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HIV/NCD Integration in Eswatini

Dr. Clara M Nyapokoto
Eswatini National AIDS Program
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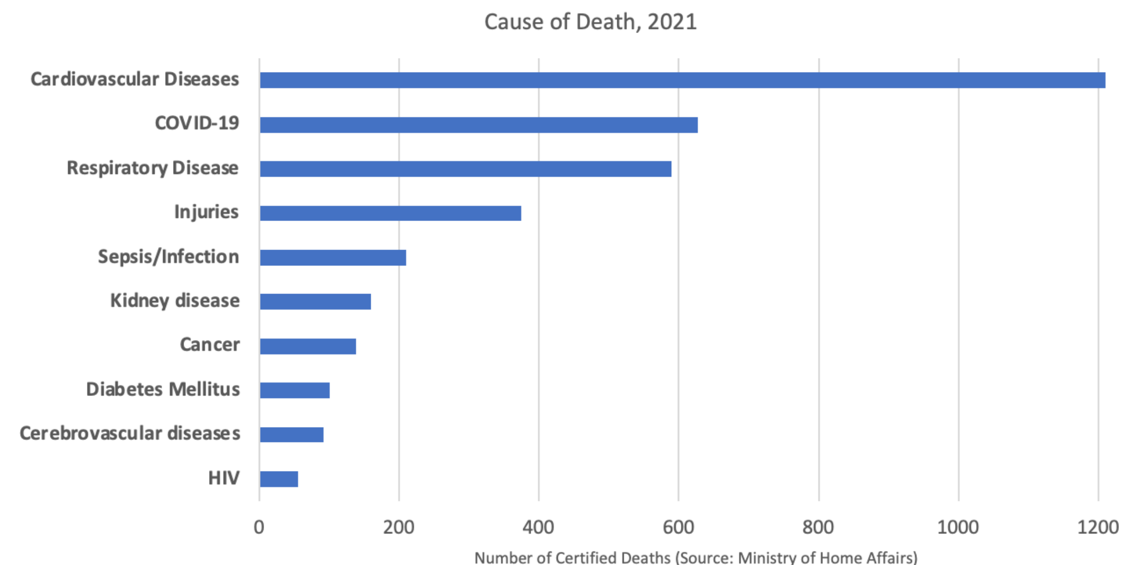
Outline

- Situational Analysis
- HIV/NCD integration in Eswatini
    - Coordination
    - Guiding documents
    - Caregivers and services at different levels of care
    - Basic package of care
    - HIV/NCD service provision models
- Opportunities and successes
- Challenges and recommendations
- Next steps
- Bibliography
- Acknowledgements

