



BRIDGE Retention Toolkit: Design, implementation, and responses to the tools

In 2026, the Retain6 Project piloted a set of tools designed to improve HIV treatment client outcomes during the early treatment period (first six months after ART initiation or re-initiation). Based on Retain6's earlier findings, the BRIDGE Retention Toolkit focused on gaps in treatment literacy, lack of understanding of the treatment experience, and social support for clients and on guideline awareness and compliance support for providers. It was developed through a participatory process involving healthcare providers, ART clients, NDOH officials, and other experts on HIV treatment delivery. For practical purposes, we focused on tools that we believed could be implemented at very little additional budgetary cost to providers or clients and that would require minimal additional time beyond what is currently required to provide or receive HIV treatment. The Toolkit included five specific tools:

- HIV Treatment Client Roadmap
- HIV Treatment Intervention Navigator
- Client Tracing Job Aids
- Guideline Job Aid
- WhatsApp AI Health Coach (developed by PSI)

The pilot took place over an 11-week period between March and June 2026 at six primary health clinics, four in Gauteng Province (West Rand District) and two in KwaZulu-Natal Province (King Cetshwayo District). The study team provided brief startup and refresher trainings to facility staff, who were then responsible for utilizing the tools in routine service delivery. After the pilot, we conducted a qualitative evaluation of the intervention addressing implementation fidelity, consistency of use, resource requirements, acceptability to providers and clients, and client satisfaction with their experience. For the evaluation, we interviewed healthcare providers who used the tools and clients who were exposed to them.

In the pages that follow, we describe each of the BRIDGE tools, how it was developed and used, and provider and client responses to it. Further details about the BRIDGE Retention Toolkit can be found at <https://verixiv.org/articles/3-133/v2> (protocol manuscript), and pdfs of the tools themselves are posted at <https://sites.bu.edu/ambit/retain6-resources/>. We encourage those interested in using or adapting the tools for their own programs to contact Dr. Mhairi Maskew at mmaskew@heroza.org.

HIV Treatment Client Roadmap: “Your Journey to Health”

“You see, the road has a little car on it. So me, I’m that car. I’m following that road. It shows me step 1, 2, 3, and 4. And I see those people in the little boxes. Because I want to be like them. I want to be healthy.”

What is it?

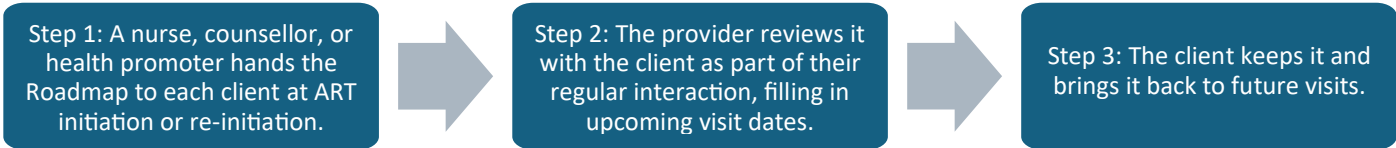
The **HIV Treatment Client Roadmap** is a client-facing visual guide to the first 12 months of HIV treatment, developed as part of the Retain6 Retention Toolkit. It translates the South African 2023 ART guideline visit schedule into a simple, personal journey that clients keep and refer to throughout their first year on treatment. It is designed to cost facilities nothing beyond printing, to take little or no extra time during clinic visits, and to be flexible to meet future facility, provider, and client needs.



Why it matters

Our earlier research demonstrated that many clients starting ART do not fully understand the treatment pathway ahead, leading to misunderstanding, discouragement, and potentially disengagement. The Roadmap addresses this directly by giving every client a clear, plain-language map of what to expect and when. It also helps providers explain the milestones ahead.

How it is used



A poster of the Roadmap can also be placed in the waiting area or consultation rooms. The Roadmap was designed to require little extra clinical time, beyond the counselling that already takes place, and no new staff roles.

What it contains

Section of the roadmap	What it covers	Intended purpose
First visit (starting treatment) to 12 months	A month-by-month timeline of the five key visits in the first year, each with a checklist of what happens at each visit	Sets clear, concrete expectations so clients know what is coming and when
In-clinic care and self-care	What happens if your viral load is not yet suppressed, alongside simple self-care guidance and information	Keeps clients engaged and supported even if they are “not yet stable” in care
Barriers and concerns	Common reasons clients miss visits and available options to help avoid this	Normalizes common barriers and gives clients language to ask providers for support
Glossary and personal information	Plain-language glossary of common treatment terms plus a fill-in box for the client's own clinic and provider details.	Builds treatment literacy and makes the tool a personal, ongoing reference

Availability

The Roadmap is available in English, isiZulu, Sesotho, Setswana and isiXhosa, all commonly spoken local languages. Facilities can utilize whichever language(s) match their client population; more languages will be added on request. It is currently a paper tool (A4 paper size tri-fold pamphlet, colour printing); a digital version for client download or online use is being developed. [Download the current English version of the Roadmap.](#)

How it was developed

The Roadmap was designed through a co-design process with the Department of Health, HIV care providers, and recipients of care through focus group discussions, group interviews, and meetings with experts. Development began with an illustration of the visit steps set out in the national guidelines, which was then refined through input from the stakeholders. This iterative process produced the current tri-fold format: a map illustration of the treatment journey on one side and user-friendly reference information (barriers, options, terminology, clinic details) on the other. The Roadmap will continue to be refined based on staff and client feedback gathered and as HIV treatment guidelines change, and users are welcome to modify it on their own, as needed.

Implementation challenges and ideas for solving them

The Roadmap was introduced and tested for a period of 11 weeks at six primary healthcare facilities in Gauteng and KwaZulu-Natal provinces. During this period, several challenges in using the Roadmap arose.

Staffing constraints: Shortages of key clinical staff led to periods where the Roadmap was not used. Although it is intended not to require any additional staff time, providers often thought it would, and when short-handed, they chose not to use it. **Better orientation for providers, direct client access to the Roadmap, so that clients can remind providers about it, and having counsellors and lay staff distribute the Roadmap** may help to solve this problem.

Training coverage: Training gaps also created obstacles. Although several training sessions were held at the facilities, not all staff members at every facility could participate. Limited communication between trained and untrained staff meant some providers didn't know what to do with the Roadmap or what resources or support were available while using it. **More training sessions on different days and at different times of the day and monitoring who is trained to ensure that all staff are exposed to the Roadmap** may help to solve this problem.

Language availability: Language barriers remained difficult to solve, especially in areas with migrant populations where clients did not understand any of the languages into which the Roadmap is currently translated. **Translation into common languages from neighboring countries** and making these languages available online is likely to solve this problem.

Sustaining routine use: Enthusiasm for using the Roadmap declined over time, with some staff who were initially very motivated to make routine use of Roadmap becoming less willing to utilize it at some facilities. **Incorporating the Roadmap into guidelines, training, and routine care procedures and offering it directly to clients, who can then ask providers for guidance on it,** may help to solve this problem.

Early responses to the Roadmap

Providers and clients who were exposed to the Roadmap were interviewed to learn about their perspectives on it. We talked to 29 providers and 62 clients.

What did providers say?

<p>How was it used?</p>	<ul style="list-style-type: none"> At most sites, providers reported using the Roadmap frequently in their day-to-day work with new initiators and re-initiators. How? <ul style="list-style-type: none"> During clinical appointments: Many providers reported reviewing the Roadmap with clients during counselling/consultations. At home: Providers sent clients home with a printed copy of the Roadmap to review in their own time (as intended by study team). 	<p><i>"They go through it by themselves even at home... This thing gives them a lot of support to be serious about taking their treatment." – Gauteng Province, HTS Counsellor</i></p> <p><i>"Even the defaulters need to be educated as well... they need to know about their journey because we start fresh."- KZN Province, Outreach Team Lead</i></p>
<p>Was it acceptable?</p>	<ul style="list-style-type: none"> Providers found the content of the Roadmap acceptable and felt comfortable using it with their clients; the milestones shown in the Roadmap align with recommendations from the standard NDoH treatment guidelines. Providers believe that the Roadmap will offer clients a clearer picture about the treatment journey ahead, set clear expectations and answer questions that clients often have, and give clients agency in knowing what to expect in upcoming appointments, which may improve treatment outcomes and help them stay on track. Providers described it as being motivational, addressing existing needs, and fitting naturally alongside existing counselling practices. 	<p><i>"When they start treatment, there are many questions like, "Sister, what am I going to do next?" But due to this Journey to Health, it's easy for the patient to know what's next... they already know what's going to be done." – KZN Province, Professional Nurse</i></p> <p><i>"We encourage patients to follow all those steps so that [they] get motivated about where [they are] going with the treatment and then we emphasize that there are greener pastures..."- Gauteng Province, Community Health Worker</i></p> <p><i>"When they get to know that, 'I'm going to get two months,' they look at that to see how many months you will give them. If you rob them, they tell you, 'No, I'm expecting this.'" - KZN Province, Outreach Team Lead</i></p>

What did clients say?

