Leadership in Action: Case Studies in Implementing HIV Treatment for All

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WHO, Geneva
13 Oct 2016
WHO 2016-2021 HIV strategy and guidelines support reaching 90-90-90

- 90% tested
- 90% treated
- 90% suppressed

- 57% (53–62%) of people living with HIV who know their HIV status
- 46% (43–50%) of people living with HIV who are on antiretroviral
- 38% (35–41%) of people living with HIV who are virally suppressed
The first 90: Reaching the undiagnosed

Current emphasis

- **Increased focus** and strategic choices (focus on men, KPs and community testing)
- **New approaches** (lay providers, test for triage, self-testing and assisted partner notification)
- **Improving quality**, preventing misdiagnosis (QA, re-testing before ART initiation)

New developments

- **WHO HIV self-testing and assisted partner testing guidelines** - launched for WAD
- Working with pre-qual and GFATM to support RTD for HIVST
- **Support to countries** to improve positivity rate, linkage, quality and uptake of new methods
HIV self-testing (HIVST) in Africa (STAR) Project
The largest HIVST programme (UNITAID funded)
Supporting countries to address knowledge gaps by large scale implementation projects

Where:
High HIV prevalence locations

Where:
Zambia

Where:
Malawi

Where:
Zimbabwe

Where:
Phase II South Africa.. others

The Consortium

psi
World Health Organization
London School of Hygiene & Tropical Medicine
LSTM
UCL

Funded by
UNITAID

Populations to be Reached
• M & F, >16yrs (esp Men)
• Rural, peri-urban & urban
• Undiagnosed, 1st time testers

Populations to be Reached
• Pops at increased HIV risk
• Key populations
• VMMC clients

Population to be Reached

• Increase access: 2.7 million self-tests kits distributed (750,000 in phase I)
• Increase informed demand
• Reduce structural, policy & regulatory barriers
• Different distribution models explored
The second 90: Treat All with better drugs

Current emphasis (2016 ARV GL)
- Treat all at any CD4 (impact in mortality, morbidity and \textit{transmission})
- Simplification: FDCs, one pill \textsl{per day} preferred 1\textsuperscript{st} line (convenience, adherence, more efficient procurement, lower risk of stock outs and resistance)
- Phased introduction of new drugs and formulations (new drug class, optimized dosing and formulations)

Existing gaps and new developments
- Long term implications of earlier ART initiation (adherence, retention, HIVDR)
- Safety/efficacy DTG among pregnant women \& TB (studies ongoing)
- Role of emerging ARVs (TAF, long acting ARVs)
- Same day start and streamlined care
Movement to ‘Treat All’ is happening
Policy uptake for adults and adolescents, July 2016
• Implementation is just getting underway and the majority of countries have not yet fully put the policy into practice for Treat All
## Building country capacity for “Treat all”

### 7 Joint WHO Guidelines Dissemination Meetings in 2016

(110 countries)

<table>
<thead>
<tr>
<th>Locations / Date</th>
<th>Regions</th>
<th>N=649</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trinidad and Tobago, March 2016</td>
<td>PAHO; NAP</td>
<td>120</td>
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<td>Colombia, April 2016</td>
<td>PAHO; NAP</td>
<td>52</td>
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<td>South Africa, May 2016</td>
<td>Anglophone AFR/EMR</td>
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<td>Cameroon, June 2016</td>
<td>Francophone AFR/EMR</td>
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<td>Mozambique, June 2016</td>
<td>Lusophone AFR</td>
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<tr>
<td>Thailand, August 2016</td>
<td>SEAR/WPR/EMR/Rwanda</td>
<td>130</td>
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<tr>
<td>Belarus, September 2016</td>
<td>EECA</td>
<td>80</td>
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</table>
Implementing Treat All in Mozambique

- **Phased approach:**
  - Aug 2016 – Dec 2017: 29 districts (57% of PLHIV currently in care)
  - Jan 2018: All country
  - Periodic M&E

- **New protocols on testing, care and treatment and monitoring**

- **Major focus:** retention improvement, simplified care models, health system integration, new testing strategies and ↑domestic financing
TDF/XTC/EFV adopted widely, July 2016

