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# Consolidated guideline on sexual and reproductive health and rights of women living with HIV





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### **Web supplement: WHO recommendations on SRHR of women living with HIV: evidence base**

The standardized criteria used in grading the evidence and the GRADE tables have been published in this separate Web supplement. The Web supplement is available online at:  
[www.who.int/reproductivehealth/publications/gender\\_rights/srhr-women-hiv/en/](http://www.who.int/reproductivehealth/publications/gender_rights/srhr-women-hiv/en/)

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# Abbreviations and acronyms

<b>AIDS</b>	acquired immunodeficiency syndrome
<b>ALC</b>	WHO Department of Ageing and Life Course
<b>ART</b>	antiretroviral therapy
<b>ARV</b>	antiretroviral (medication)
<b>BSC</b>	brief sexuality communication
<b>CESCR</b>	United Nations Committee on Economic, Social and Cultural Rights
<b>C-section</b>	caesarean section
<b>CSE</b>	comprehensive sexuality education
<b>DOI</b>	declaration of interest
<b>EMTCT</b>	elimination of mother-to-child transmission
<b>ERG</b>	External Review Group
<b>FGM</b>	female genital mutilation
<b>FP</b>	family planning
<b>FWC</b>	WHO Family, Women's and Children's Health Cluster
<b>GBV</b>	gender-based violence
<b>GDG</b>	Guideline Development Group
<b>GER</b>	WHO Gender, Equity and Human Rights Team
<b>GPS</b>	good practice statement
<b>GRADE</b>	Grading of Recommendations, Assessment, Development and Evaluation
<b>GRC</b>	Guidelines Review Committee
<b>GVPS</b>	Global Values and Preferences Survey
<b>HIV</b>	human immunodeficiency virus
<b>HPV</b>	human papillomavirus
<b>HRP</b>	The UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction
<b>HSV</b>	herpes simplex virus
<b>ICPD</b>	International Conference on Population and Development
<b>IPV</b>	intimate partner violence
<b>M&amp;E</b>	monitoring and evaluation
<b>MCA</b>	WHO Department of Maternal, Newborn, Child and Adolescent Health
<b>MEC</b>	Medical eligibility criteria for contraceptive use (WHO publication)
<b>mhGAP</b>	Mental Health Gap Action Programme
<b>mhGAP-IG</b>	Mental Health Gap Action Programme – intervention guide
<b>MIWA</b>	meaningful involvement of women living with HIV and AIDS
<b>MNS</b>	mental, neurological and substance use
<b>MSD</b>	WHO Department for Mental Health and Substance Abuse
<b>MSM</b>	men who have sex with men
<b>OHCHR</b>	Office of the United Nations High Commissioner for Human Rights
<b>PAR</b>	participatory action research
<b>PICO</b>	population, intervention, comparator, outcome(s)

<b>PMNCH</b>	Partnership for Maternal, Newborn & Child Health
<b>PMTCT</b>	prevention of mother-to-child transmission
<b>PPT</b>	periodic presumptive treatment
<b>PrEP</b>	pre-exposure prophylaxis
<b>RCT</b>	randomized controlled trial
<b>REC</b>	recommendation
<b>RHL</b>	Reproductive Health Library
<b>RHR</b>	WHO Department of Reproductive Health and Research
<b>RTI</b>	reproductive tract infection
<b>SDG</b>	Sustainable Development Goal
<b>SG</b>	WHO Guideline Steering Group
<b>SPR</b>	Selected practice recommendations for contraceptive use (WHO publication)
<b>SRH</b>	sexual and reproductive health
<b>SRHR</b>	sexual and reproductive health and rights
<b>STI</b>	sexually transmitted infection
<b>TB</b>	tuberculosis
<b>UN</b>	United Nations
<b>UNAIDS</b>	Joint United Nations Programme on HIV/AIDS
<b>UNDP</b>	United Nations Development Programme
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children's Fund
<b>USAID</b>	United States Agency for International Development
<b>VAW</b>	violence against women
<b>WHO</b>	World Health Organization

# Executive summary

HIV is not only driven by gender inequality, but it also entrenches gender inequality, leaving women more vulnerable to its impact. Providing sexual and reproductive health interventions for women living with HIV that are grounded in principles of gender equality and human rights can have a positive impact on their quality of life; it is also a step towards long-term improved health status and equity.

## Introduction

There were an estimated 17.8 million women aged 15 and older living with HIV in 2015, constituting 51% of all adults living with HIV. Adolescent girls and young women are particularly affected; in 2015 they constituted 60% of young people aged 15–24 years who were living with HIV, and they also accounted for 58% of newly acquired HIV infections among young persons in that age group. In many countries, women living with HIV do not have equitable access to good-quality health services and are also faced with multiple and intersecting forms of stigma and discrimination. Furthermore, women living with HIV are disproportionately vulnerable to violence, including violations of their sexual and reproductive rights.

Many significant changes in HIV-related policies, research and practice have occurred in the 10 years since the World Health Organization (WHO) published *Sexual and reproductive health of women living with HIV/AIDS: guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings* in 2006. These changes include the rapid expansion of antiretroviral therapy (ART) and the release in 2015 of WHO recommendations to offer immediate ART to all individuals living with HIV and to offer pre-exposure prophylaxis (PrEP) to individuals at substantial risk of HIV infection as an additional prevention choice. Given the significant difference in scope, this guideline was viewed as a new submission by the WHO Guidelines Review Committee, rather than an update of the 2006 guidelines. This guideline responds to requests from organizations, institutions and individuals for guidance which consolidates existing recommendations specific to women living with HIV along with new recommendations and good practice statements. It is expected to support front-line health-care providers, programme managers and public health policy-makers around the world to better address the sexual and reproductive health and rights (SRHR) of women living with HIV.

The starting point for this guideline is the point at which a woman has learnt that she is living with HIV, and it therefore covers key issues for providing comprehensive SRHR-related services and support for women living with HIV. As women living with HIV face unique challenges and human rights violations related to their sexuality and reproduction within their families and communities, as well as from the health-care institutions where they seek care, particular emphasis is placed on the creation of an enabling environment to support more effective health interventions and better health outcomes.

This guideline is meant to help countries to more effectively and efficiently plan, develop and monitor programmes and services that promote gender equality and human rights and hence are more acceptable and appropriate for women living with HIV, taking into account the national and local epidemiological context. It discusses implementation issues that health interventions and service delivery must address to achieve gender equality and support human rights.

This guideline aims to provide:

- **Evidence-based recommendations** for the SRHR of women living with HIV in all of their diversity, with a particular focus on settings where the health system has limited capacity and resources; and
- **Good practice statements** on key operational and service delivery issues that need to be addressed to (i) increase access to, uptake of, and the quality of outcomes of sexual reproductive health (SRH) services, (ii) improve human rights and (iii) promote gender equality for women living with HIV.

## A woman-centred approach

Woman-centred health services involve an approach to health care that consciously adopts the perspectives of women, their families and communities. This means that health services see women as active participants in, as well as beneficiaries of, trusted health systems that respond to women's needs, rights and preferences in humane and holistic ways. Care is provided in ways that respect women's autonomy in decision-making about their health, and services must include provision of information and options to enable women to make informed choices. The needs and perspectives of women, their families and communities are central to provision of care, and to the design and implementation of programmes and services. A woman-centred approach is underpinned by two guiding principles: promotion of human rights and gender equality.

## Guiding principles

**Human rights:** An integrated approach to health and human rights lies at the heart of ensuring the dignity and well-being of women living with HIV. This includes, but is not limited to, the right to the highest attainable standard of health; the right to life and physical integrity, including freedom from violence; the right to equality and non-discrimination on the basis of sex; and the right to freedom from torture or cruel, inhuman or degrading treatment. The right to SRH is an integral part of the right to health, enshrined in article 12 of the International Covenant on Economic, Social and Cultural Rights.

**Gender equality:** The promotion of gender equality is central to the achievement of SRHR of all women, including women living with HIV in all their diversity. This means recognizing and taking into account how unequal power in women's intimate relationships, harmful gender norms and women's lack of access to and control over resources affect their access to and experiences with health services.

## Guideline development methods

The WHO Department of Reproductive Health and Research (RHR) led the development of this consolidated guideline, following WHO procedures and reporting standards laid out in the 2014 *WHO handbook for guideline development*. To help ensure that the guidance appropriately reflects the concerns of women living with HIV in all their diversity, WHO commissioned a global survey on the SRHR priorities of women living with HIV – the Global Values and Preferences Survey (GVPS)<sup>1</sup>. This process was placed at the heart of the development of this guideline and the findings of the survey are included throughout the guideline.

To develop the scope of this guideline, the WHO Guideline Steering Group (SG) mapped all existing WHO SRHR guidance for women living with HIV, then reviewed these documents to determine the relevance of existing recommendations that have undergone the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) for inclusion in this consolidated guideline. The SG identified the following eight topic areas for new recommendations or good practice statements: psychosocial support, ageing and healthy sexuality, economic empowerment and resource access (including food security), integration of SRHR and HIV services, empowerment and self-efficacy around safer sex and reproductive decision-making, facilitating safe disclosure for women living with HIV who fear or experience violence, modes of delivery for best maternal and perinatal outcomes (specifically caesarean section), and safe medical and surgical abortion. Development of the new recommendations and good practice statements to respond to these eight topic areas began with systematic and narrative reviews of the evidence. The Guideline Development Group (GDG) assessed the quality of the available evidence for the new recommendations and considered the benefits and risks, values and preferences, human rights, equity, costs and feasibility of implementation to determine the strength of each recommendation.

## Creating an enabling environment

Implementing comprehensive and integrated SRHR and HIV programmes to meet the health needs and rights of the diverse group of women living with HIV requires that interventions be put into place to overcome barriers to service uptake, use and continued engagement. In all epidemic contexts, these barriers occur at the individual, interpersonal, community and societal levels. They may include challenges such as social exclusion and marginalization, criminalization, stigma, gender-based violence and gender inequality, among others. Strategies are needed across health system building blocks to improve the accessibility, acceptability, affordability, uptake, equitable coverage, quality, effectiveness and efficiency of services for women living with HIV. If left unaddressed, such barriers undermine health interventions and the SRHR of women living with HIV.

## Implementation and updating of the guideline

Action on the recommendations in this guideline requires a strategy that is informed by evidence, appropriate to the local context, and responsive to the needs and rights of women living with HIV. In addition, programmes should aim to achieve equitable health outcomes, promote gender equality, and deliver the highest-quality care efficiently at all times. Effective implementation of the recommendations and good practice statements in this guideline will likely require reorganization of care and redistribution of health-care resources, particularly in low- and middle-income countries. Potential barriers are noted and a phased approach to adoption, adaptation and implementation of the guideline recommendations is advised.

