

Lessons from COVID-19

to reshape a sustainable response to HIV, TB and HCV among inadequately served populations in the countries of Eastern Europe and Central Asia

May 2020

Introduction

As a result of the COVID-19 pandemic, health systems around the world have to become more robust, flexible, and results-oriented. Changes have been made in the approach that some health systems have taken to the delivery of a range of services, including interventions for the management of HIV and opioid dependence as well as the treatment of tuberculosis (TB) and viral hepatitis C (HCV) among key population groups. Many of these changes have been welcomed by communities, with a window of opportunity to revisit and refresh issues of drug use regulations, policing, amnesty for people in prisons and other closed settings.

In early May 2020, a webinar was held on YouTube (in English) and simultaneously on Facebook (in Russian) by the Sustainability of Services (SoS) Project of the Alliance for Public Health (APH) funded by the Global Fund to Fight AIDS, TB and Malaria¹, that brought together experts to consider opportunities to improve the sustainability of HIV programmes for key populations in 14 countries of

Eastern Europe and Central Asia (EECA) as a result of the response to the COVID-19 pandemic. Presenters included Volodymyr Kurpita, a regional expert on public health and HIV/AIDS based in Ukraine; Fifa Rahman, a specialist in International Trade/Intellectual Property Law and a UNAIDS Board Member for NGOs; Anton Basenko, a regional expert on drug policy, community, gender and human rights with the Alliance for Public Health; and Niamh Eastwood, the Executive Director of Release, the British centre of expertise on drugs and drug law; the session was moderated by Andriy Klepikov, the Executive Director of the Alliance for Public Health and a member of the Global Fund Board for the Developing Countries NGO Delegation. The online event considered which developments should be retained and promoted as countries pass through the peak of the epidemic and grow accustomed to the presence of the virus at a more manageable level. Specifically, how recent actions at global and national levels in response to COVID-19 have provided opportunities to increase access to medicines and services, the role of human rights within health systems, and how to build upon the newly emerging good practices.

Reshaping of healthcare systems in response to COVID-19

Health systems can be defined in various ways and can involve organisations, institutions, and resources that are devoted to producing health actions. WHO highlights four key functions of a health system that includes stewardship (often referred to as governance or oversight), financing, human and physical resources, and the organisation and management of service delivery².

The timeframe from the outbreak of COVID-19 to it being declared a pandemic by WHO was very short (*Figure 1*), giving the health sector in those countries initially faced with the new coronavirus very little time to prepare and to organise their respective responses.

The health sector has been faced with a number of specific challenges that included the need to make fast decisions based on access to, and the level of confidence in, data shared by other countries; this is akin to the well-known adage of ‘know your epidemic’, as has been used in the HIV response.

National health systems have had to rapidly enable surge capacity in hospitals and, for many, to try to acquire mechanical ventilators at extremely short notice. As more was learned about the virus, health systems sought to access modern pharmaceuticals in a bid to find therapeutic treatment approaches. The impact of the epidemic on different population groups has raised issues around the ethics and equity of access to health interventions and the social determinants of health, particularly due to the economic impact brought about by the need to socially distance and the resultant high levels of job losses among lower paid people in the service and manual labour sectors in many countries.

- 1. Effective communication by governments is crucial in a crisis to prepare the public for what is likely to occur, using a ‘whole of society’ approach to elicit population-level involvement in the response.** In most countries, evidence-based strategies rapidly became paramount rather than political expediency. Budget allocation, health standards/infection control, regulation of pharmaceuticals, procurement strategies and the protection of information all became critical areas of attention for governments.

Figure 1: *Timeline of the rapid development of the COVID-19 pandemic*



2. Release of emergency funds is critical. In many countries, initial responses were funded from existing budgets followed by emergency regulations to increase funding and in earmarking interventions to focus on COVID-19; this is similar to the initial response to HIV. The timely release of funds to frontline services has become paramount, with expenditure procedures relaxed and a balance struck between flexibility and accountability using a risk-based approach that can be of great benefit in response to any disease.

