HIV NURSING MATTERS

A publication by the Southern African HIV Clinicians Society

Towards Inclusive HIV Care

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Protecting AGYW health: The impact of USAID funding cuts

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Towards Inclusive HIV Care

HIV NURSING MATTERS

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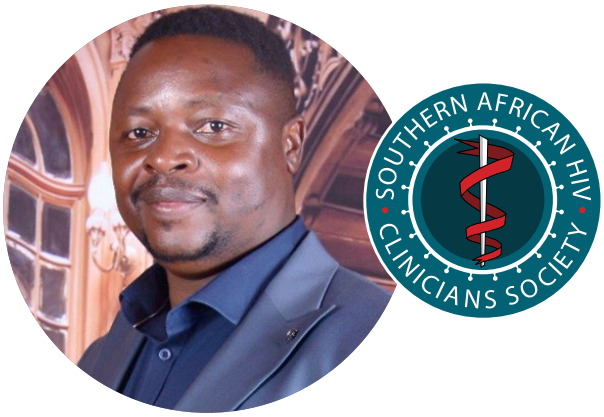
For more information
SA HIV Clinicians Society
Suite 233 Post Net Killarney
Private Bag X2600
Houghton
2041
www.sahivsoc.org

Tel: +27 (0) 11 728 7365
Fax: +27 (0) 11 728 1251
E-mail: sahivcs@sahivcs.org



Prof Lufuno Makhado
PhD in Nursing (Community Nursing Science), MCur (Community Nursing Science), RN, BCurNS(Hons). Full Professor, Department of Public Health, Faculty of Health Sciences, University of Venda.

Towards Inclusive HIV Care — Resilience, Compassion, and the Power of Nursing

The global HIV response is entering a defining chapter. In South Africa, 2025 has been a year marked by both uncertainty and courage – a year when funding shifts, policy transitions, and systemic strain tested the very heart of our healthcare system. Yet, even in this turbulence, one truth has endured: nurses remain the bridge between policy and people, between crisis and continuity.

This issue of *HIV Nursing Matters,* themed "Towards Inclusive HIV Care," is a celebration of that bridge. It captures the stories of inclusion in its broadest sense, thus the inclusion of young women, key populations, returning clients, data-driven decision-makers, and the caregivers themselves. It embodies a vision of HIV care that saves lives and views people in their own diversity, vulnerability, and resilience.

When the sudden cuts to USAID and PEPFAR funding reverberated across South Africa earlier this year, their impact was felt most sharply in the spaces where hope had begun to take root. Sweetness Kola and colleagues poignantly describe this in their article on the Youth Ambassador (YA) programme in Cape Town. This peer-led initiative has created safe spaces for adolescent girls and young women (AGYW) to access HIV prevention and

sexual health services without fear or stigma. Its abrupt termination left clinics quieter, youth corners empty, and peer supporters without a source of income. Yet, remarkably, many YAs continued their work voluntarily, connecting with young clients through WhatsApp and community outreach. Their determination, even without pay, stands as a living definition of inclusive care: care that is relational, trusted, and grounded in solidarity rather than hierarchy.

That same spirit of inclusion drives Dr M.E. Collins' piece on *reconnecting key populations with care* following the closure of PEPFAR-supported clinics. Her reflections are both ethical and deeply practical. She challenges the system and all of us within it to ensure that *no one is turned away,* even when referral letters or medical records are missing. Her guidance is clear: *"Be approachable. Assume good faith. Act immediately."* These are not only clinical instructions but moral imperatives, reminders that inclusion begins the moment a patient walks through the door and is met with dignity, not doubt.

Inclusion also means welcoming people *back* into care with empathy, not judgment. Lynne Wilkinson and Musa Manganye's article reframes re-engagement as resilience rather than relapse. They highlight that each person who returns after a treatment interruption is, in fact, demonstrating strength and self-worth. Through differentiated service delivery (DSD), multi-month dispensing (MMD), and same-day ART restart, nurses have the power to turn a moment of vulnerability into one of empowerment. Their message is simple yet transformative: *"Re-engagement is not failure – it is courage."*

The same courage is echoed in Mukovhe Rammela and Lufuno Makhado's policy commentary, which situates funding cuts within the larger context of youth health and sustainability. They show how adolescent-focused services, already stretched, have borne the brunt of external funding losses. Yet they also chart a hopeful path forward, where nurse-led models, mobile clinics, digital platforms, and mental health integration ensure that young people remain seen, supported, and safe, even in the absence of donor aid. Their call is for innovation born from compassion for a health system that adapts to keep its most vulnerable close.

Inclusion, however, is not only about the clients we serve; it extends to the nurses who carry the system on their shoulders. A powerful reflection on the *psychosocial support needs of nurses in HIV care* brings this truth to light. It captures the emotional reality of frontline nursing: long hours, relentless patient loads, and the invisible toll of compassion fatigue. Yet, this does not stop at diagnosis; it also provides and offers healing, peer support, wellness programmes, reflective practice, and leadership that models empathy. Her message reframes resilience not as endurance, but as *community care for the caregivers*.

Meanwhile, Dr Christi Jackson's guide to managing Cryptococcal Antigen (CrAg) Results for Action reports and Dr Ahmad Haeri Mazanderani's introduction of the Paediatric and Adolescent Results for Action Dashboard (RfAD) demonstrate how inclusion extends to *data and systems*. Their work ensures that no patient is lost between a laboratory result and a clinical response, embodying a form of digital empathy – where data becomes a tool for justice, ensuring every child, every result, and every opportunity for treatment counts.

Finally, this issue closes with the Southern African HIV Clinicians Society's (SAHCS) latest guideline updates from PrEP and PEP to ART, AHD, and STI management. These guidelines are not merely technical; they are instruments of inclusion, ensuring that evidence-based care reaches every nurse, every clinic, and every community.

Across these pages, a shared narrative emerges: inclusion is not an abstract ideal but a lived practice, one shaped daily by nurses who listen, act, and lead with compassion. In a time when global aid is uncertain and systems are strained, it is this inclusive spirit that will sustain South Africa's HIV response. Because inclusion is not just about access to care, it is about belonging and ensuring that everyone, from patients to providers, has a place in the healing process. And as this issue of *HIV Nursing Matters* so powerfully shows, when nurses lead with inclusion, the system itself becomes stronger, fairer, and more humane.

Supporting re-engagement in care in South Africa: Practical guidance for nurses

LS Wilkinson[1,2], BA, LLB, MSc; **M Manganye**[3], BCur, MPH and DrPH
[1]*International AIDS Society, Johannesburg, South Africa*
[2]*Centre for Infectious Epidemiology and Research, Faculty of Health Sciences, University of Cape Town, South Africa*
[3]*National Department of Health - South Africa, HIV/AIDS and STIs, Pretoria, South Africa*

Corresponding author: Lynne S Wilkinson, lynne.susan.wilkinson@gmail.com

Why re-engagement matters

Interruptions in antiretroviral therapy (ART) are common[1-3]. Most people who miss a scheduled appointment return quickly, with only a small minority remaining out of care for more than three months[4,5]. Each return after a missed schedule appointment is an opportunity to ensure that the treatment interruption is not prolonged unnecessarily, thereby reducing the risk of advanced HIV disease (AHD), hospitalisation, and onward transmission. Re-engagement is now central to South Africa's Close the Gap campaign, aiming to bring 1.1 million people living with HIV into sustained care. Nurses are central to making these returns successful. The way clients are received and managed when attempting to return, plays a critical role in whether clients can better deal with future challenges, thereby reducing the chances of a repeat disengagement.

Reasons for disengagement and re-engagement

Disengagement from HIV care stems from individual, interpersonal, and structural vulnerabilities that reduce resilience and increase the likelihood of disengagement when unexpected events occur–such as unplanned travel for work or social responsibilities–that disrupt a person's ability to stay in care[6,7]. Fortunately, studies repeatedly identify individual's strong self-motivation to return to care. However, their timely re-engagement often depends on removing barriers that could obstruct or delay restarting ART and introducing valued facilitators[8-10].

Re-engagement barriers and facilitators

Clients describe many barriers to returning: long waiting times on the day of return, being required to attend the clinic more than once to obtain

ART again; fear of, or experienced, negative interactions with healthcare workers; having to collect transfer documentation elsewhere; and increased frequency of scheduled appointments after a late return despite previous challenges with attendance[8-11]. In addition to these interpersonal challenges, operational hurdles such as patient record mismatches often leave nurses needing to problem-solve in real time. While this can be demanding, resolving barriers at the point of return is vital – as extended waiting times or requiring extra visits can deter clients and result in prolonged interruptions. Such interruptions are far harder to manage, requiring costly tracking and tracing, and are known to be less effective[12,13]. Reducing these barriers and introducing known facilitators is key. People re-engage more easily when services are:

- Respectful and welcoming;
- Fast and simple, with same-day ART restart; and
- Flexible future appointment scheduling which reduces the frequency of visits, making continued care less burdensome, with access to multi-month dispensing (MMD) and differentiated service delivery (DSD) models[14].

South Africa's national re-engagement guidance

South Africa's 2023 ART guidelines (including differentiated models of care SOP 8)[15] provide guidance on supporting people returning to care, emphasising respectful care and moving away from a one-size-fits-all model of intensified clinical management characterised by monthly appointments and multiple adherence counselling sessions. This approach is recognised as unnecessarily burdensome for clients and healthcare workers alike. For clients, the added burden increases the risk of further treatment interruption, while for healthcare workers it reduces their capacity to be empathetic[16] and to provide the additional support needed by those with more complex clinical or psychosocial needs[17].

Re-engagement guidance further introduced differentiated care pathways. These identify individuals who are simply "late" for their scheduled visit, with no or only a brief treatment interruption, and who can continue routine care, including in less-intensive differentiated models of care (DMOC) and those who require further assessment of two key factors to guide differentiation. First, clinical stability, assessed through signs of opportunistic infections, mental health concerns, AHD, or an elevated viral load prior to disengagement. Second, time since the missed appointment which indicates potential interruption duration and AHD risk[14].

South Africa differentiates care at three points in its re-engagement algorithm (Figure 1).

1st differentiated pathway:
Routine versus re-engagement care

Clients who are well, not on TB treatment, and not more than 28 days late are not regarded as re-engaging and should continue routine care in the same service delivery model as before their late appointment. This allows such clients to continue receiving MMD or to collect treatment through repeat prescription collection strategies (RPCs)–including external pick-up points, facility one-stop pick-up points, or adherence clubs. For those not yet accessing MMD or RPCs, these less intensive service delivery options should be considered, and eligibility assessed, with the aim of enrolling clients who are late for scheduled appointments to reduce the future burden of frequent visits. Late attendance alone does not disqualify a person. Their viral load testing schedule remains unchanged.

