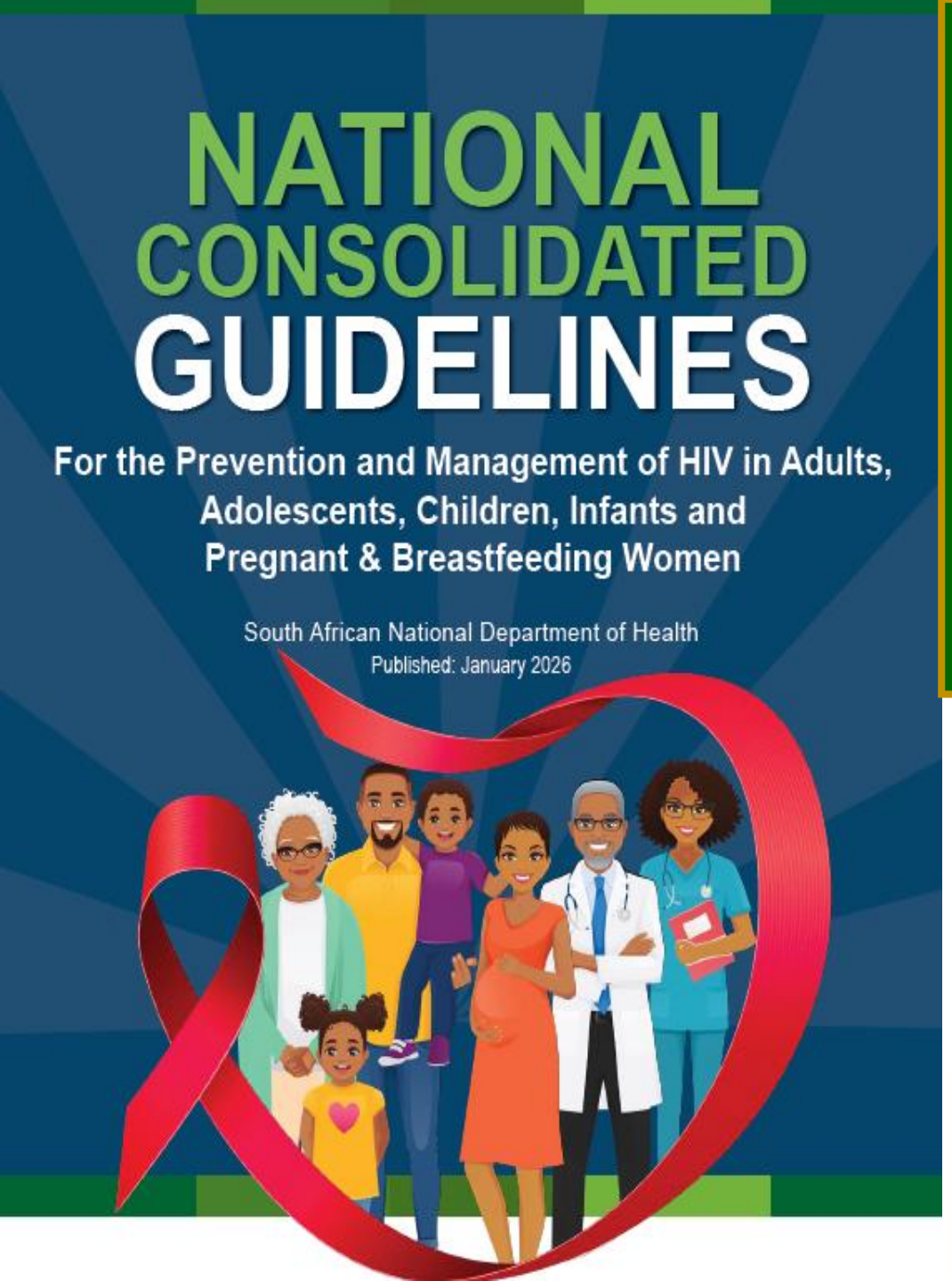

Webinar 3

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

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
  - SOP 9 Advanced HIV Disease Education and Counselling (AHD-EC)
  - SOP 4.2 Facility-provided 6MMD

