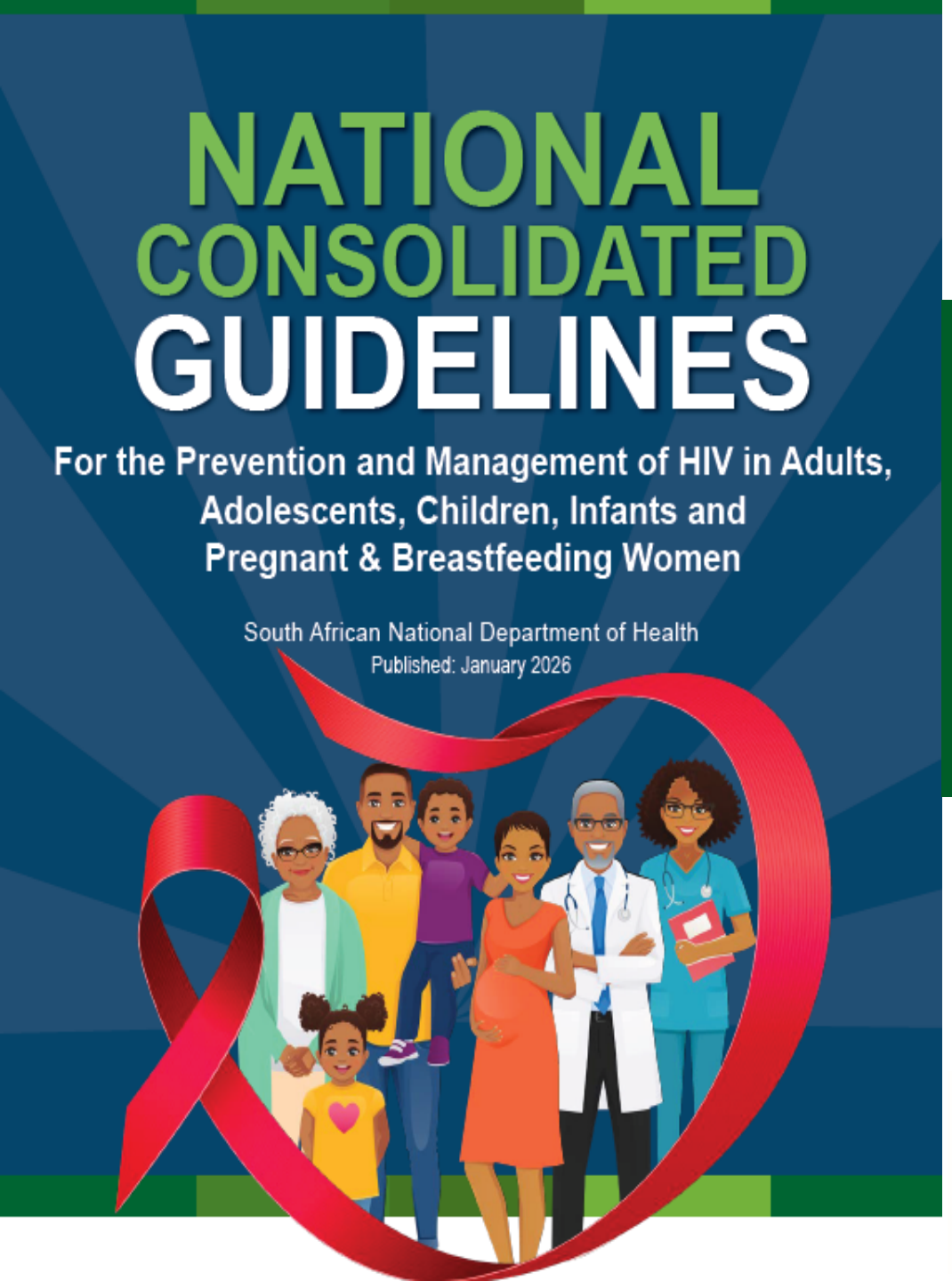


health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Overview of the Advanced HIV Disease

Chapter of the 2026 Consolidated ART Guideline

Dr Jeannette Wessels

AWACC Conference

Oct 2026

CLINTON HEALTH ACCESS INITIATIVE

World Health Organization

THE GLOBAL FUND

2030 NDP

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

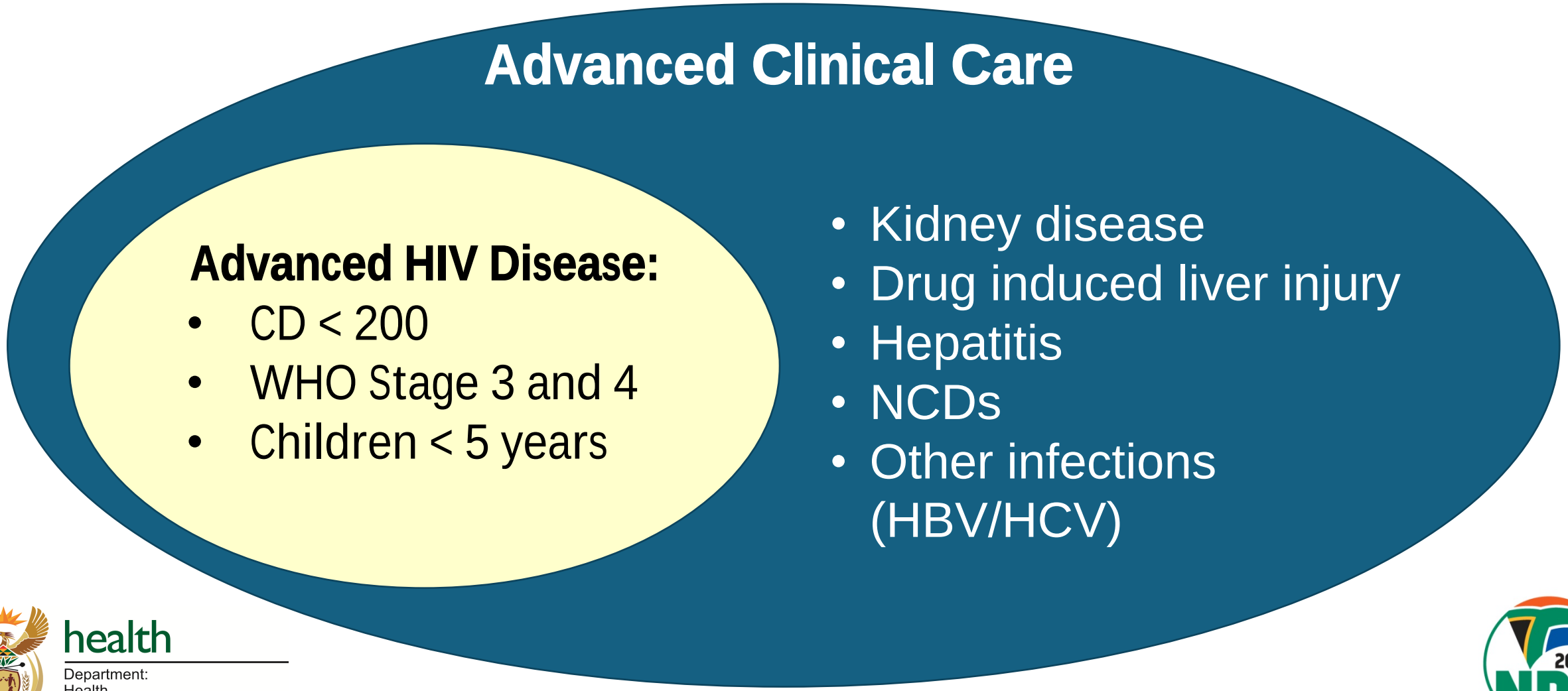
What is advanced HIV disease?

