



# Bi-directional Lessons Learned Along the HIV Treatment Cascade Between the Ryan White HIV/AIDS Program and President's Emergency Plan for AIDS Relief Programs

## White Paper

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# 1. Introduction

The Health Resources and Services Administration (HRSA) HIV/AIDS Bureau (HAB) contracted Abt Associates (Abt) in September 2018 to explore potential areas for bi-directional sharing between the Ryan White HIV/AIDS Program (RWHAP) and the President’s Emergency Plan for AIDS Relief (PEPFAR). The RWHAP operates domestically, while PEPFAR operates internationally. Both programs have bent the trajectory of the HIV epidemic in unprecedented ways, enabling millions of people with HIV to lead longer, healthier, and more productive lives. Under this contract, the Bi-directional Lessons Learned project, Abt implemented a multi-modal approach to develop an understanding of best practices and lessons learned from both domestic and international HRSA-funded HIV initiatives.

**The global AIDS response is at a precarious point—partial success in saving lives and stopping new HIV infections is giving way to complacency.**

—UNAIDS Executive Director  
Michel Sidibé, July 2018

This project emerged alongside bold federal plans calling for rapid and emerging approaches to end the HIV epidemic within the United States and globally: the National HIV/AIDS Strategy and the recently released “Ending the HIV Epidemic: A Plan for America.” HRSA aligned with these plans by reinforcing its commitment to achieving the four goals: 1) Reducing new HIV infections; 2) Improving access to care and health outcomes; 3) Reducing HIV-related health disparities; and 4) Achieving a more coordinated national response.<sup>i,ii</sup> The

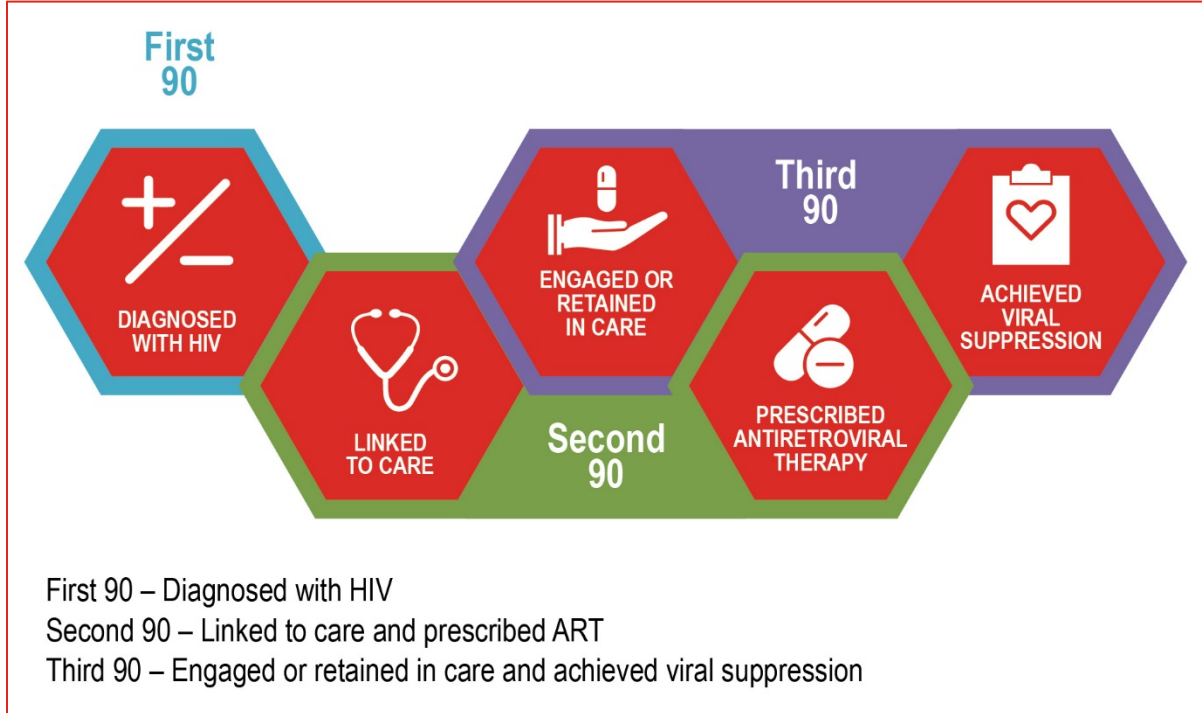
government released the Ending the HIV Epidemic plan in early 2019 for launch in fiscal year 2020. The plan seeks to reduce the number of new HIV infections in the United States by 75 percent within five years, and then by 90 percent (to fewer than 3,000 new infections per year) within 10 years. Reducing new infections to this level means that HIV transmissions would be rare and meet the definition of ending the epidemic. The initiative will focus efforts in 48 counties plus Washington, DC; San Juan, Puerto Rico; areas identified as having extremely high rates of new HIV infections in 2016 and 2017, as well as seven states with a substantial HIV burden in rural areas.<sup>ii</sup>

**We have a once-in-a-generation opportunity to end the HIV epidemic in the United States. Now is the time.**

—Ending the HIV Epidemic: A Plan for America,  
February 2019

Similarly, PEPFAR is striving to meet the ambitious but achievable goals in the PEPFAR Strategy for Accelerating HIV/AIDS Epidemic Control, 2017-2020 (“Epidemic Control Strategy”).<sup>iii</sup> This strategy sets a bold course for 13 high HIV burden countries that are on pace to control their HIV epidemics by 2020. The Joint United Nations Programme on HIV/AIDS (UNAIDS) Fast-Track Strategy for Ending the Global AIDS Epidemic by 2030 defines epidemic control as having 95 percent of all people with HIV aware of their HIV status; 95 percent of all people with diagnosed HIV infection receiving sustained antiretroviral therapy (ART); and 95 percent of all people receiving ART achieving viral suppression.<sup>iv</sup> The relationship between the stages of the HIV care continuum and the 90-90-90 goals are depicted below.

## Relationship Between Stages of the HIV Care Continuum and 90-90-90



Experts state that the US has the right tools and interventions exist to end the HIV epidemic. This is based on a combination of major scientific breakthroughs and accumulated lessons learned over decades of testing and scaling up HIV interventions. The experts also believe the achievement of these ambitious targets will require targeted and fast-tracked adoption of emerging strategies and evidence-informed interventions. That, in turn, necessitates heightened commitment and coordination from all parties involved, both domestically and abroad.

This white paper describes HRSA HAB's critical role in the HIV field and the ways its contributions can help achieve domestic and international goals for HIV epidemic control. HRSA is in a unique position implementing both RWHAP and PEPFAR programs. This advantage affords HRSA an understanding of the factors and key

components of successful intervention strategies of each program. Both domestic and global programs have documented their emerging strategies and evidence-informed models of care. However, RWHAP and PEPFAR have shared many of the lessons learned and best practices only with their respective audiences. Now we must determine whether they will work in different contexts, geographies and client populations. To move towards the goal of ending the epidemic, RWHAP must consider ways to adapt, implement successful PEPFAR intervention strategies, best practices, and lessons learned, where feasible. Likewise, PEPFAR must adapt, implement and operationalize RWHAP successes in appropriate contexts. If successful adoption of these intervention strategies work, they can reduce new HIV infections and provide high-quality, client-centered HIV care and services both domestically and globally.

