Solange Baptiste, ITPC, South Africa & Geoff Garnett, BMGF, USA

Differentiated service delivery for HIV treatment in 2022

AIDS 2022

Conflict of interest disclosure

We have no relevant financial relationships with ineligible companies to disclose.

Session 3: DSD to support sustained re-engagement: It shouldn't be one-size-fits all

Session co-chairs

Solange Baptiste
ITPC, South Africa

Geoff Garnett
BMGF, USA

Session presenters

Katy Godfrey
OGAC, USA

Kombatende Sikombe
CIDRZ, Zambia

Helen Bygrave
IAS, UK

Diana Mokoena
Anova, South Africa

Overview of session 3

DSD to support sustained re-engagement: It shouldn't be one-size-fits all
• **Changing epidemic: From initiation to re-engagement,** Katy Godfrey, OGAC, USA
• **Why people disengage from HIV treatment programmes**, Kombatende Sikombe, CIDRZ, Zambia
• **It's time for differentiation at re-engagement**, Helen Bygrave, IAS, UK
• **The South Africa case for DSD at re-engagement: Policy and implementation**, Diana Mokoena, Anova, South Africa
• **Moderated discussion: Where to from here?**
• Q&A / Discussion

AIDS 2022

Please engage

#AIDS2022

Post your questions virtually

Katy Godfrey, OGAC, United States

DSD for HIV treatment in 2022

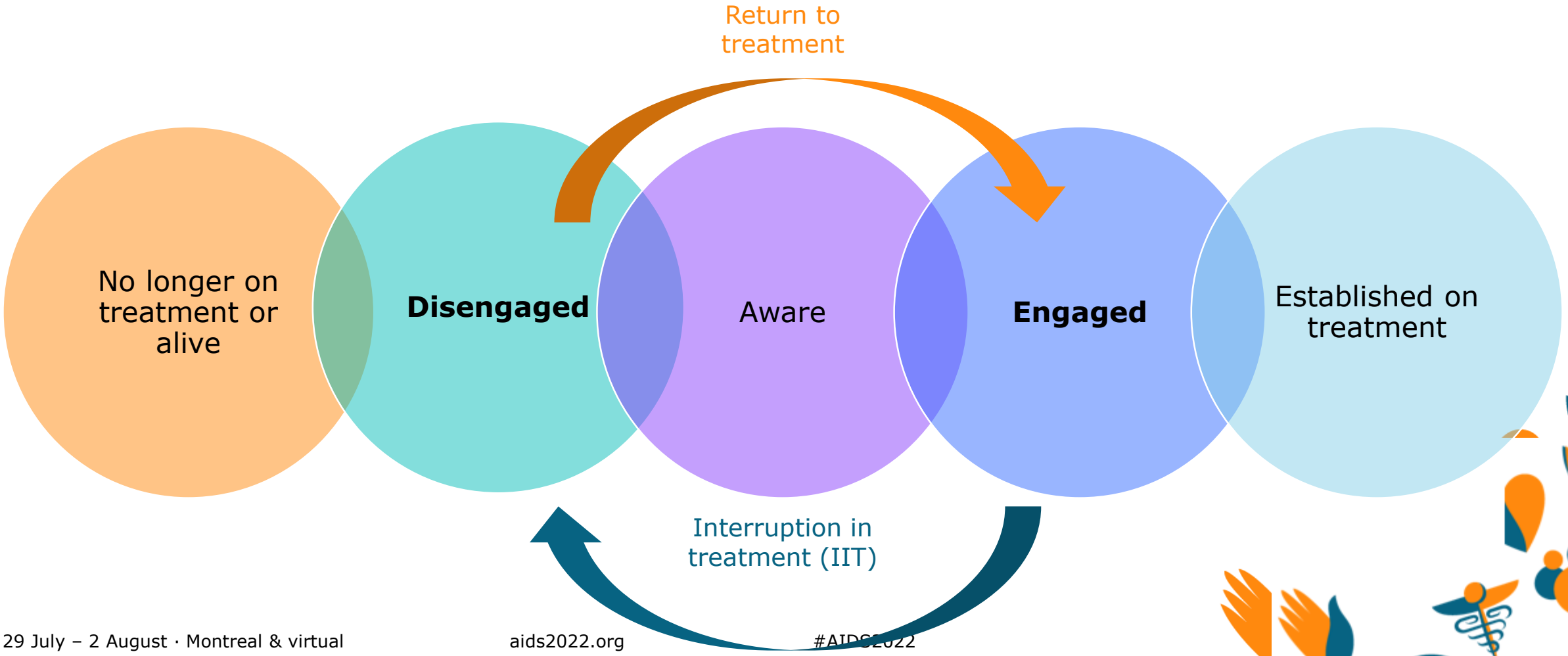
Changing epidemic: From initiation to re-engagement

AIDS 2022

AIDS 2022

I have no relevant financial relationships with ineligible companies to disclose

Engagement and reengagement in ART



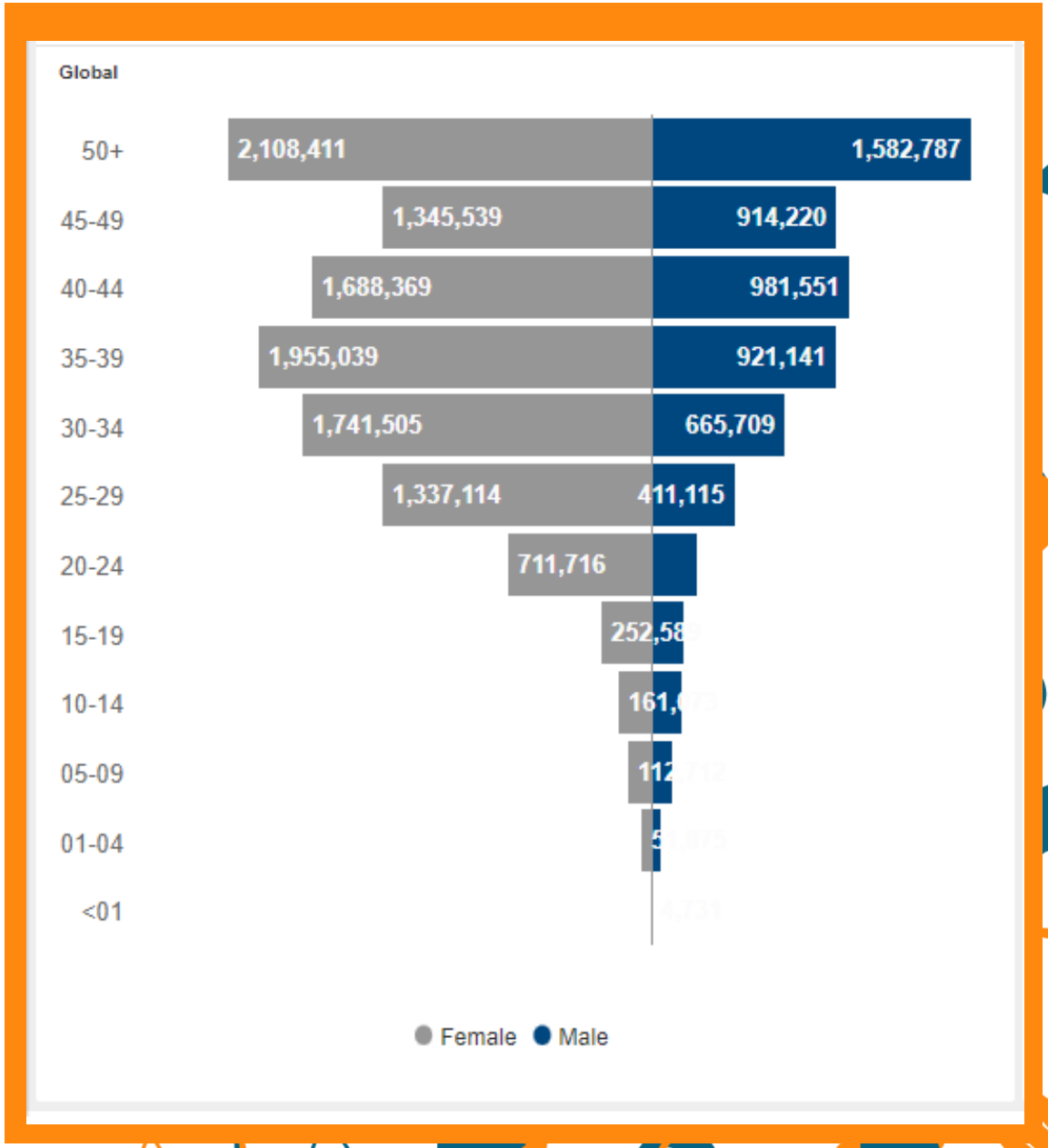
AIDS 2022

What do we know about interruptions?

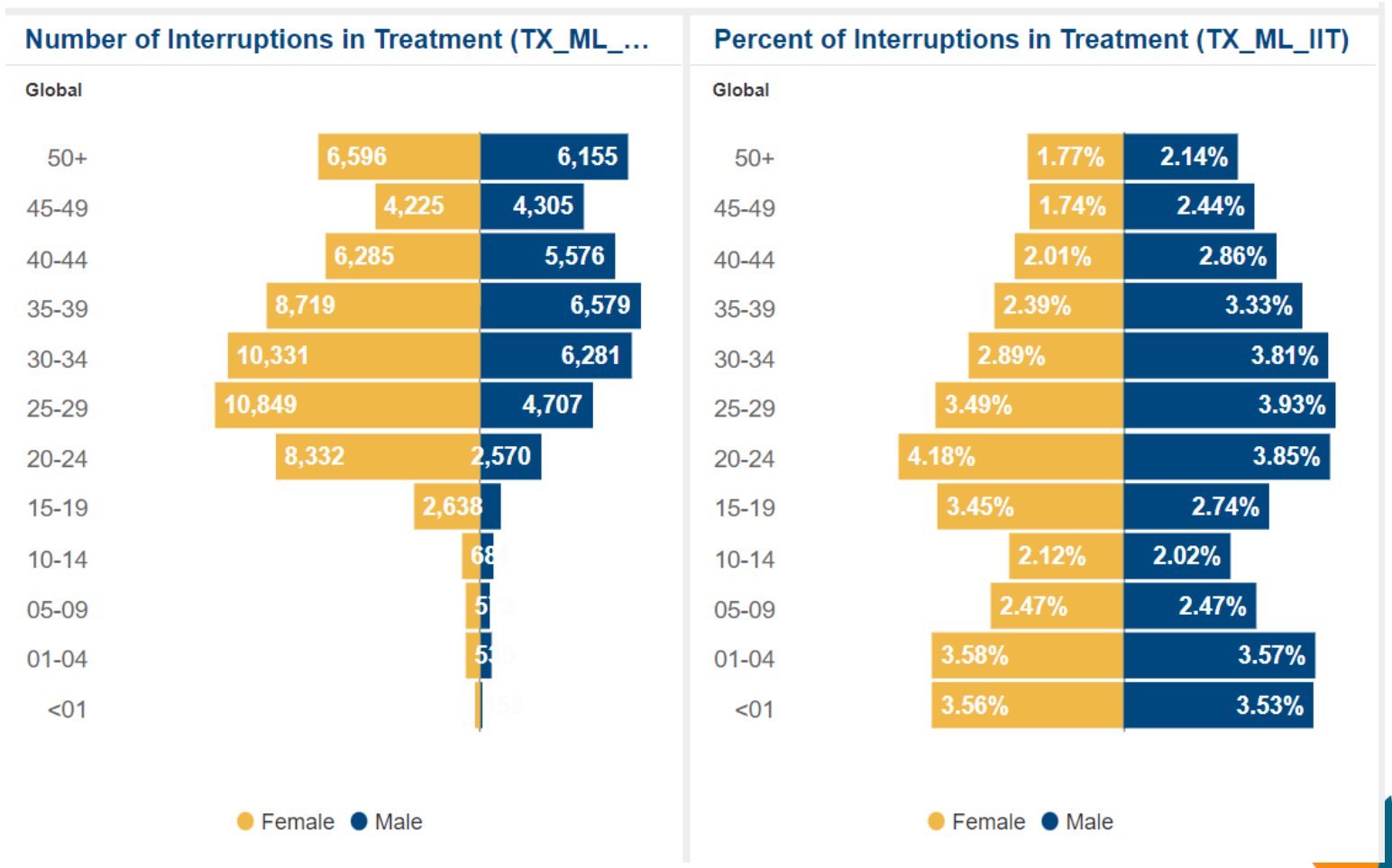
- **Age and sex**
- **Early in treatment vs late**

AIDS 2022

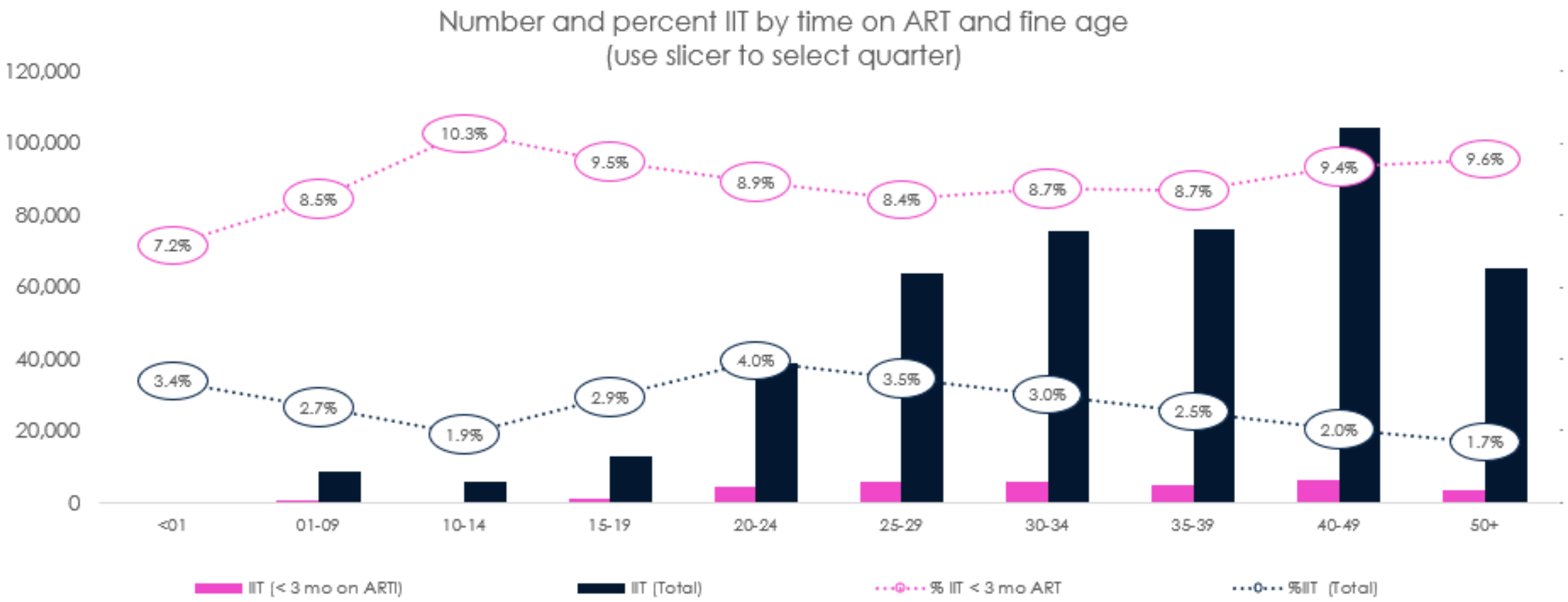
Number, age and sex of individuals with HIV supported by PEPFAR (FY22 Q2)



Treatment interruptions by age and sex (Jan-Mar 2022)



Interruptions in treatment (Jan-Mar 2022)



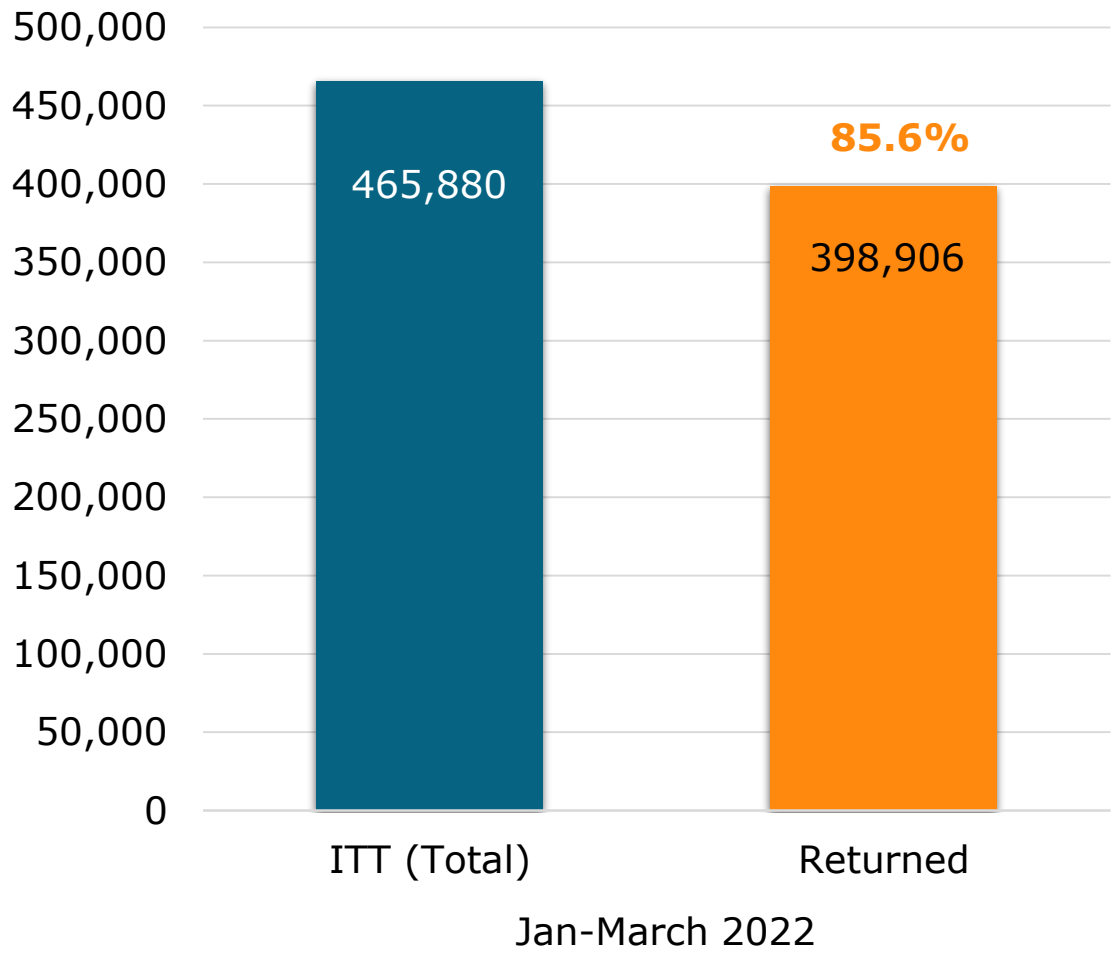
What about re-engagement?

