



Eswatini Specific DSD and HIV Policy Changes made in response to COVID-19 to protect both providers and recipients of care

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Outline



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Background



- On the 17th of March 2020, His Majesty King Mswati III declared COVID-19 a Public Health Emergency in the Kingdom of Eswatini
- A full lockdown with checkpoints and Police enforcement were implemented
- Only essential services have been allowed to operate, including health facilities, food outlets, and a few others businesses (e.g water and electricity suppliers)
- The National Disaster Management Agency has become responsible for the overall coordination of the COVID-19 response.



Impact of the country's Lockdown



Negative impact

- Clients missing their appointment due to unavailability of public transport
- Unintentional disclosure of HIV status at Police check points
- Disruption of supply chain, resulting to limited stock of commodities including ARVs
- Limited access to Viral Load (VL) test
- Suspension of all group models (Teen & Treatment Clubs, and CAGs), with a consequence of limiting access to adherence and psychosocial support

Generally, Risk of losing HIV program gains and achievements realized prior COVID-19 era

Positive impact

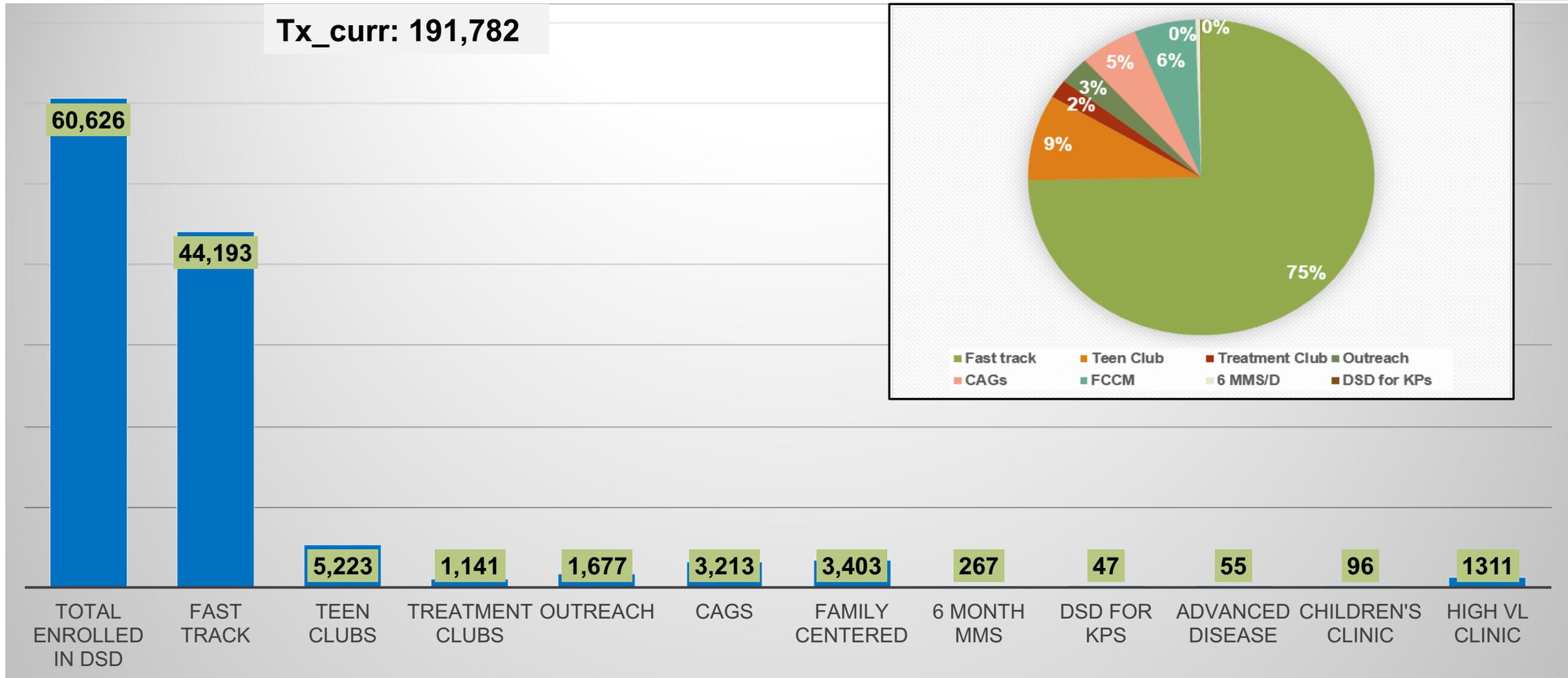
- Multi-sectoral engagement to respond to the pandemic and other health related issues
- Implementation of new models of care responding to specific client's needs
- Multiple months refills models have been taken to scale
- Integration of other health services into HIV services has been reinforced
- Wellness units have been re-activated to screen and update staff's files



