NATIONAL CONSOLIDATED GUIDELINES

FOR THE PREVENTION OF MOTHER-TO-CHILD TRANSMISSION OF HIV (PMTCT) AND THE MANAGEMENT OF HIV IN CHILDREN, ADOLESCENTS AND ADULTS

NATIONAL DEPARTMENT OF HEALTH
SOUTH AFRICA, APRIL 2015
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FOREWORD

I am proud to present the new consolidated guidelines for the prevention of mother-to-child transmission of HIV (PMTCT) and management of HIV in children, adolescents and adults.

The 10 point plan of the Health Sector is aimed at creating a well-functioning health system capable of producing improved health outcomes. Priority 7 of the 10 point plan alludes to accelerate implementation of the HIV/AIDS plan and the reduction of mortality due to TB and associated diseases.

The Department of Health is committed to ensuring universal access to Anti-Retroviral Therapy (ART) in order to improve the quality of lives and country health outcomes. The eligibility criteria for ART initiation have been revised to increase access to treatment. With effect from the 1st January 2015, the following criterion to start patients on lifelong ART applies:

» all HIV positive pregnant and breastfeeding women, regardless of CD4 count or WHO staging and
» Children > 5 years old, adolescents and adults with CD4 ≤ 500 cells/mm³.

This new criteria will increase access to ART for more people as well as reducing new infections through viral suppression.

The new consolidated guidelines provide standardized, simplified and less toxic drug combinations harmonized for the management of Prevention of Mother to Child Transmission (PMTCT), children, adolescents and adults with HIV/AIDS, TB and other common opportunistic infections. It will provide guidance for clinicians, managers and trainers on the use of available regimens within the context of continuum of HIV comprehensive care for prevention, treatment and support for all age groups in private and public sector to realize our vision of A LONG AND HEALTHY LIFE FOR ALL CITIZENS. This approach will also ensure that people living with HIV are started on the right regimen at the right time.

I am grateful to all the internal and external stakeholders who actively contributed to the development of these guidelines despite their demanding schedules.

It is our sincere wish that all clinicians at PHC clinics, community health centers and hospitals across the board will use these consolidated guidelines to offer quality, comprehensive services to the public.

DR AARON MOTSOALEDI
MINISTER OF HEALTH
DATE: 11/01/2015
ACKNOWLEDGEMENTS

The Department of Health would like to thank all individuals, organisations and experts who contributed towards the development of these guidelines. We would like to also acknowledge the three clusters namely Child and School Health; HIV/AIDS and STIs; Maternal, Neonatal and Women's Health for providing leadership in the development process.

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WHO TECHNICAL SUPPORT
1. WHO SA - Dr Busisiwe Msimang and Dr Augustin Ntilivamunda for their Technical Assistance, and special thanks to Dr Msimang for the development and pulling together of the consolidated ART guidelines
2. WHO headquarters team - Dr Meg Doherty, Dr Nathan Shaffer, Dr Martina Penazzato and Dr Nathan Ford for their contributions

SPONSORS:
1. WHO
   a. Funding for a 3-day meeting for consolidation of the guidelines at Emperor’s Palace
   b. Printing of 5,000 copies of guidelines for distribution to all public health facilities
2. UNICEF
   a. Printing 200 copies of draft guidelines used during training on the consolidated ART guidelines
   b. Funding the editing of the guidelines for first printing
3. FPD and ITECH
   a. Funding the 3-day training of master trainers from all provinces
4. AURUM Institute
   a. Desk aids ‘Managing HIV A Clinician’s Tool’ and design and formatting of guidelines
5. Right to Care
   a. Printing of 2000 copies of the guidelines
## Abbreviations and Acronyms

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<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>3TC</td>
<td>Lamivudine</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>ALT</td>
<td>Alanine transaminase</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal care</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral therapy</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral</td>
</tr>
<tr>
<td>ATV</td>
<td>Atazanavir</td>
</tr>
<tr>
<td>AZT</td>
<td>Zidovudine</td>
</tr>
<tr>
<td>BCG</td>
<td>Bacille Calmette Guerin (TB vaccine)</td>
</tr>
<tr>
<td>BD</td>
<td>Twice-daily</td>
</tr>
<tr>
<td>BMI</td>
<td>Body mass index</td>
</tr>
<tr>
<td>CD4</td>
<td>T-lymphocyte cell bearing CD4 receptor</td>
</tr>
<tr>
<td>CICT</td>
<td>Client-initiated counselling and testing</td>
</tr>
<tr>
<td>CLAT</td>
<td>Cryptococcal latex antigen test</td>
</tr>
<tr>
<td>CPT</td>
<td>Cotrimoxazole preventive therapy</td>
</tr>
<tr>
<td>Cr</td>
<td>Creatinine</td>
</tr>
<tr>
<td>CrAg</td>
<td>Cryptococcal antigen</td>
</tr>
<tr>
<td>CrCl</td>
<td>Creatinine clearance</td>
</tr>
<tr>
<td>CSF</td>
<td>Cerebrospinal fluid</td>
</tr>
<tr>
<td>CTX</td>
<td>Cotrimoxazole</td>
</tr>
<tr>
<td>d4T</td>
<td>Stavudine</td>
</tr>
<tr>
<td>DOT</td>
<td>Directly observed treatment</td>
</tr>
<tr>
<td>E</td>
<td>Ethambutol</td>
</tr>
<tr>
<td>EFV</td>
<td>Efavirenz</td>
</tr>
<tr>
<td>eGFR</td>
<td>Estimated glomerular filtration rate</td>
</tr>
<tr>
<td>ELISA</td>
<td>Enzyme-linked immunosorbant assay</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded programme on immunisation</td>
</tr>
<tr>
<td>EPTB</td>
<td>Extrapulmonary tuberculosis</td>
</tr>
<tr>
<td>FBC</td>
<td>Full blood count</td>
</tr>
<tr>
<td>FDC</td>
<td>Fixed dose combination</td>
</tr>
<tr>
<td>FTC</td>
<td>Emtricitabine</td>
</tr>
<tr>
<td>GFR</td>
<td>Glomerular filtration rate</td>
</tr>
</tbody>
</table>
GIT | Gastrointestinal tract
--- | ---
Hb | Haemoglobin
HBCAg | Hepatitis B core antigen
HBsAg | Hepatitis B surface antigen
HBV | Hepatitis B virus
HCT | HIV counselling and testing
HCV | Hepatitis C virus
HDL | High density lipoproteins
HIV | Human immunodeficiency virus
INH | Isoniazid
IPT | Isoniazid preventive therapy
IRIS | Immune reconstitution inflammatory syndrome
LDH | Lactose dehydrogenase
LFT | Liver function tests
LPV | Lopinavir
LPV/r | Lopinavir/Ritonavir
LTFU | Loss to follow-up
MCC | Medicines Control Council
MCH | Maternal and child health
MC&S | Microscopy, culture and sensitivity
MDR-TB | Multi-drug resistant tuberculosis
MNCCH | Maternal, newborn and child health
MTCT | Mother-to-child transmission of HIV
NNRTI | Non-nucleoside reverse transcriptase inhibitor
NRTI | Nucleoside reverse transcriptase inhibitor
NVP | Nevirapine
OD | Once daily
OHL | Oral hairy leukoplakia
OI | Opportunistic infection
p24 | HIV antigen test
Pap smear | Papanicolaou test
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>PCR</td>
<td>Polymerase chain reaction (a laboratory nucleic acid detection test)</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary healthcare</td>
</tr>
<tr>
<td>PI</td>
<td>Protease inhibitor</td>
</tr>
<tr>
<td>PICT</td>
<td>Provider-initiated counselling and testing</td>
</tr>
<tr>
<td>PLWHA</td>
<td>Person living with HIV/AIDS</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of mother-to-child transmission of HIV</td>
</tr>
<tr>
<td>PPD</td>
<td>Purified protein derivative (Screening test for TB)</td>
</tr>
<tr>
<td>PTB</td>
<td>Pulmonary tuberculosis</td>
</tr>
<tr>
<td>PZA</td>
<td>Pyrazinamide</td>
</tr>
<tr>
<td>QID</td>
<td>Four times daily</td>
</tr>
<tr>
<td>R (RIF)</td>
<td>Rifampicin</td>
</tr>
<tr>
<td>RBC</td>
<td>Red blood cells</td>
</tr>
<tr>
<td>RTH</td>
<td>Road to Health</td>
</tr>
<tr>
<td>S</td>
<td>Streptomycin</td>
</tr>
<tr>
<td>SANAC</td>
<td>South African National AIDS Council</td>
</tr>
<tr>
<td>Sd NVP</td>
<td>Single-dose nevirapine</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and reproductive health</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infections</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TDF</td>
<td>Tenofovir</td>
</tr>
<tr>
<td>VL</td>
<td>Viral load (HIV)</td>
</tr>
<tr>
<td>WBC</td>
<td>White blood cells</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
<tr>
<td>XDR-TB</td>
<td>Extensively drug resistant tuberculosis</td>
</tr>
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## DEFINITION OF KEY TERMS

<table>
<thead>
<tr>
<th>Term</th>
<th>Working definition in these guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant</td>
<td>Child younger than one year of age</td>
</tr>
<tr>
<td>Child</td>
<td>10 years of age and younger</td>
</tr>
<tr>
<td>Adolescent</td>
<td>Aged 10 to 19 years inclusive</td>
</tr>
<tr>
<td>Early Adolescent</td>
<td>Age 10 to 15 years</td>
</tr>
<tr>
<td>Late Adolescent</td>
<td>Age 15 to 19 years inclusive</td>
</tr>
<tr>
<td>Adult</td>
<td>Older than 19 years of age</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral therapy refers to the use of combination of three or more ARV drugs to achieve viral suppression and is usually given for life</td>
</tr>
<tr>
<td>ARV</td>
<td>Antiretroviral drugs refer to the medicines themselves and not to their use</td>
</tr>
<tr>
<td>Birth HIV PCR testing</td>
<td>HIV PCR testing at birth for all HIV exposed neonates</td>
</tr>
<tr>
<td>CICT</td>
<td>Client initiated counselling and testing; testing process initiated by an individual who wants to learn his/her HIV status</td>
</tr>
<tr>
<td>Community Health Workers</td>
<td>Health workers who received standardised training outside a nursing/medical curriculum</td>
</tr>
<tr>
<td>Continuum of care</td>
<td>Concept of an integrated system of care that guides and tracks clients over time, through a comprehensive array of health services spanning from screening for HIV, to diagnosis and management of HIV, to initiation onto ART, retention in care and psychosocial support</td>
</tr>
<tr>
<td>Couple</td>
<td>Two people in an ongoing sexual relationship</td>
</tr>
<tr>
<td>Eligible for ART</td>
<td>Refers to people living with HIV for whom ART is indicated</td>
</tr>
<tr>
<td>Healthcare provider</td>
<td>Anyone who renders healthcare; includes doctors, nurses, counsellors</td>
</tr>
<tr>
<td>High-risk neonates</td>
<td>Neonates classified as having an increased risk of being infected with HIV in utero or at birth</td>
</tr>
<tr>
<td>HIV symptomatic infant</td>
<td>Any HIV-exposed infant displaying failure to thrive, haematological abnormality such as anaemia or thrombocytopenia, congenital pneumonia, pneumonia, hepatosplenomegaly, extensive oral candidiasis, significant lymphadenopathy and any opportunistic infections</td>
</tr>
<tr>
<td>HIV-exposed infant</td>
<td>Infant born to a woman who is HIV-positive or who becomes HIV-positive anytime during pregnancy, labour and delivery or breastfeeding. The infant is at risk of acquiring HIV infection from the mother. The infant/child may test HIV-positive on antibody testing, reflecting the mother’s antibodies</td>
</tr>
<tr>
<td>Key populations</td>
<td>Both vulnerable and most-at-risk populations</td>
</tr>
<tr>
<td>----------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>PICT</td>
<td>HIV testing and counselling recommended by healthcare provider in a clinical setting</td>
</tr>
<tr>
<td>Sero-discordance</td>
<td>Sexual partners where one partner is living with HIV and the other is HIV-negative</td>
</tr>
<tr>
<td>Treatment failure</td>
<td>Treatment failure in adults and children, including infants, is defined by a persistently detectable viral load exceeding 1000 copies/ml (that is, 2 consecutive viral load measurements within a 2-month interval, with adherence support between measurements) after at least six months of using ARV drugs</td>
</tr>
<tr>
<td>Viral suppression</td>
<td>Refers to the aim of ART to maintain viral load below detectable levels of available assays (&lt;50 copies/mL)</td>
</tr>
<tr>
<td>Virological failure</td>
<td>See treatment failure</td>
</tr>
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1 INTRODUCTION

1.1 BACKGROUND AND CONTEXT

The Government of South Africa has adopted a new outcome-based approach to accelerate the attainment of the objectives outlined in the Negotiated Service Delivery Agreement for the health sector. The main outputs include increasing life expectancy, reducing maternal and child mortality rates, combating HIV and AIDS, and decreasing the burden of diseases from TB, as well as strengthening health system effectiveness.

On 1 December 2009, on World AIDS Day, the Honourable President Jacob Zuma announced new key interventions to improve antiretroviral treatment (ART) access to special groups (all HIV-positive infants, and pregnant women and people with TB and HIV co-infection and with CD4 counts less than or equal to 350 cells/µl), in order to decrease the disease burden, to address maternal and child mortality and to improve life expectancy. This resulted in more than 2.6 million people being initiated on ART by mid-2014.

In 2013, the fixed-dose combination pill (FDC) was introduced, made up of the regular three drugs used in the first-line regimen (TDF,FTC/3TC and EFV) to improve adherence and retention. On 23 July 2014, the Minister of Health, Dr. Aaron Motsoaledi announced that the threshold for initiation of ART will rise to CD4 count ≤500/µl and that the PMTCT programme will now adopt the option B+ approach, which entitles every pregnant and breastfeeding woman to lifelong ART regardless of CD4 count or clinical staging. This was effected on January 2015.

Great strides have been made in the prevention of mother-to-child transmission (PMTCT) of HIV, with coverage of HIV testing of pregnant women now being close to 100%. PMTCT is offered in almost all health facilities in South Africa (98%), the percentage of HIV-positive pregnant women receiving ART to reduce MTCT has steadily increased from 83% in 2009 to 87.1% in 2012, and MTCT has decreased to 2.7% in 2011.

These successes are underpinned by a range of interrelated, evidence-guided strategic and operational plans, monitoring initiatives, and policies and guidelines – paving the way for South Africa to attain its objective of reducing mortality from HIV and TB.

There is a need, however, to strengthen focus on adolescents and prevent them from acquiring HIV and to treat and support them to take medication, in line with the new health department 2030 aspirational targets of having 90% of people tested for HIV and 90% of those eligible for treatment on treatment, with at least 90% of those on treatment virally suppressed. These new guidelines will assist in providing the necessary guidance towards improved management of HIV across different populations.

1.2 WHAT IS NEW IN THESE GUIDELINES

The main changes for pregnant/breastfeeding women, paediatrics, adolescents and adults are summarised in Boxes 1-3 below.

Box 1: Changes specific to pregnant/breastfeeding women

» Immediate initiation of lifelong ART for all HIV-positive women who are pregnant, breastfeeding or within 1 year post-partum, regardless of CD4 cell count
» Use of EFV as part of the first-line regimen, regardless of the gestation of the pregnancy
» Use of maternal lifelong ART throughout pregnancy and breastfeeding to reduce MTCT
» Viral load testing for women on ART≥3 months at confirmation of pregnancy to direct management
» Repeat HIV testing for HIV-negative women 3-monthly during pregnancy, at labour/delivery, at the 6 week Expanded Programme on Immunisation (EPI) visit and 3-monthly throughout breastfeeding. This should be done during routine antenatal care, postnatal care and EPI/child health follow-up visits
» Women with contraindications to FDC should be considered high-risk pregnancies. They should be initiated on AZT immediately and referred urgently for initiation on to three single ART drugs
» Provision of birth HIV PCR for all HIV exposed neonates
» Use of extended 12 weeks NVP or dual post-exposure prophylaxis with NVP and AZT for infants where maternal viral load suppression may be inadequate
Box 2: Changes specific to infants and early adolescents

» Provision of ART for all children under 5 years, regardless of their CD4 cell count or clinical staging
» ART initiation for children ≥5 years now starts at CD4 count ≤500 cells/µl regardless of clinical staging
» Immediate initiation of infant ART with first positive HIV PCR, whilst waiting for confirmatory test results
» Use of second HIV PCR test as a confirmatory for positive HIV PCR test
» No longer use viral load as part of baseline assessment for ART initiation in children
» Birth PCR HIV testing of all HIV-exposed neonates, repeated at 10 weeks and Rapid HIV test at 18 months. For those on extended 12 week NVP, the PCR will be repeated at 18 weeks and a Rapid HIV test at 18 months.

Box 3: Changes specific to late adolescents and adults

» Earlier initiation of ART at CD4 count ≤500 cells/µl
» Provision of ART for those with Hepatitis B (HBV) co-infection, regardless of CD4 count or clinical staging
» Harmonised ART regimen across populations, mainly pregnant and breastfeeding women, adolescents and adults
» Initiation of ART for all HIV/TB coinfected patients
» Inclusion of guidance on HIV for key populations
» Use of simplified fixed-dose combinations for ART
» Use of viral load for monitoring treatment success and early identification of treatment failure
» Routine cryptococcal infection screening for all HIV-infected patients with CD4 <100 cells/µl
» Use of Tuberculin Sensitivity Test (TST) as part of screening for IPT
» Use of third-line drugs for patients failing second-line regimens

1.3 RATIONALE FOR CONSOLIDATED GUIDELINES

» The consolidated, integrated guidelines offer guidance on using ARV drugs within the context of the continuum of HIV-related prevention, treatment and care. The major aspects of HIV-related care for all age groups and populations are addressed
» The respective ART guidelines for adolescents and adults have been combined with those for children and PMTCT, thereby harmonising ARV regimens and treatment approaches to the extent that is possible across different age groups and client populations
» Consolidation has allowed for new recommendations to be aligned across these groups, reduce duplication of information and promote consistency of approaches
» In addition, the consolidated document strengthens integration of services at facilities. This simplifies access to guidelines for healthcare providers for different groups of people seeking care. The guidelines reinforce family-centred care and one-stop-shop approaches to service provision
» The consolidated guidelines also enable more timely, consistent and simultaneous updates on new science and emerging practice applicable to all groups
1.4 GOALS AND OBJECTIVES

The main purpose of these guidelines is to improve the clinical outcomes of people living with HIV, reduce morbidity due to TB/HIV co-infection, reduce HIV incidence and avert AIDS-related deaths in the most cost-efficient manner by ensuring that people living with HIV start with the right therapy at the right time.

General objectives:

» Ensure timely HIV diagnosis, management, treatment and initiation of ARVs for treatment for all eligible populations to achieve best health outcomes in the most cost-efficient manner

» Contribute to strengthening of the health sector’s capacity to deliver high-quality integrated health and wellness services

» Implement cascade management and ensure continuity of care

» Provide standardised and simplified less toxic treatment, which is harmonised amongst pregnant women, breastfeeding mothers, adolescents and adults in both the private and public sector

» Simplify guidance for health workers to improve the quality of HIV care for all people living with HIV and HIV-exposed infants

» Prevent new infections and reduce AIDS-related deaths among children, adolescents and adults

Specific objectives:

» Promote viral load testing as a preferred approach for monitoring ART success and diagnosing treatment failure

» Provide lifelong ART for all pregnant and breastfeeding women living with HIV

» Initiate ART earlier at a CD4 count threshold of 500 cells/µl

» Prioritise initiation of patients with CD4 count of ≤350 cells/µl, severe HIV disease and HIV/TB co-infection

» Strengthen retention in care and adherence to ART

» Reinforce phasing out of d4T in first-line regimens

» Ensure that HIV and TB services are provided as part of integrated maternal and child health, and sexual and reproductive health services

» Test all HIV-exposed and symptomatic children and initiate ART in all children under <5 years of age who are HIV-positive

1.5 TARGET AUDIENCE

All categories of healthcare professionals, healthcare workers, managers of the national health laboratory services, programme managers at district, provincial and national level and community-based organisations working with people living with HIV.

1.6 THE SCOPE AND CONTENT

These guidelines address clinical and programmatic aspects of HIV treatment and prevention amongst pregnant and breastfeeding women, children, adolescents and adults by making use of the continuum of care, from HIV testing and counselling, linkage with care and treatment, general HIV care and all aspects of ART management. This includes ART initiation (when to start and selection of ART regimen for respective populations), adherence and retention strategies and monitoring and evaluation.

The guidelines do not provide detail for complementary programmes such as sexually transmitted infections, cervical cancer screening, contraception and fertility planning. These are covered in other guiding documents.
1.7 THE STRUCTURE AND CONTENT

The structure of these guidelines uses the continuum of care approach, also referred to as the treatment cascade, which reflects the different services that people living with HIV need to achieve optimal health outcomes. These include HIV testing and diagnosis, linkage to appropriate medical care (and other health services), support while in care, access to HIV treatment if eligible, support with treatment adherence and retention in care. The guidelines, however, do not include services for people who are HIV-negative.

The document also looks at different population groups starting from pregnant and breastfeeding women, infants and children, adolescents and adults. Early adolescents are addressed in the same sections as children, while late adolescents are addressed in the adult sections.

Chapter 1: Describes the background, context, rationale and objectives of the guidelines and the target audience. It also provides a summary of what is new in these guidelines

Chapter 2: Outlines the guiding principles that underpin these guidelines

Chapter 3: Summarises HIV testing and counselling approaches and describes these in different populations

Chapter 4: Summarises general HIV care for individuals from the time that they are diagnosed with HIV infection to the time that they are initiated on ART. Addresses practices for linking people diagnosed with HIV infection to HIV care and treatment, the components of a general care package and preparing individuals for starting ART

Chapter 5: Outlines the principles of adherence to treatment and approaches for HIV disclosure

Chapter 6: Provides guidance on the eligibility criteria and optimal timing for ART initiation (when to start). Describes the first and second-line treatment regimens for the different populations (what to start or what to switch to) and provides recommendations for monitoring the response to and toxicity of ART. The chapter also includes guidance on labour, delivery and postnatal care for mother and baby

Chapter 7: Describes the different dosing recommendations for ARV drugs, ARV drug interaction with other drugs, their side-effects and toxicity

Chapter 8: Summarises the nutrition and feeding principles for infants and children

Chapter 9: Outlines the diagnosis and treatment of anaemia in people living with HIV for different populations

Chapter 10: Gives guidance on the prevention and management of opportunistic infections

Chapter 11: Provides guidance on a range of tools and indicators to be used to monitor the performance of programmes across the HIV continuum of care. It also provides data flow and reporting mechanisms for the different components of the treatment cascade
2 GUIDING PRINCIPLES

2.1 INCREASING EFFECTIVENESS AND EFFICIENCY OF PROGRAMMES

Due to the limited resources and competing priorities within a strained health system, it is essential to give priority to providing ARV drugs to people living with HIV who are eligible and most in need to achieve the desired impact.

2.2 MANAGING HIV AS A CHRONIC HEALTH CONDITION

With such a vigorous response to HIV, sustained high survival rates of patients can be expected and HIV-positive people now live longer, healthier lives, placing HIV in the realm of chronic diseases. The emerging chronic character of HIV means that the course of illness is longer and may also show some stability. As such, HIV interventions at primary healthcare settings should be re-conceptualised within the chronic disease management model which allows the coordination of interventions that occur at the level of clinical services, the community and individual patient.

2.3 STRENGTHENING INTEGRATION OF SERVICES

People living with HIV often have other health issues and integration of HIV services with primary healthcare (PHC), maternal, new-born and child health (MNCH) and TB provides an opportunity for more patient-centred care. Different services such as sexual and reproductive health, TB and HIV services, and operational programmes can be joined to maximise on collective outcomes.

2.4 PROMOTING HUMAN RIGHTS AND HEALTH EQUITY

Access to HIV prevention, care and treatment is key to ensuring the universal right to care. Healthcare providers and institutions should render services based on principles of medical ethics and the right to equitable and quality healthcare. As signatories of the United Nations Convention of the Rights of the Child, healthcare providers in South Africa are obliged to comply with principles pertaining to children, which include the right of a child to life, survival and development; the right to equitable treatment and care and that all actions should be based on the best interests of the child.

2.5 PROMOTING A FAMILY APPROACH TO HIV CARE

Family-centred approaches represent the most appropriate and cost-effective models for responding to the challenges of HIV prevention, treatment and care. This includes ensuring that programmes provide appropriate care to women before, during and after pregnancy and, integrates maternal and child care services such that children have timely access to treatment and that early child development is supported. Couples and families, especially mothers and their infants, should receive healthcare at the same consultation regardless of the service point.
2.6 THE HIV CONTINUUM OF CARE APPROACH

This document gives guidance across the continuum of care, as shown in the diagram above. It flows from HIV testing and counselling, through linkage to care and treatment, to general HIV care and retention in care. It also acknowledges that patients cycle in and out of care and includes all aspects of ART.

HIV testing is the first component of the continuum of care approach and offers those that are unaware of their HIV status an opportunity to know their HIV status, or those who are HIV-negative to repeat the HIV test to be able to access appropriate care. This includes testing pregnant and breastfeeding women, early infant diagnosis using age-appropriate testing and testing adolescents as well as adults. Those who test negative should receive counselling to assess risk and be offered tailor-made risk reduction counselling that reinforces risk reduction behaviour.
3 HIV COUNSELLING AND TESTING

3.1 OVERARCHING PRINCIPLES OF HIV COUNSELING AND TESTING

HIV counselling and testing (HCT) is vital for identifying HIV-positive persons and provides an entry point to comprehensive HIV prevention, treatment, care and support. It encourages individuals, couples, families and communities to know their HIV status and supports positive living, healthy lifestyles and good nutrition. It also helps identify and reduce behaviours that increase HIV transmission risks.

HCT is the first component of the continuum of care, and forms part of the HIV treatment cascade. For those who test HIV-positive, HCT provides an important opportunity for patient education on HIV disease and adherence, and is an essential step towards successful referral pathways that link patients to HIV care.

There are many different circumstances where a patient may be tested for HIV, for example, for individuals and couples; pregnant mothers for PMTCT as part of clinical care and screening; in cases of sexual assault or domestic violence; for abandoned babies; in response to a court order; and as part of medical male circumcision. In all instances, HCT must be ethical, confidential, based on human rights, conducted within a supportive environment, and be performed where there is relevant and adequate healthcare infrastructure.

All forms of HCT should be voluntary and adhere to the five C’s: consent, confidentiality, counselling, correct test results and connections to care, treatment and prevention services. People who are tested for HIV after counselling must give informed consent to be tested and be informed of their right to decline testing.

HCT services are confidential, however, shared confidentiality with a partner or family members and trusted others and with healthcare providers is often beneficial and is usually encouraged.

There are two types of HCT, client-initiated counselling and testing (CICT), as well as provider-initiated counselling and testing (PICT).

Children may self-consent to HIV testing if they are 12 years of age and above, and the child is of sufficient maturity to understand the benefits, risks, and social implications of an HIV test. However, for children over the age of 12 with insufficient maturity to understand the benefits, risks, and social implications of an HIV test, a parent or caregiver must give consent for the test. The recognition of a caregiver as a surrogate decision-maker for children in relation to HIV testing recognises that the absence of a parent or guardian should not serve as a barrier to a child accessing HCT.

A caregiver is defined as anyone who is responsible for the day-to-day care of the child in the absence of a parent or guardian.

These guidelines will discuss the general principles of HCT for pregnant and breastfeeding women, children and infants, adolescents and adults.

3.2 PROCESS FOR HIV COUNSELLING AND TESTING

All patients receiving both CICT and PICT should provide, at a minimum, verbal consent for HIV testing. Where possible, those receiving CICT can provide verbal consent only, which should be documented by the healthcare provider in the patient’s file.

HCT should be done according to the Department of Health testing algorithm (Figure 1). All patients tested for HIV should be recorded in the HCT register, regardless of where the HCT is done. Those who test positive for HIV should be further recorded in the pre-ART register to ensure tracking of linkage to care.

A group session should outline the benefits of HCT to the patient and if the patient is pregnant, it should include the benefits for the baby.

The individual HCT sessions should include an assessment of whether the information communicated in the group session has been understood and remaining questions answered, with an aim to clarify any misunderstanding, and address any concerns. For those who test HIV-positive, a second confirmatory HIV test is mandatory. All patients must receive post-test counselling, regardless of their HIV results. This includes risks for HIV transmission; safe sex and the use of condoms (even during pregnancy); contraception and fertility planning; HIV testing for sexual partners and children; repeat HIV testing for those who are HIV-negative; and PMTCT including safe infant feeding and infant prophylaxis.
Figure 1: Algorithm: HCT using rapid antibody test (adolescents/adults including pregnant/breastfeeding women)

- Group information session to all clients
- Individual information session and offer to test
- Agree to test (Patient provides verbal consent)
  - Tests HIV NEGATIVE (Final result is negative)
    - Post-test counselling
    - Repeat HIV test after 3 months
    - Educate on window period and HIV risk reduction
    - Repeat HCT for women on PMTCT program
  - Tests HIV POSITIVE (Confirm by 2nd rapid HIV test)
    - 2nd Tests HIV POSITIVE (Final result is positive)
      - Post-test counselling
      - Same day: TB screening (if not done), HIV education, CD4 cell count, HBsAg, creatinine (if indicated), clinical staging
      - If pregnant/breastfeeding: Initiate ART same day
      - 2nd test HIV NEGATIVE (Final result INDETERMINATE)
        - Do HIV ELISA
          - Final HIV positive/negative result depends on ELISA results
- Refuse to test
  - • Post-refusal counselling
  - • Continuously offer PICT with each visit
3.3 MANAGING CLIENTS WHO TEST HIV-NEGATIVE

Patients who test HIV-negative should be offered a repeat test after 3 months if exposed, and educated on the window period. They should also be counselled on HIV risk reduction behaviour and be offered HIV prevention services such as medical male circumcision and condoms.

Pregnant and breastfeeding women who test negative should be considered part of the PMTCT programme and be offered routine repeat HIV testing throughout pregnancy, labour and breastfeeding periods. In South Africa, 4% of women who were initially HIV-negative become HIV-positive later in pregnancy. Regular repeat testing is essential.