3. Global communication and advice is an important source for national informed decisions. WHO has taken the leading global role in updating guidelines with a lower threshold used for recommendations as speed has trumped perfection owing to the relative lack of time to study this new virus. Many efforts are being made to investigate potential therapies and the “off-label” use of some medications. The urgent need to acquire equipment, such as mechanical ventilators, and consumables, especially personal protective equipment (PPE), has seen the centralisation of procurement by governments and the recognition of the need for high quality management of international supply chains, including the application of minimum quality standards. Coordination of such procurement has also been seen, such as by the European Union, which is a recognition that no one country can tackle such a health crisis alone. This is also reflected in the relatively open access to data between countries and the role played by the public in providing oversight of the response to such a health crisis and in being willing to raise the alarm when frontline workers lack the means to protect themselves or to administer aid to patients.

4. The use of information technology (IT) as a means to monitor and protect the public from COVID-19 has been a notable development in countries of East and South-East Asia, such as China, Singapore and South Korea, who experienced similar public health emergencies in the recent past, including Severe Acute Respiratory Syndrome (SARS). For some people,

privacy equates with secrecy, as was the initial response to HIV. But in the world of COVID-19, an increasing number of societies are, in general, having to accept the exchange of privacy for health security, raising questions over individual human rights and the demands of a public health approach marshalled by politicians through cover of medical and scientific expert advice.

Building on the increased availability of, and access to, diagnostics and medicines

As the magnitude of the COVID-19 emergency became apparent, WHO urged its member states to respond rapidly. On 13 March 2020, Dr. Michael Ryan, the Executive Director of the WHO Health Emergencies Programme, told a global press conference,

“Perfection is the enemy of the good when it comes to emergency management. Speed trumps perfection and the problem in society we have at the moment is everyone is afraid of making a mistake, everyone is afraid of the consequence of error. But the greatest error is not to move, the greatest error is to be paralysed by the fear of failure...”³

This eluded to the relative lack of evidence in which to respond during the early stages of the outbreak. Those countries that responded rapidly, such as China, Malaysia, and South Korea, fared far better than those who did not. For example, Malaysia has, thus far, suffered fewer than 200 deaths from COVID-19 even though it has strong trading and tourism links with China. This relatively limited impact from the coronavirus was due to the rapid building of surge capacity in its health service, including the very fast renovation of hospitals in February 2020 and the procurement of diagnostic testing equipment from a diverse range of suppliers together with contact tracing implemented from the very beginning of the emergency.

Even with very limited evidence around treatment efficacy, profiteering by pharmaceutical companies

has been evident. For example, on 29 April 2020 it was reported that Remdesivir – a broad-spectrum antiviral medication developed by Gilead Sciences for the treatment of HCV – had the potential to treat severe cases of COVID-19. However, the research findings from the first trial of the drug in China that involved less than 300 people, noted that “remdesivir was not associated with statistically significant clinical benefits” although it did result in “the numerical reduction in time to clinical improvement in those treated earlier”⁴. Some pharmaceutical companies’ stock market value rose 20% compared to the start of 2020 with questions raised as to whether, or to what extent, such companies should be allowed to profit from the COVID-19 pandemic⁵.

5. New global mechanisms are needed to prevent local stock outs. Stockouts in hospitals and delays in the supply chain for the most sought-after equipment, medicines and consumables resulted in higher prices and, in some cases, lower quality of items received. To increase access to such items, there is an increasing global consensus on intellectual property solutions, reflected in the Coronavirus Global Response pledging event on 4 May 2020 that sought to gather significant funding to ensure the collaborative development and universal deployment of diagnostics, treatments and vaccines against coronavirus⁶, or what the UN Secretary-General has called ‘global public goods’ that need to be protected and enhanced⁷.

6. Revision of patent rights should be considered to respond to emergencies. Countries have demonstrated that they are willing to take the necessary steps to ensure more equitable access to medicines in particular. For example, it is reported that AbbVie, a US-based drug maker, dropped its patent rights for Lopinavir/Ritonavir (sold under the brand name Kaletra) after Israel took steps to issue a compulsory licence for the drug combination’s use against coronavirus; this development could also make the drugs more available to people living with HIV elsewhere in the world⁸.

