IAS

Differentiation at re-engagement in HIV care: A multi-country workshop

Hosted by IAS – the International AIDS Society – in collaboration with the World Health Organization (WHO)

Tuesday, 12 November – Thursday, 14 November 2024
Johannesburg, South Africa

International AIDS Society

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Executive summary

The workshop, "Differentiation at re-engagement in HIV care: A multi-country workshop", took place in Johannesburg, South Africa. It was co-convened and facilitated by the International AIDS Society and the World Health Organization (WHO) over two and a half days (Tuesday-Thursday, 12-14 November 2024). The workshop brought together four country teams – Eswatini, Kenya, Malawi and Uganda – to explore implementation of the recent WHO policy brief, "Supporting re-engagement in HIV treatment services". South Africa and Zimbabwe have national guidance supporting differentiation at re-engagement, but there is a paucity of guidance in other countries. The objective of the workshop was to support country teams to discuss and design context-specific service delivery pathways for people re-engaging in treatment services and support their countries' HIV treatment programmes.

Each country team included stakeholders from its national government, networks of people living with HIV, those implementing community-led monitoring, and those implementing HIV treatment services and/or engaged in implementation science research in the country. Faculty of the workshop included advocates from the re-engagement programmes in South Africa and Zimbabwe, as well as other consultants.

The first day focused on setting the scene, covering introductions, and outlining the challenges around re-engagement. Sessions were designed to provide an overview of data on re-engagement in care, including an overview of the cyclical cascade, how to define disengagement and re-engagement, and advanced HIV disease. Presenters also covered the range of reasons for disengagement and re-engagement, as well as the latest WHO guidance. After each set of presentations, country groups discussed lessons learnt and analysed country-specific disengagement and re-engagement data.

The first half of the second day concentrated on key considerations for designing a re-engagement pathway for people who return to care.

Presenters from South Africa and Zimbabwe showcased their country's journeys towards the development and implementation of a re-engagement algorithm. Country teams, guided by facilitators, delved into national policies and data and discussed the development of a country-specific re-engagement algorithm.

Common themes across country action plans included the development of re-engagement pathways or algorithms and steps needed to update national service delivery guidelines and standard operating procedures.

The third day served country teams to finesse their country action plans and present these to the other workshop participants. Each workshop participant signed a pledge document with a personal action item for implementation.

The workshop successfully facilitated knowledge exchange and collaboration among country teams, emphasizing the importance of clearly defining re-engagement pathways and determining priorities for tracing. The country action plans outline tangible steps towards country-specific re-engagement algorithms that are included in national guidance and disseminated among healthcare providers. The outcomes of the workshop contribute to the broader goal of supporting countries with high HIV burdens to achieve the second and third 95 global treatment targets.

All the workshop resources and presentations can be accessed on a dedicated page of the Differentiated Service Delivery website.

Background

In July 2024, the World Health Organization (WHO) published the policy brief, "Supporting re-engagement in HIV treatment services". The brief draws attention to the reality that in many countries, particularly those in eastern and southern Africa, supporting individuals to re-engage in HIV services will be critical for reaching the 95-95-95 global HIV targets by 2030. Achieving these targets represents a key milestone in ensuring that people living with HIV can live healthy lives and in reducing new HIV acquisitions.

In 2023, according to the Joint United Nations Programme on HIV/AIDS (UNAIDS), regional data from eastern and southern Africa showed an average of 93-90-94 progress towards these targets. However, there were large data discrepancies between countries, with the second 95 target – 95% of people diagnosed with HIV are on HIV treatment – ranging from 73% to 98%. Viral suppression rates in the region ranged from 76% to 98%. In addition, the percentages vary greatly when data is disaggregated by age and sex. Therefore, it is imperative to assess the reasons for different groups of people living with HIV to disengage from treatment services and to identify sustainable solutions to improve their access to and retention in HIV treatment services.

In addition, programmatic data increasingly highlights that the HIV care cascade is not linear, but cyclical. There is a growing proportion of people living with HIV who re-initiate antiretroviral therapy (ART) and who do so more than once during their lifelong ART journey. While strides have been made to differentiate HIV services for people established on ART –providing less-intense models to support continued engagement – less guidance has been provided on how to best adapt services to support the diverse needs of people re-engaging in HIV treatment services. There is a need to differentiate at re-engagement as those who are re-engaging in care form a heterogeneous group with different clinical and service delivery needs, depending on the duration of their treatment interruption and their clinical status.

Workshop aim and objectives

The workshop, "Differentiation at re-engagement in HIV care: A multi-country workshop", provided a platform to discuss the different reasons for people living with HIV to disengage from care services and interrupt their HIV treatment. It further highlighted the heterogeneity of clinical and service delivery needs of people re-engaging in care. Participants reviewed the latest global normative guidance, epidemiological data, and scientific evidence on disengagement and re-engagement.

IAS – the International AIDS Society – in collaboration with WHO brought together four country teams from Eswatini, Kenya, Malawi and Uganda. Each team included representatives from ministries of health and civil society, as well as researchers and implementing partners (see Annex 2: List of attendees).

The aim was for each team to develop a country-specific re-engagement pathway and concrete action plan to support differentiation at re-engagement, considering contextual factors. The workshop agenda is available as Annex 1.

To facilitate meaningful discussion during the workshop, country teams completed a data survey and provided all relevant national policies, guidelines and standard operating procedures (SOPs) in advance.

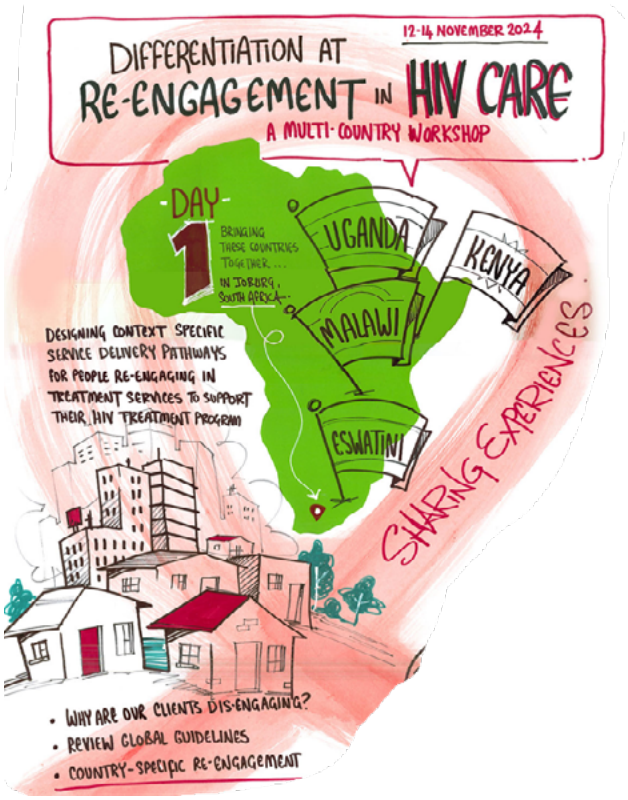
The workshop objectives were to:

- **Understand the different reasons for disengagement and the heterogeneity of clinical and service delivery needs of clients re-engaging in care**
- **Review the latest global normative guidance on re-engagement**
- **Discuss and design country-specific re-engagement pathways to support differentiation at re-engagement**

Day 1: The challenge of re-engagement in HIV care

The first day was divided into five sessions:

1. **Introduction**
2. **Is there a problem? Data on re-engagement in care**
3. **Reasons for disengagement and re-engagement**
4. **WHO guidance on re-engagement**
5. **Wrap up and reflections**



Each block of presentations was followed by facilitated country discussion sessions to cover re-engagement data, reasons for disengagement and re-engagement, and takeaways from the WHO re-engagement guidance related to each country's specific context. The first day of the workshop ended with a welcome reception for all participants.

The sessions highlighted different aspects of re-engagement in HIV care, including an overview of the cyclical HIV care cascade and defining re-engagement in comparison with related concepts, such as "missed visit" and "loss to follow up" (LTFU). Presentations also covered important aspects of the nexus between re-engagement and advanced HIV disease (AHD). To increase understanding of reasons for disengagement and re-engagement, presentations highlighted the perspectives and experiences of people living with HIV and related scientific evidence.