3.4 SUMMARY OF WHEN TO REPEAT HCT

Table 1: When to repeat HCT

<table>
<thead>
<tr>
<th>WHO</th>
<th>WHEN</th>
</tr>
</thead>
</table>
| Pregnant/Breastfeeding women (to detect HIV sero-conversion) | » Every 3 months throughout pregnancy  
» At labour/delivery  
» At the 6 week EPI visit  
» Every 3 months throughout breastfeeding  
(See Box 4) |
| HIV-exposed babies               | Birth, 10 or 18 weeks, 18 months          |
| General population                | 6–12-monthly depending on risk            |
| Adolescents                      | » 6–12-monthly if sexually active or  
» more frequently if they have new sexual partner/s or  
» if having unprotected intercourse |
| If exposed to HIV (adult and adolescent) | After 6 – 12 weeks for window period |
| Key populations (MSM and sex workers) | Every 6– 12 months |
| Families of index cases          | As soon as possible after the family member is diagnosed |

3.5 HCT IN PREGNANT AND BREASTFEEDING WOMEN

» HCT should be offered to all pregnant and breastfeeding women with unknown HIV status or those who tested HIV-negative 3 or more months previously

» All pregnant and breastfeeding women must be screened for TB symptoms using the screening tool at every visit to the clinic, irrespective of their HIV status.

» All women attending antenatal care (both first-time attendees and women attending follow-up visits) should be given routine information about HIV testing and the PMTCT programme

» All pregnant women should be encouraged to book into antenatal care early, as soon as they believe they are or are confirmed to be pregnant. They should be offered HCT at their first antenatal visit, and if HIV-negative, follow HCT protocol as stipulated in section 3.6
» The partner/spouse and older children should be encouraged to test for HIV as well and they should be counselled on safer sex, provided with condoms and discuss future family planning options

» Regardless of whether they test positive or negative, all pregnant women should be considered as part of the PMTCT programme and should be offered information on the availability of PMTCT interventions during all healthcare consultations. They must also be counselled on safe infant feeding, be assisted in making appropriate feeding choices, be informed and counselled that exclusive breastfeeding for the first six months is the best option. They should also be informed and counselled that complementary foods should only be introduced from 6 months of age, with continued breastfeeding for at least 12 months

» All pregnant women are encouraged to involve partners or spouses during HCT and in caring for the pregnancy. Condom use during pregnancy should be encouraged.

» All pregnant women are encouraged to be registered on MomConnect

» Women who test HIV-positive on the initial screening test should have their HIV status confirmed using a second rapid HIV test with another test type in compliance with HCT policy as in Algorithm 1. Discordant results should be confirmed with an ELISA test. All confirmed HIV-positive women are eligible for immediate initiation with lifelong ART, preferably FDC

» Women who initially test negative and subsequently test HIV-positive at any time during pregnancy or breastfeeding should initiate FDC on the day of diagnosis following the guidance (refer to Section 6.1)

» Women who choose not to be tested must be provided with individual ‘post-refusal’ counselling and be offered HIV testing at every subsequent visit in a non-coercive manner during the antenatal period, at the onset of labour and, if this is not possible, shortly after childbirth. They should also be provided with a TB symptom screen at each visit

» Unbooked women reporting in labour must be counselled and tested for HIV at the earliest opportunity during labour and if positive, be provided with ART (refer to Section 6.1)

3.6 PREGNANT WOMEN WHO TEST HIV-NEGATIVE

All women who test negative should be offered repeat HIV testing every 3 months throughout pregnancy, at labour/delivery, at the 6-week EPI visit and 3 monthly throughout breastfeeding. They should also be provided with a TB symptom screen with each visit.

Post-test counselling of HIV-negative women should include:

» Education on HIV risk-reduction behaviour and where possible, must involve partners or spouses, focusing mainly on how to maintain their HIV-negative status

» Encourage correct and consistent use of condoms, particularly during pregnancy

» Provide routine antenatal, labour/delivery, postnatal and breastfeeding care

» Receive education and counselling about exclusive breastfeeding for the first 6 months, with complementary foods from 6 months

» If the woman remains HIV-negative, to continue breastfeeding up to 24 months

» Education about TB symptoms, what to do when they have them and prevention of transmission
Box 4: Rationale for repeat HIV testing in HIV-negative women

In South Africa, approximately 4% of women who initially test HIV-negative in early pregnancy test HIV-positive later in the same pregnancy. Therefore, regular repeat testing is essential to detect new HIV infections (sero-conversions) occurring during pregnancy or breastfeeding. HIV sero-conversion results in a very high viral load and subsequent high risk of MTCT. If new maternal HIV infection goes undetected, there is up to 30% risk of MTCT. Detecting new HIV infections quickly enables the woman to be started on ART as soon as possible and the infant to be identified and managed as HIV-exposed. Repeat testing also addresses false negative results. Always ensure the HIV test is conducted according to procedure, including waiting the correct duration of time before reading the result.

3.7 HIV COUNSELLING AND TESTING (HCT) IN INFANTS AND CHILDREN

3.7.1 HIV tests in infants and children (HIV PCR or Rapid HIV antibody test)

Birth testing will be conducted in all HIV-exposed neonates. This is done to identify intra-uterine infected infants who are in the health care system at the time of birth. The intra-partum infections will be detected by a later test, done at 10 weeks. Birth testing would ensure that more HIV-infected infants access testing and would enable early initiation of treatment which will improve health outcomes and reduce infant mortality.
### Table 2: Infants and children who should be offered HCT

#### RECOMMENDED INTERVALS FOR INFANT AND CHILD TESTING

<table>
<thead>
<tr>
<th>HIV PCR test</th>
<th>Rapid HIV Antibody test</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>At birth</strong></td>
<td><strong>At 18 months:</strong> All HIV exposed infants</td>
</tr>
<tr>
<td>» ALL HIV-exposed neonates</td>
<td><strong>Breastfed infants: (6 weeks post cessation of breastfeeding)</strong></td>
</tr>
<tr>
<td>These infants can be regarded as high-risk cases that need an urgent diagnosis so should receive HIV PCR as soon as possible after birth.</td>
<td>All HIV exposed infants- age appropriate: if</td>
</tr>
<tr>
<td>Repeat HIV PCR testing at 10 weeks or 18 weeks should be done on all HIV-exposed infants without confirmed HIV infection, regardless of earlier testing.</td>
<td>&lt;18 months old- do HIV PCR</td>
</tr>
<tr>
<td>Any infant with a positive birth PCR should be urgently referred/discussed telephonically for ART initiation by a paediatric HIV expert</td>
<td>&gt;18 months old – do rapid HIV Antibody test</td>
</tr>
<tr>
<td><strong>At 10 weeks:</strong> All HIV-exposed infants</td>
<td><strong>Family and social history (at all times)</strong></td>
</tr>
<tr>
<td><strong>At 18 weeks:</strong> All infants who received 12 weeks of NVP prophylaxis</td>
<td>» Parental request to test the child</td>
</tr>
<tr>
<td></td>
<td>» Father or sibling with HIV infection</td>
</tr>
<tr>
<td></td>
<td>» Death of mother, father or sibling</td>
</tr>
<tr>
<td></td>
<td>» When the mother’s HIV status is unknown, her whereabouts are unknown, or she is unavailable to be tested</td>
</tr>
<tr>
<td>All children (at all times) with:</td>
<td><strong>All children (at all times) with:</strong></td>
</tr>
<tr>
<td>» Clinical features suggestive of HIV infection</td>
<td>» Clinical features suggestive of HIV infection</td>
</tr>
<tr>
<td>» Acute, severe illness</td>
<td>» Acute, severe illness</td>
</tr>
<tr>
<td>» IMCI classification of Suspected symptomatic HIV infection</td>
<td>» IMCI classification of Possible HIV infection</td>
</tr>
<tr>
<td>» IMCI classification of Possible HIV infection</td>
<td>» TB diagnosis or history of TB treatment</td>
</tr>
<tr>
<td>» TB diagnosis or history of TB treatment</td>
<td>» Risk of sexual assault</td>
</tr>
<tr>
<td>» Risk of sexual assault</td>
<td>» Wet-nursed or breastfed by a woman with unknown or HIV-positive status</td>
</tr>
<tr>
<td>» Children considered for fostering or adoption</td>
<td></td>
</tr>
</tbody>
</table>

#### 3.7.2 What HIV tests to do in infants and children

HIV counselling and consent from parents or primary caregivers is required before testing young children. The two HIV tests that are available are:

» HIV antibody detection tests e.g. HIV ELISA test and rapid tests

» HIV viral detection tests e.g. HIV PCR (polymerase chain reaction)
HIV antibody detection tests cannot distinguish between the mother and the baby’s antibodies. Maternal HIV antibodies are transferred via the placenta to the baby during pregnancy so that all vertically exposed babies will be born with HIV antibodies, and will test positive on antibody detection tests. These antibodies can remain in the baby’s blood for up to 18 months. If antibodies to HIV are found in children <18 months of age, the child is HIV-exposed (i.e. born to an HIV-positive mother) and a viral detection test such as an HIV PCR is required to establish the infection status of the child.

The HIV PCR test is highly accurate in determining the HIV infection status of an infant provided that all infants that test PCR positive have a confirmatory second HIV PCR test on the day of initiation of ART. The second HIV PCR to confirm every positive PCR test is mandatory. Initiation of ART should not be delayed while awaiting the result of the confirmatory viral detection assay. If the positive HIV status of a child already initiated on ART is disputed, additional HIV testing in consultation with the closest referral centre is warranted.

A negative antibody detection test at any age excludes HIV infection, provided the child was last breastfed 6 or more weeks before the test and has no clinical signs of HIV infection. If the mother is not available and there is no record of her HIV status, the HIV antibody tests can be done in children less than 18 months of age in order to determine whether or not the infant is HIV-exposed. If the rapid test is positive, immediately do an HIV PCR to determine if the infant is HIV-positive or HIV-negative.

**Box 5: HIV PCR for infants <18 months**

**Under 18 months: Use HIV PCR**

- This test detects HIV genes in human cells and is highly sensitive (98.8%) and specific (99.4%) from 6 weeks of age
- It will detect virtually all infections that have occurred in utero, during labour, delivery and breastfeeding in infants younger than 18 months. An HIV-exposed but uninfected child will test HIV PCR negative and an HIV-exposed infected child will test HIV PCR positive
- All HIV exposed infants will have a repeat HIV PCR at 10 weeks, which is four weeks after stopping NVP. However, there is a possibility of a false negative or indeterminate result, if the test is done to an infant who is still on NVP prophylaxis. Therefore, those on 12 week extended NVP should have their repeat PCR at 18 weeks. It is essential that any infant who presents to a facility with symptoms of ill health has a HIV PCR repeated, even if the previous PCR is negative
- For infants receiving extended NVP, at 10 week EPI visit, remind caregiver to continue NVP for 2 more weeks
- At the 14 week EPI visit, ensure NVP was stopped at 12 weeks. Remind caregiver of repeat PCR at 18 weeks.
- The HIV PCR test is highly accurate in determining the HIV infection status of an infant provided that all infants that test PCR positive have a confirmatory second HIV PCR test as stipulated in the algorithm in figure 2 on the day of initiation of ART
- Initiation of ART should not be delayed while awaiting the result of the confirmatory HIV PCR test
- If the positive HIV status of a child already initiated on ART is disputed, additional HIV testing in consultation with the closest referral centre is warranted
- Establish the best methods for reliably obtaining PCR test results from the laboratory and ensure effective troubleshooting if PCR test results are problematic
Figure 2: Algorithm for testing children <18 months of age

Check every child's HIV status at every health care visit. Repeat maternal HIV testing at 6 weeks EPI visit and then 3 monthly throughout breastfeeding in women who test HIV negative.

Mother HIV positive
- HIV PCR test at birth, at 10 weeks or any other time if indicated
- If HIV positive, take confirmatory PCR
- If HIV PCR indeterminate, repeat HIV PCR and viral load at the earliest possible opportunity
- If still breastfeeding, repeat HIV test 6 weeks after cessation of breastfeeding

Mother HIV uninfected
- No HIV test for child, unless symptomatic of HIV at any time
- HIV PCR negative
- Child HIV uninfected
- HIV PCR indeterminate, repeat HIV PCR and viral load at the earliest possible opportunity
- If still breastfeeding, repeat HIV test 6 weeks after cessation of breastfeeding

HIV-exposed infants who are PCR negative 6 weeks after stopping breastfeeding should have a confirmatory rapid test at 18 months of age. Infants of newly diagnosed HIV-positive breastfeeding mothers must receive an age-appropriate HIV test; HIV PCR if <18 months and HIV rapid test if ≥18 months, and start on NVP and AZT immediately. If the HIV test is negative, stop the AZT and continue daily NVP for 12 weeks. If the infant’s HIV test is positive, stop NVP and urgently initiate paediatric triple ART while retesting and confirming the HIV result.
Box 6: HIV rapid antibody test for infants ≥18 months

Older than 18 months: Use rapid HIV antibody test

» Use the same test used to diagnose or exclude HIV infection in adults

» If negative, the child is not infected provided there are no clinical features of HIV and breastfeeding stopped >6 weeks before the HIV test was done

» If positive, a second, different rapid test is used for confirmation. If the second rapid test is positive, the child is infected (as per National HCT guidelines)

» If the second rapid test is negative, an HIV ELISA test should be submitted to establish the child’s HIV status

All HIV tests performed and results obtained must be documented in the Road-to-Health (RTH) booklet, including the laboratory tracking barcode
Figure 3: Algorithm for routine testing children ≥18 months of age

All HIV-exposed children require a rapid test at 18 months, except HIV-infected children on ART.

Note: Healthcare workers must check with every HIV exposed child >18 months whether they received this rapid HIV test at 18 months. If it was missed, an HIV rapid test must be done regardless of how much older than 18 months the child is.
Box 7: HIV PCR for infants, including abandoned infants

- HIV rapid antibody tests can be used in children less than 18 months of age in order to determine whether or not the infant is HIV-exposed
- HIV status of abandoned infants <72 hours old should be established as soon as possible
- If the rapid test is positive, the child should be given stat dose and daily Nevirapine (NVP) until six weeks of age
- If the rapid test result cannot be obtained within 1-2 hours, treatment with NVP should be commenced
- If the infant tests antibody negative, NVP should be discontinued.
- The child should receive other treatments such as cotrimoxazole (at 6 weeks) for HIV-exposed infants if the status is still unknown or the infant is HIV-positive
- HIV PCR should be done if the rapid test is positive. If HIV PCR is positive, infant ART should be initiated urgently

3.7.3 Repeat HIV testing follow-up for HIV-exposed infants

Early infant diagnosis is vitally important and is closely linked to well-baby care. In the first year of life, monthly visits that incorporate immunisations should be scheduled for all infants during which routine health checks should be performed. Every contact with the healthcare service should be used to ensure that the child’s HIV-exposure status is known and documented in the RTH booklet. The HIV-exposure status of the child can be established by referring to the RTH booklet, taking a history from the mother or offering the mother an HIV test if her status is unknown or she requires repeat testing (Figure 1).

Table 3 provides the recommended routine immunisation schedule for all babies; HIV-exposed, HIV-positive and non HIV-exposed infants.
Table 3: Expanded Programme on Immunisation (EPI) schedule

<table>
<thead>
<tr>
<th>Age</th>
<th>Immunisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>» BCG</td>
</tr>
<tr>
<td></td>
<td>» OPV 0</td>
</tr>
<tr>
<td></td>
<td>» Bacillus Calmette-Guérin</td>
</tr>
<tr>
<td></td>
<td>(Do not give BCG to symptomatic HIV exposed infants and to infants born to mothers with active TB disease and have been on treatment for less than two months.)</td>
</tr>
<tr>
<td></td>
<td>» Oral Polio Vaccine</td>
</tr>
<tr>
<td>6 Weeks</td>
<td>» RV 1</td>
</tr>
<tr>
<td></td>
<td>» DTaP-IPV-HB-Hib</td>
</tr>
<tr>
<td></td>
<td>» Rotavirus Vaccine</td>
</tr>
<tr>
<td></td>
<td>» Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Vaccine and Haemophilus influenza type b and Hepatitis B Vaccine</td>
</tr>
<tr>
<td></td>
<td>» Pneumococcal Conjugated Vaccine</td>
</tr>
<tr>
<td>10 weeks</td>
<td>» DTaP-IPV-HB-Hib</td>
</tr>
<tr>
<td></td>
<td>Diphtheria, Tetanus, acellular Pertussis, Inactivated Polio Vaccine and Haemophilus influenza type b</td>
</tr>
<tr>
<td>14 weeks</td>
<td>» RV2</td>
</tr>
<tr>
<td></td>
<td>» DTaP-IPV-HB-Hib</td>
</tr>
<tr>
<td></td>
<td>» PCV2</td>
</tr>
<tr>
<td>6 months</td>
<td>Measles vaccine</td>
</tr>
<tr>
<td></td>
<td>Only for HIV-positive children</td>
</tr>
<tr>
<td>9 Months</td>
<td>» Measles Vaccine 1</td>
</tr>
<tr>
<td></td>
<td>» PCV3</td>
</tr>
<tr>
<td>18 Months</td>
<td>» DTaP-IPV-HB-Hib</td>
</tr>
<tr>
<td></td>
<td>» Measles Vaccine 2</td>
</tr>
<tr>
<td>6 years</td>
<td>Td Vaccine</td>
</tr>
<tr>
<td></td>
<td>Tetanus and reduced strength Diphtheria Vaccine</td>
</tr>
<tr>
<td>12 Years</td>
<td>Td Vaccine</td>
</tr>
</tbody>
</table>

Please note that the schedule is the same for both HIV positive and HIV negative infants, except for the 6 months measles vaccine, which is given only to HIV positive infants.

TB screening must be conducted at every EPI visit for both mother and child.
3.7.4 Using monthly well-baby visits for HCT

It is important to note that routine PCR is no longer done at 6 weeks for HIV exposed infants, but rather at 10 weeks, or 18 weeks, unless the infant is symptomatic of HIV or the birth PCR was not done.

**HIV testing at 6-week immunisation visit**

- Cotrimoxazole prophylaxis for all HIV-exposed infants starts at 6 weeks of age.
- At 6 weeks of age, establish and document every infant’s HIV exposure status, including the infants birth HIV PCR results.
- If the birth HIV PCR result is negative but the infant is symptomatic of HIV at the 6 week follow-up visit then repeat the HIV PCR test.
- If the baby was HIV exposed but did not have a birth PCR, do HIV PCR at the 6 week visit.

Appropriate responses are based on the mother’s HIV status is shown in Table 4 below:

- Maternal adherence should be reinforced.
- Initiate infant onto cotrimoxazole syrup from 4-6 weeks after birth.
- Discontinue NVP syrup unless infant is eligible for extended (12 week) course (indicated in Table 9).
- Obtain results for HIV PCR within the week. If positive, take a second HIV PCR and initiate ART while waiting for the confirmatory result.
- Continue cotrimoxazole syrup.
- If the HIV PCR test result is negative, continue cotrimoxazole syrup until the infant is confirmed HIV uninfected and has stopped breastfeeding completely.
- Repeat infant HIV PCR 6 weeks after breastfeeding cessation.
- Monitor infant growth.
- HIV-negative mothers should be offered an HIV test; if the result is positive, the infant should have an HIV PCR test.
- All mothers should be counselled about options for contraception.
- Reinforce infant feeding counselling.

**Table 4: HIV testing at six-week visit**

<table>
<thead>
<tr>
<th>Mother’s HIV status</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative maternal HIV status</td>
<td>Rapid test should be offered to mother to ensure she has remained HIV-uninfected</td>
</tr>
<tr>
<td>Unknown maternal HIV status</td>
<td>Offer a rapid test to the mother. If she tests positive then her infant should have a HIV PCR at the same visit. Provide the mother with the care she requires</td>
</tr>
<tr>
<td>Unknown maternal HIV status and mother refuses testing</td>
<td>Post-refusal counselling with encouragement to test at the next visit or at any time. If infant shows any signs suggestive of HIV then advise mother on the necessity to test the infant even if she refuses testing for herself</td>
</tr>
</tbody>
</table>
**HIV testing at 10-week immunisation visit**

» Ensure that the birth HIV PCR results have been documented

» HIV PCR testing should be performed in all HIV-exposed infants at 10 weeks of age, including HIV-exposed infants with a negative PCR performed at birth (except infants who are on 12 week NVP prophylaxis – these would have an HIV PCR done at 18 weeks)

» Consent to test the child for HIV can be obtained from the primary caregiver

» If the results of the HIV PCR done at 10 weeks is available sooner and is positive, contact the mother or caregiver and arrange for an earlier visit as the highest risk of infant death is between 2 and 3 months of age. If no HIV PCR results are available and a repeat sample is required, also arrange for an earlier visit

» Ensure that systems are in place to trace HIV PCR results and infants who have defaults in their visits

» Ensure that it is possible to fast-track positive HIV PCR results to mother-infant pairs

» If the HIV PCR is positive, a confirmatory HIV PCR must be sent immediately and the infant should be initiated onto lifelong ART (do not wait for the confirmatory result before initiating ART)

» If the HIV PCR test is negative and the child has not been breastfed since birth, then the infant is not infected

» If the HIV PCR test is negative, but the child was breastfed (within the six weeks preceding the test) or has continued to be breastfed, then repeat HIV testing will be required 6 weeks after breastfeeding has stopped or anytime if the child develops clinical features suggestive of HIV infection. The repeat HIV test will be a PCR if the child is below 18 months of age and an antibody rapid test if the child is older

**HIV testing at monthly well-baby visits between 10 weeks and 18 months**

» Every child’s HIV-exposure status should be determined at each monthly visit and mothers of unknown status or previously negative HIV status should be offered HIV testing according to Figure 1 (Algorithm 1, Section 3.2)

» Check at every visit if breastfeeding has stopped to ensure that an age-appropriate HIV test is performed 6 weeks after cessation of breastfeeding

» HIV testing should be repeated at any point if the child is symptomatic

» Every infant on 12 weeks of NVP prophylaxis must have a repeat PCR performed at the 18 week (4 month) well-baby visit. The result must be checked at the 5 month visit or sooner, if possible

**HIV testing at 18-month immunisation visit**

» Remember all HIV-exposed children with a negative HIV PCR test should have a repeat HIV (antibody) test at 18 months of age. Final infection status should be documented in the RTH booklet

» An HIV (antibody) test at 18 months of an HIV-positive child on ART is not required

» Children still breastfeeding at the 18-month visit require a further HIV antibody test 6 weeks after cessation of breastfeeding has occurred

3.7.5 HIV testing for breastfed children

Postnatal transmission via breast milk can occur at any time during breastfeeding. If breastfed infants test HIV PCR positive at any age then they are confirmed HIV-positive. They should be initiated on ART, a confirmatory HIV test sent and breastfeeding should be continued. HIV infection can only be excluded by documenting a negative HIV test 6 weeks after breastfeeding has completely stopped. Depending on the age of the child, a viral detection or antibody detection test to assess for postnatal transmission of HIV should only be done 6 weeks after breastfeeding has stopped.
All breastfed, HIV-exposed children should receive an HIV test as follows:

» HIV PCR test at 10 weeks of age for infants who are on 6 week NVP prophylaxis

» Repeat HIV PCR at 18 weeks for all infants who received an extended course of 12 weeks of NVP prophylaxis

» A rapid HIV test at 18 months of age

» An age-appropriate HIV test 6 weeks after breastfeeding has stopped

» Additional age-appropriate HIV tests if an HIV-uninfected, breastfed infant develops clinical features suggestive of HIV or if the mother is considering cessation of breastfeeding, and her decision will be influenced by the child’s HIV status

» Consider performing an age-appropriate HIV test if a infant is being breastfed and the mother’s latest viral load result is >1000 copies/ml

3.8 HCT IN ADOLESCENTS

The population of South African children with HIV are ageing into adolescence as a result of a maturing HIV epidemic, with an increase in the number of long-term non-progressors. The country has seen improved survival of HIV-positive children due to the provision of ART and an increase in behaviourally HIV-infected adolescents. Addressing the specific needs of perinatally HIV-infected adolescents and behaviourally HIV-infected adolescents and preventing pregnancies and HIV in adolescents are national priorities.

Even though adolescence is marked by rapid physical, intellectual and emotional growth, there is significant variation in the timing of developmental milestones and in the timing and degree of changes in rates of growth during adolescence. This means that there can be variation in development among adolescents of the same age, and that there are often significant differences between girls and boys.

For many reasons, adolescents are less likely than adults to be tested for HIV and less likely to be linked to services, whether they test positive or negative. More perinatally HIV-infected children are surviving into adolescence. Adolescents are vulnerable to and at relatively high risk of HIV infection.

HCT is not an end in itself, but rather a means to engage adolescents and link them to essential HIV treatment, care and prevention interventions. It also provides an opportunity to encourage health-seeking behaviour both among those testing negative (e.g. future re-testing for HIV, safe sex etc.) and those testing positive (e.g. linking to care services and supporting adherence to ART).

The following groups of adolescents are considered to be most-at-risk for HIV (often referred to as adolescents from key populations):

» Adolescent males who have sex with men (MSM)

» Adolescents who are sexually exploited and adolescents engaged in sex work

» Adolescents who inject drugs

» Transgender (TG) adolescents (male and female)

» Adolescents affected by AIDS (orphans and children of chronically ill caregivers)

» Adolescent clients of sex workers and the partners of these clients

It should also be noted that women aged 15 to 24 are the group with the highest rate of new HIV infections in South Africa and should therefore be considered to be at most risk.

HCT, with linkages to prevention, treatment and care should be offered to these adolescents. They should be counselled about the potential benefits and risks of disclosure of their HIV status to others and empowered and supported to determine it, when, how and to whom to disclose. Regardless of the HIV acquisition route, under-utilisation of HCT services results in late diagnosis and increased uptake results in earlier diagnosis and more effective care.
Disclosure of HIV status is a continuous process that occurs throughout adolescence and ranges from informing young people of their HIV status – either at diagnosis or later, depending upon their age – to adolescents independently sharing their HIV status with others when they are ready to do so. Adolescents and young people need a lot of support from healthcare providers, peers and the community to disclose safely and confidently, and to be able to cope with any negative reactions from family, friends and their community. Adolescents and young people in key populations are particularly sensitive to confidentiality issues as they often risk legal consequences and abuse linked to their high-risk practices and lifestyles.

### 3.9 HCT in Adults

All adults should be offered HCT whenever an opportunity arises, and this should be repeated annually, depending on the risk. Couple HCT increases access to earlier ART initiation and reaches more men. This can be extended to family counselling to identify children and adolescents in households who were not previously diagnosed.
4. GENERAL PRINCIPLES FOR LINKAGES AND RETENTION IN CARE

The outcome of HCT is only successful if those who are HIV-negative are supported to reduce their risk of acquiring HIV, and if those who are HIV-positive are successfully linked to the continuum of HIV care. For various reasons there is significant loss of patients from the time that people are diagnosed with HIV to the first assessment of ART eligibility. The treatment cascade shows two main leakages: people lost between a positive HIV test and the CD4 test, and those lost between CD4 test and the return visit for the CD4 test result.

Barriers include having to travel long distances to the clinic, long waiting times at the clinic, clinic staff shortages, inability to take time off work, lack of full understanding of the treatment plan, and fear of stigma and discrimination. However, when effectively linked to prevention, treatment and care services, HCT enables those being tested to make positive health-related decisions.

It is the responsibility of healthcare providers to identify appropriate services, connect with referral services, and clearly outline pathways of linkage and support patients, especially adolescents, to engage with the services that are available. People living with HIV need to enrol in care as soon as they become aware of their HIV-positive status.

Box 8: Strategies to improve linkage to care

» Post-test counselling provides an opportunity to discuss the importance of linking to other HIV-related services and sets out referral pathways with the patient. It is imperative that post-test counselling is provided to all clients, whether their results are HIV-positive or HIV-negative

» If acceptable to the adolescent, allow and encourage them to invite a supportive adult or friend to be present to support them

» At the time of HIV diagnosis, the healthcare provider should involve the patient in the decision-making process of ART initiation, and explain the entire treatment plan and follow-up visit schedules

» During HCT, identify and address any possible barriers to linkage to care

» Assessment for ART eligibility should be timely and done within clear referral pathways

» Services should be provided within the same facility where possible and minimise sending patients to a different institution for ART eligibility

» In terms of referrals, directly make appointments with the receiving institution on behalf of the patient and provide the patient with the appointment date and a referral letter

» Provide the patient with the contact information for referral services

» Treat mother and baby as a pair and provide services to both

» Where possible, engage patient in post-diagnosis support groups

» Register pregnant women on MomConnect at the first antenatal care (ANC) visit

» Use of SMS technology to remind patients of appointments

» Capacity-building and support for peer support worker approaches and community-based outreach workers

» Encourage the buddy system, whereby mutual support is provided by someone in a similar situation, or with a similar experience

» Loss to follow-up protocols to keep track of adolescents through the system

» Make a list of people close to the adolescent who could assist the adolescent to adhere to treatment and attend appointments
4.2 THE WELLNESS PROGRAMME (PRE-ART)

When patients have been diagnosed with HIV but are not yet eligible for ART initiation, they should be kept within the wellness programme where they are encouraged and given support to live a healthy lifestyle. Their CD4 cell count should be checked regularly, at least 6-monthly to assess eligibility for ART. The pre-ART or wellness programme should include the following:

» TB symptom screening at every visit: test all who have a positive symptom screen; initiate INH prophylaxis if eligible and give TB treatment if tested positive for TB

» Conduct clinical staging at every visit

» Screening and management of sexually transmitted infections

» Counselling on how to avoid HIV transmission to sexual partners and children

» Information and counselling on risk-reduction and combination HIV prevention approaches

» Support for disclosure and partner notification

» Information and counselling related to fertility, including planning for conception or contraception, as needed

» Counselling on nutrition and healthy lifestyle

» Screening and management of co-morbidities and non-communicable diseases

» Repeat CD4 testing and WHO clinical staging 6-monthly in adults and adolescents

» An annual cervical cancer screening (pap smear) for all HIV-positive women

» Advise patients to come back whenever they have health problems

4.3 PREPARATION FOR INITIATION ON ART

It is important to discuss the patient’s willingness and readiness to start ART. They should be educated on the benefits of treatment and the possible side-effects. Consider the nutritional status of the patient, co-morbidities and possible drug-interactions, and address any mental health and substance abuse issues.

