Ntombifuthi Ginindza, Ministry of Health, Eswatini

DSD beyond HIV treatment

Building on DSD for HIV: The integrated chronic disease management (ICDM) framework for Eswatini

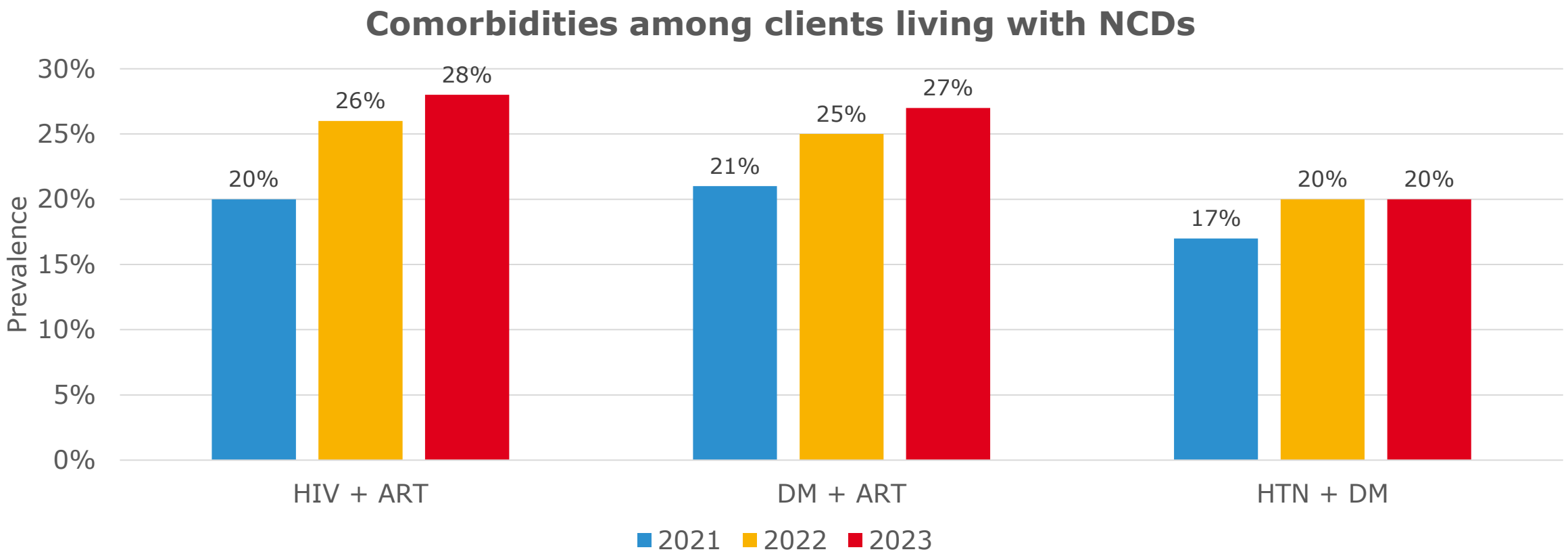
AIDS 2024

Non-communicable diseases (NCDs) and HIV in Eswatini

- High burden of non-communicable disease (NCDs), **46% of deaths in 2019**
- **Majority (80%) of NCD-related deaths are preventable** with access to care
- **Adult HIV prevalence (15-49 year olds) is 25.9%** (95% CI 24.7 - 26.5)
- **NCDs are predicted to be the largest cause of mortality** (more than HIV, TB, malaria and maternal complicated combined) **by 2030**

