WESTERN CAPE ART CLINICAL GUIDELINES 2023 (Infants and children < 10 years and/or < 30kg)

March 2024, Version 3 (Updated January 2025)

ART ELIGIBILITY AND DETERMINING THE TIMEFRAME FOR ART INITIATION

WHO IS ELIGIBLE?

All people living with HIV (PLHIV), regardless of age, CD4 cell count and clinical stage. ART should be initiated within 7 days unless there is a reason to defer (see below). Infants and children under five years, and those with advanced HIV disease should be prioritised for rapid initiation. Same day initiation is encouraged if the child is clinically well

REASONS TO DEFER STARTING ART	WHEN TO INITIATE ART*
TB symptoms (cough, fever, night sweats,	No TB: Same day or within 7 days
failure to thrive)	<u>Confirmed TB at non-neurological site:</u> Start ART within 2 weeks once patient is stable and tolerating TB medicines
Signs and symptoms of meningitis (headache, confusion, fever, neck stiffness or coma)	Investigate for meningitis before starting ART TBM (DS or DR): 4 weeks after starting TB treatment CM: 4 - 6 weeks after starting antifungal treatment
Other acute illnesses e.g. <i>Pneumocystis</i> <i>jirovecii</i> pneumonia or bacterial pneumonia	Defer ART for 1 - 2 weeks after commencing treatment for the infection
Clinical symptoms or signs of liver disease	Do ALT and bilirubin. Investigate and manage possible causes. Initiate ART as soon as possible

SOCIAL CONSIDERATIONS

The following points are important to maximise adherence:

• One named, responsible primary caregiver able to administer ART to the child

• Disclosure to another adult living in the same house able to supervise the child's ART when primary caregiver is unavailable

*Clients already on ART should NOT have their treatment interrupted upon diagnosis of the above conditions

BASELINE CLINICAL EVALUATION

TEST AND PURPOSE	INTERPRETATION/ACTION
Recognise the client with respiratory, neurological or abdominal danger signs	Identify danger signs as classified in the IMCI Chart booklet. Refer urgently
Nutritional assessment To monitor growth, developmental stage and deter- mine correct dosing of ART	Use the growth chart to plot the weight, height and head circumference (if < 2 years). Measure MUAC to identify moderate and severe malnutrition
Screen for symptoms of meningitis To diagnose and treat clients with cryptococcal and other forms of meningitis and reduce associated morbidity and mortality	Identify symptoms of headache, confusion or visual disturbances. Other symptoms may include fever, neck stiffness or coma. Do/refer the client for a lumbar puncture. Defer ART if meningitis is confirmed
Screen for TB To identify TB/HIV co-infection and eligibility for tuberculosis preventive therapy (TPT)	Suspect TB in clients with the following symptoms: coughing, night sweats, fever, failure to thrive. If present, confirm or exclude TB. Ask about TB contacts
WHO clinical staging To determine immune status, priority of initiating ART and need for cotrimoxazole preventive therapy (CPT)	See eligibility for CPT under CD4 cell count/% section in baseline laboratory evaluation below
Screen for active depression in older children and epilepsy in all ages To exclude drug-drug and drug-disease interactions	Identify the child with epilepsy and be aware of and monitor for potential drug-drug interactions and drug- disease interactions
Neurodevelopmental screen To identify neurocognitive or developmental delays	Screening tool is available in Road To Health Booklet (RTHB)

BASELINE LABORATORY EVALUATION

TEST AND PURPOSE	INTERPRETATION/ACTION
Confirm HIV test result To confirm HIV status for those without documented HIV status	Ensure that the national testing algorithm has been followed. Infants < 1 month: HIV drug resistance test for infant if mother is failing treatment on TLD2 or a PI-based regimen
Haemoglobin (Hb) - for clients starting AZT To identify anaemia	Can use AZT if Hb ≥ 8 g/dL. Children with anaemia: < 5 years: Treat with iron supplementation and deworm child ≥ 5 years: Do FBC and manage according to Primary Health Care EML
CD4 cell count/% To determine eligibility for cotrimoxazole preventive therapy (CPT)	 Eligibility for CPT: All HIV-positive infants < 1 year irrespective of CD4 % or clinical stage HIV-positive child 1 - 5 years with WHO stage 3 or 4, or CD4 % ≤ 25 % HIV-positive child under 5 years of age with PJP infection: start CPT after PJP treatment is completed HIV-positive child > 5 years with WHO stage 3 or 4, or CD4 ≤ 200
TB-NAAT (e.g. GXP) To diagnose TB	Only for those with a positive TB symptom screen

If patient comes from a different facility provide patient with treatment on the day of presentation. Referral letters are helpful, however a patient shouldn't be required to leave the facility without treatment to first obtain a referral/transfer letter

