

*HIV in Albania:  
A National Programme Report*

September 2014



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# HIV in Albania: A National Programme Report

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## Abbreviations:

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
EU	European Union
GP	General Practitioner
GF	Global Fund
HR	Harm Reduction
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency virus
IPH	Institute of Public Health
IBBS	Integrated bio-behavioural Survey
MSM	Men who have sex with men
MMT	Methadone Maintenance Treatment
NGO	Nongovernmental Organization
NNRTI	Non-Nucleoside Reverse-Transcriptase Inhibitors
NRTI	Nucleoside Reverse-Transcriptase Inhibitors
NSP	Needle and Syringe Exchange Programme
OST	Opioid Substitution Therapy
OI	Opportunistic Infections
PI	Protease Inhibitor
PLHIV	People Living with HIV
PWID	People who Inject Drugs
SW	Sex Workers
STI	Sexually Transmitted Infections
TB	Tuberculosis
TUH	Tirana University Hospital
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

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## Executive summary

The key aim of Albania's national HIV strategy (2009-2014) was to ensure the country continued to have a low prevalence epidemic. At the close of the strategy, this aim has been realized with only 699 diagnoses reported by end 2013; this is equivalent to 3/100 000 population. Contributing to this success is the availability of free health care, HIV testing and HIV treatment which have reduced barriers for those most at risk. Albania also benefits from passionate and committed clinical and public health expertise with established HIV surveillance systems for monitoring testing and epidemiological trends and established and supportive NGOs.

While HIV prevalence remains low, the potentially unrecognized epidemic in men who have sex with men (MSM), the large proportion of people unaware of their HIV infection, and the high rates of sharing of needles and syringes among people who inject drugs indicate there is a risk that the HIV situation within Albania will deteriorate.

This report details findings from a WHO mission to identify the strengths and challenges in the programmatic efforts related to the Albanian HIV epidemic, and the development of recommendations to improve the public health response in five priority areas. These five priority areas and recommendations will form part of an application to The Global Fund in early 2015.

1. develop **governmental political and financial commitment** and partnership with NGOS to establish sustainable HIV prevention, and management and treatment programmes;
2. **establish antenatal screening and increase access to HIV testing** (including access to rapid tests), establish routine testing for patients presenting with HIV indicators diseases and outreach to key populations (men who have sex with men (MSM), sex workers (SW), people who inject drugs (PWID) and persons who attend methadone maintenance programmes;
3. **develop an effective HIV treatment and care programme to ensure high enrolment and retention care and high ART coverage**. Establish a board with responsibility for the management of HIV care, including the procurement and provision of HIV treatment and laboratory tests (CD4 counts, viral loads and drug resistance tests);
4. **review and improve access to, and scope of harm reduction services** for key populations. This should include optimal dosing, ongoing psychological support, and provision of methadone in prison settings and for opioid users;
5. **develop friendly and non-judging services and reduce stigma and discrimination** for people living with HIV (PLHIV), sex workers, PWID and towards Roma people and lesbian, gay, bisexual and transgender (LGBT) communities.

# 1. Introduction

## 1.1 Country epidemic: latest trends

Albania has a low-level HIV epidemic with 699 cumulative cases diagnosed by the end of 2013 (1). The first case was diagnosed in 1993 with very low number of cases reported annually in the first decade (1993-2002). Between 2008 and 2013, the number of HIV diagnoses more than doubled from 48 in 2010 to 124 in 2013. The ratio of male to female cases has been consistently around 2:1 with the majority of cases diagnosed between the ages of 25-44 years (60%) followed by 45-54 years olds (17%). This indicates that Albania is likely to have an underreported and unrecognized HIV epidemic in men who have sex with men (MSM) and possibly among people who inject drugs (PWID).

To date, 122 deaths have been reported among people living with HIV, corresponding to a crude death rate of 17% among the HIV diagnosed population. About half of diagnoses were reported in the capital, Tirana (52%) followed by the cities of Durres, Elbasan and Vlora. All but three of the 36 districts in the country have reported a least one case.

People are tested for HIV infection in a variety of settings including voluntary counselling and testing (VCT, available in 12 cities), inpatient hospital, Public Health Institute, general practitioners and specialist physicians. Over three quarters of patients are diagnosed with a CD4 count under 350 cells with 52% presenting with a CD4 count under 200 cells. This indicates that a relatively high proportion of people living with HIV infection in Albania are likely to be unaware of their HIV infection. All HIV positive tests are sent to the Institute of Public Health (IPH) reference laboratory for confirmation on western blot based in Tirana. Following an HIV positive diagnosis, patients are referred to Tirana University Hospital (TUH) which cares for all patients living with diagnosed HIV infection across Albania. As of March 2014, the total number of patients enrolled on anti-retroviral therapy (ART) was 335 (first and second line).

A full analysis of the Albanian epidemic and the national surveillance systems is included in a separate report.

## 1.2 National response to HIV

Albania's national response to HIV is guided by the National Strategy of Prevention and Control of HIV/AIDS in Albania 2009-2014 (2). Its overall goal was to ensure that Albania remains a low HIV prevalence country, delivered through three strategic priorities: prevention of new HIV/STI infections in key groups and the general population; improved treatment, care and support for people living with HIV; and further system infrastructure and health provider capacity development to ensure high quality and timely service to all people affected by HIV/AIDS.

A new HIV strategy is currently under development and scheduled for publication at the end of 2014. The working group comprises the Ministry of Health, the IPH, the Hospital of Infectious Diseases, the Institute of Health Insurance and representation from the people living with HIV (PLWHA) association. The development process has been collaborative, and the work builds upon the previous strategy, but incorporates a number of new and/or re-enforced elements. These include:

- emphasizing the need for timely and accurate epidemiological data through case reporting and regular integrated bio-behavioural surveys (IBBS);
- prioritizing the need for antenatal screening for HIV;
- re-emphasizing the importance of targeted prevention activities among key populations (particularly men who have sex with men (MSM) and people who inject drugs (PWID));
- improving the provision of care and treatment for people living with HIV (revising the CD4 threshold for ART in line with the consolidated World Health Organization (WHO) guidelines) (3);
- early diagnosis of HIV, and diagnosis and treatment of co-infections;
- updating ART provision); and
- promoting provider initiated HIV testing in routine health settings.

