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Advanced HIV Disease - Reengagement and adherence support, and the need to monitor these processes

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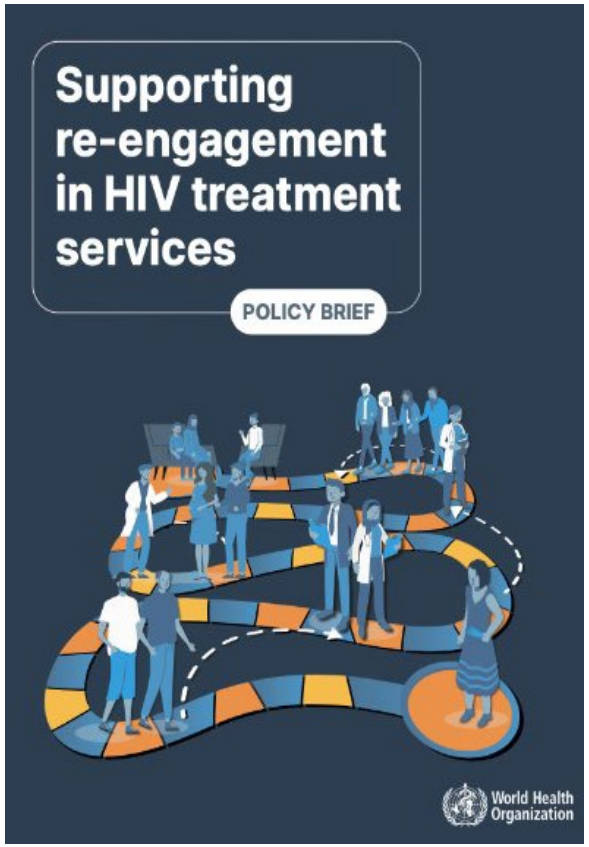
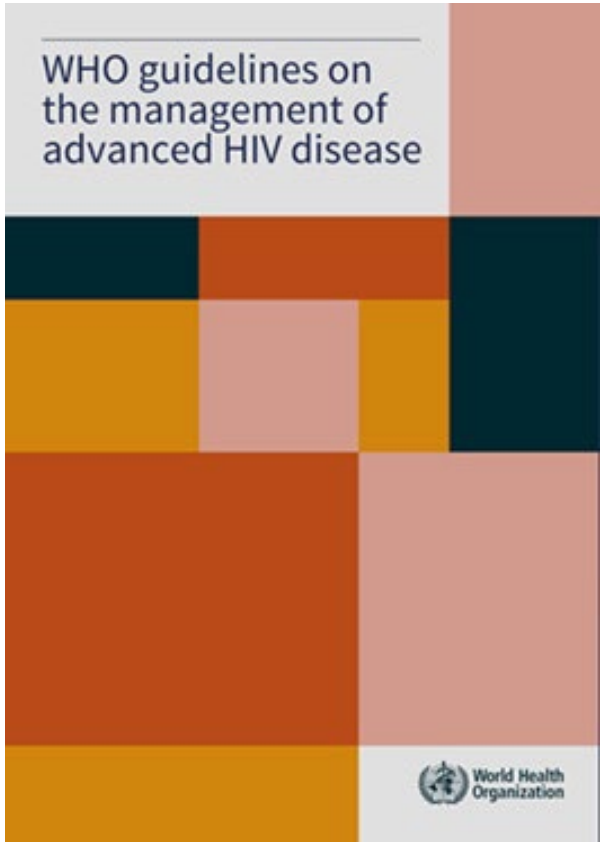
Works in Progress: Transforming the HIV Response in a Time of Change, April 20-22, 2026 | Nairobi, Kenya

Latest WHO Normative Guidelines



Supporting re-engagement in HIV treatment services
https://www.who.int/publications/i/item/9789240097339

WHO guideline on HIV service delivery
https://www.who.int/publications/i/item/9789240113879



WHO guidelines on the management of advanced HIV disease
https://www.who.int/publications/i/item/9789240118164

WHO recommendations to support continuous engagement and re-engagement

Adherence support interventions should be provided to people on ART *(from 2016 updated in 2025).*