		ART REG	GIMENS	IN NE	W CL	IENTS.							MONITORI	NG WI	HILE OI	N ART			
kg to < 30 k	g, <u>and</u> ≥ 4 weeks	to < 10 years ^{##}			ABC + 3	BTC + DTG (d	dosing as pe	r paed dosing cha	rt)		V	IRAL LOA	\D		CLI	NICAL ASSESS	MENT		
nates [#] - bii h birth wei	th to < 4 weeks o ght ≥ 2.0 kg and ≥	f age 35 weeks gesta	itional age at	birth)	AZT + 3	TC + NVP (s	ee dosing be	elow)		WHEN: r	nonth 4, ear olds	12, then ann	ually k 14. month 12	WHEN:	every visit				
Avail	able formulation	Zidovudir 10 mg Dose in mL	ne (AZT) g/mL Dose in mg	Lami Dose ii	vudin 10 mg/r	e (3TC) mL Dose in mg	Neviraj 10 Dose in m	pine (NVP) mg/mL L Dose in mg		and then	emembe	er a VL ≥ 50 i emergency	s a medical	 Heigl neuro accor Ask a TB & 	ht, weight, odevelopm rding to we about side- other opp	head circumference nent (remember to a eight) effects ortunistic infection s	(< 2 years) and djust ART dosage		
	≥2-<3	1 mL BD	10 mg BD	0.5 ml	BD	5 mg BD	1.5 mL BD) 15 mg BD						• WHC) staging				
	≥3-<4	1.5 mL BD	15 mg BD	0.8 ml	BD	8 mg BD	2 mL BD	20 mg BD		RES	PONSE	TO VL ON D	TG REGIMEN			CD4 COUN	r .		
ing is based reases in the neonates wit	≥ 4 - < 5 on the birth weight of first week or two of h birth weight < 2.0	2 mL BD of the child. It is no life; Consult with a kg or gestational a	20 mg BD t necessary to c a clinician exper ge < 35 weeks,	1 mL change the rienced in as well as	BD e dose be paediatri infants ≥	10 mg BD fore 28 days ic ARV prescri 28 days of ag	3 mL BD of age if, for ex ibing or the HI ge but weight	30 mg BD xample, the weight V hotline (0800 212 < 3 kg	506),	• VL < 50: • VL ≥ 50: an eleva intercurr interactio	with VL) VL ≥ 1000 cells/µL ses (i.e. new WHO heduled visit by > 90								
NVP to DTG SWITCHING EXISTING CLIENTS TO DTG-CONTAINING REGIMENS										tions, inc Also see	cluding E section o	AC. Repeat V on CD4 monit	Lafter 3 months. oring	INTER ART-a:	PRETATIOI ssociated in	N: Stop cotrimoxazol mmune reconstitutio	e once on has occurred:		
	50011011100									RESPONS	SE TO <u>RI</u>	<u>EPEAT </u> VL ON	I DTG REGIMEN	• HIV-	positive inf	fants < 12 months: s	hould remain on CPT		
	CLIRREN		PENDENT	KEGI	VIEIN 3			Γ <u>Ω</u> .		• VL < 50:	Continue Re-asses	e yearly moni	toring	(If pr	evious PJP,	, stop at 5 years old i	f meets \geq 5 years		
LPV/r or	ATV/r regimen fo	or < 2 years		-			$BC^* + 3TC +$			urg	gently an	d see below		categ • HIV-I	gory) positive ch	ild ≥ 5 years: If CD4 of	count ≥ 200 cells/μL		
; + 3TC + (EFV or NVP)	- 1		_	lf ch	nild is ≥ 30 kg a	and ≥ 10 years:	switch client to TLD	f							•			
+ 3TC + (I	EFV or NVP)				eGFR:	80 mL/min. I Refer	No additional V to Adult ART 20	'L needed before swi 023 poster	tch.	RESPO	NSE TO	o <u>repeat</u>	HIGH VL WH	ILE ON	I DTG-C	ONTAINING R	EGIMEN		
Clients o	۱ PI-based regim swit	VL-DEPEI nens > two yea ich to DTG is ba	NDENT RE	EGIME e never ir VL wit	N SWI used a hin the	ITCHES DTG-conta last 12 m	aining regin onths	nen in the past					First line DTG regim remains ≥ 1000, diso first line DTG regime	e n[#]: Rep cuss with en or dru	eat VL afte an expert g interactio	r 6 months. If adher (consider RT if: inco ons)	ence > 80 % and VL rect classification as		
L (c/mL) hin the las 2 months)	CURRENT REGIMEN	CRITERIA F	FOR SWITC	CH AND)/OR R	REGIMEN	IF CHANG	GE IS INDICAT	ED		DTG re < 2 yea	gimen Irs	Second ^{##} or third lir Discuss RT with TLA 9 months AND 3 or	Repeat VL after 3 mo econd ^{##} or third line [#] /Ls ≥ 1000 (or at leas	onths ^{##} DTG regimen for ≥ t 1 VL ≥ 1000 with				
	LPV/r or	Switch to DTG-containing regimen ABC [*] + 3TC + DTG											either a CD4 < 200 c	or an OI) m treatin	AND docu	mented adherence >	[,] 80% on 2 occasions		
′L < 1000	ATV/r based regimen ≥ 2 years	<pre>1 VL mast 12 < 1000: swite assessment a n </pre>	ch, but do AB and provide E eeded	CDE AC if	If child if eGFR	Repe is ≥ 30 kg ar > 80 mL/mi	at VL after 3 nd ≥ 10 year in. Refer to A	months s: switch client to Adult ART 2023 p	TLD oster	Response		1	Adherence < 80 % of persistent low-level viraemia (2 or more	r	•Intensify	y adherence (ABCDE)			
o or more	Adherence < 80 %	Switch to A l Repeat VL	BC [*] + 3TC + D after 3 month ell. discuss wi	o TG ns. ith an	If rep If child if eGFR	oeat VL < 10 is ≥ 30 kg ar > 80 mL/mi	00: continu nd ≥ 10 year in. Refer to A	e ABC[*] + 3TC + D s: switch client to Adult ART 2023 p	r G TLD oster	VL after previous VL ≥ 50 [¥]		(consecutive VLs bety and 999)	ween 50	First line I	DTG regimen [#]			
$en \ge 2$ years er starting	5	e	expert		If repe	eat VL≥ 100 hot	0: Discuss w line (0800 21	vith HIV expert or 12 506)	the		DTG re	gimen	Adherence > 80 %, a	> 80 %, and with		 Repeat VL after 6 months 			
/r or ATV/r regimen	Adherence > 80 %	Discuss wit resistance t	th HIV expert test. Provide i repeat V	or the ho individua 'L after 3	otline (0 lised re months	800 212 50 gimen as re to confirm	6) to author commended re-suppress	ise and interpret I by HIV expert ar ion	a Id		≥ 2 yea	irs 2	2 or more VLs ≥ 1000 ≥ 2 years after starti DTG-based regimen east one VL ≥ 1000 ;	0 taken ng a OR at and	 Do RT after discussion with TLART only: If client was incorrectly classified as first line DTG regimen (including perinatally infected adolescents): or 				
r 2 years of V/r or ATV/	Do ABCDE a	ssessment, EAC	if applicable, one	repeat V of the ab	VL after 3 months. This result will group the client in above categories								either CD4 < 200 or a opportunistic infecti	an ion	Relevant Second lin	t drug interactions			
egimen		CLIENTS CL	JRRFNTLY	ON A	ZT + 3	TC + DTG	ì								• Do VL 3	months after new re	gimen implemented		
VL < 50	Switch to TL	D (if no renal dy	/sfunction, ≥ 1 for TDF	10 years switch to	of age a	nd weight ≧ 3TC + DTG	2 30 kg). If cli	ient does not qua	lify	[#] First line Di before switc most probab (TLD2, ALD2	TG regime hing from ble cause fo !): client when to DTG	ns (TLD1, ALD1): a first line ART r or non-suppressi ho was switched	client who was ART-naïv egimen to DTG. Resistant on. Most clients will re-su from a first line ART reg.	ve when DT ce to a first uppress on imen to DT itched from	G was initiat line DTG reg a first line DT G when the V	red <u>OR</u> client who had a V imen is rare. Suboptimal TG regimen if adherent; ^{#1} /L ≥ 50, <u>OR</u> client who wa a to DTG when the VL > 2	L < 50 within 6 months adherence remains the "Second line DTG regimens is switched from a second 0 without resistance		
$VL \ge 50$	vpersensitivity: AZT	ASSESS FOR RT. SE + 3TC + DTG: [¥] Resis	tance testing mi	response	icated if t	hile on DTC	-containing	regimen	l fail-	testing; ### TI resistance m	hird line D	TG regimen: clie o a PI in a previo	nt who was switched to o us second line reaimen:	an individu Resistance	alised DTG-ba	ased regimen based on re to be indicated if there is	evidence of clinical and/or		
ith good adh	erence—discuss with	an expert or call th	ne hotline							immunologi	cal failure	with good adher	ence—discuss with an e	xpert or ca	ll the hotline		,		
adherence	HOV to be > 80 %, patie	N TO MEA	SURE AD	HERE	NCE	OBJECT	IVELY			DO THI	e foll	OWING T	ESTS IF THE CLI ADV	IENT IS FRSF F	ON TH	E DRUG THAT I	MAY CAUSE THE		
 Pharmad Attendation 	:y refills > 80 % in nce of > 80 % of so	the last 6 - 12 m cheduled clinic v	nonths /isits in the las	st 6 - 12 ı	nonths					DRU	JG	TEST	FREQ	UENCY	,	ACTION/INT	ERPRETATION		
alculate ad	nerence percenta	ge in the past 6 ·	- 12 months: An An	mount of s	schedule	d visits actua d visits	ally attended l	by client/caregiver	X 100	AZT		FBC + differential WCC	At months 1 and thereafter if clin indicated	ł 3, ically		Hb ≥ 8 g/dL: Contir Hb < 8 g/dL or neu persistently < 1000 alternative – consu	ue AZT trophil count) cells/μL: Use Ilt with expert		
dren taking	CHIL ART and TB treatme	DREN CO-	INFECTEI	D WIT	H TUBERCULOSIS ^Φ mount of medication. Intensify adherence support.				PI-based regimen (LPV/r, A DRV/r)	TV/r,	Cholestero Triglyceride (TG)	ol + At month 3, if above ac les range, do fasting choles TG		eptable erol and	To monitor PI-relat side-effects. If fast are still above the obtain expert advice	ed metabolic ing cholesterol and TG acceptable range, ce			
G -based men	AND receiving treatment and	g a rifampicin -containing TB regimen: Boosting of DTG required while on rifampicin-containing TB d until two weeks after rifampicin has been stopped. See ART Drug Dosing Chart for Children 2022					ALT	If signs/symptoms of hepatitis (e.g. nausea, vomiting, jaundice) If ALT is abnormal, refer to sp phone the HIV hotline (0800				refer to specialist or line (0800 212 506)							
-based regir	nen No dose adjus	stments or change	es in ART regim	nen neede	d for DS	-TB treatmer	nt			NVP		ALT	It rash develops			If ALT is abnormal, phone the HIV hot	reter to specialist or line (0800 212 506)		
/r -based men	AND receiving a rifampicin-containing TB regimen: Additional ritonavir should be added or the LPV/r dose -based increased according to the ART Drug Dosing Chart for Children 2022. TB treatment should be dosed at standard doses. Stop additional ritonavir or increased LPV/r dose 2 weeks after TB-treatment completed									3TC = lamivudi AZT = zidovudi DTG = dolutegr	ne; ABC = ab ne; CM = cry ravir; DRV/r	pacavir; ALT = Alanir ptococcal meningit = darunavir and rito	e transaminase; ART = antire s; CPT = cotrimoxazole preve onavir; EAC = enhanced adher	troviral thera ntive therapy ence counse	apy; AST = Aspar /; CrAg = cryptoo lling; EFV = efavi	rtate transaminase; ATV/r = a coccal antigen; DR = drug-resi irenz; eGFR = estimated glome	tazanavir and ritonavir; stant; DS = drug-sensitive; erular filtration rate; EML =		