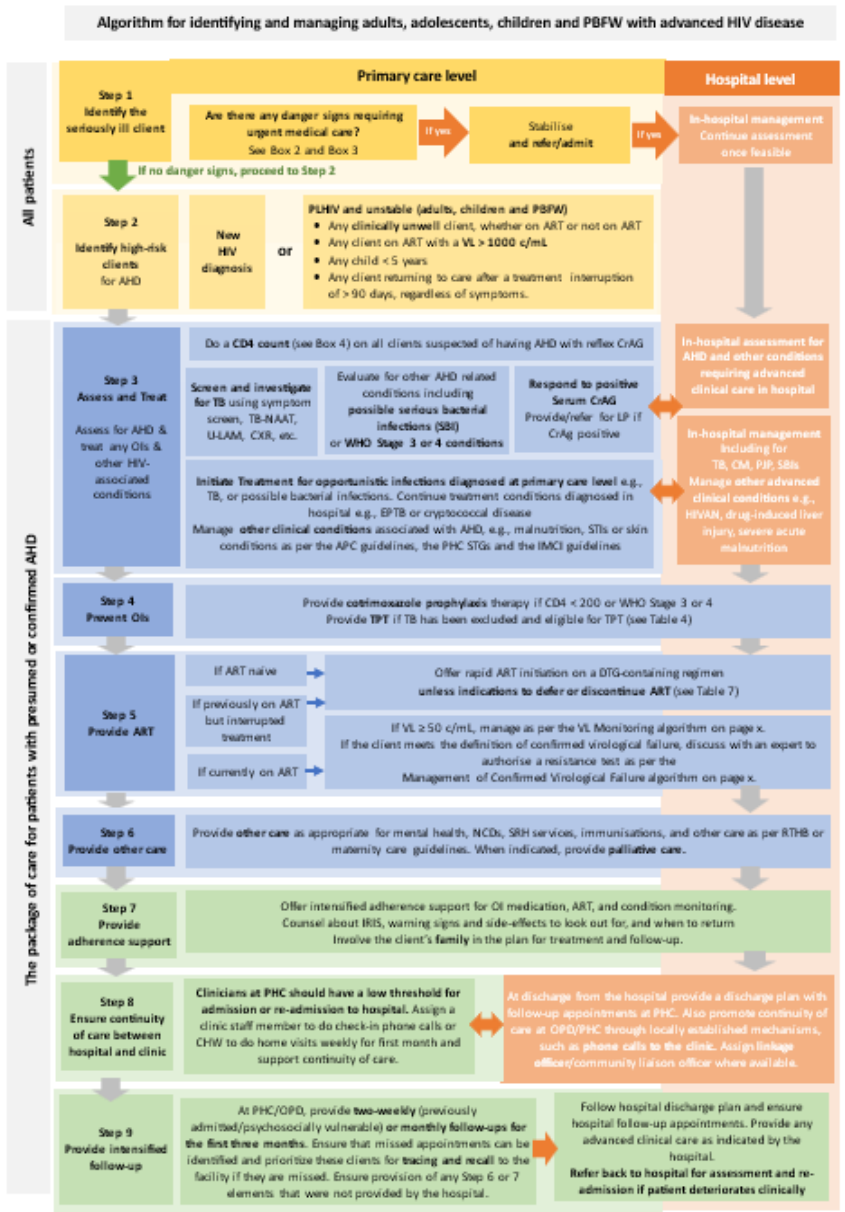
What is advanced HIV disease?

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

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

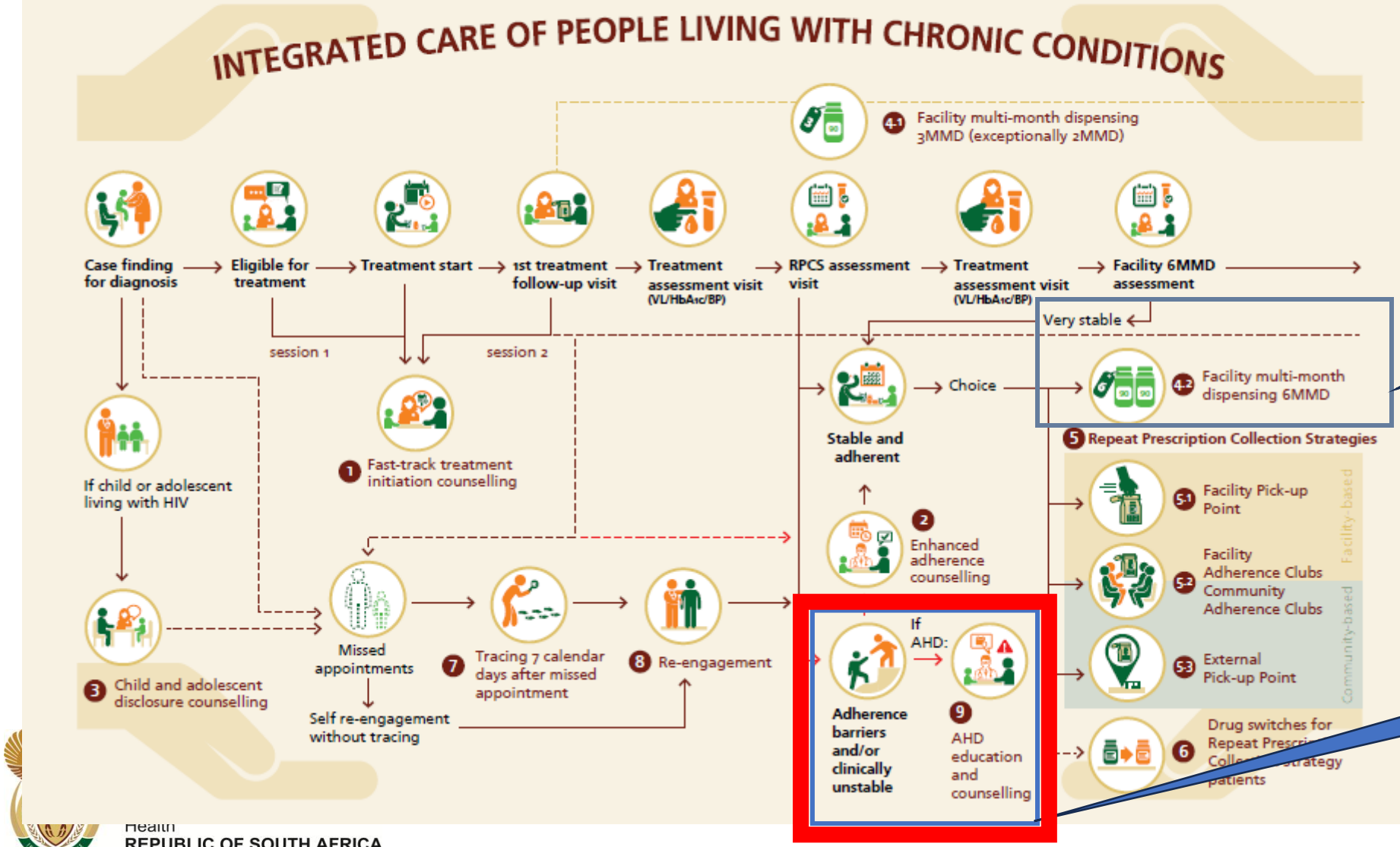
STEP 6
Provide other care

STEP 7
Provide adherence support

STEP 8
Ensure continuity of care between hospital and clinic

STEP 9
Provide intensified follow-up

MINIMUM DIFFERENTIATED MODELS OF CARE PACKAGE TO SUPPORT LINKAGE TO CARE, ADHERENCE AND RETENTION IN CARE



Facility-based 6MMD for very stable chronic care clients

AHD education and counselling

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.

