The Strategic Use of Antiretrovirals:

Progress since the launch of the WHO 2013 Consolidated Guidelines on the Use of ARVs

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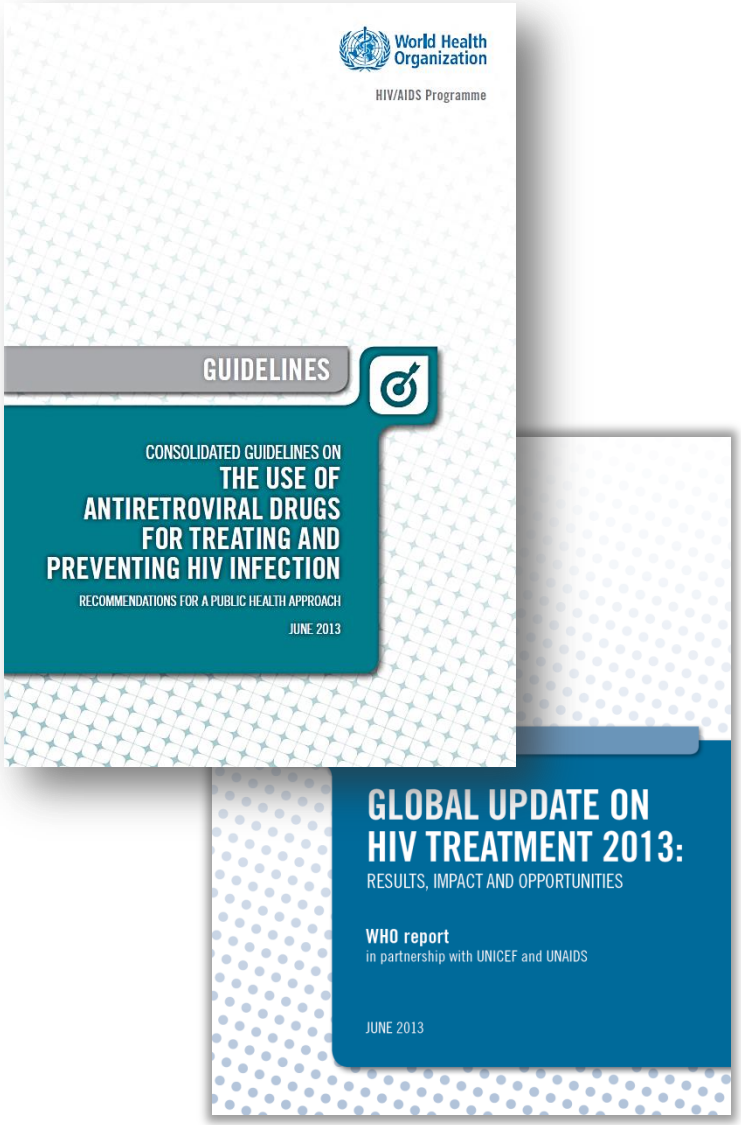
World Health Organization

Two Key WHO Documents in 2013



- **New Guidelines – launched at a strategic time to increase HIV treatment scale-up**
- **Supporting the adaptation and adoption process at country level**
- **Implications and challenges for countries and regions**

Why new WHO guidelines in 2013…?

- **Advances in science/technology and vision**
  - Technologies (PoC CD4 & VL, new drug formulations)
  - ART for individual and population benefits
- **HIV as a chronic health condition**
  - Treatment adherence and retention
  - Chronic care models – decentralization, integration
- **Despite scale-up, continuing challenges**
  - Low ART coverage among children, adolescents and key populations
  - Major gaps in quality and in retention along the continuum of care