During the guideline development process, the GDG identified important knowledge gaps that need to be addressed through primary research. This guideline will be updated five years after publication unless significant new evidence emerges that necessitates earlier revision.

Tables 1 and 2 present the new and existing recommendations and good practice statements, respectively. Figure 2.1, at the end of Chapter 2, presents a visual framework that brings together all the elements of the guideline, with women living with HIV at the core.

**Table 1: Summary list of WHO recommendations for the sexual and reproductive health and rights (SRHR) of women living with HIV**

Note: Where recommendations apply to “key populations” this includes women living with HIV and therefore these have been included in these guidelines.

<b>A. Creating an enabling environment</b>	
<b>Recommendation (REC)</b>	<b>Strength of recommendation, quality of evidence</b>
<b>Healthy sexuality across the life course</b>	
<b>REC A.1:</b> Adolescent-friendly health services should be implemented in HIV services to ensure engagement and improved outcomes. <sup>1</sup>	Strong recommendation, low-quality evidence
<b>Integration of SRHR and HIV services</b>	
<b>REC A.2:</b> In generalized epidemic settings, antiretroviral therapy (ART) should be initiated and maintained in eligible pregnant and postpartum women and in infants at maternal and child health care settings, with linkage and referral to ongoing HIV care and ART, where appropriate.	Strong recommendation, very low-quality evidence
<b>REC A.3:</b> Sexually transmitted infection (STI) and family planning services can be integrated within HIV care settings.	Conditional recommendation, very low-quality evidence
<b>REC A.4, A.5 and A.6:</b> Decentralization of HIV treatment and care should be considered as a way to increase access to and improve retention in care: <ul style="list-style-type: none"> <li>• initiation of ART in hospitals with maintenance of ART in health facilities;</li> <li>• initiation and maintenance of ART in peripheral health facilities;</li> <li>• initiation of ART at peripheral health facilities with maintenance at the community level.</li> </ul>	Strong recommendation, low-quality evidence Strong recommendation, low-quality evidence Strong recommendation, moderate-quality evidence
<b>REC A.7:</b> Trained and supervised lay providers can distribute ART to adults, adolescents and children living with HIV.	Strong recommendation, low-quality evidence
<b>REC A.8:</b> Trained non-physician clinicians, midwives and nurses can initiate first-line ART.	Strong recommendation, moderate-quality evidence
<b>REC A.9:</b> Trained non-physician clinicians, midwives and nurses can maintain ART.	Strong recommendation, moderate-quality evidence
<b>REC A.10:</b> Trained and supervised community health workers can dispense ART between regular clinical visits.	Strong recommendation, moderate-quality evidence
<b>Protection from violence and creating safety</b>	
<b>REC A.11:</b> Women who disclose any form of violence by an intimate partner (or other family member) or sexual assault by any perpetrator should be offered immediate support. Health-care providers should, as a minimum, offer first-line support when women disclose violence. If health-care providers are unable to provide first line support, they should ensure that someone else (within their health-care setting or another that is easily accessible) is immediately available to do so. <sup>2</sup>	Strong recommendation, indirect evidence
<b>REC A.12:</b> Health-care providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence, in order to improve diagnosis/identification and subsequent care.	Strong recommendation, indirect evidence

1. Reference for this and all the existing recommendations in the next section on integration of services: Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach, second edition. Geneva: World Health Organization; 2016 ([http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684_eng.pdf)).
2. Reference for this and all the rest of the existing recommendations in this section on violence and safety: Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization; 2013 ([http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf)).

<p><b>REC A.13:</b> In-service training and training at pre-qualification level and in first-line support for women who have experienced intimate partner violence and sexual assault should be provided to health-care providers (in particular doctors, nurses and midwives).</p> <p><b>REC A.14:</b> Pregnant women who disclose intimate partner violence should be offered brief to medium-duration empowerment counselling (up to 12 sessions) and advocacy/support, including a safety component, offered by trained service providers where health-care systems can support this. The extent to which this may apply to settings outside of antenatal care, or its feasibility in low- or middle-income countries, is uncertain.</p> <p><b>REC A.15:</b> Care for women experiencing intimate partner violence and sexual assault should, as much as possible, be integrated into existing health services rather than as a stand-alone service.</p> <p><b>REC A.16:</b> Mandatory reporting of intimate partner violence to the police by the health-care provider is not recommended. However, health-care providers should offer to report the incident to the appropriate authorities (including the police) if the woman wants this and is aware of her rights.</p>	<p>Strong recommendation, very low-quality evidence</p> <p>Conditional recommendation, low-quality evidence</p> <p>Strong recommendation, very low-quality evidence</p> <p>Strong recommendation, very low-quality evidence</p>
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### Community empowerment

<p><b>REC A.17:</b> Provide free HIV and tuberculosis (TB) treatment for health workers in need facilitating the delivery of these services in a non-stigmatizing, gender-sensitive, confidential, and convenient setting when there is no staff clinic and/or their own facility does not offer ART, or where health workers prefer services off-site.<sup>3</sup></p> <p><b>REC A.18:</b> Introduce new, or reinforce existing, policies that prevent discrimination against health workers with HIV or TB, and adopt interventions aimed at stigma reduction among colleagues and supervisors.<sup>4</sup></p>	<p>Strong recommendation, weak evidence</p> <p>Strong recommendation, moderate-quality evidence</p>
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## B. Health interventions

Recommendation (REC)	Strength of recommendation, quality of evidence
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### Sexual health counselling and support

<p><b>REC B.1 (NEW):</b> WHO recommends that for women living with HIV, interventions on self-efficacy and empowerment around sexual and reproductive health and rights should be provided to maximize their health and fulfil their rights.</p>	<p>Strong recommendation, low-quality evidence</p>
<p><b>REC B.2:</b> Brief sexuality-related communication (BSC) is recommended for the prevention of sexually transmitted infections among adults and adolescents in primary health services.<sup>5</sup></p>	<p>Strong recommendation, low- to moderate-quality evidence</p>
<p><b>REC B.3:</b> Training of health-care providers in sexual health knowledge and in the skills of BSC is recommended.<sup>6</sup></p>	<p>Strong recommendation, low- to very low-quality evidence</p>

3. Joint WHO/ILO policy guidelines on improving health worker access to prevention, treatment and care services for HIV and TB. Geneva: World Health Organization; 2010 ([http://apps.who.int/iris/bitstream/10665/44467/1/9789241500692\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/44467/1/9789241500692_eng.pdf)).

4. Ibid.

5. Brief sexuality-related communication: recommendations for a public health approach. Geneva: World Health Organization; 2015 ([http://apps.who.int/iris/bitstream/10665/170251/1/9789241549004\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/170251/1/9789241549004_eng.pdf)).

6. Ibid.



## Violence against women services

<p><b>REC B.4 (NEW):</b> WHO recommends that policy-makers and service providers who support women living with HIV who are considering voluntary HIV disclosure should recognize that many fear, or are experiencing, or are at risk of intimate partner violence.</p>	<p>Strong recommendation, low-quality evidence</p>
<p><b>REC B.5 (NEW):</b> WHO recommends that interventions and services supporting women living with HIV who are considering voluntary HIV disclosure should include discussions about the challenges of their current situation, the potential associated risk of violence, and actions to disclose more safely, and facilitate links to available violence prevention and care services.</p>	<p>Strong recommendation, low-quality evidence</p>
<p><b>REC B.6:</b> Adolescents 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.<sup>7</sup></p>	<p>Conditional recommendation, very low-quality evidence</p>
<p><b>REC B.7:</b> HIV testing services for couples and partners, with support for mutual disclosure, should be offered to individuals with known HIV status and their partners.<sup>8</sup></p>	<p>Strong recommendation, low-quality evidence for all people with HIV in all epidemic settings; conditional recommendation, low-quality evidence for HIV-negative people depending on the country-specific HIV prevalence</p>
<p><b>REC B.8:</b> Initiatives should be put in place to enforce privacy protection and institute policy, laws and norms that prevent discrimination and promote tolerance and acceptance of people living with HIV. This can help create environments where disclosure of HIV status is easier.<sup>9</sup></p>	<p>Strong recommendation, low-quality evidence</p>
<p><b>REC B.9:</b> Children of school age* should be told their HIV positive status; younger children should be told their status incrementally to accommodate their cognitive skills and emotional maturity, in preparation for full disclosure.<sup>10</sup></p>	<p>Strong recommendation, low-quality evidence</p>
<p><b>REC B.10:</b> Children of school age* should be told the HIV status of their parents or caregivers; younger children should be told this incrementally to accommodate their cognitive skills and emotional maturity.<sup>11</sup></p>	<p>Conditional recommendation, low-quality evidence</p>
<p>* In the document, school-age children are defined as those with the cognitive skills and emotional maturity of a normally developing child of 6–12 years.</p>	

## Family planning and infertility services

<p><b>REC B.11:</b> In countries where HIV transmission occurs among serodiscordant couples, where discordant couples can be identified and where additional HIV prevention choices for them are needed, daily oral PrEP (specifically tenofovir or the combination of tenofovir and emtricitabine) may be considered as a possible additional intervention for the uninfected partner.<sup>12</sup></p>	<p>Conditional recommendation, high-quality evidence</p>
<p><b>REC B.12:</b> ART should be initiated in all adults living with HIV, regardless of WHO clinical stage and at any CD4 cell count.<sup>13</sup></p>	<p>Strong recommendation, moderate-quality evidence</p>

7. 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. Geneva: World Health Organization; 2013 ([http://apps.who.int/iris/bitstream/10665/94334/1/9789241506168\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/94334/1/9789241506168_eng.pdf)).
8. Guidance on couples HIV testing and counselling including antiretroviral therapy for treatment and prevention in serodiscordant couples: recommendations for a public health approach. Geneva: World Health Organization; 2012 ([http://apps.who.int/iris/bitstream/10665/44646/1/9789241501972\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/44646/1/9789241501972_eng.pdf)).
9. Guideline on HIV disclosure counselling for children up to 12 years of age. Geneva: World Health Organization; 2011 ([http://apps.who.int/iris/bitstream/10665/44777/1/9789241502863\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/44777/1/9789241502863_eng.pdf)).
10. Ibid.
11. Ibid.
12. Guidance on oral pre-exposure prophylaxis (PrEP) for serodiscordant couples, men and transgender women who have sex with men at high risk of HIV: recommendations for use in the context of demonstration projects. Geneva: World Health Organization; 2012 ([http://www.who.int/hiv/pub/guidance\\_prep/en/](http://www.who.int/hiv/pub/guidance_prep/en/)).
13. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach, second edition. Geneva: World Health Organization; 2016 ([http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684_eng.pdf)).



