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Supporting Continuity of ART for PLHIV: Successes and Lessons Learned

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29 September, 2021

Objectives

1. Understand current trends and metrics related to continuity of treatment (CoT) used by PEPFAR treatment programs
2. Describe common gaps and challenges to ensure CoT for PLHIV and strategies to address and mitigate interruptions in treatment (IIT)
3. Describe action steps that can be applicable to improve CoT and reduce IIT in PEPFAR/USAID treatment programs

Reminder:

Enter your questions for the speaker into the **Q and A** box

Agenda

- Welcome and introductions
- Overview of continuity of treatment in PEPFAR/USAID treatment programs (Lana Lee)
- SI Overview of Continuity of Treatment in PEPFAR (Cody Adelson)
- Program Spotlight #1 : Dr. Katie Simon, Medical Director, Tingathe - Client-Oriented Response for HIV Epidemic Control (CORE)
- Program Spotlight #2: Dr. Godwin Emmanuel, Chief of Party, KP-CARE-1, Heartland Alliance Nigeria
- MMD/DSM Impact on Continuity of Treatment (Lauren Bailey)
- Panel Discussion / Q&A
- Closing

— Overview of Continuity of Treatment in PEPFAR/USAID Treatment Programs

Lana Lee, MD
Medical Officer, Adult Clinical
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USAID, Office of HIV/AIDS



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FROM THE AMERICAN PEOPLE

Poll Question #1:

In your treatment programs, how frequently is the issue of continuity of treatment (aka retention) discussed or addressed in your program?

- A. I rarely have a need to address issues or challenges related to treatment continuity in my program; this is not a priority for my program
- B. I sometimes have a need to address issues or challenges related to treatment continuity in my program;
- C. I have to address issues or challenges related to treatment continuity nearly every day

Your responses are anonymous.

PEPFAR's Number 1 Treatment Priority: Supporting Clients by Facilitating Continuous ART

- MER 2.5
 - Continuity of Treatment (COT): Replaces “Retention”
 - Interruptions in Treatment (IIT): Replaces “Loss to Follow-up”
- COP21 Guidance (p. 174):
 - Continuity of care requires therapeutic alliance between client, HCP, health care system
 - “Retention” and “Adherence” replaced by “continuity of treatment and “interruptions in treatment” to emphasize the therapeutic alliance that is important for successful treatment of all PLHIV



PLHIV Experiences on ART Evolve Throughout the Treatment Journey: A Cyclical Clinical Cascade?

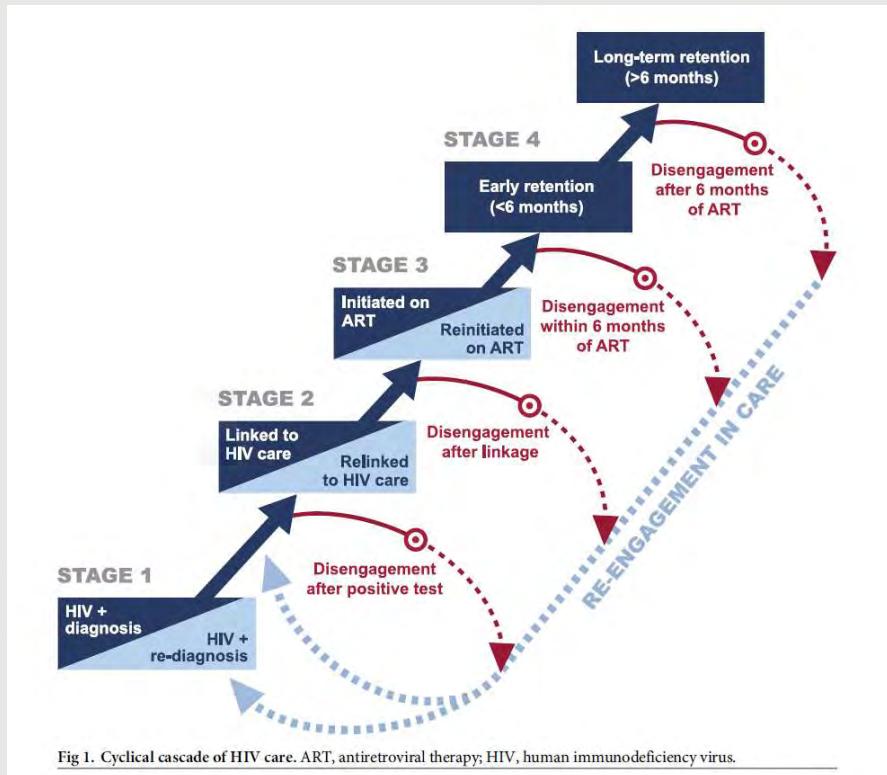
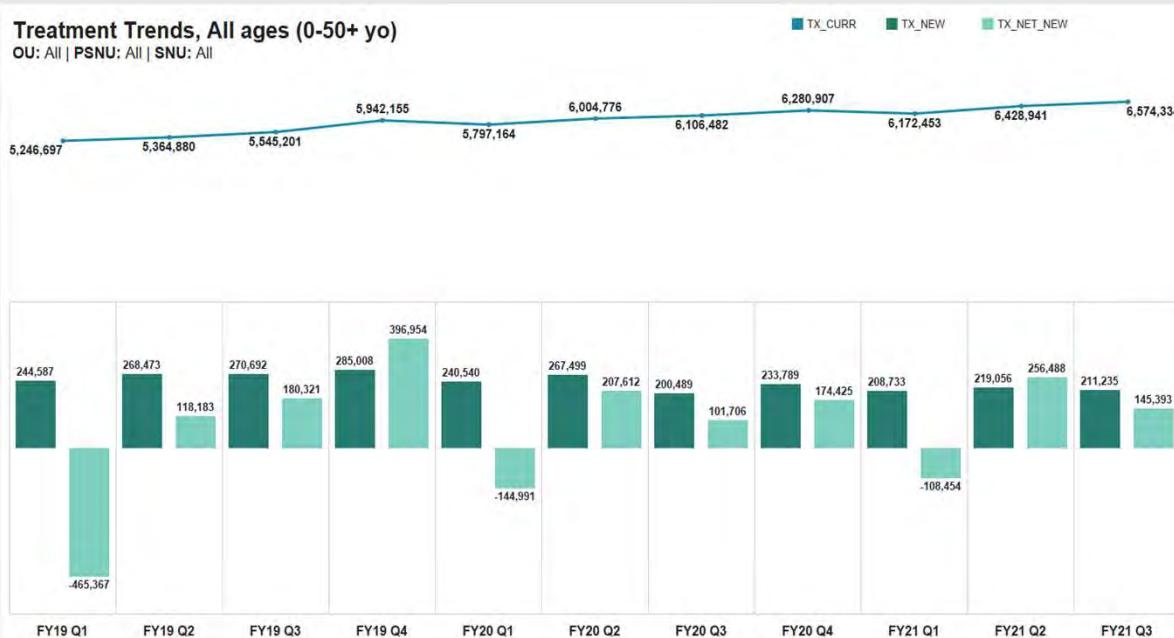


Fig 1. Cyclical cascade of HIV care. ART, antiretroviral therapy; HIV, human immunodeficiency virus.

- Many clients experience disengagement from HIV treatment
- Disengagement and re-engagement may occur along several points from diagnosis and before achieving long-term continuous engagement and adherence to treatment
- Understanding disengagement-reengagement cycles are critical to ensuring PEPFAR-supported programs remain responsive to PLHIV needs

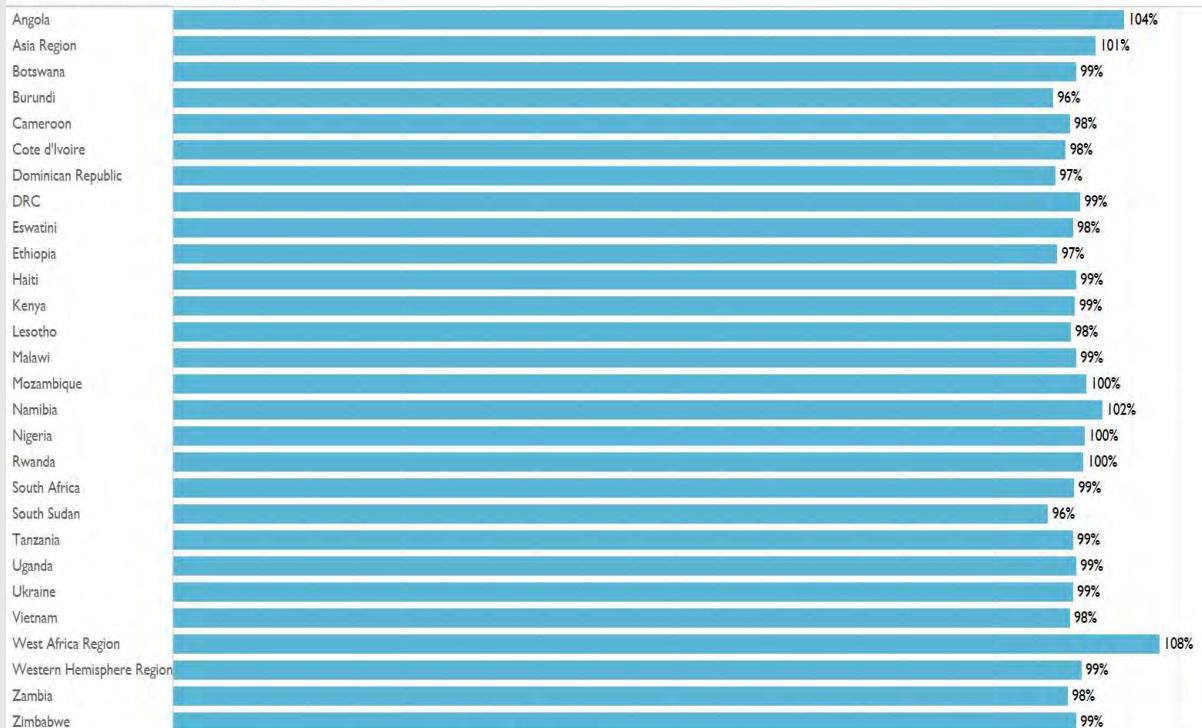
Overall Treatment Program Growth Trends are Important Performance Measures, but May Not Tell Entire Story



- TX_CURR trends generally show steady growth over many years for most OUs
- TX_NEW often exceeds TX_NET_NEW, suggesting evidence of PLHIV experiencing disruptions
- TX_NET_NEW has limitations, especially when examining trends over time, as it does not account for program shifts such as closing or start-up of projects, geographic shifts, aging in/out of age bands

Most PEPFAR Country Programs Demonstrate High Continuity of Treatment Proxies

Continuity of Treatment Proxy by Operating Unit

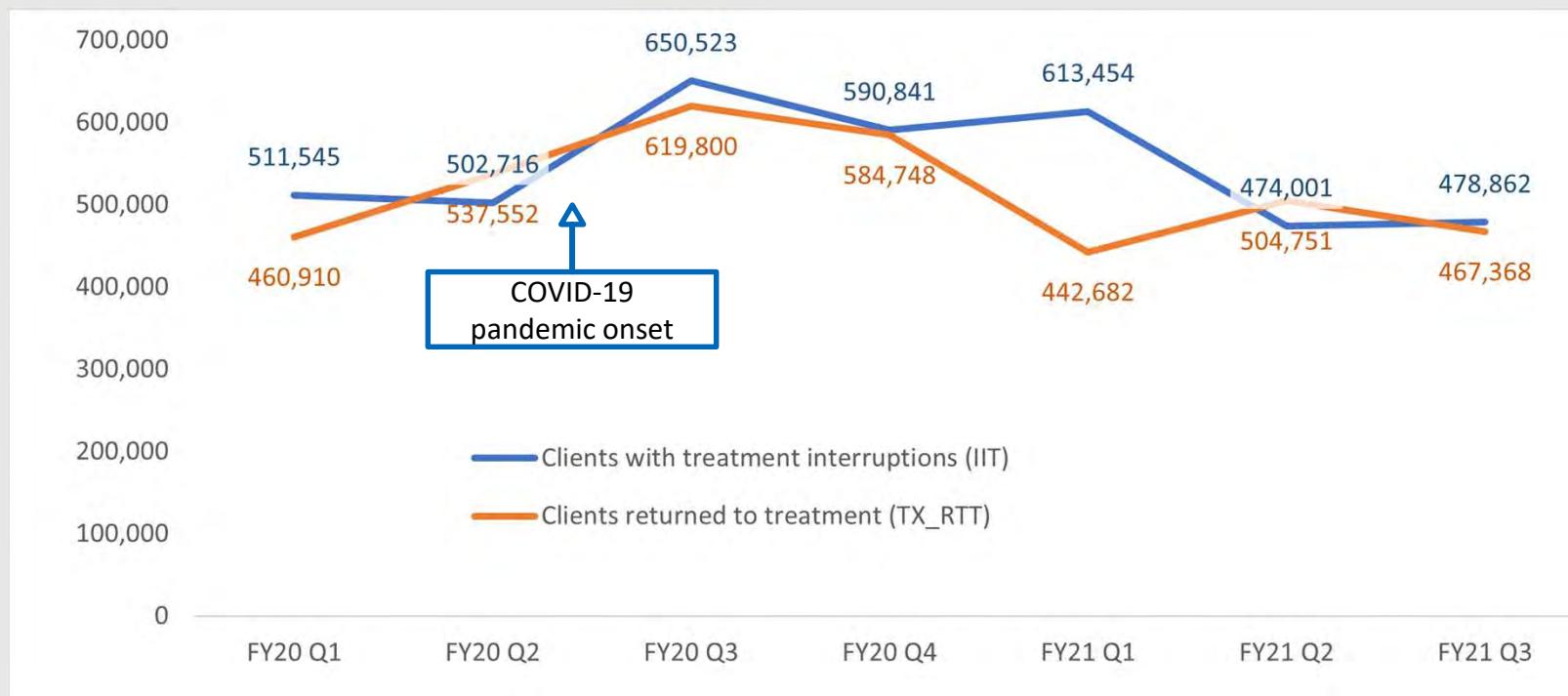


Metric: TX_CURR/(TX_CURR_1 qtr previous+TX_NEW) | Period: FY21 Q3 | Agency: All | Partner/IM: All | Sort: TX_CURR value

Source: Treatment Workbook, MSD FY21 Q3 2.i Hyperfile.2021.09.26, Last Update: 9/27/2021 12:55:40 PM

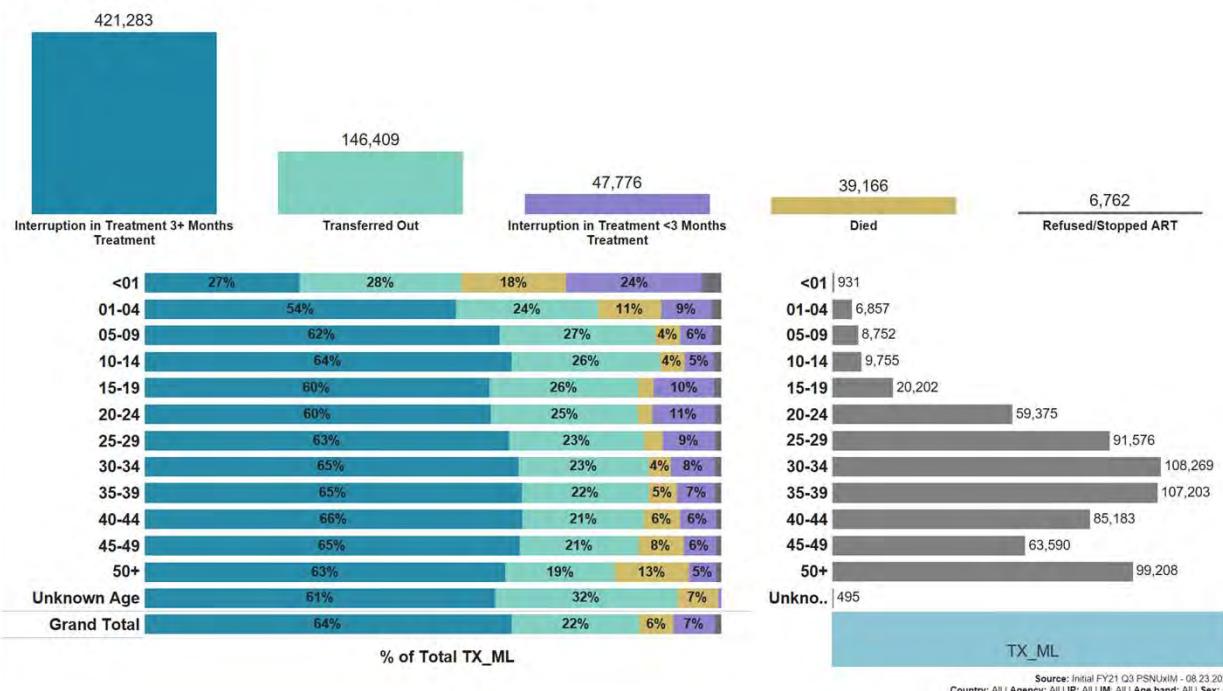
- PEPFAR benchmark for CoT is 98% or higher
- Despite high CoT, TX_CURR does not always keep pace with expected growth
- TX_ML and TX_RTT may help paint a more dynamic picture of the treatment cohort in PEPFAR programs

Many PLHIV on ART in PEPFAR Programs Experience Treatment Interruptions or Return to Care: Churn is Common



Several Reasons for No Clinical Contact within a Quarter: Interruptions in Treatment (IIT) is the Predominant Cause

FY21 Q3 TX_ML Totals & Proportions, No Contact Outcome
OU: All | PSNU: All | SNU: All

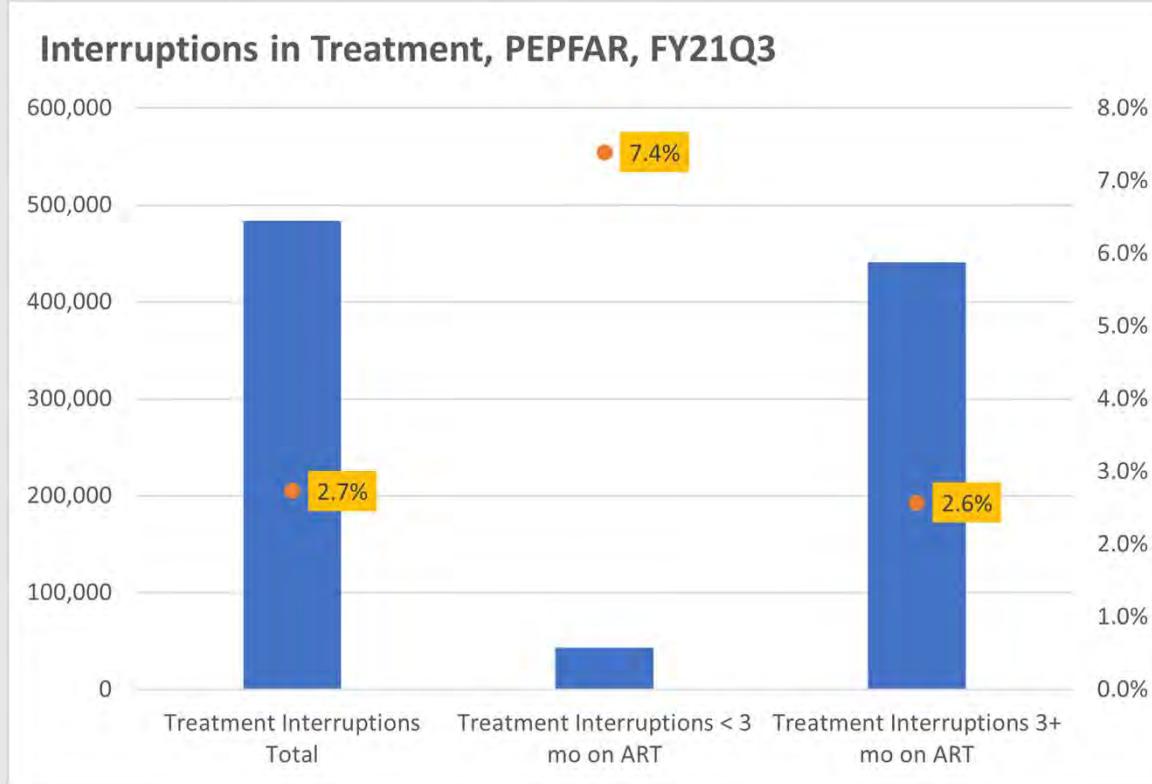


- Reported through TX_ML indicator
- Across all ages, IIT is the predominant cause for losses in PEPFAR
- Data quality for IIT evolving; however TX_ML_IIT provides additional data to understand gaps and challenges that may hinder treatment growth and continuity
- Not a cohort monitoring indicator; cannot aggregate over time

Poll Question #2: Is your program using TX_ML data?

- A. Yes! It is our primary metric for retention (continuity of treatment)
- B. Somewhat - we use a mixture of the retention proxy and TX_ML
- C. Very little or not at all - we use the retention proxy or other data to assess continuity of treatment

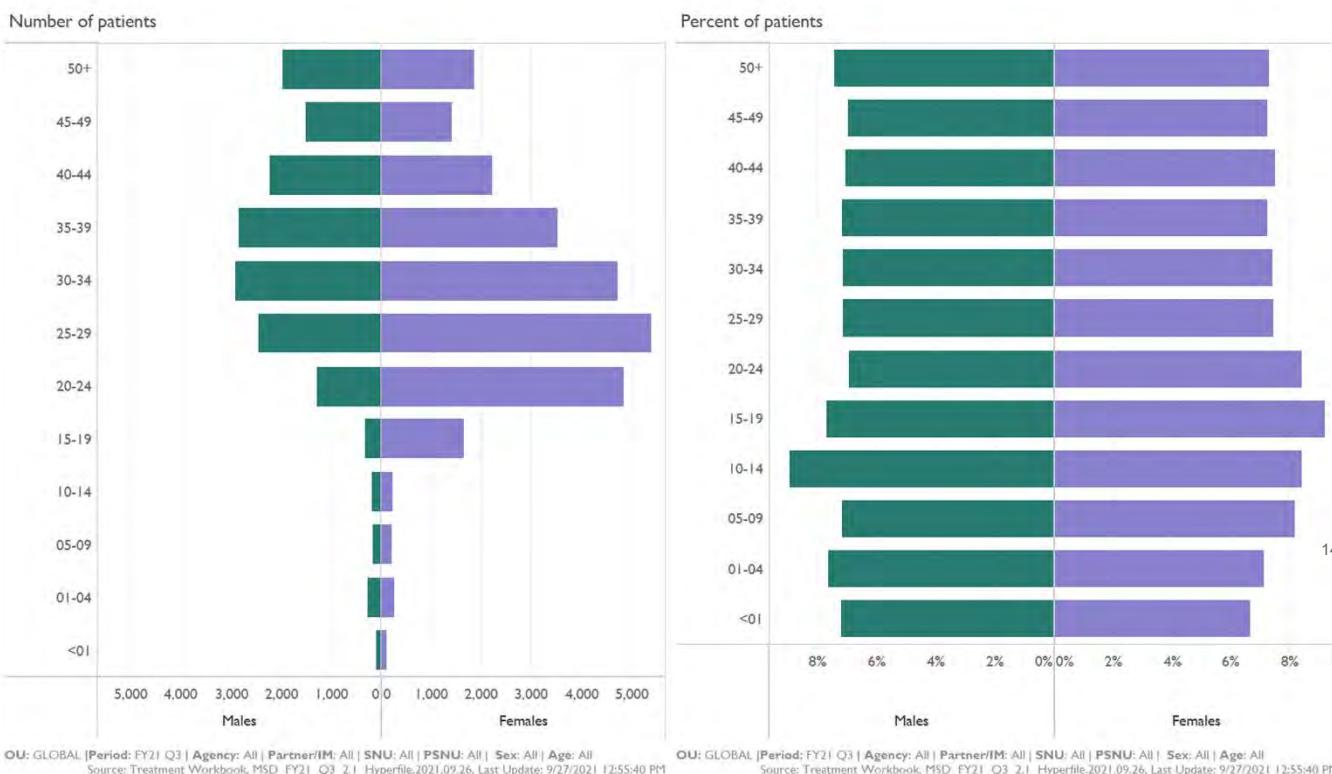
Risk of Treatment Interruptions Nearly 3 Times Greater for New Clients on ART



- Absolute number of IIT is greatest among PLHIV on ART for 3 months or more
- However, PLHIV new on ART experience IIT nearly 3 times more
- Highlights need for durable linkage and treatment engagement early in client's treatment journey
- MMD for those new on ART may mask early IIT and may be insufficient to prevent IIT; assess need for additional support

New Clients Regardless of Age/Sex Experience High IIT Rates

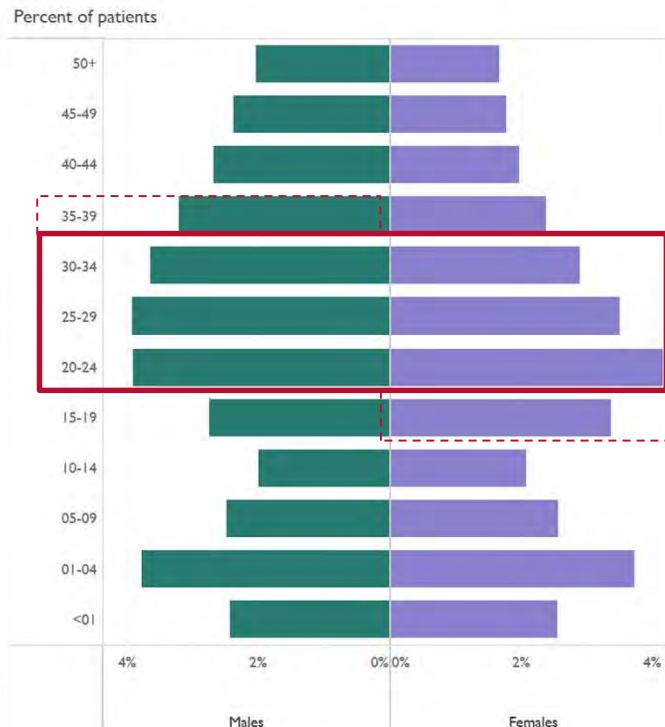
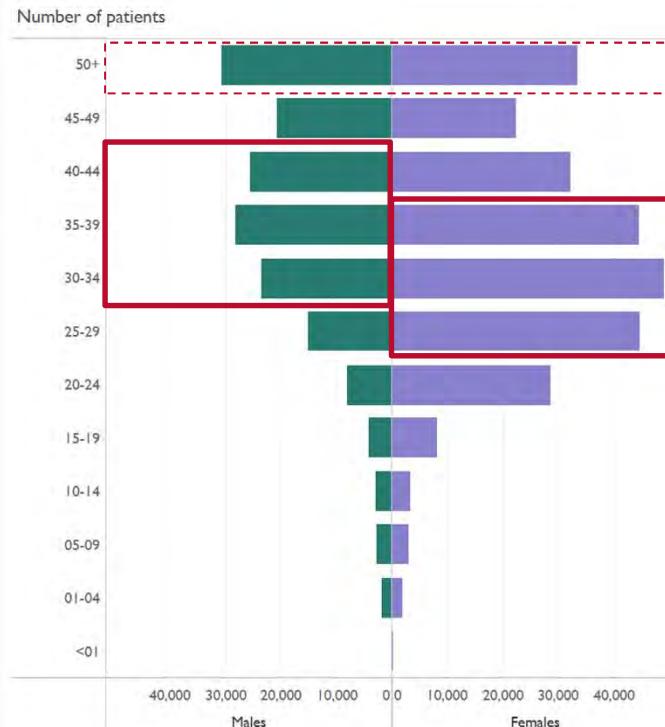
Interruptions in Treatment (< 3 months on ART) by Age and Sex, PEPFAR, FY21Q3



- Although numbers of PLHIV who experience IIT during first 3 months of ART vary, when weighted by TX_NEW, high rates are consistent across age/sex bands
- Implementation of client-centered approaches to prevent IIT for new clients across all age/sex populations are needed

Young Men and Women 20-34 yo Experience Highest Rates of Treatment Interruptions among Clients on ART \geq 3 Months

Interruptions in Treatment (3+ months on ART) by Age and Sex, PEPFAR, FY21Q3



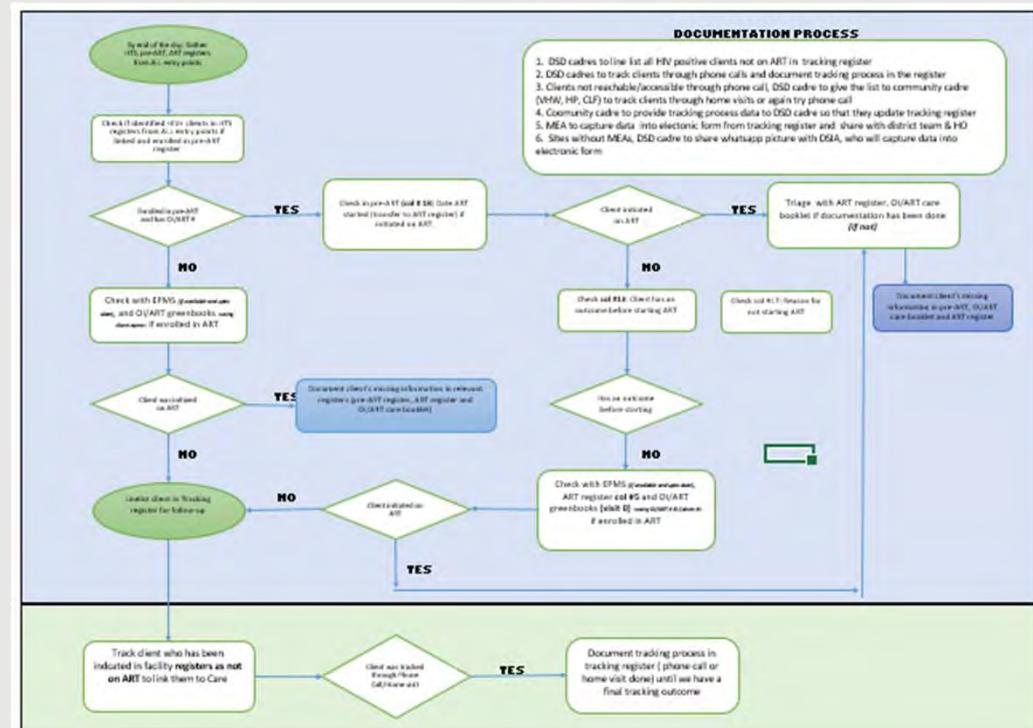
- Peak IIT numbers shift slightly by sex
- IIT occurs in all age/sex bands, including older PLHIV and young CLHIV
- Highest rates of IIT among young men and women 20-29 yo
- Interventions to support young adults' access to ART and appointments are needed (e.g. mental health, family-centered care)

OU: GLOBAL | Period: FY21 Q3 | Agency: All | Partner/IM: All | SNU: All | PSNU: All | Sex: All | Age: All
Source: Treatment Workbook, MSD_FY21_Q3_2.1_Hyperfile.2021.09.26, Last Update: 9/27/2021 12:55:40 PM

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Source: Treatment Workbook, MSD_FY21_Q3_2.1_Hyperfile.2021.09.26, Last Update: 9/27/2021 12:55:40 PM

Mitigating LIT as Best Practice and PEPFAR Priority

- WHO and PEPFAR guidance emphasize the importance of tracing and tracking patients who are not linked to ART and those who experience interruption in treatment
- Understanding root causes leading to treatment interruptions are critical to ensure all PLHIV have continuous access to HIV treatment in order to achieve durable viral load suppression
- Returning and successful re-engagement to HIV treatment is also critical to ensure successful long-term treatment outcomes



[Loss to Follow-up Tool, PEPFAR Zimbabwe. PEPFAR Solutions Website.](#), Accessed 9/28/21

Summary

- Treatment growth and continuity remain critical to achieving 95-95-95 and maintaining epidemic control
- TX_ML indicator and proxy metrics for IIT provides additional information on which clients are at greater risk of experiencing treatment interruptions
- PLHIV newly initiated on ART deserve special attention and support to ensure treatment continuity. Implementation of core standards that address IIT in the first few months of treatment are important for all age/sex bands (e.g. First 180 Days package)
- Young adults are at highest risk of IIT; Better identification of individual barriers to treatment and tailored interventions will have significant impact on treatment continuity
- Other subpopulations including young children and older PLHIV should not be forgotten
 - MMD and other differentiated service delivery models may help overcome barriers to ART access for most clients, however some vulnerable populations may require additional support

Poll Question #3:

How confident do you feel with the quality of TX_ML and TX_RTT data?

- A. Very confident – Site-level TX_ML data are probably the most accurate way to monitor interruptions in treatment.
- B. Somewhat confident
- C. Minimally confident - I still worry that data are not complete or captured accurately enough to effectively interpret program performance

— Ensuring Continuity of Treatment for PLHIV: Strategic Information Overview

CODY ADELSON, MSc

Data Analyst, Strategic Information, Evaluation, and Informatics (SIEI) Division,
USAID, Office of HIV/AIDS

September 29, 2021



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Continuity of Treatment

TX_NEW

Total number of **newly enrolled** treatment naive people enrolled on antiretroviral therapy (ART)



TX_RTT

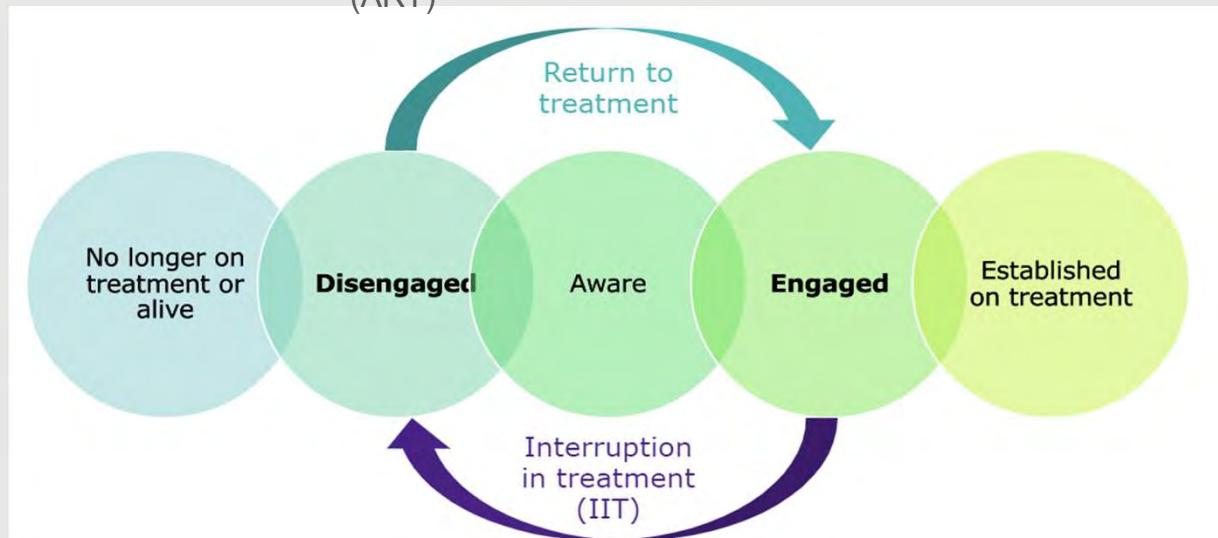
Patients previously lost to follow up who **returned to treatment** and remained on until the end of the period

TX_CURR

Total number of adults and children **currently receiving** antiretroviral therapy (ART)

TX_ML

Patients on ART at the beginning of the reporting period or initiated treatment during the period who then **lost clinical contact**



Disaggregate reporting differs by indicator

Complete reporting guidance available in the MER Indicator Reference Guide and Datim

These indicators only report N, so calculated variables may use other indicators as denominators

			TX_CURR_N	Indicator TX_ML_N	/ Numerator TX_NET_N	Denom TX_NEW_N	TX_RTT_N
Standardized Disaggregate	Other Disaggregate						
Age/Sex/ARTCauseofDeath	COD: HIV Disease Resulting in Cancer COD: HIV Disease Resulting in Other Infectious and Parasitic Disease COD: HIV Disease Resulting in TB COD: Non-Natural Causes COD: Other HIV Disease COD: Other Natural Causes COD: Unknown Cause			1 36 7 11 20 6 102			
Age/Sex/ARTNoContactReason/HIVStatus	Died No Contact Outcome - Interruption in Treatment 3+ Months Treatment No Contact Outcome - Interruption in Treatment <3 Months Treatment Refused/Stopped Treatment Transferred Out			216 339 53 58 189			
Additional disaggregates make up age & sex, so the total add up to Total Numerator							
Age/Sex/ARVDispense/HIVStatus	3 - 5 mo <3 mo ≥6 mo			14,076 1,423 29,730 45,229	-277 114 1,308 1,142		
Age/Sex/HIVStatus	Null				1,270	550	
KeyPop/HIVStatus	FSW MSM People in prisons and other enclosed settings TG			772 963 140 1	191 322 -3 1	138 33 8 1	29 35
PregnantOrBreastfeeding/HIVStatus	Breastfeeding					12	
Total Numerator	Null		45,229	855	1,142	1,270	550

Interruption in Treatment (IIT) tells part of the Continuity of Treatment story

How many patients experience interruptions in treatment and at what stage of treatment does IIT occur?

IIT for patients on ART <3 mo

Numerator: TX_ML
(Disaggregate: IIT <3mo.)

Denominator: Mean
TX_NEW in last two
reported quarters

IIT for patients on ART +3 mo

Numerator: TX_ML
(Disaggregate: IIT 3+mo.)

Denominator: TX_CURR
(1 qtr previous)

Total Interruptions in Treatment (IIT)

Numerator: TX_ML (Sum of
Disaggregates for IIT <3mo. + IIT
3+mo.)

Denominator: TX_CURR (1 qtr
previous) + TX_NEW

- Performance benchmarks have not yet been identified, use trends for comparison (ie. What is the variation of Interruptions in Treatment)
- TX_ML cannot be aggregated across quarters - needs to be looked at on a quarter by quarter basis

Key Updates and Changes: MER 2.5 to MER 2.6

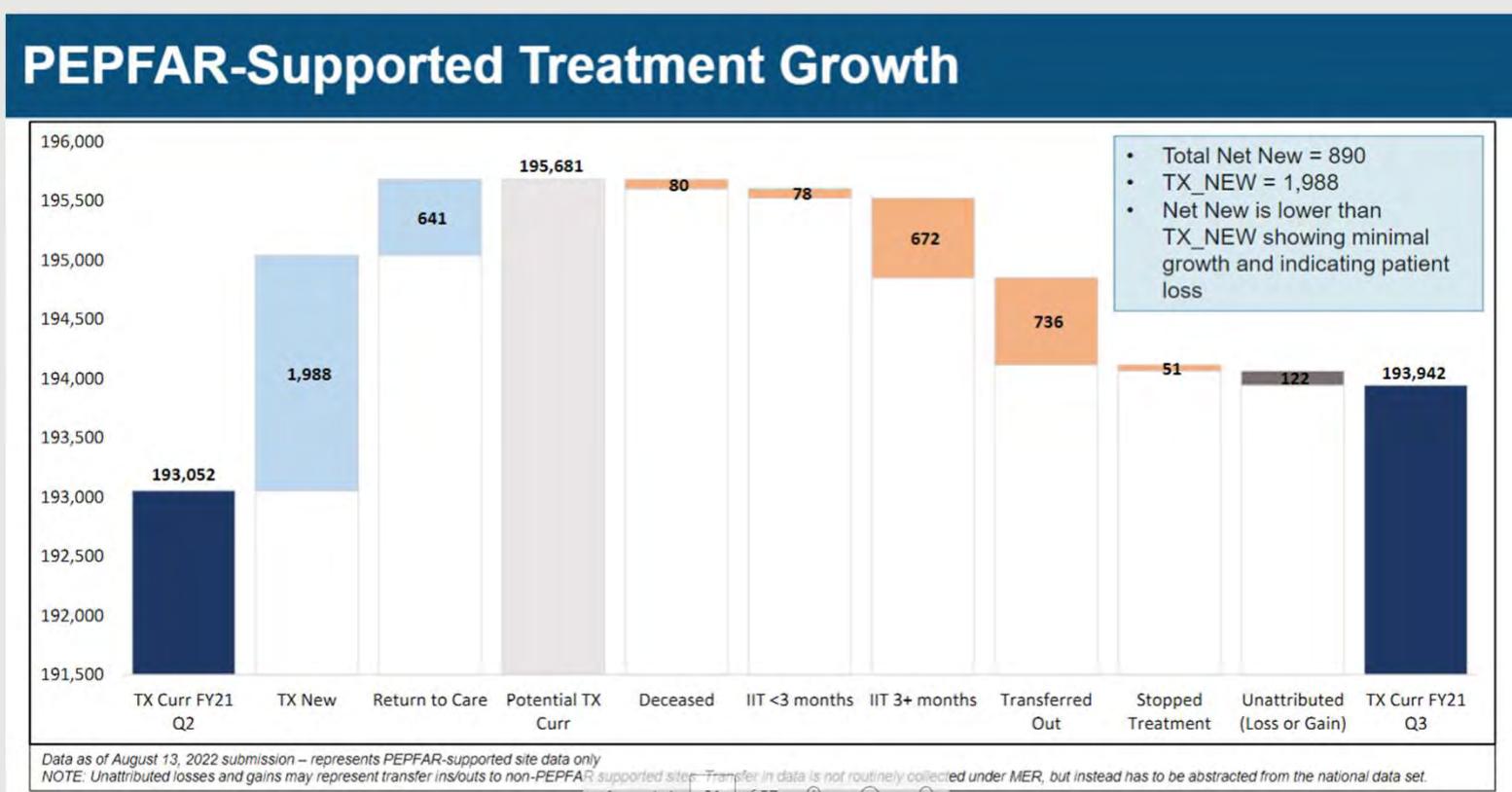
MER 2.5

- Language was added to TX_RTT to state that patients must have
 - (1) initiated ART prior to the start of the reporting period,
 - (2) were not on treatment at the beginning of the reporting period,
 - (3) restarted ARVs during the reporting period, and
 - (4) remained on treatment at the end of the reporting period.
- Clarify that TX_ML requires a patient is
 - on treatment at the beginning of the reporting period or newly initiated treatment during the reporting period,
 - experience an interruption in treatment during the reporting period.
- Therefore, a patient cannot be counted in TX_ML and TX_RTT in the same reporting period.

MER 2.6

- TX_RTT to include duration of interruption in treatment
- TX_ML to include additional IIT disaggregate (<3, 3-6, 6+ mo)

The Treatment Waterfall uses each indicator to detail the spectrum of program loses and gains



Program Churn, TX_ML and TX_RTT



Program Churn (Tx_ml [iit] + tx_rtt / tx_curr)	6.5%	6.7%	8.0%	6.8%	6.3%	5.7%	5.3%
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Data Completeness impacts IIT

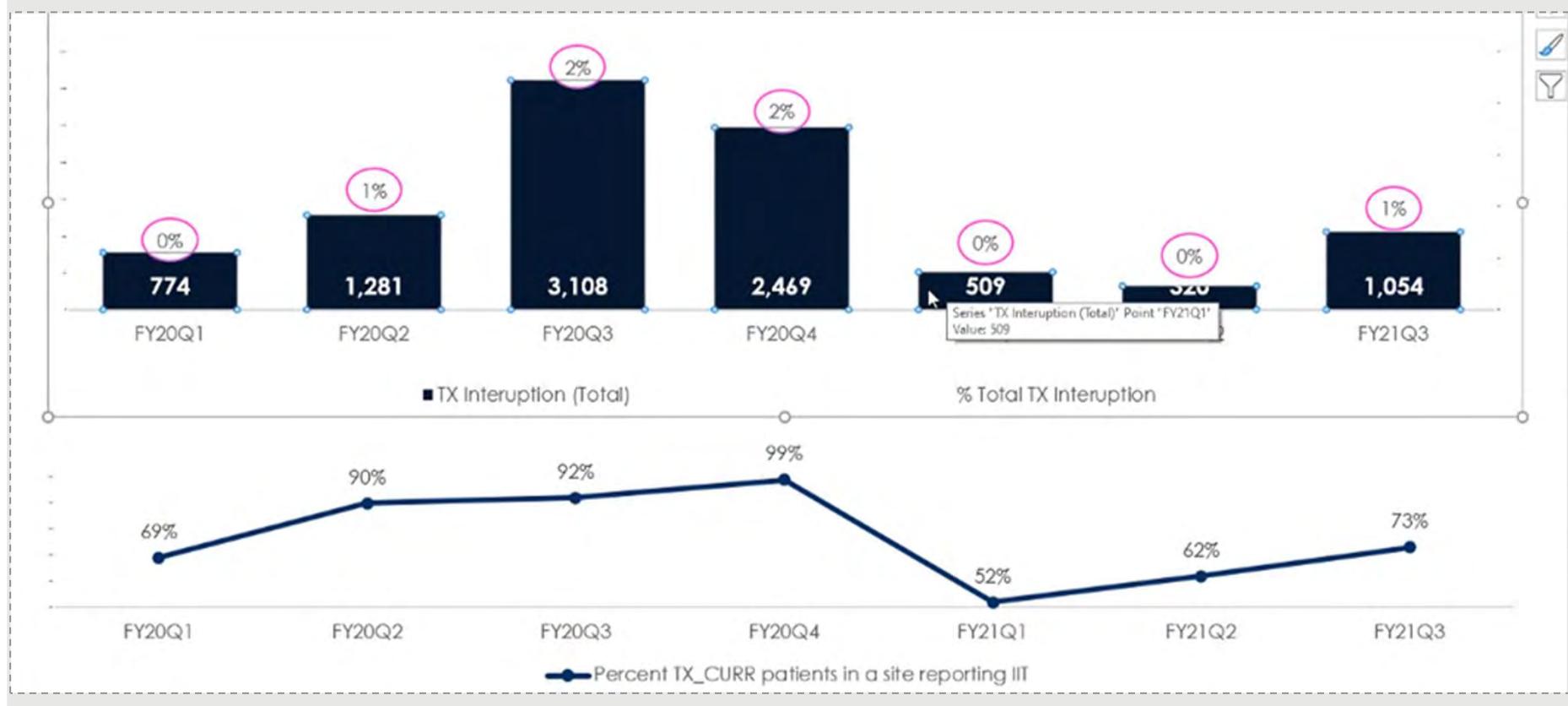
OU	% TX_CURR sites reporting IIT	% TX_CURR sites (>1000 patients) reporting IIT	%IIT
Angola	91%	83%	7%
South Sudan	57%	86%	7%
Dominican Republic	93%	100%	7%
South Africa	97%	100%	4%
Asia Region	58%	93%	4%
Western Hemisphere	88%	97%	4%
Ukraine	69%	100%	4%
Mozambique	36%	92%	4%
Malawi	92%	96%	3%
West Africa	79%	90%	3%
Tanzania	74%	89%	2%
Uganda	63%	80%	2%
CDI	47%	72%	2%
Nigeria	77%	91%	2%
Cameroon	79%	95%	2%
Zambia	43%	70%	2%
Haiti	52%	57%	2%
Kenya	58%	87%	1%
Lesotho	80%	88%	1%
Ethiopia	49%	97%	1%
Vietnam	77%	90%	1%
Burundi	33%	60%	1%
Zimbabwe	41%	70%	1%
Botswana	27%	69%	1%
DRC	35%	59%	0%
Eswatini	41%	60%	0%
Rwanda	40%	52%	0%

Higher IIT with more complete reporting

Lower IIT with less complete reporting

Limitation of completeness check: The difference between zero reported IIT and no reported IIT cannot be distinguished when calculating completeness, for this reason the percent completeness may be underestimated.

Comparison of IIT results and reporting completeness over time



Ensuring Continuity of Treatment for PLHIV: Tingathe - Client- Oriented Response for HIV Epidemic Control (CORE)

Dr. Katie Simon
Medical Director, Tingathe Program
Baylor College of Medicine Children's Foundation-Malawi (BCM-CFM)
29 September, 2021



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Outline

- Background, Epidemiology and Clinical Cascade Data
- Tingathe's Approach to Promote Retention in Treatment
- Challenges, Highlights, and Successes
- Key Points

Baylor College of Medicine Children's Foundation-Malawi

BCM-CFM has been a leader in paediatric, adolescent and family HIV care since 2006 with the opening of the COE, the largest pediatric outpatient ART clinic in Malawi.

Since 2006, Baylor-supported services have expanded to include provision of acute inpatient paediatric care, obstetrics and gynecology, pediatric oncology and surgical services, in addition to delivery of comprehensive care to PLHIV and their families.

Through the USAID-funded Tingathe-CORE program, BCM-CFM **supports over 200,000 PLHIV**, of whom over 30,000 are children and youth.



Tingathe CHWs have supported HIV care in Malawi for over a decade

- BCM-CFM has innovated since 2007 in the use of Community Health Workers (CHWs) to support the health system and provide client-centered support to PLHIV
- One of the first organizations in Africa to professionalize lay HW; negotiated with MOH to support task-shifting of HTS
- Currently over 900 Tingathe CHWs supporting comprehensive cascade of HIV care

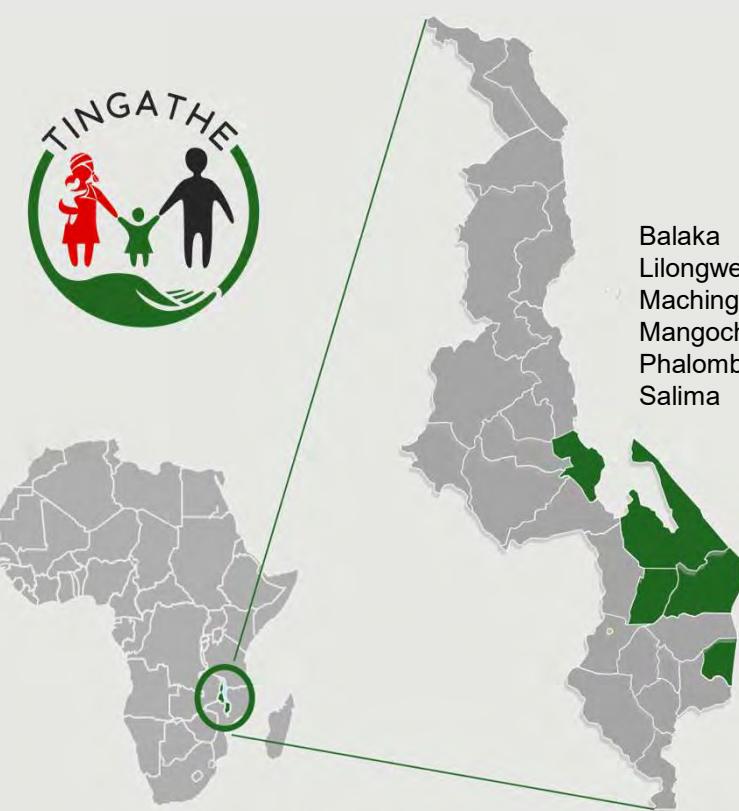


First class of
CHWs - 2008

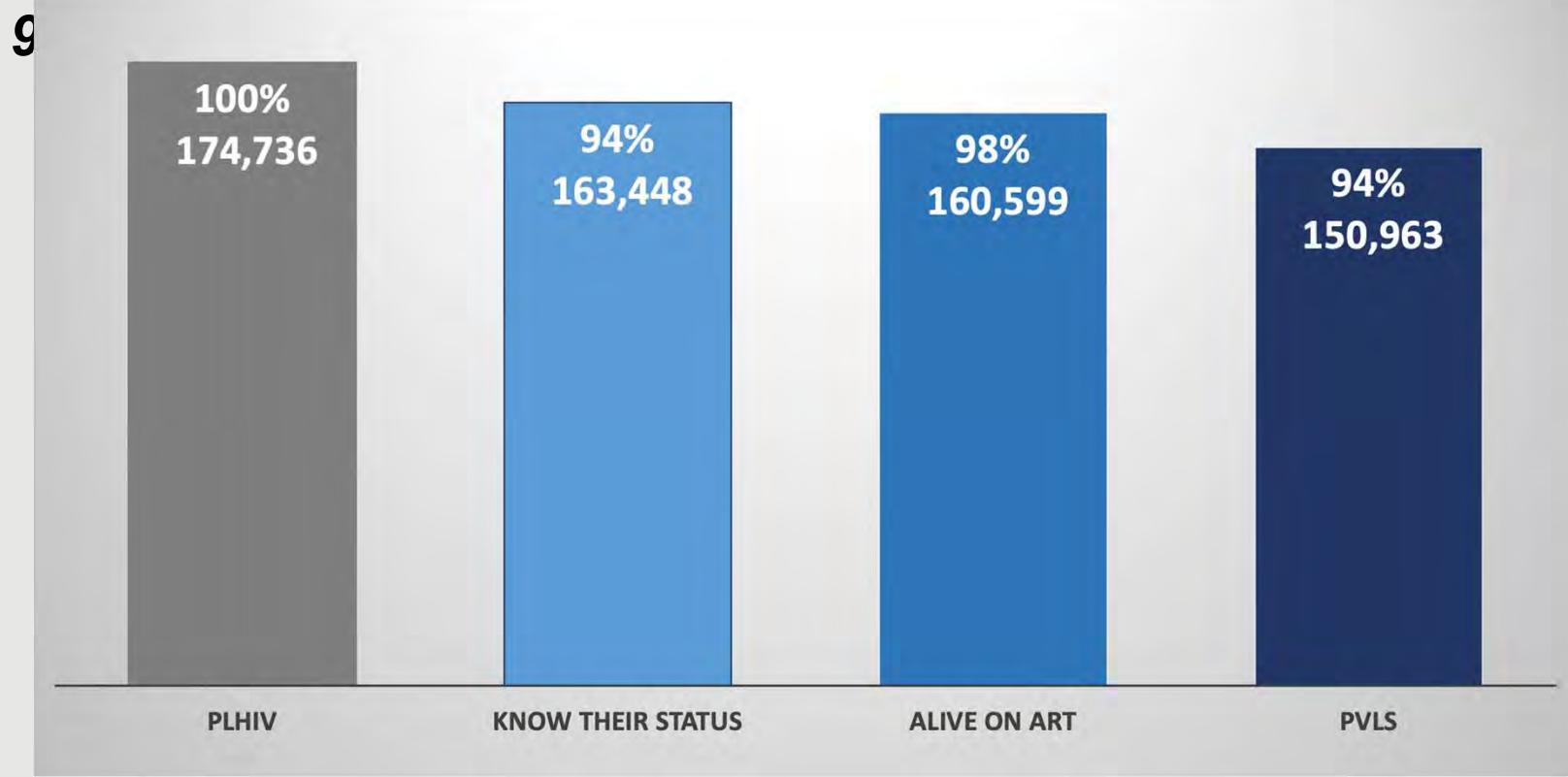
BCM-CFM Tingathe in 2021: CORE project

Baylor-Malawi's Tingathe program works collaboratively with MOH and partners supporting 95 health facilities in 6 districts to help families live healthy, fulfilled lives through:

- Development and implementation of innovative programming
- Building local capacity and sustainable health systems
- Delivering high-quality services



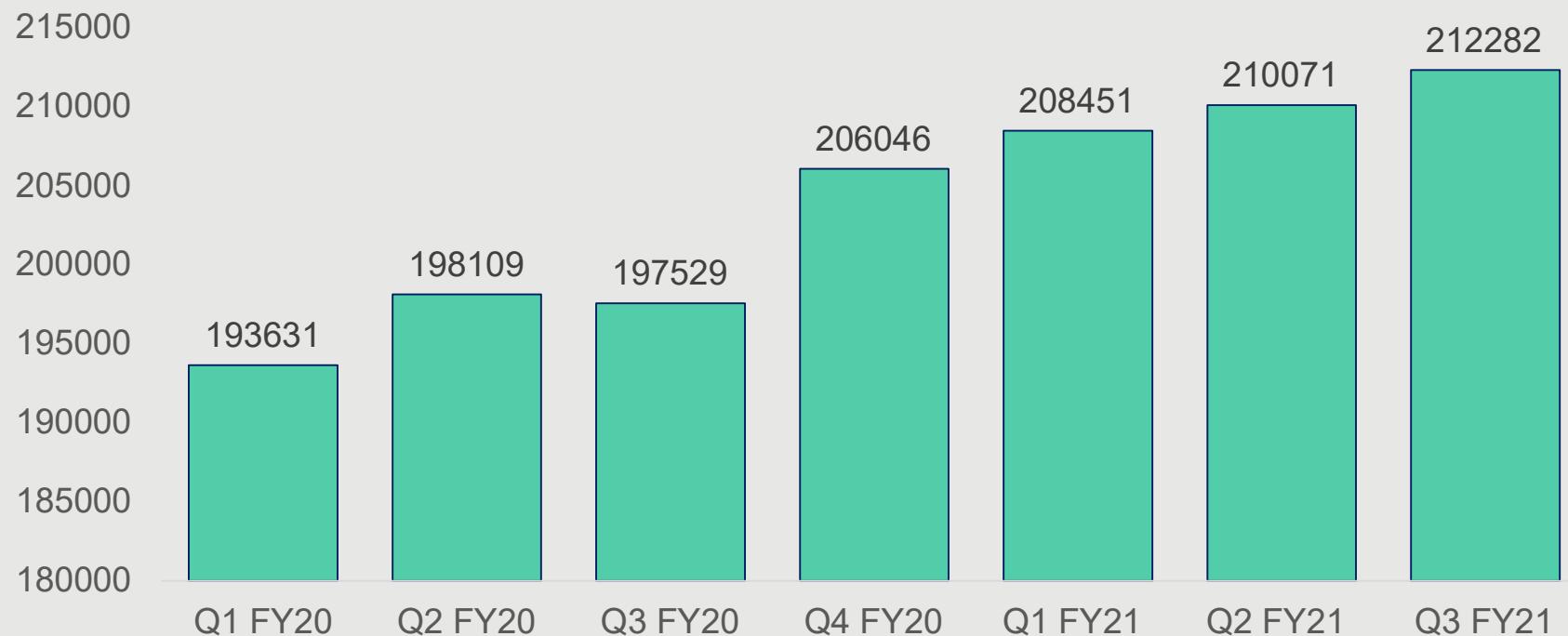
Treatment Cascade in BCM-CFM supported districts:



Data source: DATIM, Spectrum Naomi model v5.89 and Malawi LIMS. VL suppression from LIMS applied to PLHIV on ART

Sustained ART cohort growth despite COVID-19 pandemic

TX_CURR, Tingathe supported sites



Tingathe's approach to treatment retention

1) CLIENT CENTERED

- An evidence-based approach that seeks to understand clients' needs/desires and to develop and implement tailored approaches based on these needs/desires

2) DELIVERED AT THREE CRITICAL TIME POINTS

- PREVENTION – creating lasting engagement from ART initiation
- MITIGATION – rapid identification and support from the moment of missed appointment
- WELCOME back to care – engagement upon return to prevent future IIT

3) CQI – continuously evaluated, optimized, and improved via CQI

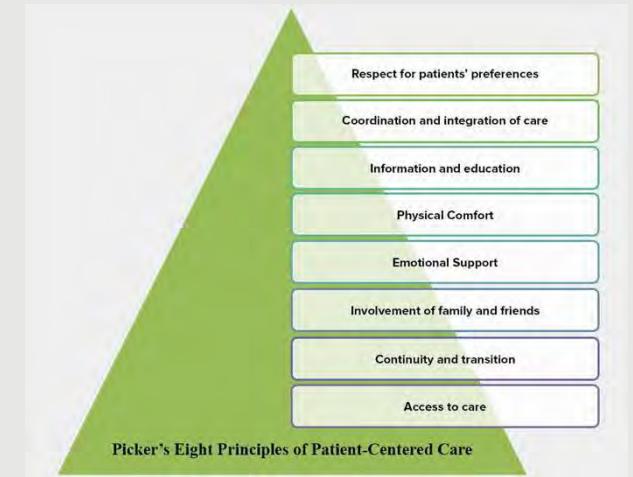


Client-Centered care:

caring with dignity and respect / information sharing / client participation and collaboration in care

1) UNDERSTAND

- Exit interviews
- Informal interviews with providers
- Client-specific counseling



2) DEVELOP and IMPLEMENT

- Select interventions targeted to client needs from among various differentiated service delivery models (DSDs)

Client centered care-- effective prevention and mitigation necessitates understanding why clients interrupt treatment

- Disclosure
 - disclosure support, PSC eval, referrals
- Stigma
 - psychosocial counselling, peer support
- Safety
 - GBV evaluation, psychosocial assessment, referrals
- Transport
 - Distance – Community ART distribution, MMD, transfer of care
- Scheduling
 - Extended clinic hours, MMD, client-led advocacy for appropriate appointment dates, emergency refills



*Reasons for treatment interruption shared with
psychosocial counsellors, Tingathe program 2020-2021*

Exemplary solutions:

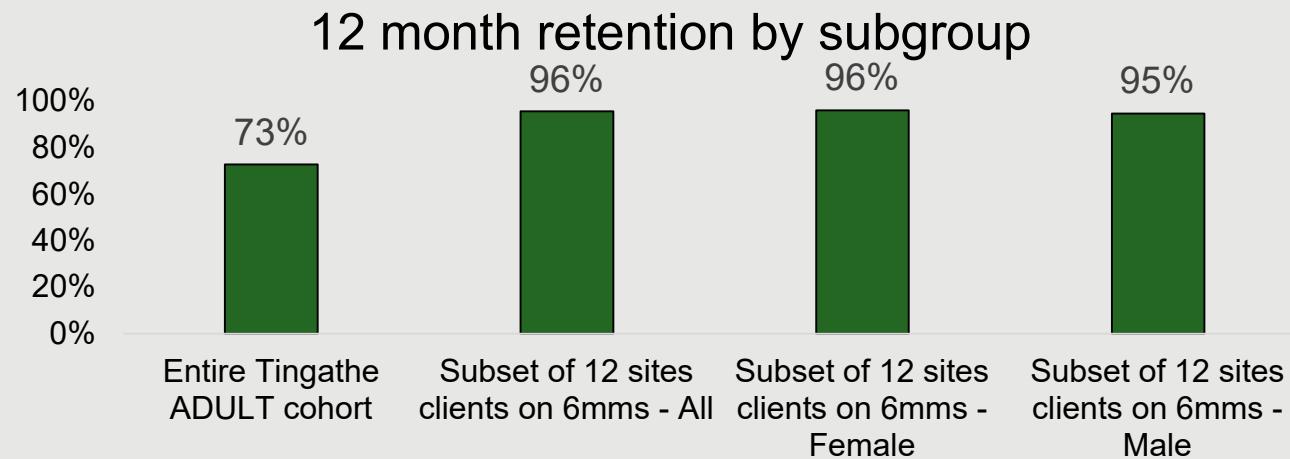
DSD models facilitate age- and gender-appropriate care at convenient times and locations with counseling tailored to client-specific needs



ICAC | Male Clinics | Early AM/PM. | Family/child clinics |
MIP Clinics | Teen Clubs | PMTCT | Community ART distribution



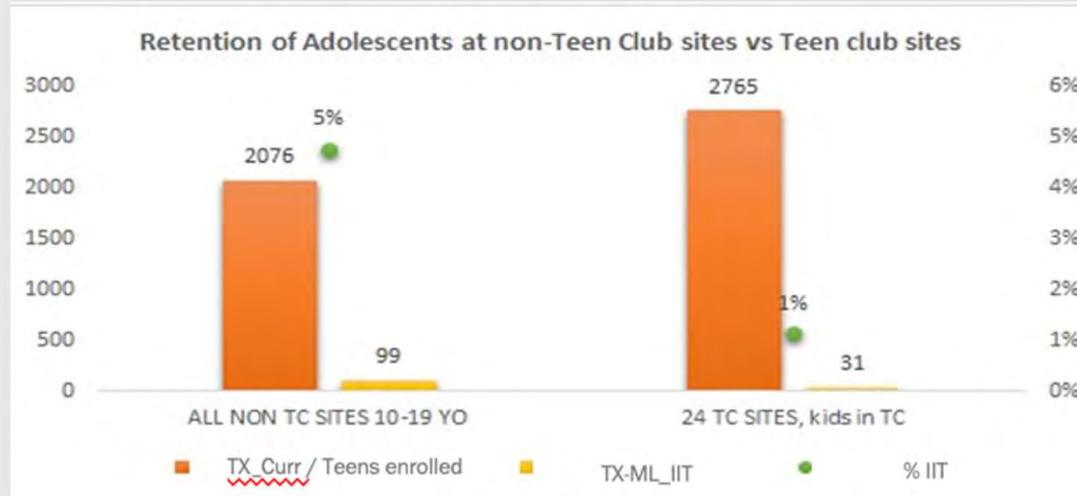
Multi-month scripting promotes retention in care



- **Clients receiving 6MMD in a subset of facilities had 96% 12-month retention as compared to 12-month retention of 73% among the overall ART population at all facilities**

Data source: Baylor collected (via EMRS and mastercards)

IIT) and exceptional retention of adolescents at Teen club sites (1% IIT)



- Training and sensitization of guardians, teens, lay and clinical HW result in competency to
- address common adolescent challenges such as disclosure
- engage adolescents to be proactive in their care

- Sensitize clinical and lay HW to normal adolescent development, needs and care resulting in low IIT
- Practical trainings through role play lead to experience sharing and skills-building
- Teen clubs provide adolescent-friendly ART and SSRH care to ALHIV on weekends with clinical and psychosocial services
- Flexible hours, MMD and community ART clinics overcome transport and travel time barriers
- Phone follow-up for psychosocial support between visits

Interventions to promote retention take place along a continuum



- a) **PREVENTION** of interruptions in treatment (IIT)
 - a) Provide client-centered ART care to identify anticipated barriers and prevent treatment interruption before it happens
- b) **MITIGATION** – rapid identification and client support for IIT
 - Identify clients who have interrupted treatment rapidly, provide tailored support to promote return to care
- c) **WELCOME** – client-centered support to prevent repeat IIT
 - Bring clients back to care and address barriers to prevent future treatment interruption through Takulandirani Welcome Service

a) **PREVENTION** of treatment interruption

- Client-centered ART care to identify anticipated barriers to adherence and retention and develop client-centered approaches to prevent interruption
- Newly diagnosed clients and those who have previously interrupted treatment:
 - Clinical triage- assessment for advanced HIV disease; referral and treatment
 - Retention-focused client empowerment health talks
 - CHW assigned for ongoing support and counseling at months 1,2,3 and 6
 - **Identification of anticipated client-specific barriers and plans to address them**
 - Consultation with psychosocial counselor
 - Appointment reminders for clients with phones

b) **MITIGATION** of treatment interruption

- **Rapid Identification** of clients who have missed appointments
 - Use EMR to generate list of clients who have missed appointment
 - CHWs call clients with phones (~20%) called 1 day after missing appointment and again at 7 days if no return
 - Phone tracing: clients with phones are called first, if fails traced in person
 - Physical tracing: CHWs assigned within geographic catchment areas
- Rapid **tracing** of clients who have missed appointments to ensure they do not miss ARV doses
- **GOAL:** Clients return to care without missing ARV doses

c) WELCOME back to care - Takulandirani

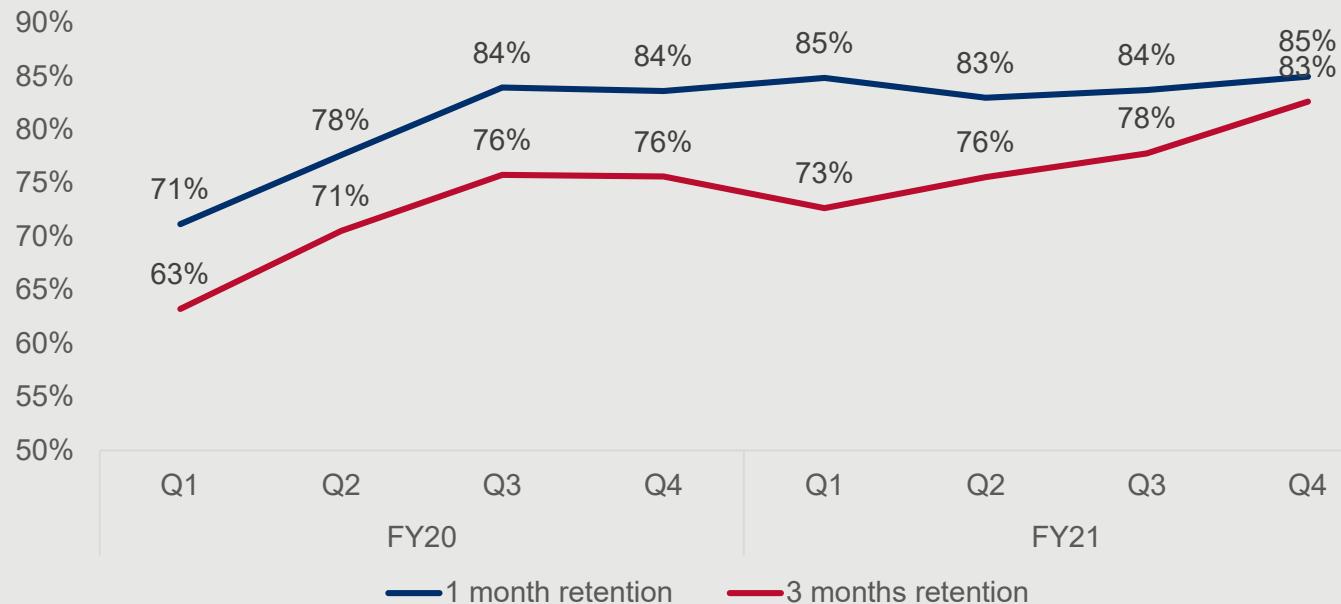
- Upon return to the health facility, **Identify** clients who have interrupted treatment, **provide tailored welcome support** to promote ongoing retention in care
- Takulandirani Welcome Service:

- **Welcome** the patient
- **Normalise** - treatment challenges
- **Acknowledge** – everyone has difficulties at times with engagement
- **Support** –we are here to support through enhanced counselling and referral
- **Empower** patient to make decision to stay / restart plan to address them



Delivery of client-centered care results in excellent 1- and 3-month retention despite COVID disruptions

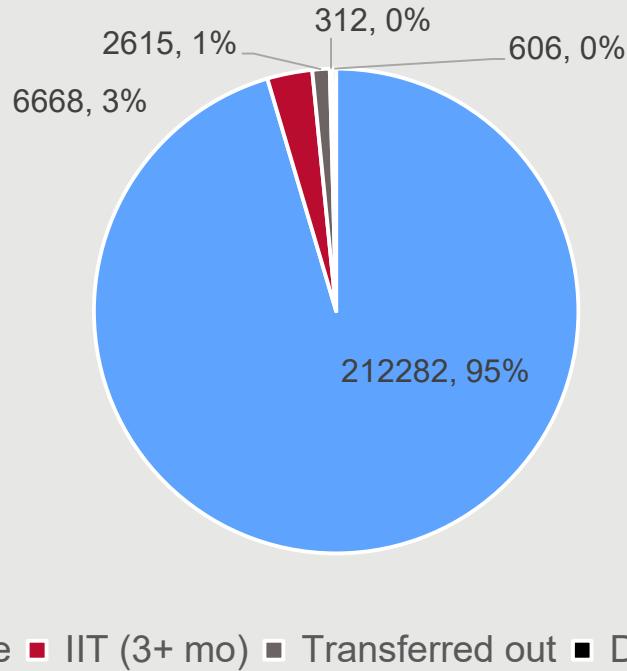
Tingathe Program,, Early retention among clients newly initiated on ART



Data source: ART Mastercard Review

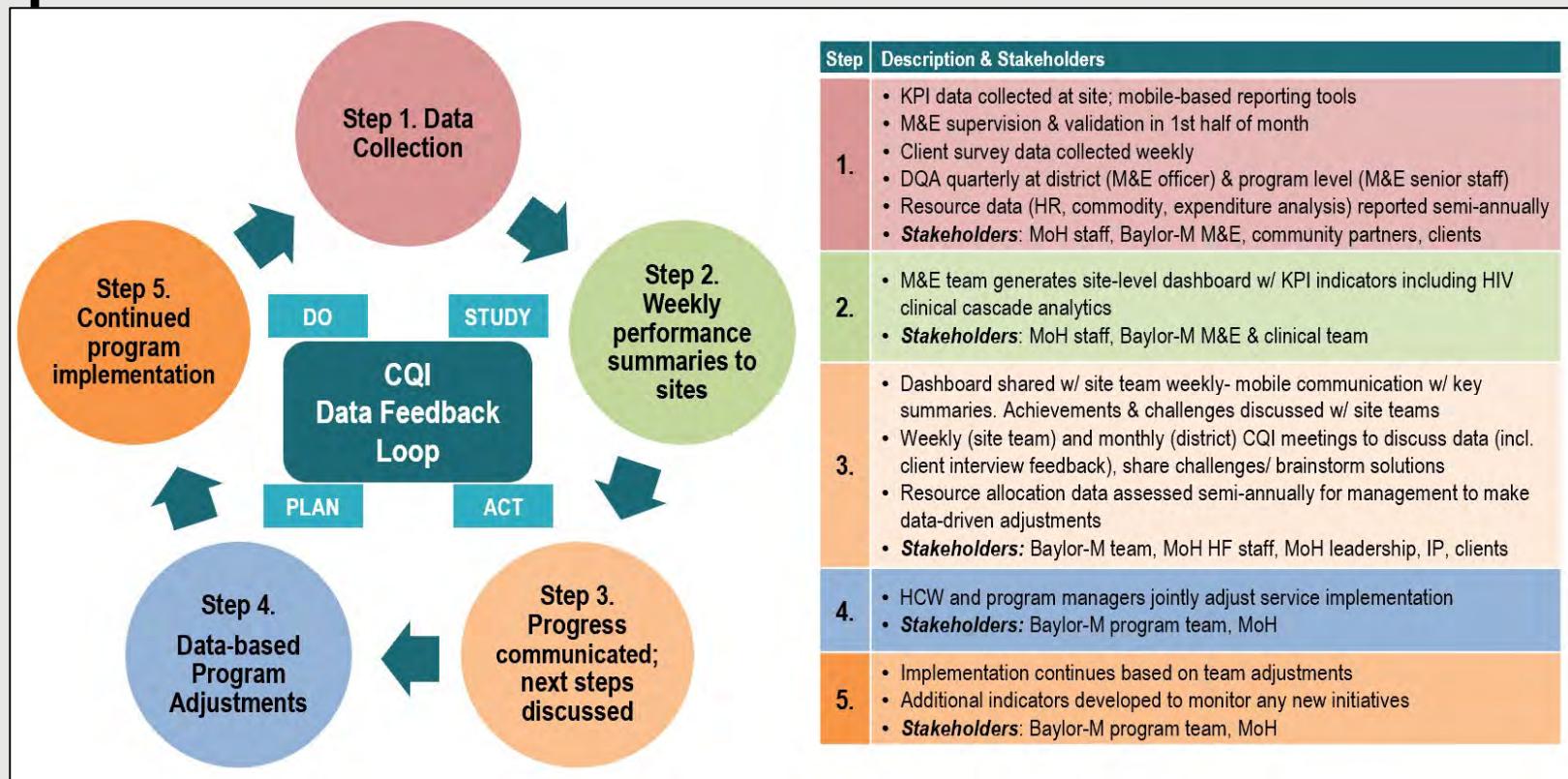
In our active cohort in Q3FY21, only 4% of clients experienced treatment interruption

TX_ML Tingathe Supported Sites, Q3FY21



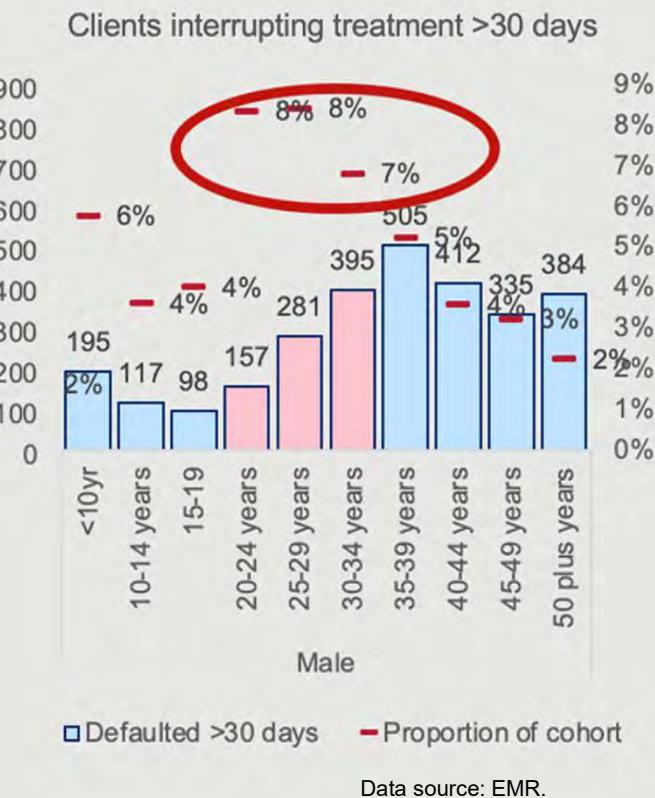
- 95% of cohort remained active in care
- 1% transferred care to other facilities
- 1% experienced treatment interruption of < 3 months
- 3% experienced treatment interruption of 3+ months
- <1% died

CQI: Tingathe-CORE programming is continuously evaluated, optimized, and improved via CQI data feedback loops



Exemplary use of data to demonstrate impact

IIT rates among men 20-34 informs tailored retention interventions



Challenge:

- Higher rates of treatment interruption among men 20-34 years (7-8%)

Interventions:

- Use EMR to generate missed appointment list and track clients returning to care
- Exit interviews with male clients and informal interviews with lay and clinical HW understand barriers informed clinic adjustments →
extended am/pm/weekend hours, male clinics, gender-paired clinical and lay HW support
- Client-specific Takulandirani counseling to identify tailored individual needs →
MMD, CAD, transfers, referrals to community support groups (CBOs, FBOs) and other partners, PSC support

Key Points

- **Client-centered care, delivered across a continuum to prevent, mitigate, welcome clients back to care, and continuously evaluated by robust CQI data feedback loops** is critical to promoting retention in care.
- Retention in care requires **client-centered engagement** from the client's first care encounter via CHW-led, client-tailored counseling and support to anticipate and address challenges before they emerge
- Client-centered care through takulandirani welcome approach identifies **individualized solutions** to promote retention among clients who have previously interrupted treatment

ZIKOMO!



THANK YOU!

Ensuring Continuity of Treatment for PLHIV: KP-CARE 1

Dr. Godwin Emmanuel
Chief of Party, KP-CARE 1
Heartland Alliance Ltd/Gte Nigeria
29 September 2021



PEPFAR



Project Overview

- Key Population Community HIV/AIDS services Action and Response 1 (**KP CARE-1**)
- A five years (**October 28, 2019 – September 31, 2024**) cooperative agreement with USAID/Nigeria.

Current geographic Coverage

Presently 60 LGAs, and 3 states

- 31 LGAs in Akwa Ibom
- 18 LGAs in Cross River
- 11 USAID-delineated LGAs in Lagos and other hotspots within the priority states as identified & in coordination with USAID.

Project Goal

- To reduce HIV incidence, morbidity, and mortality among KPs as well as their sexual partners and children by increasing their access to and success in HIV prevention, diagnosis, and treatment by addressing the biological, social, and structural drivers of the epidemic using human rights principles and sustainable, peer-led approaches
- It seeks to address critical gaps and bottlenecks in the response to HIV among KPs by implementing a comprehensive package of services in line with the WHO guidelines



Current Project areas

- HIV/AIDS/PEP/PrEP
- Tuberculosis
- Cervical cancer
- Viral hepatitis
- Gender/post-GBV
- Mental
- Health/Harm Red..
- Sexual and Reproductive health and rights
- Human rights
- Advocacy

Current target Population

- MSM
- FSW
- PWID
- Transgender persons
- Persons in Correctional Centers and other confined spaces
- OVC

Project objectives

- Increased demand for and access to comprehensive HIV prevention and treatment services and interventions for KPs
- Strengthened sustainability and Organizational Systems for Program and Data Management and Quality assurance of Programs by KP-Competent and KP-led civil society.
- An enabling environment established for KP community-based programming through advocacy, data management systems, and other interventions promoting KP supportive health policy, ideas, and norms.

Background

Current Geographic Coverage

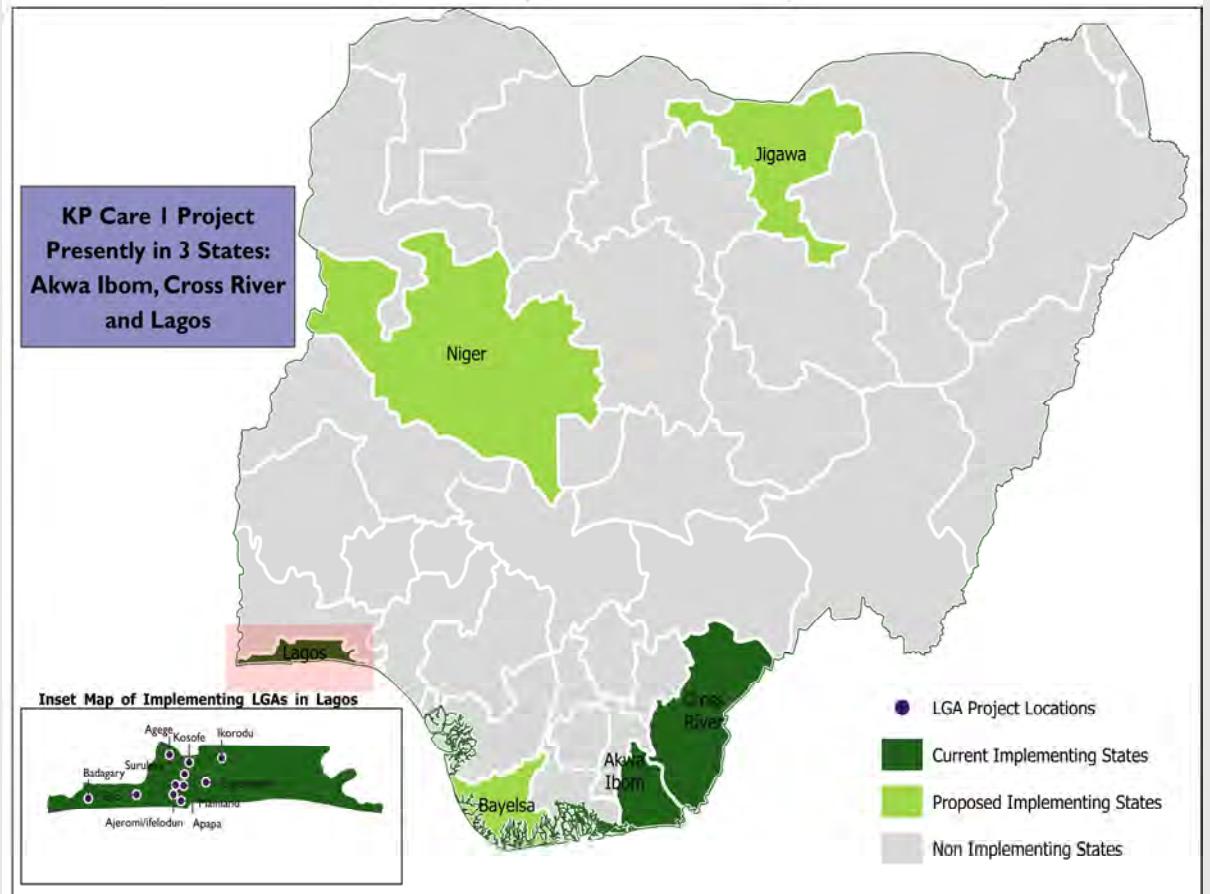


- 60 LGAs, 3 states and 8 zones**
- 31 LGAs in Akwa Ibom
 - 18 LGAs in Cross River
 - 11 USAID-delineated LGAs in Lagos.

Proposed Geographic Coverage

- Niger State
- Bayelsa State
- Jigawa State

USAID KP Care I Current Project and Proposed Locations in Nigeria

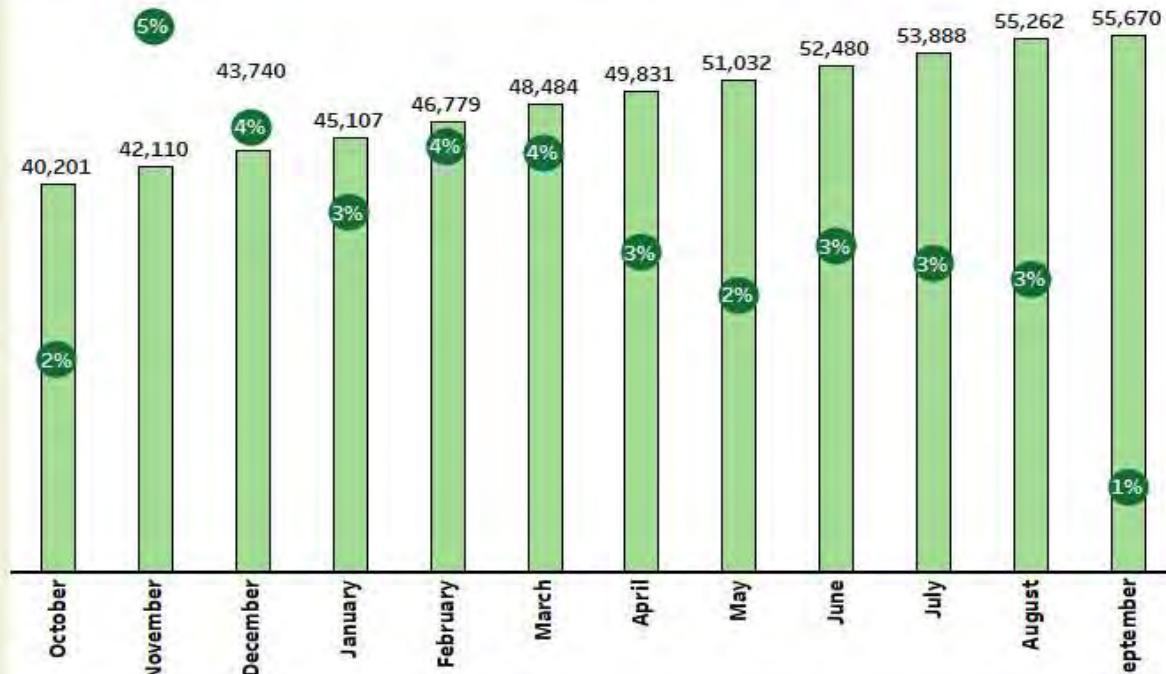


Epidemiology and Clinical Cascade Data

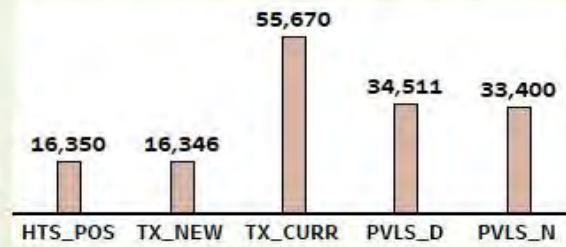
Legend

- Continuity in Treatment
- Treatment Growth

Treatment program growth trends and continuity in treatment (CIT)



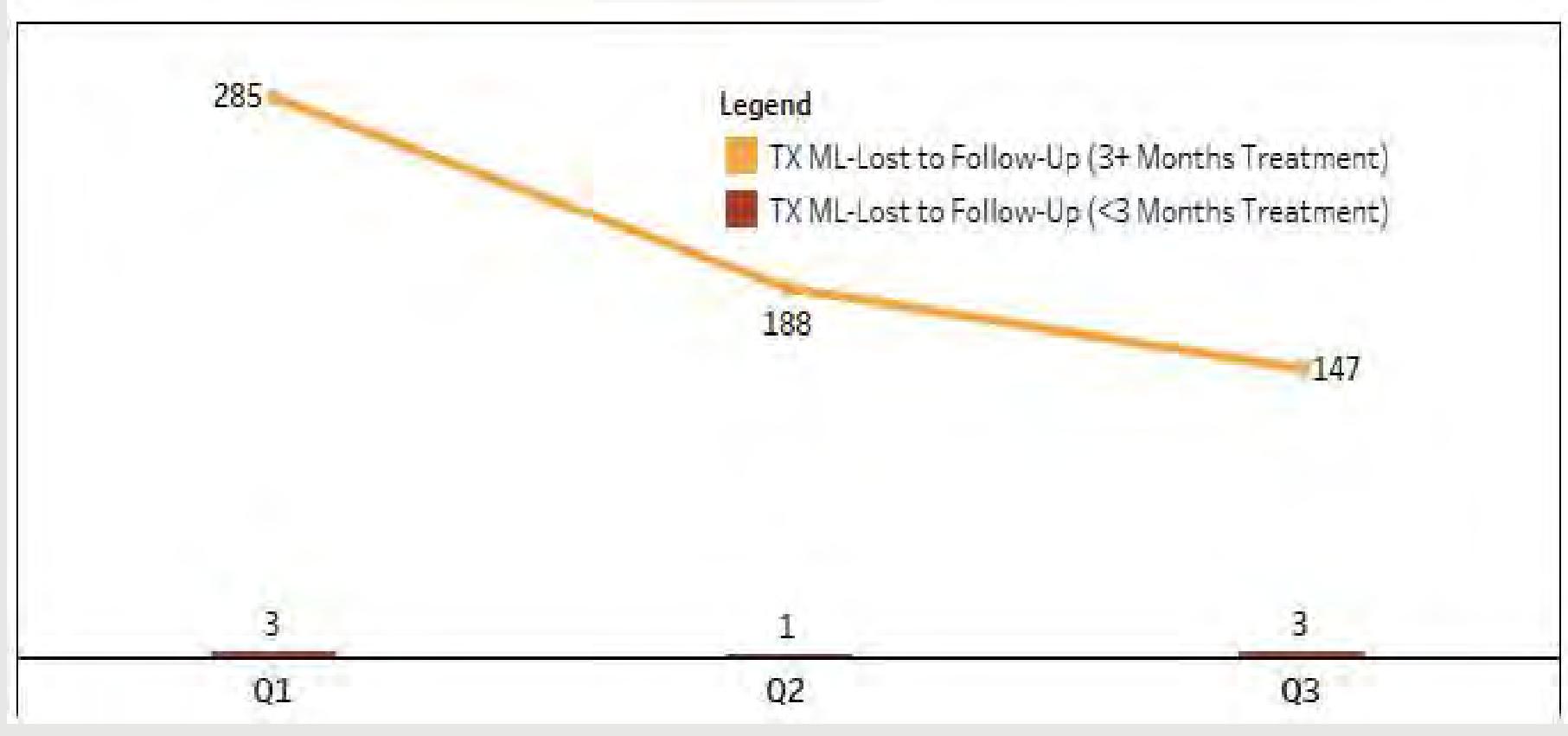
Clinical Cascade Data (FY21)



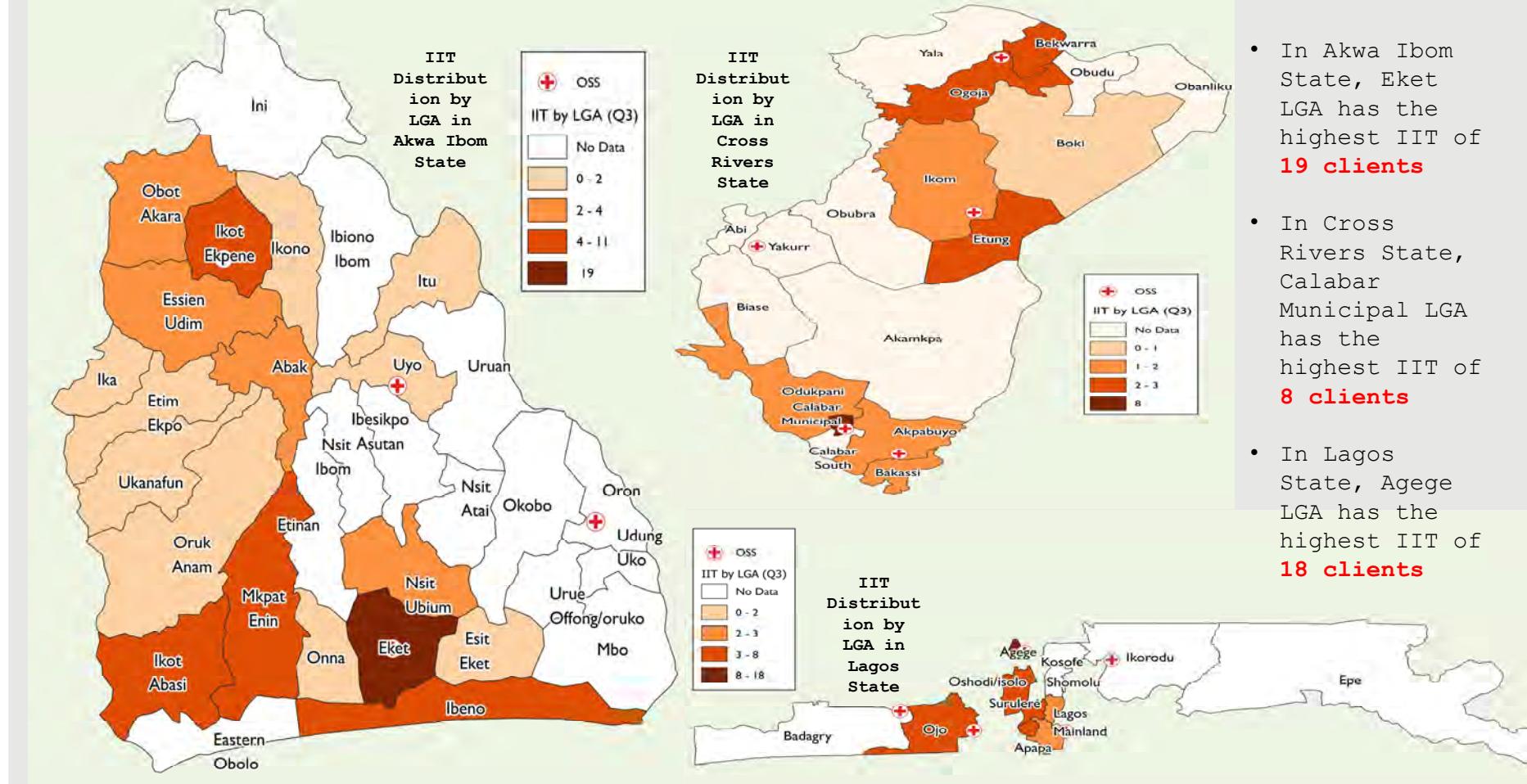
Interruption in treatment (IIT) Q3



IIT Trend According to Duration on Treatment



IIT Distribution in Akwa Ibom, Cross River & Lagos (Q3,2021)



Strategic Approach to ensure Continuity of Treatment.

A Enrolment follow up calendar
Consolidate adherence, address concerns and ADR).

B Be ready to identify needs and preferences, support systems, Pre-emptive clients tracking, IIT Case Reviews.

C Commence Multi-Months Scripting/Dispensing, Care and Support system of CBOs. Courier Services

D Decentralization of Support Groups, Deploy other wrap around services, Age-appropriate disclosure.

E Engagements with KPLHIV for feedbacks, Client satisfaction surveys., deployment of call centers.

F Family centered care-collapsed appointment, Pediatric Care, AYP friendly clinics and platforms.

G Care Cells formations – FSP community model of care, Virtual Mentorship Program for providers, Quality improvement approaches.

H Health -MHPSS, Cervical Cancer intervention, Men's health, Hepatitis testing and referrals .

Understanding IIT

IIT Task Team

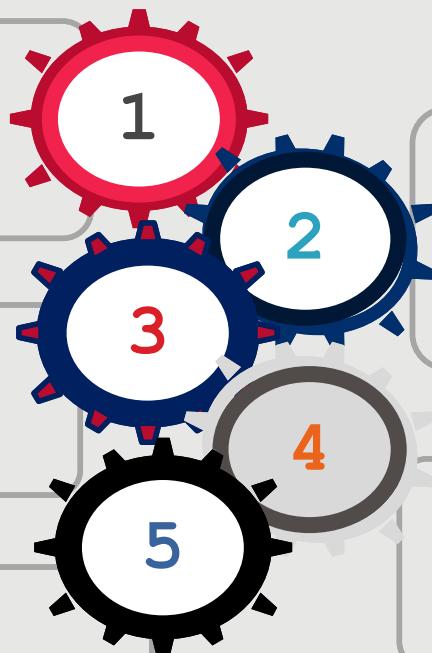
Set Up of IIT task Team in each OSS . Tasked with twice-weekly gap analysis and progress report of tracking efforts.

Task shifting/LIP Offices/DIC

Intensifying community-based services/ Exploitation of LIP offices and DIC for refills

Reviews

Tracking of transferred outs, stopped ART and Mortality reviews.



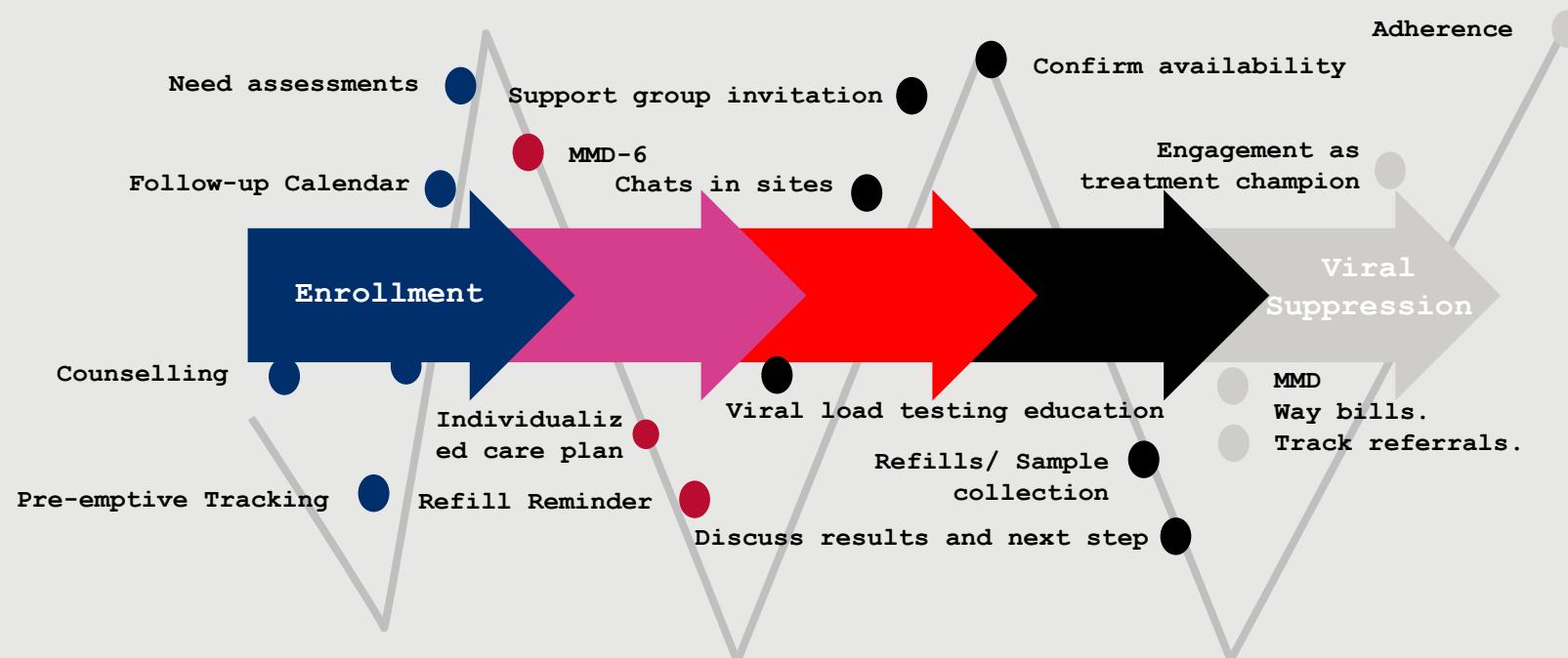
Case Management/Peer Navigation

Line Listing of Defaulters/IIT drawn weekly and PNs/LIP Care and support officers tasked with tracking targets

Flexible Client Centered services

- Call and visit to clients plus assurances of tailored services.

Treatment Navigation Plan



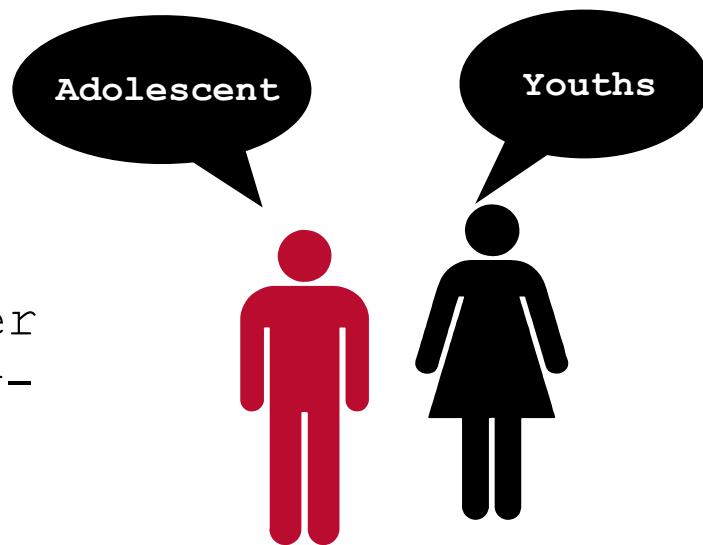
Follow-up calendar

- ◆ DAY 1: The FSP places a call to client same day after enrollment for re-assurance.
- ◆ DAY 5: The FSP places a call to the client on adherence and ADR issues.
- ◆ DAY 15: The FSP places a call again to check on the client to ensure adherence.;
- ◆ DAY 20: FSP-Invitation to Support Groups.
- ◆ DAY 29: The FSP checks again for ADR issues and respond to any concerns from clients.

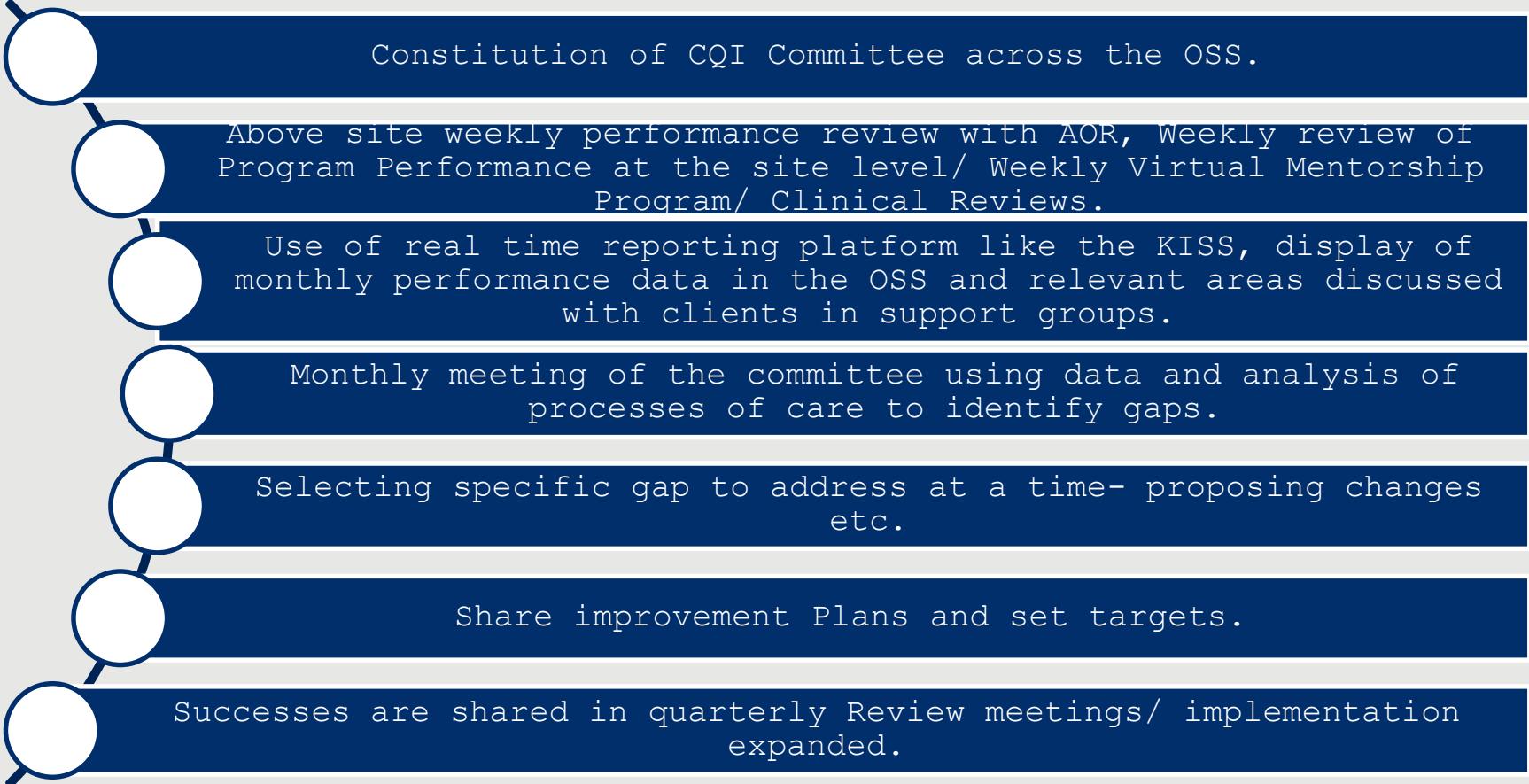
WEEK	SUN	MON	TUE	WED	THU	FRI	SAT
49	29	30	1	2	3	4	5
50	6	7	8	9	10	11	12
51	13	14	15	16	17	18	19
52	20	21	22	23	24	25	26
01	27	28	29	30	31	1	2
02	3	4	5	6	7	8	9

Adolescent and Youths Specifics

1. Flexible/ extended clinic hours/ weekend services.
2. Community center activities
3. AYP clubs/ support groups.
4. Treatment buddies/Peer-2-Peer refill/ home deliveries (way-bills).
5. Social media platforms/App.
6. Provider behaviour change.



QI Site Level Practices

- 
- Constitution of CQI Committee across the OSS.
 - Above site weekly performance review with AOR, Weekly review of Program Performance at the site level/ Weekly Virtual Mentorship Program/ Clinical Reviews.
 - Use of real time reporting platform like the KISS, display of monthly performance data in the OSS and relevant areas discussed with clients in support groups.
 - Monthly meeting of the committee using data and analysis of processes of care to identify gaps.
 - Selecting specific gap to address at a time- proposing changes etc.
 - Share improvement Plans and set targets.
 - Successes are shared in quarterly Review meetings/ implementation expanded.

Challenges / Solutions.

Challenges

- Stigma and Discrimination
- High mobility /Difficult terrain
- Pill burden
- Law enforcement issues

Solutions

- Advocacies, Legal literacy, state actors/ Stakeholders' engagement.
- Dynamic innovative community service provision strategies.
- Treatment literacy/ Peer support.
- Engage Law enforcement agencies

Scaling MMD to Support COT

Lauren Bailey
MMD Advisor, Adult Clinical Branch
USAID, Office of HIV/AIDS



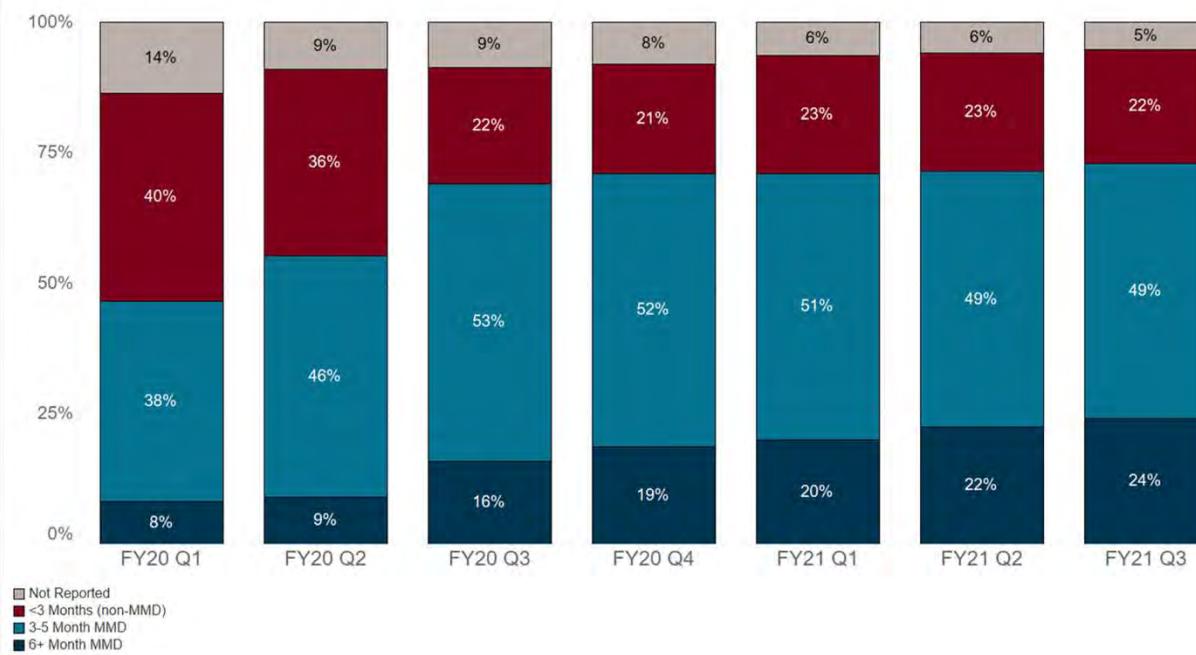
PEPFAR



Percent of ART clients on MMD by number of months of ARVs dispensed

MMD Breakdown

TX_CURR by MMD Duration



- MMD coverage measured as the # of clients on MMD/total number of clients on ART

- MMD coverage has grown tremendously from FY20Q1, but has largely plateaued from the FY20 Q3 COVID surge.

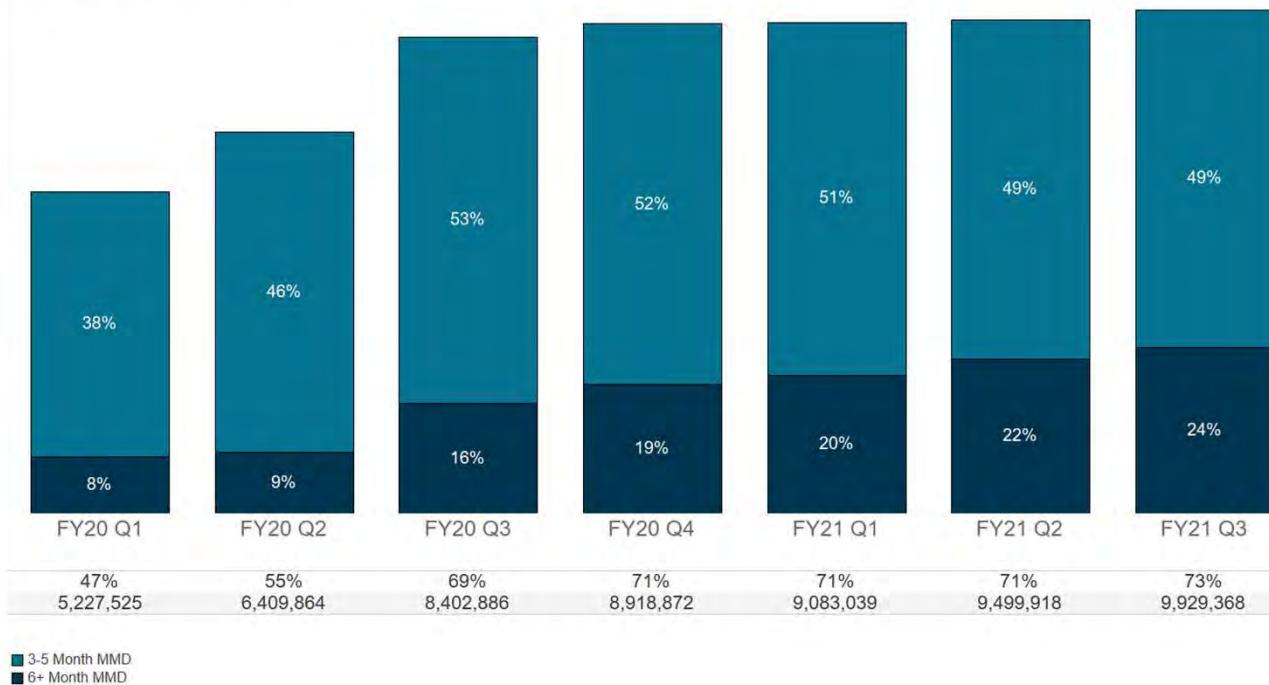
- Need to ensure all sites are reporting and the data are accurate.

South Africa data not included

Quarterly MMD coverage & absolute number of clients on MMD

MMD Totals

TX_CURR by MMD Level

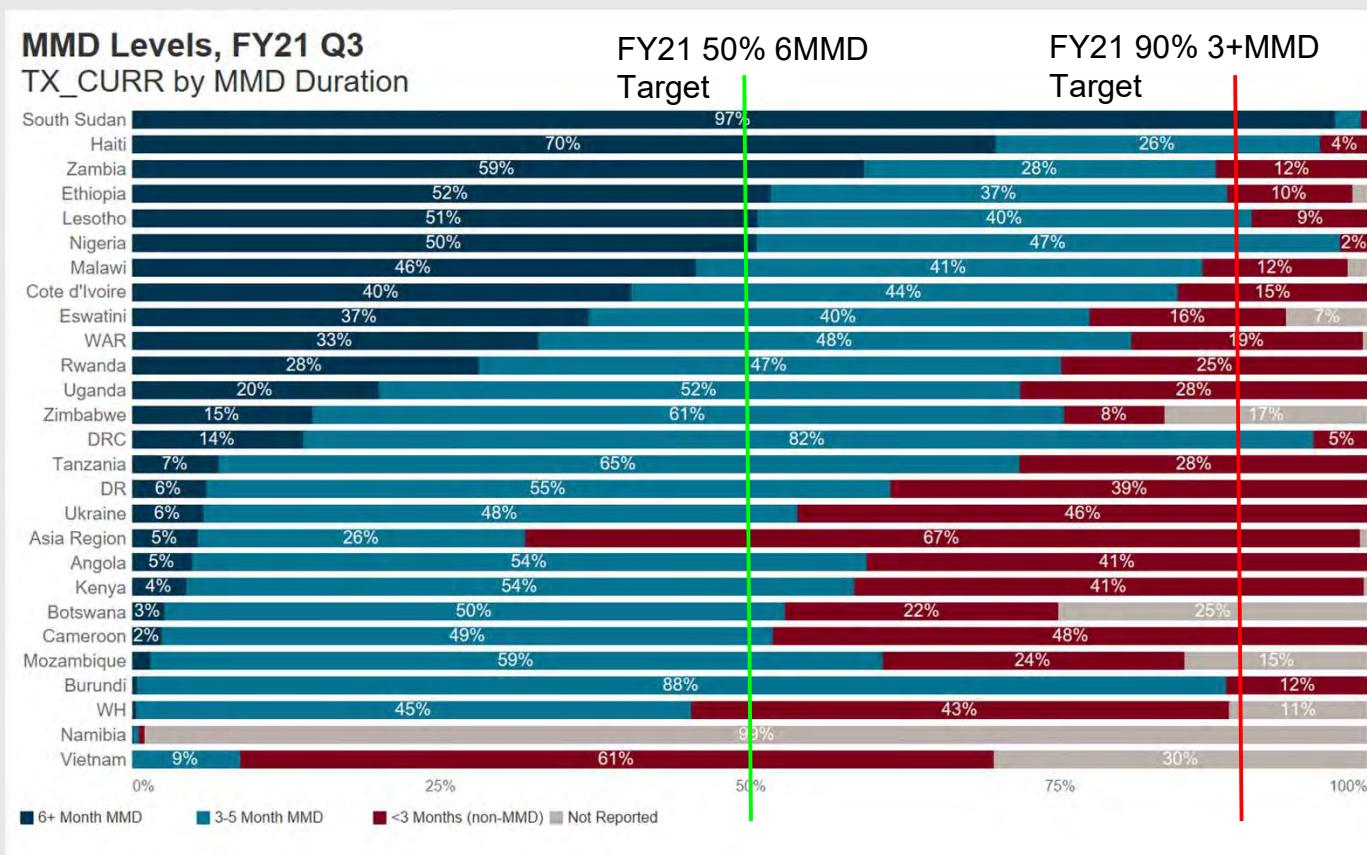


South Africa data not included

The PEPFAR program has added over 4 million clients to MMD since FY20 Q1 more than doubling the number of clients on MMD.

How can we accelerate MMD, particularly 6MMD, and ensure all eligible clients have access to extended ARV dispensing?

FY21Q3 country-level MMD coverage performance



Quarterly pediatric (<15) MMD coverage & absolute number of children on MMD

MMD Totals
TX_CURR by MMD Level



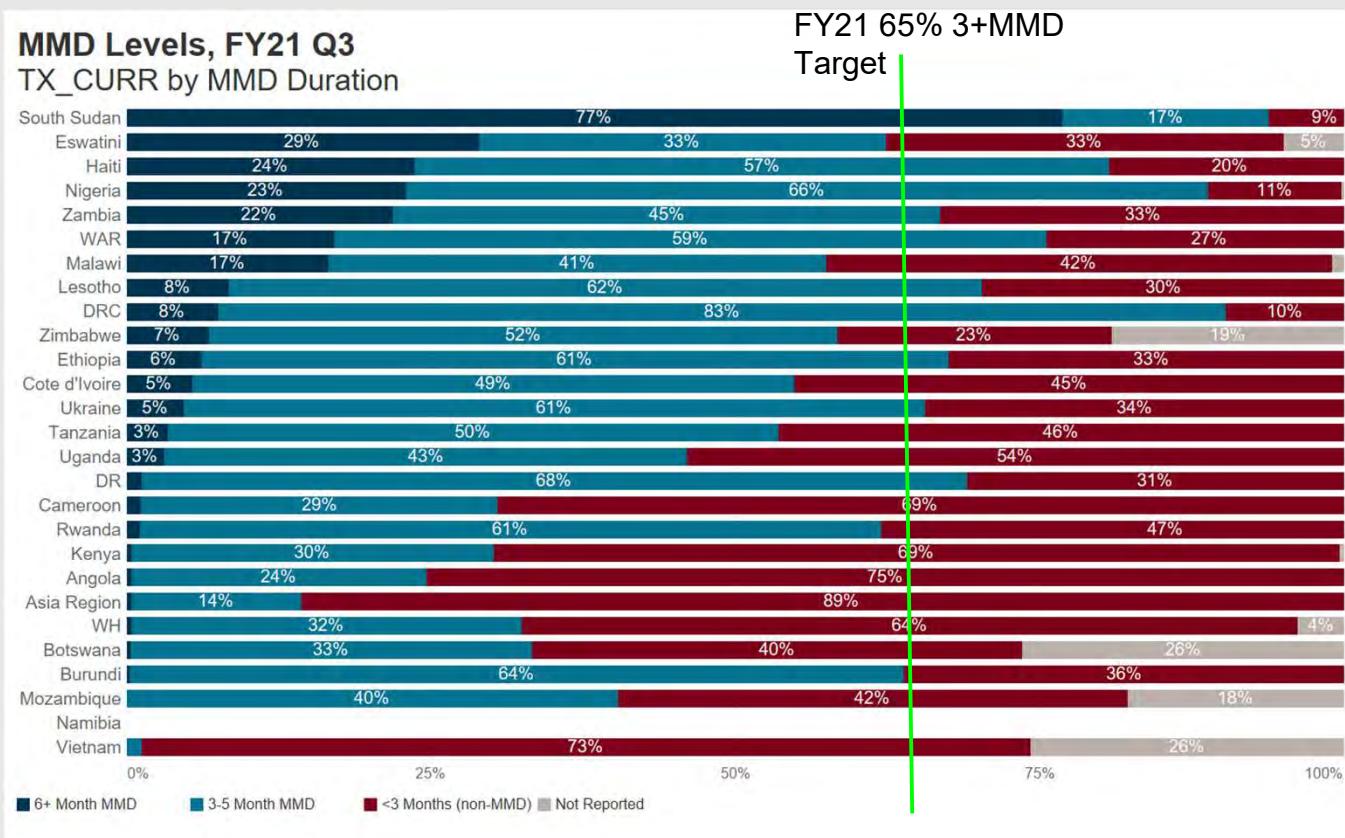
PEPFAR is struggling to scale pediatric MMD. The program had a substantial bump in coverage during the FY20Q3 COVID surge; however, coverage and # of children on MMD decreased for the first time in Q3.

Coverage is likely higher due to the imperfect proxy measure; but downtrend is concerning.

What barriers are facing uptake of pediatric MMD?

South Africa data not included

FY21Q3 country-level pediatric MMD coverage performance



What are some key components to successfully scaling MMD?

- Enabling policy environment and clear guidelines
- Strong supply chain management at all levels
 - Procurement, stock analysis, supply planning, distribution, etc.
- Efficient and well-equipped laboratory system
- Trained health workforce
 - Knowledgeable on guidelines and benefits of MMD, system in place for identifying/enrolling eligible clients
- Empowered patients
 - Demand-creation
 - Treatment literacy
- Tools and technology for monitoring and supporting all aspects of MMD implementation

Sample Policy Analysis

Ghana (3-6MMD)



- On current ART regimen for 12 months
- Virally suppressed (<1,000 copies/mL)
- No treatment failure/resistance issues
- Children < 5 ineligible
- Clinically stable pregnant women are eligible

Kenya (3MMD)



- On current ART regimen for 12 months
- Most recent LV undetectable
- No active OIs
- Adherent to scheduled clinic visit
- Children < 2 ineligible
- PBFW are ineligible

Laos (3-6MMD)



- On ART for 12 months
- No adverse drug reactions/current illness
- Good understanding of lifelong adherence
- Virally suppressed (<1,000 copies/mL)
- PBFW are ineligible

DRC (3-6MMD)



- On ART for 12 months
- Virally suppressed (<1,000 copies/mL)
- No OIs in the last 3 months
- No adverse reactions
- Children < 2 ineligible
- PRFW are eligible

Updated WHO guidelines, 2021

Criteria for determining whether a person is established on ART

To support the implementation of these recommendations, WHO has developed criteria for determining whether a person has been successfully established on ART:

- receiving ART for **at least six months**;
- **no current illness**, which does not include well-controlled chronic health conditions;
- good **understanding of lifelong adherence**: adequate adherence counselling provided; and
- **evidence of treatment success**: at least one suppressed viral load result within the past six months (if viral load is not available: CD4 count >200 cells/mm³ or CD4 count >350 for children 3-5 years or weight gain, absence of symptoms and concurrent infections).



- ⚠ **INCLUDES all populations established on ART:**
- Individuals receiving **second- and third-line regimens**
 - PLHIV with **controlled comorbidities**
 - **Children and adolescents**
 - **Pregnant** and **breastfeeding** women
 - **Key populations**

Minimum time on ART reduced from 12 to 6 months

Inclusion of sub-populations in the definition of “established on ART”

- Opportunity to advocate for the inclusion of children, PBFW and clients on second and third-line regimens

What does the literature say about MMD and treatment outcomes?

IMPLEMENTATION SCIENCE

Twelve-Month Outcomes of Community-Based Differentiated Models of Multimonth Dispensing of ART Among Stable HIV-Infected Adults in Lesotho: A Cluster-Randomized Noninferiority Trial

Betty B. Tukei, MSc, BSc,^a Geoffrey Fatti, MBChB, MPH,^{b,c}

- Similar to Fatti et al. in Zimbabwe
- Thirty facilities in Lesotho randomized to three arms:
 - Facility 3-monthly ART (3MF) (control),
 - Community 3-monthly ART groups (3MC);
 - 6-monthly community distribution points (6MCD)

Outcome Measure	3MF	3MC	6MCD
Retention (12 mos)	97.1% (N=1,842)	96.5% (N=1,504)	94.7% (N=1,781)
VLS (12 mos)	98.6% (N=1,503)	98.1% (N=1,126)	98.3% (N=1,285)

There were no significant differences in retention and VL suppression for stable HIV-infected participants receiving MMD within community-based differentiated models when compared to the facility-based standard of care model

Continuity of treatment and viral load suppression remain high and non-inferior to the standard of care with 6MMD



Interval Study: Malawi and Zambia (Hoffman et al.)

- Cluster-randomized, non-inferiority trial conducted at 30 health facilities in Malawi and Zambia
- Comparing three ART dispensing strategies for stable patients
 - Standard of care (based on provider opinion)
 - 3-month ART dispensing
 - 6-month ART dispensing
- Participants were virologically suppressed adults on first-line ART and not pregnant/breastfeeding
- Primary outcome: retention at 12 months

Outcome	Standard of care (N=3,012)	Three-month ART (N=2,726)	Six-month ART (N=2,981)
Retained	2,478 (82.3%)	2,356 (86.4%)	2,729 (91.5%)
LTFU	463 (15.3%)	296 (10.9%)	186 (6.2%)
Transferred	60 (2.0%)	66 (2.4%)	58 (1.9%)
Died	11 (0.4%)	8 (0.3%)	8 (0.3%)

Result: Six-month dispensing was associated with a 9.1% (95% CI 0.9%, 17.2%) absolute increase in retention in care at 12 months after model entry

Research Paper

Estimating the effect of increasing dispensing intervals on retention in care for people with HIV in Haiti

Canada Parrish^{a,*}, Anirban Basu^a, Paul Fishman^a, Jean Baptiste Koama^b, Ermane Robin^c, Kesner Francois^c, Jean Guy Honore^d, Joelle Deas Van Onacker^c, Nancy Puttkammer^a

^a University of Washington, 12054 42nd Ave S. Tukwila, Seattle, WA 98169, USA

^b Centers for Disease Control and Prevention, Port-au-Prince, Haiti

^c Ministère de la Santé Publique et de la Population (MSPP), Programme National de Lutte contre le VIH/SIDA (PNLS), Port-au-Prince, Haiti

^d Center Haïtien de Renforcement du Système Sanitaire (CHARESS), Port-au-Prince, Haiti

- Extending ART dispensing intervals increased the probability of retention at 12 months after ART initiation, with up to a 24.2%-point increase (95%CI: 21.9, 26.5) in the likelihood of retention with extending dispenses by 30 days for those receiving one-month dispenses.
- Observed statistically significant gains to retention with MMD with up to an approximately 4-month supply of ART
- Bottom line: MMD for ART is an effective service delivery strategy that improves care retention for new ART recipients.

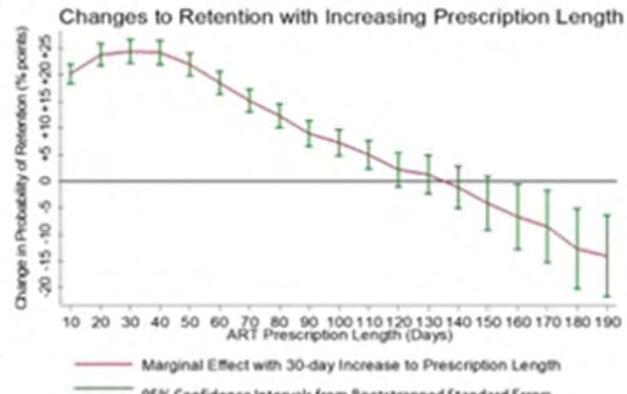


Fig. 1. Changes to retention with increasing prescription length.

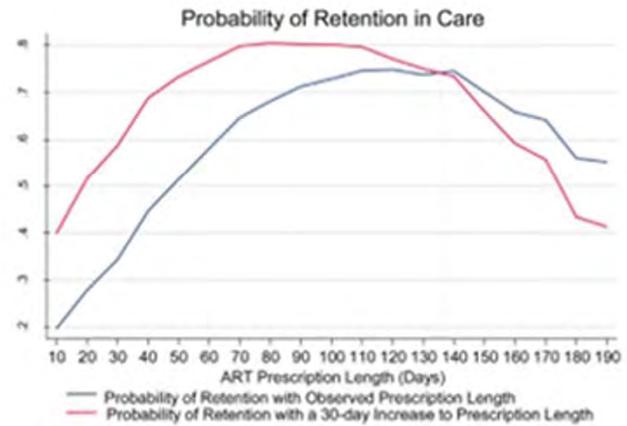
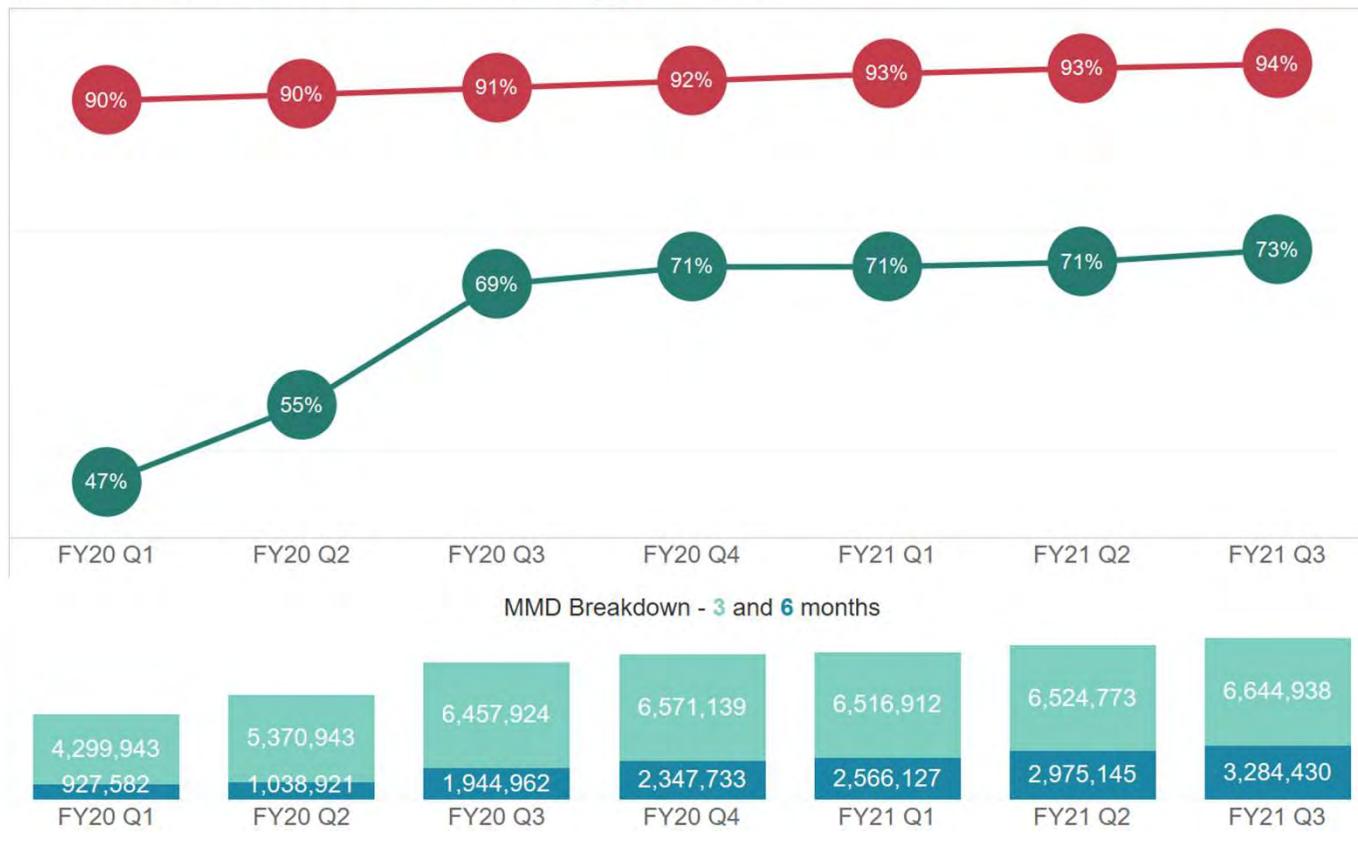


Fig. 2. Probability of retention in care at observed prescription lengths and 30-day increases to prescription lengths.

What does PEPFAR data tell us about MMD and VLS?

Trends in MMD and Viral Load Suppression

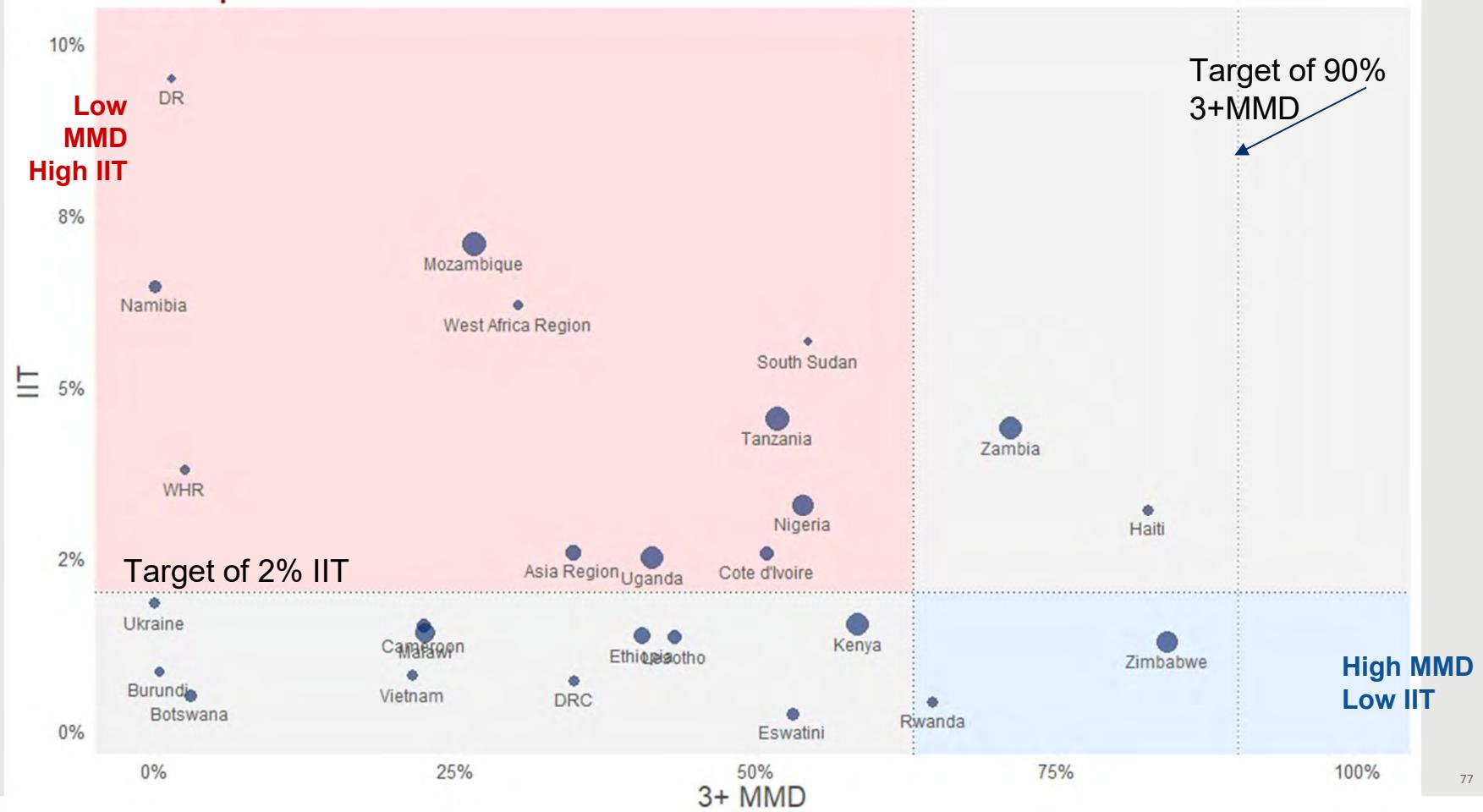


There are limitations with how we can interpret PEPFAR data. But as we've scaled MMD, there has not been a subsequent drop-off in VLS rates.

This visual does not take into account VLC or TLD, which can both affect VLS; it also does not incorporate the lag time between MMD enrollment and next VL test.

INTERRUPTIONS IN TREATMENT AND 3+ MMD LEVELS

2020 qtr1



Uganda policy shift has helped to accelerate MMD

Telephone: General Lines: 256 - 417 - 71226
Permanent Secretary's Office: 256 - 417 - 71221
Toll Free: 089438064
E-mail: ADM@mohs.go.ug
Website: www.mohs.go.ug



Ministry of Health
P.O. Box 272
Plot 6, Langata Road,
Mombasa &
KAMPALA
UGANDA

REF: ADM:148269.01

22nd February, 2021

"CIRCULAR"

All Health Facilities Providing ART Services
All Regional Referral Hospital Directors
All District Health Officers
All Regional Implementing Partners

RE: GUIDANCE ON VIRAL LOAD (VL) TESTING FOR ART OPTIMISATION AND MULTI MONTH DISPENSING (MMD).

1. Guidance on Viral Load Testing for ART Optimization

Viral Load testing is the key monitoring tool for treatment success among People Living with HIV (PLHIV) on ART. Uganda is currently optimizing ART regimens for PLHIV for better treatment outcomes and VL monitoring is critical to this optimization. The global COVID 19 pandemic has resulted in unanticipated disruptions to VL testing mainly due to disruptions in shipments of reagents and associated consumables resulting in a backlog of untested samples at the national lab projected to be end of March 2021. This has in turn affected ART optimization due to delayed VL results. As such, Ministry of Health issues the below guidance on VL testing for ART optimization:

- Viral Load test result requirement for ART optimization:** For ART optimization to be done, the patient should have a demonstrable suppressed VL. The 2020 *Consolidated Guidelines for the Prevention and Treatment of HIV/AIDS in Uganda* provides for a suppressed VL within the previous 6 months. Given the current delays in turnaround time of VL results, all patients with a suppressed VL result in the last 12 months should be transitioned to the optimal regimen as per the guidelines.
- Re-bleeding PLHIVs for VL testing in case of delayed results:** Facility staff managing ART clinics should desist from re-bleeding patients whose VL results have delayed to return as these are being tested overtime.

iii. **Sample Collection** Health facilities that had moved away from collecting plasma samples due to stock out of PPT tubes and those with the capacity to handle plasma should revert to plasma sample collection as the stock of PPT tubes has normalized and the lab achieves quicker result turnaround time (TAT) for plasma than DBS. In addition, plasma assays provide a lower quantification limit for viral load copies. Facilities without cold chain capacity and other tools for plasma sample collection should work with district leadership and IPs to establish this capacity.

2. Viral Load testing and Multi Month Dispensing:

The ARV supply that is dispensed to a client should no longer depend upon the viral load due date. Therefore, clients can receive 3- and 6-month MMD irrespective of their viral load due date. As a reminder, implementation guidelines permit a 4-month window period around the due date of the VL test. This means that a client may be bled from 2 months before to 2 months after their VL due date. To ensure that clients return for VL testing within this window period, facilities should implement strategies to remind clients of their due date and actively follow them up (e.g., text messaging, use of peers or community resource persons) as well as provide easy access to VL testing, including community VL testing. In addition, clinics should employ strategies to ensure that VL results are returned to clients as soon as possible. Clients with a non-suppressed VL should be contacted immediately and asked to return to the clinic for intensive adherence counseling and management.

3. Guidance on MMD of 3- and 6-months for clients newly initiated on ART

The 2020 *Consolidated Guidelines for the Prevention and Treatment of HIV/AIDS in Uganda* allow for 3- to 6-month MMD for clients newly initiating ART only after they have been on treatment for at least 6 months and have confirmed viral suppression. To ensure continuity of ART, especially in the context of COVID-19, newly initiating clients may now receive 3- to 6-month MMD after being on ART for 3 months. At the time of ART initiation, clients can be given 1- or 2-month supply of ARVs.

Three months after initiation, the client should be offered a 3-6-month supply of ARVs provided both of these conditions are met:

- i. The client has tolerated the ARVs during the first three months on ART, and
- ii. The client has been linked to a peer, a PLHIV group, a community resource person, or a community-based organization to provide psychosocial and adherence and ensure that clients return for the scheduled 6-month VL test.

4. **Implementation guidance:** District Health officers and Regional implementing partners are requested to support their respective Districts and Facilities to observe the guidance immediately.

The purpose of this communication is to request you to take note of the contents of this circular and implement the guidance immediately.

In case of need for more clarification, kindly contact **Dr. Cordelia Katureebe** on 0772-372411 or contact **Dr. Arthur Ahimbisibwe** on 0774-684286.

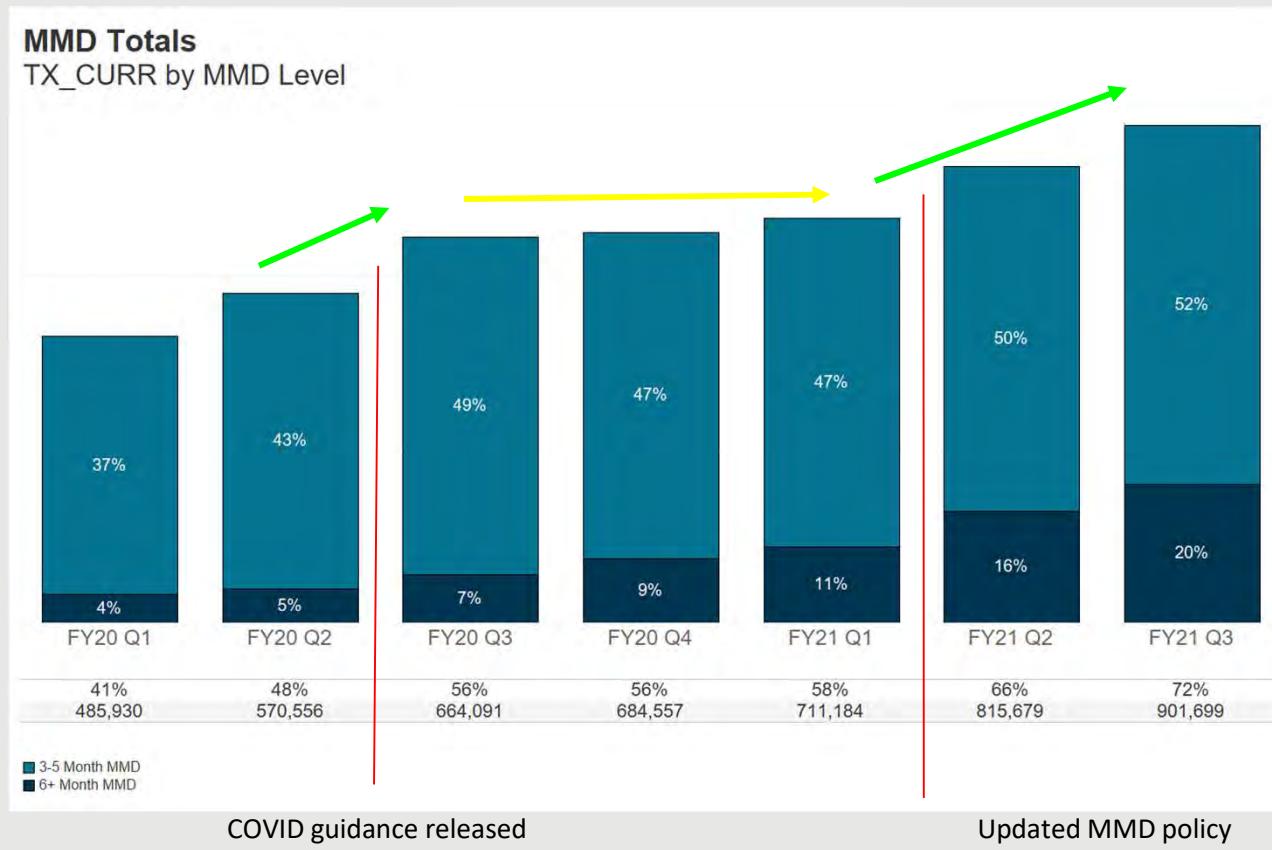
Dr. Henry G. Mwebesa
DIRECTOR GENERAL HEALTH SERVICES

C.c Permanent Secretary:

Revision to implementation guidance

- **ART optimization:** allow clients with 12 mos suppressed VL to transition to optimal regimens
- **MMD:** Provide 3-6 MMD irrespective of VL due date
- **Early retention:** Permit MMD for newly initiating clients

Policy changes in Uganda accelerated 3-6MMD



What are some patient/provider concerns about MMD?

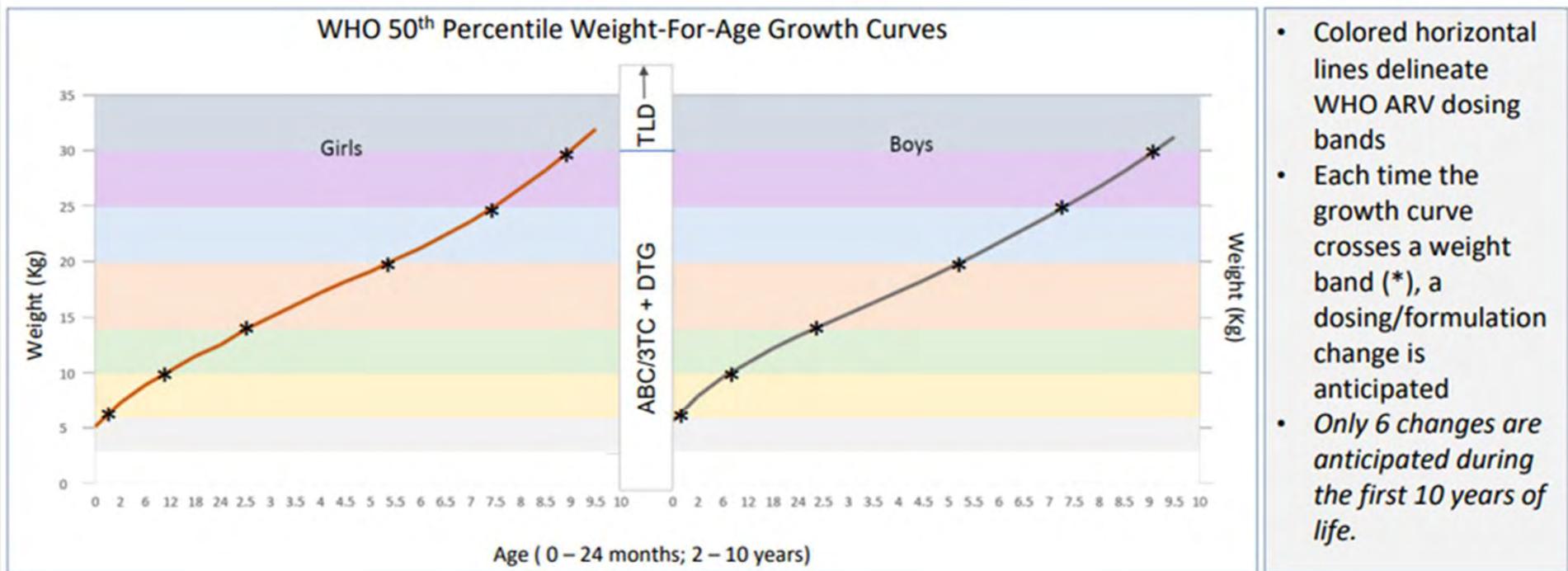
Provider

- Less contact with client → adherence issues and risk of IIT
- Children have weight-based dosing changes making MMD a challenge
- Fear of running out of stock
- Don't have the proper tools/technology for monitoring MMD (e.g. site level stock management or client tracking)
- Storage issue at the facility

Patient

- Feeling of abandonment
- Need for support between ART pickups
- Stigma/fear of unintended disclosure
- Storage challenges
- Poor treatment literacy and/or understanding of MMD

Pediatric ARV Dosing and Formulation Optimization Changes Do Not Require Monthly Clinic Visits



- DTG 10 mg for CLHIV 3 - < 20 kg • DTG 50 mg for CLHIV 20 - < 30 kg • TLD for CLHIV \geq 30 kg •

Enhancing provider/patient knowledge of MMD for C/ALHIV

In May 2020, USAID requested three global projects – ACHIEVE, EpiC, and RISE – to collaborate in supporting the scale-up of multi-month dispensing (MMD) of ARVs among children and adolescents living with HIV (C/ALHIV) in Burundi and Nigeria. The partnership aimed to facilitate a combination of the complementary technical expertise of treatment and OVC partners to promote MMD for C/ALHIV and a strengthening of linkages between facility- and community-level services to support adherence, continuity of care, and improved treatment outcomes.

Drawing from the results of a rapid baseline assessment of MMD coverage among C/ALHIV at selected ART sites and OVC program areas as well as the successes and barriers to MMD scale-up facing implementers at both treatment and OVC program levels, the ACHIEVE/EpiC/RISE partnership identified some important gaps, including in the availability of tools to support MMD scale-up. The partnership has since developed several materials which are available to support facility- and community-based health providers to promote MMD for C/ALHIV. These materials were developed for use in Burundi and Nigeria but would be easily adapted for use in other settings.

TECHNICAL GUIDE FOR HEALTHCARE WORKERS ON PEDIATRIC MULTI-MONTH DISPENSING (MMD)

SUMMARY: A guide for health care providers responsible for assessing MMD eligibility and prescribing 3MMD or 6MMD for C/ALHIV, aiming to address identified barriers to greater MMD uptake among C/ALHIV on ART, including provider concerns about less frequent clinical follow-up.

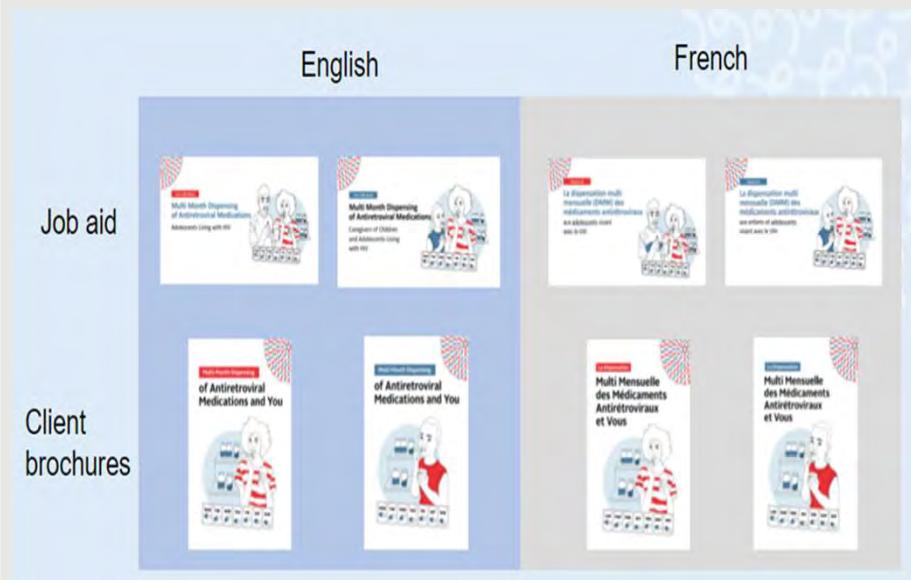
INCLUDES:

- information on the requirements for successful MMD, including defined eligibility criteria, optimized regimens and formulations, supply chain, client sensitization, and systems for monitoring between clinical visits, including the importance of partnerships with community-based programs such as OVC programs
- a description of required competencies for selecting optimal regimens, clinical management of C/ALHIV on ART, managing the ARV supply chain, and pediatric counseling
- a discussion of MAE for MMD, including tool templates

AVAILABLE IN: English

- EpiC, RISE & ACHIEVE developed a suite of materials to help support the scale-up of MMD to C/ALHIV
- Goal is to educate and encourage discussion about MMD between providers, case workers, counselors, caregivers, and C/ALHIV
- Tools are available in English and French and have been field-tested in Nigeria and Burundi (but can be easily adapted)

Available tools to support scaling MMD to C/ALHIV



- Technical Guide for Healthcare Workers for assessing MMD eligibility and prescribing 3MMD or 6MMD for C/ALHIV
- Technical Guide for CHWs to understand the importance of MMD and to understand their role and responsibilities in supporting MMD for C/ALHIV
- Job Aid for Healthcare Providers, Case Workers, and Other Counselors to Discuss MMD with Caregivers of C/ALHIV
- Job Aid for Healthcare Providers, Case Workers, and Other Counselors to Discuss MMD with C/ALHIV
- Two Handout Brochures: MMD of ARVs and You (one for caregivers, other for ALHIV)

Link to tools here: [Multi-Month Dispensing of Antiretroviral Medications for Adolescents and Children Living with HIV | FHI 360](#)

How can these tools be incorporated into your work?



- Many countries capitalized on the TLD transition as an opportunity to help scale MMD
- As pediatric DTG10 is introduced, this can also be an opportunity to scale pediatric MMD AND utilize the information, education and communication (IEC) tools to ensure responsible adoption of MMD among C/ALHIV
- Any other thoughts, ideas, recommendations?

— Panel Discussion / Q and A



PEPFAR