Concept Behind Consolidation…

- Consolidation across **populations and ages**

- Consolidation along the **continuum of care**

- **Consolidation of new with existing guidance**

HIV TREATMENT

Earlier treatment and service delivery closer to home

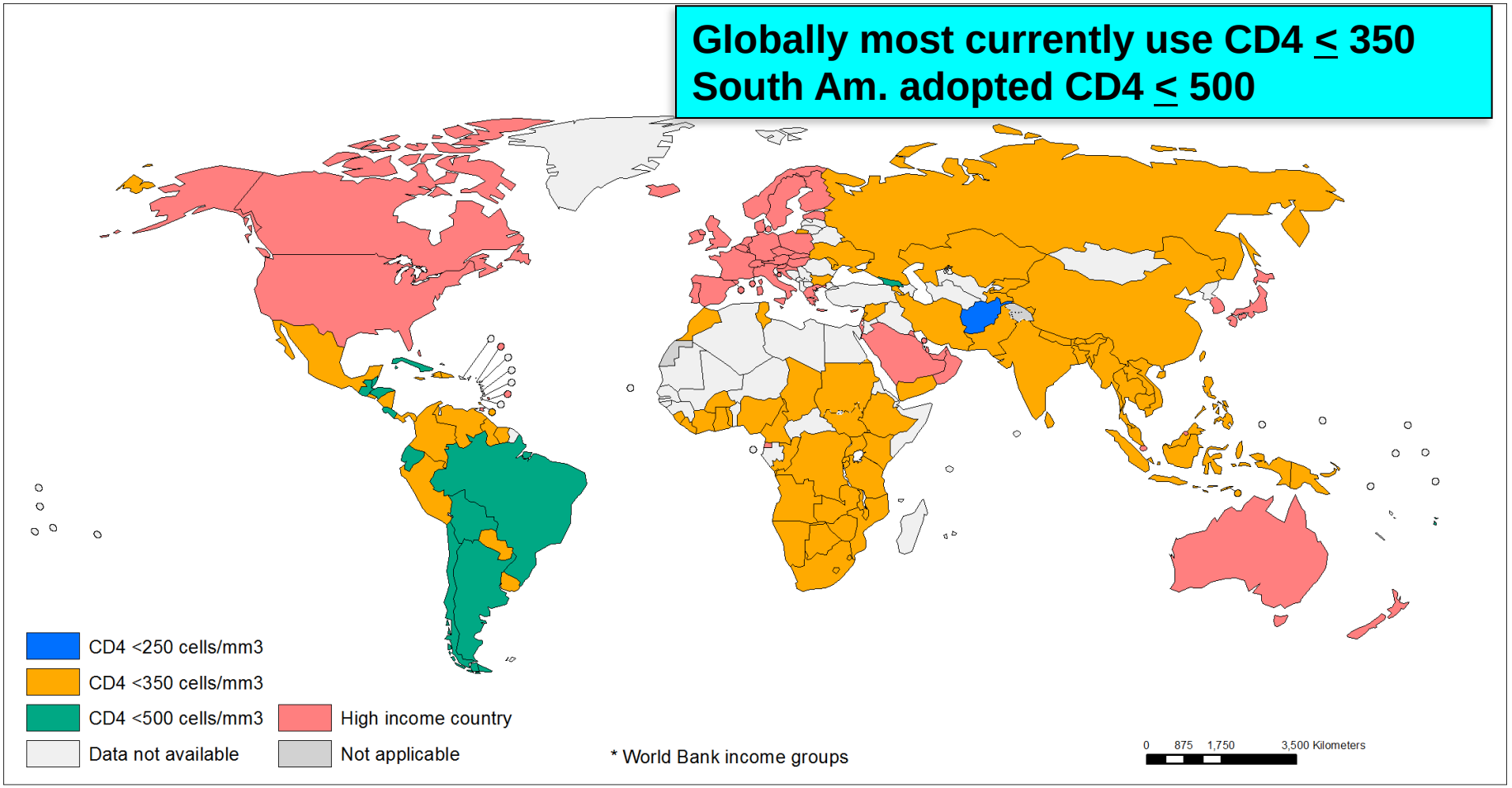
Clinically relevant

- **Earlier initiation of ART** (CD4 ≤ 500)
- **Immediate ART for children below 5 years**
- **ART for all pregnant and breastfeeding women** (Option B/B+)
- Simplified, fewer, and less toxic 1st-line regimens **(TDF/XTC/EFV)**

Operationally relevant

- Use of **Fixed Dose Combinations**
- Improved patient monitoring with **increased use of viral load**
- Recommend **task shifting, decentralization, and integration**
- **Community based testing and ARV delivery**

Countries are already moving.. Adult Eligibility for ARVs in 2012



Data Source: World Health Organization
Map Production: Health Statistics and Health Information Systems (HSI)
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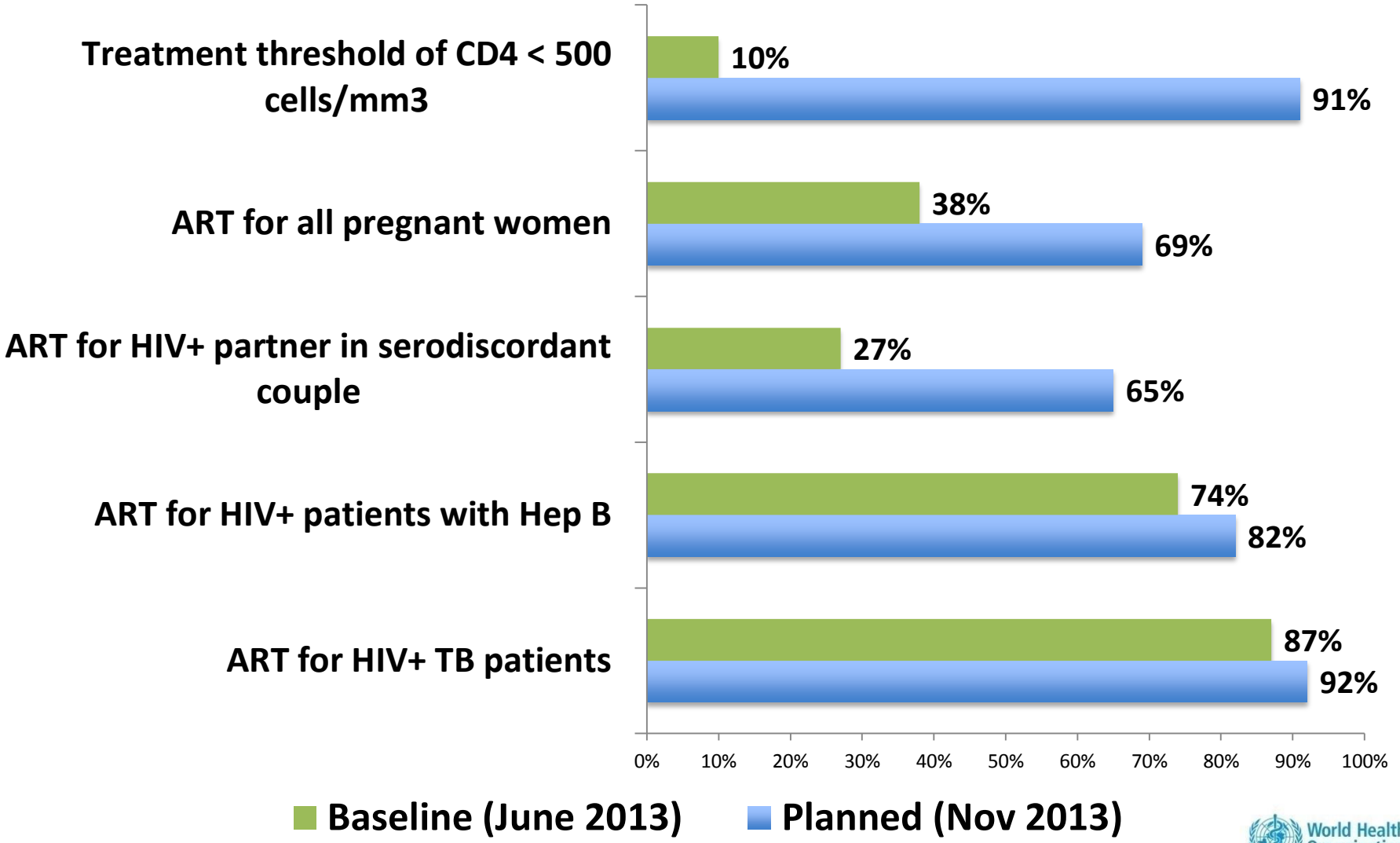
Percent of Countries Adopting CD4 ≤ 500 and CD4 Independent Criteria for ARVs



