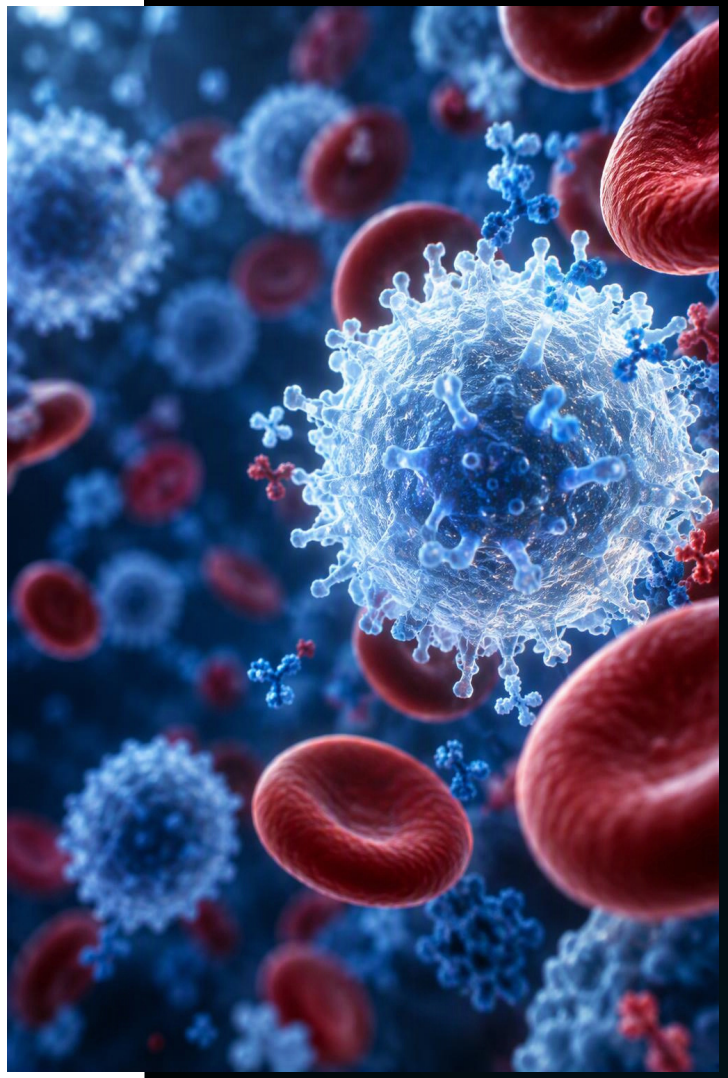
Addressing the drivers of Advanced HIV Disease: Priority actions to reduce HIV-related mortality

18TH AWACC 2026

DR.HENRY SUNPATH …PhD (MEDICINE) -UKZN
MBBS, MFamMed, DIpHIVMan, MPH
Dept of Infectious Diseases ,
NRM School of Medicine ,UKZN

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



ADMITTED PLWH -much higher risk of death

Of the **16%** deaths of in –patients

25%
die during admission

25%
die within 48hours of admission

80-90%
die within two weeks

Further
30%
die after discharge

Risk might persist after discharge

Major Causes of death	TB	Severe bacterial infections	Cryptococcal meningitis	PCP

NEED TO MAINTAIN CONTINUITY OF CARE

and improve HCWs competency at relevant site

Ford ,Nathan etal Outcomes of PLWH after hospital discharge –a systematic reviewand metaanalysis .The Lancet vol 9,3(2022)

The key — continuity of care

CDC — AHD and ACC draft

01 IDENTIFY

Identification by a nurse

Clients present at PHC as either a new HIV diagnosis or a known client receiving ART, and require referral to a higher level if unwell

UP REFERRAL FOR ASSESSMENT

02 INVESTIGATE

Investigation & diagnosis

by onsite doctor at PHC or referral to hospital to make a definitive diagnosis in an unwell client

UP REFERRAL FOR ADMISSION

03 TREAT

Admission and treatment as inpatient

or treatment as an outpatient

Down referral for chronic care

RETURN TO PRIMARY / CHRONIC CARE

Source: Identifying common opportunistic infections among people with advanced HIV disease: policy brief. Geneva: WHO; 2023.

Planning for discharge and follow-up care

WHY INPATIENT CARE MAY BE NEEDED

A person might require inpatient care for several reasons.

01 CLOSE CLINICAL MONITORING

For serious illness, deteriorating or fluctuating symptoms, or higher levels of nursing care—including position changes, mobility support and pain management.

02 EXPERT CASE MANAGEMENT

Professionals may need substantial clinical decision-making expertise as clinical conditions change rapidly.

