CONSOLIDATED HIV AND AIDS JOB AIDE

AIDS AND TB UNIT ZIMBABWE

Name of health facility: ______________________________

Address: ______________________________

Province: ______________________________

District: ______________________________

Contact number: ______________________________

Email: ______________________________

Ministry of Health and Child Care (MoHCC)

Mission Statement:

The overall purpose of the Ministry of Health and Child Care is to promote the health and quality of life of the people of Zimbabwe. In pursuing this, the Ministry of Health and Child Care is committed to:

Equity: The MoHCC seeks to achieve equity in health by targeting resources and programmes to the most vulnerable and needy in our society.

Primary Health Care: The primary health care approach will be the main strategy for health development.

Priority Health Issues: Priority health problems will be identified and resources will be targeted to alleviating those problems.

Quality Programmes will seek to provide high quality care which is accessible and appropriate.

Health Promotion Programmes will emphasise on health promotion and disease prevention.

Calendar 2017

JANUARY

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Calendar 2018

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Contacts

Service Area	Organisation	Contact Address	Contact Number

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HIV TESTING SERVICES (HTS)

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- Pre- and post-test counselling messages 10
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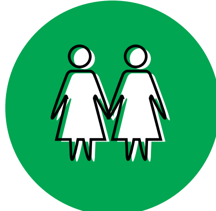
All HTS counselling should adhere to the 6Cs:



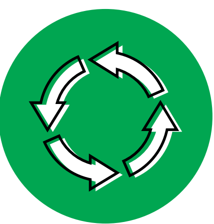
COMFORT

CONSENT

CORRECT AND ACCURATE HIV TEST RESULTS

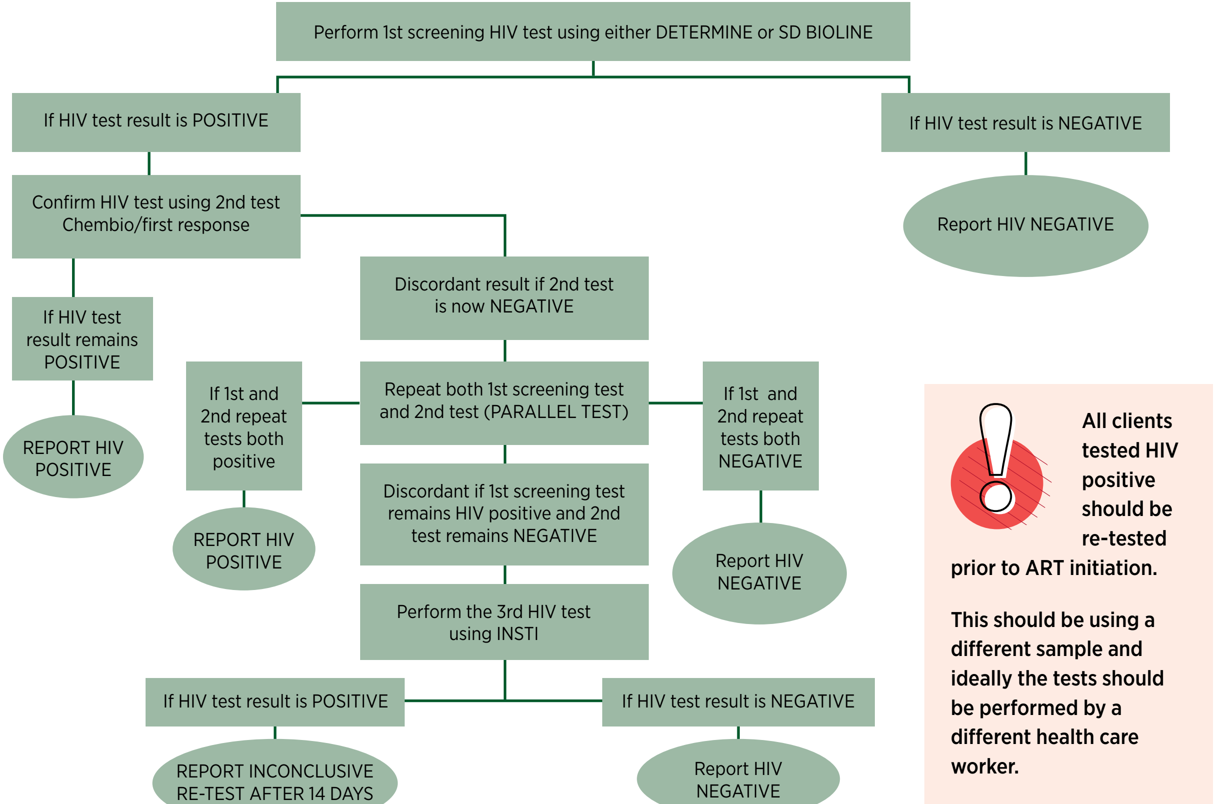
CONFIDENTIALITY

COUNSELLING



CONNECTIONS TO HIV PREVENTION, TREATMENT, CARE AND SUPPORT SERVICES

HIV testing algorithm



All clients tested HIV positive should be re-tested prior to ART initiation.

This should be using a different sample and ideally the tests should be performed by a different health care worker.

Pre- and post-test counselling messages

PRE-TEST INFORMATION SESSION

- Identify target group (patients, spouses, parents, caregivers, etc.). Make sure group is comfortable, assure privacy and confidentiality

KEY AREAS FOR PRE-TEST INFORMATION SESSION:

- Notify client/s of routine offer of HIV testing & counselling
- Ensure a clear understanding of the benefits of HIV testing and counselling
- Basics of HIV (transmission, prevention, treatment, care and support)
- Testing and counselling as entry point to prevention, treatment, care and support
- Explanation of testing and counselling procedures, possible results and linkages to prevention or treatment
- Disclosure and referral

PROVIDER ROUTINELY OFFERS HIV TEST INDIVIDUALLY AND CONFIDENTIALLY
RECORD ALL CLIENTS IN HTS REGISTER, INCLUDING THOSE WHO OPT OUT

IF CLIENT AGREES TO PROCEED, HIV TEST PERFORMED*

HIV test declined or deferred

- Offer individual counselling
- Address barriers to testing
- Risk assessment & risk reduction; link with medical care
- Re-offer HIV test
- If client accepts HIV test, proceed with testing
- If client declines/defers HIV test, develop a plan to return for HIV test
- Provide referrals, take-home information

Subsequent health care visits

- Review HIV test declined messages; provide referrals where necessary
- Re-offer HIV test

HIV negative post-test result counselling

- Provision of result; deal with emotions
- Risk assessment and risk reduction
- Discuss disclosure
- Partner & children referral for HIV test
- Continued medical care
- Provide take-home information

Emphasis is on "Staying NEGATIVE". Link with prevention services (Condoms, VMMC, PreP)

Subsequent health care visits

- Review post-test counselling messages
- Re-test according to risk assessment
- Provide referrals

HIV positive post-test counselling

- Provide HIV test result; deal with emotions
- Review/conduct risk assessment & risk reduction
- Discuss disclosure
- Partner & children referral for HIV test
- Discuss positive living
- Screen for TB
- Referral to OI clinic
- Referral to other support services
- Provide take-home information

Emphasis is on "Support and Positive Living"

Subsequent health care visits

- Review post-test counselling messages, provide referrals. **Emphasis is on early treatment of OIs, early initiation of ART and positive living.**

***Follow national HIV testing algorithm. Rapid HIV testing with same-day results is highly recommended.**

Information before distribution of HIV self-testing kits

HIV self-testing (HIVST) is when a person collects his/her own specimen and then performs a test and interprets the results, in private or with someone he/she trusts

The oral self-test is a triaging test. It does not provide a final HIV diagnosis
Anyone who tests HIV positive using a triaging test must undergo another different test to confirm the diagnosis, prior to being treated for HIV.

Explain:

- How HIV is and is not transmitted
- How the HIVST is able to detect HIV in oral fluid if HIV can't be transmitted through saliva
- Why people on ART should not use the test
- How it's possible for sexual partners to have different HIV statuses

Consent to give test kits

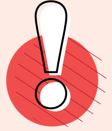
Refresher on how to use test kit

- How to read the test result (negative, positive, inconclusive)
- What to do if the test is negative, positive or inconclusive

Explanation of how and why to link to care

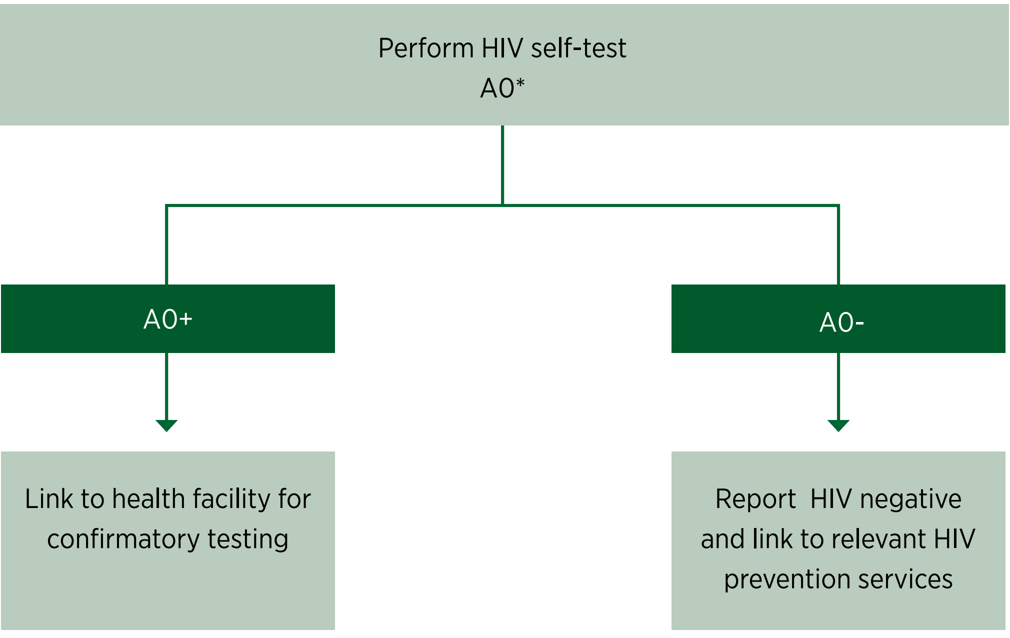
- The benefits of being on ART (emotional and physical)
- The benefits of VMMC
- How to present the self-referral card at the clinic

Collection of client information in self-testing M&E tools



Use the HIVST Job Aide and the demonstration video to explain how to use the test to the patient.

HIV self-testing algorithm

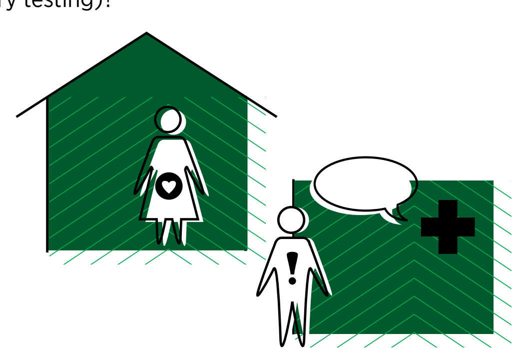


*A0 = the test to be performed

Information when presenting after individual self-test

INTRODUCTION

- Why are you following up (linkage to prevention or confirmatory testing)?
- Affirm client for presenting to the facility or outreach point



ASK ABOUT THEIR EXPERIENCE USING THE TEST

- Any challenges using the test?
- Any challenges interpreting the test?
- Any instances of harm?

IF CLIENT IS REQUESTING LINKAGES FOR PREVENTION

- Explanation of HIV prevention methods
- Referral to VMMC site for men
- Explore and address any barriers to VMMC

IF CLIENT IS REQUESTING CONFIRMATORY TESTING

- Offer HIV testing using the national algorithm

Index client testing

STEP 1

- Client tests HIV positive
- Ask client to consent for partner and family testing

STEP 2

- List all family members on Page 5 of the patient care and treatment book

STEP 3

- Ask client to bring partner and family members to the facility for testing
- Previous partners should be contacted directly by the client or anonymously by the HCW

STEP 4

- If partner and family members are not tested after one month, trigger community-based index client testing

STEP 5

- Perform community-based index client testing through one of these strategies:
  - Health care worker outreach
  - Links with a community-based cadre who is trained to test. This may be through supervised use of self-tests
  - Giving the client self-tests for unsupervised self-testing to be performed at home

LINKAGES TO PREVENTION, TREATMENT, CARE AND SUPPORT SERVICES

Empower all clients to continue with their risk reduction strategies

HIV negative

- Screen for TB
- Screen for STIs
- Provide condoms and refer to HIV prevention services, VMMC and cervical cancer screening

HIV positive

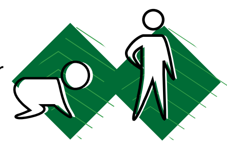
- Discuss need for re-testing before ART initiation
- Link with community health worker or expert client
- Refer for OI and ART services – all clients are eligible for ART
- Screen for TB, STIs and other OIs
- Refer for other services as appropriate (family planning , nutrition and psychosocial support)
- If client does not link to care, use the AIDS and TB referral form to trace the client

HIV re-testing

Population	Recommendation
General population with ongoing risk behaviours, including: • People with a known HIV-positive partner • Individuals seen for diagnosis or treatment of STIs • People with known recent HIV exposure • TB patients who are at high risk of HIV exposure • OPD patients with OIs	Offer re-testing at least annually
Key populations	Re-test according to risk assessment (Suggest 3 monthly)
HIV-negative pregnant women and lactating women	Re-test previously HIV-negative women in the first trimester of pregnancy and at third trimester/or at delivery 6 weeks post-natal and 6 monthly during the breastfeeding period. Visits to EPI should be time points where maternal HIV status is reassessed
HIV-positive individuals before initiation of ART	Re-test all people newly and previously diagnosed with HIV before they initiate ART Re-testing should ideally be conducted by a different service provider with a different specimen. However, if there is only one health worker at the facility, they can take another blood sample a few hours apart and re-test
Individuals on PrEP	Re-test every 3 months

Consent for children and adolescents

Any child who is aged 16 years or older, is married, pregnant, is a parent or who requests HIV testing services is considered to be able to give full informed consent. The consent of a parent or caregiver is required before performing an HIV test on a child who is younger than 16 years.



YOU CAN TEST A CHILD FOR HIV BASED ON THE BEST INTERESTS OF THE CHILD AND MATURE MINOR PRINCIPLES

SEEK ADVICE FROM THE PERSON IN CHARGE OF THE FACILITY

BEST INTERESTS OF THE CHILD

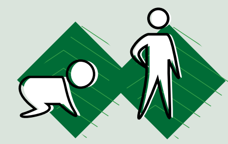
- A child is ill and diagnosis will facilitate appropriate care and treatment
- A child is a survivor of sexual abuse
- A child is sexually active
- A child is concerned about mother-to-child transmission
- A child has been exposed to HIV through vertical or sexual transmission
- A child expresses concern that, given an HIV-positive result, he or she will be denied access to care and treatment by a parent/caregiver

MATURE MINOR

A counsellor should consider the following factors in determining whether a child or adolescent should be treated as a mature minor:

- The minor's ability to appreciate the seriousness of HTS and the test result, and to give informed consent
- The minor's physical, emotional and mental development
- The degree of responsibility that the minor has assumed for his or her own life, such as heading a household or living independently from a parent/caregiver

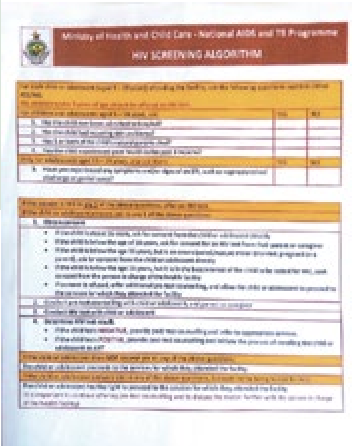
HTS screening tool for children and adolescents



0-5 years – do not use screening tool. Offer all HTS

5-14 years – use tool

15-19 years – use tool and ask additional questions on STIs



Ministry of Health and Child Care - National AIDS and TB Programme

HIV SCREENING ALGORITHM

- Has the child ever been admitted to hospital?
- Has the child had recurring skin problems?
- Has one or both of the child's natural parents died?
- Has the child experienced poor health in the past three months?
- For adolescents: any symptoms or signs of an STI?

IF YES TO ANY OF THE ABOVE, OFFER AN HIV TEST

CONSENT FOR PEOPLE LIVING WITH DISABILITIES

In the case of people with mental health concerns, regardless of age, a guardian should provide informed consent

People living with disabilities, such as hearing and visual impairments, should be provided with appropriate materials to ensure full understanding of the HIV test, results, and prevention, treatment, care and support services

PREVENTION

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VMMC

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- Eligibility criteria for VMMC 22
- Counselling prior to VMMC 23
- Skin preparation for VMMC 24
- Weight-based dosing for skin anaesthesia 25
- Wound care advice 26
- Severe adverse events 27
- Tetanus alert 27
- Referrals and linkages post circumcision 28

PrEP

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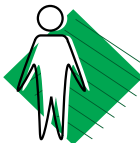
- Indications and contraindications for PrEP 30
- Practical screening questions for PrEP 31
- PrEP in sero-discordant couples 31
- Baseline and monitoring requirements 32
- Treatment regimens for PrEP 33

PEP

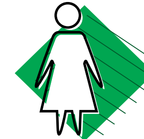
- Steps to follow for PEP 34
- ART for PEP 35

BENEFITS OF MALE CIRCUMCISION



Benefits for men:

- Improves hygiene of the male organ
- Reduces the risk of getting other sexually transmitted infections, such as herpes and syphilis
- Helps prevent cancer of the male organ
- Reduces complications that involve the foreskin, such as inability to retract the foreskin
- Reduces risk of acquiring HIV by 60% in heterosexual sex, in combination with other preventive mechanisms



Benefits for women:

- Reduces chances of contracting the virus that causes cervical cancer (HPV)
- As an indirect benefit, reduces chances of HIV infection to the woman
- Lowers the risk of chlamydial infection, which can cause infertility if it remains undetected

Eligibility criteria for VMMC

- Men and boys above the age of 10 years
- Must not have any contraindications, such as keloids, bleeding, hypospadias or epispadias
- Should provide a signed consent for the procedure
- An HIV test is recommended before the procedure. However, clients are still eligible for MC if they decline a test. Record all results in the HTS register
- All minors below the age of 16 years:
  - Should be issued with their HIV-negative result unaccompanied and then proceed to be circumcised
  - Should be issued with their HIV-positive result in the presence of their parents, caregivers or legal guardians for purposes of linkages to other care services

Counselling prior to VMMC

- Ask clients what they know about male circumcision
- Discuss the benefits, evidence of effectiveness and partial protection of male circumcision
- MC offers only partial protection and has to be used together with other prevention methods
- Circumcised men can still get infected with HIV. Promoting and providing safe male circumcision does not replace other interventions to prevent heterosexual transmission of HIV, but provides an additional strategy
- Circumcised men, if HIV positive, can infect their sexual partners
- Discuss HIV prevention and demonstrate condom use
- Explain surgical and device procedures
- **Discuss importance of review dates:**
  - **Surgical: Day 2, 7 and 42**
  - **Device: Day 7, 14 and 49**
- Refer adolescents to the nearest youth centre or organisation(s) for ASRH information & services

ENSURE AND ASSURE CONFIDENTIALITY AND PRIVACY!

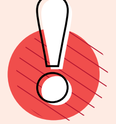
Skin preparation for VMMC

Surgical/device placement:

- Use 10% povidone-iodine solution or chlorhexidine if allergic to iodine
- Clean the foreskin completely retracted, starting from the glans to the sulcus, inner and outer foreskin ending with scrotal area
- Repeat an additional 2 times
- Let the clean penis lay on a clean gauze
- Wait for 2 minutes before proceeding

Device removal:

- Use povidone iodine 10% solution
- First cleaning – before cutting the necrotic tissue
- Second cleaning – after removing necrotic tissue
- Third cleaning – after removal of the two rings



NB: Cleaning with povidone iodine 10% will destroy tetanus spores

WEIGHT-BASED DOSAGING FOR MC ANAESTHESIA

A.	With 2% Lignocaine (Lidocaine)			
Weight in kgs	Recommended dose 0.5 % Bupivacaine in mls	Recommended dose Lignocaine 2% in mls (when used with 0.5% Bupivacaine)	Recommended dose Total volume (0.5% Bupiva-caine + 2% Lignocaine)	Maximum dose of 2% Lignocaine in mls (when used alone)
20-29	-	4ml	4ml	4ml
30-39	2ml	3ml	5ml	5ml
40-49	2.5ml	3.5ml	6ml	6ml
50-59	2.5ml	5ml	7.5ml	7.5ml
60-69	2.5ml	5ml	7.5ml	9ml
70+	2.5ml	5ml	7.5ml	10.5ml

B.	With 1% Lignocaine (Lidocaine)			
Weight in kgs	Recommended dose 0.5% Bupivacaine in mls	Recommended dose Lignocaine in mls (when used with 0.5% Bupivacaine)	Recommended dose Total volume (0.5% Bupiva-caine + 1% Lignocaine)	Maximum dose of 1% Lignocaine when used alone
20-29	-	5ml	5ml	6ml
30-39	2ml	6ml	8ml	9mls
40-49	2.5ml	7.5ml	10ml	12ml
50-59	2.5ml	7.5ml	10ml	15ml
60-69	2.5ml	7.5ml	10ml	18ml
70+	2.5ml	7.5ml	10ml	21ml

WOUND CARE ADVICE

- Keep your penis clean and dry at all times. Avoid disruption of the wound due to physical work, sports or cycling
- Keep penis in upright position at all times to reduce swelling and pain
- Wear clean and well-fitted underwear to provide comfort and support
- Mild swelling and pain is normal, but visit your clinic if swelling or pain worsens
- Go to the VMMC clinic for removal of the bandage on Day 2
- Do not engage in sexual activity or masturbate for at least 6 weeks
- The penis must be immersed in clean salty water twice a day after bandage removal
- Do not apply any medication, ointment, cream or antiseptic to the wound.
- Do not use traditional herbs on the wound
- Keep the wound protected from any contamination with soil, dirt or unclean water
- Stitches should not be removed as they will dissolve on their own

SEVERE ADVERSE EVENTS

Return to clinic urgently if:

- Excessive bleeding
- Excessive pain
- Difficulty and pain when passing urine
- Pus or white liquid from the penis
- Excessive swelling of the penis, including haematoma
- Wound rupture
- Fever a week after circumcision
- Stiffness of the jaw or neck

TETANUS ALERT

When to return immediately:

- Headaches, jaw cramping, muscle spasms
- Difficulties in swallowing
- Fever and sweating
- Jerking/seizures

Any of above symptoms – refer urgently to next level of care

Referrals and linkages post circumcision

For HIV-positive clients, refer to HIV care and treatment services

- Provide client with AIDS and TB referral form

For HIV-negative clients,

- Proceed to MC
- Encourage mutual disclosure and partner testing
- Provide follow-up care:
    - Risk reduction counselling
    - Give information on correct and consistent use of condoms
    - Demonstrate and provide condoms for sexually active clients
    - Promote early treatment and management of STIs
- For adolescents, encourage them to visit nearest youth centre/ organisation for more information or services on ASRH
- Behaviour change – Abstinence, Be mutually faithful, Engage in safer sex methods

What you need to know about PrEP?

