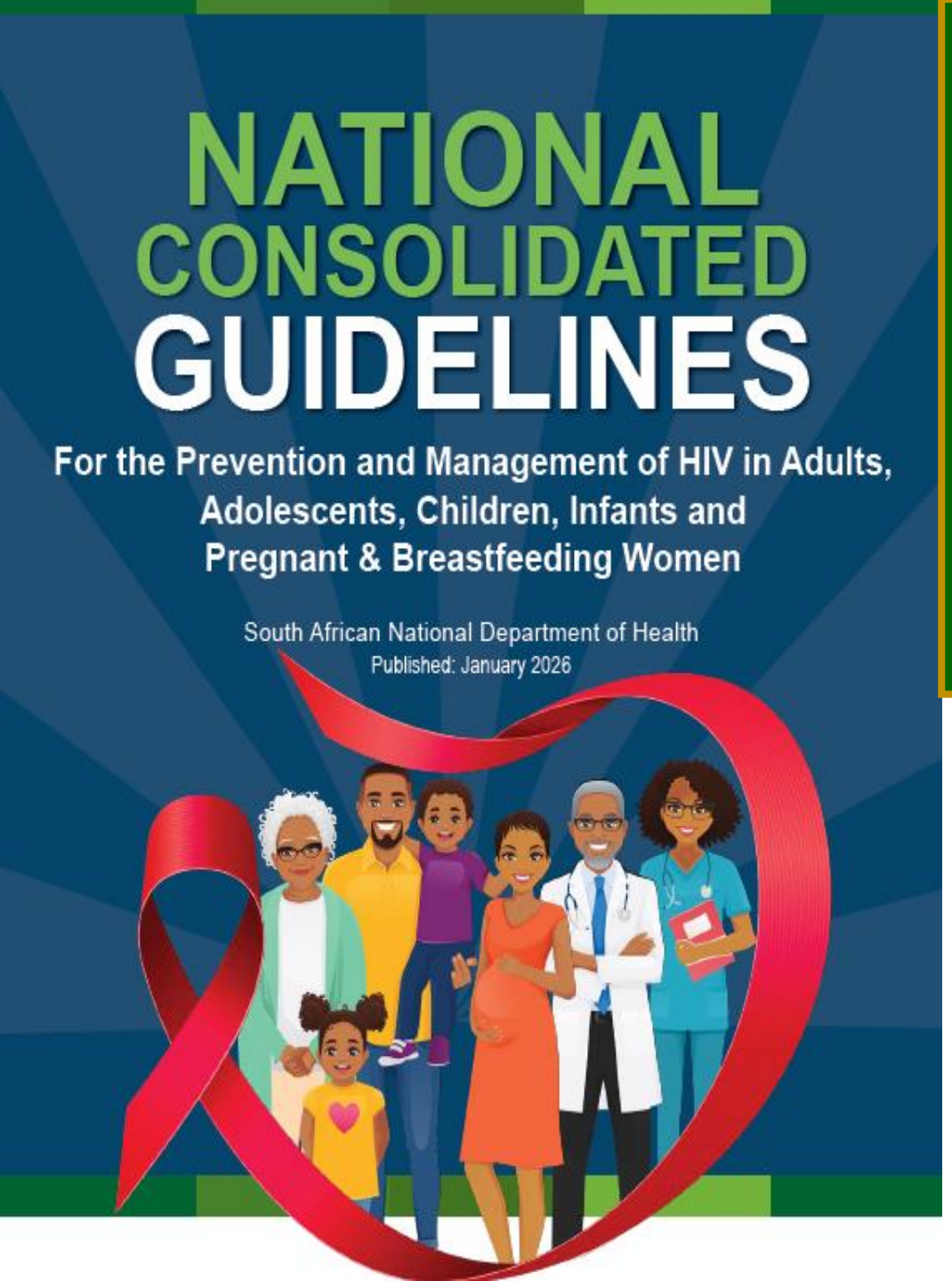

Webinar 1

2026 National Consolidated Guidelines for the Prevention and Management of HIV in Adults, Adolescents, Children, Infants, Pregnant and Breastfeeding Women

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CLINTON HEALTH ACCESS INITIATIVE

World Health Organization

THE GLOBAL FUND

Background

Consolidated ART GL consists of:

1. Existing Guidelines:

- 2023 ART Clinical Guideline
- 2023 VTP Guideline
- HTS Guideline, 2025
- DMOC SOPs, 2025

2. "New" chapter

- Advanced HIV disease

- Standard treatment Guidelines and EML
- SA HIV Clinicians Society Guidelines
- World Health Organisation Guidelines
- Other National Guidelines
  - Adult Primary Care Guideline
  - IMCI Guideline
  - TPT Guideline and TB Screening SOP
  - DS and DR-TB

Summary of other updates to the Consolidated ART Guidelines

- AHD Chapter
- TPT for pregnant women with CD4 < 200 as part of a comprehensive package of care for Advanced HIV Disease
- CPT eligibility for WHO stages 3 and 4 only
- Earlier eligibility for drug-resistance testing and drug-level testing as the gatekeeping mechanism
- New postnatal EGK code for VL monitoring at 6 months postpartum and during breastfeeding
- ALD access for term infants from 2kg
- New DMOC SOPs

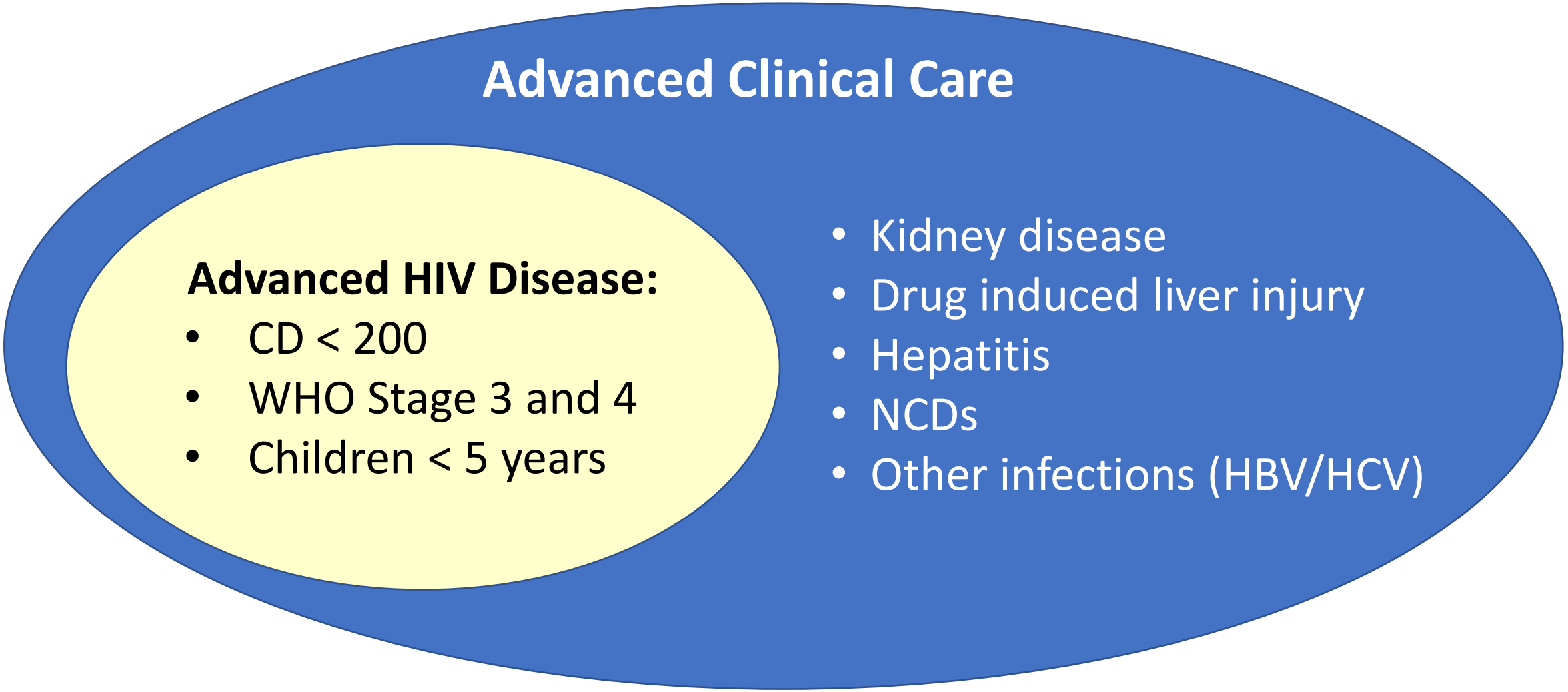
What is advanced HIV disease?

Box 1 The definition of Advanced HIV Disease (AHD)

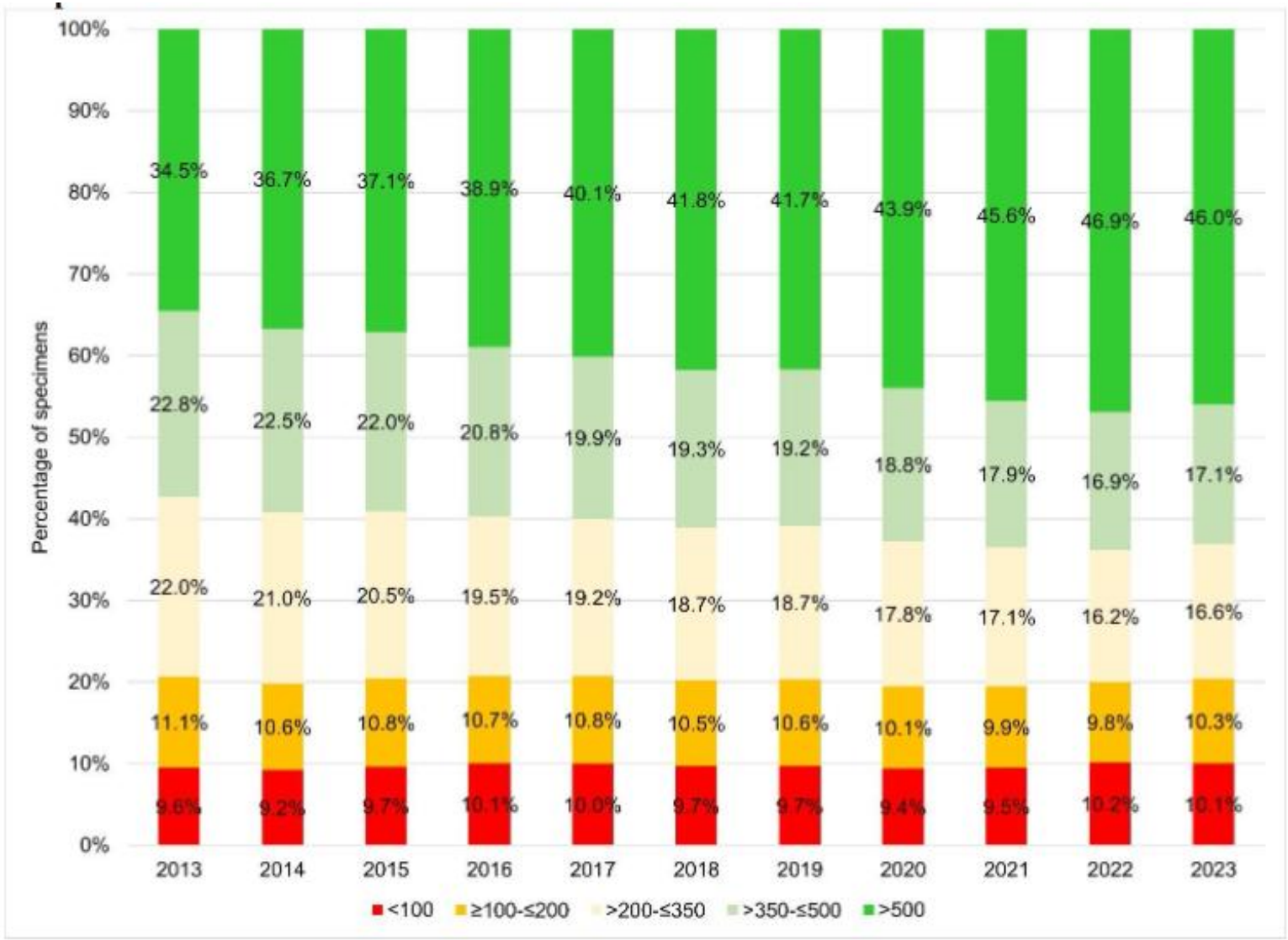
- For adults, adolescents, and children **older than five years**, advanced HIV disease is defined as
  - **a CD4 cell count <200 cells/μL** or
  - **a WHO clinical stage 3 or 4 condition**

- All children living with HIV **younger than five years** should be considered as having advanced HIV disease (regardless of CD4% or clinical stage) unless they have been receiving ART for longer than one year and are clinically stable on ART

Advanced HIV Disease vs Advanced Clinical Care



CD4 count trends in South Africa 2013 - 2023



Cassim N, et al., Retrospective analysis of CD4 count trends in South Africa. South Afr J HIV Med. 2024

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Prevalence of AHD disease in ART-naïve clients

- This systematic review
  - 53 studies from 5 provinces in South Africa,
  - involving 11,545,460 patients who received ART services
  - between 2010 and 2022.
- AHD among ART-naive patients was 43%
- The proportion of patients presenting with AHD remains high but has decreased over time (2% yearly decline 2010-2022) due to increased HIV testing and access to ART.

