دائـــــرة الـــصـــحـــة
DEPARTMENT OF HEALTH

مـركـز أبـوظـبـي للـصـحـة الـعـامـة
ABU DHABI PUBLIC HEALTH CENTRE

Circular No.(2023 / 89) تعميـم رقم

Date: 30/05/2023

التاريخ: 2023/05/30

To:
All Healthcare Facilities
All Healthcare Professionals

إلى:
جميع المنشآت الصحية
جميع المهنيين الصحيين

Subject: Launching Abu Dhabi HIV Management Guideline

We would like to extend you our greetings wishing you all the best and success.

With reference to the above subject, enclosed herewith a copy of the above-mentioned guideline issued by the Abu Dhabi Public Health Center, that includes case definition, diagnosis and treatment; for you to act accordingly.

For more information or inquiries in this regard, kindly contact the Infectious Disease Programs Section/ADPHC via Email: idp@adphc.gov.ae

We hope that all will adhere to the above, for the best interest of work.

Thanking you for your kind cooperation,,,

"This circular is designed for regulatory procedures and should not be used as content for media publication".

الموضوع: إطلاق دليل إمارة أبوظبي لعلاج نقص المناعة المكتسبة

بداية، يسرنا أن نتقدم لكم بخالص التحية والتقدير متمنين لكم دوام التوفيق والسداد.

بالإشارة إلى الموضوع أعلاه، نرفق لكم نسخة من الدليل المذكور أعلاه الصادر عن مركز أبوظبي للصحة العامة والذي يتضمن تعريف الحالة والتشخيص والعلاج وذلك للعمل بموجبه.

ولمزيد من المعلومات أو الاستفسار بهذا الشأن، يرجى التواصل مع قسم برامج الأمراض المعدية بمركز أبوظبي للصحة العامة عبر البريد الإلكتروني: idp@adphc.gov.ae

آملين من الجميع الالتزام بما ورد أعلاه، لما فيه مصلحة العمل.

شاكرين لكم حسن تعاونكم معنا،،،

"هذا التعميم للإجراءات التنظيمية وغير مخصص كمحتوى للنشر الإعلامي".

د. نورة خميس الغيثي

وكيل دائرة الصحة

RESTRICTED

ABU DHABI PUBLIC HEALTH CENTRE | مركز أبوظبي للصحة العامة

Abu Dhabi HIV Management Guideline

Version 1.0 - 2023

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Abbreviation list

Abbreviation	Description
ADPHC	Abu Dhabi Public Health Center
AIDS	Acquired immunodeficiency syndrome
ART	Antiretroviral therapy
CDD	Communicable disease department
DoH	Department of health
EIA	Enzyme immunoassay
E-IDN	Electronic -Infectious disease notification system
EMA	European Medicines Agency
FDA	U.S Food and Drug Administration
GAM	Global AIDS monitoring
HAV	Hepatitis A virus
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human immunodeficiency virus
ID	Infectious Disease
IDN	Infectious Disease Notification
KPI	Key Performance Indicator
MENA	Middle East and North Africa
MOHAP	Ministry of health and prevention
PCR	Polymerase chain reaction
PEP	Post-Exposure prophylaxis
PLHIV	People living with HIV
PrEP	Pre-Exposure prophylaxis
STI	Sexually transmitted Infection
TB	Tuberculosis
TDF/FTC	Tenofovir disoproxil fumarate /emtricitabine
UAE	United Arab Emirates
US or U.S	United States
UNAIDS	The Joint Nation Program on HIV/AIDS
WHO	World Health Organization

Section 1: Overview

The human immunodeficiency virus (HIV) targets the immune system and weakens people's defense against many infections and some types of cancer that people with healthy immune systems fight off easily. As the virus destroys, and impairs the function of immune cells, infected individuals gradually become immunodeficient. Immune function is typically measured by CD4 cell count and can be assessed by other tests.

The most advanced stage of HIV infection is acquired immunodeficiency syndrome (AIDS), which can take many years to develop if not treated, depending on the individual. AIDS is defined by the development of certain cancers, infections or other severe long-term clinical manifestations.

Section 2: Objectives of the guideline

This HIV guidelines aim to provide evidence-based recommendations for the prevention, diagnosis, and treatment of HIV infection; with the goal of improving the health outcomes of people living with HIV and reducing the transmission of the virus in the Emirate of Abu Dhabi

Section 3: Epidemiology

According to the World Health Organization (WHO), HIV remains a major global public health issue, having claimed almost 40.1 million lives so far.

