

**Table 2.1: HTS Recommendations for Different Populations and Settings**

Population	Recommendation
Birth testing of infants born to known HIV-positive mothers (Figure 2.2)	<ul style="list-style-type: none"> <li>• Birth testing (HIV testing of infants at birth or at first contact within 2 weeks after birth) can be conducted where feasible and in settings where return of results is feasible within 24 hours and ART can be initiated immediately*). Infants tested at birth must be tested at the 6 weeks immunization visit regardless of the results of the initial test at birth.</li> <li>• Infants with an initial positive HIV DNA PCR result should be presumed to be HIV infected and started on ART in line with national guidelines, with a new sample for confirmatory HIV DNA PCR and baseline viral load taken at the time of ART initiation (<b>ART initiation is based on the initial HIV DNA PCR result</b>)</li> </ul>
Infants and children aged less than 18 months (Figure 2.1)	<ul style="list-style-type: none"> <li>• HIV exposure status of all infants should be established at first contact.</li> <li>• To establish HIV exposure status of a child less than 18 months of age, conduct HIV antibody testing for mothers with unknown status or who previously tested negative during antenatal care at the 6-week immunization visit or first contact. If the mother declines to be tested or is not available for testing, then conduct a rapid HIV antibody test for the child to determine exposure (if antibody test is positive this confirms HIV exposure)</li> <li>• When HIV exposure is confirmed, ARV prophylaxis should be started immediately.</li> <li>• All HEIs should have DNA PCR testing at the 6-week immunization visit or first contact thereafter.</li> <li>• Infants with an initial positive HIV DNA PCR result should be presumed to be HIV infected and started on ART in line with national guidelines, with a new sample for confirmatory HIV DNA PCR and baseline viral load taken at the time of ART initiation (<b>ART initiation is based on the initial HIV DNA PCR result</b>)</li> <li>• All HEI with initial HIV negative results should continue infant ARV prophylaxis and be followed as HEIs, including additional PCR testing at 6 months and 12 months, and antibody testing at 18 months and every 6 months during breastfeeding, and at 6 weeks after complete cessation of breastfeeding</li> </ul>
Children older than 18 months till age 9 years (Figure 2.3)	<ul style="list-style-type: none"> <li>• Conduct HIV testing and counselling for all children of adults living with HIV as soon as possible after confirming the HIV positive status of the adult. Within health facilities, testing should be conducted at in-patient wards, nutrition clinics, and all high HIV burden settings.</li> </ul>

Pregnant and breastfeeding women	<ul style="list-style-type: none"> <li>● During the first ANC visit, HIV testing of pregnant women should be done using a dual test for HIV and syphilis, unless the woman is known to be living with HIV.</li> <li>● Women who test negative for both HIV and Syphilis should be offered a repeat HIV-Syphilis dual test in the third trimester.</li> <li>● Prevention services should be offered to all pregnant and breastfeeding women who test HIV negative. They should be screened for eligibility and willingness for PrEP.</li> <li>● At labor and delivery, HIV testing should be done for all women with unknown HIV status and those who previously tested negative (even if tested negative in the third trimester).</li> <li>● All breastfeeding mothers (unless known HIV positive) should be counselled and tested at the 6-week infant immunization visit. The HIV test (if negative) should be repeated every 6 months until complete cessation of breastfeeding.</li> <li>● For mothers considered to be at high risk of HIV infection, retesting postnatally should be done every 3 months; these include mothers categorized as key population; in a HIV discordant relationship, or having ongoing sexual or injecting behavior that places her at risk, including new or multiple sexual partners.</li> <li>● Mothers should be counselled on the schedule for repeat HIV testing in pregnancy and postnatal as part of routine ANC and postnatal education.</li> <li>● All pregnant and breastfeeding women who are not tested, opt-out or decline HIV testing during the first contact should be offered HIV counselling and testing in subsequent visits with appropriate referral and linkage for prevention, care, and support services.</li> <li>● All HIV positive pregnant and breastfeeding women enrolled into care should receive counselling and support (assisted disclosure), case management and follow-up. It should also include linkage to general care for ANC, delivery and post-natal care</li> <li>● All spouses/partners as well as children of pregnant and breastfeeding women testing HIV positive should be offered HIV testing and counselling.</li> </ul>
Sexual partners & children of index clients (HIV positive person who is newly diagnosed or already in HIV care)	<ul style="list-style-type: none"> <li>● All PLHIV enrolled into HIV care should receive disclosure counselling and be supported to disclose their HIV status (assisted disclosure)</li> <li>● HIV testing and counselling (facility-based or community-based) should be encouraged for all partners including sexual partners, needle sharing partners, and children of index clients, with appropriate linkage to treatment and prevention services.</li> </ul>

**Table 2.2: Summary of HIV Testing Services Package**

<p><b>Pre- Test Counselling</b></p> <p>Pre-test counselling may be provided to an individual or a couple presenting for HTS. Group information can also be offered during pre-test.</p> <p>The objectives of the pre-test counselling session are to:</p> <ul style="list-style-type: none"><li>– Provide information on the benefits of knowing one's HIV status, including outcomes for people on ART and undetectable = Untransmittable (U=U).</li><li>– Provide an explanation for the HIV testing process including time the session will take, confidentiality, and interpretation of test results</li><li>– Obtain informed consent for HIV testing.</li><li>– Explore the client's risk of HIV infection.</li><li>– Discuss the importance of disclosure to partners and other family members.</li><li>– Explain the benefits of couple testing and partner services/index testing.</li></ul> <p>Provide information on available post-test services, including referrals for prevention or HIV care services</p>
<p><b>Perform test.</b></p> <p>The goal of HIV testing is to:</p> <ul style="list-style-type: none"><li>• Provide accurate HIV diagnosis as per the nationally approved testing algorithm</li><li>• Provide same day HIV test results</li></ul> <p>During the 15 minutes as you wait for the test results:</p> <ul style="list-style-type: none"><li>– Discuss Combination Prevention e.g., PrEP, PEP, Risk Reduction, STI treatment, condom information and demonstration, VMMC, Elimination of Mother to Child Transmission of HIV (eMTCT)</li><li>– Screen, provide information and referrals for; Intimate Partner Violence (IPV), STI and cancer screening, Tuberculosis (TB), Family planning/contraceptive needs, etc.</li><li>– Establishing number of sexual contacts and biological children for the purpose of index testing.</li><li>– Document in the HTS, Lab, referral and linkage register (MOH 362).</li></ul> <p><i>Discuss further on index testing and HIVST as you perform the second and the third test, as per the national algorithm, for the clients who test positive with the screening test</i></p>
<p><b>Post-test counselling</b></p> <ul style="list-style-type: none"><li>– Check if the client is ready for results and help them to interpret.</li><li>– Check what the client understands by the results.</li><li>– Allow the client to share his/her initial reactions and verbalize their initial feelings.</li><li>– Explore and acknowledge client's immediate feelings and concerns.</li></ul>
<p><b>Offer necessary support</b></p>

**Table 2.2 Cont.**

<p><b>NEGATIVE RESULT</b></p> <ul style="list-style-type: none"> <li>– Explain test results.</li> <li>– Review implications of being HIV negative.</li> <li>– Support clients to develop a risk reduction plan (see HTS operational manual)</li> <li>– Provide information on methods to prevent HIV acquisition.</li> <li>– Provide male and/or female condoms, lubricant, and guidance on their use.</li> <li>– Emphasize on importance of knowing the status of sexual partners and information about the availability of partner and couples testing services.</li> <li>– Referral and linkage to relevant HIV prevention services</li> </ul> <p>Explain the need for repeat testing for people who test negative but report risky behavior within the prior 4 weeks (i.e., unprotected sex with a partner of unknown status or Known HIV positive status); if they test HIV negative again after 4 weeks and are at ongoing risk of HIV acquisition, they should be advised to return for testing every 3 months</p>	<p><b>POSITIVE RESULT</b></p> <ul style="list-style-type: none"> <li>– Review implications of being HIV positive.</li> <li>– Help the index client to cope with emotions arising from the diagnosis.</li> <li>– Discuss immediate concerns and help for the client to decide who in his or her social network may be available to provide immediate support.</li> <li>– Discuss positive living.</li> <li>– Provide clear information on ART and its benefits for maintaining health and reducing the risk of HIV transmission, as well as where and how to access ART</li> <li>– Refer clients who turn HIV positive to CCC for linkage to treatment.</li> <li>– Revisit index testing and HIVST to determine partner notification plan/approach (refer to HTS operational manual and APNS operational Manual).</li> <li>– Discussion of the risks and benefits of disclosure to partners; couples counselling should be offered to support mutual disclosure.</li> </ul> <p>Encourage and offer HIV testing for sexual partners, injecting partners, biological children, and other family members, which can be done through couples testing, family testing and/or assisted partner notification service.</p>
<p><b>Assessment of other health related conditions</b></p> <p>Assess risk for sexually transmitted infections (STIs) and opportunistic infections that would also require management</p>	
<p><b>Referral and linkage to care</b></p> <p>Obtain accurate locator information from the index client (physical location, phone number)</p> <p>Physically escort the client for re-testing and linkage to ART</p> <p>Document the outcomes of partner follow up(s)</p>	
<p><b>Post-Test Counseling in the Era of Test-and-Treat</b></p> <p>Post-test counselling should, at a minimum, include three key messages that being the ART treatment preparation process for all PLHIV:</p> <ul style="list-style-type: none"> <li>– Treatment (called antiretroviral therapy or ART) is available and is recommended for everyone with HIV.</li> <li>– Starting treatment as soon as possible (preferably within two weeks from testing positive for HIV) reduces the chance of your illness getting worse or of passing HIV to others. If you take your ART properly and do not miss pills you can expect to live a long and productive life</li> </ul>	

## **Early Infant Diagnosis**

### **Confirmation of HIV infection in HIV Exposed Infants and Children < 18 Months Old**

HIV exposure of an infant or child can occur in utero, at labour and delivery and through breast milk. Confirmation of HIV infection should immediately follow.

