

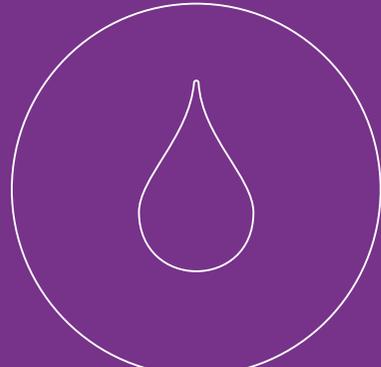


IPPF COMPREHENSIVE HIV SERVICES PACKAGE

PREVENTION



TESTING



TREATMENT
& CARE



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A COMPREHENSIVE APPROACH ALONG THE PREVENTION TO CARE CONTINUUM

A comprehensive approach to sexual and reproductive health and rights (SRHR) requires the inclusion of HIV. The Guttmacher-Lancet Commission on SRHR (2018) recommends that an essential package of sexual and reproductive health (SRH) interventions includes the prevention and treatment of HIV and other sexually transmitted infections (STIs).

Within IPPF's Integrated Package of Essential Services (IPES), HIV is included as one of the eight SRH service components to be available at all service delivery points. At a minimum, this should include the availability of HIV counselling and testing, along with the provision of condoms.

The continuum of HIV services and retention cascade provides a useful framework for implementation (see Figure 1). A comprehensive package of HIV services requires elements across the full continuum, including prevention, testing, treatment and care:

- **PREVENTION** – HIV prevention is an integral part of a comprehensive package. A combination prevention approach should be promoted, which recognizes that any one prevention intervention does not and cannot work in isolation. Primary prevention of HIV, other STIs, and unintended pregnancies are critical to the HIV response.
- **TESTING** – HIV testing services are at the core of a comprehensive package of HIV services. HIV testing is the essential first step in enabling an individual to know their own HIV status, and is a critical entry point to facilitate access to and uptake of appropriate HIV prevention, treatment and care services, and other SRH information and services.

- **TREATMENT AND CARE** – Following an HIV diagnosis, a package of treatment and care services is required for all people living with HIV, including access to antiretroviral therapy, to prevent individual disease progression and the onward transmission of HIV. As more people start and stay on HIV treatment, preventing and managing comorbidities, addressing mental health, and providing chronic care are increasingly important services.

IPPF Member Associations should provide and enable services across the entire continuum of services for preventing and diagnosing HIV infection, and for providing treatment and care for people living with HIV. The aim of the continuum is to reach those who are HIV negative with prevention interventions to support them to stay negative over time, and to diagnose, link and retain those living with HIV into treatment and care for sustained viral suppression.

Improving people's quality of life and wellbeing across this continuum is also of paramount importance. Service providers should be aware of the different needs of individuals from specific groups or communities, and be able to provide tailored, integrated, and client-centred services.

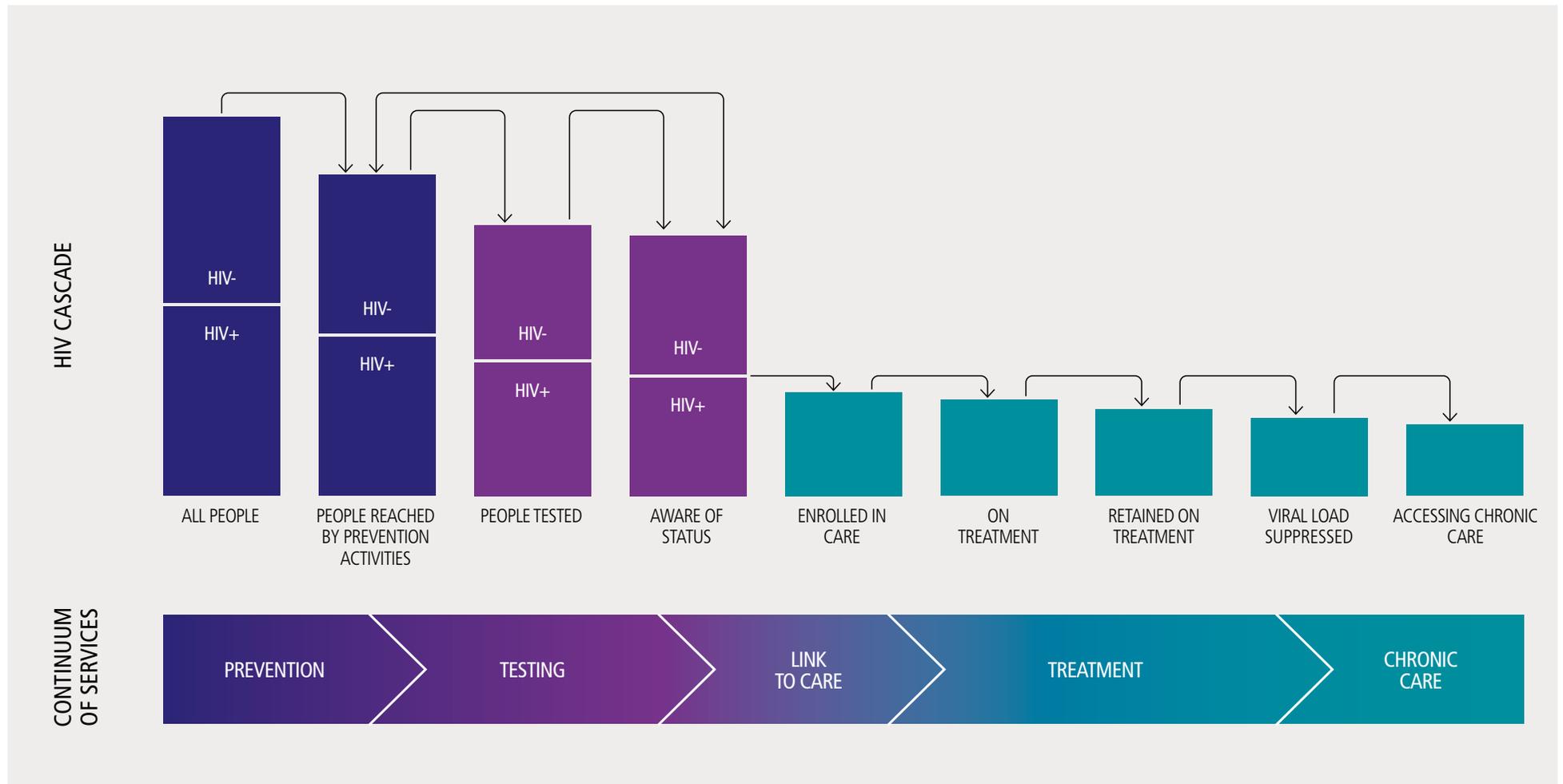
Individuals from the following groups or communities are at higher risk of acquiring HIV:

- **KEY POPULATIONS**, defined as groups who, due to specific higher-risk behaviours, are at increased risk of HIV irrespective of epidemic type or local context, and who also often face legal and social issues related to their behaviours that increase their vulnerability to HIV. Key populations include men who have sex with men (MSM), people who use or inject drugs, people in prisons and other closed settings, sex workers and their clients, and transgender people.
- **VULNERABLE POPULATIONS**, defined as groups of people who are particularly vulnerable to HIV infection in certain situations or contexts. These may include adolescents and young people, people with disabilities, refugees and other displaced people, survivors of sexual violence, and those who are unable to afford services.
- **PREGNANT AND BREASTFEEDING WOMEN** are potentially at risk of having or acquiring HIV if they live in a generalized HIV epidemic setting, are in a serodiscordant relationship, or are from a key population group.
- **PEOPLE IN SERODISCORDANT SEXUAL RELATIONSHIPS** where there is a high risk of transmission to the HIV-negative partner from the HIV-positive partner.

An emphasis on the full continuum is required to meet the UNAIDS fast-track targets by 2030:

- 95% of people living with HIV know their status
- 95% of people living with HIV who know their status are receiving treatment
- 95% of people on treatment have suppressed viral loads

In order to achieve these targets, additional emphasis is required to ensure access to combination HIV prevention options and sexual and reproductive health services, especially among adolescents and young people in high-prevalence countries, and key populations through a rights-based, people-centred approach.

FIGURE 1. THE CONTINUUM OF HIV SERVICES AND RETENTION CASCADE

Adapted from WHO's *Global health sector strategy on HIV, 2016–2021*

IPPF COMPREHENSIVE HIV SERVICES PACKAGE

Within the previous IPPF Strategic Framework 2005-2015, one of the Global Indicators was the proportion of Member Associations providing at least six out of nine services along the HIV prevention-to-care continuum. This was a successful strategy with 64 percent of Member Associations reporting at least six services by 2012. The nine recommended services included in the package were:

- Behaviour change communication (BCC), condom distribution, sexually transmitted infection (STI) management, voluntary counselling and testing (VCT), psychosocial support, prevention of mother-to-child transmission (PMTCT), treatment of opportunistic infections (OI), antiretroviral treatment, and palliative care.

With new evidence and updated global guidelines, this service package needed to be reviewed and updated to be relevant for IPPF for 2020 and beyond. As outlined in Table 1, the updated nine recommended service components for HIV prevention, testing, treatment and care includes:

- Condoms & lubricants, sexually transmitted infections (STIs), risk reduction, ARV-based prevention, HIV testing services, linkage to care and support, prevention of perinatal transmission, antiretroviral therapy (ART), and coinfections & comorbidities.

This guidance is designed for use by IPPF Member Associations to strengthen and define a comprehensive package of services for HIV prevention, testing, treatment and care. In collaboration with communities and key stakeholders, it is recommended that this package be periodically reviewed in light of changing epidemics, and new knowledge and innovation. It is also important to consider criteria including: effectiveness, cost, cost-effectiveness, acceptability, feasibility, relevance, demand, and ethics.

This guide specifically focusses on services with the aim to give updated information on the essential elements of a comprehensive HIV service package without providing in-depth detail. Where possible, links to useful and up-to-date resources and guidelines are provided for further details. It also is not meant to cover every intervention that could be useful in a comprehensive response to HIV, as elements of community empowerment, addressing stigma and discrimination, and service delivery approaches are not included in this guidance.

The success of HIV prevention, testing, treatment and care programmes depends, in large part, on the creation of an enabling environment where individuals live free from stigma and discrimination; and have the capacity, skills, and opportunities to meaningfully make the decisions that affect their sexual and reproductive lives and wellbeing. An enabling environment facilitates behaviour change to reduce HIV transmission and promotes the quality of life for people living with HIV and their families.

TABLE 1. IPPF COMPREHENSIVE HIV SERVICES PACKAGE

| PREVENTION | | | | TESTING | TREATMENT AND CARE | | | |
|---|--|--|--|---|---|---|---|--|
| CONDOMS & LUBRICANTS | SEXUALLY TRANSMITTED INFECTIONS | RISK REDUCTION | ARV-BASED PREVENTION | HIV TESTING SERVICES | LINKAGE TO CARE & SUPPORT | PREVENTION OF PERINATAL TRANSMISSION | ANTIRETROVIRAL THERAPY | COINFECTIONS & COMORBIDITIES |
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| <ul style="list-style-type: none"> • Promotion of condoms • Provision of condom-compatible lubricants | <ul style="list-style-type: none"> • Screening and management of STIs • Screening and management of other infections | <ul style="list-style-type: none"> • Risk reduction information and counselling • Sexual & gender-based violence screening and prevention • Harm reduction for people who use drugs • Voluntary medical male circumcision (VMMC) | <ul style="list-style-type: none"> • Pre-exposure prophylaxis (PrEP) • Post-exposure prophylaxis (PEP) | <ul style="list-style-type: none"> • Pre-test information • HIV diagnostic testing • Post-test counselling • Partner notification and testing | <ul style="list-style-type: none"> • Post-diagnosis counselling and support • CD4 cell count testing • Positive prevention communication and counselling | <ul style="list-style-type: none"> • Primary prevention • Prevention of unintended pregnancies • Prevention of transmission to infants • Provision of treatment, care and support | <ul style="list-style-type: none"> • ART initiation, support and counselling • Viral load monitoring • Adherence and retention support | <ul style="list-style-type: none"> • Assessment and management of common coinfections • Screening and management of STIs including viral hepatitis and HPV • Assessment and management of communicable diseases |

LINKAGES TO IPPF'S INTEGRATED PACKAGE OF ESSENTIAL SERVICES (IPES)

IPES is a package of services which addresses the client's minimum SRH needs that IPPF has committed to deliver. In addition to HIV, this package includes: *counselling, contraception, safe abortion care, STIs, HIV, gynaecology & reproductive health, obstetrics & prenatal*

care, and sexual & gender-based violence. All components are key entry points to comprehensive HIV services, and HIV services are a key entry point to all IPES components and comprehensive SRH services (see Table 2).

