CHAPTER NINE: ANNEXES

Annex 1: KP Minimum Service Package

KP Minimum Services Package	Frequency of Service Delivery	Resources (Equipment / Supplies)	Provider Support Tools	Formats and Registers	HIV Coordination	Remarks
I. Community based KP Outreach Services						
Providing peer education (home based) on HIV benefits of HIV Counseling and Testing including HIVST by Trained Peer Navigators.	Daily	■ HIVST kits ■ Condoms ■ Penile model ■ Leaflet & broachers	■ HIVST Client information card ■ KP mapping tool ■ Service directory	■ Peer Navigator Outreach activity monitoring Register (Amharic Version) ■ Peer Navigator HIVST Register (Amharic Version) ■ Peer Navigator one to one HE Template ■ Peer Navigator Monthly Reporting Template	Peer Navigators	
Distributing of male condoms.						
Distributing IEC / BCC Materials						
Organizing and forming - up support groups (Positive and Negative FSWs)	Once					
Conducting LTFU tracing (For HIV Positive FSWs who lost from treatment & declined to be enrolled)	Daily					
Updating data on mapping of venues, FSWs hotspot sites	Quarterly					
Conducting an update on FSWs distribution						
Following – up of the migration / movement of FSWs						
Monthly outreach activity reporting to facility KP focal person	Monthly					

KP Minimum Services Package	Frequency of Service Delivery	Resources (Equipment / Supplies)	Provider Support Tools	Formats and Registers	HIV Coordination	Remarks
II. Health Facility Based KP Friendly Clinical Services						
A. HIV Services Accessibility & Acceptability						
All FSWs have the right to choose receiving KP friendly service at public, private and NGO health facilities.	24 Hours /7 Days	■ Poster at the gate	■ KP Workflow Chart	■ Roles and Responsibilities of Health Care Providers ■ Roles and Responsibilities of Peer Navigators	Clients	
All HIV prevention, testing, care & treatment services should be provided at KP-DSD friendly clinical service clinic.					HF CEO/ Medical Director	
KP-DSD services should provide by ART & KP trained nurse and/or health officer.						
All HIV prevention, testing, care & treatment services to be available during off working hours (Lunch break and Weekends).					HF Medical director	
All FSWs & their sexual partners should be screened and Offred HIV testing & prevention services.					KP Service Providers & PNs	
All FSWs who doesn't wish to come HFs should offer directly assisted HIVST using PNs and Unassisted HIVST for those who doesn't want to be assisted.						
KP friendly community outreach service will be provided by trained Peer Navigators.					HF Medical director	
KP friendly clinical service will be provided by trained health professional.						

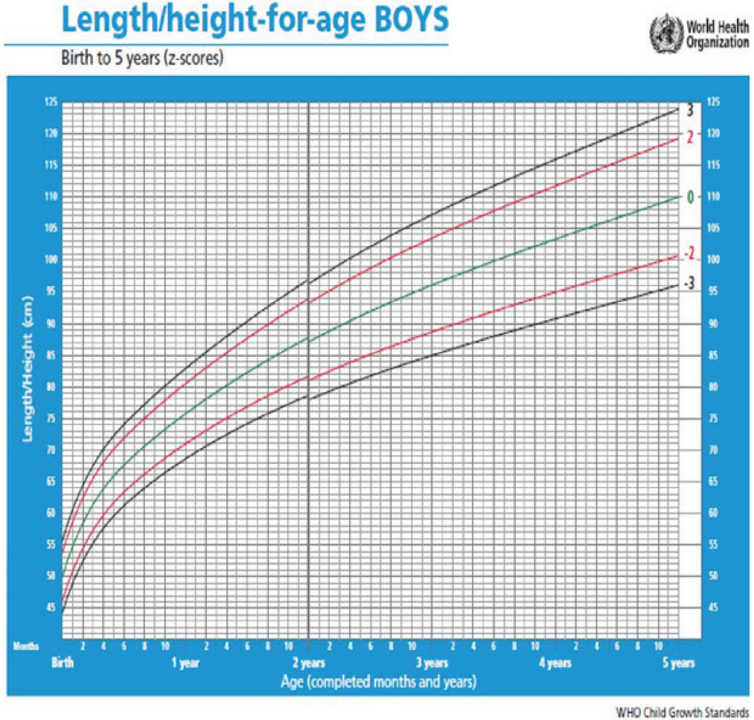
KP Minimum Services Package	Frequency of Service Delivery	Resources (Equipment / Supplies)	Provider Support Tools	Formats and Registers	HIV Coordination	Remarks
B. HIV Testing & Prevention Services for HIV Negative FSWs						
Conduct Retesting of HIV Negative FSWs every six months	24 Hours /7 Days	■ HIV rapid test & HIVST kits ■ STI's Drugs ■ Condom & FP methods ■ ARV drugs for PrEP & PEP	■ Post Test Counseling Wall Chart ■ STI's Syndromic Management Wall Charts ■ CEMs for PrEP	■ HIV Negative FSWs Follow Up Card ■ PrEP screening tools for eligibility ■ HIVST Register ■ PrEP Register ■ KP Register for HIV Negative FSWs	KP Service Providers	
Conduct Screening, diagnosing and managing STIs using the Syndromic Case Management approach						
Conduct Screening, diagnosing and managing TB						
Promoting on and providing Family Planning Services including male condoms.						
Promoting and providing Pre- Exposure Prophylaxis (PrEP) services						
Promoting and providing Post Exposure Prophylaxis (PEP) services						
Promotion and provision of Gender Based Violence (GBV) services						
C. HIV Prevention, Care & Treatment Service for HIV Positive FSWs						
Referring and linking HIV Positive FSWs for HIV Care and Treatment Services.	24 Hours /7 Days	■ Chair ■ Guest chairs ■ Tables ■ Shelves Examination Coach Speculum (medium & large size)	■ Post-Test Counseling Wall Chart ■ STIs Syndromic Management Wall Chart ■ Linkage to Care Flow Chart	■ HIV Reporting Form ■ IPV Risk Screening Tool ■ Referral Forms ■ ART register ■ ART FU Card ■ ASM Register		
Conducting initial and follow up adherence assessment						
Provide 3MMD ART for newly diagnosis FSWs and 6MMD ART for previously enrolled HIV Positive FSWs.						
Conduct Screening, diagnosing and managing STIs using the Syndromic Case Management approach.						
Conduct Screening, diagnosing and managing TB.						
Promoting and providing mental illness screening and management						

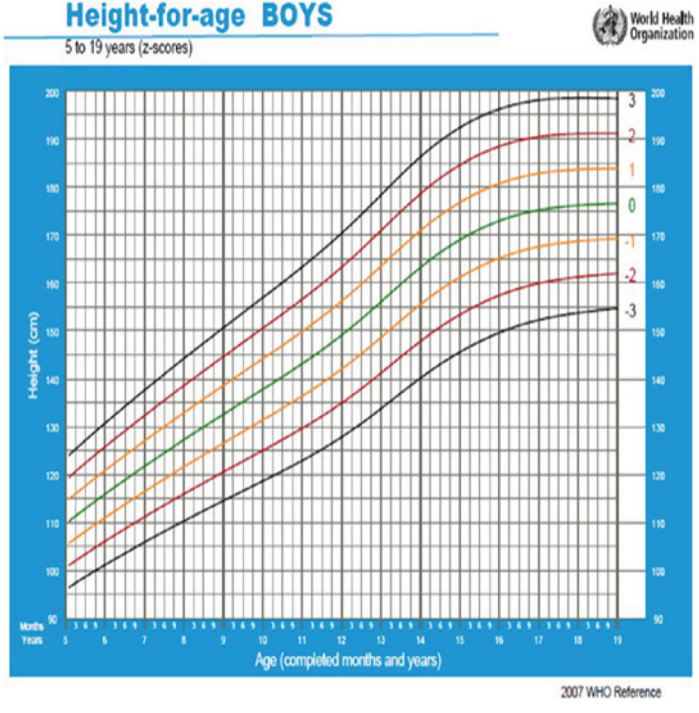
KP Minimum Services Package	Frequency of Service Delivery	Resources (Equipment / Supplies)	Provider Support Tools	Formats and Registers	HIV Coordination	Remarks
Promoting and providing cervical cancer screening and management Promoting and providing Family Planning Services including male condoms. Promoting and referring HIV Positive pregnant FSWs to access PMTCT services Promoting and providing Pre- Exposure Prophylaxis (PrEP) services for partners of HIV Sero-discordant couples. Promoting and providing Post Exposure Prophylaxis (PEP) related services Conducting intimate partner violence (IPV) risk screening and Post Violence care (PVC) services including referrals. Complete HIV case based reporting form for assessing clients for eligibility for recency testing. Conducting HIV recency testing for all eligible FSWs. Promoting and providing P & FB ICT services Conducting HTS for all HIV Positive Index-FSWs elicited HIV unknown status contacts. Offering Unassisted HIVST for all HIV Positive Index-FSWs elicited HIV unknown status contacts who doesn't wish to come HFs. Conducting viral load test every 6, 12 and 12 months. Promoting and providing EAC sessions for HVL FSWs. Referral service for support groups for HIV Positive FSWs.	24 Hours /7 Days	■ Examination gloves ■ Penile model ■ Condoms b(Males) ■ HIV Testing kits including HIVST ■ Waste disposal items (for IP)	■ LTFU Tracking SOP ■ ART Desktop Reference ■ P & FB ICT Counseling Script ■ P & FB ICT SOP	■ VL Monitoring Register ■ HVL FU Register ■ VL Request Form ■ P & FB ICT Register ■ P & FB ICT Screening Tools ■ PrEP Register ■ PrEP FU card ■ HIVST Register ■ Mental Health Illness Screening Tools ■ Referral Register ■ Retesting Register	ART & KP Service Providers	

Annex 2: Immunization schedule for HIV exposed infants

S/NO	Vaccines	Target diseases to be prevented	Age	Route/Site of administration
1	Hep-B Vaccine Birth dose	Hep B Virus Infection	At birth or within 24 hours of birth. If child is born out of HFs or at home, track baby and vaccinate until the age of 14 days.	IM, left anterolateral Thigh
2	BCG	Severe forms of Tuberculosis	At Birth or as soon as possible after birth	
3	PCV	Meningitis and pneumonia associated with Streptococcus pneumonia bacteria	Weeks 6,10 & 14	Intramuscular (IM), Right anterolateral thigh
4	OPV	Poliomyelitis	Birth (OPV0), weeks 6,10 & 14	Oral drops
5	IPV	Poliomyelitis	Week 14	IM, right anterolateral thigh 2.5 cm apart from the injection site of PCV
6	DPT-Hib-Hep-B	Diphtheria, Pertussis, Meningitis, and pneumonia associated with Hemophilus influenzae bacteria and Liver disease due to Hepatitis B virus.	Weeks 6,10 & 14	IM, Left anterolateral thigh
7	Measles containing vaccine	MCV	9 and 15 months	Subcutaneous (SC), Left deltoid
8	Rota virus vaccine	Rota virus associated gastero-enteritis.	Weeks 6 & 10	Oral only

