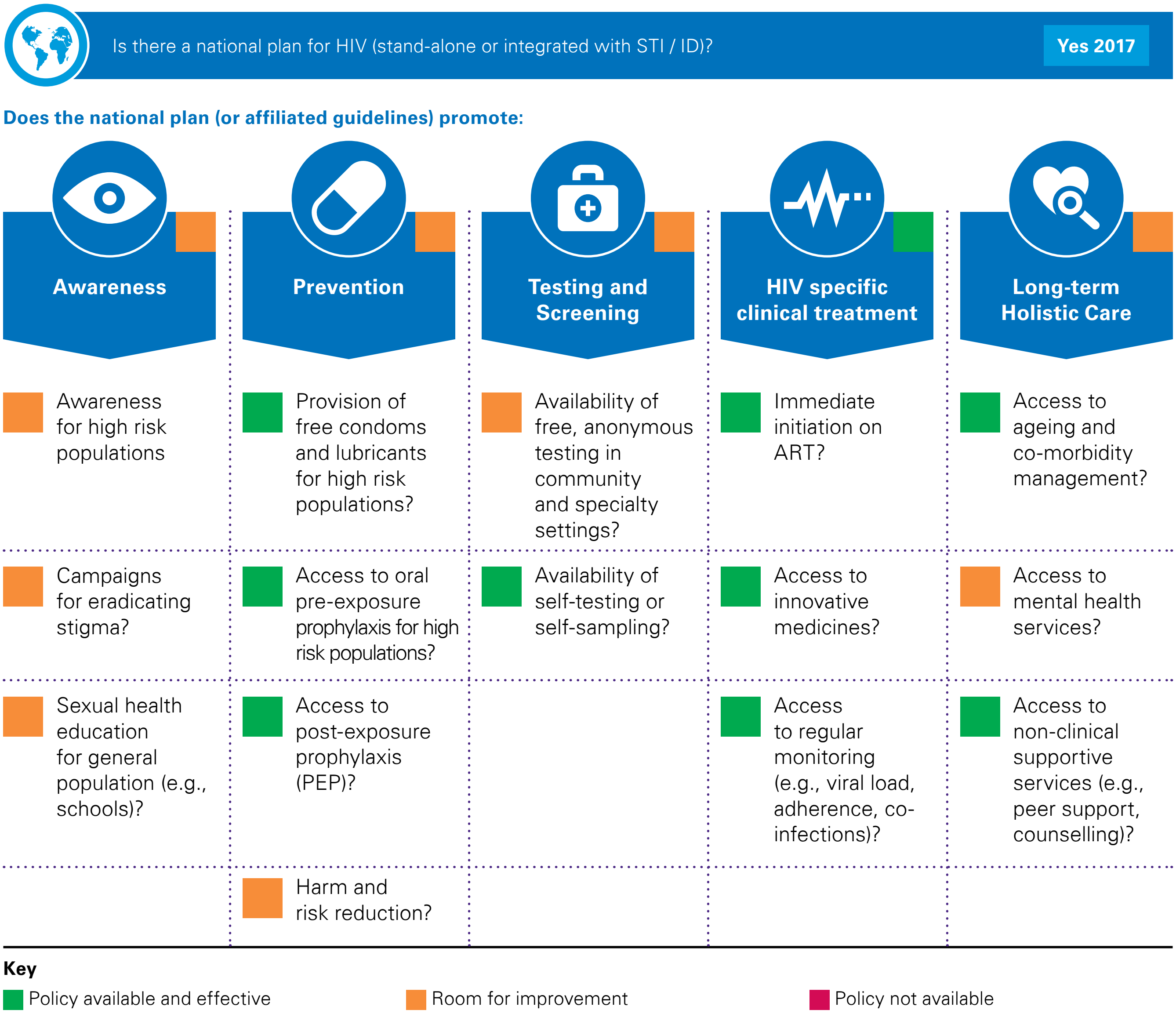
> “On paper in the national sexual health strategy there is everything we need to have an impact in HIV… but different regions will choose to implement in different ways.”
>
> **HIV NGO representative, France**

The new policy document, together with the roadmap, are considered by experts to be comprehensive, but they indicate consistent implementation across the country will a critical factor for its success.

To understand the ability of France’s HIV strategy in tackling 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.

Figure 2. Assessment of HIV policy in France



Is there a national plan for HIV (stand-alone or integrated with STI / ID)? **Yes 2017**

Does the national plan (or affiliated guidelines) promote:

🟧 **Awareness**	🟧 **Prevention**	🟧 **Testing and Screening**	🟩 **HIV specific clinical treatment**	🟧 **Long-term Holistic Care**
🟧 Awareness for high risk populations	🟩 Provision of free condoms and lubricants for high risk populations?	🟧 Availability of free, anonymous testing in community and specialty settings?	🟩 Immediate initiation on ART?	🟩 Access to ageing and co-morbidity management?
🟧 Campaigns for eradicating stigma?	🟩 Access to oral pre-exposure prophylaxis for high risk populations?	🟩 Availability of self-testing or self-sampling?	🟩 Access to innovative medicines?	🟧 Access to mental health services?
🟧 Sexual health education for general population (e.g., schools)?	🟩 Access to post-exposure prophylaxis (PEP)?		🟩 Access to regular monitoring (e.g., viral load, adherence, co-infections)?	🟩 Access to non-clinical supportive services (e.g., peer support, counselling)?
	🟧 Harm and risk reduction?			

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, as related to stage of the HIV care continuum, is available in section 5)

Awareness

- Awareness campaigns targeting high risk populations are available, however they are often limited to regions of high prevalence and are lacking among the general population, particularly those addressing stigma and serophobia
- Stigma is a pressing issue, with a lack of national, large-scale, consistent interventions
- Awareness of sexual health is varied, and effective implementation of policy is critical to ensuring consistency across the country

What is the policy position?

The importance of raising awareness throughout the population has been highlighted in policy. The recent roadmap for implementation advocates for the organisation of 'annual campaigns in the regions specifically for HIV testing, viral hepatitis and other STIs' [19].

Stigma of HIV has also been flagged as an issue. The National Strategy recommends working on the prejudices against people living with HIV and fighting 'against stigmatisation and discrimination based on health status' [1] but clear actionable steps have not been recommended.

What happens in practice?

In practice, targeted one-off campaigns in the regions most affected by the HIV epidemic, such as Île-de-France, Provence-Alpes-Côte d'Azur and Rhône-Alpes, have been put forward in order to address the current insufficient awareness levels. These often tend to target a subset of high risk populations such as MSM. Gaps in frequency and consistency of interventions are partially filled by NGOs, however again there is an emphasis on certain subpopulations.