**All HIV exposed infants (HEI) should be tested with DNA PCR within 6 weeks of age or first contact thereafter; if negative then another DNA PCR at 6 months, and if negative then repeat DNA PCR at 12 months.**

If the HEI develops symptoms suggestive of HIV as per WHO staging criteria, an additional DNA PCR test should be conducted immediately.

An antibody test should be performed for all HEI at 18 months of age and every 6 months thereafter during breastfeeding, and at 6 weeks after complete cessation of breastfeeding (Figure 2.1).

## HIV Testing Services and Linkage to Treatment and Prevention

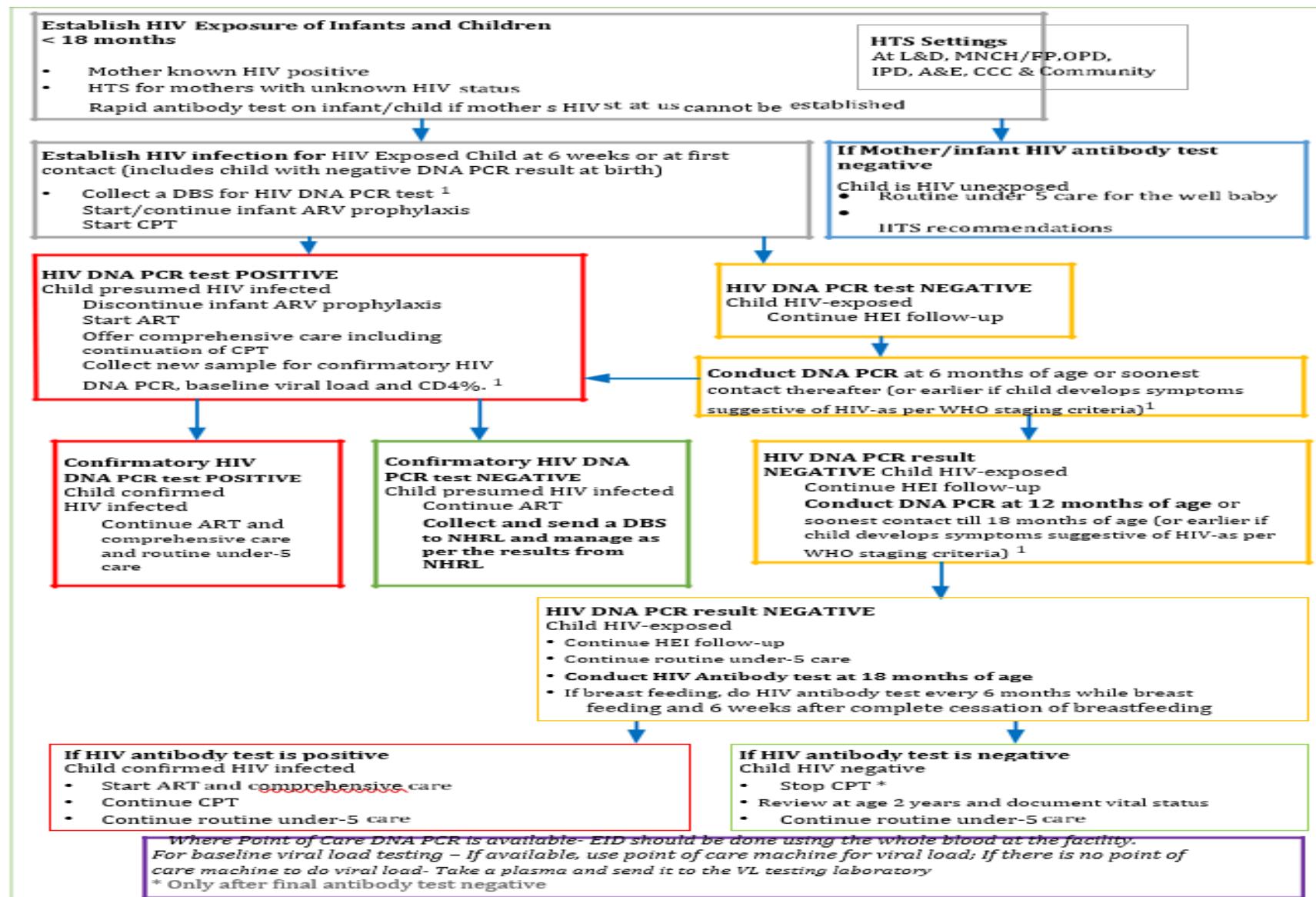


Figure 2.1 Algorithm for Early Infant Diagnosis in Infants and Children < 18 months of age

## **Presumptive Diagnosis of Severe HIV Disease in Children under 18 Months**

Occasionally, children less than 18 months of age present to hospital with severe illness; and a rapid HIV antibody test confirms HIV exposure. Lack of immediate availability of HIV DNA PCR results for confirmation of HIV could result in undue delay in starting life-saving ART. In such children, a presumptive diagnosis of HIV infection can be made using the criteria in Table 2.3. ART can be initiated while awaiting HIV DNA PCR results to confirm HIV infection.

**Table 2.3: Presumptive Diagnosis of HIV in children <18 months while awaiting DNA PCR Results**

HIV antibody test positive AND symptomatic  
with; 2 or more of the following:

- Oral candidiasis/thrush
- Severe pneumonia
- Severe sepsis

OR any of the following:

- Any WHO Clinical Stage 4 condition
- Recent maternal death (if likely to have been HIV-related) or advanced HIV disease in mother
- Child's CD4% < 25%

### **2.4.1.2 Birth Testing**

Birth testing is defined as HIV testing (with DNA PCR) at birth or around birth for infants born to HIV-positive mothers. Birth testing has the potential to improve survival for infants who are infected during pregnancy, around labour and delivery by identifying them early for rapid ART initiation. Do not use cord blood for birth testing as this could result in false positive results.

**A DNA PCR test can be offered at birth or around birth where feasible.**

**ALL children initially tested at birth should be retested at 6 weeks of age and the EID algorithm followed (Figure 2.2.)**

#### **Considerations for providing birth testing:**

Birth testing may be prioritized for newborns who are at high risk of HIV acquisition including those born to:

Mother who seroconvert during pregnancy.

Mother who have unsuppressed or unknown viral loads during delivery.

Mother who received a HIV positive diagnosis for the first time at or after 28 weeks gestation or during labour and delivery

Mother on ART for less than 12 weeks prior to delivery

DNA PCR results can be returned the same day e.g., where on site point of care is available.

ART regimens recommended for neonates as per national guidelines are available and can be initiated immediately.

Follow-up of the newborn is done to ensure no lost to follow-up.