TABLE 2. POSSIBLE ENTRY POINTS TO THE COMPREHENSIVE HIV SERVICES PACKAGE FROM INDIVIDUAL IPES COMPONENTS

|  COUNSELLING |  CONTRACEPTION |  SAFE ABORTION CARE |  SEXUALLY TRANSMITTED INFECTIONS |  GYNAECOLOGY & REPRODUCTIVE HEALTH |  OBSTETRICS & PRENATAL CARE |  SEXUAL & GENDER-BASED VIOLENCE |
|--|--|---|--|---|--|--|
| <ul style="list-style-type: none"> • HIV testing services • STI screening and management • HIV prevention information risk reduction counselling • Additional counselling related to sexuality/ HIV status | <ul style="list-style-type: none"> • HIV testing services • STI screening and management • Condom promotion for prevention of HIV and other STIs • Pre-exposure prophylaxis (PrEP) • Prevention of perinatal HIV transmission | <ul style="list-style-type: none"> • HIV testing services • STI screening and management • Prevention of perinatal HIV transmission • Sexual and gender-based violence screening and prevention | <ul style="list-style-type: none"> • HIV testing services • Condom promotion for prevention of HIV and other STIs • Pre-exposure prophylaxis (PrEP) • Screening and management of other infections | <ul style="list-style-type: none"> • HIV testing services • STI screening and management • Pre-exposure prophylaxis (PrEP) • Voluntary medical male circumcision (VMMC) | <ul style="list-style-type: none"> • HIV testing services • Prevention of perinatal HIV transmission • STI screening and management | <ul style="list-style-type: none"> • HIV testing services • STI screening and management • Post exposure prophylaxis (PEP) • Additional counselling/trauma |

PRIORITY ACTIONS FOR INTEGRATING HIV WITHIN SRH SERVICES

Following the recent Evidence for Contraceptive Options and HIV Outcomes (ECHO) Study, the WHO calls for urgent action to expand HIV prevention, STI services, and contraceptive choices in the broader context of providing SRH services. This requires differentiated approaches for settings with low, medium, high, and extremely high HIV prevalence (see Table 3).

The most urgent need for more effective integration of HIV and STI prevention is in areas with the highest HIV incidence. In these settings, the following key actions should be considered, especially among adolescent girls and women at high risk of acquiring HIV who access contraceptive or other SRH services:

- **HIV prevention options**, including counselling, male and female condoms with lubricants, and pre-exposure prophylaxis (PrEP);
- **Symptomatic STI diagnosis and treatment**, targeted STI screening (when etiological diagnosis for syphilis, chlamydia and gonorrhoea are feasible) and treatment of asymptomatic women with infections, and partner notification and management when feasible;

- **HIV testing with linkage to ART services** for women who are diagnosed with HIV. Offering HIV self-testing to women as they wait for contraception services can be considered;
- **Voluntary assisted partner testing services** that could include, for example, offering clients HIV self-tests for their sexual partners. Follow-up services for partners could include prevention counselling, information about and referral for VMMC, referral for ART, and partner testing and treatment for STIs.

In settings with low or medium levels of HIV incidence, HIV prevention choices within contraceptive services remain critical for women at higher risk of HIV. In all settings, STI prevention, treatment, and management services need to be scaled up and strengthened.

Ensuring contraceptive and other SRH services are inclusive and acceptable to women from key populations, including sex workers and women who use drugs, is critically important in all settings.

TABLE 3. DIFFERENTIATED APPROACHES TO INTEGRATING HIV SERVICES INTO CONTRACEPTIVE SERVICES, BY HIV PREVALENCE

| OFFER AS PART OF CONTRACEPTIVE AND SRH SERVICE DELIVERY | | HIV PREVALENCE AMONG ADULT WOMEN | | | |
|---|--|---|---|---|-----------------------|
| | | LOW (<1%) | MEDIUM (1-5%) | HIGH (5-20%) | EXTREMELY HIGH (>20%) |
| 1 CONDOMS & LUBRICANTS | Male and female condoms and lubricant | YES | YES | YES | YES |
| | Condom promotion & skills building | YES Focused offer | YES Routine offer | YES Routine offer | YES Routine offer |
| 2 SEXUALLY TRANSMITTED INFECTIONS | STI risk assessment | YES Focused offer (routine offer if high STI prevalence) | YES Focused offer (routine offer if high STI prevalence) | YES Routine offer | YES Routine offer |
| | STI diagnosis & treatment of symptomatic clients (including partners) | YES | YES | YES | YES |
| | STI diagnosis & treatment of asymptomatic clients (including partners) | Focus on key populations | Focus on key populations | YES Focused offer (routine offer if high STI prevalence) | YES Routine offer |
| 3 RISK REDUCTION | HIV risk assessment | YES Focused offer | YES Routine offer | YES Routine offer | YES Routine offer |
| | HIV prevention & risk reduction counselling | YES Focused offer | YES Routine offer | YES Routine offer | YES Routine offer |
| 4 ARV-BASED PREVENTION | Pre-exposure prophylaxis | Focus on key populations (referrals for clients at higher risk) | Focus on key populations (referrals for clients at higher risk) | Yes Focused offer | YES Routine offer |
| 5 HIV TESTING SERVICES | HIV testing services (including self-test) | YES Focused offer | YES Focused offer | YES Routine offer | YES Routine offer |
| | Partner HIV testing (e.g. invitation letter + self-test) | Referrals for partners of HIV-positive clients | Referrals for partners of HIV-positive clients | YES Routine offer | YES Routine offer |
| 6 LINKAGE TO CARE & SUPPORT | ART | YES | YES | YES | YES |

Focused offer service available and known to clients; active offer made to key populations or with an HIV-positive partner

Routine offer service offered to all clients and provided with informed choice and consent

Adapted from WHO (2020) *Actions for improved clinical prevention services and choices: Preventing HIV and other sexually transmitted infections among women and girls using contraceptive services in contexts with high HIV incidence.*

| HIV SERVICE AREA | KEY DETAILS AND ACTIVITIES | RELATED GUIDELINES AND RESOURCES |
|--|---|--|
| PREVENTION | | |
| <p data-bbox="159 276 248 408">1</p> <p data-bbox="159 432 327 491">CONDOMS & LUBRICANTS</p> <p data-bbox="159 520 383 895">The correct and consistent use of condoms with condom-compatible lubricants is recommended to prevent sexual transmission of HIV and other STIs, and unintended pregnancies.</p> | <p data-bbox="421 264 1061 293">Promotion and provision of condoms and lubricants</p> <p data-bbox="421 320 1458 419">Correct and consistent use of male (external) and female (internal) condoms significantly reduces the sexual transmission of HIV. Condom use also reduces the risk of acquiring other sexually transmitted infections (STIs) and reduces the risk of unintended pregnancies.</p> <p data-bbox="421 443 1379 472">Many different kinds and brands of condoms are available. They differ in such qualities as:</p> <ul data-bbox="421 483 1379 715" style="list-style-type: none"> • Material (latex/natural rubber, polyurethane, polyisoprene, nitrile polymer/synthetic rubber) • Size (small/slim/snug, regular/medium, large, extra-large) • Thickness (ultra-thin to standard) • Texture (smooth, textured, or ribbed surface) • Colour (opaque, transparent, various colours) • Fragrance and flavour (a variety of scents or tastes, or non-flavoured/regular) <p data-bbox="421 751 1458 887">Female (internal) condoms are an alternative to male (external) condoms. Instead of going on the penis, they go inside the vagina. They can also be used inside the anus. Some people prefer to use a female (internal) condom as it means not having to rely on the insertive partner to wear a condom, or who find male (external) condoms too restrictive.</p> <p data-bbox="421 911 1442 1046">The use of condom-compatible lubricants (water- or silicone-based) helps to prevent male condoms from breaking and slipping, particularly during anal sex, and can increase comfort and pleasure for both partners during penetrative sex. Oil-based lubricants – such as moisturisers or lotions and Vaseline – damage latex and should not be used with latex condoms.</p> <p data-bbox="421 1070 1447 1273">Increasing the availability, accessibility, affordability and use of condoms and condom-compatible lubricants is an essential component of any comprehensive HIV service package, and a component of IPES. A variety of condoms, including various sizes, should be available at ALL service delivery points. Condom-compatible lubricant should also be available alongside both male (external) and female (internal) condoms and distributed in individual sachets or multi-use dispensers, such as bottles, pumps or tubes.</p> | <p data-bbox="1473 264 2011 435">Comprehensive condom programming: a guide for resource mobilization and country programming. UNFPA, 2011. http://www.unfpa.org/webdav/site/global/shared/documents/publications/2011/CCP.pdf.</p> <p data-bbox="1473 459 2074 560">Condom programming for HIV prevention: a manual for service providers. UNFPA, 2005. http://www.unfpa.org/public/global/pid/1291</p> <p data-bbox="1473 584 2056 716">Condom and lubricant programming in high HIV prevalence countries. UNAIDS, 2014. http://www.unaids.org/sites/default/files/media_asset/condoms_guidancenote_en.pdf</p> <p data-bbox="1473 740 2051 911">Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. WHO, 2016. https://apps.who.int/iris/bitstream/handle/10665/246200/9789241511124-eng.pdf?sequence=8</p> <p data-bbox="1473 935 2033 1067">Female condom: a powerful tool for protection. PATH/UNFPA, 2006. https://www.path.org/publications/files/RH_female_condom.pdf</p> <p data-bbox="1473 1091 2056 1224">Female condom, generic specification, prequalification and guidelines for procurement. UNFPA, 2012. https://www.who.int/reproductivehealth/publications/family_planning/femcondom/en/</p> <p data-bbox="1473 1248 2051 1380">Male latex condom specification, prequalification and guidelines for procurement. WHO, 2010. http://www.who.int/reproductivehealth/publications/family_planning/9789241599900/en/</p> |

