CONSOLIDATED HIV AND AIDS
JOB AIDE

2022 EDITION

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 2023

January

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Calendar 2024

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Contacts

Service Area	Organisation	Contact Address	Contact Number

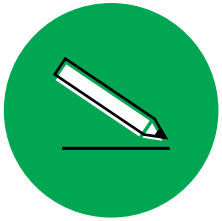
CONTENTS

HIV TESTING SERVICES (HTS)

Section contents:

All HTS counselling should adhere to the 6Cs:

COMFORT

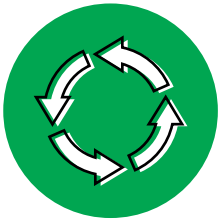


CONSENT

CORRECT AND ACCURATE HIV TEST RESULTS

CONFIDENTIALITY

COUNSELLING



CONNECTIONS TO HIV PREVENTION, TREATMENT, CARE AND SUPPORT SERVICES

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

CONSENT FOR PEOPLE WITH DISABILITIES

In the case of people with mental health concerns, regardless of age, a parent or caregiver 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

Adult HTS Pre-test checklist

	QUESTIONS	RESPONSES
1	**When was the last time you were tested for HIV?**	Ask the RoC when they last had an HIV test done. All RoCs who were tested less than three months before are ineligible for testing. See page 24 for frequency of re-testing.
	1a. If previously tested, what was the result?	If the RoC previously tested for HIV, ask them to state the results they obtained. Ask them if they have ever been on ART. If yes when did they start and stop treatment.
2	**If negative, do you consider yourself to be at risk of HIV?**	Document RoC self-perception of risk as categorized: not at all – 0; low – 1; medium – 2; and high – 3. NB: Offer HIV testing for all levels of risk (from low – 1 to high – 3).
	2a. If inconclusive	If the previous HIV test result was inconclusive and it's now 14 days or more, offer HIV testing as per the HTS algorithm.
3	**Do you have a sexual partner who tested HIV positive in the past 2 years?**	Find out if the RoC had sexual partner/s who tested positive for HIV in the past 2 years. If yes, the RoC is an index case contact and eligible for HIV testing.
4	**Have you experienced poor health in the past 3 months?**	Ask the RoC if they have been unwell and/or admitted to the hospital in the past 3 months and tick the appropriate box. Ill-health in the past 3 months includes presumptive TB symptoms, such as night sweats, chest pains, productive cough or coughing up blood lasting 2 weeks, loss of appetite, recent diagnosis with TB and unexplained weight loss of >10%.
5	**Have you experienced any symptoms or signs of an STI, such as urethral or vaginal discharge or genital sores?**	Ask the RoC if they have had any of the listed symptoms. Include genital itchiness, pain during urination or intercourse, rashes on the genital area, vaginal or urethral discharge, genital or anal sores, blisters or sores in or around the mouth, and lower abdominal pain.

Children and adolescents: HTS Pre-test checklist

The TB screening tool on page 138 should be carried out in combination with this tool.

PRE-TEST CHECKLIST FOR CHILDREN AND ADOLESCENTS		
For each child or adolescent (aged 5-15 years) attending the facility, ask the following questions and tick either YES or NO. All children under 5 years of age should be offered an HIV test.		
For children and adolescents aged 5-15 years, ask	**YES**	**NO**
1. Has the child ever been admitted to the hospital?		
2. Has the child had a recurring skin problem?		
3. Has one or both of the child's natural parents died?		
4. Has the child experienced poor health in the past 3 months?		
If the answer is YES to any 1 of the above questions, offer an HIV test.		
If the child or adolescent answers YES to any 1 of the above questions:		
1. Obtain consent • If the child or adolescent is above 16 years, ask for consent from the child or adolescent directly. • If the child is below 16 years, ask for consent for an HIV test from their parents or caregiver. • If the child or adolescent is an emancipated/mature minor (married, pregnant or a parent), ask for consent from the child or adolescent directly. • If it is in the best interest of the child to be tested for HIV, seek consent from the person in charge of the health facility. • If consent is declined, offer additional pre-test counselling and allow the child or adolescent to proceed to the services for which they attended the facility		
2. Conduct pre-test counselling with the child or adolescent and parent or caregiver.		
3. Conduct HIV test with child or adolescent.		
4. Determine HIV results • If the child or adolescent tests **NEGATIVE**, provide post-test counselling and referral to appropriate services. • If the child or adolescent tests **POSITIVE**, provide post-test-counselling, verify the test results, and initiate the process of enrolling the child or adolescent on ART.		
If the child or adolescent does not answer YES to any of the above questions:		
The child or adolescent proceeds to the services for which they attended the facility.		
If the child or adolescent answers YES to any of the above questions, but opts out of being tested for HIV:		
The child or adolescent has the right to proceed to the services for which they attended the facility. It is important to continue offering pre-test counselling and to discuss the matter further with the person in charge of the facility.		

Summary of provider initiated counselling and testing

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 (including option for HIVST)
- Disclosure and referral

PROVIDER USES AGE APPROPRIATE HIV TESTING SCREENING TOOL AND IF POSITIVE OFFERS HIV TEST OR HIV SELF TEST.

IF CLIENT OPTS IN HIV TEST PERFORMED OR OFFER HIVST*

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
- IPV and Mental health screening

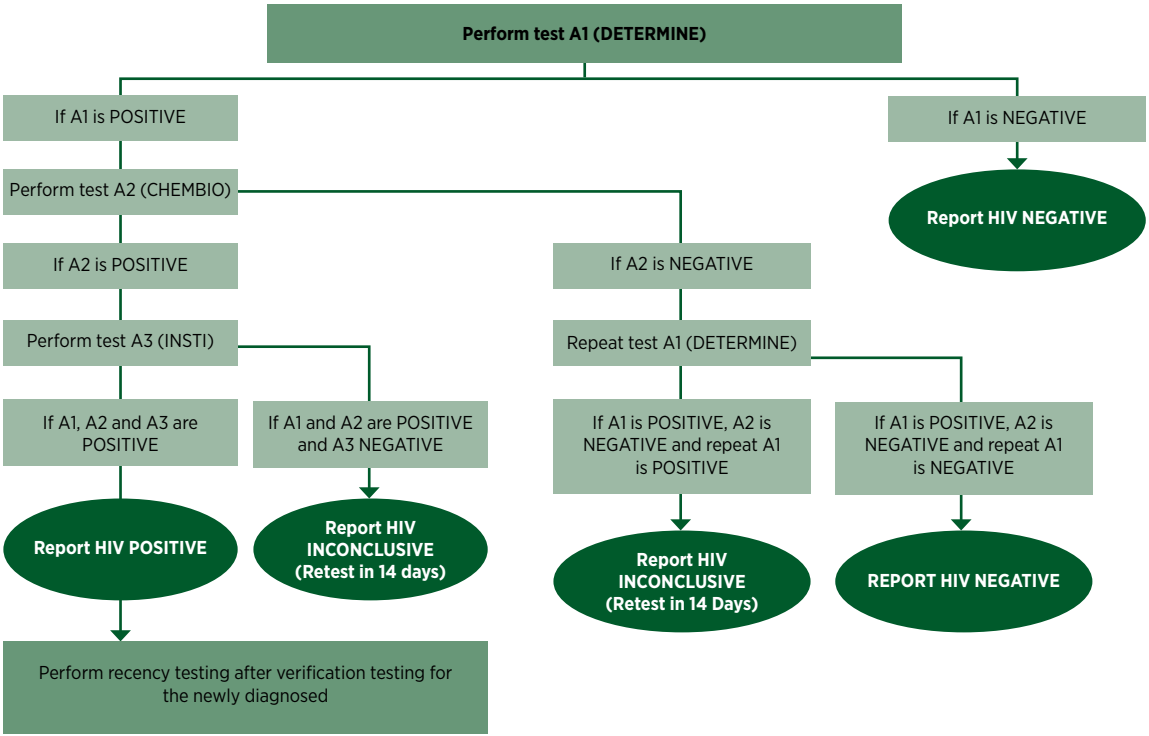
Emphasis is on "Support and Positive Living"

Subsequent health care visits

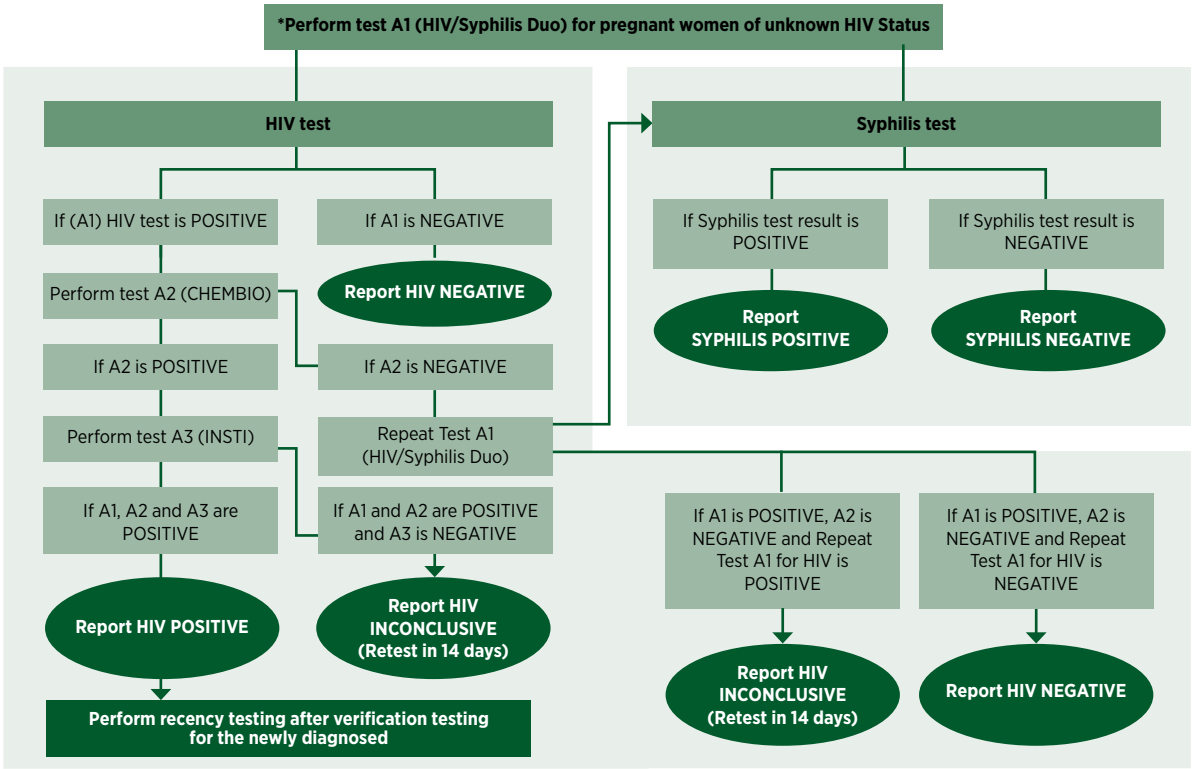
- Review post-test counselling messages, provide referrals. **Emphasis is on early treatment of OIs, early initiation of ART and positive living.**

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

HIV testing algorithm for general population >18 months

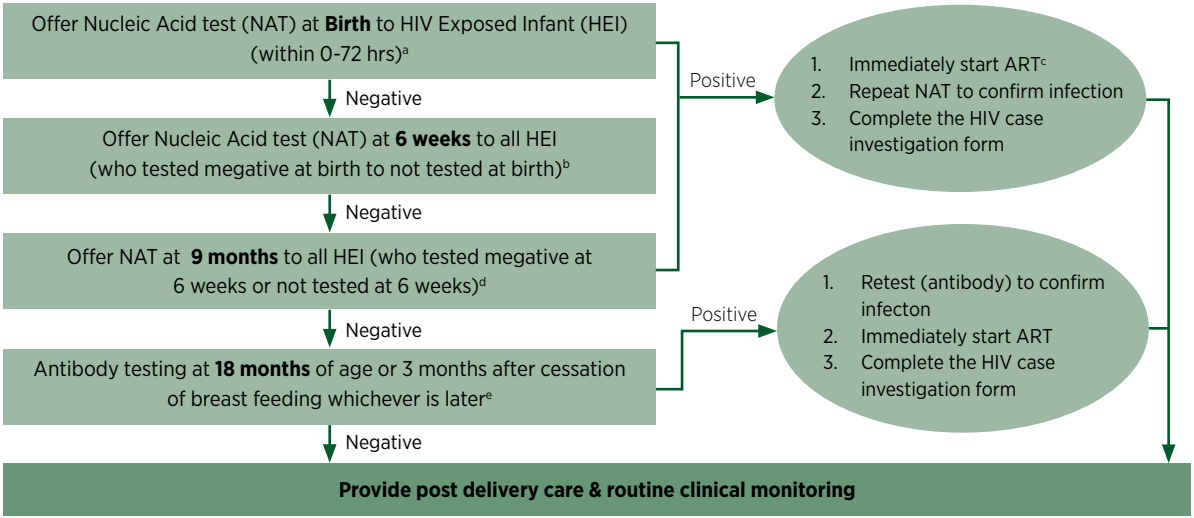


HIV and Syphilis testing algorithm: Pregnant women



Version 1 2021 *NB: Where HIV/Syphilis Duo test is not available, test for HIV using the HIV testing algorithm for the general population and test for syphilis using the separate syphilis rapid test kit. At any time when the syphilis test result is positive, treat for syphilis

Algorithm for Early Infant Diagnosis of HIV



[a] Point of care NAT can be used to diagnose HIV infection and to confirm a positive test

[b] Birth testing does not replace 6 weeks testing unless the infant tested positive at birth

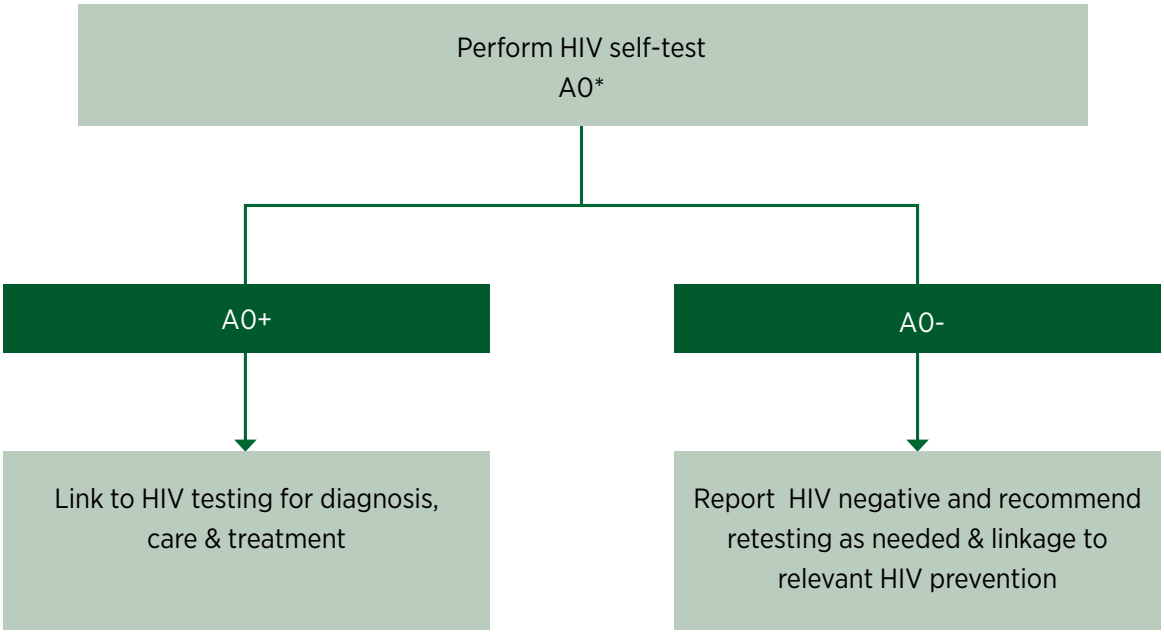
[c] Start ART without delay. If the second test to confirm an HIV positive result is negative, a third NAT should be done before interrupting ART

[d] NAT/DNA PCR is now routinely offered to HEI at 9 months

[e] If breast feeding extends beyond 18 months, the final diagnosis of HIV status can only be assessed at least 3 months after the end of breast feeding

NB Please note any HEI who presents to the health facility after 6 weeks and never been tested prior should be tested for HIV at the point of contact.

HIV self-testing algorithm



*A0 = the test to be performed

Source: WHO HTS guideline 2021

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 HIV self-test is a triaging test. It does not provide a final HIV diagnosis
Anyone who tests 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 importance of linkage for all self testers:
  - reactive testers for confirmatory testing, and
  - non-reactive testers for preventive services.
- The benefits of being on ART (emotional and physical)
- The benefits of VMMC and other prevention services

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.

Post test counselling following HIVST

HIV non-reactive result

- Affirm clients for sharing HIV self-test result
- Review how the client conducted the testing to ascertain proficiency and validity of result-a valid HIVST result conducted proficiently is interpreted as HIV negative with no need for further testing
- Risk assessment and reduction plan
- Disclosure and partner referral for HIV test
- Link to Post-test services
- Provide take – home information

Emphasis is on "Staying NEGATIVE"

HIV Reactive result

- Affirm clients for sharing HIV self-test result
- Review how the client conducted the testing to ascertain proficiency
- Discussion of Result; Ask about their experiences using the test and implication of results
- Any challenges using the test or interpreting the result
- Any incidences or risk of Intimate Partner Violence (IPV)
- Review basic facts on HIV
- Provide HIV Test according to national algorithm
- Referral to other support services
- Partner referral for HIV test and disclosure counselling

Key counselling messages: HIV negative pregnant and lactating women

Key action points

- Syphilis positive mothers to complete treatment and their exposed infants to be treated at birth
- Mother who book late (third trimester or unknown status in labour and delivery) should be tested at first contact and then retested at 14 weeks after delivery then after every six months
- Self-testing should be offered as an opt out option for the partners
- Offer PrEP to Pregnant and Lactating Women at substantial risk of contracting HIV

Time of presentation	Who to test and document	Key messages
First ANC Contact with HIV negative / unknown status (and Partner/s) N.B. Offer pre-test information (group/couple/individual). HIV test and individual couple post-test counselling	Offer PITC and conventional testing (Document in ANC booklet: in Notes section)	1. Importance of pregnant women and their partners • HIV • Syphilis 2. Basic facts on HIV (use counselling tools e.g. soldier game 3. Basic facts on EMTCT (mother to baby transmission in utero, delivery and breast feeding, importance of HIV testing, prevention and retesting algorithm for HIV negative mothers, treatment and care for the HIV positive mothers, partners and baby to be discuss for those testing HIV positive) 4. Basic facts about STIs and syphilis including relationship between STIs and HIV (Adverse outcome if not treated to mother and baby) • HIV: Negative, Positive & Inconclusive • Syphilis: Positive and negative 5. Explain testing procedure and meaning of results • HIV: Negative, Positive & Inconclusive • Syphilis: Positive and negative

Key counselling messages: HIV negative pregnant and lactating women

Time of presentation	Who to test and document	Key messages
First ANC Contact with HIV negative / unknown status (and Partner/s) N.B. Offer pre-test information (group/couple/individual). HIV test and individual couple post-test counselling	Offer PITC and conventional testing (Document in ANC booklet: in Notes section)	6. Referral and linkage • HIV positive: Retest for verification of HIV diagnosis • HIV negative: HIV Retesting at 32 weeks, 6 weeks post delivery and every 6 months during breast feeding • HIV inconclusive: Retest after 14 days • Syphilis: Treatment of positive mother and the infant at delivery 7. Disclosure, partner involvement (including partner testing) and secondary distribution of HIV self-test kit for partner (if available) 8. Risk assessment and reduction measures 9. Identify the risk reduction measure using counselling (eg. empty chair technique) and widen the system to ensure psychosocial support. 10. Offer routine focused ANC services
Subsequent ANC Visits	• At 32 weeks gestation or third trimester if tested in the first trimester. • At 6 weeks after delivery. • Every six months until cessation of breastfeeding	1. Affirm for coming and check on implementation of previous recommendations (see #8 First ANC Contact with HIV negative/unknown status (and Partners) • Disclosure and partner HIV testing • Partner syphilis testing and treatment if mother is HIV positive • Risk reduction e.g. condom use • 2. Affirm for decisions actioned and attend to unmet previous recommendations 3. Review basic facts and offer HIV retesting 4. Emphasize adoption of risk reduction behaviours 5. Revise risk reduction plan and way forward where necessary (e.g. condom use and negotiation skills, disclosure and partner testing) 6. Offer routine focused ANC services

Key counselling messages: Women testing HIV positive at booking and women booking already HIV Positive (But not yet on ART)

Time of presentation	Key messages
Women testing HIV positive at booking and women booking already HIV Positive (But not yet on ART)	**Rapid adherence counselling** Review basic facts about HIV and PMTCT – Book as soon as you know you are pregnant **Rational for starting ART** • Goals of ART and EMTCT • How to take the ARVs medicines • Use of a reminder tools e.g. alarm, watch • Importance of adherence and time • Importance of routine ANC contact • Common side effects of ARVs • Safe sex practices Discuss the importance of disclosure Discuss Male involvement (include Partner testing) Secondary distribution of HIV Self Testing kits for partners Explore client's concerns Help to develop support systems including identifying a treatment buddy and joining a support group Counsel on adherence and adherence on ART Syphilis and TB Screening

Key messages for discordant couples

Time of presentation	Key messages
Discordant couple	• If partner is negative and is exposed to ongoing risk, offer PrEP • Provide basic facts on Pre-Exposure Prophylaxis • Conduct individual risk assessment for eligibility • Provide further education and counselling for PrEP as a complement to existing HIV Prevention risk reduction strategies (e.g. correct and consistent use of condoms, voluntary medical male circumcision etc.) • Conduct further clinical assessment, syndromic STI screening or syphilis test (if available) • Once eligible, initiate client same day and counsel client on adherence, side effects, for PrEP to be effective • Client to receive a 30 day supply of oral PrEP medication at initiation • A 90 day supply at two subsequent clinic visits, re-test for HIV and provide additional adherence and risk reduction counselling • Commence HIV positive partner on ART • Counsel client to support partner in taking ARVs

Recommendations for Re-testing

POPULATION	RECOMMENDATION
General population not at ongoing risk	Offer re-testing at least annually.
Individuals with inconclusive HIV test results	Re-test after 14 days.
Individuals on PEP	Re-test at 3 months and 6 months after the initial test.
Individuals on PrEP	Re-test after every 3 months.
Key populations	Re-testing according to risk assessment (suggestion is for testing every 3 months)
HIV-negative pregnant women and lactating women	Re-test women who previously tested HIV negative in the first trimester of pregnancy and in the third trimester or at delivery. Re-test at 6 weeks postnatal and 6 monthly during the breastfeeding period. Visits to EPI and 6 weeks (DTP) and at 9 months (measles) should be time points where maternal HIV status is reassessed.
Individuals positive for HIV before initiation of ART	Verification testing to verify all people newly and previously diagnosed with HIV before they initiate ART. Verification 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 an hour apart and re-test.

SOP Index Case Testing

STEP 1

- RoC tests HIV positive and receives post test counselling.
- Ask the RoC to consent to partner and family testing.
- Elicit RoC's contacts and document in the ICT register and RoC OI/ART care booklet.

STEP 2

- List all sexual contacts and biological children below 15 years old on Page 5 of the RoC OI/ART care booklet.
- Screen each listed contact for IPV (physical, emotional, sexual, financial).
- Offer first-line support if there is an indication of IPV, refer as appropriate, and proceed with safe contact tracing modality.

STEP 3

- Ask the RoC about their preferred contact testing model (facility/community) and time frame.
- Ask the RoC to bring contacts (sexual partners, biological children below 15 years of age as guided by recency testing results where available) to the facility for testing or secondary distribution of HIVST kits.

NB: To avoid accidental disclosure, contacts should be contacted directly by the RoC or anonymously by the HCW.

STEP 4

- If contacts do not present for the appointment, initiate follow-up after 72 hours from the appointment date.
- If the RoC does not present for testing within 7 days from the date the index case was identified, offer community testing and reaffirm consent for community follow-up and trigger community-based index case testing.

