What to ask for in COP23 to improve ART continuity Retention

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In COP21, retention and adherence were replaced by ‘continuity of treatment’ and ‘interruption in treatment’ to emphasize the therapeutic alliance that is important for successful treatment of all people living with HIV.
Interventions across the cascade…
The goal of treatment for all people living with HIV is durable viral suppression, which reduces morbidity and mortality and prevents HIV transmission. Continuity of treatment is critical to maintaining health and achieving epidemic control."
But the cascade is not linear
What's NEW?

IMPORTANT
When a person engages with HIV services, they are supported to be successful whether trying to achieve and maintain viral suppression or aiming to stay HIV free. This care continuum is sometimes described as status-neutral care.
An example of universal test-and-connect (status neutral) approach to HIV services with linkage to PrEP
**IAS**

**What’s new**
Section 6.1 Linkage to ART, early engagement, and treatment literacy

<table>
<thead>
<tr>
<th>Section Number</th>
<th>Section Title</th>
<th>Edit Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1.1</td>
<td>Linkage to ART, Early Engagement, and Treatment</td>
<td>Section updated to identify that longitudinal patient centered data is preferred.</td>
</tr>
<tr>
<td></td>
<td>Literacy</td>
<td></td>
</tr>
<tr>
<td>6.1.2.1</td>
<td>Differentiated Service Delivery for Children</td>
<td>Wording was updated to align with policy that all children irrespective of age should be eligible for multi-month dispensing (MMD) of ART.</td>
</tr>
<tr>
<td>6.1.3.2</td>
<td>Interruptions and Re-engagement in Treatment</td>
<td>Updated to include recommendations for clinical management of individuals returning to care and the use of longitudinal data for understanding interruptions.</td>
</tr>
</tbody>
</table>
1 Linkage to ART, early engagement, and treatment literacy (1 of 2)

- Availability of immediate ART (offered as a multi-month starter pack)
  - WHO evidence-based recommendation includes immediate ART following assessment for contraindications
- Escorted linkage and navigation from a peer
- Friendly clinic services
- Access to in person counselling and remote psychosocial support
- An accountable staff member responsible for linkage and early engagement
- Emphasis on family approach (to linkage and early treatment)
1 Linkage to ART, early engagement, and treatment literacy (2 of 2)

○ Same day – same place – same provider

○ The importance of a coordinated linkage and entry into treatment to reduce early interruptions for people newly diagnosed with HIV

○ Defining HIV treatment literacy to support policy progress and utilize data collected by community-led monitoring (CLM) to empower people and communities to drive long-term epidemic control
  ○ MISSED OPPORTUNITY - Programmes only address differentiated service delivery (DSD) when a person is being evaluated for access rather than when a client is making decisions about ART initiation and short term retention (first 3 months).
2 Sustained treatment
Core package to durable and effective treatment

- Scale-up of fixed-dose combination of TLD for all those eligible
- Treatment literacy (including the science behind U=U)
  - MISSED OPPORTUNITY - Programmes only address DSD when a person is being evaluated for access
- DSD models adapted to needs
- Multi-month dispensing (MMD) and decentralized drug distribution (DDD)
- Person-centered services, using feedback from community-led monitoring (CLM)
- Elimination of formal and informal user fees
"The foundation to empowering people in their treatment journey is treatment literacy. Providers should describe new treatment paradigms using hopeful language that includes benefits of viral suppression (including the science of U=U) achieved by consistently taking ARVs."
DSD for HIV treatment models

- Multi-month dispensing is an enabler
- Clinical consultations can be considered separately to ART refills and psychosocial support

**GROUP MODELS**
- Teen clubs
  - Facilitated by a healthcare worker – lay provider or clinical
- Family ART groups
  - Managed by the people living with HIV in the
- Health worker-managed groups
- Client-managed groups

**INDIVIDUAL MODELS**
- Adolescent corners
- Outreach or youth center pick up points
- Facility-based individual
- Out-of-facility, community, individual
Evidence for DSD for HIV treatment