| HIV SERVICE AREA | KEY DETAILS AND ACTIVITIES | RELATED GUIDELINES AND RESOURCES |
|--|--|---|
| PREVENTION | | |
| 1 CONDOMS & LUBRICANTS (CONTINUED) | <p>Promotion and provision of condoms and lubricants (continued)</p> <p>Healthcare providers can offer condoms to individual clients (e.g. 10 condoms per client) but should avoid making assumptions about who may benefit from information about condoms based on factors such as age or relationship status alone. Instead, all clients should be offered with information, condoms and lubricants, as needed. Counselling and the distribution of condoms and lubricants increases knowledge, develops skills and empowers clients to use condoms and lubricants correctly and consistently. This approach can be supplemented by peer-led and community-based approaches.</p> <p>Providing information to clients about how to use condoms correctly is critical. This can include demonstrating and practicing how to put on and take off condoms using models (e.g. vaginal, penile, anal) to make clients feel more confident about using condoms. Decisions about whether to use condoms during sex are usually made in the context of a specific interaction between two individuals. Navigating this interaction successfully can require communication skills, including confidence to discuss HIV risk with partners, to suggest and persuade condom use with partners, and to refuse sex they do not want, including when partners demand not using a condom.</p> | <p>Position statement on condoms and the prevention of HIV, other sexually transmitted infections and unintended pregnancy. UNFPA, WHO, UNAIDS, 2015. http://www.unaids.org/en/resources/presscentre/featurestories/2015/july/20150702_condoms_prevention#54</p> <p>Use and procurement of additional lubricants for male and female condoms: advisory note. WHO, 2012. http://apps.who.int/iris/bitstream/10665/76580/1/WHO_RHR_12.33_eng.pdf</p> <p>Rapid response: female condom use for men who have sex with men. Ontario HIV Treatment Network, 2013. http://www.ohtn.on.ca/Pages/Knowledge-Exchange/Rapid-Responses/Documents/RR74-Female-condoms.pdf</p> |

| HIV SERVICE AREA | KEY DETAILS AND ACTIVITIES | RELATED GUIDELINES AND RESOURCES |
|---|--|--|
| PREVENTION | | |
| <p data-bbox="161 274 271 408">2</p> <p data-bbox="161 432 394 523">SEXUALLY TRANSMITTED INFECTIONS (STIS)</p> <p data-bbox="161 603 394 807">Effective screening, diagnosis and treatment services for STIs and other infections are crucial for HIV prevention.</p> | <p data-bbox="423 264 857 293">Screening and management of STIs</p> <p data-bbox="423 320 1460 560">The epidemiological synergy between HIV and sexually transmitted infections (STIs) is well established, with the presence of a STI greatly increasing the risk of acquiring or transmitting HIV. With more than 30 different bacteria, viruses and parasites known to be transmitted through sexual contact, common STIs include: syphilis, gonorrhoea, chlamydia and trichomoniasis. These bacterial or protozoal infections are curable with treatment. Common viral infections in addition to HIV are: hepatitis B, herpes simplex virus (HSV), and human papillomavirus (HPV). Symptoms or disease due to incurable viral infections can be reduced or modified through treatment.</p> <p data-bbox="423 584 1440 715">The provision of basic STI services is an essential component of comprehensive HIV prevention services, and a key component within IPES. All clients should have access to acceptable, effective and high-quality STI services. This includes the management for both symptomatic and asymptomatic STIs.</p> <p data-bbox="423 738 1424 978">Provision of services to clients with STI symptoms should be a priority. Symptomatic STI clients may be aware they are infected and are more likely to seek care. The specific approach to the diagnosis and treatment should be based on national guidelines (where available). In resource-limited settings where reliable STI diagnostic testing is not feasible or available, a syndromic approach should be used. Common syndromes include: vaginal discharge, urethral discharge, genital ulcers, and abdominal pain. STIs that cause genital ulcers, like herpes and syphilis, can increase the risk of HIV acquisition three-fold or more.</p> <p data-bbox="423 1002 1453 1241">Clients must also be aware of the benefit of receiving STI testing even if they do not have symptoms or show signs of infection. Regular screening for asymptomatic infections among those most at risk, using laboratory tests is cost-effective given the high rates of STIs, and should be promoted amongst these groups. Many STIs, including chlamydia, gonorrhoea, hepatitis B, herpes, HIV and syphilis, can also be transmitted from mother-to-child during pregnancy and childbirth. All pregnant women should be tested for HIV, syphilis and hepatitis B, at least once during their pregnancy, and as early as possible.</p> | <p data-bbox="1478 264 2056 400">Consolidated guidelines on HIV testing services for a changing epidemic. WHO, 2019. https://www.who.int/publications-detail/consolidated-guidelines-on-hiv-testing-services-for-a-changing-epidemic</p> <p data-bbox="1478 424 2063 560">Guidelines for the prevention, care and treatment of persons with chronic hepatitis B infection. WHO, 2015. http://www.who.int/hiv/pub/hepatitis/hepatitis-b-guidelines/en/</p> <p data-bbox="1478 584 2063 719">Guidelines for the screening, care and treatment of persons with hepatitis C infection. WHO, 2014. http://apps.who.int/iris/bitstream/10665/111747/1/9789241548755_eng.pdf</p> <p data-bbox="1478 743 2063 839">Guidelines for the treatment of <i>Chlamydia trachomatis</i>. WHO, 2016. http://www.who.int/reproductivehealth/publications/rtis/chlamydia-treatment-guidelines/en/</p> <p data-bbox="1478 863 1995 999">Guidelines for the treatment of <i>Genital Herpes Simplex Virus</i>. WHO, 2016. http://www.who.int/reproductivehealth/publications/rtis/genital-HSV-treatment-guidelines/en/</p> <p data-bbox="1478 1023 2063 1118">Guidelines for the treatment of <i>Neisseria gonorrhoeae</i>. WHO, 2016. http://www.who.int/reproductivehealth/publications/rtis/gonorrhoea-treatment-guidelines/en/</p> <p data-bbox="1478 1142 2078 1278">Guidelines for the treatment of <i>Treponema pallidum</i> (syphilis). WHO, 2016. http://www.who.int/reproductivehealth/publications/rtis/syphilis-treatment-guidelines/en/</p> <p data-bbox="1478 1302 2051 1437">Guideline on syphilis screening and treatment for pregnant women. WHO, 2017. https://www.who.int/reproductivehealth/publications/rtis/syphilis-ANC-screenandtrat-guidelines/en/</p> |

| HIV SERVICE AREA | KEY DETAILS AND ACTIVITIES | RELATED GUIDELINES AND RESOURCES |
|---|---|---|
| <p>2 SEXUALLY TRANSMITTED INFECTIONS (CONTINUED)</p> | <p>Screening and management of STIs (continued)</p> <p>Serological tests are available for the laboratory diagnosis of syphilis, hepatitis B and hepatitis C. Diagnosis of chlamydia and gonorrhoea requires laboratory diagnosis through microscopy or NAAT/PCR (Nucleic Acid Amplification Test/Polymerase Chain Reaction) of either a urine sample or urethral/anorectal/pharyngeal swab. Etiological diagnosis of STIs (or diagnostic testing) is problematic in many settings due to the length of time it takes, the need for trained laboratory staff, resources required, and costs. Similar to HIV, rapid diagnostic tests (RDTs) are available for syphilis diagnosis, with option of a dual HIV/syphilis RDT available.</p> <p>Where laboratory diagnosis is available, laboratories should be staffed by qualified personnel with adequate training to perform technically demanding procedures, with quality assurance systems in place. Absence of diagnostic tests should not be a barrier to screening and treating clients for STIs. By performing genital and anorectal examination, it is possible to look for symptoms of STIs, including urethral discharge (often gonococcal or chlamydial infection) and genital ulcers (often syphilis, chancroid or genital herpes). These symptoms are harder to detect internally, and may require additional examination.</p> <p>Following a positive diagnosis of an STI, it is important to recommend that the client notify their sexual partners, where possible, so that they too can be tested and treated, if necessary. Partner notification can be active (where the facility contacts the partner) or passive (where the facility asks the clients to inform or bring their partners). This should be discussed with the client following a positive diagnosis, and support provided. Comprehensive management also includes the promotion and provision of condoms and condom-compatible lubricants, support for compliance with treatment, and risk reduction communication.</p> | <p>Information note on the use of dual HIV/syphilis rapid diagnostic tests (RDT). WHO, 2017. http://www.who.int/reproductivehealth/publications/rtis/dual-hiv-syphilis-diagnostic-tests/en/</p> <p>Laboratory diagnosis of sexually transmitted infections, including human immunodeficiency virus. WHO, 2013. http://www.who.int/reproductivehealth/publications/rtis/9789241505840/en/</p> <p>Partner notification for sexually transmissible infections. BASHH, 2013. http://www.bashh.org/documents/2012%20Partner%20Notification%20Statement.pdf</p> <p>Actions for improved clinical prevention services and choices: Preventing HIV and other sexually transmitted infections among women and girls using contraceptive services in contexts with high HIV incidence. WHO, 2020. https://www.unaids.org/en/resources/documents/2020/preventing-hiv-sti-among-women-girls-using-contraceptive-services</p> |

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|---|--|---|
| PREVENTION | | |
| <p>2 SEXUALLY TRANSMITTED INFECTIONS (CONTINUED)</p> | <p>Screening and management of other infections</p> <p>There are other common infections of the reproductive and urinary tract that are not usually sexually transmitted, but are also associated with an increased risk of acquiring and transmitting HIV. Two common infections include bacterial vaginosis (BV) and female genital schistosomiasis (FGS).</p> <p>Bacterial vaginosis (BV) is a condition which occurs when the normal balance of bacteria in the vagina becomes disrupted. This can result in an over-growth of certain bacteria, which can be accompanied by unpleasant symptoms. BV is a common condition and sometimes goes away by itself as the balance of bacteria in the vagina corrects itself. While it is not always necessary to have it treated, it can be easily treated with antibiotics (e.g. metronidazole).</p> <p>Female genital schistosomiasis (FGS) is a waterborne neglected tropical disease transmitted through skin contact with larvae in contaminated fresh water in more than 44 countries in sub-Saharan Africa. FGS causes open sores on the cervix and vagina, inflammation and bleeding. Women and girls with FGS have a three-time higher risk of acquiring HIV and two-times higher risk for HPV. FGS can be prevented by improving access to clean water and toilets, as well as basic hygiene practices like hand washing.</p> <p>FGS can be prevented and treated at low cost, through the use of anthelmintics (e.g. praziquantel). However, if left untreated it can lead to inflammatory lesions. Women who have been treated with praziquantel at least once before age 20 years are 50% less likely to develop FGS later in life.</p> <p>FGS remains largely underdiagnosed. Those who experience FGS symptoms (e.g. pelvic pain, vaginal discharge) are often misdiagnosed by healthcare workers who are not trained in diagnosing FGS.</p> | <p>Female genital schistosomiasis: a pocket atlas for clinical health-care professionals. WHO, 2015. https://www.who.int/schistosomiasis/resources/9789241509299/en/</p> <p>No more neglect: female genital schistosomiasis and HIV. UNAIDS, 2019. https://www.unaids.org/sites/default/files/media_asset/female_genital_schistosomiasis_and_hiv_en.pdf</p> <p>Sexually transmitted and other reproductive tract infections: a guide to essential practice. WHO, 2005. http://www.who.int/reproductivehealth/publications/rtis/9241592656/en</p> |