		ART RE	GIMENS	IN NE	EW CL	IENTS.						MONITORIN	NG W	HILE OI	N ART		
kg,	<u>and</u> ≥4 weeks t	o < 10 years ^{##}			ABC + 3	BTC + DTG (dosing as per	paed dosing chart)		١	/IRAL LOA	٨D		CLI	NICAL ASSESSME	NT	
oirth eigh	to < 4 weeks of t ≥ 2.0 kg and ≥	age 35 weeks gesta	ational age at	birth)	AZT + 3	TC + NVP (s	ee dosing bel	ow)	WHEN: For < 5 y	month 4 rear olds	, 12, then ann done at wee	ually k 14, month 12	WHEN:	every visit	: head circumference (< 2 y	oars	
		Zidovudi	ne (AZT)	Lam	ivudin	e (3TC)	Nevirap	ine (NVP)	and the	n yearly			neur	odevelopm	nent (remember to adjust A	ART c	
ilab	le formulation	10 m	g/mL		10 mg/r	mL	10 n	ng/mL	R	ememb	er a VL ≥ 50	is a medical	acco • Ask a	rding to we	eight) effects		
eight	t (kg) at birth	Dose in mL	Dose in mg	Dose	in mL 🛛 🛛	Dose in mg	Dose in mL	Dose in mg			emergency	/!	• TB &	other opp	ortunistic infection screen		
≥	2 - < 3	1 mL BD	10 mg BD	0.5 m	il BD	5 mg BD	1.5 mL BD	15 mg BD					• WHO) staging			
2	2 3 - < 4	1.5 mL BD	15 mg BD	0.8 m	il BD	8 mg BD	2 mL BD	20 mg BD	RES	PONSE	TO VL ON D	TG REGIMEN			CD4 COUNT		
≥	≥ 4 - < 5	2 mL BD	20 mg BD	1 ml	BD	10 mg BD	3 mL BD	30 mg BD	aVI < 50	Continu	lo voarly mon	itoring		at 12 mon	ths on APT (aligned with)	 /1 \	
d on ne firs vith b	the birth weight of st week or two of l pirth weight < 2.0 k	f the child. It is no ife; Consult with g or gestational a	ot necessary to c a clinician expen age < 35 weeks,	change th rienced ir as well as	le dose be 1 paediatri s infants ≥	fore 28 days ic ARV prescr 28 days of ag	of age if, for exa ibing or the HIV ge but weight <	ample, the weight hotline (0800 212 50 3 kg	5), b), b), b), b), b), b), b), b), b), b	Do thor ted VL. rent infe	ough assessm Consider adhe ections, incorr resistance. In	ent of the cause of erence problems, ect ART dose, drug nplement interven-	 Repeat 6 monthly: if CD4 ≤ 200 OR VL ≥ 1000 c Repeat if: any clinical indication arises (i.e. new stage 3 or 4) OR a client missed a scheduled vis days 				
3 S									tions, in Also see	cluding I section	EAC. Repeat V on CD4 monit	L after 3 months. toring	INTER ART-a	PRETATIO	N: Stop cotrimoxazole once mmune reconstitution has	ecci e	
31	WITCHING	EXISTING		ועטו	G-CUI	NIAININ		IEINS	RESPON	SE TO <u>R</u>	<u>EPEAT</u> VL OI	N DTG REGIMEN	• HIV-	positive inf	fants < 12 months: should	rema	
		NON VL-DE	EPENDENT	REGI	MEN S	WITCHE	S		• VL < 50:	Continu	e vearly mon	itoring	• HIV-	positive ch	ild 1 – 5 years: If CD4 perc	entag	
	CURRENT	REGIMEN				ļ	SWITCH T	0:	• VL ≥ 50:	Re-asse	ss and resolve	e adherence issues	(If pr	evious PJP, gory)	, stop at 5 years old if mee	is ≥ 5	
r AT	V/r regimen fo	r < 2 years				А	BC [*] + 3TC + I	DTG	ur	gently ar	nd see below		• HIV-	positive ch	ild ≥ 5 years: If CD4 count	≥ 200	
(EF	V or NVP)	-			lfc	nild is > 30 kg a	and > 10 years: s	witch client to TLD if					•				
(=:	(or NIVP)				eGFR :	> 80 mL/min.	No additional VL	needed before switch	RESPO	NSF T	O REPEAT			DTG-C	ONTAINING REGI	MFI	
	V OF NVP)					Refer	to Adult ART 202	23 poster				First line DTG regim	en [#] : Rep	eat VL afte	r 6 months. If adherence >	. 80 %	
on D	bacad ragim				IN SW		ning rogim	on in the nact:				remains \geq 1000, disc	cuss with	an expert	(consider RT if: incorrect c	lassif	
	swite	ch to DTG is b	ased on thei	ir VL wi	thin the	alast 12 m	onths	en in the past.				first line DTG regime	en or dru	g interactio	ons)		
)	CUIDDENIT									DTG re	egimen	Second ^{##} or third lin	<pre>ie^{###} DTG regimen: Repeat VL after 3 months</pre>				
ist	REGIMEN	CRITERIA Switch to DTG	FOR SWITC	CH ANI	D/OR R		IF CHANG			< 2 ye	ars	Discuss RT with TLA 9 months AND 3 or 1 either a CD4 < 200 o	RT comr more com or an OI)	nittee if: Sensecutive V AND docu	econd ^{##} or third line ^{###} DTG /Ls ≥ 1000 (or at least 1 VL mented adherence > 80%	i regi ≥ 10(on 2	
	LPV/r or ATV/r based	If VL in last 1	$2 \text{ months} \ge 50$	0 but								plus motivation from	n treatin	g clinician			
	regimen ≥ 2	< 1000: swit	tch, but do AB	CDE	If child	Repe	at VL after 3 r	nonths			,	Adherence < 80 % or	r				
	years	assessment	and provide E needed	AC IT	if child	$15 \ge 30 \text{ kg a}$ > 80 ml /m	na ≥ 10 years in. Refer to A	dult ART 2023 post	er Response		,	viraemia (2 or more		 Intensify 	adherence (ABCDE)		
e		Switch to A	ABC [*] + 3TC + D	тG	If rep If child	peat VL < 10 is ≥ 30 kg a	000: continue nd ≥ 10 years	ABC[*] + 3TC + DTG : switch client to T	D To repeat	:		consecutive VLs betv and 999)	ween 50	•Repeat \	VL after 6 months		
e	< 80 %	If child is unw	aπer 3 montr /ell, discuss wi expert	ith an	if eGFR If rep€	> 80 mL/m eat VL ≥ 100	in. Refer to A 00: Discuss wi	dult ART 2023 post th HIV expert or th	er $VL \ge 50^{4}$						 Intensify adherence (ABCDE) Repeat VL after 6 months 		
g			•		L	hot	line (0800 212	2 506)		DTG re	egimen	Adherence > 80 %, a	nd with	nepeur			
/r	Adherence > 80 %	Discuss wi resistance	th HIV expert test. Provide i repeat V	or the h ndividua Lafter 3	iotline (0 alised reរូ 3 months	800 212 50 gimen as re to confirm	6) to authoris commended re-suppressio	e and interpret a by HIV expert and on		≥ 2 ye	ars	2 or more VLs ≥ 1000 ≥ 2 years after starti DTG-based regimen	more VLs ≥ 1000 taken years after starting a i-based regimen OR at t one VL ≥ 1000 and er CD4 < 200 or an ortunistic infection		 Do RT after discussion with TLART only If client was incorrectly classified as first line DTG regimen (inc perinatally infected adolescents); or 		
000	•				<u></u>							least one VL \ge 1000 a					
on	Do ABCDE as	sessment, EAC	if applicable,	repeat	VL after 3	3 months. T	his result will	group the client in				opportunistic infecti			t drug interactions		
//r			one	of the a	bove cate	egories								Request	resistance testing		
					77 1 3		•							• Do VL 3	months after new regimer	ı imp	
_			UKKEINILI		21 + 3				#First line D	TG regime	ens (TLD1, ALD1)	client who was ART-naïv	ve when D	TG was initiat	red <u>OR</u> client who had a VL < 50 v	vithin	
	Switch to TLL) (if no renal d	for TDF	10 years switch t	to ABC +	nd weight 2	≥ 30 kg). If clie	ent does not qualif	most proba	ching from ble cause j	for non-suppress	egimen to DIG. Resistant ion. Most clients will re-si	ce to a first uppress on	a first line DTG reg	imen is rare. Suboptimal adherei TG regimen if adherent; ^{##} Seconc	ice re I line I	
	Δ	ssess for RT S		resnons		hile on DT(S-containing r	regimen	(TLD2, ALD2 line PI regin	?): client w nen to DTC	vho was switched 6 when the VL < 5	l from a first line ART regi 50, OR client who was swi	imen to DT itched fron	G when the V n a PI regimer	/L ≥ 50, <u>OR</u> client who was switcl n to DTG when the VL ≥ 50 witho	ned fro ut res	
` hvn	ersensitivity: A7T +	3TC + DTG ^{· ¥} Resi	stance testing m	ight he in	dicated if	there is evide	nce of clinical an	d/or immunological f	testing; ^{###} T	hird line D)TG regimen: clie to a PL in a previo	ent who was switched to a	an individu Resistance	alised DTG-ba	ased regimen based on resistance	e testi e of c	
here	nce—discuss with a	an expert or call t	he hotline		alcatea il t				immunologi	cal failure	with good adhe	rence—discuss with an ex	xpert or ca	ll the hotline			
o to		/ TO MEA	SURE AD	HER	ENCE	OBJECT	IVELY		DO TH	e foli	LOWING T	ESTS IF THE CLI	IENT IS		E DRUG THAT MAY	CA	
acy i	refills > 80 %, patie	he last 6 - 12 r	nonths	owing c	intena.						_	ADV	ERSE E	VENT			
ance	e of > 80 % of sc	heduled clinic	visits in the la	st 6 - 12	months				DR	UG	TEST	FREQ	UENCY	,	ACTION/INTERPI	RET/	
dherence percentage in the past 6 - 12 months: <u>Amount of scheduled visits actually attended by client/caregiver</u> X 1 Amount of scheduled visits								.00		FBC + differential WCC	At months 1 and thereafter if clin indicated	i 3, ically		Hb \geq 8 g/dL: Continue AZ Hb < 8 g/dL or neutrophi persistently < 1000 cells/	T l cou ′μL: L		
	CHILI	DREN CO-	INFECTE	D WI	тн ти	BERCU	LOSIS ^Φ		PI-based regimen		Cholestero Triglyceride	I + At month 3, if at range, do fasting	oove acc g cholest	eptable erol and	To monitor PI-related me side-effects. If fasting ch	tabc olest	
g AR add	T and TB treatme pyridoxine (vitam	nt together will in B6) if client is	have to tolerate taking isoniazi	e a large d or teriz	amount o vidone	of medicatio	n. Intensify adł	nerence support.	(LPV/r, A DRV/r)	TV/r,	(TG)	TG	ns of her	natitis	are still above the accept obtain expert advice	able	
	AND receiving	a rifampicin-col	ntaining TB regi	imen: Bo	osting of l	DTG require	d while on rifar	npicin-containing TE art for Children 2022	ning TB en 2022 NVP or EFV (e.g. nausea, vomiting, jaundice)			phone the HIV hotline (0	800 2				
ime	n No dose adjust	ments or chang	es in ART regim	nen need	ed for DS	-TB treatmer	nt		NVP		ALT	If rash develops			If ALT is abnormal, refer	to sp	
,	AND receiving	a rifampicin-co	ntaining TB regi	imen: Ad	ditional r	itonavir shou	uld be added o	r the LPV/r dose							phone the HIV notline (0	500 4	
	increased according to the ART Drug Dosing Chart for Children 2022. TB treatment should be dosed at standard doses. Stop additional ritonavir or increased LPV/r dose 2 weeks after TB-treatment completed 3TC = lamivudine; ABC = abacavir; ALT = Alanine transaminase; ART = antiretroviral therapy; CrAg = cryptococcal antiger; DR = drug-resistant; DS = DTG = dolutegravir; DRV/r = darunavir and ritonavir; EAC = enhanced adherence counselling; EFV = efavirenz; eGFR = estimated glomerular filtra									and rit = drug ration							

