AMBULATORY CARE OF THE CHILD LIVING WITH HIV/AIDS

Improving quality of life through basic health measures

HIV/AIDS is a major child health problem

- The incidence of HIV infection in antenatal women in the Province of the KZN was about 30% in 2001. With no vertical transmission intervention, about 33% of their babies will contract HIV infection.
- PMB delivers about 17000 babies per year. Approximately 5100 babies are born yearly who are perinatally exposed to HIV infection. Of those about 1700 (without PMTCT) will be infected, 850 with PMTCT (single dose NVP to mother and baby). So, we should be seeing about 1000 new HIV infected children per year in PMB.
- HIV/AIDS accounts for about 25-50% of admissions.

HIV infection is a major health problem facing children and their carers in our region. Even before initiating anti-retroviral drugs basic health measures can make a difference to the quality and duration of their lives.

Should a mother who is HIV-infected breastfeed her child?

- Breastfeeding carries an additional transmission risk of 14% to 50%.
- A mother who can afford infant formula and has access to safe water should be advised not to breastfeed.
- If a mother is poor and from an area without access to safe water, the risks of not breastfeeding may outweigh the risks of breastfeeding in terms of an increased risk of malnutrition, gastro, ARI's and other infections.

Mothers who are breastfeeding must be encouraged to EXCLUSIVELY breastfeed for 6 months.

According to National Policy, free formula feeds SHOULD be available at all clinics. Therefore poor mothers SHOULD be given this option. This is a human rights issue.

What other nutritional aspects are important?

1) Calorie intake

All children with HIV infection are at risk of failing to thrive

1) Give an age appropriate nutritious and balanced diet.
2) Useful advice to poor mothers is to add a spoon or two of fat (margarine or cooking oil) to the child’s food to increase nutritional density.
3) Monitor and intervene early. Refer all children with HIV/AIDS to Integrated Nutrition Programmes in your area for nutritional supplements i.e. milk and vitamins.

2) Micronutrients

Vitamin A and Other Vitamins

Give the standard dose of a MULTIVITAMIN daily from birth.

Folate

FOLATE 2,5 mg 24H may be of benefit in symptomatic patients.

Iron

If inadequate intake give prophylactic Fe to prevent Iron deficiency (ELEMENTAL IRON 3 mg/kg 24H).

3) Practical Feeding Advice

HIV infection is often accompanied by a loss of appetite due to chronic ill health and painful swallowing (mouth ulcers, oral thrush)

Anorexia:

- Frequent small meals (5 - 8 per day)
- Appetite is usually bigger in the morning so plan bigger meals in the morning.
- Give all fluids as calorie-containing: juices, milk etc (not water).
- Always have favourite foods available and “bribe” the child if necessary to eat less favoured foods.
- Company promotes appetite so make meals a social occasion and encourage activity.

Painful Eating:

- Soft non acidic foods of even consistency i.e. mashed potatoes and mincemeat.
- Cold liquids help to numb the mouth.
- Avoid salty, spicy or acidic foods i.e. pickles.
- Good oral hygiene to reduce oral infection.
- Local anaesthetic e.g. Tgel
- Treat oral candida infections.
What infection prophylaxis should be given?

1) Pneumocystis Carinii Pneumonia
   - Identify at risk infants (antenatally preferably, but in our setting the infants usually present with clinical signs of HIV infection).
   - Start PCP prophylaxis at 4-6 weeks of age (i.e. at the same visit as first vaccine).
   - Cotrimoxazole prophylaxis should be continued until 1 year of age unless the infant is proven to be HIV negative (See Site Manual).
   - After 1 year of age if the child is completely asymptomatic, cotrimoxazole can be discontinued. Any child who has asymptomatic HIV infection should be continued on cotrimoxazole prophylaxis for life unless you are monitoring CD4 counts.
   - The recommended dose of COTRIMOXAZOLE is 5mg/kg/day of the trimethoprim component daily. This is practically just under 1ml/kg/day of the cotrimoxazole: trimethoprim 40mg/5 ml.

2) Tuberculosis Prophylaxis
   - Ask carefully about household TB contacts.
   - If there is a contact, exclude TB (Skin test and CXR and Gastric Washings or Induced Sputum for AFB’s) and treat according to national guidelines. (INH/RIF for 3 months).
   - A child suspected as having HIV infection with a reactive skin test (induration of 2 mm of any of the 4 puncture sites) or a Mantoux induration of 5 mm who has no clinical evidence of TB and has a normal CXR will also need 3 months of INH/RIF or INH for 6 months.
   - You need to trace the sputum culture of TB contact as MDR is more and more common. If the child is exposed to an MDR-TB case you need to liaise with a MDR-TB center to start an appropriate TB prophylaxis.

3) Measles and Chickenpox prophylaxis
   - Measles: Prophylactic IMMUNOGLOBULIN (0.5ml/kg) within 5 days of exposure to measles.
   - Chicken pox: ZOSTER IMMUNE GLOBULIN (0.15ml/kg) within 3 days of exposure chickenpox.

4) Immunisations
   - Children with HIV infection should receive all the routine childhood immunisations.
   - Babies born to HIV positive mothers should get BCG at birth.
   - BCG should not be given to infants with symptomatic HIV infection.
   - Avoid measles immunisation only in severely immunosuppressed patients.
   - Yearly influenza vaccine is a benefit and should be given.

5) Deworming
   - Deworm with mebendazole 6 monthly, after the age of ambulation.

6) Skin
   - The skin is usually one of the first organs showing that the immune system is not happy. It is important to carefully treat the skin conditions of the child and refer to the skin specialist if no response to the usual management. In some instances the skin will only improve after restoration of the immune system following antiretroviral therapy.

Follow up
   - All newborns born of HIV infected mothers should start Cotrimoxazole prophylaxis at their “first vaccine visit” at 6 weeks of age.
   - Asymptomatic children can be seen 3 monthly at their local clinic, CD4 must be checked at diagnosis of HIV infection and must be repeated every 6 months. WHO staging must be redone at each visit at the clinic and hospital levels.
   - Symptomatic children should be seen monthly at focused outpatient clinics and started on ARVs as soon as they are eligible. WHO staging must be redone at each visit and CD4 checked 6 monthly.
   - The caregiver’s health must be reassessed at each visit and if HIV infected, he/she MUST know his/her CD4 count. HIV infected children, whose mother survives, have an overall better life expectancy than HIV infected orphans.

Outpatient management of common paediatric problems in children living with HIV

- Children with HIV infection with intercurrent infections and other minor problems should be managed no differently from uninfected children. However HIV infected children are prone to more serious, prolonged and recurrent infections and their mothers should be advised to come back if there is no improvement on outpatient treatment.
- Remember to stage children frequently, because children who meet staging eligibility criteria for ART must be referred to an Antiretroviral Clinic.