> "Essentially, campaigns have reduced significantly with only certain populations, such as MSM, being targeted. These do not reach young people nor certain vulnerable populations such as immigrants."
>
> **HIV policy expert, France**

There is a lack of focus on the issue of stigma, which has fallen off the public agenda. While consistent data on the scale of the problem is not available, smaller studies indicate continued prevalence of stigma, e.g., a 2015 study noted 17% of the dental and gynaecological offices making discriminatory remarks against people living with HIV, and a third of dental offices refusing to offer care [20].

> "There is stigma in healthcare settings, e.g., GP's and there are almost no campaigns specifically on stigma."
>
> **HIV patient and policy expert, France**

What do the experts say?

Expert consensus is that efforts to raise awareness of HIV in high risk populations and target stigma are not sufficient. Current campaigns are often sporadic and short-lived, continuing to miss key sub-populations. This poor awareness around HIV has been reflected in studies. Although now dated, a survey from 1992-2010 indicated an increase of misinformation around the HIV transmission, such as a mosquito bite or using a public toilet [21].

> "The government doesn't do enough on awareness, it's done only by NGOs, it's not endorsed by the national government."
>
> **HIV clinician and policy expert, France**

Stigma has not recently been a target of any government campaigns. Prevalence of stigma in the community is evident, e.g., a 2016 campaign commissioned by the Ministry of Health to target MSM populations and raise awareness of HIV by displaying posters across 130 towns was subject to social stigma, with the posters being removed in certain French cities as a result of public backlash [22].

> "I haven't seen a campaign for ten years… stigma is strong, but very poorly addressed."
>
> **HIV clinician and policy expert, France**

Policy outlines measures to improve sexual health education across France, but implementation is still in infancy and success is yet to be measured

What is the policy position?

Sexual Health education in France is mandated through policy. Previous plans focused on raising awareness of HIV in young people, but have been replaced with a strategy to improve sexual health education as a whole, without a specific focus on HIV. This offering is targeted at all school levels, universities, and university services [1], with specific budget requirements and key stakeholders covered by the strategy roadmap [19]. The target is for 100% of young people to have received high quality education in sexuality and the associated risks throughout their school curriculum [1].

The 2017 – 2030 strategy also goes further than previous plans, by targeting those out of school or university curriculums [1]. For example, the strategy puts forward a plan to make sexual health information resources available to everyone in a single database (Public Health Information Service) [1].

What happens in practice?

The level and quality of sexual health education is reliant on the region and provincial administrations. In certain provinces, such as Paris and the South East of France, the government uses local associations (CRIPS) to provide on-demand sexual health education for State-run secondary schools. However this service is optional, and is not in place nationally.

> "Teachers are supposed to conduct sexual health education, some do, some don't, some don't feel very skilled in the area."
>
> **HIV clinician and policy expert, France**

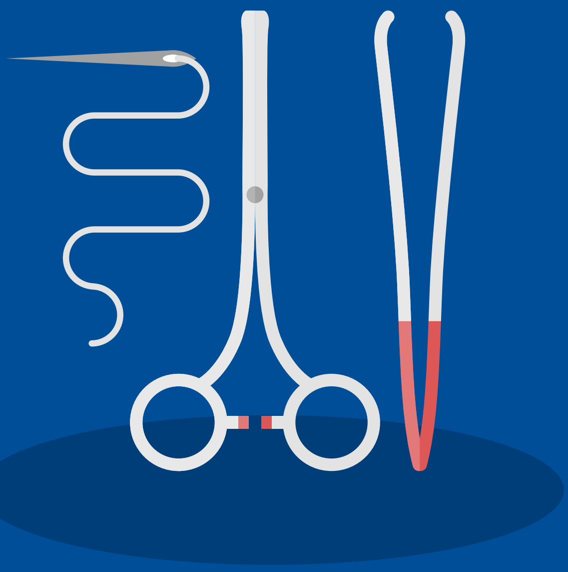
What do the experts say?

Expert opinion is that improvements are needed in the provision of sexual health education in France. They cite concern over the possibility that HIV is no longer viewed as a severe disease, which may be contributing towards risky behaviours. Trends indicating a decline of condom use, tripling the rate of people diagnosed with chlamydia and gonorrhoea, have also served as indicators of a growing challenge [21] [23].

> "Most of the young generation don't know the basics of HIV – risk of transmission, prevention etc. and most of them have heard HIV can be cured with one pill once a day and is not a big deal anymore."
>
> **HIV HCP and policymaker, France**

Previous attempts to deliver consistent, quality sexual health education has faced problems. Experts cite limitation in adaptation to suit variations across regions (e.g., urban vs rural settings), as well as use of most effective channels. The 2017-2030 strategy highlights a concentrated effort to address the challenges, and emphasises the need for targeted campaigns which utilise different media platforms, however its impact is yet to be seen.

> "The Ministry of Health and French Authorities are trying to make it so that there is no inequality across territories."
>
> **HIV clinician, France**



Prevention

- Condoms, PrEP and PEP are generally widely available although some regional variations in availability may be seen
- There are a lack of easily accessible STI clinics (most of which are based in hospitals), with just a few pilot community-based clinics
- Harm reduction is generally effective, however changing patterns of risk need to be better addressed through policy and implementation

What is the policy position?

France has a wide ranging and robust strategy towards prevention, combining condoms, harm reduction and biomedical interventions (PrEP and PEP).

Policy position towards condom distribution has evolved from being free for at-risk populations to being accessible to everyone, along with targeted educational, screening and psycho-social treatment programmes – but with no explicit statement that the provision should be free. However, the implementation roadmap advocates trialling a condom PASS for those under 25 in high prevalence STI areas, along with diversifying the condom range available, complimented with an increased social media marketing campaign to boost uptake. As of December 2018, the Minister of Health has announced that condoms can be prescribed by a doctor and consequently reimbursed by the national health insurance [24].

PrEP has been covered by policy in France since 2016. *The National Sexual Health Strategy 2017-2030* outlines promoting, supporting and securing access to PrEP for key groups, including MSM and the sub-Saharan African community, and in particular women in risky situations [1]. The updated policy states that from March 2017, PrEP can be renewed by any doctor in combination with quarterly monitoring following an initial prescription by an HIV experienced doctor in a hospital, thereby widening access to the drug. The caveat is that the prescription must be repeated every year in a hospital or STI clinic (CeGIDD).

