Earlier first viral load: what does the evidence tell us?

Lynne Wilkinson, IAS | Simplifying HIV service delivery: from evidence to national policy | Johannesburg, 27 October 2026

Three key messages

1

Earlier first VL makes sense

In the DTG era: most people are suppressed by month 3

2

Earlier first VL does not add VL tests

Same number of VLs – the first one just comes sooner

3

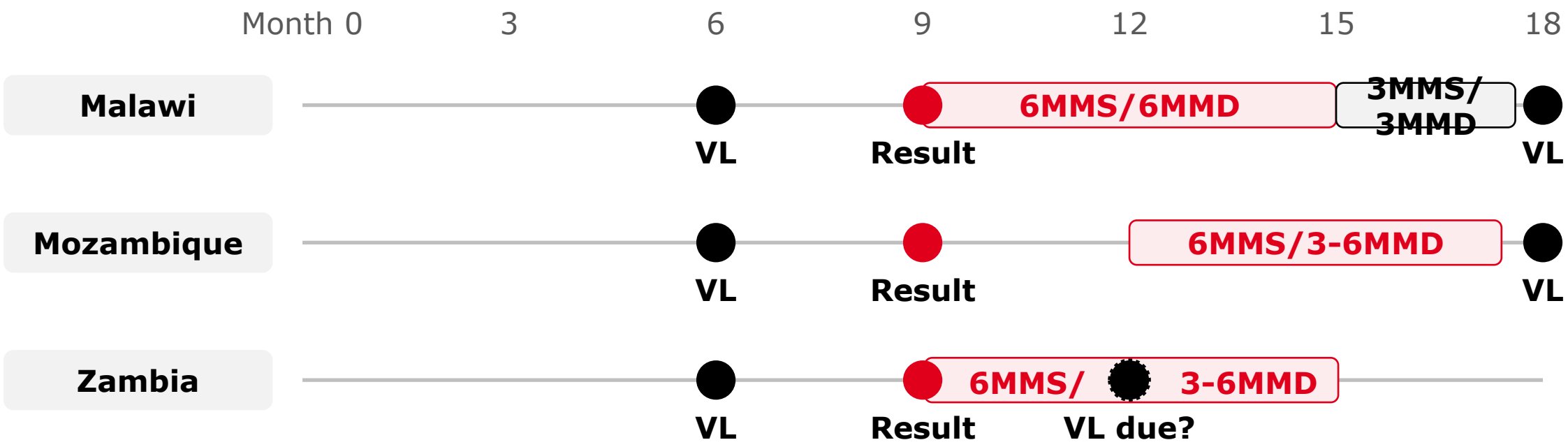
Earlier first VL enables earlier DSD

In line with WHO: 6 months on ART and one suppressed VL

Malawi, Mozambique and Zambia

Where we are

All three countries take the first viral load at month 6 – DSD can start from month 9–12



Zambia: the guideline does not say how the month-12 VL fits with 6MMD from month 9; in practice 6MMD reportedly starts once VL is suppressed.

Sources: country preparation reviews (2026); Malawi clinical HIV guidelines 2022, Figure 4 (6MMD to month 15, then 3MMD to the month-18 VL); Mozambique 2023 DSD circular (DSD at month 12); Zambia consolidated guidelines, Dec 2022 version, pp.59, 148 (DSD after ≥6 months on ART with VL <1,000; VL at months 6 and 12, then annually).

Eligibility for less frequent visits differs by country – not directly comparable

	What it offers	VL and time on ART	Other requirements
Malawi	6-month dispensing; 3 contacts a year	Suppressed VL in last 12 months; ≥6 months on ART	≥24 years (18–24 with a supporter); no TPT; not pregnant or breastfeeding
Mozambique	6-monthly clinical review; 3- or 6-month dispensing	VL <1,000; ≥6 months on ART; no WHO stage III/IV	≥5 years + ≥30 kg ; not pregnant or breastfeeding; TPT/CPT completed for 6MMD
Zambia	6-monthly clinical review; 6-month dispensing	VL <1,000 in last 12 months; ≥6 months on ART	≥2 years; no adverse drug reactions or current illness

Sources: Malawi clinical HIV guidelines 2022, p.104; Mozambique pocket guide and DSD guide 2023; Zambia consolidated guidelines 2022, p.148, and 2025 minimum package.

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Earlier viral load testing already happens in pregnancy and breastfeeding

	Viral load in pregnancy and breastfeeding
Malawi	First VL at month 6, then every 6 months
Mozambique	Month 3 after starting ART; then first antenatal visit, 36 weeks, 3 months postpartum, then 6-monthly
Zambia	Baseline VL at ART start, then every 3 months (first at month 3); VL within 4 weeks before delivery

The system already runs earlier viral load testing for some clients.

Sources: Malawi clinical HIV guidelines 2022, p.92; Mozambique pocket guide 2023 (algorithms 4 and 5); Zambia consolidated guidelines, Dec 2022 version, pp.57–58 (Figure 21).

Key message 1 · Why month 3?

Earlier first VL makes sense in the DTG era

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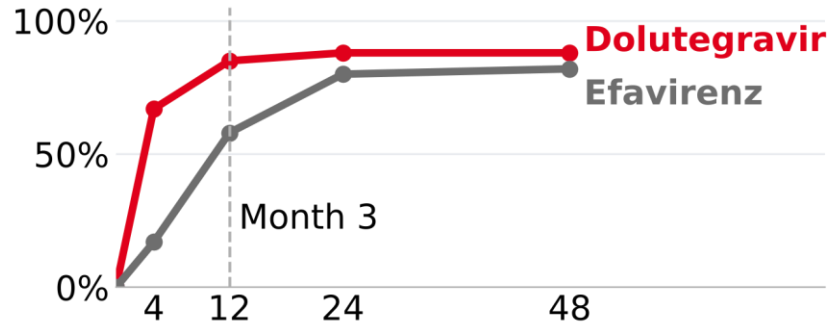
Because dolutegravir suppresses much faster than efavirenz

Median time to <50 copies/mL

28 days on dolutegravir

84 days on efavirenz

Viral suppression by week after starting ART

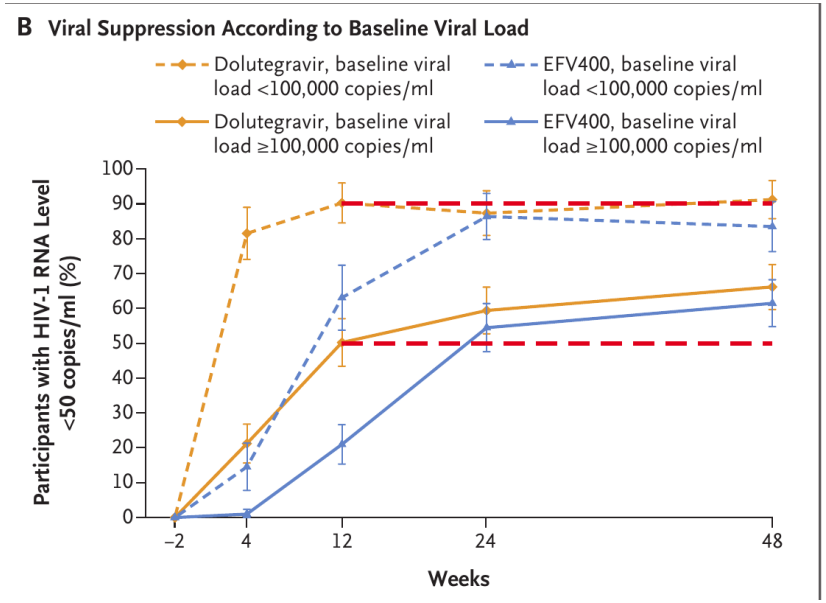


Viral suppression	Week 4	Week 12	Week 24	Week 48
Dolutegravir	≈67%	**≈85%**	≈88%	≈88%
Efavirenz	≈17%	≈58%	**≈80%**	≈82%

≈ values read from the modelled figure – not reported as numbers.