<p><b>REC B.13:</b> The correct and consistent use of condoms with condom-compatible lubricants is recommended for all key populations to prevent sexual transmission of HIV and sexually transmitted infections (STIs).<sup>14</sup></p>	<p>Strong recommendation, moderate-quality evidence</p>
<p><b>REC B.14:</b> Women living with asymptomatic or mild HIV clinical disease (WHO stage 1 or 2) can use the following hormonal contraceptive methods without restriction: combined oral contraceptive pills (COCs), combined injectable contraceptives (CICs), contraceptive patches and rings, progestogen-only pills (POPs), progestogen-only injectables (POIs; depot medroxyprogesterone acetate [DMPA] and norethisterone enanthate [NET-EN]), and levonorgestrel (LNG) and etonogestrel (ETG) implants (MEC Category 1). Women living with asymptomatic or mild HIV clinical disease (WHO stage 1 or 2) can generally use the LNG-IUD (MEC Category 2) (Part I, section 12b).<sup>15</sup></p> <p><b>REC B.15:</b> Women living with severe or advanced HIV clinical disease (WHO stage 3 or 4) can use the following hormonal contraceptive methods without restriction: COCs, CICs, contraceptive patches and rings, POPs, POIs (DMPA and NET-EN), and LNG and ETG implants (MEC Category 1). Women living with severe or advanced HIV clinical disease (WHO stage 3 or 4) should generally not initiate use of the LNG-IUD (MEC Category 3 for initiation) until their illness has improved to asymptomatic or mild HIV clinical disease (WHO stage 1 or 2). However, women who already have an LNG-IUD inserted and who develop severe or advanced HIV clinical disease need not have their IUD removed (MEC Category 2 for continuation). LNG-IUD users with severe or advanced HIV clinical disease should be closely monitored for pelvic infection (Part I, section 12c).</p> <p><b>REC B.16:</b> Women taking any nucleoside/nucleotide reverse transcriptase inhibitor (NRTI) can use all hormonal contraceptive methods without restriction: COCs, contraceptive patches and rings, CICs, POPs, POIs (DMPA and NET-EN), and LNG and ETG implants (MEC Category 1) (Part I, section 12d).</p> <p><b>REC B.17:</b> Women using ART containing either efavirenz or nevirapine can generally use COCs, patches, rings, CICs, POPs, NET-EN and implants (MEC Category 2). However, women using efavirenz or nevirapine can use DMPA without restriction (MEC Category 1) (Part I, section 12d).</p>	<p>Strength of recommendation is indicated by MEC category, which is noted in text.<sup>16</sup></p> <p>Moderate- to very low-quality evidence</p> <p>Moderate- to very low-quality evidence</p> <p>Low- to very low-quality evidence</p> <p>Low- to very low-quality evidence</p>
<p><b>REC B.18:</b> Women using the newer non-nucleoside/nucleotide reverse transcriptase inhibitors (NNRTIs), etravirine and rilpivirine, can use all hormonal contraceptive methods without restriction (MEC Category 1) (Part I, section 12d).</p> <p><b>REC B.19:</b> Women using protease inhibitors (e.g. ritonavir and antiretrovirals [ARVs] boosted with ritonavir) can generally use COCs, contraceptive patches and rings, CICs, POPs, NET-EN, and LNG and ETG implants (MEC Category 2), and can use DMPA without restriction (MEC Category 1) (Part I, section 12d).</p> <p><b>REC B.20:</b> Women using the integrase inhibitor raltegravir can use all hormonal contraceptive methods without restriction (MEC Category 1) (Part I, section 12d).</p> <p><b>REC B.21:</b> Intrauterine device (IUD): Women using ARV medication can generally use LNG-IUDs (MEC Category 2), provided that their HIV clinical disease is asymptomatic or mild (WHO stage 1 or 2). Women living with severe or advanced HIV clinical disease (WHO stage 3 or 4) should generally not initiate use of the LNG-IUD (MEC Category 3 for initiation) until their illness has improved to asymptomatic or mild HIV clinical disease. However, women who already have an LNG-IUD inserted and who develop severe or advanced HIV clinical disease need not have their IUD removed (MEC Category 2 for continuation). LNG-IUD users with severe or advanced HIV clinical disease should be closely monitored for pelvic infection (Part I, section 12d).</p>	<p>Low- to very low-quality evidence</p> <p>Low- to very low-quality evidence</p> <p>Low- to very low-quality evidence</p> <p>Low- to very low-quality evidence</p>

14. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations – 2016 update. Geneva: World Health Organization; 2016 (<http://apps.who.int/iris/bitstream/10665/246200/1/9789241511124-eng.pdf>).

15. Reference for this and all the rest of the existing recommendations in this section on contraception, and for the next footnote: Medical eligibility criteria for contraceptive use, fifth edition. Geneva: World Health Organization; 2015 ([http://apps.who.int/iris/bitstream/10665/181468/1/9789241549158\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/181468/1/9789241549158_eng.pdf)).

16. MEC categories (Medical eligibility criteria for contraceptive use, fifth edition, WHO, 2015):  
1: A condition for which there is no restriction for the use of the contraceptive method  
2: A condition where the advantages of using the method generally outweigh the theoretical or proven risks  
3: A condition where the theoretical or proven risks usually outweigh the advantages of using the method  
4: A condition which represents an unacceptable health risk if the contraceptive method is used.

## Antenatal care and maternal health services

<b>REC B.22 (NEW):</b> WHO recommends that elective caesarean section (C-section) should not be routinely recommended to women living with HIV.	Strong recommendation, low-quality evidence
<b>REC B.23:</b> Late cord clamping (performed approximately 1–3 minutes after birth) is recommended for all births while initiating simultaneous essential newborn care. <sup>17</sup>	Strong recommendation, moderate-quality evidence
<b>REC B.24:</b> ART should be initiated in all adolescents living with HIV, regardless of WHO clinical stage and at any CD4 cell count. <sup>18</sup>	Conditional recommendation, low-quality evidence
<b>REC B.25:</b> As a priority, ART should be initiated in all adolescents with severe or advanced HIV clinical disease (WHO clinical stage 3 or 4) and adolescents with a CD4 count $\leq 350$ cells/mm <sup>3</sup> . <sup>19</sup>	Strong recommendation, moderate-quality evidence
<b>REC B.26:</b> ART should be initiated in all pregnant and breastfeeding women living with HIV, regardless of WHO clinical stage and at any CD4 cell count, and continued lifelong. <sup>20</sup>	Strong recommendation, moderate-quality evidence
<b>REC B.27:</b> Mothers living with HIV should breastfeed for at least 12 months and may continue breastfeeding for up to 24 months or longer (similar to the general population) while being fully supported for ART adherence. <sup>21</sup>	Strong recommendation, low-quality evidence for 12 months, very low-quality evidence for 24 months
<b>REC B.28:</b> The use of amniotomy alone for prevention of delay in labour is not recommended. <sup>22</sup>	Weak recommendation, very low-quality evidence
<b>REC B.29:</b> The use of amniotomy and oxytocin for treatment of confirmed delay in labour is recommended. <sup>23</sup>	Weak recommendation, very low-quality evidence

## Safe abortion services

<b>REC B.30 (NEW):</b> WHO recommends that safe abortion services should be the same for women living with HIV who want a voluntary abortion as for all women.	Strong recommendation, very low-quality evidence
<b>REC B.31 (NEW):</b> WHO suggests that women living with HIV who want a voluntary abortion can be offered a choice of medical or surgical abortion, as for all women.	Conditional recommendation, very low-quality evidence

## Sexually transmitted infection and cervical cancer services

<b>REC B.32:</b> Sexually transmitted infection (STI) and family planning services can be integrated within HIV care settings. <sup>24</sup>	Conditional recommendation, very low-quality evidence
<b>REC B.33:</b> WHO recommends the human papillomavirus (HPV) vaccine for girls in the age group of 9–13 years. Girls receiving a first dose of HPV vaccine before the age of 15 years can use a two-dose schedule. The interval between the two doses should be six months. There is no maximum interval between the two doses; however, an interval of no greater than 12–15 months is suggested. If the interval between doses is shorter than five months, then a third dose should be given at least six months after the first dose. Immunocompromised individuals, including those who are living with HIV, and females aged 15 years and older should also receive the vaccine and need three doses (at 0, 1–2, and 6 months) to be fully protected. <sup>25</sup>	No details on strength or quality found, but recommendation is based on the GRADE approach

17. WHO recommendations for the prevention and treatment of postpartum haemorrhage. Geneva: World Health Organization; 2012 ([http://apps.who.int/iris/bitstream/10665/75411/1/9789241548502\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/75411/1/9789241548502_eng.pdf)).

18. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach, second edition. Geneva: World Health Organization; 2016 ([http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684_eng.pdf)).

19. Ibid.

20. Ibid.

21. Guideline: updates on HIV and infant feeding: the duration of breastfeeding, and support from health services to improve feeding practices among mothers living with HIV. Geneva: World Health Organization; 2016 (<http://apps.who.int/iris/bitstream/10665/246260/1/9789241549707-eng.pdf>).

22. WHO recommendations for augmentation of labour. Geneva: World Health Organization; 2014 ([https://www.ncbi.nlm.nih.gov/books/NBK258875/pdf/Bookshelf\\_NBK258875.pdf](https://www.ncbi.nlm.nih.gov/books/NBK258875/pdf/Bookshelf_NBK258875.pdf)).

23. Ibid.

24. Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach, second edition. Geneva: World Health Organization; 2016 ([http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684_eng.pdf)).

25. Comprehensive cervical cancer control: a guide to essential practice. Geneva: World Health Organization; 2014 ([http://apps.who.int/iris/bitstream/10665/144785/1/9789241548953\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/144785/1/9789241548953_eng.pdf)).

**Table 2: Summary list of WHO good practice statements for the sexual and reproductive health and rights (SRHR) of women living with HIV**

Note: Where good practice statements apply to “key populations” this includes women living with HIV and therefore these have been included in these guidelines.

## A. Creating an enabling environment: Good practice statements (GPS)

### Psychosocial support

**GPS A.1 (NEW):** Psychosocial support interventions, such as support groups and peer support, provided by, with, and for women living with HIV, should be included in HIV care.

### Healthy sexuality across the life course

**GPS A.2 (NEW):** Women living with HIV in all their diversity should be supported in their choice to have safe and fulfilling sexual relationships and sexual pleasure as they age. Women living with HIV who choose not to be sexually active should also be supported in their choice.

### Economic empowerment and resource access

**GPS A.3 (NEW):** Comprehensive assessment of food security with linkage to appropriate services is an integral component of the care of women living with HIV.

### Integration of SRHR and HIV services

**GPS A.4 (NEW):** Women living with HIV should have access to integrated and tailored comprehensive\* sexual and reproductive health (SRH) and HIV services.