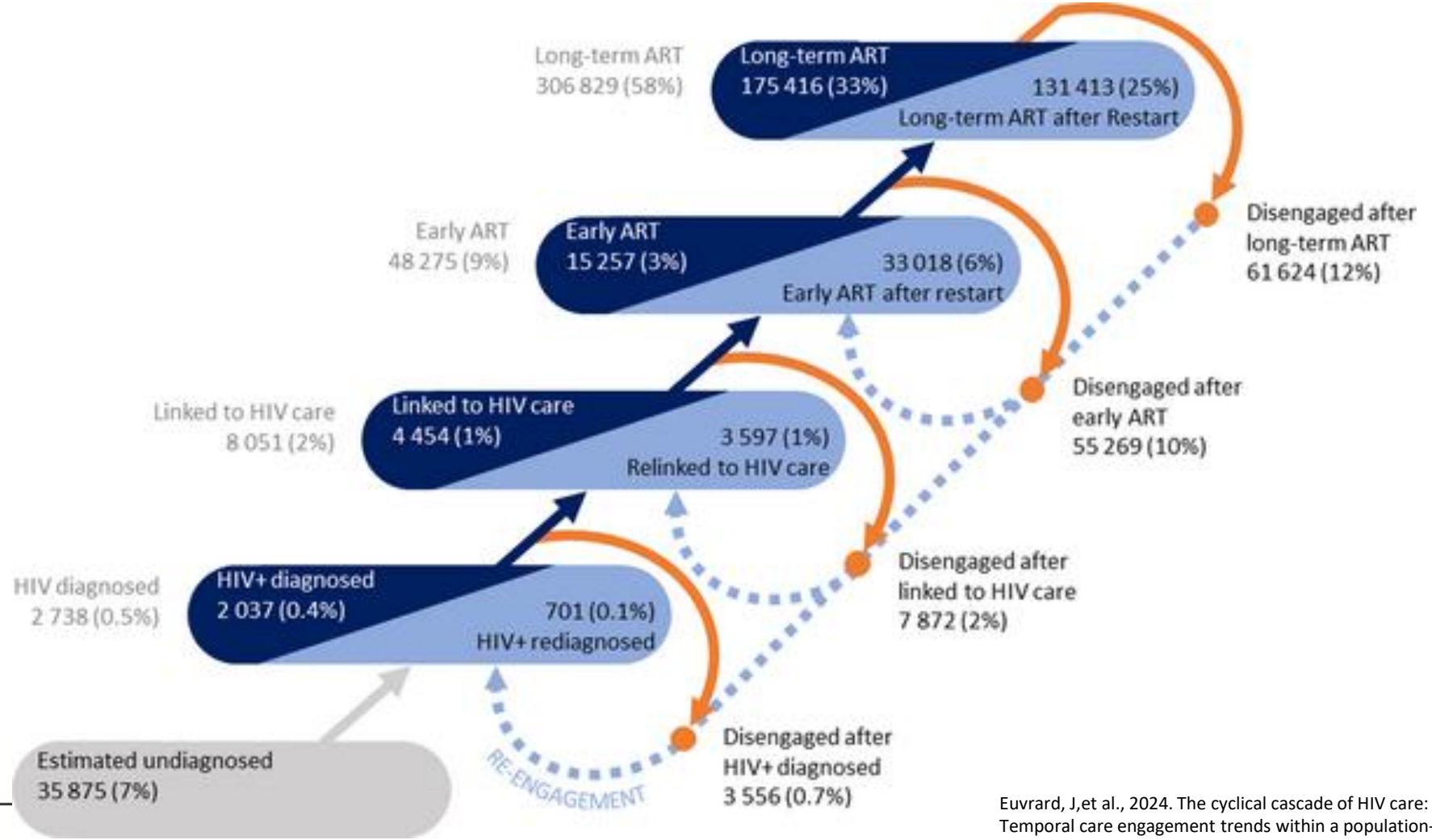
Kitenge, *et al.* Prevalence and trends of advanced HIV disease among antiretroviral therapy-naïve and antiretroviral therapy-experienced patients in South Africa between 2010-2021: a systematic review and meta-analysis. *BMC Infect Dis* **23**, 549 (2023). https://doi.org/10.1186/s12879-023-08521-4

Prevalence of AHD in ART-experienced clients

- AHD among ART-experienced patients was 58%
  - Disengage from care
  - Treatment failure
- More and more people who are in HIV programs are treatment-experienced.
  - Overlap with ART-naïve
    - Patients cycle of in and out of care (as per diagram on next slide)
  - Strategies for retention in care are important!
    - DMOC & re-engagement interventions
    - Integrated service delivery approaches (e.g. Integrated Clinical Services Management of Ideal Clinic

Kitenge, *et al.* Prevalence and trends of advanced HIV disease among antiretroviral therapy-naïve and antiretroviral therapy-experienced patients in South Africa between 2010-2021: a systematic review and meta-analysis. *BMC Infect Dis* **23**, 549 (2023). https://doi.org/10.1186/s12879-023-08521-4

Non-linear HIV cascade



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Euvrard, J,et al., 2024. The cyclical cascade of HIV care: Temporal care engagement trends within a population-wide cohort. PLOS Medicine 21, e1004407..https://doi.org/10.1371/journal.pmed.1004407

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In 2026 should anyone die from HIV/AIDS?

No

But people are still dying

Why?

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What are the top 3 conditions that cause the highest mortality in patients with AHD?

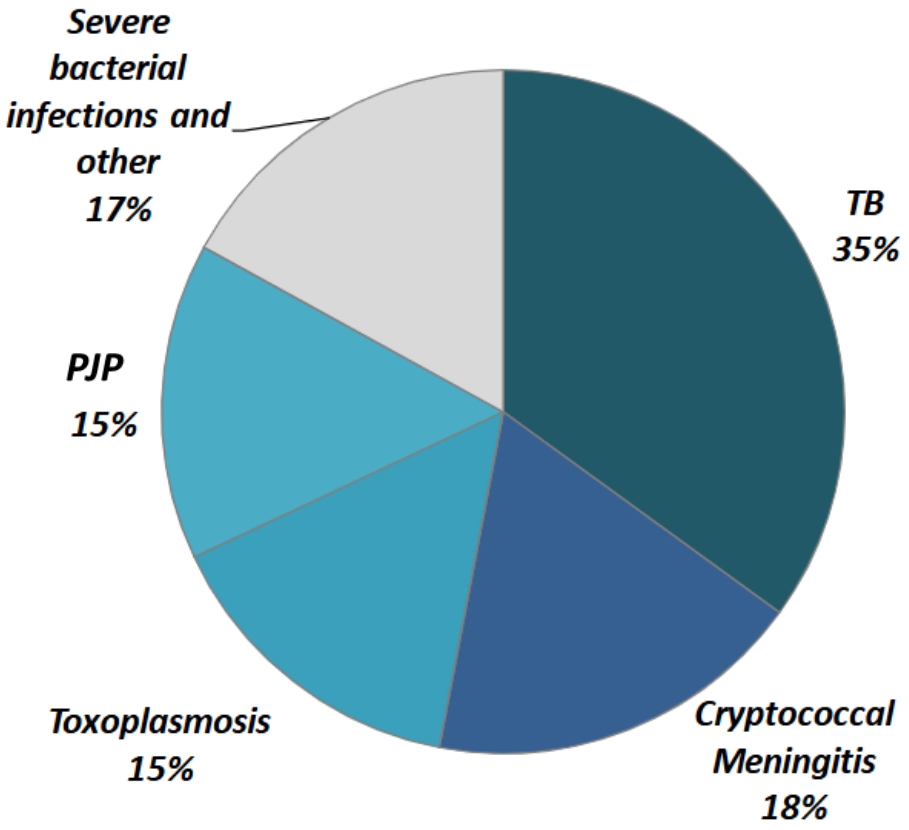
Choose multiple answers

- Cryptococcal meningitis
- Serious bacterial infections
- Pneumocystis *Jerovecii* pneumonia (PJP)
- Toxoplasmosis
- Kaposi sarcoma
- Tuberculosis

What are they dying of?

Why?

The majority of AIDS-related deaths of hospitalized adults are caused by opportunistic infections, including:



Source: WHO AHD Guidelines, 2017.

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Why are they getting opportunistic infections?

They have a weakened immune systems from Advanced HIV Disease

Not on effective treatment

- Delayed HIV diagnosis
- Delayed ART initiation
- Inadequate adherence to effective ART
- Treatment resistance
- Disengaged from care

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Why are they not accessing effective ART?

Demand (patient)-side issues

- Fear of stigma and discrimination
- Other psychosocial challenges that impact diagnosis, adherence or retention in care
- Barriers to accessing care (poverty, agency)
- Lack of understanding/ health literacy
- Mental health problems
- Physically weak and frail

We might be in the same storm, but

Would you agree that these people need more help?

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Why are they not accessing effective ART?

Why?

Supply-side (health care) issues

- Quality of clinical care
- Quality of education and psychosocial support
- Inefficient operational processes within a facility
  - Appointment systems
  - Lab results management
  - Long waiting times
- Lack of patient-centred strategies to improve retention in care, e.g. DMOC, integrated clinical care

Would you agree that we need to do more?

AHD is an indicator of Healthcare failure!

When someone gets AHD, it indicates a health system failure on so many levels!!

When the system fails someone that is well (in a strong boat) the effects have less impact

When the system fails someone with AHD (in a weak boat) the effects can be CATASTROPHIC!

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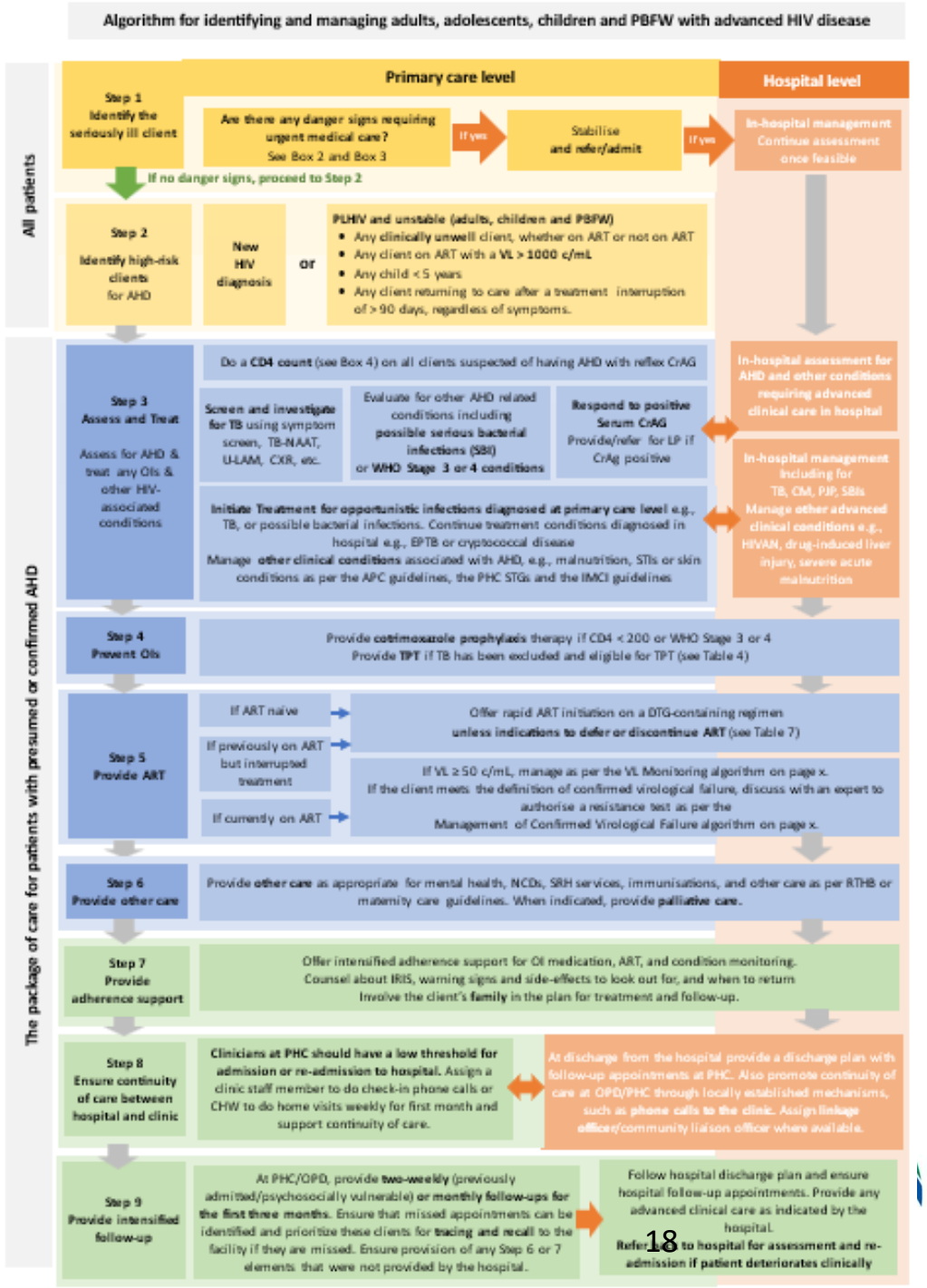
Provide Package of Care

So how can we save them?



