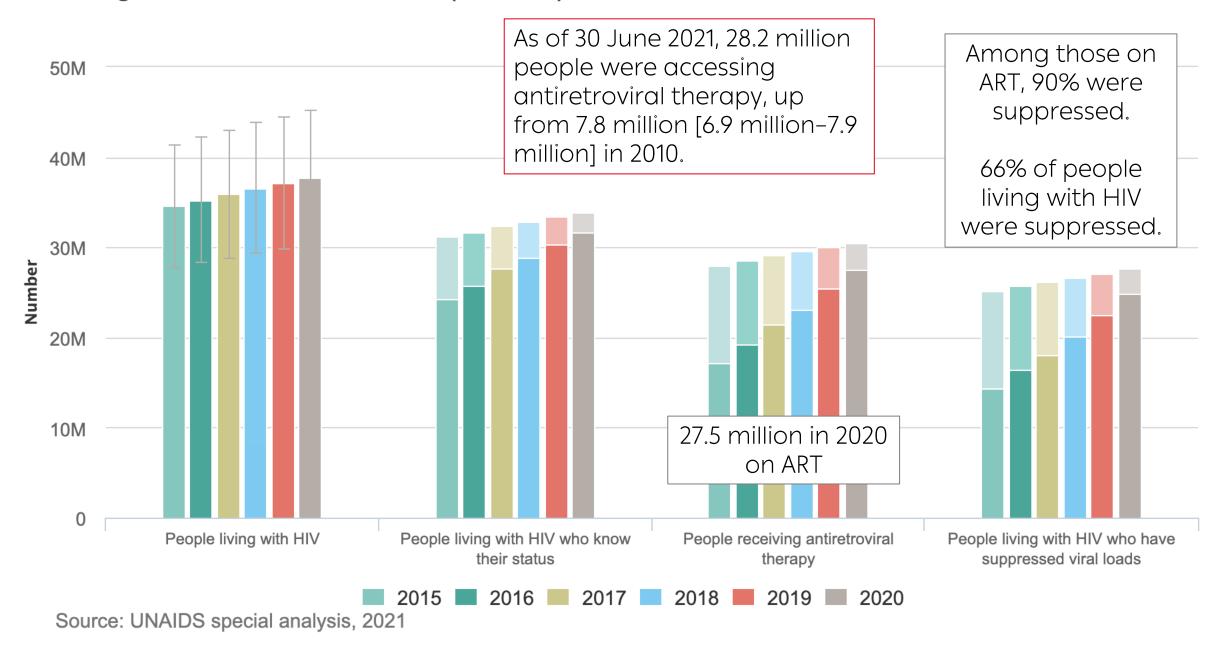


Differentiated service delivery (DSD) for HIV: Current landscape and challenges that could be addressed by long-acting formulations and delivery platforms



How are people living with HIV currently accessing their HIV treatment and care?

HIV testing and treatment cascade (number)

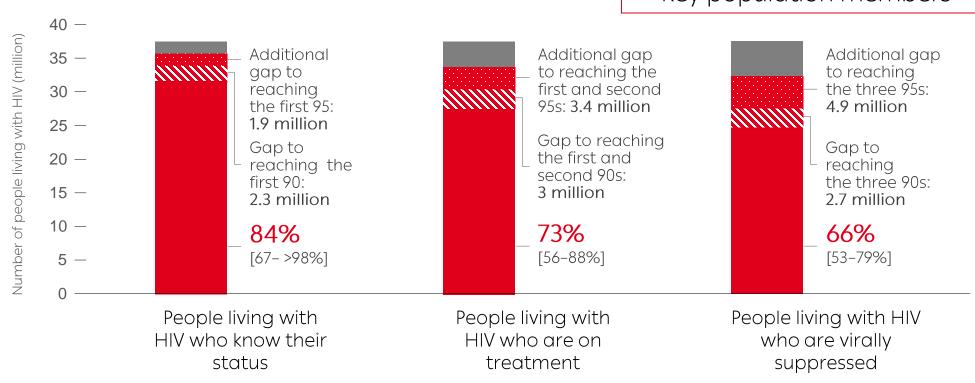




HIV testing and treatment cascade, global, 2020

Lower rates of viral suppression among

- Younger populations
- Men compared to women
- Key population members

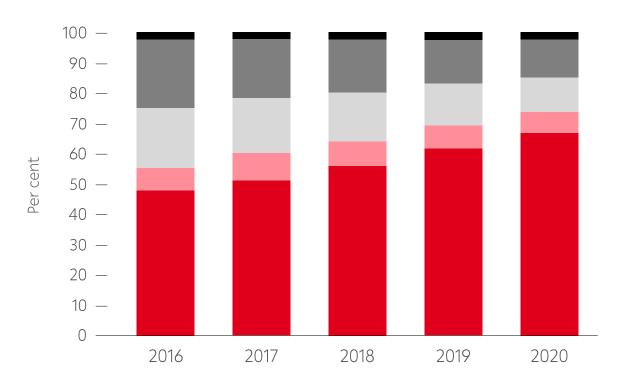


Source: UNAIDS special analysis, 2021.



Gaps and challenges are changing with time

People living with HIV, people newly infected in the past six months, and HIV testing and treatment cascade, adults (aged 15+ years), global, 2016–2020



- People living with HIV who were infected in the past six months
- People living with HIV who don't know their status and were infected more than six months ago
- People living with HIV who know their status but are not on treatment
- People living with HIV who are on treatment but are not virally suppressed
- People living with HIV who are on treatment and are virally suppressed

Source: UNAIDS special analysis, 2021.

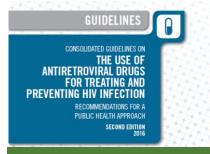


DSD for HIV treatment



Not just what to start and when to start but how to deliver ART

- Marked shift from the one-size-fits all approach that had supported reaching 15 million people
- Acknowledgement of the diversity of clinical needs of people living with HIV





SERVICE DELIVERY

6

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Differentiated service delivery (DSD), or differentiated care, is a person-centred approach. It simplifies and adapts HIV services across the cascade of HIV care to reflect the preferences and expectations of various groups of people living with or at risk of acquiring HIV while reducing unnecessary burdens on the health system.

Adapted from Grimsrud et al, JIAS, 2016.



DSD makes sense for clients and for health care workers



How will I keep my job if I have to spend a day a month at the clinic?

Why are new clients, sick clients and adherent clients all coming to the clinic at the same frequency?

Why must I queue to see a nurse and queue at the pharmacy if I'm only coming to collect my ART refill?

How can we support clients who are failing treatment if we are overwhelmed with adherent clients?







