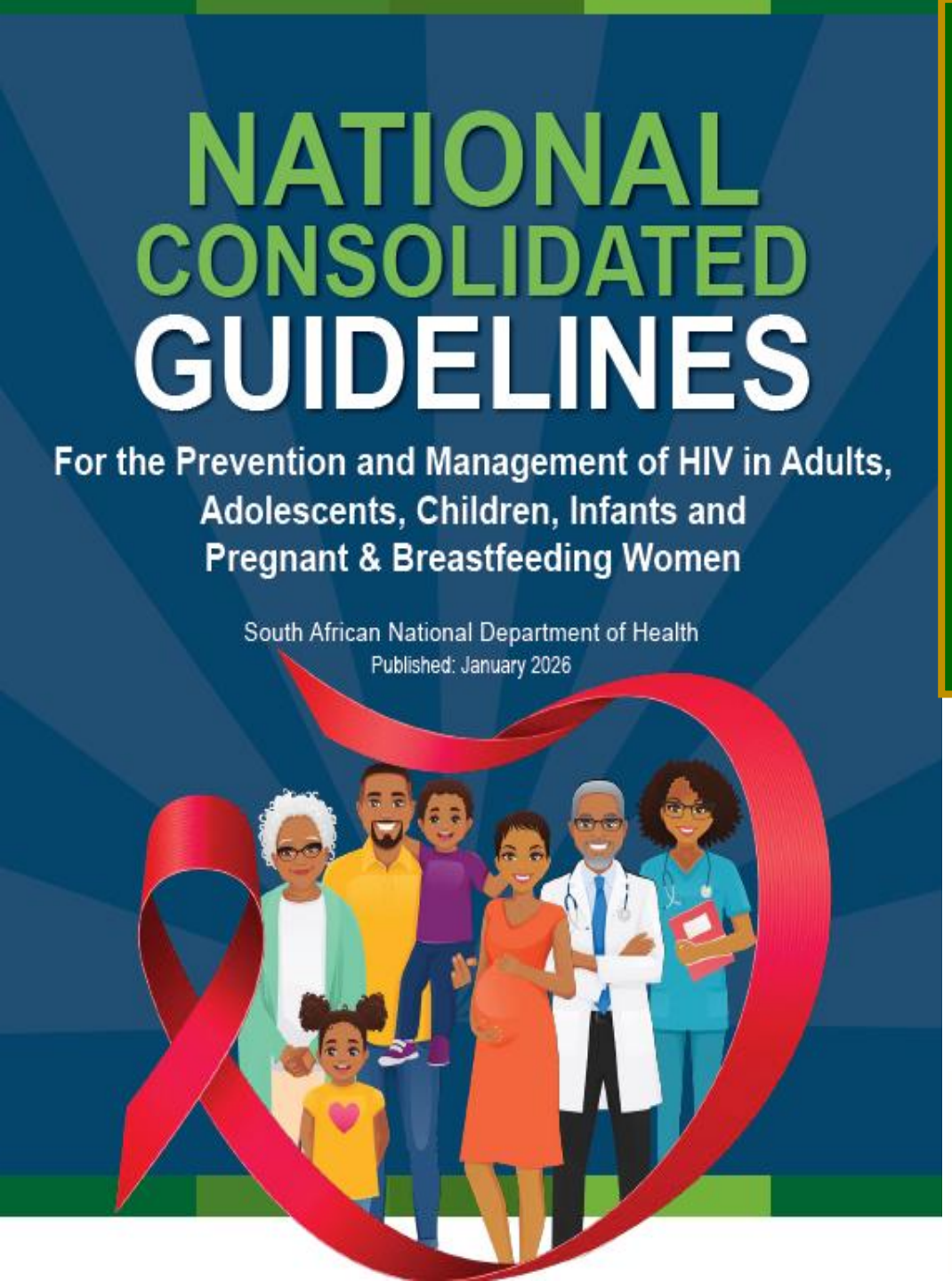

Webinar 2

2026 National Consolidated Guidelines for the Prevention and Management of HIV in Adults, Adolescents, Children, Infants, Pregnant and Breastfeeding Women

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World Health Organization

THE GLOBAL FUND

Background

Consolidated ART GL consists of:

1. Existing Guidelines:

- 2023 ART Clinical Guideline
- 2023 VTP Guideline
- HTS Guideline, 2025
- DMOC SOPs, 2025

2. "New" chapter

- Advanced HIV disease

- Standard treatment Guidelines and EML
- SA HIV Clinicians Society Guidelines
- World Health Organisation Guidelines
- Other National Guidelines
  - Adult Primary Care Guideline
  - IMCI Guideline
  - TPT Guideline and TB Screening SOP
  - DS and DR-TB

Summary of other updates to the Consolidated ART Guidelines

- AHD Chapter
- TPT for pregnant women with CD4 < 200 as part of a comprehensive package of care for Advanced HIV Disease
- CPT eligibility for WHO stages 3 and 4 only
- Earlier eligibility for drug-resistance testing and drug-level testing as the gatekeeping mechanism
- New postnatal EGK code for VL monitoring at 6 months postpartum and during breastfeeding
- Facility-provided 6MMD
- ALD access for term infants from 2kg

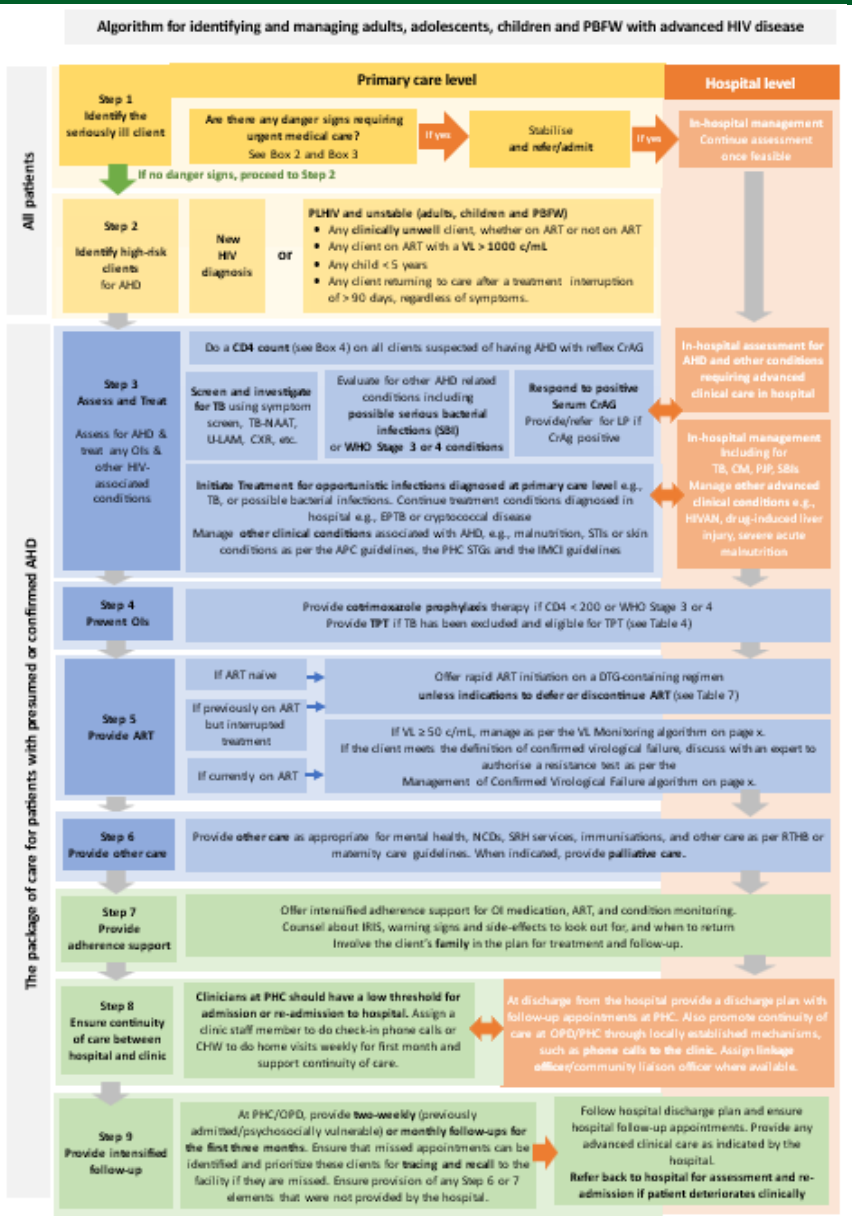
What is advanced HIV disease?

Box 1 The definition of Advanced HIV Disease (AHD)

- For adults, adolescents, and children **older than five years**, advanced HIV disease is defined as
  - **a CD4 cell count <200 cells/μL** or
  - **a WHO clinical stage 3 or 4 condition**

- All children living with HIV **younger than five years** should be considered as having advanced HIV disease (regardless of CD4% or clinical stage) unless they have been receiving ART for longer than one year and are clinically stable on ART

Summary of the 9 Steps



STEP 1
Identify the seriously ill client

STEP 2
Identify high-risk clients for AHD

STEP 3
Assess and Treat
Assess for AHD & treat any OIs & other HIV-associated conditions

STEP 4
Prevent OIs

STEP 5
Provide ART

STEP 6
Provide other care

STEP 7
Provide adherence support

STEP 8
Ensure continuity of care between hospital and clinic

STEP 9
Provide intensified follow-up

New VL monitoring/ resistance testing algorithm

Summary of other updates to the Consolidated ART Guidelines

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- Facility-provided 6MMD

DTG regimen classification (Table 32)

Not new

	Previous ART exposure	Regimen
1st-line TLD1 / ALD1	• ART-naïve patients who initiated ART on a DTG-containing regimen • Patients who were switched to DTG from a first-line non-DTG-based regimen (e.g., TEE) with a VL < 50 c/mL in the last 12 months	**Tenofovir/lamivudine/dolutegravir [TLD 1]** **Abacavir/lamivudine/dolutegravir [ALD 1]**
2nd-line TLD2 / ALD2	• Patients who were switched to DTG from a first-line ART regimen (NNRTI or PI-based) with a VL ≥ 50 c/mL • Patients who were switched to DTG from a second-line PI-based ART regimen with a VL < 50 c/mL in the last 12 months • Patients who were switched to DTG from a PI-based regimen with a VL ≥ 50 c/mL without a genotypic resistance test	**Tenofovir/lamivudine/dolutegravir [TLD 2]** **Abacavir/lamivudine/dolutegravir [ALD 2]**
3rd-line TLD3 / ALD3 or individualised	• Patient was switched to a third-line DTG-based regimen based on the results of a genotypic resistance test showing resistance mutations to PI in a previous second-line regimen	**Individualised DTG-based regimen**
If clients are not eligible to use TDF and they had an ABC hypersensitivity reaction, use AZT/3TC/DTG		

! At certain times, the distinction between a TLD1 and TLD2 classification may not be clear. This is especially true for clients re-engaging in care after a treatment interuption. Many clients initiating ART as TLD1 may well be TLD2, but are not disclosing their earlier ART exposure. If in doubt, discuss with an expert, or err on the side of caution and classify as TLD2, as misclassification may affect their eligibility for resistance testing.

Poll 1 Which of these clients will be classified as TLD 1?

- A treatment-naïve patient started ART for the first time 6 months ago on TLD.
- A patient on TEE (TDF/3TC/EFV) with VL 4,500 c/mL. Switched to TLD.
- A patient on TLD since 2019. Was originally switched from TEE with VL suppressed.
- A patient who was on second-line ART (AZT/3TC/LPVr) and was switched to TLD with a suppressed viral load.
- A perinatally infected adolescent now on TLD

Poll 2 Which of these clients will be classified as TLD 2?

- A treatment-naïve patient started ART for the first time 6 months ago on TLD.
- A patient on TEE (TDF/3TC/EFV) with VL 4,500 c/mL. Switched to TLD.
- A patient on TLD since 2019. Was originally switched from TEE with VL suppressed.
- A patient who was on second-line ART (AZT/3TC/LPVr) and was switched to TLD with a suppressed viral load.
- A perinatally infected adolescent now on TLD

Poll 3 Will the following client be classified as TLD 1 or TLD 2classified as TLD 2?

“46-year-old male, re-initiating ART today. Previously on ART for 7 years. Registered in Tier.net as TLD1 since 2020. One elevated VL in Tiet.net 6 years ago. No viral loads in the system since then. Treatment interruptions on 2 occasions.”

- TLD 1
- TLD 2

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When in doubt…

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When do we do viral load test?

Not new

For Everyone

- 3 months after initiation or re-initiation
- 10-12 months after initiation
- Annually if VL<50
- 6 monthly if breastfeeding

If VL>50

- Address adherence and ABCDE
- Repeat after 3 months
- If PBFW repeat in 4-6 weeks
- If VL still >50, follow the high VL algorithm

What do these Viral load results mean?

Not new

VL<50 is suppressed

*HIV is **not** replicating*

VL<50

- Sufficient levels of effective ARVs

VL>50 is unsuppressed

*HIV **is** replicating*

Low level viraemia

VL: 50-1000

- Not perfect adherence
- Might start to develop resistance mutations

Viral Failure= 2x VL>1000

VL>1000

- Not enough ARVs in the system (e.g., due to sub-optimal adherence/ drug interactions)
- Resistance (?)
- Or both

Do ABCDE

Not for resistance test

Possibly for resistance test

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How do we do the ABCDE assessment?

A	**Adherence**	Transport costs, loss of income, side-effects, depression, anxiety, GBV, non-disclosure, alcohol/substance abuse
B	**Bugs**	TB symptom screen, STI screen. Note: immunocompromised, malnourished & pregnant patients may NOT show overt TB symptoms
C	**Correct dose**	Check weight (especially children and patients with renal impairment). Confirm the patient is dosing as prescribed
D	**Drug interactions**	Rifampicin, anti-epileptics (carbamazepine, phenytoin, phenobarbital), iron, calcium supplements, antacids, St John's wort
E	**Resistance**	Consider ONLY after A–D have been excluded or addressed. Refer to the VL algorithm for eligibility criteria

KEY RULE: E — Resistance is ALWAYS last. A resistance test on a non-adherent patient is wasted and provides no clinically useful information.

New evidence and considerations

- Earlier indications were that DTG- drug resistance mutations would only develop after 2 years of being on treatment, similar to PIs
- New evidence: For patients on second- and third-line DTG-containing regimens, resistance mutations to DTG can develop earlier than 2 years, even as soon as after 9 months on TLD2
- ARTIST data 2025: approx 1-2% of participants on TLD2 developed DTG resistance after 2-3 years on TLD2
- Approximately 50% of patients with an unsuppressed VL had no detectable ARV drugs in their system (meaning that they were not taking their treatment at all)
- **'E' in our ABCDE (for rEsistance) is considered only after all ABCD have been assessed, addressed, and they now have 2 VLs > 1000 c/mL**

van Heerden JK, Zhao Y, Keene CM, Griesel R, Omar Z, Goliath R, Delaney K, van Zyl G, Maartens G, Meintjes G. Longer-term virologic outcomes on tenofovir-lamivudine-dolutegravir in second-line ART. South Afr J HIV Med. 2025 Apr 30;26(1):1677. doi: 10.4102/sajhivmed.v26i1.1677. PMID: 40356938; PMCID: PMC12067616.