PrEP:

- Is for people who are at high risk of HIV through sexual contact
- Is taken daily during periods of risk
- Is not for life
- Reduces the risk of HIV infection by 90% when taken consistently and correctly
- Requires strict taking of medication and regular HIV testing
- Works best as part of other HIV prevention methods
- Should be used together with male and female condoms

PrEP does not:

- Prevent STIs
- Prevent pregnancy
- Protect one from HIV after exposure

Indications for PrEP

In Zimbabwe, groups that are likely to be at substantial risk (>3% incidence) of HIV infection include:

- Adolescent girls and young women
- Male and female sex workers
- At-risk men (MSM, prisoners, truck drivers)
- Sero-discordant couples
- Women in relationships with men of unknown status
- Transgender people

Contraindications for PrEP

- HIV-positive status
- Unknown HIV status
- Allergy to any medicine in the PrEP regimen
- Unwilling/unable to adhere to daily PrEP
- Known renal impairment: estimated creatinine clearance <60ml/min

Indications for PrEP by history over the past 6 months:

- **HIV negative** and sexual partner with HIV who has not been on effective therapy for the preceding 6 months **OR**
- HIV negative and sexually active in high HIV prevalence settings **AND** any of the following:
    - Vaginal or anal intercourse without condoms with more than one partner, **OR**
    - A sexual partner with one or more HIV risk factors, **OR**
    - A history of an STI by laboratory testing or self-report or syndromic STI treatment, **OR**
    - Any recurrent use of post-exposure prophylaxis (PEP), **OR**
    - Requesting PrEP

Practical screening questions for PrEP

Any "yes" answer should prompt a discussion of the risks and benefits of PrEP

In the past 6 months:

- Have you had sex with more than one person?
- Have you had sex without a condom?
- Have you had sex with anyone whose HIV status you do not know?
- Are any of your partners at risk of HIV?
- Do you have sex with a person who has HIV?
- Have you received a new diagnosis of a sexually transmitted infection?
- Do you desire pregnancy?
- Have you used or wanted to use PEP or PrEP for sexual exposure to HIV?

PrEP in sero-discordant couples

Any "no" answer to any of the questions below, may indicate increased risk for HIV infection and indication for PrEP

- Is your HIV positive partner taking antiretroviral therapy (ART) for HIV?
- Has your partner been on ART for more than 6 months?
- At least once a month, do you discuss whether your partner is taking therapy daily?
- If you know when your partner had his or her last HIV viral load test, what was the result?
- Do you use condoms every time you have sex?
- Are you using effective contraception with a HIV-positive partner?

Baseline requirements for PrEP

REQUIRED

- HIV test negative
- Clinical screening for acute HIV infection
- HIV risk assessment (using a screening tool)
- Adherence counselling

RECOMMENDED
(should not hinder access to PrEP):

- Hepatitis B test
- Blood creatinine level check
- Pregnancy test (although unlikely PrEP contraindicated in pregnancy)
- STI screening and treatment

Monitoring for PrEP

REQUIRED

- After initiating PrEP, the client should be reviewed after 1 month to monitor adherence and side effects, as well as for resupply of medicines
- Ongoing follow up is 3 monthly
- **HIV re-test every 3 months**
- Adherence and risk reduction counselling at every visit
- Side-effects counselling at every visit

RECOMMENDED
(should not hinder access to PrEP):

- Blood creatinine – every 6 months
- STI screening and treatment
- Access to contraception/pregnancy screening

Treatment regimens for PrEP

	Drug	Dosage
Preferred regimen	Tenofovir (TDF) (300mg) plus Emtricitabine (FTC) (200mg)	Fixed-dose combination; one tablet once a day
Alternative regimens	TDF (300mg) plus 3TC (300mg)	Fixed-dose combination; one tablet once a day

PrEP reaches **maximum effectiveness after 7 daily doses**

When to stop PrEP

PrEP can be stopped 28 days after the last possible exposure to HIV if the client is no longer at substantial risk for HIV infection

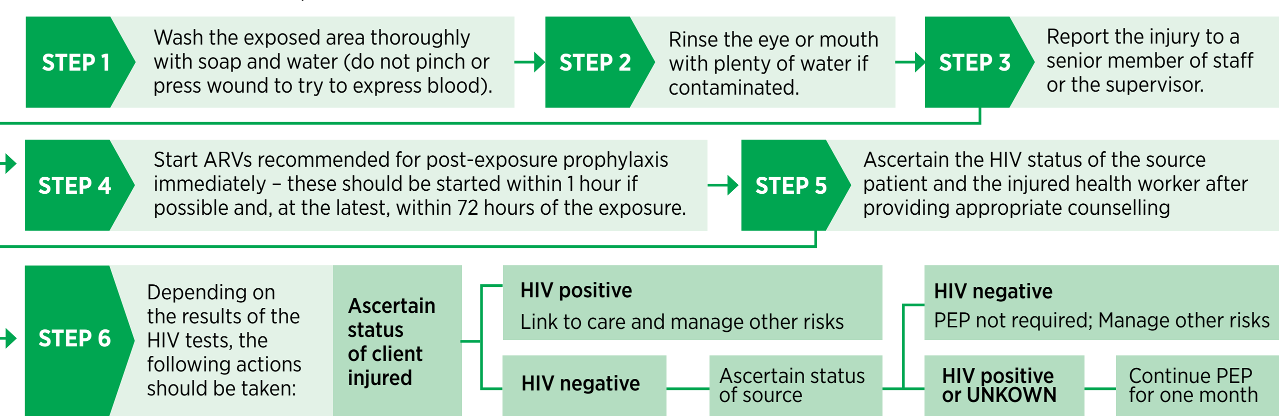
It should also be stopped if the client:

- Has a positive HIV test
- Develops renal disease (creatinine clearance <60ml/min)
- Has an adverse medicine reaction
- In sero-discordant couples, when the HIV-infected partner on ART has achieved viral suppression

Steps to follow for PEP

Who needs post-exposure prophylaxis (PEP)? The following types of exposures should be considered for post-exposure prophylaxis:

- Needle-stick injury or injury with a sharp object used on a patient
- Mucosal exposure of the mouth or eyes by splashing bodily fluids
- Broken skin exposed to a small volume of blood or secretions, such as may occur with **sexual assault (rape, intimate partner violence or sexual abuse)**



- In the event of a health care worker being exposed to HIV infection, the greatest risk of transmission to other individuals is in the first six weeks. The exposed HCW should be instructed to use measures to reduce the potential risk of HIV transmission to others, e.g., condom use, abstinence and refraining from blood transfusion until the 6-month serologic test is negative.
- Health care workers who are breastfeeding should consider stopping breastfeeding following exposure to HIV. This avoids infant exposure to ARVs and HIV in breast milk if the mother is infected.
- Post-exposure prophylaxis with hepatitis B immune globulin (HBIG) and/or hepatitis B vaccination series should be considered for occupational exposure (within 24 hours) after evaluating the hepatitis B status of the source patient and the vaccination status of the exposed person. Hepatitis B vaccine and HBIG can be given at the same time but using different injection sites. Routine pre-exposure hepatitis B vaccination should be offered to all health-care workers. Ideally the hepatitis C status of the source patient should be ascertained.

ART for PEP

Adult and adolescent PEP

Tenofovir 300mg orally once daily

PLUS

Lamivudine 300mg orally once daily

PLUS

Atazanavir 300mg/ritonavir 100mg orally once daily

The above regimen is given for one month

Paediatric PEP

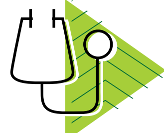
- AZT + 3TC is recommended as the preferred backbone regimen for HIV post-exposure prophylaxis for children 10 years and younger
- ABC + 3TC or TDF + 3TC (or FTC) can be considered as alternative regimens
- LPV/r is recommended as the preferred third drug for HIV post-exposure prophylaxis for children younger than 10 years
- An age-appropriate alternative regimen can be identified among ATV/r, RAL, DRV, EFV and NVP

SEXUALLY TRANSMITTED INFECTIONS (STIs)

Section contents:

- Steps in the management of STIs 37
- Assessment of a patient with vaginal discharge 38
- Management of vaginal discharge syndrome 39
- Management of lower abdominal pain in women 41
- Management of urethral discharge in men 42
- Management of genital ulcers 43
- Management of inguinal bubo/swelling 45
- Management of acute scrotal swelling 46
- Management of sexual violence 47

Steps in the management of STIs



- Take a full history, including sexual history
- Examine the patient to make the correct diagnosis
- Offer HIV testing to all STI patients
- Explain to the patient how the infection was acquired and how it could be prevented in the future
- Emphasise the need to complete the course of treatment
- Patient to come back if no improvement within 7 days or if symptoms worsens
- Encourage patients to bring their sexual partners for treatment
- Encourage the correct and consistent use of male or female condoms

Assessment of a patient with vaginal discharge

If patient complains of vaginal discharge:

1. Take history (especially sexual history) and determine risk score
2. Do bimanual pelvic exam, pass speculum
3. Clean and inspect cervix
4. Observe nature of vaginal discharge
5. Give health education and prevention messages

Risk Assessment:

RISK FACTOR	SCORE
Partner has Urethral discharge	2
New partner in last 3 months	1
More than 1 partner in last 3 months	1
Age less than 21 years	1

If Risk Score 2 or more, treat for Cervicitis

Management of vaginal discharge syndrome

Management of vaginal discharge syndrome

Treat for applicable combinations as determined on previous page

Gonorrhoea

First line:
Ceftriaxone 250mg IM single dose
OR
Kanamycin 2 grams IM single dose

Substitute:
Cefixime 400mg orally as a single dose
OR
Spectinomycin 2g IM stat

+

Chlamydia

First line:
Doxycycline 100mg orally twice daily for 7 days
OR
Azithromycin 1g orally as a single dose

Substitute:
Erythromycin 500mg orally 4 times a day for 14 days
OR
Ofloxacin 300mg orally twice a day for 7 days

+

Trichomonas vaginalis

First line:
Metronidazole 2 grams, orally, single dose
OR
Metronidazole 400mg, orally, three times daily for 5 days

+

Candidiasis

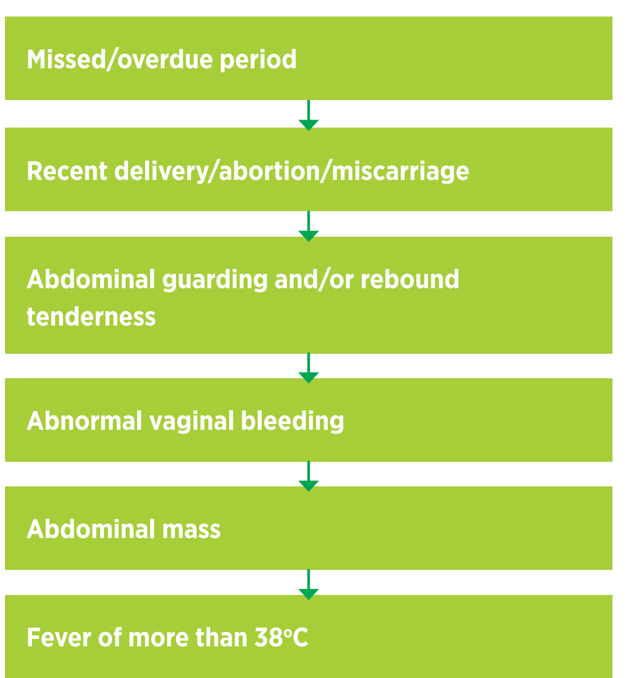
First line:
Miconazole 2% cream topically twice daily for 7 days

Substitute:
Nystatin cream, topically,twice daily for 7 days
OR
Clotrimazole 1% cream, topically, twice daily for 7 days

Refer to EDLIZ for more specific dosing information

Management of lower abdominal pain (LAP) in women

1) Are any of the following present?



2a) If YES,
refer patient urgently
(Set up an IV line and apply resuscitatory measures if necessary)

2b) If NO,
Are any of the following present?

- Vaginal discharge
- Cervical excitation tenderness
- Abdominal tenderness

If yes, treat for PID

- Ceftriaxone 250mg by intramuscular injection
- Doxycycline 100mg orally twice a day for 14 days
- Metronidazole 400mg orally twice a day for 14 days

Management of urethral discharge syndrome (UDS)

If urethral discharge present

Treat for both gonorrhoea and chlamydia

Gonorrhoea

First line:
Ceftriaxone 250mg IM, single dose

Substitute:
Kanamycin 2 grams IM, single dose
OR
Cefixime 400mg orally, single dose
OR
Spectinomycin 2 grams IM, single dose

+

Chlamydia

First line:
Doxycycline 100mg orally twice daily for 7 days

Substitute:
Azithromycin 1 gram orally, single dose
OR
Erythromycin 500mg orally 4 times a day for 7 days
OR
Ofloxacin 300mg orally twice a day for 7 days

Refer to EDLIZ for more specific dosing information

Management of genital ulcers in men and women

- Treat for syphilis and chancroid
- Provide treatment for genital herpes
- Advise on basic care of the lesion (keep dry and clean)
- Aspirate any fluctuant glands through normal skin (surgical incision should be avoided)
- Promote and provide condoms
- Offer HIV counselling and testing
- Advise the patient to return in 7 days if not fully healed or sooner if clinical condition becomes worse
- Assist with the management of sexual partners

Treatment of genital ulcer syndrome in men and women

If genital ulcer (s) or sore(s) present, treat for syphilis, chancroid and HSV-2

Syphilis

Benzathine penicillin 2.4 million units by single intramuscular injection

Note: For patients with a positive syphilis test and no ulcer, administer the same dose at weekly intervals for a total of 3 doses

If pregnant, breastfeeding or under 16 years:
Benzathine penicillin 2.4 million units by single IM injection
OR
Erythromycin 500mg orally, 4 times a day for 14 days

+

Chancroid

Ciprofloxacin 500mg orally twice a day for 3 days

If pregnant, breastfeeding or under 16 years:
Erythromycin 500mg orally 4 times a day for 7 days
OR
Azithromycin 1g orally as a single dose
OR
Ceftriaxone 250mg as a single intramuscular injection

+

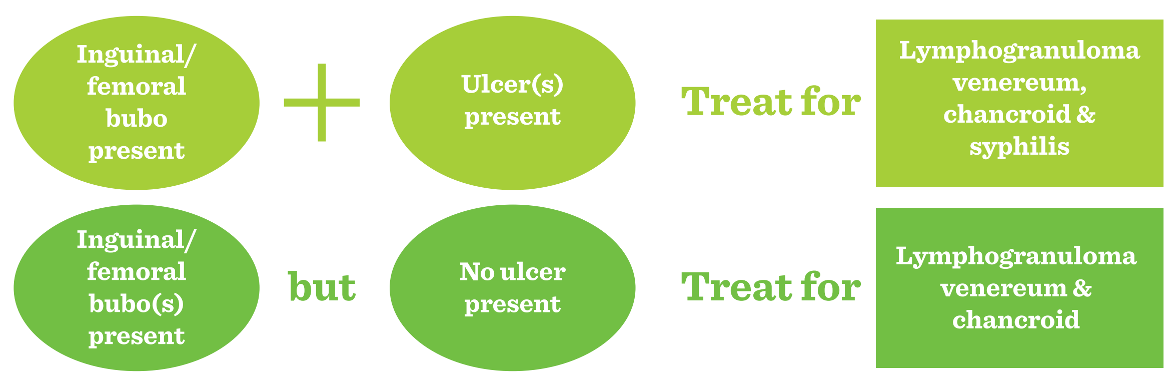
Genital herpes

Primary infection
Aciclovir 400mg orally 3 times a day for 7 days
OR
Acyclovir 200mg orally 5 times a day for 7 days

If recurrent infection
Aciclovir 400mg orally 3 times a day for 7 days
OR
Acyclovir 200mg orally 5 times a day for 7 days

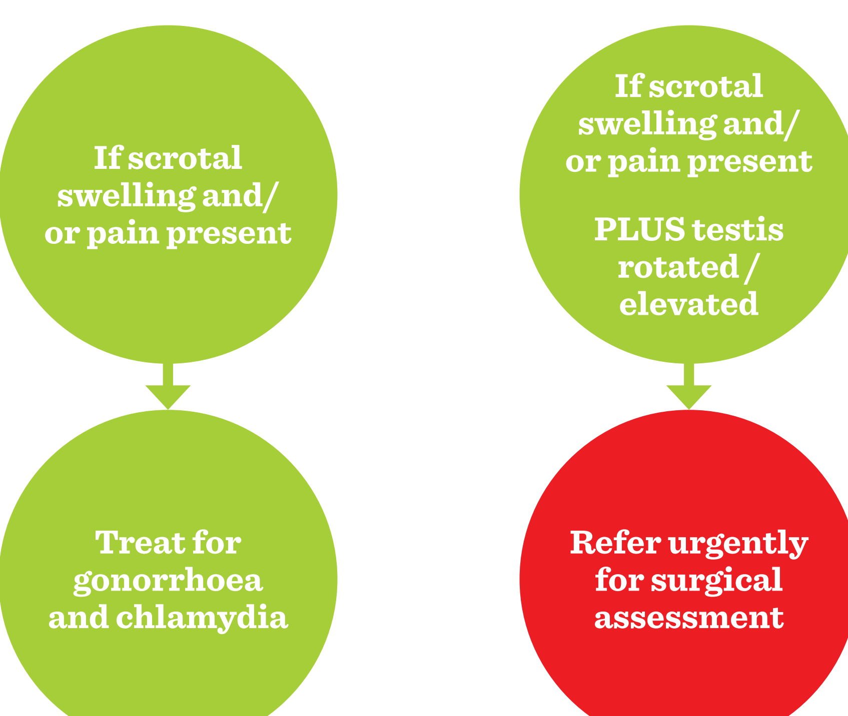
If pregnant, breastfeeding or under 16 years:
Use acyclovir only when benefit outweighs risk. Dosage is the same as for primary infection

Management of inguinal bubo/swelling in men and women



Chancroid			LGV
First line Ciprofloxacin 500mg orally twice a day for 3 days OR Erythromycin 500mg orally 4 times a day for 7 days	**If pregnant, breastfeeding or under 16 years:** Erythromycin 500mg orally, 4 times a day for 14 days (covers chancroid and LGV)	+	Doxycycline 100mg orally, twice a day for 14 days

Management of acute scrotal swelling



Management of sexual violence

Ascertain history, carry out medical examination

↓

Test for HIV

↓

Give patient prophylactic medications: emergency contraception, PEP for HIV, STI presumptive treatment within 72 hours

↓

HBV vaccine within 24 hours
Refer to guidelines for doses of medications

↓

Manage or refer to next level of care

- Many people delay seeking services for sexual and gender violence offences
- Health care workers should sensitise their local community and police services about the services that may be provided

ANTIRETROVIRAL TREATMENT IN ADULTS

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- Antiretroviral side effects 50
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- Definition of treatment failure 73
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When to start ART

All clients are eligible to start ART regardless of CD4 or age

What to start: first-line ART

	Preferred first-line regimen	Alternative regimens
Adolescents (10-19 years) ≥35kg **Adults, including pregnant & breastfeeding women, TB/HIV, HBV/HIV**	TDF + 3TC + EFV	TDF + 3TC + NVP AZT + 3TC + EFV AZT + 3TC + NVP