HRSA is in a unique position to equip RWHAP and PEPFAR practitioners with tools and resources to execute emerging strategies and evidence-informed interventions. For example, PEPFAR could benefit from decades of learning from the U.S. client-centered approach and comprehensive system of care that RWHAP has implemented. In turn, RWHAP would benefit from PEPFAR’s methods for tracking facility-level data on a monthly (and sometimes weekly) basis to observe positive and negative trends in pushing toward the 90-90-90 goals. The tracking enables PEPFAR implementers to revise programs quickly to improve outcomes. RWHAP providers could benefit from learning about PEPFAR’s use of real-time data for decision-making. The exhibit below shows the areas included in this paper that PEPFAR and RWHAP can share bi-directionally. Some of these lessons draw from the same intervention strategies implemented differently in RWHAP or PEPFAR settings.

### Sharing Lessons Learned Can Improve HIV Care in the United States and Abroad

RWHAP Lessons for PEPFAR	PEPFAR Lessons for RWHAP
<ul style="list-style-type: none"> <li>• Case management</li> <li>• Integration of behavioral health services</li> <li>• Trauma-informed care</li> <li>• Capacity building of local institutions</li> <li>• Use of community health workers in treatment initiation and adherence</li> </ul>	<ul style="list-style-type: none"> <li>• Differentiated service delivery</li> <li>• Sustainability index dashboards</li> <li>• Data use for real-time decision-making</li> <li>• Capacity building of local institutions</li> <li>• Use of community health workers in treatment initiation and adherence</li> <li>• Rapid initiation of treatment</li> </ul>

This paper provides officials at multiple levels of government and other stakeholders information that yields a greater understanding of the possibilities for bi-directional sharing across RWHAP and PEPFAR. In addition, it offers tools and strategies to community practitioners and organizations who deliver care and services. Combining lessons bi-directionally will improve the lives of people with HIV.

## 1.1 Methods

This paper synthesizes information obtained over the course of the Bi-directional Lessons Learned project. In order to gain a comprehensive overview of HAB’s work, Abt conducted the following data-gathering activities:

- December 2018: Design, execution, and reporting from a systematic literature review. Abt reviewed over 490 peer-reviewed, English-language journal articles and gray literature articles published between January 1, 2010, and November 1, 2018, to assess implementation of 18 RWHAP programs and four PEPFAR programs using the Proctor Model of Implementation framework.<sup>v</sup>
- April 2019: Design, facilitation, and reporting from a one-day Stakeholder Workgroup Meeting attended by 35 RWHAP and PEPFAR stakeholders. The purpose of this meeting was to further develop an understanding of HRSA-funded domestic and international initiatives with potential for bi-directional sharing.
- May and June 2019: Design, facilitation, and reporting from three virtual focus groups with stakeholders to further explore specific interventions, experiences, and lessons learned from the Stakeholder Workgroup Meeting for possible inclusion in the white paper.

Abt designed and executed each of these activities with extensive input and review from HRSA HAB project leadership, a project-specific Technical Work Group, and selected RWHAP and PEPFAR expert reviewers. Abt conducted these activities sequentially so that the conclusions from one activity informed the development of the next.

The remainder of this white paper provides several topic areas and recommendations for sharing bi-directionally between RWHAP and PEPFAR. HAB selected these topics as a result of the data-gathering project activities described above. The examples and resources shared in this paper are not exhaustive. The project team's approach to integrating project findings in this paper was purposeful and is not reflective of a meta-analysis. Each section includes a high-level description of the program, populations, and settings that could benefit from the intervention strategy; considerations for implementation; and resources where more information may be found. The end of this paper includes recommendations for HRSA HAB leadership.

## 2. Areas for Sharing RWHAP Lessons with PEPFAR

RWHAP provides HIV care to more than half of all people with HIV in the United States. Most clients are racial/ethnic and sexual minorities who live below the federal poverty level. The RWHAP is organized to fill gaps in core medical and support services by supporting providers at all levels of the healthcare system, including federal, state, municipal, and community-based agencies. The focus of the current federal administration is on improving the U.S. system of HIV care to reflect changes in the HIV epidemic and incorporate new technologies related to the prevention and treatment of HIV. This section presents select RWHAP intervention strategies from which PEPFAR could potentially benefit.

### Features of RWHAP's Models of Care:

- Availability of core medical and support services
- Accessible services in terms of location, public transportation, and hours
- Appropriate services for diverse populations of people with HIV based on characteristics such as race/ethnicity, sexual orientation, gender/gender identity, age, and risk factors
- Provider staff speak needed languages, are culturally competent, and have appropriate training and skills
- Services provided in accordance to HHS Clinical Guidelines for the Treatment of HIV/AIDS and contribute to viral suppression and other positive medical outcomes

## 2.1 Medical and Non-medical Case Management

**Description:** Case management is a service category designed to link clients to medical and supportive services. It has various models, but its core components include supporting client engagement and identifying and eliminating barriers to HIV care.<sup>vi</sup> The RWHAP defines medical case management (MCM) as a core medical service which must be offered to RWHAP clients. MCM includes the provision of a range of client-centered services that link clients with healthcare, psychosocial care, and other trained health professionals with the goal of improving clients' health outcomes and adherence to care in alignment with the HIV care continuum.

This work is distinct from non-medical case management, which consists of supportive services with the objective of providing guidance and assistance to clients to improve their access to medical, social, community, legal, financial, and other needed services.<sup>vii</sup> The provision of these services is undergirded by a philosophy of empowering clients so that, eventually, they are educated, empowered, and self-reliant, and no longer need these services. Enhanced case management tailors services for clients with particular needs, such as people with mental health conditions or substance use disorders. Enhanced



case management provides a more intensive level of support to clients in assessing and addressing barriers to care, as well as assistance in accessing needed care, treatment, and services. Project stakeholders who have researched MCM and enhanced case management interventions have identified them as successful intervention strategies to improve HIV outcomes.

**Populations and Settings:** The RWHAP funds both medical and non-medical case management services; these services particularly target key populations. Numerous Special Projects of National Significance (SPNS) initiatives have adapted case management models for RWHAP tailored to address the needs of a number of special populations. These projects are each customized to specific settings and populations experiencing difficulty remaining in HIV care.<sup>viii, ix, x, xi, xii, xiii, xiv</sup> These vulnerable populations may include people with unstable housing or comorbidities such as behavior health diagnoses, and/or a history of trauma. The Medical University of South Carolina Ryan White Clinic conducted an intervention that included MCM, which it found to be a cost-effective strategy for clinics with a large volume of clients who: are at risk of falling out of care, do not have an outreach coordinator, or have had limited success with their current outreach coordination interventions.<sup>xv</sup>

Outside the U.S. RWHAP context, a community-based program with similar components in Ethiopia included stable HIV clients from the community who were trained as peer support workers and partnered with newly diagnosed individuals, providing very intensive, community-based, one-on-one support similar to MCM. Experience from such projects supports the feasibility of using MCM with other client-driven strategies to improve retention in care and viral suppression.

