It’s time for differentiation at re-engagement

South Africa’s journey to a re-engagement algorithm

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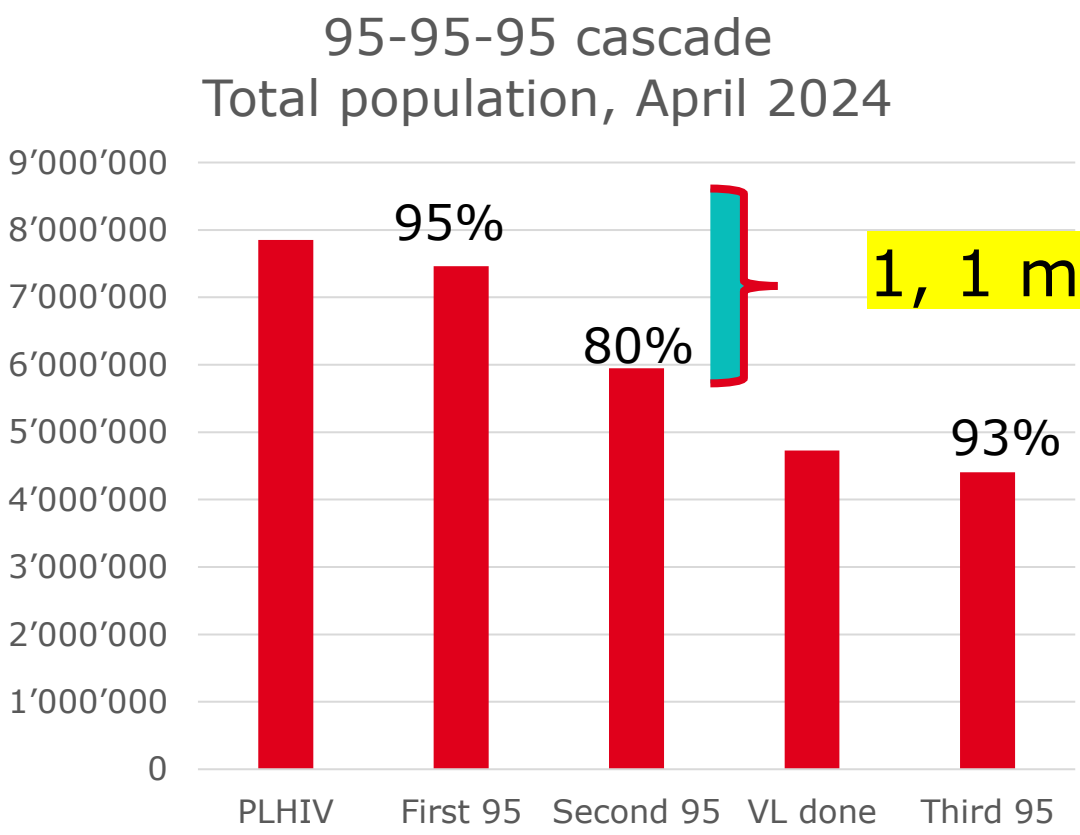
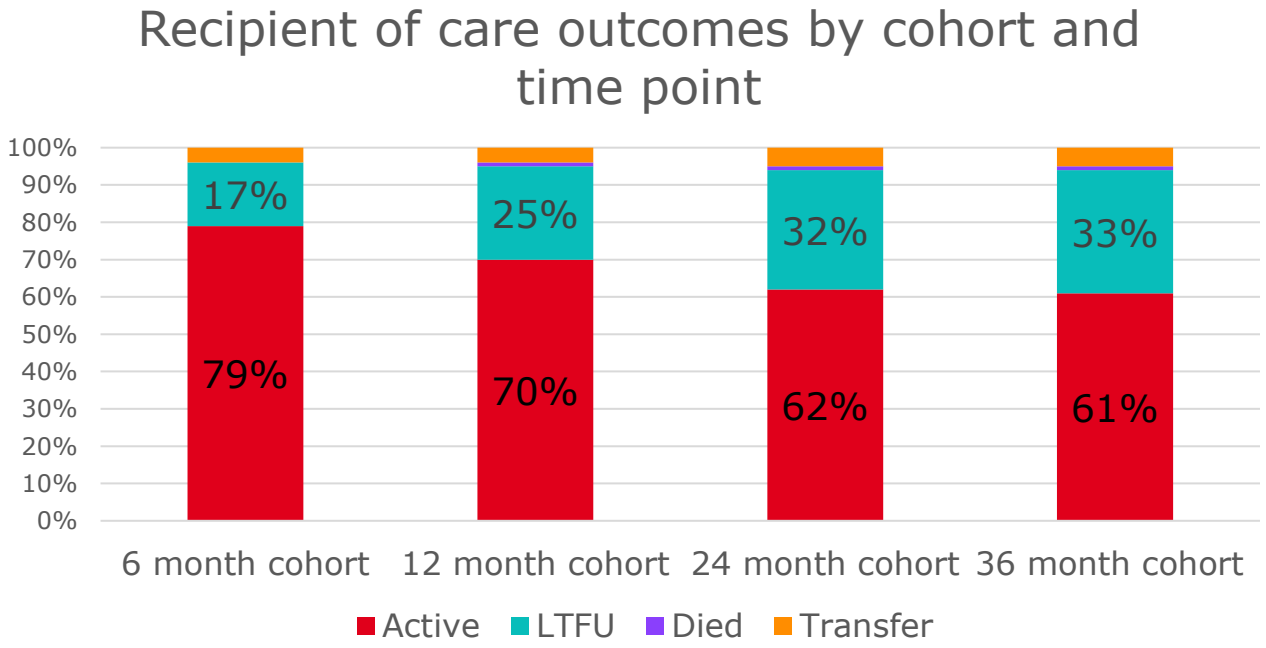
South Africa's cascade

95-80-93



- Cascade figures vary by population
  - Adult females: 96-84-94
  - Adult males: 95-73-94
  - Children (<15): 82-66-69

Two largest challenges: Sub-optimal 12-month retention and viral suppression



- **80% of cohort has a viral load done.**
- Of those:
  - 907,658 have a VL 50-1000 copies/mL
  - 321,462 have a VL >1000 copies/mL