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



Prevalence of AHD disease in ART-naive 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

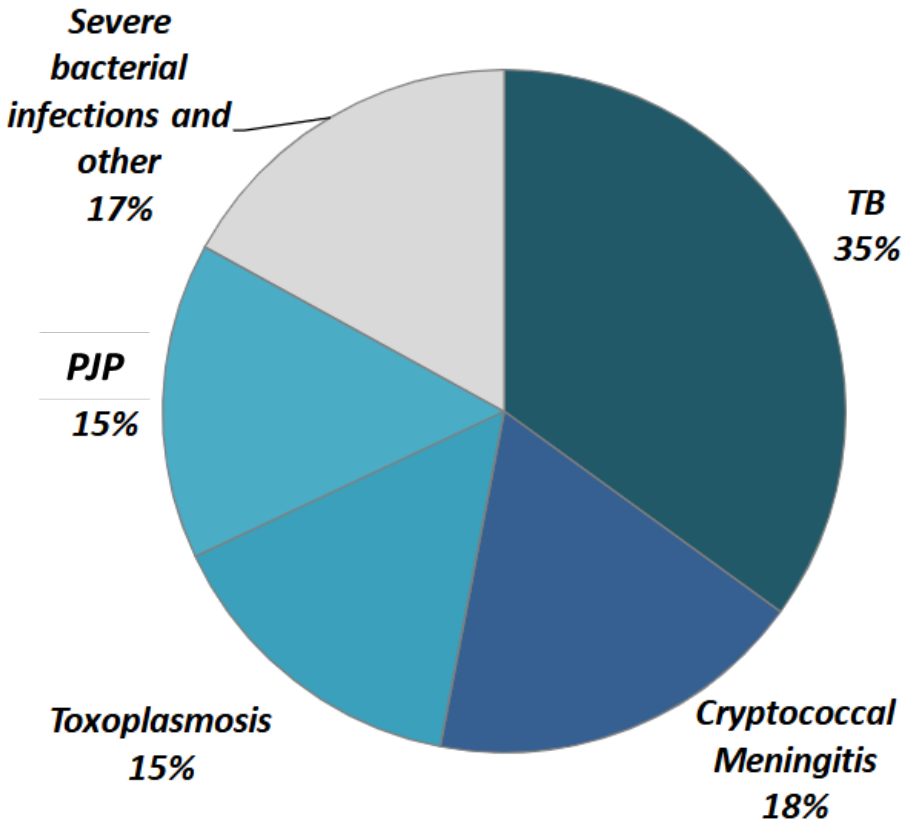
- AHD among ART-experienced patients was 58%
  - Disengage from care
  - Treatment failure
- More and more people who are in HIV programs are treatment-experienced.
  - Overlap with ART-naïve
    - Patients cycle of in and out of care (as per diagram on next slide)
  - Strategies for retention in care 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

What are they dying of?



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



Source: WHO AHD Guidelines, 2017.

Why are they getting opportunistic infections?