Where children are concerned, a caregiver who will be responsible for ensuring that the child takes treatment and adheres to clinic appointments should be identified. A comprehensive nutritional, growth and development assessment for children and adolescents is essential.

Risk reduction counselling and combination HIV prevention approaches should be emphasised including safe sex, availability and use of condoms (especially during pregnancy), contraception and future fertility.
4.4 PREPARATION OF PREGNANT HIV-POSITIVE WOMEN

» HIV-positive pregnant women should be offered information on the availability of PMTCT interventions at all healthcare consultations and not only when visiting the antenatal clinic

» At the first ANC visit/HIV diagnosis, the patient should have a CD4 cell count test and serum creatinine taken and be staged clinically

» The patient should have a TB symptom screen at each visit, with further TB investigations if any of the answers to the screening questions are positive

» Patients should be screened and treated for syphilis and other STIs, in line with basic antenatal care

» The patient should receive FDC at the first antenatal visit, whether newly diagnosed or known to be living with HIV but not on ART. If FDC is contraindicated, these patients are considered to have high-risk pregnancies and require urgent referral to HIV/ART services. They should be given AZT 300mg twice daily until triple ART can be initiated

» HIV-positive women should return 1 week after their initial ANC visit to follow up their creatinine and CD4 cell count result and be managed accordingly

» Patients should receive counselling on safer sex, family planning, postnatal contraception, partner testing and routine cervical cancer screening

» Patients should undergo nutritional assessment and be equipped with appropriate nutritional care and support
5.1 PRINCIPLES OF ADHERENCE TO HIV TREATMENT

Education on adherence to treatment starts at the beginning of the treatment cascade, when a patient is diagnosed as HIV-positive. Adherence includes taking treatment as prescribed, keeping to appointments for test results, referrals and further investigation. The patient’s motivation to continue engaging with care regardless of eligibility for ART is influenced by their experience with the healthcare system and the attitude of healthcare providers.

Patients who are supported in their adherence efforts are much more likely to maintain viral loads (VL) that are undetectable. The link between VL suppression, clinical outcome and adherence should be explained. This should clarify to the patient how the VL is used to show that the treatment is working and allow patients to identify obstacles to successful adherence.

Adherence, especially to lifelong treatment, requires ongoing assessment and monitoring, which should be part of each clinic visit, as factors that influence adherence are dynamic and require different approaches as they change over time.

- Adherence counselling should start at the time of diagnosis, where patient education on HIV should be explained in detail. The treatment plan should be explained and expected clinic visits discussed.
- Encourage disclosure to family or friends who can support the treatment plan.
- Monitor and offer ongoing adherence support. Be supportive and non-judgmental to encourage open and honest patient communication.
- Adherence goal is >95% of doses taken. Patients with adherence <80% require more adherence support.
- Missed appointments for prescription pick-ups are a powerful predictor of poor adherence, and should trigger immediate questions about issues that may affect attendance and adherence.
- Routine adherence discussion/education with adherence counsellors is valuable. This should be an open-ended discussion, with time for questions and key points about adherence reinforced.
- Patients should be reassured on the transient nature of side-effects such as nausea and vomiting at treatment initiation.
- Address adverse events, interim illness and issues around stigma and disclosure.
- Encourage caregiver participation in a support group.
- There should be monthly counselling visits for the first 3 months and quarterly thereafter, and feedback given to the rest of the team to develop a better profile of the patient’s environment.
- Identify food insecurity and actively address this through government support programmes.
- Ensure communication between clinic visits and between referral points.
5.2 STRATEGIES TO PROMOTE ADHERENCE

**Box 9: Strategies to promote adherence**

<table>
<thead>
<tr>
<th>Ensure quality adherence counseling</th>
<th>Support patient with adherence tools</th>
</tr>
</thead>
<tbody>
<tr>
<td>» Spend time with the patient and explain the disease, the goals of therapy and need for adherence</td>
<td>» Encourage attendance and participation in a support group</td>
</tr>
<tr>
<td>» Discuss the role of VL and suppression</td>
<td>» Self-reporting on adherence should be encouraged</td>
</tr>
<tr>
<td>» Negotiate a treatment plan that the patient can understand and commits to</td>
<td>» Reinforce use of pillboxes or a daily dosing diary</td>
</tr>
<tr>
<td>» Explain to patients how to avoid adverse drug-drug interactions</td>
<td>» Encourage a ‘treatment buddy’</td>
</tr>
<tr>
<td>» The patient should understand the possible consequences of mixing other prescribed or recreational drugs and substances</td>
<td>» Caregiver and/or patient are introduced to therapeutic counselor and patient advocate, if available and agreed to or nominated by patient, and a home visit is arranged</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Impart knowledge</th>
<th>Modify patient behaviour</th>
</tr>
</thead>
<tbody>
<tr>
<td>» Improve understanding: patients often have limited knowledge and understanding about why they have to take ART, how it works and how it benefits them</td>
<td>» Encourage patients to manage their condition themselves</td>
</tr>
<tr>
<td>» Focus on patient-provider shared decision-making</td>
<td>» Ensure patients understand the risks of not taking their medications</td>
</tr>
<tr>
<td>» Involve patient’s family/caregiver if possible</td>
<td>» Address fears and concerns</td>
</tr>
<tr>
<td>» Advise on how to cope with medication costs</td>
<td>» Provide encouragement and recognition for adherence</td>
</tr>
<tr>
<td>» Provide prescription instructions clearly</td>
<td>» Provide pre-treatment information and education as per visit schedule</td>
</tr>
<tr>
<td>» Reinforce all discussions often</td>
<td>» Reinforce use of pillboxes or a daily dosing diary</td>
</tr>
</tbody>
</table>

5.3 HIV DISCLOSURE IN CHILDREN, ADOLESCENTS AND ADULTS

All patients should be supported for disclosure and partner notification. The United Nations Convention on the Rights of Children (Article 12) states that children have the right to participate in decisions about their own healthcare. The decision to inform the child of his/her HIV status should be viewed as mandatory and be age appropriate. It is important that disclosure follows a planned process and to understand that there are levels of disclosure over time. The process of disclosure is cyclical, it needs to be repeated as new information or deeper levels of information are shared with the child.
Diagram 1: Approaches to HIV disclosure in children

- Issue a follow up date
- Encourage multidisciplinary team
- Ensure ongoing assessment of child well being

- Disclosure must be age-appropriate
- Provide a child-friendly space
- Linkages and follow up date

- Support and follow up
- Preparation and planning

- Disclosure and Health promoting tasks

- Assessment

- Prepare a conducive environment to discuss
- Document every process
- Provide appropriate tools for disclosure

- Assess child's emotions, developmental stage, and provide support
- Assess who the primary caregiver is
- Decide on the type of disclosure - complex or simple
### Box 10: HIV disclosure in children

**Reasons for disclosing HIV status in children**

- As the age of children living with HIV steadily increases, it will result in a population of sexually active young people with HIV infection
- Keeping their HIV-positive status a secret can be a burden
- Disclosure should always be in the best interests of the child. This applies to the disclosure itself as well as the manner of disclosure
- Benefits of disclosure include recognition of the child’s autonomy, increased intimacy with those close to the child and improved psychological adjustment
- Children may need to prepare for tasks ahead (sickness, painful procedures etc.)
- Children often know more than adults give them credit for
- Children who are not told about their disease often have much more anxiety and distress
- Disclosure needs to take place before the stage of adolescence

**How to communicate with children**

- Find out how much the child knows about his/her illness and what they want to know
- Children need to know that they are loved and will be cared for
- Assure the child that his/her HIV status or the parent’s HIV status is not a punishment for any wrongdoing
- Educate them on how HIV is transmitted
- Disclosure must be age appropriate
- Be honest. If you don’t know the answer to the child’s questions, say so
- Be led by the child in terms of the amount of information he/she requires
- Use age-appropriate language in line with education and emotional readiness
- Anticipate possible responses by the child and plan for the future
- Anticipate the impact of the disclosure on other family members, friends, the school and the community and plan for this
- Monitor the child’s behaviour after disclosure (sleeping, school problems, and withdrawal). Changes in behaviour can indicate a need for more support and intervention
- Be respectful of the child’s needs, feelings and responses
5.4 STEP-UP ADHERENCE IN PATIENTS WITH NON-ADHERENCE OR TREATMENT FAILURE

Box 11: Strategies for stepping-up adherence

This applies to all patients with <80% adherence at any visit and those with first VL>1000 copies/ml

- The therapeutic counsellor/nurse or doctor needs to re-educate the patient, caregiver and their ‘buddy’ about the importance of adherence
- The long-term benefits of adherence need to be re-emphasised
- Evaluate the support structures in place; whether they are appropriate, how they can be improved and explore other options
- Encourage the patient to consider the use of pillboxes and/or a daily dosing diary
- Encourage the patient to participate in a support group or create a link with a patient advocate
- Consider doing a psychological profile, assess for mental health issues/substance misuse
- Investigate the family situation through a social worker and actively address food security
- Increase home visits by therapeutic counsellors/patient advocates to daily or weekly at a minimum
- Spot pill counts can be done at home
The goal of ART is to reduce the patient’s VL to an undetectable level and ensure that it remains undetectable, as well as to improve the immunological status with the CD4 count rising and remaining above the baseline.

6.1 ART IN PREGNANT AND BREASTFEEDING WOMEN

All HIV-positive women require management and care during the antenatal, labour, delivery and postnatal phases. This includes iron, folate and calcium supplementation; haemoglobin testing; the provision of ARVs; the diagnosis, prevention and management of opportunistic infections, including TB screening, testing, treatment and prevention; the modification of obstetric practices, especially during labour and delivery; and counselling on infant feeding, safer sex, family planning and contraception.

Women who are put on a FDC (TDF+3TC (FTC)+EFV) in their pregnancy should be monitored and managed, where possible, by the same provider in the same facility through the antenatal and postnatal periods until the end of breastfeeding. They should then be referred to appropriate services to continue lifelong ART as part of the general adult ART population.

6.1.1 When to start: eligibility criteria for ART in pregnant and breastfeeding women

It is important to avoid unnecessary delays in initiating ARVs during pregnancy or breastfeeding. All HIV-positive pregnant women should receive ART with appropriate counselling from their first antenatal visit regardless of gestational age. The first choice ART regimen is TDF+FTC+EFV given as a FDC. All women should start this regimen at the first antenatal clinic visit. Baseline CD4 cell count should also be done to assess eligibility for Cryptococcal antigen (CrAg) and Cotrimoxazole (CTX), but should not delay ART initiation.

All HIV-positive pregnant women are eligible for lifelong ART. They should receive adequate support and counselling, particularly addressing ART adherence, and should be retained in ART services throughout pregnancy, breastfeeding and as part of lifelong care.

All women diagnosed as HIV-positive within the first year postpartum are to be initiated on lifelong ART regardless of CD4 count or infant feeding practice.

Table 5: Eligibility criteria for pregnant and breastfeeding women

<table>
<thead>
<tr>
<th>POPULATION</th>
<th>WHEN TO START</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant and breastfeeding women</td>
<td>Initiate lifelong ART in all pregnant or breastfeeding women on the same day of diagnosis regardless of CD4 count</td>
<td>Emphasise exclusive breastfeeding for the first 6 months, with complementary feeding only from 6 months and breastfeeding continued until 12 months</td>
</tr>
<tr>
<td></td>
<td>All unbooked women who test positive during labour should be given prophylactic ART during labour and initiated on lifelong ART before being discharged</td>
<td></td>
</tr>
</tbody>
</table>
### 6.1.2 What to start: First-line ART regimens in pregnant and breastfeeding women

**Table 6: ART regimens for pregnant and breastfeeding women**

<table>
<thead>
<tr>
<th>Population</th>
<th>Drugs</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1st ANC visit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All pregnant women not on ART (any gestational age)</td>
<td>TDF + 3TC (or FTC) + EFV</td>
<td>If there is a contraindication to the FDC</td>
</tr>
<tr>
<td>All breastfeeding women not on ART</td>
<td>Provide as fixed-dose combination (FDC)</td>
<td>Contraindication to TDF: renal insufficiency</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Contraindication to EFV: active psychiatric illness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>start AZT immediately and refer patient for individual drugs</td>
</tr>
<tr>
<td>Pregnant women currently on ART</td>
<td>Continue current ART regimen</td>
<td>Check a VL as soon as pregnancy diagnosed, regardless of when the last VL was done</td>
</tr>
<tr>
<td></td>
<td>Change to FDC if on individual first-line drugs and virally suppressed and no contraindications to FDC</td>
<td>Patients with confirmed 2nd or 3rd line regimen failure should not breastfeed their infants</td>
</tr>
<tr>
<td><strong>2nd ANC visit (1 week later)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnant women</td>
<td>Continue FDC</td>
<td></td>
</tr>
<tr>
<td>Creatinine ≤85µmol/l and any CD4 cell count</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creatinine &gt;85 µmol/l TDF contraindicated</td>
<td>Stop FDC, initiate AZT if Hb ≥7g/dl</td>
<td>High-risk pregnancy: refer urgently for alternate triple therapy within 2 weeks, with dose adjustment if indicated, and investigation of renal dysfunction</td>
</tr>
<tr>
<td>Contraindication to EFV (active psychiatric illness)</td>
<td>Continue AZT until initiated on individual drugs</td>
<td>Refer urgently for alternate triple therapy CD4 &lt;250cells/µl: NVP 200mg daily for 2 weeks, then 200mg BD CD4 ≥250cells/µl LPV/r 2 tablets 12 hourly</td>
</tr>
<tr>
<td>Labour</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unbooked and presents in labour and tests HIV positive</td>
<td>sdNVP + sd Truvada and AZT 3-hourly in labour</td>
<td>Woman qualifies for lifelong ART</td>
</tr>
<tr>
<td>Emergency caesarean section in an unbooked woman with no ART</td>
<td>sdNVP + sd Truvada for C/S</td>
<td>Do creatinine and CD4 testing. Woman should get results at the 3-6 days visit</td>
</tr>
<tr>
<td>Post-Partum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother diagnosed with HIV within 1 year post-partum or still breastfeeding beyond 1 year</td>
<td>Lifelong FDC initiated immediately</td>
<td></td>
</tr>
</tbody>
</table>
Figure 4: Algorithm for initiation of ART for HIV-positive women (ART naïve)

For women who are newly diagnosed HIV-positive or are known to be HIV-positive but not yet on ART and are identified at any time during pregnancy, whilst breastfeeding or within 1 year post-partum.

HIV-positive not on ART (known and newly diagnosed)
History and clinical assessment including for TB screening and WHO staging
Blood specimens sent for creatinine and CD4 cell count

If no active psychiatric illness or history of renal disease
Start FDC on the same day
Return in 1 week to review results

If history of renal disease or active psychiatric illness:
the woman has a high risk pregnancy and needs urgent referral
If HB ≥7g/dl, start AZT 300mg bd

1 week later:
Review results of CD4 cell count, serum creatinine

If serum creatinine ≤85µmol/L:
Continue FDC lifelong

If serum creatinine >85µmol/L: the woman has a high risk pregnancy and needs urgent referral
If Hb ≥7g/dl, start AZT 300mg bd and stop the FDC
(Will require individual agents for ART and investigation for renal compromise)

Check CD4 count

If CD4 <100:
Send cryptococcal latex antigen test
Figure 5: Algorithm for management of pregnant woman already on ART for >3 months

Woman on ART with confirmed pregnancy

- Perform viral load at the same visit (Irrespective of when last done)
  Emphasise importance of adherence

- Review viral load result within 2 weeks

Viral load <1000 copies/ml

- Continue current ART regimen
  (If appropriate, switch from 3 individual ARVs to FDC to allow integrated follow up at local ANC clinic)

Viral load undetectable or ≥1 log drop in viral load

Viral load >1000 copies/ml

- Provide comprehensive adherence counselling

- Repeat viral load one month after initial test

- Review repeat viral load result

Viral load unchanged OR <1 log drop OR increased

- Switch to second line regimen as per adult ART guidelines

- Infant requires prophylaxis with AZT plus NVP and birth PCR testing
6.1.3 Baseline and routine monitoring for pregnant and breastfeeding women

When determining renal function in pregnancy, it is important to note that other methods of estimating renal function, including estimated glomerular filtration rate (GFR) from the Cockroft-Gault equation, are inaccurate in pregnancy. The use of serum creatinine and not the GFR should be used.

*Box 12: Standardised baseline monitoring (pregnant and breastfeeding women)*

<table>
<thead>
<tr>
<th>Phase of HIV Management</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV diagnosis (First ANC visit)</td>
<td>To confirm HIV-positive status in patients who present without documented proof of positive HIV status</td>
</tr>
<tr>
<td>Confirm HIV result with rapid antibody test if no test results are available</td>
<td>To assess risk</td>
</tr>
</tbody>
</table>
| WHO clinical staging if HIV-positive | » To identify eligibility for CrAg or CLAT (CD4<100 cells/μL)  
» Not used to determine eligibility if pregnant/breastfeeding or has TB or HIV/HepB co-infected or has WHO stage IV |
| CD4 count | » Assessment of effectiveness of treatment and to detect treatment failure  
» Do VL for all pregnant and breastfeeding women at first visit regardless of when the last VL was done |
| (Women who become pregnant while on ART) | To identify high-risk pregnancy |
| Screen for chronic diseases (hypertension, diabetes, proteinuria, previous renal disease) | To detect any nutritional deficiencies and provide appropriate nutrition care and support |
| Nutritional assessment | To provide counselling on safer sex, family planning, postnatal contraception, partner testing and routine cervical cancer screening. |
| Ask about family planning | To identify women with TB symptoms for investigation and to assess eligibility for INH/IPT |
| Screen for TB symptoms using the TB screening tool | To identify and treat those with STI |
| Screening for STIs and syphilis | To identify and provide treatment for disseminated cryptococcal infection |
| CrAg test if CD4<100 cells/ml | To detect anaemia or neutropenia |
| Do Hb or FBC | To assess renal sufficiency |
| Do creatinine | To exclude liver dysfunction |
| ALT only if requires NVP | CD4 at initiation of ART, at 12 months, then annually if clinically indicated | To monitor immune response to ART |
Do VL at confirmation of pregnancy if already on ART >3 months, do VL at months 3, 6, 12, 18, 24 throughout pregnancy and breastfeeding

- To identify treatment failures and problems with adherence
- To ensure women who conceive on ART are fully suppressed to minimise risk of MTCT
- To more actively monitor VL throughout pregnancy and breastfeeding to inform urgent response to detectable VL as this increases risk of MTCT

<table>
<thead>
<tr>
<th>Test</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alanine transaminase (ALT) if on NVP and develops rash or symptoms of hepatitis</td>
<td>To identify NVP toxicity</td>
</tr>
<tr>
<td>FBC at month 3 and 6 if on AZT and then every 12 months</td>
<td>To identify AZT toxicity</td>
</tr>
<tr>
<td>Creatinine at month 3 and 6, month 12, then every 12 months if on TDF</td>
<td>To identify TDF toxicity</td>
</tr>
</tbody>
</table>

Figure 6: Algorithm for VL monitoring in HIV-positive pregnant women
6.1.4 Viral load monitoring for first-line regimen in pregnant and breastfeeding women

Table 7: Viral load monitoring for first-line regimens in pregnant and breastfeeding women

<table>
<thead>
<tr>
<th>Viral Load (VL)</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;400 copies/mL</td>
<td>» 6 monthly VL monitoring and routine adherence support</td>
</tr>
<tr>
<td>400-1000 copies/mL</td>
<td>» Assess adherence carefully</td>
</tr>
<tr>
<td></td>
<td>» If VL≤1000 copies/mL, continue on current ART regimen</td>
</tr>
<tr>
<td></td>
<td>» If concerns about adherence consider doing another viral load within 6 months</td>
</tr>
<tr>
<td></td>
<td>» Repeat viral load at 6 months, if suppressed, return to 6 monthly VL testing</td>
</tr>
<tr>
<td>&gt;1000 copies/mL</td>
<td>Pregnant women: If VL&gt;1000 copies/mL, provide adherence counselling, repeat the VL in 1 month</td>
</tr>
<tr>
<td></td>
<td>» If second VL result is undetectable or has shown a reduction in viral load of 1 log (10-fold) or greater, continue with the existing regimen</td>
</tr>
<tr>
<td></td>
<td>» If the VL result is unchanged or has not shown a 1 log (10-fold) reduction or has increased, the woman should be switched to second-line therapy urgently</td>
</tr>
<tr>
<td></td>
<td>» Any woman who requires a switch to second-line therapy must receive intensive adherence counselling and support to ensure high-level adherence and rapid viral load suppression</td>
</tr>
</tbody>
</table>

Always check for Hepatitis B before stopping TDF. If patient has chronic hepatitis B, stopping TDF may lead to a fatal hepatitis flare. If Hepatitis B outcome is positive, TDF should be continued as a 4th drug in the second regimen.

If a pregnant woman is diagnosed with HBsA positive, the neonate must receive HepB immunoglobulin and HepB immunisation at birth and then continue with routine immunisations as per protocol.

6.1.5 Recommended second-line regimen for pregnant/breastfeeding women

Table 8: Recommended second-line treatment for patients failing first-line regimen

<table>
<thead>
<tr>
<th>Second-line regimen</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Failing on a TDF-based 1st line regimen</td>
<td>AZT + 3TC + LPV/r</td>
</tr>
<tr>
<td></td>
<td>AZT + TDF + 3TC + LPV/r (4 drugs if HBV co-infected)</td>
</tr>
<tr>
<td>Failing on a d4T or AZT-based 1st line regimen</td>
<td>TDF + 3TC (or FTC) + LPV/r</td>
</tr>
<tr>
<td>Dyslipidaemia or diarrhoea associated with LPV/r</td>
<td>Switch LPV/r to ATV/r</td>
</tr>
</tbody>
</table>
6.2 LABOUR, DELIVERY AND POSTNATAL FOLLOW-UP OF MOTHER AND BABY

6.2.1 Overview of the PMTCT programme

The PMTCT programme aims to reach out to all women before and during pregnancy, through labour and delivery, and through the postnatal period up to 18 months.

The programme aims to identify and promote the health of HIV-positive mothers and their HIV-exposed infants, including the diagnosis, management and prevention of opportunistic infections. The various components of the PMTCT programme are highlighted in Box 13, and the goals and management thereof are summarised according to the woman’s HIV status and the infant’s HIV exposure.

Box 13: Key components of the PMTCT programme

Mothers are encouraged to exclusively breastfeed their infants during the first 6 months of life, with appropriate complementary foods being introduced from 6 months and breastfeeding continuing for up to 2 years and beyond.
Box 14: PMTCT – Key points to note

- All HIV-exposed infants not on ART should have a rapid test at 18 months of age to confirm HIV status conferred by the birth, 10-week HIV PCR test, or the 18-week HIV PCR performed 6 weeks post the 12-week NVP prophylaxis, or 6 weeks post-cessation of breastfeeding test.
- All HIV-positive women should have access to TB symptom screening, INH prophylaxis plus pyridoxine and/or cotrimoxazole prophylaxis, nutritional and psychosocial support, cervical cancer screening, counselling on and access to family planning options, monitoring of CD4 cell count, viral load and clinical staging.
- Mothers of unknown HIV status or who are HIV-negative should be tested 3-monthly, throughout pregnancy, at labour/delivery, at the 6-week EPI visit and 3-monthly throughout breastfeeding. At initial PICT in ANC, mothers will be consenting for the protocol of initial and repeated HIV testing so as to ensure that the tests can be done efficiently without any requirement for further counselling, unless indicated.
  - All HIV-positive women who started FDC (TDF+FTC(3TC)+EFV) or another triple-drug regimen during the antenatal period should continue to receive this regimen throughout labour and delivery.
  - Unbooked women in labour or newly diagnosed in labour should be counselled and provided with ART to prevent MTCT, and initiated on lifelong ART before being discharged.
  - They should have their CD4 and creatinine checked and reviewed at the 3-6 day postnatal visit.
  - Caesarean sections should be done for obstetric indications and are not recommended to reduce MTCT.
  - In an emergency caesarean section, a woman who is not on ART should receive sdNVP and TDF + FTC (Truvada®) as prophylaxis prior to the procedure.
  - All HIV-positive women who undergo caesarean section should receive prophylactic antibiotics.
  - All women diagnosed HIV-positive within the first year postpartum are to be initiated on lifelong ART regardless of CD4 count or feeding practice.

Safer delivery technique: MTCT risk is increased by prolonged rupture of membranes, assisted instrumental delivery, invasive monitoring procedures, episiotomy and invasive suctioning of the neonate’s nose and airway. These invasive interventions should be avoided in HIV-positive women and their infants. If there is meconium stained liquor this requires laryngoscopy and suctioning under direct vision only for those babies who are flat at birth and require resuscitation. Routine suctioning of the airways of newborns where there is meconium staining of the liquor is not recommended. Only suction the baby’s nose and airway and wipe the neonate carefully at birth if required. Most newborns at birth do not require suctioning.

Caesarean section: All HIV-positive women to receive prophylactic antibiotics and HIV-positive women not on ART must receive sdNVP and TDF + FTC (Truvada®) beforehand.
### 6.2.2 Immediate post-delivery period

**Box 15: Immediate post-delivery period for women**

<table>
<thead>
<tr>
<th>Mother: Immediate post-delivery care</th>
<th>Before leaving the facility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mother: Within an hour of delivery</strong></td>
<td><strong>All women must be counselled about:</strong></td>
</tr>
<tr>
<td>» Infants born to HIV-positive women should receive skin-to-skin contact with their mothers almost immediately, regardless of the mother’s infant feeding choice</td>
<td>» The need for consistent maternal ART adherence and infant prophylaxis to reduce risk of MTCT</td>
</tr>
<tr>
<td>» Initiate exclusive breastfeeding immediately or within one hour of delivery</td>
<td>» The importance of exclusive breastfeeding for the first 6 months</td>
</tr>
<tr>
<td>» If the mother has decided to exclusively formula feed, she should be provided with formula within one hour of delivery</td>
<td>» The dangers of mixed feeding – providing a combination of breast milk plus infant formula, water or other foods or fluids (excluding prescribed medications) within the first 6 months</td>
</tr>
<tr>
<td>» Initiate HIV-exposed infants on ARV prophylaxis immediately after birth or very soon after</td>
<td><strong>All women should:</strong></td>
</tr>
<tr>
<td>» Discuss contraception options and offer appropriate method to the mother</td>
<td>» Be given at least 8 week’s supply of ART and 6 or 12 week supply for infant prophylaxis on discharge</td>
</tr>
<tr>
<td></td>
<td>» Follow-up at a health facility within 3-6 days and again 6 weeks post-partum</td>
</tr>
<tr>
<td></td>
<td>» Have a correctly completed RTH booklet</td>
</tr>
<tr>
<td></td>
<td>» Have a finalised plan for the mother-baby pair before the pair is discharged after delivery. Mothers and their infants should receive healthcare at the same consultation regardless of service point</td>
</tr>
<tr>
<td></td>
<td>» Receive documentation regarding mother-baby pair, including referral letters</td>
</tr>
</tbody>
</table>
6.2.3 Care of HIV-exposed infants in the immediate post-delivery period

**Box 16: Immediate post-delivery care for infants**

- Infants to be vaccinated as per the EPI schedule
- BCG given to all infants, unless they are HIV exposed and symptomatic or the mother has active TB disease and has had <2 months of TB treatment at the time of birth.
- If mother has active TB disease at birth and has been on treatment for <2 months, exposed infants must be screened for congenital TB.
  (See Annexure 4)
- ALL HIV-exposed infants must be tested for HIV at birth
- ART prophylaxis given at birth to all HIV-exposed infants is effective in reducing MTCT whether maternal ART is received or not. It is also highly effective in reducing MTCT through breast milk
- Infants born to HIV-positive women should receive daily NVP for 6 weeks, unless there are circumstances that warrant 12 weeks of NVP or NVP plus AZT
- Abandoned babies must receive NVP prophylaxis immediately until HIV-exposure status has been determined, using an HIV antibody test. This applies also in cases in which the mother is indisposed (due to severe illness, coma, mental illness, or death)
- EPI-scheduled visits for vaccination at 6, 10 and 14 weeks at EPI clinic and a routine health check must be performed
- First postnatal visit for the infant is scheduled for day 3, and should occur within 6 days of life at the health facility

*Note: Where the mother is known to be HIV-positive, but she refuses any ART prophylaxis for the infant, a counsellor must intervene to explain the risks of MTCT and the benefits of ART prophylaxis and therapy. If this fails to convince the mother to take infant prophylaxis, the mother should then be informed of the infant’s right to receive protection from acquiring HIV. The healthcare provider should consult the head of the facility and, with their permission, provide the necessary treatment in the best interest of the infant. In all actions concerning children, the best interests of the child shall be a primary consideration (Children’s Act, No. 38 of 2005).*

6.2.4 Immediate postnatal care for HIV-positive infant

A full plan for the mother-baby pair follow-up should be finalised before the pair is discharged after delivery. Whenever possible, mothers and their infants should receive healthcare at the same consultation regardless of service point. The RTH booklet should be completed prior to discharge after delivery, and should include a record of the HIV treatment received by the mother during pregnancy and postpartum, maternal illnesses, infant HIV prophylaxis and intended feeding method. Women should be provided with clear documentation to take with them to enable them to continue lifelong ART, without interruption, whenever they move to a new healthcare facility. A transfer or referral letter must at the minimum stipulate when ART was initiated, which regimen has been prescribed, record baseline and monitoring blood results and outline the management plan for both mother and infant.

If a mother/caregiver is concerned about the infant’s health, including poor feeding, lethargy or jaundice, they should urgently present to a healthcare facility.

The first postnatal visit for the infant is scheduled for day 3 but should take place within 6 days of life at a health facility. Ensure that the birth PCR results have been documented for all the HIV exposed neonates.

Adequacy of breastfeeding must be checked by noting the infant’s state of hydration and general condition. Any concerns around infant feeding should be addressed and follow-up sooner than 6 weeks arranged.
6.3 ART PROPHYLAXIS IN HIV-EXPOSED INFANTS

In order to make breastfeeding safer, all HIV-exposed children should receive prophylactic NVP from birth for 6 weeks. If there is no breastfeeding, the infant must take NVP until six weeks of age. In several cases daily NVP will be required beyond 6 weeks (see Table 9 below).