2nd differentiated pathway:
Clinically well or unwell

Those who self-identify as unwell, are on TB treatment (irrespective of duration since missed appointment), or have missed appointments for more than 28 days undergo a clinical assessment. Unless deferral is clinically indicated, all clients continue or restart ART on the same day.

Clinically unstable individuals, regardless of interruption duration, require a repeat CD4 test to identify AHD, and their follow-up schedule is determined by clinical management needs until a follow-up viral load three months later. A month later, if the client is virally suppressed and well, the individual should be assessed for and enrolled in RPCs and, at a minimum, be given 3MMD.

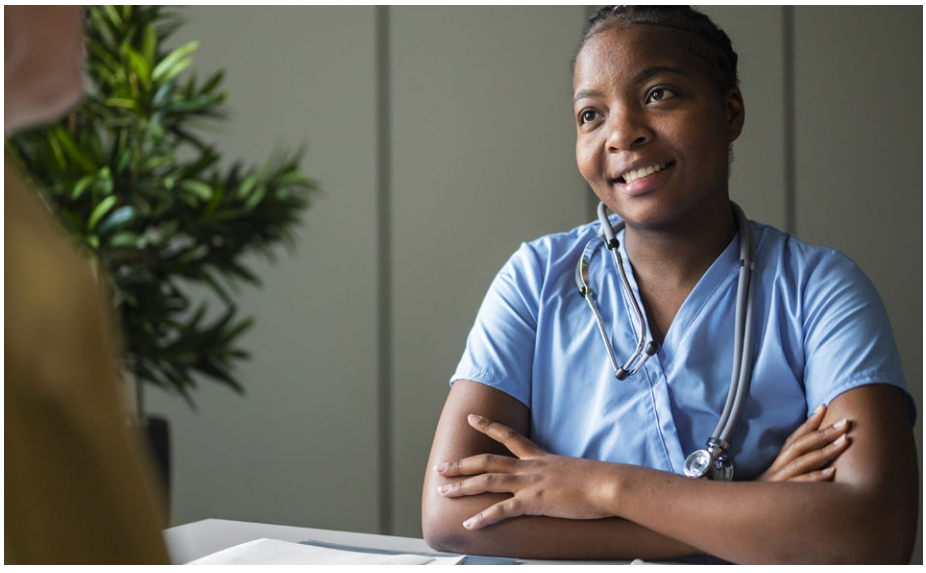
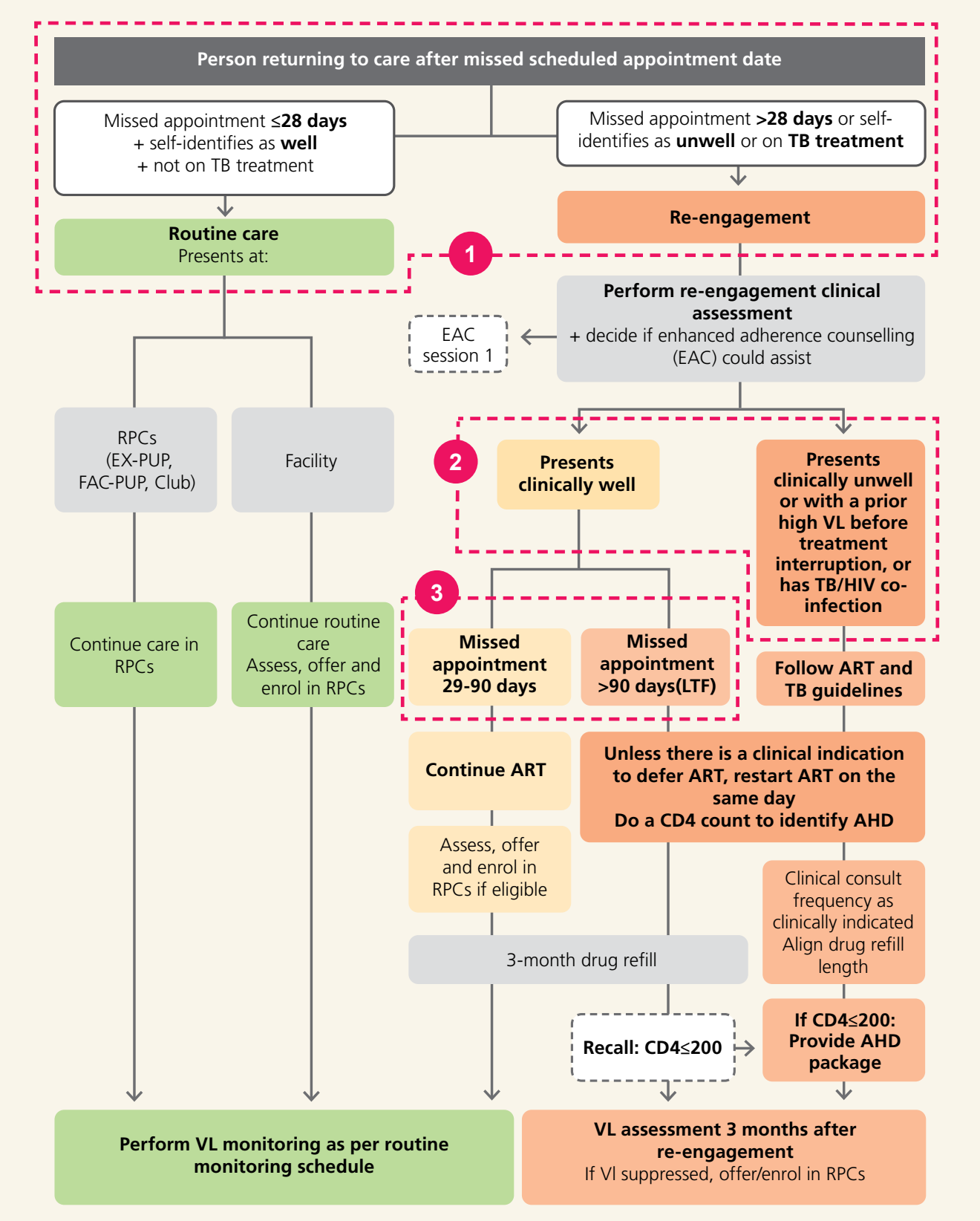


Figure 1. National re-engagement in care algorithm



Key

1 **1st differentiated pathway:** Routine versus re-engagement care

2 **2nd differentiated pathway:** Clinically well or unwell

3 **3rd differentiated pathway:** Time interval since missed appointment

The way clients are received and managed when attempting to return, plays a critical role in whether clients can better deal with future challenges, thereby reducing the chances of a repeat disengagement.

3rd differentiated pathway:

Time interval since missed appointment

Clinically stable individuals are assessed for time since the missed appointment, with CD4 testing required for those more than 90 days late. They are provided with 3MMD until their viral load follow-up three months later and recalled to the facility earlier if their CD count is less than 200 and they require AHD management. A month later, if the client is virally suppressed and well, the individual should be assessed for and enrolled in RPCs and, at a minimum, be given 3MMD.

Clients missing appointments by 29–90 days are managed the same as those ≤ 28 days late. They should be rescripted for their RPCs, or if not yet enrolled, their eligibility should be assessed and RPCs options offered. The only difference is that, because South Africa's centralised supply chain mechanism (CCMDD) pre-dispenses and pre-packs ART refills for RPCs, any refills not collected within 28 days are returned from the pick-up point. These clients therefore need to return to the clinic for a new prescription before continuing in RPCs.

For further support with implementing the re-engagement algorithm, please download the re-engagement job aid at: https://knowledgehub.health.gov.za/elibrary/implementation-streamlined-re-engagement-hiv-treatment-and-care-dmoc-sop-job-aids

What can nurses do

Nurses play a pivotal role in reducing barriers to return and supporting sustained re-engagement. Beyond clinical management, they are often the first to rebuild a client's confidence in the health system. A non-judgmental problem-solving approach can restore dignity and act as a protective factor against future disengagement. Practical steps include:

- Welcome clients back without judgement – acknowledge that interruptions happen and focus on the opportunity of return.
- Act quickly – restart ART on the same day, avoid multiple visits or extra steps like collecting transfer letters.
- Know and apply South Africa's guideline re-engagement pathways algorithm (Figure 1) to determine the appropriate differentiated management plan.
- Avoid unnecessary burdens – don't increase clinic appointment frequency unless clinically necessary. Support clients with immediate access to 3MMD and if eligible less-intensive DMOCs as soon after return as possible.

Conclusion

Re-engagement is not failure–it is resilience. It takes bravery and valuing your care and treatment to return. By embedding respect, simplification, and differentiation into routine practice, nurses can ensure that clients returning to care are welcomed, restarted on ART, and supported to remain retained and virally suppressed. In doing so, they reduce the risk of repeat interruptions, safeguard continuity of treatment, and help secure both the gains of South Africa's HIV response and the country's trajectory towards epidemic control and sustainability beyond 2030.

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Protecting AGYW health: The impact of USAID funding cuts on peer-to-peer HIV prevention and support programmes in Cape Town health facilities

S Kola[1,3] (MPH; PGDip Primary Health Care, Occupational Health Nursing, Nursing Management; DipN); **Z Cekiso**[2], (PGDip HIV Management; DipN); **T Crowley**[1] (PhD; MNurs; PGDip Primary Care Nursing, Nursing Education, Health Services Management; BNurs)

[1]*School of Nursing, Faculty of Community and Health Sciences, University of the Western Cape (UWC), Western Cape.*
[2]*Africa Centre for Health Inclusive Management, Faculty of Economics and Management Science, Stellenbosch University, Western Cape.*
[3]*Former Project Manager: Adolescent and Youth Program, Anova Health Institute, Western Cape.*

Corresponding author: Sweetness Kola, kolasweetness@gmail.com

Introduction and background

The United States President's Emergency Plan for AIDS Relief (PEPFAR) has played an important role in expanding access to antiretroviral therapy (ART) and significantly reducing HIV/AIDS mortality globally[1]. However, in early 2025, the United States halted substantial portions of its foreign aid to South Africa, affecting key health initiatives such as USAID and research funding from the National Institutes of Health (NIH)[2]. This decision raised concerns about potential job losses, disruptions to HIV/AIDS services, and setbacks in scientific research.