03 CENTRALIZED TREATMENTS

Some treatments are only delivered centrally, including supplemental oxygen or intravenous medicines.

04 CENTRALIZED DIAGNOSTICS

Diagnostic or radiology services and procedures may only be provided at larger health-care facilities.

DISCHARGE & FOLLOW-UP

Support the transition back to outpatient care—and reduce avoidable readmissions.

Hospitalized people with HIV may be provided interventions to support transitions to outpatient care and reduce avoidable readmissions.

Conditional recommendation / Low-certainty evidence

INTERVENTIONS MAY INCLUDE

01 **Pre-discharge goal setting**

02 **Medication review**

03 **Transitional care planning**

04 **Telephone follow-up**

05 **Home visits by health-care providers and/or peer supporters**

06 **Individualized support**

We need to understand the context into which they are being discharged









CONTINUITY OF CARE REQUIRES A STANDARD HANDOVER

One hospital SOP should define both referral directions—and the information that follows the patient.

01 UP REFERRAL

PHC / CHC → HOSPITAL

Define when PLWH need assessment or admission

Give PHC–CHC staff clear up-referral guidelines.

URGENT / IMMEDIATE

versus

NON-URGENT / BOOKED

02 STANDARD HANDOVER

INFORMATION AT EVERY TRANSFER

Use existing stationery consistently

Educate every level of care on the key information required before up- or down-referral.

Improve the quality of the discharge summary

03 DOWN REFERRAL

HOSPITAL → OPD / PHC

Define discharge steps and communication

Set clear guidelines for the discharge process and communication with the down-referral site—OPD / PHC.

ENABLER

Ongoing mentorship for staff entering the unit

CLEAR CRITERIA • COMPLETE INFORMATION • CONFIRMED CONTINUITY

M&E : BASELINE AUDITS - and Monthly after SOP training by hospitals /CHCs of PHCs

PHC AUDIT

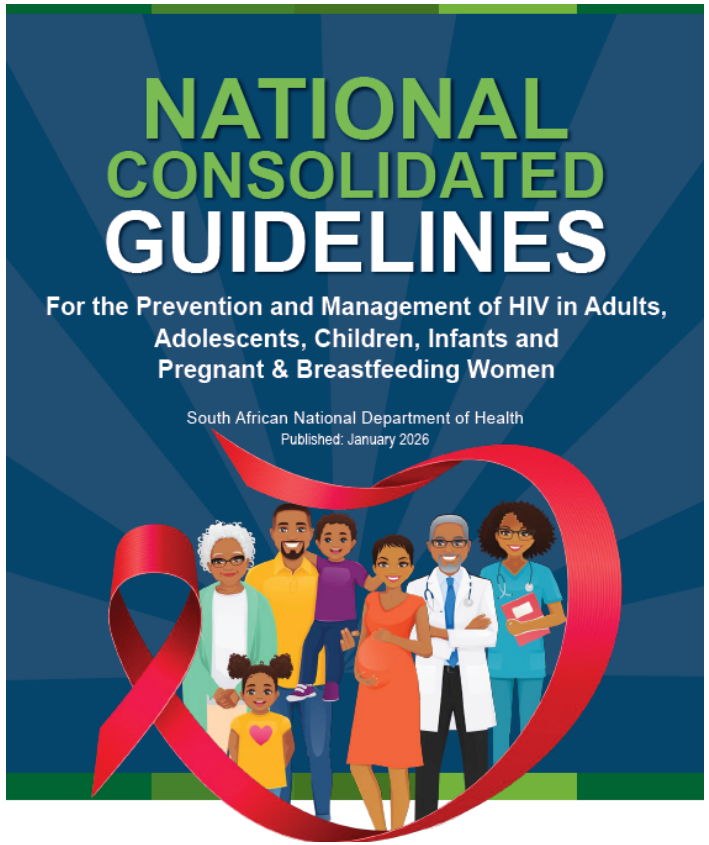
- 1. PHC questionaire
- 2. File and facility audit

HOSPITALS

- Morbidity and mortality stats
- Diagnosis
- CD4 count
- Deaths
- ART experience