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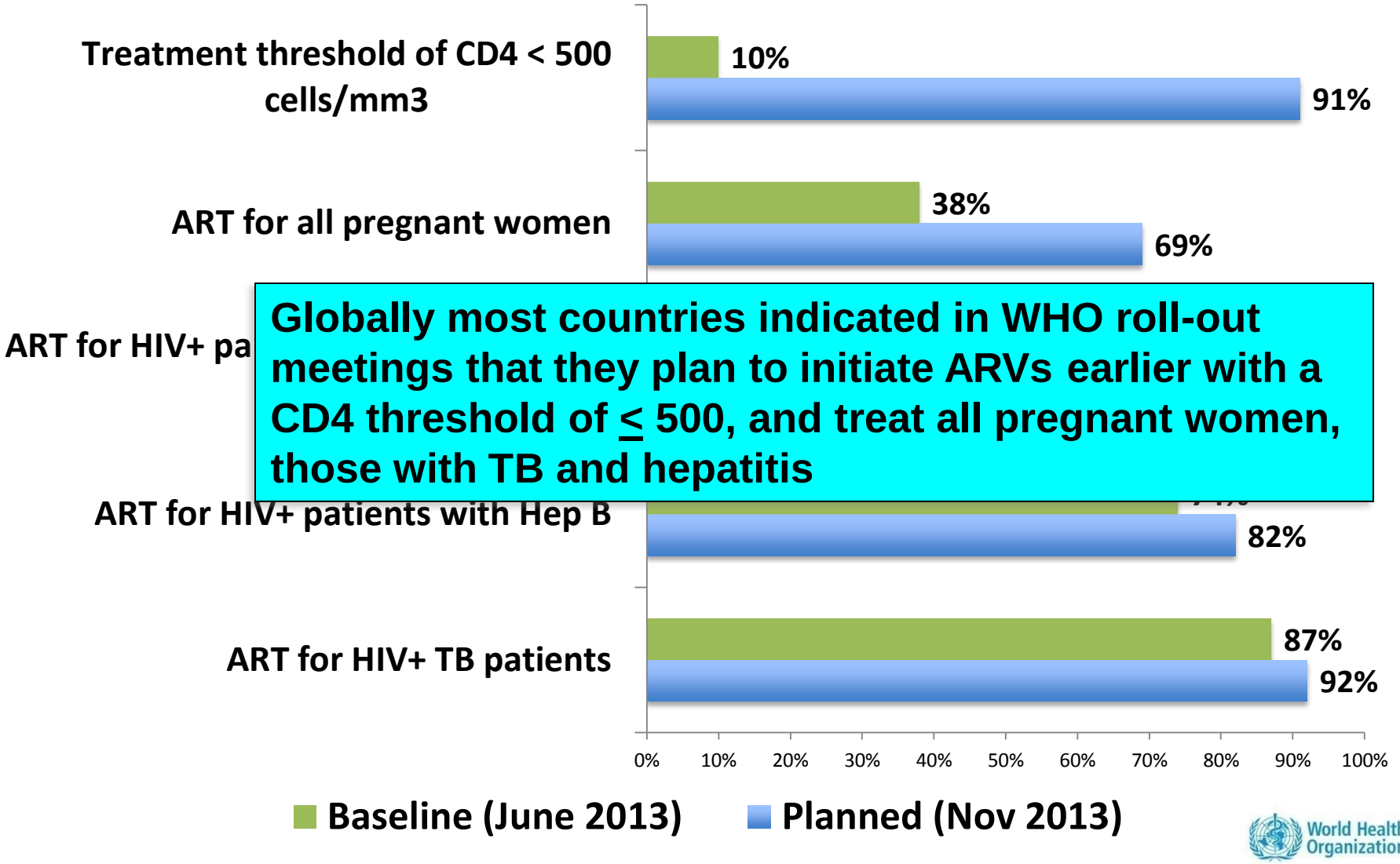
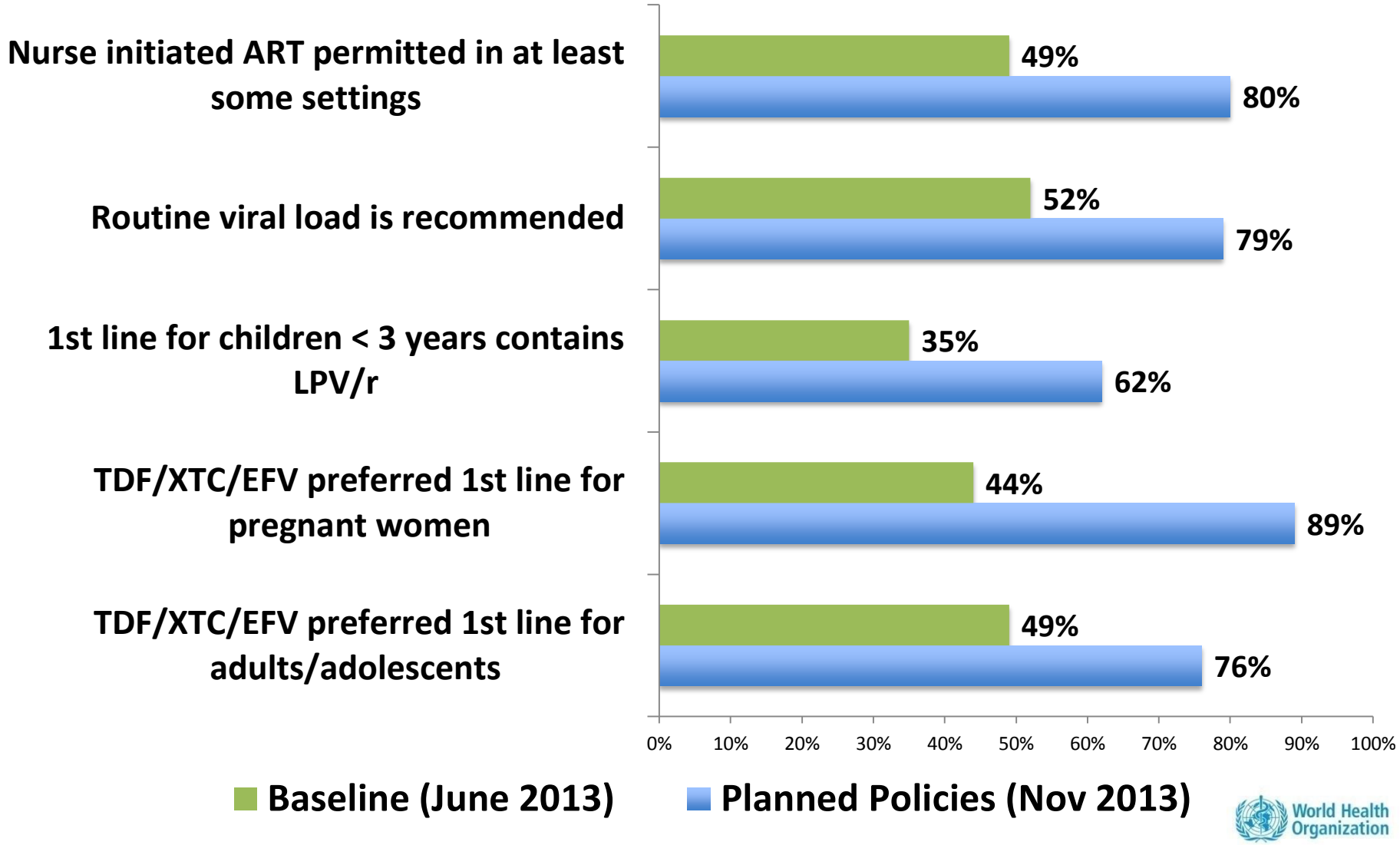


Globally most countries indicated in WHO roll-out meetings that they plan to initiate ARVs earlier with a CD4 threshold of ≤ 500, and treat all pregnant women, those with TB and hepatitis