Infant post-exposure prophylaxis should be used for 6-12 weeks after delivery, dependent on when maternal ART was initiated. Some infants will receive dual prophylaxis with NVP plus AZT. After infant prophylaxis has been completed, the mother will continue to breastfeed and reduced MTCT will be reliant on maternal adherence to lifelong ART throughout the breastfeeding period. HIV positive women are recommended to breastfeed until 12 months of age.

6.3.1 When to start: Eligibility criteria for ART prophylaxis in HIV-exposed infants

<table>
<thead>
<tr>
<th>Mother</th>
<th>Infant regimen</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother on lifelong ART</td>
<td>NVP at birth and then daily for 6 weeks</td>
<td>Mother has been on ART for &gt;4 weeks prior to delivery</td>
</tr>
<tr>
<td>Mother did not get any ART before or during delivery and tests HIV-positive &gt;72hours post-delivery</td>
<td>NVP as soon as possible and daily for 12 weeks (if infant is breastfed)</td>
<td>12 weeks extended NVP is only necessary if the infant is being breastfed. Check feeding practice at the 6 week EPI visit to ensure infant receives correct duration of prophylaxis</td>
</tr>
<tr>
<td></td>
<td>OR Mother newly diagnosed HIV-positive within 72 hours of delivery</td>
<td>If mother received no ART before delivery, infant should receive birth PCR</td>
</tr>
<tr>
<td></td>
<td>OR Mother started ART less than 4 weeks prior to delivery</td>
<td>An additional HIV PCR test is required 4 weeks after NVP is discontinued</td>
</tr>
<tr>
<td></td>
<td>Breastfeeding mother diagnosed with HIV</td>
<td>This extended period of infant prophylaxis is required to allow time for maternal viral suppression. It takes up to 12 weeks for the viral load to become undetectable on ART</td>
</tr>
<tr>
<td></td>
<td>Start mother on a FDC immediately</td>
<td>Do HIV PCR and return for results in 7 days</td>
</tr>
<tr>
<td></td>
<td>If infant tests HIV PCR negative: stop AZT and continue NVP for 12 weeks</td>
<td>Additional HIV PCR 4 weeks after stopping NVP</td>
</tr>
<tr>
<td></td>
<td>If mother has received 12 weeks of ART then infant NVP can be stopped</td>
<td>Infant HIV testing 6 weeks post-cessation of breastfeeding (either HIV PCR or ELISA, depending on age)</td>
</tr>
<tr>
<td></td>
<td>If infant tests HIV PCR+, initiate ART immediately</td>
<td>If rapid test is positive do an HIV PCR. If negative, repeat HIV PCR at 10 weeks. If HIV PCR positive, initiate baby on triple ART immediately and send confirmatory HIV PCR</td>
</tr>
<tr>
<td>Unknown maternal status for any reason, including orphans and abandoned infants</td>
<td>Give NVP immediately*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Test infant with rapid HIV test*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If positive continue NVP for 6 weeks</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If negative discontinue NVP</td>
<td></td>
</tr>
<tr>
<td>Status</td>
<td>Action</td>
<td>Notes</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Mother with latest viral load &gt;1000 copies/ml</td>
<td>Dual ARV for 6 weeks (NVP and AZT). Perform an HIV PCR at or shortly after birth</td>
<td>PCR at birth, if negative follow up with a 10 week HIV PCR Manage the mother as per Table 7 If repeat maternal viral load &gt;1000 copies/ml then refer to/discuss telephonically with paediatric expert before the infant is 6 weeks old and prophylaxis is due to be discontinued Infants of mothers on 2nd or 3rd line regimens and VL&gt;1000 should not be breastfed</td>
</tr>
<tr>
<td>Non-breastfeeding mother diagnosed with HIV</td>
<td>If more than 72 hours since delivery, no infant NVP Perform an HIV PCR, if positive initiate ART</td>
<td>Do HIV PCR, if &lt;18 months Do rapid test if ≥18 months, Repeat PCR 6 weeks after last HIV exposure</td>
</tr>
</tbody>
</table>

*If rapid HIV test can be done within 2 hours, then wait for HIV result before commencing NVP*

Note: Remember to repeat the HIV PCR 6 weeks after breastfeeding cessation for all breastfed infants if <18 months and a repeat HIV rapid test if ≥18 months
Figure 7: Algorithm for initiation of infant prophylaxis or ART >72 hours after delivery

For any woman who is newly diagnosed HIV-positive >72 hours after delivery and is either breastfeeding or within 1 year post-partum

Any postnatal visit >72 hours after delivery and mother newly diagnosed HIV-positive:

- History and clinical assessment including TB screening and WHO staging, bloods sent for creatinine and CD4 cell count
- See Figure 1 for further management of mother

Infant HIV PCR

If the infant is currently being breastfed or stopped breastfeeding less than a week previously:
- Provide AZT and NVP until PCR result available, ideally 7 days later. If infant >6 weeks old, start co-trimoxazole syrup

Infant PCR negative
- Continue NVP for a total of 12 weeks
- Stop AZT
- Do PCR 4 weeks after NVP stops
- Repeat PCR 6 weeks after breastfeeding cessation
- 18 months rapid test
- Test at any time if symptomatic with age-appropriate test

Infant PCR positive
- Confirm with a second PCR
- Stop NVP and AZT
- Initiate ART while waiting for the confirmatory PCR result
- Infant <10 weeks old
  - Do PCR at 10 weeks
  - Repeat PCR 6 weeks from last breastfeeding exposure, if ever breastfed
  - 18 months rapid test
  - Test at any time if symptomatic, with age-appropriate test

Infant never breastfed or breastfeeding stopped more than a week previously:
- Do not provide infant with ART post exposure prophylaxis as >72 hours since delivery

Infant PCR negative
- Confirm with a second PCR
- Start cotrimoxazole
- Initiate ART while waiting for the confirmatory PCR result

Infant PCR positive
- Confirm with a second PCR
- Start cotrimoxazole
- Initiate ART while waiting for the confirmatory PCR result

Infant >10 weeks old
- Do PCR 4 weeks after first PCR
- Repeat PCR 6 weeks from last breastfeeding exposure, if ever breastfed
- 18 months rapid test
- Test at any time if symptomatic, with age-appropriate test

Note: When the child is PCR negative, NVP should be stopped at 12 weeks only if the mother is on ART, and has been for 12 weeks. (Refer to table 9)
### 6.3.2 When to start: Eligibility criteria for cotrimoxazole prophylaxis in HIV-exposed infants

All HIV-positive and HIV-exposed infants must receive cotrimoxazole prophylaxis from 4-6 weeks of age as outlined in Table 10.

**Table 10: Pneumocystis Jiroveci Pneumonia (PCP) prophylaxis using cotrimoxazole**

<table>
<thead>
<tr>
<th>Indications for cotrimoxazole</th>
<th>When to start</th>
<th>When to stop</th>
</tr>
</thead>
<tbody>
<tr>
<td>All HIV-exposed exclusive formula feeding children (EFF)</td>
<td>Start from 4-6 weeks after birth</td>
<td>Stop when PCR negative AND infant is clinically HIV negative AND EFF is expected to continue</td>
</tr>
<tr>
<td>All HIV-exposed breastfeeding children</td>
<td>Start from 4-6 weeks after birth</td>
<td>Stop when PCR is negative ≥6 weeks after full cessation of breastfeeding AND infant is clinically HIV negative</td>
</tr>
<tr>
<td>HIV-positive infants &lt;12 months old</td>
<td>Start from 4-6 weeks after birth or as soon as possible after HIV diagnosis even if on ART</td>
<td>All infants &lt;12 months should remain on prophylaxis</td>
</tr>
<tr>
<td>For HIV-positive children 1-5 years with or without ART</td>
<td>All symptomatic children (WHO clinical stage 2, 3 or 4) OR CD4&lt;25% OR CD4&lt;500 cells/µl.</td>
<td>Stop once ART-associated immune reconstitution has occurred for ≥6 months i.e. CD4 percentage ≥25% or CD4 count ≥500 cells/µl on ≥2 occasions, 3-6 months apart</td>
</tr>
<tr>
<td>HIV-positive children ≥5 years of age with or without ART</td>
<td>Start if CD4 count &lt;350 cells/µl or WHO clinical stage 3 or 4 disease (including TB)</td>
<td>Stop once ART-associated immune reconstitution has occurred for ≥6 months, i.e. CD4 ≥350 cells/µl on ≥2 occasions, 3–6 months apart</td>
</tr>
<tr>
<td>Any HIV-positive child with high risk for bacterial infections or at risk of malaria</td>
<td>Start cotrimoxazole prophylaxis even with ART immune-reconstitution</td>
<td>Do not stop until risk has been eliminated and all CD4 cell percentage or CD4 cell count criteria listed above have been met</td>
</tr>
<tr>
<td>HIV-positive child with previous PCP infection</td>
<td>Start as soon as first PCP episode has been treated</td>
<td>Stop at age 5 years if CD4 criteria is met</td>
</tr>
</tbody>
</table>

*Note: Any one of the criteria could be used for starting therapy*

Recommended doses of cotrimoxazole by age or weight of child are shown in Table 11.
6.3.3 What to start: Dosing guide for NVP, AZT and Cotrimoxazole in infants

Table 11: Prophylactic Nevirapine (NVP) dosing guide for HIV-exposed infants

<table>
<thead>
<tr>
<th>Drug</th>
<th>Age or Weight</th>
<th>Age/daily dose</th>
<th>Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nevirapine (NVP)</td>
<td>Birth – 6 weeks</td>
<td>Birth to 2 weeks: 2mg/kg</td>
<td>0.2ml/kg</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 to 6 weeks: 4mg/kg</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.0 – 2.5kg</td>
<td>Birth to 6 weeks: 10mg</td>
<td>1ml</td>
</tr>
<tr>
<td></td>
<td>&gt;2.5kg</td>
<td>Birth – 6 weeks: 15mg</td>
<td>1.5ml</td>
</tr>
<tr>
<td></td>
<td>Any weight</td>
<td>6 weeks to 12 weeks: 20mg</td>
<td>2ml</td>
</tr>
<tr>
<td>Nevirapine (NVP)</td>
<td>All</td>
<td>20mg/day</td>
<td>2ml</td>
</tr>
<tr>
<td>6 weeks – 6 months</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 month – 9 months</td>
<td>All</td>
<td>30mg/day</td>
<td>3ml</td>
</tr>
<tr>
<td>&gt;9 months</td>
<td>All</td>
<td>40mg/day</td>
<td>4ml</td>
</tr>
</tbody>
</table>

Table 12: Simplified infant AZT dosing birth to 6 weeks

| Zidovudine (AZT) | 2000 to 2499g | 10mg twice daily | 1ml twice daily |
|                 | >2500g        | 15mg twice daily | 1.5ml twice daily |

Table 13: Recommended dosing guide for prophylactic cotrimoxazole for infants and children

<table>
<thead>
<tr>
<th>Age or weight of child</th>
<th>Dose</th>
<th>Suspension</th>
<th>Single strength tablet</th>
<th>Double strength tablet</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;6 months or &lt;5 kg</td>
<td>100mg SMX/20 mg TMP</td>
<td>2.5 ml</td>
<td>¼ tablet</td>
<td>–</td>
</tr>
<tr>
<td>6 months – 5 years or 5–15kg</td>
<td>200mg SMX/40 mg TMP</td>
<td>5 ml</td>
<td>½ tablet</td>
<td></td>
</tr>
<tr>
<td>6–14 years or 15–30 kg</td>
<td>400mg SMX/80 mg TMP</td>
<td>10 ml</td>
<td>1 tablet</td>
<td>½ tablet</td>
</tr>
<tr>
<td>&gt;14 years or &gt;30 kg</td>
<td>800mg SMX/160 mg TMP</td>
<td>–</td>
<td>2 tablets</td>
<td>1 tablet</td>
</tr>
</tbody>
</table>

Cotrimoxazole can cause erythema multiforme and Stevens-Johnson syndrome. If this occurs, stop the cotrimoxazole.

Dapsone should be used in Cotrimoxazole intolerant patients. The recommended dose is 2 mg/kg/day or 4 mg/kg/week. The maximum daily dose is 100 mg (1 tablet).
6.4 ART IN INFANTS, CHILDREN AND EARLY ADOLESCENTS

6.4.1 General principles of ART care in infants and children

The goal of ART for children is to increase survival and decrease HIV-related morbidity and mortality.

When a child is on ART:

» The child’s CD4 count should rise and remain above the baseline count

» The child’s viral load should become undetectable (<50 copies/mL) and remain undetectable

In some children, a suppressed though detectable viral load, with sustained elevation in CD4 count and absence of inter-current and/or opportunistic infection, may be the best achievable goal.

Children should be started on ART as soon they become eligible using the standard drug regimens that have proven efficacy and seldom have serious side-effects. Children who may need non-standard regimens should only have treatment initiated by experienced clinicians. Constant availability of ARVs must be assured and clinicians must be vigilant for drug interactions and monitor patients for the development of resistance and adverse reactions. Adherence is the key to successful therapy, ensure that ongoing support is provided to the patient and family in order to maintain adherence. A minority of patients may not respond to ART and continue to progress in spite of good adherence. This may occur especially in those who are severely ill prior to commencing ART or those who have transmitted viral resistance. Underlying opportunistic infections should be sought and resistance testing may be of value.

Ongoing care for children on ART includes:

» Monitoring treatment response and adherence to ART

» Monitoring growth and developmental milestones

» Providing the necessary ARVs on a regular basis

» Assessment for drug side-effects or other complications

» Provision of routine care e.g. immunisation

» Management of inter-current infections and illnesses

» Counselling and support of the parents/caregivers

» Arranging for palliative care where appropriate, with the support of NGOs

» Consider the child’s home as an important factor in his/her care and the conditions must not be overlooked

» Home visits together with a social worker must be encouraged

» Updating the RTH booklet whenever necessary (caregivers to be encouraged to bring it to all visits)

Administration of ARVs

Most ARVs are currently available separately. However, some fixed-dose combinations are already available e.g. 3TC/ABC 300mg/600mg FDC and AZT/3TC 300mg/150mg FDC. In addition other fixed-dose combinations and co-packaged formulations will become available in the near future. These will facilitate dispensing of ARVs, and promote adherence by reducing the number of medicines that patients have to take. The use of FDCs is encouraged and patients are advised to:

» Switch to tablets or capsules from syrups or solutions as soon as possible

» Keep Lopinavir/Ritonavir solution cool (<25ºC), and it should be refrigerated prior to dispensing. It can be kept out of the fridge for 42 days
6.4.2 When to start: Eligibility criteria for ART in infants, children and early adolescents

There must be a confirmation of diagnosis of HIV infection, including the criteria in Table 14.

Table 14: Criteria for initiating ART in children <10 years

<table>
<thead>
<tr>
<th>CLINICAL CRITERIA</th>
<th>Eligibility for Treatment</th>
<th>SOCIAL CRITERIA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child less than 5 years</td>
<td>All children should be started on ART</td>
<td>» Social criteria are extremely important for the success of the programme and need to be adhered to. The principle is that adherence to treatment must be at least probable.</td>
</tr>
<tr>
<td>5 – 10 years</td>
<td>Symptomatic (stage 3 or 4) irrespective of CD4 count OR CD4 ≤500 cells/µl irrespective of WHO stage</td>
<td>» At least one identifiable caregiver who is able to supervise the child for administering medication (all efforts should be made to ensure that the social circumstances of vulnerable children, e.g. orphans, are addressed so that they too can receive treatment)</td>
</tr>
</tbody>
</table>

Criteria for fast-tracking (i.e. start ART within 7 days of being eligible)

» Children less than 1 year of age
» CD4 count ≤200 cells/µl or <15%
» WHO clinical stage 4
» MDR or XDR-TB

6.4.3 What to start: First-line ART regimens for infants, children and early adolescents

Standard starting regimens for children initiating ART are shown in Table 15. Doses are based on the child’s weight (see ARV Dosing Chart for Children 2013). It is important to regularly check that children receive the correct dose based on their weight. In older children or adolescents ensure that maximum doses are not exceeded. Children on ART should initially be seen monthly for regular follow ups and monitoring. Once they stabilise, follow up visits can occur 3-6 monthly.

Table 15: First-line regimens for ART initiation in children

<table>
<thead>
<tr>
<th>Child</th>
<th>Regimen</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children &lt;3 years or older children weighing &lt;10kg</td>
<td>ABC + 3TC + LPV/r</td>
<td>Doses are based on child’s weight and need to be adjusted as the child grows</td>
</tr>
<tr>
<td>Children 3-10 years and &gt;10kg</td>
<td>ABC + 3TC + EFV</td>
<td>Do not exceed maximum dosage</td>
</tr>
<tr>
<td>Adolescents 10-15 years or &lt;40kg</td>
<td>Children who started on ABC/3TC/LPV/r before 3 years must remain on same regimen at 3yr</td>
<td>If adolescents weight &lt;40kg, align treatment with children’s regimen</td>
</tr>
<tr>
<td>Children on d4T</td>
<td>Change all d4T to ABC</td>
<td>If VL suppressed: change to ABC</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If VL &gt;1000 copies/ml, manage as treatment failure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>If VL 50-1000 copies/ml, consult specialist</td>
</tr>
<tr>
<td>Children on ddI</td>
<td>Change all ddI to ABC</td>
<td>Change all regardless of VL</td>
</tr>
</tbody>
</table>
### 6.4.4 Baseline and routine clinical and laboratory monitoring for infants, children and early adolescents

**Table 16: ART monitoring in infants and children on ART**

<table>
<thead>
<tr>
<th>At initial diagnosis of HIV</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verify HIV status</td>
<td>Ensure that national testing algorithm has been followed</td>
</tr>
<tr>
<td>Document weight, height, head circumference (&lt;2 yrs) and development</td>
<td>To monitor growth and development + identify eligibility for ART</td>
</tr>
<tr>
<td>Screen for TB symptoms</td>
<td>To identify infants and children with TB symptoms for further investigations/ testing.</td>
</tr>
<tr>
<td></td>
<td>To identify infants and children eligible for IPT</td>
</tr>
<tr>
<td>WHO clinical staging</td>
<td>To determine if child ≥5 years is eligible for ART</td>
</tr>
<tr>
<td>CD4 count testing</td>
<td>Children &lt;5 years – Baseline and eligibility for fast-tracking, DO NOT wait for CD4 count to start ART</td>
</tr>
<tr>
<td></td>
<td>Children ≥5 years – To determine eligibility for ART, fast-tracking and start cotrimoxazole prophylaxis as per national guideline</td>
</tr>
<tr>
<td>Hb or FBC</td>
<td>To detect anaemia – do Hb/FBC; to detect neutropenia – do FBC</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>At routine follow-up visits (non-eligible patients)</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Document weight, height and development</td>
<td>To monitor growth and development and assess clinical staging</td>
</tr>
<tr>
<td>Check that a CD4 count has been done in the last 6 months</td>
<td>To determine if patient has become eligible for ART</td>
</tr>
<tr>
<td>WHO clinical staging</td>
<td>To determine if patient has become eligible for ART and CPT</td>
</tr>
<tr>
<td>Screen for TB symptoms</td>
<td>To identify infants and children with TB symptoms for further investigations/ testing.</td>
</tr>
<tr>
<td></td>
<td>To identify infants and children eligible for IPT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>At initiation of ART (Baseline)</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hb or FBC</td>
<td>If less than 8 g/dl start ART and discuss with a specialist for opinion</td>
</tr>
<tr>
<td>CD4 count (if not performed in last 6 months)</td>
<td>Baseline assessment</td>
</tr>
<tr>
<td>Cholesterol + Triglyceride if on PI-based regimen</td>
<td>Baseline assessment</td>
</tr>
<tr>
<td>ALT (if jaundice or on TB treatment)</td>
<td>To assess for liver dysfunction</td>
</tr>
<tr>
<td>TB symptom screen</td>
<td>To identify infants and children with TB symptoms for further investigations/ testing.</td>
</tr>
<tr>
<td></td>
<td>To identify infants and children eligible for IPT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>On ART</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height, weight, head circumference (&lt;2 yrs) and development</td>
<td>To monitor growth and developmental milestones</td>
</tr>
<tr>
<td>Clinical assessment</td>
<td>To monitor response to ART and exclude adverse effects</td>
</tr>
<tr>
<td>Test</td>
<td>Purpose</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>CD4 at 12 months, then annually if clinically indicated</td>
<td>To monitor response to ART, stop cotrimoxazole prophylaxis as per national guideline</td>
</tr>
<tr>
<td>VL at month 6, 1 year into ART, then every 12 months</td>
<td>To monitor viral suppression response to ART; To identify treatment failure and to identify problems with adherence</td>
</tr>
<tr>
<td>Hb or FBC at month 1, 2, 3 and then annually if on AZT</td>
<td>To identify AZT-related anaemia</td>
</tr>
<tr>
<td>Cholesterol + Triglyceride at 1 year and then every 12 months if on PI based regimen</td>
<td>To monitor for PI-related metabolic side-effects</td>
</tr>
<tr>
<td>Clinical drug-related adverse events</td>
<td>To identify drug-related adverse events; If develops jaundice or rash on EFV or NVP do Liver function test and refer to specialist</td>
</tr>
</tbody>
</table>

### 6.4.5 Viral load monitoring and first-line ARV treatment failure for infants and children

Changing a child from first to second-line ARV is a decision that should only be undertaken after careful consideration and discussion (even telephonically) with an expert. Second-line treatment is generally used following treatment failure, as reflected by a VL greater than 1000 copies/mL despite good adherence. General considerations prior to defining treatment failure:

- Allow reasonable trial on therapy with good adherence (at least 12 – 24 weeks) before concluding that a regimen is failing. Monitor adherence closely during this time.
- Once treatment failure is identified, changes should be made within 6 months. There is little purpose in leaving a child on a failing regimen for an extended period of time.
- Always attempt to improve adherence before switching regimens, as poor adherence to treatment is the most common cause of virological failure.
- If it is not possible to improve adherence:
  - Treat any inter-current opportunistic infections
  - Holding strategies or Directly Observed Therapy (DOT) may be attempted. DOT can be done with a healthcare worker or the trusted ‘other’ family member or friend
  - Exclude Immune Reconstitution Inflammatory Syndrome (IRIS)
  - Ensure adequate nutrition
Table 17: Viral load monitoring and recommended responses

<table>
<thead>
<tr>
<th>Viral load (VL)</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;50 copies/mL</td>
<td>12-monthly VL monitoring and routine adherence support</td>
</tr>
</tbody>
</table>
| 50*-1000 copies/mL | Repeat VL in 6 months  
Begin step-up adherence package if VL still between 50* – 1000 copies/mL |
| >1000 copies/mL | Begin step-up adherence package  
Repeat VL in 2 months  
If <50*, return to routine VL monitoring as above  
If between 50 and 1 000 copies/mL, continue step-up adherence and repeat VL after 6 months  
If >1 000 copies/mL, despite stepped up adherence support, AND child is on an NNRTI-based regimen, discuss with expert regarding new regimen.  
If >1000 copies/mL and child is on a PI-based regimen:  
Reinforce adherence (very difficult to fail a PI-based regimen unless the child received unboosted PI or was on rifampicin containing TB treatment while on a PI)  
Discuss with an expert regarding new regimen if VL >30 000 copies/mL,  
If the child received an unboosted PI (e.g. ritonavir alone) in the past or received TB treatment while on an LPV/r regimen and the VL is >1000 copies/mL, discuss with an expert regarding new regimen.  
Resistance testing is indicated in these situations but should only be done if the child has been reliably taking their ARVs in the past month. |

6.4.6 Second-line regimens in infants, children and early adolescents

Children may occasionally need to change a drug from the first-line regimen to one from the second-line regimen, because of intolerance or a serious adverse reaction. Switching limits the patient’s second-line treatment options. The decision to switch must be made by a doctor with ARV experience. Switching of one drug should only be done if there is full viral suppression, failing which the whole regimen may need to be altered.

Table 18: Second-line ART regimens for children

<table>
<thead>
<tr>
<th>Second-line regimen</th>
<th>Failed first-line protease inhibitor (PI) based regimen</th>
<th>Recommended second-line regimen</th>
</tr>
</thead>
</table>
| Failed first-line PI-based regimen | ABC + 3TC + LPV/r  
d4T + 3TC + LPV/r | Consult with expert for advice |
| Unboosted PI based regimen |  |  |
| Failed first-line NNRTI-based regimen (discuss with expert before changing) | ABC + 3TC + EFV (or NVP)  
d4T + 3TC + EFV (or NVP) | AZT + 3TC + LPV/r  
AZT + ABC + LPV/r |
6.4.7 Third-line ART regimens

Children who fail second-line treatment should be referred to an expert so that the treatment with third-line agents can be considered.

6.4.8 General care of HIV-exposed infants and HIV-positive infants and children

**Box 17: Identifying children with HIV infection**

It is important to identify children who are HIV-positive at an early stage to ensure that they and their families obtain optimal care. The disease progresses more rapidly in children than in adults and therefore children may be the first in the family to fall ill.

**Early identification/diagnosis makes it possible to:**

- Plan regular follow-up and initiate ART when indicated
- Ensure children receive routine preventive health interventions (immunisation, growth monitoring and promotion, Vitamin A supplementation)
- Prevent opportunistic infections – through the provision of cotrimoxazole prophylaxis and IPT
- Treat inter-current illnesses early and effectively, such as TB
- Establish whether any other members of the family are HIV-positive and provide appropriate treatment
- Provide psychosocial support to the family/caregiver through counselling and support
- Facilitate access to social grants, income generation opportunities and other support structures

Constant vigilance is essential in order to ensure that all children who are HIV-positive are identified as early as possible. The possibility of HIV infection should be considered during every contact with the health system, whether at PHC, district hospital or referral level.

**Box 18: Proactive steps to detect children with HIV infection**

- PMTCT records should identify all HIV-exposed and HIV-positive children, and have documented results for all the HIV PCR’s done
- Children in whom maternal HIV status is unknown must be tested for HIV
- The IMCI case management process includes consideration of possible HIV infection in all children who present to PHC facilities. Correct application of the IMCI case management process would therefore result in identification of almost all HIV-positive children
- Children with pneumonia (especially severe pneumonia), malnutrition and TB must be tested for HIV
- Siblings of children diagnosed as HIV-positive should be tested
- Orphans and abandoned children are at special risk of HIV infection and their HIV status should be established
- All adults testing positive during HCT need to be asked to bring their children for testing
- All adults diagnosed with TB who test positive for HIV need to also bring their children in for both HIV and TB screening
Care for a child with possible or confirmed HIV infection

Caring for a child who is suspected to have HIV infection includes PMTCT follow-up, confirmation of the HIV status and referral for ART if eligible, provision of regular follow-up and preventive care, provision of cotrimoxazole prophylaxis and the additional preventive care offered to the child.

The child’s HIV status needs to be confirmed with a second, age appropriate, confirmatory test.

If a child tests positive for HIV, the following steps should be followed:

- The child should be clinically staged and baseline bloods (CD4 count and percentage, Hb and lipogram) done
- The child’s eligibility for ART should be assessed using the criteria in Table 14
- If eligible, ART should be started as soon as possible, especially in infants
- If child is not eligible for ART, regular follow-ups which include regular reassessment of ART eligibility using staging and laboratory criteria must be done at least six monthly, and more frequently if the child is sick or is not thriving
- The child must be screened for TB to exclude TB disease and to determine eligibility for IPT and for early diagnosis and treatment of TB

Whilst initiation of ART is important, other aspects of care, such as ensuring that the child receives routine preventive care such as immunisation and growth monitoring and promotion, should not be neglected. These should be provided through regular follow-up visits, as outlined below.

Growth monitoring, promotion and immunisation

Growth faltering is an important indicator of disease progression in HIV-positive children. In children receiving ART it may be an early sign of treatment failure.

- Weight must be recorded on the child’s RTH booklet. For children older than 5 years on their weight-for-age chart in the child’s clinic file
- Growth faltering must be assessed by means of careful examination for evidence of infections such as TB, respiratory, gastrointestinal or urinary tract infections
- Feeding advice and food supplementation (see Nutritional Support) should be provided
- All children, HIV-positive and HIV-exposed children should be immunised according to the EPI schedule (Table 3 in Section 3.6.3)
- BCG should routinely be given at birth. However, if BCG is delayed, the infant may receive BCG after completion of 6 months IPT prophylaxis.
- It is recommended that asymptomatic HIV exposed infants be given BCG and monitored closely for Disseminated BCG disease
- BCG should not be given after 1 year of age

Routine treatments

It is important to ensure that HIV-positive children receive regular routine treatments as stipulated in IMCI, such as Vitamin A supplementation, Cotrimoxazole prophylaxis from six weeks of age and deworming medication. The recommended schedules are shown in Tables 19 and 20.

Table 19: Vitamin A supplementation

<table>
<thead>
<tr>
<th>Target group</th>
<th>Dosage</th>
<th>Schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>6 - 12 months</td>
<td>100,000IU</td>
<td>A single dose at the age of between 6 and 11 months (preferably at 9 months when child comes for immunisation)</td>
</tr>
<tr>
<td>1 - 5 years</td>
<td>200,000IU</td>
<td>A single dose at 12 months and then every 6 months until the age of 5 years</td>
</tr>
</tbody>
</table>
Table 20: Routine deworming

<table>
<thead>
<tr>
<th>Age</th>
<th>Weight</th>
<th>Mebendazole</th>
</tr>
</thead>
<tbody>
<tr>
<td>12-24 months</td>
<td>&lt;10kg</td>
<td>100mg twice a day for 3 days every six months</td>
</tr>
<tr>
<td>&gt;24 months</td>
<td>10kg or more</td>
<td>500mg as a single dose every six months</td>
</tr>
</tbody>
</table>

Additional preventive care for HIV-positive children

Normal trans-placental transfer of antibodies from the HIV-positive mother to the child may be impaired and neutrophil function depressed. The infant is therefore at greater risk of developing measles, TB and infections due to encapsulated organisms (Haemophilus influenzae and pneumococcus) at a young age.