STEP 5

- Perform community-based index case testing through one of these strategies:
  - Healthcare worker (facility staff/CBDA) outreach
  - Links with a community-based cadre who is trained to test. This may be through supervised use of HIV self-test kits
  - Giving the contact self-test kits for self-testing at a time they choose
  - Camouflage testing (anonymous)

Screening tool for intimate partner violence

Question	YES	NO
1. Has [partner's name] ever threatened to hurt you?		
2. Has [partner's name] ever hit, kicked, slapped, or otherwise physically hurt you?		
3. Has [partner's name] ever forced you to do something sexually that made you feel uncomfortable?		
4. Has your partner ever threatened you in other ways, such as divorce, desertion, lack of support, taking away access to your children, or other threats?		
5. Has your partner ever threatened to Kill you?		
6. Has your partner ever threatened to "out you" or reveal your sexual orientation, gender identity or status as a sex worker?		
7. Has your partner ever harm you on the basis of your sexual orientation, gender identity or status as a sex worker.		
If you answer yes to one question, provide first line support and refer to appropriate services		

DSD for HIV testing services

	MOBILIZING	HIV TESTING AND COUNSELLING	LINKING
WHEN	Initiate HTS at strategic points along each RoC's journey of healthcare at community or facility level. The mobilizer, provider or RoC should be able to determine at what point HTS is most relevant, such as ANC visits.	a. Frequency of HIV testing (see Table X) b. Timing of HIV testing (provide out-of-work hours; adapt for specific populations) c. Verification testing of newly diagnosed RoCs to verify status before linkage to ART d. Determined by recency testing	Same day as test or within 7 days, for both linkage to treatment and prevention Follow-up of untested contacts
WHERE	Demand creation and geographic location are determined by the following: • Recency and index testing • High prevalence of STIs and teenage pregnancies	HTS clinics, OPD, IPD STI, TB, immunization, malnutrition, ANC and PNC, FP clinics and all services for key populations Out-of-facility sites; youth centres; key population drop-in centres; identified hotspots Mobile outreach testing sites Workplaces Home	Link RoC to preferred ART or PrEP or other HIV prevention services (such as VMMC) Facility or community If tested in community, consider out-of-facility initiation (See section 2.4.3) PrEP should be integrated into priority sites where HTS is offered (e.g., STI clinics, FP, FCH, HTS, VMMC sites; see Section 2.3.2)
WHO	Healthcare workers; primary counsellors; community cadres, including CATS and key population peer supporters	Trained HIV testing service providers: healthcare workers, primary counsellors Community cadres, including CATS, key population peers and index clients can distribute HIV self-test kits. Client performing self-test	The same service provider who provides HIV testing should support linkage

DSD for HIV testing services

	MOBILIZING	HIV TESTING AND COUNSELLING	LINKING
WHAT	Address population-specific HTS knowledge gaps within the communities and facilities that are barriers to testing Address population-specific HTS knowledge gaps within the communities and facilities that are barriers to testing	HIV testing service package: 1. Screening for eligibility, and ensure RoC is not already on ART 2. Pre-test information giving 2.1 NB: Prepare couples for possible seroconcordant negative or positive and serodifferent results before testing 3. Conduct HIV test according to the current national HIV testing algorithm 3.1 Where HIVST is used, ensure private and confidential space and assist where necessary 4. Post-test counselling (NB: Use counselling principles, skills and techniques) 4.1 Deal with RoC's emotions 4.2 Risk assessment and risk reduction (demonstration and provision of condoms, Section 2.3.1, and empowerment with negotiation skills where necessary) 4.3 Link to HIV prevention and treatment services 4.4 Assess for intimate partner violence (Appendix 1) and refer accordingly 4.5 Mental health screening (see Section 2.7.5) and referral accordingly 5. For RoCs who are HIV positive 5.1 Re-test for verification of HIV diagnosis 5.2 Recency testing 5.3 Index contact testing 6. Secondary distribution of HIVST kits and Information giving	Service package provided for linkage to prevention services (if eligible) including: 1. Targeted prevention information and education 2. PrEP initiation or linkage support package (For example: Offer on-site same-day PrEP initiation, facility-based peer navigation; provide scheduled appointment [if same-day offer not accepted]; follow up after missed scheduled appointment) 3. VMMC linkage support package (For example: Refer to VMMC site; provide scheduled appointment; follow up after missed scheduled appointment) 4. Provision of condoms and lube and demonstration of use Service package provided for linkage to treatment 1. Assessment of AHD 2. Clinical and psychosocial readiness 3. Rapid initiation

HTS testing strategies for specific populations

	0-2 YEARS	2-4 YEARS	5-9 YEARS	10-14 YEARS	15-19 YEARS	20-24 YEARS	ADULTS	PREGNANT & REASTFEEDING WOMEN	KEY POPULATIONS
Facility-based All populations									
Community-based All populations but, in particular, focus resources on adolescents, young adults, key populations and men									
Index testing (HIV partner services and social network approaches)									

Model should be offered

Model not a priority for this population

Building blocks of HTS by population OSDM

	0-2 YEARS	2-4 YEARS	5-9 YEARS	10-14 YEARS	15-19 YEARS
WHEN FREQUENCY	Exposed infants according to EID algorithm Birth NAT 6 weeks NAT 9 months NAT 18 months or 12 weeks after cessation of breastfeeding; rapid test	Test if not previously tested and maternal status unknown or child not tested after cessation of breastfeeding; test in EPI Any symptomatic child or presenting with recurrent upper respiratory symptoms or ear infections Any child with TB Any child admitted or presenting with malnutrition	Any symptomatic child or presenting with recurrent upper respiratory symptoms or ear infections Any child with TB Any child admitted or presenting with malnutrition Asymptomatic; use paediatric pre-test checklist	Any symptomatic adolescent Any adolescent with STI or TB, or admitted Asymptomatic; use paediatric pre-test checklist to age of 15	Any symptomatic adolescent Any adolescent with STI or TB, or admitted Use age appropriate pre-test checklist
WHEN	Clinic opening hours	Clinic opening hours	Clinic opening hours After school, evenings, weekends and holidays	Clinic opening hours After school, evenings, weekends and holidays	Clinic opening hours After school, evenings, weekends and holidays
WHERE	FCH IPD PHC Outreach site	FCH IPD PHC Outreach site	FCH IPD PHC Outreach site	OPD, IPD, STI clinics, FP PHC Youth centres Community locations	OPD, IPD, STI clinics, FP PHC Youth centres Community locations
WHO	Nurse Primary counsellor	Nurse Primary counsellor	Nurse Primary counsellor	Nurse Primary counsellor	Nurse Primary counsellor From 16 years, clinic staff or CATS can distribute self-test kits at the facility or in the community for RoCs to perform assisted or unassisted tests
WHAT	Pre-test information and post-test counselling NAT testing (birth, 6 weeks, 9 months, then rapid tests)	Pre-test information and post-test counselling Provider-delivered test	Pre-test information and post-test counselling Provider-delivered test	Pre-test information and post-test counselling Provider-delivered test	Pre-test information and post-test counselling Provider-delivered test Distribution of self-test kits from age 16

Building blocks of HTS by population OSDM

	20-24 YEARS	ADULTS	PREGNANT & BREASTFEEDING WOMEN	KEY POPULATIONS
WHEN FREQUENCY	Any symptomatic young adult Any young adult with STI or TB or admitted Asymptomatic; refer frequency of re-testing (page 24)	Any symptomatic adult Any adult with STI or TB or admitted Asymptomatic; refer frequency of re-testing (page 24)	All pregnant and breastfeeding women with unknown status at booking In first trimester or 1st ANC visit; in 3rd trimester or at delivery; 6 weeks postnatal and 6 monthly postnatal; align testing with EPI visits (6 weeks DTP) or 14 weeks for those who tested in labour and 9 months (measles)	Re-test according to risk assessment; suggest 3 monthly
WHEN	Clinic opening hours After college, evenings, weekends and holidays	Clinic opening hours After college, evenings, weekends and holidays	Clinic opening hours 24 hours in maternity	Clinic opening hours Adapted hours for specific key populations
WHERE	OPD, IPD, STI clinics, FP PHC Youth centres Community locations	OPD, IPD, STI clinics, FP PHC Workplaces Community locations	FCH- ANC PNC Outreach ANC/PNC activities	OPD, IPD, STI clinics, FP PHC Agreed community locations, hotspots Key population drop-in centres
WHO	Nurse Primary counsellor Clinic staff or CATS can distribute self-test kits at the facility or in the community for RoCs to perform assisted or unassisted tests	Nurse Primary counsellor Clinic staff or community cadres can distribute self-tests at the facility or in the community for RoCs to perform assisted or unassisted tests	Nurse Primary counsellor Clinic staff or community cadres, including mother mentors, can distribute self-tests at the facility or in the community for RoCs to perform assisted or unassisted tests	Nurse Primary counsellor Clinic staff or key population peer supporters can distribute self-tests at the facility or in the community for RoCs to perform assisted or unassisted tests
WHAT	Pre-test information and post-test counselling Provider-delivered test Distribution of self-test kits	Pre-test information and post-test counselling Provider-delivered test Distribution of self-test kits	Pre-test information and post-test counselling Provider-delivered test Distribution of self-test kits from age 16	Pre-test information and post-test counselling Provider-delivered test Distribution of self-test kits from age 16

Building blocks for linkage to prevention and treatment

	WHEN	WHERE	WHO	WHAT
To prevention	Offer linkage on the same day as a negative HIV test Link within 7 days of a negative HIV test	Link from testing site to prevention site Facility-based PrEP initiation Community-based PrEP initiation (see Section 2.3)	HCW or lay cadre performing the HIV test links to prevention	Physical escort where appropriate Follow up through SMS or telehealth Use the MoHCC referral form Service package provided for linkage to prevention services (PrEP, PEP, VMMC, SRH, FP)
To treatment	Offer linkage on the same day as a positive HIV test Link within 7 days of a positive HIV test	Link from testing site to treatment site Facility-based ART initiation (hospital, PHC) Out of facility ART initiation (See Section 2.4.3)	HCW or lay cadre performing the HIV test links to treatment	Physical escort where appropriate Use MoHCC referral form in the community and where services are not provided on site Referrer should follow up RoC in 2 weeks to ensure they have linked to care
Referral to post-GBV services **Facilities should have a directory where clients identified to be at risk or experiencing IPV can be referred for services**	Immediately after identifying risk of IPV	Linkage from testing site to referral site	HCW or lay cadre who has administered screening	Physical escort where appropriate Use MoHCC referral form in the community and where services are not provided on site
Referral to mental health Services	Immediately after mental health screening as per the stepped care referral pathway (see Section 2.7.5)	Linkage from testing site to referral site	HCW or lay cadre who has administered screening	Physical escort where appropriate Use MoHCC referral form in the community and where services are not provided on site

PREVENTION

Section contents:

How to use male and female condoms

MALE	FEMALE
1. Ensure packet is intact. 2. Check expiry date. 3. Carefully open and remove condom from package – do not use teeth or any sharp object. 4. Make sure condom will unroll from the correct side. 5. Squeeze air out of the tip of condom. 6. Place condom on erect penis. 7. Roll condom down the penis. 8. Smooth out air bubbles. 9. Add additional lubricant if required and if available. 10. With condom on, insert erect penis for intercourse. 11. After ejaculation, hold on to condom at base of penis. 12. Withdraw penis while still erect. 13. Remove condom from penis. 14. Dispose of condom safely (burn/bin toilet). **Please note:** • Do not use oil-based lubricants on latex condoms. • Use one condom at a time. • Use once only and discard.	1. Ensure packet is intact. 2. Check expiry date. 3. Spread lubrication. 4. Find notch on top right and tear downwards. 5. Remove condom from pack. 6. Grasp condom with one hand and squeeze inner ring with thumb and fingers of other hand to form a point. 7. Choose a position that you are comfortable with: • Squatting • Sitting at edge of bed/chair/toilet seat • Placing one foot on a chair or toilet seat • Lying on your back 8. Separate lips of vagina. 9. Gently insert ring into vagina. 10. Place index finger inside condom and push ring as far as it will go. 11. When ready, gently guide partner's penis into condom (he could do it also). 12. After use, when ready to remove, twist outer ring and gently remove condom before standing. 13. Do not reuse. 14. Place in packet or wrap in paper and throw in garbage. **Please note:** • You can use oil- or water-based lubricants with FC2. • Use one condom at a time. • You put on the condom just before sex. • Remember the one wearing the condom is the one condomizing.

DSD Building blocks for condom and lube distribution

WHEN

Clinic opening hours – any interaction with health system (e.g., HTS, STI screening, FP, OPD services)

Any time from private pharmacies or community distributors or through community pick-up points

WHO

Healthcare workers

Community-based distributors
(FP community distributors, VHWs, CATS, peer supporters)

WHAT

Male and female condoms
Lubricants
Demonstration models for male and female condoms

WHERE

Facility

At any interaction with health service (e.g., HTS, STI screening, OI/ART services, PrEP services, FP, youth centres, OPD services, inpatient services, FCH services, bathrooms and toilets)

Out of facility

During any community-based HTS, EPI outreach

Integrated into mobile and out-of-facility activities

ART refill sites

Strategic community distribution points

Where they can be accessed for free:

- Beerhalls
- Nightclubs
- Filling stations
- Tuckshops
- Tertiary institutions

Where they can be bought:

- Supermarkets
- Pharmacies

Pre-Exposure Prophylaxis (PrEP): What is PrEP?

- PrEP is the use of antiretroviral medicines by HIV-negative individuals at substantial risk of getting HIV to reduce the risk of acquisition of HIV infection.
- PrEP is not for life and is taken during period of HIV exposure
- To be effective PrEP needs high levels of adherence and regular (3 monthly) HIV testing
- Should be used in combination with male and female condoms
- PrEP does NOT
  - Prevent STIs
  - Prevent pregnancy
  - Protect an individual after an exposure to HIV

APPROVED AND AVAILABLE

Oral Pre-Exposure Prophylaxis (PrEP).
A pill that greatly reduces the risk of HIV when taken prior to exposure. The pill contains two ARVs (TDF plus FTC or 3TC)
that can be taken every day for the period of risk or intermittently according to risk exposure
(only for men).

APPROVED, BUT LIMITED TO DEMONSTRATION SITES

Dapivirine Ring
This is a silicone ring that is inserted into the vagina and used continuously for 28 days to slowly release the ARV dapivirine.

Long-acting injectable PrEP
Long acting cabotegravir is an injectable form of PrEP which is given every 2 months.

IN DEVELOPMENT

Other long-acting oral, injectable and implant PrEP formulations

Dual prevention pills and rings for contraception and PrEP

Oral PrEP

Regimen	Medicine	Dosage	Duration
Preferred	TDF (300mg) plus FTC (200mg)	Fixed dose combination one tablet once a day	Period of substantial risk
Alternative	TDF (300mg) plus 3TC (300mg)	Fixed dose combination one tablet once a day	Period of substantial risk

Dapivirine ring

- The Dapivirine vaginal ring is a flexible silicone device containing Dapivirine a NNRTI
- The ring should be continuously worn for 28 days, including during menses and then replaced with a new ring
- The ring must be worn for 24 hours before it is effective
- The ring should be used in combination with other prevention interventions
- HIV testing is required before the dapivirine ring is offered and then repeated every three months
- Stored at room temperature and therefore three month prescription of rings may be provided

Cabotegravir - Long Acting

- CAB-LA is given as an intramuscular (IM) injection.
- It belongs to the class of Integrase Strand Transfer Inhibitors (INSTI).
- The current approved dose range is 600mg every 8 weeks for adults.
- Patients starting CAB-LA for the first time may be started with a 30mg oral tablet taken daily for 4 weeks and then are given the CAB-LA 600mg as a loading dose after the 4 weeks. This is to ensure tolerability.

Who is eligible for PrEP?

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 (high-risk groups such as diabetics or those with uncontrolled hypertension should have blood creatinine tested before initiation) (not applicable for DVR)

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?

Renal Monitoring for PrEP (lack of access should not prevent PrEP use)

- Any individual with a result ≥60 mL/min can safely be prescribed oral PrEP.
- Since results can be reviewed at a follow-up visit, waiting for results should not delay oral PrEP initiation.
- If the results are <60 mL/min, the test should be repeated on a separate day before stopping oral PrEP, and oral PrEP should be stopped if the result of the repeat test is abnormal.
- Oral PrEP can be restarted if results are confirmed to be ≥60 mL/min within one to three months after stopping medicines.

Population(s)	Initiation Screening	Follow-up Screening
Individuals 29 years and younger with no kidney-related comorbidities	Optional	If not conducted or if baseline test is normal, follow-up is optional until 30 years of age or if kidney-related comorbidities develop. If conducted, and baseline test result is <90 mL/min, conduct follow-up screening every six to 12 months, if available.
Individuals 30–49 years with no kidney-related comorbidities	Conduct once within one to three months of oral PrEP initiation, if available.	If baseline test is normal, further screening is optional until 50 years of age or if kidney-related comorbidities develop. If baseline test result is <90 mL/min, conduct follow-up screening every six to 12 months, if available.
Individuals 50 years and older Individuals of any age with kidney-related comorbidities Individuals with previous creatinine screening of <90 mL/min	Conduct once within one to three months of oral PrEP initiation, if available	Conduct follow-up screening every six to 12 months, if available.

Follow up Schedule for PrEP

Intervention	Schedule following PrEP initiation
Confirmation of HIV negative status	Every 3 months
Address side effects	Every visit
Provide STI screening, condoms, contraception, or safer conception services	At every visit
Counselling regarding effective PrEP use (adherence), prevention of sexually transmitted infections, recognition of symptoms of sexually transmitted infections, and issues related to mental health, intimate partner violence, and substance use and HIV risk assessment	Every visit
Where available	
Hepatitis C antibody	Consider testing MSM every 12 months. Incident HCV infections have been reported among PrEP users who deny injection drug use

Follow Up Counselling for PreP

- Reasons for ongoing monitoring while on PrEP
- How to recognize symptoms of acute HIV infection
- Side effects &side effects management
- Facilitators and barriers of PrEP use
- How to safely discontinue and restart PrEP
- Dosing requirements for highest protection
- What to do if a dose is missed
- Adherence strategies
- Current context of sexual health and protection strategies (condoms, etc.)
- Assessment of continued risk of HIV and continuing need for PrEP
- Explore support system
- Assess for IPV

DSD building blocks for PrEP

	MOBILIZATION FOR PREP	RISK SCREENING	INITIATION
WHEN	During consultations at the identified health service delivery points During outreach activities, including those for adolescents and young adults, key populations During HTS group and individual counselling, including in ANC	Immediately after receiving a negative HIV test	Same day as negative test or within 7 days
WHERE	Adolescent and young adult services and clubs ANC and PNC clinics Key population outreach sites STI clinics Family planning clinics Drop-in centres for key populations Facility-based HIV testing sites OI/ART department OPD IPD Cervical cancer services VMMC	All facility or out-of-facility HTS sites PrEP should be initiated in ANC and PNC	Same site as HTS where possible (facility or out of facility where HCW present) OPD and IPD PrEP should be initiated in ANC and PNC
WHO	Nurse Primary counsellors CATS Key population peer supporters	Nurse Primary counsellor	Doctor Nurse
WHAT	Education on what, why and how of PrEP	Risk assessment tool Linkage to combination prevention, including PrEP	Clinical assessment and baseline investigations (see clinical guidelines) 1-month PrEP refill Assess pregnancy status and offer FP or referral

DSD building blocks for PrEP

	MONTH 1 FOLLOW-UP	MONTH 3 FOLLOW-UP	MONTH 6 AND 3 MONTHLY THEREAFTER IF ONGOING EXPOSURE
WHEN	Yes	Yes	Yes 3 monthly Adapted times for key populations to access PrEP
WHERE	Same site as HTS where possible (facility or community where HCW present) OPD and IPD PrEP should be followed up in ANC and PNC	Same site as HTS where possible (facility or community where HCW present) OPD and IPD PrEP should be followed up in ANC and PNC	Same site as HTS where possible (facility or community where HCW present) OPD and IPD
WHO	Doctor Nurse Primary counsellor (HTS) Review side effects	Doctor Nurse Primary counsellor (HTS) Review side effects	Doctor Nurse Primary counsellor (HTS)
WHAT	Review side-effects and adherence 2-month PrEP refill Assess pregnancy status and offer FP or referral	HTS Review side-effects and adherence 3-month PrEP refill Assess pregnancy status and offer FP or referral	HTS Review side effects and adherence 3-month PrEP refill Assess pregnancy status and offer FP or referral

DSD building blocks for providing PrEP to pregnant and breastfeeding women

WHEN

Aligned with ANC and PNC appointments

WHERE

Same room as ANC and PNC services delivered

FP services

WHO

Same midwife as ANC and PNC
Same HCW as FP

WHAT

Daily oral PrEP
Condoms and lubricant

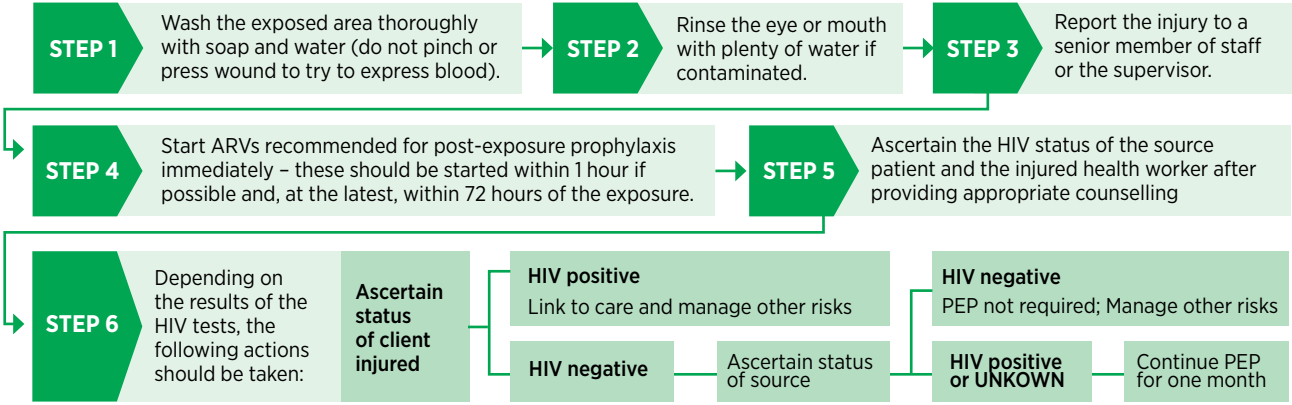
Stopping and starting oral PrEP

POPULATION(S)	STARTING ORAL PrEP	STOPPING ORAL PrEP
People using oral PrEP to prevent HIV acquisition from non-sexual exposures People assigned female at birth People assigned male at birth who are using oestradiol-based exogenous hormones	Take a single dose daily for seven days before potential exposure.	Take a single dose daily for 7 days after last potential exposure.
People assigned male at birth using PrEP to prevent HIV acquisition during sex who are not using oestradiol-based exogenous hormones (those taking ED-PrEP)	**ED-PrEP:** Take a double dose two to 24 hours before potential sexual exposure (for those intending to use ED-PrEP). Ideally, this loading dose should be taken closer to 24 hours before potential exposure. **Daily oral PrEP:** Take a single dose daily for seven days before potential exposure.	**ED-PrEP:** Take a single dose daily for two days after the last potential exposure. **Daily oral PrEP:** Take a single dose daily for 7 days after last potential exposure.

Post-Exposure Prophylaxis (PEP): 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)**
- High risk unprotected sexual encounters with an HIV positive, virally unsuppressed person, unknown HIV status.



- 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.

ARVs for PEP

Adults (Daily for 1 month)

- Tenofovir 300mg

Plus

- Lamivudine 300mg

Plus

- Dolutegravir 50mg

Children (Daily for 1 month)

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

Voluntary Male Medical 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 15 years and uncircumcised
- Must not have any contraindications, such as haemophilia, keloids, bleeding, hypospadias or epispadias and others

NB: Clients with adhesions should be referred to a doctor for circumcision

- Should provide a signed consent for the procedure and if under 18 the guardian should sign the consent.
- HIV testing remains part of the VMMC programme however all clients should be screened using the HTS screening tool and those eligible offered testing. Clients who request testing must still be offered the service. If tested record results in the relevant clinical records with status of those not tested being recorded as unknown
- 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
- Male circumcision does not replace other interventions to prevent heterosexual transmission of HIV, but provides an additional strategy.
- **Emphasise on key messages:**
  - **MC offers only partial protection and has to be used together with other prevention methods**
  - **Abstain from sexual activity for 6weeks(surgical)and 7 weeks(device)**
  - **Avoid application of any medicines and home remedies on the wound**
- Discuss HIV and demonstrate male and female condom use
- Explain surgical and device procedures
- **Discuss importance of review dates:**
  - **Surgical: Day 2, 7 and 42**
  - **Device: Day 7, 14 and 49**
- Explain modes of review- physical, telehealth e,g 2Way texting
- Refer adolescents to the nearest youth centre or organisation(s) for ASRH information and services

ENSURE PRIVACY AND CONFIDENTIALITY

General wound care

- Keep the 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
- 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

Specific for surgical VMMC

- 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 saline water twice a day after bandage removal
- Stitches should not be removed as they will dissolve on their own
- Do not rub the wound when drying but just dab

Specific device wound care - Device in situ

- Showering and bathing are recommended, though the client should dry the area afterward, and keep the penis and genitalia clean and dry while the ShangRing is in place
- Do not touch the device
- Client to return to facility for device removal at day 7
- Take analgesics as prescribed at the facility
- Client to contact facility if any unusual symptoms

Post device removal care

- Sexual abstinence is essential until the wound is healed (average 7 weeks, up to 9–10 weeks)
- If a client resumes sexual intercourse before then, wear a condom to protect the healing wound and prevent HIV transmission
- WHO recommends that condoms be used to protect the wound for at least six months after male circumcision, even after it appears that the wound is completely healed
- Showering and bathing are recommended, though the client should dry the area afterward, and keep his penis and genitalia clean and dry while the ShangRing is in place
- Wash and dry the circumcision area with clean water after passing urine
- Do not use home remedies on the wound, such as salt water, soil, ashes, or animal dung, and do not apply ointment or cream unless it has been given to him by the provider who performed the circumcision

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

DSD Building blocks of VMMC

WHEN

Procedure

Services provided every working day from static sites, outreach and mobile site

Every working day from static sites

Outreach and mobile sites during periods of high demand

Outreach sites may be visited 2-3 times per month

Mobile sites may be set up for a one-week period and then change location

Follow-up

Days 2, 7 and 42 for surgical procedure

Days 7, 14 and 49 with device circumcision

WHERE

Procedure

Static model using approved private and public health facilities

Outreach model using approved health facilities that do not routinely offer VMMC

Mobile site using tents and caravans in hard-to-reach areas

Follow-up

May be carried out face to face or through telehealth, e.g., using two-way texting

WHO

VMMC team:

Static site: two trained circumcisers, two nurse assistants, one theatre assistant and one receptionist

Outreach and mobile model: one trained circumciser, three nurses, one theatre assistant, one receptionist and one driver

WHAT

Giving health information

HIV risk assessment

HTS (optional)

Risk assessment for wound infection

Screening and management of social vulnerability

Screening for co-morbidities, STIs, haemophilia

Physical examination

Surgical or non-surgical circumcision (ShangRing)

Post-procedure counselling

Follow-up – days 2, 7, 14 and 42

Adverse event surveillance, management and reporting

ANTIRETROVIRAL THERAPY

Section contents:

First line ART regimens

ADULTS AND ADOLESCENTS INCLUDING PREGNANT AND BREASTFEEDING WOMEN

Adults and adolescents including pregnant and breastfeeding women

- The preferred first line is
- **TDF 300mg + 3TC 300mg + DTG 50mg**
- TB patients on Rifampicin to receive DTG 50mg twice daily
- ABC/3TC/DTG may be administered to patients weighing at least 20kg
- TAF may substitute TDF as part of alternative 1st line regimen
- AZT/3TC backbone may be used in special circumstances (for example where TDF is contraindicated and TAF is unavailable)

