



Advanced HIV Disease (AHD) update: Eswatini



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HIV in Eswatini



HIV in Eswatini



- ❑ HIV prevalence in adults aged 15 years and older was 27.0% (20.4% males, 32.5% females)*
- ❑ HIV incidence among adults aged 15 years and older was 1.36% (1.02% males, 1.70% females)*
- ❑ Eswatini has achieved each of the 2030 targets: 95-95-95**
- ❑ Eswatini and Switzerland are the only countries surpassing the 2030 target of 95–95–95, which equates to a minimum of 86% of PLHIV having suppressed viral loads**

* SHIMS2, 2016-2017

**SEIZING THE MOMENT. Tackling entrenched inequalities to end epidemics. GLOBAL AIDS UPDATE | 2020



2019 AHD Prevalence and Mortality in Eswatini



- AHD prevalence rate is 18%
- HIV Mortality rate
- TB/HIV mortality rate is 8%
- Cryptococcal meningitis prevalence 2.4% amongst patients CD4 less than 100.
- Cryptococcal meningitis mortality rate is 22%

Baseline CD4 count and WHO staging for PLHIV at ART

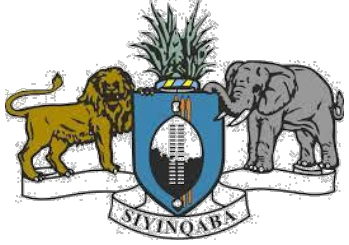
initiation by sex

(Eswatini National HIV Report 2018)



| SEX | Baseline CD4 Count | | | | | | TOTAL |
|--------|--------------------|---------|---------|---------|-------|---------|--------|
| | <100 | 100-199 | 200-349 | 350-500 | >=500 | Unknown | |
| FEMALE | 694 | 901 | 1,288 | 1,184 | 1,566 | 5,093 | 10,726 |
| | 6% | 8% | 12% | 11% | 15% | 47% | 100% |
| MALE | 576 | 719 | 820 | 480 | 554 | 2,880 | 6,029 |
| | 10% | 12% | 14% | 8% | 9% | 48% | 100 |
| TOTAL | 1,270 | 1,620 | 2,108 | 1,664 | 2,120 | 7,973 | 16,755 |
| | 8% | 10% | 13% | 10% | 13% | 48% | 100% |

| SEX | WHO Clinical Stage | | | | | Total |
|--------|--------------------|--------|--------|-------|---------|--------|
| | I | II | III | IV | Unknown | |
| Female | 6,985 | 970 | 970 | 101 | 786 | 9,395 |
| | 74.4% | 10.3% | 10.3% | 1.1% | 8.4% | 100 |
| Male | 3,389 | 837 | 837 | 113 | 428 | 5,375 |
| | 63.05% | 15.57% | 15.57% | 2.10% | 7.96% | 100 |
| Total | 10,374 | 1,807 | 1,807 | 214 | 1,214 | 14,770 |
| | 70.2% | 12.2% | 12.2% | 1.5% | 8.2% | 100 |



Advanced HIV disease (AHD) in Eswatini



AHD Coordination and Leadership



National Coordination

- ❑ AHD coordinated under the national TB/HIV office of the national AIDS program (SNAP)
- ❑ Task team established from different stakeholders to give technical support to the AHDM roll out program. (CDC/PEPFAR, implementing partners, facilities, national AIDS program, national TB program)

Recipients of care involvement

- ❑ Recipient of care sit in the TB/HIV national coordinating committee overseeing the national TB/HIV collaborative activities.
- ❑ However, there is no representation of recipient of care in the task team responsible for guidelines development



AHD Policies and Guidelines



- A national AHD strategy exists and is integrated into the NSF, HSRP and TB NSP.
- AHD guidelines incorporated in the national HIV and TB guidelines
- National AHD SOP developed and disseminated.
- Standard national training slides were developed and are also incorporated in the advanced IMAI, NARTIS, TB training package.
- Job aids, IEC material also developed and disseminated.



