DOH STRATEGY TO IMPROVE

95-95-95 TARGETS

WITH A FOCUS ON VL MONITORING

AWACC
28 - 30 October 2026
18th ANNUAL WORKSHOP ON ADVANCED CLINICAL CARE - AIDS

KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

2030 NDP



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Dept of Infectious Diseases , NRM School of Medicine ,UKZN

Outline of talk

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1. Summary of a learning health system (LHS)
2. Priorities at AWACC 2026
3. KZN HAST 95-95-95 stastistics –implications
4. Action to maintain first 95
5. Minding the gap to improve the second 95
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Collective message from experiences of LHS

- Significant learning generated across South African health system

- Critical challenges undermine health system learning
  - Weaknesses in individual, organisational capabilities
    - Limited learning at both levels
  - Demands of service delivery
    - Limits reflection, experimentation and collective learning
  - Localised learning, and pilot innovation
    - Isolated learning vs transforming system-wide improvement

HEALTH SYSTEMS TRUST

Why does being a learning health system(LHS) matter (HST & SAHR 2026)



-

System leadership -Strengthening system leadership for the District Health System Publication Date: 04/30/2026 .SAMJ

By: L Gilson, H Schneider, B Engelbrecht, M Shung-King



Associated with a set of behaviours and practices that enable people working in many different places, spaces and levels, and across professional and disciplinary boundaries, to act collectively to address complex health needs;•



Practised by individual leaders and by leadership teams, working within and across organisations, who offer purposeful leadership in the parts of the system where they have influence;



Entails both collective action to address complex health needs and intentional change in workplace routines to nurture and sustain collective leadership



Enabled by senior organisational managers who take action to spread organisational authority and adapt structures and processes to support system leadership

1. Message for local networks- HCWs, managers ,community members /organisations

- Local networks can learn together despite the pressures
- Learning improves the quality of action
- A key shift –do meetings differently to create time to learn from experience – reflect ,deliberate, collaborate

2. Message for researchers/educators

Own our role as official allies , part of the health system.

Work differently to strengthen the health system

- Are we educating to support system learning
- Are we learning through collaboration with local networks
- Do we support research about HLS
- Are we supporting experience sharing across spaces and places

Challenging own structural foundations

-collective learning seen as valued organisational outputs

3.Messages for ministers ,CEOs and HODs

- Make learning part of long term strategic vision for the health system
- Role model and authorise learning
- 1. Enable and support inclusive learning process
- 2.Value learning from experience ,especially from problems
- 3. Support collaborations for learning
- 4.Strengthen distributed leadership

Learn in groups and teams across all loops will result in us becoming a learning health system



1. Learn about your own activities and strengthen learning to adapt those activities



2. Learning about the system in which our activities are implemented and using that learning to revise the assumptions, objectives and activities underlying those activities



3. Learning about the system of which we are part and using that learning to generate orgasiontional changes that support continuous learning – orgasionational virtues ,beliefs and norms

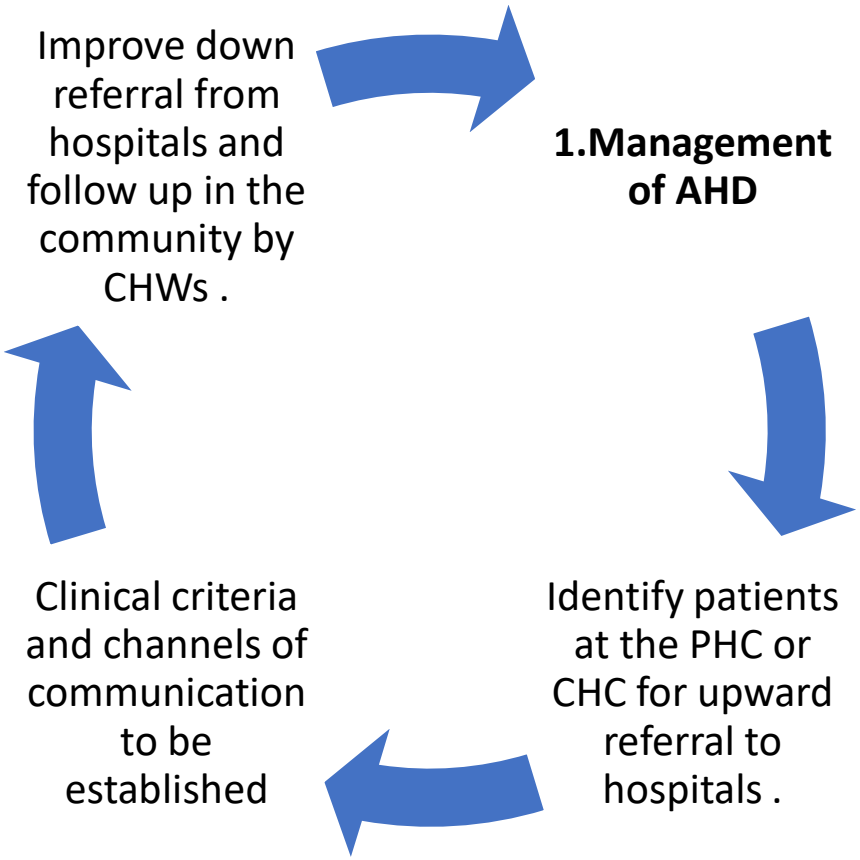
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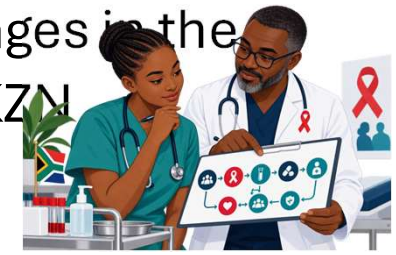
AWACC 2026
PRIORITIES IN TRAINING AND MENTORSHIP

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2. Prevention (including biomedical prevention strategies)-

- Overview of PrEP rollout (including long-acting PrEP), PEP, VMMC, condom programming, behavioural interventions, and emerging biomedical prevention technologies.
- Progress and challenges in the LENCAP program in KZN



Treatment and Care-

ART optimisation,

Differentiated service delivery,

Retention and adherence strategies

Interventions supporting population-level VS.

4. **Health Systems Strengthening (to be included in each session)**

- Workforce capacity,
- Service integration (including management of co-morbidities viz NCDs and mental health)),
- Data for decision-making,
- Community-led monitoring,
- Peer navigation,
- Social mobilisation



Focus through 2030

Four priorities for the final push

ADVANCED HIV DISEASE

Four priorities will determine progress to 2030

01 Close treatment and care gaps

Expand ART and sustained care—including AHD management—through people-centred, integrated services.

02 Reaccelerate HIV prevention

Reduce new infections and widen access to long-acting injectables and primary prevention.

03 Sustain two decades of progress

Adapt the HIV response to major changes in international donor funding.

04 Make innovation equitable

Close inequities in access to the benefits of innovation.

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18th Annual Conference on Advanced Clinical care
KZN STATS -95-95-95

Presenter: Dr. H.Sunpath & Mr.S.Gasa

Date: 28/10/2026

PRESENTATION OUTLINE

Cascades

General populations

Sub populations

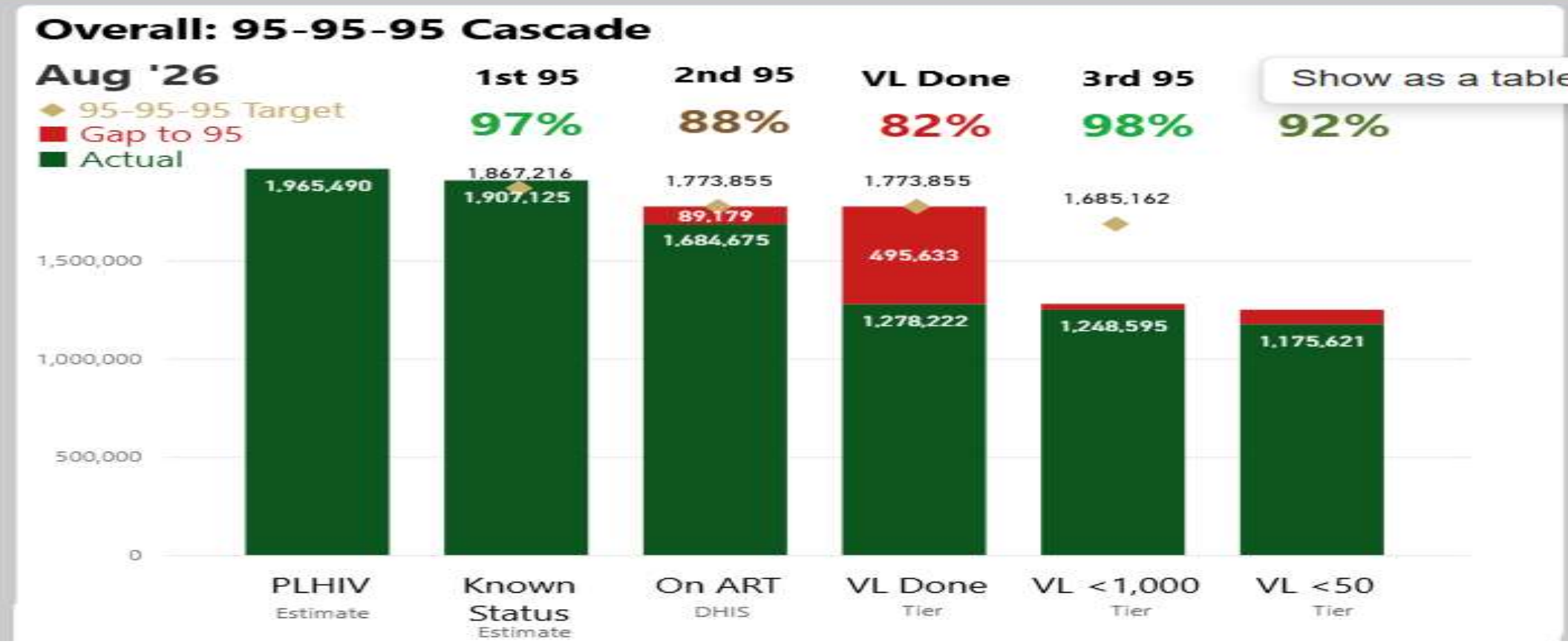
Comparison on cascades <15 and 15 -24 years- May vs August

