A MANUAL TO SUPPORT COMMUNITY ANTIRETROVIRAL TREATMENT LITERACY IN ZIMBABWE

Zimbabwe National Network of People Living with HIV
ZNNP+

Vision
To create an environment where people can live positively

Mission
ZNNP+ is committed to be the leading national organization for advocating and lobbying for the rights of PLHIV to improve their quality of life

Goal
Our goal is to assist in ensuring that the infected and affected (by HIV and AIDS) have access to holistic care and support, prevention, treatment and mitigation in a transparent and accountable manner and to ensure that the infected and affected participate in decisions that affect them at all levels.
A MANUAL TO SUPPORT COMMUNITY ANTIRETROVIRAL TREATMENT LITERACY IN ZIMBABWE

June 2016
Zimbabwe has approximately 1.4 million people living with HIV, including 156,718 children aged below 15 years. Simplified treatment guidelines and decentralisation of antiretroviral treatment (ART) has resulted in improved access to treatment and increased the number of adults and children receiving ART. ‘Task shifting’ has also meant that a broader range of healthcare workers and community workers can be engaged in treatment and care.

The community, and especially people living with HIV (PLHIV), needs to play a greater role in supporting HIV prevention, treatment and care, including adherence and retention in care. Community members must be actively involved in shared responsibilities towards improved access to quality services, with equitable and efficient utilisation of resources. It is vital that the scale-up of the community-based treatment programmes does not increase the already disproportionate burden of care for women.

The National Antiretroviral Therapy (Treatment) Literacy Manual aims to strengthen the linkages between communities, health professionals and health centres and support government efforts to serve PLHIV better. The manual’s primary thrust is on rights-based peer education for people living with HIV and equipping communities to look after their own health, through improved adherence and uptake of HIV testing and counselling. It is also intended to help people living with HIV demand and realise their rights through advocacy support.

The launch of this manual as a national treatment literacy support tool is in line with government efforts to respond to the double epidemics of HIV and TB. The information presented here has been updated in line with recent developments and is intended to train, support and raise awareness for PLHIV and HIV support group members.

I trust that the use of the manual will contribute towards improved HIV treatment literacy throughout Zimbabwe, enhance adherence and retention in care and ultimately, improve quality of life among people living with HIV in Zimbabwe.

Brigadier General (Dr) G. Gwinji
Secretary for Health and Child Care
ACKNOWLEDGEMENTS

Through an initiative sparked by ZNNP+, this manual was updated on behalf of the Ministry of Health and Child Care (MoHCC), Zimbabwe Network of People Living with HIV (ZNNP+) and the National AIDS Council (NAC) by SAfAIDS, with the invaluable participation of members of the following review committee.

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The production of this manual was also made possible through the support of Trócaire, the official development agency of the Catholic Church in Ireland.

This manual necessarily builds from materials developed by others and adapted to the Zimbabwean context. Special acknowledgment is made to Trocaire for their ongoing support for this project and especially for their funding of the ZNNP+ Community Treatment Literacy Manual, developed in 2011. The success of this manual resulted in the decision to develop this national treatment literacy manual. It was important to use reliable sources and tried and tested approaches to ensure that supported communities get the very best assistance. All materials used are referenced.

Given the ever-changing nature of treatment information, it is recommended that this manual be updated at least every two years, or as and when changes are made to international guidelines on HIV treatment and prevention.
Towards achieving the 90, 90, 90 target in Zimbabwe
Contents

FOREWORD .................................................................................................................. i
ACKNOWLEDGEMENTS ............................................................................................... ii
INTRODUCTION ............................................................................................................. 1

1. I KNOW, DO YOU? – HIV TESTING & COUNSELLING ........................................ 11

2. ARVs IN ZIMBABWE ............................................................................................... 23

3. TREATMENT AS PREVENTION .............................................................................. 31

4. THE IMPORTANCE OF ADHERENCE ................................................................... 37

5. HIV, AIDS and OTHER ILLNESSES ....................................................................... 47

6. ARVs and ADULTS ................................................................................................... 59

7. ARVs AND ADOLESCENTS .................................................................................... 69

8. ARVs AND CHILDREN ............................................................................................ 77

9. PMTCT ..................................................................................................................... 83

10. ARVs AND KEY POPULATIONS ............................................................................. 89

Important terms and explanations ............................................................................ 99

Annexes ....................................................................................................................... 107

Annex I: Summary – Classes of ARV and the Drugs in Each Class ............................ 107
Annex II: The Patient’s Charter .................................................................................... 110
Annex III: Disclosure to Intimate Partners, Friends and Others ............................... 115
INTRODUCTION

What is This Manual All About?

This manual focuses on key aspects of HIV testing, counselling, prevention and treatment literacy for those infected and affected by HIV. It covers entry point level information on treatment and support information, including preventing and treating TB.

It is intended to be used by group leaders, trainers and support groups at community level, to equip communities with up-to-date information to better manage and lobby for quality HIV prevention and treatment, TB prevention and support services.

The manual’s primary thrust is on rights-based peer education for people living with HIV (PLHIV) and equipping communities to look after their own health, through improved adherence and uptake of HIV Testing and counselling. It is also intended to help people living with HIV (PLHIV) demand and realise their rights through advocacy support and to help Zimbabwe achieve the 90.90.90 targets.

One of the ways in which the rights of PLHIV can be achieved is by empowering communities and ensuring that people living with HIV enjoy a better quality of life through improved adherence to ARVs, positive health, dignity and prevention, as enshrined in the Zimbabwe National AIDS Strategic Plan II (ZNASP II).

How to use this manual

KNOWLEDGE TRANSFER: The manual is designed to equip stakeholders at community level with standardised and up-to-date information to improve treatment literacy amongst those infected and affected by HIV. It is both a reference document and an interactive learning tool. The manual is targeted primarily at PLHIV groups including those affiliated to ZNNP+, but everyone working with PLHIV and their families can and should use this manual as a national standard on current treatment, care and support.

Know more about: entry points for treatment, first line regimens, second line regimens, drug side effects.
**FLEXIBLE FOLLOW-UP:** There are ten sections in this manual and each starts with a fun activity. This allows groups and communities to begin with what they know on each topic. **This activity has a dual purpose;** it can also be used to measure knowledge levels on a topic and as an evaluative tool post training. Invite groups to re-do the activity a few months after learning and record how knowledge levels have changed!

*Monitor and evaluate change at community level using simple edutainment through quizzes and role-plays.*

**MODULAR APPROACH:** Each section in the manual can be shared and questions dealt with. It also provides time for reflection on what communities can do to improve their access to treatment, care and support. This is where the manuals key messages come in. Use the key messages to plan for action in your local community.

**Ten modules, two hours each, twenty flexible hours of learning and discussion!**

**This Community Treatment Literacy Manual’s Key Messages**

This manual is to support knowledge for action. The information shared has several purposes:

**RESPECT**
Ensure understanding and compliance to existing guidelines to ensure everyone’s rights and responsibilities are being respected.

**REVIEW**
Highlight gaps and issues around HIV treatment that Zimbabwe, as a nation, can continue to improve on and support in relation to HIV care, treatment and support.

**ENGAGE**
Encourage self-awareness, wellness and care towards improved positive health, dignity and prevention for all those infected and affected by HIV in Zimbabwe.

**ADVOCATE**
Community mobilisation is critical if the Government’s plans to support the good health of all in the community are to be realised. Look out for opportunities to take action in support of improved HIV treatment, care and support.
Whenever you see a box with one of these *four knowledge for action terms*, take time to discuss the issue and plan action for change. Use the simple Action Planning Matrix below to help you.

### Your Action Planning Matrix

<table>
<thead>
<tr>
<th>OBJECTIVES (List of goals)</th>
<th>TASKS (What you need to do to achieve the goals)</th>
<th>SUCCESS CRITERIA (How you will identify your success)</th>
<th>TIME FRAME (By when do you need to complete the tasks)</th>
<th>RESOURCES (What or who can help you complete tasks)</th>
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**Key messages in the WHO guidelines**

The national HIV treatment guidelines embrace new treatment regimens, new approaches and other good practices in HIV treatment care and support. There is now a much stronger focus on treatment and prevention. This means people living with HIV who are on treatment, and adhering, are far less likely to pass on the virus. This also means offering people the option to start treatment earlier, such as pregnant HIV positive women and all children under 5 years of age.
A Rights-Based Approach

In line with ZNASP II, this manual is presented from a rights-based perspective. Everyone using this manual must be committed to supporting and enhancing the rights of all PLHIV and participants in their programming.

What does taking a rights-based approach mean in practical terms? Very simply put, taking a rights-based approach to anything – including supporting PLHIV and their families – means considering the following four principles:

1. **Participation and inclusion** – this means that people living with and affected by HIV should be at the centre of the response. This means more than just getting those infected and affected by HIV involved; it also means sharing and passing on the skills and information that can make their involvement meaningful.

2. **Non-discrimination and equality** – We already know that HIV does not discriminate – the young and the old, the promiscuous and the faithful, the rich the poor, men, women, girls and boys. Support for people infected and affected should also not discriminate.

3. **Accountability and transparency** – make important information easily available and respect the rights of freedom of expression and association, in order to obtain and share important information.

4. **Understanding the context** – taking care to make decisions and choices that take into account all the issues that PLHIV and their families face together and as individuals.
### Your commitment to a rights-based approach

Go through this list and make your commitment. Go through it with your support groups and get their commitment too. Tick or sign the box if you agree.

<table>
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<tr>
<th>Commitment</th>
<th>I/We Agree</th>
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<tr>
<td>I/We are committed to ensuring equal and full participation of all stakeholders, especially potential programme beneficiaries, at all stages of the programme cycle.</td>
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<td>I/We are committed to building the capacity of both rights holders and duty bearers to claim their rights and to promote, protect and respect the rights of others.</td>
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<td>I/We are committed to holding both state and non-state actors accountable for the enjoyment of all human rights for both the infected and affected by using our voice and learning, as well as broad and meaningful participation as members of this group and of the broad community of Zimbabweans.</td>
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<td>I/We are committed to helping lobby for and promote the provision of legal services to ensure redress for HIV-related discrimination experienced by PLHIV and marginalised populations.</td>
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<td>I/We are committed to the effective implementation of the MIPA (meaningful involvement of people living with HIV) principle in all that we do, whether they be simple meetings or advocacy campaigns.</td>
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<tr>
<td>I/We are committed to promoting an enabling and protected environment to facilitate the participation of PLHIV in all that we do.</td>
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Ethics in HIV Programming Support

Even with increased efforts to scale up care and treatment for PLHIV not everyone in need can gain access to antiretroviral therapy (ARV) or other treatment needs immediately. However, Government is committed to increasing access to ARVs to everyone who needs them. You and your groups can help lobby for this to become a reality.

**Ethics are all about the principles of ‘fair’ processes.** Fairness should always guide decision-making. This is especially important when many people and places are involved.

Recent advances in HIV treatment means that treatment support, can be successfully provided in settings where basic health services are weak. HIV services are now being integrated with sexual and reproductive health and primary health care services. This will strengthen primary health care, reduce duplication of services and help reduce stigma and discrimination.

Here are some issues to explore, discuss and debate – you may have others.

- **Access to ARVs** – who should receive medication when there isn’t enough to go around?

- **Informed consent** – the right to choose and access to the information that informs that choice.

- **Confidentiality** – the right to share information about your health when, where, with whom, and how, you choose.

- **Controlled clinical trials** – being informed of and understanding the risk and being an active and consensual participant in trials.

- **Trade barriers** – such as the use of imported or generic drugs (TRIPS – Agreement on Trade-Related Aspects of Intellectual Property Rights).
**Top Facilitation Tips for Community Engagement**

A useful technique when using this manual to engage individuals and groups at community level is the ASK technique. All good trainers and group leaders use this technique. The ASK technique is an acronym that stands for:

- **Attitude** – of YOU the trainer/group leader
- **Skills** – that YOU the trainer/group leader need to have or learn
- **Knowledge** – that YOU the facilitator should bring along with you

**Attitude means**

- Being honest and friendly
- Believing in people learning for themselves
- Being sensitive to the different needs of women and men, girls and boys in your group
- Respecting people’s different cultures
- Being creative when training – that is keeping the learning sessions interesting and lively, use the different activities provided in the manual
- Being tactful and careful not to be offensive (think before you speak)
- Using energisers appropriately and wisely

**Skills means**

- Active listening
- Open communication
- Managing discussions
- Conflict resolution
- Summarising
- Time keeping

**Knowledge means having an understanding of**

- HIV and AIDS
- Gender issues
- The community and its culture
- The participant groups
When you are working with support groups and other community members remember you have been appointed because you:

- Are warm, loving and sincere.
- Have an ability to maintain firm boundaries.
- Have an ability to recognise when someone needs to be referred elsewhere for further help.
- Have an ability to gain the trust of group members so that they can talk about personal issues.
- Are a strong believer in confidentiality of member’s personal issues.
- Are non-judgemental.
- Are always punctual – you need to be at the meeting before the group and start on time.
Tips for Facilitating a Learning Group

What to do as a facilitator

- Prepare and know your subject.
- Research your subject.
- Ask questions.
- Ensure that all participants have a role and can participate.
- Speak slowly and clearly.
- Use group work
- Take account of barriers such as language.
- Clarify key concepts.
- Keep focused.
- Guide group discussions.
- Give summaries at the end of activities.
- Practice time management.
- Manage crisis by being creative.
- Create an environment conducive for working.

What not to do as a facilitator

- Dominate the discussion.
- Be judgemental.
- Presume you know what participants want to say.
- Panic if things don’t go your way.
- Think of yourself as an expert.
- Leave shy or difficult people out.
- Forget that HIV and AIDS are real and sensitive for many participants.
- Allow discussion to wander.
- Allow everyone to talk at the same time.
- Leave a discussion without a conclusion.
- Get too personally involved.

Remember – you don’t have to know everything to be a good trainer/group leader. Nobody expects you to have all the answers. A good trainer/group leader will always say when they are unsure and then make a plan to find out the answer.

Before you get started:

1. Read the manual from start to finish!
2. Review the reference section for any documents you may need to get to help you support community members (or just know more).
3. Plan for each session—they should not be longer than 2 hours and each session has three parts to plan for—a learning and sharing activity, a knowledge session so key information can be passed on and an action planning session to encourage demand creation and linkages.
I KNOW, DO YOU? – HIV TESTING SERVICES

A Learning and Sharing Activity

Ask individuals in the community/group to prepare a group role play of someone reluctantly going for an HIV test and testing negative; another of a person going for an HIV test and testing positive; and another of a guardian taking a ten-year-old child for an HIV test, who tests positive.

Discuss the pros and cons of HIV testing raised by the role play, including having to disclose to partners, or to a child, whatever the result. Are there others? Make a list – this is your baseline of HIV testing barriers for the community!

Follow-up: Repeat the exercise, have the barriers changed?

Knowledge Session: Information to share and discuss

HIV Testing Services In Zimbabwe

HIV negative people can take steps to stay negative by:
  • changing their sexual behaviours.
  • using condoms consistently and correctly each time they have sex.
  • they should also get retested at least once a year, or after having risky sex.

HIV testing services (HTS) are the entry point to treatment and care. What does it mean?
  • People get treatment early.
  • If a person is HIV positive, they can take better care of their health and practice positive living.
  • Early treatment means you can protect your loved ones from becoming infected.
  • Family members should be encouraged to go for HIV testing services too.
**Where can I get HTS?**

HTS is available at:
- local clinics,
- hospitals,
- pharmacies, and
- other testing centres, such as New Start Centres, or at mobile units that offer services in your community.

**What is an HIV test?**

The rapid HIV test tests a small sample of blood (through a pin prick) for antibodies to HIV.

- If antibodies are found in the sample, the person has been infected with HIV and the body has developed antibodies against the virus.
- Results are available within 20 minutes.
- If the test is positive, another test is performed to confirm the result.

**Couples testing:** People in relationships are encouraged to go together for HTS. This means couples learn their status together, with a counsellor present to help them understand the results.

**Provider-initiated HIV testing and counselling (PITC)**

Routine PITC is recommended at health facilities regardless of the condition for which the client is visiting. Everyone, including children and adolescents who attends a clinic for maternal and neonatal health checks, or for an outpatient visit and in-patients should be offered PITC.

**HIV testing in adolescents:** As more children born with HIV survive into adolescence, HIV testing is also encouraged for young people.

Those under 16 years of age need the consent of a guardian, unless he or she is a ‘mature minor’ or an ‘emancipated minor’ – see Terms and Explanations.

**Important:** young people who test HIV positive may not be sexually active – they may have had the infection from birth, or acquired it through being sexually abused.

If a parent or caregiver will not or cannot give consent for a child below 16 years of age, a health worker can exercise the
'best interests of the child' principle and seek approval from the person in charge of the clinic or hospital to perform the HIV test.

The best interests of the child include the following situations. Where a child is:

- Ill and diagnosis will facilitate appropriate care and treatment.
- A survivor of sexual abuse or is sexually active.
- Worried they have been infected at birth or has been exposed to HIV through sexual transmission.
- Concerned that he or she will be denied access to care and treatment by a parent or caregiver if the test is positive.

**HIV re-testing in HIV positive people who are on ARVs**

It has recently been learned that some people on ARVs are opting to be re-tested for HIV using rapid HIV testing. This is not necessary. There is NO CURE for HIV.

- When someone is confirmed HIV positive and before they are put on ART, two tests are carried out to confirm the infection.
- If you want more information about your health status, request a viral load test, which will show how your body is managing the HIV.
- Since there is no cure for HIV, you remain HIV positive and must continue to take your ARVs to maintain your health.
- When HIV is well controlled and a PLHIV has an undetectable viral load, some of the rapid HIV test kits may give a false negative result! This does not mean you are HIV negative, especially if you have previously had CD4 counts that show a weakened immune system (less than 500 cells/m³).

If you do have a negative HIV result, speak to a healthcare worker about having an Elisa test. This will detect HIV in the blood where a rapid test cannot, but carry on taking your ARVs. If you stop your ARVs you will get sick very quickly and develop AIDS. Stopping ARVs can also encourage HIV to become resistant to the medicines you have been taking.

**It is always dangerous to stop taking ART unless you are advised to do so by a healthcare professional!**
**Self testing**

Self testing is becoming an important part of broadening the ‘I know my status – do you?’ approach. Many people prefer self-testing to find out their status because it offers ease-of-use and privacy, confidentiality and convenience.

Government, together with partners, is piloting self testing kits that allow an individual to test a blood or saliva sample and get the result within 20 to 40 minutes, just like with a home pregnancy test.

The MoHCC will issue Guidelines on how to conduct the test; what to do if the result is positive; and how to access treatment care and support.

**Issues around HTS**

- **Infants and children** aged 10-19 (especially girls), are at high risk of HIV infection. They need access to HTS and information on HIV prevention.
- Youths and adolescents should be involved in decisions on their own HIV testing and be informed of their status.
- Young girls also need to know about delaying first sex and dual protection (use of condoms plus another form of contraception).

**Discordant couples:** are couples where one sexual partner is HIV positive and the other is HIV negative. This can be a stressful result for a couple and post-test counselling is critical.

- Couples are always encouraged to test together.

**The window period:** This is the time immediately after HIV infection, before HIV antibodies appear in the person’s blood.

