# Session 6A

# 6.3 Zimbabwe's journey to a re-engagement algorithm

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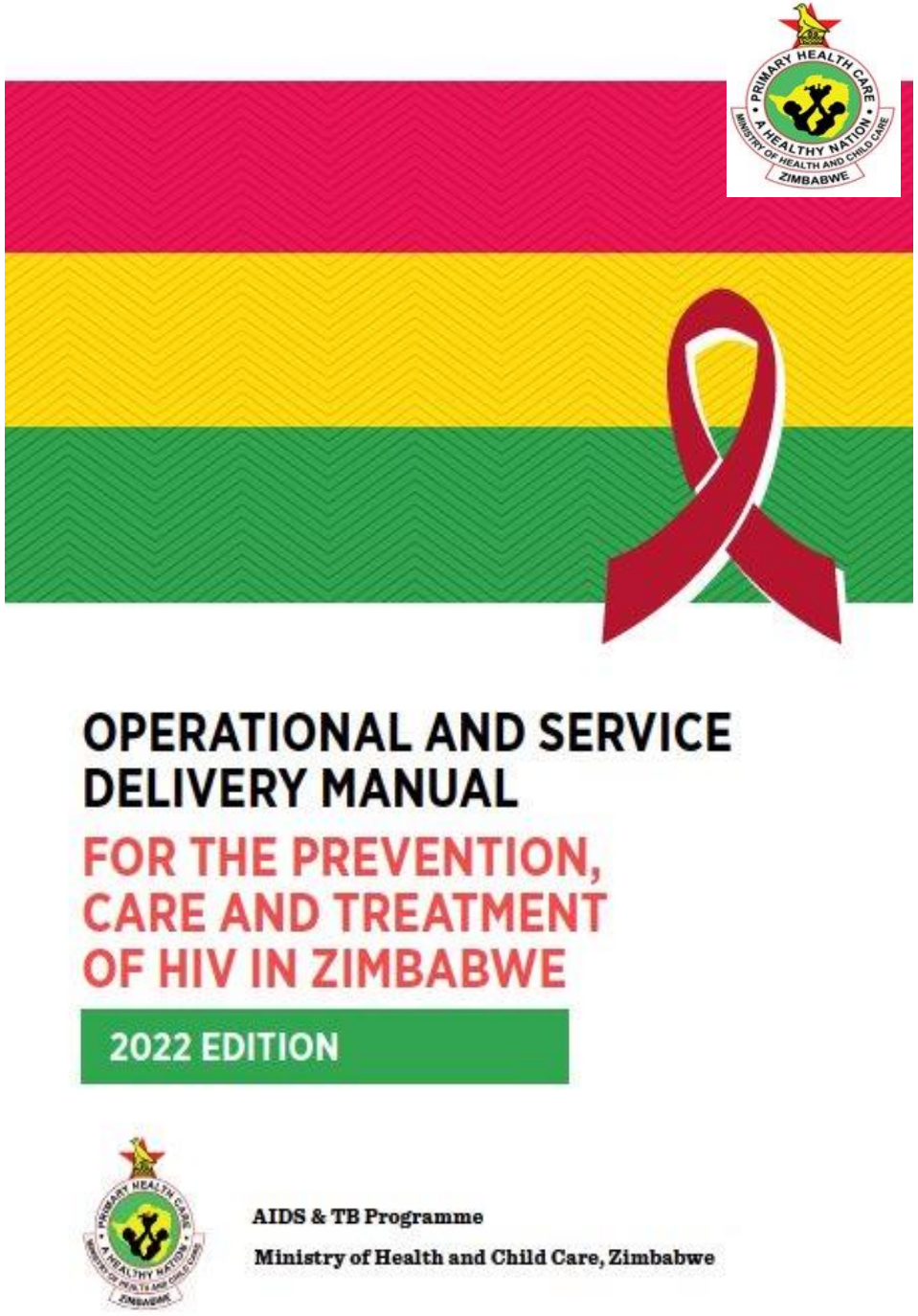
# Zimbabwe's updated Operational and Service Delivery Manual (OSDM)

- The Ministry of Health and Child Care (MOHCC) updated its HIV Prevention, Testing and Treatment guidelines in 2022 in line with updated WHO guidelines – the "**what to do**",
- To accompany this, the *Operational and Service Delivery Manual was updated* - "**how to do it**" to increase retention at all steps of the cascade
    - For doctors, clinical officers, nurses, counselors, pharmacists, health information officers, health promotion officers, community health workers and community-based organizations (CBOs)