	ART RE	GIMENS I	IN NE	EW CI	LIENTS						MONITORIN	IG WI	HILE OI	N ART								
eekst	to < 10 years ^{##}			ABC +	3TC + DTG (d	losing as per p	aed dosing chart)		v	IRAL LOA	AD		CLI	NICAL ASSESSM	IENT							
eks of ind ≥	^r age 35 weeks gesta	ational age at b	oirth)	AZT + 3	3TC + NVP (s	ee dosing belo	w)	WHEN: m	nonth 4,	12, then ann	ually k 14. month 12	WHEN:	every visit	:								
	Zidovudi	ne (AZT)	Lam	ivudin	ne (3TC)	Nevirapii	ne (NVP)	and then	yearly	done at wee	k 14, month 12	 Heigl neur accor 	nt, weight, odevelopm rding to we	head circumference (< nent (remember to adju eight)	2 years) ust ART c							
tion	10 m	g/mL Doco in ma	Dece	10 mg/	/mL Doco in ma	10 mg	g/mL	Re	membe	er a VL ≥ 50	is a medical	• Ask a	bout side-	effects								
un	1 ml BD	10 mg BD	0.5 m		5 mg BD	1.5 ml BD	15 mg BD			entergency	/:	• IB &	other oppo Staging	ortunistic infection scre	een							
	1.5 mL BD	15 mg BD	0.8 m	LBD	8 mg BD	2 mL BD	20 mg BD	RESI	PONSE 1	ro vl on d'	TG REGIMEN		0.0									
	2 mL BD	20 mg BD	1 mL	BD	10 mg BD	3 mL BD	30 mg BD															
ight o wo of < 2.0 iuideli	f the child. It is no life; Consult with kg or gestational a nes for baseline to EXISTING	ot necessary to cl a clinician experi age < 35 weeks, a esting and follow	hange th ienced in as well as up for ne	e dose be paediatr s infants a conates <	efore 28 days of ric ARV prescri ≥ 28 days of ag a 4 weeks of age NTAININ	of age if, for example bing or the HIV h the but weight < 3 c; ^{##} No VL needed	nple, the weight otline (0800 212 506), kg when transitioning	• VL < 50: C • VL ≥ 50: I an elevat intercurre interaction tions, inc Also see s	Do thorce ed VL. C ent infectors and r luding Ed section c	ough assessm onsider adhe ctions, incorre resistance. In AC. Repeat V on CD4 monit	toring ent of the cause of erence problems, ect ART dose, drug nplement interven- L after 3 months. coring	•Repe •Repe stage days INTER ART-a:	at 12 mon eat 6 montl eat if: any c 2 3 or 4) OR PRETATION ssociated in	It is on ART (aligned with high edition of the constant of the constant of the constant of the constitution of the constituti	th VL) ≥ 1000 (; (i.e. nev :duled vis once has occu							
	NON VL-DE	EPENDENT	REGI	MEN S	SWITCHE	S						• HIV-	positive ch	ild 1 – 5 years: If CD4 p	percentag							
ENT	REGIMEN			_	9):	● VL < 50: (● VL ≥ 50: (Lontinue Re-asses	s and resolve	toring e adherence issues	(If pr	evious PJP,	, stop at 5 years old if n	neets ≥ 5							
en fo	or < 2 years				AF	$3C^{*} + 3TC + D^{*}$	TG	urg	ently an	d see below		•HIV-	positive ch	ild ≥ 5 years: If CD4 co	unt ≥ 200							
	If child is > 30 kg and > 10 years: switch client to TLD if													-								
				eGFR	> 80 mL/min. N	No additional VL n	eeded before switch.	RESPON	ISE TO	O REPEAT	HIGH VL WHI	LE ON	I DTG-C		GIME							
egim	VL-DEPE ens > two yea	NDENT RE	GIME	N SW	/ITCHES	ining regime	n in the past:				First line DTG regime remains ≥ 1000, disc	en [#] : Rep uss with	eat VL afte an expert	r 6 months. If adheren (consider RT if: incorre	ce > 80 % ect classif							
swit	ch to DTG is b	ased on their	r VL wi	thin the	e last 12 mo	onths			DTC ro	rimon	Second ^{##} or third lin	e ^{###} DTG	i regimen:	Repeat VI after 3 mon	ths							
NT EN	CRITERIA	FOR SWITC	D/OR I	REGIMEN		IS INDICATED		< 2 years		Discuss RT with TLAI 9 months AND 3 or r either a CD4 < 200 o	ART committee if: Second ^{##} or third line ^{###} DT(more consecutive VLs \ge 1000 (or at least 1 VL or an OI) AND documented adherence > 80%			DTG regi ↓ VL ≥ 10(80% on 2								
r	If VL in last 1	$2 \text{ months} \ge 50$) but		А		G				plus motivation from	n treatin	g clinician		• • • • •							
≥ 2	< 1000: swit assessment a r	tch, but do ABC and provide EA needed	CDE AC if	If child if eGFF	Repea l is ≥ 30 kg ar R > 80 mL/mi	at VL after 3 m nd ≥ 10 years: s n. Refer to Adu	onths switch client to TLD ult ART 2023 poster	Response			Adherence < 80 % or persistent low-level viraemia (2 or more	•Intensi •Repeat		y adherence (ABCDE)								
ce	Switch to A Repeat VL	ABC [*] + 3TC + D [*] after 3 month	TG s.	If re If child if eGFF	peat VL < 10 l is ≥ 30 kg ar R > 80 mL/mi	00: continue A nd ≥ 10 years: s n. Refer to Ade	BC[*] + 3TC + DTG switch client to TLD ult ART 2023 poster	VL after previous		(1	consecutive VLs betv and 999)	veen 50	First line [DTG regimen [#]								
)		expert	uran	If repeat VL ≥ 1000: Discuss with HIV expert or the hotline (0800 212 506)				If repeat VL ≥ 1000: Discuss with HIV expert or the hotline (0800 212 506)				n If repeat VL ≥ 1000: Discuss with HIV expert or the hotline (0800 212 506)				DTG re	gimen	Adherence > 80 %, a	herence > 80 %, and with $\frac{1}{2}$		y adherence (ABCDE) VL after 6 months	
ce	Discuss wi resistance	th HIV expert of test. Provide in repeat VL	or the h ndividua _ after 3	otline (alised re months	0800 212 500 egimen as rec s to confirm	5) to authorise commended by re-suppressior	and interpret a y HIV expert and n		≥2 yea	rs i	2 or more VLs ≥ 1000 ≥ 2 years after startir DTG-based regimen (least one VL ≥ 1000 a	DO taken ting a n OR at Do RT • If clie classit		RT after discussion with TLART only lient was incorrectly ssified as first line DTG regimen (incl inatally infected adolescents): or								
DE as	ssessment, EAC	C if applicable, one o	repeat of the a	VL after bove ca	3 months. T tegories	his result will ខ្	roup the client in				either CD4 < 200 or a opportunistic infection	in on	Relevant Second lin	t drug interactions	.5), 01							
													Request Do VI 3	resistance testing	mon imn							
to TLI	CLIENTS CU D (if no renal d	URRENTLY ysfunction, ≥ 1	ON A	ZT + 3 of age a	BTC + DTG and weight ≥	30 kg). If clier	t does not qualify	<i>First line DT</i> before switch	G regimer aing from a	n s (TLD1, ALD1) : a first line ART ro or non-suppressi	: client who was ART-naïv egimen to DTG. Resistanc ion, Most clients will resu	e when DI e to a first	G was initiat	red <u>OR</u> client who had a VL < imen is rare. Suboptimal adl	50 within							
	COCC for DT C	tor TDF s	switch t	0 ABC +	+ 3IC + DTG	containing	gimon	(TLD2, ALD2)	client wh	when the VI < 5	from a first line ART regin	men to DT	G when the V	$L \ge 50$, <u>OR</u> client who was s n to DTG when the VL > 50 w	witched fro							
-/ + AZT :	+ 3TC + DTG: [¥] Resi	stance testing mi	espons ght be in	dicated if	there is evider	ce of clinical and	/or immunological fail-	testing; ###Th resistance m	ird line Di	G regimen: clie	ent who was switched to a bus second line regimen: *	<i>n individu</i> Resistance	alised DTG-ba	ased regimen based on resis	<i>stance test</i>							
with	an expert or call t	he hotline	But se m	allouted if				immunologic	al failure v	with good adher	rence—discuss with an ex	pert or ca	ll the hotline									
OV patie	V TO MEA	SURE AD	HERE	INCE	OBJECT	IVELY		DO THE	FOLL	OWING T	ESTS IF THE CLI			E DRUG THAT M	AY CAI							
% in [.]	the last 6 - 12 r	nonths						DRI		TEST	EREO											
of sc	heduled clinic to in the past 6	visits in the las	t 6 - 12	months	5				UG	FBC +	At months 1 and			Hh > 8 g/dL Continue								
enta	Amount of scheduled visits actually attended by client/caregiver X 1 Amount of scheduled visits									differential WCC	thereafter if clini indicated	ically		Hb < 8 g/dL or neutro persistently < 1000 or alternative – consult	ophil cou ells/µL: L with exp							
HIL	DREN CO- nt together will	INFECTED	D WI a large	TH TU	JBERCUI of medicatior	LOSIS ^Φ n. Intensify adhe	rence support.	PI-based regimen (LPV/r, AT	℃/r,	Cholestero Triglyceride (TG)	I + At month 3, if ab range, do fasting TG	ove acce cholest	eptable erol and	To monitor PI-related side-effects. If fasting are still above the act	d metabo g cholest ceptable							
(vitan eiving	hin B6) if client is a rifampicin -con	taking isoniazid ntaining TB regins	d or teriz men: Bo	idone osting of	DTG required	while on rifam	picin-containing TB	TB treatm NVP or EF	ent or V	ALT	If signs/symptom (e.g. nausea, von	ns of hep niting, ja	oatitis jundice)	If ALT is abnormal, re phone the HIV hotlin	efer to sp e (0800 2							
adjus	tments or chang	es in ART regime	en need	ed for DS	S-TB treatmen	t		NVP		ALT	If rash develops			If ALT is abnormal, re phone the HIV hotlin	fer to sp e (0800 1							
eiving a rifampicin -containing TB regimen: Additional ritonavir should be added or the LPV/r dose d according to the ART Drug Dosing Chart for Children 2022. TB treatment should be dosed at standard top additional ritonavir or increased LPV/r dose 2 weeks after TB-treatment completed									e; ABC = ab e; CM = cry avir; DRV/r =	acavir; ALT = Alanin ptococcal meningit = darunavir and rito	ne transaminase; ART = antiret is; CPT = cotrimoxazole preven onavir; EAC = enhanced adhere	roviral thera tive therapy ence counsel	apy; AST = Aspar ; CrAg = crypto lling; EFV = efavi	rtate transaminase; ATV/r = ataza coccal antigen; DR = drug-resistar irenz; eGFR = estimated glomerul	anavir and rit nt; DS = drug lar filtration							

