Supporting Continuity of ART for PLHIV: Successes and Lessons Learned

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USAID Office of HIV/AIDS
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 Branch
USAID, Office of HIV/AIDS
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?

- 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

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

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

- 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

- 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

- 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 ≥ 3 Months

- 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)
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
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

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<th>Standardized Disaggregate</th>
<th>Other Disaggregate</th>
<th>TX_CURR N</th>
<th>Indicator TX ML N</th>
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<th>TX_NEW N</th>
<th>TX_RTT N</th>
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Additional disaggregates make up age & sex, so the total add up to Total Numerator.

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

Some disaggregate categories equal Total Numerator...

...while others don’t
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 \((\text{Tx_ml [iit]} + \text{tx_rtt} / \text{tx_curr})\) | 6.5% | 6.7% | 8.0% | 6.8% | 6.3% | 5.7% | 5.3% |
Data Completeness impacts IIT

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<th>OU</th>
<th>% TX_CURR sites reporting IIT</th>
<th>% TX_CURR sites (&gt;1000 patients) reporting IIT</th>
<th>%IIT</th>
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<td>4%</td>
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<td>4%</td>
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<tr>
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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
Outline

• Background, Epidemiology and Clinical Cascade Data
• Tingathe’s Approach to Promote Retention in Treatment
• Challenges, Highlights, and Successes
• Key Points
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 Tingatethe-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
BCM-CFM Tingatethe in 2021: CORE project

Baylor-Malawi’s Tingatethe 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:

- 94% PLHIV know HIV status; 98% alive on tx; 94% virally suppressed

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 LIT

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
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

12 month retention by subgroup

- Entire Tingathe ADULT cohort: 73%
- Subset of 12 sites clients on 6MMD - All: 96%
- Subset of 12 sites clients on 6MMD - Female: 96%
- Subset of 12 sites clients on 6MMD - Male: 95%

• 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)
BCM- CFM has excellent retention of ALHIV in care (5% IIT) and exceptional retention of adolescents at Teen club sites (1% IIT)

- 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

- 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
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 start / restart and stay on ART
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

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<tr>
<td>Q4</td>
<td>83%</td>
<td>85%</td>
</tr>
</tbody>
</table>

Data source: ART Mastercard Review
In our active cohort in Q3FY21, only 4% of clients experienced treatment interruption

- 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

<table>
<thead>
<tr>
<th>Step</th>
<th>Description &amp; Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>KPI data collected at site; mobile-based reporting tools</td>
</tr>
<tr>
<td></td>
<td>M&amp;E supervision &amp; validation in 1st half of month</td>
</tr>
<tr>
<td></td>
<td>Client survey data collected weekly</td>
</tr>
<tr>
<td></td>
<td>DOA quarterly at district (M&amp;E officer) &amp; program level (M&amp;E senior staff)</td>
</tr>
<tr>
<td></td>
<td>Resource data (HR, commodity, expenditure analysis) reported semi-annually</td>
</tr>
<tr>
<td></td>
<td><strong>Stakeholders:</strong> MoH staff, Baylor-M M&amp;E, community partners, clients</td>
</tr>
<tr>
<td>2.</td>
<td>M&amp;E team generates site-level dashboard w/ KPI indicators including HIV clinical cascade analytics</td>
</tr>
<tr>
<td>3.</td>
<td>Dashboard shared w/ site team weekly; mobile communication w/ key summaries. Achievements &amp; challenges discussed w/ site teams</td>
</tr>
<tr>
<td></td>
<td>Weekly (site team) and monthly (district) CQI meetings to discuss data (incl. client interview feedback), share challenges/ brainstorm solutions</td>
</tr>
<tr>
<td></td>
<td>Resource allocation data assessed semi-annually for management to make data-driven adjustments</td>
</tr>
<tr>
<td></td>
<td><strong>Stakeholders:</strong> Baylor-M team, MoH HF staff, MoH leadership, IP, clients</td>
</tr>
<tr>
<td>4.</td>
<td>HCW and program managers jointly adjust service implementation</td>
</tr>
<tr>
<td></td>
<td><strong>Stakeholders:</strong> Baylor-M program team, MoH</td>
</tr>
<tr>
<td>5.</td>
<td>Implementation continues based on team adjustments</td>
</tr>
<tr>
<td></td>
<td>Additional indicators developed to monitor any new initiatives</td>
</tr>
<tr>
<td></td>
<td><strong>Stakeholders:</strong> Baylor-M program team, MoH</td>
</tr>
</tbody>
</table>
Exemplary CQI: Using TX_ML to demonstrate higher 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

Data source: EMR.
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
**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.

**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.

**Current target Population**

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

**Current Project areas**

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

**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
Epidemiology and Clinical Cascade Data

Treatment program growth trends and continuity in treatment (CIT)

Clinical Cascade Data (FY21)

Interruption in treatment (IIT) Q3

Legend
- Continuity in Treatment
- Treatment Growth

<table>
<thead>
<tr>
<th>Month</th>
<th>October</th>
<th>November</th>
<th>December</th>
<th>January</th>
<th>February</th>
<th>March</th>
<th>April</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>August</th>
<th>September</th>
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<tbody>
<tr>
<td>HTS_POS</td>
<td>16,350</td>
<td>16,346</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>TX_NEW</td>
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<td>PVLS_D</td>
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<td></td>
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</tr>
</tbody>
</table>

One Stop Shop
- Eket KP: 52
- Acoce KP: 33
- Ikot Ekpene: 23
- Calabar Municipal KP: 10
- Lagos Island: 19
- Ogoja KP: 17
- Ojo KP: 15
- Ikom KP: 15
- Bakassi KP: 14
- Uyo KP: 12
- Yakurr KP: 10
- Oron KP: 0
- Ikorodu KP: 0
- Badagry KP: 0
IIT Trend According to Duration on Treatment
In Akwa Ibom State, Eket LGA has the highest IIT of 19 clients.

In Cross Rivers State, Calabar Municipal LGA has the highest IIT of 8 clients.

In Lagos State, Agege LGA has the highest IIT of 18 clients.
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.
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.
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

<table>
<thead>
<tr>
<th>Practice</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitution of CQI Committee across the OSS.</td>
<td></td>
</tr>
<tr>
<td>Above site weekly performance review with AOR, Weekly review of Program Performance at the site level/ Weekly Virtual Mentorship Program/ Clinical Reviews.</td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>Monthly meeting of the committee using data and analysis of processes of care to identify gaps.</td>
<td></td>
</tr>
<tr>
<td>Selecting specific gap to address at a time- proposing changes etc.</td>
<td></td>
</tr>
<tr>
<td>Share improvement Plans and set targets.</td>
<td></td>
</tr>
<tr>
<td>Successes are shared in quarterly Review meetings/ implementation expanded.</td>
<td></td>
</tr>
</tbody>
</table>
# 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
Percent of ART clients on MMD by number of months of ARVs dispensed

- 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

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

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?
FY21Q3 country-level pediatric MMD coverage performance

<table>
<thead>
<tr>
<th>Country</th>
<th>6+ MMD Coverage</th>
<th>3-5 MMD Coverage</th>
<th>&lt;3 MMD Coverage</th>
<th>Not Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Sudan</td>
<td>0%</td>
<td>97%</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>Eswatini</td>
<td>26%</td>
<td>77%</td>
<td>33%</td>
<td>0%</td>
</tr>
<tr>
<td>Haiti</td>
<td>30%</td>
<td>62%</td>
<td>33%</td>
<td>0%</td>
</tr>
<tr>
<td>Nigeria</td>
<td>29%</td>
<td>61%</td>
<td>32%</td>
<td>0%</td>
</tr>
<tr>
<td>Zambia</td>
<td>23%</td>
<td>52%</td>
<td>48%</td>
<td>0%</td>
</tr>
<tr>
<td>WAR</td>
<td>17%</td>
<td>45%</td>
<td>55%</td>
<td>0%</td>
</tr>
<tr>
<td>Malawi</td>
<td>17%</td>
<td>62%</td>
<td>33%</td>
<td>0%</td>
</tr>
<tr>
<td>Lesotho</td>
<td>8%</td>
<td>83%</td>
<td>17%</td>
<td>0%</td>
</tr>
<tr>
<td>DRC</td>
<td>8%</td>
<td>72%</td>
<td>28%</td>
<td>0%</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>6%</td>
<td>22%</td>
<td>78%</td>
<td>0%</td>
</tr>
<tr>
<td>Ethiopia</td>
<td>6%</td>
<td>41%</td>
<td>59%</td>
<td>0%</td>
</tr>
<tr>
<td>Cote d'Ivoire</td>
<td>5%</td>
<td>52%</td>
<td>48%</td>
<td>0%</td>
</tr>
<tr>
<td>Ukraine</td>
<td>5%</td>
<td>49%</td>
<td>51%</td>
<td>0%</td>
</tr>
<tr>
<td>Tanzania</td>
<td>4%</td>
<td>81%</td>
<td>19%</td>
<td>0%</td>
</tr>
<tr>
<td>Uganda</td>
<td>7%</td>
<td>81%</td>
<td>19%</td>
<td>0%</td>
</tr>
<tr>
<td>DR</td>
<td>3%</td>
<td>43%</td>
<td>57%</td>
<td>0%</td>
</tr>
<tr>
<td>Cameroon</td>
<td>29%</td>
<td>68%</td>
<td>32%</td>
<td>0%</td>
</tr>
<tr>
<td>Rwanda</td>
<td>30%</td>
<td>61%</td>
<td>39%</td>
<td>0%</td>
</tr>
<tr>
<td>Kenya</td>
<td>24%</td>
<td>89%</td>
<td>11%</td>
<td>0%</td>
</tr>
<tr>
<td>Angola</td>
<td>24%</td>
<td>89%</td>
<td>11%</td>
<td>0%</td>
</tr>
<tr>
<td>Asia Region</td>
<td>14%</td>
<td>89%</td>
<td>11%</td>
<td>0%</td>
</tr>
<tr>
<td>WI</td>
<td>14%</td>
<td>89%</td>
<td>11%</td>
<td>0%</td>
</tr>
<tr>
<td>Botswana</td>
<td>13%</td>
<td>89%</td>
<td>11%</td>
<td>0%</td>
</tr>
<tr>
<td>Burundi</td>
<td>13%</td>
<td>89%</td>
<td>11%</td>
<td>0%</td>
</tr>
<tr>
<td>Mozambique</td>
<td>13%</td>
<td>89%</td>
<td>11%</td>
<td>0%</td>
</tr>
<tr>
<td>Namibia</td>
<td>13%</td>
<td>89%</td>
<td>11%</td>
<td>0%</td>
</tr>
<tr>
<td>Vietnam</td>
<td>0%</td>
<td>73%</td>
<td>27%</td>
<td>0%</td>
</tr>
</tbody>
</table>

FY21 65% 3+MMD Target
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
- PBFW are eligible
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?

- 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)

<table>
<thead>
<tr>
<th>Outcome Measure</th>
<th>3MF</th>
<th>3MC</th>
<th>6MCD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retention (12 mos)</td>
<td>97.1% (N=1,842)</td>
<td>96.5% (N=1,504)</td>
<td>94.7% (N=1,781)</td>
</tr>
<tr>
<td>VLS (12 mos)</td>
<td>98.6% (N=1,503)</td>
<td>98.1% (N=1,126)</td>
<td>98.3% (N=1,285)</td>
</tr>
</tbody>
</table>

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

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

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.
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.
What does PEPFAR data tell us about MMD and VLS?

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.

South Africa data not included
Uganda policy shift has helped to accelerate MMD

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

COVID guidance released
Updated MMD policy
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
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
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- Storage challenges
- Poor treatment literacy and/or understanding of MMD

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

WHO 50th Percentile Weight-For-Age Growth Curves

- Colored horizontal lines delineate WHO ARV dosing bands
- Each time the growth curve crosses a weight band (*), a dosing/formulation change is anticipated
- Only 6 changes are anticipated during the first 10 years of life.

- DTG 10 mg for CLHIV 3 - < 20 kg
- DTG 50 mg for CLHIV 20 - < 30 kg
- TLD for CLHIV ≥ 30 kg

Contributors: Rachel Golin (USAID), Gina Sarfaty (USAID), Kelsey Mirkovic (CDC), Henry Miller (USAID), Stephanie Hackett (CDC)

Last updated: 13 May 2021.
Feel free to reach out to Rachel Golin (rgolin@usaid.gov) with any questions.
Enhancing provider/patient knowledge of MMD for C/ALHIV

- 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