Why we need to differentiate re-engagement

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

In this session

Tuesday 27 October
13:25–13:50

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Why differentiate re-engagement?

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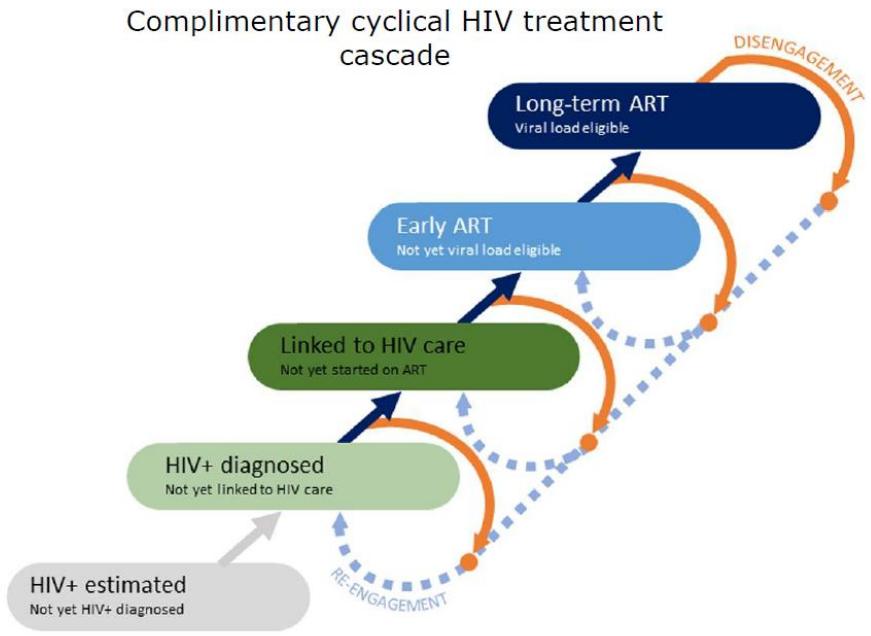
Differentiating care at return

Part 1 of 4

Why differentiate re-engagement?

