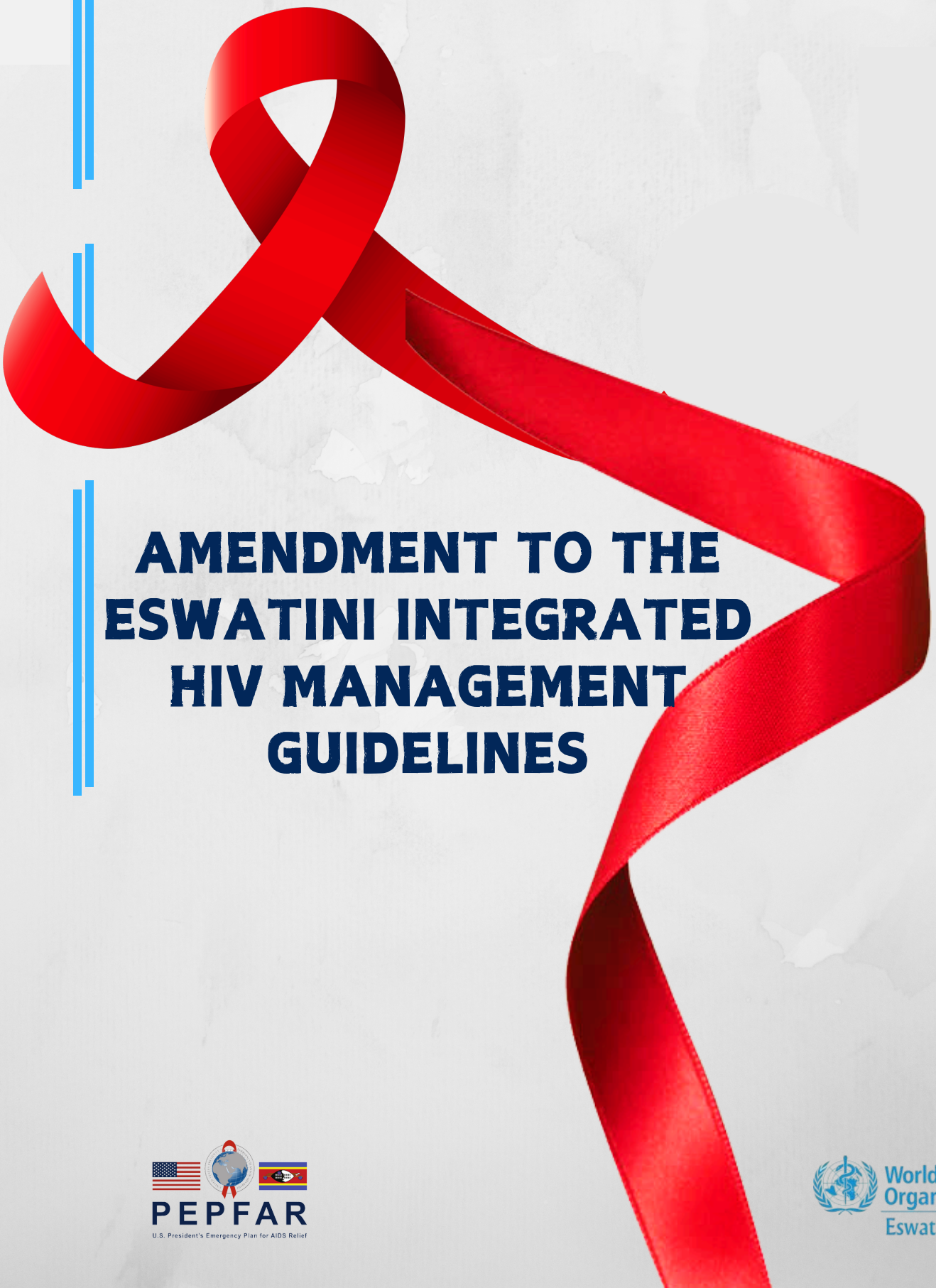
Kingdom of Eswatini
Ministry of Health

2024



AMENDMENT TO THE ESWATINI INTEGRATED HIV MANAGEMENT GUIDELINES

PEPFAR
U.S. President's Emergency Plan for AIDS Relief

World Health Organization
Eswatini

PREFACE

Eswatini has made significant strides towards achieving the UNAIDS 95-95-95 epidemic control goal by 2030. This is evidenced by data from the 2019 annual report which reported that 98% of all people living with HIV (PLHIV) in Eswatini were aware of their status while 96% were on ART and 92% had achieved viral suppression. However, further analysis of the health management and information systems (HMIS) data, shows that there are sub-population differences. Among those tested for HIV, more than 90% are found to have long-term infection. These may be late presenters, patients already on ART presenting for retesting, or those who had disengaged from care and using HIV testing as a re-entry point of care. The country still needs to investigate why such happens. With 96% of PLHIV on ART, viral load suppression and retention in care also differ by age and gender. From the collected samples in 2020, more females than males had a suppressed viral load. Additionally, among children viral load coverage remains suboptimal partly due to a lack of skills in collecting samples from children and because they depend on adults to present themselves to the hospital. It is therefore important to prioritise males especially young men as well as adolescents and young children if the country is to maintain the gains attained so far. A significant proportion of PLHIV are dying from non-AIDS related deaths which on one hand shows the success of the HIV program and on the other further emphasizes the need to provide integrated services.

The Eswatini Ministry of Health commissioned the 2022 Integrated HIV Management Guidelines in May 2022. In light of recent global evidence, the Ministry of Health through the Eswatini National AIDS Program (SNAP), has issued this amendment to the Guidelines to expand access to optimal antiretroviral regimens and HIV testing and linkages services for People living with HIV to improve their clinical outcome and health.

This document serves to inform all HIV service providers about the official changes as highlighted in the Amendment to the 2022 HIV Management Guidelines and pocket guidelines.
This guidelines amendment and implementation guide includes the following key updates: (a) Intensified case finding gaps in specific sub-populations including among children, women 15-24, men 25-34, the military and key populations (MSM & FSW). (b) Linkages to prevention and treatment and care (c) basic care package for HIV-Positive individuals including the introduction of pretreatment Viral Load (d) Paediatric, HIV (e) HIV/NCDs (f) TB/HIV and (g) Mental Health.

I would like to take this opportunity to thank the Ministry of Health program leads, technical working group members, recipients of care, key stakeholders, and implementing partners for their contribution and support in developing and implementing these guidelines.

Dr VJ. Okelo
Director of Health Services, Ministry of Health

ACKNOWLEDGMENTS

The Amendment to the 2018 Swaziland Integrated HIV Management Guidelines has been made possible by the commitment of the Eswatini National AIDS Program thematic leads and their implementing partners. This team worked tirelessly to ensure that guidance given in this document is up to date, evidence-based and applicable in the Eswatini context. The guidelines content development was led by the thematic leads and focal people within the Ministry of Health.

Appreciation goes to the following:

• Dr Clara Nyapokoto	***HIV Care & Treatment***
• Ms Lenhle Dube, • Ms Takhona Mkhabela • Mr Musa Ginindza	***HIV Testing Services***
• Ms Harriet Mamba	***Extended Linkage Case Management***
• Ms Nobuhle Mthethwa	***Paediatrics Care & Treatment***
• Ms Gugulethu Madonsela • Mr Malvern Masango	***TB/HIV & Advanced HIV Disease***
• Ms Setsabile Gulwako • Ms Bongiwe Mhlanga	***Monitoring & Evaluation***
• Mr Wiseman Mngometulu • Ms Ntombikayise Dlamini	***Sexual Reproductive Health Unit-Prevention of Mother-to-Child Transmission***

• Ms Nompilo Gwebu	***Adherence & Psychosocial Support***
• Mr Nhlanhla Magagula	***Risk Communication***
• Ms Ntombi Ginindza • Ms Zinhle Shabangu • Dr Njeri Nyanja	***Non-Communicable Diseases***
• Ms Thembie Dlamini	***Quality Improvement***
• Ms Promise Dlamini • Ms Salaphi Dlamini	***Mental Health/HIV -Psychological Care and Support***
• Mr Sabelo Mlambo • Mr Mndeni Sukati	***Voluntary Medical Male Circumcision***

For their technical support, appreciation also goes to Country Directors and contributors from WHO Country Office, PEPFAR, USAID, CDC, UNAIDS, GU, the ASPIRE Project, URC, ICAP, MSF, FHI 360, Jhpiego, Baylor, AHF, TLC, PSI and PACT. To the different civil society organizations and recipients of care who participated in this guideline development, your inputs are greatly appreciated.

Special appreciation is given to the ENAP Program Manager, Ms Sindy Matse who provided overall oversight of the guideline addendum development process.

The following professionals and country teams are appreciated for their inputs and review:

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ACRONYMS

3TC	Lamivudine
ABC	Abacavir
ACEI	Angiotensin-Converting Enzyme Inhibitor
AHI	Acute HIV Infection
ALT	Alanine Aminotransferase
ANC	Antenatal Care
ARB	Angiotensin Receptor Blocker
ART	Antiretroviral Therapy
ARV	Antiretroviral (Drug)
AST	Aspartate Aminotransferase
ATT	Anti-Tubercular Therapy
AZT	Zidovudine
BCG	Bacillus Calmette-Guerin
BDQ	Bedaquiline
CAGs	Community ART Groups
CCB	Calcium Channel Blocker
CIHTS	Client-Initiated HIV Testing Services
CPT	Co-Trimoxazole Preventive Therapy
CrAg	Cryptococcal Antigen
DBS	Dry Blood Spot
DMA	Delamanid
DRV/r	Darunavir/Ritonavir
DSD	Differentiated Services Delivery
DTG	Dolutegravir
ECP	Emergency Contraception
EFV	Efavirenz
EID	Early Infant Diagnosis
EIMC	Early Infant Male Circumcision
eIP	Enhanced Infant Prophylaxis
eMTCT	Elimination of Mother-To-Child Transmission
EPI	Expanded Programme on Immunization
FDC	Fixed-Dose Combination
FTC	Emtricitabine
GBV	Gender-Based Violence
HBeAg	Hepatitis B Envelope Antigen
HBsAg	Hepatitis B Surface Antigen
HBV	Hepatitis B Virus
HCTZ	Hydrochlorothiazide
HCV	Hepatitis C Virus
HCW	Healthcare Worker
HIVST	HIV Self-Testing
INSTI	Integrase Strand Transfer Inhibitor
IPV	Intimate Partner Violence
IRIS	Immune Reconstitution Inflammatory Syndrome
IUD	Intrauterine Device
LAM	Lipoarabinomannan
LDL	Low-Density Lipoprotein (Cholesterol)
LEEP	Loop Electrosurgical Excision Procedure
LFA	Lateral Flow Assay
LF-LAM	Lateral Flow Urine Lipoarabinomannan Assay
LPV	Lopinavir
LPV/r	Lopinavir/Ritonavir

ACRONYMS

LTBI	Latent Tuberculosis Infection
MDR-TB	Multidrug-Resistant Tuberculosis
MNCH	Maternal, Newborn and Child Health
NAT	Nucleic Acid Test
NNRTI	Non-Nucleoside Reverse-Transcriptase Inhibitor
NRTI	Nucleoside Reverse-Transcriptase Inhibitor
NSAID	Non-Steroidal Anti-Inflammatory Drug
NVP	Nevirapine
PCR	Polymerase Chain Reaction
PEP	Post-Exposure Prophylaxis
PI	Protease Inhibitor
PIHTS	Provider-Initiated HIV Testing Services
PJP	Pneumocystis Jiroveci Pneumonia
PLHIV	People Living With HIV
PMTCT	Prevention Of Mother-To-Child Transmission
PrEP	Pre-Exposure Prophylaxis
RIF	Rifampicin
STI	Sexually Transmitted Infection
SUAC	Stepped-Up Adherence Counselling
TB	Tuberculosis
TDF	Tenofovir Disoproxil Fumarate
TPT	TB Preventive Therapy
VIA	Visual Inspection with Acetic Acid
VL	Viral Load
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization

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CHAPTER 3:
HIV TESTING SERVICES

CHAPTER 3: HIV TESTING SERVICES

INTRODUCTION

Even though Eswatini has made tremendous progress towards HIV Epidemic Control, findings from SHIMS3 (2021) indicate that critical case-finding gaps remain at the sub-population level among children 15 years and below, women 15-29 years, men 25-34 years, the military and key populations (MSM & FSW). These HTS gaps need to be addressed to ensure Eswatini fully achieves and maintains the first 95 UNAIDS HIV epidemic control target.

PURPOSE

This addendum seeks to provide guidance to address current HTS gaps through strategic shifts in HTS implementation, and adoption of a status-neutral approach as the key gateway for entry into care.