High prevalence of co-morbidities

CMIS 2021-2023



DM – Diabetes mellitus
HTN - hypertension

AIDS 2024

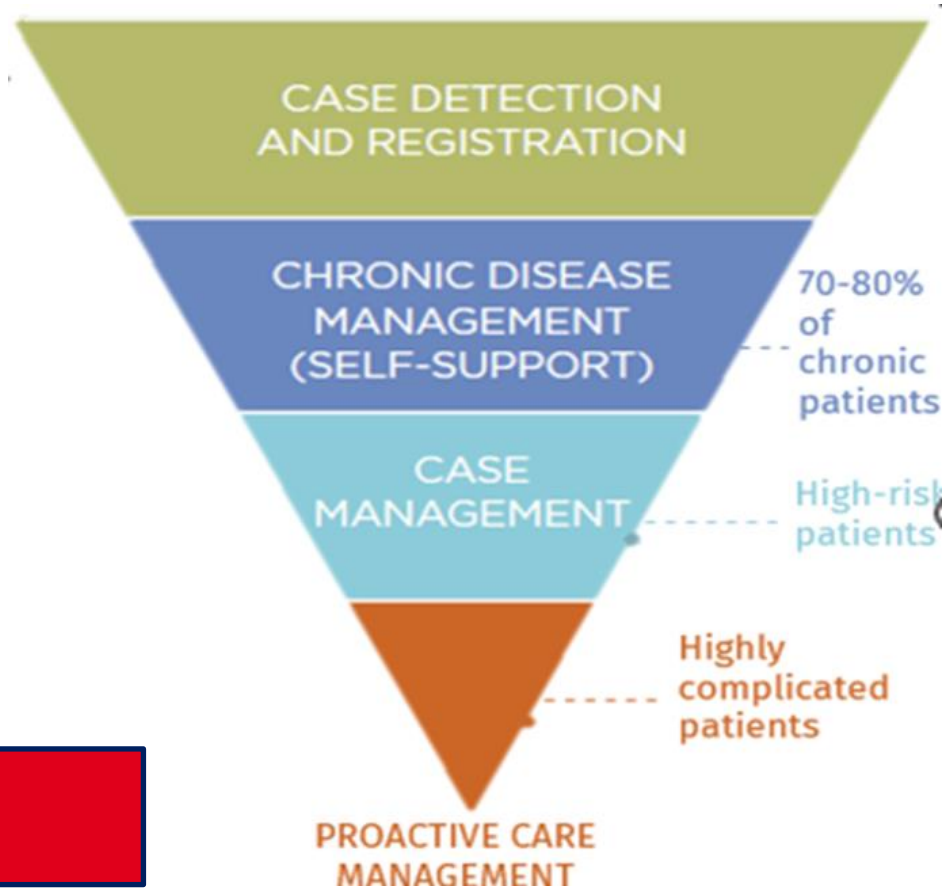
Household survey data of people over 40 years

Data from WHO-PEN@scale household survey 2020-2023

- Of the 10,940 screened, **27% had hypertension and 5% had diabetes**
- **72% of those with hypertension or diabetes had one additional condition** (e.g. depression, HIV)
- **21% of those with hypertension were also living with HIV**

Why Eswatini wanted to develop an integrated chronic disease framework

- Integrated Chronic Diseases Management (ICDM) provides integrated prevention, treatment and care of chronic patients at primary healthcare level (PHC) to ensure a seamless transition to “assisted” self-management within the community.
- ICDM aims to achieve optimal clinical outcomes for patients with chronic communicable and non-communicable diseases (NCDs)
- Empowers the individual to take responsibility for their own health