Population	Preferred 1st line regimen	Alternative 1st line regimen
Adults and adolescents including women of childbearing potential	TDF + 3TC + DTG (Once daily FDC) (TLD1)	TDF (TAF) + 3TC (FTC) + EFV 400 TDF (TAF) + 3TC (FTC) + ATV/r ABC (AZT) + 3TC + DTG (EFV400)

CHILDREN AND NEONATES

	Neonates (0 to 4 weeks of age)	Children (>4 weeks of age)
Preferred	AZT+3TC+RAL	ABC+3TC+DTG
Alternatives	AZT+3TC+NVP	ABC+3TC+LPV/r
Special circumstances	AZT+3TC+LPV/r*	ABC+3TC+EFV AZT+3TC+LPV

* LPV/r can be used from 2 weeks of age

ARV dosing for neonates 0-4 weeks

RECOMMENDED DAILY DOSING								
			2-<3kg		3-<4kg		4-<5kg	
Drug	**Strength**		**AM**	**PM**	**AM**	**PM**	**AM**	**PM**
AZT	10mg/ml		1ml	1ml	1.5ml	1.5ml	2ml	2ml
3TC	10mg/ml		0.5ml	0.5ml	0.8ml	0.8ml	1ml	1ml
AZT/3TC	60/30 dispersible tablets		-	-	1 tablet	1 tablet	1 tablet	1 tablet
RAL	10mg/ml (oral granules for suspension: 100mg/sachet	< 1 week	0.4ml once daily		0.5ml once daily		0.7ml once daily	
		>1 week	0.8ml	0.8ml	1ml	1ml	1.5ml	1.5ml

ARV dosing for children from 4 weeks for DTG-based regimens

RECOMMENDED DAILY DOSING							
Formulation	**3 – 5.9 kg**	**6 – 9.9 kg**	**10 – 13.9 kg**	**14 – 19.9 kg**	**20 – 24.9 kg**	**25 – 29.9 kg**	**≥ 30 kg**
ABC/3TC 120/60mg scored dispersible tablet	1	1.5	2	2.5	3	-	-
DTG 10mg scored dispersible tablet	0.5	1.5	2	2.5	[transition to DTG 50mg]*	-	-
ABC/3TC 600/300 mg tablet	-	-	-	-	-	1	-
DTG 50 mg tablet	-	-	-	-	1	1	[transition to TLD]
TDF/3TC/DTG 300/300/50 mg tablet	-	-	-	-	-	-	1

ARV Dosing ABC, 3TC and LPV/r

RECOMMENDED DAILY DOSING															
		3 – 5.9 kg		6 – 9.9 kg		10 – 13.9 kg		14 – 19.9 kg		20 – 24.9 kg		25 – 29.9 kg		≥ 30 kg	
Drug	**Strength**	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**	**AM**	**PM**
ABC/ 3TC	120 mg/ 60mg tablet	0.5	0.5	0.5	1	1	1	1	1.5	3		Adult 600/300*		TLD	
	60mg/ 30mg tablet	1	1	1.5	1.5	2	2	2.5	2.5	6					
LPV/r Granules	40mg/ 10mg sachet	2	2	3	3	4	4	5	5	DTG 50mg					
LPV/r tablets	100mg/ 25mg tablet	-	-	-	-	2	1	2	2						

Second and third line regimens

ADULTS AND ADOLESCENTS INCLUDING PREGNANT AND BREASTFEEDING WOMEN

Failing 1st line regimen	Preferred 2nd line regimen	Alternative 2nd line regimen
TDF (or TAF) + 3TC + DTG or ABC + 3TC -F DTG	AZT + 3TC+ ATV/r	AZT +3TC +LPV/r (or DRV/r)
TDF (or TAF) +3TC (or FTC) + ATV/r TDF (or TAF) + 3TC (or FTC) + EFV	AZT + 3TC + DTG	AZT +3TC +LPV/r (or DRV/r)
AZT +3TC (or FTC) + EFV	TDF (or TAF) + 3TC (or FTC) + DTG	TDF (or TAF) + 3TC (or FTC) + ATV/r (or DRV/r)
1st line Regimen	**2nd line Regimen**	**3rd line Regimen**
Two NRTIs + DTG	Two NRTIs + ATV/r (or LPV/r or DRV/r)	DRV/r + 1–2 NRTIs + DTG* Optimize the regimen using a genotype profile
Two NRTIs + EFV	Two NRTIs + DTG (or ATV/r or LPV/r or DRV/r)	Two NRTIs + (ATV/r, DRV/r or LPV/r) + DTG* Optimize the regimen using a genotype profile

CHILDREN

- DRV/r cannot be used for children younger than three years
- DTG dose must be doubled when used in Integrase Inhibitor experienced patient

First-line ART regimen	Second-line ART regimen	Third-line ART regimen
Two NRTIs + DTG	Two NRTIs + LPV/r (or ATV/r)	DRV/r + 1–2 NRTIs + DTG Optimize the regimen using a genotype profile for children younger than three years
Two NRTIs + LPV/r	Two NRTIs + DTG	DRV/r + 1–2 NRTIs + DTG Optimize the regimen using a genotype profile for children younger than three years
Two NRTIs + NNRTI	Two NRTIs + DTG	Two NRTIs + (ATV/r, LPV/r or DRV/r + DTG

ARVS: Drug interactions

ARV Medicine	Key Interaction	Suggested Management
DTG	Rifampicin	Double the daily dose of DTG by giving it twice daily (50mg 12 hourly in adults). Continue with twice daily dosing of DTG for 2 weeks after use of rifampicin has ended
	Metformin	Avoid high-dose metformin with DTG; Maximum daily dose of Metformin is 1gram
	Polyvalent cation products containing Mg, Al, Fe, Ca, and Zn. Multivitamins supplements	Use DTG at least two hours before or at least six hours after supplements
	Carbamazepine	Double the dose of DTG
	Phenobarbitone / Phenytoin	Use alternative anticonvulsant
	Amodiaquine	Use alternative anti-malarial
EFV	EFV may lower the efficacy of some long-acting hormonal contraceptives	Use alternative or additional contraceptive methods e.g., Condoms
Boosted PIs (ATV, LPV and DRV/r)	Hormonal contraceptives	Use alternative or additional contraceptive methods
	Rifampicin	Substitute PI with appropriately dose adjusted DTG. If available, substitute rifampicin with rifabutin
	TDF	Monitor renal function

ARV interactions with TB medications

ART Regimen	What to do when TB treatment is started
DTG based regimen	DTG dose is doubled (Should be taken 12hrly)
LPV/r regimen	Transition to DTG-based regimen (with appropriate dose adjustment) is preferable, and if not possible, LPV/r dose is doubled
ATV/r regimen	Change of regimen needed: replace ATV/r with DTG if DTG naïve (with appropriate dose adjustment) with LPV/r if DTG experienced with appropriate dose adjustment
TAF-containing regimen	Change of regimen needed: TAF to be replaced by ABC or TDF
DRV/r-based regimen	Change of regimen needed: replace DRV/r with DTG if DTG naive, with LPV/r if DTG experienced with appropriate dose adjustment. For patient on third line ART, substitute rifampicin with rifabutin
EFV-400 based regimen	No dose adjustment is necessary

Baseline investigations

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

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 for diagnosis of AHD**
- **CrAg and LAM if CD4 < 200 cells/mm³**
- **Syphilis testing for pregnant women**
- **Viral hepatitis screening subject to availability**

Timing of starting ART

Rapid Initiation

- All clients who are HIV positive are eligible to start ART.
- Rapid initiation should be offered after steps 1-4, outlined below, have been assessed.
- Same day ART should be offered but if the client is not ready, the goal should be to initiate all clients within seven days.

Reasons for delay

A patient may be deferred (delayed) from starting therapy if the patient

- has cryptococcal meningitis (defer for4-6 weeks)
- needs further psychosocial counselling (e.g., for substance use),
- Is being investigated for TB, aim to start ART 2 weeks after TB treatment
- has TB Meningitis (defer starting ART for at least a month)
- needs further information on HIV and AIDS,
- is terminally ill and unable to swallow oral medication (palliative care is then offered to such a patient).

4 steps of Differentiated ART initiation

STEP 1

HIV and ART education

Give basic HIV and ART education

STEP 2

Clinical readiness
clinical history, examination and investigation

Clinically ready, asymptomatic and no AHD

Clinically NOT ready
Symptomatic or AHD 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

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 primary counsellor, village health worker, CATS or key population peer supporter

Aim to start within one week of diagnosis

Out of facility Initiation

Definition

Out-of-facility ART initiation is when a RoC who tests positive is initiated on ART outside the facility.

Who can perform out-of-facility initiation

Out-of-facility initiation can be performed by the following cadres: doctors, clinical officers or nurses.

Who can be initiated out of the facility

Any RoC regardless of age who tests positive may be initiated at an out-of-facility site if:

- The healthcare worker is trained to initiate ART.
- The setting provides space for privacy to perform history taking and examination.
- Weight can be accurately assessed for children.

What must be carried out during out-of-facility initiation

- The RoC must have Steps 1-4 (JA page 68) assessed as per the standard ART initiation procedure.
- During the counselling, explore in a non-judgemental way any prior ART use. If there is prior ART, go to the re-engagement algorithm (Page 94).
- Assessment of advanced HIV disease: POC CD4 (LAM and CrAg where possible) should be offered at the community location to identify advanced HIV to differentiate the initial follow-up schedule. Where this is not possible: if the RoC is asymptomatic, the baseline CD4 may be performed at month one when linked to the nearest facility; if the RoC is seriously unwell or if blood CrAg is positive, refer them to the appropriate facility for further investigation.
- If the RoC has TB symptoms, a sputum sample should be collected and follow-up at the facility of the RoC's choice should be arranged within one week. If LAM testing is indicated, available and positive, initiate TB treatment and notify the RoC according to standard protocols. Still collect a sputum sample for Xpert MTB/Rif testing. Provide two weeks of treatment and book follow-up at the facility of choice for the RoC.
- For those without TB symptoms, one month of ART should be provided and the RoC should be linked to the facility of their choice for the follow-up visit.
- The same standard or intensive follow-up schedule for the first six months should be followed according to the process set out (pages 95-99)

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 (see follow up schedule), 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 verified 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 (CrAg and TB-LAM if CD4 < 200 cells /mm3) 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

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 and anxiety
- 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 (ART, cotrimoxazole and other integrated medications) 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.

MONITORING ART

Section contents:

ARV Toxicity

ARV	Major types of toxicity	Risk Factors	Suggested Management
ABC	Hypersensitivity reaction	Presence of HLA-B*5701 gene	Substitute AZT or TDF.
AZT	Anaemia, neutropaenia	Baseline anaemia orneutropaenia CD4 cell count of ≤200 cells/mm3	Substitute TDF or ABC
	Lactic acidosis or severe hepatomegaly with steatosis Lipoatrophy lipodystrophy Myopathy	BMI >25 (or body weight >75 kg) Prolonged exposure to NRTIs	Substitute TDF or ABC
TDF	Chronic kidney disease Acute kidney injury and Fanconi syndrome	Underlying renal disease Older than 50 years old BMI <18.5 or low body weight (<50 kg), notably among women Untreated diabetes Untreated hypertension Concomitant use of nephrotoxic drugs or a boosted PI	Substitute AZT or ABC or TAF
TAF	Body weight gain Dyslipidemia	Female sex Concomitant use of DTG	Monitor body weight and promote anti-obesity measures (Such as diet, physical exercise). If significant increase despite measures, consider substituting with ABC/ AZT or TDF
DTG	Hepatotoxicity Hypersensitivity reactions	Coinfection with hepatitis B or C Liver disease	Substitute another therapeutic class: EFV or boosted PIs

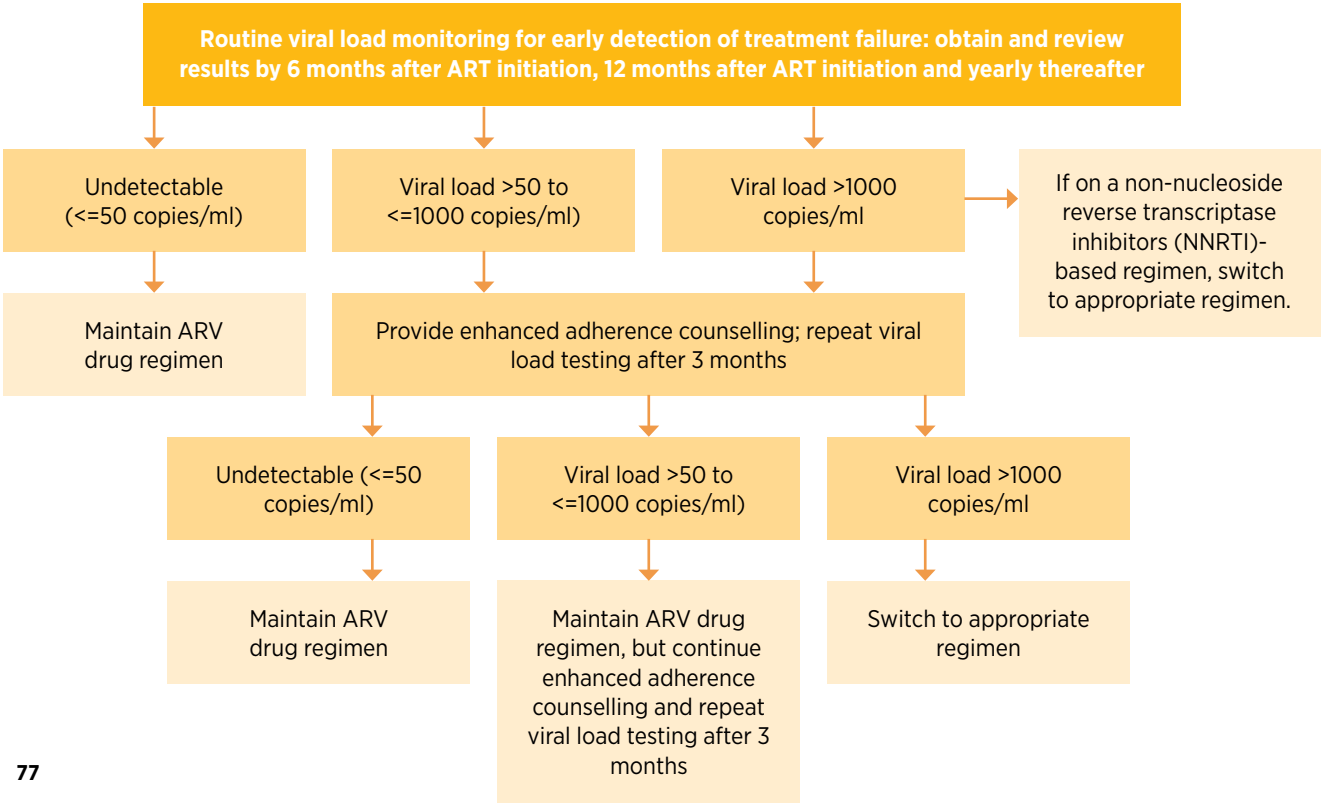
ARV Toxicity

ARV	Major types of toxicity	Risk Factors	Suggested Management
DTG	Insomnia Body weight gain or obesity	Older than 60 years Low CD4 or high viral load Female African ethnicity Concomitant use of TAF	Consider morning dose or substitute EFV, boosted PI or RAL Monitor body weight and promote anti-obesity measures (such as diet and physical exercise). If significant increase despite measures, consider substituting EFV or boosted PI
EFV	Persistent central nervous system toxicity (Such as dizziness, insomnia and abnormal dreams) or mental symptoms (anxiety, depression and mental confusion)	Depression or other mental disorder (previous or at baseline) Daytime dosing	For central nervous system symptoms, dosing at bedtime. EFV 400 mg/day is recommended or an DTG if EFV 400 mg is not effective at reducing symptoms
	Hepatotoxicity	Underlying hepatic disease Coinfection with hepatitis B or C Concomitant use of hepatotoxic drugs	For severe hepatotoxicity or hypersensitivity reactions, substitute another therapeutic class (INSTIs or boosted PIs)
	Gynaecomastia	Risk factors unknown	Substitute another therapeutic class (INSTIs or boosted PIs)
ATV/r	Indirect hyperbilirubinaemia (Clinical jaundice)	Presence of UDPglucuronosyltransferase 1-1 enzyme (UGT1A1*28 gene)	This phenomenon is clinically benign but potentially stigmatizing. Substitute only if adherence is compromised.
DRV/r	Hepatotoxicity	Underlying hepatic disease Coinfection with hepatitis Bor C Concomitant use of hepatotoxic drugs	Substitute with ATV/r or LPV/r. When it is used in third-line ART, limited options are available

Definitions of Treatment Failure

Virological failure	Viral load greater than 1,000 copies/ml based on two consecutive VL measurements after 3 months with enhanced adherence counselling. ART switch after first viral load >1,000 copies/mL for those receiving NNRTI-based regimens
Immunological failure	**Children** Younger than 5years – Persistent CD4 level below 200cells/ mm3 Older than 5 years – Persistent CD4 levels below 100 cells/mm3 **Adults and adolescents** CD4 count below 200 cells/mm3 following clinical Failure or persistent CD4 levels below 100cells/mm
Clinical failure	**Children** New or recurrent clinical event indicating advanced or severe immunodeficiency (WHO stage 3 and 4 clinical conditions with exception of TB after 6 months of effective treatment **Adults and Adolescents** New or recurrent clinical event indicating severe immunodeficiency (WHO stage 4 clinical condition) after 6 months of effective treatment

Viral Load Algorithm



DSD building blocks for taking VL

	WHEN	WHERE	WHO	WHAT	LINK WITH DSD FOR ROCS ESTABLISHED-ON-TREATMENT MODEL
TAKING VL	General population and children: month six after initiation, month 12 after initiation, and annually Pregnant and breastfeeding women newly initiated on ART: month three after initiation; women already on ART at first ANC visit All women at gestational weeks 34-36: three months after delivery and then six monthly	Facility Out of facility	Nurse Primary counsellor (DBS)	Plasma or DBS sample POC, where available, for priority groups* Centralized testing (flag priority groups as urgent on request form)	In group models, align members' annual VLs

Priority groups include children and adolescents, pregnant and breastfeeding women, and RoCs with advanced HIV disease or who need a repeat VL after previous low-level viraemia or unsuppressed VL.

DSD building blocks for managing high VL

	WHAT	WHEN	WHERE	WHO
Documentation	Enter VL result into RoC OI/ART care booklet	As soon as possible after VL result delivery	Facility	Doctor Nurse
History and examination	Screen for TB and identify any staging conditions	As soon as possible after VL result delivery	Facility	Doctor Nurse
CD4	>50 to ≤1000 copies/ml: No (unless clinically unwell – Stage 3 or 4 condition identified) >1000 copies/ml: Yes	As soon as possible after VL result delivery	Facility	Nurse Primary counsellor Laboratory technician/ scientist/ microscopist
Refill	RoC keeps refills in hand if already dispensed at annual visit. If RoC needs refills, discuss duration. If distance and cost for additional visits are challenges, consider community-based or telehealth EAC 2 and provide 3-monthly refills.	At first EAC	Facility	Doctor Nurse
EAC 1	Open EAC form (Page 13 of RoC OI/ ART care booklet) EAC 1 (Page 81-85); face to face	As soon as possible after result delivery	Facility: face to face Out of facility*	Nurse Primary counsellor CATS Key population peer supporter Community cadre

*Where out-of-facility models are run by HCW or primary counsellors, e.g., mobile outreach or drop-in centres

DSD building blocks for managing high VL

	WHAT	WHEN	WHERE	WHO
EAC2	EAC 2 (Pages 86-87); face to face is preferred but where access is a major challenge, consider a community cadre (CATS, key population peer supporter) or through telehealth If significant psychosocial challenges are identified, consider additional EAC or referral to appropriate additional services	4 weeks after EAC 1	Facility Out of facility* Face to face is preferred, but where access is a challenge, consider doing it in community or by telehealth	Nurse Primary counsellor CATS Key population peer supporter Community cadre
Repeat VL	12 weeks after EAC 1, where possible, using POC VL; if not available, flag the test on the VL request form as urgent	12 weeks after EAC 1	Facility Out of facility*	Nurse Primary counsellor Laboratory technician/ scientist/ microscopist
Action on repeat VL	Enter VL into EAC form in RoC OI/ART care booklet If suppressed, enter or return to DSD model for established on ART If not suppressed, follow viral load algorithm	As soon as possible after receipt of repeat VL	Facility	Doctor Nurse

*Where out-of-facility models are run by HCW or primary counsellors, e.g., mobile outreach or drop-in centres

EAC session 1 (For all with VL > 50 copies/ml)

Enhanced adherence session 1

Counsellors should document their findings in the RoC OI/ART care booklet EAC section.

Timing	Session 1: Date high viral load result given to RoC
Duration	Approximately 15 minutes
Mode	Individual; face to face is preferred, but where it is not possible (e.g., access is challenging), consider community-based or telehealth
Tools	EAC session guide and job aide

Introduce yourself to the patient.

Step 1: Viral load education review

Assess the RoC's understanding of undetectable viral load, low-level viraemia and unsuppressed viral load. Ask the RoC to explain to you what each means. If they require more explanation, you can say things like:

- The main job/work of your ARVs is to reduce the HIV in your body to a very small amount.
- We can measure this amount of HIV by taking a blood test that we call a viral load test. If ARV treatment is successful, the amount of HIV in the blood will be very low/small/suppressed and you will be healthy.
- The reason it is important to take your medication every day is to make sure that treatment is successful and the amount of virus in the blood is low.
- We have noticed that your viral load is going up. This is not something that can be ignored. We have to find the cause, overcome it, and make sure that your viral load becomes suppressed. We are here to help you achieve this.
- Most of the time, the cause of a high viral load is when you sometimes forget to take your medication.
- Learning to take these medicines is complex, but very possible. Just like learning anything new, it can be overwhelming at first and may take a lot of effort, but with practice, can become part of your daily routine.

Step 2: Discuss the patient's reason/explanation for his or her high viral load

Sometimes the RoC already knows why their viral load is going up. Here you can give them a chance to give their own explanation. Often, they will already tell you at this point that they are struggling with their adherence.

EAC session 1 (For all with VL > 50 copies/ml)

If they really don't know why their viral load is high, you can say:

- *We notice that when people sometimes forget to take their ARVs every day, it gives the virus a chance to multiply. Do you think that you sometimes forget?*

Make a short note of the RoC's explanation. Then move on to the next step. Don't linger too long on this step.

Step 3: Screen the RoC for depression and anxiety using the Symptom Questionnaire (SQ14) (Appendix 4)

Step 4: Review the time the medication is taken (dosing times) and create a medication schedule

This step is to review the time that the RoC has chosen to take their ARV doses. Establish what the RoC is doing and where they are at the time they have chosen. For example, if the RoC has chosen 9pm, but is already asleep in bed by 9pm, then that is not a good dosing time.

Establish with the RoC whether the time they are meant to take their medication is appropriate or whether the time is a problem.

If the time is a problem, then determine a new, more appropriate time with the RoC based on their schedule.

Remind them if on a once-a-day regimen and they are less than 12 hours late for a dose, they should take the dose as soon as they remember and still take their next dose at the appropriate time.

Then write down the new medication schedule in the counsellor's notes and in the RoC-held record.

Other reminders that may be used include a cell phone alarm, a specific TV or radio programme, or taking the medication with meals.

Step 5: Plan for storing medications

Help the RoC identify where at home they are going to keep their medications. If they are afraid of people seeing or finding the medication, then brainstorm a good place to hide them.

- Storage place:_____

Deciding on where to keep extra or emergency doses

Keeping an extra supply of tablets in specific places is always helpful in emergencies.

Help the RoC identify where they can keep an extra supply of medication in case they don't get home in time to take their medication This could be: handbag, locker at work, backpack, wallet, jacket pocket, briefcase or car.

These tablets are only to be used when not home in time to take the next dose.

- Extra/emergency supply will be carried in:_____

EAC session 1 (For all with VL > 50 copies/ml)

Step 6: Motivation cards

This step can help RoCs learn strategies for remembering to take medications and for thinking helpful thoughts each time they look at their tablets. It is especially helpful for RoCs who have treatment fatigue, are depressed or are stigmatizing themselves.

Introduce the RoC to the notecard. Ask the RoC to think of their own personal goals and dreams for their future. What are the three most important things they still want to achieve in their future?

Have them write it in their own language on a notecard:

For example: "I want to see my children grow up"; "I want to be healthy for my job".

Ask the RoC if ARVs can help them achieve these goals in the future?

Encourage the RoC to place the notecard where they will read it every day, preferably right before they take their medication. This will associate taking ARVs with the positive things they want for their future.

- Top 3 goals for the future: _____

_____

- Do you think that your ARVs can help you achieve your goals for the future?

Step 7: Discuss the RoC's support system

Has the RoC disclosed their status to any family, friends or co-workers? You can ask the RoC:

- *Do you have any people in your life who you can talk to about your HIV and ARVs? Suggest to the RoC that they enlist the support of their family, friends and co-workers in reminding them to take their medication if they have not already done so*
- The members of the RoC's support system are: _____

If they have not disclosed to anyone, write "none".

EAC session 1 (For all with VL > 50 copies/ml)

Step 8: Planning for substance use

In the past, the message given to RoCs was that they shouldn't mix ARVs with alcohol or drugs; the result is that RoCs decide not to take their ARVs on the day that they use alcohol or drugs. In time, we can support the RoC to stop abusing alcohol or drugs, but in the meantime, we want to help them adhere to ARVs while using alcohol or drugs.

You can ask the RoC in a casual way (not in an accusing way) if they sometimes like to have a few drinks.

Explain to the RoC:

- "We know now that taking ARVs together with alcohol or drugs is not a problem."
- "Taking alcohol or drugs sometimes makes it difficult for us to remember to take treatment. If possible, it is best to limit your use, but if you are planning to take any alcohol or drugs, it is important to plan ahead so that you don't forget to take your treatment."
- "Can you think of ways to still remember to take ARVs while drunk or high?"
- "It is a good idea to take ARVs before you start drinking, even if it is before your scheduled dosing time."
- "If you are already out, ask a friend who is not drinking to make sure that you take your ARVs."
- "Ask your wife or a family member to bring your medication to you and remind you to take them on time."
- "If you feel that your alcohol or drug use is affecting your adherence, would you feel ready to be referred to some professionals that may help you to work on that problem?" (Refer this RoC to an alcohol support service, if available.)