## HIV Testing Services and Linkage to Treatment and Prevention

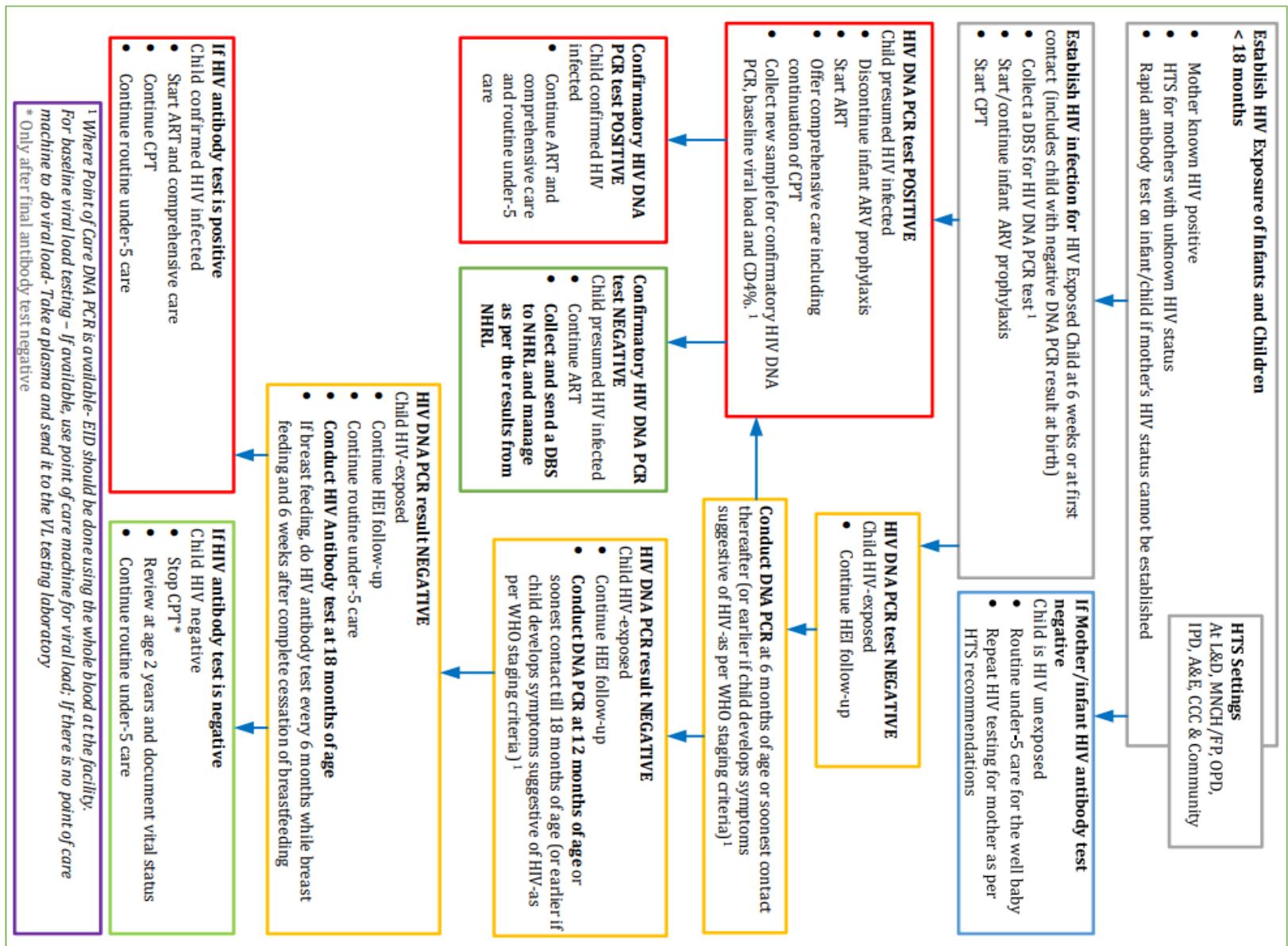
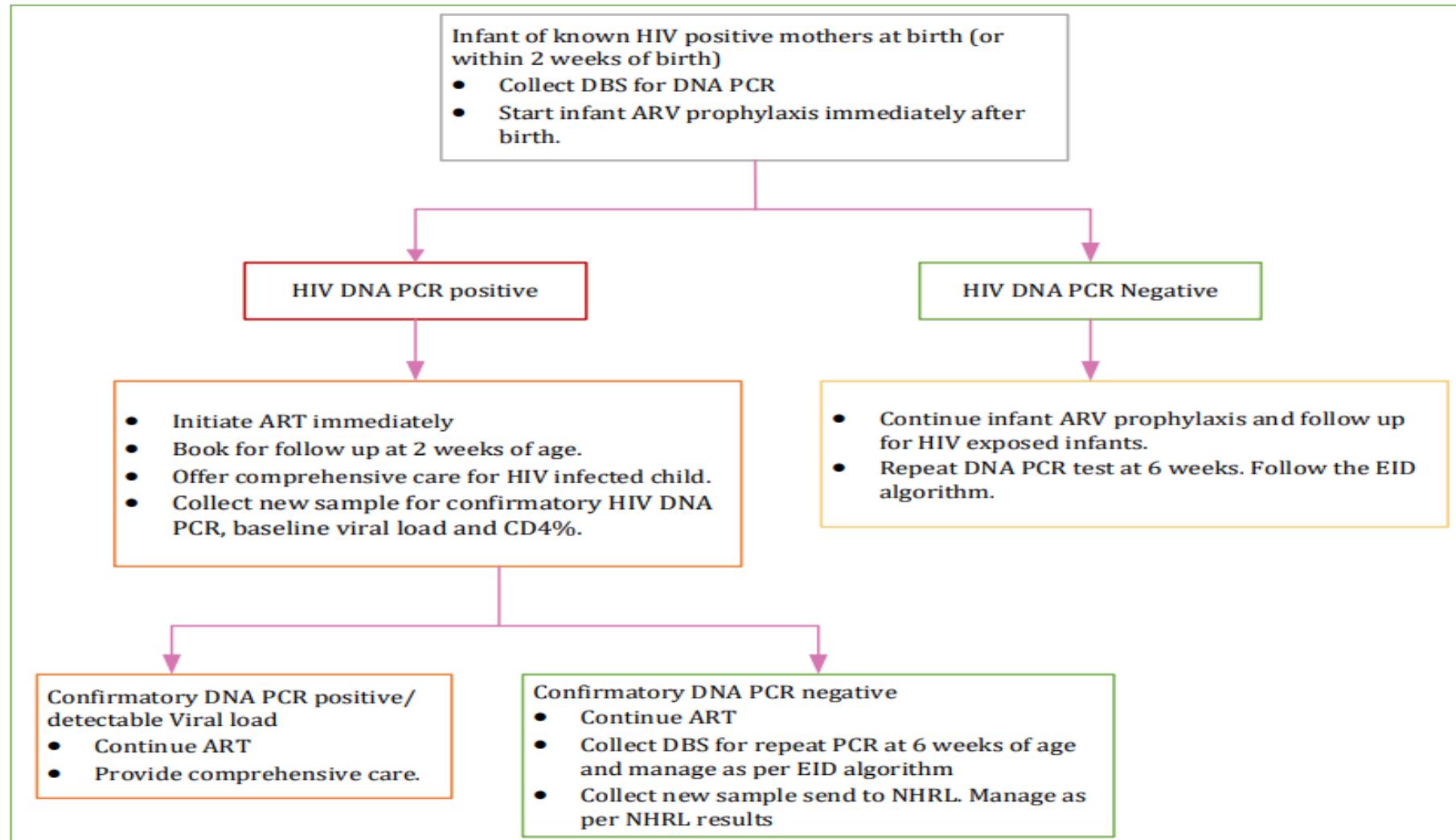


Figure 2.1 Algorithm for Early Infant Diagnosis in Infants and Children < 18 months of age

## HIV Testing Services and Linkage to Treatment and Prevention



### **2.4.1.3 Use of Point of Care testing for Children**

Point-of-care testing occurs at the health facility where care is being provided, with results being returned to the patient or caregiver on the same day as sample collection. Point of care DNA PCR testing for early infant diagnosis of HIV can reduce the turnaround time for testing and return of results and allow immediate initiation of ART among infants. Point of care DNA PCR testing can be used to diagnose HIV infection as well as to confirm positive results.

## **2.4.2 Diagnosis of HIV Infection in the Older Child ( $\geq$ 18 months), Adolescents and Adults**

Serial testing, using approved rapid HIV antibody testing kits, is used to diagnose HIV infection in children older than 18 months, adolescents, and adults, and (refer to Figure 2.3)

An HIV-positive diagnosis will be made **using three consecutive reactive assays**. This three-test strategy as well as retesting aims to ensure that at least a 99% Positive Predictive Value (PPV) is maintained, and false positive misdiagnosis is avoided.

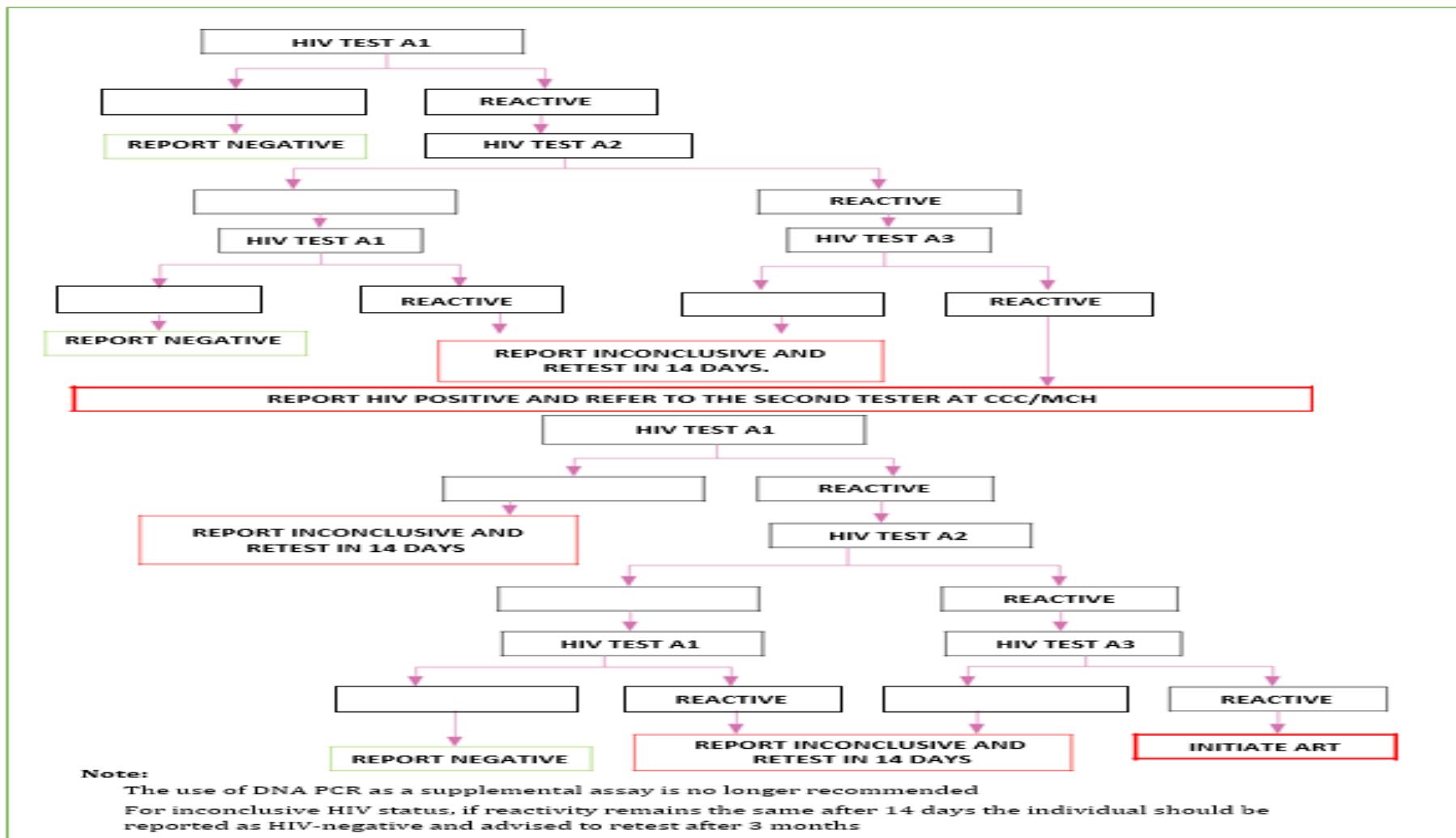
Offer adequate information to all clients and obtain consent prior to the HIV test (verbal consent is adequate but should be documented by the health care worker in client records). For children below the age of 14 year who are not emancipated minors, a written consent from the guardian is recommended.

Individuals 15 years and older and emancipated minors can provide self-consent.

Clients who test positive should be linked to care and treatment. Counselling support, index and family testing should be offered to these clients.

Clients who test negative should be counselled on HIV risk reduction behaviors and linked to combination HIV prevention services (such as VMMC, RH/FP, condoms, PrEP, etc.) depending on individual risk profile. Table 2.5 provides recommendations for re-testing those who test HIV negative.