Among clients interviewed, roughly two-thirds could recall using the Roadmap. Some remembered but had not been given a copy to take home. Others remembered features of the Roadmap (colours, road signs) but could not recall or discuss content.

<p>What clients thought of the roadmap</p>	<ul style="list-style-type: none"> Overall acceptability was high: clients found the Roadmap easy to use and informative The Roadmap metaphor was easy to use and resonated with readers. Clients also found it motivating: it helped knowing what to expect throughout the treatment journey and was encouraging to know when and how they can become eligible for less intensive care. Several clients reported reviewing the Roadmap at home after being given a printed copy. Interview respondents recommended that the Roadmap be given to all clients and should be translated into more local/regional languages to overcome barriers to use. 	<p><i>"It's not confusing at all... I wrote my next appointment date when I have to go to the clinic and I can see it. It's easy for me... Even if you are afraid and you don't understand why you have to go to the clinic, you will find information here... It helps me to remember. If I have a problem, I take my paper and look at it." – Gauteng Province</i></p> <p><i>"The Roadmap said that every month, I should go to the clinic to fetch my medication. Then after three months, they take my blood to check viral load. Yes, then if I continue taking my pills at the right time, then they shift me to fetch medication for three months, they give me three months' supply. Then if I continue taking them well, step number four I'll fetch</i></p>
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medication for six months... Before I used to go to the clinic to fetch medication, but there was a problem that I didn't understand why I was going there.” – Gauteng Province

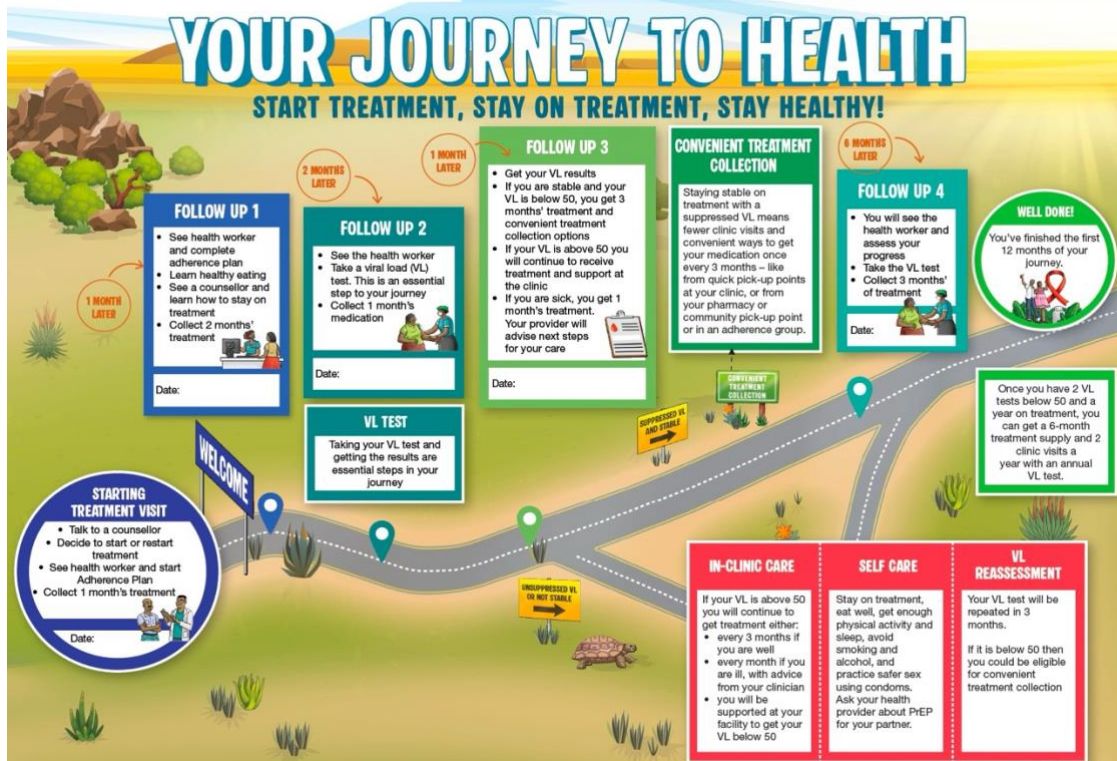
Next steps

The Client Roadmap offers a low-touch opportunity to turn national treatment guidelines and policy recommendations into an easy-to-access, client-facing format with the potential to support treatment adherence and progress towards success on their care journey. Key next steps will include identifying the pathway to scale—how best to get this tool directly into client hands across diverse settings and contexts. For example:

- Embedding the Roadmap within existing clinical services, such as initiation counselling and scheduled follow-up visits, could help broaden client access to this tool without adding extra load to health providers.
- Exploring digital and mobile device options, including adding the Roadmap to existing apps, may also offer solutions for hard to reach populations or those with limited access to routine health services.
- Providing copies to outreach, lay, and community health workers may prevent any extra burden for facilities while still putting the Roadmap in clients’ hands.
- Creating new Roadmaps tailored to specific populations, both for HIV and other conditions; these might include versions for pregnant women, older people, NCDs, and mental health.

For more information or to request access to the Roadmap and supporting materials, please contact Dr. Mhairi Maskew, mmaskew@heroza.org.





Staying on your treatment journey can be challenging sometimes...



Ask about these options to help:



- ✓ Fast track queues
- ✓ Rescheduling your visit to a more convenient day
- ✓ Getting several month's medication at a time
- ✓ More convenient medication pick up points
- ✓ Combining visits for family planning, TB, hypertension, diabetes or asthma.
- ✓ Make sure your family members are in the same service delivery model.

If you feel alone or scared, a treatment buddy or counselor can support you and help share your status with others.



If you are pregnant or breastfeeding, stay on treatment and test your baby regularly until 18 months or until breastfeeding stops. Talk to your health provider about pregnancy and baby care. You'll get three months of treatment at a time, with visits aligned to your baby's immunization schedule.

What if I can't attend my clinic visit?



My treatment journey visit plan:

Date	Notes

THE FIRST YEAR OF YOUR CARE JOURNEY

WHAT TO EXPECT

Congratulations on starting your treatment and taking the first step in your Care Journey! This guide will help you understand what to expect during your first year of treatment. If you have any questions or need more details, please talk to your provider.



TERMS TO KNOW

HEALTH PROVIDERS – Doctors, nurses, counsellors, and community health workers who support your care.

CD4 COUNT – A measure of your immune system's strength. Higher is better. The goal is above 200 cells/mm³.

VIRAL LOAD (VL) – The amount of HIV in your blood. Lower is better. The goal is lower than 50 copies/mL. This is called a suppressed viral load.

UNDETECTABLE = UNTRANSMISSIBLE (U=U) – When your VL is suppressed, the virus is so low it cannot be detected. This keeps you healthy and prevents passing HIV to others.

SERVICE DELIVERY OPTIONS – Different ways you can receive your treatment, depending on your health.

STABLE – If you are well, not pregnant, and your VL is suppressed (<50), you may have fewer clinic visits and more flexible options for picking up your treatment.

NOT YET STABLE OR UNSTABLE – If your VL is above 50, you will continue collecting treatment at the facility until it is suppressed. If you are pregnant, caring for a child under 5, or ill from HIV or another disease, your provider will guide your treatment options.