Albania has a number of other strategies relevant to HIV that relate to health more broadly. Firstly, the Health System Strategy (2007-2013) (4) aimed at:

1. increasing the capacity and efficiency of current health services;
2. increasing access to health services;
3. improving health system financing; and
4. improving health system governance.

In addition, Albania had a Public Health and Health Promotion Strategy entitled “Towards a Healthy Country with Healthy People” (5). This identifies key public health issues; sexual and reproductive health is included with prominence particularly given to HIV prevention among school-aged populations. Finally, the national strategy on tuberculosis (TB) for 2013-2019 (6) makes explicit the need to undertake HIV testing among all people with TB, but recognises the capacity and referral challenges in this area.

### **1.3 Health Care Provision**

Throughout Albania, access to health care is free through a health insurance scheme. Children, people past the age of retirement, and people who are unable to work receive free health care. People who are eligible for work but who are not employed receive health care dependent upon registration of intention to find paid employment. Whilst contact with health services is free, patients are asked to pay a contribution (usually <\$40) towards interventions and prescriptions. The exception is HIV, where first line anti-retroviral therapy (ART) is paid for by the government, with second line therapy is paid for by the Global Fund.

The Ministry of Health is working towards a redesign of the health care structure. This involves creating a system of health care funded through taxation. It is hoped that this change, planned for 2017, will reduce bureaucracy and simplify health care access at the point of care. Further changes include the introduction of electronic patient records. It is anticipated that these developments will facilitate tracking of patients across different health care services. Discussions are planned as to how the sensitivities of certain medical information (including HIV), included in patient records, will be protected.



## **1.4 The Global Fund**

Albania's response to the HIV epidemic has been supported by a Round 5 grant from The Global Fund to fight AIDS Tuberculosis and Malaria (GFATM). This funding expired in 2012, and Albania is currently in the process of preparing an application for Round 10 with deadline for submission in October 2014.

The Round Ten application is focused on seven key areas. These have been selected as they are vital to ensuring that Albania remains a low prevalence country, and because they are areas in which funding gaps have been identified. They comprise: prevention programmes for MSM and transgender people; prevention programmes for PWID and their partners; prevention of mother to child transmission; treatment, care and support; TB/HIV; health information systems, monitoring and evaluation; and programme management.

## **2. Aims and objectives**

The aim of this mission was to evaluate the strengths and challenges of the HIV epidemic in Albania and to generate recommendations for improving outcomes and impact of the national response. These recommendations will be considered for the concept note for The Global Fund application in early 2015. Appendix One outlines the Terms of Reference for this mission.

## **3. Methods**

The evaluation builds on a desk review and a country mission which took place from 8 to 11 September 2014 to Tirana, Albania. Information and data were collated from secondary sources including national publications, epidemiological reports, WHO and Global Fund reports. The WHO experts also met with the Ministry for Health, epidemiologists from the Institute of Public Health, clinicians and procurement professionals at TUH, VCT workers and Nongovernmental Organization (NGO) representatives (Aksion plus, Stop AIDS, and People living with HIV and AIDS (PLWHA), Albanian Lesbian and Gay Association (ALGA). A full list with names and organizations is provided in Appendix Two. Preliminary feedback on the priority areas was presented on day four to the country coordinating group (Appendix Three).

## **4. Findings**

### **4.1 Strengths**

Albania remains a country with low HIV prevalence by the close of its national strategy. There are several key strengths both in the provision for HIV care and in response to the HIV epidemic. Firstly, the availability of free health care, HIV testing and HIV treatment is not only beneficial for the individual patients living with HIV but reduces barriers for testing among those populations most at risks.

Secondly, Albania benefits from a central public health laboratory with public health infrastructure, a dedicated AIDS coordinator and well established HIV prevention activities as well as a small number of harm reduction activities. The IPH has passionate and committed epidemiological expertise with established HIV surveillance systems for monitoring, testing and epidemiological trends. Thirdly, Albania has highly skilled HIV clinicians and a dedicated HIV clinic with free and accessible antiretrovirals (ART).

Fourthly, the country has committed and active NGOs that provide a critical role in delivery of prevention activities and services. Finally, there is strong legal framework protecting those living with HIV (2008) and other key groups such as LGBT against discrimination (2010).

## **4.2 Challenges**

While Albania remains a low HIV prevalence country, the rise of new HIV diagnoses in Albania is concerning. The large majority of people present at a late stage of infection and the crude death among the diagnosed population is 17%. These data underscore a large undiagnosed HIV population and an urgent need for expanded testing. Current surveillance show a 2:1 male to female ratio which implies that MSM and PWID activities are under-reported among newly diagnosed cases.

Whilst those diagnosed and in care benefit from free treatment, stock outs are frequent and drug regimens restricted to available generics through a cumbersome and bureaucratic process. Whilst there are some dedicated NGOs, the country would benefit from a stronger network of NGOs with improved coordination and programmes better targeted to key populations.

### **4.2.1 Governmental political and financial commitment**

In order to ensure that the response to the HIV epidemic is proportionate and sustainable, it is important to obtain governmental commitment. Albania provides free health care through its public system and also has a few private providers. During the Global Fund Round 5, NGOs developed a number of prevention and harm reduction initiatives with government support, but since funding ended in 2012, these activities have not been sustained. The programmes have been evaluated by the National Commitments and Policies Instruments as inadequate and under-funded, particularly among key populations (7). The commitment required is therefore not only financial but also political to demonstrate the commitment to the success of sustainable programmes.

In the context of HIV, NGOs focus on harm reduction for PWID and lobby for rights for people living with HIV. There are three NGOs focusing on LGBT issues; however the focus of these organizations is LGBT equality and rights. NGOs feel in competition for the limited funding and the degree of coordination is currently limited. While NGOs are able to reach most at risk populations more effectively than public health authorities, their impact is limited due to lack of funds and required skill set. Greater partnerships between government/public health and NGOs are therefore required.