Antiretroviral side effects

MEDICINE	SIDE EFFECTS	RISK FACTORS	ACTION TO BE TAKEN
Nucleotide/nucleoside reverse transcriptase inhibitors (NRTIs)			
Tenofovir (TDF)	Renal complications	Underlying renal disease; age >50 years; untreated diabetes and hypertension; concomitant use of nephrotoxic medicines or PI	Monitor creatinine; substitute with zidovudine
	Decreases in bone mineral density	Vitamin D deficiency; risk factors for osteoporosis or bone mineral density loss	
	Other SE: gastrointestinal (GI) symptoms, rash		
Zidovudine (AZT)	Anaemia, neutropenia, lipoatrophy, lipodystrophy, myopathy, headache, lactic acidosis	CD4 <200 cells/mm^3 Anaemia at baseline	Monitor full blood count; if severe anaemia, change to tenofovir (TDF) or abacavir (ABC)
Lamivudine (3TC)	Usually nil		
Abacavir	Severe hypersensitivity reactions		Withdraw medicine immediately; give alternative like tenofovir (TDF) or zidovudine (AZT). Do not restart medicine, as this can be fatal
Non-nucleoside reverse transcriptase inhibitors			
Efavirenz (EFV)	Central nervous system symptoms (dizziness, confusion, convulsions, headache, sleep disturbance, abnormal dreams) or mental symptoms (anxiety, depression, mental confusion) usually during the first three weeks and then resolve		Monitor; withdraw medicine if symptoms are severe
	Hepatotoxicity	Underlying hepatic disease or concomitant use of hepatotoxic medicines	Withdraw EFV and substitute with boosted PIs
	Gynaecomastia	Risk factors unknown	Substitute efavirenz (EFV) with nevirapine (NVP)
Nevirapine (NVP)	Liver toxicity, abnormal liver function tests (LFTs) Mild or severe skin rashes (e.g., Stevens-Johnson syndrome [rare]), fever, fatigue, nausea	Underlying hepatic disease or concomitant use of hepatotoxic medicines High baseline CD4 cell count (>250 cells/mm^3 in women and >400 cells/mm^3 in men)	If LFTs are suggestive of hepatitis or if jaundice is present, discontinue; if rash is severe, discontinue and replace with efavirenz

Antiretroviral side effects

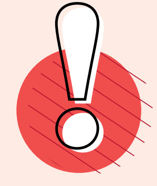
MEDICINE	SIDE EFFECTS	RISK FACTORS	ACTION TO BE TAKEN
Protease inhibitors (PIs)			
Atazanavir (ATV/r)	Jaundice, nausea, diarrhoea, headache, hyperbilirubinaemia		Monitor; withdraw medicine if symptoms are severe
Lopinavir/ ritonavir (LPV/r)	Hepatotoxicity Pancreatitis Hyperlipidaemia, GI intolerance, diarrhoea, hyperglycaemia, lipodystrophy	Underlying hepatitic disease Advanced HIV disease and alcohol misuse Obesity, diabetes	Give loperamide for the diarrhoea
Darunavir (DRV/r)	Hepatotoxicity Severe skin and hypersensitivity reactions	Underlying hepatic disease or concomitant use of hepatotoxic medicines Sulfonamide allergy	Monitor; withdraw medicine if symptoms are severe
Integrase inhibitor			
Raltegravir (RAL)	Mood changes, depression, myopathy, skin reactions, e.g., Stevens-Johnson syndrome		Monitor; withdraw medicine if symptoms are severe
Dolutegravir (DTG)	Hepatotoxicity and hypersensitivity reactions	Underlying liver disease	Monitor; withdraw medicine if symptoms are severe

Antiretroviral medicine interactions

ARV MEDICINE	KEY INTERACTIONS	SUGGESTED MANAGEMENT
Efavirenz (EFV)	EFV may lower the efficacy of some long-acting hormonal contraceptives	Use alternative or additional contraceptive methods, e.g., condoms
	Amodiaquine (anti-malarial)	Use alternative anti-malaria drug
Nevirapine (NVP)	Rifampicin	Substitute nevirapine (NVP) with efavirenz (EFV)
	Ketoconazole and Itraconazole	Use alternative anti-fungal drug
Boosted PIs (ATV/r, LPV/r and DRV/r)	Hormonal contraceptives	Use alternative or additional contraceptive methods
	Rifampicin	Substitute rifampicin with rifabutin if available For children, adjust dose of LPV/r or substitute with three NRTIs
	Tenofovir (TDF)	Monitor renal function
Dolutegravir (DTG)	Carbamazepine, phenobarbital and phenytoin	Use alternative anti-convulsants

Baseline investigations

- **Urine dipstick (glucose, protein)**
- **Haemoglobin or FBC**
- **ALT, creatinine**
- **Pregnancy test**



Lack of access to baseline investigations should not delay initiation of ART

BUT

ensure the client has been screened for TB and symptoms of severe OIs

- **CD4 count for immunologic staging**
- **Cryptococcal antigen screening for adults with CD4 count <100 cells/mm^3**
- **RPR or VDRL to screen for syphilis if 12 years or older**
- **HBsAg to screen for hepatitis B infection and hepatitis C serology**

4 steps of Differentiated ART initiation

STEP 1

HIV and ART education

Give basic HIV and ART education

(See Page 106-124 Job Aide)

STEP 2

Clinical readiness, clinical history, examination and investigation

Clinically ready, asymptomatic and POC baseline CD4 >100 cells/mm^3 (or CD4 screening at baseline is not available)

Clinically NOT ready

Asymptomatic and POC baseline CD4 <100 cells/mm^3

OR

Symptomatic and requires further investigation and clinical management

↓

Screen for Cryptococcal disease

Screen for TB according to the TB screening algorithms

Manage clinical condition

STEP 3

Psychosocial readiness

Complete counsellors' ART initiation checklist

Page 55 Job Aide

STEP 4

Treatment plan

Clinically and psychosocially ready

Offer rapid initiation

Psychosocially ready but clinical reason for delay (e.g TB , cryptococcal disease) delay ART initiation according to clinical guidelines

Clinically ready but psychosocial reason for delay

Give further counselling

Use counselling tools and link to expert client where possible

Aim to start within one week of diagnosis

COUNSELLORS' ART initiation checklist

Assess readiness to start

- Ask patient what would be the 3 most important reasons for them stay healthy and alive
- Assess willingness to start ART

Recap knowledge of ART education session (Page 113, Job Aide).

- For each of the drugs, know the name, frequency and side effects that might occur
- Use of herbs: Why it's important to stick to ARVs as a treatment
- Why it is important to come on the review date given, and what to bring (all remaining medications)
- What to do in case of travel

Plan with patient how they will take the drugs:

- What would be best timing for you to take your drugs, taking into account your daily habits?
- What tools will you use to remind yourself to take your drugs (alarm, time you leave for school)?
- Where will you store your drugs?
- Where will you keep extra doses in case you are out of the house?
- How will you manage missed doses?
- What will you do in case of side effects?

Explain follow-up plans: At the beginning of ART treatment, your follow up will be quite intense (D14 if on NVP regimen or initiated on same day as testing, M1, M2, M3), but appointments will be more spaced out with time. We will discuss options for long-term follow up at later counselling sessions

Ask for their consent to be called or traced if they miss an appointment

Document your findings and refer to clinician

CLINICIANS’ ART initiation checklist

- STEP 1: Has HIV testing been confirmed with a repeat-test, on a different sample, ideally by a different health care worker?
- STEP 2: Does the client have sufficient understanding about HIV and ART, and is the client psychologically ready to start ART?
- STEP 3: Screen again for TB
- STEP 4: Ensure all OIs and other infections have been screened for (cryptococcal disease if CD4 <100 cells/mm^3; STI) and treated
- STEP 5: Examine the client
- STEP 6: Review the baseline laboratory tests
- STEP 7: Choose a regimen
- STEP 8: Review potential side effects of the medication
- STEP 9: If all of the above steps have been checked and the client is ready, initiate ART
- STEP 10: Enter the client in the chronic ART register or send the patient care and treatment booklet for entry into the EPMS

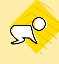
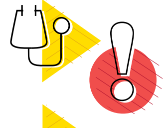
ART follow-up schedule

	D0	WK 2	MTH1	MTH 3	MTH 6	MTH 7	MTH 9	MTH 12	LONG-TERM FOLLOW UP
CLINICAL	Complete ART initiation checklist	If on a NVP-based regimen or Had same-day initiation				Review first VL result CHOOSE REFILL OPTION.	REFILL OPTION		If patient remains virologically suppressed continue with patients refill option. 3-monthly supplies of ARVS and cotrimoxazole should be given. If monitored with viral load, see for clinical review yearly. If no viral load, see for clinical review every 6 months. If not virologically suppressed follow the viral load algorithm.
COUNSELLING	Complete readiness assess-ment				Give viral load key messages. Discuss refill options.				Adherence should be assessed by the nurse at each clinical visit. At refill visits, peer support for adherence is given by the group members if the refill system is in a club or CARG. After month 6, clients should see the counsellor only if a red-flag sign is picked up by the nurse, or if client attends late, or has a high viral load.
LABORATORY	CD4, Cr if on TDF, Hb if on AZT		Hb if on AZT		VL			VL	Viral load yearly If no viral load available, CD4 6 monthly Creatinine (TDF), HB (AZT), ALT (NVP) should be checked if there is any suspicion of side effects.

ART follow-up schedule – special considerations

<table>
<tr><th colspan="3">FIRST YEAR</th><th>LONG TERM FOLLOW UP</th></tr>
<tr><td>
PREGNANT WOMEN</td><td> </td><td>Pregnant or breast feeding women initiating ART as part of PMTCT undergo rapid initiation on the same day as testing.

They should then be seen at week 2, month 1 and then monthly while they are attending for ANC and PNC/bringing the exposed baby monthly. As described in Section 1.4. this should be offered as an integrated one-stop service.

A counselling session is given at week 2 to ensure more detailed HIV and ART education is given. Counselling follow up is adapted to the changing motivation for taking ART over time; discussion on delivery; infant testing and infant feeding should be included at the appropriate time.</td><td>Once the baby is diagnosed HIV negative (6 weeks post cessation of breastfeeding), the woman can decide which refill option she would like to consider for future long-term follow up.</td></tr>
<tr><td>
CHILDREN</td><td></td><td>Infants up to 2 years old should be reviewed monthly. Thereafter children should be seen every 3 months. THIS IS BECAUSE THE DOSE MUST BE ADJUSTED FOR THE WEIGHT.

For children, follow the adult counselling schedule until month 6 and then see them 3 monthly until full disclosure is achieved.

Plan to group your children on the same day each week/month. This automatically allows for peer support to enhance adherence.</td><td> Until on adult doses, children should be seen every 3 months for clinical review.

Once on adult doses, follow up as for adolescents.

 Children should continue to see the counsellor every 3 months until full disclosure is achieved.</td></tr>
<tr><td>
ADOLESCENTS</td><td> </td><td>If starting on adult doses, adolescents can follow the routine follow-up schedule as above for the first year.

The counselling content should be adapted to their particular needs (SRH, coping with school, starting new relationships etc.).</td><td>Until fully disclosed (goal by age 12) continue to see clinician and counsellor every 3 months. Once disclosed and on adult doses, adolescents should be seen clinically once every 6 months, unless serious psychosocial issues are identified.

Offer a facilitated group refill (Page 85).</td></tr>
</table>

Standard operating procedure for defaulter tracing

- At enrolment, clients should be asked **if they agree to consent to tracing**. Their decision should be clearly indicated on page 2 of the patient care and treatment booklet.
- **All sites should have an appointment system for HIV-positive clients.** In primary care clinics, all clients should be booked in the same clinic diary. In larger facilities, each clinic (OI, MCH, TB) will have their own appointment diaries.
- **The nurse in charge of the clinic must be clear which staff member** (nurse, nurse aid, PC, receptionist) **is responsible** for updating the diary on a daily basis and for initiating the defaulter tracing process.
- **All clients registered for ART preparation, ART and PMTCT (including the HIV exposed infant)** services should be given an appointment date, which is recorded in the EPMS or clinic appointment diary. In some sites, it may be appropriate to give a booked time (morning or afternoon), as well as a day in order to stagger appointments. If group club refills are implemented, the group number should be recorded in the appointment diary and a booked time for the group allocated.
- The OI number, client's name, telephone number and the reason for the next appointment (clinical consultation +/- counselling, refill for drugs, blood draw for VL) should be listed in the diary.
- The diary or EPMS list can be used to pull the patient care and treatment booklets the day before and also to pre-pack refills in larger sites.
- When the client arrives, it should be marked off in the diary that they have attended.
- At each visit, whoever is registering the client should check that an up-to-date phone number is available and is documented in the EPMS or appointment diary.
- If the client does not attend for their appointment, their patient care and treatment booklet should be kept aside in a tray or shelf allocated for late-attenders. Tracing is not triggered immediately and patients' files coming 1-3 days late should be found in this tray.
- If the client has not attended for three days, the client should be traced. All clients, when first registered, should give consent to be traced.
- For each patient to be traced, an **AIDS and TB programme referral form (Appendix 1 OSDM)** should be completed and given to the appropriate staff member to carry out the tracing. If just phone tracing is required, this may be done by the nurse; if phone or home visit is required, this may be done by the primary counsellor, village health worker or other CBO/expert client representative. Who is performing the tracing should be clear within the health centre human resource management structure.
- Files for patients being traced should be placed in a "tracing" tray.
- Tracing should be carried out as follows:
    - If a phone number is recorded, phone the client with the clinic phone. If not reachable on first attempt, try again on two subsequent days.
    - If there is no phone number or no response on phoning, proceed to visit at home.
    - If client or relative is not found at home, attempt again after seven days, and then monthly until three months from the referral for tracing.

Decision framework for differentiating ART delivery

STEP 1
Situation Analysis

- Use the tool in Appendix 4 to guide your assessment
- Assess facility level retention and workload data.
- If possible disaggregate data by age and subpopulation
- Assess challenges being faced by your health care workers
- Assess challenges being faced by clients in your facilities

STEP 2
Define challenges for each facility

- What are the common challenges
- What are challenges specific to certain facilities or client subpopulations

STEP 3
Define the priority subpopulation

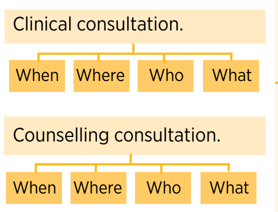
- Define the priority subpopulation/s for whom ART should be differentiated
- What is the districts priority in the next six months?

STEP 4
Design a model of ART delivery

Ask the following questions

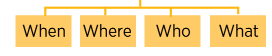
- Is the maximum refill (3 months) being offered?
- Could ART be offered on additional days of the week?
- Could opening hours be extended for provision of ART refills?

Design a model of ART clinical and counselling follow up:



Define steps for ART refills:

- For **stable clients** choose a refill option that addresses the local challenges.
- For **other subpopulations** design a refill model to address their particular needs.



STEP 5

- Implement the differentiated ART delivery model
- Evaluate it's impact
- Consider further adaptations to differentiated ART delivery to address other identified challenges

Eligibility and frequency of follow up for differentiated ART delivery for stable adult clients

A stable client on ART (first or second line) is defined as someone who:

Where viral load is available:

Eligibility:

- Has no current OIs
- Has a VL <1000 copies/ml
- Is at least 6 months on their current regimen

Frequency of follow up:

- For adults, perform clinical assessment and repeat VL **once every 12 months**
- **3-month refills of ART and cotrimoxazole** should be provided

Where viral load is NOT available:

Eligibility:

- Has no current OIs
- Has a CD4 >200 cells/mm^3
- Is at least 6 months on their current regimen

Frequency of follow up:

- For adults, perform clinical assessment and repeat CD4 **once every 6 months**
- **3-month refills of ART and cotrimoxazole** should be provided

Checklist for action at a clinical review visit

- Is the weight increasing or stable? Assess nutritional status and screen for TB
- What family planning method is being used or is the client now pregnant?
- Screen for TB: Is TB preventive therapy due?
- Screen for STIs
- Take blood pressure and screen for depression
- Are there any other complaints today?
- Are there any side effects of the medication being prescribed?
- Check adherence to medications (not just the ART!)
- Are there any blood results, viral load, creatinine, etc. that should be documented and reviewed today? If yes, have I acted on them?
- Are there any blood tests that should be ordered today?
- Prescribe medications (cotrimoxazole and ART) needed for today and complete documentation for subsequent ART refills
- Whatever the refill option chosen, complete the patient care and treatment booklet and patient notebook as shown on pages 63-66 of the Job Aide

Standard operating procedure for documentation of the clinical visit

Documentation in patient care and treatment booklet

- Column 2 now indicates the code for the type of ART refill model the client has selected.
- For today's clinical visit, complete all columns.
- To prescribe medication for subsequent one (if no VL monitoring) or three (where VL monitoring) refills, complete columns 11, 20a and 25.

OI/ART NUMBER P P - D D - S S - Y Y Y Y - A - S S S S S

1	2	3	4	5	6	7	8	9		10	11		12		13	14	
Visit No. *(Includes visits made at other facility while the patient is away)*	Date of review	Weight (kg)	Height for Children below 15 years (cm)	5a. Pregnancy/ Lactating Status *(see codes below)*	Family Planning Status *(multiple response: use codes below)*	Functional Status *(use codes below)*	WHO *Clinical Stage (1-4) refer to Page 1*	TB Status		Opportunistic Infections and Other Problems *(use codes below)*	Cotrimoxazole Prophylaxis		IPT Criteria		Reason for Not Starting or Stopping IPT *(use codes below)*	Isoniazid Preventive Therapy	
	Visit Type *(use codes below)*			5b. Date of 1st ANC booking and LNMP date				9a. TB Screening *(use codes below)*	9b. TB Investigation Result *(use codes below)*		Quantity dispensed (tablets/ ml)	% Adherence	12a-IPT Eligibility (Y/N)	12b - IPT Status *(use codes below)*		14a. Quantity dispensed (tablets/ ml)	14b. % adherence
												X					X
	1/1/16 F	68		N/A	C	W	2	Y			90	100%	NE				
											90						
											90						
											90						

OI/ART NUMBER P P - D D - S S - Y Y Y Y - A - S S S S S

15		16	17	18	19	20			21	22	23			24	25	26	27	28	
Fluconazole		ARV Status (see codes below)	Adverse Events Status (see codes below)	ARV Reason (see codes below)	ARV combination regimen (see codes below)	ARV medicine			CD4 count/ % & Test Date	Viral Load & Test Date	a) ALT (Alanine Transaminase)	b) Creatinine	c) Other diagnostics test	Referred To: (see codes below)	Next Review date	Visit Status (see codes below)	Follow up Status (see codes below)	Name	
15a. Quantity prescribed (tablets/ ml)	15b. Quantity dispensed (tablets/ ml)					20a) Quantity prescribed (tablets/ ml)	20b) Quantity dispensed (tablets/ ml)	20c) % Adherence										Of Clinician (Initials)	Of Pharmacy (Dispenser) (Initials)
								X								X			
		3			IF	90	90	100%							25/3/16	OT	TX	AA	BB
						90									17/6/16				
						90									9/9/16				
						90									2/12/16				

Standard operating procedure for documentation of the clinical visit

Documentation in patient notebook

1/1/16

TDF/3TC/EFV (po) 3/12

CTX 960 mg (po) 3/12

Repeat above prescription on 25/3/16

17/6/16

9/9/16

TCB for clinical review and VL 2/12/16

Standard operating procedure for documentation of refill visit

Documentation in patient care and treatment booklet

- Fill or tick off columns 1, 11, 20b, 26, 27, 28 to show that the patient has attended and the refill has been dispensed.