Download the OSDM & job aide

# What's in the OSDM on HIV care and treatment

1. Re-engagement in care
2. Differentiated ART initiation
3. Integration of other medical needs into DSD models for RoCs established on treatment SRH/HIV, DM and HPTN and mental health integration
4. Differentiated service delivery for advanced HIV

**Definition of re-engagement**

Re-engagement refers to any RoC who is presenting to HIV services who has:

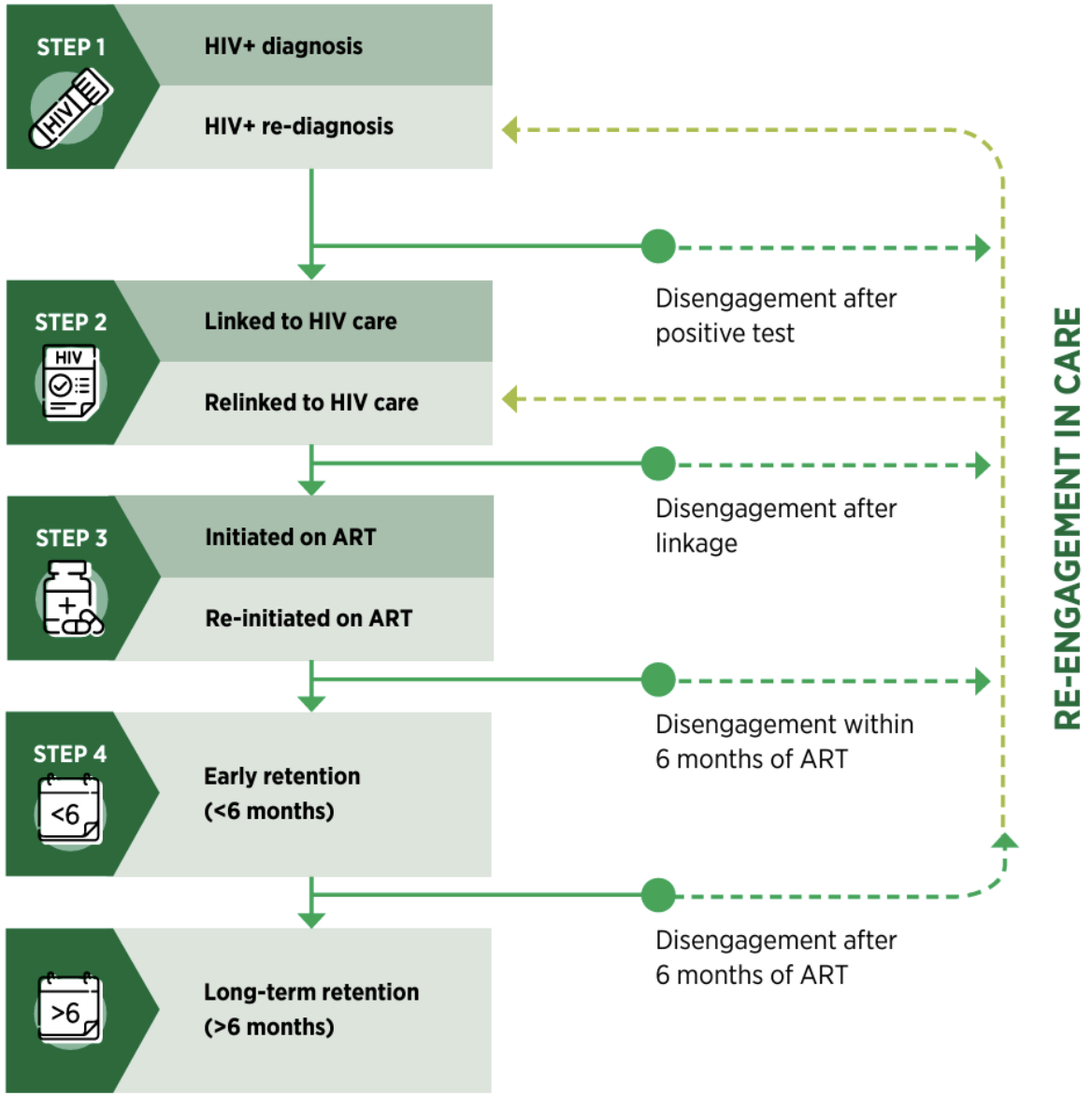
- Previously tested positive but never linked to treatment
- Previously been on ART but stopped