Access to PEP has been widened from occupational exposures in healthcare workers to include non-occupational exposures, such as sexual exposures and syringe sharing. In these cases it is available through emergency departments in hospitals and CeGIDD.

The need to improve access to substance abuse risk reduction programmes has been raised. Government-funded harm reduction centres, CARRUD, have been established since 2004 and have seven missions pertaining to risk reduction policy in drug use [25][26]. Recent policy from the 2017 – 2030 strategy advocates implementing personal support interviews for MSM populations at high risk of contracting HIV [1], whilst also targeting certain sub-populations such as sex workers for risk reduction. The adjoining roadmap focuses on universities, and suggests allowing the University Services of Preventative Medicine Promotion (SUMPPS) to provide contraceptive and Preventative counselling [19].

Specific reference has also been made to the growing issue of chemsex and its contribution to the HIV epidemic [1]. The recommendation is to develop a chemsex consultation service comprising of specialists and integrate it into the wider healthcare system.

What happens in practice?

There is a wide distribution of free condoms, from venues such as Regional Health Agencies (ARS), medical and screening centres, NGOs such as AIDES and places where high risk populations may gather (e.g., bars and saunas). A recent decline in the number of government funded distribution has been noted, due to budget cuts at the Ministry of Health [27].

> “In gay venues you can get condoms as long as they are available, but there always comes a time in the year, around August, where they run out of budget.”
>
> **HIV patient representative, France**

France is active in the distribution of PrEP, and was one of the first countries to offer the treatment for free to at-risk populations. The number of people being treated with a form of PrEP has risen steadily since January 2016, to 10,405 as of June 2018, with the huge majority being men (97.7%) and a concentration of users located in the Île-de-France region (48%) [28]. Interim data from June 2018 indicated no new HIV infections among the 1,628 participants who chose either ‘on-demand’ or daily PrEP [29], showcasing the strategy’s effectiveness. Similarly, PEP is available and accessible (e.g., through Emergency Departments), however the scale of treatment use is not well documented [30].

There is a wide coverage of harm reduction throughout France. A CARRUD centre operates in every region in the nation [31], offering needle and syringe programmes, advice on safer drug use, naloxone distribution, and general health advice including condom distribution [31]. Outside of this, it is estimated that approximately 12 million syringes are distributed or sold to people who use drugs, mainly through pharmacies or dispensed from vending machines for free - further supporting the assertion that France takes active steps to reduce harm in its population.

In addition, there are current efforts looking at how to further improve harm reduction across France, including an ongoing six-years trial in Paris and Strasbourg of two drug consumption rooms [31] and investigating better methods of connecting marginalised drug addicts to medical professionals and social workers.

Despite the work done around harm reduction, there have been limited steps taken to address the growing issue of chemsex. Current initiatives to tackle the problem have not yet been implemented at scale – for example the AIDES emergency phone line and Whatsapp group.

What do the experts say?

Expert opinion on the different prevention methods and policies is varied. Whilst there is wide access to free condoms throughout France, Ministry of Health budget cuts are decreasing availability.

> “The budget from the national administration has been decreasing so the number of condoms available has been decreasing.”
>
> **HIV patient representative, France**

With regards to PrEP, expert consensus is that access is of a generally high standard across France - but room for improvement exists within awareness among the general population and medical professionals. Expert opinion is that the general population, outside of MSM, is not necessarily aware of PrEP and doctors may not feel comfortable in renewing PrEP prescriptions. Steps are being taken to rectify this, with the French agency for research on AIDS (ANRS) in partnership with AIDES carrying out a wider study to measure the benefits of PrEP in the Paris region [32]. It is hoped that the results of this study will determine the best ways to deliver PrEP and engage migrants and other populations with relatively low awareness levels of PrEP [32].

> “Access to oral PrEP depends on which city you are in. In Paris you can have access and in Marseille too, but there are still cities where it is too complicated to get access because some doctors are reluctant to use it.”
>
> **HIV clinician and policy expert, France**

Expert opinion on PEP is positive, highlighting that PEP is widely accessible through France in both emergency rooms and CeGIDDS, and that the policy is well implemented. Only minor improvements have been suggested, such as widening access from hospitals, with a growing need to include PEP initiation kits in HIV NGOs.

> “PEP is only available in hospitals, not available in the pharmacy or in primary care. Our tradition is always hospital, hospital, hospital…”
>
> **HIV policymaker, Paris**

Whilst traditional harm reduction is well covered in clinical (see case study) and community settings, expert opinion is that chemsex needs to be on the political and public agenda. There is limited understanding of the scale of the challenge, as well as best routes through which to engage this population.

> “We did a great job with syringe reduction and opiate substitution therapy and as a result have a low level of new infections in PWIDs – we’ve been doing it for ten years and this has been successful.”
>
> **HIV HCP and policymaker**

> “With regards to chemsex, nobody knows what to do. It’s more of a question of how to convince and reach people who are having chemsex – is giving syringes enough?”
>
> **HIV clinician and policymaker**

Case study: Équipes de coordination et d’intervention médicale auprès des usagers de drogues (ECIMUD)

What is it?

Multidisciplinary medical teams that operate in hospitals in Paris and intervene when patients are admitted to hospital who have problems with addiction (when the hospitalization is not necessarily related to addiction). The teams’ mission is to ensure that patients’ needs specific to addictive behaviours are met.

What are the key features?

- Run across 6 centres in Paris, the teams typically comprise of doctors, nurses, social workers and medical secretaries
- Provides holistic services for drug users, including linking into harm reduction services

Why is it a good practice?

- Proactively engaging PWIDs into prevention is important to continue to address the epidemic among PWIDs. Engaging at the point of an acute health event provides the opportunity to evaluate addictive and cognitive disorders, thus supporting the patient in entering care for their addiction, whilst also coordinating with hospital teams and caregivers to increase their education.

Testing and screening

- Testing has not yet integrated effectively into daily practice in primary care settings, resulting in missed opportunities
- Room for improvement exists in better implementation of repeat testing across all settings of care

What is the policy position?

National policy encourages various routes of testing, including through clinical and community settings and alternatives (e.g., self-tests). A national screening policy existed, with recommendation to screen all members of the public between 15-75 years of age at least once in their life time regardless of their risk of exposure. More regular screening of at-risk populations, such as an annual screening of MSM, injecting drug users and individuals with multiple partners from sub-Saharan Africa and the Caribbean, was also advocated [33][34]. An update to this policy was introduced in 2017. This includes recommendations to repeat HIV screenings every three months among MSM, every year among PWIDs and annually for people from high prevalence areas [33]. There are also further recommendations to test for HIV following an event such as STI, Hepatitis B or C or tuberculosis diagnosis, rape, pregnancy, abortion or incarceration [33].