The presentation on the WHO technical brief, "Supporting re-engagement in HIV treatment services", ensured that all participants received an update of the latest global normative guidance on re-engagement. After each set of presentations, country teams reviewed and discussed their country's data on the specific aspects of re-engagement, any existing definitions, and what their data suggests regarding designing a re-engagement pathway.

1. Introductions and workshop overview

Anna Grimsrud, IAS Senior Technical Advisor, facilitated the overview and introductory session. She outlined the workshop programme and objectives, emphasizing the desire for the workshop to be interactive and participatory, with each session being followed by facilitated country team discussions. The introductory session ended with an icebreaker bingo, which gave participants the opportunity to meet one another.

2. Is there a problem? Data on re-engagement in care

Overview of the "cyclical cascade"

The first thematic presentation by Anna Grimsrud explored the concept of a "cyclical cascade" (Ehrenkranz et al, 2021, PLoS Med) and discussed cyclical cascade data from South Africa (Euvrard, 2024, PLoS Med). The data from South Africa revealed that there was substantial disengagement at every point of the cascade and there were no obvious differences in routinely available client characteristics. While disengagement occurred proportionally more in the early treatment period, it occurred absolutely more in the long-term ART period. Therefore, an intervention targeted at the early ART period would target individuals at a time of higher vulnerability but miss the majority of those at risk of disengagement.

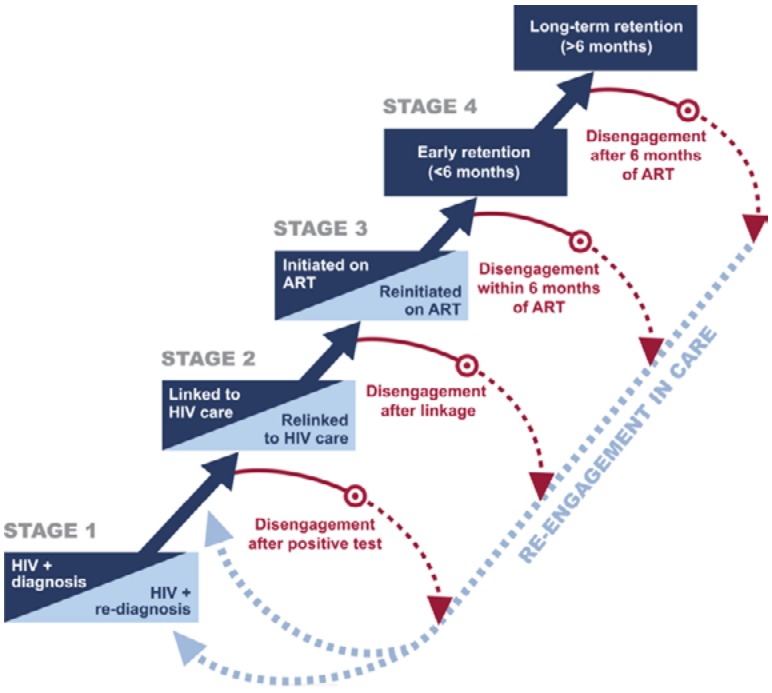


Fig 1: Cyclical cascade of HIV care, Ehrenkranz et al

The key takeaway message was that clients from all populations disengage at all stages of the cascade. PEPFAR data for South Africa also showed that despite measured improvements in the return to care indicator, there was no growth in the treatment cohort as the number of those returning was similar to the number of those interrupting treatment.

While there are multiple ways to re-engage in services – return to care (late), (silent) transfer to a new facility, presenting for HIV (re-)testing – Anna emphasized that the focus of the workshop was on those clients who return (late) to the ART programme. She highlighted the need for scalable and inclusive interventions to address disengagement and that supporting re-engagement (and decreasing disengagement) is critical to achieving global HIV targets and reducing HIV transmission, morbidity and mortality.

Defining re-engagement

An aim of the workshop was to support country teams in discussing and defining their own re-engagement pathways. As a first step, it was therefore necessary to define the concept of re-engagement to differentiate this from related concepts, such as LTFU, missed visit or treatment interruption.

The second presentation, delivered by Lynne Wilkinson (IAS) highlighted that defining re-engagement is important to decide who needs routine service delivery and who needs differentiated re-engagement service delivery. Lynne reminded participants that people have a personal motivation to not get sick, but that there are important barriers, such as inflexible clinic schedules, limited resources, lack of transport money and other competing priorities, that can make it very difficult to re-engage. Therefore, it is important not to focus on who is just late, but on stopping prolonged disengagement.

The WHO re-engagement brief defines a missed visit as a missed ART refill or clinical appointment. WHO recommends initiating tracing and recall interventions when a person has missed an appointment by more than seven days. A client is declared lost to follow up when they have not been seen at the facility or community service delivery site for 28 days or more since their last missed appointment, including ART refill visit.

Lynne highlighted that not all individuals who miss appointments discontinue or interrupt treatment and that clients may be late or miss a scheduled visit, but still have access to ART or obtain ART to cover the days they missed. It is important to be aware of the unknown outcomes of people who have not returned to care, such as undocumented ("silent") transfers, people who have died and people who have interrupted treatment.

WHO definition of disengagement

"Disengagement refers to individuals who were diagnosed with HIV, initiated ART and subsequently interrupted treatment. Disengagement is distinct from missing a visit and being lost to follow-up."

WHO definition of re-engagement

"Re-engagement … [is] the return of those that have previously disengaged."

Lynne explained how these definitions can help people understand that there is no need for re-engagement if a client has not actually interrupted their treatment. Such a client can continue routine care, including in their differentiated service delivery (DSD) model. For reliable measures of treatment interruption, Lynne recommended defining time intervals since the person missed their scheduled appointment. The more time passes after a missed appointment, the more the client's clinical needs, mortality risk, support needs for sustained engagement and AHD screening needs increase. Based on evidence from several re-engagement studies, Lynne pointed out that not all people who have missed an appointment have interrupted treatment. The majority of those re-engaging were previously virally suppressed and only a few clients re-engaging had clinical concerns. The studies showed large numbers of returns within 28 and 90 days of missing a scheduled appointment.

Lynne concluded that, therefore, a definition of re-engagement should:

- Ensure that a returning person who needs a clinical assessment gets one
- Aim to reduce unnecessary burdens for the client and the healthcare system
- Be practical and simple to implement

Re-engagement and AHD

To conclude this round of introductory presentations, Tendai Nyagura (Genesis Analytics, South Africa) presented key data on re-engagement and AHD. At least one in four clients initiating ART presents with AHD. Tendai showed that the duration of disengagement increases the likelihood of presenting with AHD and explained that DSD principles can be applied to the design of service delivery models for clients with AHD at re-engagement. She emphasized that despite the scale up of HIV treatment, there is still a large cohort of people with AHD. In some places, limited access to CD4 count testing poses a barrier to identifying all people who could develop AHD. Tendai explained that CD4 count testing coverage has been affected by manufacturing changes and discontinuation of some machines.

She then described how DSD principles can be used to deliver the AHD package to people who need it and which components to consider when designing the DSD building blocks for clients with AHD at re-engagement.

3. Reasons for disengagement and re-engagement

Recipient of care perspectives and experiences

Ndivhuwo Rambau (Ritshidze, South Africa) presented community-led monitoring (CLM) data on the reasons for disengagement and re-engagement, based on clients' perspectives and lived experiences. Ndi explained that "Ritshidze" – meaning "Saving our lives" in TshiVenda – was developed by people living with HIV and activists to give communities the tools and techniques to monitor the quality of health services provided at clinics and escalate challenges to those in charge of solving them. Data are collected through observations, as well as "ART continuity surveys" with clients and healthcare providers.

"I lost my clinic card but knew my return date for my ARVs. A nurse in the consultation room called me a "defaulter", shouting at me while the door was open. Some of the patients and clinical staff were moving around and they could hear what was going on. She also chased me and said "I dont have time for defaulters, there are serious people that seek my help" As she said this, she was standing up and telling me to sit outside while she helps serious people first and I was going to be last. I was so sad, felt humiliated and disrespected because I made every effort to visit the clinic early so that I could return to work to provide food at home."

