How the three policy changes fit together

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1
Annual clinical visit
2
Earlier Viral Load
3
Differentiated Re-engagement

Part 1 of 4

The challenge

HIV care is moving into settings that are already stretched

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HIV care is moving into settings that are already stretched



Overburdened settings

HIV cohorts are being transferred to integrated settings in primary care and OPD that are already overburdened



Reduced staffing

Fewer staff in these settings, including counselling staff

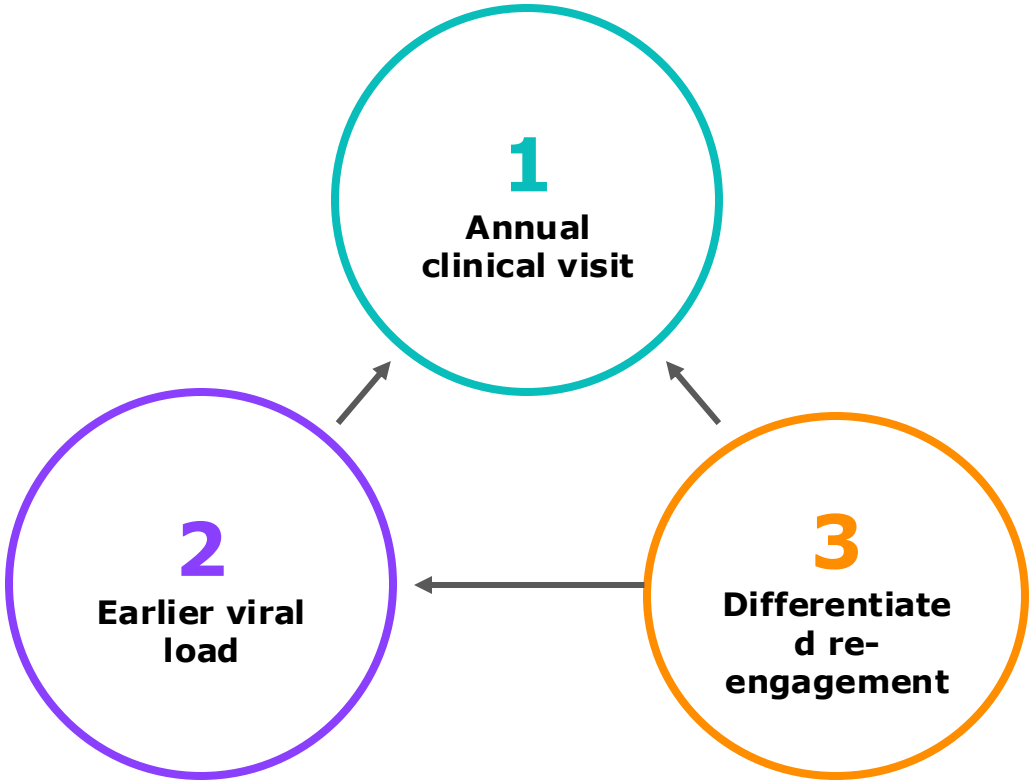


Diminishing resources

Less funding for the staff, tests and systems that HIV care relies on

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Can the three interlinking policy changes help?



How the three policy changes fit together

Maintain quality
Retention in care and viral load suppression

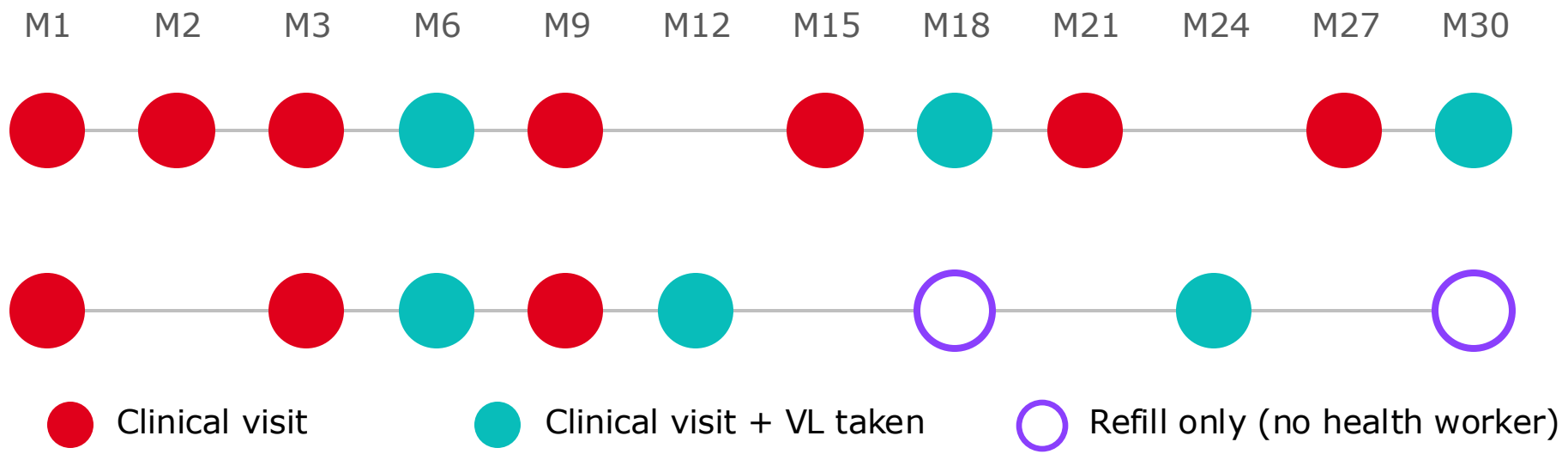
Reduce the burden of visits
For clients and for the health system