This can be addressed by:

» HIV-infected children admitted to hospital should receive measles vaccine. This is an additional dose and the child should still receive routine doses at 9 and 18 months of age

» Varicella immunoglobulin (VZIG) is recommended for children who have been exposed to chickenpox. VZIG should be given as soon as possible after exposure to chickenpox or shingles, but within 96 hours for maximum efficacy (as per hospital essential drug list). The varicella vaccine can be used both as prevention and as post-exposure prophylaxis if given within 3 days post-exposure

» The influenza vaccine should be given yearly in all HIV-positive children >6 months of age

» Every child should be immunised according to the EPI schedule (Table 3, Section 3.7.3)

6.4.9 Management of children who are not eligible for ART

» Assess the child at least 6 monthly and preferably every 3 months

» CD4 count 6-monthly and WHO staging at every visit

» Document weight, height and developmental milestones

» Prescribe cotrimoxazole prophylaxis if eligible

» Screen for TB symptoms, investigate if necessary and assess for IPT eligibility

» Treat inter-current infections

» Ongoing counselling and continue process of disclosure

» Ensure health of entire family

» Reassess for ART eligibility at each visit. Children who become eligible must be identified early and initiated
6.5 ART FOR ADOLESCENTS AGED 10-15 YEARS

The Department of Health’s definition of adolescent is in line with the definition used by the United Nation (UN) and the World Health Organisation (WHO). The term adolescent is used to describe young people aged between 10 and 19 years. These guidelines apply to any adolescent living with HIV (ALHIV). Adolescents may fall into either the perinatally infected or behaviourally infected category, however in terms of combination ART there would be no difference in approach between these groups.

6.5.1 When to start ART in adolescents 10-15 years and <40kg

**ART eligibility criteria**

<table>
<thead>
<tr>
<th>Criteria for initiation</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHO stage 3 or 4</td>
</tr>
<tr>
<td>CD4 count ≤500 cells/µl</td>
</tr>
</tbody>
</table>

**Fast-tracking (initiating ART within 7 days of being eligible)**

<table>
<thead>
<tr>
<th>Criteria for initiation</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD4 count of ≤200 cells/µl</td>
</tr>
<tr>
<td>WHO stage 4 disease</td>
</tr>
<tr>
<td>MDR/XDR-TB</td>
</tr>
</tbody>
</table>

6.5.2 What to start: ART first-line regimen for adolescents 10-15 years

**Table 21: ART first-line regimen for adolescents 10-15 years**

<table>
<thead>
<tr>
<th>First-line regimen</th>
<th>Adolescent</th>
<th>Regimen</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Weight &lt;40 kg or age &lt;15 years</td>
<td>ABC + 3TC + EFV</td>
<td>NVP can be used if EFV is contraindicated</td>
</tr>
<tr>
<td></td>
<td>Weight ≥40 kg and age ≥15 years</td>
<td>TDF + 3TC/FTC + EFV (Use FDC)</td>
<td>Use TDF if creatinine clearance is &gt;80mL/min with no proteinuria. If &lt;80 mL/min, use ABC+3TC+EFV and adjust dosages according to renal dysfunction, and discuss with expert</td>
</tr>
</tbody>
</table>
6.5.3 Second-line regimen for adolescents 10-15 years

Table 22: Second-line ART regimens for adolescents 10-15 years

<table>
<thead>
<tr>
<th>First-line virological failure</th>
<th>Drugs</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC/TDF + 3TC/FTC + EFV</td>
<td>AZT +3TC + LPV/r</td>
<td>» Virological failure is 2 consecutive VL&gt;1000 copies/mL that are more than 1 month apart</td>
</tr>
</tbody>
</table>
| d4T + 3TC + EPV                | AZT + ABC + LPV/r | » If VL >1000 copies/mL:  
  › Include intensified adherence for a month  
  › Then repeat VL after 3 months after the elevated VL  
  › If after 3 months VL remains >1000 copies/ml on NNRTI regimen or 10,000 copies/ml on PI regimen, then treat as virological failure  
  » Never switch only one drug in a failing regimen and do not continue therapy with a failing NNRTI regimen for prolonged periods as there is an increased risk of accumulating NRTI resistance mutations |

6.5.4 Second-line treatment failure and third-line regimen in adolescents 10-15 years

Table 23: Second-line treatment failure and third-line regimen for adolescents

| Third-line regimen | Failing any second-line regimen | Refer for specialist opinion – Regimen based on genotype resistance testing, expert opinion and supervised care  
  Access to third-line ART will be managed centrally by the National Department of Health |

6.6 ART IN LATE ADOLESCENTS AND ADULTS

6.6.1 Transition from paediatric ART regimens to adolescent/adult regimens

» Adolescents with an undetectable VL (<50 copies/mL) and no side-effects on ABC + 3TC + EFV can remain on the same regimen until the patient becomes eligible for the TDF + FTC + EFV (FDC) at 15 years old and weighing ≥40kg

» When an adolescent with an undetectable viral load (within the last 8 weeks) reaches 15 years of age and is >40kg, a creatinine Clearance (CrCl) and urine dipstick should be performed

» If the CrCl is >80mL/min and no proteinuria on urine dipstick, then the patient can be switched to the FDC (TDF + FTC + EFV)

» If the CrCl is <80mL/min or >1+ proteinuria on urine dipstick then refer to an expert for advice before switching
Diagram 2: Transition from child-adolescent regimen

- **Adolescent 15 years and >40kg**
  - **Viral load undetectable (within 8 weeks)**
  - **Do CrCl and urine dipstix**
  - **CrCl >80 and no proteinuria**
  - **Start FDC**

If the HIV VL is between 50-1000 copies/ml, consult an expert for advice.

If the HIV VL is >1000 copies/ml, exclude non-adherence then treat as virological failure.

6.6.2 General management of adolescents and adults on ART

**Creatinine Clearance**

TDF can only be used in patients with Creatinine clearance >50 mL/min and creatinine <100 μmol/L.

While the serum creatinine gives an indication of renal function, patients can have significantly reduced renal function with a serum creatinine in the high normal range. This is particularly the case in older people and those with low body weight where the serum creatinine is a poor indication of renal function.

It is essential to calculate the creatinine clearance in all patients with:
- Age >50 years
- Weight <50kg
- Serum creatinine >100 μL/L
- Co-morbidities that may affect renal function, such as hypertension or diabetes
- Patients that are taking drugs that impair renal function

In all other patients where serum creatinine is <100 μmol/L, the calculated creatinine clearance is likely to be >50 mL/min, and they can safely start Tenofovir.

Creatinine may be elevated in acute illness, and repeating the measurement when the patient is recovered may give a better reflection of clearance.

In patients with renal impairment, it may be necessary to reduce the dosage of some ARVs. As renal function improves, do not forget to readjust the dosages accordingly, to ensure patients are not on suboptimal ARV dosage, putting them at risk of virological failure.
Initiating patients on NVP

Patients on NVP must be seen in the first two weeks after initiation of ART, in addition to their regular schedule for monitoring. NVP dosing must be 200mg daily for first two weeks, thereafter 200mg twice daily (BD).

» NVP reactions may be more common at higher baseline CD4 counts, especially in women with CD4 ≥250 cells/µl, or men with CD4 counts ≥400 cells/µl. Avoid NVP in these patients

» NVP related adverse events occur in the first 3 months of therapy, especially in the first few weeks, and can be fatal; all patients should be warned to return to clinic immediately if they develop a rash, any significant muco-cutaneous reactions, fever, jaundice or abdominal pain. Patients with any severe symptoms, or more than two of the above, require immediate hospitalisation with investigation and monitoring. ART, particularly NVP should be interrupted in these cases

» Monitor ALT levels according to symptoms; check ALT in all cases of rash, as concomitant hepatotoxicity may occur. Note that ALT often becomes elevated after the rash has started, so it is important to repeat the ALT after 7-14 days in patients without a significantly elevated ALT at the time the rash develops

» Ensure correct dosing change at 2 weeks. Do not increase the dose to 200 mg BD in the presence of a rash. Delay increase until the rash stabilises. If it does not resolve within a week or worsens, stop NVP and switch to an alternative drug

» While side effects in the first three months can be severe, long-term NVP is very safe. Any patient started on NVP with no side-effects should not be changed to another drug unless virological failure occurs, or if the patient requests to change or for simplification

» NVP should only be used in patients in whom the benefit of use far outweighs the risks associated with using NVP

6.6.3 Immune Reconstitution Inflammatory Syndrome (IRIS)

» IRIS occurs when improving immune function unmasks a previously occult opportunistic infection which subsequently presents with an unusually aggressive inflammatory presentation, or causes paradoxical deterioration of an existing opportunistic disease

» Patients with advanced HIV disease, particularly those with a CD4 count <100 cells/µl, may become ill with IRIS, usually during the first 3 months of ART

» Most cases can be managed on an outpatient basis with disease-specific therapies and anti-inflammatories. Very ill or complex patients may need to be referred for advice regarding investigation and management

» TB is the most common IRIS reaction in South Africa. Some patients starting ART when on treatment for TB will experience recurrence of their TB symptoms/signs or worsening or new manifestations

» The most common of these presentations is with enlarging lymph nodes, often with extensive caseous necrosis. In addition, lung infiltrates or effusions may worsen. It is important to exclude multi-drug resistance(MDR) TB in all these cases, as well as non-adherence to TB medication

» MDR or Extensively drug resistant tuberculosis (XDR) TB needs to be excluded before paradoxical IRIS is diagnosed. TB culture of sputum, blood, lymph nodes and other affected tissue is essential

» Opportunistic infections may also present in atypical ways during this phase of immune reconstitution

» Rashes (including zoster, herpes, molluscum and others), cryptococcal meningitis, and hepatitis due to hepatitis B/C that occur in the first weeks and months of ART initiation are other manifestations of IRIS

Note: IRIS is not indicative of drug failure or drug side-effects. It is not a reason to stop ART, or to change the ARV regimen. However, careful counselling is needed to ensure that the patient understands this.
6.6.4 When to start: ART eligibility in late adolescents ≥15 years and adults living with HIV

Box 19: ART eligibility criteria

Eligible to start ART

CD4 count ≤500 cells/µl irrespective of clinical stage
(Prioritise those with CD4 ≤350 cells/µl)

OR

Severe or advanced HIV disease (WHO clinical stage 3 or 4), regardless of CD4 count

OR

Irrespective of CD4 count or clinical stage:
» Active TB disease (including drug-resistant and EPTB)
» Pregnant and breastfeeding women who are HIV-positive
» Known hepatitis B viral (HBV) co-infection
» Prioritise those with CD4 ≤350 cells/µl or advanced HIV disease

Timing of ART initiation

» ART should be started as soon as the patient is ready, and within at least 2 weeks of CD4 count being done
» If diagnosed with TB, start with TB treatment first, followed by ART as soon as possible and within 8 weeks
» If CD4 <50 cells/µl initiate ART within 2 weeks of starting TB treatment, when the patient’s symptoms are improving and TB treatment is tolerated
» If CD4 >50 cells/µl initiate ART within 2-8 weeks of starting TB treatment
» In cryptococcal or TB meningitis: Defer ART initiation for 4-6 weeks

IMMEDIATE INITIATION: All HIV-positive pregnant or breastfeeding women, as long as no active TB or contraindication to FDC (TDF/FTC/EFV) - in which case start AZT 300mg bd immediately and switch to FDC/alternative triple regimen at appropriate time.

FAST TRACKING (within 7 days:)
» Patients with CD4 ≤200 cells/µl
» HIV stage 4, even if CD4 is not yet available
### 6.6.5 What to start: ART first-line regimen for adolescents $\geq 15$ years and adults

Table 24: ART regimens for adolescent and adults, including pregnant and breastfeeding women

<table>
<thead>
<tr>
<th>POPULATION</th>
<th>DRUG</th>
<th>COMMENTS</th>
</tr>
</thead>
</table>
| Adolescents $>15$ years and weighing $>40$kg | TDF + 3TC (or FTC) + EFV provide as fixed-dose combination (FDC) | Replace EFV with NVP in patients:  
» With significant psychiatric co-morbidity or intolerance to EFV  
» Where the neuropsychiatric toxicity of EFV may impair daily functioning, e.g. night shift workers |
| Adults | | |
| All HIV/TB co-infection | | |
| All HBV co-infection | | |
| Adults and adolescents on d4T | Change d4T to TDF  
(No patient must be on d4T) | Switch to TDF if virally suppressed and the patient has normal creatinine clearance, even if d4T well tolerated  
If $\text{VL} > 1000$ copies/mL, manage as treatment failure and consider switching to second line |
| Adolescents $<15$ years or weight $<40$kg | ABC + T3C + EFV | If adolescent weight $<40$kg, align with paediatric regimen |

<table>
<thead>
<tr>
<th>CONTRAINDICATION</th>
<th>SUBSTITUTION DRUG</th>
<th>COMMENTS</th>
</tr>
</thead>
</table>
| Contraindication to EFV:  
» Significant psychiatric co-morbidity  
» Intolerance to EFV  
» Impairment of daily function (shift workers) | TDF + FTC (or 3TC) + NVP or LPV/r | If CD4 $<250$ females and $<400$ males, give NVP 200mg daily for 2 weeks, then 200mg BD  
CD4 $\geq 250$ females and $\geq 400$ males, use LPV/r 2 tablets 12 hourly |
| TDF contraindication:  
Creatinine clearance of $<50$ mL/min | ABC + T3C + EFV (or NVP) | Renal disease or the use of other nephrotoxic drugs e.g. aminoglycosides  
MDR treatment |

The modified Cockroft-Gault equation:

$\text{Creatinine clearance} = \frac{(140 \cdot \text{age}) \times \text{ideal weight}}{\text{serum creatinine}}$

*For women, multiply the total by 0.85*
Baseline and routine clinical and laboratory assessment for late adolescents and adults

**Table 25: Standardised baseline monitoring (all adults/adolescents/pregnant and breastfeeding women)**

<table>
<thead>
<tr>
<th>Phase of HIV management</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HIV diagnosis</strong></td>
<td></td>
</tr>
<tr>
<td>Confirm HIV result with rapid antibody test if no test results are available</td>
<td>To confirm HIV-positive status in patients who present without documented proof of positive HIV status</td>
</tr>
<tr>
<td>WHO clinical staging if HIV-positive</td>
<td>To assess eligibility for ART and timing of initiation</td>
</tr>
<tr>
<td>CD4 count</td>
<td>To identify eligibility for ART (CD4 ≤500/µl)</td>
</tr>
<tr>
<td>CD4 ≤350/µl</td>
<td>To identify eligibility for prioritisation (CD4 ≤350/µl)</td>
</tr>
<tr>
<td>CD4 ≤200/µl</td>
<td>To identify eligibility for fast-tracking (CD4 ≤200/µl)</td>
</tr>
<tr>
<td>CD4 &lt;100/µl</td>
<td>To identify eligibility for CrAg or CLAT (CD4 &lt;100/µl)</td>
</tr>
<tr>
<td>Screen for pregnancy or ask if planning to conceive</td>
<td>To identify women who need ART for PMTCT and offer appropriate family planning</td>
</tr>
<tr>
<td>Assessment of hypertension and diabetes with blood pressure and urine glycosuria</td>
<td>To identify any concomitant chronic diseases</td>
</tr>
<tr>
<td>Screen for TB symptoms using the TB screening tool</td>
<td>To identify those with TB symptoms and to assess eligibility for INH</td>
</tr>
<tr>
<td>Screen for HBV (HBsAg)</td>
<td>To identify those co-infected with HBV so that they can be initiated on ART regardless of CD4 count</td>
</tr>
<tr>
<td>Screening for STIs and syphilis</td>
<td>To identify and treat STIs</td>
</tr>
<tr>
<td>Weight and height in adolescent</td>
<td>To check if the weight is above or below 40kg to determine which ARV drugs to use</td>
</tr>
<tr>
<td>Cryptococcus Antigen (CrAg) test if CD4 &lt;100 cells/µl</td>
<td>To assess if there is disseminated Cryptococcal infection and if flucanazol treatment is indicated</td>
</tr>
<tr>
<td>Do Hb or FBC if requires AZT</td>
<td>To detect anaemia or neutropenia</td>
</tr>
<tr>
<td>Creatinine if requires TDF</td>
<td>To assess renal sufficiency</td>
</tr>
<tr>
<td>ALT if requires NVP</td>
<td>To exclude liver dysfunction</td>
</tr>
<tr>
<td>Fasting cholesterol and triglycerides if requires LPV/r</td>
<td>To identify at risk of LPV/r related hyperlipidaemia. If above 6 mmol/L, consider (ATV/r) instead of LPV/r (if available)</td>
</tr>
</tbody>
</table>

**On ART**

<table>
<thead>
<tr>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screen for TB symptoms at each visit</td>
</tr>
<tr>
<td>WHO clinical staging at every visit</td>
</tr>
<tr>
<td>Ask about side effects at each visit</td>
</tr>
<tr>
<td>CD4 at 12 months, then annually if clinically indicated</td>
</tr>
<tr>
<td>VL at month 6, month 12 on ART and then every 12 months</td>
</tr>
</tbody>
</table>
ALT if on NVP and develops rash or symptoms of hepatitis
FBC at month 3 and 6 if on AZT and then every 12 months
Creatinine at month 3 and 6, month 12, then every 12 months if on TDF
Fasting cholesterol and triglycerides at month 3 if on LPV/r

6.6.6 Viral load monitoring and first-line ARV treatment failure in late adolescents ≥15 and adults

Consider switching patients on the first-line drug regimen if the patient has experienced virological failure (VL > 1000 copies/mL) on at least two occasions two months apart despite good adherence.

All patients being assessed for switching should have their hepatitis B status checked, especially if on TDF and 3TC/FTC. Withdrawal of TDF can be associated with severe hepatitis in chronic hepatitis B patients (hepatitis B surface antigen positive).

- Check cholesterol, if above 6mmol/l, give Atazanavir/r instead of LPV/r (if available).

Table 26: Viral load monitoring for first-line regimens

<table>
<thead>
<tr>
<th>Viral Load (VL)</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;400 copies/mL</td>
<td>» VL monitoring according to duration of ART and routine adherence support</td>
</tr>
<tr>
<td></td>
<td>» Continue routine VL monitoring as it may be 12 monthly depending on how long patient is on treatment</td>
</tr>
<tr>
<td></td>
<td>» Provide intensified adherence for those patients whose viral load are above 50 copies/mL</td>
</tr>
<tr>
<td>400-1000 copies/mL</td>
<td>» Assess and manage adherence carefully</td>
</tr>
<tr>
<td></td>
<td>» Repeat VL in 6 months and manage accordingly</td>
</tr>
<tr>
<td>&gt;1 000 copies/mL</td>
<td>» Adherence assessment and intense adherence support</td>
</tr>
<tr>
<td></td>
<td>» Repeat VL in 2 months and check HBV status and Hb, if not already done</td>
</tr>
<tr>
<td></td>
<td>» If &lt;1000 copies/mL, repeat in 6 months and then reassess</td>
</tr>
<tr>
<td></td>
<td>» If &gt;1000 copies/mL and adherence issues addressed, switch to second line therapy after checking HBV status and Hb</td>
</tr>
</tbody>
</table>
6.6.7 Second-line regimen for late adolescents and adults

**Table 27: ART regimens**

<table>
<thead>
<tr>
<th>Second-line regimen: adolescents ≥15 years and adults</th>
<th>Drugs</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Failing on a TDF-based first-line regimen</td>
<td>AZT + 3TC + LPV/r</td>
<td>If non-adherent, address causes of non-adherence</td>
</tr>
<tr>
<td></td>
<td>AZT + TDF + 3TC + LPV/r</td>
<td>If the VL &gt;1000 copies/mL at any point, intensify adherence and repeat VL in 2 months</td>
</tr>
<tr>
<td></td>
<td>(If HBV co-infected)</td>
<td></td>
</tr>
<tr>
<td>Failing on a d4T or AZT-based first line regimen</td>
<td>TDF + 3TC (or FTC) + LPV/r</td>
<td>If VL remains at &gt;1000 copies/mL after 2 months, then switch to second line regimen</td>
</tr>
<tr>
<td>Dyslipidaemia (total cholesterol &gt;6 mmol/L) or diarrhoea associated with LPV/r</td>
<td>Switch LPV/r to ATV/r</td>
<td></td>
</tr>
<tr>
<td>Anaemia and renal failure</td>
<td>Switch to ABC</td>
<td></td>
</tr>
</tbody>
</table>

6.6.8 Second-line treatment failure and third-line regimen in late adolescents and adults

South Africa has a public health approach to HIV treatment with standardised first and second-line regimens based on efficacy, safety and tolerability. In addition, there are predictable resistance mutations that develop after first-line failure, therefore the second-line therapy selected should achieve viral suppression.

There is a third-line review committee that has been set up to coordinate the management of patients failing on the second-line regimen. It has determined that all adult patients who have been on a protease inhibitor (PI) containing regimen for at least a year and have not achieved viral suppression would be eligible for a genotype to determine if third-line was necessary. Should resistance to a boosted PI be identified, a full treatment history must then be submitted to the committee via the National Department of Health for consideration. Once consensus is reached, a decision is conveyed to the local facility and if third-line is indicated, the drugs are sent to the facility on a named patient basis.
Figure 8: Algorithm for diagnosis of second-line treatment failure

1. **HIV RNA > 1000 copies/ml on second-line ART for longer than one year**
   - Check for adherence, compliance, tolerability and drug-drug interaction and assess psychological issues
   - Repeat VL after 6 months

2. **VL ≤ 1000 copies/ml**
   - Continue second-line regimen

3. **VL > 1000 copies/ml**
   - Specialist referral as needed
   - Genotypic resistance testing
   - Specialist decision regarding further management
Access to third-line ART is limited to patients who have documented resistance to the PIs they are currently taking. If PI resistance mutations are present then Darunavir-Ritonavir is authorised by an expert committee, together withRaltegravir and Etravirine and possibly other ARVs depending on the resistance profile and patient ART history.

Box 20: Third-line regimen for late adolescents and adults

| Failing any second-line regimen | Most likely regimens may contain: Raltegravir, Darunavir/Retravirine adjusted according to genotype interpretation and patient history | An expert panel will manage patients failing on second-line therapy. The drugs for third-line will be managed centrally. Should take into account prior exposure and predictable mutations |

6.6.9 Management of patients previously on ART

If a patient is referred in (e.g. from the private sector), and is still on ART and the regimen is successful (VL undetectable and no side-effects), where possible, the patient should be continued on the same regimen.

If the patient has interrupted treatment and was on a previous regimen as above, or where the prior regimen is unknown, take a full history to establish why the treatment was stopped. If the interruption was NOT due to toxicity or clear virological failure, check the VL and restart first line treatment as above, and repeat the VL after 2 months.

If patients have failed a previous regimen, initiate appropriate second line treatment.

If patient was previously on ART but has interrupted treatment, establish the cause of the interruption. If it is due to social or psychological factors, address these and follow up on interventions. If the patient stopped as a result of side effects, evaluate other drug choices and offer appropriate options. If the interruption was due to drug supply issues, and there were no non-adherence, resistance or toxicity issues, the previous ART regimen should be reinitiated as soon as possible.

NB: If NVP is restarted after an interruption of >1 week, re-commence with the 2 week lead-in dose and check the ALT if the patient becomes symptomatic.
ARVs commonly have side-effects and occasionally serious adverse events (SAEs) can occur. However, side-effects are far less common in children than in adults.

Side-effects or adverse events are those reactions to drugs that are known to occur and would be listed in the package insert e.g. nausea, abdominal pain, vomiting etc. Life threatening episodes would be referred to as serious adverse events.

Mild side-effects include mild nausea, vomiting, diarrhoea, dizziness, general malaise, peripheral neuropathy and nail discolouration.

Generally it is recommended that patients continue with the medication if the side-effects are mild.

Stavudine in adolescents should be switched before adverse effects develop. Patients should have a recent (within last 8 weeks) HIV Viral load.

- HIV Viral Load <50 copies/ml - Stavudine should be changed to abacavir if they are <15 years or <40kg or changed to tenofovir if ≥15 years and ≥40kg.
- HIV viral load between 50-1000 copies/ml - consult an expert for advice.
- HIV viral load >1000 copies/ml - treat as virological failure.

Adverse events should be recorded and reported regularly to the National HIV and AIDS Cluster. Serious adverse events (SAEs) should be reported within 48 to 72 hours (Grade 4 or death) to the Medicines Control Council. After the patient has recovered from the adverse event, it may be possible to recommence therapy with a different regimen. The decision to recommence therapy should be done in consultation with a treatment expert.

Grading of adverse events: All adverse events are graded from grade 1 to grade 4 depending on the severity of the event as well as the age of the child.

Response to adverse events:

- Grades 1 and 2: Continue with treatment and repeat the test. Reasses the patient within 2 weeks.
- Grade 3: Requires that the test be repeated within 1 week and if it still remains at grade 3, all ARVs must be stopped and patient managed with the assistance of a specialist.
- Grade 4: Requires that all drugs be stopped immediately and be referred to hospital. The patient can restart therapy after getting better, and if the same grade 4 occurs again, then the drug must be withdrawn and substituted.

Management of adverse events requires an individualised approach.

If there is a need to discontinue ART, it is advisable to discontinue all ARVs rather than continuing with one or two agents alone. When a patient discontinues a NNRTI-containing regimen, attempt to continue the NRTI component for 2 days after stopping the NNRTI.

Remember: Complete an adverse event form and submit the form to the local pharmacy service (See Annexure 8).
### 7.1 ARV DOSING AND SUBSTITUTION IN INFANTS AND CHILDREN

*See Annexure 5*

### 7.2 ARV DOSING AND SUBSTITUTION IN ADOLESCENTS AND ADULTS

**Table 28: ARV treatment dosing guide for adolescents and adults**

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dosage</th>
<th>Comments</th>
<th>Replacement drug</th>
</tr>
</thead>
<tbody>
<tr>
<td>TDF (Tenofovir)</td>
<td>300mg daily</td>
<td>TDF is contraindicated if serum creatinine &gt;85µmol/L during pregnancy, or creatinine clearance of &lt;50mL/min in non-pregnant adults</td>
<td>ABC</td>
</tr>
<tr>
<td>d4T (Stavudine)</td>
<td>Discontinue use</td>
<td></td>
<td>TDF</td>
</tr>
<tr>
<td>3TC (Lamivudine)</td>
<td>300mg daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FTC (Emtricitabine)</td>
<td>200mg daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NVP (Nevirapine)</td>
<td>200mg daily X 14 days, then 200mg twice daily</td>
<td>Use with caution in TB treatment. Avoid NVP if CD4 count ≥250cells/µl for women, and ≥400cells/µl for men</td>
<td>EFV or LPV/r if EFV is contraindicated</td>
</tr>
<tr>
<td></td>
<td>In unbooked women in labour, sdNVP is used as a 200mg tablet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EFV</td>
<td>600mg at night (400mg if body weight &lt;40kg)</td>
<td>Contraindicated if active psychiatric illness present</td>
<td>NVP or LPV/r if EFV is contraindicated</td>
</tr>
<tr>
<td>Lopinavir 200mg / Ritonavir 50mg</td>
<td>2 tabs twice daily (LPV 400mg/r 100mg) 4 tablets twice daily if on TB treatment (rifampicin)</td>
<td>Preferably taken with food For TB patients, increase dose gradually, from 2 BD by taking 3 BD for a week, then 4 BD</td>
<td>Depending on reason for substitution, use ATV/r if available (ATV 300mg/r 100 mg daily)</td>
</tr>
<tr>
<td>AZT (Zidovudine)</td>
<td>300mg twice daily</td>
<td>Avoid if severe anaemia (Hb&lt;8g/dL, or &lt;7g/dL in pregnant women)</td>
<td>ABC</td>
</tr>
</tbody>
</table>
7.3 COMMON DRUG TOXICITIES IN PREGNANT WOMEN, ADOLESCENTS AND ADULTS

Fat Redistribution Syndrome (FRS) (lipodystrophy/lipoatrophic/lipoatrophy) is common in adolescents adherent to NRTIs such as Stavudine and Didanosine. Signs of FRS include loss of subcutaneous fat, facial wasting, truncal adiposity, enlarged breasts and buffalo hump. It is important for clinicians to recognise these debilitating signs as they may contribute to body image problems and are stigmatising in children and adolescents and can result in poor adherence.

Bone density reduction due to tenofovir. HIV itself is a risk factor for bone density reduction but studies show an initial increase in bone loss which seems to plateau after about 24 weeks. Current resource constraints do not allow for routine bone density measurements (DEXA scanning), however, any signs of possible osteoporosis (e.g. vertebral, rib, hip, wrists or other fractures not adequately explained by the degree of trauma fractures) warrant investigation.

Renal tubular dysfunction due to tenofovir. Regular monitoring of creatinine clearance (CrCl) and urine dipstick is necessary, particularly if TDF is used with a PI such as Lopinavir/Ritonavir. Urine dipstick should be performed as per monitoring guideline. Proteinuria ≥1+ in the absence of leukocytes/nitrates or glycosuria warrant further investigation including a blood urea, creatinine, calcium/magnesium/phosphate (CMP) and HCO3 and thendiscussion with an expert to determine need for further investigation/referral. CrCl should be measured at baseline (prior to ART initiation) 3 months, 6 months, 12 months and yearly thereafter. It is important that CrCl tests are actively followed up to ensure results are received as quickly as possible (preferably 1–4 weeks) and that the CrCl is calculated using the formula provided above. The automatic calculations of national laboratories are made based on age and gender and do not accurately reflect the CrCl of the growing adolescent. Such active follow-up can be beneficial and ultimately, life-saving.

Abacavir-related hypersensitivity reaction (ABC HSR). ABC HSR is uncommon in black African patients but may occur in up to 5% of Caucasian patients. It usually occurs within the first few weeks of initiation and is suspected with the presence of at least 2 symptoms from the following: fever, rash, constitutional symptoms, gastrointestinal symptoms and respiratory symptoms. There is a strong association with HLA B5701 typing, rarely investigated locally.

If ABC HSR develops, supportive therapy, usually including hospital admission is required and all ART must be discontinued if the adolescent is unstable, or ABC can be switched if the adolescent is stable. When the adolescent has stabilised, ART can be restarted but ABC must not be included in the regimen as re-exposure is potentially life threatening.

Hyperlipidaemia in adolescents with HIV. Hyperlipidaemia is challenging to manage in all children and adolescents. The American Academy of Pediatrics criteria for intervention and treatment of persistent pediatric hyperlipidaemia suggests using LDL>4.9 mmol/L for children with no known Cardiovascular Disease (CVD) risk factors or LDL >4.1 mmol/L for children with 2 or more CVD risk factors for intervention. HIV as a chronic inflammatory condition may represent a risk factor but is not clearly stated as such. Protease inhibitors and stavudine are associated with increased risk of abnormal lipid profile.