OI/ART NUMBER P P - D D - S S - Y Y Y Y - **A** - S S S S S

1	2	3	4	5	6	7	8	9		10	11		12		13	14	
Visit No. *(Includes visits made at other facility while the patient is away)*	Date of review / Visit Type *(use codes below)*	Weight (kg)	Height for Children below 15 years (cm)	5a. Pregnancy/ Lactating Status *(see codes below)* / 5b. Date of 1st ANC booking and LNMP date	Family Planning Status *(multiple response: use codes below)*	Functional Status *(use codes below)*	WHO *Clinical Stage (1-4) refer to Page 1*	TB Status: 9a. TB Screening *(use codes below)*	9b. TB Investigation Result *(use codes below)*	Opportunistic Infections and Other Problems *(use codes below)*	Cotrimoxazole Prophylaxis: Quantity dispensed (tablets/ ml)	% Adherence	IPT Criteria: 12a-IPT Eligibility (Y/N)	12b - IPT Status *(use codes below)*	Reason for Not Starting or Stopping IPT *(use codes below)*	Isoniazid Preventive Therapy: 14a. Quantity dispensed (tablets/ ml)	14b. % adherence
												X					X
	1/1/16 F	68		N/A	C	W	2	Y			90	100%	NE				
	25/3/16 F										90 ✓						
											90						
											90						

OI/ART NUMBER P P - D D - S S - Y Y Y Y - **A** - S S S S S

15		16	17	18	19	20			21	22	23			24	25	26	27	28	
Fluconazole: 15a. Quantity prescribed (tablets/ ml)	15b. Quantity dispensed (tablets/ ml)	ARV Status (see codes below)	Adverse Events Status (see codes below)	ARV Reason (see codes below)	ARV combination regimen (see codes below)	ARV medicine: 20a) Quantity prescribed (tablets/ ml)	20b) Quantity dispensed (tablets/ ml)	20c) % Adherence	CD4 count/ % & Test Date	Viral Load & Test Date	a) ALT (Alanine Transaminase)	b) Creatinine	c) Other diagnostics test	Referred To: (see codes below)	Next Review date	Visit Status (see codes below)	Follow up Status (see codes below)	Name: Of Clinician (Initials)	Of Pharmacy (Dispenser) (Initials)
								X								X			
		3			1F	90	90	100%							25/3/16	OT	TX	AA	BB
						90	90								17/6/16	OT	TX		BB
						90									9/9/16				
						90									2/12/16				

Standard operating procedure for documentation of the refill visit

Documentation in patient notebook

1/1/16

TDF/3TC/EFV (po) 3/12

CTX 960 mg (po) 3/12

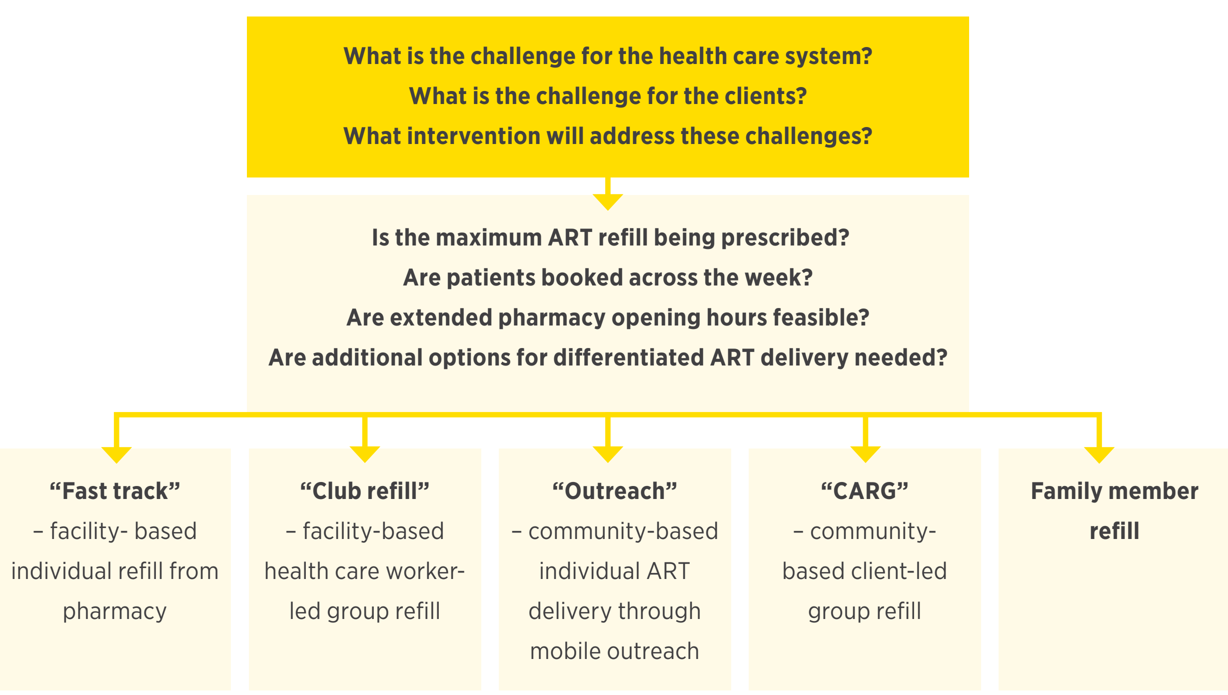
Repeat above prescription on 25/3/16✓ BB

17/6/16

9/9/16

TCB for clinical review and VL 2/12/16

Options for differentiated ART delivery for stable adults



Whenever a patient presents with a high viral load or other indication of challenges to adherence (late appointments , mental health issues), ensure referral for enhanced adherence and clinical follow up

"FAST TRACK" – Facility based Individual Refill from pharmacy

See page 56 OSDM

WHEN?

Every 3 months

Any time during opening hours

WHERE?

Direct from dispensing point

WHO?

The client does not see the nurse, only the ART dispenser

WHAT?

ART and CTX refill only

Clinical review is annual if VL available; Twice yearly if VL not available

STEP 1

- Ideally the day before use the EPMS appointment list or patient appointment diary to pull out the patient care and treatment books for the next day.
- Identify which clients are receiving ART in the fast-track model.

STEP 2

- For clients in the fast-track model, send the patient care and treatment books to the dispensing point.

STEP 3

- Client attends on day of refill appointment any time during clinic opening hours.
- Client attends the dispensing point directly.
- Client does not have individual nurse assessment unless patient requests.

STEP 4

- Dispenser provides refill as prescribed, and completes patient care and treatment book and patient notebook according to the refill documentation (See page 65 and 66 of Job Aide).

STEP 5

- The patient care and treatment book is sent to the data clerks for entry into EPMS.
- At paper-based sites, the next refill date is written into the appointment diary.
- If any client does not collect medication as per their appointment, the standard defaulter tracing system should be triggered (See page 59 of Job Aide).

"CLUB REFILL"– Facility based health care worker led Group Refill

See page 58 OSDM

WHEN?

Every 3 months

At fixed meeting time for the group

WHERE?

Refill takes place in room allocated for group refills

WHO?

The group can be facilitated by a nurse, primary counsellor or expert client

WHAT?

Group discussion and peer support

ART and CTX refill

If lay worker distributing ART, must be pre-packed

STEP 1

- The day before use the EPMS appointment list or patient appointment diary to identify which groups are attending the next day.
- Pull the patient care and treatment books for groups identified.

STEP 2

- In settings where a lay cadre will distribute ART to the group (or where the team feels that pre-packing of medication will facilitate dispensing in the group room by the nurse), send the patient care and treatment books to the dispensing point for ART to be dispensed and pre-packed in patient-named bags.

STEP 3

- At the time of the refill, the patient care and treatment books and dispensed pre-packed medication should be sent to the group meeting room.
- The clients in the group attend at the specified time for their group.
- If any clinical problem is identified, they are referred to see the nurse. This may be in the OI clinic or where the nurse facilitates the group, she may also consult directly if there is privacy.

STEP 4

- Faciliated discussion is held for 30-45 minutes.
- The HCW distributes ART to the clients.
- The HCW distributing the medication should complete the patient care and treatment book as indicated in the refill SOPs (See page 65 and 66 of Job Aide).

STEP 5

- The patient care and treatment books are sent to the data clerks for entry into EPMS.
- The next refill date for the group, indicating the group number, is written into the appointment diary.
- If any client does not collect medication as per their appointment, the standard defaulter tracing system should be triggered (See page 59 of Job Aide). Group members themselves may be used to facilitate tracing.

Clinical review is done as a group. Annual if VL available; Twice yearly if VL not available

"OUTREACH" – Community based individual ART delivery through mobile outreach

See page 60 OSDM

WHEN?

Every 3 months

At fixed date and time

WHERE?

At fixed mobile outreach site

WHO?

The nurse

WHAT?

ART and CTX refill only

STEP 1

- The day before use the EPMS or patient appointment diary to pull the patient care and treatment books for clients booked for mobile outreach.

STEP 2

- Care and treatment books are used to prepare ART medication for outreach.
- If pre-packing, label medication with name of client and place all medication in a bag with client's name.

STEP 3

- Patient care and treatment books, ART and cotrimoxazole medication are transported to the mobile outreach site.
- Patients attend at the designated outreach site and are seen individually either by the nurse or lay cadre.

STEP 4

- ART may be dispensed by the nurse who completes the patient care and treatment book according to the refill SOP (See page 65 and 66 of Job Aide).
- If pre-packed, ART may be distributed by the primary counsellor or other lay worker supporting the outreach activity. The distributor must complete the patient care and treatment book according to the refill SOP (See page 65 and 66 of Job Aide).

STEP 5

- On return, the patient care and treatment book is sent to data clerks for entry into the EPMS.
- At paper-based sites, the next mobile refill date for each client is documented in the appointment diary.
- If any client does not collect medication as per their appointment, the standard defaulter tracing system should be triggered (See page 59 of Job Aide).

Clinical review is annual if VL available; Twice yearly if VL not available

"CARG"– Community-based, client led group refill

See page 62 OSDM

WHEN?

Every 3 months at agreed time in community and appointed date at facility

WHERE?

Community meeting is held at group members house or chosen community venue. Medication dispensed at facility or at a mobile outreach site and distributed in community

WHO?

Group Leader completes community form

Chosen group representative collects medication and distributes

Nurse sees group representative

WHAT?

ART and CTX refill only

Peer support

Clinical review is done as a group. Annual if VL available; Twice yearly if VL not available.

STEP 1

- The day before their refill date or early morning on the refill date, the community group members meet at chosen house/community venue.
- The group leader completes the CARG refill form together with the group members.
- The group chooses a representative to attend the clinic to collect the ART; if a member has a clinical problem, this member is selected. The group representative takes the completed community ART refill form from the previous visit and the one completed for this refill to the clinic.

STEP 2

- At the facility, use the EPMS or patient appointment diary to pull the patient care and treatment books for clients booked for CARG refill; care and treament booklets should be filed according to their group membership.
- The CARG representative is seen by the clinic nurse.

STEP 3

- The nurse reviews signatures from the previous refill form to ensure all clients have received their medication (this form is filed in a "CARG refill folder").
- Prescription of ART is given and documentation of any results is made on today's refill form.
- Today's community group refill form is given back to the CARG representative.
- Patient care and treatment book is filled according to the refill SOP (Page 65 and 66 of Job Aide).

STEP 4

- Patient care and treatment book is sent to data clerks for entry into EPMS.
- Next refill date for the group is documented in the appointment book (can document group number rather than individual names).
- If any group representative does not collect medication as per their appointment, the standard defaulter tracing system should be triggered (Page 59 of Job Aide).

STEP 5

- Group representative returns to the community and distributes the ART to their group members.
- Each member signs that they have received their refill.

Family member ART Refill

See page 66 OSDM

WHEN?

Every 3 months

WHERE?

Family group completes group refill form at home

Medication is collected from the facility or mobile outreach point

Medication is then distributed at home

WHO?

Nurse sees family representative at facility or mobile outreach

WHAT?

ART and CTX refill only

Clinical review is done as a group. Annual if VL available; Twice yearly if VL not available

Any child should be followed up clinically according to their age (See page 84 of Job Aide)

STEP 1

- The day before use the EPMS or patient appointment diary to pull the patient care and treatment books for clients booked for refill via this model.

STEP 2

- Family representative completes the group refill form at home.
- Family representative attends facility or mobile outreach site, bringing today's refill form and the completed refill form from the previous visit.

STEP 3

- Family representative is reviewed by nurse.
- ART for all family members is dispensed.
- Dispenser completes patient care and treatment book according to the refill SOPs (page 65 and 66 of Job Aide).

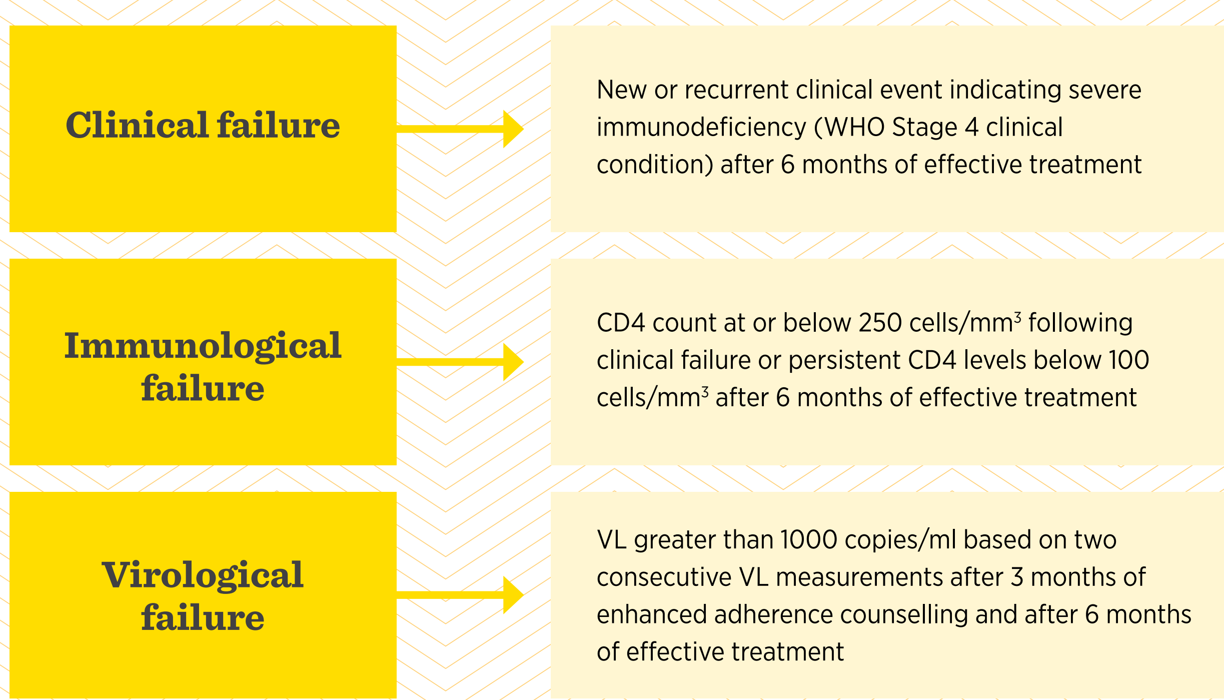
STEP 4

- Patient care and treatment book is sent to data clerks for entry into EPMS on return.
- The next appointment for the family group is documented in the appointment diary.
- If any client does not collect medication as per their appointment, the standard defaulter tracing system should be triggered (See page 59 of Job Aide).

STEP 5

- Family member distributes ART to other family members at home.
- Each member signs that they have received the medication.

Definition of treatment failure in adults



Routine viral load monitoring algorithm

TAKE VIRAL LOAD TEST :

- **Any patient with clinical or immunological failure must be urgently assessed individually**
- Routinely at 6 months after starting ART, 12 months after starting ART and then every 12 months (24, 36 months etc.)
- Give viral load key messages before client is bled for VL

VL <1000 COPIES/ML

- Maintain first-line therapy
- Schedule next VL testing at month 12 after ART initiation then yearly thereafter
- Offer client options for differentiated ART delivery for stable clients

VL >1000 COPIES/ML

Assess for and address any possible causes of non-adherence and treatment failure

Refer for enhanced adherence counselling (EAC)

1st EAC session on day of result

- 2nd EAC session after 4 weeks
- 3rd EAC and additional sessions as required over the next 8 weeks

Repeat VL 12 weeks after result has been given

VL <1000 COPIES/ML

- Maintain current regimen
- Offer client options for differentiated ART delivery for stable clients
- Schedule next VL testing at month 12 and yearly

VL >1000 COPIES/ML

- Refer to clinician experienced in switching to second line
- Gather information on patient from both clinicians and counsellors
- Switch to second line within 2 weeks from receipt of second high viral load unless clear clinical or psychosocial contraindication
- Urgency of switch will be dependent on clinical condition of patient, CD4 or if woman is pregnant or breastfeeding

This algorithm should be completed within 6 months

Use the EPMS appointment system to identify client:

Who is due VL testing

Whose last viral load was >1000 copies/ml. These clients need:

Enhanced adherence counselling

OR

Repeat VL testing

OR

Change of regimen

If there is evidence of clinical or immunological failure the patient should be referred to a clinician and a treatment plan made on an individual basis. In these cases a switch to second line may be considered earlier and without repeat of VL in some cases.

If point of care viral load is available, use this for patients who are clinically unwell and for the repeat VL test after enhanced adherence.

How to prepare a VL DBS sample from EDTA whole blood

1 PREPARATION

1.1 Wash hands vigorously.

1.2 Wear powder-free gloves and change gloves between patients.

1.3 Confirm identity of patient and ensure that all data elements on the form are complete, accurate and consistent.

2 PHLEBOTOMY

2.1 Write name and number of the patient on a purple cap EDTA tube (4mL) with an indelible marker.

2.2 Use a tourniquet or get the patient to clamp his/her fist to locate the veins.

2.3 Clean the puncture site with alcohol or disinfectant. Do not touch again after cleaning.

2.4 Insert the needle into a holder and then into the patient's vein, bevel upwards. The back of the needle is used to pierce the top of the vacutainer tube.

2.5 The vacuum makes the tube fill to the required level.

2.6 Remove the tube and mix gently by inverting several times to mix the blood with the anticoagulant.

2.7 Blood collection can be difficult on a patient with low blood pressure. In this case, use a syringe. The use of a butterfly can also assist in the collection of blood.

3 DBS PREPARATION

3.1 Prepare the material required to make the DBS.

3.2 Write patient name, number and date on the space provided on the card.

3.3 Position the DBS card in a way that the circles do not touch the surface of the bench.

3.4 Mix the blood gently once again by inverting several times.

3.5 Open the EDTA tube.

3.6 Squeeze the end of the Pasteur pipette before inserting it in the tube.

3.7 Insert the pipette in the blood and release the end to suck up the blood.

3.8 Gently apply enough blood to each circle to fill them completely. Apply blood to one side only.

3.9 Make sure that the individual blood circles do not touch each other.

3.10 Place completed DBS cards on the rack to dry. Make sure that the cards do not touch each other.

3.11 Let the DBS cards dry for at least 3-4 hours. Keep out of direct sunlight.

3.12 All used items should be disposed of in an appropriate biohazard container.

3.13 When dry, each card should be packed individually in a plastic zip-lock bag with 2 desiccant sachets and a humidity indicator card.

3.14 Store the packed DBS at room temperature and send to the laboratory within a week after preparation.

4 PITFALLS

4.1 Avoid touching the area within the circle before and after blood spotting.

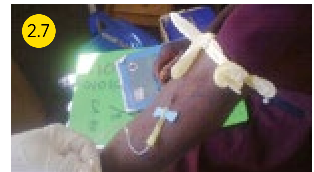
4.2 DBS cards should always be handled with gloves and only touched on the edges, never on the circles.

4.3 DBS's should be prepared in a dry and clean room, free of wind and dust.

4.4 Blood can be collected from several (5-10) patients before preparing the DBS's. Make sure that the collected blood is spotted within 1 hour.

4.5 Do not pack the DBS cards in the plastic zip-lock bag until thoroughly dry. Insufficient drying adversely affects test results.

2.1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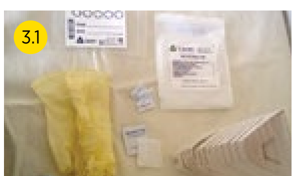

3.1

3.9

Acting on viral load results

RESULTS ARRIVE

- All VL results are entered into the EPMS
- All VL results are filed
- For all VL results >1000 copies/ml, files should be kept out and flagged either by placing in HVL tray or with a red sticker (these must be removed once the patient has stabilised)
- Document results in viral load result column
- Open the high viral load summary form

TRACE PATIENTS WITH HIGH VIRAL LOAD

- Staff member is delegated to trace patients with high viral load via phone or through the community health worker
- SMS of high viral load results to both clinic and patients may be introduced as an additional means of contacting patients

PATIENT ATTENDS FOR FIRST EAC SESSION

- Patient is identified through the flagging system and is triaged to EAC on arrival
- Patient is given 1-month refill and booked for a second EAC session in 1 month
- Follow the viral load algorithm
- If client requires further counselling sessions, this should be decided case by case

Use the EPMS appointment lists to identify any patient whose last VL was >1000 copies/ml

These clients need:

EAC

or

A repeat VL

or

Change of regimen

What to start for second line ART

TARGET POPULATION	PREFERRED SECOND-LINE REGIMENS	
Adolescents 10-19 years **Adults, pregnant and breastfeeding women**	If TDF was used in first-line ART	AZT + 3TC + ATV/r* or LPV/r
	If AZT was used in first-line ART	TDF + 3TC + ATV/r* or LPV/r
HIV and TB co-infection	Patients receiving rifampicin	Same NRTI backbone as recommended for adults and adolescents plus double dose LPV/r (800mg/200mg BD)
HIV and HBV co-infection		AZT + TDF** +3TC +ATV/r* or LPV/r

*Atazanavir (ATV/r) is the preferred protease inhibitor

**Those patients with hepatitis B infection will always need tenofovir and lamivudine as these medications also treat the hepatitis B

ANTIRETROVIRAL TREATMENT IN CHILDREN AND ADOLESCENTS

Section contents:

- Cotrimoxazole prophylaxis in children 79
- When and what to start 80
- Paediatric ART dosing chart 81
- Developmental red flags 82
- Definition of treatment failure 83
- Differentiated ART delivery for stable children and adolescents 84

Cotrimoxazole prophylaxis in children

AGE	Suspension (240mg/5ml)	Adult tablets (480mg)	Paediatric tablets (120mg)
0 – 6 months	2.5ml	¼	1
6 months – 3 years	5ml	½	2
Over 3 years	10ml	1	3

When and What to start

All children and adolescents testing HIV positive are eligible for ART regardless of age or CD4 count

AGE	FIRST LINE	SECOND LINE
0 – 2 weeks	AZT +3TC+NVP	
2 weeks to less than 3 years	Preferred: ABC + 3TC + LPV/r	Preferred: AZT+3TC +RAL
	Alternative: AZT+ 3TC + LPV/r ABC+ 3TC+ NVP	Alternative: ABC+3TC+RAL
3 years to less than 10 years	Preferred: ABC + 3TC + EFV	AZT+3TC+LPV/r or RAL
	Alternative: AZT + 3TC + EFV AZT + 3TC + NVP TDF + 3TC+ EFV (or NVP)	ABC +3TC + LPV/r ABC+3TC+ATV/r