Sources: Kanters et al., EClinicalMedicine 2020;28:100573, Fig. 3 (p.6; network meta-analysis, 68 trials); median time to HIV-1 RNA <50 copies/mL from SINGLE (Walmsley et al., N Engl J Med 2013;369:1807–18).

Even with high baseline viral loads, dolutegravir at week 12 almost matched efavirenz at week 24



High suppression rates with dolutegravir at 12 weeks

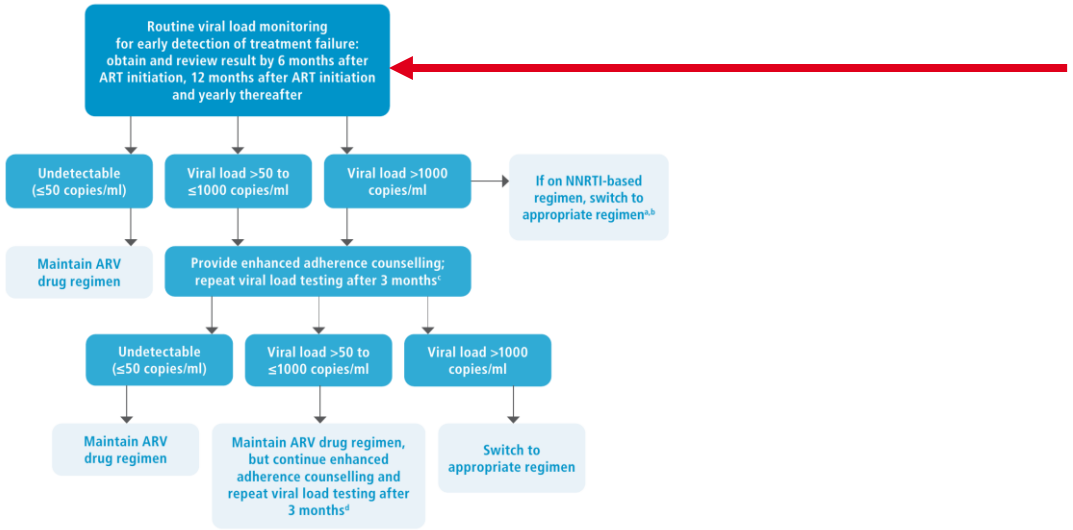
<50 copies/mL	Wk 4	Wk 12	Wk 24	Wk 48
DTG <100k	≈82%	**≈90%**	≈87%	91.3%
EFV <100k	≈14%	≈63%	**≈86%**	83.5%
DTG ≥100k	≈22%	**≈50%**	≈59%	66.2%
EFV ≥100k	≈1%	≈21%	**≈54%**	61.5%

Weeks 4–24: ≈ read from Fig. 2B – not reported as numbers (week 4 and 12 samples tested retrospectively). Week 48 as reported. DTG, dolutegravir; EFV, efavirenz 400.

Source: NAMSAL ANRS 12313 Study Group, N Engl J Med 2019;381:816–26, Fig. 2B (p.821) and Fig. 3 (p.822).

WHO 2021: obtain and review the result by month 6 – so the test must come before month 6

Fig. 4.2 Treatment monitoring algorithm updated in 2021



The change

Before 2021: take the first viral load test at month 6.

Since 2021: "obtain and review result by 6 months after ART initiation".

Why it matters: the test has to be taken before month 6 so that action, including DSD entry, can happen at month 6.

Source: WHO consolidated guidelines 2021, Fig. 4.2 (p.148) and pp.151–152 ("for many people… result delivery occur beyond that time period").

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WHO kept the timing flexible in 2021 to suit two different first-line regimens

2021

"Obtain and review result by 6 months after ART initiation" allowed timing by regimen.

Testing too early on efavirenz risked mistaking slow suppression for failure – and unnecessary switching.

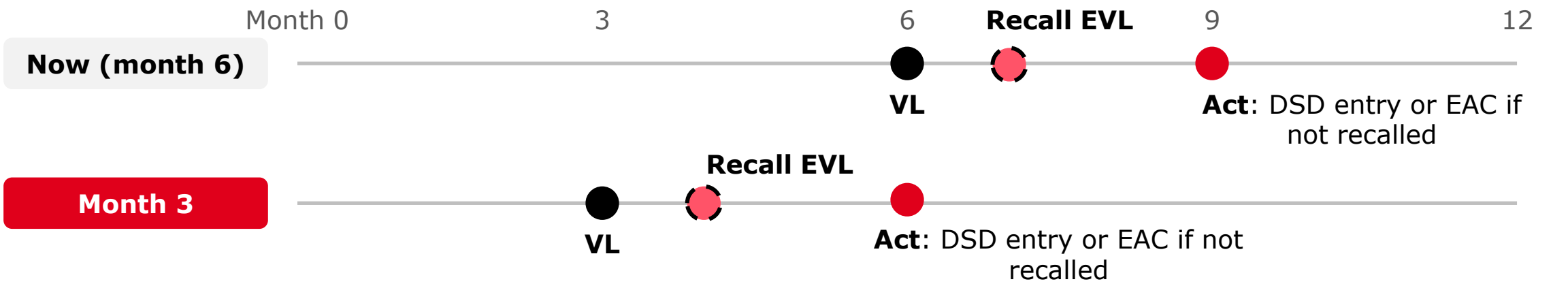
Now

97%

of adults on ART are on dolutegravir. An elevated VL leads to adherence support and a repeat test – not a switch.

Sources: WHO 2021 consolidated guidelines (pp.131, 151–152); CHAI HIV Market Report 2025, p.37 (generic-accessible LMICs, 2024).

The biggest gain: acting on an elevated viral load sooner – at the latest at month 6, not month 9



What does first-year disengagement look like in your country?

Zambia
33% → 47%
disengaged, M6 → M12

Malawi
17%
lost, months 0–6

South Africa
16% → 23%
disengaged, M6 → M12

Sources: Benade et al., BMJ Glob Health 2025;10:e017930 (159,429 adults starting or restarting ART, 543 facilities, 2018–23; >28 days late, no return); Tweya et al., PLoS One 2026;21:e0323983 (6,303 starting ART, 2 Lilongwe clinics, 2020–21; ≥60 days late); Maskew et al., PLOS Glob Public Health 2024;4:e0002956.