Support integrated care
The move to quality, person-centred integrated care

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Current approach to follow-up is variable

Scheduled contacts in the first 30 months on ART, by country policy



Up to month 30: 10 contacts with a health worker in Malawi, 6 in Zimbabwe

Part 2 of 4

Policy 1: Comprehensive annual clinical visit

One comprehensive consultation a year, with a 12-month script

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Policy 1: one comprehensive clinical visit a year

One comprehensive consultation a year with a health worker (doctor, clinical officer or nurse) that includes:

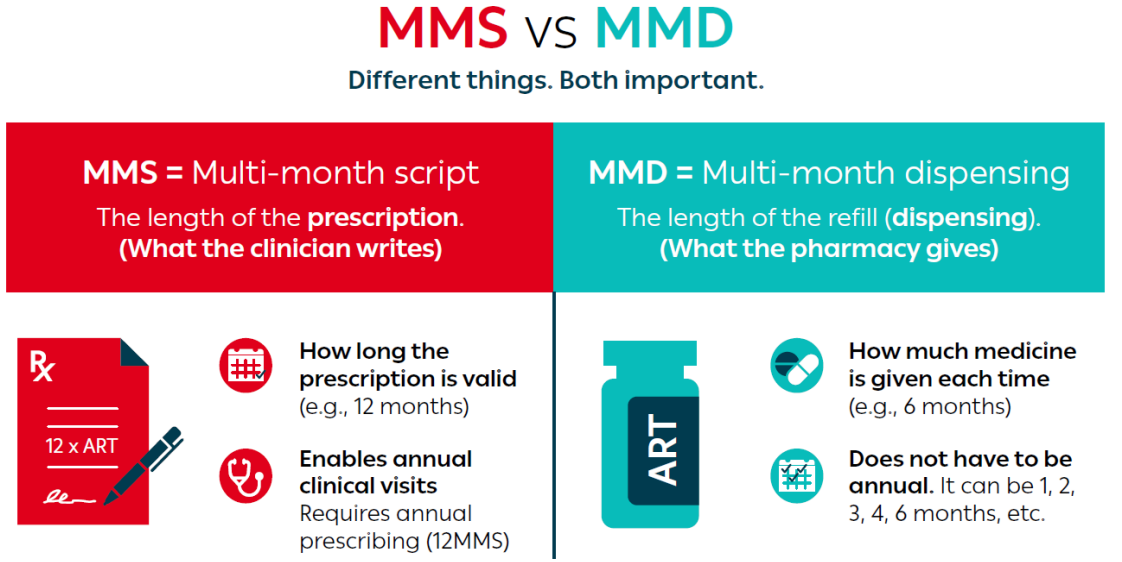
History and examination with a clear checklist, including screening (BP, mental health, cervical cancer)

Taking **the viral load**

Explaining how the **result will be delivered, and recall**

A **script for 12 months** of medication

Dispensing for the **maximum refill**



Integrate DSD and annual clinical review across chronic diseases, otherwise the benefit is lost

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Why DSD for chronic disease matters

25–30%

of the HIV cohort also has hypertension

For them, annual HIV visits have no impact unless DSD for chronic disease is addressed

Multi-month scripting is possible even without MMD
MMS could be possible even where MMD is not, for any medication

Extend DSD for chronic disease to HIV-negative clients
This would decongest primary care and OPD sites and free up time for a quality annual clinical visit

Implementation considerations:
Annual clinical visit

Multi-month scripting and dispensing regulations and policies

Investment in treatment literacy

A template/checklist for the comprehensive annual review

A reliable result delivery and recall system
Client empowerment: “know your viral load”

Part 3 of 4

Policy 2: Earlier viral load

Facilitating earlier access to DSD and annual clinical visits

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Earlier viral load opens earlier access to DSD and annual clinical visits

1

Earlier viral load

Month 3

2

Earlier entry to DSD

Months 4–6

3

Earlier access to the annual clinical visit

But only if…

- the definition of "established on treatment" is adapted
- clinical visits are separated from refill visits: that is where the benefit is felt

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In many countries, VL timing is delaying access to DSD

15

Sub-Saharan African countries reviewed

›

12

schedule first VL at month 6 with result review thereafter

›

9

of those don’t enable less-intensive DSD model enrolment until month 12

Disengagement is high in early ART – and care is still more intensive than required

Policy review of 15 countries · Wilkinson, Golob & Grimsrud, CQUIN 2024 · IAS DSD policy dashboards, differentiatedservicedelivery.org