SUMMARY OF CHANGES

2022 GUIDANCE	2024 GUIDANCE
Training of HTS counsellors to be conducted by PSI and TASC	• Any accredited institution recognized by SNAP and EHLS may train HTS Counsellors • Entry requirements for HTS training is completion of Form V
The HIV testing screening tool will be used to determine eligibility for HTS.	• HIVST replaces the risk based HTS screening tool in all individuals 12 years and above (excluding clients eligible for routine testing). • Routine testing following the National HIV Testing Algorithm should be offered to malnourished and sick children, HIV-exposed children, clients with confirmed or presumptive TB disease, STI clients, index contacts and inpatient, pregnant and lactating women and KPs.
Use the HIV screening tool for children and adolescents (6-15yrs) to determine eligibility for HTS.	• All children 2-11 years utilize the paediatric HIV screening tool in all entry points unless they qualify for routine testing
HIV Self-test kits/Oraquick can be distributed at the health facility level and performed privately in the client's home or facilitated by a healthcare worker in a private setting at a health facility.	• The age of consent for HIVST has been reduced from 16 years to 12 years

2022 GUIDANCE	2024 GUIDANCE
Frequency of rescreening for HIV undefined	• For children 2-11 years rescreen at every encounter using the risk assessment tool. • For all individuals 12 years and above rescreen at every facility encounter using HIVST • For ANC and PMTCT, retesting guidelines remain unchanged. ***Refer to Eswatini Integrated HIV Management Guidelines – 2022 (Chapter 3)*** • For all clients eligible for routine testing, retesting guidelines remain unchanged. **Refer to Eswatini Integrated HIV Management Guidelines – 2022 (Chapter 3)** • PrEP retesting guidelines remain unchanged. ***Refer to Eswatini Integrated HIV Management Guidelines – 2022 (Chapter 3)***

3.1 HIV TESTING SERVICE DELIVERY APPROACHES

3.1.1 HIV SELF TESTING (HIVST)

ASSISTED AND UNASSISTED – WHO DEFINITION

Directly Assisted HIVST refers to when individuals who are self-testing for HIV receive tailored, translated or pictorial instructions for use with additional support such as a local telephone hotline, virtual real-time support or supervision through online platforms, an in person or video-based instruction or as part of a large group (e.g., waiting room) from a trained provider or peer before distribution of the HIVST kit, with instructions on how to perform a self-test and how to interpret the self-test result. This assistance is provided in addition to the manufacturer-supplied instructions for use. **Directly assisted HIVST does not mean that the test must be performed in the presence of a provider.**

Unassisted HIVST refers to the distribution of HIVST kits with the manufacturer-supplied instructions, but without additional instruction or assistance.

Age of consent: The age of consent has been reduced from **16 years to 12 years.**

Distribution points: Unchanged. Refer to Eswatini Integrated HIV Management Guidelines – 2022 (Chapter 3)

QUALITY ASSURANCE IN HIVST

1. HIVST must be conducted using the nationally approved oral or blood-based HIV rapid self-test kits
2. Quality assurance practices must be taken into consideration during HIV self-testing to ensure quality results. For detailed information refer to the SOP
3. HIVST must not be used for clients who are HIV positive and /or on treatment
4. Even though HIVST results may be highly sensitive and specific, a single reactive HIVST result is insufficient to provide a definitive HIV-positive diagnosis. Individuals with a reactive test result must receive further testing from a trained tester using the National HIV Testing Algorithm. Confirmatory testing may NOT be done through HIVST.
5. Non-reactive HIV self-testing results should be considered HIV-negative, with no need for immediate further testing.
6. Invalid HIV self-testing results need to be repeated using another HIV self-testing kit or client should alternatively seek testing from a trained provider

3.2 HIV SCREENING TOOLS

All clients presenting in the facility or community must be screened for HIV. First determine eligibility of the client using the HIV eligibility screening process flow below ***(Figure 3.1)***. This process flow does not apply for clients eligible for routine testing (i.e. malnourished and sick children, HIV-exposed children, clients with confirmed or presumptive TB disease, STI clients, index contacts, pregnant and lactating mothers, inpatient and key populations (KPs).

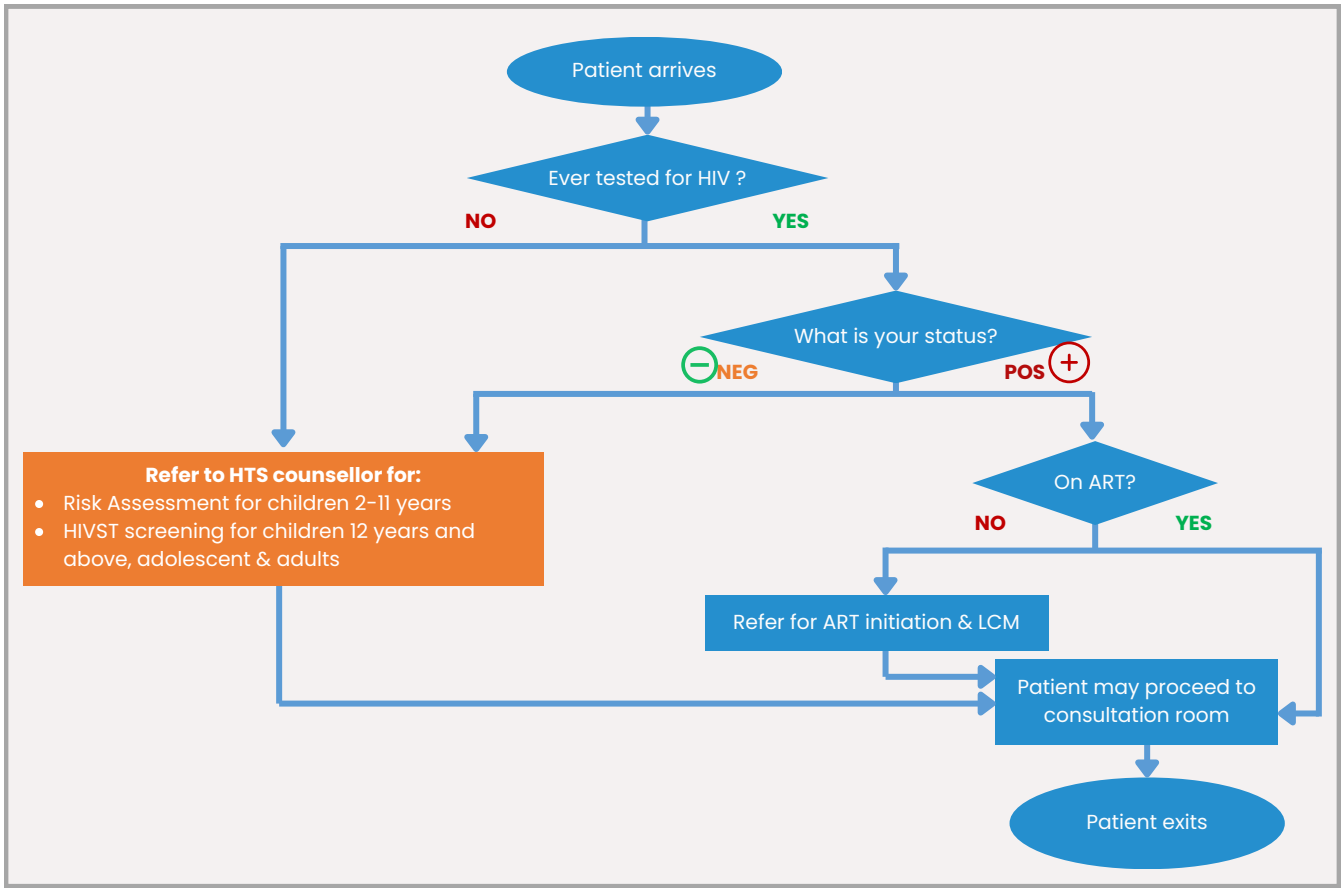

Figure 3.1 The HIV eligibility screening process flow.

3.2.1 RISK ASSESSMENT TOOL

Risk assessment will only be done for HIV negative children aged 2-11 years presenting in the facility or community. All children aged 2-11 years will be risk assessed using the paediatric HIV screening tool (see annex) at all entry points unless they qualify for routine testing following National HIV Testing Algorithm (i.e. malnourished and sick children, HIV-exposed children, clients with confirmed or presumptive TB disease, STI clients, index contacts and inpatient).

3.2.2 HIVST AS A SCREENING TOOL

Eswatini has adopted HIVST as a screening tool because of its higher specificity and sensitivity compared to the HIV risk assessment tools for children above 12 years, adolescents and adults. However, the priority groups (i.e. malnourished and sick children, HIV-exposed children, clients with confirmed or presumptive TB disease, STI clients, index contacts and inpatient, pregnant and lactating women) should continue with routine testing.

Patients eligible for HIVST screening are:

- All individuals 12 years and above
- PrEP initiations and follow-ups (only Oral and Ring)

3.2.2.1 Use of HIV-ST Among All Individuals 12 Years & Above

Screen all individuals 12 years and above eligible for HTS with HIVST, unless among priority groups who qualify for routine testing (i.e. malnourished and sick children, HIV-exposed children, clients with confirmed or presumptive TB disease, STI clients, index contacts, pregnant and lactating mothers, inpatient and key populations (KPs). If they test HIV negative, actively link them to prevention services. If the test results are HIV positive, offer partner notification services and link to treatment services.

Re-screen at every facility encounter (initial visit and every 2 months thereafter) at every entry point.

1.Use of HIV-ST among PrEP Clients

There are two key approaches where HIVST can be considered as part of PrEP delivery:

1. ***Demand generation and linkage to PrEP***: HIVST can be an important tool to generate demand for PrEP by reaching individuals who may not otherwise test or access health facilities.
2. ***PrEP (re-)initiation and follow-up visits:*** HIVST can be used for clients (re-)initiating or continuing oral PrEP or the PrEP ring. For **CAB-LA users**, a National HIV Testing Algorithm **needs to be used**.

PrEP (re-) Initiation

	Oral PrEP (daily, ED, or alternating) or PrEP Ring	CAB-LA
HIV test	An HIVST can be used to rule out HIV infection except for PBFW for whom a National HIV Testing Algorithm is recommended.	National HIV Testing Algorithm needs to be used to rule out HIV infection.
Assess PEP eligibility	For any UNPROTECTED sexual exposure in the last 72 hours, clients should be assessed for PEP eligibility, prior to PrEP initiation.	
Volume dispensed	1 month prescription (1 bottle) of TDF/3TC or 1 DPV ring.	Initiation injection 1 is given.
Next appointment	Schedule next visit date after 1 month.	Schedule next visit date for initiation injection 2 after 1 month days (+/- 7 days).
HIVST distribution	Can be provided as an exit test or for ED PrEP users before a new cycle of exposure.	N/A

PrEP F/U Visits

	Oral PrEP or PrEP Ring	CAB-LA
HIV testing Frequency	At one month, then every three months.	At one month, then every two months.
HIV testing type	HIVST for all clients except PBFW who will receive a National HIV Testing Algorithm during their ANC/PNC visit.	National HIV Testing Algorithm

	Oral PrEP or PrEP Ring	CAB-LA

Volume dispensed	• At the first follow-up visit (M1), oral PrEP/ PrEP ring can be dispensed for a maximum of three months.
	• For the second refill (M4), the PrEP method can be dispensed for a maximum of six month if the client meets the following criteria:
	  • Client is attending the FU appointment on time (within 7 days of scheduled visit date)
	  • Clients do not report any side-effects.
	  • Client wants to continue with the same PrEP method,
	  • Client is not pregnant or breastfeeding or has any comorbidities.
	  • Client is willing to take an HIVST to conduct after three months and:
	  • If HIV negative to continue with remaining three month of PrEP.
	  • If positive to discontinue their PrEP method and report to the facility for confirmation of the test result and linkage to ART.
	• For clients not meeting the above criteria, a maximum refill of three months can be done at any time.
		After initiation injection 1 and 2, re-injections will be given every 2 months (+/- 7 days).

HIVST distribution	• Clients eligible and receiving 6MMD should be provided with an HIVST to test after using 3 months of their PrEP product. • For ED PrEP clients, consider providing 2 HIVST for any in between exposure.	N/A
Next appointment	• 3 or 6 months depending if client qualifies for 6MMD and available stock. • For PBFW clients, PrEP visits should be aligned with ANC and PNC visits.	After initiation injection 2, follow up appointments and re-injection will be every 2 months.

CHAPTER 4:
REFERRAL & LINKAGES

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INTRODUCTION

Even though Eswatini has made tremendous progress towards HIV Epidemic Control, findings from SHIMS3 (2021) indicate that there are still gaps for the 2nd 95 targets. Males aged 25-34 years know their HIV status yet 13% are not on ART.

Linkages to prevention and treatment can be implemented at both the facilities and community levels. Community engagement especially engaging AGYW, key populations and men on status neutral is crucial to create demand, reduce new infections and reduce stigma and discrimination. Subpopulations that are at risk for getting infected with HIV should be prioritized for combination prevention as this can improve testing as well as prevention and care outcomes. Clients delaying ART initiation should be referred according to the facility-based escalation counselling.