- An HIV test at this stage may be negative, even though the person is infected.
- The window period can be from six weeks to three months.

If you have had risky sex within this period before your test, you should have another HIV test about 12 weeks after the first one.
Stigma and discrimination

- You and your family may be receiving negative emotions and reactions from others.
- You may be part of negative emotions and actions towards others.
- Talking about HIV improves awareness in the community and can reduce feelings of being left out, hurt and unsupported, as well as help to cope with stigma and negative behaviours.

Knowing means you can seek support and guidance; practice positive health, dignity and prevention; seek treatment for opportunistic infections; and make sure you remain with your family for longer and stay happier.

Need for support: You and your loved ones may be worried about being HIV positive or having AIDS.

Talking about it can help stop the worry and encourage testing to find out one’s HIV status once and for all. Knowing is often less frightening than not knowing – it allows you to act!

HIV Diagnosis in Infants and Children

HIV exposure should be checked on the first contact with the health services, ideally before 6 weeks of age.

Possible HIV exposed infants should have their status checked by testing a dried blood spot (DBS). This is used in a special test (HIV DNA PCR or chain reaction test) to confirm if the baby is really HIV positive. The mother’s antibodies in the baby’s blood may give a false HIV positive result with other tests.

- A positive HIV antibody test below the age of 18 months means the child is HIV exposed. HIV status should be confirmed by PCR testing.

Parents of these babies should receive counselling.

A negative rapid HIV or PCR test more than three months after possible exposure means the baby is not infected with HIV; BUT if it is being breastfed, the baby is still at risk of infection and must be tested again at least one week after breastfeeding has stopped.
Presumptive diagnosis: Babies with a positive HIV antibody test and oral thrush, severe pneumonia or sepsis should be started on ARVs immediately. They are presumed HIV positive until and unless they have a negative HIV test.

- All children under the age of five who are confirmed to be HIV positive should be put on ARVs.

For children over the age of 18 months an antibody test (rapid or Elisa) is the preferred way to diagnose HIV infection.

- A negative antibody test means the child is not infected, unless clinical signs or later events suggest otherwise.

**Disclosing An HIV Positive Status**

*A Learning and Sharing Activity*

Ask individuals in the community/group to prepare a group role play around disclosing to others and full disclosure to a young person born with HIV. One group will role play a guardian making full disclosure to a young person about their HIV status. The other group will role play a young person living with HIV disclosing their HIV status to a potential boyfriend or girlfriend.

*In plenary, discuss the two role plays and the issues around disclosure to children and disclosure by PLHIV to others. What are the barriers to disclosure? Make sure you cover the issues below.*

**Follow-up:** Repeat the exercise, have the issues or the barriers to disclosure changed?

**Knowledge Session: Information to share and discuss**

**Disclosure for adolescents and children**

The basic points about disclosure for adolescents and for children are similar.

- The process needs to be done in a sensitive, caring way, according to their age and ability to understand.
- It is led by the parent or caregiver, when they are ready to disclose to the child.
- Currently, **only** the caregiver can decide to disclose, even for older adolescents who are not aware they are HIV positive and who are failing on ART.
- Full disclosure should occur before the age of 12.
The section below on disclosing to others is especially important for adolescents and young people.

**Disclosure of HIV Status**

Sometimes it seems like it is just too difficult to talk about HIV – in fact, many of us do not even like to use these words, calling it other names instead. But not talking about it could be much worse than the things one actually fears; it can put you and your loved ones at higher risk of infection.

**Why disclose?**

Disclosure to children can reduce their fears and help them understand and take charge of their health, as well as ensuring they do not infect others.

Disclosure is a sensitive process rather than a one-time event; it means telling a child or young person about their HIV positive status. It can begin any time between five and seven years of age and should be done in a positive, planned and supportive way over time.

Caregivers need to consider any personal issues about telling a child about their HIV status:

- They may be not want to inform children about their own HIV status, or because of their own fears and beliefs, or their lack of understanding of the child’s needs.
- They may fear stigma and discrimination; or believe that the child will not be able to understand or cope with the knowledge.
- They may feel guilty about their own and the child’s infection.
- They may fear the child’s reaction, or that the child will tell others.

However

- Children who know of their HIV status tend to cope better with their illness and can participate in their treatment.
- Knowing they are HIV positive can be empowering and improve their sense of self esteem and confidence, as well as reducing anxiety.
- Knowing allows them to make choices and decisions about treatment and issues that affect them.
• Knowing can encourage children to take their treatment as they should (adhere), as they know the medicine is to keep them healthy.

• Keeping the information that a child is HIV positive from them can lead to distrust and confusion and leaves the child unprepared to deal with related issues that will later arise in their lives, such as possible stigma.

• Finding out about their HIV infected status may come as a relief to children who are ill.

**Disclosure should:**

• Be based on the need to protect the best interests of the child at all times and on the child’s needs, understanding and maturity.

• Be honest and not involve lies.

• Help the child understand their illness

• Be a two-way conversation.

• Respect the child’s feelings and emotions.

The child’s age, emotional maturity and any family issues that may affect the process need to be taken into account. Assess the child’s knowledge and coping ability. Older children are better able to understand what their illness means and will need help to cope with their condition.

• Children who are ill, especially if they need to be hospitalised, should be informed of their HIV status, as there is a strong chance that they will learn it accidentally in a hospital setting.

• Children may have picked up the fact that they are unwell before they are formally told. Younger children who are ill want to know what will happen to them in the near future. Tell them how the illness and how it will affect them now. Leave naming HIV to an appropriate time.

• Naming HIV itself may be less important for some children at first, but an accurate, honest explanation about what is happening to them – given as early as possible – will help them to cope better. If HIV itself is not named immediately, this is called partial disclosure, e.g. the child is told they have an illness and that the medication they take will help them from getting sick. But this is a temporary stage and HIV should be named in good time.
Caregivers need to be ready to answer children’s questions about the disease – what HIV is and how it makes you sick. To avoid anxiety and confusion, the child also needs to be told how they acquired it. Many caregivers have difficulty with this because of fears of discussing sexual transmission and their own HIV status, but being honest from the beginning will be easier for everyone.

Try to:

• Address any fears or misunderstandings the child has about their condition.
• Help them to understand the benefits (and risks) of treatment.
• Help the child decide to whom they should disclose.
• As the child gets older they should be fully informed of the nature of their illness and be encouraged to participate actively in their own medical care.
• Prepare the child or young person to deal with the reactions of others to their status.
• Look out for any signs of psychological distress, depression or denial and seek help for psychosocial and mental health support.

Ongoing counselling and support are essential.

**How not to disclose:** Do NOT disclose:

• By accident or without planning; as a punishment.
• After the child already knows.
• Without the presence of the caregiver, or
• When a child is dying.

*Improving relationships, communication and trust.*

Open and honest communication through timely disclosure from a primary caregiver to a young person encourages love, care and confidence. This makes the challenges of being HIV positive easier to cope with.

• Young people who know their HIV status are better able to tell those who need to know – teachers, carers and relationship partners; this builds a stronger circle of care.
• Young people who know their HIV status have access to other support services, including joining support groups and access to professional counselling services. These keep them healthier and happier.
Timely disclosure means that a caregiver discloses a child’s HIV positive status when the child is emotionally well prepared and mature enough to deal with the new information, AND before he or she is sexually active or considering a sexual relationship. This gives the young person time to deal with being HIV positive before they start to think about relationships or marriage.

Delayed disclosure is when a caregiver discloses to a child when he or she is already sexually active or is thinking about becoming sexually active. Dealing with emotions about being HIV positive along with the changes of adolescence can be very confusing.

Accidental disclosure. It is important to avoid accidental disclosure, which can happen when a caregiver avoids timely disclosure. This can happen if the child needs to be hospitalised, or overhears others talking about them, or at school. School students are often involved in blood donation campaigns. Donating blood is very important, but it can be a risk for accidental disclosure for children living with HIV, as all blood donors are tested for HIV and other infections.

Disclosure to Others

It is up to each individual and their family and caregivers to decide who else to tell about an HIV infected status. Other people may be told on a ‘need-to-know’ basis – those who are told should be advised to keep this knowledge confidential.

It is the child, young person or other PLHIV’s decision who to tell or not to tell. For example, it can be helpful if teachers are aware of a child’s HIV status, but this can lead to stigma and discrimination and to the child’s status being made public. It must be the child’s choice.

Positive health, dignity and prevention

Positive health, dignity and prevention aim to increase the self esteem and confidence of HIV positive people to protect their own health; seek and demand their rights; avoid passing the infection to others; or becoming more sick themselves through re-infection. With good nutrition, prevention of other infections, taking medication exactly as instructed and taking positive action for their health and future (positive living) PLHIV can live healthy and productive lives and prevent the
spread of HIV to others. Positive health, dignity and prevention stresses that PLHIV:

- are more than patients.
- should not be treated as vectors of the disease.
- are not all responsible for HIV.
- have needs and desires to be fulfilled.

**REVIEW**

*Points for young people to consider about disclosing to others*

- Disclosing can help them accept their HIV status and reduce the stress of coping alone.
- It can help people access the medical services and other support they need.
- Disclosure can help people to protect themselves and others.
- Openness about their HIV positive status may help women and young girls or boys to negotiate safer sex.
- It promotes responsibility and may encourage the person’s loved ones to plan for the future.
- Disclosure can help reduce stigma, discrimination and denial around HIV.

Also see Annex III: Disclosure to Intimate Partners, Friends and Others

**Action Planning: Respect, Review, Engage, Advocate!**

Go through all the knowledge for action boxes in this section again. Identify which, if any are a priority for the group/community (there may be others too!). List them. Use the action planning matrix on page 3 to prioritise them and create a plan of action to help you address issues around HIV testing and counselling in your area.

Nationally less than half the people living with HIV know their status. This means late diagnosis, delays in initiating antiretroviral treatment (ARV) and higher levels of sickness and death.
ARVs IN ZIMBABWE

A Learning and Sharing Activity

Use the following Q & A as a quiz, mix and match test (cut them out and match them up) or plenary discussion.

Follow-up: Repeat the quiz- have the answers improved?

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>What can be done if someone thinks they have been at risk of HIV infection?</td>
<td>They can take ARVs within the first 72 hours after exposure as post-exposure prophylaxis (PEP). They must have an HIV test and go for the recommended follow-up tests. If you are pregnant and at risk, PMTCT can help you and your family by: providing treatment to reduce the risk of the baby being born HIV positive, and ARVs for life for the mother.</td>
</tr>
<tr>
<td>What are antiretroviral medicines (ARVs)?</td>
<td>ARVs are given to people with CD4 counts below 500, or those who have a suppressed immune system. ARVs help your body to control the virus and live longer.</td>
</tr>
<tr>
<td>How do antiretroviral medicines work?</td>
<td>They make HIV lose power to replicate. This helps your immune system stay strong and keeps you healthy.</td>
</tr>
<tr>
<td>Is HIV the same as AIDS?</td>
<td>HIV is not the same as AIDS. Having HIV does not mean someone has AIDS. People living with HIV can live normal and healthy lives. When someone has AIDS they are now very sick – HIV levels in their body have become very high and damaged the immune system so that it is weak.</td>
</tr>
<tr>
<td>When should you start taking ARVs?</td>
<td>• Those born with HIV and breastfeeding babies of HIV positive women are given ARVs soon after birth.</td>
</tr>
<tr>
<td></td>
<td>• All HIV positive children under five should be put on ARVs.</td>
</tr>
<tr>
<td></td>
<td>• Women who are pregnant or breastfeeding and HIV positive should start ARVs (Option B+).</td>
</tr>
<tr>
<td></td>
<td>• All others found to be HIV positive will get ARVs when their CD4 count is 500 or less</td>
</tr>
<tr>
<td></td>
<td>• Once started, ARVs should be taken for life. Pregnant and breastfeeding women may choose to take ARVs only during pregnancy and breastfeeding. This is not recommended, as they risk developing drug resistance from starting and stopping treatment.</td>
</tr>
<tr>
<td>Questions</td>
<td>Answers</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>What is a CD4 count?</td>
<td>A CD4 count is a test that counts the CD4 cells in your blood. CD4 cells are cells in the blood that fight disease and keep our immune system healthy. The CD4 count shows how well the immune system is working – a higher CD4 count, means greater protection against disease.</td>
</tr>
<tr>
<td>Which of these is true?</td>
<td>ART improves the quality of life of a person living with HIV and helps them live longer.</td>
</tr>
<tr>
<td>What is viral load?</td>
<td>Viral load shows the level of HIV in your blood. (It measures virus particles – not the virus itself). Knowing your viral load helps monitor how well HIV medicines are working. High viral load usually goes along with a low CD4 count and low (or undetectable) goes along with a higher CD4 count. <strong>Undetectable means the virus particles are too few to measure. It does not mean you no longer have HIV!</strong></td>
</tr>
</tbody>
</table>
| Name three good things about starting ARVs. | • ARVs strengthen the immune system; a strong immune system means improved health, energy and strength.  
• ARVs reduce a person’s risk of getting opportunistic infections; fewer opportunistic infections means a longer and better life.  
• ARVs can lift your spirit by giving you hope for the future.  
• ARVs help you stay an active and useful member of your family and community.  
• ARVs stop HIV positive mothers transmitting the virus to their babies |
| Name three common side effects of ARVs | • Nausea  
• Vomiting  
• Diarrhoea  
• Stomach pain  
• Headache  
• Tiredness  
• Skin rash  
• Loss of appetite |
| What is the term for taking ARVs in the right way? | Adherence |
Knowledge Session: Information to share and discuss

Zimbabwe’s Treatment Priorities

Zimbabwe has embraced the worldwide call for scale-up of ART and set targets for universal access guided by the WHO and by regional and international guidelines. ART scale-up is being achieved by upgrading community-level facilities to issue and monitor ARVs, as well as taking a family-centred approach.

Zimbabwe reached 76.8% ARV coverage in 2014, but paediatric ARV coverage remains low at 40.5%\(^1\). This success in scaling up ART reflects the strong government and institutional support for reducing AIDS deaths. HIV treatment services are now widely available at community level and there have been significant investments in training, supportive supervision and clinical mentoring for staff.

The objectives of the ARV programme are:

- To reduce HIV-related sickness and death.
- To reduce new HIV infections in both adults and children in Zimbabwe.
- To improve the quality of life for PLHIV.

Important things to know about ARVs:

- ARVs do **NOT** cure HIV – and neither do faith healers!
- While on ARVs, people living with HIV can still transmit HIV (although with good adherence the chances are significantly reduced).
- They can still become re-infected with another type of HIV (which will make their condition worse).
- ARVs reduce replication of the virus.
- ARVs are taken for life.
- Whether you need to take ARVs depends on your CD4 count or viral load measures and other criteria (see the Guidelines on p26).

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\(^1\) Report of Mid-Term Review of the National eMTCT Strategic Plan 2011–15, MoHCC
Paediatric HIV refers to HIV in children. They may have acquired the infection from the mother during pregnancy, delivery or breastfeeding (also called vertical transmission), or they may have acquired it since birth.

Children over the age of five who are not eligible for ARVs should have a CD4 count every three months. Weight and height should also be checked.

Zimbabwe has started a programme to wipe out paediatric HIV called elimination of mother-to-child transmission (eMTCT). PMTCT services have been upgraded to Option B+, which means that all pregnant women are put on ARVs for life.

Zimbabwe’s prioritisation for ART access is guided by the WHO guidelines and is as follows:

1. Treat All! Everyone who tests HIV positive should be put on ART when they are ready, whatever their CD4 count. However, certain people will be prioritised to receive treatment, as shown below.
2. Regardless of the CD4 count, to provide ARVs for:
   a. All HIV positive pregnant and lactating women
   b. All HIV positive partners in serodiscordant couples
   c. ALL HIV positive children below 5 years of age
   d. All HIV positive individuals with TB co-infection
   e. All HIV positive with chronic severe liver disease
   f. All HIV positive in WHO clinical stage 3 or 4
3. The preferred first line regimen for adults and adolescents and older children is: Tenofovir, Lamivudine and Efavirenz
4. ARVs are to be offered to the HIV positive partner in a serodiscordant relationship irrespective of the level of their CD4 count.
5. Life long ARVs for HIV positive pregnant and lactating women (Option B+) will be given for prevention of mother-to-child transmission (PMTCT) even without a CD4 count.
6. Continue early infant diagnosis using dried blood spot and polymerase chain reaction (PCR) or nucleic acid testing (NAT).
7. Early initiation of ART in HIV-infected children under 5 years of age, regardless of immunological or clinical status.
8. Apart from exclusive breastfeeding for the first six months, prolonged breastfeeding up to 2 years of age.
9. First-line regimens for infants below 3-years of age should include the use of a protease inhibitor (PI).
10. There will be a gradual phasing in of viral load monitoring.

NB. The criteria for ART initiation and the regimens used will be changed based on new and emerging evidence and technologies. Always refer to the current national guidelines.
**How ARVs work**

- ARVs stop HIV from making copies of itself within the body. Different ARVs work in different ways to prevent HIV replicating within the blood. Various treatment regimens (medicine combinations) are used to achieve the required effect with the lowest level of side effects.
- If HIV cannot copy itself it is unable to cause the damage to the immune system that results in opportunistic infections and eventually, AIDS.

**ARV supplies**

Once patients are considered stable on ART (see Terms & Abbreviations), they will receive one month’s supply of ARVs (and of Cotrimoxazole, if needed), at each visit.

If a child is sick they may only receive two weeks supply, or as instructed by the healthcare provider. If fewer medicines are supplied (if some medicines are replaced with others), the client should be told why. PLHIV support groups and Community ART Refill Groups (CARGs – see page 28 for more information) should monitor drug supply problems and engage with the programme manager where this occurs.

**Special Issues on ARVs**

- ARVs are not the same for all people at all times of life. This is why people should never take ARVs unless they are prescribed by a health professional. Sharing someone else’s ARVs is dangerous for both of you!
- **ARVs and OIs:** PLHIV may need to take other medicines called ‘prophylaxis’ that help to prevent infection with common OIs. The medicine most commonly taken is Cotrimoxazole. It helps prevent pneumonia and many gastrointestinal (digestive system) infections.
- **ARVs and TB co-infection** Some ARVs should not be taken by PLHIV with TB. For example, they should use Efavirenz instead of Nevirapine, because Nevirapine reacts with Rifampicin, one of the most common drugs used for treating TB.
- **ARVs and women:** women and girls who do not want to get pregnant and are taking ARVs and oral contraceptives (the pill) should use condoms as well. Some ARVs may reduce the effectiveness of the pill, e.g. Nevirapine should not be taken with hormonal contraceptives.
However, since condoms help prevent reinfection, all PLHIV should use condoms correctly and consistently every time they have sex. Using condoms – plus another form of contraception is called dual protection and ensures against reinfection, passing on HIV and unplanned pregnancy.

- **Pregnant women** can reduce the chances of passing HIV to their babies by continuing with their ARVs and accessing prevention of mother-to-child transmission (PMTCT) services.
- **HIV exposed babies** should be given Nevirapine from birth up to 6 weeks of age.
- **Dosing varies according to the baby’s weight.**
  - If the baby is brought to the clinic after 6 weeks of age, it should be given Nevirapine for six weeks while the mother starts her ARVs.
  - The baby should also be given Cotrimoxazole until proven HIV negative, or for at least six weeks after breastfeeding is stopped.