Revised ART & differentiated models of care (DMOC) guidelines central approach

Aim 1: Implement optimized ART regimens

- Clinical updates

Aim 2: Create an enabling environment to support (re)engagement in care and adherence

- Person-centred service delivery updates

- Updated clinical **and** service delivery guidance at the same time
- Coordinated national technical working group
- Reviewed previous re-engagement algorithm

DMOC and ART Clinical Guidelines assume full integrated approach in South Africa

- The first time **clinical** and **service delivery** guidelines were revised together to ensure coordinated approach to of both components of HIV care

Enabling environment for continued engagement

- 3MMD more widely available, not only for stable patients
- Earlier VL at 3/12s to identify adherence problems earlier and differentiate earlier
- Earlier access to RPCS models at month 4
- Reducing visit frequency through visit integration and coordination

Visit Schedule for Integrated Care for the Mother living with HIV and her HIV-exposed Infant (HEI)

The principles are as follows:

1. Wherever possible, try to align the mother's ART, VL monitoring, and contraception visits with that of the child's visit schedule so the mother-baby pair need only attend the facility once for both consultations on the same day
2. Wherever possible, allow the mother and baby to receive care at the same facility

Age group	Age of child	Routine visits as per RTHB	ART Dispensing cycle (DC)	Follow-up for the HIV-exposed baby	ART Follow-up for mother	Immunisations	Feeding advice	Growth monitoring	Development	Head circumference	Vit A	Deworming	Oral Health	TB Screen	Mother's contraception
Neonate	1st week of life	3-6 days postnatal (PN) visit for mother and baby	1	• Follow-up results of birth PCR# and mother's delivery VL If birth PCR negative, re-classify the risk profile of the HEI: • Delivery VL < 50 c/mL (low-risk) • Stop AZT and continue NVP daily for six weeks • Delivery VL ≥ 50 c/mL (higher-risk) • Continue AZT twice daily for six weeks • Continue NVP daily for minimum of 12 weeks • Check adherence to NVP and AZT dispensed at delivery	• Follow-up results of mother's delivery VL • Delivery VL ≥ 50 c/mL: manage as per *"Viral Load Monitoring Schedule" on page 20.* • Check ART supply: The mother should have been provided with 2 months ART at discharge from labour ward which will last her until 6 week PN visit • Adherence check-in for mother • Provide breastfeeding support and routine PN care		x	x						x	x**
2-6 months (monthly follow-up)	6 weeks	6 weeks	2*	• Ensure that birth PCR and mother's VL results were checked, recorded and acted upon correctly • If low-risk, stop NVP • If higher-risk, stop AZT and dispense NVP for additional 6 weeks	• Postnatal clinical review and adherence check-in. If delivery VL ≥ 50 c/mL, repeat VL at this visit • Provide breastfeeding support. • Provide ART for 2 DCs (2MMD) for mother*	x	x	x						x	
	10 weeks	10 weeks	3	• **Do 10 week HIV-PCR #** • If higher-risk, check result of repeat maternal VL done at 6 weeks visit. • If VL < 50 c/mL, advise to stop NVP after 12 weeks • If VL still ≥ 50 c/mL, dispense and continue NVP until the breastfeeding mother's VL is confirmed to be < 50 c/mL	• If VL repeated at 6 weeks, review results. Manage as per *"VL Non-Suppression Algorithm" on page 21* • If mother received either DMPA (Depo Provera®) or NET-EN (Nur Isterate®) after delivery, give repeat injection at this visit***	x	x	x						x	x
	14 weeks	14 weeks	4	• Check that 10 week HIV-PCR results were checked, recorded and acted upon correctly	• Adherence check-in for mother • Provide breastfeeding support. • Provide ART for 3 DCs (3MMD) for mother	x	x	x	x	x				x	
	18 weeks	4 months	5				x	x						x	
	22 weeks	5 months	6				x	x						x	
	26 weeks	6 months	7	• **Do 6-month HIV-PCR test #** • Review results of PCR and VL in 1 week using NHLS RfA reports. If mother's VL ≥ 50c/mL, restart/extend infant prophylaxis if still breastfeeding. Go to *"Management of a High Maternal Viral Load after Delivery" on page 24.*	• **Clinical review and '6-month' VL.** • Provide breastfeeding support and discuss the introduction of complementary feeding at age 6 months • Script for and provide ART for 3DCs at a time (3MMD) • Review results of VL and PCR in 1 week using NHLS RfA reports. If VL ≥ 50c/mL, manage mother as per the *"VL Non-Suppression Algorithm" on page 21*	x	x	x	x		x			x	x

* Review and repeat script at 6 weeks (rather than 8 weeks) to align with the RTHB visit schedule. The additional 2 weeks Rx that the mother will have in reserve will allow for alignment with the 6-month RTHB appointment which usually happens around week 26 (compared to 6 DCs of ART which will only provide enough ART for 24 weeks)

** Confirm the mother's FP method choice. Inform her that the DMPA injection or the combined oral contraceptive pill (COCP) can be repeated 3-monthly, and will align well with her ART and well-baby visit schedules. Using the NET-EN 2-monthly injection will require additional visits by the mother, as a 2-monthly repeat injection will not always align with the visit schedule outlined above.

*** As per WHO recommendations[18], the repeat injection of DMPA and NET-EN can be given up to 2 weeks early. The repeat DMPA injection can be given up to 4 weeks late without requiring additional contraceptive protection. The repeat NET-EN injection can be given up to 2 weeks late without requiring additional contraceptive protection.

HIV testing should only be done in those who previously tested HIV negative. If a child tests HIV positive at any stage, stop NVP prophylaxis, initiate ART, do a confirmatory HIV PCR, and initiate cotrimoxazole prophylaxis.