SUMMARY OF CHANGES

2022 GUIDANCE	2024 GUIDANCE
• Referral and linkages to prevention or care and treatment services should be provided to both negative and positive clients, respectively.	• The old guidance is unchanged. • However, providers should shift to implementing a status neutral approach: all individuals provided with HTS should be directly linked to services appropriate to their health needs (prevention or ART services) regardless of HIV status.

4.1 STATUS NEUTRAL APPROACH

Even though Eswatini has made tremendous progress towards HIV Epidemic Control, findings from SHIMS3 (2021) indicate that there are still gaps for the 2nd 95 targets. Males aged 25-34 years know their HIV status yet 13% are not on ART.

Linkages to prevention and treatment can be implemented at both the facilities and community levels. Community engagement especially engaging AGYW, key populations and men on status neutral is crucial to create demand, reduce new infections and reduce stigma and discrimination. Subpopulations that are at risk for getting infected with HIV should be prioritized for combination prevention as this can improve testing as well as prevention and care outcomes. Clients delaying ART initiation should be referred according to the facility-based escalation counselling.

Status neutrality seeks to address social and structural barriers to engagement in combination with biomedical prevention (e.g. PrEP, PEP, VMMC, STI screening, Condoms, treatment as prevention (TaP) and behavioural prevention (e.g. condom use, delaying sexual debut and reducing the number of sexual partners).Status-neutral approaches in HIV prevention and care are essential because they prioritize the health needs of

individuals irrespective of their HIV status, fostering an environment where testing, prevention, and treatment services are more readily accepted and utilized. This strategy enhances early detection, and continuous care, which is crucial for controlling the HIV epidemic and improving patient outcomes across diverse populations.

Benefits of status neutral are:

1. Dramatically decrease new HIV infections.
2. Supports and enables optimal health through continual engagement in comprehensive, "whole person" care.
3. Increases opportunities for more efficient service delivery.
4. Improves health equity.

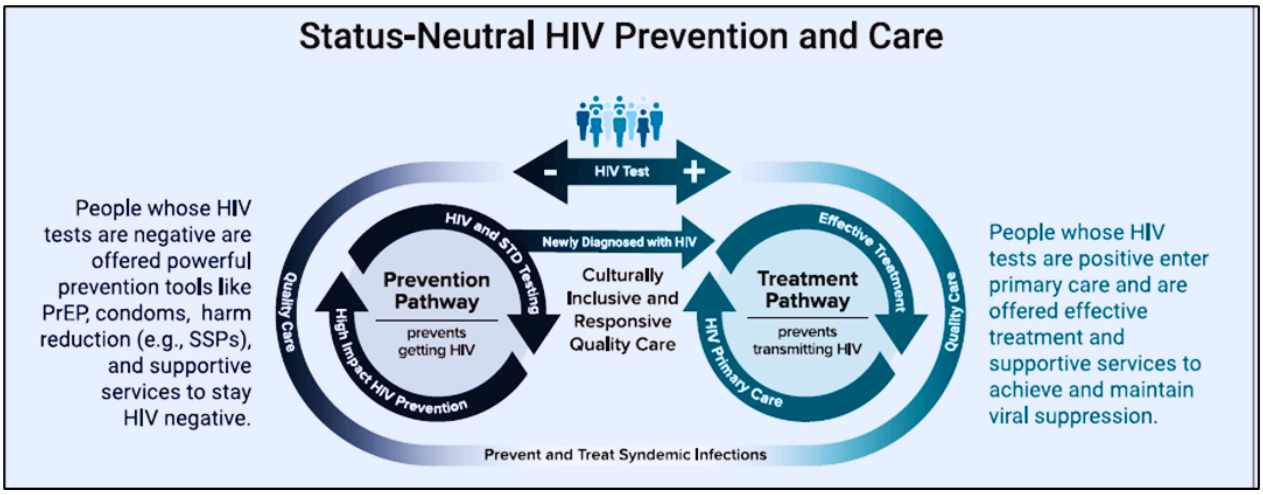

Figure 3.2 The HIV eligibility screening process flow.

4.2 RE-ENGAGEMENT

Clients disengage and re-engage into care for various reasons throughout the continuity of care. Additionally, clients may move between health facilities.

2022 GUIDANCE	2024 GUIDANCE
• It is recommended that the client present transfer letters from the transferring facility.	• Should a client fail to present a transfer letter, healthcare workers should continue the re-engagement and contact the transferring facility to complete the transfer process.

It is important to identify the reason why the client interrupted treatment and develop and action plan based on the reasons for treatment interruption.

- Clients should not be dismissed/declined services health facilities for failing to present a transfer letter, instead contact the transferring facility to complete the transfer process.
- Clients who present as new clients and were verified as having interrupted treatment should not be documented as new but be re-linked back to care and managed according to the guidance in the reengagement strategy.

4.3 VISUAL COUNSELLING TOOL- B-OK (PHILA) BEADS

Healthcare workers are encouraged to use visual aids e.g Phila beads, to assist clients in understanding issues around HIV as the language of science is not the language of the people. The medical terminology results in the client not understanding the terms that healthcare workers are using. The beads are more client centered.

Figure 3.3 B-OK (Phila) Beads.

Visual aid consists of 3 bottles of coloured beads in varying ratios as seen above.

1. The Counsellors explain that red beads symbolize the HIV virus,
2. Green beads the CD4 count (healthy body).

When a person is diagnosed with HIV, they may be like the middle bottle if they are asymptomatic, with an almost even mix of red and green beads. Though they may be feeling well, HIV is rapidly multiplying in the body, damaging their immune system, and making it possible for them to pass the virus on to others through sex, childbirth, or breastfeeding. If they do not start treatment, HIV will take over (the bottle with almost all red beads), until their immune system is reduced, and they develop opportunistic infections. However, if they start and stay on ART, the treatment will suppress the HIV in their body, until there is so little left, they will not get sick and they will not be able to pass it on. The few red beads in the last bottle demonstrate that this is not a cure: there is always a little HIV hiding out in the body.

But if the client takes their ARVs every day without fail, this little bit will never be able to increase, and they will stay healthy and not transmit. We call this “HIV safe.” The Counsellors can also use it to explain disease progression, low level viraemia and long-term Sero-discordant relationship. Moreover, it helps with understanding of the following:

- The importance of starting treatment early
- The importance of treatment adherence
- Viral suppression and undetectable viral load
- The relationship between undetectable viral load and HIV prevention
- The ability to get completely back to normal with viral suppression while living with HIV.

CHAPTER 5: BASIC CARE PACKAGE FOR HIV-POSITIVE INDIVIDUALS

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SUMMARY OF CHANGES

2022 GUIDANCE	2024 GUIDANCE
	• Pretreatment VL for all newly diagnosed clients initiating ART. Clients returning to care should not receive PTVL
• The first routine VL test is to be done by 6 months post-ART initiation	• The first routine VL test is to be done 3 months post-ART initiation. Ensure that all clients have a VL test done BY 6 months of starting ART
• The 2nd routine VL test should be done 6 months after an initial suppressed VL test result	• The 2nd routine VL test should be done 6 months after an initial suppressed VL test result and then annually thereafter. For children, pregnant and breastfeeding women, it should be done every 6 months
• 3MMD can be started after a suppressed VL done 6 months following ART initiation	• Up to 3MMD of ARVs can be started after an initial suppressed VL test results done at 3 months • Up to 6MMD can be given following 2 consecutive suppressed VL test results
	• Remnant blood samples of all infants who test HIV positive may be stored and used for surveillance purposes (plasma or DBS) for HIVDR survey activities
	• Routine HIVDR testing for all PrEP breakthrough infections

5.1 PRETREATMENT VIRAL LOAD

Viral load remains the mainstay in monitoring response to ART. The viral load before starting ART and the magnitude of VL decline following ART initiation is an important indicator of disease progression. Pretreatment viral load (PTVL) monitoring is now introduced as a standard of care:

- To establish a baseline in preparation for monitoring response to antiretroviral therapy (ART), including facilitating regimen selection.

- As an additional tool to be used by counsellors during motivational counselling of individuals who are not ready to start ART.
- To facilitate the identification and clinical management of “return to care” clients re-engaging in care through the HTS entry point, as “re-testers” so that they can then be offered a tailored “Welcome Back Package”.

All newly diagnosed PLHIV should have a pretreatment viral load test done as part of ART baseline laboratory tests.

5.2 HIV DRUG RESISTANCE TESTING

The country will for specified periods, collect data on early warning indicators for HIVDR. To routinely conduct HIV drug resistance surveys, the country will adopt the use of remnant viral load samples (plasma or DBS) for HIVDR survey activities.

1. Remnant blood samples of all clients with high viral load may be stored and used for surveillance purposes to guide program and policy changes.
2. Remnant blood samples of all infants who test HIV positive may be stored and used for surveillance purposes (plasma or DBS) for HIVDR survey activities.

To routinely estimate pretreatment drug resistance, HIVDR testing should be performed on all breakthrough infections among clients taking PrEP.

5.3 HIV CARE ESCALATION PLAN

An HIV escalation plan refers to a structured set of procedures and protocols designed to manage and address escalating situations related to HIV and AIDS care, treatment, and support services. The plan is developed for healthcare workers to ensure timely and appropriate responses to various barriers or to provide comprehensive care to clients in HIV care. Client escalation is when you arrange for another HCW/ practitioner to provide services which fall beyond one's scope, understanding and education.

The aim of the escalation plan is to ensure that clients are linked to the next level of care to the right HCW, with the right information, at the right time and that they receive the right care. It is essential to ensure continuity of care and efficient use of Health care services, while minimizing the cost for the client. The diagram below indicates the client escalation plan for HIV care.

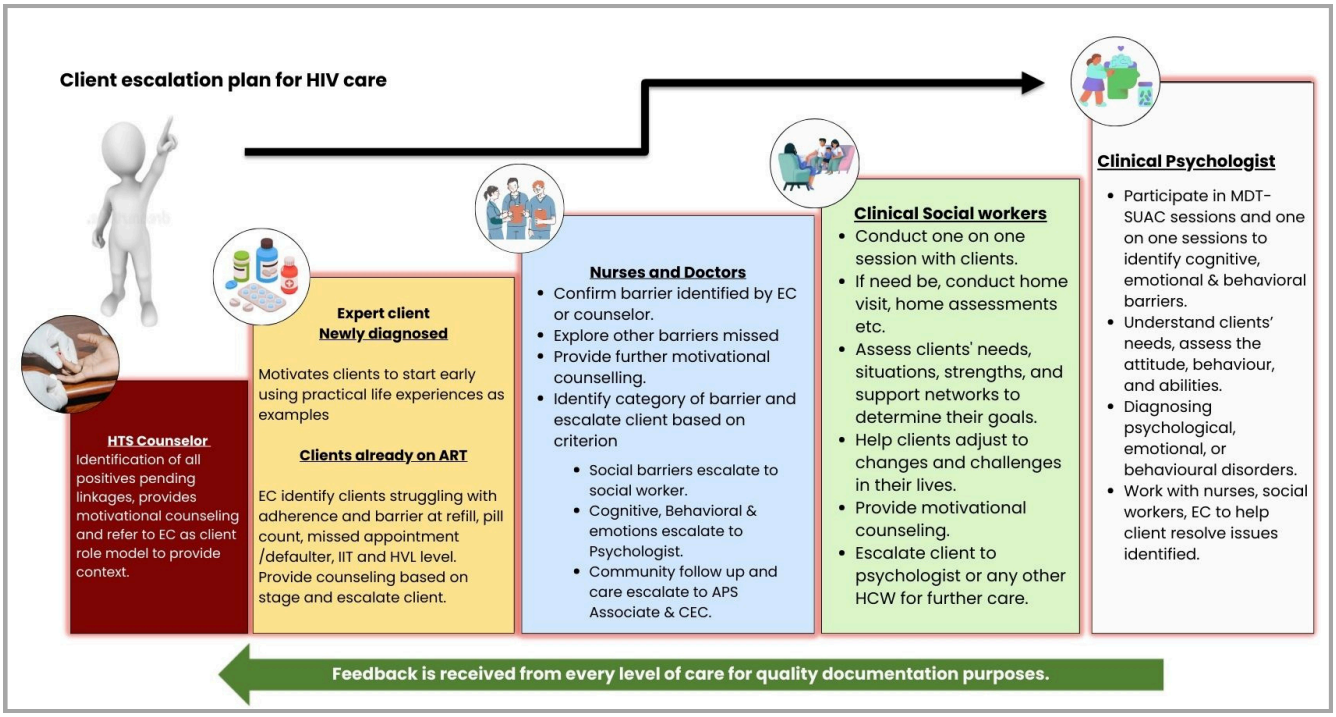


Figure 5.1 National Client Escalation Plan for HIV care.