My clinic name _____
 Address _____
 Phone number _____
 Operating hours _____

START TREATMENT, STAY ON TREATMENT, STAY SUPPRESSED AND HEALTHY!

HIV Treatment Intervention Navigator: “There Are Options to Support You”

Also called the Client Navigator

What is it?

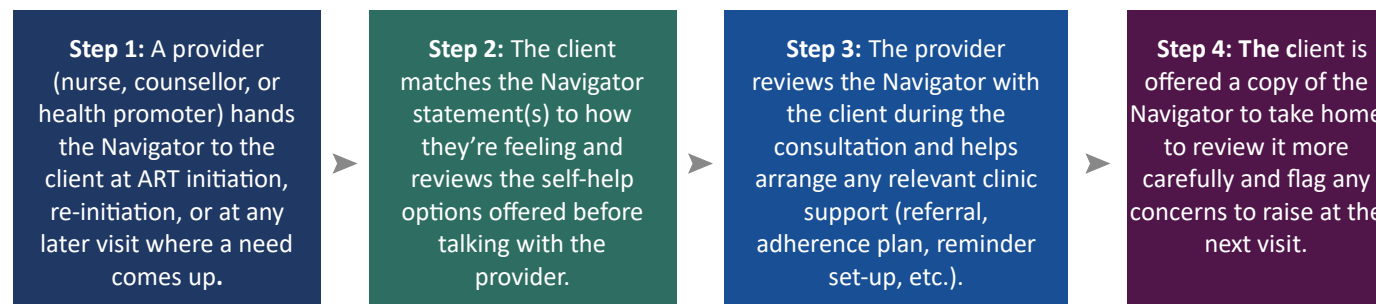
The HIV Treatment Intervention Navigator (the Navigator) is a combined self-assessment and retention intervention-mapping tool, developed as part of the Retain6 BRIDGE Retention Toolkit. It groups common barriers that can contribute to client disengagement from HIV care into four broad categories: psychosocial challenges, logistical barriers, concurrent health concerns, and adherence support. Within each category, we developed statements that describe in relatable, easy to follow language what clients may experience if facing one of these barriers. Each barrier category was paired with a matching “menu” of interventions and options that the client can do on their own and/or the clinic may be able to offer.

The Navigator was designed to require no direct facility costs beyond printing and to complement existing counselling procedures by providing clients and providers accessible solutions to challenges to staying in care.

Why it matters

Clients starting or restarting ART are most likely to disengage from care in their first six months of treatment, because of barriers at the individual level (e.g. forgetfulness, side-effects, psychosocial factors), interpersonal level (e.g. stigma, concerns about confidentiality), structural level (e.g. transport costs, travel distance, or work commitments), and health facility level (e.g. long waiting times, unwelcoming providers, and inflexible appointment schedules). Some of these barriers go unspoken during a routine consultation unless a client is asked directly. The Navigator is designed to act as a conversation template for both clients and providers. Rather than relying on a provider to guess, remember, or have time to ask about the full range of possible barriers, the Navigator gives the client a structured, low-pressure way to name what is actually going on for them, and gives the provider a ready-made link to a concrete next step.

How it is used



THERE ARE OPTIONS TO SUPPORT YOU ON YOUR TREATMENT JOURNEY, NO MATTER WHAT YOU'RE FACING!

<p>"I'm not ready to be on treatment for the rest of my life."</p> <p>"I have nobody to talk to."</p> <p>"What if people find out my status?"</p> <p>I AM AFRAID OR I AM NOT READY</p> <p>There are options!</p>	<p>I can do these things:</p> <ul style="list-style-type: none"> Set my health goals Identify people who can support me in deciding to start/take treatment Read my Client Roadmap to prepare for my treatment journey Ask questions at my visit or on the WhatsApp Health Coach Choose where to store my treatment 	<p>My clinic may also be able to offer:</p> <ul style="list-style-type: none"> Fast track initiation counseling with new adherence plan Disclosure support and treatment information A Client Roadmap Referral to a social worker Referral to WhatsApp Health Coach
<p>"My visit is going to take too long"</p> <p>"I live far away from the clinic"</p> <p>"It's difficult to arrange care for my children"</p> <p>IT'S DIFFICULT TO ATTEND MY VISITS</p> <p>There are options!</p>	<p>I can do these things:</p> <ul style="list-style-type: none"> Ask for longer treatment supply and/or less frequent clinic visits Ask family to help me get to my visits Ask about convenient ways and places to collect my treatment Ask for more treatment or a transfer letter when I travel Ask for same supply, visits and collection points as family members 	<p>My clinic may also be able to offer:</p> <ul style="list-style-type: none"> 3-month treatment supply Repeat prescription collection strategies 1. Pick-up point outside the facility (e.g. Clicks) 2. Facility one-stop fast pick-up 3. Support group 6-month script + 3-month treatment supply 6-month script + 6-month treatment supply Aligned child/partner visit schedule
<p>"I'm pregnant – what does this mean for me and my baby?"</p> <p>"The treatment makes me feel sick"</p> <p>"I already come to the clinic a lot for my high blood pressure"</p> <p>I HAVE OTHER HEALTH CONCERNS</p> <p>There are options!</p>	<p>I can do these things:</p> <ul style="list-style-type: none"> Tell my provider how I am feeling Tell my provider I am re-starting treatment so my convenient treatment collection options should start today Tell my provider I have other conditions and ask for extra clinical check ups Ask for help if I experience side effects Ask for help to take treatment if I am intoxicated or using drugs 	<p>My clinic may also be able to offer:</p> <ul style="list-style-type: none"> A detailed health assessment A mental health assessment Referral to appropriate provider e.g. social worker, dietician Help with with antenatal care booking Aligned visit schedule with my other conditions Scheduling more clinical visits if needed
<p>"I forgot when my appointment is"</p> <p>"I work nights and don't know when to take my treatment"</p> <p>I NEED APPOINTMENT ASSISTANCE/REMINDERS</p> <p>There are options!</p>	<p>I can do these things:</p> <ul style="list-style-type: none"> Tell clinic how to contact me if I miss a visit: SMS, call, home visit Update my contact details so I can manage my appointments and get reminders Choose time of day I can take treatment Create my treatment reminder strategy such as phone, alarm, friend, pill box, WhatsApp Health Coach 	<p>My clinic may also be able to offer:</p> <ul style="list-style-type: none"> Review of my adherence plan in fast track initiation counseling SMS/phone visit reminders if available Explaining how to change appointment dates Asking me to choose next visit date Referral to WhatsApp Health Coach

Not all clinics can offer all the services shown; ask your provider what is available.

Staying on your treatment journey is important!
Once you have two viral load tests <50 copies/mL, you can get a 6-month treatment supply and two clinic visits a year.

Scan me with a smartphone for online version

What it contains

If a client says...	Common concerns	Options offered
Readiness and fear <i>"I am afraid or I am not ready..."</i>	Fear of lifelong treatment, disclosure worries, not feeling ready to start or restart treatment	Self-help: identify a support person, read the Client Roadmap, ask questions via the PSI WhatsApp Health Coach. Clinic can offer: fast-track initiation counselling, disclosure support, referral to a social worker.
Access and logistics <i>"It's difficult to attend my visits..."</i>	Distance, cost, time off work, childcare, travel	Self-help: ask for a longer supply or less frequent visits, ask about family-aligned visit dates. Clinic can offer: multi-month scripts, alternative pick-up points, support groups.
Other health needs <i>"I have other health concerns..."</i>	Pregnancy, treatment side effects, comorbidities, substance use	Self-help: tell the provider how you're feeling, ask for extra check-ups. Clinic can offer: detailed or mental health assessment, referral to a dietician/social worker, aligned visit scheduling.
Forgetfulness and uncertainty <i>"I need appointment assistance/reminders..."</i>	Forgetting appointments, shift work, unclear contact process	Self-help: update contact details, choose a reminder method (SMS, alarm, PSI WhatsApp Health Coach). Clinic can offer: SMS/phone reminders, help changing appointment dates.