Eligibility criteria for a resistance test

New

DTG-containing regimens

- 2nd or 3rd line DTG for at least 9 months, OR TLD1/ALD1 with special circumstances (Box 17), AND
- Two or more consecutive VLs > 1000 c/mL, AND
- At least two adherence assessments and interventions

PI-containing regimens

- On LPV/r or ATV/r for at least 2 years, AND
- Two or more consecutive VLs ≥ 1000 c/mL taken at least 2 years after starting the PI regimen, AND
- At least two adherence assessments and interventions

Special circumstances

New

Box 17 — Special circumstances for TLD1/ALD1 (resistance testing not routine, but may be considered case-by-case)

- Patients with AHD on DTG for ≥ 9 months
- Prior or current drug interactions (rifampicin, carbamazepine, phenytoin, phenobarbital, polyvalent cations)
- Incorrectly classified as TLD1 after prior ART exposure
- Perinatally infected adolescents (must be reclassified as TLD2)

Poll 4 Which of the following clients will be eligible for a resistance test?

- A client on TLD1 for 7 months with suspected adherence challenges.
- Patient on TLD2 for 22 months, with 2 consecutive VLs > 1000 c/mL
- A patient on TLD1 since 2019 who also had rifampicin-based TB treatment without boosting their DTG to compensate for drug interactions. They now have 2 consecutive VLs > 1000 c/mL
- A perinatally infected adolescent on TLD who has 2 consecutive VLs > 1000 c/mL

Poll 4 Which of the following clients will be eligible for a resistance test?

- A client on TLD1 for 7 months with suspected adherence challenges.
  - **Not eligible**
- Patient on TLD2 for 22 months, with 2 consecutive VLs > 1000 c/mL
  - Eligible for RT
- A patient on TLD1 since 2019 who also had rifampicin-based TB treatment without boosting their DTG to compensate for drug interactions. They now have 2 consecutive VLs > 1000 c/mL
  - Eligible for RT
- A perinatally infected adolescent on TLD who has 2 consecutive VLs > 1000 c/mL
  - Eligible for RT

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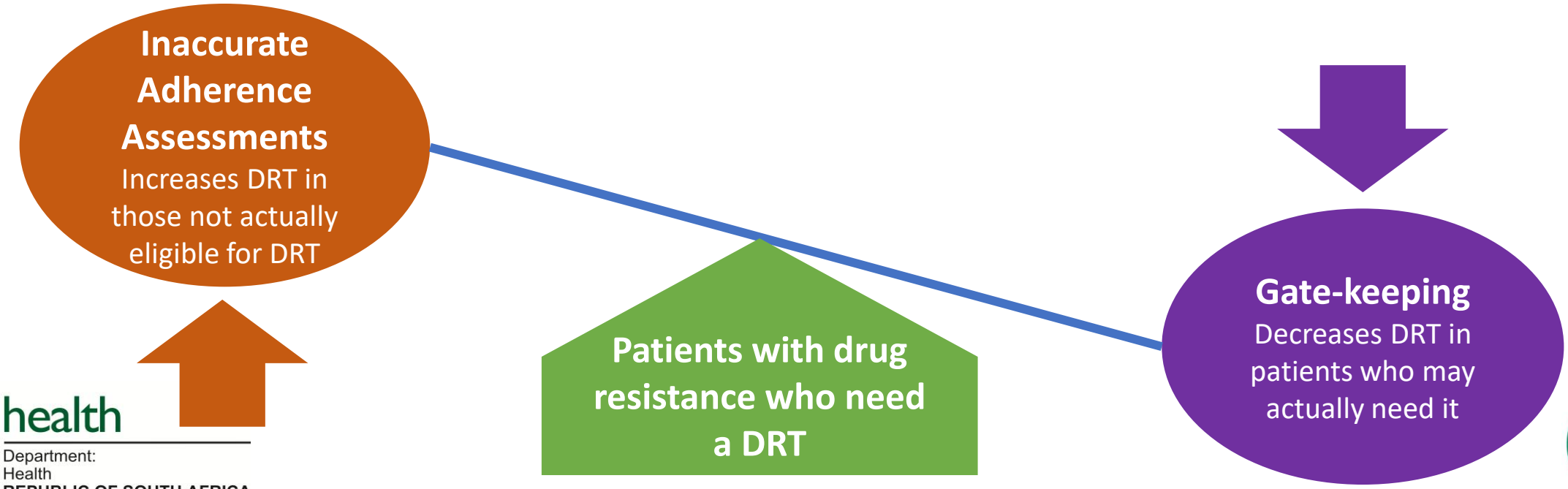
Challenges with Drug Resistance Testing

- Effective ART is crucial to long-term survival
- For a small number of patients, drug resistance testing is crucial to selecting the right, effective ART regimen
- But drug resistance testing is costly, and if the patient isn't actually adherent, the test is ineffective.



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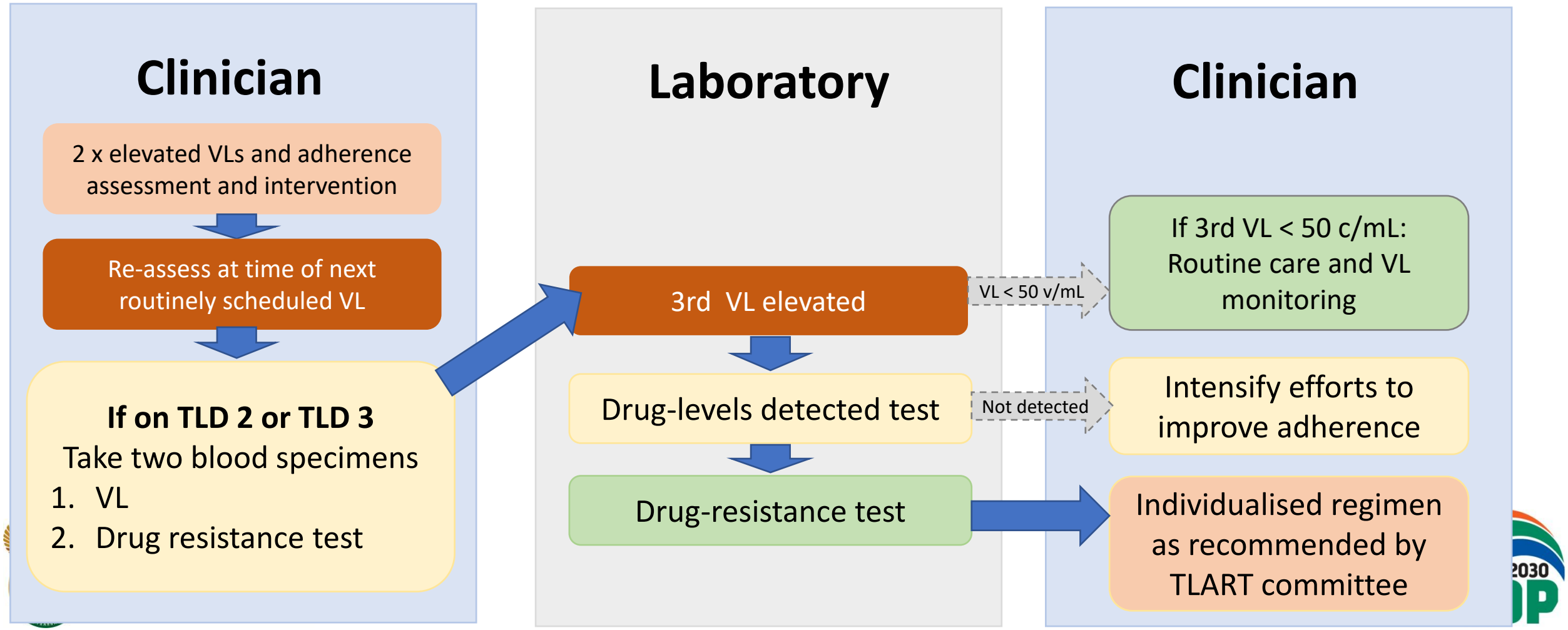
How can we do better at “gate-keeping” DRT?

New



Drug-level testing (DLT) as a gatekeeper

No DTG detected

- Patient has NOT taken DTG in at least the last 5 days
- **Resistance test is NOT performed by the laboratory**
- Action: provide DLT-informed adherence counselling and remain on TLD

DTG detected

- Patient took DTG within the last 5 days
- Does NOT confirm consistent adherence — 'white coat phenomenon' is possible
- **If VL ≥ 1000 c/mL, lab proceeds to the resistance test**

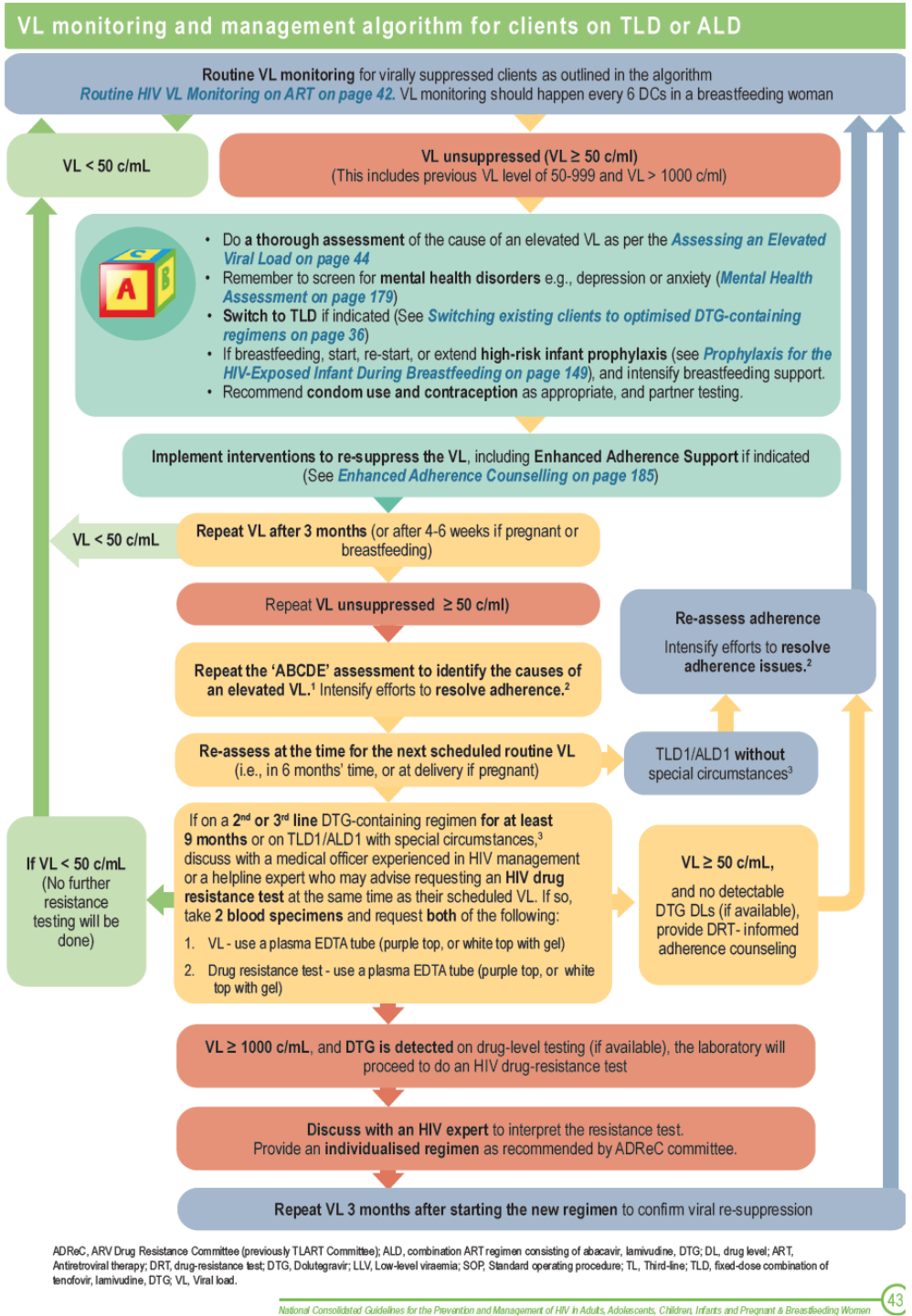
When a resistance test is advised: collect 2 EDTA plasma tubes simultaneously

- Tube 1: HIV viral load — plasma EDTA tube (purple top or white top with gel)
- Tube 2: Drug resistance test — plasma EDTA tube (purple top or white top with gel)

DLT is a laboratory reflex test — clinicians do NOT request it separately. This protects against costly, uninformative resistance tests in non-adherent patients.

New

Page 43



Remember that to qualify for a resistance test the client needs:

- 2nd or 3rd line **DTG for at least 9 months**, OR TLD1/ALD1 with special circumstances (Box 17), AND
- **Two or more consecutive VLs > 1000 c/mL**, AND
- At least **two adherence assessments and interventions**

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VL monitoring and management algorithm for clients on TLD or ALD

Routine VL monitoring

1st VL elevated

1st ABCDE assessment and interventions

Routine VL monitoring for virally suppressed clients as outlined in the algorithm *Routine HIV VL Monitoring on ART on page 42.* VL monitoring should happen every 6 DCs in a breastfeeding woman

VL unsuppressed (VL ≥ 50 c/ml)
(This includes previous VL level of 50-999 and VL > 1000 c/ml)

- Do **a thorough assessment** of the cause of an elevated VL as per the *Assessing an Elevated Viral Load on page 44.*
- Remember to screen for **mental health disorders** e.g., depression or anxiety (*Mental Health Assessment on page 179*)
- **Switch to TLD** if indicated (See *Switching existing clients to optimised DTG-containing regimens on page 36*)
- If breastfeeding, start, re-start, or extend **high-risk infant prophylaxis** (see *Prophylaxis for the HIV-Exposed Infant During Breastfeeding on page 149),* and intensify breastfeeding support.
- Recommend **condom use and contraception** as appropriate, and partner testing.