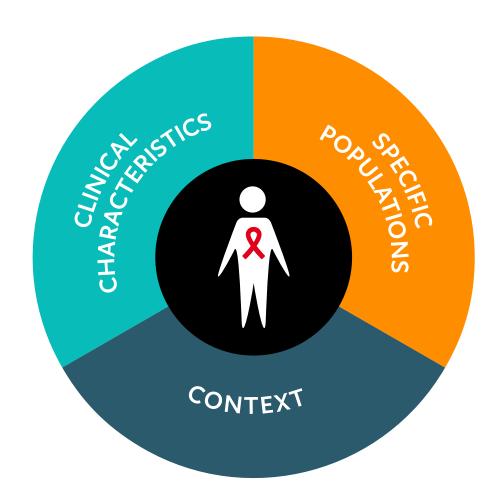


Stable on ART

	2016		
Term	Stable		
Time on ART	12 months on ART		
Inclusion of pregnant women	Pregnant women excluded		
Inclusion of children and adolescents	Children and adolescents included		
Regimen	Second and third line not explicitly stated		
Viral load / evidence of treatment success	Two consecutive viral loads <1000 copies/ml		

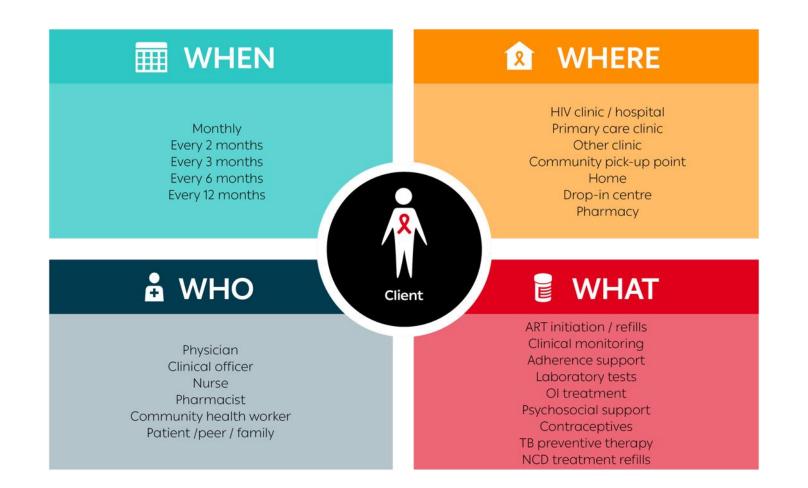


Elements to consider



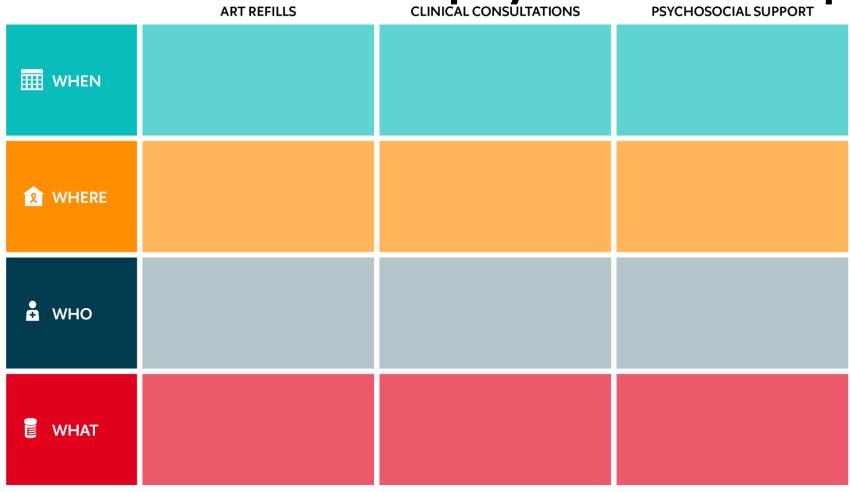


Building blocks of service delivery





Define the building blocks for ART refills, clinical consultations and psychosocial support







"The critical intervention is separation of drug delivery from clinical care. This innovation reduces the burden at clinical sites and allows more attention to the patients who need clinical evaluation and allows for less frequent clinical evaluations for individuals who are well."

- PEPFAR COP Guidance, 2022



For example → Community ART refill group (CARG)

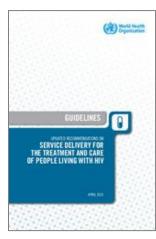
	ART REFILLS	CLINICAL CONSULTATIONS	PSYCHOSOCIAL SUPPORT	
₩ WHEN	Every 6 months	Annually	Every 6 months	
🗴 WHERE	Group members house or community venue	Primary health care facility	Group members house or community venue	
WHO	Group members*	Nurse	Group members*	
WHAT	ART and CTX refill	ART and CTX refill Annual scripting VL monitoring	Peer support	

Example from Zimbabwe's Operational and Service Delivery manual

*Group leader completes the form, chosen group representative collects medication for the group (sees a nurse)



In March 2021, WHO revised eligibility criteria for determining whether a person is established on ART



ions;

provided;

To support the implementation of these recommendations, WHO has developed criteria

for determ

√ receivin

√ no curre

✓ good ur

and

"The definition of being established on ART (stability) should be applied to all populations, including those receiving second- and third-line regimens, those with controlled comorbidities, children, adolescents, pregnant and breastfeeding women and key populations."

six months (if viral load is not available: CD4 count >200 cells/mm3 or weight gain, absence of symptoms and concurrent infections).

World Health Organization, <u>Updated recommendations on service delivery for the treatment and care of people living with HIV.</u> April 2021.

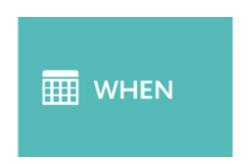


Summary – change in eligibility

	2016	2021	
Term	Stable	Established on ART	
Time on ART	12 months on ART	6 month on ART	
Inclusion of pregnant women	Pregnant women excluded	Pregnant women included	
Inclusion of children and adolescents	Children and adolescents included	Children and adolescents included	
Regimen	Second and third line not explicitly stated	Any ART line included	
Viral load / evidence of treatment success	Two consecutive viral loads <1000 copies/ml	At least one viral load <1000 copies/ml in last 6 months	



WHO recommendations



7.5.3 Frequency of clinical visits and ART pick-up



People established on ART should be offered clinical visits every 3—6 months, preferably every six months if feasible (strong recommendation, moderate-certainty evidence).

^aWhen routine clinical consultations are due, they should be coordinated with planned medicine pickups to reduce visit frequency.

