Advanced HIV Disease: Updates from the CQUIN Network

Tuesday, August 3, 2021

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HIV Learning Network

The **CQUIN** Project for Differentiated Service Delivery

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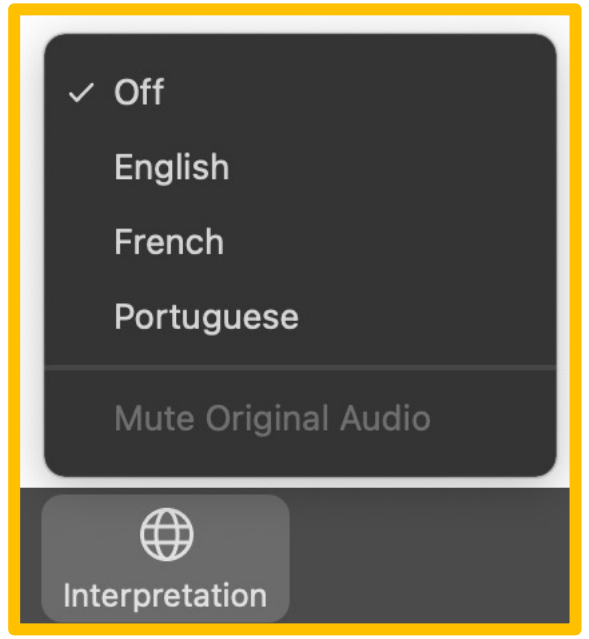


Moderator

Miriam Rabkin

Associate Professor of Medicine & Epidemiology
Director for Health Systems Strategies
ICAP at Columbia University
Columbia University Mailman School of Public Health

Agenda

Presentations:

- Maureen Syowai, ICAP Kenya: The CQUIN AHD Dashboard: Summary of pilot findings
- Malvern Masango, MOH Eswatini: Establishing the AHD Hub-and-Spoke model in Eswatini
- Lazarus Momanyi, NASCOP Kenya: AHD Implementation in Kenya - Taking AHD Services to Scale

Panel discussion:

Moderators: Maureen Syowai, ICAP Kenya and Ajay Rangaraj, WHO

- James Conroy, CHAI
- Alexander Jordan, CDC
- Peter Odenyo, NEPHAK Kenya
- Malvern Masango, MOH Eswatini
- Lazarus Momanyi, NASCOP Kenya

AHD and the CQUIN Network

- The HIV Coverage, Quality and Impact Network is a south-to-south learning network designed to advance differentiated service delivery (DSD) to achieve HIV epidemic control
- Funded by the Bill & Melinda Gates Foundation
- Convened/led by ICAP at Columbia University
- Advisory Group inclusive of Ministries of Health, civil society, PEPFAR, CDC, USAID, WHO, Global Fund, UNAIDS, International Treatment Preparedness Coalition (ITPC)
- Supported by a Community Advocacy Network chaired by ITPC
- Focuses on the gap between policy and implementation
- DSD for Advanced HIV Disease has been a focus since Year 1

21 Member Countries

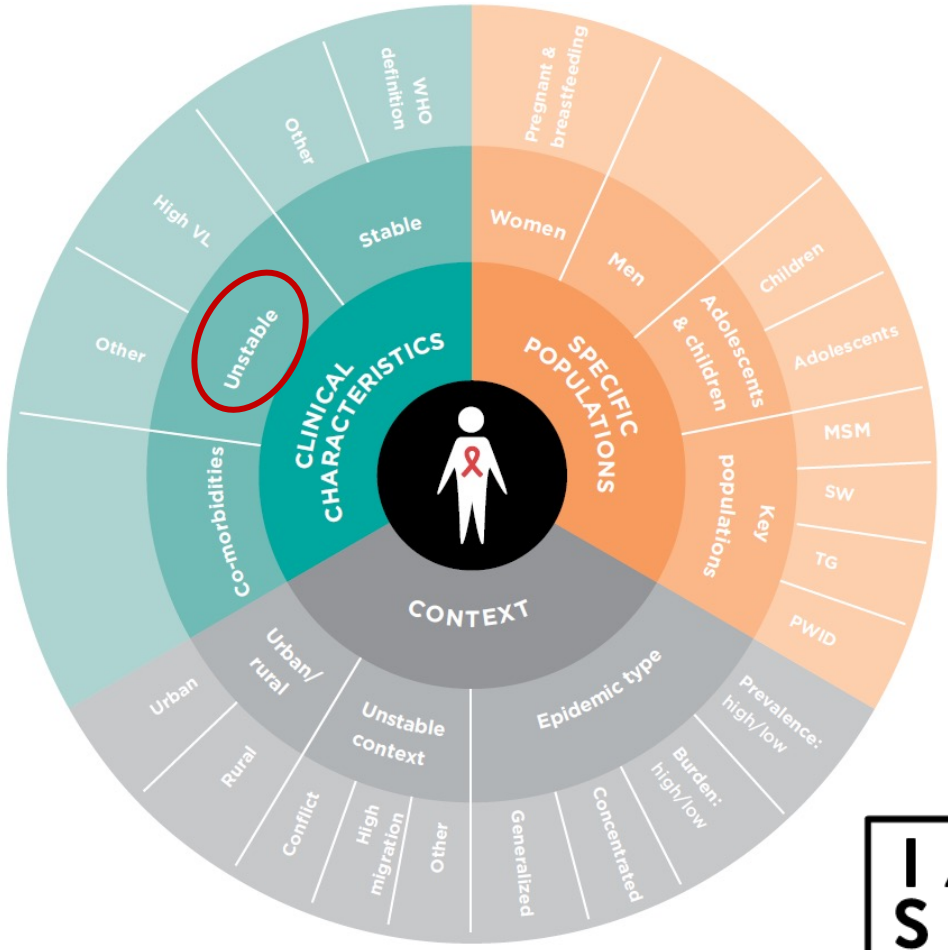
- Burundi
- Cameroon
- Cote d'Ivoire
- DRC
- Eswatini
- Ethiopia
- Ghana
- Kenya
- Liberia
- Malawi
- Mauritania
- Mozambique
- Nigeria
- Rwanda
- Senegal
- Sierra Leone
- South Africa
- Tanzania
- Uganda
- Zambia
- Zimbabwe

Network Focus Areas

- **Knowledge exchange**
  - Sharing information across countries as well as generating new knowledge and spreading best practices
- **Joint learning**
  - Solving problems together via collaboration and joint work to develop strategies, tools, and other resources
- **Innovation and Catalytic Research**
  - Collaboratively adapting existing knowledge and/or generating new interventions and strategies

DSD and AHD: Making the Connection

- Differentiated service delivery is not just for people thriving on ART
- Critical to design evidence-based person-centered models for people with advanced HIV disease and people at high risk of HIV disease progression (P@HR)
- This has been a theme within CQUIN since its inception



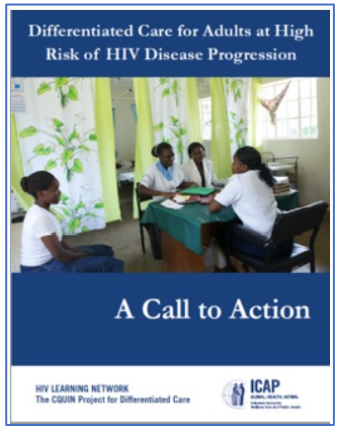
The CQUIN AHD Journey

July 2017

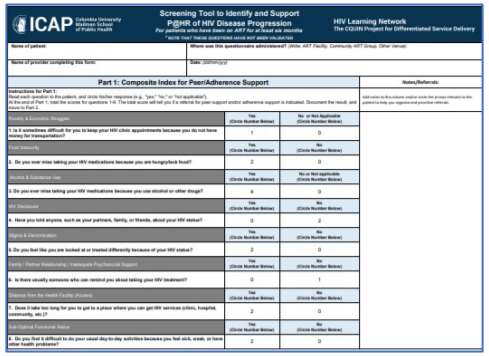
Harare, Zimbabwe

All-network meeting on DSD for people with advanced HIV disease and people at high risk of HIV disease progression (P@HR)

2017 - 2019



Differentiated Care for Adults at High Risk of HIV Disease Progression: A Call to Action



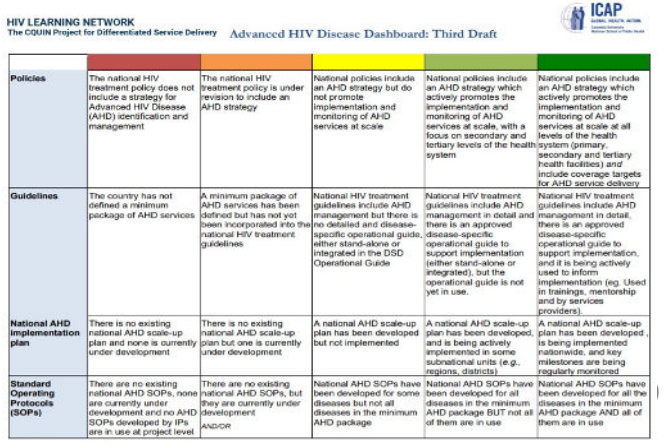
AHD Community of Practice: Screening Tool to Identify and Support P@HR

2020

Virtual AHD Workshop

Co-hosted w/ CHAI & UNITAID

Development and piloting of CQUIN AHD Dashboard



Key messages from the CQUIN AHD community of practice

- "Nothing about us without us"
  - Suboptimal messaging and education related to AHD
  - Scant demand-side pressure for AHD services in many settings
  - Community engagement and community-led monitoring are valuable tools
- Access to CD4 testing remains suboptimal
  - At baseline and when re-engaging in care
- M&E of AHD services is limited
  - Incomplete documentation of baseline assessment data (CD4, WHO staging)
  - No longitudinal registers / cohort follow up
  - AHD indicators not routinely reported (e.g., CrAg results, initiation/completion of CM treatment, CD4 for people who interrupt ART or those with suspected ART failure, TB-LAM volume/results)
- A systems strengthening approach to AHD includes inpatient *and* outpatient services

CQUIN AHD Community of Practice 2021

- AHD dashboard collaboratively revised and expanded
- Piloted in 5 countries: Cote d'Ivoire, Eswatini, Kenya, Mozambique, Sierra Leone
- Key take-home point: It is critical to consider the "AHD cascade" as well as availability of diagnostics, medications and trained staff
  - What proportion of people with AHD are identified?
  - What proportion of them are appropriately screened for OI risk?
  - What proportion of those eligible receive IO prophylaxis?
  - What proportion of those with OIs receive appropriate treatment?

