

Supporting re-engagement in HIV treatment services

Policy brief



Supporting re-engagement in HIV treatment services

Policy brief

Contents

Acknowledgements	iii
Key messages	iv
1. Introduction – what is re-engagement in hiv treatment services and why is it important?	1
What is re-engagement in HIV treatment services?	1
Overview of the disengagement and re-engagement challenge for HIV programmes	2
What are the consequences of disengagement?	2
Purpose of this policy brief	3
Approach to this brief development	3
2. Reasons for disengagement and re-engagement	4
Research findings	4
Health system considerations	5
3. WHO recommendations to support continuous engagement and re-engagement	6
Recommendations to support continuous engagement	6
Recommendations to support re-engagement	7
4. Tracing approaches	8
Considerations for tracing criteria and priorities	8
Operationalizing the tracing process	8
5. Guiding principles for differentiated re-engagement	11
Ensuring a welcoming, non-stigmatizing environment	11
Supporting adherence challenges	12
Providing immediate treatment and care	12
Providing advanced HIV disease identification and rapid screening for opportunistic infections	12
Ensuring equitable access to care	13
Engaging communities	13
6. What to consider when defining differentiated service delivery pathways to support re-engagement in HIV treatment and care	14
Clinical assessment and rapid ART reinitiation	14
Psychosocial assessment and adherence support needs	15
Addressing treatment interruption	15
Considerations for specific populations	17
7. Looking ahead	20
References	21

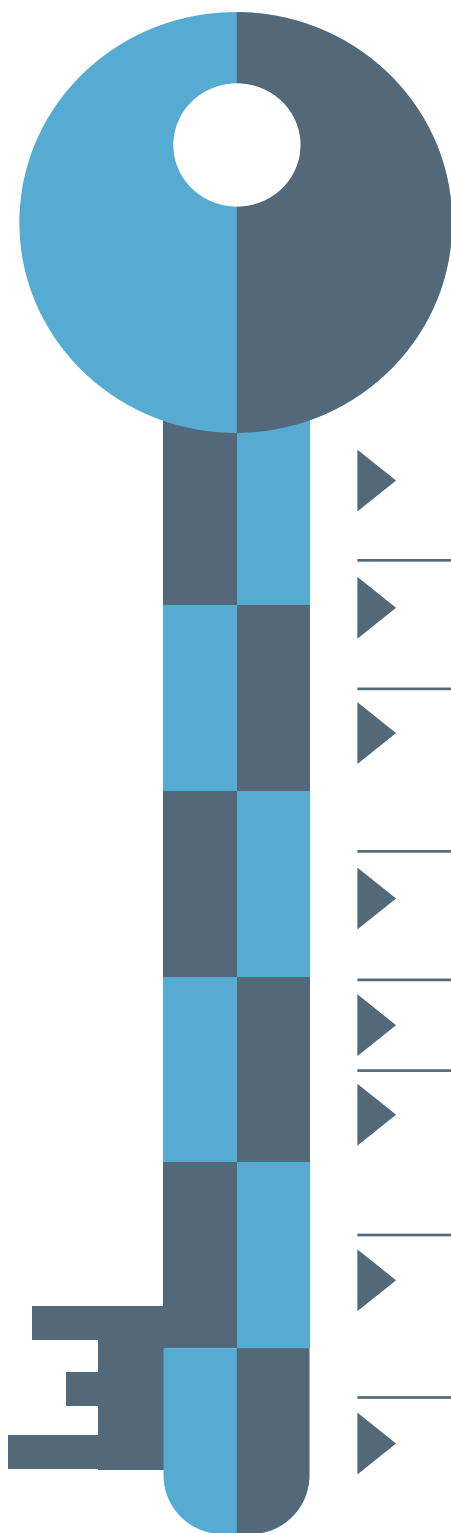
Acknowledgements

This brief writing and review process was coordinated by Clarice Pinto and Nathan Ford (Department of Global HIV, Hepatitis and Sexually Transmitted Infections Programmes), under the leadership of Meg Doherty (Director, Department of Global HIV, Hepatitis and Sexually Transmitted Infections Programmes). This publication was drafted by Anna Grimsrud (Cape Town, South Africa).

World Health Organization (WHO) staff members contributed to developing these guidelines: Ajay Rangaraj, Antons Mozalevskis, Ivy Kasirye, Morkor Newman Owiredu, Nandita Sanjay Sugandhi, Wole Ameyan, Hiwot Teferra Haile-Selassie, Francoise Renaud, Shona Dalal, Busisiwe Msimanga, Carlota Baptista Da Silva, Cheryl Case Johnson (Department of Global HIV, Hepatitis and Sexually Transmitted Infections Programmes), Doroux Aristide Charles Billy (Regional Office for Africa), Muhammad Shahid Jamil (WHO Regional Office for the Eastern Mediterranean), and Omar Sued (Pan American Health Organization).

WHO gratefully acknowledges the contributions of the following individuals to developing this policy brief: Brenda E Crabtree-Ramírez (Departamento de Infectología, Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubirán, México City, México), Charles Holmes (Georgetown Center for Innovation in Global Health, Washington D.C, United States of America), Florence Riako Anam (The Global Network of People Living with HIV, Kisumu, Kenya), Kenneth Mwehonge (Coalition for Health Promotion and Social Development, Kampala city, Uganda), Khumbo Phiri (Partners in Hope, Lilongwe, Malawi), Lynne Wilkinson (International AIDS Society, South Africa, Cape Town), Nittaya Phanuphak (Institute of HIV Research and Innovation, Bangkok, Thailand), and Raphael Adu-Gyamfi (National AIDS/STI Control Programme, Accra, Ghana). None of the individuals who supported this policy brief declared any significant conflict of interest relevant to the subject at hand.

Key messages



- ▶ People who have been diagnosed with HIV may disengage from care after starting antiretroviral therapy (ART) and may do so more than once.
- ▶ Individuals with interrupted HIV care and treatment may re-engage to care with advanced HIV disease and a range of clinical, psychosocial and service delivery needs.
- ▶ WHO recommends tracing people who have disengaged from care and providing support for re-engagement back in care, including adherence support and differentiated service delivery for HIV treatment to reduce the risk of future disengagement.
- ▶ Health-care providers must refrain from punitive actions and ensure a welcoming, non-stigmatizing environment and equitable access to services.
- ▶ Programmes should engage communities at different levels to ensure effective re-engagement strategies tailored to clients' needs.
- ▶ When differentiated service delivery pathways are designed at re-engagement, factors such as the clinical profile, the diverse needs and reasons for disengagement and specific population needs should be considered; person-centred solutions should be explored.
- ▶ How engagement in care and treatment is supported and measured urgently needs to be improved, including close monitoring of treatment adherence and viral suppression and identifying and responding to inconsistent patterns of retention in care.
- ▶ Sustained engagement in HIV care and treatment is critical to achieving sustained undetectable viral load and optimal clinical and public health outcomes.

1. Introduction – what is re-engagement in HIV treatment services and why is it important?

What is re-engagement in HIV treatment services?

In this policy brief, re-engagement in HIV treatment services refers to individuals returning to HIV services after a period of interruption (after missing scheduled visit(s) or appointment(s) and not receiving treatment). Box 1 defines additional key terms used in this brief.

Box 1. Additional key terms used in this brief



A missed visit is a missed appointment either for an antiretroviral refill or a clinical visit. WHO-suggested criteria for initiating tracing and recall interventions includes missing an appointment or visit by more than seven days (1).



WHO defines lost to follow-up as “patients who have not been seen at the facility/community service delivery site for 28 days or more since the last missed appointment (including missed antiretroviral [drug] refills in either facility or community settings)” (2).

In this document, disengagement from HIV care and treatment refers to individuals who were diagnosed with HIV, initiated ART and subsequently interrupted treatment. Disengagement is distinct from missing a visit and being lost to follow-up (Box 1). This distinction is important because not all individuals who miss appointments discontinue or interrupt treatment. For example, clients may be late or miss a scheduled visit but still have access to ART or obtain ART to cover the days they missed.