• There is strong evidence for all four models
• For diverse populations, across multiple settings
Multi-month dispensing (MMD) and decentralized drug delivery (DDD)

“MMD is an important part of differentiated service delivery but should not be equated with differentiated service delivery. The critical intervention is separation of drug delivery from clinical care.”
Multi-month dispensing (MMD) and decentralized drug delivery (DDD) (1)

○ **Six-month** dispensing is preferred
  ○ There may be circumstances where three-month dispensing is necessary

○ Requirements (a minimum time on ART, documented suppressed viral load) are barriers to the successful scale-up

○ At a minimum, most clients (adults, children, adolescents/youth, pregnant and breastfeeding women, members of key populations, and foreign nationals) should be offered prescriptions for six months of ART
Multi-month dispensing (MMD) and decentralized drug delivery (DDD) (2)

- Individuals newly on ART and those re-engaging in treatment should be offered MMD
  - All new clients should be given a minimum of 3 months’ worth of drug supply even if a follow-up visit is needed in less than 3 months

- For children initiating and refilling ART, every effort should be made to supply them with a 3-month supply of ARVs for children 2-5 years old and a 6-month supply for children age 5+ years.

- Countries should continue to scale up programs for 6-month MMD for adults and a minimum of 3-month MMD for children.
6.1.2.1 Differentiated service delivery for children

- “All children irrespective of age should be eligible for multi-month dispensing (MMD) of ART”

- “Programs should make every effort to supply all CLHIV 2 years and older with a 3-month supply (3MMD) at initiation of treatment. Children 5 years of age and older who are already on treatment should be supplied with a 6-month supply.”

- “ART refills can be delinked from clinical consultation visits, provided outside of health facilities, and managed by trained lay providers”
Accelerated uptake of MMD across PEPFAR±

By Q4 2021, 36% of PEPFAR ART clients on 6MMD (4.6M)

By Q4 2021, 44% of PEPFAR ART clients on 3-5MMD (5.7M)

From Oct 2019-Dec 2021, the proportion of ART clients receiving MMD increased from 49% to 80% (>10M)

± Excludes South Africa
From Bailey L, AIDS 2022 DSD pre-conference
Including MMD for children and adolescents±

By Q4 2021, 13% of ART clients <15 were on 6MMD (68,000)

By Q4 2021, 47% of ART clients <15 were on 3-5MMD (252,000)

From Oct 2019-Dec 2021, the proportion of ART clients <15 receiving MMD increased from 27% to 60% (320,000+)

± Excludes South Africa
From Bailey L, AIDS 2022 DSD pre-conference
Key considerations for MMD

○ Create demand by counselling clients
○ Involve community health workers, patient navigators, lay workers to support clients with in-person or virtual engagement between ART refills
○ Promote family-centered approaches synchronizing MMD schedules
○ Where possible – integrate other medicines into MMD of ART including TPT, TB treatment, family planning and non-communicable disease medicines
How does community-led monitoring data relate to retention?
How satisfied are you with the external pick-up point that you use?

From 2,799 recipients of care surveyed, 91% were satisfied or very satisfied (Oct-Dec 2022)

Source: Patient survey
Would people living with HIV like to collect ARVs closer to home?

From 12,093 recipients of care surveyed, the majority said yes – with 40% wanting collection closer to home and 42% having this already (Oct-Dec 2022)
3. Re-engagement (6.1.3.2)

“Clinical management of individuals who have been out of care differs between those who re-engage quickly and those who have been out of care for some time. Individuals who re-engage after being out of care for one year or more require an evaluation for advanced HIV disease with a measurement of CD4 as part of that initiation evaluation. Individuals re-engaging after 3-6 months should be offered DSD models including MMD, based on clinical considerations and country policies.”
Re-engagement in Johannesburg

There are more clients returning to treatment (including restarts) than initiating treatment for the first time.

*Data source: NDOH report for the City of Johannesburg*
Returns vs restarts

- Restarts ≥ 90 days late
- Returns <90 days late

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
Key principles for returning patients
How many days late is not re-engagement/needs no special attention?