## **HIV Testing Services and Linkage to Treatment and Prevention**



**Figure 2.3: HIV Testing Services Algorithm**

## 2.4.3 HIV testing for Pregnant Women

For pregnant women, the HIV/syphilis dual test should be used as the A1 test (Figure 2.4). The dual test kit is recommended for:

Pregnant women during their first ANC, unless the woman is known to be living with HIV.

For those who test negative for both HIV and Syphilis repeat testing should be conducted in the third trimester using the HIV and syphilis dual test.

Partners accompanying pregnant women for the first-time during ANC

HIV/Syphilis dual test should not be used for retesting women on ART or with known positive HIV status, or women diagnosed with syphilis during pregnancy.

See Figure 2.4 for the full algorithm when considering HIV and syphilis (TP) results concurrently.

## HIV Testing Services and Linkage to Treatment and Prevention

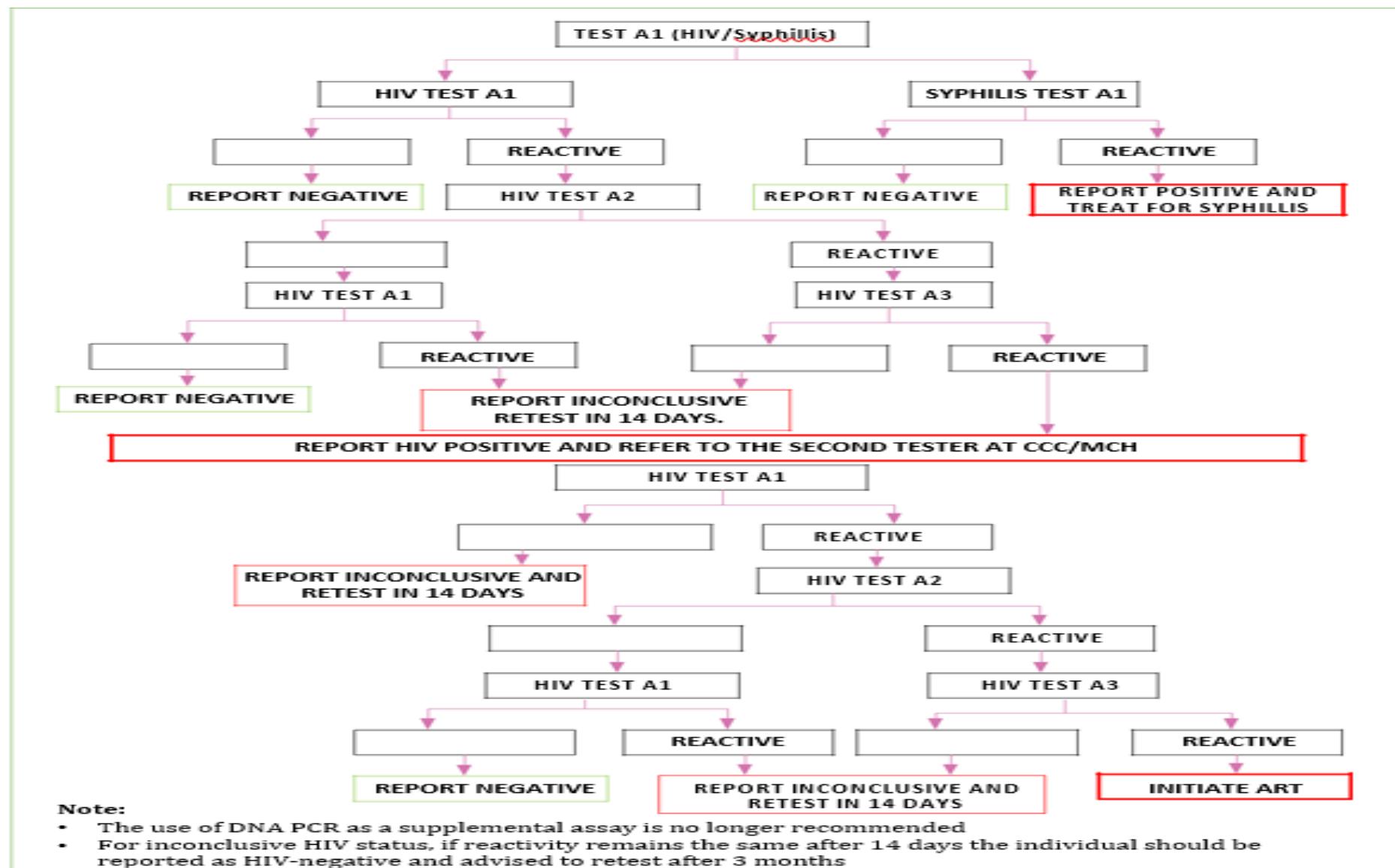


Figure 2.4 Dual HIV/syphilis Testing Algorithm

RESULTS	INTERPRETATION
A1 HIV-, Syphilis Test (TP) -	HIV negative, syphilis negative
A1 HIV-, Syphilis Test (TP)+	HIV negative, syphilis positive
A1 HIV+, Syphilis Test (TP)-	Syphilis negative and proceed with A2 for HIV
A1 HIV+, Syphilis Test (TP)+	Syphilis positive and proceed with A2 for HIV
A1 (HIV+); A2+; A3+	HIV-positive
A1(HIV+); A2-; Repeat A1+	HIV-inconclusive (retest after 14 days). If reactivity remains the same after 14 days, the individual should be reported as HIV-negative
A1(HIV+); A2-; Repeat A1-	HIV-negative
A1(HIV+); A2+; A3-	HIV- inconclusive (retest after 14 days). If reactivity remains the same after 14 days, the individual should be reported as HIV-negative

**Table 2.5: Recommendations for Retesting HIV Negative Clients**

Scenario/population	Recommendation for retesting
<b>General population</b>	All general population to be screened every 2 years using the approved NASCOP HTS screening tool and those eligible get tested
<b>Key populations (FSW, MsM, TG, PWID)</b>	Re-test every 3 months
<b>Negative partner in discordant</b>	<p>Retest HIV negative partner at the initiation of ART for the HIV positive partner, at 6months and 12 months once viral suppression is achieved.</p> <p>Retest annually if the positive partner remains virally suppressed.</p>
<b>Pregnant women</b>	Test in first trimester or first contact; Re-test in the third trimester and, during labour and delivery.
<b>Breastfeeding mothers</b>	<p>Re-test 6 weeks after delivery, at 6 months then every 6 months until complete cessation of breast feeding.</p> <p>For mothers considered to be at high risk of HIV infection, retesting postnatally should be done every 3 months</p>
<b>Persons who had a most recent (e.g., less than one month) high risk exposure to HIV</b>	Test at initial presentation and re-test at 4 weeks, after which National testing guidelines apply
<b>STI symptomatic patients or patients with symptoms suggestive of acute HIV</b>	Test at initial presentation and re-test at 4 weeks, after which national testing guidelines apply
<b>Individuals on Pre-exposure prophylaxis (PrEP)</b>	Test at initiation of PrEP; Retest at month one, and then every 3 months

**2.7 Approach to Patients on ART with a Discrepant HIV Test Result:** HIV testing should not be performed to patients who are already enrolled into HIV care and on ART. However, some patients self-refer for HIV antibody testing without disclosing that they are known HIV positive and on ART. Figure 2.5 provides recommendations on managing patients who have a non-reactive antibody test while on ART.

**Education/counselling for patients who are on ART and present with a new negative HIV antibody test**

- The new HIV antibody test may be a false negative, the patient may still be HIV-infected but their antibody levels may be suppressed as a result of effective ART. This is more common for patients who start ART very soon after HIV infection

Those with prior history of detectable viral loads, positive DNA PCR results, or low CD4 counts are almost always truly HIV positive

Continue their ART until a special test is performed (a new sample for DNA PCR) at the National HIV Reference Laboratory (NHRL)

Stopping ART before HIV status is confirmed could result in a rapid rise in viral load, decline in CD4, and increased risk of developing an opportunistic infection or dying

**Draw a sample for DNA PCR and send to the NHRL** (preferably a whole blood EDTA sample following cold-chain protocols within 24 hours of collection; DBS is acceptable if EDTA is not possible)

**Specify that this is a sample for confirming HIV status** of a patient who is on ART, and provide the dates and results for all prior antibody tests, DNA PCR tests, and RNA viral load tests in the request form

**If HIV DNA PCR sample is positive**

This confirms the patient is HIV positive

Provide additional counseling on the reasons why the antibody test may have been falsely negative and discourage the patient from any repeat antibody testing

Emphasize that the patient's ART is working and the need for continued excellent adherence

**If HIV DNA PCR sample is negative**

The patient may be HIV negative, or it could be that the patient is HIV positive but the HIV DNA levels have been suppressed below the testing limit (this is more common if a DBS sample was used)

Inform the patient that they may still be HIV positive and need to be monitored closely for an additional 6 months before confirming they are HIV negative

Inform the patient that ART should be stopped immediately

They should return for HIV viral load performed at 1 month, 3 months, and 6 months after stopping ART (samples for HIV viral load should be sent to the designated VL/EID network laboratory assigned to the requesting facility with all past details)

**Figure 2.5: Managing Patients on ART Who Present with a New Negative HIV Antibody Test**

## **Differentiated Care for Children, Adolescents and Pregnant/ breastfeeding Women**

Children, adolescents, pregnant and breastfeeding women, and key populations face unique challenges in retention and viral suppression and hence may benefit more from differentiated service delivery models adapted to their needs.

**Children:** Children's care is dependent on family and care giver dynamics. Family centered approaches to care where clinic visits for parents/caregivers and the child are synchronized, should be used. Assessment and categorization to determine establishment on ART should be conducted for pairs and follow-up tailored to their situations. Weight-based dose adjustments should be incorporated in both the facility and community models (e.g., by using portable weighing scales if out of the health facility) to determine optimal doses for ARVs at each review. Aligning appointments with school calendar should be considered to avert disruption of treatment and learning of the child.