Loss to follow-up (Box 1) generally refers to the

unknown outcomes of people living with HIV who have not returned to a facility or community ART site for their HIV care or to collect their antiretroviral drugs. The category of lost to follow-up includes undocumented “silent” transfers, people who have died and those who have interrupted treatment (2).

The duration of care and treatment interruption varies across contexts and partners, and this brief does not specifically address the duration of these interruptions but provides considerations on how to address them.

Overview of the disengagement and re-engagement challenge for HIV programmes

There has been considerable progress towards achieving the UNAIDS 95–95–95 global HIV targets (3).¹ In 2022, 86% [73% to >98%] of people living with HIV knew their HIV-positive status, 89% [75% to >98%] who know their status were receiving ART and 93% [79% to >98%] receiving ART achieved viral suppression (4), with considerable variation globally. These targets, which helped to drive the HIV response, describe a linear cascade from knowledge of status to treatment initiation and viral suppression. The response to the HIV epidemic has evolved from its initial focus on increasing awareness of one’s HIV status to then ensuring access to ART for everyone living with HIV. The importance of undetectable equals untransmissible – U=U – for ongoing control of the epidemic has provided renewed emphasis on lifelong adherence to ART and retention in care through adapted and differentiated service delivery models for HIV treatment.

“A recent systematic review found that 20%–50% of people who present for ART in sub-Saharan Africa had already been exposed to ART”

However, the HIV care cascade is not linear: many people engage and disengage from care for a variety of reasons (5). As countries approach the 95–95–95 targets, there is a need to focus on supporting individuals who may be aware of their HIV status but are not actively engaged in care and treatment. A recent systematic review found that 20–50% of people who present for ART in

sub-Saharan Africa had already been exposed to ART (6). Programmatic data from South Africa show that an increasing proportion of individuals disengaged from care and then re-started ART (7,8). By 2023, about two thirds of the people initiating treatment in the Western Cape cohort had previously received ART (7).

People who have disengaged from care constitute a growing proportion of those presenting with advanced HIV disease (8) despite increasing ART access (7). Data from the Western Cape in South Africa show that, by 2018, more than half the people experiencing HIV-associated illness resulted from ART-experienced individuals who were not in continuous care and did not have full viral suppression (8).

HIV programming needs to be shifted from focusing solely on improving knowledge of status and ART initiation to ensuring continuity on treatment and sustained viral suppression. Since perfect adherence to almost any treatment is challenging, programmes need to include person-centred interventions to support engagement, active tracing and re-engagement in treatment and care.

What are the consequences of disengagement?

Disengaging from HIV treatment services poses several risks to people’s well-being, including progression to advanced HIV disease, increased risk of mortality, increased risk of developing antiretroviral drug resistance and increased risk of onward transmission.

Disengagement, and viral rebound, increases the likelihood of HIV transmission. Increasingly, morbidity, mortality and HIV transmission result from people disengaged from care: aware of

¹ 95% of people living with HIV know their HIV-positive status, 95% of those who know their status are receiving treatment and 95% of those receiving treatment achieve viral suppression.



Salimu, a motorcyclist, gives Diana, a community health worker, a ride to the next village as her team continues a door-to-door exercise in a remote part of Arusha on 16 June 2023. ©WHO – Ethnovision – Billy Miaron

their HIV-positive status but not receiving ART (9). Reducing disengagement and facilitating re-engagement are therefore crucial to improve individual outcomes and reach HIV programmatic goals.

Purpose of this policy brief

This policy brief provides an overview of the complexities and challenges of people re-engaging in HIV treatment services. It highlights person-centred interventions that address the reasons for disengagement, the importance of providing support at re-engagement tailored to individual needs and country examples of tracing and re-engagement interventions. The brief summarizes WHO guidance and emphasizes the importance of implementing relevant recommendations to support adherence, continuous engagement, tracing and sustained re-engagement.

This brief aims to assist health policy-makers, health ministries, practitioners, implementers and communities to improve understanding of the

various challenges and solutions for re-engaging individuals to support better health outcomes. It provides guidance on supporting people living with HIV to sustain re-engagement without further interruptions in treatment and care. The goal is to reduce HIV-related morbidity and mortality, prevent new infections and the risk of drug resistance.

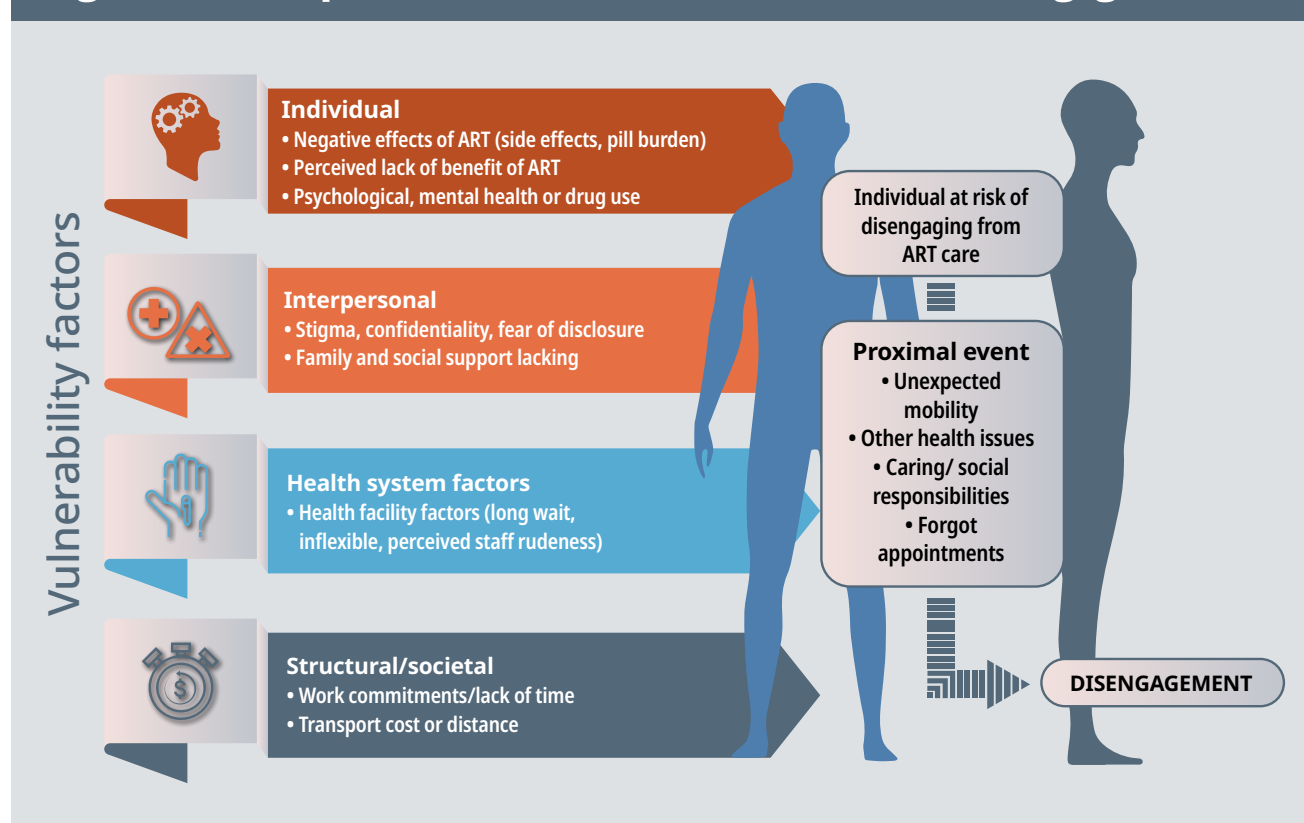
Approach to this brief development

The methodology for developing this policy brief involved an initial literature review conducted to gather existing WHO guidelines and recommendations and the results of a literature review on the reasons for disengagement. The draft policy brief was subjected to external peer review adhering to WHO standards. The peer reviewers, who were experts in public health, programme management, and community representation, evaluated the draft and provided feedback on its clarity and content. This thorough process ensured that the final publication was comprehensive and embodied a broad spectrum of expert perspectives.