People established on ART should be offered refills of ART lasting 3–6 months, preferably six months if feasible (strong recommendation, moderate- to low-certainty evidence).



WHO recommendations



7.5.1 Initiating ART outside the health facility

ART initiation may be offered outside the health facility (conditional recommendation, low- to moderate-certainty evidence).



This recommendation is additional to the routine offer of ART initiation at the health facility.

7.8 Decentralization

Decentralization of ART care should be considered as a way to increase access and improve retention in care. The following approaches have demonstrated effectiveness in improving access and retention:

- initiation of ART in hospitals with maintenance of ART in peripheral health facilities (strong recommendation, low-certainty evidence);
- initiation and maintenance of ART in peripheral health facilities (strong recommendation, low-certainty evidence);
 and
- initiation of ART at peripheral health facilities with maintenance at the community level^a (strong recommendation, moderate-certainty evidence).



WHO recommendations



7.7 Task sharing

7.7.1 Task sharing for initiation and maintenance of ART

These recommendations apply to all adults, adolescents and children living with HIV

Trained non-physician clinicians, midwives and nurses can initiate first-line ART (strong recommendation, moderate-certainty evidence).

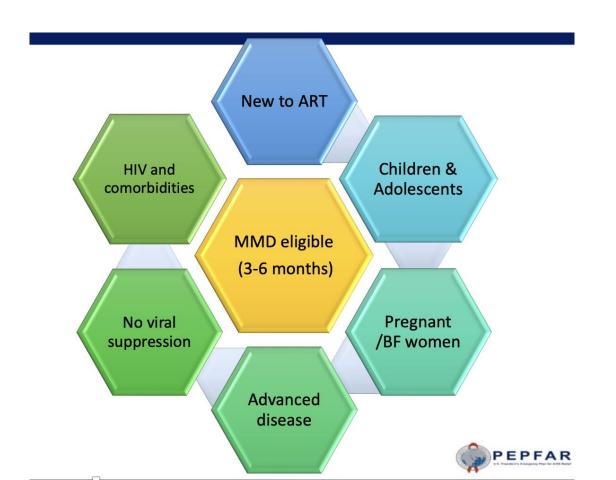
Trained non-physician clinicians, midwives and nurses can maintain ART (strong recommendation, moderate-certainty evidence).

Trained and supervised community health workers can dispense ART between regular clinical visits (strong recommendation, moderate-certainty evidence).

Trained and supervised lay providers can distribute ART (strong recommendation, low-certainty evidence).



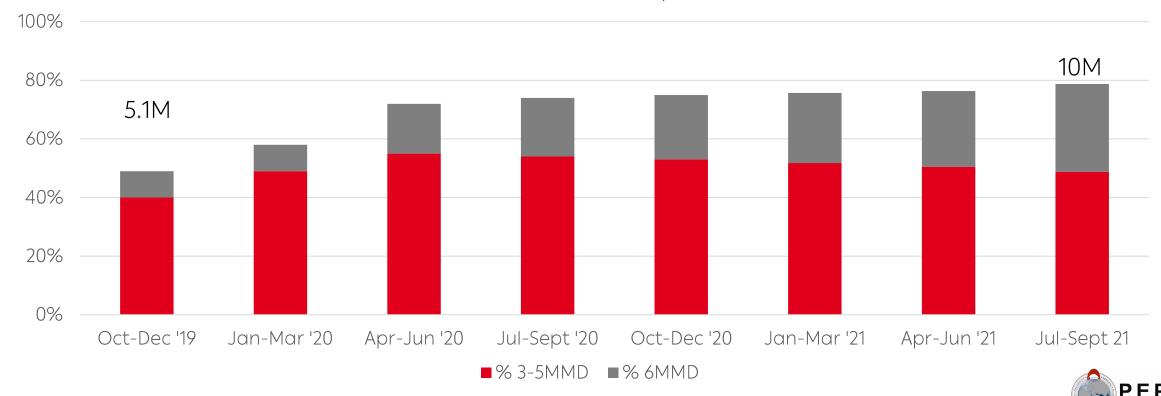
PEPFAR expanded eligibility for multimonth dispensing (MMD) during COVID-19





PEPFAR has doubled the number of people receiving MMD in two years

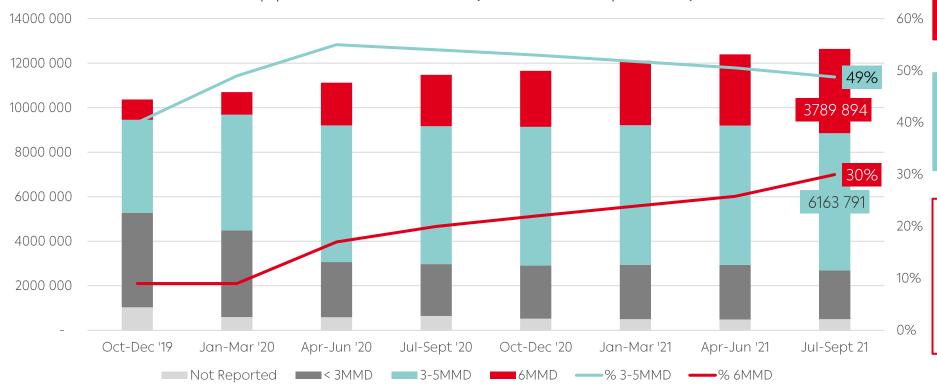
% MMD, Oct 2019-Sept 2021





% on MMD continues to increase





By Q3 2021, 30% of PEPFAR clients on 6MMD (3.8M)

By Q3 2021, 49% of PEPFAR clients on 3-5MMD (6.1M)

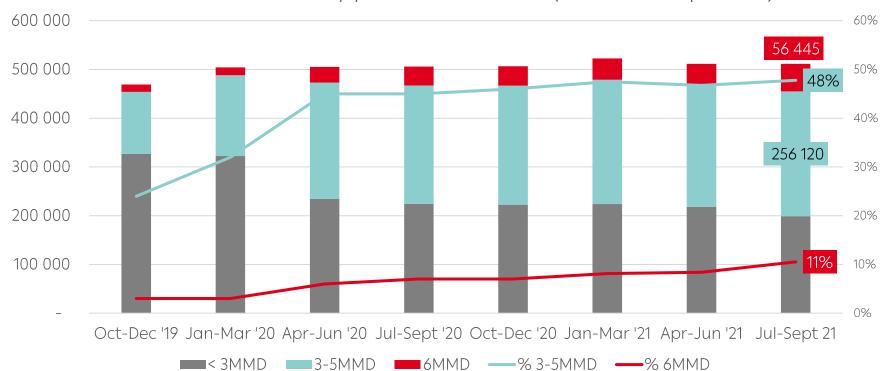
From Oct 2019-Sept 2021, % of ART clients receiving MMD increased from 49% to 79% (almost 10M)