A further aspect of the potential development of global public goods is the proposal from the Cos-

ta Rican President and the Health Minister to the WHO Director-General suggesting that a repository of information be created on diagnostic tests, devices, medication or vaccines to combat COVID-19, with free access or licensing on reasonable and affordable terms in all WHO member states⁹. Such efforts are also supported by UNITAID and related agencies such as the Medicines Patent Pool, building a groundswell of support for truly equitable access to disease prevention, care and treatment diagnostics, medicines and future vaccines.

7. Reprogramming available international aid to support COVID-19. Reprioritisation and reprogramming by many bi- and multi-lateral agencies is also taking place to address the challenges presented by COVID-19. Global Fund has allocated USD 1 Billion through reprogramming and new mechanism [C19RM](#). UNITAID has allowed ITPC to use its existing grant for the COVID-19 response in support of people living with HIV. However, there are concerns that previous funding for HIV, TB and HCV in regions such as the EECA will be negatively impacted by efforts to counter the coronavirus. And yet there are also opportunities to build on the COVID-19 responses in support of all communicable disease prevention, care and treatment programmes, including cheaper medicines and diagnostics, and more stable and affordable international supply chains.

Reshaping models of HIV, TB and HCV service provision for key populations

8. Revision and simplification of service delivery modalities for the benefit of patients. Key WHO guidance to reduce community transmission of COVID-19 includes self-isolation at home for those with minor symptoms and, more generally, avoiding contact with other people through social distancing¹⁰. Complying with such public health direction has required a rethinking

and simplification of service delivery models for the prevention, care and treatment of communicable diseases, including HIV, TB and HCV, among key populations who, due to a usually lower immunity than the general population and a higher prevalence of co- and multi-morbidities, are at greater risk of contracting, and dying from, coronavirus. Prior to COVID-19, such services in countries of the EECA region involved waiting in often crowded rooms during regular visits to health centres and/or hospitals. Such legacy service modalities are dangerous within the context of breaking the transmission of COVID-19.

Consequently, increased flexibility has been seen across the region in how regulations are implemented, with some jurisdictions demonstrating how more progressive approaches to service delivery can be both cost-effective, efficient and in accordance with a greater role for the individual in deciding how they wish to access and receive such services.

Some notable service delivery modalities resulting from COVID-19 include:

- The use of **syringe vending machines (SVMs)** that remove the need for face-to-face, close contact with people distributing sterile injecting equipment. A recent survey of people who inject drugs (PWID) who had made use of SVMs in Tbilisi, Georgia, found that virtually all respondents were in favour of this approach because: it was a free service; provided uninterrupted 24/7 access; maintained the individual's privacy and anonymity; it removed the need to interact with pharmacies, an aspect of legacy NSPs that has a negative connotation for some users; SVMs can cover geographic areas where fixed or mobile NSPs do not operate; require very limited human resource support, thereby reducing overhead and transactional costs of running the service; and over three-quarters of PWID using the SVMs had never before received any harm reduction services, including younger PWID and women who use drugs¹¹.

However, the specific location of a SVM needs to take into account potential negative views of the local community.

This approach is already in place in some West European countries as well as in Canada and is particularly useful in removing the potential threat of exposure to people with COVID-19. It also allows PWID to access as many safe injecting supplies and related paraphernalia as they require, thereby not being limited to quotas forced upon them by external actors and further expanding the coverage and reach of key HIV and HCV prevention efforts.

- **eHealth and online consultations** with service providers, including doctors, and communication through email and social media, have become the main method of supporting key populations in various countries of the EECA and South Eastern Europe (SEE). Such eHealth approaches remove the need to leave home to consult with health and social service providers, removing travel time and costs, improving patient adherence to appointments, as well as avoiding potential contact with people infected with COVID-19. Since the start of 2020, online counselling in Bosnia and Herzegovina has increased by 70% and in Georgia, more than 700 consultations with people from key populations have been conducted in the first half of 2020. In Ukraine, the national hotline on Opioid Substitution Therapy (OST) and drug use has seen a 50% increase in the number of calls¹². There is increasing potential for key populations to use such eHealth options in Ukraine and other countries such as North Macedonia, and Serbia¹³.
- **HIV self-testing** is not new, per se, in many countries of Western Europe, for example, but is a new reality in countries of the EECA due to restrictions imposed to reduce transmission of COVID-19. It is a cost-effective approach by reducing travel time and related costs to the individual and is not dependent upon the

opening times of HIV test facilities. In Georgia and Kazakhstan, for example, at least 150 clients have received HIV self-testing by mail or courier as a pilot initiative. The wide scale introduction of HIV test vending machines, similar to those used for sterile injecting equipment, could considerably increase the number of HIV self-tests conducted and would be readily accessible by key population groups.