In conjunction with this, French policy advocates the use of rapid diagnostic tests (RDTs). It recommends they are deployed in certain populations, such as those with a high prevalence of HIV (MSM, PSP, IDU, migrants), and those who do not use the health care system or have difficulties using it, for example people in vulnerable or isolated areas [33]. These tests can be administered by trained non-medical personnel [35], which is hoped to boost uptake in these populations.

Self-testing kits are approved by the regulations in France [35], [36], and can either be purchased in pharmacies, or distributed for home use by trained personnel in centres that are authorised to carry out RDT screening [1]. French policy does not currently recommend self-sampling, with on-going studies by Public Health France to determine their effectiveness [33].

What happens in practice?

Testing is available through multiple settings of care: free tests (together with other STI testing) can be obtained from a medical practice, free and anonymous testing is available through community clinics Centres gratuits d'information, de dépistage et de diagnostic (CeGIDD), and Rapid Diagnostic Tests (RDTs). Particular success has been noted in the use of RDTs, with research indicating that community based RDTs have been particularly beneficial to MSM in areas of high prevalence and to sex workers, although participation of migrant populations were not as high [33] [37]. Hospital-based RDTs have also contributed to increased testing numbers when piloted, with 70% of patients accepting an opt-in rapid HIV test during a pilot project in six emergency departments in Paris [38] – showing promising levels of acceptability and uptake amongst the general population [33].

The provision of self-testing is robust throughout France. Self-tests are available at pharmacies nationally, with widespread access and generally a good level of awareness of such kits and their availability. The current cost of a self-test kit is EUR 23-28, with some NGOs in discussion to supply self-tests for free - provided funding is secured from the government and other sources. Data available shows 74,650 HIV self-test were sold in pharmacies in 2016 [39].

> “If you walk down the street in a large French city, you see pharmacists providing self-tests, you see the adverts.”
>
> **HIV patient and policy expert, France**

In addition, a few community health clinics have opened in large cities (e.g., Le 190 in Paris, Spot by AIDES in Paris and Marseille) in order to deliver a comprehensive sexual health offering to high risk populations. It offers repeat testing, STI testing and PrEP support, and is run by NGOs, which is particularly attractive to high risk populations such as MSM.

What do the experts say?

Experts acknowledge that the efforts made towards testing are having an impact. However, they emphasise that more needs to be done to tackle undiagnosis and late-diagnosis, evidenced by the average duration between contracting the HIV infection and being tested estimated at 3.3 years in 2016 [40].

A key challenge is the limited efficacy of testing in primary care settings, with a study from 2016 indicating the then existing screening strategy was not well integrated into the daily practice of GPs [15]. Lapse in knowledge among the GPs of the existing guidance is likely to be a key driver. Expert opinions state community sexual health clinics targeting high risk populations should be supported, funded and developed to increase the efficacy of testing.

Related to this, is the limited implementation of repeat testing, even within high risk populations. Again drivers vary, however, lapse in GP awareness and real or perceived stigma are often cited. In addition, experts state repeat testing is still not a key priority for neither high risk populations nor healthcare stakeholders.

> “Repeat testing is frequently not being carried out for high risk populations. If you want to get testing every 6 – 8 weeks, you’d be looked down at.”
>
> **HIV patient and policy expert, France**

France also struggles to target hard to reach populations, e.g., newly arrived migrants. These populations are often reluctant to engage with state-run or public health services, therefore free, anonymous and convenient testing facilities are required.

> “If you want to get tested in France, first you have to find the information on where to get tested: there are 10 – 15 websites and it’s not clear which has the correct information… then, even in Paris, most free testing facilities close when work closes and are not open on weekends.”
>
> **HIV patient and policy expert, France**

While expert consensus on self-testing is generally positive; there is healthy uptake, with good levels of awareness and accessibility, the cost of the service may present a barrier. Despite the availability of self-tests, expert opinions state there is reluctance around using self-tests, with inadequate promotion and funding further hindering uptake. Furthermore, a current lack of data on which populations are using self-tests has also hindered the ability to determine if the benefits are reaching at risk / hard to reach populations effectively.

> “We don’t know if there’s an added value in comparison to other testing methods e.g., are we attracting other populations we wouldn’t normally?”
>
> **HIV clinician and policy expert, France**

HIV specific clinical treatment

- Immediate initiation on ART is recommended and available
- Physicians do not face restrictions on which medicines can be prescribed
- Long-term monitoring on viral load suppression is conducted to a high standard

What is the policy position?

French policy advocates immediate initiation on ART following diagnosis regardless of CD4 count. The 2017 – 2020 strategy reinforces this, highlighting the need to reduce time between infection and treatment, and the need to address issues such as transport, health cover and other inequalities that impede access to treatment [1].

Generally, no restrictions exist in prescribing following French regulatory (ANSM) approval of medicines already approved by the European Marketing Authorization (EMA).

Current French policy has a dedicated section for promoting adherence to treatment. This includes guidance on issues that may limit adherence, such as social, psychological and behavioural challenges [41]. There is further guidance on how to regularly monitor adherence including the measuring of viral load and CD4, with the overall aim being to achieve an undetectable viral load within six months, maintaining suppression thereafter [41].

Haute Autorité de Santé (HAS) also provides guidance on co-infections: all co-infections with relations to HIV should be investigated and treated, such as Hepatitis A, B and C, TB and other STIs, with the drugs used to treat them investigated for any interaction with ART [41]. The policy recommends consultation with the National Drug Interactions database, which is regularly updated by the Agency for the Safety of Healthy Products (AFFSAPS).

What happens in practice?

Policy implementation for clinical management is of a very good standard. People living with HIV are generally initiated on ART irrespective of CD4 count, however, time to initiation may vary. While policy recognises the need for reducing time between diagnosis and treatment, this may not always be implemented - with anecdotal evidence of longer time frames in linkage to care and initiation on ART. Physicians are free to prescribe, with no restrictions or caps on approved medicines. In line with much of Western Europe, rapid access to innovative drugs through clinical trials or access schemes is available.

There is also a robust network of HIV specialists across France, which contributes towards the strong clinical outcomes seen. The French HIV research institute (ARNS) maintains this network, enabling a high level of collaboration across specialists.