Implement interventions to re-suppress the VL, including **Enhanced Adherence Support** if indicated (See *Enhanced Adherence Counselling on page 185*)

Repeat VL after 3 months (or after 4-6 weeks if pregnant or breastfeeding)

VL < 50 c/mL

Repeat VL to confirm re-suppression

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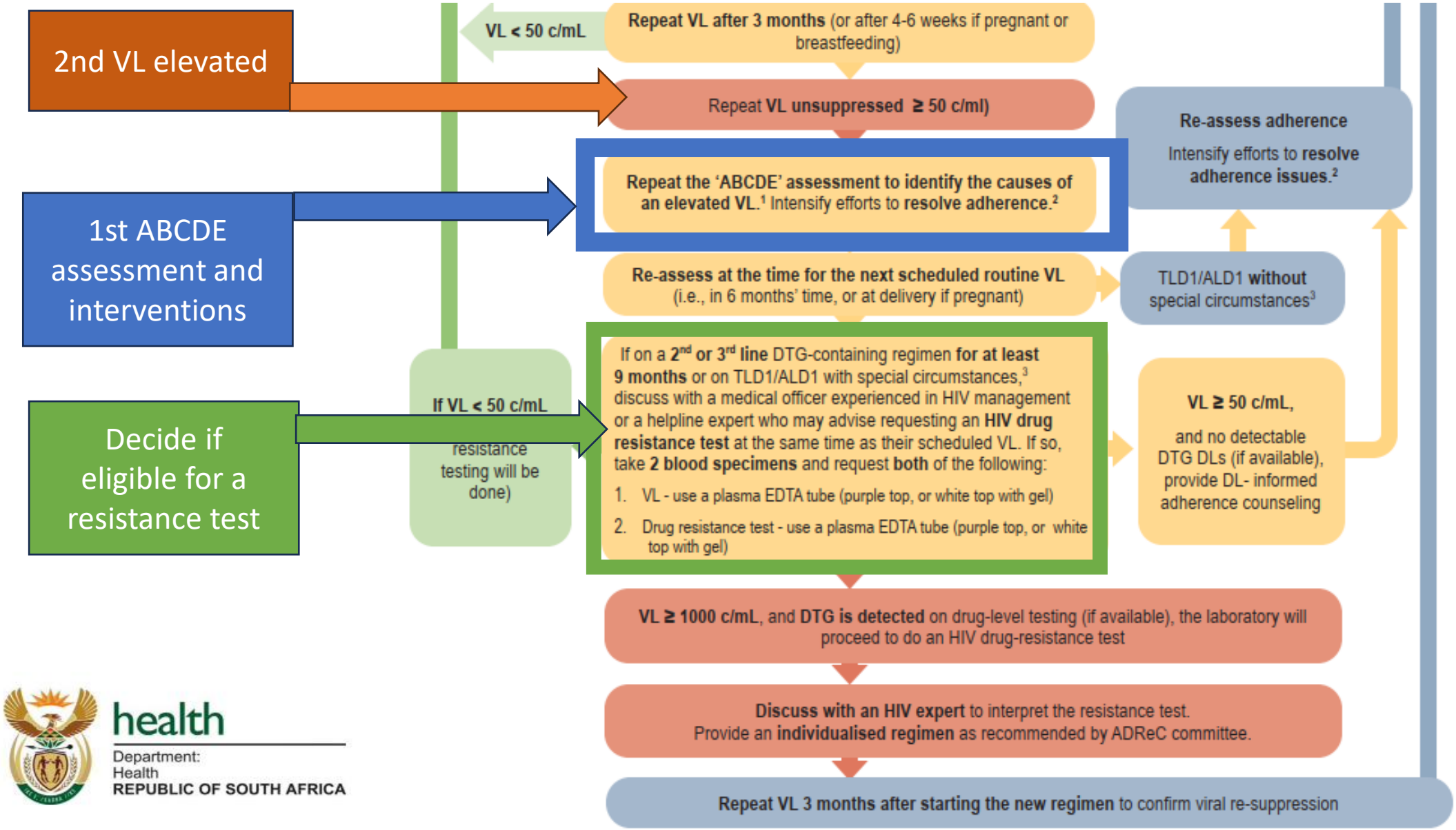
VL monitoring and management algorithm for clients on TLD or ALD

New



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New

Footnotes to VL monitoring algorithm

1. **Repeat ABCDE assessment** as outlined below. Remember to ask about treatment side-effects, the potential cost of transport or loss of income related to clinic visits, mental health symptoms, non-disclosure, gender-based violence (GBV), and current or prior drug interactions. Provide EAC if indicated.
2. Due to their high genetic barrier, resistance to a first-line DTG-containing (TLD1) regimen is extremely rare. If other reasons for an unsuppressed VL have been addressed or excluded, **suboptimal adherence remains the most probable cause for non-suppression**. The highest probability of improving adherence would be to remain on a once-daily, well-tolerated, fixed-dose combination regimen (TLD) while identifying and addressing the underlying root causes of non-adherence.
3. **Special circumstances**

- TLD1 patients with persistent virological failure despite good adherence may be discussed with an expert to consider a resistance test on a case-by-case basis:
- Patients with AHD and on a DTG-containing regimen for at least 9 months.
- Current or previous drug interactions with rifampicin, carbamazepine, phenytoin, phenobarbital, or the polyvalent cations that may have resulted in the development of resistance.
- Incorrect classification as TLD1 after prior ART exposure and failing an ART regimen in the past
- Perinatally infected adolescents (perinatally infected adolescents should be classified as TLD2 due to the high likelihood of ART exposure and virological failure in the past).

Additional considerations if VL > 1000 c/mL

- Monitor CD4 count every 6 months see *Monitoring on ART on page 41*
- If CD4 < 200 cells/mm^3, discuss with an HIV expert
- Consider eligibility for cotrimoxazole prophylaxis see *Indications for Starting and Stopping Cotrimoxazole Preventive Therapy on page 30*

Step 2 Identify high-risk clients

Step 2

Identify high-risk clients for AHD

New HIV diagnosis

or

PLHIV and unstable (adults, children and PBFW)

- Any **clinically unwell** client, whether on ART or not on ART
- Any client on ART with a **VL > 1000 c/mL**
- Any child < 5 years
- Any client returning to care after a treatment interruption of > 90 days, regardless of symptoms.

At risk of drowning…

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ARV Drug Resistance Committee (ADReC) referral after confirmed resistance

1 Resistance confirmed (DTG or PI)

2 Do NOT switch independently

3 Email TLART@HEALTH.GOV.ZA with ADReC form + test results

4 ADReC recommends individualised regimen

Repeat VL 3 months after starting the new regimen to confirm viral re-suppression.

Key rules:

- Even if the clinician knows the ADReC algorithm, no independent switches are permitted.
- Every client requiring a third-line regimen requires notification to ADReC — no exceptions.
- ADReC continuously reviews local resistance patterns to inform evidence-based, individualised regimens.

ADReC: **TLART@HEALTH.GOV.ZA** · HIV Hotline: **0800 212 506** · HIV Expert: **082 352 6642** · KZN Paeds: **0800 006 60TEE**

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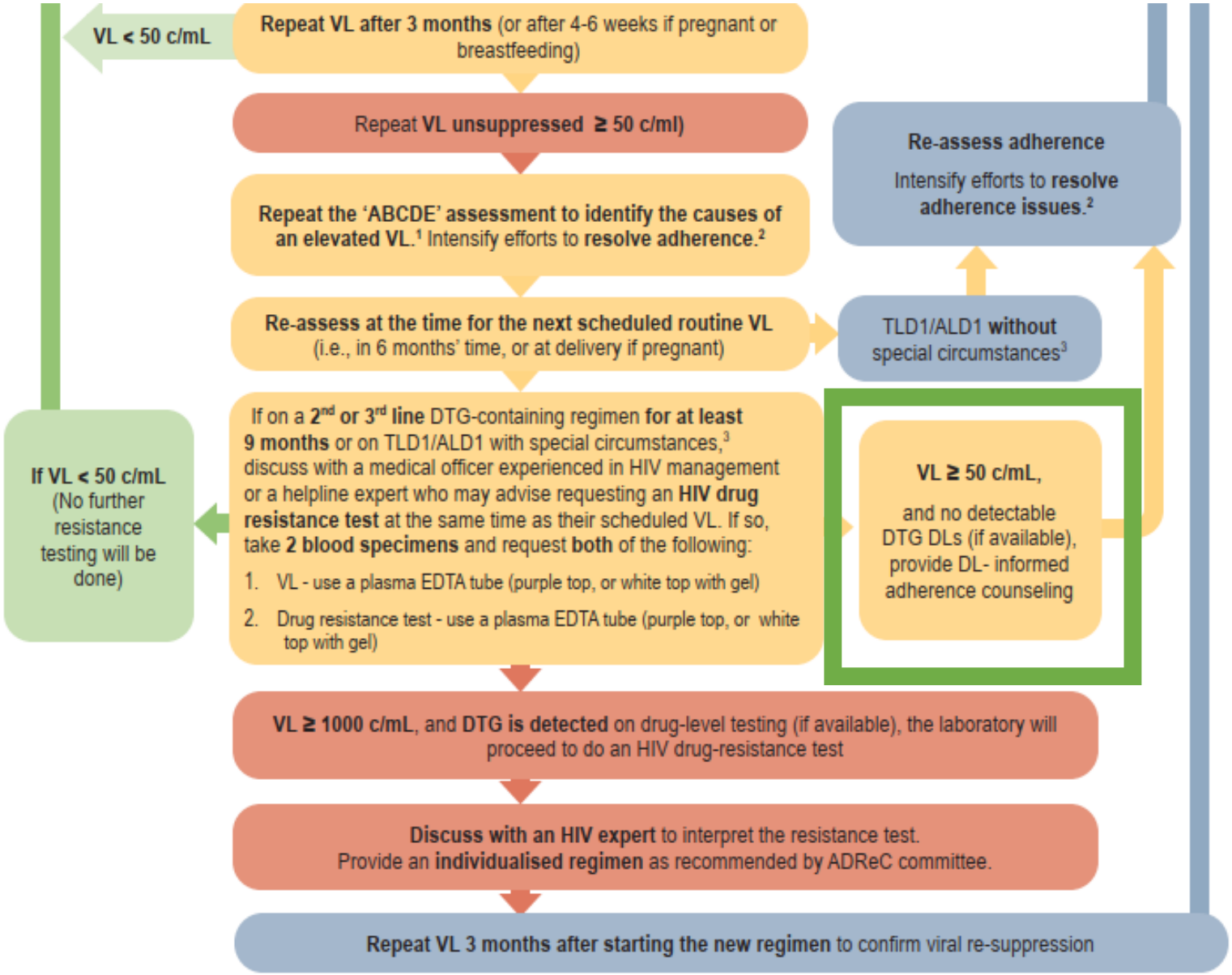
VL monitoring and management algorithm for clients on TLD or ALD

New



Drug-level informed counselling

Drug-level informed counselling (DLIC)

Before the Conversation

- **Review the result privately** before speaking to the patient
- Remind yourself: an undetectable drug level is clinical information, not proof of dishonesty
- Approach the conversation with curiosity, not suspicion

Opening the Conversation

- Start with rapport — ask how the patient is feeling generally
- Use neutral, open language: *"Your blood test gave us some information I'd like to talk through with you today"*
- Never lead with accusation or surprise

Sharing the Result

- Be simple and factual: *"The test measured the level of your ARV medication in your blood, and drugs were not detected in your blood"*
- Pause and allow the patient to respond — do not fill the silence immediately
- Normalise it: *"This happens for many reasons, and it helps us support you better.*
- *Let's explore together what could be making things difficult for you"*

Explore barriers **(The Core of DLIC)**

Use open, non-judgmental questions to understand **why** doses may have been missed:

Category	Example Question
Forgetting	"Do you have a routine that helps you remember your pill?"
Side effects	"Have you noticed anything after taking your pill that bothers you, and may prevent you from taking it?"
Pill fatigue	"How do you feel about taking this pill every day for a long time?"
Stigma/privacy	"Is it ever difficult to take your pill around other people?"
Access issues	"Have you ever run out of medication or had trouble collecting it?"
Mental health	"Are there days when things feel too heavy to manage your treatment?"

Key Communication Rules in DLIC

- ✅ Use **"we"** language — *"Let's figure this out together"*
- ✅ Validate whatever the patient shares — *"Thank you for telling me that"*
- ✅ Acknowledge that **daily treatment is hard**

- ❌ Never say *"But you told me you were taking it"*
- ❌ Never say *"But you have been lying to me"*
- ❌ Never express visible frustration or disappointment
- ❌ Never compare the patient to others

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Closing the Session

- Summarise the barriers identified together
- Collaboratively agree on **one or two practical solutions** (pill reminder, changed collection day, treatment supporter, etc.)
- Set a follow-up date — this is an ongoing conversation, not a once-off
- End on an encouraging note:
- *"You came today, and that matters. Let's work on this together."*

Remember the Bigger Picture

Drug level testing is a **tool to support the patient**, not to catch them out. The goal is to remove barriers so that viral suppression becomes achievable, not to assign blame. Don't lose your patient's trust.

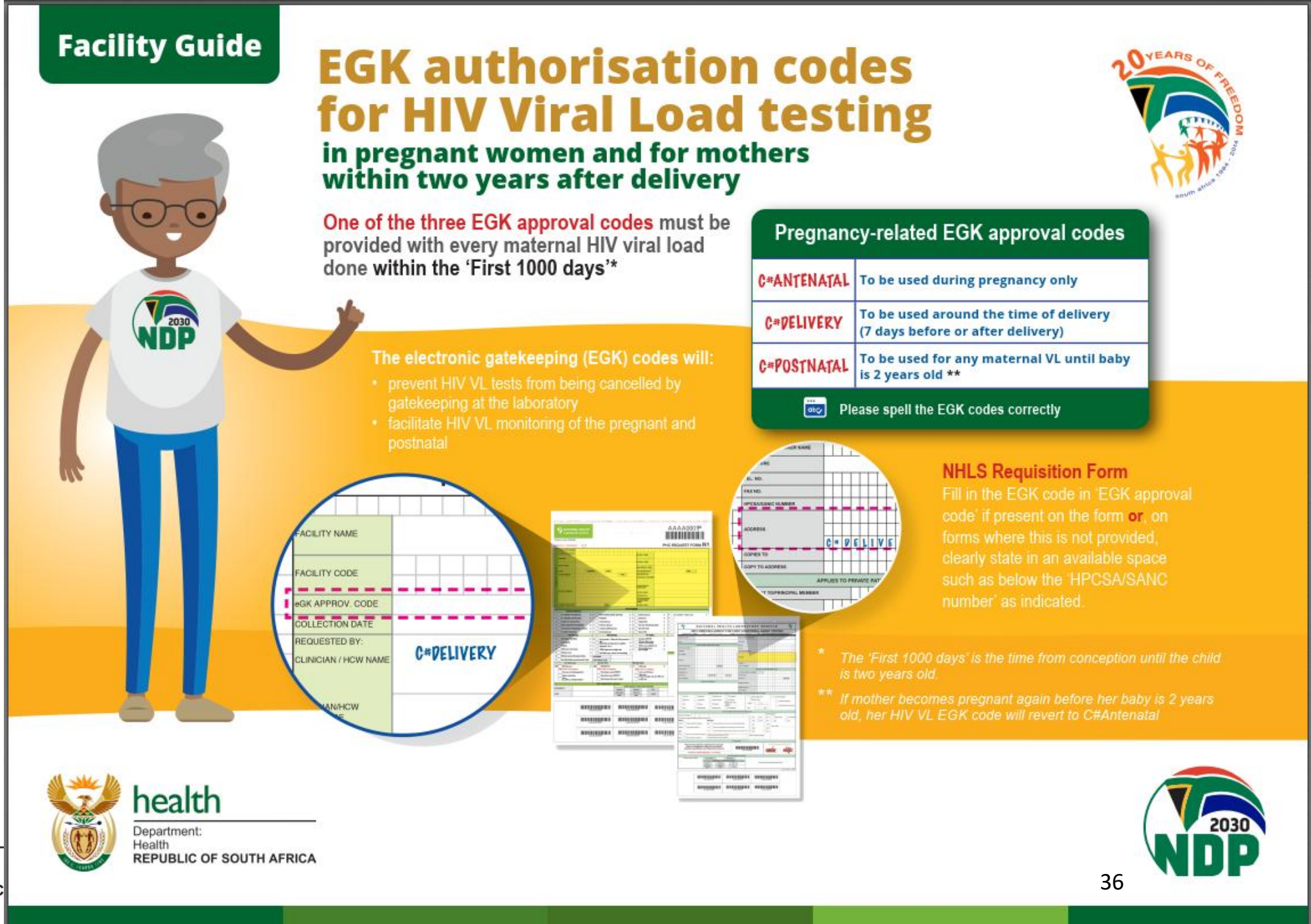
Electronic Gate Keeping (EGK) Codes for PBFW

EGK codes serve three functions:

1. Prevent sample rejection
2. Allow individual patients to be traced using the NHLS RfA reports
3. Monitor VL suppression rates at a program level

3-codes

- C # Antenatal
- C # Delivery
- C # Postnatal



EGK authorisation codes for HIV Viral Load testing

in pregnant within two y

One of the three E
provided with ever
done within the 'Fi

Pregnancy-related EGK approval codes	
C*ANTENATAL	To be used during pregnancy only
C*DELIVERY	To be used around the time of delivery (7 days before or after delivery)
C*POSTNATAL	To be used for any maternal VL until baby is 2 years old **

Please spell the EGK codes correctly

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Poll In the following scenario, which EGK code will you place on the NHLS blood form when you do a VL for this women?