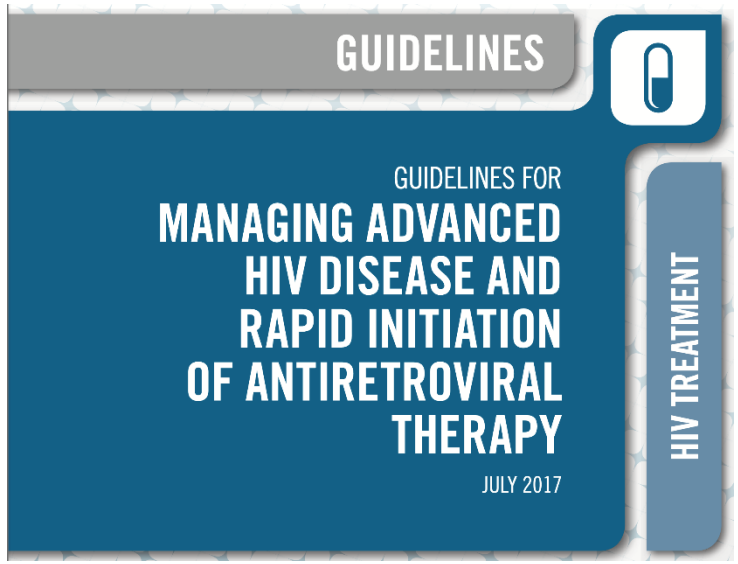
In patient management …SAHCS and NDOH guidelines

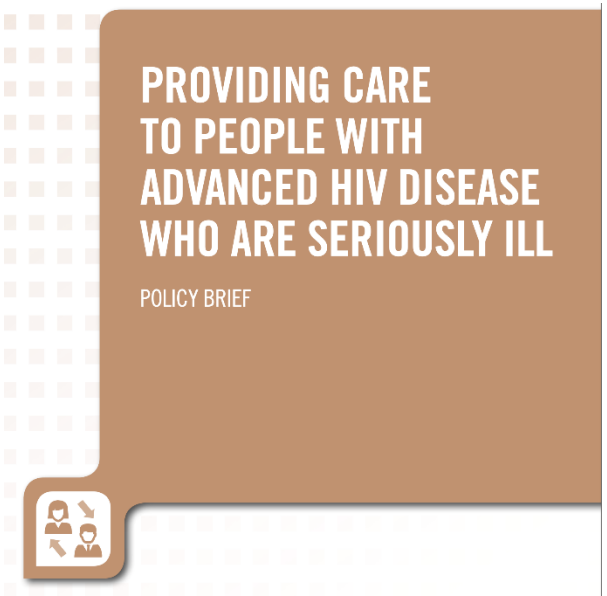
- 1. Pulmonary presentation including TB
- 2. Cryptococcal meningitis
- 3. Cerebral space occupying kesions
- 4.Renal failure
- 5.Chronic diarrhoea
- 6. Sepsis syndrome
- 7.Patients not responding despite optimal management
- 8. Cancers
- 9. Patients failing ART
- 10. Managing ART adverse events



Guidelines

- WHO guidelines mostly concentrate on outpatients (2017)
- 2023 WHO policy brief for “seriously ill” AHD patients – quite scanty inpatient advice though.
- SA HIV Clinicians Society







Advanced Clinical Care Toolkit: Overview

Advanced Clinical Care for Management of Advanced HIV Disease (AHD) Toolkit

Training

National ACC Master Training



- National curriculum on Knowledge Hub platform
- Master trainers from DoH & DSPs become experts to cascade the material to build ACC capacity

National ACC Tutorials



- Bi-monthly accredited online sessions support ACC Master Training Knowledge Hub curriculum
- Expert panelists with interactive learning

Ahd Online Modules for Primary Healthcare Workers



- 13 accredited online modules for primary HCWs to equip them with capacity to manage AHD, developed by KI

ACC Monthly Case Studies



- Monthly online sessions to support ACC learning through practical application
- Facilitated by KI

Reference Tools

National HIV & TB Healthcare Worker Hotline

- National FREE hotline operating Mondays to Fridays 8am – 4pm for TB & HIV-related queries

National HIV & TB HCW App



- Drug-drug interaction checker
- National guideline posters
- Dosing tools
- Patient management algorithms

Vula Mobile

- E-Referral App online system used by HCWs to connect and chat securely
- Patients receive specialist-guided healthcare at their local facility
- 30 000+ HCWs registered in SA

Kheth'Impilo
Choose Life for an AIDS Free Generation
INNOVATION in PUBLIC HEALTH

Specialist /Expert Consultation For Complex Cases -KZN

Adult or Paediatric Infectious disease Hotline (King Edward VIII Hospital):

- Adult Infectious Disease Unit:
  - **080 011 1740**
- Paediatric Infectious Dise
  - **031 360 3111 or 031**



- Ngwelezane Hospital:
  - **0800 222 500**

Outline of talk



- [ ] 1. Summary of a learning health system (LHS)
- [ ] 2.Priorities at AWACC 2026
- [ ] 3.KZN HAST stastistics –implications
- [ ] 4. Action to maintain first 95
- [ ] 5.Minding the gap to improve the second 95
- [ ] 6. SA VL monitoring stats -2019 -2026
- [ ] 7. Can HIV viral load (VL)monitoring help measure SA’s progress towards the UNAIDS 95-95-95 targets?
- [ ] 8.Quality improvement project for VL coverage