WHO recommendations to support continuous engagement and re-engagement

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Good practice statements

- Health systems should invest in **people-centred practices** (2016 guidance)
- The offer of **same-day ART initiation** should include approaches to improve uptake, treatment adherence and retention such as **tailored patient education, counselling and support**. (2021 guidance)
- **Non-judgmental**, tailored approaches to assessing adherence (2021 guidance)

Engagement recommendations

- People established on ART should be offered **clinical visits every 3–6 months**, preferably every six months if feasible (2021 guidance)
- People established on ART should be offered **refills of ART lasting 3–6 months**, preferably six months if feasible (2021 guidance)
- Programmes should provide **community support** for people li
with HIV to improve retention in HIV care (2016 guidance)

Re-engagement recommendations

- **To support those who are disengaged to re-engage in HIV care** (2021 guidance)

Programmes should implement interventions to trace people who have disengaged from care and provide support for re-engagement

- **To improve re-engagement and retention in care** (2023 guidance)

Use of person-centred patient data is recommended to continuously assess interruption of HIV treatment to improve re-engagement and retention in care

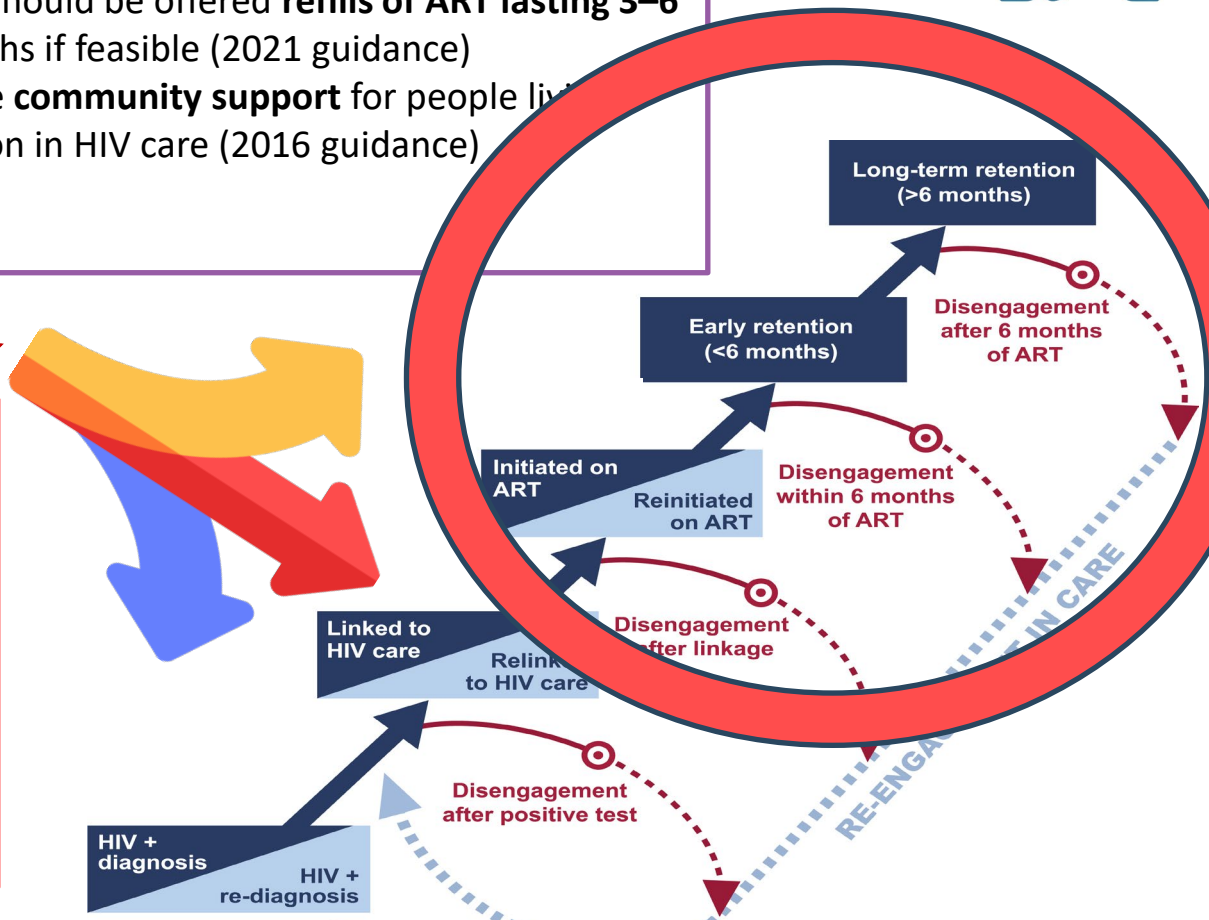


Figure Source: The revolving door of HIV care: Revising the service delivery cascade to achieve the UNAIDS 95-95-95 goals
Ehrenkranz P, Rosen S, Boulle A, Eaton JW, Ford N, et al. (2021) The revolving door of HIV care: Revising the service delivery cascade to achieve the UNAIDS 95-95-95 goals. PLOS Medicine 18(5): e1003651. https://doi.org/10.1371/journal.pmed.1003651

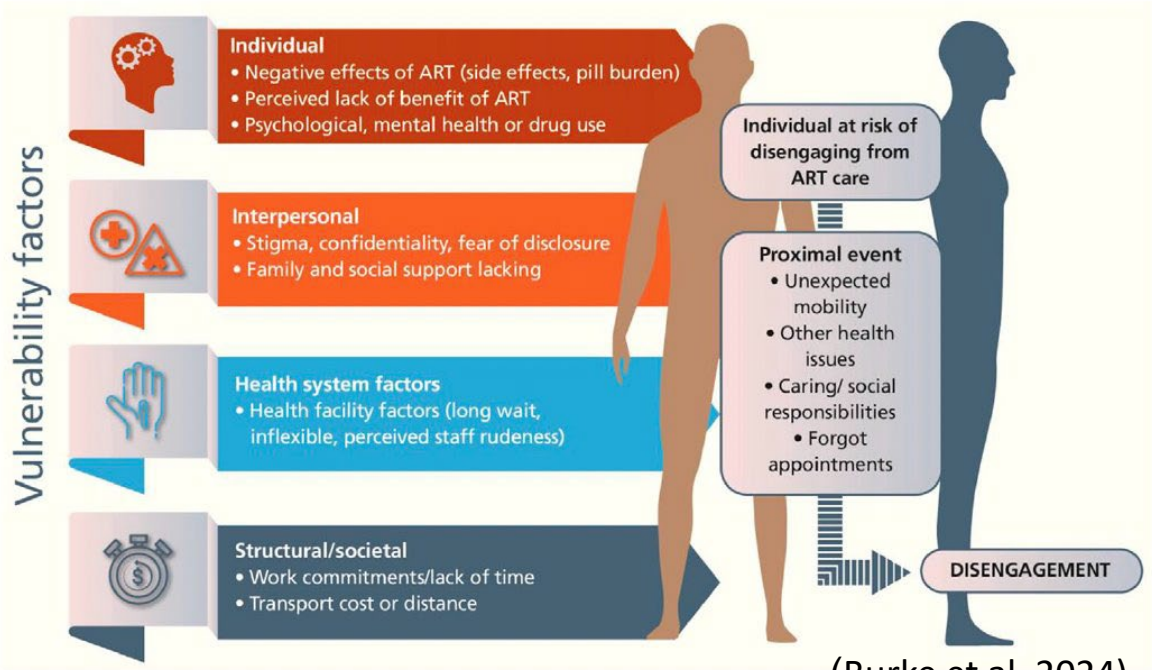
What is re-engagement in HIV treatment services?

Disengagement from care may happen after starting antiretroviral therapy (ART) and may occur more than once.

Re-engagement in HIV treatment services refers to people returning to HIV services after a period of interruption.

- This occurs when a person misses scheduled visits or appointments and does not receive treatment for a certain period of time.
- **Note:** The defined duration of care and treatment interruption will vary across contexts, and this brief does not specifically address the duration of these interruptions but provides considerations on how to address them.