"A 26-year-old mother LHIV is currently breastfeeding. She attends her baby's 6-month EPI visit. You offer her family planning and also explain that she is due for her 6-month post-delivery VL. Which EGK code will you use?

- C#Antenatal
- C#PMTCT
- C#Postnatal
- C#Delivery

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Take home messages

1. Any VL ≥ 50 c/mL is a medical emergency requiring ABCDE assessment and action
2. Resistance (E) is last — Process to exclude ABCD with thorough assessments and repeat VLs
3. Perinatally infected adolescents are ALWAYS TLD2 — never TLD1
4. DLT is a laboratory reflex test that gatekeeps unnecessary resistance tests
5. No independent switches. Every third-line patient requires ADReC notification

Thank you!

HELPLINES

If in doubt about any aspect of viral load management or switching to second-line, contact one of the following resources:

National HIV & TB Health Care Worker Hotline:

0800 212 506

Right to Care Pediatric, Adolescent and Adult HIV Helpline:

082 352 6642

KZN Paediatric Hotline:

0800 006 603

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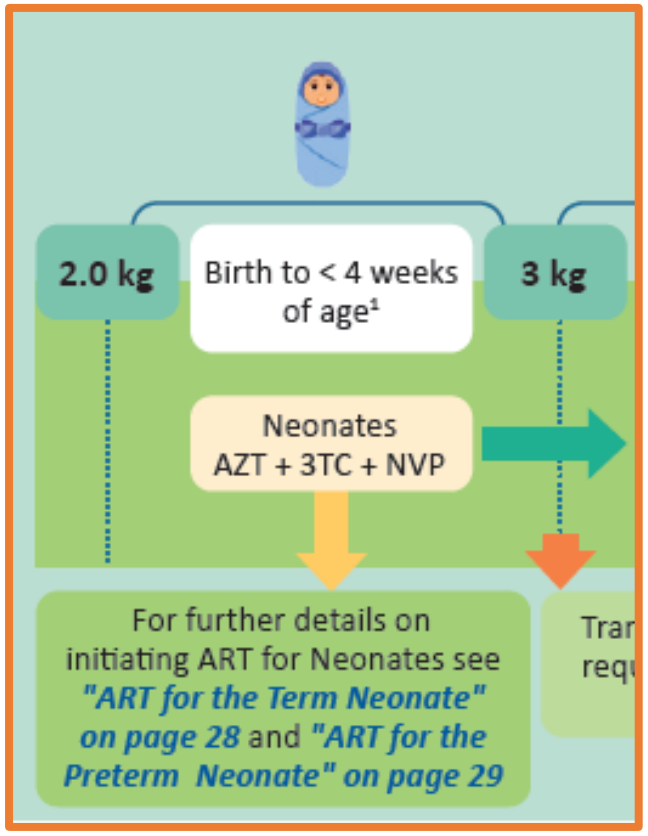
Paediatric ART regimens

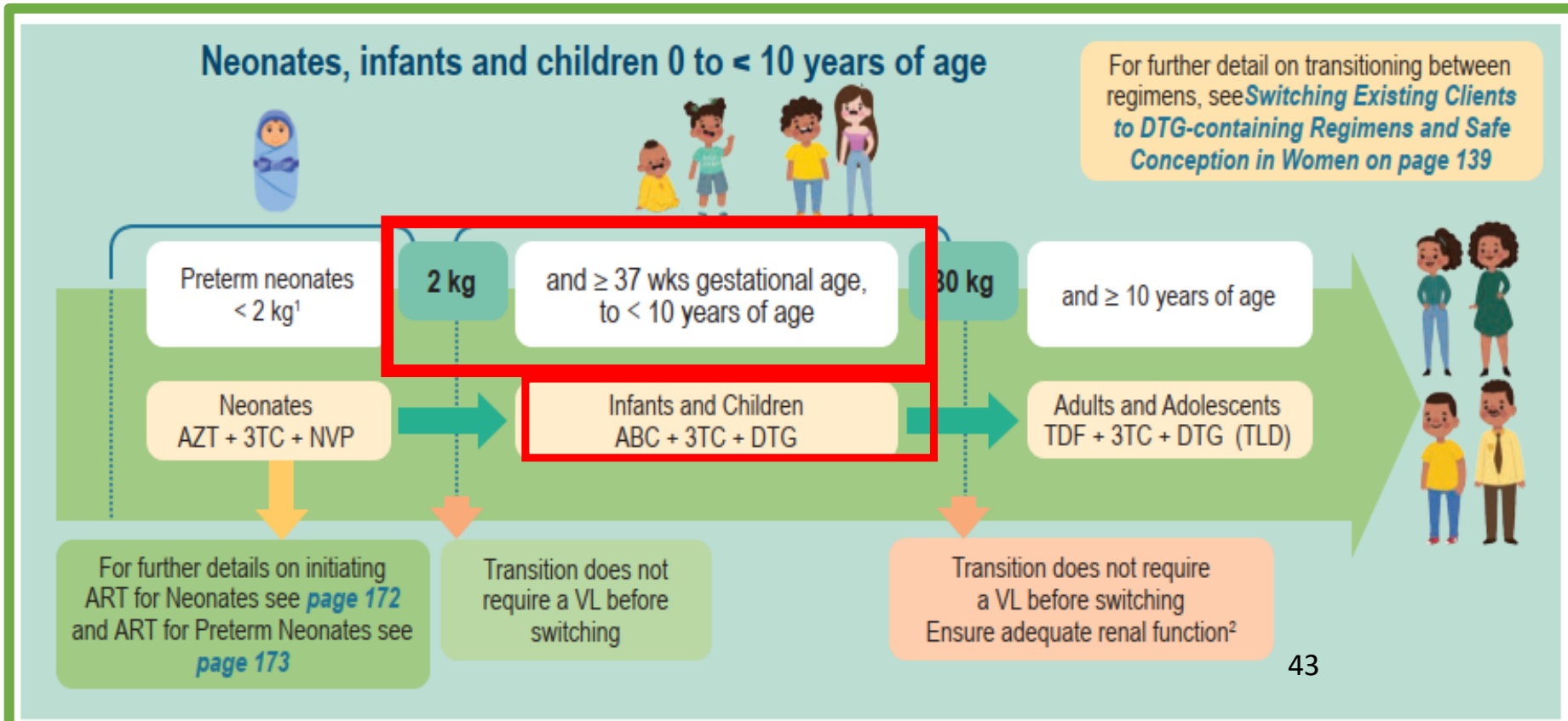
Summary of other updates to the Consolidated ART Guidelines

- AHD Chapter
- TPT for pregnant women with CD4 < 200 as part of a comprehensive package of care for Advanced HIV Disease
- CPT eligibility for WHO stages 3 and 4 only
- Earlier eligibility for drug-resistance testing and drug-level testing as the gatekeeping mechanism
- New postnatal EGK code for VL monitoring at 6 months postpartum and during breastfeeding
- ALD access for term infants from 2kg
- Facility-provided 6MMD

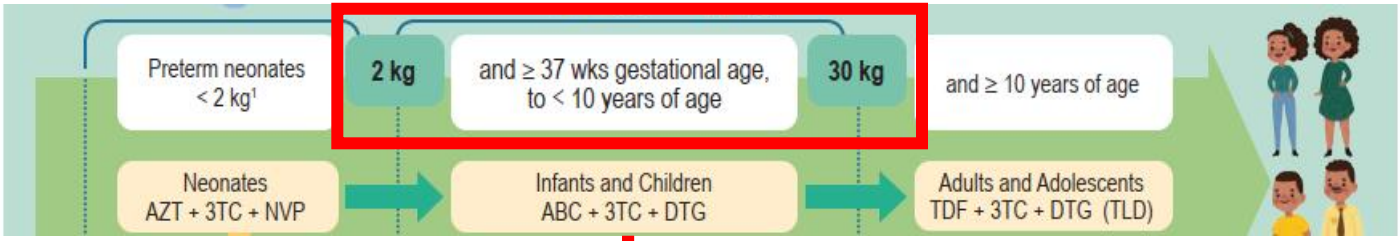
Previously

Now…
ABC + 3TC + DTG for **term** infants
(≥ 2kg and ≥ 37 weeks gestational age at birth





Same regimen, different formulations



All formulations are given ONCE DAILY

2 kg

30 kg

2kg – 25kg

Abacavir/3TC
120/60 tablets
Dispersible Tablets

pDTG 10mg
dispersible,
scored tablets

2kg– 25kg

Paediatric ALD (pALD)
ABC/3TC/DTG
60/30/5mg

25 kg – 30kg

ALD
ABC/3TC/DTG
600/300/50mg

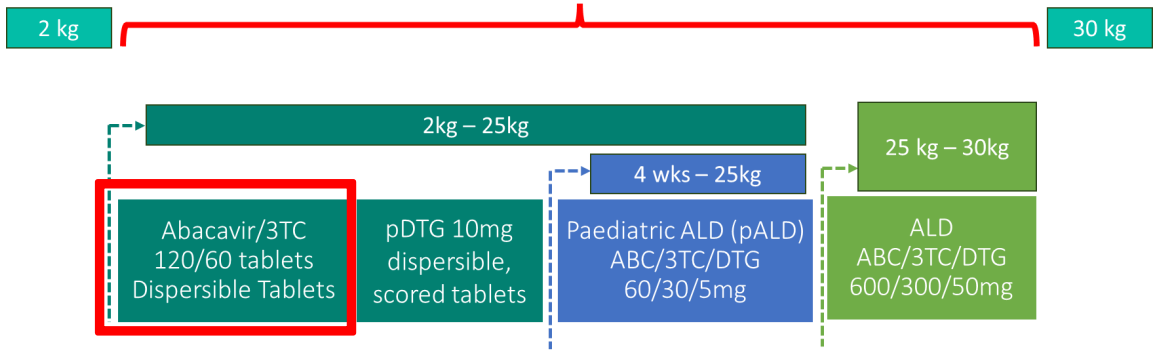
Neonates 0- 4 weeks of age
Special dose
Can only use separate formulations

Can only be used from
4 weeks of age

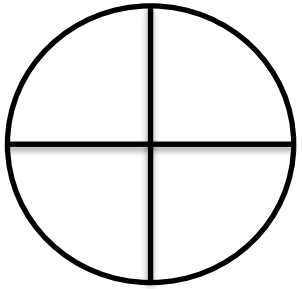
pALD is the new formulation

Abacavir/3TC 120/60 tablets Dispersible Divudine Tablets

- Scored and Dispersible
- Can be used from 2kg till 25kg
- At 25kg can use ABC/3TC 600/300 tabs



- Can be swallowed, chewed, crushed or dissolved in water
- One formulation is double scored and that can be used to treat neonates
- Special neonatal dose from 2 kg and 37 weeks gestational age at birth
- Is cost effective



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ARV DRUG DOSING CHART FOR CHILDREN ≥ 28 DAYS (2025)

Compiled by National HIV & TB Health Care Worker Hotline and the Child and Adolescent Committee of SA HIV Clinicians Society in collaboration with the Department of Health