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| <p data-bbox="159 272 264 411">3</p> <p data-bbox="159 427 383 459">RISK REDUCTION</p> <p data-bbox="159 483 405 794">A package of behavioural and biomedical interventions can support risk reduction to prevent HIV transmission and increase uptake of services.</p> | <p data-bbox="421 263 994 295">Risk reduction communication and counselling</p> <p data-bbox="421 319 1397 523">To reduce the risk of acquiring HIV and other STIs, people must understand their risk and have the knowledge, skills and belief in their self-efficacy to reduce that risk. Risk reduction communication can provide information, motivation, education and skills-building to help individuals reduce higher risk behaviours and sustain this positive change. This can be delivered to individuals or groups. Counselling is a key component within IPES, with sex and sexuality-related and relationship counselling an essential service.</p> <p data-bbox="421 547 1442 821">Brief sexuality communication is one approach to promote sexual well-being where the service provider uses counselling skills to address sexuality and related personal or psychological issues, as well as to promote sexual well-being. One-to-one counselling may focus on awareness of personal risk and risk reduction strategies; for example, counsellors or community workers may discuss risk behaviours, relate a client's activities directly to HIV risk, and consider strategies to reduce this risk. Counselling should include decision-making skills about when to use various approaches and how to couple with other HIV prevention tools, such as condoms and pre-exposure prophylaxis (PrEP).</p> <p data-bbox="421 845 1442 1050">Service providers should be aware that some clients use adaptive strategies such as serosorting – where a person chooses a sexual partner known to be of the same HIV serostatus to reduce the risk of acquiring or transmitting HIV, or sero-positioning – a practice among MSM, where couples decide who will be the receptive or insertive partner based on their HIV status. Information should be provided about the benefits and risks, and service providers should make it clear that adaptive strategies are an approach to risk reduction, not risk elimination.</p> <p data-bbox="421 1074 1442 1380">Clients seeking contraceptive services should also be advised on how to minimize their risk of acquiring HIV and other STIs. Risk of HIV should not restrict contraceptive choices. According to revised MEC guidelines (2019), women at high risk of HIV acquisition are eligible to use all methods of contraception without restriction including progestogen-only pills (POPs); DMPA-IM and DMPA-SC, norethisterone enanthate (NET-EN) injectables; levonorgestrel (LNG) and etonogestrel (ETG) implants; Cu-IUDs and LNG-IUDs; and combined hormonal contraceptive methods, such as combined oral contraceptives (COCs), combined injectable contraceptives (CICs), combined contraceptive patches and combined vaginal rings. Only condoms provide combined protection from HIV, other STIs and unintended pregnancies.</p> | <p data-bbox="1478 263 2060 399">After the ECHO trial: expanding access and choice through integrated services. IPPF, 2019. https://www.ippf.org/sites/default/files/2019-10/After%20the%20ECHO%20trial%20-%20English.pdf</p> <p data-bbox="1478 422 2038 590">Brief sexuality-related communication: recommendations for a public health approach. WHO, 2015. http://www.who.int/reproductivehealth/publications/sexual_health/sexuality-related-communication/en/</p> <p data-bbox="1478 614 2038 750">Consolidated guideline on self-care interventions for health: sexual and reproductive health and rights. WHO, 2019. https://apps.who.int/iris/bitstream/handle/10665/325480/9789241550550-eng.pdf?ua=1</p> <p data-bbox="1478 774 2072 981">Contraceptive eligibility for women at high risk of HIV guidance statement – recommendations on contraceptive methods used by women at high risk of HIV. WHO, 2019. https://www.who.int/reproductivehealth/publications/contraceptive-eligibility-women-at-high-risk-of-HIV/en/</p> <p data-bbox="1478 1005 2049 1173">Risk reduction assessment, planning and support toolkit for HIV prevention. FHI 360, 2011. http://www.fhi360.org/sites/default/files/media/documents/Risk_Reduction_Assessment_Planning_and_Support_Toolkit_for_HIV_Prevention.pdf</p> <p data-bbox="1478 1197 2060 1436">Actions for improved clinical prevention services and choices: Preventing HIV and other sexually transmitted infections among women and girls using contraceptive services in contexts with high HIV incidence. WHO, 2020. https://www.unaids.org/en/resources/documents/2020/preventing-hiv-sti-among-women-girls-using-contraceptive-services</p> |

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| 3 RISK REDUCTION (CONTINUED) | <p>Sexual and gender-based violence screening and prevention</p> <p>The link between violence and HIV is bidirectional. Evidence suggests that sexual and gender-based violence (SGBV), including intimate partner violence, is associated with an increased risk of HIV and other STIs. At the same time, disclosure of an HIV-positive status can also trigger SGBV. SRH services, including HIV, serve as key entry points for identifying and responding to experiences of sexual and gender violence and trauma.</p> <p>SGBV takes many forms, and individuals who have experienced SGBV have an increased risk of HIV and other STIs, unintended pregnancies, gynaecological disorders, obstetric complications, and reduced uptake and use of contraceptives. Violence can also have an impact on individual's mental health and well-being, leading to conditions such as post-traumatic stress disorder (PTSD), depression, anxiety, substance use, self-harm. Survivors of SGBV may also face stigma and rejection from their community and family, further preventing them from accessing health services.</p> <p>The WHO suggests that service providers should be capable of offering care in four different areas:</p> <ul style="list-style-type: none"> • Immediate emotional/psychological health needs • Immediate physical health needs • Ongoing safety needs • Ongoing support and mental health needs <p>Sexual and gender-based violence is a key component within IPES, with the screening for gender-based violence and referral mechanisms both essential services. Service providers should consider screening for violence in order to offer relevant support. Providers should be especially aware of intimate partner violence and familial violence, homophobic and transphobic violence, or violence encountered through sex work and drug use.</p> <p>Service providers who address violence-related injuries should assess and facilitate access to post-exposure prophylaxis (PEP) for HIV and emergency contraception (EC) pills as soon as possible after unprotected intercourse. Other services include counselling, STI screening and treatment, hepatitis B immunization, testing for pregnancy and HIV. Referrals to legal services, where available and accessible, should also be made.</p> | <p>Gender-based violence quality assurance tool: standards for the provision of high quality post-violence care in health facilities. CDC/Jhpiego/PEPFAR/WHO, 2018. https://www.who.int/reproductivehealth/publications/post-violence-care-in-health-facilities/en/.</p> <p>Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook. WHO, 2014. http://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/</p> <p>Identifying violence against most-at-risk populations: a training manual for health providers. Futures Group, Health Policy Initiative, 2009. http://www.healthpolicyinitiative.com/Publications/Documents/1097_1_GBV_MARPs_Workshop_Manual_FINAL_4_27_10_acc.pdf</p> <p>Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. WHO, 2017. https://apps.who.int/iris/bitstream/handle/10665/259270/9789241550147-eng.pdf;jsessionid=F556CC8EE59E19528BC5FF82A2FB4D27?sequence=1</p> <p>Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. WHO, 2013. http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/</p> <p>Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: a manual for health managers. WHO, 2017. https://apps.who.int/iris/bitstream/handle/10665/259489/9789241513005-eng.pdf?sequence=1</p> |

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| 3 RISK REDUCTION (CONTINUED) | <p>Harm reduction for people who use drugs and their partners</p> <p>Harm reduction interventions for people who use drugs are an important component of HIV prevention. People who inject drugs (PWID), and their sexual partners are at risk of HIV as well as hepatitis B and C through the use and sharing of injecting equipment. In some settings, drug use may be more prevalent among people from other key populations groups, including sex workers and people living in closed settings. Women who use drugs are disproportionately affected by HIV and SGBV, and their SRH needs often go unaddressed.</p> <p>In addition to comprehensive SRH services, including HIV, a comprehensive package of interventions for people who use drugs includes the following interventions:</p> <ul style="list-style-type: none"> • Needle and syringe programmes (NSPs) • Opioid substitution therapy (OST) and other evidence-based drug dependence treatment • Provision of naloxone and training on overdose prevention for PWID community <p>To implement these recommendations, providers should be able to provide: access to clean needles and syringes (or refer clients to an NSP); access to and support with switching to OST such as oral methadone; counselling or psychosocial interventions about the risks of using opioids and other drugs and how to decrease or stop using them; and should be up to date with the emergency management of overdoses (i.e. providing naloxone and instructions for its use).</p> <p>Providers should be able to provide clients with harm reduction counselling and advice on safer injecting practices. Individuals who do not inject may also be at risk from HIV acquisition due to misuse of other substances such as alcohol, methylenedioxy-methamphetamine (MDMA), cocaine, and amyl nitrate; use of these substances lowers inhibitions and affects the ability to make safer choices. Some also have physiological factors that can facilitate transmission of HIV. Therefore, providers need to be aware of the full range of harm reduction services available locally and be able to make referrals that are appropriate for each individual client.</p> | <p>Addressing the specific needs of women who inject drugs: practical guide for service providers on gender-responsive HIV services. UNODC/INPUD, 2016. https://www.unodc.org/documents/hiv-aids/2016/Addressing_the_specific_needs_of_women_who_inject_drugs_Practical_guide_for_service_providers_on_gender-responsive_HIV_services.pdf</p> <p>Advancing the sexual and reproductive health and rights of women who use drugs: a guide for programmes. Frontline AIDS/WHRIN, 2020. https://frontlineaids.org/wp-content/uploads/2020/02/Guide-for-harm-reduction-programmes-FINAL-24Feb-WEB.pdf</p> <p>Comprehensive harm reduction package. WHO/EURO, 2012. http://www.euro.who.int/en/health-topics/communicable-diseases/hivaids/policy/policy-guidance-for-areas-of-intervention/harm-reduction</p> <p>Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. WHO, 2016. http://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/</p> <p>Drug facts. National Institute on Drug Abuse, 2016. https://www.drugabuse.gov/publications/finder/t/160/DrugFacts</p> |

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| 3 RISK REDUCTION (CONTINUED) | <p>Harm reduction for people who use drugs and their partners (continued)</p> <p>Screening and brief intervention (SBI) for alcohol-related problems within services can be an effective and efficient way to reduce alcohol consumption by hazardous and risky drinkers. Brief interventions are those practices that aim to identify a real or potential alcohol problem and motivate an individual to do something about it. These interventions are low in cost and have proven to be effective across the spectrum of alcohol problems. Harm reduction information can also help to reduce substance misuse and empower people to make safer and informed choices, especially among young people. This includes the provision of rights-based information with accurate facts to enable the understanding of risks related to using a specific substance. Harm reduction information also needs to be gender-sensitive to ensure addresses needs of women who use drugs.</p> | <p>Guidelines on community management of opioid overdose. WHO, 2014. https://www.who.int/substance_abuse/publications/management_opioid_overdose/en/</p> <p>HIV prevention, treatment, care and support for people who use stimulant drugs. WHO, 2019. https://www.who.int/hiv/pub/idu/hiv-prevention-treatment-for-people-use-drugs/en/</p> <p>International treatment standards for the treatment of drug use disorders. WHO/UNODC, 2020. https://www.unodc.org/documents/drug-prevention-and-treatment/UNODC-WHO_International_Treatment_Standards_March_2020.pdf</p> <p>Screening and brief intervention for alcohol problems in primary health care. WHO, 2001. http://www.who.int/substance_abuse/activities/sbi/en/</p> |

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| 3 RISK REDUCTION (CONTINUED) | <p>Voluntary medical male circumcision (*depends on geographical context)</p> <p>Voluntary medical male circumcision (VMMC) reduces the risk of female-to-male sexual transmission of HIV by approximately 60 per cent and is recommended by WHO as an additional HIV-prevention intervention for heterosexual men in 15 countries in eastern and southern Africa. These countries have high HIV prevalence and low male circumcision rates.</p> <p>Within these contexts, VMMC is recommended for uncircumcised men and boys who are at least 10 years old, with caution as some methods not suitable or at higher risk of adverse events for those under 15 years old. The integration of VMMC services for adolescent boys and men may also be required in other selected locations where severe localized, and largely heterosexual, HIV epidemics are occurring, or in the context of enhancing the safety of traditional male circumcision practices.</p> <p>As a key entry point, VMMC should be delivered as part of integrated SRH services for men and adolescent boys, and promoted alongside other HIV prevention methods including condoms. Circumcision only provides partial protection against female-to-male HIV infection, and does not adequately prevent HIV transmission to other partners.</p> <p>VMMC should be provided by trained medical professionals, who are competent to provide this service. All providers of VMMC should access approved training to ensure safety and quality in accordance with national guidelines. Some methods enable lower-cadre service providers to perform VMMC.</p> <p>The provider also has a role in giving information about VMMC and signposting clients to other services even if they cannot provide the surgical procedure at their facility. Accurate information about VMMC including risks and benefits of the procedure, must be provided to ensure fully informed consent prior to the procedure.</p> <p>Men who are already circumcised should be screened for possible adverse/dysfunction caused by procedure and provided with ongoing prevention messaging including use of condoms. VMMC is not recommended for men who have sex with men, as limited evidence of protective effect for anal intercourse. However, in settings where VMMC is being scaled up, men who have sex with men should not be excluded from these programmes.</p> | <p>Manual for male circumcision under local anaesthesia and HIV prevention services for adolescent boys and men. WHO, 2018. http://www.who.int/hiv/pub/malecircumcision/male-circumcision-guide-2018/en/</p> <p>A framework for voluntary medical male circumcision: Effective HIV prevention and a gateway to improved adolescent boys' & men's health in eastern and southern Africa by 2021 – policy brief. WHO, 2016. https://www.who.int/hiv/pub/malecircumcision/vmmc-policy-2016/en/</p> <p>Voluntary medical male circumcision for HIV prevention. WHO, 2012. http://www.who.int/hiv/topics/malecircumcision/fact-sheet/en/</p> <p>Tetanus and voluntary medical male circumcision: risk according to circumcision method and risk mitigation. WHO, 2016. https://www.who.int/hiv/pub/malecircumcision/tetanus-vmmc-report/en/</p> <p>Global sexual and reproductive health package for men and adolescent boys. UNFPA & IPPF, 2017. https://www.unfpa.org/publications/global-sexual-and-reproductive-health-package-men-and-adolescent-boys</p> |

