ALMATY MODEL FOR HIV EPIDEMIC CONTROL

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Almaty Model for Epidemic Control is designed to create and implement a cost-effective, inclusive and sustainable city program that works to achieve HIV epidemic control in Almaty.
Almaty

- The largest metropolis in Kazakhstan
- 2 million people
- The first city in Central Asia, whose authorities signed Paris Declaration on July 20, 2017

However, by 2020 the proportion of estimated PLWH with suppressed viremia was still below the desired target of 73% needed to turn the curve of the HIV epidemic
Almaty Model for Epidemic Control

• Funded by the RADIAN Initiative of the Elton John AIDS Foundation
• June 2020-June 2024
• Implemented by a consortium of local organizations led by ICAP at Columbia University
• Focused on people living with HIV and most vulnerable communities, including people who use drugs, men who have sex with men, transgender people and sex workers.
• Designed and implemented based on locally-led solutions and governmental structures and information management systems

• To **strengthen** the city’s clinical and community-based HIV **service delivery**
• To **remove or reduce barriers** to uptake of HIV prevention, testing and treatment services, such as provider- and self-stigma and discrimination,
• To **increase demand** for HIV services
HIV Testing – activities to improve the 1st “95”

Key objectives:
• Improve community-based targeted HIV testing among key populations with prompt linkage to antiretroviral therapy ART and/or prevention
• Increase access to and use of HIV self-testing
• Enhance index partner testing

Key interventions:
• Network-based peer-driven incentivized recruitment of clients for testing
• Online self-test give-away service
• Online and offline anonymous partner notification options
• Routine and regular mentoring support and training of providers to ensure quality counselling
HIV Treatment – activities to improve the 2nd “95”

Key objectives:
• Initiate prompt ART initiation for all PLHIV
• Ensure effective patient follow-up and tracing to support ART restart after treatment interruptions
• Improve ART retention support and monitoring to prevent treatment interruptions

Key interventions:
• Intensive mentoring support to review data to identify people not on ART, understand reasons and develop ART initiation plans
• Active patient tracing efforts in case of a missed visit
• Automated pre-appointment reminders for clinical visits and ARV pickups
• Performance-based incentives to providers to ensure all people diagnosed with HIV are initiated ART
Viral load suppression – activities to improve the 3rd “95”

Key objectives:
• Ensure high viral load coverage for all people on ART
• Provide patient-centered approach to ART adherence

Key interventions:
• Nurse-led home-based structured ART adherence support
• Engagement of multidisciplinary teams
• Automated SMS-based notifications with viral load test results
• Telegram-based bot and chat for peer-to-peer adherence support
HIV prevention

Key objectives:
• Ensure all people from key populations have access to a basic package of effective HIV prevention services
• Initiation and scale-up of PrEP
• Development and implementation of electronic PrEP register

Key interventions:
• Counselling and referral to government services
• Training and mentoring to providers to ensure same day PrEP initiation
• Dissemination of information among key populations, PLHIV and their partners
• Community-based counseling and distribution of PrEP
Key successes

- Improved collaboration between community-based organizations and the AIDS Center
- Improved capacity of service providers to deliver quality services
- Effective network-based peer-driven outreach for testing
- Scale-up of self-testing
- Improved timing of ART initiations
- Improved adherence support to patients
- Launch of PrEP
HIV cascade, Almaty (data as of the end of June 2020 (red) & June 2022 (green))

- Estimated number of PLHIV: 5000 (2020), 5300 (2022)
- PLHIV who know their status: 3945 (2020), 4414 (2022) (79% of 5000, 83% of 5300)
- PLHIV enrolled in care: 3173 (2020), 3968 (2022) (61% of 5000, 75% of 5300)
- PLHIV receiving ART: 2890 (2020), 3606 (2022) (58% of 5000, 75% of 5300)
- PLHIV on ART tested for viral load: 2008 (2020), 3101 (2022) (64% of 3280, 95% of 3375)
- PLHIV on ART virally suppressed: 1771 (2020), 2701 (2022) (54% of 3280, 86% of 3375)
Lessons learnt aka prerequisites of success

• Close collaboration between clinical and community-based providers
  – Multidisciplinary teams to provide patient-centered care
  – Regular communication and exchange of data between providers

• Routine data collection and analysis, and targeted site-level support to identify program gaps and develop quality improvement interventions
  – Use of patient lists to prioritize activities, link or relink diagnosed PLHIV to HIV treatment
  – Performance-based financial incentives to providers
  – Individual and frequent data quality audits, mentoring and training support to providers

• Use of technology to empower clients to manage their care
  – Online services to order HIV self-tests, notify index partners, appointments for ARV pick-up and clinical visits, sharing of viral load results
  – Use of social media to provide information to clients

• Uninterrupted supply of commodities (drugs, test-kits, etc.)
Plans for the next year

- Online distribution of harm reduction supplies
- Structured interventions to follow-up of patients with severe disease
- Piloting decentralization of HIV services to the primary health care level
- Launch of HIV mobile clinic
Thank you!

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