National DSD Enrollment (December 2019)



Tx_curr: 191,782

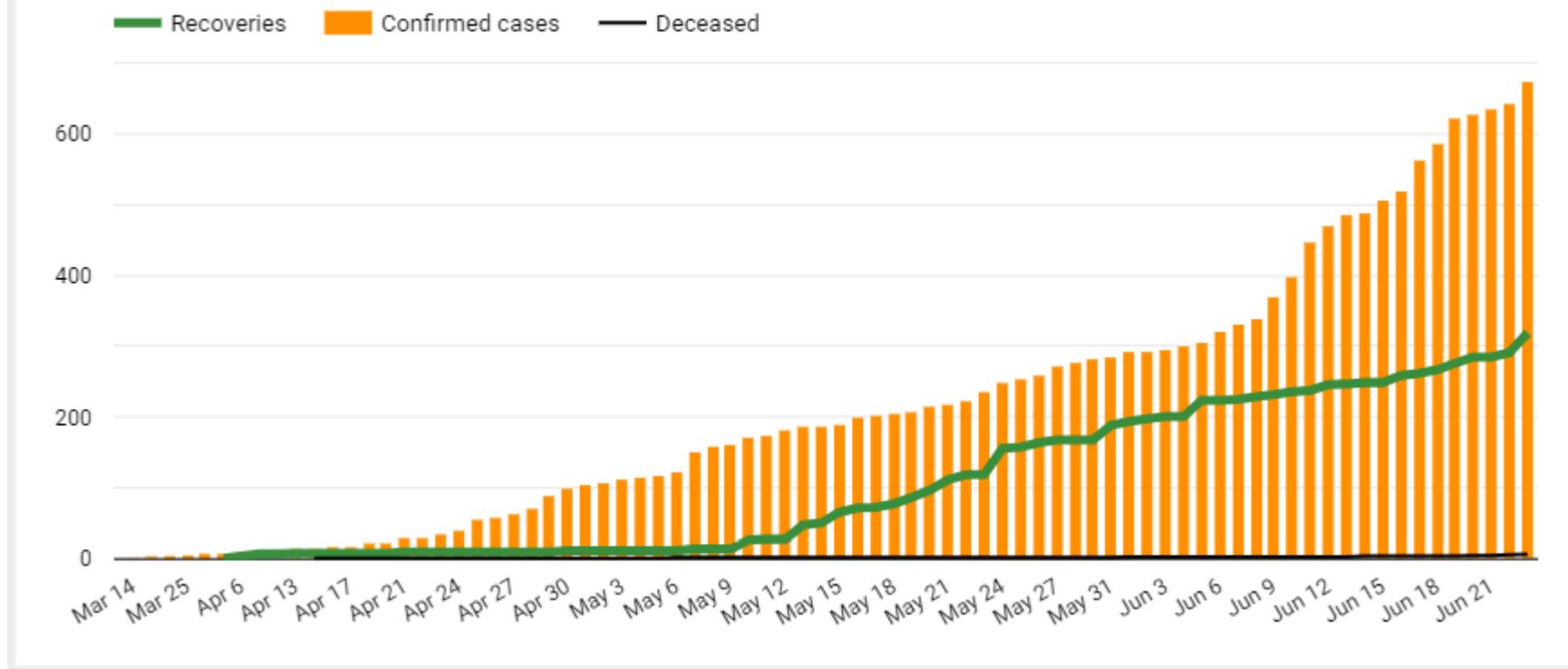




Eswatini COVID-19 Updates (23 June 2020)



Cumulative confirmed cases and recoveries



Total Confirmed Cases

674

Active Cases

348

Total recovered

319

Total Deaths

7

Total confirmed cases per 100K of pop.

61.65

Total confirmed cases relative to pop.