Situational Analysis: HIV and NCDs in Eswatini – 1

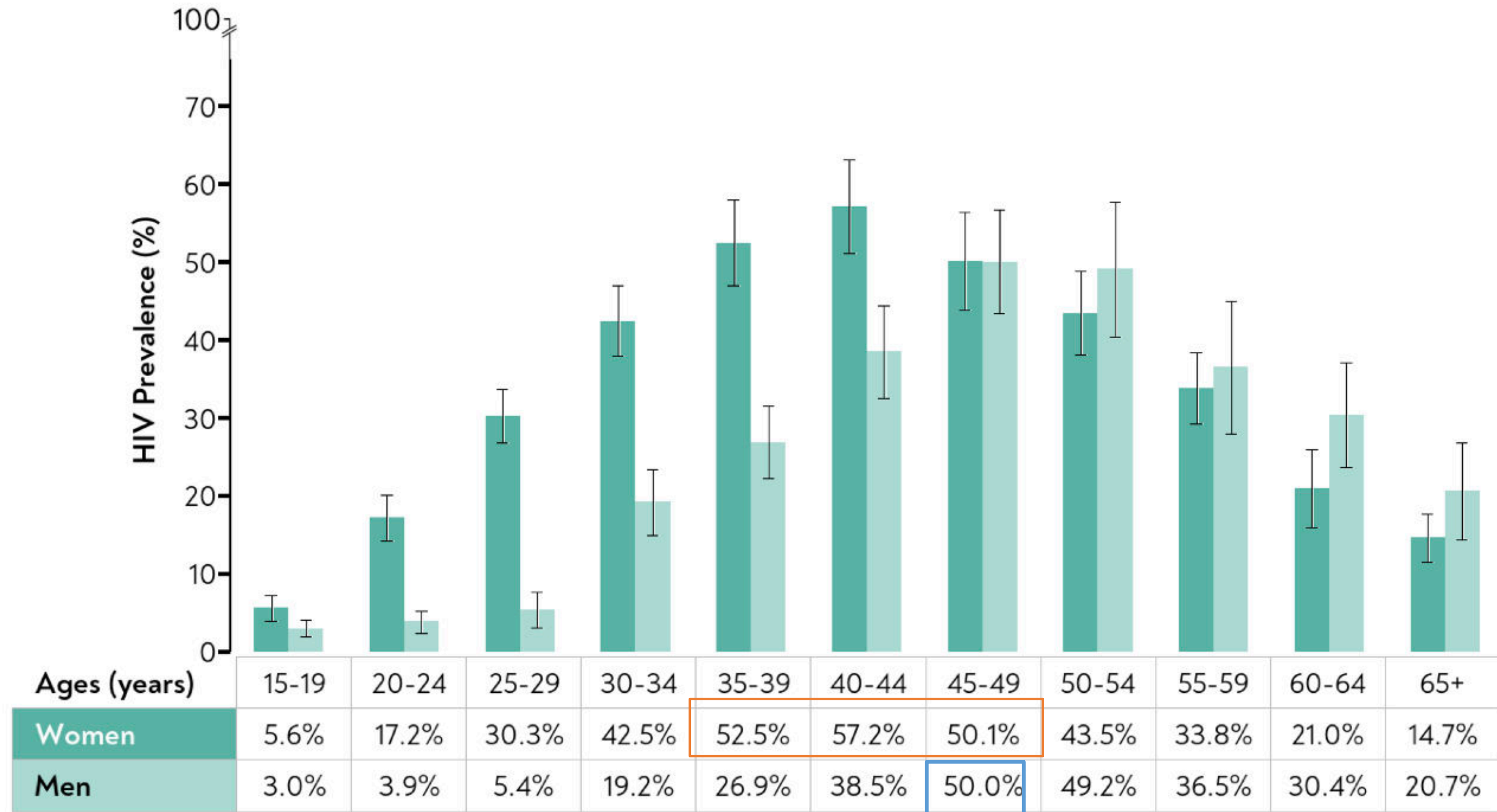
- HIV prevalence amongst adults in Eswatini = 25.9% [24.7-26.5]
- Eswatini was the first country in Africa to achieve the 95-95-95 goals and HIV incidence has decreased from 2.48% in 2011 to 0.62% in 2021*
- As of 2021, *NCDs are the leading cause of death* nationwide
  - Cardiovascular disease
  - Chronic respiratory disease (COPD)
  - Cancer
  - Diabetes



*Source: SHIMS1, 2011 and SHIMS3, 2021

Situational Analysis: HIV and NCDs in Eswatini – 2

- HIV prevalence in older people is high with peaks in males 45-49 yrs and females 35-49 yrs
- Expanded access to care and treatment means the cohort of people with HIV is aging and at increasing risk for NCDs
- 6.7% of people on ART have documented NCDs; prevalence may be higher given data gaps