Gynaecomastia and lipomastia. Breast enlargement occurs in both boys and girls usually in the adolescent age group. Efavirenz (EFV) seems to be the offending agent. This could potentially impact on adherence. Changing EFV to another agent may be helpful. In severe cases these patients may require a surgical opinion.
7.3.1 Lactic acidosis in children

All nucleoside analogues have been associated with lactic acidosis. It is a rare but potentially life-threatening metabolic complication of treatment. The pathogenesis is believed to involve drug-induced mitochondrial damage. Initial symptoms are variable; cases have occurred as early as one month and as late as 20 months after starting therapy, and are usually associated with Didanosine or Stavudine.

Note: there are no good screening tests to detect lactic acidosis and a high index of clinical suspicion should be maintained.

<table>
<thead>
<tr>
<th>CLINICAL FEATURES</th>
<th>LABORATORY ABNORMALITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>» Generalised fatigue, weakness</td>
<td>» Hyperlactataemia (&gt;2mmol/L)</td>
</tr>
<tr>
<td>» Gastrointestinal symptoms (nausea, vomiting, diarrhoea, abdominal pain hepatomegaly, anorexia, and/or sudden unexplained weight loss)</td>
<td>» Increased anion gap [(Na + K) - (Cl + HCO3); normal &lt;15]</td>
</tr>
<tr>
<td>» Respiratory symptoms (tachypnoea and dyspnoea)</td>
<td>» Elevated aminotransferases, CPK, LDH, lipase, and amylase</td>
</tr>
<tr>
<td>» Neurologic symptoms (including motor weakness)</td>
<td>» Micro vesicular steatosis is seen on histology of the liver</td>
</tr>
</tbody>
</table>

MANAGEMENT

» Discuss with a treatment expert
» ART should be discontinued in patients with symptoms
» Symptoms associated with lactic acidosis may continue / worsen after discontinuation of ART
» Therapy is primarily supportive (fluid, bicarbonate administration and respiratory support)
» Administration of Riboflavin, Thiamine and/or L-carnitine has been reported by some to have benefit in case reports
7.3.2 Abacavir hypersensitivity reaction (HSR)

**CLINICAL FEATURES**
This is a multi-organ process manifested by signs or symptoms from at least two of the following groups:

» Fever is the most common manifestation occurring in 80% of cases. Chills have been reported to accompany fever

» Rash is experienced by 70% of cases and pruritus can also occur. In contrast to NVP, the rash is often mild and may go unnoticed by patients. When rash occurs in the absence of other features of HSR, Abacavir should not be discontinued

» Gastrointestinal symptoms such as nausea, vomiting, diarrhoea and abdominal pain are all features of HSR but may also occur in the absence of HSR, particularly when Abacavir is used with Zidovudine. Therefore, as with rash, patients with isolated gastrointestinal symptoms should not discontinue Abacavir but should be followed closely

» Constitutional symptoms include fatigue, myalgias and generalized malaise

» Respiratory symptoms occur in 18% of cases and include dyspnoea, cough and pharyngitis. Symptoms may be difficult to distinguish from influenza and other respiratory viruses. Respiratory symptoms together with abdominal symptoms suggest HSR rather than influenza or other respiratory illness. Clusters and combinations of symptoms are important in the diagnosis of Abacavir HSR

» With Abacavir HSR, there is an accentuation of symptoms in the hours immediately after the dose and worsening of symptoms with each subsequent dose. Stopping therapy is followed by rapid improvement in the symptoms

» If Abacavir is not stopped or is restarted after temporary cessation, the HSR will progress to hypotension, renal dysfunction and bronchospasm and ultimately, death. Abnormal laboratory findings may include leucopenia, anaemia and thrombocytopenia, as well as elevations in transaminases, urea, creatinine and LDH. Eosinophilia is usually absent. Patch testing is currently only a research tool

» Resuming with Abacavir may lead to anaphylaxis and should be avoided even in cases where there was diagnostic uncertainty.

**MANAGEMENT**
On commencement of Abacavir, patients should be counselled in detail about the possible signs of HSR and be advised to contact their care provider should any occur. Therapy should not be initiated in patients with inter-current symptoms to avoid confusion.

It is advisable for patients to discuss symptoms early with the clinician rather than terminating therapy without consultation. Where termination without consultation occurs, Abacavir cannot be reinitiated. Patients should also be made aware of the special “patient alert card” that comes in the packaging. This card should be presented to any healthcare provider who sees the patient especially when care is not given by the usual provider. Providers at emergency facilities may be less familiar with this condition and where possible contact information for the usual care provider should be provided as well.

Deciding whether to stop therapy in a patient with suggestive symptoms can be difficult given the very non-specific nature of the presentation. A detailed medical history should be obtained. The following should be considered:

» When was Abacavir initiated? In the case of Abacavir HSR usually within the past 6 weeks

» Are two or more systems involved?

» Do the symptoms increase with each dose?

» Do the symptoms exacerbate just after the dose?

» Do the symptoms fit into the well-recognized clusters?

» What other medications are used and what was the timing of their initiation?

If patients present with mild symptoms and it is not clear whether symptoms are due to HSR, the clinician may consider allowing an additional dose. The patient should be able to report back or else hospitalization may be required for observation. If symptoms worsen, Abacavir should be terminated immediately and permanently. If symptoms do not worsen, Abacavir can be carefully continued while other possible reasons for the patient’s symptoms are investigated. In patients where the diagnosis is thought to be clear or where there is sufficient concern, Abacavir should be terminated immediately and permanently.

Hospitalization and special investigation will depend on the severity of symptoms. Corticosteroids do not prevent or alter the natural history. The reaction usually improves within 48 hours.
7.3.3 BCG adverse events

**PRESENTATION**
Adverse events related to BCG immunization have also been reported during immune reconstitution. These include:

» Abscess at the site of injection 10-15mm
» Lymphadenitis (>1.5cm) (lymphadenopathy may also occur at other sites, e.g. supraclavicular and cervical)
» Suppurative lymphadenopathy in association with BCG injection
» Disseminated BCG disease (indicated by failure to thrive, fever, hepatosplenomegaly)
» Osteitis
» Skin and eye reactions including erythema nodosum, lupus vulgaris and iritis

**MANAGEMENT**
If these adverse events are noted it is important to notify the authorities on a vaccine adverse event form. If an abscess is present, it should be drained to avoid sinus formation.

Pus may be sent for TB culture and PCR for detection of Mycobacterium bovis - BCG should be requested.

Most infants with localized BCG reaction will get better without anti-mycobacterial drugs, especially if it is part of an immune reconstitution inflammatory syndrome (IRIS)

Dissemination of BCG disease should be looked for with sputum, abdominal sonar and other investigations as indicated.

Only children with disseminated BCG disease should routinely receive treatment with INH (20mg/kg/day), Rifampicin (15 mg/kg/day) and Ethambutol (25 mg/kg) for a period of 6 months. BCG is inherently PZA resistant and the current strain of BCG used in South Africa has low-level resistance to INH, hence the choice of drug regimen.

Single TB drugs are usually only available at hospital level and the patients should be referred appropriately.

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7.4 Common side-effects of drug sensitive TB therapy and ART

*Table 29: Common side-effects of drug sensitive TB therapy and ART*

<table>
<thead>
<tr>
<th>Side-effect</th>
<th>ARVs</th>
<th>TB Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea</td>
<td>AZT; PIs</td>
<td>Pyrazinamide</td>
</tr>
<tr>
<td>Hepatitis</td>
<td>NVP; EFV; PIs</td>
<td>Pyrazinamide, Rifampicin, INH</td>
</tr>
<tr>
<td>Peripheral neuropathy</td>
<td>d4T; ddI</td>
<td>INH</td>
</tr>
<tr>
<td>Rash</td>
<td>NVP; EFV</td>
<td>Rifampicin; INH; Pyrazinamide</td>
</tr>
</tbody>
</table>

TB therapy carries significant side effects and attention by the healthcare worker to this is as important as with ART.
### 7.5 COMMON DRUG TOXICITIES AND SIDE-EFFECTS OF ARV DRUGS

Table 30: Common side-effects of ARV drugs

<table>
<thead>
<tr>
<th>DRUG</th>
<th>SIDE-EFFECTS</th>
<th>RISK FACTORS</th>
<th>SUGGESTED MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abacavir</td>
<td>Hypersensitivity reaction</td>
<td>Presence of HLAB*5701gene</td>
<td>» If ABC is being used in first-line ART, substitute with TDF or AZT</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>» If ABC is being used in second-line ART, substitute with TDF</td>
</tr>
<tr>
<td>Atazanavir/r</td>
<td>Indirect hyperbilirubinaemia (clinical jaundice)</td>
<td>» Underlying hepatic disease</td>
<td>LPV/r or DRV/r. If boosted PIs are contraindicated and NNRTIs have failed in first-line ART, consider integrase inhibitors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>» HBV and HCV co-infection</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>» Concomitant use of hepatotoxic drugs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Electrocardiographic abnormalities (PR interval</td>
<td>» Pre-existing conduction disease</td>
<td></td>
</tr>
<tr>
<td></td>
<td>prolongation)</td>
<td>» Concomitant use of other drugs that may prolong the</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>PR interval</td>
<td></td>
</tr>
<tr>
<td>Emtricitabine</td>
<td>Severe skin and hypersensitivity reactions</td>
<td>Unknown</td>
<td>Limited options are available</td>
</tr>
<tr>
<td></td>
<td>Hyperpigmentation of palms and soles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Zidovudine (AZT)</td>
<td>Anaemia, neutropenia, myopathy, lipatrophy or lipodystrophy</td>
<td>Baseline anaemia or neutropenia</td>
<td>If AZT is being used in first-line substitute with TDF or ABC</td>
</tr>
<tr>
<td></td>
<td>Lactic acidosis or severe hepatomegaly with steatosis</td>
<td>» BMI &gt;25 (or body weight&gt;75 kg)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>» Prolonged exposure to nucleoside analogues</td>
<td></td>
</tr>
<tr>
<td>Lamivudine (3TC)</td>
<td>Headache, dry mouth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nevirapine (NVP)</td>
<td>Hepatotoxicity</td>
<td>» Underlying hepatic disease</td>
<td>If the person cannot tolerate either NNRTI, use boosted PIs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>» HBV and HCV co-infection</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>» Concomitant use of hepatotoxic drug</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Hypersensitivity reaction, Stevens-Johnson syndrome</td>
<td>Risk factors unknown</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>» Convulsions</td>
<td></td>
</tr>
<tr>
<td>DRUG</td>
<td>SIDE-EFFECTS</td>
<td>RISK FACTORS</td>
<td>SUGGESTED MANAGEMENT</td>
</tr>
<tr>
<td>----------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Efavirenz (EFV)</td>
<td>Persistent central nervous system toxicity (such as abnormal dreams, depression or mental confusion)</td>
<td>Depression or other mental disorder (previous or at baseline)</td>
<td>Daytime dosing</td>
</tr>
<tr>
<td>Tenofovir (TDF)</td>
<td>» Flatulence, nausea, diarrhoea, abdominal discomfort</td>
<td>» Active against hepatitis B but not FDA approved for treatment of hepatitis B. In patients with HIV and hepatitis B co-infection, hepatitis may flare upon discontinuation of Tenofovir</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Asthenia</td>
<td>» Gastrointestinal symptoms may be worse in lactose-intolerant patients; Tenofovir is formulated with lactose</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Acute renal insufficiency, Fanconi syndrome</td>
<td>» Adjust dosage for renal insufficiency or failure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Chronic renal insufficiency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lopinavir/ ritonavir</td>
<td>» Diarrhoea, nausea, vomiting, Dyslipidaemia</td>
<td>» Available in tablets or oral solution. Tablets do not require refrigeration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Elevations in liver function tests</td>
<td>» Oral solution contains 42% alcohol</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Taste perversion</td>
<td>» Avoid combining oral solution with Metronidazole or Disulfiram. Alcohol in the oral solution may cause Disulfiram-like reaction</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ritonavir</td>
<td>» Nausea, vomiting, diarrhoea, abdominal pain</td>
<td>Capsules are stable at room temperature for up to 30 days</td>
<td>Avoid combining oral solution with Metronidazole or Disulfiram. Alcohol in the oral solution may cause Disulfiram-like reaction</td>
</tr>
<tr>
<td></td>
<td>» Elevations in liver function tests</td>
<td></td>
<td>Has significant interactions with many other medications</td>
</tr>
<tr>
<td></td>
<td>» Fatigue</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Circumoral or peripheral numbness</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Taste perversion</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>» Hyperuricemia</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
HIV infection in children often leads to multiple nutritional deficiencies and general malnutrition. Decreased food intake, impaired absorption and increased nutrient requirements all contribute to this.

HIV infection can impair the nutritional status of infected children from soon after infection. Length/height and weight are reduced in almost all infected children and growth faltering often occurs before opportunistic infections or other symptoms present. Growth failure is indeed a sign of possible undiagnosed HIV infection. HIV causes increased energy requirements in the infected child. This initially results in the wasting of lean body tissue and then of fat mass. Lean body tissue is the total amount of muscle and non-fat tissue in the body. Children with severe growth failure and loss of muscle (lean body tissue) are at an increased risk of mortality. ART improves weight, growth and development of infected children and improves their survival.

Besides weight and length/height, another good indicator of a child’s general nutritional status is the mid-upper arm circumference (MUAC).

8.1 INFANT FEEDING: BREASTFEEDING AND FORMULA FEEDING

All pregnant HIV positive, HIV-negative women or women with unknown HIV status should receive at least 4 antenatal counselling sessions on infant feeding. At every visit, they should be advised to exclusively breastfeed their infants during the first 6 months of life, with appropriate complementary foods being introduced from 6 months and on expressing breast milk and appropriate storage of expressed breast milk.

Breastfeeding can continue for up to 2 years and beyond in HIV-negative women, or may continue up to 12 months for HIV-positive breastfeeding women. Mothers must be counselled about the risks of mixed feeding their infants during their first 6 months of life, as exclusive breastfeeding reduces the risk of HIV transmission and improves child survival.

Pregnant/breastfeeding women must be tested for HIV (Table 1, Section 3.4).

Infants of HIV-positive mothers who are on second or third-line ART for >3 months and have a viral load >1000 copies/L should not be breastfed. This is a medical contra-indication to breastfeeding.

They should also be intensively counselled about the importance of long-term adherence to ART and provided with adherence support where issues or barriers are identified. All HIV-exposed infants must be provided with prophylactic NVP alone or with AZT as stipulated in section 6.21 above. Infants who are growth faltering, are at risk of poor growth and should be referred for appropriate nutritional care and support assistance.

HIV-positive mothers who decide not to breastfeed their infants (after appropriate counselling and education) should understand that formula is not routinely provided as part of the PMTCT programme at public health facilities and be counselled on appropriate exclusive formula feeding in amount and frequency for optimal growth and development. They should be able to provide adequate formula for their infant as a replacement feed to their HIV uninfected infants when specific conditions are met (Box 21).
Box 21: Conditions for replacement infant feeding

» The mother or caregiver is able to provide sufficient infant formula to safely exclusively formula feed the infant for the first 12 months of life
» The mother or caregiver can, in the first 6 months, exclusively give adequate infant formula milk
» Safe water and sanitation are assured at the household level and in the community
» The mother or caregiver can prepare infant formula hygienically and correctly
» The mother or caregiver can provide adequate, appropriately constituted formula feeds frequently enough so that it provides adequate nutrition to ensure optimal growth and development of the infant
» Choose a breast milk substitute (commercial infant formula milk product) that is appropriate for the infant’s age and circumstances:
  › Infants weighing <2kg should receive a special low birth weight formula until the infant weighs at least 2kg; thereafter infant formula for a full term infant can be given
  › A soy protein-based formula should not be given to an infant <2kg

All healthcare providers caring for mothers, infants, and young children should fully adhere with all the provisions of the South African Regulations Relating to Foodstuffs for Infants and Young Children.

8.2 ASSESSING THE NUTRITIONAL STATUS OF CHILDREN

The nutritional needs of children who are HIV-positive vary according to age, stage of disease, the presence of acute and/or chronic infections and the treatment they receive. Nutritional needs are best met through a balanced and varied diet in adequate quantities. In the absence of this, additional support may be needed.

Appropriate and adequate nutrition is needed to achieve the full benefits of ART. Children often gain weight and their height increases when ART is initiated, although height gain is generally much slower than weight gain. Monitoring of weight while on treatment is important, as growth failure is often an indicator of treatment failure.

Refer to the South African National Guidelines on Nutrition for People Living with TB, HIV, AIDS and Other Chronic Debilitating Conditions for more information on the nutritional management of children who are HIV-positive.

The ABCDE of nutritional care should be followed when assessing HIV-infected children:

Anthropometry: Plot the child’s growth on the relevant growth chart (RTH booklet or clinic chart). Use the chart to assess the child’s growth. Classify the child’s growth as:

» Normal
» Wasted (weight-for-height <3rd centile)
» Stunted (height-for-age <3rd centile)
» Underweight (weight-for-age <3rd centile)

Biochemistry: These are total cholesterol, serum triglycerides, serum glucose and haemoglobin (Hb)
Clinical: The nutritional needs of children who are HIV-positive for growth, development and immunological function, depend on the stage of disease and history of recent complications such as persistent diarrhoea or opportunistic infections. Children who are HIV-positive have increased energy needs due to the infection itself, also because children with other opportunistic infections will have even higher requirements.

Dietary: First find out who the child’s main caregiver is and who else is involved in feeding and care. This helps to understand the quality and consistency of care practices. Take a brief history of the child’s diet to assess the preparation methods, amount and type of food consumed. Children who are HIV-positive often have loss of appetite and opportunistic infections that interfere with the absorption of the nutrients in their food. Questions regarding socio-economic status should be included when talking to the caregiver.

If a child is given infant formula, careful examination of the methods of sterilization of utensils and mixing of the formulas should be performed.

If it is apparent that the child has food insecurity or is not meeting her/his energy requirement, where possible she/he should be referred to a dietician and a social worker to ensure access to child grants and other support.

Evaluation: When a patient has returned for follow-up visits, determine if they were seen by the other health worker(s) they were referred to and assess whether they have improved. Continue to refer until the patient is no longer classified as malnourished or food insecure.

Caregivers should receive appropriate nutritional advice with consideration of cultural and financial constraints. Provide information on food preparation, hygiene, improving energy and nutrient density of meals and give examples of nutritious low cost foods. Adequate nutrition must be established early on as it will help to protect against malnutrition and will improve and maintain the child’s growth and quality of life by avoiding infections such as diarrhoea. Preventive measures such as good hygiene, immunisations and regular vitamin A supplements help protect the child against infections and undernourishment.

8.3 Management of severely malnourished children with HIV

The WHO recommends that children that have symptomatic HIV need an additional 30% energy, while symptomatic children with severe malnutrition require up to 100% more energy. It may be difficult to reach an additional 100% of energy requirements, thus the use of nutritional supplement may be required. The IMCI Chart Booklet (page 20) provides information on managing feeding problems in infants and young children.

In terms of food supplementation as part of the Integrated Nutrition Programme, the Nutrition Supplementation Programme (NSP) Scheme addresses the problem of malnutrition in children. Food supplementation is provided for children whose weight has been monitored on the RTH booklet and is found to be growth faltering (not gaining weight for 2 to 3 consecutive visits) or underweight <-2SD weight for age) or moderate acute malnutrition (MAM) without complications (low weight for height/length [z-score between -2SD and -3SD] or MUAC between 11.5 and 12.5cm). The programme is administered at primary healthcare facilities.

Parents or caregivers must also be informed about IMCI feeding recommendations from the IMCI Chart Booklet (pages 18, 19) and referred to any community support agencies.

Children with severe acute malnutrition (SAM) (very low weight for height/length [z-score <-3]) and any medical complications (or below 6 months of age) must be hospitalised. HIV-positive children with SAM should be managed like all other children with SAM and receive urgent treatment including daily assessment by a doctor. They should be nursed in a high care area until they are feeding well, infections are under control and diarrhoea has stopped. Treatment is aimed at managing the following serious complications: hypoglycaemia, hypothermia, dehydration, electrolyte imbalances, micronutrient deficiencies and infections.
9 HIV AND ANAEMIA

9.1 ANAEMIA IN PREGNANCY

A pregnant woman is deemed to be anaemic when her haemoglobin (Hb) level is below 11g/dl. An Hb <7g/dl is classified as severe anaemia in pregnancy and the women should be referred to a more specialised level of care. Anaemic women have an increased risk of pregnancy complications, including death. If anaemia is corrected, the woman would be able to better withstand the complications of haemorrhage and sepsis. Anaemia is a very common condition, and is more common in women infected with HIV.

9.1.1 Prevention of anaemia in pregnancy

All pregnant women should receive ferrous sulphate (FeSO₄) 1 tablet daily and folic acid 5 mg (1 tablet) daily throughout their pregnancy. All women should be given nutritional advice and counselled on the importance of taking their tablets.

9.1.2 Screening for anaemia in pregnancy

» Measure haemoglobin level
  › At first ANC visit
  › At 32 weeks gestational age
  › Near the time of delivery (36 weeks gestational age)
» Look for conjunctival pallor and palmar pallor
» Ask pregnant women at each visit if they get tired or get short of breath doing routine tasks

9.1.3 Management of anaemia in pregnancy

Immediate action should be taken if there is anaemia, as summarised in Table 29.

<table>
<thead>
<tr>
<th>Hb</th>
<th>Action</th>
</tr>
</thead>
</table>
| If Hb <7g/dl| » Ferrous sulphate (FeSO₄) 1 tablet three times a day  
              » Folate 5mg daily  
              » Urgently refer for obstetrician review |
| Hb 7-10g/dl | » FeSO₄ 1 tablet three times daily  
              » Folate 5mg daily  
              » Check Hb again 2 weeks later – if no improvement, consult with an obstetrician |
| Hb >10g/dl  | » FeSO₄ 1 tablet twice a day  
              » Folate 5mg daily  
              » Check Hb again 4 weeks later–if no improvement consider referral for obstetrician review or consult with an obstetrician |

NOTE: All women should be counselled on the importance of taking their tablets and appropriate nutritional care and support provided.
9.2 ANAEMIA IN INFANTS AND CHILDREN

9.2.1 Common causes of anaemia in infants and children

Anaemia is common in children who are HIV-positive and establishing a cause depends on the clinical features and the ability to investigate and refer infants. Children should be treated for possible common causes and see if they will respond well before referral. Common causes are summarized in Box 22.

Box 22: Common causes of anaemia in HIV-positive children

- Nutritional deficiency
- Opportunistic infections
- Drugs (Cotrimoxazole, Zidovudine and other ARVs)
- Auto-immune haemolysis
- Parvovirus infections
- Direct effects of HIV on bone marrow
- Sickle cell anaemia
- Thalassaemia
- Other congenital causes of anaemia may co-exist
- Malaria (less common in South Africa)

Iron deficiency occurs commonly in HIV-positive and HIV-uninfected children. Geohelminths such as Trichuris trichuria (whipworm) and Necator americanus (hookworm) are prevalent and contribute towards anaemia.

Anaemia is due to iron-deficiency in many cases. A therapeutic trial of iron can be attempted ONCE and only prior to referral for more investigations. It should be preceded by a baseline Hb and REPEATED after 3 weeks to document a response (expected response ≥2g/dL). A baseline reticulocyte count is most useful in differentiating between haemolytic anaemia and marrow suppression.

9.2.2 Treatment for iron deficiency anaemia

Elemental Iron: 2mg/kg 8 hourly with meals for 3 weeks; if Hb increases ≥2g/dL then continue for 3 more weeks

9.2.3 Dietary management of iron deficiency anaemia

Iron deficiency can be caused by a diet poor in iron rich foods or high consumption of food that prevent the absorption of iron. Caregivers of children should be encouraged to feed their children diets rich in iron. There are two types of iron that are absorbed into the body differently and come from different sources. The first is called haem iron, which is found in meat and meat products. Calcium is the only nutrient to negatively affect the absorption of haem iron. Non-haem iron is found in a variety of foods. The absorption of non-haem iron is affected by the amount of iron the body has in its stores and other nutrients that are eaten with the source of non-haem iron.
9.3 ANAEMIA IN ADOLESCENTS AND ADULTS

Patients should have a full clinical history, an examination, a full FBC, smear and reticulocyte count to characterise the anaemia. Decisions regarding further investigation can be made once this has been done. AZT may complicate this further, and should be used with care and close monitoring in these patients.

Anaemia pre-ART:
Anaemia is very common in patients with low CD4 counts. Those who are relatively asymptomatic or who have a serious opportunistic infection (OI) like TB, that explains the anaemia, should have their ART started right away and be monitored carefully. In other patients, an Hb<8 g/dl with no clear cause should generally trigger additional investigations; usually, there is an underlying serious OI, often TB, and this requires urgent diagnosis and treatment. A low Hb is an independent poor prognostic factor in HIV, so these patients should not delay ART if at all possible.

Anaemia immediately after ART initiation:
Confirm that the Hb has dropped, by comparing previous results. Again, a full history, examination and interpretation of an FBC/smear/reticulocyte count are helpful. Common causes of anaemia in the first few weeks and months of treatment include IRIS, disseminated TB, and AZT containing regimens, although many other conditions can cause this.

Anaemia once on established ART (>6 months):
This is unusual and often suggests a serious OI or a condition unrelated to HIV. However, drugs should still be considered as AZT, pure red cell aplasia from 3TC or cotrimoxazole may also cause FBC abnormalities.

Figure 9: Algorithm on anaemia in adults
10 PREVENTION AND MANAGEMENT OF OPPORTUNISTIC INFECTIONS

10.1 ISONIAZID PREVENTIVE THERAPY

10.1.1 Exclusion of active tuberculosis

It is essential to exclude active TB in every patient prior to starting preventive therapy. This is critical in order to avoid giving a single anti-TB drug to patients who require a full treatment regimen. All people living with HIV should be screened for TB at every visit to a health facility or contact with a health worker. Symptom based TB screening is sufficient to exclude TB among adults and adolescents living with HIV.

TB screening involves asking questions about TB symptoms to identify TB suspects and to find out if the patient may have active TB. This must be done routinely by trained lay counsellors or healthcare workers, as stipulated in Table 30 and refer or investigate as appropriate.

Screening for TB in children should be part of all routine health visits, especially the HIV- infected children.

Table 32: TB symptom screening

<table>
<thead>
<tr>
<th>TB symptoms screen (adolescents/adults/pregnant women)</th>
<th>TB symptoms screen (infants and children)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current cough of any duration</td>
<td>Current cough</td>
</tr>
<tr>
<td>Persistent fever of more than two weeks</td>
<td>Persistent fever of more than two weeks</td>
</tr>
<tr>
<td>Unexplained weight loss of &gt;1.5kg in a month, or failure to gain weight (pregnant women)</td>
<td>Fatigue</td>
</tr>
<tr>
<td>Drenching night sweats</td>
<td>Poor weight gain</td>
</tr>
</tbody>
</table>

All patients with one or more of these symptoms and signs must be further investigated for active TB disease as per national TB guidelines.

A child with symptoms of TB and a history of recent (<12 months) close contact with a person diagnosed with infectious TB should be considered to have TB unless proven otherwise.

10.1.2 Eligibility for TB preventive therapy

IPT Eligibility in Children

» Post-exposure IPT is recommended in the following children after exclusion of TB disease and other contraindications:

» All children less than five years of age, irrespective of HIV status

» All HIV-infected children irrespective of age or ART status

» Prior exposure (and possible eligibility for post-exposure IPT) is evidenced by either:

Close contact with an infectious pulmonary TB case or Tuberculin skin test positive (induration >10mm in HIV-uninfected; >5mm in HIV- infected or malnourished children) in the absence of previous IPT or TB treatment

» IPT should be repeated with each new exposure to an infectious TB case as previous IPT or TB treatment does not protect against future TB infection or disease. If re-exposure to an infectious source case of TB occurs while on IPT, IPT should be continued for as long as the source case remains infectious

» Children who have successfully completed TB treatment should not routinely (i.e. without a new source case) be started on IPT.

» Pre-exposure IPT is not recommended for any child, regardless of HIV status.

All HIV-positive adults and adolescents with no signs or symptoms suggestive of active TB are eligible for TB preventive therapy.
Table 33: IPT eligibility criteria

<table>
<thead>
<tr>
<th>POPULATION</th>
<th>Duration of IPT</th>
<th>COMMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant/breastfeeding HIV positive women</td>
<td></td>
<td>» All should be on lifelong ART</td>
</tr>
<tr>
<td></td>
<td></td>
<td>» IPT can be started anytime during pregnancy/breastfeeding, but ART</td>
</tr>
<tr>
<td></td>
<td></td>
<td>should be started first and IPT added after a minimum of 1 month</td>
</tr>
<tr>
<td></td>
<td></td>
<td>» Woman who fall pregnant on IPT should continue IPT</td>
</tr>
<tr>
<td></td>
<td></td>
<td>» If TST negative, re-assess TST status 1 year after completing IPT</td>
</tr>
<tr>
<td></td>
<td>TST positive: 36 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TST negative: 12 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TST not available: 12 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children &lt;5years old with recent exposure to</td>
<td>6 months</td>
<td>Recent refers to &lt;12 months</td>
</tr>
<tr>
<td>TB contact regardless of HIV status</td>
<td></td>
<td>» If re-exposed to a TB case after completion of 6 months IPT, repeat</td>
</tr>
<tr>
<td>All HIV-positive children up to 15years old</td>
<td></td>
<td>another course of IPT irrespective of interval between treatment and</td>
</tr>
<tr>
<td>with recent exposure to TB case</td>
<td></td>
<td>re-exposure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>» If child is exposed to new infectious source while on IPT, continue</td>
</tr>
<tr>
<td></td>
<td></td>
<td>IPT for as long as source remains infectious</td>
</tr>
<tr>
<td>Pre-ART patients regardless of CD4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Adolescent/Adult)</td>
<td>TST positive: 36 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TST negative: No IPT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TST not available: 6 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If later TST becomes negative</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» stop IPT</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If later TST becomes positive</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» extend to 36 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients on ART (Adolescent/adult)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>TST positive: 36 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TST negative: 12 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TST not available: 12 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td>If later TST becomes positive</td>
<td></td>
</tr>
<tr>
<td></td>
<td>» extend IPT to 36 months</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Former TB adult patients (Excluding MDR/XDR and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>children)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** If TST is not initially available at initiation of IPT, it must be done within ONE month of initiating IPT. If TST is negative, re-assess TST status annually until it becomes positive.
There is currently no evidence for repeating IPT in those who have completed 36 months or extending IPT beyond 36 months.

