The CQUIN Learning Network

Differentiated Care:
Experience, Guidelines, and Best Practices in Ethiopia

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HIV LEARNING NETWORK
The CQUIN Project for Differentiated Care

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Outline

- Country profile
- HIV Profile
- Treatment guideline for P@HR
- Best practices/lesson learnt

Ethiopia Country Profile

- Ethiopia is located in the Horn of Africa on the continent's northeast coast
- Population is over 90 million people
- Addis Ababa is the capital city

HIV profile in Ethiopia 2017

- Adult HIV prevalence 1.1%
  - Regional variation in HIV prevalence (lowest in SNNPR 0.54 and highest in AA 5%)
- Approximately 722,248 people living with HIV
  - 60.6% are women
  - 92% are adults
- Estimated number of new HIV infections: 22,827
  - 60.4% of new infections occur among women
  - 94.4% of new infections occur among adults 15+

Scope of the Problem: P@HR

- First 90s=72%
- Second 90s=58%
- Of the ART clients who have viral load results,20% have viral load level more than 1000 copies/ml
- However, the viral load coverage has not yet reached 75% to report for the third 90's

Treatment Guidelines – 1

Package of care for P@HR that is in our national guidelines:

For patients presenting with advanced disease

- Complete clinical assessment (history taking, complete physical examination and relevant lab tests)
- Prevention, screening and management of opportunistic infections and co-morbidities
- WHO clinical staging
- Support for disclosure and partner notification

Treatment Guidelines – 2

- Risk reduction, counseling and combination HIV prevention approaches
- Screening for and managing mental health problems and substance use
- Adherence and psychosocial counseling and support
- Nutritional assessment and counseling

Treatment Guidelines – 3

- Screening for other STIs
- Prevention and screening of cervical cancer
- Management of pain and symptoms
- Pregnancy status, family planning and contraception

Treatment Guidelines.....

For patients on ART who are “unstable”

- Enhanced Adherence Counseling
- Major types of ARV toxicities
- Assess drug to drug interaction
- Viral load testing

Diagnostic methods….

- Baseline CD4 and Follow up Assessment
- CBC, ALT, creatinine
- At every visit conduct screening for TB
- If presumptive TB diagnosis → Gene Xpert.
- Pregnancy and other tests as necessary.
- Review clinical and lab data

Who treats them?

- Task shifting-Primarily physicians
  - Nurses
  - Health officers
- Adherence support
  - Adherence supporters
  - Case managers
  - Mother support group

Where are they treated?

- There are more than 1000 ART sites, 3400 HCT sites and 3000 PMTCT sites
- Hospital
  - Referral
  - Tertiary
  - Primary
- Health center

Best Practices / Lessons Learned

To achieve the three 90's

- Test and treat was launched
- Catch up campaign was launched
  - Focused HIV testing in hot spot areas
  - Able to achieve double national HIV prevalence
- Appointment spacing scale up at nationwide

When

For stable patients:

- Routine clinical visit and medication refill is every three months
- Patients are appointed every six months for clinical visit and medication refill for appointment spacing
- Differentiated care piloted in six high load hospitals and more recently scaled up at national level

When

- For new patients
- Baseline follow up
- Second visit-After 0ne week
- Third visit-After two weeks
- Fourth visit-After four week
- Fifth-eighth visit-After eight weeks
- Sixth visit- after –12th weeks

When…

- Appointment spacing provided for clients labeled “ Stable”
- Category 4: Stable individuals are defined as those who have received ART for at least one year and have no adverse drug reactions that require regular monitoring and have good understanding of lifelong adherence and evidence of treatment success (i.e. two consecutive viral load measurements below 1000 copies/mL) with no current illnesses excluding children, adolescents, pregnant and lactating women. In the absence of viral load monitoring, rising CD4 cell counts or CD4 counts above 200cells/mm3 with an objective of adherence measure.

P@HR

Patients at high risk are categorized in the ART treatment guideline:

- Category 2: People with advanced disease are defined as those presenting to care with a CD4 count below 200cells/mm3 or WHO disease stages 3 and 4.
- Category 3: Those who are already on ART but need careful monitoring to ensure timely action as required (Treatment failure suspects, patients with other chronic comorbidities, patients with identified adherence barriers).

Differentiated Care for P@HR

- Barriers for differentiated care for P@HR
  - Unstable patients needs frequent clinical check up
- Solutions:
  - If community ART delivery is launched, it might make it easier to start appointment spacing as the community health care worker can review the status of the patients

Thanks!