**Considerations for Implementation:** The focus on addressing an individual's specific needs is already a component of global HIV services,

such as differentiated service delivery (DSD). This argues for the adoption of MCM and/or enhanced case management in an international setting. Global health systems that need to sustain large numbers of people in care over a longer period of time may benefit from MCM or enhanced case management approaches. Such approaches could help these actors understand what clients need in order to address their immediate needs and manage their health over an increasingly long lifetime. Stakeholders raised questions about the global implementation and how providers can ascertain from the very beginning who will need additional support and how it can be provided, particularly for clients who have more-challenging situations in a differentiated model. The U.S. healthcare landscape has a smaller public sector and larger private sector compared with the global healthcare context.

**Additional Resources:**

- Target HIV Case Management Resource Library: <https://targethiv.org/library/topics/case-management>

## 2.2 Integration of Behavioral Health Services

**Description:** Addressing and treating behavioral health is important for people with HIV. Behavioral health services are designed to attend to a combination of mental health conditions and/or substance use disorders. Stakeholders identified the complex needs that may arise when a client's behavioral health issues are not fully addressed, such as self-medication and poor health outcomes. Conversely, when individuals' behavioral health needs are comprehensively met, they have an increased ability to advocate for themselves and their care.

People with HIV may face unique challenges, such as HIV-related stigma and discrimination, which contribute to a disproportionate prevalence of behavioral health problems in this population. These may include depression, anxiety,

psychological trauma, and substance use.<sup>xvi,xvii,xviii</sup> Furthermore, people with HIV may be at increased risk of developing mental health conditions as they adjust to their diagnosis and the realities of living with a chronic infectious disease. UNAIDS cites studies from over five continents that have estimated HIV prevalence among people living with severe mental illness from 1.5 percent in Asia and up to 19 percent in Africa.<sup>xix</sup> People with HIV may experience behavioral health issues that negatively affect their quality of life and interfere with seeking care and adhering to treatment.<sup>xix</sup> Studies among 38 countries found that 15 percent of adults and 25 percent of adolescents living with HIV reported depression or feeling overwhelmed, which may be a barrier to ART adherence.<sup>xix</sup>

Globally, HIV infections among people who inject drugs increased from an estimated 1.2 percent in 2011 to 1.4 percent in 2017.<sup>xx</sup> In the United States, the opioid crisis is elevating risks of HIV and other infectious diseases.<sup>xxi</sup>

The Bi-directional Lessons project neither fully explored the behavioral health needs of people with HIV nor the different models of integrating HIV primary care with behavioral health services. Behavioral health needs stemming from trauma and the importance of trauma-informed care for people with HIV were the main topics related to behavioral health that emerged from the Stakeholder Workgroup Meeting and virtual focus groups. These topics are further addressed in section 2.3.

**Populations and Settings:** A few multisite RWHAP projects described in the literature review, including SPNS initiatives, addressed the behavioral health needs of people with HIV. The Minority AIDS Initiative Retention and Re-Engagement in HIV Care Project focused on improved access to resources, housing, and care for racial and ethnic minority communities where the HIV epidemic continues to grow and there is an increased need for mental health and outpatient substance use disorder treatment services. The

service settings integrated HIV primary care, substance use disorder treatment, mental health services, and housing resources to support engagement and retention in care.<sup>xxii</sup> Another SPNS initiative developed medical homes for multiply diagnosed people experiencing homelessness.<sup>xxiii</sup> The project's intervention strategies were tailored to the local context and target populations to improve HIV care engagement and retention among persons who were homeless, unstably housed, and living with co-occurring mental illness and/or substance use disorders. The Primary Care Psychology Program, a primary care behavioral health program, was designed to address the mental health needs of people with HIV in Puerto Rico.<sup>xxiii</sup> The program used co-located services (i.e., psychologists who shared the same physical space but made independent treatment plans) and fully integrated primary care behavioral health services (i.e., services in the same physical space and integrated treatment plans).

**Considerations for Implementation:** There are many potential challenges for healthcare facilities looking to integrate accessible, high-quality behavioral health services into primary care. Many RWHAP clinics have integrated behavioral health into their services by hiring staff such as licensed social workers for counseling and part-time psychiatry professionals for assessment, diagnosis, and dispensing medications. Common barriers include funding, workflow, and workforce shortage issues.

There is a global shortage of behavioral health workers and providers (especially in rural communities and low-resource settings) who can offer low-barrier, culturally-conscious services.<sup>xxiv</sup> Task shifting and digital solutions are viable options to help bridge this gap. Furthermore, cost, language, and cultural stigma can influence a person's ability to seek behavioral health services. Additionally, well-intentioned clinic leadership may experience administrative barriers to



integrating existing, yet siloed, behavioral health services.

Despite these potential challenges, integration of behavioral health services is essential in addressing the barriers faced by people with HIV in linking to and remaining in care. These services should be explored more fully in the contexts where HRSA HAB operates. Providing behavioral health services in settings where people with HIV already seek care could enhance access to these needed services. For example, primary care providers could be trained for screening and treatment of the main mental health and substance use disorders to link people to behavioral health services. In international settings, behavioral health intervention strategies need to be developed and adapted within the cultural contexts where they will be provided. Holistically integrating behavioral health services with primary care is key to supporting improved engagement in HIV care, increasing adherence to ART medication, and ultimately achieving viral suppression.<sup>xxv,xxvi</sup>

### 2.3 Trauma-Informed Care

**Description:** It is well documented that histories of traumatic experiences, including physical and/or sexual abuse and intimate partner violence, are far more prevalent among people with HIV than in the general population. Among people with HIV, experiences of trauma are associated with poor mental health, increased engagement in HIV

#### Five Principles of Trauma-Informed Care

- Safety
- Transparency and Trustworthiness
- Choice
- Collaboration and Mutuality
- Empowerment

high-risk transmission behaviors (i.e., substance use, high-risk sexual activity), poor adherence to HIV care, and earlier onset of opportunistic

infections.<sup>xxvii</sup> Untreated trauma histories can be barriers to linking to and remaining engaged in HIV care.<sup>xxviii,xxix,xxx</sup> Studies show that recent

experience of trauma was the single significant predictor of ART failure.<sup>xxxi</sup>

Trauma-informed care recognizes past trauma and the resulting coping mechanisms when attempting to understand behaviors and treat clients. The foundational philosophy is compassion, guided by an understanding that trauma can render some clients more vulnerable to health conditions while also acting as an obstacle to effective treatment for those conditions. Trauma-informed care involves accurately identifying trauma and related symptoms as part of a path toward healing as well as a commitment to minimizing re-traumatization. It is an organizational-level culture cultivated by leadership and staff to ensure the physical and emotional safety of clients is addressed. Trauma-informed care also seeks to empower clients by emphasizing their strength and resiliency.<sup>xxxi</sup>

