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Strategies for Improving Paediatric Viral Load Coverage and Suppression in Eswatini

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Partners in
HOPE
and deed



**Science, policy and
community: the next priorities
for a sustainable HIV
response in Malawi**

19-20 October 2026

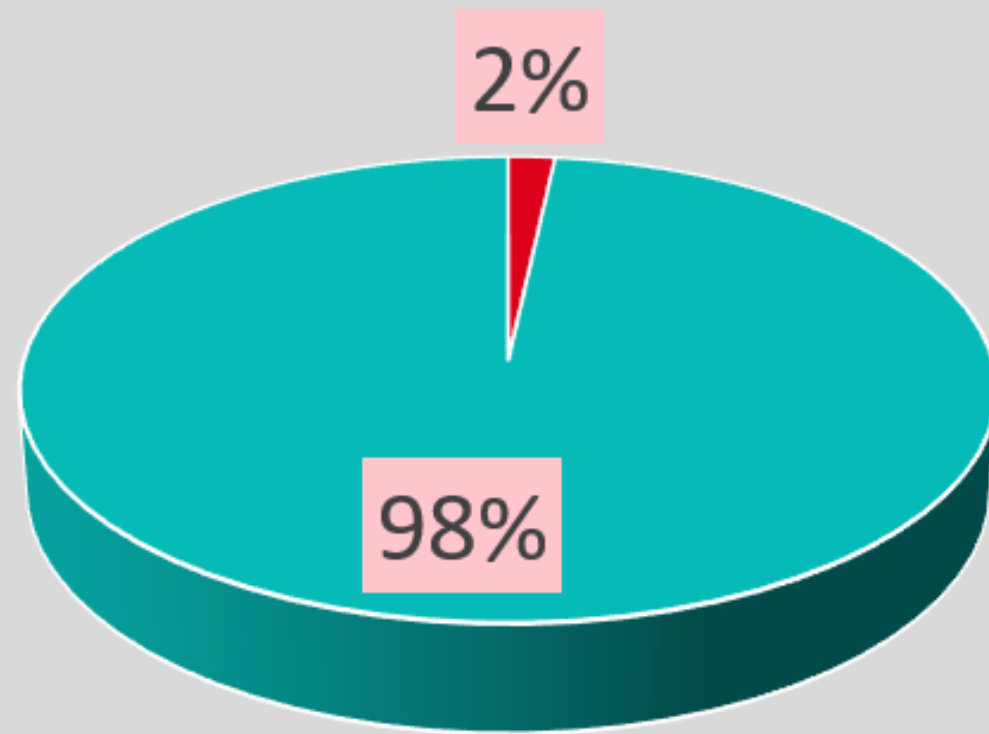
