Fast-tracking municipal health responses for vulnerable populations – examples from Eastern Europe and Central Asia

Tetiana Deshko, Director: International Programs

Alliance for Public Health
EECA cities epidemic burden

Cities represent high burden areas for HIV in EECA, shares of PLWH registered in some cities compared to national data:

On average, the share of representatives of key population among all PLHA in EECA is assumed to be up to 70%, while the majority of them are PWID (about 80% of all HIV-infected representatives of key populations).
HIV Prevalence in GP in 5 countries

Coverage

- PWID
- CSW
- MSM
- General population

Balti: -42.0%
Odesa: -76.0%
Tbilisi: -21.0%
Sofia: -49.0%
Almaty: -57.0%

HIV prevalence: 41.8%, 30.2%, 21.5%, 21.0%, 18.1%, 13.0%, 10.3%, 8.2%, 8.1%, 7.6%, 5.4%, 2.3%, 0.6%, 1.0%, 0.5%, 0.4%
A hidden epidemic - MSM: underestimated, underreported and underserved

The MSM population is drastically underestimated.

- The percent of the cities’ male population that are MSM is reported to be only: 0.4% in Almaty; 0.7% in Sofia; 1.7% in Balti.
- In Almaty, HIV prevalence among MSM was reported to be 2.3% (92 out of an estimated 4000 MSM) in 2015 and there were 107 new cases reported among MSM in 2016. The drastic underestimate of the MSM challenges interpretation of the data.
- Unreliable population estimates lead to unreliable data on coverage of MSM by key services.

HIV transmission among MSM is likely underreported.

- NGOs and community members report that, due to stigma, MSM don’t admit homosexual contact to AIDS Center staff. Stigma for MSM may be even higher than for other key affected populations.

National targets and coverage often lower among MSM compared to other populations.

- In Bulgaria, there is no target for MSM (but there is one for PWIDs), though there are more new cases among MSM than among PWID nationally.
- In Balti, access to HIV testing for MSM is strikingly low – only 1%, while 30-43% of SW and PWID accessed testing.

A new, hidden, growing and possible major epidemic.

- In Sofia, more than 50% of new HIV cases are reported among MSM.
- Several Optima reports across the region note that MSM are to face a major epidemic if not now, then in the future.
Criminalization of behaviors and stigma associated with people from key populations continues to be a major barrier to accessing health and related services throughout the region.

<table>
<thead>
<tr>
<th>Country</th>
<th>IDU (use, possession, transporting small doses) criminalised</th>
<th>SW criminalised</th>
<th>MSM criminalised</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kazakhstan</td>
<td>-</td>
<td>Yes, indirectly, administrative punishment for providing premises for prostitution and pimping, Administrative Criminal Code, art. 449-450</td>
<td>-</td>
</tr>
<tr>
<td>Moldova</td>
<td>Yes, use, Penal Code of Republic of Moldova, art. 217-219</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Ukraine</td>
<td>Yes, possession, Administrative Offences Code, art. 44</td>
<td>Yes, Administrative Offences Code, 181-1</td>
<td>-</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>Yes, possession, Penal code, art. 354a</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Georgia</td>
<td>Yes</td>
<td>Yes, administrative</td>
<td>Pimping is criminalised</td>
</tr>
</tbody>
</table>

EECA cities: political barriers
ART coverage is very low

**Sofia**
- Estimated number of PLHIV: 1188
- Registered PLHIV: 946
- PLHIV in ART: 617
- PLHIV with viral suppression: 52%

**Almaty**
- Estimated number of PLHIV: 4700
- Registered PLHIV: 4071
- PLHIV in ART: 1648
- PLHIV with viral suppression: 35%

**Odesa**
- Estimated number of PLHIV: 17047
- Registered PLHIV: 11391
- PLHIV in ART: 4019
- PLHIV with viral suppression: 24%

**Balti**
- Estimated number of PLHIV: 6000
- Registered PLHIV: 1119
- PLHIV in ART: 500
- PLHIV with viral suppression: 8%
HIV+PWID have lower access to treatment than PLHIV who do not use drugs

- People who use drugs in Almaty have lower access to HIV treatment cascade components, though equal rates of access can be achieved with adequate support
- Lack of access to OST probably contributes to this problem
- Treatment cascade data disaggregated by key population is helpful in defining priorities
Opioid Substitution Therapy: dangerously low levels of access