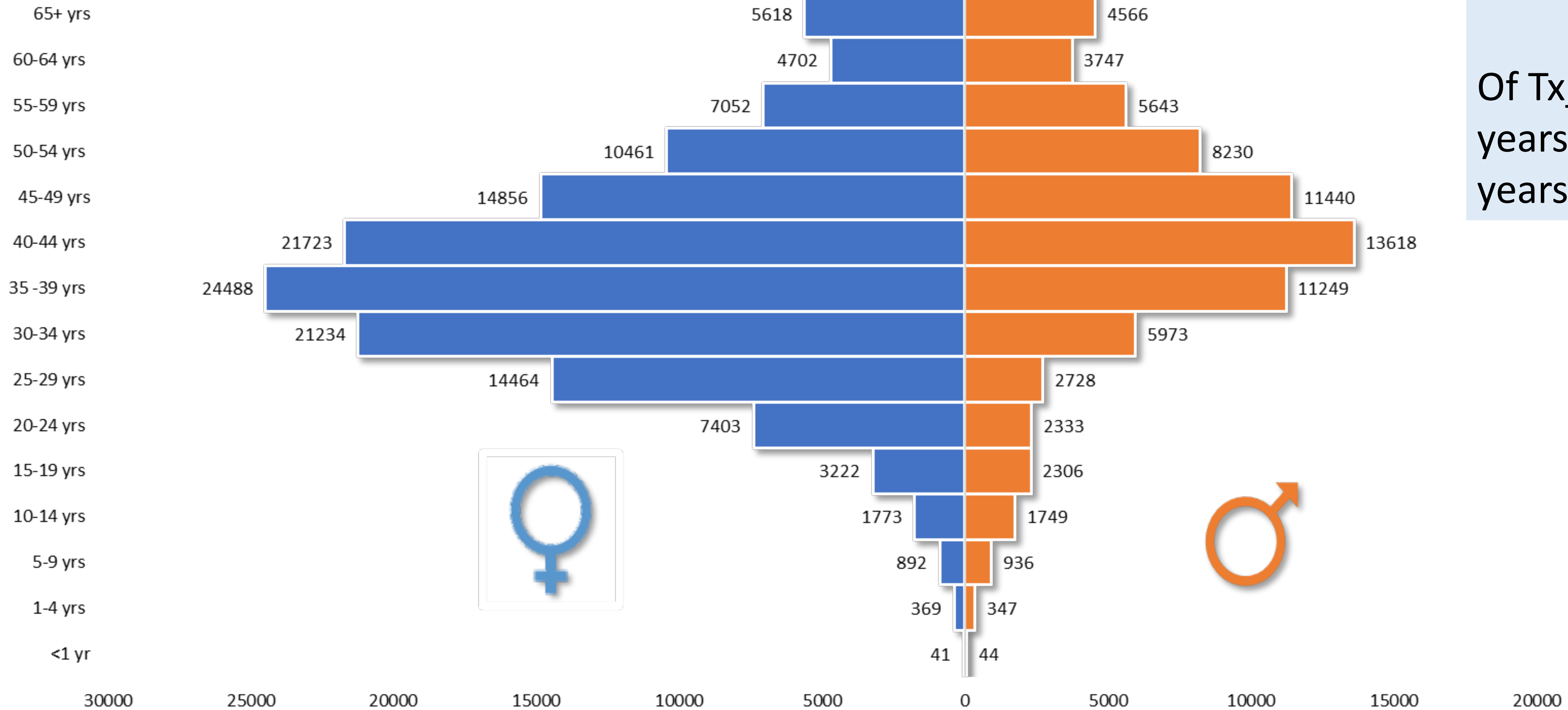


Ages (years)	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
Women	5.6%	17.2%	30.3%	42.5%	52.5%	57.2%	50.1%	43.5%	33.8%	21.0%	14.7%
Men	3.0%	3.9%	5.4%	19.2%	26.9%	38.5%	50.0%	49.2%	36.5%	30.4%	20.7%

Error bars represent 95% CIs.