INDICATIONS FOR THE HIV CARE ESCALATION PLAN

HCWs are encouraged to escalate (refer) any clients they experience difficulties in managing including the ones mentioned below. Management of such patients requires a multidisciplinary team (MDT) approach. In addition, referrals can be made for specialised services e.g., psychiatrists, physicians, paediatricians etc.

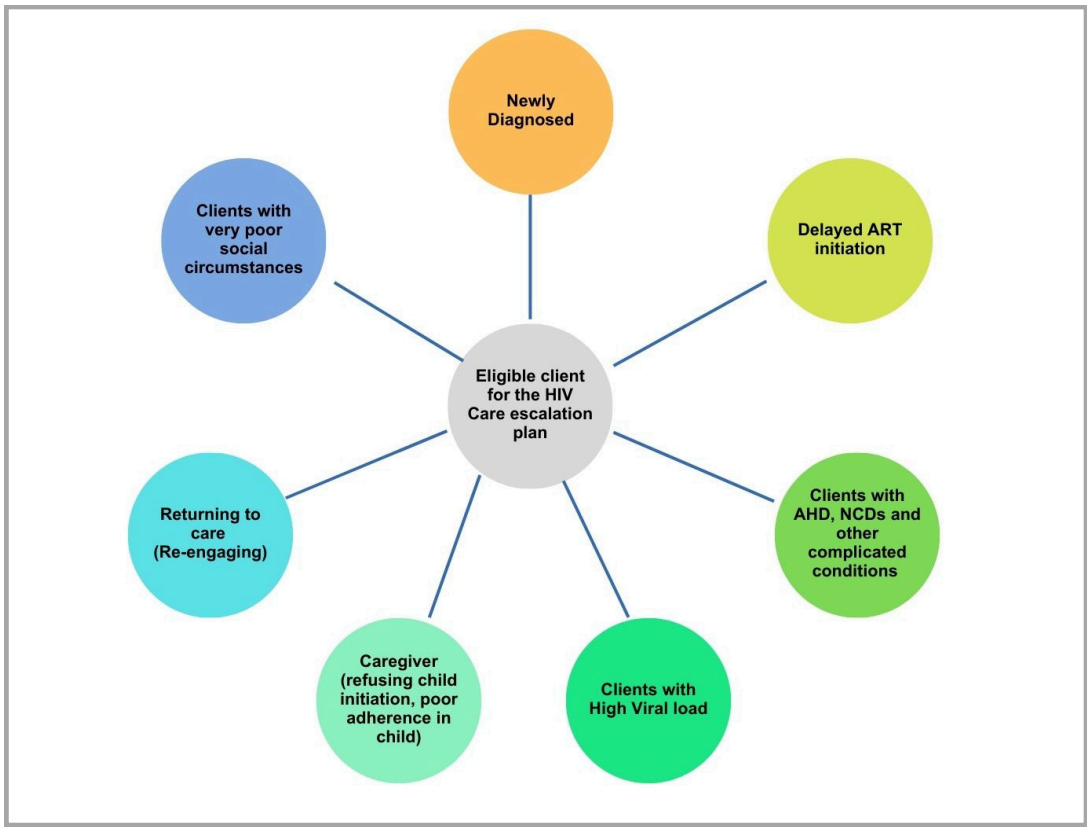


Figure 5.2 Clients eligible for Care escalation plan.

CHAPTER 6:
TB HIV COLLABORATIVE ACTIVITIES & ADVANCED HIV DISEASE

CHAPTER 6: TB HIV COLLABORATIVE ACTIVITIES & ADVANCED HIV DISEASE

SUMMARY OF CHANGES

2022 GUIDANCE	2024 GUIDANCE
INH/CTX/VitB6 is an option for TPT for PLHIV.	INH/CTX/VitB6 is phased out as a TPT option.
TB LAM diagnosed patients are classified as clinically diagnosed patients.	TB LAM diagnosed patients are classified as **bacteriologically confirmed** TB patients.
3HP (900mg/900mg) recommended for children and adolescents > 12 years and 25kgs.	3HP (900mg/900mg) recommended for children and adolescents > 14 years and 30kgs.
Levofloxacin + Ethambutol recommended for TPT for high-risk contact of a MDR, INH mono and PDR patients.	Levofloxacin recommended for TPT for high-risk contact of a MDR, INH mono and PDR patients.
PIMA is the platform of choice for baseline CD4 count test.	VISITECT CD4 for Advanced HIV disease is the platform of choice for baseline CD4 test where available.
CrAg screening recommended for PLHIV with CD4 ≤ 100 cell/ml.	CrAg screening recommended for PLHIV with CD4 ≤ 200 cell/ml.
TB LAM test recommended for inpatients with CD4 ≤ 200 cell/ml, outpatients with CD4 ≤ 100 cell/ml.	TB LAM test recommended for inpatients and outpatients with CD4 ≤ 200 cell/ml.

6.1 TUBERCULOSIS

6.1.1 TB DIAGNOSIS

Clients (PLHIV) diagnosed with TB using TB LAM are classified as bacteriologically confirmed cases of TB. House-hold contacts of index cases diagnosed with TB using TB LAM are therefore eligible for TPT.

TB Lam diagnosed TB patients should be classified by site as Extrapulmonary TB, iF there is no Gene Xpert/Xpert ultra MTB/RIF confirmation.

6.1.2 TB PREVENTION

Recommended TPT options are as follows:

POPULATION GROUP	PREFERRED REGIMEN	ALTERNATIVE REGIMEN
• All TPT naïve PLHIV including children and adolescents above 14 years and 30kg • PLHIV on completion of DSTB or DRTB treatment despite previous TPT. • PLHIV who are household contacts to bacteriologically confirmed TB, despite previous TPT	• 3 months of Rifapentine/Isoniazid (3HP) 900mg/900mg • 1 month of INH/Rifapentine (1HP), once available	• 6 months of INH monotherapy (6H)
• CLHIV (<14 years or <30kgs)	• 6H	
• HIV-negative (household contact, other at-risk groups)	• 3 months of Rifapentine/Isoniazid (3HP) 900mg/900mg • 3 months of Rifampicin/Isoniazid (3RH) • 4 months of Rifampicin (4R)	• 6months of INH (6H)
• DR-TB contacts	MDR-TB/RR-TB/Rif mono-resistance • Levofloxacin INH Mono and PDR • Levofloxacin Pre-XDR and XDR • For DRTB expert review	

6.2 ADVANCED HIV DISEASE

- ·VISITECT CD4 for advanced HIV Disease point of care test if available should be used for AHD screening among the following populations;
- ·New HIV positive in care
- ·Treatment interrupters returning to care after at least 6 months
- ·Clients with VL > 1000 copies/ml

Figure 6.1 The VISITECT® CD4 Advanced Disease Test

In the absence of VISITECT POC test, the conventional quantitative CD4 test should be used to screen for AHD in these populations.

NB: VISITECT CD4 test should not be used for follow-up testing. A quantitative CD4 test should be used (e.g PIMA)

- Blood CrAg and TB LAM should be performed among all PLHIV with CD4 ≤ 200 cell/ml

ADVANCED HIV PACKAGE

AREA OF PACKAGE	INTERVENTION	CD4 COUNT	ADULTS & ADOLESCENTS	CHILDREN < 10 YEARS
Screening and diagnosis	Sputum for Xpert/Xpert ultra MBT/RIF as first test for TB diagnosis in symptomatic patients	Any	Yes	Yes
	Urine LF-LAM for TB diagnosis in symptomatic patients or those with low CD4 count	• Symptomatic patients: All patients regardless of CD4 count with TB signs and symptoms. • Seriously ill patients*: All patients regardless of CD4 count or TB signs and symptoms. • Inpatients and outpatients: CD4 ≤ 200 cells/ml regardless of TB signs and symptoms.	Yes	Yes
	Cryptococcal antigen CrAg screening	CD4 ≤ 200 cells/ml	Yes	No
	Histoplasma antigen test	All PLHIV	Yes	Yes

AREA OF PACKAGE	INTERVENTION	CD4 COUNT	ADULTS & ADOLESCENTS	CHILDREN < 10 YEARS
Prophylaxis and pre-emptive treatment	Cotrimoxazole prophylaxis (CPT)	CD4 ≤350cells/ml or WHO stage 3 or 4	Yes	Yes
	TB preventive treatment (TPT)	Any	Yes	Yes
	Fluconazole pre-emptive treatment for CrAg positive patients without evidence of meningitis	CD4 ≤200cells/ml	Yes	No
	Itraconazole prophylaxis for histoplasma antigen positive patients	Any CD4 count until 12 months or stable on ART and virally suppressed	Yes	Yes
ART initiation	Rapid ART initiation	Any	Yes	Yes
	Defer ART initiation if signs and symptoms of TB, CCM or CNS histoplasmosis	Any	Yes	Yes
Adapted adherence support	Tailored counselling to support adherence to AHD package, including home visits where feasible	CD4 ≤200 cells/ml	Yes	Yes

CHAPTER 7: ADULT ANTIRETROVIRAL THERAPY

CHAPTER 7: ADULT ANTIRETROVIRAL THERAPY

SUMMARY OF CHANGES

2022 GUIDANCE	2024 GUIDANCE
	• All clients on 3rd line ART should have routine VL testing done every 6 months.
Suppressed VL: VL <1000 copies/mL Low level viraemia: VL 50 – 999 copies/mL	Suppressed VL: VL <200 copies/mL Low-level viraemia: VL 200 – 999 copies/mL
• SUAC for all clients with a VL >1000 copies/mL	SUAC for all clients with a VL > 200 copies/mL

Following ART initiation, a minimum VL decline of at least by at least 0.5 $\log_{10}$ copies/mL (3-fold) is considered significant. However, the goal for people on ART is an undetectable VL (VL <50 copies/ml).

To ensure that community transmission remains at a minimum, the threshold for viral suppression has been decreased to a VL <200 copies/mL. The figure below shows new thresholds for VL monitoring.

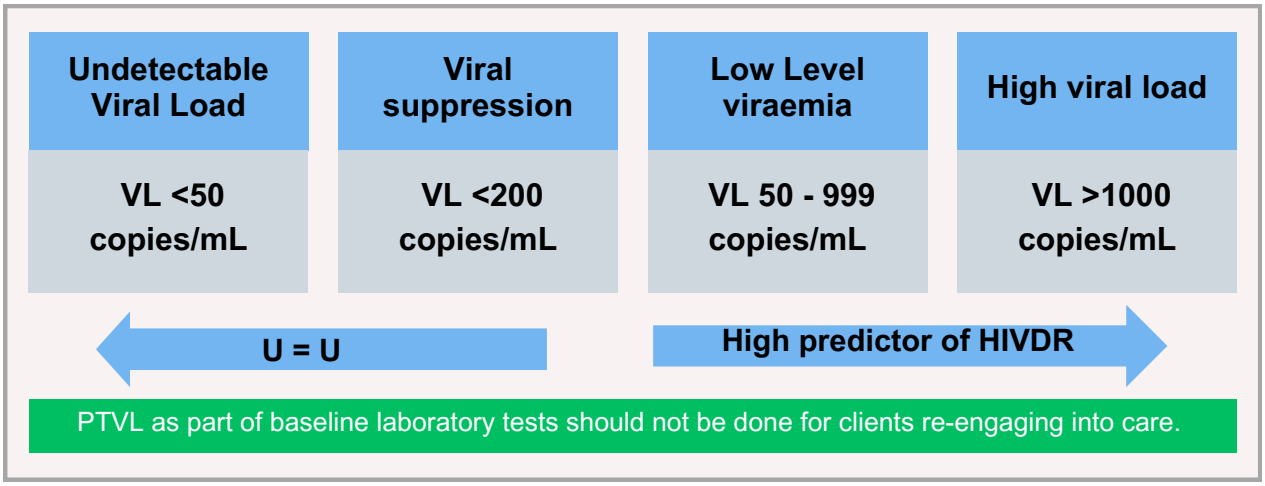


Figure 7.1 Updated viral load thresholds.

7.1 ROUTINE VL MONITORING

All clients on initiating or reinitiating ART should receive their first routine VL three months after (re)initiating ART and at 9 months thereafter. After two consecutive undetectable VL test results, routine VL testing should be done as indicated below.

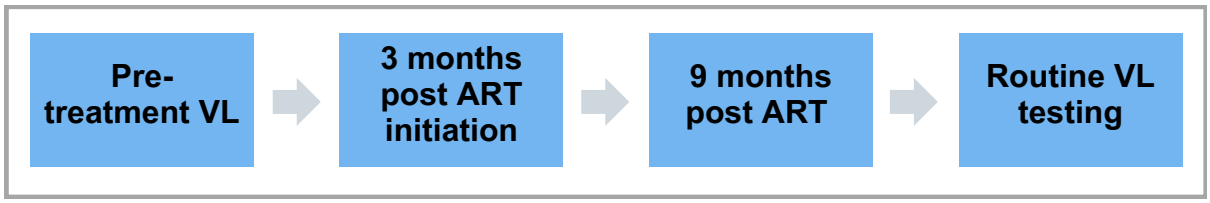


Figure 7.2 Update viral load monitoring schedule.