Not on effective treatment

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

Demand side influences

Supply side issues

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

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

We might be in the same storm, but







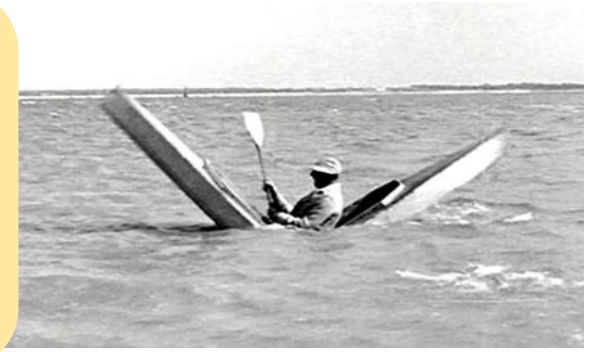


We are not all in the same boat

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



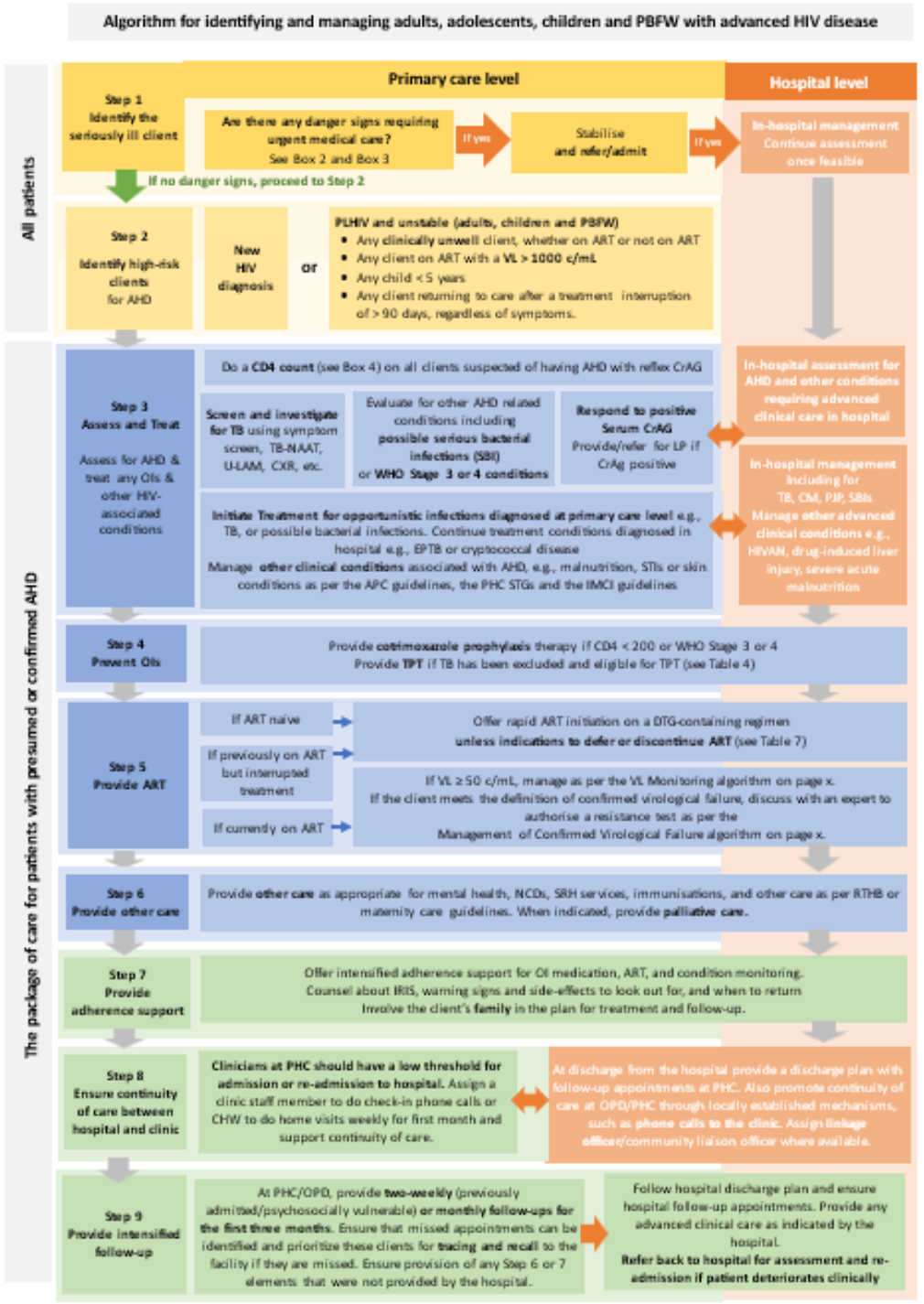
When the system fails someone with AHD (in a weak boat) the effects can be CATASTROPHIC!



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

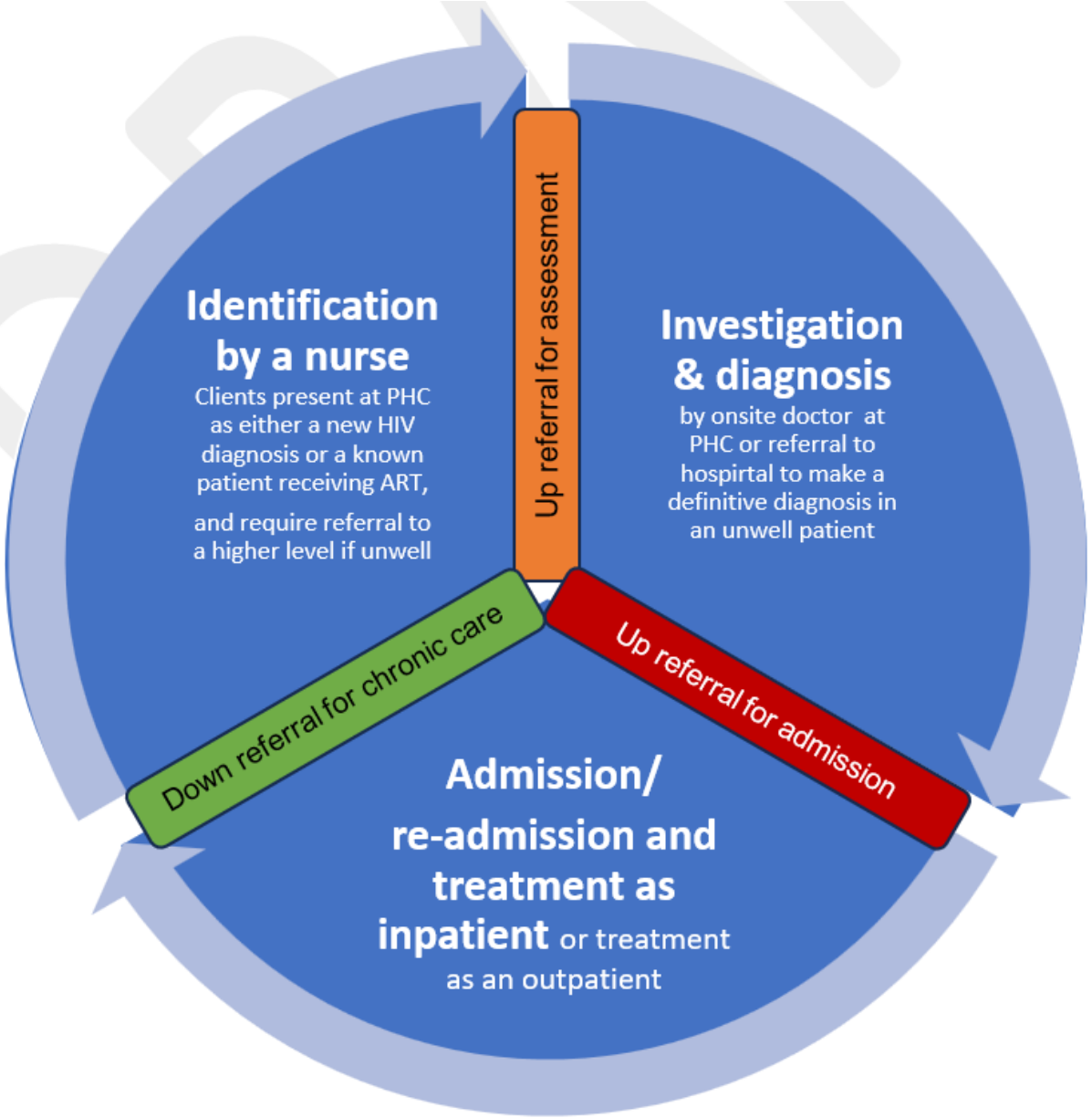
9 Steps for managing a patient with AHD

Overview



health
Department:
Health
REPUBLIC OF SOUTH AFRICA

2030 NDP



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.