We can look at re-engagements in addition to interruptions

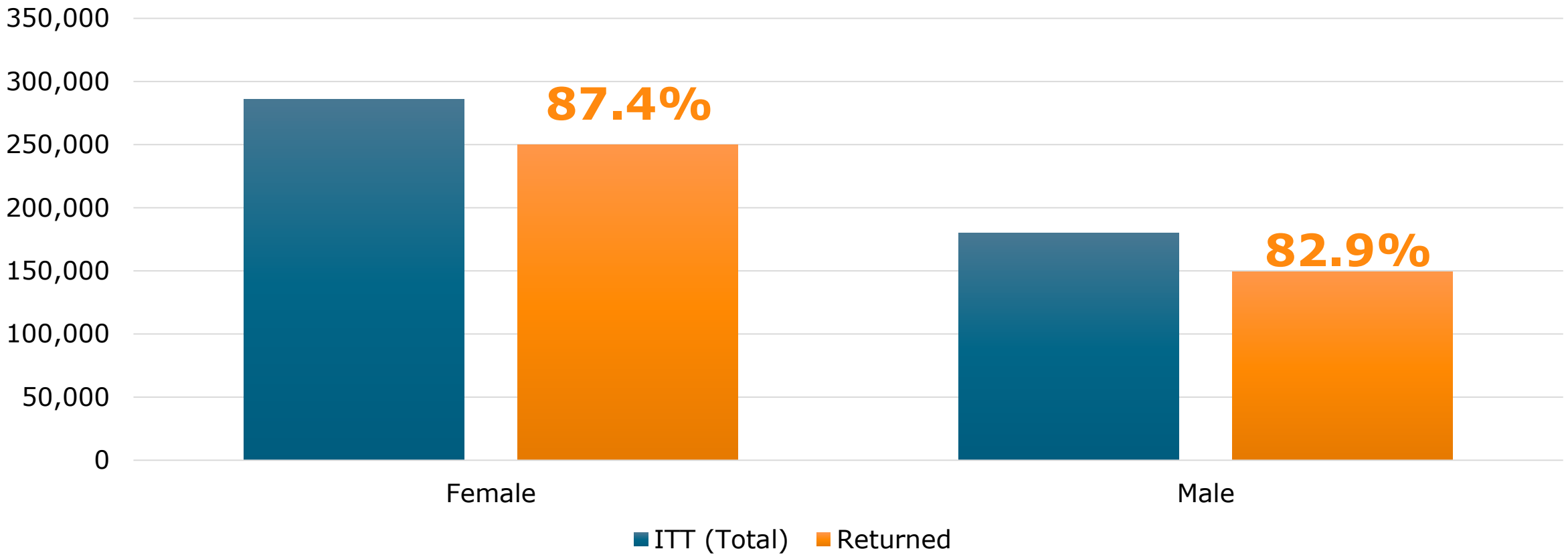
- Returns are defined as the number of individuals returning to care after having been out $\geq$ 28 days since the last expected contact with the health system
- Aggregate data-so this does not follow a particular individual
- We would like returns to match interruptions

What about re-engagement?

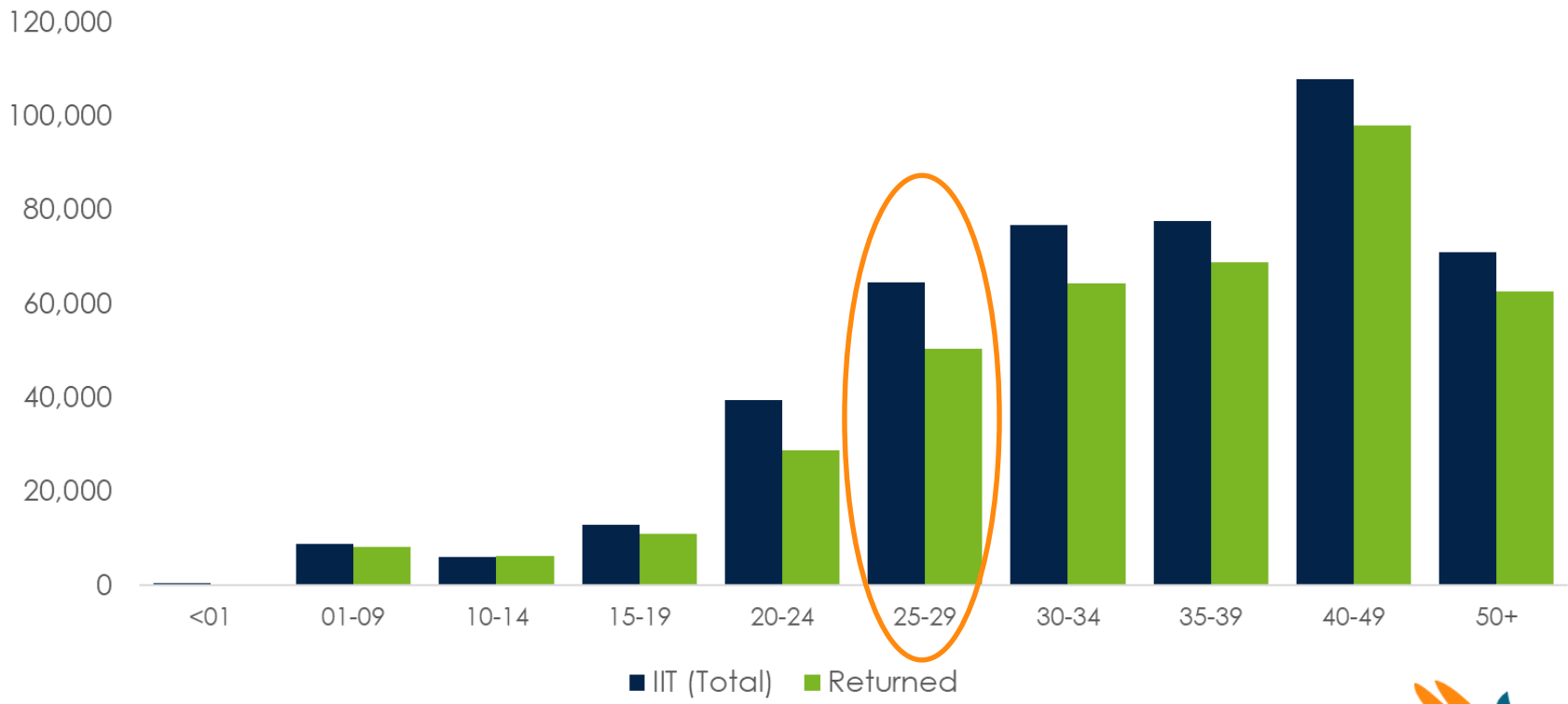
- Returns are defined as the number of individuals returning to care after having been out ≥ 28 days
- Aggregate data - does not follow a particular individual
- We would like returns to match interruptions.



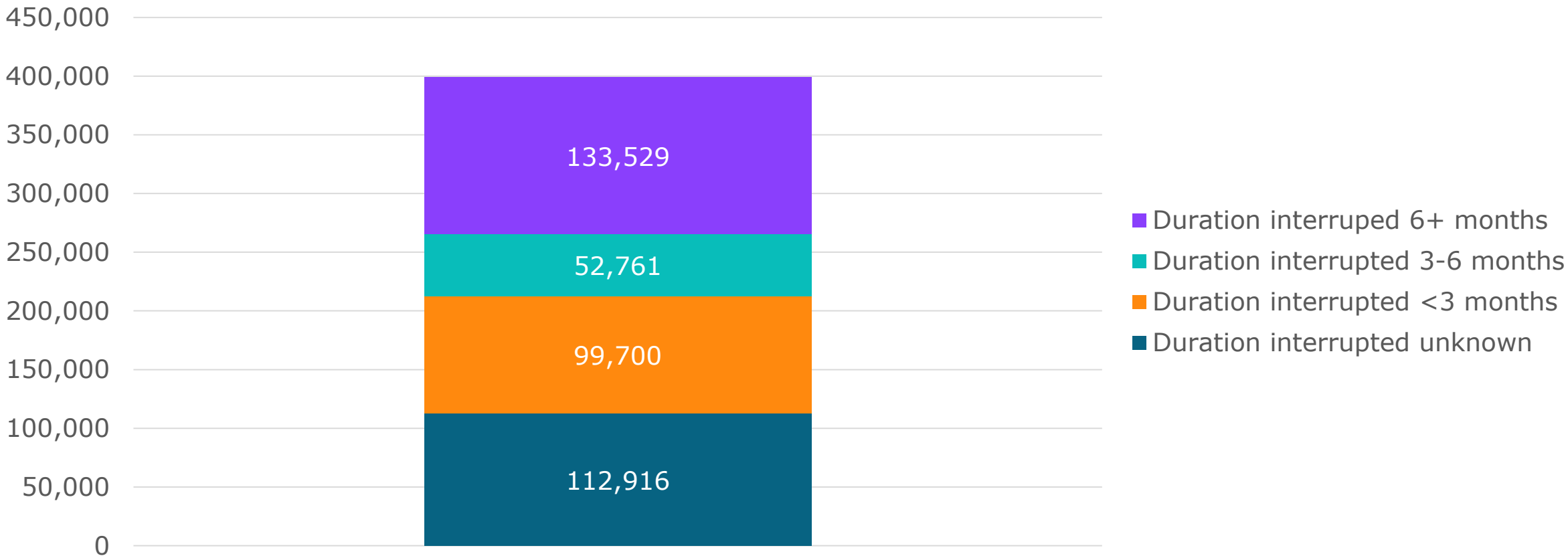
Re-engagement by sex (Jan-Mar 2022)



Reengagement by age (Jan-Mar 2022)



Length of interruption before return (Jan-Mar 2022)

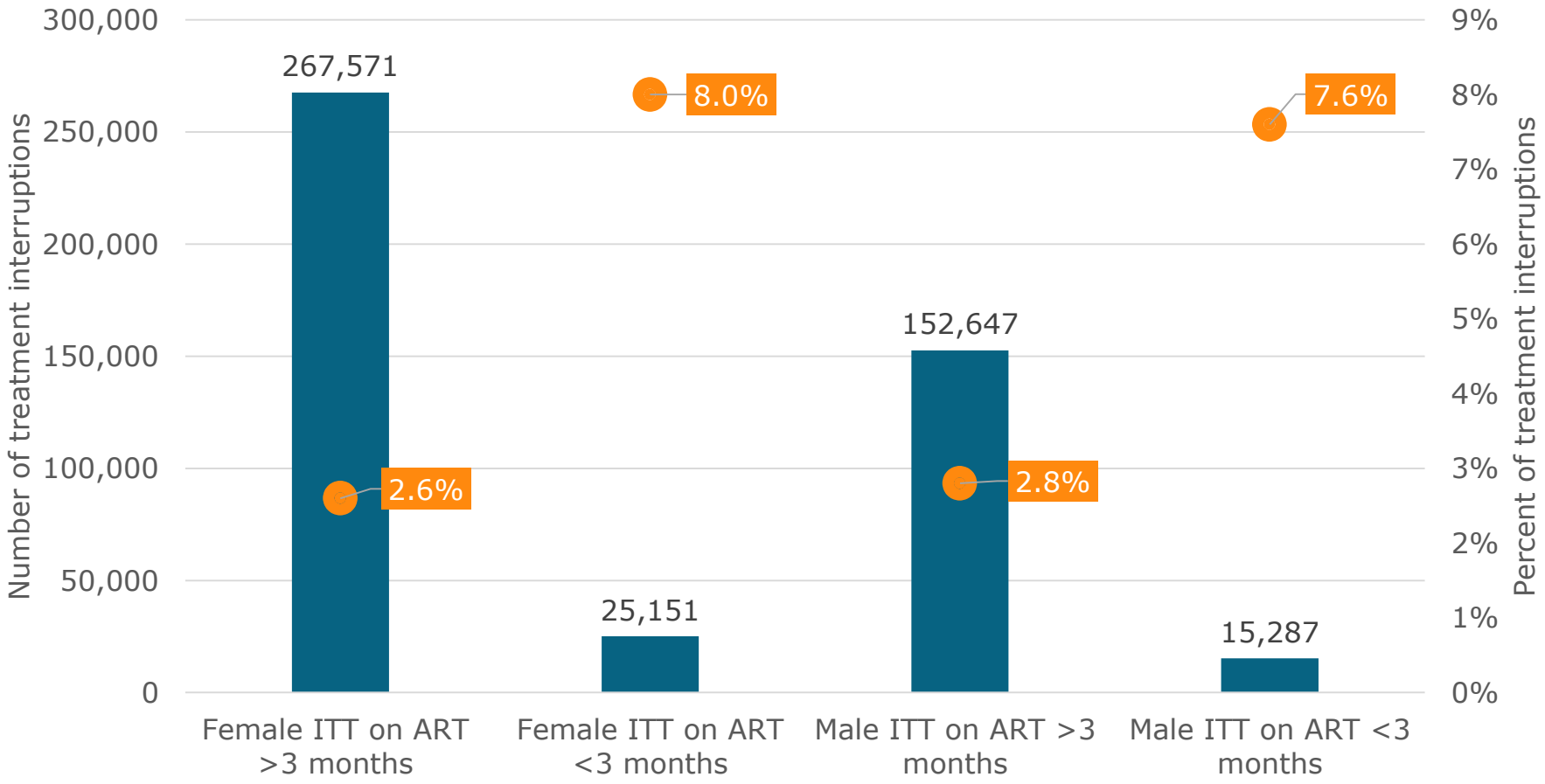


AIDS 2022

What about the re-engagers?

- Why do they come back?
- When do they come back?
- Where do they come back?
- How do they re-engage?

Interruptions in treatment (Jan-Mar 2022)



Disaggregated by:
a) Sex
b) Time on ART

Other considerations

1. Package of care upon return
   - If interrupted ≥ 1 year need assessment for advanced HIV disease (including TB)
   - When to assess viral load?

2. Timeline for resumption of less intensive DSD models

3. For children assure alignment with other family members

Acknowledgments: the interagency treatment continuity community of practice

John Aberle-Grasse	Danielle Connor
Patricia Agaba	Jacqueline Devine
Pat Bachanas	Lana Lee
Lauren Bailey	Jessica Stephens
Caitlin Biedron	Michelle Williams Sherlock
	Isaac Zulu

Kombatende Sikombe, Centre for Infectious Disease Research in Zambia (CIDRZ), Zambia, London School of Hygiene and Tropical Medicine (LSHTM), UK

DSD for HIV treatment in 2022

Why people disengage from HIV treatment programmes

AIDS 2022

CIDRZ for a healthy Zambia 20 years

AIDS 2022

I have no relevant financial relationships with ineligible companies to disclose

A global challenge for HIV programs

- Engagement in HIV care is a critical
- Number of people lost to HIV care follow up is large
  - Up to 15-20% of those in HIV care are lost to follow-up
  - Rates of repeat lost to follow up - 30%
- Reducing/minimizing uninterrupted treatment is key for continued epidemic control
  - U=U
  - Reduced morbidity and mortality
  - Reduced opportunity for drug resistance
- More people re-engaging compared to new initiates

AIDS 2022

Understanding disengaged people living with HIV: A key to care improvement?

What
Real outcomes among people living with HIV?