Individuals suspected of having TB should be investigated and if it is not found, they should not be given IPT. They should be re-assessed for IPT eligibility after 3 months.

**10.1.3 Treatment and dosing guide for INH for children, adolescents and adult**

*Table 34: Dosing guide for standard regimen for TB preventive therapy*

<table>
<thead>
<tr>
<th>Adolescents/Adults/Pregnant women</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isoniazid (INH): 5 mg/kg/day (maximum 300 mg per day)</td>
<td>INH 10 mg/kg/day</td>
</tr>
<tr>
<td>Vitamin B6 (pyridoxine): 25 mg/day</td>
<td>Crush appropriate fraction of the 100mg INH tablet and dissolve in water or multi-vitamin syrup before giving it to the child</td>
</tr>
<tr>
<td>Vitamin B6 given with INH to prevent peripheral neuropathy</td>
<td>HIV-positive or malnourished, add Pyridoxine daily for 6 months at the following dosages:</td>
</tr>
<tr>
<td>Issue 1-month drug supply for 3 months, thereafter a 3-month supply can be issued</td>
<td>» &lt;5 years of age: 12.5mg daily</td>
</tr>
<tr>
<td></td>
<td>» ≥5 years of age: 25mg daily</td>
</tr>
</tbody>
</table>

**10.1.4 Infants born to mothers with TB**

The following neonates are eligible for IPT:

» If TB has been excluded on basis of clinical, radiological (CXR) and bacteriological (gastric aspirates) assessments and

» Mother is non-infectious and has drug susceptible TB

If eligible, prescribe INH 10mg/kg daily for 6 months.
If infant is well and asymptomatic, give BCG 2 weeks after completion of IPT prophylaxis.

At the end of treatment period:
Screen for TB again
If TB screen negative, give BCG 2 weeks later

Figure 10: Management of infants born to mothers with TB

10.1.5 Who is not eligible for TB Isoniazid Preventive Therapy?
- People with confirmed or unconfirmed active TB
- Patients with active liver disease (acute or chronic)
- Patients with symptoms of peripheral neuropathy
- Patients with a history of adverse reaction to Isoniazid
- People who are HIV positive but TST negative in pre-ART care
- Patients with excessive alcohol use; more than 28 units per week for men and 21 units per week for women
- People who have completed treatment of MDR- or XDR-TB
- Patients who are ill and/or are in unstable condition
### 10.1.6 Isoniazid side-effects and management

**Table 35: Isoniazid side effects and management**

<table>
<thead>
<tr>
<th>Side-effect</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peripheral neuropathy</td>
<td>» Increase vitamin B6 (pyridoxine) to 100 mg daily; keep patient on that dose until the symptoms disappear</td>
</tr>
<tr>
<td></td>
<td>» If peripheral neuropathy is severe, discontinue INH immediately and refer patient to hospital</td>
</tr>
<tr>
<td></td>
<td>» If patient needs to take d4T for medical indication, discontinue INH</td>
</tr>
<tr>
<td>Hepatotoxicity</td>
<td>Stop INH immediately and refer patient to hospital</td>
</tr>
<tr>
<td>GI effects</td>
<td>» Rule out other causes of nausea and vomiting</td>
</tr>
<tr>
<td></td>
<td>» Consider LFTs</td>
</tr>
<tr>
<td></td>
<td>» Treat symptomatically (if no other cause is found)</td>
</tr>
<tr>
<td>Flushing reaction</td>
<td>» Reassure patients and advise that they avoid tyramine and histamine-containing foods while on INH</td>
</tr>
<tr>
<td></td>
<td>» Flushing is usually mild and resolves without therapy</td>
</tr>
<tr>
<td>Hypersensitivity</td>
<td>» Discontinue until the reaction resolves</td>
</tr>
<tr>
<td></td>
<td>» Re-challenge after resolution of reaction</td>
</tr>
<tr>
<td></td>
<td>» Begin with INH 50mg on day 1</td>
</tr>
<tr>
<td></td>
<td>» If the original reaction was severe, begin with INH 5mg on day 1</td>
</tr>
<tr>
<td></td>
<td>» If a reaction does not occur after day 1 dose, increase to 300mg on day 2</td>
</tr>
<tr>
<td></td>
<td>» If a reaction does not occur after the day 2 dose, continue INH 300mg daily</td>
</tr>
<tr>
<td></td>
<td>» If a reaction occurs during drug re-challenge, stop INH</td>
</tr>
<tr>
<td></td>
<td>» Treat with antihistamines and follow-up</td>
</tr>
</tbody>
</table>
10.2 COTRIMOXAZOLE PREVENTIVE THERAPY

10.2.1 Cotrimoxazole prophylaxis in infants, children and early adolescents

Refer to Section 6.2.2

10.2.2 Cotrimoxazole prophylaxis in late adolescents and adults

Cotrimoxazole prophylaxis markedly reduces hospitalization and mortality and provides protection against Pneumocystis Jirovecii pneumonia (PCP), toxoplasmosis, malaria and many other bacterial infections.

**Table 36: Eligibility criteria for Cotrimoxazole prophylaxis**

<table>
<thead>
<tr>
<th>Children</th>
<th>Adolescents and Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV-exposed infants &lt;1 year, start CTP at 4-6 weeks age</td>
<td>WHO stage 2, 3 or 4</td>
</tr>
<tr>
<td>HIV-positive infants &lt;1 year</td>
<td>HIV/TB co-infection</td>
</tr>
<tr>
<td>HIV-positive children 1-5 years with WHO stage 2,3, or 4, CD4&lt;25% or &lt;500 cells/µL</td>
<td></td>
</tr>
<tr>
<td>HIV-positive&gt;6years with WHO stage 3 or4</td>
<td></td>
</tr>
<tr>
<td>TB/HIV co-infection</td>
<td></td>
</tr>
<tr>
<td>Any child at risk of malaria or any bacterial infection</td>
<td></td>
</tr>
</tbody>
</table>

- Cotrimoxazole is safe to use in pregnancy. Pregnant women must continue on CPT
- Prescribe 160/800 (2 single strength tablets or one double strength tablet) orally once daily
- Monitor patient clinically at 3 monthly interval
- Do not delay ART in favour of cotrimoxazole initiation. Ideally, initiate cotrimoxazole immediately at first adherence visit, if not done already, prior to ART
- Cotrimoxazole’s most common side effect is a maculo-papular rash. Prophylaxis may be continued in the presence of mild rash or interrupted and then reintroduced. Treatment should not be continued in the presence of fever, hepatitis or mucous membrane lesions e.g. Stevens-Johnson syndrome
- Neutropenia is a rare side effect of CPT – routine blood count monitoring is not necessary
- Use Dapsone for patients who have had a mild reaction to cotrimoxazole. The recommended dose is 2 mg/kg/day or 4 mg/kg/week. The maximum daily dose is 100 mg (1 tablet). Dapsone should not be used after severe reactions, as there may be cross-reactivity. Dapsone does not provide protection against bacterial infections and provides only limited protection against toxoplasmosis
- Stop CPT only once well on ART and CD4 ≥350 cells/µl on more than two occasions
- Recommence cotrimoxazole when CD4 drops below 350 cells/µl or if ART fails or a new opportunistic infection develops
- Cotrimoxazole can cause erythema multiforme and Stevens-Johnson syndrome. If this occurs, stop the cotrimoxazole.
10.3 CRYPTOCOCCUS (CRYPTO) SCREENING AND TREATMENT

Cryptococcus is found in soil from bird droppings that are breathed in as dust. It cannot be passed in the air from one infected person to another. Infection can be dormant for many years.

Cryptococcus is usually only a problem if CD4 count drops to below 100 cells/µl. Smokers and people who work outdoors have higher risk of Cryptococcus.

10.3.1 Screening for cryptococcal disease in adults

» HIV-positive adults with a CD4 count <100 cells/µl should be screened for cryptococcal disease before ART is started

» Screen for cryptococcal antigaemnia by reflex laboratory/clinician-initiated testing

» Patients with a prior diagnosis of cryptococcal meningitis do not need to be screened

» Patients with a positive cryptococcal antigen (CrAg) blood test have disseminated cryptococcal disease and should be specifically evaluated for symptoms/signs of meningitis

» CrAg-positive patients with symptoms/signs should be referred for lumbar puncture (LP) to exclude cryptococcal meningitis. If cryptococcal meningitis is confirmed on LP, patients should be managed in hospital (for at least 2 weeks) and ART deferred for 4-6 weeks

» CrAg-positive patients without symptoms/signs may be offered an LP, if this is immediately accessible, to exclude subclinical meningitis. For CrAg-positive patients without suspected meningitis, oral fluconazole (800 mg for 2 weeks, followed by standard consolidation and maintenance treatment) is recommended as well as for patients with an LP that is cryptococcal test-negative. For patients without signs or evidence of meningitis, ART is recommended to be started 2 weeks after anti-fungal therapy is initiated

» Pregnancy: Women of childbearing age who screen CrAg-positive should have a pregnancy test prior to starting fluconazole (teratogenic); those who are not pregnant and are started on fluconazole should be advised to avoid pregnancy during treatment. CrAg-positive patients who are pregnant should be offered an LP and discussed with an expert before a decision is made regarding management

» Liver disease: Patients with evidence of clinical liver disease warrants careful monitoring because fluconazole may cause liver injury

10.3.2 Recommended cryptococcal treatment

Table 37: Cryptococcal treatment

<table>
<thead>
<tr>
<th>Screening</th>
<th>Antifungal treatment</th>
<th>ART</th>
</tr>
</thead>
<tbody>
<tr>
<td>CrAg Screening test positive (bloodstream disease) but no evidence of meningitis</td>
<td>Oral fluconazole (800 mg per day) for 2 weeks, followed by standard consolidation and maintenance antifungal treatment</td>
<td>Start after 2 weeks of antifungal treatment</td>
</tr>
<tr>
<td>Screening test positive with evidence of meningitis</td>
<td>Intravenous antifungal treatment for 2 weeks, followed by standard consolidation and maintenance antifungal treatment</td>
<td>Start after 4-6 weeks of antifungal treatment</td>
</tr>
</tbody>
</table>
10.3.3 Cryptococcal screening and treatment

Figure 11: Algorithm for cryptococcal screening and treatment

- Contact patient for urgent follow-up
- Screen for symptoms of meningitis*
- Check for special situations

Cryptococcal antigen screening when CD4+T-lymphocyte count <100 cells/µL

Positive

- Symptomatic
  - Start fluconazole 1 200 mg daily and refer immediately for lumbar puncture
  - Lumbar puncture (+)
    - Amphotericin B plus fluconazole 800 mg daily for 2 weeks in hospital
  - Lumbar puncture (-)
    - Fluconazole 800 mg daily for 2 weeks as outpatient

- Asymptomatic
  - Start fluconazole 1 200 mg daily and refer immediately for lumbar puncture
  - Fluconazole 400 mg daily for 2 months then 200 mg daily
    - Continue fluconazole for minimum of 1 year in total and discontinue when patient has had 2 CD4 counts >200 cells/µL taken at least 6 months apart

Negative

- Initiate ART
- No fluconazole

Start ART after 4-6 weeks of antifungal therapy
Start ART after 2 weeks of antifungal therapy
10.4 TUBERCULOSIS

HIV-positive patients are at higher risk of developing TB compared to the general population, especially during the period immediately after initiating ART, therefore all HIV-positive patients should be screened for TB. If an HIV-positive patient has symptoms suggestive of TB, investigate appropriately using sputum/GeneXpert and TB culture as per guidelines. It is very important to investigate patients for TB before starting ART and to routinely screen patients on ART. The guidelines remain the same for pregnant women.

10.4.1 Diagnosis of TB

Suspect TB if one or more of the following are present:

1. Cough of 2 weeks duration
2. Sputum production which may occasionally be blood stained
3. Fever
4. Drenching night sweats
5. Unexplained weight loss
6. Loss of appetite, malaise, tiredness
7. Shortness of breath, chest pains
8. New palpable lymphadenopathy

In children the presence of any three or more of the following features is suggestive of TB:

» TB symptoms (cough, fever, failure to thrive, weight loss)
» Physical signs suggestive of TB
» Positive TST
» Chest x-ray findings suggestive of TB
### 10.4.2 TB treatment in HIV

#### Table 38: ART for adults with concomitant TB

<table>
<thead>
<tr>
<th>TB develops while on ART</th>
<th>TB diagnosed before starting ART</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continue ARV therapy throughout TB treatment</td>
<td>In TB/HIV co-infection not on ART</td>
</tr>
<tr>
<td>First-line regimen:</td>
<td>Start with TB treatment first, followed by ART as soon as possible and within 8 weeks</td>
</tr>
<tr>
<td>Patient can remain on the regimen they are taking (unless they are on NVP)</td>
<td>If CD4 &lt;50 cells/µl initiate ART within 2 weeks of starting TB treatment, when the patient’s symptoms are improving and TB treatment is tolerated</td>
</tr>
<tr>
<td>Second-line regimen:</td>
<td>If CD4 &gt;50 cells/µl initiate ART within 2-8 weeks of starting TB treatment</td>
</tr>
<tr>
<td>The Lopinavir/Ritonavir (LPv/r) dose should be doubled (increase gradually from 2 tablets 12 hourly to 4 tablets 12 hourly) while the patient is on Rifampicin-based TB treatment</td>
<td>First line ART regimen:</td>
</tr>
<tr>
<td>Monitor ALT monthly</td>
<td>» Tenofovir 300mg daily</td>
</tr>
<tr>
<td>Reduce Lopinavir/Ritonavir to standard dose 2 weeks after TB treatment is completed</td>
<td>» Lamivudine 300mg or Emtricitabine 200mg daily</td>
</tr>
<tr>
<td></td>
<td>» Efavirenz 600mg at night</td>
</tr>
</tbody>
</table>

**NOTE:** HIV positive TB patients qualify for lifelong ART regardless of CD4 cell count.

Complete 2 to 8 weeks maximum, of TB therapy before commencing ART (and as soon as possible if CD4 count is less than 50 cells/µl). In general, ART should be initiated as soon as the patient is tolerating their TB therapy; this is usually within 2-4 weeks.

EPV-based regimens are generally preferred in patients with active TB; however, other regimens are also effective. Dose adjustment of PI may be required. Patients on Lopinavir/Ritonavir should have their dose doubled slowly over two weeks (to 800/200 mg twice a day); all other regimens can be continued unmodified. Monitor and investigate appropriately for hepatotoxicity symptoms. Continue these changes to Lopinavir/Ritonavir until two weeks after completion of TB treatment.

**Patient developing TB while on ART:**

ART should be continued throughout TB treatment, and remember to boost LPV/r if patient is on second line regimen.
11 MONITORING AND EVALUATION

11.1 PURPOSE

The purpose of the monitoring and evaluation section is to:

» Strengthen monitoring and evaluation of the ART programme
» Provide monitoring and evaluation guidance to the consolidated ART guidelines

Monitoring and evaluation activities allow health facilities, the health department at national, provincial and district level, and their partners to assess the extent to which ART programme is being implemented and achieving the intended objectives. Planned and systematic data gathering, analysis and interpretation are essential for the purpose of:

» Monitoring clinical care
» Patient outcome improvement
» Logistical appropriateness
» Program cost-effectiveness
» Performance measures and improvement
» Monitoring effectiveness and quality of services

Monitoring is a continuous function that uses the systematic collection of data on specified indicators to provide management and the main stakeholders of an ongoing development intervention with indications of the extent of progress and achievement of objectives and progress in the use of allocated funds (World Bank, 2009:2).

Evaluation is the systematic and objective assessment of an ongoing or completed project, program or policy including its design implementation and results (World Bank, 2009:2).

11.2 DATA COLLECTION TOOLS

To facilitate a standardised and systematic monitoring, it is compulsory for ART (including paediatric and antenatal care) service points to utilise the approved monitoring data collection tools. Clinicians treating patients should ensure that all required data collection tools are completed in detail. The following tools should be used to collect ART related data:

» Patient-held card: The patient-held card should be completed at every visit by the attending clinician and to be given to the patient

» Maternity case record: Medical record used by the clinicians for recording the antenatal clinic visits for the duration of the pregnancy including labour and delivery

» RTH booklet: The RTH booklet is a record of immunisations and growth rate given to mothers when their infant is born and is used to monitor the development of the child until he/she is five years old

» HIV and ART clinical stationery: HIV and ART clinical stationery is a legal record designed for the treatment and care of ART patients in PHC context. The stationery is used to record details of treatment and should be completed in detail at every clinic visit by the treating clinician. This record is facility-based. After every patients visit, information from the clinical stationery is then transcribed into TIER.Net system or ART register

» ANC register: A register that chronicles the ANC visits for the duration of the pregnancy

» Postnatal register: A register that is used to document the postnatal services received by mother and new-born pair within three days and subsequent visits

» Well-baby register: A register that is used to document the baby clinic visits
PHC register: This register may supersede other registers once rationalisation process is finalised

Pre-ART register: Information of all persons who are HIV positive and registered for HIV care (not necessarily receiving ART) is recorded in this register. Once the person is initiated on ART, s/he is registered in the ART enrolment register and followed there. The purpose of registers in general is to collect the same information about an entire group of patients in one location. This allows you to monitor what is happening with your whole group of patients in HIV care, and provides information about starting ART at your facility.

ART register (3 Tier systems): The ART register is a tool designed to monitor patients once they have started on ARVs. Once patients are initiated on ART, relevant information from the pre-ART register is transferred to the ART register. Thereafter, only the ART register is used to track these patients (even if the patient subsequently stops ART).

For Tier 1 facilities, information from the register is collated manually and reported monthly. For patient monitoring and programme monitoring reasons, the purpose of the ART register is to collect the information about groups of patients (cohorts or ART start-up groups) who start ART at the same time. For Tier 2 (phase 6) information from the paper-based ART register is transcribed ideally by data capturers into electronic TIER.Net. Data is produced at facility level generated by aggregating individual patient outcomes and exported into the district health information system (DHIS) using data exchange between TIER.Net and DHIS. Data is reported quarterly and, similar to the TB programme, is reported one quarter in arrears.

Birth register: A register used to document labour and birth data elements.

Adverse drug reaction reporting form: A form used to report any untoward reaction to the prescribed drug.

District health information system: A routine system for tracking health service delivery in the public health sector. It also plays a pivotal role in the collection, capturing, storage, collation, analysis and reporting of routine data.

11.3 DATA TRANSMISSION, ANALYSIS, REPORTING AND USAGE

The responsibility for data collection, analysis, management, reporting and usage rests at four levels (facility/hospital, sub-district/district, province and national). The process of data management involves:

- Clinical documentation by clinicians and pharmacists
- Service provision capturing in register
- Data entry by data capturer
- Data aggregation/collation
- Data analysis
- Reporting by programme coordinator (paper or electronic based)
- Data usage

11.4 ROLES AND RESPONSIBILITIES

ART (including paediatric and antenatal care) service points: Data generation, improvement of data quality, data analysis, maintenance of patient records and registers, reporting to the sub-district or district Department of Health and using the information in patient management, drug stocking and referral. Facilities are also encouraged to play specific role in reducing patients’ loss to follow-up.
Loss to follow-up (LTFU) tracing

Loss to follow-up is a pervasive challenge noted throughout the country. A loss to follow-up report can be generated through TIER.Net. Data capturers are advised to extract the early and late missed appointment in Tier 2 facilities for sharing with facility and ART (including PMTCT and paediatric) staff to ensure follow-up.

Table 39: Loss to follow-up tracing: report and action required

<table>
<thead>
<tr>
<th>REPORT</th>
<th>WHEN TO GENERATE</th>
<th>CONTENT</th>
<th>WHO EXTRACTS REPORT AND ACTION NEEDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early missed appointment</td>
<td>Every Friday morning</td>
<td>List of patients needing to be called/visited at home to prevent LTFU</td>
<td>Data clerk to draw each patient folder and confirm missed appointment. Report then to be submitted to facility manager (FM). FM to sign off on list. FM to assign staff member (suggest counsellor) to call each patient and encourage him or her to return. Result of each call to be recorded on list. List to go back to FM for filing</td>
</tr>
<tr>
<td>(2 weeks ago)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Late missed appointments</td>
<td>1st Friday of every month</td>
<td>List of patients who need a home visit to stop potential LTFU</td>
<td>Data clerk to draw each patient folder and confirm missed appointment. The necessary information should be pulled from patient folders to fill in Community Based (CBS) registers. CBS register and report then to be submitted to FM. FM to sign off on list and report. FM to assign staff member to call each patient or conduct a home visit. Result to be written on report and given back to data clerk. Data clerk to manually enter LTFU for all patients with incorrect address/phone numbers or for those patients not willing to return to facility. Transfer Out (TFO) and name of new facility should be manually entered if the patient is receiving treatment at another facility and the name of the facility is known. Report to be filed in FM office.</td>
</tr>
<tr>
<td>(2 months ago)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Defaulter report</td>
<td>1st Friday of every month</td>
<td>List of patients absent or not having drugs in hand for 90 days or more.</td>
<td>Data clerk to draw each patient folder and confirm missed appointment. Report then to be submitted to FM. FM to sign off on report and give back to data clerk for entry of LTFU for all patients remaining on list. Once completed, list to be filed in FM office.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>NOTE: Patients already captured as LTFU will not be on this list</td>
<td></td>
</tr>
</tbody>
</table>
**Sub-district, District and Provincial Department of Health:** Data analysis, quality audit, assessment of ART (including paediatric and antenatal care) service points, supervision, feedback and dissemination of information to National office and stakeholders.

**National Department of Health:** Compilation, analysis, quality audit, monitoring and evaluation, planning, advocacy resource allocation, drug supply and dissemination of information to national and international stakeholders.

### 11.5 REPORTING

Reports required by different organisations will be passed up the national monitoring and evaluation reporting channels. Note that reporting is bi-directional. Monitoring and evaluation data, whether analysed or raw must be utilised and reported to the section responsible for corrective action. The principles of continuous quality improvement dictate that monitoring and evaluation data are not be used punitively nor accessed for anything else, including the courts, other than for performance and quality of care improvement action.

Information from the prescribed records and registers is compiled and used to populate various monitoring reports, which are forwarded to the Sub-district, District and National Departments of Health. Monthly and quarterly reports should be forwarded to the next level of reporting according to the district health management information system (DHMIS) policy. Below is data flow diagram for ART.

*Figure 12: Data flow diagram for the ART programme*

<table>
<thead>
<tr>
<th>Level</th>
<th>ART Data Flow</th>
<th>Validation Responsibility</th>
<th>Sign off</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>M&amp;E Directorate</td>
<td>M&amp;E Directorate</td>
<td>Director General</td>
</tr>
<tr>
<td></td>
<td>CCMT Directorate</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Information Management: DHIS</td>
<td>Information Manager HAST M&amp;E Coordinator</td>
<td>Head of Department</td>
</tr>
<tr>
<td>Province</td>
<td>Information Management: DHIS</td>
<td>HAST Coordinator Information Officer PHC Manager</td>
<td>District Manager</td>
</tr>
<tr>
<td></td>
<td>Information Management: DHIS</td>
<td>CCMT manager Information Officer</td>
<td>Sub-district manager</td>
</tr>
<tr>
<td>District</td>
<td>Information Management: DHIS</td>
<td>Facility Manager Programme Coordinator Data capturer</td>
<td>Facility Manager</td>
</tr>
<tr>
<td>Sub-district</td>
<td>Information Management: DHIS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Facility</td>
<td>ART service point</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prison</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospitals TB Hospital</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Reports to be submitted

The reports that should be submitted are monthly/quarterly ART/PMTCT and cohort analysis reports. The data elements collected in various facilities are important in better understanding of cascade of care. The cascade of care and relevant indicators is presented on the next page.

*Figure 13: Cascade of care*

<table>
<thead>
<tr>
<th>Estimated no. of pregnant women living with HIV</th>
<th><strong>ESTIMATION</strong></th>
<th><strong>HCT</strong></th>
<th><strong>PRE-ART</strong></th>
<th><strong>ART INITIATION</strong></th>
<th><strong>ART MAINTENANCE</strong></th>
<th><strong>CLINICAL OUTCOMES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Estimated no. of child &lt;15 years living with HIV</td>
<td>ANC client receiving HCT</td>
<td>ANC client HIV positive</td>
<td>Antenatal client eligible for ART initiation</td>
<td>Antenatal client already on ART at 1st visit</td>
<td>Infant 1st PCR test done at birth</td>
<td>Child with viral load suppressed rate at 12.24,36,48 &amp; 60 months</td>
</tr>
<tr>
<td>Estimated no. of adults living with HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Infant 2nd PCR at 10 or 18 weeks</td>
<td>Child on 2nd line regimen at intervals</td>
</tr>
<tr>
<td>Estimated total no. of people living with HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Child rapid HIV test around 18 months</td>
<td>Child percentage died after 6,12,24,36,48 &amp; 60 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HIV test child 19-59 months</td>
<td>Adult with viral load suppressed rate 12,24,36,48 &amp; 60 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HIV test child 5-14 years</td>
<td>Adult on 2nd line regimen at intervals</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No of child &lt;15 years receiving HCT</td>
<td>Adult percentage died after 6,12,24,36,48 &amp; 60 months</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Infant 1st PCR test positive around 6 weeks rate</td>
<td>Adult naive female started ART</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HIV test positive child 12-59 months rate</td>
<td>Adult male started ART</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HIV test positive child 5-14 years rate</td>
<td>Adult ART experienced started</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>No of child &lt;15 years diagnosed with HIV</td>
<td>Total patients remaining in care</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Child under 15 years CD4 done at start of ART</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HIV test client 15 years and older</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HIV test positive client 15 years and older</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>HIV prevalence amongst clients older than 15 years tested</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Adult CD4 done at start of ART</td>
<td></td>
</tr>
</tbody>
</table>
# ANNEXURES

## 12.1 ANNEXURE 1: WHO CLINICAL STAGING OF HIV/AIDS FOR CHILDREN, ADOLESCENTS AND ADULTS

<table>
<thead>
<tr>
<th>CLINICAL STAGE</th>
<th>CLINICAL CONDITIONS OR SYMPTOMS (Adolescents and Adults)</th>
<th>CLINICAL CONDITIONS OR SYMPTOMS (Children)</th>
</tr>
</thead>
</table>
| Primary HIV infection | > Asymptomatic  
> Acute retroviral syndrome |  |
| Clinical stage 1 | > Asymptomatic  
> Persistent generalized lymphadenopathy | > Asymptomatic  
> Persistent generalized lymphadenopathy |
| Clinical stage 2 | > Moderate unexplained weight loss (<10% of presumed or measured body weight)  
> Recurrent respiratory infections (sinusitis, tonsillitis, otitis media, and pharyngitis)  
> Herpes zoster  
> Angular cheilitis  
> Recurrent oral ulceration  
> Papular pruritic eruptions  
> Seborrheic dermatitis  
> Fungal nail infections | > Unexplained persistent weight loss  
> Hepato-splenomegaly  
> Papular pruritic eruptions  
> Extensive wart virus infection  
> Extensive molluscum contagiosum  
> Fungal nail infections  
> Recurrent oral ulcerations  
> Unexplained persistent parotid enlargement  
> Lineal gingival erythema  
> Herpes zoster  
> Recurrent or chronic upper respiratory tract infections (otitis media, otorrhoea, sinusitis or tonsillitis) |
Clinical stage 3

- Unexplained severe weight loss (>10% of presumed or measured body weight)
- Unexplained chronic diarrhoea for >1 month
- Unexplained persistent fever for >1 month (>37.6°C, intermittent or constant)
- Persistent oral candidiasis (thrush)
- Oral hairy leukoplakia
- Pulmonary tuberculosis (current)
- Severe presumed bacterial infections (e.g. pneumonia, empyema, pyomyositis, bone or joint infection, meningitis, bacteremia)
- Acute necrotizing ulcerative stomatitis, gingivitis, or periodontitis
- Unexplained anaemia (haemoglobin < 8 g/dL)
- Neutropenia (neutrophils < 500 cells/µL)
- Chronic thrombocytopenia (platelets < 50,000 cells/µL)

Clinical stage 4

- HIV wasting syndrome
- Pneumocystis pneumonia
- Recurrent severe bacterial pneumonia
- Chronic herpes simplex infection (oro-labial, genital, or ano-rectal site for >1 month or visceral herpes at any site)
- Oesophageal candidiasis (or candidiasis of trachea, bronchi, or lungs)
- Extra pulmonary tuberculosis
- Kaposi sarcoma
- Cytomegalovirus infection (retinitis or infection of other organs)
- Central nervous system toxoplasmosis
- HIV encephalopathy