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				
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.	√ Check if the doctor did this at hospital level. If not, contact family	√	√	Step 7

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

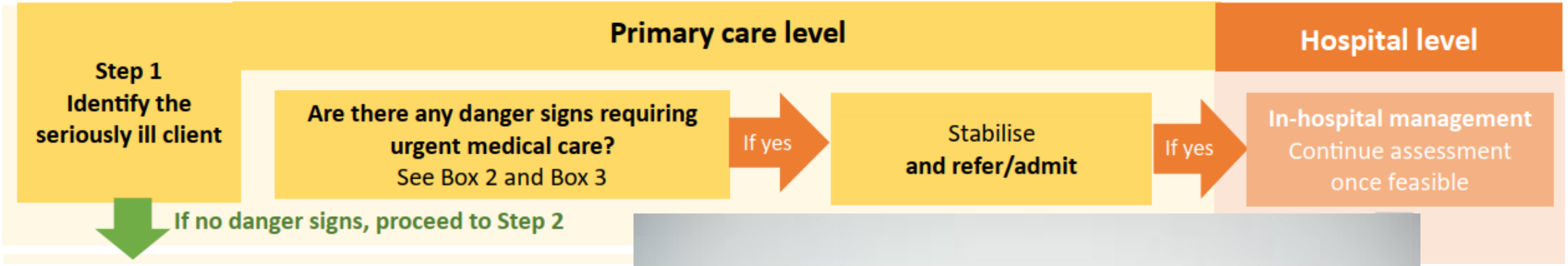
Element of care	Nurse at PHC	Doctor at PHC level	Doctor at Hospital Level	
Identification & management of danger signs	√ Where/when within the scope of practice of a nurse (as per APC and IMCI guidelines). Referral to a higher level of care	√	√	Step 1
Identify clients at risk of AHD	√	√	√	Step 2
CD4 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

Table 4 The "Who' and 'Where" and "what" of investigating and managing TB

Element of care	Nurse at PHC	Doctor at PHC level	Doctor at Hospital Level
Systematic TB screening	Screen all clients using the TB symptom screening tool Identify at-risk clients who require investigations, whether TB symptoms are present or not	√	√
Investigations	For diagnosis of pulmonary TB: Sputum testing (TB-NAAT ± culture), U-LAM, request CXR as per NTCP and TPT guideline Nurses should refer for further investigations if the client is very unwell or TB is suspected but the diagnosis unclear	For diagnosis of PTB or EPTB: Interpret CXR Lymph node FNA	Any investigations for diagnosis of PTB or EPTB, including ultra-sounds, other imaging and fluid taps
TB diagnosis and treatment initiation	√ If uncomplicated, bacteriologically confirmed PTB.	√ Bacteriologically or clinically diagnosed PTB or EPTB	√ Bacteriologically or clinically diagnosed PTB or EPTB
Monitor on TB treatment	√	If clinical complications arise or treatment resistance is detected	If clinical complications arise

Abbreviations: CrAg, cryptococcal antigen; CXR, chest X-ray; EPTB, extra-pulmonary TB; FNA, fine needle aspiration; LP, lumbar puncture; NTCP, National TB Control Programme; PTB, pulmonary TB; TB, tuberculosis; TB-NAAT, TB nucleic acid amplification test; TPT, TB preventive therapy; U-LAM, urinary lipoarabinomannan assay

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…



health
Department:
Health
REPUBLIC OF SOUTH AFRICA

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

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

More detail on this tomorrow…

2030 NDP

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

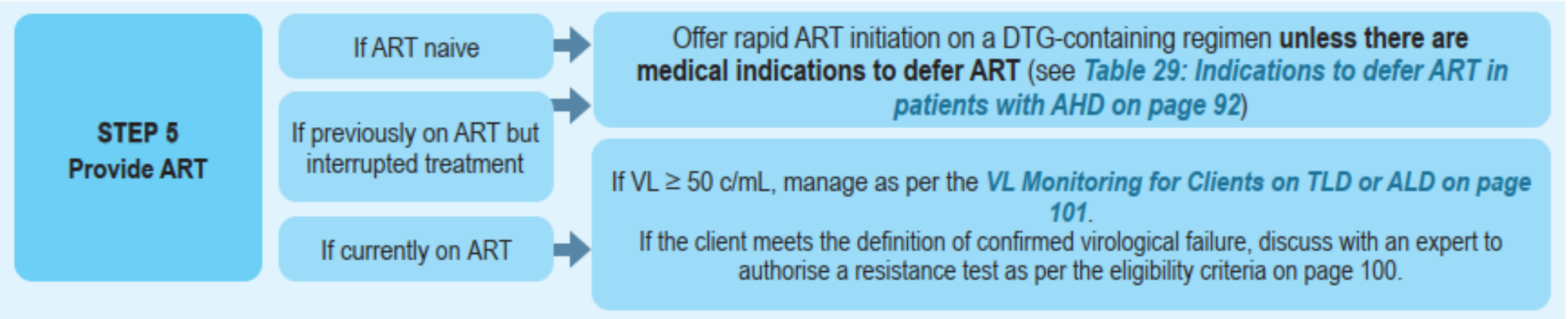
Source: SA NDoH 2023 ART Clinical Guidelines

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)