Availability

The Navigator is available in English, Afrikaans, isiXhosa, Setswana, and isiZulu, as a client handout, a consultation-room poster for display in consultation and counselling rooms and waiting areas (including for group information sessions), and an online version reached by scanning the QR code on the poster for clients who prefer to use it on their own phone. The poster is a single vertical page, while the handout is a double-sided horizontal page.

How it was developed

The Navigator originated as two documents: (i) a risk-scoring tool predicting a client's likelihood of disengaging from care; and (ii) an accompanying list of interventions, based on what is actually available at facilities, that providers could offer in response. The original design envisaged providers assessing each client's risk of missing their next appointment or discontinuing care, then identifying appropriate interventions available at the facility — such as multi-month dispensing — based on that assessment. Consultation with facility providers led to a revised approach: a combination of the two tools, with clients assessing their own risk and concerns rather than providers assessing it on their behalf, and that risk matched directly to a corresponding intervention.

Implementation challenges and ideas for solving them

The Navigator was introduced and tested over an 11-week pilot at six primary healthcare facilities in Gauteng and KwaZulu-Natal provinces. During this period, several challenges in using the Navigator arose.

Staffing and human resources

Recurring staff shortages, leave, and turnover pulled trained providers away from the tools for stretches at nearly every site, and provider motivation visibly waned over the course of the pilot. Training backup providers per shift, and continuing refresher support and outcome feedback for as long as implementation runs, may help.

Training and workflow clarity

Some sites were not clear on who would introduce the Navigator, or at what point in the visit, reflecting broader confusion about its role as a support tool. Clarifying the Navigator's role as a support tool and agreeing on a workflow per facility at orientation, revisited at refreshers, may help with both.

Materials, language, and supply

Flyers weren't always available in clients' languages (notably for clients from other African countries), and some sites ran out of stock between visits. Pre-positioning translated flyers based on each site's actual patient demographics, defaulting to print materials for clients unlikely to engage digitally, and setting a minimum stock threshold with scheduled resupply, may help.

Patient volume and recruitment

Some weeks had few eligible patients for reasons unrelated to implementation (month-end, bad weather, grant-payment days), and recruiting male participants specifically became harder as the pilot progressed. Flagging known low-volume periods in reporting, and using a targeted male-recruitment approach alongside the general rollout, may help.

Early responses to the Navigator

Providers and clients who were exposed to the Intervention Navigator were interviewed to learn about their perspectives on it. We talked to 29 providers and 62 clients.

What did providers say?

How was it used?	<ul style="list-style-type: none">Providers described variability in use:<ul style="list-style-type: none">Some providers reported reviewing the Navigator with clients during clinical consultations or counselling sessionsSome providers cited time constraints and sent clients home with the Navigator to review and discuss at their next visit.Providers had mixed perceptions of who is best poised to use the Navigator and which cadre's workflow it fits into most naturally.	<p><i>"... We resorted to giving this tool to take home so they can go through it comfortably [and] answer honestly. I believe when they have to answer and I'm waiting for them, they might give me wrong answers. Just to please me." – Professional Nurse, Gauteng Province</i></p> <p><i>"[It is] not really practical because we are busy. There's no time to sit with the patient for hours and go through this intervention one-on-one. I think maybe it's more practical for the counsellors because they can spend more time." – Professional Nurse, Gauteng Province</i></p>
Was it acceptable?	<ul style="list-style-type: none">The Navigator received mixed reviews.<ul style="list-style-type: none">Providers who liked the tool felt that it opened opportunities for honest conversation with clients and aligned with existing motivations to offer high-quality counselling.Providers who found it difficult to use typically cited two main barriers:<ul style="list-style-type: none">Text-heavy format does not meet the needs of clients who cannot read or do not speak the available languages.Clients may not be emotionally ready for the discussions that the tool encourages, if they have just learned their HIV status and are overwhelmed.	<p><i>"... Patients thought that we don't care about their challenges... This tool enlightens patients to show them that even if you've got challenges... we can collectively come up with solutions." - Community Health Worker, Gauteng Province</i></p> <p><i>"When it comes to newly diagnosed patient, I think they need to absorb the whole information... I think it will be best if they take away those questionnaires to go through it. Imagine, if you are newly diagnosed, it's a shock. Now we're going through all of those information." – Lay Counsellor, Gauteng Province</i></p>

- Some providers suggested that the Navigator be simplified, shortened, or otherwise made more accessible to clients (more images, audio-based, integrate into a digital format, primarily use by clients at home, etc.)

"It fits well, but only if they can make picture [summaries]...I don't think the patient will have time to go through this in the follow-up rooms." - Professional Nurse, Gauteng Province

What did clients say?

Among the 62 clients interviewed, roughly two-thirds could recall reviewing the Navigator. Consistent with what providers said, some clients reported reviewing the Navigator with their provider and others took it home.

What clients thought of the tool

- Clients reported using the Navigator in several ways: some discussed it with their healthcare provider during a clinical visit, and some reviewed it independently while waiting for their visit or from home (but reported that a provider did not discuss with them).
- Clients generally reported that the questions and scenarios posed in the tool were relevant and responsive to their situations.
- Clients who encountered the tool were generally satisfied with the tool and its content.

"The time I started the drugs... There was no one who explained well like this nurse... there was no one who asked me what is happening. During this last visit, the nurse explained and I could speak about my feelings... It was the first time I could talk about those things with a professional, because even at home, I don't talk to many people about that." – Male client, Gauteng Province

"...It makes me realize that I'm not the only one with the challenges I might be facing.[My provider] went step by step with me, she didn't rush through it." - Female client, Gauteng Province

"[The navigator was] important because they made me speak out and be free, without having any shame about myself." – Male client, KZN Province

Next steps

The Intervention Navigator offers clients a structured, self-led way to express their own barriers to care and ask for assistance. Key next steps will include simplifying the Navigator and identifying the pathway to scale and incorporate it into routine practice:

- Replace as much text as possible with simple visual aids.
- Promote the QR-code online version as a fallback for clients when printed stock is low or for use at home.
- Embed the Navigator into the routine triage/counselling workflow at each facility.
- Pre-position translated stock ahead of rollout based on each facility's client language profile.
- Incorporate the Navigator into training for structuring provider-client conversations.

For more information or to request access to the Navigator and supporting materials, please contact Dr. Mhairi Maskew, mmaskew@heroza.org.



Welcome! How are you feeling today?

While waiting to see your provider, please read these lists below describing challenges that some clients have seeking care. Tick any boxes that you would like to talk about with your provider during your consultation. There are many options to manage these challenges yourself and services that this facility offers to support your care journey. *Not all clinics can offer all the services shown; ask your provider what is available.*

I HAVE OTHER HEALTH CONCERNS

- ☐ I feel sick today
- ☐ I have other health conditions like TB, high blood, high sugars
- ☐ I am worried I have STI
- ☐ I am pregnant or breastfeeding
- ☐ I have mental health concerns
- ☐ I use alcohol or drugs I'm worried it may affect my treatment
- ☐ The treatment makes me feel sick
- ☐ I take other medication
- ☐ I don't think my treatment is working
- ☐ I don't have food at home

I can do these things:

- ☐ Tell my provider how I am feeling
- ☐ Tell my provider I am re-starting treatment so my convenient treatment collection options should start today
- ☐ Tell my provider I have other conditions and ask for extra clinical check ups
- ☐ Ask for help if I experience side effects
- ☐ Ask for help to take treatment if I am intoxicated or using drugs

My clinic may also be able to offer:

- ☐ A detailed health assessment
- ☐ A mental health assessment
- ☐ Referral to appropriate provider e.g. social worker, dietician
- ☐ Help with antenatal care booking
- ☐ Aligned visit schedule with my other conditions
- ☐ Scheduling more clinical visits if needed

I NEED APPOINTMENT/ASSISTANCE REMINDERS

- ☐ I forget when my next visit is
- ☐ I forget to take my treatment some days
- ☐ I sometimes use alcohol or drugs and forget my visit
- ☐ I don't know when my next visit date is
- ☐ I can't come on my scheduled visit date
- ☐ I don't get visit reminders

I can do these things:

- ☐ Tell clinic how to contact me if I miss my visit: SMS, phone, house visit
- ☐ Update my contact details so I can manage my appointments and get reminders
- ☐ Choose time of day I can take treatment
- ☐ Create my treatment reminder strategy such as phone, alarm, friend, pill box, WhatsApp Health Coach

My clinic may also be able to offer:

- ☐ Review of my adherence plan in fast track initiation counseling
- ☐ SMS/phone visit reminders if available
- ☐ Explaining how to change appointment dates
- ☐ Asking me to choose next visit date
- ☐ Referral to WhatsApp Health Coach

☐ I have different concerns to discuss today

☐ I don't have concerns to discuss today

Not all clinics can offer all the services shown; ask your provider what is available.