**GPS A.5 (NEW):** Women living with HIV should be included in the design and delivery of these services.

\*As defined in the WHO Global Reproductive Health Strategy, 2004<sup>26</sup>

### Protection from violence and creating safety

**GPS A.6:** Violence against people from key populations should be prevented and addressed in partnership with key population-led organizations. All violence against people from key populations should be monitored and reported, and redress mechanisms should be established to provide justice.<sup>27</sup>

**GPS A.7:** Health and other support services should be provided to all persons from key populations who experience violence. In particular, persons experiencing sexual violence should have timely access to comprehensive post-rape care in accordance with WHO guidelines.

**GPS A.8:** Law enforcement officials and health- and social-care providers need to be trained to recognize and uphold the human rights of key populations and to be held accountable if they violate these rights, including perpetration of violence.

### Social inclusion and acceptance

**GPS A.9:** Policy-makers, parliamentarians and other public health leaders should work together with civil society organizations in their efforts to monitor stigma, confront discrimination against key populations and change punitive legal and social norms.

**GPS A.10:** Health-care workers should receive appropriate recurrent training and sensitization to ensure that they have the skills, knowledge and understanding to provide services for adults and adolescents from key populations based on all persons’ right to health, confidentiality and non-discrimination.

**GPS A.11:** It is recommended to make contraceptives affordable to all, including adolescents, and that law and policy support access to contraception for disadvantaged and marginalized populations.

26. Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets. Global Strategy adopted by the 57th World Health Assembly. Geneva: World Health Organization; 2004 ([http://apps.who.int/iris/bitstream/10665/68754/1/WHO\\_RHR\\_04.8.pdf](http://apps.who.int/iris/bitstream/10665/68754/1/WHO_RHR_04.8.pdf)).

27. Reference for this and all the rest of the existing good practice statements in section A of this table: Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations – 2016 update. Geneva: World Health Organization; 2016 (<http://apps.who.int/iris/bitstream/10665/246200/1/9789241511124-eng.pdf>).

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## Community empowerment

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**GPS A.12:** Programmes should be put in place to provide legal literacy and legal services to key populations so that they know their rights and applicable laws and can receive support from the justice system when aggrieved.

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## Supportive laws and policies and access to justice

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**GPS A.13:** Countries should work towards decriminalization of behaviours such as drug use/injecting, sex work, same-sex activity and nonconforming gender identities, and towards elimination of the unjust application of civil law and regulations against people who use/inject drugs, sex workers, men who have sex with men and transgender people.

**GPS A.14:** Countries should work towards developing non-custodial alternatives to incarceration of drug users, sex workers and people who engage in same-sex activity.

**GPS A.15:** Countries are encouraged to examine their current consent policies and consider revising them to reduce age-related barriers to HIV services and to empower providers to act in the best interest of the adolescent.

**GPS A.16:** It is recommended that sexual and reproductive health services, including contraceptive information and services, be provided for adolescent girls without mandatory parental and guardian authorization/notification.

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**GPS A.17:** Countries should work towards developing policies and laws that decriminalize same-sex behaviours and nonconforming gender identities.

**GPS A.18:** Countries should work towards legal recognition for transgender people.

**GPS A.19:** For transgender people the legal recognition of preferred gender and name may be important to reduce stigma, discrimination and ignorance about gender variance. Such recognition by health services can support better access, uptake and provision of HIV services.

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## B. Health interventions: Good practice statements (GPS)

### Brief sexuality communication (BSC)

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**GPS B.1:** Health policy-makers and decision-makers in health-care professional training institutions need to ensure that, where BSC is introduced, it respects, protects and fulfils clients' human rights.<sup>28</sup>

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### Contraception

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**GPS B.2:** It is recommended that third-party authorization requirements be eliminated, including spousal authorization requirements for women living with HIV for obtaining contraceptives and related information and services.<sup>29</sup>

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### Prevention of perinatal transmission of HIV

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**GPS B.3:** Mothers living with HIV and health-care workers can be reassured that ART reduces the risk of postnatal HIV transmission in the context of mixed feeding. Although exclusive breastfeeding is recommended, practising mixed feeding is not a reason to stop breastfeeding in the presence of ARV drugs.<sup>30</sup>

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28. Brief sexuality-related communication: recommendations for a public health approach. Geneva: World Health Organization; 2015 ([http://apps.who.int/iris/bitstream/10665/170251/1/9789241549004\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/170251/1/9789241549004_eng.pdf)).

29. Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations – 2016 update. Geneva: World Health Organization; 2016 (<http://apps.who.int/iris/bitstream/10665/246200/1/9789241511124-eng.pdf>).

30. Guideline: updates on HIV and infant feeding: the duration of breastfeeding, and support from health services to improve feeding practices among mothers living with HIV. Geneva: World Health Organization; 2016 (<http://apps.who.int/iris/bitstream/10665/246260/1/9789241549707-eng.pdf>).

# Chapter 1. Introduction

## 1.1 Background

There were an estimated 17.8 million women aged 15 and older living with HIV in 2015, constituting 51% of all adults living with HIV (1). Adolescent girls and young women are particularly affected; in 2015 they constituted 60% of young people aged 15–24 years who were living with HIV, and they also accounted for 58% of newly acquired HIV infections among young persons in that age group (1). In many countries, women living with HIV do not have equitable access to good-quality health services and are also faced with multiple and intersecting forms of stigma and discrimination. Furthermore, women living with HIV are disproportionately vulnerable to violence (2), including violations of their sexual and reproductive rights (3).

In 2016, the United Nations (UN) Committee on Economic, Social and Cultural Rights (CESCR) defined the right to sexual and reproductive health (SRH) as an “integral part of the right to health” (4). To ensure the sexual and reproductive health and rights (SRHR) of women and girls living with HIV, attention must be paid to the following critical dimensions (5):

- Human rights and gender equality must be placed at the centre of a comprehensive approach to health programming, in particular in relation to sexuality and sexual health.
- Health systems must be responsive to the inequalities in access to health care and quality of care, which negatively affect women living with HIV.
- Women living with HIV should be empowered and engaged in the development of policies and programmes that affect them.
- Monitoring, evaluation and accountability procedures must be strengthened to provide good-quality data, and to ensure remedies for violations of the rights of women living with HIV.

This new consolidated guideline has been developed by the World Health Organization (WHO) Department of Reproductive Health and Research (RHR) in response to requests from a wide range of organizations and individuals for an updated version of the 2006 WHO guidance, *Sexual and reproductive health of women living with HIV/AIDS: guidelines on care, treatment and support for women living with HIV/AIDS and their children in resource-constrained settings* (6).

Many significant changes in HIV-related policies, research and practice have occurred in the 10 years since the publication of the 2006 guidelines. These changes include the rapid expansion of antiretroviral therapy (ART), and the release in 2015 of WHO recommendations to offer immediate ART to all individuals living with HIV and to offer pre-exposure prophylaxis (PrEP) to individuals at substantial risk of HIV infection as an additional prevention choice (7). These changes in turn have contributed to advancing the SRHR of women living with HIV (8). Consequently, this guideline was considered by the Guidelines Review Committee (GRC) as a new guideline.

This guideline aims to provide:

- **Evidence-based recommendations** for the SRHR of women living with HIV in all of their diversity, with a particular focus on settings where the health system has limited capacity and resources; and
- **Good practice statements** on key operational and service delivery issues that need to be addressed to (i) increase access to, uptake of, and the quality of outcomes of SRH services, (ii) improve human rights and (iii) promote gender equality for women living with HIV.

WHO guidance exists on several specific aspects of SRHR and of HIV, but not all include considerations specific to the SRHR of women living with HIV. This consolidated guideline seeks to bring together both new

and existing recommendations and good practice statements related to the SRHR of women living with HIV into one document. Where current WHO guidance applies to all women, including women living with HIV, this document refers readers to these other publications for further information, as well as to other relevant WHO tools and documents on programme activities.

The recommendations and good practice statements presented in this guideline relate to either creating and maintaining an enabling environment for SRHR of women living with HIV (Chapter 3), or to specific health-related interventions relevant to the SRHR of women living with HIV (Chapter 4). All of the new and existing WHO recommendations presented in this guideline (and summarized in Table 1 in the Executive summary) have been developed using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach (9).

This guideline is meant to help countries to more effectively and efficiently plan, develop and monitor programmes and services that promote gender equality and human rights and hence are more acceptable and appropriate for women living with HIV. This guideline also includes discussion of implementation issues that managers of health interventions and service delivery must address to achieve gender equality and uphold human rights.

### Box 1.1: Definitions as used in this guideline

*An adolescent\**: a person 10–19 years of age, inclusive.

*An adult\**: a person older than 19 years of age.

*Key populations\*\**: People in the following groups: men who have sex with men, people in prisons and other closed settings, people who inject drugs, sex workers and transgender people, including adolescents and young people from key populations and people with overlapping vulnerabilities and differing risks. Key populations may also include other groups of women living with HIV in contexts of marginalization or vulnerability, as defined by the local context.

\* It is acknowledged that countries may have other definitions under their respective national laws.

\*\* The definition of key populations is taken from the WHO *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations – 2016 update* (10).

## 1.2 Target audience

This new guideline is expected to support front-line health-care providers, programme managers and public health policy-makers around the world to better address the SRHR of women living with HIV. It is primarily designed for national-level programme managers, policy-makers and other decision-makers within the ministry of health. Acknowledging that the woman-centred approach of this guideline (see section 1.4.1) may require multisectoral engagement, the guideline will also be useful for national-level programme managers from other ministries, such as the ministries of education, gender, family and social welfare, who can be partners in delivering interventions that support a holistic approach to SRHR.

Health services and programmes in low-resource settings will benefit most from the guidance presented here, as they face the greatest challenges in providing services tailored to women living with HIV in all their diversity. However, this guideline is relevant for all settings regardless of the situation of the HIV epidemic or the economic context, and should, therefore, be considered as global guidance. In implementing these global recommendations, WHO regions and countries can adapt them to the local context, taking into account the HIV epidemic, economic conditions, and existing health services and facilities.



The users of this guideline, including health-care providers, programme managers and public health policy-makers, are urged to: (i) implement a woman-centred, gender-sensitive approach to addressing the SRH needs, aspirations and rights of women living with HIV, and to (ii) meet the health needs and support the aspirations of all women living with HIV throughout all stages of the life course, including the post-menopausal years.

## 1.3 Scope

### 1.3.1 Population of interest

With reference to the 2015 WHO *Consolidated guidelines on HIV testing services* (11), this guideline will not include HIV testing, but is relevant for women from the point when they already know they are living with HIV. Women living with HIV who are not aware that they have HIV must first be reached by safe, voluntary, non-coercive HIV testing and counselling, and follow-on services, which need to be expanded and strengthened. In addition, although this guideline focuses on women who have been tested and know their positive HIV serostatus, it is acknowledged that the SRHR issues highlighted are, in many cases, similar for all women.