Re-engagement is not just about bringing people back through tracing

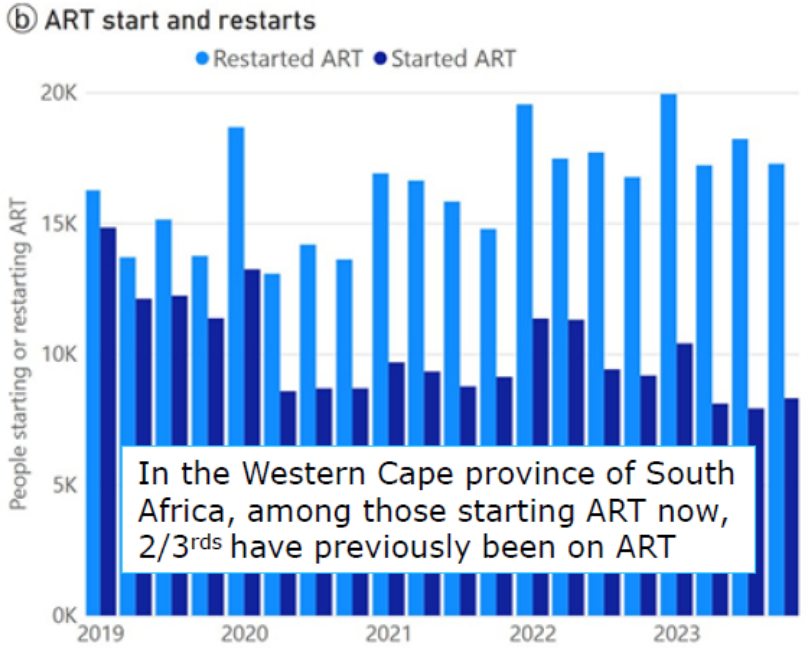
We all know about the cyclical cascade



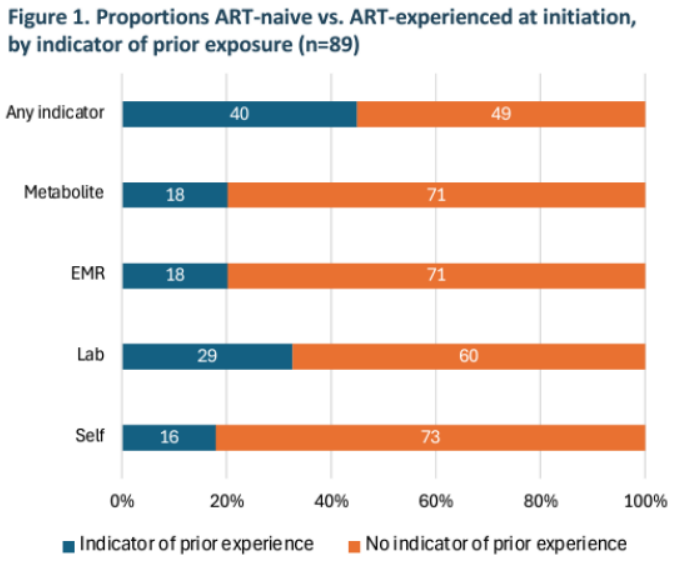
Disengagement is present at every step

What data are available at each step?

Increasingly, people initiating ART are not ART-naïve



Sentinel sites: Mpumalanga, KZN, Gauteng



2 in 3

people starting ART in the Western Cape have been on ART before

45%

of people "initiating" ART at sentinel sites had an indicator of prior ART (40 of 89)

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Re-engagement is NOT just about bringing people back through tracing

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Differentiated re-engagement is about what we do at re-initiation to improve retention

Acknowledging	that a growing proportion of ART "initiations" are people who have already been on ART
Adapting	how we manage people who have already been on ART when they return
Facilitating	the client to stay on ART when they come back, not making it more difficult

Part 2 of 4

Who is re-engaging?

Definitions, documentation and time since the missed visit

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Do we need to look at our definitions?

> 7 days

Missed visit

A missed appointment for an ART refill or a clinical visit. WHO-suggested criteria for starting tracing and recall include missing an appointment or visit by more than 7 days.

≥ 28 days

Lost to follow-up

"Not seen at the facility or community service delivery site for 28 days or more since the last missed appointment (including missed ART refills in facility or community settings)"

Being late, or missing a visit, does not necessarily mean a treatment interruption

Source: WHO Re-engagement brief

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A re-engaging client

1

Has missed an appointment, or is late

and

2

Has stopped taking ART

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Late, but not re-engaging



Silent transfers



Accumulated buffer stock



One-off collection from a different facility when travelling



Purchase or loan of ART

Many explanations for why a client may not have stopped ART

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When there is no documentation, how do we know if there's an interruption?

A good predictor

Self-reporting an interruption

is a good predictor that an interruption took place

Thorman et al. 2019

Poor predictors

Self-reporting no interruption or good adherence

social desirability bias: clients want to please their provider

Stirratt et al. 2015; Castillo-Mancilla et al. 2018; Smith et al. 2022

Clinician assessment of adherence

is a poor predictor of adherence

Bangsberg et al. 2001; Smith et al. 2022

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Time since the missed visit should be part of what we do at re-engagement

Duration of possible interruption



Late: < 14 or 28 days | Short interruption: ~90 days | Long interruption: 180+ days

Shorter time out of care

- Fewer clinical needs
- Limited risk of mortality
- Could benefit from accelerated access (back) to less-intensive DSD

If the person self-returns "quickly": more self-motivated, with fewer barriers needing psychosocial support?

Longer time out of care

- More clinical needs
- Higher risk of mortality
- Screen for AHD
- Then ongoing support for sustained engagement

Potentially more psychosocial support needs?

Note: the proportion established on treatment is inversely related to the duration of interruption; a suppressed viral load is needed to confirm it

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Results from a cohort study in Johannesburg, South Africa

65%

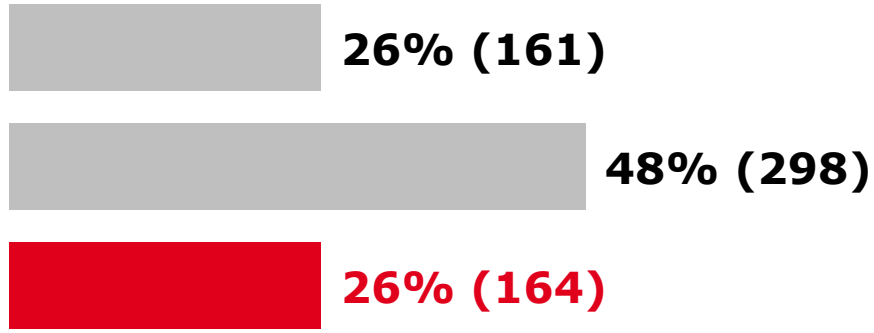
of people who missed an appointment were less than 2 weeks late

Missed appointment, but not re-engaging: 1,523 of 2,342

35% (819) were 2 or more weeks late and re-engaging in care

Among those re-engaging: time since the scheduled appointment

n = 623 with further data



Less than a third of those re-engaging had been out of care for more than three months

Source: Mutyambizi et al. 2024, JIAS (in press)

If people re-engaging are...