0.0617%

Test results received

9897



Rational to implement change



Risk from traveling to health facility

- Reduce need to take public transport
- Increase access to commodities during lockdown situation

Patient volume at health facility

- Decongest facilities
- Reduce risk of community transmission from visiting health facilities

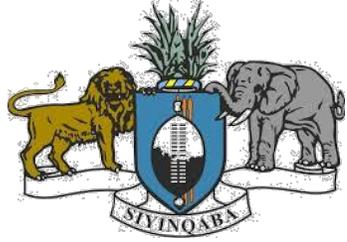
Community-Level Considerations

- Integrated services
- Reduce stigma and increase chances of service delivery uptake

Overarching aim:

To reduce COVID-19 exposure for people at higher risk of presenting severe form of COVID-19, including:

- PLHIV with high VL
- Patients with TB
- Patients with NCDs



Key Policy Changes



Relaxation of eligibility criteria for DSD models (being of ART for 12 months or more; Two consecutive undetectable VL; No OIs; Good History of adherence)

- Scaling-up Community Commodities Distribution for ART, TPT, TB, and NCDs
- Provision of multiple months dispensing (MMD) for the following categories of clients:

Category of Clients	Model of Care
Clients receiving TLD and TLE	6 MMD
Children and Adolescents aged < 17 years	3 MMD
Clients on Second line ART regimen	3 MMD
Newly initiated on ART	3 MMD
Pregnant & Lactating Women on ART	3 MMD or refills aligned with ANC
Clients on TPT, NCDs, and TB treatment	2-3 MMD



Viral load sample collection experience

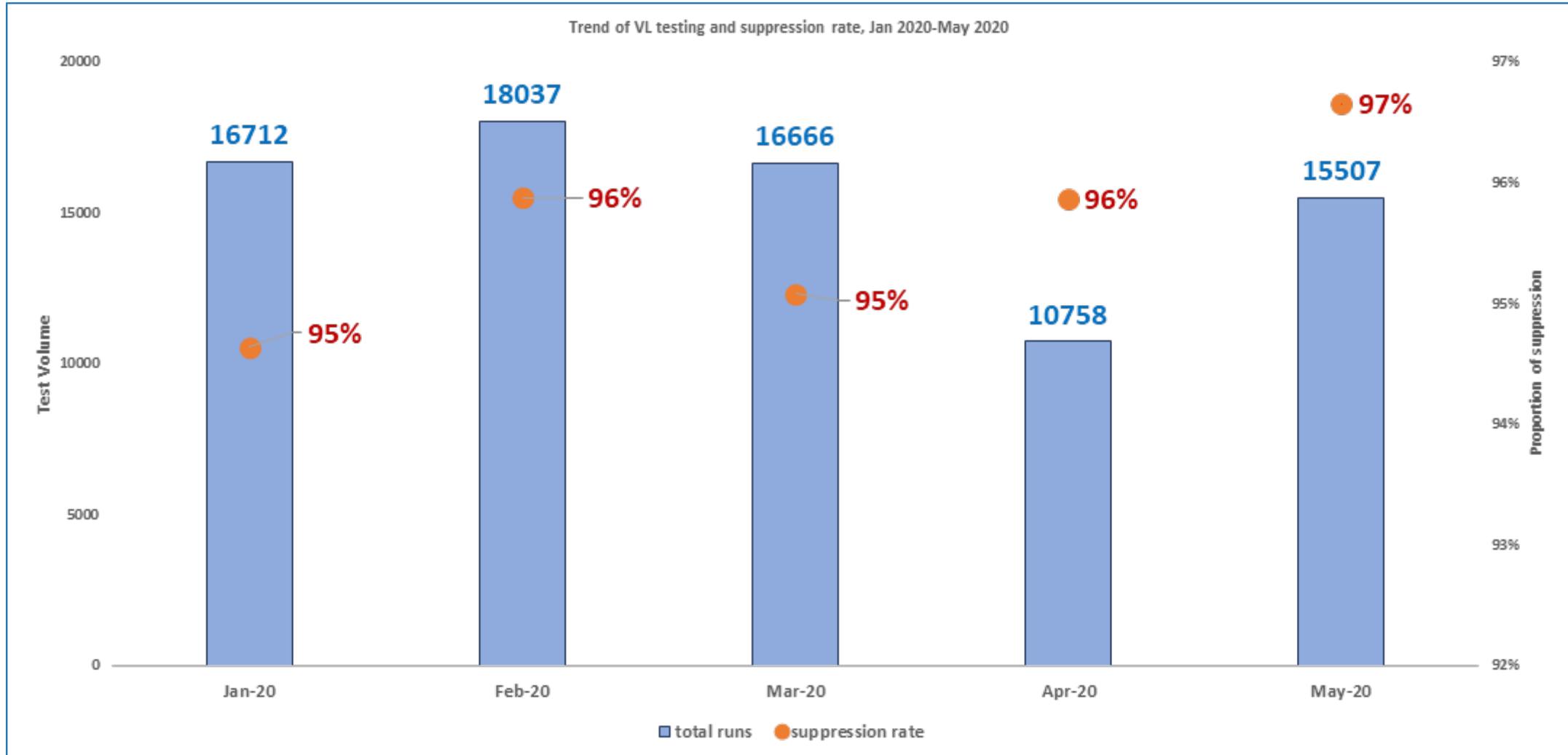


- VL sample collection have declined because clients could not come to facilities, and also because of limited staffs and logistics for community commodities distribution model
- Samples collected using full blood or DBS for these categories:
 - Clients on second line
 - Clients with detectable VL
 - First clinical review after initiation
 - Clients with poor adherence
- **Action taken:** Additional staffs and logistics have been made available to collect sample in the community, so far the suppression rate has been maintained beyond 95%.