The Albanian response to HIV/AIDS had been focused on prevention and includes measures of primary, secondary and tertiary prevention. A large proportion of measures for HIV/AIDS prevention is based on health education more generally. Due to the low level of HIV/AIDS risk in Albania these measures are predominantly focused on promotion of protective behaviour in the general and adolescent populations and on prevention of determined risk behaviour within certain most-at-risk groups. Current HIV testing services and public health messages are not targeted at MSM and PWIDs.

#### **4.2.2 HIV testing and screening**

Albania needs to scale up its provision of HIV testing facilities with urgency. Investment in HIV testing will prevent mortality, reduce morbidity and lengthy hospital stays. Furthermore, a reduction in the size of the undiagnosed HIV population will reduce onward transmission through ensuring PLHW are aware of their infection and have access to ARV to decrease the risk of onward transmission. However, the uptake of HIV testing remains too low as indicated by the high proportion of patients diagnosed with a late stage of HIV infection.

##### ***Antenatal screening and testing***

There is currently no antenatal screening for HIV, hepatitis or syphilis in Albania. In 2013, there were six cases of mother-to-child transmission of HIV with some cases of congenital syphilis also reported. Assuming an HIV transmission rate of 25% among untreated HIV positive women (8); this means at least 24 HIV positive women were pregnant in Albania in 2013. This is likely to be a conservative estimate most people are diagnosed late and other infants who acquired their infection vertically may not yet be symptomatic and presenting for HIV testing.

The establishment of an antenatal screening programme is feasible since most women attend at least one gynaecological/obstetrician appointment during the course of their pregnancy. The benefits of an antenatal screening programme are clear. The absence of antenatal screening is not only putting infants at risk of transmission, but also deprives women living with HIV opportunities for prompt diagnosis and treatment. The higher median CD4 counts among women compared to men internationally demonstrates that antenatal screening also works to reduce undiagnosed HIV infection in the general population, particularly women combined with partner notification. From surveillance perspective, data from an antenatal screening programme would also provide robust estimates of national prevalence, since pregnant women are broadly representative of the general population.

##### ***Voluntary Confidential Testing***

Centres for VCT have been established since 2005 and are available in 12 prefectures - Tirana, Durres, Vlora, Lezha, Shkodra, Korca, Gjirokastra, Berat, Fier, Elbasa, Kukës and Peshkopi.<sup>1</sup> The number people tested in VCT settings increased from 250 tests in 2005 to 3,063 in 2013.

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<sup>1</sup> According to the information obtained during the mission in August 2014, voluntary testing is defined as testing which is done upon request of a person, without prior consultation with a healthcare professional. Recommended testing is the one done upon

During testing, clients are interviewed in relation to their demographic details, sexual history and reason for test. Rapid testing is undertaken using venous samples. Clients found to be HIV positive receive post counselling care from a psychologist, who also refers them to the HIV clinic in TUH. Few new diagnoses are reported through VCTs (exact number not reported) indicating that these are largely attended by low risk individuals. Staff at the Tirana clinic report around 50 patients self-refer themselves for testing each year. Interviews with VCT staff indicate that the majority of tests are conducted among persons as part of a visa requirement for work or study abroad. There is little outreach activities in relation to HIV testing.

VCT clinics are therefore currently underutilised. The location of the Tirana VCT clinic (the only clinic visited during the mission) within a government building is likely to deter those most in need of testing from attending. Partnerships with NGOs are essential to reach key populations at risk of HIV with specific focus on MSM, PWID and sex workers. Capacity building for outreach is important to reach key populations at risk of HIV, with specific focus on MSM, PWID and sex workers.

A redesign of VCT services is needed to better target and outreach to key populations and link them to friendly and integrated services is required. In addition to HIV testing, services should consider the provision of STI screening and sexual health, contraception services, social and legal advice and general medical care as well as outreach activities.

The location (and therefore accessibility) of the service as well as appropriate training of staff to ensure a non-judging and welcoming attitude is critical to its success. Integration of services would greatly benefit vulnerable persons with high health needs in addition to their risk of HIV infection. Increase partnership between public health and NGO services may be a suitable model for delivering integrated services. Provision of comprehensive sexual health care by trained and dedicated staff in a gay friendly environment is also recommended. HIV testing need not include lengthy pre-test counselling, nor use venous samples, both of which may be barriers for testing. Instead, a finger prick test can be under taken rapidly with limited training, and is much more accessible to key populations.

Use of media campaigns and promotions could increase awareness of HIV and promote the benefits of HIV testing. The European HIV testing week provides an excellent opportunity to offer HIV testing to key groups in partnership with NGOs. It is also vital to that patients found to be positive are actively followed up to ensure they reach treatment and care services and are provided with ongoing support.

### ***Provider led testing in clinical settings***

The current extent of provider-led testing in clinical services is unknown. Such an intervention is likely to be important given the high proportion of patients diagnosed at a late stage of HIV infection. While the TB strategy emphasises the importance of provider led screening among TB patients, no data are available on the uptake of testing in outpatient settings, including TB clinics.

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recommendation from healthcare providers who have established risk factors while interviewing a client/patient.

Adequate training as well as a cultural shift is needed to increase routine HIV testing among patients with HIV indicator diseases. Universal offer of a HIV by clinic staff could be piloted within respiratory, TB, and dermatological outpatients given that the most common AIDS defining illnesses are PCP, TB or Kaposi's sarcoma (informed by surveillance data). Patients diagnosed with viral hepatitis B and C should also be offered an HIV test as part of routine care. Training of health professionals is critical to the success of testing programmes in these setting. A sexual or drug history is not required during pre-test counselling. Increase provider led, routine offering of HIV test to in hospital setting

NGOs in contact with key populations including PWID and sex workers currently do not incorporate point of care testing as part of their services. Patients attending methadone maintenance treatment programmes (MMT) and needle and syringe exchange programmes (NSP) should routinely be offered an HIV test at least annually.