Annex 3: Growth curves

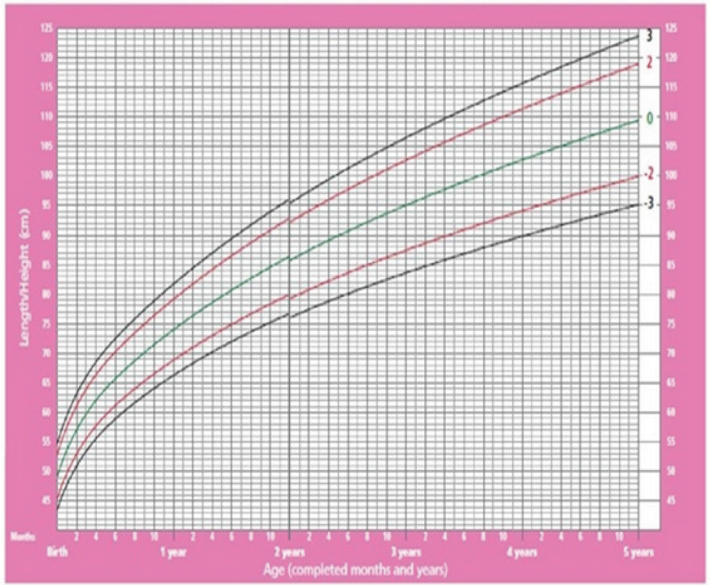




Length/height-for-age GIRLS

Birth to 5 years (z-scores)

World Health Organization

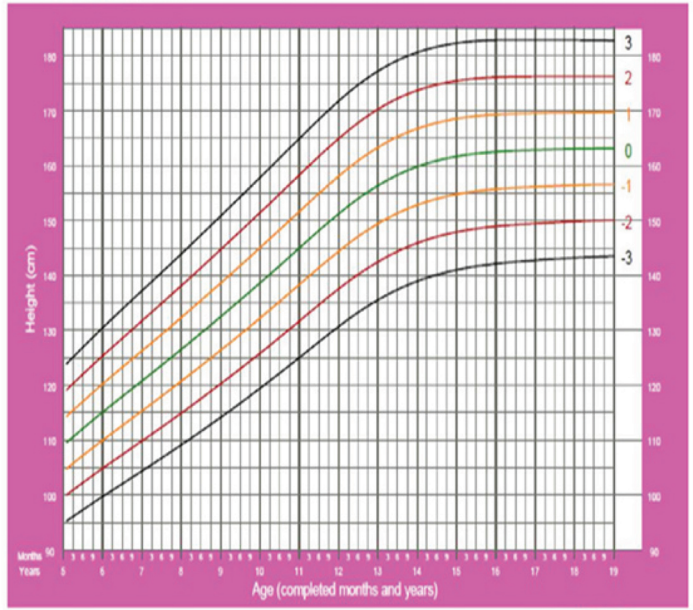


WHO Child Growth Standards

Height-for-age GIRLS

5 to 19 years (z-scores)

World Health Organization

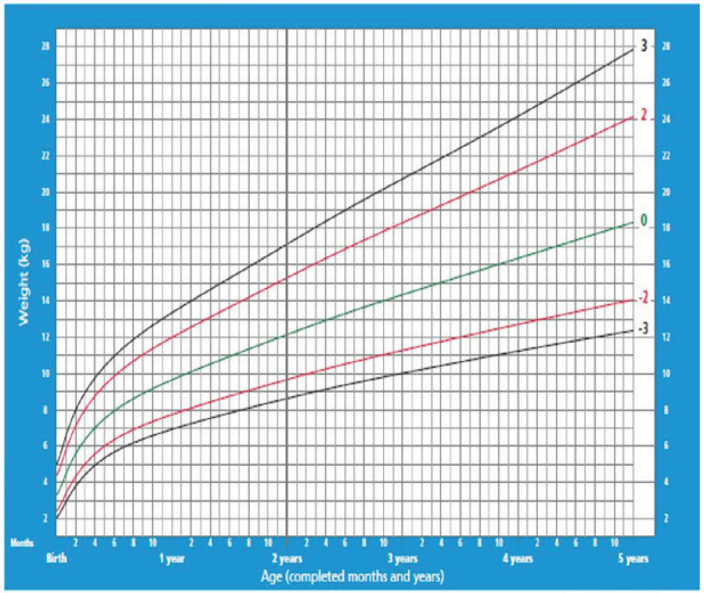


2007 WHO Reference

Weight-for-age BOYS

Birth to 5 years (z-scores)

World Health Organization

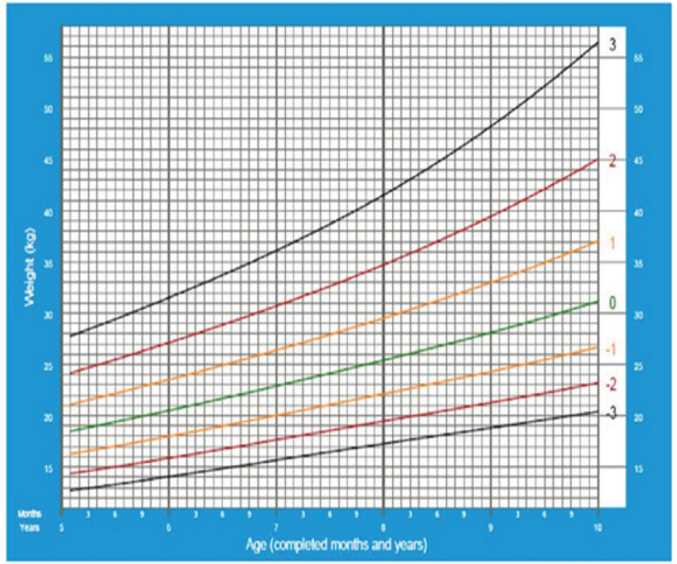


WHO Child Growth Standards

Weight-for-age BOYS

5 to 10 years (z-scores)

World Health Organization

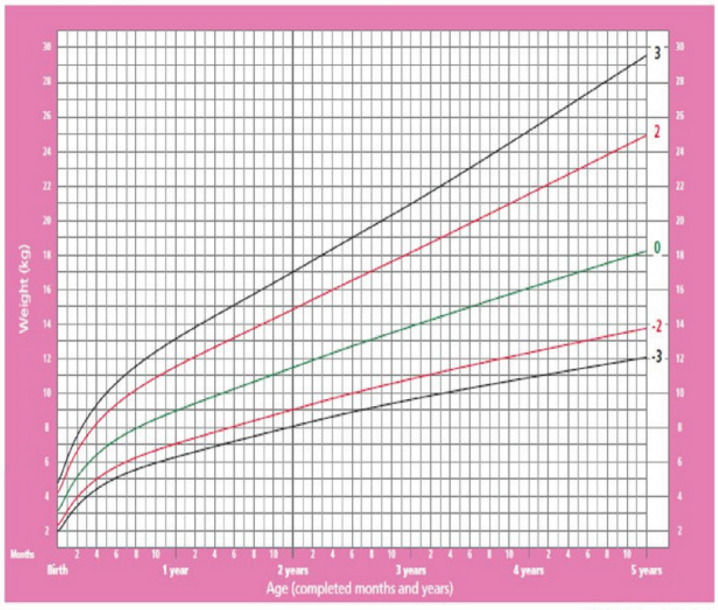


2007 WHO Reference

Weight-for-age GIRLS

Birth to 5 years (z-scores)

World Health Organization

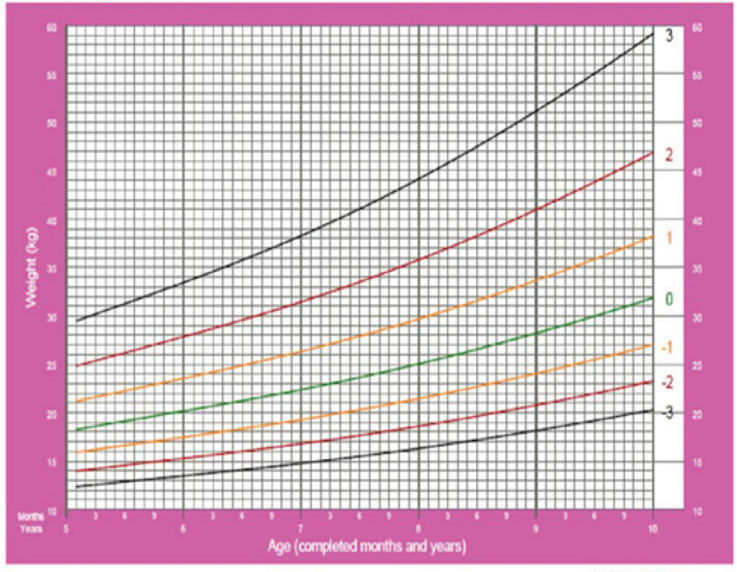


WHO Child Growth Standards

Weight-for-age GIRLS

5 to 10 years (z-scores)

World Health Organization

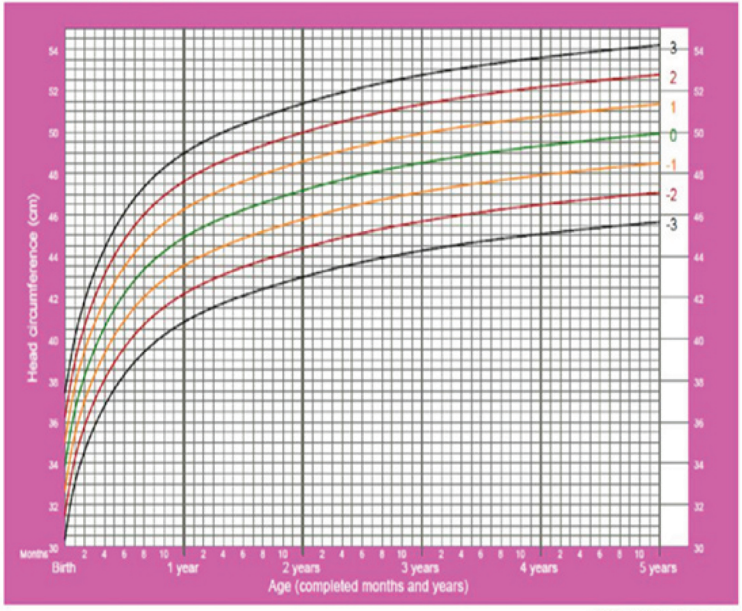


2007 WHO Reference

Head circumference-for-age GIRLS

World Health Organization

Birth to 5 years (z-scores)