National VL coverage and Suppression Rate (from LIS)

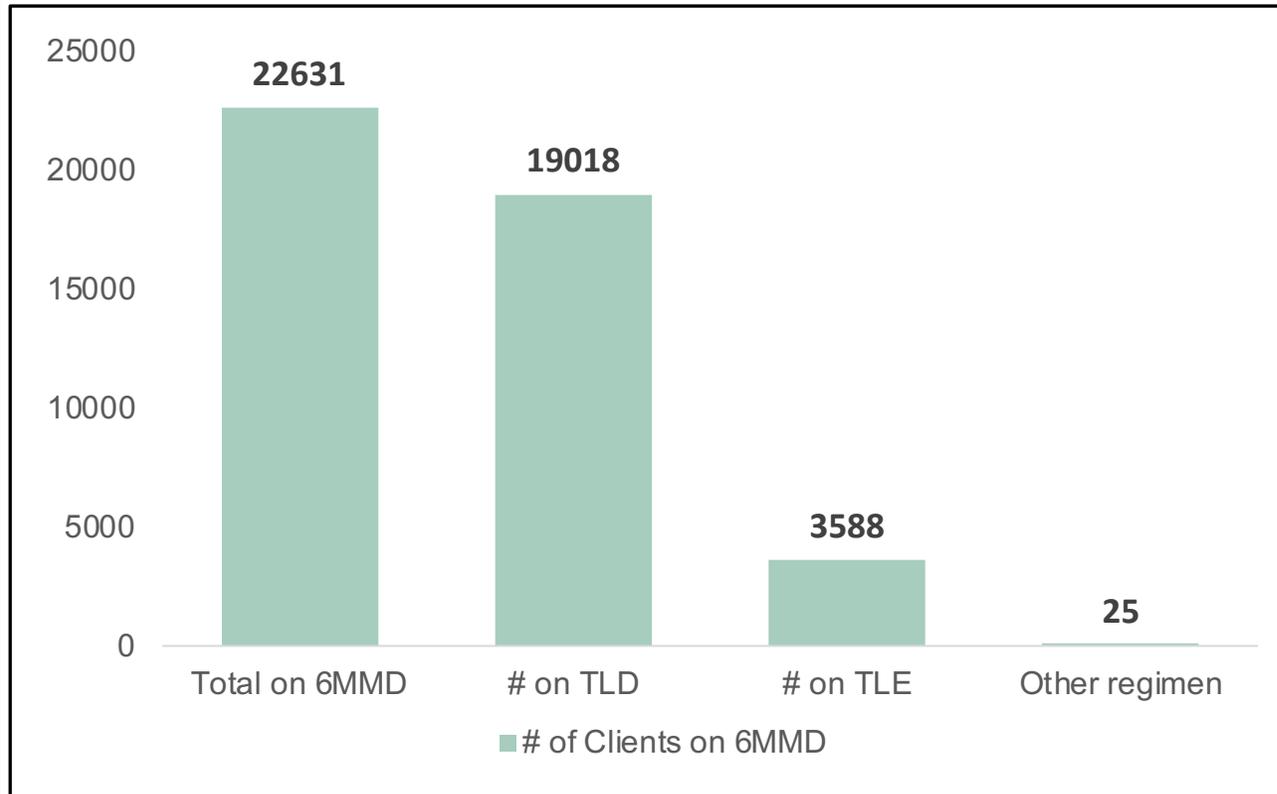




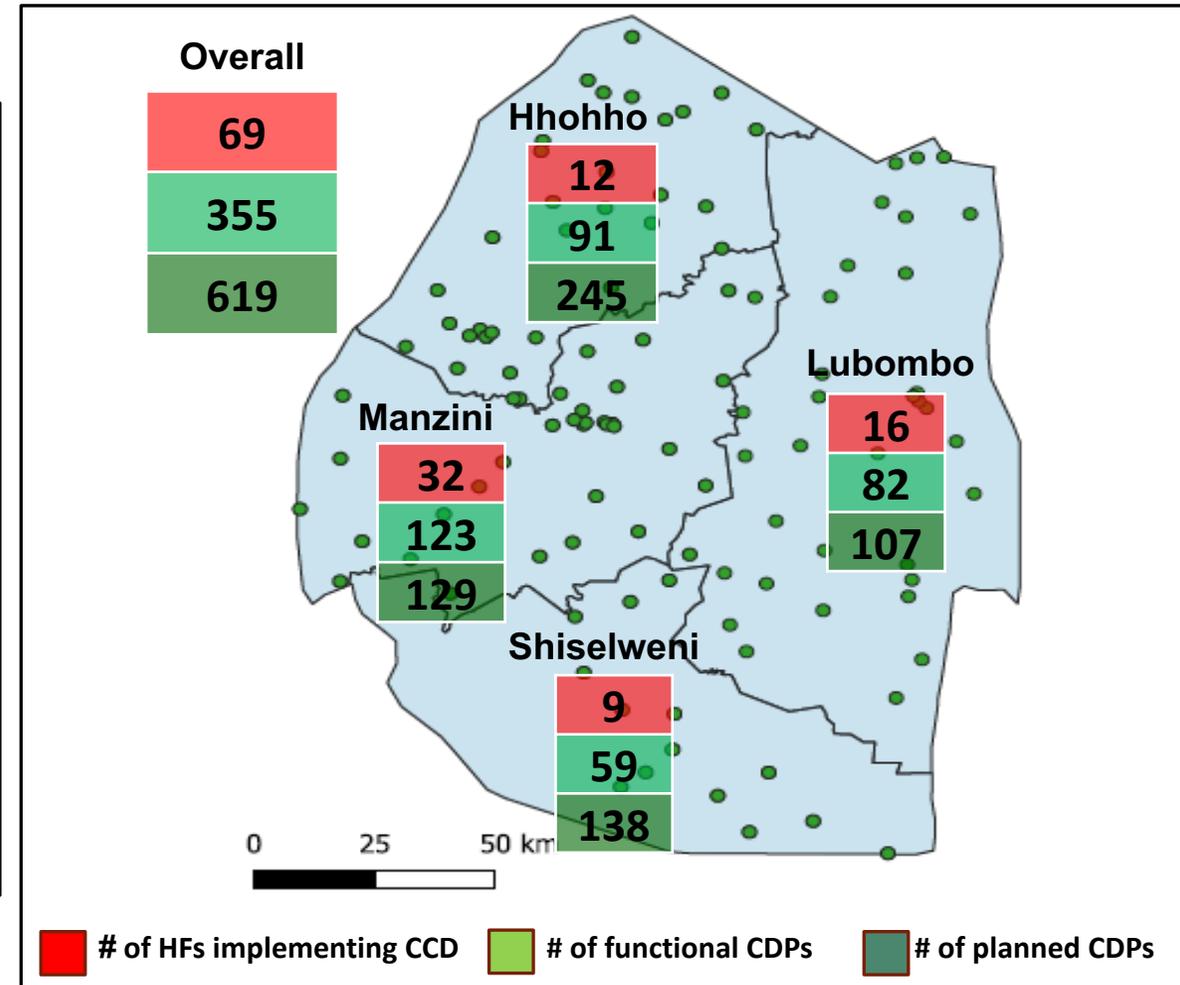
Coverage of implemented models



Number of clients enrolled in 6 MMD by regimen



Distribution of Community Distribution Points (CDPs)





Lessons learnt from Community Commodities Distribution (CCD)



- Health Facilities have been decongested due to 6MMD and CCD
(Pictures: ART units at two high volume facilities at pick time)
- The model allowed health facilities to identify possible sites for permanent outreach services
- Defaulters have been actively followed up and reviewed in the community or at health facilities
- The majority of clients are excited about the model and are asking facilities to maintain the model after the COVID-19 period
- Engagement of clients on their preferred point of refill is important for the success of CCD
- Different channels of communication necessary to reach clients e.g Telephone, RHMs, expert clients
- M&E Challenges: using paper based forms to collect data in the community. Plan to have CMIS light version for Tables
- Strategies to reduce Stigma: Use of non-branded vehicles, Recruitment of clients through existing ART support groups, integration of other services (NCDs)





Country's Priority Questions



- Effect of the country's lockdown due to COVID-19 on recipient of care's adherence to ART
- Effect of the news models of care on Viral load coverage and suppression rate
- Trend of "Missed appointments" during COVID-19 period
- Effect of the Global Lockdown due to COVID-19 on the country's supply chain
- COVID-19 management outcome for patients who are concurrently taking ART



Thank you