#### **4.2.3 HIV care and treatment**

##### ***Link to, and retention in HIV care***

HIV treatment and care have been available since mid-2004 through the inpatient and outpatient (established through global funds in 2007) units based at the TUH based in Tirana. Following a positive HIV diagnosis, patients are referred to a psychologist and referred to TUH for their HIV treatment and care. There is no active follow up of patients newly diagnosed who do not attend care – otherwise known as those who are lost to follow up (LTFU).

Since the epidemic began, 699 patients have been diagnosed with HIV in Albania. Of these, it is known that fewer than half (335 (48%)) are currently receiving treatment and 122 (17%) have died. While a number may be receiving HIV care but not treatment, there is no pre-ART register to monitor this. Therefore, 242 (35%) patients ever diagnosed with HIV remain unaccounted for in current monitoring systems. Once established in care and receiving treatment, clinic records are used to monitor retention in care. However, these data are not routinely reported. A representative from the PLWHIV association noted that co-ordination between paediatric and adult care for HIV was not optimal, with particular difficulties for adolescents transitioning to adult HIV care.

The relatively small size of the diagnosed population and the presence of only one treatment setting mean it should be feasible to follow up patients who are LTFU. This exercise is important to reduce mortality and morbidity. Factors that may be associated with LTFU in Albania may include financial and practical difficulties attending care (TUH is the only setting in Albania providing care) and consequences due to ART stock out. Strategies to address delays in enrolment and retention in HIV care should be developed. This could include developing systems of SMS reminders for appointments and active follow-up through involved peer support through NGOs.

Once in care, it is recommended that IPH and TUH work together monitor annual retention in care by patient residence and other important factors. It is recommended that the time between HIV diagnosis to the first CD4 count taken following diagnosis is routinely monitored for each HIV positive report. This will enable measurement of the extent of loss to follow up after diagnosis and will also inform whether an ambulatory HIV service for those residents outside of Tirana is required. Infrastructure to establish a clinical database for

patient care and transfer of data (e.g. CD4 and viral load information) to the national IPH is required to produce and monitor continuum of care indicators.

### ***HIV treatment***

HIV treatment and care have been available since mid-2004 through the inpatient and outpatient units based at the TUH. The number of people receiving ART has doubled in two years (from 161 in 2011 to 335 in 2014).

The Albanian national guidelines on ART are based on WHO 2004 guidelines<sup>1</sup> and recommendations of 2010<sup>2</sup>; national guidelines have not been updated since 2007. These guidelines indicate ART initiation based on CD4 counts (<350 cells/mm<sup>3</sup>) and other clinical criteria. Second line drugs are funded through The Global Fund continuation of services agreement. Of those receiving treatment in 2013 (316 adults and 19 children), 88 were receiving second line therapy. Table 1 outlines the number of patients receiving each ART regimen.

Table 1: Number of patients receiving ART by drug class and regimen, March 2014

Drug class	Drug regimen	Number receiving
NRTI	ZDR/3TC	191
	FTC/TDF	99
	TDF	18
	3TC	17
	ABC	6
	ddl	11
	ZDV	1
NNRTI	EFV	233
PI	LPV/r	80
	ATZ	3

It is important for Albania to review the current national ART guidelines to consider their continued relevance in light of the current WHO guidelines (3). This includes a review of the specific recommendations from WHO guidelines with regard to populations who should start ART regardless of CD4 count and those who should start ART with a CD4 count <500 cells/mm<sup>3</sup>.

### ***Procurement and supply management***

The current contractual process for pharmaceutical drugs is cumbersome, bureaucratic and time consuming for clinicians and hospital administrators. Patented pharmaceuticals for HIV treatment are deemed too expensive by the Ministry of Health. Generic drugs are available through a governmental contract with UNICEF. This is a cheaper solution and there are currently 10 ART regimens available at TUH which is in line with WHO consolidated guidelines on use of ARTs (3).

Stock-outs of ART are frequent particularly over the summer resulting in patients not receiving any treatment or switching of drugs regimens depending on drug availability. It is estimated that ART is not available for approximately three months of every year. An almost doubling in the numbers of persons requiring ARVs is expected in the next three years to >600 and with increased testing uptake, this is likely to be substantially higher. The new procurement system should have the ability for forecasting of drugs and diagnostic required.

ART stock outs and inflexibility of procurement specific regimens is likely to have contributed to patient deaths, particularly among those presenting late. ART stock outs also contribute to the relatively high proportion of patients currently on second line regimens which means prescribing decisions are based upon clinical indications only.

Finally, the lack the limited availability of ART means patients are prescribed with sometimes only one month drug supply. This means frequent attendance to TUH which will negatively impact on patients having to take time from work or those travelling from outside of the capital.

It is recommended that an advisory group is set up to improve the ART procurement and provision process. This group should be comprised of HIV clinicians, procurement personnel, ministry of health officials, Institute of Public health as well as representation from people living with HIV and AIDS. In addition to the review of current national ART guidelines against WHO guidelines (3), this group could also put forward international pressure for wider availability of generic drugs. The availability of CD4, viral load and drug resistance testing also seem to be associated with budgeting issues and would fit under the agenda of this group.

### ***Clinical monitoring***

Viral load and CD4 monitoring is not performed routinely due to shortages of kits, although according to interviews with staff, the situation is improving. This means that the proportion of patients adherent to ART and treated successfully cannot be measured. This is an important public health measure since such individuals have negligible risk of passing on their infection though sex. WHO guidelines indicate that patients should have viral loads and CD4 counts measured twice a year (3).

Drug resistance monitoring is not available. While WHO does not recommend drug resistance monitoring for countries with limited resources, guidelines indicate that virological failure should be used to inform decisions to switch to second line regimens (3). The absence of viral load information therefore has clinical consequences with ART regimen changes instead based upon clinical indications and drug availability.

HIV positive cases are not screened for TB because there is no PPD skin test available. TB is currently diagnosed through x-ray and other clinical indications.

#### **4.2.4 Harm reduction among PWID and prisoners**

Harm reduction (HR) is an important drug policy approach focusing not only on individuals but also on community health. It refers to policies and programmes aimed at reducing the harms associated by drug use, but not drug use per se (11). Key features of HR include: reducing the harm caused by drugs, rather than drug use; acceptance that drug consumption is an inevitable component of modern society and will never be eliminated; the priority is immediate realistic goals; harm reduction corresponds to basic values such as pragmatism and human rights concepts.