- Unexplained moderate malnutrition not adequately responding to standard therapy
- Unexplained persistent diarrhoea (14 days or more)
- Unexplained persistent fever (above 37.5°C intermittent or constant for longer than one month)
- Persistent oral candidiasis (after first 6-8 weeks of life)
- Oral hairy leukoplakia
- Acute necrotizing ulcerative gingivitis or periodontitis
- Lymph node tuberculosis
- Pulmonary tuberculosis
- Severe recurrent bacterial pneumonia
- Symptomatic lymphoid interstitial pneumonitis
- Chronic HIV-associated lung disease including bronchiectasis
- Unexplained anaemia (< 8 g/dL), neutropenia (< 0.5 × 10⁹ per litre)
- And/or chronic thrombocytopenia (< 50 × 10⁹ per litre)
<table>
<thead>
<tr>
<th>Clinical stage 4 (cont.)</th>
<th>Clinical stage 4 (cont.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&gt; Cryptococcosis, extra pulmonary (including meningitis)</td>
<td>&gt; HIV encephalopathy</td>
</tr>
<tr>
<td>&gt; Disseminated non-Tuberculosis mycobacteria infection</td>
<td>&gt; Cytomegalovirus infection: retinitis or cytomegalovirus infection affecting another organ, with onset at age older than one month</td>
</tr>
<tr>
<td>&gt; Progressive multifocal leuko-encephalopathy</td>
<td>&gt; Extra pulmonary cryptococcosis (including meningitis)</td>
</tr>
<tr>
<td>&gt; Candida of the trachea, bronchi, or lungs</td>
<td>&gt; Disseminated endemic mycosis (extra pulmonary histoplasmosis, coccidiomycosis)</td>
</tr>
<tr>
<td>&gt; Chronic cryptosporidiosis (with diarrhoea)</td>
<td>&gt; Chronic cryptosporidiosis</td>
</tr>
<tr>
<td>&gt; Chronic isosporiasis</td>
<td>&gt; Chronic isosporiasis</td>
</tr>
<tr>
<td>&gt; Disseminated mycosis (e.g., histoplasmosis, coccidioidomycosis, penicilliosis)</td>
<td>&gt; Disseminated non-tuberculous mycobacterial infection</td>
</tr>
<tr>
<td>&gt; Recurrent non-typhoidal Salmonella bacteraemia</td>
<td>&gt; Cerebral or B-cell non-Hodgkin lymphoma</td>
</tr>
<tr>
<td>&gt; Lymphoma (cerebral or B-cell non-Hodgkin)</td>
<td>&gt; Progressive multifocal leuko-encephalopathy</td>
</tr>
<tr>
<td>&gt; Invasive cervical carcinoma</td>
<td>&gt; Symptomatic HIV-associated nephropathy or HIV-associated cardiomyopathy</td>
</tr>
<tr>
<td>&gt; Atypical disseminated leishmaniasis</td>
<td>&gt; HIV-associated recto-vaginal fistula</td>
</tr>
<tr>
<td>&gt; Symptomatic HIV-associated nephropathy</td>
<td></td>
</tr>
<tr>
<td>&gt; Symptomatic HIV-associated cardiomyopathy</td>
<td></td>
</tr>
<tr>
<td>&gt; Reactivation of American trypanosomiasis (meningo-encephalitis or myocarditis)</td>
<td></td>
</tr>
</tbody>
</table>
12.2 ANNEXURE 2: TB SCREENING ALGORITHM FOR IPT IN ADOLESCENTS AND ADULTS

HIV Positive Adults /Adolescents

TB Symptom screen
Current cough, Fever, loss of weight, drenching night sweats

YES

INVESTIGATE FOR TB, as per national TB management guidelines. If patient has silicosis, a chest x-ray must be done

NO

ASSESS FOR CONTRA INDICATIONS TO IPT
Exclude excessive alcohol use, liver disease, peripheral neuropathy, and history of adverse reactions to INH

Contraindications present
DEFER IPT

No Contraindications
Do TST
Read within 48-72 hours

TST negative
Pre ART
No IPT

TST positive
On ART
IPT for 12 months

SCREEN FOR TB REGULARLY
At every consultation with the patient
12.3 ANNEXURE 3: TB SCREENING ALGORITHMS FOR IPT IN CHILDREN

**Documented TB Exposure**
Close contact with an adult, adolescent or child who has/had smear/culture positive PTB in the past 12 months

**Are there any current symptoms or signs of TB disease?**
Cough of two weeks or more, wheeze, fever, lethargy, fatigue, weight loss, failure to thrive, visible mass in the neck

- **No TB Symptoms and signs**
  - Child is <5 years & HIV positive
    - Give Isoniazid for 6 months
  - Child is <5 years & HIV negative
  - Child is ≥5 years & HIV positive
    - No preventative therapy
  - Child is ≥5 years & HIV negative
  - Regular follow up
    - Screen for TB Symptoms; Evaluate or refer if symptoms recur

- **TB Symptoms and signs**
  - Investigate for TB
    - No TB diagnosed
      - Treat accordingly and follow-up after 1-2 weeks
        - Child is asymptomatic
          - Child is <5 years & HIV positive
          - Give Isoniazid for 6 months
          - No preventative therapy
          - Regular follow up
            - Screen for TB Symptoms; Evaluate or refer if symptoms recur
          - Child is ≥5 years & HIV positive
            - No preventative therapy
            - Regular follow up
              - Screen for TB Symptoms; Evaluate or refer if symptoms recur
          - Child is ≥5 years & HIV negative
          - No preventative therapy
          - Regular follow up
            - Screen for TB Symptoms; Evaluate or refer if symptoms recur
          - Child is asymptomatic
            - Child still has persistent symptoms
              - Treat for TB
                - Monitor response to treatment closely
                - Start TB treatment and register patient
                - Child still has persistent symptoms
                  - Treat for TB
                    - Monitor response to treatment closely
                    - Start TB treatment and register patient

- **TB diagnosed**
  - Start TB treatment and register patient
  - Child still has persistent symptoms
    - Treat for TB
      - Monitor response to treatment closely
      - Start TB treatment and register patient
12.4 ANNEXURE 4: INFANTS BORN TO MOTHERS WITH TB

» The following neonates are eligible for IPT:
  › TB disease has been excluded on basis of clinical, radiological (CXR) and bacteriological (gastric aspirates) assessments and
  › Mother is non-infectious and has drug susceptible TB

» If eligible, prescribe INH 10mg/Kg daily for 6 months (see dosing table above)

» All infants born to mothers with TB at any point during their pregnancy must have an HIV PCR conducted at birth
**Antiretroviral Drug Dosing Chart for Children 2013**

Compiled by the Child and Adolescent Committee of the SA HIV Clinicians Society in collaboration with the Department of Health

<table>
<thead>
<tr>
<th>Target Dose</th>
<th>Abacavir (ABC)</th>
<th>Lamivudine (3TC)</th>
<th>Efavirenz (EFV)</th>
<th>Lopinavir/ritonavir (LPV/rtv)</th>
<th>Stavudine (d4T)</th>
<th>Didanosine (ddI)</th>
<th>Nevirapine (NVP)</th>
<th>Zidovudine (AZT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;3kg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3-3.9</td>
<td>3ml bd</td>
<td>2ml bd</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4-4.9</td>
<td>4ml bd</td>
<td>3ml bd</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-5.9</td>
<td>5ml bd</td>
<td>4ml bd</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-6.9</td>
<td>6ml bd</td>
<td>5ml bd</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7-7.9</td>
<td>7ml bd</td>
<td>6ml bd</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8-8.9</td>
<td>8ml bd</td>
<td>7ml bd</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9-9.9</td>
<td>9ml bd</td>
<td>8ml bd</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>17-19.9</td>
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<td>12ml bd</td>
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<tr>
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<td>35-39.9</td>
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</table>

**Available Formulations**

- Sol. 20mg/ml (oral dispersible), 300mg (not scored), ABC/3TC 600/300mg
- Caps. 50, 200mg (oral dispersible), Paracetamol 100mg
- Sol. 300/150mg (oral dispersible), Paracetamol 100mg
- Caps. 25, 50, 100mg (dispersible in 30ml water)
- Tabs 50, 200, 600mg (not scored)
- Adult Tabs 200/50mg, Paeds Tabs 100/25mg
- Sol. 80mg/ml
- Sol. 10mg/ml
- Tabs 150mg (scored), 300mg, ABC/3TC 600/300mg
- ABC/3TC 600/300mg
- Tabs 200/50mg, Paeds Tabs 100/25mg
- Caps 50, 100mg (oral dispersible)
- Caps 250mg (oral dispersible)
- Tabs 25, 50, 100mg (oral dispersible)
- Tabs 200mg (oral dispersible)
- Sol. 80/20mg/ml
- Tabs 150mg (scored), 300mg (not scored)

**Target Dose**

- 2mg/kg/day TWICE daily OR
- 1mg/kg/day TWICE daily OR
- 1mg/kg/day TWICE daily

**Contraindications**

- Avoid LPV/rtv solution in any full term infant <14 days of age and any premature infant <14 days after their due date of delivery (40 weeks post conception) or obtain expert advice.
- Children 25-34 kg may also be dosed with LPV/rtv 200/50mg adult tabs: 2 tabs am, 1 tab pm

**Weight (kg)**

<3 3-4.9 5-9.9 10-13.9 14-29.9 ≥30

**Cotrimoxazole Dose**

- 2.5ml bd
- 5ml od
- 5ml bd
- 10ml or 1 tab od
- 2 tabs od

**Multivitamin Dose**

- 2.5ml bd
- 5ml od
- 5ml bd
- 10ml or 1 tab od
12.6 ANNEXURE 6: CREATININE CLEARANCE TABLES

These tables are provided to assist with manual calculation. Please note that the new NHLS forms incorporate creatinine clearance calculation (see form following these tables) using 3 data points: gender, age and weight. Remember, creatinine clearance is not to be used to assess renal function in pregnant women.

CREATININE CLEARANCE in ml/min

Table 1: Female, age 15-40 years
CREATININE CLEARANCE in ml/min

Table 2: Female, age 41-65 years

<table>
<thead>
<tr>
<th>weight in kg</th>
<th>30-35</th>
<th>36-40</th>
<th>41-45</th>
<th>46-50</th>
<th>51-55</th>
<th>56-60</th>
<th>61-65</th>
<th>66-70</th>
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<td>8 to 12</td>
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<td>7 to 10</td>
<td>8 to 11</td>
<td>10 to 12</td>
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</table>

(140 - age) x weight in kg x 1.04

pCr in umol/liter
12.6 ANNEXURE 6: CREATININE CLEARANCE TABLES (cont.)

CREATININE CLEARANCE in ml/min

Table 3: Male, age 15-40 years

<table>
<thead>
<tr>
<th>weight in kg</th>
<th>30-35</th>
<th>36-40</th>
<th>41-45</th>
<th>46-50</th>
<th>51-55</th>
<th>56-60</th>
<th>61-65</th>
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<td>107 to 143</td>
<td>116 to 154</td>
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<td>47 to 62</td>
<td>54 to 69</td>
<td>61 to 78</td>
<td>69 to 86</td>
</tr>
</tbody>
</table>

\[(140 - \text{age}) \times \text{weight in kg} \times 1.04\]

pCr in umol/liter
### CREATININE CLEARANCE in ml/min

**Table 4: Male, age 41-65 years**

(140 - age) x weight in kg x 1.04

<table>
<thead>
<tr>
<th>weight in kg</th>
<th>30-35</th>
<th>36-40</th>
<th>41-45</th>
<th>46-50</th>
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### 12.7 ANNEXURE 7: GRADING OF ADVERSE EVENTS IN ADULTS AND CHILDREN

**Source:** Division of AIDS table for grading the severity of adult and pediatric adverse events, version 1.0, December 2004; clarification August 2009

<table>
<thead>
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<th>Feature</th>
<th>Grade 1</th>
<th>Grade 2</th>
<th>Grade 3</th>
<th>Grade 4</th>
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<td><strong>Haematology</strong></td>
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<tr>
<td>Haemoglobin Infant 1-21 days</td>
<td>12.0-13.0 g/dL</td>
<td>10.0-11.9 g/dL</td>
<td>9.0-9.9 g/dL</td>
<td>&lt;9.0 g/dL</td>
</tr>
<tr>
<td>Haemoglobin Infant 22-35 days</td>
<td>9.5-10.5 g/dL</td>
<td>8.0-9.4 g/dL</td>
<td>7.0-7.9 g/dL</td>
<td>&lt;7.0 g/dL</td>
</tr>
<tr>
<td>Haemoglobin Infant 36-56 days</td>
<td>8.5-9.4 g/dL</td>
<td>7.0-8.4 g/dL</td>
<td>6.0-6.9 g/dL</td>
<td>&lt;6.0 g/dL</td>
</tr>
<tr>
<td>Hb ≥57 days (HIV-positive only)</td>
<td>8.5-10.0 g/dL</td>
<td>7.5-8.4 g/dL</td>
<td>6.5-7.4 g/dL</td>
<td>&lt;6.5 g/dL</td>
</tr>
<tr>
<td>Absolute neutrophil count Infant 1 day</td>
<td>4.0-5.0x10⁹/l</td>
<td>3.0-3.9x10⁹/l</td>
<td>1.5-2.9x10⁹/l</td>
<td>&lt;1.5 x 10⁹/l</td>
</tr>
<tr>
<td>Absolute neutrophil count Infant 2 – 7 days</td>
<td>1.25-1.5x10⁹/l</td>
<td>1.0-1.24x10⁹/l</td>
<td>0.75-0.99x10⁹/l</td>
<td>&lt;0.75x10⁹/l</td>
</tr>
<tr>
<td>Absolute neutrophil count Children ≥7 days</td>
<td>1.0-1.3x10⁹/l</td>
<td>0.75-0.9 x10⁹/l</td>
<td>0.5-0.75 x10⁹/l</td>
<td>&lt;0.5 x10⁹/l</td>
</tr>
<tr>
<td>Platelets (cells/µl)</td>
<td>100,000–124,999/mm³</td>
<td>50,000–99,999/mm³</td>
<td>25,000–49,999/mm³</td>
<td>&lt;25,000/mm³ or bleeding</td>
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<tr>
<td><strong>Gastro-intestinal</strong></td>
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</tr>
<tr>
<td>Bilirubin</td>
<td>1.1–1.5 x ULN</td>
<td>1.6–2.5 x ULN</td>
<td>2.6 – 5.0 x ULN</td>
<td>&gt;5 x ULN</td>
</tr>
<tr>
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<td>1.25–2.5 x ULN</td>
<td>2.6– 5.0 x ULN</td>
<td>5.1– 10.0 x ULN</td>
<td>&gt;10.0 x ULN</td>
</tr>
<tr>
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<td>2.6-5.0 x ULN</td>
<td>5.1– 10.0 x ULN</td>
<td>&gt;10.0 x ULN</td>
</tr>
<tr>
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<td>&gt;15.0 x ULN</td>
</tr>
<tr>
<td>Pancreatic Amylase</td>
<td>1.1–1.5 x ULN</td>
<td>1.6 – 2.0 x ULN</td>
<td>2.1 –5.0 x ULN</td>
<td>&gt;5.0 x ULN</td>
</tr>
<tr>
<td><strong>Diarrhoea</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult and paediatric ≥ 1 year</td>
<td>Transient or intermittent episodes of unformed stools OR Increase of ≥3 stools over baseline per 24-hour period</td>
<td>Persistent episodes of unformed to watery stools OR Increase of 4 – 6 stools over baseline per 24-hour period</td>
<td>Bloody diarrhoea OR Increase of ≥7 stools per 24-hour period OR IV fluid replacement indicated</td>
<td>Life-threatening consequences (e.g., hypotensive shock)</td>
</tr>
<tr>
<td>Condition (Paediatric &lt;1year)</td>
<td>Diarrhoea</td>
<td>Constipation</td>
<td>Nausea</td>
<td>Vomiting</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------</td>
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<td>----------</td>
</tr>
<tr>
<td>Liquid stools (more unformed than usual) but usual number of stools</td>
<td>Liquid stools with increased number of stools OR Mild dehydration</td>
<td>Persistent constipation requiring regular use of dietary modifications, laxatives, or enemas</td>
<td>Persistent nausea resulting in decreased oral intake for 24 – 48hours OR Aggressive rehydration indicated (e.g., IV fluids)</td>
<td>Frequent episodes of vomiting with no or mild dehydration OR Aggressive rehydration indicated (e.g., IV fluids)</td>
</tr>
<tr>
<td>Liquid stools with moderate dehydration</td>
<td>Obstructive evacuation indicated</td>
<td>Persistent nausea resulting in minimal oral intake for &gt;48 hours OR Aggressive rehydration indicated (e.g., IV fluids)</td>
<td>Persistent vomiting resulting in orthostatic hypotension OR Aggressive rehydration indicated (e.g., IV fluids)</td>
<td>Extensive/generalized bullous lesions OR Stevens-Johnson syndrome OR Laceration of mucous membrane involving two or more distinct mucosal sites OR Toxic Epidermal Necrolysis (TEN)</td>
</tr>
<tr>
<td>Nervous system</td>
<td>Developmental delay—Paediatric &lt;1 Years</td>
<td>Moderate developmental delay, motor or cognitive, as determined by comparison with a developmental screening tool appropriate for the setting</td>
<td>Severe developmental delay, motor or cognitive, as determined by comparison with a developmental screening tool appropriate for the setting</td>
<td>Developmental regression, either motor or cognitive, as determined by comparison with a developmental screening tool appropriate for the setting</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Neuromuscular weakness (including myopathy and neuropathy)</td>
<td>Asymptomatic with decreased strength on exam OR Minimal muscle weakness causing no or minimal interference with usual social and functional activities</td>
<td>Muscle weakness causing greater than minimal interference with usual social and functional activities</td>
<td>Muscle weakness causing inability to perform usual social and functional activities</td>
<td>Disabling muscle weakness causing inability to perform basic self-care functions OR Respiratory muscle weakness impairing ventilation</td>
</tr>
<tr>
<td>Neurosensory alteration (including paraesthesia and painful neuropathy)</td>
<td>Asymptomatic with sensory alteration on exam or minimal paraesthesia causing no or minimal interference with usual social and functional activities</td>
<td>Sensory alteration or paraesthesia causing greater than minimal interference with usual social and functional activities</td>
<td>Sensory alteration causing inability to perform usual social and functional activities</td>
<td>Disabling sensory alteration or paraesthesia causing inability to perform basic self-care functions</td>
</tr>
<tr>
<td>Other</td>
<td>No therapy, monitor condition</td>
<td>May require minimal intervention and monitoring</td>
<td>Requires medical care or possible hospitalisation</td>
<td>Requires active medical intervention, hospitalisation or hospice care</td>
</tr>
</tbody>
</table>
12.8 ANNEXURE 8: GUIDELINES FOR ADVERSE DRUG REACTION REPORTING

National Pharmacovigilance Programme

The National Pharmacovigilance Centre (NPC) coordinates the programmatic implementation of pharmacovigilance (PV). Reports of ADRs flow from facilities in districts across the provinces, through increasingly higher provincial authorities, to the NPC at the National Department of Health. Duplicate copies of the ADR forms are sent to NPC.

Programmatic PV activities by the NPC in SA involve monitoring of medicine safety used in public health programmes. Currently, the mainstay of NPC PV activities in SA involves creating awareness of the need for detecting and reporting suspected ADRs through targeted spontaneous reporting. ADR report forms and guides for detecting and reporting ADRs have been designed and are in distribution to HCP nationwide.

The decentralised approach to PV emphasises improved patient care at the facility level where ADRs are identified, thereby both increasing awareness of ADRs and simultaneously improving the associated patient outcomes. The NPC also organises provincial and/or regional training workshops for HCP in government institutions nationwide.

What is Pharmacovigilance?

Pharmacovigilance is defined as the science and activities concerned with the detection, assessment, understanding and prevention of adverse reactions to medicines (i.e. adverse drug reactions). The ultimate goal of this activity is to improve the safe and rational use of medicines, thereby improving patient care and public health.

What is an Adverse Drug Reaction (ADR)?

The Medicines Control Council (MCC) defines an Adverse Drug Reaction (ADR) or adverse reaction as a response to a medicine that is noxious and unintended, including lack of efficacy, which occurs at any dosage and can also result from overdose, misuse or abuse of a medicine.

Who should report Adverse Drug Reactions?

All healthcare workers, including doctors, dentists, pharmacists, nurses and other health professionals are encouraged to report all suspected adverse reactions to medicines (including vaccines, X-ray contrast media, traditional and herbal remedies), especially when the reaction is not in the package insert, potentially serious or clinically significant.

What happens to a report?

All ADR reports are entered into a national ADR database. Each report is evaluated to assess the causal relationship between the event and the medicine. A well-completed adverse drug reaction/product quality form submitted could result in any of the following:

- Additional investigations into the use of the medicine in South Africa
- Educational initiatives to improve the safe use of the medicine
- Appropriate package insert changes to include the potential for the reaction
- Changes in the scheduling or manufacture of the medicine to make it safer

The purpose of ADR reporting is to reduce the risks associated with the use of medicines and to ultimately improve patient care.
Will reporting have any negative consequences on the health worker or the patient?

An adverse drug reaction report does not constitute an admission of liability or that the health professional contributed to the event in any way. The outcome of a report, together with any important or relevant information relating to the reaction, will be sent back to the reporter as appropriate. The details of a report are stored in a confidential database. The names of the reporter or any other health professionals named on a report and the patient will be removed before any details about a specific adverse drug reaction are used or communicated to others. The information is only meant to improve the understanding of the medicines used in the country.

Assessing whether an event is possibly an ADR

The following factors should be considered when an adverse drug reaction is suspected:

1. What exactly is the nature of the reaction? (Describe the reaction as clearly as possible and where possible provide an accurate diagnosis)
2. Did the reaction occur within a reasonable time to suggest relationship to starting treatment with the suspected medicine? (Some reactions occur immediately after administration of a medicine while others take time to develop)
3. Is the reaction known to occur with the particular medicine as stated in the package insert or other reference? (If the reaction is not documented in the package insert, it does not mean that the reaction cannot occur with that particular medicine)
4. Did the patient recover when the suspected medicine was stopped? (Some reactions can cause permanent damage, but most reactions are reversible if the medication is stopped)
5. Did the patient take the medicine again after the reaction abated (i.e. rechallenge). If so, did the same reaction occur again? (In most situations it is not possible or ethical to rechallenge the patient with the same medicine. If such information is available or if such a rechallenge is necessary, recurrence of the event it is a strong indicator that the medicine is may be responsible)
6. Can this reaction be explained by other causes (e.g. underlying disease/s; other medicine/s; toxins or foods)? (It is essential that the patient be thoroughly investigated to decide what the actual cause of any new medical problem is. A medicine-related cause should be considered, when other causes do not explain the patient’s condition)

What types of reactions should be reported?

The following adverse drug reactions should be reported:

» All ADRs to newly marketed drugs or new drugs added to the EDL
» All serious reactions and interactions
» ADRs that are not clearly stated in the package insert
» All adverse reactions or poisonings to traditional or herbal remedies

Report even if you are not certain the medicine caused the event

What product quality problems should be reported?

The following product quality problems should be reported:

» Suspected contamination
» Questionable stability
» Defective components
» Poor packaging or labelling
» Therapeutic failures
How can ADRs be prevented from occurring?

Some ADRs are unavoidable and cannot be prevented. However, most ADRs can be prevented by following the basic principles of rational use of medicines.

How are adverse drug reactions reported?

An adverse drug reaction/product quality report form is enclosed in this book and should be completed in as much detail as possible before returning it by fax or post to any of the addresses provided below. Additional forms can be obtained by contacting the National Pharmacovigilance Centre at these address below.

The National Pharmacovigilance Coordinator
National Pharmacovigilance Centre,
Private Bag X828,
Pretoria, 0001

Tel: (012) 395 9506/8099/9641
Fax2email: 086 241 2473
email: npc@health.gov.za
## National Consolidated Guidelines for the Prevention of Mother-to-Child Transmission of HIV (PMTCT) and the Management of HIV in Children, Adolescents and Adults

### Suspected Adverse Drug Reaction Report

**HIV/AIDS and TB Treatment Programme**

**National Pharmacovigilance Centre (NPC)**

**Tel:** 012 395 9506 / 8099

**Facsimile:** 065 242 2473

**Email:** npc@health.gov.za

(See please instructions on back page. Please send duplicate to NDoH and complete additional information on a separate sheet)

#### Patient Details:
- **Patient Initials:**
- **Age:**
- **Date of Birth (dd/mm/yyyy):**
- **Gender:**
- **Pregnant:**
- **Yes**
- **No**
- **Allergy:**
  - **Weight (kg):**
  - **Height (cm):**
  - **Estimated Gestational Age:**

#### Medicines (and Concomitant Medicines, Including Herbal Products, if Known)

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Suspect Drug/ Trade Name</th>
<th>Dose</th>
<th>Interval</th>
<th>Route</th>
<th>Date Started</th>
<th>Date Stopped</th>
<th>Prescriber (Dr/ Pharm/Nurse)</th>
</tr>
</thead>
</table>

#### Adverse Drug Reaction

- **Date of onset of reaction (dd/mm/yyyy):**
- **Date reported (dd/mm/yyyy):**

#### Description of reaction or problem (tick all that apply) – Attach additional information if required:
- Abdominal pain
- Diarrhoea
- Nausea
- Vomiting

#### Laboratory Results: Select Abnormal One(s) and Write the Values (BL=Baseline; CUR=Current)

- **K+**
- **Creat**
- **eGFR**
- **ALT**
- **AST**
- **Hb**
- **Platelets**
- **CD4**
- **Viral Load**
- **Lact**
- **Other**

#### Adverse Reaction Outcome

- **Intervention:**
  - Patient Counseled
  - Additional laboratory request
  - Referred to expert
  - Additional clinic visit
  - Discontinued

- **Action Taken:**
  - Discontinued suspected drug
  - Replacement
  - Decreased dose
  - Other

- **Patient Outcome:**
  - Recovering
  - Died
  - Other

#### Relevant Clinical History (Attach additional information if required)

- **Date patient initiated ARVs (dd/mm/yyyy):**
- **Initial regimen:**
- **Years: Months**

- **How long has patient been on ARV treatment:**
- **Years:**
- **Months:**

#### Concomitant Medical Condition(s) (Tick All That Apply):

- HTN
- DM
- KS
- Hep B
- PCP
- Esophageal Candidiasis
- Oropharyngeal Candidiasis
- **Cryp Meningitis**
- Other(s)

#### Reported By:

- **Name:**
- **Designation:**
  - Doctor
  - Nurse
  - Pharmacist
  - Other
- **Email:**
- **Tel:**
- **Signature:**
- **Date:**

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**Version 29.0 dated 12-Mar-2015**

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**National Consolidated Guidelines for the Prevention of Mother-to-Child Transmission of HIV (PMTCT) and the Management of HIV in Children, Adolescents and Adults**

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Instructions on filling the ADR Report

A) Patient Details – All fields to be completed

B) Medicines (and Concomitant medicines, including herbal products) – All fields to be completed as per the example below:

| Medicines (and Concomitant medicines, including herbal products, if known) |
|---|---|---|---|---|---|---|
| Medicine | Suspect drug/Trade Name | Dose | Interval | Route | Date started | Date stopped | Prescriber (Dr/Pharm/Nurse) |
| 1 | AZT/Retrovir | 300mg | SD | PO | 16-Oct-2014 | NA | Doctor |
| 2 | Paracetamol | 3g | TDS | PO | 16-Oct-2014 | 19-Oct-2014 | Nurse |
| 3 | St John’s Wort | 2 drops | TDS | PO | 16-Sep-2014 | NA | Pharmacist |


In the first column, please insert preferably the accepted abbreviation of the name of the medicine the patient is taking (AZT in the example), in the second column, insert the name of the drug suspected of causing the ADR, preferably its trade name (in this case it is AZT and the Trade name is Retrovir). You should then enter the dose, route of administration, the date started and stopped (where applicable) and the professional category of the prescriber namely, Doctor, pharmacist or nurse. You may also use the numeric key if you prefer e.g. 1 instead of AZT.

C) Adverse Drug Reaction – Please complete the date of onset of the ADR and please tick ADRs presented in the form as appropriate. If they do not appear on the list, please complete in the section labelled other. Please provide as much detail as possible.

D) Laboratory Results – Please select the abnormal laboratory results and write the value. (BL = Baseline; Cur = Current). If they are not among the ones listed, there is a section provided for other lab results. Please complete in as much detail as possible.

E) Adverse Drug Reaction Outcome – Please complete the intervention, action taken and patient outcome in all fields. A section is provided in cases where interventions, actions and outcomes other than those provided occur.

F) Relevant Clinical History – Please complete all fields in this section

G) Concomitant Medical Conditions – Please complete all fields in this section. If they are not among the ones listed, there is a section provided for other lab results. Please complete in as much detail as possible.

H) Reported by – Please complete all fields. Your contact details may be required in case of follow up to clarify information

Abbreviations:

<table>
<thead>
<tr>
<th>AZT</th>
<th>Zidovudine</th>
</tr>
</thead>
<tbody>
<tr>
<td>FTC</td>
<td>Stavudine</td>
</tr>
<tr>
<td>ETR</td>
<td>Efavirenz</td>
</tr>
<tr>
<td>APV</td>
<td>Amprenavir</td>
</tr>
<tr>
<td>TDF</td>
<td>Tenofovir</td>
</tr>
<tr>
<td>IDV</td>
<td>Indinavir</td>
</tr>
<tr>
<td>FTC</td>
<td>Indinavir</td>
</tr>
<tr>
<td>NNF</td>
<td>Nelfinavir</td>
</tr>
<tr>
<td>DRV</td>
<td>Darunavir</td>
</tr>
<tr>
<td>NFV</td>
<td>Nelfinavir</td>
</tr>
<tr>
<td>RAL</td>
<td>Raltegravir</td>
</tr>
<tr>
<td>SQV</td>
<td>Saquinavir</td>
</tr>
<tr>
<td>TPV</td>
<td>Tenofovir</td>
</tr>
<tr>
<td>R</td>
<td>Ritonavir</td>
</tr>
<tr>
<td>Cs</td>
<td>Cefotaxime</td>
</tr>
<tr>
<td>E</td>
<td>Ertibumol</td>
</tr>
<tr>
<td>Km</td>
<td>Kanamycin</td>
</tr>
<tr>
<td>Lzd</td>
<td>Linzolid</td>
</tr>
<tr>
<td>TRD</td>
<td>Tenofovir</td>
</tr>
<tr>
<td>Pm</td>
<td>Pometonide</td>
</tr>
<tr>
<td>Cs</td>
<td>Cefotaxime</td>
</tr>
<tr>
<td>Csf</td>
<td>Ciprofloxacin</td>
</tr>
<tr>
<td>AZI</td>
<td>Azithromycin</td>
</tr>
<tr>
<td>Csf</td>
<td>Clarithromycin</td>
</tr>
<tr>
<td>Csf</td>
<td>Capreomycin</td>
</tr>
<tr>
<td>MFX</td>
<td>Moxifloxacin</td>
</tr>
<tr>
<td>LFX</td>
<td>Levofloxacin</td>
</tr>
<tr>
<td>Gfx</td>
<td>Gatifloxacin</td>
</tr>
<tr>
<td>E</td>
<td>Ertibumol</td>
</tr>
<tr>
<td>ENF</td>
<td>Ofloxacin</td>
</tr>
<tr>
<td>Rtv</td>
<td>Fosamprenavir</td>
</tr>
</tbody>
</table>