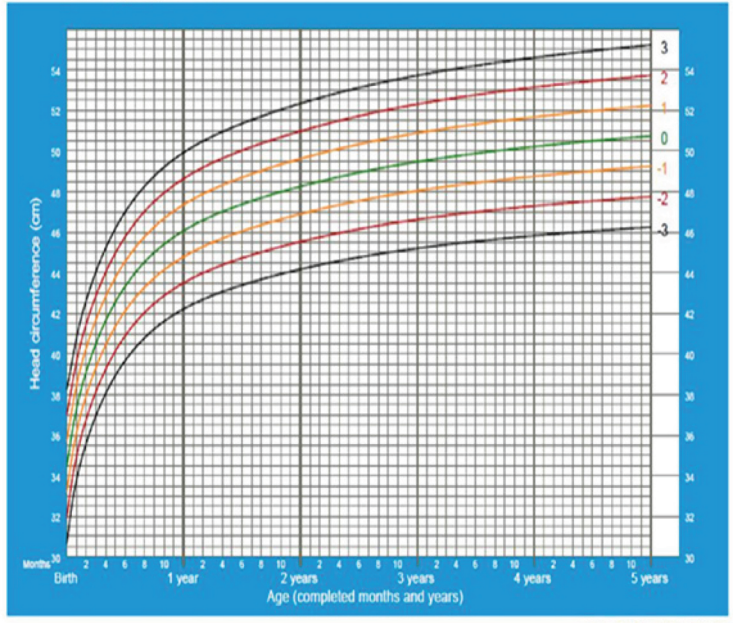


WHO Child Growth Standards

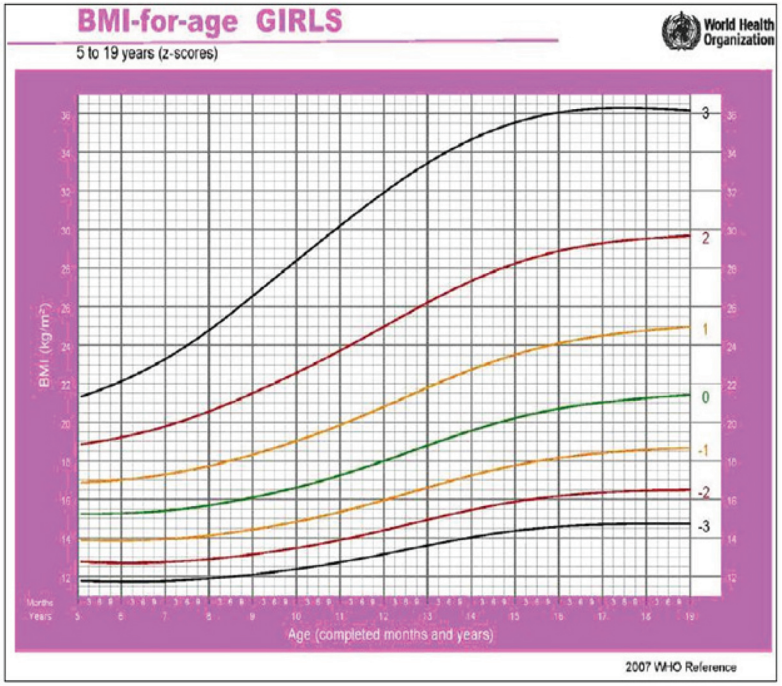
Head circumference-for-age BOYS

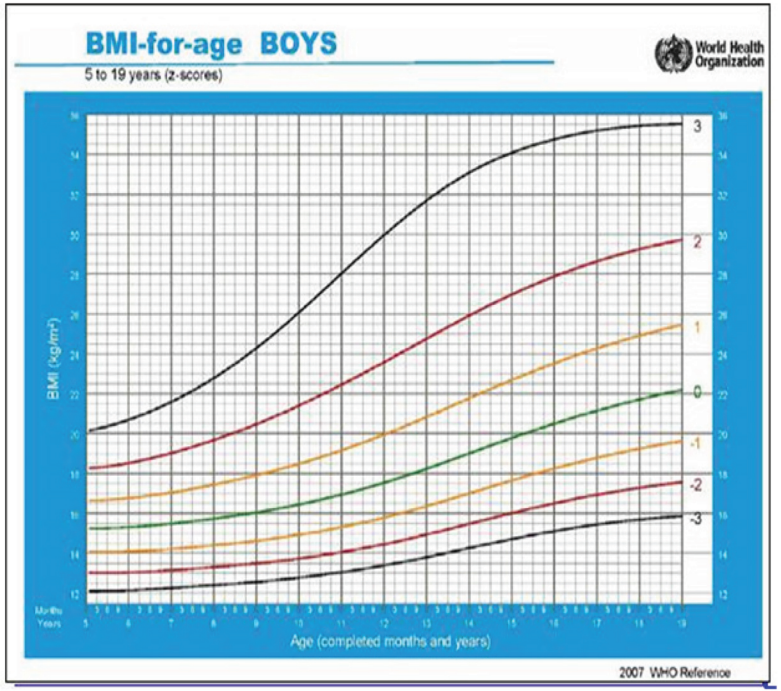
World Health Organization

Birth to 5 years (z-scores)

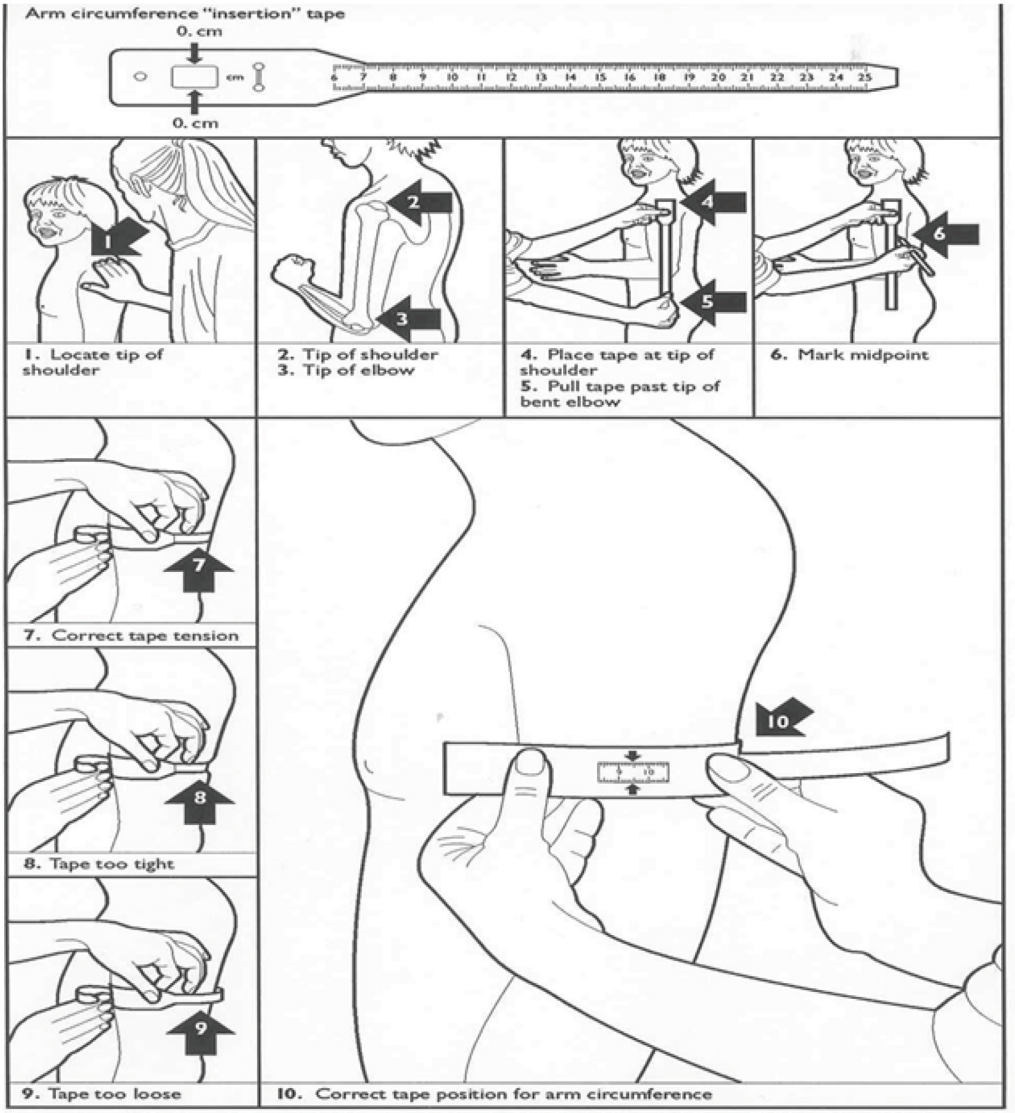


WHO Child Growth Standards


BMI-for-age GIRLS
5 to 19 years (z-scores)
World Health Organization
BMI (kg/m²)
3
2
1
0
-1
-2
-3
Months
Years
Age (completed months and years)
2007 WHO Reference


BMI-for-age BOYS
5 to 19 years (z-scores)
World Health Organization
BMI (kg/m²)
3
2
1
0
-1
-2
-3
Months
Years
Age (completed months and years)
2007 WHO Reference

Annex 4. Instruction for MUAC measurement



Source: How to Weigh and Measure Children: Assessing the Nutritional Status of Young Children, United Nations, 1986.

Annex 5a. HIV Risk assessment tool for children <15 years of age

Name _____ **Age** _____ **Date:** ____/ ___/ ____

For a child <18 months of age					
A. Mother's HIV status Known:	If Negative…… No action If Positive……..Test child unless mother is on PMTCT care and child/infant is on follow up.				
B. Mothers HIV status Unknown	Test mother and decide according to the above options ("A")				
C. If Child is orphan	Test the child				
For a Child > 18 months of age					
Step 1. Assess for Child's HIV Status	1. Unknown 2. Known Positive & on ART 3. Negative				
Step 2. If Child's HIV status is unknown, assess for the criteria below: If "Yes" to one of them, Child is eligible for HIV testing. Test the child.					
1. Are child's biological parents living with HIV?	Y ☐ N ☐				
2. Is the child Orphan or vulnerable with unknown parental HIV status?	Y ☐ N ☐				
3. Is the child diagnosed to have ANY ONE of the following? (If yes tick) (☐) ■ Confirmed or suspected TB ( ), ■ Recurrent lower respiratory infections (pneumonia) of > 2 in the past 6 months ( ), ■ Prolonged fever (> 2 weeks) ( ), ■ Chronic ear discharge ( ), ■ Chronic or recurrent diarrhea ( ), ■ Recurrent or extensive skin lesion ( ), ■ Severe malnutrition or failure to thrive ( ), ■ Developmental delay / regression ( ),					

4. Unexplained poor-health in the last three months.	Y ☐ N ☐
5. History of repeated admissions to hospital for medical illnesses.	Y ☐ N ☐
If the child is older than 10 years of age (10 to 14 years)	
6. Is the child having ANY ONE of the following? (If yes tick) (□) ■ Is the child sexually active or sexually exploited? ( ) ■ Is the child living on street? ( ) ■ Is the child leading a family? ( ) ■ Does the child use substance or alcohol? ( ) ■ Is the child out of school or missed schools repeatedly? ( ) ■ Does the child have history of STI? ( )	
If Yes or (□) to any one the above, child is Eligible for HIV testing. Test the child.	Eligible ☐ Non Eligible ☐
HIV test result	Positive ☐ Negative ☐

Annex 5b. HIV Risk assessment tool for adults and adolescents > 15 years of age

Direction: Evaluate clients using the tool and offer HTS services if a client is eligible. Note that a known HIV positive client should not be tested for HIV and a client who received HIV testing less than 3 months ago may not need HIV testing. Please refer to the current consolidated HIV Prevention, Care and Treatment guideline for details.