Among the programmes affected was the Youth Ambassador (YA) support programme, which Anova launched in February 2022 in the City of Cape Town, Western Cape, South Africa. The YA programme was a key component of the DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) programme, which is a PEPFAR-funded initiative focused on preventing HIV among adolescent girls and young women (AGYW)[3,4].

The YAs acted as peer educators, navigators, mobilisers and demand creators at ground level, assisting in delivering critical services and activities such as awareness campaigns, youth-friendly discussion (peer education) sessions, and supported the sexual and reproductive health (SRH) care package, linkage to pre-exposure prophylaxis (PrEP) and ART services, including strengthening adherence support. Hence, the YA programme was a cornerstone of youth-friendly services and central to improving AGYW access to health services, in which YAs were driving uptake of HIV prevention (PrEP services), ART, and SRH services, aiming at reducing the incidence of HIV among AGYW and their vulnerability to HIV[3].

YAs trained under USAID DREAMS and related youth leadership programs were first-line responders for gender-based violence (GBV) survivors, often providing immediate psychosocial support, referral services, and linking relevant clients to advanced psychosocial support in and outside health facilities[5,6]. The aim of implementing the YA programme was to utilise a peer-to-peer (P2P) support programme to improve the uptake and continuation of PrEP among AGYW, while also strengthening their access to integrated SRH services. The programme initially employed a team of a Project Manager, one Technical Assistant and 10 YAs in February 2022, which expanded to three Technical Assistants, three Professional nurses, one Monitoring and Evaluation officer and 35 YAs by December 2024. Evidence shows that this P2P support programme improved PrEP and ART initiation, uptake, and retention among AGYW, and reduced missed appointments through digital and group-based support[7-9]. The YAs were at the heart of adolescent and youth-friendly services where they provided relatable, non-judgmental support within clinics. The USAID's financial support was instrumental in sustaining the programme activities and therefore played a central role in improving health outcomes for AGYW in health facilities[10]. However, the recent complete termination of USAID funding has significantly disrupted and had a profound impact on the P2P support programme.

Benefits of peer-to-peer support programmes

Numerous studies have found P2P support programmes to be beneficial, where young cadres such as YAs or peer navigators or educators have been used[11,12]. The YA programme that was implemented in the City of Cape Town has played a crucial role in creating safe spaces (youth zones/youth corners) for AGYW, empowering them to engage in SRH and HIV prevention services. These YAs championed safe spaces (youth zones), which were critical in bridging the gap between health facilities and AGYW. They also provided emotional support and improved mental health outcomes[13]. P2P support programmes have been shown to foster self-esteem, empowerment, and sisterhood among AGYW in South Africa[13]. P2P conversations and engagements helped AGYW gain a clear understanding of the services available at health facilities. Subsequently, the programme contributed to reducing fear and apprehension among young clients, making health facilities more youth-friendly and enhancing AGYW's engagement with health services[11]. A study conducted in Malawi highlighted that the health facilities using peer educators achieved higher SRH service uptake[14]. The same study found that AGYW felt more comfortable accessing care when younger cadres were present, and services were adapted to their needs, for example, by extending service hours and ensuring privacy[14]. In KwaZulu-Natal and Kenya, studies by[15,16] found that peer-to-peer support for HIV self-screening significantly increased HIV testing uptake among AGYW. The Kenyan study also demonstrated high PrEP initiation rates among AGYW[16]. Peers played a critical role in facilitating linkage to HIV services and reducing barriers to PrEP access[16]. They strengthened empowerment, reduced stigma, and improved service uptake, making them an essential strategy for HIV prevention and reproductive health programming in African contexts[16]. This underscores the vital role of such programmes in improving health outcomes for AGYW and highlights the severe consequences of discontinuing them, specifically in the South African context, where AGYW are disproportionately affected by HIV.

> There is anticipated risk of reversal in HIV prevention gains (potential risk of sero-conversion) in HIV negative AGYW, as the interruption of continuous PrEP service, engagement and empowerment activities may contribute to increased vulnerability and lead to rising new HIV infections among AGYW populations.

Impact of USAID funding cuts on peer-to-peer support for AGYW

1. Termination of the peer (YAs) workforce

The Anova YA programme was discontinued on 28 January 2025, due to funding cuts, resulting in reduced peer staffing. This has affected health system services: fewer safe-space activities, weakened demand creation and uptake of HIV testing services (HTS), PrEP and SRH services. This also affected ART linkage and weakened appointment follow-up systems, while compromising retention and adherence among AGYW already on treatment[2]. In addition, their absence has left significant gaps that compromised

psychosocial and gender-based violence (GBV) support.

During this period, all YAs faced job losses. Most were permanently employed had relied on salaries provided through USAID funding. This has led to financial insecurity, food insecurity (as some were breadwinners) and loss of benefits (medical aid). Several have reported facing situations that affect their mental well-being with no means of accessing health care. A few resilient YAs have continued to support clients via WhatsApp, but overall, the motivation to seek employment has diminished.

2. Impact on the Adolescents and Young People (AYP) programme

The immediate suspension of many key activities, such as peer health education sessions, awareness campaigns, and mentorship, led to significant operational and strategic challenges. Consequently, years of progress in HIV prevention have been jeopardised. These cuts not only disrupted service delivery but also silenced youth voices and leadership in HIV prevention and weakened health systems' ability to engage youth effectively.

The capacity for programme monitoring and evaluation has also been reduced. Thus, the fund termination negatively impacted the programme's ability to systematically track progress (on AYP indicators), making it challenging to adapt strategies or demonstrate outcomes for alternative funding. This has weakened the HIV prevention and care continuum as there is potential reduction in peer support, with respect to: decreased demand creation for condom use, contraceptives, HTS and PrEP services and ART linkage. This disruption increases the risk of unplanned pregnancies, treatment interruptions (due to decreased peer follow-up and adherence monitoring), and HIV acquisition among AGYW. Furthermore, critical monitoring and quality improvement functions have been compromised. YAs previously tracked client attendance, followed up on missed visits, and provided feedback for service improvement. The loss of these functions has affected facilities' ability to identify and respond to AGYW-specific gaps. Collectively, the funding cut has a potential risk of reversing hard-won gains in HIV prevention and treatment for AGYW, particularly in underserved facilities where peers often represent the only consistent link to access youth-friendly care services[17].

3. Impact on clients (AGYW)

With funding termination, peer-led youth zones group sessions, after-school hours' sessions or weekend support activities have been scaled-down, thus, facilities can no longer sustain the dedicated "youth zones" or tailored sessions for AGYW. Consequently, AGYW may face reduced access to services due to limited opportunities for relatable, youth-friendly guidance and counselling. The funding termination has had profound consequences on the broader goals of the DREAMS initiative in terms of decreased reach to vulnerable AGYW. Many at-risk AGYW have lost access to critical HIV prevention education, HTS, and other supportive services. Importantly, AGYW may also lose the safe spaces where they previously felt comfortable engaging and seeking support. There is anticipated risk of reversal in HIV prevention gains (potential risk of sero-conversion) in HIV negative AGYW, as the interruption of continuous PrEP service, engagement and empowerment activities may contribute to increased vulnerability and lead to rising new HIV infections among AGYW populations. The funding cuts may lead to trust issues, as YAs have built rapport with supported AGYW. The abrupt nature of the cuts could also cause distress and psychological strain among clients, as they were unprepared for the sudden disruption in services.

4. Impact on Youth Care Clubs (YCCs)

YAs supported HIV-positive AGYW in Youth Care Clubs (YCCs). These peer supporters played a critical role in improving ART adherence and retention among young clients in YCCs[18,19]. Their involvement included: peer support, counselling, facilitating club sessions, and providing psychosocial referrals, youth-friendly environments that enhance engagement, self-expression, and overall retention in HIV care[19]. The clients were reported to appreciate being attended to by young cadres, who were more approachable and allowed them to express themselves freely. YAs also ensured smooth

transitioning of clients from YCCs to Adult Clubs. Retention counsellors, who also championed these services, were similarly affected. The immediate funding cuts may result in the scaling down of peer-led YCCs and their activities, which could negatively affect clients' psychological well-being, lowering morale and causing hesitation or reduced engagement in YCCs. Older healthcare workers may replace YAs, if these services continue at all, but these staff members may not replicate the same peer-level rapport. If the YCC model collapses, treatment interruptions may occur, increasing the risk of complications for ART clients.

5. Impact on stakeholders

Implementing partners struggled to maintain staff and infrastructure without USAID funding, resulting in layoffs and reduced coordination capacity. Established partnerships with local organizations were strained or discontinued. The abrupt action also undermined community trust and morale, affecting the confidence of YAs who had been key change agents in communities. Additionally, the programme's role in developing youth leadership and advocacy skills was compromised, limiting opportunities for young people to contribute to health and social development initiatives. Ongoing community engagement efforts and momentum were similarly disrupted.

6. Impact within facilities

Facilities are reporting a low headcount of AGYW, with decreased uptake of HTS, PrEP, condoms, and contraceptives following an unexpected termination of peer-led demand creation, which YAs previously managed. Service data have declined due to the lack of consistent follow-up, peer check-ins, and support groups. YCCs and Youth Zones have lost their youth-led energy, making them less appealing and increasingly inaccessible to AGYW. These services are gradually becoming inactive due to staff shortages, as they were primarily supported and driven by direct service delivery (DSD) NPO staff members, including clinicians, YAs, counsellors, administrative clerks, and data capturers. AGYW clients appear to have lost trust in the clinics, as they no longer encounter familiar peers who previously guided them, making them feel less comfortable engaging with adult healthcare workers. This disruption may lead to unfavourable health outcomes. Facility clinicians, in the absence of NPO support (including Anova staff), are experiencing increased workloads and strain, raising concerns about potential burnout.

Conclusion

The peer-to-peer support programme has proved to be valuable in improving AGYW's engagement. It also provided safe, supportive, and youth-friendly pathways for AGYW to access SRH, PrEP and ART services. This programme has assisted in reducing fear of young clients, leading to most facilities being more youth-friendly and with improved AGYW's engagement. The funding cuts threaten to reverse gains achieved in reducing new HIV infections among AGYW by weakening the P2P support model, which is crucial for youth-friendly, trusted, and accessible health services within facilities. Urgent action is needed to restore and sustain peer-led programmes, as they are central to achieving equitable, youth-friendly health services and protecting the well-being of AGYW.