Write the RoC's plan down in the counsellor's notes.

Step 9: Getting to your clinic appointment

This step helps the RoC solve problems associated with getting to their appointments.Make a plan for getting to appointments:

- Make a plan for getting to appointments:
- How do you get to your medical appointments?
- What would you do if your usual way of getting to your appointments was not an option (for example, if there was a taxi strike or it was raining when you usually walk)?
    - How do you usually get to clinic: _____
    - Back-up plan: _____
- If they are not able to come on the appointment date: remind the RoC that if they are unable to make their appointment, they must make sure to go to the clinic the next day, BEFORE they run out of medication.

EAC session 1 (For all with VL > 50 copies/ml)

Step 10: Review plans and plan the way forward

- Briefly summarize the plans made above.
- Identify the steps that the RoC needs to complete at home before your next visit, for example, placing emergency doses in their handbag and their new dosing time.
- Give a short motivational summary of how you believe in the RoC. Together, you will make sure that they suppress their viral loads.

Plan a way forward

- Inform the RoC that they will have another counselling session after four weeks.
- VL will be repeated after 12 weeks, ideally using a point-of-care device.
- VL results will be reviewed together and a way forward will be discussed.

EAC Session 2 (only for those with VL > 1000 copies/ml)

Enhanced adherence session 2	
Timing	Session 2: One month after 1st EAC
Duration	Approximately 10 minutes
Mode	Individual; face to face at facility; if access is a challenge, consider carrying out EAC in the community or through telehealth
Tools	EAC session guide and job aide

Step 1: Identify any difficulties with plans and solve problems in any new issues

- Review action plan from previous session: for example, motivation card and emergency doses.
- Ask the RoC if they think that adherence has improved in the last month. Enquire in a friendly way if any doses have been missed.
- If the RoC experienced any difficulties implementing the plans, brainstorm solutions for the identified problem.
- Also solve problems in any new issues that may have come up in the past month.

Step 2: How to learn from mistakes

- This step may help RoCs prepare to recover from missing doses, which in the long run, is likely to occur.
- If a mistake occurs, the best choice is to return to one's adherence programme as soon as possible instead of acting on hopeless thoughts and giving up.
- Identifying what led to the mistake can provide important information that can help avoid future mistakes.
- It should be stressed that mistakes are normal and not a big problem. They only become a big problem when they lead to giving up.
- It is important to tell the RoC that they must not beat themselves up if they miss a dose. They must tell themselves that they are only human and that mistakes happen, but that they must return to their medication schedule as soon as possible. If they continue to have many mistakes, then the RoC must speak to their medical team as soon as possible.
- Make a plan with the RoC::
  - Positive thoughts you can think after you made a mistake _____

    _____
  - What can you learn from a mistake that will help you avoid another in the future? _____

    _____

    _____

    _____

EAC Session 2 (only for those with VL > 1000 copies/ml)

Step 3: Check your notes to see whether the RoC has been referred to other services – if not, skip this step

- This includes referrals to psychology services, substance abuse groups and social services.
- Ask the RoC if they attended the appointment? Assure them that if they answer NO, the topic will not be brought up again during these sessions (for example, we won't force them to go to substance abuse groups).
- If they answer YES, then check in on their experience with the referral services.

Step 4: Preparing for travel

- Holidays are always a risk for poor adherence or default of treatment. Encourage RoCs to plan for holidays, to make sure that they have enough medication on hand before they leave town, and to remember to pack it.
- Make sure that all relevant information is in the RoC's notebook – clinic's phone number, RoC's current regimen and doses, latest VL, etc.
- Explain to them that if they are ever away from home and run out of medication, they must go to the closest ARV clinic and show their RoC notebook. Hopefully, that clinic can help them access medication.
- As backup, have the RoC programme their local clinic phone number and file number into their phone. This way, they have it on their phone in case they lose their RoC notebook.
- Save on phone: clinic number; my folder number.
- Identify where the RoC usually travels to and ask if they know where the closest ARV clinic is.

Step 5: Review plans

- Give another short motivational discussion on how you know they can do this. Together, you will make sure that they suppress their viral load.
- Book for repeat VL in two months.
- If additional EAC sessions are needed, schedule an appointment earlier.
- Repeat viral load should still be taken 12 weeks after EAC 1.

Second line preparation session

If indicated by the viral load algorithm, switching to a new regimen should be carried out within two weeks of receipt of the second high viral load.

Pregnant and breastfeeding women should be switched with priority and followed up with a repeat VL after three months.

Second-line preparation session

Provide repeat (second) viral load result

- If VL is >1000 copies/ml and there are no major adherence barriers, switch to second-line ART. The decision to start second-line ART is taken as a team (nurse and counsellors), supported by the mentors. It does not require a specific meeting.
- How does the RoC feel about the result?

Give general info on second-line treatment

- Explain how second-line treatment consists of other drugs, which will be able to fight the virus, if taken correctly.
- Explain the benefits of second-line treatment: CD4 will increase, OI will decrease, and viral load should be undetectable.
- Explain that second-line treatment can have some side effects (yellow eye with ATV/RIT; dizziness and breathlessness with AZT).
- Explain the need for good adherence on second-line treatment.
- Revise strategies identified during EAC on how to ensure good adherence.

Second line preparation session

Second-line preparation session

Assess readiness to start second-line treatment

Counselling and clinical follow-up after second-line initiation is the same as for first-line initiation. Undertake to follow the RoC and give adherence support at:

- M1
- M3
- M6 – emphasize that the RoC will be bled for viral load
- Then follow the refill option of choice if eligibility criteria are met

Switching from DTG to a new regimen should not require referral of the RoC to a higher-level facility unless the RoC is seriously unwell, needs admission or needs further investigations not available at the primary care clinic.

Nurses at primary care clinics should be able to switch and, where needed, technical support should be provided by a doctor at the district through telehealth or through the mentorship team.

RoCs failing second-line antiretroviral regimens should be referred to the tertiary level for assessment for genotyping and assessment for possible third-line ART.

DIFFERENTIATED SERVICE DELIVERY FOR ART

Section contents:

DSD for ART initiation

1. THE CLINICAL CONDITION OF THE RoC

Identification of advanced HIV disease, which includes clinical examination AND a baseline CD4, will differentiate the clinical package at initiation

2. WHETHER THE RoC IS RE-ENGAGING IN CARE

3. THE RoC'S CHOICE OF LOCATION FOR INITIATION

ART initiation may be performed at the facility or out of facility

Evidence suggests that being able to offer ART initiation out of facility on the same day may increase linkage and long-term retention.

The building blocks of differentiated ART initiation

WHEN

All RoCs should be assessed for and offered **rapid initiation on the same day as HTS.**

If the RoC is not ready on the same day for clinical or psychosocial reasons, then ongoing medical investigation and/or counselling support should be provided with the aim of **initiating ART as soon as possible, ideally within 1 week unless there is a clinical contraindication.**

WHERE

ART initiation may be performed **at the facility or out of facility (page 69)**

If the RoC is not ready for initiation on the same day as testing, follow-up counselling may be performed in the community or by telehealth.

WHO

Initiation may be performed by the following cadres: doctor, clinical officer or nurse.

WHAT

Step 1: Provision of HIV and ART education

Step 2: Clinical readiness and assessment of RoC with advanced HIV disease (including CD4, screening for TB [LAM] and cryptococcal disease if CD4 is <200 cells/mm^3)

Step 3: Psychosocial readiness assessment

Step 4: Treatment plan

Always assess whether the RoC is re-engaging in care (page 93-94).

Re-engagement

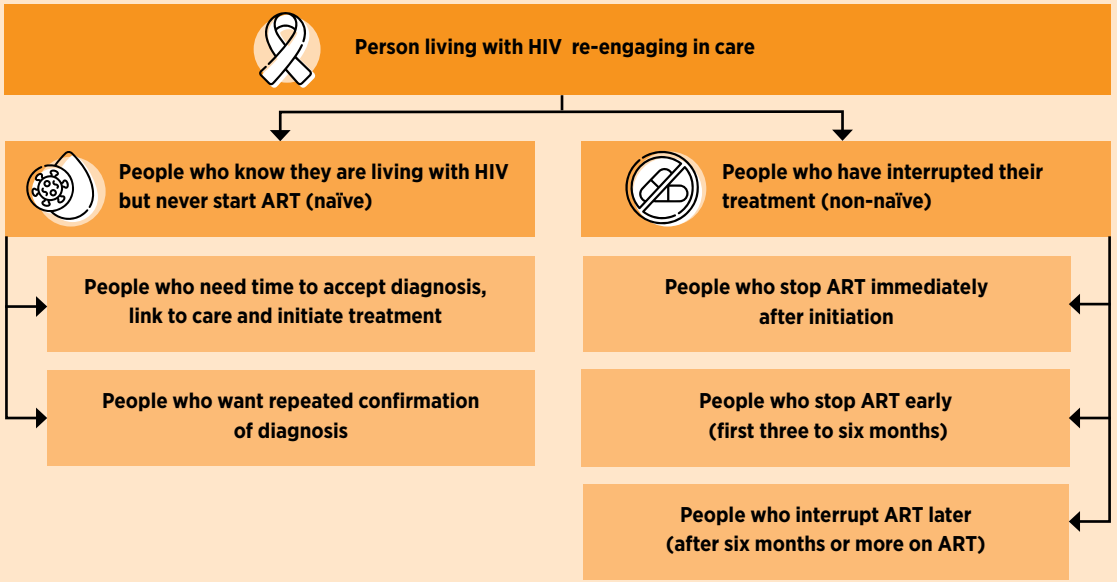
Definition

Re-engagement refers to any RoC who is presenting to HIV services who has:

- Previously tested positive but never linked to treatment
- Previously been on ART but stopped

The RoC may re-engage:

- At HIV testing sites or through HIV self-testing
- At an ART site where they are known or not known.



Management of a client re-engaging in care

Person living with HIV re-engaging in care

Perform clinical and psychological assessment

Establish when ART was last dispensed

Clinically well and last VL <50 copies/mL in the past 12 months

No ART for less than 3 months

Counselling to address factors that led to stopping

Rapid initiation

Offer immediate entry/re-entry to DSD model

6MMD

VL according to annual schedule

No ART for more than 3 months

Perform CD4

Counselling to address factors that led to stopping

CD4 >200 copies/mm³

Rapid initiation

Follow-up under standard follow-up schedule (See Table 22)

VL after 6 months

Clinically unwell and/or last VL >50 copies/mL in the past 12 months
OR
Major psychosocial barrier identified

Treat as clinically indicated

If VL >1000 copies/mL, perform CD4

If CD4 <200 copies/mm³ offer AHD package

CD4 <200 copies/mm³ offer AHD package

Rapid initiation

Follow up under intensive follow up schedule (See Table 22)

VL after 6 months

Follow up in the first year

Differentiated follow up in the first year

Follow-up in the first three months is differentiated into:

- Standard
- Intensive

ACTIVITY	CRITERIA FOR INTENSIVE FOLLOW-UP
Clinical monitoring	Active OIs or AHD identified
Counselling	Mental health condition identified, drug or substance misuse, adolescents, pregnant or breastfeeding women, key populations
Viral load monitoring	Earlier VL at month three for pregnant and breastfeeding women Where available, use of POC VL for children, adolescents, pregnant and breastfeeding women Where POC not available, flag specimen as urgent on request form for children, adolescents, pregnant and breastfeeding women

WHEN

Follow-up schedule: standard or intensive

WHERE

Facility

Community or telehealth may be considered for intensive follow-up where appropriate and where access is challenging to the RoC

WHO

Clinical: Doctor, nurse

Counselling: Primary counsellor

Additional psychosocial support: Community cadres, including CATS, key population supporters, young mother mentors

Laboratory: Samples taken by nurse or primary counsellor

WHAT

Clinical assessment

Ongoing counselling

ART, CTX and other integrated medication

VL at months six and 12

VL at month three for pregnant women

Schedule for first year of follow up 0-2 yrs

	CLINICAL	COUNSELLING*	LABORATORY
INITIATION	X	X	Baseline bloods
WK 2	X	X Where possible, a home assessment is encouraged	
MTH 1	X	X	
MTH 2	X	X	
MTH 3	X	X	
MTH 4	X	X	
MTH 5	X	X	
MTH 6	X	X	VL Where possible, use POC VL Where POC not available, flag VL request as urgent
MTH 7	X	X	
MTH 8	X	X	
MTH 9	X	X	
MTH 10	X	X	
MTH 11	X	X	
MTH 12	X	X	VL Where possible, use POC VL Where POC not available, flag VL request as urgent
ONGOING FOLLOW-UP	Monthly until 2 years		Annual VL Where possible, use POC VL Where POC not available, flag VL request as urgent

*If particular psychosocial challenges are identified, consider further community-based support for children and caregivers.

Schedule for first year of follow up 2-9 yrs

	CLINICAL	COUNSELLING*	LABORATORY
INITIATION	X	X	Baseline bloods
WK 2	X	X Where possible, a home assessment is encouraged	
MTH 1	X	X	
MTH 2	X	X Facility or community	
MTH 3	X	X	
MTH 4	X	X	
MTH 5	X	X	
MTH 6	X Give 3MMD	X	VL Where possible, use POC VL Where POC not available, flag VL request as urgent
MTH 9	X Give 3MMD	X	
MTH 12	X	X	VL Where possible, use POC VL Where POC not available, flag VL request as urgent
ONGOING FOLLOW-UP	See for clinical visit every four months with four-month refill		Annual VL Where possible, use POC VL Where POC not available, flag VL request as urgent

*If particular psychosocial challenges are identified, consider further community-based support for children and caregivers.

Schedule for first year of follow up adolescents and adults

	CLINICAL		COUNSELLING*		LABORATORY
	Standard	**Intensive: Active OIs AHD**	**Standard**	**Intensive Adolescents, pregnant and breastfeeding women, key populations**	
INITIATION	X	X	X	X	Baseline bloods
WK 2		X May be offered as community or telehealth		X May be offered as community or telehealth May be delivered by CATs or key population supporter For adolescents, a home visit is encouraged, where feasible	
MTH 1	X	X	X	X	
MTH 2		X May be offered as community or telehealth		X May be offered as community or telehealth May be delivered by CATs or key population supporter	
MTH 3	X Give 3MMD	X	X	X	VL for pregnant and breastfeeding women (follow specific VL schedule, Section 2.5.7) Where possible, use POC VL Where POC not available, flag VL request as urgent
MTH 6	X Give 3MMD	X	X	X	VL for all (except pregnant and breastfeeding women) Where possible, use POC VL for adolescents Where POC not available, flag VL request as urgent

Schedule for first year of follow up adolescents and adults

	CLINICAL		COUNSELLING*		LABORATORY
	Standard	**Intensive: Active OIs AHD**	**Standard**	**Intensive Adolescents, pregnant and breastfeeding women, key populations**	
MTH 9	X Give 3MMD	X	X	X	
MTH 12	X	X	X	X	VL for all Where possible, use POC VL for adolescents and pregnant or breastfeeding women Where POC not available, flag VL request as urgent
ONGOING FOLLOW-UP	If established on treatment (VL in past six mths <50 copies/ml) Offer DSD for established-on-treatment model Clinical and refill frequency according to Table 24, Page 68 If not established on treatment, follow viral load algorithm on Page 100				Annual VL Six-monthly VL for pregnant and breastfeeding women until cessation of breastfeeding Where possible, use POC VL for adolescents, pregnant and breastfeeding women Where POC not available, flag VL request as urgent

*If particular psychosocial challenges are identified, consider further community-based support for RoCs.

Defaulter tracking flow chart

HIV CARE AND TREATMENT DEFAULTER TRACKING FLOW CHART

Conduct daily check of RoCs who have missed appointment from available electronic systems (ePMS, eHR, ePOC) and/or appointment diary. Verify with the ART register, ART pharmacy register and RoC OI/ART care booklet.

DAY 0 TO DAY 3 Place OI/ART care booklets for RoCs who have missed appointments in the tray for early defaulters. Booklets for RoCs coming 1-3 days late are found in this tray.

If RoC fails to come for appointment within 3 days of scheduled appointment

DAY 4 & DAY 5 Record RoC in the defaulter tracking register and send SMS or make first follow-up call. If RoC does not have a phone number, jump straight to home visits; do not wait for Day 8.

If RoC was not reachable

DAY 6 Make a second follow-up call & record outcome in the health facility defaulter tracking register.

If RoC was not reachable

DAY 7 Make a third follow-up & record outcome in the health facility defaulter tracking register.

If RoC has not been reached through phone calls within 7 days

DAY 8 CBHW enters defaulter who consented to community follow-up in the community defaulter tracking pocket diary. Conducts home visit. Records outcome in the pocket diary & health facility defaulter tracking register.

If RoC not found on first home visit

DAY 15 CHWS conducts a second home visit and records the outcome in defaulter tracking community pocket diary and health facility defaulter tracking register.

If RoC not found on second home visit

DAY 22 CHW conducts a third home visit. Records the outcome in defaulter tracking community pocket diary and defaulter tracking register.

FINAL OUTCOME CBHW records final outcome in the pocket diary. Updates the defaulter tracking register, the OI/ART booklet and ART register.

If the RoC does not return to care after day 28, they are declared lost to follow-up

Definition of established on treatment

A RoC (adult, child over two years, adolescent, pregnant or breastfeeding woman, or member of a key population) established on ART (any treatment line) is defined as someone who:

- Has no current OIs
- Has good understanding of lifelong adherence
- Is at least six months on their current regimen
- Has a VL of <50 copies/ml in the past six months*

*Pregnant and breastfeeding women must have a VL <50 copies/ml in the past three months and be attending ANC or PNC and follow-up for a baby exposed to HIV.

Frequency of clinical and refill visits

	FREQUENCY CLINICAL VISITS	REFILL DURATION
0-2 years (not established on ART)	Monthly	1 month
2-9 years	4 monthly	4 months
10-19 years	4 monthly	4 months
20-24 years	6 monthly	*3 or 6 months with preference for 6
Adults	Annual	*3 or 6 months with preference for 6
Pregnant and breastfeeding (see Section 2.9.4 for further detail)	6 monthly In addition to HIV clinical visit, pregnant women must attend • 8 ANC contact visits • Attend monthly postnatally for follow-up of baby exposed to HIV	*3 or 6 months with preference for 6 months Pregnant women, if established on treatment, can continue to receive 6MMD but must also attend • 8 ANC contacts • Attend monthly for follow-up of baby exposed to HIV
Key populations	Annual	*3 or 6 months with preference for 6

*Group models should offer the choice of receiving three- or six-month medication refills. Where they receive six-month refills, they may choose to meet more frequently for social reasons and peer support. Individual models based at the facility or out of facility should offer six-month medication refills.

Categorisation of DSD models for RoCs established on treatment

GROUP MODELS MANAGED BY HEALTHCARE WORKERS	GROUP MODELS MANAGED BY ROC	INDIVIDUAL MODELS BASED AT A FACILITY	INDIVIDUAL MODELS NOT BASED AT FACILITY
Clubs Adapted: Carer and child clubs Adolescent adherence clubs Youth club Mbereko clubs (pregnant and breastfeeding women) Key population-led clubs	Community ART refill groups (CARGS)	Fast-track	Mobile outreach by HCW Health posts ART delivery by community cadre, including CATS and key population supporter Drop-in centre: KPs House of Smiles (for those of no fixed abode) O'Malayitsha model for mobile populations

Which DSD model for established on treatment by population

	0-2 YEARS	2-4 YEARS	5-9 YEARS	10-19 YEARS
Frequency of clinical visits	Monthly	4 monthly	4 monthly	4 monthly
Duration of ART refill	Monthly	4 monthly	4 monthly	4 monthly
Group model led by healthcare worker. Club	Adapted carer and child club			Adapted adolescent adherence club Adapted carer club and young adolescent club
Group model led by RoC CARGS				
Individual model based at facility Fast-track				
Individual model not based at facility Mobile outreach Health post Community health worker, Trained peer (e.g., CATS, key population) delivery Drop-in centres	Where model provided by trained healthcare worker and if accurate weighing possible			Where model provided by trained healthcare worker and if accurate weighing possible

Adapted SOP applies

Model not suitable for this population

Which DSD model for established on treatment by population

	20-24 YEARS	ADULTS	PREGNANT & BREASTFEEDING WOMEN	KEY POPULATIONS
Frequency of clinical visits	6 monthly	Annually	6 monthly	Annually
Duration of ART refill	*3 or 6 monthly	*3 or 6 monthly	*3 or 6 monthly	*3 or 6 monthly
Group model led by healthcare worker. Club			Adapted Mbereko groups for pregnant and breastfeeding mothers and their infants exposed to HIV (including specific young mothers' groups)	Adapted club for key population groups
Group model led by RoC CARGS	Adapted CATS led CARG if 3-monthly refills		Choice of woman to remain in existing CARG	Adapted key population supporter-led CARG
Individual model based at facility Fast-track	If 3-monthly refills		If 3-monthly refills	
Individual model not based at facility Mobile outreach Health post Community health worker, Trained peer (e.g., CATS, key population) delivery Drop-in centres	Where model provided by trained healthcare worker and if accurate weighing possible			Where model provided by trained healthcare worker and if accurate weighing possible

Standard SOP applies

Adapted SOP applies

Model not suitable for this population

SOP group model led by healthcare workers

WHEN
According to refill frequency table
Group meets at booked time for the club refill

WHERE
Allocated room for the club refill (can be facility or community based)

WHO
Club may be facilitated by:

Nurse
Primary counsellor
Expert RoC
CATS
Key population peer supporter

WHAT
ART
CTX
Other integrated medications (TPT, FP, NCD)
Group
Psychosocial support

	0-2 YEARS	2-4 YEARS	5-9 YEARS	10-19 YEARS	20-24 YEARS	ADULTS	PREGNANT & REASTFEEDING WOMEN	KEY POPULATIONS
Frequency of clinical visits	Monthly	4 monthly	4 monthly	4 monthly	6 monthly	Annually	6 monthly	Annually
Duration of ART refill	Monthly	4 monthly	4 monthly	4 monthly	*3 or 6 monthly	*3 or 6 monthly	*3 or 6 monthly	*3 or 6 monthly
Group model led by healthcare worker. Club	Adapted carer and child club			Adapted adolescent adherence club Adapted carer club and young adolescent club			Adapted Mbereko groups for pregnant and breastfeeding mothers and their infants exposed to HIV (including specific young mothers' groups)	Adapted club for key population groups

Standard SOP applies

Adapted SOP applies

Model not suitable for this population

SOP group model led by healthcare workers

STEP 1

- The day before or morning of, clinic uses the electronic system or clinic diary to generate the list of RoCs attending club refill.
- In paper-based sites, pull the RoC OI/ART care booklets for RoCs attending a club for that day.

STEP 2

- Send the RoC care and treatment books to the dispensing point or use electronic system to dispense refills for group members attending the next day.
- Refills should be pre-packed if this facilitates distribution by a primary counsellor, expert RoC, CATS or key population peer supporter.

STEP 3

- Club members attend at the allocated club refill appointment time.

STEP 4

- The club facilitator asks everyone together if there are any health problems today (open question, not checklist).
- If YES, the RoC is directed to the clinic.
- Group discussion is held – encourage RoCs to prioritize topics, share challenges and successes; adapt content to a specific population.
- Club facilitator distributes the refills and completes the refill documentation.

STEP 5

- The RoC OI/ART booklet is sent to the data clerks for entry into electronic system or the refill is recorded directly in the electronic system.
- At paper-based sites, the next refill date is written into the appointment diary.

STEP 6

- If any RoC does not collect medication as per their refill appointment, the defaulter tracking SOP should be triggered (Page 100).

Adaptations group models led by healthcare workers

	WHICH INDIVIDUAL OUT OF FACILITY MODEL	WHEN (CLINICAL)	WHEN (REFILL)	WHERE	WHO	ADDITIONAL WHAT
Children 0-2	Caregiver and child Mother and child booked together in the club	Monthly	Monthly for child 3-6MMD for mother	FCH	Nurse	Disclosure counselling Childhood immunizations Growth monitoring Nutrition advice
Children 2-5	Caregiver and child Mother and child booked together in the club	4 monthly	4 monthly for child 4MMD for mother	FCH	Nurse	Disclosure counselling Childhood immunizations Growth monitoring Nutrition advice
Children 5-9	Caregiver and child Mother and child booked together in the club	4 monthly Weekends, after school, holidays	4 monthly for child 4MMD for mother	OI clinic	Nurse	Disclosure counselling Childhood immunizations Growth monitoring Nutrition advice
Adolescents	Adolescent adherence club	4 monthly Weekends, after school, holidays	4 monthly	OI clinic or adolescent health corner	Nurse CATs	Form group according to age Adapted counselling Integrated SRH services Mental health support Adapted counselling for transitioning
Young adults	Adapted youth club	6 monthly	6 monthly (can meet 3 monthly for social interaction)	OI clinic or youth venue	Nurse CATs	Adapted counselling Integrated SRH services Mental health support Transition to adult care

Adaptations group models led by healthcare workers

	WHICH INDIVIDUAL OUT OF FACILITY MODEL	WHEN (CLINICAL)	WHEN (REFILL)	WHERE	WHO	ADDITIONAL WHAT
Pregnant women	Mbereko group for pregnant women Including young mother clubs	6 monthly PLUS 8 ANC contacts	6 monthly	OI clinic or ANC	Nurse Midwife Young mother mentor	Remain in previous club OR Transfer to pregnant mothers or young mother club at ANC Counselling related to PMTCT Additional VL
Breastfeeding women	Mbereko postpartum groups Mother and baby exposed to HIV booked together in the club	6 monthly PLUS Follow-up of baby exposed to HIV	6 monthly	OI clinic or PNC	Nurse Midwife Young mother mentor	Remain in previous club OR Transfer to postpartum club Counselling related to PMTCT Additional VL FP and SRH services Exposed infant care (prophylaxis, EID, nutrition, vaccination)
Key populations	Key population clubs	Annual	6 monthly	Facility Drop-in centre	Nurse Counsellor Expert key population peer	Adapted counselling Integrate additional medical needs (Section 2.9.5)

SOP group models led by RoCs

WHEN

According to refill frequency table
Group meets in community day before or on morning of refill date
Nominated member distributes medication on same day it is collected

WHERE

Agreed community location for group meeting and drug distribution
Medication collection from:
Facility
Agreed out-of-facility location (outreach point, drop-in centre)

WHO

Group leader – completes refill form
Group representative – collects medication
Nurse/pharmacy cadre – dispenses group medication
Group representative – distributes medication

WHAT

ART
CTX
Other integrated medications
(TPT, FP, NCD)
Psychosocial support

	0-2 YEARS	2-4 YEARS	5-9 YEARS	10-19 YEARS	20-24 YEARS	ADULTS	PREGNANT & REASTFEEDING WOMEN	KEY POPULATIONS
Frequency of clinical visits	Monthly	4 monthly	4 monthly	4 monthly	6 monthly	Annually	6 monthly	Annually
Duration of ART refill	Monthly	4 monthly	4 monthly	4 monthly	*3 or 6 monthly	*3 or 6 monthly	*3 or 6 monthly	*3 or 6 monthly
Group model led by RoC CARGS					Adapted CATS led CARG if 3-monthly refills		Choice of woman to remain in existing CARG	Adapted key population supporter-led CARG

Standard SOP applies

Adapted SOP applies

Model not suitable for this population

SOP group models led by RoCs

STEP 1

- The day before or morning of, clinic uses the electronic system or clinic diary to generate the list of RoCs attending for CARG refill.
- In paper-based sites, pull the RoC OI/ART care booklets for RoCs attending for CARG refill that day.