The AHD Essential Package



- Cryptococcus antigen (CrAg screening) and Fluconazole pre-emptive therapy : $CD4 \leq 100$
- CD4 count testing
- Gene X-pert and Urine Lam for TB diagnosis.
 - TB –LAM : $CD4 < 100$
 - seriously ill, regardless of CD4
 - TB Presumptive
- TB preventive therapy: for ALL after Active TB is ruled out.
- CTX : $CD4 \leq 350$ or WHO stage 3 /4
- Rapid ART initiation if no TB/crypto meningitis (same day if possible)
- Enhanced counselling and adherence support



AHD essential package provision at different health care levels



Provided at all Facilities
 Provided in some Facilities
 Not provided/referral to higher level

| Service | Hospitals | Health centres | High volume clinics | Low volume clinics |
|--|-----------|----------------|---------------------|--------------------|
| CD4 count testing | | | | |
| TB screening | | | | |
| CrAg screening | | | | |
| Gene X-pert | | | | |
| Urine TB LAM | | | | |
| TB preventive therapy (TPT) | | | | |
| Cotrimoxazole therapy | | | | |
| Rapid ART initiation | | | | |
| Enhanced counselling and adherence support | | | | |
| Pre-emptive treatment for Cryptococcal infection | | | | |
| CCM treatment | | | | |
| TB treatment | | | | |



Laboratory Services: CD4 Testing



How and where are CD4 tests done in Eswatini?

- Most facilities have CD4 POC
- All facilities have access to hub laboratories that offer CD4 tests and reflex CrAg tests for CD4 less than 100cell/ml



DSD Models for AHD and P@HR(People at High Risk for disease progression)



- AHD patients and people at risk of AHD are seen in facility based mainstream model of DSD
- These patients include
 - New ART patients enrolling into care
 - Treatment interrupters returning into care
 - Patients failing ART treatment
- Once patients are stable they may be enrolled onto other less intensive DSD models
- Patients with CD4 between 100 and 200 will remain in mainstream model

DSD Models for AHD and P@HR



| | New ART Initiation | Unstable Patients on ART |
|----------------------------------|--|---|
| What services? | <ul style="list-style-type: none"> <input type="checkbox"/> Rapid initiation of ART with close follow-up and monitoring of IRIS and Side effects <input type="checkbox"/> Screening of Cryptococcus antigen in the blood <input type="checkbox"/> Screening and treatment for TB, or TPT, as indicated <input type="checkbox"/> Cotrimoxazole prophylaxis <input type="checkbox"/> Adherence preparation, monitoring, and support <input type="checkbox"/> Intensive Follow-up | <ul style="list-style-type: none"> <input type="checkbox"/> Intensive and/or advanced clinical care <input type="checkbox"/> Management of OIs and Co-morbid chronic conditions (NCDs) <input type="checkbox"/> Enhanced adherence/psychosocial supports with VL and CD4 monitoring <input type="checkbox"/> Timely switch to second or third line if indicated <input type="checkbox"/> HIV Drug resistance testing |
| More Intensive DSD Models | Main Stream up to 12 months | High VL Clinics or Challenge clinic |
| When? | Drug pick up every 2-3 months | Drug pick up every 1-2 months |
| Who? | Doctors, Nurses, ECs, Pharmacist | MDT: Doctors, Nurses, ECs, Lay counselor, Social workers, Pharmacist Third Line Committee |
| Where? | Health Facility or Community Outreach | Health Facility |



Monitoring & Evaluation of AHD



Data or documentation related to AHD

- Paper based AHD data collection tool (AHD register) developed and disseminated.
- Electronic system (CMIS) is being developed to capture AHD indicators



Challenges and recommendations for AHD in Eswatini



Challenges

- ❑ The program is partner funded and may not be sustainable in the near future
- ❑ Some of the services are not yet decentralized: CrAg screening, TB-LAM, Gen-Xpert, Fluconazole pre-emptive therapy
- ❑ Inconsistent supply of laboratory commodities (e.g. CD4 count reagents, PIMA machines)
- ❑ Training gaps: not all HCWs are trained
- ❑ M&E:
 - CMIS does not capture all AHD indicators
 - Incomplete documentation in the AHD register
 - Gaps in tracking treatment interrupters and patients with high viral load for CD4 testing and AHDM
- ❑ Access and high cost of better AHD medication (Flucytocine, Liposomal AmB)



Priorities for 2020 – 2021 (Recommendations)



- Decentralization of AHD services
- Strengthening the M&E
- Scale up training, and introduction of virtual training
- Reclassification of Fluconazole
- Introduction of newer, safer treatment of Cryptococcal meningitis
- Involvement of Recipients of care in AHD Task team



Acknowledgements