Scenario 1

Care for a mother and baby without visit coordination or integration

Scheduled visit	Well baby visit	HIV exposed infant	ART/HIV prevention mother	Mother's Family planing	Number of Visits
3-6 day visit	x	Birth PCR result Risk profile	Delivery VL result		1
6 weeks	x	stop NVP			1
8 weeks			ART	NET-EN	2
10 weeks	x	10 week PCR			1
12 weeks			HIV test	Depo/COCP	2
14 weeks	x				1
20 weeks			ART		1
6 months	x	6 month PCR	ART & VL test	x	2

10-11 Visits

- Coordinate visits (lose visits at 8, 12 and 20 wks)
- Integrate care at each visit

8 weeks X

12 weeks X

20 weeks X

Scenario 2

Care for a mother-baby-pair with visit coordination and integration

Scheduled visit	Well baby visit	HIV exposed infant	ART/HIV prevention mother	Mother's Family planing	Number of Visits
3-6 day visit	x	Birth PCR result Risk profile	Delivery VL result		1
6 weeks	x	stop NVP	ART	NET-EN	1
10 weeks	x	10 week PCR	HIV test	Depo/COCP	1
14 weeks	x		ART		1
6 months	x	6 month PCR	ART & VL test	x	1

5 Visits

SA considerations for managing re-engaging clients

1

For returning patients, the *first return visit experience* is critical

Welcoming, supportive and empathetic

Clear facility visit flow focused on a positive patient experience

2

Not all patients **late for scheduled appointments are re-engaging patients**

Defined period

3

All re-engaging patients *DO NOT have* the same service delivery needs

Easier access to treatment

Psychosocial support

Clinical management

Clinical Factors

Duration since missed appointment

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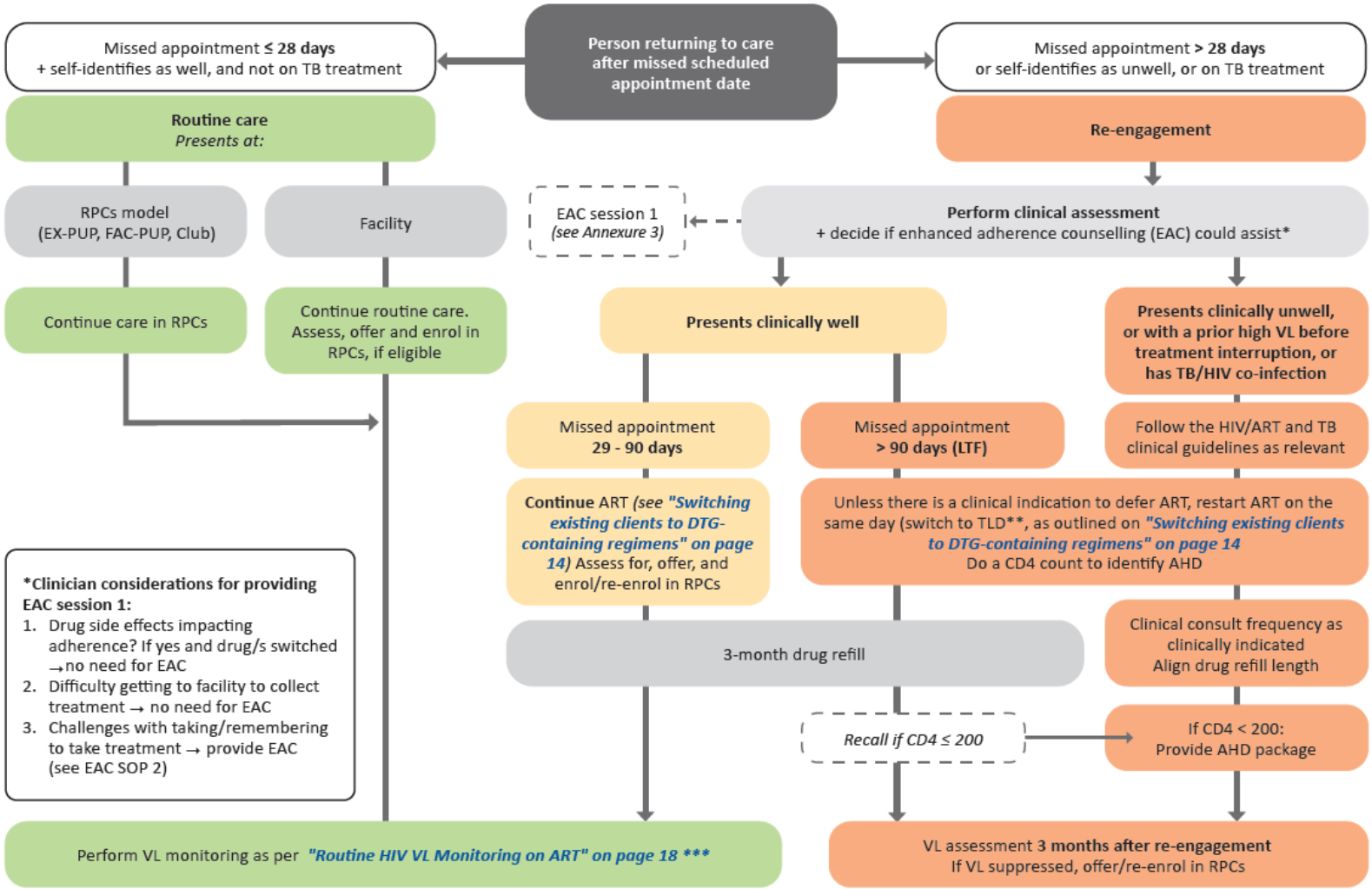
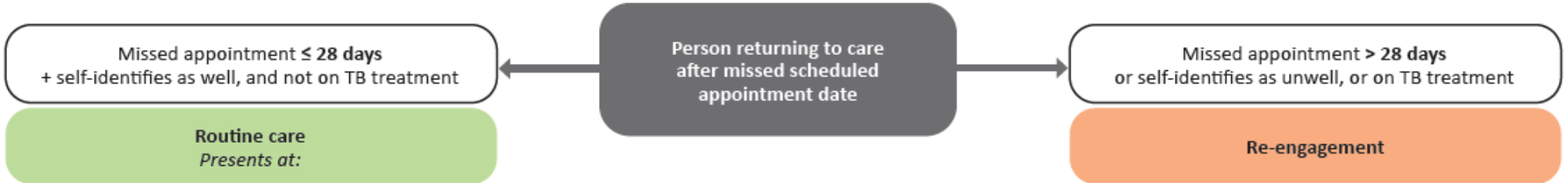
Updated clinical + service delivery algorithm