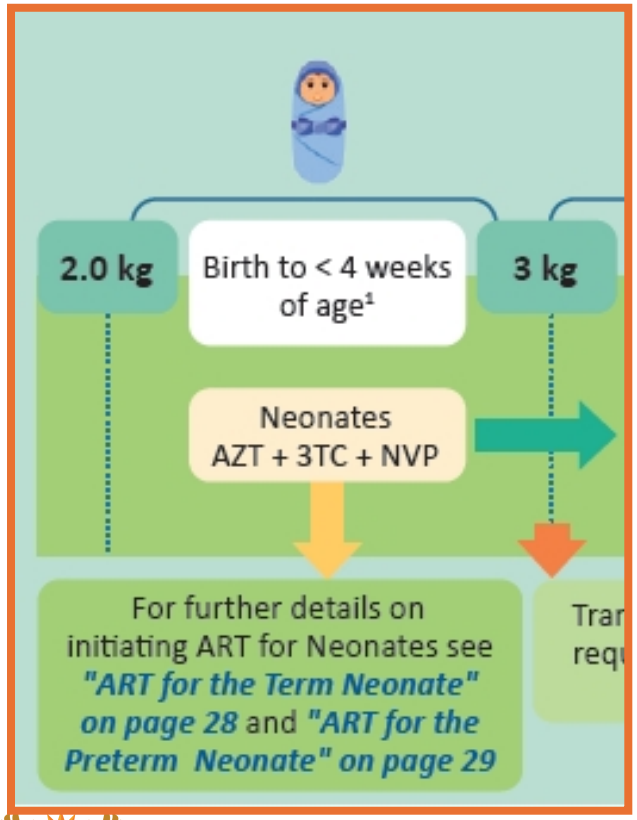
- Pregnant women with AHD are at significant risk of TB
- Recommendations for TPT in pregnancy have been aligned with the recommendations for all clients with AHD
  - CD4 counts < 200 cells/mm3 → 12 months of TPT
  - CD4 counts ≥ 200 cells/mm3, → defer to the post-partum period.
  - In the absence of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

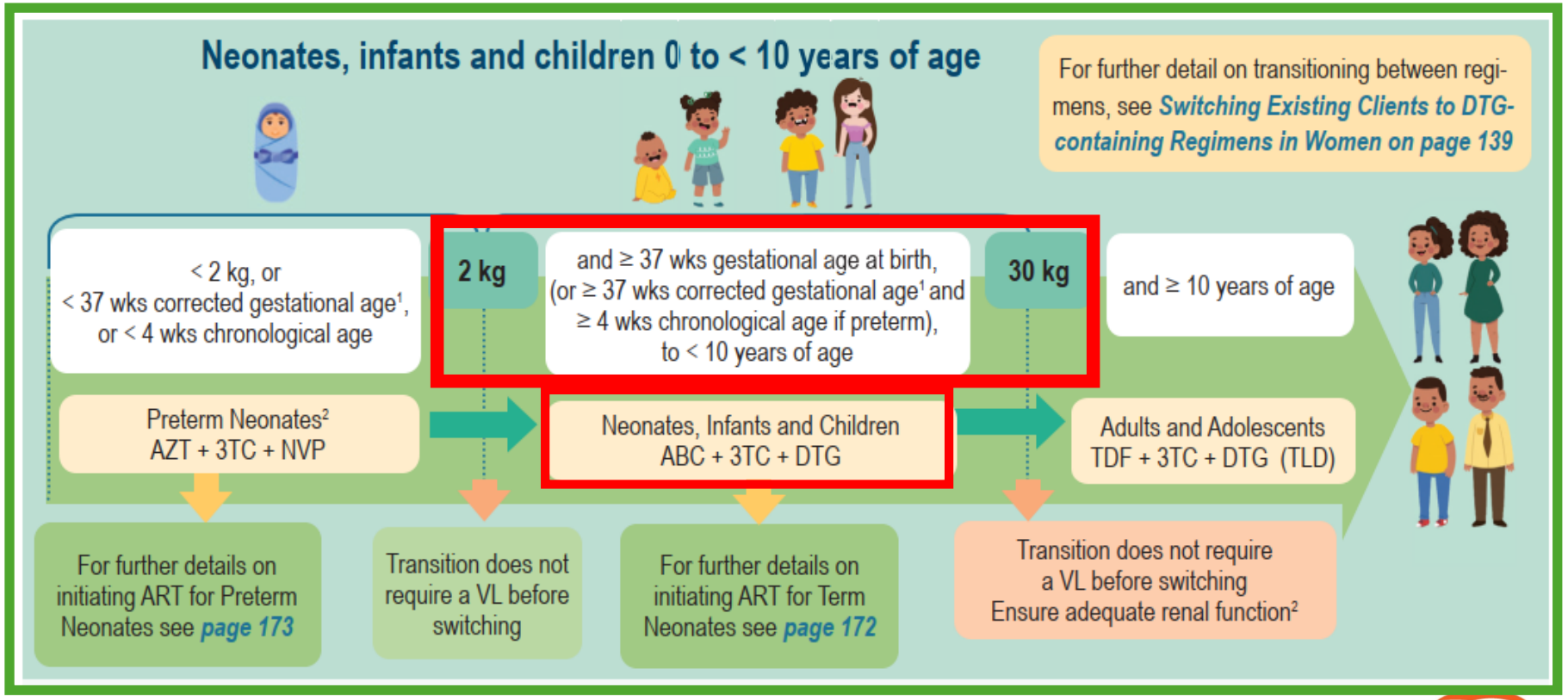
Steps 5 Provide ART



Previously

Now…
ABC + 3TC + DTG for **term** infants
(≥ 2kg and ≥ 37 weeks gestational age at birth

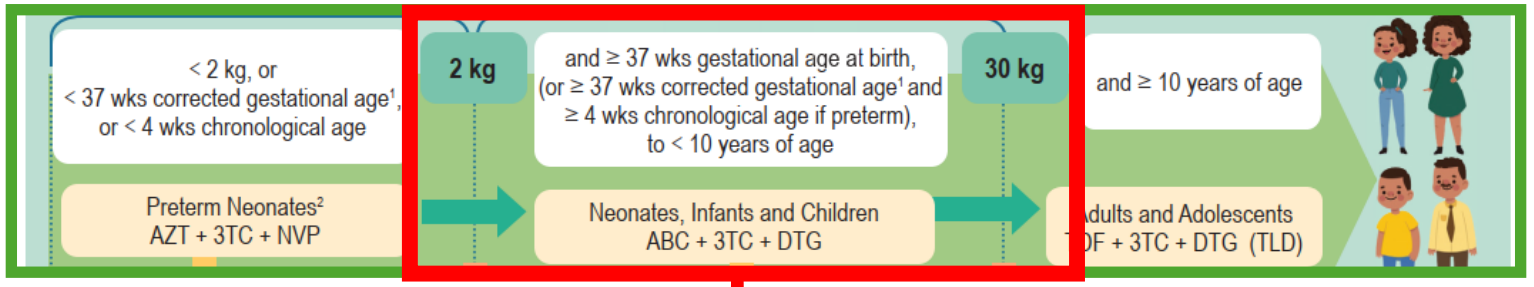




health
Department:
Health
REPUBLIC OF SOUTH AFRICA

2030 NDP

Same regimen, different formulations



2 kg — **30 kg**

2kg – 25kg

Birth to <4 weeks of age

Abacavir/3TC 120/60 tablets dispersible tablets

pDTG 10mg dispersible, scored tablets

≥ 4 weeks of age
(and ≥ 37 wks corrected gestational age, if preterm)