> “Even before European approval, there are possibilities to have authorisation for people who need it.”
>
> **HIV clinician and policy expert, France**

> "The ANRS network involves 95% of all clinicians in France, if you are a medical HIV specialist you therefore know of the latest innovations through this network and you have access to them."
>
> **HIV patient and policy expert, France**

Access to regular monitoring for people living with HIV is well implemented in France. The efficacy of adherence guidelines was shown in a study using the French National Healthcare Insurance Database, which revealed adherence to a single-tablet regimen ART was 89.6% [42]. Co-infections are actively addressed, with a study on those co-infected with HIV and Hepatitis C (HCV) suggesting that if the annual treatment coverage rate of 30% remains stable, a decline is predicted in active HCV prevalence in high risk MSM group [43].

> "We are good at making sure that doctors working in different diseases connect with one another; helped by the strong ANRS network."
>
> **HIV patient and policy expert, France**

What do the experts say?

Expert consensus is that clinical management is a strength for France, with people living with HIV initiated rapidly on ART and virological suppression achieved. This is evident in France succeeding in meeting the 2nd and 3rd of the UNAIDS treatment targets. As a result, the recent policy document has extended the targets to 95-95-95 by 2020 [1].

> "There is a national policy and it is implemented, not only in Paris or big cities but across France."
>
> **HIV patient and policy expert**

Experts note at times treatment initiation for undocumented migrants may face delays, as although they are entitled to free treatment, (see Box 1) the requirements around documentation may take weeks to be organised. It may also contribute towards individuals not presenting to care and therefore being lost from the healthcare system.

Concern has been raised over budget restrictions, which may have implications for access to newer and innovative, and therefore more expensive, medications in the future. A move towards the use of generics, including breaking combinations (single tablet regimens), has also contributed towards this, however a recent study has indicated no impact on treatment adherence between STR and non-STR regimens [44].

> "We have been giving generics for about a year and not seen any problems regarding patient well-being."
>
> **HIV clinician, France**

> "This year for instance, we are being asked to use generic ART. So what does this mean for new treatments? Will they have to sell at prices close to generics, we don't know."
>
> **HIV clinician, France**

Long-term holistic care

- Policy details interventions covering multiple aspects of long-term well-being, including ageing, co-morbidities, and clinical (e.g., mental health) and non-clinical (e.g., peer support) as well as social support
- Implementation is generally effective, however, areas for improvement such as mental health provision remains

What is the policy position?

Policy towards long-term care is wide ranging and robust on the whole. French guidelines, *'Infection par le virus de l'immunodeficience humaine (VIH)'*, recommend that HIV patients with co-morbidities should be referred to a team and specialised hospital without delay [41]. This policy also includes recommendations for therapeutic education to ensure the patient is informed about the prevention and management of co-morbidities [41]. The 2017 – 2030 strategy also addresses ageing in this context. It acknowledges the need to improve the prevention and screen of comorbidities amongst ageing people living with HIV [1].

The policy towards mental health provision was reformed in 2011 and 2013 [45]. It advocates psychiatric treatment within hospitals or medical psychological centres following a referral from a doctor. Acknowledgement of the requirement to improve the quality of mental healthcare provided to people living with HIV was articulated in the *National Plan Against HIV / AIDS 2010 – 2014*, which states the need to 'strengthen the psychological and psychiatric care of the people' [46].

Supportive services for people living with HIV are detailed in policy, with a particular emphasis on peer support and counselling. Such support can be seen in the 2010 – 2014 National Plan, which put forward actions to 'improve the effectiveness of the post announcement support system from diagnosis into care' [46]. HAS guidelines build on this, emphasising that newly diagnosed patients need 'active listening and support that takes into account the personal, social, cultural and environmental characteristics of the patient' [41].

Proactive measures to provide support are outlined in the 2018 – 2020 roadmap [19]. It provides examples of community health approaches (e.g., 56 Dean Street Clinic) which could be replicated in France to offer counselling, support, individual coaching and / or self-help groups.

Housing and finances for people living with HIV are addressed in the 2017 – 2030 strategy [1]. It states there should be 'good access to insurance and finance, which takes into consideration scientific progress with regard to care' [1]. The French system classifies HIV as a long-duration illness and as such is 100% covered by social security. PHLIV are also eligible for disability benefits if the specific needs are communicated to professionals in disability benefits [1].

What happens in practice?

Co-morbidity care in France is on the whole well implemented. Some room for improvement, such as long waiting times for appointments with non-HIV specialists, has been noted. A 2018 study found that most patients hospitalised with HIV in France presented an opportunistic infection of at least one co-morbidity that contributed to costs of hospitalisation[47], possibly reflecting the need for greater collaboration between healthcare professionals to ensure comorbidities are identified and managed optimally. Further, certain subpopulations such as prisoners may not have access to more innovative medicines (e.g., combinations), instead being treated with earlier modalities of ART (associated with higher rates of side effects).

> “While access to comorbidity care is good, sometimes the organisation of care is complicated, for example, if you need to see another specialist you may have to wait months for an appointment.”
>
> **HIV clinician and policy expert, France**

Mental health support is available, however capacity constraints often result in delays. There have been pro-active steps by the government to address this issue, e.g., Réseau ESPAS provides mental health guidance and therapy for people living with HIV or people presenting with other STIs [48], with services either provided by the ESPAS team at their premises or via home / hospital visits. The ESPAS team also works with various stakeholders such as drug addiction centres and housing services in the local neighbourhood of the individual (see case study) [48].

> “If you have something that is clinically wrong, you can be treated and usually quite quickly, however, if you have a mental issue you need luck – we don’t have enough mental health clinics.”
>
> **HIV patient and policy expert, France**

Non-clinical support services are widely available, primarily through an extensive network of NGOs, many of which are publicly funded. Regional variations in the level of support

Case study: Réseau ESPAS [48]

What is it?

The ESPAS network is a public psychiatry unit created in 1992 in Paris, providing support not only to HIV positive people, but also their relatives.

What are the key features?

- The team consults with people living with HIV to assess needs and organize psychological or psychiatric support in the community
- The network coordinates with stakeholders including home care, city hospital networks, drug addiction services, and social and housing services
- ESPAS also offers information about sexuality and risky behaviour and prevention training for people with mental disorders, and healthcare professionals

Why is it a good practice?

- Providing psychological and psychiatric support to people living with HIV is important due to the greater prevalence of mental health issues. Co-ordination of services in the community fills the gap left by provision within the national health system.