Research findings on Reasons for Disengagement



(Burke et al, 2024)

- Disengagement is a multi-dimensional issue influenced by a mix of factors, often driven by immediate life events that can overlap in time.
- Most common issues: Mobility issues, Lack of perceived benefits of ART, Structural/societal factors, such as transport costs or distance

Key Terms from the WHO Re-engagement Policy Brief

A missed visit is a missed appointment either for an antiretroviral refill or a clinical visit. WHO-suggested criteria for initiating tracing and recall interventions includes missing an appointment or visit by more than seven days (1).

- Not everyone who misses their appointments stops or interrupts their treatment.
- Clients might arrive late or miss a scheduled visit, but they can still access ART or get enough ART to cover the days they missed.

WHO defines lost to follow-up as "patients who have not been seen at the facility/community service delivery site for 28 days or more since the last missed appointment (including missed antiretroviral [drug] refills in either facility or community settings)" (2).

- The outcomes for people living with HIV who have not returned for follow-up are unknown.
- This includes undocumented "silent" transfers, people who have died, and those who have interrupted their treatment

(1) Consolidated guidelines on HIV prevention, testing, treatment, service delivery and monitoring: recommendations for a public health approach, 2021 (2) . Consolidated guidelines on person-centred HIV strategic information: strengthening routine data for impact. Geneva: World Health Organization; 2022

Guiding Principles for Sustained Engagement

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Welcome, Don't Punish
Cultivate a non-stigmatizing environment. Ensuring equitable access to care
Missed appointments are part of the chronic care journey.

Active AHD identification
Conduct a CD4 test upon re-engagement to identify AHD, provide the specialized package of care.

Rapid ART
Providing immediate treatment and care

Differentiate the Pathway
Adapt visit frequency and refill durations to the individual's clinical and psychosocial realities.

Community engagement
Continuous communities engagement, community-led and based services, service quality monitoring and feedback

Person-Centred approach
Tailored adherence and re-engagement support, adapted to people's needs and engagement barriers.

Monitor to Act, Not Just to Count
Person-centered data systems can generate timely alerts and measure continuous engagement, moving beyond the linear 95-95-95 targets.

Empowered communities and person-centered systems are the foundation of ending HIV

Pathways to support re-engagement in HIV treatment and care

Clients who stopped ART returned

Reception in clinic is respectful and non-judgemental

Provide clinical assessment and rapid ART reinitiation

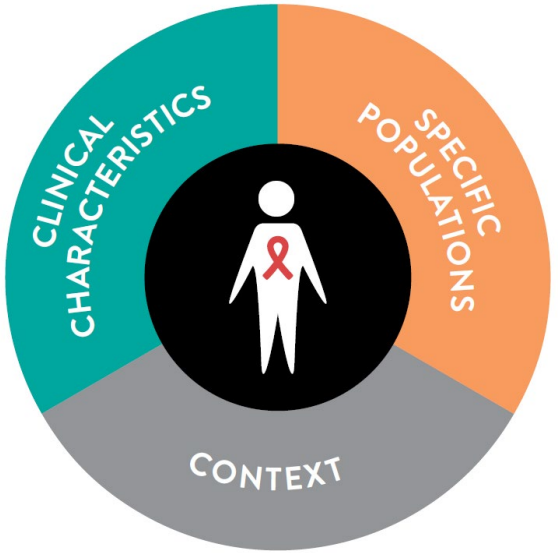
With or without tracing/ outreach intervention

Assessment of previous ART regimen, time spent disengaged, adherence counselling

- **Provide comprehensive clinical assessment** to determine current clinical stability
- **Review all available clinical data**, including the most recent viral load results
- **Conduct a CD4 test** to assess for advanced HIV disease
- Immediately **consider seriously unwell clients as having advanced HIV disease** and manage accordingly
- **Screen for opportunistic infections** to ensure timely diagnosis and treatment
- **Rapidly reinitiate antiretroviral therapy (ART)** on the same day of re-engagement

Psychosocial and adherence support

- Discuss previous adherence success
- Assess factors affecting adherence
- Provide mental health screening
- Refer to specialized support services if needed
- Identify set of adherence interventions to address reasons for disengagement
- Incorporate peer and community support into adherence plan
- Adapt psychosocial and adherence support over time