Districts cascades table

Low Level Viraemia

Tables on VLD and VLS over time

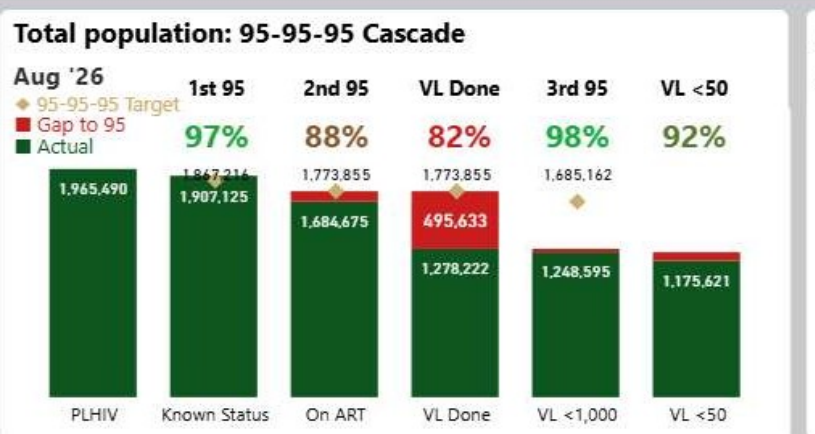
General Population Cascades

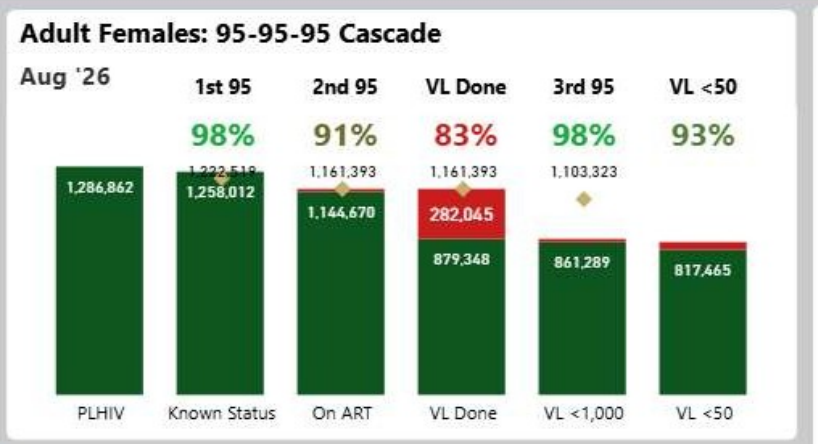


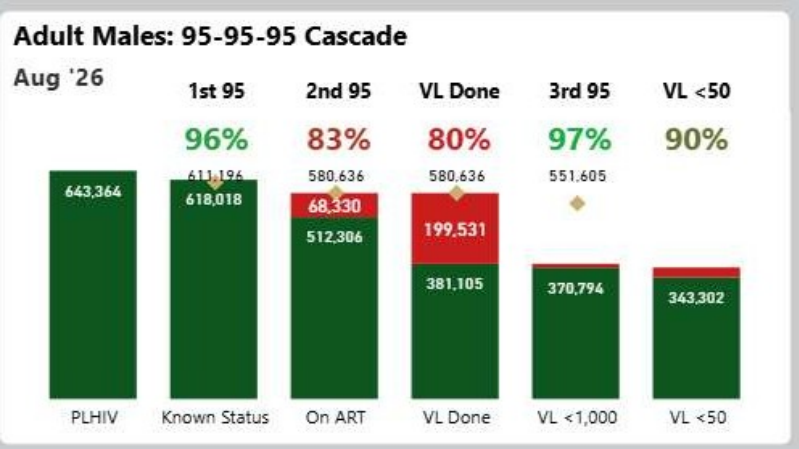
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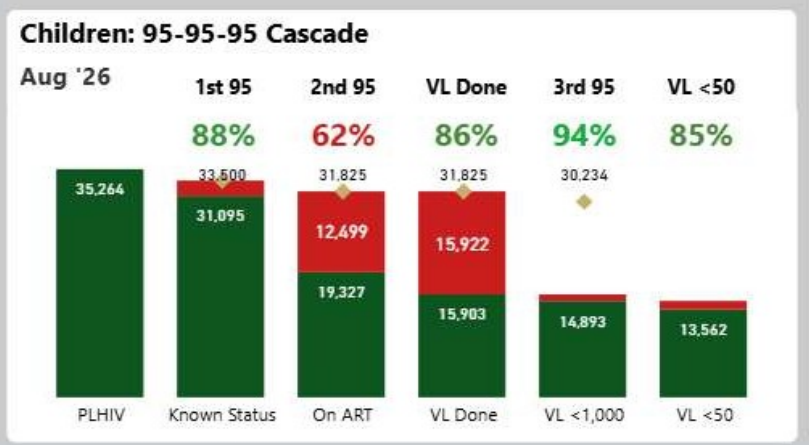
ASIBE HEALTHY KZN

Sub-Populations Cascades









95-95-95 Cascades Summary

As of Aug '26 the Overall cascade is at 97-88-98 for the total population including the following sources: Public (DHISxTier age/sex), private, foreign.

Results for each of the sub-populations vary, with:
- Adult Females at 98-91-98,
- Adult Males at 96-83-97,
- Children (<15) at 88-62-94.

To achieve the 2nd 95 target, increase the number of:
- Total Clients on ART by 89,179,
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- Children (<15) on ART by 12,499.

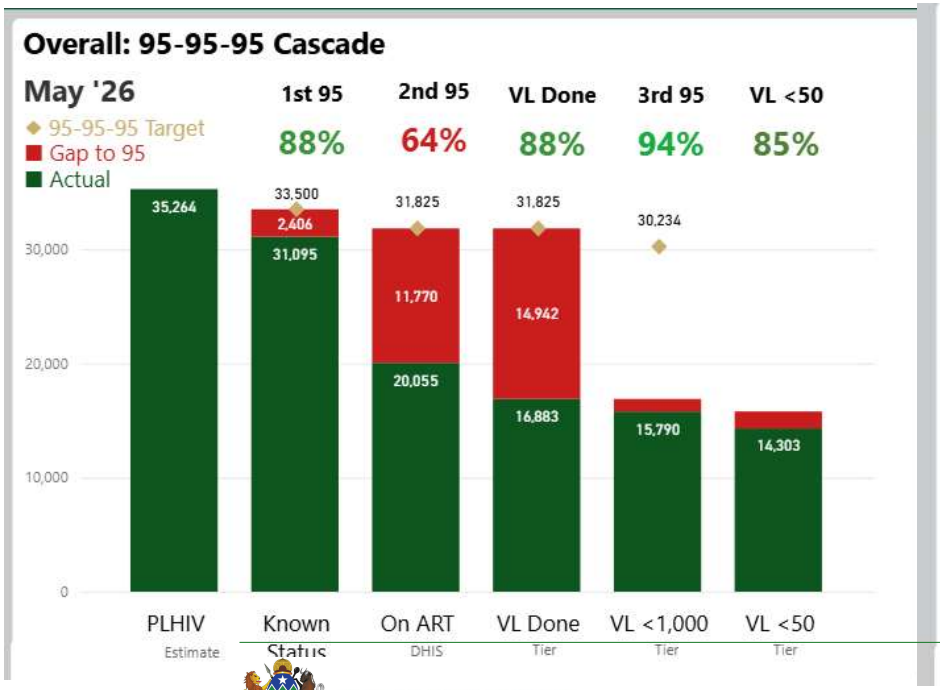
Clients eligible for DMOC (VL <50) include:
- Total Clients by 1,175,621,
- Adult Females 817,465,
- Adult Males 343,302,
- Children (<15) 13,562.

Clients who access ART through the Private sector:
- 100,941 Total Clients,
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- 30,665 Adult Males,
- 527 Children (<15)

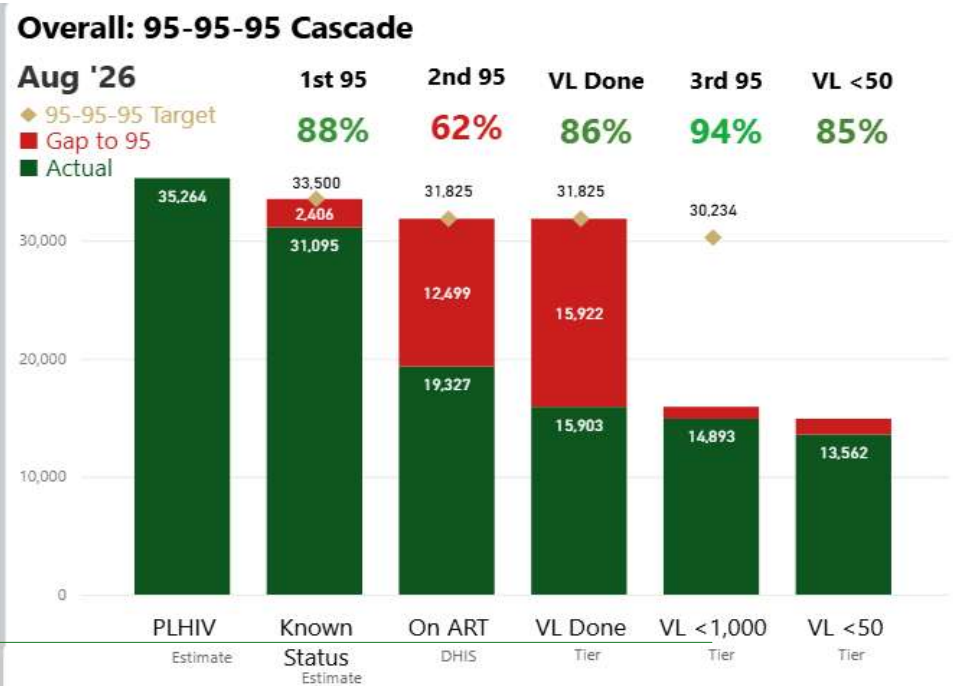
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<15 Years quarter Comparison

May 2026



August 2026

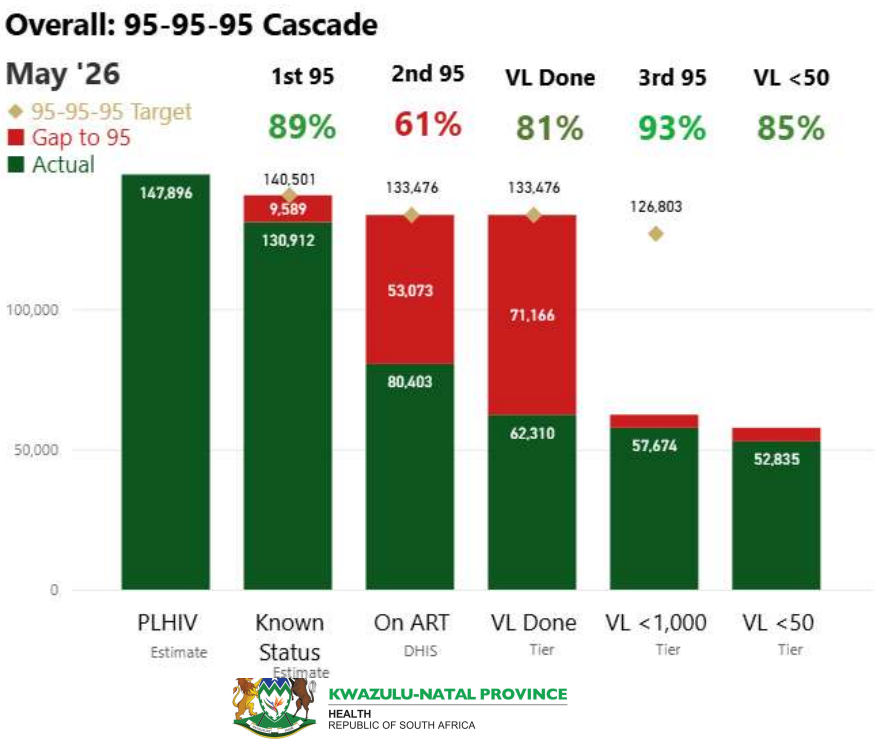


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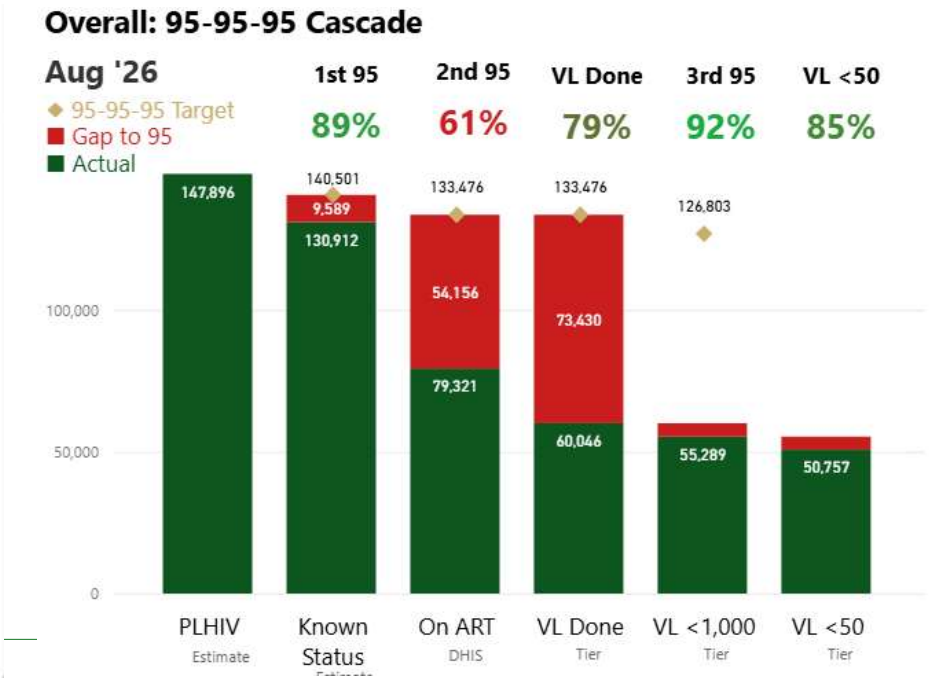
ASIBE HEALTHY KZN

