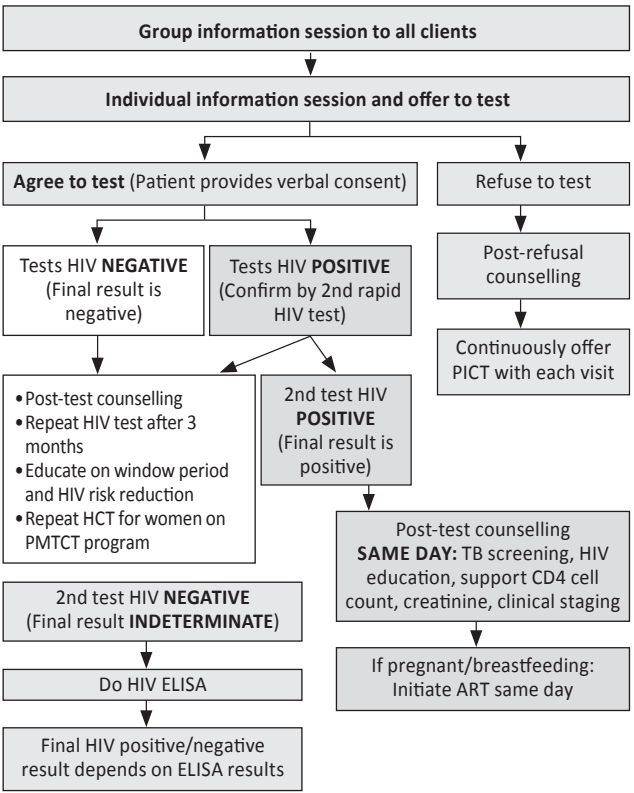
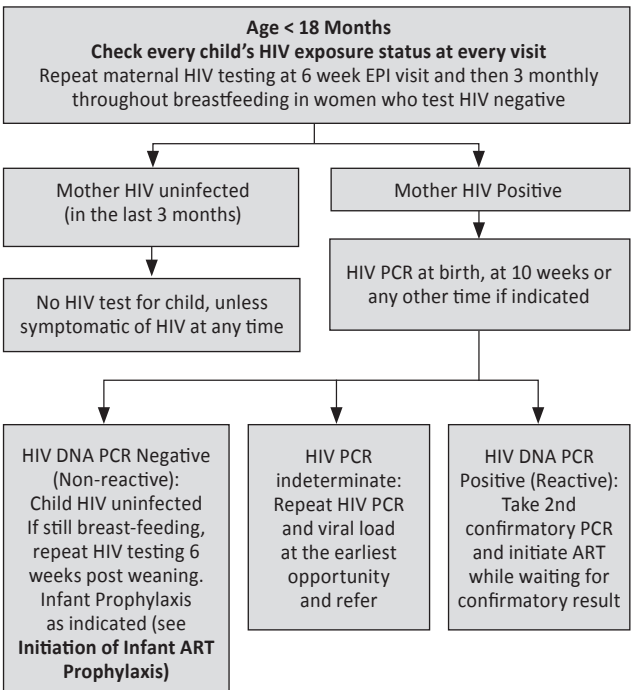
HIV TESTING AND STAGING

HIV Testing Algorithm



Source: National consolidated guidelines for the prevention of mother-to-child transmission of HIV (PMTCT) and the management of HIV in children, adolescents, and adults, December 2014.

Paediatric Testing Algorithm

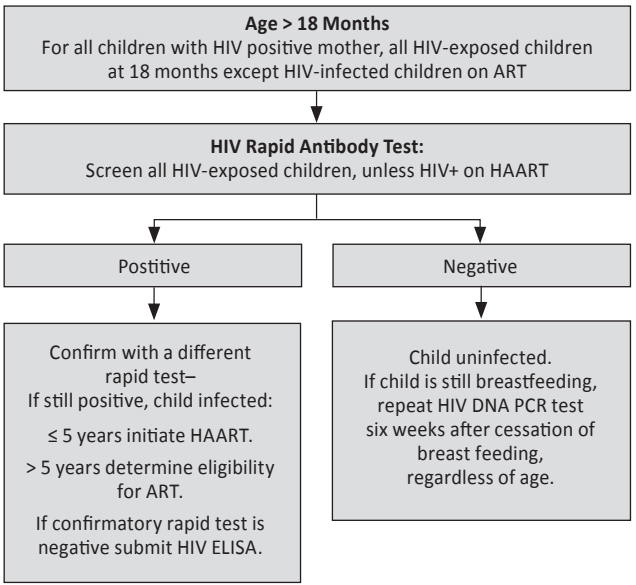


Source: National consolidated guidelines for the prevention of mother-to-child transmission of HIV (PMTCT) and the management of HIV in children, adolescents and adults.