Lilongwe, Malawi

Country profile

Population: 1.4 million

204 ART clinics

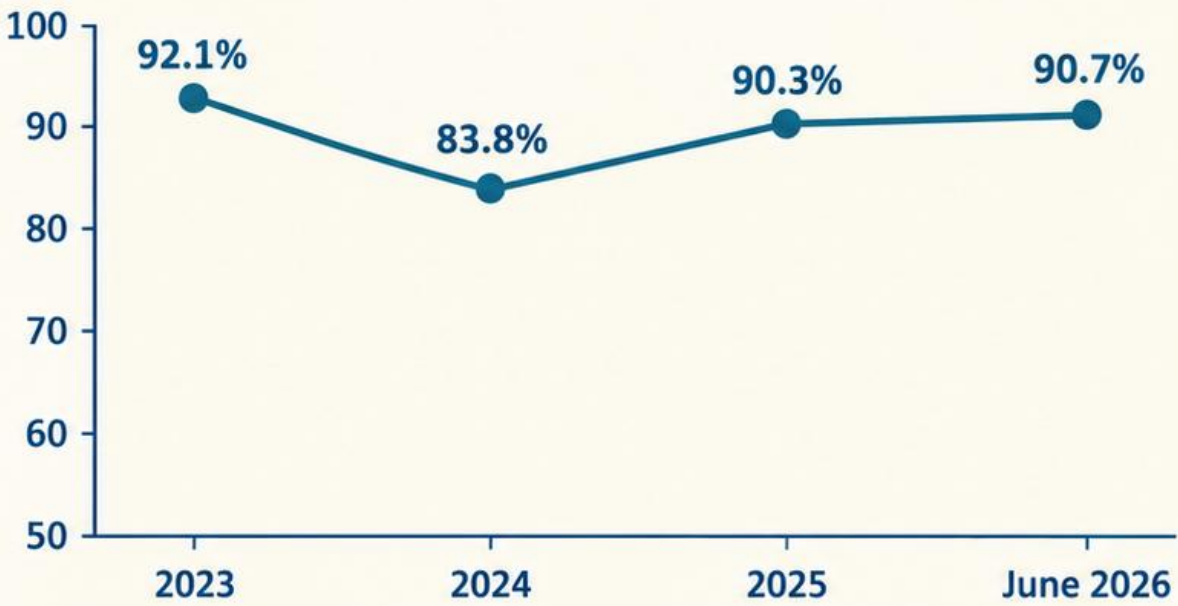
213 416 people on ART



■ 0-14yrs ■ 15+ yrs

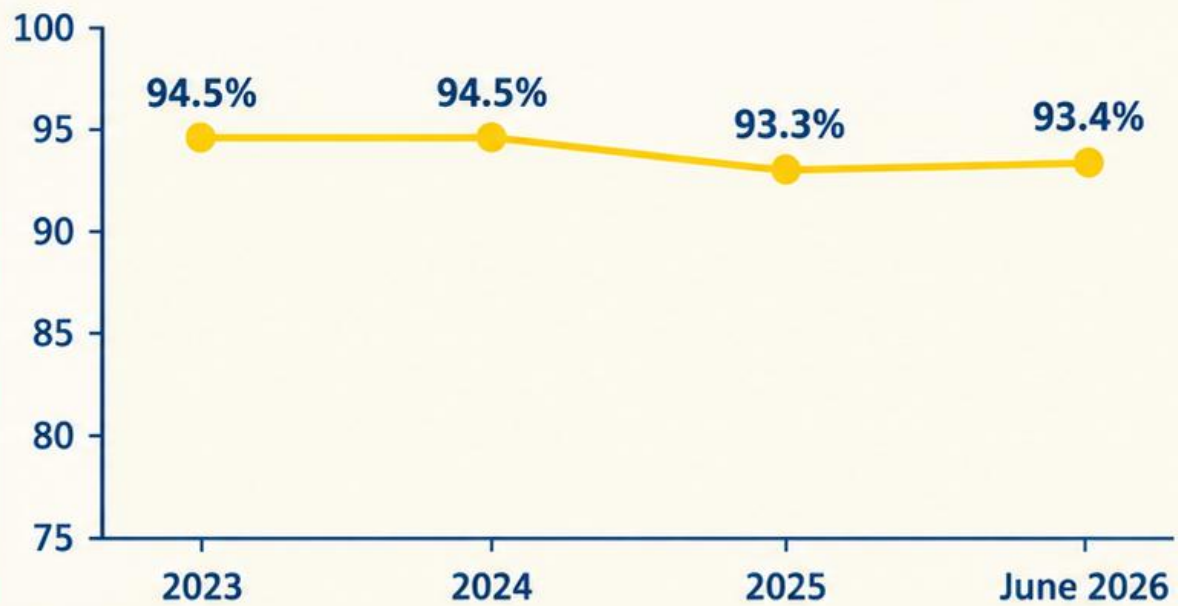
VLC and VLS trend in CALHIV

Viral Load Coverage (%)



	2023	2024	2025	June 2026
On ART	5,636	4,867	4,074	3,785
Done viral load	5,190	4,078	3,679	3,434

Viral Load Suppression (%)