How frequently should routine VL testing be done?

- For children and adolescents (0-19 years), every 6 months
- Pregnant and breastfeeding women, every 6 months
- 3rd line clients, every 6 months
- Adults >19 years, annually

The management of HVL remains the same. The viral load testing algorithm will therefore be as depicted below.

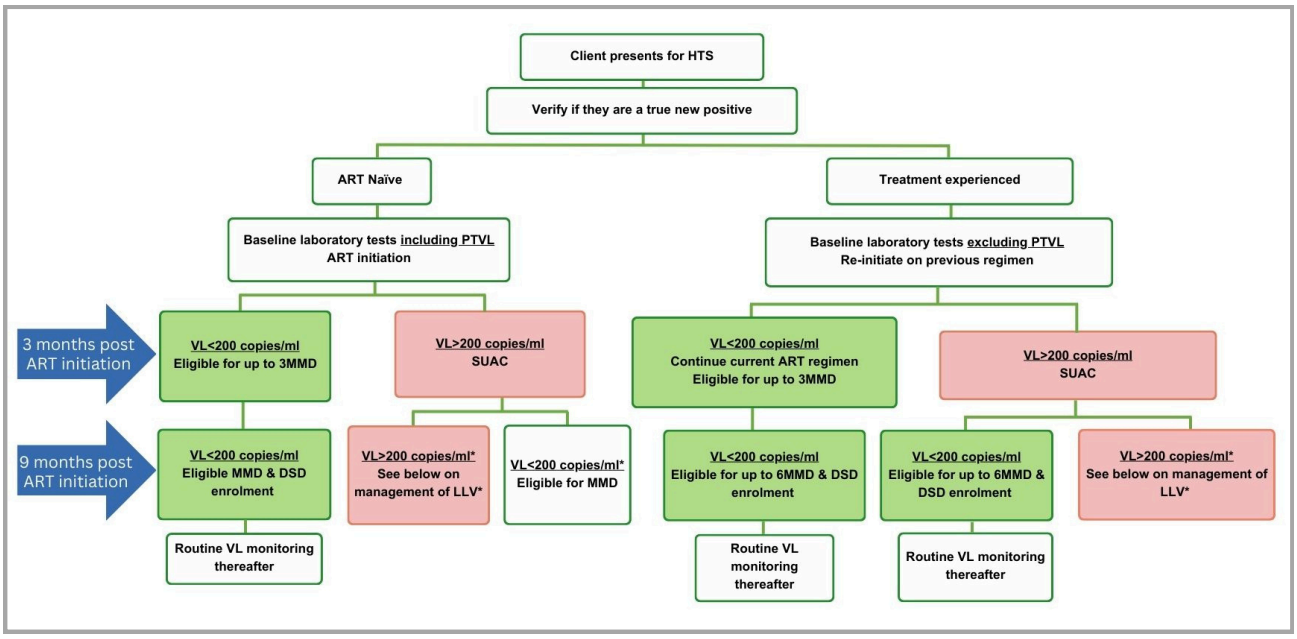


Figure 7.3 The viral load testing algorithm.

a If VL 200 - 999 copies/mlFollow management of LLV below
b If VL > 1000 copies/ml, start SUAC
c Repeat VL after 3 months and consult clinical advisor of HIVDR for persistent low-level viraemia

All clients with a detectable viral load should be closely monitored with adherence support until they are undetectable

MANAGEMENT OF LOW-LEVEL VIREMIA

People living with HIV and receiving antiretroviral therapy (ART) have a goal of achieving and maintaining optimal viral suppression to undetectable levels of <50 copies/mL. However, in certain individuals, there is persistence of low-level viraemia (LLV), defined as viral load levels of 51–999 copies/mL, despite consistent medication adherence, lack of drug interactions and no genotypic resistance. LLV has been associated with adverse virological and clinical outcomes. LLV should not be confused with blips, defined as a single VL between 50 and 200 copies/mL occurring after an initial period of virological suppression, and followed by a return to an undetectable result.

Blips: A single VL 50–200 copies/mL preceded and followed by an undetectable VL is usually not a cause for clinical concern but does not require any change in regimen. However, it should trigger clinical vigilance, adherence reinforcement, check for possible interactions, and repeat VL in 3 months.

Low-level Viremia: A VL result of 200 - 999 copies/mL may be indicative or predictive of virological failure. In this context:

- Assess the patient for treatment adherence, tolerability, and toxicity.
- Changing ART regimens is not recommended unless ART toxicity or intolerability is identified.
- Repeat VL testing in 3 months.
- Genotyping is not recommended unless the VL result is ≥1000 copies/mL.

EFV single formulations are not currently in the market so clients should be optimised according to 2019 addendum guidelines.

CHAPTER 8: PREVENTION OF MOTHER TO-CHILD TRANSMISSION OF HIV

CHAPTER 8: PREVENTION OF MOTHER TO-CHILD TRANSMISSION OF HIV

SUMMARY OF CHANGES

2022 GUIDANCE	2024 GUIDANCE
Genotypes were recommended for pregnant or breastfeeding women failing a DTG or PI based ART regimen.	Updated guidance provides more details for same day clinical care decisions and consideration of empiric therapy for women deemed highest risk while awaiting genotype results. Emphasis is placed on intensive adherence interventions for all women with a DVL >50.
No specific recommendations for breastfeeding infants of mothers found to have seroconverted.	3 drug PEP after appropriate testing is recommended for breastfeeding infants of mothers found to have seroconverted.
Repeat VL 1 month after SUAC	Specific recommendation to consult the DR committee for all women who remain with VL > 50 despite 1 month of intensive adherence support.

SAME DAY MANAGEMENT OF VIREMIA IN PREGNANT WOMEN

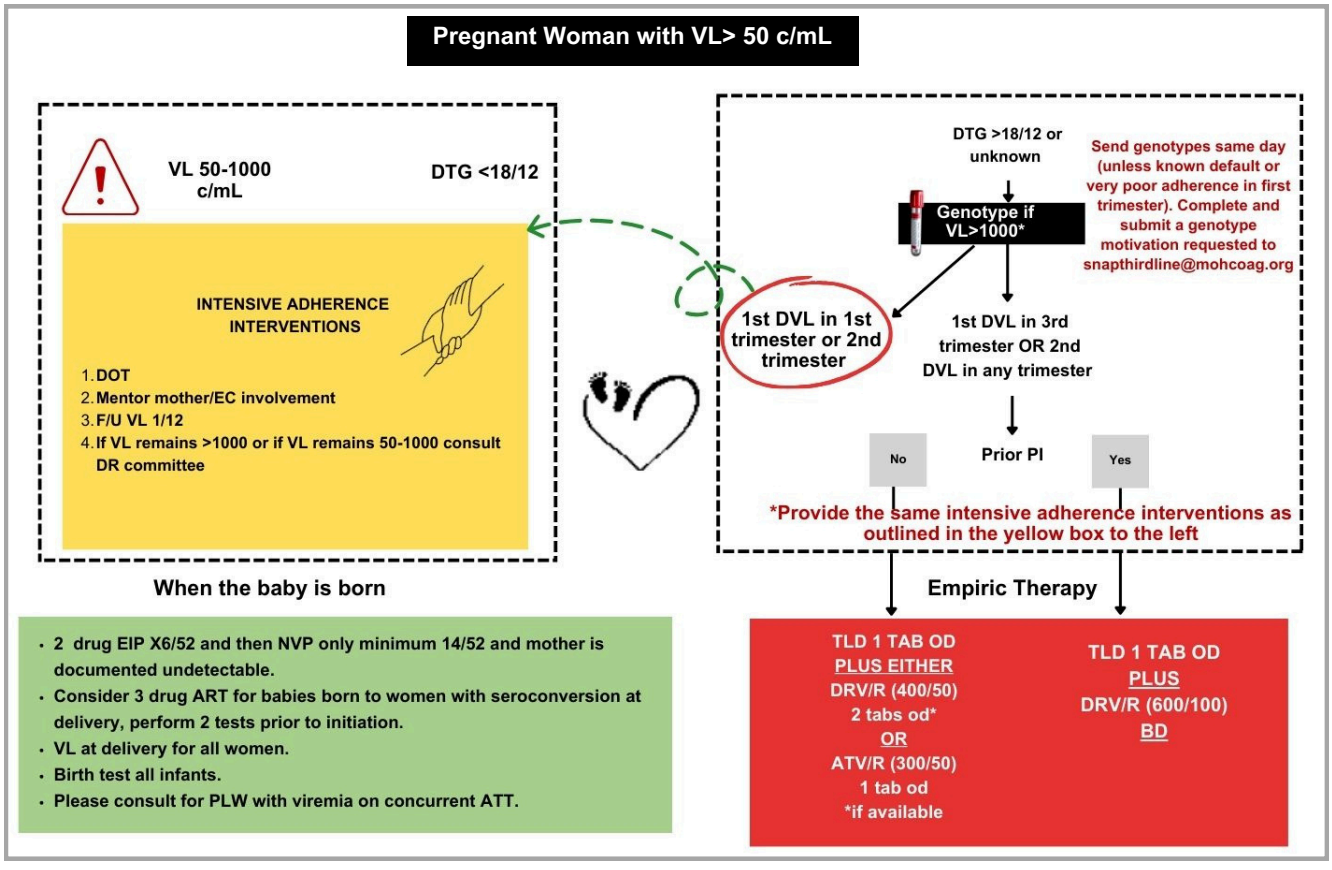


Figure 8.1 Same day management of viremia in pregnant women.

SAME DAY MANAGEMENT OF VIREMIA IN BREASTFEEDING WOMEN

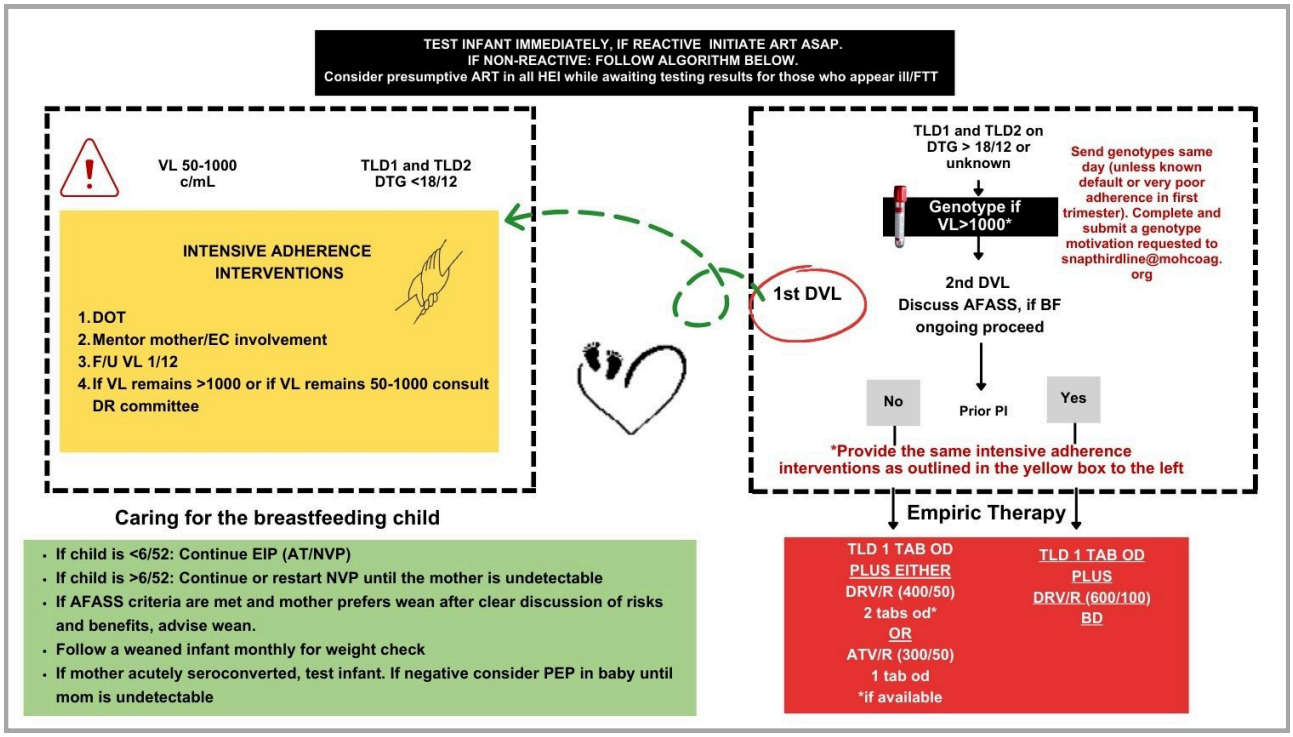


Figure 8.2 Same day management of Viremia in breastfeeding women.