2. Reasons for disengagement and re-engagement

Understanding how to optimally support consistent engagement in HIV treatment and care services requires understanding the challenges and reasons for disengagement, which can be described as individual, interpersonal, health system and structural or societal (10) (Fig. 1).

Figure 1. Conceptual framework for the reasons for disengagement



Source: Burke et al. (10).

Research findings

A recent systematic review identified reasons for disengagement from care reported in the literature and found that mobility, lack of perceived benefits of ART and structural and societal factors (commonly transport cost or distance) were frequently reported (10). Underlying vulnerability factors (individual,

interpersonal, structural and health care) taken together with unexpected proximal events, such as unplanned mobility, were associated with disengagement. A study from Zambia that traced individuals who were lost to follow-up (11) found that relocation and unexpected work commitments were frequently cited reasons for treatment interruption. Those who had disengaged expressed a desire for clinic

improvements such as reduced waiting times and improved quality, and nearly half of those traced reported that they intended to return to care even in the absence of changes.

Research from Malawi, South Africa, Uganda and Zambia indicates that people commonly return to care when their HIV treatment becomes a priority – because their health has deteriorated or through encouragement from social networks, peer supporters or community health workers (11–14).

Health system considerations

These reported reasons for disengagement highlight important considerations for health systems to enhance the quality of HIV service delivery both to discourage disengagement and

encourage re-engagement (11–13,15–17). Flexibility within services is essential. There are many reasons why an individual may miss a scheduled visit or need a different appointment date, and health services need to accommodate these unanticipated realities. Health systems should avoid insisting on frequent, unnecessary visits at re-engagement and instead consider individual circumstances (17).

“Health systems should avoid insisting on frequent, unnecessary visits at re-engagement and instead consider individual circumstances”

3. WHO recommendations to support continuous engagement and re-engagement

This section presents WHO recommendations that emphasize the importance of maintaining individuals living with HIV in continuous care and treatment to ensure ART effectiveness, reduce HIV-associated mortality, prevent people from acquiring HIV and prevent the development of drug resistance.

Recommendations to support continuous engagement

WHO has recommendations and best practice statements aimed at supporting continuous engagement and thus reducing disengagement from care (Box 2).

- Alongside the offer of same-day ART initiation, people should be provided education, counselling, person-centred care and support to facilitate adherence and retention.
- WHO also recommends task sharing and decentralization to expand access points and extended ART refills and reduced frequency of clinical visits to simplify care. Several adherence support interventions – including peer counsellors, mobile phone text messages and reminder devices – are recommended as well as community support and community-led interventions that improve retention.

All these interventions have been designed to overcome challenges with sustained engagement such as providing services closer to home, expanding the range of cadres who can provide psychosocial support and treatment refills and ensuring that people are supported with knowledge and health literacy around HIV.

Engagement in care can also be supported by health systems providing people-centred care.

Box 2. WHO recommendations to support continuous engagement (1)

Good practice statement

The offer of same-day ART initiation should include approaches to improve uptake, treatment adherence and retention such as tailored patient education, counselling and support.

Recommendations

Adherence support interventions should be provided to people on ART (2016 recommendation).

People established on ART should be offered clinical visits every 3–6 months, preferably every six months if feasible.

People established on ART should be offered refills of ART lasting 3–6 months, preferably six months if feasible.

Programmes should provide community support for people living with HIV to improve retention in HIV care.

- WHO recommends that health systems invest in people-centred practices and communication, including ongoing training, mentoring, supportive supervision and monitoring health-care workers, to improve the relationships between patients and health-care providers.

Recommendations to support re-engagement

In addition to supporting continuous engagement, WHO provides recommendations and guiding principles to facilitate return by those who have disengaged (Box 3).

Interventions to support re-engagement include navigation back to care and outreach from peers or health-care providers and through systems interventions such as mechanisms to alert providers when someone has disengaged.

- Interventions could include text messaging or phone call reminders, financial incentives or conditional cash transfers or case management and policy interventions (1). Section 4 provides more details on tracing approaches.

People re-engage in HIV care through various pathways and at various stages of the care continuum. Some re-engage at the same clinic; others go to a different clinic and may or may not disclose their previous ART use; and some use HIV testing to return to care (18).

- Testing services can be an important way to re-engage, especially for those who fear being disadvantaged (such as mistreated, stigmatized or punished) for disclosing their treatment interruption and seeking a simple and accessible way to facilitate re-entry (19).
- Although some people may re-engage silently through testing and not self-report their previous positive test result or ART use, others may re-engage and self-report

their interruption or their HIV status can be clinically documented.

- Importantly, WHO does not recommend retesting those with a previous positive diagnosis who were receiving treatment at re-engagement. However, when this occurs, it is important to support clients, provide them a pathway and encouragement back into care while also carefully explaining testing results.
- WHO does support retesting for people (a) who choose to re-engage through HIV testing services, (b) who are struggling to accept their status and need more support to accept their status despite having previously received ART and (c) who return to care at a new or temporary facility and request ART continuation with no documentation or other means to confirm previously diagnosed (laboratory or electronic system).

For further guidance, see the WHO consolidated guidelines on differentiated HIV testing services (20).

Box 3. WHO recommendations on re-engagement



To support those who are disengaged to re-engage in HIV care

Programmes should implement interventions to trace people who have disengaged from care and provide support for re-engagement (1).



To improve re-engagement and retention in care

Use of person-centred patient data is recommended to continuously assess the interruption of HIV treatment to improve re-engagement and retention in care (2).

4. Tracing approaches

WHO recommends implementing tracing interventions to identify individuals who have disengaged from care and provide them with support for re-engagement (1).

- Tracing approaches can include a blend of remote communication (such as phone, text messages, mail and email), in-person tracing and a combination of both approaches.
- Importantly, not every client who has disengaged may require tracing to return to care. In addition, not all traced clients can be located, nor do all contacted individuals necessarily return to care (22).

An increasing number of people living with HIV access treatment through less-intensive differentiated service delivery ART models, visiting clinics every three, six or 12 months. Tracing interventions should therefore be designed and implemented for both people who miss clinical appointments and those who miss ART collection visits, which may occur outside the health facility.

Considerations for tracing criteria and priorities

In the 2021 consolidated HIV guidelines, WHO outlined four options countries may consider when deciding the combination of factors to build their own tracing criteria: (a) people initiating treatment in the past six months with advanced HIV disease, (b) people with abnormal laboratory test results, (c) people not initiating treatment and (d) people overdue for clinical consultations or laboratory tests (11).

The 2022 WHO person-centred HIV strategic information guidelines provide a detailed list of who could be traced should resources allow (2). Priority setting for tracing should consider available resources alongside risk of morbidity and mortality (abnormal laboratory results). When setting priorities for who to trace, programmes should

consider the unique vulnerability and potential for vertical transmission of HIV from mother to child and children, adolescents, pregnant women and breastfeeding mothers living with HIV (1).