Access to OST is extremely low.
- Access to OST in the EECA region is far lower than the 40% recommended by WHO
- There was ZERO access in Almaty until 2017
- In Balti, only 4.39% access of people who inject opioids
- Sofia does better at 19.4% access. This is higher than in most of EECA but lower than most of the EU

National OST targets are lacking or inadequate.
- Bulgaria does not have an OST target
- Moldova sets a very low target of only 4.2% by 2020!
- Georgia sets a low target of only 9% by 2018

Low OST access hampers prevention and treatment and adds to cost.
- Constrained prevention impact & costs of additional cases
- Missed opportunity for better HIV/TB treatment adherence & costs related to resistance and/or late initiation
Severe MDR-TB burden

High MDR-TB shares, 2016 cases

Vulnerable groups among MDR-TB cases and active TB cases in Balti, 2016

Still low treatment success rates, 2016
High rates of HIV/TB coinfection, while with positive but uneven trends

More interlinked deaths among HIV and TB
### City responses to HIV and TB

<table>
<thead>
<tr>
<th>City, country</th>
<th>City HIV program</th>
<th>City coordinating mechanism for HIV</th>
<th>GDP, country, 2015</th>
<th>Which budget is funding AIDS response (prevention and treatment), any city funding released?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almaty, Kazakhstan</td>
<td>-</td>
<td>-</td>
<td>10 508</td>
<td>City budget is funding prevention work, republican – drugs and equipment procurement</td>
</tr>
<tr>
<td>Balti, Moldova</td>
<td>Yes, almost</td>
<td>Yes</td>
<td>1 843</td>
<td>Prevention funded by GF, procurement by national budget. The municipality is funding provision of premises for NGOs</td>
</tr>
<tr>
<td>Odesa, Ukraine</td>
<td>No</td>
<td>Yes</td>
<td>2 115</td>
<td>Prevention funded by GF, procurement by national budget. City ‘Health’ program is releasing some limited funds including as social contracts.</td>
</tr>
<tr>
<td>Sofia, Bulgaria</td>
<td>In process</td>
<td>Yes, update needed</td>
<td>6 820</td>
<td>Prevention - Global Fund, treatment - national budget</td>
</tr>
<tr>
<td>Tbilisi, Georgia</td>
<td>-</td>
<td>-</td>
<td>3 796</td>
<td>Prevention funded by GF, procurement by national budget</td>
</tr>
</tbody>
</table>

### Amount city budgets spent for HIV and TB in 2016 (USD)

<table>
<thead>
<tr>
<th>City</th>
<th>HIV</th>
<th>TB</th>
</tr>
</thead>
<tbody>
<tr>
<td>Almaty</td>
<td>5 000 000</td>
<td>5 333 000</td>
</tr>
<tr>
<td>Balti</td>
<td>2 870</td>
<td>1 350</td>
</tr>
<tr>
<td>Odesa</td>
<td>375 073</td>
<td>43 296</td>
</tr>
<tr>
<td>Sofia</td>
<td>42 000</td>
<td>240</td>
</tr>
<tr>
<td>Tbilisi</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
How much cities allocate for HIV responses in 2016 (per 1 reported PLHIV)

Bern – 2 706 $

Sofia – 0,25 $

Odesa – 33 $

Balti – 2,5 $

Tbilisi – 0 $

Almaty – 1 228 $
Example of Bern canton harm reduction program

Canton Bern allocated **9 159 725** CHF for PWID programs in 2016, implemented by CONTACT

Targeted clients are recorded per type of service, if at all:
- Total addiction treatment: 385 therapy places
- Total housing programs: 201
- Total mobile interventions: 3595 night-life interventions plus 688 other mobile interventions
- Total work integration programs: 337
- Total drop-in centers: 1192
Transition challenge in Sofia

Critical situation with Bulgarian harm reduction programs after The Global Fund HIV prevention grant was closed in May 2017.

Some needle exchange program is still being done on voluntary basis once a week in Sofia. Testing and condom distribution are missed. During GF grant it was 7 days a week.