**Populations and Settings:** The main approaches to trauma-informed care in HIV service delivery identified by this project originated in RWHAP. For example, sites participating in the SPNS Transgender Women of Color Initiative made extensive effort to provide gender-affirming environments where clients could feel confident in any expression of gender. Trauma-informed care is slowly integrating into PEPFAR services as well, and the use of trauma-informed services was included for the first time in PEPFAR 2019 Country Operational Plan Guidance for all PEPFAR Countries. In RWHAP, a number of multisite programs described in the project literature review, including SPNS initiatives, provided trauma-informed care by targeting services to specific populations: people who are homeless, people who are multiply diagnosed, racial/ethnic minority communities, women of color, and, specifically, transgender women of color.<sup>x</sup> The settings for these RWHAP programs ranged from clinical sites to community-based programs to institutional settings such as jails.

**Considerations for Implementation:** It is important to note that providing trauma-informed care is a continuous process as opposed to a one-time event. It requires a commitment to continuous training. Offering care that is trauma-informed involves educating and producing a cultural shift among healthcare providers, case managers, and ancillary clinic staff in how they interact with clients. It is a relatively low-cost intervention; however, there are numerous barriers to its implementation. Delivering trauma-informed care requires high levels of cultural competency (i.e., the ability to understand, communicate with, and interact with people from various backgrounds in a manner that is respectful and effective). Thus, using peer leadership (i.e., trauma survivors and those in trauma recovery from the communities most impacted) in service delivery models is important. Additionally, the use of trauma-informed care should be complimented by policy reform and civil society involvement with government to eliminate structures and systems that perpetuate trauma among people with HIV, including racism, homophobia, transphobia, classism, and patriarchy.

The impact of implementing trauma-informed services can be difficult to measure. Studies from RWHAP have evaluated the integration of trauma-informed care using measures of stigma, gender affirmation, and other mental health metrics and compared these to retention indicators. However, there are currently no PEPFAR targets or indicators related to mental health or these associated metrics. Currently, PEPFAR is deeply focused on achieving the 90-90-90 goals, meaning it can be challenging to use limited funding for trauma-informed interventions that cannot demonstrate results directly related to HIV outcomes.

#### Additional Resources:

- NACCHO Toolkit: Trauma Informed Approaches to HIV Care: <https://essentialelements.naccho.org/archives/12619>
- Trauma-informed Care at AIDS Service Organizations: <https://www.targethiv.org/library/trauma-informed-care-aids-service-organizations>
- NASTAD Trauma-informed approaches toolkit: [https://www.nastad.org/sites/default/files/resources/docs/nastad\\_traumatoolkit\\_12142018.pdf](https://www.nastad.org/sites/default/files/resources/docs/nastad_traumatoolkit_12142018.pdf)
- Cold Spring Center Toolkit on Trauma-informed Excellence: <http://coldspringcenter.org/trauma-informed-excellence.html>
- PEPFAR 2019 Country Operational Plan Guidance: <https://www.pepfar.gov/documents/organization/288731.pdf>

## 2.4 Capacity Building of Local Institutions

**Description:** Capacity building has been addressed in various forms in both RWHAP and PEPFAR settings and is a topic that provides an opportunity for ongoing potential bi-directional sharing. The project identified different types of capacity building, such as workforce development, professional education and training, coaching and technical assistance, and learning collaboratives, in response to the assessed local capacity needs to improve the quality of life of people with HIV.<sup>v</sup>

**Populations and Settings:** A number of large-scale projects have conducted capacity building in the United States and its territories. The AIDS Education and Training Center (AETC) Program provides training, technical assistance, and capacity-building support for RWHAP recipients and is comprised of multiple programs. The AETC Program offers training using in-person, online, and distanced-based platforms. It targets providers who serve marginalized and resource-poor populations of high HIV prevalence, including individuals who are homeless, incarcerated, adolescent/young adult, transgender, gay/bisexual men, persons living with substance use disorder, and/or migrant persons. The AETCs focus on training diverse groups of clinicians, such as physicians, advanced practice nurses, physician

assistants, nurses, oral health professionals, and pharmacists, as well as other multidisciplinary HIV care team members. Thus, the training of such groups targets providers working in RWHAP and sexually transmitted infections (STI) clinics, hospitals, community-based organizations, health departments, mental health and substance use disorder treatment facilities, and other healthcare facilities.

Learning Collaborative projects have been implemented in RWHAP over several years and in a variety of clinic and service organization populations. These projects offer a framework and group consultation to improve HIV care systems and the provision of HIV care by defining effective, quality management plans and implementation processes to ensure and demonstrate quality of care and services. Through the years, HRSA HAB Technical Assistance Projects have supported capacity building at the jurisdictional and clinical site levels. This TA has included efforts to train and orient community members to the HIV planning process. HAB Project Officers and other staff provide or arrange for needed TA as part of their oversight and monitoring responsibilities.

### **Considerations for Implementation:**

Capacity assessments, such as the Clinical Assessment for Systems Strengthening (CLASS) framework developed by the International Training and Education Center for Health (I-TECH), is a way for organizations to look at governance as well as clinical and administrative operations. Identifying capacities in need of development for quality improvement or scale-up of programs is an important early step in capacity building. Given typically high rates of staff turnover, capacity development should occur at the organizational level. Further, given the reach and volume of training, education, and consultation provided by programs like the regional AETCs, this program would be appropriate for academic institutions or centers

with the ability to provide training, education, or capacity building to support the provision of high quality care. The International AETC (IAETC) may be an opportune structure for facilitating such exchanges.

#### **Additional Resources:**

- AIDS Education and Training Center National Coordinating Resource Center: <https://aidsetc.org/>
- HIVQUAL Workbook: Guide for Quality Improvement in HIV Care: <http://www.ihl.org/resources/Pages/Tools/HIVQUALWorkbookGuideforQualityImprovementinHIVCare.aspx>

## **2.5 Use of Community Health Workers in Treatment Initiation and Adherence**

**Description:** Community Health Workers (CHWs) are frontline public health workers who are trusted community members and/or have a strong understanding of the community they serve.<sup>xxxii</sup> This trusting relationship allows the CHW to serve as a liaison between the client and community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through activities such as outreach, community education, informal counseling, social support, and advocacy.

A Peer is often a non-licensed professional whose qualifications and roles are based on connections with the community they serve.<sup>xxxiii</sup> This may include a person from the community who has HIV. Persons with HIV who work as CHWs are typically referred to as Peers.

CHW and peer interventions have demonstrated positive impacts on linkage and retention for people with HIV as well as positive impacts on clinical care teams. CHWs and Peers often develop trusting relationships with clients in which clients feel comfortable sharing information they would not otherwise share with their clinicians.