**Adolescents:** Adolescents require psychosocial support, ongoing adherence assessments and counselling which should be aligned with clinic visits, community follow-up as well as school calendar. Considerations should be factored in during the clinical encounters with more focus to those with adherence and viral suppression challenges. Adolescents and Youth Friendly services that incorporate life skills and extracurricular activities should be integrated where feasible.

**Pregnant/breastfeeding women:** Pregnant and breastfeeding women who have been established on ART should have their HIV clinic appointments synchronized with Antenatal Care visits and with follow-up of the HIV-exposed infant. Those initiated on ART during pregnancy may need close follow up to support them in adherence, retention and achieving viral suppression. Breast feeding women and their babies will have their clinical visit aligned with the immunization clinics schedule. Psychosocial support groups are encouraged for both pregnant and breastfeeding mothers including peer to peer support.

## **Standard Package of Care for HIV-Exposed and HIV-Infected Infants**

Determine HIV status at first contact through HTS/EID and link to HIV care

Provide ARV prophylaxis for all HEIs and ART for all HIV-infected children (**confirming correct weight-based dosing of ARVs at every visit**); perform clinical and laboratory assessment

Provide nutritional assessment, counselling and support (NACS, Section 4.7) and monitor growth and development of the child (Annex 3)

Ensure that all immunizations are provided following the national schedule (Section 4.8.1)

Clinical assessment at every visit, treat infections early, identify, manage and report adverse drug reactions aggressively and refer appropriately where specialized care is required.

Screen for opportunistic infections and provide prophylaxis (cotrimoxazole, TB Preventive Therapy (TPT), deworm every 6 months (starting at 1 year of age) and provide supplemental Vitamin A every 6 months (starting at age 6 months)

Educate the caregiver on all aspects of care for the child including infant feeding, immunizations, personal hygiene, HIV education/counselling, adherence, availability of support for child disclosure, and follow-up requirements

Adherence assessment, counselling and support

Provide age-appropriate psychosocial support for the family and child and refer to community-based support programs as appropriate

Ensure that the caregiver and family members are receiving appropriate care, support and treatment

Provide intensive case management for mother/infant pair until 2 years postpartum; identify defaulters and prioritize this population for tracking

Enroll in Orphans and Vulnerable Children (OVC) program for social protection and other services.

#### **4.2.1 Screening for Gender-Based Violence (GBV)/Intimate-Partner Violence (IPV)**

National data (KDHS 2014) shows that 45% of women and 44 % of men aged 15-49 years have experienced physical violence since age 15.; 14% of women and 6% of men age 15-49 report having experienced sexual violence at least once in their lifetime. To identify these survivors screening is recommended. WHO recommends that facilities should meet the minimum requirement before starting to routinely screening clients.

The minimum requirements are:

- A protocol or Standard Operating Procedure exists for providing post-GBV and Violence Against Children services
- A questionnaire, with standard questions where providers can document responses.
- Providers offer first-line support (LIVES)
- Providers have received training on how to ask about GBV and Violence Against Children
- Private setting, confidentiality ensured
- A system for referrals or linkages to other services within the facility is in place

If any of these minimum requirements is missing, GBV and Violence Against Children services are considered inadequate, and providers should ensure to have these systems in place before conducting routine enquiry or universal screening

**All clients accessing HIV care services should be screened for any form of violence including IPV as part of the standard package of care for PLHIV.**

The following script can be used for screening:

"Many people do not realize that violence can lead to various serious health problems. Many people have problems with their husbands, partners or other people in their lives. Sometimes the people who love us can hurt us. Has this ever happened to you?"

Has your partner ever:

- Insulted you or made you feel bad about yourself?
- Belittled or humiliated you in front of other people?
- Did things to scare or intimidate you on purpose
- Threatened to hurt you or someone you care about?
- Slapped you or thrown something at you that could hurt you?
- Kicked, dragged, beat you up?
- Chocked or burned you on purpose?
- Threatened to use or actually used a gun, knife or other weapon against you?
- Physically forced you to have sexual intercourse when you did not want?
- Did you ever have sexual intercourse you did not want because you were afraid of what he might do?
- Forced you to do something sexual that you found degrading or humiliating?

If a survivor answers yes to any of these questions provide them with LIVES and do a mental assessment

**Table 4.2a: Components of screening for GBV/IPV (LIVES)**

Listen	Listen to the client closely, with empathy and without judging
Inquire	Assess and respond to the client's various needs and concerns
Validate	Show the client that you understand and believe them. Assure the client that they are not to blame
Enhance safety	Discuss a plan to protect the client from further harm if violence occurs again
Support	Support the client by helping them to access information, services and social support

Supportive messages that may be helpful include:

“What happened to you is not your fault”

“Many women/men are in the same situation as you”

“You are not to blame.”

“Everybody deserves to feel safe at home if you feel like you are in immediate danger, we can involve the police or local administration “

Men, the elderly, and children suffer different forms of violence and should be assessed if there is any clinical suspicion. Key populations are particularly vulnerable to abuse, including MSM, transgender, and prisoners. For children art and play therapy is used during history taking and psychological assessment.

#### **4.3.1 Cotrimoxazole Preventive Therapy (CPT)**

**CPT is no longer recommended as life-long prophylaxis**, and is only recommended in the following sub populations, unless they have an allergy to sulfur drugs or develop toxicity from CPT:

HIV exposed infants

HIV infected children and adolescents <15 years of age

PLHIV > 15 years of age:

Living in malaria-endemic zones\*

Presenting with WHO stage 3 or 4 event, or meeting the criteria

AHD ○ Suspected treatment failure

All Pregnant and Breast-feeding women

For HIV exposed and infected infants, CPT should start at 6 weeks of age. CPT is effective in AHD, and preventing specific OIs for patients with low CD4 counts (PCP and toxoplasmosis), as well as reducing the risk of common bacterial infections, sepsis, diarrhea illness and malaria.

\*Refer to the National Guidelines for the Diagnosis, Treatment and Prevention of Malaria in Kenya for the current Kenya Malaria endemicity map

**Table 4.3: Co-trimoxazole Preventive therapy**

Sub-Population	Starting/Restarting criteria	Ending criteria
HIV exposed Infants	All infants, starting 4-6 weeks after birth	Child is confirmed HIV-negative
HIV-infected children and adolescents ≤ 15 years old	All children	Attains 15 years of age
PLHIV > 15 years old	Suspected treatment failure WHO Clinical Stage 3 and 4	Clinically stable: ○ On ART for at least 12 months ○ Showing no signs or symptoms of WHO Clinical Stage 2,3 or 4
HIV-positive Pregnant and breastfeeding women	All	Clinically stable: ○ On ART for at least 12 months ○ Showing no signs or symptoms of WHO Clinical Stage 2,3 or 4 ○ Not pregnant or breastfeeding

**Table 4.4: Daily Dose of Cotrimoxazole Preventive Therapy**

Weight (kg)	If using oral suspension (240mg per 5ml)	If using single strength tablet 480 mg (SS)	If using double strength tablet 960 mg (DS)
1 - 4	2.5 ml	¼ SS tab	--
5 - 8	5 ml	½ SS tab	¼ DS tab
9 - 16	10 ml	1 SS tab	½ DS tab
17-30	15 ml	2 SS tabs	1 DS tab
> 30	20 ml	2 SS tabs	1 DS tab
Adult (any weight)		2 SS tabs	1 DS tab

Note: If  $\text{CrCl}$  15-30 ml/min then use 50% of normal recommended dose; if  $\text{CrCl} < 15$  ml/min then CTX should be avoided

**During pregnancy, CPT should be initiated irrespective of the gestational age and should continue throughout pregnancy and breastfeeding. Additional intermittent preventive therapy (sulfadoxine-pyrimethamine (SP)) for malaria is not required for women already on CPT.**

Cotrimoxazole can cause anaemia and neutropenia in some patients, as well as a skin rash.

## **4.4.2 Family Planning and Pre-Conception Counselling**

Pregnancy status should be determined for all women of reproductive age at every visit (based on history of last menstrual period and, if uncertain, irregular, or delayed, then a urine pregnancy test should be performed).

Pregnancy intention should be determined for all women of reproductive age and their partners so that appropriate family planning or pre-conception counselling can be provided.

For patients who do not have an immediate desire to become pregnant, dual contraception (defined as condoms plus another form of effective contraception) should be provided immediately with follow-up appointments scheduled to ensure no interruption in contraception provision. Table 4.8 outlines contraception options for PLHIV based on the ARVs they are using.