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

Studies show that outcomes are better if families are involved.

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The Adherence Support Plan

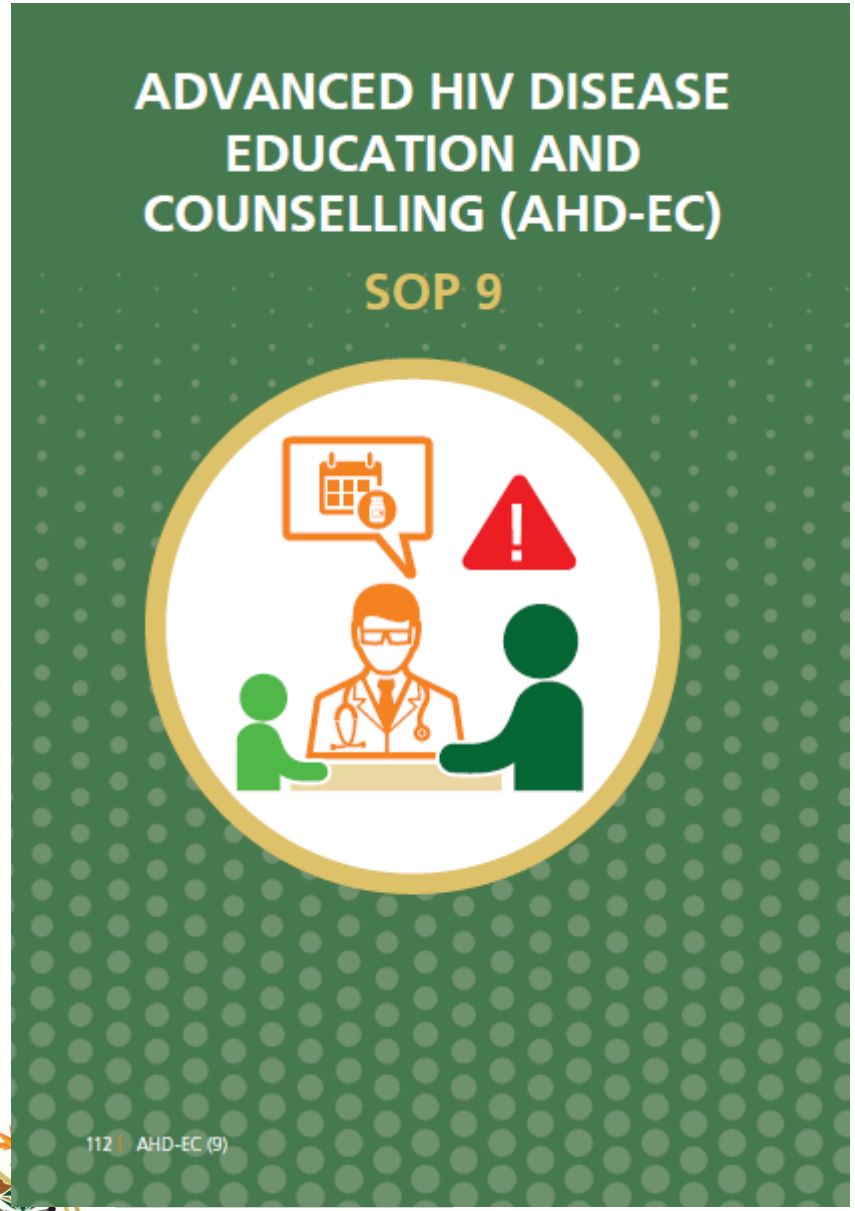
Table 30: **Adherence support plan for clients with AHD: Key components**

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

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:	EFFECTIVE DATE:
AGL: AHD-EC (1)	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.