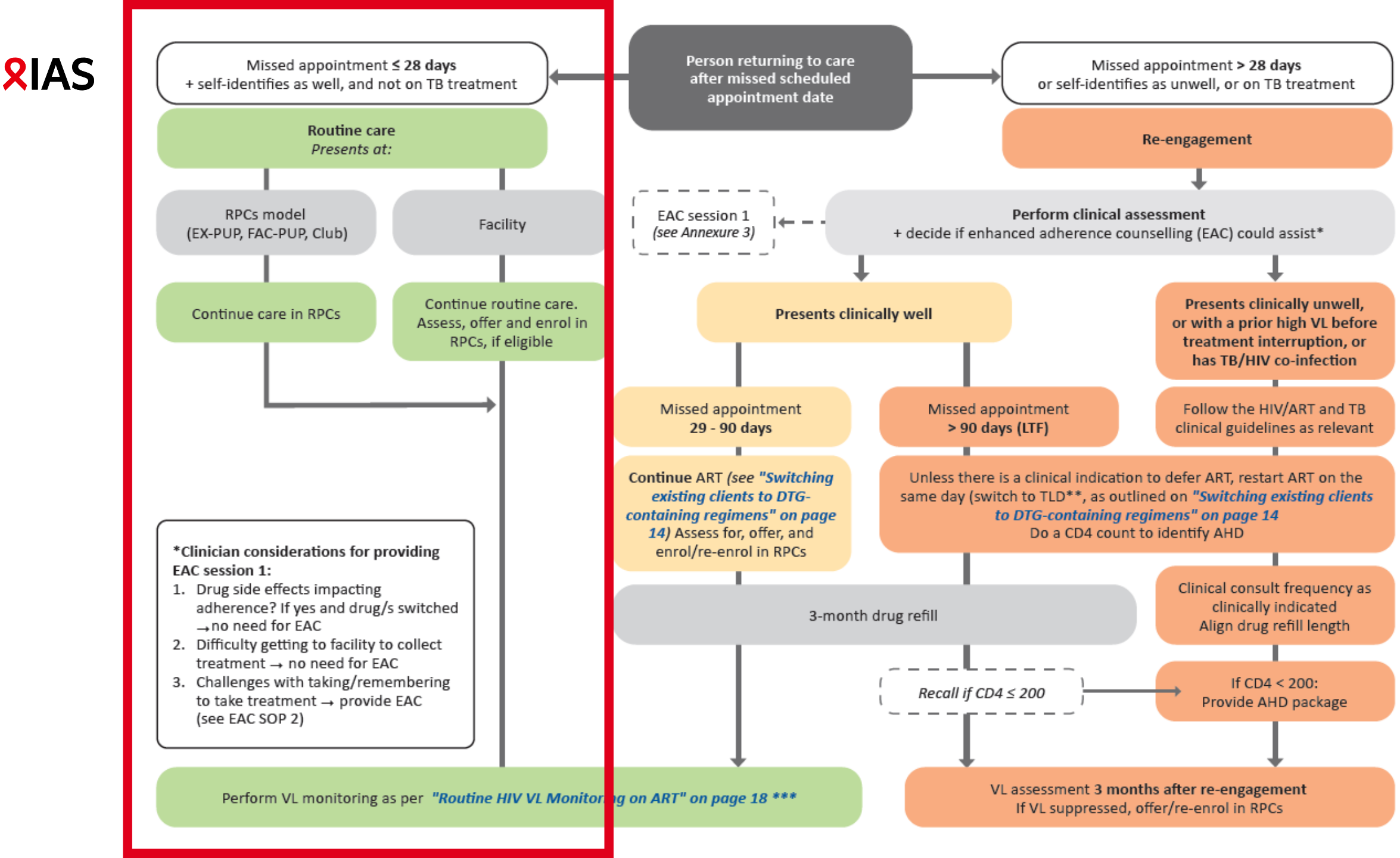


1. Clarifies returning clients are NOT ALL re-engaging clients



1. **If client not complaining of illness and less than 28 days late for appointment**
   - Continue in routine care
2. **If client complaining of illness or on TB treatment or more than 28 days late for appointment – needs to be seen by a clinician**
   - Manage as a re-engaging client

