health
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Health
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TO: NATIONAL, PROVINCIAL AND DISTRICT HAST MANAGERS
NATIONAL, PROVINCIAL AND DISTRICT MCWH MANAGER
DISTRICT MANAGERS
HOSPITAL CEOs
PHC MANAGERS
PHC FACILITY MANAGERS
DISTRICT CLINICAL SPECIALIST TEAMS (DCSTs)
REGIONAL TRAINING CENTRE MANAGERS
ALL DOCTORS, NURSES AND PHARMACISTS

RE: IMPLEMENTATION OF THE UNIVERSAL TEST AND TREAT STRATEGY FOR HIV POSITIVE PATIENTS AND DIFFERENTIATED CARE FOR STABLE PATIENTS

Background

In line with the National Development Plan (NDP) 2030, the UN Sustainable Development Goals and UNAIDS 90-90-90 targets of 2020, the Minister of Health, announced during his budget speech on the 10th May 2016, that South Africa would scale-up NHI facility decongestion to reach 800,000 patients in the FY16/17. The country would implement the World Health Organization (WHO) evidence based guidelines of Universal Test and Treat (UTT) by 1st September 2016.

Policy shift implications

South Africa is among the first countries in Africa to formally adopt UTT in accordance with the WHO new guidelines on HIV treatment. UTT directly supports UNAIDS 90-90-90 targets of ensuring that 90% of all people living with HIV know their HIV status, 90%

of people with diagnosed HIV infection receive sustained ART and 90% of all people receiving ART have viral suppression. South Africa embraces UTT to complement case finding and holding strategies that are reflected in the revised 2016 National HIV Testing Services (HTS) Policy and the 2016 HIV Disclosure guidelines. Key to the success of UTT is implementation of the National Adherence Policy and Service Delivery Guidelines interventions for linkage to care, adherence to treatment and retention in care.

Eligibility Criteria for UTT

With effect from 1st September 2016 the following criteria to start patients on lifelong ART applies:

- All HIV positive children, adolescents and adults regardless of CD4 count will be offered ART.
- Patients in the Pre-ART and Wellness programme shall be considered for UTT.
- Willingness and readiness to start ART shall be assessed and patients who are not ready after assessment shall be kept in the wellness programme and continuous counseling on the importance of early treatment and scheduled CD4 as per SA clinical guidelines shall continue at every visit.
- Baseline monitoring of CD4 count will still be done as it is the key factor in determining the need to initiate Opportunistic Infection prophylaxis at CD4 ≤200 cells/mm^3, identify eligibility for CrAg at CD4 ≤100, prioritisation at CD4 ≤350 cells/mm^3 and fast tracking at CD4 ≤200 cells/mm^3.

Timing of ART initiation

ART should be started as soon as the patient is ready and within 2 weeks of CD4 count being done.

Fast track initiation:

HIV stage 4.
Patients with CD4 ≤200 cells/mm^3.

Immediate priority:

All HIV-positive pregnant or breastfeeding women, with no active TB or contraindication to first line Art, i.e. TDF/FTC/EFV (TEE FDC).
All HIV positive children, adolescents and adults with CD4 ≤350 cells/mm^3.

In case of TB:

If diagnosed with TB, start TB treatment first, followed by ART as soon as possible and within 8 weeks.

If CD4 <50 cells/mm^3 initiate ART within 2 weeks after starting TB treatment, when the patient's symptoms are improving and TB treatment is tolerated.

If CD4 >50 cells/mm^3 initiate ART within 8 weeks after starting TB treatment.

In cases with Cryptococcal or TB meningitis defer ART initiation for 4-6 weeks.

Clinical monitoring for all patients

HIV testing services and clinical monitoring of patients will be done according to the SA clinical guidelines.

An addendum will be included in the revised National consolidated Adult ART guidelines for the Prevention of Mother-To-Child Transmission of HIV (PMTCT) and the Management of HIV in Children, Adolescents and Adults.

Differentiated Care for stable adult patients

In order for South Africa to realize implementation of UTT, there will be a need for all high volume facilities to free up space and human resources at facilities through implementation of differentiated care facillty decongestion strategies.

Differentiated care facility decongestion strategies provides benefits to adherent and stable chronic patients with a faster service and flexlbility to choose their preferred medication collection service (client-centered focus) through 3 options that are reflected in the adherence policy and service delivery guidelines, mainly:

1. Spaced and Fast Lane Appointment system (also known as ICDM);
2. Adherence Clubs (AC); and
3. Central Chronic Medication Dispensing and Distribution (CCMDD).

Resource Implications

There is a need to ensure procurement and proper management of medicines at all levels to avoid supply challenges.

Demand Creation

The National Department of Health, with support from the Communication Cluster is developing a strategy to inform the public, patients and service provides on the benefits of decongesting facilities. Provinces, Districts and District Support Partners should also mobilise communities for early HIV testing and treatment and existing HIV positive patients with CD4 > 500 cells/mm^3 to return to facilities for UTT.

Private Public Partnerships

There will be a need for District Implementing Partners to assist the Department of Health with facility readiness, training, mentorship, strengthen M&E systems and procurement of adherence implementation support tools to support UTT and differentiated care for stable adult patients.

Provinces are requested to indicate their readiness to implement and monitor progress on differentiated care facility decongestion strategies and Universal Test and Treat to the National Department of health (NDOH) on a monthly basis.

For any more information please contact: - **Dr Z Pinlni at 012 395 9157/9200 or 060 971 1040**

Thanking you in advance for your cooperation.

Kind regards,

Dr Y PILLAY **DR Y PILLAY** **DEPUTY DIRECTOR-GENERAL:** **HIV AND AIDS, TB AND MCWH** **DATE:** 23 August 2016	**DR A PILLAY** **DEPUTY DIRECTOR-GENERAL:** **HEALTH REGULATION AND COMPLIANCE MANAGEMENT** **DATE:** 31/08/2016