STEP 2

- Send the RoC care and treatment books to the dispensing point or use electronic system to dispense refills for group members.
- Refills should be pre-packed where possible in named RoC bags.

STEP 3

- The day before or early on the morning of the refill, the CARG meets at an agreed location.
- The group leader completes the CARG refill form with the group members.
- The group chooses a representative to take the refill form to the clinic and collect ART and other integrated medications.

STEP 4

- The nurse meets the group representative at the facility or at an out-of-facility location agreed on for medication collection.
- If three-monthly, the nurse checks the previous refill form to ensure members have signed that they received their medication. (If six-monthly, this will be checked at the group's annual review.)
- The CARG refill form for this refill is checked to ensure that there are no clinical issues to address.

STEP 5

- The nurse dispenses or provides the pre-packed ART and other integrated medications, and documents this on the CARG refill form.
- RoC OI/ART care booklet is filled or information entered into the electronic system directly.

STEP 6

- The representative takes the refill form and medications back to the group.
- Group members sign that they have had their ART distributed to them.

STEP 7

- If any CARG member does not collect their medication as per their refill appointment, the defaulter tracking SOP should be triggered (Page 100).

Adaptations group models led by RoCs

NAME	POPULATION	COMMENT	WHY?
CARG pickup from an out-of-facility location	Any eligible CARG population	Where there is a regular out-of-facility ART refill model (e.g., outreach, drop-in centre), a CARG may also collect their medication for the group from this location	This adaptation is particularly relevant where distance is a major challenge or during specific seasons when travel may be restricted, e.g., due to flooding
Key population CARGs	Any key population	Groups are formed of a key population – most common example is sex workers	Provides peer support Reduces visits to clinics, which may be stigmatizing

CARG refill form documentation

Community ART group refill monitoring form														
Facility name:			CARG number:											
Date group meeting before refill ../ .. /....			Signature of group leader:											
Date ART prescribed by nurse ../ .. /....			Signature of nurse:											
Date ARVs distributed ../ .. /....														
	To be completed By Group Leader						To be completed by nurse				To be completed By CAG member			
CARG member number	Full name	Pregnant (P) or on family planning (FP)	TB symptoms* Y/N	Other "alert" problems**	ARV tablets remaining	CTX tablets remaining	ARV regimen prescribed / quantity	CTX quantity prescribed	VL result (CD4 if not available)	Date VL	Full name	Signature of recipient	Date drugs received	Comments (include any reason for temporary clinic follow up)
1										../ .. /....			../ .. /....	
2										../ .. /....			../ .. /....	
3										../ .. /....			../ .. /....	
4										../ .. /....			../ .. /....	
5										../ .. /....			../ .. /....	
6										../ .. /....			../ .. /....	
7										../ .. /....			../ .. /....	
8										../ .. /....			../ .. /....	
9										../ .. /....			../ .. /....	
10										../ .. /....			../ .. /....	
11										../ .. /....			../ .. /....	
12										../ .. /....			../ .. /....	
*TB symptoms: Ask if the member has a current cough of any duration, is losing weight, has night sweats or has had contact with TB patient in last month														
**Alert problems: Ask if the member has any ankle swelling, puffiness of the face, breathlessness, diarrhea for more than 2 weeks, severe headache														

Step 1:

In the community meeting the group leader completes this section.

They ask all group members about TB symptoms, family planning needs and other clinical or adherence problems.

Step 2:

The group representative attends the clinic bringing the refill form from previous visit and from this refill.

The nurse checks the previous form to ensure all clients have received their medication.

The nurse completes this section and completes the patient care and treatment booklet according to the refill SOP.

Step 3:

The group representative distributes the medication and shares any results. Each group member must sign that they have received their medication.

SOP individual model based at facility

WHEN
According to refill frequency table
RoCs should be able to attend any time during opening hours
Consider out of hours and weekends for working RoCs

WHERE
Direct from dispensing point
RoCs do not need to go through triage or see a clinician

WHO
Nurse/pharmacy cadre
If refills, pre-packed lay distributor

WHAT
ART
CTX
Other integrated medications (TPT, FP, NCD)

	0-2 YEARS	2-4 YEARS	5-9 YEARS	10-19 YEARS	20-24 YEARS	ADULTS	PREGNANT & REASTFEEDING WOMEN	KEY POPULATIONS
Frequency of clinical visits	Monthly	4 monthly	4 monthly	4 monthly	6 monthly	Annually	6 monthly	Annually
Duration of ART refill	Monthly	4 monthly	4 monthly	4 monthly	*3 or 6 monthly	*3 or 6 monthly	*3 or 6 monthly	*3 or 6 monthly
Individual model based at facility					If 3-monthly refills		If 3-monthly refills	
Fast-track								

Standard SOP applies

Adapted SOP applies

Model not suitable for this population

SOP individual model based at facility

STEP 1

- The day before or morning of, clinic uses the electronic system or clinic diary to generate the list of RoCs attending fast track.
- In paper-based sites, pull the RoC OI/ART care booklets for RoCs attending fast-track for that day.

STEP 2

- Send the RoC care and treatment books to the dispensing point
- Fast-track refills should be pre-packed where possible if this facilitates distribution by a lay worker in the clinic.

STEP 3

- RoC attends on day of refill appointment any time during clinic operating hours.
- RoC should register attendance and move straight to the fast-track window.

STEP 4

- Dispenser asks if there are any health problems today (open question, not checklist).
- If YES, directs to the clinic.
- If NO, provides refill and completes refill documentation.

STEP 5

- The RoC OI/ART care booklet is sent for entry into the electronic system or information for the refill is directly entered into the electronic system.
- At paper-based sites, the next refill date is written into the appointment diary.

STEP 6

- If any RoC does not collect their medication as per their refill appointment, the defaulter tracking SOP should be triggered (Page 100).

SOP Individual model not based at a facility

WHEN

According to refill frequency

WHERE

Mobile outreach site
Health post
Distribution from agreed location by community cadre (VHW, CATS, key population peer supporter)
O'Malayitsha model for mobile populations
Key population drop-in centre

WHO

Nurse
VHW
CATS
Key population peer supporter
Registered representative for RoC overseas

WHAT

ART
CTX
Other integrated medications (TPT, FP, NCD)

SOP Individual model not based at a facility

	0-2 YEARS	2-4 YEARS	5-9 YEARS	10-19 YEARS	20-24 YEARS	ADULTS	PREGNANT & REASTFEEDING WOMEN	KEY POPULATIONS
Frequency of clinical visits	Monthly	4 monthly	4 monthly	4 monthly	6 monthly	Annually	6 monthly	Annually
Duration of ART refill	Monthly	4 monthly	4 monthly	4 monthly	*3 or 6 monthly	*3 or 6 monthly	*3 or 6 monthly	*3 or 6 monthly
Individual model not based at facility Mobile outreach Health post Community health worker, Trained peer (e.g., CATS, key population) delivery Community pharmacy Drop-in centres	Where model provided by trained healthcare worker and if accurate weighing possible						Choice of woman to remain in existing out of facility model	Adapted key population drop-in centre with integrated key population-specific services Key population peer delivery

Standard SOP applies

Adapted SOP applies

Model not suitable for this population

Adaptations individual model not based at a facility

HUB ART FACILITY

The day before outreach or beginning of the week, use appointment list to identify who is attending an out-of-facility refill model that week.

Pull OI/ART booklets of RoCs attending out-of-facility refill models.
Dispense and pre-pack medications in named and labelled bags.
Complete refill documentation.

Mobile outreach

Facility team travels to mobile outreach site.

Team distributes medications.

o'Malayitsha model

Registered representative (family member, colleague, friend) of RoC working out of the country collects medication.

Posts or couriers medication to RoC across the border.

Community cadre delivery

Community cadre, CATS or key population peer supporter collects medication for the group of RoCs they support.

They distribute medication at agreed location.

Distributor completes documentation.

Fixed site

Medication is transported from the hub site to the drop-in centre or health post.

HCW or key population peer supporter at drop-in centre distributes medication.

RoC confirms receipt of medication to the clinic.

They return documentation that refills have been distributed.

The RoC care and treatment book is sent to the data clerk for entry in the EHR.
At paper-based sites, the next refill date is written into the appointment diary.

If any RoC does not collect medication as per their refill appointment, the defaulter tracing SOP should be triggered (Page 100).

Adaptations individual model not based at a facility

	WHICH INDIVIDUAL OUT OF FACILITY MODEL	WHEN (CLINICAL)	WHEN (REFILL)	WHERE	WHO	ADDITIONAL WHAT
Children 0-2	Must be seen by HCW – mobile outreach Must be able to weigh child accurately	Monthly	Monthly for child 6MMD for mother	Agreed outreach site	Nurse	Weighing Disclosure counselling Nutrition Childhood immunizations and monitoring
Children 2-5	Must be seen by HCW – mobile outreach Must be able to weigh child accurately	4 monthly	4 Monthly for child 4MMD for mother	Agreed outreach site	Nurse	Weighing Disclosure counselling Nutrition Childhood immunizations and monitoring
Children 5-9	Must be seen by HCW – mobile outreach	4 monthly Weekends, after school, holidays	4 Monthly for child 4MMD for mother	Agreed outreach site	Nurse	Weighing Disclosure counselling Nutrition Childhood immunizations and monitoring
Adolescents	Must be seen by HCW – mobile outreach	4 monthly	4 monthly	Agreed outreach site	Nurse CATs where psychosocial support needed	Adapted counselling Integrated SRH and mental health services
Young adults	Must be seen by HCW -mobile outreach	6 monthly	6 monthly	Agreed outreach site	Nurse	Adapted counselling Integrated SRH and mental health services

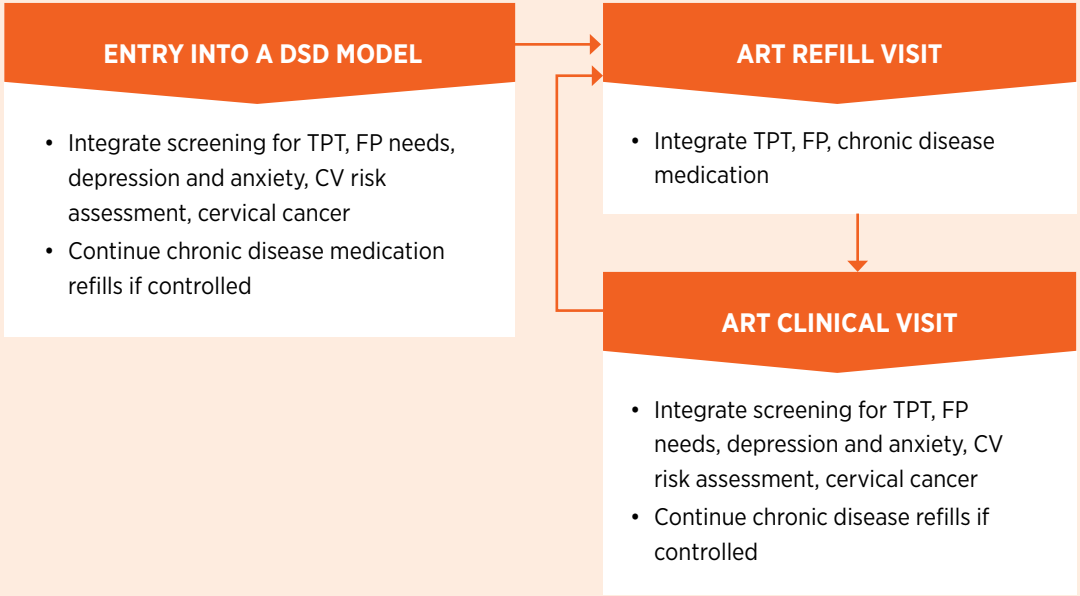
Adaptations individual model not based at a facility

	WHICH INDIVIDUAL OUT OF FACILITY MODEL	WHEN (CLINICAL)	WHEN (REFILL)	WHERE	WHO	ADDITIONAL WHAT
Pregnant women	Outreach with integrated ANC	6 monthly PLUS 8 ANC contacts	6 monthly	Agreed outreach site	Nurse Midwife Young mother mentor	Ensure ANC Additional VL Counselling related to PMTCT including SGBV screening
Breastfeeding women	Outreach with integrated PNC	6 monthly PLUS Follow-up of baby exposed to HIV	6 monthly	Agreed outreach site	Nurse Midwife Young mother mentor	Counselling related to PMTCT including SGBV screening Additional VL FP Exposed infant care (Prophylaxis, EID, vaccination)
Key populations	Key population drop-in centres Distribution by peer supporters Any of the individual out-of-facility models may be offered	Annual	6 monthly	Drop-in centre Agreed location with key population peer supporter	Nurse Primary counsellor Key population peer supporter	Adapted counselling Additional medical needs STI screening Integrated harm reduction services Hormonal treatment Comprehensive prevention package, including condoms, lubes, FP

DSD FOR INTEGRATION

Section contents:

Opportunities for integration of other health needs into DSD for HIV treatment models



DSD building blocks for TPT integration

	SCREENING FOR TB	INITIATION OF TPT	TPT MAINTENANCE	COMPLETION OF TPT
WHEN 	Every clinical visit Every CARG refill	Clinical visit	Multi-month script of TPT	Clinical visit
WHERE 	Facility Community	Facility Community Home	Facility Community Home Remote follow up	Facility Community Remote follow-up
WHO 	Peer, lay worker, nurse, clinical officer, doctor Community cadres, including CATS and key population peer supporters	Nurse, clinical officer, doctor	Peer, lay worker, nurse, clinical officer, doctor Community cadres, including CATS and key population peer supporters	Nurse, clinical officer, doctor
WHAT 	Verbal TB screen and TB tests according to local TB diagnostic algorithm	TPT eligibility assessment (incl. contraindications for TPT); treatment literacy for TPT side-effects; and TB symptoms Script for TPT refills and align with ART refills Register TPT start	Assess adherence Provision of TPT and ART refills TPT follow-up TPT side-effects/TB symptoms Register TPT follow-up	TPT completion documentation Educate on the need to repeat TPT in three years

DSD building blocks for TPT integration

TPT may be integrated using the building blocks into any of the four standard DSD for HIV treatment models and into those models adapted for specific populations.

TPT must also be offered to children and adolescents and integrated into their adapted DSD for HIV treatment models.

WHEN: Multi-month refills of TPT may be given. For INH, three- or six-monthly refills should be provided and the full three months of 3HP may be given at initiation. The full course of TPT should be assigned to any RoC initiated on TPT to avoid treatment interruption.

Recommended follow up is:

- 3HP: Follow-up call at week 2, month 1, month 3 – document completion
- 6INH: Follow-up call at week 2, month 1, month 3, month 6 – document completion

WHERE: When multi-month TPT refills are given, clinical follow-up, as outlined under WHEN, can be carried out by telehealth or in the community.

WHO: TB screening and TPT maintenance can be task shared to community cadres, VHW, CATS, key population peer supporters and expert RoCs.

DSD building blocks for family planning integration

	IUD	IMPLANT	ORAL PILLS	SUB-CUTANEOUS 3-MONTHLY INJECTABLE	INTRA-MUSCULAR 3-MONTHLY INJECTABLE	CONDOMS
WHEN 	At DSD entry At DSD clinical visits At facility walk-in services in between visits	At DSD entry At DSD clinical visits At facility walk-in services in between visits	At same clinical and refill visit as ART Every 3 months	Not yet available	At DSD entry At DSD clinical visits At facility walk-in service Every 3 months	At same clinical and refill visit as ART Every 3 months
WHERE 	Offer at ART clinic or through referral Primary care clinics Hospitals	Offer at ART clinic or through referral Primary care clinics Hospitals	Primary care clinics Hospitals	Not yet available	Primary care clinics Hospitals	Primary care clinics Hospitals
WHO 	IUD-trained doctor, midwife or nurse	Implant-trained doctor, midwife or nurse	FP-trained doctor, midwife, nurse, clinical officer, community-based distributor	Not yet available	FP-trained doctor, midwife, nurse, clinical officer	Doctor, clinical officer, midwife, nurse, community distributor, VHW, CATS and key population peer supporters
WHAT 	IUD information, counselling, insertion/ removal, management of side-effects	Impact information, counselling, insertion/ removal, management of side-effects	Combined and progestin-only pills, information, dispensing of pills, management of side-effects	Not yet available	Injectable information, counselling, giving of injections, management of side-effects	Male and female; information, counselling, dispensing of condoms

DSD building blocks for family planning integration

FP may be integrated using the building blocks into any of the four standard DSD for HIV treatment models and into those models adapted for specific populations.

FP must be offered to adolescents and young adults with a non-judgemental approach and integrated into their adapted DSD for HIV treatment models.

WHEN:

- A quality FP consultation should be carried out at entry into a DSD model and at each clinical visit.
- Those methods requiring ongoing commodities should be given on the same day and time as ART.
- Align pill refills and depot with ART refills.
- Women should always be still offered a six-month ART refill.
- For pills, if the supply chain cannot match 6MMD, provide a multi-month script that can be collected directly from the pharmacy, community distributor or via a refill model.
- Injections should be booked for the same date as ART refills or clinical visits. Women on three-monthly injectables should still be able to receive 6MMD of ART, and the additional visits should be offered at the site they receive their ART.

WHERE:

- Same location as ART
- In some settings, referral may be needed for insertion of IUDs and implants, but the goal should be for other methods to be available where ART is delivered.
- Contraceptive pills and condoms can be distributed in community locations.

WHO:

- The same HCW as providing ART
- Referral may be needed for IUDs and implants.
- In high-volume sites, the goal should be for one HCW to be trained to insert IUDs and implants.
- Community distribution of pills may also be performed by family planning community distributors.
- Condoms may be distributed by community distributors, VHWs, CATS and key population peer supporters.

Criteria for established on treatment for hypertension and diabetes

CONSIDERATION FOR INTEGRATION	HTN	DM
Control target	<140/90 measured on two occasions at least one month apart	HbA1C <7% recorded in the last 3 months Or Fasting blood sugar (FBS) < 7 mmol/L recorded in the last 3 months
Duration on current regimen	At least three months on current regimen	At least three months on current oral regimen
Other co-morbidities	No other uncontrolled co-morbidities requiring more frequent clinical interventions	No other uncontrolled co-morbidities requiring more frequent clinical interventions
Adherence	Good understanding of lifelong adherence: adequate adherence counselling provided	Good understanding of lifelong adherence: adequate adherence counselling provided

DSD building blocks for HTN/DM integration

	IUD	IMPLANT	ORAL PILLS	SUB-CUTANEOUS 3-MONTHLY INJECTABLE
WHEN 	At ART initiation/re-initiation Entry into DSD Clinical visits If normal, repeat BP annually Repeat screening for DM according to national NCD guidance	At ART initiation/re-initiation Entry into DSD Clinical visits	Booked monthly visits until hypertension is controlled	Three monthly clinical and refill visit for HTN/DM When controlled, repeat 3 monthly checks for fasting blood sugar (or HbA1c), BP & BMI. Annual clinical visit and three or six-monthly refills for ART Align HTN/DM/ART clinical and refill appointments
WHERE 	Same location as ART	Same location as ART	Same locations as ART	Same location as ART
WHO 	Nurse Community cadres	Same healthcare worker as ART Doctor Nurse	Same healthcare worker as ART Doctor Nurse	Same healthcare worker as ART Nurse VHW, key population peer supporter for distribution
WHAT 	Correct measurement of BP; fasting glucose; HBA1C	Correct selection of initial BP or DM medication according to algorithm	Correct measurement of BP/ testing of FBG or HBA1C and titration of HTN/DM medication according to algorithm	Hypertension, DM and ART refills

DSD building blocks for HTN/DM integration

HTN/DM medications may be integrated using the building blocks into any of the four standard DSD for HIV treatment models as long as BP or a FBS can be checked in that model. Hence for those with comorbidities integration into group models managed by healthcare workers, a modified fast track or an out of facility model led by a HCW (so that BP/FBS can be checked) should be the initial models chosen for HTN/DM integration.

WHEN:

- Same day and time as ART
- Align duration of all chronic medications: ART, diabetes and hypertension.

What if we cannot provide multi-month medication refills for HTN and DM?

- Multi-month refills of all chronic medications should be the goal.
- **BUT, if that is not possible, DSD models are the means to reduce the burden on the health system and RoCs.**
- Provide multi-month scripting as you would for a refill model.
- Dispensing then will be according to availability or how much the RoC can afford to purchase.
- The dispenser will indicate how much has been dispensed, but the RoC can collect the remaining refill directly from the dispensing point, rather than attending the clinic again for another script.

WHERE:

- Same location as ART (facility, out of facility)
- Consider out-of-facility BP checks when RoCs collect their six-monthly refill to enable annual clinical visits.

WHO:

- The same HCW as providing ART
- Community distribution of refills may also be performed by community cadres, including key population peer supporters.

Mental health screening: PHQ9

PATIENT HEALTH QUESTIONNAIRE 9 (PHQ-9)					
Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems?		**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1	Little interest or pleasure in doing things.	0	1	2	3
2	Feeling down, depressed, or hopeless.	0	1	2	3
3	Trouble falling or staying asleep or sleeping too much.	0	1	2	3
4	Feeling tired or having little energy.	0	1	2	3
5	Poor appetite or overeating.	0	1	2	3
6	Feeling bad about yourself — or that you are a failure or have let yourself or your family down.	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3
	• **0 – 4 None-minimal** • **5 – 9 Mild** • **10 – 14 Moderate** • **15 – 19 Moderately Severe** • **20 – 27 Severe**	**PHQ9 total score:**			

Mental health screening: GAD7

GENERALISED ANXIETY DISORDER 7- ITEM ASSESSMENT (GAD-7)					
Over the last 2 weeks, how often have you been bothered by any of the following problems?		**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1	Feeling nervous, anxious or on edge.	0	1	2	3
2	Not being able to stop or control worrying.	0	1	2	3
3	Worrying too much about different things.	0	1	2	3
4	Trouble relaxing.	0	1	2	3
5	Being so restless that it is hard to sit still.	0	1	2	3
6	Becoming easily annoyed or irritable.	0	1	2	3
7	Feeling afraid as if something awful might happen.	0	1	2	3
	• **Score 0-4: Minimal Anxiety.** • **Score 5-9: Mild Anxiety.** • **Score 10-14: Moderate Anxiety.** • **Score greater than 15: Severe Anxiety.**	**GAD7 total score:**			

Community Mental Health Screening Tool – SQ14

COMMUNITY MENTAL HEALTH SCREENING TOOL – SQ14			
CLIENT NAME:_____ **CLIENT ID:**_____ **DATE:**_____			
During the course of the past week:		**YES**	**NO**
1	Did you sometimes think deeply or think about many things?		
2	Did you find yourself sometimes failing to concentrate?		
3	Did you lose your temper or get annoyed over trivial matters?		
4	Did you have nightmares or bad dreams?		
5	Did you sometimes see or hear things others could not see or hear?		
6	Was your stomach aching?		
7	Were you frightened by trivial things?		
8	Did you sometimes fail to sleep, or did you lose sleep?		
9	Were there times when you felt life was so tough you cried or wanted to cry?		
10	Did you feel run down (tired)?		
11	Did you sometimes feel like committing suicide?		
12	Were you generally unhappy with the things you were doing each day?		
13	Was your work lagging behind?		
14	Did you feel you had problems deciding what to do?		

	Scoring : Add together the number of questions to which the client responded " yes"
	• **0-7: Not At Risk of Anxiety or Depression: Re-screen according to sub-population recommendation.**
	• **8-14: Considered at Risk of Anxiety or Depression**
	  • **Provide brief counselling intervention.**
	  • **Refer for further assessment and to CBO for psychosocial services.**
	  • **If a client scores 7 or less but is still suspected of mental health symptoms, they should be considered to have a positive score and receive a brief counselling intervention and referred appropriately.**		

Stepped care for depression and anxiety for RoCs in HIV care and treatment

WHAT: This tool is intended for use by health care workers to guide mental health screening, referrals and treatment of all clients in HIV care annually as recommended in the Operational Service Delivery Manual.

WHO and WHEN: All clients in routine HIV care during annual assessment and/or clients presenting with red flag issues at any time (virological failure, missed appointments, challenging psychosocial issues, substance misuse).

WHY: Poor mental health reduces quality of life and treatment outcomes.

HOW: Use the tool to guide decision-making for providing appropriate referrals. Document screening outcomes and referrals made in client OI/ART booklet comments.