This guideline focuses on the SRHR of women living with HIV; while the SRHR of men living with HIV must also be addressed, this is not within the scope of this guideline. HIV is not only driven by gender inequality, but it also entrenches gender inequality, leaving women more vulnerable to its impact. The focus on women living with HIV is justified because many face unique and particular challenges and rights violations in relation to their gender, sexuality and reproductive roles within their families and communities, as well as from the health-care institutions where they seek services.

### 1.3.2 Creating and maintaining an enabling environment

The SRHR of women living with HIV is strongly influenced by a range of social, cultural, political and economic factors. Factors that can impede SRHR include, but are not limited to: inequitable gender norms; gender-based and intimate partner violence (GBV and IPV); stigma and discrimination; lack of empowerment among women and girls; violations of human rights; and restrictive and often punitive laws and policies that increase the vulnerability of women living with HIV and limit their health, well-being, and realization of their rights. These factors also pose significant barriers to accessing and utilizing high-quality SRH and HIV services. Policies, programmes and interventions to improve the SRHR of women living with HIV exist in some places, but these alone will not bring about improved health outcomes in the absence of a safe and supportive enabling environment. For this reason, issues related to creating and maintaining an enabling environment, and specific relevant recommendations and good practice statements, including five new good practice statements (GPSs A.1–A.5), are included in the scope of this new consolidated guideline. These are presented in Chapter 3 under the following eight topic areas: psychosocial support; healthy sexuality across the life course; economic empowerment and resource access; integration of SRHR and HIV services; protection from violence and creating safety; social inclusion and acceptance; community empowerment; and supportive laws and policies as well as access to justice (see also section A of Tables 1 and 2 in the Executive summary, and Figure 2.1 at the end of Chapter 2).

### 1.3.3 Priority questions and outcomes of interest for health interventions

Four priority questions in PICO format (population, intervention, comparator, outcome) were drafted for the development of this guideline, including details of the priority outcomes of interest for each, that could lead to improved SRHR for women living with HIV (see Chapter 2, section 2.5.1). The six new evidence-based recommendations that emerged from the guideline development process (RECs B.1, B.4, B.5, B.22, B.30, B.31), and all the other consolidated existing recommendations and good practice statements that relate to health-care interventions are presented in Chapter 4 of this guideline under the following six types of services: sexual health counselling and support services; violence against women services; family planning and infertility services; antenatal care and maternal health services; safe abortion services; and sexually

transmitted infection (STI) and cervical cancer services (see also section B of Tables 1 and 2 in the Executive summary, and Figure 2.1 at the end of Chapter 2).

## 1.4 Approach and guiding principles

This guideline is grounded in and advocates for a strengthened, comprehensive, woman-centred approach to SRHR, with the assumption that if access to quality services is improved for all women, this will also benefit women living with HIV, and vice versa. This approach is underpinned by the guiding principles of gender equality and human rights.

### 1.4.1 Woman-centred approach

Woman-centred health services involve an approach to health care that consciously adopts the perspectives of women, their families and communities (12).

A woman-centred approach:

- sees women as active participants in, as well as beneficiaries of, trusted health systems that respond to their needs, rights and preferences in humane and holistic ways;
- emphasizes the promotion of gender equality as central to the achievement of SRHR of all women, including women living with HIV, and promotes gender-transformative health services which examine critical gender norms and support gender equality;
- requires that women are empowered – through education and support – to make and enact decisions in all aspects of their lives, including in relation to sexuality and reproduction;
- calls for strategies that promote women’s participation in their own health care;
- recognizes the strengths of women living with HIV as active agents in relation to SRHR, and not merely passive recipients of health services; and
- is organized around the health needs and priorities of the women themselves rather than disease management and control.

This guideline is intended to address women living with HIV in all their diversity, including, but not limited to: women who are heterosexual, lesbian, bisexual, transgender or intersex; women who use or have used drugs; women who are or have been involved in sex work; women who are single, married or in stable relationships, separated, divorced or widowed; women who are and are not sexually active; women and girls who have undergone female genital mutilation (FGM); women who have tuberculosis (TB), malaria, hepatitis B or C and/or other co-morbidities; women who are currently or have previously been incarcerated, detained or homeless; women who are economic or political migrants; women who are indigenous; women living with disabilities; as well as adolescent girls who have acquired HIV perinatally, in childhood or during adolescence. This guideline recognizes that in all countries, but especially in areas with high HIV prevalence, some health workers are, themselves, women living with HIV who have their own priorities, needs and aspirations that require special consideration. The guideline captures diversity across age groups, emphasizing that health services that promote SRHR are important for women throughout all stages of the life course, including the post-menopausal years.

Many women living with HIV face multiple and intersecting forms of inequality and discrimination, depending on the local context. Each country should therefore understand and identify specific populations of women living with HIV that are particularly vulnerable and also those groups that are most relevant to the local epidemic, and should develop their response based on this local epidemiological and social context.

This guideline makes every effort to use language that is respectful of women living with HIV. It also promotes positive messages around health, instead of focusing exclusively on health problems. This woman-centred, rather than disease-centred, orientation can reduce stigma and support a life-enhancing, positive approach to SRHR (13).



## 1.4.2 Guiding principles: human rights and gender equality

An integrated approach to health and human rights lies at the heart of ensuring the dignity and well-being of women living with HIV. The protection of human rights for all women living with HIV is therefore fundamental to this guideline. This includes a variety of human rights, namely: the right to the highest attainable standard of physical and mental health (14); the right to life and physical integrity, including freedom from violence (15); the right to equality and non-discrimination on the basis of sex (15); and the right to freedom from torture or cruel, inhuman or degrading treatment or punishment (16). Furthermore, article 27 of the Universal Declaration of Human Rights states that everyone has the right freely to share in scientific advancement and its benefits (16). Recently, in its *General Comment No. 22 (2016) on the right to sexual and reproductive health*, the UN Committee on Economic, Social and Cultural Rights (CESCR) defined the right to SRH as an “integral part of the right to health enshrined in article 12 of the International Covenant on Economic, Social and Cultural Rights” (4).

The Programme of Action of the International Conference on Population and Development (ICPD) in 1994 highlighted reproductive and sexual health issues within a human rights framework (17). Since then, international and regional human rights standards and jurisprudence related to the right to SRH have evolved considerably. Most recently, the 2030 Agenda for Sustainable Development includes Sustainable Development Goals (SDGs) and targets to be achieved in the area of SRH (18), as does the Global Strategy on Women’s, Children’s and Adolescents’ Health 2016–2030 (19).

The ICPD Programme of Action defines reproductive health as: “a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes” (17, para 7.2). The Programme of Action also refers to sexual health, “the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases”. It further defines reproductive rights as follows:

[R]eproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents (17, para 7.3).

Importantly, the CESCR’s recent *General Comment No. 22* recognizes that “people living with HIV/AIDS are more likely to experience multiple discrimination” and that “States must reform laws that impede the exercise of the right to sexual and reproductive health, including in relation to HIV status and transmission”, and recommends adoption of “appropriate legislative, administrative, budgetary, judicial, promotional and other measures to ensure the full realization of the right to sexual and reproductive health” (4, para 45).

In the course of developing this guideline, two literature reviews were conducted to support the rights-based case for strengthened services that meet the needs and aspirations of women living with HIV. These reviews included a special focus on: (i) the challenges of ensuring that human rights considerations are highlighted by normative bodies (20); and (ii) analysis of human rights within policies and programmes affecting women living with HIV (21). The reviews highlighted key gaps in jurisprudence among international, regional and national bodies. The guidance from these bodies reflects only a few health and human rights considerations related to women living with HIV and SRH. The approach of these bodies has been largely ad hoc and lacks a systematic integration of the human rights concerns of women living with HIV in relation to their SRH. Of the articles and documents reviewed, not a single peer-reviewed article described the explicit implementation of human rights in SRH programming, and only two documents from the grey literature did so. With one possible exception, no articles or documents were found that addressed human rights comprehensively, or addressed the majority of relevant rights. As the two literature reviews were explicitly about the SRHR of women living with HIV, and they reviewed articles that implicitly dealt with these issues and built upon the nine agreed-upon human rights dimensions that are the foundation to good SRHR (see Table 1.1), this highlights a significant gap.

**Table 1.1: Human rights dimensions that are foundational to good SRHR**

Standard terminology	Alternative terminology
Equality and non-discrimination	reduce discrimination, reduce criminalization, combat negative social and cultural attitudes, stigma, prejudice, (domestic) violence, gender inequality
Participation	involvement, engagement, advocacy, influence
Privacy and confidentiality	–
Informed decision-making	(direct) consent, choice, informed, comprehensible
Availability	make available, provide, exist
Accessibility	access, receive, affordable, eligible
Acceptability	conscientious objection, medical ethics, human rights sensitivity
Quality of services	proper medical care, adequacy
Accountability	liability, responsibility, calling upon States Parties, enforcement, legal measures

Source: WHO, 2014 (22).

In addition, in the articles included in the reviews, the language of rights was used most often to describe the apparent neglect or violation of human rights, as opposed to describing efforts to protect, promote or fulfil rights. When rights-related language was used, it primarily addressed only a few rights (most commonly the rights to access and non-discrimination) in the context of a few areas within SRH, while the issues of STIs, violence and ageing, for instance, were largely neglected.

The two reviews also highlighted the need for Member States to establish and enforce antidiscrimination and protective laws, derived from international human rights standards, in order to eliminate stigma, discrimination and violence faced by women living with HIV (20, 21).

Such laws and policies should also address gender inequalities, including harmful gender norms and stereotypes, unequal power in intimate relationships, and women’s relative lack of access to and control over resources. All of these inequalities exacerbate the vulnerability of women living with HIV, affect their access to and experience of health services, and create barriers that prevent them from fully exercising their rights to health, including SRH. The promotion of gender equality is central to the achievement of SRHR of all women, including women living with HIV in all their diversity.

### 1.4.3 Applying the woman-centred approach and guiding principles

In recognition of all the issues and gaps that have been identified and mentioned here, this guideline aims to propose a comprehensive package of SRH services for women living with HIV, emphasizing that attention must be paid to adopting a woman-centred approach and applying the principles of human rights and gender equality, with reference to the guidance presented in Box 1.2. Box 1.3 provides a list of key WHO resources on human rights and SRH in general and in relation to specific health interventions and stakeholders. While the focus in this guideline is on human rights as they pertain to SRH, it is acknowledged that all aspects of human rights are important.