CHAPTER 9: ANTIRETROVIRAL THERAPY FOR CHILDREN & ADOLSCENTS

CHAPTER 9: ART FOR CHILDREN & ADOLESCENTS

SUMMARY OF CHANGES

2022 GUIDANCE	2024 GUIDANCE
9.3: Omitted	Any ill-appearing HIV exposed infant should start ART **presumptively** while awaiting results.
9.6: No mention of pALD (+ Annex)	**pALD** included in the new paediatric dosing chart
9.8: Missing TPT dosing for CALHIV	**Dosing chart included for TPT** in CALHIV
9.9: Spelling correction in table	Spelling corrected for NRTI
9.10: Clinical Monitoring of Children and Adolescents on ART: MMD guidance change	All children stable on ART >1-2 years may receive up to 3MMD, and all **children stable on ART >2 years may receive up to 6 MMD.**
9.11: 3 months VL was a substitute test	**Baseline and 3-month VL test are additional tests.** This will align with the CWF visits and support service integration.
9.12: Second Line ART revised to remove: "Refer to National HIVDR Clinical Expert Committee if on DTG for < 2 years"	Align with adult guidance and highlight **all** PI and DTG treatment failures will require **genotype guided switches**. "HIV resistance testing should be done for all clients failing on a DTG based ART regimen. Only switch to 2nd line if resistance test shows DTG resistance and the 2nd line regimen should be a boosted PI + 2 NRTIs determined by the genotype results". ***(From Table 7.11 Recommended Sequence of Second Line NRTI Options)***

9.1 WHEN TO START ART FOR CHILDREN & ADOLESCENTS

Any ill-appearing HIV exposed children <5 years are by definition at risk for advanced HIV disease. If all attempts for same day HIV diagnostics have been exhausted, start ART presumptively while awaiting PCR results. It is imperative to confirm all presumptively diagnosed children < 18 months old with two PCR samples prior to initiation.

A Presumptive Diagnosis of Severe HIV Disease Should Be Made ONLY If:
All attempts to access POC PCR have been exhausted AND The child is confirmed as being HIV antibody positive AND If the infant has symptoms of 2 or more of the following: • Oral Thrush • Severe pneumonia • Severe Sepsis OR A diagnosis of any WHO AIDS indicator conditions[1] can be made.
Other clues that support the diagnosis of severe HIV disease in an HIV-seropositive infant include: • A recent HIV related maternal death; or • Advanced maternal HIV disease; or • The child's CD4 count is < 20%; or • Evidence of acute maternal HIV infection while pregnant or breastfeeding.
All Presumptively Diagnosed Children should have TWO DNA PCR samples sent prior to initiation. No need to await results.

1 AIDS indicator conditions include pneumocystis pneumonia, cryptococcal meningitis, severe wasting/stunting/malnutrition, esophageal candidiasis, Kaposi sarcoma, and extrapulmonary tuberculosis.

9.2 TREATMENT OPTIMIZATION (ANNEX 11.17)

Paediatric pALD (ABC-3TC-DTG) dispersible tablet (DT)

The country will soon introduce a new FDC (fixed-dose-combination). This is the first triple fixed-dose combination (FDC) dispersible unscored tablet of paediatric ABC/3TC/DTG 60/30/5 mg (pALD), providing the 1st line recommended ART regimen in one convenient tablet for CLHIV who weigh at least 6 kg and up to 24.9 kg. This dispersible tablet (DT) can be swallowed whole but is meant to be dissolved in water for younger children. This complete 3-drug pALD regimen is a simplified formulation, dispersed into a small amount of water and easily administered to children, rather than having to take different pills or formulations. This has simplified prescriptions for providers and administration by caregivers as only one bottle of medication is required and the pill does not have to be split in half (unlike pDTG 10mg). Given that ABC+3TC 60/30mg plus pDTG 10mg have the same components as the FDC pALD 60/30/5mg, the potential adverse events are the same and are rare.

CLHIV who are still required to use separate products/formulations of ABC+3TC plus pDTG as per the dosing table include:

1. Children who weigh 3-5.9 kg. This is because the ratio of the component medications of ABC/3TC and DTG does not allow for the recommended dosing for children in this weight range.
2. Receiving Rifampicin-based treatment for Tuberculosis (TB) co-infection
3. On second-line and third-line treatment who have not previously been on DTG

Please see the updated paediatric dosing chart below which includes pALD.

Paediatric ARV Formulation	Weight in KG							
	3 - 5.9	6 - 9.9	10 - 13.9	14 - 19.9	20 - 24.9	25 - 29.9	30 - 39.9	>40
pABC/3TC/DTG 60/30/5mg pALD Tablet (dispersible)	Use separate products	3 OD	4 OD	5 OD	6 OD			
ABC/3TC 120mg/60mg Tablet (dispersible)	1 OD	1.5 OD	2 OD	2.5 OD	3 OD			
ABC/3TC 600mg/300mg Tablet (Adult)	Not recommended					1 OD	1 OD	1 OD
AZT/3TC 60mg/30mg Tablet (dispersible)	1 BD	1.5 BD	2 BD	2.5 BD	3 BD			
AZT/3TC 300mg/150mg Tablet (Adult)	Not recommended					1 BD	1 BD	1 BD
DTG 10mg Tablet (scored/dispersible)	0.5 OD	1.5 OD	2 OD	2.5 OD	Change to Adults DTG 50mg tab OD			
DTG 50mg Tablet (Adult)	Not recommended				1 OD	1 OD	1 OD	1 OD
TDF+3TC+DTG 300mg/300mg/50mg TLD Tablet (Adult)	Not recommended						1 OD	1 OD
LPV/r 100mg/25mg Tablet	Not recommended			2 BD	2 BD	3 BD	3 BD	
LPV/r 200mg/50mg Tablet (Adult)	Not recommended				1 BD	2 AM 1 PM	2 AM 1 PM	2 BD
ATV/r 300mg/100mg Tablet (Adult)	Not recommended							1 OD
TDF+3TC+EFV 300mg/300mg/400mg Tablet (Adult)	Not recommended							1 OD

9.3 TUBERCULOSIS PREVENTIVE THERAPY (TPT) FOR TREATMENT OF LATENT TB INFECTION (LTBI)

<table>
<tr><th>Population</th><th>Drug Regimen</th><th>Dosing</th></tr>
<tr><td rowspan="3">All clients on DTG or EFV based ART</td><td>Preferred ≥14 yr & 30kg:

3HP+Vit B₆ (Once-weekly Isoniazid +Rifampicin x 3mo)</td><td>Vit B6 Once Weekly
+
3 Adults Tabs Once Weekly
3HP (300mg INH/300mg Rifapentine)</td></tr>
<tr><td>Alternative:
6H</td><td>See INH dosing chart</td></tr>
<tr><td>Preferred
<14 yr or <30kg:

6H +Vit B₆
(Once daily Isoniazid +B₆ x 6 mo)

*TPT in those <12 months only if there is a new known pulmonary TB contact</td><td>*Vit B6 OD+
<table><tr><td colspan="6">6H (100mg INH) Dosing</td></tr><tr><td><5kg</td><td>5-9.9kg</td><td>10-13.9kg</td><td>14-19.9kg</td><td>20-24.9kg</td><td>≥25kg</td></tr><tr><td>0.5 OD</td><td>1 OD</td><td>1.5 OD</td><td>2 OD</td><td>2.5 OD</td><td>1 Adults Tab (300mg)</td></tr></table></td></tr>
<tr><td>All clients on PI-Based ART</td><td>Preferred:
6H</td><td>See INH dosing chart</td></tr>
</table>

***See below for Pyridoxine (Vit B6) Dosing**

Population	Pyridoxine (Vitamin B6)	Special Considerations
All Clients on INH	1-2 mg/kg daily Typically given as12.5mg or 25mg daily dose. May increase to 50mg-100mg daily if peripheral neuropathy persists at lower doses.	To be given with INH. May Increase dose if peripheral neuropathy persist at lower doses (2mg/kg).

9.4 ART FOR CHILDREN & ADOLESCENTS WITH TB/HIV COINFECTION (ANNEX 11.16)

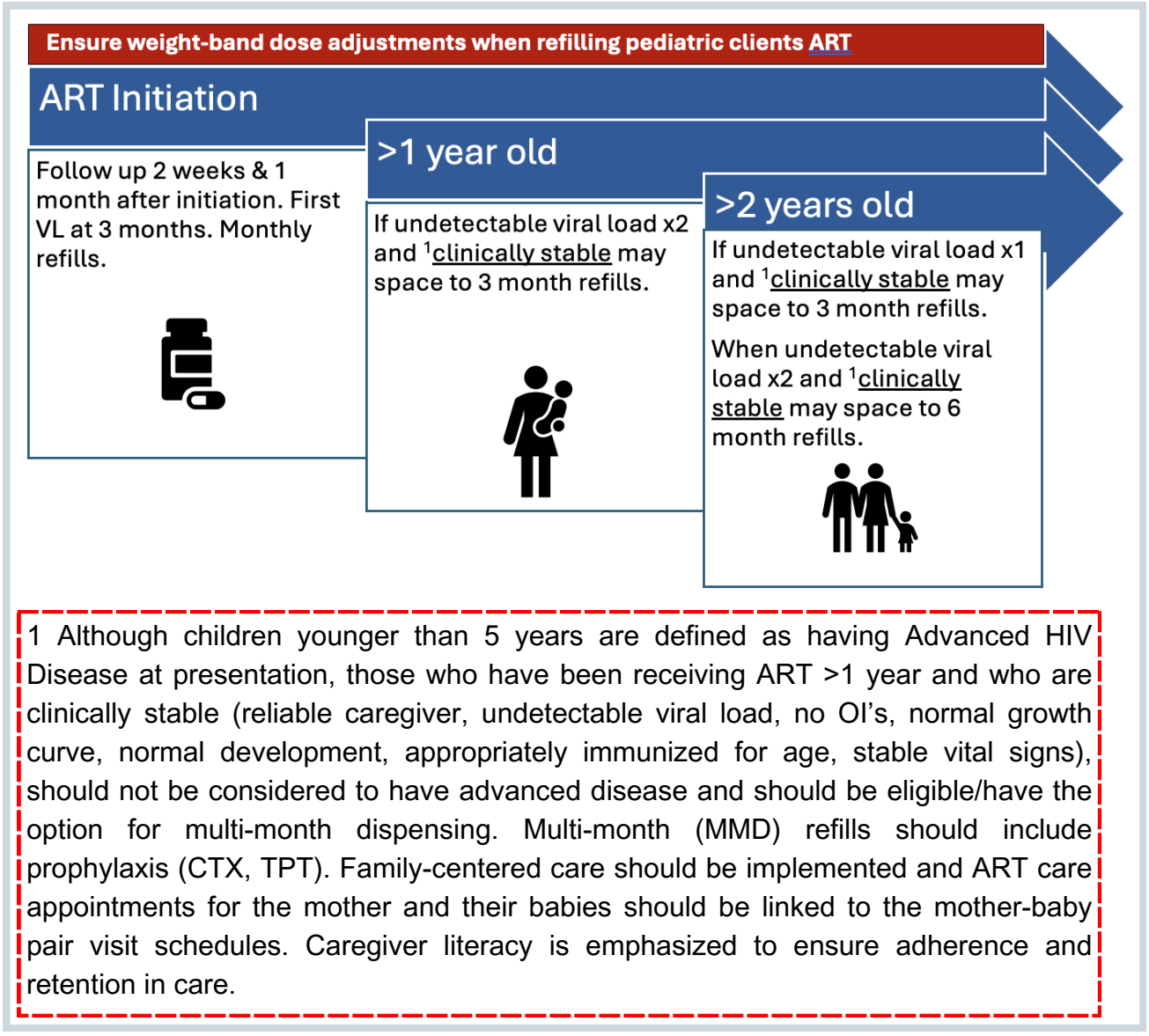
Children Initiating TB treatment while on ART		
Current ART	**Changes**	**Notes**
DTG2-based	Increase DTG² to twice daily dosing. Continue current backbone	• *Maintain all dose adjustments for 2 weeks after completion of ATT. • *The preferred regimen for children with DTG resistance is an optimized NRTI backbone with LPV/r³. If this is not available a holding regimen of AZT/3TC/ABC OR NNRTI based therapy may be necessary. Please consult with an expert in Paediatric HIV/TB
LPV/r3	*Preferred* If DTG-naïve, transition to a DTG2-based regimen (with appropriate dose adjustment). Continue current backbone. *Alternative* If DTG is not possible, LPV/r3 dose adjustment is needed: Ritonavir (RTV) dose needs to be "super-boosted" to achieve the same dose as LPV in mg, in a ratio equal to or approaching 1:1. In older children and adolescents swallowing tablets the LPV/r dose can be doubled.	
DRV/r	Change of regimen is needed: replace DRV/r with DTG2 if DTG-naive or with LPV/r3 if DTG-experienced (with appropriate dose adjustment). Continue current backbone.	
ATV/r	Change of regimen is needed: replace ATV/r with DTG if DTG-naive or with LPV/r³ if DTG-experienced (with appropriate dose adjustment). Continue current backbone.	
Neonates (first 28 days of life) initiating TB treatment while on ART		
1NVP-Based	Change of regimen is needed: substitute NVP as soon as possible with DTG² or LPV/r³ (with appropriate dose adjustment).	