- Restrictions on movement in many EECA countries has greatly contributed to making **ART (Antiretroviral therapy) home delivery** a reality. It is a cost-effective approach by eliminating travel time and costs and does not rely upon the opening times of health facilities or pharmacies. In 6 regions of Ukraine, a NGO arranges delivery of ART by mail. In Georgia, ART home delivery has increased by 70% since the beginning of 2020 and by 50% in North Macedonia¹⁴. Every person who requires ART in Kazakhstan is ensured home delivery of their medication due to travel restrictions imposed by the response to COVID-19, and where people living with HIV are not at home but residing elsewhere in the country, an online service for temporary registration is available. Courier services are also used for home delivery of ART in Moldova and in parts of Russia.

In addition, the volume of ART prescribed at one time has increased in many countries of the EECA because of COVID-19 restrictions on movement. Prior to the onset of the pandemic, ART medications were given for between one and three months, but supplies for three months are now provided in Kyrgyzstan and for between 4 and 6 months in Ukraine, with some regions providing ART for up to 9 months. The approach to dispensing of TB medications has also evolved, with up to 2 weeks supply provided at one time in Georgia, Kyrgyzstan and Ukraine, with a similar approach being adopted in some places for HCV treatment¹⁵.

- **Take-Home OST medication** has expanded considerably since the emergence of COVID-19. For example, the supply of medication

has increased from 2 days to 4 days in Moldova and Estonia; up to 5 days supply in Kyrgyzstan; from 5 to 7 days in Georgia and Lithuania; and for up to 14 days in Romania. Take-home OST was already available in Moldova and Ukraine for a limited number of clients, but its availability has now increased which is a very positive development for a considerably larger number of OST clients. In Ukraine, there were 13,000 OST clients as of 1 April 2020 with up to half receiving take-home medication for up to 10 days each before the onset of COVID-19. By the end of April 2020, around 90% of all OST clients in the country were receiving between 10 and 15 days of take-home medication, with one region prescribing up to 30 days supply. In addition, OST clients can access counselling remotely and OST sites have optimised their working hours to comply with social distancing requirements due to COVID-19¹⁶.

Public health and human rights in a COVID-19 world

The COVID-19 pandemic has provided opportunities for a new understanding of, and the need for reforms to, the global health system and drug control policy.

9. COVID-19 has galvanised a public health response, almost completely free of law enforcement involvement. A similar health-led approach has been advocated by many stakeholders for some years. **Decriminalisation and programmes to divert people who use drugs from the criminal justice to the public health sector** have shown very positive outcomes, such as in Portugal and Australia. As the stark economic fallout from COVID-19 becomes apparent, there are many economic arguments for an increasing number of countries to decriminalise the possession and use of drugs, with political arguments often underpinned by their economic costs or savings. Experience from countries including the Czech Republic, Spain

and Italy highlights how the decriminalisation of drug use and possession results in a considerable reduction in the cost of law enforcement. Decriminalisation in Portugal has seen a 18% saving in social costs that includes a reduced drain on resources of the police and courts over the past decade¹⁷.

10. Reducing the number of people incarcerated

has also been an approach used by some countries to counter the transmission of COVID-19. Globally, of all those incarcerated for drug related crimes 83% have been convicted for drug use and/or possession. This has been the case in various countries of Asia and some in Africa. A big part of the prison population has been locked up for low level offending and could be freed. For example, 25,000 prisoners were released in Myanmar in response to COVID-19, equating to around one-quarter of all incarcerated people in that country. However, far fewer prisoner releases have been seen in Europe¹⁸.