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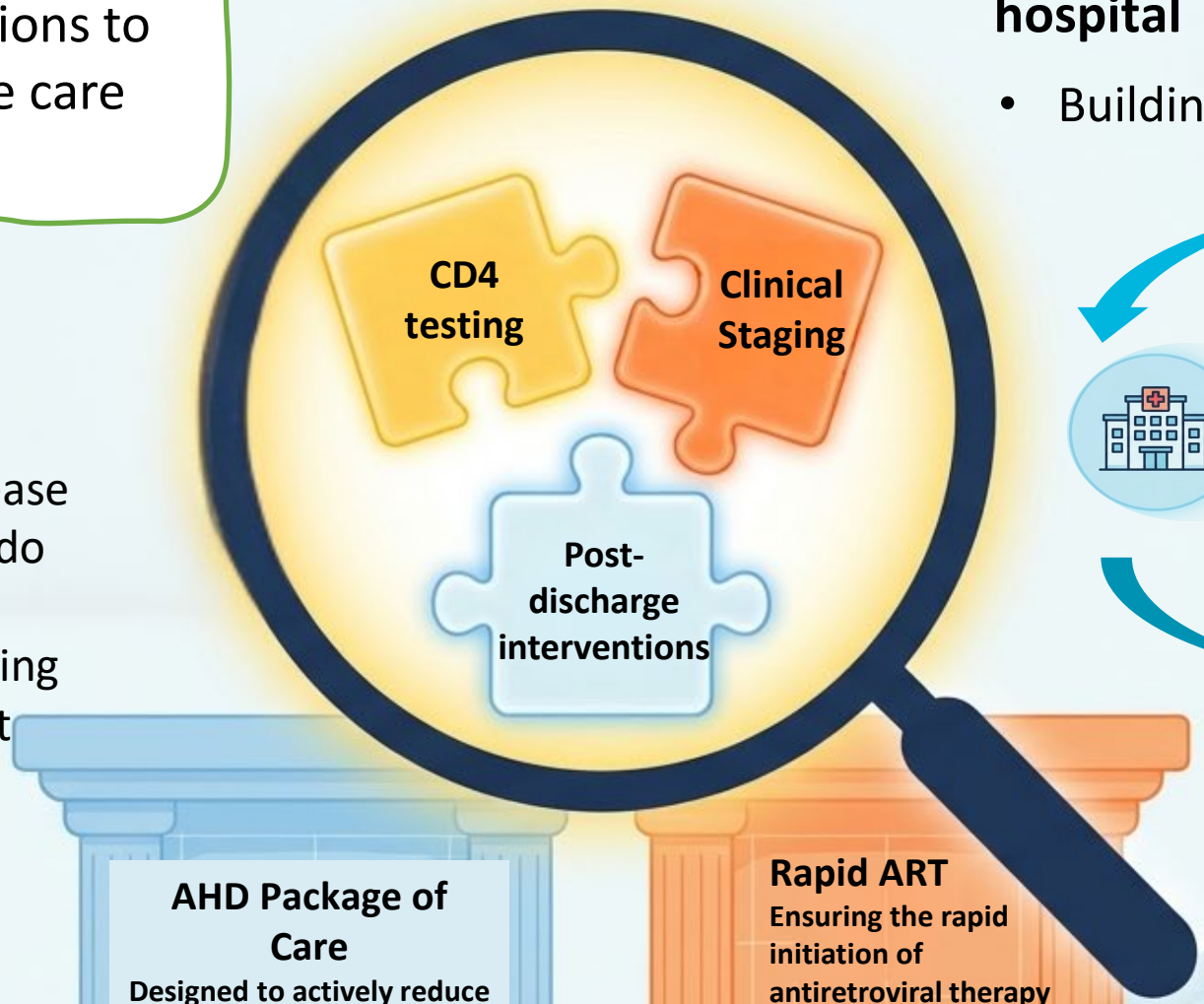
New AHD recommendations that helps build a strong foundation to care journey

The 2025 AHD guidelines consolidates existing knowledge with new recommendations to close critical gaps in the care journey.