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	

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

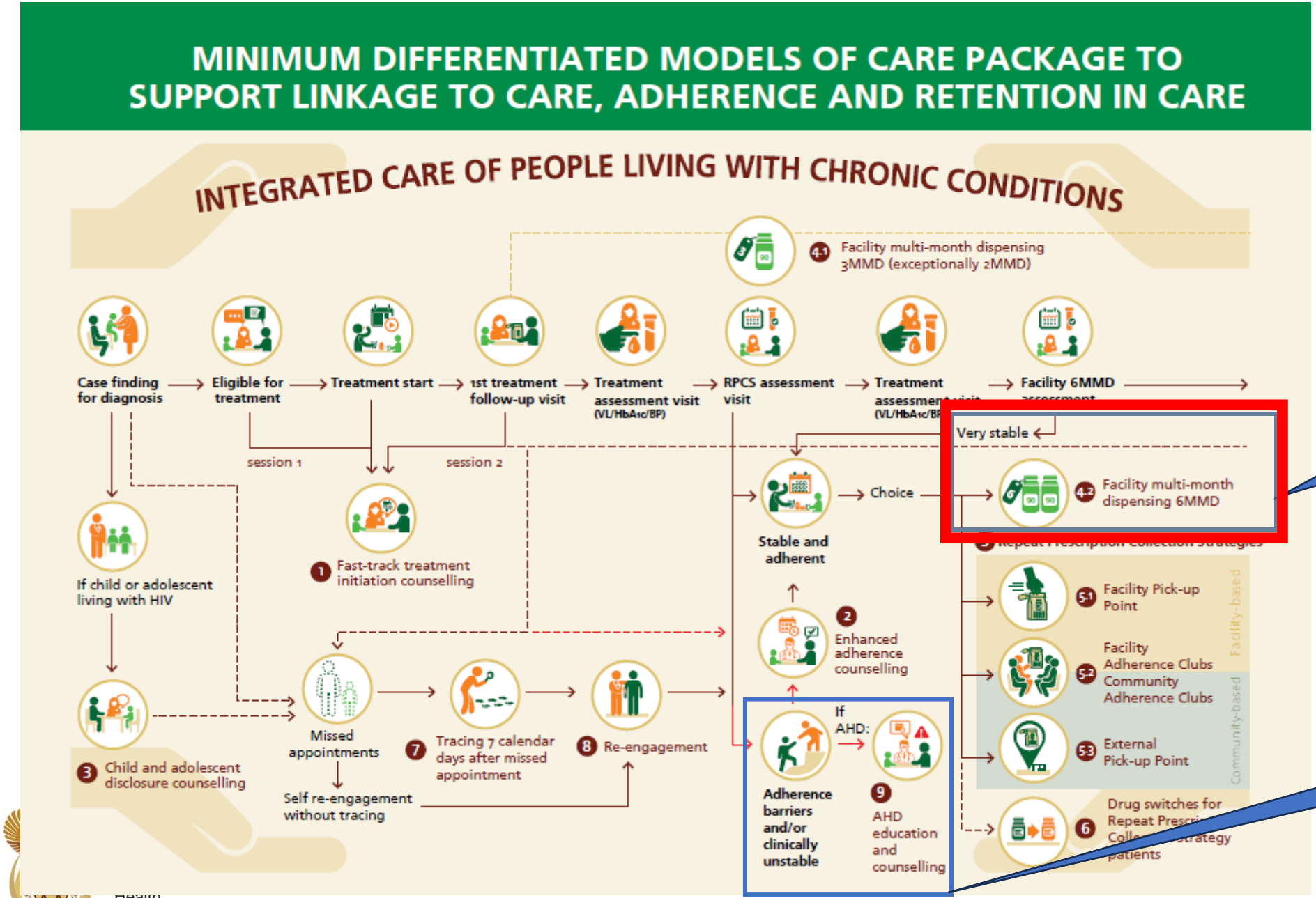
Contents of an AHD treatment literacy session (SOP 9)

- 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

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

MINIMUM DIFFERENTIATED MODELS OF CARE PACKAGE TO SUPPORT LINKAGE TO CARE, ADHERENCE AND RETENTION IN CARE



Facility-based 6MMD for very stable chronic care clients

AHD education and counselling

Facility-based 6MMD

ART chapter pg. 40 + DMOC SOP 4.2

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You will remember 2023 ART guideline training: Our biggest challenges…and they still are

Sub-optimal retention

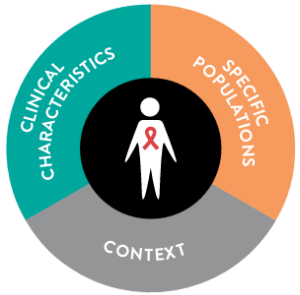
especially in the first 12 months

Sub-optimal VL suppression (<50 copies/ml)

Massive health system burden high number of people living with HIV and people at risk of acquiring HIV requiring ongoing **HIV treatment and prevention services**

To create an enabling environment to support engagement in care and adherence

Clinical updates



Client-centred service delivery updates

- Empower clients and their support systems with the knowledge and skills they need
- Identify adherence challenges earlier
- Reduce unnecessary visits and increase convenience
- Integrate service delivery including alignment of visits

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Improved/clarified terms to understand (1/3)

Differentiated models of care (DMOC): All service delivery models of care that are differentiated either by the patient's clinical characteristics (e.g. suppressed viral load or symptomatic) and/or their population (e.g. child under 5 years old).

Facility provided service delivery: the patient is **managed at the facility** by a clinician who prescribes treatment during clinical review which is dispensed by the clinician or the clinic pharmacy.

Repeat Prescription Collection strategies (RPCs): models of care where the patient **collects their repeat** pre-packed treatment collection (also called treatment refills) **from an external pick-up point, facility pick-up point or an adherence club.**

Improved/clarified terms to understand (2/3)

Multi-month scripting (MMS): Prescriptions of more than one month

- 3MMS = 3-month prescription covering the 3-month period between clinical reviews
- 6MMS = 6-month prescription covering the 6-month period between clinical reviews

Multi-month dispensing (MMD): Treatment supply of more than one month dispensed for one collection

- 3MMD = 3-months of treatment supplied for one collection
- 6MMD = 6-months of treatment supplied for one collection

Improved/clarified terms to understand (3/3)

Standard service delivery: The **default model** of care for all clients, provided at a health facility by a clinician, with **clinical contacts at the recommended frequency**.

More intensive service delivery: A model of care with a **higher frequency of clinical contacts for clients requiring closer clinical management**. This approach is more resource-intensive and less convenient for both clients and the health system but is necessary when increased clinical follow-up is needed.