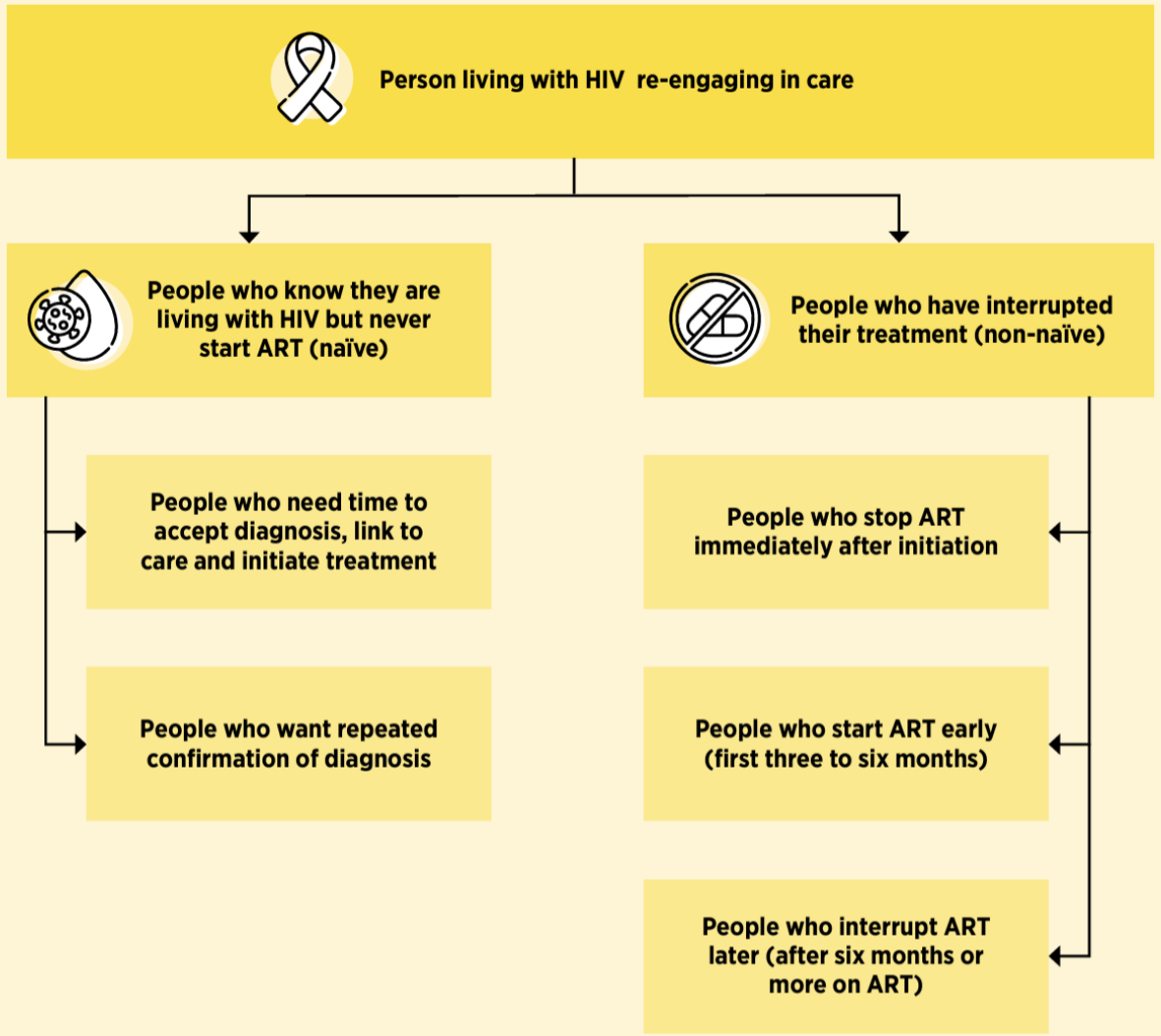
The RoC may re-engage:

- At HIV testing sites or through HIV self-testing
- At an ART site where they are known or not known

New guidelines recognize the cyclical nature of HIV care and treatment

## Figure 4: Re-engagement cycle across the HIV care and treatment cascade






New guidelines recognize that some people disengage without ever starting treatment – and that some people re-engage through HTS programmes

**RoCs who are re-engaging through HTS**

Recognizing RoCs who may be re-engaging in care through HTS is very important.

RoCs should be assessed with respect and HCWs must be non-judgemental as to why the RoC has presented for re-testing.