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

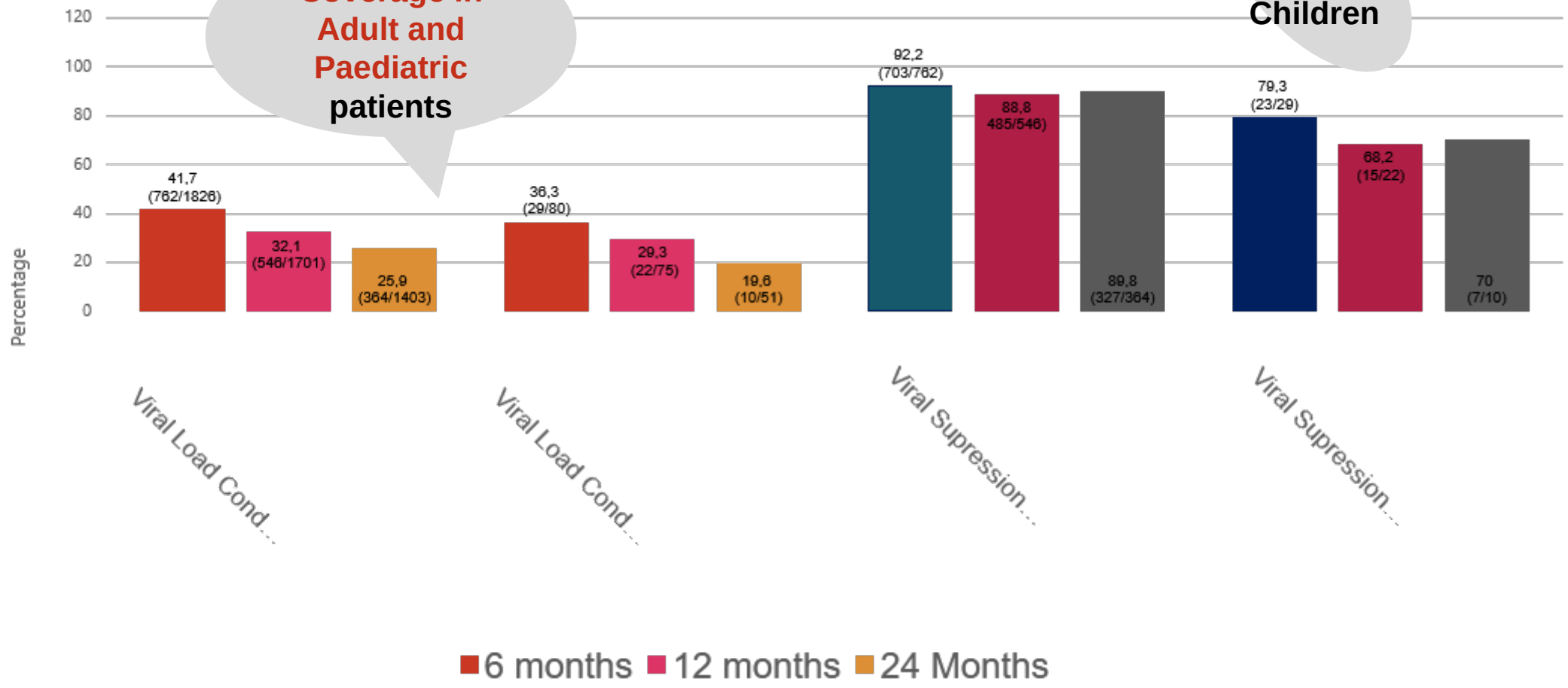
CDC CENTERS FOR DISEASE CONTROL AND PREVENTION

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

Viral Load Coverage in Adult and Paediatric patients

Viral Suppression Rates in Adults and Children

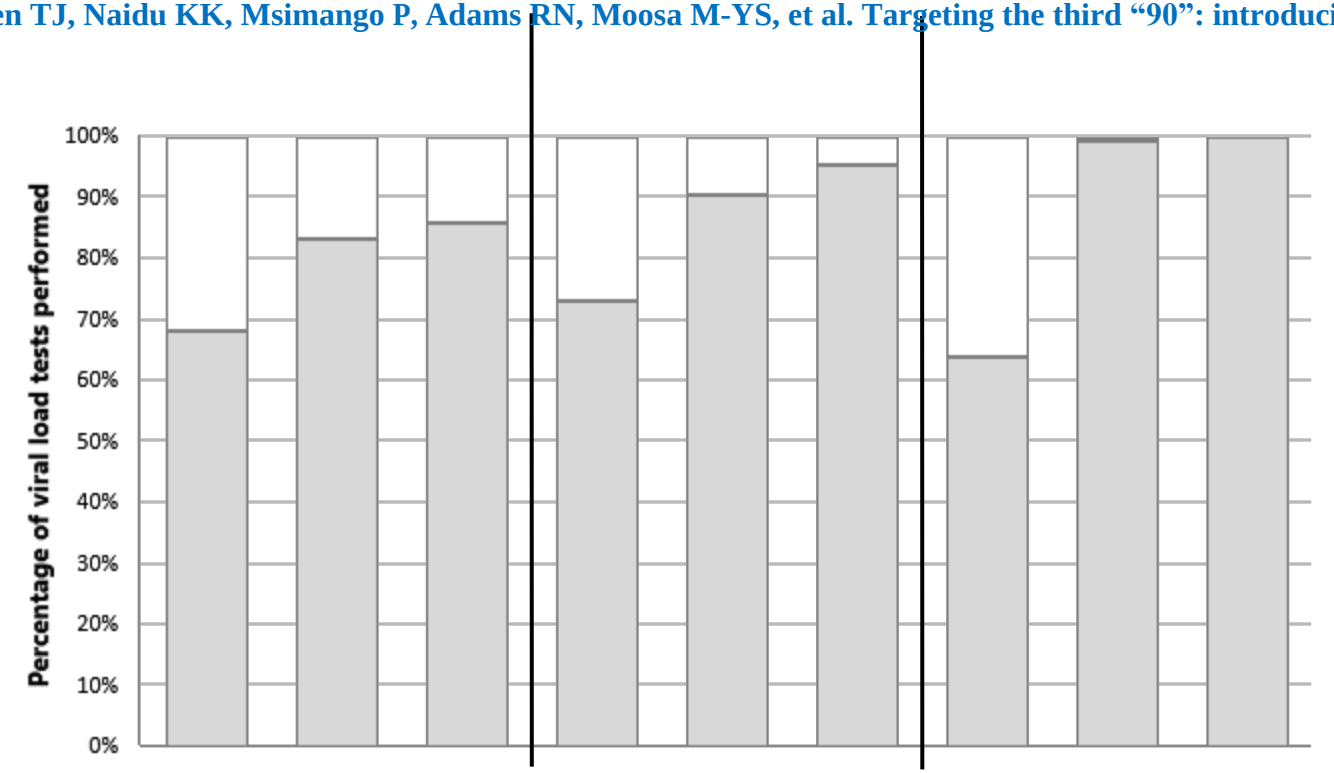


1.1. Naidoo K, Sunpath H. CAPRISA Advanced Clinical Care: strategies to optimize identification of unsuppressed viral load in patients on second-line antiretroviral therapy. Data Use Innovations and Best Practices Workshop. ([https://za.usembassy.gov/wp-content/uploads/sites/19/S11_1425_NaidooK_Strategies-to-optimize-ID.pdf