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Practical steps for managing cryptococcal antigen Results for Action reports in facilities

C Jackson[1], MBChB, MSc TMIH, Dip HIV Man
[1]*Mpumalanga Department of Health*

Corresponding author: Christi Jackson; DrChristiJackson@outlook.com

Cryptococcal meningitis (CM) remains one of the leading causes of HIV-related deaths in South Africa, especially among people with advanced HIV disease (AHD). Early identification of cryptococcal infection and rapid treatment can prevent progression to meningitis and save lives.

To support early diagnosis, the National Health Laboratory Service (NHLS) performs reflex cryptococcal antigen (CrAg) testing on all blood samples where the CD4 count is below 100 cells/µL (with some provinces amending the cut-off to <200 cells/µL). Positive results are collated by the National Institute for Communicable Diseases (NICD) into weekly CrAg Results for Action (RfA) reports, which are accessible via the NICD M&E Dashboard online portal (https://www.nicd.ac.za/).

How the Results for Action (RfA) reporting system works

Health workers can register for access to the CrAg RfA portal via the NICD website. Registration can be:

- **Facility level:** A clinician may sign up for one or more facility and view reports only for the site(s) selected.
- **District level:** Managers, supervisors, or programme coordinators can sign up for a broader catchment area, allowing them to oversee and support multiple facilities.

The weekly CrAg RfA reports are consolidated line lists, updated every Monday morning, to reflect newly reviewed CrAg results. Users can log in at any time to view results which contain patient-level results reviewed the previous week Monday to Sunday (in some instances older results that were not previously reported also appear). Email reminders are sent on Monday

mornings to prompt users to check the RfA portal. The reminder emails include an RfA user guide, Protection of Personal Information Act (POPIA) compliance checklist, as well as links to the RfA Portal.

This flexible design allows both frontline providers and supervisors to monitor newly identified CrAg-positive patients, ensuring that no case is overlooked.

Practical steps for using the RfA reports

Although the RfA reports flag positive results, health outcomes depend on how quickly and effectively teams act on this information. Here are some practical steps for how the CrAg RfA reports can be used to improve outcomes of people living with AHD:

Step 1: Reviewing and organising information

It is important to review the CrAg RfA portal regularly (i.e. on a weekly basis) as positive CrAg results need to be identified and acted on urgently.

When viewing the list of new cases:

- Compare the list of new cases with previous reports to avoid duplication.
  - CrAg can stay positive for a long period, even if the client was successfully treated. Therefore, a client may appear several times over the course of months if repeat CD4 testing is performed.
- Keep a secure register (electronic or paper-based) to track cases, noting identifiers, dates, and outcomes.
  - This creates a single source for your team, supports continuity if staff rotate, and allow staff to see at a glance which clients still need to be followed up.
  - It is vital that all records/ reports/files that include personal identifying data is kept securely as the information is confidential. The NICD POPIA compliance check-list has been developed to support the legal and responsible use of this data.

Step 2: Checking for lumbar puncture (LP) results

According to South African National Guidelines, all people living with AHD with a positive CrAg require an LP regardless of whether they have symptoms of meningitis or not. Subsequently, it should be ensured that all clients on the RfA report have an LP done as soon as possible. It is usually helpful to check the NHLS TrakCare portal to see if LP results are already available:

- Search each new CrAg-positive client on TrakCare, using the file number of the facility where the LP will be done (if available), or the name(s), surname and date of birth of the client.
- If LP results are found, capture them in the register immediately. This avoids unnecessary tracing and helps you identify patients still needing follow-up and linking to LP. Proceed to step 4.
- If LP results are not found, proceed to step 3.

Step 3: Following up at facility level and ensuring LP is conducted and correct treatment is given

For patients with no LP result found on TrakCare:

This step is different depending on whether the CrAg was collected at a site where LPs are done (e.g. a hospital) or not done (e.g. primary care facility):

- In a hospital: Trace the client's folder to confirm whether an LP has been done. Results may not be traceable on TrakCare if a different name or spelling was used.
- In a primary care facility: Trace the folder to verify if the client had been referred for LP.
  - If there is no evidence of referral, contact the client immediately. After identifying yourself and confirming that you are speaking to the correct client, explain that one of their blood results are abnormal and that further investigations need to be done at the referral centre. Ask if they are experiencing any symptoms of meningitis (fever, headache, photophobia, confusion etc). Request them to attend the facility as soon as possible for further management.
  - If the client arrives at the primary care facility, immediately assess for any danger signs and stabilise the client if necessary. Start fluconazole therapy pre-emptively (fluconazole 1200mg daily). Provide a referral letter that includes the medical history, all relevant laboratory results, physical examination findings and the client's current medication. Facilitate the referral as soon as possible (preferably that same day or the following day).
  - If the client cannot be reached over the phone, attempts should be made to trace the client at home. This can be done through ward-based outreach teams (WBOTs) or other community-based organisations that are available in your area.
  - If the folder shows that the referral had already been done, contact the referral centre to verify that the client had arrived and that the LP was done.
- If the patient declines immediate referral or the LP is delayed for any reason, ensure pre-emptive fluconazole is started.
- Ensure that cryptococcal treatment protocols are followed depending on whether LP results show cryptococcal meningitis or

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Accreditation:	CPD accredited for 20 Clinical points.
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not. Refer to the Advanced HIV Disease guidelines for details on clinical management.
- Verify that ART is timed correctly: If not yet on ART, defer for 6-8 weeks if cryptococcal meningitis is confirmed. If the LP excludes meningitis, ART can be started. If already on ART, do not interrupt it unless the client is critically ill. Manage unsuppressed viral loads through enhanced adherence counselling and further interventions according to guidelines. This step relies heavily on communication between doctors, nurses and coordinators. An HIV helpline can be contacted for clinical advice if necessary. Well established referral pathways are essential in ensuring all clients are managed timeously and correctly.

Step 4: Tracking outcomes

Each patient should be categorised in the register:
- LP completed, with positive or negative result
- LP refused or delayed
- Started on anti-fungal therapy (fluconazole alone, while awaiting LP result or if cryptococcal meningitis was excluded on LP; or combination anti-fungal therapy if meningitis was confirmed)
- Death
- Loss to follow-up

Tracking these outcomes allows teams to calculate LP uptake rates, positivity rates, and mortality. Over time, this data highlights gaps in service delivery and helps guide quality improvement efforts.

Step 5: Reviewing and learning

Regular review meetings are key to highlight the number of clients with positive CrAg who have or have not yet received appropriate management. Including CrAg screening as a standing agenda item at facility or district review meetings helps to:
- Ensure all clients receive urgent appropriate management and are not forgotten
- Discuss individual cases and troubleshoot barriers
- Share successes between sites
- Reinforce accountability for timely follow-up
- Remind all staff of the importance of managing CrAg-positive patients correctly and according to the latest guidelines.

Why the RfA report system matters

Without an organised process, many CrAg-positive clients risk being lost between the laboratory report and clinical action. The outcomes of the RfA reporting system are only as strong as the health teams who use the RfA reports. Nurses, doctors, counsellors, and managers all play a role in ensuring results are followed up quickly, patients receive the right treatment, and outcomes are tracked.

By using the RfA system consistently, health teams can close the gap between diagnosis and treatment, thereby turning lab reports into meaningful, life-saving actions.

Ask for help

If you need advice on management of any clients on the PCR or CrAg RfA reports, please contact your referral centre or one of the HIV helplines for advice.

HIV Expert Helpline: 082 352 6642
National HIV & TB health care worker hotline: 0800 212 506

The NICD Paediatric & Adolescent Results for Action Dashboard – Supporting the Global Alliance to End Child AIDS by 2030

AF Haeri Mazanderani[1,2], MBChB, MMed, PhD; **TY Murray**[1,2], BSc, MSc, PhD; and **GG Sherman**[1], MBBCh, MMed, PhD

[1]*Department of Paediatrics & Child Health, Faculty of Health Sciences, University of the Witwatersrand, and*
[2]*Centre for HIV & STIs, National Institute for Communicable Diseases, a division of the National Health Laboratory Service*

Corresponding author: AF Haeri Mazanderani, ahmadh@nicd.ac.za

Background

The Global Alliance to End AIDS in Children by 2030 is a strategic action-oriented alliance of multisectoral stakeholders at national, regional and global levels. Concerned by the slow progress among children living with HIV (CLHIV) when compared with adults, UNAIDS, UNICEF, WHO and partners launched the new Global Alliance in 2022. In addition to the United Nations agencies, national governments from the twelve most affected countries joined the alliance in the initial phase, including South Africa[1].

Achieving an end of AIDS in children requires keeping CLHIV healthy on antiretroviral therapy (ART), preventing new infections among children, as well as addressing rights, gender equality and social and structural barriers that hinder access to services. South Africa's Global Alliance Country Plan outlines the interventions required for achieving these goals which include comprehensive testing programmes to find and link to care all infants and children living with HIV, as well as data-driven approaches for improving quality of care, including HIV viral load monitoring[2].

NICD Results for Action (RfA) reports

In 2015, the National Institute for Communicable Diseases (NICD) launched the HIV PCR Results for Action (RfA) reports to support improved linkage to care and reduced loss to follow up within the Early Infant Diagnosis (EID) programme. The initial RfA offering has subsequently expanded to include laboratory results from other test-sets and age-groups, as well as a range of additional developments to ensure these patient-level consolidated line-lists with personal identifiers are

By accommodating NHLS data from across the country, RfAD provides a unique opportunity for enhancing laboratory data with tracing and ART data which can be leveraged for generating automated care cascades.

compliant with South Africa's legislative framework, including the Protection of Personal Information Act (POPIA), Act 4 of 2013. Additionally, the RfA reports have been incorporated into the National Vertical Transmission Prevention and Consolidated HIV Guidelines[3], and have become a central tracking and tracing tool with 450 active users downloading >13 000 RfA reports across 50 districts between March – September 2025.

With increased usage of the NICD RfA reports within the health districts, both from Department of Health structures and support partners, it became apparent that a secure real-time platform for tracking and tracing CLHIV was required. The Paediatric and Adolescent HIV Results for Action Dashboard (RfAD) was developed as the natural next step for RfA reporting. It accommodates tracing and clinical outcome data from the field, which supports automated line-list generation and analytics, thereby improving efficiency and effectiveness of teams responsible for clinical care and monitoring and evaluation.

