The CQUIN Learning Network

Patients at High Risk:
Experience, Guidelines, and Best Practices in Zimbabwe

Dr. Tsitsi Apollo
Zimbabwe Ministry of Health and Child Care

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HIV LEARNING NETWORK
The CQUIN Project for Differentiated Care

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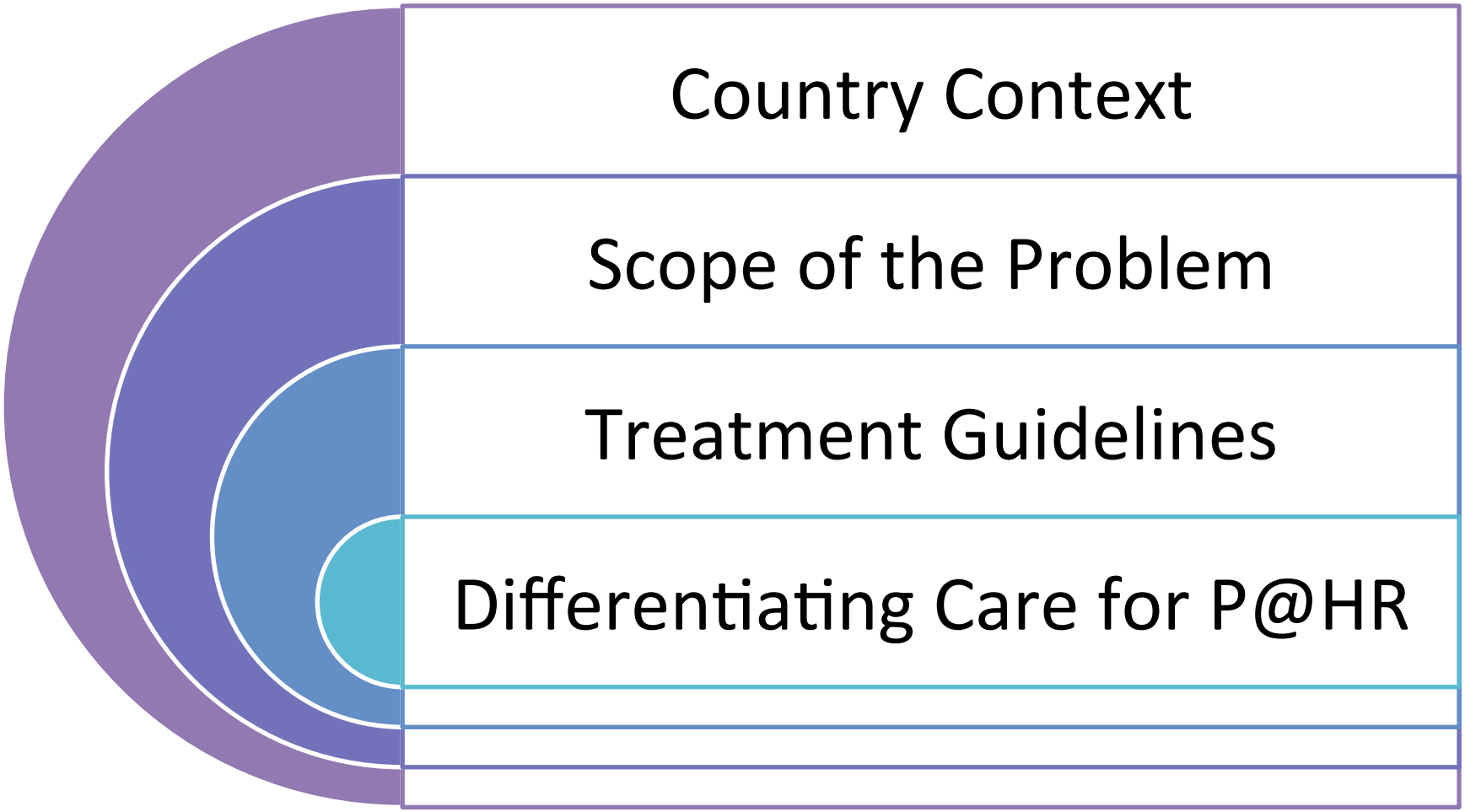
Differentiated Care for P@HR: Country Experience



Country Context:

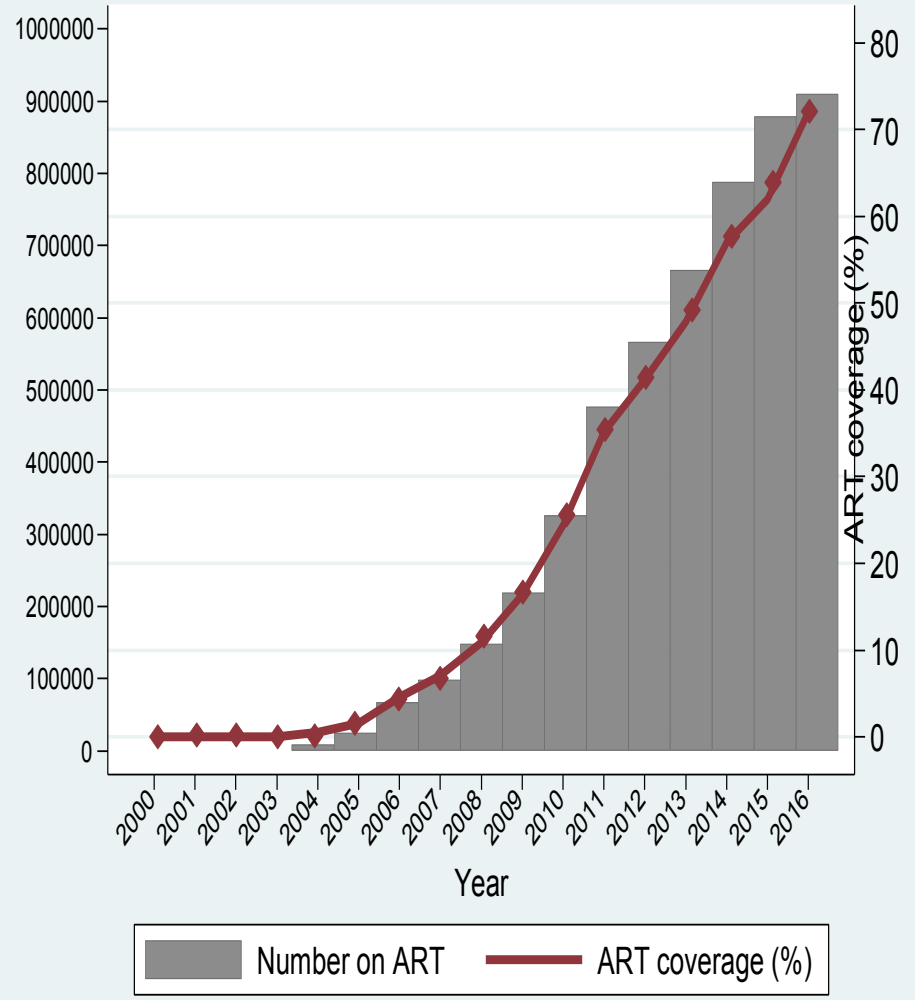
- Zimbabwe has a generalized HIV epidemic
  - Prevalence: 13.7% (15-49yrs)
  - Incidence: 0.48% (15-49yrs)
- Total population: 13.5 million (Census 2012)
- Total PLHIV: 1,3 m (76,682 children)
  - Male 42%
  - Female 58% (2016 HIV Estimates)
- TB/HIV co-infectivity rate 70% (source: Global TB Report, 2016)

Source: ZIMPHIA 2016; 2016 HIV Estimates

Background:

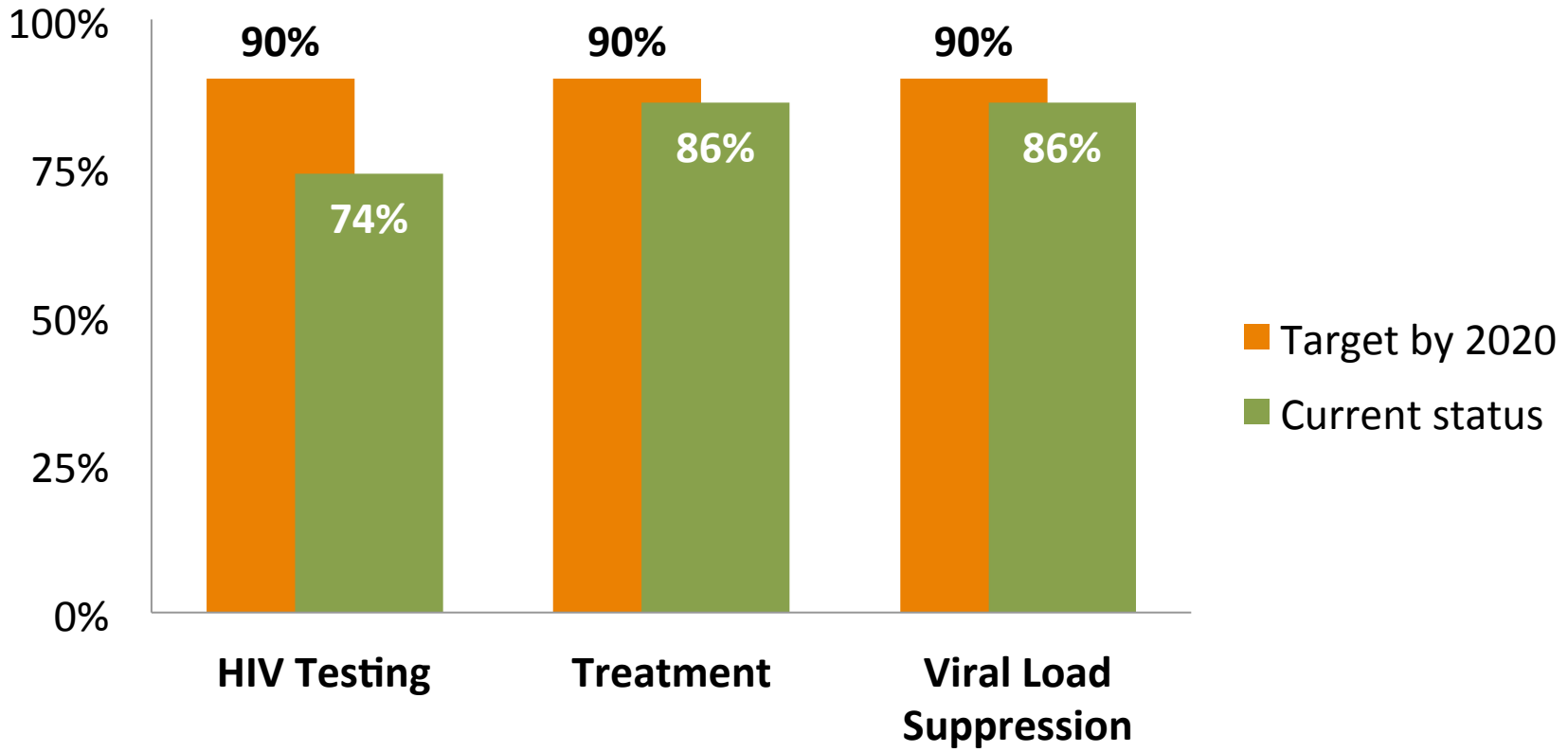
- Over a million people on ART: 1,029, 719
  - 961,473 adults
  - 68,246 children
- Treatment coverage (as of end of Dec 2016)
  - Adults (15+ yrs) – 72.2%
  - Children (0- 14yrs) – 92.9%
- Patients receiving treatment:
  - 1st line: 96%
  - 2nd line: 3.9%
  - 3rd line <0.02%

(2016 ART Annual Report)