15-24 years quarterly Comparison

May 2026



August 2026



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ASIBE HEALTHY KZN

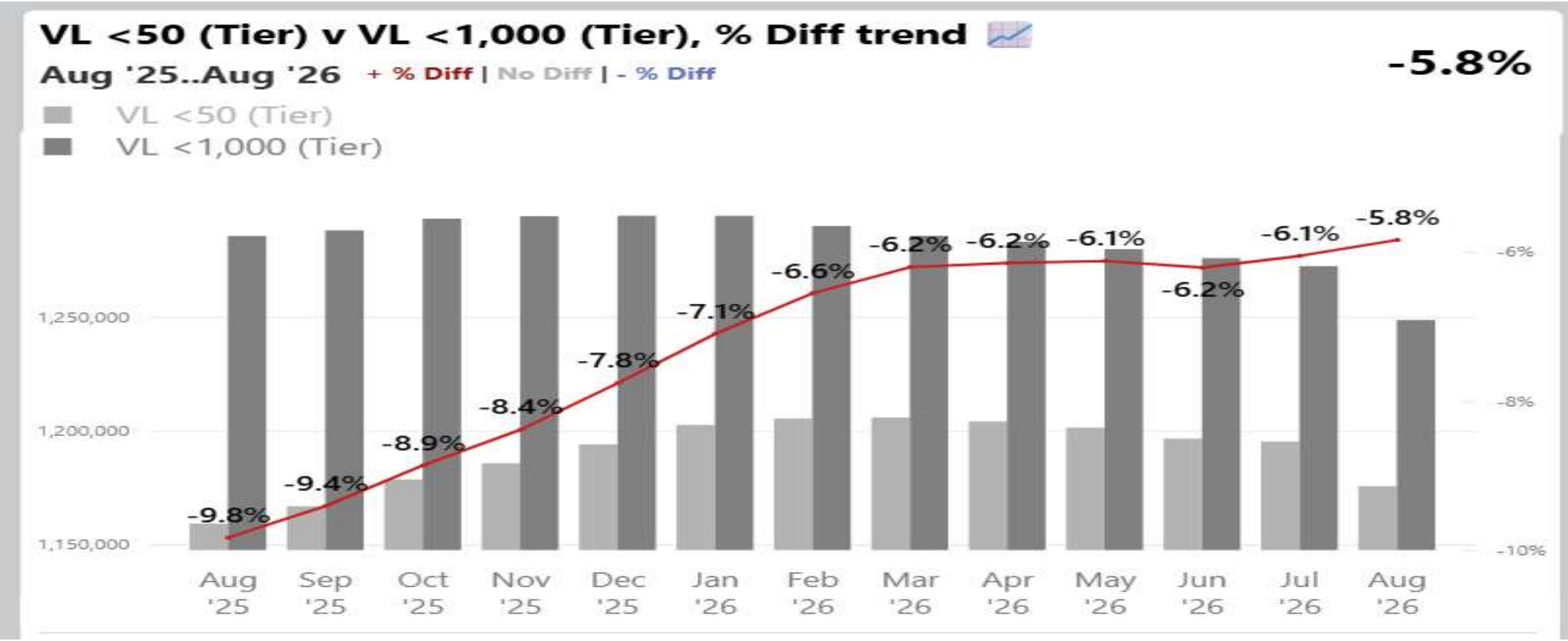
Districts Table Cascades –
KZN -226 105 /1821918 (12.4%)
ETK – 33% of cohort.

Districts: 95-95-95 Cascade

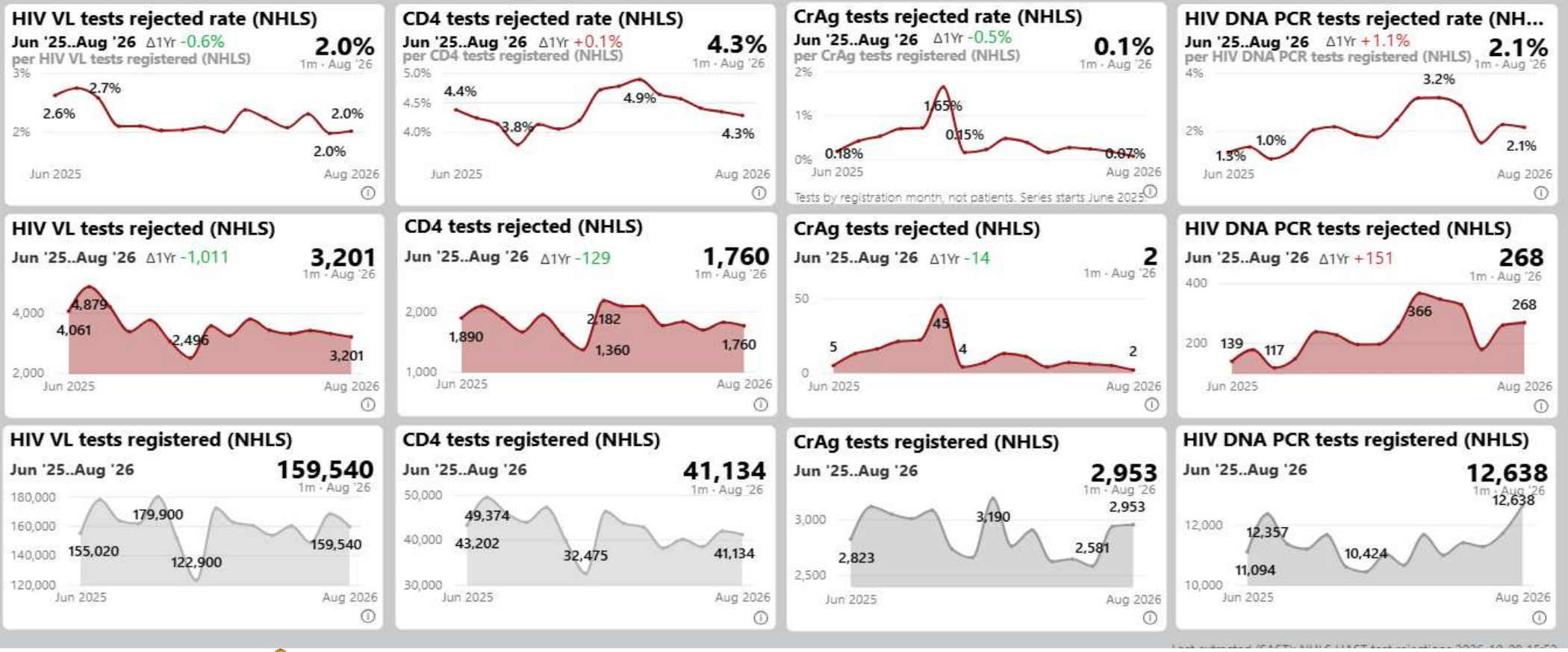
Aug '26

District	1st 95	2nd 95	3rd 95	VL <50 (Tier)	PLHIV	On ART	Not on ART	2nd 95 Gap	Known Status	<1000	<50
kz Amajuba	96%	79%	98%	94%	100,274	75,931	19,840	14,566	95,772	55,805	53,277
kz iLembe	97%	86%	98%	93%	112,666	93,832	15,512	7,849	109,344	68,357	65,200
kz uMgungundlovu	97%	87%	98%	93%	209,568	178,165	25,761	10,970	203,926	129,780	123,582
kz eThekwini MM	98%	88%	97%	91%	616,769	528,884	72,870	27,750	601,754	368,741	343,723
kz Umzinyathi	97%	88%	98%	93%	90,842	77,660	10,399	4,325	88,059	59,043	55,867
kz Uthukela	97%	88%	98%	95%	126,876	109,087	14,247	5,419	123,334	91,898	88,625
kz King Cetshwayo	97%	89%	97%	92%	184,409	158,777	20,500	7,652	179,278	120,648	113,672
kz Ugu	97%	89%	97%	88%	140,662	122,094	14,626	4,853	136,719	93,699	85,070
kz Harry Gwala	97%	91%	98%	93%	83,326	73,500	7,604	1,702	81,104	60,316	57,415
kz Umkhanyakude	98%	91%	98%	95%	141,165	124,875	12,851	2,527	137,726	91,797	88,888
kz Zululand	98%	92%	98%	90%	157,361	141,871	11,895	147	153,766	108,511	100,302

VLS <1000 vs <50 (LL Viraemia)



Tests Rejections



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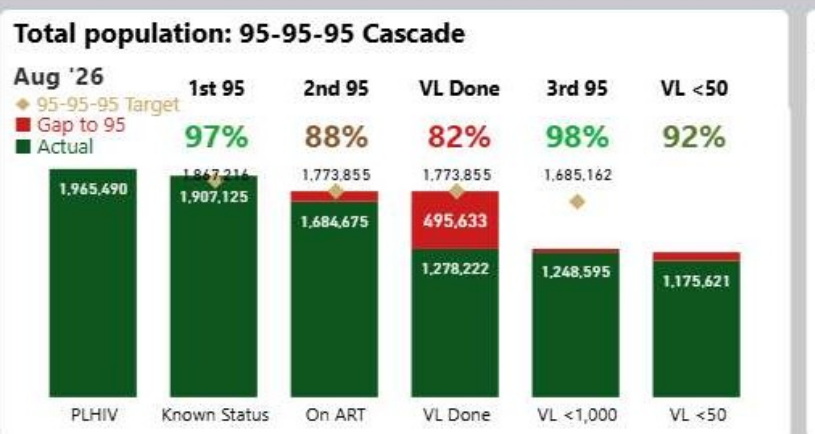
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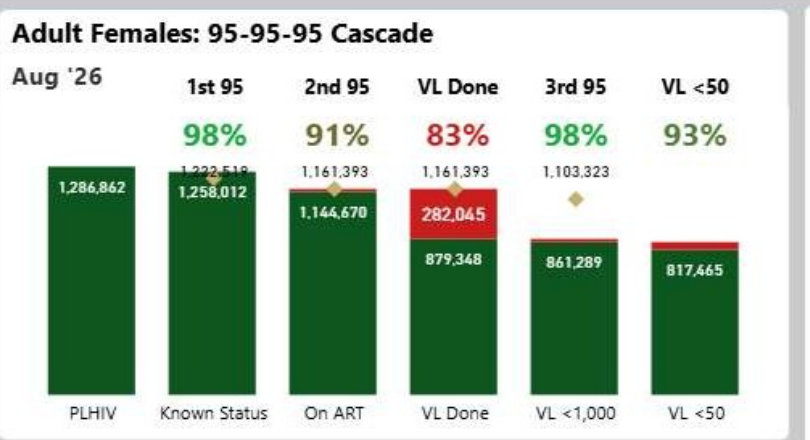
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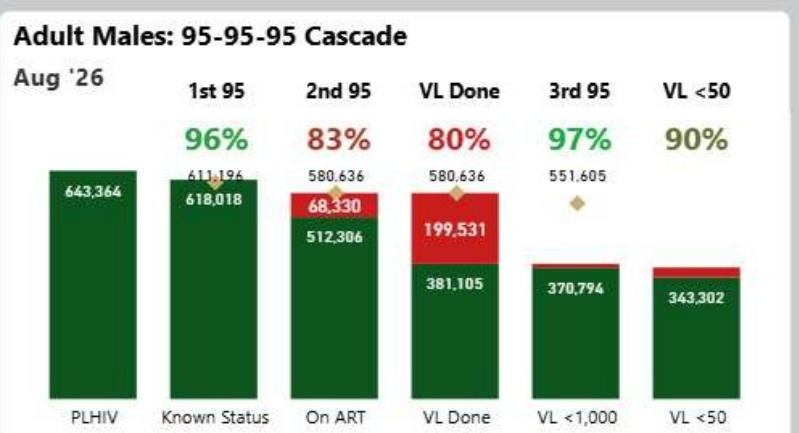
FIRST 95

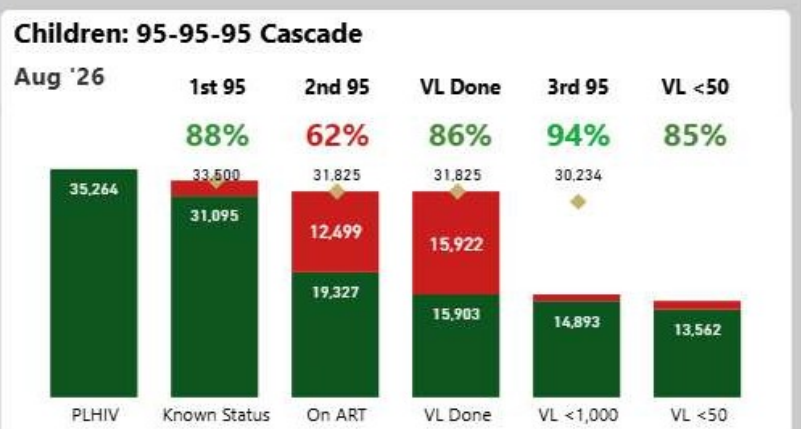
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Early testing can reduce AHD and mortality

AIDS2026.ORG

01	**The burden remains high**	Late diagnosis and AHD remain unacceptably high across all regions.
02	**Facilities miss people**	Significant opportunities for HIV testing are still missed in facilities.
03	**Community testing reaches earlier**	Community and household testing can reach people before they become symptomatic—but remains underutilized.
04	**Early testing prevents harm**	With adequate linkage and retention, early testing reduces progression to AHD, improves management and prevents deaths.

Make testing routine, accessible and connected to care.

The pathway to late HIV diagnosis - Stigma, Fear and Missed Opportunities

RESEARCH ARTICLE

Significant association between perceived HIV related stigma and late presentation for HIV/AIDS care in low and middle-income countries: A systematic review and meta-analysis

Hailay Abrha Gesesew[1,2]*, Amanuel Tesfay Gebremedhin[3], Tariku Dejene Demissie[4], Mirkuzie Woldie Kerie[5], Morankar Sudhakar[6], Lillian Mwanri[2]

2.4×

higher odds of late presentation with high perceived HIV-related stigma

Gesesew et al., PLOS One 2017

01 STIGMA & FEAR

- Fear of disclosure
- Fear of discrimination
- Testing becomes something to avoid

02 DELAYED TESTING

- Symptoms ignored
- Risk underestimated
- Testing postponed until illness

03 MISSED OPPORTUNITIES

Healthcare encounters without HIV testing
Provider risk assumptions persist

04 ADVANCED HIV DISEASE

Diagnosis occurs late
Lower CD4 count
More morbidity and mortality

Normalize HIV testing: opt-out testing • integrated services • peer-led community reach • self-testing • stigma-free care

Late diagnosis is often not a failure of the individual — it is the cumulative result of stigma, fear, missed opportunities and health-system design.