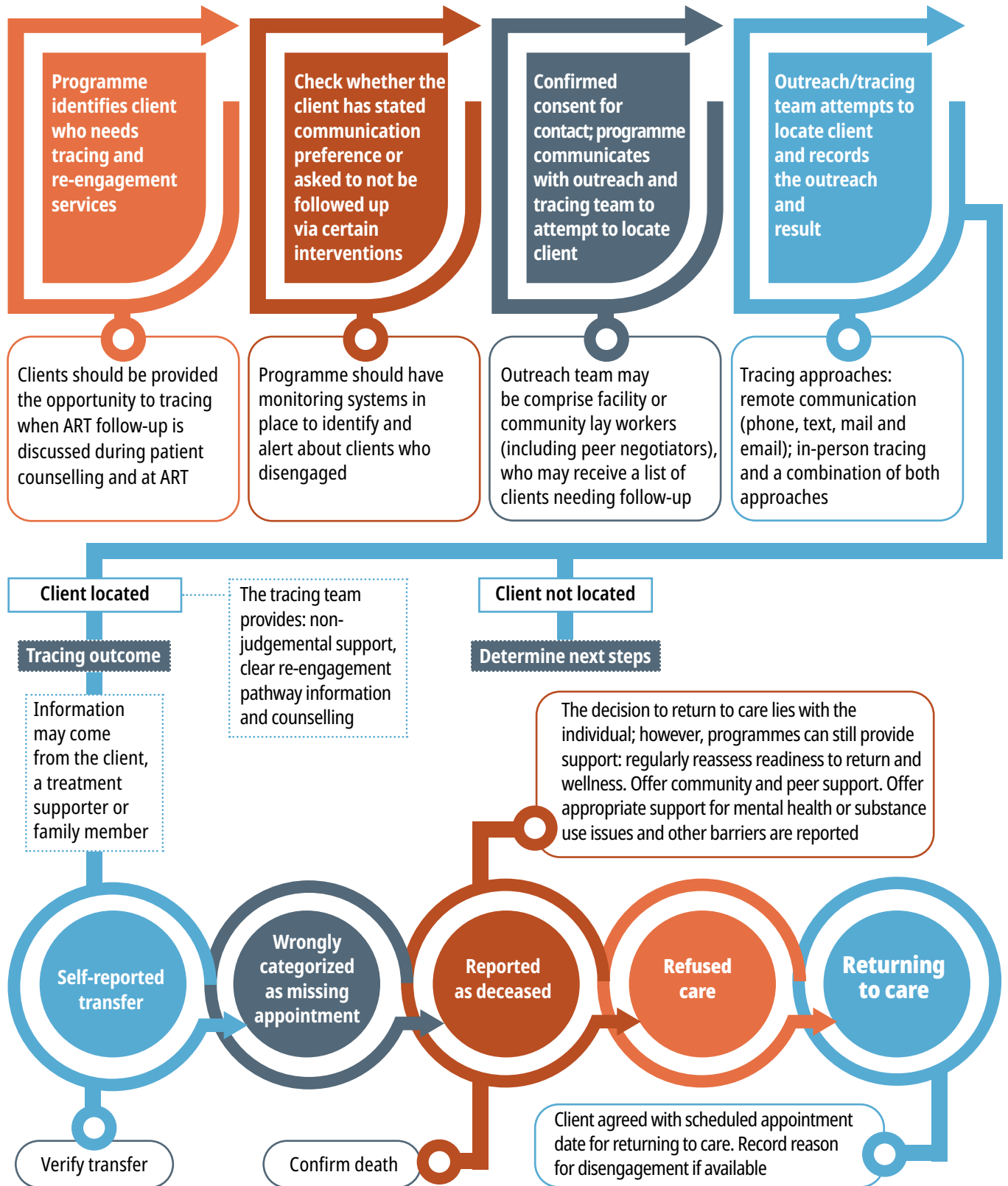
Operationalizing the tracing process

- Programmes should have monitoring systems in place to identify and alert about clients on ART who disengage.
- When a client is eligible and given priority for tracing and when consent for tracing has been given, the programme should coordinate with the outreach or tracing team to locate the client.
- The tracing team may include lay workers, peer supporters and community health workers, who are tasked with following up a list of clients (1).
- This approach must ensure that tracing efforts are respectful, consensual and tailored to the needs and preferences of each client, enhancing the effectiveness of re-engagement strategies in care.
- Once the client is reached through tracing, it is important to be supportive and non-judgemental and give clear information and counselling to encourage re-engagement in care and treatment.

Fig. 2 describes these and additional tracing process considerations.

“Tracing interventions should be designed and implemented both for people who miss clinical appointments and those who miss ART collection visits”

Figure 2. Tracing process



Source: adapted from Digital adaptation kit for HIV: operational requirements for implementing WHO recommendations in digital systems (23).

Box 4. Tracing programme in Pakistan

In 2020, a demonstration project in Pakistan was implemented to trace, engage and re-link people living with HIV who had no contact with the health facility for at least the previous six months. This peer-led project, implemented by the Association of People Living with HIV Pakistan and scaled up as part of the Global Fund to Fight AIDS, Tuberculosis and Malaria grant, was conducted at two ART centres, one in Islamabad and the other in the Khyber Pakhtunkhwa province. Between September 2020 and May 2021, the national Management Information System identified more than 1500 clients who had no contact with their ART facility in at least the last six months, with about 27% being people who inject drugs. Peer trackers from an association led by people living with HIV traced the clients through phone calls and home visits, and 81% of those who were alive (325 of 401) successfully re-engaged with treatment. Of those not successfully linked, 43% had died, 9% were receiving treatment at another clinic and 2% had migrated (24).



Dispensing ART after an individual therapeutic education session by a mediator ©FHI360 - Raymond Varvatos

“Re-engagement interventions included identifying and addressing barriers, providing social support, conducting motivational interviewing and providing multimonth dispensing”

Box 5. Back to Care campaigns and tracing activities in Burkina Faso, Papua New Guinea and Togo

Back to Care campaigns to trace and support people disengaged to care were conducted in Burkina Faso, Papua New Guinea and Togo. Tracking and tracing lists were developed from facility records with clients followed up through phone and home-based tracing. Of those identified as being in treatment interruption, 67% of 10 362 clients in Burkina Faso, 15% of 1126 clients in Papua New Guinea and 55% of 9299 clients in Togo re-engaged in care. Many people were also receiving treatment at other sites (10% in Burkina Faso, 31% in Papua New Guinea and 16% in Togo). Re-engagement interventions included identifying and addressing barriers, providing social support, conducting motivational interviewing and providing multimonth dispensing (29,30).

5. Guiding principles for differentiated re-engagement

Addressing the challenges associated with disengagement, treatment interruption, and supporting sustained re-engagement will depend on the context, the burden of HIV, specific population needs and the healthcare delivery system. This section introduces some guiding principles for improving the quality of HIV services that are relevant across contexts to support durable re-engagement.

Box 6. Zambia’s welcome package for returning clients

In Zambia, the welcome package for clients receiving ART plays a crucial role in supporting individuals returning to care after treatment interruption. This package, designed for health-care providers and counsellors, emphasizes a non-judgemental, empathetic approach to re-engage people. It includes a structured appointment system with reminders to ensure adherence, a detailed plan to track patients and prevent loss to follow-up and consistent monitoring of missed visits. The welcome package also fosters strong community support by establishing links with home-based care workers and volunteers. Dedicated health facility personnel are assigned to contact patients who miss visits, ensuring timely follow-up and personalized support. This approach not only improves adherence and reduces loss to follow-up but also creates a supportive environment for those returning to care. The welcome package’s emphasis on empathetic engagement, continuous monitoring and community involvement is vital in reshaping the narrative around HIV treatment and care in Zambia (21).

“Identify and discuss the reasons and challenges that led to disengagement and implement appropriate interventions to prevent future interruptions”



Community health worker Blaise Talotsing, Ntouessong 8, Soa health district, Cameroon. ©WHO – Kayi Lawson

Ensuring a welcoming, non-stigmatizing environment

- All personnel at the health-care facility, from security guards to clinicians or peer supporters, should be welcoming to everyone in a non-stigmatizing manner.
 - All health-care providers should actively challenge and address stigma and discrimination.
- Interpersonal communication should be improved by developing the capacity of health-care providers (including adherence and peer supporters) to welcome people returning to care with a non-judgemental approach, which is critical to supporting re-engagement (1).
- All categories of health-care providers should:
 - acknowledge that missed appointments

or treatment interruptions are part of the client's unique HIV journey while emphasizing the importance and availability of support to sustain treatment adherence; and

- reinforce motivating messaging that an undetectable viral load is the goal of ART for all people living with HIV, benefitting their own health and to prevent onward transmission (25).
- HIV programmes should:
 - provide people-centred care that is focused and organized around the health needs, preferences and expectations of people and communities, upholding individual dignity and respect, especially for vulnerable populations, and engage and support people and families to play an active role in their own care by informed decision-making (1); and
 - implement participatory training and mentorship for both health-care providers and clients, develop comprehensive guidelines and foster long-term client-provider relationships to address fears and misconceptions about HIV and reduce stigma and discrimination (26–28).
 - address health facility related reasons for disengaging from HIV care and treatment reported by clients.