	2023	2024	2025	June 2026
Suppressed VL	4,907	3,853	3,434	3,206



IAS **1st line regimen in CALHIV**

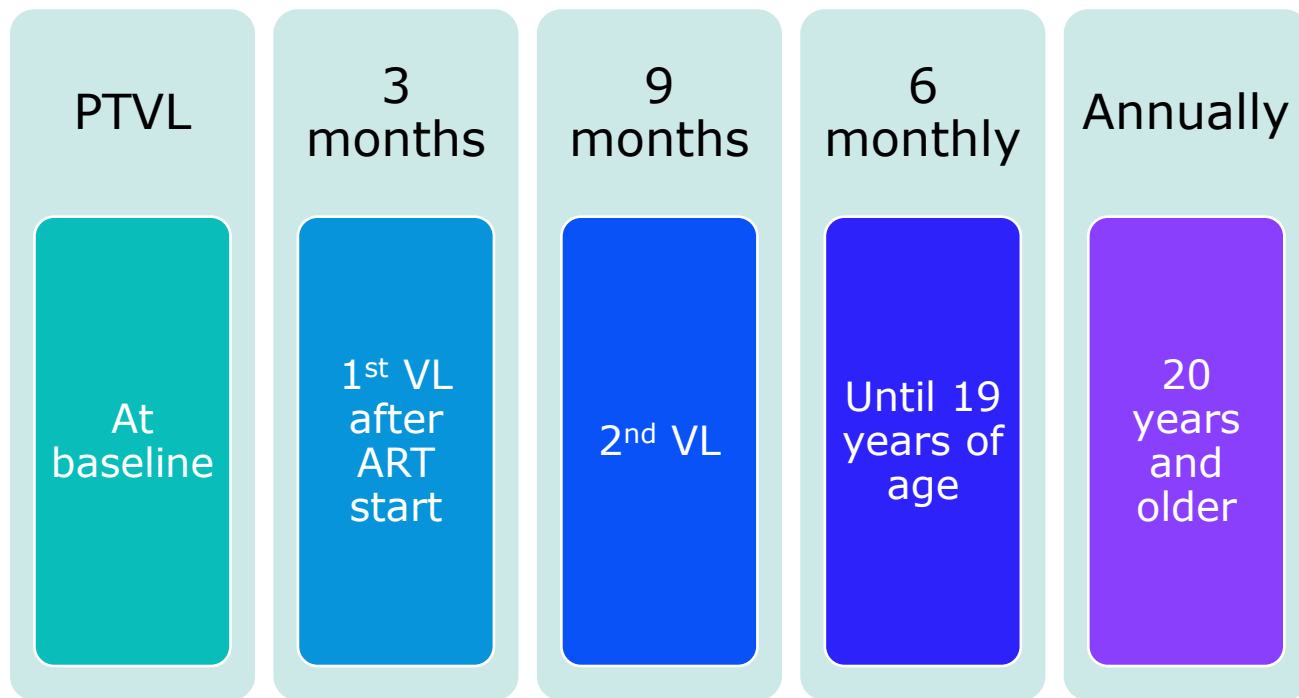
PRINCIPLES

1. Use most potent non NNRTI regimen 1st
2. Use most palatable formulation
3. Reduce pill burden

Recommended 1st line regimens for newly initiating ART

Age	< 4 weeks	> 4 weeks		
Weight/Age	<3 kg	≥ 3 – 24.9 kg	25 – 29.9 kg	≥ 30 kg
Regimen	ABC/3TC 120/60 mg + pDTG 10 mg	ABC + 3TC + DTG (pALD) 60/30/5 mg	ABC/3TC 600/300 mg + DTG 50 mg	TDF + 3TC + DTG
Special considerations	Preterm neonates: AZT/3TC/NVP holding regimen Use FDCs where possible Consult paediatrician for preterm babies			

VL schedule in CALHIV on ART



<50: undetectable
50 – 199: suppressed VL
200 – 999: Low level viraemia
≥1000: High viral load