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Roles and Responsibilities

An important aspect of ensuring prompt identification, screening, and management of AHD is a clear understanding amongst the HIV care team of the roles and responsibilities in delivering the AHD package and where the package's elements are provided.

Table 2 The "Who' and 'Where" of investigating and managing a patient with AHD

Element of care	Nurse at PHC	Doctor at PHC level	Doctor at Hospital Level	
Identification & management of danger signs	√ Where/when within the scope of practice of a nurse (as per APC and IMCI guidelines). Referral to a higher level of care	√	√	Step 1
Identify clients at risk of AHD				
CD4 count				
History and clinical examination	Wh			
Systematic TB screening, incl. CXRs				
Screening and investigation for CM	C (ider If			
Recall clients with CD4<200 or other abnormal results (CrAG pos, TB-NAAT/culture pos)				
TB diagnosis	ba Nu inve b			
Initiate TB treatment				
Make a diagnosis of CM or cryptococcosis and initiate treatment				
Diagnosis and management of severe bacterial infections	N p furt			
CPT				
Initiate TPT				
ART initiation/ re-initiation				
Provide other care				

Element of care	Nurse at PHC	Doctor at PHC level	Doctor at Hospital Level	
Counsel on adherence to OI medication and ART and identification of warning signs that may require the patient to return to the clinic/hospital urgently.	√	√	√	Step 7
Involve the client's family or another supporter in their follow-up plan. The supporter should be able to monitor for warning signs and know when to respond with urgency.	√	√	√	Step 7
	Check if the doctor did this at hospital level. If not, contact family			

Table 2 The "Who' and 'Where" of investigating and managing a patient with AHD

Element of care	Nurse at PHC	Doctor at PHC level	Doctor at Hospital Level	
Identification & management of danger signs	√ Where/when within the scope of practice of a nurse (as per APC and IMCI guidelines). Referral to a higher level of care	√	√	Step 1
Identify clients at risk of AHD	√	√	√	Step 2
CD4 count	√	√	√	Step 3
History and clinical examination	√ Where/when within the scope of practice of a nurse	√	√	Step 3
Systematic TB screening, incl. CXRs	√ Request CXR	√ Interpret CXR	√	Step 3

Patient category	Potential risks
Severely ill with danger signs	Inappropriate pre-referral management or delays in referral to the appropriate level of care may increase mortality.
Unwell/unstable but not sick enough to warrant immediate referral to hospital	More complex conditions may be missed, or there may be delays in referrals for hospital-level investigations.
Appearance of being **clinically well or asymptomatic**	Clients with CD4 counts < 200 may initially appear well but may rapidly deteriorate and remain at a higher risk for death. Such patients are at risk of receiving a less intensive clinical assessment when their CD4 count is taken.

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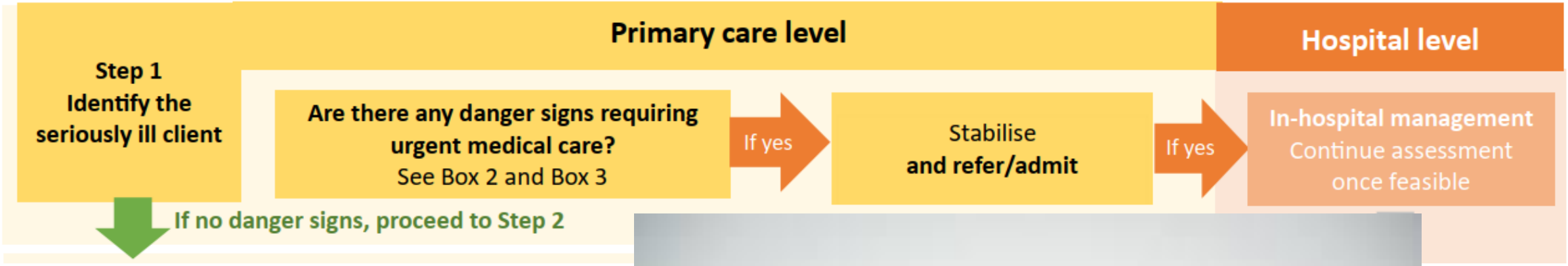
Step 1 Identify the seriously ill client



In severe danger…

Step 2 Identify high-risk clients

Step 2

Identify high-risk clients for AHD

New HIV diagnosis

or

PLHIV and unstable (adults, children and PBFW)

- Any **clinically unwell** client, whether on ART or not on ART
- Any client on ART with a **VL > 1000 c/mL**
- Any child < 5 years
- Any client returning to care after a treatment interruption of > 90 days, regardless of symptoms.

At risk of drowning…

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Step 3 Assess and Treat

Step 3
Assess and Treat

Assess for AHD & treat any OIs & other HIV-associated conditions

Do a **CD4 count** (see Box 4) on all clients suspected of having AHD with reflex CrAG

Screen and investigate for TB using symptom screen, TB-NAAT, U-LAM, CXR, etc.

Evaluate for other AHD related conditions including **possible serious bacterial infections (SBI)** or **WHO Stage 3 or 4 conditions**

Respond to positive Serum CrAG
Provide/refer for LP if CrAg positive

Initiate Treatment for opportunistic infections diagnosed at primary care level e.g., TB, or possible bacterial infections. Continue treatment conditions diagnosed in hospital e.g., EPTB or cryptococcal disease
Manage **other clinical conditions** associated with AHD, e.g., malnutrition, STIs or skin conditions as per the APC guidelines, the PHC STGs and the IMCI guidelines

In-hospital assessment for AHD and other conditions requiring advanced clinical care in hospital

In-hospital management
Including for TB, CM, PJP, SBIs
Manage **other advanced clinical conditions** e.g., HIVAN, drug-induced liver injury, severe acute malnutrition

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More detail on this tomorrow…

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When do we do CD4 count?

Box 4: Indications for CD4 testing

Routine CD4 monitoring should be done for all patients:

- At HIV diagnosis and ART initiation
- After 10-12 months/dispensing cycles (DCs) on ART (aligned with annual VL).

CD4 monitoring is indicated in specific situations:

- If CD4 is ≤ 200 or ≤ 25% (in children under 5 years): repeat every 6 months until CD4 > 200/>25%
- If VL ≥ 1000 c/mL: do a CD4 to identify AHD and repeat CD4 every 6 months until VL < 1000 c/mL
- If a clinical indication arises, such as a new confirmed or presumed WHO Stage 3 or 4 condition in a previously well patient
- If a patient returns to care > 90 days after missing a scheduled appointment

Source: SA NDoH 2023 ART Clinical Guidelines

Clients with AHD may appear clinically well

New HIV Diagnosis,
CD4 = 850

New HIV Diagnosis,
CD4 = 15

WHO Clinical Staging

Box 11: WHO clinical staging before and after ART initiation

Determining a patients WHO clinical stage helps us to understand the severity of a patients condition. It gives an indication of the patients level of immune suppression, and will therefore not improve until the patient initiates ART. The purpose of ART is to restore the patients immune function and it is therefore expected that a patient's clinical condition, and therefore their clinical stage, should improve once ART is initiated. It is therefore helpful to consider a patient's WHO Clinical Stage in two categories:

The pre-ART WHO clinical stage:

- This will not improve until ART is initiated, as their immune function cannot be restored until ART is initiated.

The WHO clinical stage after ART initiation:

- This may fluctuate based on the level of adherence and the effectiveness of the patient's ART regimen.
- It is expected to improve on effective ART. However, a new stage 3 or 4 condition in a previously well patient on ART indicates AHD and requires urgent intervention.

The patient's clinical stage should be determined and documented whenever the patient receives a clinical assessment by a clinician.

Which of the following patient's would be classified as AHD?

Choose multiple answers

- 22-year-old woman with pulmonary TB and CD count 460
- A 45-year-old male, clinically asymptomatic (WHO Stage I), CD4 count 170 count
- A 4-year-old child initiated on ART at 6 weeks of age, clinically well and VL < 50 c/mL
- A woman with shingles (WHO II) and CD4 count 320
- A 36-year-old male on ART with a positive CrAG and a CD4 count of 76

Let’s remind ourselves of the AHD definition

Box 1 The definition of Advanced HIV Disease (AHD)

- For adults, adolescents, and children **older than five years**, advanced HIV disease is defined as
  - **a CD4 cell count <200 cells/µL** or
  - **a WHO clinical stage 3 or 4 condition**

- All children living with HIV **younger than five years** should be considered as having advanced HIV disease (regardless of CD4% or clinical stage) unless they have been receiving ART for longer than one year and are clinically stable on ART

Which of the following patient's would be classified as AHD?

Choose multiple answers

- 22-year-old woman with **pulmonary TB (WHO III)** and **CD count 460**
- A 45-year-old male, clinically asymptomatic **(WHO Stage I),** **CD4 count 170**
- A **4-year-old** child initiated on ART at 6 weeks of age **(on ART > 1year),** clinically well and VL < 50 c/mL **(clinically stable)**
- A woman with shingles **(WHO II)** and **CD4 count 320**
- A 36-year-old male on ART with a **positive CrAG** and a **CD4 count of 76**

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AHD is an indicator of Healthcare failure!

When someone gets AHD, it indicates a health system failure on so many levels!!

When the system fails someone that is well (in a strong boat) the effects have less impact

When the system fails someone with AHD (in a weak boat) the effects can be CATASTROPHIC!

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Findings from mortality audits…

Lady initiated on ART and given 1 month prescription	Man re-initiated on TLD, given 1 month prescription	Lady pregnant, baseline bloods done, booked for next ANC visit
Didn't come back	*Didn't come back*	*Didn't come back*
CD4: 3 CrAg: positive	CD4: 7 TB NAAT positive	Hb: 4

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Interpreting Laboratory Results

Is it ok to take blood tests and only check the results a month or more later?

No

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Box 5: Laboratory results management process

An efficient results management process requires the following steps:

- Inform the patient about the tracing and recall process:
  - → This should be discussed as part of their Adherence Support Plan, as detailed in Table 19 under AHD Step 7: Support Adherence
  - → Obtain necessary consent from the patient for the tracing and recall process
  - → Update the patient's contact details and that of their treatment supporter, if available
- Review results daily in order to identify abnormal results timeously:
  - → All lab results must be reviewed and triaged by a clinician on the same day they arrive at the fa
  - → Clinicians should separate abnormal results from normal results to prioritise urgent cases (e.g. Hb < 6g/dL) for immediate action.
- Document results:
  - → Results should be recorded in the relevant documents (TB Identification flagging the urgency for abnormal result follow-up
- Recall the patient for action (as per DMOC SOP 7):
  - → Patients with abnormal results requiring urgent clinical management (see ***Tab l: Recall tin at PHC level on page 63***) before their next scheduled appointment must be reca ed to the fac WhatsApp.
  - → If a patient does not return within 7 days of the recall, further attempts should be made using fo home visits as per the patient's consent.
  - → Document recall efforts in the patient's file.
  - → Ensure patient confidentiality throughout the tracing and recall processes.
- Data capture and register management:
  - → Data clerks should use the TIER.Net Pending Tests functionality to capture all abnormal and normal lab results that have been signed off by a clinician.
  - → After capturing in the relevant register, clerks should mark the results as "captured" in the patient records (clinical stationery) and initial and date them.