In the mid-1980s, the first cases of AIDS in the Middle East and North Africa (MENA) region were reported; most of the reported cases were associated with HIV exposure abroad and through contaminated blood products or organ transplants.

However, the new pattern of transmission started to emerge among key populations and high-risk groups in the early 1990s.

Middle East and North Africa (MENA) is the region with the lowest HIV prevalence in the world, according to the latest statistics published by UNAIDS. The MENA region had 180,000 people living with HIV at the end of 2021. Although the prevalence is considered low worldwide, it is also home to one of the fastest growing epidemics, and the rate of new HIV infections increased by 33% from 2020 to 2021, making the MENA region one of the only three regions in the world where HIV is still on the rise. Despite the substantial progress that has been made in understanding the global HIV epidemic in recent years, knowledge of this region's epidemic is comparatively limited. As a result, the MENA region failed to achieve the UNAIDS 90-90-90 targets in 2020. These targets are:

- By 2020, 90% of all people living with HIV will know their HIV status.
- By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy.

- By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.

In 2020, less than half of the people living with HIV in the MENA region were aware of their HIV status; 50% of people living with HIV started treatment, and only 44% were virally suppressed in 2021.

In order to meet the new UNAIDS 95-95-95 target by 2025, there are major gaps in the treatment cascade that need to be strengthened in the MENA region countries, which are:

- By 2025, 95% of all people living with HIV will know their HIV status.
- By 2025, 95% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy.
- By 2025, 95% of all people receiving antiretroviral therapy will have viral suppression

Section 4: Transmission

- HIV can be transmitted via the exchange of a variety of body fluids from infected people, such as blood, breast milk, semen and vaginal secretions.
- HIV can also be transmitted from a mother to her child during pregnancy and delivery (vertical transmission)
- Individuals are not known to become infected through ordinary day-to-day contact such as kissing, hugging, shaking hands, or sharing food and water.

It is important to note that people with HIV who are taking ART, and are virally suppressed, are unlikely to transmit HIV to their sexual partners. Early access to ART, and support to comply with treatment is therefore critical not only to improve the health of people with HIV but also to prevent HIV transmission.

Section 5: Risk factors

Behaviors and conditions that put individuals at greater risk of contracting HIV include:

1- Having unsafe anal or vaginal sex;
2- Having another sexually transmitted infection (STI) such as syphilis, herpes, chlamydia, gonorrhea and bacterial vaginosis;
3- Engaging in harmful use of alcohol and drugs in the context of sexual behavior;
4- Sharing contaminated needles, syringes and other injecting equipment and drug solutions when injecting drugs;
5- Receiving unsafe injections, blood transfusions and tissue transplantation, and medical procedures that involve unsterile cutting or piercing;

6- Experiencing accidental needle stick injuries, including among health workers.

Section 6: Surveillance Case Definition

The case definition for HIV surveillance is used to identify and track cases of HIV infection in a population. This is important for monitoring trends in HIV incidence and prevalence, evaluating prevention and treatment programs, and allocating resources to address the HIV epidemic.

The case definition for HIV surveillance typically includes the following criteria:

- *Laboratory Confirmation:* A laboratory test that confirms the presence of HIV antibodies or viral nucleic acids in the blood or other body fluids.
- *Clinical Symptoms:* The presence of one or more clinical symptoms consistent with HIV infection, such as fever, weight loss, or opportunistic infections.
- *Risk Factors:* Identification of one or more known risk factors for HIV infection, such as unprotected sexual activity, injection drug use, or exposure to HIV-infected blood or body fluids.

The specific case definition may vary depending on the purpose of the surveillance and the population being studied. For example, the case definition for HIV surveillance among infants born to HIV-positive mothers may include different criteria than the case definition for surveillance among high risk populations.

Section 7: Laboratory criteria for diagnosis

Adults, adolescents and children aged >= 18 months

Any one of the following:

- Positive result from an HIV antibody screening test (e.g., reactive enzyme immunoassay [EIA]) confirmed by a positive result from a supplemental HIV antibody test (e.g., Western blot or indirect immunofluorescence assay test.)