**Community ART Groups, Family Groups and Medication Refills**

Clients who are clinically stable on ART do not need to see a healthcare worker on every visit but can have refill (repeat prescription) visits only. Each client must choose for themselves whether they wish to be part of the Community ART Refill group (CARG) or not.

For these clients, CARGs can:

- Reduce the time and money spent collecting ARVs and other drug refills.
- Offer important support and improve adherence.

CARGs are co-ordinated by the nurses at the clinic, who will appoint a CARG focal person and carry out a basic CARG training.

- Members of the CARG complete a membership form, which is kept together with their patient care and treatment booklets in the CARG folder.
- All CARG members attend for clinical assessment and CD4 or viral load monitoring on the same day.
- Group members complete a refill form with basic health questions and pill counts.
• The selected CARG representative/s take the forms to the clinic, where they fetch the refill medication for the group.
• The medication will be dispensed in individual, named bags.
• Each member then signs that they have received their medication.
• CARG members with signs of clinical, immunological or virological failure, or who fail to sign for their refill, will be asked to attend the clinic for individual follow up.

Family groups may also receive their refills as a group so that not all family members need to travel to the clinic.

**Monitoring visits**

Clients being monitored clinically (using CD4 counts) should have a clinical visit and repeat CD4 count every 6 months.

Clients being monitored with viral load monitoring should have a clinical visit and viral load test every 12 months.

Some signs and symptoms mean the patient should attend the clinic without waiting for their normal appointment date. Examples of these are:

- Candidiasis (thrush)
- Symptoms/ signs of TB
- Diarrhoea or vomiting
- Persistent fever
- New rashes
- Signs and symptoms related to possible medicine side effects.

**If you are concerned, go to the clinic!**

Zimbabwe’s Patients Charter lists the services clients should receive when attending a healthcare centre (see Annex II). Have a session to go through the Charter so that clients understand what to expect and can request appropriate care if it is not provided.

**Action Planning: Respect, Review, Engage, Advocate!**

*Go through all the knowledge for action boxes in this section again. Identify which, if any, are a priority for the group/community (there may be others too!). List them. Use the action planning matrix on page 3 to prioritise them and create a plan of action to help you address access to ARVs in your area.*
TREATMENT AS PREVENTION (TasP)

A Learning and Sharing Activity

Ask a group of participants to role play this scenario.

Simba is HIV positive and on ARVs. He and his partner are serodiscordant – in other words, she is HIV negative – and they want to start a family. His last viral load test was undetectable, but Simba is still worried about infecting his partner. His treatment buddy tells him about TasP and how it can reduce the chances of his partner getting infected when they try for a baby.

In plenary, discuss the practical issues of a serodiscordant couple having a baby, and how TasP can help PLHIV enjoy their full sexual and reproductive health rights.

Follow-up: Repeat the exercise, have the issues around serodiscordant couples having a baby changed?

Knowledge Sharing Session: Information to share and discuss

The Link between Treatment and Prevention

There is strong evidence of the link between treatment and prevention. People living with HIV who are on ART are much less likely to pass on the virus; therefore early testing and treatment can significantly reduce the spread of HIV.

ARVs to prevent HIV transmission

Taken correctly and consistently, ARVs lower the amount of HIV in the blood. If a PLHIV has an **undetectable viral load**, then the ARVs they take can also act as treatment as prevention (treatment as prevention – TasP).

This means that PLHIV are much less likely to transmit HIV to their partners in the case of a condom burst, for example, or if trying to have a baby.

Because of the effectiveness of TasP, universal coverage of ARVs is now recognised as an important aspect of preventing HIV.

**REVIEW**

Undetectable does not mean uninfected – it only means there is not enough virus in the blood for the test to detect. An undetectable viral load means it was **undetectable AT THE TIME OF THE TEST**.

Viral load can change quickly, especially if you get sick with a cold or flu, or even if you get vaccinated. This increase is temporary and will return to what is normal for you, once the illness if over or the immune system adjusts to the vaccination. However, during this viral load spike you could infect your partner if you have unsafe sex.
However, **condoms should also be used** in case of a viral load ‘blip’ (when the viral load goes up temporarily for some reason). This can happen when someone does not take their ARVs consistently, or when they have another illness or infection.

In addition, treatment can now be used in HIV negative people to prevent them becoming infected – see the section below on PreP.

**Disclosure**

Disclosure of an HIV positive status is an important issue for all PLHIV and for caregivers of infants and young people living with HIV. See Annex III of this manual for a discussion on disclosure, which you can use discuss the issue with participants, as needed.

**Other interventions to reduce the spread of HIV**

**PEP** – short for post-exposure prophylaxis – is a month-long course of ARVs prescribed for people who may have been exposed to HIV, for example in cases of rape or sexual assault; blood-to-blood exposure (e.g. needle stick injuries in healthcare workers); or when a condom bursts. PEP can stop the virus becoming established in the body of an exposed person. It must be taken as soon as possible after the incident (before 72 hours) to be effective. You can seek PEP for a condom burst from a private doctor.

**PrEP** – is short for pre-exposure prophylaxis. It involves taking two ARV medicines (Tenofovir and Emtricitabine) daily. These medicines can stop the virus from building a permanent infection if the user is exposed to HIV through unprotected sex.

- When taken consistently, PrEP can reduce the risk of HIV infection in people who are at high risk by up to 92%.
- It can also be used in couples who are having consensual unprotected sex. Someone in a sexual relationship with a PLHIV may choose to take PrEP to reduce the chances of being infected with HIV.
- PrEP can also be taken by an HIV negative woman in a serodiscordant relationship to reduce the chances of her contracting HIV if the couple is trying for a baby.

**REVIEW**

Those wishing to use PrEP in Zimbabwe are likely to have to pay for the medicine themselves as this is not currently provided under the government ARV programme.
PrEP is also taken by men who have sex with men, by sex workers and other people at risk of exposure to reduce their chances of contracting HIV.

*PrEP is much less effective if it is not taken consistently*

**Serodiscordant Couples**

A serodiscordant couple is where one person is HIV positive and the other is HIV negative. With modern treatment options and correct precautions, it is quite possible for serodiscordant couples to lead a normal married life – and to have healthy, HIV negative children.

**Special issues for serodiscordant (mixed-status) couples**

People in mixed-status relationships face all the same issues as other couples, but there are some extra concerns.

- The HIV-positive partner may fear infecting their partner, while the HIV-negative partner may concentrate on taking care of the other person. This can cause a serious lack of balance in the relationship.
- Anti-HIV medications may have unpleasant side effects which may give the HIV-positive partner negative feelings about their body and their health. They may find it difficult to feel attractive and have a normal romantic relationship.
- Fear of transmitting HIV may even stop all sexual activity.

**Reducing the risks**

ARVs control HIV infection very well, when taken as instructed. Good adherence to ARVs is recognised as a way of preventing HIV spread (TasP). If your viral load stays undetectable, the chances are good that you will not pass on HIV.

However, remember:

- You must take your ARVs exactly as instructed for TasP to work.
- The viral load test only measures HIV in the blood – It doesn’t tell you about HIV in sexual fluids (sperm or vaginal fluids).
**Other ways to reduce risk**

- Avoid unprotected sexual activity during any other infectious illness, such as a sexually transmitted disease, or even a cold or flu.
- Avoid sexual activity within a couple of weeks of getting any vaccinations.

**If You are Exposed to HIV...**

If you are HIV negative and in a relationship with an HIV positive partner, discuss PEP with your doctor in advance, so that you know what your options are in case of a condom break or other exposure. For PEP to work, it must be taken within 72 hours of exposure to HIV.

**PEP is provided free in cases of rape!**

**Having Children**

The sperm of an HIV-infected man can be ‘washed’ so that it can be used to fertilise a woman and produce a healthy baby. This is effective but expensive; this facility is not available in Zimbabwe.

- It is possible for the woman to take PreP before having unprotected sex – although this is not a guarantee that transmission will not occur.
- If the HIV positive partner is on ARVs and has an undetectable viral load and the other partner takes PreP the chances of HIV transmission are much reduced. The female partner should monitor her ovulation times so that unprotected sex is limited to her most fertile times.
- If the woman is the HIV positive partner, then the safest option is artificial insemination with her partner’s sperm. This is quite simple and allows pregnancy to occur without exposing the man to HIV.
A note on criminalisation of HIV transmission.

While TasP is now recognised as an important means of reducing the spread of HIV, it is important to remember that under Zimbabwe law, a PLHIV may still be charged with deliberately transmitting HIV.

Honesty is the best policy. It is important to disclose your HIV positive status to all sexual partners and to use condoms correctly and consistently every time you have sex. See Annex III for more information on disclosure.

Remember too, that relationships change over time and that someone who knowingly had sex with you may change that position later. In terms of the law, you need to be able to prove that someone was aware of your HIV positive status and that they agreed to have sex with you while being fully aware of the risks.

Action Planning: Respect, Review, Engage, Advocate!

Go through all the knowledge for action boxes in this section again. Identify which, if any, are a priority for the group/community (there may be others too!). List them. Use the action planning matrix on page 3 to prioritise them and create a plan of action to help you support in your area!
THE IMPORTANCE OF ADHERENCE

A Learning and Sharing Activity

Explain that there are five areas that impact on a person’s ability to adhere to a treatment regimen. These are: patient related impacts; healthcare system impacts; social/economic impact; treatment related impacts; and HIV/TB related impacts, as shown in the diagram below. Hand out pieces of card and ask each participant to write down one possible issue under each area of impact (if the group is large you can allocate one area of impact per group).

After about 10 minutes, collect the cards and stick them up under each area of impact. Add any from the table below that have been missed. The group may have identified some new ones!

Use this activity to highlight that being able to adhere is a very complicated issue and is different for each individual.

Follow-up: Repeat the activity – have the answers improved?

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**Table:**

<table>
<thead>
<tr>
<th>Impact Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social/economic impact</td>
</tr>
<tr>
<td>Treatment related impacts</td>
</tr>
<tr>
<td>Healthcare system impacts</td>
</tr>
<tr>
<td>Patient related impacts</td>
</tr>
<tr>
<td>HIV/TB related impacts</td>
</tr>
</tbody>
</table>

---

4.
### Patient related impacts

- Patient has hearing or visual impairments
- Patient is mentally unwell or depressed and unable to follow instructions
- Patient has swallowing problems
- Client has limited knowledge or understanding about the disease, does not believe he or she is at risk from not adhering
- Is in denial about being HIV positive
- Has little motivation to adhere because of limited life prospects - education, job opportunities
- Suffers from alcohol or substance abuse
- Is frustrated by the attitudes of healthcare providers
- Is experiencing psychological distress, anxiety or anger

### Healthcare system impacts

- Poor attitudes of healthcare providers
- Poor communication skills of healthcare providers in explaining the benefits of medication and side effects
- No positive encouragement from healthcare providers
- Poor education and poor follow up
- Inability to suggest ways to improve adherence
- Drug costs / consultation fees
- Poor access leading to missed appointments
- Long waiting times
- No continuity of care – client sees different provider on each visit

### Social/economic impact

- Low treatment literacy
- Limited family/ support network
- Poor living conditions/ homelessness
- Limited access to healthcare facility – no money for transport, or to pay for consultation or drugs
- Cultural beliefs about the illness/ medication
- Stigma about being seen going to the clinic

### Treatment related impacts

- Complicated treatment regimen – many pills, different times of day, need for food with medicine
- Stigma attached to taking medicines
- Actual or perceived side effects of medicine
- Lack of immediate improvement in health condition

### HIV/ TB related impacts

- Client has chronic symptoms which will not improve with treatment
- Client is very ill and unable to take treatment
- Has a psychotic disorder or dementia as a result of HIV
Knowledge Sharing Session: Information to share and discuss

What is Adherence?

It is critical that the group takes away an understanding of what adherence involves.

What Does Adherence Involve?

- Taking medicines that are part of a person’s treatment regimen (both ARVs and other medicines like TB drugs and Cotrimoxazole in the right amounts).
- Taking medicines at the right time.
- Eating and drinking the right things with your pills. Knowing what other foods and medicines can cause problems with your ARVs so as to avoid or change them. Some medicines should be taken with food and some without food, but the latest regimens can usually be taken with or without food. Certain foods should be avoided with some medicines.
- Knowing about interactions between ARVs and other types of medicine; some other medicines can change the way ARVs work in the body.
- PLHIV get the best results when adherence is 100% – this means taking all your ARVs exactly as instructed.

Why is adherence important?

Adherence is the most important factor in the success of ART because:

- Without good adherence ARV medicines do not work well. This can put the PLHIV’s life at risk.
- Taking ARVs is a lifelong process. Once you start you should not stop unless told to do so by a qualified health professional.
- Not adhering can cause resistance to the ARVs. If you stop or delay taking them it gives HIV a chance to adapt and fight the medicine.
- The first line of ARV treatment is affordable and readily available – second and third lines are not. Second and third line ARVs can cost up to 6 times more than first line and are generally more difficult to adhere to.

CARGs can help improve the lives of people with ART and support adherence.

Seven ways to enhance adherence:

1. Develop a treatment plan; learn about the side effects of ARVs and get counselling.
2. Pill boxes are special containers for storing ARV medicines that separate each dose to help PLHIV remember what ARVs to take and when to take them.
3. Electronic devices such as alarm clocks, watches, or cell phones can remind you when to take your ARVs.
4. The buddy system; team up with a friend or family member or other PLHIV to remind you when and how to take your ARVs.
5. Medication diaries record the date and time of each medicine dose, any missed doses or any side effects experienced.
6. Support groups can help PLHIV adhere by providing opportunities to openly discuss how ARV is affecting their life.
7. Pill charts show the names of ARVs being taken and the doses for each medicine each day to remind you what to take and when.
A special note on adherence in children

Because of their age, children’s adherence is dependent on their caregiver remembering to give them their medication as prescribed.

• Caregivers must understand the importance of adherence.
• One person should take responsibility for giving the child their medication.
• If the child often moves from one home to another, then a caregiver in each place should be responsible for ensuring the child takes their medicines as instructed.
• If the child is old enough, the child should be involved in deciding when and how they will take their medicines.
• Young children are often on a protease inhibitor – these may have special dietary requirements. All caregivers should know what these are and ensure that the child keeps to them.

What is a treatment supporter? A treatment supporter or ‘buddy’ is someone who helps with day-to-day adherence to ARV. A good treatment buddy is someone who is:

• Aware of and accepts your status.
• Committed to supporting you for a long time.
• Able to meet health personnel with you and be educated on HIV and AIDS issues.
• Available daily (if needed) and live close by.
• Someone who will keep your information confidentially and that you can rely on.

Measuring adherence means keeping track of medicines (knowing where they are and arranging for refills before they run out), remembering when to take doses, identifying times when doses have been missed and why.

• An ARV diary helps you report back on your adherence.
• Pill counting – healthcare providers and home-based care workers count the number of pills remaining in a prescription during a clinic visit. If there are more or less pills than there should be, then there may be problems with adherence.

Directly Observed Therapy (DOT) where health care staff are with PLHIV when they take their medicines.

Remember! Adherence is NOT always easy
Tips for adherence

• Discuss adherence problems with a health care provider (not just for ARVs but for other medicines too).
• Learn from difficulties or mistakes; do not get discouraged.
• It is also very important to attend all your clinic appointments. Do not miss them!
• If you are travelling, always take enough medication with you for the time you will be away and allow for possible delays in returning.
• Disclosing your HIV positive status can also help adherence.
• Develop plans for how to overcome problems faced now and in the future.
• People with alcohol and drug abuse problems often have more difficulty in adhering – get help!
• People who are depressed or have other mental health issues also have more difficulty adhering. Having a treatment buddy can help.
• Get help and keep asking questions about your treatment and health.\(^2\)
• It may be appealing to be told by a faith healer that you no longer need to take your ARVs – but this is very dangerous. There is no cure for HIV as yet.

Important: Special attention to support and capacity build around adherence is important for people with disabilities, especially the hearing impaired and those with mental disabilities. Those with mental health issues will also need additional support.

---

Quick facts on non adherence

- It is a main cause of ARV treatment failure
- Can be deliberate, OR accidental, OR circumstantial (e.g. domestic violence)
- Non adherence can cause resistance so that the drugs will not work well for you in the future
- Understanding the difficulties of adherence can help
- Non disclosure to a child is known to contribute to poor adherence.

Forms of non adherence

- Missing doses
- Not taking the right amount and/or at the right time
- Not following instructions (diet, fluids, etc.)

ENGAGE

Drug availability is erratic

Make sure you do not run out – get you medicines in good time. Tell your support group – as a group you might be able to do something about it.

Shortage of health personnel/staff

Be prepared for long waits and make sure you have your medicines and some food in case there are delays. Time with the staff member could be short so get to the point and insist that your issues be heard.

Shortage of local health facilities

This means you really have to plan your time and resources if you have to travel far to get treatment.

Shortage of information on HIV, ARVs, TB etc.

Make good use of your friends and networks and request information from your health centre. As support groups, find the people who can give you the info you need!
**What is drug resistance?**

ARVs slow down the replication of HIV in the body, but they do not stop it completely so some HIV is able to survive despite ongoing HIV treatment.

- When HIV multiplies, it often makes small mistakes, so each new generation of HIV is slightly different from the one before – mutations.
- Some of these mutations occur in the parts of HIV targeted by ARVs, so although some HIV in the body continues to be attacked by the medicines, some may not be affected.
- This HIV is called drug resistant HIV; it is able to multiply despite the ARVs. The amount of HIV in the blood rises and the risk of the person becoming ill increases.
- Failure to adhere to your ARVs allows some of these mutations to take advantage of the low levels of ARVs in your blood and learn to fight the ARVs.

**Drug resistance is one of the main reasons why antiretroviral treatment fails.** If resistance develops, usually the ARV regimen needs to be changed.

**What does ‘resistance’ to an ART regimen mean?’**

Resistance means the combination of ARV medicines is no longer able to prevent HIV from replicating. It is mostly caused by not taking medicines properly, although it is also possible to be infected with a virus that is resistant to some of the most common ARVs.

**Cross-resistance:** Resistance can limit future treatment options. If HIV is resistant to one ARV, it is likely to be resistant to similar drugs in the same treatment group. This is called cross-resistance and means that some ARVs will not work for you, even if they have not been used before.

**ENGAGE**

Reduce your risk of drug resistance by:

- Ensuring that the drug combination is strong to begin with – this usually means taking a combination of 3 ARVs.
- Taking medication exactly as prescribed – adherence. This is a very important part of avoiding resistance.
- Regular viral load testing is important. The results can indicate if a drug resistant strain of HIV is developing. If the drug combination is working, the viral load should be undetectable. An increasing viral load can be a sign of growing drug resistance.
**What does ‘treatment failure’ mean?**

Treatment failure is when the ARVs someone is taking no longer work to prevent HIV from replicating and stop being effective. It is identified when new OIs occur whilst taking ARVs for at least six months, or when WHO stage 3 and 4 recurs.

