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# Differentiated re-engagement after treatment interruption

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Simplifying HIV service delivery: from evidence to national policy | Johannesburg, 27 October 2026

# Presentation outline

1. Status before the November 2024 re-engagement workshop
2. National policy change
3. Implementation experience
4. How our electronic medical register (EMR) is supporting re-engagement

Section 1

# Status before the November 2024 workshop

Eswatini’s starting point, the agreed revision plan and the data we had

# **November 2024:** the discussions that shaped revision

## Eswatini's starting point

Existing SOPs needed clearer care for unwell clients returning to treatment (RTT) and better understanding of interruption data.

## Clinical differentiation

Time since the missed visit, clinical condition and psychosocial needs should guide care.

## Service differentiation

Some clients can resume convenient DSD. Others need intensified assessment and support.

Source: IAS and WHO. Differentiation at re-engagement in HIV care: a multi-country workshop, Johannesburg, 12–14 November 2024 (report, pp.16, 23–24).

# **The workshop produced** a specific revision plan

| Target date | Agreed action | Status |
|---|---|---|
| **Nov–Dec 2024** | Pause printing. Align definitions with M&E. Build core-team and TWG consensus. | **Done** |
| **Jan–Feb 2025** | Simplify the draft and seek external technical review. | **Done** |
| **March 2025** | Finalize and print the revised SOP. | **Done** |
| **June–July 2025** | Train clinical mentors and sensitize supervisors and communities. | **In progress** |

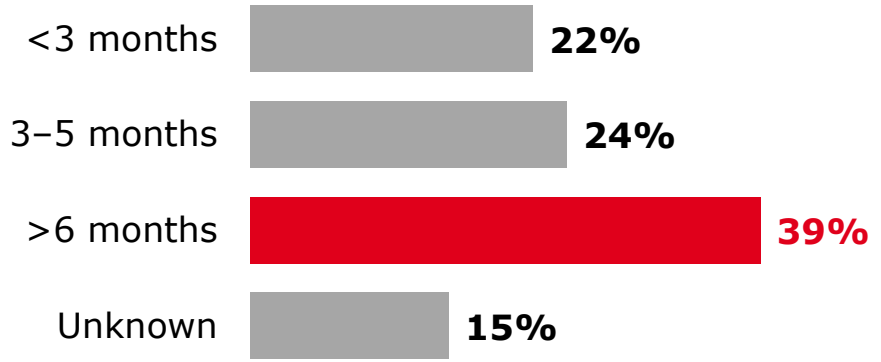
Source: IAS and WHO. Differentiation at re-engagement in HIV care: a multi-country workshop, Johannesburg, 12–14 November 2024 (report, pp.16, 23–24).

# Return to treatment and length of IIT – March 2023

| Age group | 28 days - 3 months | 3–5 months | >6 months | Unknown | Total |
|---|---|---|---|---|---|
| **<1 yr** | 1 | 0 | 1 | 0 | **2** |
| **1–4 yrs** | 12 | 7 | 4 | 8 | **31** |
| **5–9 yrs** | 13 | 18 | 26 | 16 | **73** |
| **10–14 yrs** | 24 | 33 | 42 | 25 | **124** |
| **15–19 yrs** | 72 | 65 | 74 | 24 | **235** |
| **20–24 yrs** | 97 | 133 | 196 | 102 | **528** |
| **25–29 yrs** | 164 | 215 | 319 | 188 | **886** |
| **30–34 yrs** | 231 | 281 | 469 | 172 | **1,153** |
| **35–39 yrs** | 279 | 296 | 560 | 212 | **1,347** |
| **40–44 yrs** | 274 | 278 | 435 | 151 | **1,138** |
| **45–49 yrs** | 199 | 183 | 331 | 107 | **820** |
| **50–54 yrs** | 112 | 131 | 197 | 59 | **499** |
| **55–59 yrs** | 66 | 62 | 125 | 32 | **285** |
| **60–64 yrs** | 34 | 64 | 92 | 21 | **211** |
| **65+ yrs** | 70 | 81 | 107 | 40 | **298** |
| **Total** | **1,648** | **1,847** | **2,978** | **1,157** | **7,630** |

IIT: interruption in treatment. Returns to treatment by age group and length of interruption, March 2023.