##### ***PWID***

Survey data indicate that 1% of PWID in Albania are living with HIV infection. Frequent injection is common with 44% reporting multiple injections daily. The levels of needle sharing and condomless sex are high, and could result in a major outbreak if HIV was introduced among this population.

HR programmes for PWIDs began in Albania in 1995. They are currently offered by four NGOs (Aksion Plus, APRAD, Stop AIDS and UKPR) operating in the field of drug demand and HIV/AIDS reduction with a clear focus on harm reduction activities, as well as by the public VCT Centres. Harm reduction responses are focused on NSP, MMT, peer education, information and counselling, basic medical support and psychosocial support.

NSP services are offered only in the capital Tirana through NGO facilities. Through such programmes, PWIDs are not only exchanging needles and syringes but also obtaining condoms, disinfectants, information and education materials, as well as social and psychological assistance. By the end of 2010, a total of 4050 IDUs had benefited from needle exchange programmes. The number of distributed syringes is about 175 per year, however these data only relate to attendees of NSPs and there is likely to be sufficient distribution across the country as a whole.

In 2011, survey data indicated that 62% of PWID had received treatment for their drug addiction. Of those receiving treatment, 86% were receiving MMT and 14% were under detoxification with other drugs. However, it is likely that the estimated proportion of PWID who had received treatment is biased towards people who had attended drug services.

The current average dose of methadone of 51mg/day is well below the recommended dose of 80-120 mg. There is a risk that clients may continue to inject drugs because of the low doses. NSP staff have anecdotally reported that clients who attend MMT in the morning return in the afternoon to use the syringe exchange facilities. It is recommended to undertake a study to measure retention and success in MMT.

There is a lack of recognition among medical professionals that opioid dependence is a chronic disease, and methadone is currently only prescribed by psychiatrists. Consideration should be given to training general practitioners and family doctors in this field. This will provide a more holistic approach to the medical care provided to clients. While psychological support is provided, medical help is limited and needs to be incorporated as part of the service.



Currently services are also missing opportunities for diagnoses of HIV and other blood borne viruses. Most MMT clients have not been tested for HIV and HCV, one of the reasons being that the misconception that available rapid tests require venipuncture which can be difficult for PWID. It is recommended that, as part of MMT services, clients are offered rapid finger prick tests for HIV and other BBV and are screened annually. Vaccination against hepatitis B for newborns has been available since 1994 and the IPH has offered vaccinations against hepatitis B to PWIDs free of charge since 2001, but the uptake is not known<sup>2</sup>.

Given ongoing police interference in drug treatment and prevention programmes, education and training for police officers to explain the importance of the HR approach.

### ***Prisoners***

Stop AIDS also offers harm reduction activities to prisoners in six prisons, focusing on information, counselling, peer education, HIV, syphilis, hepatitis B and C testing, training of medical and psycho-social personnel and provision of condoms.

There is limited prevention initiatives in Albanian prisons with fewer than 20 prisoners currently enrolled in MMT programmes. Since prisons have a zero tolerance drug policy, NSP are banned in prison settings.

However, the literature indicates that despite such policies, injecting drug use in prison setting is prevalent, with an estimate of between 3 and 53% of all inmates injecting at some point while incarcerated (12,13,14). While PWID do so less frequently in prison settings compared to community settings, HIV transmission risks are markedly elevated within prisons because a scarcity of injection equipment leads to increased high-risk sharing (15). This may in part contribute to findings that prior incarceration is independently associated with HIV infection (16).

The high documented rates of sharing of injecting equipment within prisons indicate the need for prison staff to be trained in harm reduction concepts and interventions. There is convincing evidence that NSP should be provided in prisons. It is also recommended to conduct a special study of prison population because without this a majority of public health issues remain unrecognized or underestimated (12).

#### **4.2.5 Social determinants and legislation**

The HIV and AIDS Act (2008) and the anti-discrimination act (2011) stipulate that PLWH have a right to privacy, normal education, health care, housing, and non-discriminatory relations in all aspects of their lives. While there is a strong legal protection for those living with HIV, the society for people living with HIV report high levels of HIV stigma with anecdotal evidence of challenges, and education and employment discrimination.

While Albania has anti-discrimination laws that relate to the LGBT society, it remains a hetero-normative society. LGBT are not visible in the media, and LGBT NGOs report high levels of stigma including verbal and physical abuse. It is likely that the high proportion of gay men reporting also being in sexual relationships with women, and the few reports of

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<sup>2</sup> <http://www.emcdda.europa.eu/publications/country-overviews/al#harm>

same sex contact at HIV diagnosis is in part due to actual and/or perceived homophobia in society.

Gay, bisexual and other MSM remain a hidden and stigmatized population in Albania. Despite strong anti-discrimination laws, anecdotal evidence suggests that MSM are likely to be victims of verbal or physical abuse. Consequently most MSM are not open about their sexual identity.

Despite a positive legal framework, stigma and discrimination of PLHIV and LGBT persons remains a major challenge in Albania. It is recommended to organize workshops and training of key staff and in particular those from the health care, police force and education sectors. Unless attitudes are challenged and changed, PLHIV and MSM will remain marginalized and isolated and at risk of ill-health.

Evidence suggests police interfere in treatment and prevention programmes. There is a new legislation about drug turnover and prevention activities, but still in action the Criminal Code, which allows police to harass PWID without reasonable cause.

There are very limited data relating to sex workers and sex work in Albania. Sex work is illegal and carries the risk of prosecution and custodial sentences for both sex workers and their clients. There are anecdotal reports of sex workers being imprisoned and beaten by police. It is thought that a disproportionate number of sex workers belong to Roma communities. No prevalence survey or outreach testing has been conducted in this group.

There is a large body of evidence showing the benefits of education on behaviour and improvement of health. Greater general awareness of HIV through education campaigns as well as comprehensive sex education programmes in schools is recommended. In line with WHO recommendations (3), Albania should focus efforts and resources to key populations.