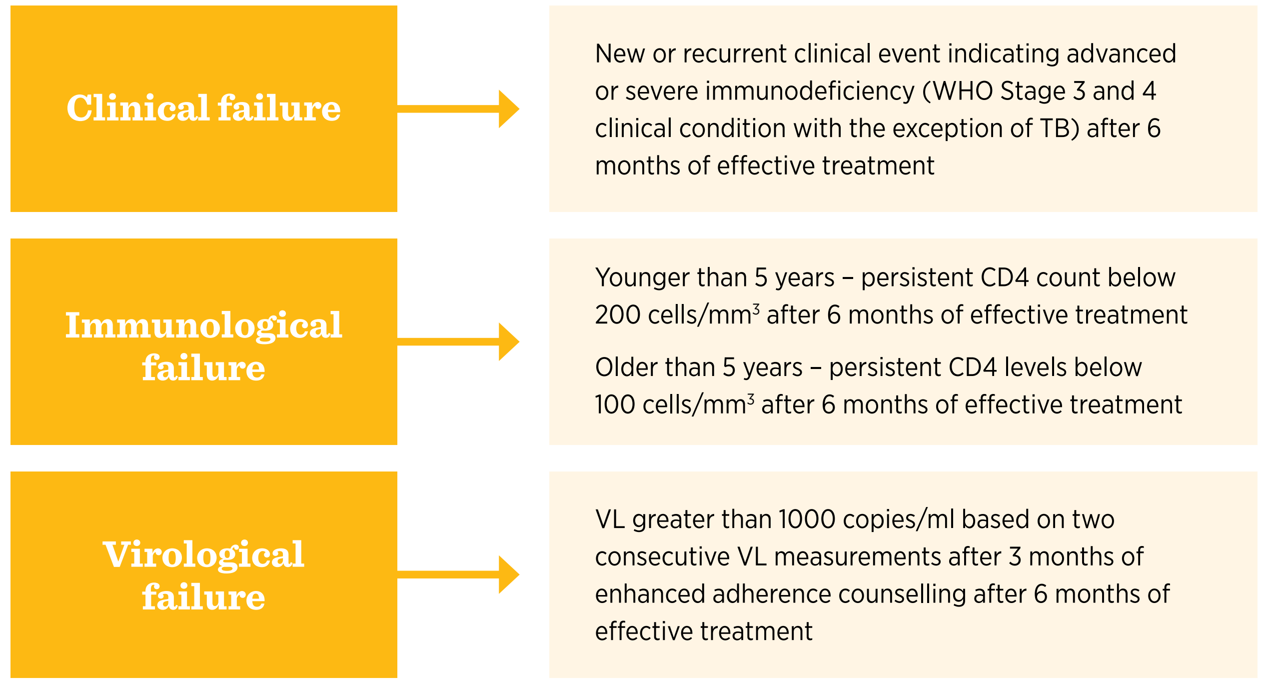
Paediatric ART dosing chart

Drug	Strength of tablets (mg) or oral liquid (mg/ml)	Number tablets or ml by weight –band morning (AM) and evening (PM)										Strength of adult tablet (mg)	Number of tablets by weight band	
		3.0-5.9 kg		6.0-9.9 kg		10.0-13.9 kg		14.0-19.9 kg		20.0-24.9 kg			25.0-34.9 kg	
		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM		AM	PM
Solid Formulations														
AZT	Tablet (dispersible) 60 mg	1	1	1.5	1.5	2	2	2.5	2.5	3	3	300 mg	1	1
ABC	Tablet (dispersible) 60 mg	1	1	1.5	1.5	2	2	2.5	2.5	3	3	300 mg	1	1
NVP[b]	Tablet (dispersible) 50 mg	1	1	1.5	1.5	2	2	2.5	2.5	3	3	200 mg	1	1
EFV	Tablet 200mg and 50mg as described	Not advised	Not advised	Not advised	Not advised	0	1x 200mg	0	1x 200mg + 1x50mg	0	1 x 200mg + 2x50mg		0	25.0-29.9kg 1.5x 200mg + 1x50mg 30.0-34.9kg 2x200mg
LVP/r[c]	Tablet[d] 100 mg/25 mg	-	-	-	-	2	1	2	2	2	2	100 mg/25 mg	3	3
	Pellets[e] 40 mg/10 mg	2	2	3	3	4	4	5	5	6	6	100 mg/25 mg	3	3
DRV	Tablet 75 mg	-	-	-	-	3	3	5	5	5	5			
RAL	Chewable tablets 25 mg	-	-	-	-	3	3	4	4	6	6	400 mg	1	1
	Chewable tables 100 mg	-	-	-	-	-	-	1	1	1.5	1.5	400 mg	1	1
	Granules[g]	0.25	0.25	0.5	0.5	-	-	-	-	-	-		-	-
Liquid formulations														
AZT	10 mg/ml	6 ml	6 ml	9 ml	9ml	12ml	12ml	-	-	-	-	-	-	-
ABC	20 mg/ml	3ml	3ml	4ml	4ml	6ml	6ml	-	-	-	-	-	-	-
3TC	10 mg/ml	3ml	3ml	4ml	4ml	6ml	6ml	-	-	-	-	-	-	-
NVP[b]	10 mg/ml	5ml	5ml	8ml	8ml	10ml	10ml	-	-	-	-	-	-	-
LVP/r[c]	80/20 mg/ml	1 ml	1 ml	1.5ml	1.5ml	2ml	2ml	2.5ml	2.5ml	3ml	3ml	-	-	-
DRV	100 mg/ml	-	-	-	-	2.5ml	2.5ml	3.5ml	3.5ml	-	-			

DEVELOPMENTAL RED FLAGS

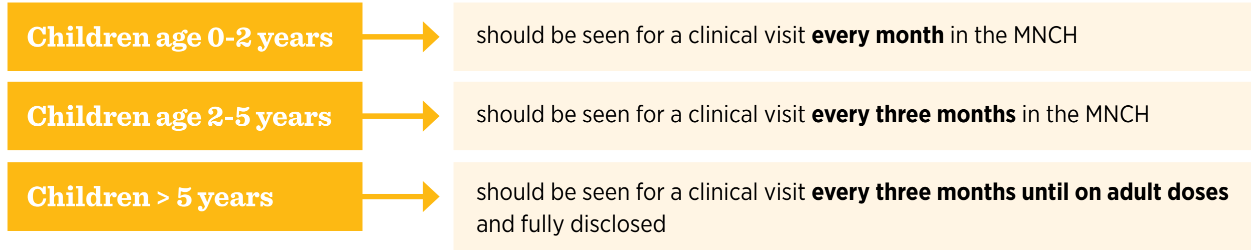
Age	Red flags
Birth to 3 months	• Failure to alert to environmental stimuli • Rolling over before 2 months (hypertonia) • Persistent fisting at 3 months
4 to 6 months	• Poor head control • Failure to smile • Failure to reach for objects by 5 months
6 to 12 months	• No baby sounds or babbling • Inability to localise sounds by 10 months
12 to 24 months	• Lack of consonant production • Hand dominance prior to 18 months (contralateral weakness) • No limitation of speech and activities by 16 months
Any age	• Loss of previously attained milestones

Definition of treatment failure in children



For viral load monitoring, follow the VL algorithm page 74

Differentiated ART delivery for stable children and adolescents



Mothers (and fathers) should be seen on the same day as their child in the MNCH

Book children on the same day to provide peer support for the guardians and to have a child friendly ART day

Adolescents who are on adult doses, who are fully disclosed, have VL < 1000 copies/ml and no current Ois should:

- **Be seen for a clinical visit every six months**
- **Receive 3 monthly ART refills**
- **Be offered fast track, family member refill or adolescent group refill options**

Facility-based adolescent group refill

See page 72 OSDM

WHEN?

Every 3 months

WHERE?

At the facility

WHO?

Nurse assisted by primary counsellor or community adolescent treatment supporter

WHAT?

ART and cotrimoxazole refills

Peer support

SRH education and services for adolescents

STEP 1	• The day before use the EPMS appointment list or patient appointment diary to identify which groups are attending the next day. • Pull the patient care and treatment books for groups identified.
STEP 2	• In settings where a lay cadre will distribute ART to the group (or where the team feels that pre-packing of medication will facilitate dispensing in the group room by a nurse facilitating the groups), send the patient care and treatment books to the dispensing point for ART to be dispensed and pre-packed in patient-named bags.
STEP 3	• At the time of the refill, the patient care and treatment books and pre-packed medication should be sent to the group meeting room. • The clients in the group attend at the specified time for their group. • If any clinical problem is identified, they are referred to see the nurse. This may be in the OI clinic, or the nurse may also consult when she facilitates the group.
STEP 4	• Faciliated discussion is held for 30-40 minutes and fun games and activities for another 30-40 minutes. • The HCW distributes ART to the clients. • The HCW distributing the medication should complete the patient care and treatment books according to the refill SOP (See page 65 and 66 of Job Aide).
STEP 5	• The patient care and treatment books are sent to the data clerks for entry into EPMS. • The next refill date is written into the appointment diary indicating the group number. • If any client does not collect medication as per their appointment, the standard defaulter tracing system should be triggered (See page 59 of Job Aide).

PMTCT

Section contents:

- Summary of actions for PMTCT 87
- Re-testing HIV negative pregnant and lactating women 88
- Infant feeding counselling for women who are HIV positive 89
- Infant risk assessment and ARV prophylaxis 90
- Infant dosing for NVP and AZT prophylaxis 91
- Infant cotrimoxazole prophylaxis 92
- Differentiated ART delivery for pregnant and breastfeeding women 93

Summary of actions for PMTCT

HIV-positive patients

Conduct post-test counselling

Commence on lifelong ART after rapid initiation counselling and clinical and psychosocial readiness assessment

Two weeks after initiation of ART (TDF-3TC-EFV) start cotrimoxazole 960mg once a day if WHO stage 2,3,4 or CD4 < 350

Advise on ANC follow up and infant feeding counselling. Consider conditions to safely formula feed

HIV-negative patients

Conduct post-test counselling

Discuss VMMC for partner and other preventive strategies

Advise on ANC follow up and infant feeding counselling

Re-test for HIV according to the guidance on page 88

Discordant couples

Commence positive partner on ART

If woman is negative and is exposed to ongoing risk, offer PrEP during pregnancy and breastfeeding

Patients declining testing

Continue offering HTS on subsequent visits

Re-testing HIV negative pregnant and lactating women

TIME OF PRESENTATION	WHEN TO TEST
1st or 2nd trimester: HIV-negative status known	Re-test in third trimester
1st or 2nd trimester: HIV-negative status unknown	Offer HIV test; re-test in third trimester
3rd trimester: HIV-negative status known	Re-test 6 weeks post delivery
3rd trimester: HIV-negative status unknown	Offer HIV test; re-test at 6 weeks post delivery
Labour and delivery: HIV-negative status known from third trimester	Re-test at 6 weeks post delivery
Labour and delivery: HIV-negative status known from 1st or 2nd trimester	Re-test immediately, then 6 monthly
Labour and delivery: HIV status unknown	Offer HIV test, then 6 monthly
Breastfeeding woman: HIV-negative status known	Re-test every 6 months until cessation of breastfeeding
Breastfeeding woman: HIV-negative status unknown	Offer HIV test immediately Re-test every 6 months until cessation of breastfeeding

Infant feeding counselling for women who are HIV positive

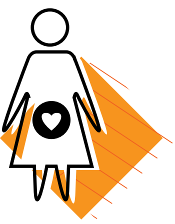
Explain risks of mother-to-child transmission

Discuss:

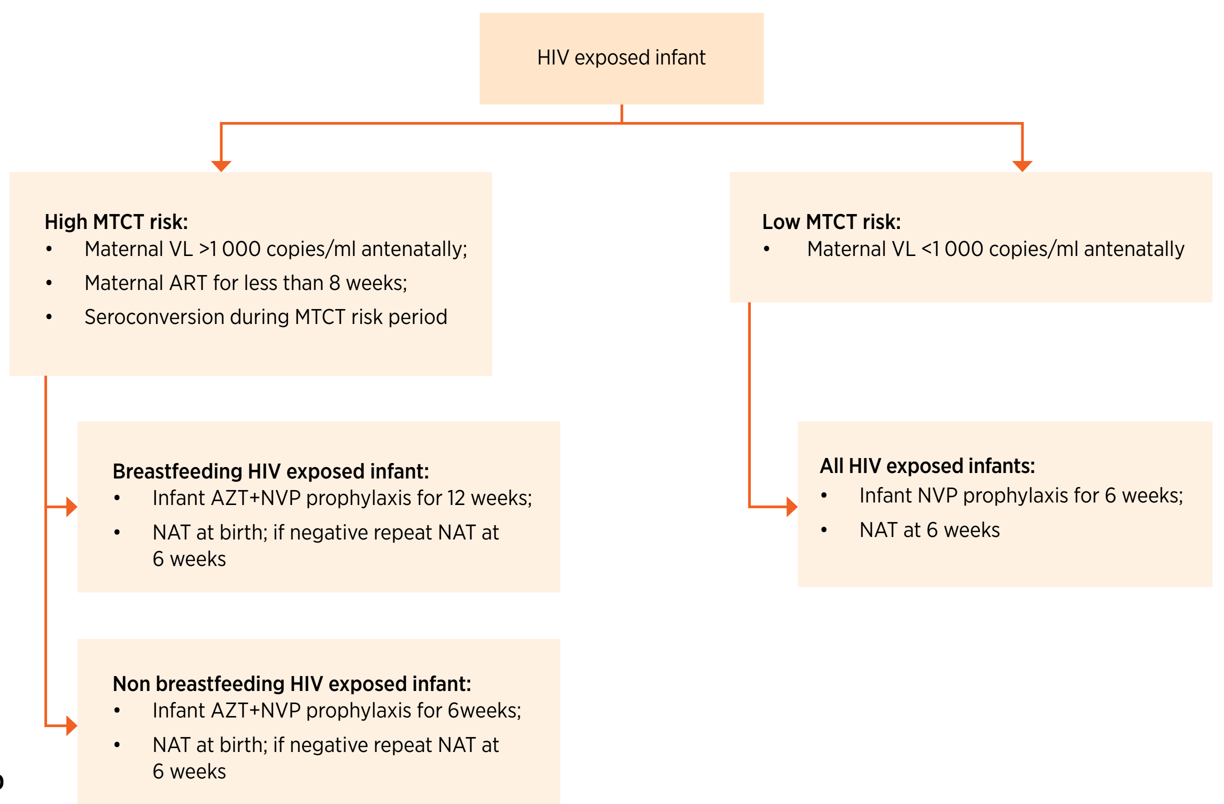
- exclusive breastfeeding for the first 6 months (recommended feeding method),
- complimentary feeding
- and guidance on the recommended duration of breast feeding (24 months and beyond)

If mother decides not to breastfeed, establish reasons and address accordingly

If mother maintains position not to breastfeed, discuss exclusive commercial feeding for the first 6 months



Infant risk assessment and ARV prophylaxis



Infant dosing for NVP and AZT prophylaxis

INFANT AGE	NVP DOSING	AZT DOSING
Birth to 6 weeks		
Birth weight less than 2000 grams and older than 35 weeks of gestational age*	2 mg/kg per dose once daily	AZT 4 mg/kg per dose twice daily
Birth weight 2000–2499 grams	10 mg once daily (1 ml of syrup once daily)	10 mg twice daily (1 ml of syrup twice daily)
Birth weight ≥2500 grams	15 mg once daily (1.5 ml of syrup once daily)	15 mg twice daily (1.5 ml of syrup twice daily)
6-12 weeks		
	20 mg once daily (2 ml of syrup once daily or half a 50 mg tablet once daily)	60 mg twice daily 6 ml of syrup twice daily or a 60 mg tablet twice daily

*Premature infants younger than 35 weeks of gestational age should be dosed using expert guidance

Infant CTX prophylaxis

Cotrimoxazole should be given to all children born to HIV-positive mothers from six weeks of age until they are tested and confirmed to be HIV negative, six weeks after the end of MTCT risk period.

AGE	DOSE (ML)		
	Suspension (240mg/5ml)	Adult tablets (480mg)	Paediatric tablets (120mg)
0 – 6 months	2.5ml	¼	1
6 months – 3 years	5ml	½	2

Differentiated ART delivery for pregnant and breastfeeding women

- PMTCT and antenatal, delivery and postnatal services should be integrated. Services should be provided
    - On the same day
    - Under the same roof
    - By the same health care provider
- Mothers and their exposed babies should be seen on the same day in MNCH
- Facility based group refill options "Club refill" may be offered postnatally with integrated exposed baby follow up
- Women already on ART who become pregnant may choose to continue to receive their ART
    - through their chosen refill option or
    - continue to meet with their group for peer support and receive their ART at MNCH
    - BUT they must attend for the additional ANC , postnatal and exposed baby follow up.
    - Attending for these additional services may be supported by their group

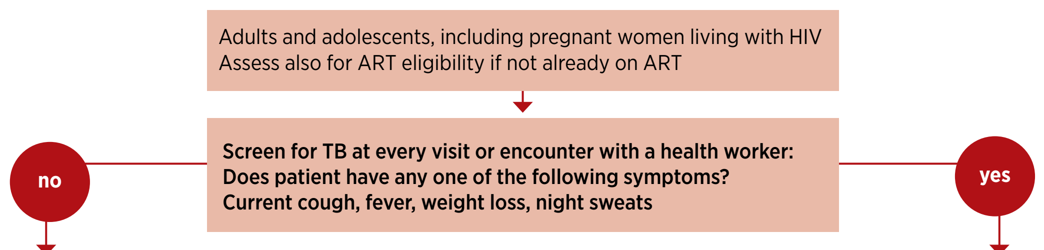
HIV/TB AND OPPORTUNISTIC INFECTIONS

Section contents:

- TB screening algorithm for HIV-positive adults, adolescents and pregnant women 95
- TB screening algorithm for children more than one year of age and living with HIV 96
- TB diagnostic algorithm 97
- Administration of TB preventive therapy 98
- Side effects of INH 99
- Special situations with TB preventive therapy 100
- TB/HIV co-infection 101
- Diagnosis, screening and pre-emptive treatment of cryptococcal meningitis 102
- Treatment of cryptococcal meningitis 103
- Cotrimoxazole prophylaxis 104

TB screening algorithm for adults and adolescents including pregnant women living with HIV

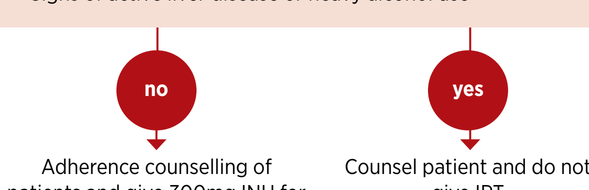
Adults and adolescents, including pregnant women living with HIV
Assess also for ART eligibility if not already on ART



Screen for TB at every visit or encounter with a health worker:
Does patient have any one of the following symptoms?
Current cough, fever, weight loss, night sweats

Assess for IPT eligibility:
Does patient have any of the following?

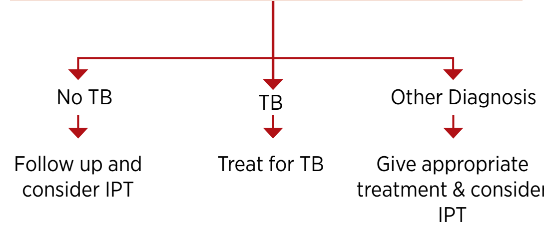
- Symptoms and signs suggestive of active TB
- Patient currently on treatment for TB treatment
- Completed IPT in the past 3 years
- Patients on ART for 3 months or less
- Patients on ART for more than 3 years who are doing well [CD4 >450]
- Signs of active liver disease or heavy alcohol use



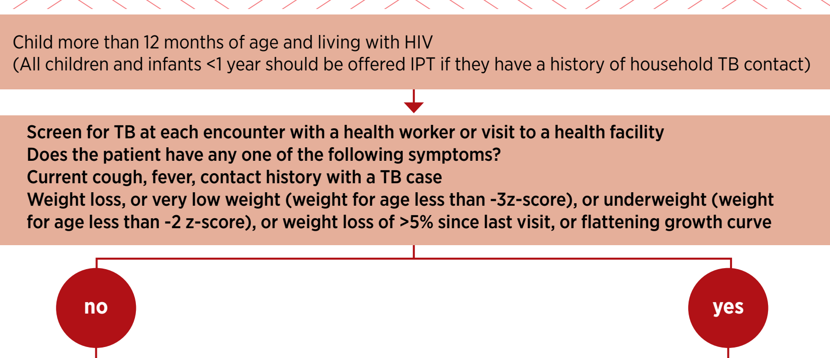
Adherence counselling of patients and give 300mg INH for 6 months

Counsel patient and do not give IPT

INVESTIGATE FOR TB USING XPERT AS THE PREFERRED STANDARD
(where not accessible, microscopy or other investigative methods may be used)
Investigate for other differentials of TB and manage according to nationally agreed guidelines



TB screening algorithm for children more than one year of age and living with HIV



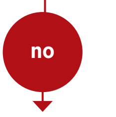
Child more than 12 months of age and living with HIV
(All children and infants <1 year should be offered IPT if they have a history of household TB contact)

Screen for TB at each encounter with a health worker or visit to a health facility
Does the patient have any one of the following symptoms?
Current cough, fever, contact history with a TB case
Weight loss, or very low weight (weight for age less than -3z-score), or underweight (weight for age less than -2 z-score), or weight loss of >5% since last visit, or flattening growth curve

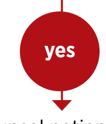
no:

Assess for IPT eligibility: Does patient have any of the following?