11. Before the onset of COVID-19, one-in-three of all drug-related deaths in Europe occurred in the UK, especially through the use of opioids. The number of opioid-related overdose deaths in the UK has been at a record high for the past 7 years in a row. There will be a catastrophic increase in such deaths if fentanyl and its analogues become more prevalent in the UK, especially in Scotland. Consequently, monitoring of drug use is being undertaken. **In response to COVID-19, ‘essential journey cards’ have been developed and distributed to PWUD** for when they need to leave their house to pick up medication or harm reduction equipment, or both, and to thereby ensure that the journey is treated as an essential one as outlined in Government rules during the coronavirus; such a card can be useful in an attempt to avoid unlawful detention by police¹⁹ and could be applied to many other countries.

COVID-19 has raised the issue of a patient/client-centred and driven response to drug use and possession as well as to the provision of health and social services. Reducing transaction costs of every

intervention will likely be paramount as the burden of debt rapidly increases for most countries as a result of COVID-19. Consequently, an opportunity now exists to embed the rights of the individual to decide upon their own actions related to drug use and the way in which they wish to interact with harm reduction, drug treatment and related health and social services.

Practical Recommendations

HIV, TB and HCV services in each country of Eastern Europe and Central Asia must mainstream a patient/client-centred approach - in the form of revised systems, guidelines and standard operating procedures – based on the positive changes resulting from the COVID-19 pandemic that facilitates greater coverage and quality of interventions for key populations, including:

1. Open access to data within and between countries and the crucial monitoring role played by the public in providing oversight of health and related social responses and in being willing to raise the alarm when frontline workers lack the means to protect themselves or to administer evidence-based services to patients/clients;
2. Global communication and advice from trusted sources, such as the World Health Organization, to provide evidence-based guidance for national authorities to make informed decisions;
3. The need for high quality management and coordination of international supply chains, including the application of minimum quality standards;
4. The release of patent regulations to respond to the urgent need of patients/clients; some countries have demonstrated that they are willing to take the necessary steps to ensure more equitable access to diagnostic equipment and medicines;
5. Revision and simplification of service delivery modalities for the benefit of patients/clients including:

- a) The rapid expansion in the availability of vending machines in appropriate community locations to supplement the provision of harm reduction consumables and diagnostics;
 - b) Online and telephone consultations with doctors and nurses as a standard approach for all;
 - c) Online and telephone ordering of diagnostics and medications;
 - d) The expansion in the availability of home delivery of diagnostics and medications by post or courier services throughout the country; and,
 - e) Allow online and telephone applications for temporary residency to allow receipt of diagnostics and medication by individuals away from their official, registered address;
6. Increase the quantity of medications prescribed to enable an individual to receive enough supply for a minimum of one month, including OST for those people who have achieved a stable maintenance dose;
 7. Provision of online counselling services, both one-on-one and group counselling, with special attention to the needs of females and individuals who recognise themselves as lesbian, gay, bisexual, transgender, queer/questioning, intersex, and asexual (LGBTQI);
 8. Increase the number, and comprehensiveness, of contracts between the Ministry of Health (and associated institutions) and NGOs and CBOs delivering services to inadequately served populations across the country, including to rural areas not currently served by harm reduction approaches;
 9. Assess the economic benefits of these new approaches for the delivery of HIV, TB and HCV services and use the findings to advocate with senior government decision-makers at a time of reduced budgets for health;
 10. Provide an amnesty for all those in prison and other closed settings for drug use and possession of small quantities of drugs, and develop a plan to take specific steps to decriminalise drug use and possession of small quantities for personal use based on the lessons learned from countries who have already implemented such an approach.