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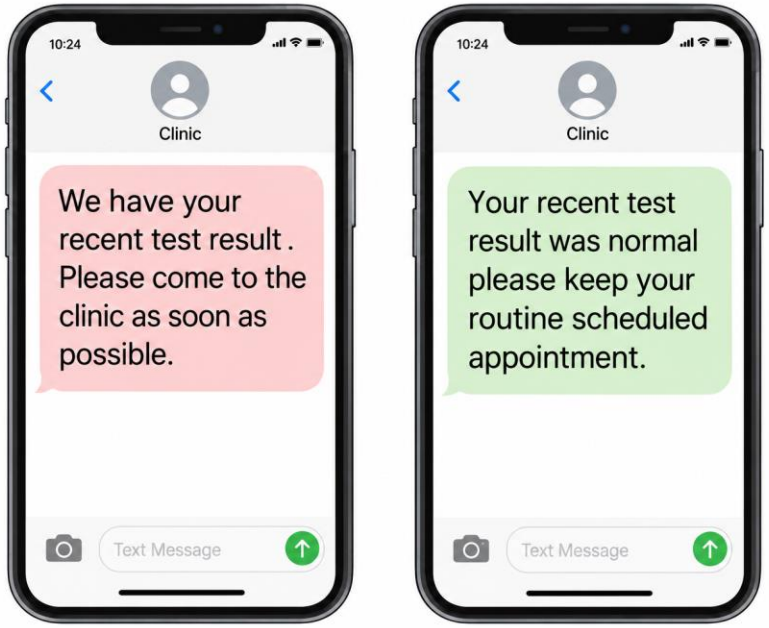
Do our result delivery and recall systems support an annual visit?

Options for returning results

To the facility	Linked to EMR, SMS, paper
To the client, direct from the lab	SMS
To the client, from the clinic	SMS, call, in person, paper

Are people with high viral load being recalled effectively?

Is there any audit or data on recall and action on high viral load?



Month 3 for everyone would also simplify VL timing

Earlier VL already happens for some groups – one first-VL time point for all is simpler for clinics, labs and monitoring.

Newly starting ART

Today: first VL at month 6 in Malawi, Mozambique and Zambia.

First VL at month 3

Returning to care

Restarting ART after an interruption.

First VL at month 3

Pregnant and breastfeeding

Already at month 3 in Mozambique and Zambia.

First VL at month 3

Sources: country guidelines as on the earlier slides on current policy and on pregnancy and breastfeeding.

Implementation considerations:
Viral load timing and frequency

Platform used
Centralized or point-of-care

Turnaround time for results

Result delivery and recall systems

Cost

Part 4 of 4

Policy 3: Differentiated re-engagement

Can clients re-engaging in care benefit from policies 1 and 2?



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For example: Theresa



Theresa's story

On ART for 10 years
Her last 7 annual viral loads were suppressed

Annual clinical visit with 2 × 6MMD
For the last 4 years

Came 6 weeks late for her appointment
She had to travel suddenly for a relative's funeral

Off ART for 4 weeks
She had 14 extra pills; she is completely well, with no clinical symptoms

What the nurse tells her

She will need 4 visits before a viral load at 6 months, and the result at month 9, before she can be offered 6MMD again

9 months

before Theresa is back on 6MMD

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Imagine instead: Theresa



A different visit

Arrives 6 weeks late for her appointment

Has a friendly encounter
She is welcomed back, without blame

Is assessed to be sure she is clinically well
No symptoms, no reason to step up care

Stays in her DSD model
6MMD, annual visits and VL schedule unchanged

What the nurse tells her

Because she is 6 weeks late and clinically well, she can stay on 6MMD. Her next viral load stays on her current schedule.

Today

Theresa leaves with 6MMD, no waiting

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Re-engagement with earlier viral load and annual visits

Not everyone who is late will have stopped ART

For those re-engaging, differentiate initiation and follow-up by: clinical presentation, and time since the last missed appointment (including the offer of CD4 by time off ART)

Out of care for less than 28 days

Could clients be offered immediate DSD with MMD?

Out of care for more than 90 days, and well

If viral load is offered earlier (3 months after re-initiation), could clients access DSD and the comprehensive annual clinical visit earlier?

Implementation considerations:
Re-engagement

Tracing algorithm	Who is traced: prioritization Time to trace Tracing method: call, SMS, in person
AHD package	Availability of CD4: priority for use Availability of the AHD package: decentralization, task sharing, training in integrated settings
Training and mentorship	Is it "simple enough"? WhatsApp microlearning module implemented in South Africa

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Summary



1

Annual clinical visits

If approved, will support simplification and self-management

2

Earlier viral load

Allows earlier DSD and earlier access to annual clinical visits

3

Differentiated re-engagement

Let's people returning to care access both policies, facilitating their return

4

DSD for chronic disease

Without it (and family planning), the benefit of fewer ART visits is lost

How the three policy changes fit together

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"Simplifying HIV care isn't rationing. It's **matching care to need.**"

Plenary: Q&A and discussion