The Government allocated 500 000 euro for prevention services for key populations in 2017. But, it has no mechanisms to contract NGOs.
City HIV/TB model

Alliance for Public Health (Ukraine), licit (Switzerland), AFEW-International (the Netherlands), STOP TB Partnership with technical guidance of UNAIDS EECA implement a regional city program to respond to TB/HIV among key populations to the Global Fund (2017-2019)
City HIV/TB model: example of Odesa

Coordinating NGO

City Task Force
City HIV/TB model: example of Odesa

Coordinating NGO

City Task Force

Municipality commitment

Odesa signed Paris Declaration

Odesa joined Zero TB Cities
City HIV/TB model: example of Odesa

Protecting Human Rights

PWID representative Julia Kogan joined City Coordination Council

Engaging key populations

Coordinating NGO City Task Force

Municipality commitment

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City HIV/TB model: example of Odesa

- Engaging key populations
- Piloting TB treatment success model
- Developing HIV/TB city program 90-90-90
- Coordinating NGO City Task Force
- Municipality commitment

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City HIV/TB model: example of Odesa

- Municipality commitment
- Piloting TB treatment success model
- Developing HIV/TB city program 90-90-90
- Engaging key populations
- Coordinating NGO: City Task Force
- Municipality commitment

- 20% increase in municipal budget allocation
- Protecting Human Rights
- PWID representative Julia Kogan joined City Coordination Council
- Odesa joined Zero TB Cities
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City HIV/TB model: example of Odesa

- Piloting TB treatment success model
- Developing HIV/TB city program 90-90-90
- Coordinating NGO City Task Force
- Engaging key populations
- Protecting Human Rights

- 8% AIDS mortality reduction
- 10% TB mortality reduction
- 20% increase in municipal budget allocation

- PWID representative Julia Kogan joined City Coordination Council
- Odesa joined Zero TB Cities
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Results-based financing models in cities are reinforcing national health reforms

Example of the implementation research within Odesa city project on improved TB treatment outcomes to counter Semashko hospital-based planning approach with poor outcomes

<table>
<thead>
<tr>
<th>THEN</th>
<th>NOW</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Service</strong></td>
<td>Specialized TB</td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
<td>Hospital-based</td>
</tr>
<tr>
<td><strong>Financing approach</strong></td>
<td>Planned TB hospital beds x patient cost = high facility costs not linked to treatment outcomes</td>
</tr>
<tr>
<td><strong>Treatment success</strong></td>
<td>Susceptible – 57%</td>
</tr>
</tbody>
</table>
Balti HIV/TB focus

Revising HIV testing protocol to use 2 rapid tests for diagnosis, already in process

Conduct early TB detection through WHO TB screening questionnaire to 100 000 (almost city population) persons through outreach for key populations and all the medical facilities in the city

Case management organized in AIDS, TB and Narcological services

DOT for 30% patients representing key populations using RBF model

Advocacy to include core TB services into medical insurance scheme

Interlinked deaths among HIV and TB

<table>
<thead>
<tr>
<th>Year</th>
<th>% of TB-related deaths among deceased PLHIV</th>
<th>% of HIV-infected among deceased TB patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>54%</td>
<td>48%</td>
</tr>
<tr>
<td>2013</td>
<td>49%</td>
<td>51%</td>
</tr>
<tr>
<td>2014</td>
<td>42%</td>
<td>42%</td>
</tr>
<tr>
<td>2015</td>
<td>44%</td>
<td>50%</td>
</tr>
<tr>
<td>2016</td>
<td>64%</td>
<td>54%</td>
</tr>
</tbody>
</table>
Almaty HIV care cascade improvement

- Developing low-threshold testing standards and protocol with introduction of rapid HIV assisted (during outreach) testing and self-testing
- HIV assisted/self-testing 6000 tests
- 300 newly diagnosed registered with AIDS facilities
- 200 lost-to-follow up linked to ART
- 500 started ART increasing ART coverage from 35% to 45%
A series of educational films are planned in 5 program implementing cities and in Amsterdam and Bern (as model cities) on harm reduction programs, NGOs and public health facilities working in the field of TB and HIV.

The idea is to show from outside perspective how to buy/exchange syringe, how to get tested for HIV and how to enroll on OST program in the cities.

As for now, films on Balti, Sofia and Odesa are available on program Youtube Channel @hivtbcities
Conclusions

• Epidemics differ in different cities and city-specific responses are critical
• Key populations must be prioritized in EECA taken how they got affected by epidemics, low access to services and criminalization of related behaviors
• Cities can control their epidemics as they plan and allocate resources through integrative multisectoral process. There should be acknowledgement of the role of civil society and communities
• Interventions must shift from resource intensive capital investments Semashko model to patient-centered approach with orientation on health outcome. ICT and e-Health solutions contribute to cost optimization and patient comfort
• Examples form HIV and TB models and efficiencies catalyze broader health modernization and reform
• City interventions attract attention and effort of other cities
Thank You

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