		ART REGIMENS IN N	EW CLIENTS						MONITORIN	IG WI	HILE OI	N ART
≥ 3 kg to < 30	kg, <u>and</u> ≥ 4 week	s to < 10 years ^{##}	ABC + 3TC + DTG (d	osing as per	paed dosing chart)		\	VIRAL LO	AD		CLI	NICAL ASSESSMENT
Neonates [#] - b (with birth we	irth to < 4 weeks ight > 2.0 kg and	of age > 35 weeks gestational age at birth)	AZT + 3TC + NVP (se	ee dosing bel	ow)	WHEN: n	nonth 4	, 12, then anr	nually	WHEN:	every visit	
Avai We	lable formulation ight (kg) at birth $\geq 2 - < 3$	Zidovudine (AZT) Lan 10 mg/mL Dose in mL Dose in mg Dose 1 mL BD 10 mg BD 0.5 mg	ivudine (3TC) 10 mg/mL in mL Dose in mg nL BD 5 mg BD	Nevirapi 10 m Dose in mL 1.5 mL BD	ine (NVP) ng/mL Dose in mg 15 mg BD	For < 5 years and then	ear olds yearly	oer a VL ≥ 50 emergency	ek 14, month 12 is a medical y!	 Heigh neuro accor Ask a TB & WHO 	nt, weight, odevelopm ding to we bout side- other oppo staging	head circumference (< 2 years) nent (remember to adjust ART c eight) effects ortunistic infection screen
	≥ 3 - < 4	1.5 mL BD 15 mg BD 0.8 r	nL BD 8 mg BD	2 mL BD	20 mg BD	RES	PONSE	TO VL ON D	TG REGIMEN			CD4 COUNT
Dosing is based decreases in th for neonates w	≥ 4 - < 5 on the birth weight e first week or two o ith birth weight < 2.0	2 mL BD 20 mg BD 1 m of the child. It is not necessary to change t of life; Consult with a clinician experienced D kg or gestational age < 35 weeks, as well a	L BD 10 mg BD he dose before 28 days o in paediatric ARV prescrik as infants ≥ 28 days of ag	3 mL BD f age if, for exa bing or the HIV e but weight < 2	30 mg BD ample, the weight hotline (0800 212 506), 3 kg	 VL < 50: Continue yearly monitoring VL ≥ 50: Do thorough assessment of the cause of an elevated VL. Consider adherence problems, intercurrent infections, incorrect ART dose, drug interactions and resistance. Implement intervention WHEN: at 12 months on ART (aligned to the cause of an elevated VL. Consider adherence problems, intercurrent infections, incorrect ART dose, drug interactions and resistance. Implement intervention 						
"See protocol in t from NVP to DTG	he ART Clinical Guide	elines for baseline testing and follow up for r	neonates < 4 weeks of age	ed when transitioning	tions, inc Also see	luding E section	EAC. Repeat V on CD4 moni	/L after 3 months. toring	days INTER	PRETATION	N: Stop cotrimoxazole once	
	SWITCHING	G EXISTING CLIENTS TO D	IG-CONTAININ	G REGIM	IENS	RESPONS	SE TO <u>R</u>	REPEAT VL O	N DTG REGIMEN	ART-as • HIV-p	ssociated in positive inf	mmune reconstitution has occu ants < 12 months: should remain
		NON VL-DEPENDENT REG	IMEN SWITCHES	5		• VL < 50;	Continu	ue vearly mon	itoring	• HIV-p	ositive chi	ild 1 – 5 years: If CD4 percentages
	CURREN	IT REGIMEN	S	WITCH TO	0:	• VL ≥ 50:	Re-asse	ess and resolv	e adherence issues	categ	gory)	stop at 5 years old if meets 2 5
Any LPV/r or	ATV/r regimen	for < 2 years	AB	8C [*] + 3TC + D	DTG		entry ar			• HIV-p	oositive ch	ild \geq 5 years: If CD4 count \geq 200
ABC + 3TC +	(EFV or NVP)		If child is ≥ 30 kg a eGFR > 80 mL/min. N	nd ≥ 10 years: s Io additional VL	witch client to TLD if needed before switch.	DECDO						
AZT + 3TC +	EFV or NVP)		Refer to	o Adult ART 202	23 poster	RESPO	NSE I	O <u>REPEA</u>	I_HIGH VL WHI		DIG-C	ON TAINING REGIMET
Clients o	n PI-based regi sw	VL-DEPENDENT REGIM mens > two years, who have neve itch to DTG is based on their VL w	EN SWITCHES r used a DTG-conta ithin the last 12 mo	ining regimonths	en in the past:				remains ≥ 1000, disc first line DTG regime	uss with	an expert g interactio	(consider RT if: incorrect classif ons)
VL (c/mL) (within the la 12 months)	st CURRENT REGIMEN	CRITERIA FOR SWITCH AN	D/OR REGIMEN	IF CHANG	E IS INDICATED]	DTG re < 2 yea	egimen ars	Second ^{##} or third lin Discuss RT with TLAN 9 months AND 3 or r	e^{###} DTG RT comn more cor	Repeat VL after 3 months econd ^{##} or third line ^{###} DTG regi ′Ls ≥ 1000 (or at least 1 VL ≥ 100	
	LPV/r or	Switch to DTG-containing regimen	A	BC [*] + 3TC + D	στG				either a CD4 < 200 o plus motivation from	r an OI) n treating	AND docui g clinician	mented adherence > 80% on 2
VL < 1000	ATV/r based regimen ≥ 2 years	< 1000: switch, but do ABCDE assessment and provide EAC if needed	Repea If child is ≥ 30 kg an if eGFR > 80 mL/mir	at VL after 3 n Id ≥ 10 years: n. Refer to Ac	nonths : switch client to TLD dult ART 2023 poster	Response			Adherence < 80 % or persistent low-level viraemia (2 or more		•Intensify	/ adherence (ABCDE) /Lafter 6 months
Two or more consecutive	Adherence	Switch to ABC[*] + 3TC + DTG Repeat VL after 3 months.	If repeat VL < 100 If child is ≥ 30 kg an if eGFR > 80 mL/min	00: continue Id ≥ 10 years: n. Refer to Ac	ABC [*] + 3TC + DTG switch client to TLD dult ART 2023 poster	VL after previous VL ≥ 50 [¥]			consecutive VLs betv and 999)	veen 50	First line D	DTG regimen [#]
$taken \ge 2$ year	rs	expert	If repeat VL ≥ 1000 hotli	D: Discuss wit ine (0800 212	th HIV expert or the 2 506)		DTG regimen		Adherence > 80 %, a	• Repeat V		/L after 6 months
LPV/r or ATV/ regimen	Adherence > 80 %	Discuss with HIV expert or the resistance test. Provide individu repeat VL after	hotline (0800 212 506 Ialised regimen as rec 3 months to confirm r	 b) to authoris commended b re-suppression 	e and interpret a by HIV expert and on		≥ 2 yea	ars	2 or more VLs \ge 1000 \ge 2 years after startin DTG-based regimen (Do RT after of ing a OR at Classified as		ter discussion with TLART only: was incorrectly d as first line DTG regimen (incl
Only 1 VL > 10 after 2 years of a LPV/r or ATV	00 Do ABCDE //r	assessment, EAC if applicable, repeat one of the a	VL after 3 months. Th above categories	nis result will	group the client in				either CD4 < 200 or a opportunistic infectio	an on	Perinata Relevant Second lin	Illy infected adolescents); or t drug interactions ne DTG regimen^{##}
regimen		CLIENTS CLIRRENTLY ON A	\7T + 3TC + DTG								• Do VL 3	months after new regimen imp
VL < 50	Switch to T	LD (if no renal dysfunction, ≥ 10 year for TDF switch	s of age and weight ≥ to ABC + 3TC + DTG	30 kg). If clie	ent does not qualify	*First line D1 before switch most probabe (TLD2, ALD2)	G regime hing from ole cause f): client w	ens (TLD1, ALD1) n a first line ART I for non-suppress who was switched	: client who was ART-naïv regimen to DTG. Resistanc ion. Most clients will re-su d from a first line ART regi	e when DT te to a first oppress on men to DT	G was initiat line DTG regi a first line D1 G when the V	ed <u>OR</u> client who had a VL < 50 within imen is rare. Suboptimal adherence re TG regimen if adherent; #"Second line IL ≥ 50, <u>OR</u> client who was switched fro
VL ≥ 50		Assess for RT. See section on respon	se to VL while on DTG	-containing r	egimen	testing; ### T	en to DIG hird line D	5 when the VL < 3 DTG regimen: clie to a PL in a provi	50, <u>OR</u> client who was swit ent who was switched to a	tched from In individue Resistance	a PI regimer alised DTG-ba tosting migh	n to DFG when the VL ≥ 50 without res ased regimen based on resistance test the indicated if there is ovidence of a
ure with good adl	nypersensitivity: A2 nerence—discuss wit	h an expert or call the hotline	ndicated if there is eviden	ce of clinical an	d/or immunological fall-	immunologio	cal failure	e with good adhe	rence—discuss with an ex	pert or cal	I the hotline	It be indicated if there is evidence of c
	HO	W TO MEASURE ADHER	ENCE OBJECTI	VELY		DO TH	e foli	LOWING T	ESTS IF THE CLI	ENT IS		E DRUG THAT MAY CAU
 For adherence Pharma 	to be > 80 %, pat cv refills > 80 % ii	ient must meet one of the following n the last 6 - 12 months	criteria:					_	ADVI	ERSE E	VENT	
 Attenda 	ance of > 80 % of	scheduled clinic visits in the last 6 - 12	2 months			DRU	JG	TEST	FREQ	UENCY		ACTION/INTERPRET
To calculate ad	lherence percent	age in the past 6 - 12 months: <u>Amount o</u> Amount o	/ client/caregiver X 100	AZT		FBC + differentia WCC	At months 1 and thereafter if clini indicated	3, ically		Hb ≥ 8 g/dL: Continue AZT Hb < 8 g/dL or neutrophil cou persistently < 1000 cells/μL: L alternative – consult with exp		
Children taking	CHI ART and TB treatm	LDREN CO-INFECTED WI	TH TUBERCUL amount of medication	OSIS ^Φ . Intensify adh	nerence support.	PI-based regimen (LPV/r, A DRV/r)	TV/r,	Cholestero Triglycerid (TG)	ol + At month 3, if ab es range, do fasting TG	ove acce choleste	eptable erol and	To monitor PI-related metabolic side-effects. If fasting cholest are still above the acceptable obtain expert advice
DTG-based regimen	AND receiving treatment and	AND receiving a rifampicin -containing TB regimen: Boosting of DTG required while on rifampicin-co treatment and until two weeks after rifampicin has been stopped. See ART Drug Dosing Chart for Ch					nent or V	ALT	If signs/symptom (e.g. nausea, von	ns of hep niting, ja	atitis undice)	If ALT is abnormal, refer to sp phone the HIV hotline (0800 2 If ALT is abnormal, refer to sp
EFV-based reg	men No dose adju	ustments or changes in ART regimen needs	ded for DS-TB treatment	t Id be added or	the I P\//r doca						phone the HIV hotline (0800 2	
LPV/r-based regimen	increased ac doses. Stop	cording to the ART Drug Dosing Chart for additional ritonavir or increased LPV/r do	Children 2022. TB treat se 2 weeks after TB-treat	ment should be atment comple	be dosed at standard eted	3TC = lamivudir AZT = zidovudir DTG = dolutegr	ne; ABC = al ne; CM = cr avir; DRV/r	abacavir; ALT = Alani ryptococcal meningi r = darunavir and rit	ne transaminase; ART = antiret tis; CPT = cotrimoxazole preven onavir; EAC = enhanced adhere	roviral thera ntive therapy ence counsel	py; AST = Aspar ; CrAg = cryptod ling; EFV = efavi	rtate transaminase; ATV/r = atazanavir and ri coccal antigen; DR = drug-resistant; DS = drug irenz; eGFR = estimated glomerular filtration