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| <p data-bbox="159 276 286 408">4</p> <p data-bbox="159 432 327 491">ARV-BASED PREVENTION</p> <p data-bbox="159 520 398 794">Antiretroviral-based HIV prevention interventions should be available as additional prevention choices within a comprehensive HIV prevention package.</p> | <p data-bbox="421 264 815 296">Pre-exposure prophylaxis (PrEP)</p> <p data-bbox="421 320 1458 523">Oral pre-exposure prophylaxis (PrEP) is an effective intervention that can prevent acquisition of HIV by those who anticipate being exposed to HIV, through the use of ARV medications. The most common regimen must be taken orally and should start at least one week prior to exposure. Unlike ART for people living with HIV, PrEP can be started and stopped as a person chooses, based on their anticipated exposure or choice of different prevention options. Current availability often depends on national guidelines.</p> <p data-bbox="421 547 1451 647">The WHO recommends that oral PrEP containing tenofovir disoproxil fumarate (TDF) should be offered as an additional prevention choice for individuals at substantial risk of HIV infection, and as part of a comprehensive package of HIV prevention services and approaches.</p> <p data-bbox="421 671 1447 807">The offer of oral PrEP should be based on individual assessment, rather than belonging to a specific population group. Offering PrEP should be a priority among serodiscordant heterosexual couples, men who have sex with men, sex workers, people who use drugs transgender women, and other populations with an HIV incidence of about 3 per 100 person-years or higher.</p> <p data-bbox="421 831 1453 1066">Clients may not know about PrEP and health providers should clearly explain its benefits, namely that it is highly effective and safe when taken and the great majority of PrEP users experience no side-effects. Service providers also have a responsibility to create opportunities for PrEP users to share their experiences and concerns. PrEP does not prevent other STIs or pregnancy, so it should be offered alongside other prevention methods like condoms, and other contraceptive methods, depending on the client's needs. PrEP is safe to take during pregnancy, or while using hormonal contraception.</p> <p data-bbox="421 1090 1400 1190">Where PrEP is not yet available, or is not available free of charge, those who choose to self-procure PrEP should be advised on how to take PrEP safely and should be assisted with access to monitoring services, such as renal function tests, where available.</p> <p data-bbox="421 1214 1417 1417">There are other methods of PrEP that are in various stages of clinical trials, including a long-acting injectable PrEP (cabotegravir), a vaginal ring (dapivirine), and a dual protection pill which combines PrEP and the oral contraceptive pill. Topical vaginal PrEP (tenofovir gel), has only demonstrated moderate effectiveness in preventing HIV acquisition, and no effectiveness among women with genital inflammation, which can affect up to a third of women.</p> | <p data-bbox="1473 264 2074 400">Access guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. WHO, 2015. http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en/</p> <p data-bbox="1473 424 2051 525">Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. WHO, 2016. http://www.who.int/hiv/pub/arv/arv-2016/en/</p> <p data-bbox="1473 549 2029 649">Pre-exposure prophylaxis: an introductory factsheet. AVAC, 2020. https://www.avac.org/resource/pre-exposure-prophylaxis-introductory-factsheet</p> <p data-bbox="1473 673 2069 774">Implementation tool for pre-exposure prophylaxis of HIV Infection. WHO, 2017. http://www.who.int/hiv/pub/prep/prep-implementation-tool/en/.</p> <p data-bbox="1473 798 2022 933">Policy brief on oral pre-exposure prophylaxis of HIV infection (PrEP). WHO, 2015. http://www.who.int/hiv/pub/prep/policy-brief-prep-2015/en/</p> <p data-bbox="1473 957 2040 1093">Technical update on pre-exposure prophylaxis (PrEP). WHO, 2015. http://www.who.int/hiv/pub/prep/prep-technical-update-2015/en/</p> <p data-bbox="1473 1117 2063 1351">Actions for improved clinical prevention services and choices: Preventing HIV and other sexually transmitted infections among women and girls using contraceptive services in contexts with high HIV incidence. WHO, 2020. https://www.unaids.org/en/resources/documents/2020/preventing-hiv-sti-among-women-girls-using-contraceptive-services</p> |

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| 4 ARV-BASED PREVENTION (CONTINUED) | <p>Post-exposure prophylaxis (PEP)</p> <p>Post-exposure prophylaxis (PEP) is currently the only method to reduce the risk of HIV infection in an individual who has been exposed to HIV, and should be available as part of a comprehensive package of HIV prevention services. The WHO recommends that PEP should be available to all eligible people on a voluntary basis after possible exposure to HIV.</p> <p>PEP is the use of antiretroviral medications as soon as possible after exposure to HIV (and within 72 hours) in order to significantly reduce the likelihood of HIV infection. PEP is often recommended in occupational settings when someone working in a healthcare setting is potentially exposed to material infected with HIV. Upon a risk assessment, it can also be given in non-occupational settings when someone is potentially exposed to HIV from sexual violence, sexual intercourse, or sharing injecting equipment for drug use.</p> <p>PEP consists of 2-3 antiretroviral medications taken for 28 days, and includes counselling, first aid care, HIV testing, and follow-up care. The WHO recommended PEP regimens for adults are tenofovir combined with either lamivudine (3TC) or emtricitabine (FTC), and ritonavir-boosted lopinavir (LPV/r), which are also recommended by WHO as preferred drugs for HIV treatment.</p> <p>Trained non-physicians, midwives, nurses, and other non-clinical healthcare providers can initiate and dispense ART medications for PEP. Clients should be made aware of the risks and benefits of PEP, including potential drug–drug interactions and possible side effects and toxicity, and verbal consent should be sought.</p> <p>Promoting adherence is critical to improving PEP completion rates, which are generally low in most populations and settings.</p> <p>Therefore, counselling and other adherence support measures are recommended. If available, offering pre-exposure prophylaxis (PrEP) after completion of the 28-day PEP course could be considered for people who present with repeated high risk behaviour or for repeat courses of PEP.</p> | <p>Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. WHO, 2016. http://www.who.int/hiv/pub/arv/arv-2016/en/</p> <p>Guidelines on post-exposure prophylaxis for HIV and the use of co-trimoxazole prophylaxis for HIV-related infections among adults, adolescents and children. WHO, 2014. http://www.who.int/hiv/pub/guidelines/arv2013/arvs2013supplement_dec2014/en/</p> <p>Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook. WHO, 2014. http://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/</p> <p>Post-exposure prophylaxis to prevent HIV infection: joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection. WHO, 2007. http://whqlibdoc.who.int/publications/2007/9789241596374_eng.pdf</p> <p>Post-exposure prophylaxis to prevent HIV infection: factsheet. WHO, 2014. http://www.who.int/hiv/topics/prophylaxis/info/en/</p> |

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| <p data-bbox="163 272 264 411">5</p> <p data-bbox="163 432 322 491">HIV TESTING SERVICES</p> <p data-bbox="163 520 405 794">HIV testing services should be routinely offered to all clients and refers to the full range of services that should be provided together with HIV testing.</p> | <p data-bbox="423 264 667 293">HIV testing services</p> <p data-bbox="423 320 1420 523">HIV testing services are at the core of the comprehensive package of HIV services, and an essential component of IPES. HIV testing is the essential first step in enabling people to know their HIV status, and is a critical entry point to HIV prevention, treatment and care services, and other sexual and reproductive health (SRH) services. In SRH settings, it is recommended that everyone be offered an HIV test if they do not know their HIV status, are pregnant, or are determined to be at on-going risk of HIV exposure.</p> <p data-bbox="423 550 1458 683">HIV testing services include a range of services that should be provided together with HIV testing – counselling (pre-test information and post-test counselling); linkage to appropriate HIV prevention, treatment and care services and other SRH and support services; and coordination with laboratory services to support quality assurance and the delivery of correct results.</p> <p data-bbox="423 710 1442 874">Providers should be aware that false-positive and false-negative results are possible with poor quality HIV tests. Only quality-assured diagnostics should be used (with quality-assurance both before and after the product is on the market), and they must be stored and used in accordance with the manufacturer’s instructions. To ensure an accurate diagnosis, it is also critical to follow recommended national testing strategies/algorithms.</p> <p data-bbox="423 901 1458 1066">A common testing strategy among clinics is to provide the initial test using a rapid diagnostic test (RDT). Those who have a reactive test (positive test result) are either directly referred to a government clinic for confirmation or are re-tested using another RDT or enzyme immunoassay (EIA) prior to referral. New guidance recommends a testing strategy which uses <i>three</i> consecutive reactive tests to provide a positive diagnosis.</p> <p data-bbox="423 1118 992 1147">Pre-test information and post-test counselling</p> <p data-bbox="423 1174 1413 1342">Counselling remains an essential component of HIV testing services with pre-test information and post-test counselling. Pre-test information and messaging can be provided in a group setting, but everyone should have the opportunity to ask questions in a private setting if they request it. Evidence suggests that peer-led and digital platforms, including short pre-recorded videos, are tools that can be considered for encouraging HTS uptake.</p> | <p data-bbox="1480 264 2056 400">Consolidated guidelines on HIV testing services for a changing epidemic. WHO, 2019. https://www.who.int/publications-detail/consolidated-guidelines-on-hiv-testing-services-for-a-changing-epidemic</p> <p data-bbox="1480 427 2056 563">Consolidated guideline on self-care interventions for health: sexual and reproductive health and rights. WHO, 2019. https://www.who.int/reproductivehealth/publications/self-care-interventions/en/</p> <p data-bbox="1480 587 2056 722">Consolidated guidelines on HIV testing services: 5Cs: consent, confidentiality, counselling, correct results and connection. WHO, 2015. http://who.int/hiv/pub/guidelines/hiv-testing-services/en/</p> <p data-bbox="1480 746 2002 946">Guidance on couples HIV testing and counselling including antiretroviral therapy for treatment and prevention in sero-discordant couples: recommendations for a public health approach. WHO, 2012. http://whqlibdoc.who.int/publications/2012/9789241501972_eng.pdf</p> <p data-bbox="1480 970 2056 1074">Guidelines on HIV self-testing and partner notification. WHO, 2016. http://www.who.int/hiv/pub/vct/hiv-self-testing-guidelines/en/</p> <p data-bbox="1480 1098 1962 1233">Guidance on provider-initiated HIV testing and counselling in health facilities. WHO, 2007. http://whqlibdoc.who.int/publications/2007/9789241595568_eng.pdf</p> <p data-bbox="1480 1257 2056 1393">HIV and adolescents: guidance for HIV testing and counselling and care for adolescents living with HIV. WHO, 2013. http://www.who.int/hiv/pub/guidelines/adolescents/en/</p> |