Differentiation is critical – move away from a one size all approach to returning patients.
Key considerations for differentiation on re-engagement
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 models

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 already on TLD or needs to be switched/transitioned
CD4 declines rapidly when stopping ART

Approx. 200-250 cells/mm³ by 12 weeks


Re-engagement

- Very important in 2023 in the HIV response
- More guidance is needed – globally, nationally and for implementers
- What is late vs. re-engagement
- Consider duration not on ART and clinical factors
- PEPFAR guidance that waiting until 12-months off treatment to be assessed with CD4 for advanced HIV disease is too long considering how rapidly CD declines
- Let’s talk more about this
Treatment interruption

“It is now recognized that individuals sometimes disengage from care and later reengage, often cycling in and out of care. Measures of TX_ML and TX_RTT show that disengagement and engagement occurs for a significant proportion of clients. For example, in the final quarter of 2020, 1.1 million clients disengaged or reengaged in care. Planning for and normalizing this phenomenon is a harm-reduction activity.”
Zimbabwe

Updated policy to include algorithm for re-engagement
MER indicators related to continuity of treatment ("retention")

- TX_CURR
  - Disaggregated by ARV dispensing quantity
- Retention*
  - *Proxy indicator calculated from TX_NEW & TX_CURR
- TX_NEW
- TX_NET_NEW
- TX_ML (treatment interruption)
  - Disaggregated by recently initiation on ART (<3 months), established on ART (3+ months)
- TX_RTT
- TX_IIT
In summary

- PEPFAR guidance is strong on continuity of treatment
  - Client agency and therapeutic alliance

- Question is more around resourcing and ensuring investment in strategies that are client-centered
“The primary responsibility for linkage to HIV treatment rests with the testing partner regardless of where the testing was done.”
What should countries consider demanding to support and improve continuity of treatment?
10-point retention checklist

**What to ask for (1)**

1. Resourcing for quality community, rapid, treatment initiation
2. *Treatment literacy on DSD in early treatment (first 3 months)*
3. *Targets that include i) % any DSD), ii) % MMD, iii) % with a group model and iv) % with an community-based/DDD model*
4. *Targets for DSD coverage to be shared and discussed with civil society, and community-led monitoring (CLM) data used in setting and monitoring targets*
5. *Strengthened supply chain to ensure scale-up of extended ART refills and decentralized drug distribution/community-based models of ART delivery*
6. Recognition of peers/lay workers as DSD providers (funding and sustainability plan)
7. Access to DSD for all populations – particularly for children and adolescents
8. Consideration of annual clinical consultations
9. Integration of MMD of ART with other commodities – family planning and NCDs
10. Development and implementation of re-engagement algorithms, including accelerated access to DSD for those who re-engage and assessing advanced HIV disease in those with longer interruptions
What to ask for across the cascade...

1. Resourcing for quality community, rapid, treatment initiation
2. Treatment literacy on DSD in early treatment (first 3 months)
3. Targets that include i) % any DSD, ii) % MMD, iii) % with a group model and iv) % with an community-based/DDD model
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Differentiated service delivery for HIV treatment
Online course

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www.differentiatedservicedelivery.org
ADVOCACY TO ENSURE U=U PRIORITIZATION IN PEPFAR COP/ROP 2023

MARTINE KABUGUBUGU
PREVENTION ACCESS CAMPAIGN, U=U
26 JANUARY 2023
What is HIV global situation?

At end 2021:

**Situation of the 95-95-95 global goals:**
Of all people living with HIV:
- 85% knew their status,
- 75% were accessing treatment and,
- 68% were virally suppressed.