If identified as a RoC who has previously been on ART, follow the re-engagement algorithm outlined in Section 2.4.8.

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# Re-engagement in care

"Re-engagement services should ensure that RoCs who re-engage are received with dignity, are assisted and clinically managed and receive quality psychosocial services from healthcare workers. RoCs re-engaging in care are often those struggling the most with adherence and should not be penalized by being asked to attend more frequently unless there is a clinical indication."

Counselling for a RoC re-engaging in care should include:

- Exploring treatment literacy
- Addressing the reasons for stopping ART
- Identifying motivational factors for starting ART
- Identifying mental health issues

Healthcare worker attitudes are key to supporting those returning to care and should be non-judgemental and welcoming.

**Is the RoC re-engaging in care?**

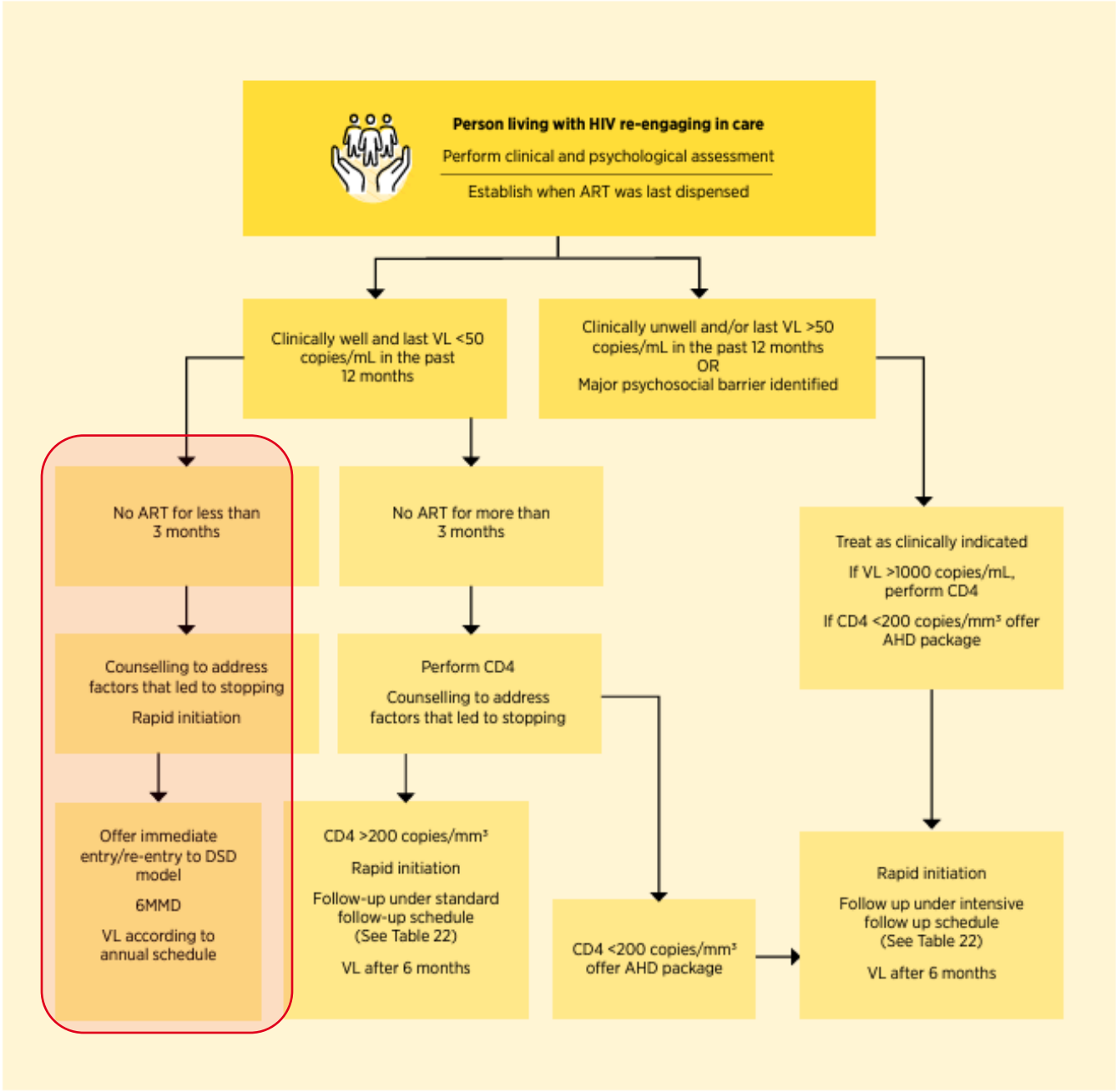
If the RoC has previously been on ART, explore reasons for stopping.