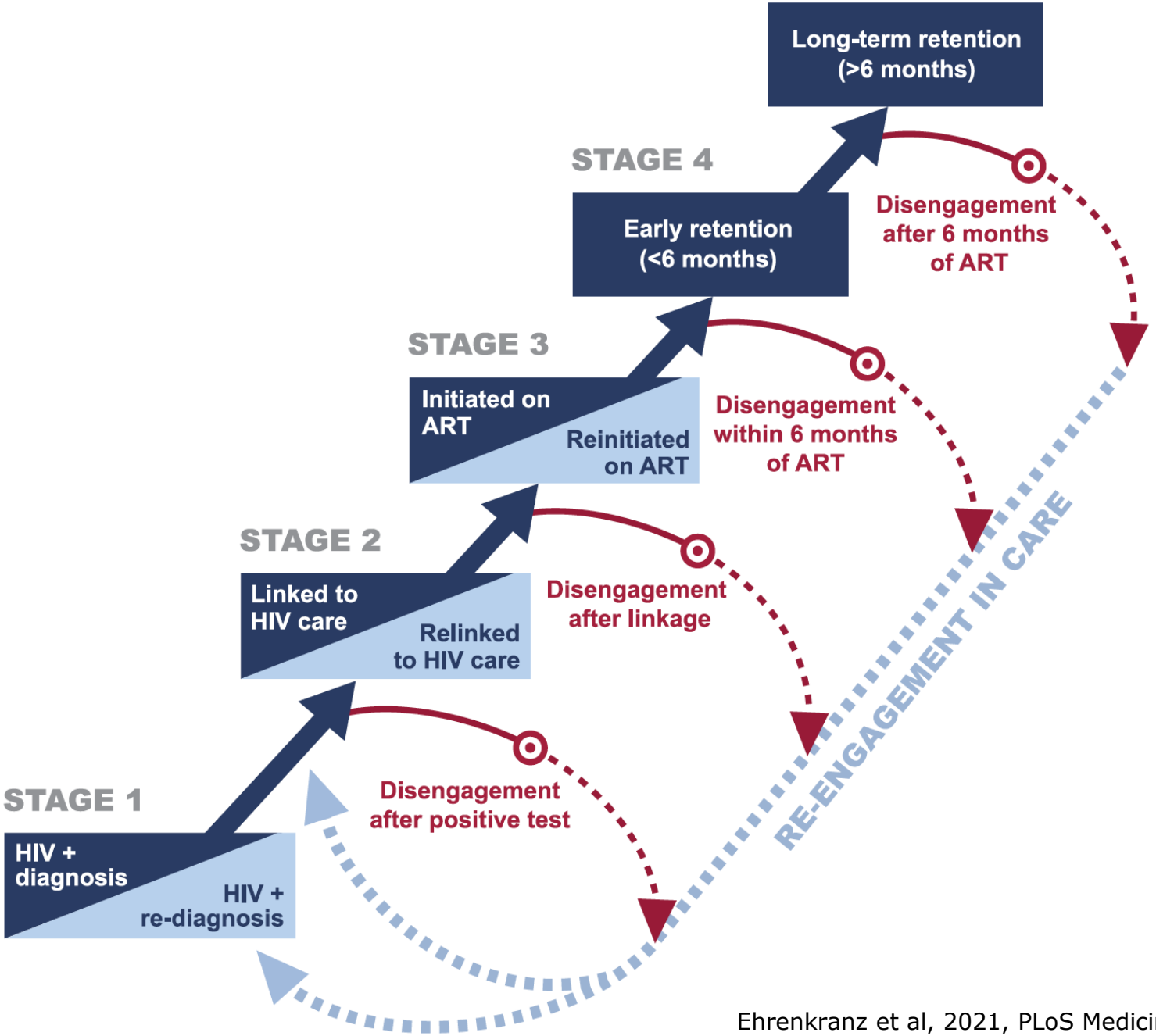
Why
Why did they drop out, change clinics or die? What do they want from health care?

Who
Which subgroups are at risk for poor outcomes?

Where
Are there hotspots for poor outcomes?

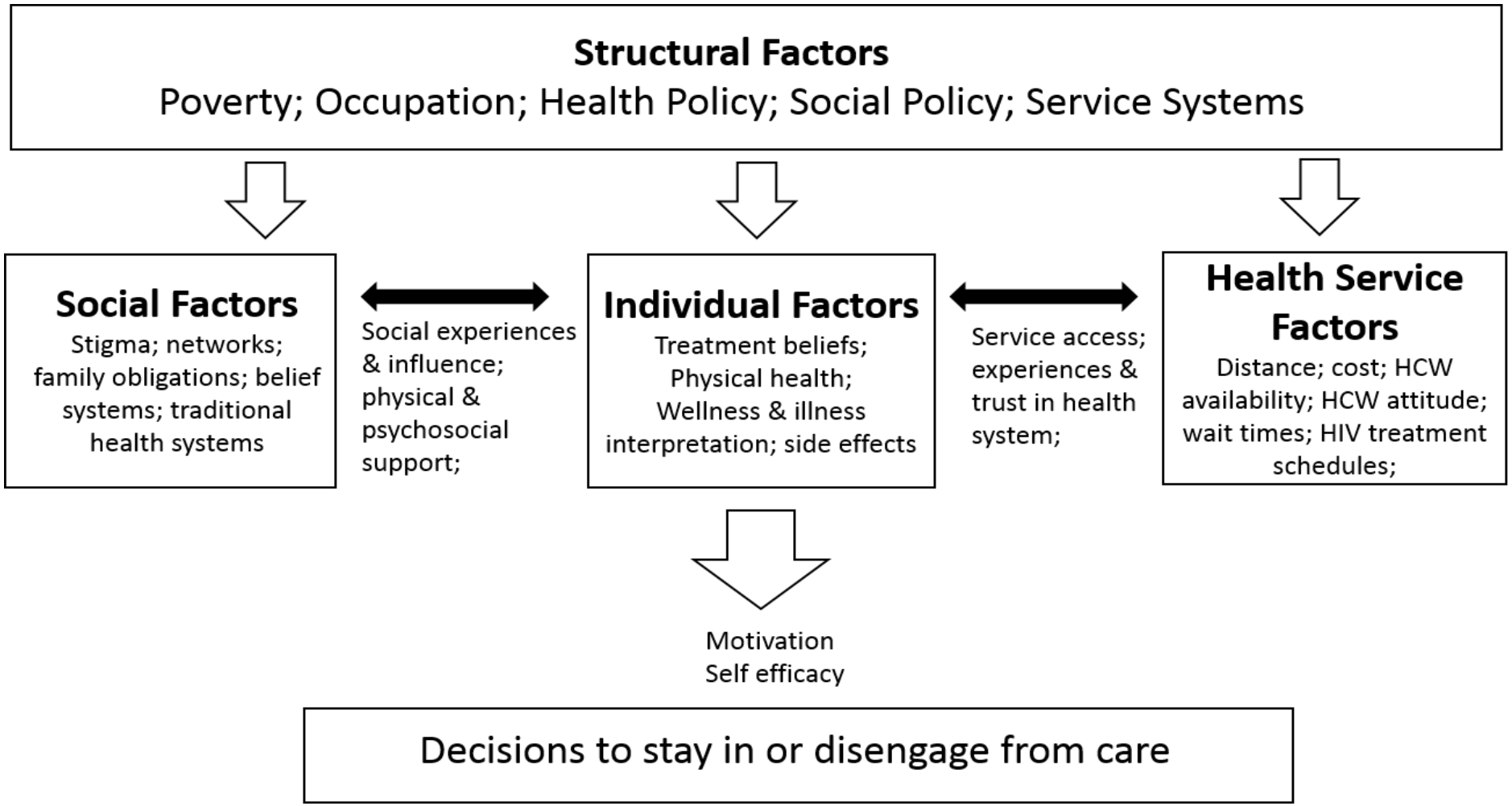
When
What are the vulnerable points in the cascade?

AIDS 2022



Ehrenkranz et al, 2021, PLoS Medicine

Conceptual framework

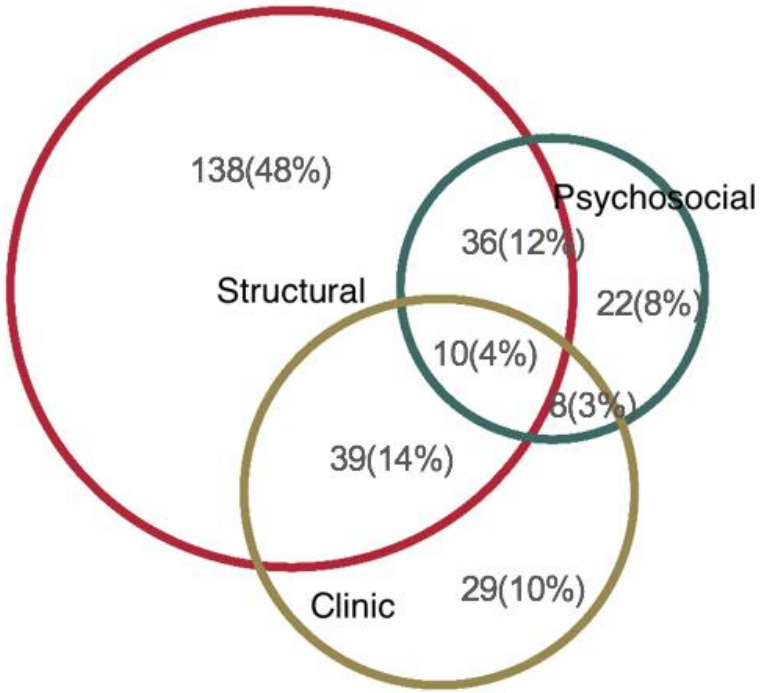


Adapted Social-Ecological Framework

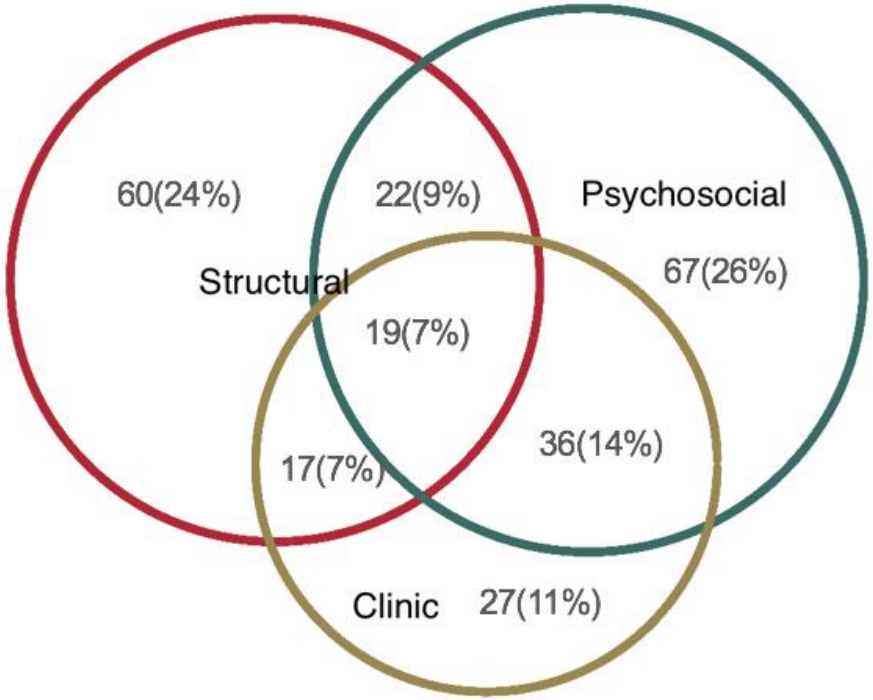
Musheke, M., Bond, V. and Merten, S. (2012), Individual and contextual factors influencing patient attrition from antiretroviral therapy care in an urban community of Lusaka, Zambia. Journal of the International AIDS Society, 15: 17366. https://doi.org/10.7448/IAS.15.3.17366

Reasons for silent transfer, disengagement or changes required to return

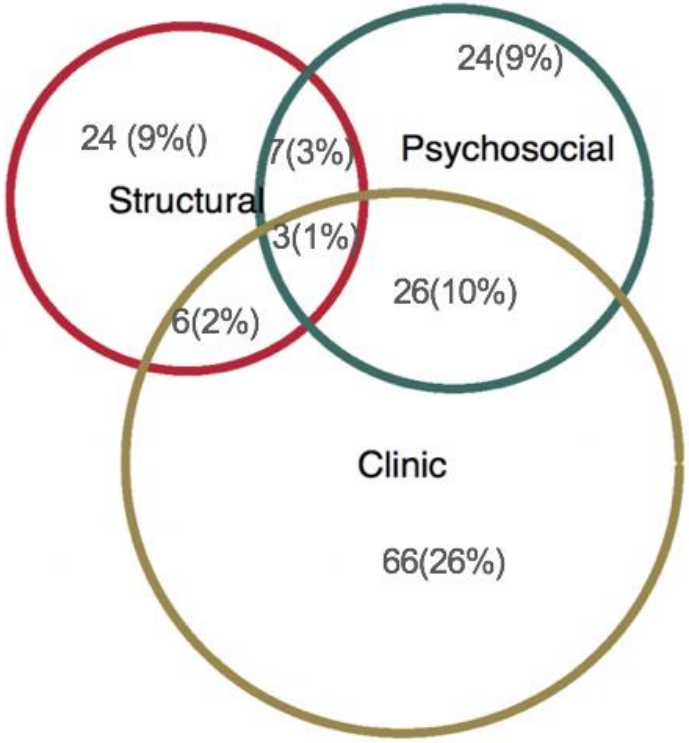
a. Reasons for silent transfer (N=289)



b. Reasons for disengagement (N=255)



c. Changes required for disengaged to return (N=255)

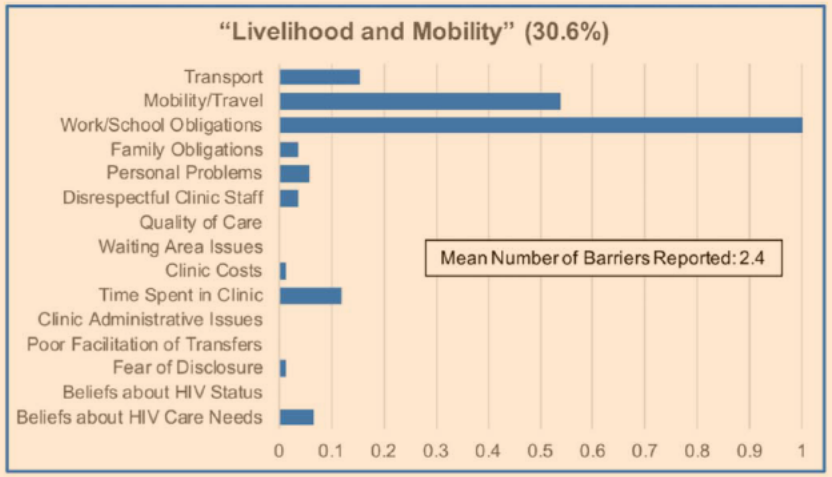


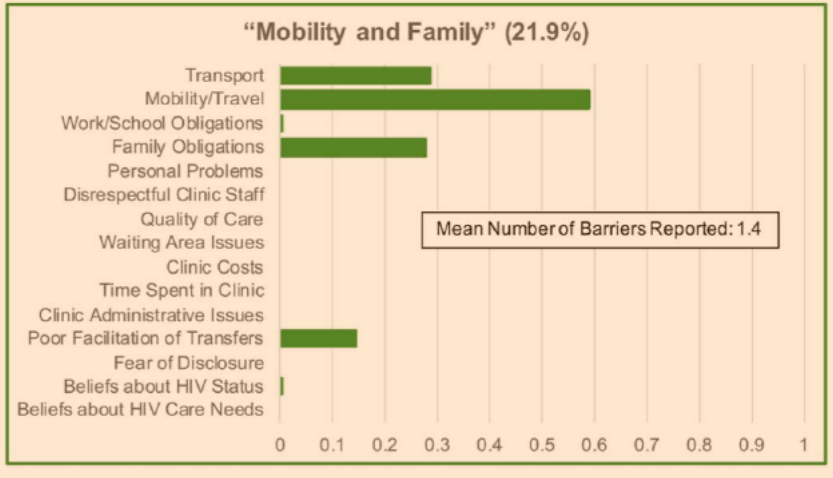
Sikazwe, Eshun-Wilson, Sikombe, et al, 2021. *Clin Infect Dis*