- When viral load is above 1,000 copies on two consecutive occasions (virological failure)
- When CD4 count falls to baseline or below, or remains consistently below 100 (immunological failure).
- In children below the age of five, immunological failure is considered when the CD4 count is consistently below 200 or the CD4 percentage is less than 100.
- In children above the age of five, immunological failure is considered when the CD4 count is consistently below 100.
- Virological failure in children is when the viral load is above 1,000 copies on two consecutive occasions after the provision of three months adherence support.

**Your healthcare worker should take action if your CD4 count falls below baseline or if your viral load is greater than 100 on two successive occasions!**

In the case of treatment failure, second line treatment can only be started after consultation with a specialist in HIV care.

When treatment failure is identified, intensive adherence support and monitoring should be put in place. This may enable the client to remain on their existing treatment.

**Action Planning: Respect, Review, Engage, Advocate!**

*Go through all the knowledge for action boxes in this section again. Identify which, if any, are a priority for the group/community (there may be others too!). List them. Use the action planning matrix on page 3 to prioritise them and create a plan of action to help you address adherence in your area.*
## HIV and TB

**A Learning and Sharing Activity**

*Use the following Q & A as a quiz, mix and match test (cut them out and match them up) or plenary discussion.*

**Follow-up: Repeat the quiz – have the answers improved?**

<table>
<thead>
<tr>
<th>Quick quiz questions on OIs and TB</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis (TB) is caused by a virus</td>
<td></td>
<td>×</td>
</tr>
<tr>
<td>TB is caused by bacteria</td>
<td>×</td>
<td></td>
</tr>
<tr>
<td>TB can be transmitted from person to person through touching or sharing plates/cups etc.</td>
<td></td>
<td>×</td>
</tr>
<tr>
<td>TB can be transmitted through singing</td>
<td></td>
<td>×</td>
</tr>
<tr>
<td>TB only affects the lungs</td>
<td>×</td>
<td></td>
</tr>
<tr>
<td>1/3 of the world’s population is infected with TB and not everyone who has it shows symptoms</td>
<td></td>
<td>×</td>
</tr>
<tr>
<td>TB can be cured</td>
<td></td>
<td>×</td>
</tr>
<tr>
<td>PLHIV are more at risk of getting TB because their immune systems are weaker</td>
<td></td>
<td>×</td>
</tr>
<tr>
<td>PLHIV can be treated for TB, even if taking ARVs</td>
<td></td>
<td>×</td>
</tr>
<tr>
<td>Opportunistic Infections (OIs) take advantage of a weak immune system, whether you are HIV positive or HIV negative</td>
<td></td>
<td>×</td>
</tr>
<tr>
<td>Different OIs typically appear at different stages of HIV infection</td>
<td></td>
<td>×</td>
</tr>
<tr>
<td>HIV-positive people can reduce their exposure to OIs by being careful around uncooked meat, domestic animals, using good hygiene</td>
<td></td>
<td>×</td>
</tr>
<tr>
<td>Condoms prevent HIV. They do not prevent OIs</td>
<td></td>
<td>×</td>
</tr>
<tr>
<td>Cotrimoxazole can be used to prevent several HIV-related infections (including TB, bacterial pneumonia, septicaemia and PCP)</td>
<td></td>
<td>×</td>
</tr>
</tbody>
</table>
Knowledge Sharing Session: Information to share and discuss

Basic facts on HIV and AIDS

Definition of HIV and AIDS:

- HIV is the virus that leads to AIDS, if left untreated.
- It attacks the immune system – the body’s defence against disease.
- HIV is found in blood, breast milk, semen and vaginal fluids.
- Once a person is infected, the virus remains in the body for life.
- Without treatment, the body’s immune system gradually weakens, leading to serious illness and eventual death (AIDS).

The immune system helps the body to fight disease and infections. Special white blood cells – CD4 cells – help to identify and fight bacteria and viruses in the body. HIV can destroy entire ‘families’ of CD4 cells, allowing the diseases that these families were designed to fight, to easily take over. This is when opportunistic infections are likely to develop.

AIDS is the name given to a group of serious illnesses that can develop in HIV positive people. These illnesses arise when the body is no longer able to fight off infection because of lowered immunity.

How is HIV transmitted?

HIV is present in body fluids: semen, blood, vaginal fluids and breast milk have the most HIV. It is transmitted through exchange of these fluids in three main ways:

1. Unprotected sexual contact – this is the most common way people contract HIV (92% of cases).
2. Mother-to-child transmission (MTC) – mothers can pass HIV to their babies during pregnancy, childbirth or breastfeeding (7% of cases).
3. Other – of which 0.1% is blood contact – through blood transfusion, sharing injection needles or other sharp objects (razor blades) contaminated with infected blood (1%). NAC ZNASP II, 2011-2015.
**Ways in which HIV is NOT transmitted:**

- Social contact: hugging, kissing, shaking hands, breathing the same air, coughs, sneezes, sweat, contact through sport, tears.
- Sharing items: toilet seats, food utensils or drinking cups, clothes, public baths or swimming pools.
- Insect bites: mosquitoes, bed bugs.

**ENGAGE: Ways to prevent HIV transmission**

- Practicing safer sex, which means: correct and consistent use of condoms, being faithful to your partner, avoiding casual sex, practicing non-penetrative sex, abstinence.
- Prevention of mother-to-child transmission (PMTCT): pregnant women taking ARVs to stop them passing HIV to the baby during pregnancy, childbirth or breastfeeding.
- Harm reduction: Behaviour change – consistent condom use, reducing high-risk behaviours such as having multiple partners and anal sex.
- Precautions against infection: ‘universal precautions’ – taking steps to ensure no contact with blood or body fluids during caring activities. Covering all open wounds, disposing of waste properly and not sharing sharp objects such as razor blades and needles.

**ENGAGE**

A person with any of the following symptoms may have pulmonary TB; a cough for two weeks or more and one of the following:

- Productive cough which may be blood-stained.
- Night sweats.
- Fever.
- Weight loss.
- Chest pain.
- A general feeling of being unwell.
### WHO Staging for HIV and AIDS

**Stage 1 initial HIV infection**
- HIV gets into your body and starts to replicate. You might get a ‘flu-like’ illness at this stage.
- The window period is typically 3-6 months. During this period, the body has not produced enough antibodies to HIV to be detected by a blood test. This is the time you are most likely to pass on the infection. There are generally no signs and symptoms; only you will know if you have been at risk or not.

**Stage 2: asymptomatic (say, A, as in the letter ‘A’) -symptom-atic)**
- No signs and symptoms. If you are under stress or do not have a healthy lifestyle this period can be short. Knowing your status and living positively can improve quality of life and the length of this phase. You can still transmit the disease to others during this time.

**Stage 3: HIV related illness**
- Signs and symptoms start to show. You may lose weight and get OIs at this stage. TB is the most common OI and it is often on diagnosis of TB that people discover their HIV infection. This stage can last for months or years depending on your lifestyle, treatment of OIs and access to ARV medication and other medicines to prevent illness, such as Cotrimoxazol and Isoniazid.

**Stage 4: AIDS**
- The immune system is very weak and cannot cope with infections. Unexplained weight loss is common. Often the CD4 cell count is very low. Antiretroviral treatment is necessary.

### Opportunistic infections, other Illnesses and TB co-infection

An opportunistic infection is a disease that takes advantage of the body’s weak defences – such as TB, thrush, fever, chronic diarrhoea, meningitis, Kaposi’s sarcoma (a kind of skin cancer) and skin diseases.

Other illnesses include: chlamydia trachomatis (a bacterial infection that can lead to infertility if untreated); human papilloma virus (HPV) which can cause cervical cancer in women, penile cancer in men or anal cancer in both sexes; genital herpes (sores and blisters); chancroid (ulcers); hepatitis B and C (severe liver infection); infections of the gut and intestines; and other parasitic diseases.
It is important that PLHIV seek early treatment for OIs and other illnesses to prevent their immune systems being further weakened.

What is TB?

Tuberculosis, or TB, is the most common OI in people living with HIV. It progresses faster in PLHIV and can kill quickly if left untreated.

- TB is an infectious disease caused by bacteria.
- TB that affects the lungs is known as pulmonary TB
- TB can also affect other parts of the body, such as the brain, kidneys, spine and joints – this type of TB is called extra-pulmonary TB.
- Extra-pulmonary TB is not infectious (except for TB of the throat).

It is important to report to your nearest health facility quickly if you suspect you have TB.

How is TB spread?

TB is spread through droplets in the air when someone who has untreated pulmonary TB or TB in the throat coughs, laughs, talks, sings or sneezes. This can happen anywhere: at home, work or in the community.

- People living in the same home with a person who has active TB should get screened for TB at the local clinic.
- Overcrowding, poor nutrition, and poor living conditions provide fertile conditions for TB to spread.
- Children (and older people) who are in close contact with someone with pulmonary TB are more likely to be infected.

TB is not:

- Hereditary (does not run in the family).
- Sexually transmitted.
- Brought about by witchcraft or by breaking taboos.
- Caused by trauma/injury to the chest.
- Spread by sharing food or drink.
Many people (about 1 in 3) carry the TB bacteria in their bodies, but do not get sick (latent TB). The bacteria are kept sleeping by the body’s immune system. Latent TB is not infectious to others.

When the body’s immune system is weak, as in PLHIV, the bacteria eventually wake up and the person develops active TB disease. When someone has active TB of the lungs and throat, they can pass the bacteria on to others (they are infectious).

**Standard treatment regimen for TB**

<table>
<thead>
<tr>
<th>Essential Anti-TB drugs</th>
<th>Mode of action, most important target</th>
<th>Recommended dose in mg/kg (Daily)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isoniazid (H) (INH)</td>
<td>Bactericidal, kills metabolic active bacilli</td>
<td>5 (4-6)</td>
</tr>
<tr>
<td>Rifampicin (R) (RIF)</td>
<td>Bactericidal, kills semi-dormant bacilli</td>
<td>10 (8-12)</td>
</tr>
<tr>
<td>Pyrazinamide (Z) (PZA)</td>
<td>Bactericidal, kills intra-cellular bacilli</td>
<td>25 (20-30)</td>
</tr>
<tr>
<td>Streptomycin (S) (SM)</td>
<td>Bactericidal, kills metabolic active bacilli</td>
<td>15 (12-18)</td>
</tr>
<tr>
<td>Ethambutol (E) (EMB)</td>
<td>Bacteriostatic (stops the TB bacteria from multiplying)</td>
<td>15 (12-18)</td>
</tr>
</tbody>
</table>

Untreated, TB kills up to half of all people living with HIV worldwide and is the leading cause of death among PLHIV!
Review: Antiretroviral Therapy and TB Prevention

Studies have shown that the risk of developing TB is significantly decreased among PLHIV who are on ARVs, because of the HIV treatment’s effect in strengthening the body’s defence system. ARVs can reduce TB risk by up to 92% and reduce TB re-infection rates by 50%. This is why testing for and treating HIV is an important part of reducing the spread of TB. PLHIV should be screened for symptoms of TB disease at every clinic or home visit, whether or not they have received or are receiving IPT or ARVs.

Understanding TB and HIV Co-infection

- TB and HIV are two separate diseases but they act on each other in a way that worsens the health of a person infected with both diseases.

- TB is harder to diagnose in people living with HIV and occurs earlier in the course of HIV infection than many other opportunistic infections.

- TB progresses faster in people living with HIV and shortens survival; it is important to get diagnosed and treated early.

- TB in people living with HIV is almost certain to be fatal if undiagnosed or left untreated.

- PLHIV who have not developed TB may benefit from preventative therapy with Cotrimoxazole and Isoniazid. (treatment to prevent them developing active TB disease and protect their health and that of their family. Ask your health worker or health centre for more information.

Clients with TB and HIV co-infection should first be started on TB treatment; ART can be started two weeks after commencing TB treatment.

People being treated for both TB and HIV must take the pills for both TB and HIV every day as instructed by the healthcare provider.

The body can easily cope with taking both the pills for TB and HIV, because they are helping the body to get strong again.

Remember – TB treatment is temporary but ART for HIV must be taken for life.

Zimbabwe is among those countries with a high burden of HIV and TB disease. The WHO estimates that the HIV/TB co-infection rate is over 70%.

Untreated, TB kills up to half of all people living with HIV worldwide and is the leading cause of death among PLHIV!
Treatment for HIV/TB co-infected persons is given according to the CD4 count, as shown in the table below.

<table>
<thead>
<tr>
<th>CD4 cell count</th>
<th>ARV regimen</th>
<th>Timing of ART in relation to start of anti-TB treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>CD4 &lt; 500 cells/mm³</td>
<td>Start ARVs</td>
<td>Between 2 and 8 weeks</td>
</tr>
<tr>
<td>CD4 &gt; 500 cells/mm³</td>
<td>Defer ARVs</td>
<td>Re-evaluate patient at 8 weeks and at the end of anti-TB treatment</td>
</tr>
<tr>
<td>CD4 not available</td>
<td>Recommend ARVs</td>
<td>Between 2 and 8 weeks</td>
</tr>
</tbody>
</table>

**Children and TB/HIV**

Children are more prone to becoming infected with TB because their immune systems are still developing. A child usually gets TB from being on close contact with an adult who has active TB, for instance by living in a household where an adult has TB.

- Children younger than five are at higher risk of contracting TB.
- Children living with HIV are also at higher risk of contracting TB because their immune system is already weak.
- All children living in a home with an adult with TB infection should be screened for TB.
- Isoniazid preventive therapy (IPT) is recommended for children under five who are in contact with TB patients.

**TB diagnosis and treatment for children**

TB diagnosis and treatment are much harder to get right with children. Diagnosis is difficult because:

- The symptoms are similar to those of other common childhood diseases.
- Skin testing and chest x-rays can be difficult to interpret.
- It is hard to get a sputum test from a child.
Treatment is more complicated because of:

- Dosing issues.
- Poorer adherence (because someone else needs to give them the drugs) and
- Because children do not and cannot report side effects as well as adults.

Treating TB in children – especially children living with HIV – is very serious. This table shows the typical first line drugs and doses for treating children with TB.

<table>
<thead>
<tr>
<th>Anti-TB Drug</th>
<th>Dose (daily)</th>
<th>Maximum Daily Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isoniazid (H) (INH)</td>
<td>10mg/kg</td>
<td>300mg</td>
</tr>
<tr>
<td>Rifampicin (R) (RIF)</td>
<td>10-20mg/kg</td>
<td>600mg</td>
</tr>
<tr>
<td>Pyrazinamide(P) (PZA)</td>
<td>25-40mg/kg</td>
<td>2000mg</td>
</tr>
<tr>
<td>Ethambutol (E) (EMB)</td>
<td>20 (15-25mg/kg)</td>
<td>1200mg</td>
</tr>
<tr>
<td>Streptomycin(S) (SM)</td>
<td>15 (12-18mg/kg)</td>
<td>1000mg</td>
</tr>
</tbody>
</table>

**Treating children co-infected with HIV**

There are two main issues when treating HIV/TB co-infected infants, children and adolescents.

- Starting anti-TB treatment is the first priority, just as in adults.
- The child must be given pyridoxine (5–10 mg/day) especially when the child is malnourished, or is a breastfeeding infant or a pregnant teenager.

If the child develops TB whilst already on ART then the following applies:

- If the child is on Nevirapine and aged 3 years or above and weighs over 10kg, they should be switched to Efavirenz.
- If the child is on Nevirapine and under 3 years old, or weighs less than 10kg, the child should be switched to boosted Lopinavir/Ritonavir (if available).
**What is MDR TB?**

MDR is a kind of TB where the germs are resistant to two or more of the four basic drugs used to treat TB (Rifampicin and Isoniazid). This means these drugs no longer work to fight the TB germs.

**How do you get MDR TB?**

- If you do not receive the correct basic four-drug combination for treating TB.
- If you do not adhere to the prescribed daily treatment of six months, exactly as instructed by your healthcare provider.
- If you contract TB from someone else who has MDR TB.

**How is MDR TB treated?**

- MDR TB is much harder to treat than normal, drug sensitive TB.
- Treatment for MDR TB takes at least two years
- Drugs to treat MDR TB can cause more side effects, which may be severe.
- If MDR treatment is not taken exactly as instructed by your healthcare provider, you may develop an even more resistant kind of TB called extensively drug resistant TB (XDR TB), which is very difficult to cure.

Avoid MDR TB by making sure you take your TB medicines exactly as instructed by your healthcare provider and finish the course – even if you start to feel better.

- Keep your windows open to improve air circulation and sit outside in the sun.
- Wear a special mask, if your nurse or doctor recommends it.
- Take your medicine every day, exactly as instructed by your healthcare provider until the end of your treatment.
Summary – HIV / TB infection

• Treatment and positive living bring hope to all PLHIV. Because of ARVs, HIV is now regarded as a manageable chronic illness, just like diabetes. So, stay hopeful, as we do not know what tomorrow holds.

• The window period can be from 6 weeks to 3 months after you have been exposed (through unprotected sex or contamination with blood and other body fluids). If you have been exposed to HIV risk, a first negative test may need to be followed up 12 weeks later with another test.

• Knowing your status is critical. You have the right to test for HIV if you feel you have been at risk or been exposed to the risk.

• Even children need to know their HIV status.

• TB is a very common OI for PLHIV.

• TB is very treatable if diagnosed early.

• TB can be prevented in PLHIV through IPT.

• Managing TB in the wider community supports the well-being of PLHIV.

• There are four main phases from HIV infection to AIDS, understanding and knowledge can help you better manage your health.

• Knowledge is power for PLHIV. The more questions you ask, the more chance you have of managing care treatment and support that is effective for you.

• Knowing your TB status is just as important as knowing your HIV status.

• Anyone can get TB, whether or not they are HIV positive. PLHIV can develop active TB at any time.

• Having TB does not mean you have HIV but people who are HIV positive can develop TB more easily, so it is common in PLHIV.

Action Planning: Respect, Review, Engage, Advocate!

Go through all the knowledge for action boxes in this section again. Identify which, if any are a priority for the group/community (there may be others too!). List them. Use the action planning matrix on page 3 to prioritise them and create a plan of action to identify and treat OIs and TB earlier!
ARVs and ADULTS

Prior to starting ARVs, adult patients should always be counselled on ARVs and adherence. Their ARV regimen should be explained to them including: dosing and scheduling; possible side effects; and what monitoring is needed. A list of the different classes of ARVs and the drugs that belong to each class can be found in Annex I.

A Learning and Sharing Activity

Read the statements in Column A and try to find the words from Column B to match the statement. Some answers in Column B may be used more than once, and some may not be used at all.

Follow-up: Repeat the quiz- have the answers improved?