It is important that healthcare workers adopt a non-judgemental approach for the RoC who is re-engaging in care.

The RoC should be congratulated for re-engaging in care and the reasons for stopping and the barriers faced should be openly discussed.

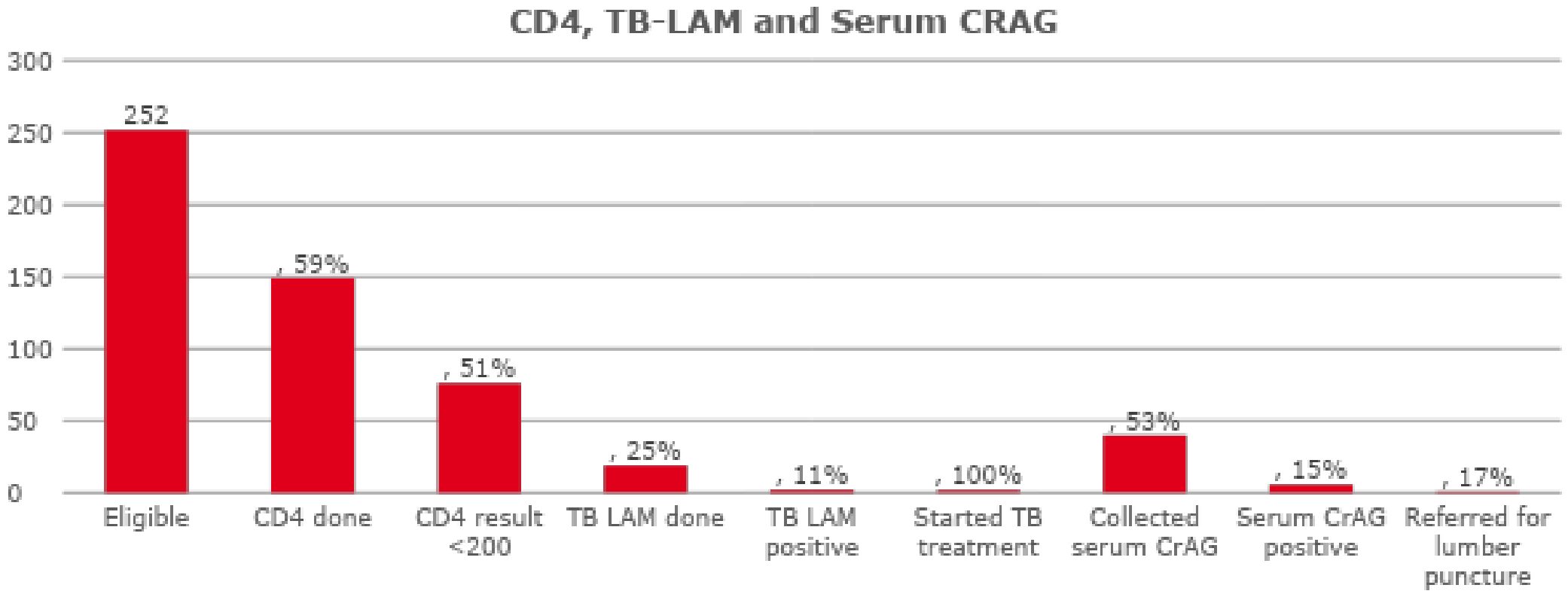
**Re-engagement**

Figure 17: Algorithm for the management of a RoC re-engaging in care

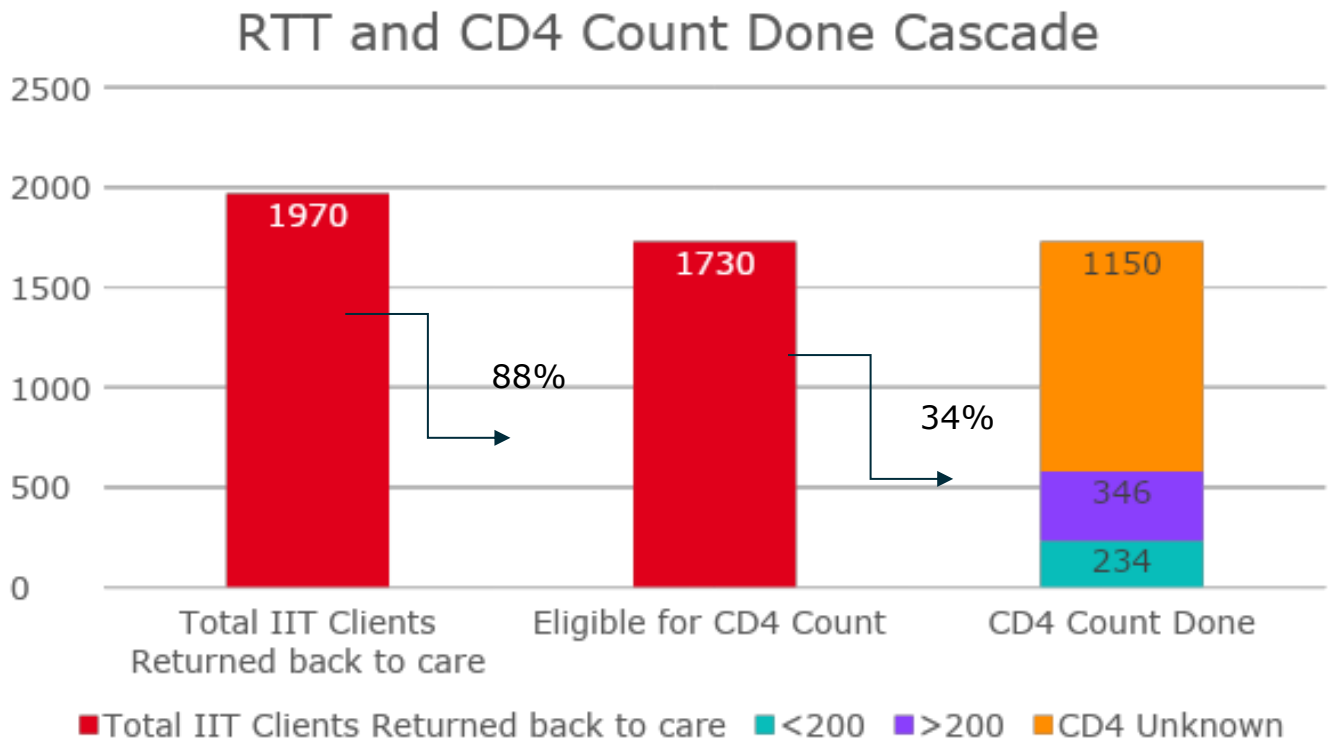



**Zimbabwe's re-engagement algorithm**

# Implementation experiences: re-engaging in care July–Sep 2024, n=190 facilities, 5 provinces



# Implementation Experiences: Re-engaging in care Oct 23 to Sep 24, N=346 Facilities




| District | Total Clients Returned back to care | Eligible for CD4 Count | CD4 <200 | CD4 >200 | CD4 Unknown | RTT with CD4 as a percentage |
|---|---|---|---|---|---|---|
| Bulawayo | 769. | 665 | 176. | 249. | 240. | 64% |
| Masvingo | 103. | 95 | 7. | 37. | 51. | 46% |