		ART REGI	MENS IN	N NEW (CLIENTS							MONITORI	NG WI	HILE OI	N ART	
≥ 3 kg to < 30	0 kg, <u>and</u> ≥ 4 weeks	s to < 10 years ^{##}		ABC	+ 3TC + DTG (dosing as per	paed dosing chart)			١	VIRAL LO	AD	CLINICAL ASSESSMENT			
Neonates [#] - I (with birth w	birth to < 4 weeks o veight ≥ 2.0 kg and 3	of age ≥ 35 weeks gestatior	nal age at bir	rth) AZT ·	+ 3TC + NVP (s	see dosing be	low)		WHEN: m	nonth 4	1, 12, then an	nually	WHEN:	every visit		
Ava	ailable formulation	Zidovudine ((AZT)	Lamivud	i ne (3TC) g/mL	Nevirap	bine (NVP) mg/mL	1	For < 5 ye and then Re	ear olds yearly memb	s done at wee per a VL ≥ 50	is a medical	 Heigh neuro accor Ask a 	nt, weight, odevelopm ding to we bout side-	head circumference (< ient (remember to adju ight) effects	2 years) Ist ART c
w	eight (kg) at birth	Dose in mL Do	ose in mg D	Dose in mL	Dose in mg	Dose in mL	L Dose in mg				emergenc	y!	• TB &	other oppo	ortunistic infection scre	een
	≥2-<3 ≥3-<4	1.5 mL BD 10	5 mg BD (0.5 mL BD	8 mg BD	2 mL BD	20 mg BD		RES	PONSE		TG REGIMEN	• WHO	Jaging		
	≥4-<5	2 mL BD 20	0 mg BD	1 mL BD	10 mg BD	3 mL BD	30 mg BD									
Dosing is base decreases in t for neonates	ed on the birth weight he first week or two o with birth weight < 2.0	of the child. It is not nee f life; Consult with a clir) kg or gestational age <	ecessary to char nician experien < 35 weeks, as v	inge the dose nced in paedi well as infant	before 28 days atric ARV prescr s ≥ 28 days of a	of age if, for ex ibing or the HIV ge but weight <	ample, the weight / hotline (0800 212 506 < 3 kg	 •VL ≥ 50: Do thorough assessment of the cause of an elevated VL. Consider adherence problems, intercurrent infections, incorrect ART dose, drug interactions and resistance. Implement intervention •VL ≥ 50: Do thorough assessment of the cause of an elevated VL. Consider adherence problems, intercurrent infections, incorrect ART dose, drug interactions and resistance. Implement intervention 								th VL) ≥ 1000 ((i.e. nev duled vis
from NVP to DT	from NVP to DTG										EAC. Repeat V on CD4 mon	/L after 3 months.	INTER	PRETATIO	N: Stop cotrimoxazole c	once
	SWITCHING	EXISTING CLI	IENTS TO	DTG-C	ONTAININ	IG REGIN	1ENS		RESPONS	E TO R	REPEAT VL O	N DTG REGIMEN	ART-as	ssociated in positive inf	mmune reconstitution l ants < 12 months: shou	has occu uld rema
		NON VL-DEPE	NDENT R	REGIMEN	SWITCHE	S			• VI < 50:	Continu	ue vearly mor	nitoring	• HIV-	positive ch	ild 1 – 5 years: If CD4 p	ercenta
	CURREN	T REGIMEN				SWITCH T	ю:		• VL ≥ 50:	Re-asse	ess and resolv	e adherence issues	(If pro	evious PJP, gory)	stop at 5 years old if m	neets ≥ 5
Any LPV/r o	or ATV/r regimen f	for < 2 years			Α	BC [*] + 3TC +	DTG		urg	ently ar	nd see below		• HIV-p	ositive ch	ild ≥ 5 years: If CD4 cou	unt ≥ 200
ABC + 3TC +	- (EFV or NVP)			I C	f child is \geq 30 kg	and ≥ 10 years:	switch client to TLD if	1				$\overline{\mathbf{V}}$				
AZT + 3TC +	(EFV or NVP)			eG	-R > 80 mL/min. Refer	to Adult ART 20	23 poster		RESPOR	NSE T	fo <u>repea</u>	<u>T HIGH VL WH</u>	ILE ON	I DTG-C	ONTAINING REC	GIME
Clients	on PI-based regir swi	VL-DEPEND nens > two years, v tch to DTG is base	DENT REG who have n d on their V	IMEN SN never used VL within t	VITCHES a DTG-conta he last 12 m	aining regim onths	nen in the past:					First line DTG regim remains ≥ 1000, disc first line DTG regime	en": Rep cuss with en or dru	eat VL afte an expert g interactio	r 6 months. If adherend (consider RT if: incorred ons)	ce > 80 % ct classif
VL (c/mL (within the la 12 months	-) ast BEGIMEN	CRITERIA FOF	R SWITCH	AND/OF	REGIMEN	IF CHANG	E IS INDICATED			DTG re < 2 yea	egimen ears	Second ^{##} or third lin Discuss RT with TLA 9 months AND 3 or	ne ^{###} DTG .RT comn more cor	Repeat VL after 3 mont econd ^{##} or third line ^{###} I 'Ls ≥ 1000 (or at least 1	ths DTG regi VL ≥ 100	
	LPV/r or	Switch to DTG-con	ntaining regir	men	Δ	\BC [*] + 3TC + [DTG					either a CD4 < 200 c	or an OI) m treating	AND docu	mented adherence > 80	0% on 2
VL < 1000	ATV/r based regimen ≥ 2 years	<pre>If VL in last 12 mo < 1000: switch, l assessment and need</pre>	onths ≥ 50 b but do ABCD provide EAC led	DE DE Cif If chi	Repe Id is ≥ 30 kg a FR > 80 mL/m	at VL after 3 nd ≥ 10 years in. Refer to A	months s: switch client to TLI dult ART 2023 poste	Der	Response			Adherence < 80 % or persistent low-level viraemia (2 or more	r	Intensify	adherence (ABCDE)	
Two or mor consecutiv	re e Adherence	Switch to ABC * Repeat VL afte	+ 3TC + DTG er 3 months.	G If chi if eG	repeat VL < 10 Id is ≥ 30 kg a FR > 80 mL/m)00: continue nd ≥ 10 years in. Refer to A	e ABC [*] + 3TC + DTG s: switch client to TLI dult ART 2023 poste	D er	to repeat VL after previous VL $\ge 50^{2}$			consecutive VLs bety and 999)	rence > 80 %, and with nore VLs \geq 1000 taken based regimen OR at		DTG regimen [#]	
$VLS \ge 1000$ taken ≥ 2 yes	ars	expe	ert	lfre	peat VL≥ 100 hot	00: Discuss wi line (0800 21	ith HIV expert or the 2 506)	2		DTG re	egimen	Adherence > 80 %. a			Repeat VL after 6 months	
LPV/r or AT regimen	//r Adherence > 80 %	Discuss with H resistance test.	IV expert or . Provide ind repeat VL a	the hotline lividualised after 3 mont	(0800 212 50 regimen as re hs to confirm	6) to authoris commended re-suppressi	se and interpret a by HIV expert and on			≥ 2 yea	ears	2 or more VLs \geq 1000 \geq 2 years after starti DTG-based regimen least one VL \geq 1000			 Do RT after discussion with TLART If client was incorrectly classified as first line DTG regimen paripatally infected adolescents); c 	
Only 1 VL > 10 after 2 years a LPV/r or AT	on Do ABCDE a V/r	assessment, EAC if a	opplicable, re one of	epeat VL afte the above o	er 3 months. T ategories	his result wil	l group the client in					either CD4 < 200 or a opportunistic infecti	an ion	 perinatally infected adolescents); or Relevant drug interactions Second line DTG regimen ^{##}		
regimen)NI A7T +		2								• Do VL 3	months after new regin	men imp
VL < 50	Switch to T	LD (if no renal dysfur	nction, ≥ 10 y for TDF sw	years of age vitch to ABC	and weight a + 3TC + DTG	≥ 30 kg). If clie	ent does not qualify		First line DT before switch most probab (TLD2, ALD2)	G regime hing from le cause f : client w	ens (TLD1, ALD1 n a first line ART for non-suppress who was switche): client who was ART-naïv regimen to DTG. Resistand sion. Most clients will re-su d from a first line ART regi	ve when DT ce to a first uppress on imen to DT	G was initiat line DTG reg a first line D1 G when the V	ed <u>OR</u> client who had a VL < imen is rare. Suboptimal adh ʿG regimen if adherent; ***Sec 'L ≥ 50, <u>OR</u> client who was sv	50 within herence re cond line witched fre
VL ≥ 50		Assess for RT. See se	ection on res	sponse to V	while on DT	G-containing	regimen		line PI regime testing; ###Th	en to DTO i rd line D	G when the VL < DTG regimen: cli	50, <u>OR</u> client who was swi ent who was switched to g	itched from an individu	n a PI regimer alised DTG-bo	to DTG when the VL \ge 50 w ased regimen based on resist	ithout res
*If client has AB ure with good ac	C hypersensitivity: AZT dherence—discuss witl	+ 3TC + DTG; Resistanc n an expert or call the ho	ce testing might otline	t be indicated	if there is evide	nce of clinical ar	nd/or immunological fai	il-	immunologic	al failure	to a PI in a previ e with good adhe	erence—discuss with an ex	Resistance xpert or cal	l testing migh Il the hotline	t be indicated if there is evid	dence of c
	HO	W TO MEASU	JRE ADH	IERENC	E OBJECT	IVELY			DO THE	E FOLI		TESTS IF THE CL	IENT IS		E DRUG THAT MA	ay cai
For adherence	te to be > 80 %, pat	ient must meet one	of the follow	ving criteria	:							ADV	ERSE E	VENT		
Attend	dance of > 80 % of s	scheduled clinic visits	tris is in the last 6	6 - 12 mont	ns				DRU	JG	TEST	FREQ	UENCY	,	ACTION/INTER	RPRET
To calculate adherence percentage in the past 6 - 12 months: <u>Amount of scheduled visits actually attended by client/caregiv</u> <u>Amount of scheduled visits</u>								00	AZT		FBC + differentia WCC	At months 1 and thereafter if clin indicated	l 3, ically		Hb ≥ 8 g/dL: Continue Hb < 8 g/dL or neutro persistently < 1000 ce alternative – consult \	e AZT phil cou ells/μL: ι with exp
Children takin	CHII	DREN CO-INI ent together will have	WITH T	VITH TUBERCULOSIS [©] rge amount of medication. Intensify adherence support.					∿/r,	Cholestero Triglycerid (TG)	ol + At month 3, if al les range, do fasting TG	oove acce g choleste	eptable erol and	To monitor PI-related side-effects. If fasting are still above the acc obtain expect advice	l metabo cholest ceptable	
Remember to DTG-based regimen	o add pyridoxine (vitamin B6) if client is taking isoniazid or terizidone AND receiving a rifampicin -containing TB regimen: Boosting of I treatment and until two weeks after rifampicin has been stoppe				of DTG require pped. See ART [d while on rifa Drug Dosing Ch	mpicin-containing TB nart for Children 2022		TB treatm NVP or EF	ent or V	ALT	If signs/symptoms of h (e.g. nausea, vomiting		obtain expert adviceof hepatitisIf ALT is abnormal, refer tting, jaundice)phone the HIV hotline (08)	fer to sp e (0800 2	
EFV-based re	gimen No dose adju	stments or changes in	n ART regimen	n needed for	DS-TB treatmer	nt		NVP ALT If rash develops If ALT phone					If ALT is abnormal, ref phone the HIV hotline	fer to sp e (0800 2		
LPV/r-based regimen	AND receivin increased ac doses. Stop a	g a rifampicin -contain cording to the ART Dru additional ritonavir or i	ning TB regime ug Dosing Char increased LPV,	en: Additiona Int for Childre //r dose 2 we	l ritonavir shou n 2022. TB trea eks after TB-tre	uld be added o atment should eatment comp	or the LPV/r dose be dosed at standard leted		3TC = lamivudir AZT = zidovudir DTG = dolutegra	ne; ABC = a ne; CM = cr avir; DRV/r	abacavir; ALT = Alan ryptococcal mening /r = darunavir and ri	ine transaminase; ART = antire itis; CPT = cotrimoxazole prevei tonavir; EAC = enhanced adher	troviral thera ntive therapy ence counsel	apy; AST = Aspar ; CrAg = crypto ling; EFV = efavi	tate transaminase; ATV/r = ataza coccal antigen; DR = drug-resistan renz; eGFR = estimated glomerula	navir and ri nt; DS = drug ar filtration