Source: 2016 HIV Estimates, 2016 Annual ART Report

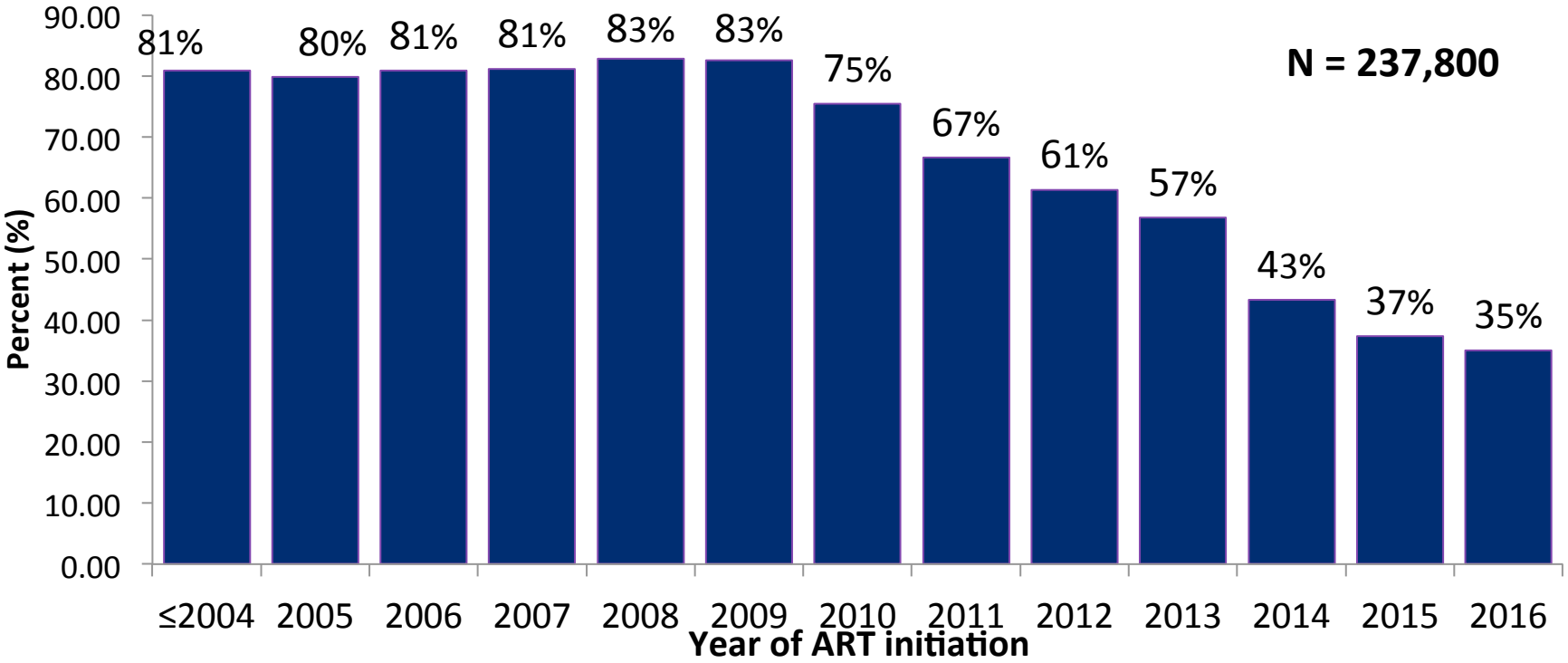
Zimbabwe has made great progress in controlling the HIV epidemic and is well positioned to achieve the 90-90-90 Fast Track targets



- The biggest gap to achieving the 90-90-90 targets is in **testing.**
- The new national HTS Strategy (2016- 2020) shifts focus from testing for coverage to targeted testing for identification of those living with undiagnosed HIV.