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Month 3 for everyone would also simplify VL timing

Earlier VL already happens for some groups – one 3-month time point, for the first VL and for follow-up after an elevated VL, is simpler for clinics, labs and monitoring.

Newly starting ART

Today: first VL at month 6 in Malawi, Mozambique and Zambia.

First VL at month 3

Returning to care

Restarting ART after an interruption.

First VL at month 3

Pregnant and breastfeeding

Already at month 3 in Mozambique and Zambia.

First VL at month 3

Elevated VL

After an elevated VL: adherence support, then a follow-up VL.

Follow-up VL 3 months later

Sources: country guidelines as on the earlier slides on current policy and on pregnancy and breastfeeding; WHO consolidated guidelines 2021 (follow-up VL after 3 months of adherence support).

Key message 1 · Country experience

What happened in countries that moved to month 3

Three countries have already moved to month 3 – and cut early visits

South Africa



First VL at about month 3 since April 2023.

Year-1 clinical visits: 8 → 5 (minimum)

DSD from the month-4 result review

Kenya



First VL at month 3 (2026 guidelines).

Suppressed at M3: no visits at months 4–5

DSD from month 6, once established on ART

Eswatini



First VL at month 3 since May 2024.

3MMD from month 3, not 6: no visits at months 4–5

DSD at month 12 after a 2nd suppressed VL at month 9

Dr Momanyi will share more about the Kenya experience next.

Sources: Rees et al., South Afr J HIV Med, in press, Table 1 (minimum clinical visits); Kenya NASCOP 2026, Table 1.26 note 2 (p.33) and pp.31–33; Eswatini 2024 amendment, pp.13, 22–23 (3MMD after a suppressed month-3 VL; previously after the month-6 VL).

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Earlier first VL, earlier DSD entry – and the same suppression (first 8 months of implementation)

66.5%

First VL completion

↑ from **58.9%**.

51.8%

First VL at month 3

↑ from **13.5%** (days 78–112).

186 days

Median time to DSD

↓ from **367**, from ART start.

85.5%

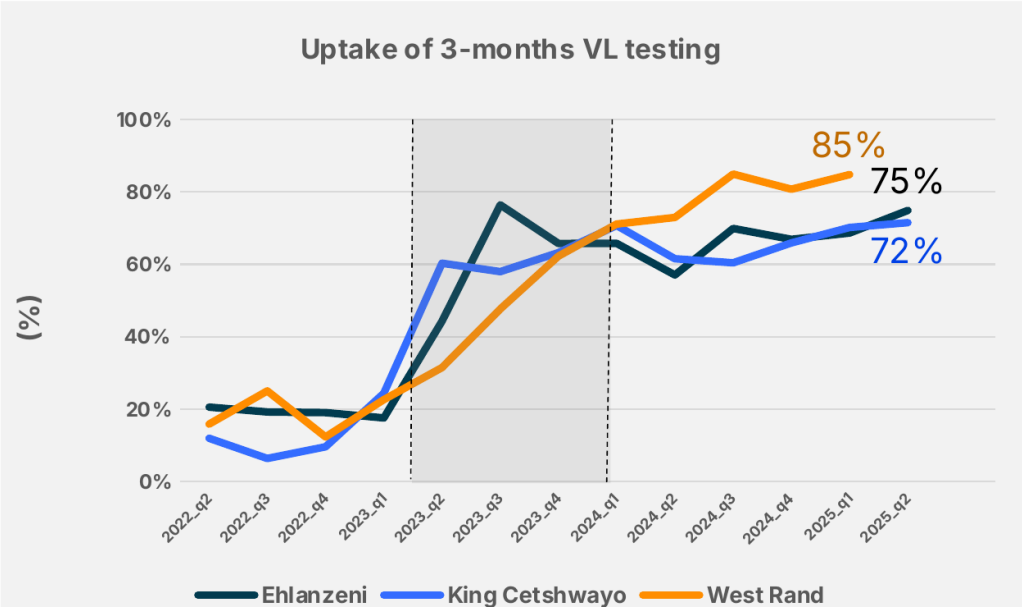
First VL <200

Unchanged:
84.9% before.

Timing and suppression among people with a first VL recorded.

Source: Rees et al., South Afr J HIV Med, in press (TIER.Net; Johannesburg, Sedibeng, Capricorn, Mopani; ART starts Jan 2022–Apr 2023, n=91,723, vs May–Dec 2023, n=39,084).

Month-3 testing was taken up quickly – with the same suppression and fewer visits



First viral load <50

72.2% **vs 71.7%**

month 3 vs month 6

Median clinic visits in year 1

8 → 7 → 6

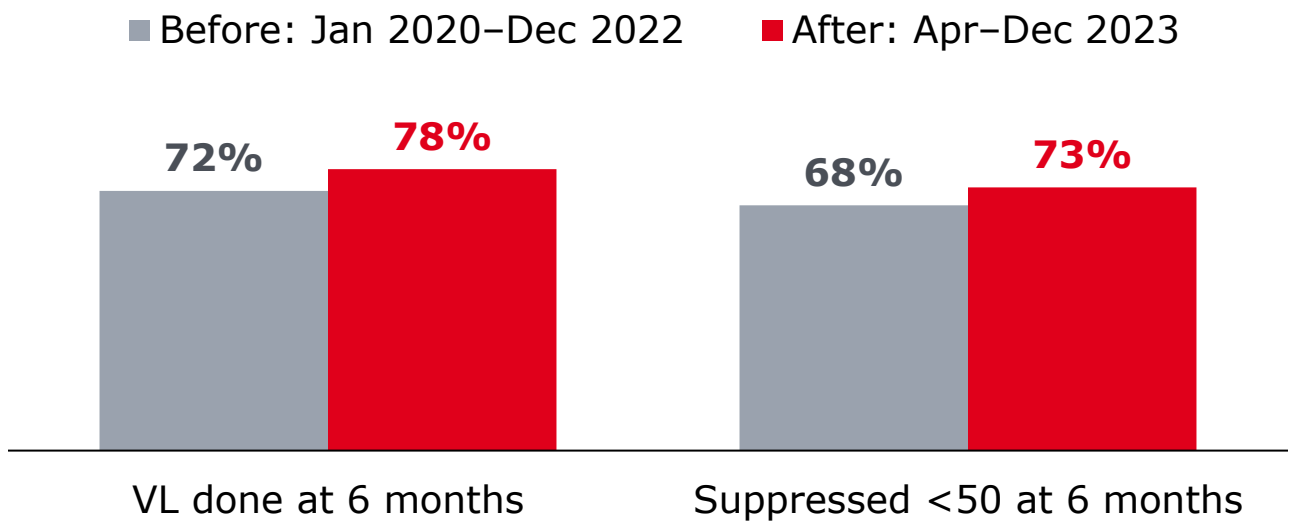
2022 → 2023 → 2024

Chart from the presentation.