**Duration of IIT at return to treatment**




**39%** had interrupted treatment for more than 6 months (2,978 of 7,630)

Section 2

# National policy change

What we changed in policy – and the differentiated re-engagement flowchart

# Policy changes

## Some policies were prohibitive and promoted disengagement

### 1 Visitors

Visitors should get the full package of care

### 2 Care anywhere

HCWs should use CMIS effectively so clients can receive care anywhere within the country

### 3 First appointment after ART initiation

- 2 weeks if AHD or WHO stage 3 or 4
- 1 month if stage 1 or 2 and clinically stable

### 4 First viral load

3 months after ART initiation – give 3MMD if suppressed

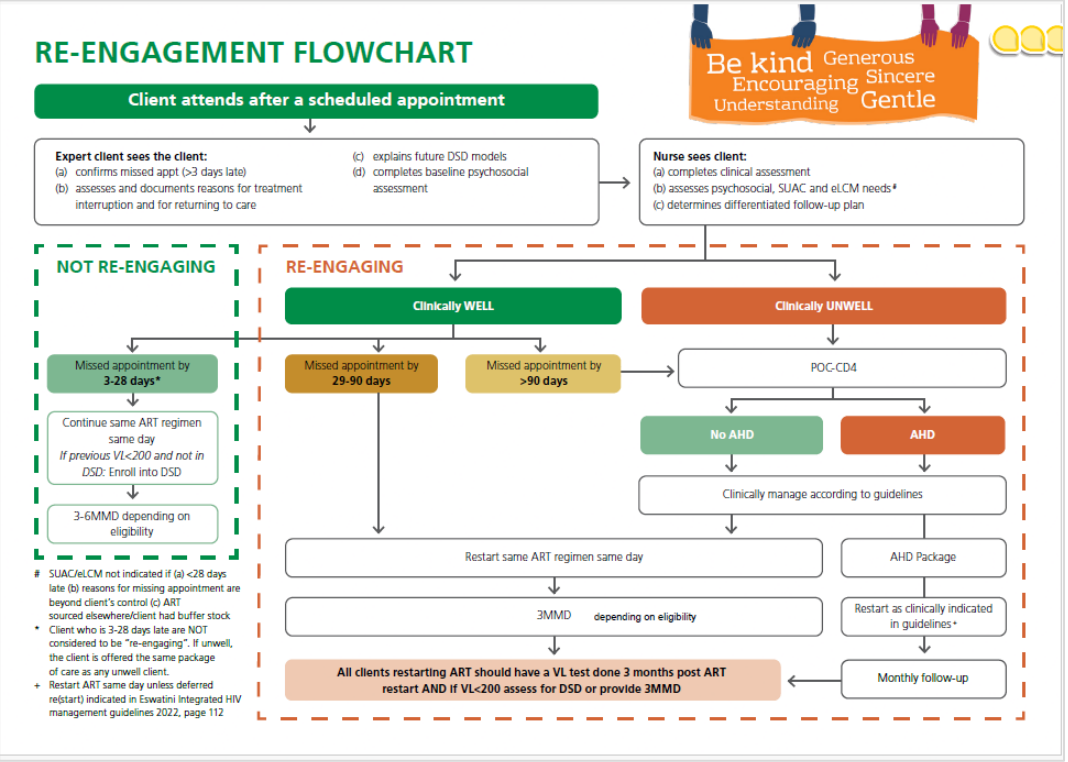
### 5 International students

Allow up to 1 year supply

### 6 On return to the facility

Confirm duration of treatment interruption (not taking medicines) and differentiate it from days since last appointment

# **Re-engagement differentiated** according to duration of treatment interruption and clinical status




| | |
|---|---|
| **Not re-engaging** | **Missed by 3–28 days:** continue same regimen same day; enrol in DSD if last VL <200 and not in DSD; 3–6MMD depending on eligibility |
| **Clinically well** | **Missed by 29–90 days:** restart same regimen same day; 3MMD depending on eligibility<br>**Missed by >90 days:** POC CD4 |
| **Clinically unwell** | **POC CD4.** No AHD: manage clinically, restart same day. AHD: AHD package, restart as clinically indicated, monthly follow-up |
| **All restarting ART** | **VL 3 months after restart** – if VL <200, assess for DSD or provide 3MMD |

Source: Eswatini re-engagement flowchart (restart same day unless deferred re(start) indicated – Eswatini Integrated HIV Management Guidelines 2022, p.112).