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| <p>5 HIV TESTING SERVICES (CONTINUED)</p> | <p>Pre-test information and post-test counselling (continued)</p> <p>All HIV testing must be accompanied by appropriate and high-quality post-test counselling, based on the specific HIV test result and HIV status reported. For those with a negative test result, post-test counselling offers a valuable opportunity to provide accurate risk reduction information relevant to the person tested in order to support staying HIV negative. Those who test HIV positive, may need more intensive counselling and follow-up to ensure enrolment in care and timely ART initiation. Voluntary assisted partner notification, for a client's sexual and injecting partners, should also be offered.</p> <p>Service delivery approaches</p> <p>HIV testing can be offered by a provider in a clinic or in a community-based setting, such as at a mobile clinic or a workplace. WHO also recommends that lay providers who are trained and supervised can independently conduct safe and effective HIV testing using RDTs. An oral fluid and/or blood specimen (saliva or finger-stick whole blood) will be required depending on the test, or combination of tests, used.</p> <p>HIV testing can be client-initiated 'voluntary counselling and testing' (VCT) – where a client attends specifically to seek an HIV test, or provider-initiated testing and counselling (PITC) – when the client attends for other SRH services, or broader health services, and the provider takes the opportunity to provide information on HIV and the importance of knowing one's HIV status, and offers HIV testing services.</p> <p>Countries offer couples HIV testing and counselling (CHTC), where a couple means two 'partners' in an ongoing sexual relationship, CHTC promotes mutual disclosure of HIV status and increases adoption of prevention measures, especially in the case of serodiscordant couples. Partner testing with mutual disclosure can be considered a form of CHTC, even though one partner has already been tested in advance (e.g. a pregnant woman who is tested during antenatal care, and then brings in partner for testing). The provider for CHTC should make clear that both HIV testing and post-test counselling can be provided individually, if either partner prefers, and that disclosure of HIV status to the other person is not required.</p> <p>WHO also recommends HIV self-testing (HIVST) as a safe, accurate and effective way to reach people who may not otherwise test. With HIVST, the person uses a simple rapid HIV test kit to collect their own specimen, perform the test and interpret their result, at a time and place convenient for them. Individuals with a reactive test result must seek further testing from a service provider. Following a negative self-test result, retesting is only necessary for those at ongoing risk and those reporting potential HIV exposure in the preceding 12 weeks.</p> | <p>Information note on the use of dual HIV/syphilis rapid diagnostic tests (RDT). WHO, 2017. http://www.who.int/reproductivehealth/publications/rtis/dual-hiv-syphilis-diagnostic-tests/en/</p> <p>Laboratory diagnosis of sexually transmitted infections, including human immunodeficiency virus. WHO, 2013. http://apps.who.int/iris/bitstream/10665/85343/1/9789241505840_eng.pdf</p> <p>Policy brief: WHO recommends HIV self-testing. WHO, 2016. http://www.who.int/hiv/pub/vct/who-recommends-hiv-self-testing/en/</p> <p>Policy brief: WHO recommends HIV testing by lay providers. WHO, 2016. http://www.who.int/hiv/pub/toolkits/policy-hiv-testing-by-lay-provider/en/</p> <p>Service delivery approaches to HIV testing and counselling (HTC): a strategic HTC policy framework. WHO, 2012. http://apps.who.int/iris/bitstream/10665/75206/1/9789241593877_eng.pdf</p> <p>Actions for improved clinical prevention services and choices: Preventing HIV and other sexually transmitted infections among women and girls using contraceptive services in contexts with high HIV incidence. WHO, 2020. https://www.unaids.org/en/resources/documents/2020/preventing-hiv-sti-among-women-girls-using-contraceptive-services</p> |

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| <p data-bbox="161 277 282 411">6</p> <p data-bbox="161 437 394 497">LINKAGE TO CARE & SUPPORT</p> <p data-bbox="161 523 403 759">A package of support interventions should be offered following an HIV diagnosis to ensure timely linkage to care for all people living with HIV.</p> | <p data-bbox="423 268 909 300">Post-diagnosis counselling and support</p> <p data-bbox="423 325 1458 529">A package of supportive interventions should be offered to clients as part of post-test counselling for a positive HIV diagnosis. Given the possible emotional impact of the diagnosis and the amount of information to discuss, a client may require repeated visits of counselling to cover all the areas. Depending on the client's readiness, appointments and referrals should be made as soon as possible to ensure timely linkage to treatment and care, so that this can be delivered effectively for all people living with HIV.</p> <p data-bbox="423 555 1442 791">All healthcare providers supporting people living with HIV should be prepared to signpost clients to community/peer-led support groups where possible. Information and counselling on disclosure of HIV status to partners, family members, friends and employers should be provided as and when needed, since each new disclosure may come with a risk of stigma, violence, and isolation. This is particularly important in countries or settings where disclosure of HIV status is criminalized. Interactions with healthcare providers must provide a safe, non-judgemental space for HIV-positive clients to talk freely.</p> <p data-bbox="423 817 1442 1021">Providers should be trained to detect signs of decline in mental health as clients come to terms with their diagnosis and the associated social impacts. Clients may have or develop mental health issues such as depression and anxiety (or dementia and cognitive dysfunction as part of disease progression) and may require referral. It is important to give mental and physical health needs equal weight and to identify interventions that can be easily integrated with other treatment and care services.</p> <p data-bbox="423 1046 1442 1181">Women are often more vulnerable to the impact of HIV due to gender inequality, discrimination, stigma, lack of equal access to good-quality healthcare and disproportionate vulnerability to violence. WHO recommends that for women living with HIV, interventions on self-efficacy and empowerment around SRHR should be provided to maximize their health and fulfil their rights.</p> <p data-bbox="423 1206 1442 1366">Integrated and comprehensive services provide the opportunity for patient-centred prevention, care and treatment for the possible emotional and mental health issues affecting people living with HIV. During successive contacts between provider and client, it is essential to have ongoing dialogue about the continued need to access other SRH services, including prevention and early detection of STIs, and avoidance of HIV transmission.</p> | <p data-bbox="1476 268 2047 440">Advancing the sexual and reproductive health and rights of people living with HIV: a guidance package. GNP+, 2010. http://srhhivlinkages.org/wp-content/uploads/2013/04/advancingsexualreproductivehealthhumanrightshiv_2009_en.pdf</p> <p data-bbox="1476 466 2018 600">Consolidated guideline on sexual and reproductive health and rights of women living with HIV. WHO, 2017. https://apps.who.int/iris/bitstream/handle/10665/254885/9789241549998-eng.pdf</p> <p data-bbox="1476 625 2051 721">Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. WHO, 2016. http://www.who.int/hiv/pub/arv/arv-2016/en/</p> <p data-bbox="1476 746 2074 810">HIV care and support. UNAIDS, 2016. http://www.unaids.org/en/resources/documents/2016/HIV-care-and-support</p> <p data-bbox="1476 836 2058 932">Positive health, dignity, and prevention: operational guidelines. GNP+/UNAIDS, 2013. http://www.gnpplus.net/assets/wbb_file_updown/3250/English.pdf</p> <p data-bbox="1476 957 2029 1053">Psychosocial support for PLHIV. NAT, 2010. http://www.nat.org.uk/media/files/publications/july-2010-psychological-support-for-plhiv.pdf</p> <p data-bbox="1476 1078 2040 1251">Quality of life for people living with HIV: what is it, why does it matter and how can we make it happen. Frontline AIDS, STOPAIDS, APPG HIV/AIDS, 2018. https://frontlineaids.org/resources/quality-of-life-for-people-living-with-hiv/</p> |

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| <p>6 LINKAGE TO CARE AND SUPPORT (CONTINUED)</p> | <p>CD4 cell count testing</p> <p>CD4 cell count testing can be used to assess disease progression and prioritize clients for urgent linkage to care and ART initiation. CD4 cell count testing measures the number of T-cells expressing CD4. These cells are a marker of how well the immune system is functioning.</p> <p>CD4 count is not a prerequisite for initiation of ART but should ideally be conducted for all patients entering or re-entering HIV care to indicate treatment baseline, whether they are starting ART or not. It should be conducted, as clinically indicated, on patients who are unstable or with advanced HIV, to determine the recommended package of care. It should be used with clinical monitoring to diagnose treatment failure, especially where <i>viral load testing is not routinely available</i>.</p> <p>Providers should be aware of any changes in the availability of CD4 cell counting and viral load testing in their locality in order to ensure that patients have access to measures for assessing risk of HIV disease progression and transmission.</p> | <p>Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. WHO, 2016. http://www.who.int/hiv/pub/arv/arv-2016/en/</p> <p>Information note: what's new in treatment monitoring: viral load and CD4 testing. WHO, 2017. https://www.who.int/hiv/pub/arv/treatment-monitoring-info-2017/en/</p> <p>Fact sheet: what's new in monitoring HIV treatment and care. WHO, 2015. http://www.who.int/hiv/pub/arv/arv2015-monitoring-factsheet/en/</p> |

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| <p>6 LINKAGE TO CARE AND SUPPORT (CONTINUED)</p> | <p>Positive prevention communication and counselling</p> <p>People living with HIV require positive information to support their overall wellbeing, protect their sexual health, avoid other STIs, delay disease progression, and avoid transmitting HIV infection to others. People living with HIV also require support to access information and services related to the diagnosis and other SRHR-related issues.</p> <p>Individual counselling and information can assist people living with HIV to understand their own rights and SRH options. People living with HIV must be supported in their voluntary choices around sexual relationships and family planning and be given information and resources to engage in safe, enjoyable sexual experiences, or to not engage in sex, depending on their personal preference, with counselling and support tailored to their decision-making, desires and needs.</p> <p>Disclosure of HIV status is a process, and people living with HIV considering voluntary disclosure should be counselled about the potential benefits and risks of disclosure of their HIV status to others, and empowered and supported to determine if, when, how and to whom to disclose. Possible challenges of disclosure often relate to the reactions of sexual partners, family members, friends or others (such as employers, schools or clients), which could possibly lead to increased stigma, violence or reduced access to resources. In countries where HIV transmission is criminalized, safe disclosure may not be possible, and clients should be supported to navigate such legal environment.</p> | <p>Advancing the sexual and reproductive health and rights of people living with HIV: a guidance package. GNP+, 2010. http://srhhivlinkages.org/wp-content/uploads/2013/04/advancingsexualreproductivehealthhumanrightshiv_2009_en.pdf</p> <p>Consolidated guideline on sexual and reproductive health and rights of women living with HIV. WHO, 2017. http://www.who.int/reproductivehealth/publications/gender_rights/srhr-women-hiv/en/</p> <p>HIV and adolescents: guidance for HIV testing and counselling and care for adolescents living with HIV. WHO, 2013. http://www.who.int/hiv/pub/guidelines/adolescents/en/</p> <p>Positive health, dignity, and prevention: operational guidelines. GNP+/UNAIDS, 2013. http://www.gnpplus.net/assets/wbb_file_updown/3250/English.pdf</p> <p>Quality of life for people living with HIV: what is it, why does it matter and how can we make it happen. Frontline AIDS, STOPAIDS, APPG HIV/AIDS, 2018. https://frontlineaids.org/resources/quality-of-life-for-people-living-with-hiv/</p> |