MRN: ..... Age: ..... Sex: ..... Date: ...../...../.....

Exam room: .....

1. OI's & Vulnerability Status

1.1. Does the client have clinical signs/symptoms of HIV/AIDS? (Refer clinical S/S Job aid):

Yes ☐ No ☐ if yes offer HTS. If no, go to number 1.2.

1.2. Is the client a partner or biological child of an index case?

Yes ☐ No ☐ if yes offer HTS. If no, go to number two.

2. Marital Status

2.1. Is the client divorced or Widowed or widower?

Yes ☐ No ☐ if yes offer HTS.If no, go to number three.

3. KP/PP; Others

3.1. Does the client have Occupational HIV risk or other risks stated below?

Yes ☐ No ☐ if yes offer HTS.

{1. Female sex worker, 2. Prisoners, 3. PWID, 4. Long distance truck driver, 5. High risk workers in hotspot areas, 6. Daily laborer and mobile workers, 7. Others: GBV survivors, Homeless/street dweller; having multiple sexual partners; Substance and Alcohol abuse.}

KEY: if "yes" (√) to one of the criteria, Patient/client will be eligible for HIV testing

Conclusion: **Eligible** ..... **Non-Eligible** .....

Annex 6a. Clinical Conditions that make eligible for HIV Testing Service in adults and adolescents

- Persistent Generalized Lymph adenopathy
- Unexplained weight loss (> 10% of body weight)
- Unexplained persistent hepatosplenomegaly
- Unexplained Chromic diarrhea > 1 month
- Recurrent Respiratory tract Infections (sinusitis, tonsillitis, otitis media , pharyngitis)
- Herpes Zoster
- Angular Cheilitis
- Recurrent Oral ulcerations
- Popular Pruritic Eruptions
- Fungal nail Infections
- Seborrheic Dermatitis
- Unexplained Persistent Fever > 1 month
- Persistent oral candidiasis
- Oral Hairy Leukoplakia Pulmonary TB.
- Recurrent /Severe Bacterial Infections (Pneumonia , Empyema,
- Pyomyosities, Bone or joint Infections , meningitis , Bacteremia)
- Unexplained pancytopenia (anemia -< 8gm/dl, neutropenia<
- 0.5*109 , or thrombocytopenia < 50*109 /L)
- PCP (Pneumocystis (Jirovicini) Pneumonia)
- Esophageal Candidiasis (candidiasis of Trachea , Bronchi or Lungs)
- Extra Pulmonary Tuberculosis
- Kaposi Sarcoma
- CMV Infections (Retinitis or infection of Other Organs)
- CNS Toxoplasmosis
- Extra pulmonary Cryptococosis (eg . Meningitis)
- Disseminated Non tuberculosis mycobacterial Infections
- PML (Progressive Multi focal Leukoencephalopathy)
- Chronic Isosporiasis
- Chronic Crypto Sporadiosis)
- CNS Lymphoma (B_ Cell NHL)
- Recurrent Septicemia (Including non-typhoid Salmonella)
- Invasive Cervical Carcinoma
- Visceral Leishmaniosis
- Atypical Disseminated Leishmaniosis

Annex 6b. Clinical Conditions that make eligible for HIV Testing Service in children

- Persistent Generalized Lymphadenopathy
- Unexplained persistent hepatosplenomegaly
- Recurrent or chronic upper respiratory tract infections (Otitis media, Otorehea, sinusitis, tonsillitis)
- Herpes Zoster
- Lineal gingival erythema
- Recurrent oral ulceration
- Popular Pruritic eruptions
- Fungal nail Infections
- Extensive wart virus infections
- Extensive molluscum contagiosum
- Unexplained malnutrition(moderate or severe) not responding to therapy
- Unexplained persistent diarrhea (> 14 days)
- Unexplained persistent fever (>1month)
- Persistent oral candidiasis (after 6weeks of life)
- Oral hairy leukoplakia
- Lymph node TB Pulmonary TB
- PCP (Pneumocystis jiroveci Pneumonia)
- Recurrent severe bacterial infections (Empyema, Pyomyosities, Bone or joint Infections , meningitis , Bacteremia excluding pneumonia)
- Esophageal Candidiasis (candidiasis of Trachea , Bronchi or Lungs)
- Extra Pulmonary Tuberculosis
- Kaposi Sarcoma
- CMV Infections (Retinitis or infection of Other Organs with onset at age more than 1 month)
- CNS Toxoplasmosis (after neonatal period)
- Extra pulmonary Cryptococosis (eg. Meningitis)
- Disseminated Non tuberculosis mycobacterial Infections
- PML (Progressive Multi focal Leukoencephalopathy)
- Chronic Isosporiasis
- Chronic Crypto Sporadiosis)
- CNS Lymphoma (B_ Cell NHL)
- Symptomatic lymphoid Interistial pneumonitis
- Acute necrotizing ulcerative gingivitis
- Unexplained anemia , neutropenia or chronic thrombocytopenia
- Severe recurrent pneumonia

Annex 6b. Clinical Conditions that make eligible for HIV Testing Service in children

- Excessive dryness of the skin (Xerosis cutis)
- Scabies
- STI (Sexually Transmitted Infections)
- Herpes Zoster
- Popular Pruritic Eruptions
- Fungal nail Infections (Dermatophytosis, thrush, deep fungal infections)
- Seborrheic Dermatitis
- Kaposi Sarcoma
- Bacterial Skin Infections (Cellulitis, Impetigo, Carbuncle)
- Viral Infections (Recurrent Herpes Simplex infections on the mouth, Genital Herpes Simplex Infection)
- Genital warts

Annex 7: Dosage of antiretroviral drugs for adults and adolescents

Nucleoside reverse-transcriptase inhibitors (NRTIs)	
Abacavir (ABC)	300 mg twice daily or 600 mg once daily
Emtricitabine (FTC)	200 mg once daily
Lamivudine (3TC)	150 mg twice daily or 300 mg once daily
Zidovudine (AZT)	250–300 mg twice daily
Nucleotide reverse-transcriptase inhibitors (NtRTIs)	
Tenofovir (TDF)	300 mg once daily
Non-nucleoside reverse-transcriptase inhibitors (NNRTIs)	
Efavirenz (EFV)	400–600 mg once daily
Etravirine (ETV)	200 mg twice daily
Proteases inhibitors (PIs)	
Atazanavir + ritonavir (ATV/r)	300 mg + 100 mg once daily
Darunavir + ritonavir (DRV/r)	800 mg + 100 mg once dailya or 600 mg + 100 mg twice dailyb
Lopinavir/ritonavir (LPV/r)	400 mg/100 mg twice daily
	Considerations for individuals receiving TB therapy
	In the presence of rifabutin, no dose adjustment required. In the presence of rifampicin, adjusted dose of LPV/r: LPV 800 mg + RTV 200 mg twice daily or LPV 400 mg + RTV 400 mg twice daily).or, SQV/r (SQV 400 mg + RTV 400 mg twice daily), with close monitoring.
Integrase strand transfer inhibitors (INSTIs)	
Dolutegravir (DTG)	50 mg once daily
Raltegravir (RAL)	400 mg twice daily

a For individuals with no previous use of protease inhibitors.

b For individuals with previous use of proteaseinhibitors.

Annex 8: Dosage of antiretroviral drugs in children

Table 8a: Solid and oral liquid formulations for **once-daily dosing** for infants and children > 4 weeks of age

Drug	Formulations (tablet, capsule or oral liquid) and strength (mg/tab. or mg/ml for liquids)	Dose as number of tablets by weight band					Adult tablets & strength in mg	Dose as number of tablets or ml by weight band	
		3– 5.9Kg	6-9.9kg	10-13.9kg	14-19.9kg	20-24.9kg		25-29.9kg	30-34.9kg
DTG	50mg tablet	-	-	-	-	1	50mg	1	1[a]
DTG**	10mg tablet (scored, dispersible)	0.5	1.5	2	2.5	Use the film coated DTG 50mg tablet, 1 tablet daily.			
DRV [b]	600mg tablet	-	-	-	1	1	600mg	1	1
	150mg tablet	-	-	-	4	4			
RTV [c]	25mg tablet				4	4	100mg	1	1
	50mg tablet				2	2			
ABC/3TC	120mg/60mg (scored, dispersible tablet)	1	1.5	2	2.5	3	600mg/300mg	1	1
ABC/3TC	60mg/30mg (scored, dispersible tablet)	2	3	4	5	6	600mg/300mg	1	1
EFV [d]	200mg tablet	-	-	1	1.5	1.5	200 tab	2	2
	50mg capsule	-	-	4	6	6	600mg		

Table 8b: Solid and oral liquid formulations **for twice-daily dosing** for infants and children > 4 weeks of age

Drug	Formulations (tablet, capsule or oral liquid) and strength (mg/tab. or mg/ml for liquids)	Dose as number of tablets/capsules or ml by weight band, morning (AM) and evening (PM)										Adult tablets and their strength in mg	Dose by weight band	
		3 – 5.9Kg		6-9.9 kg		10-13.9kg		14-19.9kg		20-24.9 kg			25 – 34.9 KG	
		AM	PM	AM	PM	AM	PM	AM	PM	AM	PM		AM	PM
Solid formulations														
ABC/3TC	120mg/60mg (scored, dispersible tab)	0.5	0.5	0.5	1	1	1	1	1.5	1.5	1.5	600mg/300mg tab	0.5	0.5
AZT/3TC	60mg/30mg (scored, dispersible tab)	1	1	1.5	1.5	2	2	2.5	2.5	3	3	300mg/150mg tab	1	1
LPV/r [b,c]	100mg/25mg tablet	-	-	-	-	2	1	2	2	2	2	-	3	3
	40mg/10mg oral pellets per capsule	2	2	3	3	4	4	5	5	6	6	200mg/50mg	2	1
DRV	75mg tablet	-	-	-	-	-	-	5	5	5	5	-	-	-
RTV	25mg tablet	-	-	-	-	-	-	2	2	2	2	100mg tab	2	2
RAL	100 mg, chewable tablet	-	-	-	-	-	-	1	1	1.5	1.5	400mg tab	1	1
	25mg, chewable tablet	1	1	2	2	3	3	4	4	6	6		1	1
Liquid formulations														
AZT	10mg/ml	6ml	6ml	9ml	9ml	12ml	12ml	-	-	-	-		-	-
NVP d	10mg/ml	5ml	5ml	8ml	8ml	10ml	10ml	-	-	-	-		-	-
LPV/r e	80mg/20mg/ml	1ml	1ml	1.5ml	1.5ml	2ml	2ml	2.5ml	2.5ml	3ml	3ml		-	-
RTV	80mg/ml	0.5ml	0.5ml	0.5ml	0.5ml	0.5ml	0.5ml	-	-	-	-		-	-

c RTV should only be used as a boosting agent in combination with DRV.

d Two EFV 50mg capsules is administered in combination with EFV 200mg tablet for children weighing 14-24.9KG.