Presenters

Maureen Syowai
Regional Technical Advisor
ICAP in Kenya

Malvern Masango
National TB/HIV Technical Advisor
MOH Eswatini

Lazarus Momanyi
DSD Coordinator
MOH/NASCOP Kenya

The CQUIN AHD Dashboard:
Summary of Pilot Findings

Dr Maureen Syowai

Regional Technical Specialist

3 August 2021

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The **CQUIN** Project for Differentiated Service Delivery

Outline

- Rationale
- Methods
- AHD Dashboard pilot findings
  - Overall AHD Dashboard findings
  - Diagnostic capacity analysis
  - Facility coverage analysis
  - Patient coverage analysis
  - AHD cascade by country
- Key take-away messages

Rationale

- Rapid ART scale up globally
- Drop in HIV associated deaths
- High risk of mortality and morbidity - Worse with CD4 <50 cell/mm^3
- Less robust CD4 recovery after initiating ART
- High risk of OIs

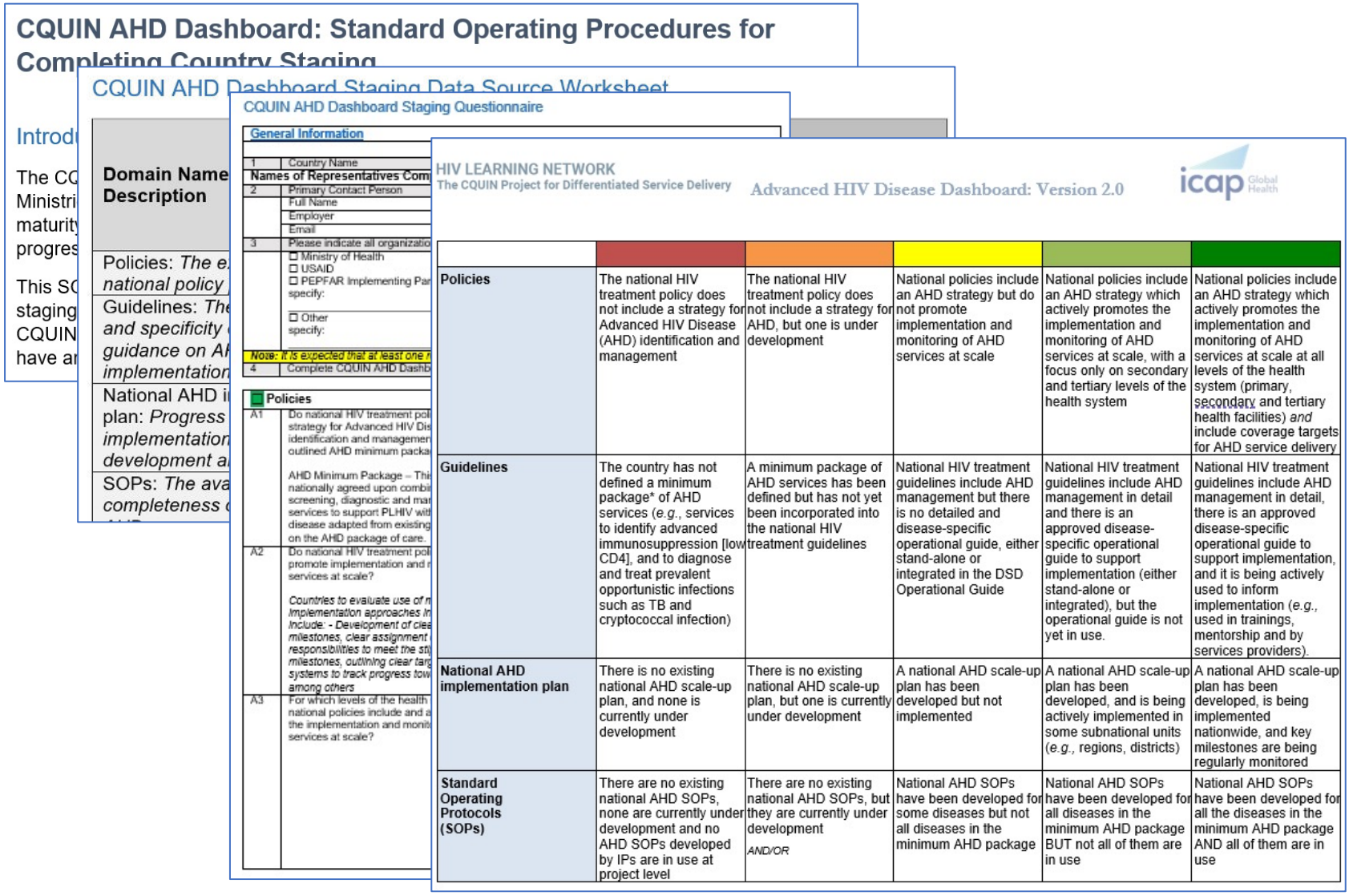
Methods

- **Project design:** Survey using a self-administered capability maturity model questionnaire conducted across 5 countries.
- **Sampling:** Purposive selection of 5 countries (Cote d'Ivoire, Eswatini, Kenya, Mozambique and Sierra Leone) - limited to countries that had participated in the first AHD dashboard pilot in July 2020 which had:
  - Representation from CQUIN member countries in west, east and southern Africa
  - Countries with motivated and well-enough resourced DSD staff to lead the survey
- **Pilot duration:** April to May 2021
- **Data Period:** April 2020 to March 2021
- **Data analysis:** June 2021
- **Limitations:** Given that only countries that had participated in the initial AHD dashboard pilot were included and these countries had relatively high DSD capacity and availability to complete the survey, the results are not generalizable to all CQUIN member countries

AHD Dashboard and AHD Dashboard SOPs

Complete AHD Dashboard Pilot Package:

- CQUIN AHD Dashboard Staging SOP
- CQUIN AHD Dashboard Staging Data Source Worksheet
- CQUIN AHD Dashboard Staging Questionnaire
- CQUIN AHD Dashboard Version 2.0
- CQUIN AHD Dashboard Staging Meeting Roster

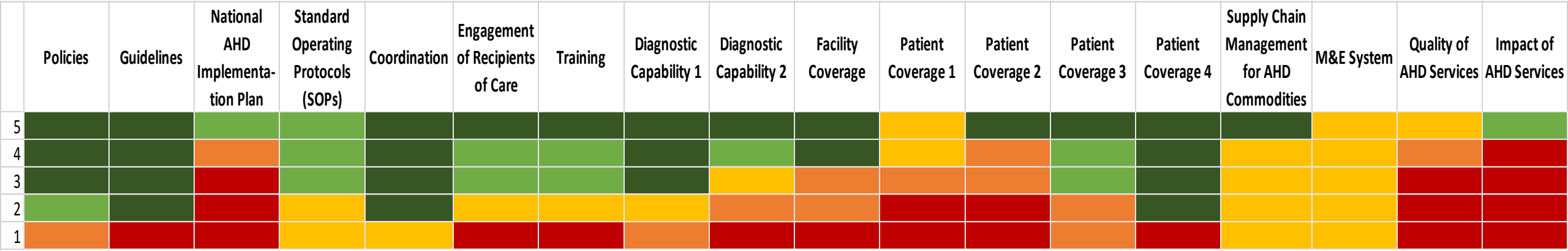


Policies	The national HIV treatment policy does not include a strategy for Advanced HIV Disease (AHD) identification and management	The national HIV treatment policy does not include a strategy for AHD, but one is under development	National policies include an AHD strategy but do not promote implementation and monitoring of AHD services at scale	National policies include an AHD strategy which actively promotes the implementation and monitoring of AHD services at scale, with a focus only on secondary and tertiary levels of the health system	National policies include an AHD strategy which actively promotes the implementation and monitoring of AHD services at scale at all levels of the health system (primary, secondary and tertiary health facilities) *and* include coverage targets for AHD service delivery
Guidelines	The country has not defined a minimum package* of AHD services (*e.g.*, services to identify advanced immunosuppression [low CD4], and to diagnose and treat prevalent opportunistic infections such as TB and cryptococcal infection)	A minimum package of AHD services has been defined but has not yet been incorporated into the national HIV treatment guidelines	National HIV treatment guidelines include AHD management but there is no detailed and disease-specific operational guide, either stand-alone or integrated in the DSD Operational Guide	National HIV treatment guidelines include AHD management in detail and there is an approved disease-specific operational guide to support implementation (either stand-alone or integrated), but the operational guide is not yet in use.	National HIV treatment guidelines include AHD management in detail, there is an approved disease-specific operational guide to support implementation, and it is being actively used to inform implementation (*e.g.*, used in trainings, mentorship and by services providers).
National AHD implementation plan	There is no existing national AHD scale-up plan, and none is currently under development	There is no existing national AHD scale-up plan, but one is currently under development	A national AHD scale-up plan has been developed but not implemented	A national AHD scale-up plan has been developed, and is being actively implemented in some subnational units (*e.g.*, regions, districts)	A national AHD scale-up plan has been developed, is being implemented nationwide, and key milestones are being regularly monitored
Standard Operating Protocols (SOPs)	There are no existing national AHD SOPs, none are currently under development and no AHD SOPs developed by IPs are in use at project level	There are no existing national AHD SOPs, but they are currently under development *AND/OR*	National AHD SOPs have been developed for some diseases but not all diseases in the minimum AHD package	National AHD SOPs have been developed for all diseases in the minimum AHD package BUT not all of them are in use	National AHD SOPs have been developed for all the diseases in the minimum AHD package AND all of them are in use

AHD Dashboard Pilot Findings

AHD Dashboard by Maturity of Domains

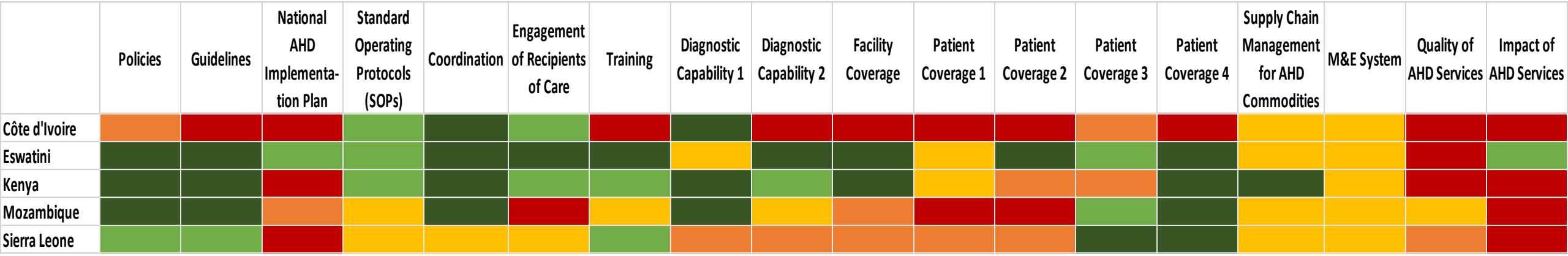
CQUIN AHD Dashboard Pilot 2021



- Based on the summary of AHD staging by Maturity of Domains, these countries are in the initial stages of AHD implementation
- Note the domains in dark green and green are predominantly on the left and the domains in red, orange and yellow colors are predominantly on the right.