Gesesew et al. Plos One 2017; Somji et al. 2026; Parisi et al. 2025; Galicia et al. 2026.

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2ND 95

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The 1.1 Million HIV Campaign-(#CloseTheGap):

- Launched by the NDOH - targeted campaign aims to close the **1.1 million treatment (second 95) gap** by

1. **Enrolling diagnosed individuals onto sustained ART**
2. **Reducing disengagement from care of those already on ART**

Talks by

J.Wessels

A.Castle

C.Ordonez

N.Mokoena

Mental health symposium

Areas of Focus

VLD coverage – we remain far below required threshold on 100% (all on

Treatment should have at least 1 viral load per year

We have certainly improved on VLS suppression

We need to monitor low level viraemia closely

We need to scale up retention in care both on 2nd 95

Outline of talk

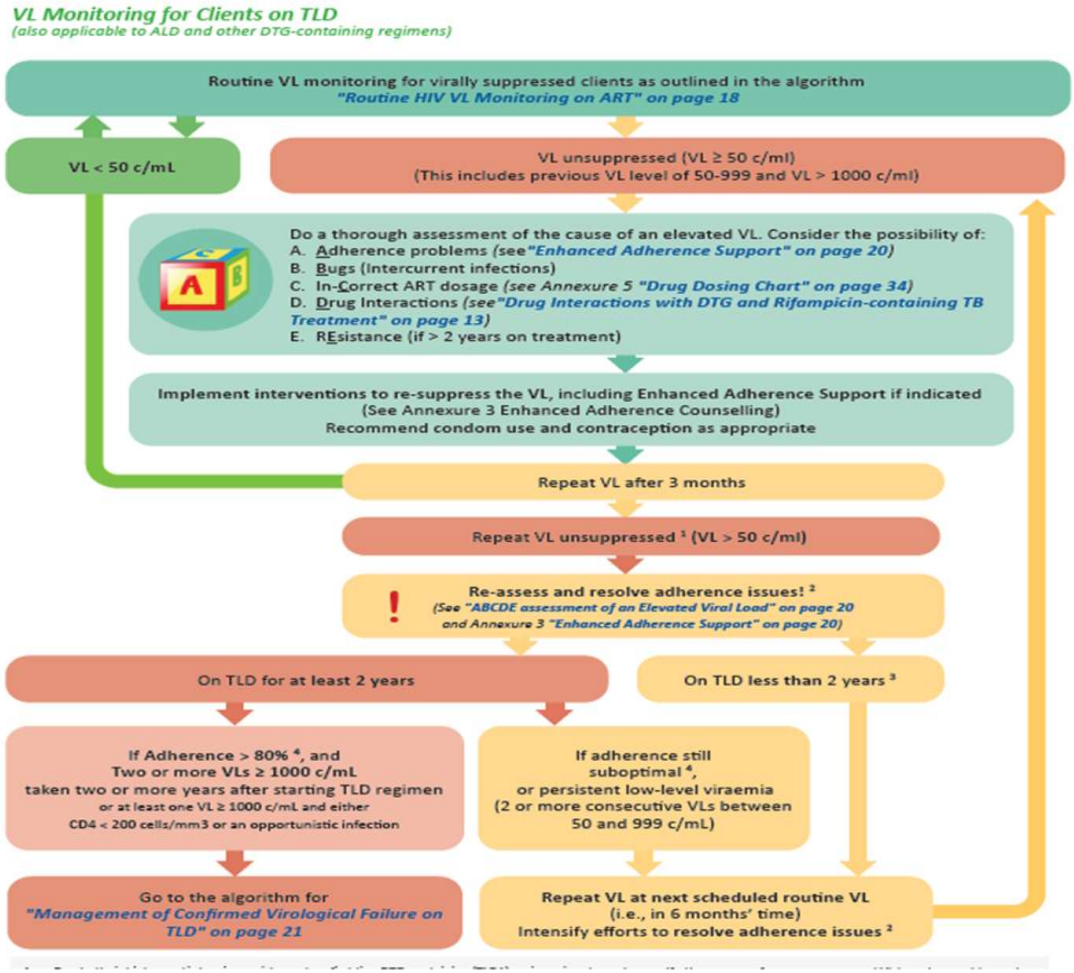
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FOCUS ON VL MONITORING

AWACC 2026



- In the 2019 and updated in 2023 guidelines - **testing at around 3- and 9-months ART initiation**.

If If with a **VL ≥50 cpml - repeat in 3 months**

and 6 months thereafter for patients with persistent low-level viraemia (i.e. 50-999 cpml).

Routine HIV VL Monitoring on ART

A dispensing cycle is defined as the number of days for which a client would have treatment if a single standard "monthly" quantity of tablets was dispensed. The term 'dispensing cycle (DC)' is preferred to the previously used term 'month' due to the potential discrepancy that may arise between the days of treatment dispensed (if 28 day pack sizes are used) and the days in a month (on average, 30 days). However, the term dispensing cycle can be applied to single pack sizes of 28 tablets (1DC) or larger pack sizes of 90 tablets (3 DCs).

Routine VL monitoring	Intervention	EAC indicated?
First VL after ART initiation	Do 1st VL after **3 dispensing cycles**	• Allows for earlier detection of factors influencing viral suppression • Allows for earlier decanting for suppressed clients to minimise visits and promote continued engagement in care • This VL will form part of the **6 month VL completion cohort** in Tier.net
Second routine VL after ART initiation (in clients who remain virally suppressed)	This VL can be done from **10 dispensing cycles** but should be aligned with the clients scripting cycle	• This VL will form part of the **12 month VL completion cohort** in Tier.net
Third routine VL after ART initiation (in clients who remain virally suppressed)	This VL can be done **from 22 dispensing cycles**, but should be aligned with the clients scripting cycle	• This VL will form part of the 24 month **VL completion cohort** in Tier.net
Fourth and all subsequent VLs	VLs will be taken at intervals of 12 dispensing cycles for all clients who remain virally suppressed	
The timing of dispensing cycles, follow-up visits, and VL monitoring is illustrated in the diagram below		

Low level viraemia

WHY LOW-LEVEL VIRAEMIA MATTERS

Persistent LLV - to serious non-AIDS illness

Chronic immune activation and inflammation may raise the risk of:

- CANCERS
- CARDIOVASCULAR EVENTS
- LIVER CIRRHOSIS
- KIDNEY DISEASE

Ganesan A et al. Low-level viremia is associated with serious non-AIDS events in people with HIV. Open Forum Infectious Diseases, published online 30 March 2024.

VIRAL LOAD MONITORING

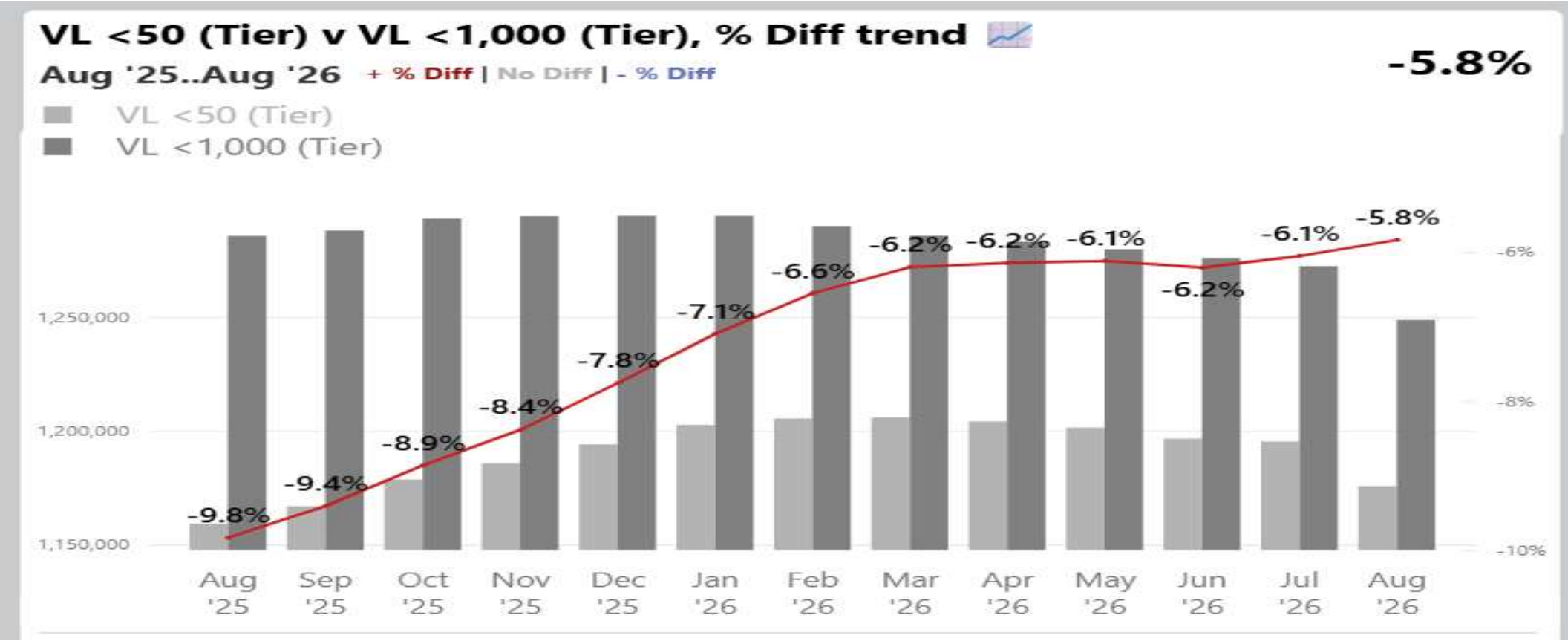
LLV –risk of treatment failure with ART resistance

The result determines whether control is confirmed or closer follow-up is needed.

01 UNDETECTABLE	02 SUPPRESSED, BUT DETECTABLE	03 UNSUPPRESSED
<50 cp/ml	**50–999 cp/ml**	**≥1 000 cp/ml**
Viral load is below the detectable threshold.	Low-level viraemia remains detectable despite suppression	Viral suppression has not been achieved.
	RISK OF ART RESISTANCE.AND TREATMENT FAILURE	RISK OF ART RESISTANCE.AND TREATMENT FAILURE



VLS <1000 vs <50 (LL Viraemia)



CONCLUSION

Low-level viraemia is not clinically benign

Monitor early to protect treatment success.

LLV is associated with virological failure, drug resistance and clinical complications.

01 ACT NOW

Use VL monitoring to identify adherence problems and potential resistance.

02 REASSESS THE THRESHOLD

Policy decision ? whether 1 000 copies/ml remains appropriate in the INSTI era.

Large numbers LLV

03 CLOSE THE EVIDENCE GAP

Define the causes and optimal management of persistent LLV

Viz. adherence,ART resistance,drug interactions etc.

Outline of talk

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8. Quality improvement project for VL coverage

Public Health Bulletin
South Africa

Trends in HIV Viral Load monitoring in the South African National HIV Treatment programme between 2019 and 2025.

Gayle Sherman[1,2], Natasha Soldin[2], Tanya Murray[1,2,3], Ahmad Haeri Mazanderani[1,2,3*]

[1] Department of Paediatrics & Child Health, School of Clinical Medicine, Faculty of Health Sciences, University of the Witwatersrand, Johannesburg, South Africa

[2] Paediatric HIV Diagnostics, Wits Health Consortium, Johannesburg, South Africa

[3] Centre for HIV & STIs, National Institute for Communicable Diseases, a division of the National Health Laboratory Service, Johannesburg, South Africa

VL Monitoring -2019 to 2025 - Summary

THE CORE QUESTION

Can HIV viral load (VL)monitoring help measure SA's progress towards the UNAIDS 95-95-95 targets?

TO ACHIEVE THE TARGETS:

01	02	03
Renewed testing effort	retain on optimised ART	and VL monitoring

Annual VL testing - a valuable measure of treatment retention and virological suppression.

Together with national estimates of PLWH , these data can be used to monitor progress towards the **second and third 95 UNAIDS 95-95-95 targets.**

Methods

DATASET & PERIOD

HIV VL testing data from 2019 to 2025,

VL test data were accessed on 14 January 2026 from the Surveillance Data Warehouse (SDW) at the NICD, a division of the NHLS, for the period 01 January 2019 to 31 December 2025.