Source: SHIMS3, 2021

Situational Analysis: HIV and NCDs in Eswatini – 3

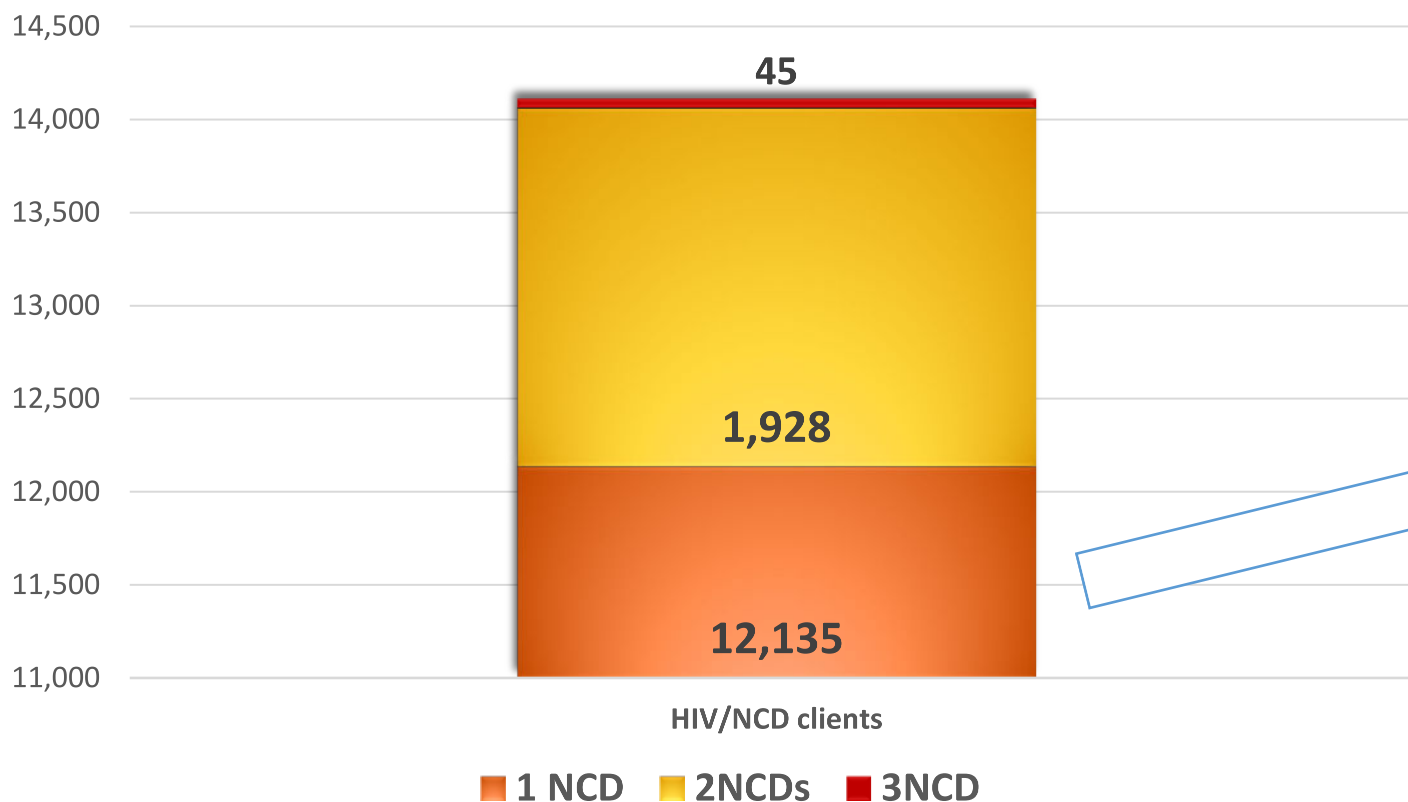


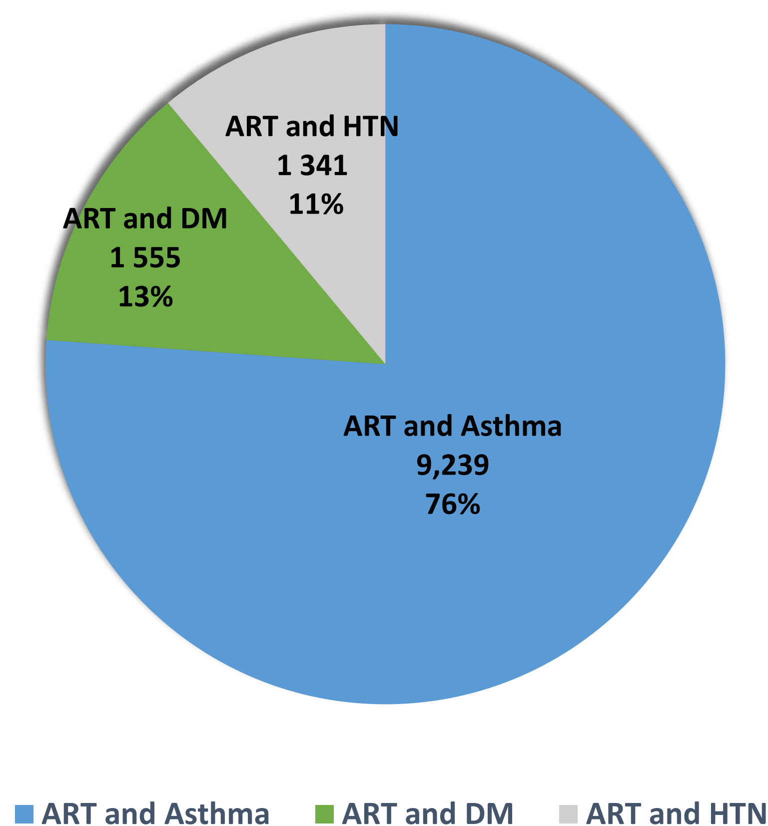
> 60% of people on ART are in Primary Health Clinics