Strategies to improve VLC

LABORATORY SYSTEM UPGRADES

- Minilabs in primary care facilities
- Phlebotomists absorbed by government
- Laboratory network optimisation with shorter sample routes
- LIS-CMIS integration
- Real time lab results access
- Near POC-VL introduction
- DBS-VL to Plasma separation cards
- Tracking utilisation of VL results by facilities

DATA & ACCOUNTABILITY

- CMIS updates and expansion to 88% ART sites
- Facility dashboards to identify gaps and directed follow up
- Line list clients who missed VL
- Facility and subnational data reviews
- Quarterly national data reviews
 - VLC and VLS monitoring by priority population

WHO GUIDELINE ADOPTION

- Routine VL monitoring for all adopted in 2016 and fully scaled up in 2017
- PTVL and VL testing from 3 months since 2025



Strategies used to attain and sustain viral suppression

Treatment access

- Test and start - 2016
- PHC and community decentralization
- Guideline concordant regimens
- Darunavir access expansion – New Horizons
- Paeds friendly formulations: DTG- 2019, 2021 (pDTG), 2025 (pALD)
- TAF in 2027
- NEW: client should receive full package of care even if they present to a facility as a visitor

HIVDR prevention & management

- National HIVDR clinical expert committee
- Genotype & VL guided regimen optimisation
- MDT clinical case discussions
- Expanded HIVDR genotype access to all DTG/PI Virologic failure
- Decentralized 3rd line (New Horizons)
- HVL clinics

Adherence and Retention

- Align PNC visits to ART refills for MBP in 1st 2 years of life
- MMD from 2 years
- Adherence support for all detectable VL
- Peer support for teens (CATS, Teen clubs) case management and community tracing improved retention
- Adolescent-friendly approaches improved acceptability.
- Caregiver treatment literacy
- Escalation of complicated clients to social

HSS

- Weight and age band focused quantification and forecasting
- HCW capacity building
- Data driven mentorship

National averages hide paediatric gaps – disaggregate by age groups and priority populations

Close the bottlenecks to VL access – phlebotomy, specimen transport, return of results

Regimen optimization – weight-based forecasting reduces stock outs

Psychosocial support – use peer, caregiver and HCWs to support ART services and improve self care

Close the HVL loop – high VLC without action doesn't improve outcomes

Simplify services for children and adolescents



IAS

Recommendations for countries seeking to improve paediatric and adolescent VLS

Define the cascade

- Count children due for VL, sampled, with results returned, with elevated VL, retested and appropriately switched.

Plan the ART transition

- Forecast each weight band, train teams in dosing and administration, and monitor supply at facility level.

Design for infants

- Equip phlebotomy teams; use DBS or point-of-care VL where each has a clear practical advantage. Preferred high-barrier regimens, child-friendly formulations

Assign results ownership

- Use named staff as case managers, create line lists, recall families/clients and track every repeat test until VLS