Less intensive service delivery: A model of care with a **lower frequency of clinical contacts for clinically stable clients**. This approach allows for longer treatment supply either covering the full period between clinical contacts or treatment collection outside of clinical contacts using an RPCs option

DIFFERENTIATED MODELS OF CARE (DMOC)			
Clinically unstable	**Not yet stable**	**Stable**	**Very stable*** **
Symptomatic acute/sick <6 months old Pregnant AHD	New on ART OI on treatment 6m to 5yrs old Newly re-engaged Post-natal <12 months Elevated VL	1 x VL<50 copies/ml 1 x HbA1c ≤8% 2 x BP <140/90	12 months on ART 2 x VLs <50 copies/ml 2 x HbA1c ≤8% 2 x BP <140/90
More intensive service delivery	Standard service delivery	Less-intensive service delivery	
Monthly** clinical reviews and script	3-monthly* clinical reviews + 3 month script (**3MMS***)	6-monthly clinical review + 6 month script (**6MMS**)	
Facility **monthly**** dispensing	Facility **3MMD***	RPCs: EX-PUP, FAC-PUP or AC **3MMD (or 2+4MMD)**	Facility **6MMD*****

New table which explains that there are differentiated models of care (DMOC) for **4** categories of patients:

- Clinically unstable requiring **more intensive service delivery: Monthly clinical reviews**
- Not yet stable requiring **standard service delivery (default model): 3-monthly clinical reviews** with 3MMD
- Stable requiring **less-intensive service delivery: 6-monthly clinical reviews** with 2 x 3MMD
- Very stable requiring even **less-intensive service delivery: 6-monthly clinical reviews** with 6MMD

What is Facility-based 6MMD?

- Facility-provided 6MMD means **6 months of treatment is supplied in one collection at the facility** by the clinician or pharmacy

→ **6 months of treatment**

→ Dispensed at **one time**

→ From the **facility by the clinician or pharmacy**

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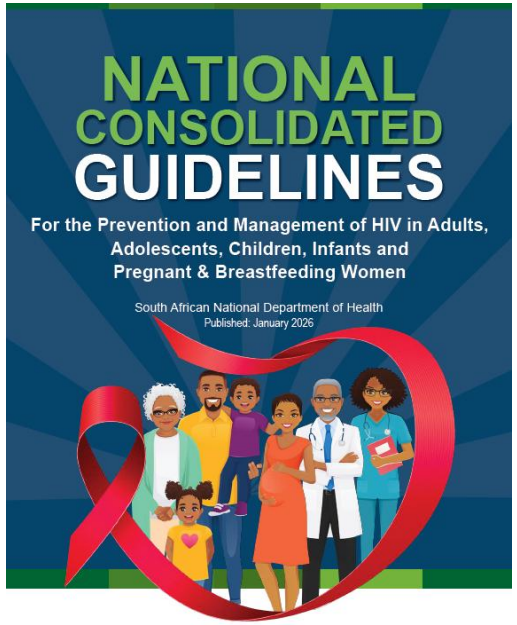


6MMD

Facility-provided 6MMD is now operational.
See **DMOC SOP 4.2: Facility-provided 6MMD**

Eligibility criteria:

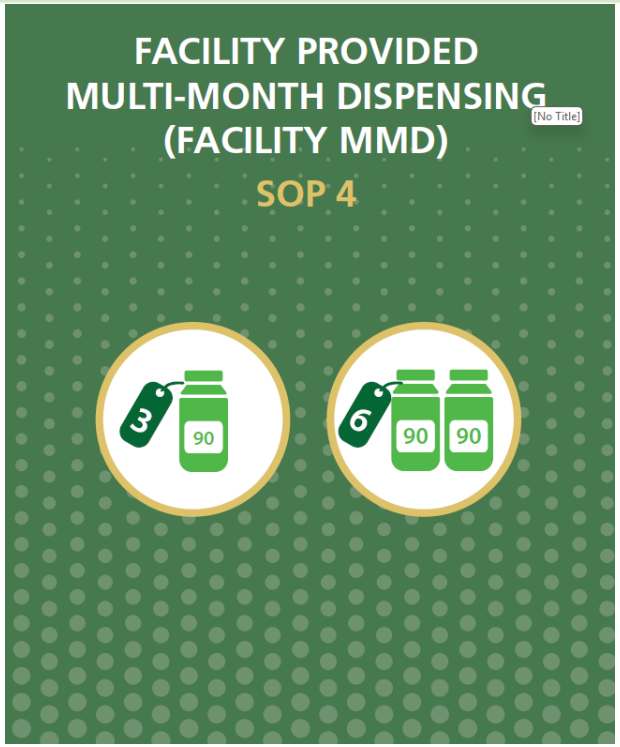
- On ART* for at least 12 months
- 2 most recent VLs < 50 c/mL
- Other RPCs eligibility criteria also met (not pregnant or post-natal < 12 months, above 5 years of age, clinically well with no OIs/ uncontrolled NCD or mental health condition or malnutrition).

* Limited to clients only on TLD until national medicine stock availability is confirmed for other ART regimens and hypertension and diabetic treatment

At any scheduled clinical review, check that the chosen RPCs model is still suitable. If eligible, offer client facility-provided 6MMD as an alternative option to RPCs

Should a client accept 6MMD, renew prescription for next 6 months, with full 6-months supply issued today from the facility.

Consider supplying 2 x 84-90 day pill bottles (now available) rather than 6 x 28-30 day pill bottles to reduce the number of containers.