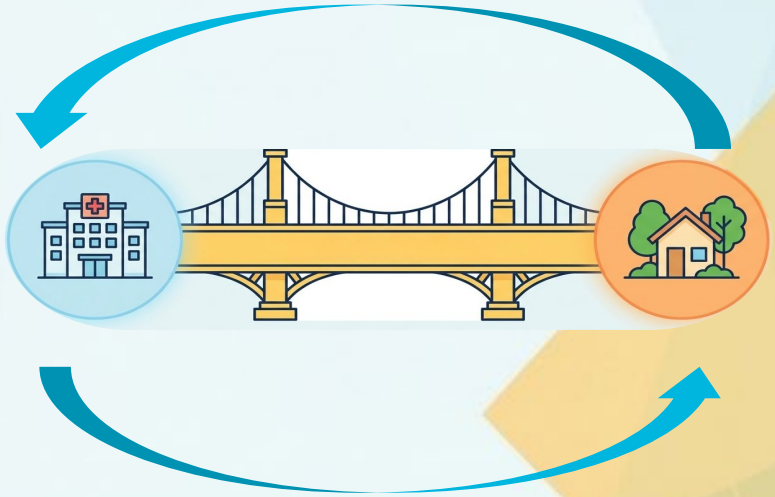
Finding AHD Sooner

- Proactive approaches to identify advanced HIV disease
- We cannot treat what we do not see.
- Identifying people presenting with AHD earlier is the first crucial step in preventing AIDS-related deaths



Protecting those leaving the hospital

- Building a Safe Bridge Back to Care

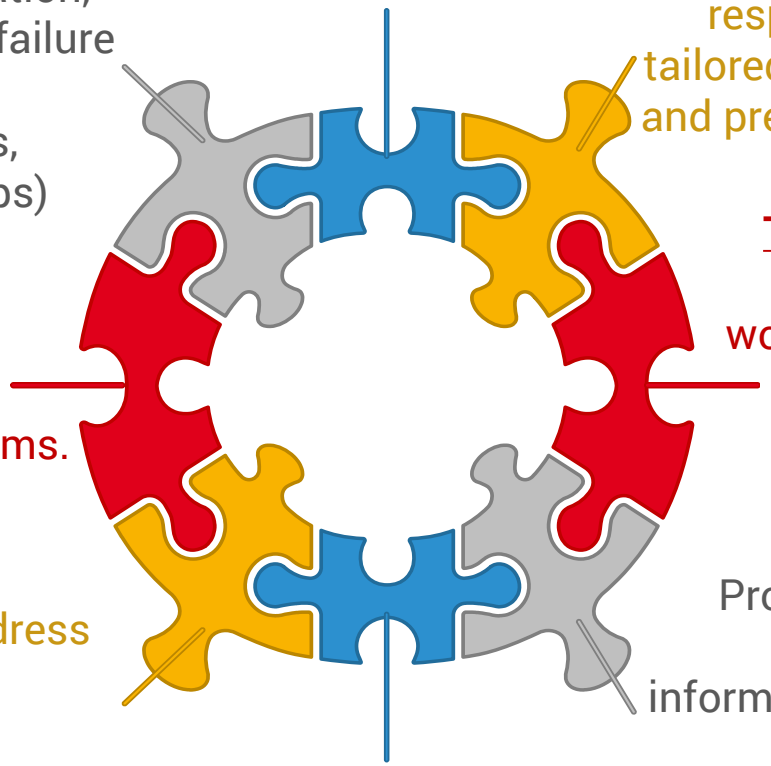


People at the center: Considerations for the Tracing Process

Develop a process to obtain informed **consent** from clients for tracing activities.

Establish **criteria** (e.g. recent treatment initiation, abnormal lab results, failure to initiate treatment, overdue consultations, most vulnerable groups)

Ensure **tracing methods** (e.g. remote or in-person) are respectful, consensual, and tailored to the individual needs and preferences of each client.



Monitoring tracing outcomes can help improve health systems.