0800 212 506

	Abacavir + Lamivudine (ABC + 3TC)	Abacavir (ABC)	Lamivudine (3TC)	Zidovudine (AZT)	Dolutegravir (DTG)	Abacavir + Lamivudine + Dolutegravir (ALD)	Dolutegravir (DTG) or Abacavir/Lamivudine/ Dolutegravir (ALD) when on Rifampicin	Lopinavir/ritonavir (LPV/r)	Lopinavir/ritonavir when on rifampicin (and for 2 weeks after stopping rifampicin)		[#]Atazanavir (ATV) + Ritonavir (RTV)	
Target dose	As for individual medicines ONCE daily	8 mg/kg/dose TWICE daily OR If ≥ 10kg: 16 mg/kg/dose ONCE daily	4 mg/kg/dose TWICE daily OR If ≥ 10kg: 8 mg/kg/dose ONCE daily	180-240 mg/m^2/dose TWICE daily	By weight band ONCE daily **IF PATIENT IS ON RIFAMPICIN TB TREATMENT, ADD ADDITIONAL DTG UP TO TWO WEEKS AFTER STOPPING RIFAMPICIN. SEE NEXT COLUMN**	By weight band ONCE daily	By weight band TWICE DAILY	300/75 mg/m2/dose LPV/r TWICE daily	LPV/r std dose + super-boosting with ritonavir (RTV) powder TWICE daily (≥0.75xLPV dose bd)	OR Double-dose LPV/r tabs ONLY if able to swallow whole LPV/r tabs TWICE daily	By weight band ONCE daily	Target dose
Available formulations	Dispersible tablet FDC: ABC/3TC 120/60 mg Tablets FDC: ABC/3TC 600/300 mg ABC/3TC/DTG (ALD) 600/300/50 mg	Sol. 20 mg/ml Tabs 60 mg (scored, dispersible), 300 mg (not scored)	Sol. 10 mg/ml Tabs 150 mg (scored)	Sol. 10 mg/ml, Tabs 100 mg; 300 mg FDC: AZT/3TC 300/150 mg	Dispersible tabs (DT) 10 mg, Film coated (FC) tabs 50 mg, FDC: TLD 300/300/50 mg OR ALD 600/300/50 mg **DT AND FC TABLETS ARE NOT BIOEQUIVALENT**	Dispersible tablets (DT) FDC: pALD 60/30/5 mg ALD 600/300/50 mg	Dispersible tabs (DT) 10 mg, Film coated (FC) tabs 50 mg, FDC: TLD 300/300/50 mg OR ALD DT 60/30/5 OR ALD 600/300/50 mg **DT AND FC TABLETS ARE NOT BIOEQUIVALENT**	Sol. 80/20 mg/ml Adult tabs 200/50 mg, Paed tabs 100/25 mg **TABLETS MUST BE SWALLOWED WHOLE**	Oral powder 100 mg/packet	Adult tabs 200/50 mg, Paed tabs 100/25 mg	FDC: ATV/RTV 300/100 mg ATV/r FDC **TABLETS MUST BE SWALLOWED WHOLE**	Available formulations
Wt. (kg)	Consult with a clinician experienced in paediatric ARV prescribing for neonates (< 28 days of age) and infants weighing < 2kg											Wt. (kg)
2 - 2.9	½ x 120/60 mg tab od	-	-	-	½ x 10 mg DT od	1 x pALD DT (60/30/5 mg) od	½ x 10 mg DT bd **OR** [pALD DT (60/30/5) 1 tabs od + ½ x 10 mg DTG DT approx. 12 hours later]	-	-	-	-	2 - 2.9
3 - 5.9		3 ml bd **OR** 1 x 60 mg tab bd	3 ml bd	6 ml bd				* 1 ml bd	LPV/r std dose (see purple column) + oral RTV powder 100 mg (1 packet) bd	Do not use double-dose LPV/r tabs	No preparation available	3 - 5.9
6 - 9.9	1½ x 120/60 mg tabs od	4 ml bd **OR** 1½ x 60 mg tab bd	4 ml bd	9 ml bd	1½ x 10 mg DT od	3 x pALD DT (60/30/5 mg) od	1½ x 10 mg DT bd **OR** [pALD DT (60/30/5) 3 tabs od + 1½ x 10 mg DTG DT approx. 12 hours later]	* 1.5 ml bd				6 - 9.9
10 - 13.9	2 x 120/60 mg tabs od	**Once daily dosing > 10 kg** 4 x 60 mg tabs od **OR** 12 ml od	**Once daily dosing > 10 kg** 12 ml od	12 ml bd **OR** 1 x 100 mg tabs bd	2 x 10 mg DT od	4 x pALD DT (60/30/5 mg) od	2 x 10 mg DT bd **OR** [pALD DT (60/30/5) 4 tabs od + 2 x 10 mg DTG DT approx. 12 hours later]	2 ml bd **OR** [2 x 100/25 mg **paed tabs** am + 1 x 100/25 mg **paed tab** pm]	LPV/r std dose (see purple column) + oral RTV powder 200 mg (2 packets) bd	3 x 100/25 mg **paed tabs** bd		10 - 13.9
14 - 19.9	2½ x 120/60 mg tabs od	5 x 60 mg tabs od **OR** 1 x 300 mg tab od	1 x 150 mg tab od	2 x 100 mg tabs am + 1 x 100 mg tab pm **OR** 15 ml bd	2½ x 10 mg DT od	5 x pALD DT (60/30/5 mg) od	2½ x 10 mg DT bd **OR** [pALD DT (60/30/5) 5 tabs od + 2½ x 10 mg DTG DT approx. 12 hours later]	2.5 ml bd **OR** 2 x 100/25 mg **paed tabs** bd **OR** 1 x 200/50 mg **adult tab** bd		4 x 100/25 mg **paed tabs** bd **OR** 2 x 200/50 mg **adult tabs** bd		14 - 19.9
20 - 24.9	3 x 120/60 mg tabs od	1 x 300 mg tab + 1 x 60 mg tab od **OR** 6 x 60 mg tabs od	2 x 150 mg tabs od	2 x 100 mg tabs bd **OR** 20 ml bd	3 x 10 mg DT od **OR** 1 x 50 mg FC tab od	6 x pALD DT (60/30/5 mg) od	3 x 10 mg DT bd **OR** 1 x 50 mg FC tab bd **OR** [pALD DT (60/30/5) 6 tabs od + 3 x 10 mg DTG DT 12 hours later] **OR** [pALD DT (60/30/5) 6 tabs od + 1 x 50 mg DTG FC approx. 12 hours later]	3 ml bd **OR** 2 x 100/25 mg **paed tabs** bd **OR** 1 x 200/50 mg **adult tab** bd				20 - 24.9
25 - 29.9	1 x 600/300 mg tab od **OR** ALD (600/300/50 mg) 1 tab od	2 x 300 mg tabs od		1 x 300 mg tab bd **OR** 1 x AZT/3TC 300/150 mg tab bd	1 x 50 mg FC tab od **OR** ALD (600/300/50 mg) od	ALD (600/300/50 mg) x 1 tab od	1 x 50 mg FC tab bd **OR** [ALD (600/300/50 mg) 1 tab od + 50 mg DTG FC tab approx. 12 hours later]	3.5 ml bd **OR** 3 x 100/25 mg **paed tabs** bd **OR** [1 x 200/50 mg **adult tab** bd + 1 x 100/25 mg **paed tab** bd][5]	LPV/r std dose (see purple column) + oral RTV powder 300 mg (3 packets) bd	6 x 100/25 mg **paed tabs** bd **OR** 3 x 200/50 mg **adult tabs** bd	1 x ATV/RTV 300/100 mg FDC od	25 - 29.9
30 - 34.9					1 x 50 mg FC tab od **OR** FDC: TLD, if eligible, 1 tab od **OR** ALD (600/300/50 mg) 1 tab od		1 x 50 mg FC tab bd **OR** FDC: [TLD if eligible od + 50 mg DTG FC tab 12 hours later] **OR** [ALD (600/300/50 mg) x 1 tab od + 50 mg DTG FC tab approx. 12 hours later]	5 ml bd **OR** 4 x 100/25 mg **paed tabs** bd **OR** 2 x 200/50 mg **adult tabs** bd		8 x 100/25 mg **paed tabs** bd **OR** 4 x 200/50 mg **adult tabs** bd		30 - 34.9
≥35												≥35

[*]Avoid LPV/r solution in any full-term infant <14 days of age and any premature infant <42 weeks post conceptual age (corrected gestational age) or obtain expert advice. [$] Children weighing 25-29.9 kg may also be dosed with LPV/r 200/50 mg adult tabs: 2 tabs am + 1 tab pm. [#]Atazanavir + ritonavir should not be used in children/adolescents on treatment with rifampicin, obtain expert advice.

od = once a day; nocte = at night; bd = twice a day; am = in the morning; pm = in the evening; std = standard; ALD = abacavir/lamivudine/dolutegravir; FDC = fixed dose combination; TLD = tenofovir/lamivudine/dolutegravir; pALD = paediatric ALD (60/30/5 mg)

Weight (kg)	3 - 5.9	6 - 13.9	14 - 24.9	≥ 25
Cotrimoxazole Dose	2.5 ml od	5 ml or ½ tab od	10 ml or 1 tab od	2 tabs od
Multivitamin Dose	2.5 ml od	2.5 ml od	5 ml od	10 ml od

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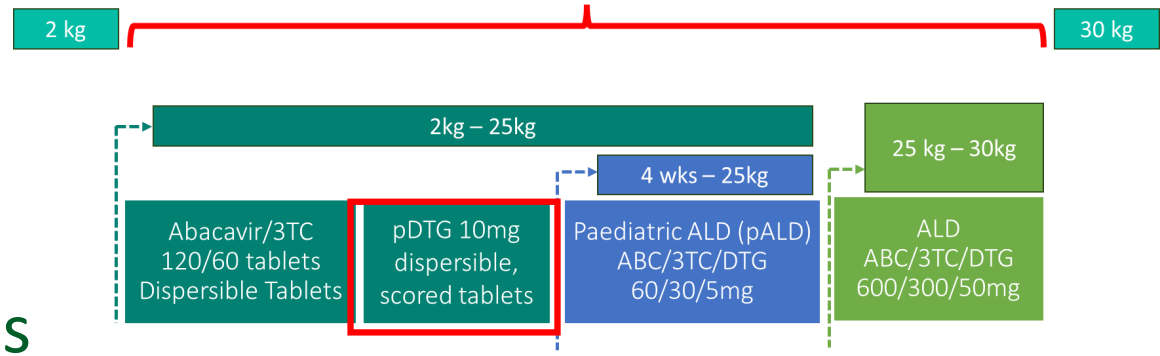
	Abacavir + Lamivudine (ABC + 3TC)
Target dose	As for individual medicines ONCE daily
Available formula-tions	Dispersible tablet FDC: ABC/3TC 120/60 mg Tablets FDC: ABC/3TC 600/300 mg ABC/3TC/DTG (ALD) 600/300/50 mg
Wt. (kg)	
2 - 2.9	½ x 120/60 mg tab od
3 - 5.9	
6 - 9.9	1½ x 120/60 mg tabs od
10 - 13.9	2 x 120/60 mg tabs od
14 - 19.9	2½ x 120/60 mg tabs od
20 - 24.9	3 x 120/60 mg tabs od
25 - 29.9	1 x 600/300 mg tab od OR ALD (600/300/50 mg) 1 tab od
30 - 34.9	

Note that dosage in this weight band has changed

pDTG dispersible, scored tablets



- 10mg scored dispersible generic tabs
- Can be used from birth for term infants ≥ 2kg *
  - But special neonatal dose for first 4 weeks of life
- Can be added to water, milk or soft foods
- Can be swallowed whole but not chewed or crushed
- Are not bioequivalent with the 50mg film-coated DTG tabs
  - 30mg of dispersible tabs =one 50mg film-coated tab (factor of 1.6)
- After 20kg, children should generally be switched to the DTG 50mg formulation, unless there are challenges swallowing whole tablets.
- DTG 50mg tabs can be crushed

ARV DRUG DOSING CHART FOR CHILDREN ≥ 28 DAYS (2025)

Compiled by National HIV & TB Health Care Worker Hotline and the Child and Adolescent Committee of SA HIV Clinicians Society in collaboration with the Department of Health

	Abacavir + Lamivudine (ABC + 3TC)	Abacavir (ABC)	Lamivudine (3TC)	Zidovudine (AZT)	Dolutegravir (DTG)	Abacavir + Lamivudine + Dolutegravir (ALD)	Dolutegravir (DTG) or Abacavir/Lamivudine/ Dolutegravir (ALD) when on Rifampicin	Lopinavir/ritonavir (LPV/r)	Lopinavir/ritonavir when on rifampicin (and for 2 weeks after stopping rifampicin)		#Atazanavir (ATV) + Ritonavir (RTV)	
Target dose	As for individual medicines ONCE daily	8 mg/kg/dose TWICE daily OR If ≥ 10kg: 16 mg/kg/dose ONCE daily	4 mg/kg/dose TWICE daily OR If ≥ 10kg: 8 mg/kg/dose ONCE daily	180-240 mg/m²/dose TWICE daily	By weight band ONCE daily IF PATIENT IS ON RIFAMPIC ADD ADDITIONAL DTG UP TO STOPPING RIFAMPICIN. SE	By weight band ONCE daily TB TREATMENT, WO WEEKS AFTER NEXT COLUMN	By weight band TWICE DAILY	300/75 mg/m2/dose LPV/r TWICE daily	LPV/r std dose + super-boosting with ritonavir (RTV) powder TWICE daily (≥0.75xLPV dose bd)	OR Double-dose LPV/r tabs ONLY if able to swallow whole LPV/r tabs TWICE daily	By weight band ONCE daily	Target dose
Available formulations	Dispersible tablet FDC: ABC/3TC 120/60 mg Tablets FDC: ABC/3TC 600/300 mg ABC/3TC/DTG (ALD) 600/300/50 mg	Sol. 20 mg/ml Tabs 60 mg (scored, dispersible), 300 mg (not scored)	Sol. 10 mg/ml Tabs 150 mg (scored)	Sol. 10 mg/ml, Tabs 100 mg; 300 mg FDC: AZT/3TC 300/150 mg	Dispersible tabs (DT) 10 mg, Film coated (FC) tabs 50 mg, FDC: TLD 300/300/50 mg OR ALD 600/300/50 mg DT AND FC TABLETS ARE NOT BIOEQUIVALENT	Dispersible tablets (DT) FDC: ALD 60/30/5 mg ALD 600/300/50 mg	Dispersible tabs (DT) 10 mg, Film coated (FC) tabs 50 mg, FDC: TLD 300/300/50 mg OR ALD DT 60/30/5 OR ALD 600/300/50 mg DT AND FC TABLETS ARE NOT BIOEQUIVALENT	Sol. 80/20 mg/ml Adult tabs 200/50 mg, Paed tabs 100/25 mg TABLETS MUST BE SWALLOWED WHOLE	Oral powder 100 mg/packet	Adult tabs 200/50 mg, Paed tabs 100/25 mg	FDC: ATV/RTV 300/100 mg ATV/r FDC TABLETS MUST BE SWALLOWED WHOLE	Available formulations
Wt. (kg)	Consult with a clinician experienced in paediatric ARV prescribing for neonates (< 28 days of age) and infants weighing < 2kg											Wt. (kg)
2 - 2.9	½ x 120/60 mg tab od	-	-	-	½ x 10 mg DT od	1 x pALD DT (60/30/5 mg) od	½ x 10 mg DT bd OR [pALD DT (60/30/5) 1 tabs od + ½ x 10 mg DTG DT approx. 12 hours later]	-	-	-	-	2 - 2.9
3 - 5.9		3 ml bd OR 1 x 60 mg tab bd	3 ml bd	6 ml bd				* 1 ml bd	LPV/r std dose (see purple column) + oral RTV powder 100 mg (1 packet) bd	Do not use double-dose LPV/r tabs	No preparation available	3 - 5.9
6 - 9.9	1½ x 120/60 mg tabs od	4 ml bd OR 1½ x 60 mg tab bd	4 ml bd	9 ml bd	1½ x 10 mg DT od	3 x pALD DT (60/30/5 mg) od	1½ x 10 mg DT bd OR [pALD DT (60/30/5) 3 tabs od + 1½ x 10 mg DTG DT approx. 12 hours later]	* 1.5 ml bd				6 - 9.9
10 - 13.9	2 x 120/60 mg tabs od	Once daily dosing > 10 kg: 4 x 60 mg tabs od OR 12 ml od	Once daily dosing > 10 kg: 12 ml od	12 ml bd OR 1 x 100 mg tabs bd	2 x 10 mg DT od	4 x pALD DT (60/30/5 mg) od	2 x 10 mg DT bd OR [pALD DT (60/30/5) 4 tabs od + 2 x 10 mg DTG DT approx. 12 hours later]	2 ml bd OR [2 x 100/25 mg paed tabs am + 1 x 100/25 mg paed tab pm]	LPV/r std dose (see purple column) + oral RTV powder 200 mg (2 packets) bd	3 x 100/25 mg paed tabs bd		10 - 13.9
14 - 19.9	2½ x 120/60 mg tabs od	5 x 60 mg tabs od OR 1 x 300 mg tab od	1 x 150 mg tab od	2 x 100 mg tabs am + 1 x 100 mg tab pm OR 15 ml bd	2½ x 10 mg DT od	5 x pALD DT (60/30/5 mg) od	2½ x 10 mg DT bd OR [pALD DT (60/30/5) 5 tabs od + 2½ x 10 mg DTG DT approx. 12 hours later]	2.5 ml bd OR 2 x 100/25 mg paed tabs bd OR 1 x 200/50 mg adult tab bd		4 x 100/25 mg paed tabs bd OR 2 x 200/50 mg adult tabs bd		14 - 19.9
20 - 24.9	3 x 120/60 mg tabs od	1 x 300 mg tab + 1 x 60 mg tab od OR 6 x 60 mg tabs od	2 x 150 mg tabs od	2 x 100 mg tabs bd OR 20 ml bd	3 x 10 mg DT od OR 1 x 50 mg FC tab od	6 x pALD DT (60/30/5 mg) od	3 x 10 mg DT bd OR 1 x 50 mg FC tab bd OR [pALD DT (60/30/5) 6 tabs od + 3 x 10 mg DTG DT 12 hours later] OR [pALD DT (60/30/5) 6 tabs od + 1 x 50 mg DTG FC approx. 12 hours later]	3 ml bd OR 2 x 100/25 mg paed tabs bd OR 1 x 200/50 mg adult tab bd				20 - 24.9
25 - 29.9	1 x 600/300 mg tab od OR ALD (600/300/50 mg) 1 tab od	2 x 300 mg tabs od		1 x 300 mg tab bd OR 1 x AZT/3TC 300/150 mg tab bd	1 x 50 mg FC tab od OR ALD (600/300/50 mg) od	ALD (600/300/50 mg) x 1 tab od	1 x 50 mg FC tab bd OR [ALD (600/300/50 mg) 1 tab od + 50 mg DTG FC tab approx. 12 hours later]	3.5 ml bd OR 3 x 100/25 mg paed tabs bd OR [1 x 200/50 mg adult tab bd + 1 x 100/25 mg paed tab bd][5]	LPV/r std dose (see purple column) + oral RTV powder 300 mg (3 packets) bd	6 x 100/25 mg paed tabs bd OR 3 x 200/50 mg adult tabs bd	1 x ATV/RTV 300/100 mg FDC od	25 - 29.9
30 - 34.9					1 x 50 mg FC tab od OR FDC: TLD, if eligible, 1 tab od OR ALD (600/300/50 mg) 1 tab od		1 x 50 mg FC tab bd OR FDC: [TLD if eligible od + 50 mg DTG FC tab 12 hours later] OR [ALD (600/300/50 mg) x 1 tab od + 50 mg DTG FC tab approx. 12 hours later]	5 ml bd OR 4 x 100/25 mg paed tabs bd OR 2 x 200/50 mg adult tabs bd		8 x 100/25 mg paed tabs bd OR 4 x 200/50 mg adult tabs bd		30 - 34.9
≥35												≥35