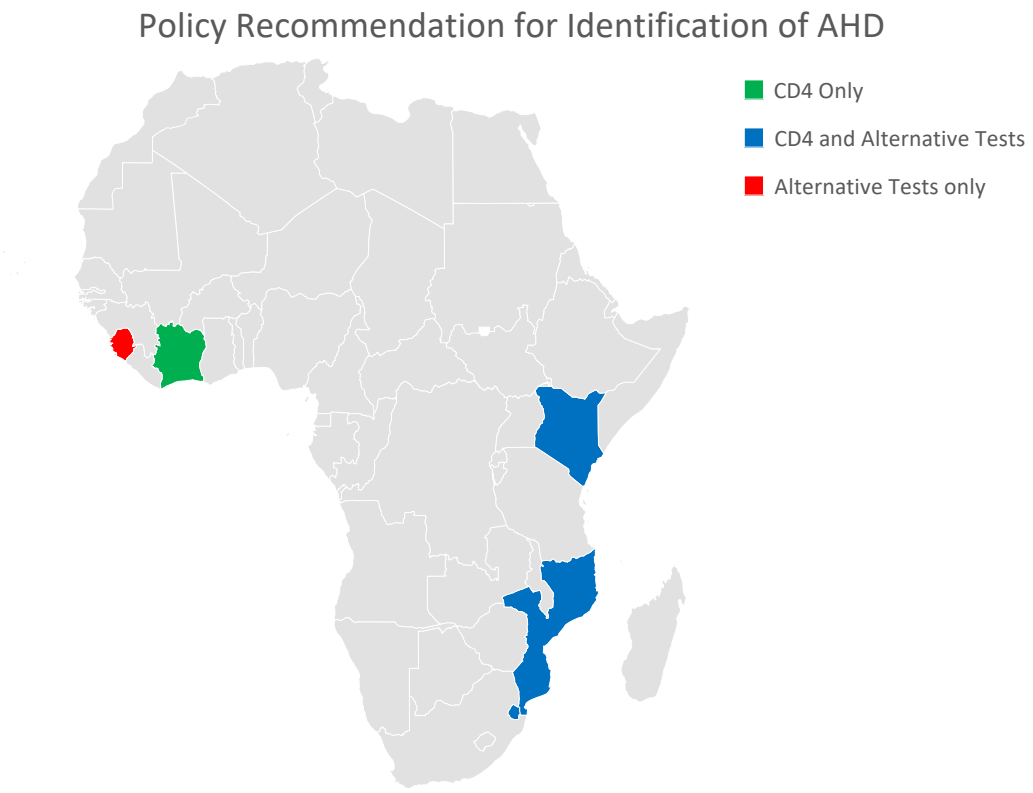
AHD Dashboard by Country

CQUIN AHD Dashboard Pilot 2021



- Lack of AHD policy and guidelines is likely to influence maturity of critical AHD domains – diagnostic capability, facility & patient coverage domains among others
- Where policies and guidelines exist, there is variable translation of this guidance on maturity of other AHD domains – diagnostic capability, facility & patient coverage domains among others
- Presence of a national AHD implementation plan, SOPs, RoC engagement, training are likely facilitators to AHD implementation

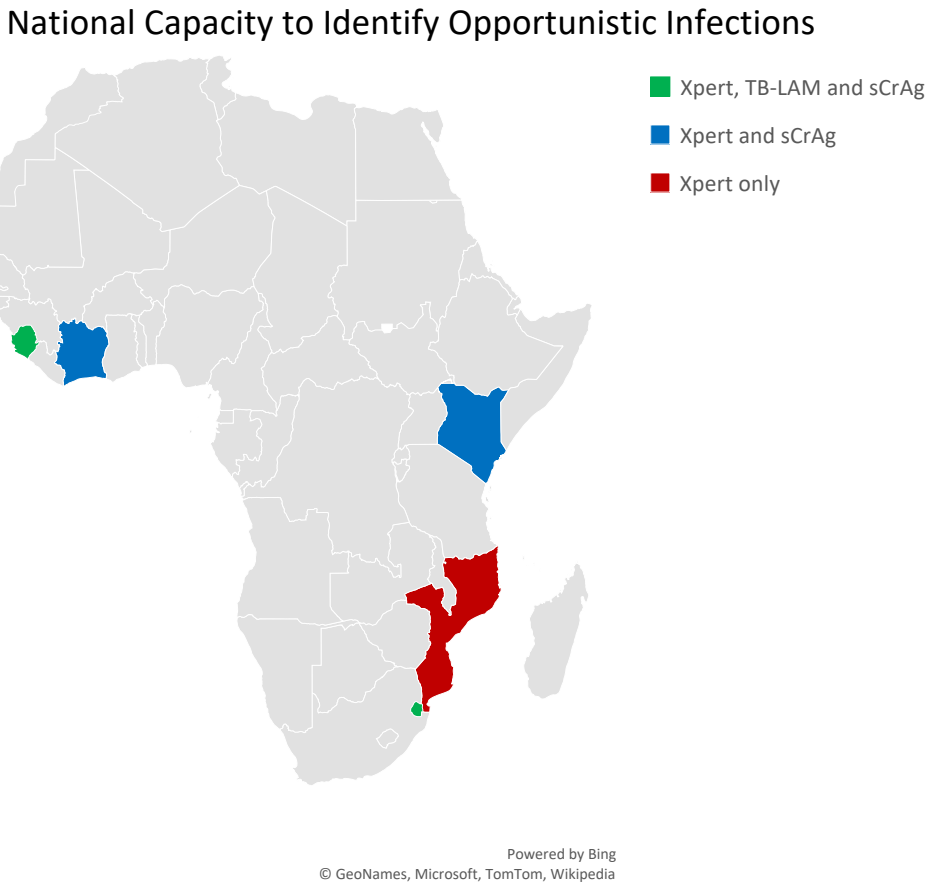
Diagnostic Capability 1 – Testing Capability



*Alternative Tests = sCrAg Labs and/or TB-LAM

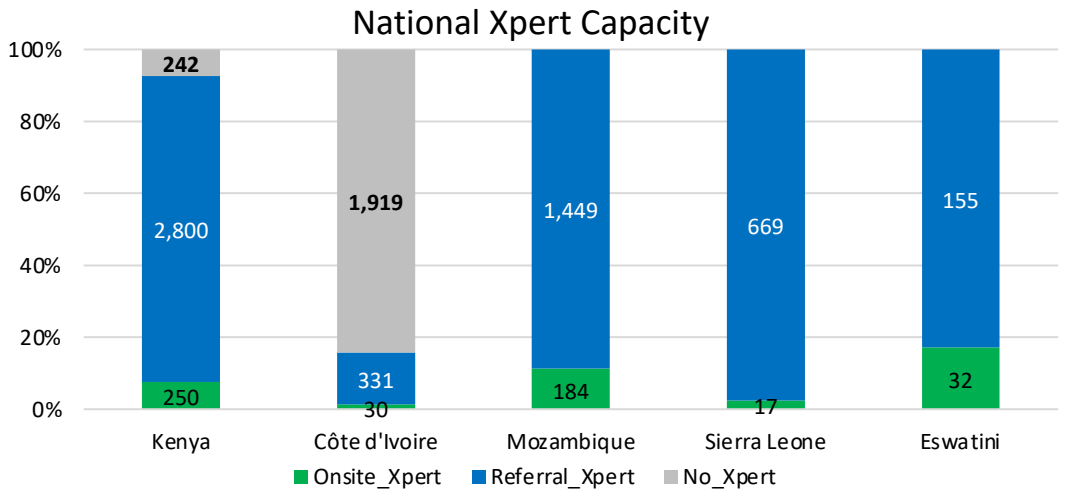
- Four out of five countries had policies supportive of CD4 testing for identification of AHD
- In these four countries; **99%** (7,284/7,392) of HF report CD4 access either on site or through referral
- In two countries with on-site CD4 diagnostic capability data, the ratio of on-site vs referral for CD4 testing was 1:7

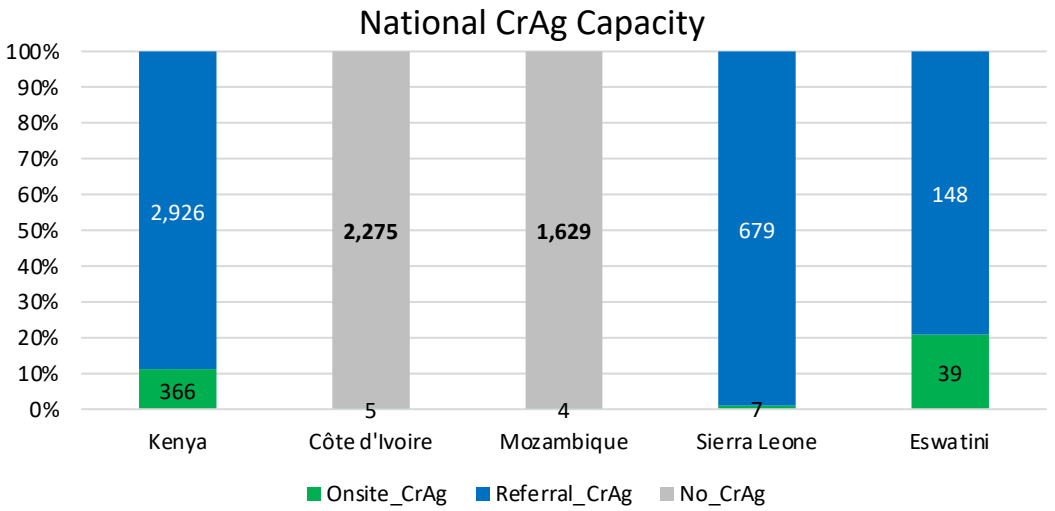
Diagnostic Capability 2 – Identification of OIs

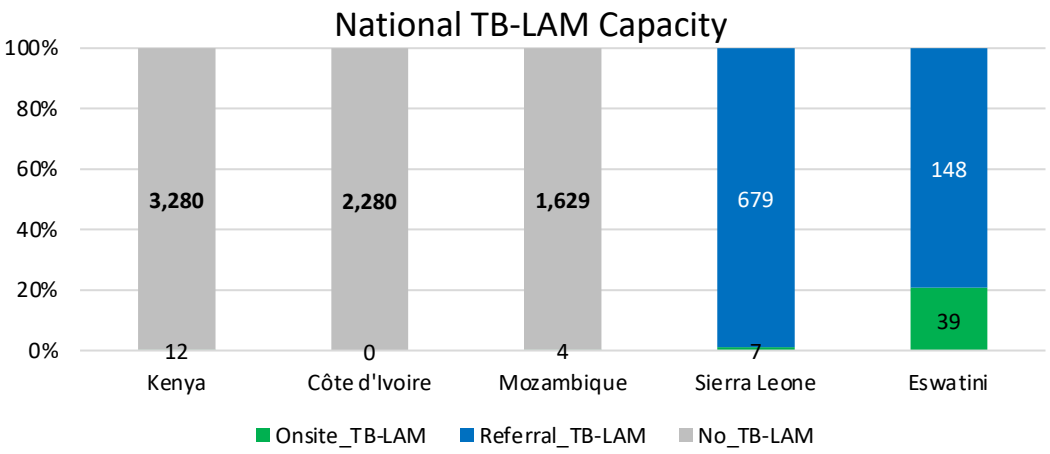


Two of the five countries report national capacity to identify TB and CM using Xpert, TB-LAM and sCrAg on-site or via a referral system