<table>
<thead>
<tr>
<th>Column A</th>
<th>Column B</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If you do not have HIV, your test will show…</td>
<td>A. HIV antibodies</td>
</tr>
<tr>
<td>2. You can get tested at…</td>
<td>B. Compulsory testing</td>
</tr>
<tr>
<td>3. The test for HIV looks for…</td>
<td>C. Wait or come back</td>
</tr>
<tr>
<td>4. The test is accurate to…</td>
<td>D. A positive result</td>
</tr>
<tr>
<td>5. To get the test result you may have to…</td>
<td>E. Window period</td>
</tr>
<tr>
<td>6. “Voluntary” testing is the opposite of…</td>
<td>F. 99%</td>
</tr>
<tr>
<td>7. What is not present in the blood during the window period?</td>
<td>G. A negative result</td>
</tr>
<tr>
<td></td>
<td>H. Infectious</td>
</tr>
<tr>
<td>8. What would be the result if you got tested during the window period?</td>
<td>I. Negative</td>
</tr>
<tr>
<td></td>
<td>J. Health centre, hospital, STI clinic, or a special HTS centre such as New Start Clinics</td>
</tr>
<tr>
<td>9. During the window period, people may be able to pass HIV on to others, meaning they are…</td>
<td>K. White blood cells</td>
</tr>
<tr>
<td></td>
<td>L. 89%</td>
</tr>
</tbody>
</table>

Answers to the Voluntary Counselling and Testing Quiz
Answers: 1 – G ; 2 – J ; 3 – A ; 4 – F ; 5 – C ; 6 – B ; 7 – A ; 8 – G ; 9 – H
Knowledge Sharing Session: Information to share and discuss

The provision of ARVs aims to ensure:

- Reduction of HIV-related sickness and death through long term prevention of HIV replication in the blood.
- Recovery and/or securing of immune function, leading to improved quality of life.
- Prevention of mother-to-child transmission of HIV (paediatric or vertical transmission).
- Reduced transmission of HIV – TasP.

**Medical criteria for beginning ART in adults**

Priority is given to individuals with severe/advanced HIV disease (WHO clinical stage 3 or 4) and to those with CD4 counts less than or equal to 350 cells/mm³.

- Current MoHCC guidelines recommend that everyone who is confirmed HIV positive who has a CD4 count of less than or equal to 500 cells/mm³ should access ARVs. This, combined with Option B+ for pregnant women, means that many more healthy people will be receiving ARVs.

ARVs are also recommended for:

- Those with active TB disease.
- All pregnant and breastfeeding women with HIV.
- HIV positive individuals who are in serodiscordant relationships.
- People with Hepatitis B co-infection and severe chronic liver disease.
- Patients with CD4 counts below 100 cells/mm³ should also be fast tracked and be given Cotrimoxazole (or Dapsone, for those who are unable to take Cotrimoxazole) and Isoniazid prophylaxis. They should be closely monitored for three months in case they develop bacterial infections, TB, or immune reconstitution inflammatory syndrome (IRIS).
**Drug interactions**

The action of ARVS may be affected by certain other medicines. This can reduce their effectiveness by lowering the amount of ARVs absorbed, leading to treatment failure.

ARVs may also make other medications less effective, e.g. certain contraceptives. This can lead to unintended pregnancy.

_**Women living with HIV and taking oral contraceptives and/or hormone replacement therapy**_ need to talk to their doctor about possible drug interactions.

_**PLHIV on TB treatment**_ including Rifampicin also need to check with their doctor if their ARVs will affect their TB treatment.

_**Recreational drugs, such as alcohol and marijuana (dagga),**_ are broken down in the liver, as are ARVs. They may interact with the ARVs and result in liver damage or increased toxicity. Avoid taking alcohol or _mbanje_ when you are on ARVS.

_It is important to tell your doctor of any other medicines or herbs you are taking._

**What is a first line regimen?**

A first-line regimen is the name of the first combination of ARV medicines used to reduce the replication of HIV. ART is always taken as a combination of THREE antiretroviral drugs since:

- It takes a lot of force to stop HIV. Anti-HIV drugs from different drug groups are needed to stop the activities of different chemical reactions of the virus in the body.
- Combinations of anti-HIV drugs can overcome or delay resistance.

**First line regimens**

The preferred first line regimen is a triple combination of Tenofovir (300mg) + Lamivudine (300mg)+ Efavirenz (600mg). These ARVs have relatively few negative effects.
**Special note on Efavirenz:** PLHIV taking Efavirenz should be aware that this medication can cause mood changes, anxiety and problems with concentration. For these reasons, it is recommended that people take their medication a couple of hours before sleeping, when it is less likely to cause them problems. Note that, at least in the beginning, it may also cause very vivid dreams. These side effects usually reduce after a few weeks of taking the medication. If they do not improve, speak to your healthcare provider.

<table>
<thead>
<tr>
<th>Alternative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescents (10-19 years) ≥ 25kg Adults including pregnant &amp; breastfeeding women &amp; those with TB/HIV &amp; Hepatitis/HIV</td>
</tr>
<tr>
<td>• Tenofovir (TDF) + Lamivudine (3TC) + Nevirapine (NVP)</td>
</tr>
<tr>
<td>• Zidovudine (AZT) + Lamivudine (3TC) + Efavirenz/ Nevirapine (EFV/NVP)</td>
</tr>
<tr>
<td>• Tenofovir (TDF) + Emtricitabine (FTC) + Efavirenz/ Nevirapine</td>
</tr>
</tbody>
</table>

**Alternative first line regimen**

Because Nevirapine sometimes causes severe side effects, treatment is started on a lower dose, as a ‘starter pack’, to check for toxicity. If the drug is well tolerated, then the person is moved onto the final regimen.

<table>
<thead>
<tr>
<th>Two-week Starter pack</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Morning dose</strong></td>
</tr>
<tr>
<td>Dual combination of Tenofovir (300mg) + Lamivudine (300mg)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Final regimen (assuming no serious side effects experienced within first 2 weeks)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Morning dose</strong></td>
</tr>
<tr>
<td>Combination of Tenofovir (300mg) + Lamivudine (300mg) + Nevirapine (200mg)</td>
</tr>
</tbody>
</table>
**Note:** Stavudine (d4T) has been phased out because of high toxicity. Limited stocks will be available for those patients who are unable to tolerate Tenofovir or Zidovudine-based regimens.

**Second line regimens**

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Preferred second line regimens</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combination of Tenofovir (300mg) + Lamivudine (300mg) + Nevirapine (200mg)</td>
<td>If Tenofovir was used in first line ART  Zidovudine + Lamivudine + Lopinavir/Ritonavir or Atazanavir /Ritonavir*</td>
</tr>
<tr>
<td></td>
<td>If Zidovudine was used in first line ART  Tenoforv + 3TC + Atazanavir /Ritonavir or Lopinavir/Ritonavir</td>
</tr>
<tr>
<td>HIV and TB co-infection</td>
<td>Patients receiving Rifampicin  Same NRTI backbone as recommended for adults and adolescents plus double dose Lopinavir/Ritonavir (800mg/200mg BD)</td>
</tr>
<tr>
<td>HIV and HBV co-infection</td>
<td>Zidovudine + Tenofovir+ Lamivudine + Atazanavir / Ritonavir or Lopinavir/Ritonavir*</td>
</tr>
</tbody>
</table>

* ATVr – Atanazivir. This is the preferred Protease inhibitor (the drug that stops the HIV virus multiplying inside the cells in the body)*

**If the person also has TB and is receiving Rifampicin** they will receive the same treatment with the addition of a double dose of Lopinavir, boosted with Ritonavir, twice daily.

**If the person has Hepatitis co-infection** – Zidovudine, Lamivudine and Tenofovir, plus either: Atazanavir boosted with Ritonavir; or Lopinavir boosted with Ritonavir.

**Note:** Abacavir /Lamuvudine 600 mg /300mg orally once daily plus Atazanavir/Ritonavir one daily or Lopinavir/Ritonavir twice daily may be prescribed for patients who are unable to take Tenofovir or Zidovudine.

**What is a third line ART regimen?**

If the first and second regimens fail, your doctor may prescribe you a ‘salvage cocktail’. In adults, this consists of Raltegravir (400mg) twice a day and Darunavir (800mg)/Ritonavir (100mg) once daily, used with other medicines, after carrying out resistance tests. Third line regimens are only available through Central Hospitals.
**Side effects of ARVs**

All medicines have side effects – or unwanted effects – on the body.

ARVs are very strong medicines, and some people experience bad side effects. These are especially common when you first start treatment, but often disappear as the body gets used to the medicines. Other people have very few side effects.

It is important to understand the difference between mild and severe side effects and to see your local health facility immediately if severe side effects occur. Record your side effects and when they occur so you can seek the advice of your healthcare worker. *Never stop taking ARVs* without being advised to do so by your healthcare worker.

PLHIV are encouraged to record side effects in a diary and bring this information to each medical appointment for discussion.

*Mild side effects include:* sleeplessness, upset stomach and nausea, diarrhoea, drowsiness, headache, fatigue, mild rash, confusion, nightmares and dizziness. Minor side effects will get better after a few weeks, or can be easily treated.

*Major side effects include:*

- Severe headaches, tingling in hands, arms, legs or feet, changes in fat distribution in the body,
- Severe stomach pain,
- Yellowing of the skin or pain of internal organs,
- Facial or ankle swelling, or changes in frequency of urination – especially if urination reduces or stops
- Severe rash, severe fatigue or shortness of breath, fever,
- Severe mental disturbance,
- Severe muscle pain or cramping,
- Anaemia (not enough red blood cells).
**Specific drug effects**

- **Zidovudine** can cause anaemia (usually within two months of taking it).
- **Tenofovir** should never be used in children as it affects bone development.
- **Stavudine** has been withdrawn because of toxicity. (patients taking it may experience pain and tingling in the hands and feet).
- **Efavirenz** can cause very vivid dreams or even mental illusions, as well as mood swings. These usually go away within the first six weeks – if they persist or are causing problems tell your healthcare worker. Efavirenz may also aggravate depression.

It is important for PLHIV to record any side effects they may experience from ARVs. Discuss the table below. Use this template!
### A Checklist for Recording Information and taking action on Side Effects

<table>
<thead>
<tr>
<th>QUESTIONS TO BE ANSWERED</th>
</tr>
</thead>
</table>
| **Frequency**  
The “When?” of Side Effects |
| - How often do you get these symptoms? |
| - Where are the symptoms felt in your body? |
| - When do symptoms occur? Do the symptoms occur all day, all night, only in the morning? |
| **Duration**  
The “How Long?” of Side Effects |
| - How long do the symptoms last? For example, do they last for 30 minutes, or for several hours? |
| - Is there a pattern to when you get the symptoms? For example, immediately after you take your medication or a few hours after a certain dose? |
| **Severity**  
The “How Bad?” of Side Effects on a scale of 1-5 |
| - How bad are the symptoms? |
| - Is there anything that makes the symptoms better? |
| **Quality of Life**  
“How are Side Effects impacting your life?” |
| - Are the symptoms affecting you? For example, is diarrhoea or headache stopping you from working or going outdoors |
| - Has your sleep been disturbed because of the symptoms? |
| - Are you able to eat as you normally would? |
| - Has your sex drive been affected? |
| - Are you worried about your weight or body appearance? |
| **Adherence**  
“Are Side Effects changing the way you take ARVs?” |
| - Are the side effects stopping you from taking your pills? |
| - Do you forget to take pills or change the times they are taken due to side effects? |

COPY AND SHARE THIS CHECKLIST – EVERYONE YOUNG AND OLD CAN BENEFIT FROM USING IT!
Action Planning: Respect, Review, Engage, Advocate!

Go through all the knowledge for action boxes in this section again. Identify which, if any, are a priority for the group/community (there may be others too!). List them. Use the action planning matrix on page 3 to prioritise them and create a plan of action to help you address improved treatment support for men and women in your area.
ARVs AND ADOLESCENTS

Who are adolescents?

Adolescents are those between the ages 10 and 19. Adolescents are undergoing important physical and mental changes. These may affect how they respond to a diagnosis of HIV and how well they adhere to ART. Families, communities, peers and HIV support groups are important in supporting adherence in this age group.

Adolescents who are recently diagnosed may sometimes experience different issues from those whose infection has been known from birth and who have been on treatment as children. While the principles of ART in adolescents are similar to those in adults and children, supporting adolescents on ARVs may need different approaches.

A Learning and Sharing Activity

Draw the picture for a bridge model on a flip chart. Make silhouettes of young boys and girls. Make it interactive with different coloured cards that can be written on and pasted on the bridge model picture.

ADVOCATE

Encourage and support the establishment of youth PLHIV support groups in your area.
The aim of the activity is to get the young people safely across the river to the goal where they are healthy and safe, and to consider all the difficulties that may prevent them from doing so.

The risk of becoming HIV infected – and the difficulties of negotiating adolescence and adulthood as a young person with HIV – offer special risks and challenges for young people growing up in Zimbabwe.

Developing life skills is an important aspect of their survival.

Ask the group to define what life skills are (emphasise the need for different sets of skills for particular situations).

Brainstorm the dangers in the water (some suggestions are given).

Then discuss the skills adolescents need to avoid the dangers, stay healthy and live positively: assertiveness, understanding consequences; negotiation and disclosure skills; youth empowerment; self esteem; self respect; confidence; goal setting skills; decision making skills; new values for boys; a sense of responsibility; resistance to peer pressure; redressing some cultural practices and beliefs; – all that may be deemed necessary to help young people towards positive health, dignity and prevention. Allow participants time to link the need for life skills with adolescence and the discipline needed to continue taking ARVs.

Follow-up: Repeat the exercise, what has changed? Is awareness improving? How are we helping young people cope with HIV?

Knowledge Sharing Session: Information to share and discuss

Special issues on ARVs and adolescents

- Adolescents have the right to HTS and should be involved in discussions about HIV testing and counselling, together with their caregivers if they wish.
- Their status should be disclosed to them as early as possible.
- Assessing the correct dosing for adolescents affected by stunting and wasting can be difficult. All adolescents should be weighed before commencing ART; those weighing 25kgs and below should be dosed according to paediatric dosage guidelines.
- Weight, height and stage of puberty should be monitored throughout adolescence.
• Adolescents should attend for clinical review every six months, or as instructed by the clinic.

• HIV positive adolescents are also at risk of other chronic non-infective diseases, including lung disease and cardiomyopathy (say car-di-o-my-op-athy) and should be monitored for these.

• Regular CD4 counts are important to help monitor how well the body is responding to the ARVs. Viral load should also be measured, especially where there may be a problem with adherence.

**Supporting adherence**

Adherence can be particularly problematic for adolescents as they face mental and social issues that can limit access to services and support. Acknowledging this and having a non-judgemental approach is essential. Counselling should be adolescent friendly and conducted in privacy to allow them to talk about personal concerns.

• Adolescents should be supported to find ways of keeping clinic appointments without exposing them to stigma.

• Peer support groups can be very helpful – young people should be encouraged to join these.

• A family member should be identified as a treatment buddy to help the young person take their medicines. Peers are also extremely effective treatment buddies.

• Ways of taking medicines at school should also be addressed, if necessary. This is particularly important for children at boarding school. Local clinics can provide longer supplies of ARVs if they are made aware of the need.

**Moving from paediatric to adult care**

Adolescents who are moving from paediatric care into adult care are known to have additional challenges.

• Those who have been adhering well may begin to have difficulties due to the emotional changes of adolescence.

• Adolescents face greater pressure to fit in and desire to be like everyone else.
• Adolescents who have not disclosed their status or joined support groups may have special problems at this stage.

• Parents and guardians need to give the young person additional support, while encouraging them to join a peer support group.

Newly diagnosed adolescents

Many young people who were infected with HIV from birth are now surviving into adulthood, while other young people are becoming newly infected in their teens.

- It is important that they find out their HIV status as early as possible, so they can begin treatment, as well as to reduce new infections.

Disclosure to newly diagnosed young people, or to those who have not been informed of their status during their childhood, must be done carefully and sensitively – preferably with the ongoing help of a trained counsellor. This group needs additional post-test counselling to ensure that they understand and accept their HIV positive status.

The adolescent may be unaware that their parents are or were HIV positive; others are orphans, and caregivers have been reluctant to share this information. Young people may associate the mother’s HIV positive status with promiscuity.

- These young people should be encouraged to join peer support groups.
- Finding out their HIV positive status in adolescence can be upsetting and have negative effects on the young person’s mental health and ability to adhere to ARV.
- They may feel great anger, isolation and fear; they need to be encouraged to express this in a safe way.

First line regimens

The preferred first line regimen is a triple combination of Tenofovir (300mg) + Lamivudine (300mg)+ Efavirenz (600mg). The brand name is Tenolam. These ARVs have relatively few negative effects.

Special note on Efavirenz: Young people taking Efavirenz should be aware that it can cause or aggravate mood changes or anxiety and cause problems with concentration. For these reasons, it is recommended that people take their medication
a couple of hours before sleeping, when it is less likely to cause them problems. In adolescents, dizziness is a common side effect in the early days of treatment. Note that, at least in the beginning, it may also cause very vivid dreams. These side effects usually reduce after a few weeks of taking the medication, but if they do not improve, the adolescent should speak to their healthcare provider.

**Special note on Tenofovir.** Tenofovir is known to affect bone density and for this reason it should be avoided in children and young people who have not yet acquired physical sexual maturity.

### Alternative

<table>
<thead>
<tr>
<th>Adolescents (10-19 years) ≥ 25kg Adults including pregnant &amp; breastfeeding women &amp; those with TB/HIV &amp; Hepatitis/HIV</th>
<th>Tenofovir (TDF) + Lamivudine (3TC) + Nevirapine (NVP)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Zidovudine (AZT) + Lamivudine (3TC) + Efavirenz/ Nevirapine (EFV/NVP)</td>
</tr>
<tr>
<td></td>
<td>Tenofovir (TDF) + Emtricitabine (FTC) + EFV/ NVP</td>
</tr>
</tbody>
</table>

### Alternative first line regimen

Because Nevirapine sometimes causes severe side effects, treatment is started on a lower dose, as a ‘starter pack’ to check for toxicity. If the drug is well tolerated, then the person is moved onto the final regimen.

#### Two-week Starter pack

<table>
<thead>
<tr>
<th>Morning dose</th>
<th>Evening dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dual combination of Tenofovir (300mg) + Lamivudine (300mg)</td>
<td>Nevirapine (200mg)</td>
</tr>
</tbody>
</table>

#### Final regimen (assuming no serious side effects experienced within first 2 weeks)

<table>
<thead>
<tr>
<th>Morning dose</th>
<th>Evening dose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combination of Tenofovir (300mg) + Lamivudine (300mg)+ Nevirapine (200mg)</td>
<td>Nevirapine (200mg)</td>
</tr>
</tbody>
</table>
Stavudine (d4T), which used to be the first line treatment has been phased out because of high toxicity. Limited stocks will be available for those patients who are unable to take Tenofovir or Zidovudine-based regimens.

**Second line regimens**

<table>
<thead>
<tr>
<th>Target Population</th>
<th>Preferred second line regimens</th>
</tr>
</thead>
</table>
| Adolescents ≥10 years, Adults, Pregnant and Breastfeeding women | If Tenofovir was used in first line ART  
Zidovudine + Lamivudine + Lopinavir/Ritonavir or Atanazavir*  
If Zidovudine was used in first line ART  
Tenofovir + Lamivudine + Atanazavir/Ritonavir or Lopinavir/Ritonavir* |
| HIV and TB co-infection                          | Patients receiving Rifampicin  
Same NRTI backbone as recommended for adults and adolescents plus double dose Lopinavir/Ritonavir (800mg/200mg twice daily) |
| HIV and HBV co-infection                        | Zidovudine + Tenofovir + Lamivudine + Atanazavir/Ritonavir or Lopinavir/Ritonavir* |

* Atanazavir. This is the preferred Protease inhibitor

If the person also has TB and is receiving Rifampicin they will receive the same treatment with the addition of a double dose of Lopinavir, boosted with Ritonavir, twice daily

If the person has Hepatitis co-infection – Zidovudine, Lamivudine and Tenofovir, plus either Atazanavir boosted with Ritonavir or Lopinavir, boosted with Ritonavir.