Profiles among those disengaged

More Likely to Remain Disengaged

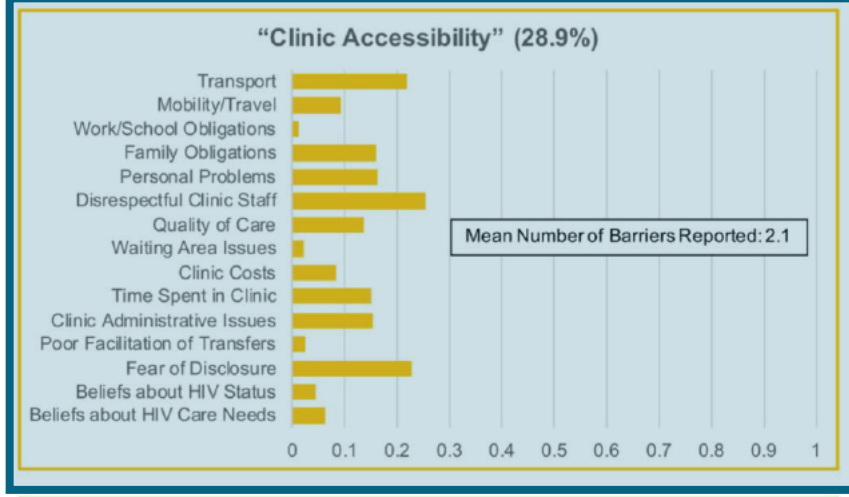
*including Men Mobile for Work

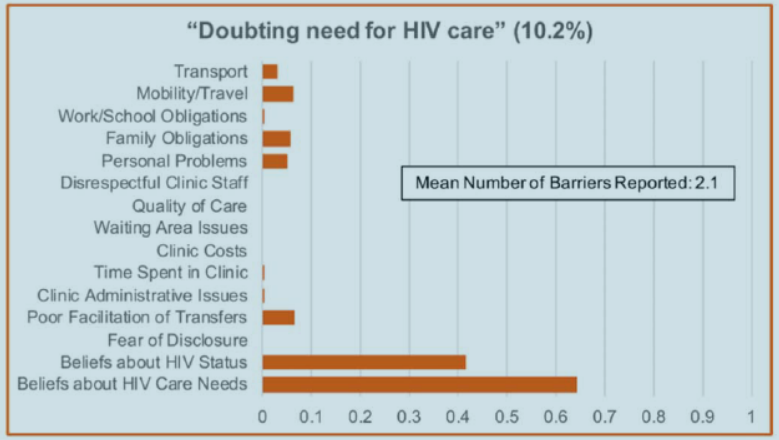


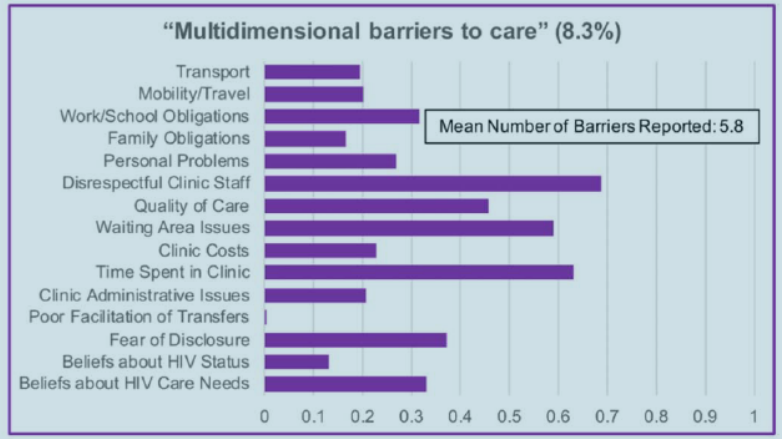


More Likely to <u>Transfer</u> Facilities

*except Men Mobile for Work

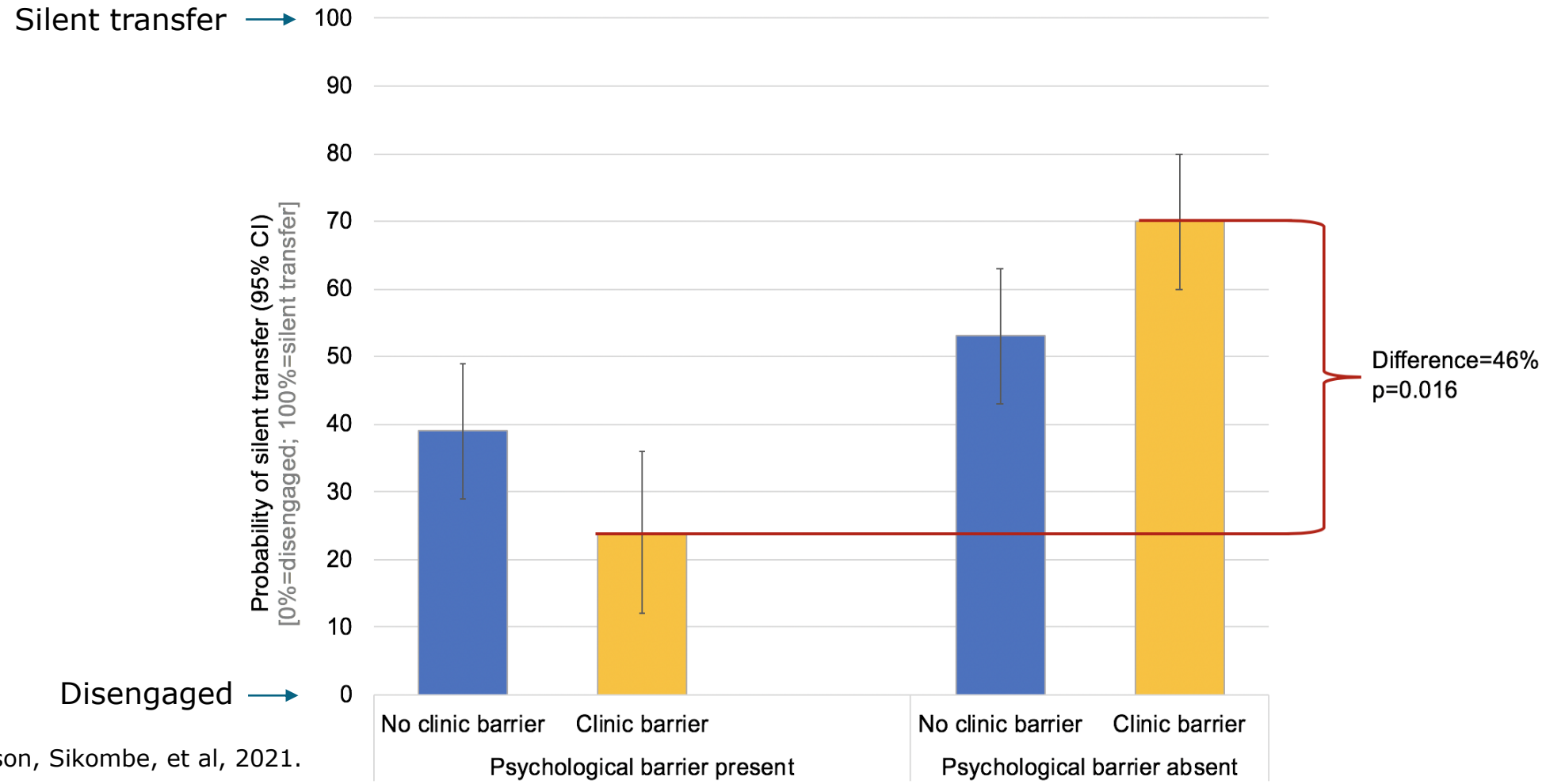






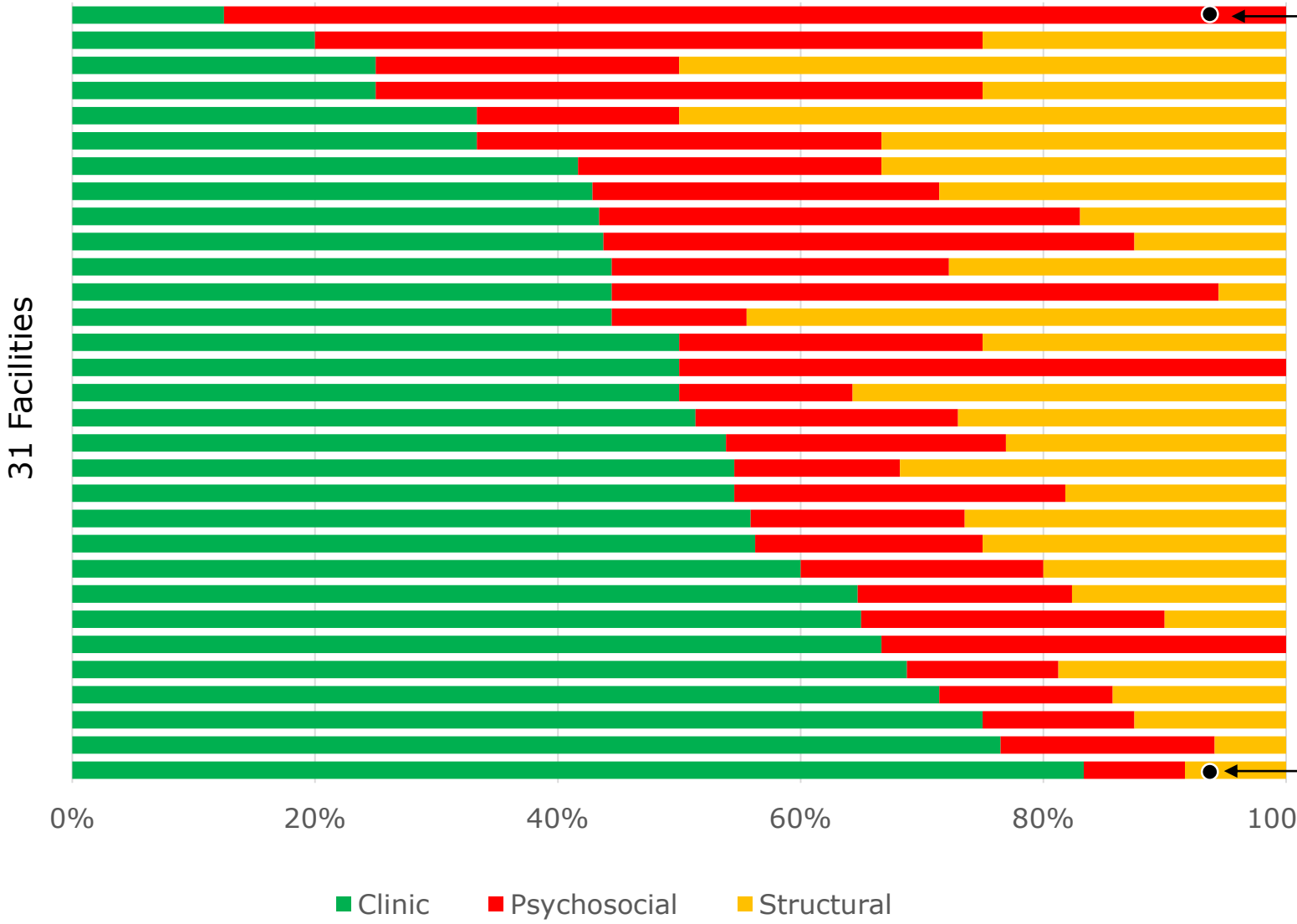
Mody A, Sikombe K, Beres L.K et al. Profiles of HIV Care Disruptions Among Adult Patients Lost to Follow-up in Zambia: A Latent Class Analysis (2021), J Acquir Immune Defic Syndr;86:62–72

Probability of silent transfer and disengagement: Interaction of barrier domains



Sikazwe, Eshun-Wilson, Sikombe, et al, 2021. *Clin Infect Dis*

What will it take to return?



Public health: priority setting is necessary
Focus facility efforts on *prevailing* barriers

Prioritize psychosocial based barriers

Prioritize clinic-based barriers

Sikazwe, Eshun-Wilson, Sikombe, et al, 2021. *Clin Infect Dis*

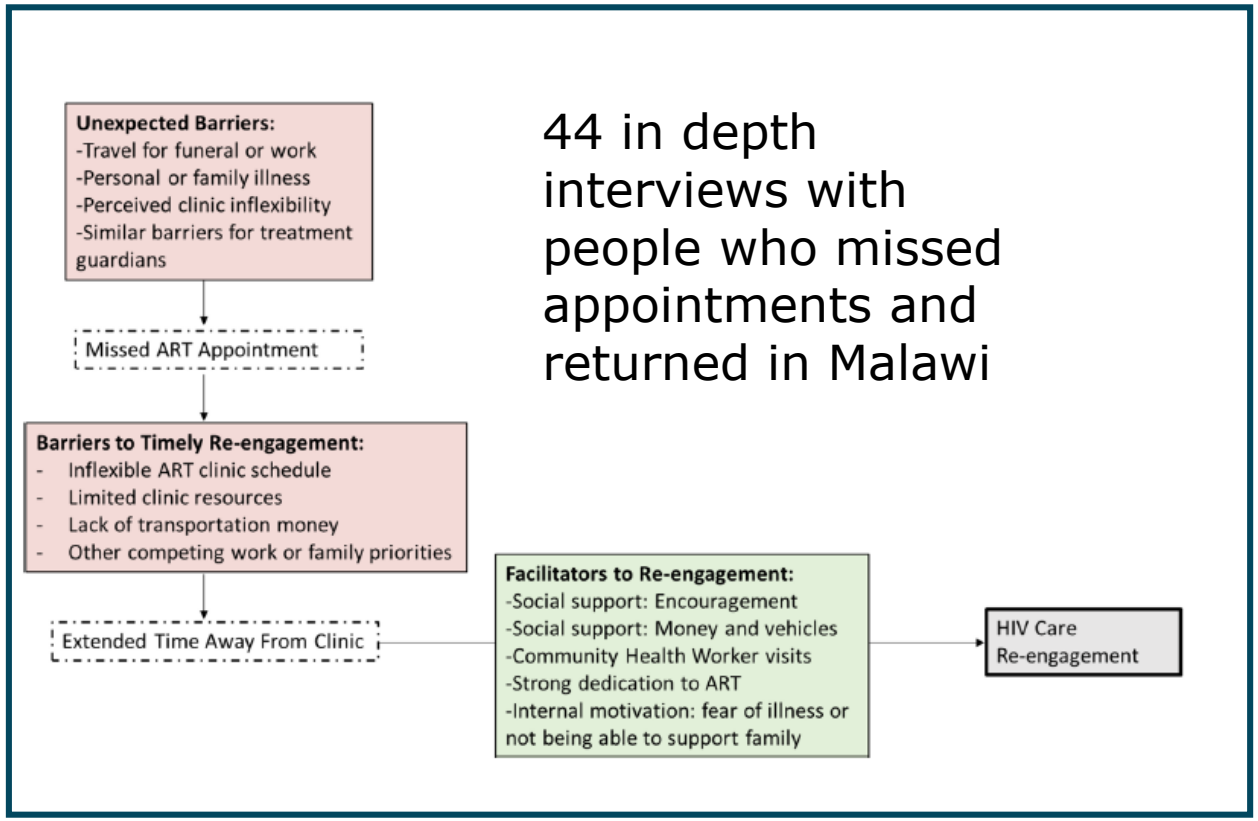
Factors associated with not re-engaging

- Male gender
- Under 30 years of age
- Without a regular partner
- WHO stage III/ IV
- High CD4 count
- Previous gap in care

- Competing income priorities
- Urban health facilities
- Inflexible ART clinic schedule
- Lack of privacy
- Distance to health facilities

Gosset A, et al. (2019) J Acquir Immune Defic Syndr, Aaloke Mody et al. (2020) *Clinical Infectious Diseases,* Yonga et al. 2020 International Health

Reasons and facilitators supporting return



Chamberlin et al, 2022, AIDS and Behaviour

Reasons for re-engagement (n=341)

- Worried about being off ART (47%)
- Sick (23%)
- Access to services has become easier for the person returning (21%)
- Tracing (12%)
- Concern for children's long term welfare (5%)

Mechanisms underlying re-engagement

20 in depth interviews with Zambians who returned to care

- Patients feeling valued
- Establishing supportive accountability through caring relationships with health care workers or family
- Guidance on practical steps required to re-start care
- Improved treatment accessibility
- Identifying and supporting management of specific barriers, such as depression

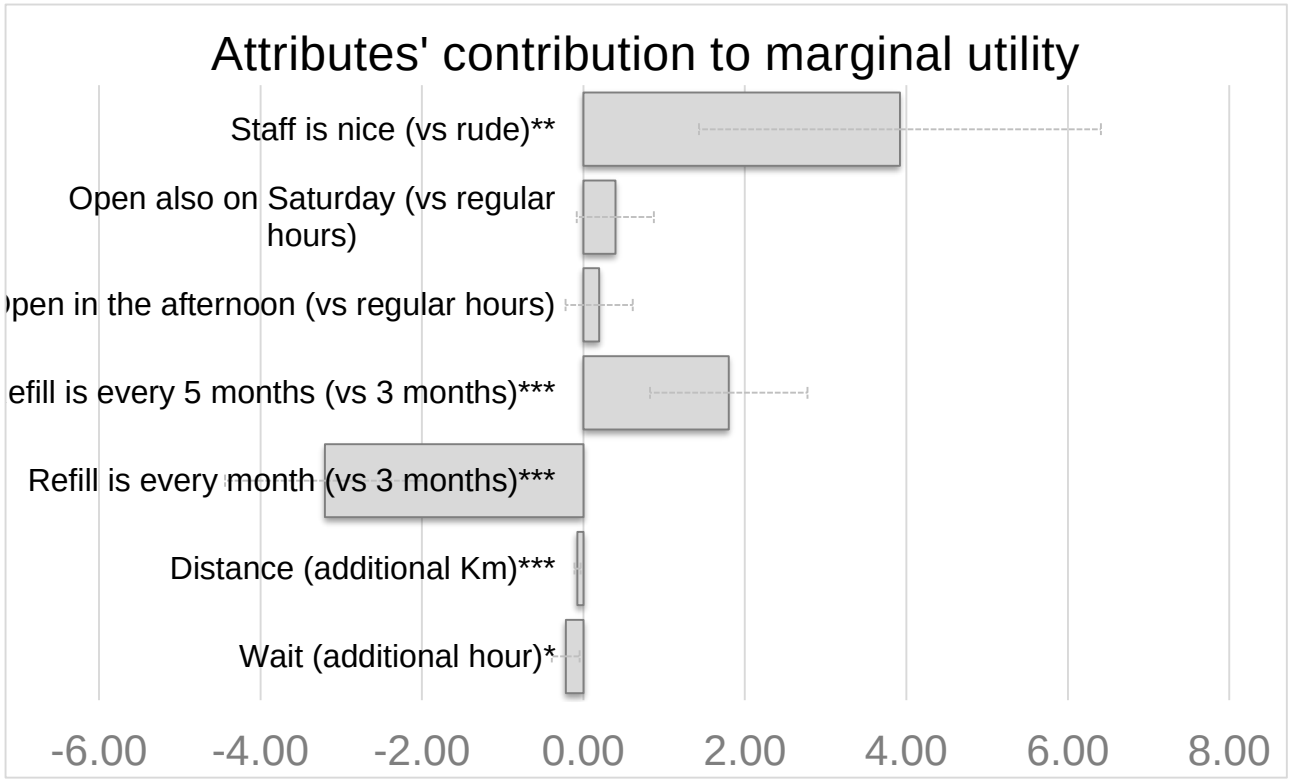
Bisnauth et al, 2021, PLoS One, Beres et al, 2020, AIDS

Recent systematic review of interventions to facilitate re-engagement

- Largely limited to tracing interventions
  - Did not assess interventions to support retention once re-engaged
- Contacting those interrupted resulted in 58% return among those found to be alive and out of care
- Interventions resulted in 20% increase from SOC, only 7% increase in lower and middle- income countries

Mirzazadeh et al, 2022, PLoS Medicine

Client service delivery preferences on re-engagement



Zanolini, Sikombe, Sikazwe et al, 2018, PLoS Medicine

"A recurring theme in respondents' descriptions of barriers to care was the **inflexibility of HIV visit schedules and associated medication refills**. Nearly half the patients mentioned these schedules, with experiences ranging from inconvenience to fundamental clashes with family or work commitments"

69 in-depth interviews, 8/31 randomly selected facilities including engaged, disengaged and family of deceased patients

Topp, Mwamba, Sharma et al, 2018, PLoS One

What does this all tell us about service delivery needs after re-engagement?