Comparison of Baseline and Planned Service Delivery Policies, 2013



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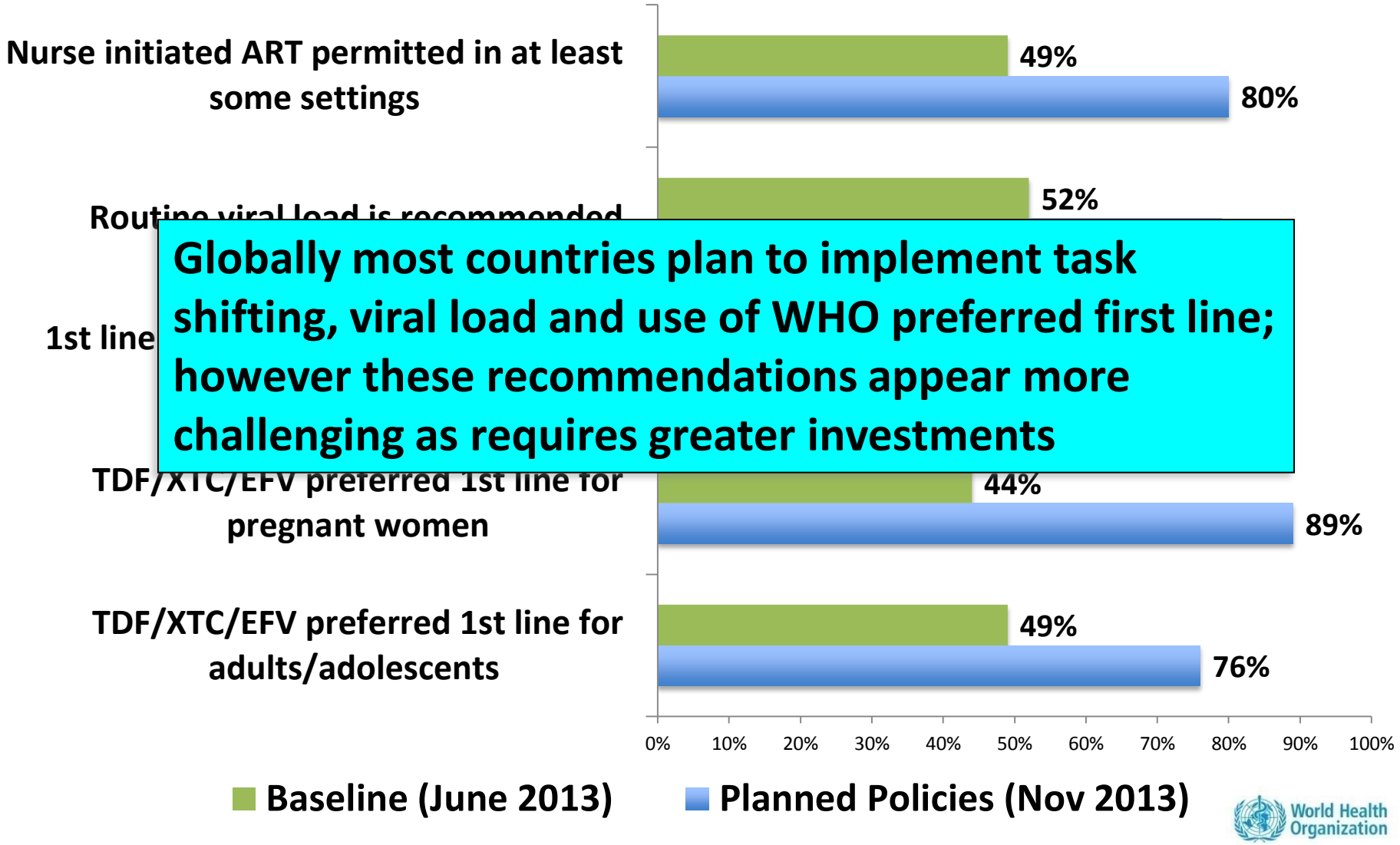
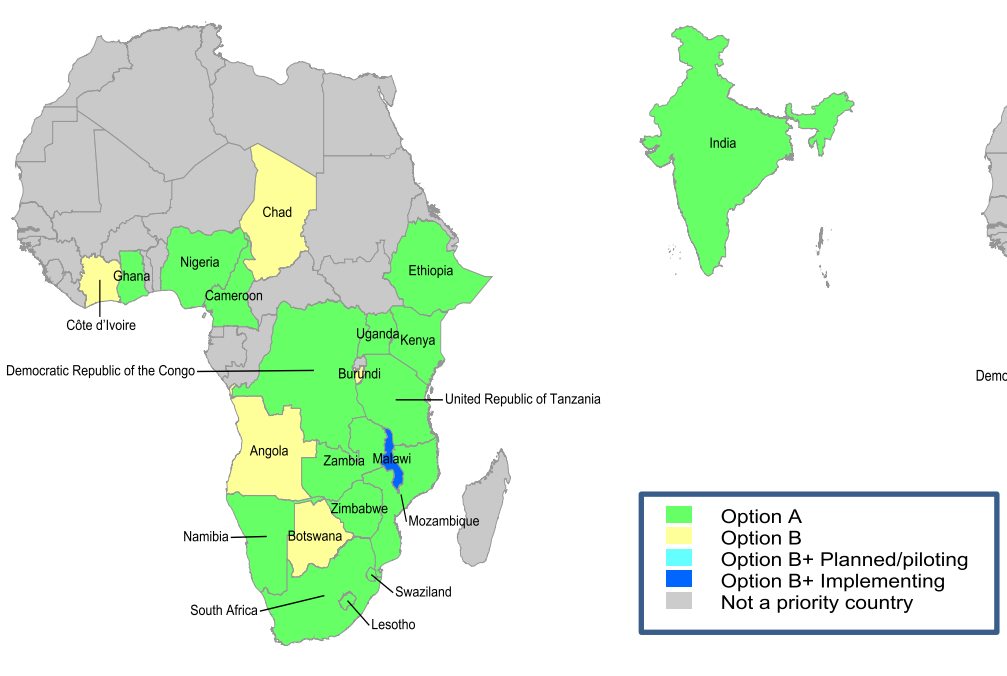
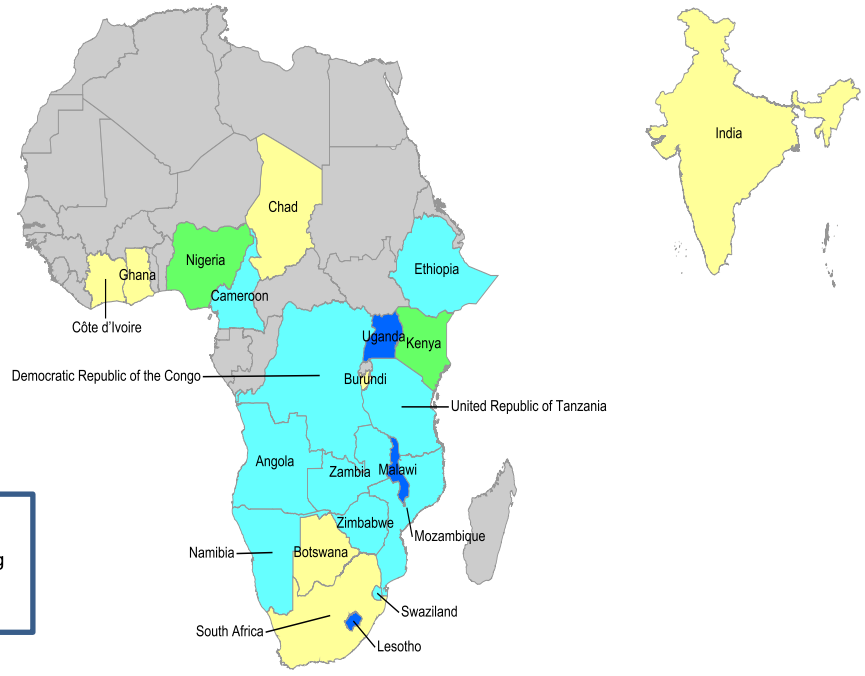