### Box 1.2: Guidance on the application of a woman-centred approach based on principles of human rights and gender equality for SRHR of women living with HIV

1. Uphold and foster human rights and gender equality to address power imbalances, GBV, stigma, discrimination and rights-related barriers to SRH at all levels.
2. Strengthen health systems to increase programme effectiveness and efficiency to facilitate improved delivery of a holistic range of high-quality woman-centred health services.
3. Engage and empower women living with HIV in the development of policies and programmes that affect them, to ensure these address their lived realities.
4. Promote or advocate for a conducive legal and policy environment which safeguards and promotes SRHR of women living with HIV.
5. Support access to, and affordability and utilization of, quality health services for prevention and treatment of SRH concerns.
6. Ensure acceptability of services to women living with HIV in all their diversity to overcome barriers based on exclusion, isolation, criminalization and poor understanding of women's strengths and needs.
7. Promote women's agency and empowerment, including through health literacy and education, and support them to make informed choices and enact decisions that promote their own, their families' and their communities' health.
8. Strengthen linkages and/or integration in service provision where needed, to ensure holistic woman-centred health care.
9. Promote accountability of health systems to ensure avenues for redress of rights violations and problems if they arise.

### Box 1.3: Key WHO human rights and sexual and reproductive health resources

- *Sexual health, human rights and the law*, 2015 (23)
- *Sexual and reproductive health and rights: a global development, health, and human rights priority*, 2014 (24)
- *Brief sexuality-related communication: recommendations for a public health approach*, 2015 (25)
- *The prevention and elimination of disrespect and abuse during facility-based childbirth: WHO statement*, 2015 (26)
- *Reproductive, maternal, newborn and child health and human rights: toolbox for examining laws, regulations and policies*, 2014 (27)
- *Eliminating forced, coercive and otherwise involuntary sterilization: an interagency statement*, 2014 (28)
- *Framework for ensuring human rights in the provision of contraceptive information*, 2014 (22)
- *Ensuring human rights in the provision of contraceptive information and services: guidance and recommendations*, 2014 (29)
- *Ensuring human rights within contraceptive service delivery: implementation guide*, 2015 (30)
- *Ensuring human rights within contraceptive programmes: a human rights analysis of quantitative indicators*, 2014 (31)
- *Safe abortion: technical & policy guidance for health systems*, 2012 (32)
- *Safe abortion: technical & policy guidance for health systems, legal and policy considerations – key messages*, 2015 (33)

*Summary reflection guides on a human rights-based approach to health application to sexual and reproductive health, maternal health and under-5 child health* – issued by Office of the United Nations High Commissioner for Human Rights (OHCHR), Harvard FXB Center for Health and Human Rights, the Partnership for Maternal, Newborn and Child Health (PMNCH), the United Nations Population Fund (UNFPA) and WHO, for the following stakeholder groups:

- Health workers, 2016 (34)
- Health policy makers, 2015 (35)
- National human rights institutions, 2015 (36)

## 1.5 Values and preferences of women living with HIV

Unique to the development of this WHO guideline, a global survey was conducted to assess the SRHR priorities of women living with HIV so that their values and preferences could be placed at the heart of the guideline. This global survey, hereafter referred to as the Global Values and Preferences Survey (GVPS), is the largest survey to date on the SRHR of women living with HIV. It was conducted by and for women living with HIV in 2014 to capture their perspectives in their own voices. The report of findings, *Building a safe house on firm ground: key findings from a global values and preferences survey regarding the sexual and reproductive health and human rights of women living with HIV* (37), and a related article published in the *Bulletin of the World Health Organization*, include detailed descriptions of the methods and limitations of the survey (37, 38). The limitations included the fact that the survey was most likely to reach women living with HIV globally who were (i) actively involved in networks of people living with HIV; (ii) aware of and potentially more open about their HIV status; and (iii) able to access an online survey using the Internet or participate in the focus group discussions.

A total of 945 women living with HIV participated in the survey, including 832 (from 94 countries) who responded to the quantitative survey, and another 113 (from 7 countries) who participated in focus group discussions. Respondents ranged in age from 15 to 72 years and came from a diverse range of backgrounds and experiences, including: women identifying as heterosexual, lesbian, bisexual, transgender or intersex; women who reported that they use or have used drugs; women involved in sex work; women who reported being single, married or in stable relationships; women who had undergone FGM; women who had TB, malaria, hepatitis B or C and/or other co-morbidities; women who had been incarcerated, detained or homeless; women who reported being economic or political migrants; women identifying as indigenous; women living with disabilities; and women who work as health-care providers.

The GVPS results were presented at a stakeholder consultation on SRHR of women living with HIV at the WHO headquarters in Geneva, in January 2015. The WHO Department of RHR continues to work with the community of women living with HIV, including representatives from key constituencies and different regions of the world. A special supplement in the *Journal of the International AIDS Society (JIAS)*, published in December 2015, highlighted a few of the key issues that have emerged from the discussions and collaboration, in particular related to violence against women living with HIV, and mental health issues (8). In addition, several activities have taken place as a result of the survey, including the development of further peer-reviewed publications and webinars, led by the community of women living with HIV.

The findings of the GVPS (summarized in Box 1.4) informed the development of this guideline as a whole. The Guideline Development Group (GDG) took the findings of the GVPS into account when drafting the PICO (population, intervention, comparison, outcome) questions for the development of new recommendations (see Chapter 2, section 2.5 and Table 2.2) and when drafting the questions that formed the starting point for the new good practice statements. The GVPS also informed the GDG in writing and finalizing the recommendations, the good practices statements and the full guideline document. In particular, relevant survey findings are included in each topic area addressed throughout Chapters 3 and 4.



This symbol representing the values and preferences of women living with HIV is used to alert the reader wherever results from the GVPS are reported.

#### Box 1.4: Key findings of the Global Values and Preferences Survey (GVPS)

- For women living with HIV, safety was considered paramount. Most survey respondents had experienced violence or fear of violence, before, since or because of their HIV diagnosis, and they called for measures to ensure safety for women living with HIV within health services, at home and in the community.
- Respondents highlighted the need to redress human rights violations, including mandatory testing, involuntary disclosure, and coerced or forced sterilization and abortion.
- Women living with HIV reported gaps in clinical care, practice, policy and research for girls and women outside the reproductive years and for women who do not have children. A holistic, woman-centred con(tra)ception-to-old-age approach to SRH care, with a comprehensive package of age- and stage-appropriate services, was consequently felt to be essential.
- Respect for women living with HIV in all their diversity, including respectful provision of health services and respect for their ability to make informed decisions about their own SRH care, was considered indispensable, particularly given the reported difficulty and considerable lack of empowerment in decision-making around when, how and with whom to have sex, and whether and when to have children.
- Women living with HIV sought further acknowledgement of the importance of peer support and meaningful involvement in decisions that affect their own lives.
- Widespread concerns about punitive and repressive laws were reported, with these laws viewed as barriers to their achievement of health and human rights.
- Many reported challenges to achieving a pleasurable and satisfying sex life, including lack/loss of sexual desire and fear of onward HIV transmission, pregnancy and STIs, linked with difficulties around condom availability, negotiation and use, as well as fears of the impact and consequences of HIV disclosure (including violence).
- Fear of onward transmission of HIV to a child or partner was often compounded by stigmatizing attitudes from health workers.
- Many respondents reported being on HIV treatment and experiencing side-effects that they felt affected their sexual health and overall well-being.
- Respondents also emphasized the challenges of poverty and financial insecurity, which could be a barrier to accessing services and realizing human rights, as well as the associated strain on mental, physical and sexual health. In particular, the wide range and high prevalence of mental health difficulties cited by women living with HIV highlighted the complex implications of an HIV-positive diagnosis.
- Finally, women wanted support for interactions with their children, partners and communities

Source: The Salamander Trust, 2016 (37).

# Chapter 2. Methodology and process for development of the guideline

The WHO Department of Reproductive Health and Research (RHR) led the development of this consolidated guideline, following WHO procedures and reporting standards laid out in the *WHO handbook for guideline development* (39). Given the significant difference in scope to the 2006 guidelines (6), a new title was proposed by the WHO Guideline Steering Group: *Consolidated guideline on sexual and reproductive health and rights of women living with HIV*. Consequently, this guideline was presented and viewed as a new submission by the WHO Guidelines Review Committee (GRC) and not considered an update of the 2006 document.

## 2.1 Guideline development working groups

The RHR Department set up three working groups to perform specific guideline development functions: the WHO Guideline Steering Group (SG), the Guideline Development Group (GDG) and the External Review Group (ERG). Members of the groups were selected so as to ensure a range of expertise and experience, including appropriate representation in terms of geography, gender and the community of people living with HIV. The three working groups are described in the following subsections and the names and institutional affiliations of the participants of each group are listed in Annex 1.

### 2.1.1 The WHO Guideline Steering Group (SG)

The SG, chaired by the RHR Department, led the guideline development process. The SG included participants from three departments within the WHO Family, Women's and Children's Health Cluster (FWC) – the RHR Department, the Department of Maternal, Newborn, Child and Adolescent Health (MCA) and the Department of Ageing and Life Course (ALC) – as well as from the Gender, Equity and Human Rights Team (GER), and from other WHO departments including the Department of HIV/AIDS and the Department for Mental Health and Substance Abuse (MSD), along with representatives from the WHO Regional Offices for Africa, the Americas, Europe, the Eastern Mediterranean and South-East Asia. The SG drafted the initial scope of the guideline and drafted the priority questions in PICO format (population, intervention, comparator, outcome), identified individuals to participate as guideline methodologists and as members of the systematic review teams, the Guideline Development Group (GDG) and the External Review Group (ERG). The SG also finalized and published the guideline document, and will oversee dissemination of the guideline and be involved in the development of implementation tools.

### 2.1.2 The Guideline Development Group (GDG)

The SG identified and invited external experts and stakeholders from the six WHO regions to form the GDG, ensuring geographic representation and gender balance. The members of the GDG had expertise in a wide range of SRHR and HIV issues covered in this guideline; they included clinicians, researchers, policy-makers, programme managers and representatives of communities of people living with HIV. The GDG members were involved in reviewing and finalizing key PICO questions and reviewing evidence summaries from the commissioned systematic reviews. They were also responsible for formulating new WHO recommendations and good practice statements, as well as for achieving consensus on the final content.

### 2.1.3 The External Review Group (ERG)

The ERG included peer reviewers with a broad range of expertise in issues related to SRHR and HIV, drawn from the community of people living with HIV, clinicians, researchers, policy-makers and programme managers. The group ensured that the guideline decision-making processes had considered and incorporated



the contextual values and preferences of persons affected by the recommendations. The ERG members provided their feedback and comments on the draft of the guideline that was shared with them after being drafted, reviewed and revised by the SG and GDG. It was not within the ERG's remit to change the recommendations that had been formulated by the GDG.