Remember: There is no health without mental health.

Stepped care for depression and anxiety for RoCs in HIV care and treatment

1. Screen Adults annually at clinical visit
2. 18–24-year-olds every six months at clinical visit
3. Adolescents at least twice a year at their clinical visit (suggest alternate 4 monthly visits)
4. Any RoC with red flag issues (including substance misuse)

- **Facility (OI ART Centre)**: HCWs use PHQ-2 and GAD-2
- **Community:**
  - Community lay cadre to use Community Mental health Questionnaire (SQ-14)
  - Can Offer Problem Solving Therapy (PST)

IF YES TO ANY OF PHQ-2/GAD-2; OR SQ SCORE 8-14; OR HAS 'RED FLAG' ISSUES:

- Administer **PHQ9** and/or
- If substance misuse/use conduct additional screening with TICS/CAGE screening tool(s).

If VL > 50 copies/ml clients should also receive EAC and repeat VL after 3 months.

Assess adherence and need to switch ART regimen context of mental health and clinical presentation

IF NO FOR ALL PHQ-2 AND GAD-2 QUESTIONS; OR SQ14 (0-7):

- Provide information on:
  - Importance of mental health & symptoms which should prompt contacting community-or facility-health worker.
  - Emphasize importance of self-care and available support groups.
- **Re-screen according to OSDM subpopulation recommendations.**

PHQ9 [0-4]; GAD7 [0-4]; NO SUBSTANCE USE/ABUSE

Depression: Mild; Moderate; Moderate Severity; Severe
Anxiety: Mild; Moderate; Severe]; Substance use/abuse

AT ANY TIME

Acute Instability; Suicide Ideation; Self-harm; Psychosis; Alcohol Or Other Sedative Withdrawal; Acute Alcohol Intoxication; Sedative Overdose Or Intoxication; Any adolescent or Pregnant Or Breastfeeding Woman with moderate to severe depression/anxiety requiring pharmacotherapy; Victims of Intimate Partner Violence (IPV) or Gender Based Violence (GBV):

Treat as an emergency.

Manage According to mhGAP Intervention guide:

1. Provide Psychoeducation
2. Reduce stress and strengthen social supports
3. Promote functioning in daily activities
4. Psychological Treatment [psychotherapy and /or other community-based support such as friendship bench, CATS etc].
5. Psycho-pharmacotherapy

Involve occupational therapist & social services

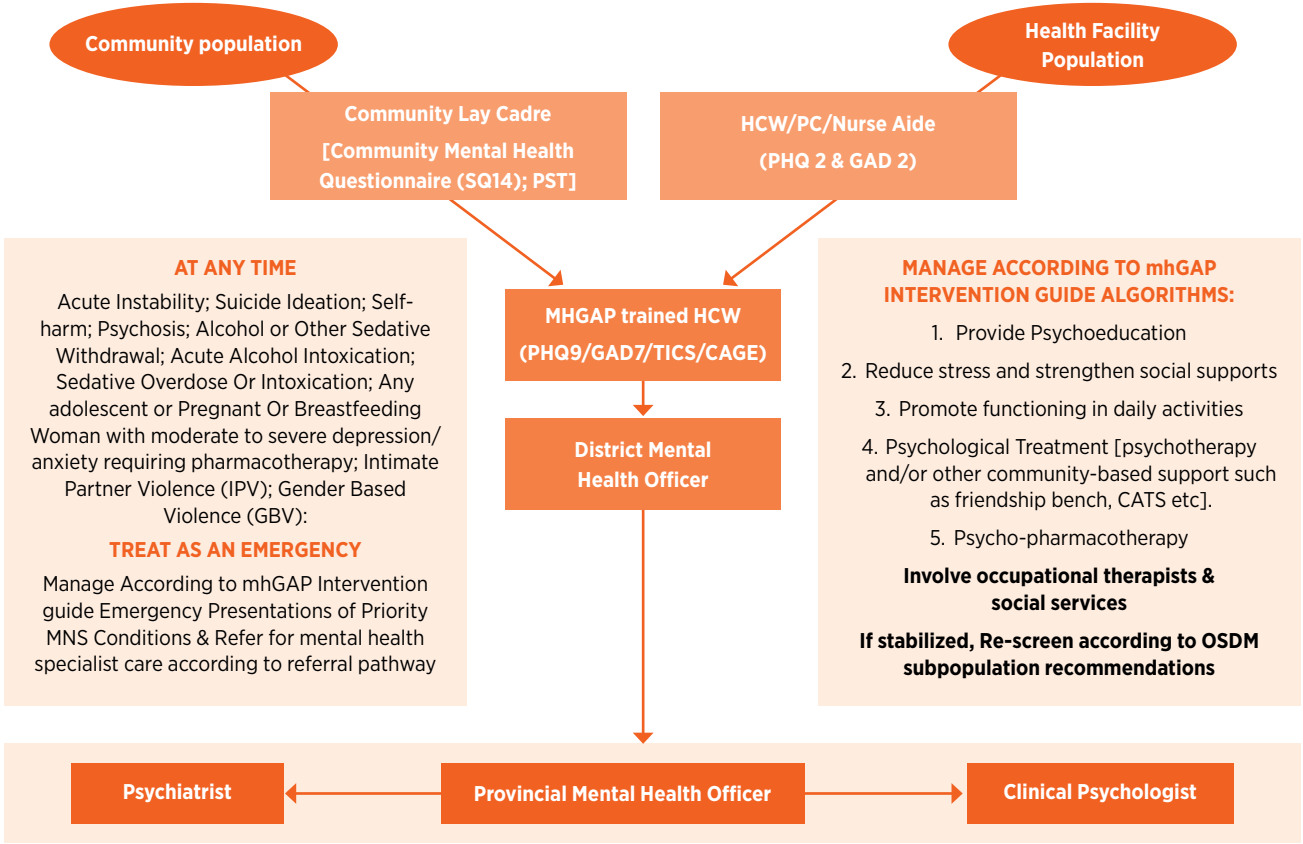
If stabilized, Re-screen according to OSDM subpopulation recommendations.

Manage According to mhGAP Intervention guide Emergency Presentations of Priority MNS Conditions.

AND:

Refer for mental health specialist care according to mental health patient referral pathway

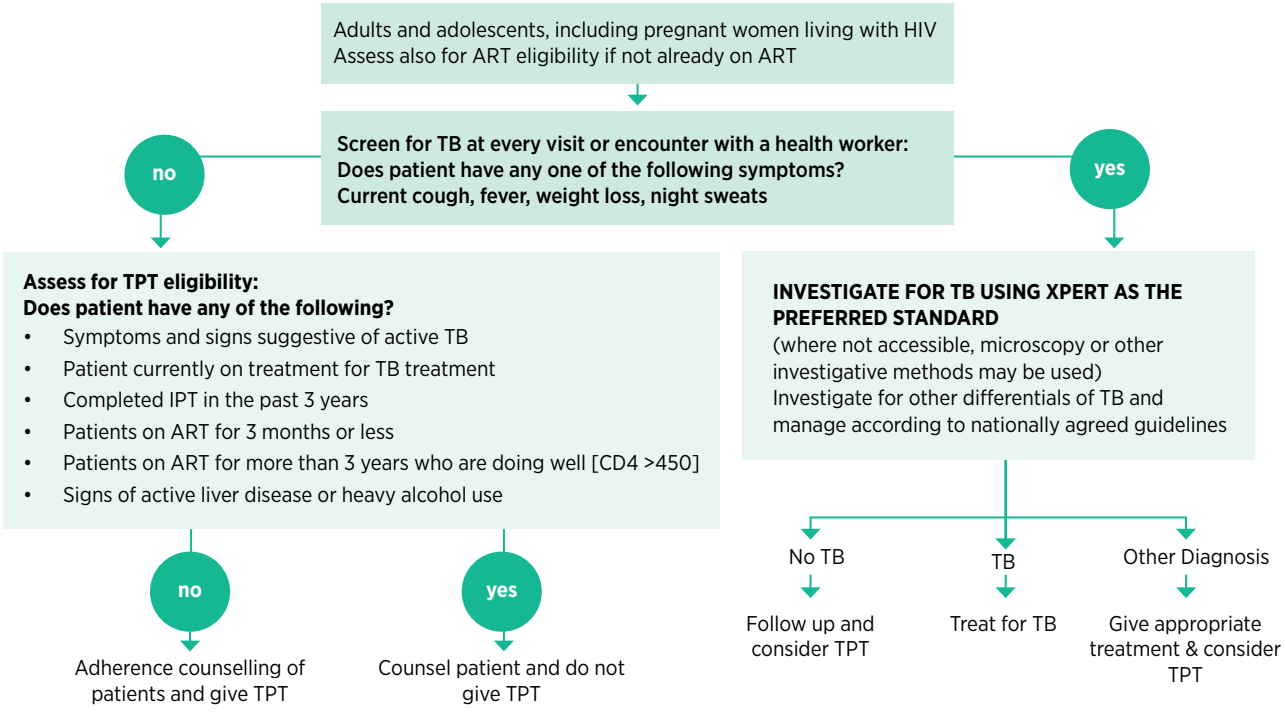
Mental Health Client Referral Pathway



MANAGING OPPORTUNISTIC INFECTIONS AND ADVANCED HIV DISEASE

Section contents:

Adult TB screening



Paediatric TB Screening tool

TB SCREENING ALGORITHM FOR CHILDREN AND ADOLESCENTS		
Ministry of Health and Child Care: National AIDS and TB Programme TB SCREENING ALGORITHM		
For each child or adolescent (aged 0-19 years) attending the facility, ask the following questions and tick either YES or NO.	**YES**	**NO**
1. Has the child or adolescent had a cough for 1 week or more and not improved on treatment?		
2. Has the child or adolescent had a persistent fever for more than 2 weeks?		
3. Has the child or adolescent had documented weight loss or failure to gain weight?		
4. Has the child or adolescent experienced fatigue (i.e., being less playful and/or always tired)?		
5. Has the child or adolescent been in contact with someone within or outside of the household with active/confirmed TB or with someone who has a chronic cough?		
If the answer is YES to any 2 of the above questions, they should be investigated for TB.		
If the child or adolescent answers YES to any 2 of the above questions:		
1. Obtain a sample for a TB test and conduct a TB test. • If the child or adolescent can produce sputum, GeneXpert should be utilized for TB testing depending on availability of the machines. Where GeneXpert is not available, smear microscopy can be done. Following analyses of results, they should be sent back to the clinician at the facility. • If the child or adolescent cannot produce sputum, alternative or additional methods can be utilized. These include stool, nasopharyngeal aspiration, LF-LAM (for children/adolescents living with HIV), gastric aspirates, chest X-rays and TST.		
2. Determine TB test result. • If the child or adolescent tests **POSITIVE**, refer for initiation onto TB treatment. • If the child or adolescent tests **NEGATIVE**, a clinical assessment should be conducted to determine clinical suspicion of TB. • If there is clinical suspicion, TB treatment may be commenced despite a negative TB test result.		
If the child or adolescent screens NEGATIVE for TB:		
The child or adolescent continues to the services for which they attended the facility.		

First Line TB regimens

	REGIMEN	HTN	DM
ADULTS	**2HRZE/4HR** OR **6HR**	2 months HRZE	4 months HR OR (6 months HR in TB of meninges, bone, joint, pericardium, disseminated spinal disease)
CHILDREN	**2HRZE/4HR** OR **10HR**	2 months HRZE	4 months HR OR (or 10HR for patients with TB of the meninges, bone joint, pericardium, military TB or TB spine)

Diagnostic recommendations for AHD

INTERVENTION	PRIORITY TARGET POPULATION	AGE
CD4 testing	• PLHIV newly presenting to care (ART naïve). • Patients returning to care who have interrupted ART for at least 90 days • Patients on ART who have suspected or confirmed treatment failure	All ages
TB-LAM testing	Outpatient and Inpatient settings: in HIV-positive adults, adolescents, and children • with signs and symptoms of TB • with advanced HIV disease • who are seriously ill or, • irrespective of signs and symptoms of TB and with a CD4 cell count < 200. A negative TB-LAM test does not exclude TB; however, a positive LAM test confirms it	All ages
Cryptococcal antigen	Any PLHIV with CD4<200cells/mm3 PLHIV with clinical stage 3 or 4 illness	All ages

Advanced Disease Package

	INTERVENTION	CD4 CELL COUNT	ADULTS	ADOLESCENTS	CHILDREN
DIAGNOSIS	TB-LAM for TB diagnosis among people with symptoms and signs of TB	Any CD4 count when patient seriously ill or stage 3 and 4	Yes	Yes	Yes
	Cryptococcal antigen screening	<200	Yes	Yes	No
PROPHYLAXIS AND PREEMPTIVE TREATMENT	Co-trimoxazole prophylaxis	≤350 Stage 2,3, and 4	Yes	Yes	All children born of HIV positive mothers from six weeks of age until they are tested and confirmed to be HIV negative
	TB preventive treatment	Any On ART or Post TB treatment (Immediately following the successful completion of TB treatment). No signs and symptoms of TB (Based on adult TB Screening guidelines)	Yes	Yes	Yes
	Fluconazole pre-emptive therapy for cryptococcal antigen– positive people without evidence of meningitis	<200	Yes	Yes	Not applicable
ART INITIATION	Rapid ART Initiation. Defer initiation if clinical symptoms suggest TB or cryptococcal meningitis	Any	Yes	Yes	Yes

Management of advanced HIV disease in children

INTERVENTION	COMPONENT	<5 YEARS	5 – 9 YEARS	10 -1 9 YEARS
SCREENING AND DIAGNOSIS	Systematic screening for TB at each clinic visit using any one of thes ymptoms of current cough, fever, weight loss, night sweats or close contact with a person with TB for children younger than 10 years	Yes	Yes	Yes
	Use C-reactive protein for screening for TB disease additionally	No	No	Yes[a]
	Use of chest X-ray for screening for TB disease additionally	May be considered	May be considered	Yes
	WHO-recommended rapid diagnostic test, (induced or expectorated) sputum, gastric aspirate, stool or nasopharyngeal aspirate or other Extrapulmonary specimens (induced or expectorated)	Yes	Yes	Yes
	Inpatients in HIV wards in which the TB prevalence is >10% use WHO-recommended rapid diagnostic tests	No	No	Yes
	LF-LAM assay	Yes	Yes	Yes
	Crytococcal antigen screening (specimen: serum, plasma or whole blood) If blood cryptococcal antigen positive or symptomatic, lumbar puncture	No	No	Yes
PREVENTION, PROPHYLAXIS AND PRE-EMPTIVE TREATMENT	Pneumococcal conjugate vaccine (catch-up)	Yes	No	No
	Co-trimoxazole[b]	Yes	Yes	Yes
	TB preventive treatment	Yes	Yes	Yes
	Fluconazole pre-emptive therapy for cryptococcal antigen-positive without evidence of meningitis[c]	Not applicable	Not applicable	Yes

[a] Depending on the resources available, C-reactive protein, chest X-ray or molecular WHO-recommended rapid diagnostic test may be used in addition to the four-symptom screen to enhance TB screening among adolescents.

[b] See text for when to discontinue.

[c] Screening for cryptococcal antigen followed by pre-emptive antifungal therapy among cryptococcal antigen-positive adolescents to prevent the development of invasive cryptococcal disease is recommended before initiating or reinitiating ART for adolescents living with HIV who have a CD4 count <1000 cells/mm3 (strong recommendation, moderate-certainty evidence) and may be considered at a higher CD4 count threshold of <200 cells/mm3 (conditional recommendation).

Management of suspected TB in patients with AHD

All patient settings (In-patients and outpatients): in HIV-positive adults, adolescents, and children:

- with signs and symptoms of TB
- with advanced HIV disease
- who are seriously ill or,
- irrespective of signs and symptoms of TB and with a CD4 cell count < 200.

Xpert and LAM performed concurrently (for sputum scarce patients perform LAM only)

Xpert positive

Treat according to Rif Resistance. If rifampicin resistance is detected send additional sputum for DST (LPA or Culture)

Xpert negative

LAM negative

Consider on or more of the following options:

- Send sputum/non sputum sample for TB culture and DST to rule out DR TB
- Commence antibiotics for bacterial chest infection if appropriate
- Perform chest Xray and inpatients abdominal USS, start empiric TB treatment if these are suggestive of TB
- Consider PCP if dyspnea is a prominent symptom, if respiratory rate above 30, or if CXR shows an interstitial infiltrate
- Defer treatment while awaiting cultures and radiological investigations do not suggest TB
- Ensure patient follow up

LAM positive

Initiate on TB treatment. Treat for DS-TB.

Send sputum /non sputum sample for Xpert. (Sputum send for Xpert is not to confirm the Positive Lam test, these are different sample types. It is for DST). If Xpert is negative, send sputum/non sputum for culture and DST to rule in DR-TB

TPT

TPT should be repeated every three years

POPULATION GROUP	COMPONENT	<5 YEARS
ADULTS		
PLHIV on EFV and DTG based regimen	Three months of weekly Rifapentine and Isoniazid (3HP)	Six months of daily Isoniazid alone (6H)
PLHIV on TAF, PIs and NVP based regimen	Six months of daily Isoniazid alone (6H)	
HIV negative contacts (adults and adolescents > 15 years)	Three months of weekly Rifapentine and Isoniazid (3HP)	Six months of daily Isoniazid alone (6H)
CHILDREN		
CLHIV on EFV-based regimen (Adolescents, children > 2 years)	Three months of weekly Rifapentine and Isoniazid (3HP)	Six months of daily Isoniazid alone (6H)
CLHIV on DTG, PIs and NVP based regimen	Six months of daily Isoniazid alone (6H)	
HIV negative contacts (Children under 15 years)	Three months of daily Rifampicin and Isoniazid (3RH)	Six months of daily Isoniazid alone (6H)
SPECIAL GROUPS		
MDR-TB Contacts	Six months of daily Levofloxacin (6LFX)	
Pregnant women	Six months of daily Isoniazid alone (6H)	

Pyridoxine should be prescribed in ALL patients receiving INH based TPT especially 6H, . Its unavailability should not be a barrier to initiate 3HP or 3RH.

TB preventive therapy with 6 month INH regimen

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

TB preventive therapy using 3HP regimen

MEDICINE	FORMULATION	WEIGHT BANDS FOR PATIENTS 2-14 YEARS					COMMENTS
		10-15kg	16-23kg	24-30kg	31-34kg	>34kg	
Isoniazid	100mg	3	5	6	7	7	Adult 300mg tab can reduce pill burden
Rifapentine	150mg	2	3	4	5	5	
Isoniazod + Rifapentine	300mg/300mg	2	3	4	5	5	FDC being developed
MEDICINE	**FORMULATION**	**WEIGHT BANDS FOR PATIENTS >14 YEARS**					**COMMENTS**
		30-35kg	36-45kg	46-55kg	56-70kg	>70kg	
Isoniazid	100mg	3	3	3	3	3	Adult 300mg tab can reduce pill burden
Rifapentine	150mg	6	6	6	5	6	
Isoniazod + Rifapentine	300mg/300mg	3	3	3	3	3	FDC being developed

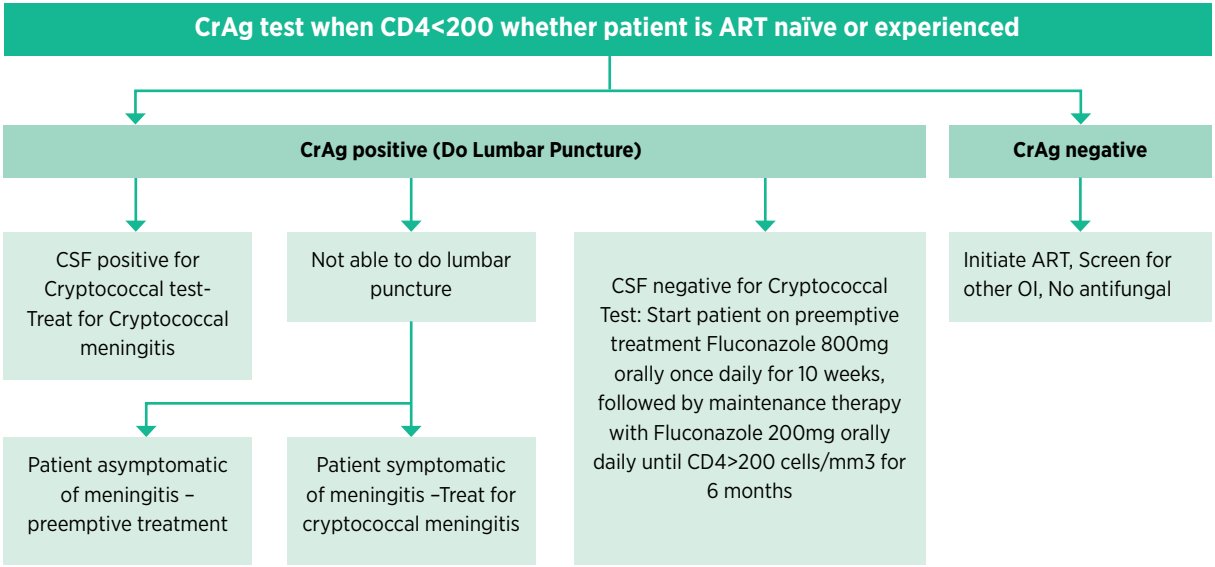
Criteria for initiating and stopping cotrimoxazole

POPULATION	CRITERIA FOR INITIATING COTRIMOXAZOLE	CRITERIA FOR DISCONTINUING COTRIMOXAZOLE
Adults (including pregnant women) living with HIV	WHO clinical stage 2, 3 and 4 CD4 cell count < 350 cells/mm3	Stop for those who are clinically stable, with evidence of immune recovery (CD4>350 cells/mm3) and/or suppression of viral loads on ART
Children and adolescents living with HIV	Initiate for everyone regardless of WHO clinical stage or CD4 cell count As a priority: • Initiate for everyone younger than five years regardless of WHO clinical stage or CD4 cell count • Initiate for everyone five years and older with severe or advanced HIV disease (WHO clinical stage 3 or 4) or CD4 cell count < 350 cells/mm3	Continue until adulthood then use adult criteria for discontinuing
HIV-exposed infants	Initiate for everyone starting at 4–6 weeks after birth	Until the risk of HIV transmission ends, and HIV infection is excluded with age-appropriate test
People living with HIV and TB	Initiate for everyone with active TB regardless of CD4 cell count	Until the criteria for discontinuation for adults or children are met

Cotrimoxazole Dosing

AGE/ WEIGHT	RECOMMENDED DAILY DOSAGE	SUSPENSION (5ML – 200MG/40MG)	PAEDIATRIC FORMULATION (100MG/20MG)	SINGLE – STRENGTH ADULT TABLET (400MG/80MG)	DOUBLE – STRENGTH ADULT TABLET (800MG/160MG)
<6 MONTHS OR <5 KG	100mg sulfamethoxazole/ 20 mg trimethoprim	2.5ml	1	¼	-
6 MONTHS – 5 YEARS OR 5 – 15 KG	200 mg sulfamethoxazole/ 40 mg trimethoprim	5ml	2	½	-
6 – 14 YEARS OR 15 – 30 KG	400 mg sulfamethoxazole/ 80 mg trimethoprim	10ml	4	1	½
> 14 YEARS OR >30KG					1
FREQUENCY – ONCE DAILY					

Screening and management of cryptococcal meningitis



Treatment of cryptococcal meningitis

INDUCTION

The following is recommended as the preferred induction regimen.

- Liposomal Amphotericin B 10mg/kg as a single dose plus Flucytosine 100mg/kg/day and Fluconazole 1200mg/day for two weeks

The following induction regimens are recommended as alternative options.

- For adults, adolescents and children, a short-course (one-week) induction regimen with liposomal amphotericin B (3-5 mg/kg per day) and flucytosine (100 mg/kg per day, divided into four doses per day) is the preferred option for treating cryptococcal meningitis among people living with HIV
- Two weeks of liposomal amphotericin B (3-5mg/kg per day) + fluconazole (1200 mg daily, 12 mg/kg per day for children and adolescents up to a maximum of 800 mg daily)
- Two weeks of fluconazole (1200 mg daily, 12 mg/kg per day for children and adolescents) + flucytosine (100 mg/kg per day, divided into four doses per day)

CONSOLIDATION

Fluconazole (800 mg daily for adults or 6–12 mg/kg per day for children and adolescents up to a maximum of 800 mg daily) is recommended for the consolidation phase for eight weeks following the induction phase

MAINTENANCE

Fluconazole (200 mg daily for adults or 6 mg/kg per day for adolescents and children) is recommended for the maintenance phase until CD4 count >200 for 6 months and VL<1000copies/ml for 6 months

Screen, Treat and Optimise to prevent AHD

SCREEN

Tuberculosis

- Screen for TB using a clinical algorithm followed by X-ray when indicated and available.
- Use the following diagnostic tests to confirm TB as applicable:
  - Rapid molecular (Xpert® MTB/RIF OR ULTRA) on (induced) sputum, stool, gastric aspirate, or nasopharyngeal aspirate or other extrapulmonary samples if relevant.
  - Lateral flow urine lipoarabinomannan (LF-LAM) assay

Cryptococcal infection among adolescents and adults

- Serum or plasma or blood cryptococcal antigen screening followed by lumbar puncture if positive or symptomatic

Malnutrition among children

- Weight for height
- Height for age
- Mid-upper arm circumference among children 2-5 years old

TREAT

- Treat TB, severe pneumonia, severe bacterial infections, cryptococcal meningitis and severe acute malnutrition according to national guidelines.

OPTIMISE

- Rapid antiretroviral therapy starts - within 7 days with optimal regimens (except in patients with cryptococcal meningitis where treatment should be deferred for 4 – 6 weeks of antifungal treatment initiation).
- Antiretroviral therapy counselling.