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



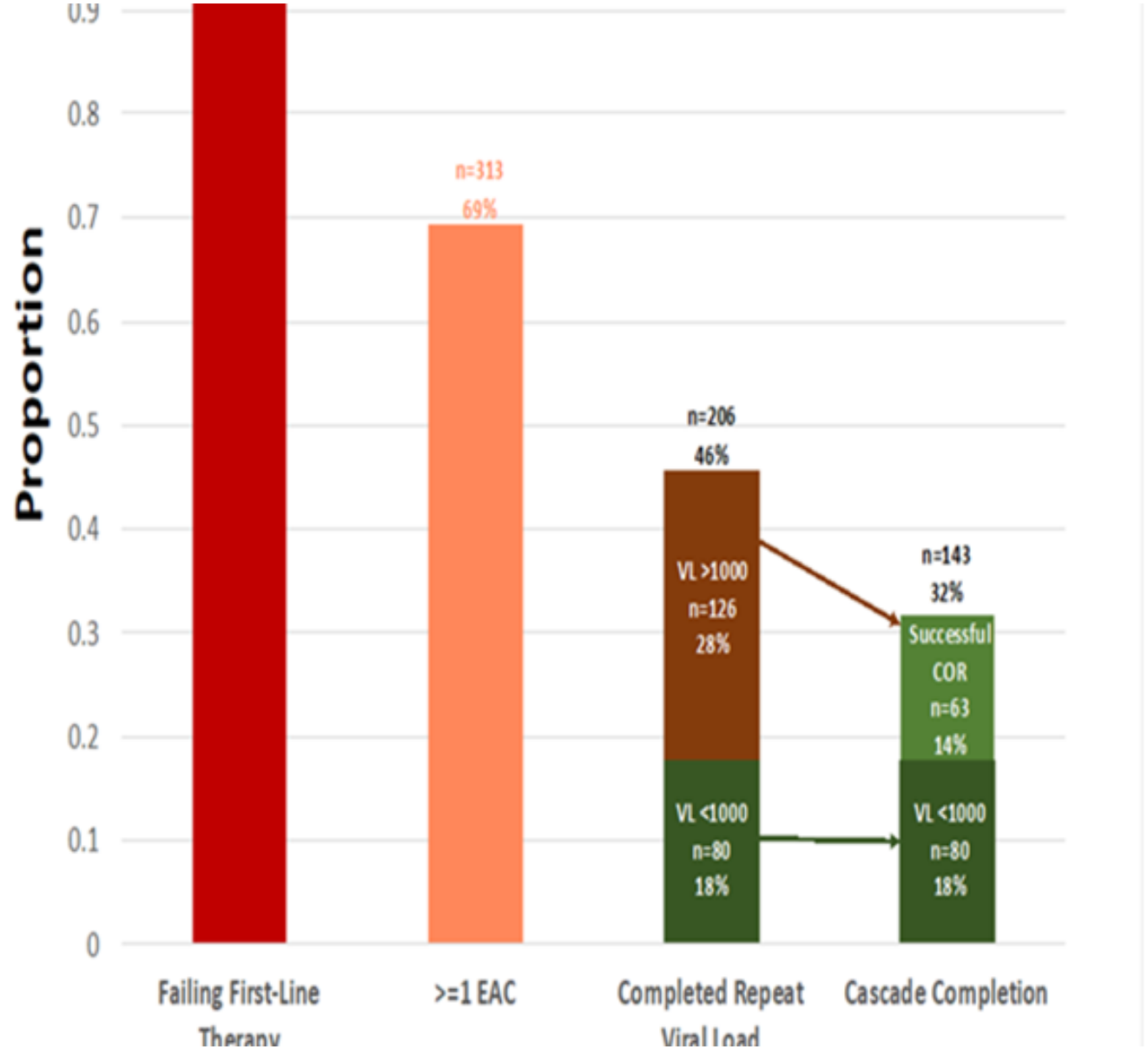
Cochran-Armitage Trend Test for viral load tests performed per site:

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

							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

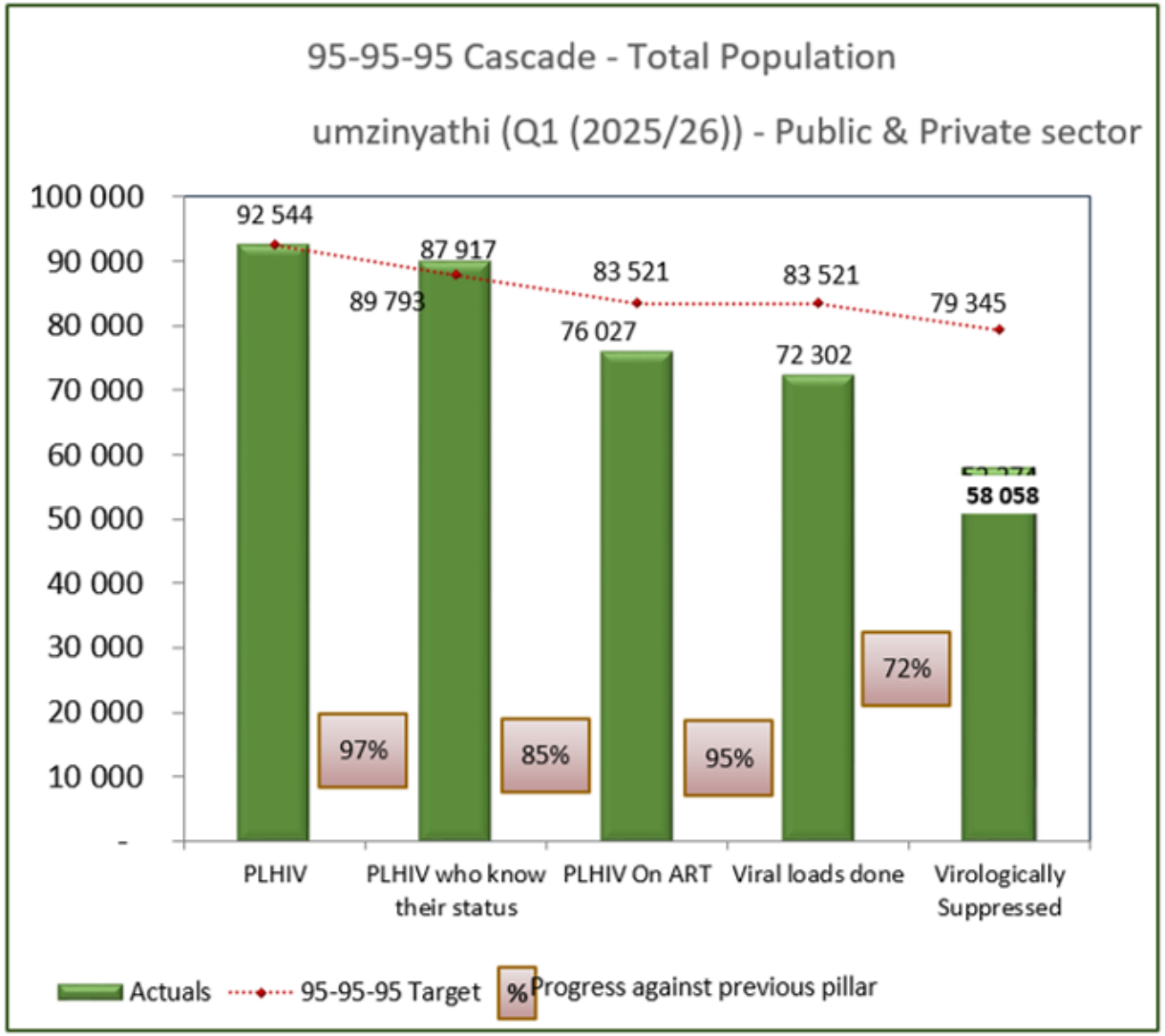
- Of 11 studies from South Africa, four were conducted in **Cape Town** , reporting relatively high VL coverage of **72-89%.** Other studies were conducted in KwaZulu-Natal [21, 30, 31], Eastern Cape [23, 27] and Gauteng , and another study [28] included data from ART patients in nine different provinces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