Including for children and adolescents





By Q3 2021, 11% of those <15 were on 6MMD (56,000)

By Q3 2021, 48% of those <15 were on 3-5MMD (256,000)

From Oct 2019-Sept 2021, % of those <15 receiving MMD increased from 27% to 59% (310,000+)

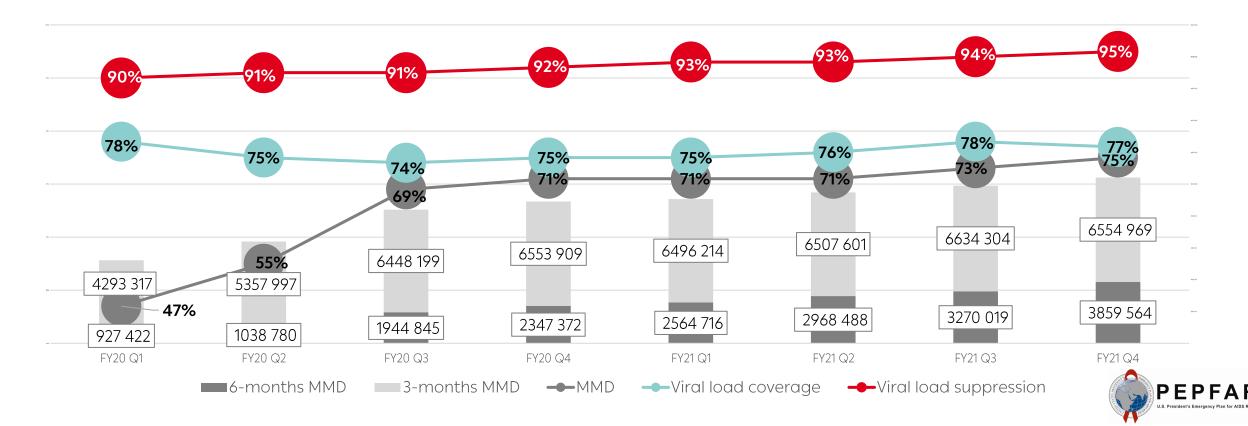




With MMD scale up, no drop in viral load coverage or suppression Note: Confounded by

Trends in MMD, viral load coverage and viral load suppression

Note: Confounded by the negative impact of viral load testing in many places, data excludes South Africa





Four models of DSD for HIV treatment



- Multi-month dispensing is an enabler
- Clinical consultations can be considered separately to ART refills and psychosocial support



Diversity of individual models not based at facilities including:

- Home delivery
- Private pharmacy
- Community pharmacy
- Community based organization
- Drop-in centers
- Mobile / outreach services













MAXIMUM DURATION OF ART REFILLS FOR ADULTS WITHIN **DSD FOR HIV TREATMENT**

Version: 20 January 2022 www.differentiatedservicedelivery.org

	<3MMD	3MMD	3-6MMD	6MMD
Angola				
Burkina Faso				
Burundi*				
Cameroon				
Cote D'Ivoire				
DRC				
Eswatini		*	*	
Ethiopia				
Ghana*				
Guinea				
Haiti				
India				
Kenya				
Laos				
Lesotho				
Liberia				
Malawi				*
Mozambique				
Myanmar*				
Namibia				*
Nepal				
Nigeria				
Papua New				
Guinea				
Rwanda				
Senegal				
Sierra Leone				
South Africa*				
South Sudan				
Tanzania*				
Togo				
Uganda				
Zambia				

Key National policy Duration dependent on model COVID-19 policy adaptation Duration dependent on model

References

Click on the ovals in the table to access the referenced policy.

Notes

Burundi: Implementation plan differs with 3-6MMD

Ghana: 6MMD for facility-based individual DSD models where supply chain allows

Myanmar: Graduation to 6MMD from 12 months on ART

South Africa: 3MMD encouraged for TLD regimen in COVID policy

Tanzania: 3MMD graduating to 6MMD

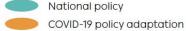
Zimbabwe: 6MMD for mobile populations



Version: 20 January 2022 www.differentiatedservicedelivery.org



Key



References

Click on the ovals in the table to access the referenced policy.

Notes

Burkina Faso: 6 monthly consultations for first DSD year then annual

Ghana: 3 monthly consultations for children >2 years until on adult ART doses

Guinea: 6 monthly consultations from 6-12M then annual

Haiti: 3 monthly telephone check-up

Mozambique: 3 monthly if 2-9 yrs, on IPT or lactating

Namibia: 6-month ART prescriptions

Rwanda: 3 monthly clinical consultations for children, adolescents and pregnant women

South Africa: 6-month ART prescriptions

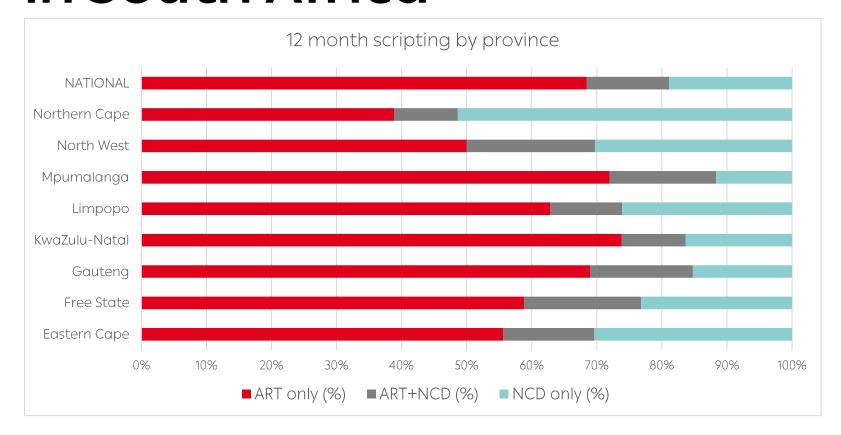
Tanzania: Annual consultations for migrant populations

Uganda: 3 monthly consultations for children >2 yrs and adolescents (10-19yrs)

Zimbabwe: 6 monthly consultations if viral load testing not available /Adolescents 6 monthly/ Children >2 years 3 monthly