1. Well



+

2. Previously suppressed



+

3. Out of care for < 28–90 days



Is this a group of people where we can make it easier to re-start and access ART?



Potential group to make it easier to re-start and access ART

Part 3 of 4

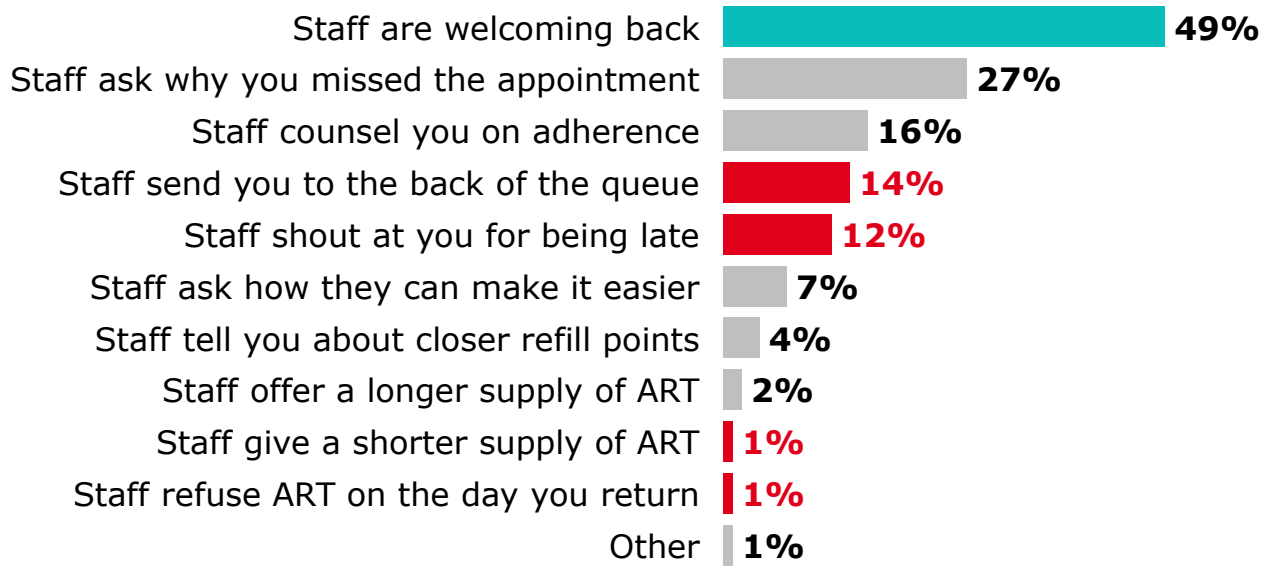
The experience of coming back

What is the client experience when they attend late?

What happens when people return late

Community-led monitoring data, South Africa

"When you return late, which of the following happens?" % of 5,917 people living with HIV (more than one answer allowed)