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|  <p data-bbox="161 430 362 523">PREVENTION OF PERINATAL TRANSMISSION</p> <p data-bbox="161 550 403 890">A package of interventions are necessary to prevent transmission of HIV from a mother living with HIV to their infant during pregnancy, labour and delivery or during breastfeeding.</p> | <p data-bbox="423 263 873 295">Prevention of perinatal transmission</p> <p data-bbox="423 319 1456 523">Perinatal transmission of HIV, also known as vertical transmission or mother-to-child transmission of HIV, refers to the transmission of HIV from a woman living with HIV to their infant during pregnancy, labour and delivery, and during breastfeeding. It also focuses on early initiation of ART in the mother and assuring the mother's health. A comprehensive strategy for prevention of perinatal transmission includes four components as outlined below, and can be covered by other services within the comprehensive HIV services package, as well as IPES.</p> <p data-bbox="423 571 1232 603">Primary prevention of HIV acquisition among women of childbearing age</p> <p data-bbox="423 614 1433 890">Primary prevention refers to services such as information counselling on HIV; treatment as prevention for women; STI screening and management; condom promotion; PrEP; HIV testing services for women of childbearing age including pregnant and breastfeeding women not living with HIV. In high HIV prevalence settings, HIV retesting is required for all women with an unknown or HIV-negative status during late pregnancy (third trimester). Clinics should also consider performing another additional test during the post-partum period in districts where HIV incidence is high, or for women from key populations, as well as women in sero-discordant relationships.</p> <p data-bbox="423 938 1187 970">Prevention of unintended pregnancies among women living with HIV</p> <p data-bbox="423 981 1411 1082">This includes services such as information and counselling to support sexual and reproductive rights including rights-based family planning, access to a range of contraception options to prevent unintended pregnancies, and access to safe abortion and post abortion care.</p> | <p data-bbox="1478 263 2072 399">A treatment literacy guide for pregnant women and mothers living with HIV. IATT, 2013. http://emtct-iatt.org/treatment-literacy-guide-for-pregnant-women-and-mothers-living-with-hiv/</p> <p data-bbox="1478 422 2072 558">Consolidated guidelines on HIV testing services for a changing epidemic. WHO, 2019. https://www.who.int/publications-detail/consolidated-guidelines-on-hiv-testing-services-for-a-changing-epidemic</p> <p data-bbox="1478 582 2072 718">Consolidated guideline on sexual and reproductive health and rights of women living with HIV. WHO, 2017. http://www.who.int/reproductivehealth/publications/gender_rights/srhr-women-hiv/en/</p> <p data-bbox="1478 742 2072 845">Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. WHO, 2016. http://www.who.int/hiv/pub/arv/arv-2016/en/</p> <p data-bbox="1478 869 2072 1005">Eliminating mother-to-child transmission of HIV and keeping their mothers alive: job aid for healthcare workers. IATT, 2013. http://srhhivlinkages.org/wp-content/uploads/2013/10/IATT_EMTCTJobAid_WEB.pdf</p> <p data-bbox="1478 1029 2072 1125">Male involvement in the prevention of mother-to-child transmission of HIV. WHO, 2012 www.who.int/reproductivehealth/publications/rtis/9789241503679/en/</p> |

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| 7 PREVENTION OF PERINATAL TRANSMISSION (CONTINUED) | <p>Prevention of HIV transmission from women living with HIV to their infants</p> <p>This includes services such as initiating ART to all pregnant women living with HIV (or providing facilitated referrals); treatment literacy; adherence support during pregnancy and breastfeeding; nutrition support during early ART uptake and breastfeeding; advice on breastfeeding and nutrition; HIV prophylaxis for infants exposed to HIV as per guidelines; and access to safe delivery services.</p> <p>Provision of appropriate treatment, care and support for mothers with HIV, their children and families</p> <p>For infants exposed to HIV this includes early infant diagnosis test and infant ART for infants diagnosed with HIV as per guidelines. For mothers and their partners who are HIV positive, this includes couple counselling on family planning and adherence support throughout treatment.</p> <p>Stigma, lack of male involvement, and gender-based violence are three important areas that need to be addressed to improve quality and outcomes of all prevention of perinatal transmission services mentioned above.</p> | <p>Preventing HIV during pregnancy and breastfeeding in the context of PrEP: technical brief. WHO, 2017. https://www.who.int/hiv/pub/toolkits/prep-preventing-hiv-during-pregnancy/en/</p> <p>Preventing HIV and unintended pregnancies: strategic framework. IATT, 2013. http://srhhivlinkages.org/wp-content/uploads/2013/04/pmtct1_2_en.pdf</p> <p>Recommendations on antenatal care for a positive pregnancy experience. WHO, 2016. https://www.who.int/reproductivehealth/publications/maternal_perinatal_health/anc-positive-pregnancy-experience/en/</p> <p>Stigma and discrimination: key barriers to achieving global goals for maternal health and elimination of new child HIV infections. HPP, 2012. http://www.healthpolicyproject.com/pubs/92_WorkingPaperStigmaPMTCTJuly.pdf</p> |

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| <p data-bbox="161 274 286 411">8</p> <p data-bbox="161 430 385 494">ANTIRETROVIRAL THERAPY (ART)</p> <p data-bbox="161 518 398 826">All people living with HIV should have access to and supported to sustain antiretroviral therapy to prevent disease progression and HIV transmission by reducing viral load.</p> | <p data-bbox="423 263 1193 295">Antiretroviral therapy (ART) initiation, support and counselling</p> <p data-bbox="423 319 1451 523">Standard antiretroviral therapy (ART) consists of the combination of antiretroviral (ART) drugs to maximally suppress the HIV virus and stop the progression of HIV disease. ART also prevents onward transmission of HIV. The WHO recommends ART for all people with HIV as soon as possible after diagnosis without any restrictions of CD4 cell counts. While initiation should be in line with national HIV treatment guidelines, ART should be initiated among all adults with a CD4 count ≤ 350 cells/mm³.</p> <p data-bbox="423 547 1451 715">Efforts should be made to remove barriers to ART initiation once an individual is diagnosed HIV positive, and to reduce the time between HIV diagnosis and ART initiation, based on the person's readiness. ART initiation is rarely urgent, but it may need to be expedited in certain circumstances, such as serious ill health and for pregnant women in labour whose HIV test result is positive.</p> <p data-bbox="423 738 1451 978">Providers supporting clients diagnosed with HIV must be able to provide information and counselling to clients on the benefits and risks of ART to enable each client to make an informed decision about whether and when to begin ART. Ideally, this will be done at the same facility and same visit where the client received a positive diagnosis). Even if the client will need to be referred to a separate facility to access ART, the provider should be able to provide the initial information and counselling, provide a clear referral pathway that is acceptable to the client, and make plans for follow-up care.</p> <p data-bbox="423 1002 1451 1241">Poor HIV treatment literacy is one of the causes of poor adherence which in turn can lead to treatment failure. It is critical, therefore, to ensure that the information given to clients is complete and correct, and is provided in a positive, stigma-free, and empowering way to support the individuals in making their own informed decision about whether and when to start treatment, and engaged in a comprehensive discussion about their willingness and readiness, the scheduling of the drug regimen and monitoring visits, and the likely benefits and possible adverse effects of the medications.</p> | <p data-bbox="1478 263 2049 367">Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. WHO, 2016. http://www.who.int/hiv/pub/arv/arv-2016/en/</p> <p data-bbox="1478 391 2049 486">HIV and adolescents: guidance for HIV testing and counselling and care for adolescents living with HIV. WHO, 2013. http://www.who.int/hiv/pub/guidelines/adolescents/en/</p> <p data-bbox="1478 550 2049 646">Update of recommendations on first- and second-line antiretroviral regimens. WHO, 2019. https://www.who.int/hiv/pub/arv/arv-update-2019-policy/en/</p> |

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| 8 ART (CONTINUED) | <p>Viral load monitoring</p> <p>Monitoring people on antiretroviral therapy (ART) is important to ensure successful treatment, identify adherence problems and determine whether ART regimens should be switched in case of treatment failure. Viral load is recommended as the preferred monitoring approach to diagnose and confirm treatment failure. Measuring viral load can help to discriminate between treatment failure and non-adherence. Viral load gives clients a measure of understanding, control and motivation to adhere to treatment and understand their HIV status.</p> <p>Routine viral load testing should be conducted at 6 months after initiation and can be repeated at 12 months and every 12 months thereafter to synchronise with routine monitoring. Dried Blood Spot (DBS) specimens provide a way to improve coverage and reach of viral load testing, particularly in remote and rural areas. Evidence suggests that for individuals stable on ART who are monitored virologically, routine CD4 counting can be stopped. Long term CD4 monitoring adds little value in these circumstances and stopping CD4 testing can be cost saving.</p> <p>Where viral load testing is unavailable, service providers should provide clear information on possible referral options or use other methods such as CD4 counting to track disease progression.</p> | <p>Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. WHO, 2016. http://www.who.int/hiv/pub/arv/arv-2016/en/</p> <p>Information note: what's new in treatment monitoring: viral load and CD4 testing. HIV treatment and care, WHO, 2017. https://www.who.int/hiv/pub/arv/treatment-monitoring-info-2017/en/.</p> |

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| 8 ART (CONTINUED) | <p>Adherence and retention support</p> <p>Efforts should be made to remove barriers to ART initiation once an individual is diagnosed HIV positive, and to reduce the time between HIV diagnosis and ART initiation, based on the person's readiness. ART initiation is rarely urgent, but it may need to be expedited in certain circumstances, such as serious ill health and for pregnant women in labour whose HIV test result is positive.</p> <p>Programmes should provide community support for people living with HIV to improve retention in HIV care. Interventions that have demonstrated effectiveness in improving adherence and virological suppression include peer counsellors, mobile phone text messages, reminder devices, and counselling (cognitive behavioural therapy). Adherence counselling needs to address the implications of a detectable or undetectable viral load.</p> <p>Adolescents, in particular, have a high risk of loss to follow up and suboptimal adherence, and may require special additional care and support. Community-led interventions have demonstrated benefit in improving retention in care, such as adherence clubs and peer-mentoring schemes, and extra care for high risk persons.</p> | <p>Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. WHO, 2016. http://www.who.int/hiv/pub/arv/arv-2016/en/</p> <p>Effectiveness of community adolescent treatment supporters (CATS) interventions in improving linkage and retention in care, adherence to ART and psychosocial well-being: a randomised trial among adolescents living with HIV in rural Zimbabwe: BMC Public Health, 2019. https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-019-6447-4</p> <p>HIV and adolescents: guidance for HIV testing and counselling and care for adolescents living with HIV: recommendations for a public health approach and considerations for policy-makers and managers. WHO, 2014. http://www.who.int/hiv/pub/guidelines/adolescents/en</p> <p>Interventions to improve adherence to antiretroviral therapy: a rapid systematic review. WHO, 2014. http://www.who.int/hiv/pub/journal_articles/improve_arv_adherence/en/</p> |