**Note:** Abacavir/Lamuvudine 600 mg /300mg orally once daily plus Atazanavir/Ritonavir one daily or Lopinavir/Ritonavir twice daily may be prescribed for patients who are unable to take Tenofovir or Zidovudine.

**What is a third line ART regimen?**

If the first and second regimens fail, the doctor may prescribe a ‘salvage cocktail’. In adults Raltegravir (400mg) twice a day and Darunavir (800mg)/Ritonavir (100mg) once daily are used with other medicines, following resistance tests. Third line regimens are available only through Central Hospitals.
Side effects of ARVs for adolescents

Adolescents who have been vertically infected with HIV are likely to have been on ARVs for a significant period of their lives. Adolescence can throw all their ideas about adherence into confusion and they will need additional support during this period. They may fear side effects, both short and long term, and need on-going counselling so that they understand these and the importance of adherence.

As adolescents continue to grow up on ARVs, more is being understood about the impact of long term treatment on the health of this age group. However, there is still a huge gap. The following points may help.

Normal development in adolescence is often associated with behavioural and emotional changes, including mood swings and even depression. As Efavirenz can cause or aggravate mood swings, loss of concentration and lead to insomnia as a result of vivid dreams, it is important to be aware of this. Any young person experiencing these symptoms should speak to their healthcare worker.

Remember that all adolescents living with HIV have a right to access to sexual and reproductive health services. This should be recognised as an essential part of their HIV care and where possible, HIV and sexual and reproductive health services should be integrated.

Action Planning: Respect, Review, Engage, Advocate!

Go through all the knowledge for action boxes in this section again. Identify which, if any, are a priority for the group/community (there may be others too!). List them and prioritise them to create a plan of action using the action planning matrix on page 3 to help you address issues facing adolescents in your area. Stigma, relationship management, future planning and transition of care are VERY important areas for support. And don’t forget disclosure too! See Annex III
ARVs AND CHILDREN & INFANTS

A Learning and Sharing Activity

Take this quick quiz on children and HIV. (Answers in bold!)

Follow-up: Repeat the quiz- have the answers improved?

1. True or False: HIV infections are found in every country of the world.
2. True or False A child under the age of five can only have become HIV infected during pregnancy, birth or breastfeeding.
3. True or False If a child born to an HIV-positive mother is not infected at birth, the child is safe from getting the infection from the mother.
4. True or False: Treating children who are diagnosed HIV-positive with ARVs within their first 12 weeks of life reduces risk of death by 75%³
5. True or False: Most children living with HIV become infected through mother-to-child transmission⁴.

³ UNAIDS JULY 2014, THE GAP REPORT
⁴ Ibid
Knowledge Sharing Session: Information to share and discuss

A child is anyone between the ages of 5-9 years. Those below the age of 5 are considered as infants. More than 90% of HIV in children is acquired through mother-to-child transmission.

• HIV in children infected in the womb progresses faster, hence the need for early infant diagnosis and ARV initiation. However, a child may be well and still be HIV positive.

• Infants below the age of three are usually started on a regimen that contains a protease inhibitor, to best support their immune systems.

• Children who begin ARVs before their immune systems have been badly damaged recover their CD4 levels more quickly.

• All infants should have their HIV-exposure status established at their first contact with the health system, ideally before six weeks of age.

• HIV exposed infants should have their HIV status confirmed with dried blood spot (DBS) and polymerase chain reaction (PCR) testing and should attend the clinic for monthly follow up visits until they are 18 months old. Weight, height and nutritional status (and feeding method) should be assessed at each visit.

Criteria for initiating infants and children on ARVs

• All infants under 5-years of age who test HIV positive MUST be started on ARVs.

• All children over 5-years of age with paediatric WHO clinical stage 3 or 4 disease MUST be started on ARVs.

• Children over 5-years of age with WHO clinical stage 1 or 2 and a CD4 count less than 500 should be started on ARVs.

RESPECT
Never give a child adult HIV medicines

ENGAGE
It is estimated that 962,779 people, including 104,937 children, were in need of ART in Zimbabwe in 2013, based on a CD4 ≤ 500 (Guidelines for Antiretroviral Therapy for the Prevention and Treatment of HIV in Zimbabwe, 2013.) These numbers will change as the criteria for beginning HIV treatment change in line with current national guidelines.
**First line regimens**

<table>
<thead>
<tr>
<th>First line ART regimen</th>
<th>Alternative</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children &lt; 3years</strong></td>
<td></td>
</tr>
<tr>
<td>Zidovudine (AZT) + Lamivudine (3TC) + Lopinavir boosted with Ritonavir (LPV/r)</td>
<td>Zidovudine (AZT) + Lamivudine (3TC) + Nevirapine (NVP)</td>
</tr>
<tr>
<td></td>
<td>Abacavir (ABC) + Lamivudine (3TC) + Lopinavir boosted with Ritonavir (LPV/r)</td>
</tr>
<tr>
<td></td>
<td>Abacavir (ABC) + Lamivudine (3TC) + Nevirapine (NVP)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Children between 3 and 10 and adolescents weighing less than 35kgs</strong></th>
<th><strong>Alternative</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Zidovudine (AZT) + Lamivudine (3TC) + Nevirapine (NVP)</td>
<td>Abacavir (ABC) + Lamivudine (3TC) + Efavirenz (EFV)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Children with anaemia or other condition preventing use of use AZT will receive d4T</strong></th>
<th><strong>Alternative</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Stavudine (d4T) + Lamivudine + LPV/r</td>
<td></td>
</tr>
<tr>
<td>Lamivudine (3TC) + Lopinavir boosted with Ritonavir (LPV/r)</td>
<td></td>
</tr>
<tr>
<td>Stavudine (d4T) + Lamivudine (3TC) + Nevirapine (NVP)</td>
<td></td>
</tr>
</tbody>
</table>

Regular CD4 counts are important for everyone on ARVs – and especially for infants and children – as this shows how well their body is responding to treatment and can help show how good their adherence is. All infants and children should have CD4 count done at least once a year.

Once an infant on ARVs reaches the age of three, their regimen should be swapped from one containing a PI to one containing a non-nucleoside reverse transcriptase inhibitor (NNRTI), unless there is clinical reason for not doing so.

Caregivers should check with the clinic whether their baby’s ARVs need to change once they reach the age of 3-years old.
Side effects of ARVs

Children on ARVs need to be closely monitored, as their ARV dosage is affected by their weight. Height and weight are also important indicators of how well children are doing on treatment.

Carers of infants and children need to know the signs and symptoms of side effects well, as children may not explain them easily.

All medicines have side effects – or unwanted effects – on the body. Side effects usually get better over time, as the body gets used to the medicine.

ARVs are very strong medicines. Some people have very few side effects while taking ARVs and some people experience serious side effects. ARVs should be continued, even if you experience serious side effects.

It is important to understand the difference between mild and serious side effects and to see your local health facility immediately if serious side effects occur.

Record any side effects and when they occur (before food, in the morning, etc.), so you can seek the advice of your healthcare worker. Never stop ARVs without being advised to do so by your healthcare worker.

Caregivers should record side effects in a diary and bring this information to each medical appointment for discussion.

Mild side effects include: sleeplessness, upset stomach and nausea, diarrhoea, drowsiness, headache, fatigue, mild rash, confusion, nightmares and dizziness. Minor side effects usually get better after a few weeks, or can be treated. ARVs should be continued.

Serious side effects include:

- Severe headaches, tingling in hands, arms, legs or feet, changes in fat distribution in the body,
- Severe stomach pain,
- Yellowing of the skin or pain of internal organs,
- Severe rash, severe fatigue or shortness of breath, fever,
- Severe mental disturbance,
- Severe muscle pain or cramping,
- Anaemia (not enough red blood cells).

See the healthcare worker immediately if a child has any of the serious side effects, as they may need to change their ARV regimen.
Advocate!

Communities should act and encourage all young people to be tested for HIV, especially those who are vulnerable and may have been exposed. A child’s height and weight should also be checked at least every six months! HIV support groups should advocate on the importance of CD4 and viral load counts and encourage PLHIV to ask for them, if the clinic does not offer them.

Action Planning: Respect, Review, Engage, Advocate!

Go through all the knowledge for action boxes in this section again. Identify which, if any, are a priority for the group/community (there may be others too!). List them. Use the action planning matrix on page 3 to prioritise them and create a plan of action to help you address the concerns of BOTH parents and children on HIV testing and counselling, treatment and disclosure. CHILDREN NEED TO KNOW!
**PREVENTION OF MOTHER-TO-CHILD TRANSMISSION**

*A Learning and Sharing Activity*

**Follow-up: Repeat the quiz- have the answers improved?**

<table>
<thead>
<tr>
<th>Knowledge of PMTCT</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>PMTCT means protecting the unborn child from getting HIV infection</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>HIV can be passed from mother to child at birth i.e. during delivery, through breast milk</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>HIV can be passed from one person to another through mixing of blood</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>ARVs should only be given to pregnant women only if they are sick</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>There is need to stress treatment adherence, care at delivery and exclusive breastfeeding</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>HIV cannot be passed from mother to child.</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>A single dose of Nevirapine when a woman is in labour can help prevent the baby being infected with HIV</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>HIV infected pregnant and lactating women should continue lifelong ART</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Infants should be exclusively breastfed for the first six months of life</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>If parents die of an AIDS related illness it means all their children will be positive.</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Different OIs typically appear at different stages of HIV infection</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>HIV-positive people can reduce their exposure to OIs by being careful around uncooked meat, domestic animals, using good hygiene</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Condoms prevent HIV not OIs</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Cotrimoxazole can be used to prevent several HIV-related infections, including TB, bacterial pneumonia, septicaemia and PCP.</td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>
Knowledge Sharing Session: Information to share and discuss

What is PMTCT?

PMTCT is a full range of services, including HIV testing and counselling, for couples planning to have a baby and woman already pregnant. Couples should attend the clinic together for HIV testing and counselling, ideally before the pregnancy, and again before delivery.

Women who test negative at first test should be retested throughout pregnancy and breastfeeding, because if the woman is infected during this time, her high viral load more likely that she will transmit HIV to her baby.

PMTCT includes the provision of ARVs to reduce the likelihood of HIV infection in the unborn baby. It also includes ARVs for the newborn. The new policy – Option B+ – includes the provision of ARVs for the mother for life regardless of CD4 count.

Healthy women who are started on ARVs under Option B+ need extra support to adhere to ARVs for life. Mother-to-mother mentors (both HIV positive and HIV negative) or PLHIV support groups can help.

Once a woman has stopped breastfeeding for more than six weeks, she can be allowed to attend for refill appointments only, unless the baby tests positive for HIV.

When to start ARVs in HIV positive pregnant and breastfeeding women.

All HIV infected pregnant and breastfeeding women should be started on lifelong antiretroviral treatment (ART) whatever their CD4 count or WHO clinical stage (option B+). HIV medication is not harmful to the baby.

- Women who are not ready for lifelong ART should be put on triple ARVs up to the end of breastfeeding, to reduce the risk of mother-to-child transmission through breast milk.
- HIV positive breastfeeding women who are eligible for treatment, i.e. CD4 count 500 or less should continue with lifelong treatment.
- Lifelong ART ensures that in any future pregnancy, the baby is protected from HIV.
Successful PMTCT involves:

- Emphasising how HIV is transmitted and prevented, PMTCT, and access to care and treatment.
- Giving birth in a health facility to ensure clean, safe delivery and care of the newborn, as well as giving preventive ARVs for the newborn.
- Attending all antenatal visits and ensuring that infants receive the necessary ARVs in the early weeks of life.
- Being offered support on care of the infant, child feeding and maternal nutrition.
- Explaining exclusive breastfeeding (no additional foods, not even water) for the first six months. If breastfeeding is discontinued at 6 months, mothers need to be advised on how to ensure the baby receives adequate nourishment during the weaning period.
- Preventing STI or HIV reinfection during pregnancy and breastfeeding to avoid additional risk to child; stressing condom use to avoid reinfection.
- Encouraging breastfeeding for up to two years, with the introduction of additional family foods (mashed up) from six months onwards.
- Providing counselling support on sexual reproductive health, family planning and the need for use of condoms to prevent reinfection plus another method of contraception (dual protection).
- Mothers attending for family planning appointments six weeks after birth.

**REVIEW**

Pregnant women who were started on Zidovudine prophylaxis should be discontinued and commenced on lifelong Art (Option B+)

**REVIEW**

Commence Cotrimoxazole prophylaxis for HIV exposed infants from 6 weeks of age.
# ARVs for mother and baby

<table>
<thead>
<tr>
<th>Pregnancy</th>
<th>Labour</th>
<th>Post Delivery (Breastfeeding and non-breastfeeding)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal</td>
<td>Infant – birth to six weeks)</td>
<td></td>
</tr>
<tr>
<td>Preferred First line</td>
<td>Birth weight &lt;2,500:Nevirapine 10mg daily Birth weight &gt; 2,500 Nevirapine 15mg</td>
<td></td>
</tr>
<tr>
<td>Tenofovir + Lamivudine+ Efavirenz</td>
<td>Alternative first line</td>
<td>Birth weight &lt;2,500:Nevirapine 10mg daily Birth weight &gt; 2,500 Nevirapine 15mg</td>
</tr>
<tr>
<td>Zidovudine+ Lamivudine+ Efavirenz</td>
<td>Birth weight &lt;2500:Nevirapine 10mg daily Birth weight &gt; 2500 Nevirapine 15mg daily</td>
<td></td>
</tr>
</tbody>
</table>

## Paediatric ART and infants

ARVs for babies are guided by the following:

<table>
<thead>
<tr>
<th>Age</th>
<th>Nevirapine daily dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth to 6 weeks</td>
<td>10 or 15mg depending on birth weight</td>
</tr>
<tr>
<td>6 weeks to 6 months</td>
<td>20mg also Cotrimoxazole until HIV has been excluded</td>
</tr>
<tr>
<td>6 months to 9 months</td>
<td>30 mg</td>
</tr>
<tr>
<td>9 months to end of breastfeeding</td>
<td>40mg</td>
</tr>
</tbody>
</table>
Babies born of HIV positive mothers can only be regarded as HIV negative if they test negative three months after birth AND three months after exposure through breastfeeding has ended.

Severe HIV infection is indicated by a positive HIV test accompanied by oral thrush, severe pneumonia and severe sepsis - say sep-sis (an infection of the blood that causes the body to swell).

Infants who are HIV positive should see a healthcare worker every month until the age of 18 months. Thereafter, their visits can be reduced to clinical review every three months.

**Male involvement**

The involvement of male partners is an essential element of successful PMTCT – it takes two to make a healthy child! Men need to support their partners in attending for ante and postnatal care and in making plans for the safe delivery of the baby in a health facility. Condoms should be used correctly and consistently every time a couple has sex during pregnancy and breastfeeding to reduce the chances of HIV re-infection, or of transmitting the virus to the baby during this time.

**Action Planning: Respect, Review, Engage, Advocate!**

Go through all the knowledge for action boxes in this section again. Identify which, if any, are a priority for the group/community (there may be others too!). List them. Use the action planning matrix on page 3 to prioritise them and create a plan of action to help you support better uptake of PMTCT service and help families stay healthier for longer!
ARVs AND KEY POPULATIONS

Key populations are those groups in society that are at higher risk of HIV infection, and who have difficulties in accessing and remaining on treatment. In Zimbabwe, these include:

- Mobile populations such as long distance truck drivers and migrant workers;
- People with disability and the mentally ill
- Sex workers
- Injecting drug users
- Prisoners and those on remand
- Young people living on the streets
- Men who have sex with men (MSM), including prisoners and men in other closed situations.
- ex prisoners
- Transgender and intersex persons, and women and girls.

Members of these groups are more likely to acquire HIV infection because of social factors, their lifestyles and because they lack access to the information and health services that can protect them from HIV. Key populations are often both marginalised and criminalised. They may also be prone to substance abuse; this includes using illegal drugs such as marijuana, and abusing prescription drugs. Excessive use of alcohol (more than two drinks every day) is also a form of substance abuse. All substance abuse can have serious effects on the ability of a PLHIV to adhere to their medication and attend clinic appointments as needed.

A Learning and Sharing Activity

Who are our key populations?

Ask the group to list all the people they think are at most risk of contracting HIV on a flip chart. Sort them out, discuss and group them. Now ask the group to prioritise the list then give reasons why.

Ask individuals in the community/group to prepare a group role play around stigma and discrimination, they can choose one of the key populations they identified such as young people visiting a clinic for condoms or sex workers Disclosing to others and full disclosure to a young person born with HIV.
In plenary, discuss the two role plays and how stigma and discrimination prevent HIV testing and counselling, treatment and adherence.

Follow-up: Repeat the exercise, have the issues around stigma and discrimination changed?

Knowledge Sharing Session: Information to share and discuss

Mobile populations and internally displaced persons

Mobile populations include anyone who spends long periods away from their normal residence and from their family, such as migrant workers, but especially long distance truck drivers, who, right from the beginning of the epidemic have had higher rates of HIV infection than the general population.

It also includes internally displaced people and those in temporary settlements (as a result of natural disasters or political disturbances) who may not have legal rights or easy access to local health care.

Where people are displaced, they need to visit the nearest clinic to their new place of residence as soon as possible and explain their circumstances. They should bring with them any medical cards, or samples of the medicines they have been taking, so that the clinic can register them and ensure they continue with their ARVs without interruption.

Mobile populations are at particular risk of HIV infection for several reasons:

- They may seek the company of sex workers due to loneliness and boredom whilst away from home
- They are less likely to access information regarding HIV prevention and treatment because of their mobility
- They may miss clinic appointments resulting in them running out of ARVs, which exposes them to the risk of developing drug resistance.

In addition to their own personal risk, members of mobile populations may also expose their wives and families to HIV infection because of inconsistent condom use, especially with long term partners.
Members of mobile populations on ARVs should inform the clinic of their intention to travel. They may be able to access 3-6 months of medication, depending on availability and should request a transfer-out letter, even if they intend to be back in time for their next clinical appointment. These letters may be used to obtain treatment both within Zimbabwe, in neighbouring countries and at the borders.

The sessions on Adults and ART, and Disclosure will also be of value to these people.

**Migrant populations**

Migrant HIV positive populations are a special group who may have difficulty in maintaining their ARV treatment due to moving from one country to another. PLHIV intending to cross into another country should inform their clinic of their intention. They should request a transfer-out letter, which may be used to obtain treatment both within Zimbabwe, both in neighbouring countries and at the borders.

**Sex workers**

The term sex workers includes both those who engage in sex work for a living, as well as those who engage in transactional sex for any reason (e.g. college students with sugar daddies or mummies, etc.). They may be male, female or transgender. All such individuals are at risk of HIV because:

- They engage in multiple sexual partnerships
- They are often exposed to violence in the course of their work
- They may lack the power to refuse unprotected sex because they are being paid
- Their clients may offer them additional money for unprotected sex
- They may miss clinic appointments because of their working hours. And run out of ARVs
- They may fear stigma and discrimination at the clinic because of their occupation.