Globally most countries plan to implement task shifting, viral load and use of WHO preferred first line; however these recommendations appear more challenging as requires greater investments

Rapid Change Towards B/B+

Transition in PMTCT Regimens in the 22 Global Plan Priority Countries





After 2010 WHO PMTCT ARV guidelines

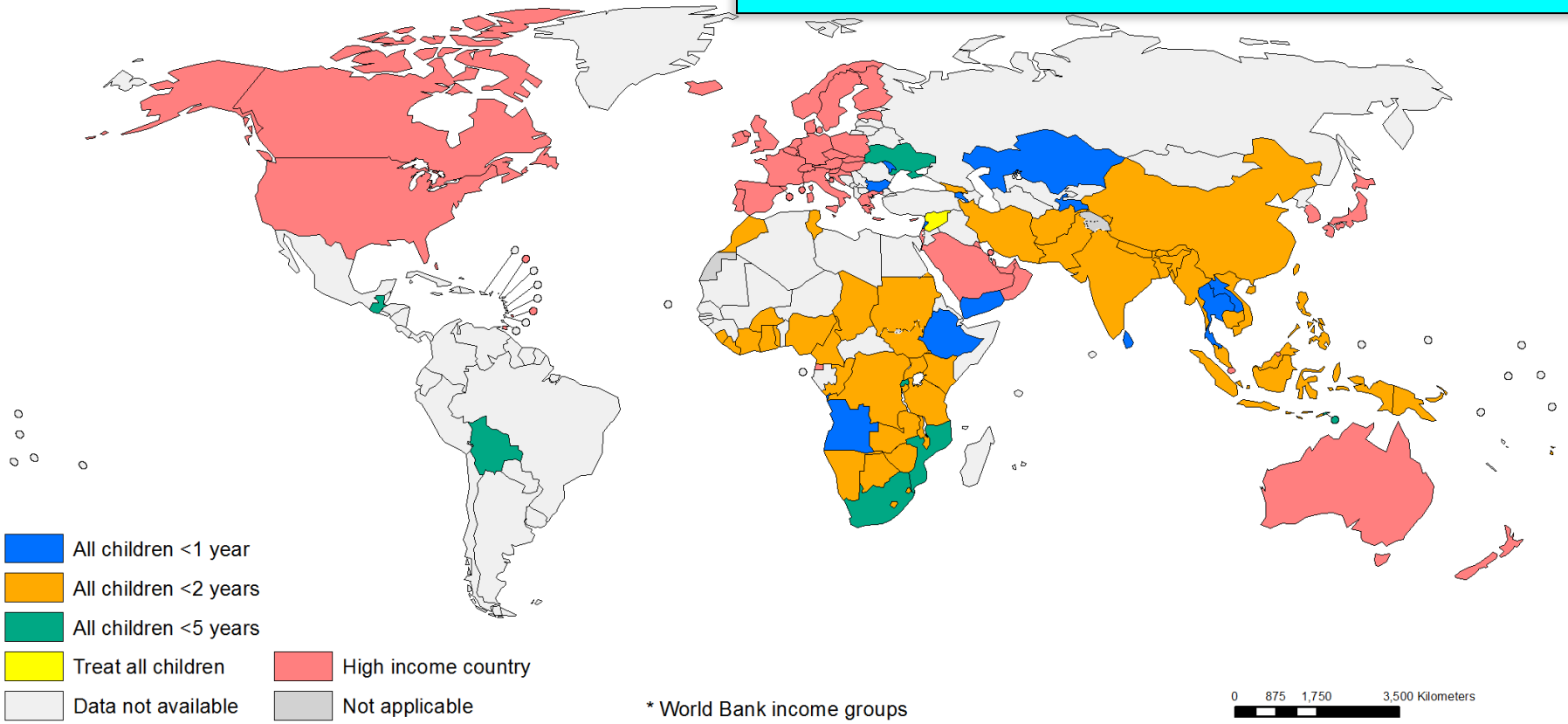
As of June 2013

World Health Organization

HIV TREATMENT

Pediatric Eligibility for ARVs in 2012

Globally most countries implementing WHO recommendations from 2010



Data Source: World Health Organization
Map Production: Health Statistics and Health Information Systems (HSI)
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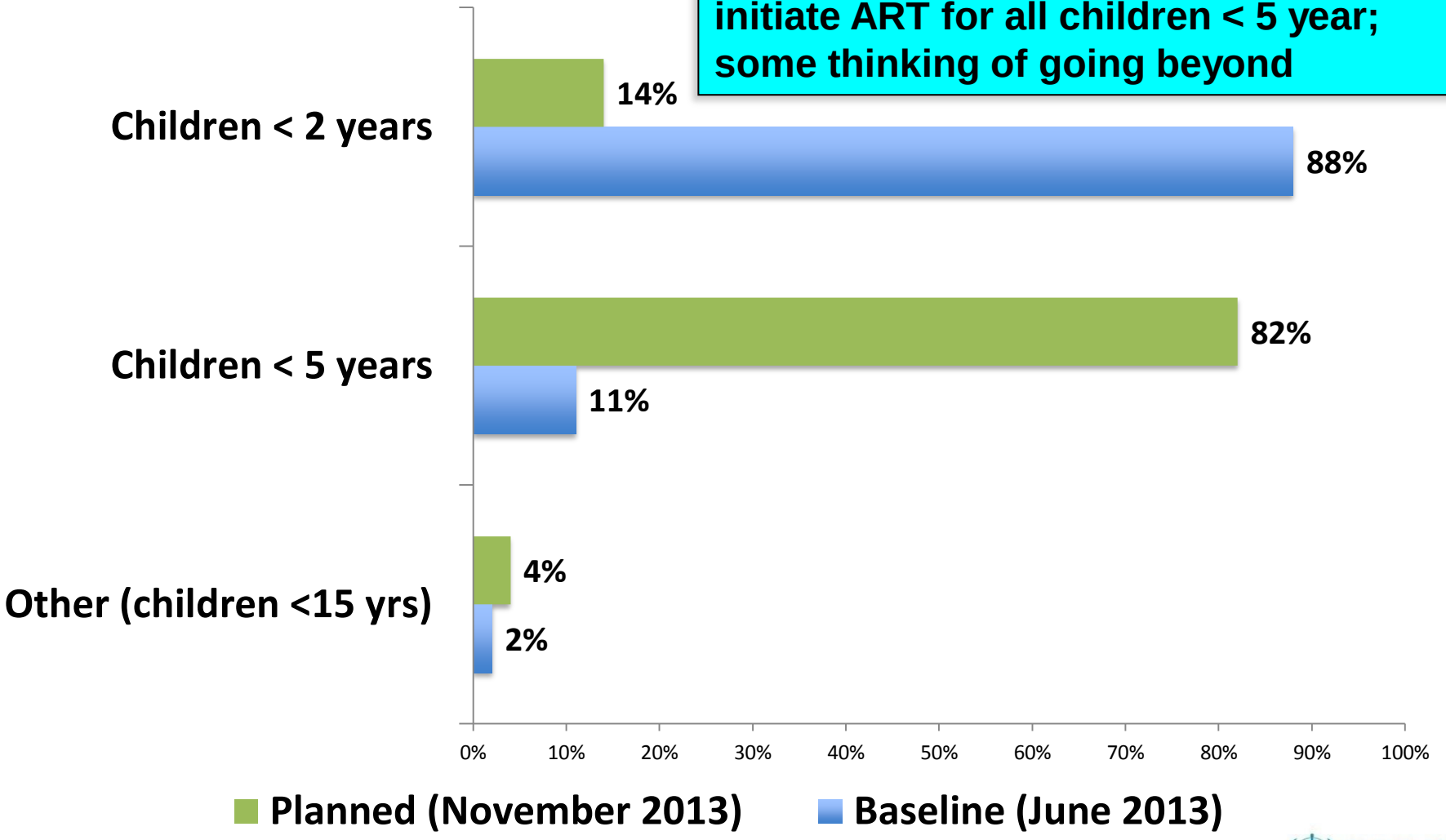
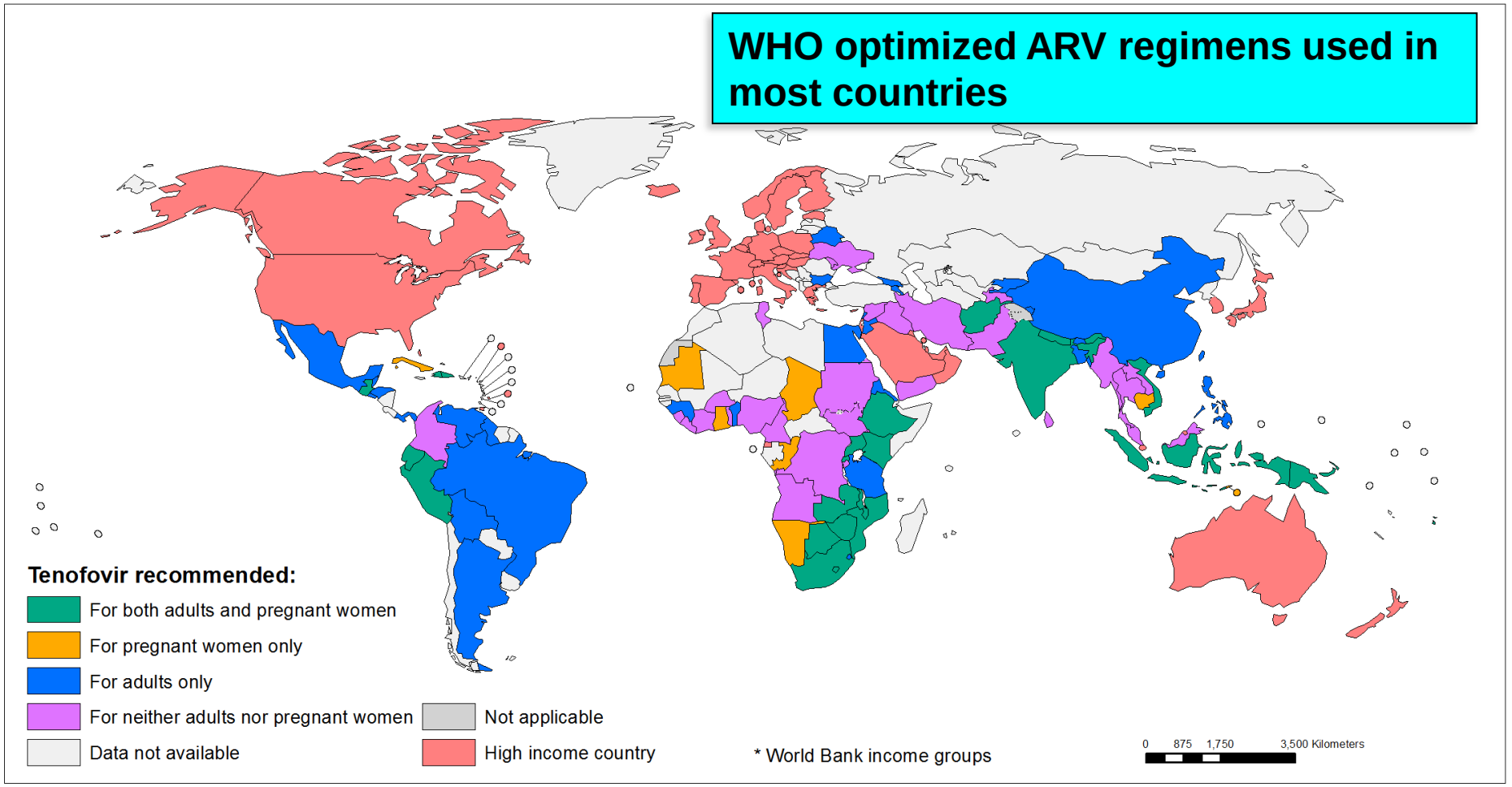
Global Policies on Treatment for Children at any clinical stage or CD4 count 2013

Globally the majority of countries will initiate ART for all children < 5 year; some thinking of going beyond



HIV TREATMENT

Global Trends in recommended WHO ARV regimens, 2012-13



Data Source: World Health Organization
Map Production: Health Statistics and Health Information Systems (HSI)
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ART in the community

IMPLEMENTATION AND OPERATIONAL RESEARCH: CLINICAL SCIENCE

Distribution of Antiretroviral Treatment Through Self-Forming Groups of Patients in Tete Province, Mozambique

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Background: As antiretroviral treatment cohorts continue to expand, ensuring patient retention over time is an increasingly important concern. This, together with capacity and human resource constraints, has led to the consideration of out-of-clinic models for the delivery of antiretroviral therapy (ART). In 2008, Médecins Sans Frontières and the Provincial authorities launched a model of ART distribution and adherence monitoring by community groups in Tete Province, Mozambique.

Programme Approach: Patients who were stable on ART for 6 months were informed about the community ART group model and invited to form groups. Group members had 4 key functions: facilitate monthly ART distribution to other group members in the community, provide adherence and social support, monitor outcomes, and ensure each group member undergoes a clinical consultation at least once every 6 months. Group members visit the health centre on a rotational basis, such that each group member has contact with the health service every 6 months.