## 5. Priority areas, recommendations and targets

We have set out five priority areas below, each with key recommendations and targets. The priority areas and recommendations were discussed at the AIDS coordination group meeting on the final day of the mission (see Appendix Two).

### **5.1 Priority area 1: Develop sustainable governmental political and financial commitment**

#### **5.1.1 Recommendations**

- Produce a national HIV strategy with full commitment from all parts of government, NGOs and PLHIV.
- This strategy should emphasize all aspects of HIV prevention, treatment and care and key populations most at risk of HIV and other STIs.
- The Global Fund application contains explicit reference to sustainability of programmes, both financially and politically.
- Contracts to be developed between government and Nongovernmental Organizations to improve access to, and content of, prevention services aimed at key populations.

### 5.1.2 Targets

- National HIV strategy published by end 2014.
- Contracts established for targeted HIV prevention between government and NGOs by 2015.

## 5.2 Priority area 2: Establish antenatal screening and increase access to HIV testing

### 5.2.1 Recommendations

- A universal antenatal screening programme should be implemented with urgency, including testing for HIV, hepatitis B/C and syphilis.
- HIV testing among most-at-risk populations should be scaled up.
- VCT services should be redesigned to:
  - target and outreach into key populations
  - provide gay-friendly services
  - use non-medical staff to offer tests
  - use rapid HIV testing using finger prick samples
  - and omit detailed pre-test counselling process
  - ensure people tested positive are actively followed up to HIV treatment and care services, ensuring support where needed
- Provider led, routine HIV testing among patients with HIV indicator diseases should be increased, with HIV tests offered for patients presenting with AIDS defining illnesses.
- Provide integrated STI screening and other sexual health services within HIV-related services (e.g. VCT clinics, methadone and needle exchange programmes).

### 5.2.2 Targets

- 90% of pregnant women to be offered and tested for HIV by end 2016.
- 50% of VCT clinics to contain an outreach component of their programme by end 2016.
- 100% of VCT clinics to use finger prick rapid HIV testing by end 2015.
- 90% of PWID and SW clients to be offered and have an HIV test annually by end 2016.
- 90% of patients with clinical symptoms of AIDS defining illness (e.g. TB, Pneumocystis pneumonia, etc.) to be offered and tested for HIV by end of 2016.
- 90% of patients with viral hepatitis B and C to be offered and tested for HIV by end 2016.
- Reduce late diagnoses rates by 50% by 2016.

### **5.3 Priority area 3: Develop an effective HIV treatment and care programme**

#### **5.3.1 Recommendations**

- Introduce strategies to address delays in enrolment and retention in HIV care and ART.
- Provide IT infrastructure and establish a clinical database which also allows or transfer of epidemiological and quality of care indicators (e.g. CD4 and viral load information) to the national Institute of Public Health.
- Ensure monitoring of patient CD4, and viral load testing is available for each patient twice a year.
- Introduce screening for TB for patients diagnosed with HIV.
- Provide better integrated care for children and adolescents living with HIV and their transition into adult care.
- Establish an advisory group to oversee procurement and provision of ART and laboratory tests (CD4 and viral load).
- Review the current ART treatment guidelines to ensure they are consistent with WHO guidelines. This includes specific recommendations for those who should start ART <500 cells and those who should commence treatment regardless of ART.
- Introduce a procurement system with a formalized methodology for forecasting.

#### **5.3.2 Targets**

- 90% of patients diagnosed with HIV to be established in HIV care within three months of diagnosis by 2016.
- 90% of diagnosed and eligible for ART patients provide ART.
- 90% of persons with opportunistic infections to receive free and prompt treatment.
- For national ART guidelines to be reviewed against WHO treatment guidelines by end 2015.
- 0% stock outs by 2016.
- All patients to have CD4 test at time of HIV diagnosis and two CD4 and viral load counts each year.
- 80% of patients receiving ART for at least 12 months to be virally suppressed.

### **5.4 Priority area 4: Review and improve access to and scope of harm reduction services**

#### ***Recommendations***

- Offer and recommend a test for HIV and hepatitis B and C on entry and every year.
- Review and consider raising the methadone dose from an average of 51 mg/day to 80-120 mg/day.
- Implement routine monitoring of retention and outcomes for MMT. Provide training of methadone management to a wider range of health professionals.
- Provide training to prison staff on harm reduction interventions.

- Provide access to basic medical care and psychological support at MMT and needle exchange clinics.
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### ***Targets***

- 90% of MMT clients to be tested for HIV and hepatitis on entry to services.
- Conduct review of methadone prescribing to ensure clients are on optimal dosing by end 2015.

## **5.5 Priority area 5: Develop friendly and non-judgemental services and reduce perceived HIV stigma and homophobia**

### ***Recommendations***

- Seek technical support in order to develop supportive and non-judging services for key populations.
- Design and deliver workshops and training of key staff (health care, police and education) on HIV and LGBT awareness.
- Design and hold workshops to help create enabling environments and increase capacity to deliver HIV prevention programmes and services to key populations (SW, PWID, MSM).
- Generate greater awareness of HIV through education campaigns in addition to comprehensive sex education programmes in schools.

### ***Suggested targets***

- Run series of workshops with key staff by end 2015;
- Plan and redesign of HIV services (VCT, MMT etc.) to ensure they are friendly and non-judgemental by 2016.