Annex 9: Pediatric ARV drug formulations, side effects and special considerations in children

Drug / Formulation	Dosing recommendation and instructions	Side Effects
Nucleoside reverse transcriptase		
Lamivudine (3TC) : Formulations: Fixed-Dose Combination Tablets ■ With Abacavir : 3TC60mg+120mgABC, scored and dispersible tablet With Zidovudine :	**Instruction for dosing/administration:** ■ Can be given with food. ■ For those who can't swallow whole tablet, dispersible tablets can be dissolved with 2 teaspoons (10ml) water in a small and clean container and taken immediately. ■ Scored tablets can be broken to administer lower doses for younger children as recommended in the national ART guidelines. **Note:** ■ Adult formulations are to be used for children older than 10 years with body weight > 35kg. ■ Please see dosing Chart for dose recommendation. ■ Storage: ■ Can be stored at room temperature	Side effects of 3TC: **Common:** head ache, nausea, abdominal pain. **Less common:** pancreatitis, neutropenia, increased LFTs. Hepatitis may exacerbate after discontinuation of lamivudine in the setting of chronic Hepatitis B virus infection. For those patients with HBV and HIV co-infection please consult "the national guideline on management of HBV infection-2021."
Abacavir (ABC) : **Formulations:** Fixed-Dose Combination Tablets With Lamivudine : ABC120mg+3TC60mg, scored and dispersible tablet	**Instruction for dosing/administration:** ■ Can be given with food. ■ For those who can't swallow whole tablet, dispersible tablets can be dissolved with 2 teaspoons (10ml) water in a small and clean container and taken immediately. ■ Scored tablets can be broken to administer lower doses for younger children as recommended in the national ART guidelines. **Note:** ■ **Adult formulations are to be used for children older than 10 years with body weight > 35kg.** ■ Please see dosing Chart for dose recommendation. **Storage:** ■ Can be stored at room temperature	Side effects of ABC: **Common:** head ache, GI upset and rash. **Less common:** lactic acidosis, hepatomegaly with steatosis. **Life threatening:** potentially fatal hypersensitivity reaction (fatigue, rash, nausea and vomiting, sore throat, joint and muscle pain, cough, and dyspnea). Occurrence of hypersensitivity reactions requires **immediate and permanent discontinuation** of ABC. Advise patients/care givers what to do if hypersensitivity reactions occur at home. **DO NOT** re-challenge after hypersensitivity reaction.

Drug / Formulation	Dosing recommendation and instructions	Side Effects
Zidovudine (AZT or ZDV) **Formulations:** Oral solution, 50mg/5ml, 100 ml	**Instruction for dosing/administration:** ■ Can be given with food. ■ The syrup is for infant prophylaxis. ■ For those who can't swallow whole tablet, dispersible tablets can be dissolved with 2 teaspoons (10ml) water in a small and clean container and taken immediately. ■ Scored tablets can be broken to administer lower doses for younger children as recommended in the national ART guidelines. **Note:** ■ Adult formulations are to be used for children older than 10 years with body weight > 35kg. ■ Please see dosing Chart for dose recommendation. **Storage:** ■ Can be stored at room temperature ■ Syrup is light sensitive, store in a brown glass jar and protect from sun light.	Side effects of AZT: **Common:** neutropenia, anemia, granulocytopenia, macrocytosis, and head ache. **Less common:** myositis, myopathy, mitochondrial disease.
Nucleotide reverse transcriptase inhibitor		
Tenofovir (TDF)	TDF is only approved for use for children 2 years and older. Target dose: 8 mg/kg or 200 mg/m2 (maximum 300 mg). In case of TDF toxicity, substitute with AZT or ABC. Do not initiate TDF at eGFR <50 mL/min.	Chronic kidney disease Acute kidney injury and Fanconi syndrome Decreases in bone mineral density Lactic acidosis or severe hepatomegaly with steatosis

Drug / Formulation	Dosing recommendation and instructions	Side Effects
Non-nucleoside reverse transcriptase:		
Efavirenz (EFV) Formulations: Efavirenz 200 mg, scored tablet. Efavirenz 50 mg, tablet or capsule	**Instructions for dosing/administration:** ■ **Used only for children > 3 yrs.** ■ Can be given with food but avoid administration with a high-fat meal because of potential for increased absorption that leads to CNS toxicity. ■ Bedtime dosing is recommended, particularly during the first 2 to 4 weeks of therapy, to improve tolerability of central nervous system side effects. ■ Scored tablets can be broken to administer lower doses for younger children as recommended in the national ART guidelines. ■ Efavirenz can be swallowed as a whole capsule or tablet. For children who can't swallow the whole capsule/tablet, the capsule content can be administered by sprinkling on food to avoid/mask peppery taste of EFV. **For sprinkling:** ■ Hold capsule horizontally over a small container and carefully twist to open to avoid spillage. ■ Gently mix capsule contents with 1–2 teaspoons of an age-appropriate soft food (e.g. yogurt or banana or infant formula milk) at room temperature. ■ Administer the mixture that contains the sprinkle using a 10-mL syringe. ■ After administration, an additional 2 teaspoons of food or infant formula must be added to the container, stirred, and dispensed to the patient. Note: ■ **Adult formulations are to be used for children older than 10 years with body weight > 35kg.** ■ **Please see dosing Chart for dose recommendation.** Storage: ■ Can be stored at room temperature.	Side effects of EFV: Common: skin rash, dizziness, somnolence, insomnia, abnormal dreams, confusion, hallucinations, impaired concentration, psychosis, seizures, and suicidality. Less common: increased LFTs.

Drug / Formulation	Dosing recommendation and instructions	Side Effects
Nevirapine (NVP) **Formulations:** Nevirapine oral syrup, 50mg/5ml (10mg/ml)	**Instructions for administration:** Can be given with food. The syrup is for infant prophylaxis **Storage:** Store at room temperature.	Side effects of NVP: **Common:** skin rash, head ache, nausea, diarrhea. Patients should be warned of rash. Do not escalate dose if rash occurs. **Less common:** increased LFTs. Life threatening: Steven Johnsons syndrome, TEN, fatal hepatitis. For SJS and TEN discontinue drug and do not re-challenge.
Protease Inhibitors		
Lopinavir (LPV) **Formulations:** Combined with Ritonavir: Oral syrup, (LPV 80mg+RTVLPV20mg)/ml Oral pellets, (LPV40mg+Ritonavir10mg) / capsule Tablet, (LPV100mg+Ritonavir25mg)	**Instructions for administration:** ■ Do not administer to neonates before a post-menstrual age of 42 weeks and a postnatal age of at least 14 days. ■ Should be taken with food. ■ For the capsules: open the capsules, add the pellets from the capsule content onto small soft or milk (not more than 2ml) and administer immediately. ■ Tablets should not be opened or crushed, swallow whole. Tablets are for older children. ■ Liquid has low volume but bitter taste. Caution: Multiple drug interactions. **Note**: ■ **Adult formulations are to be used for children older than 10 years with body weight > 35kg.** ■ **Please see dosing Chart for dose recommendation.** **Storage**: ■ For the syrup, store it in a refrigerator at least until dispensed. Can be stored at room temperature (250C) for 60 days. ■ For tablets and oral pellets, store at room temperature.	Side effects of LPV **Common:** diarrhea, head ache, nausea, vomiting,, increase in blood lipids **Less common:** pancreatitis, diabetes, hyperglycemia, hepatic toxicity, fat redistribution.

Drug / Formulation	Dosing recommendation and instructions	Side Effects
Ritonavir (RTV) **Formulations:** Combined with Lopinavir or Atazanavir:	Take with food to increase absorption and reduce GI side effects. Oral solution must be refrigerated. Can be kept at room temperature (250C) if used within 30 days. Bitter taste, coat mouth with peanut butter or chocolate milk.	Side effects of RTV: **Common:** N/V, diarrhea, headache, abdominal pain, anorexia **Less Common:** circumoral paraesthesia, increased LFTs, lipodystrophy, elevated cholesterol and triglycerides, hyperglycemia.
Danuravir (DRV) 75 mg tab; chewable tablets 25 mg; 100 mg/ml liquid	Substitute with LPV/r. When it is used in third-line ART, limited options are available. For hypersensitivity reactions, substitute with another therapeutic class.	Hepatotoxicity; severe skin and hypersensitivity reactions

Annex 10: Grading of toxicity in adults and adolescents

Item	Grade 1 (Mild toxicity)	Grade 2 (Moderate toxicity)	Grade 3 (Severe toxicity*)	Grade 4 (Severe life-threatening toxicity)
Peripheral neuropathy	■ Transient or mild discomfort, no limitation of activity. ■ No medical intervention/ treatment required.	■ Moderate limitation of activity, some assistance might be needed. ■ Non-narcotic analgesia required.	■ Marked limitation in activity, some assistance usually required, medical intervention/ therapy required, and hospitalization possible. ■ Severe discomfort and/ or severe impairment (decrease or loss of sensation up to knees or wrists) narcotic analgesia required.	■ Life-threatening, extreme limitation in of activity, significant assistance required, significant medical intervention/ therapy required, hospitalization/ hospice care. ■ Incapacitating or not responsive to narcotic analgesia. ■ Sensory loss involves limbs and trunk.
Cutaneous/Rash/ Dermatitis**	Erythema, pruritus	Diffuse, maculopapular rash or dry desquamation	Vesiculation or moist desquamation or ulceration*	Erythema multiforme or suspected Stevens-Johnson syndrome or Toxic Epidermal Necrolysis (TEN).
Management	Continue ARV; provide careful clinical monitoring; and consider change of a single drug if condition worsens.		Substitute responsible drug	Stop ARV and consult experienced physician.