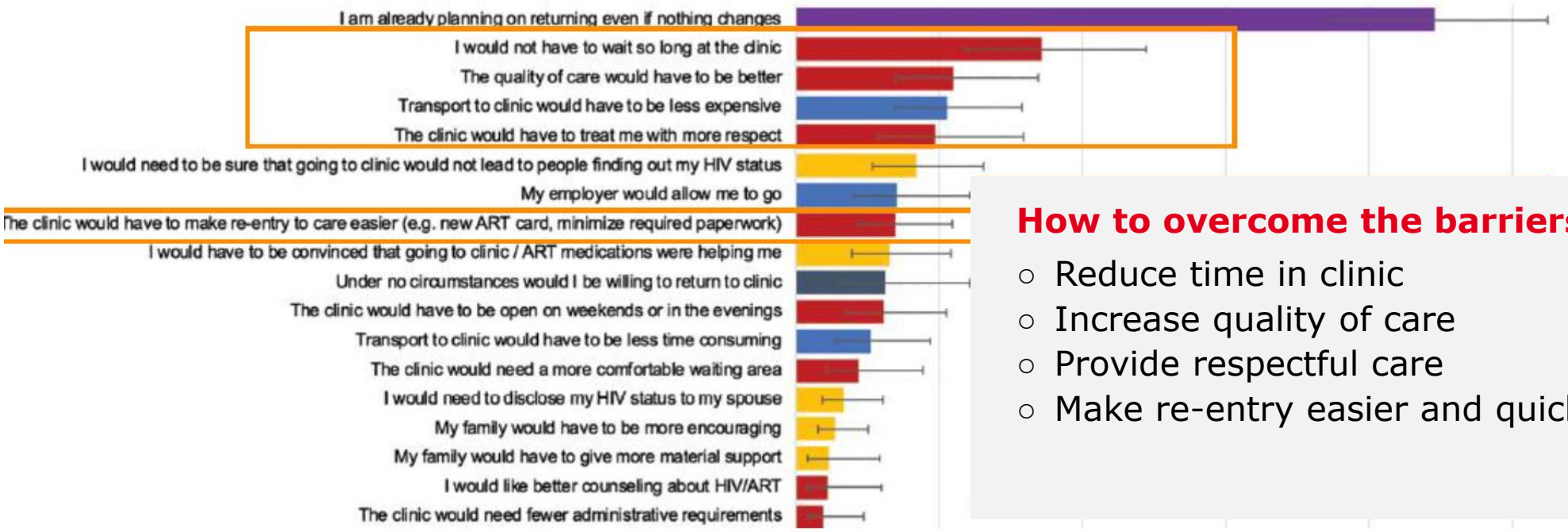
In their words

"We get punished for missing dates. I went to the clinic for five months without being helped."

"This month I missed my appointment because I was at work. I was sent away. Even now I have not received my pills."

Source: Ritshidze community-led monitoring, South Africa

What would make it easier to come back to care?