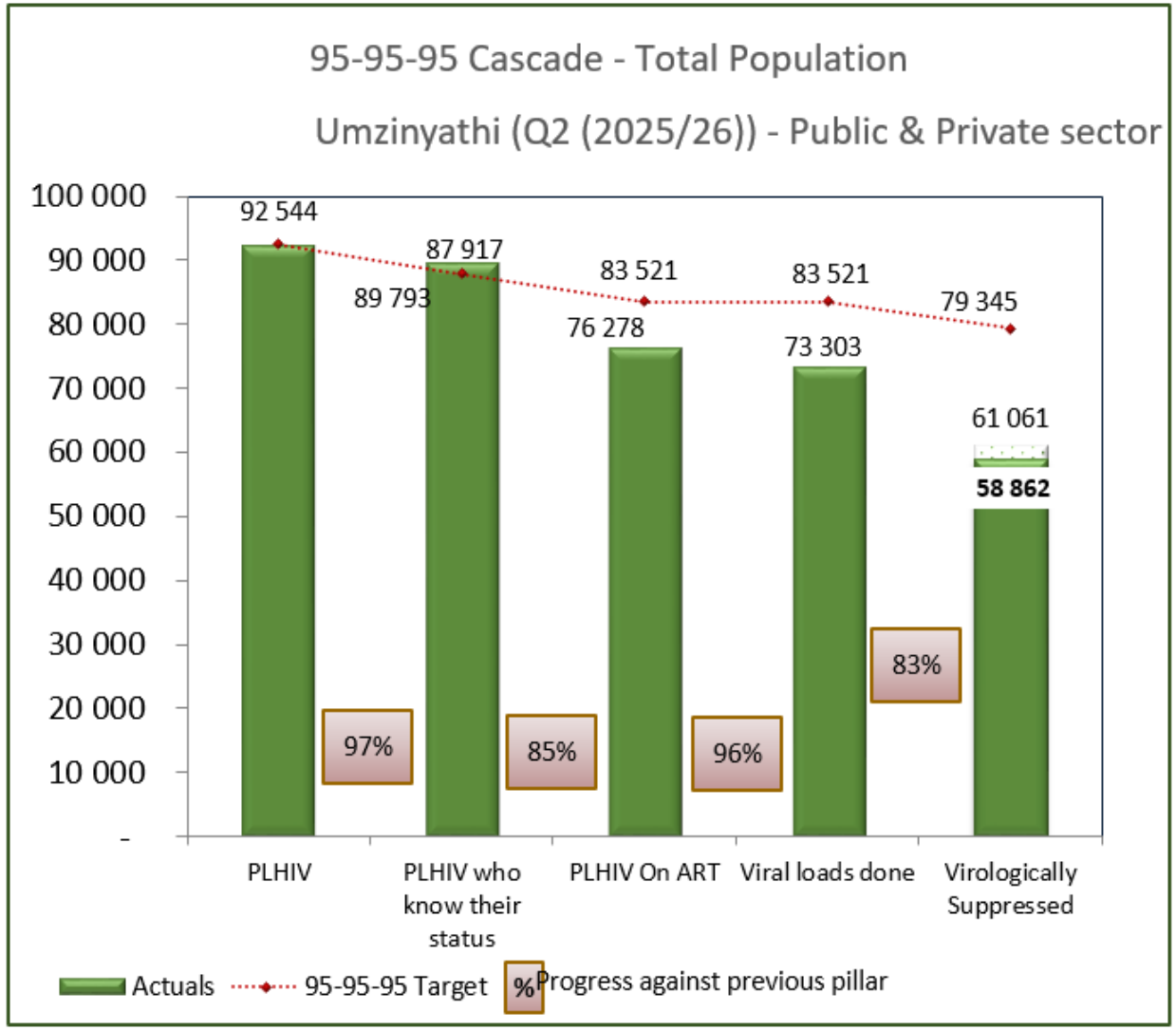
- Few studies with **interventions to improve quality of ART program had a VL coverage of >90% . O** ther studies reported a **VL range of 25%-81%.**