Annex 11- Grading of adverse events in children

Parameter	Grade 1 Mild	Grade 2 Moderate	Grade 3 Severe	Grade 4 Severe Life-threatening
Diarrhoea ≥1 year of age <1 year of age	Transient or intermittent episodes of unformed stools OR increase of ≤3 stools over baseline per day. Liquid stools (more unformed than usual) but usual in number.	Persistent episodes of unformed to watery stools or increase of 4-6 stools over baseline per day. Liquid stools with increased number of stools or mild dehydration.	Grossly bloody diarrhea or increase of ≥7 stools per day or IV fluid replacement indicated. Liquid stools with moderate dehydration.	Life-threatening consequences (e.g. Hypotensive shock). Liquid stools resulting in severe dehydration with aggressive rehydration indicated or hypotensive shock.
Nausea	Transient (<24 hours) or intermittent nausea with no or minimal interference with oral intake.	Persistent nausea resulting in decreased oral intake for 24-48 hours.	Persistent nausea resulting in minimal oral intake for >48 hours or aggressive rehydration indicated (e.g. IV fluids).	Persistent nausea with no or minimal oral intake resulting in dehydration with aggressive rehydration indicated.
Vomiting	Transient or intermittent vomiting with no or minimal interference with oral intake.	Frequent episodes of vomiting with no or mild dehydration.	Persistent vomiting resulting in orthostatic hypotension or aggressive rehydration indicated (e.g. IV fluids).	Life threatening consequences (e.g. hypotensive shock).
Acute systemic allergic reaction	Localized urticaria (wheals) lasting a few hours.	Localized urticaria with medical intervention indicated or mild angio oedema.	Generalized urticaria or angio oedema with medical intervention indicated or symptomatic mild bronchospasm.	Acute anaphylaxis or life-threatening bronchospasm or laryngeal oedema.

Pancreatitis	NA	Symptomatic and hospitalization not indicated (other than emergency treatment).	Symptomatic and hospitalization not indicated (other than emergency treatment).	Life-threatening consequences (e.g. Circulatory failure, haemorrhage, sepsis).
Rash	Localized macular rash	Diffuse macular, maculopapular, or morbilliform rash or target lesions.	Diffuse macular, maculopapular, or morbilliform rash with vesicles or limited number of bullae or superficial ulcerations of mucous membrane limited to one site.	Extensive or generalized bullous lesions or Stevens-Johnson syndrome or ulceration of mucous membrane involving two or more distinct mucosal sites or Toxic Epidermal Necrolysis.
Alteration in personality-behavior or mood	Alteration causing no or minimal interference with usual social and functional activities	Alteration causing greater than minimal interference with usual social and functional activities.	Alteration causing inability to perform usual social and functional activities and intervention indicated.	Behavior potentially harmful to self or others or with life-threatening consequences.
Altered Mental Status	Changes causing no or minimal interference with usual social and functional activities	Mild lethargy or somnolence causing greater than minimal interference with usual social and functional activities.	Onset of confusion, memory impairment, lethargy, or somnolence causing inability to perform usual social and functional activities.	Onset of delirium, obtundation, or coma.
Source: Antiretroviral therapy of HIV infection in infants and children in resource-limited settings. WHO 2006				

Annex 12. Laboratory grading of adverse events in adults and adolescents (ACTG)

Laboratory Test Abnormalities				
Item	**Grade 1 toxicity**	**Grade 2 toxicity**	**Grade 3 toxicity**	**Grade 4 toxicity**
Haemoglobin	8.0-9.4 g/dL	7.0-7.9 g/dL	6.5-6.9 g/dL	<6.5 g/dL
Absolute Neutrophil Count	1,000-1,500 mm3	750-990 mm3	500-749 mm3	<500 mm3
Platelets	-75,0000- 99,000	50,000-74,999	20,0000-49,999 mm3	<20,000
ALT	1.25-2.5 X upper normal limit	2.5-5 X upper normal limit	5.0-10 X upper normal limit	10 X upper normal limit
Bilirubin	1-1.5XULN	1.5-2.5 X ULN	2.5-5 x upper limits of normal	>5 x upper limits of normal
Amylase/lipase	1-1.5XULN	1.5-2 X ULN	2-5 x upper limits of normal	>5x upper limits of normal
Triglycerides *	200-399mg/dL	400-750 mg/dL	751-1200mg/dL	>1200mg/dL
Cholesterol *	1.0 –1.3 X Upper normal limit	1.3-1.6 X Upper normal limit	1.6-2.0 X Upper normal limit	2.0 X Upper normal limit
Management	Continue ARV Repeat test 2 weeks after initial test and reassess		Substitute responsible drug	Stop ARV and consult experience physician
	Lipid imbalances could be managed with diet, exercise and pharmacologically with the use of fibrates. ALWAYS SEEK EXPERT ADVICE IN CASE OF DOUBT			

Grade 1 (Mild reaction): are bothersome but do not require changes in therapy
Grade 2 (Moderate reaction): consider continuation of ART as long as feasible. If the patient does not improve in symptomatic therapy, consider single-drug substitution.
Grade 3 (Severe reaction): Substitute offending drug without stopping ART. Closely monitor using laboratory and clinical parameters.
Grade 4 (Severe life-threatening reaction): Immediately discontinue all ARV drugs, manage the medical event with symptomatic and supportive therapy, and reintroduce ARV drugs using a modified regimen (i.e. with an ARV substitution for the offending drug) when the patient is stabilized. Life-threatening toxicity includes severe hepatitis, pancreatitis, lactic acidosis or Steven-Johnson syndrome.

Annex 13 -Grading toxicities in children by selected laboratory findings

Parameter	Grade 1 Mild	Grade 2 Moderate	Grade 3 Severe	Grade 4 Severe Life threatening
Haemoglobin (g/dL)	8.5 – 10.0	7.5 –<8.5	6.5 – <7.5	<6.5
ANC (mm3)	750 – <1,000	500 – 749	250 – 500	<250
Platelets (mm3)	100,000 – <125,000	50,000– <100,000	25,000 – <50,000	<25,000 or bleeding
ALT (SGPT)	1.25 – 2.5 x ULN	2.6 – 5.0 x ULN	5.1 – 10.0 x ULN	>10.0 x ULN
AST (SGOT)	1.25 – 2.5 x ULN	2.6 – 5.0 x ULN	5.1 – 10.0 x ULN	>10.0 x ULN
Bilirubin (>2 weeks of age)	1.1 – 1.5 x ULN	1.6 – 2.5 x ULN	2.6 – 5.0 x ULN	>5.0 x ULN
Lipase	1.1 – 1.5 x ULN	1.6 – 3.0 x ULN	3.1 – 5.0 x ULN	>5.0 x ULN
Pancreatic amylase	1.1 – 1.5 x ULN	1.6 – 2.0 x ULN	2.1 – 5.0 x ULN	>5.0 x ULN
Cholesterol (fasting, <18 years old) mg/dL	170 – <200	200 – 300	>300	NA
Glucose, serum, Nonfasting (mg/dL)	116 – <161	161 – <251	251 – 500	>500
Glucose, serum, high: Fasting (mg/dL)	110 – <126	126 – <251	251 – 500	>500
Lactate	<2.0 x ULN without acidosis	2.0 x ULN without acidosis	Increased lactate with pH <7.3 without life threatening consequences or related condition present	Increased lactate with pH <7.3 with life threatening consequences (e.g. neurological findings, coma) or related condition present
Triglycerides: Fasting (mg/dL)	NA	500 – <751	751 – 1,200	>1,200

Source: Antiretroviral therapy of HIV infection in infants and children in resource-limited settings. WHO 2006

Annex 14: Pediatric TB screening tool

		Follow Up Visit				
Children TB screening questions		**Date:**	**Date:**	**Date:**	**Date:**	**Date:**
1. Current cough						
2. Fever						
3. Poor weight gain*						
4. Close Contact history with TB pt.						
*poor wt gain = reported wt loss, very low wt (<-3 Z-score), or underwt (< -2 Z-score), or confirmed wt loss (> 5%) since the last visit, or growth curve flattening						
Evaluation for positive TB screening						
Bacteriology: Gastric Aspirate/ Induced sputum/ Sputum for AFB	date ordered					
	date result received					
	result (+, -ve, Not Done)					
Radiology: CxR, etc.	date ordered					
	date received					
	result (Suggestive, inconclusive, other dx, Not Done)					
Other: FNA, etc	date ordered					
	date received					
	result (+, -ve, Not Done)					
TB diagnosis date: / / Circle type of TB: PTB :- smear pos, smear neg, EPTB TB Rx start date / /						
Is the child eligible for IPT? Yes___ No____ If no, reason If yes, start IPT and use the chart below						
Contraindications for IPT: Active TB, active hepatitis, allergy to INH, peripheral neuropathy						

Date INH collected	TB Symptoms [cough, fever, failure to gain wt or wt loss] (yes, no)	Hepatitis Sx [abd pain, nausea, vomiting, abnormal LFT] (yes, no)	Neurologic Sx [numbness, tingling, paresthesia](yes,	Rash (yes, no)	Adherence (≥95% =good; 85-94%= Fair <85%=Poor)	Remark
___/____/__						
___/___/___						
___/___/___						
___/___/___						
___/___/___						
___/___/___						

Outcome of IPT (Write Date): Completed __ /___ /____ Defaulted____ /____ /____Died ____ /____ /____ /

Interrupted for any reason_____ /_____ /_____

Note:

- If there are symptoms suggesting TB during follow up, stop INH and work up for TB.
- If there are symptoms suggesting hepatitis, hold INH. Can resume when liver function normalizes.
- If there are neurologic symptoms, continue INH and give pyridoxine 50mg daily. This side effect is rare if the child is already on pyridoxine skin rash is very rare, if occurs and is extensive, discontinue INH, and give anti histamine.