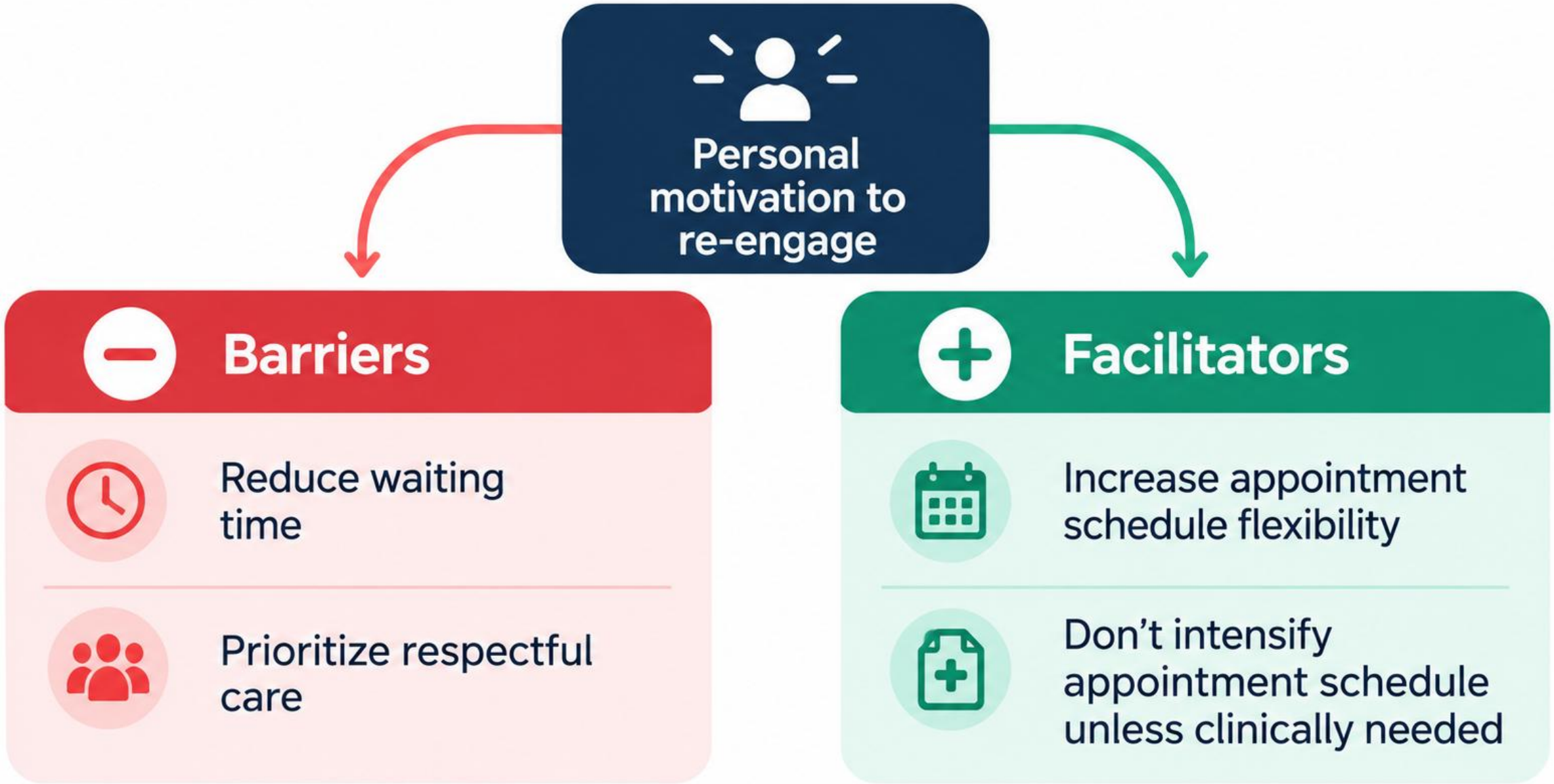


How to overcome the barriers people cite

- Reduce time in clinic
- Increase quality of care
- Provide respectful care
- Make re-entry easier and quicker

Source: Sikazwe et al. 2021

What could we do differently?



Part 4 of 4

Differentiating care at return

Who can return directly to DSD, and who needs more support?

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Why do we need differentiated re-engagement?

To identify who can return directly to a DSD model



- Stable
- Previously suppressed
- Short period out of care

To identify who needs additional support (clinical or psychosocial)



- Clinical support
- Psychosocial support
- Additional follow-up

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What are the key factors to consider?

Clinical / Psychosocial Needs



- Clinical needs
- Psychosocial needs
- Mental health and wellbeing
- Social support available

+

Time since last appointment

("Duration of interruption")



- **Short** (eg < 28 days)
- **Intermediate** (eg 28–90 days)
- **Long** (eg > 90 days)

Time since last appointment
("duration of interruption")

Identify who has had a treatment interruption (or not)

Does the client self-identify as interrupting treatment?

After what duration from the last appointment (or how late) is it likely the person interrupted treatment?
More than 28 days?

Clinical needs

Identify who has clinical needs (or not)

Presenting with symptoms?
Any WHO stage 3 or 4 condition = AHD

Does time since last appointment indicate a need for CD4?
More than 3 months: CD4 to deliver the AHD package

When was the last viral load, and was it suppressed?
Previous demonstration of adherence
Timing of viral load after re-engagement

Psychosocial needs

Identify who needs a psychosocial support package (or not)

Known history of severe psychiatric disorder, alcohol or substance misuse

Use of a two-question screening tool
For example, PHQ-2 and GAD-2

But does this mean they need more visits and shorter refills?

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A differentiated re-engagement pathway asks

1

Who is “late”, and who is re-engaging?

2

Among those re-engaging:

Who is well and out of care for not too long?

Who is unwell, or out of care for long?

3

What services do these groups need?

On the day of re-engagement, and for follow-up

Kenya: re-engagement after a missed appointment



Kenya

Three successive decision points sort people returning to care into three groups, each with its own pathway

Source: Kenya national HIV guidelines, Figure 1.18: Re-engagement to care after missed appointment