# Appendix One: Terms of Reference

WORLD HEALTH ORGANIZATION

REGIONAL OFFICE FOR EUROPE



ORGANISATION MONDIALE DE LA SANTÉ

BUREAU RÉGIONAL DE L'EUROPE

WELTGESUNDHEITSORGANISATION

REGIONALBÜRO FÜR EUROPA

ВСЕМИРНАЯ ОРГАНИЗАЦИЯ ЗДРАВООХРАНЕНИЯ

ЕВРОПЕЙСКОЕ РЕГИОНАЛЬНОЕ БЮРО

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## Evaluation of the HIV programmes in Albania

**7-11 September 2014**

### **1. Background**

Albania has a growing HIV epidemic. By the end of 2012, Albania reported a cumulative total of 577 HIV cases to the joint database of the WHO Regional Office for Europe and the European Centre for Disease Prevention and Control (ECDC). The rate of newly diagnosed HIV infections in 2012 was 2.9 per 100 000 population; the rate has steadily increased since 2006 when it was 1.0 per 100 000 population. The majority of new HIV cases in 2012 were male (70%). Among the newly diagnosed HIV cases there are only 25,6% with information about transmission mode which implies a possible gap in surveillance. Among the general population, HIV testing coverage is low; in 2011 only 2 590 people were tested. Only 2% of Albanian health facilities offered HIV testing services. Undiagnosed HIV is a major issue to achieving the individual and public health benefits of ART. Some 335 people were receiving ART in 2013. Concerns may exist regarding different treatment regimens, national ARV supplies and a range of antiretrovirals used in Albania. Despite its currently low HIV prevalence, considering existing gaps and challenges in the healthcare system, Albania is at a high risk for an expanding epidemic in the region.

Country's response to the HIV epidemic is supported by the Global Fund (TGF) grant and the country is reliant on TGF in covering cost of HIV treatment. The country is in the process of preparing an application for an HIV grant which requires external technical support in terms of reviewing the current situation and aligning with the WHO guidelines and recommendations.

WHO and the Global Fund have Cooperative Agreement regarding the provision of WHO technical assistance to applicants to the Global Fund prior to submission of their concept notes. The contract is effective during period from 1 January 2014 until 31 December 2015.

Technical assistance is organized through external consultants and based on discussions with the countries and the Global Fund Portfolio Managers and formal Country Requests.

Albania is eligible for the Global Fund grant county to support both national programmes on Tuberculosis and on HIV/AIDS. The country requested the WHO Regional Office to provide technical assistance on in both HIV/AIDS programme.

## **2. Objectives of the mission**

The WHO country mission will evaluate the HIV treatment and care program in Albania along the cascade of care and services and will provide recommendations on: standardisation of treatment regimens (including use of fixed dose combinations); reducing the number of different regimens/ARVs; standardising diagnostic and treatment monitoring algorithms; optimization of the HIV grant from the public health perspective so to ensure alignment of the proposal with the WHO recommendations and high coverage with services for those who need them.

The following key technical areas will be evaluated:

- Population groups that are at an increased risk to acquire HIV and needs of these key population groups
- HIV services for key populations (PWID, MSM, CSW, other): special focus on HIV prevention and diagnosis among MSM and their partners; needle and syringe program, drug dependency treatment, ART access, penitentiaries, community outreach including HIV testing, ARV dispense, case management/social support
- HIV testing and counselling, including community-based testing for key populations and linkage to HIV treatment and care services, routine provider-initiated counselling and testing (PICT), informed consent, CD4 count at time of diagnosis
- Early HIV diagnosis, MTCT and paediatric ART
- Enrolment and retention in HIV care, including general HIV care, management of co-infections and co-morbidities, integration of HIV/Viral hepatitis, HIV/TB, HIV/OST services
- Access to and coverage with HIV treatment and care services for key populations: IDUs, MSM, CSW
- ART: estimated need and coverage, criteria for ART initiation, retention and adherence
- ART regimens – ways to optimize and minimize number of regimens for TGF application
- ARV prices, procurements and supply chain
- Monitoring of ART response: Viral load, ARV toxicity, HIVDR – ways to optimize clinical/laboratory management and cost for TGF application
- HIV/TB collaborative activities and services integration in the overall healthcare system
- National HIV strategy
- National HIV treatment and care guidelines

- National VCT policies
- Compliance of approaches and recommendations with the main WHO recommendations, i.e. 'Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection' 2013<sup>3</sup> and 'Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations' 2014<sup>4</sup> will be ensured.

The programme evaluation mission is expected to:

- Review and suggest recommendations for updating the current national HIV treatment guidelines, including possibility to rationalize existing patient regimens and support improved drug forecasting and supply chain management;
- Conduct an overall analysis of the current HIV situation in Albania and subsequently conduct a program review;
- Provide feedback and comments on the national counterparts on primary findings during the mission and assure comments and suggestions on the national strategy

### **3. Participants**

- Valerie Delpech, Public Health England (lead consultant on mission)
- Alison Brown, Public Health England (consultant on mission)
- Sergey Dvoryak, Harm Reduction expert, Head of the Board, Ukrainian Institute on Public Health Policy, IAS Governing Council Member, European region (consultant on mission)

### **4. Methodology**

Readily available information will be withdrawn from the secondary sources (publications, reports, etc.) during preparation stage, the mission and after the mission for desk review and analysis.

During the country mission WHO expert will visit relevant institutions and facilities and discuss with key informants: policy makers, health care providers and beneficiaries, NGOs, other national partners where appropriate. Together with local clinical experts they will also have access to medical records of PLHIV for a review of clinical management of PLHIV.

Logistic support will be provided by the WHO and national health authorities.

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<sup>3</sup> <http://www.who.int/hiv/pub/guidelines/arv2013/download/en/>

<sup>4</sup> <http://www.who.int/hiv/pub/guidelines/keypopulations/en/>



## **5. Time, duration and geographical sites of the mission**

Mission is planned for 7-11 September 2014. Additional days are added for consultancy assignment for national and background documents desk review (2 days), analysis and report writing (5 days).

## **6. Deliverables**

Major findings and recommendations will be shared with the national counterparts and TGF principal recipient by the end of the mission. During the mission a specific concluding meeting will be organized and focused on presenting and discussing with the local counterparts the immediate feedback and recommendations as a result of initial evaluation.

As a result of the mission a report with findings and recommendations on improving the national treatment and care programme and optimization of HIV grant application will be prepared and submitted in September 2014.

Subsequent to the mission and first submission, on request, the report has been split into two separate reports; one outlining the HIV epidemic and the other outlining the programmatic response to HIV. Both make recommendations that will inform The Global Fund application.

The reports will be posted on the WHO EURO web site.