Facility-based 6MMD provided for in the ART chapter

Supported by DMOC SOP 4 which has now been split into:

- **DMOC SOP 4.1: 3MMS + 3MMD**
- **DMOC SOP 4.2: 6MMS + 6MMD**

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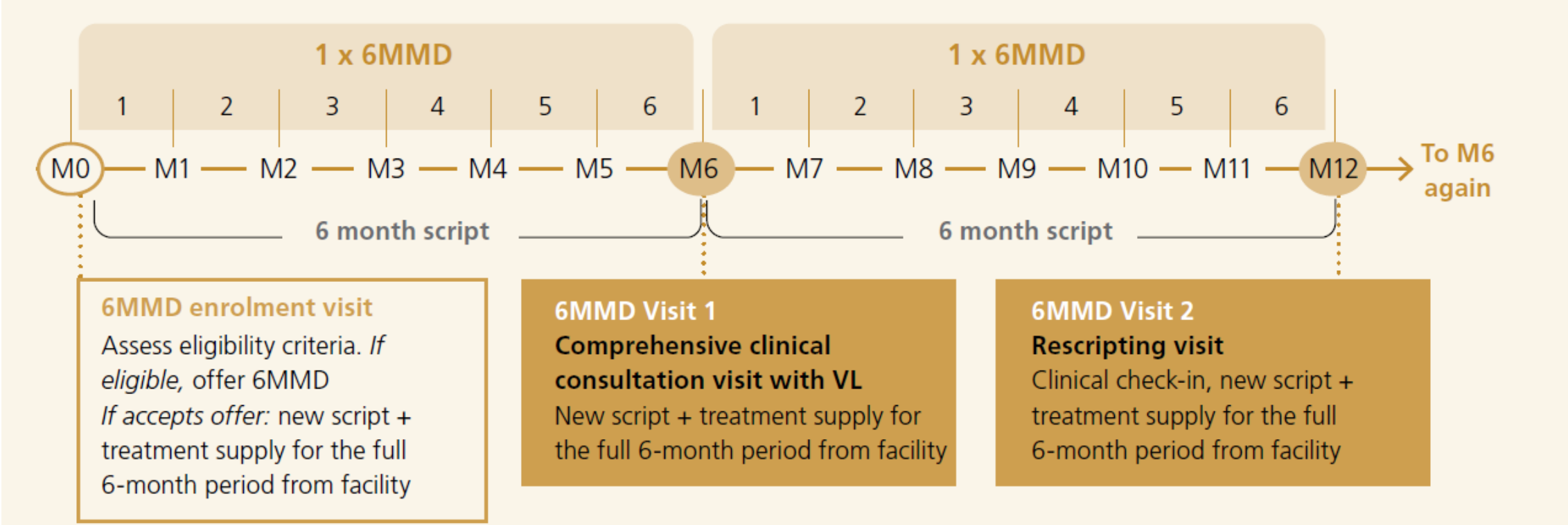
Facility-based 6MMD eligibility criteria:

- On **ART for more than 12 months**
- **Clinically stable**: no current TB, other opportunistic infection, malnutrition, new or uncontrolled mental health or chronic condition requiring clinical review more regularly than once every 6 months
- **Two most recent consecutive VL results <50 c/mL**
- **Older than 5 years**
- **Not pregnant or within 12 months of delivery**
- Clinician confirms eligibility and voluntarily chosen by client

NOT eligible for 6MMD currently *(until supply chain ready)*:

- Stable ART clients who also have an **NCD** (e.g. hypertension, diabetes), even if it is controlled
- On ART regimens **other than TLD**

Facility-based 6MMD visit schedule



- **6-monthly clinical review**
- **6-month prescription (6MMS)**
- **6-month supply/refill (6MMD)**

- **2 visits per year for the client to the facility**
- **No additional visits for refill collection**

Facility-based 6MMD visit schedule

- 6-monthly clinical review
- 6-month prescription (6MMS)
- 6-month supply/refill (6MMD)

- 2 visits per year for the client to the facility
- No additional visits for refill collection

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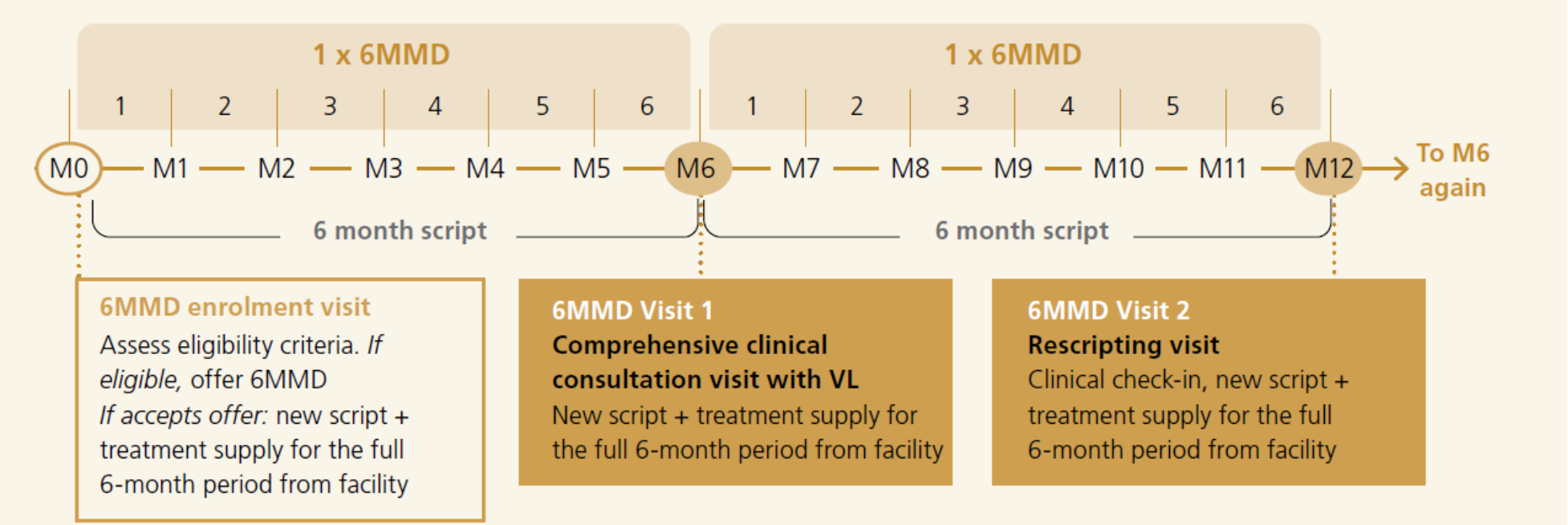
Facility-based 6MMD viral load schedule



VL is taken at the clinical review closest to when the next VL is due.