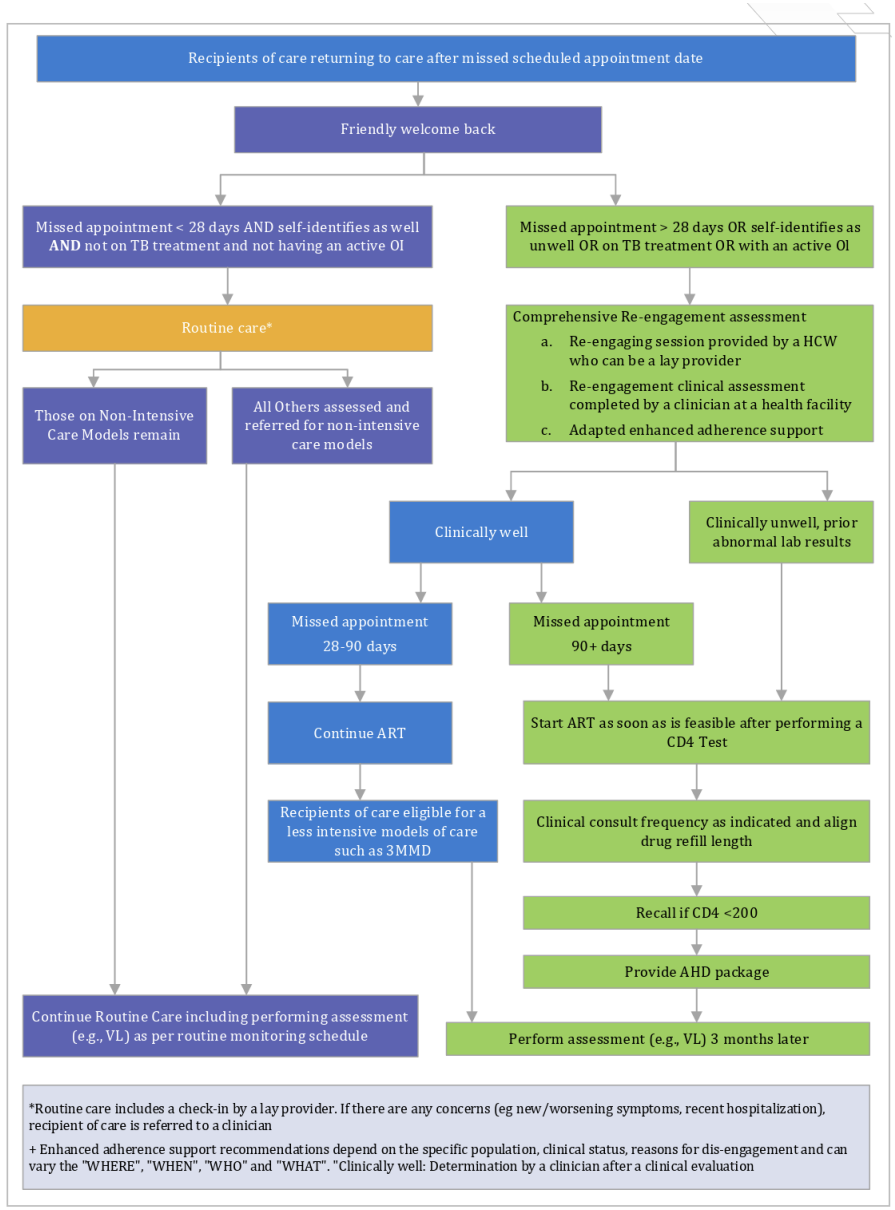
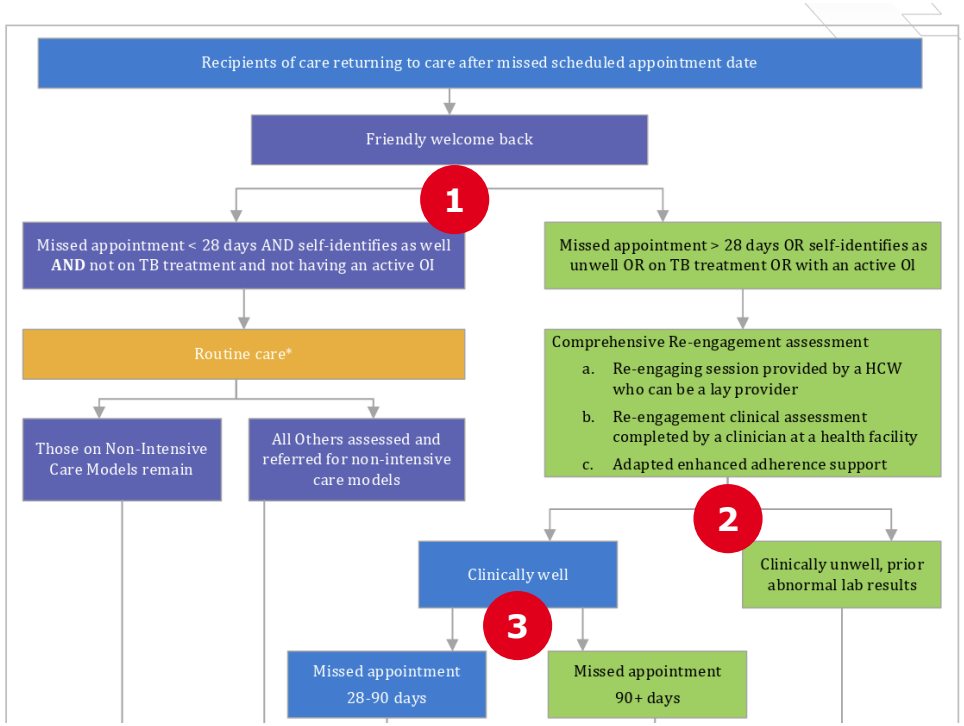