**Table 4.9: Pre-Conception Counselling Messages and Services for PLHIV**

Scenario	Key Counselling Messages	Pre-conception Services (in addition to the Standard Package of Care for PLHIV)
All women/couples with intention to conceive	<ul style="list-style-type: none"> <li>● All PLHIV qualify for ART, with initiation preferably within 2 weeks of HIV diagnosis</li> <li>● Deferring pregnancy until confirmed viral suppression reduces risk of vertical transmission to the baby, improves infant outcomes, and reduces risk of cross-transmission to the sexual partner</li> <li>● Unprotected sex should be limited to days when ovulation is expected (based on basal temperature monitoring, fertility calendar based on menstrual cycles, and/or fertility calendar app)</li> <li>● Routine ANC and delivery by a skilled birth attendant improves outcomes for mother and baby</li> </ul>	<ul style="list-style-type: none"> <li>● ART for all PLHIV, including those intending to become pregnant</li> <li>● Baseline investigations <ul style="list-style-type: none"> <li>○ Hb (with management of anaemia)</li> <li>○ Syphilis screening</li> <li>○ Cervical cancer screening</li> </ul> </li> <li>● STI symptom screening</li> <li>● Nutritional assessment, counselling, and support</li> <li>● Folic acid supplementation</li> <li>● Standard VL monitoring (Figure 6.6)</li> <li>● PrEP for the HIV-negative partner</li> </ul>
Additional messages for discordant couples: male partner HIV positive	<ul style="list-style-type: none"> <li>● Defer unprotected sex until confirmed viral suppression in the HIV positive partner</li> <li>● Discuss use of PrEP for the HIV-negative partner (Chapter 11)</li> <li>● In situations where viral suppression is challenging, consider specialist referral for additional options such as sperm washing and artificial insemination</li> </ul>	
Additional messages for discordant couples: female partner HIV positive	<ul style="list-style-type: none"> <li>● Defer unprotected sex until confirmed viral suppression in the HIV-positive partner</li> <li>● Discuss use of PrEP for the HIV-negative partner (Chapter 11)</li> <li>● Discuss self-insemination during the peri-ovulatory period, where appropriate/as preferred</li> <li>● In situations where viral suppression is challenging, consider specialist referral for additional options such as artificial insemination</li> </ul>	



**Table 7.1: Essential Package of Antenatal Care**

Intervention	Recommendation/Description
<b>Group &amp; Individual Education</b>	<p>Include information on importance of at least 8 ANC visits, details of ANC services (including health checks and treatment of any illness, medical tests including HIV, syphilis testing and hepatitis B, monitoring of maternal and fetal wellbeing, etc.), nutrition, personal care, recognizing and responding to danger signs during pregnancy, birth preparedness including skilled birth attendance, post-natal care including immunization, family planning and maternal and infant nutrition, HIV prevention and treatment (HTS, preventing new infections during pregnancy including PrEP where appropriate, ART for those who are HIV positive, monitoring of ART and ARV prophylaxis and follow-up for HEIs) and triple elimination (preventing HIV/ syphilis/hepatitis B transmission from mother to child).</p>
<b>Counselling</b>	<ul style="list-style-type: none"> <li>● <b>Pre-conception</b> – Women in reproductive age who are known to be HIV positive should have pregnancy intention assessment visit at every visit. If they desire to become pregnant, pregnancy should be planned i.e., attain viral load suppression, immune reconstitution and have Iron and Folic Acid Supplementation (IFAS) administered prior to conception.</li> <li>● Women who are <b>newly diagnosed with HIV</b> and/or newly initiating ART require more intensive adherence counseling and HIV education, which may include a case manager and/or mentor mother</li> <li>● <b>Birth preparedness:</b> support the pregnant woman and her partner to develop an individual birth plan that includes place of delivery with skilled attendants, emergency transport, birth companionship and readiness for infant care</li> <li>● <b>Pregnancy danger signs:</b> offer information on returning to ANC as soon as possible in case they develop fever, lower abdominal pain, severe headache, swollen feet, convulsions and per vaginal bleeding.</li> <li>● <b>Maternal, infant and young child nutrition (MIYCN):</b> All pregnant women should receive information on proper nutrition during pregnancy and breastfeeding, safe infant feeding and optimal nutrition practices. Promote exclusive breastfeeding for the first 6 months irrespective of HIV status, followed by complementary feeding (Table 7.7). During pregnancy, provide iron, folate and multivitamins; monitor for <b>anemia</b>, advise on adequate caloric intake (HIV positive women require an additional 10% of recommended daily allowance (RDA))</li> </ul>



**Counselling**

**HIV testing services**

- All pregnant women (unless known HIV positive) should be counselled and tested for HIV, syphilis and Hepatitis B during their first ANC visit and if negative, repeat HIV and syphilis testing in the third trimester.
  - All pregnant and breastfeeding mothers with continued HIV risk (Key populations) should be ~~counselled~~ and tested for HIV every 3 months until post-cessation of breastfeeding.
  - Pregnant and breastfeeding mothers should be educated and offered a self-test kit for their sexual partner(s)
  - At Labour and delivery, HIV testing should be done for all women with unknown HIV status or that previously tested negative, even if tested during the third trimester
  - All breastfeeding mothers (unless known HIV positive) should be counselled and tested at the 6-week infant immunization visit. The HIV test (if negative) should be repeated every 6 months until complete cessation of breastfeeding.  
**Note:** key population mothers (FSWs and PWIDs) get retested every 3 months (Table 2.5)
    - Women should be counselled about the schedule for repeat HIV testing in pregnancy and postnatally as part of routine ANC and postnatal education
  - All pregnant and breastfeeding women who are not tested, opt-out or decline HIV, Syphilis or Hepatitis testing during the first contact should be offered counselling and testing in subsequent visits with appropriate linkage and referral for prevention, care and support services. Daily Witnessed Ingestion (DWI) is advised to support Viral suppression for newly initiated clients and those whose regimens are being switched. This is to support viral suppression among women with high viral load.
  - All HIV positive pregnant and breastfeeding women enrolled into care should receive counselling and support (including assisted disclosure), case management linkage and follow-up for comprehensive treatment and prevention (including lifelong ART)
  - All Syphilis and Hepatitis B positive clients should be given appropriate care as defined in Table 7.3 "triple elimination".
    - All partners of pregnant and breastfeeding women should be offered HIV testing and counselling and all biological children if the mother is HIV positive
- All pregnant and breastfeeding women should receive information on risk reduction, including ~~PrEP~~ where appropriate
- Post-partum contraception: counsel on contraception methods and help patient develop a plan for effective contraception from 6-weeks post-partum to avoid

**Table 7.2: Summary of Use of ART for HIV Positive Pregnant and Breastfeeding Women**

Overall recommendations	
When to start	ART should be initiated in all pregnant and breastfeeding women living with HIV, regardless of gestation, WHO clinical stage and at any CD4 cell count and continued lifelong. ART should be started, ideally, on same day as HIV diagnosis after readiness assessment with ongoing enhanced adherence support including community-based case management and support.
What to start with ( <u>first-line ART</u> )	TDF/3TC/DTG
Infant prophylaxis	<ul style="list-style-type: none"> <li>• AZT+NVP for 6 weeks, NVP should be continued until 6 weeks after <u>complete cessation of breastfeeding</u> For more comprehensive information Refer to Table 7.3</li> </ul>
Monitoring	<p><b>Viral load monitoring during pregnancy and breast-feeding (Figure 6.6)</b></p> <ul style="list-style-type: none"> <li>• Whenever possible, use same-day point-of-care methods for viral load testing of pregnant and breastfeeding women to expedite the return of results and clinical decision-making. If this is not available, viral load specimens and results for pregnant and breastfeeding women should be given priority across the laboratory referral process (including specimen collection, testing and return of results).</li> <li>• <u>For</u> pregnant and breastfeeding women newly initiated on ART, obtain VL 3 months after initiation, and then every 6 months until complete cessation of breastfeeding</li> <li>• <u>For</u> HIV positive women already on ART at the time of confirming pregnancy or breastfeeding, obtain a VL irrespective of when prior VL was done, and then every 6 months until complete cessation of breastfeeding</li> <li>• <u>For</u> pregnant or breastfeeding women with a VL <math>\geq 50</math> copies/ml: assess for and address potential reasons for viremia, including intensifying adherence support, repeat the VL <b>after 3 months of excellent adherence, including daily witnessed ingestion, where feasible and appropriate</b> <ul style="list-style-type: none"> <li>◦ If the repeat VL is 200 - 999 copies/ml consult the Regional or National HIV Clinical TWG</li> <li>◦ If the repeat VL is <math>\geq 1,000</math> copies/ml, change to an effective regimen. Refer to Table 6.10 <ul style="list-style-type: none"> <li>◦ If the repeat VL is <math>&lt; 200</math> copies/ml (LDL) then continue routine monitoring</li> </ul> </li> </ul> </li> </ul>

Scenario	
Pre-conception planning for women already on ART (not yet pregnant)	Maintain ART Carry out a VL test if not done in the prior six months to confirm viral suppression (Figure 6.6) Refer to Table 4.8 for pre-conception care for women on ART who desire pregnancy, including laboratory screening, TT immunization, folic acid, etc.
On ART at the time of confirming pregnancy/breastfeeding	Maintain ART. Carry out a VL at first identification of pregnancy, irrespective of when a prior viral load was done, to confirm viral suppression (Figure 6.6) Manage the baby as HEI (Figure 2.1 for EID, and Table 7.3 for infant prophylaxis)
Not on ART at the time of confirming pregnancy	Prepare the patient and start on ART as soon as possible. ART initiation should occur preferably on the same day HIV infection is confirmed. Perform VL 3 months after ART initiation. Pregnant and <u>breastfeeding women</u> with a history of treatment interruption returning to care should have reasons for interruption assessed and preferentially re-started on a DTG-containing regimen unless the reason for interruption was DTG intolerance or failure. Viral load monitoring in this case should be done after 3 months of initiation and 6 months thereafter until cessation of breastfeeding. Additional adherence support should be made available.
Not on ART during labour and delivery	Start on ART during labour. After delivery, continue treatment preparation and adherence support and continue ART Manage the baby as HEI (Figure 2.1 for EID, and Table 7.3 for infant prophylaxis)
Not on ART during post-partum/breastfeeding	Prepare (readiness assessment) and start on ART as soon as possible preferably on the same day HIV infection is confirmed. Manage the baby as HEI (Figure 2.1 for EID, and Table 7.3 for infant prophylaxis). Adherence support for both mother and infant, consider daily witnessed ingestion (DWI) support.
Managing labour and delivery	Minimize vaginal examinations, use aseptic techniques to conduct delivery, avoid artificial rupture of membranes, monitor labour and avoid prolonged labour by use of the partograph, avoid unnecessary genital tract trauma

Note that certain patient groups e.g., recent HIV infections, pregnant adolescent girls and young women, women with previous children with HIV infection, patients with high viral load at time of pregnancy confirmation, patients with poor social support systems, patients with history of default from care and those with active co-morbidities etc. may require additional adherence and psychosocial support