Annex 15: Adult TB screening tool

		Follow Up Visit				
Children TB screening questions		**Date:**	**Date:**	**Date:**	**Date:**	**Date:**
1. Current cough						
2. Fever						
3. Weight lose						
4. Night seats						
Evaluate for TB if "yes" to anyone of the above (positive TB screening)						
Bacteriology: Sputum for AFB (+/- induced)	Done = yes/no					
	result (+, -ve, unknown)					
Radiology: CxR, etc.	Done = yes/no					
	Result (Suggestive, inconclusive, other dx, Not Done)					
FNA, culture, ultrasound etc	Done = yes/no					
	If done result					
TB diagnosed	Yes (write type of TB)/No					
Is patient eligible for IPT	Yes/No					
Contraindications for IPT: Active TB, active hepatitis, allergy to INH, peripheral neuropathy						
IPT start date _____						

Date INH collected	TB Symptoms [cough, fever, failure to gain wt or wt loss] (yes, no)	Hepatitis Sx [abd pain, nausea, vomiting, abnormal LFT] (yes, no)	Neurologic Sx [numbness, tingling, paresthesia](yes,	Rash (yes, no)	Adherence (≥95% =good; 85-94%= Fair <85%=Poor)	Remark
___/____/__						
___/___/___						
___/___/___						
___/___/___						
___/___/___						
___/___/___						

Outcome of IPT (Write Date): Completed __/___/____

Defaulted__/___ /_____Died/___/____/Patient stopped_____/_____/_____

Stopped _____/_____/_____Transferred out ___/___/____

Annex 16: Follow-up form for Clients Whose Viral Load Result >50 copies/ml

1. Patient Information		
Name: _____Age: ___ Sex: __ UAN: _____MRN:_____		
2. ARV Information		**Viral Load Results**
ARV Regimen (circle the regimen type) 1. 1st line 2. 2nd line 3. 3rd line	Date of Initiation (dd/mm/yy) e.c: ____/____/____ ____/____/____ ____/____/_____	1st result>50 copies/ml: _____Copies/ml Date: ____/____/____ Date of 1st EAC1 given: ____/__/___ Cohort Month: _____ (Refer High VL Register)

3. Communicate the viral load test result and explain the following to the client
■ Viral Load is the number of HIV copies in the blood
■ High VL result can be due to poor adherence to medication or can be due to primary resistance.
■ When VL result is high in the blood, the CD4 count decreases, OIs will flare up and disease progresses.
■ High VL can be reduced as a result of good adherence to medication within three months.
■ Note: Enhanced Adherence Counseling(EAC) will be provided for 1st results >50 copies/ml

4. Assess current adherence to treatment and document				
4.1. How many ARV dose/s do you take/day? Once or Twice				
4.2. Did you miss ARV doses in the past one month? Yes/No				
	Adherence Rate	**>95%, Good**	**85-94%, Fair**	**<85%, Poor**
4.3. If yes, how many dose/s did you miss? __ (select one)	Once per day	≤ 2 doses	3-4 doses	≥ 5 doses
	Twice per day	≤ 3 doses	4-9 doses	≥ 9 doses

5. Explore Medical and Psychosocial Reasons for High VL	
5.1. Identify Medical Reasons for High Viral Load	EAC-1 Session
5.1.1. Did you take other drugs than ARVs without consulting your physician? (Yes, No), If Yes, identify the drug/s, review interaction with ARVs, counsel the client & take measure	
5.1.2 Have you ever developed recurrent OIs including cough, fever, weight loss, night sweat, diarrhea, and vomiting in the past? (Yes, No). If yes, investigate for TB and chronic diarrhea and manage	
5.1.3. Have you ever developed severe ARV drugs side effects in the past? (Yes, No), If Yes, investigate and manage for ARVs side effects.	
5.1.4 Have you ever taken ART/PMTCT prophylaxis in the past prior to ART initiation? (Yes, No), If Yes, suspect primary resistance and consult ART physician	
5.1.5. Did you discontinue your ARV in the past? (Yes, No), If Yes, identify reasons and develop treatment plan with the client.	
5.1.6 If the client is a child, check proper dosing for weight by reviewing chart and readjust ARV dosing for weight	
5.2 Identify Psychosocial Reasons for High Viral Load	
5.2.1 Cognitive barriers: understanding and expectation - counsel and explain expected outcomes ■ What were the reason/s for missing your ARV dose/s in the past? Identify the reason/s, counsel and motivate the client to develop medication taking plan.	
5.2.2. Socio-economic barriers: lack of social support, disclosure, stigma, & poor living condition ■ Have you disclosed your HIV status to anyone? If No, provide disclosure counseling and encourage ■ Do you have treatment supporter? (Yes, No) If No, counsel to designate treatment supporter	
5.2.3 Behavioral barriers: attitude, motivation, confidence & skills educate, motivate, and empower client to manage medication taking and develop reminder ■ What do you do to remind yourself to take drugs on time? ■ Are you confident to take your ARV openly at home? If no, advise reminder mechanisms	
5.2.4 Psychological/Emotional barriers: common mental illness: depression, PTSD, substance abuse, and psychosis – link to psychiatric clinic for psychotherapy & treatment ■ Have you ever felt sad for more than 2 weeks? Have you ever lost interest in activities that usually give you pleasure for more than 2 weeks? Have you regularly taken alcohol or chew Khat? If yes, counsel the client to avoid alcohol and/or Khat.	

6. Follow-up EAC Sessions																
6.1. Assess current adherence to treatment and circle adherence rate		Subsequent EAC Sessions						Repeat three EAC Sessions for clients whose confirmatory viral load > 50 and ≤ to 1000 copies/ml(Low Level Viremia)								
		Rate at EAC-2			Rate at EAC-3			Rate at EAC-1			Rate at EAC-2			Rate at EAC-3		
		>95% Good	85 to 94% Fair	<85% Poor	>95% Good	85 to 94% Fair	<85% Poor	>95% Good	85 to 94% Fair	<85% Poor	>95% Good	85 to 94% Fair	<85% Poor	>95% Good	85 to 94% Fair	<85% Poor
6.2. If Yes, how many dose/s did you miss?	One per day	≤ 2	3-4	≤ 2	3-4	≥ 5	≤ 2	≤ 2	3-4	≤ 2	≤ 2	3-4	≤ 2	≤ 2	3-4	≤ 2
	Two per day	≤ 3	4-9	≤ 3	4-9	≥ 9	≤ 3	≤ 3	4-9	≤ 3	≤ 3	4-9	≤ 3	≤ 3	4-9	≤ 3
7. Follow-up status of identified Reasons for High VL		EAC 2			EAC 3			EAC-1			EAC-2			EAC-3		
		Date: ___/___/_____			Date: ___/___/_____			Date: ___/___/_____			Date: ___/___/_____			Date: ___/___/_____		
7.1. Medical reason/ s(y/N)																
7.2 Psychosocial																
7.2.1. Cognitive barriers(Y, N):																
7.2.2. Socio-economic barriers(Y,N):																
7.2.2. Behavioral Barriers(Y,N)																
7.2.3. Psychological/ emotional(Y,N):																
8. Outcome of EAC Sessions																

Did the patient attend all the appointments? (Yes No) If no, any reason? _____

Note: Client should have three consecutive good adherences before confirmatory(2nd) VL test

2nd Viral Load - Date ordered: __/__/___, 2nd Viral Load Result: _____ copies/ mL, Date Received __/__/___,

Measure Taken

1. Continue 1st Line, 2. Continue 2nd line 3. Continue Third line 4. Switched to 2nd Line, 5. Switched to 3rdLine

Comment: _____ ART Physician:/ART clinician _____Date: ____/____/_____

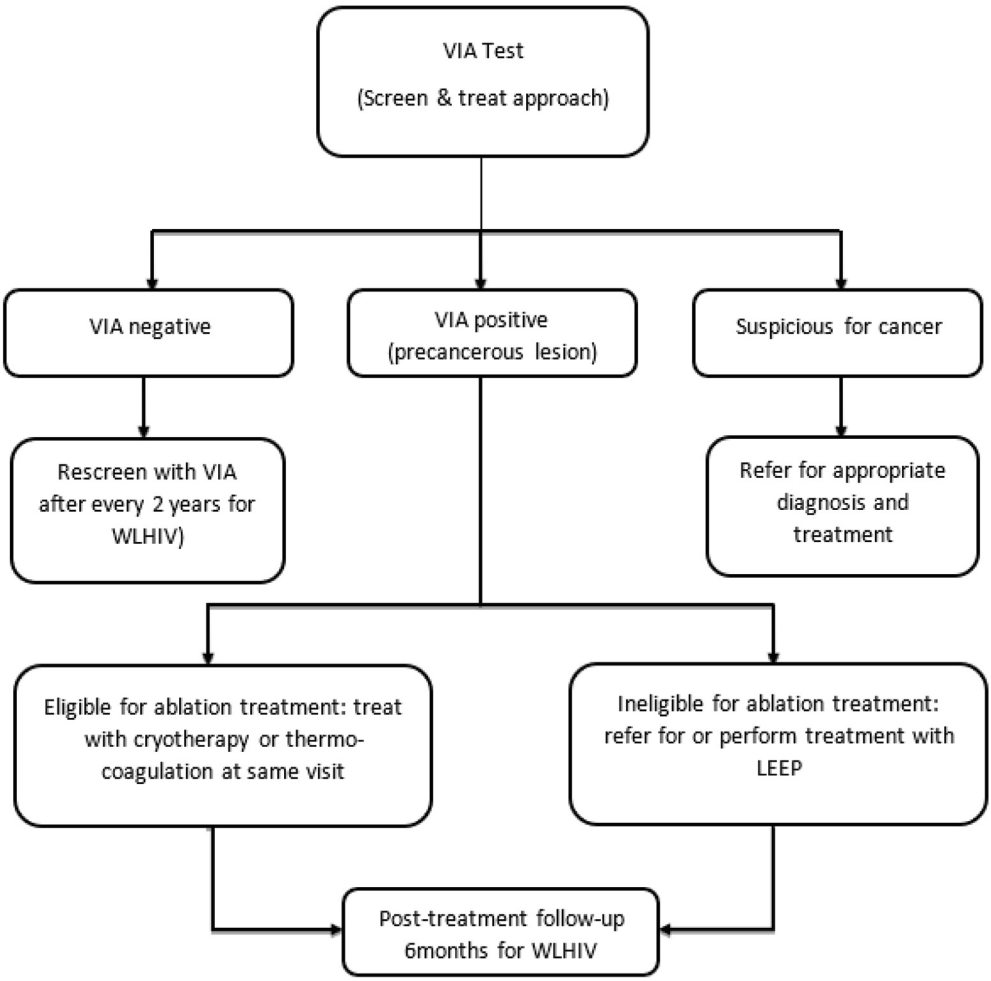
Annex 17 Cohort register for clients with unsuppressed viral load(>50copies/ml)

Cohort Register for client with Unsuppressed Vial Load(>50 copies/ml)