Supporting adherence challenges

- Clients re-engaging in care may be those who have the greatest barriers to adherence. It is advisable to identify and discuss the reasons and challenges that led to disengagement and implement appropriate interventions to prevent future interruptions.

- Some of the barriers to adherence may be related to social determinants. If possible, these barriers should be addressed through holistic approaches and psychosocial support.
- Challenges to sustained re-engagement in care and treatment should be addressed through tailored adherence support, including enabling less-intensive service delivery and/or providing counselling and peer support at the facility or in the community with the relevant referrals required.
- The frequency of health facility visits should be in accordance with clinical needs. People who re-engage should not be required to make additional health facility visits unless clinically indicated.

Providing immediate treatment and care

- Offering treatment reinitiation on the day of return, following the same principles as same-day ART initiation, is critical to support viral suppression. This is also critical for clients transferring from other facilities.

Providing advance HIV disease identification and rapid screening for opportunistic infections

- A CD4 cell count should be taken upon return to care, and those with advanced HIV disease should be provided prophylaxis and screened for common opportunistic infections (including TB, cryptococcal meningitis and histoplasmosis) as part of the immediate treatment and care provided to people re-engaging in services.

“The provision of treatment must not be punitively withheld and a client must not be made to return to a different facility for a treatment refill or to collect transfer documentation”

Ensuring equitable access to care

- All providers must refrain from taking punitive actions against those who are returning to care. In most settings, adopting a first-come, first-served approach to queue management will be the most equitable approach.
- Re-engaging clients should not be relegated to the back of the queue or be made to wait until all other clients have been served. The provision of treatment must not be punitively withheld, and a client must not be made to return to a different facility for a treatment refill or to collect transfer documentation.

Engaging communities

- Empowered communities are vital to a resilient health system. Community representatives should be engaged in designing, implementing and monitoring re-engagement interventions to ensure that they are culturally sensitive and meet the needs of the community.
- Community members may also be best placed to identify people who have disengaged from care and support them in re-engaging. Peer support may also be

appropriate to support adherence and retention.

- Community-based or -led organizations play an important role in raising awareness about the importance of adhering to treatment and re-engaging in HIV services and the support available for individuals with adherence barriers and other people considering returning to care.

Ensuring high-quality services that give priority to people's needs, provide safe and appropriate clinical and non-clinical services and optimize resource utilization are essential. In addition, emphasis should be placed on enhancing user experiences and addressing stigma and discrimination, especially within the health-care system, and fostering a culture of quality of HIV care (1).

“It is essential to ensure high-quality services that prioritize people's needs, provide safe and appropriate clinical and non-clinical services, and optimize resource utilization”

6. What to consider when defining differentiated service delivery pathways to support re-engagement in HIV treatment

Key factors should be part of defining a step-by-step approach to differentiated service delivery at re-engagement: clinical assessment and rapid ART reinitiation, psychosocial assessment and adherence support needs, addressing treatment interruption and specific population engagement needs (Table 1).



National AIDS Program. ©WHO – Gonzalo Bell

Clinical assessment and rapid ART reinitiation

- Provide a complete clinical assessment on re-engagement in care to determine the clinical stability of the person who is re-engaging.
- Review all available clinical data, including the most recent viral load result.
- Conduct CD4 test for individuals who re-engage in care after a period of disengagement to assess for advanced HIV disease.
- Clients who present seriously unwell should immediately be considered as having advanced HIV disease (31).
- Screening and diagnosing opportunistic infections is critical in ensuring timely treatment and care (32).
- Individuals re-engaging in care after treatment interruption should be rapidly reinitiated on ART on the same day (1).

Psychosocial assessment and adherence support needs

- Discuss previous adherence success, especially for people with a previously suppressed viral load, to help to address the reasons for disengagement.
- Assess factors affecting adherence to create a personalized adherence support plan that should be flexible to meet the client's changing needs.
- Provide mental health screening and management.
- Refer clients with significant mental health conditions (such as alcohol and other substance use) or social conditions (such as food insecurity, domestic violence, unstable housing) if possible.
- Incorporate peer support and community interventions (such as adherence and psychosocial support provided in the community and community ART refill points).
- Adapt the intensity, type and combination of adherence and retention support interventions following re-engagement to the client's changing priorities.
- Consider the following adherence and retention support interventions to build the re-engagement support plan according to the client's specific needs:
 - mobile phone text messages and reminder devices (such as an alarm);
 - medication organizer (such as a pillbox);
 - peer support and counselling (such as a treatment buddy);
 - treatment literacy (such as behavioural skills training and medication adherence training);
 - partner or child or adolescent disclosure support;
 - individual (such as cognitive behavioural therapy) and group counselling and peer support groups;
 - adherence clubs;
 - community-based adherence support interventions (such as patient advocates

and treatment and peer support interventions providing adherence and psychosocial support in the community);

- less-intensive differentiated service delivery models for HIV treatment;
- reduced frequency of clinical consultations and longer ART refills (multimonth ART dispensing); and
- home-based care (such as mobile clinics).

“Adapt the intensity, type and combination of adherence and retention support interventions following re-engagement to the client's changing priorities”

Addressing treatment interruption

- Disengagement is currently defined differently in various contexts. Considering the impact of this interruption on an individual's clinical well-being is essential.
- The intensity of following up clients after re-engagement can vary depending on clinical and psychosocial needs, the duration treatment was interrupted and the client's needs and preferences.
- Clients who are clinically well should access less-intensive differentiated service delivery ART models and multimonth dispensing once established on ART.
- Clients who present unwell may benefit from home-based care or palliative care options, providing them with tailored support and comfort in their own environment.

Once these factors have been considered, differential service delivery re-engagement pathways can be supported with variation in the intensity of the clinical follow-up, the modality and frequency of psychosocial support, adherence support and other interventions to address the reasons for disengagement.

Box 7. Treatment interruptions in Malawi

In Malawi, an analysis of more than 1 million individuals attending a clinic between January 2022 and September 2023 assessed re-engagement in care and time since last visit among those re-engaging (33). A treatment interruption was defined as being 28 or more days late for a scheduled visit. More than 60% of individuals had at least one interruption during the period, with more than 80% re-engaging. Of those who re-engaged, 82% re-engaged within six months of their scheduled visit.

“Differential service delivery re-engagement pathways can be supported with variation in the intensity of the clinical follow-up, the modality and frequency of psychosocial support, adherence support and other interventions”

Box 8. Characteristics of those re-engaging in care in Gauteng, South Africa

Administrative clerks collected data on individuals returning to nine primary health care facilities in Gauteng, South Africa between July and November 2022 who were late for their visits (34). Of the 2111 individuals who were late, nearly 60% were returning less than two weeks after their scheduled appointment. Among those more than two weeks late, 25% were returning 14–28 days after their missed appointment, 46% 5–12 weeks after their missed appointment and 30% more than 12 weeks after. Almost half (47%) of those returning two or more weeks after their missed appointment self-reported not interrupting treatment and using buffer stock or treatment sourced from elsewhere to cover the missed appointment period.