## Appendix Two: Summary of meetings

**WHO Regional Office for Europe**

**Mission to Albania**

**HIV programme evaluation**

**8-12 September, 2014**

**September 8, 2014**

**9.00-10.00 Meeting with representatives of the Ministry of Health**

Dr Gazmend Bejtja- Director, Health Care Department  
Dr Roland Bani

**11.00-13.00 Meeting with the Department of Infectious Diseases at University Hospital Centre**

Topics: HIV testing, counselling, treatment and care including national and Global Fund supported programs; national HIV programme framework, including surveillance, prevention, PMTCT, co-infections, referrals, clinical reporting system; national funding for HIV programs in the country, HIV prevention, treatment and care interventions in the context of Global Fund support.

Dr Silvia Bino

Dr Roland Bani

Dr Marjeta Dervishi

**14.00-17.00 Meeting with the National Institute of Public Health**

Topics: HIV prevention, treatment and care system, national guidelines on prevention, treatment and care, national surveillance protocols, national studies and additional surveys conducted to monitor the overall situation in the country, ART monitoring. The meeting will identify national level interventions and discuss examples from country's sites/districts (if any).

Dr Roland Bani,

Dr. Marjeta Dervishi

## **9 September 2014**

**10.00-12.00 Meeting with representatives from local organizations implementing HIV prevention, treatment and care activities with focus on key populations**

Aksion Plus

STOP AIDS

PLWHIVA association

**13.00-14.00 Observers in the national AIDS advisory group meeting to discuss The Global Fund application**

**15.00-17.00 Site visit to Department of Infectious Diseases at University Hospital Center**

Facility assessment: provision of services, quality of provided services, coverage, health status and procurement of ART

- Dr Arjan Harxhi
- Dr Daniela Nika, Vice Director, Anilinda Pogoj, Liridan Cake (procurement team, Tirana University Hospital)

## **10 September 2014**

**9.00-10.00 Site visit to Tirana VCT centre**

-Ermelinda Murati, Chief epidemiologist

- Ina Gishto, psychologist

**10.13:00 Site visits to NGO to assess prevention and MMT programmes, including interviews with sex workers/PWIDs.**

-Arian Bocci

- Dr Pasho Maksuti

- and other representatives and clients of Aksion Plus (an NGO providing NSP)

**13.00 – 17.00 Meeting with IPH and technical advisor for the Global Fund to discuss preliminary findings and The Global Fund Application**

- Dr Roland Bani

- Dr Roger Drew

**11 September 2014**

**10.00-11.00 Meeting with representative**

- ALGA (Albanian lesbian gay association)

**12.00 – 13.00 Meeting with CCM**

**Concluding meeting with all national counterparts, including representatives of the Ministry of Health, CCM, National Institute of Public Health, Department of Infectious Diseases at University Hospital Center, other leading national entities and community representatives**

Topic: National HIV programme in light of the Global Fund grant application.

Debriefing for national counterparts included inputs on the current situation, discussion on identified possible gaps and recommendations on next steps, agreement on follow up actions within the technical assistance

## Appendix Three: Presentation given to the country co-ordinating team on day four.

### WHO Consultancy

Dr Valerie Delpech, Dr Šergij Đvoriak  
Dr Alison Brown

### Strengths of HIV response in Albania

- Remains a low HIV prevalence country
- Established IDU and VCT programmes and good clinical management
- Data collection system in place and epidemiological expertise
- Active and committed NGOs
- Free ARV available and health care available free for most people
- Law on HIV and AIDS (2008) and anti-discrimination law (2010)

### Challenges and recommendations 1

- **Concern to see high increase in new cases**
- **Governmental commitment (financial and engagement)**
  - a) Financial commitment and spending transparency
  - b) Commitment to sustainable programmes
  - c) Partnerships with NGOs (VCT, key groups and MMC)

### Recommendations 2

- **HIV testing and screening**
  - a) Universal antenatal testing
  - b) Testing for respiratory, TB, dermatology & other relevant clinical conditions
  - c) Point of care HIV testing using finger prick
  - d) Annual testing of MMC clients
  - e) Capacity building for outreach HIV testing (focus on MSM, sex workers, and PWID)
  - f) Use of campaigns (e.g. media and HIV testing week aimed at key groups)

### Recommendations 3

- **Care and treatment for people living with HIV**
  - a) Strategies to improve link to care pathway
  - b) Stock out of ARV
    - i) advisory group to improve ARV access
    - ii) International pressure for generic drug availability
  - c) Availability of CD4, VL, and drug resistance testing
  - d) Development of clinical database to better track quality of care

### Recommendations 4

- **HIV surveillance, monitoring and evaluation**
  - a) Epidemiological follow-up of new cases
  - b) Measurement of undiagnosed infection
  - c) Prevalence rates among key groups (ANC, blood donors, VCT, MSM, MMC, sex workers)
  - d) Develop measures of quality of care (e.g. continuum of care, mortality rates)
  - E) Development of databases and linkable to HIV clinical data, HIV testing and MMC

### Recommendations 5

- **People who inject drugs**
  - a) Review methadone prescribing policy and quality of treatment
  - b) Develop referral pathway
  - c) Routine HIV testing on entry and thereafter, annually
  - d) Strengthen needle/syringe exchange provision
  - e) Outreach to police for training and awareness
  - f) Effectiveness evaluation
- **Prisons:**
  - a) Syringe, condoms provision
  - b) Improved harm reduction
  - c) Better understanding of population
  - d) Communication with public health system

### Recommendations 6

- **Greater engagement of key populations**
  - A) MSM
  - B) Sex workers
- **For both**
  - Partnership with NGOs
  - Outreach and Education
  - Welcoming, client focussed services
  - Sexual health screens and HIV testing

### Recommendations 6

- **Stigma & discrimination (HIV and homophobia)**
  - a) Workshop and Training of key staff (e.g. Healthcare, police and education)
  - b) Work with media to ensure positive messages, including champions
  - c) Comprehensive sex education

### Recommendations 8

- **Strengthening and integration of health care facilities:**
  - a) Friendly, welcoming services which meet wider needs of key populations
  - b) Increase partnership between public health and NGO services
  - c) Training for health care workers

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