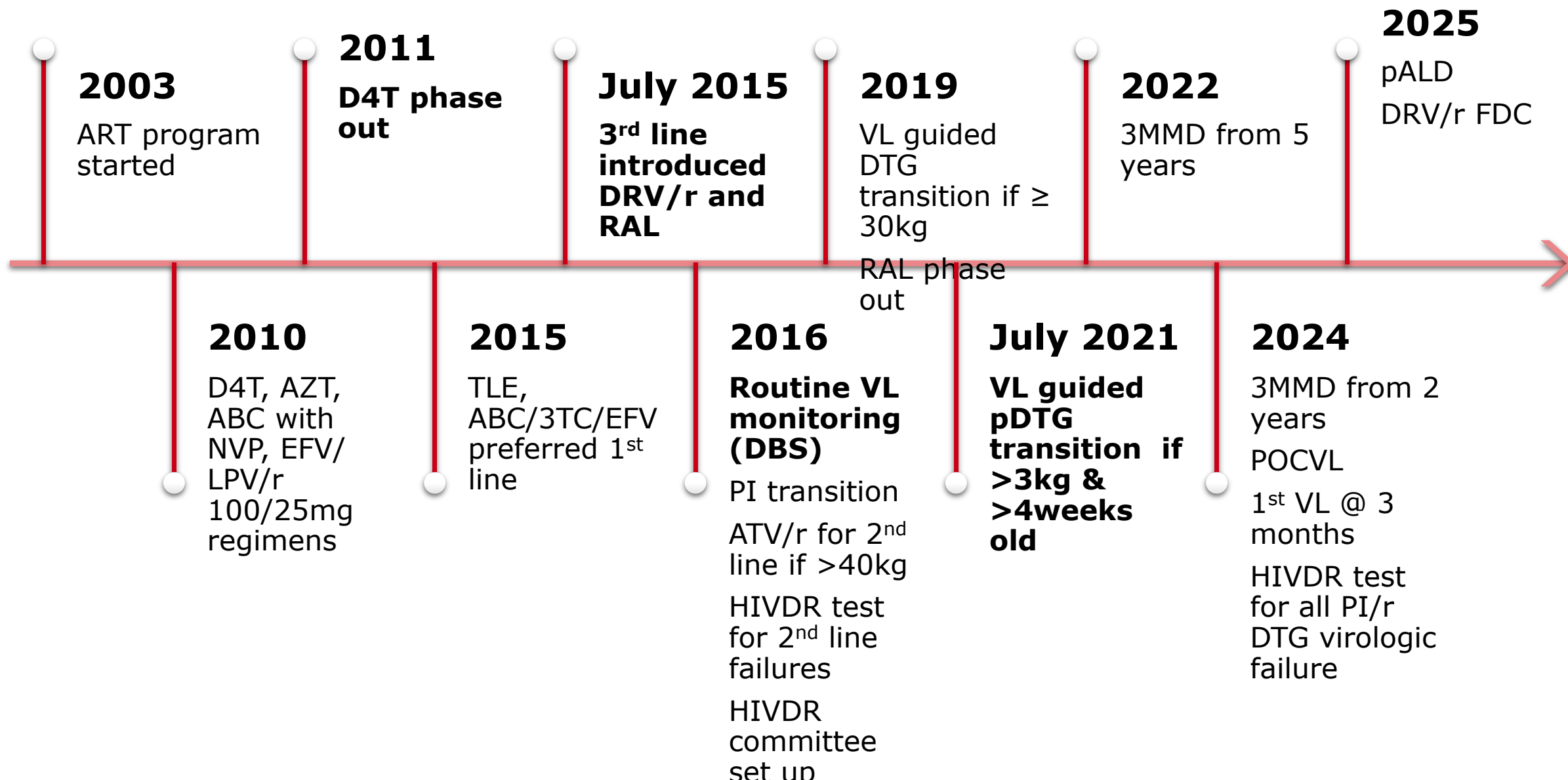
Escalate persistent viraemia

- Offer structured adherence support, multidisciplinary review and genotype-guided care when indicated

M&E

- Manage with a small action-oriented indicator set. Review outcomes by age and facility, then test focused quality-improvement changes.

Major milestones



Acknowledging our stakeholders

Roles overlapped, but the Ministry of Health provided the policy and service-delivery backbone.



POLICY & STEWARDSHIP

MOH / ENAP • NERCHA • WHO

SPECIALIST PAEDIATRIC CARE

Baylor • EGPAF

SERVICE QUALITY & CQI

URC • Georgetown • PEPFAR partners • Chemonics

EVIDENCE & DATA

ICAP • Data.FI • SHIMS/PHIA partners

FACILITY & COMMUNITY DELIVERY

Nazarene institutions • Good Shepherd • faith-based and local providers

BROADER SUPPORT NETWORK

Community, OVC, prevention and outreach partners, ROCs

And that's where I will stop,
before I start
making things up.

Thank you

Questions welcome