TDF/3TC (FTC)/EFV is the preferred first-line ARV combination for treatment initiation among adults and adolescents in national guidelines in low- and middle-income and Fast-Track countries (situation as of July 2016)

- 90% of LMIC adopted TDF + 3TC (or FTC) + EFV as the preferred first-line therapy
Botswana: New opportunities with INSTIs

• June 2016: Botswana announced a tender agreement with originator (first country in SSA to adopt DTG in 1st line)
• Target to treat 100,000 patients.
• New National ART guidelines already updated with this new policy
Brazil: New opportunities with INSTIs

Medicine dolutegravir is new option for patients with HIV in Brazil
Option is for new patients and for those who have resistance to other drugs.
Ministry managed 70.5% discount on the purchase of dolutegravir.

- Adopted ‘Treat all’ in 2013
- September 2016: announced a negotiated 70% price reduction of DTG,
- 100,000 PLHIV on DTG by end 2017
- National ART protocols under review
“Treat All” is happening for children and adolescents

BUT WE STILL NEED TO DIAGNOSE SOONER AND TREAT BETTER
“Option B+” has been one of the most widely adopted WHO HIV recommendations.

Overall, 88% of 144 LMICs have adopted the Option B+ approach to provide lifelong ART to pregnant and breastfeeding women.
As result of this high uptake, globally 70% of all pregnant women with HIV were on ART by end 2015

Estimated number of PW living with HIV receiving ARVs for PMTCT, by regimen, global, 2000-2015

- Option B+ (ART)
- Option B (triple prophylaxis)
- Option A
- Dual ARVs
- Single-dose nevirapine
- Pregnant women not receiving ARVs for PMTCT
And an estimated 1.6 million new infections in children have been averted.

Percentage of PW with HIV receiving most effective PMTCT regimens and new HIV infections in children.
But...we still have unfinished business!

1. ART initiation is high but retention is poor leading to higher MTCT rate peripartum and postpartum

2. Incident HIV infection among HIV negative pregnant and breastfeeding women is an important driver of new infections
The Third 90: low retention rates leading to limited viral suppression

Current emphasis (2016 ARVGL)
- **Differentiated care models** (reduce late presentation, improve retention)
- Less frequent clinic and ARV pick up visits
- Integration with other services to provide people-centered quality care
- Expanded use of **routine VL** to monitor ARV response
- ARV distribution in **community settings** (lay providers)
- Need to better understand reasons for low retention in different settings
Uptake of Service delivery recommendations, July 2016

- ART in TB clinics
- TB treatment in ART clinics
- ART in MNCH clinics
- ART in OST settings
- ART in PHC settings
- CHW providing ART and support
- ART in the community - differentiated care model
- CVD screening and management by ART providers
- MH screening and treatment by ART providers
- Other
Viral Load Challenges: policy into practice

Routine viral load is fully implemented in 47% of LMIC and partially implemented in 26% of LMIC.
Viral load scale up in SSA

VL Scale Up

1. Well-established VL program
   Scaling-up to improve access
   - Botswana
   - Kenya
   - South Africa
   - Namibia

2. Piloting or with recently rolled out VL program
   Secured funding and have initiated testing
   - Malawi
   - Rwanda
   - Swaziland
   - Tanzania
   - Uganda
   - Lesotho

3. Feasibility analysis and launch planning
   Assessment, costing, and TWGs in development
   - Zimbabwe
   - Ethiopia
   - Nigeria
   - Senegal
   - Zambia
   - Cote d’Ivoire
   - Cameroon
   - Sierra Leone

4. In consideration
   Reviewing scope and reasoning for public scale-up
   - Mozambique
   - Mali

CHAI, 2016
2015 Viral load volumes
HIVDR – a little known but growing threat
Recent signals of high levels of resistance

Update on HIVDR in ARV-Naïve in LMIC, by year of specimen collection (2010-2015)