Of Tx_curr, 27% are ≥40 years and 12% are ≥50 years

Source: HMIS, 2023

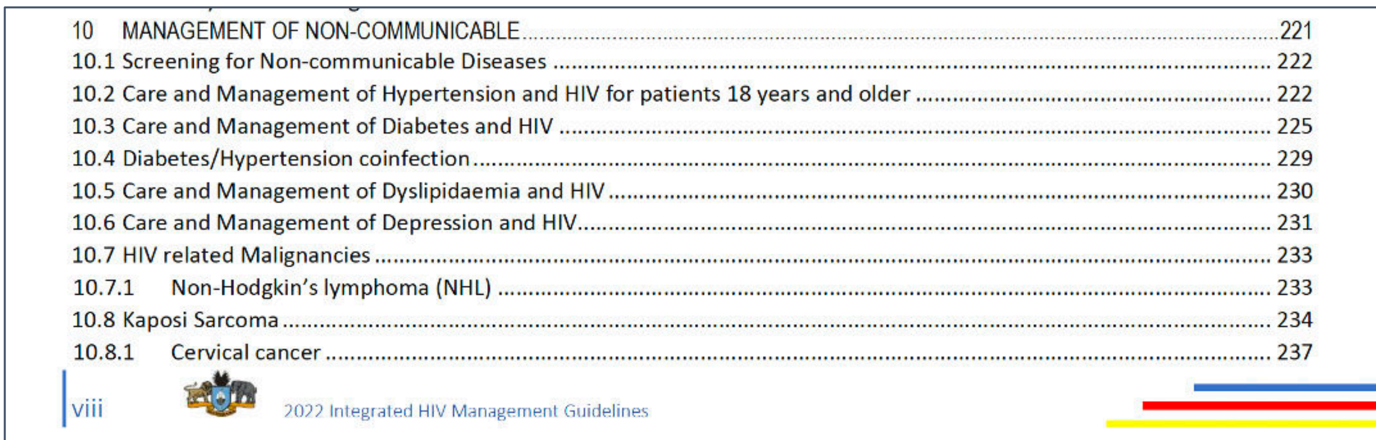
Situational Analysis: HIV and NCDs in Eswatini – 4