EXAMINES

Trends in testing coverage, Viral suppression

ANALYTIC RULES

01

Annual number of HIV VL tests registered = valid and rejected HIV VL tests

02

Valid results only = number of patients undergoing **VL monitoring/ coverage and suppression rates.**

03

All ages were included in the analysis, including tests registered with an unknown date of birth, with taken date used to describe the period of testing.

Analysis

VL indicators calculated annually per calendar year:

01

The total number of **VL tests submitted and registered** within the NHLS;

02

The total number of patients receiving at least one **valid VL test per year,**

retaining only the most recent VL result per patient per annum

03

The VL suppression rates at both the **<50 and <1 000 cpml thresholds.**

These were calculated using patient-level data as the proportion of patients whose most recent VL result in a given year met the relevant suppression threshold.

---

04 **HIV VL testing coverage in a given year =**

$$= \frac{\text{Total number of patients having a valid VL test}}{\text{The estimated 'Total PLWH or 'Total on ART' outputs obtained from the Thembisa 4.8 Model.}}$$

Findings

PROGRAMME SCALE · 2019 → 2025

ESTIMATED PLWH

7.46 → 8.12M

increased from 7.46 to 8.12 million

NUMBER ON ART

5.17 → 6.39M

increased from 5.17 to 6.39 million

VL TESTS SUBMITTED

5.84 → 6.83M

rose from 5.84 million to 6.83 million

UNIQUE PATIENTS WITH A VL TEST

4.81 → 5.73M

increased from 4.81 million to 5.73 million

COVERAGE MOVED IN DIFFERENT DIRECTIONS

64.5% → 70.5%

National HIV VL monitoring coverage increased from 64.5% in 2019 to 70.5% in 2025, with a peak of 71.4% reached in 2023.

93.1% → 89.6%

Expressed as a proportion of patients on ART with a VL done, this decreased from 93.1% in 2019 to 89.6% in 2025.

ANNUAL SCALE TREND

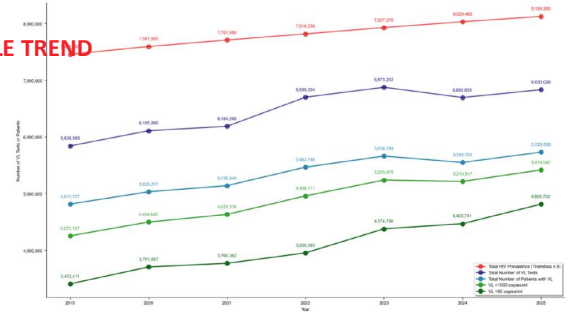


Figure 1a. Number of viral load (VL) tests and results in comparison to HIV prevalence, South Africa, 2019–2025. The total HIV VL tests performed and the total number of patients receiving a VL test in comparison to the Thembisa 4.8 model HIV prevalence estimates. VL suppression at the <1 000 cpml and <50 cpml thresholds are represented for the total number of patients undergoing VL testing (cpml=copies per millilitre).

MONITORING COVERAGE TREND

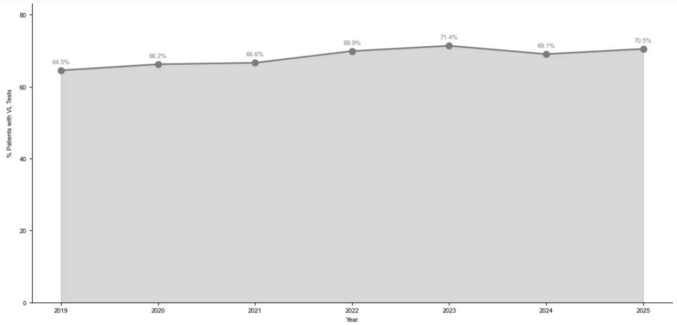


Figure 1b. Annual viral load (VL) coverage by year, South Africa, 2019–2025. The coverage of VL tests for all people living with HIV is given using the Thembisa HIV prevalence rates as a denominator.

FINDINGS · 2019 → 2025

Suppression reached 94.5% as low-level viraemia fell

VIRALLY SUPPRESSED · <1 000 cp/ml

94.5%

5.41M

patients in 2025

LOW-LEVEL VIRAEMIA

17.6% → 10.5%

50–1000 cp/ml

UNDETECTABLE VL

84.0%

<50 cp/ml in 2025

ANNUAL SUPPRESSION TREND

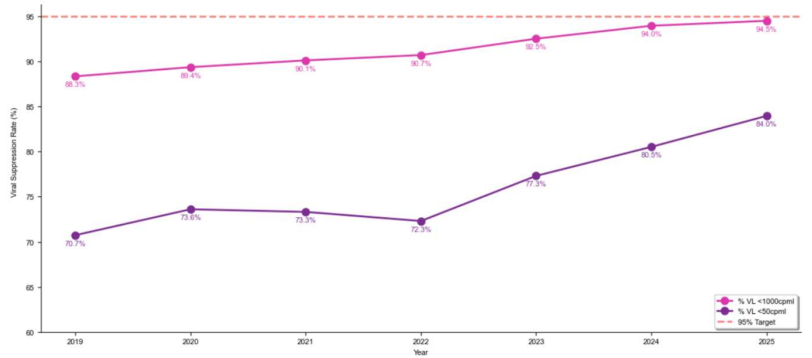


Figure 2a. Viral load (VL) suppression rates. HIV VL suppression rate trends in patients undergoing VL testing

More patients achieved viral control, while the LLV share narrowed by 7.1 percentage points.

Peak values reported for 2025.

DISCUSSION · 2019 → 2025

VL monitoring coverage rose to 70.5% as treatment expanded

HOW COVERAGE IS ESTIMATED

Thembisa 4.8 provides the estimated PLWH denominator.

Public-sector patient-level VL testing supplies the numerator.

ESTIMATED VL MONITORING COVERAGE

64.5% → 70.5%

A 6.0 percentage-point gain.

ESTIMATED PLWH

7.46M → 8.12M

Population living with HIV increased.

PROPORTION ON ART

69.4% → 78.7%

Treatment reach expanded.

PATIENTS WITH A VL TEST

4.81M → 5.73M

More patients received annual monitoring.

Coverage improved even as both the PLWH population and ART programme grew.

DISCUSSION · METHOD

Patient linkage turns VL tests into an annual care proxy

South Africa lacks a universally implemented unique patient identifier.

01 LINK

NICD SDW probabilistically links multiple VL tests to the same individual.

02 COUNT

Linked records estimate unique patients receiving VL testing each year.

03 INTERPRET

Annual patient-level VL testing serves as a proxy for patients in care.

WHY THE PROXY IS VALID

Guidelines recommend at least one VL test per year for every patient receiving ART.

The resulting annual patient count is comparable to the NDoH-DHIS total remaining on ART (TROA).[6]

DISCUSSION · 2025 SIGNAL

Record suppression masks stalled VL monitoring momentum

NHLS tests reported through the NICD SDW show a clear 2025 paradox:

OUTCOMES REACHED A NEW HIGH

Strongest

viral suppression in the 7-year period

Highest

number of PLHIV receiving a VL test

MONITORING MOMENTUM STALLED

↓ Total VL tests

below the 2023 volume

2 consecutive years

of negative year-on-year growth

BOTTOM LINE

Annual VL testing coverage remained essentially static at ~71%.

CONCLUSION · PRIORITY ACTION

THE 2025 SIGNAL

South Africa achieved its strongest viral suppression outcomes and reached the highest number of PLHIV through VL testing.

But plateauing test volumes and coverage suggest that strong outcomes among patients already in care—not sufficient expansion to reach more PLWH.

ACTION NOW

Stabilise and expand VL testing after programme funding reductions.

Investigate practical strategies urgently to restore the earlier growth trajectory.

USE AN ANNUAL VL TEST AS A PROXY FOR

01 **Patients initiated on ART**

02 **Patients retained in care**
2nd 95

03 **Patients with VL <1,000 copies/mL**
3rd 95

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ART ADULT VIRAL LOAD DONE RATE

organisationunitname	Jul - Sep 2023	Oct - Dec 2023	Jan - Mar 2024	Apr - Jun 2024	Jul - Sep 2024	Oct - Dec 2024	Jan - Mar 2025	Apr - Jun 2025
kz eThekwini Metropolitan Municipality	76.6	79.8	86.2	85.4	84.5	81.7	85.	79.3
kz Amajuba District Municipality	73.4	78.7	85.6	89.2	84.7	83.7	85.7	80.4
kz iLembe District Municipality	77.9	80.2	85.8	84.5	87.8	82.9	87.5	83.1
kz Umkhanyakude District Municipality	82.	83.6	83.8	87.8	90.7	89.6	87.8	83.8
kz Harry Gwala District Municipality	74.9	79.1	80.4	85.3	85.4	84.5	88.5	84.3
kz Ugu District Municipality	74.9	79.7	84.6	87.2	85.5	86.1	88.2	84.4
kz KwaZulu-Natal Province	80.	83.7	87.5	88.2	88.4	87.2	89.1	84.7
kz Zululand District Municipality	86.2	90.9	92.6	93.2	92.9	91.3	90.9	88.
kz uMgungundlovu District Municipality	84.8	86.9	89.5	92.9	91.5	92.4	91.6	88.8
kz King Cetshwayo District Municipality	82.6	85.8	87.6	85.8	88.9	90.2	96.1	91.7
kz Uthukela District Municipality	81.7	92.8	93.5	93.	95.4	96.4	95.5	92.3
kz Umzinyathi District Municipality	92.8	94.	94.2	95.1	97.7	98.	95.4	95.

- uThukela and uMzinyathi consistently doing well s
- Improvement noted in KCD over last 3 cohorts
- uMgungundlovu and Zululand have been doing well except for last cohort
- 6 districts consistently struggling to achieve 90% with eThekwini consistently being the lowest district

ART CHILD VIRAL LOAD DONE (VLD) AND SUPPRESSION (VLS)

CHILD VIRAL LOAD DONE

organisationunitname	Jul - Sep 2023	Oct - Dec 2023	Jan - Mar 2024	Apr - Jun 2024	Jul - Sep 2024	Oct - Dec 2024	Jan - Mar 2025	Apr - Jun 2025
kz Amajuba District Municipality	15	10	15	9	12	10	23	15
kz eThekwini Metropolitan Municipality	87	52	77	71	53	54	56	49
kz Harry Gwala District Municipality	15	5	7	7	3	8	9	8
kz iLembe District Municipality	16	21	21	13	12	16	18	4
kz King Cetshwayo District Municipality	26	23	19	25	21	32	24	13
kz Ugu District Municipality	22	11	17	16	8	16	21	8
kz uMgungundlovu District Municipality	27	20	43	28	15	23	31	18
kz Umkhanyakude District Municipality	30	21	25	17	19	15	14	9
kz Umzinyathi District Municipality	12	12	14	11	13	16	17	11
kz Uthukela District Municipality	12	19	27	22	14	17	14	9
kz Zululand District Municipality	31	22	34	21	17	15	36	19
kz KwaZulu-Natal Province	293	216	299	240	187	222	263	163

CHILD VIRAL LOAD DONE RATE

organisationunitname	Jul - Sep 2023	Oct - Dec 2023	Jan - Mar 2024	Apr - Jun 2024	Jul - Sep 2024	Oct - Dec 2024	Jan - Mar 2025	Apr - Jun 2025
kz Ugu District Municipality	91.7	68.8	68.	94.1	100.	94.1	87.5	57.1
kz Umkhanyakude District Municipality	93.8	87.5	96.2	94.4	90.5	100.	100.	75.
kz eThekwini Metropolitan Municipality	82.1	70.3	85.6	86.6	93.	83.1	80.	83.1
kz uMgungundlovu District Municipality	87.1	87.	97.7	93.3	93.8	95.8	93.9	85.7
kz KwaZulu-Natal Province	86.7	82.4	89.5	90.6	94.4	91.	92.6	87.6
kz Amajuba District Municipality	88.2	83.3	93.8	90.	100.	76.9	100.	93.8
kz Harry Gwala District Municipality	93.8	62.5	87.5	87.5	75.	100.	90.	100.
kz iLembe District Municipality	80.	95.5	91.3	65	80.	80.	94.7	100.
kz King Cetshwayo District Municipality	72.2	82.1	76.	96.2	100.	97.	100.	100.
kz Umzinyathi District Municipality	100.	100.	100.	100.	100.	100.	100.	100.
kz Uthukela District Municipality	92.3	95.	100.	100.	100.	94.4	100.	100.
kz Zululand District Municipality	100.	95.7	94.4	100.	100.	100.	100.	100.