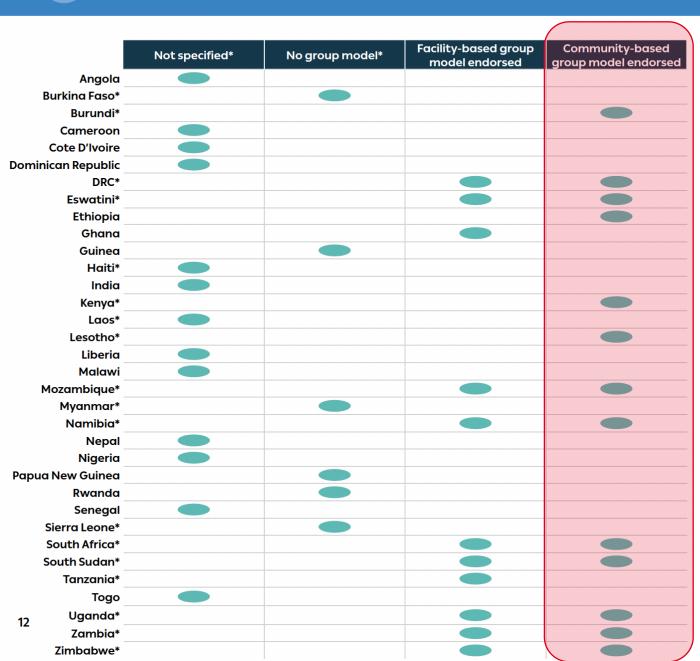


More than a million people living with HIV with 12 month scripting during COVID-19 in South Africa



Through Central Chronic Medicines Dispensing and Distribution (CCMDD), 1.5 million received 12-month scripts:

- 1 million ART only
- 2,000,000 ART + NCD
- 300,000 NCD only



Key



National policy

References

Click on the ovals in the table to access the referenced policy.

Notes

'Not specified' applies to countries that do not specify any group or individual DSD models, 'No group model' applies to countries that specify individual, but not group DSD models, or which explicitly exclude group DSD models.

Angola: Community ART groups (acronym is GAACs in Portuguese) are mentioned, but not specifically endorsed

Burkina Faso: Support groups available for clients accessing six monthly facility-based refills (RAVI6m)

Burundi: Points de distribution communautaires (PODI) facilitator distributes 3MMD ART to support groups of 5-30 people

DRC: Three monthly facility-based adherence clubs and monthly Community Adherence Groups (CAGs)

Eswatini: Facility-based adherence clubs and CAGs

Ethiopia: Urban health extension professional/health extensionmanaged community ART refill groups (UHEP/HEP_CAG) and peerled community-based ART distribution model (PCAD) endorsed in addition to facility-based family ART refills.

Ghana: Facility-based ART refill groups

Haiti: Mentions that 6MMD can be integrated into community support groups and CAGs, although no detail on models is offered

Kenya: CAGs

Laos: Adherence clubs are mentioned as potentially beneficial, but not specifically endorsed

Lesotho: CAGs

Mozambique: Facility-based teen and viraemic clubs, community-based support and adherence groups (GAACs),

Myanmar: Facility-based patient support meetings endorsed, although not specified whether this integrates with ART provision

Namibia: Facility-based ART adherence clubs and CAGs

Sierra Leone: No group models detailed for general population, but does endorse facility-based ART refill groups for adolescents

South Africa: Facility- and community-based adherence clubs

South Sudan: Facility-based club refills and community-based ART refill groups (CARGs)

Tanzania: Facility-based group refills including counselling (e.g., teen or youth clubs)

Uganda: Facility-based groups and Community Client Led ART Delivery (CCLADs)

Zambia: Facility-based Urban Adherence Groups (UAGs) and CAGs Zimbabwe: Facility-based group refills (catering for various specific

and general populations) and CARGs



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	Not specified	Only facility-based DSD models endorsed	Facility and community- based DSD models endorsed	
Angola				
Burkina Faso*				
Burundi*				
Cameroon*				
Cote D'Ivoire*				
Dominican Republic				
DRC*				
Eswatini*				
Ethiopia*				
Ghana*				
Guinea				
Haiti*				
India*				
Kenya*				
Laos*				
Lesotho*				
Liberia				
Malawi*				
Mozambique*				
Myanmar				
Namibia*				
Nepal*				
Nigeria*				
Papua New Guinea*				
Rwanda				
Senegal*				
Sierra Leone*				
South Africa*				
South Sudan*				
Tanzania*				
Togo				
13 Uganda*				
Zambia*				
Zimbabwe*				

References National policy Click on the ovals in the table to access the referenced policy.

Notes

Burkina Faso: 6MMD at both facility and community level

Burundi: Community models are 3MMD community groups managed by facilitator collecting ART from facility (called PODI)

Cameroon: Separate policy for community-based organizations to dispense ART

Cote D'Ivoire: Covid-19 policy introduced home delivery of ART for those over 60 years and/with co-morbidities

DRC: Community-based models are PODI (3MMD) and community adherence groups (CAGs) (1MMD)

Eswatini: Community outreach model and CAGs; KP specific community models: Fast track at outreach mobile model and KP Community ART groups serviced by mobile outreach (not clinic) and KP clubs at mobile outreach

Ethiopia: Urban health extension professional/health extension-managed community ART refill groups (UHEP/HEP_CAG) and peer-led community-based ART distribution model (PCAD) endorsed. COVID-19 policy introduced home delivery of ART.

Ghana: Community-based models are community health points (CHPs), drop-in centers and community pharmacy refills. Home delivery of ART is also permitted during routine home visits by Community Health Officers or peer supporters.

Guinea: After 12 months in the model, the 6MMD can be moved to community-based refills (with an annual clinical consultation)

Haiti: 6MMD model can be integrated into community-based models including home delivery, support groups and CAGs

India: COVID-19 policy introduced community-based models for ART refills including home delivery/ peer networks

Kenya: Community-based models including home delivery via community health workers (CHWs) and CAGs

Laos: Community-based models endorsed but not detailed in policy

Lesotho: Community-based model is CAGs

Malawi: Models include Teen Clubs, mobile clinics like ART-provider managed Community ART Groups, drop-in centres, and pharmacy fast-track refills

Mozambique: Community-based models include mobile outreach (called Mobile Brigades) and CAGs (acronym in Portuguese is GAACs)

Namibia: Community-based models include comprehensive community-based health services (old C-BART/outreach), CAGS, community-based, client-led distribution groups

Nepal: Community-based model is community ART centres

Nigeria: Community-based models endorsed but not detailed in policy

Papua New Guinea: Community-based models include individual refill model using CHWs, pharmacy dispensers or peer-led provided trained

Senegal: Community models endorsed but not detailed in policy

Sierra Leone: Community-based models include community ART refill collection points and drop-in centres

South Africa: Community-based models include external pick-up points (including private pharmacies/containers, lockers, community pick-up points) and community-based adherence clubs

South Sudan: Community-based models include outreach and community ART refill groups **Tanzania:** Community-based model is mobile outreach services

Uganda: Community-based models include community drug distribution points (CDDPs) and community client-led ART delivery (CCLAD)

Zambia: Community-based models include health post dispensation, home delivery, community based pick-up, CAGs and Urban Adherence Groups (UAGs); Covid-19 policy mentions community based pick-up and home delivery

Zimbabwe: Community-based model is community adherence refill groups (CARGs)



So will long-acting "reburden" the health system? And how can we avoid that?