A client at Gompo Clinic (Buffalo City), Interview in March 2023

Ndi presented findings from data collection in 471 facilities. The challenges people perceived around service access included:

- Not enough staff
- Appointment systems
- Lack of options for ART refill locations/models
- ART refill length
- Filing systems
- Unwelcoming attitudes of healthcare workers and clinic staff
- Refused access to services without a transfer letter and/or an ID

Learning from this data, Ndi recommended that healthcare systems take the following steps to improve re-engagement in care: stop punitive behaviour at return; improve the health system quality by assessing the negative impact of structural issues (for example, poor filing systems); and provide people on treatment with options for ART refills.

Reasons for disengagement

Clarice Pinto, WHO Technical officer and DSD ART focal point, talked about the reasons for disengagement, including some considerations for specific populations. She explained that sometimes when we talk about reasons for disengagement, we focus only on individual factors, but it's crucial to understand disengagement as a multi-dimensional issue influenced by a mix of factors. These include:

- Mobility issues
- Lack of perceived benefits of ART
- Structural and societal factors, such as transport costs or distance

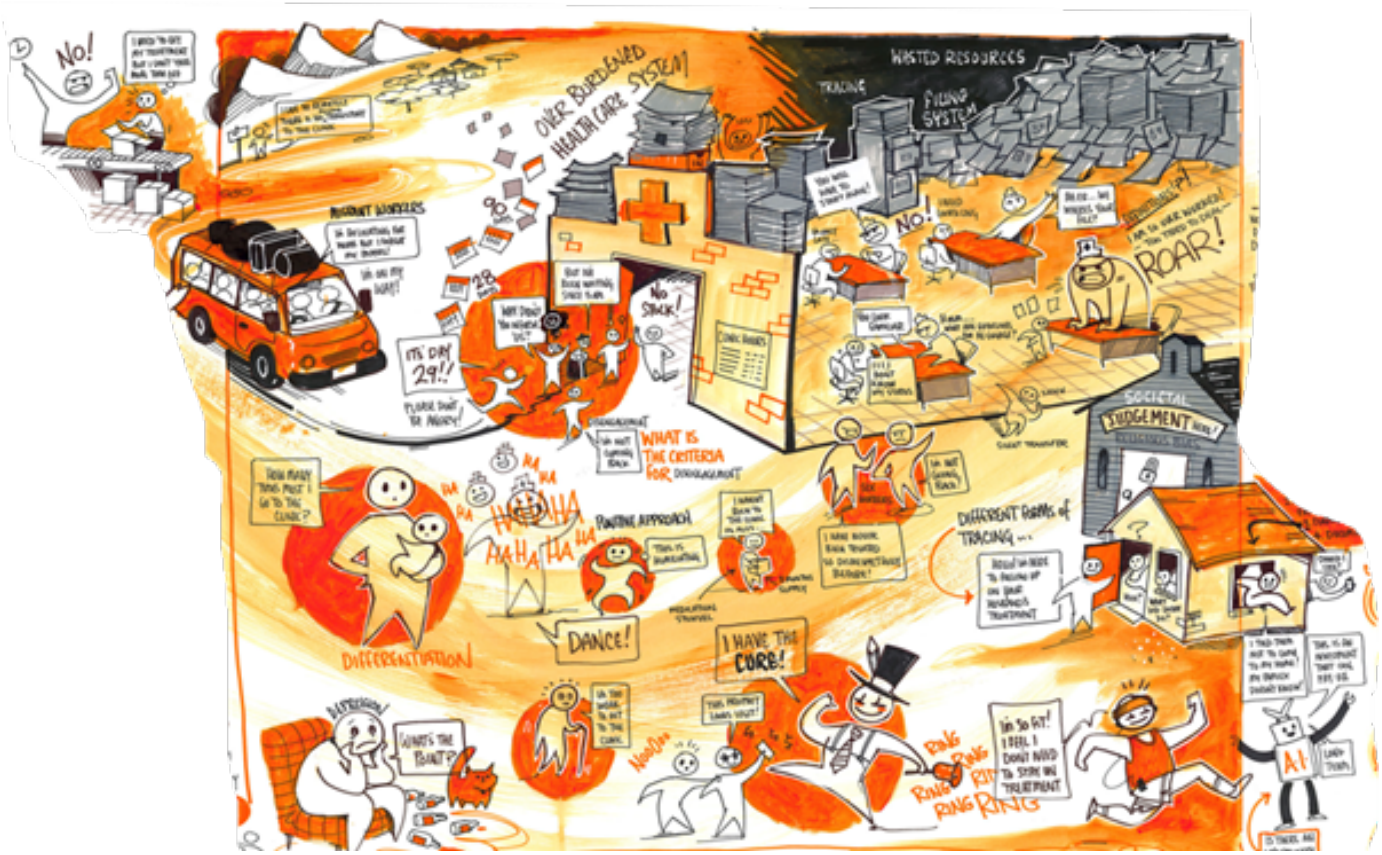
Clarice then outlined the conceptual framework for reasons for disengagement, detailing the individual, interpersonal, health system and structural and societal factors that can lead to disengagement. She characterized the trigger for disengagement as a "proximal event", which can consist of unexpected mobility, other health issues, caring and/or social responsibilities or forgetting an appointment. When these factors combine or accumulate, they increase the likelihood of an individual becoming disengaged from ART. Clarice then described the different considerations for specific populations at re-engagement, based on their age or gender and/or being part of a key population or a vulnerable population, such as people who are displaced or migrants.

Reasons for re-engagement

Lynne Wilkinson then presented the facilitators for re-engagement. For people who have missed an ART appointment, she described facilitators for re-engagement as a combination of personal motivation, removal of unexpected barriers (inflexible clinic schedule, limited clinic resources, lack of transportation money, competing work or family priorities) and factors such as social support or community healthcare workers visits. For people who have disengaged for a longer period, facilitators of re-engagement are a mix of social support and encouragement, social support through money and vehicles, community health worker visits, a strong dedication to ART and internal motivation, for example, fear of illness. Lynne emphasized that a person's perception of healthcare workers' response at return to care impacts the timelines of re-engagement.

Her recommendations for enabling easy, quick, durable returns are to:

- **Prioritize respectful care for people returning and those observing others returning**
- **Complete re-engagement on the day of return**
- **Increase appointment schedule flexibility both when missing a visit and at return**
- **Reduce waiting time at the clinic when returning**
- **Not intensify appointment schedule at return unless clinically necessary**
- **Enable "silent" transfers**


No!
OVER BURDENED HEALTHCARE SYSTEM
WASTED RESOURCES
TRACING
FILING SYSTEM
ROAR!
SOCIETAL JUDGEMENT
ITS DAY 29!!
PLEASE WAIT TO BE CALLED
No STOCK!
WHAT IS THE CRITERIA FOR
HA HA HA HA HA HA HA
ROUTINE APPROACH
DANCE!
DIFFERENTIATION
I HAVE THE CORE!
DIFFERENT FORMS of TRACING ...
WHAT'S THE POINT?
RING RING RING
A1

4. WHO guidance on re-engagement

WHO technical brief: "Supporting re-engagement in HIV treatment services"

To give participants a clear understanding of the latest global normative guidance on re-engagement, Clarice Pinto gave a detailed presentation of the WHO policy brief, "Supporting re-engagement in HIV treatment services". The brief is intended to assist countries and communities to adopt and adapt WHO's tracing and re-engagement recommendations. It does so by providing an overview of the challenges and reasons for disengagement and re-engagement and highlights key WHO guidance on continuous engagement, tracing and re-engagement, in particular, key differentiated re-engagement guiding principles and differentiated pathways to support re-engagement in HIV treatment and care.

5. Wrap up and reflections

Following the presentations, participants had time to ask questions and discuss.

Participants reflected on their learning from the CLM presentation on client experiences in the South African healthcare system and highlighted that healthcare worker attitudes and resulting behaviour, such as shouting at clients, pose important barriers and hence require interventions and capacity development for the workforce. Participants also discussed the need for collaboration between the health programme and community teams to respond to CLM findings. It was also clarified that CLM is primarily intended to function as an accountability mechanism to advocate for change.