Integrating a CHW and/or Peer into a clinical team provides clinicians with additional information and perspective to support them in providing better client-centered care.

CHWs are occasionally referred to as Patient Educators, Outreach Workers, Patient Navigators, Peer Counselors, Health System Navigators, and/or Linkage to Care Coordinators. In the RWHAP context, CHWs and Peers are important members of the healthcare workforce who reduce the burden and stress of large caseloads and enhance traditional RWHAP care teams.<sup>xxxiv</sup>

**Population and Settings:** The Improving Access to Care: Using CHWs to Improve Linkage and Retention in HIV Care is an initiative aimed to provide training, support, and technical assistance to those facilities that wished to integrate CHWs into their care team.<sup>xiv</sup> The implementation guide for this initiative, which is in the final HRSA review process, heavily promotes the use of CHWs in the clinical settings, citing their role versatility and ability to positively impact experiences clients have when seeking HIV treatment.

Two other examples come from projects that focused on using peer interventions. The Minority AIDS Initiative Retention and Re-Engagement in HIV Care Project cited earlier focused on providing increased access to resources, housing, and proper care for racial/ethnic minority communities.<sup>xxiii</sup> The project engaged people with HIV as peers to work with persons with HIV of color who were newly diagnosed, loosely engaged in care, or who had fallen out of care or were at risk of doing that. Demonstration sites also integrated HIV primary care, substance use treatment, mental health services, and housing resources to support engagement and retention in HIV care. The Minority AIDS Initiative Retention and Re-Engagement in HIV Care Project was unique in that it was a randomized controlled trial evaluating the effectiveness of a standardized peer intervention.

Another example came from the Peer Education and Evaluation Resource Center (PEER Center), a centralized training and technical assistance center and three national peer education, training, and capacity building sites.<sup>xxxv</sup> Through Minority AIDS Initiative funding, the PEER Center: (1) provided training and education to peer educators living with HIV; (2) created and implemented train-the-trainer models to replicate successful peer education programs; and (3) built organizational capacity to build or launch a peer education program. The PEER Center provided trainings and technical assistance to over 60 organizations and 800 people with HIV.

**Considerations for Implementation:** The addition of CHWs, including Peers with HIV, supports a multidisciplinary approach to strengthening care teams and enhances the ability to not only identify and engage people with HIV, but also focus on racial and ethnic minorities in a given community to improve linkage and retention in HIV care. In addition, CHWs have been identified as a cost-effective approach for improving client retention in care. Although several barriers have been identified surrounding the use of CHWs—such as restrictive human resource policies, the need for additional training, and the need to include supportive clinical supervision—the overall lessons learned indicate promising potential for use of CHWs in a bi-directional capacity.

Input from project stakeholders further supports CHWs as full members of care teams as a way to ensure that all multidisciplinary team members are accountable for achieving viral suppression.<sup>xxxvi</sup> In the United States, CHW and/or peer staff are typically paid for their work. Globally, CHWs and Peers can help clients achieve viral suppression as well, but they are not necessarily paid staff. Some of the differences between RWHAP and PEPFAR (e.g., paid staff vs. volunteer status) may need to be assessed for feasibility of the different components in global contexts.

#### Additional Resources:

- Using Community Health Workers to Improve Linkage and Retention in Care: <https://targethiv.org/chw>
- Dissemination of Evidence-Informed Interventions initiative: Peer Linkage and Re-Engagement of HIV-Positive Women of Color: <https://nextlevel.targethiv.org/deii/peers>
- The Minority AIDS Initiative Retention and Re-Engagement in HIV Care Project: <https://ciswh.org/project/minority-aids-initiative-retention-and-re-engagement-in-hiv-care-project/>
- Building Blocks to Peer Program Success: Toolkit for Developing HIV Peer Programs <https://www.targethiv.org/library/building-blocks-peer-program-success-toolkit-developing-hiv-peer-programs>

### 3. Areas for Sharing PEPFAR Lessons with RWHAP

PEPFAR is led and managed by the U.S. Department of State's Office of the Global AIDS Coordinator and Health Diplomacy (S/OGAC) and implemented by seven U.S. government departments and agencies. Since its inception in 2003, PEPFAR has expanded and is currently working in over 50 countries. Its most recent strategy, *PEPFAR 3.0*, outlines its approach for reaching sustainable control of the HIV epidemic through transparency, accountability, and impact. This section presents PEPFAR intervention strategies identified for their potential contribution to RWHAP.

#### 3.1 Differentiated Service Delivery

**Description:** DSD, also referred to as differentiated care or differentiated models of care, is a client-centered approach that simplifies and adapts HIV services across the HIV continuum to reflect the preferences and expectations of different groups of people with HIV. This service delivery also reduces unnecessary burdens on the health system, thus allowing the health system to reallocate resources to those most in need.<sup>xxxvii</sup>

Differentiated ART delivery intervention strategies include multi-month ART scripting for stable clients, which is provided in conjunction with clinical care consultation. Another DSD model is the empanelment of clients, which is the process of linking each patient to a primary care clinician and, ideally, to a stable team. Empanelment creates continuity for patients and their clinicians so that the patients do not have to see different providers every time they come in for an appointment, laying the foundation for longitudinal relationships. This method is expected to improve retention and viral suppression.

Differentiated ART delivery intervention strategies can be divided into four categories: (1) healthcare worker-managed group models; (2) client-managed group models; (3) facility-based individual models; and (4) out-of-facility individual models. In all of these models, clients continue to have clinical consultations as part of their package of care. The main consideration when adapting services is the client's needs.

**Populations and Settings:** DSD has been implemented in several countries and with diverse PEPFAR populations.<sup>xxxviii,xxxix,xi</sup> A Jamaican DSD example shared by project stakeholders tested two approaches. The "Rapid Pathway" for virally suppressed clients aims to fast-track services to allow clients to have fewer clinic appointments and standardized follow-ups. Targeted interventions for virally unsuppressed clients include services such as case review, extended clinic hours, intensive case management and enhanced adherence support. By monitoring clients' viral load, the providers were able to understand why they were not achieving suppression and provide the support needed to make sure clients achieve suppression. This approach of linking clients to providers and systematically empaneling them to one provider was adapted from RWHAP.



**Considerations for Implementation:** The main feature of DSD—adapting services to meet clients’ needs—is similar to client-centered approaches being used in U.S. care and service settings. Despite this similarity, bi-directional sharing among U.S. and Ugandan providers revealed there is not always a clear understanding of what DSD should be, suggesting an opportunity for bi-directional sharing to better understand the DSD approach to client-centered services.<sup>xxxvi</sup> The emphasis on DSD being tailored to drug delivery approaches is a unique approach in PEPFAR settings to overcome barriers to ART retention such as wait times in clinics. In PEPFAR, analyzing disaggregated data can identify populations to engage using DSD. Further, DSD is important to address the needs of the individuals outside of managing HIV with ART.

For example, RWHAP providers who are addressing clinic wait times as barriers to care and ART adherence may benefit from DSD approaches. Where overlaps exist in RWHAP and PEPFAR client-centered approaches, sharing across intervention strategies may yield new and emerging refinements to meeting clients’ needs related to HIV as well as other needs.