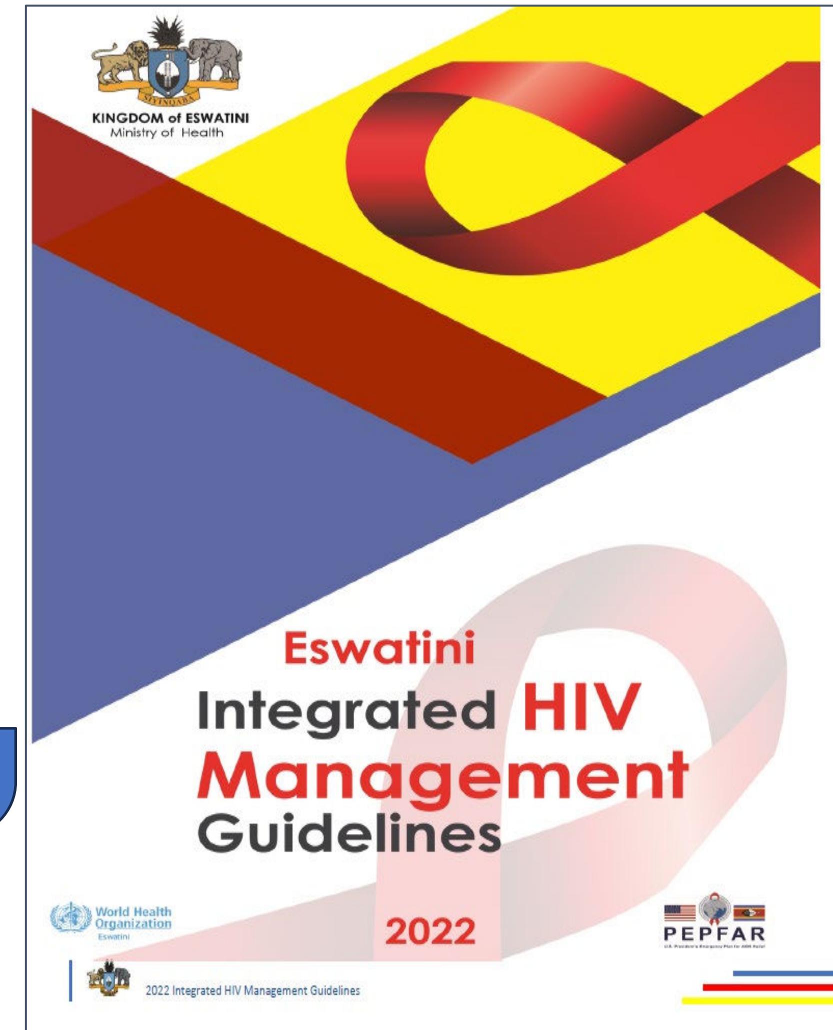
Guiding Documents

- SOPs for Facility-based Treatment Clubs (FTCs) including Fast Track model
- SOPs for Community-based Adherence Groups (CAGs)
- NCD Guidelines