Scenario	
Pre-conception planning for women already on ART (not yet pregnant)	Maintain ART Carry out a VL test if not done in the prior six months to confirm viral suppression (Figure 6.6) Refer to Table 4.8 for pre-conception care for women on ART who desire pregnancy, including laboratory screening, TT immunization, folate, etc.
On ART at the time of confirming pregnancy/breastfeeding	Maintain ART. Carry out a VL at first identification of pregnancy, irrespective of when a prior viral load was done, to confirm viral suppression (Figure 6.6) Manage the baby as HEI (Figure 2.1 for EID, and Table 7.3 for infant prophylaxis)
Not on ART at the time of confirming pregnancy	Prepare the patient and start on ART as soon as possible. ART initiation should occur preferably on the same day HIV infection is confirmed. Perform VL 3 months after ART initiation. Pregnant and <u>breastfeeding women</u> with a history of treatment interruption returning to care should have reasons for interruption assessed and preferentially re-started on a DTG-containing regimen unless the reason for interruption was DTG intolerance or failure. Viral load monitoring in this case should be done after 3 months of initiation and 6 months thereafter until cessation of breastfeeding. Additional adherence support should be made available.
Not on ART during labour and delivery	Start on ART during labour. After delivery, continue treatment preparation and adherence support and continue ART Manage the baby as HEI (Figure 2.1 for EID, and Table 7.3 for infant prophylaxis)
Not on ART during post-partum/breastfeeding	Prepare (readiness assessment) and start on ART as soon as possible preferably on the same day HIV infection is confirmed. Manage the baby as HEI (Figure 2.1 for EID, and Table 7.3 for infant prophylaxis). Adherence support for both mother and infant, consider daily witnessed ingestion (DWI) support.
Managing labour and delivery	Minimize vaginal examinations, use aseptic techniques to conduct delivery, avoid artificial rupture of membranes, monitor labour and avoid prolonged labour by use of the partograph, avoid unnecessary genital tract trauma

Note that certain patient groups e.g., recent HIV infections, pregnant adolescent girls and young women, women with previous children with HIV infection, patients with high viral load at time of pregnancy confirmation, patients with poor social support systems, patients with history of default from care and those with active co-morbidities etc. may require additional adherence and psychosocial support

TRIPLE ELIMINATION		
CONDITION in mother	INFANT MANAGEMENT	MATERNAL MANAGEMENT
Syphilis-VDRL or diagnosed with Dual kit	Crystalline Penicillin 50,000 IU/kg BD (if <7 days) or TDS if (>7 days old) for a total of 10 days.	Penicillin G 2.4 MU IM Stat or Ceftriaxone 1gm IM daily for 8-10 days in case of penicillin allergy.
Congenital syphilis		
Hepatitis B – HbsAg test	Hepatitis B immunoglobulin 0.5ml IM within 12 hours after birth. Hepatitis B vaccine 0.5ml three doses at birth, 1 month and 6 months.	Refer to viral hepatitis management guidelines
<p>Note: If child has contraindication or unable to tolerate NVP or AZT then give the tolerated drug up to complete cessation of breastfeeding. If the infant is on AZT prophylaxis, give up to a minimum of 12 weeks or until maternal viral load is suppressed. In situations where neither AZT nor NVP are tolerated 3TC may be used as a third option if available.</p> <p>HIV exposed infants with TB infection, infant prophylaxis should include AZT plus 3TC fixed dose (60/30 mg). For 12 weeks or until maternal viral load is suppressed (3-5.9 – 1 tab BD, 6-9.9kg 1.5tab BD, 10-13.9 kg 2 tabs BD). For more details, refer to Annex 10 A.</p> <p>After TB treatment, revert to NVP until 6 weeks post cessation of breastfeeding.</p> <p>HB monitoring should be done to all HEIs on AZT prophylaxis as per the recommendations (Table 6.7: management of AZT associated bone marrow suppression)</p> <p>Groups considered higher risk for mother to child transmission who may need additional adherence and psychological support include:</p> <ul style="list-style-type: none"> <li>All new HIV positives irrespective of time identified</li> <li>HIV positive adolescent Girls and Young Women (AGYW) &lt;19 yrs. including OVC</li> <li>VL &gt;200 copies/ml</li> <li>Clients with stigma, declining treatment, poor adherence</li> <li>PMTCT client with previous HIV infected infant</li> <li>Client with active comorbidities - DM, OIs, malnourished (low MUAC), mental health etc.</li> <li>Clients who sero-convert during ANC/PNC follow up</li> <li>Poor socio-economic and family support structures</li> <li>Those who drop off ART</li> <li>Key population – FSW, PWID</li> </ul> <p>Alcohol use and brewers/sellers</p>		

**Table 7.3: ARV Prophylaxis for HIV-Exposed Infants**

Infant Scenario	Infant Prophylaxis	Maternal Scenarios
HIV Exposed Infant	<ul style="list-style-type: none"> <li>● Infant prophylaxis               <ul style="list-style-type: none"> <li>○ AZT+NVP for 6 weeks, NVP + cotrimoxazole should be continued until 6 weeks after complete cessation of breastfeeding</li> <li>○ <u>Infant prophylaxis can be discontinued after a minimum of 12 weeks on NVP if the child is not breastfeeding (death of mother or separation with mother)</u></li> <li>□ The infant prophylaxis regimen applies to all infants irrespective of age when identifying HIV exposure (e.g., mother diagnosed HIV-positive in the postpartum period)</li> </ul> </li> <p>DBS or whole blood for PCR at 6 weeks or first contact, following EID algorithm (Figure 2.1)</p> <p>Birth testing (Figure 2.2) may be conducted in sites where point of care has been implemented and when medically indicated</p> </ul>	<p>If mother not on ART, initiate ART as soon as possible (preferably same day)</p> <p>If mother is on ART for <math>\geq</math> 3 months and the VL is <math>\geq</math> 50 copies/ml, intensify adherence, repeat the VL</p> <p>If VL <math>&lt;50</math> copies/ml, continue current regimen</p> <p>Follow Viral load algorithm Figure 6.6</p>

**Table 7.4: Dosing of ARVs for Infant Prophylaxis from Birth to 12 Weeks of Age**

Age/Weight	Dosing of NVP (10mg/ml) OD	Dosing of AZT (10mg/ml) BD
<b>Birth to 6 weeks</b>		
Birth weight < 2,000 g	2 mg/kg per dose, OD	4 mg/kg per dose, BD
Birth weight 2,000-2,499 g	10 mg (1 ml), OD	10 mg (1 ml), BD
Birth weight ≥ 2,500 g	15 mg (1.5 ml), OD	15 mg (1.5 ml), BD
<b>&gt; 6 weeks to 12 weeks of age*</b>		
Any weight	20 mg (2 ml), OD	60 mg (6 ml), BD
<b>&gt; 12 weeks (Table 7.5 and 7.6)</b>		

**Table 7.5: NVP Dosing for Infant Prophylaxis beyond 12 Weeks of Age \***

Age	Dosing of NVP (10mg/ml) Once Daily
12 weeks – 6 months	25 mg (2.5 ml), OD
7 months – 9 months	30 mg (3 ml), OD
10 months – 12 months	40 mg (4 ml), OD
> 12 months	Consult the Regional or National HIV Clinical TWG ( <a href="#">Uliza</a> Hotline 0726 460 000; <a href="https://nhcsc.nascop.org/clinicalform">https://nhcsc.nascop.org/clinicalform</a> )

\* If child presents to facility late and has to be on AZT and NVP beyond 12 weeks of age

**Table 7.6: AZT Dosing for Infant Prophylaxis beyond 12 Weeks of Age \***

Weight	Dosing of AZT: (10mg/ml syrup) Twice Daily
3.0-5.9 kg	6 ml, BD
6.0-9.9 kg	9 ml, BD
10.0-13.9 kg	12 ml, BD
14.0-19.9 kg	15 ml, BD

\* If child presents to facility late and has to be on AZT and NVP beyond 12 weeks of age

## 7.4 Infant and Young Child Nutrition in the Context of HIV

**Exclusive breastfeeding** involves giving the baby only breast milk with no other liquids (including water) or solids for the first six months of life. Giving of vitamins, mineral supplements or medicines are permitted if prescribed.

**Mixed feeding** is giving other liquids and/or foods together with breast milk to infants under 6 months of age **and is not recommended**. Mixed feeding during this period is associated with significantly higher risk of mother-to-child HIV transmission, diarrhoeal and respiratory tract illnesses, among other consequences and should be prevented

All infants irrespective of HIV status should be exclusively breastfed for the first 6 months of life, with timely introduction of appropriate complementary foods after 6 months, and continued breastfeeding up to 24 months or beyond.

Should mothers be physically separated from their infants (back to work), support them to sustain lactation and to exclusively breastfeed including mentorship on expressing breast milk (refer to current MIYCN Policy)

All mothers, irrespective of HIV status, should be encouraged and supported to exclusively breastfeed for the first six months and continue breastfeeding with appropriate complementary feeding after 6 months, for a period of 24 months or beyond. Breastfeeding should ONLY stop once a nutritionally adequate and safe diet without breast milk can be sustained.

HIV positive mothers and HIV positive infants should always be on ART and given extra attention for adherence support, VL monitoring and optimal retention in care

Breastfeeding mothers who do not know their HIV status or who previously tested HIV negative should be encouraged to be retested for HIV at the 6-week immunization visit, and then every 6 months thereafter until complete cessation of breastfeeding (Table 2.5)

Access for HIV testing and STI/HIV prevention interventions should be reinforced for partners of pregnant and breastfeeding women

Mothers who are diagnosed with HIV while breastfeeding should immediately start appropriate ART, giving extra attention to adherence support, VL monitoring, and optimal retention in care. The infant should immediately start ARV prophylaxis and receive PCR testing (Table 7.3).

Mothers who decide to stop breastfeeding at any time should stop gradually within one month (and only when a nutritionally adequate and safe diet without breast milk can be sustained), and HIV positive mothers and HIV positive infants should continue with ART. Continued breastfeeding is recommended for HIV positive infants for as long as the mother is willing and able to do so.

In special medical circumstances, determined by clinicians, where an infant cannot breastfeed, refer to current MIYCN Policy and Breast Milk Substitute (BMS) Regulation and Control Act, 2012.