If eligibility was assessed based on VL result:

- 6-months previously, the next VL will be taken at 6MMD visit 1 (6-months later)
- At date of 6MMD enrolment, the next VL will be taken at the 6MMD visit 2 (12-months later)

No additional visits only to take VL or review VL

How is 6MMD different from RPCs?

External PUPs, Facility PUPs & Adherence Clubs (CCMDD)

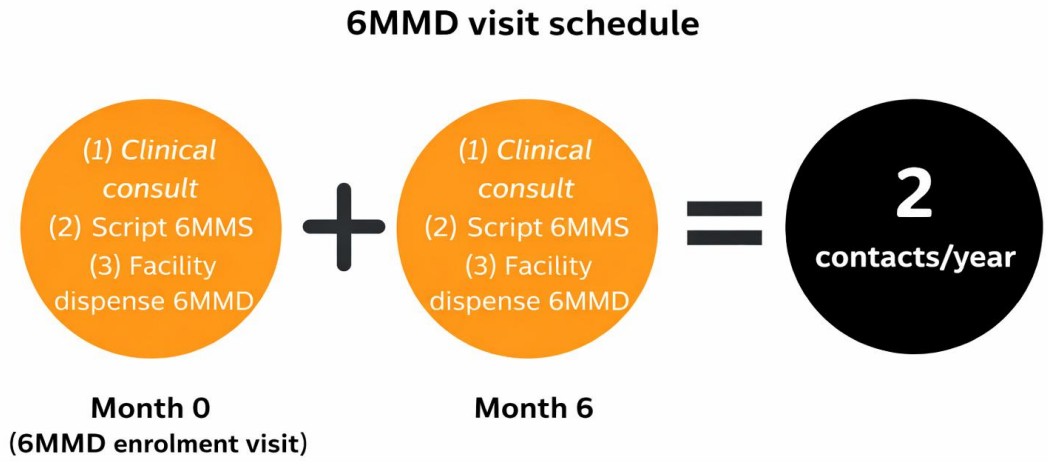
Eligibility criteria: Only differences in ORANGE

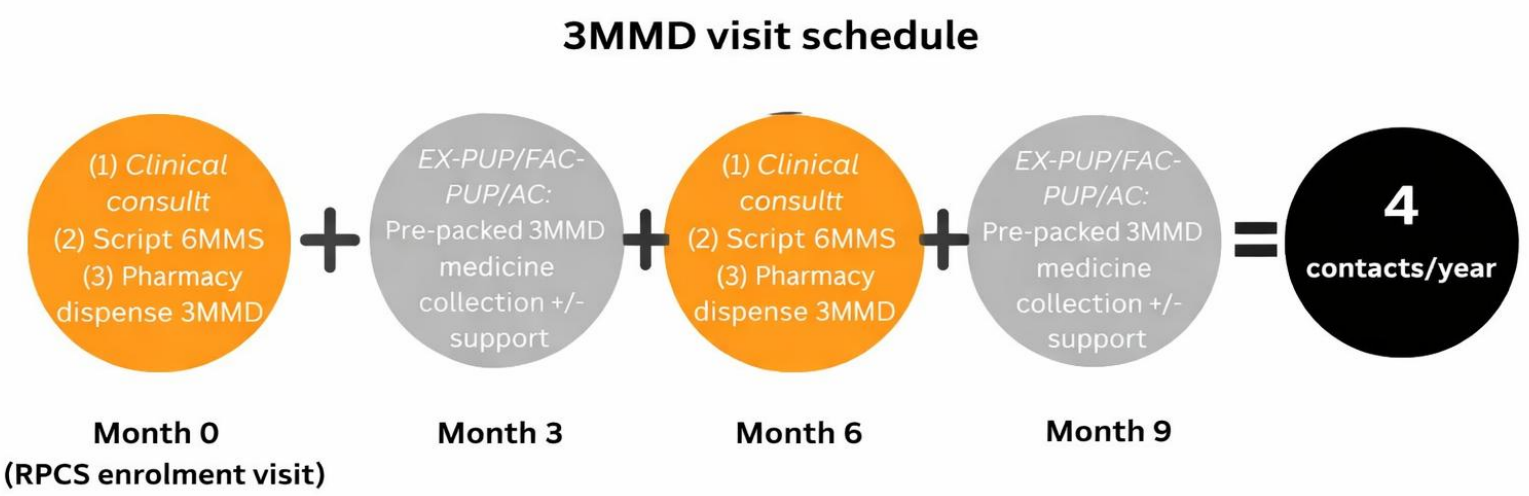
RPCs (DMOC/CCMDD) = STABLE	Facility-based 6MMD = VERY STABLE
Clinically stable requiring clinical review 6-monthly	Clinically stable requiring clinical review 6-monthly
>5 years old	>5 years old
Not pregnant or within 12 months of delivery	Not pregnant or within 12 months of delivery
No time on ART requirement	**On ART for more than 12 months**
Most recent VL results <50 copies/mL	**Two most recent consecutive VL results <50 c/mL**
Clinician confirms eligibility	Clinician confirms eligibility
Voluntarily chosen by client	Voluntarily chosen by client
Includes people with controlled NCDs	**Initially only ART***
All ART regimens	**Initially only TLD***
	** Guidelines already provide for controlled NCDs and other regimens – awaiting supply chain readiness*

How is 6MMD different from RPCs?