NICD Paediatric & Adolescent Results for Action Dashboard (RfAD)

The Results for Action Dashboard (RfAD) is a secure bi-directional repository of HIV laboratory data from the NHLS and clinical data submitted by RfAD users in the field, for children and adolescents (i.e. those ≤19 years of age). RfAD was developed to a) facilitate access to HIV test results, b) improve and enhance data quality in the NICD's Surveillance Data Warehouse (including linking multiple test results to a single patient), c) improve patient care by highlighting patients in need of urgent attention at district- and facility-levels in real-time, and d) support automated analytics to identify programmatic gaps.

The dashboard includes diagnostic test result line-lists at both district- and facility-level, facility-level patient lists that can easily be sorted to identify patients who are virologically unsuppressed (including those with likely virological failure), patients with overdue HIV VL monitoring, and patients who are no longer in care. Furthermore, diagnostic and HIV VL monitoring analytics are available as are consolidated line-lists identifying patients in need of urgent follow-up based on laboratory results and clinical outcomes submitted on the dashboard.

How the Results for Action Dashboard can support the Global Alliance to End Child AIDS

As South Africa works towards ending child AIDS by 2030, it is imperative that each and every child living with HIV is correctly and consistently identified and provided with the optimum package of services. The lack of an operationalised national unique patient identifier from birth has negatively impacted both

patient care and monitoring progress towards eliminating vertical transmission and ending child AIDS.

To support retrieval of longitudinal HIV test records as well as monitoring the number of infected children, linkage to care and virological suppression rates, RfAD uses a combination of methods to obtain patient-level data. These include a data warehouse-based record-linking algorithm whereby a unique identifier is generated based on a patient's registered demographic details, and the ability to manually merge test results on RfAD, both from within and across different facilities, enabling a reliable means of de-duplicating laboratory data and tracking patients seeking care at multiple facilities.

Furthermore, as RfAD provides patient-level demographic data, including both the patient folder numbers and the Health Patient Registration Number (HPRN), it supports districts and facilities with improving data quality within routine health settings.

By accommodating NHLS data from across the country, RfAD provides a unique opportunity for enhancing laboratory data with tracing and ART data which can be leveraged for generating automated care cascades. These can provide important insight into programmatic gaps as well as enabling ready identification of the children who have fallen through those gaps.

Figure 1 is an example of a district-level cascade for children diagnosed with a positive HIV PCR result through to each patients last viral load result. The cascade highlights relatively high ART initiation rates, but poor early retention in care after ART initiation with low virological monitoring and suppression rates during infancy and early childhood for those diagnosed by HIV PCR testing. This pattern has previously been described from routine data sources but has unfortunately persisted[4].

Figure 1. HIV Care Cascade for patients aged <24 months, with a HIV PCR positive diagnosis from January-December 2024 (as of current date)

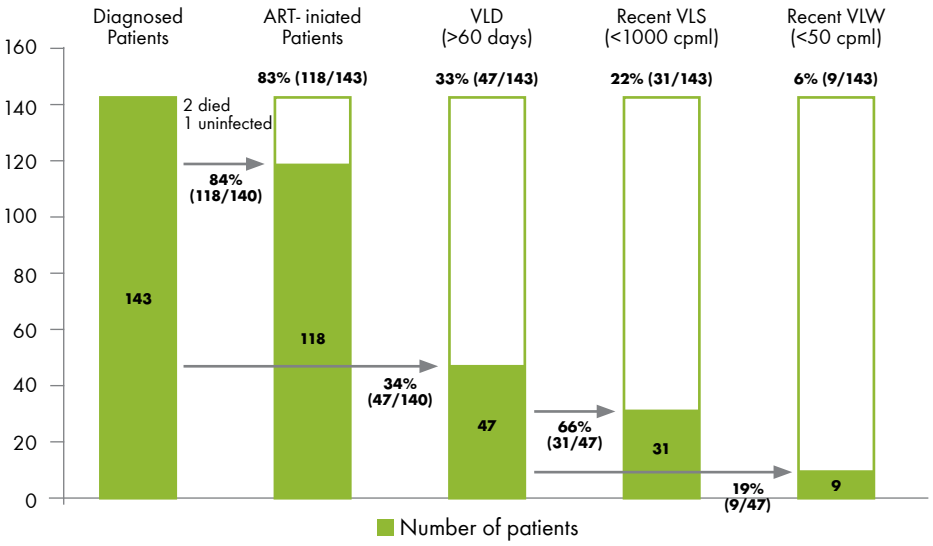

Figure 2. Registering for and accessing RfAD on the NICD self-service portal.

Training sessions can be requested through the Department of Health structures or support partners. Furthermore, weekly support online meetings coordinated by the NICD Centre for HIV & STIs have enabled a community of learning and practice. RfAD usage reports are also distributed monthly to stakeholders.

Importantly, the analytics generated are dependent on the extent and quality of engagement with the dashboard, in particular deduplicating results and ensuring ART initiation outcomes are submitted. The dashboard can be used in various ways by different colleagues, from clinical facility-based staff to roving data capturers.

It is therefore considered best practice to regularly review the RfAD analytics and usage at both district- and facility-levels. This is best done by adopting a team approach at both district and facility level whereby staff are assigned specific roles and responsibilities that are monitored and reported back to the Health District team.

Access and support

Registration and access to RfAD is via the NICD Self Service Portal on the NICD website (Figure 2). The Dashboard has convenient built-in training videos to support self-initiated user-centered learning. The training videos are broken down into chapters covering the three main areas of the Dashboard (viz. a) Diagnosed Line-List, b) Facility Patient List and c) Analytics) to enable targeted learning. Furthermore, there is a separate Protection of Personal Information Act compliance training video. A built-in desk function aids users in reporting technical challenges to streamline prompt and efficient IT support.

Training sessions can be requested through the Department of Health structures or support partners. Furthermore, weekly support online meetings coordinated by the NICD Centre for HIV & STIs have enabled a community of learning and practice. RfAD usage reports are also distributed monthly to stakeholders.

The reports summarise the number of users registered for, logging into and submitting patient tracing/outcomes

on the dashboard per district. Requests for further information can be directed via email to the NICD Paediatric HIV Surveillance Team (HIV@nicd.ac.za).

Summary

The NICD RfAD provides a unique opportunity to support near real-time tracking, tracing and monitoring the clinical outcomes of children and adolescents living with HIV who have engaged with laboratory services. It supports the Global Alliance goal of ending AIDS in children by highlighting district- and facility-level programmatic gaps and identifying those children who are in danger of being left behind.

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Reconnecting Key Populations with HIV Care: Ethical and practical approaches for nurses

ME Collins[1] MBChB, DipHIVMan
[1]*Wits RHI, University of the Witswatersrand, Johannesburg, South Africa*

Corresponding author: ME Collins, mcollins@wrhi.ac.za

The end of January 2025 saw the immediate and unprecedented freezing of United States Agency for International Development (USAID) funding to HIV programmes in South Africa. This led to the sudden closure of several health facilities and extensive job losses across the sector. Reports indicate that a total of 12 specialised facilities providing comprehensive HIV treatment and prevention services to an estimated 63,000 members of key populations (KP) were forced to close as a result[1,2]. Integrating those affected into the Department of Health (DoH) clinics has proven to be a significant challenge. A rapid survey conducted in Cape Town among 278 respondents (previously accessing antiretroviral therapy [ART] and HIV pre-exposure prophylaxis [PrEP] and USAID sites) found that up to 37% were no longer receiving their respective treatments by August 2025[3]. Reported barriers to accessing DoH facilities include being turned away for not having a referral letter, fear of discrimination or stigma, and concerns about confidentiality[3,4]. It has been estimated that discontinuing PEPFAR-supported services without suitable replacement could result in an additional 150,000–296,000 new HIV infections and 56,000–65,000 HIV-related deaths between 2025 and 2028. Maintaining ART) and PrEP services for key populations has been identified as the most cost-effective intervention to mitigate these impacts[5].

Being turned away – or even the fear of being turned away – for not having a referral letter is one of the most frequently cited barriers among those previously in care. As with all chronic conditions, having access to a patient's history is incredibly valuable. Unfortunately, in the absence of a national electronic health record system that links facilities across provinces, districts, and programmes, the only means of transferring this information remains a physical referral letter. This requires patients to visit their previous treating facility in preparation for transfer – a process that often involves unplanned financial costs and significant time commitments, which can make it inaccessible for many. The sudden and unforeseen termination of USAID funding led to the closure of specialised clinics across the country within less than 24 hours, leaving no time to generate and distribute tens of thousands of referral letters. If we are to limit the setbacks to South Africa's HIV programme, these patients must

be able to access HIV treatment and prevention services at their nearest clinics – with or without a referral letter. The question then becomes: how do we achieve this? This can be explored in two strategic categories.

The first is **crisis management** – how we address the current situation and attend to patients who have been thrust into the public healthcare system without referral letters. The *2023 ART Clinical Guidelines for the Management of HIV in Adults, Pregnancy and Breastfeeding, Adolescents, Children, Infants and Neonates* are clear on this point. On page 17, the guidelines state:

> *"If a patient comes from a different facility, it is critical that the patient be provided with treatment on the day of presentation to limit any further treatment interruption and its impact on viral suppression. While referral letters are helpful, a patient cannot be required to leave the facility without treatment to first obtain a referral/transfer letter."*[6]

This is entirely logical when one considers the consequences of treatment interruption – including viral load rebound, the development of drug resistance, increased morbidity and mortality, and ongoing HIV transmission. Drawing from national guidance and practical experience across multiple levels of care, a clinically sound approach to managing patients who present without referral letters may include the following steps:

1. Be approachable and welcoming.
A calm, respectful manner helps reduce any fear or apprehension the patient may feel. This first encounter sets the tone for the provider–patient relationship – and can be a determining factor in whether the patient chooses to remain in care or disengage.

2. Assume good faith.
Patients who arrive at a clinic without a referral letter have often overcome significant barriers simply to be there. In keeping with ethical principles of veracity and respect, healthcare providers should assume that patients are providing truthful information unless there is clear evidence to the contrary.

3. Take a thorough history.
Patients are often able to recall key details such as when they were diagnosed, the treatment they were taking, and when blood tests were last performed. Creativity may be needed – some may bring empty medication containers, photos of medications, or be able to identify the packaging or dosing if shown examples.

4. Document clearly and comprehensively.
Clinicians may be understandably cautious about initiating or continuing treatment without a referral letter. Detailed notes outlining the information provided by the patient, any corroborative information obtained (see point 5), and the clinical reasoning behind management decisions help ensure transparency and accountability. Where appropriate, the patient may be asked to confirm in writing that the information they have provided is accurate to the best of their knowledge.

