# The President's Emergency Plan for AIDS Relief

FY 2013

# Technical Considerations

## Provided by PEPFAR Technical Working Groups for

## FY 2013 COPS and ROPS

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high risk for onward transmission are likely to vary by context but may include patients who have difficulties adhering to ART, who have substance abuse issues, and/or those patients in a serodiscordant partnership.

It is critical at this stage when country programs are working towards achieving the goals of an AIDS-free generation that countries describe concisely SMART (specific, measurable, achievable, realistic and time-bound) plans to support full integration of the Prevention with PLHIV/PwP principles into the platforms of care and support. Further guidance on these interventions can be found in section 1.5, Prevention for People Living with HIV.

- ***Screening and treatment to prevent Cryptococcal Meningitis (CM)*** — CM accounts for more than 500,000 deaths in sub-Saharan Africa annually, likely exceeding deaths from TB in HIV-infected persons in this region.[261] Persons with CD4 counts <100 cells/mL are at highest risk. CM is preceded by the presence of Cryptococcal Antigen (CrAg) in blood. A recently available lateral flow assay (LFA) for CrAg has made it possible to inexpensively screen patients for Cryptococcal infection, and subsequently treat those with positive CrAg screening tests to prevent CM. This "screen and treat" approach will likely reduce Cryptococcal disease-related morbidity and mortality and may be cost-saving in settings with CrAg prevalence great than 3% (most areas in SSA).[262] Thus, screening patients who have CD4 counts <100 cells/mL for CrAg using low-cost assays (either latex agglutination or LFA) and pre-emptively treating those who test positive with anti-fungal therapy (oral fluconazole), should be considered prior to ART initiation in settings with high prevalence of CrAg. WHO has recently published rapid advice on the diagnosis, prevention and management of Cryptococcal disease in HIV-infected adults and children, available at: http://whqlibdoc.who.int/publications/2011/9789241502979_eng.pdf

- ***Diagnosis, prevention and management of viral hepatitis in HIV-infected persons*:** There is increasing recognition of the importance of viral hepatitis, particularly Hepatitis B and C, in HIV-infected individuals. Five to ten percent of people living with HIV are also infected with hepatitis B (HBV). In sub-Saharan Africa, the prevalence of HBV co-infection among PLHIV varies regionally and is estimated at 5-17%[263]. The prevalence of hepatitis C (HCV) co-infection among PLHIV from key populations ranges from 4-8% in HIV-positive MSM to an estimated 60-90% in HIV-positive injecting drug users. Data on HIV-HCV co-infection in sub-Saharan Africa is sparse and often of very poor quality. However, the prevalence of HCV among those with HIV is estimated to be highest in west and central Africa (1-24%) and lower in east and southern Africa (0-9%)[264].

[261] Park BJ, Wannemuehler KA, Marston BJ, Govender N, Pappas PG, Chiller TM. Estimation of the current global burden of cryptococcal meningitis among persons living with HIV/AIDS. AIDS **2009**;23:525-30.
[262] Meya DB, Manabe YC, Castelnuovo B, et al. Cost-effectiveness of serum cryptococcal antigen screening to prevent deaths among HIV-infected persons with a CD4+ cell count < or = 100 cells/microL who start HIV therapy in resource-limited settings. Clin Infect Dis **2010**;51:448-55.
[263] Hofmann, C. et al. "Clinical implications of HIV and hepatitis B co-infection in Asia and Africa." Lancet Infect Dis. 2007 Jun;7(6):402-9.
[264] Modi, AA. AIDS Rev. 2007 Jan-Mar;9(1):25-39. Viral hepatitis and HIV in Africa.