Staying on your treatment journey is important!

Once you have two viral load tests <50 copies/mL, you can get a 6-month treatment supply and two clinic visits a year.



Client Tracing Job Aids

What is it?

Two job aids were developed as part of the Retain6 BRIDGE Retention Toolkit to help facility staff who trace clients who have missed a scheduled HIV treatment visit or medication pickup. The first is a tracing support tool, available as a desk reference, poster, or pocket card, that walks tracing staff (counsellors, ward-based outreach team members, and community health workers) step by step through the client tracing process and documenting outcomes. The second is a pre-printed contact-detail sticker attached to a client's file to prompt reception clerks and administrative staff to update and confirm contact details at every visit, rather than only at the initiation visit.

Why it matters

Missed visits and missed medication pickups are extremely common during clients' first year on ART. Guidelines recommend that facilities attempt to contact clients who are >7 days late for a scheduled visit, a process known as "tracing and recall", starting with phone calls and escalating to a home visit if the client cannot be reached by phone. Retain6 research showed that clients eligible for tracing can only be reached 50% of the time. Facilities report that a major reason for this is not having current contact details on file, since clients often change their contact details without informing the clinic. Another frequent obstacle is that the facility's list of clients who should be traced is not up to date when tracers access it. As a result, many clients who might benefit from tracing contact cannot be found, while others who do not need tracing are contacted unnecessarily.

What it contains

Component	Format	Use	Staff cadre	Use schedule
Tracing support tool	Handout/poster for tracing staff	Used before starting to trace any client, to confirm all steps (identify, confirm, trace, document) have been completed	Counsellor, Ward-Based Outreach Team, Community Health Worker, other tracer	Every tracing action

TRACING SUPPORT TOOL

STEP 1 - IDENTIFY

- Access TIER.net Missed Visits List
- Verify Using Client File
 - Last visit date & next appointment
 - Any documented outcome

STEP 2 - CONFIRM

Don't trace if visited/transferred/LTFU/deceased

Capture Details

- Name, age
- File number
- Missed visit date
- Type of appointment
- Phone number
- Address

Pre-Tracing Check

- Phone number valid?
- Alternative contact available?
- Tracing method consented for?

STEP 3 - TRACE

NO DISCLOSURE OF CLIENT STATUS

Tele-Tracing

- Make three separate calls
- Record date & outcome

Home Visits

- ONLY if tele-tracing fails
- 3 attempts
- Record date & outcome

STEP 4 - DOCUMENT

If Unreachable

- Document reason
- Wrong number/address
- Voicemail
- Client unknown

Client Contacted:

- Establish reason for missed visit
- Reschedule & record appointment
- Refer for support
- Record outcome & date

Update Records:

- Register (return/LTFU/death date)
- File (contact details/address)
- Check EMR updated

File number:
Phone (Primary):
Phone (Alt):
Physical address:

Contact method: ☐ Call ☐ SMS ☐ WhatsApp ☐ Home visit ☐ Other _____
Best call time: ☐ Morning ☐ Midday ☐ Afternoon
Trusted Contact (optional):
Relationship:
Phone:

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Component	Format	Use	Staff cadre	Use schedule
Client contact detail sticker	Pre-printed sticker/adhesive note sheet kept at reception	Attached to the client file; used to update and confirm contact details, preferred contact method, and best call time	Clerk or nurse	Every visit

The Tracing Support Tool

Availability

The tracing job aid is provided as a single-page poster/handout for tracing staff, summarizing all four steps of the tracing process in one place for quick reference before and during a tracing action.

Implementation of the tool

The tracing support tool walks tracers through four steps that should be taken every time a client becomes eligible for tracing (misses a scheduled visit or medication pickup by more than 7 days).

STEP 1: Identify <ul style="list-style-type: none"> Identify clients in need of tracing: <ul style="list-style-type: none"> Pull the missed-visits list from TIER.net Important: Verify against the client file (last visit, next appointment, any outcome already documented) Stops unnecessary tracing e.g. for clients who have already come to the clinic or transferred or are known to be lost to follow up or deceased 	STEP 2: Confirm <ul style="list-style-type: none"> Capture name, age, file number, missed-visit date, appointment type, phone number, address Pre-tracing check: Check if valid number; if there is an alternative contact; if client consented to tracing method 	STEP 3: Trace <ul style="list-style-type: none"> Tele-trace: three separate calls, dates and outcomes recorded Home visit only if tele-tracing fails, up to three attempts, dates and outcomes recorded No disclosure of client HIV status at any point 	STEP 4: Document <ul style="list-style-type: none"> If unreachable, record reason (wrong number/address, voicemail, client unknown) If contacted, establish reason for missed visit, reschedule, refer for support, record outcome Update the register and the client's file and confirm the EMR is updated
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How it was developed

The tracing job aid was built directly from the national tracing-and-recall guidelines (SOP 7), translated into a step-by-step algorithm, then refined through consultation with facility providers and the National Department of Health, who gave feedback before it was finalized.

Providers' responses

Providers who were exposed to the Tracing Support Tools were interviewed to learn about their perspectives on it. We talked to 29 providers about the BRIDGE Retention Toolkit, asking about each component. During the interviews, few providers mentioned the tracing support tool. While one provider acknowledged using it to conduct tracing, another said that they prefer other tracing approaches. *"I think with the follow-up, the one that we've adopted as a facility is working better for us. We cannot say I can say we've been resistant to the one that you suggested, but I think the one that we are using is best."*

From prior research, the study team knew that some facilities in South Africa conduct tracing within one day of a missed visit, even though it is not recommended by tracing SOPs or clinical guidelines. Some facilities also extended their tracing efforts beyond the 90-day period recommended in the 2023 Guidelines in response to a national initiative to re-engage people not on ART or who had dropped out of care which was launched at the same time as the BRIDGE pilot. Results of our pilot thus cannot provide guidance on the optimal timing of tracing efforts.

The Client Contact Sticker

Availability

The contact-detail sticker is formatted as a printed sheet containing 6 individual stickers that reception or administrative staff can peel off and attach to a client's paper file, to be completed and updated at every visit rather than only at ART initiation.

How it was developed

The contact-detail sticker went through several design iterations during co-creation. The team considered having clients complete a contact card at registration and hand it back at the desk, but providers raised concerns about cards not being returned, limited access to pens, and the risk of signaling a client's ART status to others in the waiting area. A second option, capturing details at registration and re-entering them into TIER.net, was ruled out because registration records and TIER.net do not currently exchange data. The team ultimately settled on a sticker that administrative staff attach to and remove from the client's folder, discarded once the information has been captured in TIER.net. Providers at each facility decided who should be responsible for attaching the stickers to folders, who should update contact details, and where on the folder the sticker should be placed.

Providers' responses

Providers referred frequently to using the stickers on client files, finding them easy to use and integrate into the existing workflow. They valued having a system to document contact information that did not take a lot of time to complete and did not rely entirely on clinical staff. The stickers could not overcome the persistent problem of inaccurate or incomplete contact details but did improve overall accuracy.

Next steps

Based on BRIDGE findings, stickers to attach to client files to improve capture of contact details can be incorporated into routine care without further research. The tracing support tool should be re-considered in light of facilities' preferences for their own existing procedures and policy makers' views on balancing guideline compliance with facility preferences.