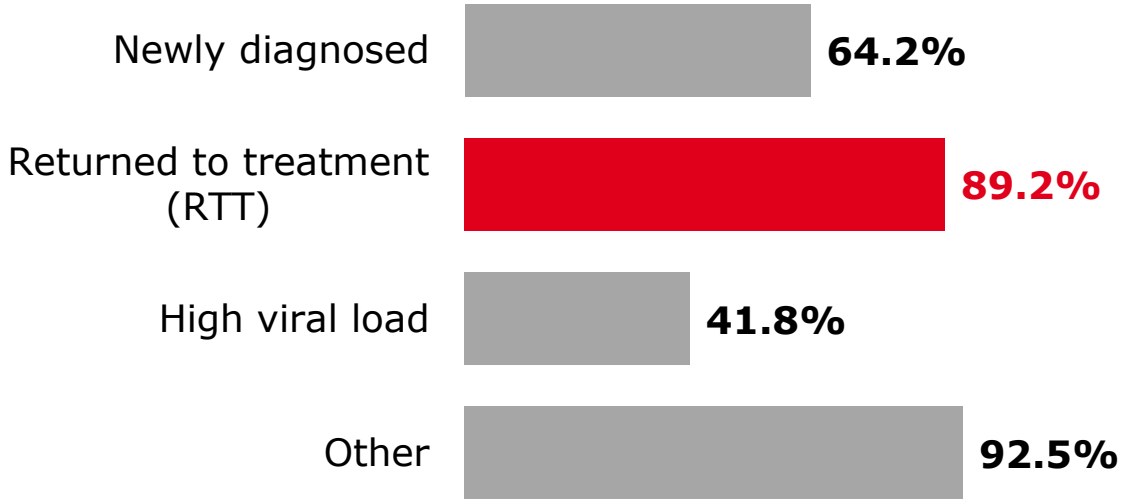
Section 3

# Implementation experience

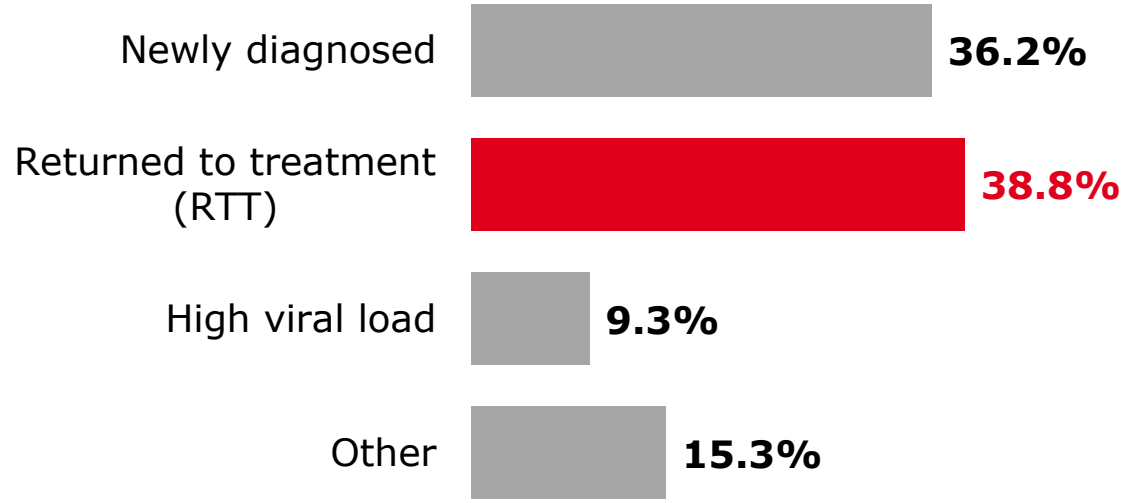
AHD at return to treatment, attrition and retention