- Symptoms and signs suggestive of active TB
- Patient on treatment for TB
- Patient completed IPT within past 3 years
- Patient has been on ART for 3 months or less
- Patients on ART for more than 3 years who are doing well [CD4 >450 or CD4% >25]
- Signs of active liver disease



Adherence counselling of patient and give isoniazid (INH) at 10mg/kg for 6 months

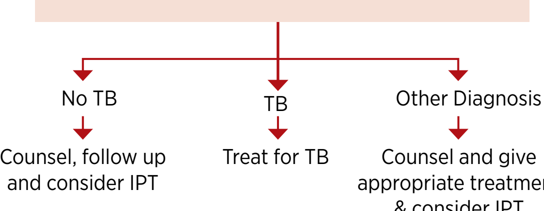


Counsel patient and do not give IPT

yes:

INVESTIGATE FOR TB USING XPERT AS THE PREFERRED STANDARD
(where not accessible, microscopy or other investigative methods may be used)

- Investigate for other differentials of TB and manage according to nationally agreed guidelines

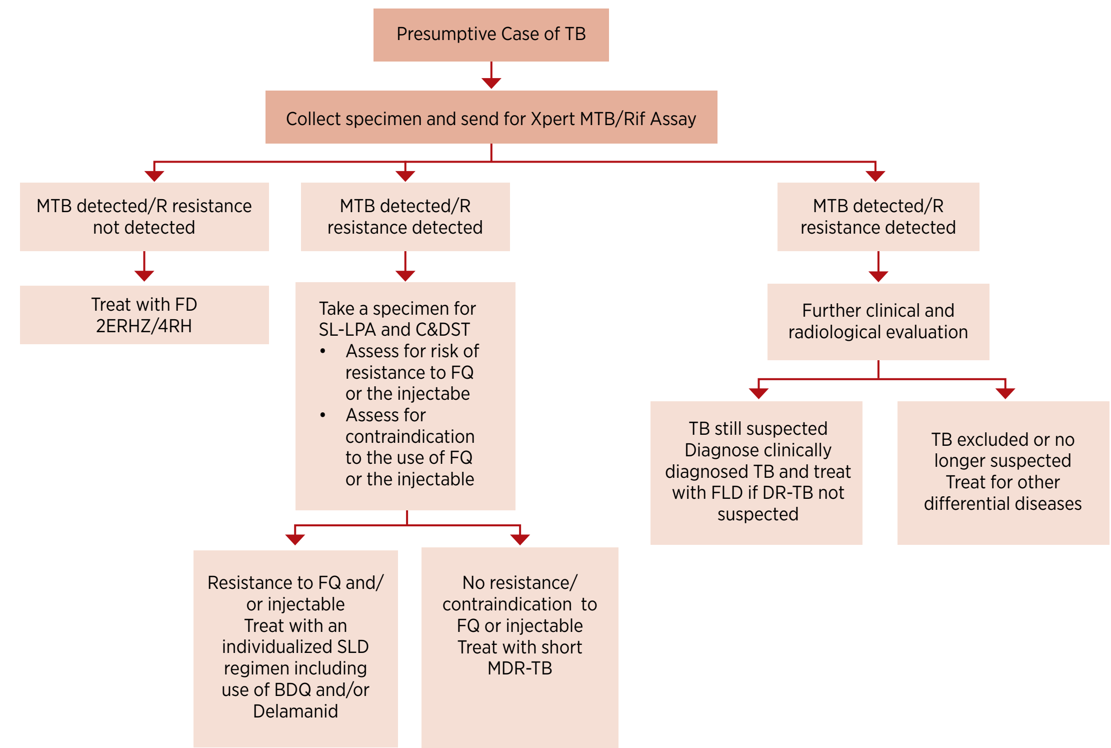


No TB → Counsel, follow up and consider IPT

TB → Treat for TB

Other Diagnosis → Counsel and give appropriate treatment & consider IPT

TB diagnostic algorithm



Administration of TB preventive therapy

ADULTS

Give 5mg/kg/day INH (max doses 300mg/day) concurrently with pyridoxine (vitamin B6) 25mg/day

CHILDREN

Give 10mg/kg/day INH (refer to weight bands table below)

Weight range (kg)	Number of 100mg tablets of INH per dose	Dose given (mg)
<5	½	50
5.1–9.9	1	100
10–13.9	1 ½	150
14–19.9	2	200
20–24.9	2 ½	250
>25	3 tablets or one adult tablet	300

Common INH side effects and management

	Side effect	Management
Mild	Tingling/burning sensation Joint pains Mild skin rash Abdominal pains Increased appetite Headache Itchy skin Diarrhoea Nausea Decreased libido or energy	Continue INH Reassure and safety net Reassess and manage accordingly
Severe	Hepatitis/jaundice Severe skin rash with peeling skin Disabling peripheral neuropathy Convulsions Psychosis	STOP INH Refer for further management

Special situations with TB preventive therapy

SITUATIONS IN IPT	GUIDANCE
Development of TB during IPT	Stop INH Start anti-TB treatment If on NVP, substitute with EFV Collect sputum for DRTB diagnosis
Patient misses 2 consecutive monthly refills	Stop INH Investigate for active TB and manage accordingly Offer counselling
Develops INH intolerance (serious side effects) Becomes terminally ill	Stop INH permanently Refer urgently for further management
PLHIV started on ART	Defer INH initiation by 3 months to allow undiagnosed OIs to be unmasked
Adults and adolescents living with HIV who have successfully completed TB treatment	Commence INH immediately after successful treatment for an additional six months
Patients who would have successfully completed MDR-TB and XDR-TB treatment	Do not initiate INH (no evidence of the potential role of INH in this population)

Summary of management of TB/HIV co-infection

HTS should be routinely offered to all persons suspected or known to have TB

Case definitions and anti-TB treatment regimens are the same for HIV-positive and HIV-negative TB patients

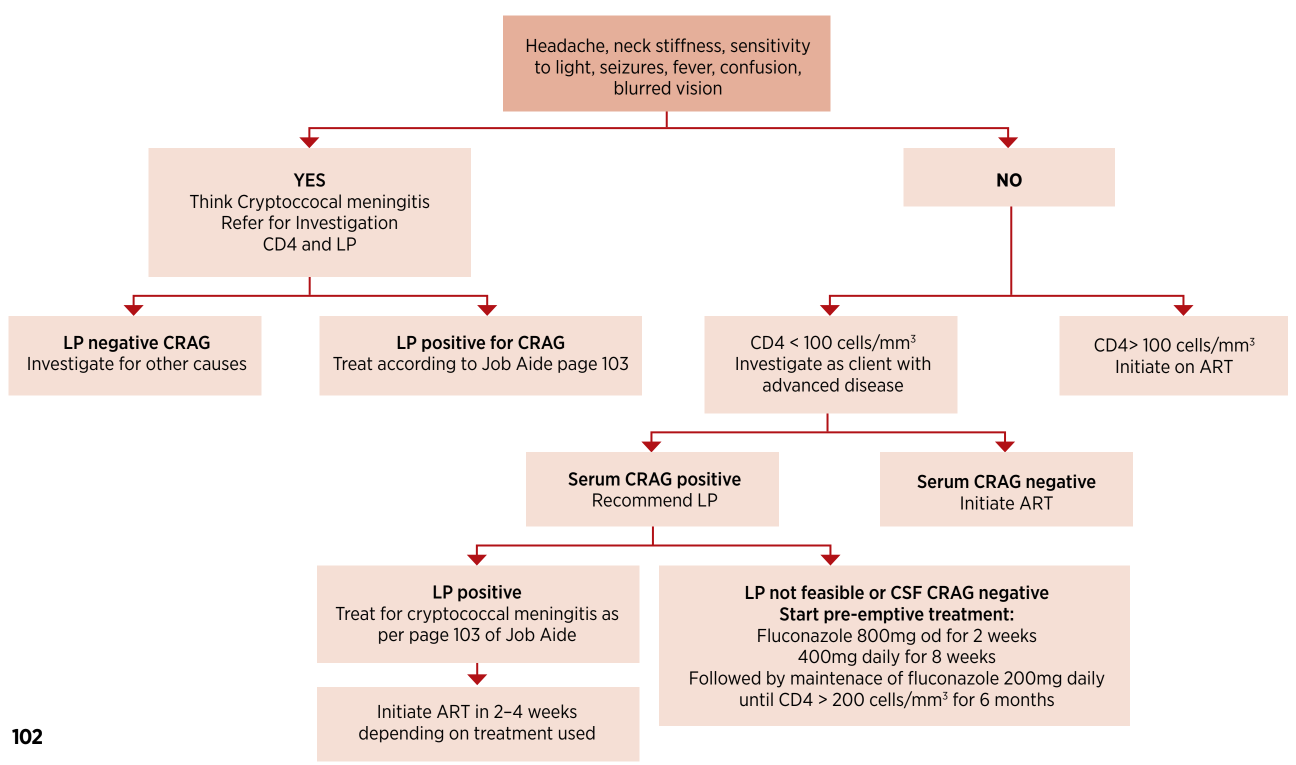
In TB/HIV co-infection, the priority is to initiate anti-TB treatment, followed by cotrimoxazole and then ART

All people living with HIV with active TB disease, irrespective of CD4 and the site of TB disease, should be initiated on ART within the first 8 weeks of TB treatment

If CD4 <50 cells/mm^3, start ART within the first two weeks of initiating TB treatment

Children, adolescents and adults, including pregnant women living with HIV, should be screened for TB using the clinical algorithm at every clinical visit

Diagnosis, screening and pre-emptive treatment of cryptococcal meningitis



Management of cryptococcal meningitis

	Induction (14 days)	Treatment consolidation phase (8 weeks)	Maintenance/prophylaxis
Amphotericin B +/- flucytosine if available with monitoring	Amphotericin B with flucy-tosine	Fluconazole high dose (400-800mg od)	Fluconazole low dose (200mg od)
Amphotericin B available but no monitoring available for 2 weeks	Amphotericin 5-7 day short course AND fluconazole (800mg od)	Fluconazole high dose (800mg od)	Fluconazole low dose (200mg od)
No amphotericin available	Fluconazole (1200mg od) with flucytosine OR fluconazole monotherapy (1200mg od)	Fluconazole high dose (800mg od)	Fluconazole low dose (200mg od)

Fluconazole prophylaxis must continue for at least one year and be stopped after two consecutive CD4 readings above 200 cells/mm^3

Cotrimoxazole prophylaxis

When to start:

- **Cotrimoxazole prophylaxis for adults**, including pregnant and breastfeeding women, should be given to the following:
  - All patients with WHO Clinical Stages II, III, and IV disease
  - All patients with CD4 counts of less than 350 cells/mm^3

- **Cotrimoxazole prophylaxis for HIV infants, children and adolescents** should be given to the following:
  - All HIV-positive infants, children and adolescents, irrespective of clinical and immunological condition
  - All children born to HIV-positive mothers at six weeks of age until they are tested and confirmed to be negative

- In settings where malaria or severe bacterial infections are highly prevalent: provide CTX to all HIV-infected infants, children, adolescents and adults, including pregnant and breastfeeding women, regardless of CD4 cell count and WHO clinical stage

When to stop:

- **In settings with low prevalence for both malaria and bacterial infections:**
  - CTX may be discontinued for children 5 years of age and older who are clinically stable or virally suppressed on ART for at least 6 months and with a CD4 count of more than 350 cells
  - For adults, pregnant and breastfeeding women, discontinue when clinically stable on ART, with evidence of immune recovery and viral suppression

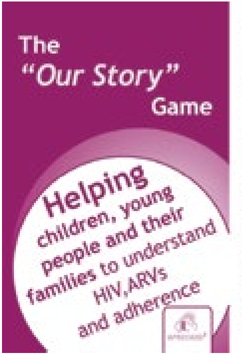
- **In malaria endemic settings/or areas with high prevalence of severe bacterial infections, once CTX has been initiated, it should be continued (do not stop)**

COUNSELLING TOOLS

Section contents:

- How to use the HIV and ART counselling game 106
- Basic HIV education 111
- Basic ART education 113
- Planning for travel 119
- Viral load testing 121
- Choosing a refill option 123
- Disclosure counselling for children 125
- Initiation checklist 138
- Enhanced adherence checklist 139

ART education: How to use the HIV and ART Counselling Card Game



"Our Story" book was written in 2006 by HIV positive children and adolescents from Africaid's Zvandiri programme in Zimbabwe. They wrote this book because they wanted to help other children and adolescents living with HIV to understand more about what it means to live with HIV, to help them to stay strong and to look positively towards the future.

They also hoped that the book would provide a useful tool for health workers when counselling children and families with HIV. Chapters 3 and 7 in the book provide a child-friendly explanation of HIV, ARVS and Adherence. This "Our Story" game has now been developed to accompany the book, and is a fun game to play with children and their caregivers when counselling on particular issues such as disclosure, starting Antiretroviral drugs and adherence counselling.

The game includes different cards using the same pictures from the book:

Warriors (CD4 cells), Weak Warriors (Weak CD4 cells), the HIV virus, Antiretroviral drugs and Opportunistic infections.

Together with the child, the cards are placed on a flat surface in the same way as described in the "Our Story" book, adding and removing cards as the health worker explains what happens to the immune system during HIV infection and the way in which ARVs help to make the immune system strong again.

The game can be made personal to each child's situation. For example, when placing the OI card in to the game, describe any OIs which the child has experienced.

When using the ARV card, describe the regimen the child will be taking or is already taking.

The idea is to have fun with the child and to give them a visual description of the way in which HIV is affecting him/her and the way in which adherence to ARVs can help him/her to control HIV and to become strong again. Ideally, the game is played with the caregiver present so that they then have a common way of talking about HIV and ARVs and this can be returned to each time they come to clinic. Providing the child with his/her own copy of "Our Story" book then means the child can refer back to the game and counselling session at any time, using the same explanations in the book.

We have found this game an extremely powerful tool for children, their caregivers and health workers. You can be as creative as you like....

...Have fun!!

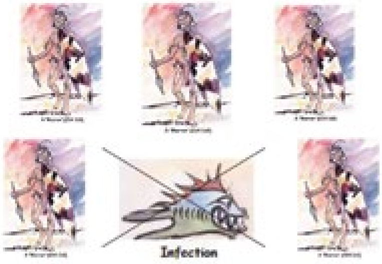
ART education: How to use the HIV and ART Counselling Card Game

The **immune system** is the part of the body which **protects** us from illnesses

The immune system is made up of different '**cells**' which work together to protect us from illness. They keep us **strong and healthy**.

These cells are found in the blood and in other parts of the body. They are small and cannot be seen with our eyes.

The scientific name for these cells is **CD4 cells**. We find it helpful to think of them like '**warriors**'. Some call them '**soldiers**'

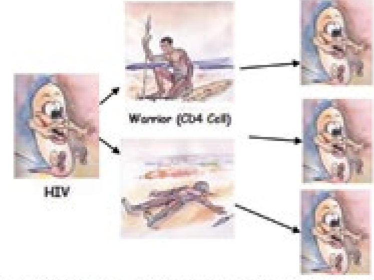


The warriors (or CD4 cells) work together to fight off infections and keep us **strong and healthy.**

If there are lots of strong warriors (CD4 cells) in the blood, the immune system is said to be strong

This means that the **body can fight** off infections

Strong warriors = Strong immune system



HIV is a **virus.** Viruses are germs. Some other well known viruses are flu or measles

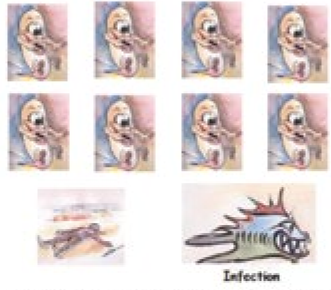
When HIV enters the human body, it uses the warriors (CD4 cells) to make more HIV

Over time, more and more HIV is made and the amount of HIV in the body increases

Unfortunately, when HIV uses the warrior (CD4 cells) to make more HIV, it also **damages the warriors.** The warriors become weak and few in number

Weak Warriors = Weak Immune System

ART education: How to use the HIV and ART Counselling Card Game



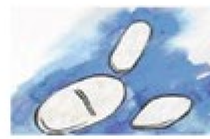
As time passes, the amount of HIV in the body becomes more. (HIGH VIRAL LOAD)

The number of warriors (CD4 cells) in the body becomes less (LOW CD4 count)

The Immune system therefore becomes weaker and weaker

When the immune system is weak, the body cannot fight off infections.

This is why people with HIV become sick



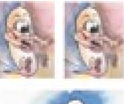
But there are now medicines which fight against HIV

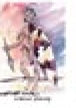
These are called Antiretroviral medicines (or ARVs)

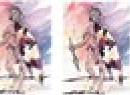
ARVs control the HIV virus, making it difficult for it to multiply

So the amount of HIV in the body becomes less.

When the viral load is so low that it cannot be seen in a blood test, it is UNDETECTABLE







With less HIV in the body, the warriors (CD4 cells) are therefore protected.

The number of strong CD4 cells increases

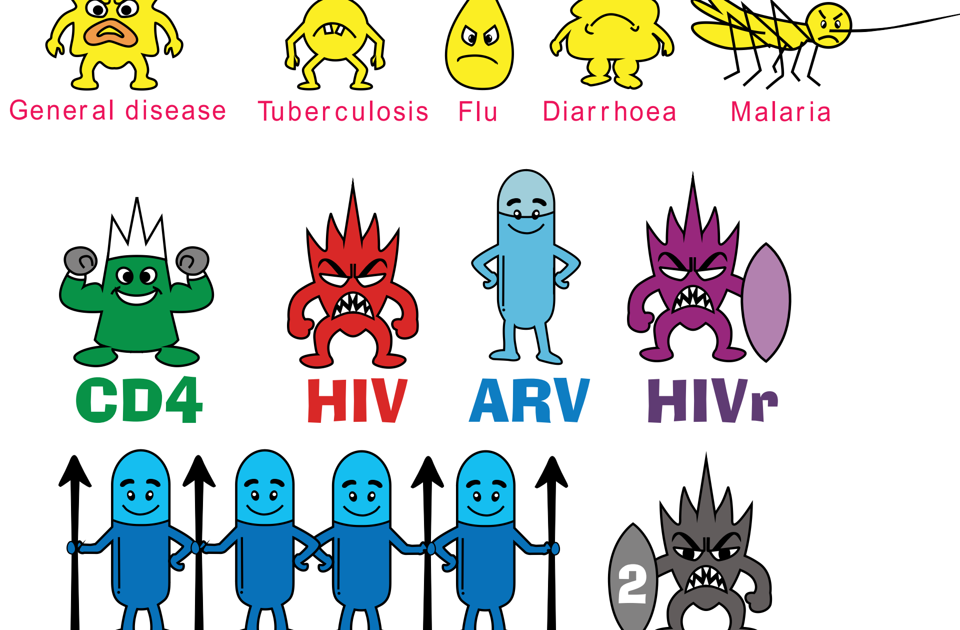
The immune system is stronger and it is possible to fight against infections again.

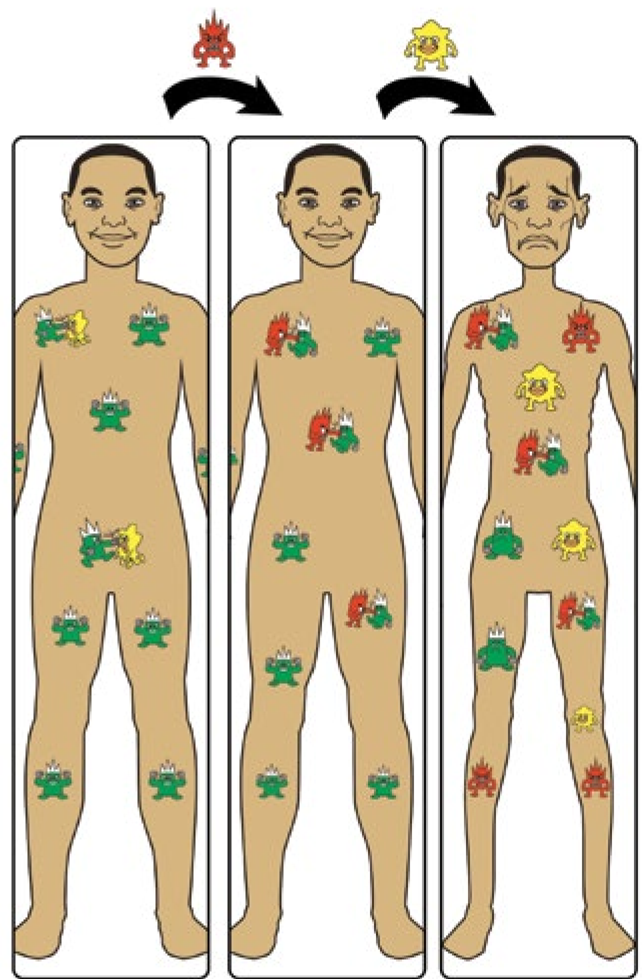
ARVs work very well but they are not a cure – they cannot remove HIV completely

You must adhere:

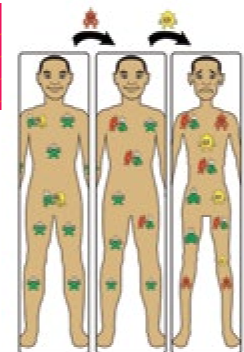
- Take every single dose
- At the right time
- For Life