References

- ¹ <http://aph.org.ua/en/our-works/eastern-europe-and-central-asia/resservices/>
- ² World Health Organization. The World Health Report 2000 - Health Systems: Improving Performance. Geneva; WHO, June 2000. https://www.who.int/whr/2000/en/whr00_en.pdf
- ³ World Health Organization. Transcript of WHO Emergencies Press Conference on coronavirus disease. Geneva; WHO, 13 March 2020. <https://www.who.int/docs/default-source/coronaviruse/transcripts/who-transcript-emergencies-coronavirus-press-conference-full-13mar2020848c48d2065143bd8d07a1647c863d6b.pdf>
- ⁴ Wang Y, Zhang D, Du G, Du R, Zhao J, et al. Remdesivir in adults with severe COVID-19: a randomised, double-blind, placebo-controlled, multicentre trial. The Lancet, published online April 29, 2020. DOI: [https://doi.org/10.1016/S0140-6736\(20\)31022-9](https://doi.org/10.1016/S0140-6736(20)31022-9)
- ⁵ Duffy C. Gilead may have a breakout coronavirus drug in remdesivir, but how do you market a pandemic treatment? Cable Network News (CNN), 0258 GMT May 8, 2020. <https://edition.cnn.com/2020/05/07/business/gilead-remdesivir-coronavirus-profit/index.html>
- ⁶ European Commission. Coronavirus Global Response: €7.4 billion raised for universal access to vaccines. Brussels; European Commission, 4 May 2020. https://ec.europa.eu/commission/presscorner/detail/en/ip_20_797

-
- ⁷ Keating C. Petersberg Climate Dialogue: UK says governments have ‘duty’ to build climate-resilient economies post-Covid-19. BusinessGreen, 28 April 2020. <https://www.businessgreen.com/news/4014548/petersberg-climate-dialogue-uk-governments-duty-build-climate-resilient-economies-post-covid-19>; See also, remarks made by the UN Secretary-General, António Guterres, time stamp 12:30, in response to Questions and answers with the ministers, High Level Segment, 11th Petersberg Climate Dialogue. Federal Ministry for the Environment, Nature Conservation and Nuclear Safety, Germany, 28 April 2020. <https://player.admiralcloud.com/?v=9de1566f-3000-4dc8-b3e8-e481626abb8b>
-
- ⁸ Mancini DP, Kuchler H. AbbVie drops patent rights for Kaletra antiviral treatment. London; The Financial Times Ltd., 23 March 2020. <https://www.ft.com/content/5a7a9658-6d1f-11ea-89df-41bea055720b>; see also, <https://www.keionline.org/32503>
-
- ⁹ Costa Rica submits proposal for WHO to facilitate access to technologies to combat COVID-19. Office of the President of Costa Rica, 24 March 2020. <https://www.presidencia.go.cr/comunicados/2020/03/costa-rica-submits-proposal-for-who-to-facilitate-access-to-technologies-to-combat-covid-19/>
-
- ¹⁰ World Health Organization. Coronavirus disease (COVID-19) advice for the public. Geneva; WHO, 29 April 2020. <https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public>
-
- ¹¹ Otiashvili D, Kirtadze I, Vardanashvili I, Tabatadze M, J. Ober AJ. Perceived acceptability of and willingness to use syringe vending machines: results of a cross-sectional survey of out-of-service people who inject drugs in Tbilisi, Georgia. Harm Reduction Journal (2019) 16:21. <https://doi.org/10.1186/s12954-019-0292-8>
-
- ¹² Basenko A. Simplification of service provision models for KPs in the region – which of the improved practices should be maintained after COVID-19? Presentation to the online discussion, COVID-19 lessons: what can make the HIV programmes in the EECA countries more sustainable? Kiev, Ukraine; Alliance for Public Health, 5 May 2020, 08:00-11:00 UTC. <https://www.youtube.com/watch?v=D3wsgsTgXGU>
-
- ¹³ Arak P, Wójcik A. Transforming eHealth into a political and economic advantage. Warsaw; Polityka Insight, June 2017. http://ec.europa.eu/newsroom/document.cfm?doc_id=45571
-
- ¹⁴ Basenko A, Ibid.
-
- ¹⁵ Basenko A, Op.cit.
-
- ¹⁶ Basenko A, Op.cit.
-
- ¹⁷ Eastwood N. Presentation to the online discussion, COVID-19 lessons: what can make the HIV programmes in the EECA countries more sustainable? Kiev, Ukraine; Alliance for Public Health, 5 May 2020, 08:00-11:00 UTC. <https://www.youtube.com/watch?v=D3wsgsTgXGU>
-
- ¹⁸ Eastwood N, Ibid.
-
- ¹⁹ “Essential journey” cards. Coronavirus/Covid-19 Resources. London, UK; Release. <https://www.release.org.uk/coronavirus-covid19-resources>

Acknowledgements

Special thanks to Graham Shaw for his contribution to this publication.