Paediatric DS-TB guidelines and EML/STG for PHC, NDoH, Dec 2024

(м**і**с

			ART REG	IMENS	IN NEW	CLIENTS		MIONITORING WHILE ON ART										
≥ 3 kg to <	< 30 kg, <u>aı</u>	<u>nd</u> ≥ 4 weeks †	to < 10 years ^{##}		ABO	C + 3TC + DTG (dosing as per	paed dosing cha	rt)		V	IRAL LO	AD		CLI	NICAL ASSESSMENT		
Neonates (with birt	[#] - birth to h weight ≧	o < 4 weeks of ≥ 2.0 kg and ≥	^f age 35 weeks gestati	ional age at I	birth) AZ1	+ 3TC + NVP (see dosing bel	ow)		WHEN: m	nonth 4,	12, then and	nually	WHEN:	every visit			
			Zidovudine	e (AZT)	Lamivu	dine (3TC)	Nevirap	ine (NVP)		and then	yearly	uone at wee	ek 14, month 12	Height neuro	nt, weight, odevelopm cding to we	head circumference (< 2 years) nent (remember to adjust ART o night)		
	Available	formulation	10 mg/	′mL	10 r	ng/mL	10 m	ng/mL		Rei	membe	er a VL ≥ 50	is a medical	• Ask a	bout side-	effects		
	Weight (kg) at birth	Dose in mL C	Dose in mg	Dose in m	Dose in mg	Dose in mL	Dose in mg				emergency	y!	• TB &	other opp	ortunistic infection screen		
	≥ 2	2 - < 3	1 mL BD	10 mg BD	0.5 mL BD	5 mg BD	1.5 mL BD	15 mg BD						• WHC) staging			
-	≥ 3	3-<4	1.5 mL BD	15 mg BD	0.8 mL BD	8 mg BD	2 mL BD	20 mg BD		RESF	PONSE	to vl on d	TG REGIMEN			CD4 COUNT		
Dosing is b decreases for neonat	oased on th in the first tes with birt ol in the AR	e birth weight o week or two of th weight < 2.0 T Clinical Guideli	of the child. It is not in life; Consult with a construction of the second seco	necessary to c clinician exper e < 35 weeks, a ting and follow	hange the dos ienced in paed as well as infa	e before 28 days liatric ARV prescr hts ≥ 28 days of a	of age if, for exa ribing or the HIV ge but weight < 2	mple, the weight hotline (0800 212 3 kg	506),	 VL < 50: 0 VL ≥ 50: 0 an elevate intercurre interaction 	Continue Do thore ed VL. C ent infee ons and	e yearly mon ough assessm Consider adhe ctions, incorr resistance. Ir	itoring nent of the cause of erence problems, ect ART dose, drug nplement interven-	WHEN: • Repe • Repe stage davs	at 12 mon at 6 mont at if: any c 3 or 4) OF	ths on ART (aligned with VL) hly: if CD4 ≤ 200 OR VL ≥ 1000 of linical indication arises (i.e. new a client missed a scheduled vis		
SWITCHING EXISTING CLIENTS TO DTG-CONTAINING REGIMENS											luding E section (AC. Repeat V on CD4 moni	Lafter 3 months. toring	INTER ART-as	PRETATIOI ssociated in	N: Stop cotrimoxazole once mmune reconstitution has occu		
					DECIME		:c			RESPONS	е то <u>Ri</u>	<u>EPEAT </u> VL O	N DTG REGIMEN	• HIV-p	positive inf	fants < 12 months: should remain the should rema		
		CUDDEN			REGIIVIE			2.		• VL < 50: (Continu	e yearly mon	itoring	(If pr	evious PJP,	, stop at 5 years old if meets ≥ 5		
A much DV (/n on (T) (SWIICH IC	J:	_	• VL ≥ 50: F urge	Re-asses ently an	ss and resolve	e adherence issues	categ	gory)	ild > F wearen if CD4 count > 200		
		r regimen ic	or < 2 years			Α	BC + 3TC + E	DTG						• niv-p	bositive ch	iid 2 5 years: II CD4 count 2 20		
ABC + 31					е	If child is ≥ 30 kg GFR > 80 mL/min.	and ≥ 10 years: s No additional VL	witch client to TLD i needed before swit	tch.	DECDON	ICE T							
AZI + 31	C + (EFV)	or NVP)				Refer	to Adult ART 202	3 poster		RESPON		U <u>REPEA</u>	First line DTG regim	en [#] : Ren	eat VL afte	r 6 months If adherence > 80.9		
Clier	nts on PI-	based regim swit	VL-DEPEN ens > two years ch to DTG is bas	IDENT RE s, who have sed on thei	GIMEN S e never use r VL within	WITCHES d a DTG-cont the last 12 m	aining regim	en in the past:					remains ≥ 1000, disc first line DTG regime	cuss with en or dru	an expert g interaction	(consider RT if: incorrect classif ons)		
VL (c/i	mL)										DTG regimen Second ^{##} or third lin					Repeat VL after 3 months		
(within th	ne last	REGIMEN	CRITERIA FO	OR SWITC	H AND/O	R REGIMEN	IF CHANG	E IS INDICAT	ED		< 2 yea	ars	Discuss RT with TLA	s RT with TLART committee if: Second ^{##} or third line ^{###} [
12 mon	ths)		Switch to DTC of	ontoining ro	aiman			10					9 months AND 3 or 1 either a $CD4 < 200$ or	more cor or an OI)	nsecutive V AND docu	$Ls \ge 1000$ (or at least 1 VL ≥ 100) mented adherence > 80% on 2		
		LPV/r or	If VL in last 12 r	monthing remonths ≥ 50) but	ŀ	ABC + 31C + D	16					plus motivation from					
VL < 10	000 ⁷	regimen ≥ 2 years	< 1000: switch assessment an nee	h, but do AB nd provide E eded	CDE ACif Ifc ife	Repe nild is ≥ 30 kg a GFR > 80 mL/m	eat VL after 3 n and ≥ 10 years: ain. Refer to Ac	nonths switch client to dult ART 2023 po	TLD oster	Response			Adherence < 80 % or persistent low-level viraemia (2 or more	•	•Intensify	/ adherence (ABCDE)		
Two or r consecu	nore Itive	Adherence	Switch to AB Repeat VL af	C[*] + 3TC + D fter 3 month	TG If c	f repeat VL < 10 nild is ≥ 30 kg a GFR > 80 mL/m	000: continue ind ≥ 10 years: iin. Refer to Ac	ABC [*] + 3TC + D1 switch client to dult ART 2023 po	r G TLD oster	VL after previous		·	consecutive VLs betv and 999)	ween 50	First line [DTG regimen [#]		
VLs ≥ 1 taken ≥ 2	000 years rting	< 80 %	If child is unwel ex	ll, discuss wi pert	th an If	repeat VL ≥ 100 hot	00: Discuss wit tline (0800 212	h HIV expert or 2 506)	the	VL 2 50	DTG re	gimen	Adherence > 80 %, a	herence > 80 %, and with or more VLs ≥ 1000 taken 2 years after starting a G-based regimen OR at 1st one VL ≥ 1000 and her CD4 < 200 or an portunistic infection		/ adherence (ABCDE) /L after 6 months		
LPV/r or regim	ATV/r en	Adherence > 80 %	Discuss with resistance te	n HIV expert est. Provide i repeat V	or the hotlir ndividualise Lafter 3 mo	e (0800 212 50 d regimen as re hths to confirm	06) to authoris ecommended b re-suppressio	e and interpret a by HIV expert an on	a 1d		≥ 2 yea	nrs	2 or more VLs ≥ 1000 ≥ 2 years after starti DTG-based regimen			ter discussion with TLART only was incorrectly d as first line DTG regimen (incl		