# **CD4 testing coverage has improved** – and AHD is very high among clients returning to treatment

**CD4 testing coverage, by reason (%)**




**CD4 <200 among those tested, by reason (%)**

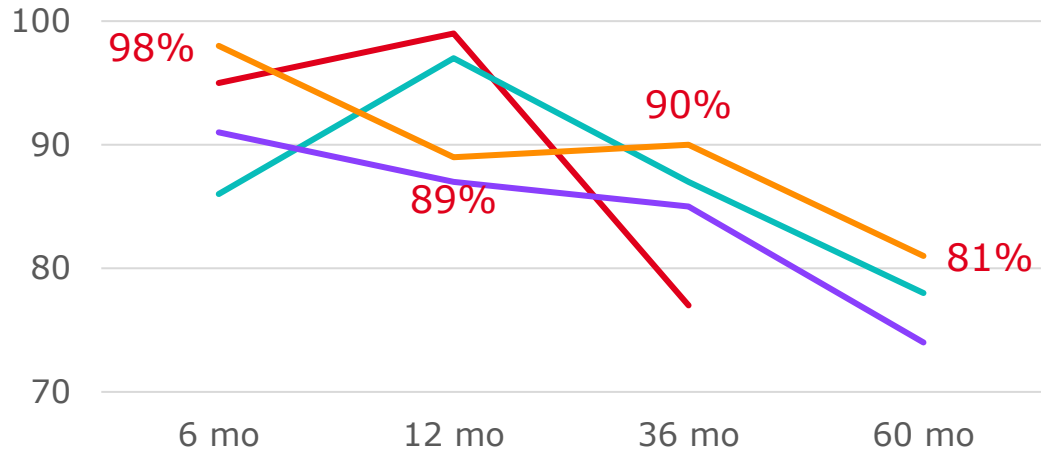



Source: AHD_and_TPT.xlsx

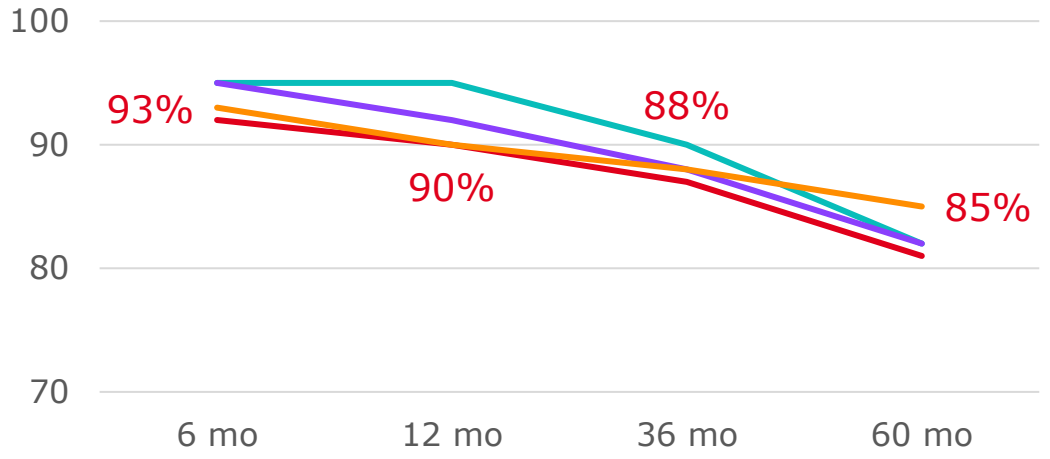
# How is our retention so far?

Retention on ART, % by months since initiation: — **2022** — **2023** — **2024** — **2025**

**Children <15 yrs**




**Adults 15+ yrs**




| **What affected implementation** | Training HCWs on the new SOP | Patient follow-up not done during SWO | Departure of most IPs affected implementation |
|---|---|---|---|

Section 4

# How our electronic medical register (EMR) is supporting re-engagement

CMIS updates, re-engagement indicators – and what we learned

# How CMIS tracks re-engagement

## What CMIS does

- Identifies clients lost to follow-up
- Generates re-engagement lists and alerts
- Supports targeted outreach and linkage to care

## 1. Intake and verification

**1 Register client**
Look up the client and create a profile

**2 Verify history in HTS**
Cross-check the record against the HTS and ART database

**3 Previous positive flagged**
Starts retester sequence; no duplicate baseline entry

## 2. Retester management

**A Record reason for returning to care**
Second opinion, gap in care, or work or travel requirement

**B Provide targeted counselling**
Confirm prior result; support ART start and adherence, DSD sensitisation

**C Document on Retester page**
Save in CMIS module, lock page, refer to linkage officer

# New in our CMIS and M&E system

## Reason for interruption

Captured when a client **reinitiates ART**

## Reinitiation date

Now included in the **ART summary**

## Re-engagement indicators

- Number and % of PLHIV **interrupting** care during the reporting period
- Number and % of clients who **interrupted** treatment, **returned** to care, restarted ART and remained in care during the reporting period

# Challenges and recommendations

| Challenge | Recommendation |
|---|---|
| **Delayed data capturing:** Clients misclassified; many recorded as restarting ART in the next quarter | **Strengthen data systems:** Real-time capture, staff training on accuracy, mentorship |
| **Return with advanced HIV disease (AHD):** Increased morbidity and mortality risk | **Enhance AHD management:** Screen all re-engaging clients, provide rapid AHD package, community sensitisation |
| **Treatment interruptions:** Clients disengage after accumulating excess ART | **Scale up re-engagement strategies:** SMS/phone tracing, home visits, stigma-free environment<br>**Improve adherence monitoring:** Routine pill counts, refill audits, digital reminders |
| **Private sector gap:** HCWs in private facilities not yet trained on re-engagement SOP | **Expand training coverage:** Train private facility HCWs, foster public–private collaboration |
| **Funding freeze impact:** USG support suspension disrupted client follow-up | **Mitigate funding gaps:** Explore alternative financing, prioritise high-impact low-cost interventions, use patient-facing digital platforms to support adherence and follow-up |

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# Thank you