- More welcoming, non-judgmental providers
  - Need to understand people's preferences, barriers
  - Accepting of transfers
  - Continue tracing
- Quality HIV initiation/re-initiation experience

- Tailor resources to heterogenous disengaged
- Increase visit schedule flexibility to support rather than punish high mobility
  - Home delivery, Community dispensation, Multi-month dispensing
  - Fast-tracking those who are busy
  - Weekend pick ups, after hours
  - Better visit alignment
- Increase social support opportunities
  - Link to someone living with HIV
- Men's clinic

Eshun-Wilson et al, 2019 PLoS One, Mody et al, 2019, PLoS Medicine, Grimsrud et al, 2020, Current HIV/AIDS Reports, Sikombe et al, 2020, PLoS One

Addressing challenges ahead

1. Train and mentor providers

2. Systematic measurement of patient experience (SMS, Exit) and clinical outcomes

3. Monitor change with ongoing data review and gentle incentive

CQI

Acknowledgements

Recipients of Care

Ministry of Health

Bill & Melinda Gates foundation

CDC Centers for Disease Control and Prevention

Washington University in St. Louis School of Medicine

London School of Hygiene & Tropical Medicine

CIDRZ for a healthy Zambia 20 years

Georgetown University

Johns Hopkins University

Helen Bygrave, IAS, UK

DSD for HIV treatment in 2022

It's time for differentiation at re-engagement

AIDS 2022

AIDS 2022

I have no relevant financial relationships with ineligible companies to disclose

Where does WHO 2021 guidance mention re-engagement?

5.7.1 People re-engaging with care after treatment interruption or treatment failure

People re-engaging with care after treatment interruption with advanced HIV disease should be offered comprehensive clinical assessment. The package should be given to people who are re-engaging with care after a period of ART interruption or when ART fails and they have developed advanced HIV disease, since such people are likely to benefit from the same set of interventions as ART-naive people with advanced HIV disease.

People interrupting treatment on a NNRTI– containing regimen are at risk of drug resistance and may require more intensive virological monitoring, and consideration should be given to restarting ART using a different regimen – whenever possible a DTG-containing regimen – with a goal of re-establishing viral suppression *(79)*.

For people presenting with diagnoses consistent with treatment failure (defined as a new or recurrent clinical event indicating severe immunodeficiency), WHO recommends viral load testing; CD4 cell count testing is no longer recommended for ART monitoring for people receiving ART who are clinically stable where viral load monitoring is available *(77)*; however, CD4 cell count testing should be specifically prompted for people with a viral load exceeding 1000 copies/mL and for everyone whose clinical presentation suggests advanced HIV disease regardless of ART exposure. For people with suspected treatment failure and advanced HIV disease, CD4 cell count and viral load should be carried out in parallel.

People presenting with advanced HIV disease as a result of treatment failure should also benefit from the advanced HIV disease package, and if they are severely ill, an expedited switch to a new regimen should be considered by reducing the time between the first and second viral load tests (1–3 months) and by paying increased attention to ensuring rapid turnaround and action on the results. Where rapid viral load testing is not available, the decision to switch should be assessed according to the individual clinical presentation. Further research is required to demonstrate the impact of providing such a package of interventions to people presenting with treatment failure: for example, before switching to second-line ART.

Clients re-engaging in care should be assessed for AHD and offered the advanced HIV disease package

Where does WHO 2021 guidance mention re-engagement?

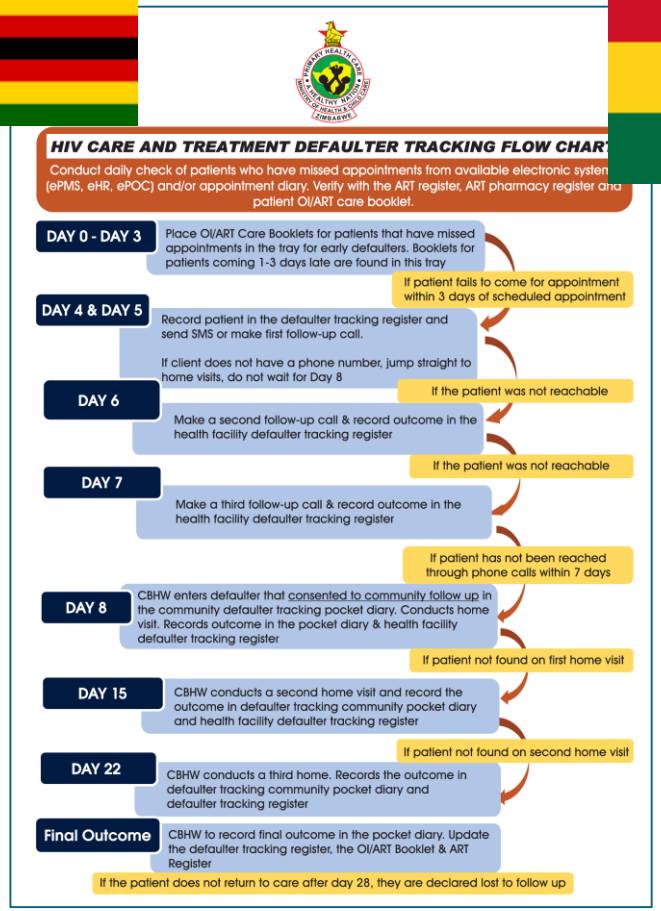
Recommendation	Update or new
ART initiation may be offered outside the health facility *(Conditional recommendation; low- to moderate-certainty evidence)*	New
People established on ART should be offered clinical visits every 3–6 months, preferably every six months if feasible *(Strong recommendation; moderate-certainty evidence)*	Update[a]
People established on ART should be offered refills of ART lasting 3–6 months, preferably six months if feasible *(Strong recommendation; moderate- to low-certainty evidence)*	Update[b]
HIV programmes should implement interventions to trace people who have disengaged from care and provide support for re-engagement *(Strong recommendation; low-certainty evidence)*	New
Sexual and reproductive health services, including contraception, may be integrated within HIV services *(Conditional recommendation; very-low-certainty evidence)*	Update[c]
Diabetes and hypertension care may be integrated with HIV services *(Conditional recommendation; very-low-certainty evidence)*	New
Psychosocial interventions should be provided to all adolescents and young adults living with HIV *(Strong recommendation; moderate-certainty evidence)*	New
Task sharing of specimen collection and point-of-care testing with non-laboratory personnel should be implemented when professional staffing capacity is limited *(Strong recommendation; moderate-certainty evidence)*	Update[d]

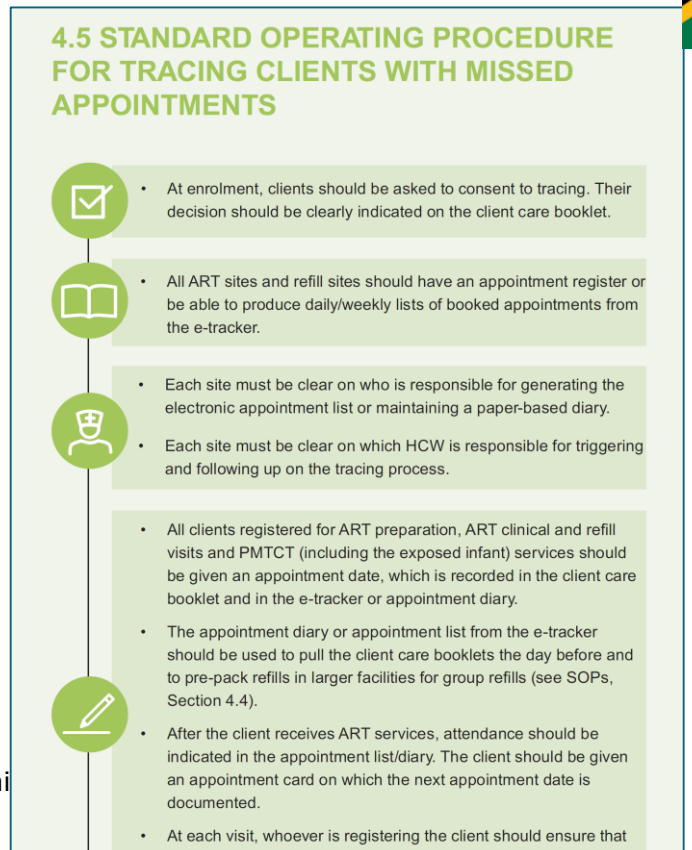
HIV programmes should implement interventions to trace people who have disengaged from care and provide support for re-engagement

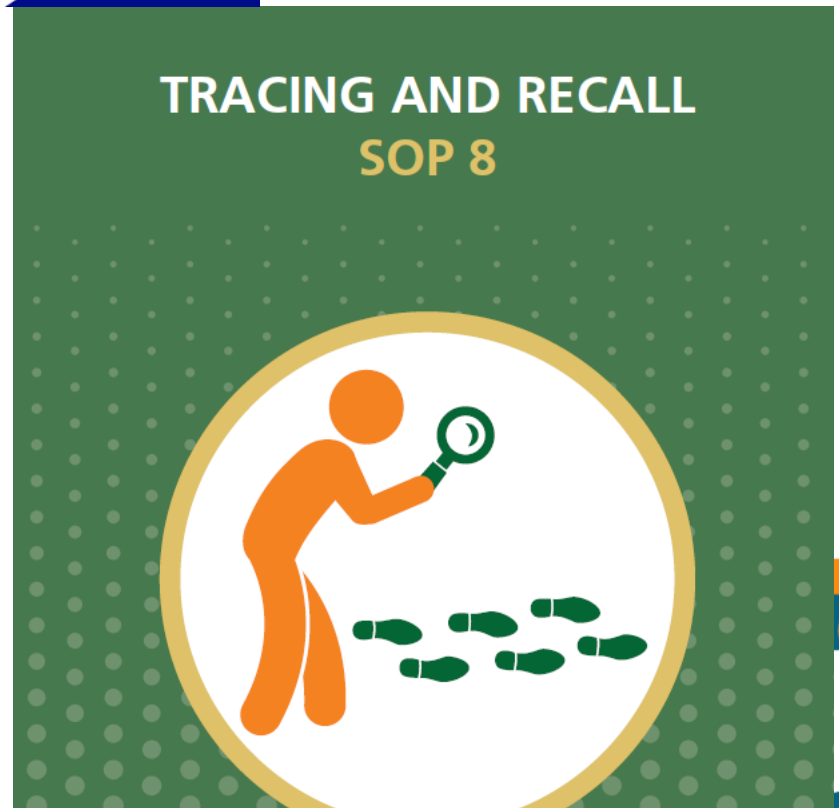
New recommendation

Strong recommendation, low certainty evidence

National guidelines already including SOPs for tracing







AIDS 2022

But what do we do once the client does return to clinic?

- Do we treat all re-engagers the same or is “differentiation” needed ?
- Currently no WHO specific guidance on this
- A few countries (South Africa, Zimbabwe) have developed algorithms to try and address this differentiation

AIDS 2022

How could we adapt our services for clients who have previously been on ART ?

What if health systems barriers contributed to disengagement?

How can we support retention for these clients?

Key considerations at re-engagement for differentiation

Duration not on ART

+

Clinical Factors

The duration not on ART determines:

Who to return immediately to DSD model

Who to return to facility based follow up and appropriate refill length (1-3 months) after re- initiation

Clinical considerations

1. Clinical assessment

-Clinically assessed as unwell or stage 3 or 4
- Psychosocial challenge
- Uncontrolled mental health condition

2. When to perform a CD4

-If clinically unwell

-Previous documented VL not suppressed

-If not on ART for 3 months or more

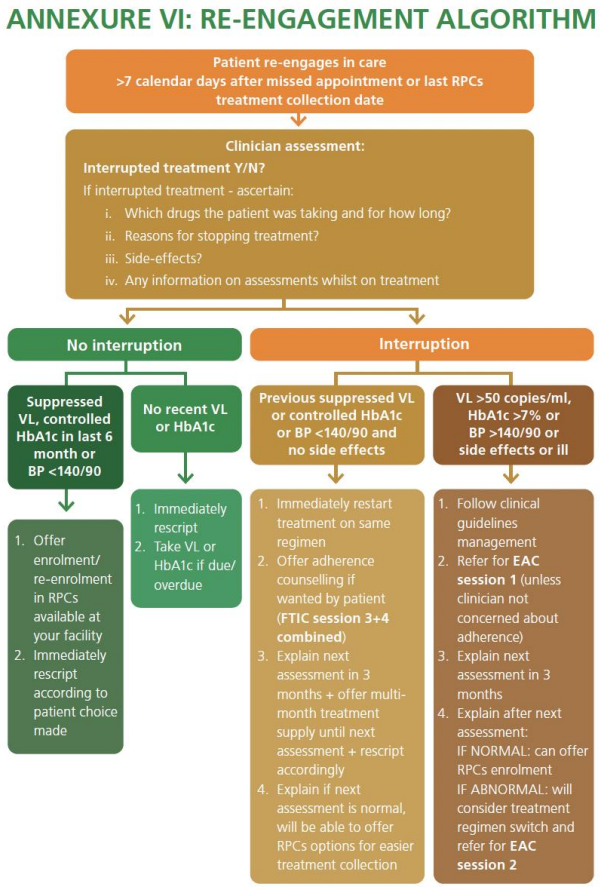
3. Viral load

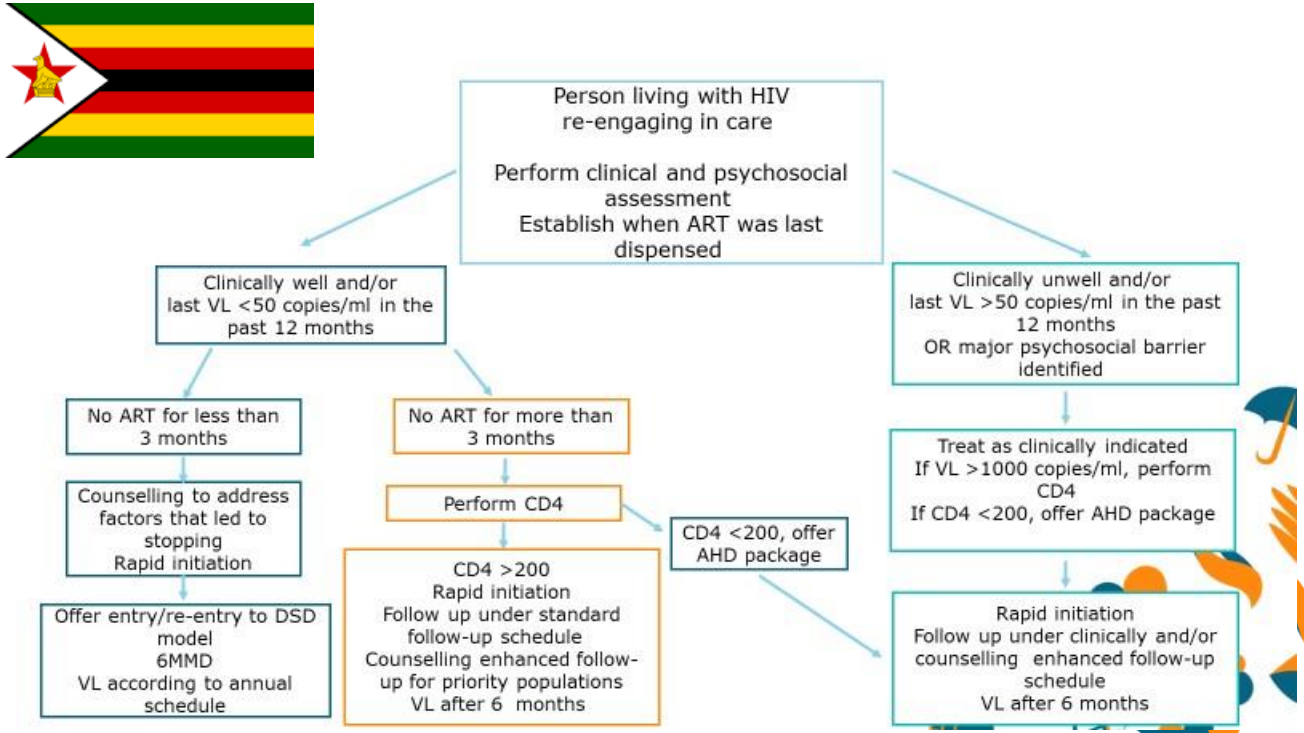
- Is there a VL documented within the last 6-12 months
- Was the last VL suppressed
- When to perform the first VL after re-initiation

4. Regimen

Is client eligible to transition to WHO preferred DTG based regimen

Two countries have used these considerations to develop an algorithm





Example: Use of the considerations in Zimbabwe algorithm

1. Clinical Assessment

Person living with HIV re-engaging in care

Perform clinical and psychosocial assessment
Establish when ART was last dispensed

Clinically well and/or last VL <50 copies/ml in the past 12 months

Clinically unwell and/or last VL >50 copies/ml in the past 12 months
OR major psychosocial barrier identified

No ART for less than 3 months

Counselling to address factors that led to stopping
Rapid initiation

Offer entry/re-entry to DSD model
6MMD
VL according to annual schedule

No ART for more than 3 months

Perform CD4

CD4 >200
Rapid initiation
Follow up under standard follow-up schedule
Counselling enhanced follow-up for priority populations
VL after 6 months

CD4 <200, offer AHD package

Treat as clinically indicated
If VL >1000 copies/ml, perform CD4
If CD4 <200, offer AHD package

Rapid initiation
Follow up under clinically and/or counselling enhanced follow-up schedule
VL after 6 months

AIDS 2022

2. When to perform a CD4

Person living with HIV re-engaging in care

Perform clinical and psychosocial assessment
Establish when ART was last dispensed

Clinically well and/or last VL <50 copies/ml in the past 12 months

No ART for less than 3 months

Counselling to address factors that led to stopping
Rapid initiation

Offer entry/re-entry to DSD model
6MMD
VL according to annual schedule

No ART for more than 3 months

Perform CD4

CD4 >200
Rapid initiation
Follow up under standard follow-up schedule
Counselling enhanced follow-up for priority populations
VL after 6 months

CD4 <200, offer AHD package

Clinically unwell and/or last VL >50 copies/ml in the past 12 months
OR major psychosocial barrier identified

Treat as clinically indicated
If VL >1000 copies/ml, perform CD4
If CD4 <200, offer AHD package