Source: Kachingwe et al., AIDS 2026, presented at the Global DSD Research Collaborative, 28 Sept 2026 (RETAIN6; 16,338 adults, Ehlanzeni, King Cetshwayo, West Rand; 3,130/4,336 vs 3,466/4,831).

With earlier VL testing, coverage and suppression by month 6 increased

Looking before and after the guideline change



Pre–post programme data, not a controlled comparison. Periods read from the poster figure (third 'after' cohort labelled Jan–Mar 2023).

Source: Kgokolo et al., National Department of Health, AIDS 2024 (poster; averages as reported in the poster figure: VL done at 6 months 72% → 78%; suppressed <50 at 6 months 68% → 73%).

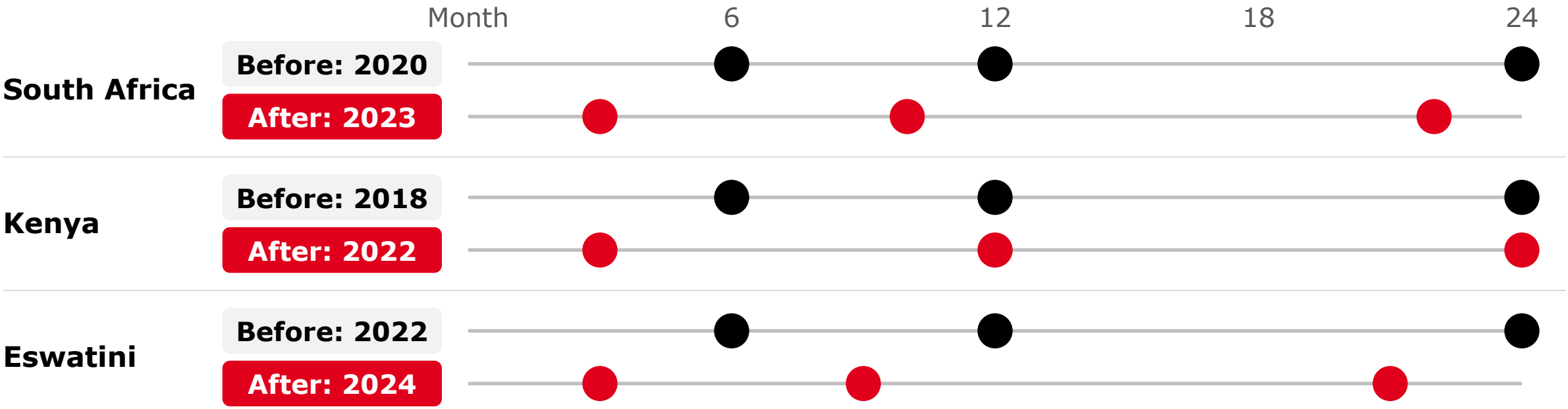
Key message 2

Earlier first VL does not add VL tests

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Moving the first VL to month 3 did not add tests – it is still three by month 24

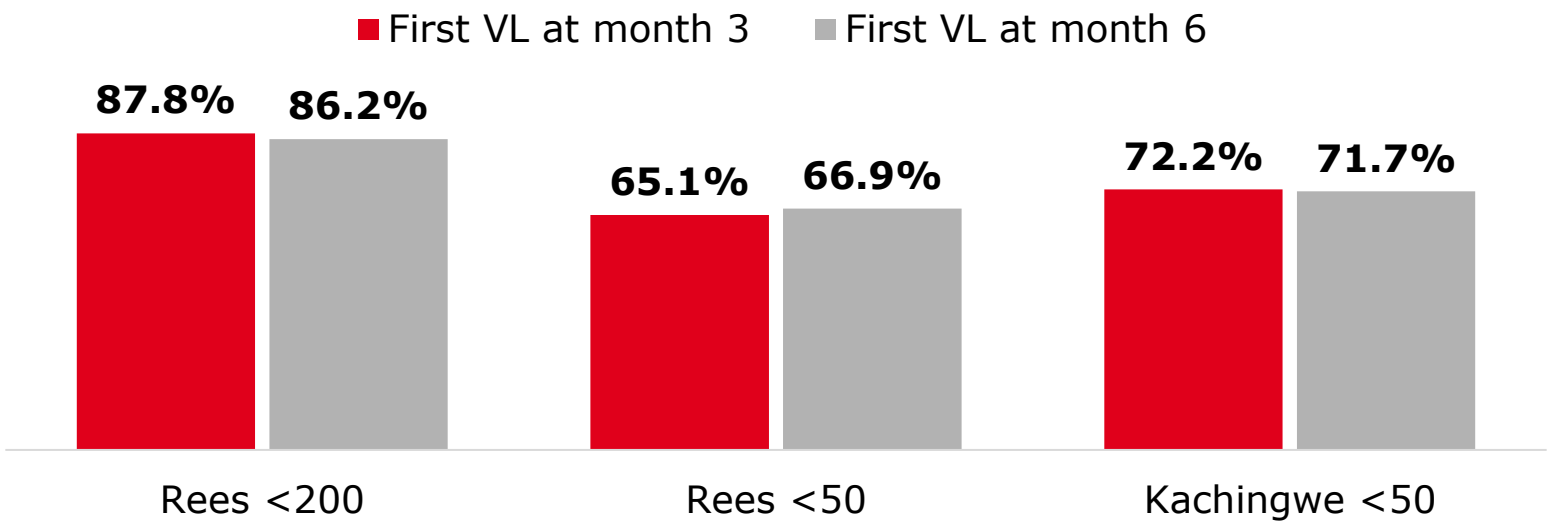
Each country moved the first VL from month 6 to month 3 – the total by month 24 did not change.



Schedules, not outcome data. Eswatini 2022: annual VL after month 12 assumed – to confirm.

Sources: South Africa – 2nd VL at month 12 after a month-6 VL, month 10–12 after month 3 (Kachingwe et al., GDRC 2026; Rees et al., Table 1); Kenya ARV guidelines 2018 and 2022 (adults ≥25); Eswatini 2024 amendment, p.13.

No additional follow-up tests: same suppression at month 3 as at month 6



Sources: Rees et al., South Afr J HIV Med, in press, Table S2 (May–Dec 2023); Kachingwe et al., AIDS 2026 (18 clinics).

Key message 3

Earlier first VL enables earlier DSD

In 2021, WHO changed DSD eligibility: from one year and two suppressed viral loads to six months and one VL

Before 2021

12 months on ART AND two suppressed viral loads.

2021

6 months on ART AND one suppressed viral load in the past 6 months.