Fixed-dose combination paediatric ALD (pALD) ABC/3TC/DTG 60/30/5mg

25 kg – 30kg

ALD ABC/3TC/DTG 600/300/50mg

pALD is the new formulation

All formulations are given ONCE DAILY

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

Steps 7 Adherence support

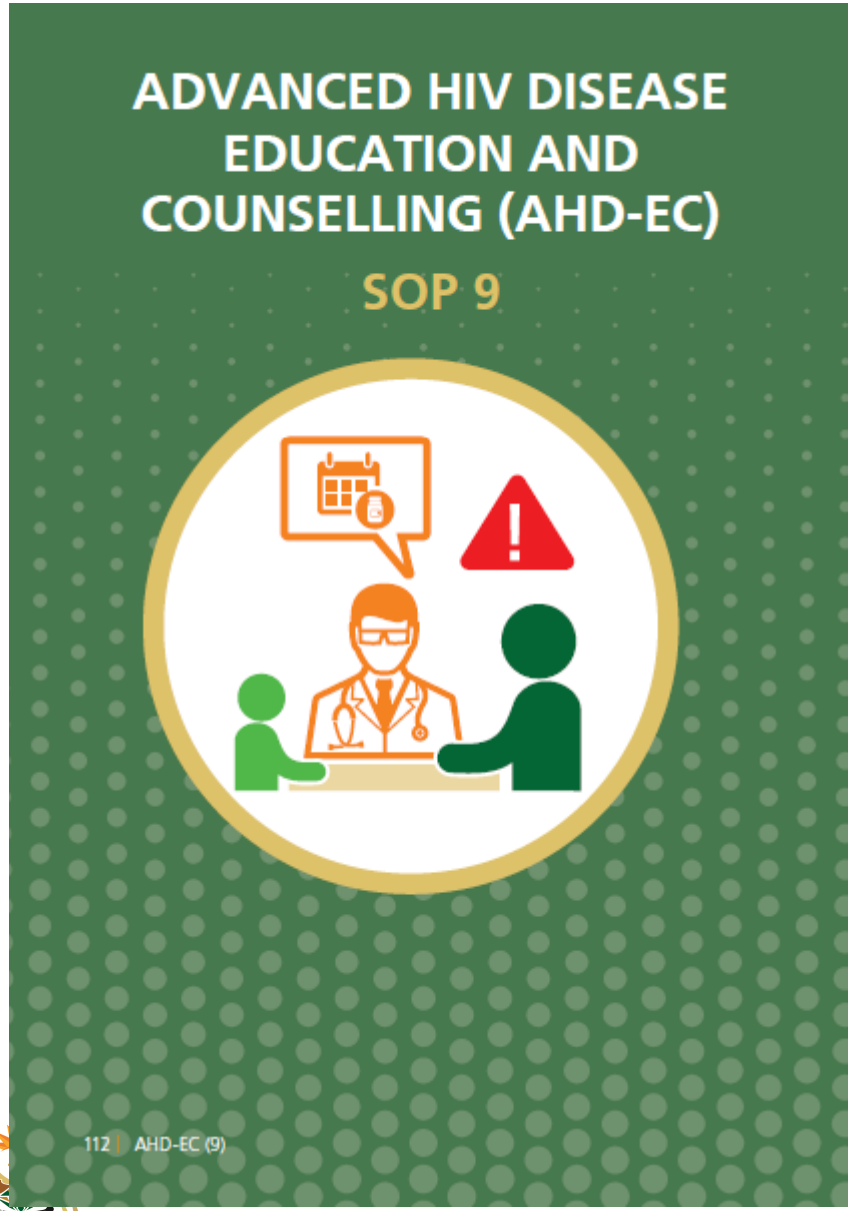
Step 7 **Provide adherence support**	Offer intensified adherence support for OI medication, ART, and condition monitoring. Counsel about IRIS, warning signs and side-effects to look out for, and when to return Involve the client's **family** in the plan for treatment and follow-up.





health
Department:
Health
REPUBLIC OF SOUTH AFRICA

2030 NDP



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.	

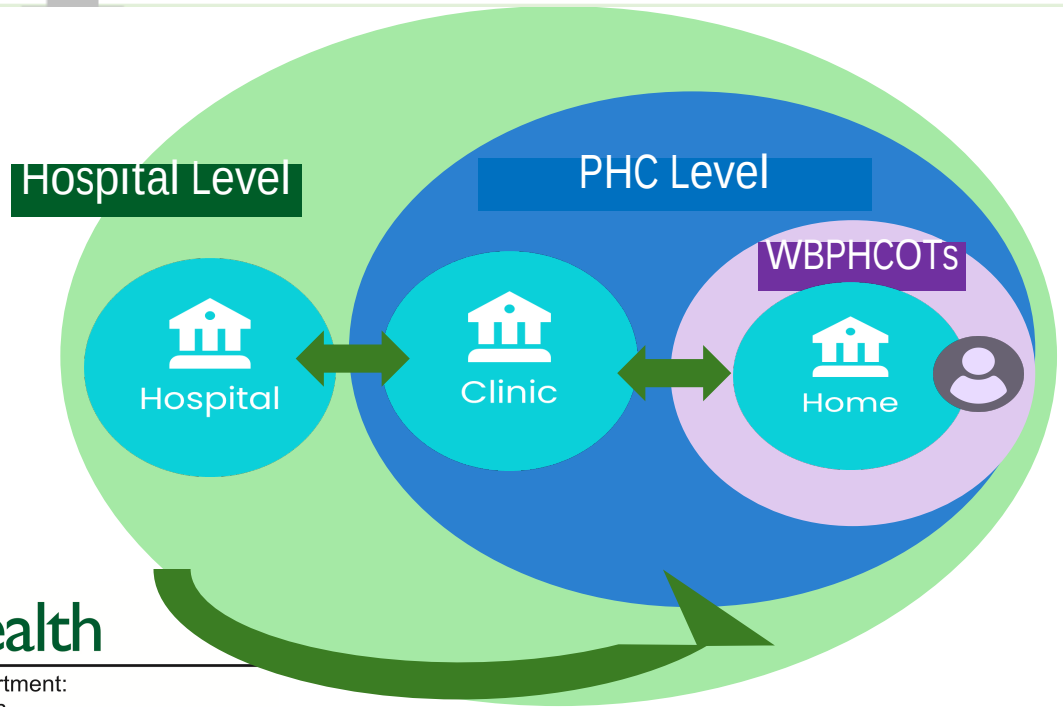
Session provides exact wording that can be used by a nurse/trained counsellor if helpful

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.