Through differentiated service delivery!



Challenges in DSD for HIV treatment

- People established on ART need to attend health facilities regularly for other prevention needs or chronic conditions
 - NCD drugs could be integrated
 - o Challenge for contraceptive care



Unmet family planning need and method mix

Country	Unmet need	IUD	Implant	Oral pills	Injectable	S/C injectable
Eswatini	24%	0.2%	4.6%	12%	30%	
Ghana	37%	1.9%	285	18%	28%	Υ
Kenya	23%	6%	18%	14%	48%	Υ
Malawi	26%	1.8%	20%	4%	50%	Υ
Uganda	38%	4%	17%	6%	51%	Υ
Zambia	27%	1.5%	17%	16%	54%	Υ
Zimbabwe	14%	0.8%	17%	57%	15%	



In summary for treatment

Majority of people living with HIV on treatment are accessing at least 3 months of ART at a time

There is a shift towards both longer durations of ART refills and annual clinical consultations (to align with viral load monitoring)

There are concerted efforts to ensure both group and community-based models of ART refills

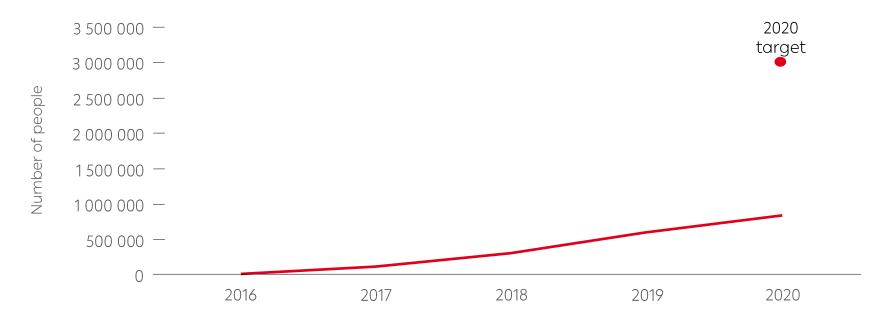


Now, what about PrEP?



Far behind global targets

Number of people who received pre-exposure prophylaxis at least once during the reporting period, global, 2016–2020, and 2020 target

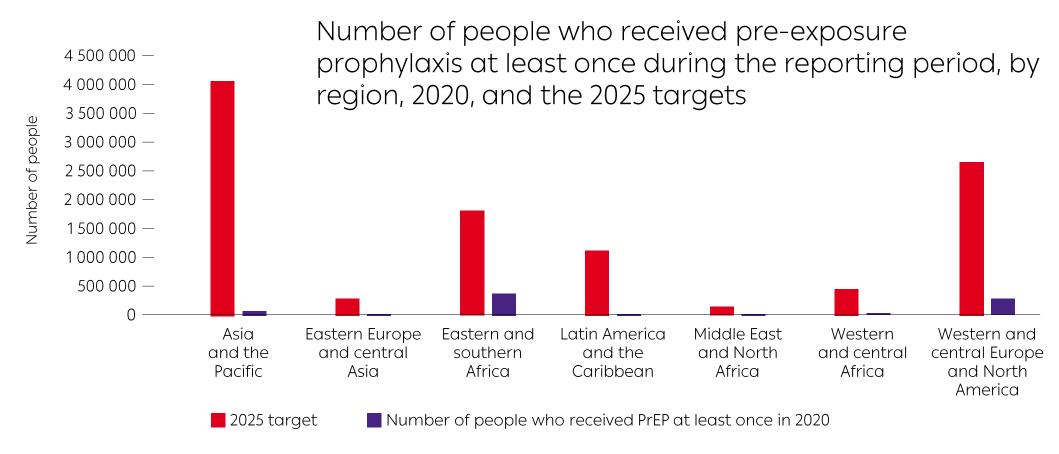




»The current oral PrEP roll out in LMIC. is far from ideal. The goal of 3 million PrEP users across the globe by 2020 as set by The Joint United Nations Programme on HIV/AIDS has not been met, with high levels of inequity across PrEP programs and different settings. The vast majority of PrEP users reside in high-income countries".



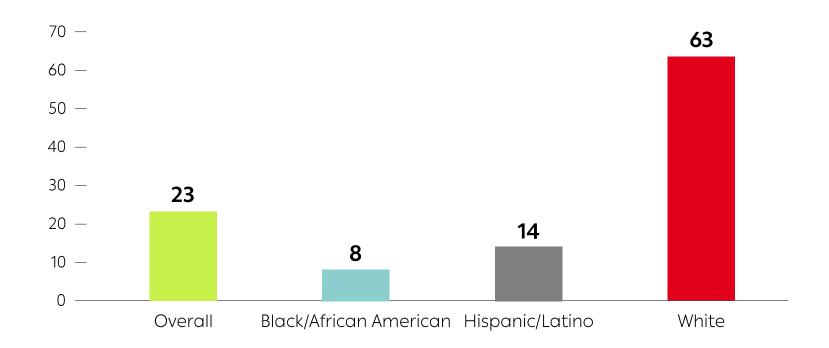
Varied uptake by region



Source: UNAIDS Global AIDS Monitoring, 2021 (https://aidsinfo.unaids.org/); Country Updates. In: PrEPWatch [Internet]. AVAC; c2020 (https://www.prepwatch.org/ in-practice/country-updates/); and country documents and meeting reports (available on request).



PrEP coverage among eligible adults, by race/ethnicity group, USA, 2019



Source: 2019 National HIV surveillance system reports. In: cdc.gov [Internet]. 27 May 2021. Atlanta (GA): Centers for Disease Control and Prevention; c2021 (https://www.cdc.gov/nchhstp/newsroom/2021/2019-national-hivsurveillance-system-reports.html).

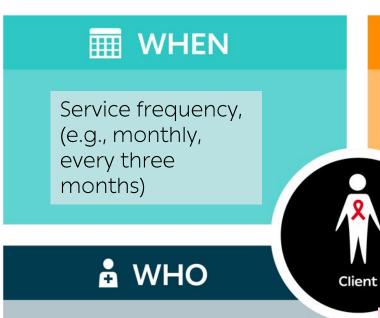


It's time to differentiate PrEP service delivery!