"I think the one that you put the sticker on the patient's file to write the contact details if they've changed, I think that one is easy, anybody can do it." – Gauteng Province, Professional Nurse

"You'll find when it comes to interrupters, you'll find that the stickers are working more because you'll find that the addresses are wrong or they moved from their old addresses or the cell phone numbers. So, that one is more effective in regarding to treatment interrupters." – Gauteng Province, Lay Counsellor

For more information or to request access to the Tracing Job Aids and supporting materials, please contact Dr. Mhairi Maskew, mmaskew@heroza.org.



Guideline Job Aid

What is it?

The Guideline Job Aid, also known as Key Visit Milestones, was developed as part of the Retain6 BRIDGE Retention Toolkit to help healthcare providers deliver guideline-concordant care during the early stages of antiretroviral therapy (ART). It is a simple, single-page visual summary of South Africa's 2023 ART Clinical Guidelines, highlighting recommended assessments, counselling, laboratory tests, and dispensing milestones during the first four visits.

Designed for use at the point of care, the Job Aid enables providers to quickly check what needs to happen at each visit without needing to consult the full 232-page guideline document. It is available as an A3 desk reference and a vertical poster, with no costs to facilities beyond printing.

Why it matters

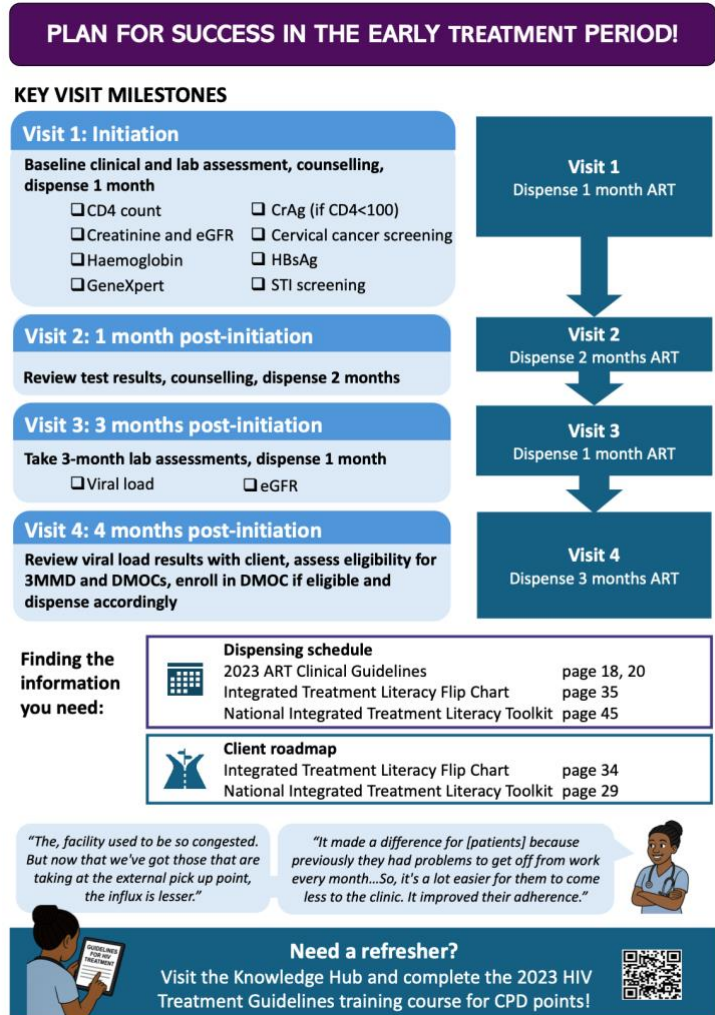
The Job Aid is a practical bridge between policy and the consultation room, intended to help providers deliver recommended assessments, counselling and ART dispensing at the appropriate time. It is also intended to help new providers follow the NDoH ART guidelines.

It turns guidelines into practice. Guideline documents are lengthy and may be difficult to consult in a busy clinic. A visual guide makes it easier for providers to know what needs to be done, and when, helping bridge the gap between having a guideline and applying it consistently in practice. It also gives page references to the guidelines and national treatment literacy materials for the dispensing schedule and the client roadmap.

It focuses on the high-risk early treatment period. The first few months on ART are when clients are more likely to disengage from care and when important baseline conditions – such as advanced HIV disease, TB, hepatitis B, kidney disease, sexually transmitted infections and cervical cancer – need to be identified. This period is also when early treatment response and viral suppression are assessed. The 2023 Guidelines introduced several changes to HIV management during this period, which providers may need to reference or refresh their knowledge. The Job Aid is intended to help providers keep track of critical steps.

It supports standardized, quality care. A shared guideline reference is intended to help ensure that clients receive a consistent core package of care, regardless of the facility or provider. Cues in the Job Aid reinforce recommendations for comprehensive counselling, laboratory assessments, and differentiated models of care (DMOC) eligibility assessment.

It encourages ongoing learning. By linking the tool to the NDoH Knowledge Hub, providers are encouraged to access training and CPD points, complementing existing continuing professional development strategies.



What it contains

Key visit milestones	Questions answered	Specific contents	Intended result
Four-visit checklist	<i>"What must I do at this visit?"</i>	A summary of key assessments, laboratory investigations, counselling activities, and review of results across the first four visits.	Helps providers identify the key activities required at each visit and reduces the risk of overlooking essential steps.
Dispensing pathway	<i>"How much ART should I dispense, and when should the dispensing interval change?"</i>	A visual pathway showing recommended ART dispensing intervals and their progression during early treatment, alongside considerations for monitoring and differentiated models of care (DMOC).	Provides a quick reference for dispensing decisions during early treatment.
Guideline references and related resources	<i>"Where can I find more detailed guidance?"</i>	Page references to relevant sections of the 2023 ART Clinical Guidelines and related resources, including the Client Roadmap.	Helps providers locate additional information when they need more detail than the Job Aid provides.
Testimonials and additional learning	<i>"Why does this work, and how do I learn more?"</i>	Evidence of real-world benefits drawn from user interviews and access to NDoH accredited refresher training	Shares peer perspectives and provides access to further learning and professional development.

Availability

The Guideline Job Aid was developed in English and made available in two formats: a one-sided A3 desk reference and a vertical poster for display in consultation rooms. Both formats were intended to make the information readily accessible during patient consultations. Download the A3 version of the Job Aid.

How it was developed

The Guideline Job Aid was developed using South Africa's 2023 ART Clinical Guidelines as its primary source. The team identified key clinical and service-delivery milestones across the first four ART visits, including assessments, laboratory investigations, counselling, review of results, and ART dispensing. These were condensed into a single-page reference designed for use during clinical consultations.

The Job Aid incorporated a "Finding the information you need" section with page references to facilitate use of the full guidelines document and literacy toolkit. A link to the NDoH Knowledge Hub's 2023 ART Guidelines course was included to connect the reference tool with an existing training resource and support providers interested in further learning and professional development. Following consultations with providers and field teams, the final tool was produced in English as a one-sided A3 desk reference and a vertical poster for display in consultation rooms.

Implementation experience

The Guideline Job Aid was introduced during an 11-week pilot at six primary healthcare facilities in Gauteng and KwaZulu-Natal provinces. The study team intended for posters to be placed at eye-level, adjacent to the consulting desk in consultation rooms for clear visibility and access. Most sites were able to display posters in their consultation rooms and place the tool on clinicians' desks, but some sites experienced challenges with displaying posters due to limited wall space in the consultation rooms.

Provider responses

Twenty-nine healthcare providers were interviewed about the BRIDGE Retention Toolkit, with questions covering each component separately. Their responses to the Guideline Job Aid were mixed. Some providers described the tool as a useful reference for conducting consultations and monitoring required blood tests, but those interviewed mentioned it less often than other components of the Toolkit. The interviews did not establish how consistently the tool was used in

"The Key Visit Milestones helps us a lot as healthcare workers so that we can conduct the patient visits well and monitor the blood tests according to the guidelines. It helps a lot. We work with them every day. It helps, yes." - KZN Province, Professional Nurse

"... [I like] the guideline because it's where I start as a nurse. I need to know the guidelines. So, it has been summarized, it's in front of me, so I don't think I'll miss any of the things that is expected from me if I've got a guideline in front of me." – Gauteng Province, Professional Nurse

practice, nor whether limited mention of it reflected low uptake or its relative lack of novelty, compared to other Toolkit components.