Source: NDoH Bulk Capturing of Normal Laboratory Results Guidance, DMOC SOP 7 (Tracking and Recall)

Summarised on the next slide

How to routinely review Lab results

Inform patients

Consent	Contact details

Review results daily

Clinician reviews	Flags abnormal results

Document results

Patient Records	N4 specimen register	Other e.g. TB ID Register

Recall Patient

Check Patient records	Phone call or home visit	Document recall efforts

Data capture

TIER.net Pending Tests	“captured” in patient records

Recall times

Page 63

Table 11: Recall timelines for abnormal test results at PHC level

Element of care	
Urgent recall within 1 to 3 days	
First/new CrAg positive	Recall for urgent lumbar puncture (LP) and clinical assessment for meningitis
TB-NAAT positive and not yet on TB treatment	Recall patient for TB treatment initiation
Hb < 6 g/dL	Recall for immediate referral to hospital emergency department for assessment and possible blood transfusion
ALT >200, regardless of symptoms	Recall within 1-3 days
eGFR <30mL/min and on TLD	Recall within 1-3 days to change their ART and investigate underlying causes of renal failure
Recall as soon as possible within the next 7 days	

CD4 count < 200	Review the clinical file:
	• If the patient was symptomatic, ensure that the appropriate tests were done, management provided, and an appropriate return date given as per the APC guideline. If management was appropriate, no recall is needed, and the patient can be seen at their next scheduled appointment within one month.
	• Recall the patient within 7 days if there are any of the following concerns:
	  • the patient does not return for their follow-up visit, or
	  • the timing of the visit was inappropriate based on the client's symptoms or clinical condition, or
	  • there are any concerns that the client did not receive the thorough clinical assessment indicated for a client at risk of AHD

TB-NAAT negative and TB symptoms present	• Confirm that the patient has been given a date to return for their results after two days • If the patient did not receive an appointment date or missed the appointment, recall them for additional TB investigations.
HB between 6-7,9 g/dL	• If anaemia is not already being managed by means of TB treatment or ART, recall the patient for further investigations and management.
ALT >120-199 and no symptoms documented at last visit	• Recall within 7 days.
eGFR 30 - 50mL/min and on TLD	• Recall within 7 days to change their ART and investigate underlying causes of renal failure
No recall required: review results at the next scheduled appointment within 30 days	
TB-NAAT negative and no TB symptoms were present at the last visit.	• Patient can initiate TPT at the next scheduled visit if eligible
ALT 50-120	• Assess at the next scheduled visit
Abnormal Pap smear	• Ensure action if HSIL or infection at the next scheduled appointment.
HBsAg positive	• No recall required if on a TDF-based regimen. ART also treats HBV.
CrAg positive	• No recall if CrAg positive after treatment for CM or previous antigenaemia

Urgent

Within **1-3** days

As soon as possible

Within **7** days

No recall

Within **30** days

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Urgent : Within **1-3** days

Element of care	
Urgent recall within 1 to 3 days	
First/new CrAg positive	Recall for urgent lumbar puncture (LP) and clinical assessment for meningitis
TB-NAAT positive and not yet on TB treatment	Recall patient for TB treatment initiation
Hb < 6 g/dL	Recall for immediate referral to hospital emergency department for assessment and possible blood transfusion
ALT > 200, regardless of symptoms, or ALT > 120 WITH symptoms or jaundice or tot Bili>40 µmol/l	Recall within 1-3 days
eGFR <30mL/min and on TLD	Recall within 1-3 days to change their ART and investigate underlying causes of renal failure

As soon as possible: Within 7 days

CD4 count < 200	Review the clinical file:
	• If the patient was symptomatic, ensure that the appropriate tests were done, management provided, and an appropriate return date given as per the APC guideline. If management was appropriate, no recall is needed, and the patient can be seen at their next scheduled appointment within one month.
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TB-NAAT negative and TB symptoms present	• Confirm that the patient has been given a date to return for their results after two days • If the patient did not receive an appointment date or missed the appointment, recall them for additional TB investigations.
HB between 6-7,9 g/dL	• If anaemia is not already being managed by means of TB treatment or ART, recall the patient for further investigations and management.
ALT >120-199 and no symptoms documented at last visit	• Recall within 7 days.
eGFR 30 - 50mL/min and on TLD	• Recall within 7 days to change their ART and investigate underlying causes of renal failure

No recall: Within **30** days

TB-NAAT negative and no TB symptoms were present at the last visit.	• Patient can initiate TPT at the next scheduled visit if eligible
ALT 50-120	• Assess at the next scheduled visit
Abnormal Pap smear	• Ensure action if HSIL or infection at the next scheduled appointment.
HBsAg positive	• No recall required if on a TDF-based regimen. ART also treats HBV.
CrAg positive	• No recall if CrAg positive after treatment for CM or previous antigenaemia

Which of the following patient's need to be urgently recalled to the clinic for action?

Choose multiple answers

- A 22-year-old woman with a positive TB GXP result
- A 45-year-old male, HBsAG positive
- A woman with jaundice and ALT 320
- A 28-year-old pregnant women, HB of 9 g/dL, recently started on ART and pregnancy supplements
- A 36-year-old male on ART with a positive CrAG

Steps 4 Prevent Opportunistic infections

Step 4
Prevent OIs

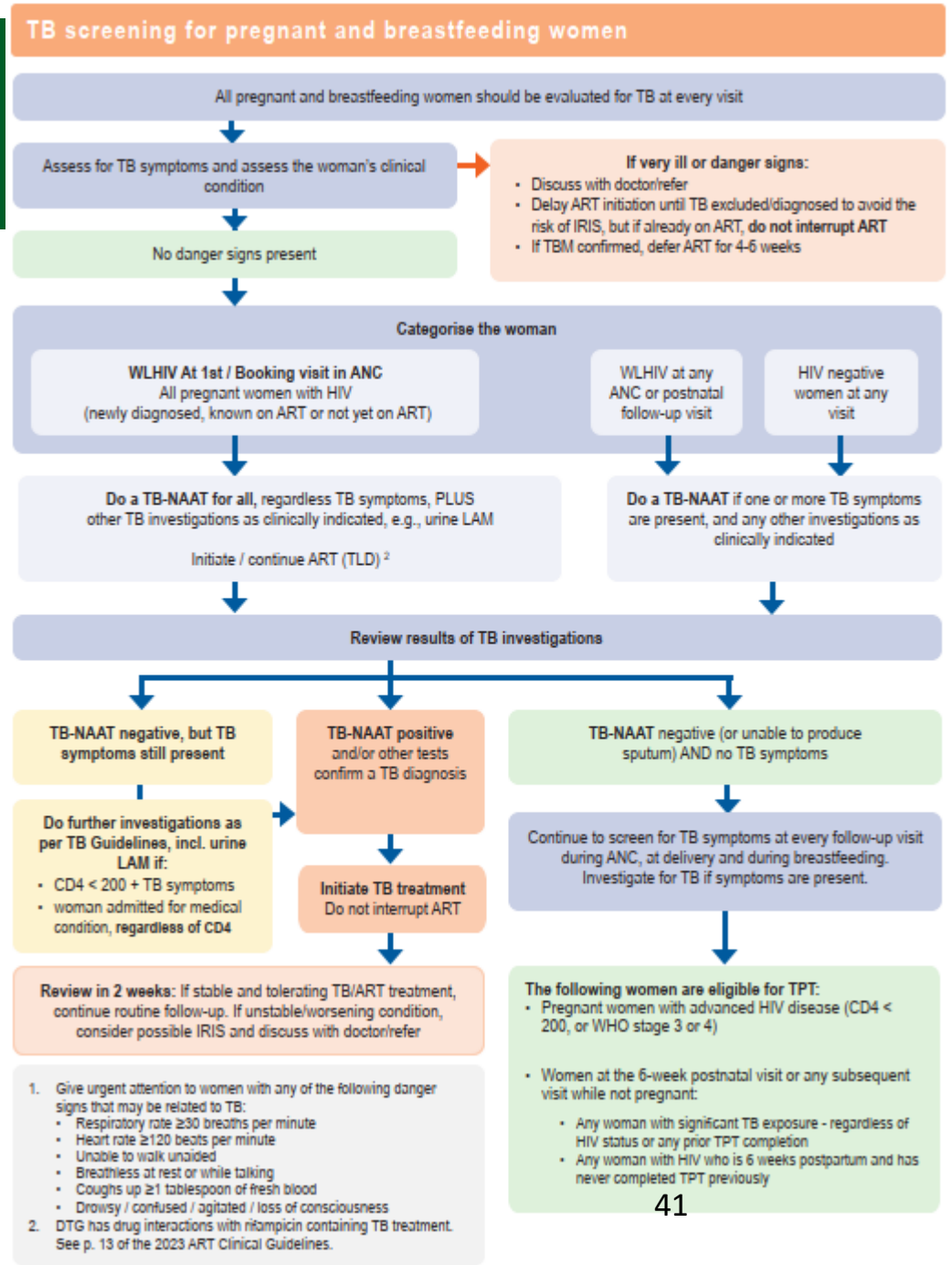
Provide **cotrimoxazole prophylaxis** therapy if CD4 < 200 or WHO Stage 3 or 4
Provide **TPT** if TB has been excluded and eligible for TPT (see Table 4)

Table 23: Indications for starting and stopping Cotrimoxazole Preventive Therapy (CPT)

Age	When to start	When to stop
HIV-positive infant under 1 year	All children under 1 year should be on cotrimoxazole irrespective of CD4% or clinical stage	
HIV-positive child 1-5 years of age	CD4% ≤ 25%, or WHO Stage 3 and 4	Discontinue if CD4% > 25% regardless of clinical stage
HIV-positive child under 5 years of age with PJP infection	Start CPT after PJP treatment is completed	Continue CPT until 5 years of age and stop after that only if CD4 > 200 cells/µL
HIV-positive adults and children older than 5 years, including pregnant and breastfeeding women	CD4 ≤ 200 cells/µL, or WHO Stage 3 or 4	Discontinue if CD4 > 200 cells/µL regardless of clinical stage

TPT in Pregnancy

- Pregnant women with AHD are at significant risk of TB
- Recommendations for TPT in pregnancy have been aligned with the recommendations for all clients with AHD
  - CD4 counts < 200 cells/mm3 → 12 months of TPT
  - CD4 counts ≥ 200 cells/mm3, → defer to the post-partum period.
  - In the absence of TPT initiation, continued active screening for TB throughout pregnancy



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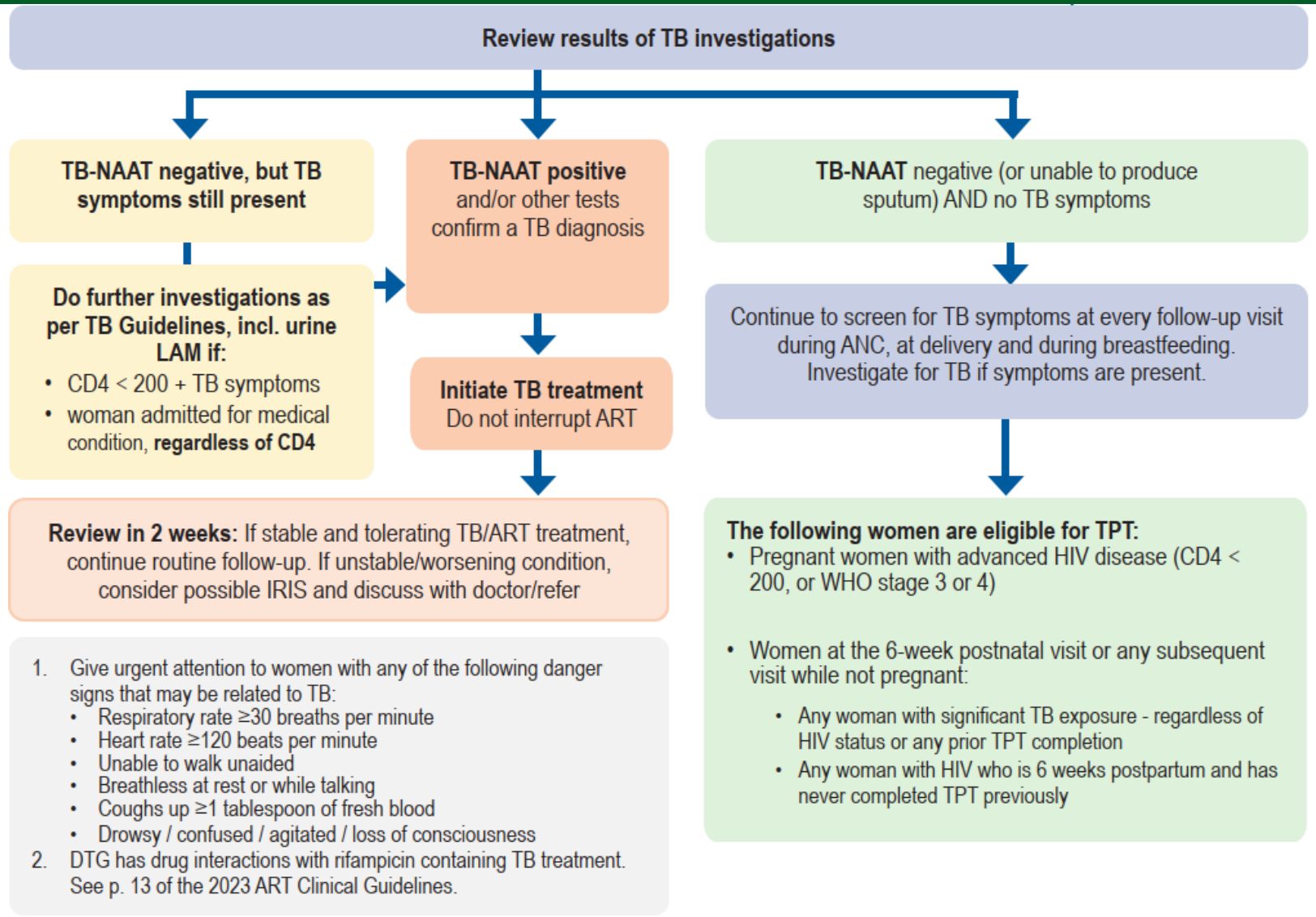
TPT in pregnant and breastfeeding women