**Complimentary feeding** means giving other foods to complement breast milk after six months of exclusive breastfeeding. Complimentary feeds provide additional nutritional value to meet the child's increasing nutritional needs for growth (Table 7.7).

Furthermore, complementary feeding helps the child to gradually become accustomed to eating family foods while breastfeeding continues to be an important source of nutrients. It is worth noting that breastfeeding continues to have child growth/survival benefits for up to two years or longer. Emphasis should be made on consuming all the seven (7) food groups for children in various meals.

- Cereal/tubers and roots ○ Beans, pulses and nuts ○ Dairy and dairy products
- Eggs and Flesh (meat/poultry/insects/organ meat)
- Vitamin A rich food (orange/yellow fruits) and green vegetables ○ Fats and high sugar foods Other fruits and vegetables

## Table 11:1 HIV Screening questions

Screening question refer to the past 6 months & include:

“Have you had sex with more than one person?”

“Have you had sex without a condom?”

“Have you had sex with anyone whose HIV status you do not know?”

“Are any of your partners at risk of HIV?”

“Have you had sex with a person who has HIV?”

“Have you received a new diagnosis of a sexually transmitted infection?”

“Do you desire pregnancy?”

“Have you used or wanted to use PEP or PrEP for sexual exposure to HIV?”

“Have you injected drugs that were not prescribed by healthcare provider? If yes, did you use syringes, needles or other drug preparation equipment that had already been used by another person?”

“Have you received money, housing, food or gifts in exchange for sex?”

“Have you been forced to have sex against your will?”

“Have you been physically assaulted, including assault by a sexual partner?”

### **11.1.3 Criteria for PrEP Eligibility**

To be eligible for PrEP, individuals identified to be at risk of HIV infection from Risk Assessment must meet ALL the following criteria prior to initiating PrEP.

Confirmed HIV negative status through rapid antibody testing following the HTS algorithm.

Determine if the client is willing to take PrEP as prescribed. (This is done by adherence education and counselling on the PrEP regimen to be given, and assessing the client's readiness to follow the regimen.)

Does not have a current or recent (within the past one month) illness consistent with acute HIV infection (fever, sore throat, muscle or joint pains, swollen glands, diarrhoea or headache) in combination with a preceding high-risk exposure for HIV.

No contraindication to use of any of the ARVs recommended for PrEP e.g., TDF +/- FTC (or 3TC) for those who choose oral PrEP.

Renal or liver disease

- Clients with renal and liver disease should receive further clinical and laboratory tests, to determine the renal/liver function and extent of disease.

**Client seeking any service from the facility/Community**  
**(See section on PrEP Integration)**



**Clinician/ Lay providers**

**SCREENING FOR HIV RISK**

Provide the service the client came to seek

**SCREEN for ongoing risk for HIV**

(See Behavioral Risks) and offer HIV test

**TEST for HIV**



**HIV Positive – link/refer**



**Additional Screening:**

GBV/HIV



**Clinician**

**DETERMINE PrEP ELIGIBILITY**

- Ongoing Risk of HIV (Behavior)
- HIV Test Negative (same day)
- No suspicion of acute HIV infection (AHI)
- No medical contraindication (serum creatinine, proteinuria, liver disease)
- No Risk to intimate partner violence (IPV)
- Initiate PrEP



If indicated Take  
blood/send for  
Creatinine  
clearance



Review Client after 1month: AHI, adherence, retesting and PrEP refill

### **11.2.1 Pre-Initiation Checklist**

This checklist is intended to help the service provider ensure all necessary screening and assessments are done prior to PrEP initiation

**Table 11.2: Pre-Initiation Assessment Checklist**

ITEM	Y/N
Screening and Support for GBV	
HIV Testing	
Check symptoms of acute viral infection in last 6 weeks	
Behavior risk assessment	
Substance use and mental health screening	
Partner information	
Pre-initiation education and understanding of PrEP	
Client readiness and willingness to adhere to prescribed PrEP and follow-up schedule	
STI screening and treatment	
For women	
Pregnancy test, pregnancy intention and / or breastfeeding	
Screen for contraception use using appropriate contraceptive screening tool	
Highlight the need for condom use	
Discussed plans for continually accessing PrEP	
Additional laboratory tests (Availability of these test should not delay initiation of PrEP)	
Serum creatinine and creatinine clearance	
HBsAg	
HCV serology	
<i>NB: absence of these tests should not hinder initiation</i>	
Medication history and potential drug interactions	

**Table 11.4: Antiretrovirals for Use in PrEP**

PrEP Dosing Strategies	Preferred	Alternative
Daily Oral PrEP	TDF/FTC (300 mg/200 mg) as FDC once daily	TDF/3TC (300 mg/300 mg) as FDC once daily
Event Driven Oral PrEP	TDF/FTC (300 mg/200 mg) as FDC - two pills taken between 2 and 24 hours in advance of anticipated sex; then, a third pill 24 hours after the first two pills and a fourth pill 48 hours after the first two pills; 2-1-1	TDF/3TC (300 mg/300 mg) as FDC - two pills taken between 2 and 24 hours in advance of anticipated sex; then, a third pill 24 hours after the first two pills and a fourth pill 48 hours after the first two pills; 2-1-1
<p>*Recommended Long-acting Products: These products are at different stages of approval and availability in Kenya. The Ministry of Health will issue specific implementation guidelines when they become available.</p>		

## Pregnancy or Breastfeeding

Pregnancy and breastfeeding are not contraindications to provision of PrEP.

Pregnant or breastfeeding women whose sexual partners are HIV positive or are at high risk of HIV infection may benefit from PrEP as part of combination prevention of HIV infection.

PrEP is also indicated for HIV-negative women in sero-different partnerships who wish to conceive. PrEP in these situations can be prescribed during the pre-conception period and throughout pregnancy to reduce risk of sexual HIV infection.

**Table 6.2: Preferred First-line ART Regimens and Dosing for Children, Adolescents and Adults<sup>1</sup>**

Age	Weight	Preferred Regimen	Dosing <sup>2</sup> (correct weight-based dosing must be confirmed at every visit)
Birth to 4 weeks	Any	AZT + 3TC + NVP <sup>3</sup>	Refer to Annex 10 for weight-based dosing
> 4 weeks to < 15 years	< 30 kg	ABC + 3TC + DTG <sup>4</sup>	Refer to Annex 10 for weight-based dosing
	≥ 30 kg	TDF + 3TC + DTG <sup>5,6</sup>	TDF/3TC/DTG (300/300/50mg): 1 tab once daily
≥ 15 years	Any	TDF + 3TC + DTG <sup>5,6</sup>	TDF/3TC/DTG (300/300/50mg): 1 tab once daily

<sup>1</sup> Patients currently on first-line regimens that are not included in the indicated preferred (Table 6.2) or alternative (Table 6.3) regimens should be considered for regimen optimization as per Section 6.5.1

<sup>2</sup> See Annex 10 for weight-based dosing of all single-drug and fixed-dose combination formulations

<sup>3</sup> Infants who initiate ART at less than 4 weeks of age should initiate on AZT+3TC+NVP irrespective of previous ART exposure; metabolism of other ARVs is not well known for this age group. As soon as these infants become 4 weeks old, they should switch to ABC/3TC+DTG (dosing included in Annex 10). Consult the Regional or National HIV Clinical TWG (Uliza Hotline 0726 460 000, ulizanascop@gmail.com) in case of pre-term infants

<sup>4</sup> Once adolescents reach 30 kg, if virally suppressed they should be considered for transition as per Figure 6.2

<sup>5</sup> TAF may become the preferred NRTI once fixed-dose combinations are available

<sup>6</sup> DTG/3TC dual therapy may be considered for HBV-negative patients once fixed-dose combinations are available

**Table 6.3: Use of Alternative ARVs in First-Line Regimens<sup>1</sup>**

Age	Weight	Scenario and ARV Affected	Alternative ARV to Use
Birth to 4 weeks	Any	NVP: Develops hypersensitivity reaction	Use RAL granules or LPV/r granules (over 2 weeks of age) or defer ART until 4 weeks of age, then start ABC+3TC+DTG
		AZT: Infant Hb < 9.5 g/dL	Defer ART until 4 weeks of age, then start ABC+3TC+DTG
> 4 weeks to < 15 years	< 30 kg	ABC: Develops ABC hypersensitivity reaction <sup>2</sup>	Use AZT (if Hb ≥ 9.5 g/dL); if Hb < 9.5 g/dL consults Regional or National HIV Clinical TWG (call Uliza Hotline 0726 460 000; ulizanascop@gmail.com)
		DTG: Unable to tolerate	Use LPV/r at standard weight-based BD dosing, if 4-in-1 available this is preferred
		DTG: Currently on rifampicin-containing anti-TB medications	Increase DTG dosing frequency to twice daily for duration of rifampicin-containing TB treatment and for an additional 2 weeks after TB treatment is completed, then revert to once daily dosing <sup>3</sup>
	≥ 30 kg	TDF: Impaired renal function (CrCl ≤ 50 ml/min)	Use ABC <sup>4,5</sup> or TAF (once available)
		DTG: Unable to tolerate	Use EFV (for PWID use ATV/r)
		DTG: Currently on rifampicin-containing anti-TB medications	Give TDF/3TC/DTG FDC morning + DTG 50mg evening for duration of rifampicin-containing TB treatment and for an additional 2 weeks after TB treatment is completed, then revert to TDF/3TC/DTG FDC OD <sup>3</sup>
≥ 15 years	Any	TDF: Impaired renal function (CrCl ≤ 50 ml/min)	Use ABC <sup>4,5</sup> or TAF (once available)
		DTG: Unable to tolerate	Use EFV (for PWID use ATV/r)
		DTG: Currently on rifampicin-containing anti-TB medications	Give TDF/3TC/DTG FDC morning + DTG 50mg evening for duration of rifampicin-containing TB treatment and for an additional 2 weeks after TB treatment is completed, then revert to TDF/3TC/DTG FDC OD <sup>3</sup>