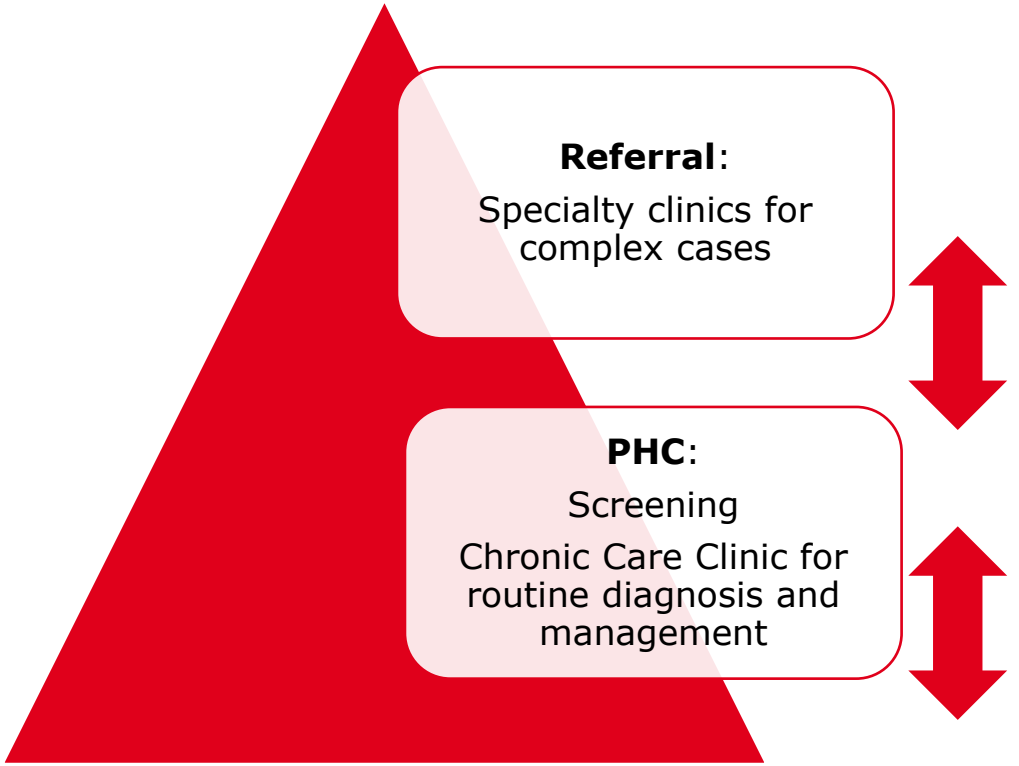
The main aim is to ensure early detection & appropriate management of people at high-risk

AIDS 2024

Integrated care defined as a ‘one-stop’ chronic care facility, where patients with either one or more of the three conditions (HIV, diabetes and hypertension) receive care at same triage point, sharing the same waiting area, reviewed by the same clinician and given single return appointment if they have more than one condition.

Chronic care requires strong PHC with referral and support structures

RHMT: integrated supervision and mentorship



Priority chronic conditions:

- HIV
- Hypertension
- Breast and Cervical Cancer
- Diabetes Mellitus
- Mental illness
- Mental Health
- Family Planning
- TB screening

Primary health care level: ART clinic → "Chronic care clinic"

Rationale:

- ART clinics are already almost fully decentralized
- Currently 50% of 45–49-year-olds are PLHIV; HIV will become increasingly prevalent among the aging population as this cohort ages up, increasing the likelihood of NCD comorbidities
- HIV treatment has already shifted to a chronic care model; same approach can be utilized as a foundation for other chronic conditions, even for those who are not living with HIV

WHO-PEN@SCALE: NCD/HIV DIFFERENTIATED SERVICE DELIVERY MODELS(DSD)

AIDS 2024

1

Fast Track: offered to stable clients who wish to refill at the facility individually.

2

Treatment club model: a group of stable clients form a club (~ 20 people)

3

Community Adherence Groups (CAGs): CAGs are groups of 2 – 6 clients, who take turns to visit the facility to get refills on behalf of the other group members.

INCLUSION CRITERIA

Stable clients with diabetes and hypertension (NCDs only)

Stable clients with NCDs and HIV (co-morbidities)

DM – Diabetes mellitus
HTN - hypertension

Lessons learned from development of the ICDM

- **Integration is Key**: Integrating services for communicable and non-communicable diseases can streamline care, reduce duplication, and improve patient outcomes. Combining HIV/AIDS, tuberculosis, diabetes, and hypertension services proved to be effective.

- **Primary Healthcare Focus**: Strengthening primary healthcare facilities is crucial. Decentralizing care from hospitals to primary clinics makes services more accessible and will improve overall care delivery.

- **Patient-Centered Care**: Involving patients in their care plans and emphasizing self-management and education are vital. Empowered patients are better able to manage their conditions and adhere to treatment plans.

- **Multidisciplinary Teams:** Collaboration among healthcare professionals, including doctors, nurses, and community health workers, is essential for providing comprehensive care. Team-based approaches ensure all aspects of a patient's health are addressed.

AIDS 2024

“Put people first!”

Theme: AIDS 2024, the 25th International AIDS Conference

22 – 26 July · Munich, Germany and virtual

aids2024.org