5. Seek corroborative information where possible.
If feasible, review old clinic appointment cards, contact the patient's previous clinic for a summary or recent clinical notes. Reviewing available laboratory records, such as through NHLS LABTRAK, may also assist in confirming treatment history or monitoring results.

6. Seek guidance when uncertain.
Consult senior colleagues, your local hospital HIV clinic, or the helplines listed in the ART Guidelines for additional support when needed.

7. Make evidence-based treatment decisions.
Using all available information, select the most appropriate regimen according to current national guidelines. In most cases, TLD remains the recommended first- and second-line regimen.

8. Conduct appropriate investigations.
Where indicated, perform investigations such as CD4 count, HIV viral load, creatinine, or TB GeneXpert/NAAT. While not necessarily the patient's baseline results, these serve as your baseline for continued management. Clinicians should exercise their professional judgment and follow standard protocols.

9. Schedule and follow up.
Arrange a follow-up visit, sooner if there are concerns. This allows time for additional information to be gathered – such as a referral letter, medicine containers, or discharge summaries – and for laboratory results to be reviewed. By this stage, sufficient information is usually available to integrate the patient fully into the clinic system.

The second component involves identifying strategies to reduce the risk of patients presenting without clinical information when moving between facilities – particularly in the absence of a fully implemented national electronic medical record. As many clinicians have observed, large numbers of patients continue to present for care without transfer documentation. Research has found that at least 45% of patients presenting for ART initiation had prior ART exposure, and only about one-third of these individuals disclosed this history voluntarily. Reasons cited included fear of delayed access to treatment, being asked for additional documentation, or experiencing negative treatment from staff[7]. Additional studies report that patients often lack transfer letters due to transport costs, fear of stigma or reprimand, and limited awareness

of transfer procedures[8]. To mitigate these challenges, patient empowerment and information retention strategies can be promoted at the facility level. Examples may include encouraging patients to learn or record the names of their medications, supporting those with limited literacy by noting the information for them, or advising patients to photograph their medication containers or the longitudinal summary in their clinic file. Such approaches may enhance continuity of care by ensuring that patients retain key health information even when formal documentation is unavailable. Strengthening patient self-management in this way benefits both the individual and the broader healthcare system by facilitating smoother handovers of care and improving treatment continuity.

Addressing the concerns related to stigma and discrimination calls on healthcare professionals to reaffirm their commitment to providing equitable, patient-centred care to all–without discrimination or judgment–and to do so in accordance with the four cornerstones of medical ethics:

1. **Autonomy** – meaning "self-rule" or "self-governance". In clinical practice, it represents respect for the patient's right to make informed decisions about their own health and treatment.
2. **Beneficence** – literally means "to do good". It embodies the duty to act in the patient's best interest and to promote their overall well-being.
3. **Non-maleficence** – means "not doing harm". In healthcare, this principle obliges providers to avoid actions or omissions that could cause harm, whether through direct intervention or failure to act.
4. **Justice** – refers to fairness and equity in healthcare delivery–ensuring that all patients receive equitable treatment and that resources are distributed justly[9,10].

These cornerstones of medical and nursing ethics also underpin many of the frameworks that guide healthcare practice in South Africa, including the Patient's Rights Charter, which is displayed in all primary healthcare facilities. The Charter affirms that every individual is entitled to equitable, respectful, and high-quality healthcare services. It specifically upholds patients' rights to access healthcare, to be treated with dignity, and to be protected from discrimination[11].

These commitments are further supported by the Batho Pele principles of Access and Courtesy, which require that patients receive care without discrimination or undue delay[12]. Together, these guiding principles challenge healthcare providers to embody the spirit of ethical and compassionate care in every encounter–reminding us that even the smallest acts of respect can reaffirm the dignity of those we serve.

In closing, I want to extend my sincere gratitude to all the hardworking, dedicated, and resilient healthcare workers–and especially to the professional nurses in our primary healthcare clinics–who continue to serve as the backbone of South Africa's HIV response. It hardly seems fair to ask even more of you as we move forward, yet it is with deep respect and appreciation that we do so, knowing that the gains we strive to sustain are the result of your tireless efforts and unwavering dedication.

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Disclaimer

The information provided here is based on current national HIV guidelines and best-practice principles. It is intended to support clinicians in managing practical challenges within the public healthcare system. It should not be interpreted as prescriptive advice and does not replace formal Department of Health protocols or professional clinical judgment.

SOUTHERN AFRICAN HIV CLINICIANS SOCIETY **GUIDELINE ON PRE-EXPOSURE PROPHYLAXIS TO PREVENT HIV**

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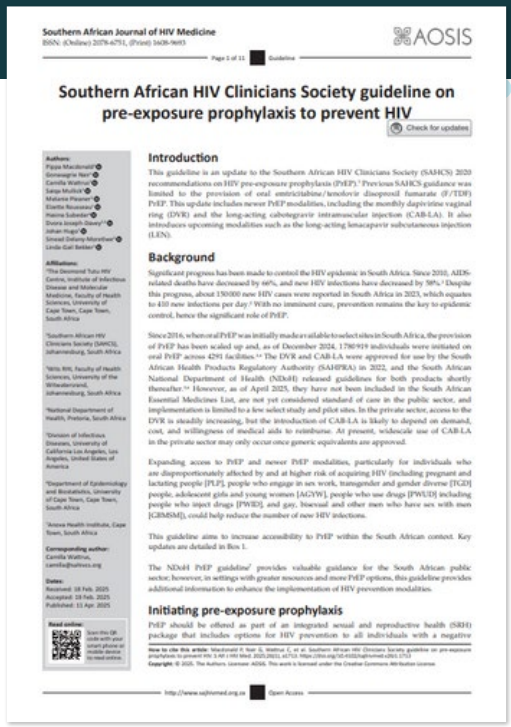
Southern African Journal of HIV Medicine

AOSIS

Southern African HIV Clinicians Society guideline on pre-exposure prophylaxis to prevent HIV

Introduction

Background

Initiating pre-exposure prophylaxis

This guideline is an update to the SAHCS 2020 recommendations on HIV pre-exposure prophylaxis (PrEP). Previous SAHCS guidance was limited to the provision of oral emtricitabine/tenofovir disoproxil fumarate (F/TDF) PrEP.

This update includes newer PrEP modalities, including the monthly dapivirine vaginal ring (DVR) and the long-acting cabotegravir intramuscular injection (CAB-LA). It also introduces upcoming modalities such as the long-acting lenacapavir subcutaneous injection (LEN).

This comprehensive guideline, authored by leading experts in the field, addresses key topics to support the effective implementation of PrEP, enhance patient outcomes, and guide healthcare providers in delivering evidence-based HIV prevention.

- Overview of PrEP
- Clinical assessment for PrEP initiation
- PrEP options and regimens Monitoring and follow-up Adherence support
- Drug resistance and safety considerations
- Special populations and considerations PrEP delivery models
- Integration with broader HIV prevention strategies
- Future directions and ongoing research

Read or download the full guideline here:
https://sahivsoc.org/Files/SAHCS%20PrEP%20guideline%202025.pdf

Navigating HIV Care After USAID funding cuts: Sustaining youth services and clinical responses in South Africa

M Rammela[1], B.N.S, MBA, MPH, PhD; Lufuno Makhado[1], B.N.S, M.Cur, PhD.
[1]*Department of Public Health, Faculty of Health Sciences, University of Venda, Thohoyandou, Limpopo, South Africa*

Corresponding author: Mukovhe Rammela, mukovherammela038@gmail.com

Introduction

South Africa continues to face one of the world's highest burdens of HIV, with nearly one in five adolescents infected[1]. Over the past two decades, the United States Agency for International Development (USAID) has played a pivotal role in funding the country's HIV response. However, recent decisions to reduce international aid by 17%, following U.S. policy shifts, have created significant challenges for national HIV programmes[2].

The United States remains the largest donor, contributing approximately 73% of all international HIV funding in low- and middle-income countries[3]. Cuts to USAID and other foreign aid sources, such as those projected by the United Kingdom (40%) and the Netherlands (70%), raise deep concerns about the sustainability of South Africa's HIV progress. The withdrawal of support threatens the continuity of essential prevention and treatment services, particularly those targeting adolescents and young adults.

For healthcare practitioners, these developments translate to increased clinical pressures, disrupted ART continuity, and the potential resurgence of HIV transmission. The situation underscores the need for nurse-led, community-driven strategies to sustain HIV services and protect vulnerable youth populations.

Impact of funding cuts on HIV Service delivery

The reduction in USAID funding has led to the closure of multiple HIV treatment clinics across South Africa. Reports indicate that over 63,000 patients lost access to care through 12 USAID-funded clinics, while up to 220,000 people experienced interruptions in their antiretroviral therapy (ART)[4]. These service disruptions have had both physical and psychological effects, with many patients reporting symptoms

of depression and hopelessness after losing consistent access to treatment.

Recent modelling data estimate that the funding freeze could result in 150,000–295,000 additional HIV infections by 2028 unless the South African government replaces lost support[5]. This potential reversal of progress highlights the fragility of donor-dependent healthcare systems.

The clinical impact extends beyond HIV care. Overstretched public health facilities face higher patient volumes, longer waiting times, and limited human resources. These conditions compromise treatment adherence and retention, particularly among young people. Without targeted interventions, clinicians may soon confront increasing cases of treatment failure, drug resistance, and advanced HIV disease (AHD). Sustainable HIV progress depends not only on financial aid but on resilient, nurse-led service delivery models that ensure continuity of care even amid funding uncertainty.

Youth-specific challenges

Adolescents and youth in South Africa continue to face a disproportionate burden of HIV and other sexual and reproductive health (SRH) challenges. Limited access to youth-friendly services, stigma, and mental health challenges compound the impact of funding cuts. Globally, funding disruptions have grounded numerous youth-focused programmes that addressed HIV prevention, family planning, and mental health support[4]. In South Africa, the situation is acute—young women and girls account for 44% of all new HIV infections, and among those aged 15–24, 62% of new infections occur in adolescent girls and young women (AGYW)[6].

Barriers to access include:

- **Limited PrEP availability:** Many clinics have reduced access to Pre-Exposure Prophylaxis (PrEP) due to supply constraints[7].
- **Stigma and discrimination:** Adolescents often face judgment from healthcare workers when seeking sexual health services[8].
- **Mental health strain:** The prevalence of depression among South African adolescents ranges from 14.7% to 38.3%, exacerbated by disrupted care and isolation[6].
- **Financial hardship:** Youth are disproportionately affected by unemployment, limiting their ability

The United States remains the largest donor, contributing approximately 73% of all international HIV funding in low- and middle-income countries[3].