Rapid initiation
Follow up under clinically and/or counselling enhanced follow-up schedule
VL after 6 months

AIDS 2022

3. VL

Person living with HIV re-engaging in care

Perform clinical and psychosocial assessment
Establish when ART was last dispensed

Clinically well and/or last VL <50 copies/ml in the past 12 months

Clinically unwell and/or last VL >50 copies/ml in the past 12 months
OR major psychosocial barrier identified

No ART for less than 3 months

Counselling to address factors that led to stopping
Rapid initiation

Offer entry/re-entry to DSD model
6MMD

VL according to annual schedule

No ART for more than 3 months

Perform CD4

CD4 >200
Rapid initiation
Follow up under standard follow-up schedule
Counselling enhanced follow-up for priority populations
VL after 6 months

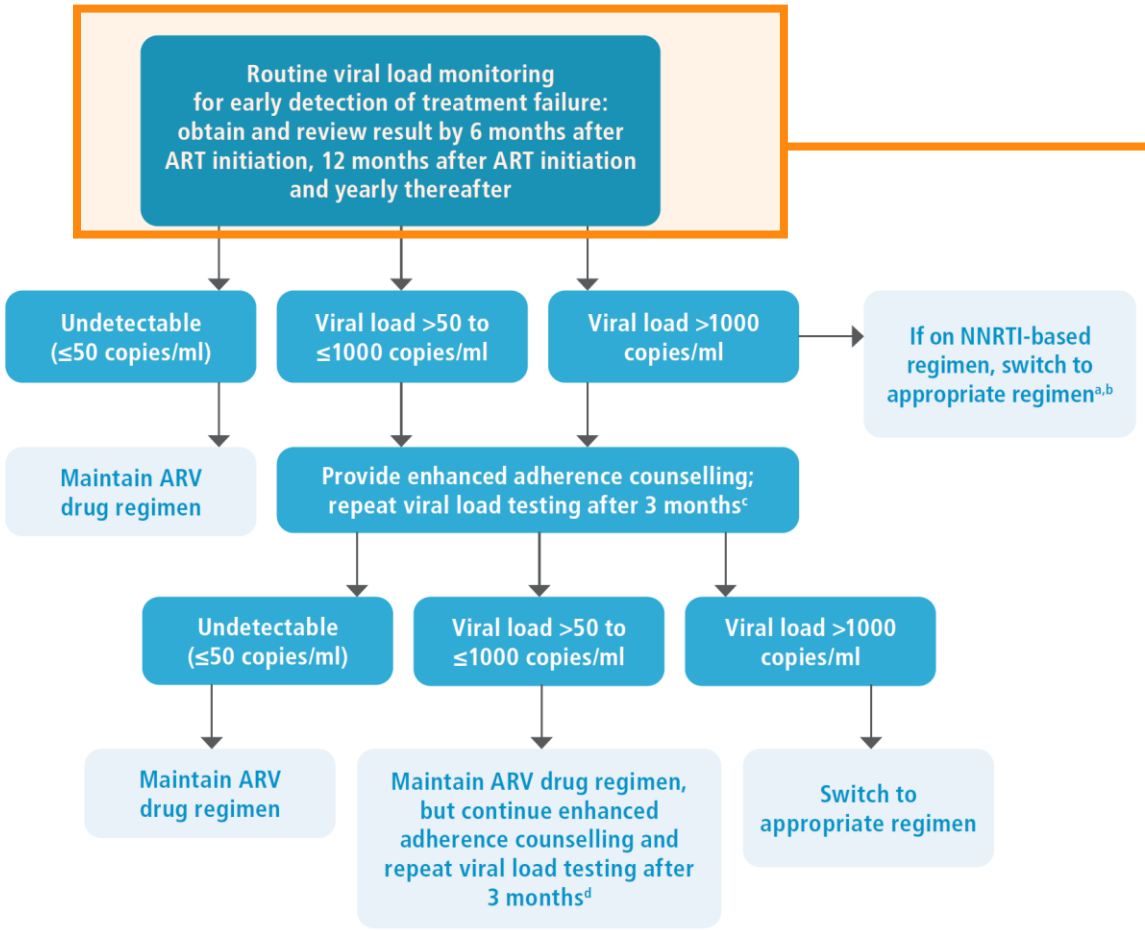
CD4 <200, offer AHD package

Treat as clinically indicated
If VL >1000 copies/ml, perform CD4
If CD4 <200, offer AHD package

Rapid initiation
Follow up under clinically and/or counselling enhanced follow-up schedule
VL after 6 months

WHO VL algorithm

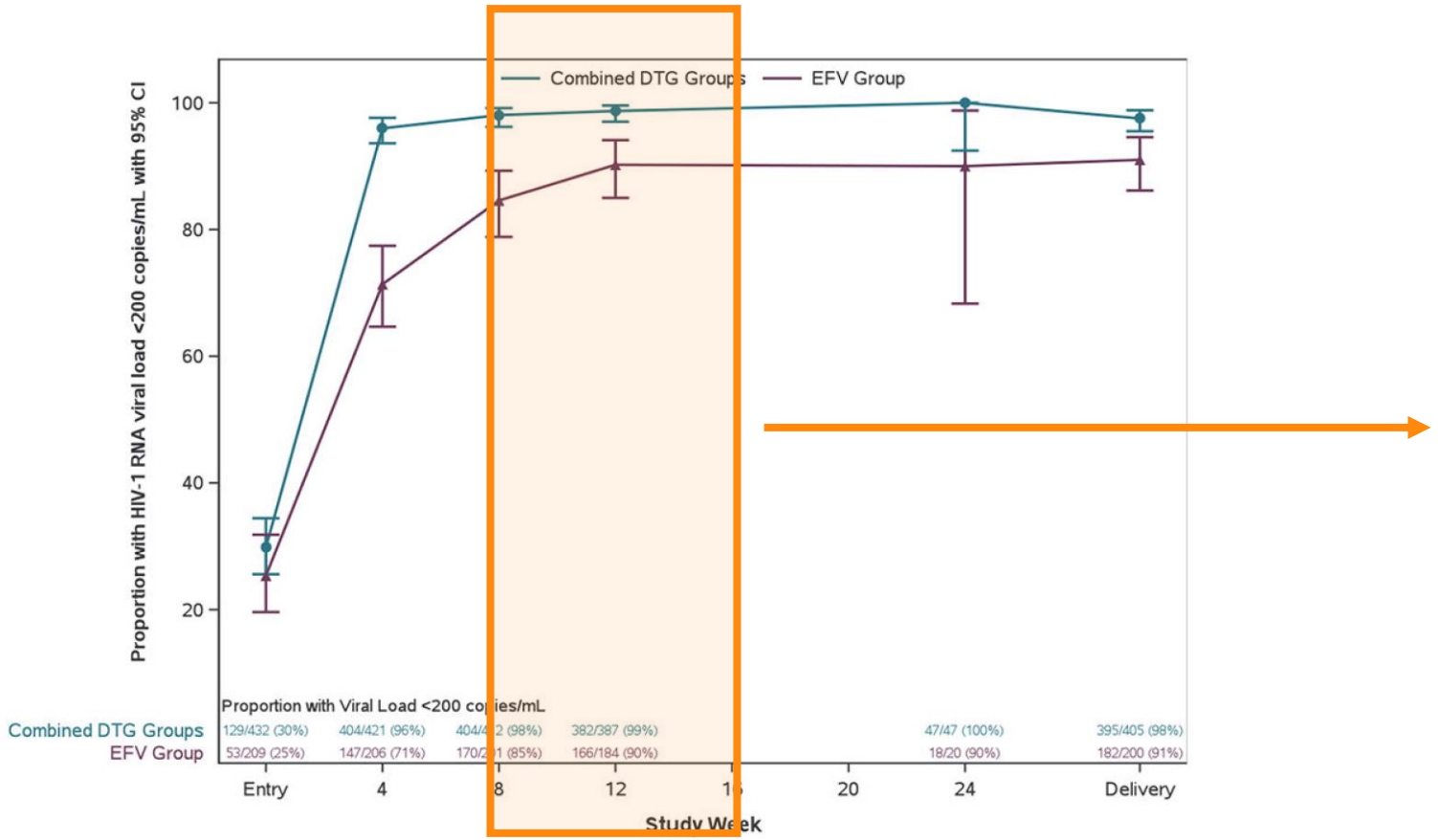
Fig. 4.2 Treatment monitoring algorithm updated in 2021



Obtain and review result by 6 months

Often VL taken at 6 months

Rates of suppression with DTG



High suppression rates with DTG at 12 weeks

Can VL be take earlier e.g 3 months especially in context of re-initiation

If suppressed enabling earlier entry / re-entry to DSD for clients established on ART

Lockman S et al ;Lancet. 2021 Apr 3;397

AIDS 2022

Who eligible for immediate return to DSD

Person living with HIV re-engaging in care

Perform clinical and psychosocial assessment
Establish when ART was last dispensed

Clinically well and/or last VL <50 copies/ml in the past 12 months

No ART for less than 3 months

Counselling to address factors that led to stopping
Rapid initiation

Offer entry/re-entry to DSD model
6MMD
VL according to annual schedule

No ART for more than 3 months

Perform CD4

CD4 >200
Rapid initiation
Follow up under standard follow-up schedule
Counselling enhanced follow-up for priority populations
VL after 6 months

CD4 <200, offer AHD package

Clinically unwell and/or last VL >50 copies/ml in the past 12 months
OR major psychosocial barrier identified

Treat as clinically indicated
If VL >1000 copies/ml, perform CD4
If CD4 <200, offer AHD package

Rapid initiation
Follow up under clinically and/or counselling enhanced follow-up schedule
VL after 6 months

AIDS 2022

Who to return to facility based follow up and appropriate refill length (1-3 months) after re- initiation

Person living with HIV re-engaging in care

Perform clinical and psychosocial assessment
Establish when ART was last dispensed

Clinically well and/or last VL <50 copies/ml in the past 12 months

No ART for less than 3 months

Counselling to address factors that led to stopping
Rapid initiation

Offer entry/re-entry to DSD model
6MMD
VL according to annual schedule

No ART for more than 3 months

Perform CD4

CD4 >200
Rapid initiation
Follow up under standard follow-up schedule
Counselling enhanced follow-up for priority populations
VL after 6 months

CD4 <200, offer AHD package

Clinically unwell and/or last VL >50 copies/ml in the past 12 months
OR major psychosocial barrier identified

Treat as clinically indicated
If VL >1000 copies/ml, perform CD4
If CD4 <200, offer AHD package

Rapid initiation
Follow up under clinically and/or counselling enhanced follow-up schedule
VL after 6 months

Key messages

- More of the people we are initiating on ART have been on ART before
- No current WHO guidance on the " how to" sustain re-engagement including timing of VL
- Re-engagement pathways should not be a one size fits all
- Re-engagement pathways should not become a barrier to retention and should adapt to address client access challenges
- When designing a re-engagement pathway
  - Consider the duration the client has been off ART
  - Consider the clinical considerations

Diana Mokoena, Anova Health Institute, South Africa

DSD for HIV treatment in 2022

The South Africa case for DSD at re-engagement: Policy and implementation

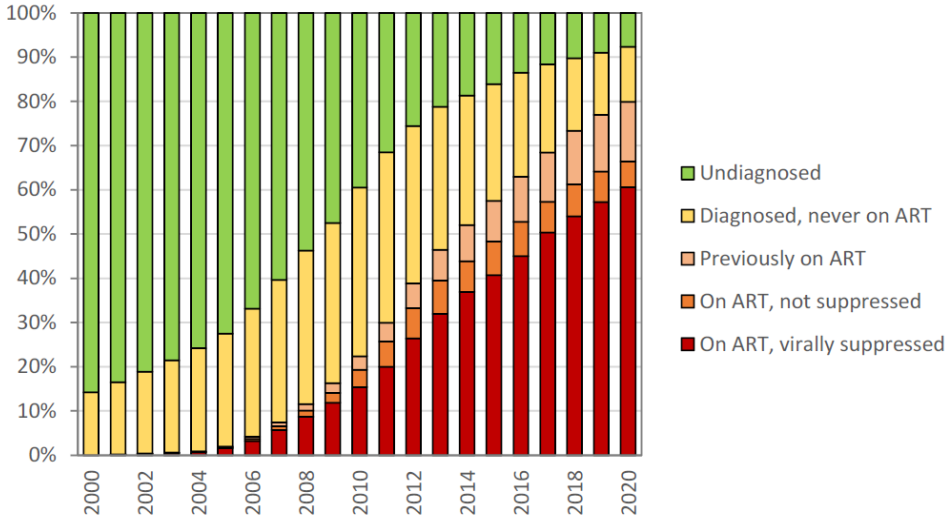
AIDS 2022

Conflict of interest disclosure

I have no relevant financial relationships with ineligible companies to disclose

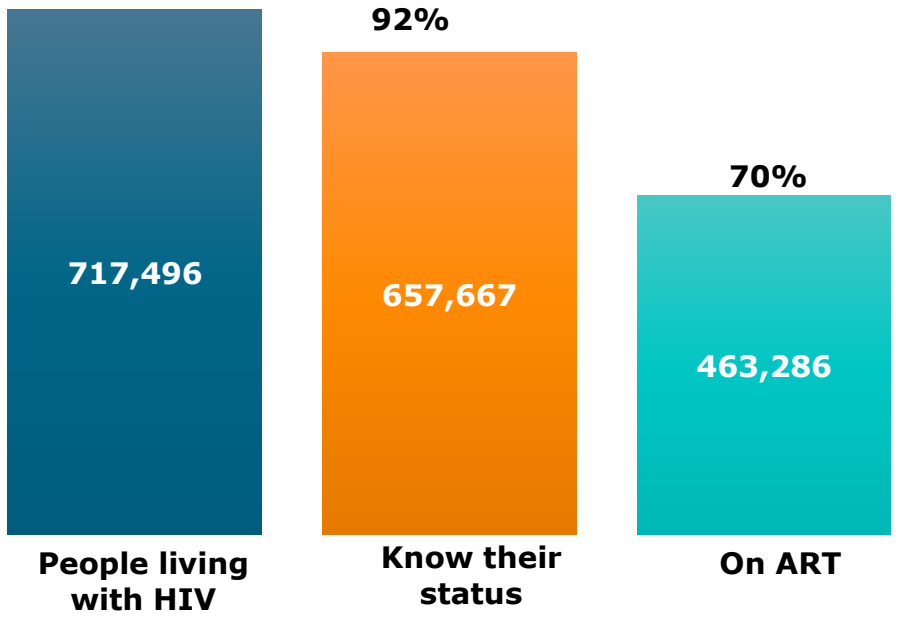
Is disengagement from HIV care a big problem in South Africa?

Changing engagement in HIV care[1]



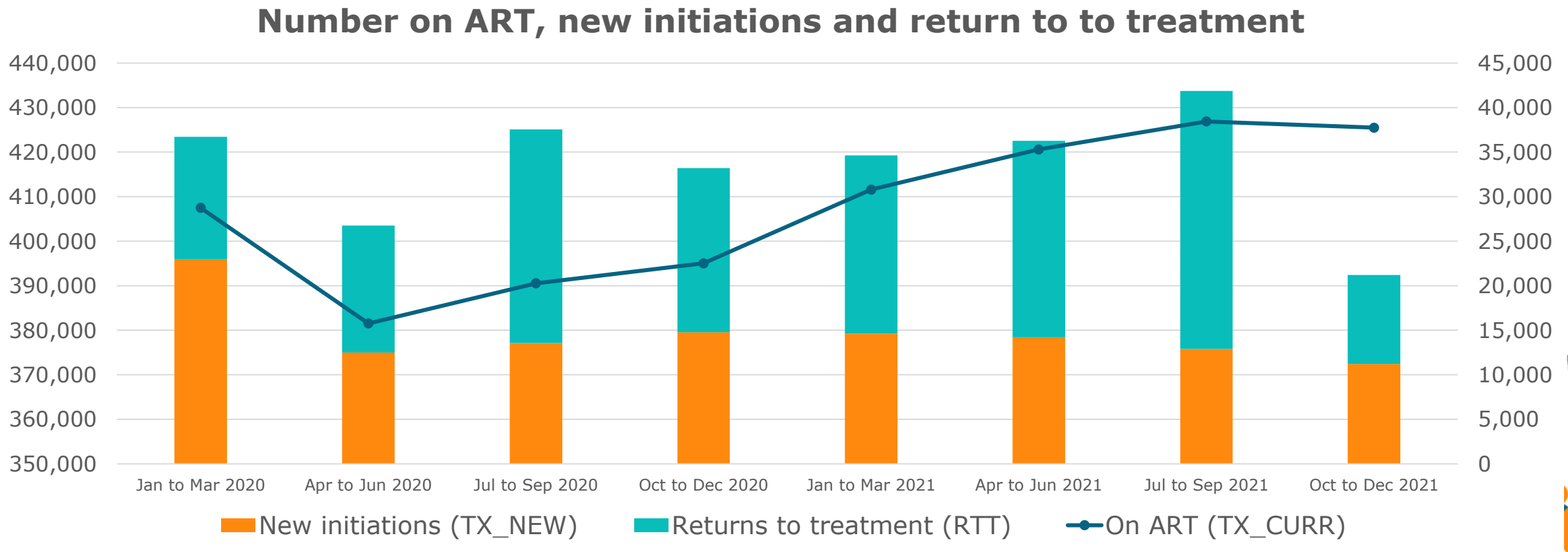
Increasing proportion of people know their status – but not all are on ART