Diagnostic Capability 2 – Identification of OIs

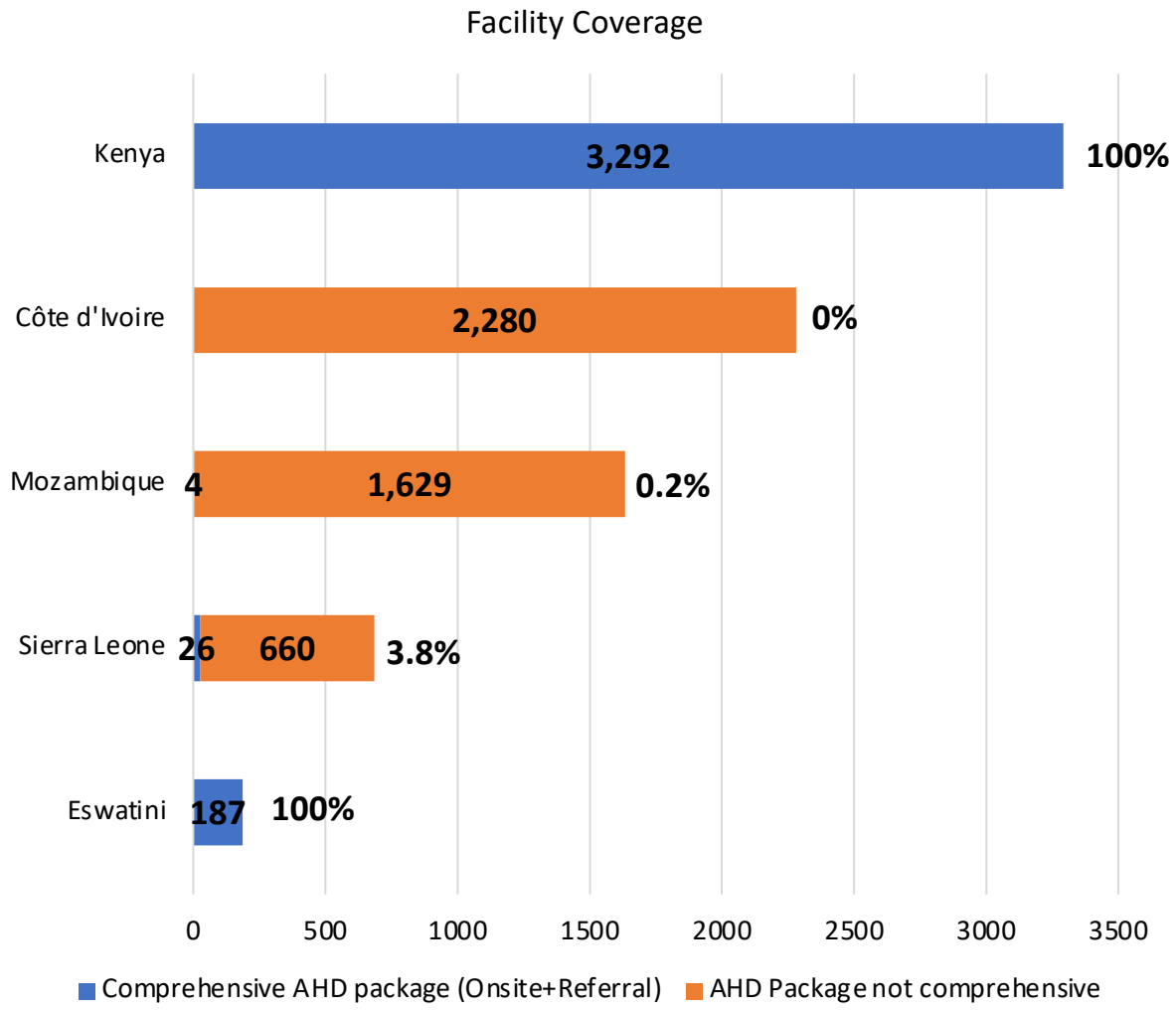


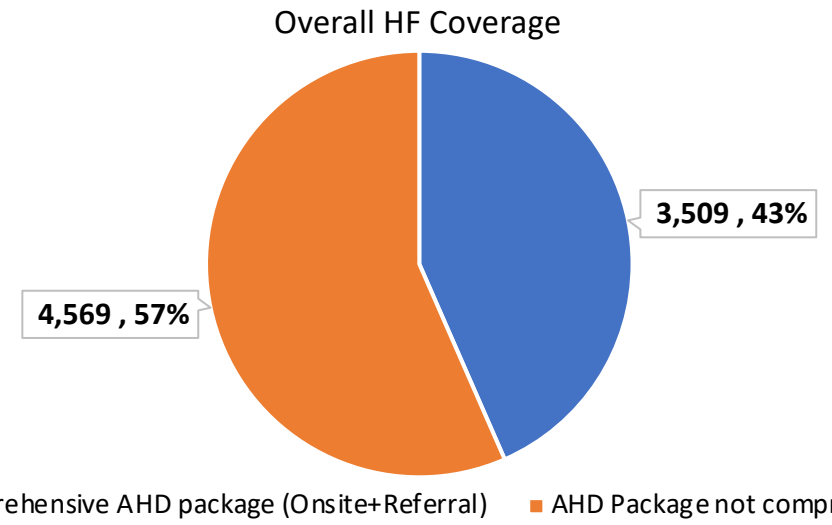




- Xpert capacity:
  - Overall capacity was at 73% (5,917/8,078) with onsite capacity present at 6% (513/8,078) of HF
- TB-LAM:
  - Overall capacity was at 15% (889/5,798) with onsite capacity present at 1% (62/5,798) of HF
  - Kenya and Mozambique have TB-LAM available in pilot facilities
- CrAg capacity:
  - Overall capacity was at 52% (4,174/8,078) with onsite capacity present at 5% of HF

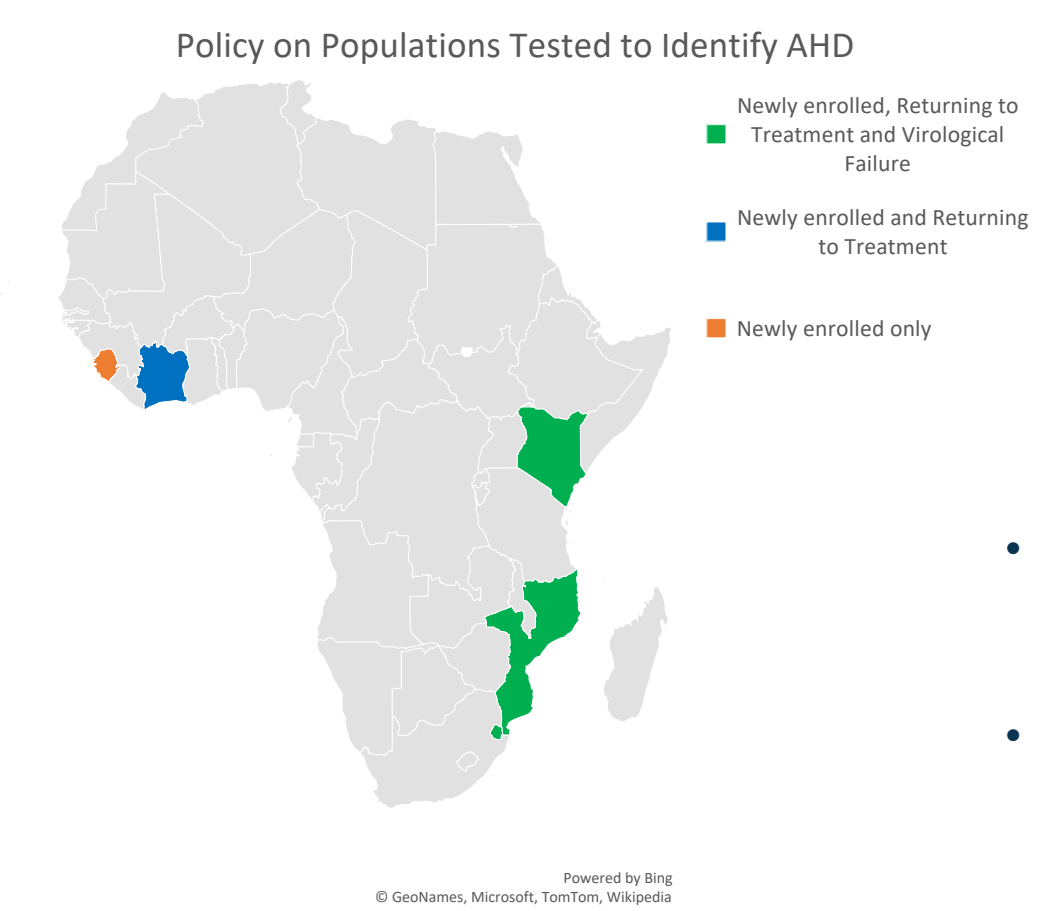
AHD Facility Coverage

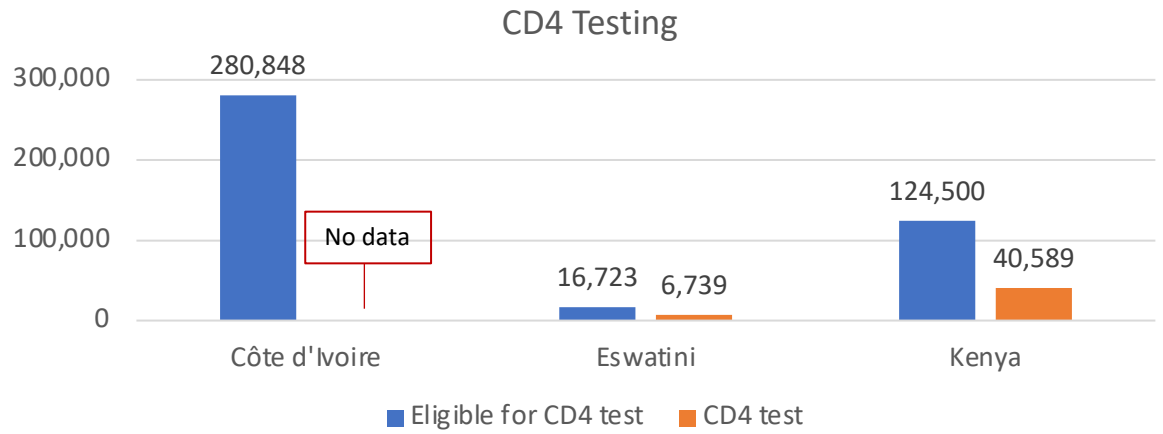




- AHD facility coverage was determined by countries as the % of health facilities with ART providing the minimum package of AHD services (on site or by referral)
- AHD Minimum Package – This refers to a nationally agreed upon combination of screening, diagnostic and management services to support PLHIV with advanced HIV disease adapted from existing global guidance on the AHD package of care

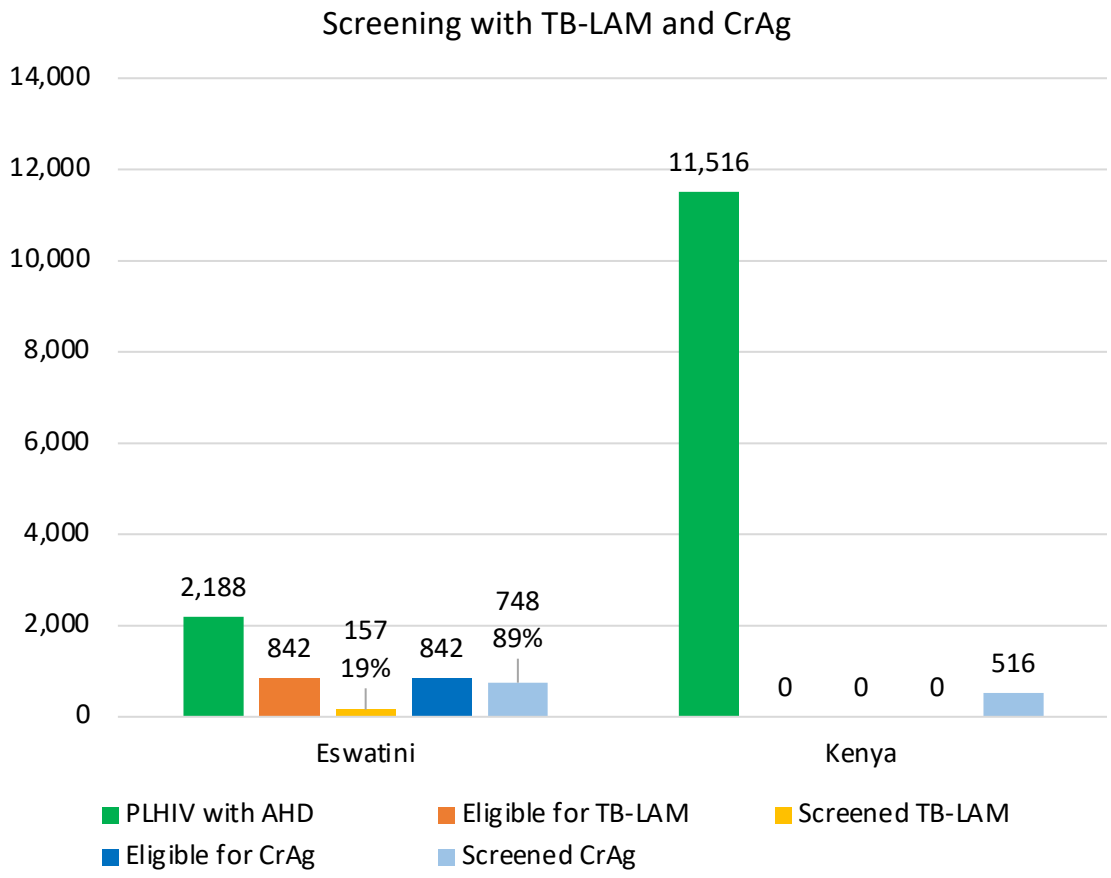
Patient Coverage 1 - Testing to Identify AHD