- 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.

VEC 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:

PROPOSED SOP · APPENDIX SET

List of Appendices to Proposed SOP for VL management in T' 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.**

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

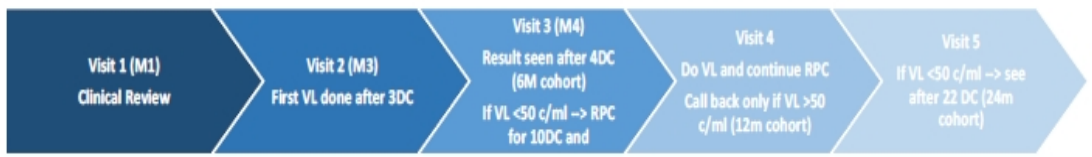
DESIGN LOGIC

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:

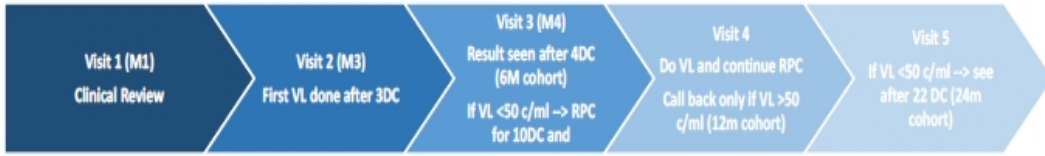


REGISTER 1 B : MANAGEMENT OF TLD 1 and TLD 2 WITH THE FIRST VL ≥ 50 c/ml after start /change of ART (M0)

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: ADDERNDOV

QA Tool 1: ADULT ARV CHART REVIEW

Date: _____

me 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	Abnc Test actio
			Urine dipstix			Cr Cl		
			Preg test			ALT		
l			TB Screen			Hep B SAg		
O Stage			STI screen			Chol (f)		
mination			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

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

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

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- HST NDOH LEARNING HUB

THANK YOU

Asibe HEALTH KZN

Community health workers connect people to care

01 COMMUNITY OUTREACH

Travel into neighbourhoods, schools, or residences to

- • Conduct wellness checks,
- • Trace patients who miss treatments,
- • Identify local health needs.
- • Target high-risk or vulnerable groups.

02 HEALTH EDUCATION AND COACHING

(easy-to-understand and culturally appropriate language.)

- • How to manage chronic conditions,
- • Improve nutrition,
- • Adopt healthy habits

03 CARE COORDINATION AND

- Schedule appointments, Understand health plans,
- Connect with social services or external medical providers

Effective community health workers need four connected training domains

TRAINING FRAMEWORK

Build the person, practice the pathway care.

Training combines community context, health-system knowledge and practical care skills.

01

ROLE & CONTEXT

- CHW role and identity
- Situational analysis
- Environmental health
- Community development

02

HEALTH-SYSTEM FOUNDATIONS

- District health and PHC
- Body systems
- Health education and promotion
- Disability awareness

03

DISEASE & TREATMENT SUPPORT

- Acute and chronic care at home
- TB and DOTS
- HIV counselling, support and ART
- Infectious diseases

04

MATERNAL & CHILD HEALTH

- Maternal and child health
- Integrated childhood-illness management
- Prevention of mother-to-child transmission

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