- Positive result or report of a detectable quantity (i.e., within the established limits of the laboratory test) from any of the following HIV virologic (i.e., non-antibody) tests:
    - HIV nucleic acid (DNA or RNA) detection test (e.g., polymerase chain reaction [PCR])
    - HIV p24 antigen test, including neutralization assay
    - HIV isolation (viral culture)

Diagnosis of HIV infection in children (Children aged <18 months)

Positive results on two separate specimens (excluding cord blood) from at least one of the following three:

- Isolation of HIV
- Detection of HIV nucleic acid (HIV-RNA, HIV-DNA)
- Demonstration of HIV by HIV p24 antigen test, including neutralization assay in a child >=1 month of age

*Refer to Annex (3): Laboratory testing algorithm for HIV

Section 8: Case Classification

- *Suspected:* A case with positive ELISA result, awaiting further laboratory confirmation.
- *Confirmed:* A case that is laboratory confirmed

Section 9: Clinical Presentation

People infected with HIV may present with signs and symptoms of any of the stages of HIV infection. Although incubation periods can be as long as ten months, symptoms can be variable; the most commonly reported symptoms are flu-like symptoms or an acute self-limited mononucleosis-like illness within two to four weeks after infection, but there are no specific physical findings associated with HIV infection. The diagnosis is based on laboratory criteria.

When people get infected with HIV and don't receive the proper treatment, the infection will progress into three different stages of HIV infection as follows:

- *Stage 1 Acute HIV infection*: the earliest stage, which develops within two to four weeks after acquiring the infection. There is a wide range of symptoms that have been described in patients with acute or early HIV infection, such as fever, lymphadenopathy, sore throat, rash, myalgia or arthralgia, diarrhea, weight loss, headache, and maculopapular rash. At this stage, people who are infected with HIV can be highly contagious, and the risk of HIV transmission increases due to the high viral load.

- *Stage 2 (clinical latency) or chronic HIV infection:* at this stage, the virus continues to multiply, but at very low levels. Infected individuals might not have symptoms, but without HIV treatment, people can stay in this stage for a decade or longer.

- *Stage 3 (acquired immunodeficiency syndrome, or AIDS*): This is the late and most severe stage of infection. Due to a severely damaged immune system, the body cannot fight off opportunistic infections. AIDS is diagnosed when the CD4 count is less than 200 cells/mm3 or if they have certain opportunistic infections. Without the initiation of appropriate treatment, people diagnosed with AIDS are expected to survive about 3 years.

Without treatment, and if the CD4 count of people living with HIV infection becomes very low, complications such as opportunistic infections, cancer, and other medical complications are expected to develop.

Section 10: Differential Diagnosis

A healthcare provider shall consider HIV infection in patients with recurrent or unusual occurrences of serious infections, especially in those with risk factors for HIV infection.

Any of the opportunistic infections or cancers associated with acquired immune deficiency syndrome (AIDS) can also occur in the absence of HIV infection, although they usually develop in immunocompromised patients (e.g., patients on chemotherapy or with immune disorders, severe combined immune deficiency, severe malnutrition).

List of Differential Diagnoses:

- Burkitt Lymphoma
- Candidiasis
- Coccidioidomycosis and Valley Fever
- Cryptococcosis
- Cryptosporidiosis
- Cytomegalovirus (CMV)
- Disseminated gonococcal infection
- Herpes Simplex
- High-Grade Malignant Immunoblastic Lymphoma
- Mononucleosis due to Epstein-Barr virus (EBV)
- Mycobacterium Avium Complex (MAC) (Mycobacterium Avium-Intracellulare [MAI])
- Rubella
- Syphilis
- Toxoplasmosis
- Viral Hepatitis
- Other viral infections

Section 11: Breaking Bad News for Newly Diagnosed Patients

Breaking bad news is an essential skill for medical practice; it is never an easy task, but gaining this skill can make patients receiving the delivered news feel more respected and supported going forward. In the context of patients testing positive for HIV, breaking bad news becomes even more challenging because of stigma and discrimination.

It is important that healthcare providers practice the skill of breaking bad news in the most appropriate way in order to gather all the important information needed from the patient, deliver

and transmit medical knowledge, provide support to the patient, and elicit the patient's collaboration in developing a strategy or treatment for the future.

There are different approaches and protocols that can be used to break bad news, such as BREAKS, SPIKES, and ABCDE.

Table 1: Summary of approaches and protocols used in breaking bad news

BREAK	SPIKES	ABCDE
Background **R**apport **E**xplore **A**nnounce **K**indling **S**ummarize	**S**etting **P**erception of condition/ Seriousness **I**nvitation from the patient to give information **K**nowledge **E**xplore emotions and **S**ympathize **S**trategy and Summary	**A**dvance Preparation **B**uild a therapeutic **C**ommunicate Well **D**eal with patient and family reactions **E**ncourage and validate emotions

Section 12: Infection Control and Prevention

Blood and bodily fluid precautions should always be applied for all individuals because medical history and examination cannot accurately identify all patients who are infected with HIV or other blood-borne infections. So, people living with HIV are managed according to the "Standard Precautions" in healthcare facilities. This approach, should be used in the care of all patients, particularly those in emergency-care settings where the risk of blood exposure is increased and the patient's infection status is typically unknown.