PREVENT

Bacterial infections and Pneumocystis pneumonia

- Co-trimoxazole prophylaxis

TB

- TB preventive treatment

Cryptococcal meningitis among adolescents and adults

- Fluconazole pre-emptive therapy

Vaccinations

- Pneumococcal vaccine
- Human papillomavirus
- Measles
- BCG
- COVID-19

Timing of ART Initiation

TB

Among people living with HIV not yet on ART and with signs and symptoms of TB , investigate for TB first. If TB is diagnosed start TB treatment followed by ART after at least 2 weeks

Cryptococcal Meningitis

Defer ART for 4-6 weeks from the initiation of treatment for CM

DSD for AHD: Identification of AHD

	IDENTIFYING CLINICAL SIGNS AND SYMPTOMS	PERFORMING CD4
WHEN 	Each clinical visit Any time in the community	At time of HIV diagnosis Re-engaging in care after more than 3 months off ART If VL >1000 copies/ml Presenting clinically unwell on ART
WHERE 	Facility Out of facility	Facility Out of facility
WHO 	Doctor Nurse Community cadre (including CATS, key population peer supporter, CARG member)	Laboratory technician/scientists Microscopist Nurse Primary counsellor
WHAT 	Identification of red flags and danger signs and symptoms	CD4, where possible at POC

DSD for AHD: Screening and Prevention of AHD

WHAT	TB LAM	XPERT MTB/RIF	Blood CrAg	Fluconazole pre-emptive treatment	CTX	TPT
WHEN	Outpatient and inpatient settings: in adults, adolescents and children with HIV • With signs and symptoms of TB • With advanced HIV disease • Who are seriously ill • Irrespective of signs and symptoms of TB and with a CD4 cell count <200 cells/mm3	Whenever presenting with TB symptoms	If CD4 <200 cells/mm3	If blood CrAg is positive and LP CrAg (if feasible) is negative	WHO clinical Stages 2, 3 and 4 CD4 cell count <350 cells/mm3	TB screening negative Assessment for TPT repeated every three years
WHERE	POC at same site as CD4 testing (inpatient, outpatient, primary care, out-of-facility site.)			Inpatient Outpatient Primary care site	Inpatient Outpatient Primary care site Out-of-facility site where trained cadre present	Inpatient Outpatient Primary care site Out-of-facility site where trained cadre present
WHO	Laboratory technician/scientists Microscopist Nurse Primary counsellor Doctor Nurse Doctor Nurse			Doctor Nurse	Doctor Nurse	Doctor Nurse Primary counsellor for telehealth follow-up (Section 2.7.2)

DSD for AHD: Follow up and tracing of client

	CLINICAL REVIEW	TRACING
WHEN 	If seriously unwell or discharged from an inpatient admission, individualize follow-up, but consider where community check-in is appropriate RoC is well but CD4 <200 Facility appointment at months 1 and 3 Community or telehealth check-in at week 2 and month 2	Prioritize tracing RoCs with advanced HIV disease Trigger tracing on same day as missed appointment
WHERE 	Facility Community Telehealth	From facility by phone or text At home by VHW, CATS, key population peer supporter
WHO 	Doctor Clinical officer Nurse Community check-in: community cadres, including CATS and key population peer supporters	Nurse Primary counsellor Community cadres, CATS, key population peer supporters
WHAT 	Assessment of OIs being treated IRIS Adherence	Phone or text Physical tracing Follow SOP in Section 2.6.5

Nutritional requirements: Adults and adolescents

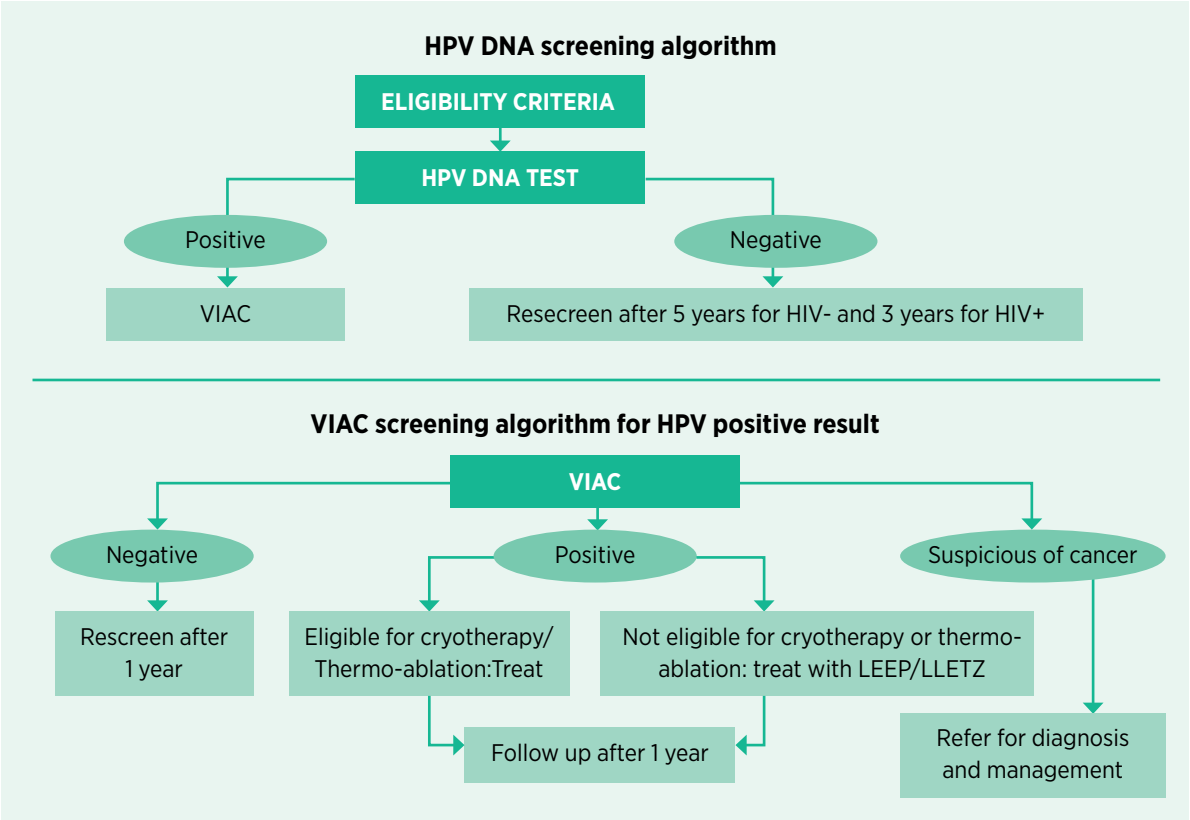
NUTRIENT	HIV -INFECTED ASYMPTOMATIC (WHO STAGE 1)	HIV-INFECTED SYMPTOMATIC (STAGE 2 AND ABOVE)
Energy / Carbohydrates	**Increase intake by 10%**	**Increase intake by 20%**
Protein	• Same as for the non-infected • Recommended uptake is 12-15% of the total energy needs or 0.8kg per kg body weight in females and 0.85kg per kg body weight in males	
Fat	Same as for a non-HIV infected person i.e., 30-35% of total energy needs	
HIV-exposed infants	Initiate for everyone starting at 4–6 weeks after birth	Until the risk of HIV transmission ends, and HIV infection is excluded with age-appropriate test
Micronutrients	• Same as in the non-infected • Specific or multiple deficiencies must be managed using standard protocols • Micronutrient supplements can be used as an addition to a balanced healthy diet but must NOT replace a healthy diet	

STAGE OF DISEASE	RECOMMENDED INTAKE
HIV-Positive Asymptomatic (WHO stage 1)	Eat 3 meals and 2-3 snacks
HIV Positive Symptomatic (WHO stage 2 and above)	Eat 4 meals and 3 snacks

Nutritional requirements pregnant and lactating women

PREGNANT		
NUTRIENT	**HIV -INFECTED ASYMPTOMATIC (WHO STAGE 1)**	**HIV-INFECTED SYMPTOMATIC (STAGE 2 AND ABOVE)**
Energy / Carbohydrates	**Increase intake by 10%**	**Increase intake by 20-30%**
Protein	30-50% of the non-pregnant woman	Same as the HIV negative woman which is 30-50% of the non-pregnant woman
Micronutrients	Daily iron-folate supplementation (400 µg of folate and 60 mg of iron) during six months of pregnancy to prevent anaemia, and twice daily supplements to treat severe anaemia Management of Iron/Folate deficiency Anemia and Iodine Deficiency remains the same as for the non-HIV-infected	Daily iron-folate supplementation (400 µg of folate and 60 mg of iron) during six months of pregnancy to prevent anaemia, and twice daily supplements to treat severe anaemia Management of Iron/Folate deficiency Anemia and Iodine Deficiency remains the same as for the HIV negative women
LACTATING		
NUTRIENT	**HIV -INFECTED ASYMPTOMATIC (WHO STAGE 1)**	**HIV-INFECTED SYMPTOMATIC (STAGE 2 AND ABOVE)**
Energy	Increase intake by 10 percent + 500 kcal to support lactation	Increase intake by 20 to 30 percent + 500 kcal to support lactation
Protein	Same as for HIV negative women which is 30- 50% of the non-pregnant women	
Micronutrients	Management of Iron/Folate deficiency Anemia and Iodine Deficiency remains the same as for the HIV negative women	

Algorithm for cervical cancer screening using HPV DNA or VIA



PMTCT

Section contents:

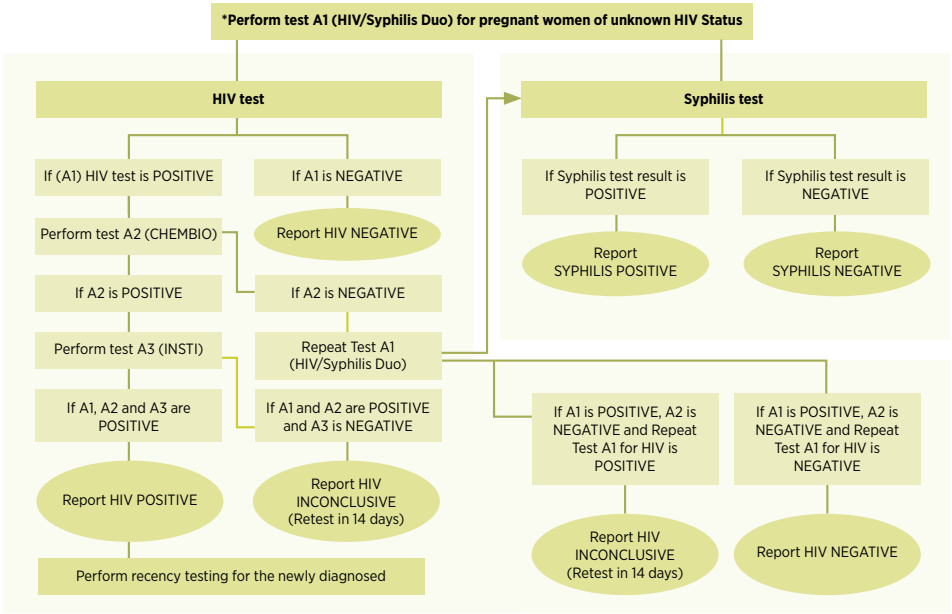
Testing of pregnant and breastfeeding women

All pregnant women should be tested as early as possible for

- HIV
- syphilis
- hepatitis B surface antigen (HBsAg) in settings where the seroprevalence is >2%) at least once and as early as possible.

Health workers should retest previously HIV-negative pregnant and breastfeeding women as follows:

- first trimester of pregnancy
- third trimester/ or at delivery
- 6 weeks post-natal and
- 6 monthly during the breastfeeding period.



Key counselling messages: HIV negative pregnant and lactating women

Key action points

- Syphilis positive mothers to complete treatment and their exposed infants to be treated at birth
- Mother who book late (third trimester or unknown status in labour and delivery) should be tested at first contact and then retested at 14 weeks after delivery then after every six months
- Self-testing should be offered as an opt out option for the partners
- Offer PrEP to Pregnant and Lactating Women at substantial risk of contracting HIV

Time of presentation	Who to test and document	Key messages
First ANC Contact with HIV negative / unknown status (and Partner/s) N.B. Offer pre-test information (group/couple/individual). HIV test and individual couple post-test counselling	Offer PITC and conventional testing (Document in ANC booklet: in Notes section)	1. Importance of pregnant women and their partners • HIV • Syphilis 2. Basic facts on HIV (use counselling tools e.g. soldier game 3. Basic facts on EMTCT (mother to baby transmission in utero, delivery and breast feeding, importance of HIV testing, prevention and retesting algorithm for HIV negative mothers, treatment and care for the HIV positive mothers, partners and baby to be discuss for those testing HIV positive) 4. Basic facts about STIs and syphilis including relationship between STIs and HIV (Adverse outcome if not treated to mother and baby) • HIV: Negative, Positive & Inconclusive • Syphilis: Positive and negative 5. Explain testing procedure and meaning of results • HIV: Negative, Positive & Inconclusive • Syphilis: Positive and negative

Key counselling messages: HIV negative pregnant and lactating women

Time of presentation	Who to test and document	Key messages
First ANC Contact with HIV negative / unknown status (and Partner/s) N.B. Offer pre-test information (group/couple/individual). HIV test and individual couple post-test counselling	Offer PITC and conventional testing (Document in ANC booklet: in Notes section)	6. Referral and linkage • HIV positive: Retest for verification of HIV diagnosis • HIV negative: HIV Retesting at 32 weeks, 6 weeks post delivery and every 6 months during breast feeding • HIV inconclusive: Retest after 14 days • Syphilis: Treatment of positive mother and the infant at delivery 7. Disclosure, partner involvement (including partner testing) and secondary distribution of HIV self-test kit for partner (if available) 8. Risk assessment and reduction measures 9. Identify the risk reduction measure using counselling (eg. empty chair technique) and widen the system to ensure psychosocial support. 10. Offer routine focused ANC services
Subsequent ANC Visits	• At 32 weeks gestation or third trimester if tested in the first trimester. • At 6 weeks after delivery. • Every six months until cessation of breastfeeding	1. Affirm for coming and check on implementation of previous recommendations (see #8 First ANC Contact with HIV negative/unknown status (and Partners) • Disclosure and partner HIV testing • Partner syphilis testing and treatment if mother is HIV positive • Risk reduction e.g. condom use • 2. Affirm for decisions actioned and attend to unmet previous recommendations 3. Review basic facts and offer HIV retesting 4. Emphasize adoption of risk reduction behaviours 5. Revise risk reduction plan and way forward where necessary (e.g. condom use and negotiation skills, disclosure and partner testing) 6. Offer routine focused ANC services

Key counselling messages: Women testing HIV positive at booking and women booking already HIV Positive (But not yet on ART)

Time of presentation	Key messages
Women testing HIV positive at booking and women booking already HIV Positive (But not yet on ART)	**Rapid adherence counselling** Review basic facts about HIV and PMTCT – Book as soon as you know you are pregnant **Rational for starting ART** • Goals of ART and EMTCT • How to take the ARVs medicines • Use of a reminder tools e.g. alarm, watch • Importance of adherence and time • Importance of routine ANC contact • Common side effects of ARVs • Safe sex practices Discuss the importance of disclosure Discuss Male involvement (include Partner testing) Secondary distribution of HIV Self Testing kits for partners Explore client's concerns Help to develop support systems including identifying a treatment buddy and joining a support group Counsel on adherence and adherence on ART Syphilis and TB Screening

Key messages for discordant couples

Time of presentation	Key messages
Discordant couple	• If partner is negative and is exposed to ongoing risk, offer PrEP • Provide basic facts on Pre-Exposure Prophylaxis • Conduct individual risk assessment for eligibility • Provide further education and counselling for PrEP as a complement to existing HIV Prevention risk reduction strategies (e.g. correct and consistent use of condoms, voluntary medical male circumcision etc.) • Conduct further clinical assessment, syndromic STI screening or syphilis test (if available) • Once eligible, initiate client same day and counsel client on adherence, side effects, for PrEP to be effective • Client to receive a 30 day supply of oral PrEP medication at initiation • A 90 day supply at two subsequent clinic visits, re-test for HIV and provide additional adherence and risk reduction counselling • Commence HIV positive partner on ART • Counsel client to support partner in taking ARVs

Preferred ART regimens in pregnant and lactating women

PREGNANT AND LACTATING WOMEN	1ST LINE THERAPY	2ND LINE THERAPY
Preferred Option	TDF + 3TC+ DTG	If TDF was used as first line, use AZT plus 3TC plus ATV/r or LPV/r If AZT was used as first line, use TDF plus 3TC plus ATV/r or LPV/r
Alternative Options	TDF+3TC+EFV400	If TDF was used as first line, use AZT plus 3TC plus DTG If AZT was used as first line, use TDF plus 3TC plus DTG

Viral load monitoring for pregnant women

Pregnant HIV positive woman not yet on ART or newly diagnosed HIV positive

Initiate ART on the same day

Viral load by 3 months after ART initiation

- Undetectable (<=50 copies/ml) → Maintain ARV drug regimen
- Viral load >50 to <=1000 copies/ml → Provide enhanced adherence counselling; repeat viral load testing after 1 month
- Viral load >1000 copies/ml → If on a non-nucleoside reverse transcriptase inhibitors (NNTI)-based regimen, switch to appropriate regimen.

Provide enhanced adherence counselling; repeat viral load testing after 1 month

- Undetectable (<=50 copies/ml) → Maintain ARV drug regimen
- Viral load >50 to <=1000 copies/ml → Maintain ARV drug regimen, but continue enhanced adherence counselling and repeat viral load testing after 3 months
- Viral load >1000 copies/ml → Switch to appropriate regimen

Viral load monitoring for pregnant women

HIV positive woman already on ART and pregnant

VL at first ANC visit

- Undetectable (<=50 copies/ml)
  - Maintain ARV drug regimen
- Viral load >50 to <=1000 copies/ml
  - Provide enhanced adherence counselling; repeat viral load testing after 1 month
    - Undetectable (<=50 copies/ml)
      - Maintain ARV drug regimen
    - Viral load >50 to <=1000 copies/ml
      - Maintain ARV drug regimen, but continue enhanced adherence counselling and repeat viral load testing after 3 months
    - Viral load >1000 copies/ml
      - Switch to appropriate regimen
- Viral load >1000 copies/ml
  - If on a non-nucleoside reverse transcriptase inhibitors (NNTI)-based regimen, switch to appropriate regimen.

Viral load at first ANC Visit maybe deferred if woman has a documented most recent VL <50 copies /ml within the previous 3 months

Viral load monitoring for breastfeeding women

All breastfeeding women regardless of when ART was started

Viral load 3 months after delivery

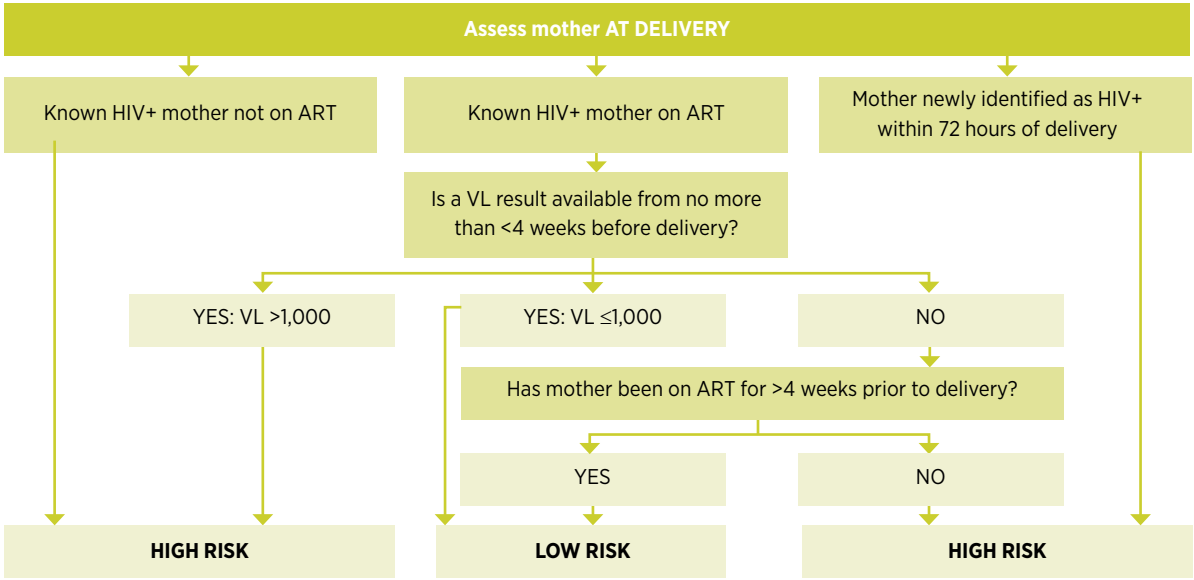
- Undetectable (<=50 copies/ml) → Maintain ARV drug regimen
- Viral load >50 to <=1000 copies/ml → Provide enhanced adherence counselling; repeat viral load testing after 1 month
  - Undetectable (<=50 copies/ml) → Maintain ARV drug regimen
  - Viral load >50 to <=1000 copies/ml → Maintain ARV drug regimen, but continue enhanced adherence counselling and repeat viral load testing after 3 months
  - Viral load >1000 copies/ml → Switch to appropriate regimen
- Viral load >1000 copies/ml → If on a non-nucleoside reverse transcriptase inhibitors (NNTI)-based regimen, switch to appropriate regimen.

Definition of a high risk HIV-exposed infant

A high-risk infant is defined as follows:

- An infant whose mother has a high viral load >1000copies/ml during the last 4 weeks before delivery
- An infant born to HIV infected woman who has received less than 4 weeks of ART at the time of delivery
- An infant born to a newly diagnosed HIV infected woman during labor, delivery and postpartum (Incident HIV infection)
- An infant whose mother has advanced HIV disease (in the absence of a VL result)

Algorithm for risk assessment at time of delivery



HIV Exposed Infant ARV Prophylaxis Regimens

High-risk infants	Low-risk infants
Breast-fed infants Daily AZT plus NVP for 12 weeks	**Breast-fed infants** Daily NVP for 6 weeks
Formula-fed infants Daily AZT plus NVP for 6 weeks	**Formula-fed infants** Daily NVP for 6 weeks

NVP and AZT Dosing for Post Natal Prophylaxis

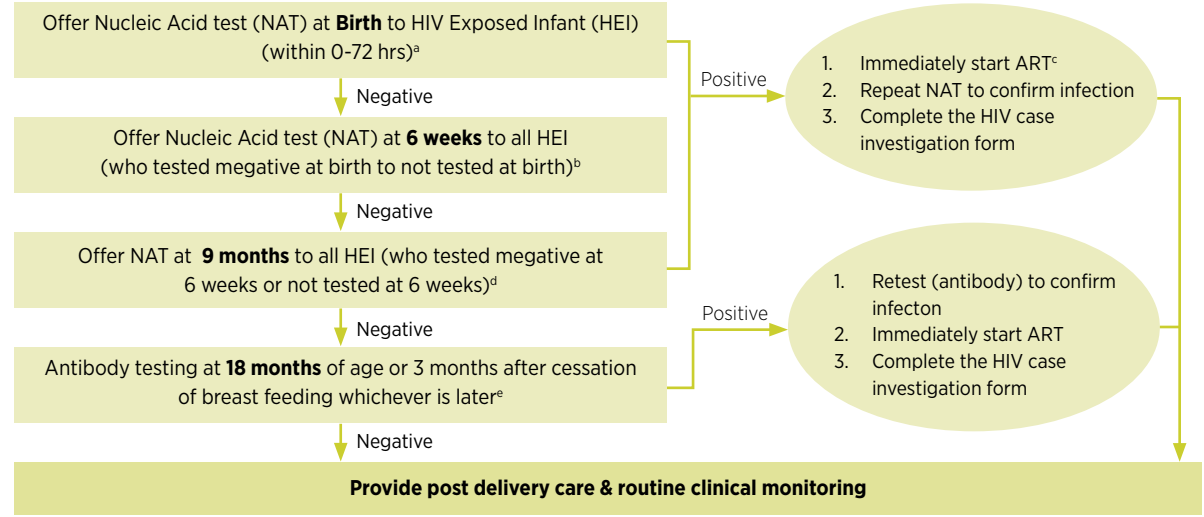
ZIDOVUDINE		
Age	**Current weight**	**Twice daily dose**
Birth to 6 weeks	<2kg >35 weeks gestation	4mg/kg twice daily
	2.0 to 2.49kg	1ml (10mg) twice daily
	>2.5kg	1.5ml (15mg) twice daily
> 6 weeks (doses according to ART drug dosing chart)	<3kg	4mg/kg dose twice daily
	3.0 to 5.9 kg	6ml (60mg) twice daily
	6.0 to 7.9 kg	9ml (90mg) twice daily
	8.0 to 13.9 kg	12ml (120mg) twice daily
NEVIRAPINE		
Age	**Current weight**	**Once daily dose**
Birth to 6 weeks	2.0-2.49kg	1ml (10mg) daily
	>2.5kg	1.5ml (15mg) daily
>6 weeks to 6 months		2ml (20mg) daily
>6 to 9 months		3ml (30mg) daily
> 9 months until 4 weeks after all breastfeeding has stopped		4ml (40mg) daily

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

Early Infant Diagnosis Algorithm



[a] Point of care NAT can be used to diagnose HIV infection and to confirm a positive test

[b] Birth testing does not replace 6 weeks testing unless the infant tested positive at birth

[c] Start ART without delay. If the second test to confirm an HIV positive result is negative, a third NAT should be done before interrupting ART

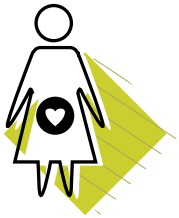
[d] NAT/DNA PCR is now routinely offered to HEI at 9 months

[e] If breast feeding extends beyond 18 months, the final diagnosis of HIV status can only be assessed at least 3 months after the end of breast feeding

NB **Please note any HEI who presents to the health facility after 6 weeks and never been tested prior should be tested for HIV at the point of contact.**