Continued

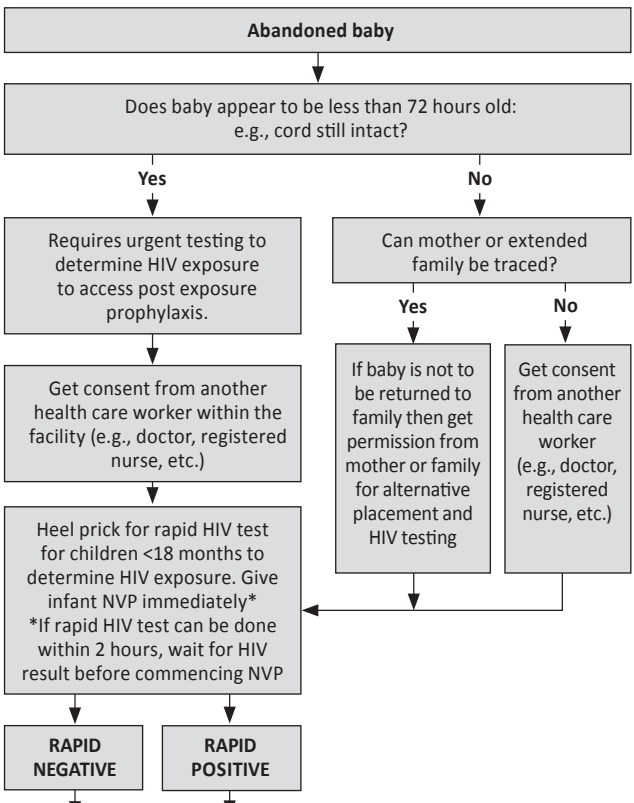
Paediatric Testing Algorithm

Continued



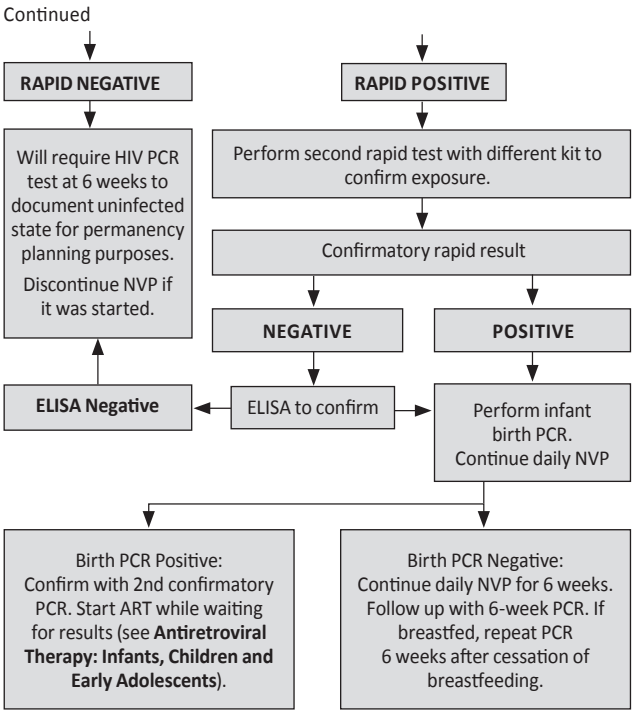
Source: National consolidated guidelines for the prevention of mother-to-child transmission of HIV (PMTCT) and the management of HIV in children, adolescents, and adults, December 2014.

Recommended Testing Algorithm for Abandoned Children



Continued

Recommended Testing Algorithm for Abandoned Children



Source: South Africa National Department of Health. Policy Guideline for HIV Counselling and Testing (HCT). 2010. National consolidated guidelines for the prevention of mother-to-child transmission of HIV (PMTCT) and the management of HIV in children, adolescents and adults. December 2014.

Recommended Intervals for Testing

When to Repeat HCT	
Who	**When**
Pregnant/Breastfeeding women (to detect HIV sero-conversion)	Every 3 months throughout pregnancy At labour/delivery At the 6 week EPI visit Every 3 months throughout breastfeeding
General population	6– 12-monthly depending on risk
Adolescents	6– 12-monthly if sexually active or more frequently if they have new sexual partner/s or if not using barrier protection
If exposed to HIV (adult and adolescent)	After 6 – 12 weeks for window period
Key populations (MSM and sex workers)	Every 6– 12 months
Families of index cases	As soon as posible after the family member is diagnosed

Recommended Intervals for Testing Infants and Children

Recommended Intervals for Infant Testing

HIV PCR test

At birth (targeted):
Birth HIV PCR testing applies to all HIGH-RISK infants including:
- All HIV exposed infants
- Low birth weight <2.5kg.
- Premature infants.
- Infants of mothers who were on TB treatment for active TB at any point during pregnancy.
- Infants born to mothers with VL>1000 copies/µl.
- Infants of mothers who were on ART <4 weeks prior to delivery
- Infants of mothers who were unbooked or diagnosed HIV-positive in labour or shortly after delivery.
- Breastfed infant of a newly diagnosed HIVpositive breastfeeding mother.
- Infants who are symptomatic at birth.
- These infants can be regarded as high-risk cases that need an urgent diagnosis so should receive HIV PCR as soon as possible after birth.
- HIV PCR testing at 6 weeks should still be done on all HIV-exposed infants without confirmed HIV infection, regardless of earlier testing.
- Any infant with a positive birth PCR should be urgently referred/ discussed telephonically for ART initiation by a paediatric HIV expert.