CHILD VIRAL LOAD SUPPRESSED RATE

organisationunitname	Jul - Sep 2023	Oct - Dec 2023	Jan - Mar 2024	Apr - Jun 2024	Jul - Sep 2024	Oct - Dec 2024	Jan - Mar 2025	Apr - Jun 2025
kz Ugu District Municipality	54.5	27.3	41.2	62.5	62.5	50.	33.3	50.
kz Amajuba District Municipality	66.7	40.	46.7	77.8	58.3	90.	82.6	53.3
kz King Cetshwayo District Municipality	53.8	60.9	84.2	72.	61.9	59.4	79.2	53.8
kz Umzinyathi District Municipality	25.	83.3	78.6	45.5	76.9	50.	58.8	54.5
kz uMgungundlovu District Municipality	81.5	70.	74.4	60.7	80.	82.6	61.3	61.1
kz eThekwini Metropolitan Municipality	54.	51.9	51.9	53.5	67.9	51.9	69.6	63.3
kz KwaZulu-Natal Province	57.3	57.9	59.2	62.1	72.2	64.9	65.8	64.4
kz Umkhanyakude District Municipality	60.	57.1	72.	64.7	89.5	80.	78.6	66.7
kz Harry Gwala District Municipality	66.7	60.	71.4	85.7	100.	75.	88.9	75.
kz iLembe District Municipality	62.5	47.6	47.6	53.8	75.	56.3	72.2	75.
kz Zululand District Municipality	51.6	59.1	35.3	71.4	58.8	73.3	47.2	78.9
kz Uthukela District Municipality	50.	78.9	70.4	68.2	92.9	88.2	78.6	88.9

- 5 districts have consistently achieved target for VL uptake in last 4 or more cohorts- Harry Gwala, iLembe, uMkhanyakude, uThukela and Zululand, with Amajuba falling short with 1.
- eThekwini seem to be struggling to achieve more than 90% consistently
- The poor performance noted in the last cohort in uMgungundlovu, uMkhanyakude and Ugu districts – is know your child being implemented in these districts?

KZN - QIP FOR VL MONITORING (2016-2026)

- ASSESMENT OF VL OVERAGE AT BASELINE
- IMPLEMENT VL CHAMPION MODEL TO MAKE VL MONITORING ROUTINE
- EXTEND MONITORING TO ENSURE ACTION ONNHIGH VL RESULTS
- ENSURE THAT HIGH VL SUPPRESSION DOES NOT MASK LOW VL COVERAGE RATES
- ONGOING MENTORSHIP AND M&E REQUIRED FOR SUSTAINABILITY



ADRENERGY RESEARCH INNOVATIONS

CAPRISA

CENTRE FOR THE AIDS PROGRAMME OF RESEARCH IN SOUTH AFRICA

UNAIDS

CAPRISA is the UNAIDS Collaborating Centre for HIV Research and Policy

LAUNCH OF THE KZN HIV VL AND DR MONITORING PROJECT

INTRODUCING THE VL CHAMP

MAKING VL MONITORING ROUTINE AND MANAGING HIGH VL

Dr.Henry Sunpath

Infectious Diseases Unit –NRMSM –UKZN

DIRECTOR MEDICATE –AIDS NPC T/A AWACC

CONSULTANT CAPRISA - ACC

AWACC 2017 -2019

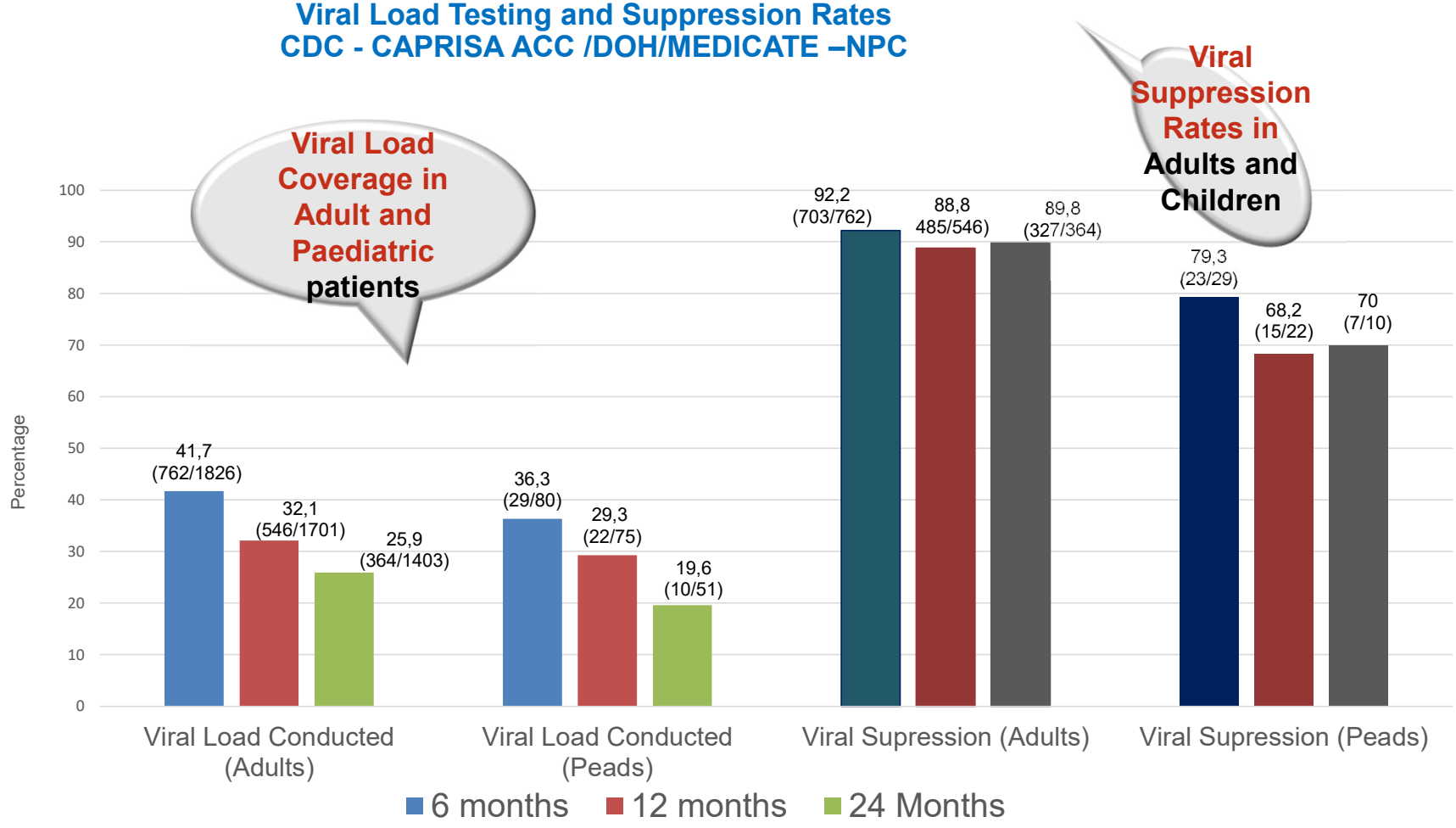
PROVINCE OF KWAZULU-NATAL
ISIFUNDAZWE SAKWAZULU-NATALI

DEPARTMENT OF HEALTH & HUMAN SERVICES-USA

CDC CENTERS FOR DISEASE CONTROL AND PREVENTION

CAPRISA CENTRE FOR THE AIDS PROGRAMME OF RESEARCH IN SOUTH AFRICA

FILE &FACILITY AUDIT (2015-16)
Viral Load Testing and Suppression Rates
CDC - CAPRISA ACC /DOH/MEDICATE –NPC

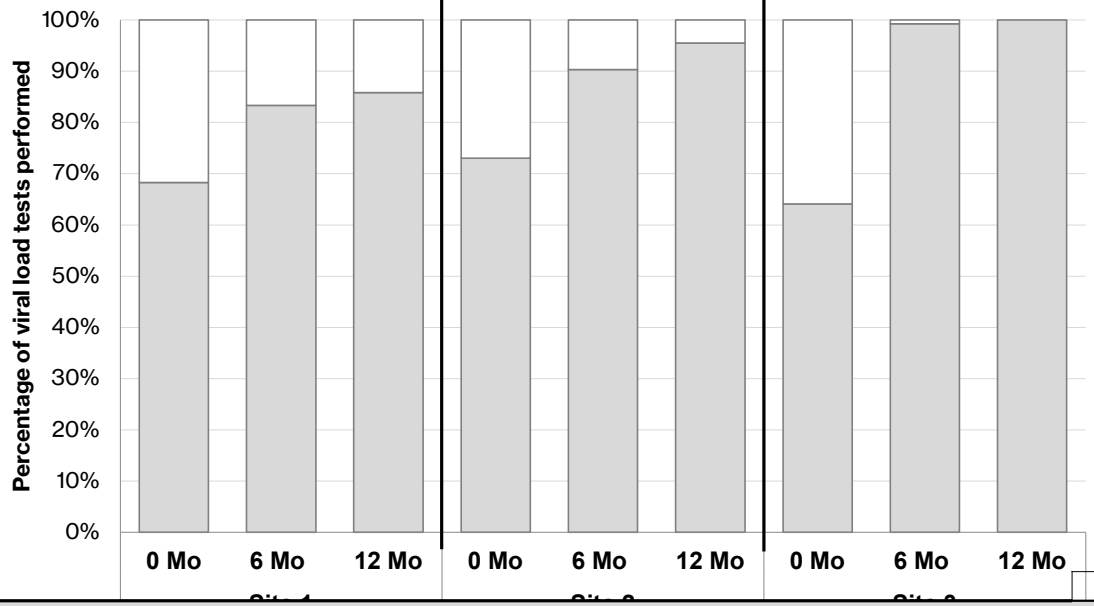


1.1. Naidoo K, Sunpath H. CAPRISA Advanced Clinical Care: strategies to optimize identification of unsuppressed viral load in patients on second-line antiretroviral therapy. Data Use Innovations and Best Practices Workshop. ([https://za.usembassy.gov/wp-content/uploads/sites/19/S11_1425_NaidooK_Strategies-to-optimize-ID.pdf

A VL champion closes testing gaps -3 pilot ART sites (eThekwini 9872 pts)

After a VL champion was introduced, all sites improved; two reached ≥97% by 12 months.

Sunpath H, Hatlen TJ, Naidu KK, Msimango P, Adams RN, Moosa M-YS, et al. Targeting the third "90": introducing the viral load champion. Public Health Action. 2018 Dec 21;8(4):225–3



Cochran-Armitage Trend Test for viral load tests performed per site:

Site 1: p < 0.0001
Site 2: p < 0.0001
Site 3: p < 0.0001
Cumulative: p < 0.0001

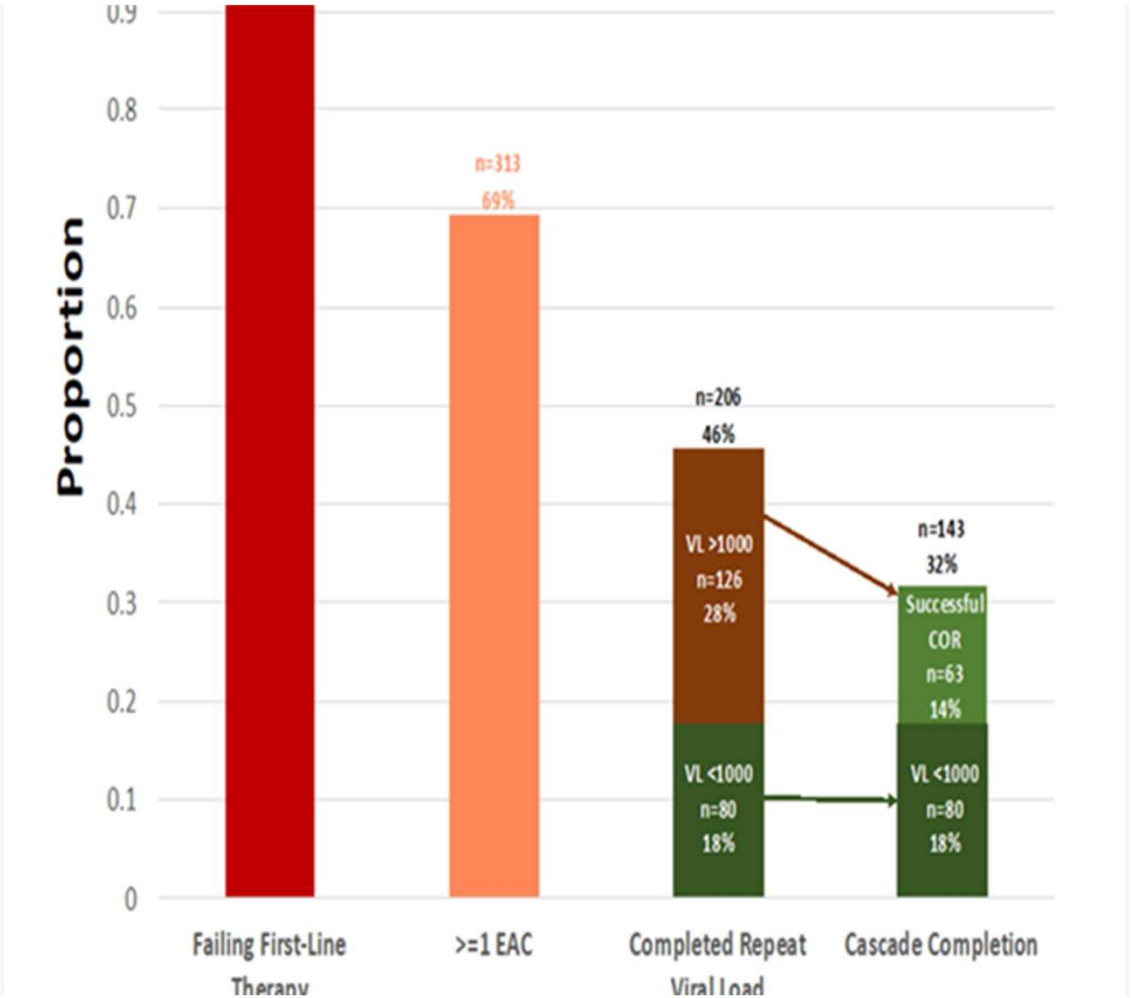
□ VL Expected
▨ VL Performed

							Cumulative	
0 Mo								
VLP/VLE	140/205	68%	84/115	73%	323/504	64%	547/864	63%
VLS/VLP	112/140	80%	78/84	93%	307/323	95%	497/547	91%
6 Mo								
VLP/VLE	995/1194	83%	793/878	90%	3101/3124	99%	4889/5196	94%
VLS/VLP	840/995	84%	758/793	96%	2996/3101	97%	4594/4889	94%
12 Mo								
VLP/VLE	2262/2636	86%	1742/1824	96%	6636/6636	100%	10640/11096	96%
VLS/VLP	1920/2262	85%	1646/1742	94%	6519/6636	98%	10085/10640	95%