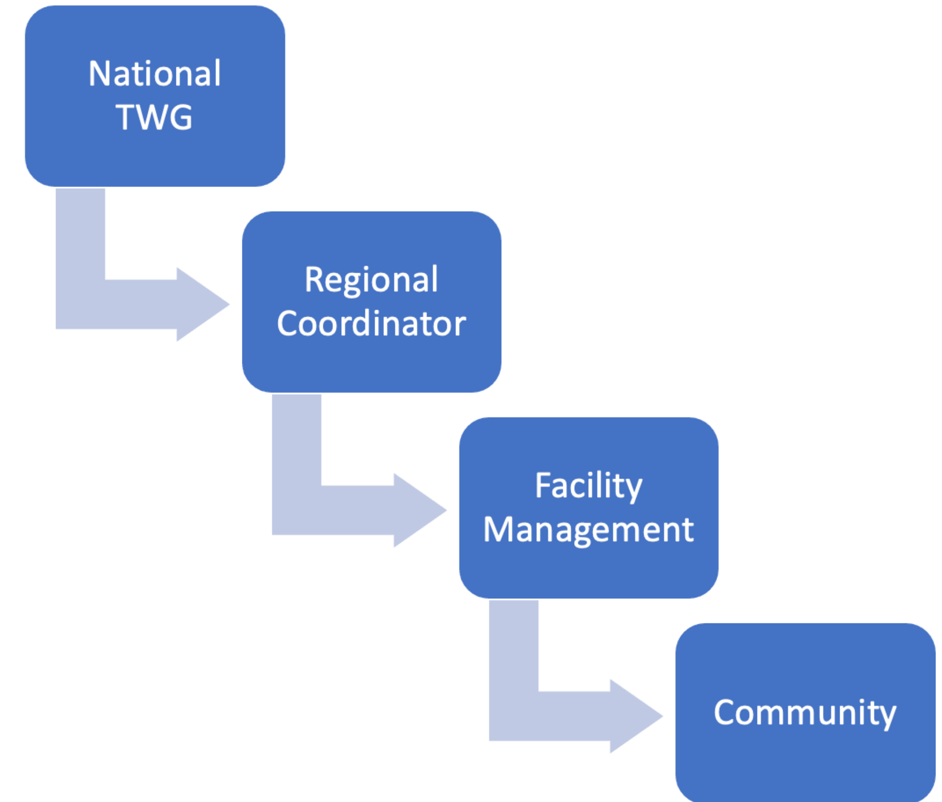
10 MANAGEMENT OF NON-COMMUNICABLE 221
10.1 Screening for Non-communicable Diseases 222
10.2 Care and Management of Hypertension and HIV for patients 18 years and older 222
10.3 Care and Management of Diabetes and HIV 225
10.4 Diabetes/Hypertension coinfection 229
10.5 Care and Management of Dyslipidaemia and HIV 230
10.6 Care and Management of Depression and HIV 231
10.7 HIV related Malignancies 233
10.7.1 Non-Hodgkin's lymphoma (NHL) 233
10.8 Kaposi Sarcoma 234
10.8.1 Cervical cancer 237

viii 2022 Integrated HIV Management Guidelines



Coordination: Integration of NCD and HIV services

- **National TWG**
  - HIV care and treatment (including integration officer from NCD Department)
- **Regional Coordinators**
  - HIV, SRH, NCD, HMIS, Quality
- **Facility Management**
  - Nurses, doctors
- **Community***
  - Community health workers



Who provides services at different levels of care?

Community

- **Community HCW**
- **Nurses**

- Contact tracing
- Prevention
- Diagnostics (Outreach)
- Curative (Outreach)
- Contact Tracing
- Referral & Linkages

PHC

- **Nurses, Lay Cadres & visiting mentors**

- +Rehab
- +Palliative care
- Psychological 1st aid

Health Centre

- **Nurses, GPs, visiting Psychologists & Clinical Advisors**

- Prevention
- Referral
- +Advanced screening
- +Advanced diagnosis
- +Advanced curative
- Psychosocial support

Regional Hospital

- **Nurses, GPs, Physicians, visiting psychologists & Clinical Advisors**

- ±Chemotherapy
- ±Dialysis
- Chemotherapy
- Advanced Rehabilitation
- Advanced Palliative Care
- Psychosocial support

National Referral Hospitals

- **Specialists**
- **Specialist services**

- +Oncology
- Dialysis
- Psychotherapy
- Radiotherapy**
- Chemotherapy

HIV/NCD service provision models

DIFFERENT HEALTH FACILITIES	UNDER 1 HEALTH FACILITY	UNDER 1 ROOF	UNDER 1 ROOM
• **Different Providers** • Most 2° and 3° facilities • HIV and NCD services not integrated	• **Different service points** • **Different providers** • Mostly in secondary – tertiary facilities • HIV and NCD appointments not always coordinated	• **Different service providers** • **1 building** • Primary – Tertiary facilities • Coordinated appointments *if* all documents available and stock allows	• **1 service provider,** • **1 service point** • Most primary care clinics • Coordinated appointments

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Facility Based Treatment Clubs for people with both HIV and NCDs