*Avoid LPV/r solution in any full-term infant <14 days of age and any premature infant <42 weeks post conceptual age (corrected gestational age) or obtain expert advice. [5] Children weighing 25-29.9 kg may also be dosed with LPV/r 200/50 mg adult tabs: 2 tabs am + 1 tab pm. #Atazanavir + ritonavir should not be used in children/adolescents on treatment with rifampicin, obtain expert advice.

od = once a day; nocte = at night; bd = twice a day; am = in the morning; pm = in the evening; std = standard; ALD = abacavir/lamivudine/dolutegravir; FDC = fixed dose combination; TLD = tenofovir/lamivudine/dolutegravir; pALD = paediatric ALD (60/30/5 mg)

Weight (kg)	3 - 5.9	6 - 13.9	14 - 24.9	≥ 25
Cotrimoxazole Dose	2.5 ml od	5 ml or ½ tab od	10 ml or 1 tab od	2 tabs od
Multivitamin Dose	2.5 ml od	2.5 ml od	5 ml od	10 ml od

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	Dolutegravir (DTG)
Target dose	By weight band ONCE daily
	IF PATIENT IS ON RIFAMPICI ADD ADDITIONAL DTG UP TO STOPPING RIFAMPICIN. SE
Available formula-tions	Dispersible tabs (DT) 10 mg, Film coated (FC) tabs 50 mg, FDC: TLD 300/300/50 mg OR ALD 600/300/50 mg DT AND FC TABLETS ARE NOT BIOEQUIVALENT
Wt. (kg)	linician experienced in p
2 - 2.9	½ x 10 mg DT od
3 - 5.9	
6 - 9.9	1½ x 10 mg DT od
10 - 13.9	2 x 10 mg DT od
14 - 19.9	2½ x 10 mg DT od
20 - 24.9	3 x 10 mg DT od OR 1 x 50 mg FC tab od
25 - 29	1 x 50 mg FC tab od OR ALD (600/300/50 mg) od
30 - 34.9	1 x 50 mg FC tab od OR FDC: TLD, if eligible, 1 tab od
≥35	(600/300/50 mg) 1 tab od

health
Department:
Health
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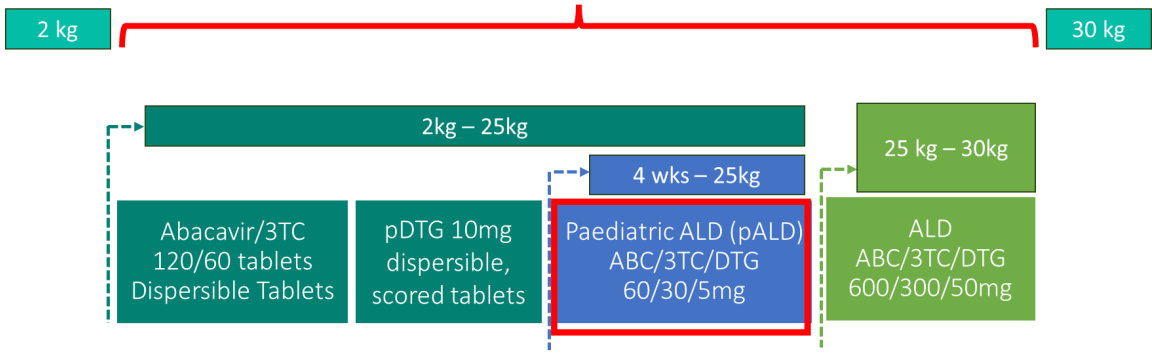
2030 NDP

Paediatric ALD ABC/3TC/DTG 60/30/5mg



- New formulation
- Can be used from 4 weeks of age and 2 kg to <25kg*
- Can be taken with or without food
- The dispersible tablets should only be dispersed in water only.
- When dispersed, the amount of water will depend on the number of tablets prescribed.
  - If 3 tabs or less- 15ml of water
  - If 4-6 tabs – 20ml of water
- The tablet should not be chewed, cut or crushed.

ARV DRUG DOSING CHART FOR CHILDREN ≥ 28 DAYS (2025)

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	Abacavir + Lamivudine (ABC + 3TC)	Abacavir (ABC)	Lamivudine (3TC)	Zidovudine (AZT)	Dolutegravir (DTG)	Abacavir + Lamivudine + Dolutegravir (ALD)	Dolutegravir (DTG) or Abacavir/Lamivudine/ Dolutegravir (ALD) when on Rifampicin	Lopinavir/ritonavir (LPV/r)	Lopinavir/ritonavir when on rifampicin (and for 2 weeks after stopping rifampicin)		#Atazanavir (ATV) + Ritonavir (RTV)	
Target dose	As for individual medicines ONCE daily	8 mg/kg/dose TWICE daily OR If ≥ 10kg: 16 mg/kg/dose ONCE daily	4 mg/kg/dose TWICE daily OR If ≥ 10kg: 8 mg/kg/dose ONCE daily	180-240 mg/m²/dose TWICE daily	By weight band ONCE daily IF PATIENT IS ON RIFAMPICIN ADD ADDITIONAL DTG UP TO TWO WEEKS AFTER STOPPING RIFAMPICIN SEE NEXT COLUMN	By weight band ONCE daily CIN TB TREATMENT,	By weight band TWICE DAILY	300/75 mg/m2/dose LPV/r TWICE daily	LPV/r std dose + super-boosting with ritonavir (RTV) powder TWICE daily (≥0.75xLPV dose bd)	OR Double-dose LPV/r tabs ONLY if able to swallow whole LPV/r tabs TWICE daily	By weight band ONCE daily	Target dose
Available formulations	Dispersible tablet FDC: ABC/3TC 120/60 mg Tablets FDC: ABC/3TC 600/300 mg ABC/3TC/DTG (ALD) 600/300/50 mg	Sol. 20 mg/ml Tabs 60 mg (scored, dispersible), 300 mg (not scored)	Sol. 10 mg/ml Tabs 150 mg (scored)	Sol. 10 mg/ml, Tabs 100 mg; 300 mg FDC: AZT/3TC 300/150 mg	Dispersible tabs (DT) 10 m Film coated (FC) tabs 50 m FDC: TLD 300/300/50 mg C ALD 600/300/50 mg DT AND FC TABLETS ARE NOT BIOEQUIVALENT	Dispersible tablets (DT) FDC: pALD 60/30/5 mg ALD 600/300/50 mg	Dispersible tabs (DT) 10 mg, Film coated (FC) tabs 50 mg, FDC: TLD 300/300/50 mg OR ALD DT 60/30/5 OR ALD 600/300/50 mg DT AND FC TABLETS ARE NOT BIOEQUIVALENT	Sol. 80/20 mg/ml Adult tabs 200/50 mg, Paed tabs 100/25 mg TABLETS MUST BE SWALLOWED WHOLE	Oral powder 100 mg/packet	Adult tabs 200/50 mg, Paed tabs 100/25 mg	FDC: ATV/RTV 300/100 mg ATV/r FDC TABLETS MUST BE SWALLOWED WHOLE	Available formulations
Wt. (kg)	Consult with a clinician experienced in paediatric ARV prescribing for neonates (< 28 days of age) and infants weighing < 2kg											Wt. (kg)
2 - 2.9	½ x 120/60 mg tab od	-	-	-	½ x 10 mg DT od	1 x pALD DT (60/30/5 mg) od	½ x 10 mg DT bd OR [pALD DT (60/30/5) 1 tabs od + ½ x 10 mg DTG DT approx. 12 hours later]	-	-	-	-	2 - 2.9
3 - 5.9		3 ml bd OR 1 x 60 mg tab bd	3 ml bd	6 ml bd				* 1 ml bd	LPV/r std dose (see purple column) + oral RTV powder 100 mg (1 packet) bd	Do not use double-dose LPV/r tabs	No preparation available	3 - 5.9
6 - 9.9	1½ x 120/60 mg tabs od	4 ml bd OR 1½ x 60 mg tab bd	4 ml bd	9 ml bd	1½ x 10 mg DT od	3 x pALD DT (60/30/5 mg) od	1½ x 10 mg DT bd OR [pALD DT (60/30/5) 3 tabs od + 1½ x 10 mg DTG DT approx. 12 hours later]	* 1.5 ml bd				6 - 9.9
10 - 13.9	2 x 120/60 mg tabs od	Once daily dosing > 10 kg: 4 x 60 mg tabs od OR 12 ml od	Once daily dosing > 10 kg: 12 ml od	12 ml bd OR 1 x 100 mg tabs bd	2 x 10 mg DT od	4 x pALD DT (60/30/5 mg) od	2 x 10 mg DT bd OR [pALD DT (60/30/5) 4 tabs od + 2 x 10 mg DTG DT approx. 12 hours later]	2 ml bd OR [2 x 100/25 mg paed tabs am + 1 x 100/25 mg paed tab pm]	LPV/r std dose (see purple column) + oral RTV powder 200 mg (2 packets) bd	3 x 100/25 mg paed tabs bd		10 - 13.9
14 - 19.9	2½ x 120/60 mg tabs od	5 x 60 mg tabs od OR 1 x 300 mg tab od	1 x 150 mg tab od	2 x 100 mg tabs am + 1 x 100 mg tab pm OR 15 ml bd	2½ x 10 mg DT od	5 x pALD DT (60/30/5 mg) od	2½ x 10 mg DT bd OR [pALD DT (60/30/5) 5 tabs od + 2½ x 10 mg DTG DT approx. 12 hours later]	2.5 ml bd OR 2 x 100/25 mg paed tabs bd OR 1 x 200/50 mg adult tab bd		4 x 100/25 mg paed tabs bd OR 2 x 200/50 mg adult tabs bd		14 - 19.9
20 - 24.9	3 x 120/60 mg tabs od	1 x 300 mg tab + 1 x 60 mg tab od OR 6 x 60 mg tabs od	2 x 150 mg tabs od	2 x 100 mg tabs bd OR 20 ml bd	3 x 10 mg DT od OR 1 x 50 mg FC tab od	6 x pALD DT (60/30/5 mg) od	3 x 10 mg DT bd OR 1 x 50 mg FC tab bd OR [pALD DT (60/30/5) 6 tabs od + x 10 mg DTG DT 12 hours later] OR [pALD DT (60/30/5) 6 tabs od + 1 x 50 mg DTG FC approx. 12 hours later]	3 ml bd OR 2 x 100/25 mg paed tabs bd OR 1 x 200/50 mg adult tab bd				20 - 24.9
25 - 29.9	1 x 600/300 mg tab od OR ALD (600/300/50 mg) 1 tab od	2 x 300 mg tabs od		1 x 300 mg tab bd OR 1 x AZT/3TC 300/150 mg tab bd	1 x 50 mg FC tab od OR ALD (600/300/50 mg od	ALD (600/300/50 mg) x 1 tab od	1 x 50 mg FC tab bd OR ALD (600/300/50 mg) od + 50 mg DTG FC tab approx. 12 hours later]	3.5 ml bd OR 3 x 100/25 mg paed tabs bd OR [1 x 200/50 mg adult tab bd + 1 x 100/25 mg paed tab bd][5]	LPV/r std dose (see purple column) + oral RTV powder 300 mg (3 packets) bd	6 x 100/25 mg paed tabs bd OR 3 x 200/50 mg adult tabs bd	1 x ATV/RTV 300/100 mg FDC od	25 - 29.9
30 - 34.9					1 x 50 mg FC tab od OR FDC: TLD, if eligible, 1 tab od OR ALD (600/300/50 mg) 1 tab od		1 x 50 mg FC tab bd OR FDC: [TLD if eligible od + 50 mg DTG FC tab 12 hours later] OR [ALD (600/300/50 mg) x 1 tab od + 50 mg DTG FC tab approx. 12 hours later]	5 ml bd OR 4 x 100/25 mg paed tabs bd OR 2 x 200/50 mg adult tabs bd		8 x 100/25 mg paed tabs bd OR 4 x 200/50 mg adult tabs bd		30 - 34.9
≥35												≥35

*Avoid LPV/r solution in any full-term infant <14 days of age and any premature infant <42 weeks post conceptual age (corrected gestational age) or obtain expert advice. [5] Children weighing 25-29.9 kg may also be dosed with LPV/r 200/50 mg adult tabs: 2 tabs am + 1 tab pm. #Atazanavir + ritonavir should not be used in children/adolescents on treatment with rifampicin, obtain expert advice.

od = once a day; nocte = at night; bd = twice a day; am = in the morning; pm = in the evening; std = standard; ALD = abacavir/lamivudine/dolutegravir; FDC = fixed dose combination; TLD = tenofovir/lamivudine/dolutegravir; pALD = paediatric ALD (60/30/5 mg)

Weight (kg)	3 - 5.9	6 - 13.9	14 - 24.9	≥ 25
Cotrimoxazole Dose	2.5 ml od	5 ml or ½ tab od	10 ml or 1 tab od	2 tabs od
Multivitamin Dose	2.5 ml od	2.5 ml od	5 ml od	10 ml od

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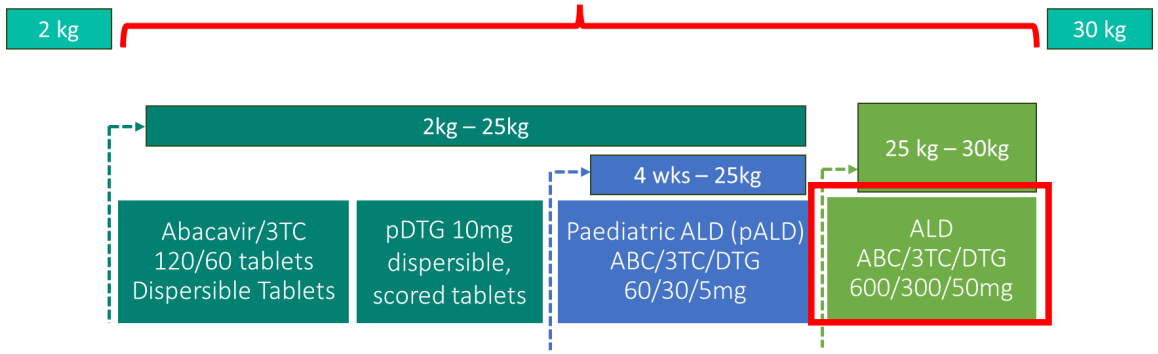
ALD (ABC/3TC/DTG) 600/300/50mg



- FDC of all 3 paediatric ARVs
- Large tablet
- Can be crushed/cut
- Can be used from 25kg
- 1 tablet daily

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2030 NDP

For ABC/3TC and pDTG dispersible tablets

Add the correct number of tablets to a clean, empty glass or cup based on the child's weight.