Source: ZIMPHIA, 2016; Spectrum Zimbabwe National HIV Estimate

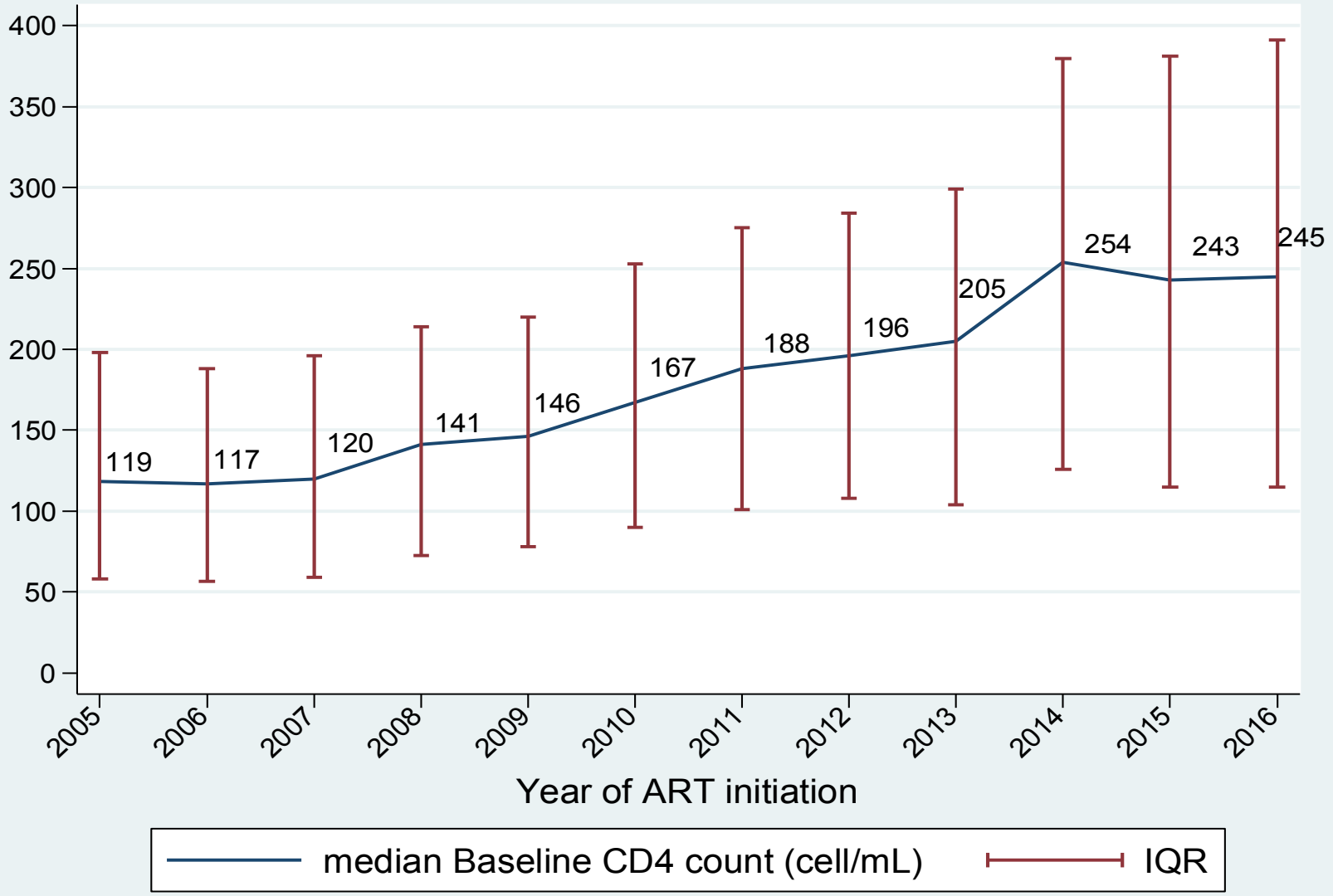
Advanced HIV (WHO Stage 3 &4) at enrolment/ART initiation stratified by Year



- A declining trend in % of patients presenting with advanced HIV disease at ART initiation.
- Evolving treatment guidelines have facilitated early ART initiation

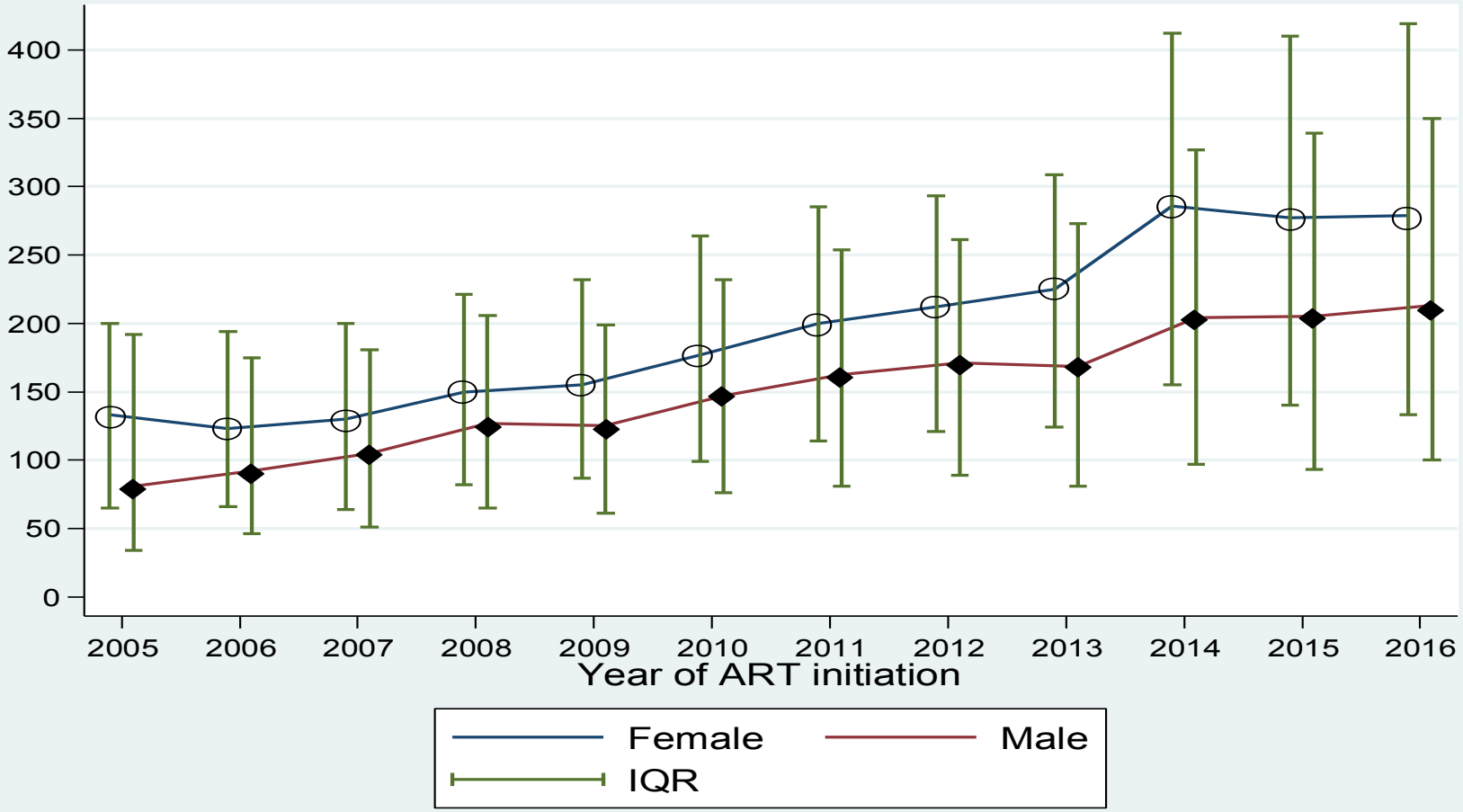
Source: Zimbabwe electronic Patient Management System ePMS, 2016