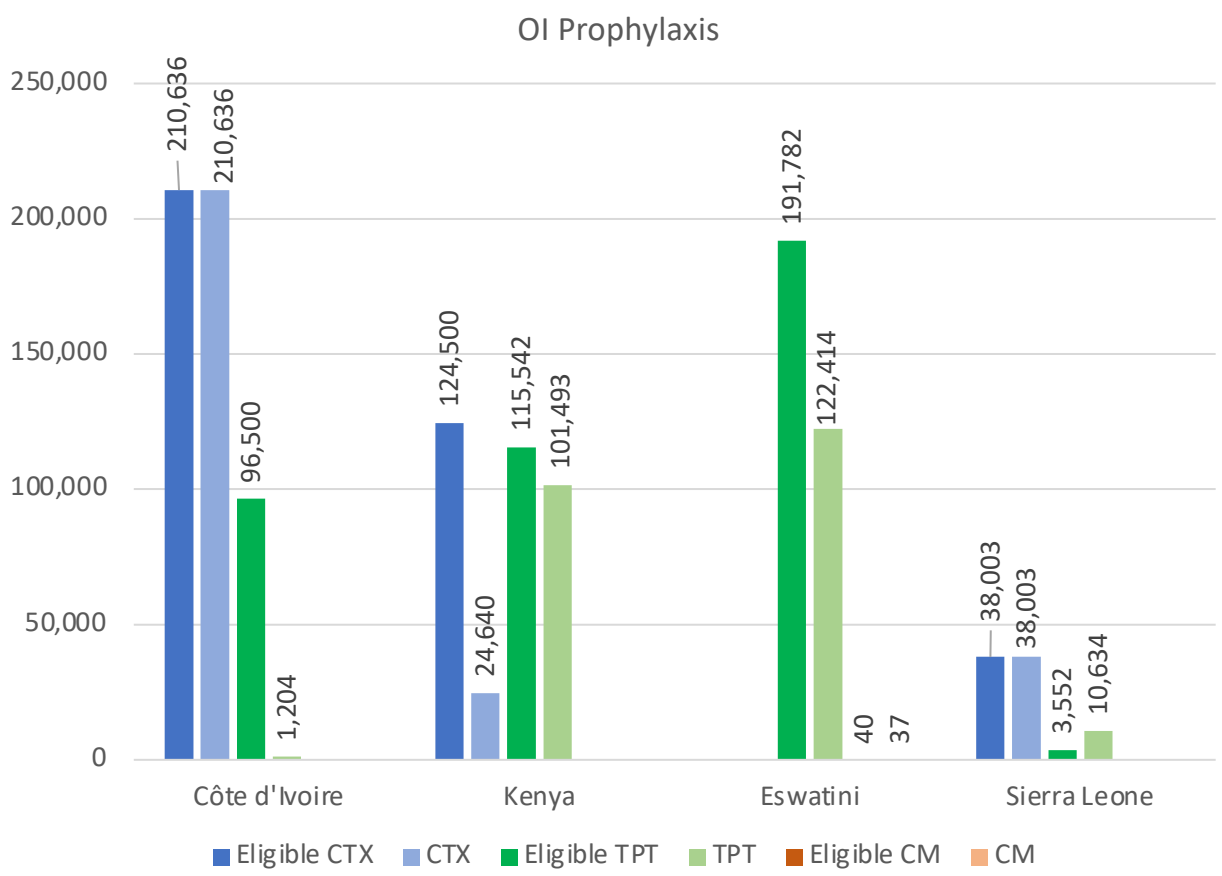
- Three countries reported having a national policy on testing all three populations of Newly enrolled, Returning to Treatment and Virological Failure for AHD
- Out of four countries with CD4 test as a policy recommendation for identification of AHD, two provided complete data on CD4 testing
- **34%** (47,328/141,223) of RoC eligible for CD4 test received a CD4 test from the two countries with complete data

Patient Coverage 2 – OI Screening among RoC with AHD



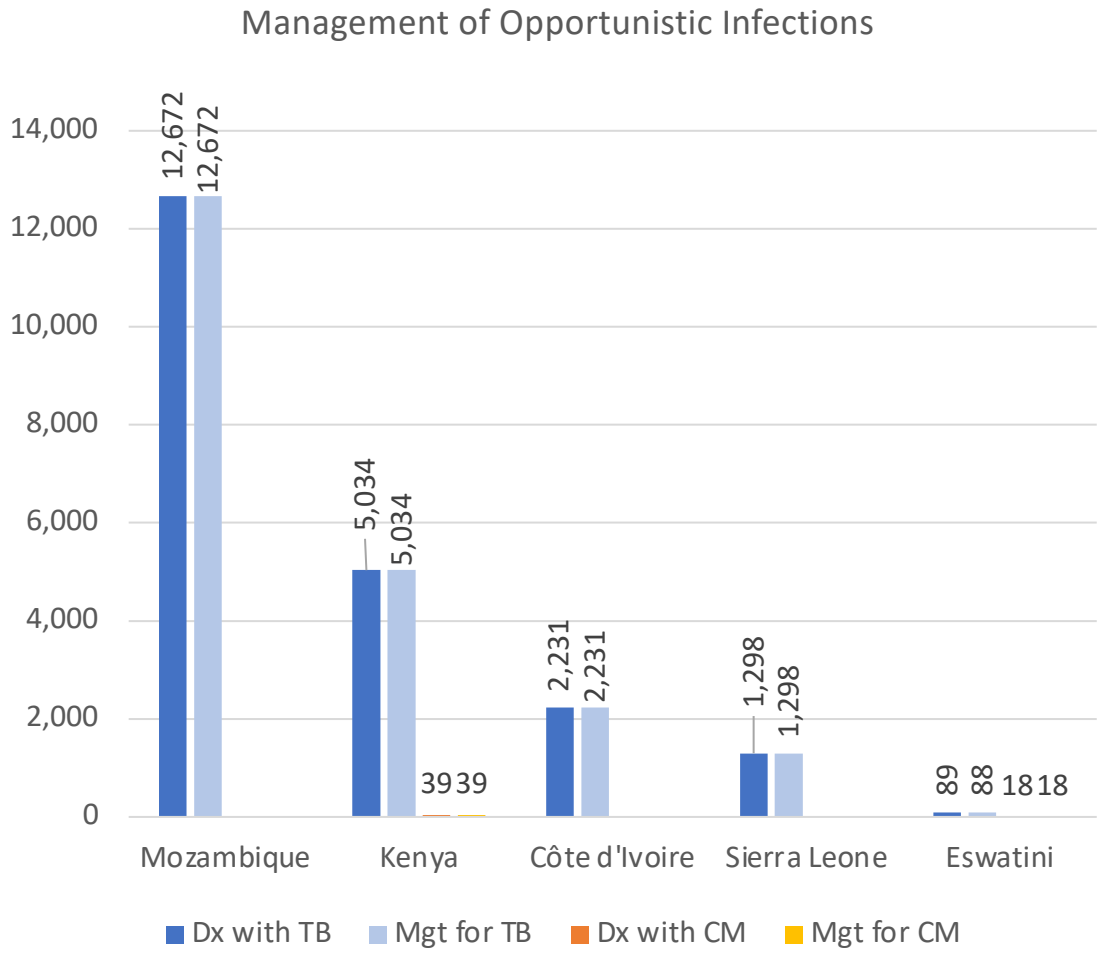
- All five countries have a national Policy on the use of TB-LAM and CrAg tests to screen for OI among PLHIV with AHD
- Only one out of five countries reported national data on both TB-LAM and CrAg
- In Eswatini, **19%** (157/842) of RoC eligible for TB-LAM screening were tested and **89%** (748/842) of those eligible for CrAg screening received a test

Patient Coverage 3 - Prevention of OIs



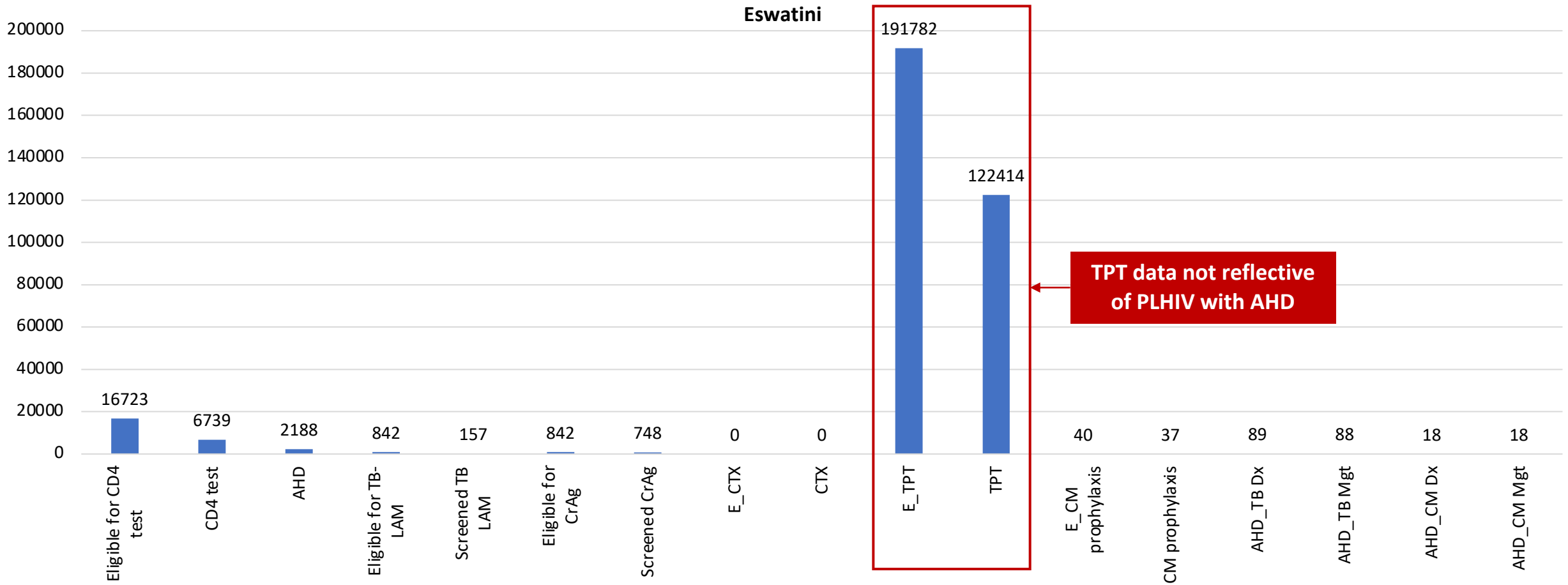
- Only one country had a national policy on all three approaches to OI prevention – CTX, TPT, and CM prophylaxis
- Four countries provided routine national data on OI prophylaxis.
- TPT is tracked through evaluations in Mozambique and Eswatini provided CM prophylaxis data from MSF
- CTX was provided in **73%** of eligible RoC while TPT provided in **58%** of eligible RoC
- In Eswatini, **93%** (37/40) of RoC eligible for CM prophylaxis received it