At 10 weeks:
- All HIV-exposed infants.

At 18 weeks:
- HIV exposed infants without confirmed HIV infection, regardless of earlier testing.
- All infants who received 12 weeks of NVP prophylaxis.
- Breastfed infants: (6 weeks post cessation of breastfeeding).
- All HIV-exposed infants – age appropriate: if <18 months old – do HIV PCR.

Continued

Recommended Intervals for Testing Infants and Children

Continued

Recommended Intervals for Infant Testing
Rapid HIV Antibody test
At 18 months: • All HIV exposed infants. • Breastfed infants: (6 weeks post cessation of breastfeeding). • All HIV exposed infants- age appropriate: if <18 months old- do HIV PCR. **Family and social history (at all times):** • Parental request to test the child. • Father or sibling with HIV infection. • Death of mother, father or sibling. • When the mother's HIV status is unknown, her whereabouts are unknown, or she is unavailable to be tested. **All children with (at all times):** • Clinical features suggestive of HIV infection. • Acute, severe illness. • IMCI classification of Suspected symptomatic HIV infection. • IMCI classification of Possible HIV infection. • TB diagnosis or history of TB treatment. • Risk of sexual assault. • Wet-nursed or breastfed by a woman with unknown or HIV-positive status. • Children considered for fostering or adoption.

Clinical Staging for HIV Disease in Adults, Adolescents and Children[1]

CLINICAL STAGE 1

- Asymptomatic
- Persistent generalised lymphadenopathy

CLINICAL STAGE 2

- Unexplained persistent hepatosplenomegaly
- Papular pruritic eruptions
- Extensive wart virus infection
- Extensive molluscum contagiosum
- Fungal nail infections
- Recurrent oral ulcerations
- Unexplained persistent parotid enlargement
- Lineal gingival erythema
- Herpes zoster
- Recurrent or chronic upper respiratory tract infections (otitis media, otorrhoea, sinusitis or tonsillitis)

Source: National consolidated guidelines for the prevention of mother-to-child transmission of HIV (PMTCT) and the management of HIV in children, adolescents and adults, December 2014.

Clinical Staging for HIV Disease in Adults, Adolescents and Children[2]

CLINICAL STAGE 3

- Unexplained moderate malnutrition not adequately responding to standard therapy
- Unexplained persistent diarrhoea (14 days or more)
- Unexplained persistent fever (above 37.5°C intermittent or constant for longer than one month)
- Persistent oral candidiasis (after first 6–8 weeks of life)
- Oral hairy leukoplakia
- Acute necrotizing ulcerative gingivitis or periodontitis
- Lymph node tuberculosis
- Pulmonary tuberculosis
- Severe recurrent bacterial pneumonia
- Symptomatic lymphoid interstitial pneumonitis
- Chronic HIV-associated lung disease including brochiectasis
- Unexplained anaemia (< 8 g/dL), neutropaenia (< 0.5 × 109 per litre)
- And/or chronic thrombocytopaenia (< 50 × 109 per litre)

Source: National consolidated guidelines for the prevention of mother-to-child transmission of HIV (PMTCT) and the management of HIV in children, adolescents and adults, December 2014.

Clinical Staging for HIV Disease in Adults, Adolescents and Children[3]

CLINICAL STAGE 4

- Unexplained severe wasting, stunting or severe malnutrition not responding to standard therapy
- Pneumocystis pneumonia
- Recurrent severe bacterial infections (such as empyema, pyomyositis, bone or joint infection or meningitis but excluding pneumonia)
- Chronic herpes simplex infection (orolabial or cutaneous of more than one month's duration or visceral at any site)
- Extrapulmonary tuberculosis
- Kaposi's sarcoma
- Oesophageal candidiasis (or candidiasis of trachea, bronchi or lungs)
- Central nervous system toxoplasmosis (after one month of life)
- HIV encephalopathy
- Cytomegalovirus infection: retinitis or cytomegalovirus infection affecting another organ, with onset at age older than one month
- Extrapulmonary cryptococcosis (including meningitis)
- Disseminated endemic mycosis (extrapulmonary histoplasmosis, coccidiomycosis)
- Chronic cryptosporidiosis
- Chronic isosporiasis
- Disseminated non-tuberculous mycobacterial infection
- Cerebral or B-cell non-Hodgkin lymphoma
- Progressive multifocal leukoencephalopathy
- Symptomatic HIV-associated nephropathy or HIV-associated cardiomyopathy
- HIV-associated rectovaginal fistula

Source: National consolidated guidelines for the prevention of mother-to-child transmission of HIV (PMTCT) and the management of HIV in children, adolescents and adults, December 2014.