Median CD4 count at ART initiation stratified by Year, All patients



Source: Zimbabwe electronic Patient Management System, 2016

Median CD4 count at ART initiation stratified by Year, by Sex



For the past 10 years; female patients have had better CD4 count at ART initiation compared to their male counterparts

Source: Zimbabwe electronic Patient Management System, 2016

Viral load suppression rates:

At 12 months after initiation of ART; 89.8% participants from HIV DR Survey achieved viral suppression of below 1000 copies/ml (MOHCW, HIV DR Surveillance, 2012)

VL suppression rates of PLHIV from a population based survey (cross-sectional) for 15-64 years olds (ZIMPHIA, 2016)

- Total 86,5%
- Males 84,1%
- Females 87,9%

Gutu Population-Based HIV Impact Study (MSF- Zimbabwe, 2016):

Results: Viral Load among participants ≥15y on ART > 6 months

VL<1000 copies: 85.7% (95%CI:82.2 -88.5)
- **Women:** 85.8% (95%CI:81.5-89.2)
- **Men**: 85.4% (95%CI:78.9- 90.1)
- **p=** 0.89

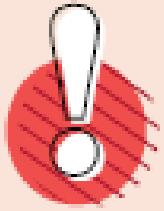
Viral load distribution in participants on ART for more than 6 months (* 20 missing results)

	Women, n(%)	Men, n(%)	Total, n(%)
<1000 copies/ml	272 (85.8)	134 (85.4)	406 **(85.7)**
>1000 copies/ml	45 (14.2)	23 (14.6)	68 **(14.3)**
Total	317 (100)	157 (100)	474 (100)

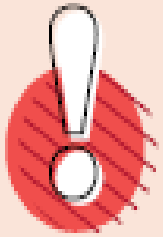
Treatment Guidelines:

Management of Patients with CD4 <100 copies/ml should be:

- Fast-tracked for treatment initiation
- Screened for symptomatic TB and Cryptococcal disease
- Receive Cotrimoxazole and Isoniazid Preventive Therapy
- Closely monitored for 3 months



Clients with TB co-infection should start TB treatment first. ART should be started after two to eight weeks of TB treatment. Those with a CD4 less than 50 cells/mm3 should receive ART within the first two weeks of TB treatment.