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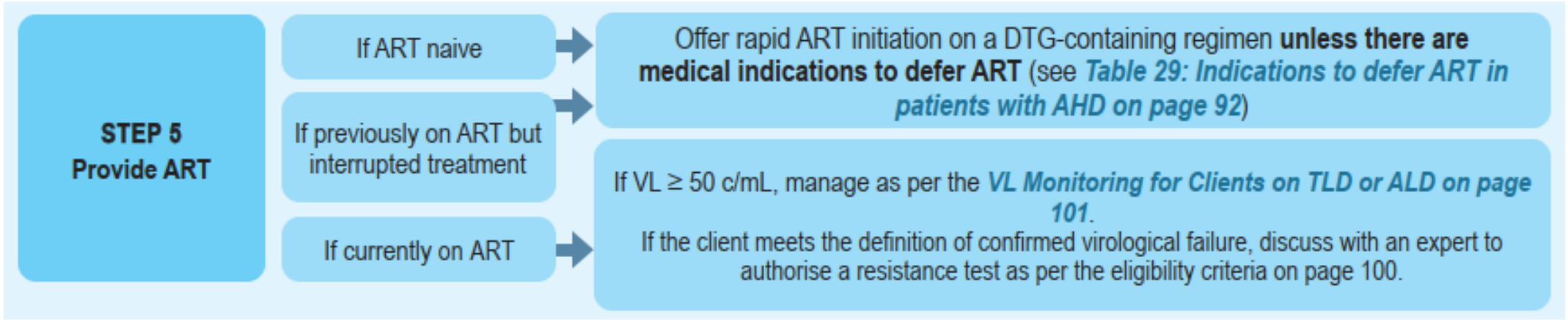
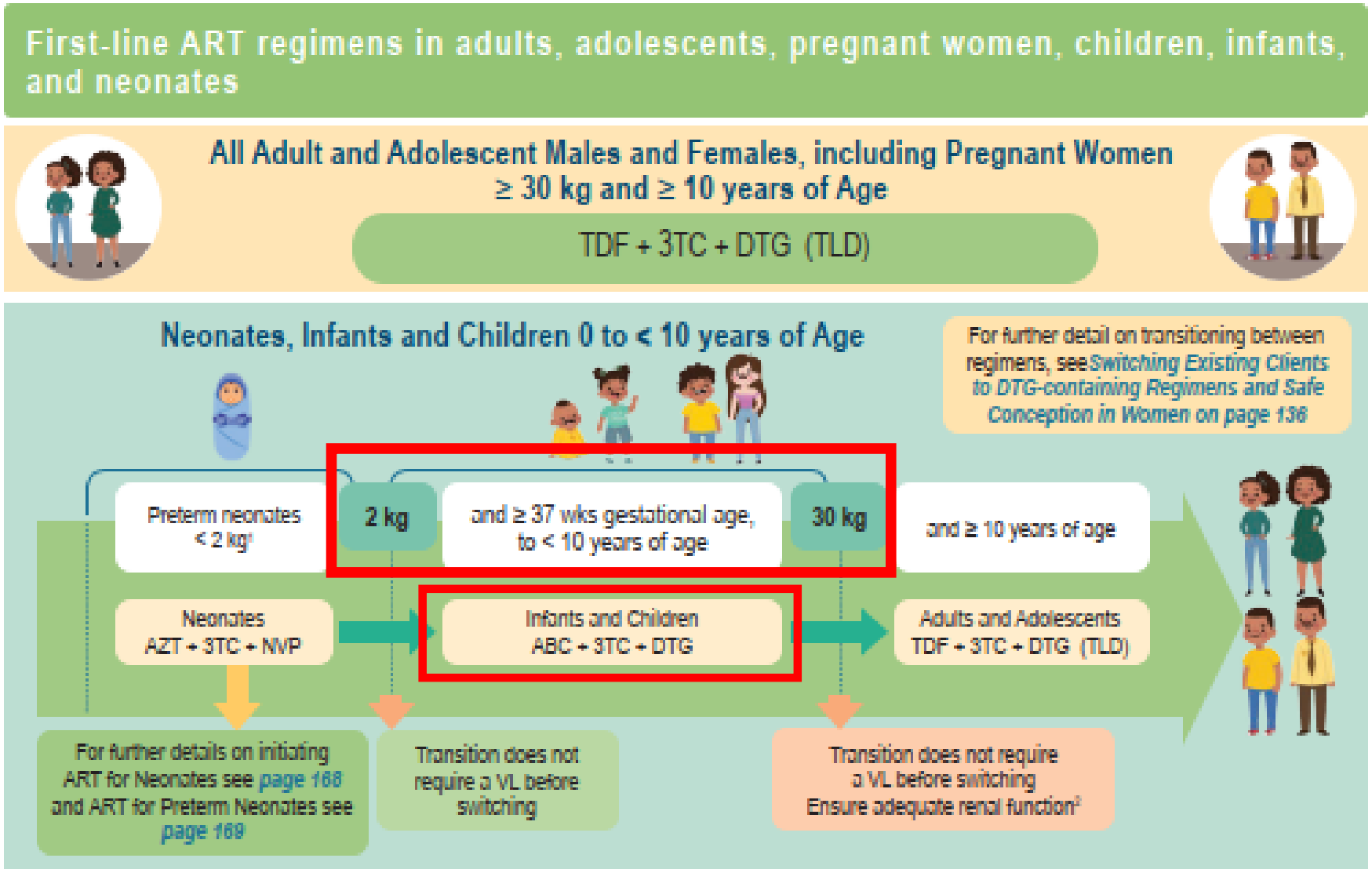
Steps 5 Provide ART



Remember, no VLs at ART initiation or re-initiation!

ABC + 3TC + DTG for term infants ≥ 2kg from birth



More on this later….

Steps 6 Provide Other care

Step 6 Provide other care	Provide **other care** as appropriate for mental health, NCDs, SRH services, immunisations, and other care as per RTHB or maternity care guidelines. When indicated, provide **palliative care.**

Identify

preventive needs, existing conditions, or screen for new conditions

Provide clinical care

APC/ART/TB

Align follow-up dates

for different conditions

Align medication

Ensure sufficient treatment/ contraceptive coverage

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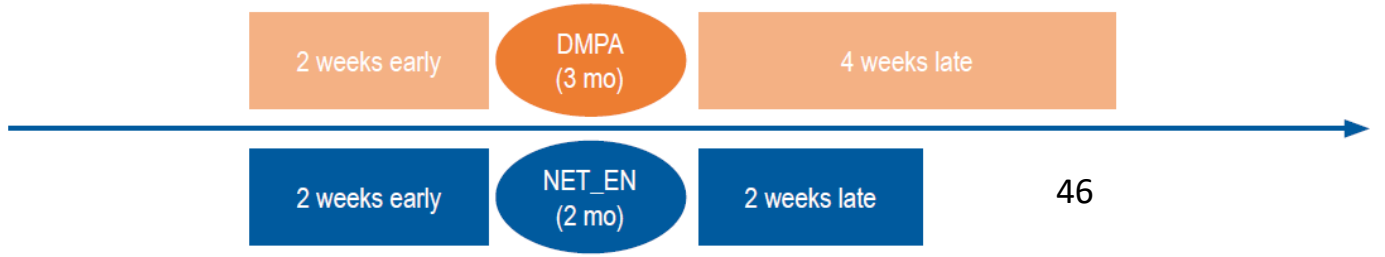
Contraceptive options and visit alignment

> **!** Every effort should be made to script contraception and NCD treatment on the same prescription and for the same refill length as ART through the same service delivery model (see DMOC SOP 4 and 5).

- Explain **contraceptive method options** and how each impacts **visit location and frequency**
- Methods and implications:
  - **Long-acting reversible contraceptives (LARC):** no increased visit frequency or alignment concerns
  - **COCP (pills):** Give 3MMD or 6MMD to align with ART refills, well-baby visits, RPCs & 6MMD
  - **Clinician- administered injectables:** Consider **FAC-PUP or facility adherence clubs** and use injection timing flexibility to ensure alignment
    - **DMPA-IM (3-monthly):** aligns with ART and well-baby visits
    - **NET-EN-IM (2-monthly):** requires additional visits
  - **DMPA-SC self-injection at home** (**3-monthly):** Give 2 units (only available from Oct 2026)



Visit schedule for integrated care for clients already on ART when diagnosed with drug-sensitive TB

Integrated visit schedule for a client on ART who develops DS-TB (not in RPCs)		Months (M) on TB Treatment (Rx)						
		Intensive Phase (IP) (months 1-2)				Continuation Phase (CP) (months 3-6)		
		TB M0	TB M1 (4 completed weeks)	7 wks	TB M2 (8 completed weeks)	TB M4 (16 completed weeks)	23 wks	TB M6 (24 completed weeks)
Integrated TB/ART clinical consult	TB screening as part of routine care	TB diagnosis and TB Rx initiation	Clinician-managed care at facility		Assess smear conversion and transition to CP of TB Rx, if smear result is negative	Clinician-managed care at facility		Confirm TB Rx completion Assess for RPCs enrolment
Investigations	TB NAAT and any other investigations as clinically indicated	Review result		Smear	Review result		Smear	Review end-of-Rx result
ART/TB script	Script ART for 1 month	Combined script for 1 month of IP TB Rx and ART	Combined script for 1 month of IP TB Rx and ART		Combined script for 2 months** of CP TB Rx and ART	Combined script for 2 months** CP of TB Rx and ART"		If eligible for RPCs: RPCs ART script for 6 months
ART-TB drug supply dispensed by facility	Dispense ART for 1 month	Dispense 1 month of IP TB Rx and DTG boosted ART	Dispense 1 month of IP TB Rx and DTG boosted ART		Dispense 2 months of CP TB Rx and 2 months DTG boosted ART	Dispense 2 months of CP TB Rx and 2 months DTG boosted ART		Dispense 3 months of ART
Ask client to return:	If client has TB symptoms or is unwell, ask client to return in 5-7 days for review *	After 4 weeks for clinical review	After 3 weeks for sputum smear	After 1 week for smear results	After 8 weeks for clinical review	After 7 weeks for end of Rx smear	After 1 week for smear results	If eligible and enrolled in RPCs: return for next ART supply at RPCs pick-up point after 3 months

Step 6: Other care -Updated mental health screening

Guidelines Annexure 7

ANNEXURE 7 Mental Health Assessment

DMOC SOP Annexure 2 (same)

ANNEXURE II: MENTAL HEALTH ASSESSMENT

Why is this important?

Mental health conditions can **negatively impact adherence** (HIV, TB, NCDs). Revised approach:

1. Rapid Clinical Screen (ask + observe) – can use any tool e.g. SRQ20
2. Identify Red Flags (urgent referral) 🚨
3. If Mild–Moderate Symptoms: How to manage at PHC level
4. Tool to screen for mental health condition:
    - Part 1 Depression & Anxiety
    - Part 2: Substance use disorder

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Mental health support tools

Summary of the 9 Steps so far...

All patients

STEP 1
Identify the seriously ill client

If no dar

STEP 2
Identify high-risk clients for AHD

STEP 3
Assess and Treat
Assess for AHD & treat any OIs & other HIV-associated conditions

STEP 4
Prevent OIs

STEP 5
Provide ART

STEP 6
Provide other care

of care for patients with presumed or confirmed AHD

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STEP 1
Identify the seriously ill client

Manage at Hospital or Clinic

STEP 2
Identify high-risk clients for AHD

STEP 3
Assess and Treat
Assess for AHD & treat any OIs & other HIV-associated conditions

STEP 4
Prevent OIs

STEP 5
Provide ART

STEP 6
Provide other care

But is that enough?