> “We have this network of HIV NGOs, 250 local HIV NGOs, most of which do peer support and are publically funded either from government or local authorities.”
>
> **HIV patient and policy expert, France**

may exist, however general services such as peer support and counselling services are generally well implemented.

What do the experts say?

Expert opinion on long-term holistic care is varied. Management of co-morbidities and provision of support services (e.g., counselling) are particularly highlighted as strengths. Areas for improvement include closer collaboration to reduce waiting times across specialties, as well as greater awareness among primary care providers to ensure people living with HIV care is continued across various settings.

> “We have psychologists and psychiatrists in our service, so we can help those with anxiety or other mild mental health issues ourselves, it’s really with the more severe cases that more support is needed.”
>
> **HIV HCP, France**

Mental health remains a pressing issue for people living with HIV in France, and is part of a wider problem of mental health services provision for the general population. It is reported that, despite existence of policy, care can be challenging to access in a timely manner – which results in some individuals paying for private mental health, costing around 80EUR a session. Data indicating an increased suicide risk of people living with HIV, which was last reported at 6.3% and therefore higher than the rest of the population, indicate the importance of high quality care provision [28].

Expert opinions state in some cases, there is a lack of knowledge of HIV among care providers in retirement houses (‘EPHAD’), with a strong need to increase awareness and acceptability of people living with HIV in these centres. Some initiatives have been noted (e.g., the project in Nice)

> “We have very clear policies on mental health services for people living with HIV, but they are not necessarily implemented, we are missing a connection between policy and implementation.”
>
> **HIV patient and policy expert, France**

Case study: Universités des personnes séropositives [49]

What is it?

A gathering of around 100 participants (people living with HIV or co-infected with HIV and HCV) coordinated by AIDES and held in order to work on individual and collective health aspects by sharing information and experiences, and increasing empowerment.

What are the key features?

- Held once a year, the event brings together people living with HIV, AIDES activists and health professionals
- The programme consists of plenary sessions, workshops and more informal social sessions in order to contribute knowledge and encourage peer support

Why is it good practice?

- Benefits for participants have also been shown, with an evaluation showing that participants experience a decline in depression and also an increase in satisfaction from richness of exchanges and a reduction in feelings of being alone. The event also helps to support community action, facilitating future collaboration between carers, patients, and AIDES.

04 Recommendations

4.1 Develop an understanding of the scale of chemsex by mandating data collection

What is the issue?

Trends of drug consumption are changing - away from PWIDs who are already served with harm reduction services in the CAARUDs. Chemsex is a key emerging challenge in drug consumption, however there are currently no guidelines in this area and the level of information and public awareness of the associated risks is low.

Addressing this population is challenging, as they may not want to be engaged through the same channels and spaces as PWIDs (e.g., CAARUDS) and often may not see themselves as part of the same risk group (i.e., are not injectors).

What is the recommendation?

Develop an evidence base of the scale of the problem, including long-term trends, key risk drivers and effective routes of engagement. Once understood, effective policy governing outreach can be developed and implemented.

This can be addressed by the introduction of guidelines to mandate data collection on chemsex through the ANRS and facilitation of longitudinal studies to understand:

- Population and regional heterogeneity
- Routes of consumption
- Key challenges, e.g., those who suffer from addiction and those who manage their drug use

4.2 Establish more detailed testing guidelines on repeat testing for high risk populations

What is the issue?

Repeat testing is a key tool in addressing the undiagnosed population and reducing the rate of late diagnosis, which remains very high. Despite guidelines advising repeat testing for high risk populations, e.g., MSM, uptake remains low. This may be a result of limited awareness among the public of current recommendations (e.g., MSM to get tested every three months), and among healthcare professionals of the existing guidelines of when to offer tests.

What is the recommendation?

Produce more detailed national guidelines on repeat testing, providing details on:

- When to offer tests
- Who is responsible for coordination / supervision e.g., GPs, NGOs
- How to test, e.g., self-tests, rapid diagnostics etc.
- Tools to monitor, e.g., automated text messages

Consideration should also be given to encouraging uptake by providing financial and policy backing to self-tests and self-sampling, and widening the range of people who are able to distribute self-tests.

4.3 Formalise assessment of mental health of people living with HIV

What is the issue?

People living with HIV suffer disproportionately from mental health issues, often a result of dealing with multiple intersecting stigmas. While services exist, these are at best in line with those available for the general population, thereby not addressing the higher burden of disease found within this population.

What is the recommendation?

Mandate assessment of mental health in people living with HIV by nurses during annual HIV check-ups in hospital clinics in order to assess the scale of the problem, and begin to link people living with HIV into mental health care when required. This can be combined with a delivery model that works closely with community organizations in order to stay close to the needs of people living with HIV. Wellbeing should be incorporated into outcomes that are tracked, not simply retention and adherence that are tracked currently.

4.4 Expand HIV / STI community sexual health centres

What is the issue?

The National Sexual Health Strategy 2017-2030 emphasises the importance of community-based services, including prevention and testing. It further recognises the need for promoting and securing access to PrEP for key groups. However, room for improvement exists, with expert consensus suggesting outside of MSM, the general population are not necessarily aware of PrEP and doctors may not feel comfortable renewing prescriptions. In addition, while testing is available through multiple settings of care, there is limited efficacy in primary care settings (driven by lapse in GP awareness and real or perceived stigma), and an insufficient presence of community-based health testing.

What is the recommendation?

Expand the number of HIV / STI community sexual health clinics with adapted schedules (e.g., easily accessible centres that are open on evenings and weekends) aimed to attract high risk populations for initial and repeated testing and PrEP programs.

Good practice should be studied and scaled up. For example existing community based clinics (e.g., Le 190 in Paris, Spot by AIDES in Paris and Marseille) and interventions for Rapid Diagnostic Tests (RDTs) which have demonstrated efficacy among certain populations such as MSM and sex workers.

05

Policy Assessment

Is there a national plan for HIV? Yes

Historically France has had a national plan for HIV / AIDS in a standalone policy document [46]. Since 2017, the Ministry of Health has integrated HIV care into the *'National Sexual Health Strategy 2017-2030 Agenda'* [1]. The national strategy has been developed by widespread collaboration between national agencies and institutions, national associations, academic societies and professional associations as well as central administrative directorates [1]. Accompanying this policy document is a detailed three-year roadmap (2018-2020) with guidance on how to implement and make this national strategy a concrete reality, outlining 26 actions to be implemented in the next three years [19].

Does the national plan (or affiliate guidelines) promote?