In the discussion of reasons for disengagement and re-engagement, participants assessed that better data is needed, including to determine if and how reasons for disengagement might be time-bound. Exchanging experiences from different countries, participants learnt that the issue of silent transfers is of varying degrees of importance in different contexts.

Participants were interested in understanding if it could be beneficial to develop and use a pre-assessment tool to screen for disengagement potential. However, instead of screening individuals, participants suggested prioritizing broad-scale interventions that benefit most people.

Regarding tracing, participants highlighted the need for additional evidence, including on popular tracing modalities and their outcomes.

Day 2: Differentiation at re-engagement – and our best tracing

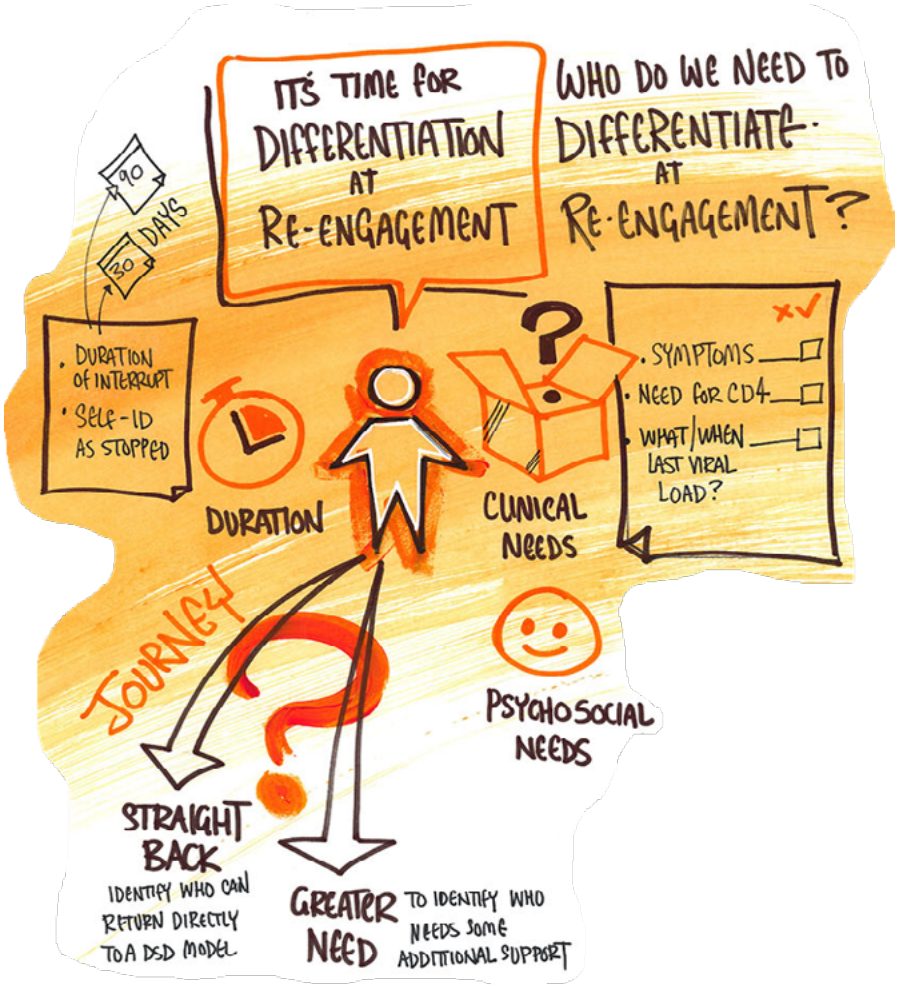
The second day of the workshop focused on re-engagement algorithms and tracing prioritization and process. The first half of the day was dedicated to increasing understanding of re-engagement pathways, split into two sessions:

1. **It's time for differentiation at re-engagement**, including three formal presentations and a two-part session
2. **Country pathways – differentiating at re-engagement**, to facilitate discussions to design country re-engagement algorithms or pathways

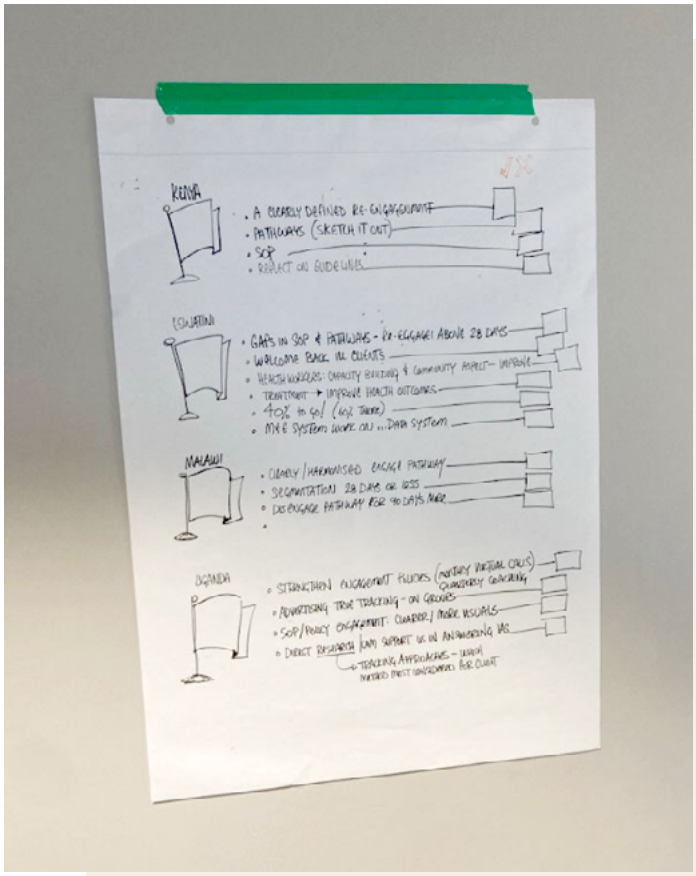
The afternoon of Day 2 focused on tracing, the process with which HIV programmes and services follow up on their clients living with HIV. It was divided into two sessions:

3. **Tracing – prioritization and process**
4. **Country discussions on tracing prioritization and process**

A short session, **Wrap up and reflections**, followed.



The second day started with brief reflections from each country team on learnings from Day 1.



The **Kenya** team emphasized the need to develop a clear definition of re-engagement as this is currently not provided in the guidelines. It also wanted to strengthen person-centredness and develop a draft re-engagement pathway and guidance for tracing, both to be included in its guidelines.

The **Eswatini** team assessed that while its efforts mostly went in the right direction, the team noticed some gaps in the country's re-engagement SOPs. The team saw the need to provide further guidance on management of returning clients who are unwell, including training for healthcare workers. It also noted that that the current M&E system should be improved to provide detailed data on clients interrupting treatment.

The **Malawi** team highlighted that the country needs to develop a harmonized re-engagement definition and pathway, differentiating between clients re-engaging after less than 28 days or less than 90 days. It will also be important to include the re-engagement pathways into data systems.

The **Uganda** team aims to strengthen implementation of the country's policy and SOPs at health facility level, including through monthly virtual calls, quarterly on-site coaching and mentorship. The team also wants to work towards including more visuals of the re-engagement pathway in SOPs and policies to improve uptake. Lastly, it aims to enhance collaboration between research teams and CLM partners to support quality of services.

6. It's time for differentiation at re-engagement

Key considerations for designing a pathway for people at re-engagement

To set the scene for the second day, Helen Bygrave (IAS) presented key considerations for designing a pathway for people at re-engagement. She reiterated that we need to differentiate at re-engagement to identify which clients who are re-engaging can return directly to a DSD model and which clients need additional support. To help country teams build their re-engagement pathway, she highlighted that the main factors to consider are the **time since the last appointment** – the duration of the interruption – and the **clinical needs** of the client re-engaging in care.