12a-Control measures:

- Isolation: Unnecessary, only apply standard precaution to hospitalized patients.
- Quarantine: Not Applicable
- Exclusion from school, work. etc.: Not Applicable
- Immunization: (Refer to section 7 and 8, National HIV Management Guideline First edition 2023 published by MOHAP)
- Prophylaxis: PrEP is available after significant exposures to help. HIV PrEP should be given within 72 hours of an exposure. (Refer to section 14)

12b-Control of environment:

School / workplace /camps:

- Avoid sharing razors, toothbrushes and nail clippers
- Use of appropriate infection control measures by all health care and emergency workers

- Use of appropriate infection control measures in all premises where skin penetration is carried out, for example electrolysis, tattooing or body piercing
- Sharps injuries, including needle stick injuries, and parenteral exposure to laboratory specimens containing HIV should be dealt with according to the infection control guidelines for the prevention of transmission of infectious diseases in the health care setting.

Section 13: HIV Management

In order to achieve optimal treatment outcomes, it is necessary for physicians treating HIV patients to follow the treatment protocols as per the MOHAP National HIV Management Guidelines (2023), and periodically update treatment protocols based on emerging evidence.

*Scan Barcode below to be linked to the MOHAP National HIV Management Guidelines (2023), or can view the document via link: https://mohap.gov.ae/assets/95c8c7f2/hiv-management-guide-vol02.aspx

13a: Long-Acting ART

Although Long-acting options Cabotegravir and Rilpivirine injections (CAB/RPV-LA) are currently not available in UAE and Abu Dhabi, the following recommendations are included for healthcare professional's reference.

CAB/RPV-LA are approved by the FDA and EMA for pre-exposure prophylaxis and treatment of HIV infection in 2022. However, there is less experience of use of

CAB/RPV-LA compared to the current oral ARVs, and long-term safety and outcomes are still to be determined.

Further detailed recommendations about its use in the UAE will be issued by ADPHC team. However, it is likely that it will only be available for eligible patients and predominantly for treatment rather than pre-exposure prophylaxis.

Use of CAB/RPV-LA is likely to require ID clinics and health facilities to have additional resources to coordinate appropriate scheduling of appointments as well as facilities to administer the injection and monitor patients after administration.

As with other European and US guidelines, access is likely to be limited to people who have had undetectable viral load for more than 6 months on their current ART with no history of viral failure or drug resistant to integrase inhibitors or NNRTIs. Patients should also be aware of the risk of viral failure despite good adherence.

Patients should also be aware that more frequent viral load monitoring is recommended i.e. with every 2 monthly dose and viral load should be repeated immediately if results become detectable. Viral failure has been associated with having two more of the following four factors:

a. BMI > 30 kg/m2
b. Low RPV levels at week 8
c. Baseline mutations to RPV
d. The A1 or A6 HIV subtype (common in Russia).

CAB/RPV-LA is likely to be recommended for people who:

- Face challenges taking daily oral ART and
- Have been virally suppressed to <50 copies/mL for at least 6 months and
- Have no known or suspected NNRTI or INSTI resistance and
- Have no history of virological failure or unplanned interruption on NNRTI or INSTI-containing ART and
- Have no history of INSTI monotherapy and
- Can commit to 2-monthly attendance for injections and
- Accept the risk of virological failure and resistance despite complete adherence and the potential implications for U=U and
- Have a BMI index of <30 kg/m2 and non-A1/A6 subtype if baseline resistance is unavailable and
- Do not need a tenofovir-containing regimen for the treatment or prevention of hepatitis

Section 14: Exposure Risk Assessment and Recommendations for HIV Exposed Individuals

14a-Post-Exposure Prophylaxis (PEP):

Short course of ART should be provided to people at risk for HIV to prevent getting HIV infection from sexual intercourse or injection drug use. ART must be started within 72 hours after possible exposure to HIV and continued daily up to 28 days as per infectious disease (ID) consultant instruction. Post-Exposure can be provided for both public population and healthcare professionals in designated ID clinics.