Awareness 🟧

Raising awareness in key populations? 🟧

The National HIV / AIDS Plan 2010-14 highlighted the importance of raising awareness of STIs in high risk populations such as young people, women and people with disabilities [46]. Though this was not specific to HIV, it did advise tailoring methods of communication, such as social networks, to specific populations such as young people [46].

The more recent roadmap for implementation of the National Sexual Health Strategy (2018-2020) describes organisation of 'annual campaigns in the regions specifically for HIV testing, viral hepatitis and other STIs' [19]. This will be driven by the Health Directorate (DGS) with Santé publique France and the French National Health Fund (CNAM) acting as partners, with scenario budgeting to cover specific or all regions calculated in the roadmap for implementation [19]. This includes deploying regional / local screening campaigns, such as 'one-off' campaigns in the regions most affected by the HIV epidemic, Île-de-France, Provence-Alpes-Côte d'Azur and Rhône-Alpes, as outlined in the Haute Autorité de Santé (HAS) recommendations of March 2017 [19], [33].

Eradicating stigma? 🟧

The National Sexual Health Strategy 2017-2030 addresses the need to 'fight against stigmatisation and discrimination based on health status', recommending working on the prejudices against people living with HIV and to encourage actions that reduce discrimination in professional settings [1].

Sexual health education for general populations (e.g., schools) 🟧

The National Plan for HIV / AIDS first highlighted the actions for developing and disseminating health education for specific audiences, including raising awareness of HIV in young people [46].

The National Sexual Health Strategy (2017-2030) later outlined policies to improve sexual health education as a whole, rather than having a specific focus on HIV, including offerings at all school levels, universities and university services [1].

As well as targeted sexual health education for those in school, the policy also targets those out of school or university curriculums [1]. One such example offered is to make sexual health information resources available to everyone in a single database (Public Health Information Service) [1].

The roadmap for implementation of the National Sexual Health Strategy covers specific budget requirements and key stakeholders to involve to realise policy changes [19].

The target for France is for 100% of young people to have received high-quality education in sexuality and the associated risks (STIs, unwanted pregnancies) throughout their school curriculum [1].

Key

🟩 Policy available and effective

🟧 Room for improvement

🟥 Policy not available

Prevention

Free condoms for key populations? 🟩

The National Plan Against HIV 2010-2014 stated that condoms should be made free for populations most at risk for HIV / STIs and the vulnerable [46].

Additionally, more recent policy from the National Sexual Health Strategy 2017-2030 states that condoms should be accessible to everyone by promoting them in conjunction with targeted educational, screening and psycho-social treatment programs. However, it does not explicitly state that this provision should be free [1].

The implementation roadmap for the National Sexual Health Strategy 2017-2030 suggests trialling a condom PASS for people under 25 years for free condoms in high prevalence STI regions [19]. The strategy also outlines ways to build the social-media marketing of condoms which are tailored to high risk populations and diversifying the range available to make them more appealing [1].

PrEP for high risk populations? 🟩

Trudava has been approved by the European Marketing Authorisation since 2005 for the treatment of HIV infection in adults [50]. A Truvada Temporary Use Guideline (RTU) was implemented in France in January 2016 by the National Agency for Drug and Health Product Safety (ANSM) [51] for PrEP in adults who are at high risk of transmitting HIV through sexual activity. The European Commission then granted an extension of Marketing Authorisation in August 2016 for Truvada [50]. Following this the ANSM released an end of the RTU for Truvada [52].

HAS currently recommends PrEP for all adults at high risk of contracting HIV [53], this includes, MSM or transgender people who have had sex without a condom with at least two different sexual partners in the last six months, have had episodes of STIs in the last 12 months, at least one post-exposure treatment for HIV in the last 12 months, or been under the influence of drugs during sexual intercourse (chemsex) [53]. Individuals in certain situations should be assessed on a case-by-case basis, including, PWIDs, sex workers and those who have unprotected sex at high risk of HIV transmission [53].

Truvada for PrEP is 100% reimbursable by the Social Security in the indication for the marketing authorisation [53].

The National Sexual Health Strategy 2017-2030 outlines promoting, supporting and securing access to PrEP for key groups, including MSM and the sub-Saharan African community, and in particular women in precarious situations [1].

From 1 March 2017 doctors experienced in HIV at hospitals or CeGIDDs can initially prescribe PrEP, but after this renewal of the prescription can be carried out by any doctor in any setting combined with quarterly monitoring [53]. One caveat to this is that the prescription must be repeated every year in a hospital or CeGIDD [53].

Key

🟩 Policy available and effective

🟧 Room for improvement

🟥 Policy not available

Occupational and non-occupational access to PEP? 🟩

In 1998, French recommendations for PEP in cases of occupational exposures in healthcare workers were extended to include non-occupational exposures such as sexual exposures, syringe drug-sharing users and other exposures (e.g. discarded syringe injuries) [54].

For non-occupational exposures, PEP is available at emergency departments in hospitals and more recently STI clinics (CeGIDD) [55].

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

The need to improve the accessibility of substance abuse risk reduction programs such as opioid substitution therapy was outlined in the National Plan for HIV / AIDS in 2010 [46]. Government-funded harm reduction centres, known as CARRUD, were established under the public health law in 2004 and have seven missions pertaining to risk reduction policy (RDR) in drug use [25], [26].

The National Sexual Health Strategy 2017-2030 recommends implementing personal support interviews for MSM populations at high risk of contracting HIV [1]. The National Sexual Health Strategy also includes the targeting of sub-populations such as sex workers for risk reduction and to promote prevention [1].

In the implementation roadmap for the sexual health strategy there is a specific focus on universities, which suggests allowing the University Services of Preventative Medicine Promotion (SUMPPS) to provide contraceptive and preventative counselling [19].

The National Sexual Health Strategy 2017-2030 also specifically addresses the issue of chemsex, and its contribution to the HIV epidemic [1]. Recommendations are to develop a specific consultation service comprising specialists which is integrated into the wider healthcare system.

Currently ECIMUD teams, which are mobile multidisciplinary teams, travel to hospitals to provide on-demand support services for drug users and can facilitate the psychiatric care or hospitalisation of people living with HIV [48].

Key

🟩 Policy available and effective

🟧 Room for improvement

🟥 Policy not available

Testing and screening 🟧

Free anonymous testing through specialty / community settings? 🟧

Recommendations from HAS 2009 were to screen all members of the general population in France between 15-75 years, at least once in their lifetime, regardless of their risk of exposure [34].

Recommendations also included the regular screening of high risk populations most at risk, such as annual screening of MSM, multi-partner, injecting drug users and multi-partners from sub-Saharan Africa and the Caribbean [33], [34]. These recommendations were targeted at primary health care providers and in particular at GPs [33], [34].