Clinical needs:

To guide healthcare workers in identifying a client's clinical needs, Helen recommended assessing:

- Whether the person presents with symptoms (Stage 3 or 4 conditions, AHD)
- Whether the time since the last appointment indicates the need for CD4 testing (>3 months) to deliver the AHD package
- When the last viral load was taken and if it was suppressed

To identify any psychosocial needs, Helen recommended assessing whether the client has a known history of severe psychiatric disorder and alcohol or substance use, and administering a two-question screening tool (for example, PHQ-2 and GAD-2). Further, it should be determined whether the findings indicate if more visits and shorter refills would be beneficial for the client.

Time since last appointment:

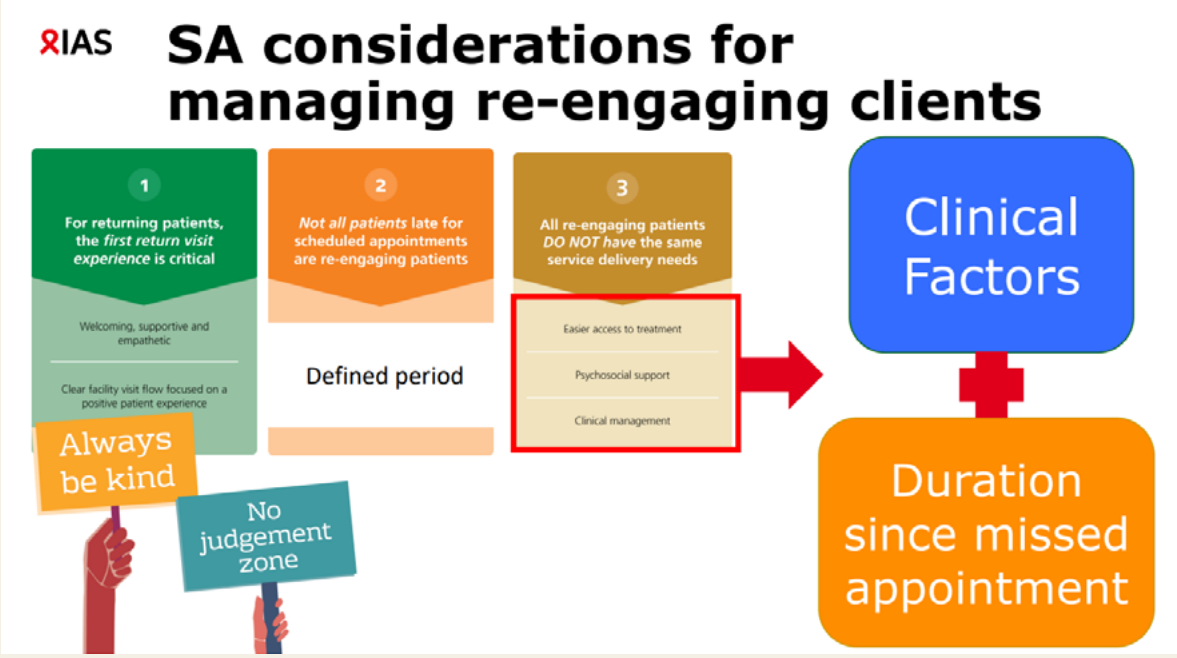
Determining how much time has passed since the last appointment – less than a month, more than a month (30 days) or more than three months (90 days) – helps identify who has had a treatment interruption versus who is presenting late. Helen pointed out that it is a good indicator of interruption if the client self-identifies as interrupting treatment.

Country case studies

To facilitate country-to-country exchange, the next two presenters shared their country experiences in designing their re-engagement pathway or algorithm: Jeannette Wessels, Senior Specialist Consultant for Public Health, University of Pretoria; and Emmanuel Govha, National Quality Improvement Coordinator, HIV/AIDS and TB Programs, Ministry of Health and Child Care in Zimbabwe. Both took part in facilitated country team discussions and answered questions from the participants.

South Africa

Jeannette explained that South Africa's journey to a re-engagement algorithm started with the need to respond to two major challenges of the country's HIV response: suboptimal 12-month retention and viral suppression. She highlighted that the country revised its ART and DSD guidelines at the same time, and generally provided an enabling environment for continued engagement, including through the wide-scale availability of three multi-month dispensing (3MMD), not only for clients who meet "stability" criteria.



Jeanette explained that the re-engagement algorithm is based on the understanding that not all clients who are returning are re-engaging. In addition, clients returning to routine care can stay in DSD models, which are called "repeat prescription collection strategies" in South Africa. She also highlighted that re-engaging clients' management depends on their clinical needs (clinical "stability"). Clients who are well but return to care more than 28 days after their missed appointment are further assessed for the duration of interruption and managed differently if they re-engage after less than 90 days or more than 90 days.

To close, Jeanette summarized South Africa's re-engagement algorithm as inclusive, rather than targeted at certain groups, and "patient-centred", which warrants putting ourselves into the shoes of the clients.

Zimbabwe

Zimbabwe's re-engagement algorithm was included in the 2022 update of its Operational and Service Delivery Manual for the Prevention, Care and Treatment of HIV. Emmanuel explained that the updated guidelines were designed in recognition of the cyclical nature of HIV care and treatment, including the fact that some people disengage without ever starting treatment post diagnosis and some people re-engage through HTS programmes. He also highlighted that Zimbabwe's guidance puts the needs of the re-engaging clients at the centre, requesting service providers to treat clients with dignity, provide quality services, and not penalize clients by increasing visit frequency without any clinical indication.

Emmanuel also shared findings and lessons learnt from implementation of the re-engagement algorithm at 18 facilities. With regard to implementation challenges, he reported issues around shortages of commodities, such as point-of-care CD4 test kits and underutilization of conventional testing platforms.

7. Tracing – prioritization and process

Overview of WHO guidelines and implementation

The last presentation of the workshop focused on tracing. Lynne Wilkinson presented WHO tracing guidelines and an overview of tracing studies. She explained that WHO recommends tracing despite low-certainty evidence, noting that: "HIV programmes should implement interventions to trace people who have disengaged from care and provide support for re-engagement (strong recommendation, low-certainty evidence)."

She shared lessons learnt on prioritization and verification processes to increase tracing effectiveness. Lynne highlighted that tracing should focus on those with missed visits (not LTFU) and abnormal results and that it should not take place before a client is more than seven days late for a missed appointment. In addition, tracing should prioritize people with increased risk of morbidity and mortality. Lynne also presented the findings of the tracing studies that informed the WHO tracing guidance and noted the main takeaways.

Further, she explained that it is important to develop a priority order for tracing different client groups because implicit prioritization can lead to greater inequity and reduce the overall impact of tracing.

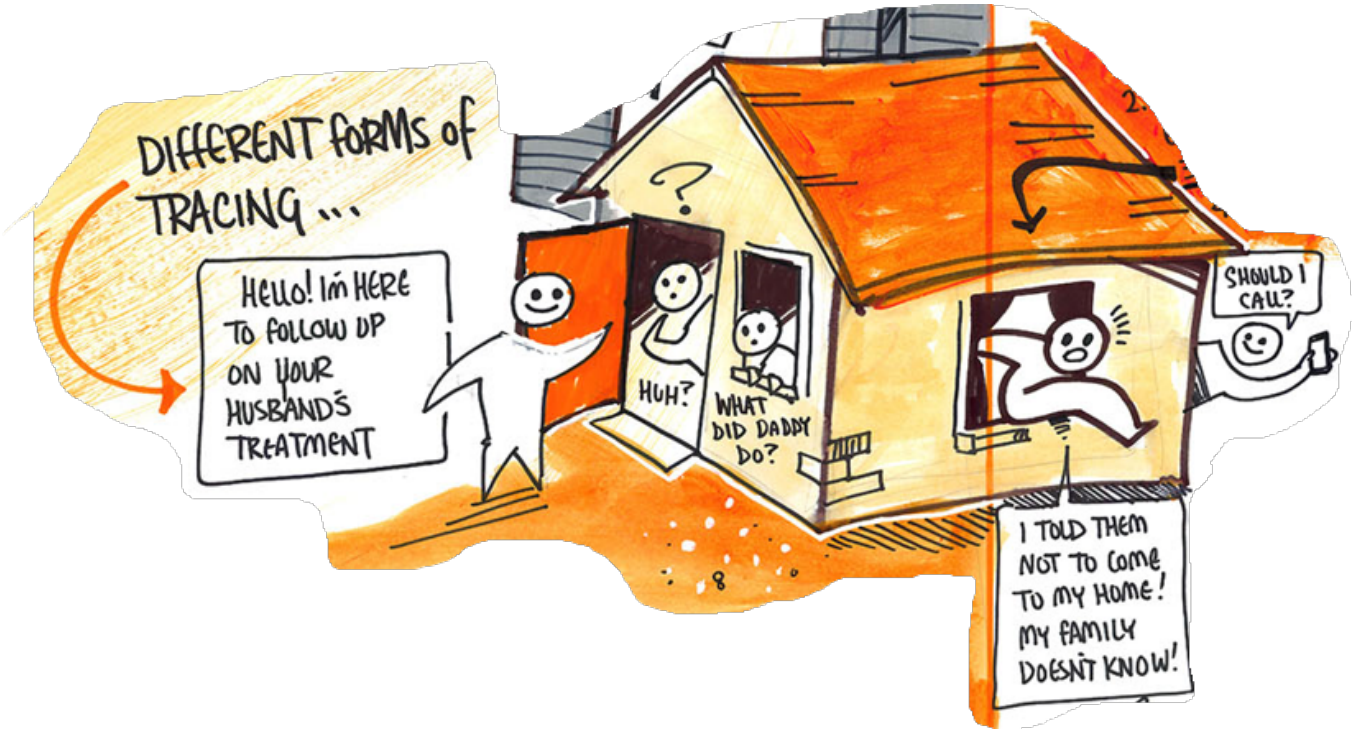
Key elements of the tracing process:

- **Monitoring systems in place**
- **Identification of eligible and prioritized clients for tracing**
- **Coordination with outreach teams**
- **Respectful and consensual tracing**
- **Supportive and non-judgemental encouragement to return to care**

Lynne's presentation informed the country teams' discussion of their own monitoring systems and tracing practices and the development of tracing SOPs.

8. Country discussions on tracing prioritization and process

The country teams then started group work to discuss tracing guidance and implementation in their contexts, as well as any populations to be prioritized with tracing efforts.



9. Wrap up and reflections

The second day wrapped up with closing remarks from workshop participants. Helen summarized key takeaways from Days 1 and 2 of the workshop, emphasizing the need to differentiate at re-engagement based on clinical needs and time since last missed appointment. She reminded participants that there is no one prescribed pathway for re-engagement as it is context dependent and should be informed by country data.

Participants noted that prioritization in the context of tracing is often understood to be determined by time since missed appointment and whether clients present with AHD, and less in relation to specific populations. To clarify this, it was suggested that details on priority populations, for example, children or pregnant and breastfeeding women, be added to the tracing SOPs. Many guidelines highlight that children are often covered under the AHD clause and that it is important to aim to trace everyone but be aware of priorities.

Other aspects of concern around tracing were how to manage issues around confidentiality and client consent for tracing, in particular related to who can trace clients.

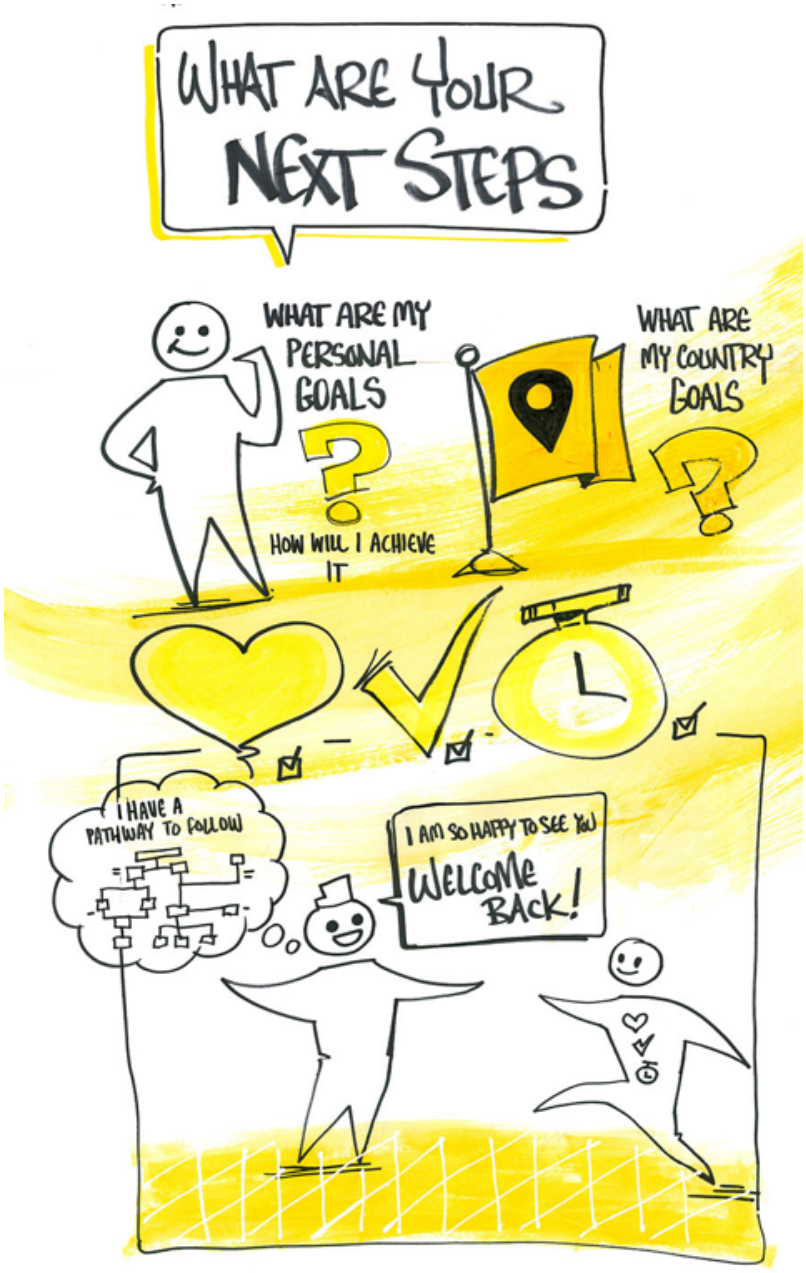
Participants discussed digitalization of tracing systems and raised questions around the comparative advantage of investing in systems for tracing where there are no electronic medical record (EMR) systems. They emphasized that in places with EMR, there are opportunities for machine learning and AI in ensuring that EMRs are set up to send specific messages to specific people.

Day 3: Implementation planning

The last day of the workshop was divided into two sessions, starting with facilitated country team discussions on:

1. **Implementation planning**
2. **Report back** by each country team at the plenary

It provided an opportunity for country teams to develop and finalize their country action plans, as well as their draft re-engagement algorithms and present these to the other participants. After the Closing remarks, the workshop ended with signing individual pledges, handing out of attendance certificates and a joint lunch.



10. Implementation planning and report back

Country action plans

Common themes across country action plans included the development of re-engagement pathways or algorithms and steps needed to update national service delivery guidelines and SOPs.