## 2.2 Additional key contributors

### 2.2.1 External partners

In accordance with guidance in the *WHO handbook for guideline development* (39), funders, donors and representatives of UN agencies were invited to attend the GDG meeting as observers. These external partners represented the following agencies:

- The Global Fund to Fight AIDS, Tuberculosis and Malaria
- Joint United Nations Programme on HIV/AIDS (UNAIDS)
- United Nations High Commissioner for Human Rights (OHCHR)
- United Nations Population Fund (UNFPA)
- United States Agency for International Development (USAID).

### 2.2.2 Women living with HIV

Crucial to the development of this guideline at all stages of the process has been the partnership and engagement with – and the meaningful involvement of – women living with HIV, both as members of the GDG and ERG and as partners in leading and developing the Global Values and Preferences Survey (GVPS), including the investigation methodology, analysis and conclusions (see Chapter 1, section 1.5) (40).

Community engagement in the guideline process was assured through participation in:

- the GVPS, conducted in 2014, and dissemination of the report of the survey findings in 2014–2015 (37);
- the stakeholder meeting in January 2015, to share results and key outcomes of the GVPS; and
- the GDG and the ERG, which both included women living with HIV as members.

## 2.3 Declaration of interests by external contributors

In accordance with WHO rules for transparency, prior to issuing formal invitations for individuals to become members of the GDG and ERG, brief biographies of the selected individuals (approximately 350 words) were made available to the public on the Department's website for three weeks (February 2016). In accordance with the *WHO handbook for guideline development* (39), all prospective members of the GDG and ERG and the other selected external collaborators were asked to declare in writing any academic, financial or other competing interests at the time of the invitation to participate in the development of the guideline. The standard WHO form for declaration of interests (DOI) was completed and signed by each expert and sent electronically, along with their curriculum vitae, to the responsible technical officer. This officer collated the signed DOI forms and curriculum vitae and, together with members of the SG, reviewed the information and determined whether a conflict of interest existed before granting final approval for the experts' invitations to participate. Where any conflict of interest was declared, the SG determined whether it was serious enough to affect the individual's ability to make objective judgements about the evidence or recommendations. To ensure consistency, the SG applied the criteria for assessing the severity of a conflict of interest in the *WHO handbook for guideline development* (39).

All findings from the received DOI statements were managed in accordance with the WHO DOI guidelines on a case-by-case basis. Where a conflict of interest was not considered significant enough to pose any risk to the guideline development process or reduce its credibility, the expert was only required to declare such conflict at the GDG meeting (also called the Technical Consultation) and no further action was taken. There were no cases of conflicts of interest that warranted management of DOI and assessment of potential conflicts of

interest by the WHO Office of Compliance, Risk Management and Ethics (CRE). On confirmation of their invitations to participate, all experts were instructed to notify the responsible technical officer of any change in relevant interests during the course of the guideline development process, in order to update and review any conflicts of interest accordingly. At both the scoping meeting in January 2015 and again at the GDG meeting in April 2016 (both held in Geneva, Switzerland), members were required to state any conflicts of interest openly to the entire group, and were required to submit a signed and updated DOI form. A summary of the DOI statements and information on how conflicts of interest were managed are included in Annex 2.

## 2.4 Defining the scope and topic areas for new recommendations and good practice statements

Working within the general scope of the guideline as presented in Chapter 1, section 1.3 – the population of interest and the intention of addressing both an enabling environment and specific relevant health interventions – the SG first mapped all existing WHO SRHR guidance with relevance for women living with HIV. The SG then reviewed these and other materials to identify gaps, overlaps and inconsistencies and to determine the relevance of existing recommendations for inclusion in this consolidated guideline. The SG identified the following eight topic areas where new recommendations or good practice statements needed to be developed for this guideline: psychosocial support; ageing and healthy sexuality; economic empowerment and resource access (including food security); integration of SRHR and HIV services; empowerment and self-efficacy around safer sex and reproductive decision-making; facilitating safe disclosure for women living with HIV who fear or experience violence; modes of delivery for best maternal and perinatal outcomes (specifically caesarean section); and safe medical and surgical abortion. The outcome of the mapping exercise was presented at the scoping meeting in January 2015.

## 2.5 Review of the evidence and formulation of recommendations

### 2.5.1 Defining and reviewing priority questions

Development of the new recommendations on health interventions (RECs B.1, B.4, B.5, B.22, B.30, B.31; see Table 1 in the Executive summary, and Chapter 4) began with formulating the PICO questions and subsequently conducting relevant systematic reviews of the evidence. The four PICO questions for the new recommendations were as follows:

1. What interventions improve self-efficacy and empowerment around safer sex and reproductive decision-making for women living with HIV?
2. What interventions facilitate safe disclosure of HIV status for women living with HIV who fear violence or who disclose that they are currently experiencing violence?
3. What modes of delivery result in the best maternal and perinatal outcomes for women living with HIV?
4. Do outcomes of medical and surgical abortion among women living with HIV differ from outcomes among HIV-uninfected women?

The full details on the population, intervention, comparator and outcomes for each of the four PICO questions are presented in Annex 3, while the summaries of the methods for each of those four systematic reviews, including the search strategies and flow charts for inclusion of studies, are included along with the evidence base (the GRADE tables) in the Web supplement to this guideline.<sup>1</sup>

A list of all 13 systematic and literature reviews conducted for the development of this guideline – including the four systematic reviews on the topics of the six new recommendations, five systematic reviews on the topics of the five new good practice statements (GPSs A.1–A.5; see Table 2 in the Executive summary, and Chapter 3), and another four literature reviews on other related topics – is presented in Annex 4.

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1. Available at: [www.who.int/reproductivehealth/publications/gender\\_rights/srhr-women-hiv/en/](http://www.who.int/reproductivehealth/publications/gender_rights/srhr-women-hiv/en/)



## 2.5.2 Interpretation of the quality of the evidence for recommendations

In accordance with the WHO guideline development process, the GDG formulated the recommendations guided by the quality of available evidence (39). WHO has adopted the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach to recommendation development, which defines the quality of evidence as the extent to which one can be confident that the reported estimates of effect (desirable or undesirable) available from the evidence are close to the actual effects of interest (41, 42, 43). The GRADE approach specifies four levels of quality of evidence, which should be interpreted as detailed in Table 2.1.

**Table 2.1: Significance of the four GRADE levels of quality of evidence**

Quality of evidence	Rationale
<b>High</b>	We are very confident that the true effect lies close to that of the estimate of the effect
<b>Moderate</b>	We are moderately confident in the effect estimate: the true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different
<b>Low</b>	Our confidence in the effect estimate is limited: the true effect may be substantially different from the estimate of the effect
<b>Very low</b>	We have very little confidence in the effect estimate: the true effect is likely to be substantially different from the estimate of effect

Source: Balshem et al., 2011 (44).

The GRADE approach (9) to appraising the quality of quantitative evidence was used for all the critical outcomes identified in the PICO questions, and a GRADE profile was prepared for each quantitative outcome within each PICO. The GRADE tables are presented in the Web supplement.

## 2.5.3 Determining the strength of a recommendation

The strength of a recommendation – assigned as either “strong” or “conditional” – reflects the degree of confidence of the GDG that the desirable effects of the recommendation outweigh the undesirable effects.

Desirable effects (i.e. potential benefits) may include beneficial health outcomes for individuals (e.g. reduced morbidity and mortality), reduced burden on the individual and/or the health services, and cost-savings for the individual, the community, the programme and/or the health system. Undesirable effects (i.e. potential harms) include adverse health outcomes for individuals (e.g. increased morbidity and mortality) and increased burden on the individual, the family, the community, the programme and/or the health system. This may include, for example, the resource use and cost implications of implementing the recommendations – which programmes, health-care providers or clients would have to bear – as well as potential legal ramifications where certain practices are criminalized.

**A strong recommendation** (for or against the intervention) is one for which there is confidence that the desirable effects of adherence to the recommendation clearly outweigh the undesirable effects. The higher the quality of the scientific evidence base, the more likely that a strong recommendation can be made. New strong recommendations in this guideline are worded as “WHO recommends...”.

**A conditional recommendation** (for or against the intervention) is one for which the quality of the scientific evidence base may be low or may apply only to specific groups or settings; or it may be assigned in cases where the GDG concludes that the desirable effects of adherence to the recommendation probably outweigh the undesirable effects or are closely balanced, but the GDG is not confident about these trade-offs in all situations. New conditional recommendations in this guideline are worded as “WHO suggests...”.

If implemented, an intervention that received only a conditional recommendation should be monitored closely and evaluated rigorously. Further research will be required to address the uncertainties and this may provide new evidence that may change the calculation of the balance of trade-offs.

The values and preferences of the end-users (women living with HIV), as well as consideration of the relevant feasibility, cost and equity issues, all contribute to determining the strength of a recommendation.

**Table 2.2: Domains considered when assessing the strength of recommendations**

Domain	Rationale
<b>Benefits and risks</b>	When a new recommendation is developed, desirable effects (benefits) need to be weighed against undesirable effects (risks), considering any previous recommendation or another alternative. The larger the gap or gradient in favour of the benefits over the risks, the more likely that a strong recommendation will be made.
<b>Values and preferences (acceptability)</b>	If the recommendation is likely to be widely accepted or valued highly, it is likely that a strong recommendation will be made. If there is a great deal of variability or strong reasons that the recommended course of action is unlikely to be accepted, it is more likely that a conditional recommendation will be made.
<b>Costs/financial implications</b>	Lower costs (monetary, infrastructure, equipment or human resources) or greater cost-effectiveness are more likely to support a strong recommendation.
<b>Feasibility</b>	The greater the feasibility of an intervention to all stakeholders, the greater the likelihood of a strong recommendation.
<b>Equity</b>	If an intervention will reduce inequities, improve equity or contribute to the realization of human rights, the greater the likelihood of a strong recommendation.

Source: Schünemann et al., 2013 (45).

## 2.6 Decision-making by the GDG during guideline development

The GDG members were guided by a clear protocol for WHO guideline development (39). The GDG reviewed the evidence and discussed the topics under consideration, led by the guideline methodologist. The GDG meeting or Technical Consultation in April 2016, in Geneva, Switzerland, was designed to allow participants to draft and consider each of the recommendations through a process of group discussion and revision. In order to gain an initial indication of GDG members' views on the direction of each recommendation (to recommend for or against an intervention), and on the strength of each recommendation (strong or conditional) as drafted, the methodologist asked participants to raise their hands in support of each separate option. This was not a formal vote, but a decision-making aid to allow the methodologist and chairs to gauge the distribution of opinion and subsequently work towards consensus through further discussion. The final adoption of each recommendation, including its direction and strength, was confirmed by unanimous consensus among all GDG members. The GDG also determined the context of recommendations by the same process of consensus, based on discussions around the balance of evidence on the potential benefits and disadvantages of the interventions across the domains evaluated. The judgements made by the GDG related to each recommendation are noted in Annex 5.