NAOMI model estimates 2021 – City of Johannesburg



Of those not on ART, 76% are aware of their status

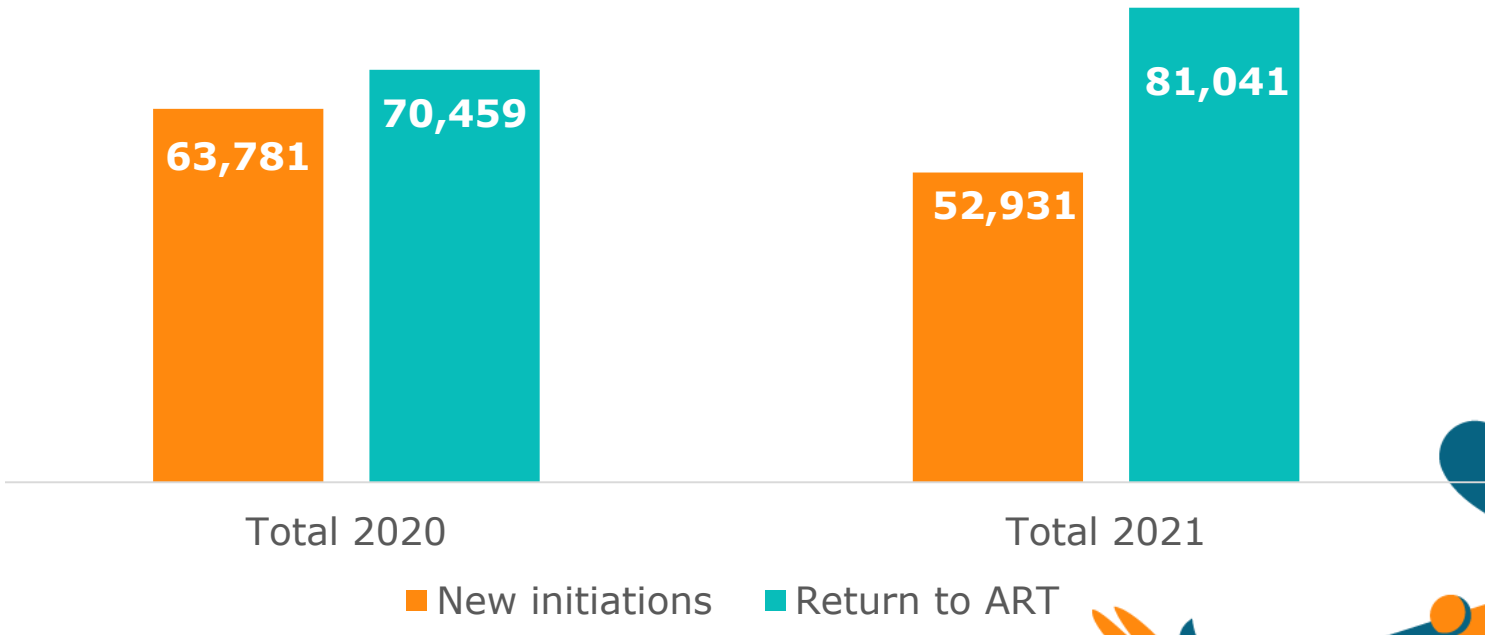
Re-engagement in Johannesburg (1)



Re-engagement in Johannesburg (2)

- There are more clients returning to treatment (including restarts) than initiating treatment for the first time
- RTT from 110% (2020) to 153% (2021) of new initiations
- More than 80,000 people RTT in 2021 *just* in City of Johannesburg

New initiations compared to return to treatment*

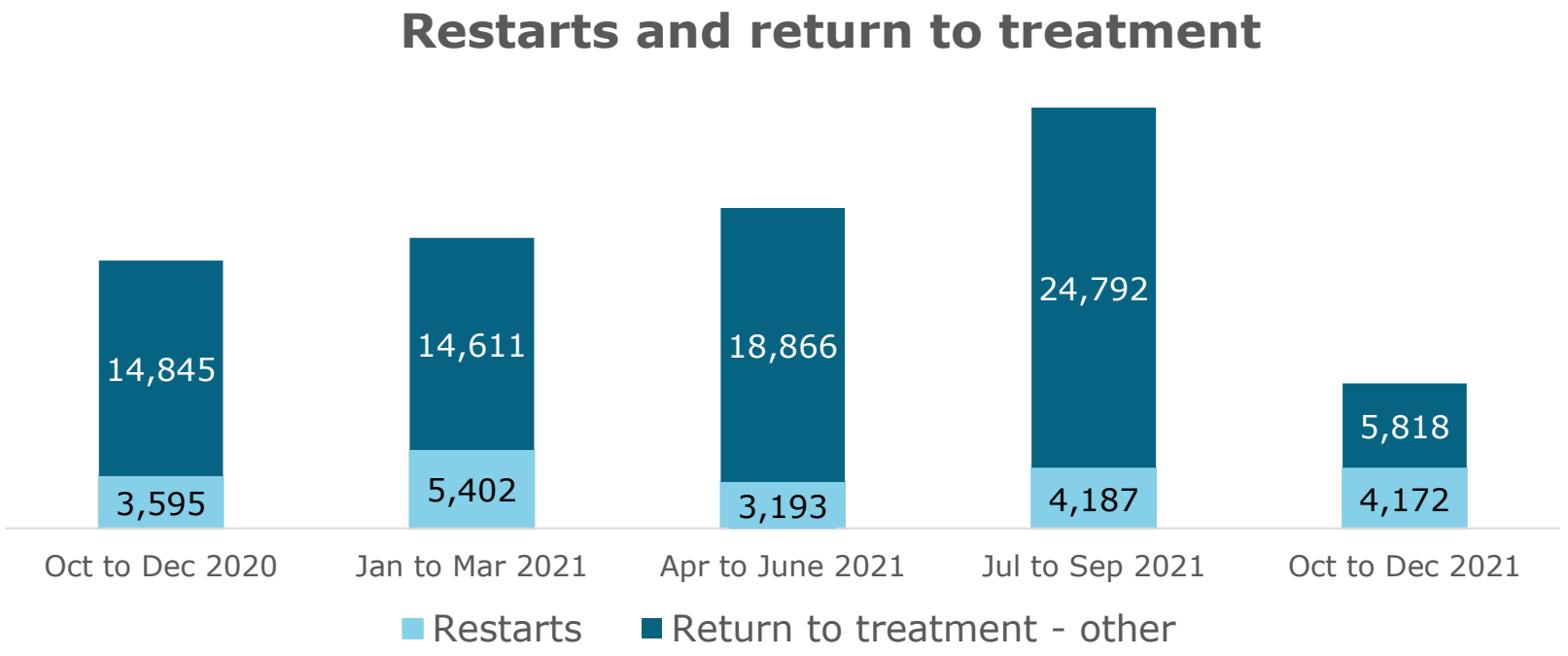


*Data source: NDOH report for the City of Johannesburg

Re-engagement in Johannesburg (3)

- Restarts are people who are more than 90 days late for their missed appointment while returns less than 90 days
- Many more people less than 3 months late with short or no interruption (sourcing ART elsewhere)

**Restarts may be underestimated as requires assignment by data capturer rather than system automated*



*Data source: NDOH report for the City of Johannesburg

Multiple reasons why people interrupt and return to ART

Among 562 people reinitiating in Joburg

- Top reasons for interruption: Mobility/relocation (30%); distance from clinic (15%) & inability to get time off work (10%)
- Reasons for returning: it becoming easier to attend the clinic (34%), worrying about not being on ART (19%)

"[…]with the kind of work that I do I travel a lot, I am a truck driver…I went to the nearest clinic to look for the treatment, but they refused to give me because they said that I did not have a transfer letter "

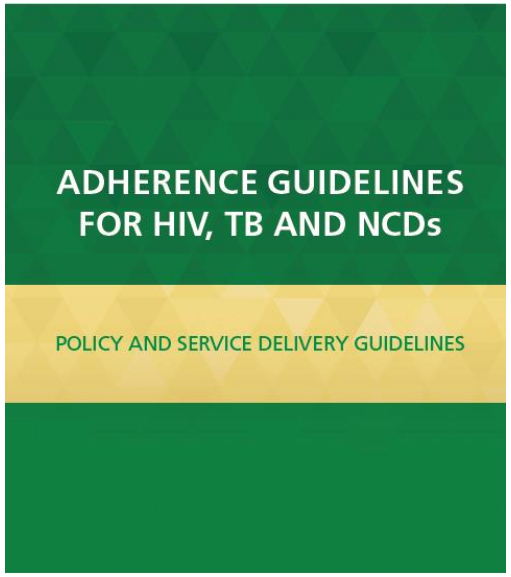
"I did not stop taking the treatment .. I was home and it was during COVID-19 and there was no transport coming to South …they were able to do the refill for me, I went back again for the second time until I was able to come to South Africa"

Bisnauth, PLoS One. 2021.

What can health services do? How can they respond to these needs?

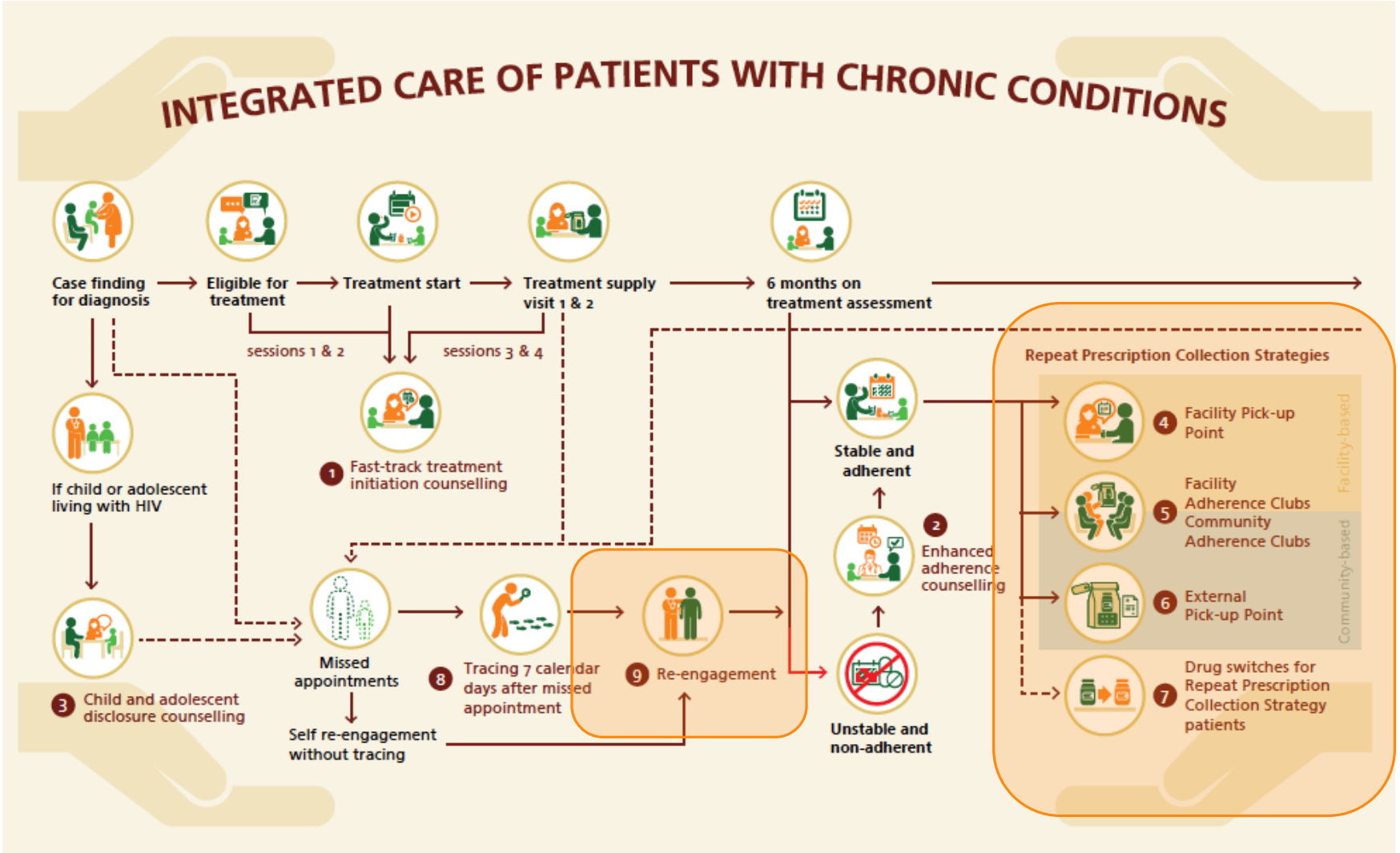
South Africa’s response

South Africa: Creating an enabling environment for re-engagement



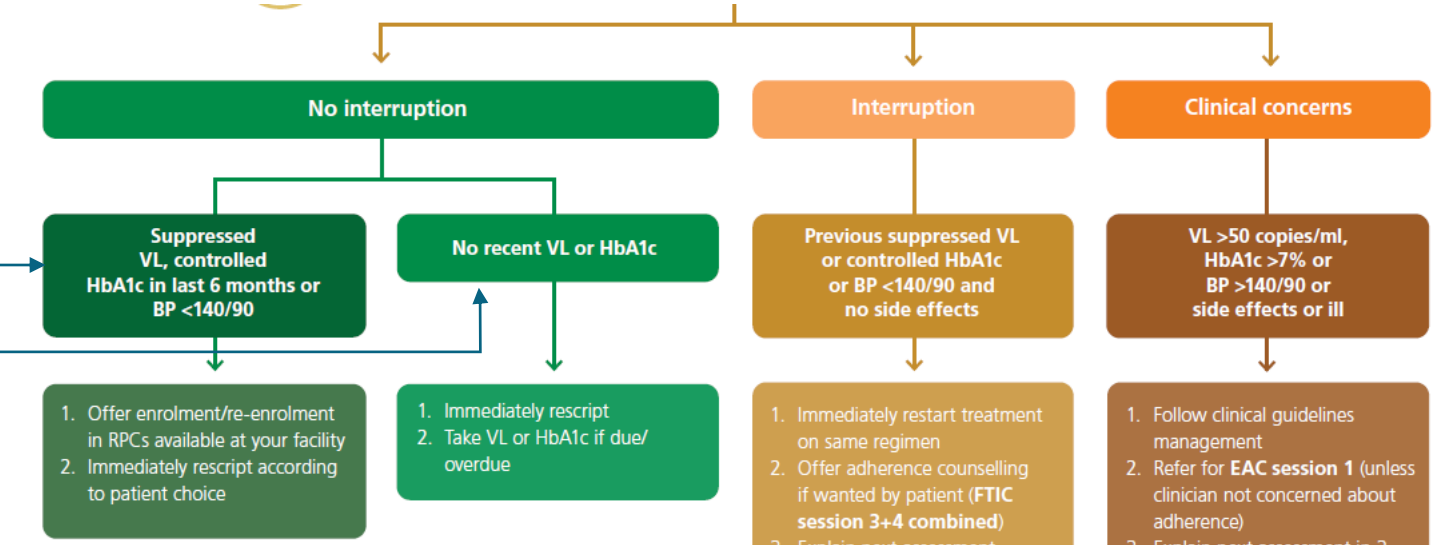
health
Department:
Health
REPUBLIC OF SOUTH AFRICA

A long and healthy life for all South Africans



SOP 9 – Differentiate between those unwell and who DID and DID NOT interrupt treatment

Accelerated access to RPCs (DSD) if no interruption



Accelerated access to 3MMD until VL assessment

7

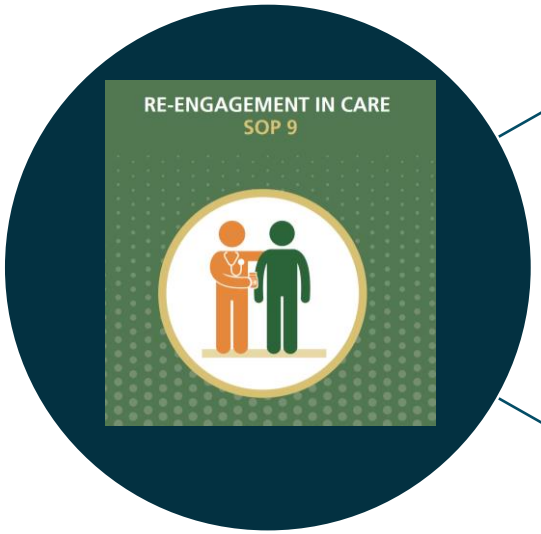
Updated in 2020

Limited uptake and implementation of this new SOP

Early VL assessment (following WHO elevated VL algorithm)

- If no interruption and overdue for VL same day as re-engagement
- If interrupted ART – 3 months after re-engagement

From policy to implementation – City of Johannesburg SOP 9 Project



1st objective

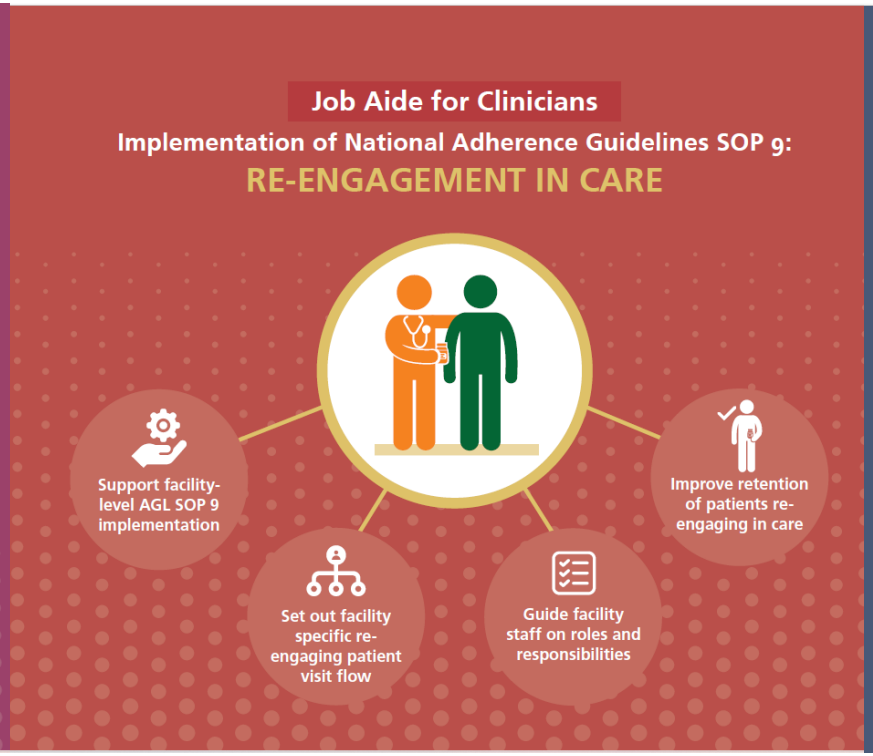
- Feasibility & acceptability of SOP in Johannesburg/ similar setting