WHY?
- Support appointment flexibility rather than disengagement in era of DTG
- Reduce unnecessary burden/administration complexity on clients and health system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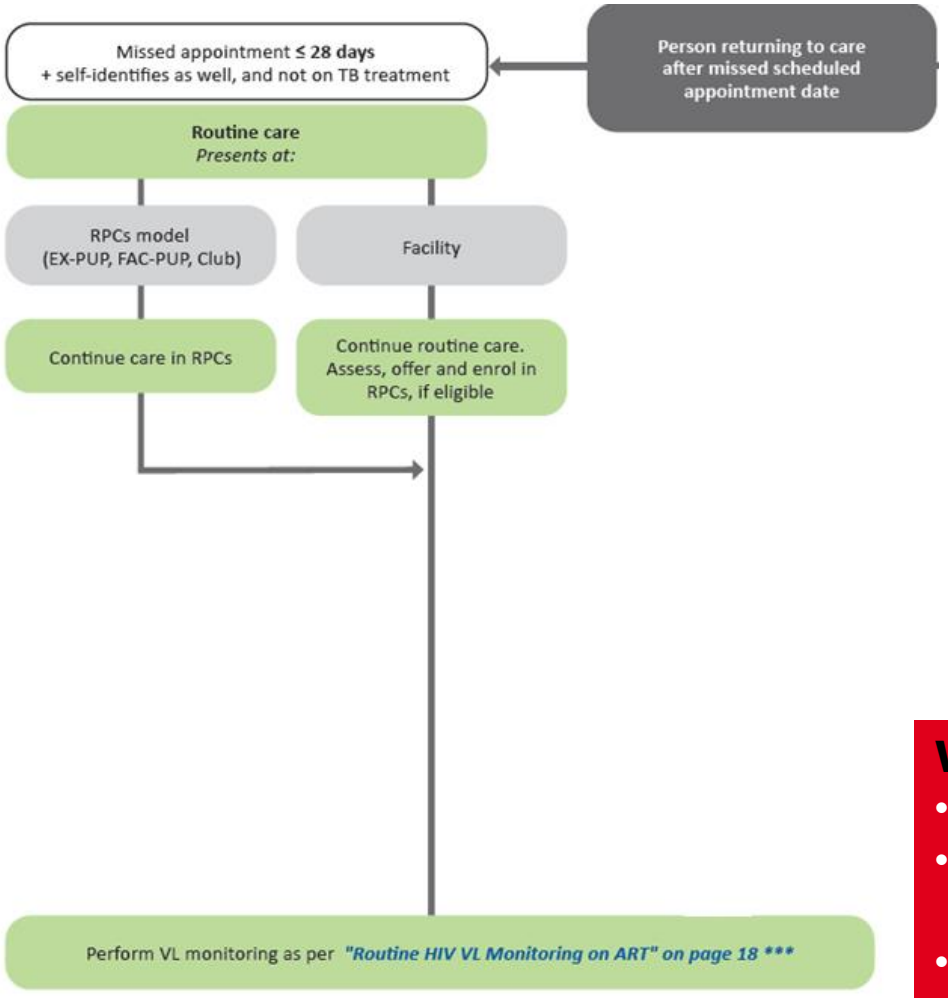
Person returning to care after missed scheduled appointment date
Missed appointment ≤ 28 days + self-identifies as well, and not on TB treatment
Missed appointment > 28 days or self-identifies as unwell, or on TB treatment
Routine care
Presents at:
Re-engagement
RPCs model (EX-PUP, FAC-PUP, Club)
Facility
EAC session 1 (see Annexure 3)
Perform clinical assessment + decide if enhanced adherence counselling (EAC) could assist*
Continue care in RPCs
Continue routine care. Assess, offer and enrol in RPCs, if eligible
Presents clinically well
Presents clinically unwell, or with a prior high VL before treatment interruption, or has TB/HIV co-infection
Missed appointment 29 - 90 days
Missed appointment > 90 days (LTF)
Follow the HIV/ART and TB clinical guidelines as relevant
Continue ART (see "Switching existing clients to DTG-containing regimens" on page 14) Assess for, offer, and enrol/re-enrol in RPCs
Unless there is a clinical indication to defer ART, restart ART on the same day (switch to TLD**, as outlined on "Switching existing clients to DTG-containing regimens" on page 14
Do a CD4 count to identify AHD
3-month drug refill
Clinical consult frequency as clinically indicated
Align drug refill length
Recall if CD4 ≤ 200
If CD4 < 200:
Provide AHD package
*Clinician considerations for providing EAC session 1:
1. Drug side effects impacting adherence? If yes and drug/s switched →no need for EAC
2. Difficulty getting to facility to collect treatment → no need for EAC
3. Challenges with taking/remembering to take treatment → provide EAC (see EAC SOP 2)
Perform VL monitoring as per "Routine HIV VL Monitoring on ART" on page 18 ***
VL assessment 3 months after re-engagement
If VL suppressed, offer/re-enrol in RPCs

2. Returning to routine care includes staying in your RPCs

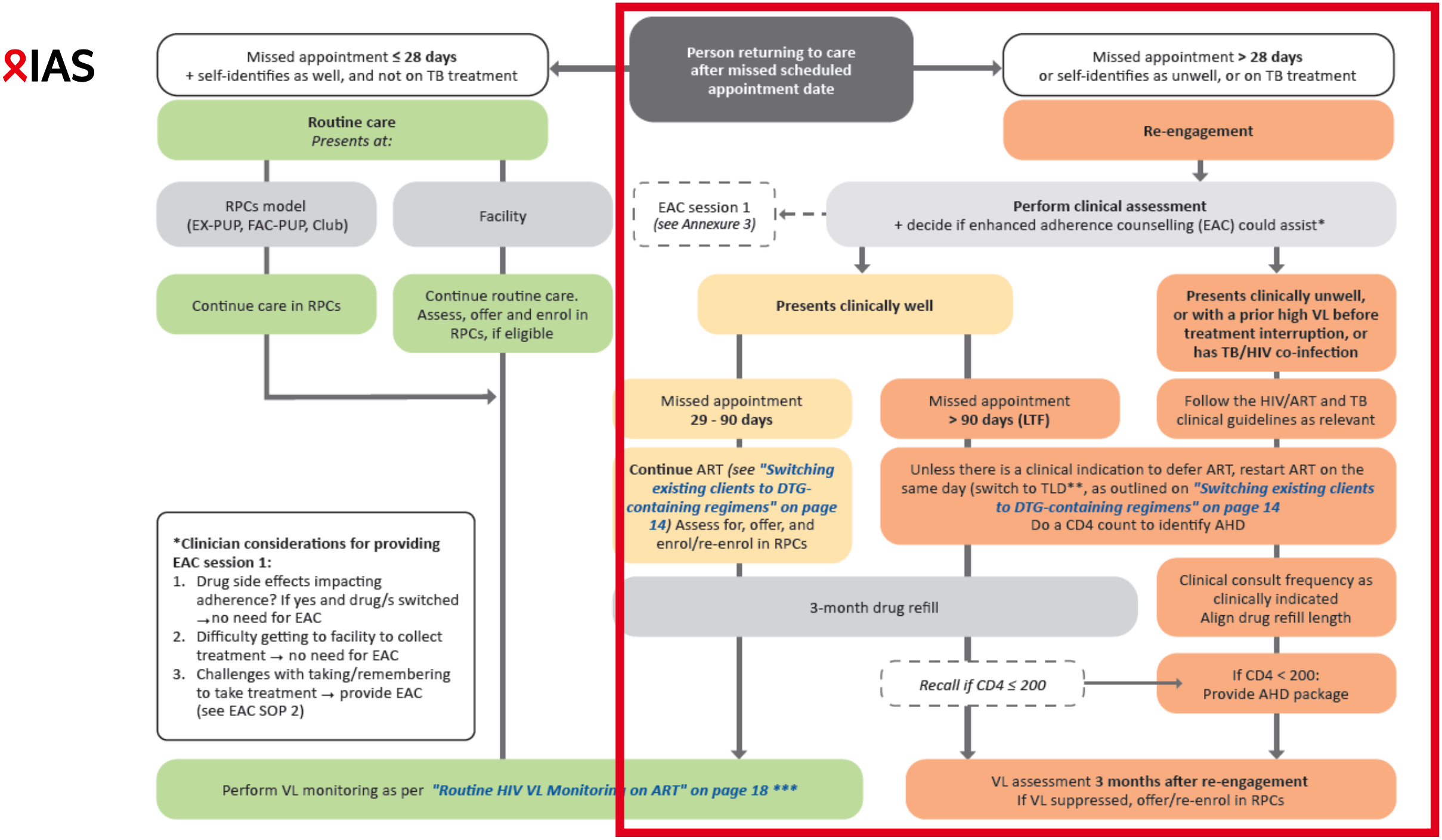


1. **If in RPCs – stay in RPCs**
2. **If not in RPCs – prioritize assessment for RPCs or rescript for RPCs**
   - Late for this appointment or previous appointments does not disqualify client BUT rather red flags for RPCs enrolment to reduce risk of disengagement

Consideration to note: supply chain complexities meant pre-packed ART could not remain at pick-up points for longer than 28 days

When do you do CD4 and VL?