1.5 million people became newly infected with HIV while the 2020 UNAIDS goal is to bring new infections down to 370,000 by 2025

*Conclusion = HIV/AIDS remains an important global health threat*

**Investments:**
- US$ 21.4 billion was available for the AIDS response against US$ 29 billion required
- U.S.A. is the largest contributor through PEPFAR programs *(nearly $1 billion annually)* and through Global Funds to fight against HIV, TB and Malaria *(USA is the largest contributor with $6 billions for current 3 years cycle)*

*Conclusion = It’s important to engage with PEPFAR to end HIV/AIDS by 2030*
U=U is a PEPFAR MPR

- PEPFAR supports countries to make good on global HIV commitments and achieve sustained epidemic control. To do so, PEPFAR has issued 16 minimum program requirements (MPR) for all PEPFAR-funded countries. U=U is one MPR and Prevention Access Campaign (PAC) is recognized by PEPFAR as the leading global organization for U=U.

- Undetectable equals Untransmittable (U=U) initiatives are internationally recognized by partners such as PEPFAR and the U.S. Administration as critical facilitators to achieve the UNAIDS 95-95-95 HIV treatment targets, the 2030 Sustainable Development Goals, and a minimum program requirement to effectively and efficiently meet PEPFAR’s goal of sustained country-level epidemic control.
- The outcomes of U=U improve the health, well-being and quality of life of people living with HIV (PLHIV), drive down rates of new HIV transmissions, reduce stigma, decrease health care costs, and lead to a healthier society, which contributes to increased economic growth.
Key Takeaways

• *Early initiation and continued use of antiretroviral therapy (ART)* have been shown to improve health and lower the risk of death for people living with HIV (PLHIV).

• *Quality of Life; U=U improves mental, sexual, and reproductive health*, providing PLHIV and their partners with choices previously thought impossible.

• *U=U is a powerful advocacy tool to reduce stigma*, increase demand for HIV testing, and remove barriers to quality care for PLHIV.

• *U=U leads to lower death rates, longer lives*, and decreased healthcare utilization, all of which have positive economic implications, particularly for the lowest-income individuals, communities, and countries.
Why U=U in the fight against HIV/AIDS?

- **U=U** is a gamechanger to reach the HIV epidemic control.
- **U=U** is a community-led, human-centered, cost-effective individual *and* public health strategy.
- Increasing access to treatment, including addressing various treatment continuity obstacles, removing social and cultural barriers to prevention, treatment & care access, leads to **U=U**.
- With **U=U**, not only we save lives of people living with HIV, but also, we prevent new transmissions, reduce health care costs and burden, contribute to economic growth, and accelerate progress toward ending the epidemic.
What Does PEPFAR Guidance Say About U=U

- Promote undetectable=untransmissible U=U messages, training for healthcare providers, violence response mechanisms, and other interventions
- Evidence of treatment literacy and viral load literacy activities supported by MoH, NAC, and other partner country leadership
- Providers should describe new treatment paradigms using hopeful language that includes the benefits of viral suppression (including the science of U=U) achieved by consistently taking ARVs
- Treatment literacy efforts should include education of healthcare workers on the benefits of treatment to prevent onward transmission (U=U), national HIV treatment guidelines or algorithms, explaining the importance of VL and management of high VL results
COP/ROP Process PEPFAR Tools?

- Know PEPFAR Five-years New Strategy (launched Dec 2022): focusing on 5 strategic pillars and relying on 3 enablers.

- Consult PEPFAR 2023 COP/COR Guidance: a useful resource to support country teams on how to develop their country plans aligning with PEPFAR Strategy.

- Set your country priorities using PEPFAR FY24 Technical Considerations: it provides detailed winning strategies & approaches for U=U along with prevention, treatment, and care across all populations.

- Country Planned Allocation & Strategic Direction Letter.
HOW TO ENGAGE IN COP PROCESS?
Through Continuity of treatment for all PLHIV

- **Early linkage to ART & treatment literacy** considering easy access, client-tailored process, and adherence achievement.
- **Differentiated service delivery with person-centered approaches** led by a positive (no stigma) alliance between people, health care provider and health care system.
- Ensure **continuity of treatment** through different approaches such as: multi-month ART dispensation, decentralized drug delivery services, treatment monitoring through PEER leadership, ...