External PUPs, Facility PUPs & Adherence Clubs (CCMDD)

Visit schedule





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CCMDD cannot be used for 6MMD

- Important note: CCMDD cannot be used for **facility-provided 6MMD** - it must be **dispensed by the clinician or facility pharmacy**.
- South Africa currently only allows a maximum of a 6-month prescription. Submission of the prescription to CCMDD for dispensing, pre-packing and delivery will mean that the client is not able to collect all 6-months supply on the same day the prescription is written.
- The overriding aim of facility-provided ART is to **reduce contacts to 2 per year**.

2026

90-day TLD bottles

90-day TLD pill bottles are already available

for procurement and direct facility delivery

6 x 28-day bottles

=

2 x 90-day bottles

Facilities

- No extra space needed
- Only two bottles to label
- Limited need for pre-packing

Clients

- Only need to take home and store **two bottles** for 6 months' supply

The NSN number for TLD 84-90 pack size is 222001255

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Clinicians Job Aid

JOB AID

Facility-provided Six Multi-Month Dispensing (6MMD) of ART

[Clinician Job Aid on Knowledge Hub]

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Poster and patient info leaflet (soon to be in all SA languages)

Scan the code to learn more

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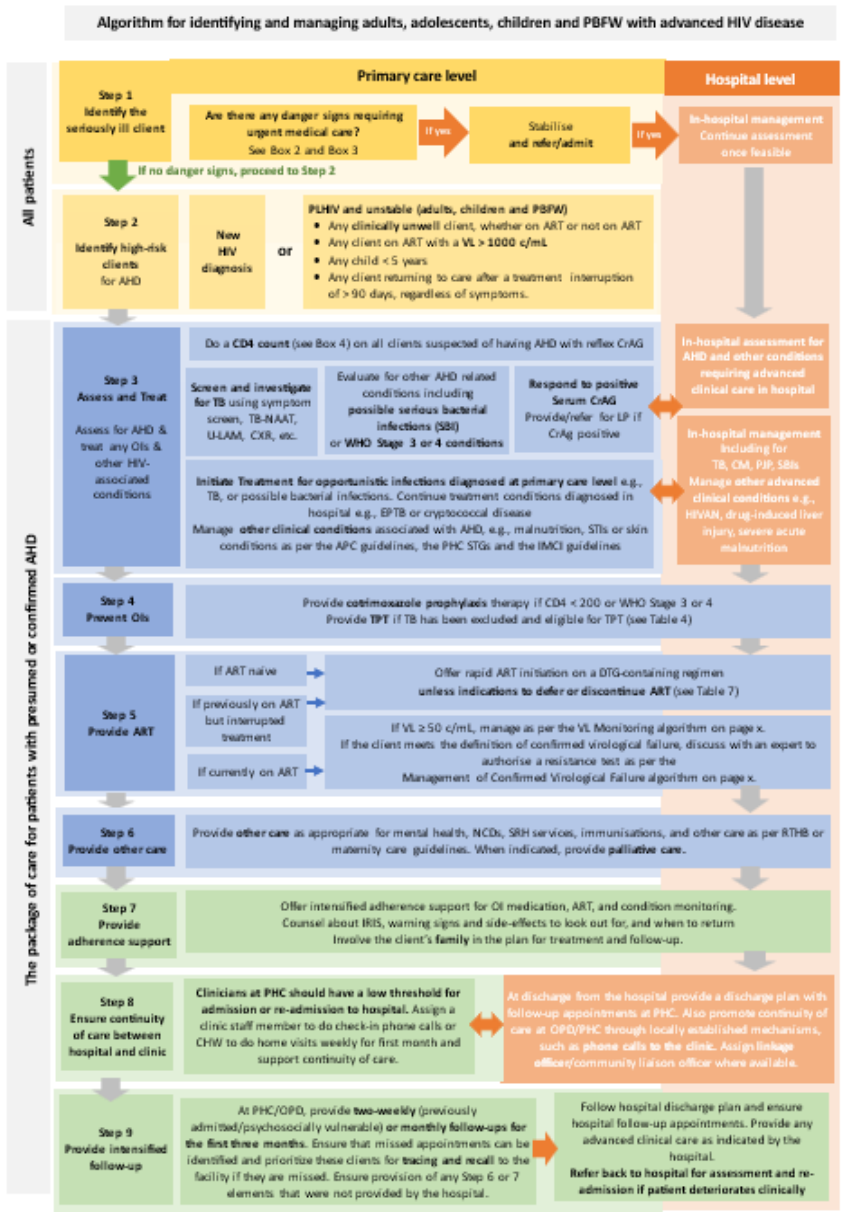
[Patient information posters and leaflet in English on Knowledge Hub]

Summary of the 9 Steps



STEP 1
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Assess for AHD & treat any OIs & other HIV-associated conditions

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Prevent OIs

STEP 5
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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

Take home messages

1. Any VL ≥ 50 c/mL is a medical emergency requiring ABCDE assessment and action
2. Resistance (E) is last — Process to exclude ABCD with thorough assessments and repeat VLs
3. Drug level testing is a tool to support the patient, not to catch them out.
4. DLT is a laboratory reflex test that gatekeeps unnecessary resistance tests
5. No independent switches. Every third-line patient requires ADReC notification

Thank you!

HELPLINES

If in doubt about any aspect of viral load management or switching to second-line, contact one of the following resources:

National HIV & TB Health Care Worker Hotline:

0800 212 506

Right to Care Pediatric, Adolescent and Adult HIV Helpline:

082 352 6642

KZN Paediatric Hotline:

0800 006 603

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Questions

- *What questions or concerns do you have?*