1. *Do not use lead in dosing and use the maximum recommended dose by neonatal dosing chart if administering with rifampicin. Transition to DTG when 3 kgs and 4 weeks of age.*
2. *DTG should be dosed twice daily in children on TB treatment. This dose adjustment must continue for 2 weeks after completing ATT.*
3. *If used, LPV/r dose adjustment is needed: ritonavir (RTV) dose needs to be "super-boosted" to achieve the same dose as LPV in mg, in a ratio equal to or approaching 1:1. In older children and adolescents swallowing tablets the LPV/r dose can be doubled. This dose adjustment must continue for 2 weeks after completing ATT.*

Preferred and alternative ART in children when initiating ART in children on TB treatment		
Age	Preferred first-line regimen, including initiation while on TB treatment	Alternative first-line regimen
Neonates	AZT + 3TC + NVP1	-
Children	ABC + 3TC + DTG2	ABC + 3TC + LPV/r3
Adolescents & adults	TDF + 3TC + DTG	ABC + 3TC + DTG2 TDF + 3TC + LPV/r3 ABC + 3TC + LPV/r3

1. *Do not use lead in dosing; use the maximum recommended dose by neonatal dosing chart if administering with rifampicin. Transition to DTG when 3 kgs and 4 weeks of age.*
2. *DTG should be dosed twice daily in children on TB treatment. This dose adjustment must continue for 2 weeks after completing ATT.*
3. *If used, LPV/r dose adjustment is needed: Ritonavir (RTV) dose needs to be "super-boosted" to achieve the same dose as LPV in mg, in a ratio equal to or approaching 1:1. In older children and adolescents swallowing tablets the LPV/r dose can be doubled. This dose adjustment must continue for 2 weeks after completing ATT.*

9.5 CLINICAL MONITORING OF CHILDREN & ADOLESCENTS ON ART

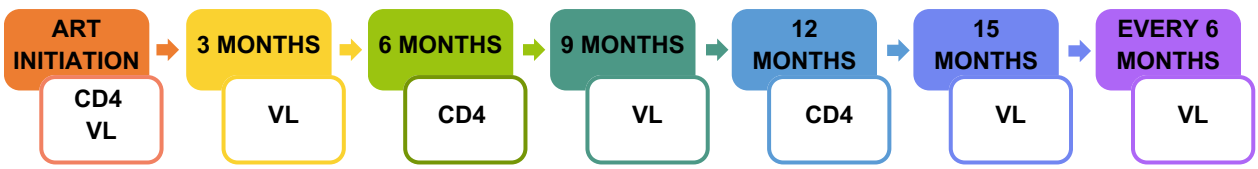


1 Although children younger than 5 years are defined as having Advanced HIV Disease at presentation, those who have been receiving ART >1 year and who are clinically stable (reliable caregiver, undetectable viral load, no OI's, normal growth curve, normal development, appropriately immunized for age, stable vital signs), should not be considered to have advanced disease and should be eligible/have the option for multi-month dispensing. Multi-month (MMD) refills should include prophylaxis (CTX, TPT). Family-centered care should be implemented and ART care appointments for the mother and their babies should be linked to the mother-baby pair visit schedules. Caregiver literacy is emphasized to ensure adherence and retention in care.

Figure 9.4 Key ART follow-up schedule for children and adolescents starting ART and MMD eligibility.

9.6 LABORATORY MONITORING OF CHILDREN & ADOLESCENTS ON ART

VL testing schedule for clients 0-19 years old: Baseline and 3-month VL test are additional tests. This will align with the CWF visits and support service integration. VL testing should be routinely done at 0, 3, 9, 15 months and thereafter every 6 months



9.7 SECOND LINE ART FOR CHILDREN & ADOLESCENTS

<table>
<tr><th>Weight</th><th>Current 1st line Regimen</th><th>Preferred 2nd Line Regimen</th><th>Alternative 2nd Line Regimen</th><th>Special Considerations</th></tr>
<tr><td rowspan="5">3 -29.9 kg</td><td>AZT + 3TC + NVP (or EFV)</td><td>ABC + 3TC + DTG</td><td>-</td><td rowspan="9">*Concept: When changing to 2nd line, in most cases, it is important to change 2 drugs to maintain a robust regimen. Evidence-based exceptions include TLE to TLD and PI based regimens where the NRTI backbone can be recycled.

*LPV/r can be changed to ATV/r once client is ≥40kg regardless of VL

**DRV/r can only be used for second line in cases of confirmed INSTI resistance on genotype. Consult HIVDR clinical expert committee</td></tr>
<tr><td>ABC + 3TC + NVP (or EFV)</td><td>AZT + 3TC + DTG</td><td>-</td></tr>
<tr><td>ABC + 3TC + DTG</td><td colspan="2" rowspan="3">Refer to National HIVDR Clinical Expert Committee.
Only switch to 2nd line if genotype test (resistance test) shows DTG-resistance or PI-resistance. The 2nd line regimen should be determined by the genotype results.</td></tr>
<tr><td>AZT + 3TC + DTG</td></tr>
<tr><td>AZT + 3TC + LPV/r
OR
ABC + 3TC + LPV/r</td></tr>
<tr><td rowspan="4">≥ 30 kg</td><td>AZT + 3TC + NVP (or EFV)</td><td>TDF +3TC + DTG</td><td>ABC + 3TC + DTG
TDF+3TC+boosted PI** (ATV/r* or LPV/r or DRV/r**)</td></tr>
<tr><td>ABC + 3TC + NVP (or EFV)</td><td>TDF +3TC + DTG</td><td>AZT + 3TC + DTG
TDF+3TC+boosted PI** (ATV/r* or LPV/r or DRV/r**)</td></tr>
<tr><td>TDF +3TC + EFV</td><td>TDF +3TC + DTG</td><td>AZT + 3TC + DTG
TDF+3TC+boosted PI (ATV/r* or LPV</td></tr>
<tr><td>TDF + 3TC + DTG
ABC + 3TC + DTG
AZT + 3TC + DTG</td><td colspan="2">Refer to National HIVDR Clinical Expert Committee
Only switch to 2nd line if resistance test shows DTG resistance and the 2nd line regimen should be a boosted PI + 2 NRTIs determined by the genotype results.</td></tr>
<tr><td colspan="5">Children and adolescents with at least 2 consecutive detectable VL results while on DTG- or PI-based regimens should be referred to the National HIVDR Clinical Expert Committee (snapthirdline@mohcoag.com) for evaluation of drug resistance and need for genotyping.
HIV genotyping (resistance testing) should be done for all clients failing on a DTG- or PI-based ART regimen. Only switch to 2nd line if the resistance test shows DTG resistance and the 2nd line regimen should be a boosted PI + 2 NRTIs determined by the genotype results.</td></tr>
</table>

Refer to Annex 11.19 for the paediatrics dosing chart.

CHAPTER 10: HIV NON-COMMUNICABLE DISEASES & MENTAL HEALTH

CHAPTER 10: HIV/NCDS & MENTAL HEALTH

10.1 PSYCHOLOGICAL CARE & SUPPORT FOR CHILDREN, ADOLESCENTS, AND ADULTS

PSYCHOLOGICAL CARE & SUPPORT FOR CHILDREN, ADOLESCENTS, & ADULTS LIVING WITH HIV

PLHIV should have access to screening for the presence of symptoms of depression, suicide, anxiety, substance use and social issues at baseline within the first three months of receiving a positive HIV diagnosis using the attached psychological disorder screening tools.

All IPV clients shall be provided psychological first aid and then referred for psychological support.

Due to the stigma associated with mental health, caregivers and treatment supporters shall be all equipped with psychological first aid (PFA) . See Annexure for PFA Pocket Guide

Secure the consent of a parent/ guardian prior to administering treatment (for all children and adolscents).

SCREENING FOR THE PRESENCE OF COMMON PSYCHOLOGICAL DISORDERS & SOCIAL ISSUES

- Depression
- Suicide
- Anxiety
- Substance Use
- Social issues

Every client seen by HCW must be screened for common psychological disorders and social Issues using Psychosocial Risk Assessment Screening Tool then provided Psychological First Aid and then referred to Psychologist or Social Worker

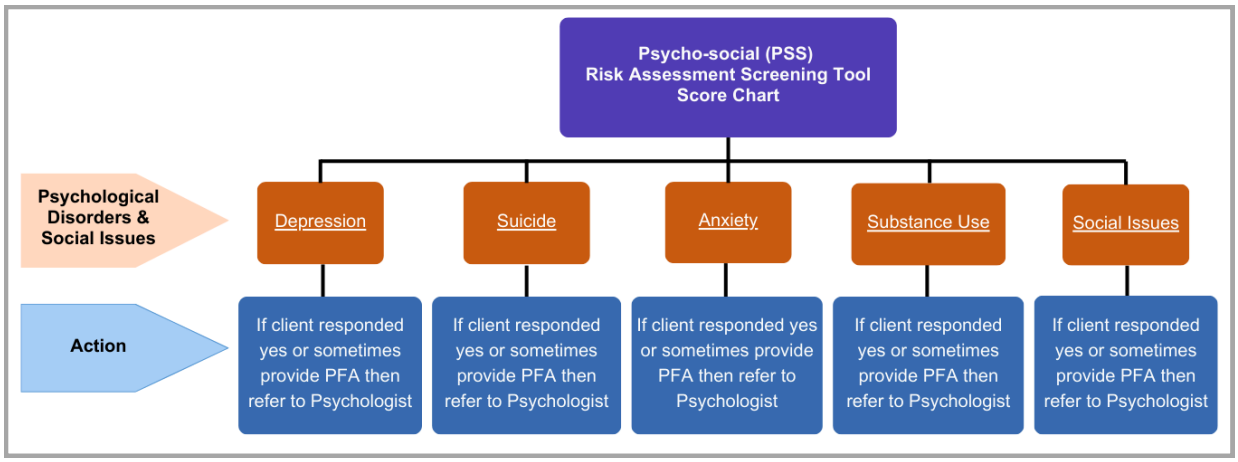


Figure 10.1 Psycho-social (PSS) Risk Assessment Screening Tool Score Chart.

- If Client respond with **"yes"** or "sometimes' for questions 1- 10 provide Psychological First Aid and refer to Psychologist
- If Client respond with **"yes'** or "sometimes" for questions 11-15 provide Psychological First Aid and refer to Clinical Social Worker
- If Client respond **"No"** continue with SUAC

Any client who answers YES to suicidal ideation should be further assessed and admitted if they are at risk of self-harm.

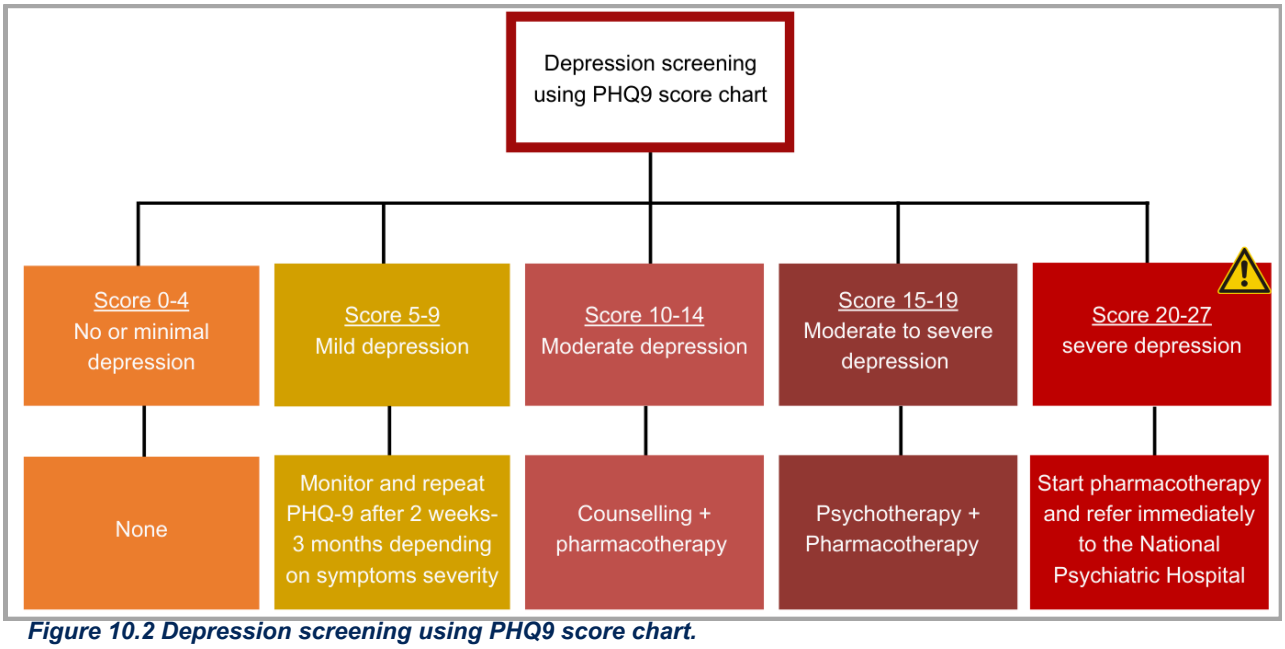


Figure 10.2 Depression screening using PHQ9 score chart.