Infant and young child feeding counselling for women who are HIV positive

Explain risks of mother-to-child transmission for HIV



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 formula feeding

Summary of DSD for pregnant and breastfeeding women

	HTS	Linkage	Combination prevention	ART initiation
WHEN	All pregnant and breastfeeding women with negative or unknown status at: • 1st ANC visit, ideally in the first trimester • Retesting of women who previously tested negative in ANC in 3rd trimester or at delivery • Women who tested negative in ANC retest at 6 weeks (14 weeks if tested at delivery) postnatal and 6 monthly postnatal; align testing with EPI visits at 6 weeks (pentavalent) and 9 months (measles) Clinic opening hours HIV testing should be available 24 hours seven days a week on maternity wards.	Same day as HTS or within 7 days	Same day as HIV-negative test or within 7 days. Initiate PrEP in pregnant and breastfeeding women at high risk of HIV transmission	Same day as HIV-positive test or within 7 days
WHERE	ANC Labour and delivery PNC Outreach ANC/PNC	Positive tests: to ART initiation in ANC, labour and delivery or PNC From community-based testing, escort to community initiation or facility ANC ART services or use the MoHCC referral form Negative test: link to combination prevention services in ANC or PNC/FCH	Same location as testing: PrEP should be available at all FCH service points (ANC, labour and delivery, PNC)	Facility (ANC, PNC) or community (as long as examination and, ideally, AHD assessment can be offered)
WHO	Doctor Nurse Primary counsellor Self-tests can be given to the woman for partner testing VHW, CATS or young mentor mothers can distribute self-tests	Person delivering the test Person distributing the self-tests NB: all reactive self-tests should have confirmatory testing by a health worker	Risk assessment: HTS provider PrEP: doctor, nurse	Doctor Nurse
WHAT	Pre- and post-test counselling Rapid HIV test Distribution of self-tests from age 16	HIV positive: facilitated referral to facility HIV negative: referral to combination prevention services, including PrEP	Risk assessment, condoms, referral If eligible, initiate PrEP and follow standard follow-up schedule	Clinical, psychosocial assessment Baseline investigations, including for AHD ART initiation

Summary of DSD for pregnant and breastfeeding women

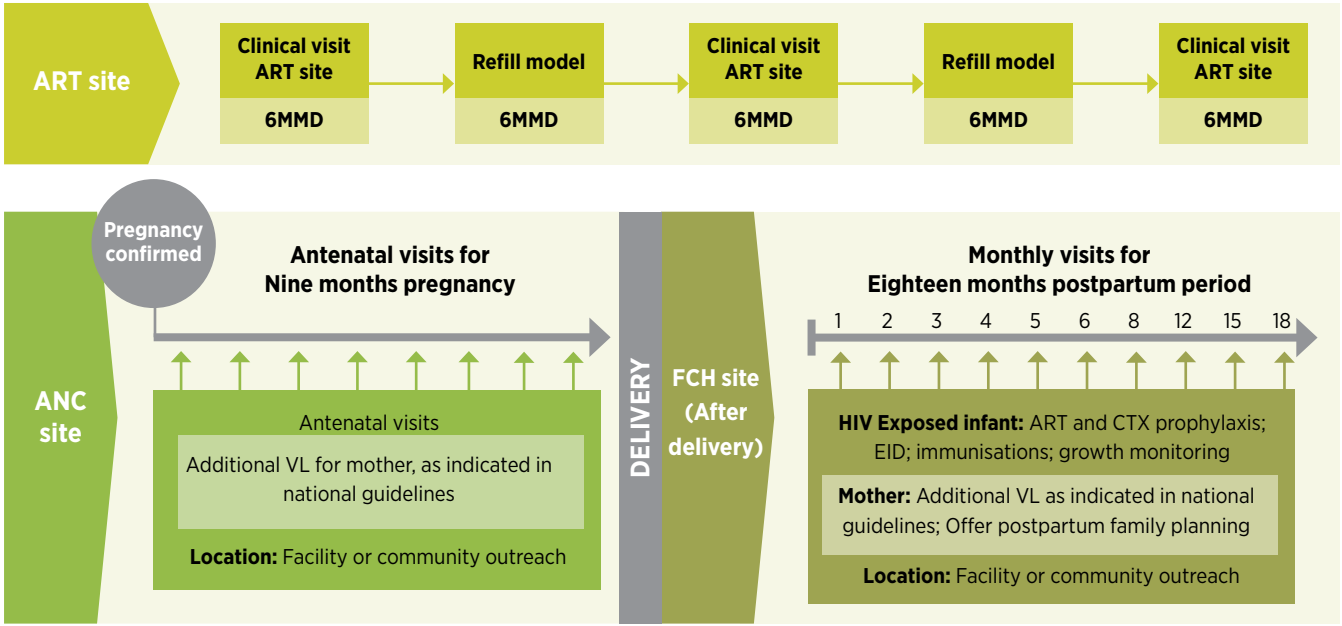
	First 12 months on ART	DSD for RoCs established on treatment	DSD for RoCs not established on ART: high VL	DSD for RoCs not established on treatment: AHD
WHEN	Take VL at booking for those already on ART at ANC booking VL at month 3 for those newly initiated on ART in ANC For all pregnant and breastfeeding women on ART, repeat VL at 34-36 weeks' gestation, 3 months post-delivery and then 6 monthly until cessation of breastfeeding Use POC where available; otherwise flag request as urgent Follow intensive follow-up schedule (additional psychosocial support at week 2 and month 2; this can be at facility, community or through telehealth. (Table 22, page 64)	Focused ANC protocol recommends 8 ANC visits 6 monthly refills (4 monthly for <25 years old)	If elevated VL >50 copies/ml, give EAC (Pages 102-106) and repeat VL 1 month after EAC 1	Assess for AHD at: • Initiation • Re-engagement after lost to follow-up • High viral load See intensive follow-up schedule (Table 22, page 64)
WHERE	Facility or out of facility Intensive counselling session can be community or telehealth	Facility (ANC, PNC) or out of facility See below for details of DSD options	EAC 1 Facility EAC 2 ideally at facility but where access a challenge out of facility or through telehealth	Facility If well but with low CD4, intensive follow-up could be out of facility or through telehealth
WHO	Doctor Nurse Primary counsellor Young mentor mother CATS	Doctor Nurse Primary counsellor Young mentor mother CATS	Doctor Nurse Primary counsellor Young mentor mother CATS	Clinical assessment: nurse, doctor POC tests: nurse primary counsellor, laboratory technician, microscopist Additional community visit by VHW or young mentor mother
WHAT	Clinical assessments Psychosocial support VL according to schedule listed under when. POC or flagged as urgent to lab	Offered adapted DSD models (Pages 76,86) Most commonly: Mbereko clubs or young mother clubs Psychosocial support	2 EAC sessions if VL >50 copies/ml and repeat VL 1 month after EAC 1 Switch to 2nd or 3rd line as appropriate Psychosocial support	Diagnosis (history, exam and CD4) Screening (CrAg, TB LAM) and prevention CTX, TPT, fluconazole if CrAg positive and not in first trimester Rapid initiation/switch Linkage IPD to OI/ART Services Psychosocial support

DSD for pregnant and breastfeeding women

Option: Stay in DSD model for ART

Attend extra ANC (counselling and additional VL) at FCH

✓ Woman on ART | ✓ Viral load suppressed | ✓ Receiving six-monthly refills

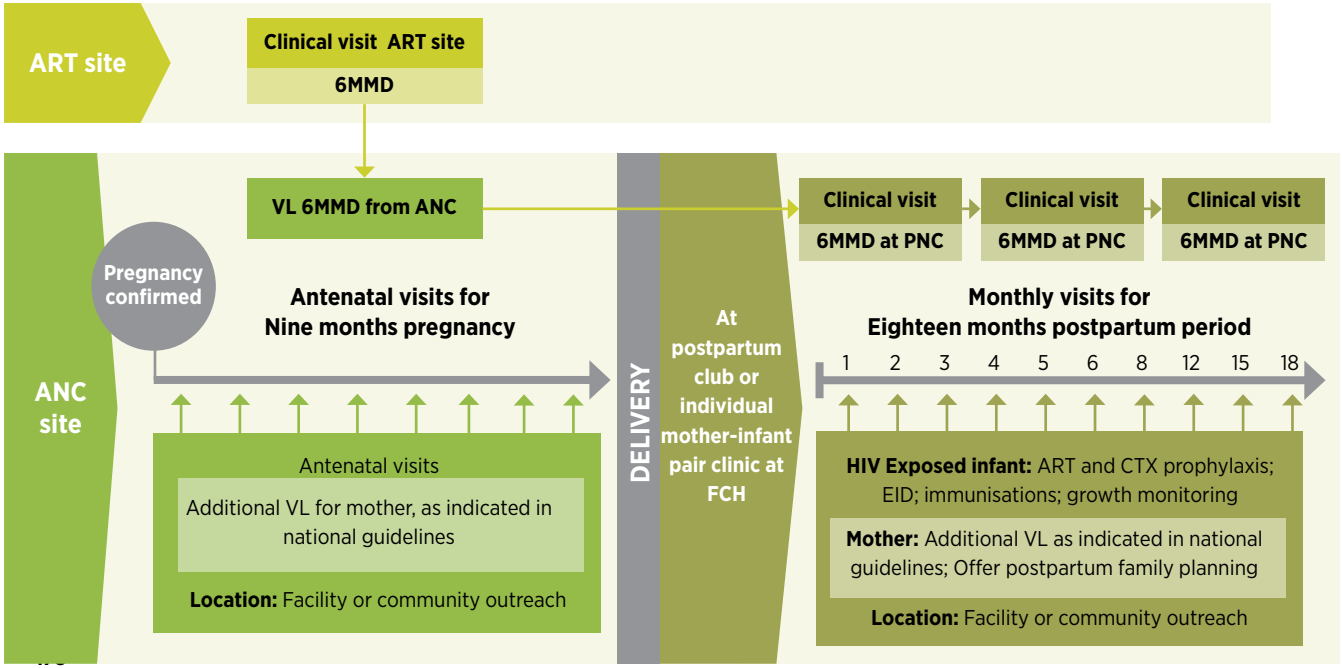


DSD for pregnant and breastfeeding women

Option: Transfer care to ANC

Attend ANC (counselling and additional VL) at ANC

✓ Woman on ART | ✓ Viral load suppressed | ✓ Receiving six-monthly refills



COUNSELLING TOOLS

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






The "Our Story" Game

Helping children, young people and their families to understand HIV,ARVs and adherence

"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!!

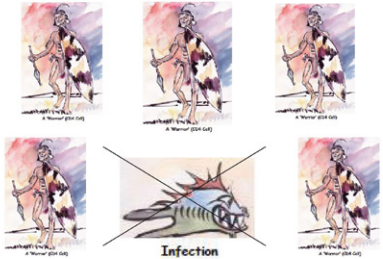
ART education: How to use the HIV and ART Counselling Card Game

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**'

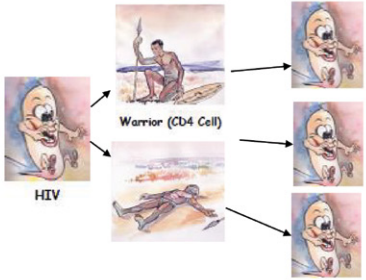


The warriors (or CD4 cells) work together to fight off infections and keep us **strong and healthy.**

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 fly 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

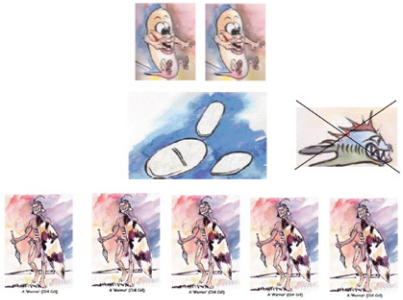
But there are now medicines which **fight against HIV**

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

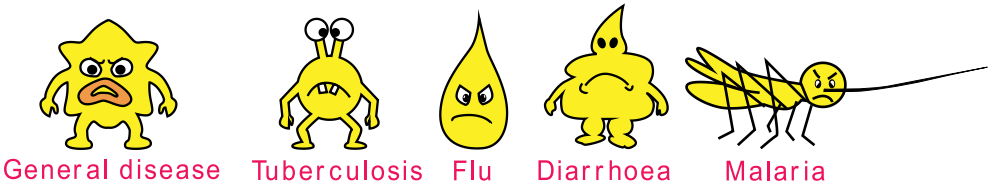
The immune system is **stronger** and it is possible to fight against infections again.

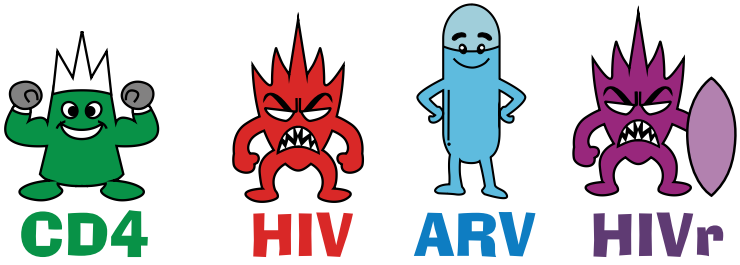
ARVs work very well but they are not a cure – they cannot remove HIV completely

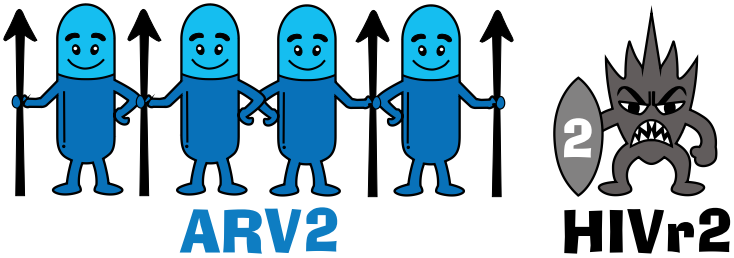
You must adhere:

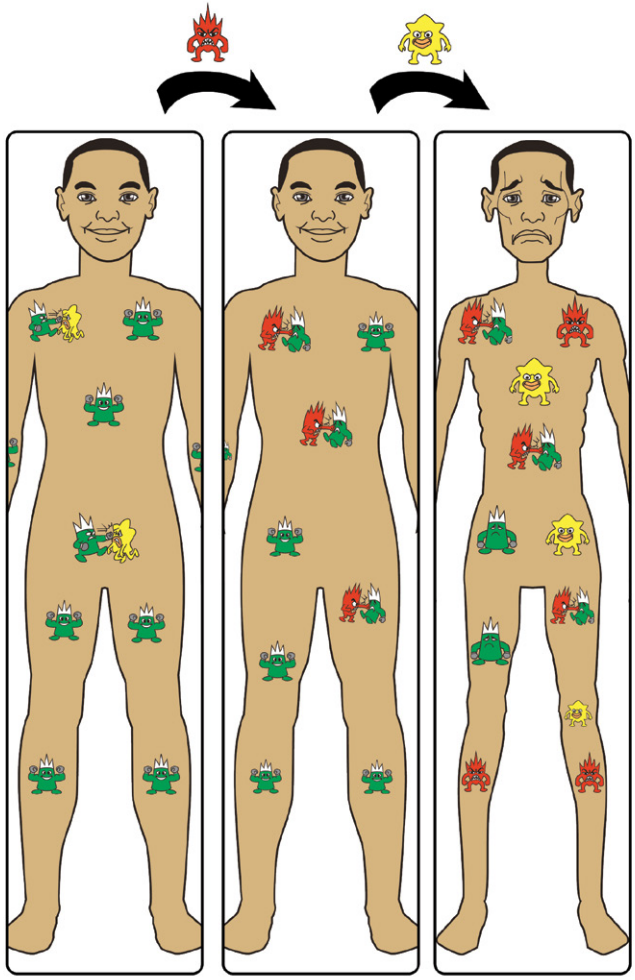
- **Take every single dose**
- **At the right time**
- **For Life**

Key to pictures in counselling tools

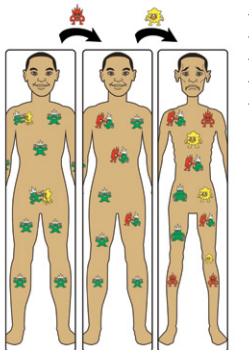




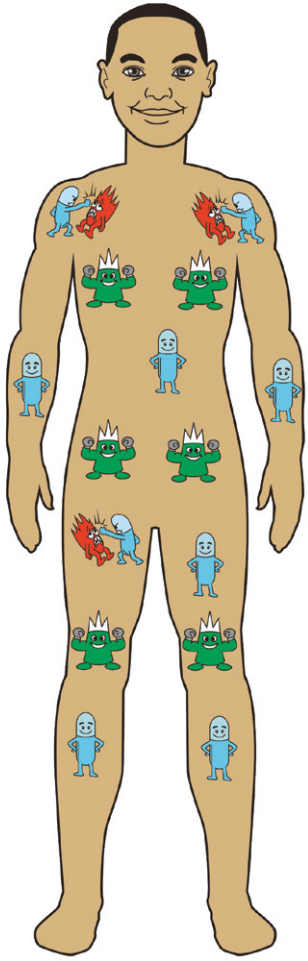




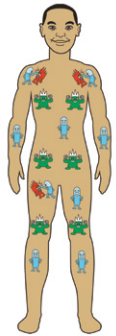
Basic HIV education



- **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.**



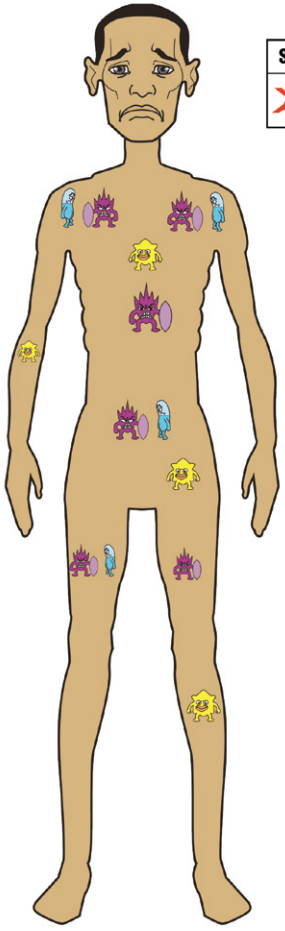
Basic ART education (1)



- **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 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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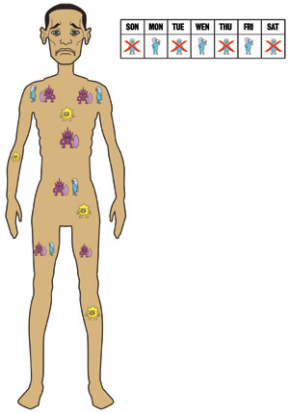
Basic ART education (3)

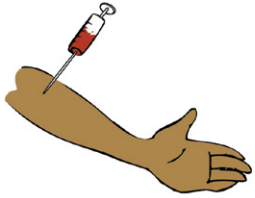


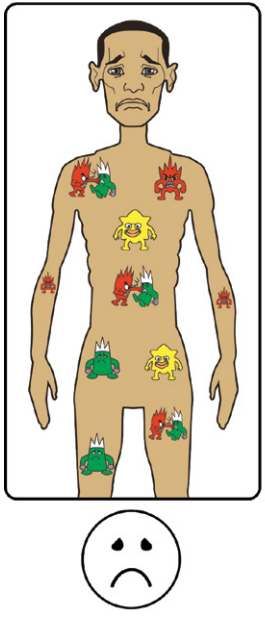
- **What is poor adherence to ART?** ARVS should be taken every day as close to the same time as possible. Poor adherence is when we take our pills late, when we forget to take a dose or when we don't take the pills at all. An example is if we stop the treatment because we are feeling better.
- **What 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/DTG.
- **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.
- **The most common side effects of DTG** are initial sleep disturbance and weight gain. Your weight will be monitored at your clinical reviews. A healthy diet and exercise will also help reduce the risk of weight gain.

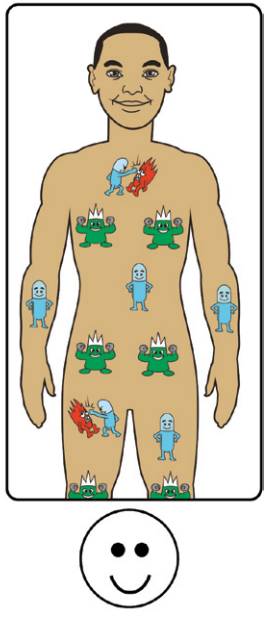

ART
CARD
Referral
Letter

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.







Viral load not suppressed

Viral load Suppressed

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 your viral load result mean?

- Viral load results can be categorized into three groups
  - Undetectable ≤50 copies/ml
  - Low-level viraemia >50 to ≤1000 copies/ml
  - Unsuppressed >1000 copies/ml
- Undetectable viral load 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.

- An 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 low level viraemia or an unsuppressed viral load mean?

- You may be facing problems to adhere to your treatment. This is the most common cause for the viral load not to be suppressed.
- By solving your adherence problems early, you can get your viral load to 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 (< 50 copies/ml) you will be offered some options for how to collect your drugs in the future.
- 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 up to 6 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.

See SOPs page 106-120 of job aide

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 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.

Preparing the child for disclosure

READINESS ASSESSMENT CRITERIA: PARTIAL AND FULL DISCLOSURE TO A CHILD AGED 5-10 YEARS	
Assessment with Caregiver	**CHECK MARK**
Confirm with the caregiver that he/she is ready to initiate disclosure	
Determine the caregiver's knowledge about HIV through playing Masas'	
Discuss around benefits and risks of disclosure	
Ascertain whether there are other people living with HIV in the child's household. Check who knows about the child's status.	
Assess available family and/or community support for the caregiver and child	
If the mother is the caregiver, check if she has feelings of guilt and help her address them	
Assessment with Caregiver and Child	
Assess what the child knows about the medicines he/she is taking and why he/she is taking them.	
Determine the child's own impression of his/her health	
Ask about school and friends – check if the child has difficulties in building and maintaining friendships with peers	

Preparing the child for disclosure

READINESS ASSESSMENT CRITERIA: PARTIAL AND FULL DISCLOSURE TO ADOLESCENT (10-14 YEARS OR OLDER)	
Assessment with the Adolescent	**CHECK MARK**
Assess the adolescent's knowledge of his/her health and find out what he knows about the medicines he/she has been taking and information about his/her illness	
Explore the adolescent's relationship with his/her peers at school, at home and in the community. Assess available family, community and peer support.	
Screen for depression using SSQ screening questions. Continue with full assessment if adolescents answers yes to these.	
Assess if the adolescent is or ever has been sexually active	
Assessment with Caregiver	
Determine the caregiver's knowledge about HIV and discuss around benefits and risks of disclosure	
Ascertain whether there are other people living with HIV in the household. Check who knows about the adolescent's status.	
Assess available family, community and peer support.	
Confirm that the caregiver is ready to disclose	

Disclosure process – partial disclosure

Points to Cover

- Explain about the immune system by using the Masas' (soldier game)
- Avoid using the word 'HIV' and refer to the card as a 'sleeping bug'
    - There are solders protecting the body from germs
    - The bug hurts the soldiers so that the germs can harm the body
    - Medications help put the bug to sleep so that the solders are fit and strong
    - If you stop taking the medications, the bug will awaken and start hurting the solders again. Therefore it's important to take them every day
    - Every year there is need to take a blood test to check if the sleeping bug is still asleep

Disclosure process – full disclosure

Points to Cover

- If you have done partial disclosure then ask the child/adolescent to play the soldier game to check his/her understanding of the immune system, the disease and the medications.
- If partial disclosure has not been done, then play the soldier game with the child/adolescent, explaining around the immune system, the disease and the medications.
- Name the “sleeping bug” as HIV.
- Talk to the child/adolescent about the difference between HIV and AIDS.
- Discuss around modes of transmission, and explain how the child/adolescent acquired HIV.
- Instructing the child/adolescent how they can live with the virus, what they should do, and how to avoid transmitting HIV to others.
- Discuss how to keep their HIV status confidential; who to tell and what to tell.
- Depending on the cognitive ability of the child/adolescent, discuss around safe sex, the potential for sexual relationships, and reproductive health (e.g., possibility of happy life, marriage and relationship with negative partner, having healthy children).
- Provide any further information, depending on the age and cognitive ability and interest of the child or adolescent.
- Allow the child or adolescent time to ask any questions. Reassure them that they can ask questions in future.
- At the end of the conversation, ask the child/adolescent to repeat what he/she has understood from this conversation.
- Invite the child/adolescent to share their thoughts and feelings around what has been discussed.

Post disclosure follow up and support

- Like adults, children may go through a period of denial, anger, or self-pity following disclosure of their HIV status. Once the HIV status has been disclosed to the child or adolescent, there should be monitoring and follow-up in the short- and long-term, providing support, additional information and evaluating for any adverse outcomes. The follow-up is meant to:
- Assess positive (such as improved self-confidence, self-awareness) any negative outcomes (such as stigma and depression) in both the caregiver and the child or adolescent
- Review the understanding of the child or adolescent about their HIV status
- Monitor how well they are coping with the diagnosis and treatment disease
- Screen for mental health. Identify needs for further referrals.
- Refer to CATS for peer support.
- Offer to link the child/adolescent to a support group.

Disclosure in the presence of HCWs

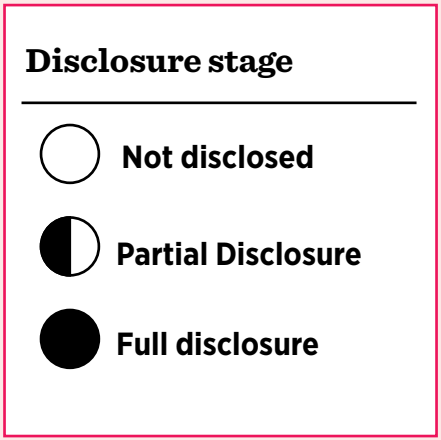
- Caregivers often prefer the active involvement of HCWs in the disclosure process, and they frequently play an integral role in the caregivers' decision to disclose. (Britto et al, 2016)

- HCWs can provide crucially important and supportive discussions and education after disclosure by the caregiver. In the absence of an appropriate family member or at the request of the family or caregiver, the HCW needs to be ready to assume the primary role in disclosure. (Beck-Sague et al, 2015)

- Many adolescents express that they would have preferred to be disclosed to in the presence of a health care worker to ensure correct information. (Kidia et al, 2014)

Documentation

- Disclosure status is documented as shown opposite when
  - opening a new file
  - is updated as the disclosure procedes



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, 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)