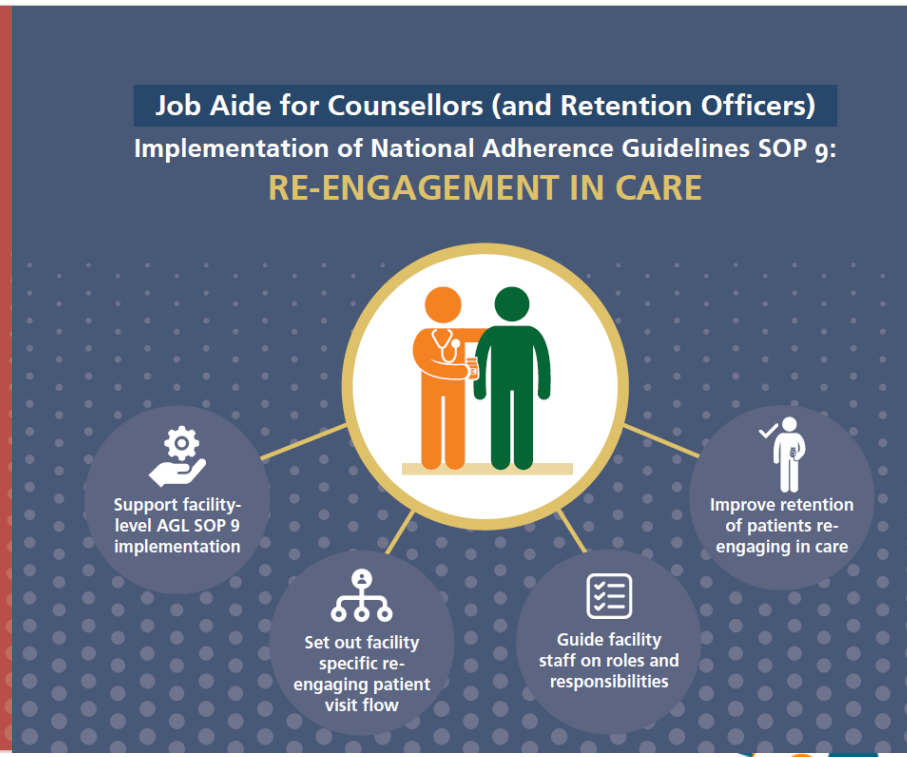
2nd objectives

- Fidelity of SOP implementation
- Quantify re-engaging clients
- Describe clinical picture of re-engaging clients
- Measure retention & viral suppression in re-engaging clients

AIDS 2022

Job aides by facility re-engagement role players





SOP 9 RE-ENGAGEMENT THREE KEY PRINCIPLES

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**

Only if they are **>14 days** after scheduled appointment
OR
silent transfer from another facility

3

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

Easier access to treatment

Psychosocial support

Clinical management

Who is a re-engaging patient?

Assess all patients returning after scheduled appointment date

≤14 days

14 days or less after scheduled appointment

Routine care patient

Patient receives care according to scheduled appointment plan

>14 days

More than 14 days after scheduled appointment or silent transfer

RE-ENGAGING (RE) patient

AGL SOP 9: Re-engagement

Clinical assessment + differentiated follow-up plan

Details clinical assessment approach for a re-engaging patient

STEP 1: Conduct clinical assessment

Step 1: Create safe supportive space for positive patient interaction

"Good to see you today" *"I hope you didn't have to wait long. This is a supportive space for your return to care"*

Step 2: Check for any clinical concerns

"How are you feeling today?" *"Any worrying illness or symptoms recently?"*

Identify patient clinically unwell or with any red flag symptoms requiring clinical action

Step 3: Check last scheduled visit and discuss reasons for missing visit

"When was your last scheduled visit?"

"Can you tell me what made it difficult for you to attend?"

Document last visit date on SOP RE-ENGAGE form

Document any **critical** reasons for missing scheduled visit relevant to assessment

Step 4: Discuss any concerns about returning to care

"Did you have any worries about coming back to us?"

"Do you have any concerns about being able to continue your care and treatment at this facility"

"Anything else you are worried about"

Step 5: Check previous history of disengagements using an open, non-judgemental approach

"Have you been off treatment before?"

"Tell me about these times and any worries you had at the time"

Check file for previous history of disengagement

Step 6: Check VL history

Review most recent VL result

Review previous VL result history

Review NCD lab history (if applicable)

Document on SOP RE-ENGAGE form

Step 7: Ask patient self-report on treatment interruption

"Did you have enough treatment" If no - *"When did you run out"*

Document on SOP 9 RE-ENGAGE form

Step 8: Decide re-engagement clinical assessment outcome

Make your assessment

1. Clinically unwell:
☐ YES or ☐ NO

2. Likely interruption took place:
☐ YES or ☐ NO

Determine SOP 9 follow-up plan

☐ interruption unlikely + VLS<6m

☐ interruption unlikely + no VL<6m

☐ interruption + well (no clinical concerns) with VLS/no VL

☐ clinical concerns/uncontrolled NCD/VL>50

Document on SOP 9 ENGAGE form

Follow SOP 9 colour coded follow-up plan

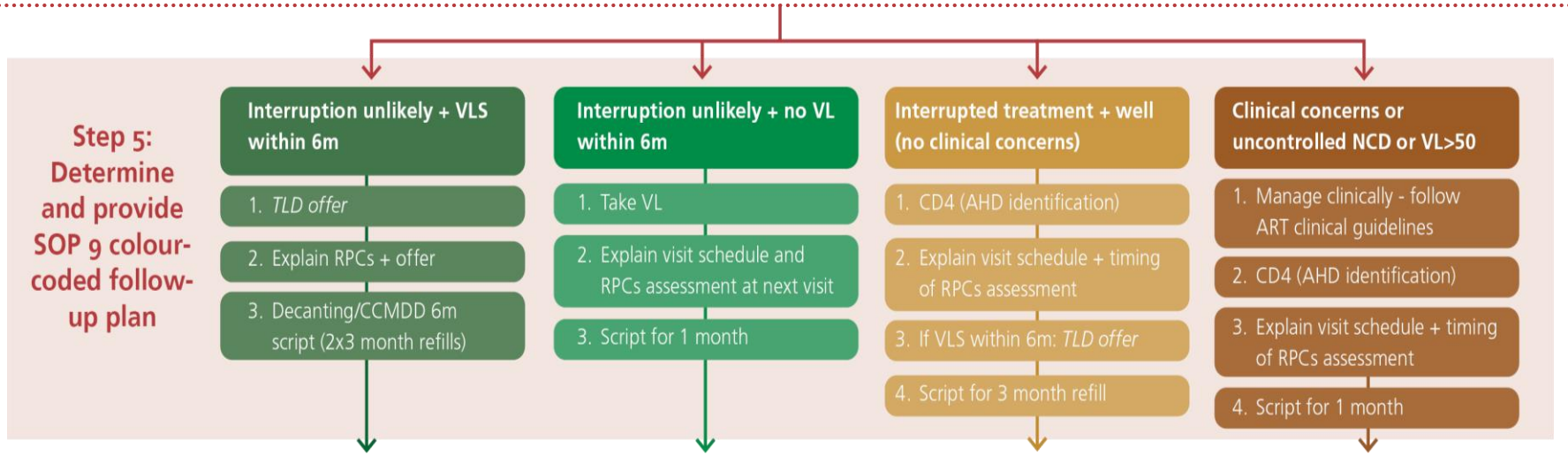
AIDS 2022

Differentiates follow-up based on each patient's needs and preferences

3

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

- Easier access to treatment
- Psychosocial support
- Clinical management



SOP 9 follow-up plans

Sets out procedural steps at re-engagement visit for each of the 4 groups

GOLD: Interrupted treatment + well (no clinical concerns) with VL suppression result or no VL result within 6 months

AHD = Advanced HIV Disease
VLS = VL suppression

Re-engagement visit procedure

Step 1: Take CD4 count IF interrupted ART>90 days

- Take CD4 count to identify AHD for AHD package provision
- *Unless CD4<200 in last 6 months, then switch to SOP 9 Brown follow-up plan*
- **IF CRAG+ RESULT RECEIVED BY FACILITY URGENTLY RECALL**

↓

Step 2: Assess for TPT

- If person has not completed TPT, assess for and initiate TPT
- **Explain visit schedule** (see below) - return in 3 months, then 1 month later for VL result and if VLS, will offer RPCs options.

↓

Step 3: Restart ART immediately

- **If NO VLS within 6 months:** rescript same ART regimen for **THREE** months ART (and TPT) refill
- **If VLS within 6 months:** offer TLD and script for **THREE** months ART (and TPT) refill
- **Record on SOP 9 form any reason 3-month ART refill could not be scripted**

↓

Step 4: Explain important to see counsellor and what counsellor will provide

- **Where clinician is of the view that patient will benefit from counselling review and VL education:** explain importance of seeing counsellor
- **At facility with case management:** explain counsellor will also offer case management support
- **Refer to counsellor for Fast Track Initiation and Counselling combined session 3 and 4 combined and low risk CM offer**

And the follow-up visit schedule

Visit schedule

Re-engagement visit
See detailed steps above

RE month 3 visit

If CD4<200 and **not already recalled for action** – provide AHD package and switch to SOP 9 Brown follow-up plan including following ART guidelines

Explain VL again and RPCs options

Take VL

1 month script + refill

RE month 4 visit

Check and communicate VL result

If VL>50 copies/ml:
Switch to SOP 9 Brown follow-up plan including following ART guidelines

If VLS AND well:
- TLD and RPCs offer
- If RPCs offer accepted: 6-month script (Decanting/ CCMDD) with **THREE** months ART (and TPT) refills

Stop low risk case management

Facilities with case management (CM) only:
Provide low risk CM support if patient accepted

Implementation plan

Phase 1

- April - May 2022
- Develop facility-based detailed implementation plan
- Develop job aides for all roles in facility

Phase 2

- June - July 2022
- Identify implementing facilities
- Stakeholder engagement
- Initial implementation

Phase 3

- Aug – Oct 2022
- Intensive implementation & monitoring

Phase 4

- Oct – Dec 2022
- Continued implementation & qualitative evaluation

Acknowledgements

We gratefully acknowledge Johannesburg Health District; the clients and Health Care Workers in facilities across the city for their warm support & enthusiastic participation.

The IAS Differentiated Service Delivery team

This presentation is made possible by the generous support of the American people through the United States Agency for International Development (USAID).

The contents are the responsibility of the Anova Health Institute and do not necessarily reflect the views of USAID or the United States Government.

Solange Baptiste, ITPC, South Africa & Geoff Garnett, BMGF, USA

Differentiated service delivery for HIV treatment in 2022

Discussion

Closing remarks

AIDS 2022

AIDS 2022

Scaled DSD = HIV treatment program resilience

Resilience requires DSD model diversity for all people living with HIV

- Only scaling individual facility DSD models puts resilience at risk
- Group models need to be rebuilt after COVID-19
- Out-of-facility models have policy support but require scaled implementation
- Need to build resilience across the needs of people living with HIV – TB preventive therapy, family planning, non-communicable diseases, etc.
- Take care to ensure 6-month ART refills do not derail in DSD model diversity (community-based and group models)

As DSD evolves with the HIV epidemic and response, identification and solutions in key areas is required

- Service delivery transitions
- Re-engagement

- Guidance from WHO on DSD in these areas is needed
- Country policy is needed to support/guide healthcare providers
- Support required for implementation
- Monitoring approaches needed to understand what is happening and what is best practice
- DSD to support sustained retention will be key to reaching global AIDS targets

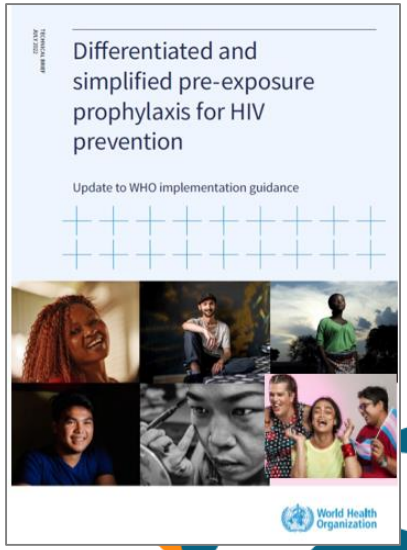
AIDS 2022

JOIN US

Expanding access to PrEP through differentiated service delivery: Lessons from COVID-19 adaptations

Saturday 30 July, 08:00-09:00

Room 517c/Channel 5



https://programme.aids2022.org/Programme/Session/434

AIDS 2022

The science of differentiated service delivery: Where we are and where we are going

Monday 1 August, 08:00-09:00

Room 516/Channel 6

https://programme.aids2022.org/Programme/Session/71

AIDS 2022

Want to learn more? Register for our free course

Differentiated service delivery for HIV treatment

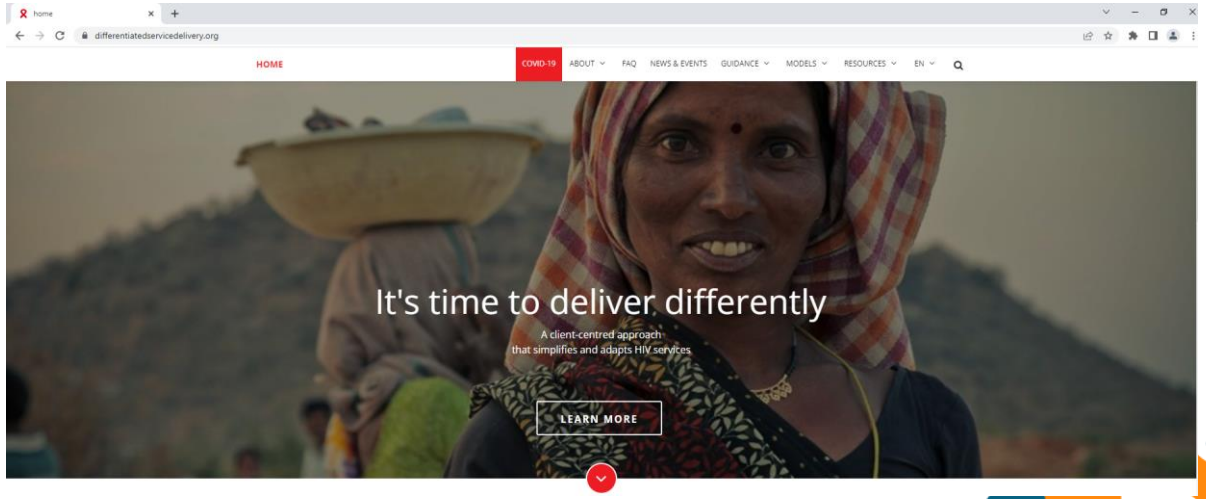
Free online course

https://ias-courses.org/

Want to learn more? Visit our website

Differentiated service delivery website

The compendium website contains tools and evidence endorsed for use by national HIV programmes and country implementing partners supported by the agencies engaged in its development.



https://differentiatedservicedelivery.org/

Download the AIDS 2022 DSD roadmap

DSD Roadmap for AIDS 2022

Check out the AIDS 2022 DSD roadmap and discover the latest DSD science – pre-conferences, satellites, symposia, oral abstract sessions and posters.

https://bit.ly/DSD_AIDS2022

AIDS 2022

DSD roadmap for AIDS 2022

Version 15 July 2022

*All times in EDT – local time Montreal, Canada.

PRE-CONFERENCE

- Differentiated service delivery for HIV treatment in 2022, Thursday, 28 July, 09:00 – 12:30 EDT

LIVE SESSIONS (satellites and symposia)

Friday, 29 July 2022

- Innovative differentiation: How best to deliver HIV testing, treatment and prevention services, Oral abstract session, Room 517b/Channel 4, 10:30 – 11:30 EDT
  - Medical drones to support HIV differentiated service delivery in an island population in Uganda - Rosalind Parkes-Ratanshi (Infectious Diseases Institute, Uganda)
  - How efficient are HIV self-testing models? A comparison of community, facility, one-stop-shop and pharmacy retail distribution models in Nigeria - Victor Abiola Adepoju (Jhpiego Nigeria (an affiliate of John Hopkins University), Nigeria)
  - How soon should patients be eligible for differentiated service delivery models for antiretroviral treatment? - Sydney Rosen (Boston University, United States)
  - The effect of six-month PrEP dispensing supported with interim HIV self-testing on PrEP continuation at 12 months in Kenya: a randomized implementation trial - Katrina Ortblad (University of Washington, United States)
- Differentiated Testing Services: Best practices and lessons learned re: optimizing HIV testing and linkage program design, Satellite, Room 524/Channel 9, ICAP at Columbia University and the Clinton Health Access Initiative (CHAI), 13:00 – 14:30 EDT
- Differentiated service delivery for Advanced HIV Disease: a health systems strengthening approach to improving the coverage and quality of AHD services, Satellite, Room 511/Channel 7, ICAP at Columbia University, 18:15 – 19:45 EDT

Saturday, 30 July 2022

- Expanding access to PrEP through differentiated service delivery: Lessons from COVID-19 adaptations, Satellite, Room 517c/Channel 5, IAS – the International AIDS Society and the World Health Organization, 08:00 – 09:00 EDT
- In it together: How to integrate health services for specific populations, Symposium, Room 517c/Channel 5, 11:45 – 12:45 EDT
  - Improving outcomes through integrated HIV, diabetes and hypertension care in sub-Saharan Africa, Shabbar Jaffar (Liverpool School of Tropical Medicine, United Kingdom)