Practical Actions for Nurses and Clinicians

- Integrate mental health screening into ART follow-up visits.
- Advocate for flexible ART refill models (multi-month dispensing or mobile delivery).
- Engage youth peer mentors to support adherence.
- Promote confidentiality and judgment-free consultation spaces.
- Collaborate with local NGOs to supplement psychosocial support.

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13. Monitoring on ART
14. Drug Interactions
15. Follow-up of the Patient on ART
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20. Paediatric HIV Management
21. Differentiated Care
22. Preventing Drug Stockouts
23. Adverse Drug Reactions and Reporting
24. ART Data Management

to travel to alternative facilities. Clinicians play a crucial role in mitigating these challenges by providing inclusive, respectful care that fosters confidentiality, trust, and consistent engagement with young patients.

Clinical strategies and innovations

To maintain service continuity despite reduced external funding, nurses and allied health professionals must adopt innovative, locally driven care models.

1. Mobile and decentralised service delivery

Mobile health clinics can extend ART refills, HIV testing, and counselling to remote or underserved areas. This approach reduces travel barriers and enhances treatment adherence among youth populations in rural communities.

2. Integration of mental health into HIV Care

Routine screening for depression using validated tools such as the PHQ-9 should be standard practice. Early identification and management of depressive symptoms can improve ART adherence and viral suppression outcomes[6,9].

3. Flexible ART refill models

Multi-month dispensing (MMD) improves ART adherence among youth living with HIV by reducing the frequency of clinic visits, alleviating logistical challenges, and reducing stigma[10]. As a result of the findings, this model may offer a practical solution to improve the adherence to ART and the health outcomes of HIV-positive young people. Such strategies maintain viral suppression and reduce the risk of resistance while easing drug supply pressures.

4. Digital health and telemedicine

Digital health platforms, such as mobile apps, Telehealth, and SMS reminders, provide discreet and youth-friendly methods for adherence support and mental health counselling. Clinicians can leverage these technologies to maintain continuity of care, particularly for individuals who are hesitant to attend in-person visits.

5. Peer and community-based support

Community health workers and peer mentors are effective in promoting

The clinical impact extends beyond HIV care. Overstretched public health facilities face higher patient volumes, longer waiting times, and limited human resources. These conditions compromise treatment adherence and retention, particularly among young people.

adherence and normalizing ART use among adolescents. Peer-led initiatives have shown significant success in reducing stigma and improving retention in care, especially when linked with schools or local youth organisations.

Looking ahead: Building sustainable systems

As The Lancet recently reported, discontinuing USAID funding could result in over 1 million new paediatric HIV infections in Africa by 2030, with half a million deaths[11]. South Africa's response must therefore focus on building self-sustaining, government-led healthcare systems that prioritize resilience and adaptability.

Nurses are central to this transformation. Beyond providing care, they serve as advocates, educators, and connectors between communities and health systems. Expanding nurse-led clinics, task-shifting models, and digital training for health workers can help fill service gaps created by donor withdrawal.

Evidence from Southern Africa also shows that adolescents living with HIV (ALHIV) have higher all-cause mortality than their HIV-negative peers, even on ART[12]. Tailored adolescent care models, including psychosocial counselling, adherence clubs, and community outreach, are critical to improving outcomes.

To achieve a truly HIV-free generation, South Africa must:

- Reinvest in domestic funding for youth-targeted HIV services.
- Integrate SRH, HIV, and mental health programmes.
- Prioritize training and retention of nursing professionals in HIV care.
- Leverage innovation to sustain progress in the face of future funding uncertainty.

Conclusion

The reduction in USAID funding represents a pivotal moment for South Africa's HIV response. While the immediate consequences are deeply concerning, this crisis presents an opportunity for innovation and resilience within the healthcare system. For clinicians and nurses on the front line, the focus must shift toward locally owned, patient-centred, and youth-responsive care. Through mobile outreach, mental health integration, peer support, and adaptive ART strategies, the healthcare community can safeguard the progress made and continue the march toward an HIV-free generation.

Final takeaway

Sustaining the HIV response requires more than financial aid; it demands committed health practitioners who innovate, advocate, and adapt to preserve the dignity and health of every young person living with or at risk for HIV.

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Psychosocial support needs and resilience strategies for nurses in HIV care in South Africa

L Makhado[1], RN, BcurNS, M.Cur, PhD
[1]*Department of Public Health, Faculty of Health Sciences, University of Venda, Thohoyandou, South Africa*

Corresponding author: Lufuno Makhado, Lufuno.Makhado@univen.ac.za

Introduction

South Africa continues to bear one of the highest global burdens of HIV, profoundly affecting healthcare workers. Nurses form the backbone of HIV care, offering treatment, counselling, and psychosocial support to people living with HIV (PLHIV). However, the emotional, social, and professional demands of their work often lead to psychological distress and burnout[1,2]. The cumulative strain of high patient loads, stigma, and limited institutional support affects both nurses' well-being and the quality of patient care[3-6]. Addressing these psychosocial challenges is crucial to sustaining effective, compassionate HIV services. This article examines the key stressors faced by South African nurses and outlines practical resilience strategies informed by both local and international evidence.

Challenges faced by South African nurses in HIV Care

- **Work-related stress and burnout**

Excessive workloads, high patient-to-nurse ratios, and emotional fatigue contribute to chronic stress. In Limpopo Province, over 60% of nurses reported moderate to severe stress, directly impacting their performance and health[3,5]. International evidence

confirms that prolonged stress correlates with reduced quality of care in HIV and palliative settings[5,7]. Persistent exposure to patient loss, stigma, and community-level suffering further heightens emotional exhaustion.

- **Secondary trauma and compassion fatigue**

Nurses often internalise patients' grief and trauma, resulting in secondary traumatic stress[5-9]. Repeated exposure to suffering can erode empathy, leading to emotional detachment and fatigue[10]. If unaddressed, these symptoms reduce compassion, lower morale, and drive attrition[11]. Given the chronic nature of HIV, this emotional toll is intensified by long-term relationships with patients facing ongoing psychological and physical challenges.

- **Stigma and socioeconomic pressures**

HIV-related stigma continues to affect both patients and healthcare providers. Nurses frequently encounter social isolation or discrimination within their workplaces and communities[12]. At the same time, many patients face poverty, unemployment, and inadequate family support, which nurses witness daily without sufficient means to intervene[5,13]. These social stressors amplify nurses' emotional burden and may contribute to depersonalisation, fatigue, and reduced adherence to care guidelines[14].

- **Under-resourced healthcare systems**

South Africa's public health system is characterised by staff shortages, limited infrastructure, and insufficient mental health resources. With approximately 100,000 new HIV cases annually and a shortage of skilled health professionals, particularly in rural areas, nurses often work beyond capacity[14]. The absence of structured debriefing, recognition, or psychosocial support mechanisms worsens fatigue and burnout[3].

- **Limited psychosocial and mental health training**

Despite their daily exposure to emotionally charged work, many nurses lack formal education in coping strategies, emotional regulation, or psychological first aid[5]. This deficit hampers their ability to manage personal distress and recognise signs of trauma in patients, underscoring the need to embed resilience and mental health training into nursing curricula.

Practical tools and resilience strategies

Building resilience among nurses demands an integrated approach that strengthens personal coping skills, fosters supportive environments, and embeds mental health into organisational culture.

- **Promoting self-care and individual coping**

Self-care is central to reducing burnout. Mindfulness, exercise, spiritual reflection, and regular rest are proven to enhance emotional regulation[15]. South African studies highlight that self-awareness and reflective practices significantly increase resilience and job satisfaction[16-18].

- **Strengthening peer support and emotional debriefing**

Peer support groups create safe, non-judgmental spaces for nurses to share experiences, debrief emotionally, and learn adaptive coping methods. It had been evident that structured peer groups led to measurable reductions in stress and absenteeism[19,20]. Emotional debriefing also fosters solidarity, which is essential for maintaining empathy and reducing feelings of isolation.

South Africa urgently needs implementation-focused research to evaluate the feasibility, impact, and integration of psychosocial models within routine HIV care.

- **Ensuring access to mental health resources**

Accessible mental health care for nurses, through on-site counselling, peer counsellors, or telepsychiatry, significantly reduces stress and stigma-related distress[21,22]. Other relevant studies further demonstrate that psychosocial interventions improve both staff morale and patient care outcomes[23,24].

- **Embedding psychosocial support in the workplace**

Sustainable well-being initiatives should be institutionalised within healthcare structures. Wellness hours, resilience workshops, and mentorship programmes normalise mental health care and reduce turnover. Leadership engagement and resource allocation remain critical to success.

- **Implementing resilience training and continuous education**

Resilience training enhances communication, conflict resolution, and stress management skills. Simulation-based workshops and mentorship programmes strengthen coping capacity when tailored to HIV care realities[1,15,25,26]. Continuous education also empowers nurses to manage emotional demands more effectively.

- **Fostering supportive leadership and policy reform**

Empathetic leadership drives organisational resilience. Nurse managers must prioritise workload balance, promote mental health literacy, and model positive coping behaviours[26,27]. Supportive management fosters trust and retention while improving overall team cohesion.

Research gaps and the need for implementation

Although several frameworks, models, and resilience strategies have been developed to support nurses in HIV care, implementation remains limited in South Africa. Studies have proposed a support model for nurses in Limpopo[2] and trialled a psychosocial intervention in Ehlanzeni District[28], among others, but both faced challenges in terms of scale and sustainability. International evidence does show measurable reductions in burnout following structured psychosocial support[29,30]. South Africa urgently needs implementation-focused research to evaluate the feasibility, impact, and integration of psychosocial models within routine HIV care.

Conclusion and key takeaways

South African nurses in HIV care face layered psychosocial challenges, ranging from chronic stress and secondary trauma to stigma and structural constraints. These stressors undermine their well-being and the ability to deliver effective services. However, evidence demonstrates that comprehensive resilience strategies, including self-care, peer networks, access to mental health services, and leadership commitment, can substantially improve both nurse and patient outcomes.

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Key takeaways for practice

- Prioritise structured peer support and emotional debriefing sessions.
- Integrate resilience and psychosocial training into all nursing curricula.
- Institutionalise wellness programmes within healthcare facilities.
- Strengthen leadership advocacy for mental health resources.
- Recognise nurse well-being as central to quality HIV care.