Results: Between February 2008 and May 2010, 1384 members were enrolled into 291 groups. Median follow-up time within a group was 12.9 months (IQR 8.5–14.1). During this time, 83 (6%) were transferred out, and of the 1301 patients still in community groups, 1269 (97.5%) were remaining in care, 30 (2%) had died, and 2 (0.2%) were lost to follow-up.

Discussion: The Community ART Group model was initiated by patients to improve access, patient retention, and decongest health services. Early outcomes are highly satisfactory in terms of mortality and retention in care, lending support to such out-of-clinic approaches.

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Key Words: antiretroviral therapy, community engagement, retention, self-management

(*J Acquir Immune Defic Syndr* 2011;56:e39–e44)

INTRODUCTION

The number of people receiving antiretroviral therapy (ART) in low-income countries continues to increase, with an estimated 5 million people on treatment as of July 2010. As treatment cohorts continue to expand and age, the question of how to ensure that patients initiated on ART are supported to remain in care is becoming an increasingly important concern. A recent systematic review of programs in sub-Saharan Africa reported that on average almost a third of patients were lost to follow-up (LTFU) within 2 years of being initiated on to ART.[1]

Several studies have indicated that practical challenges—distance to services and transport costs, work responsibilities, and family commitments—are associated with defaulting from care.[2,3] Barriers at the health facility level such as long waiting times, patient experience with the health system, stigma and discrimination, and lack of social support and information for adherence have also been reported as reasons for defaulting.[1] Thus, ensuring that ART services are accessible as close as possible to the community is an important way to improve access to and retention in care.[4–6]

ART is a lifelong therapy, and the number of patients entering treatment continues to increase, leading to concern that conventional health systems will become increasingly overwhelmed. The limited health workforce in high HIV prevalence settings together with the need to provide ART at the community level has led to consideration of out-of-clinic models of care that would engage patients in essential tasks including ART distribution and peer support for adherence and social support.[7]

Mozambique faces many problems common to high HIV burden countries in southern Africa. The government began providing ART in 2003, but the dire lack of human resources and infrastructure for heath care provision has limited coverage: in 2007, it was estimated that only around one third of people in need of ART were receiving treatment,[8] whereas overall, only around half of the population have access to an acceptable level of health care.[9] Access to and

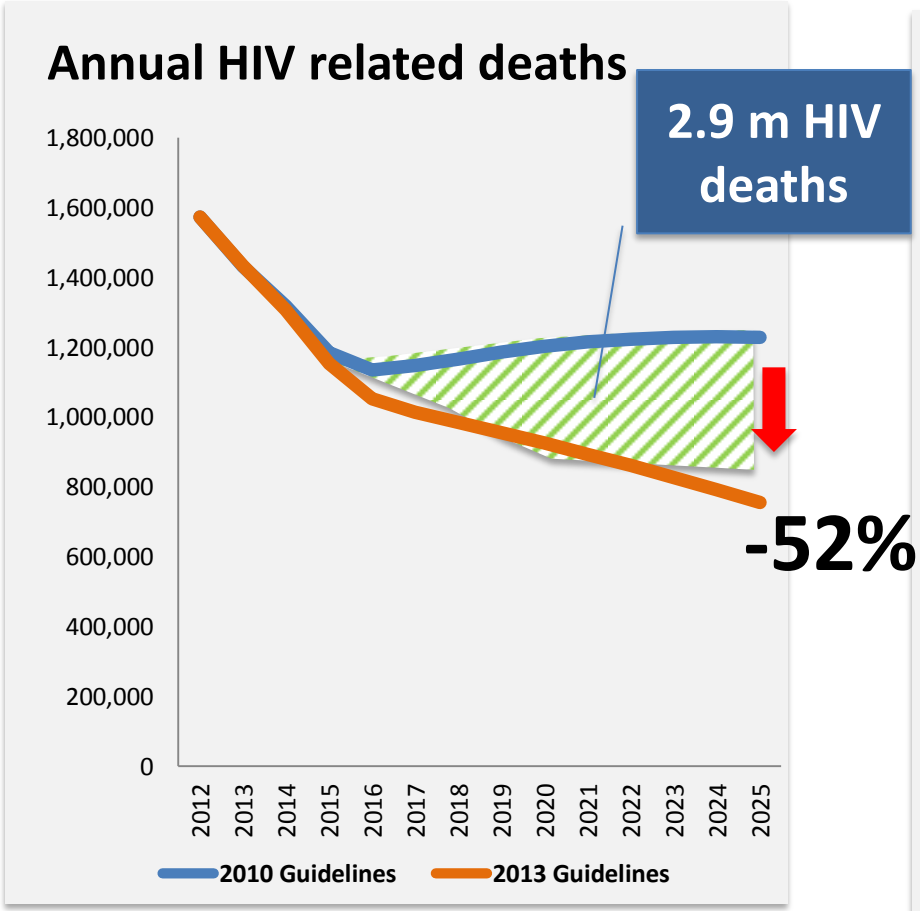
Mozambique

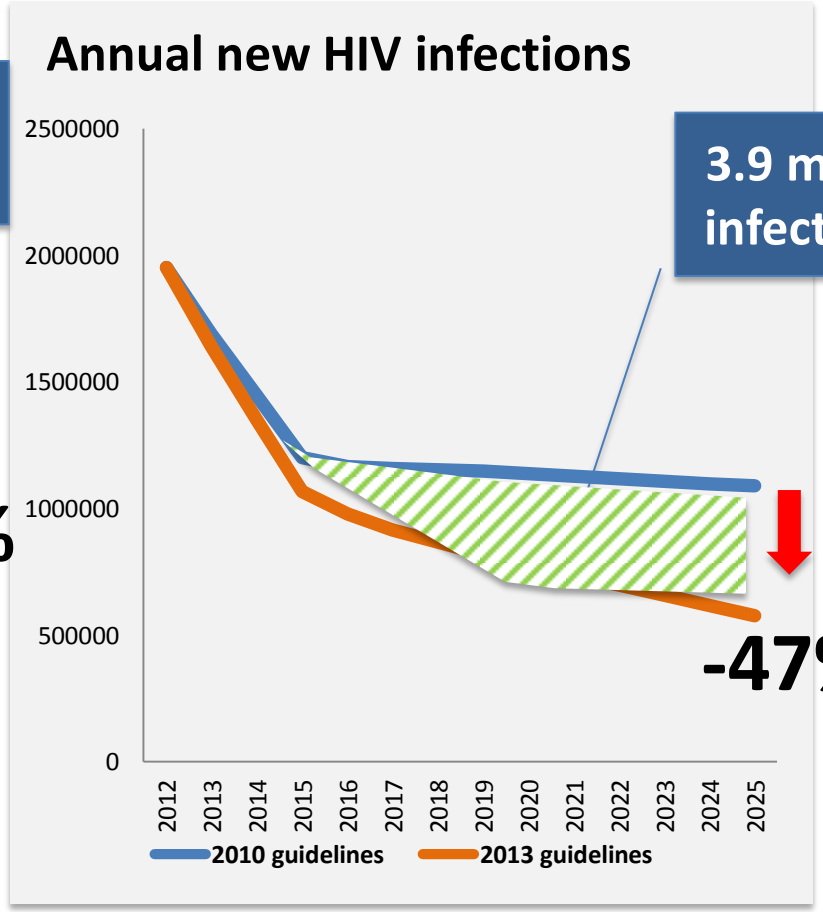
- **8000+ patients in community care (Sept 2013)**
- **95% vs. 75% adherence at 20 months**