The diagram shows the prevalence of HIV Drug Resistance (HIVDR) over different years and drug classes. The prevalence is higher for NNRTI in both 2010-2011 and 2012-2015 compared to NRTI and PI.
# Examples of country leadership in HIVDR response

<table>
<thead>
<tr>
<th>Country</th>
<th>Data for action</th>
<th>Response</th>
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<tbody>
<tr>
<td>Argentina</td>
<td>2015 HIVDR survey showed 14% resistance in ART starters</td>
<td>Ongoing policy discussion by national HIV programme on introducing HIVDR testing before ART start</td>
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</table>
| Botswana | HIVDR surveys in Gaborone showed increased HIVDR: - from 2.9% (2012) to 9.7% (2014) | Based on consideration of HIVDR levels among other factors (cost, programmatic, drug profile etc.) 1st line standard ART regimen changed:  
NNRTI+ 2 NRTIs ➔ Dolutegravir + 2 NRTIs |
| Zimbabwe | HIVDR survey in ART naive infants<18 months:  
- 23% NNRTI resistance (no PMTCT exposure)  
- 50% NNRTI resistance (PMTCT-exposed)  
EWI surveys (2006-2014):  
- Suboptimal retention  
- High LTFU  
- Suboptimal quality of programmatic data | Paediatric ART first line regimen changed from:  
Standard NNRTI containing regimen ➔ PI containing regimen  
- Defaulter tracing at clinics introduced to improve linkage into care  
- Strengthened use of patient referral forms during decentralisation  
- Data quality committees established to ensure records maintained properly and data integrity |
Global increase of LTFU over time 2004-2012
(WHO EWI report, 2016)

11.9%
24%
.6%
South Africa – early review of PrEP for Sex workers programme

PrEP programme for SW
- March 2016 - PrEP for SW announced
- June 1\textsuperscript{st} - PrEP implementation started in 11 sites
- August - review of 7 sites

Early review
- Nurse led service effective & acceptable
- Peer workers important for demand creation & support
- Adherence issues – local & individual solutions
- Now to consider other sites & next group/s for PrEP
Leadership in Action

• Rapid adoption of TREAT ALL and related policies and scale-up plans

• Several countries embracing innovation (new drugs, HIVST, PrEP..)

• Greater granularity of data and geographically and pop-focused response (COP!)

• eMTCT a success “story”, even though unfinished
..yet, some important areas that require greater focus

- Need to optimize testing ("reach the undiagnosed")
- Better understand and address poor retention; and Viral load scale-up
- Differentiated care accepted as concept, yet needs implementation
- Ensure CHW cadres empowered, trained and paid
- Need greater attention to HIVDR and programme quality
- Key populations continue to fall through the cracks overall, and also (young) men in SSA
CONSOLIDATED GUIDELINES ON THE USE OF ANTIRETROVIRAL DRUGS FOR TREATING AND PREVENTING HIV INFECTION

WHAT'S NEW

NOVEMBER 2015

Acknowledgements

• Meg Doherty
• Marco Vitoria
• Rachel Baggaley
• Martina Penazzato
• Shaffiq Essajee
• Silvia Bertagnolio
• Michel Beusenberg
• Theresa Babovic
• Florence
HIV drug resistance in ART initiators in LMIC (2010-2015) update

HIVDR in ART initiators in LMIC (2010-2015) update

Prevalence of HIVDR

0% 5% 10% 15% 20%

NRTI NNRTI PI

2010-2011 2012-2015
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<tr>
<th>Areas of action</th>
<th>ARM</th>
<th>AZE</th>
<th>BEL</th>
<th>GEO</th>
<th>KAZ</th>
<th>KVR</th>
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<td>HIV care and prevention in key populations (including migrants)</td>
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<td>Differentiated care &amp; decentralization of services</td>
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<td>ePMTCT &amp; congenital syphilis (validation)</td>
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<td>HBV treatment (NRTIs) and prevention (vaccine)</td>
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<td>Viral hepatitis surveillance</td>
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- **Green**: To be implemented until 2017
- **Yellow**: To be implemented until 2018
- **Red**: To be implemented in 2019/2020

EECA meeting, Preliminary data