Key to pictures in counselling tools

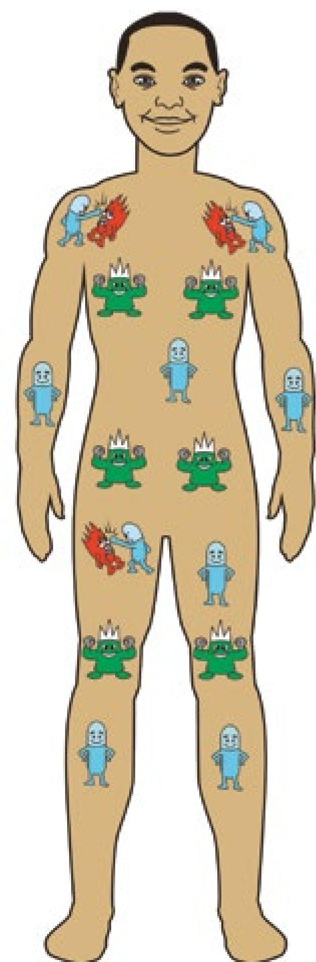




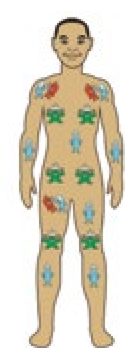
Basic HIV education



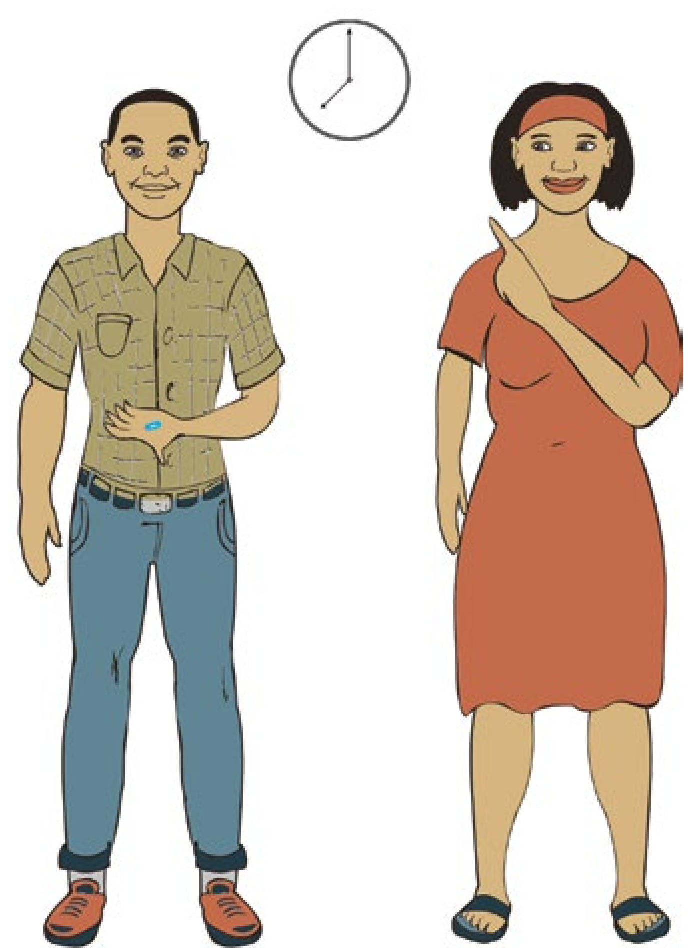
- **For each step, first assess client's initial knowledge.**
- **Health and diseases:** Diseases like TB, flu, malaria, HIV and others are caused by germs, bacteria and viruses. These diseases are your enemies and can make you sick.
- **CD4 and the immune system:** The CD4 (in green) are cells that live inside the blood and protect the body against diseases. They are like "soldiers" in your body fighting the diseases that are your enemies. All the CD4 cells together make up the army of your body. This army is your immune system.
- **What is HIV?** HIV (in red) is a virus that enters your body. It can enter your body when having sex, through the womb, through breast milk or through contaminated blood products or sharp objects, such as needles. The virus destroys the CD4 cells, meaning it destroys the soldiers that protect you.
- **The CD4 count:** The blood test you had/will have taken is called a CD4 count. This measures how strong the immune system is – how many soldiers are left in your army. Everyone now is eligible to start on medicine to treat HIV, but it is still useful for us to know how strong your immune system is.
- **Opportunistic infections:** When the HIV kills the CD4 cells, diseases can enter the body and make you sick. We call these opportunistic infections. The most frequent infection is tuberculosis.
- **The importance of starting early treatment:** Everyone is now eligible to start ART. We used to wait until the CD4 was 500, but now we know that there are benefits to starting earlier. Taking medication early helps prevent you getting infections and prevents transmission of HIV to others, including your baby if you are pregnant and your partner if they are HIV negative.
- **The importance of cotrimoxazole:** Cotrimoxazole is an antibiotic that acts on a number of infections that we might get if your CD4 count is low (i.e., your army is weak). Cotrimoxazole can reduce the risk of getting these infections. Cotrimoxazole does not act against HIV itself. Only ARVs can suppress the virus. Cotrimoxazole should be taken once a day. If you start cotrimoxazole you will continue to take it just the same as for ARVs. Cotrimoxazole can sometimes cause a rash. If you develop a rash, come back to the clinic immediately to be assessed by your clinician.
- **What's next?** Once you are diagnosed with HIV, you will be assessed to see if you are clinically and emotionally ready to start ART. Now we can talk about what antiretroviral therapy is if you are ready for this. **If this is too much today, we can schedule another session in the next few days.**



Basic ART education (1)

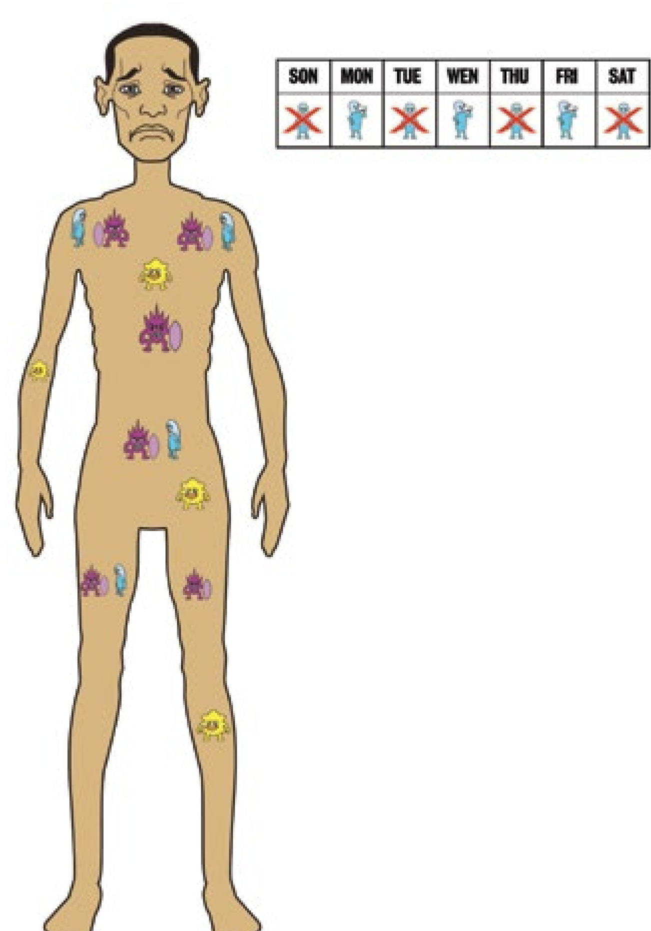


- **ARVS are drugs that stop the HIV multiplying:** When HIV stops making more viruses in our bodies, our CD4 cells can start to fight back and increase in numbers. Our army starts to get strong again and is able to fight off diseases. ARVs (in blue) do not kill all HIV in the body, but they knock the HIV virus out – making it sleep. This allows our army to gain strength.
- We need to take **3 different ARVs every day for the rest of our lives** to keep the HIV virus suppressed (asleep). Fortunately, we now have one pill that contains all three drugs that we need.
- **ARV medication is for life.** The better you take your medication, the healthier you will be. HIV-positive people who take their medication well live as long as people who are HIV negative.
- We monitor how your ARVs are working by seeing that you are more healthy and by monitoring the viral load test. If your treatment is working the viral load will be very low (less than 1000 copies/ml). This does not mean there is no more HIV in your body. It just means the ARVs are keeping the HIV under control.
- If viral load is not available we will take another CD4 test. If treatment is working well the CD4 count will increase.



Basic ART education (2)

- **The medication schedule:** ARVs must be taken every day as close to the same time as possible as the drugs only work for a certain number of hours. Most clients will need to take their treatment once a day. Some ARVs (including paediatric regimens) must be taken twice a day – every 12 hours. The client must choose the best time to take the medication according to their habits. If you are due to start ART, we will look at some simple tricks to remind you when to take your drugs.
- Make sure the client can name the drugs they are taking. This is important if the client travels and gets caught out without their medication or documentation.
- **Support system:** It can be a big help if you are able to disclose your status to someone. This person could help remind you to take your drugs, listen to your problems and also accompany you to the clinic if needed. Even if you have not disclosed, we will be able to start treatment, but we will continue to support you on this.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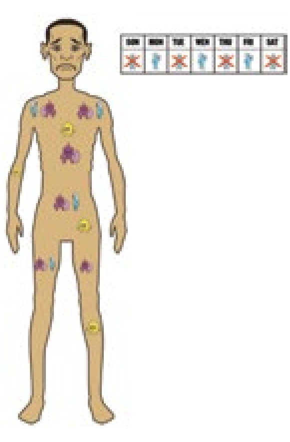
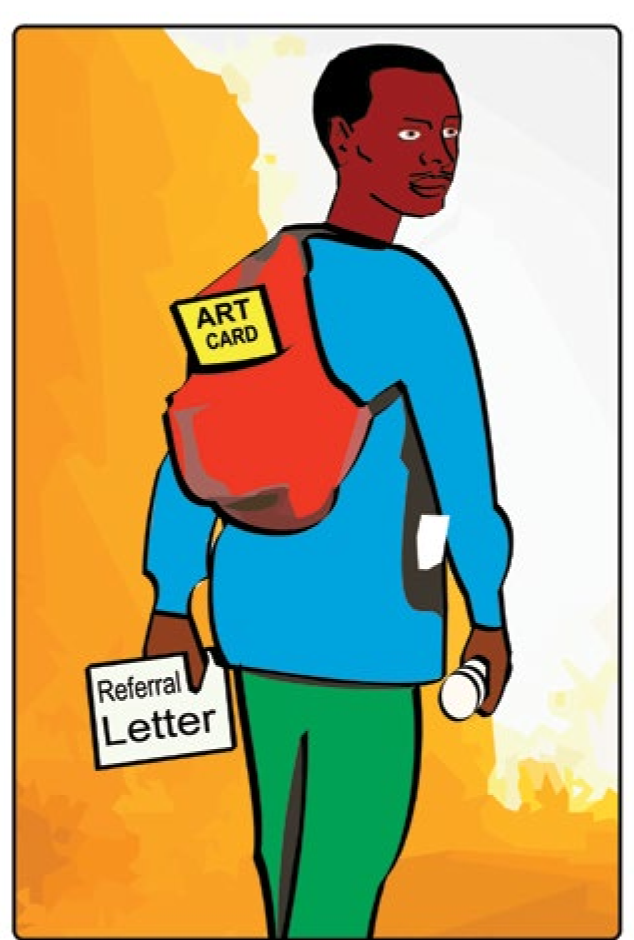
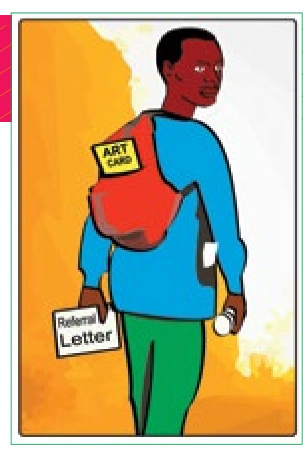
Basic ART education (3)



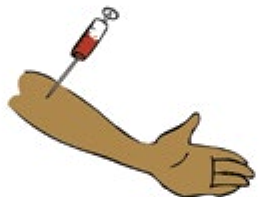
- **What is poor adherence to ART?** ARVS should be taken every day as close to the same time as possible. Poor adherence is when we take our pills late, when we forget to take a dose or when we don't take the pills at all. An example is if we stop the treatment because we are feeling better.
- **What happens if we don't adhere?** The virus becomes strong again and starts to battle against our CD4 cells (soldiers). If this goes on for long enough, we will start to get sick again and diseases come back (in yellow). Secondly, if we don't have a regular amount of the ARVs in our blood, the virus becomes clever and changes its form so that the drugs cannot work to suppress it any more (the purple virus in the picture) – this is known as resistance.
- **What side effects might you experience?** Many clients will have some slight side effects at the start of treatment. Most of these symptoms disappear within a few weeks of starting treatment.
- The **most common adult regimen** is TDF/3TC/EFV. It has a few but rare side effects, which normally disappear after a few weeks.
- **Rare side effects of TDF.** Though rare, the most serious side effect of TDF is kidney problems. Clients must report if they are passing little or no urine or develop ankle or facial oedema.
- **Side effects of EFV** include dizziness, insomnia, nightmares, depression, confusion and hallucinations. Rarely, EFV can cause skin rash and jaundice, which can be severe in some cases. If you develop skin rash, yellow eye or pain in the right upper side of the abdomen, you must come back to the clinic straight away. Side effects of EFV usually settle but if they are very bad or are persisting, please inform your clinician. Rarely EFV may also cause the breast tissue in men to enlarge. If you think this is happening please tell your clinician as soon as possible.

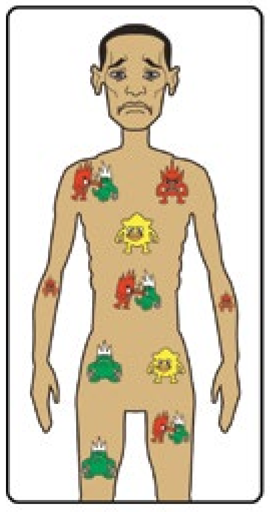

ART
CARD
Referral
Letter

Planning for travel

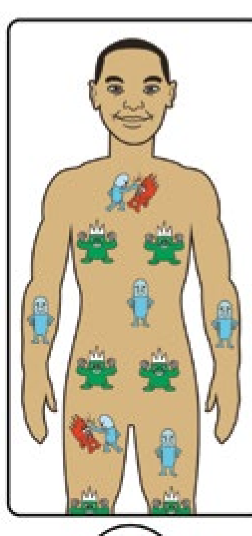


- It is important that you take your medication regularly every day.
- If you are planning to travel, please let us know.
- Your nurse can discuss whether it is possible to give you a longer drug supply or advise where you can access ARVs in the place you are travelling.
- Always take your patient notebook with you when you are travelling in case you need to access medical care while away.
- If you think you will be away for a long time, we will need to give you a transfer letter so that you can be registered at another facility.





High
viral load > 1000 copies/ml



Low or undetectable
viral load < 1000 copies/ml

Viral load testing

What is the goal of your ARV treatment?

When you take your ARVs every day, they stop your HIV multiplying (making more HIV in your body) and prevent HIV from killing your CD4 cells (the soldiers of your body). Therefore, when taking ARV's, the quantity of HIV in your body will decrease.

How to know if your ART treatment is working?

By doing a viral load test. A viral load test measures the amount of HIV in your blood and is done by drawing blood.

When to have a viral load test?

The first viral load will be taken at 6 months and then again after 1 year on treatment. After this the viral load will be taken once every year. If there is a problem with your viral load, it is taken again 3 months later. It is your right to know your viral load result! Ask your health care worker for the test and for your results.

What does a low or undetectable viral load result mean?

- A low or undetectable viral load is a viral load of less than 1000 copies/ml. It means that you have so little HIV in your blood, it can't be measured. This is because the multiplication of the virus has been stopped by the ARV treatment. An undetectable viral load in the blood does not mean you no longer have HIV it just means it can't be seen with the tests we have.
- You can compare taking ART to weeding the garden: when you weed the garden regularly (or adhere well to ART), there is hardly any weed to be seen (or no HIV to be seen – your viral load is low or undetectable). But from the moment you stop weeding the garden (or stop taking ART), the weed will pop up again (or HIV will multiply again). In the same way your viral load is undetectable when you adhere well to your treatment.
- A low or undetectable viral load is very good as it means you have your HIV under control. You should continue with your good adherence. You will now be seen less often by the clinician and will be offered easier ways to pick up your drugs.

What does a high viral load result mean?

- You may be facing problems to adhere to your treatment. This is the most common cause for a detectable viral load.
- By solving your adherence problems early, you can get your viral load to low or undetectable.
- In other cases, you could be adherent but you have already become resistant to your treatment.
- If the viral load is high on two tests (3 months apart) your clinician will discuss whether a new drug regimen is needed for you.

Choosing a refill option

Starting ART:

- When you have just started ART, you will be asked to come to the clinic regularly to see your nurse/doctor. This is so we can check you are well and you are not having any problems with your treatment.
- Once your viral load is low (<1000 copies/ml) you will be offered some options for how to collect your drugs in the future: Adapt the following locally according to whether VL or CD4 monitoring is available.
- Once you are well and your viral load is low, you will only need to see a clinician once a year. In between we will give you 3 monthly supplies of medication via one of the refill options we are running at our clinic.

Offer the options that have been selected for your particular site. Not all options will be available.

- FAST TRACK: This option is where you come yourself every 3 months to the clinic to collect your drugs straight from the pharmacy. You can also ask somebody you trust to pick up your drugs for you at the pharmacy, if you give them your patient book.
- CLUB refill: In our clinic we have formed groups of clients to collect their ART. We give the group a time to meet altogether so they can discuss issues and after this we give out the medications. The group meeting usually lasts up to an hour depending on the group. If you would like to see how this works you might like to visit one of our groups.
- CARGS: In our clinic groups of clients who live near each other have formed groups to help them collect their medication. Instead of all the clients coming every time to collect their refill they nominate a group member who collects the drugs for all the clients. If you would like I can ask a CARG member to tell you about this option
- OUTREACH: In our clinic we have a mobile team that visits certain hard to reach sites. If this site is near where you live this may make it easier to pick up your ART refill. Would you like to consider this option?
- FAMILY REFILL: In our clinic we give the option for family members who are all needing ART to collect medication refills for each other. Would this interest you?

When to report back to the clinic:

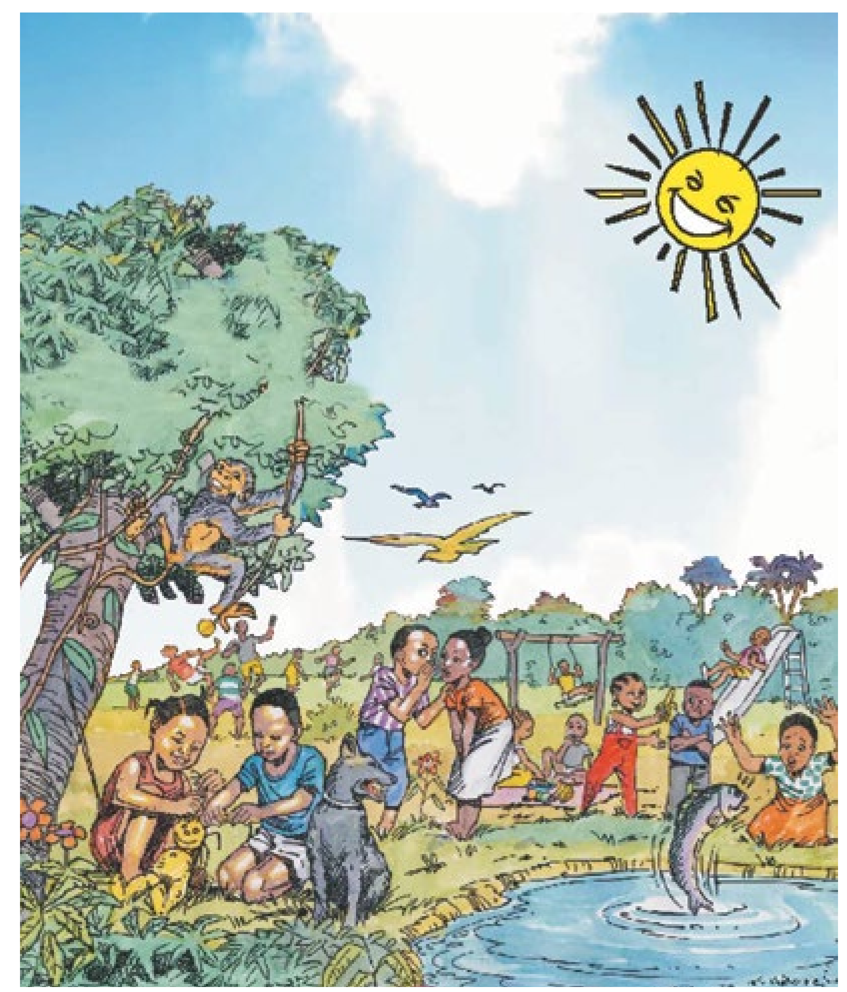
Whatever option you choose, there are a few important things to keep in mind:

- You must continue to see your clinician and have viral load done once a year
- When you have a health problem, you must always report to your clinic

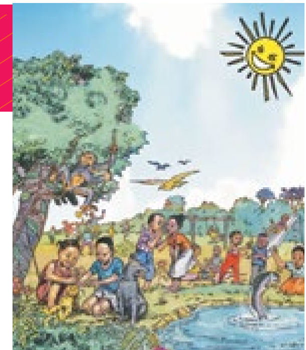
In the following cases you must report to the clinic as soon as possible:

- If you have a high viral load
- If you are pregnant
- If you have symptoms of TB like a chronic cough, tiredness, night sweats and weight loss
- If you have a severe headache that is not relieved with paracetamol
- If you have diarrhea that persists for more than one week
- If you are vomiting for more than 3 days
- If you develop a new rash
- If you develop any swelling of your feet/face or are unable to pass urine (if on TDF)
- If you have severe sleep disturbance or change in behaviour (if on EFV)
- If you have breathlessness or dizziness (if on AZT)

Once the problem or new situation has been addressed you will be able to return to your refill option.

