BACKGROUND

- Ukraine: the highest burden of HIV in Europe: with estimated 230,000 people living with HIV, most reported cases in men [1].
- Prevalence: IDU (21.9%), MSM (8.6%), FSW (7.5%), general population (0.9%) [2].
- MSM have the highest HIV incidence of all key populations 0.9%/year in developed cities (compared to 0.3% in IDU and 0.44 in FSW) [3] - the epidemic is changing from IDU-driven to sexual transmission.
- There is evidence of hidden epidemic in MSM, whose reported cases among general population are heterogeneous due to stigmatization and discrimination [4].
- There is evidence of HIV prevalence (highest in white, gay, and black or on the way) [2]. But there is not enough data on how the emerging HIV epidemic in MSM aligns with this IDU-driven mapping.
- HIV prevention programs use the general HIV prevalence map to prioritize service delivery in regions. 

The Friendly Doctor: NGO-led network-based HIV testing intervention for MSM launched in 2014:
- Online anonymous appointment scheduling through https://friendlydoctor.org (screenshots below).
- Separate office away from government clinics and LGBT-identified community centers.
- Rapid tests administered by the health workers who also run state-run AIDS Centers to facilitate linkage to care for those who test positive.

OBJECTIVES

To examine the association between the HIV prevalence in the region where an HIV test is administered and the proportion of HIV-positive test results in MSM.

METHODS – Qualitative Analysis

- 10 face-to-face interviews in 9 sites (June–July 2016).
- 5 health trainers, 2 NGO staff, 7 psychologists, and 7 local community leaders.

Most interviews lasted 45–50 min. Before the interviews, health workers were asked to fill out a brief survey on their knowledge about HIV, substance use, and MSM-related risk assessment and counseling.

- All interviews were sound recorded with the participant’s consent.
- NVivo software was used for data analysis.

RESULTS

- Positive HIV test yield: 81 (7.7%).
- Low number of HIV-positive tests found compared to the overall expected HIV prevalence.
- Older age was positively associated with receiving a positive HIV test result.

METHODS – Clinical Records Analysis

- Clinical records from 7 testing locations (excl. one black on the map) in all three HIV prevalence regions (low, medium, and high).
- Selected for 5 months of 2016, when most sites worked. Frequency analysis of positive test yield data, then logistic regressions using STATA v.14. In addition, we conducted simple comparison of Friendly Doctor positive test yield to another MSM-targeted national program in Ukraine.

LITERATURE


CONCLUSIONS

- HIV prevalence among MSM does not necessarily follow the same geographical patterns as the overall HIV prevalence, which is mostly driven by IDU populations. This is important to planning where HIV prevention and testing programs for target populations are delivered. Geographic areas that have traditionally been considered “low prevalence” may have high positive test yield if the intervention design is acceptable to hidden MSM population, and thus, should not be excluding them as “low priority” for KPs.
- Comparing HIV-positive test prevalence and the total number of tests administered demonstrate Friendly Doctor’s higher yield of HIV-positive tests given dramatically smaller number of total people tested.
- Eventually, this could be a funding saving opportunity.
- Qualitative exploration demonstrated that targeted online recruitment, offering highly confidential HIV testing as a medical procedure, rather than an essential activity to socialize – may facilitate attracting hidden MSM population for HIV testing in that area.
- LGBT health center based on evidence should be included in Ukraine’s medical schools. Health workers must be trained in strategies of sexual risk counseling, as well as identifying other potential health problems in LGBT individuals.
- Given the lack of trust of MSM in Ukraine’s health care, which often leads to delayed linkage to HIV care, one solution may be in greater involvement of the health workers from AIDS centers in NGO-run VCT programs, which should simplify linkage to care aspect (as the positive clients will already have seen the provider they would link to).

LIMITATIONS

- Because clinical data collection and management tools had been designed for program purposes, a number of limitations stemmed from this. The design of intake survey contained non-mutually exclusive response categories.
- The data set analyzed had been exported from Friendly Doctor system with a unique identifier for each individual tested.
- Because the mini study focused on positive tests, we are not able to analyze individuals. First-time testers have systematic differences from those who test regularly.

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- The staff from friendly Doctor for their support and feedback.
- Brown University Global Health Initiative – Elizabeth Jackson, Eileen Wright, for their support and feedback.

ABSTRACT


METHODS

- Case studies selected from 9 sampled cities, from the Friendly Doctor program, Jan-May 2016 prevalence, %.
- Comparison HIV-positive test prevalence and the total number of tests administered demonstrate Friendly Doctor’s higher yield of HIV-positive tests given dramatically smaller number of total people tested.
- Eventually, this could be a funding saving opportunity.
- Qualitative exploration demonstrated that targeted online recruitment, offering highly confidential HIV testing as a medical procedure, rather than an essential activity to socialize – may facilitate attracting hidden MSM population for HIV testing in that area.
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