PrEP building blocks

Longer PrEP refills for those in the PrEP continuation phase



WHERE

Service location (e.g., primary healthcare facility, community setting, virtual setting) Providing PrEP refills closer to home and support virtually (e.g. drop-in centers, community-led)

Person-centred

package of services

Demedicalize PrEP – nurse-provided and peer supported

Service provider (e.g., physician, nurse, pharmacist, peer) **WHAT**

Service package (including HIV testing, clinical monitoring, PrEP prescription and dispensing, and comprehensive services)

screening

(e.g., STI self



Current PrEP guidance from WHO

3.2 Pre-exposure prophylaxis for preventing the acquisition of HIV

3.2.1 Oral pre-exposure prophylaxis for preventing the acquisition of HIV

Oral pre-exposure prophylaxis (PrEP) containing TDF should be offered as an additional prevention choice for people at substantial risk of HIV infection^a as part of combination HIV prevention approaches (strong recommendation, high-certainty evidence).

^a See Box 3.2 for reflections on the definition of substantial risk of HIV infection.

3.2.2 PrEP using the dapivirine vaginal ring



The dapivirine vaginal ring may be offered as an additional prevention choice for women^a at substantial risk of HIV infection as part of combination prevention approaches (conditional recommendation, moderate-certainty evidence).

^aFor the recommendation on the dapivirine vaginal ring, the term women applies to cisgender women, meaning women assigned female at birth. There is no research at this time to support the dapivirine vaginal ring for other populations.



PrEP research gaps

Oral PrEP has been shown to be cost-effective when provided to individuals at substantial risk of HIV in a range of settings and populations. However, differentiated and integrated oral PrEP service delivery, including in settings such as pharmacies and through community-based dispensing, and considering varying patterns of use, may offer opportunities for cost savings and efficiency. More research on the cost and cost—effectiveness implications of these evolving models of PrEP services is required.

The global COVID-19 pandemic has accelerated a trend towards simplified, differentiated, and demedicalized oral PrEP service delivery. This includes using telehealth consultations for initiating and continuing PrEP and PrEP delivery at home and via pharmacies and other community-based locations. HIV self-tests have been used for initiating and continuing PrEP. In some places, peer and lay providers have been included in PrEP service delivery. All of these approaches have the potential to remove barriers to uptake and improve the effective use of PrEP. However, although the feasibility of these different forms of community-based PrEP delivery has been demonstrated in some settings, more operational research is needed on their effectiveness and scalability.



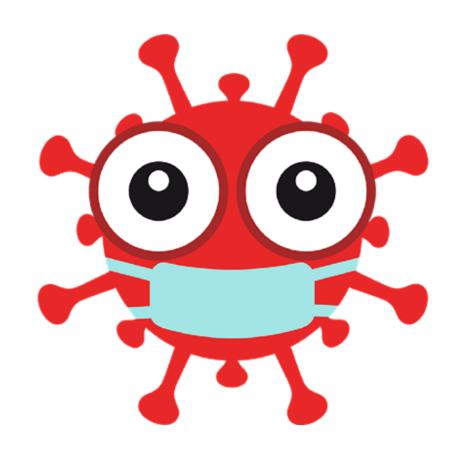
Building blocks of different PrEP service delivery

	PrEP assessment, initiation (re-initiation) and early follow-up (0-3 months)			PrEP continuation (>3 months)	
	Assessment	PrEP initiation/re-	Initial clinical	PrEP refill (or	Clinical consultation
	(after negative	initiation*	follow-up	injection) only	
	HIV test result)		(if required)		
₩HEN	Timing of PrEP assessment/offer	Timing of PrEP initiation/re-initiation	Frequency of initial follow-up	Frequency of PrEP refill collection/injections administration visits (length of PrEP product supply)	Frequency of maintenance clinical consultation for people using PrEP
№ WHERE	Locations for PrEP assessment/offer	Locations for PrEP initiation/re-initiation	Locations for initial follow-up visit/s (including virtual)	Locations where PrEP refills can be collected/injections administered (no clinical consultation required)	Locations where maintenance clinical consultation can be provided
• who	Service provider/s who can assess for PrEP and offer PrEP	Service provider/s authorized to initiate/re- initiate PrEP	Service providers who can carry out initial follow-up visit/s	Service provider/s who can distribute PrEP refills/administer injection (considering HIV testing requirements and method)	Service provider/s who may conduct PrEP maintenance clinical consultations
₩HAT	Service package for PrEP assessment and offer	Service package for PrEP initiation/re-initiation	Service package at initial follow-up visit/s	Service package with PrEP refill/injections	Maintenance clinical consultation service package



COVID-19 accelerated PrEP differentiation

- Extending PrEP drug refills to 3-monthly during COVID-19
- Using HIVST to support less frequent health facility visits
- Reducing/ limiting in-person clinical consultations through virtual check-ins (Thailand and Vietnam)
- Enabling home delivery of PrEP refills by lay cadres / peers





Science of differentiated PrEP service delivery

- Extended duration of PrEP refills in Kenya
- Key population peer-managed services
- Home/courier delivery of PrEP refills with HIVST
- Private pharmacy-prescription and management by pharmacists
- Using HIVST to support less frequent health facility visits

This means →

- Longer PrEP refills
- Less frequency facility visits for clinical consultations
- Prescription and management by other cadres





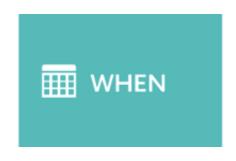
Future of differentiated PrEP service delivery

- WHO will release, "Differentiated and simplified PrEP for HIV prevention: technical brief" at AIDS 2022
- Countries are starting to consider PrEP differentiated in their guideline updates (clinical guidance and/or DSD operational guidance)
- Learning from COVID-19 lessons longer ART refills, demedicalization, etc.