| Chitungwiza | 97. | 85 | 13. | 11. | 61. | 28% |
| Bulilima | 58. | 58 | 7. | 6. | 45. | 22% |
| Beitbridge | 149. | 126 | 19. | 9. | 98. | 22% |
| Chivi | 25. | 25 | . | 4. | 21. | 16% |
| Zaka | 55. | 46 | 6. | 1. | 39. | 15% |
| Umzingwane | 59. | 35 | 2. | 3. | 30. | 14% |
| Chiredzi | 119. | 106 | . | 13. | 93. | 12% |
| Matobo | 114. | 83 | . | 8. | 75. | 10% |
| Gwanda | 72. | 71 | 1. | 3. | 67. | 6% |
| Gutu | 51. | 46 | 2. | . | 44. | 4% |
| Mwenezi | 51. | 45 | 1. | . | 44. | 2% |
| Mangwe | 52. | 50 | . | 1. | 49. | 2% |
| Insiza | 196. | 194 | . | 1. | 193. | 1% |
| **Total** | **1970.** | **1730.** | **234.** | **346.** | **1150.** | **34%** |

- Data from **346** sites in four provinces
- **221/346** facilities returned back to care at least one client during the period Oct 23 to Sep 24
- A total of **1,970** clients were returned back to care between Oct 23 and Sep 24
- **1730 (88%)** of the clients had been off treatment for 3 + months