STEP 7
Provide adherence support

STEP 8
Ensure continuity of care between hospital and clinic

STEP 9
Provide intensified follow-up

Steps 7 Adherence support

Step 7 Provide adherence support	Offer intensified adherence support for OI medication, ART, and condition monitoring. Counsel about IRIS, warning signs and side-effects to look out for, and when to return Involve the client's **family** in the plan for treatment and follow-up.

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Adherence challenges in AHD

Clients with AHD may experience difficulties due to:

- Clinically unwell and physically weakened
  → difficulty taking treatment
- Treating HIV and other OIs at the same time:
  - Increased pill burden
  - Drug side effects or unpalatable medicines
- Additional cost of clinic visits
- Undiagnosed/untreated mental conditions
- Previous challenges accessing facilities → treatment interruptions

The development of advanced HIV disease in a patient on ART should raise a 'red flag' to alert the clinician to adherence problems!

Developing an adherence support plan

- Each patient with AHD requires an individualised adherence plan
- A clinician should lead adherence support; counselling can be delegated with oversight
- Approach the patient with kindness, respect, and a nonjudgmental attitude
- Use patient-centred communication to create a safe space to discuss challenges
- Assess patient understanding across the encounter (before, during, and after), and obtain consent for recall
- Document the adherence support plan in the file

Table 30: Adherence support plan for clients with AHD: Key components

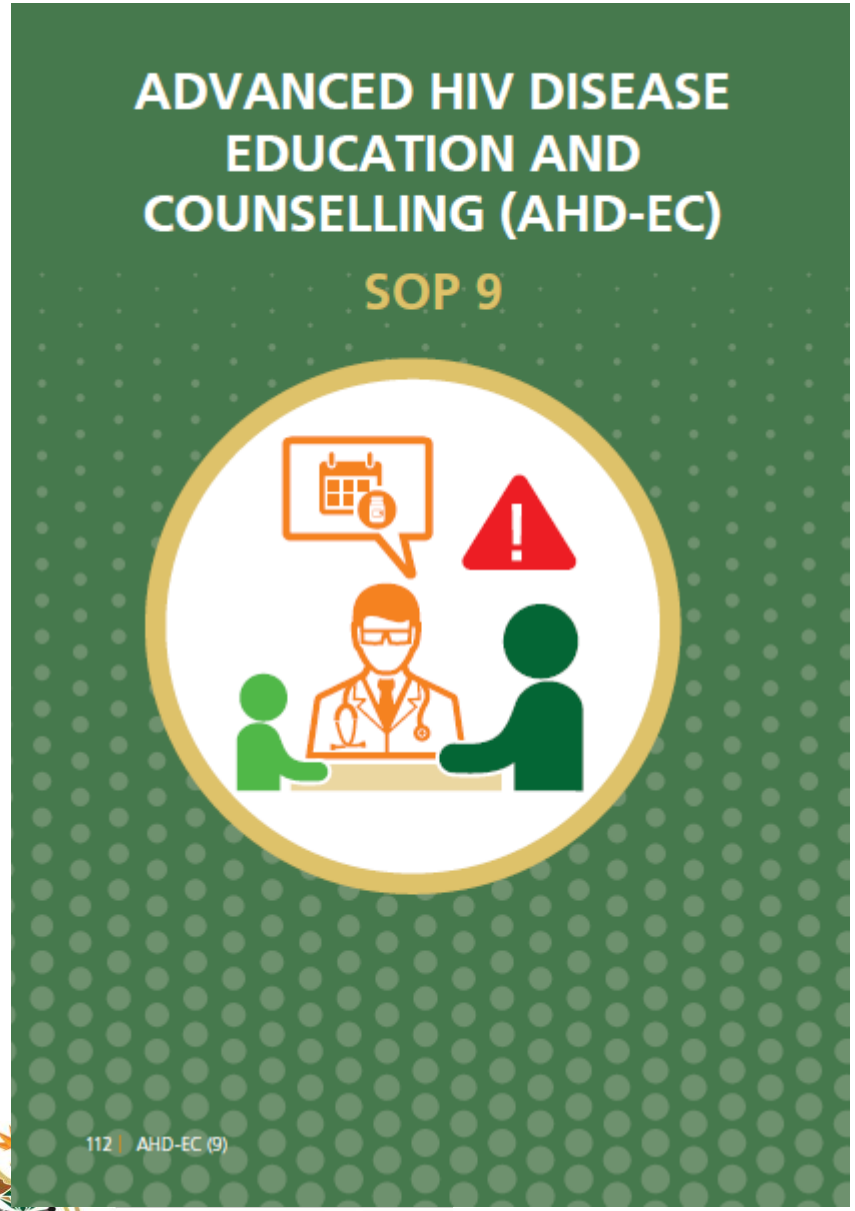
Adherence support plan for clients with AHD	
AHD treatment literacy • Explanation of AHD (WHO stage or low CD4) and increased risk of morbidity and mortality • Importance of intensified clinical management with more regular visits/check-ins to identify any deterioration for 3 months • Importance of monitoring (by the patient and their supporter) for warning signs and returning to the clinic or going to the hospital • Provide information regarding medication side effects and IRIS.	*DMoC SOP 9 on page 188*
Home support network • Identify and document the client's chosen family or friend supporter and their contact details • Ensure the identified supporter also receives information on AHD and how they can support the patient, including monitoring for warning signs and assisting with clinic attendance or hospital admission	
Adherence and disclosure counselling • If newly initiated, provide Fast Track Initiation Counselling (FTIC) as per DMOC SOP 1 • If already on ART but struggling with adherence, provide Enhanced Adherence Counselling (EAC) as per DMOC SOP 2. • For children, provide disclosure counselling when appropriate as per DMOC SOP 3. • Include adherence to OI medication	DMOC SOP 1-3 NDoH adherence plan
Mental health screening and referral • Ensure mental health screening has been done as detailed in Step 6. • Refer for further assessment and treatment if necessary	*Mental Health Assessment on page 179*
Document main adherence barriers and plan • Document the main barriers to adherence • Document a plan to address the main barriers to adherence	
Identify the patients' preferred mechanisms for support • Discuss and document the patient's chosen methods for support, depending on what is available. Potential options include: a family member or friend to check in daily or weekly; WhatsApp communication with clinician/counsellor/linkage officer; WhatsApp or in-person support group; check-in phone calls; CHW home visits; or CBO other community actor check-ins.	Each facility to identify possible support approaches
Psychosocial support referrals • Refer as appropriate for counselling or to a psychologist or social worker for assistance with food parcels, SASSA grants, ID documents, SAPS for safety, etc.	Referral SOPs
Document the agreed follow-up visit schedule and the format of the follow-up interaction e.g. in person or telehealth check-in or home visit • 1st follow-up visit (date and format) • 2nd follow-up visit (date and format) • 3rd follow-up visit (date and format)	Step 9
Tracing and recall • Discuss and get consent to phone the patient and/or visit them at home if they miss an appointment (especially in the first 3 months) or if they need to be recalled to the clinic for management of abnormal test results • Verify and update the client's contact number and residential address	DMOC SOP 7 See further detail in Step 9

1. **AHD treatment literacy**
2. **Home support network**

} **DMOC SOP 9**

Studies show that outcomes are better if families are involved.

3. Adherence and disclosure counselling
4. Mental health screening and referral
5. Document main adherence barriers and plan
6. Identify the patient's preferred mechanisms for support
7. Psychosocial support referrals
8. Document the agreed follow-up visit schedule and format (in-person, telehealth check-in or home visit)
9. Prioritized tracing and recall



TITLE: STANDARD OPERATING PROCEDURE FOR ADVANCED HIV DISEASE (AHD) EDUCATION AND COUNSELLING (AHD-EC)	
INSTITUTION: NATIONAL DEPARTMENT OF HEALTH	
REFERENCE NUMBER: AGL: AHD-EC (1)	**EFFECTIVE DATE:** AUGUST 2025
PURPOSE	
The purpose of this document is to outline the process for healthcare workers and counsellors to provide Advance HIV Disease (AHD) education and counselling.	

Session provides exact wording that can be used by a nurse/trained counsellor if helpful

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Contents of an AHD treatment literacy session (SOP 9)

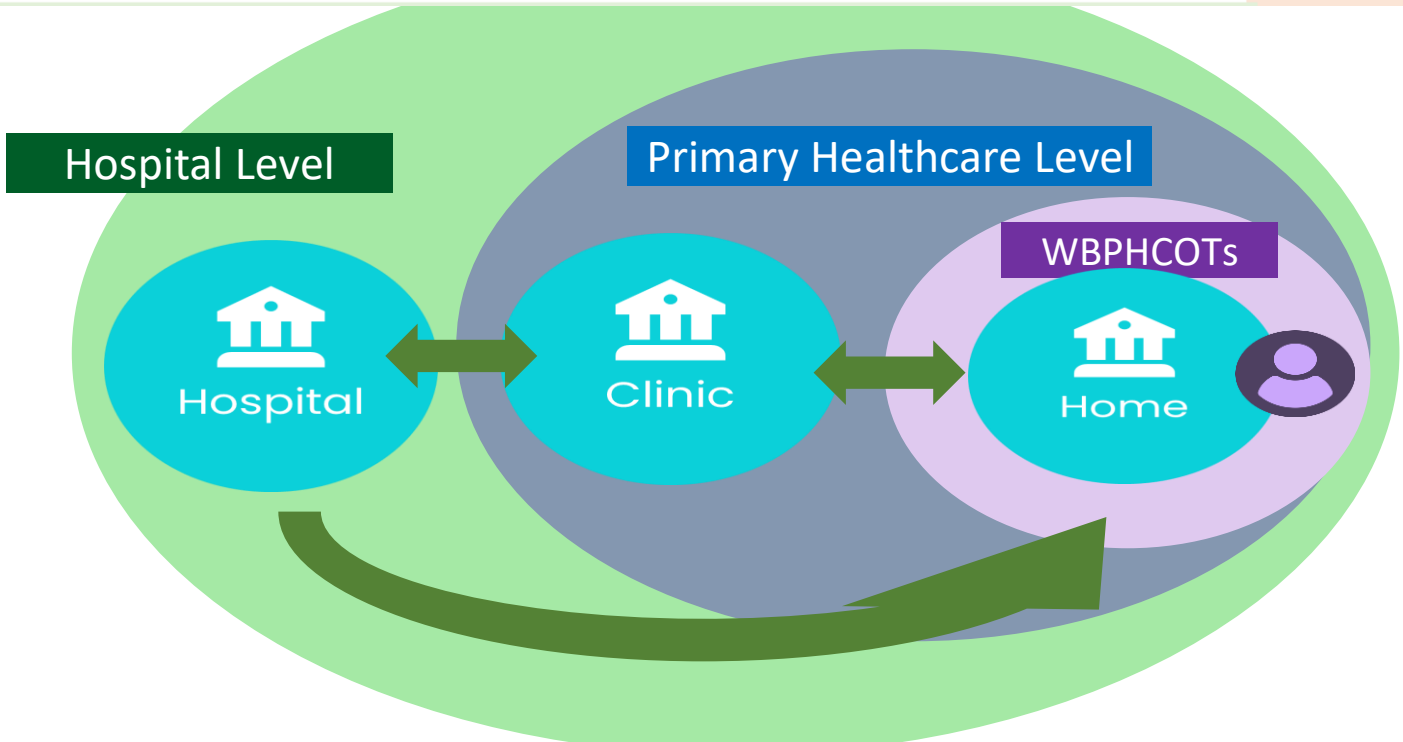
- Explain the purpose of your session
- Explain the AHD diagnosis and why we are concerned
- Educate on how to get better with appropriate treatment
- Educate on IRIS
- Educate on danger signs
- Educate on tests performed (or to be performed) and possible results
- Educate on prophylaxis
- Educate on treatment adherence incl. for TB, CM, other co-infections

Steps 8 Continuity of care

Step 8
Ensure continuity of care between hospital and clinic

Clinicians at PHC should have a low threshold for admission or re-admission to hospital. Assign a clinic staff member to do check-in phone calls or CHW to do home visits weekly for first month and support continuity of care.

At discharge from the hospital provide a discharge plan with follow-up appointments at PHC. Also promote continuity of care at OPD/PHC through locally established mechanisms, such as **phone calls to the clinic.** Assign **linkage officer**/community liaison officer where available.