**Additional Resources:**

- Differentiated Service Delivery: <http://www.differentiatedcare.org/about>
- IHIP: Integrating HIV Innovative Practices: <https://targethiv.org/ihip>
- PEPFAR Solutions Platform (Beta): <https://www.pepfarsolutions.org/>  
<https://www.pepfarsolutions.org/solutions/2018/11/6/enhanced-monitoring-and-management-of-hiv-infected-individuals-on-antiretroviral-treatment-with-high-viral-load-through-establishment-of-viremia-clinics>

### 3.2 Sustainability Index Dashboard

**Description:** The Sustainability Index Dashboard (SID) is a robust tool used to assess the current state of sustainability of national HIV/AIDS

responses across 15 critical elements based on 90 questions. Each of the 15 elements has a composite score displayed on a color-coded dashboard together with contextual charts and information. SIDs are an important routine monitoring tool and provide critical inputs to the annual development of PEPFAR Country and Regional Operational Plans. PEPFAR teams, partners, and stakeholders work together to contribute to SID completion. Monitoring the SID indicators over time allows stakeholders to track progress and gaps across these key components of sustainability.

**For PEPFAR, sustainability of the HIV response means a country has the enabling environment, services, systems, and resources required to effectively and efficiently control the HIV and AIDS epidemic.**

—PEPFAR Position Paper on Sustainable HIV Epidemic Control, November 2016

**Populations and Settings:** The SID is an above-site tool used by program administrators, and thus can be used in a variety of contexts. “Above-site” means this is a tool not directly related to on-the-ground service delivery, but instead one that should be used under the auspices of health systems strengthening. It is most effective when implemented routinely and with input from program stakeholders who can provide perspective on the sustainability of the program from various vantage points.

**Considerations for Implementation:** It is important to note that SID describes only the end point, not the steps on the path to programmatic sustainability. The tool is used to chart progress and consider sustainability using a systems approach; it is not designed to be decisional or dictate investment.<sup>xli</sup> HAB should consider sharing and adapting the SID with RWHAP stakeholders. During the Stakeholder Workgroup Meeting, a participant shared that I-TECH had cross-walked some of their programs with the SID



and suggested that the tool could be modified for domestic use.

**Additional Resources:**

- Country- and Regional-Level SIDS: <https://www.pepfar.gov/countries/cop/sids/index.htm>
- PEPFAR Position Paper on Sustainable HIV Epidemic Control: <https://www.pepfar.gov/documents/organization/264884.pdf>

### 3.3 Data Use for Real-Time Decision-Making

**Description:** In April 2018, PEPFAR reached a transparency milestone by publicly releasing program results and implementing partner performance data for more than 40,000 PEPFAR-supported facilities spanning all of its 35 country and regional programs.<sup>xliii</sup> This site-level data enables ministries of health, academic institutions, civil society organizations (CSOs), private sector partners, and the public to conduct new and emerging analyses, strengthening program accountability and accelerating progress toward achieving epidemic control. For certain under-performing sites, PEPFAR analyzes data weekly and actively monitors and reviews progress on sites to reach the 90-90-90 goals.

**PEPFAR remains deeply committed to using the best available data to drive program performance and ensure the maximum impact of U.S. taxpayer resources.**

-- Ambassador Deborah L. Birx, M.D., U.S. Global AIDS Coordinator and Special Representative for Global Health Diplomacy

**Populations and Settings:** Sites review their data on a weekly basis and participate in PEPFAR Oversight and Accountability Review Team (POART) calls, which occur quarterly for each PEPFAR-supported country or region.

**Considerations for Implementation:** Programmatic data should be accessible to all users, from top-level leaders to end users (i.e.,

district health officer or facility administrator). There should also be an emphasis on using data available for decision-making use at all levels. For example, under the AIDSRelief Project, facilities had electronic medical record data at the facility level so they could provide linkages to query the data and run simple reports. Leadership could then start encouraging the facility-level staff that it was *their* data and available for *their* needs. The staff were accustomed to requirements to report someone else's data in someone else's format, but instead needed to switch their mentality to one of ownership—both of the data and of their corresponding use of it.<sup>xxxvi</sup>

Additionally, HAB should consider creating a forum by which PEPFAR practitioners can share with the RWHAP community how they use data to set programmatic targets. In the current context of the Ending the HIV Epidemic: A Plan for America, HAB is exploring how to create indicators, update data collection procedures, and create a culture of data-driving decision making and the use of data for quality improvement purposes at regular intervals. Through this process, HAB should consider ways to foster learning opportunities from both successful and failed PEPFAR experiences. Some of the PEPFAR stakeholders mentioned the desire to further examine interventions that were not successful to try to better understand why they were not.<sup>xxxvi</sup> This is a missed learning opportunity across countries and a missed opportunity to provide TA to unsuccessful interventions that could potentially turn them into successful ones.

**Additional Resources:**

- DATIM Database: <https://www.datim.org/>

### 3.4 Capacity Building of Local Institutions

**Description:** As described in section two, capacity building has been addressed in various

forms in PEPFAR and RWHAP settings. Globally, capacity building has already demonstrated bi-directional sharing and continues to do so. A number of projects, including the IAETC and the HIV/AIDS International Twinning Center Program (Twinning) have provided numerous capacity-building activities in multiple countries. Twinning emphasizes professional exchanges and mentoring for the effective sharing of information, knowledge, and technology. I-TECH's mission is to create a global network that works with local partners to develop skilled healthcare workers and strong national health systems in resource-limited countries.

**Populations and Settings:** Twinning has created partnerships that link two entities with shared characteristics to achieve common objectives. The goal of these partnerships is to develop institutional relationships to strengthen human and organizational capacity, particularly as it relates to the scale-up of HIV prevention, care, and treatment services under PEPFAR. These partnerships focus on peer-to-peer, voluntary relationships that benefit both sides. Twinning between healthcare and related institutions contributes to capacity building and workforce development activities for a broad range of health professions, including: physicians, nurses, pharmacists and pharmacy technicians, laboratory technicians, biomedical engineers and technicians, medical technologists, counselors, clinical associates, CHWs, social workers, social welfare assistants, and para- professional social workers.

IAETC promotes local ownership to sustain effective health systems with projects in over 20 countries where they collaborate with local ministries of health, universities, non-governmental organizations, medical facilities, and other partners to support the development of skilled health workforces and well-organized national health delivery systems.