Patient Coverage 4 - Management of OIs



- Four out of five countries reported country-wide implementation of both TB and CM management
- All five countries provided data on TB management – Not confirmed that this references specifically to TB management for PLHIV with AHD in all countries
- Only Kenya and Eswatini had data on CM management with **100%** of PLHIV diagnosed with CM being put on treatment

Illustrative AHD Cascade



- **While the data may not be accurate, the above illustrative AHD cascade is proposed designed based on currently available data**
- **Future revisions will be necessary as countries improve in the M&E of their AHD programs**

Based on available variables

Highlights

- CD4 testing capability through onsite and referral systems was available in four out of five countries with one country using primarily alternative tests (sCrAg and TB-LAM) to identify PLHIV with AHD
  - In the four countries **99%** of HF reported access to CD4 testing capability (onsite & offsite)
- In two out of the four countries reporting national level data, **34%** of eligible PLHIV received a CD4 test
- The diagnostic capability for HF to diagnose TB and CM were at
  - **73%** for Xpert across all five countries,
  - **15%** for TB-LAM across four out of five countries with TB-LAM,
  - **52%** for CrAg across all five countries
- In one country which provided data on patients screened for TB and CM:
  - **19%** (157/842) of PLHIV eligible for TB-LAM screening received a test, while
  - **89%** (748/842) of those eligible for CrAg screening received a test

Highlights

- Where data on OI prophylaxis was available:
  - Data from three countries showed CTX was provided in **73%** (273,279/373,139) of eligible RoC
  - TPT was provided in **58%** (235,745/407,376) of eligible RoC from four countries
  - CM prophylaxis provided in **93%** (37/40) of eligible RoC from one country
- In terms of TB and CM treatment:
  - 100% (21,323/21,324) of PLHIV diagnosed with TB from five countries were initiated on TB treatment
  - 100% (57/57) of PLHIV diagnosed with CM reported from two countries were initiated on CM treatment
- Overall AHD package of care facility coverage was at **43%**

Key take-away messages

- A **health systems & public health approach** towards AHD implementation is necessary to deliver optimal AHD services at scale. Besides policy and guidelines, key structural / health system pre-requisites to AHD scale-up include:
  - Development of a National AHD Implementation plan
  - Development of AHD SOPs and Training materials
  - RoC engagement
  - Supply chain management for AHD commodities
  - AHD M&E system
- **Access to CD4 testing** remains a key bottleneck for the AHD cascade even where there exists referral systems to existing CD4 diagnostic centers
- Robust **national AHD M&E systems** are needed to address gaps in national level data particularly on identification of AHD as well as screening, prophylaxis and management of OI among PLHIV with AHD
- **Scale-up of the AHD Dashboard** provides MoH with a unique opportunity to understand their stage in AHD implementation and develop appropriate AHD scale-up plans that address all the health system barriers to AHD implementation
- Routine **use of the AHD cascade** can provide quick feedback on progress over time on the implementation of the AHD package of care

Thank You

Establishing the AHD Hub-and-Spoke model in Eswatini

Name: Dr Malvern Masango

Designation: National TB/HIV-Technical Advisor

Date: 03 August 2021

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The **CQUIN** Project for Differentiated Service Delivery

Outline

- Brief overview of AHD epidemiology in Eswatini
- Establishment of the AHD Coordinating Body
- Adaptation of the AHD package of care from global guidance
- Development of training materials, SOPs M&E tools
- Development of the national AHD scale up & implementation plan
- AHD implementation - Experience from the field

Brief overview of AHD epidemiology in Eswatini

Total population: 1173000

HIV Prevalence: 27% (15 – 49 years)

Proportion with CD4< 100 : 18%

Serum antigenaemia positivity: 9%

CSF antigenaemia positivity: 69%

Establishment of the AHD Coordinating Body

National level

- In Collaboration with TB/HIV Focal Person
- TB/HIV Technical Advisor
- National Coordinating Committee
- Care and treatment Technical Working Group

Regional level

- Regional AIDs Coordinator
- Regional TB Coordinator
- Regional Coordinating Committee

Facility Level

- AHD Focal Person
- Management (SMO and Nursing Sister)
- Implementing Partner

Adaptation of the AHD package of care from global guidance

- In 2017 the W.H.O released Guidelines for Managing AHD and Rapid Initiation of Antiretroviral Therapy.
- The **2018 Eswatini Integrated HIV Management Guidelines** adopted the recommendations from the WHO.
- From Sept 2018-Dec 2019, CDCF supported an AHD implementation project.
- **Aim:** To offer technical support to SNAP for the rapid implementation of the AHD package consisting of CrAg and pre-emptive treatment as well as TB LAM screening and TB treatment among eligible patients.

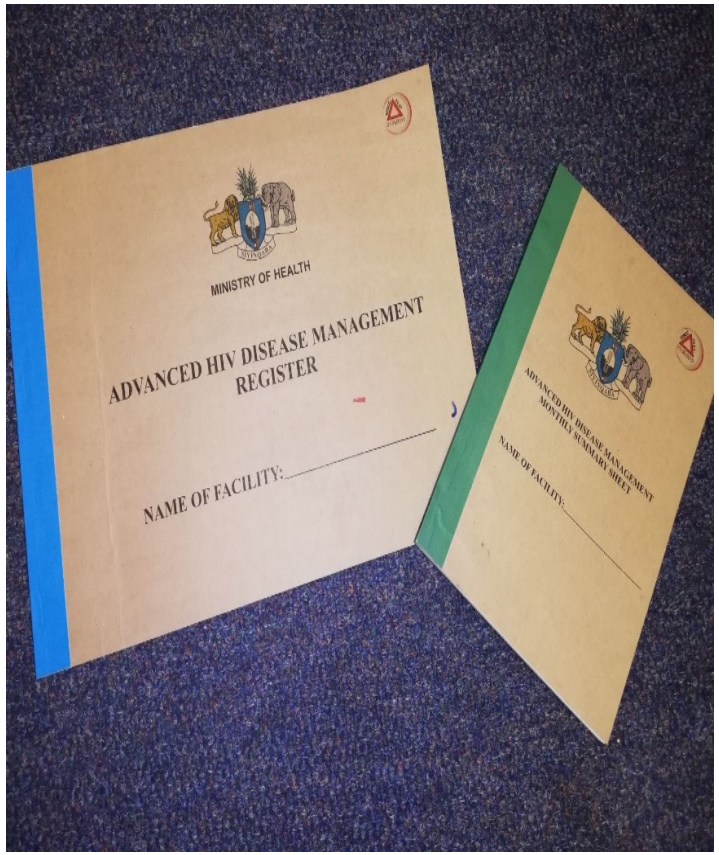
Priority Sites

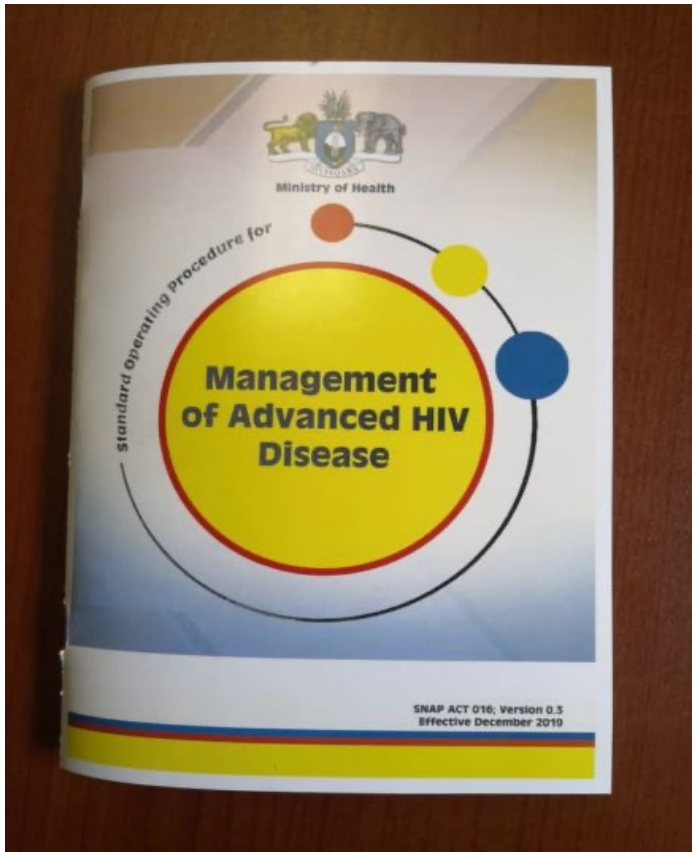
HHohho region	• Mbabane Government Hospital • Piggs Peak Hospital • Dvokolwako Health Centre • Mkhuzweni Health Centre
Shiselweni region	• Hlatikulu Government Hospital • Nhlangano Health Centre • Matsanjeni Health Centre
Lubombo region	• Good Shepherd Hospital • Lubombo Referral Hospital • Sithobela Health Centre
Manzini region	• Mankanyane Government Hospital • National TB Hospital • Raleigh Fitkin Hospital • AHF Matsapha • AHF Lamvelase • Phocweni

Development of training materials, SOPs M&E tools

- AHD task team assembled (national, regional, facility, Implementing partner, Recipients of care representation)
- Task team was led by the TB/HIV office.
- Task team was to implement a SWOT analysis, oversee project implementation, develop training material, tools and guidelines

Development of training materials, SOPs M&E tools





- SOP developed and other job aids
- M & E tool developed and approved under project implementation only.
- TOT held, followed by regional trainings using standard training materials.
- SOPs, job aids, M & E tools disseminated during trainings

Development of the National AHD scale up & implementation plan

- National implementation plan developed by the task team with the national TB/HIV office
- Hub and spoke model used, using the main hospitals as the hubs supporting primary health facilities
- Following the conclusion of the project implementation, a scale up plan was drawn (extension of tools use)
- Priority areas;
  - Decentralization of POC diagnostics
  - Decentralization of AHD medicines
  - Decentralization of tools and robust electronic M&E system
  - Trainings and capacity building

M&E of the AHD Cascade_CrAg screening

- Number of PLHIV eligible for CD4 testing (New ART patients, Patients with detectable viral load, Treatment interrupters returning to care)
- Proportion eligible tested for CD4
- Proportion with CD4 < 100 cells/ml
- Proportion of patients with CD4 <100 who had serum CrAg done
- Proportion of patients with positive serum CrAg
- Proportion of patients with positive serum CrAg with symptoms of meningitis
- Proportions of symptomatic patients with Lumbar puncture done
- Proportion with positive Lumbar puncture
- Proportion of CCM patients started on CCM treatment
- Proportion of CCM patients who die within 6 months
- Proportion of eligible patients started on pre-emptive treatment
- Proportion of pre-emptive patients who doe within 6 months