- No repeat CD4
- Repeat VL as per annual schedule
  - For RPCs client - next scheduled RPCs clinical review with VL
- If VL overdue at return perform after back on ART for 3 months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VL assessment 3 months after re-engagement
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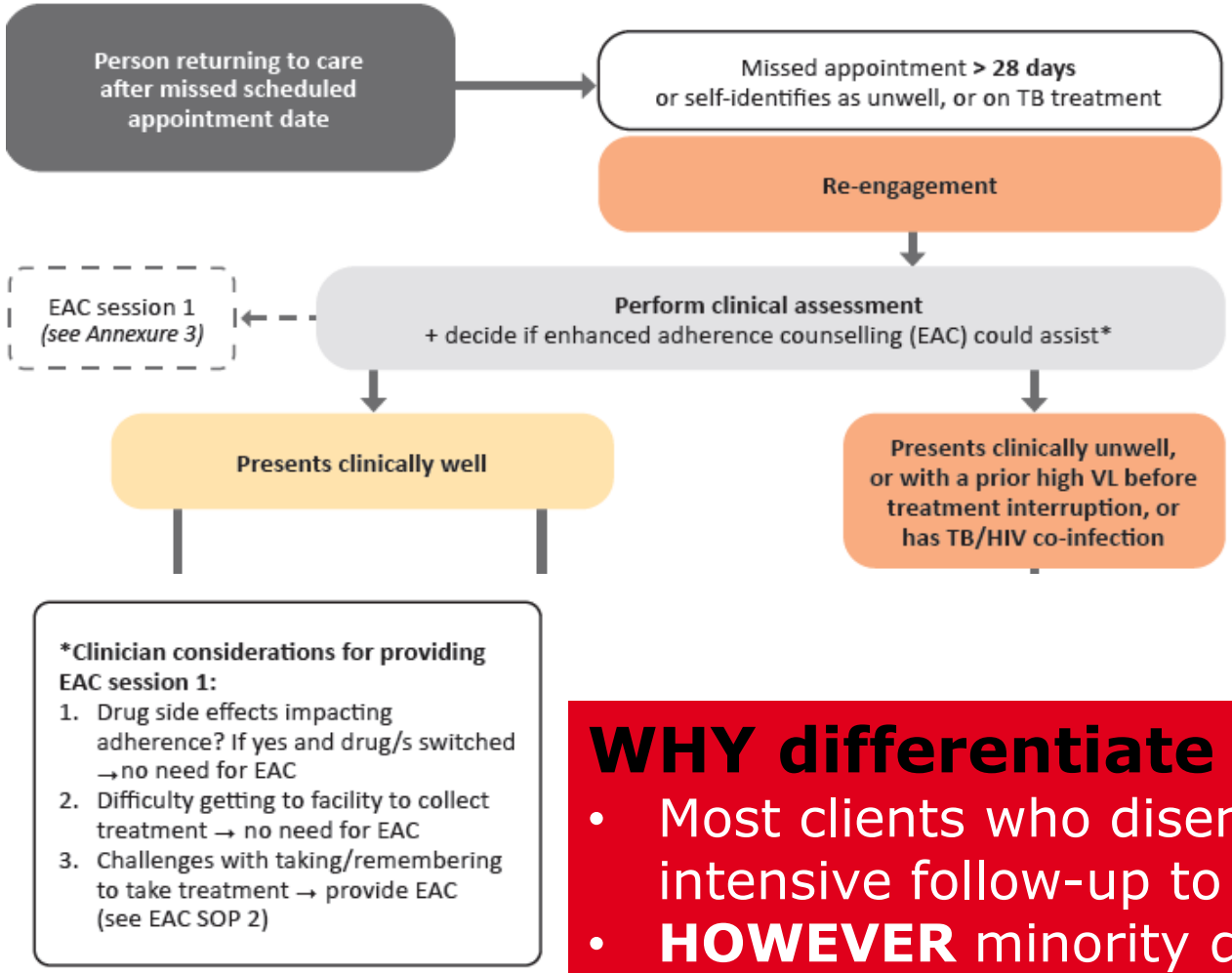
3. Re-engaging clients management depends on clinical stability