If a client scores 10 and above, they must be given psychotherapy as indicated in ***Section 5.9.2*** in the ***2022 integrated HIV Management Guidelines and Annex 11.24***.

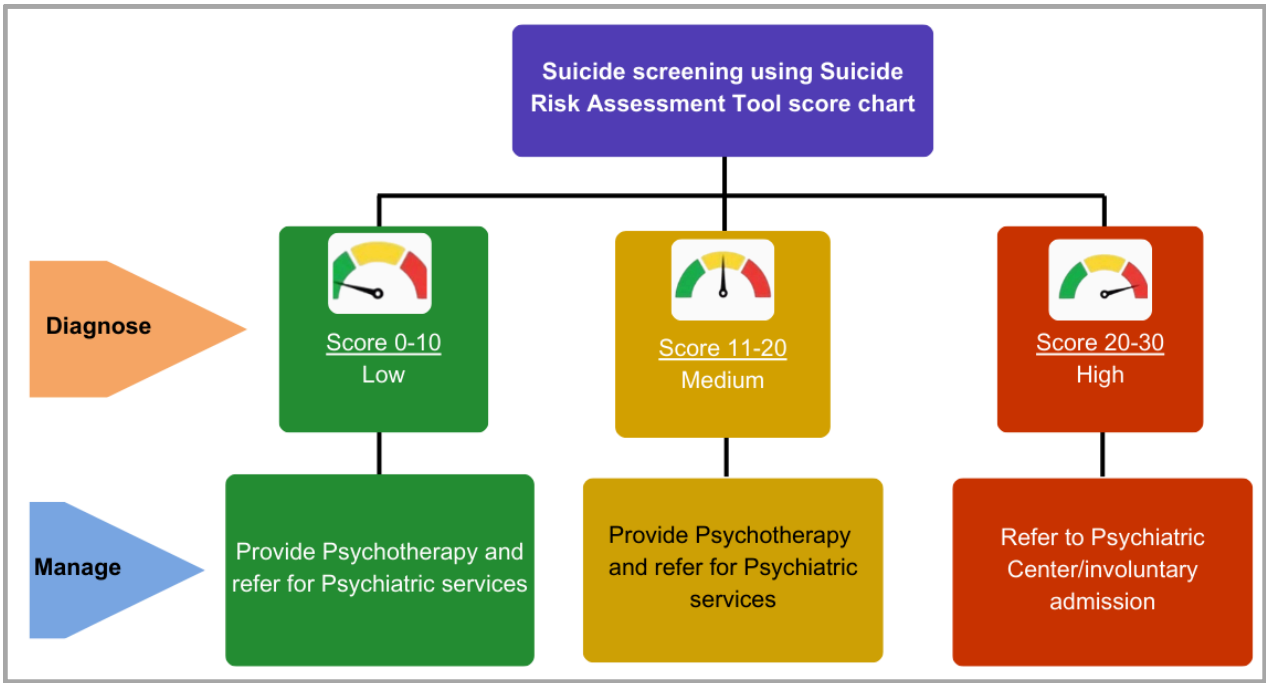


Figure 10.3 Suicide screening using Suicide Risk Assessment Tool score chart.

Provide Psychotherapy or refer. Rule out presence of mental disorders such as major depressive disorder and manage as indicated; ***(Mental Health Desk Guide, 2022)***.

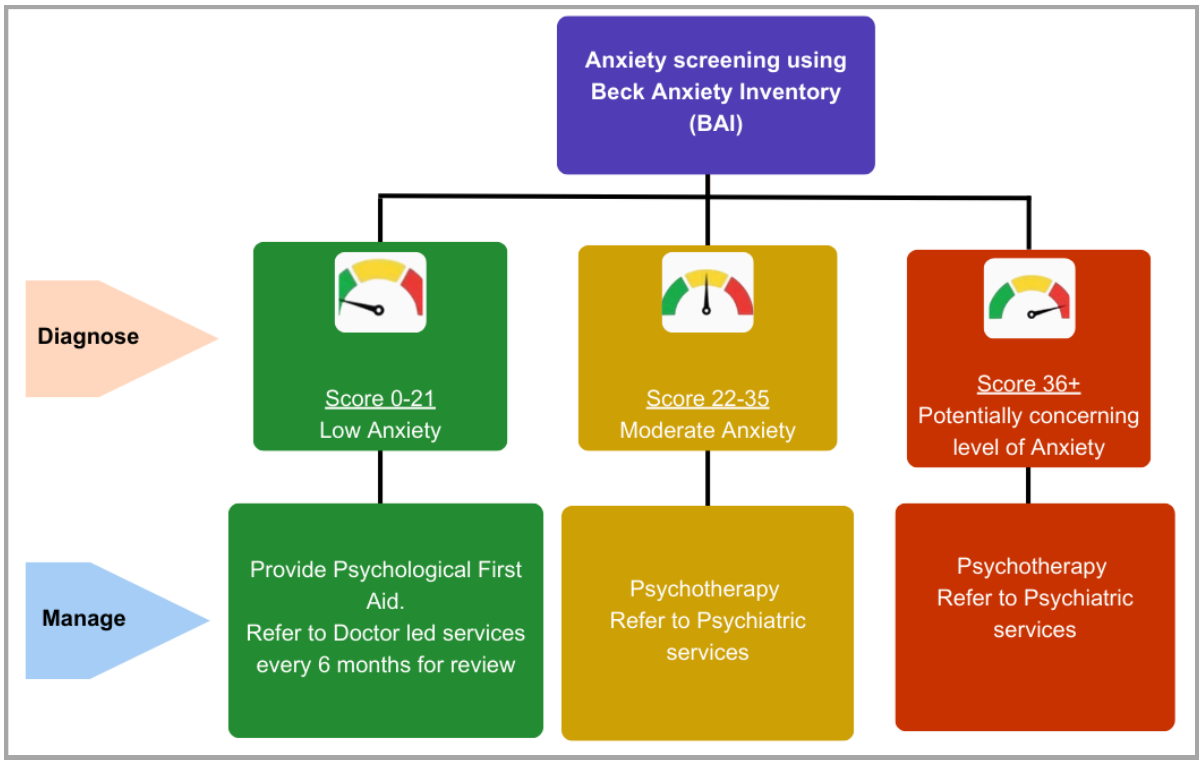


Figure 10.4 Anxiety screening using Beck Anxiety Inventory (BAI).

Refer to the Clinical Psychologist for psychotherapy if there is no improvement with counselling; ***(Mental Health Desk Guide, 2022).***

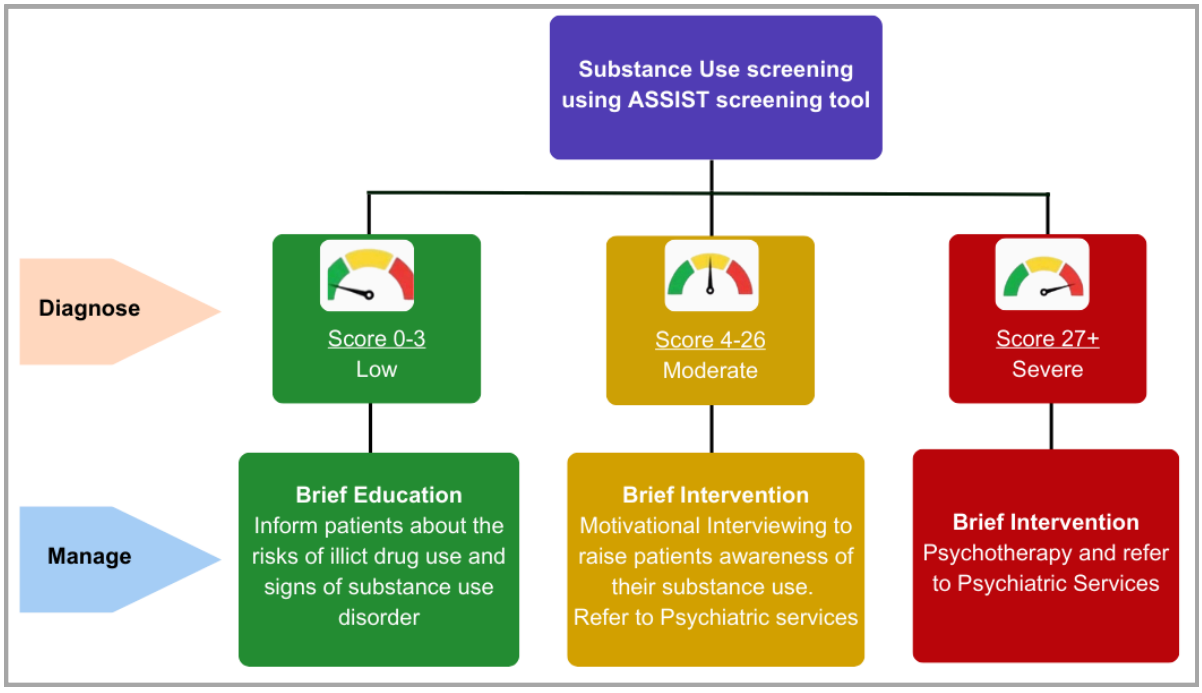


Figure 10.5 Substance Use screening using ASSIST screening tool.

Carefully assess for drug use patterns and related physical, psychological and social issues contributing to substance use behaviour; ***(Mental Health Desk Guide, 2022)***

CHECK IF CLIENT HAS

Social Issues hindering adherence to treatment

- ☐ Family support that helps taking ARVs on time
- ☐ Any financial assistance such as income or grants
- ☐ Difficulty in accessing health services due to distance to facility or transport fare or unsafe route to nearest facility
- ☐ Felt unsafe where they are currently staying.
- ☐ Been physically hurt by anyone or family

If client answers "YES" or "SOMETIMES" please refer to social worker.

Provision of Enhanced Counselling for clients disengaging from care, treatment, and support. Provide Psychoeducation to PLHV, children, adolescents, pregnant and lactating women who interrupt treatment.

10.2 PROVISION OF PSYCHOLOGICAL SUPPORT TO CLIENTS FAILING TREATMENT

Mental health challenges contribute to clients presenting with a high viral load and subsequently failing treatment. Timely recognition and management of mental health challenges aid in improving the outcomes of such clients. Follow the facility escalation plan for all clients identified to have psychosocial challenges including clients with HVL, pregnant and breastfeeding women, children and adolescents, clients delaying ART.

Psychotherapy must be part of SUAC to reduce the number of times visit health facilities for services that can be provided on the same day and by the same person. Psychotherapy should be coupled with sexual health information, and PrEP enrolment for sero-different couples.

Barriers to disclosure of a child's HIV status must be escalated to the psychologist/social worker if other healthcare workers fail successful disclosure. HCWs must support the caregiver during disclosure to ensure any fallout of disclosure of HIV status to children is well managed. ***Refer to Caregiver's curriculum Chapter 2***.

3rd line package of management of care for ALHIVs must include psychological care services as a preventative measure to treatment failure especially because of the high risk of them interrupting treatment at the adolescent stage. If there are regular check-ins with a psychologist, barriers to treatment can be prevented or addressed before they become a challenge.

MONITOR CLIENT PROGRESS

1. Use the HVL register and provide psychotherapy appointments in line with SUAC visits for all those with HVL.
2. Refer clients as the need arises and make follow-up on referrals.
3. Link clients to psychological care and support.

CONDUCT HOME VISITS ASSESSMENT FOR ALL IITS

A multi-disciplinary team comprising lay5 cadres, psychologists, social workers, and clinicians (nurses/doctors) should conduct home visits.

- Psychologists should go for home visits only if further assessment needs are necessary.
- Refer clients for the continuum of care and support with specific PCS scheduled check-ins.


PEPFAR
U.S. President's Emergency Plan for AIDS Relief


World Health Organization
Eswatini


USAID


The ASPIRE Project


UNAIDS


MOH
HIV/AIDS
SNAP


MEDECINS SANS FRONTIERES


fhi360
THE SCIENCE OF IMPROVING LIVES


GEORGETOWN UNIVERSITY
Center for Global Health Practice and Impact


CLINTON
HEALTH ACCESS
INITIATIVE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psi