Eswatini

Priority action 1: Finalize re-engagement SOP

Priority action	Focal person	Stakeholders	Resources required	Timeline
1. PAUSE PRINTING re-engagement SOP	Harriet		None	By 22 November 2024
2. Engage M&E regarding definitions	Harriet	M&E, TB/HIV, APs, IPs	Time	By 22 November 2024
3. In-country consensus core team on algorithm/key changes to SOPs	Harriet/Clara	M&E, TB/HIV, APs, IPs, EHLS, CMS	Time	By 22 November 2024
4. In-country consensus TWG on algorithm/key changes to SOPs	Harriet/Clara	Care and treatment team	Time	By mid December 2024
5. Draft changes including cutting down and focusing – less is more	Clara	Care & treatment team	Time	By mid January 2025
6. External review changes	Harriet/Clara	WHO, IAS, CQUIN, PEPFAR	Time	By mid February 2025
7. Finalize and print revised re-engagement SOP	Harriet	APS, IPs & M&E, TB/HIV, COAG	Time, financial	End of March 2025
8. Sensitize clinical supervisors/expert clients/ CLM/client support groups	Harriet Tibusiso (community)	Clinic supervisors, clients, IPs, RACs	Financial support (venue, transport, refreshments)	End of July
9. Training clinical mentors	Harriet/Clara	Clinical mentors, RACs	Financial support (venue, refreshments)	End of June

Priority action 2: Update tracing SOPs

Priority action	Focal person	Stakeholders	Resources required	Timeline
1. In-country consensus core team on priority groups for tracing	Nompilo	MoH, APS, IPs, M&E, clients, TB	Conference package	November 2024
2. In-country consensus TWG on priority groups for tracing	Nompilo	MoH, APs, IPs, M&E, ROCs, TB	Conference package	November 2024
3. Write and develop memo to clinics on prioritizing tracing	Nompilo	MoH, APs, IPs, M&E, ROCs, TB		December 2024
4. Client survey regarding tracing preferences	Nompilo (MoH), Tibusiso (CLM)	CLM, IPs, MoH		February 2025
5. Assessment of tracing effectiveness (methods and cost)	Nompilo, Liyandza, GU Nomvu, EGPAF	IPs, M&E, MoH		February 2025
6. Disseminate assessment findings	Nompilo, Liyandza, Nomvu	MoH, APs, IPs, M&E, ROCs, TB	Conference package	February 2025
7. Finalize and print revised re-engagement SOP	Nompilo, Liyandza, Nomvu	MoH, APs, IPs, M&E, ROCs	Conference package	March 2025
8. Sensitize clinical supervisors/expert clients/CLM/client support groups	Nompilo	MoH, APs, IPs, M&E, ROCs	Conference package	September 2025

Kenya

Priority action	Focal person	Stakeholders	Resources required	Timeline
1. Add questions around re-engagement and tracing to the GRC list	Kenneth	Kenya core team	IAS-WHO workshop in Johannesburg	22 November 2024
2. Refine and propose a. Re-engagement pathway b. Tracing SOP Update the evidence, share data, best practice into current GRC list	Kenneth+	All stakeholders – PEPFAR, MoH, IPs, community (including NEPHAK), counties	Technical support (subject matter experts, WHO, IAS) on evidence	15 December 2024
3. Brief the C&T and the AHD working groups at their next standing meeting + brief community networks on outcomes of this meeting/role of CLM in measuring quality	Lazarus Nelson	Kenya core team	Support with slide deck	AHD sub-committee (last week of November, 29 November) C&T TWG (next one, maybe January) Specific meeting with community (~1 December)
4. Present at the GC retreat in January	Kenneth		Potentially peer reviewers	Mid/end of January
5. Include these two components in the dissemination package & in the National HIV Integrated Training Curriculum (NHITC) [support all cadres]			Design, support development	Mid 2025
6. Consider how to integrate the core principles of person-centredness / "welcome back" into service quality & data assessments				Mid 2025
7. Bring takeaways into integration conversations	Barbara			

Malawi

Priority action	Focal person	Stakeholders	Resources required	Timeline
1. Debriefing outcomes of the workshop • Start of conversation in TWG meeting • Present action points • Form a task force	Thomson Chirwa	TWG members	Time, meeting	3 December 2024
2. Define disengagement and re-engagement in the national programme	Thomson Chirwa	MoH, NAC, implementing partners, community of people living with HIV, treatment TWG, CHAI	Time, using existing meetings, evidence (data), guidance, technical support (WHO and UNAIDS), funding	End of March 2025
3. Harmonization of time intervals (28 versus 60 days)	Dr Andrina Mwansambo	NAC, MoH, PEPFAR, CDC, USAID, implementing partners, Global Fund implementing partners, civil society organizations, CHAI	Time, WHO guidance, PEPFAR M.E.R, MoH treatment guidelines, M&E tools, technical support (WHO and UNAIDS)	End of March 2025
4. Consultation sessions with the civil society on disengagement and re-engagement	Elina Mwasinga	CSO (focus on adolescents, young people, pregnant and breastfeeding women, children and their caregivers, migrants)	Funding, technical assistance (WHO and UNAIDS)	End of March 2025
5. Development of a national tracing SOP	Misheck Mphande	NAC, MoH, PEPFAR implementing partners, Partners in Hope, Lighthouse, Baylor, CHAI	Time, WHO guidance, MoH guidelines, Zim and SA examples, technical support (WHO and UNAIDS), funding	End of March 2025
6. Develop and finalize the re-engagement pathway	Elijah Chikuse	NAC, MoH, PEPFAR implementing partners, Partners in Hope, Lighthouse, Baylor, CHAI	Time, WHO guidance, MoH guidelines, Zim and SA examples, technical support (WHO and UNAIDS), funding	End of March 2025
7. Integration of re-engagement pathway and tracing SOPs in new revised treatment guidelines	Dr Stephen Macheso	NAC, MoH, implementing partners, TWG, advocates, people living with HIV	Consultations, technical support, maybe consultant	End of 2025

Uganda

Priority action	Focal person	Stakeholders	Resources required	Timeline
1. Debrief the programme manager	Dr Arthur and team	Programme manager, Dr Arthur and team	In-person meeting, *graph algorithm	Week of 18 November
2. Debrief Care and Treatment Technical Working Group	Dr Arthur and team	Implementing partners, technical agencies, CSOs, RoCs	Virtual meeting (possibly hybrid meeting; refreshments needed in in-person component)	Week of 9 December
3. Develop the algorithm for re-engagement based on existing guidance in the CG, validate through consultations and finalize and disseminate	Dr Arthur and team	1. First draft: with input from IAS team 2. Consultations for validation with: • Civil society • CLM • HCWs • ADPs • Academia 3. Finalization Improve based on input 4. Dissemination at 3 levels by training of trainers: national, regional district level	For consultations: Set up Dissemination: training of trainers resources, such as meeting venue, allowances	Timeline: Q1 2025: hold consultations Q2 2025: Finalize by Q2 2025 Q3 and 4 2025: Dissemination
4. Synthesize contextual evidence on tracing and outcomes	Raymond, MoH research platform and team	• University librarian to support data searches • Mapping tool to be sent to potential stakeholders, including implementing partners and funders • AIDS Control Program • Reviewers from IAS	Depends on scope (to be defined), ethics exemption, publication fees	December 2024-May 2025
5. Support analysis documentation of continuity of care data including for the proportion of people re-engaging with AHD	Raymond, MoH research platform and team	As above	Depends on scope (to be defined), ethics exemption, publication fees	December 2024-May 2025

11. In closing

The workshop wrapped up with closing remarks from three members of the faculty. Tendai Nyagura thanked WHO and the IAS for organizing the workshop, which she found important, thought provoking and catalytic for change. She highlighted that further data collection and analysis are needed around re-engagement and that the M&E systems are critical for tracing and programming. On tracing, she noted that priorities should be set according to the resources available. She concluded that it is now an opportune time to start the implementation of the countries' action plans.

Clarice Pinto reminded the audience that WHO guidance is evidence informed and should be adapted to each context. While we need to address the needs of every client and care for everyone, to save lives, we should prioritize those who need it most. She highlighted the nexus between quality of care and retention in care. She further clarified that WHO can offer support to countries while they implement their action plans, thanks to various resources such as guidelines, meetings, webinars, policy briefs and experts' advice.

Anna Grimsrud thanked the country teams and faculty for their generous and engaged participation. She pointed out that the IAS can offer technical support to country teams and that it will follow up with them regularly to check on the status of their action plans. She presented the idea of hosting a virtual follow-up call in the first quarter of 2025 with all the country teams to report back on their advancement. A CQUIN network meeting might also be a great platform to share lessons learnt from the workshop. She invited everyone to submit and register for IAS 2025, which will take place in Kigali, Rwanda, from 13 to 17 July.

Each workshop participant received their certificate of attendance and signed a pledge document with a personal commitment.

A few words from the workshop participants*:

"The knowledge (gained) will benefit the national programme in the national guidelines review."

"We have planned to revise our guidelines based on the outputs of the workshop."

"Before attending the meeting, all re-engaging clients were being provided with the same package according to the period they have interrupted treatment. After the workshop, our SOP will be reviewed to develop packages for clients returning well or unwell."