Box 7.1 Criteria for determining whether a person is established on ART

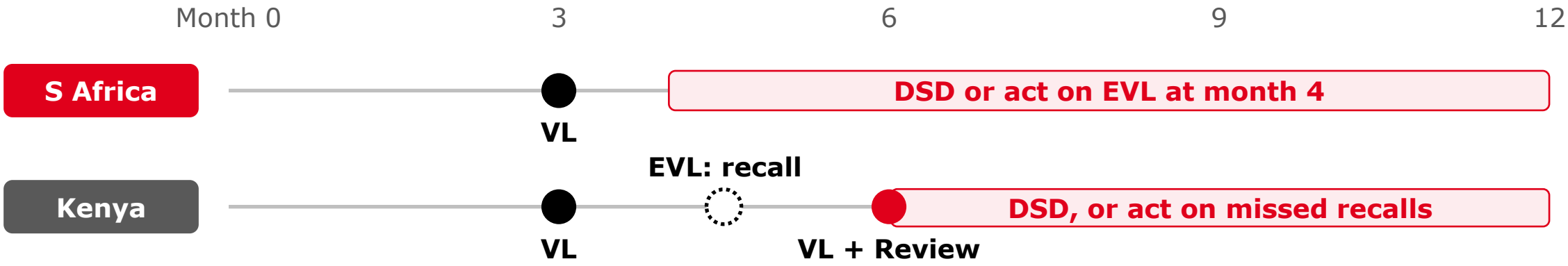
To support the implementation of these recommendations, WHO has developed criteria for determining whether a person has been successfully established on ART:

- receiving ART for at least six months;
- no current illness, which does not include well-controlled chronic health conditions;
- good understanding of lifelong adherence: adequate adherence counselling provided; and
- evidence of treatment success: at least one suppressed viral load result within the past six months (if viral load is not available: CD4 count >200 cells/mm^3 (CD4 count >350 cells/mm^3 for children 3-5 years old) or weight gain, absence of symptoms and concurrent infections).

Source: WHO 2021 consolidated guidelines, Box 7.1 (p.349).

What DSD entry needs is evidence of adherence – a suppressed viral load

WHO's 6 months on ART matched VL algorithm "result by 6 months" and covered both regimens. The suppressed result is the evidence – so action can come earlier.



Enrol at a month-4 review visit (South Africa), or at month 6 with no extra visit (Kenya).

Kenya prioritises elevated VL for tracing – no explicit result-recall step.

Sources: WHO 2021 (p.148; Box 7.1); South Africa 2023 ART guideline (Rees et al., Table 1); Kenya NASCOP 2026, Table 1.26 note 2 (p.33), Tables 1.23–1.24 (pp.30–33), p.66.

Earlier referral to community DSD was safe – but few eligible people were referred before M3 VL change

KwaZulu-Natal · 124 clinics · VL<50 at month 6

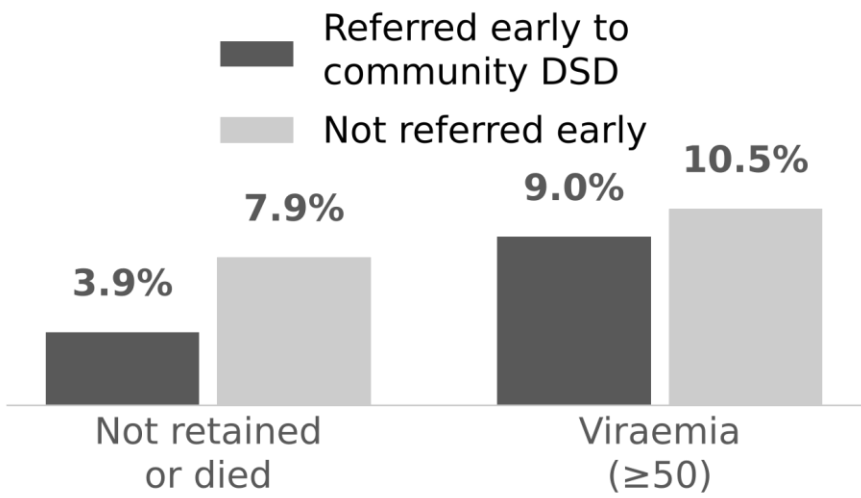
12%

of 27,855 eligible referred to community DSD within 9 months of starting ART

aRR 0.48

not retained or died at 12 months (referred early vs not)

Outcomes at 12 months



Adjusted for age, sex, CD4, district and regimen – but clinicians may still have referred people they expected to do well.

Source: van der Molen et al., JAIDS 2026;101:1108–13 (outcome cohort n=21,106, ART starts 2020–22; community DSD = ART collected at an external pickup point; viraemia RR 0.90, not significant).

Earlier less-intensive care was not linked to more treatment interruption

Zambia: 6MMD before 6 months on ART

6.5% vs 9.1%

treatment interruption by 18 months (early vs standard 6MMD)

6,142 clients, 12 facilities; adjusted OR 0.70 (0.51–0.97). Preprint.

Mozambique: 3MMD before 6 months on ART

aHR 0.63

attrition, adults on 3MMD vs monthly dispensing

7,378 starting ART 2018–21, southern Mozambique; adolescents and youth aHR 0.70.

Both observational. Kachingwe is not yet peer-reviewed; in Mozambique early enrollers benefited less than established enrollers.

Sources: Kachingwe et al., medRxiv 2026.07.30.26358576 (target trial emulation); Saura-Lázaro et al., AIDS 2024;38:1402–11 (retrospective cohort).

Moving the test is the easy part – three things must follow

1

Complete month-3 VLs

SA: completion rose – but 33.5% of new starters still had no first VL recorded.

2

Act on elevated VLs

Recall and adherence support for every elevated VL result.

3

Enrol in DSD fast

SA: only 33.5% of those suppressed (<50) were in DSD within 6 months.

Missing results may include silent transfers.

Source: Rees et al., South Afr J HIV Med, in press, Table 2 (ART starts May–Dec 2023).

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In summary – three key messages

1

Earlier first VL makes sense

On dolutegravir, a month-3 result tells us what month 6 did on efavirenz – and elevated VLs are acted on by month 6, not month 9.

2

Earlier first VL does not add VL tests

South Africa, Kenya and Eswatini still do three VLs by month 24 – and suppression is the same at month 3 as at month 6.

3

Earlier first VL enables earlier DSD

WHO: 6 months on ART and one suppressed VL. With a month-3 result, people can enter DSD at month 6 – with no sign of harm.

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For questions and discussion

Additional slides

Available to address these country concerns:

- More trial evidence of dolutegravir suppression at month 3
- Managing early elevated viral loads:
  - Can we respond? Recall capacity before the next scheduled visit
  - More switching or unnecessary early switching (including genotyping constraints)
- Which viral load threshold for DSD entry and exit?