The LoveYourself Project aims to prevent the spread of HIV/AIDS among the youth and key affected population through awareness, counseling and education. © WHO - Yoshi Shimizu

Box 9. Zimbabwe’s differentiated service delivery re-engagement pathway

In 2022, Zimbabwe included a pathway for re-engaging clients in their updated HIV operational and service delivery manual (35). Health-care workers perform clinical and psychological assessments and determine when ART was last dispensed. Re-engaging clients are differentiated into those who are clinically well and unwell, based on clinical presentation, viral load results and psychosocial barriers. Those clinically well with less than three months since their missed visit are supported to enter or re-enter a differentiated service delivery ART model, receive a six-month ART refill and follow their annual viral load schedule. Those with more than 90 days durations of ART interruptions receive a CD4 test and reinstate ART on the same day. For people identified as having advanced HIV disease, the WHO-recommended advanced HIV disease package of care is provided. Clinically unwell clients receive treatment based on their specific clinical needs.

Box 10. South Africa’s differentiated service delivery re-engagement pathway

In 2023, South Africa published an updated re-engagement pathway (36). It starts by determining the time since the missed appointment, with clients returning more than 28 days since their last scheduled appointment considered to be re-engaging. These clients undergo clinical assessment to decide whether enhanced adherence counselling is needed and to differentiate between clinically well and clinically unwell individuals, including those with abnormal results or who are coinfecting with tuberculosis. Clinically well clients are divided into those with 29–90 days and those with more than 90 days since their last appointment. Clients with 29–90 days since their last missed appointment are supported to continue treatment, are enrolled into a less-intensive differentiated service delivery ART model and receive a three-month ART refill. Those clinically well with more than 90 days since their last appointment restart ART on the same day and receive a three-month ART refill to align with the return date for a repeat viral load. Clinically unwell clients receive clinical services, with visit frequency and ART refills tailored to their needs.

Box 11. Mozambique’s approach to reduce disengagement and support clients to return within 60 days of a missed appointment

In 2023, Mozambique published its revised differentiated service delivery guidance (37). This guidance recommends that a community treatment refill be provided as a once-off intervention to clients missing their scheduled appointment by 5–59 days. In this intervention, a health-care worker visits the client’s home, provides the treatment refill and encourages continued engagement and return to the facility. The policy also supports anyone who has missed their appointment by less than 60 days to continue in their less-intensive differentiated service delivery model.

Considerations for specific populations

Each population faces unique challenges to sustained engagement in HIV treatment services. Although not specific to re-engagement, these specific challenges should be discussed and addressed at re-engagement, during the counselling and other key support interventions implemented to sustain re-engagement. Table 1 describes these population-specific considerations (the “why”) alongside how they should be addressed, including at re-engagement.

“Each population faces unique challenges to sustained engagement in HIV treatment services”

Table 1. Considerations for specific populations at re-engagement

Considerations at re-engagement	How to address specific population considerations at re-engagement
Infants, children and young adolescents (38–41)	
<ul style="list-style-type: none"> • Limited agency and depend on caregivers to manage their health care • Change of caregiver may increase risk of disengagement • Limited understanding of their own status if developmentally appropriate paediatric HIV disclosure counselling was not provided 	<ul style="list-style-type: none"> • For caregivers of young children, counselling includes a check on the caregivers' well-being (including HIV and ART status) and mental health • Consider peer support groups for caregivers and enrolment into the same differentiated service delivery models as caregivers such as mother–infant paired models) • Provide appropriate antiretroviral drug formulations and decentralized paediatric care to improve access to services • Age-appropriate HIV status disclosure and counselling to children • For infants, align the infant and mother's ART schedule with the infant's Expanded Programme of Immunization schedule and other maternal and child health services • For children and adolescents, facilitated transition from paediatric services to adolescent services and adolescent specific differentiated service delivery models at appropriate age
Women and girls (42,43)	
<ul style="list-style-type: none"> • Fear of disclosing their HIV status to partners and families • Violence against women, including intimate partner violence and sexual violence • Gender inequalities • Stigma 	<ul style="list-style-type: none"> • Adequate support for voluntary HIV status disclosure to partners and families • Provision of gender-based violence services • Educational interventions on adherence and sexual and reproductive health
Pregnant and postpartum women (44–46)	
<ul style="list-style-type: none"> • Adverse pregnancy-related conditions (such as nausea) • Learning HIV status during pregnancy • Concerns about fetal health • Fear of disclosing HIV status during the transition from antenatal care and maternal, newborn and child health services to ART care 	<ul style="list-style-type: none"> • Align ART with the antenatal care schedule and align ART and postnatal care with infants' Expanded Programme of Immunization and breastfeeding schedule; integrated prenatal and postnatal, ART and contraceptive care. • Psychosocial support, peer support (such as mentor mothers) and counselling on ART adherence during and after pregnancy, including facility-based or community-based adherence groups either specific to mothers or not
Adolescents and young adults (2,41,47)	
<ul style="list-style-type: none"> • School attendance and holiday schedule • Limited understanding of their own status if developmentally appropriate paediatric HIV disclosure counselling was not provided 	<ul style="list-style-type: none"> • Psychosocial support from peers, including in adolescent differentiated service delivery models such as adolescent adherence clubs. • Age-appropriate HIV status disclosure services and treatment literacy • Youth-friendly services

Table 1 (cont'd).

Adolescents and young adults (2,41,47)

- | | |
|--|--|
| <ul style="list-style-type: none"> • Some adolescents and young people may engage in care without fully having known or understood their HIV status | <ul style="list-style-type: none"> • Educational interventions on adherence and sexual and reproductive health • Appointment scheduling to accommodate school hours and holidays • Facilitated transition to adult ART services and adult differentiated service delivery models when they age out of adolescent-specific services, including transition planning with adolescent, gradual and cohort transition mechanisms |
|--|--|

Key populations (men who have sex with men, sex workers, people who inject drugs, trans and gender-diverse people and people in prison and other closed settings) (48)

- | | |
|---|--|
| <ul style="list-style-type: none"> • Stigma and discrimination • Criminalization of behaviour and identities associated with key populations • Lack of tailored services • Violence and other forms of human rights violations • Lack of confidentiality and privacy | <ul style="list-style-type: none"> • Peer navigators and supporters facilitate re-engagement • Supportive and rights-focused counselling • Integrated and decentralized services; including online case management platforms (when available) and multimonth dispensing • Peer-led, community-based services to reduce stigma • Do not endorse practices that restrict access to care, such as conversion therapy |
|---|--|

Men (2,49)

- | | |
|---|---|
| <ul style="list-style-type: none"> • Stigma • A perception that seeking care is a sign of weakness • Work and social obligations | <ul style="list-style-type: none"> • Community-based services (such as community-based men's spaces and men's corners) • Male-targeted health education • Men's clinics or male-friendly services at existing health clinics |
|---|---|

Migrants (including migrant workers and displaced populations) (50)

- | | |
|---|--|
| <ul style="list-style-type: none"> • Unplanned mobility (because of seasonality of work), displacement or migration • Language and cultural differences • Lack of resources and knowledge about availability of services • Stigma • Challenges to accessing the care system (legal and language) | <ul style="list-style-type: none"> • Provide extended ART refills to ensure uninterrupted treatment supply • Transfer client-held documentation or medical record in case the client is unable to return to access treatment elsewhere |
|---|--|

Older people (2,51)

- | | |
|--|--|
| <ul style="list-style-type: none"> • Polypharmacy • Comorbidities • Increasing treatment complexity | <ul style="list-style-type: none"> • Adherence support, considering comorbidities and integrated service provision, including in less-intensive differentiated service delivery models • Simplified regimens to manage pill burden |
|--|--|

7. Looking ahead

As countries reach the global 95–95–95 targets, HIV programmes will require intensified focus on providing support for those re-engaging to address treatment interruptions and disengagement from HIV services. This focus should include implementing current WHO service delivery recommendations and considering how to differentiate services to meet the needs, preferences and expectations of those re-engaging.