Figure 1.18: Re-engagement to Care after Missed Appointment

Kenya: three decision points



1 Time since the missed appointment

Less or more than 28 days; self-identifies as well or unwell; TB treatment or active OI

Less than 28 days and well: routine care, not re-engaging

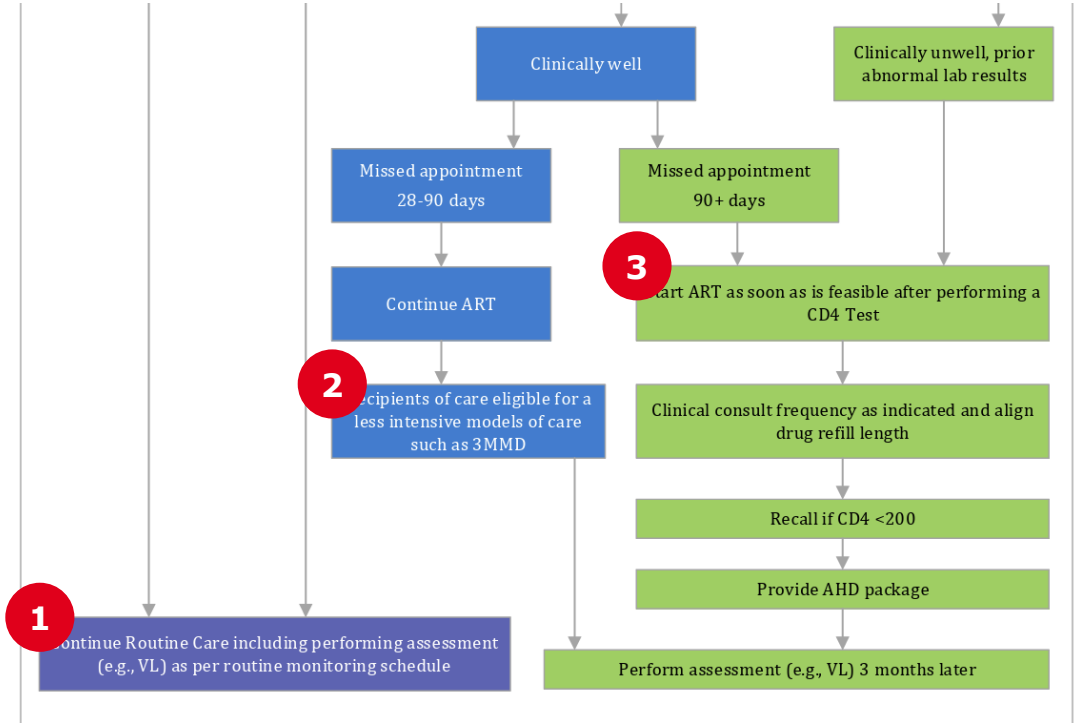
2 Clinical status

More than 28 days: comprehensive re-engagement assessment, then clinically well or unwell

3 Time since the last appointment

Among those who are well: 28–90 days, or 90+ days

Kenya: three groups, three pathways



1 Well, and less than 28 days late

Eligible for DSD and MMD; routine viral load

2 Well, and 28–90 days late

Eligible for DSD and MMD, but with an early viral load at month 3

3 Unwell, or 90+ days late

Restarted on ART after a CD4 test

Key questions



Are we addressing **clinical and psychosocial needs** for those with problems?



Are we enabling an **easy return to DSD** for clients who do not have clinical or psychosocial issues?

Eswatini: from workshop to national policy

Up next | Clara Nyapokoto, Ministry of Health, Eswatini, 13:50 | Then: Q&A and plenary discussion, 14:10