Up next: Kenya experience

Up next | Kenya experience (Lazarus, MoH Kenya), 09:10–09:30 | Then: country table work, 09:30–10:20

Annex · for questions and discussion

Additional slides

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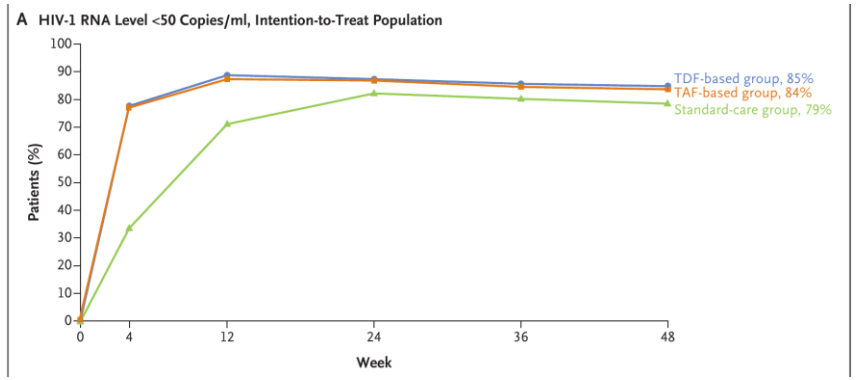
Country concerns about moving to an earlier first viral load – and where the evidence sits

Concern raised	What the evidence shows	Slides
Does dolutegravir suppress by month 3?	Yes – most by week 12 (M3), as efavirenz by week 24 (M6), incl. NAMSAL and ADVANCE	8–9, 34–37
Capacity to respond; recall and genotyping constraints	If recall fails, the result is still acted on at month 6, not month 9; it needs adherence support, not genotyping	12, 40–44
Unnecessary – and more – switching to second line	Early elevated VLs are rarely resistance; no country switches dolutegravir on results alone	39–44
Extra tests and costs	Same number of tests; same suppression, so no extra repeat tests	20–21

Annex

More evidence of dolutegravir suppression

ADVANCE, Johannesburg: TLD suppressed faster than TLE – similar by week 24



Week 4, <1,000 (table: <50)

97% vs 90%

Week 48, <50 (intention to treat)

84.9% vs 78.6%

Week 48, TLD: ≤100,000 vs >100,000

83.9% vs 88.7%

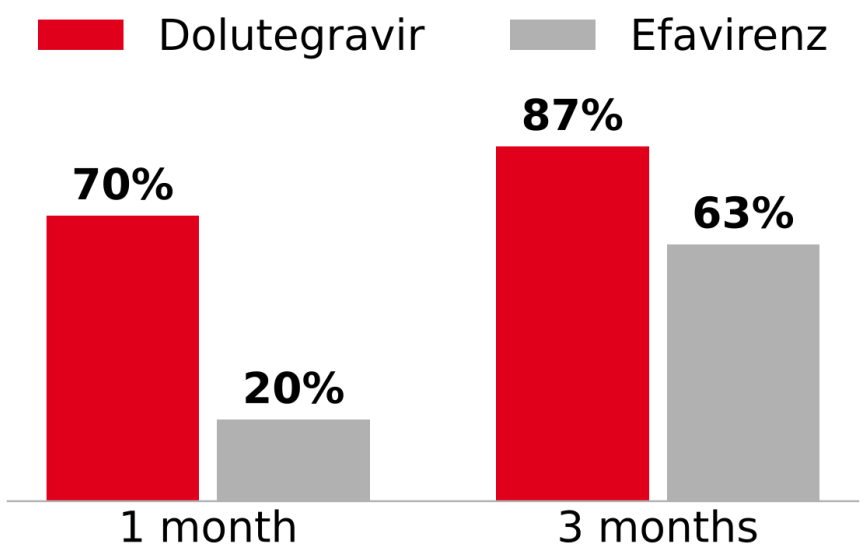
<50 copies/mL	Wk 4	Wk 12	Wk 24	Wk 48	≤100k*	>100k*
TLD	≈78%	**≈89%**	≈88%	84.9%	83.9%	88.7%
TLE	≈33%	≈71%	**≈82%**	78.6%	77.5%	82.5%

*Week 48 by baseline VL. Weeks 4–24 ≈ read from Fig. 1A. Week 4 <1,000 is a different threshold. Only 20% started >100,000 (NAMSAL 66%).

Source: Venter et al., N Engl J Med 2019;381:803–15 (n=351/arm), Fig. 1A, Table S14 (298/351 vs 276/351), Fig. 2 (TLD 235/280, 63/71; TLE 210/271, 66/80).

WHO's pooled data: 87% on dolutegravir suppressed by month 3

Suppressed <50 copies/mL



Source: WHO consolidated guidelines 2021, p.151 (narrative text citing a pooled analysis, ref. 173).

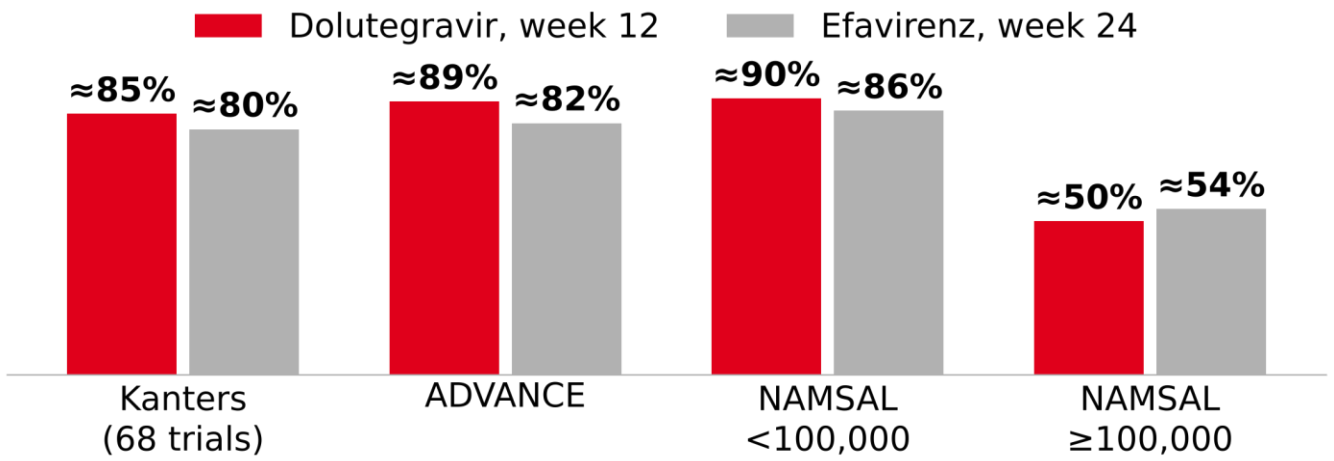
In the WHO 2021 text

From a pooled analysis of six studies in non-pregnant adults (narrative, p.151).

Month 6: WHO says only "few differences" – the analysis is unpublished, so there is no month-6 figure.