Community ART delivery being piloted in South Africa, Uganda, Zimbabwe, Mozambique, DRC

WHO consultation, Cape Town 6-7 December 2013

2013 Consolidated Guidelines impact on mortality and incidence





Source: Special analysis conducted by Futures Institute, 2013

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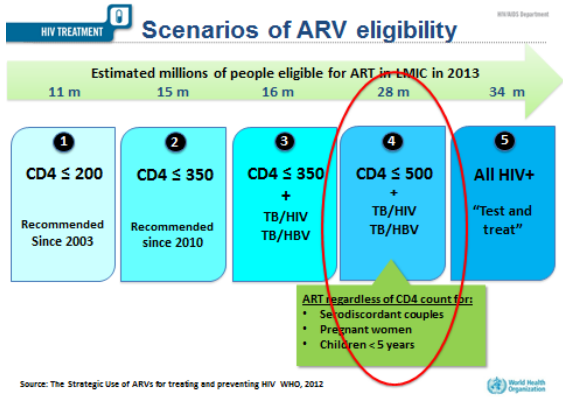
Strategic Use of ARVs for Treatment and Prevention



Priorities for 2014/2015:

- **Movement towards scenario five**

- **SUFA 3 Consultation**
  - Gaps in the current guidelines & how to fill from traditional and Implementation Science Research
  - Roadmap of guideline products

- **Setting the stage for the post-2015 era**

- **New areas to consider**
  - Cure; linkage to other outcomes & comorbidities (Hepatitis, NCDs)

Find the New 2013 WHO Consolidated ARV Guidelines on http://www.who.int/hiv/pub/guidelines/arv2013/en/index.html

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HIV/AIDS

Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection

Recommendations for a public health approach

June 2013

The 2013 *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection* provide new guidance on the diagnosis of human immunodeficiency virus (HIV) infection, the care of people living with HIV and the use of antiretroviral (ARV) drugs for treating and preventing HIV infection.

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For media

- News release: WHO issues new HIV recommendations calling for earlier treatment
- "15 facts" – key facts and figures
- Set of infographics
- Summary of key features and recommendations in En, Fr, Sp, Ar, Ch, Ru

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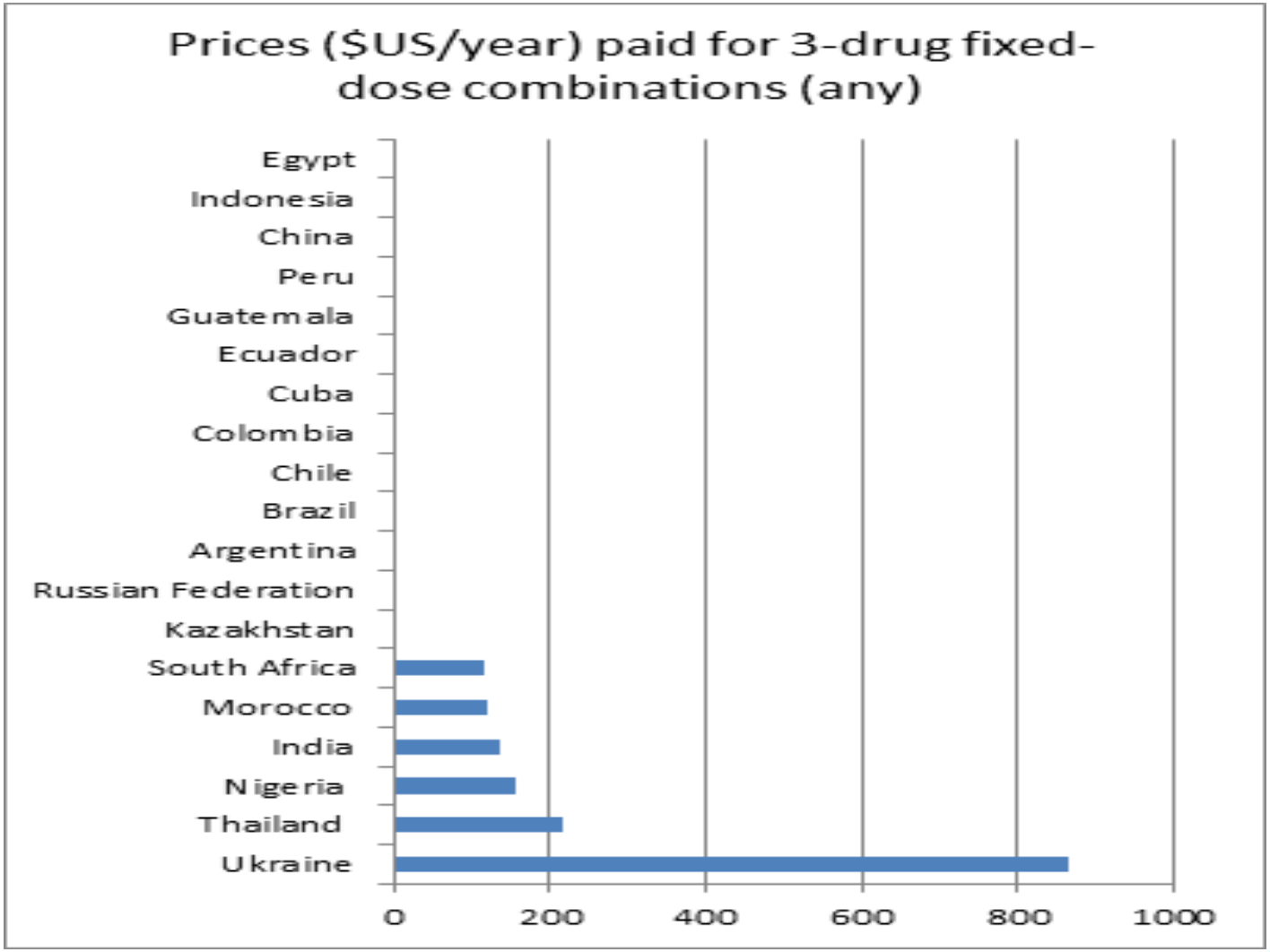
Extra Slides

Prices paid for 3 Drug fixed Dose Combinations



Trends in global market of specific ARVs