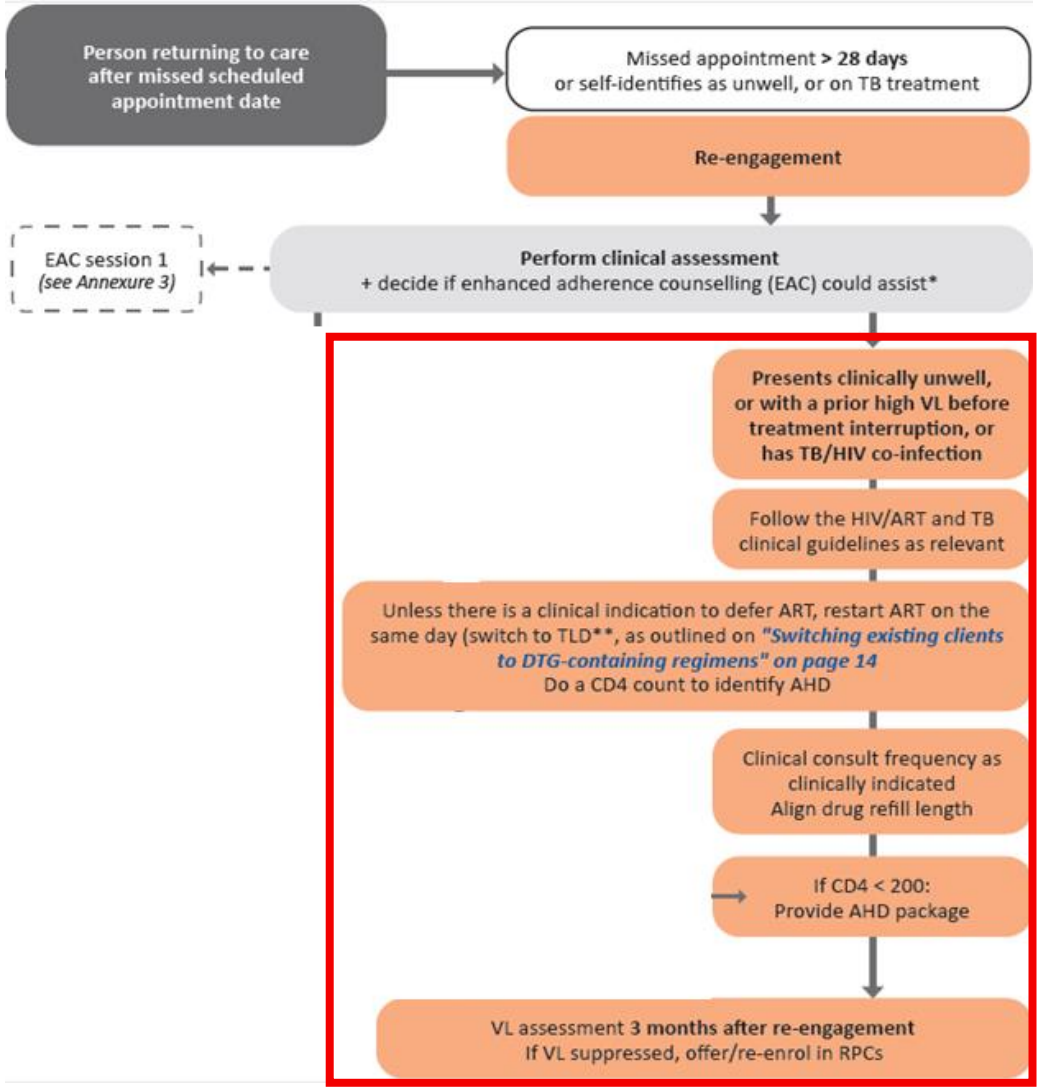


- **If return and self-identify as unwell, more than 28 days late or on TB treatment require a clinical assessment**
  - Check clinical presentation – decide if well or not?
  - Check last VL result
  - Check regimen – on TLD?
  - Assess if enhanced adherence counselling (EAC) useful. If yes, clinician to provide.
- **Differentiate again**
  - Unwell OR previous elevated VL OR on TB treatment
  - Well

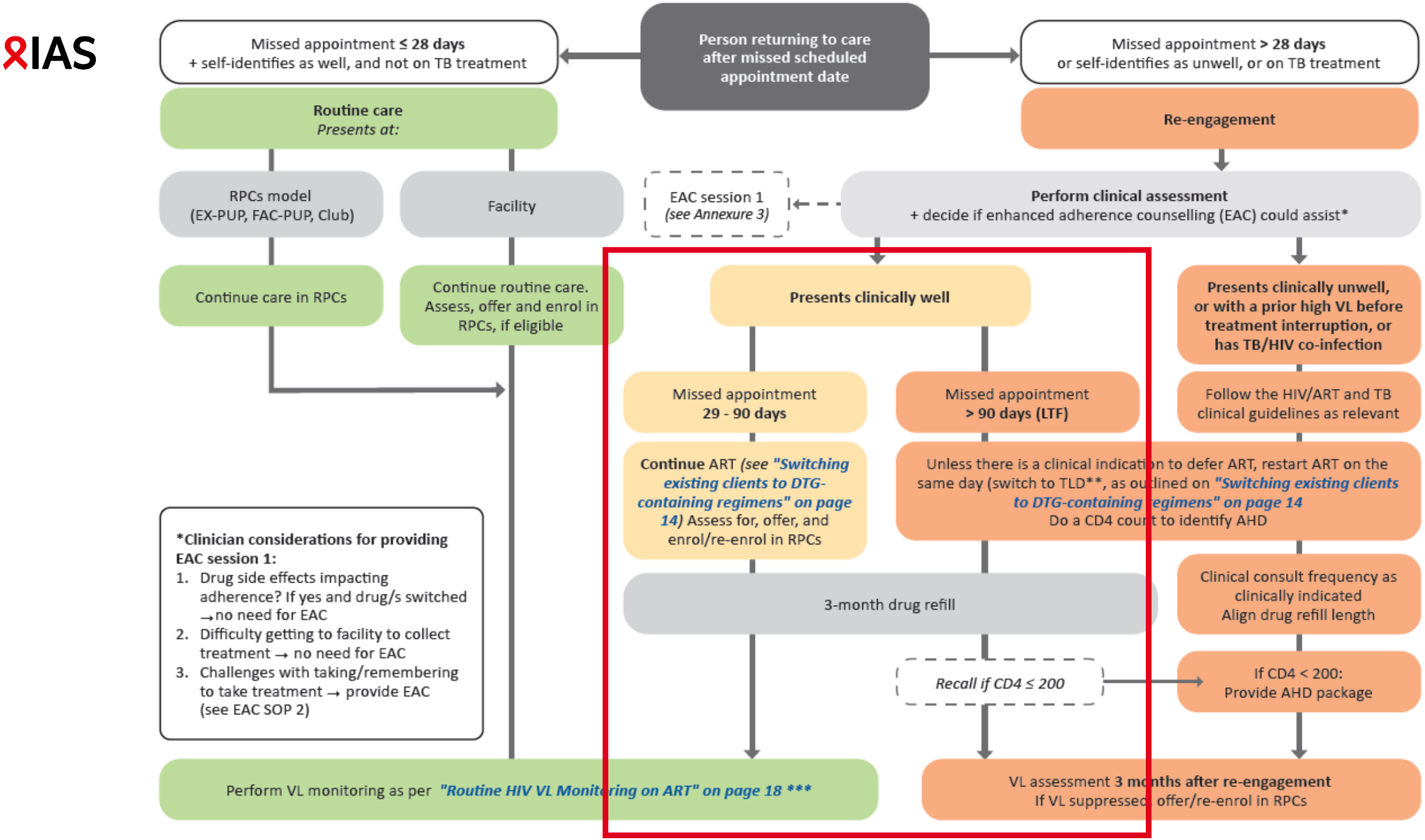
WHY differentiate care?