In 2017, HAS published a re-evaluation of the HIV screening strategy in France [33]. This has new recommendations for screening, including that HIV infection must be repeated every three months among MSM, every year among PWIDs and annually for people from high-prevalence areas [33]. Additionally, the document recommends HIV testing in the following cases: diagnosis of STI, hepatitis B or C; rape; pregnancy; signs of suggestive primary infection; prescription of contraception or abortion, incarceration and diagnosis of tuberculosis [33].

The 2017 re-evaluation document highlighted the evolution of testing in France, including the use of rapid diagnostic tests (RDTs) which are used in hard to reach populations and outside of clinical settings [33].

The Order of August 2016 has set out specific conditions for carrying out RDTs for HIV in medico-social or associative environments, which can be carried out by trained non-medical personnel [35]. The RDTs were targeted at certain populations, including, people in a population with a high prevalence of HIV (MSM, PSP, IDU, migrant people from sub-Saharan Africa) and people who do not use the health care system, or have difficulty in using it (e.g. people in vulnerable situations of living in isolated areas) [33].

Self-testing / sampling? 🟩

The National Sexual Health Strategy 2017-2030 encourages the use of HIV self-tests, offering self-tests for free at CeGIDD, CPEF, CSAPA, CAARUD, CJC and community centres that have already been authorised to carry out RDT screening [1].

Self-testing kits are approved as in vitro diagnostic devices through the national regulatory body (French National Agency for Medicines and Health Products) [35], [36].

HIV testing by self-sampling is not currently available in France [33]. Ongoing studies are being conducted by Public Health France to establish the effectiveness of self-sampling [33]. This includes the Remind project whose objective is to evaluate the effectiveness of an incentive program for repeated testing of HIV and other STIs among MSM [33].

Key

🟩 Policy available and effective

🟧 Room for improvement

🟥 Policy not available

HIV specific clinical treatment 🟩

Immediate initiation on ART? 🟩

National Health Authority (HAS) clinical guidelines state that combination ART should be initiated in patients with a CD4 rate of <350/mm^3 [41]. More recent advice, covered in the French Experts' recommendations 'French 2013 expert group recommendations for 'ART of HIV-1 infection in adults' state that treatment should be immediately initiated regardless of CD4 count [56].

The National Sexual Health Strategy 2017-2030 highlights the need to reduce the time between infection and treatment, including for HIV [1]. This includes addressing issues such as transport, health cover and other inequalities which can impede access to immediate therapy [1].

Access to innovative medicines? 🟩

Once European Marketing Authorisation is obtained through the European Medicine Agency (EMA), it then falls to the French regulatory agency (ANSM) to recommend use of the therapy.

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

National Health Authority (HAS) clinical guidelines for healthcare professionals dedicate a section to promoting adherence to treatment, providing guidance on factors limiting adherence such as social, psychological and behavioural challenges [41].

These guidelines offer prescriptive recommendations on the regular monitoring of clinical parameters to track adherence, including measuring viral load and CD4. The overall aim is to achieve an undetectable viral load (<50 copies / ml) at six months and then maintain this [41].

With regards to coinfections, National Health Authority (HAS) clinical guidelines for healthcare professionals state that coinfections related to HIV infections should be investigated and treated, including hepatitis A, hepatitis B, hepatitis C, TB and other STIs (e.g. syphilis, gonorrhoea etc.) [41].

This includes the need to consider that drugs used to treat coinfections are likely to interact with ART [41]. Recommendations are to consult the National Drug Interactions database, which is regularly updated by the Agency for the Safety of Health Products (AFFSAPS).

Key

🟩 Policy available and effective

🟧 Room for improvement

🟥 Policy not available

Long-term holistic care

Ageing and co-morbidity care? 🟩

With respect to comorbidities, the French clinical guidelines, 'Infection par le virus de l ' immunodéficience humaine (VIH)' produced by HAS in 2017 recommend that HIV patients with comorbidities should be referred to a team and specialised hospital without delay [41]. These guidelines also specify that therapeutic education should be used to ensure the patient is informed about the prevention and management of comorbidities [41].

The National Sexual Health Strategy 2017-2030 also addresses comorbidities, acknowledging the need to improve the prevention and screening of comorbidities within the context of ageing, as it is a growing concern, particularly among people living with HIV [1].

Mental health services? 🟧

The Public Health Code defines the provision of psychiatric care in France, which was reformed in 2011 and 2013 [45]. A consultation is achieved by referral from a doctor, with psychologists practicing in hospitals or medical psychological centres (Centre Médico-Psychologique).

A need to improve the quality of mental healthcare provided to people living with HIV is clearly articulated in the *National Plan Against HIV / AIDS 2010-2014*, referring to the need to 'strengthen the psychological and psychiatric care of the people: the positions of psychologists must be preserved or even developed; collaboration with psychiatry liaison strengthened' [46].

Supportive services? 🟩

French policy and clinical guidelines highlight the need for supportive services in newly diagnosed HIV patients [41], [46]. This includes actions in the *National Plan Against HIV / AIDS 2010-2014* to 'improve the effectiveness of the post-announcement support system from diagnosis into care' [46].

HAS guidelines for HIV 'Infection par le virus de l ' immunodéficience humaine (VIH)' emphasise that newly diagnosed patients need 'active listening and support that takes into account the personal, social, cultural and environmental characteristics of the patient' [41].

The National Sexual Health Strategy Roadmap 2018-2020 [19] provides examples of community health approaches that France could replicate in counselling, support, individual coaching or self-help groups by peers and / or professionals. This includes such clinics as 56 Dean Street Clinic in London, which, among other HIV services, provides follow-up care for patients who are HIV-positive and counselling which includes advice on "Telling friends, partners or family about HIV".

Key

🟩 Policy available and effective
🟧 Room for improvement
🟥 Policy not available

From a housing and finances perspective, the National Sexual Health Strategy 2017-2030 addresses the need to improve housing and accommodation options for people living with HIV [1]. The strategy also considers the financial security of people living with HIV, stating there should be 'good access to insurance and finance, which takes into consideration scientific progress with regard to care' [1]. In France, diagnosis of HIV is established as a long-duration illness (affections de longue-durée) and therefore is 100% covered by social security.

People living with HIV in France are eligible for disability benefits. However, the specific needs related to HIV / AIDS must be communicated to professionals involved in disability benefits so that they are able to implement these benefits in practice [1].

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