Only 1 VL after 2 ye a LPV/r or	> 1000 ars on ATV/r	Do ABCDE a	ssessment, EAC if	f applicable, one	repeat VL af of the above	ter 3 months. T categories	This result will	group the client	t in				either CD4 < 200 or a opportunistic infecti			and perinatally infected adolescer • Relevant drug interactions Second line DTG regimen ^{##}		Illy infected adolescents); or t drug interactions ne DTG regimen ##
regime	en						~								 Request Do VL 3 	months after new regimen imp		
		6 industri	CLIENTS CUI	RRENILY		+ 31C + DIC			1:6	[#] First line DT	G regime	ns (TLD1, ALD1)	: client who was ART-naïv	ve when DT	G was initiat	ed <u>OR</u> client who had a VL < 50 within		
VL < 5	50	Switch to TL	D (if no renal dys	function, ≥ 1 for TDF	lu years of a switch to AB	ge and weight a C + 3TC + DTG	≥ 30 kg). If clie	nt does not qua	lify	most probabl	le cause fo	a first line ART I or non-suppress	regimen to DTG. Resistand ion. Most clients will re-su	ce to a first uppress on imon to DT	a first line DTG reg	Imen is rare. Suboptimal adherence re IG regimen if adherent; #"Second line i (I > 50, OB client who was switched fr		
VL≥5	50	A	Assess for RT. See	e section on r	response to	/L while on DT	G-containing r	egimen		line PI regime	n to DTG	when the VL < S	50, <u>OR</u> client who was swi	itched from	a PI regimer	to DTG when the VL \geq 50 without res		
*If client has	ABC hyper	sensitivity: AZT +	+ 3TC + DTG; [¥] Resista	ance testing mi	ght be indicate	d if there is evide	nce of clinical an	d/or immunologica	al fail-	resistance mu	itations to	o a PI in a previo	ous second line regimen;	Resistance	e testing migh	it be indicated if there is evidence of c		
ure with goo	a adherenc	HOV	V TO MEAS		HERENO	E OBJECT	IVELY			DO THE		OWING T				E DRUG THAT MAY CAI		
For adhere	ence to be	e > 80 %, patie	ent must meet on	ne of the foll	owing criter	a:							ADV	ERSE E	VENT			
• Pha • Att	armacy re endance o	fills > 80 % in ' of > 80 % of sc	the last 6 - 12 mo cheduled clinic vis	onths sits in the las	st 6 - 12 mor	ths				DRU	IG	TEST	FREQ	UENCY	,	ACTION/INTERPRET		
To calculate adherence percentage in the past 6 - 12 months:										AZT		FBC +	At months 1 and	3,		Hb ≥ 8 g/dL: Continue AZT		
Amount of scheduled visits actually attended by client/caregiver Amount of scheduled visits												differentia WCC	l thereafter if clin indicated	ically		Hb < 8 g/dL or neutrophil cou persistently < 1000 cells/µL: U alternative – consult with exp		
Children t	aking ART :	CHIL and TB treatme	DREN CO-II	NFECTEI	D WITH	TUBERCU	LOSIS ^Φ	erence support		PI-based regimen (LPV/r, AT	V/r,	Cholestero Triglycerid (TG)	l + At month 3, if at range, do fasting TG	ove acce g cholest	eptable erol and	To monitor PI-related metabolic side-effects. If fasting cholest are still above the acceptable		
Remembe	r to add py	ridoxine (vitan	nin B6) if client is ta	aking isoniazio	d or terizidon	2				DRV/r)	ant or		If signs /symptom	ns of hor	atitic	obtain expert advice		
DTG-base	d	AND receiving	a rifampicin-conta	aining TB regi	men: Boostin	g of DTG require	d while on rifan	npicin-containing	All					phone the HIV hotline (0800				
EFV-based	d regimen	No dose adius	tments or changes	in ART regim	en needed fo	r DS-TB treatme	nt		NVP ALT If rash develops If ALT is abnor					If ALT is abnormal, refer to sp				
LPV/r-bas	ed	AND receiving increased acco	a rifampicin -conta ording to the ART D	aining TB regi Drug Dosing C	men: Addition	nal ritonavir sho en 2022. TB trea	uld be added or atment should b	the LPV/r dose be dosed at stand	ard	3TC = lamivudin AZT = zidovudin	e; ABC = ab e: CM = cry	pacavir; ALT = Alani	ine transaminase; ART = antire	troviral therapy	apy; AST = Aspar	rtate transaminase; ATV/r = atazanavir and ri		
[©] This list is n	ot exhaustiv	doses. Stop ac	a free SA HIV/TB Hot	or increased L	rv/r dose 2 w	eeks atter TB-tro	eatment comple	eted		DTG = dolutegra essential medici	nes list; FB	= darunavir and rit C = full blood coun	onavir; EAC = enhanced adher t; FTC = emtricitabine; HBV = h	ence counsel epatitis B vir	lling; EFV = efav us; HBsAg = her	irenz; eGFR = estimated glomerular filtration patitis B surface antigen; IMCI = Integrated ma		



NEED HELP?

Contact the TOLL-FREE National HIV & TB Health Care Worker Hotline



0800 212 506 / 021 - 406 6782 Alternatively "WhatsApp" or send an SMS or "Please Call Me" to 071 840 1572 www.mic.uct.ac.za

-sensitive; rate; **EML =** nagement of childhood illness; InSTI = Integrase strand transfer inhibitor; LPV/r = lopinavir and ritonavir; LP = lumbar puncture; MUAC = mid-upper arm circumference; NCD = non-communicable disease; NRTI = nucleoside reverse transcriptase inhibitor; NNRTI = non-nucleoside reverse transcriptase inhibitor; NVP = nevirapine; Paed = paediatric; PI = protease inhibitor; OI = opportunistic infection; PJP = *Pneumocystis jirovecii* pneumonia; RPC = repeat prescription collection; RT = resistance test; TB = Tuberculosis; TBM = Tuberculosis meningitis; TB-NAAT = TB nucleic acid amplification test; TC = total cholesterol; TDF = tenofovir; TLAT = third-line an-tiretroviral therapy; TLD = tenofovir + lamivudine + dolutegravir; TEE = tenofovir + emtricitabine + efavirenz; TG = Triglycerides; TPT = TB preventive therapy; VL =
 MEDICINES
 Based on the 2023 ART Clinical Guidelines for the Management of HIV in Adults, Pregnancy,

 INFORMATION
 Adolescents, Children, Infants and Neonates, South African National Department of Health, June 2023, version 4 and the Western Cape Government Circulars H108/2023; H108/2024, H145/2024, 2024

 Department
 Pregnancy
 viral load; WCC = white cell count