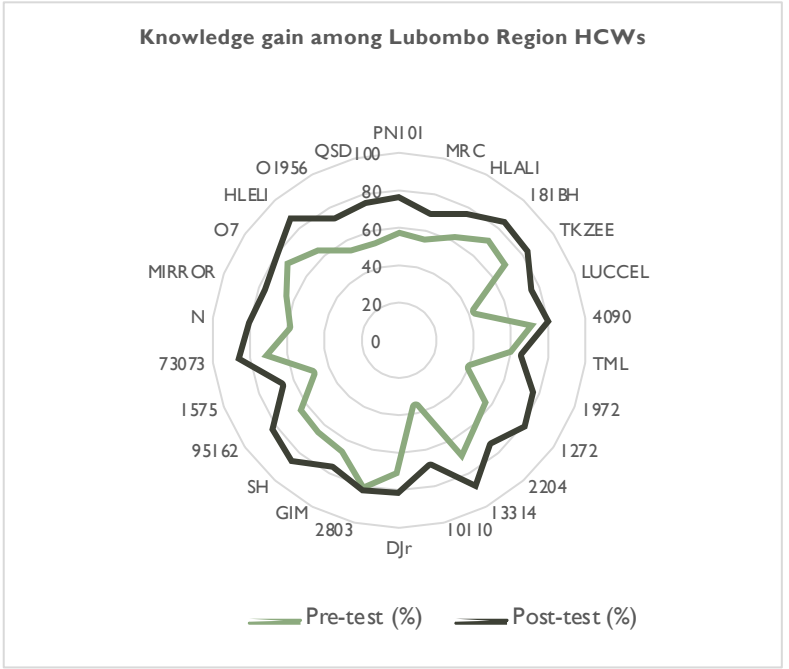
M&E of the AHD Cascade_TB LAM

- Number of patients with CD4 < 100
- Proportion of patients with CD4<100 with TB LAM done
- Proportion of patients with positive TB LAM
- Proportion of patients with CD4 < 100 with Gene Xpert done
- Proportion of patients with TB LAM and/or Gene Xpert positive started on TB treatment
- Proportion of patients with CD4 < 100 who die while on TB treatment

AHD Implementation - Experience from the field

i. AHD Clinical Care Capacity building

- Capacity building remains central to AHDM roll out
- Remarkable knowledge gaps
- Mix of training strategies (physical, On-site, virtual)
- Need for refresher training (high staff turn over, better reach, reinforce information)
- Clear, simple, readable SOPs and job aids and tools are an essential part of capacity building.



ii. Hub and spoke model mapping

- Hub and spoke model effective in service roll out
- If that framework is not in place, one should be developed following the existing patient referral pathways
- Hubs may also offer essential mentorship of the spokes in addition to Implementing partners

AHD Implementation - Experience from the field

i. Referral and linkage protocols
   - An essential part of the Hub and spoke model
   - Services at each level of care to be clearly defined and communicated with all stakeholders.
   - Referral and linkage tool/system to follow the already existing patient referral system.
   - Maybe need to develop a Referral and linkage SOP specific for AHD
   - SOP should avoid double counting of patients upon referral.

AHD Implementation - Experience from the field

i. AHD Diagnostic Capability Coverage

1. HF identification of AHD - CD4 scaleup
   - Universal CD4 coverage for all facilities offering HIV services key
   - Reagents and machine down time remains a challenge.
   - Countries to consider adopting semi-quantitative VISITECT kits for CD4 testing
   - Capacitate HCWs on the use of WHO staging in AHD assessment in the absence of CD4 testing.

2. HF diagnosis of AHD - Xpert, TB LAM, CrAg
   - All hubs should have capacity and uninterrupted supply of the above diagnostics
   - POC tests are well received at primary healthcare facilities.
   - Packaging has been a challenge for some kits, but has been addressed (TB LAM now packed in 25s)

THANK YOU

AHD Implementation in Kenya - Taking AHD Services to Scale

Dr Lazarus Momanyi
DSD Coordinator

03 Aug 2021

icap Global Health

HIV Learning Network
The **CQUIN** Project for Differentiated Service Delivery

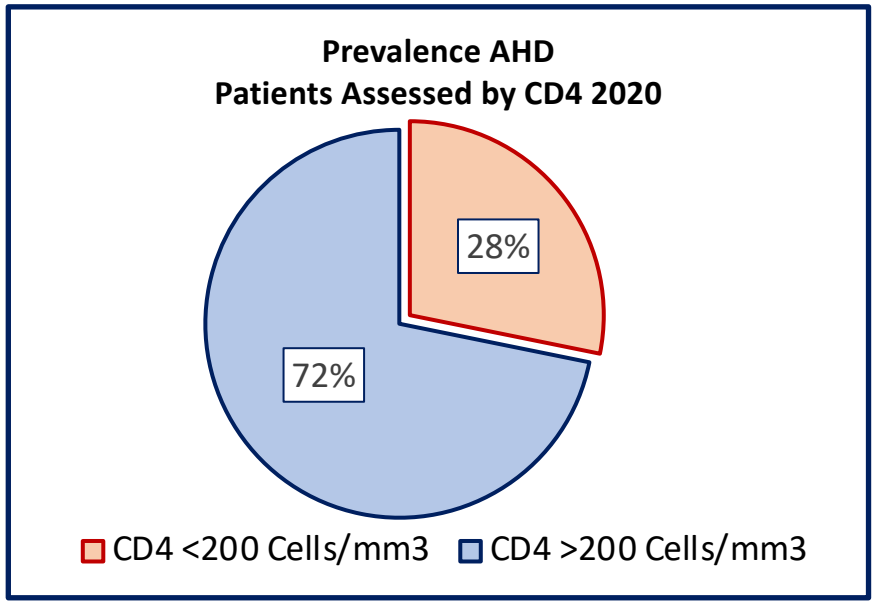
Outline

- AHD Epidemiology in Kenya
- Scaling up AHD Patient Coverage
  1. Identification of AHD
  2. TB and CM Screening
  3. TB and CM prophylaxis
     - TPT
     - Asymptomatic CM identification & prophylaxis
  4. TB and CM management
- M/E Cascade for AHD
- Challenges & Lessons Learnt

AHD Epidemiology in Kenya

Kenyan ART Guidelines Definition of Advanced HIV Disease

- WHO stage 3/4
  OR
- CD4 count ≤ 200 cells/ mm^3
  OR
- CD4% ≤ 25% for children ≤ 5 years)

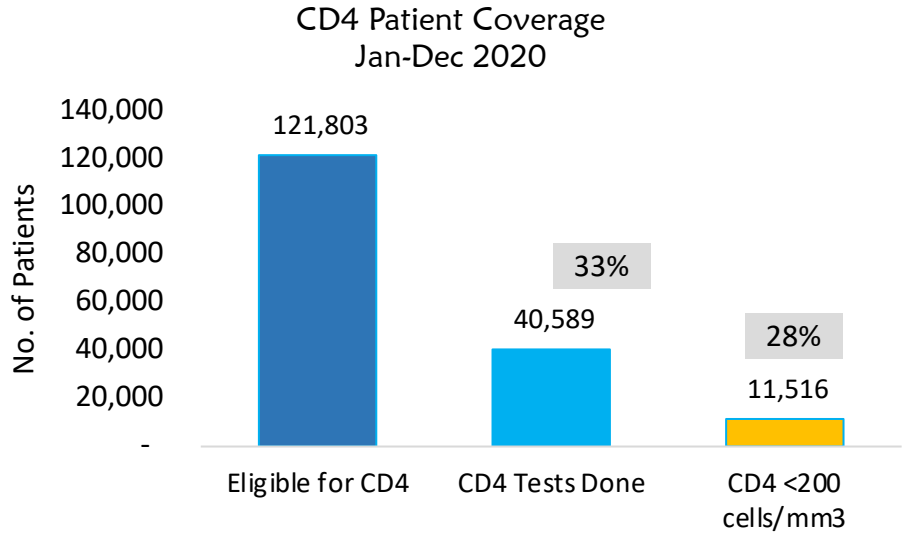


- Overall prevalence of AHD **>28%** (2020), 31% (2019)
- Up to of 84% PLHIV in the inpatient department (IPD) had AHD with associated 16.7% in- hospital mortality vs 10.3% in HIV-ve *(Homabay CR Hosp. survey)*
- AIDS related deaths declined rapidly in Kenya; 51,000 in 2010 to **20,997** in 2019, representing a **59% reduction**

Scaling up AHD Patient Coverage
AHD Identification

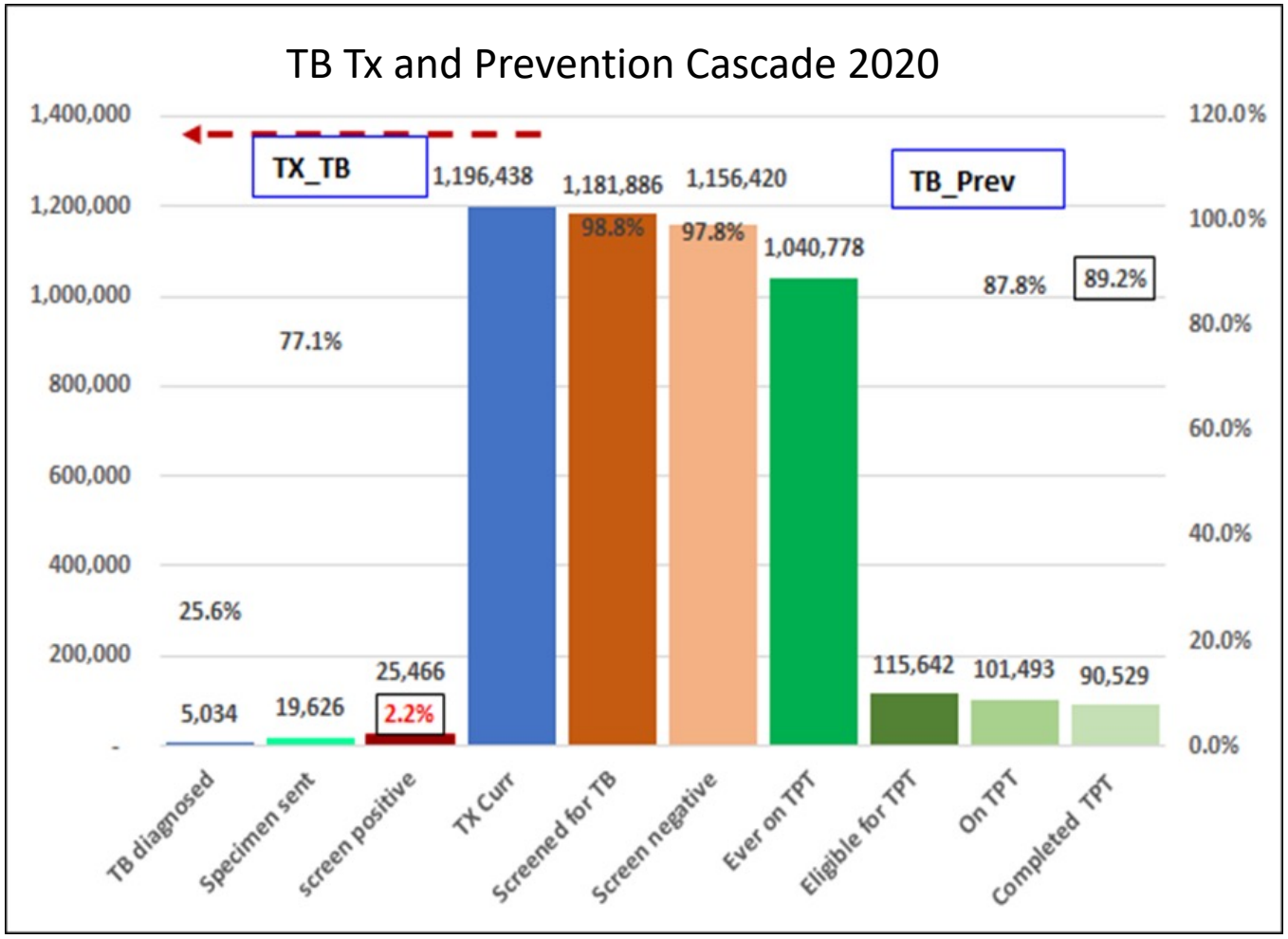
Indications for CD4 testing for identification of AHD *(Kenya ART Guidelines 2018)*

- ❖ Baseline (ALL newly enrolled on care)
- ❖ Interruption from care (off ART) for >6 months
- ❖ Treatment failure (to assess for risk of OIs)