- 580 (34%) of the eligible RTT clients had a CD4 Count done,
- Of the 580 clients with CD4 done, 234 (40%) had a CD4 less than 200
- Urban districts have a better CD4 test done compared to rural districts

# Re-engagement experiences

- Community outreach, reminders, and mental health support included in the package play a critical role in ensuring clients feel comfortable re-engaging in care
- Guidelines specifying which laboratory test to prioritize for people living with HIV returning to care helpful
- Need for flexible services that better accommodate clients' unique circumstances, like employment schedules or travel demands
- Extra work on documentation of dis-engagement and re-engagement (Client flow and staff shortages)
- Transportation of whole blood samples challenging when the riders are off route or off duty (ensure that RoC get AHD screening on point of re-engagement)
- Unavailability of a standard AHD register (data collection requires triangulation from multiple sources including patient booklet, ART register, essential changes etc.)
- Need for additional IEC materials on welcome back package

# Implementation experience from 18 HFs facilities

- Facilities with training in re-engagement guidelines confidently screened returning patients for Advanced HIV Disease (AHD)
- Newly initiating ART patients were more consistently offered CD4 tests compared to patients returning care
- Implementation was hindered by shortages of commodities such as Point-of-Care (POC) CD4 test kits and underutilization of conventional testing platforms
- Some disengaged patients live in diaspora, sending others “Malaicha” to collect ARVs, missing out on AHD screening and management

# Zimbabwe has a well defined tracking package for disengaging RoC


## Reporting

- On reporting, the program has tools that can capture LTFU and RTT disaggregated by time after missing appointment

## Defaulter Tracking & Essential Changes Registers

- Documentation of the Defaulter tracking register on day 4
- Essential Changes register – primary data source
- OI ART booklets, pocket diaries - secondary data sources.
- Essential changes register use continues to be strengthened.

## Defaulter Tracking Process

- Missed appointments, green books separated, Standard Defaulter Tracking SOP used: SMS sent (day 1 - 3), phone call after four days,
  - home visits made on days 8, 15, 22 and day 28.

## Appointment Diary

- Client cohort, clinical & demographic information, visit purpose - documented in Appointment Diaries
- Once the client visits the facility, that date and follow up statuses are also documented

# Next steps

- **Ensure the consistent availability of essential commodities**, such as CD4 test kits and other critical supplies through better forecasting, procurement, and distribution practices.
- **Implement continuous professional development and targeted mentorship** programs, particularly for new staff, are essential to maintain high standards of care (use pre-recorded training videos, and ECHO platforms)
- **Support people living with HIV to update the treatment literacy manual** to incorporate re-engagement guidelines.
- Collaborate across borders to **enhance the care for people living with HIV who are part of the diaspora**.
- **Create communication channels between facilities in reporting movements of RoC** to improve reporting, identifying and managing RoC across facilities