"This workshop has assisted in defining and creating guidance on differentiating for all clients returning and re-engaging in care."

"South-to-South learning would be appreciated to see how other countries are implementing re-engagement physically and learning from the healthcare workers on the ground."

"Initially, my understanding of re-engagement in care before attending the workshop was mainly centred on individual-focused strategies, such as counselling and follow-ups for individuals who had defaulted on their care. I believed that the barriers to care were largely personal, including stigma, lack of knowledge, or treatment fatigue, and that these issues should be addressed on a case-by-case basis. However, my perspective broadened during the workshop. I realized that re-engagement requires a multi-layered approach and that the development of effective, well-defined, and inclusive guidelines is essential. It became clear to me how data systems play a crucial role in re-engagement, helping to analyse whether missed facility appointments are tied to disengagement or not. I also recognized the importance of addressing specific barriers to care, such as transportation or economic challenges. Additionally, I learned that harmonizing the definition of re-engagement in Malawi is vital as this had not been clearly understood as a challenge until the workshop."

* Post-workshop survey. Quotes may be lightly edited for clarity and style consistency.

"We will integrate the knowledge gained into our treatment and care programming. This will involve orienting our district leaders to ensure they understand the pathways and are able to advocate for quality services at the national level through the Technical Working Groups. Our goal is to ensure that policies and guidelines address the effective needs of treatment."

"After the workshop, I had more clarity on the definition of re-engagement … I was also able to appreciate the different pathways from different country cases that were presented that helped us to design a proposed flow for Kenya."

"The knowledge gained is powerful evidence to enhance advocacy for the DSD model, which is flexible enough to facilitate the re-engagement of people living with HIV. This approach also supports the scaling up of community and peer-led initiatives."

"We need technical assistance to develop a re-engagement pathway. Adequate financial and material resources will be crucial in harmonizing the definition and creating the pathways, as well as reviewing the guidelines to incorporate the new definition. Additionally, fostering partnerships with local and international stakeholders will enhance the coverage and sustainability of these efforts. The IAS can provide technical guidance, facilitate connections with global networks, and potentially offer funding opportunities or grants for pilot projects."

Next steps

The IAS and WHO have planned concrete steps to build on the momentum of the workshop over the year 2025. In addition to follow-up communication with country teams on the implementation of their action plans, including any challenges they face and what lessons they can share with other teams, there will be virtual follow-up meetings, both with individual countries and the larger group. In that regard, an invite-only webinar will be organized at the end of Q1 2025 with the four country teams. If support is requested and resources are available, the IAS will provide technical support for the development or revision of national guidelines, implementation tools and SOPs. Moreover, it will liaise with WHO for its expertise, as needed.

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Annex 1: Agenda

Differentiation at re-engagement in HIV care: A multi-country workshop

Hosted by IAS – the International AIDS Society – in collaboration with the World Health Organization (WHO)

Day 1 – Tuesday, 12 November, 2024

The challenge of re-engagement in HIV care

Time	Session
08:30 - 09:30	**1 Hello and Welcome**
30 mins	**1.1 Registration**
30 mins	**1.2 Introductions & workshop overview**
09:30- 10:30	**2A Is there a problem? Data on re-engagement in care**
15 mins	**2.1 Overview of the cyclical cascade**
15 mins	**2.2 Defining re-engagement**
15 mins	**2.3 Re-engagement and AHD**
15 mins	**Q&A and plenary discussion**
10:30 - 11:00	Break
11:00 - 12:15	**2B Country discussion on re-engagement data**
75 mins	**Facilitated country discussions**
12:15 - 13:15	Lunch break
13:15 - 14:15	**3A Reasons for disengagement and re-engagement**
15 mins	**Client perspectives and experiences**
15 mins	**Reasons for disengagement**
15 mins	**Reasons for disengagement**
15 mins	**Q&A and plenary discussion**
14:15 - 14:45	**3B Country discussions of reasons for disengagement and re-engagement**
30 mins	**Facilitated country discussions**
14:45 - 15:15	Break
15:15 - 15:45	**4A WHO guidance on re-engagement**
20 mins	**Presentation on the WHO technical brief, "Supporting re-engagement in HIV treatment services"**
10 mins	**Q&A and plenary discussion**
15:45 - 16:15	**4B WHO guidance on re-engagement**
30 mins	**Facilitated country discussions**
16:15 - 16:45	**5 Day 1 wrap up and reflections**
17:30 - 19:00	**Welcome reception**

Day 2 – Wednesday, 13 November

It's time for differentiation at re-engagement – and our best tracing

Time	Session
09:00 - 09:30	**6 Day 2 check in**
30 mins	**Day 1 reflections, Day 2 plans**
09:30- 10:45	**6A It's time for differentiation at re-engagement**
15 mins	**6.1 Key considerations for designing a pathway for people at re-engagement**
15 mins	**6.2 South Africa's journey to a re-engagement algorithm**
15 mins	**6.3 Zimbabwe's journey to a re-engagement algorithm**
30 mins	**Q&A and plenary discussion**
10:45 - 11:15	Break
11:15 - 12:15	**6B PART 1: Country pathways – differentiating at re-engagement**
60 mins	**Facilitated country discussion**
12:15 - 13:30	Lunch break
13:30 - 14:30	**6B PART 2: Country pathways – differentiating at re-engagement**
60 mins	**Facilitated country discussion**
14:30 - 15:00	**7A Tracing - Prioritization and process**
15 mins	**7.1 Overview of WHO guidelines and implementation**
15 mins	**Q&A and plenary discussion**
15:00 - 16:00	**7B Country discussions on tracing prioritization and process**
60 mins	**Facilitated country discussion (including working tea break)**
16:00 - 16:30	**8 Day 2 wrap up and reflections**

Day 3 – Thursday, 14 November

Next steps

Time	Session
09:00 - 09:30	**9 Day 3 check in**
30 mins	**Day 2 reflections, Day 3 plans**
09:30- 11:00	**10A Implementation planning**
90 mins	**Country next steps**
11:00 - 11:30	Break
11:15 - 12:15	**10B Report back and wrap up**
4 x 10 mins	**Country report backs**
20 mins	**Wrap up and thank you**
12:30 - 13:30	Lunch break

Annex 2: List of attendees

Participants

First name	Country	Organization
Lazarus Momanyi	Kenya	NASCOP
Eunice Auma Kinywa	Kenya	County of Kisumu
Susan Arodi	Kenya	USAID Fahari ya Jamii
Kenneth Masamaro	Kenya	CDC Kenya
Nelson Otwoma	Kenya	NEPHAK
Barbara Mambo	Kenya	WHO
Arthur Ahimbisibwe	Uganda	MoH
Proscovia Namuwenge	Uganda	MoH
Raymond Tweheyo	Uganda	MakSPH
Baker Bakashaba	Uganda	AICU
Thomson Chirwa	Malawi	MoH
Andrina Mwansambo	Malawi	National AIDS Commission
Elijah Chikuse	Malawi	Partners in Hope
Misheck Mphande	Malawi	Partners in Hope
Elina Mwasinga	Malawi	Y+
Clara Nyapokoto	Eswatini	National AIDS Program
Harriet Mamba	Eswatini	National AIDS Program
Nomvuselelo Sikhondze	Eswatini	The Aspire Project (EGPAF)
Liyandza Mamba	Eswatini	Georgetown University
Tibusiso Nhlengetfwa	Eswatini	CANGO
Sibongile Ntshangase	South Africa	WHO
Nyasha Mutanda	South Africa	HE2RO
Sydney Rosen	USA	Boston University

Faculty and facilitators

First name	Country	Organization
Anna Grimsrud	South Africa	IAS
Cassia Wells	South Africa	ICAP at Columbia
Clarice Pinto	Switzerland	WHO
Emmanuel Govha	Zimbabwe	MoHCC
Helen Bygrave	UK	IAS
Jeannette Wessels	South Africa	Independent consultant
Lina Golob	France	IAS
Lynne Wilkinson	South Africa	IAS
Maëva Villard	Switzerland	IAS
Ndivhuwo Rambau	South Africa	Ritshidze
Tendai Nyagura	South Africa	Genesis Analytics