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| <p data-bbox="161 274 282 411">9</p> <p data-bbox="161 434 380 523">COMMON COINFECTIONS & COMORBIDITIES</p> <p data-bbox="161 555 403 858">Prevention, screening, and management of various coinfections, comorbidities and other concomitant health conditions should be available for people living with HIV.</p> | <p data-bbox="423 264 1093 296">Assessment and management of common coinfections</p> <p data-bbox="423 319 1458 488">Various coinfections, comorbidities, and other health conditions are common among people living with HIV due to immune suppression, and these have implications for the treatment and care of individual clients, including the timing and choice of ARV drugs. Prevention, screening, and management of various coinfections, comorbidities, and other concomitant health conditions should be available for people living with HIV.</p> <p data-bbox="423 539 730 571">Co-trimoxazole prophylaxis</p> <p data-bbox="423 584 1435 785">Co-trimoxazole (CTX) prophylaxis is a feasible, well-tolerated, and inexpensive intervention to prevent opportunistic infections, severe bacterial infections, and malaria, which can thus reduce HIV-related morbidity and mortality in people living with HIV. CTX is an off-patent drug and is widely available in resource-limited settings. It is a fixed-dose combination of two antimicrobial agents (sulfamethoxazole and trimethoprim) that treat a variety of bacterial, fungal, and protozoan infections.</p> <p data-bbox="423 810 1435 944">WHO recommends that CTX prophylaxis should be implemented as an integral component of a package of HIV care services. This includes the initiation among adults, adolescents, pregnant women and children living with HIV for prevention of pneumocystis pneumonia, toxoplasmosis and bacterial infections, as well as benefits for malaria prophylaxis.</p> <p data-bbox="423 995 510 1027">Malaria</p> <p data-bbox="423 1040 1458 1279">People living with HIV have increased risk of more frequent and higher-density infection, severe malaria and malaria-related death, depending on the malaria transmission intensity of the area. Key interventions to control malaria include early diagnosis, prompt and effective treatment with artemisinin-based combination therapies and use of insecticide-treated nets and indoor residual insecticide spraying to control the vector mosquitoes. In settings where malaria and/or severe bacterial infections are highly prevalent, co-trimoxazole prophylaxis should be initiated regardless of CD4 cell count or stage of disease progression.</p> | <p data-bbox="1476 264 2074 402">Consolidated guideline on sexual and reproductive health and rights of women living with HIV. WHO, 2017. http://www.who.int/reproductivehealth/publications/gender_rights/srhr-women-hiv/en/</p> <p data-bbox="1476 427 2051 526">Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. WHO, 2016. http://www.who.int/hiv/pub/arv/arv-2016/en/</p> <p data-bbox="1476 552 2063 683">Guidelines for managing advanced HIV disease and rapid initiation of antiretroviral therapy. WHO, 2017. https://www.who.int/hiv/pub/guidelines/advanced-HIV-disease/en/</p> <p data-bbox="1476 708 1995 839">Guidelines for treatment of drug-susceptible tuberculosis and patient care. WHO, 2017. https://www.who.int/tb/publications/2017/dstb_guidance_2017/en/</p> <p data-bbox="1476 865 2051 995">Guidelines for the treatment of malaria, third edition. WHO, 2015. https://www.who.int/malaria/policy-guidance/treatment#tab=tab_1&publication=guidelines-for-the-treatment-of-malaria</p> <p data-bbox="1476 1021 2040 1190">Guidelines on post-exposure prophylaxis for HIV and the use of co-trimoxazole prophylaxis for HIV-related infections among adults, adolescents and children. WHO, 2013. http://www.who.int/hiv/pub/guidelines/arv2013/arvs2013supplement_dec2014/en/</p> <p data-bbox="1476 1216 2074 1347">Rapid advice: diagnosis, prevention and management of cryptococcal disease in HIV-infected adults, adolescents and children. WHO, 2011. www.who.int/hiv/pub/cryptococcal_disease2011</p> |

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| 9 COMMON COINFECTIONS AND COMORBIDITIES (CONTINUED) | <p>Tuberculosis & cryptococcal disease</p> <p>Among people living with HIV, TB is the most frequent life-threatening opportunistic infection and a leading cause of death. Routine TB symptom screening for people with HIV, using an algorithm containing fever, cough of any duration, weight loss and night sweats, will help to identify people who should either be expedited for TB diagnosis or given preventive TB therapy. The combined use of isoniazid preventive therapy (IPT) and ART has been shown to have both TB prevention and mortality benefits, including in people with a higher CD4 count. The timely initiation of ART and implementation of the “Three I’s” for HIV/TB (increased TB case-finding, IPT and infection control) are critical to prevent TB and mortality from HIV-associated TB.</p> <p>Cryptococcal meningitis is a common opportunistic infection and a leading cause of death in people with HIV before and after ART is initiated, especially in sub-Saharan Africa and South-East Asia. This requires diagnosis, screening and prevention of cryptococcal infection, induction, consolidation and maintenance regimens, monitoring and managing toxicities.</p> | <p>Treatment of tuberculosis: guidelines for national programmes. WHO, 2010. http://apps.who.int/iris/bitstream/10665/44165/1/9789241547833_eng.pdf</p> |

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| <p>9 COMMON COINFECTIONS AND COMORBIDITIES (CONTINUED)</p> | <p>Screening and management of STIs including viral hepatitis and HPV</p> <p>Sexually transmitted infections (STIs) can cause complications, be transmitted to sexual partners, and enhance HIV transmission. HIV infection may also alter the natural history of STIs, e.g. it results in more frequent recurrences of herpes simplex virus (HSV) in coinfecting individuals, many of which are subclinical. Serious clinical manifestations of HSV, human papillomavirus (HPV), syphilis, and other STIs are observed among people with advanced HIV. Further relevant information on the screening and management of STIs is outlined in section 2 of this comprehensive HIV service package.</p> <p>Viral hepatitis</p> <p>Viral hepatitis is an increasing cause of morbidity and mortality among people living with HIV in some regions, including among people on ART. Chronic hepatitis B virus (HBV) infection affects 5–20% of people living with HIV worldwide, and hepatitis C virus (HCV) affects 5-15%, rising to 90% among people who inject drugs. A comprehensive approach includes prevention, HBV and HCV testing, hepatitis B vaccination and treatment and care for people with HIV who are coinfecting with hepatitis B and/or hepatitis C.</p> <p>Hepatitis B and C are bloodborne viruses and hepatitis B is also transmitted by semen and other body fluids. It is recommended that screening be offered to individuals belonging to a population with high HCV prevalence or risk/exposure behaviour, in particular, the sharing of injection equipment.</p> <p>Hepatitis B attacks the liver, which can cause acute and chronic disease, such as cirrhosis of liver or liver cancer. Hepatitis B is diagnosed in using blood tests. Oral treatments are recommended (tenofovir, entecavir) since they are the most potent at suppressing the hepatitis B virus.</p> <p>Hepatitis C infection is diagnosed by screening for anti-HCV antibodies with a serological test. If they test positive for anti-HCV antibodies, a nucleic acid test for HCV RNA is needed to confirm chronic HCV infection (some people infected with HCV have a strong immune response, clearing the infection without the need for treatment). After diagnosis, an assessment of the degree of liver damage is necessary. Antiviral drugs, called direct antiviral agents (DAA) are the newest, more effective therapies. There is no vaccine for hepatitis C.</p> | <p>Consolidated guideline on sexual and reproductive health and rights of women living with HIV. WHO, 2017. http://www.who.int/reproductivehealth/publications/gender_rights/srhr-women-hiv/en/</p> <p>Guidelines for the prevention, care and treatment of persons with chronic hepatitis B infection. WHO, 2015. http://www.who.int/hiv/pub/hepatitis/hepatitis-b-guidelines/en/</p> <p>Guidelines for the screening, care and treatment of persons with hepatitis C infection. WHO, 2014 http://apps.who.int/iris/bitstream/10665/111747/1/9789241548755_eng.pdf</p> <p>New recommendations in the updated guidelines for the screening, care and treatment of persons with chronic hepatitis C infection. WHO, 2016. http://apps.who.int/iris/bitstream/10665/204452/1/WHO_HIV_2016.01_eng.pdf?ua=1</p> <p>Sexually transmitted and other reproductive tract infections: a guide to essential practice. WHO, 2005. http://www.who.int/reproductivehealth/publications/rtis/9241592656/en</p> <p>Treatment guidelines for gonorrhoea, chlamydia, syphilis and genital herpes simplex virus. WHO, 2016 https://www.who.int/reproductivehealth/topics/rtis/stis-new-treatment-guidelines/en/</p> <p>The immunological basis for immunization series – module 22: hepatitis B. WHO, 2011. http://www.who.int/immunization/documents/ISBN_978_92_4_150475_1/en/</p> |

| HIV SERVICE AREA | KEY DETAILS AND ACTIVITIES | RELATED GUIDELINES AND RESOURCES |
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| TREATMENT AND CARE | | |
| <p>9 COMMON COINFECTIONS AND COMORBIDITIES (CONTINUED)</p> | <p>Human papillomavirus and related cancers</p> <p>Human papillomavirus (HPV) is a group of viruses most often transmitted through sexual contact. In most cases, HPV infection (including high-risk types) will resolve without treatment. HPV is the primary cause of cervical cancer and certain subtypes of HPV (type 16 and 18) cause over 70% of cases.</p> <p>While HPV vaccination is recommended before the age 15 and up to age 26, a protective effect is still possible if received later and is often recommended for people living with HIV.</p> <p>Cervical cancer is a preventable disease. The risk and persistence of HPV infection increases with low CD4 count and high HIV viral load. Women living with HIV should be followed closely for evidence of precancerous changes in the cervix, regardless of whether they are taking ART or their CD4 count or viral load. Cervical cancer screening leads to early detection of precancerous and cancerous cervical lesions that will prevent serious morbidity and mortality. All women with HIV should therefore be screened for cervical cancer regardless of age. Immediate management for precancerous and cancerous lesions should be provided.</p> <p>HPV can also cause other forms of cancer, including oropharyngeal, anal, penile, vaginal, and vulvar cancers. There is some evidence that anal cytology (e.g. Pap tests) may help to detect early cell changes or precancerous cells among people living with HIV at higher risk of anal HPV infection, including men who have sex with men.</p> | <p>Comprehensive cervical cancer control: a guide to essential practice, second edition. WHO, 2014. http://www.who.int/reproductivehealth/publications/cancers/cervical-cancer-guide/en</p> <p>Human papillomavirus (HPV) and cervical cancer, factsheet 380. WHO, 2015. http://www.who.int/mediacentre/factsheets/fs380/en/</p> <p>Human papillomavirus vaccines: WHO position paper. WHO, 2014. http://www.who.int/wer/2014/wer8943.pdf?ua=1</p> <p>HPV and cancer. National Cancer Institute, 2020. https://www.cancer.gov/about-cancer/causes-prevention/risk/infectious-agents/hpv-and-cancer#ui-id-2</p> <p>WHO guidelines for the use of thermal ablation for cervical pre-cancer lesions. WHO, 2019. https://www.who.int/reproductivehealth/publications/thermal-ablation-for-cervical-pre-cancer-lesions/en/</p> |

| HIV SERVICE AREA | KEY DETAILS AND ACTIVITIES | RELATED GUIDELINES AND RESOURCES |
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| TREATMENT AND CARE | | |
| <p>9 COMMON COINFECTIONS AND COMORBIDITIES (CONTINUED)</p> | <p>Assessment and management of non-communicable diseases</p> <p>Compared to the general population, people living with HIV are at increased risk of developing a range of chronic non-communicable diseases (NCDs), including cardiovascular disease (CVD), hypertension, diabetes, chronic obstructive pulmonary disease (COPD), kidney disease and cancers. The intersection of HIV and NCDs is strongly influenced by increasing survival due to effective ART, lifestyle factors, long-term complications of ART and other disease conditions associated with ageing.</p> <p>HIV care provides the opportunity for assessment, monitoring and managing NCDs, especially through primary care. Integrating interventions, such as nutrition assessment, dietary counselling and support, smoking cessation, exercise promotion, blood pressure monitoring and cholesterol management as part of HIV care can help to reduce the risks of NCDs among people with HIV and improve HIV treatment outcomes.</p> | <p>Package of essential noncommunicable (PEN) disease interventions for primary health care in low-resource settings. WHO, 2010. www.who.int/cardiovascular_diseases/publications/pen2010/en</p> <p>Prevention and control of noncommunicable diseases: guidelines for primary health care in low-resource settings. WHO, 2012. http://apps.who.int/iris/bitstream/10665/76173/1/9789241548397_eng.pdf</p> |



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