Dolutegravir at month 3 ≈ efavirenz at month 6 in every trial

Suppressed <50 copies/mL: dolutegravir at week 12 vs efavirenz at week 24

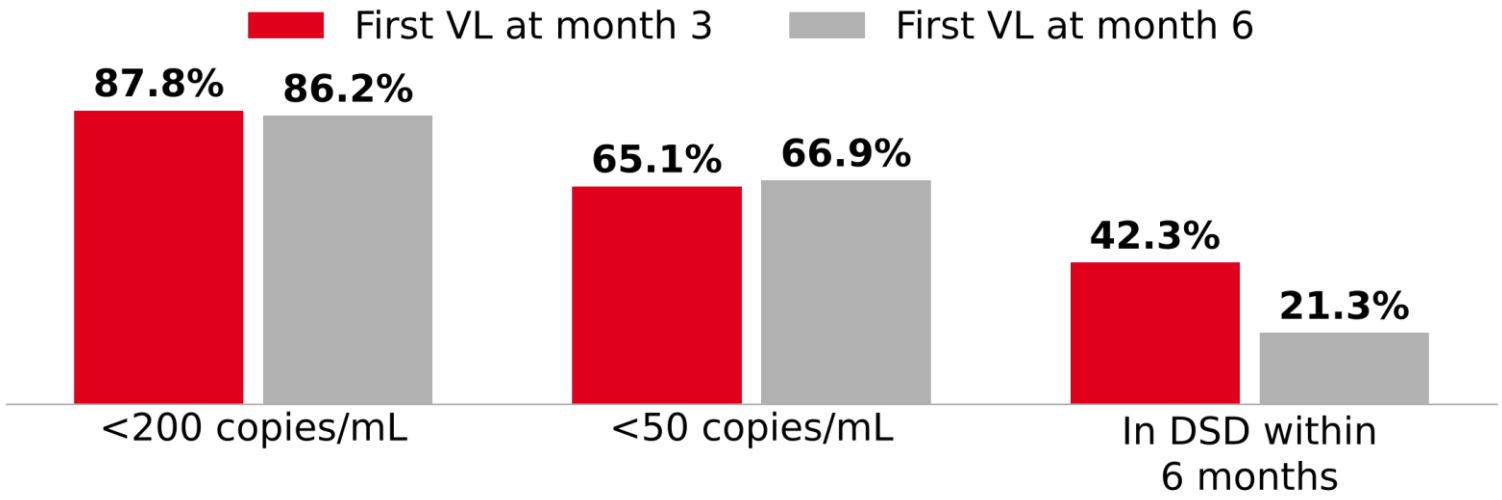


A month-3 result on dolutegravir tells us what a month-6 result on efavirenz did.

All ≈ read from the published figures – the papers do not report these time points as numbers.

Sources: Kanters et al. 2020, Fig. 3 (modelled); Venter et al. (ADVANCE) 2019, Fig. 1A (intention to treat); NAMSAL 2019, Fig. 2B.

A month-3 first viral load meant the same suppression – and DSD three months sooner



Median days from ART start to DSD: 162 (month 3) vs 252 (month 6).

Observational. Month 3 = days 78–112; month 6 = days 162–196.

Source: Rees et al., South Afr J HIV Med, in press, Supplementary Table S2 (13,462 vs 3,704 people, May–Dec 2023).

Annex

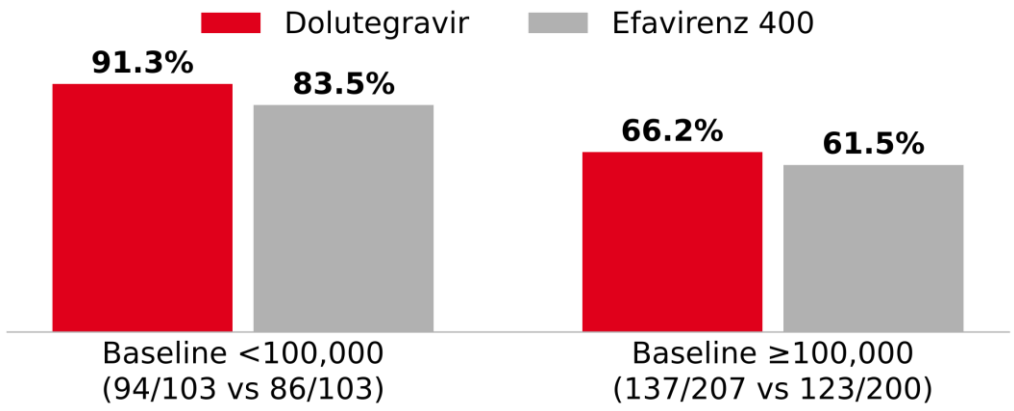
Elevated viral loads and switching

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Concern · not yet suppressed

A high viral load at initiation takes longer to suppress – even a repeat at month 6 may be too soon to switch

NAMSAL, <50 at week 48 (intention to treat)



Other trials by baseline VL

- ADVANCE (TLD, week 48):
- 83.9% if ≤100,000 vs 88.7% if >100,000 – no lower response.
- SINGLE: the dolutegravir advantage was the same above and below 100,000.
- Network meta-analysis: >100,000 subgroup similar to all trials at week 48.

Not yet suppressed at month 3 or month 6 is not treatment failure.

Only NAMSAL had many with high baseline VL (66%; ADVANCE 20%).

Sources: NAMSAL, N Engl J Med 2019;381:816–26, Fig. 3; ADVANCE, N Engl J Med 2019;381:803–15, Fig. 2 (235/280 vs 63/71); SINGLE, N Engl J Med 2013;369:1807–18; Kanters et al., EClinicalMedicine 2020;28:100573.

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Concern · unnecessary switching

An elevated month-3 result has three possible causes – each has a clear response

1. Not yet suppressed

Slow decline, often a high starting viral load.

Repeat after 3 months: it will be suppressed. No switch.

2. Adherence challenges

Identified early at month 3 (not month 6 or later).

Earlier adherence support – a gain, not a harm.

3. Resistance

Rare in treatment-naive starters on dolutegravir: 0 of 21 in DTG RESIST; 0 of 3 in NAMSAL.

Still elevated: see options 1 and 2.

Only a problem if more people are "not yet suppressed" at month 3.
But suppression is the same: 87.8% <200 at month 3 vs 86.2% at month 6.

All 59 with major integrase mutations in DTG RESIST were treatment-experienced.

Sources: Loosli et al. (DTG RESIST), Clin Infect Dis 2025;81:e128–31; NAMSAL, N Engl J Med 2019, p.823; ADVANCE, N Engl J Med 2019, p.808 (no integrase resistance); Rees et al., in press, Table S2.

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The balance

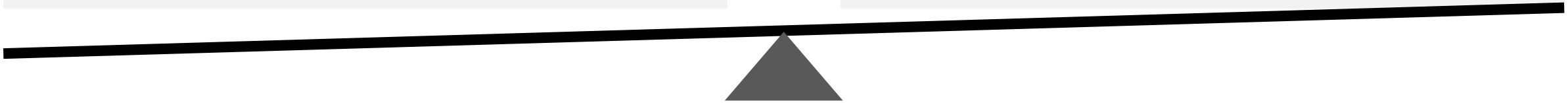
Gains for everyone – and a concern about a small group

Gains – for everyone

- Adherence problems seen at month 3 – support from month 4–6, not month 7–9.
- Reaches more people before they disengage.
- Suppressed majority enter DSD 3–6 months sooner.

Concern – a small group

- A small % still elevated at 2nd month 6 VL.
- Resistance is rare without prior ART.
- Can be managed without unnecessary switching or requiring genotyping.