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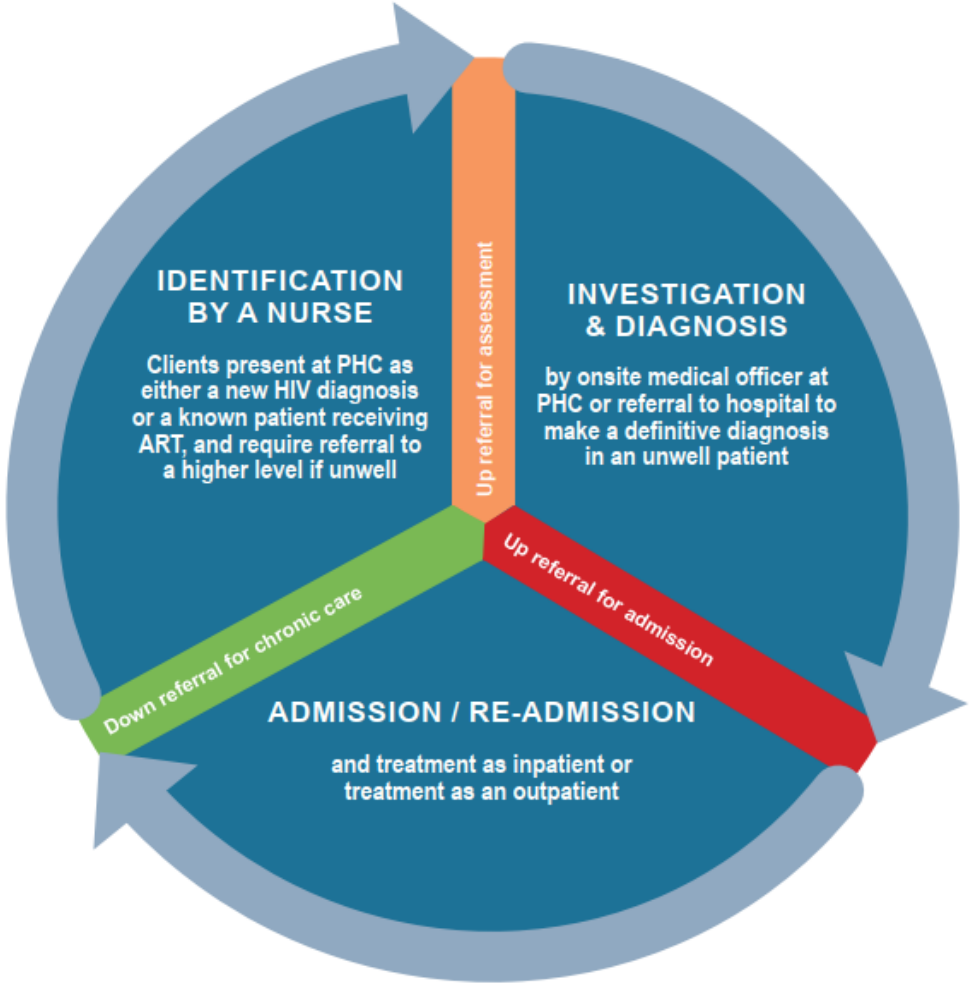
But first…we need to unpack a few complexities

- AHD clients often need to move between cadres and levels of care



! Implications for communication, care coordination

Patients with AHD: high morbidity and mortality

High-risk period:

Patients with AHD: **high morbidity and mortality**, including significant risk of death **post-discharge**

- *SA data: ~20–25% of patients die within 6 months of hospital discharge*

(Hoffman et al 2023 Clin Infect Dis.)

Remember, when the system fails someone with AHD
(in a weak boat) the effects can be CATASTROPHIC!

Maintain a low threshold for admission or re-admission to hospitals.

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What do we need for a client to move successfully between levels or cadres?

- Know who all the people are involved in your patient's care
- Have a care plan with follow-up dates for each visit at each level
- Appointment systems with safety nets (identify if appointment missed)
- Referral letters
- Web-based electronic medical record
- Care coordinators/case managers, if available
- Involve client and family

What do we need for a client to move successfully between levels or cadres?

- Know who all the people are involved in your patient's care
- Have a care plan with follow-up dates for each visit at each level
- Appointment systems with safety nets (identify if appointment missed)
- **Communication! Communication!! Communication!!!**
  - Referral letters (Box 15 (up-referral), Box 16 (down-referral with hospital discharge summary)
  - Telephone calls
  - Electronic medical record
  - Care coordinators/case managers, if available
- **Involve client and family**

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What do we need for a client to move successfully between levels or cadres?

- Identify the multidisciplinary team
- Care plan – constructed by the most senior/qualified person in the team
- Communication
  - Referral letters (Box 15 (up-referral), Box 16 (down-referral with hospital discharge summary)
  - Telephone calls
  - Electronic medical record
  - Client and family!
- Appointment systems with safety nets
- Care coordinators/case managers, if available (CHW can fulfil this role if they are included as part of the MDT and plan is communicated)

PHC Referral Letters (Page 96)

Box 15: PHC referral letters

PHC referral letter should contain the following information:

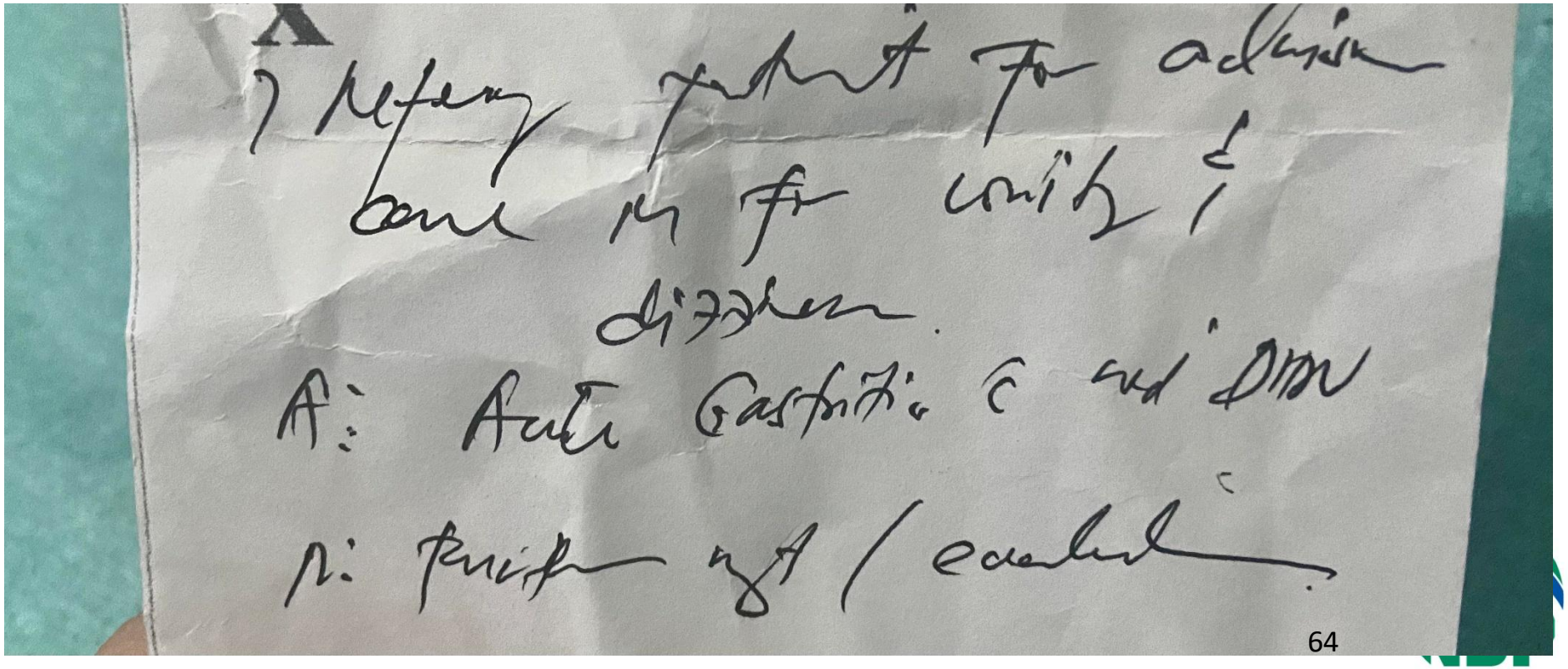
- Reason for referral:
  - → The presenting complaint, duration, associated signs and symptoms, and
  - → The suspected diagnosis
- HIV history:
  - → Date of diagnosis,
  - → Date of ART initiation
  - → Current ART regimen and its start date, previous regimens and dates taken, reasons for switches (treatment failure, poor adherence, side effects)
  - → Latest monitoring test results (viral load, CD4 count, and eGFR), and
- The findings of any previous resistance test/s.
- Estimated level of adherence
- Psychosocial circumstances and factors affecting adherence.
- Other known comorbidities and medications, whether they are well controlled or not.
- Pregnancy status, if female
- Other investigations done to date, with laboratory barcodes/references or results if available.
- Management and treatment provided to date, if relevant
- Name and contact number for referring clinician

Printing a Tier.net summary can be useful

Continuity of Care

8

Referral letters



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Discharge Summaries (Page 96-97)

Box 16: Hospital discharge summaries

Hospital discharge summaries should contain the following information:

- All diagnoses (chronic and acute) and the results of relevant investigations.
- Details of management provided in hospital, including:
  - → HIV and ART management. If ART regimens have been changed, note why and whether the change is permanent or when it can change back.
  - → Management of opportunistic infections, including treatment regimens and doses
  - → Management of any complications or side effects which developed
  - → Management of any co-morbidities
- The patient's state on discharge (to allow the nurse to assess whether the patient is improving or deteriorating).
- A detailed plan for care after discharge, including:
  - → Medication that needs to be continued after discharge, for how long the medication needs to be taken, and at what dose. Pay particular attention to continuing treatment for opportunistic infections such as Cryptococcal disease and TB, which have different phases.
    - For the consolidation and maintenance phases of cryptococcal disease, indicate the dose and duration of fluconazole to be used, as well as the intended start and stop dates for each phase (see a template for inclusion in the discharge summary in Annexure 1 CrAg positive management summary)
    - For TB, use the available TB patient card. In children, be sure to provide the disease severity classification and whether or not the child is potentially eligible for treatment shortening
  - → The plan for multidisciplinary team involvement, if indicated
  - → Clinic- and community/home-based care recommendations,
  - → The recommended frequency of follow-ups at the clinic;
  - → If relevant, the plan for follow-up appointments at the hospital (where possible, pre-book the follow-up appointments and provide the dates on the discharge summary).
- The expected prognosis
- The signs and symptoms that would require urgent management or referral b
  clinician or department to call or go to, should the patient deteriorate).

Tell the patient and family member to take it with them to the next appointment

Have a low threshold for reffering back to hospital

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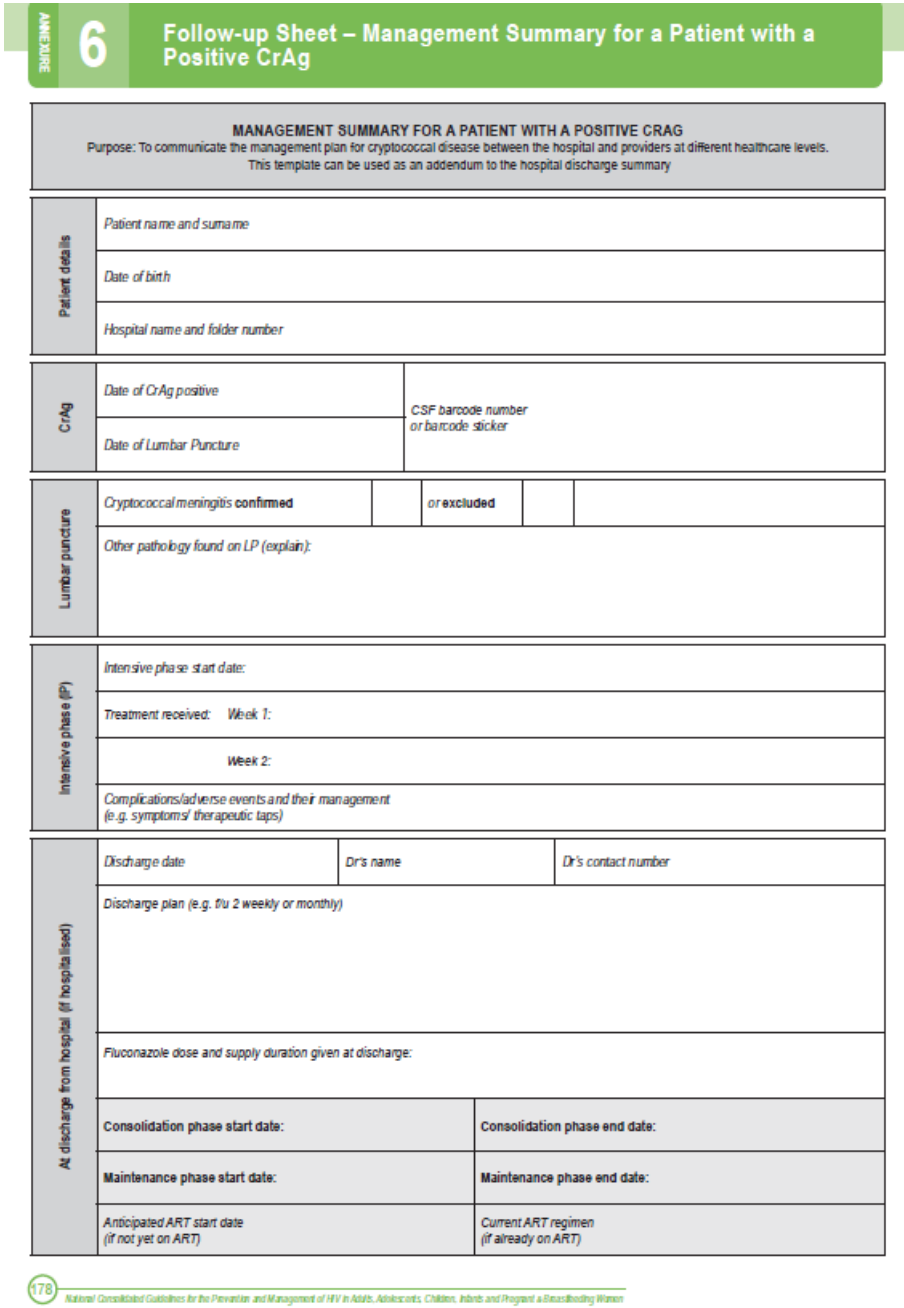
Managament Summary for positive CrAg (Page 178)