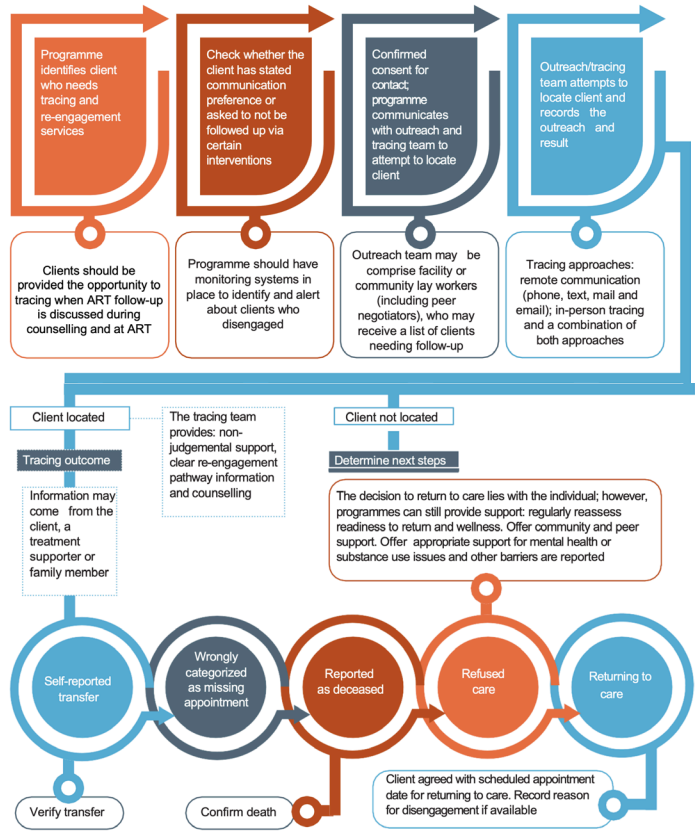
Trained and supervised Tracing Team: Lay workers, peer supporters, community health workers, and outreach teams.

Identify and address **reasons for disengagement**

Provide **non-judgmental**, supportive, and clear information and counselling services

Enhanced monitoring systems can support identifying disengagement and re-engagement dynamics that triggers tracing efforts

E.g. Tracing Process



⚠ **Important note:**

- not every client who has disengaged may require tracing to return to care
- not all traced clients can be located (e.g. wrong number or/and wrong address)
- nor do all contacted individuals necessarily return to care

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Images source: ©WHO

Data and the Dynamic Cascade

To manage a non-linear cascade that moves beyond static 95-95-95 targets, monitoring systems can track longitudinal, person-centred data across time and locations.

1 Routine Care

- Who receives targeted client communication and reminders (SMS);
- How to capture adherence barriers and recurrent delays?

2 Disengagement

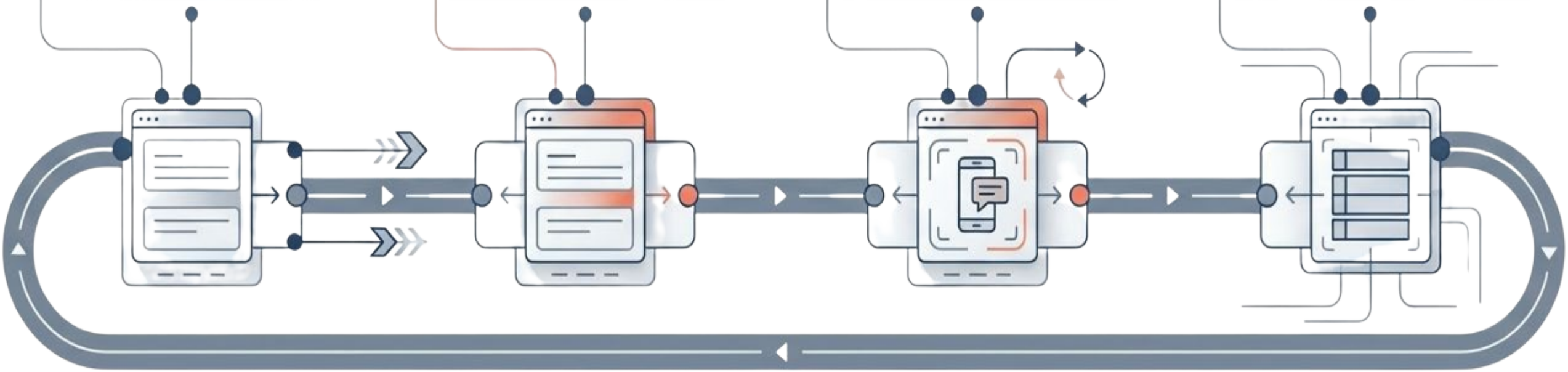
- Is tracing criteria and disengagement defined?
- Do monitoring systems automatically flags missed visits

3 Trace/Re-engage

- How is tracing/outreach outcomes (e.g., located, self-reported transfer, deceased) or re-engaged logged?