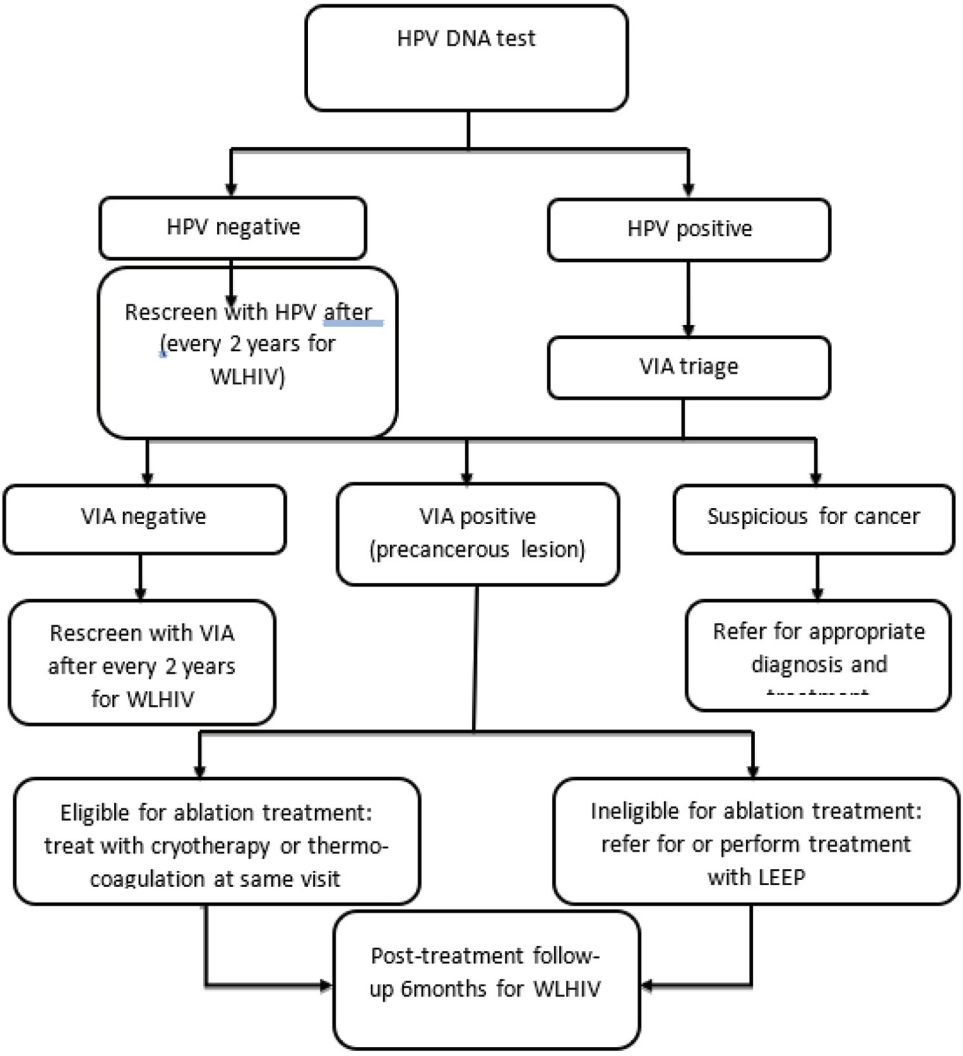
Facility Name: _____ Month:_____ Year:_____

SN	Name of Client	UAN	MRN	Age	Sex	Address (Kebele & Telephone)	PMTCT Clinic Only		Current Regimen (select one) 1st Line 2nd Line 3rd Line	1st VL Test	Code for 1st VL result	EAC Session Date		2nd VL Test	Repeat Three Session		Measure Taken (code) 1= Remain on 1st line 2= Remain on 2nd line 3= Remain on 3rd line 4= Remain on 2nd line 5= Remain on 3rd line	Reason if measure not taken	Measure Taken Date	Remark
							Pregnant	Postnatal		Order Date	1. >1000 c/ml	Three Consecutive EAC's		Order Date	For clients whose confirmatory vial Load >50 and ≤1000 copies /ml (Low Level Viremia)			1. TO 2. Lost 3. Died 4. Other, Specify		
							Gestational Age (Months)	Breast Feeding (Yes/No)		Recieved Date	2. >50 to ≤1000 c/ml			Recieved Date						
										VL Result				VL Result						
										__/__/__		EAC 1	__/__/__	__/__/__	EAC 1	__/__/__			__/__/__	
										__/__/__		EAC 2	__/__/__	__/__/__	EAC 2	__/__/__				
										VL=		EAC 3	__/__/__	VL=	EAC 3	__/__/__				
										__/__/__		EAC 1	__/__/__	__/__/__	EAC 1	__/__/__			__/__/__	
										__/__/__		EAC 2	__/__/__	__/__/__	EAC 2	__/__/__				
										VL=		EAC 3	__/__/__	VL=	EAC 3	__/__/__				

Annex 18: Screening with VIA testing using see and treat approach



Annex 19: Screening with HPV testing followed by VIA triage algorithm



Annex 20: Brief mental health disorders symptom screening tool and referral tool for PLHIV

Patient's Name:_____ Sex:_____ Age:_____ MRN:_____

This checklist is to assist you in assessing and making a timely referral of the client to the treatment team. All behaviors listed below are important and should be taken seriously; they are also designed to help you decide if you should refer the client to the treatment team for further assistance. An answer of "yes" to any one of the following questions should prompt further referral and evaluation by the treatment team or mental health professional. Please put a (√) to indicate a yes answer.

1. Questions to Identify Depression: In the past 3 months;

( ) Was there ever a time when you felt sad/ hopelessness for more than 2 weeks in a row?

( ) Was there ever a time lasting more than 2 weeks when you lost interest in most things like hobbies, work, or activities that usually give you pleasure?

2. Questions to identify suicidal ideation: Since your last visit [or in the last 2 months];

( ) Have you wished you were dead, or wished you could go to sleep and not wake up?

( ) Have you had actual thoughts of killing yourself?

( ) Have you ever attempted to harm/kill yourself?

3. Questions to Identify

Anxiety: In the past 3 months;

( ) Did you ever have a period lasting more than 1 month when most of the time you felt worried and anxious?

( ) Did you have a spell or an attack when all of a sudden you felt frightened, anxious, or very uneasy when most people would not be afraid or anxious?

( ) Did you ever have a spell or an attack when for no reason your heart suddenly started to race, you felt faint, or you couldn't catch your breath?

4. Questions to Identify Mania: In the past 3 months;

( ) When not high or intoxicated, did you ever feel extremely energetic or elated or irritable and more talkative than usual?

5. Questions to Identify Substance Abuse.

( ) Have you ever felt the need to cut down on your use of alcohol or drugs?

( ) Has anyone annoyed you by criticizing your use of alcohol or drugs?

( ) Have you ever felt guilty because of something you've done while drinking or using drugs?

( ) Have you ever taken a drink or used drugs to steady your nerves or get over a hangover (eye-opener)? A total of ≥2 may be suggestive of a problem.

6. Questions to Identify Psychosis: Observe or ask families whether the patient (in the last 3 months);

( ) Talking & acting strangely or becoming very quiet and avoid talking.

( ) Claiming to hear voices or see things that other people don't.

( ) Being very suspicions, perhaps claiming that other people are trying to harm him/her.

7. Questions to Identify Dementia: Interview the patient or families whether the patient (in the last 3 months);

( ) Has trouble with memory.

( ) Has poor concentration.

( ) Has diminished executive function.

( ) Has diminished orientation to time, place & person.

8. Questions to Identify Epilepsy:

( ) Did you ever have partial or generalized fits [sharp, shaky movements] accompanied by frothing or loss of control of bowel or bladder function, sudden loss of consciousness, and stiff limbs?

9. ( ) others

10. No identified mental health problem

Referred by: _____

Date: _____

Feedback(confirm the assessment)

The patient has:

(___) Mental Health Disorder (specify) _____

(___) Non Mental Health Disorder

Name of clinician: _____

Date: _____

The patient has:

(___) Mental Health Disorder (specify) _____

(___) Non Mental Health Disorder

Name of clinician: _____

Date: _____

Annex 21: DSD model of HIV care client classification tool/ Assessment form

A. Client's Current data(initial Assessment)

1. Client Name_____ **Fathers' Name** _____

Grand Fathers 'Name_____

For child only: - Mother's /Fathers Name: _____

2. Age: _____years/months for < 1years Sex: O M O F

3. Address: Region_____ Zone/Sub city_____Woreda_____

Kebele _____ House No._____ Telephone _____

4. Marital Status: O Never Married O Married O Divorced O Widowed

5. Level of education:

O No education O Primary O Secondary O Tertiary OOther/specify_____

6. Occupation: _____

7. Client reside within the catchments area O Yes O No , If no; Counsel and encourage for referral to a nearby facility to his/her home

8. Date ART started(EC)_____ Month on ART_____

9. Unique ART ID: _____ /_____ /_____/_____ MRN _____

10. Current ART regimen

□ First Line Regimen:_____ □ Date (ET) Initiated __/__/____ (dd/mm/yyyy)

□ Second Line Regimen:_____ □ Date (ET) Initiated __/__/____ (dd/mm/yyyy)

□ Third Line Regimen_____:_____ □ Date (ET) Initiated __/__/____ (dd/mm/yyyy)

11. Current ART Adherence □ Good >95% □ Fair (85 - 94%) □ Poor <85%

12. Is the client pregnant □Yes □No Breastfeeding □Yes □No

13. CD4 count (CD4% for <5 years): Most recent (<one Year) result ____cells/ul

Date (ET) ___/___/____

14. If VL test done: Most recent (<one year) result _____ copies/ml

15. Current Clinical observations/symptoms: WHO (Treatment) Staging:

□ I □ II □ III □ IV

B. Inclusion criteria for less intensive model

- Patients who are on ART at least six months
- No current illness, which does not include well-controlled chronic health conditions
- Good understanding of life long adherence; adequate adherence counseling provided (a patient with adherence of 95% for the last 6 months)
- Evidence of treatment success (at least one suppressed viral load result (i.e < 50 c/ml) and if no Viral Load result, a patient with rising CD4 cell count or CD4 cell count above 200 cells/millimeter cubes).
- Children with age greater than five years*
- A Patient who doesn't have current Opportunistic Infections
- A Patient with no adverse drug reactions and doesn't need careful clinical monitoring.
- A Patient who is willing or provide consent to get the ART service based on his/her preferred DSD models.

C. Inclusion criteria for more intense

- Patients who are on ART for < 6 months
- A patient with Age <5 years* Children with age greater than five years with treatment success (VL< 50)"
- Evidence of treatment failure (at least one low level viral load result (i.e > 50 c/ml) and if no Viral Load result, a patient with falling CD4 cell count or CD4 cell count below 200 cells/millimeter cubes)
- Active current illness, which includes not well controlled chronic health conditions
- A Patient who does have current Opportunistic Infections
- A Patient with adverse Drug Reactions and does need careful clinical monitoring.
- A Patient with an adherence of less than 95% for the last six months

16. Assessed client:

1.Eligable for less intensive 2.Needs more intensive

17. Consented:

1.Yes 2.No if Consent is yes go to no.18.

18. Enrollment TO DSD Models:

1.3MMD 2. ASM/6MMD 3.FTAR 4. CAG 5.PCAD

6. DSD for Adolescent 7. DSD for KP DSD 8.DSD for MCH 9.DSD for AHD

10.Other Models Specify ----------

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