Final considerations

Strengthening the health system

- Health system-related barriers to treatment adherence and sustained engagement should be addressed, and interventions to improve the quality of HIV services provided should be implemented.
- Person-centred multifaceted interventions should be implemented to support individuals in managing their treatment effectively, addressing both clinical and psychosocial factors to improve adherence and overall health outcomes.

Dynamic HIV care cascade

- The HIV care cascade is dynamic and not a one-way path, and additional data and evidence on the client engagement and disengagement patterns from other contexts and for specific populations are needed.
- Monitoring systems should be adapted to the concept of a dynamic HIV care cascade to be able to measure losses at each step of care. These data would facilitate greater understanding of disengagement and facilitate timely and tracing interventions with appropriate priority to support re-engagement.
- Monitoring efforts should be strengthened and facilitated using unique identifiers and electronic data systems.

- Further, routine programme analytics focused beyond the 95–95–95 targets and assessed interruptions and re-engagement would support improved service delivery.

Community engagement

- Community-led and community-based service delivery is essential, since it fosters significant community engagement, ensuring that services are aligned with the preferences of the people served.

The brief calls for a shift from merely increasing ART access to supporting sustained engagement. Supporting sustained and continual engagement, and re-engagement in HIV services requires providing people-centred care that acknowledges population specific needs, promotes increased self-management and self-care through strengthened HIV services. Improving the quality of HIV care services is critical to achieving sustained undetectable viral load and optimal clinical and public health outcomes.

“Improving the quality of HIV care services is critical to achieving sustained undetectable viral load and optimal clinical and public health outcomes”

References

1. Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach, 2021 update. Geneva: World Health Organization; 2021 (<https://iris.who.int/handle/10665/342899>, accessed 13 June 2024).
2. Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization; 2022 (<https://iris.who.int/handle/10665/360948>, accessed 13 June 2024).
3. The path that ends AIDS: UNAIDS global AIDS update 2023. Geneva: UNAIDS; 2023 (https://www.unaids.org/sites/default/files/media_asset/2023-unaids-global-aids-update_en.pdf, accessed 13 June 2024).
4. AIDSInfo [online database]. Geneva: UNAIDS; 2024 (<https://aidsinfo.unaids.org>, accessed 13 June 2024).
5. Ehrenkranz P, Rosen S, Boule A, Eaton JW, Ford N, Fox MP et al. The revolving door of HIV care: revising the service delivery cascade to achieve the UNAIDS 95–95–95 goals. *PLoS Med.* 2021;18:e1003651. doi: 10.1371/journal.pmed.1003651.
6. Benade M, Maskew M, Juntunen A, Flynn DB, Rosen S. Prior exposure to antiretroviral therapy among adult patients presenting for HIV treatment initiation or reinitiation in sub-Saharan Africa: a systematic review. *BMJ Open.* 2023;13:e071283. doi: 10.1136/bmjopen-2022-071283.
7. Euvrard J, Timmerman V, Keene CM, Phelanyane F, Heekes A, Rice BD et al. The cyclical cascade of HIV care: temporal care engagement trends within a population-wide cohort. *PLoS Med.* 2024;21:e1004407. doi: 10.1371/journal.pmed.1004407.
8. Osler M, Hilderbrand K, Goemaere E, Ford N, Smith M, Meintjes G et al. The continuing burden of advanced HIV disease over 10 years of increasing antiretroviral therapy coverage in South Africa. *Clin Infect Dis.* 2018;66(Suppl. 2):S118–25. doi: 10.1093/cid/cix1140.
9. Grimes RM, Hallmark CJ, Watkins KL, Agarwal S, McNeese ML. Re-engagement in HIV care: a clinical and public health priority. *J AIDS Clin Res.* 2016;7:543. doi: 10.4172/2155-6113.1000543.
10. Burke RM, Rickman HM, Pinto C, Ehrenkranz P, Choko A, Ford N. Reasons for disengagement from antiretroviral care in the era of “treat all”: a systematic review. *J Int AIDS Soc.* 2024;27:e26230. doi: 10.1002/jia2.26230.
11. Sikazwe I, Eshun-Wilson I, Sikombe K, Beres LK, Somwe P, Mody A et al. Patient-reported reasons for stopping care or switching clinics in Zambia: a multisite, regionally representative estimate using a multistage sampling-based approach in Zambia. *Clin Infect Dis.* 2021;73:e2294–302. doi: 10.1093/cid/ciaa1501.
12. Chamberlin S, Mphande M, Phiri K, Kalande P, Dovel K. How HIV clients find their way back to the ART clinic: a qualitative study of disengagement and re-engagement with HIV care in Malawi. *AIDS Behav.* 2022;26:674–85. doi: 10.1007/s10461-021-03427-1.
13. Bisnauth MA, Davies N, Monareng S, Buthelezi F, Struthers H, McIntyre J et al. Why do patients interrupt and return to antiretroviral therapy? Retention in HIV care from the patient’s perspective in Johannesburg, South Africa. *PLoS One.* 2021;16:e0256540. doi: 10.1371/journal.pone.0256540.
14. Nabaggala MS, Parkes-Ratanshi R, Kasirye R, Kiragga A, Castlenuovo B, Ochaka I et al. Re-engagement in HIV care following a missed visit in rural Uganda. *BMC Res Notes.* 2018;11:762. doi: 10.1186/s13104-018-3865-9.
15. Udeagu CN, Shah S, Misra K, Sepkowitz KA, Braunstein SL. Where are they now? Assessing if persons returned to HIV care following loss to follow-up by public health case workers were engaged in care in follow-up years. *AIDS Patient Care STDS.* 2018;32:181–90. doi: 10.1089/apc.2018.0004.
16. Topp SM, Mwamba C, Sharma A, Mukamba N, Beres LK, Geng E et al. Rethinking retention: mapping interactions between multiple factors that influence long-term engagement in HIV care. *PLoS One.* 2018;13:e0193641. doi: 10.1371/journal.pone.0193641.
17. Ondenge K, Renju J, Bonnington O, Moshabela M, Wamoyi J, Nyamukapa C et al. ‘I am treated well if I adhere to my HIV medication’: putting patient-provider interactions in context through insights from qualitative research in five sub-Saharan African countries. *Sex Transm Infect.* 2017;93(Suppl. 3):e052973. doi: 10.1136/sextrans-2016-052973.
18. Grimsrud A, Wilkinson L, Ehrenkranz P, Behel S, Chidarikire T, Chisenga T et al. The future of HIV testing in eastern and southern Africa: broader scope, targeted services. *PLoS Med.* 2023;20:e1004182. doi: 10.1371/journal.pmed.1004182.
19. Beeman A, Bengtson AM, Swartz A, Colvin CJ, Lurie MN. Cyclical engagement in HIV care: a qualitative study of clinic transfers to re-enter HIV care in Cape Town, South Africa. *AIDS Behav.* 2022;26:2387–96. doi: 10.1007/s10461-022-03582-z.
20. Consolidated guidelines on differentiated HIV testing services. Geneva: World Health Organization; in press.
21. Simwenda M, Chikuka-McLeod M, Ciccio L, Ndhlovu A, Habbanti S, Musonda M. Welcome package. Lusaka: United States Agency for International Development; 2024.
22. Beres LK, Mody A, Sikombe K, Nicholas LH, Schwartz S, Eshun-Wilson I et al. The effect of tracer contact on return to care among adult, “lost to follow-up” patients living with HIV in Zambia: an instrumental variable analysis. *Int AIDS Soc.* 2021;24:e25853. doi: 10.1002/jia2.25853.
23. Digital adaptation kit for HIV: operational requirements for implementing WHO recommendations in digital systems. 2nd ed. Geneva: World Health Organization; 2023 (<https://iris.who.int/handle/10665/375230>, accessed 13 June 2024).
24. Elsfoury S, Mugisa B, Pasha MS, Satti A, Haider O, Tariq U et al. Community-led interventions to re-engage people living with HIV into care: a novel approach for Pakistan. Submitted.
25. The role of HIV viral suppression in improving individual health and reducing transmission: policy brief. Geneva: World Health Organization; 2023 (<https://iris.who.int/handle/10665/360860>, accessed 13 June 2024).
26. Mlunde LB, Saalim K, Mbwambo JK, Kiwia P, Fitch E, Manyama W et al. Adapting a health facility HIV stigma-reduction participatory training intervention to address drug use stigma in HIV care and treatment clinics in Dar es Salaam, Tanzania. *Harm Reduction J.* 2024;21. doi:10.1186/s12954-024-00965-4.