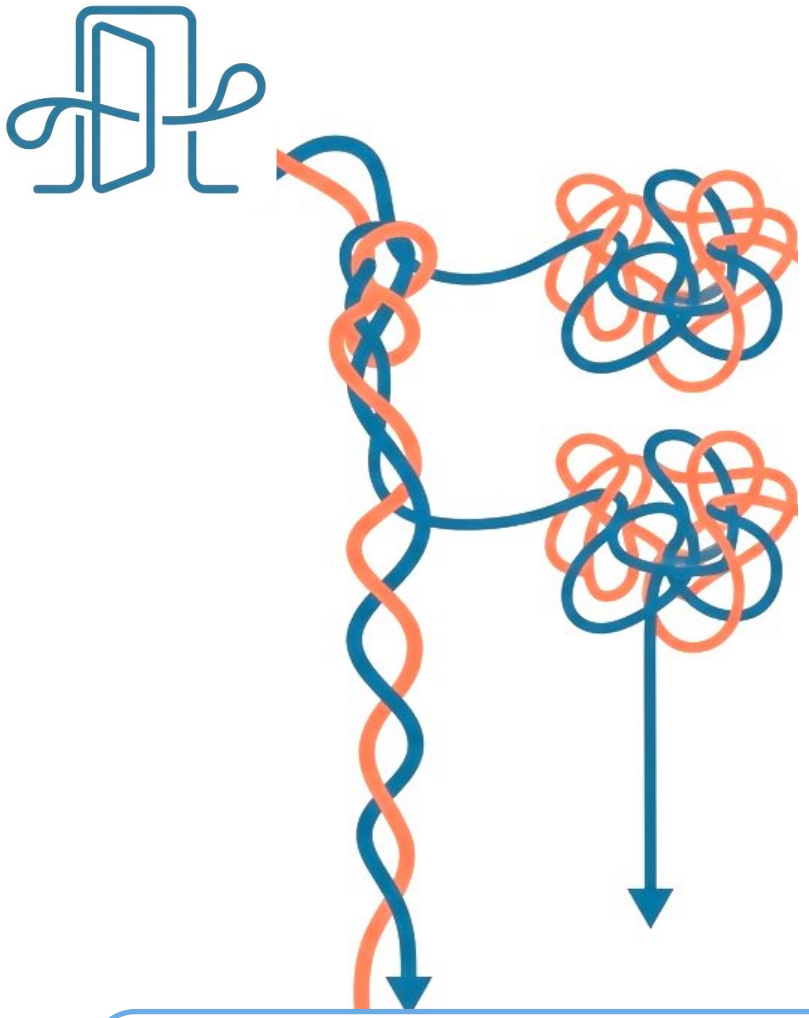
4 System integration

- Do monitoring systems reconcile “silent transfers” across facilities, ensuring accurate retention data rather than false “loss to follow-up”?



Monitoring Engagement, Re-engagement and AHD:

Key Considerations



- How often a person visits a clinic does not necessarily show whether ROC are engaged in care or have interrupted treatment.
- Monitoring indicators should match delivery models, including longer dispensing and follow-up intervals.
- Monitoring systems should recognise that people may move between facility-based and community-based care.
- Advanced HIV disease should be monitored using clinical risk indicators, not visit patterns alone.
- Re-engagement decisions should be based on multiple signals together (for example, delayed refill and missed clinical follow-up, a missed viral load test, and no contact through community services, etc), not on one missed visit alone.

Think: Dynamic, Longitudinal Monitoring

We must measure retention as a dynamic, longitudinal entity, monitoring how individuals engage across different pathways, not just if they show up at a specific building.

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Thank you!!
Merci!
Obrigada!