HIV positive sex workers should be advised of the importance of TasP and the need to adhere to their ARVs at all times, as well as the need to use condoms correctly and consistently with all sexual partners.
If they are exposed to sexual violence, they may also need access to emergency contraception to avoid unintended pregnancy. They should be advised to go for HIV testing and counselling every three to six months.

The sessions on ART and Adults, and on PMTCT will also be of value to this group.

**Persons with mental illness**

Persons with mental illness are especially vulnerable to HIV infection because friends and relatives often assume they have no sexual desires and so do not educate them on their sexual and reproductive health and HIV. In addition, they are often exposed to sexual abuse and may be infected with HIV as a result. It is also more difficult for people with mental illness to access and take their medication, as they may be dependent on caregivers to take them to the clinic and to ensure they take their ARVs as instructed by their healthcare worker and that prescription are refilled on time. Certain mental illnesses may also result in resistance to taking regular medication.

Caregivers of mentally ill persons need to be included in awareness raising sessions about their vulnerability to HIV infection.

**Injecting drug users and those who abuse other drugs**

This group is of concern because of the chances of their passing on HIV to others by:

- Sharing contaminated needles
- Having unprotected sex with long term partners
- They may also engage in transactional sex or sex work to buy their drugs
- They may forget to take their ARVs when they are 'high', or fail to attend the clinic for refills, exposing them to the development of drug resistance.
- People who abuse other drugs (including prescription drugs and alcohol) may also forget to take their ARVs, or be more likely to have unprotected sex when they are high or drunk.

They should be encouraged to use condoms correctly and consistently with all sexual partners and to engage a treatment buddy who will help them take their ARVs correctly. They should be advised to go for HIV testing and counselling every three to six months.
**Men who have sex with men (MSM)**

This group includes all biological males who engage in sexual activity with other men regardless of their sexual orientation and/or gender identity. They may be gay, bisexual or heterosexual and include prison inmates and ex-prisoners. They may be single or married and have families. Some may not regard their activities as sex because there is no risk of pregnancy; often they do not disclose their sexual practices because of the stigma and discrimination associated with them. Criminalisation of male-to-male sexual contact (sodomy) forces MSM to go underground and discourages them from disclosing their sexual practices as well as from seeking HIV prevention and treatment services and other health services. MSM may be unaware of their increased HIV risk due to the nature of their sexual activity due to the lack of information on MSM in Zimbabwe.

- They should be encouraged to seek HIV and STI testing regularly and be educated on their risk of HIV re-infection
- Anal sex carries a much higher HIV risk – use of condoms correctly and consistently – with a water-based lubricant – with their male sexual partners is essential
- Correct and consistent condom use with all their sexual partners is essential to avoid to avoid HIV infection and reinfection, and to prevent the spread of HIV to their families.

**Other persons of varied gender identities and sexual orientations**

Transgender is an umbrella term for people whose gender identity and expression does not conform to the norms and expectations traditionally associated with the sex assigned to them at birth. It includes people who are transsexual, transgender or otherwise considered gender non-conforming. Transgender people may self-identify as transgender, female, male, transwoman, transman, trans-sexual, etc. Because of this, they often behave like the opposite sex. This gender disparity is not well understood and often results in them being isolated from the community in which they live.
Transdiverse people often face difficulties in their relationships, which can cause psychological distress and risk taking. It is not uncommon for transdiverse people to engage in sex work as a way of surviving, and this exposes them to HIV infection.

HIV positive trans and homosexual persons need special support to accept their HIV positive status, and to continue taking their ARVs. They may also need support to use condoms correctly and consistently with all sexual partners to avoid reinfection.

They should be encouraged to attend for HIV and STI testing regularly (every three to six months) and be educated on their risk of HIV re-infection.

The sessions on ART and Adults, and disclosure will be of help to this group, as well as the information on sex workers, above.

**Intersex persons**

Intersex persons are born with genitals that are not considered typically male or female. They may have both male and female physical characteristics at birth – or have internal genital organs that are the opposite sex of the external genitals. Again, intersex people may suffer mental distress and be more prone to risk taking. They may also engage in sex work for a living. They may need special support to accept their HIV positive status, and to continue taking their ARVs. They may also need support to use condoms correctly and consistently with all sexual partners to avoid reinfection.

Intersex persons who are taking hormones need to be aware of possible interactions between hormone treatment and NNRTIs and protease inhibitors (PIs) this can cause problems if not properly monitored by a doctor a few times a year.

Taking ARVs may mean an intersex person taking hormones may need to increase the quantity of the hormones to get the same effect. This in turn, makes proper adherence to their ARV regimen even more critical, as failure to take their ARVs correctly can result in dangerously high levels of hormone in their blood.

Hormone therapy can also increase the risk of several other conditions, such as heart disease or reproductive cancers, some of which are already more common in people with HIV. Intersex persons should therefore be screened regularly for these.
The sessions on ART and Adults, and Disclosure will be of help to this group, as well as the information on sex workers, above.

**Young people living on the streets**

Young people living on the streets are especially at risk of HIV infection and challenges in adhering to ARV treatment. This is because of their lifestyle; they may engage in transactional sex and commercial sex work. Furthermore, because they have no fixed address, clinics may refuse to register them or provide them with treatment. These young people may also have problems with substance abuse, which may make it harder for them to adhere. They need special support. If there are young people living on the streets in your area, encourage them to set up an HIV support group, where they can help each other to adhere.

They should be encouraged to use condoms correctly and consistently with all sexual partners and to engage a treatment buddy who will help them take their ARVs correctly. They should be advised to go for HIV testing and counselling every three to six months.

**Women and girls**

Young girls are twice as likely to be infected with HIV as their young men. Zimbabwean society is male dominated and this means women and girls are less able to make decisions regarding marriage, contraceptive use, safer sex and related sexual and reproductive health rights, unless their male partners agree. High levels of poverty, transactional sex, multiple concurrent partnerships and sexual and gender-based violence are all strongly linked with high levels of HIV infection.

**Gender-based violence**

Women and girls living with HIV are more likely to experience gender-based violence. This is partly because they are more likely to find out their HIV status through attending for maternity care. In such cases, the woman may fail to return to the clinic for treatment, or to bring her baby for prevention of mother-to-child transmission services, resulting in the baby also being infected with HIV. When gender-based violence is the response to an HIV positive status, women and girls may miss out on HIV care and treatment, if their partner controls
their access to money for transport and medical care. PLHIV support groups need to look out for cases of gender-based violence and act to prevent them.

**Special points to note about young women and ARVs**

*Women living with HIV and taking oral contraceptives and/or hormone replacement therapy* need to talk to their doctor about possible drug interactions. They should always use **dual protection** – a condom plus another method of birth control to prevent both STIs and unintended pregnancy.

Younger women in intergenerational relationships, or who are married very early, also lack power in their relationships and may be unable to access medical treatment and ARVs without their partner’s permission. This is a denial of their sexual and reproductive health rights.

The sessions on ART in adults, disclosure, and PMTCT will also provide useful information for women and girls living with HIV.

**A note on faith-healing and religious sects**

Several religious sects in Zimbabwe rely on faith-healing for medical care, even with regard to HIV infection. This often means women will not seek PMTCT services or antenatal care, exposing the infant to the risk of HIV infection and both themselves and their infant to the risk of death.

Consultation with prophets also sometimes leads PLHIV to stop taking their ARVs, as they are encouraged to believe that faith in God will heal them. This is **very dangerous**; it is important that PLHIV support groups make it clear that there is **NO CURE** for HIV as yet, but ARVs can be regarded as God’s way of helping those who are living with HIV.

**Action Planning: Respect, Review, Engage, Advocate!**

*Go through all the knowledge for action boxes in this section again. Identify which, if any are a priority for the key population you are working with. List them. Use the action planning matrix on page 3 to prioritise them and create a plan of action to help you address the issue of treatment for EVERYONE in the community. The health of the entire community depends on it!*
Important terms and explanations

3TC: The medical abbreviation for Lamivudine, an NNRTI

ABC: The chemical abbreviation for Abacavir – NNRTI

Adherence: This means sticking to or being devoted to something. In antiretroviral therapy (ARV), adherence involves taking medications in the correct amount, at the correct time exactly as prescribed by the healthcare provider.

ART: Antiretroviral therapy or treatment. The term includes living positively with HIV by: taking exercise, having a healthy diet and making efforts not to infect others with HIV, as well as correctly taking the ARV medicines prescribed to control HIV. In this manual, the term ART is used interchangeably with ARVs.

AIDS: Acquired Immune Deficiency Syndrome

Antiretroviral medicines: The medicines that interfere with, or disturb the life cycle of HIV by slowing down or stopping the processes by which HIV makes copies of itself, and increases in the body.

ARVs: Antiretroviral medicines. The term ARV generally refers to one of a triple antiretroviral medicine combination. IN this manual, ARVs and ART are used interchangeably.

AZT: The chemical abbreviation for Zidovudine – NNRTI

ATZ: The chemical abbreviation for Atazanavir – PI

bd: A medical abbreviation that means a drug should be taken twice a day.

BEHAVIOUR CHANGE: The adoption and maintenance of healthy behaviours.

CLIENT-INITIATED TESTING: An alternative term for voluntary counselling and testing (VCT). All HIV testing and counselling must be carried out under conditions of the ‘three Cs’: i.e. that it be confidential, accompanied by counselling and conducted only with informed consent.

CLINICAL FAILURE: This is a kind of HIV treatment failure. It occurs when someone has been on ARVs for more than three months but then develops an HIV-related complication.

CLINICALLY STABLE: A stable patient on ART is someone who:

- has no current OIs, has a viral load below 1000 copies/ml and has been on ART for at least six months.
- If viral load is not available it is a patient with no current OIs, a CD4 > 200 and on ART for at least six months.
Adult patients who are stable on ART should be seen for a clinical assessment and repeat CD4 every six months.

**COUNSELLING:** A special form of confidential interpersonal communication between a person with a problem or issue and a service provider in which thoughts, feelings and attitudes are explored in order to make a person feel better and/or help them make the right decisions for themselves, based on correct information.

**d4T:** The chemical abbreviation for Stavudine -NNRTI

**DBS:** Dried Blood Spot – used for PCR testing in babies (see PCR below)

**ddi:** The chemical abbreviation for Didanosine – NNRTI

**DISCLOSURE:** When a person opts to share their HIV status. There are four kinds of disclosure: voluntary and involuntary; and full or partial disclosure. Full and partial disclosure also refer to disclosure to a person – usually a child, while voluntary and involuntary disclosure usually refer to disclosure by the HIV positive person themselves.

- **Voluntary disclosure** means a person shares information about their status directly and from choice.

- **Involuntary disclosure** is when someone’s HIV status is revealed to others against their will, either deliberately or by accident.

- **Full disclosure** means telling or allowing the general public to know your status.

- **Partial disclosure** means telling only selected people such as a spouse, friend or relative and asking them to keep the confidentiality.

In the case of a child, disclosure refers to the process of informing the child of his/her HIV status. Partial disclosure means explaining to the child that they are ill and need to take medication, but not naming HIV.

- **Full disclosure** – later, when the child is older, HIV may be named and this is regarded as full disclosure to the child.

**DISCORDANT COUPLES:** This is when one sexual partner tests positive for HIV and the other tests negative. This can be a stressful result for a couple and post-test counselling is critical. Couples are always encouraged to test together.

**EMANCIPATED MINOR:** A child who is already married, or a girl who already has a baby. (See also ‘mature minor’)

**FTC:** The chemical abbreviation for Emtricitabine – NNRTI
**GENDER and SEX:** The term ‘sex’ refers to biologically determined differences, whereas the term ‘gender’ refers to differences in social roles and relations between men and women. Gender roles are learned through socialisation and vary widely within and between cultures. Gender roles are also affected by age, class, race, ethnicity and religion, as well as by geographical, economic and political environments.

**HIV-INFECTED:** Usually used to indicate that evidence of HIV has been found via a blood test. **HIV-NEGATIVE:** Showing no evidence of infection with HIV (e.g. absence of antibodies against HIV) in a blood, oral fluid, or polymerase chain reaction (PCR) test. An HIV-negative person can be infected if he or she is in the window period between HIV exposure and detection of antibodies.

**HIV-POSITIVE:** Showing indications of infection with HIV (e.g. presence of antibodies against HIV) in a blood or oral fluid test. Results may occasionally (rarely) be false positive.

**HIV-RELATED DISEASE:** Symptoms of HIV infection occur once the immune system begins to break down, leading to AIDS. Eventually increased quantities of HIV in the body lead to destruction of the immune system (also referred to as advanced HIV infection) which leads to AIDS.

During initial HIV infection, some people experience flu-like symptoms but these are generally referred to as symptoms of primary infection, rather than HIV-related disease.

**HUMAN IMMUNODEFICIENCY VIRUS (HIV):** The virus that weakens the immune system and can lead to AIDS, if left untreated.

**IDV:** The chemical abbreviation for Indinavir – a PI

**IMMUNE SYSTEM:** The immune system is the body’s defence system. It is made up of special cells in the blood and in other parts of the body that protect against disease. A healthy immune system (good immunity) is able to fight off many kinds of infection or disease.

**IMMUNOLOGICAL FAILURE:** This is when the immune system fails to recover, following ARV treatment. It may be indicated when the CD4 count fails to rise, or continues to fall, once the person begins taking ARVs.

**KEY POPULATIONS:** Groups that are especially vulnerable to or affected by HIV. Their involvement is vital to an effective HIV response. Key populations vary according to the local context, but are usually marginalised or stigmatised because of their social identities or HIV status. They include people living with HIV, their partners and families, people who sell or buy sex, men who have sex with men, transgender people, people who use drugs, migrants, displaced people and prisoners.
LOPINAVIR/RITONAVIR: a Protease Inhibitor

MATURE MINOR: This is a child or adolescent who can demonstrate that they are mature enough to make a decision on their own, based on: the minor’s ability to appreciate the seriousness of HIV testing, the test result, and what giving informed consent means; the minor’s physical, emotional and mental development; how much responsibility the minor has assumed for his or her own life, such as heading a household or living independently from a parent/caregiver. See also ‘emancipated minor’.

MIPA: Meaningful Involvement of people living with HIV. A general principle of good care for people living with HIV that recognises their important contribution in the response to HIV and ensuring their involvement and active participation.

MTCT: Mother-to-child transmission of HIV.

NON ADHERENCE: The inability or failure of PLHIV to take their ARVs exactly as prescribed by the healthcare provider.

NON-DISCLOSURE: Is when a person knows their HIV status but chooses not to tell anyone. This is discouraged, as it denies the person access to support. However, with children, disclosure may be only partial, initially – HIV is not named – see under Disclosure above. In the case of a child, non-disclosure is when the child has not yet been informed of his/her HIV positive status.

NNRTIs: Non-nucleoside reverse transcriptase inhibitors (NNRTIs) A single NNRTI is generally taken with two NRTIs in first line ART regimens. NNRTIs include: Efavirenz and Nevirapine.

NRTIs: Nucleoside analogue reverse transcriptase inhibitors are normally the basis or ‘backbone’ of any anti-HIV drug combination. They include Lamivudine, Abacavir, Zidovudine, Stavudine, Didanosine and Emtricitabine.

NtRTIs: Nucleotide analogue reverse transcriptase inhibitors may be provided in place of an NRTI. Tenofovir is an NtRTI.

OPPORTUNISTIC INFECTION (OI): Diseases caused by bacteria, fungi or viruses widely present in the environment that take advantage of the weakened immune system in people infected with HIV and cause illness. Many OIs do not cause illness in people with healthy immune systems even though they may be present in the blood. Persons living with advanced HIV infection may have opportunistic infections of the lungs, brain, eyes and other organs. Tuberculosis is the leading HIV-associated opportunistic infection in developing countries.

Option B+: The current HIV treatment plan that offers all pregnant and breastfeeding women ARVs for life, to protect their own health and that of their children.
PCR Test: Polymerase chain reaction (PCR) test. A special blood test used to confirm HIV infection, usually used in babies, where the test is performed on a dried blood spot or DBS.

POSITIVE HEALTH, DIGNITY AND PREVENTION: The steps taken by PLHIV to keep themselves and others safe, improve their quality of life and realise their basic rights. Positive health, dignity and prevention stresses that PLHIV are not patients, nor are they vectors of the disease. It also stresses that PLHIV are responsible for HIV prevention and that they have needs and desires to be fulfilled, and the rights to fulfil them.

POSITIVE LIVING: A term that describes steps taken by people infected and affected by HIV that enhances their lives, reduces their risks, improves their health prospects and reduces the likelihood of their spreading the virus to others.

PREVENTION OF MOTHER TO CHILD TRANSMISSION (PMTCT): Methods that help prevent a mother passing HIV onto her baby during pregnancy, childbirth or breastfeeding.

PROTEASE INHIBITORS (PIs): This is another type of ARV that may be included in an ARV combination. PIs include Atazanavir, Lopinavir/Ritonavir, Ritonavir, Amprenavir, Fosamprenavir, Indinavir, Nelfinavir, Saquinavir.

PROVIDER-INITIATED TESTING AND COUNSELLING (PITC): HIV testing and counselling should be offered when an individual seeks medical care, regardless of the condition they present with. It may be diagnostic—as when a patient presents with symptoms that may be attributable to HIV or has an illness associated with HIV such as tuberculosis — or it may be a routine offer to an asymptomatic person.

REGIMEN: The term used to describe a combination of medicines (ARVs) used to control HIV in the body. There are first, second and third line regimens for HIV treatment.

REPLICATE: The medical term used to describe how HIV multiplies in the blood.

SAFER SEX: Sexual practices that prevent possible contact with and mixing of infected body fluids. These include sexual intercourse using a female or male condom, oral sex, non-penetrative sex and mutual masturbation; reducing the number of sexual partners; correct and consistent use of male or female condoms, to reduce the risk of HIV transmission. The term safer sex reflects the idea that choices can be made and behaviours adopted to reduce or minimise risk.

SEXUALLY TRANSMITTED INFECTION (STI): Infections that are spread by the transfer of organisms from person to person during sexual contact.

TDF: The chemical abbreviation for Tenofovir NtRTI
UNDETECTABLE VIRAL LOAD: This is the aim of antiretroviral treatment. 'Undetectable' means there are too few virus particles for the test to pick up – it does not mean you no longer have HIV! It means your ARVs are successfully preventing the virus from replicating.

VCT: Voluntary counselling and testing; also known as client-initiated testing, as opposed to provider-initiated testing. A common term for the process of taking an HIV test, when a person decides on their own to get tested for HIV.

VIRAL LOAD: Viral load is the level of HIV in your blood. (Note it measures virus particles – not the virus itself). It helps monitor how well HIV medications are working. High viral load usually goes along with a low CD4 count and low (or undetectable) goes along with a higher CD4 count.

VIROLOGICAL FAILURE: This is a type of HIV treatment failure. It is when ARVs do not work to keep a person’s viral load at less than 200 copies/mL. This may be due to drug resistance, drug toxicity, or poor treatment adherence.