27. Abdulai MA, Mevissen FEF, Kramer A, Boitelet Z, Asante KP, Owusu-Agyei S et al. A qualitative analysis of factors influencing healthcare providers' behaviour toward persons living with HIV in Ghana. *Int J Afr Nurs Sci.* 2023;18:100532. doi:10.1016/j.ijans.2023.100532.
28. Beauchamp G, Donnell D, Hosek S, Anderson PL, Chan KC, Dye BJ et al. Trust in the provider and accurate self-reported prep adherence among adolescent girls and young women in South Africa and Zimbabwe: HPTN 082 study. *BMC Womens Health.* 2023;23:276. doi:10.1186/s12905-023-02418-9.
29. Ending AIDS in west Africa (#EAWA). Bringing people living with HIV back to care. Durham (NC): FHI 360; 2021 (<https://www.fhi360.org/wp-content/uploads/drupal/documents/eawa-brief-back-care.pdf>, accessed 13 June 2024).
30. Kapus V. Lessons learned from an HIV continuity-of-treatment surge initiative during COVID-19 in Papua New Guinea. 12th IAS Conference on HIV Science, Brisbane, Australia; 23–26 July 2023 (<https://programme.ias2023.org/Abstract/Abstract/?abstractid=2198>, accessed 13 June 2024).
31. Providing care to people with advanced HIV disease who are seriously ill: policy brief. Geneva: World Health Organization; 2023 (<https://iris.who.int/handle/10665/366628>, accessed 13 June 2024).
32. Identifying common opportunistic infections among people with advanced HIV disease: policy brief. Geneva: World Health Organization; 2023 (<https://iris.who.int/handle/10665/375725>, accessed 13 June 2024).
33. Norwood K. Time matters: leveraging longitudinal, person-centred data to understanding interruptions and re-engagement in HIV treatment in Malawi from January 2020 to September 2023. 25th International AIDS Conference, Munich, Germany, 22–26 July 2024.
34. Rees K, Davies N, Motsoane N, Grimsrud A, Wilkinson L, Mutyambizi C. Heterogeneity among people re-engaging in antiretroviral therapy highlights the need for a differentiated approach: results from a cohort study in Johannesburg, South Africa. 12th IAS Conference on HIV Science, Brisbane, Australia; 23–26 July 2023 (<https://programme.ias2023.org/Abstract/Abstract/?abstractid=3019>).
35. Operational and service delivery manual for the prevention, care and treatment of HIV in Zimbabwe. Harare: AIDS & TB Programme, Ministry of Health and Child Care, Zimbabwe; 2022 (<https://www.differentiatedservicedelivery.org/wp-content/uploads/MSF-Zim-OSDM-Nov2022-WEB2.pdf>, accessed 13 June 2024).
36. Differentiated models of care: standard operating procedures. Adherence guidelines for HIV, TB and NCDs. Minimum package of interventions to support linkage to care, adherence and retention in care. Pretoria: National Department of Health, Republic of South Africa; 2023 (https://www.differentiatedservicedelivery.org/wp-content/uploads/WEB-VERSION_South-African-National-Differentiated-Models-of-Care-SOPs-2023_FINAL07062023.pdf, accessed 13 June 2024).
37. Guião orientador sobre modelos diferenciados de serviços para o HIV/SIDA em Moçambique. [Guidance on differentiated service models for HIV/AIDS in Mozambique.] Maputo: Mozambique Ministry of Health; 2023 (<https://www.differentiatedservicedelivery.org/wp-content/uploads/Mozambique-MOH-differentiated-service-delivery-Manual-WEB.pdf>, accessed 13 June 2024).
38. Grimsrud A, Walker D, Ameyan W, Brusamento S. Providing differentiated delivery to children and adolescents. Geneva: World Health Organization; 2019 (<https://iris.who.int/handle/10665/327143>, accessed 13 June 2024).
39. Adolescent friendly health services for adolescents living with HIV: from theory to practice. December 2019 technical brief. Geneva: World Health Organization; 2019 (<https://iris.who.int/handle/10665/329993>, accessed 13 June 2024).
40. Improving HIV service delivery for infants, children and adolescents: a framework for country programming. New York: UNICEF; 2020 (<https://www.childrenandaids.org/sites/default/files/2020-08/Service%20Whitepaper%20WEB%20v2.pdf>, accessed 13 June 2024).
41. Wilkinson L, Siberry GK, Golin R, Phelps BR, Wolf HT, Modi S et al. Children and their families are entitled to the benefits of differentiated ART delivery. *J Int AIDS Soc.* 2020;23:e25482. doi: 10.1002/jia2.25482.
42. Consolidated guideline on sexual and reproductive health and rights of women living with HIV. Geneva: World Health Organization, 2017 (<https://iris.who.int/handle/10665/254885>, accessed 13 June 2024).
43. Addressing violence against women in pre-service health training: integrating content from the Caring for women subjected to violence curriculum. Geneva: World Health Organization; 2022 (<https://iris.who.int/handle/10665/366517>, accessed 13 June 2024).
44. UNICEF, UNAIDS, WHO. Key considerations for programming and prioritization. Going the 'last mile' to EMTCT: a road map for ending the HIV epidemic in children. New York: UNICEF; 2020 (<https://library.unaids.org/wp-content/uploads/2020/08/1-EMTCT-Whitepaper-EN-WEB-hi-res.pdf>, accessed 13 June 2024).
45. Kankasa C, Mennecier A, Sakana BLD, Molès JP, Mwiya M, Chunda-Liyoka C et al. Optimised prevention of postnatal HIV transmission in Zambia and Burkina Faso (PROMISE-EPI): a phase 3, open-label, randomised controlled trial. *Lancet.* 2024;403:1362–71. doi: 10.1016/S0140-6736(23)02464-9.
46. Zerbe A, Brittain K, Phillips TK, Iyun VO, Allerton J, Nofemela A et al. Community-based adherence clubs for postpartum women on antiretroviral therapy (ART) in Cape Town, South Africa: a pilot study. *BMC Health Serv Res.* 2020;20:621. doi: 10.1186/s12913-020-05470-5.
47. Integrating psychosocial interventions and support into HIV services for adolescents and young adults: technical brief. Geneva: World Health Organization; 2023 (<https://iris.who.int/handle/10665/369133>, accessed 13 June 2024).
48. Consolidated guidelines on HIV, viral hepatitis and STI prevention, diagnosis, treatment and care for key populations. Geneva: World Health Organization; 2022 (<https://iris.who.int/handle/10665/360601>, accessed 13 June 2024).
49. Male engagement in HIV testing, treatment and prevention in eastern and southern Africa: a framework for action. Geneva: UNAIDS; 2022 (https://www.unaids.org/sites/default/files/media_asset/east-south-africa-engaging-men_en.pdf, accessed 13 June 2024).
50. World report on the health of refugees and migrants. Geneva: World Health Organization; 2022 (<https://iris.who.int/handle/10665/360404>, accessed 13 June 2024).
51. The Lancet Healthy Longevity. Ageing with HIV. *Lancet Healthy Longev.* 2022;3:e119. doi: 10.1016/S2666-7568(22)00041-1.

**Supporting re-engagement in HIV
treatment services: policy brief**

ISBN 978-92-4-009733-9 (electronic version)

ISBN 978-92-4-009734-6 (print version)

© World Health Organization 2024.

Some rights reserved.

**This work is available under the
CC BY-NC-SA 3.0 IGO licence.**