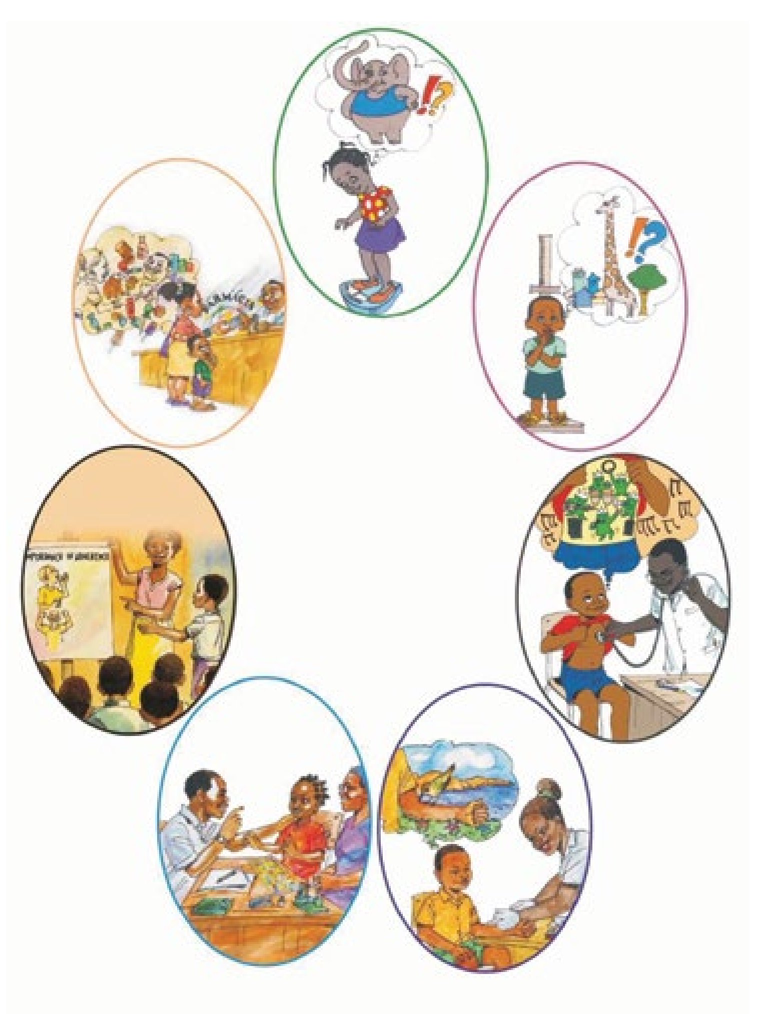


Partial disclosure – Session 1

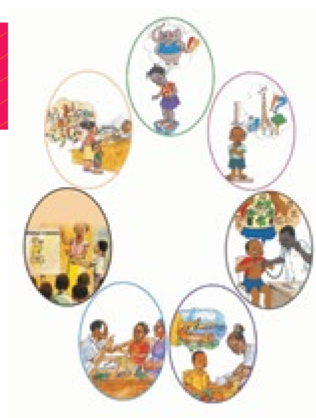


Do not name the virus as HIV in front of the child

- **Show the image to the child and discuss together what's happening in the picture.**
- **What games are the children playing?**
- **What food are they eating?**
- **What does the child/the counsellor think is the funniest image?**

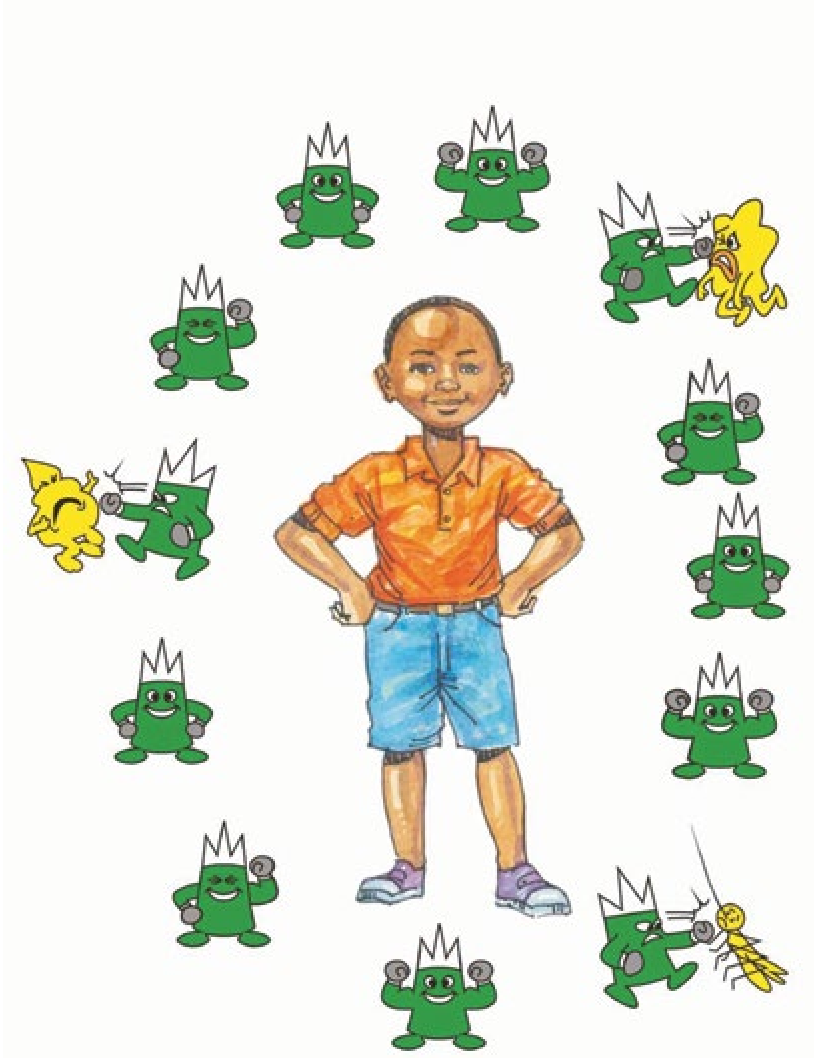


Partial disclosure – Session 1

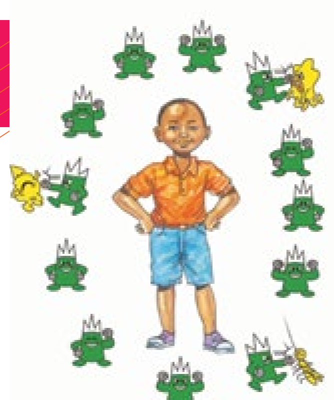


- Show the child the picture about "the visit to the hospital or clinic". Ask what they see in the picture.
- **Explain that when the child comes to the hospital, he/she has to pass though different steps:**

    1. getting **weighed** so we know if they are eating well and growing;
    2. seeing the nurse or doctor to make sure they are doing well;
    3. sometimes the laboratory or another nurse **collecting blood** in order to count the number of green soldiers in the blood or the number of the red attackers in the blood;
    4. the counsellor seeing how the treatment is going;
    5. and finally the **pharmacy** collecting the medicines that are making them strong.

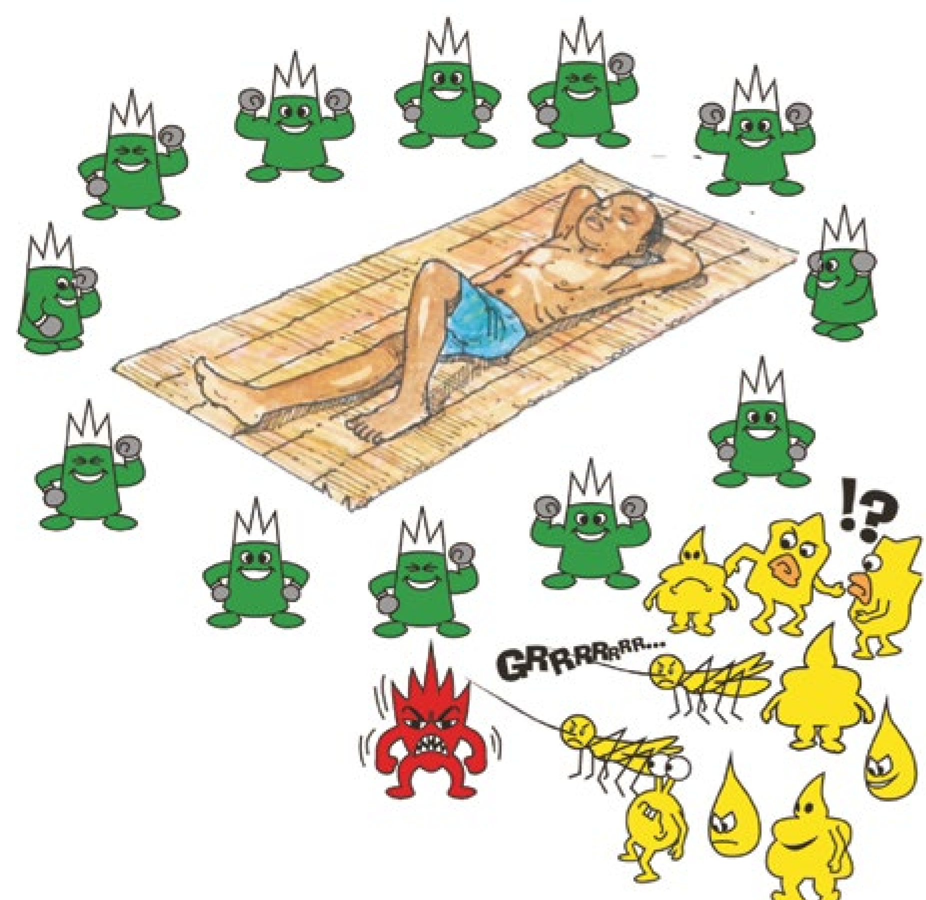


Partial disclosure – Session 1



The immune system: Ask what they see in the picture.

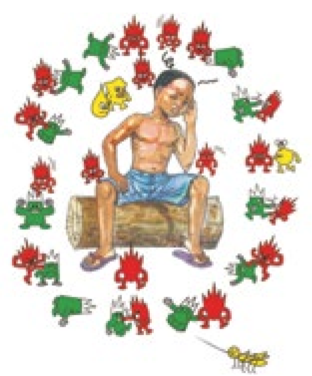
- Explain to the child that their body has green soldiers that protect them. These soldiers are always alert and on guard for any invasion. If a germ enters the blood to cause disease, the green soldiers will fight against it. When they do this, we will stay healthy.
- Allow the child to then draw a picture of themselves and their soldiers.


!?
GRRRRRRR...

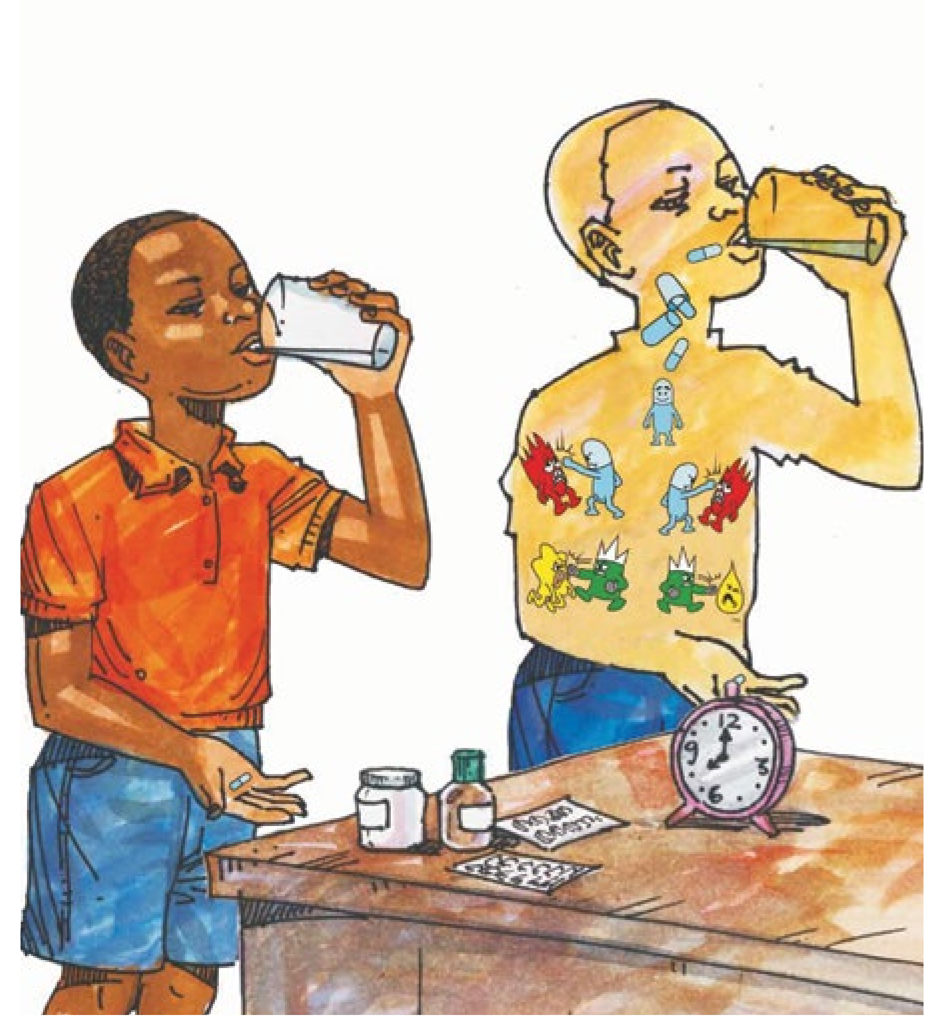
Partial disclosure – Session 2

- Let the child draw for a while to make them comfortable.
- See if they can tell you what they remember about the story of the green soldiers. Use the picture from partial disclosure Session 1 to recap.
- Ask what the child sees in the picture on this card.
- Explain to the child that the red germ is the one in their body and is different from the other yellow germs.
- Explain to the child that when the red germs enter the blood, they attack our green soldiers.
- When our soldiers cannot fight any more, we become sick.

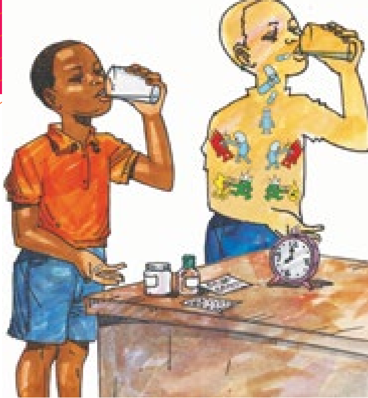
Partial disclosure – Session 2



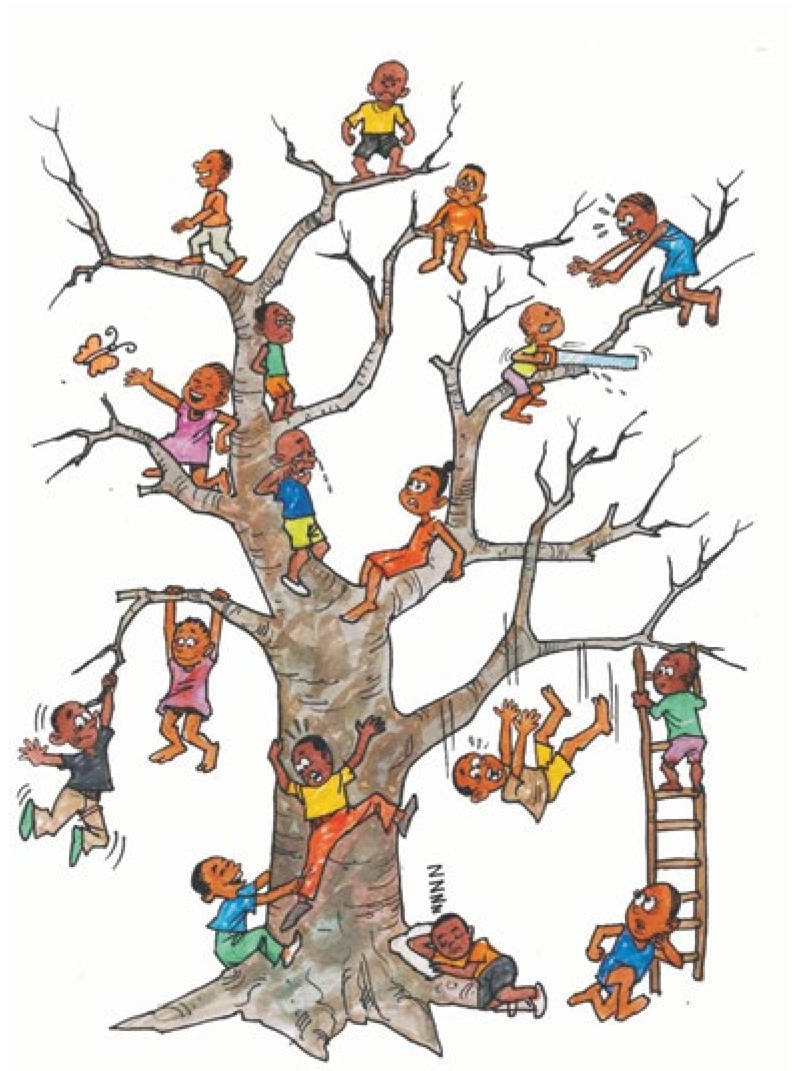
- Ask the child what they see in the picture.
- Explain that with time, the green soldiers became tired of fighting against the red germs who becomes stronger and stronger and the green soldiers start to disappear.
- When the green soldiers collapse and disappear, your body is unprotected and you start to feel bad. You might get headaches or lose weight.



Beginning the treatment



- Ask the child what they see in the picture.
- Explain to the child that these pills are the drugs they will need to take. They are a new type of soldier in the body that will help the green soldiers and fight the red germs.
- Explain that they are going to start (are taking) the medication to fight the red germs. When this happens, the green soldiers become strong again and can fight infection. When this happens, they will start to feel well again.
- Explain to the child that if he takes the pills every day at the right time, the new soldiers will make the red germs go to sleep.



Full disclosure session (full disclosure should be achieved at the latest by the age of 12)

- Explain to the child that the name of the red germ is HIV (if the caretaker agrees that you do so).
- Assess with the child and parent how they feel about knowing that the red germ is an illness called HIV (if the caretaker has named HIV at home).
- Review with the child their knowledge of the immune system, the infection with the red germ and how the medication is working (use the pictures from the previous partial disclosure sessions and give correct names, like CD4, ART, HIV).
- Explain ways of transmission to the child and review the family history.
- Discuss with the child and caretaker whom the child can trust and with whom they can talk about their HIV status.
- Ask the child to look at the picture on this card and point to the child that looks like how they are feeling.
- Explore these emotions with the child.

COUNSELLORS' ART initiation checklist

Assess readiness to start

- Ask patient what would be the 3 most important reasons for them stay healthy and alive
- Assess willingness to start ART

Recap knowledge of ART education session (Page 113, Job Aide).

- For each of the drugs, know the name, frequency and side effects that might occur
- Use of herbs: Why it's important to stick to ARVs as a treatment
- Why it is important to come on the review date given, and what to bring (all remaining medications)
- What to do in case of travel

Plan with patient how they will take the drugs:

- What would be best timing for you to take your drugs, taking into account your daily habits?
- What tools will you use to remind yourself to take your drugs (alarm, time you leave for school)?
- Where will you store your drugs?
- Where will you keep extra doses in case you are out of the house?
- How will you manage missed doses?
- What will you do in case of side effects?

Explain follow-up plans: At the beginning of ART treatment, your follow up will be quite intense (D14 if on NVP regimen or initiated on same day as testing, M1, M2, M3), but appointments will be more spaced out with time. We will discuss options for long-term follow up at later counselling sessions

Ask for their consent to be called or traced if they miss an appointment

Document your findings and refer to clinician

Enhanced adherence checklist

Use this checklist and make notes in both the patient care and treatment booklet and patient notebook

See page 79 OSDM for full session guides

Session 1

STEP 1: REVIEW EDUCATION

Viral load is: ___________________________________

High viral load is:_________________________________

Suppressed viral load is: ___________________________

STEP 2: PATIENT'S REASON FOR HIGH VL

STEP 3: REVIEW TIME MEDS TAKEN

Problem with time: ____________________________

Agreed upon time:______________________________

Late/missed doses: ____________________________

STEP 4: STORING MEDS/EXTRA DOSES

Usual storage place:____________________________

Emergency supply will be carried in:________________

STEP 5: MOTIVATION CARDS

Top 3 goals for the future:_________________________

Do you think your ARVs can help you achieve your goals for the future? Brainstorm places to put stickers & other reminders

STEP 6: PATIENT'S SUPPORT SYSTEM

Members of patient's support system

STEP 7: PLANNING FOR SUBSTANCE USE

Your plan to make sure you take your ARVs if you use alcohol or drugs

STEP 8: GETTING TO APPOINTMENTS

How do you get to clinic?________________________

Back-up plan to get to clinic_______________________

Not able to come on date _______________________

STEP 9: WAY FORWARD

Your VL will be repeated in 3 months_____(which month)

Next visit date (1mth-give 1mth ART):_______________

Session 2

STEP 1: DISCUSS ADHERENCE

DIFFICULTIES/PROBLEMS

Adherence difficulties___________________________

____

____

____

Problem solve ______________________________

____

____

____

STEP 2: CHALLENGES IN ADHERENCE

Thoughts to deal with mistakes AND learn from mistakes

____

____

STEP 3: PLANNING FOR TRIPS

Regular travel location__________________________

Remind patient to plan for enough treatment

STEP 4: REVIEW & PLAN A WAY FORWARD

Remind patient when VL will be repeated

Give 2 months' ART supply. (Next visit date for blood to be drawn for follow up VL; 2 months' time)

__________ ________________________________

(If further EAC needed, book sooner as needed)