Next steps

Further consultation with healthcare workers and policymakers is needed to assess the Guideline Job Aid's value for guideline fidelity, identify any revisions or additions that could improve its usefulness, and explore whether and how it could be disseminated more widely. The Job Aid should also be updated to reflect 2026 ART Guidelines.

For more information or to request access to the Tracing Job Aids and supporting materials, please contact Dr. Mhairi Maskew, mmaskew@heroza.org.



PLAN FOR SUCCESS IN THE EARLY TREATMENT PERIOD!

KEY VISIT MILESTONES

Visit 1: Initiation

Baseline clinical and lab assessment, counselling, dispense 1 month

- ☐ CD4 count
- ☐ Creatinine and eGFR
- ☐ Haemoglobin
- ☐ GeneXpert
- ☐ CrAg (if CD4<100)
- ☐ Cervical cancer screening
- ☐ HBsAg
- ☐ STI screening

Visit 2: 1 month post-initiation

Review test results, counselling, dispense 2 months

Visit 3: 3 months post-initiation

Take 3-month lab assessments, dispense 1 month

- ☐ Viral load
- ☐ eGFR

Visit 4: 4 months post-initiation

Review viral load results with client, assess eligibility for 3MMD and DMOCs, enroll in DMOC if eligible and dispense accordingly

Visit 1
Dispense 1 month ART

Visit 2
Dispense 2 months ART

Visit 3
Dispense 1 month ART

Visit 4
Dispense 3 months ART

Finding the information you need:



Dispensing schedule

2023 ART Clinical Guidelines page 18, 20
Integrated Treatment Literacy Flip Chart page 35
National Integrated Treatment Literacy Toolkit page 45



Client roadmap

Integrated Treatment Literacy Flip Chart page 34
National Integrated Treatment Literacy Toolkit page 29

"The, facility used to be so congested. But now that we've got those that are taking at the external pick up point, the influx is lesser."

"It made a difference for [patients] because previously they had problems to get off from work every month....So, it's a lot easier for them to come less to the clinic. It improved their adherence."



Need a refresher?

Visit the Knowledge Hub and complete the 2023 HIV Treatment Guidelines training course for CPD points!



AI Health Coach: “Let’s Chat Anytime, 24/7”

Also called WhatsApp Coach or the AI Coach

“The AI Coach, I feel like I have a support system... it helps me to be able to always continue with medication.”

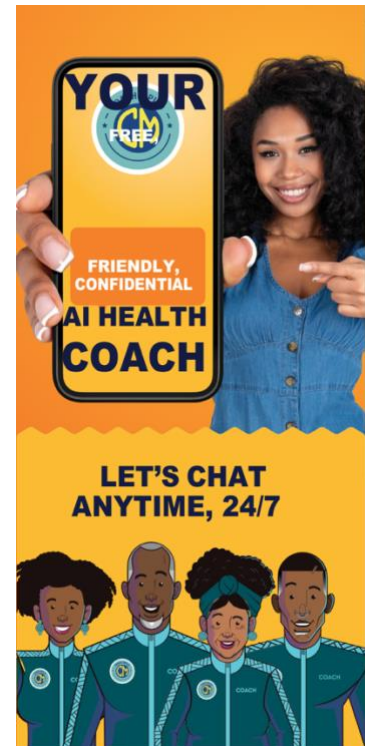
– Male client, KwaZulu-Natal Province

What is it?

The **AI Health Coach** is a free chatbot on WhatsApp that offers confidential, on-demand information, advice, and support on HIV, TB, sexual health, and wellbeing. It was developed by Population Services International (PSI), audere, and the Wits Health Consortium, drawing on South Africa’s Coach Mpilo peer-support model. Referral to the AI Health Coach through clinician recommendation and posters in the health facility was piloted in the Retain6 BRIDGE Retention Toolkit alongside tools developed by the study team

Using WhatsApp, clients can ask the AI Health Coach as many questions as they like, at any time, and can choose to remain anonymous. The coach can help clients find a clinic or pharmacy, offer encouragement, and connect a client to a real-life health coach or helpline for complex or high-risk issues. Its answers draw on trusted sources such as the Department of Health and the World Health Organization; chats are private and clients can delete them at any time.

The AI Health Coach requires no direct facility costs beyond printing posters and flyers and no new staff roles. Clients need a phone with WhatsApp and mobile data or WiFi to access the AI Health Coach.

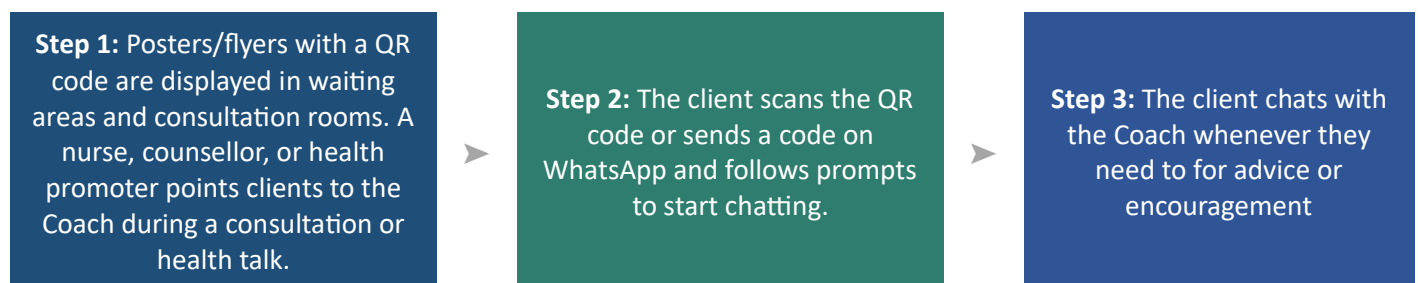


Why it matters

Many clients who took part in Retain6 surveys and focus groups said they wanted more counselling and treatment literacy support than they received in the early treatment period. With staff resources scarce and most efforts focused on making service delivery less intensive, adding more in-person counselling is not feasible.

The AI Health Coach aims to fill this gap. It gives clients a private way to ask the questions they did not raise during a consultation (due to time, shame, or other factors), and it remains available between visits whether or not the client is still in contact with the facility.

How it is used



The AI Health Coach was designed to require little or no extra clinical time: providers only need to draw clients’ attention to the poster or flyer, and clients use the service on their own.

Availability

The AI Health Coach is available 24/7 on any smartphone or device with WhatsApp, at no cost beyond WhatsApp data or WiFi. It is currently available in English and isiZulu. BRIDGE facilities received consultation-room and waiting-area posters and a tri-fold client flyer, each displaying the QR code and WhatsApp number.

How it was developed

The AI Health Coach was developed and tested by PSI, inspired by an existing coaching model (<https://www.coachmpilo.co.za/>), to replicate key functions of real-life health coaches by offering confidential, user-driven, text-based guidance through WhatsApp. BRIDGE incorporated this existing service into the Retention Toolkit so that clients could access counselling and information outside the facility without adding to provider workload.

Implementation and challenges

The AI Health Coach was introduced as part of the BRIDGE Retention Toolkit over an 11-week pilot at six primary healthcare facilities, four in Gauteng (from late March 2026) and two in KwaZulu-Natal (from mid-April 2026). During this period, several challenges in promoting and using the AI Health Coach arose.

Phone and data access

Clients without a smartphone or mobile data could not scan the QR code or use the Coach, and some had to borrow a family member’s phone, which felt less private. Older clients were often not active on WhatsApp. **A similar service through a toll-free line or a zero-data option** may help reach these clients.

Provider familiarity

Some providers were unsure how to introduce the Coach and referred clients to the study team instead. **A short live demonstration during training, so providers have used it themselves,** may improve uptake.

Language

The Coach is only available in English and isiZulu, which limited its reach at sites serving clients who speak other languages, including migrants from neighbouring countries. **Expanding to more South African and regional languages** may increase access.

Early responses to the AI Health Coach

Providers and clients who were exposed to the BRIDGE Retention Toolkit were interviewed to learn about their perspectives on it. We talked to 29 providers and 62 clients.

What did providers say?

How was it used?