14b- Pre-Exposure prophylaxis (PrEP):

PrEP (pre-exposure prophylaxis) is a biomedical intervention that involves taking antiretroviral drugs before exposure to HIV to prevent transmission. Studies have shown that consistent and correct use of PrEP significantly reduces the risk of HIV acquisition. The World Health Organization recommends offering PrEP as part of a comprehensive package of prevention services for high-risk populations.

***Refer to MOHAP HIV treatment guidelines (Section 9).**

Section 15: Reporting Cases of HIV

15a: IDN reporting of HIV

According to federal Law No. 14 of year 2014 that mandate the reporting of suspected and confirmed HIV cases. The responsibility of reporting lies on both the physician that requested the HIV test, and the laboratory performing the test. Both parties have to ensure timely notification on the DOH-ADPHC IDN system (24 hours).

Informing the patient about the diagnosis:

- The healthcare provider that have requested the HIV test is obliged to inform the patient about his/her result and explain what the results mean. This should be done with a process in place to maintain patient privacy and confidentiality.
- Health care provider should inform the person diagnosed with HIV about the legal obligation on the provider to report the case to the local public health department-Communicable Disease Department in ADPHC.

- Healthcare providers should inform the patient that he/she may be contacted by a public health officer to follow-up their care and perform contact tracing.

Referral process to healthcare facilities and the facilities involved in the management of HIV:

- It is the responsibility of the healthcare provider and the site where the HIV diagnosis was made, to refer and link the patient to the needed care. (Kindly refer to Annex (1) for the list of healthcare facilities providing HIV management in the Emirate of Abu Dhabi)
- Immediate referral and linkage of persons newly diagnosed with HIV to care is the corner stone of successful HIV treatment and HIV care continuum.

15b: Contact tracing

- Contact tracing is a process aimed to identify individuals who has been exposed to HIV infection and unaware of their infection. This process ensures that these individuals exposed will benefit from early detection and treatment, and take the needed precautionary measures to prevent spreading the infection in the community.
- The contact tracing process should be initiated by the healthcare providers and will then be followed by the public health officers in ADPHC to ensure that exposed contacts have been followed up and tested for HIV (EIA test).
    - Window period testing: for asymptomatic patients, who are considered from high-risk population or is highly suspicious to have the HIV infection and has been in contact with confirmed positive case, to repeat EIA test after 3 to 4 weeks. Otherwise, clinically symptomatic cases should be referred to specialized ID team and get evaluated as soon as possible.
    - The HIV screening test of contacts will be determined by the ID consultant, depending on the contact period.
- Healthcare workers should urge infected individuals to identify their contacts. Once the individuals identify their contacts, they should be encouraged to inform their contacts about their infection, and to get screened. This might be a difficult step for the patient, and healthcare workers are encouraged to show empathy and support in the process. ADPHC will be responsible to identify the close contacts and refer for screening
- According to Ministerial decree No. 29 of year 2010, healthcare workers should inform individuals diagnosed with HIV about their legal obligation to avoid putting other people at risk of being infected. The trace back period for a contact of a case of HIV is variable. Prioritize with the most recent contacts; to a time of known onset of risk behavior or last known negative HIV test.

15c: Reports of managed cases

Reporting managed cases is part of Global AIDS Monitoring (GAM) that aims to measure progress in developing and implementing policies, strategies and laws related to the HIV response.

Healthcare facilities are encouraged to keep and maintain a highly confidential disease registry for HIV patients that are managed in the facility.

Healthcare providers are required to submit regular reports of all confirmed and managed cases of HIV on a quarterly basis to the ADPHC team (idp@adphc.gov.ae) , with the following requirements summarized in Table (2):

Table 2 : Requirements of HIV-managed cases report *
*Only for facilities managing HIV cases (Annex 1)