Only 32% (143/452) of patients with FLART failure re-suppressed or were changed to SLART

- Only 27% (117/452) and 8% (35/452) did so within 180 and 90-days, respectively

Sunpath H, Naidu K,Pillay S ,Naidoo K ,Seidner M ,et al The Second Cascade: Management of Patients with High Viral Loads in Public HIV Clinics in Durban, South Africa. 22nd International AIDS Conference (AIDS 2018): Abstract A-899-0219-07643. www.aids2018.org



SYSTEMATIC REVIEW · ELEVATED VL CASCADE

Follow-up breaks down after elevated VL—and switching is the weakest step

Median performance across the failure cascade:

FOLLOW-UP VL

66%

after an initial elevated VL

IQR: 38–77%

CONFIRMED FAILURE

62%

among those with follow-up VL

IQR: 50–75%

SWITCHED TREATMENT

45%

among confirmed failures

IQR: 36–71%

LIKELY CAUSES

Inadequate enhanced adherence counselling and/or poor implementation of the virological-failure cascade.

PRIORITY

Test facility- and community-based interventions that strengthen the cascade and preserve first- and second-line ART efficacy.

Source: Pham et al. Viral Load Monitoring for People Living with HIV in the Era of Test and Treat: Progress Made and Challenges Ahead — A Systematic Review. PLoS One. 2019;14(4):e0214937.

Viral Load Monitoring for People Living with HIV in the Era of Test and Treat: Progress Made and Challenges Ahead – A Systematic Review

Minh D. Pham Huy V. Nguyen David Anderson Suzanne Crowe Luchters
Posted Date: November 30th, 2021 /DOI: https://doi.org/10.21203/rs.3.rs-1091142/v1

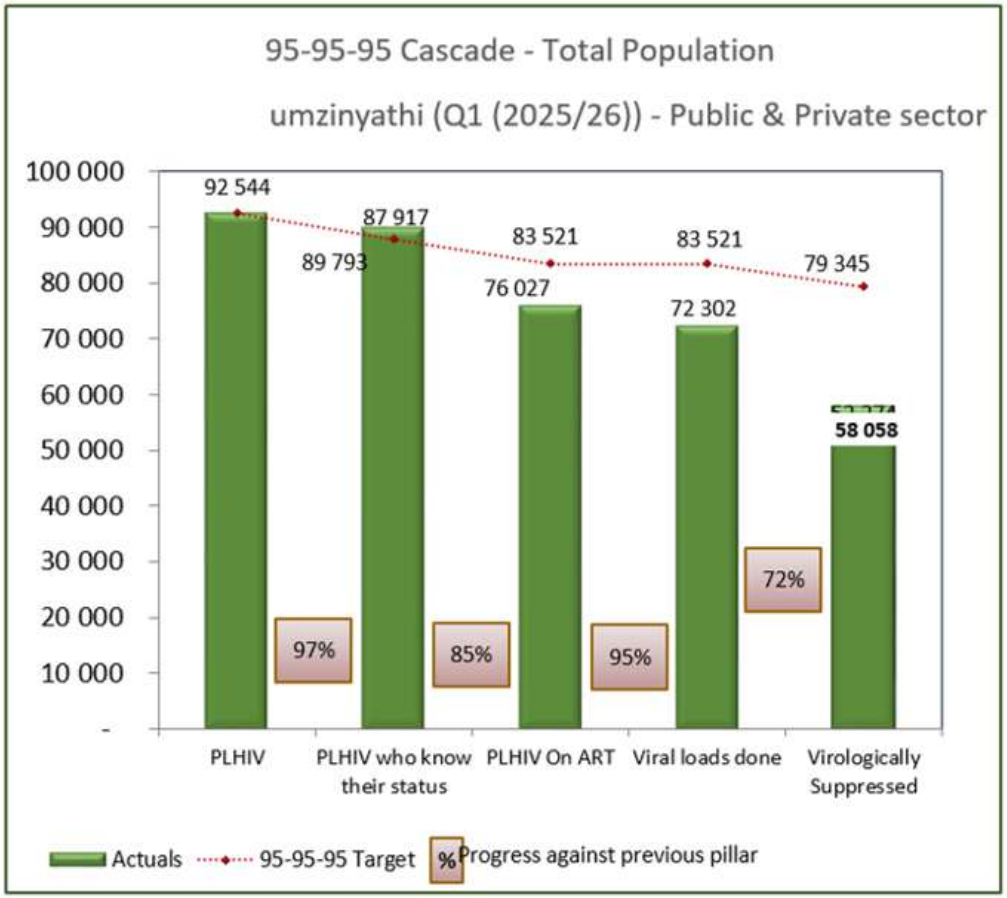
- Of 11 studies from South Africa, four were conducted in **Cape Town**, reporting relatively high VL coverage of **72–89%.** Other studies were conducted in KwaZulu-Natal [21, 30, 31], Eastern Cape [23, 27] and Gauteng , and another study [28] included data from ART patients in nine different provinces across the country.

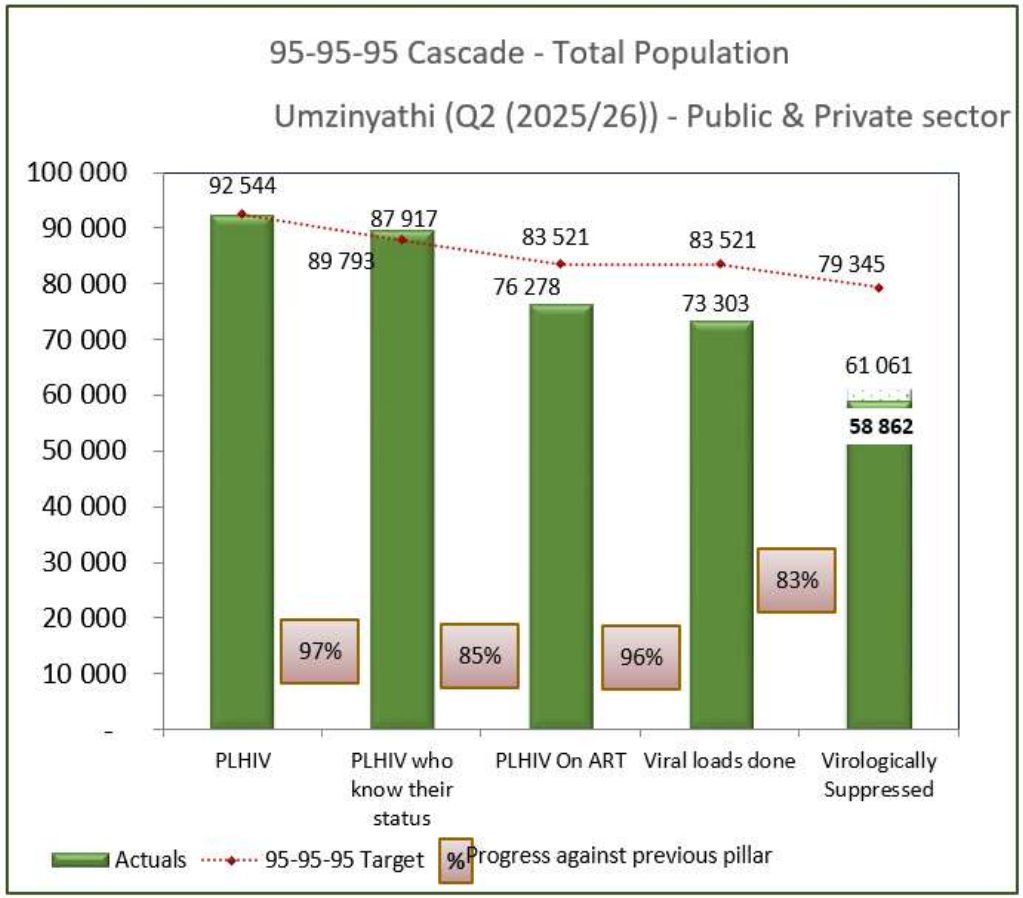
- Few studies with **interventions to improve quality of ART program had a VL coverage of >90% . O**ther studies reported a **VL range of 25%-81%.**

- The highest VL coverage at 6 months (94%) and 12 months (96%) after ART initiation were reported from a study in South Africa [30] **assessing the impact of an intervention program to improve VL monitoring in which trained nurses were designated to the role of "VL champion" to follow-up on VL testing for PLHIV on ART** (30) …

- Sunpath, H., et al., Targeting the third '90': introducing the viral load champion. Public Health Action, 2018. 8(4): p. 225–231.

VLC model -HIV Treatment Cascade Total population





KWAZULU-NATAL PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

MENTORSHIP AGREEMENT FOR EXAMPLE TRAINING

This agreement is between a **Mentor** who is an experienced practitioner in providing EXAMPLE and a **Trainee** who is leaning to provide EXAMPLE at PHC facility level.

Mentor Details	
Name	
Facility	
Contact Number	
PERSAL Number	
SANC Number	

Trainee Details	
Name	
Facility	
Contact Number	
PERSAL Number	
SANC Number	

Competencies to be mastered:

- Management of VL – roles and responsibilities at each ART site
- Management of VF -clinical and psychosocial support
- Data flow management
- Down and up referral systems /processes for PLWH with coinfections /comorbidities (SOP)
-

Agreement:
We agree to work together to the point where the Trainee has demonstrated mastery of the competencies above. This collaboration will entail direct observation and the provision of immediate feedback.