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After two elevated viral loads

On dolutegravir, no country recommends switching on two elevated VL results alone

	Time on ART	Before switching off DTG	Separate path?
Kenya	Not stated	Resistance test; regional TWG	No
Malawi	Not stated	Genotyping to confirm resistance	No
Mozambique	Not stated	Committee (not if poor adherence)	No
South Africa	≥9 months on DTG	Treatment-naive: no resistance test or switch; repeat VL in 6 months	Yes: experienced vs naive
Zambia	≥6 months	Genotype after EAC	No

Zambia: genotype only if adherent ≥30 days. Malawi and Mozambique use regimen history to choose second line.

Sources: SA national consolidated guidelines 2026, pp.xiv, 37, 100–101 (Fig 15); Kenya ART guidelines 2026, Fig 1.22 (p.114); Malawi clinical HIV guidelines 2022, p.62; Zambia consolidated guidelines 2022, p.67; Mozambique ART training package 2025, UD7 pp.51, 54; UD3 p.31.

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Responding to elevated VLs at months 3 and 6

Option 1: one more viral load at month 9 before switch considered

Month 3

VL ≥1,000: recall and adherence support.

Month 6

Repeat VL.

Recall missed? Start support now and take the VL.

Month 9

Still ≥1,000 at month 6: repeat VL.

Then

Still ≥1,000: committee decision – or genotyping where available.

Only for the few with an elevated VL – most people are suppressed and move on to DSD → Decision still at month 9, as it is now.

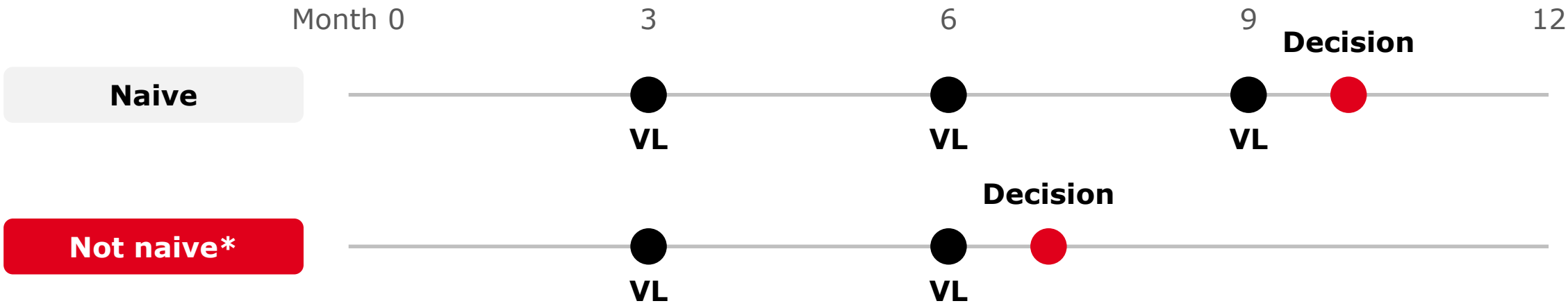
SA: failure on DTG = ≥2 VLs ≥1,000 after ≥9 months on DTG. WHO: ≥6 months on ART before failure can be determined.

Sources: NAMSAL, N Engl J Med 2019;381:816–26, Fig. 3; SA national consolidated guidelines 2026, p.xiv; WHO consolidated guidelines 2021, Table 4.11.

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Responding to elevated VLs at months 3 and 6

Option 2: three elevated VLs before referral if treatment-naive – two for everyone else



*Re-engaging, earlier ART/PMTCT/PrEP, pregnant or breastfeeding: no 9-month rule.

Only for the small % with elevated VLs – everyone suppressed moves on to DSD.

DTG RESIST: all 59 with major integrase mutations were treatment-experienced. SA: classify as TLD2 if earlier ART exposure is suspected. Mozambique: pregnant women go to committee after 2 elevated VLs from month 3.

Sources: Loosli et al. (DTG RESIST), Clin Infect Dis 2025;81:e128–31; SA national consolidated guidelines 2026, p.37; Mozambique ART training package 2025, UD7 pp.58–59.

Annex

Viral load thresholds for DSD entry

Entry and exit thresholds for DSD differ by country

	Entry to DSD (suppressed)	Exit from DSD (elevated)
Kenya	<200 in last 6 months (and ≥6 months on ART)	≥200: not established, with 1–3-monthly visits
Malawi	Suppressed: plasma <200; DBS undetectable only	Any low-level viraemia (plasma 200–999; DBS detectable) or ≥1,000: back to clinic care
Mozambique	<1,000	≥1,000 (50–999 managed as suppressed)
South Africa	<50	Only ≥1,000; at 50–999 stay in model, repeat at 3 months
Zambia	<1,000 in last 12 months	>1,000: "high risk (unstable)" – models for unstable clients

Sources: IAS LLV briefing (Malawi 2022, Mozambique 2023, SA 2026); Kenya NASCOP 2026, Tables 1.24, 1.25, 1.69; Malawi clinical HIV guidelines 2022, Table 20 (p.92) and p.103; Zambia consolidated guidelines 2022, p.148.

The threshold decides who is eligible

In South Africa, 65% at <50, 92% at <1,000

First viral loads, four South African districts, 2023 (n=40,877)



Each country needs to look at its own data before choosing a threshold.

Source: Rees et al., South Afr J HIV Med, in press, Table 3.

Before changing the threshold: who does it include, and what do we do now

Far more sit below 1,000 than above

South Africa, first viral loads: 14.2% at 200 or above; 7.6% at 1,000 or above.

Malawi, established clients: 17.5% at 200–999; 3.3% at 1,000 or above.

Weak action when elevated VL >1,000

Repeat test after an elevated VL: 31–35% in three studies (Mozambique, Zambia, South Africa).

Community ART, KwaZulu-Natal: 5.6% of results ≥1,000 had a repeat within 16 weeks.

Sources: Rees et al., in press (n=40,877); Songo et al., PLOS GPH 2023 (97/553 and 18/553); Kippen et al., BMC Public Health 2024 (Swannet 34%, Warrier 35%, Iwuji 31%); Dorward et al., PLOS GPH 2026.

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What the evidence supports – for discussion

Decision	The evidence	Data source
First VL at month 3	DTG at month 3 ≈ EFV at month 6; same suppression and tests where countries moved	Trials; WHO; SA data
Act on elevated VL	Adherence support at recall (month 3–4), before people disengage	SA schedule; SA cohort data
DSD entry	At the month-4 review (SA) or month 6 (Kenya) – no harm seen with earlier DSD	Observational (SA, Zambia, Mozambique)
Elevated VLs	Options to mitigate: ≥9 months on ART + one more VL at month 9; or 2 elevated VLs enough if not treatment-naive	Trials; country guidelines
Threshold	A threshold below 1,000 excludes more people – look at your own data first	Programme data

Evidence on the preceding slides. "Evidence" describes the type of data, not a formal grading.