Requirements of HIV managed cases report		
Requirement	**Level**	**Description**
Patient's Name	Required	The full name of the patient
Emirates Identity Number (EID)	Required	Emirates ID, format: xxx-xxxx-xxxxxxx-x
Age	Required	Patient age, rounded to full years.
Sex	Required	Patient gender: 'Male', 'Female'
Nationality	Required	UAE or Non-UAE national
Date of Diagnosis	Required	Use UK date format (dd/mm/yyyy)
Healthcare facility	Required	Name of healthcare facility reporting the case or starting ART
Date of referral	Required	Use UK date format (dd/mm/yyyy)
Established ART treatment	Required	If started on ART (Yes/ No/ unknown)
Start date on ART	Required	Use UK date format (dd/mm/yyyy)
Patient status	Desirable	Refer to general status (alive/ dead). *Needed for the purpose of follow up and exclusion from the list.
Complications	Desirable	Document only complication related to HIV or ART treatment if present
Genotypic test for HIV-1	Required	Document if the test is done. Yes / No
1st evaluation visit details	Required	Document result of CD4 count and Viral load
Follow up visit details	Required	Document result of CD4 count and Viral load. New cases to be done on Monthly basis till viral suppression is achieved and then repeated every 3 months. Old Cases (with virologic suppression for 2 years), monitoring to be done every 6 months – unless close monitoring of compliance required to repeat every 3-4 months
Co-infection with HCV	Required	Yes or No
Co-infection with HBV	Required	Yes or No
Co-infection with active TB	Required	Yes or No
If co-infected with TB , document start date of Anti-TB medications	Required	Use UK date format (dd/mm/yyyy)
Co-infection with Syphilis	Required	Yes or No
Co-infection	Required	If present, document the type of co-infections. Quantiferon testing for Latent TB Screening to be repeated on annual basis.

		Other STIs – to be repeated on annual basis or more frequently if required for high risk group.
Vaccination	Required	Status of vaccination (Not vaccinated, fully vaccinated, incomplete, unknown).
Cervical Cancer (female only) Screening	Required	Document If screened for Cervical Ca (Yes/ No)
Cervical ca. screening Date (female only)	Required	Use UK date format (dd/mm/yyyy)
Results of Cervical Ca. screening (Female only)	Required	Document the result (Text)

15d: Pregnancy and mother-to-child transmission prevention (PMTCT)

The rate of transmission of HIV from mother living with HIV to her child during pregnancy, delivery or breastfeeding can increase up to 45 % in the absence of appropriate intervention. Identifying the HIV infection should be followed immediately with linkage to health care.

All cases with confirmed HIV infection in pregnant women should be reported to ADPHC team (idp@adphc.gov.ae) to ensure timely follow-up by the ADPHC team to prevent mother-to-child transmission.

Requirements summarized in Table 3.

Table 3 : Requirements of Pregnant HIV-managed cases report*
*Only for healthcare facilities managing HIV pregnant women

Requirements of HIV managed cases report		
Requirement	**Level**	**Description**
Patient's Name	Required	The full name of the patient
Emirates Identity Number (EID)- (Mother)	Required	Emirates ID, format: xxx-xxxx-xxxxxxx-x
Age	Required	Patient age, rounded to full years.
Nationality	Required	UAE or Non-UAE national
Date of Registration	Required	Use UK date format (dd/mm/yyyy)
Date of Diagnosis	Required	Use UK date format (dd/mm/yyyy)
Healthcare facility	Required	Name of healthcare facility starting ART or managing HIV case.
Date of pregnancy	Required	Use UK date format (dd/mm/yyyy) *ADPHC team should be notified immediately after positive BhCG test to follow up the cases closely.
Mother started on ART treatment	Required	If started on ART (Yes/ No/ unknown)
Start date on ART	Required	Use UK date format (dd/mm/yyyy)
Delivery status (if delivered)	Required	Document Yes /No
If delivered, Delivery Date	Required	Use UK date format (dd/mm/yyyy)
Child/Newborn Name	Required	The full name of the patient
Emirates ID No. (Child/Newborn)	Required	Emirates ID, format: xxx-xxxx-xxxxxxx-x
Child's nationality	Required	UAE or Non-UAE national
Child's investigation status	Required	If tested for HIV to document 'Yes'
Date of first test (Child/Newborn)	Required	Use UK date format (dd/mm/yyyy)

Type of the test (Child/Newborn)	Required	Repeated in 3 occasions *Virologic diagnostic testing is recommended at birth, 14 to 21 days, 1 to 2 months, and 4 to 6 months of age
Result of the test (Child/Newborn)	Required	Report the final result of 3 tests
Child infection status	Required	Yes or infected / No or not-infected/ Pending results
Started on ART (for UAE national children/ exempted cases)	Required	Yes/ No
Date of ART initiation (Child/Newborn)	Required	Use UK date format (dd/mm/yyyy)
Father Name	Required	The full name of the patient
Father Emirates ID	Required	Emirates ID, format: xxx-xxxx-xxxxxxx-x
Father nationality	Required	UAE or Non-UAE national
Father infection status	Required	Infected/ not-infected

Section 16: Special Case Scenarios

People may be found as HIV positive in one of, but not limited to, the following screening programs, the required actions depend on the screening program:

16a: Visa screening:

- Healthcare provider in the screening center is responsible to contact the applicant and break the bad news with assurance that it is a treatable disease.
- ADPHC will conduct case investigation and perform contact screening.
- Take the required action for the index case as per the Screening standards. (Refer to DOH Visa Screening standard V 1.5)

16b: Premarital screening:

- Healthcare provider should contact the applicant and break the bad news with assurance that it is a treatable disease and they can live and work as other normal people
- Check if the patient is willing to disclose the HIV test results with the partner to continue the process of issuing the premarital screening certificate.
- IDN notification and linkage to care (See Section (15))

16c: Pre-employment screening:

- Healthcare provider should contact the applicant and break the bad news with assurance that it is treatable disease and they can live and work as other normal people
- Explain the mode of transmission of the disease and the preventive measures

- Notify ADPHC about the case through the electronic system.

Section 17: Laboratory Surveillance

- ADPHC will conduct monthly laboratory HIV case surveillance. Laboratories are expected to submit the total number of HIV lab tests and details of positive HIV cases via email: idp@adphc.gov.ae on a monthly basis.
- Positive HIV cases will be verified with notifications in the IDN system. Facilities with unreported HIV cases will be subject to investigations and further escalation, and will be required to report the cases retrospectively.

Section 18: Roles and Responsibilities of Healthcare Workers and ADPHC Team

To facilitate the workflow while dealing with HIV infection cases, healthcare professionals and ADPHC team will work cooperatively to deliver the best health care for all patients. This can be achieved by understanding the roles and responsibilities of each.

Table (4): Summary of the roles and responsibilities

	Healthcare provider	ADPHC team
Key Performance Indicators (KPIs)	Collect KPIs of all managed cases, submit it quarterly to ADPHC team.	Develop HIV program related KPIs, Follow and monitor healthcare facilities KPIs to ensure delivery of care.
Diagnosis	• Order tests as per recommendation (refer to section (7), laboratory diagnosis) • Follow the diagnostic flow chart in suspected and confirmed cases (Refer to Annex (2)). Contact cases with positive result of HIV for second sample collection.in specialized ID clinic; to proceed with further investigations needed to manage the case.	• Not Applicable • ADPHC team will follow up all suspected and confirmed cases to ensure second sample is done and result reported.
Report positive cases	• Report all new cases in the healthcare facility (include referred cases from other facilities, deal with the case as newly reported) via electronic IDN system. • Adhere with reporting mechanism and requirements (section (15)) on the requested frequencies (Quarterly).	• Review demographic data, risk factors, and investigate cases on weekly basis, discard the duplicated cases. • Report all newly infected cases to MOHAP (GAM and line-listing)

Contact tracing	To initiate the process, healthcare providers are expected to document the possible source of infection and recent contacts to be provided to ADPHC team.	ADPHC team will follow up and mainly trace the cases, make sure to record details about the case, in addition to source of infection, guide cases accordingly. ADPHC team should specify and register all details related to other contact including the screening test.
Management	• It is the responsibility of the ordering physician to break bad news of the newly diagnosed HIV case (refer to Section 11), taking patient's confidentiality in consideration. • Provide counseling for all cases diagnosed with HIV (new and old) • Healthcare provider must proceed with connecting the newly diagnosed patient to the designated healthcare facility/ ID clinic. • In specialized ID clinic; start ART prescription as per guidelines and ID consultant recommendations.	Ensure patients are linked to health care facilities, receiving ART and vaccinations.
Follow-up confirmed cases	Scheduled regular follow up and arrange appropriate referrals.	Ensure patients are compliant with following up on ID clinics.
Education	Both Healthcare providers and ADPHC team will participate in patient education to improve awareness and understanding the nature of the infection, educational activities can include: Campaigns, handouts to guide public and people living with HIV, workshops and training for healthcare professionals etc.	
Others	• Refer special cases to ADPHC/DoH, and Ensure special cases are aware about their HIV status and provide counseling even if they are not linked to healthcare facility in UAE. • Notify any challenge or issues related with positive HIV cases.	• Deal with special cases (Expatriates related process) • Identify gaps and challenges, to provide the required support for people living with HIV and healthcare professionals with dealing with the cases. • Provide MOHAP and Department of health (DoH) with the requested reporting or information as needed for old or new cases.

Section 19: Key Performance Indicators (KPIs) for Healthcare Facilities Treating HIV Cases

In order to ensure the delivery and continuity of healthcare services provided for PLHIV, the following KPIs to be submitted quarterly to ADPHC team.