Continuity of treatment leads to PLHIV who are U=U. No new infection = win-win agenda. **U=U messages:**

- Link to treatment ART for new HIV+ case
- Easy and quality access to health care
- Zero ART stock-out
- Treatment monitoring through communities
- Demand creation for U=U and treatment literacy
HOW TO ENGAGE IN COP PROCESS?
Through Primary Prevention & HIV Testing Strategies

The goal of primary prevention is to develop systems which allow to consistently find and engage individuals most vulnerable to acquiring and transmitting HIV.

- Array a **variety of prevention options** allowing people to make their choice; such as PEP, PrEP, condoms, lubricants, and U=U, …
- **HIV and risk reduction education** through different approaches such as SRH services for AGYW, DREAMS programs for youth, PEER education activities for KP, male circumcision, PMTCT for women and pregnant women,…

**Differentiated HIV testing strategies** seek to achieve and maintain HIV epidemic control, requiring a strategic combination of HIV testing approaches for all populations, ages and sex, to accelerate achievements: self-testing, index testing or other community-based strategies for case funding.

Your in-country U=U message should request:

- Introduction of differentiated prevention delivery models tailored to client and context (*PrEP, peer leadership, various testing modalities, RHS program for AGYW, condoms and lubricants*)
- Introduction of activities to lift stigma, discrimination, criminalization and other social/cultural barriers blocking access to treatment
HOW TO ENGAGE IN COP PROCESS?
Through Optimized HIV Care & treatment for Viral Load suppression

• Successful antiretroviral therapy reduces or eliminates HIV-related morbidity & mortality at all stages of HIV infection; eliminates sexual transmission and dramatically reduces vertical transmission.

Your in-country U=U messages should claim for:

➔ Easy and regular access to viral load monitoring
➔ Get your viral load suppressed
➔ Train healthcare workers on U=U (PEPFAR recommendation)
2021 Situation in ESWATINI

ESWATINI nationwide surveys demonstrate they were able cutting new infections by half in just 5 years (2011-2016), achieving a phenomenal impact at the end of 2021, which surpasses UNAIDS targets.

How? Through decentralization of HIV services, increased access to testing, increased linkages to prevention, treatment and care as well as ensuring adherence; all these with community-led approaches.

U=U can be a reality
WITH WHOM TO ENGAGE?

ALL stakeholders are called to work together to achieve the 95-95-95 global goals:

“95% of all people living with HIV know their HIV status, 95% of all people with diagnosed HIV infection receive sustained antiretroviral therapy, and 95% of all people receiving antiretroviral therapy have viral suppression by 2025”.

- **healthcare providers / professionals**: to ensure person-centered prevention, treatment and monitoring services
- **Governments and decision makers**: to promote accessible health care systems and break all access barriers
- **Civil Society Organizations and Activists**: contribute with community-led HIV response approaches along the 3 cascades for reaching U-U
- **Faith-based organizations and other community leaders**: promote U=U education, advocacy and communication to eliminate HIV related fear
- **PLHIV**: advocate for greater involvement at all levels: planning, implementation, monitoring and in key decision-making spaces
PREVENTION ACCESS CAMPAIGN

U = U is:

- a WIN for PLHIV
- A WIN for the Society (family, partners, population, work environment,...)
- A WIN for the Funder
- A WIN for Country’s economy
- A WIN for Science
Examples of PAC U=U messaging

Some key U=U messages as per country context:

- Promote differentiated approaches tailored to client at all stages
- Immediate link to treatment ART for new HIV+ case
- Zero ART stock-out
- Easy and quality access to health care
- Proximity retention monitoring through communities
- Easy and regular access to viral load monitoring
- Get your viral load suppressed

Link to PAC Win-Win Campaign graphics:
https://drive.google.com/drive/folders/13c1SHe-HavVaUZ7zi0S1yGofP3oxIvk?usp=share_link
Contact PAC for more resources

If you need more information or would like further guidance as you advocate for U=U, please contact PAC

For more resources about U=U please visit our website:
https://preventionaccess.org/resources/