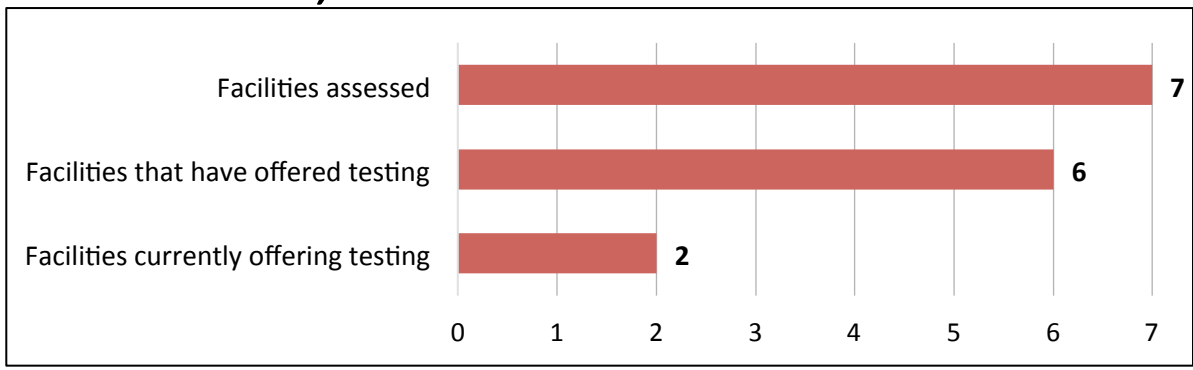
Clients diagnosed with cryptococcal meningitis should take two weeks of amphotericin B before initiation of ART. If amphotericin is not used, at least four weeks of fluconazole treatment should be taken before ART is initiated.

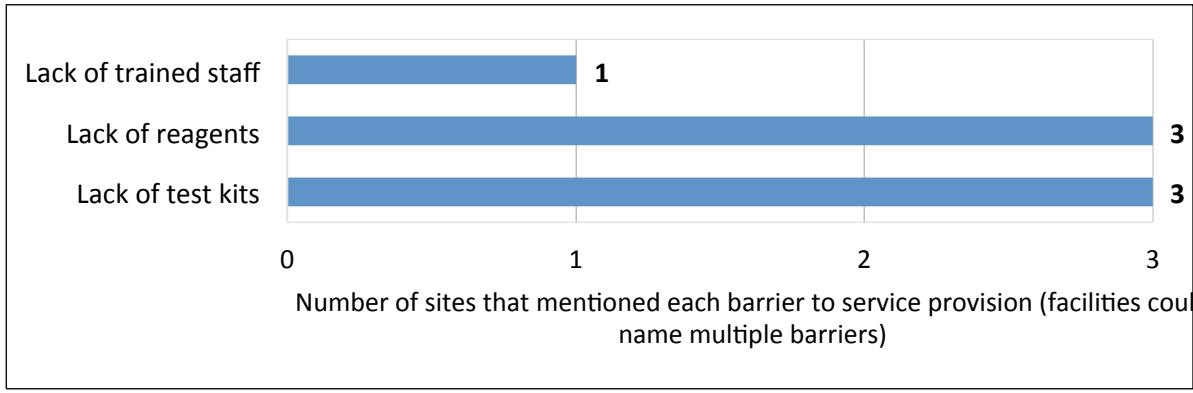
Sources: Guidelines for ART for the Prevention and Treatment of HIV in Zimbabwe, 2016
Zimbabwe Operational and Service Delivery Manual, 2017

Challenges in performing screening, diagnosis and management of Cryptococcal disease in Zimbabwe; a baseline assessment, 2016

I-TECH/MOHCC conducted a baseline assessment at 7 rural hospitals in Zimbabwe to assess:

- capacity for sites to perform Cryptococcal antigen screening
- existing laboratory services, commodity status, and human resource capacity





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Differentiated Care for P@HR

WHEN

Variable: Depends on patient's condition and treatment plan

WHERE

Secondary and tertiary hospitals (private and public), and specialised clinics

WHO

Physician (incl. specialists)
Clinical Officer
Nurse
Pharmacist
Community Health Worker
Family

WHAT

Laboratory Tests
OI Treatment
Clinical Monitoring
ART Initiation/ refills
Adherence support
Psychosocial support

Barriers

- Limited diagnostics at lower levels e.g. VL, CrAG tests
- Limited laboratory personnel at lower levels e.g. at district level
- Stock out and unavailability of critical medicines e.g. Amphotericin B

Enablers

- Well structured referral system
- Improvement in the staff complement for doctors at all referral levels
- Policy for task shifting and task sharing
- Supporting donor and implementing partners

Thank You: