WHO ‘TRACK’ Digital Learning Series - Technical Resources for AHD Capacity and Knowledge

World Health Organization

The session will begin momentarily

Turning WHO Guidance into Action: Zambia’s Approach to Supporting Re-engagement in HIV Treatment

Monday, 17 February, 2025

World Health Organization

HEALTH SCIENCES

Project ECHO

Monday, 17 February, 2025
16:00-17:00 CET

Webinar Topic:

Turning WHO Guidance into Action: Zambia's Approach to Supporting Re-engagement in HIV Treatment

WHO 'TRACK' Digital Learning Series - Technical Resources for AHD Capacity and Knowledge

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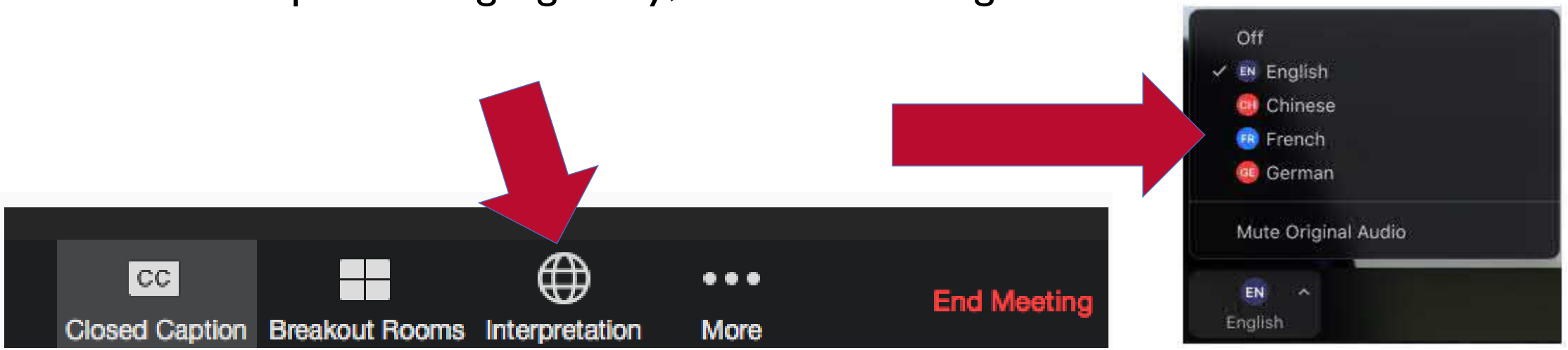

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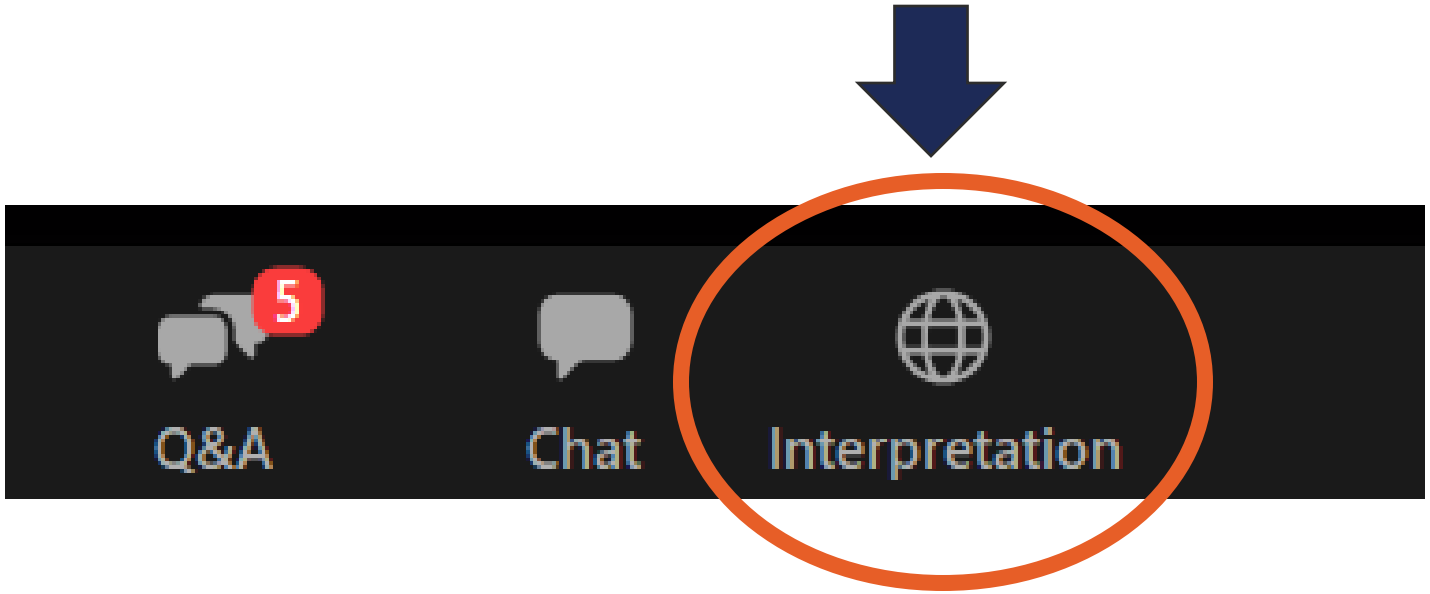
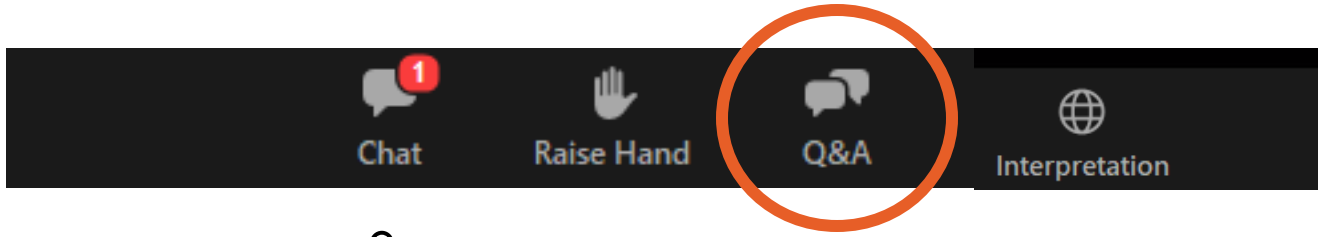
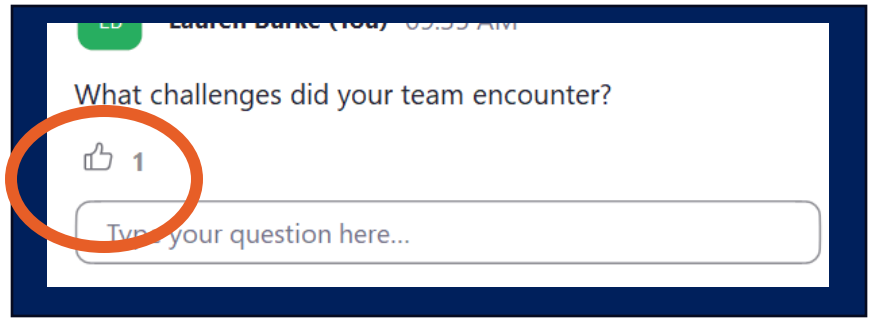


Questions and Chat

Use **Q&A** box for questions regarding the topic and presentations



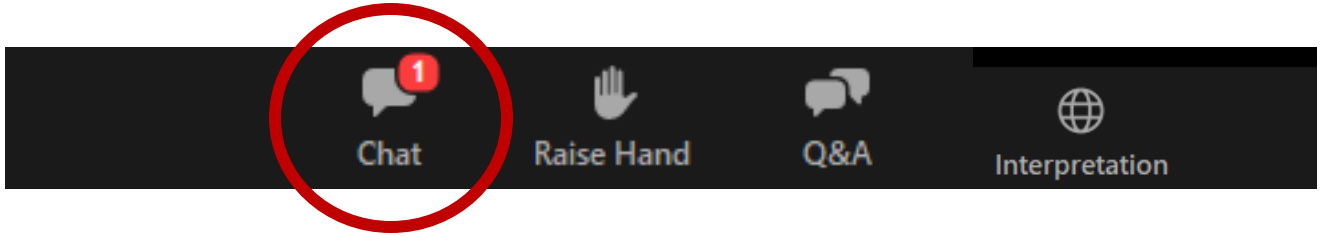
Use the **Q&A upvote** **feature** to help us identify common questions



The moderator will choose the most voted questions to ask during the Q&A

Questions and Chat

Use **Chat** box only for questions regarding IT or logistics



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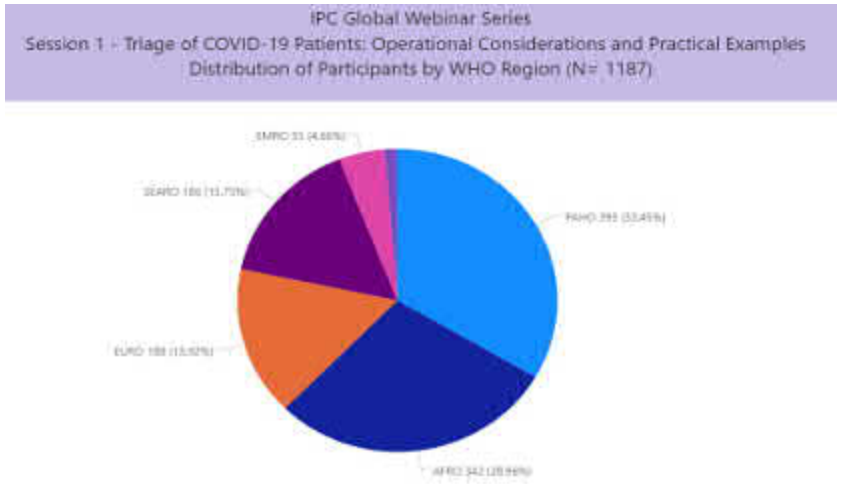

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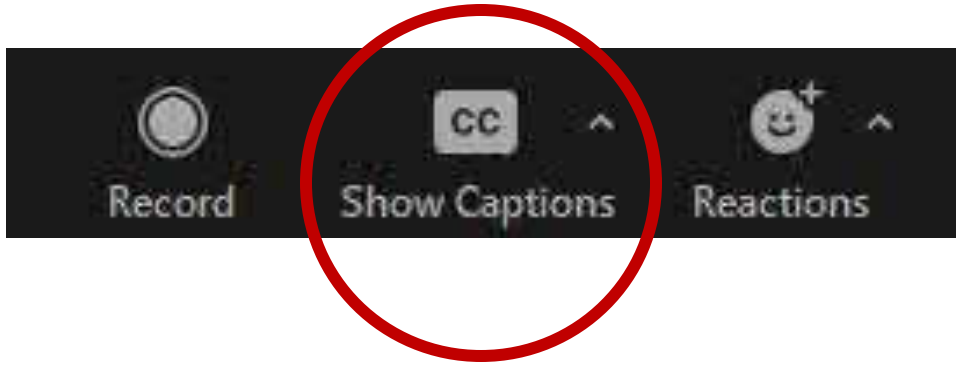

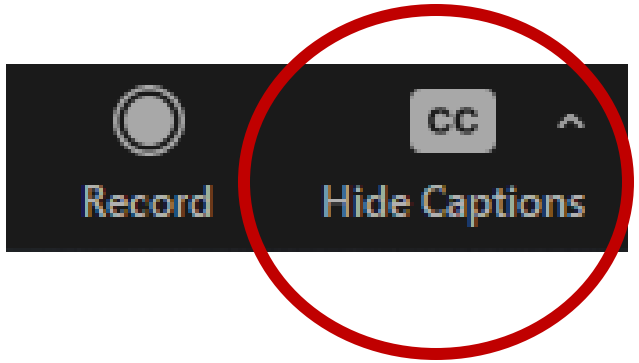

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- This session is being recorded and your attendance is consent to be recorded.
- Certificate of Attendance will be available through the University of New Mexico via a link shared in the zoom chat at the end of the session, as well as through a follow-up email. This link is only open for 48 hours and will close on .

Turning WHO Guidance into Action: Zambia's Approach to Supporting Re-engagement in HIV Treatment

📌 **Objectives:**

- Present an overview of WHO's policy brief: Supporting Re-engagement in HIV Treatment Services.
- Share country experiences and lessons learned on re-engagement strategies.
- Identify challenges and innovative solutions for re-engagement efforts.
- Highlight best practices to strengthen HIV treatment re-engagement pathways.

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Agenda

Session details	Presenters and Moderators
Welcoming Remarks	Facilitator: Clarice Pinto, WHO
WHO Supporting re-engagement in HIV treatment services policy brief overview	Presenter: Clarice Pinto, WHO
Re-engagement strategies: experiences from Zambia	Presenter: Dr Suilanji Sivile Zambia, Ministry of Health
Recipient of care perspective and experience at re-engagement	Presenter: Fred Misumbi Chungu, Network of Zambian People Living HIV and AIDS (NZP+)
Q & A	Moderator: Dr Larissa Polejack, University of Brasília, Brazil
Summary takeaways and closing remarks	Dr Larissa Polejack, University of Brasília and Clarice Pinto, WHO

Facilitator & Presenter

Clarice Pinto

Technical officer (DSD ART Focal point)

World Health Organization,

Geneva

Moderator

Dr. Larissa Polejack

Associated Professor

University of Brasília,

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Presenters

Dr Sivile Suilanji

National HIV Technical Advisor

Ministry of Health,

Zambia

Fred Misumbi Chungu

Executive Director,

Network of Zambian People Living HIV and AIDS (NZP+), Zambia

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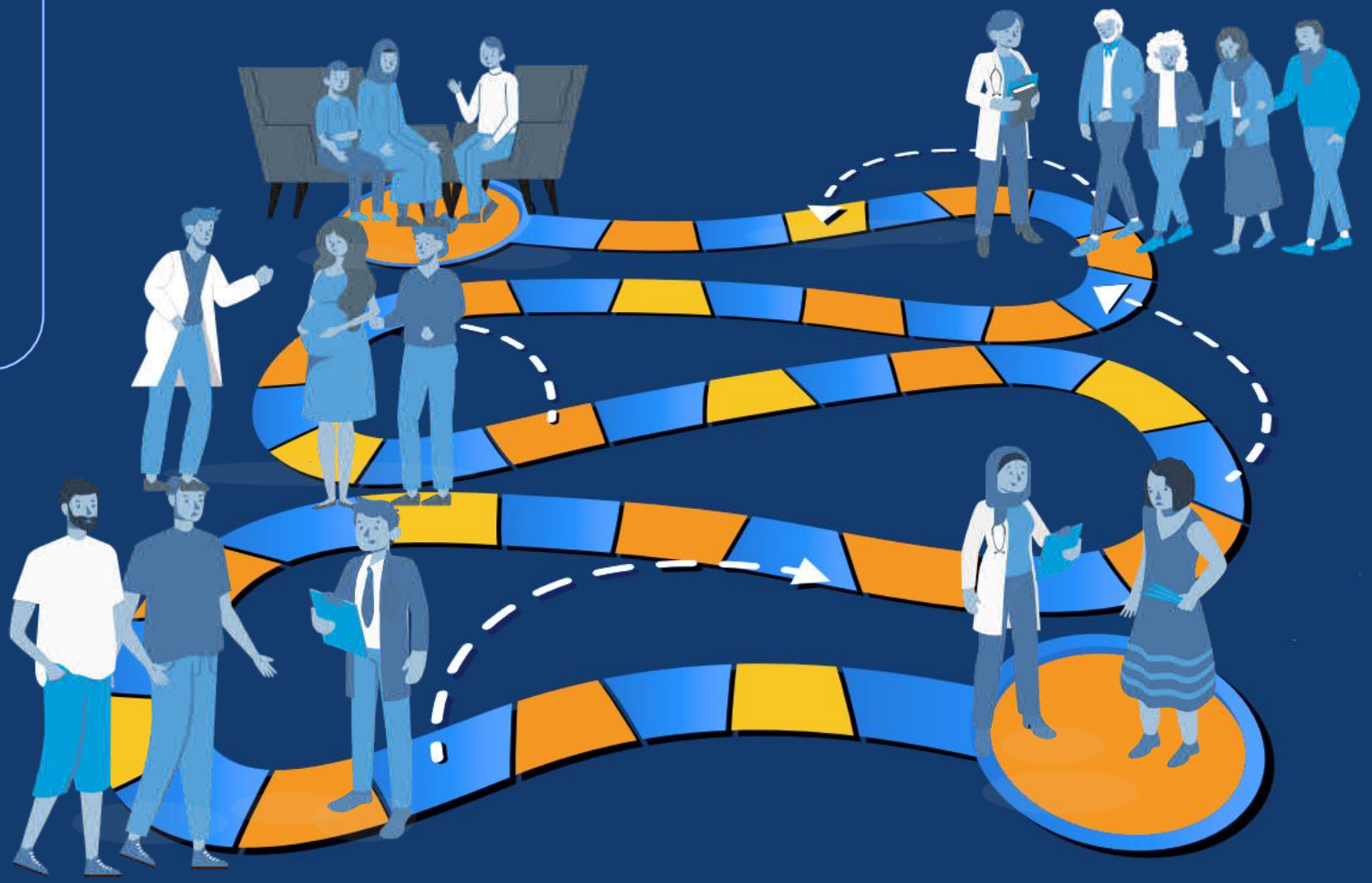
Supporting re-engagement in HIV treatment services

Policy brief



Turning WHO Guidance into Action: Zambia's Approach to Supporting Re-engagement in HIV Treatment

Monday, 17 February 2025

Clarice Pinto, WHO Geneva,
Technical officer, DSD ART Focal point

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WHO's new "Supporting re-engagement to HIV treatment: policy brief"

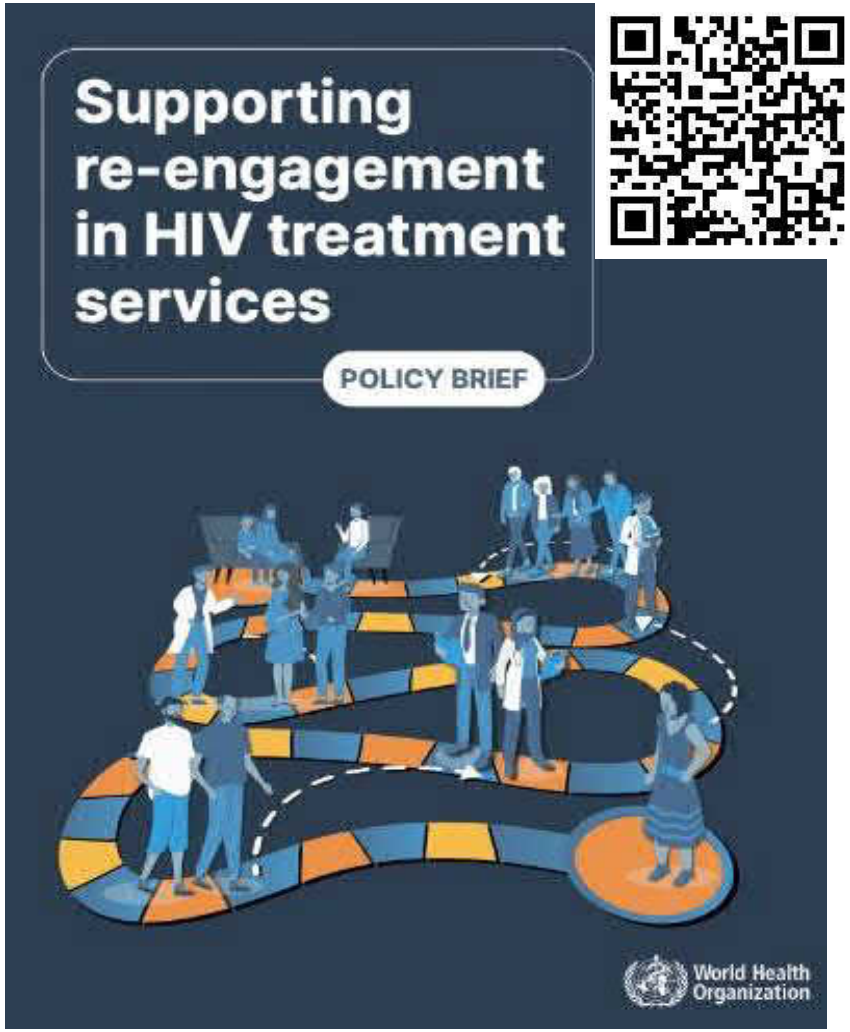
Overview of challenges and reasons for disengagement and re-engagement

Highlights key WHO guidance on continuous engagement, tracing and re-engagement

Key differentiated re-engagement guiding principles

Differentiated pathways to support re-engagement in HIV treatment and care

Assist countries and communities adopt and adapt tracing and re-engagement recommendation



WHO recommendations to support continuous engagement and maintain re-engagement

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WHO recommendation for re-engagement

Supporting those who are disconnected from HIV treatment to re-engage in HIV care:

Programs should implement interventions to locate people who have disengaged from care and provide support for their re-engagement (2021 recommendation)

Good practice statement

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

Health systems should invest in people-centred practices

Non-judgmental, tailored approaches to assessing adherence

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

People established on ART should be offered clinical visits every 3–6 months, preferably every six months, if feasible. (2021 recommendation).

People established on ART should be offered refills of ART lasting 3–6 months, preferably six months, if feasible (2021 recommendation).

Programmes should provide community support for people living with HIV to improve retention in HIV care (2016 recommendation).

Reduced frequency of visits

What is re-engagement in HIV treatment services?

Disengagement from care may happen after starting antiretroviral therapy (ART), and may occur more than once.

Re-engagement in HIV treatment services refers to people returning to HIV services after a period of interruption.

- This occurs when a person misses scheduled visits or appointments and does not receive treatment for a certain period of time.

Note: The defined duration of care and treatment interruption will vary across contexts. The WHO brief does not specifically address the duration of these interruptions but provides considerations on how to address them.

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Key terms from the WHO re-engagement policy brief

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

- Not everyone who misses their appointments stops or interrupts their treatment.
- Clients might arrive late or miss a scheduled visit, but they can still access ART or get enough ART to cover the days they missed.

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

- The outcomes for people living with HIV who have not returned for follow-up are unknown.
- This includes undocumented "silent" transfers, people who have died, and those who have interrupted their treatment

(1) Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach, 2021 update. Geneva: World Health Organization; 2021
(2) . Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization; 2022

The reasons and consequences of disengagement

Reasons

A systematic review (Burke et al, 2024) identified reasons for disengagement during the "treat all" era.

- The review highlighted main factors:
  - Mobility issues
  - Lack of perceived benefits of ART (Antiretroviral Therapy)
  - Structural/societal factors, such as transport costs or distance

Consequences

- **Health impact:**
  - progression to advanced HIV disease,
  - increased mortality,
  - increased risk of developing antiretroviral drug resistance, and
  - higher risk of onward transmission.
- **Public health impact:**
  - Morbidity, mortality, and HIV transmission resulting from people disengaged from care.

Source: Burke et al.
https://onlinelibrary.wiley.com/doi/epdf/10.1002/jia2.26230

Research findings on Reasons for Disengagement

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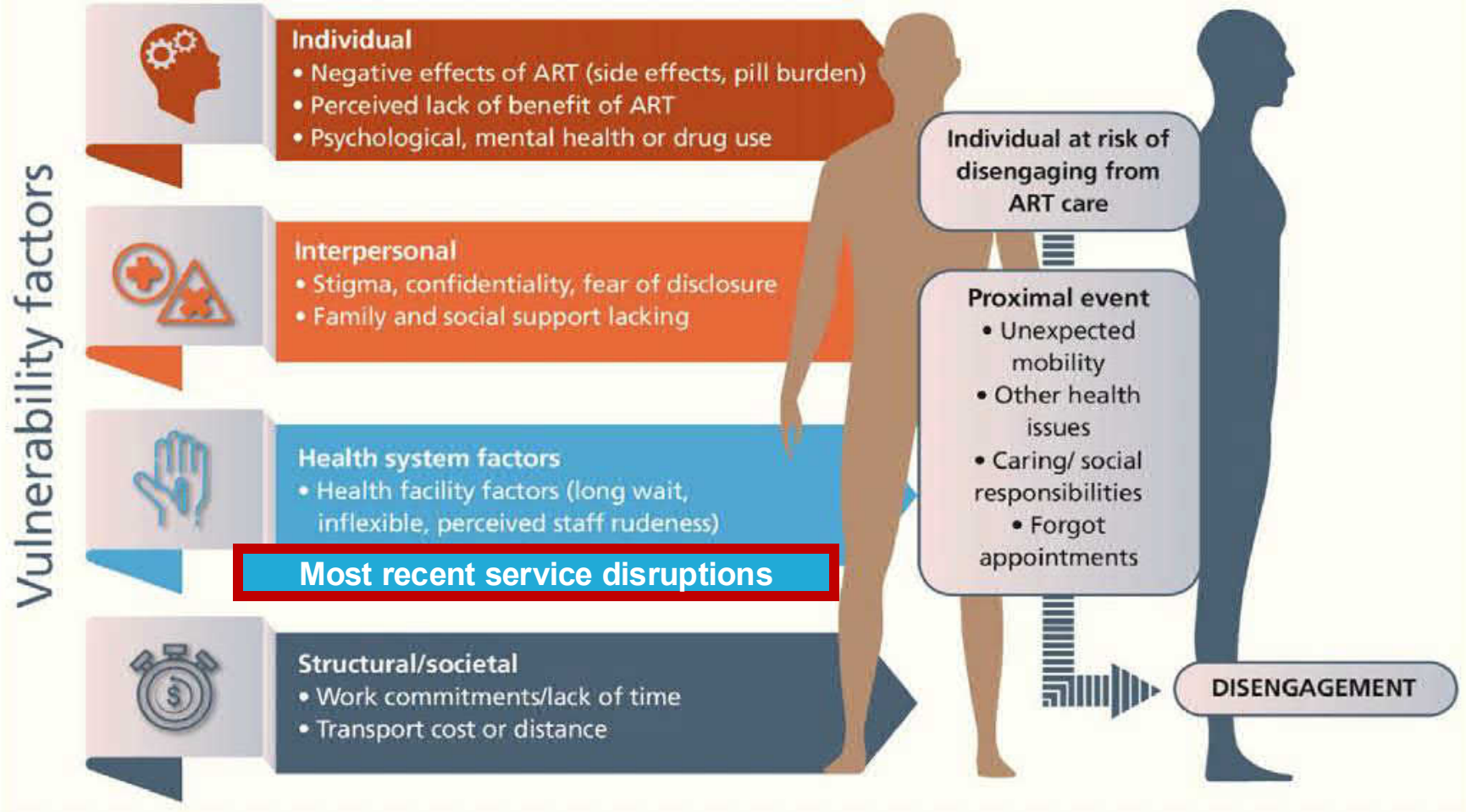
Conceptual framework for reasons for disengagement



- Disengagement is a multi-dimensional issue influenced by a mix of factors, often driven by immediate life events that can overlap in time.
- Addressing these different areas is critical for improving retention in care and supporting continuous ART adherence.

Source: Burke et al.

Individual Factors

- **Negative effects of ART**: This includes side effects from the medication, pill burden, or general treatment fatigue that can make adherence difficult.
- **Perceived lack of benefit**: Patients may disengage if they do not see or believe in the benefits of continuing their treatment.
- **Psychological, mental health, or drug use**: Issues like depression, anxiety, or substance abuse can interfere with the motivation or ability to stay in care.

Interpersonal Factors

- **Stigma and confidentiality**: Fear of being stigmatized or outed due to their status can deter individuals from seeking or continuing care.
- **Family and social support**: Lack of supportive relationships can lead to feelings of isolation and make it harder to stay engaged in treatment.

Health System Factors

- **Facility-related challenges**: Long wait times, inflexible scheduling, and interactions with perceived rude or unsupportive staff can discourage patients from attending appointments and continuing their care.

Structural/Societal Factors

- **Work commitments and time constraints**: The demands of work and lack of available time can be significant barriers, especially if clinic hours are not flexible.
- **Transport costs or distance:** The cost or difficulty of traveling to healthcare facilities can prevent consistent access to treatment.

Moving to a new location or other life changes that disrupt care routines.

New or worsening health problems that take priority over ART.

Having to care for others can divert attention away from personal health.

Missing scheduled appointments due to various reasons can interrupt care.

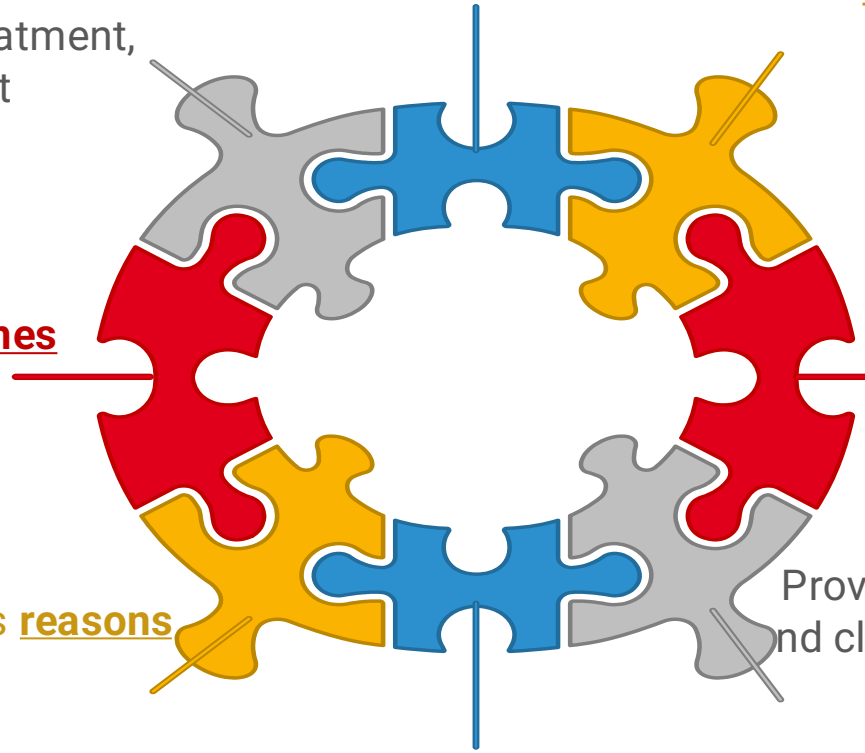
When these factors combine or accumulate, they increase the risk of an individual becoming disengaged from ART care.

People at the center:
Considerations for the Tracing Process

Develop a process to obtain informed **consent** from clients for tracing activities.

Establish **criteria** (e.g. recent treatment initiation, abnormal lab results, failure to initiate treatment, overdue consultations, most vulnerable groups)

ısure **tracing methods** (e.g. remote or in person) are respectful, consensual, and tailored to the individual needs and preferences of each client.



Monitoring tracing outcomes can help improve health systems.

Trained and supervised Tracing Team: Lay workers, peer supporters, community health workers, and outreach teams.

Identify and address **reasons for disengagement**

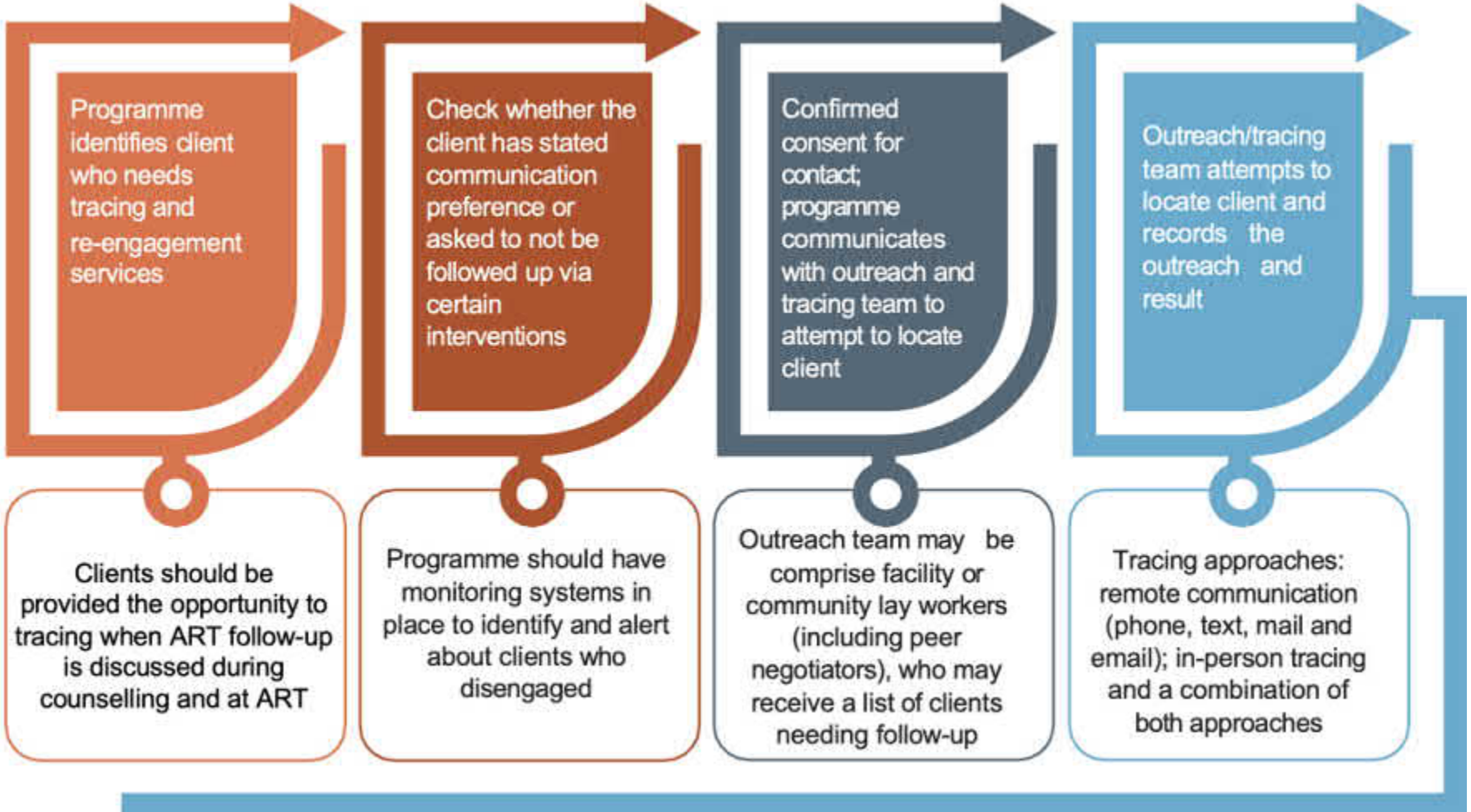
Provide **non-judgmental**, supportive, nd clear information and counselling services

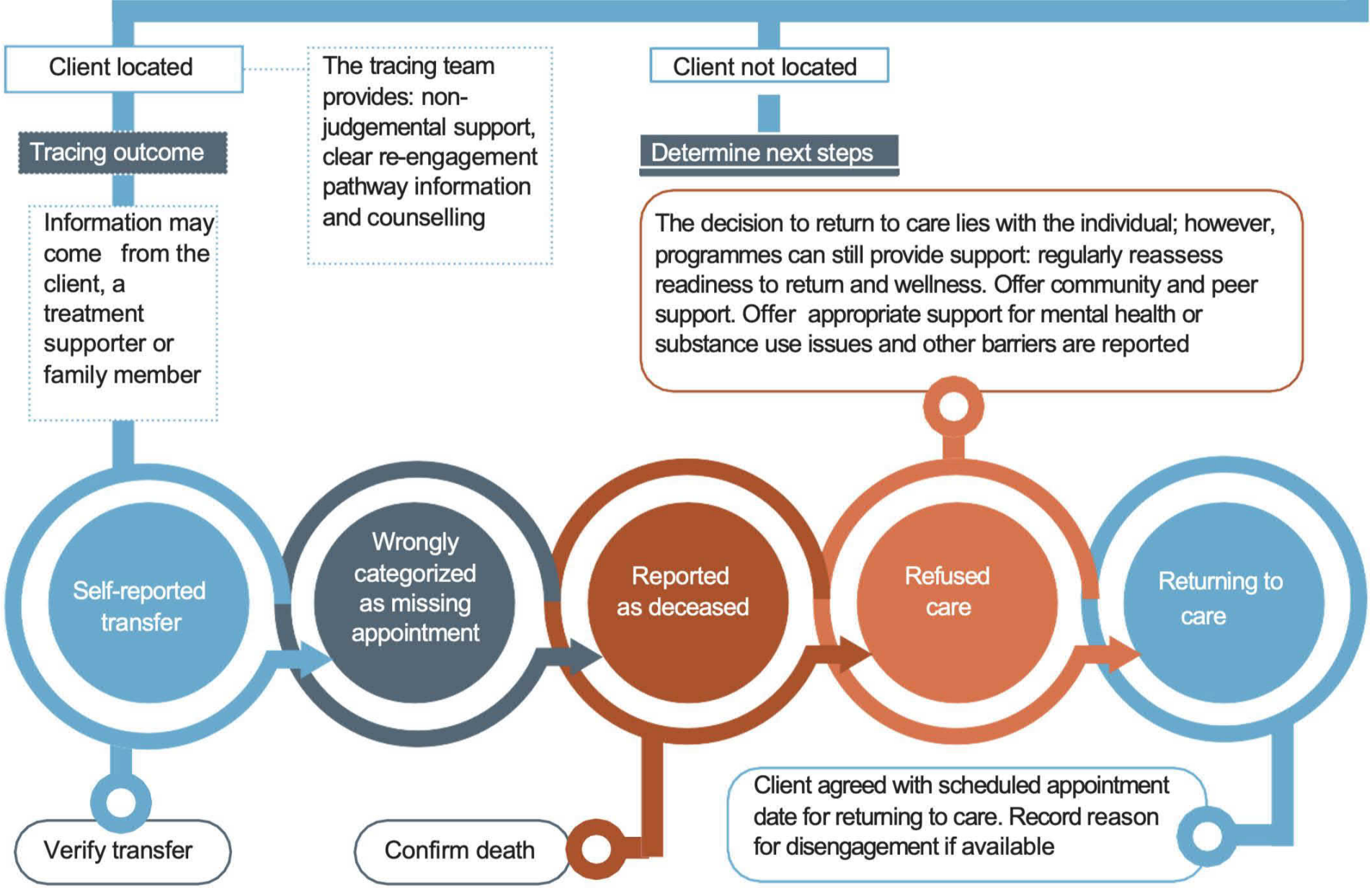
Enhanced monitoring systems can support identifying disengagement and re-engagement dynamics that triggers tracing efforts

People at the center: E.g. Tracing Process

Importantly,

- not every client who has disengaged may require tracing to return to care
- not all traced clients can be located,
- nor do all contacted individuals necessarily return to care




Client located
The tracing team provides: non-judgemental support, clear re-engagement pathway information and counselling
Client not located
Tracing outcome
Determine next steps
Information may come from the client, a treatment supporter or family member
The decision to return to care lies with the individual; however, programmes can still provide support: regularly reassess readiness to return and wellness. Offer community and peer support. Offer appropriate support for mental health or substance use issues and other barriers are reported
Self-reported transfer
Wrongly categorized as missing appointment
Reported as deceased
Refused care
Returning to care
Verify transfer
Confirm death
Client agreed with scheduled appointment date for returning to care. Record reason for disengagement if available

Guiding principles for differentiated re-engagement

Ensuring a welcoming, non-stigmatizing environments: by creating support systems that make people feel respected and safe.

Ensuring equitable access to care: everyone gets the care they need, no matter who and where they are.

Engaging communities: by involving local communities and peers in shaping and providing services.

Supporting adherence challenges: by offering supportive strategies to address barriers that can help medication taking.

Providing advanced HIV disease identification and rapid screening for opportunistic infections: Recognizing and treating severe cases early

Providing immediate treatment and care: quick access to treatment, including rapid ART re-initiation.

What to consider when defining DSD pathways to support re-engagement

Clinical assessment and rapid ART re-initiation

- Provide immediate treatment and care, including advance HIV disease identification and rapid screening for opportunistic infections

Psychosocial assessment and adherence support needs

- Support adherence challenges to sustain re-engagement

Addressing treatment interruption

- Consider impact of interruption on an individual's clinical well-being needs to develop the appropriate pathway

Specific population considerations

- Consider each population unique challenges to sustained engagement in HIV treatment services

Images source: ©WHO

Pathways to support re-engagement in HIV treatment and care

Clients who stopped ART returned

With or without tracing/ outreach intervention

Reception in clinic is respectful and non-judgemental

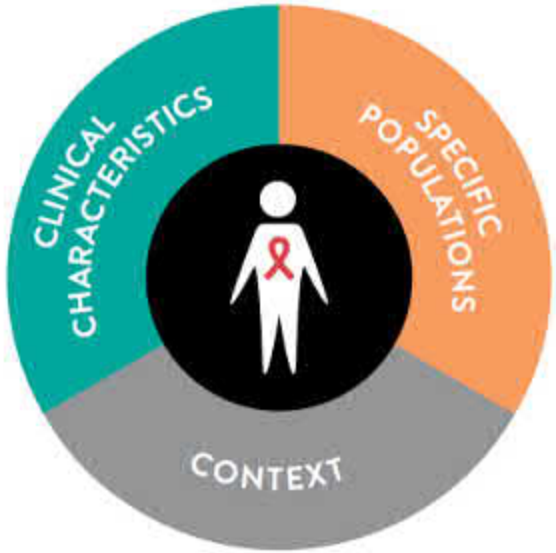
Provide clinical assessment and rapid ART reinitiation

Assessment of previous ART regimen, time spent disengaged, adherence counselling

- **Provide comprehensive clinical assessment** to determine current clinical stability
- **Review all available clinical data**, including the most recent viral load results
- **Conduct a CD4 test** to assess for advanced HIV disease
- Immediately **consider seriously unwell clients as having advanced HIV disease** and manage accordingly
- **Screen for opportunistic infections** to ensure timely diagnosis and treatment
- **Rapidly reinitiate antiretroviral therapy (ART)** on the same day of re-engagement

Psychosocial and adherence support

- Discuss previous adherence success
- Assess factors affecting adherence
- Provide mental health screening
- Refer to specialized support services if needed
- Identify set of adherence interventions to address reasons for disengagement
- Incorporate peer and community support into adherence plan
- Adapt psychosocial and adherence support over time



PEOPLE AT THE CENTER:

The combination of interventions to support adherence, retention, DSD and re-engagement will depend on the context, clinical characteristics, specific needs and preferences of the user.

Images source: ©WHO

People at the center: Combination of adherence, retention, DSD and re-engagement support interventions will depend on context, clinical characteristics, specific client's needs and preferences

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Treatment supporters (peer supporters and community-based services)

Tracing: home visits; phone calls/SMS; welcome back services

Health promotion, education & IEC materials

Adherence counselling, Behavioural skills training and medication adherence training and Cognitive behavioural therapy

Mental Health assessment and management

Behavioural

Educational

Socio – Economic - Cultural

Emotional / Psychological

Virtual interventions: Mobile phone text messages (M-heath/ SMS), Reminder devices

Differentiated service delivery ART models, incl. 3-6 monthly ART refills (MMD) and clinical visits

Easy access to treatment (Community ART services)

Individual and family/couples **Counseling**

Psychosocial support

Home visits & Palliative care

Adherence Support Groups

Restoring Services Post Funding Freeze Disruptions

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Example of Problematic scenario: Client arriving for an ART refill and finding the facility closed without notice. They leave with no information on alternative sites or reopening plans. This scenario outlines how tracing and re-engagement strategies can bring the clients back into care.

1 Coordination & Data Setup

- Form a small “Re-Engagement Taskforce” (clinic manager, data officer, peer navigator, community rep)
- Retrieve appointment logs and contact details (electronic or paper-based) to identify clients potentially affected.

2 Multi-Channel Outreach

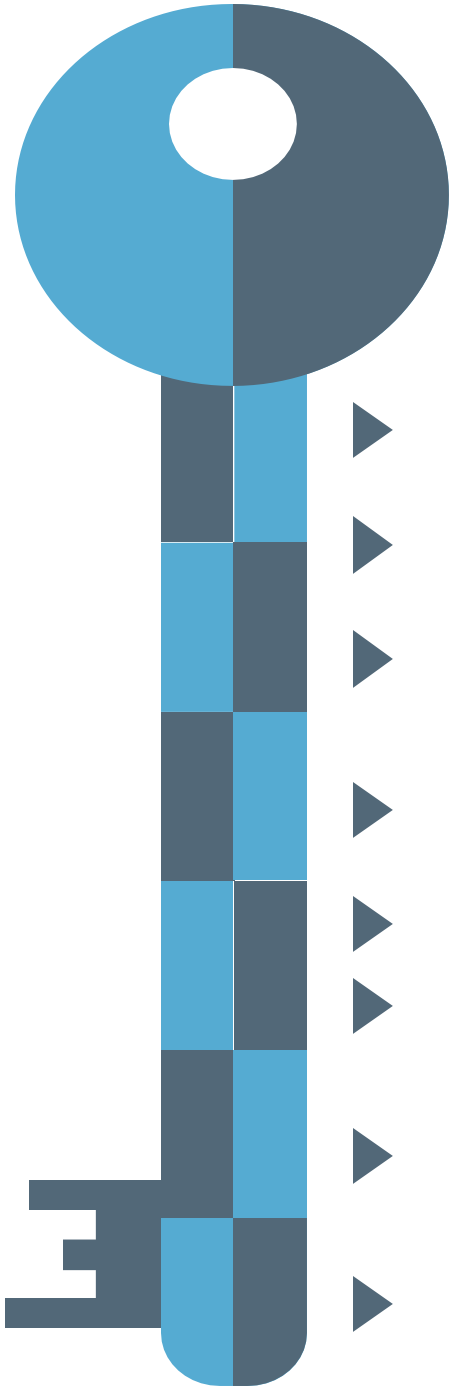
- Initiate phone calls, SMS, and community announcements (radio spots, bulletin boards).
- Clearly communicate reopening, new or temporary service points, operating hours, and emphasize to all facility staff the need to ensure communication is the same at all levels.

3 Flexible Access Points

- Set up alternative pickup sites (pharmacies, mobile clinics, community centers) for urgent medication refills.
- Provide mobile services where possible

4 Re-Engagement & Follow-Up

- Peer navigators maintain contact, ensuring clients have accurate information and encouraging them to return.
- Keep a “missed visit” log to identify anyone not yet reconnected and continuously adapt communication methods.
- Ensure clients have all clinical and other support appointments aligned.



Key Takeaways

Health systems and HIV programs should:

- **Be equipped to prevent and address disengagement.**
- **Understand the factors that lead to disengagement** (e.g., structural, clinical, individual, other).

Implement interventions to address them:

- Improve quality and user experience to minimize disengagement.
- reduce frequency of ARV visits and pick-ups for clients established on ART.
- track people who have disengaged and provide support to re-engage.

- Promote community-led service delivery to align with preferences and improve participation.
- Engaging communities to tailor re-engagement strategies to client's needs and preferences
- Ensure a non-punitive, non-judgmental, and welcoming environment for equitable access to services.

Acknowledgements

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Thank you!

Merci!

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Specific Interventions by Population Group: INFANTS, CHILDREN, AND YOUNG ADOLESCENTS

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Challenges:

👶 **Dependence on Caregivers**: Limited agency; rely on caregivers for health management.

🔄 **Caregiver Changes**: Risk of disengagement increases with changes in caregivers.

❓ **Limited Understanding**: May not fully understand their HIV status if not appropriately disclosed.

Interventions:

👫 **Caregiver Counseling**: Include caregiver well-being and mental health in counseling.

👥 **Peer Support for Caregivers**: Establish support groups for caregivers.

👫 **Joint Service Models**: Enroll child and caregiver in paired service delivery models.

💊 **Child-Friendly Medication**: Provide appropriate antiretroviral formulations.

🏥 **Accessible Pediatric Care**: Offer decentralized and child-friendly healthcare services.

🗣️ **Age-Appropriate Disclosure**: Provide HIV status disclosure counseling suitable for the child's age.

🗓️ **Aligned Scheduling**: Sync ART visits with immunization and maternal health appointments.

🚀 **Smooth Transition**: Facilitate move to adolescent services with appropriate support.

Specific Interventions by Population Group: WOMEN AND GIRLS

World Health Organization

Challenges:

😟 **Fear of Disclosure**: Worry about revealing HIV status to partners and family.

🚫 **Violence and Abuse**: Risk of gender-based violence and intimate partner violence.

⚖️ **Gender Inequalities**: Societal norms may hinder access to care.

🙅 **Stigma**: Social stigma surrounding HIV status.

Interventions:

💬 **Disclosure Support**: Provide assistance for voluntary HIV status disclosure.

🛡️ **Violence Prevention Services**: Offer services to protect against gender-based violence.

📚 **Education Programs**: Conduct educational interventions on adherence and reproductive health.

👩‍⚕️ **Women-Friendly Services**: Create a supportive environment tailored to women's needs.

Specific Interventions by Population Group: PREGNANT AND POSTPARTUM WOMEN

World Health Organization

Challenges:

🤢 **Pregnancy-Related Conditions**: Symptoms like nausea affecting adherence.

🆕 **New Diagnosis**: Learning HIV status during pregnancy.

👶 **Fetal Health Concerns**: Worry about the baby's health.

😨 **Fear During Care Transitions**: Anxiety about disclosing status when moving between services.

Interventions:

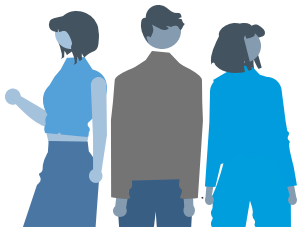
📅 **Integrated Scheduling**: Align ART with antenatal/postnatal visits and infant care schedules.

🤱 **Mother-Infant Services**: Integrate ART with immunization and breastfeeding support.

🩺 **Comprehensive Care**: Provide combined prenatal, postnatal, ART, and contraceptive services.

🤗 **Psychosocial Support**: Offer peer support through mentor mothers and counseling.

👥 **Mother-Specific Groups**: Facilitate adherence groups tailored for mothers.



Specific Interventions by Population Group: ADOLESCENTS AND YOUNG ADULTS

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Challenges:

📚 **School Conflicts**: Attendance and schedules interfere with clinic visits.

❓ **Incomplete Understanding**: May not fully grasp their HIV status without proper disclosure.

🤔 **Acceptance Issues**: Might engage in care without fully accepting their diagnosis.

Interventions:

👥 **Peer Support**: Encourage participation in adolescent peer groups.
🗣️ **Age-Appropriate Counseling**: Provide counseling suited to their developmental stage.
🎓 **Treatment Literacy**: Educate on treatment adherence and health management.
🕒 **Flexible Scheduling**: Offer appointments outside school hours and during holidays.
🚀 **Transition Assistance**: Help move from pediatric to adult services smoothly.
🏥 **Youth-Friendly Services**: Create welcoming environments for young people.

Specific Interventions by Population Group:

KEY POPULATIONS

- Men who have sex with men,
- Sex workers,
- People who inject drugs,
- Trans and gender-diverse people, and
- People in prison or closed settings

World Health Organization

Challenges:

😔 **Stigma and Discrimination**: Facing social exclusion and judgment.

⚖️ **Criminalization**: Legal issues related to behaviors or identities.

🏥 **Lack of Tailored Services**: Services not designed to meet their specific needs.

🚫 **Violence and Rights Violations**: Exposure to abuse and human rights infringements.

🔒 **Privacy Concerns**: Worry about confidentiality in care settings.

Interventions:

🧭 **Peer Navigators**: Use peers to guide and support re-engagement.

🤝 **Rights-Focused Counseling**: Provide supportive counseling respecting their rights.

🏠 **Decentralized Services**: Offer care in community settings.

💻 **Online Platforms**: Utilize digital case management where available.

💊 **Multimonth Dispensing**: Provide extended ART supplies to reduce clinic visits.

🌈 **Community Services**: Implement peer-led programs to reduce stigma

.🚫 **Non-Restrictive Practices**: Avoid endorsing harmful practices like conversion therapy.

Specific Interventions by Population Group: MEN

World Health Organization

Challenges:

😞 **Stigma**: Societal expectations may discourage seeking help.

🤦‍♂️ **Perception of Weakness**: Belief that needing care is a sign of weakness.

💼 **Work Obligations**: Job responsibilities limit time for healthcare visits.

Interventions:

🏢 **Male-Friendly Spaces**: Create men-specific areas in clinics (e.g., men's corners).

📢 **Health Education**: Provide targeted education campaigns for men.

🏥 **Men's Clinics**: Establish clinics specifically catering to men's health needs.

🏠 **Community Outreach**: Offer services in community settings accessible to men.

Specific Interventions by Population Group: MIGRANTS WORKERS AND DISPLACED POPULATIONS

World Health Organization

Challenges:

✈️ **Unplanned Mobility**: Frequent moves due to work or displacement.

🌐 **Language and Cultural Barriers**: Difficulties communicating or feeling understood.

❌ **Lack of Resources**: Unaware of available services or how to access them.

😔 **Stigma**: Fear of discrimination in new environments.

⚖️ **Legal Barriers**: Challenges accessing care due to legal status.

Interventions:

📦 **Extended ART Refills**: Provide multimonth supplies to ensure continuity.

📄 **Transferable Records**: Offer client-held medical documents for use elsewhere.

🗺️ **Navigation Support**: Assist in finding and accessing new care facilities.

🌍 **Cultural Sensitivity**: Provide services respectful of cultural differences.

Specific Interventions by Population Group: OLDER PEOPLE

World Health Organization

Challenges:

💊 **Polypharmacy**: Managing multiple medications.

❤️ **Comorbidities**: Presence of other health conditions.

🧠 **Complex Treatments**: Difficulty with complicated regimens.

Interventions:

🤝 **Adherence Support**: Tailor support to consider other health issues.

🏥 **Integrated Services**: Combine HIV care with other medical services.

🌀 **Simplified Regimens**: Use treatments that reduce pill burden.

📅 **Less-Intensive DSD ART Models**: Include in service models requiring fewer clinical visits and refills.

Thank you!


World Health Organization
European Region
EQUALIZE ACCESS TO END AIDS.
All people living with HIV are eligible for and should have access to HIV treatment

Turning WHO Guidance into Action: Zambia's Approach to Supporting Re-engagement in HIV Treatment

Dr Sivile Suilanji

National HIV Technical Advisor

Ministry of Health,

Zambia

World Health Organization

Supporting re-engagement in HIV treatment Sservices

Translating WHO guidance into Action

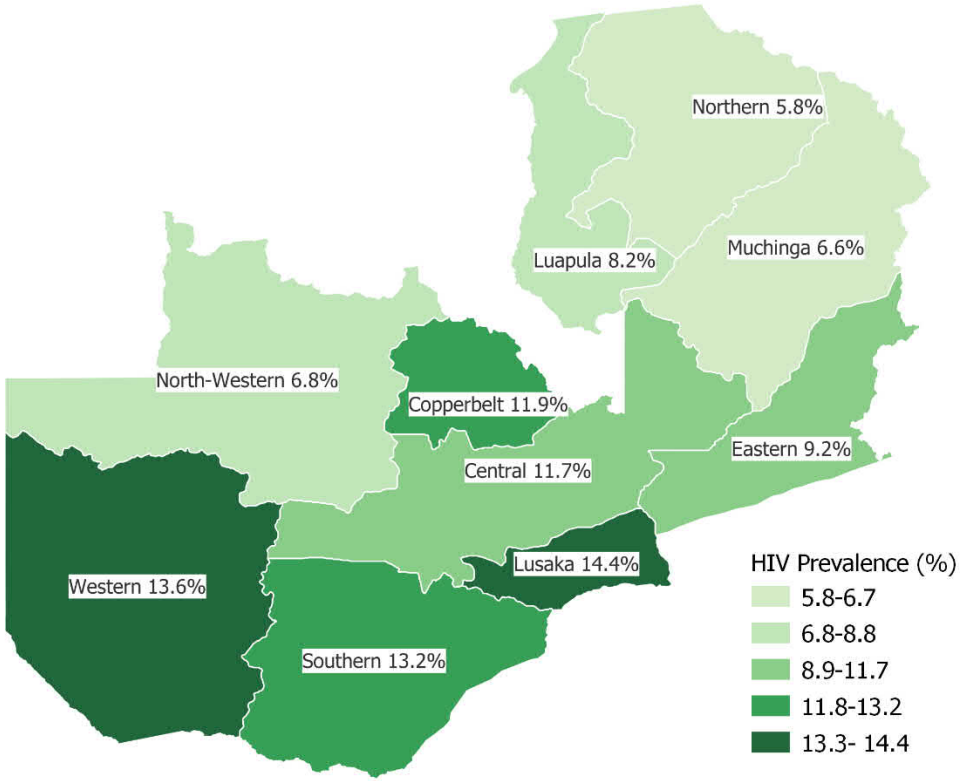
Presenter: Dr Suilanji Sivile

Country: ZAMBIA

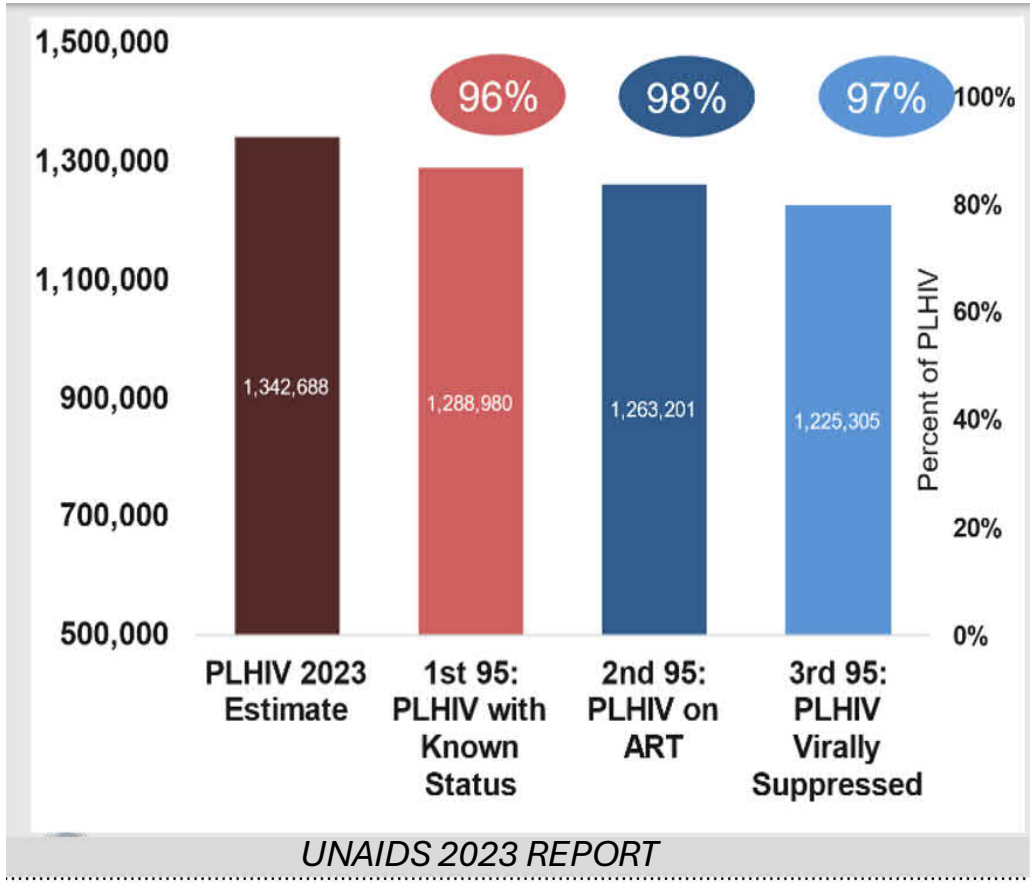
World Health Organization

Background

National HIV Prevalence at 11%

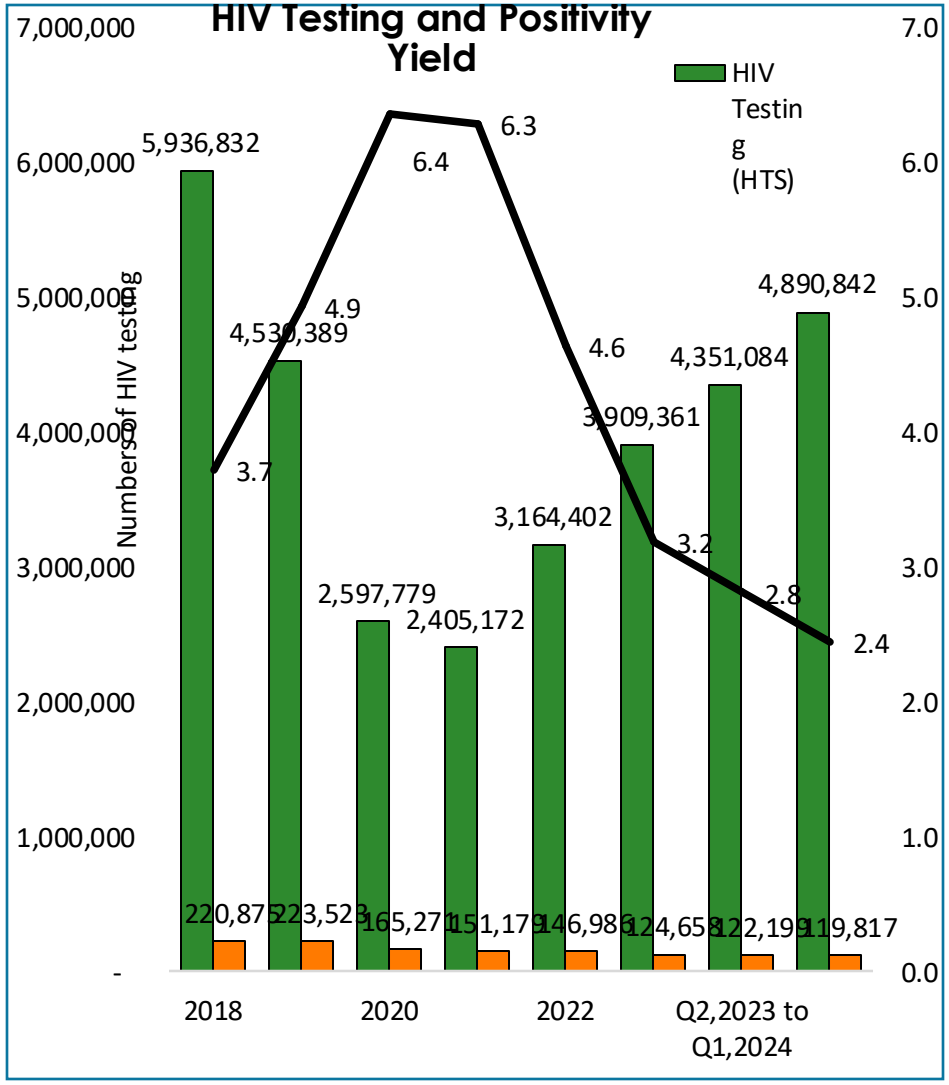


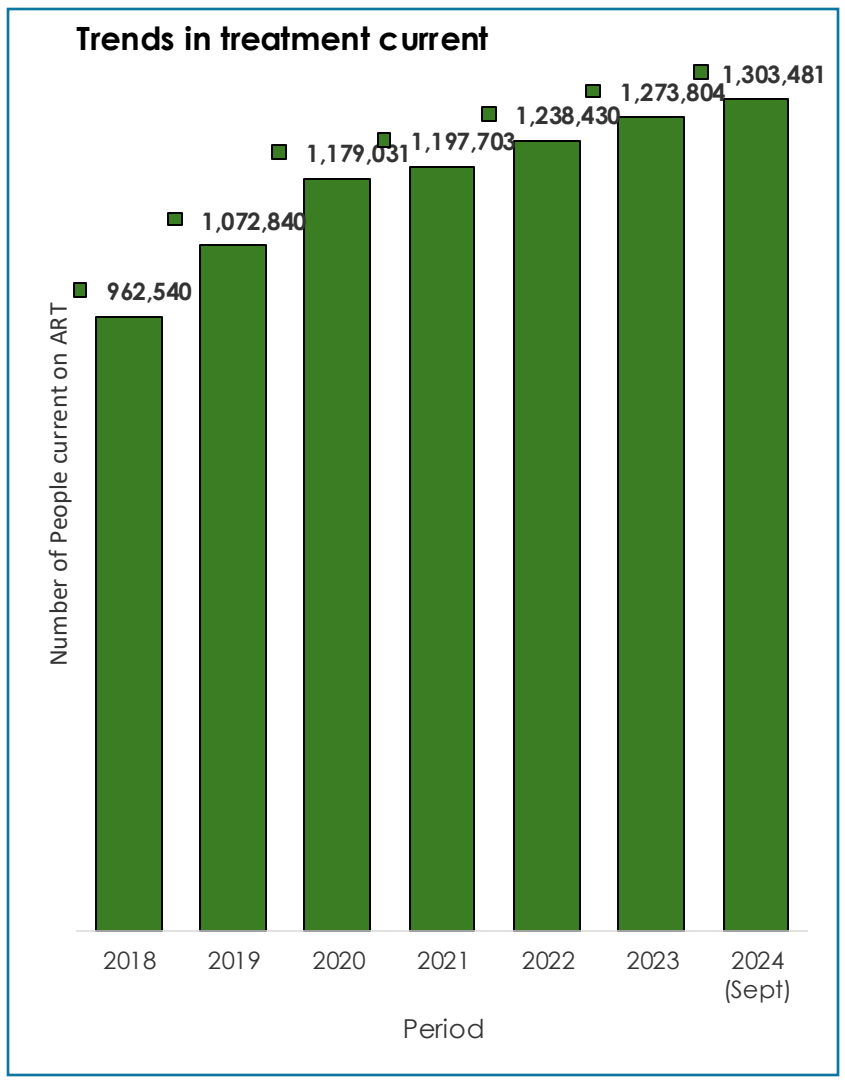
Source: ZAMPHIA 2021. Data are for persons aged ≥15 years

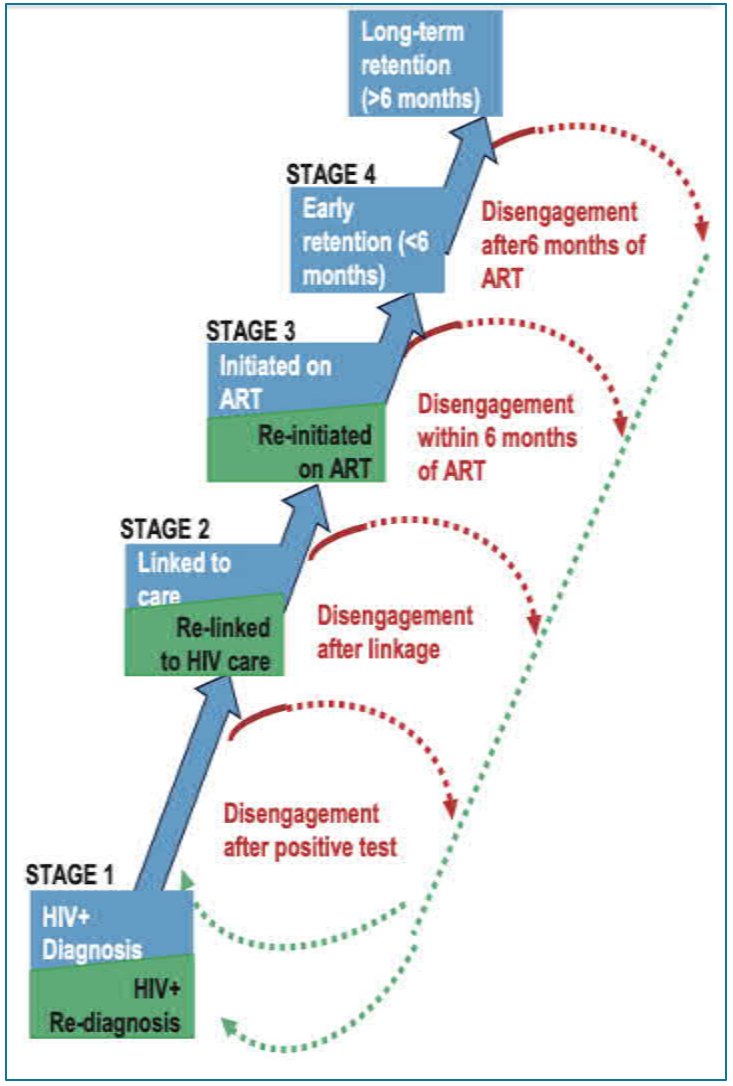


Incidence: 23,000 new case for year *(spectrum estimates)*

The Problem: High new positives against and low growth in treatment cohort







Zambia's Approach to Improving re-engagement

- Pillar 1 : Appointment reminders and patient appointment tracking
- Pillar 2: Baseline viral load testing
- Pillar 3: Enhanced Adherence Counseling and disclosure counseling
- Pillar 4: Patient Centered Care and welcome back package services
- Pillar 5: Use of electronic health record system to identify duplicated

Pillar 1: Appointment reminders and missed appointment tracking

Definitions

- **Late:** client misses a scheduled pharmacy refill visit
- **Interruption in treatment (IIT):** as no clinical contact for **28 days** after the last scheduled appointment or expected clinical contact
- **Refused** (stopped) treatment: located while late or IIT, but chooses not to return to care
- **Transferred out:** from facility A to facility B
- **Unknown status**: all active tracking interventions not exhausted
- **Silent transfers:** New positive but in care at another facility

Appointment list and reminder calls made 1 week before the appointment

Phone call made within 24 hours of missed appointment

Physical home visits for those not answering calls

Welcome back package activated once found and return care and **advanced HIV disease** screening if eligible (6months)

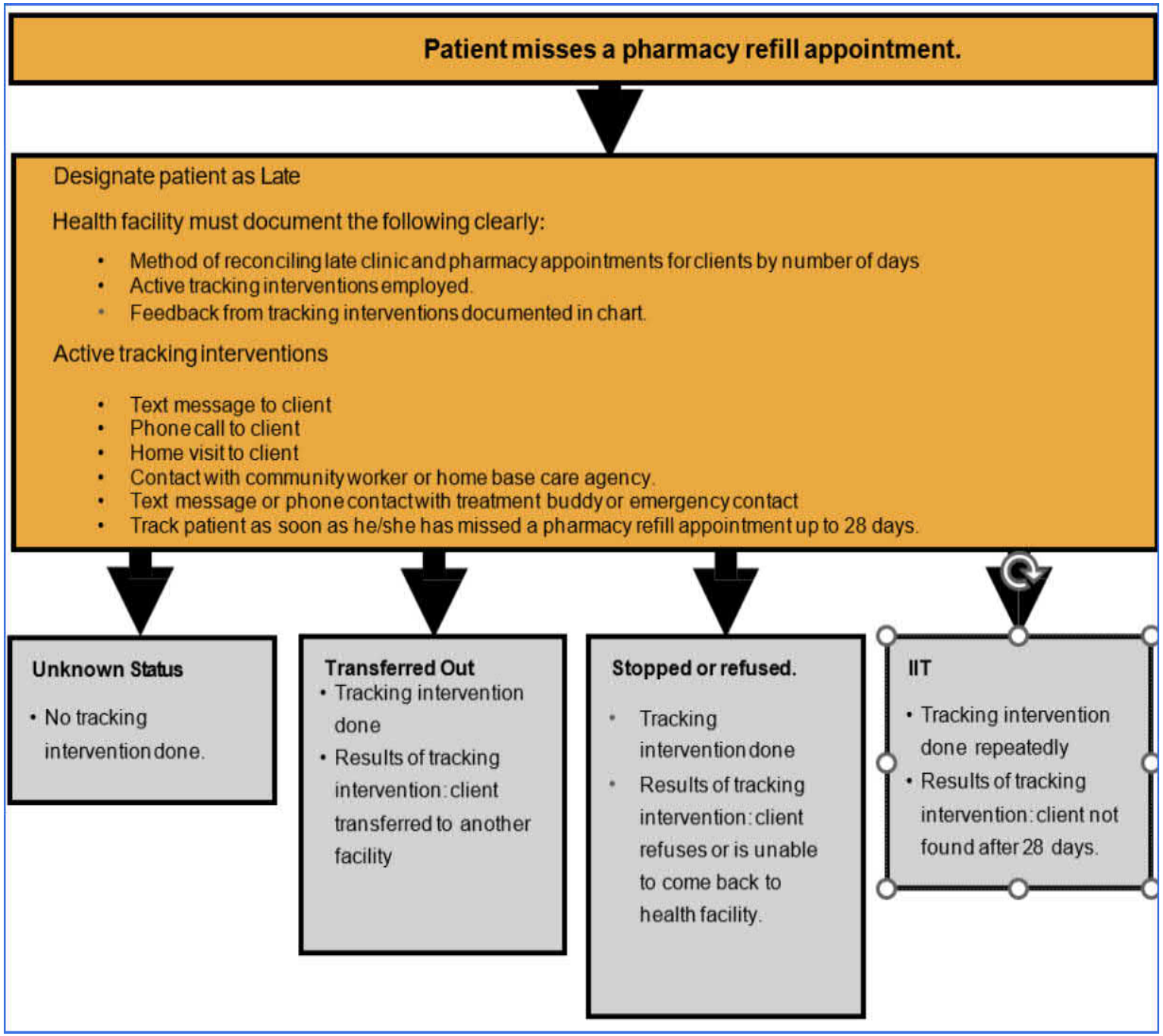
To reduce stigma and discrimination: the CBVs are obtained from PLHIV CSOs and are trained in person centered care

Common reasons for dis-engagement

- Over 80% of the individuals who miss appointment/l are taking ARVs.
  - Have enough ARVs at home
  - Are silent transfers
  - Are a passer-by at another facility
- Travel (funerals, business, work etc)

True dis-engagement

- **Facility Reasons**
  - Health worker's attitude (quality)
  - Stigma
  - Distance
- **Personal issues**
  - Mental health issues
  - Active illness or financial distress
  - Presume to have been healed or



National Electronic Medical Record System Supporting client tracking and Re-engagement

Overview of SmartCare

- National EHR
- Covers over 90% of PLHIV on ART
- Connected to one national data warehouse for record reconciliation
- Web-based SmartCare-Plus and SmartCare-Pro

Role of SmartCare in Patient Tracking

- Produces Appointment lists automatically
- Flags missed appointment
- Drops individuals who have missed appoint for over 28 days from Treatment current list
- Allows reactivation of individuals with the same old number once return to care
- Provides a unique identification number

Role of SmartCare for those returning to Care

- Flag invalid viral loads and high high viral load
- Flags those with advanced HIV disease (AHD) or who if they have been LTFU for more than 6 months
- SmartCare is critical to identify **silent transfers** at national level analysis at the moment and facility level analysis in the future

Pillar 2: Baseline Viral Load As A key Re-Engagement Strategy for Zambia

Viral Load is immediately after a positive HIV test result prior to ART initiation

To track silent transfers: local data shows that up to 40% of HIV positive tests have viral load have VL<1000copies/ml

Those with VL<1000copies/ml are deemed as **silent transfers** *(elite controllers or misdiagnosis are rear)*

Individuals with VL<1000copies/ml are called and counseled in a **non-judgemental** manner using PCC principles

Data reconciliation for silent tranfers

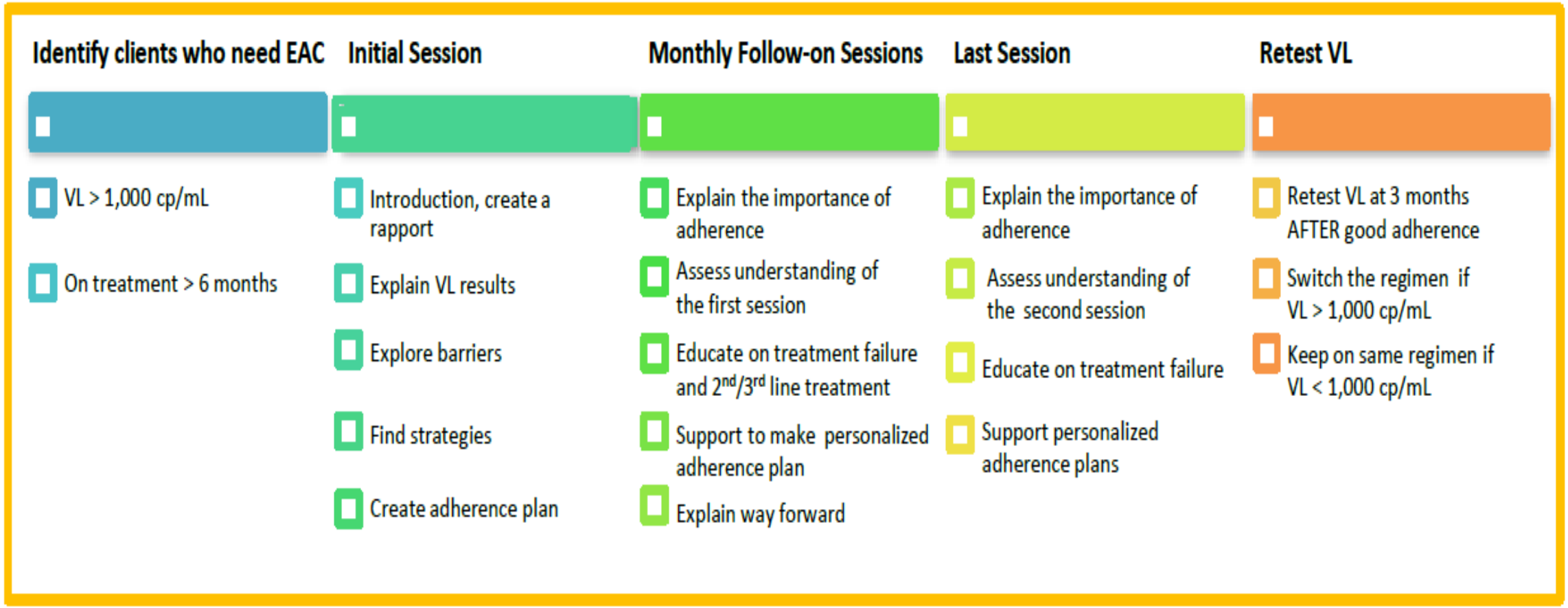
If the client disloses that they have been on ART before ?

- Records are updated as Known positive in the HTS register, as Transfer in the ART register/ or Smart care.
- HMIS and Datim should be updated
- Original facility is informed to record client as *Transferred and* old ART number is requested
- Such clients should now be considered and treated as transfer in clients – including eligibility for DSD models and rescheduling of their next VL for 12mo later .

Baseline Viral Load Reclassification:QTR2 Oct-Dec 2024

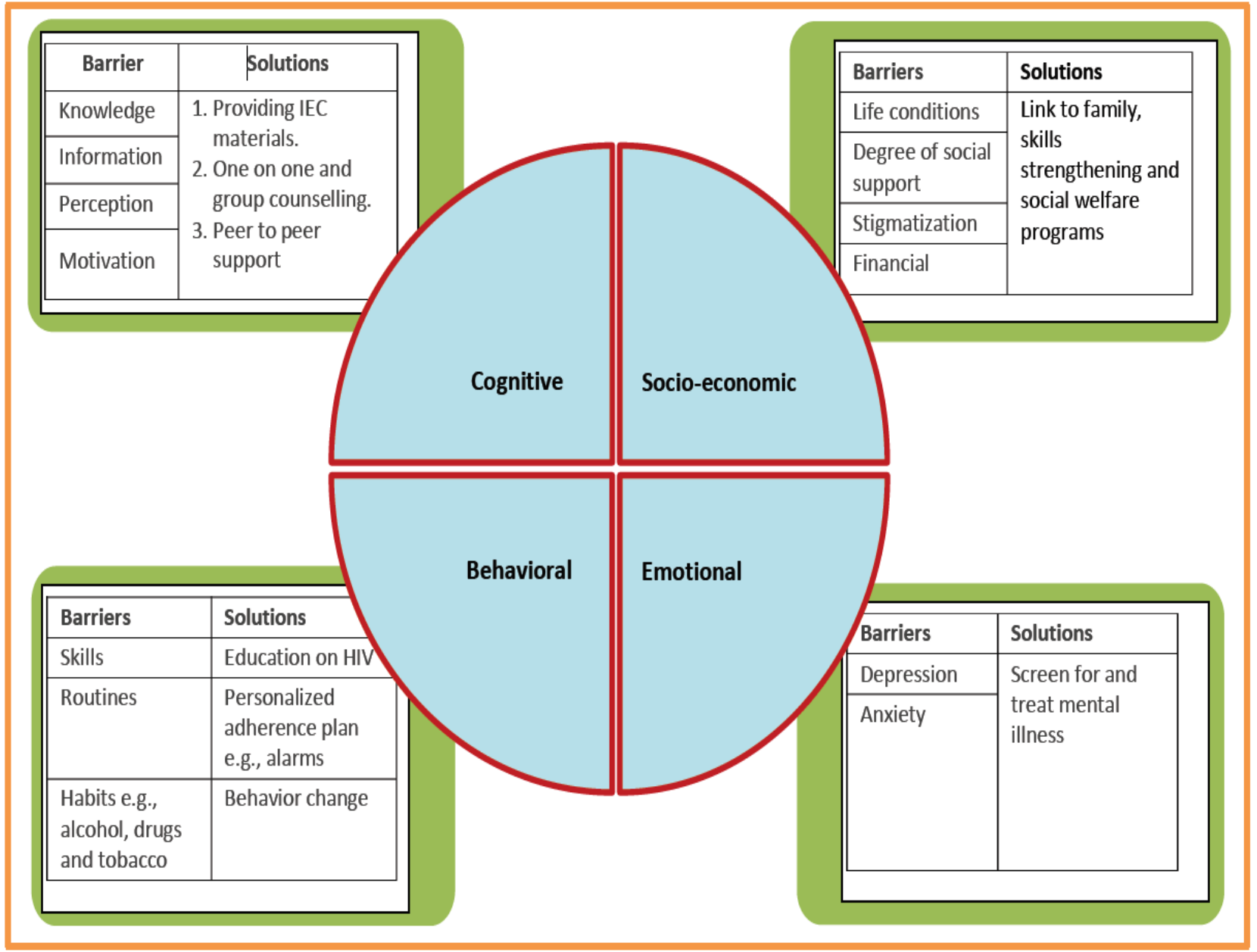
District/Constituency	Total HIV Positives QTR 1 Oct-Dec 2024 (A)	Total TX New QTR 1 Oct - Dec 2024 (B)	BVL samples sent 2weeks ago (C)	BVL resulted (D)	Suppressed BVL (E)	Suppressed BVL Reached (Contacted) (F)	Counselled (G)	Re-classified (H)	Refused (Never been on TX) (I)	%BVL samples sent (C2/D2)	%BVL result return (D/E)	%Suppression (E/D)	%Re-classified (H/E)
Lusaka District	4454	4440	4198	3687	369	170	170	166	53	95%	88%	10%	45%
Chilanga District	388	386	375	325	46	9	9	25	0	97%	87%	14%	54%
Chongwe District	442	439	430	365	40	19	9	9	4	98%	85%	11%	23%
Kafue District	289	287	275	247	5	0	0	0	0	96%	90%	2%	0%
Luangwa District	36	33	32	26	3	2	2	1	0	97%	81%	12%	33%
Rufunsa District	114	111	107	99	9	4	4	0	4	96%	93%	9%	0%
Provincial Total	**5723**	**5696**	**5417**	**4749**	**472**	**204**	**194**	**201**	**61**	**95%**	**88%**	10%	43%

Pillar 3: Enhanced Adherence Counseling for individuals with viral load >1000copier/dL and LTFU

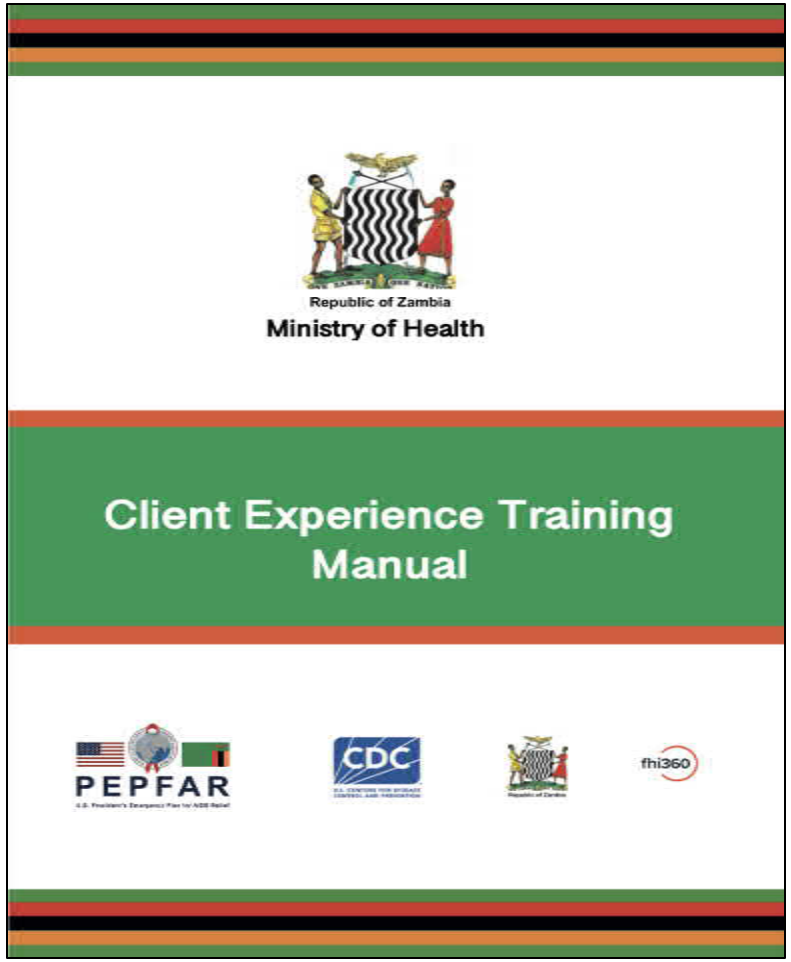


Disclosure counseling is key especially for adolescents and young people

Challenges/ barriers faced in retaining individuals in care and some suggested solutions



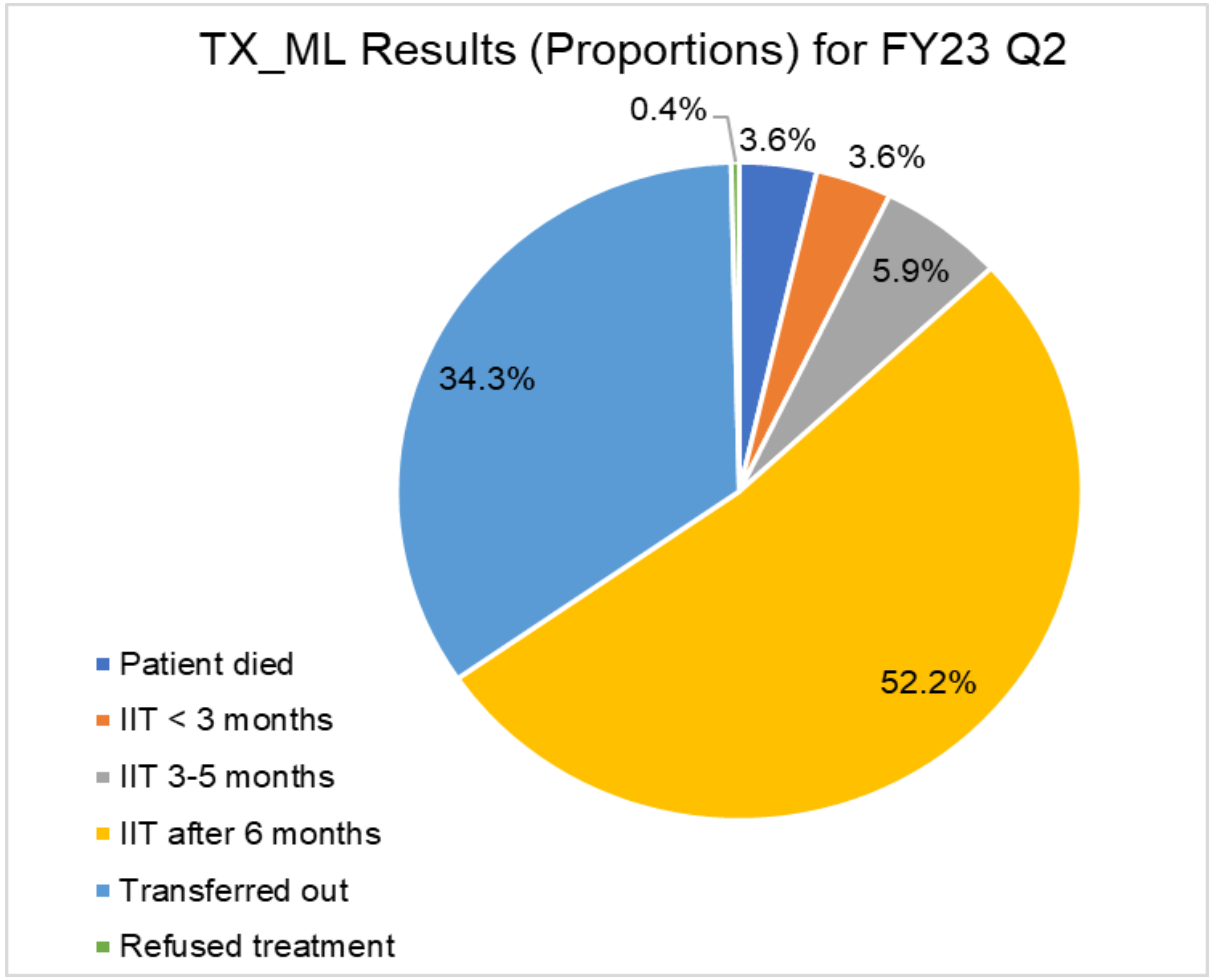
Pillar 4: Client Experience Training Curriculum



- Client Experience is an integral component of quality for differentiated person-centered health services for improving quality of care
- Client experience is delivered throughout the continuum of care to reduce interruption in treatment and improve health outcomes.
- Suitable for program managers, above-site level technical staff (e.g., subnational mentors), health facility staff (e.g., clinician, counselors, case managers)
- Topics covered in the modules of this training (listed on the right)

- **Module 1:** Introduction client experience approach
- **Module 2:** Approaches to continuity of care and treatment
- **Module 3:** Perspective of quality of care and treatment services
- **Module 4:** Effective communication for quality of care and treatment
- **Module 5:** Relationship principles for quality of care and treatment
- **Module 6**: Hospitality principles for quality of care and treatment
- **Module 7**: Applying ethics and code of conduct for quality of care and treatment
- **Module 8:** Applying psychosocial skills for quality of care and treatment
- **Module 9:** Understanding client appointment and tracking systems (electronic and paper-based medical records)
- **Module 10:** Monitoring and reporting for continuity of care and treatment
- **Conclusion and training evaluation**

Pillar 5: Improving IIT through stronger data management and service quality



Source: DATIM

Data Quality Issues

- Standardized Enhanced Data Quality Management improvement tool (eDQIT)
- Continuous retention indaba

Health Informatics/Data Management

- Scaling up SmartCare Pro
- Biometrics
- Facility phone directory

Service Quality Issues

- AHD clinical management
- Customer care training
- Patient education
- Peer models for AYP and men
- Case management for peds
- Mentor mothers for PMTCT program

Transfers out occur mostly within same province or to Lusaka

		Destination Province									
		Central	Copperb..	Eastern	Luapula	**Lusaka**	Muchinga	North W..	Northern	Southern	Western
Origin	Central	64%	8%	2%	1%	**15%**	2%	1%	1%	4%	2%
	Copperbelt	5%	67%	2%	3%	**13%**	2%	4%	2%	2%	1%
	Eastern	1%	1%	84%	1%	**11%**	0%	0%	0%	1%	0%
	Luapula	3%	11%	0%	69%	**10%**	1%	0%	5%	1%	0%
	Lusaka	8%	7%	6%	2%	**66%**	1%	1%	2%	5%	3%
	Muchinga	10%	8%	2%	1%	**13%**	56%	1%	8%	1%	1%
	North Western	2%	14%	1%	1%	**8%**	1%	69%	1%	2%	2%
	Northern	3%	5%	1%	5%	**8%**	4%	0%	72%	1%	0%
	Southern	6%	3%	2%	0%	**18%**	0%	1%	0%	66%	3%
	Western	1%	1%	0%	0%	**5%**	0%	1%	0%	2%	89%

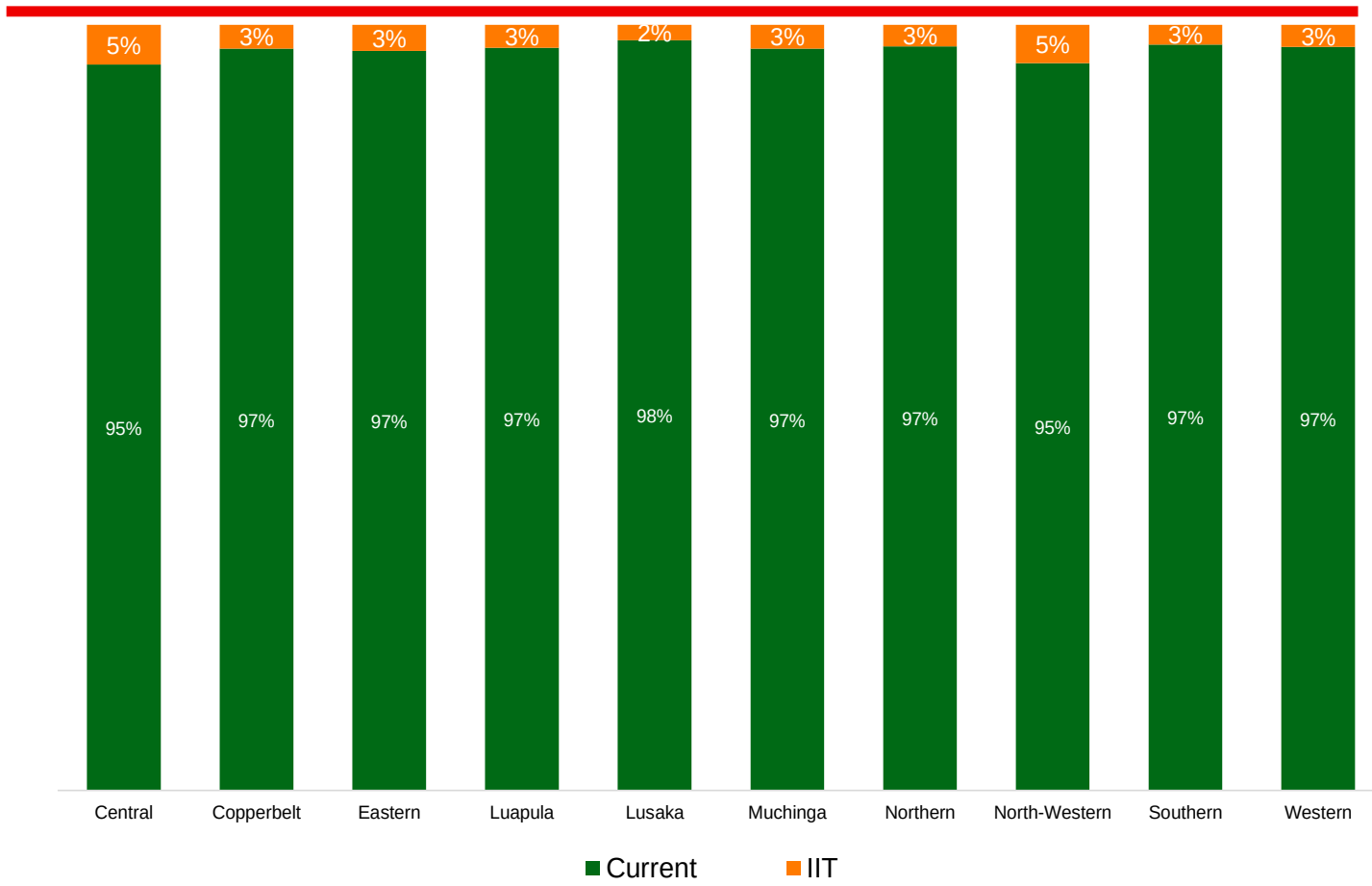
Source: CBS_CIDRZ

Achievements in improving retention in care

Note that this is a national picture, facility level picture has higher IIT due to silent transfer

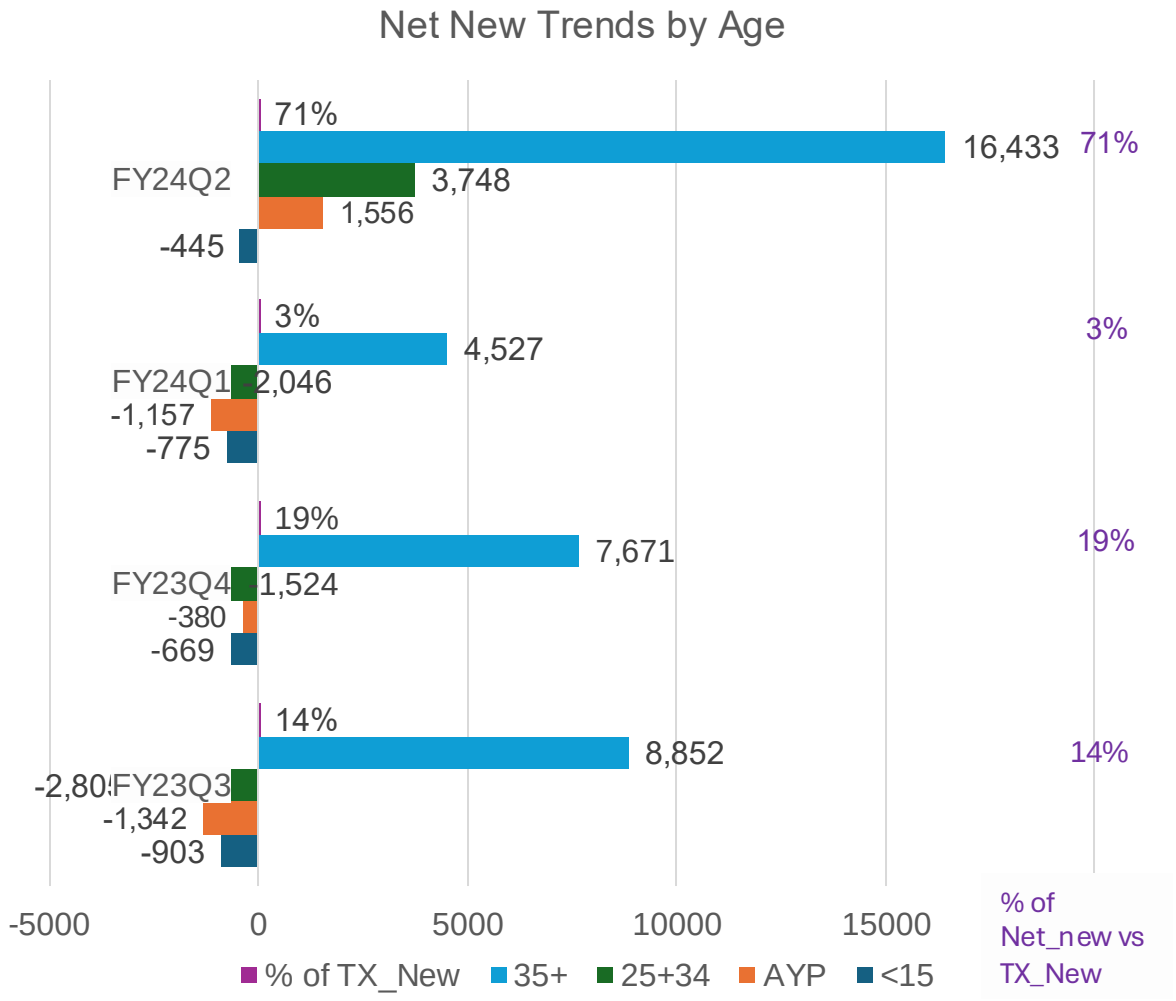
Interruption in Treatment (IIT)

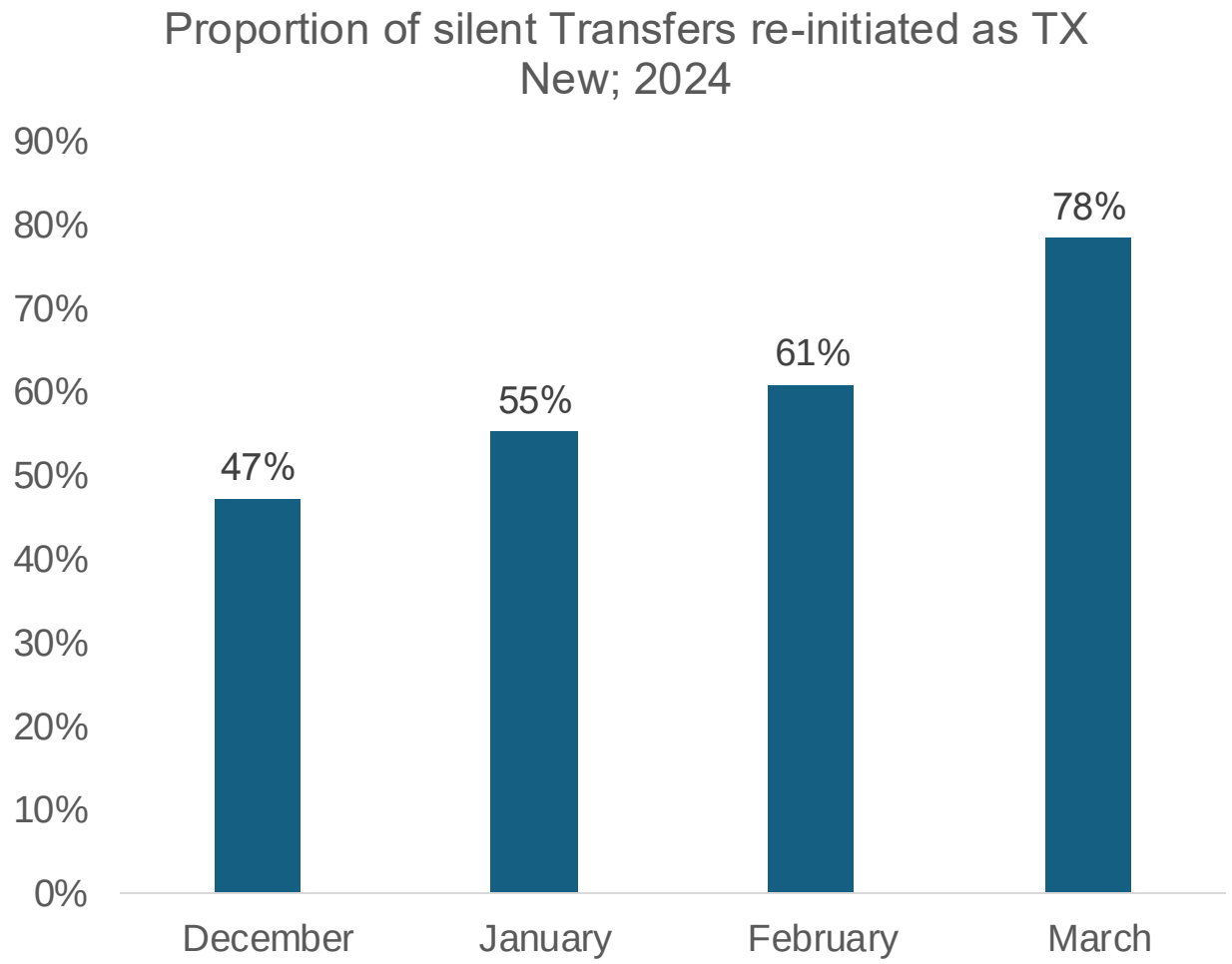
For treatment cohort (July 2023 to June 2024)



Ministry of Health Program Update – Q2 2024

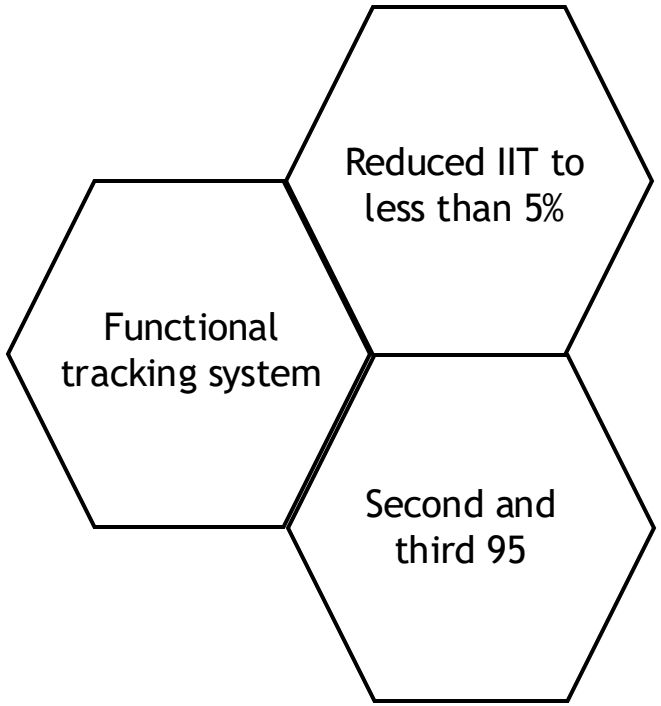
Increased the proportion of TX_NET_NEW Vs TX_NEW, however the proportion of silent transfers re-initiated as new clients at another facility remains high



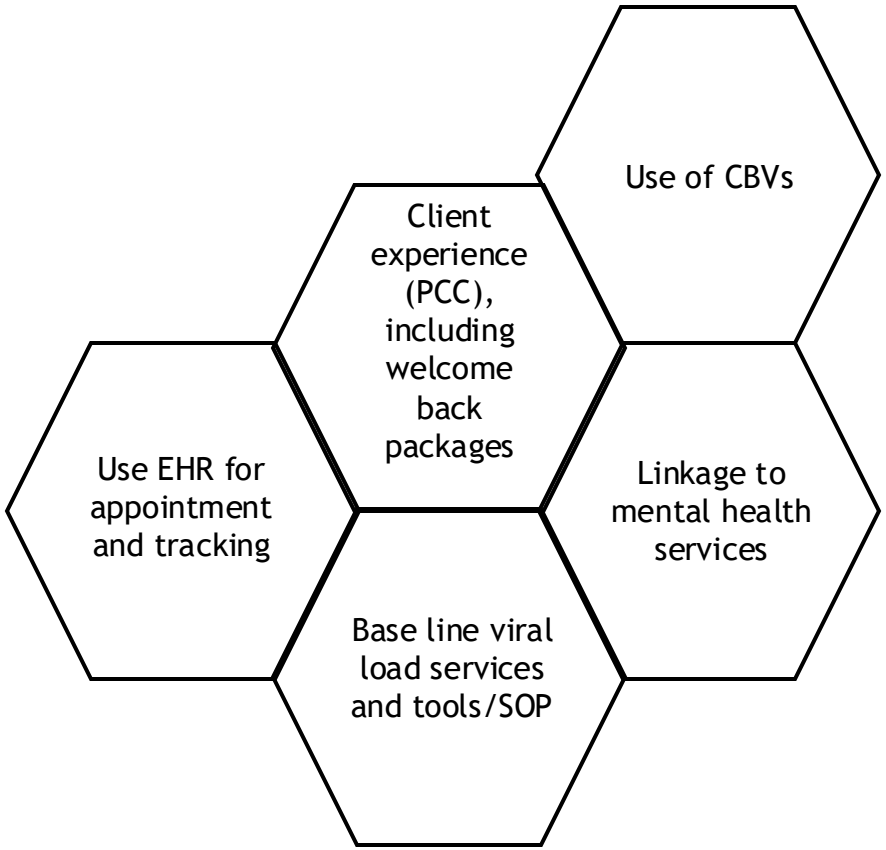


Source: SmartCare (Individual level)

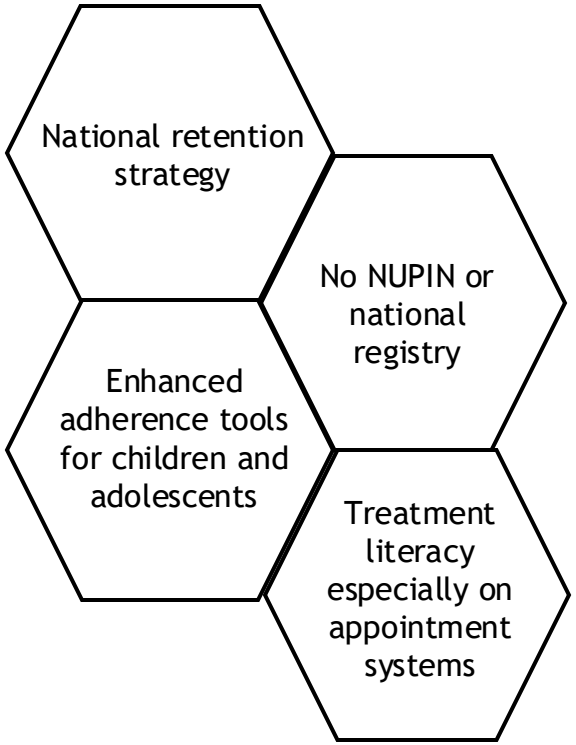
Summary



Achievements



Lessons learnt



Challenges

Impact of the PEPFAR Stop Work Order on Re-engagement in Zambia

All 2883 ART sites have continued to dispense ARVs with limited clinical services

Current situation	Impact on Re-engagement services	Mitigation Measure
• All PEPFAR workforce was withdrawn from services points including community based volunteers totaling 23,000 • Project laptops used for smart care have been withdrawn • No passwords to operate available hardware • Data clerks withdrawn for data entry and smartcare use	• Some clients are being attended to without records • Community based volunteers unavailable for counseling services • Prior appointment reminders and tracking not tacking place • The exact number of active individuals on ART unknown	• MoH staff have been reassigned to work in ART. • Few MoH data clerks redeployed • Revert limited paper-based data collection • Limited community services from CSO representing PLHIV

Plans for the restoration of services

- Intalled data systems to track service provision in all facilities to inform progress of reopening efforts
- Physical site monitoring visits will be critical
- Options for records reconciliation will include active follow-up of all individuals on treatment or a blanket statement to consider all appointments in January as active
- Active transitioning the data systems to government for sustainability
- Fast tracking the national HIV sustainability plan

Thank You

Turning WHO Guidance into Action: Zambia's Approach to Supporting Re-engagement in HIV Treatment

Fred Misumbi Chungu

Executive Director,

Network of Zambian People Living HIV and AIDS (NZP+), Zambia

World Health Organization

RECIPIENT OF CARE PERSPECTIVE AND EXPERIENCE AT RE-ENGAGEMENT

TRACKING AND KEEPING PATIENTS IN CARE

FRED MISUMBI CHUNGU

NETWORK OF ZAMBAIAN PEOPLE LIVING WITH HIV/AIDS(NZP+)

INTRODUCTION

- The Network of Zambian People living with HIV and AIDS (NZP+) and Treatment and Advocacy Literacy Campaign has been implementing a DSD model called Community ART Access Points which are community-based support Structure that are supported and supervised by Adherence Support Workers who are People living with HIV

COMMUNITY ART ACCESS POINTS

- In this model the ASW deliver treatment in the communities to PLHIV who are organized in groups of 8 people.
- CAAP model ensures ART services are brought closer to Recipients of Care
- It also ensure that Recipients of Care are retained in Care
- The model is open and sustained engagement with Recipients of care (Roc)
- Allow the RoC to choose the ASW to manage their CAAP
- Allows the RoC to decide when and where to meet.
- RoC have full information about appointments for clinical and labs
- The ASW explain to Recipients of Care the meaning of their lab results In the language they understand.

WHY TRACKING RECIPIENTS OF CARE (ROC)

- A missed appointment is a first step of a patient fall-out of care.
- Those who miss appointments should be tracked as soon as possible.
- Keeping RoC in care is essential for achieving good outcomes and preventing resistance.
- Lost to follow up (LTFU), defaulting and late drug pick-ups may lead to treatment failure, emergence of resistance, and the possibility of transmitting resistant virus.

ROLES AND RESPONSIBILITIES OF THE ASWS AND CBVS

- CBVs work as Foot Soldiers covering the entire catchment within that Site Area
- Conduct lost to follow up tracking
- Update the locator form

RESPONSIBILITIES CONTINUES

- Provide adherence support to RoC in the community
- Be able to operate cell phone to send SMS of the tracked results to the ART clinic.
- The CBV should do tracking using one or all of the following methods
- Text message to client
- • Phone call to client
- • Home visit to client
- • Contact with community worker or home base care agency
- • Text message or phone contact with treatment buddy or emergency contact

TRACKING RESULTS

- Attrition in an HIV treatment can occur as :
- Active in care –With valid next appointment but smart care not updated
- True Lost TFU – All methods have been exhausted the patient is not found
- Defaulter- Patients tracked and found but refused to resume treatment
- Death – The patient is dead
- Self Trans out– The patient decides to start accessing care from another facility without information
- Formal trans out – The patient formally transferred to his/her preferred facility but smart care not updated
- unknown status – Not all tracking methods exhausted

CONTINUE

- Return to care – The patient accept to come back to care

CHALLENGES

- Donor dependence
- Transport for the ASWs
- Inadequate Stipends for the ASWs and CBVs

- THANK YOU

Q & A

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SUMMARY TAKEAWAYS AND CLOSING REMARKS

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Content Review and Closing

Certificate of Attendance available through the University of New Mexico after completion of the feedback survey:

- Feedback survey link has been shared in the zoom chat and will also be available via a follow up email. If you opted out of receiving emails from Project ECHO, note you will not receive the follow-up email.
- This link is only open for 48 hours.

Session materials and other resources

- Please find a link in the chat to our session archive where today's presentations and recording will be available in addition to materials from past sessions of our series.

- Scan the QR code to join the TRACK WhatsApp channel to be notified of future webinar series announcements and updates

- Poll: interest in future TRACK activities

Merci!

Thank you!

Obrigada!

Gracias!

Thank you for attending the

WHO ‘TRACK’ Digital Learning Series -

Technical Resources for AHD Capacity and Knowledge!