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# Thank You

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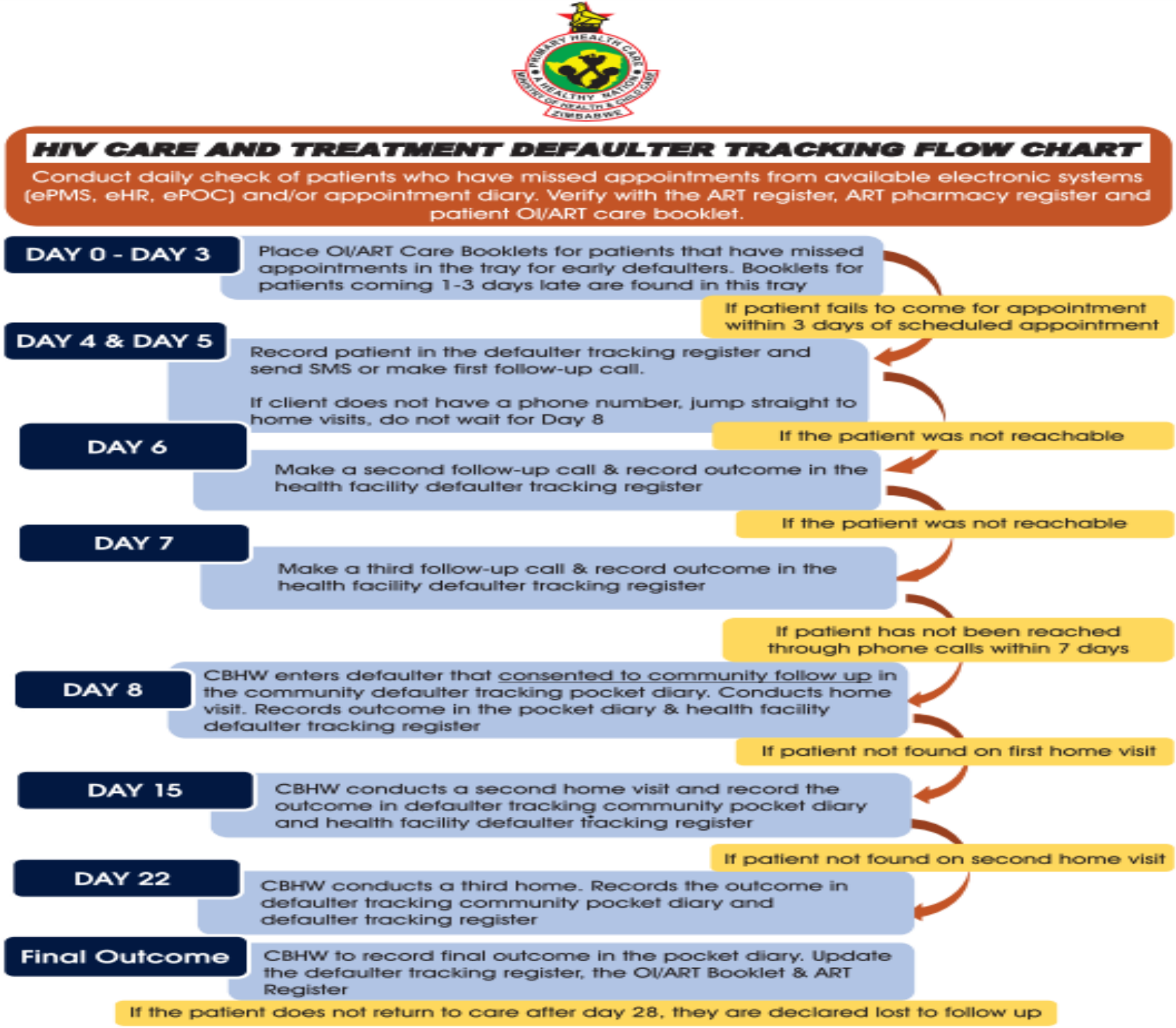
HIV CARE AND TREATMENT DEFAULTER TRACKING FLOW CHART
Conduct daily check of patients who have missed appointments from available electronic systems (ePMS, eHR, ePOC) and/or appointment diary. Verify with the ART register, ART pharmacy register and patient OI/ART care booklet.
DAY 0 - DAY 3
Place OI/ART Care Booklets for patients that have missed appointments in the tray for early defaulters. Booklets for patients coming 1-3 days late are found in this tray
If patient fails to come for appointment within 3 days of scheduled appointment
DAY 4 & DAY 5
Record patient in the defaulter tracking register and send SMS or make first follow-up call.
If client does not have a phone number, jump straight to home visits, do not wait for Day 8
If the patient was not reachable
DAY 6
Make a second follow-up call & record outcome in the health facility defaulter tracking register
If the patient was not reachable
DAY 7
Make a third follow-up call & record outcome in the health facility defaulter tracking register
If patient has not been reached through phone calls within 7 days
DAY 8
CBHW enters defaulter that consented to community follow up in the community defaulter tracking pocket diary. Conducts home visit. Records outcome in the pocket diary & health facility defaulter tracking register
If patient not found on first home visit
DAY 15
CBHW conducts a second home visit and record the outcome in defaulter tracking community pocket diary and health facility defaulter tracking register
If patient not found on second home visit
DAY 22
CBHW conducts a third home. Records the outcome in defaulter tracking community pocket diary and defaulter tracking register
Final Outcome
CBHW to record final outcome in the pocket diary. Update the defaulter tracking register, the OI/ART Booklet & ART Register
If the patient does not return to care after day 28, they are declared lost to follow up

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# Welcome Back Package

- Program is implementing a welcome back package for clients re-engaging into care based on the OSDM guidance

## Welcome Back Package:

Re-engagement in care involves the following steps:

- Warmly welcoming the client, including congratulating them for choosing to come back (Avoid scolding or being judgmental)
- Pledging support: "I am here to support you through your ART journey".
- Identifying the reason for treatment interruption
- Ascertain which drugs the patient was taking, and for how long, the reasons for stopping treatment, check if they had any side-effects.
- Reviewing chronic care/ green booklet to check last regimen and check viral documented suppressed viral loads.
- Refer client for further escalation counselling if necessary