WINDOW PERIOD: The time from infection with HIV until the body is able to make antibodies to fight HIV. The window period lasts approximately 6-12 weeks after exposure to HIV. During this time a person may test negative for HIV.
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Guidelines for Antiretroviral Therapy for the Prevention and Treatment of HIV in Zimbabwe, MoHCC, Zimbabwe, December 2013

Guidelines for Treatment of Transgender Adults with HIV, AIDS Institute, New York, September 2014

HIV Prevention, Treatment, Care and Support – A Training Package for Community Volunteers, WHO/SAFAIDS/IFRC & RCS, 2006

Integrated Management of Paediatric AIDS /HIV Care Treatment and PMTCT (IMPACT), SAfAIDS, 2012


The Gap Report, UNAIDS 2014

Zimbabwe National AIDS Strategic Plan 2011-2015 (ZNASP II)


ZNNP+ PLHIV Guidelines

Internet links

- www.who.int/
- www.unaids.org
- http://www.nac.org.zw/
- http://www.huffingtonpost.com/ward-cates/hiv-treatment-cascade_b_2170962.html
- http://www.aidstar-one.com/
Summary – Classes of ARV and the Drugs in Each Class

There are five main classes of drugs used to control the replication (multiplication, reproduction) of HIV in the body. Each class of drug prevents the replication of HIV in a slightly different way. Most ART regimens include at least 3 ARVS, from at least two classes. This is sometimes called HAART (highly active antiretroviral therapy) because it is most effective against HIV.

Most people will be given a fixed dose combination of all three drugs in one pill. This makes it easier to adhere to your medicines. However, sometimes it may be necessary to have a combination pill plus a separate pill including only one drug that needs to be taken at a different time.

The classes are: nucleoside analogue reverse transcriptase inhibitors (NRTIs); non-nucleoside reverse transcriptase inhibitors (NNRTIs); protease inhibitors (PIs) fusion and integrase inhibitors. Note: fusion and integrase inhibitors are not yet registered with Zimbabwe’s Drug Control Authority.

Nucleoside analogue reverse transcriptase inhibitors (NRTIs) are normally the basis or ‘backbone’ of any anti-HIV drug combination. They may also be called nukes. The NRTIs are:

- 3TC Lamivudine
- ABC Abacavir
- AZT Zidovudine
- d4T Stavudine
- ddC Zalcitabine
- ddi Didanosine
- FTC Emtricitabine

Common dual combinations of NRTIs that are used as a part of three or four drug combinations are: AZT/3TC 3TC/Abacavir and d4T/3TC, AZT/ddi.
Combinations that should be avoided are: d4T/AZT, d4T/ddC, d4T/ddI, 3TC/ddC and ddi/ddC. The combination of ddi with the nucleotide analogue (NtRTI) Tenofovir should only be avoided whenever possible.

FTC (Emtricitabine) is often used with the nucleotide analogue Tenofovir.

Non-nucleoside reverse transcriptase inhibitors (NNRTIs).

An NNRTI is often taken with two NRTIs as an alternative to a protease inhibitor. NNRTIs may also be called ‘non-nukes’.

Two NNRTIs are currently approved for use. These are:

- EFV Efavirenz
- NVP Nevirapine

Nucleotide analogue reverse transcriptase inhibitors (NtRTIs)

Nucleotide analogues also work against reverse transcriptase, and are usually used in place of an NRTI in a three drug combination. One nucleotide analogue is currently approved:

- TVF Tenofovir

Protease inhibitors (PIs)

Protease inhibitors were the second class of antiretroviral drugs to be available on prescription. Some protease inhibitors in current use are:

- Atazanavir
- Lopinavir/Ritonavir
- Amprenavir
- Darunavir
- Fosamprenavir
- Nelfinavir
- Ritonavir
- Saquinavir

Note: Atazanavir and Lopinavir/Ritonavir are the most commonly used PIs in Zimbabwe.

People taking a combination containing a protease inhibitor often have it ‘boosted’ by a small dose of ritonavir, as well as taking two NRTIs.

Other combinations may include one or two protease inhibitors, one NNRTI, and one or two NRTIs. If a person’s initial combination has not worked, some doctors may recommend a combination of four or more antiretrovirals.
Fusion inhibitors

This class is not yet in use in Zimbabwe, as they are very expensive. Fusion inhibitors stop HIV from binding to and entering the human cell. Two fusion inhibitors have been approved elsewhere: T20 – Enfuvirtide and MVC – Maraviroc). These are only suitable for people who have been extensively treated with other anti-HIV drugs and thus have very limited treatment options available to them.

Integrase Inhibitors (INSTIs)

Integrase inhibitors are a class of antiretroviral drug designed to block the action of integrase, a viral enzyme that inserts the viral genome into the DNA of the host cell

- RAL – Raltegravir
- DTG – Dolutegravir
- EVG – Elvitegravir
The Patient Charter aims to improve the relationship between patients and health care providers by helping or allowing the Ministry of Health and Child Welfare to:

- Listen to and act on people’s views and needs
- Set the best possible standards of health services
- Provide health services which meet these standards

The Charter explains:

- The kind of service you can expect from the health care delivery system
- Your health rights
- Your responsibilities and obligations
- How you can give feedback on the quality of services you are provided with or have required.
PATIENTS’ RIGHTS

Patients have the right to health care and humane treatment.

Every individual shall have access to competent health care and treatment regardless of age, sex, ethnic origin, religion, political affiliation, economic status or social class.

Health care services shall be available on the basis of clinical need regardless of the ability to pay. It shall be the responsibility of the government to ensure that every person has access to essential health services.

Every patient shall be treated with care, consideration, respect and dignity, without discrimination of any kind, including vulnerable groups such as children, women, people with physical challenges, and rural dwellers, taking into consideration issues of accessibility to both physical structures and information.

All drugs and vaccines shall be of acceptable standards in terms of quality, efficacy and safety.

In an emergency, every individual shall have the right to prompt treatment from the nearest medical/health facility.

A child admitted to hospital shall, whenever possible, have the right to the company of a parent or guardian.

CONFIDENTIALITY

A patient shall have the right for the details of the patient’s care (including the use of new technology) prognosis and all communication and other records relating to the patient’s care to be treated as confidential, unless:

- Release is authorised in writing by the patient
- It is undesirable on medical grounds to seek a patient’s consent, but it is in the patient’s own interest that confidentiality be broken
- The information is required by due legal process.

PRIVACY

Patients shall be interviewed, examined and treated in surroundings designed to ensure reasonable privacy and shall have the right to be accompanied during any physical examination or treatment if they so wish.

RIGHT TO CHOICE OF CARE

A patient shall have the right to a second opinion at any time while consulting the same medical or health care delivery system.

A patient or next of kin shall have the right to an explanation about their case history and medical records, and to have them explained. The patient or next of kin shall also have the right to authorise in writing for another health professional to obtain a copy of the medical records and to inform him or her of what they contain.

If a patient’s health professional refuses to allow another health professional to be called in, or breaches any other provisions of this charter, the patient shall have the right to seek alternative service/care or to take the issue up with the Health Professions Council.

RIGHT TO SAFETY

A patient, if not incapacitated, shall have the right to a clear, concise explanation – in lay terms – of the proposed procedure and of any available alternative procedure, before any treatment or investigation. The explanation shall incorporate information on risks, side-effects, problems relating to recuperation, likelihood of success, risk of death and whether the proposed procedure to be administered is an investigation.

It is a legal requirement that clients or patients accept treatment or other intervention where the condition may affect the wider public.
RIGHT TO ADEQUATE INFORMATION AND CONSENT

A patient shall have the right to know the identity and professional status of the individuals providing service to the patient and to know which health professional is primarily responsible for his or her care, including:

- The right to adequate and coherent information on prescribed and purchased medicines
- The right to choose among competitive products based on unbiased information
- The right to know his or her prognosis and everything about their medical problem
- A patient’s written consent shall be required for the inclusion of a patient in any research or teaching programme. The patient shall be adequately informed of the aims, methods, anticipated benefits and potential hazards of the study and any discomfort it may entail. The patient shall be informed that he or she is free not to participate in the study and that he or she is free to withdraw his or her consent to participate at any time
- To ensure that informed consent is not obtained under duress or from a patient in a dependent relationship to a health professional, the informed consent shall be obtained by a health professional who is not engaged in the investigation and who is completely independent of the official relationship between the patient and the health professional responsible for the research. In the case of a child, informed consent shall be obtained from the parent or guardian.

RIGHT TO REDRESS OF GRIEVANCES

A patient shall have access to appropriate grievance handling procedures, bearing in mind that health care delivery professionals are not superhuman.

A patient shall have the right to claim damages for injury or illness incurred or aggravated as a result of the failure of the health professional to exercise the duty and standard of care required of him or her, while treating the patient.

A patient shall have the right to legal advice regarding any malpractice by a health care professional.

RIGHT TO PARTICIPATION AND REPRESENTATION

A patient shall have the right to participate in decision making affecting his or her health:

- With the health professionals and other support staff involved in direct health care
- Through consumer representation, in planning and evaluating the system of health services, the types and qualities of services, and the conditions of service under which health services are or were delivered
- To give an assessment of the quality of services offered to him or her.

RIGHT TO HEALTH EDUCATION

Every individual shall have the right to seek and obtain comprehensive information advice regarding preventive and curative medicine, aftercare and good health.

THE RIGHT TO A HEALTHY ENVIRONMENT

Every individual shall have the right to an environment that is conducive to good health. This includes and extends to the health professional’s office, health centre, hospital room and any other facilities.

PATIENTS’ AND FAMILIES’ RESPONSIBILITIES/ OBLIGATIONS

Whilst you have the right to be heard, you also have an obligation to listen to medical instruction concerning your treatment.

The patient and family shall provide accurate and complete information to assist the health professional to plan for your stay and treatment adequately.

The patient and family shall produce proof of inability to pay for health care services, except in emergency cases as determined by the health care professionals.
To avoid inconvenience to yourself and to others, follow the referral chain and ensure you have the necessary documents to effect your access into hospital.

Keep your hospital notes safe and clean; you will need them during your next visit or contact with the health services.

The patient and family shall ensure that the patient understands the purpose and cost of any proposed investigations or treatment before deciding to accept it.

The patient shall insist upon explanations until he or she is adequately informed and shall consult with all relevant persons before reaching a decision.

The patient and family shall accept the consequences of the patient’s own informed decisions.

The patient and family shall establish a good relationship with the health care provider and follow the treatment, determined by the health professional primarily responsible for the patients care.

The patient and family shall inform the health professional if the patient is currently consulting with, or under the care of another health professional – including traditional medical practitioners – in connection with the same complaint or any other complaint.

The patient and family shall keep appointments and shall inform the health professional if unable to keep an appointment.

Every individual has a responsibility to maintain his or her own health and that of society by refraining from indulging in:

- Consumption of unhealthy food
- Substance abuse, such as alcohol and drugs
- Life styles that have an adverse impact on health, such as sexual promiscuity, reckless activities and physical inactivity.

Every individual has a responsibility to accept all preventive measures sanctioned by law.

The patient and family must be aware of the limits of health care providers.

Patients should not expect a prescription at every visit. Many illnesses are short term and do not require medication. You do not need a pill for every sickness.

Take your medicines exactly as instructed and complete any course of treatment

Take interest in your condition and read more information to get the best out of health promotions.

Do not share prescribed medicines.

The patient shall conduct himself or herself so as not to interfere with the well being or rights of other patients or providers of health care.

**SERVICES**

**ADMISSION AND YOUR STAY IN HOSPITAL**

In the event of an accident, illness or emergency, you will be attended to by competent health workers. You will be assessed and dealt with appropriately and immediately upon arrival.

Whether you are admitted as an emergency case or not, hospital staff shall:

- Inform your relatives, next of kin or whoever you wish, where practicable
- Keep your clothes and valuables in a safe and clean place
- Give clear information about your illness and condition and the treatment plan for your recovery
- Give clear information about domestic arrangements and any other information relevant to your stay in hospital.
OUTPATIENT SERVICES

Provided you have followed the referral chain and you do not require complex diagnostic procedures, you will receive treatment promptly.

You have the right to clear information about your full treatment. Health workers will be happy to answer your concerns.

You have the right to request for assistance or help when you require it.

INTER-HOSPITAL TRANSFERS

In some cases, it will be necessary for you or your child to be transferred to another hospital for continuation of treatment.

If this is so, staff will:
- Give you information concerning the reason for the transfer and the arrangements to effect it
- Inform your relatives, or whomever you wish, of the transfer, where such communication is possible
- Upon discharge, if need be, advise your relatives to take you home.

COMMUNITY SERVICES

Health services are based on the referral chain.

This means that you are required to visit your local health centre or general practitioner in the first instance when you are not feeling well. However, if you are involved in an accident or emergency, you can go to the nearest hospital without referral.

In addition, the following Community Health Workers are available in your locality to assist you:
- Village Health Workers (formerly known as village community workers – VCWs)
- Environmental Health Technicians (EHTs)
- Field orderlies
- Community Based Distributors (CBDs) – Family Planning
- Community Nurses
- TB Co-ordinators
- Health Centre Nurses
- Other community workers
- Home based care providers.

In the community, you have a right to:
- Communicate with health workers on matters which concern your health. You do not have to wait till you are ill
- Continuing care at home, where there is need (e.g. invalidity, old age, recuperation, etc). When you are discharged, the hospital will arrange for continuing care with your nearest health facility if there is need.

In the event that you request an ambulance, it will be dispatched to you as soon as possible. However, arrival time will depend on distance, condition of the roads and availability of ambulances.

FREE SERVICES IN ZIMBABWE

- Immunisation for children
- Immunisation for pregnant women
- Treatment for mental illness
- Treatment for epilepsy
- Treatment and rehabilitation for children under five years old
- Treatment for survivors of sexual abuse
- Clients attending opportunistic infection clinics and other HIV and AIDS services
- Treatment for tuberculosis
- Treatment of leprosy and its related complications
- Treatment for those aged, 65 years and above
- Other as stated in the Ministry of Health and Child Welfare Policies.
Annex III

Disclosure to Intimate Partners, Friends and Others

The issue of disclosing their HIV positive status is a significant issue for everyone living with HIV.

What is Disclosure?

For young people and adult HIV disclosure means telling another person your HIV-positive status.

For young people – when considering disclosing to a potential partner – if you don’t trust them enough to tell them your HIV status, then you are not ready to have sex with them!

Disclosure needs to be done in a safe space where you will not be interrupted and where you can both express your emotions.

Disclosure is a process, NOT a one-off event

Before disclosing to others, it is important to think about who you want to tell and why. What will you gain from telling them and what are the disadvantages?

Who?

Ask: Do I trust this person? You have a right to keep information about your health private and this should be respected by those you tell. Before telling anyone, make sure they understand that telling them about your HIV status is a big decision and one that you have made because you trust them completely.

How will it help me if I tell them?

It may be useful to tell:

- Family members, friends and school teachers so they can support you taking medicines, accepting sick-notes, giving you time to visit the clinic, or if bullying occurs.

- Your supervisor at your workplace, as they can help to ensure that you are given time for clinic appointments. Your employer may also have a workplace wellness programme that can help you.

Who do I need to tell?

- Anyone with whom you are in a relationship that could become a sexual relationship, so that you can work together to prevent onward HIV infection.
If a partner cannot accept your HIV positive status then they are not the right person for you!

- New doctors and other health care providers and service providers, such as family planning services, or when you move or are away from home.

**How to tell**

Protecting yourself when disclosing is very important. Think about where you will tell them – somewhere private, where you will not be disturbed.

- Test the person – start a general conversation about HIV and see how they respond. If they react negatively, ask why? Some more information might be needed before you can disclose safely!

- If they seem supportive and caring, push the topic to a more personal level. Ask what would you do if your sister/brother etc. were positive? Take it one small step at a time.

- You can also bring along someone else who knows (a caregiver or a support group member) to help.

**Am I ready for negative reactions?**

Not everyone will react well when you tell them your positive status. You must be ready if someone reacts badly and be sure that you can stay confident and happy if they do. This is where being in a support group can help.

Disclosure can also have negative consequences, including rejection and problems in relationships with dating and sexual partners, family, friends, community members, employer or colleagues.

- PLHIV need to think about how those they opt to disclose to may react. It is important to choose the person/people to disclose to carefully: they should be accepting, mature, empathic and supportive.

- Disclosing gradually rather than to everyone at once may be better.

- PLHIV need to be sure it is what they want to do. And they should plan how they will do it.

- For young people, there is the added difficulty of deciding whether to tell friends or dating partners who may seem important at the time, but who may soon move on and may or may not keep the confidentiality.

A ‘disclosure plan’ can help. It should include:

- Any preparations that need to be made before disclosure.

- Deciding whom they will inform first.
• How and where the disclosure will take place – make sure the time and place are right for disclosure.

• Identifying sources of support, such as PLHIV support groups, church members, counselling and other organisations that may be able to help.

**When it all goes wrong**

If you disclose to someone who does not react well or tells others, or if people start to treat you differently or badly, try the following:

• Speak to them – make sure they understand they are hurting you.

• Stay positive – you are not in the wrong, they are – a good friend or loving partner would not disrespect you in this way.

• Get advice from a support group member or other PLHIV – you will feel better after talking to others in the same situation – you are not alone!

• See a counsellor and talk about your feelings.

**Disclosure and confidentiality**

• Your right to confidentiality or privacy, means that you have the right to choose: whether to disclose; to whom to disclose; and when and how you do it.

• People to whom you disclose have a responsibility to respect your privacy and not share your information with others.

**Disclosure and sexual partners**

Disclosing is an emotional time for everyone, especially if you are young and inexperienced. Both disclosure and sex require maturity, factual information about how to protect yourself and your relationship partner, understanding the consequences of having sex with someone and being willing to accept responsibility for your actions.

• Not telling a partner in good time can lead to hurtful rejection and distress.

• Love protects; it is more than sex. Relationship partners can show that they love and care about each other in many ways that do not include sex. Respect and caring for each other, loyalty, honesty and trust are important signs of a healthy relationship.

• Having sex is not necessarily a sign of love and commitment.

• Disclosure shows you care. It supports counseling and access to information and treatment. Accurate information about HIV reinfection and prevention, safer sex methods and PMTCT is very important for your good health and the health of others.
Stopping Stigma!

• The more people who are aware of their own HIV status and who are open about it, the less stigma and discrimination there will be!

• Friends and relatives who are aware of your HIV positive status are in a better position to defend you and to discourage stigma and discrimination when they come across them in others.

Positive health, dignity and prevention

Positive health, dignity and prevention aim to increase the self esteem and confidence of HIV positive individuals to protect their own health, seek and demand their rights and avoid passing the infection to others, or becoming more sick themselves through re-infection. With good nutrition, prevention of other infections, taking medication consistently and properly and taking positive action for their health and future (positive living) PLHIV can live healthy and productive lives and prevent the spread of HIV to others. Positive health, dignity and prevention stresses that PLHIV:

• Are more than patients.

• Should not be treated as vectors of the disease.

• Are not all responsible for HIV.

• Have needs and desires to be fulfilled.
Promoting Positive Health, Dignity and Prevention
A MANUAL TO SUPPORT COMMUNITY ANTIRETROVIRAL TREATMENT LITERACY IN ZIMBABWE

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Promoting Positive Health, Dignity and Prevention