Table (5): Key performance indicators for treating healthcare providers and specialized infectious disease clinics/centers

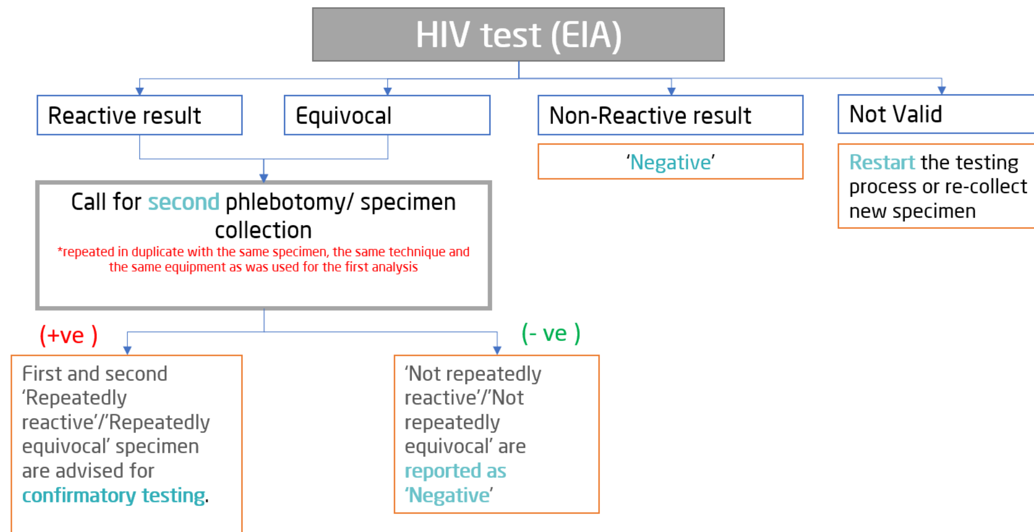
	Target	Type of Measure	Nominator/Dominator
Number of people with HIV on ART	>95%	Percentage	HIV infected patients on antiretroviral treatment / total number of patients following in the facility with HIV
Number of people with HIV that are virally suppressed	>95%	Percentage	People living with HIV on antiretroviral treatment who have suppressed viral load / total number of patients following in the facility with HIV
AIDs Mortality - Number of people dying from AIDS/HIV related causes per year	-	Number	N/A
Number of people who received any PrEP product at least once during the reporting period	-	Number	N/A
The number of HIV tests conducted (testing volume) and the percentage of HIV-positive results returned to people (positivity) in the calendar year	-	Percentage	Number of tests conducted where an HIV- positive result was returned to a person (positivity)/ Number of tests performed where results were received by a person (testing volume)
Number of people with HIV with updated immunization status	>90%	Percentage	HIV patients with updated immunization status/ total number of HIV patients followed in the facility
Number of females with HIV eligible for cervical cancer screening who had her annual cervical cancer screening test	>90%	Percentage	Female HIV patients who had a pap smear done within the past year/ Eligible female HIV patient population for cervical cancer screening

Annexes

Annex (1): List of designated healthcare facilities providing ART and care for PLHIV in the emirate of Abu Dhabi

Name of the healthcare Facility	Code	Location / Region	Contact details (Name/email)
Sheikh Khalifa Medical City	SKMC	Abu Dhabi	• Dr. Jehad Saleh Abdalla jabdalla@seha.ae • Dr. Tehmina Khan tkhan@seha.ae
Sheikh Shakeout Medical City	SSMC	Abu Dhabi	• Dr. Emmanuel Fru Nsutebu ensutebu@ssmc.ae • Hanan Mussa Elmi helmi@ssmc.ae
Tawam Hospital	TW	AL Ain	• Dr. Assad Khan Akhan@seha.ae • Dr. Dalal Saeed Naser Al Mansoori dmansoori@seha.ae
Cleveland Clinic Abu Dhabi	CCAD	Abu Dhabi	• Elias Tannous TannouE@ClevelandClinicAbuDhabi.ae • CCNOInfectionControl CCNOInfectionControl@ClevelandClinicAbuDhabi.ae
Zayed Military Hospital	ZMH	Abu Dhabi	• Dr. Saif Saeed Mohamed Al Bedwawi salbedwawi@gmail.com • Dr. Waleed Khaled Mohd Alhomran Waleed.Alhomran@msc.mil.ae

Annex (2): Interpretation of results and reporting



Annex (3): Laboratory testing algorithm for HIV