- ✔ **3,292 -** Number of ART Sites in Kenya A total of 3,292 ART sites in the Kenya
- ✔ **336** - Number of CD4 Testing Labs (both Conventional & POC) All CD4 testing labs have capability for sCrAg testing
- ✔ Networking of all ART sites to CD4 through Hub-Spoke
- ❖ Sub-optimal coverage for CD4 testing (attributed to erratic availability of reagents and HCW factors)

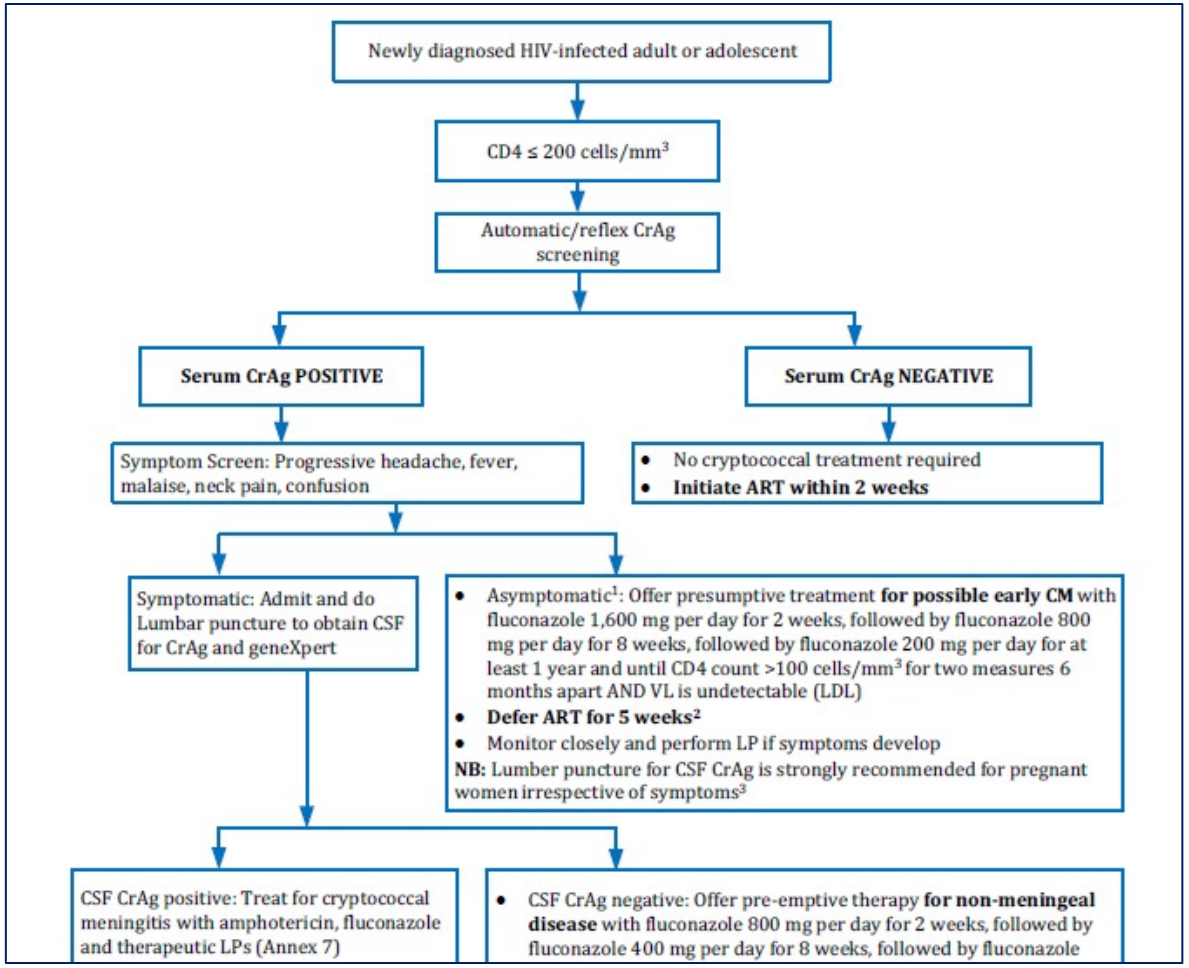
Scaling up AHD Patient Coverage
TB Screening, Prophylaxis and Mx



- TB Screening done at all sites using symptomatic screening Intensive Case Finding (ICF) tool at each visit
- Improving symptom and screening diagnosis through TB LAM and Xpert and including use of stools specimen in children
- Isoniazid used for TB Preventive Therapy(TPT) - Country has adopted use of 3HP for TPT, currently in transition, scale up
- Over 99% of those diagnosed with TB treated

PEPFAR - Source DATIM, KHIS, IP Data

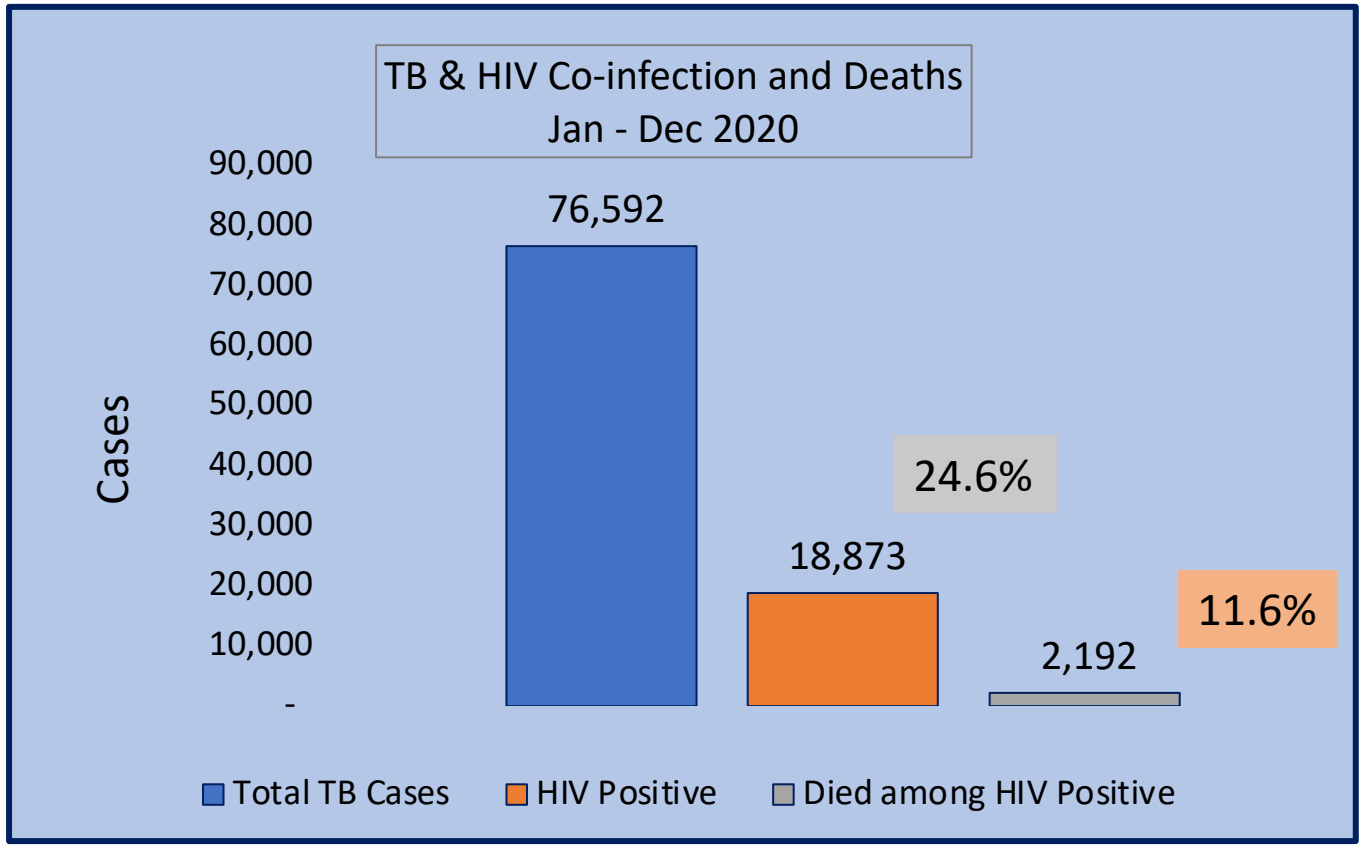
Scaling up AHD Patient Coverage
CM Screening and Management



Kenyan ART Guidelines, 2018

- Most CD4 Labs conduct 'reflex' serum CrAg testing for all samples with Cd4 <200 cells/mm³
- Kenyan ART Guidelines do not recommend prophylaxis for patients screening negative with SCrAg
- 77% of samples with <200 cells/mm³ had reflex SCrAG done
- Positivity rate for CM 7.5% (39)
- 97% (38) of cases treated
- Access to data on CM inpatient hospitalization, diagnosis and mortality is still a challenge

TB Related Deaths Amongst PLHIV - Kenya



- TB is leading cause of morbidity/mortality among PLHIV
- Case fatality rate of 11.6% amongst TB patients with HIV Co-infection

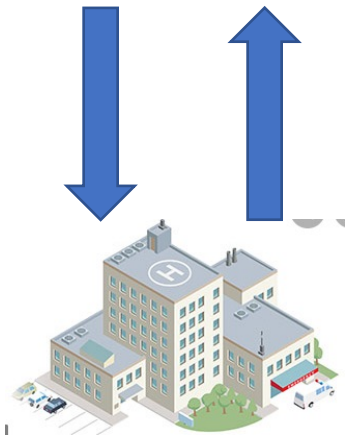
Source - TIBU (National TB Reporting Database, Kenya)

M&E of the AHD Cascade

National Data Ware House (NDWH)

Kenya Health Information Systems (KHIS)

Viral Load/EID Database



Health Facilities within Counties Paper Based/EMR

- Additional data - in patient charts/client files, Laboratory tracking logs
- Client encounter form (Green card) has limited data elements
- Approx. 90% of ART patients seen in EMR sites - opportunity to leverage on pt level data for AHD, create dashboards
- Country currently reviewing national reporting tools

AHD Dashboard Pilot - Kenya

	Dark Green	Light Green	Yellow	Orange	Red
Policies					
Guidelines					
National AHD Implementation Plan					
Standard Operating Protocols (SOPs)					
Coordination					
Engagement of Recipients of Care					
Training					
Diagnostic Capability 1					
Diagnostic Capability 2					
Facility Coverage					
Patient Coverage 1					
Patient Coverage 2					
Patient Coverage 3					
Patient Coverage 4					
Supply Chain Management for AHD Commodities					
M&E System					
Quality of DSD Services					

- Pilot conducted in May 2021
- Dark Green (6), Light Green (5), Yellow (2), Orange (2) Red (2)
- Pilot has helped Country to identify gaps need to be addressed

Challenges & Lessons Learnt

Challenges

- HCW capacity on AHD
- Sub-optimal patient level coverage for screening for OIs esp. CM
- Inability of M/E system to track AHD cascade from screening, diagnosis, prophylaxis, management

Lessons Learnt

- Scale up of POC CD4 tests including semi-quantitative rapid tests will increase AHD identification
- Continuous HCW sensitization as well Recipients of Care to create demand/awareness on AHD is critical
- An integrated fore-casting, quantification and supply chain for AHD is essential to support AHD implementation to scale

Acknowledgements

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- Networks of PLHIV

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Next steps & useful links

Slides and recordings from today's session will be posted on the CQUIN website: https://cquin.icap.columbia.edu/

The next CQUIN webinar will be on Tuesday, September 7th and will explore the topic of "Two-way texting, chatbots, and other innovations to support HIV services across the cascade."