**Considerations for Implementation:** One of the impending challenges of PEPFAR is the program's sustainability. As PEPFAR moves to channeling 70 percent of funding through indigenous partners (i.e., those based in developing countries where programs are operating) by the end of 2020, the question remains whether and how to divert resources away from epidemic control to invest in sustainability planning. Several of the project's PEPFAR stakeholders brought up the fact that PEPFAR is asking how to shift from *achieving* 90-90-90 to *sustaining* 90-90-90. Indigenous partners will need increased capacity in preparation for this transition and goal. PEPFAR stakeholders would benefit from learning from RWHAP about how to capacitate local governments with systems-level support and/or how to more deeply engage CSOs. In particular, CSOs are sharing more and more of the burden to collect, analyze, and report on data; administer funding; and meet program targets. In discussions with project stakeholders, it emerged that some trends in capacity building include shifting from training to organizational capacity building. Another shift involves capacity-building organizations that do not actually implement the programs but rather "lead from behind" to support in-country programs. These trends are timely developments to support indigenous partners in meeting this new PEPFAR goal.

Capacity-building lessons from PEPFAR settings to RWHAP could be useful as the United States prepares for Ending the HIV Epidemic: A Plan for America. This plan focuses on areas of the country that are rural and heavily impacted by the epidemic. Learning from partnerships with areas of limited resources may also benefit communities in the United States with strained public health capacity that need to participate in this emergent response led by HRSA HAB and other federal agencies.

**Additional Resources:**

- IAETC: <https://globalhealth.washington.edu/interactive-map/projects/1609/International-AIDS-Education-and-Training-Center-IAETC>
- I-TECH: <https://www.go2itech.org/>

### 3.5 Use of CHWs in Treatment Initiation and Adherence

**Description:** As described earlier, CHWs are non-clinicians trained to screen and test, help ensure linkage and treatment initiation support, and assist with medication distribution and adherence. They are extensions of facility providers who work with clients and at-risk populations in their communities, facilitating care and treatment. The International Labour Organization International Standard Classification of Occupations determines CHWs are a distinct labor group.<sup>xliii</sup> They build bridges between providers of health, social and community services, and communities that may have difficulty in accessing these services.

**CHWs provide health education and referrals for a wide range of services, and provide support and assistance to communities, families and individuals with preventive health measures and gaining access to appropriate curative health and social services.**

–International Labour Organization definition of CHW

**Populations and Settings:** Project stakeholders shared several examples of CHWs. Peer educators in Uganda have formalized roles in the clinical setting. They located people who were lost to follow-up or not virally suppressed. Studies in Ethiopia trained stable HIV clients in the community as Peer Support Workers and partnered them with newly diagnosed people with HIV. They worked with clients on issues such as adherence and getting access to care. Very high ART adherence rates for clients who had this peer support were reported. Peer Support Workers reported back to the clinic for communication

purposes. ZVANDARI in Zimbabwe uses peer engagement with adolescent peers for children living with HIV, and has had successful HIV care continuum results related to linkage to care and adherence.

**Considerations for Implementation:** Using CHWs to operationalize task-sharing will accelerate community-based testing where hard-to-reach people with HIV are more likely to be found. Modeling PEPFAR’s work with CHWs in rural areas of the United States may be a beneficial method in preparing for the rollout of “Ending the HIV Epidemic: A Plan for America.” It is important to ensure CHWs have clearly defined responsibilities and roles within the care team. As noted in the PEPFAR 2019 Country Operational Plan Guidance, facility-based staff should be trained to manage the performance of CHWs since CHWs are extensions of facility providers.

**Additional Resources:**

- PEPFAR Solutions: <https://www.pepfarsolutions.org/adolescents/2018/1/13/zvandi-peer-counseling-to-improve-adolescent-hiv-care-and-support>
- ZVANDARI overview: [https://www.youtube.com/watch?v=zfCl4\\_Up2s](https://www.youtube.com/watch?v=zfCl4_Up2s)

### 3.6 Rapid Initiation of Treatment

**Description:** The World Health Organization’s 2015 Treat All recommendations suggest ART initiation as soon as possible among all people diagnosed with HIV.<sup>xliiv</sup> Adoption of this approach has dramatically increased the number of people with HIV who are accessing treatment,<sup>xliiv</sup> and is contributing to the achievement of the UNAIDS 90-90-90 goals for testing, treating, and reducing viral load among people with HIV. The approach is referred by other names such as rapid initiation of treatment, test and treat, and test and start.

**Population and Settings:** IAETC has worked in many PEPFAR countries to build and support health systems and develop and implement policy

at multiple levels ranging from the national ministries of health to district and ART facility levels, and has designed and delivered a range of activities to improve service delivery that accompanies the treatment. The programs reached adolescents and children, sexual partners for partner notification, and other vulnerable populations. The services have used differentiated testing approaches in facilities and in partnership with other programs such as Provider-Initiated HIV Testing and Counseling and Family and Community ART Refill Groups.

**Considerations for Implementation:** The successful implementation of Treat All and achievement of the UNAIDS targets requires the development and adoption of emerging, differentiated intervention strategies for HIV testing and treatment in order to meet the diverse needs of people with HIV. Clinics should

incorporate ART planning tools that allow for increased ART procurement and supply needs in anticipation of new initial treatments and lengthier refills, such as those needed for multi-month scripting programs. In the RWHAP context, such approaches to rapid initiation of treatment would be beneficial to reduce the gap between HIV testing and linkage to care. RWHAP should review PEPFAR models of same day treatment and their challenges in implementing this approach. For example, many PEPFAR clinics could not implement rapid initiation of treatment overnight, but instead progressed there in a stepwise fashion: first their goal was initiation of treatment in the same month, then it was initiation of treatment in the same week, then initiation of treatment on the same day as diagnosis. RWHAP clinics could consider adopting a similar phased approach to implementation.






**Additional Resources:**

- Differentiated Care: <http://www.differentiatedcare.org/Resources/Resource-Library/PEPFAR-Multi-Month-Prescribing-and-Treat-All-Calculator>
- PEPFAR 2019 Country Operational Plan Guidance for all PEPFAR Countries: <https://www.pepfar.gov/documents/organization/288731.pdf>
- RAPID (The Rapid ART Program Initiative for HIV Diagnoses) in San Francisco, CA: <http://www.gettingtozerosf.org/rapid-standard-operation-procedure/>
- Test and Treat Guidance from Florida: [http://www.floridahealth.gov/diseases-and-conditions/aids/Clinical\\_Resources/\\_documents/Test\\_andTreat\\_Guidance\\_FEB2018.pdf](http://www.floridahealth.gov/diseases-and-conditions/aids/Clinical_Resources/_documents/Test_andTreat_Guidance_FEB2018.pdf)
- World Health Organization Progress Report 2016 Prevent HIV, Test and Treat All: <https://apps.who.int/iris/bitstream/handle/10665/251713/WHO-HIV-2016.24-eng.pdf;jsessionid=0711F30DDFB67443B83D11CC23CB880B?sequence=1>

## 4. Conclusions and Recommendations

An illustration of the relationship between the Stages of the HIV care continuum and the 90-90-90 goals emphasizes the overlap across RWHAP and PEPFAR goals. Furthermore, nearly all of the intervention strategies from both RWHAP and PEPFAR reviewed in this paper have a potential impact on at least two of the HIV care continuum stages, primarily the stages of engagement and retention in care and HIV viral suppression. These potential impacts provide an important opportunity for HRSA HAB to promote bi-directional sharing and strengthen the U.S. and international response to end the epidemic. The SIDs are not service-related intervention strategies, and thus not marked in the exhibit below.