- Providers referred clients to the posters and QR code, explaining that they could use the WhatsApp Coach to get personalised counselling and advice from home.
- The Coach required little provider time, and providers actively encouraged clients to use it.

“I think [the toolkit] saves us some time... somebody who’s new on this treatment there’s a lot of questions that they have... with the coach, it’s easier for this person to... ask all their questions and... if the coach finds something that cannot do it’s gonna refer the clients back to us.”
– Gauteng Province, Professional Nurse

<p>Was it acceptable?</p>	<ul style="list-style-type: none"> • Providers valued the Coach and felt clients may be more comfortable asking it questions than asking a provider in person. • They saw it as supporting continuity of care at home and saving time in understaffed clinics. • Providers trusted the information it gives and appreciated that it refers clients back to the facility for serious health issues. • Providers felt it may be easier and more acceptable for younger clients than older clients. • Concerns centred on access: clients without data or a smartphone cannot use it, and it is only available in English and isiZulu. 	<p>“Even I myself, when I’m talking to the coach, I feel much comfortable to ask some of the things that if I’m looking at a person’s eyes I won’t be able to say or ask. With the AI coach, they got it right.” – <i>Gauteng Province, Professional Nurse</i></p> <p>“Somebody who's new on treatment [has] a lot of questions, and then if they were to ask the provider, we'll be taking long hours answering. So, with the coach, it's easier for this person to... ask all their questions... I think it is really saving us time.” – <i>Gauteng Province, Professional Nurse</i></p> <p>“It needs someone to have a smartphone and data at the same time... they leave the facility knowing that there’s a QR code, but they’re not able to use it.” – <i>Gauteng Province, Professional Nurse</i></p>
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What did clients say?

Clients’ uptake of the Coach varied. About half of clients engaged with the AI Health Coach: some engaged fully, using it once or on an ongoing basis; some registered by scanning the QR code but had not yet started a conversation. Among the other half, some were aware of it but unable to use it because they lacked a smartphone or data; and others could not recall it or had not yet looked at it. Among those who engaged with the AI Health Coach, clients generally found it acceptable and easy to use.

<p>What clients thought of the AI Health Coach</p>	<ul style="list-style-type: none"> • Many clients found it very easy to use and valued the privacy and confidentiality it offers. • Clients used it for counselling and private advice and liked being able to ask questions whenever they arose, outside the facility. • Some used the appointment reminders, which helped them return for their next visit. • Lack of a smartphone/data was the main barrier for clients who would otherwise have used it. • Clients suggested adding more languages, Coach-initiated motivational messages, and pill reminders as well as appointment reminders. 	<p>“I see it as helpful because sometimes we are afraid to ask questions at the clinic to the sisters or the nurses. So, it’s easy. It helps so much.”</p> <p>– <i>Female client, Gauteng Province</i></p> <p>“There is a part where it reminds you of your clinic appointment. I liked that and it helped me to be able to go for my second appointment.”</p> <p>– <i>Female Client, Gauteng Province</i></p> <p>“I haven’t used it yet because it’s WhatsApp based so I don’t have data... I will check it when I have data.”</p> <p>– <i>Male Client, Gauteng Province</i></p>
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Next steps

The AI Health Coach offers a low-cost way to extend counselling and treatment literacy support beyond the consultation room, without adding to provider workload. Key next steps will include identifying how best to get the Coach into the hands of the clients most likely to use it.

For more information or to request access to the WhatsApp AI Health Coach and supporting materials, please contact PSI.



Can I chat in my own language?

Yes! The chat works in English and is also learning other South African languages like isiZulu. You'll be able to choose the language you prefer when you start.

What does it mean that it's AI?

AI (artificial intelligence) just means that the responses are coming from a computer, not a person.

TIPS ON HOW TO GET THE MOST FROM IT

- Pretend you're chatting with a friend.
- Be honest. Your AI health coach is safe and private and won't judge you.
- Ask one question at a time.
- Be specific with your question or comment. It will give you a better answer.
- If you want a shorter or simpler answer, just say so.
- Keep asking questions until you are happy—your coach won't get tired.
- If you don't get a good answer, try asking again in a different way.
- If you don't like your coach's advice, you can ask it to give you other options.
- If you don't believe the answer, you can ask it to explain more or give you proof.
- Ask your coach anything that's on your mind—there are no bad questions!

HOW CAN I TRY IT OUT?

WhatsApp 605 to 087 373 1634 and start chatting now.



Or connect

instantly by using your phone camera to scan the QR code.

Try it now



QUESTIONS? CHALLENGES?

You can go to the Menu at any time and select Option 3, Chat with a live health coach, and someone will contact you as soon as possible.

Clinic folder number

YOUR
FREE

FRIENDLY,
CONFIDENTIAL
**AI HEALTH
COACH**

**LET'S CHAT
ANYTIME, 24/7**



WHAT IS AN AI HEALTH COACH?

It is a free service that you can use on WhatsApp anytime to get confidential information, advice, and support on HIV, TB, and other questions about your health and wellbeing.

WHY SHOULD I TRY IT?

Sometimes you just need someone to talk to about how you're feeling and what you're dealing with, without any rush or pressure or judgment, knowing that you'll get good advice.

Have questions you didn't have time to ask the nurse during your visit?
Your coach has all the time in the world. Ask as many questions as you want.

Have a personal question you feel a bit nervous or embarrassed asking?
No stress—you're in the right place! Your coach isn't a real person, so it will never judge or gossip.

Have a question between clinic visits?
Your coach is available on WhatsApp 24/7—anytime, day or night.

Want to feel more in control of your own health?
Your coach can tell you everything you want to know, in simple terms.

WHAT KINDS OF QUESTIONS CAN I ASK?

The AI health coach is best for questions about HIV and TB, but good health and well-being includes things like love, sex, family, friends, how people are treating you, or how you're feeling about life—so feel free to ask about anything that's on your mind.

IT'S YOUR CHOICE. YOU'RE IN CONTROL.

FOR HIV, YOUR COACH CAN ANSWER QUESTIONS LIKE:

- I just found out I have HIV and I feel angry. Is that normal?
- Can I still stay strong and healthy if I have HIV?
- I have HIV but I feel fine. What will happen if I don't start treatment?
- How can I tell my partner that I have HIV? I'm worried about their reaction.
- My partner and I want to have a baby, but I have HIV. Is it possible?
- I forgot to take my pill yesterday. What should I do now?
- I'm tired of these pills. Can I take a break from my treatment?
- Sometimes I just feel like giving up. What can I do?
- I'm confused about viral load. What is it and why does it matter?

FOR TB, YOUR COACH CAN ANSWER QUESTIONS LIKE:

- I'm scared to tell anyone that I have TB. What should I do?
- I have HIV and TB. Can I take treatment for both at the same time?
- Is it true that HIV increases my risk of getting TB? What can I do?
- I've been taking TB treatment and I feel better. Does that mean I can stop now?
- I have HIV. Should I get tested for TB even if I feel fine?
- If I have TB, does it mean I also have HIV?

WHAT ELSE CAN AN AI HEALTH COACH DO?

Helpful videos: Along with answering your questions, the AI Health Coach may share short videos—often featuring real experiences—to give you practical insights on the topics you're exploring.

Service finder: Ask your coach to help you find a clinic or pharmacy, if you have moved or just want to change.

Support: Your coach can offer encouragement and help you stay motivated when you're feeling down or stressed.

What does it cost?

It's FREE. You just need WhatsApp data or WiFi.

Can I use it on my phone?

Yes. It can be used on any phone or device that has WhatsApp.

Is it available 24/7?

Yes. You can use it anytime, day or night.

Can I trust it?

The AI health coach was designed and tested to give you reliable information and solid advice. It pulls from trusted sources like the Department of Health and the World Health Organisation. If you're ever in doubt about an answer, you can also double-check it with a nurse.

Can I stay anonymous?

Yes. You do not have to share your name or any other personal information with the AI health coach if you don't want to.

Are my chats private and confidential?

Yes. All chats with the AI health coach are private and confidential. You can also delete your chats whenever you want to.

If you have an issue that the AI health coach can't help with, it may offer to transfer you to a real-life health coach, but you can decide whether to say yes or no.