- Maximum of 20 clients per club
- 3 monthly clinical reviews aligned with laboratory tests if necessary.
- If refills happen between clinical visits (i.e., at one month), refills should be fast-tracked for both ARVs and NCDs

Inclusion criteria for HIV positive clients

- ≥ 18 years old
- Hypertensive or Diabetic
- ≥ 12 months on ART
- Most recent viral load is undetectable and taken within six months of enrolment
  - In the absence of viral load monitoring, CD4 cell counts above 500 cells/mm^3
- No current TB
- Not currently pregnant or breastfeeding
- At least two ART visits at the facility

Basic HIV/NCD Package of Care – 1

- **Screening/Testing**
  - HIV testing for people with NCDs
  - NCD screening for people with HIV
- **Linkage**
- **HIV care for people known to have NCDs**
  - Assessment of readiness for ART (to identify and address potential barriers)
  - Rapid ART initiation
  - Index testing
  - Cotrimoxazole prophylaxis for all eligible PLHIV
  - Tuberculosis (TB) screening for PLHIV +/- TPT/TB Treatment
  - Monitoring of HIV Treatment (Adherence, OIs, CD4, Viral load, other lab investigations, ADRs)
  - Re-screening for NCDs (annually) or biannually if "at risk"

Opportunities and Successes

Successes

- HIV/NCD integration started at primary level facilities
- EMR can now capture some HIV/NCD variables
- NCD clients are eligible for up to 3MMD for both NCD and HIV medications
- NCD, mental health, cervical cancer, HIV related malignancies modules included in HIV training curriculum
- Chapter 10 of the Integrated HIV Management Guidelines dedicated to NCDs (DM, HTN, HIV related malignancies, mental Health)

Opportunities

- The country (MoH and RoC) recognises an aging population and need for package of care for an aging population of PLHIV
- > 80% of people on ART are on a DTG based ART regimen; weight gain is an NCD screening indicator
- Low case finding and linkage among men means NCDs, HIV, SRH must collaborate to develop packages to attract men to care
- Basic care package for PLHIV indicates NCD screening at baseline and routinely especially for “at risk” populations e.g., > 50, obese, family history of diabetes, or with a cardiovascular event
- Opportunities to collaborate with Physicians, Psychiatrists, Psychologists

Challenges and Recommendations

Challenge		Recommendation
Data	Suboptimal data capturing at health facilities	Routine data validation exercises
	• Too many registers • Larger facilities not on CMIS	Programs to align indicators and registers HMIS to increase CMIS coverage
	Limited data on prevalence of NCDs among PLHIV	Add NCD indicators in HIV related surveys
Coordination	Fragmentation of HIV/NCD coordination	Routine meetings between programs to align with NHSSP
Resources	Recurrent stock out of NCD commodities	Increased Government budget Use routine data for advocacy
	Limited HRH, especially psychiatrists, psychologists	Task sharing / capacity building of current staff on mental health
	Inadequate funding for NCD-related programming and service delivery	Leverage existing funded projects
Services	Majority of clients do not get comprehensive initial assessment at NCD diagnosis	Mentorship and supportive supervision Track baseline indicators
	Need to unlearn fragmentation of service delivery and provide integrated care in some facilities	Integration framework with clear goals and outputs
	Social services	Use data for advocacy

Next Steps

Develop a chronic disease integration model

- Allows synching of indicators, reporting tools, follow up and using available resources to provide care
- Will reduce stigma associated with chronic diseases
- Build capacity of HCWs
- Improve treatment literacy

Finalisation of national referral framework

Guidance

- Update HIV/NCD integration SoPs
- Update HIV/NCD integration indicators
- Updating the psychological 1st AID manual for HCWs

Capacity building

- Continue capacity building of HCWs to manage HIV/NCD
- Treatment literacy on HIV/NCD

Decision-making and learning

- Use data to inform programming
- Benchmarking with other countries

Acknowledgements

- SNAP Program officers
- NCD Program Officers
- M&E
- Implementing Partners
- Recipients of Care

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Thank you!