ANNEXURE 6 **Follow-up Sheet – Management Summary for a Patient with a Positive CrAg**

MANAGEMENT SUMMARY FOR A PATIENT WITH A POSITIVE CRAG
Purpose: To communicate the management plan for cryptococcal disease between the hospital and providers at different healthcare levels.
This template can be used as an addendum to the hospital discharge summary

Patient details	*Patient name and surname*	
	Date of birth	
	Hospital name and folder number	
CrAg	*Date of CrAg positive*	*CSF barcode number or barcode sticker*
	Date of Lumbar Puncture	
Lumbar puncture	*Cryptococcal meningitis* **confirmed** ☐ **or excluded** ☐	
	Other pathology found on LP (explain):	
Intensive phase (IP)	*Intensive phase start date:*	
	Treatment received: Week 1:	
	Week 2:	
	Complications/adverse events and their management (e.g. symptoms/ therapeutic taps)	
At discharge from hospital (if hospitalised)	*Discharge date* / *Dr's name* / *Dr's contact number*	
	Discharge plan (e.g. f/u 2 weekly or monthly)	
	Fluconazole dose and supply duration given at discharge:	
	Consolidation phase start date:	**Consolidation phase end date:**
	Maintenance phase start date:	**Maintenance phase end date:**
	Anticipated ART start date (if not yet on ART)	*Current ART regimen (if already on ART)*

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Steps 9 Provide intensified follow-up

Step 9 Provide intensified follow-up	At PHC/OPD, provide **two-weekly** (previously admitted/psychosocially vulnerable) **or monthly follow-ups for the first three months**. Ensure that missed appointments can be identified and prioritize these clients for **tracing and recall** to the facility if they are missed. Ensure provision of any Step 6 or 7 elements that were not provided by the hospital.	Follow hospital discharge plan and ensure hospital follow-up appointments. Provide any advanced clinical care as indicated by the hospital. **Refer back to hospital for assessment and re-admission if patient deteriorates clinically**

- Clients with AHD are at **higher risk of clinical deterioration**, including IRIS, especially in the first months after ART initiation/re-initiation
- May require **more frequent review than standard intervals** (1 DC and 3 DCs after ART initiation) – but not all AHD clients need the same follow-up schedule

Determining visit frequency

- If active OI: additional clinical check-ins to monitor adherence and clinical status
  - At least monthly follow-up (clinic, phone/WhatsApp, or home visits)
  - If particularly vulnerable: as frequent as two-weekly (at least for first month)
- If no active OI: consider telehealth or community visits
- If clinically well with elevated VL or re-engaging:
  - Frequency based on clinical needs
  - May offer 3-monthly clinical reviews with aligned ART refills (3MMD)

Indications for increased visit frequency in first 3 months after AHD diagnosis

Indications for increased patient interactions
• Recent hospital admission
• Current OIs that require increased clinical management
• Psychosocial vulnerability, e.g., an unstable home environment and/or mental health challenges
• Limited family/social support in the home environment who can monitor and respond to warning signs
• Poor treatment literacy and poor understanding of their AHD condition
• The health facility has limited telehealth/community support systems in place to carry out telehealth check-ins or home visits

Indications for standard interactions/telehealth

Indications for the standard level of interactions or using additional telehealth interactions
• No OIs identified and clinically well
• The patient experiences difficulties in getting to the clinic (cost, work, social responsibilities, mobility)
• Strong family or social support in the home environment who can monitor and respond to warning signs
• The health facility has effective telehealth/community support systems in place to carry out telehealth check-ins or home visits, and the patient has consented to such interactions
• Good treatment literacy and good understanding of their AHD condition

Follow-up planning and tracking

- Discuss and agree with the client on follow-up schedule and type of interaction (facility visit, phone/WhatsApp check-in, or home visit)
- Document consent for home visits or telehealth check-ins
- Record agreed appointment schedule and updated contact details (patient and support person)
- Ensure missed appointments can be identified (including calls/home visits)
- Prioritizing tracing abnormal results and missed appointments for clients with AHD (DMOC SOP 7). If resources limited, prioritise:
  - Patients who started/restarted ART in last 6 months with AHD
  - Patients with abnormal investigation results

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To be included in the Adherence Support Plan

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Adherence support plan for clients with AHD

AHD treatment literacy • Explanation of AHD (WHO stage or low CD4) and increased risk of morbidity and mortality • Importance of intensified clinical management with more regular visits/check-ins to identify any deterioration for 3 months • Importance of monitoring (by the patient and their supporter) for warning signs and returning to the clinic or going to the hospital • Provide information regarding medication side effects and IRIS.	*DMoC SOP on page 179* (DMOC SOP 9)
Home support network • Identify and document the client's chosen family or friend supporter and their contact details • Ensure the identified supporter also receives information on AHD and how they can support the patient, including monitoring for warning signs and assisting with clinic attendance or hospital admission	
Adherence and disclosure counselling • If newly initiated, provide Fast Track Initiation Counselling (FTIC) as per DMOC SOP 1 • If already on ART but struggling with adherence, provide Enhanced Adherence Counselling (EAC) as per DMOC SOP 2. • For children, provide disclosure counselling when appropriate as per DMOC SOP 3. • Include adherence to OI medication	DMOC SOP 1-3 NDoH adherence plan
Mental health screening and referral • Ensure mental health screening has been done as detailed in Step 6. • Refer for further assessment and treatment if necessary	*Mental Health Assessment on page 175*
Document main adherence barriers and plan • Document the main barriers to adherence • Document a plan to address the main barriers to adherence	

Identify the patients' preferred mechanisms for support • Discuss and document the patient's chosen methods for support, depending on what is available. Potential options include: a family member or friend to check in daily or weekly; WhatsApp communication with clinician/counsellor/linkage officer; WhatsApp or in-person support group; check-in phone calls; CHW home visits; or CBO other community actor check-ins.	Each facility to identify possible support approaches
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Tracing and recall • Discuss and get consent to phone the patient and/or visit them at home if they miss an appointment (especially in the first 3 months) or if they need to be recalled to the clinic for management of abnormal test results • Verify and update the client's contact number and residential address	DMOC SOP 7 See further detail in Step 9

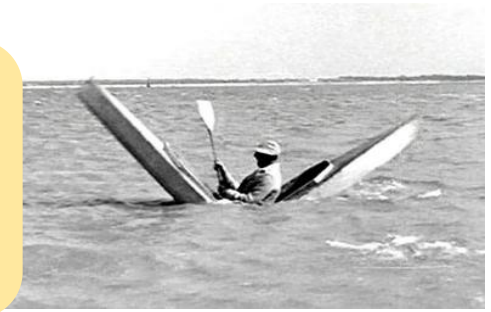
Patients who have their **family or other support persons involved** in their adherence support plan have better retention in care and better treatment outcomes

AHD needs a whole system response

When someone gets AHD, it indicates a failure in healthcare on so many levels!!

When the system fails someone that is well (in a strong boat) the effects have less impact

When the system fails someone with AHD (in a weak boat) the effects can be CATASTROPHIC!



There are many complexities and moving parts when managing a client with AHD…

Can a clinician do this on their own?

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The operational manager is responsible for ensuring the systems within her/his clinic work

For example:

- Routine results review
- Appointment systems
- Tracking and tracing systems
- Checking on patients through telehealth or CHWs
- Referral protocols – meet with hospitals

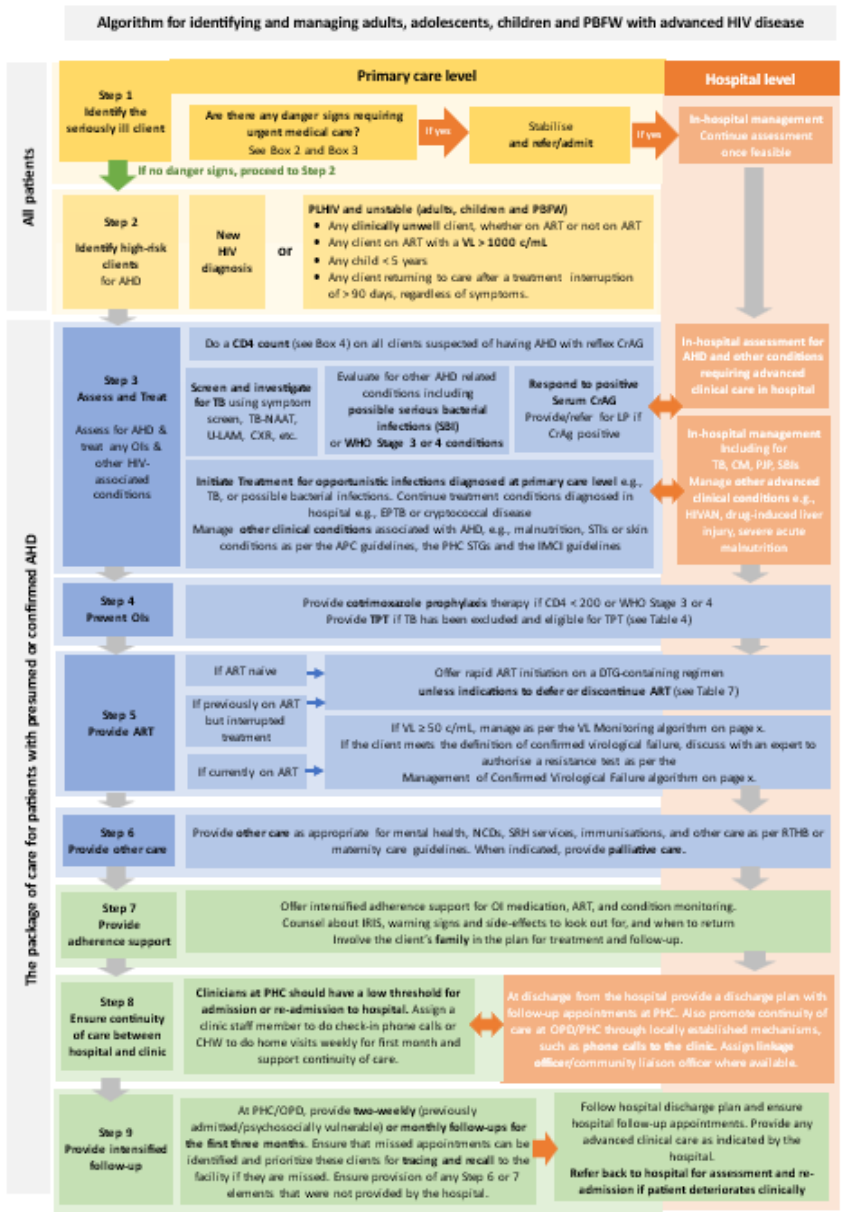
The OPM and multidisciplinary team must work together

Hospitals and clinics must work together

Questions

- *What questions or concerns do you have?*

Summary of the 9 Steps



STEP 1
Identify the seriously ill client

STEP 2
Identify high-risk clients for AHD

STEP 3
Assess and Treat
Assess for AHD & treat any OIs & other HIV-associated conditions

STEP 4
Prevent OIs

STEP 5
Provide ART

STEP 6
Provide other care

STEP 7
Provide adherence support

STEP 8
Ensure continuity of care between hospital and clinic

STEP 9
Provide intensified follow-up

Thank you