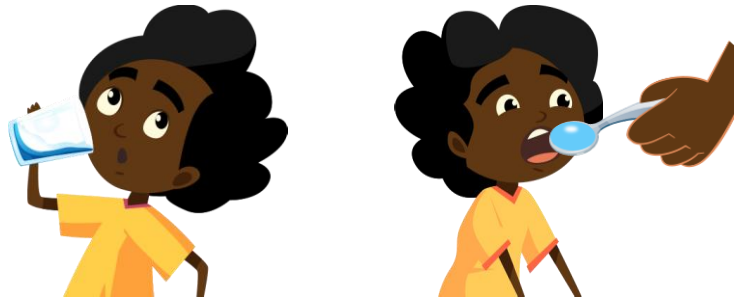
Add 10mL (2 teaspoons) of clean water into the glass or cup and stir until the tablets dissolve.

Give the medicine to the child to drink. Make sure they drink all the medicine right away or within a maximum of 30 minutes.

- pDTG can be dispersed and administered in the same solution of clean water as ABC/3TC 120/60 mg DT
- When dispersing both products together, use 10-20 mL (2-4 teaspoons) of clean water
- If the tablets do not dissolve completely (i.e., they lump together), stir and slowly add another 10ml (2 teaspoons) of extra water until the tablets fully dissolve.
- If any medicine remains in the glass, add a little more water to the glass and give it to the child. Repeat until no medicine remains in the glass.
- Other age-appropriate liquids or foods may be used (e.g., juice, milk, breast milk, yoghurt, porridge)

pALD 60/30/5mg instructions

- The number of tablets to be administered to the patient will be determined by his or her body weight.
- Remove the number of tablets recommended for one dose from the bottle using dry hands.
- Place the tablets in a container.
  - If three tablets or fewer: add 15 mL of water.
  - If four to six tablets: add 20 mL of water.
- Swirl or stir the tablets until completely dispersed.
- The suspension has a strawberry flavour.
- The child should consume the entire quantity immediately.
- Rinse the container with a small additional amount of water and ensure the child drinks this to receive the full dose.
- Do not mix the tablets with any liquid other than water.

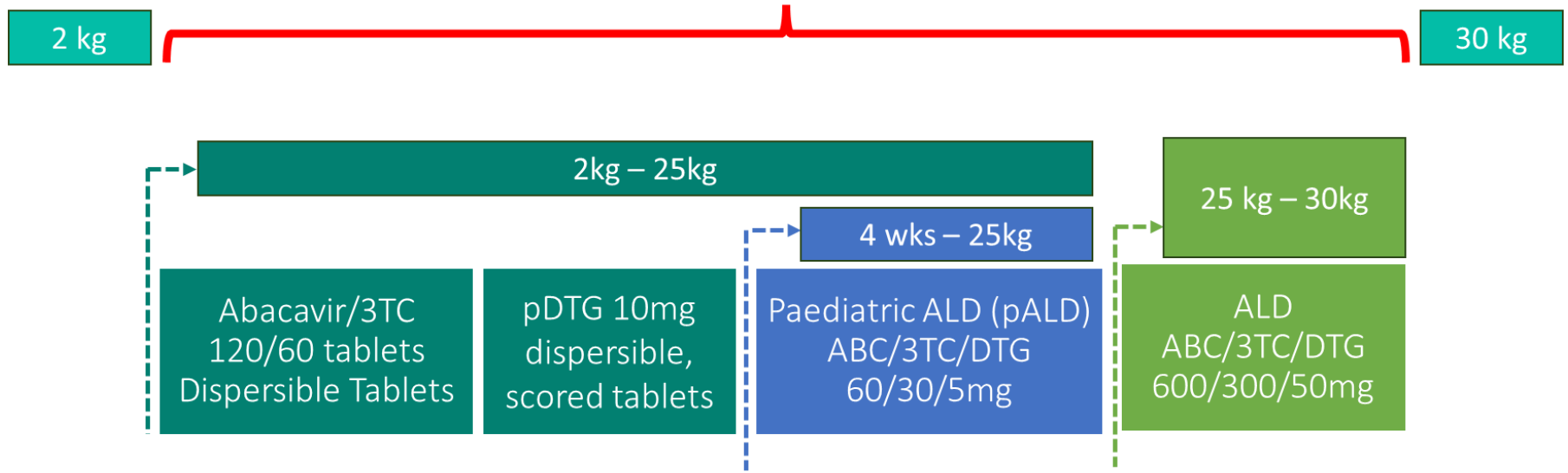


Advantages and Disadvantages of pALD

Advantages	Disadvantages
Entire regimen in 1 tablet	Often need more than 1 tablet
Only 1 product to transport	High pill burden but can be dispersed in water
Will take up less space on pharmacy shelves	Can only be used from 1 months and 2 kg*
Dispersible in water	No data on mixing with breast milk
	No data on chewing or breaking tablets
	Can't be used after 25kg

Overall, a welcome addition to our ART armamentarium.
In the NDOH, pALD will gradually be rolled out and virtually replace the individual components

Summary



Paediatric Formulation	ABC/3TC 120/60	pDTG 10mg	pALD 60/30/5	ALD 600/300/50
Minimum age and weight	2kg (+ term)	2kg (+ term)	2kg and 4 weeks of age	25kg
Maximum weight	24.9kg	24.9kg	24.9kg	
Can be swallowed whole?	Yes	Yes	No	Yes (large tablet)
Can be crushed/cut/chewed	Yes	No	No	Yes
Can be mixed with other liquids	Yes	Yes	No (water only)	Yes

NDoH recommended daily dosing for ABC/3TC & DTG-based formulations

NDoH Recommended Daily Dosing							
Formulation	**2 – 5.9 kg**	**6 – 9.9 kg**	**10 – 13.9 kg**	**14 – 19.9 kg**	**20 – 24.9 kg**	**25 – 29.9 kg**	**≥ 30 kg**
ABC/3TC 120/60mg dispersible, scored tablet [1]	0.5	1.5	2	2.5	3	*[transition to ABC/3TC 600/300mg][3]*	–
DTG 10mg dispersible, scored tablet [1&2]	0.5	1.5	2	2.5	*[transition to DTG 50mg][3]*	–	–
ABC/3TC 600/300 mg tablet [4]	–	–	–	–	–	1	–
DTG 50 mg tablet [2&5]	–	–	–	–	1	1	–
ABC/3TC/DTG 600/300/50 mg tablet	–	–	–	–	–	1	1
TDF/3TC/DTG 300/300/50 mg tablet	–	–	–	–	–	–	1

1. Can be dissolved in the same solution
2. Twice daily with concomitant use of
3. If able to swallow whole tablets
4. Transition to ABC/3TC/DTG if eligible
5. Transition to ABC/3TC/DTG or TDF/3TC/DTG if eligible

pALD (60/30/5mg)	**1**	**3**	**4**	**5**	**6**	**-**	**-**

ARV Drug	Formulations (as used in dosing chart)	Can tablets/capsules be split/crushed/ opened if unable to swallow?	Comment
Abacavir (ABC)	Oral solution: 20 mg/ml Tablets: 60 mg, 300 mg FDC tablets: - ABC/3TC 600/300 mg; - ALD 600/300/50 mg FDC dispersible tablet: - ABC/3TC 120/60 mg; - pALD 60/30/5 mg	Tablets: **YES** FDC 120/60 mg tablet is a dispersible tablet. May be split/crushed. FDC capsules should be opened and contents added to a small amount of food or dispersed in a liquid.	Hypersensitivity reaction (fever, rash, GIT & respiratory symptoms) may occur during first 6 weeks of therapy, very uncommon in black African patients. Symptoms typically worsen in the hours immediately after the dose and after each subsequent dose. Caregivers or patients should discuss symptoms early with the clinician rather than stopping therapy. Stop ABC permanently if hypersensitivity reaction has occurred.
Lamivudine (3TC)	Oral solution: 10 mg/ml Tablets: 150 mg; FDC tablets: - ABC/3TC 120/60 mg; - ABC/3TC 600/300 mg, - TLD 300/300/50 mg - ALD 600/300/50 mg FDC dispersible tablet: - pALD 60/30/5 mg		Well tolerated, adverse-effects uncommon. Pure red cell aplasia causing anaemia can occur but is very rare.
Zidovudine (AZT)	Oral solution: 10 mg/ml Tablets: 100 mg, 300 mg Capsules: 100 mg FDC tablet: AZT/3TC 300/150 mg	Tablets and FDC: **YES** Capsules: Can be opened and added to a small amount of soft food/liquid and ingested immediately.	Avoid or use with caution in neonates or children with anaemia (Hb <8 g/dl) due to potential to cause bone marrow suppression.
Tenofovir (TDF)	Tablets: 300 mg FDC tablets: - TDF/FTC 300/200 mg, - TLD 300/300/50 mg	Tablet and FDC tablets: **YES**	TDF may be prescribed for adolescents ≥ 10 years of age AND ≥ 30 kg body weight after ensuring adequate renal function by checking eGFR/creatinine using the appropriate formula (refer to HIV guidelines). TDF is usually prescribed as part of an FDC tablet: TDF/FTC, or TDF/3TC/DTG. To assess for TDF-induced nephrotoxicity, do creatinine and eGFR at months 3 and 10 and thereafter repeat every 12 months.
Lopinavir/ ritonavir (LPV/r)	Oral solution: 80/20 mg/ml Tablets: - 200/50 mg, - 100/25 mg	Tablets: **NO** **Must be swallowed whole and not divided, crushed or chewed.**	Oral solution should be refrigerated/stored at room temperature (if <25°C) for up to 6 weeks. Preferably administer oral solution with food as increases absorption. Strategies to improve tolerance and palatability of oral solution: coat mouth with peanut butter, dull taste buds with ice, follow dose with sweet foods. Many drug-drug interactions.#
Ritonavir (RTV)	Oral powder: 100 mg/packet		Each 100 mg packet of RTV powder should be mixed with a small amount of water or soft food and immediately ingested. Many drug-drug interactions.#
Atazanavir (ATV)	FDC tablets: ATV/RTV 300/100 mg	FDC tablets: **NO** **Must be swallowed whole and not divided, crushed or chewed.**	ATV is used in combination with RTV. May cause unconjugated hyperbilirubinaemia resulting in jaundice but this does not indicate hepatic toxicity and not a reason to discontinue the drug unless it is worrying the patient. Consider drug-drug interactions.#
Dolutegravir (DTG)	Dispersible tablet (DT): 10 mg Film coated (FC) tablets: 50 mg FDC tablets: - TLD 300/300/50 mg - ALD 600/300/50 mg	Dispersible tablets: **YES** Film coated tablets (including FDCs): **YES**	Iron supplements decrease DTG concentrations if taken together on an empty stomach. To prevent this, DTG and iron supplements can be taken at the same time if taken with food. May be helpful to administer as a morning dose rather than an evening dose if insomnia occurs with evening dosing. May raise creatinine levels by up to 15% without affecting renal function. Consider drug-drug interactions. # DTG DT and DTG FC tablets are not bioequivalent; 30 mg of DTG DT corresponds to 50 mg DTG FC tablets. DTG 50 mg FC tablets are preferred for children who have reached 20 kg (unless they cannot swallow tablets). pALD DT (60/30/5 mg) can only be dispersed in water, not milk or solid foods. Use approximately 15 mL of water when dispersing 3 tablets or less, and approximately 20 mL water when dispersing 4 tablets or more. Do not chew, crush or cut the tablets.