## RWHAP and PEPFAR Intervention Strategies and Alignment with HIV Care Continuum

RWHAP and PEPFAR Intervention Strategies	 Diagnosed with HIV	 Linked to Care	 Engaged/ Retained in Care	 Prescription of ART	 Viral Suppression
1. Medical and non-medical case management		X	X	X	X
2. Integration of behavioral health services		X	X		X
3. Trauma-informed care			X		X
4. Capacity building of local institutions		X	X	X	X
5. Use of CHWs in treatment initiation and adherence		X	X	X	X
6. Differentiated services delivery	X		X	X	X
7. Sustainability Index Dashboards					
8. Data use for real-time decision making		X	X	X	X
9. Rapid initiation of treatment	X	X	X	X	X

Throughout the Bi-directional Lessons Learned project, a number of topics and possible opportunities for bi-directional sharing have been suggested. These suggestions provide an opportunity for peer exchange at multiple levels to support solutions and elimination of health disparities across the HIV care continuum. The next sections summarize these recommendations for HRSA HAB.

### 4.1 Discrete Recommendations for RWHAP Leadership

- Broaden the audience for webinars offered to RWHAP recipients to include PEPFAR practitioners. To be accessible to the PEPFAR audience, the project stakeholders emphasized, this information needs to be digestible and brief.
- Invite a group of RWHAP practitioners to listen to the data review meetings during the PEPFAR Oversight and Accountability Review Team (POART) calls, which occur quarterly for each PEPFAR-supported country or region. These calls may broaden RWHAP practitioners' understanding of how to use their data, look at problems identified by the data, and address them for quality improvement.
- Assess the ways RWHAP could share experiences in data triangulation from multiple sources. PEPFAR project stakeholders described the variety and levels of data from S/GAC and how these data do not necessarily communicate or get used together when analyzing results. The PEPFAR stakeholders would like to learn about data triangulation experiences and methodology from RWHAP.

### Targeted Opportunities for Bi-directional Sharing

#### Conferences:

- International AIDS Conference (AIDS 2020)
- National Ryan White Conference on Care and Treatment 2020

#### Websites/Webinars:

- TargetHIV website
- PEPFAR Solutions platform
- AETC website
- HAB webinars
- SPNS Integrating HIV Innovative Practices (IHIP) website

#### Communications:

- PEPFAR Oversight and Accountability Review Team (POART) data review calls
- HRSA Newsletter
- RWHAP emails
- Inter-agency Collaborative for Program Improvement (ICIP) email digests

## 4.2 Discrete Recommendations for PEPFAR Leadership

- PEPFAR services in mental health are gaining attention but were considered not mature enough for bi-directional sharing. Further development of trauma-informed care and integration of behavioral health services in HIV care in various country contexts is needed to fully address the needs of people with HIV.
- Build capacity within PEPFAR CSOs, particularly by improving their health literacy and strategic use of data. In particular, project stakeholders mentioned that RWHAP typically uses contracting mechanisms to engage CSOs, whereas PEPFAR has fewer contracting mechanisms. PEPFAR would like to learn more about how to engage CSOs in a sustainable way, including the specifics of RWHAP CSO contracts, such as how RWHAP vets CSOs

for contract awards, how RWHAP holds CSOs accountable through contracts, and the experiences of RWHAP in setting up contracts with new CSOs.

- Identify ways to replicate client-centered care offered through the RWHAP comprehensive care package in the various country contexts. The RWHAP's comprehensive care package has been successful in providing client-centered care, similar to DSD, and wraparound services for RWHAP clients. Capacity building may be needed for such replication, perhaps by leveraging the AETC and international workforce training networks.
- Include information about intervention strategies from the RWHAP community to the Inter-agency Collaborative for Program Improvement (ICIP) email digests.

## 4.3 Recommendations for RWHAP and PEPFAR Leadership

- Project stakeholders observed there is less U.S. provider awareness of evidence-informed interventions from other countries, suggesting a missed opportunity overall for RWHAP providers to benefit from the experiences of global intervention strategies such as providers of rapid initiation of treatment and DSD. One way to promote greater awareness is to offer specific, by-invitation opportunities for RWHAP and PEPFAR project administrators to meet the day prior to the upcoming International AIDS Conference (AIDS 2020) scheduled to be held in the United States. In addition, a similar day or half-day session could be offered at the next National Ryan White Conference on Care and Treatment.
- Identify ways to make the TargetHIV website, AETC website, and the PEPFAR Solutions platform more widely known and



accessible to broader audiences. Offering informational webinars showcasing the platforms as well as sessions at the International AIDS Conference (AIDS 2020) and the next National Ryan White Conference on Care and Treatment may increase the reach of these websites across RWHAP and PEPFAR audiences.

- Support the future replication and adoption of bi-directional interventions through RWHAP and PEPFAR funding streams. The intervention strategies described in this paper serve as a viable starting point for bi-directional sharing and implementation. For example, a percentage of allocated RWHAP funding could be prioritized by Part to support the replication of evidence-informed interventions and emerging strategies identified for bi-directional sharing.
- Support mentorship in bi-directional learning opportunities between domestic and international projects interested in

addressing similar challenges or replicating similar intervention strategies, perhaps by leveraging the AETC and International Workforce training networks.

- Facilitate bi-directional sharing of intervention strategies along the HIV care continuum among direct service providers, including CHWs and Peers.
- Identify opportunities to work with S/GAC to create an annual award for best practices that led to best outcomes. The international community could be eligible for this award based on pre-determined criteria set by S/GAC. This event could be an annual launching point for sharing the awardee's experience and strategies with RWHAP. The awardee could be featured in RWHAP emails, webinars, and/or at the National Ryan White Conference on Care and Treatment to further promote bi-directional sharing of intervention strategies and best practices.

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## Abbreviations

AETC	AIDS Education and Training Center
ART	Antiretroviral Therapy
CHW	Community Health Worker
CSO	Civil Society Organizations
DSD	Differentiated Service Delivery
HAB	HIV/AIDS Bureau
HIVQUAL	The National HIV Quality of Care
HRSA	Health Resources and Services Administration
IAETC	International AIDS Education and Training Center
IHIP	Integrating HIV Innovative Practices
ILO	The International Labour Organization
I-TECH	International Training and Education Center for Health
MAI	Minority AIDS Initiative
MCM	Medical Case Management
PEER	Peer Education and Evaluation Resource Center
PEPFAR	President's Emergency Plan for AIDS Relief
POART	PEPFAR Oversight and Accountability Review Team
RWHAP	Ryan White HIV/AIDS Program
S/GAC	Office of the U.S. Global AIDS Coordinator
SID	Sustainability Index Dashboards
SPNS	Special Projects of National Significance
Twinning	International Twinning Center Program
UNAIDS	The Joint United Nations Programme on HIV/AIDS

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