Service delivery considerations for longacting PrEP



- Our How can we reduce visits?
 - For injections but also for multiple rings and longer oral refills
- o Can we "fast-track" injection only visits?
- How can we limit effective use gaps (no cover as seen with injectable contraceptives)



- Can injections be done outside of health facilities
 - as well as oral refills and ring distribution



Service delivery considerations for longacting PrEP



- Who can do injections?
 - o Community health workers?
 - o Self injections?
- Reducing volume / complexity of administration

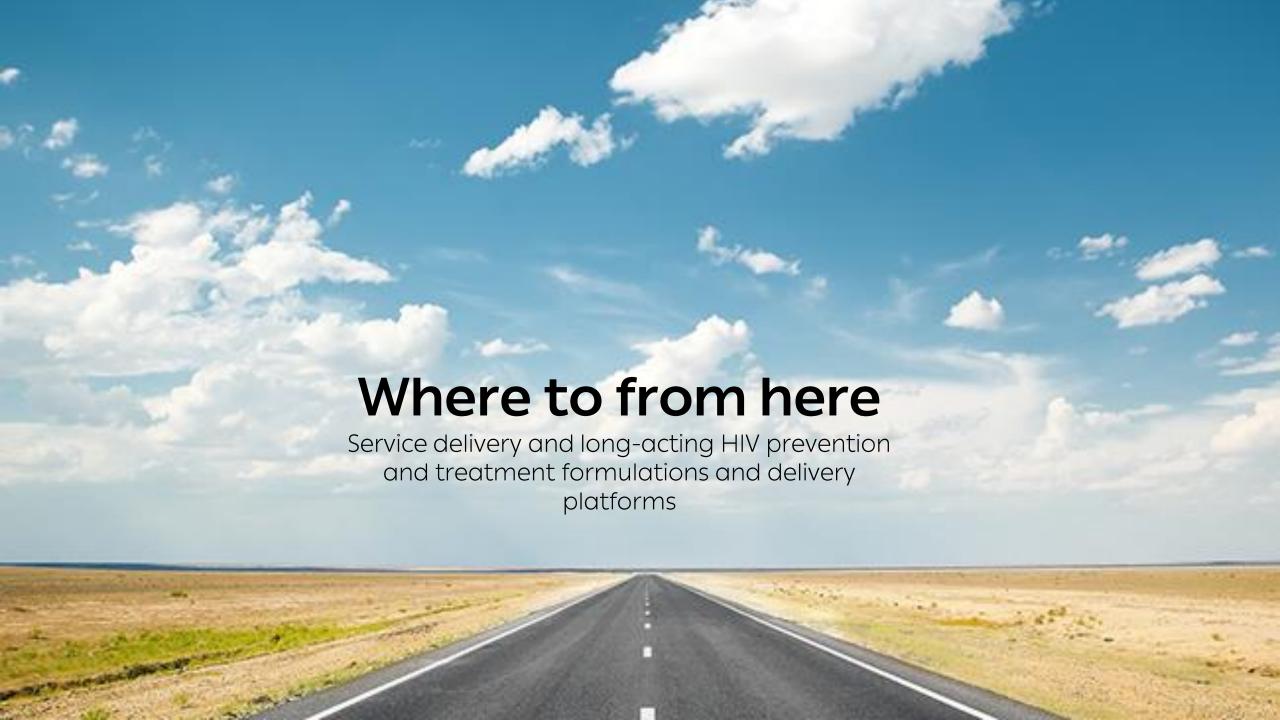


- Objective to be on the control of the control of
- Can long-acting be co-formulated with contraceptives?
- Can we integrated care with family planning and gender-affirming hormone therapy?
- o mHealth to facilitate support (and adherence to injection schedule)





»"We have much to learn from the family planning field who have managed to demedicalize and deliver injectable and implantable drugs in the most remote of settings."







Key population perceptions and opinions about long-acting antiretrovirals for prevention and treatment: a scoping review

Omar Sueda,*, Norma Nardib, and Luciana Spadaccinic,*

For prevention

- LA preferred for those assuming episodic risk or who cannot disclose or negotiate other preventions products, such as transgender women, female sex workers, and adolescents.
- Preference for self-injections or administration outside the health sector

For treatment:

- LA could alleviate pill fatigue, stigma, challenges with sustained adherence
- Preference for administration at the clinic at the same interval as clinical visits

For both treatment and prevention

- Ambivalences around impact on daily life
- Additional barriers and costs were important barriers



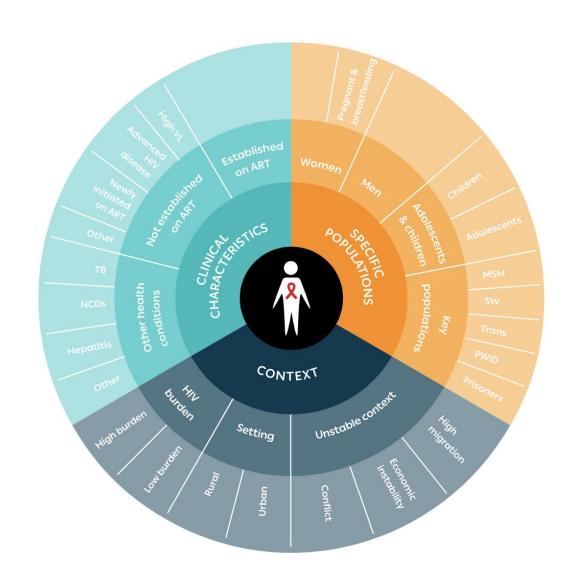
The realities for HIV treatment vs. PrEP are different

HIV treatment	PrEP	
Large numbers – 28+ million people on ART (73% of people living with HIV) Specific populations who could benefit	Small numbers – around 1 million, behind global targets	
Treatment is lifelong	PrEP depending on risk and need – changes over time	
Already differentiated – and lots of experience	Still very clinical – need for simplification, demedicalization and decentralization, integration into other service points (e.g., family planning) but recognition that it's critical	
Globally, one first-line therapy	Choice is important – has the potential to increase uptake	



Long-acting HIV treatment

- Is long-acting about a new standard of care?
- Or about reaching and supporting those for whom treatment is failing / are not engaged in treatment programmes
 - Populations who may benefit the most adolescents, pregnant individuals, those with barriers to medication adherence
 - And then how is it designed to support the challenges faced by these populations?
 - o Different first line options depending on choice of formulation (oral, injectable, implant)...





Long-acting PrEP



- Menu "informed choice" based on efficacy, ease of use, access, stigma, etc.
- o More options are important to increasing access, uptake, effective use
 - Could also have focus on targeted populations
 - Those struggling with effective use
 - Those who would benefit from co-formulation with contraception
- Differentiating service delivery to provide less intensive service delivery models (less frequent visits, more task-sharing, demedicalized) important for all methods/products – including long-acting
- Need to achieve SCALE



Long-acting prevention and treatment formulations and delivery platforms

Common goal

More people effectively treated (access, retained and suppressed) and protected from HIV acquisition (access, choice)

Should consider current realities of DSD for HIV treatment and PrEP

Should consider the "how" or the building blocks of service delivery as it relates to implementation

Can support overcoming current challenges in treatment and PrEP delivery