ALD = abacavir/lamivudine/dolutegravir; FDC = fixed dose combination; eGFR = estimated glomerular filtration rate; GIT = gastrointestinal tract; TLD = Tenofovir/ Lamivudine Dolutegravir; #EML-Antiretroviral interactions table (http://www.mic.uct.ac.za) OR www.hiv-druginteractions.org/checker OR the Liverpool HIV iChart application for smart phones, or any of the helplines: National HIV and TB Health Care Worker Hotline: 0800 212 506 or HIV Expert Helpline: 082 352 6642 or KZN Paediatric Hotline: 0800 006 60TEE

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ARV DRUG DOSING CHART FOR CHILDREN ≥ 28 DAYS (2025)

Compiled by National HIV & TB Health Care Worker Hotline and the Child and Adolescent Committee of SA HIV Clinicians Society in collaboration with the Department of Health

	Abacavir + Lamivudine (ABC + 3TC)	Abacavir (ABC)	Lamivudine (3TC)	Zidovudine (AZT)	Dolutegravir (DTG)	Abacavir + Lamivudine + Dolutegravir (ALD)	Dolutegravir (DTG) or Abacavir/Lamivudine/ Dolutegravir (ALD) when on Rifampicin	Lopinavir/ritonavir (LPV/r)	Lopinavir/ritonavir when on rifampicin (and for 2 weeks after stopping rifampicin)		#Atazanavir (ATV) + Ritonavir (RTV)	
Target dose	As for individual medicines ONCE daily	8 mg/kg/dose TWICE daily OR If ≥ 10kg: 16 mg/kg/dose ONCE daily	4 mg/kg/dose TWICE daily OR If ≥ 10kg: 8 mg/kg/dose ONCE daily	180-240 mg/m²/dose TWICE daily	By weight band ONCE daily IF PATIENT IS ON RIFAMPICIN TB TREATMENT ADD ADDITIONAL DTG UP TO TWO WEEKS AFTER STOPPING RIFAMPICIN. SEE NEXT COLUMN	By weight band ONCE daily	By weight band TWICE DAILY	300/75 mg/m2/dose LPV/r TWICE daily	LPV/r std dose + super-boosting with ritonavir (RTV) powder TWICE daily (≥0.75xLPV dose bd)	OR Double-dose LPV/r tabs ONLY if able to swallow whole LPV/r tabs TWICE daily	By weight band ONCE daily	Target dose
Available formulations	Dispersible tablet FDC: ABC/3TC 120/60 mg Tablets FDC: ABC/3TC 600/300 mg ABC/3TC/DTG (ALD) 600/300/50 mg	Sol. 20 mg/ml Tabs 60 mg (scored, dispersible), 300 mg (not scored)	Sol. 10 mg/ml Tabs 150 mg (scored)	Sol. 10 mg/ml Tabs 100 mg 300 mg FDC: AZT/3TC 300/150 mg	Dispersible tabs (DT) 10 mg, Film coated (FC) tabs 50 mg FDC: TLD 300/300/50 mg OR ALD 600/300/50 mg DT AND FC TABLETS ARE NOT BIOEQUIVALENT	Dispersible tablets (DT) FDC: ALD 60/30/5 mg ALD 600/300/50 mg	Dispersible tabs (DT) 10 mg, Film coated (FC) tabs 50 mg, FDC: TLD 300/300/50 mg OR ALD DT 60/30/5 OR ALD 600/300/50 mg DT AND FC TABLETS ARE NOT BIOEQUIVALENT	Sol. 80/20 mg/ml Adult tabs 200/50 mg, Paed tabs 100/25 mg TABLETS MUST BE SWALLOWED WHOLE	Oral powder 100 mg/packet	Adult tabs 200/50 mg, Paed tabs 100/25 mg	FDC: ATV/RTV 300/100 mg ATV/r FDC TABLETS MUST BE SWALLOWED WHOLE	Available formulations
Wt. (kg)	Consult with a clinician experienced in paediatric ARV prescribing for neonates (< 28 days of age) and infants weighing < 2kg											Wt. (kg)
2 - 2.9	½ x 120/60 mg tab od	-	-	-	½ x 10 mg DT od	1 x pALD DT (60/30/5 mg) od	½ x 10 mg DT bd OR [pALD DT (60/30/5) 1 tabs od + ½ x 10 mg DTG DT approx. 12 hours later]	-	-	-	-	2 - 2.9
3 - 5.9		3 ml bd OR 1 x 60 mg tab bd	3 ml bd	6 ml bd				* 1 ml bd	LPV/r std dose (see purple column) + oral RTV powder 100 mg (1 packet) bd	Do not use double-dose LPV/r tabs	No preparation available	3 - 5.9
6 - 9.9	1½ x 120/60 mg tabs od	4 ml bd OR 1½ x 60 mg tab bd	4 ml bd	9 ml bd	1½ x 10 mg DT od	3 x pALD DT (60/30/5 mg) od	1½ x 10 mg DT bd OR [pALD DT (60/30/5) 3 tabs od + 1½ x 10 mg DTG DT approx. 12 hours later]	* 1.5 ml bd				6 - 9.9
10 - 13.9	2 x 120/60 mg tabs od	Once daily dosing > 10 kg: 4 x 60 mg tabs od OR 12 ml od	Once daily dosing > 10 kg: 12 ml od	12 ml bd OR 1 x 100 mg tabs bd	2 x 10 mg DT od	4 x pALD DT (60/30/5 mg) od	2 x 10 mg DT bd OR [pALD DT (60/30/5) 4 tabs od + 2 x 10 mg DTG DT approx. 12 hours later]	2 ml bd OR [2 x 100/25 mg paed tabs am + 1 x 100/25 mg paed tab pm]		3 x 100/25 mg paed tabs bd		10 - 13.9
14 - 19.9	2½ x 120/60 mg tabs od	5 x 60 mg tabs od OR 1 x 300 mg tab od	1 x 150 mg tab od	2 x 100 mg tabs am + 1 x 100 mg tab pm OR 15 ml bd	2½ x 10 mg DT od	5 x pALD DT (60/30/5 mg) od	2½ x 10 mg DT bd OR [pALD DT (60/30/5) 5 tabs od + 2½ x 10 mg DTG DT approx. 12 hours later]	2.5 ml bd OR 2 x 100/25 mg paed tabs bd OR 1 x 200/50 mg adult tab bd	LPV/r std dose (see purple column) + oral RTV powder 200 mg (2 packets) bd	4 x 100/25 mg paed tabs bd OR 2 x 200/50 mg adult tabs bd		14 - 19.9
20 - 24.9	3 x 120/60 mg tabs od	1 x 300 mg tab + 1 x 60 mg tab od OR 6 x 60 mg tabs od	2 x 150 mg tabs od	2 x 100 mg tabs bd OR 20 ml bd	3 x 10 mg DT od OR 1 x 50 mg FC tab od	6 x pALD DT (60/30/5 mg) od	3 x 10 mg DT bd OR 1 x 50 mg FC tab bd OR [pALD DT (60/30/5) 6 tabs od + ½ x 10 mg DTG DT 12 hours later] OR [pALD DT (60/30/5) 6 tabs od + 1 x 50 mg DTG FC approx. 12 hours later]	3 ml bd OR 2 x 100/25 mg paed tabs bd OR 1 x 200/50 mg adult tab bd				20 - 24.9
25 - 29.9	1 x 600/300 mg tab od OR ALD (600/300/50 mg) 1 tab od	2 x 300 mg tabs od		1 x 300 mg tab bd OR 1 x AZT/3TC 300/150 mg tab bd	1 x 50 mg FC tab od OR ALD (600/300/50 mg) od	ALD (600/300/50 mg) x 1 tab od	1 x 50 mg FC tab bd OR [ALD (600/300/50 mg) 1 tab od + 50 mg DTG FC tab approx. 12 hours later]	3.5 ml bd OR 3 x 100/25 mg paed tabs bd OR [1 x 200/50 mg adult tab bd + 1 x 100/25 mg paed tab bd][5]	LPV/r std dose (see purple column) + oral RTV powder 300 mg (3 packets) bd	6 x 100/25 mg paed tabs bd OR 3 x 200/50 mg adult tabs bd	1 x ATV/RTV 300/100 mg FDC od	25 - 29.9
30 - 34.9					1 x 50 mg FC tab od OR FDC: TLD, if eligible, 1 tab od OR ALD (600/300/50 mg) 1 tab od		FDC: TLD if eligible od + 50 mg DTG FC tab 12 hours later] OR [ALD (600/300/50 mg) x 1 tab od + 50 mg DTG FC tab approx. 12 hours later]	5 ml bd OR 4 x 100/25 mg paed tabs bd OR 2 x 200/50 mg adult tabs bd		8 x 100/25 mg paed tabs bd OR 4 x 200/50 mg adult tabs bd		30 - 34.9
≥35												≥35

*Avoid LPV/r solution in any full-term infant <14 days of age and any premature infant <42 weeks post conceptual age (corrected gestational age) or obtain expert advice. [5] Children weighing 25-29.9 kg may also be dosed with LPV/r 200/50 mg adult tabs: 2 tabs am + 1 tab pm. #Atazanavir + ritonavir should not be used in children/adolescents on treatment with rifampicin, obtain expert advice.

od = once a day; nocte = at night; bd = twice a day; am = in the morning; pm = in the evening; std = standard; ALD = abacavir/lamivudine/dolutegravir; FDC = fixed dose combination; TLD = tenofovir/lamivudine/dolutegravir; pALD = paediatric ALD (60/30/5 mg)

Weight (kg)	3 - 5.9	6 - 13.9	14 - 24.9	≥ 25
Cotrimoxazole Dose	2.5 ml od	5 ml or ½ tab od	10 ml or 1 tab od	2 tabs od
Multivitamin Dose	2.5 ml od	2.5 ml od	5 ml od	10 ml od

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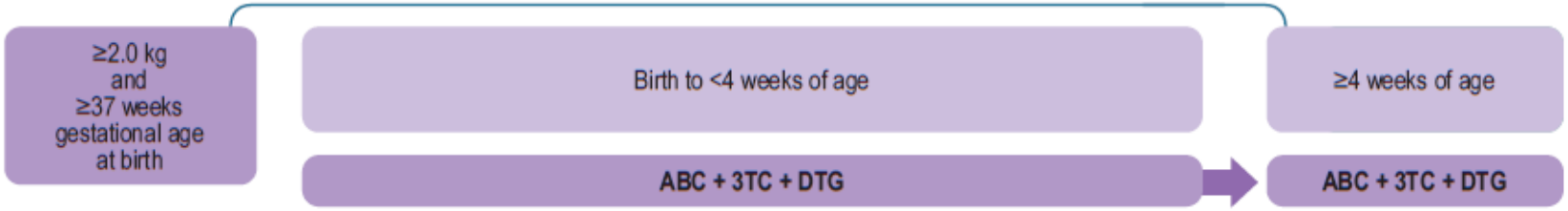
Published December 2025; V1

Neonatal ART

ART for Term Neonates



Baseline Assessment

- Clinical review
- Bloods: confirmatory HIV PCR (or HIV VL), CD4 count, FBC +/- HIV drug resistance test if mother failing treatment on TLD2 or a protease inhibitor regimen
- Counsel parent / caregiver
- Ensure the mother is on ART
- Advise that breastfeeding is recommended for all infants living with HIV.

Review after 1 week then 1-2 weekly

- Clinical review and counselling
- Check baseline blood results
- If indeterminate / negative confirmatory HIV PCR test result, refer to Guideline for Vertical Transmission Prevention of Communicable Infections

Review when 4 weeks of age

- Clinical review and counselling
- Continue ABC + 3TC + DTG - dosing as per ARV dosing chart for children ≥ 28 days
- Continue monitoring as per ***Monitoring on ART on page 41***

	Birth - < 2 weeks	2 weeks - < 4 weeks
Available formulation	**Dispersible tabs (DT) 120/60 mg (double scored tablet) #**	**Dispersible tabs (DT) 10 mg**
Abacavir + Lamivudine (ABC + 3TC)	¼ of double-scored tab once every 2nd day (alternate days)	¼ of double-scored tab **once daily**
Dolutegravir (DTG)	½ tab **once every 2nd day (alternate days)**	½ tab **once daily**
# *If ABC/3TC **Double scored** dispersible tablet (120/60 mg) is not available, use ABC and 3TC solution with the DTG dispersible tablet.*		
Abacavir (ABC) Solution (20 mg/mL)	**1.5 mL Every 2nd day**	**1.5 mL Once a day**
Lamivudine (3TC) Solution (10 mg/mL)	**1.5 mL Every 2nd day**	**1.5 mL Once a day**
Dolutegravir (DTG)	½ tab **once every 2nd day (alternate days)**	½ tab **once daily**

Example Timetable for Neonatal ART in first month

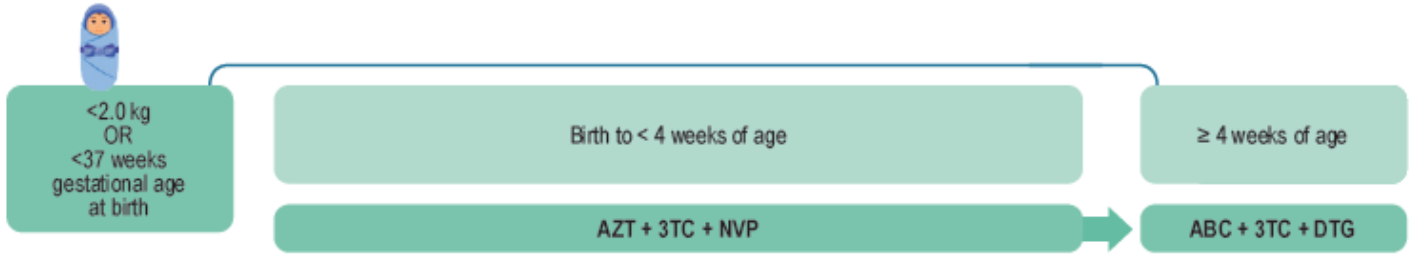
Day 1 to 14	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	X		X		X		X
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
		X		X		X	
Day 15 - 28	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	X	X	X	X	X	X	X
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	X	X	X	X	X	X	X

Every second day for 14 days

Then every day for 14 days

X = ¼ tab ABC/3TC and ½ tab pDTG

ART for Preterm Neonates



Baseline Assessment

- Clinical review
- Bloods: confirmatory HIV PCR (or HIV VL), CD4 count, FBC +/- HIV drug resistance test if mother failing treatment on TLD2 or a protease inhibitor regimen
- Counsel parent / caregiver
- Ensure the mother is on ART, and advise that breastfeeding is recommended for all infants living with HIV

Review after 1 week then 1-2 weekly

- Clinical review and counselling
- Check baseline blood results
- If indeterminate / negative confirmatory HIV PCR test result, refer to Guideline for Vertical Transmission Prevention of Communicable Infections
- Monitor weight gain and adjust ARV doses

Review when ≥4 weeks of age

- Clinical review and counselling
- If <2 kg or <37 weeks corrected gestational age, continue AZT + 3TC + NVP
- If ≥ 2 kg and ≥ 37 weeks corrected gestational age, switch to ABC + 3TC + DTG (refer to ARV dosing chart for children for doses)
- Continue monitoring and evaluations as per *Monitoring on ART on page 41*

Gestational age at birth	Chronological age	Zidovudine (AZT)	Lamivudine (3TC)	Nevirapine (NVP)
		Solution 10 mg/mL	Solution 10 mg/mL	Solution 10 mg/mL
< 30 weeks	Birth - < 4 weeks	2 mg/kg/dose twice daily	2 mg/kg/dose twice daily	2 mg/kg/dose twice daily
	≥ 4 weeks - < 8 weeks	3 mg/kg/dose twice daily		4 mg/kg/dose twice daily
	≥ 8 weeks - < 10 weeks	12 mg/kg/dose twice daily	4 mg/kg/dose twice daily	6 mg/kg/dose twice daily
≥ 30 - < 35 weeks	Birth - < 2 weeks	2 mg/kg/dose twice daily	2 mg/kg/dose twice daily	2 mg/kg/dose twice daily
	≥ 2 - < 4 weeks	3 mg/kg/dose twice daily		4 mg/kg/dose twice daily
	≥ 4 - < 6 weeks		4 mg/kg/dose twice daily	6 mg/kg/dose twice daily
	≥ 6 - < 8 weeks	12 mg/kg/dose twice daily		
≥ 35 - < 37 weeks	Birth - < 1 weeks	4 mg/kg/dose twice daily	2 mg/kg/dose twice daily	4 mg/kg/dose twice daily
	≥ 1 - < 4 weeks			6 mg/kg/dose twice daily

When weight is ≥2 kg and ≥ 37 weeks corrected gestational age, review ARVs and refer to table ART for the Term Neonate on page 168

Thank you!

HELPLINES

If in doubt about any aspect of viral load management or switching to second-line, contact one of the following resources:

National HIV & TB Health Care Worker Hotline:

0800 212 506

Right to Care Pediatric, Adolescent and Adult HIV Helpline:

082 352 6642

KZN Paediatric Hotline:

0800 006 603

health
Department:
Health
REPUBLIC OF SOUTH AFRICA