Investing in the psychosocial health of nurses is not optional; it is foundational to sustaining South Africa's HIV response.

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SAHCS
GUIDELINES

SAHCS guidelines

Access the SAHCS guidelines to stay informed and up-to-date:

- Southern African HIV Clinicians Society guideline on **pre-exposure prophylaxis to prevent HIV**
  https://sahivsoc.org/Files/SAHCS%20PrEP%20guideline%202025.pdf
- Southern African HIV Clinicians Society guideline on the **management of non-tuberculous mycobacteria in people with HIV**
  https://sahivsoc.org/Files/SAHCS%20NTM%20guideline_2024.pdf
- Southern African HIV Clinicians Society guideline for the **clinical management of Syphilis**
  https://sahivsoc.org/Files/SAHCS%20syphilis%20guideline.pdf
- Southern African HIV Clinicians Society guideline for the **management of drug-induced liver in people Living with HIV treated for Tuberculosis: 2024 update**
  https://sahivsoc.org/Files/SAHCS%20DILI%20guidelines%20-%202024.pdf
- 2023 Southern African HIV Clinicians Society **Adult Antiretroviral Therapy Guidelines: what's new?**
  https://sahivsoc.org/Files/SAHCS%20Adult%20ART%20Guidelines%202023%20update.pdf
- Southern African HIV Clinicians Society guideline for **post-exposure prophylaxis: Updated recommendations**
  https://sahivsoc.org/Files/SAHCS%202023%20PEP%20guidelines.pdf
- Southern African HIV Clinicians Society guideline for **Antiretroviral Therapy in Adults: 2023 update**
  https://sahivsoc.org/Files/SAHCS%20Adult%20ART%202023%20Guidelines%20(1107).pdf
- **Antiretroviral drug dosing chart for children 2022**
  https://sahivsoc.org/Files/PaedDosingChart_2022.pdf
- Southern African HIV Clinicians Society 2022 guideline for the **management of sexually transmitted infections: Moving towards best practice**
  https://sahivsoc.org/Files/SAHCS%202022%20STI%20guidelines.pdf
- Southern African HIV Clinicians Society clinical update - **Use of DTG-based regimens for 1st and 2nd line ART**
  https://sahivsoc.org/Files/SAHCS%20clinical%20statement_TLD%20switching_20220513.pdf
- Southern African HIV Clinicians Society guideline for **hospitalized adults with AHD**
  https://sahivsoc.org/Files/SAHCS%202022%20Adult%20AHD%20Guidelines_20220506.pdf

Clinical tips

1. See the latest SAHCS 2025 PrEP guidance here: https://sahivsoc.org/Files/SAHCS%20PrEP%20guideline%202025.pdf
2. Ensure that everyone who requests or has an HIV test is also screened for symptoms of other STIs.
3. Antenatal syphilis seroprevalence in SA is increasing. See syphilis guidelines: https://sahivsoc.org/Files/SAHCS%20syphilis%20guideline.pdf
4. Rifampicin markedly lowers concentrations of many drugs: always check co-administered drugs.
5. See latest guidance for Non-Tuberculous Mycobacteria here: https://sahivsoc.org/Files/SAHCS%20NTM%20guideline_2024.pdf
6. PEP can effectively prevent infection in a person exposed to HIV when initiated as soon as possible and at least within 72 h post-exposure.
7. Screen for TB & crypto meningitis prior to ART initiation as these may necessitate delaying ART initiation.
8. PrEP is not a lifelong commitment: clients can start, stop, restart PrEP depending on their lifestyle and requirements.
9. PrEP methods (oral, DVR, CAB-LA) can be switched to accommodate lifestyle changes and the individual's level of risk.
10. See the latest SAHCS 2025 PrEP guidance here: https://sahivsoc.org/Files/SAHCS%20PrEP%20guideline%202025.pdf
11. See the latest SAHCS DILI guidance here: https://sahivsoc.org/Files/SAHCS%20DILI%20guidelines%20-%202024.pdf
12. Risk factors for DILI: concomitant HIV, hep B or C, chronic liver disease, high alcohol intake, malnutrition, low BMI, older age, female sex.
13. First-line anti-tuberculous drugs associated with hepatotoxicity include INH, RIF and PZA.
14. In general, patients with DILI should be admitted to hospital.
15. Always ask at every visit about TB contacts and TB symptoms in all children and their caregivers.
16. A undetectable VL will prevent sexual transmission of HIV. Remember U=U.
17. With DTG dispersible formulations available, most children >3kg and >1mth of age should be on a DTG-based regimen.
18. Always ask about and manage ART side-effects as they can negatively affect adherence.
19. DTG may cause a slight increase in creatinine, this is not a cause of renal dysfunction.
20. See latest ART guidance here: https://www.sahivsoc.org/Guidelines/GuidelinesLandingPage

DTG - dolutegravir; VL - viral load; U=U - undetectable = untransmittable; TB - tuberculosis; TLD - tenofovir/lamivudine/dolutegravir; AZT - zidovudine; 3TC - lamivudine; NVP - nevirapine; ART; antiretroviral therapy; PCR - polymerase chain reaction; PrEP - pre-exposure prophylaxis.

Please contact valencia@sahivcs.org if you would like to receive our monthly clinical tips

National HIV & TB Health Care Worker Hotline

This is a free service for all health care workers

What questions can you ask?

The National HIV & TB Health Care Worker Hotline provides information on queries relating to:

- Pre-exposure prophylaxis (PrEP)
- Post exposure prophylaxis (PEP)
- HIV testing
- Management of HIV in pregnancy
- PMTCT
- Drug interactions
- Treatment/prophylaxis of opportunistic infections
- Drug availability
- Adherence support
- Management of DS and DR tuberculosis
- Antiretroviral Therapy (ART):
  - When to initiate
  - Treatment selection
  - Recommendations for laboratory and clinical monitoring
  - How to interpret and respond to laboratory results
  - Management of adverse events

We are available Monday to Friday 08:30 - 16:30

PHONE
0800 212 506
021 406 6782

E-MAIL
pha-mic@uct.ac.za

SMS/PLEASE CALL ME/WHATSAPP
071 840 1572

WEBSITE
www.mic.uct.ac.za

FACEBOOK
HIV & TB Health Care Worker Hotline, South Africa

FREE ANDROID & APPLE APP
SA HIV/TB Hotline

MEDICINES INFORMATION CENTRE

health
Department:
Health
REPUBLIC OF SOUTH AFRICA

JOIN US AS A MEMBER!

WE ARE A COMMUNITY OF HEALTHCARE PROVIDERS DEDICATED TO DELIVERING EVIDENCE-BASED, HIGH-QUALITY HIV CARE

The Southern African HIV Clinicians Society (SAHCS) is a community of healthcare professionals that work in a variety of spaces, including public, private, and allied healthcare organisations. Our commitment lies in empowering our community to deliver evidence-based, up-to-date, and patient-centred HIV healthcare of the highest quality.

We strive to support and strengthen the capacity of our members. We achieve this through the development of our clinical guidelines and job aids, offering training courses and conferences, publishing the SAJHIVMED scientific journal and the HIV Nursing Matters publication, organising regular Continuous Medical Education meetings and webinars. We are dedicated to fostering collaboration across cadres and borders to improve the lives of all those affected by HIV.

As a member of SAHCS, you will have access to trusted clinical knowledge, enabling you to enhance your clinical practice and provide high quality HIV prevention, treatment, and care.

SAHCS MEMBERSHIP BENEFITS INCLUDE:

- Free access to CME meetings and webinars
- CPD certificates for courses and webinars completed
- Free access to previous webinars to enable you to learn when it suits you
- Preferential registration to SAHCS workshops
- The opportunity to network and collaborate with other healthcare providers who have an interest in HIV
- Free access to:
  - the DHET PubMed® accredited Southern African Journal of HIV Medicine (SAJHIVMED)
  - SAHCS HIV Nursing Matters Publication
  - HIV and related diseases clinical updates and articles
  - Evidence-based SAHCS and NDoH clinical guidelines

CLICK HERE TO JOIN THE SAHCS COMMUNITY FOR FREE!

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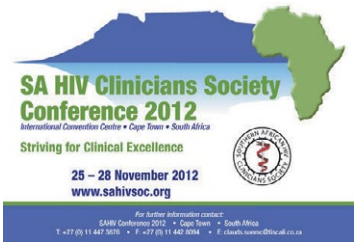
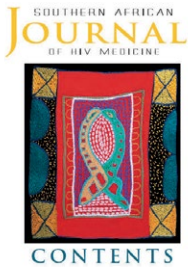
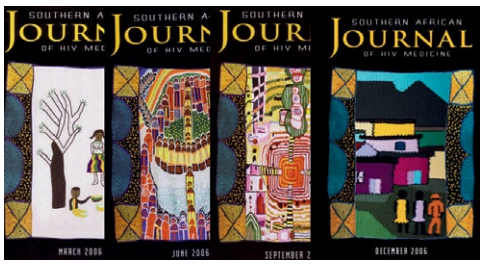
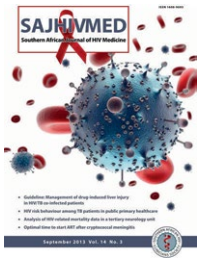
UNITING HEALTHCARE WORKERS IN HIV CLINICAL EXCELLENCE

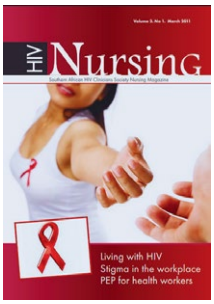
27 YEARS OF STRENGTHENING QUALITY, COMPREHENSIVE, EVIDENCE-BASED HIV HEALTHCARE IN SOUTHERN AFRICA

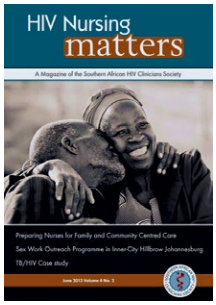


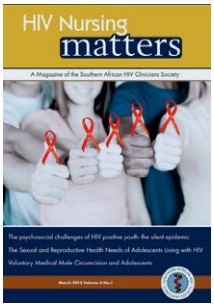












ART IN ADULTS

SOUTHERN AFRICAN HIV CLINICIANS SOCIETY

GUIDELINES FOR

ANTIRETROVIRAL THERAPY IN ADULTS