Mentor Sign:
Date:

Trainee Sign:
Date:

Commitment by Facility Manager:
I am aware of the agreement between the Mentor and Trainee and will work to create a supportive environment in which to practice the competencies. Facility Name:
Facility Manager Name:
Facility Manager Signature:

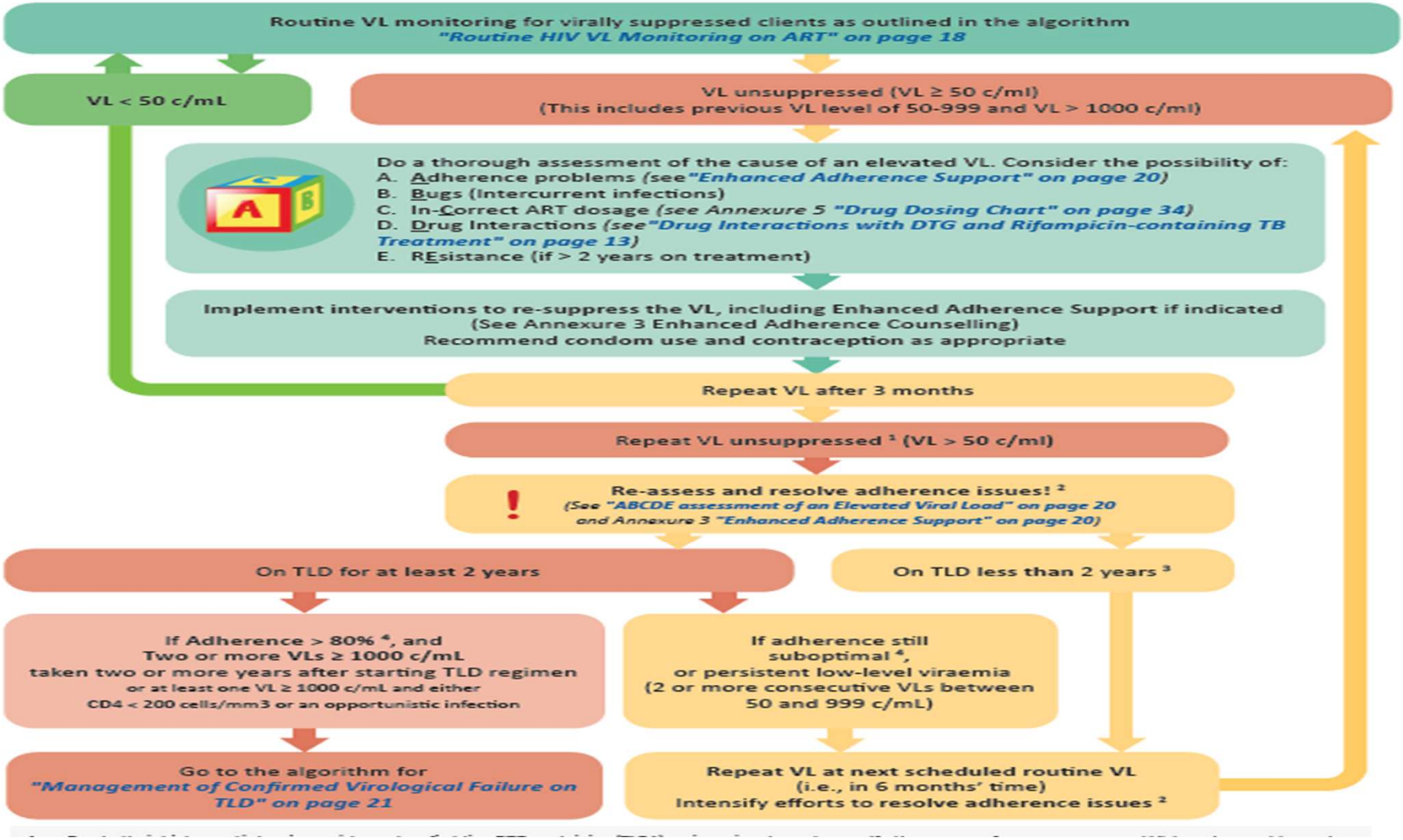
VL MANAGEMENT – SERVICE DELIVERY PROCESS –operation PHUTUMA

Six operational disciplines make routine VL monitoring work- supervised by the VL champ .

01	**SERVICE DELIVERY PROCESS**	Functional booking system Effective process to highlight patients due for VL Effective blood results management process and actioning of abnormal results Managing missed VL appointments Planned patient flow ? Bloods prior consultation
02	**STAFF COMPETENCY AND CAPABILITY**	All clinicians to be trained on interpreting blood results All clinicians cognisant of process to support VL management NIMART trained nurses to adapt ART treatment due to abnormal results
03	**DATA SYSTEM**	Print VL due reports to manage patients expected within that month Print the VL outstanding report to follow up on expected blood results Clinician to record results in patient file Manage file flow process between consultation rooms and data capturing points
04	**RESOURCES AND SUPPLIES**	Lab materials Access to LAB TRACK
05	**TEAM WORK**	Effective communication between facility and laboratory Integration and coordination of multidisciplinary team supporting VL management
06	**PATIENT ENGAGEMENT**	Routine provision of health education U=U campaign

VL Monitoring for Clients on TLD

(also applicable to ALD and other DTG-containing regimens)



PROPOSED SOP · APPENDIX SET

List of Appendices to Proposed SOP for VL management in D1,TLD2 and TLD2F regimens

VL REGISTERS

01 VL register for TLD 1 and TLD 2 and adherence <80 % with first VL> 60 c/ml

02 VL register for TLD 2 and adherence > 80% and VL > 1000 c/ml and 500 -999 c/ml

03 VL register for TLD2F regimens

IMPLEMENTATION TOOLS

04 SOP for VL management in the era of DTG regimens

05 Patient flow pathway in the clinic

06 Responsibilities of VL champion

STRUCTURE **Three regimen-specific registers + three tools to operationalise routine VL management.**

VL REGISTERS · PATIENT PATHWAYS

Route patients by adherence and viral-load result

Two registers guide the next action for TLD1/TLD2 patients.

Adherence <80% with first VL >50 copies/mL

TLD1 + TLD2 register

Adherence >80% with VL 500–999 or >1,000 copies/mL

DESIGN LOGIC

Assess adherence → classify the VL result → follow the register-defined action pathway.

REGISTER 1A: MANAGEMENT OF TLD 1 and TLD 2 WITH THE FIRST VL ≥ 50 c/ml after start /change of ART (M0)

On TLD 1 0r TLD2 (non PI regimen)-follow as per guidelines below

Patient Name	Clinic Number	ID Number	Contact number x 2	VL test M3 Date	VL result M4	EAC 1 Date	EAC 2 Date	EAC 3 Date	EAC 4 Date	EAC 5 & VL test Date	Outcome & Date:

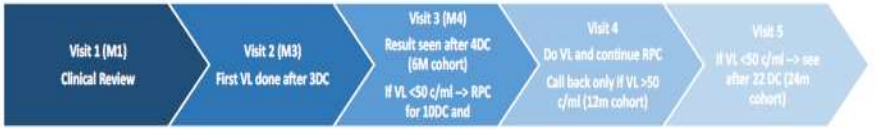


REGISTER 1 B : MANAGEMENT OF TLD 1 and TLD 2 WITH THE FIRST VL ≥ 50 c/ml after start /change of ART (M0)

NB.1. PI regimen for more than 2 years, VL < 1000 c/mL – -Switch to DTG-containing regimen. If VL in last 12 months > 50 c/mL, continue to switch same day, provide EAC if needed, and repeat the VL after 3 months and guidelines below

NB.1 Two or more VLs > 1000 c/mL more than 2 years ;-Adherence less than 80% - Switch toa DTG-containing regimen . Repeat the VL after 3 months and guidelines below

Patient Name	Clinic Number	ID Number	Contact number x 2	VL test M3 Date	VL result M4	EAC 1 Date	EAC 2 Date	EAC 3 Date	EAC 4 Date	EAC 5 & VL test Date	Outcome & Date:



REGISTER 2: MANAGEMENT OF PATIENTS WITH TLD2F

After GRT results and individualised regimen -VL after 3 months then as determined by clinician depending on VL

Two or more VLs ≥ 1000 c/mL taken two or more years after starting PI regimen - adherence more than 80%. Do a resistance test.

Discuss with an HIV expert to authorize and interpret a resistance test and provide individualized regimen. Repeat VL 3 months .

Patient Name	Clinic No	ID No	Contact no x 2	Regimen Date started	EAC 1 Clinical review Date	EAC 2 Date	EAC 3 Do VL Date	EAC 4 VL result Review Date	Date	Date	NEXT VL At 6 months annually	Outcome & Date:

Developed in Partnership with: ADDERLEDGE

QA Tool 1: ADULT ARV CHART REVIEW

Date: _____

ne of Reviewer		Designation	
ility Name		File No	

A. Initiation Visit for current regimen (Mark X to denote completed, ND to denote no evidence of completion or N/A if test was not required)

een	Done	Abnormal Test actioned	Blood Test/screen	Done	Abnormal Test actioned	Blood Test/screen	Done	Abn Test actio
			Urine dipstix			Cr Cl		
			Preg test			ALT		
l			TB Screen			Hep B SAg		
O Stage			STI screen			Chol (f)		
amination			HB/FBC			Trig (f)		

B. TB Screening, Management and IPT Completion

Was TB Screening completed?					YES		NO
% of visits TB Screening done	0%		<50%		>50%		All
Were they pregnant at baseline?	Yes		No		CD4 <100	Yes	
GXP done in all pregnant patients	Yes		No				
Was IPT initiated?	No - Active TB				YES		NO
If IPT started, number of Months of IPT completed							
Any DSTB on Aluvia/DTG/Atazanavir/Darunavir					Yes	No	N
Were the doses of Aluvia doubled during DSTB Rx?					Yes	No	N
Were Aluvia doses reduced 2 weeks after DSTB Rx end?					Yes	No	N
Were the doses of Dolutegravir doubled during DST Rx					Yes	No	N
Did they get Rifabutin while on Atazanavir or Darunavir?					Yes	No	N

C. VL Coverage and Suppression (Mark appropriate column with an X)

Patients current ART regimen		Months on Regimen	

D. Mark with X if VL was done next to the month. Add result below if applicable

nth 6		Month 12		Month 24		Month 36		Most recent
sult		Result		Result		Result		Result
epeated If ≥ Y/N)		VL repeated If ≥50 (Y/N)		VL repeated If ≥ 50 (Y/N)		VL repeated If ≥ 50 (Y/N)		VL repeated If ≥50 (Y/N)
sult		Result		Result		Result		Result

E. Management of Switch from 1st Line ART to TLD

VL result before switch to TLD in c/mL		VL completed within 6 months before switch to DTG? (Y/N)	
Patient is ≥ 10 years of age	YES		NO
Patient is ≥ 35kg	YES		NO
Creatinine clearance result			
Documentation of Counselling about DTG for women	YES		NO
Pregnancy excluded before starting DTG	YES		NO

VL management follows one controlled clinic flow

From weekly high-VL identification to patient arrival and daily data handover

0

PREPARE — Build the high-VL worklist before the visit

- NICD releases weekly RFA reports. DR/NSM access the RFA list weekly and share it with VLC.
- VLC shares the list with the data clerk/facility support officer for file retrieval.
- DC/FSO submits files to VLC; VLC separates them by VL result and gives EAC high-VL files for tracing and tracking.
- Dedicate a filing-space bin for HIV VL files until action is taken.
- When hard-copy VL results are available, the linkage officer/EN places them on patient files.
- VLC gives HIV VL lists to the EAC counsellor for entry in the appropriate high-VL register (1, 2 or 3).
- Once the HIV VL is actioned, return the file to the general filing room.
- VLC checks the dedicated high-VL bin weekly, identifies patients who did not attend, and calls them or asks the linkage officer to call.

1

PATIENT — Arrive, triage and keep contact details current

- Arrives as per appointment after being contacted for a VL check-up.
- Is triaged to AC in a separate queue.
- Comes on the next appointment date shown on the appointment card and informs staff of contact, address or travel changes.
- Returns the file to pharmacy at each visit or on leaving.

2

ADMIN / DATA — Protect the file trail and hand over data daily

- Maintains a separate filing system for patient files with high VL.
- When the clinician discharges a patient for follow-up, replaces the file in the general filing system.
- If a patient arrives for an unscheduled consultation and the file is not in the general filing room, checks among the HIV files — DO NOT OPEN A NEW FILE.
- At the end of each day, hands over files to the data clerk for entry into TIER.Net.
- REFERS ALL patients first to the EAC counselling team.

EAC COUNSELLING FIRST • THEN TIER.NET

High-VL care closes the loop across three accountable roles

EAC counselling → clinical action → active follow-up

3 **EAC TEAM · COUNSELLOR**

Engage, assess and prepare

- Engage with the patient in a non-judgemental way using the worksheets as a guide.
- Provide education on the abnormal result and common causes of treatment failure.
- Assess and address barriers to adherence.
- Review the adherence plan and set new treatment goals.
- Inform the patient about tracing and retention in care.
- Engage a social worker / psychologist as required.
- Complete the HIV VL register daily and make an entry or notes for other staff.

PATIENT ROLE

- Express barriers to adherence and the potential reason for treatment failure.
- Review and adapt the adherence plan with the counsellor.

REFER TO CLINICIAN

4 **CLINICIAN**

Review, act and document

- Confirm EAC was done.
- Review the VL result (hard copy or by phone) if required.
- Enter the VL result on the longitudinal chart and manage as per guidelines.
- Send the patient for a VL blood draw if scheduled during that visit.
- Thereafter review the medication script and renew / dispense.
- Provide the date for the next clinic visit on the appointment card.

Complete the high-VL register daily together with the EAC counsellor

5 **LINKAGE OFFICER**

Find missed follow-up

- Examine the high-VL register weekly with the VLC.
- Call patients who missed visits for EAC, blood tests, clinical review or medication.
- Maintain a call log and report LTFU.

FOLLOW-UP OUTPUT

Examine the register weekly. Call missed visits. Maintain the call log. Report LTFU.

REPORT LTFU

Tools to be familiar with

- **Databases for monitoring viral load:**
  - **National Health Laboratory Service (NHLS)**
    - Results for Action (RfA) Dashboard
    - Phuthuma Monthly Report
  - **TIER.Net**
    - 'Appointment list' report
    - 'VL overdue' report
    - '2 consecutive unsuppressed VL results' report
    - 'VL cascade' report
- **HST-CDC tools**
  - **VL Mop-up Standard Operating Procedure**
  - **VL Analysis Tool**
  - **VL Catch-up monitoring Tool**

HEALTH SYSTEMS TRUST

Acknowledgements…

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- HST NDOH LEARNING HUB

THANK YOU

Asibe HEALTH KZN