- Most clients who disengaged need <u>less</u> intensive <u>not more</u> intensive follow-up to reduce risk of interrupting treatment again.
- **HOWEVER** minority do need more intensive clinical management

4. Client unwell, previous elevated VL or on TB treatment



1. **Follow ART and TB guidelines for management of OIs**
2. **Restart ART same day* – switch if not on TLD**
3. **Take CD4 count – may now have AHD**
4. **Review CD4 count, if <200 - provide AHD screening and treatment package**
5. **VL assessment after 3 months**
6. **Do not have to see client each month until follow- up VL – clinician to decide:**
   - necessary clinical review frequency
   - align ART refills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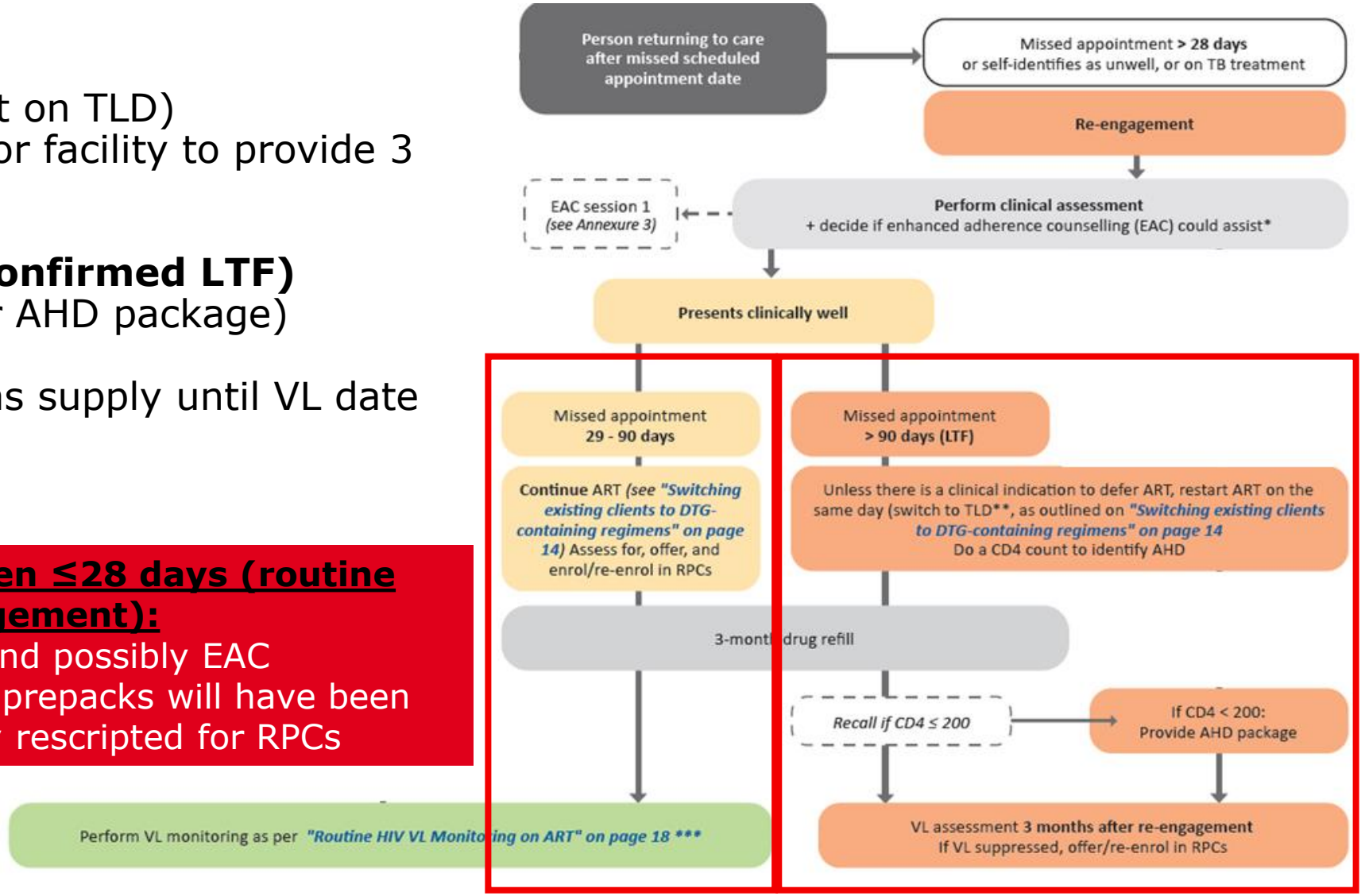
Perform VL monitoring as per "Routine HIV VL Monitoring on ART" on page 18 ***
VL assessment 3 months after re-engagement
If VL suppressed offer/re-enrol in RPCs

5. Client well BUT >28 days late

1. 29-90 days late:
- No CD4, no additional VL
- Continue ART (switch if not on TLD)
- Assess for and offer RPCs or facility to provide 3 months of ART

2. More 90 days late (unconfirmed LTF)
- CD4 (recall if CD4<200 for AHD package)
- VL in 3 months time
- Facility to provide 3-months supply until VL date

Note ONLY differences between ≤28 days (routine care) and >28 days (re-engagement):
- Must get clinical assessment and possibly EAC
- Cannot collect ART in RPCs as prepacks will have been returned. Can be immediately rescripted for RPCs



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Re-engagement algorithm

Inclusive, rather than targeted (excluding certain groups from our re-engagement algorithm)

- Persons from all populations disengage and re-engage
- The principles of differentiation need to be applicable to all populations
  - 28 days definition for re-engagement
  - Who gets a clinical assessment, CD4
- Patient-centered interventions may need modifications as per specific target group needs

"Patient centered" - What is good for the patient is not always the easiest for the health system, but if we want to improve retention, we have to put ourselves into our patients shoes

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Thank you