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

(Hoffman et al 2023 Clin Infect Dis.)

Maintain a low threshold for admission or readmission to hospitals.

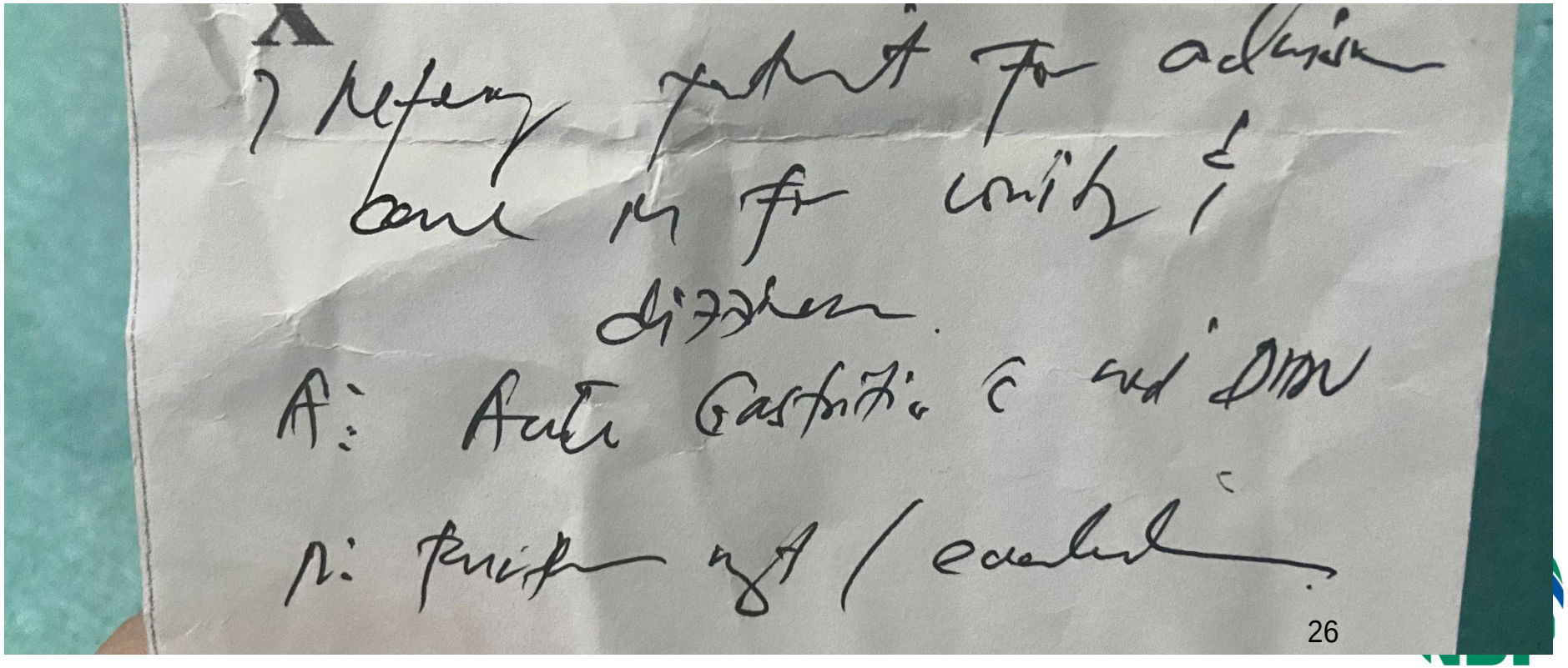
health
Department:
Health
REPUBLIC OF SOUTH AFRICA

2030 NDP

Continuity of Care

8

Referral letters



health
Department:
Health
REPUBLIC OF SOUTH AFRICA

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

Discharge Summaries (Page 96-97)

Box 16: Hospital discharge summaries

Hospital discharge summaries should contain the following information:

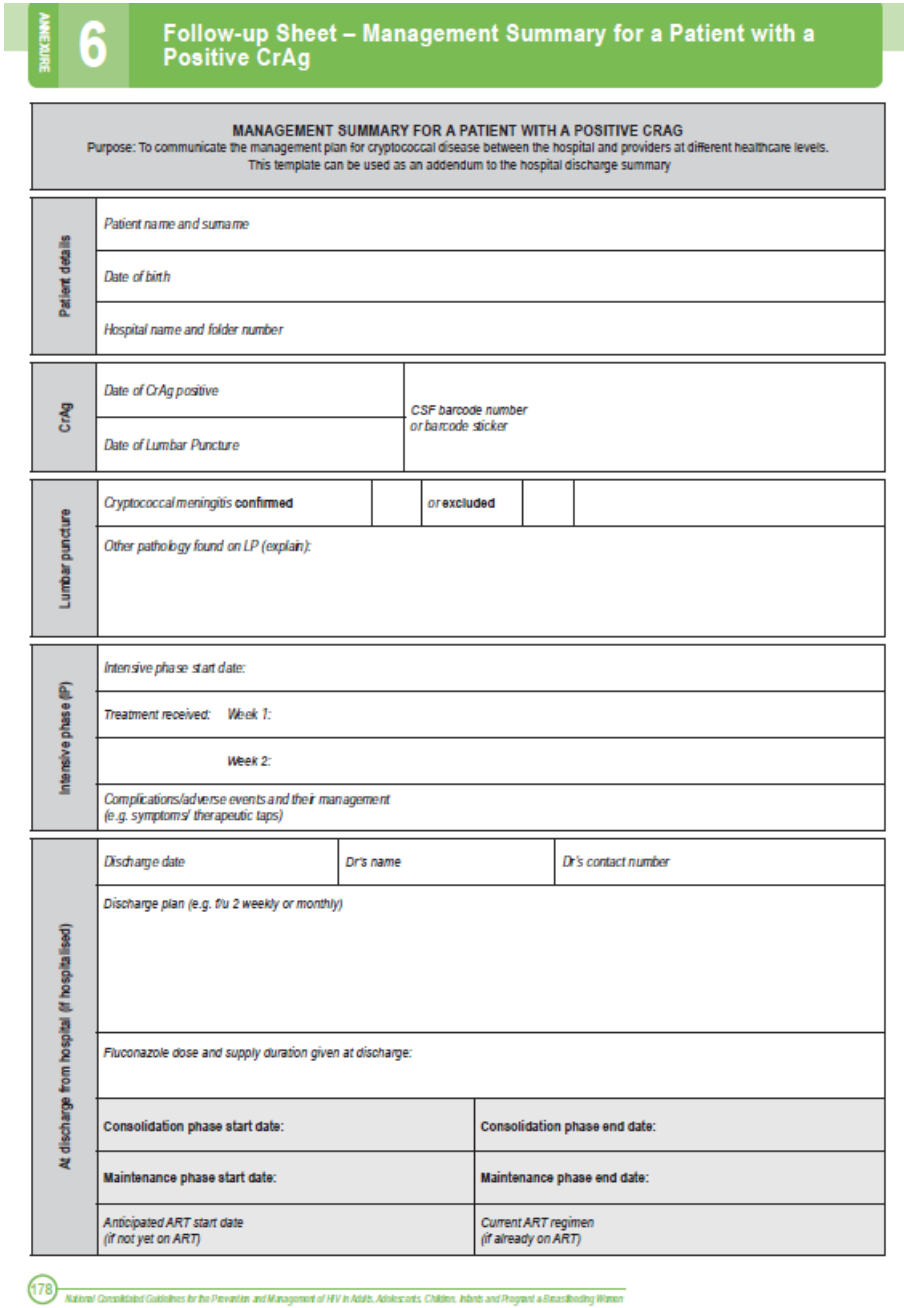
- All diagnoses (chronic and acute) and the results of relevant investigations.
- Details of management provided in hospital, including:
  - → HIV and ART management. If ART regimens have been changed, note why and whether the change is permanent or when it can change back.
  - → Management of opportunistic 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 referring back to hospital

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

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)*		

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

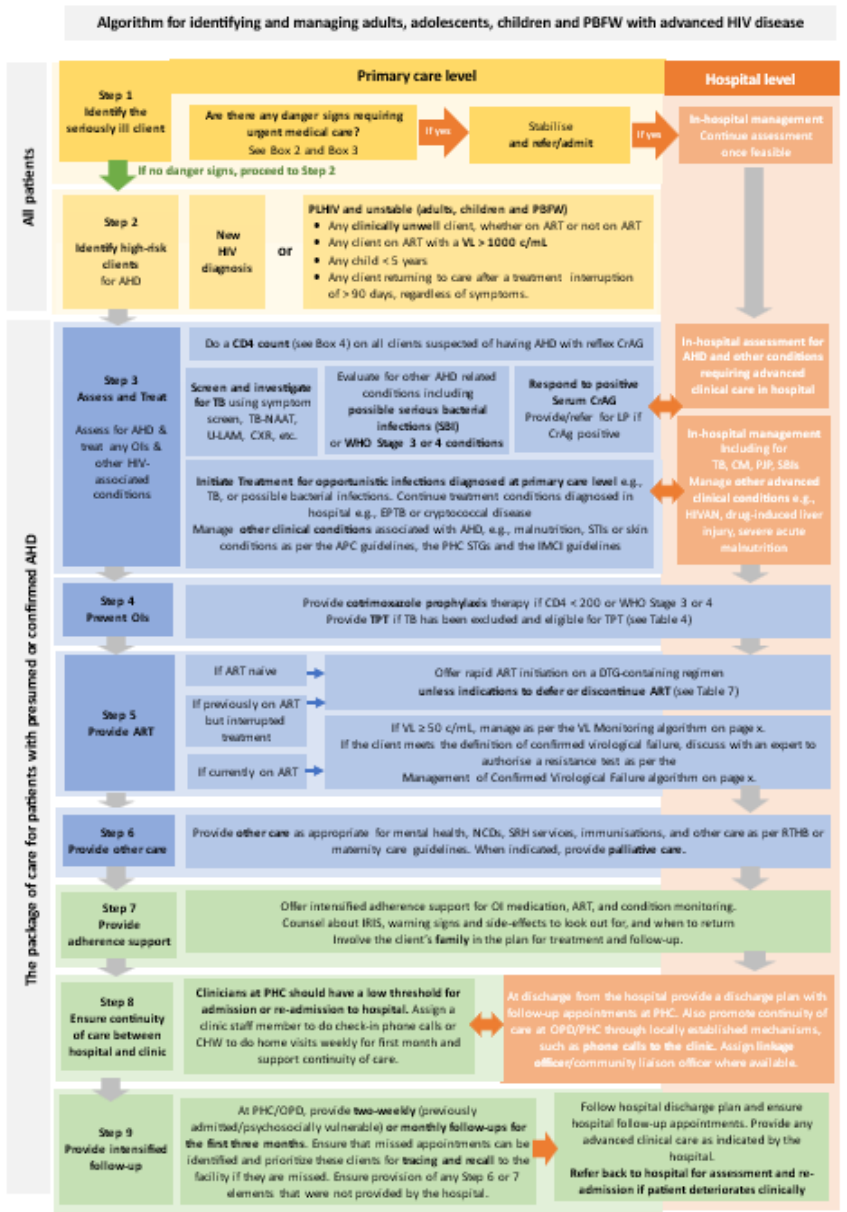
2030 NDP

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

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 7
Provide adherence support

STEP 8
Ensure continuity of care between hospital and clinic

STEP 9
Provide intensified follow-up

EGK authorisation codes for HIV Viral Load testing

in pregnant
within two y

One of the three E
provided with ever
done within the 'Fi

Pregnancy-related EGK approval codes

C*ANTENATAL	To be used during pregnancy only
C*DELIVERY	To be used around the time of delivery (7 days before or after delivery)
C*POSTNATAL	To be used for any maternal VL until baby is 2 years old **

Please spell the EGK codes correctly

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

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

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

Questions

- *What questions or concerns do you have?*