## 2.7 Compilation and presentation of guideline content

Following the GDG meeting, members of the SG prepared a draft of the full guideline document, including revisions to the recommendations to accurately reflect the deliberations and decisions of the GDG participants.

The draft guideline was then sent electronically to the GDG participants for further comment, and their feedback was integrated into the document before it was sent to the External Review Group (ERG) for their input. The SG then carefully evaluated the input of the ERG members for inclusion in the guideline document. After the GDG meeting and the external peer-review process, any further modifications made to the guideline by the SG were limited to correction of factual errors and improvement in language to address any lack of clarity. The revised final version was returned electronically to the participants of the GDG for their final approval.

This guideline presents WHO recommendations that have been newly developed and published for the first time in this guideline in 2017 (indicated by the label of “NEW” after the recommendation number) and existing recommendations that have been previously published in other WHO guidelines that applied the GRADE approach (all the recommendations not labelled as “NEW”), as well as new and existing good practice statements (again the former are labelled as “NEW”).

**The five new good practice statements** (GPSs) apply to the creation and maintenance of the enabling environment required for successful achievement of optimal SRHR of women living with HIV. These new good practice statements are presented in Chapter 3: Creating an enabling environment. Each new good practice statement is presented in a shaded box along with remarks on key implementation considerations highlighted by the GDG. Additional information relating to each of the eight topics in Chapter 3 is presented in the following order after the box or boxes presenting new or existing recommendations and/or good practice statements: (i) background information about the topic; (ii) barriers to SRHR; (iii) components of an enabling environment that will address the barriers and support SRHR; and, only in the case of the NEW GPSs, (iv) a summary of evidence and considerations of the GDG, including any additional implementation considerations, to support optimal understanding, implementation and outcomes.

**The six new recommendations** (RECs) relate to health interventions and they address new topic areas or replace previous recommendations. These new recommendations are presented in Chapter 4: Health interventions. Each new recommendation is presented in a shaded box, including information about the strength of the recommendation and the quality of the evidence it is based on (assessed using the GRADE method, as previously described in section 2.5.2), followed by a list of remarks, including key considerations for implementation highlighted by the GDG. Additional information relating to each of the six types of services in Chapter 4 is presented in the following order after the box or boxes presenting new or existing recommendations and/or good practice statements (if any): (i) background information; and, only in the case of the NEW RECs, (ii) a summary of evidence and considerations of the GDG, including results and explanations about the quality of the evidence and the strength of the recommendation, and any additional implementation considerations, including feasibility and costs, if any information is available.

For each topic area in this guideline, in both Chapters 3 and 4, there is also an icon referencing the GVPS which is placed to clearly indicate to readers the presentation of information on the values and preferences of women living with HIV, which has been drawn from the findings of the GVPS (37).

The SG also consolidated **existing recommendations** (only those based on the GRADE approach) and **existing good practice statements** into this guideline from other recent, GRC-approved WHO guidelines if they were relevant to the SRHR of women living with HIV. In all instances, these existing recommendations and good practice statements are worded exactly as in the separate guidelines where they were previously published. For existing recommendations, the strength of each recommendation and the quality of the evidence as determined by the respective GDGs for those guidelines have also been noted. These existing recommendations have not been reviewed or changed during the guideline development process in 2016 and they remain valid. The evidence base for these recommendations is not included in the supplementary material for this new consolidated guideline since it was already presented at the time of publication of the original guidance. For all existing recommendations and good practice statements, the title and web link for the existing WHO guidance is also provided in the lists of remarks, for easy access to further information from the original source.

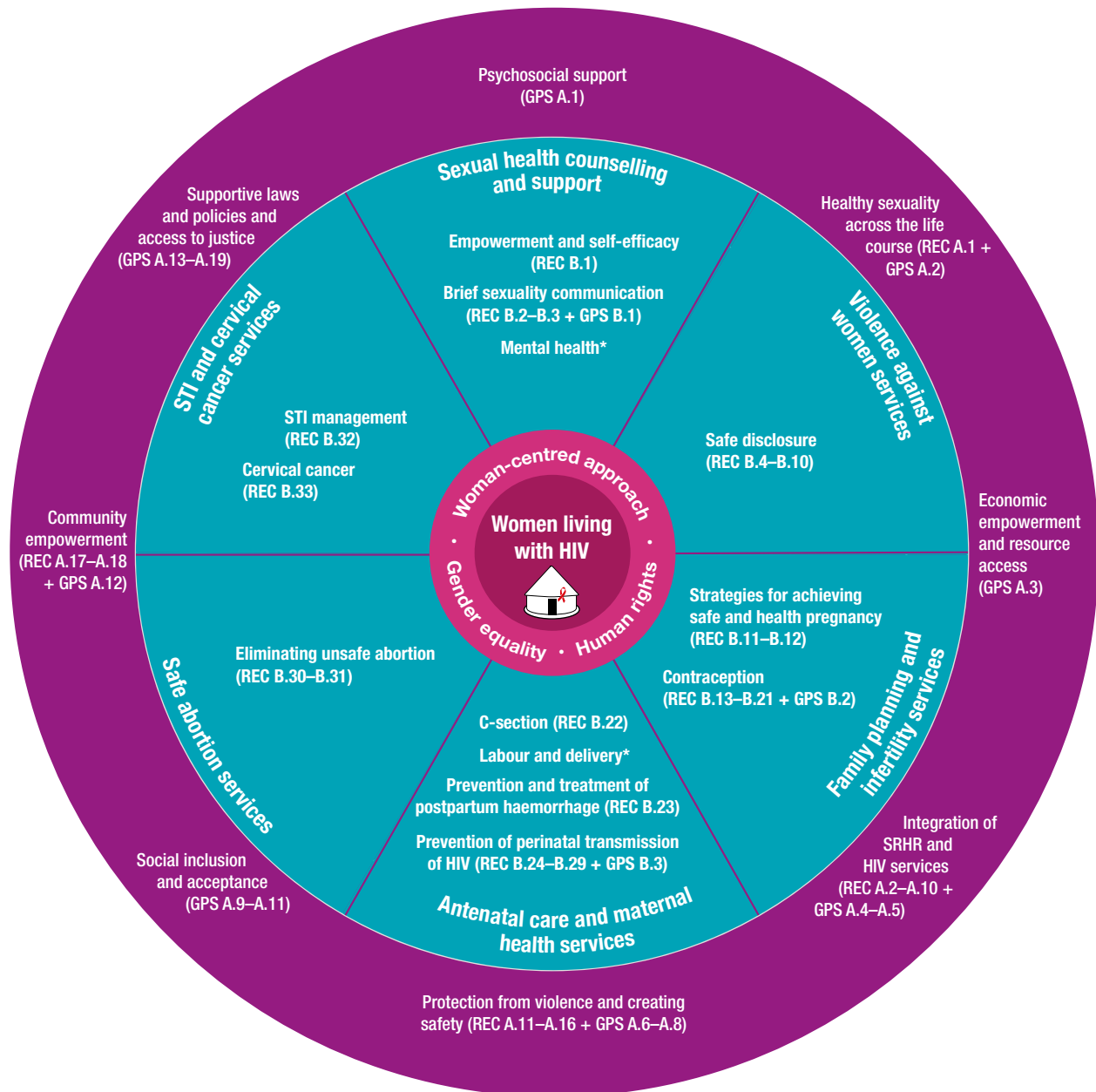
In all, this consolidated guideline includes 52 recommendations (including six new ones) and 22 good practice statements (including five new ones) relevant to SRHR of women living with HIV. All the recommendations (RECs) and good practice statements (GPSs) related to creating an enabling environment are presented in Chapter 3 (and summarized in section A in Tables 1 and 2 in the Executive summary, and in Figure 2.1) and they are labelled as REC A.1, REC A.2, etc. and GPS A.1, GPS A.2, etc., respectively, and all those relating to health interventions are presented in Chapter 4 (and summarized in section B in Tables 1 and 2 in the Executive summary, and in Figure 2.1) and they are labelled as REC B.1, REC B.2, etc. and GPS B.1, GPS B.2, etc., respectively, grouped into subsections according to the topic area and type of service.

Chapter 5 on guideline implementation and service delivery presents a discussion of key issues that would guide implementation of the recommendations to support realization of the maximum possible benefits, based on GDG discussions. Chapter 6 of the guideline presents a list of research gaps and priorities, as identified by the GDG, which require further study, and discusses the elements of a recommended inclusive approach for expanding the evidence base on SRHR of women living with HIV. Chapter 7 describes the plans for dissemination, application, monitoring and evaluation, and updating of the guideline and recommendations.

Evidence derived from the four systematic reviews in support of the six new recommendations (see Annex 4) was summarized in GRADE tables to provide the evidence base on effectiveness that informed the new recommendations in this guideline. These GRADE tables, along with the systematic review search strategies and flow charts, are presented separately in the Web supplement.

The framework presented in Figure 2.1 illustrates the essential structure of this consolidated guideline and points the reader to specific topics and relevant WHO recommendations (REC) and good practice statements (GPS). The values and preferences of women living with HIV, as expressed by respondents in the GVPS, are at the core of this guideline, which is grounded in and advocates for a comprehensive, woman-centred approach to SRHR, and is underpinned by the guiding principles of gender equality and human rights (represented in the pink circle). With this as a foundation, the framework then shows: (A) the encompassing enabling environment (outer purple circle), with all the eight topics as presented in Chapter 3 (starting at the top and running clockwise); and (B) the health interventions (central teal segments), with all six topics as presented in Chapter 4 (also clockwise from the top) – in all cases, these topics are accompanied by information on the relevant numbered RECs and GPSs, which are also listed in Tables 1 and 2, respectively (in the Executive summary).

**Figure 2.1: Framework of WHO recommendations and good practice statements to advance the sexual and reproductive health and rights of women living with HIV**



- Values and preferences
- GPS – Good practice statement
- REC – Recommendation
- Enabling environment
- Health interventions

C-section: caesarean section; SRHR: sexual and reproductive health and rights; STI: sexually transmitted infection.

\* For sections on “Mental health” and “Labour and delivery”, this guideline does not include any RECs or GPSs but refers to existing WHO guidance.

# Chapter 3. Creating an enabling environment: recommendations and good practice statements

Implementing comprehensive sexual and reproductive health and rights (SRHR) and HIV programmes to meet the health priorities of the diverse group of women living with HIV in all epidemic contexts requires that interventions be put in place to overcome major barriers to service uptake, including social exclusion and marginalization, criminalization, gender-based violence (GBV), stigma and gender inequality. These barriers need to be taken into account when putting in place strategies for improving the accessibility, acceptability, uptake, equitable coverage, quality, effectiveness and efficiency of services for women living with HIV. If left unaddressed, such barriers undermine the SRHR of women living with HIV.

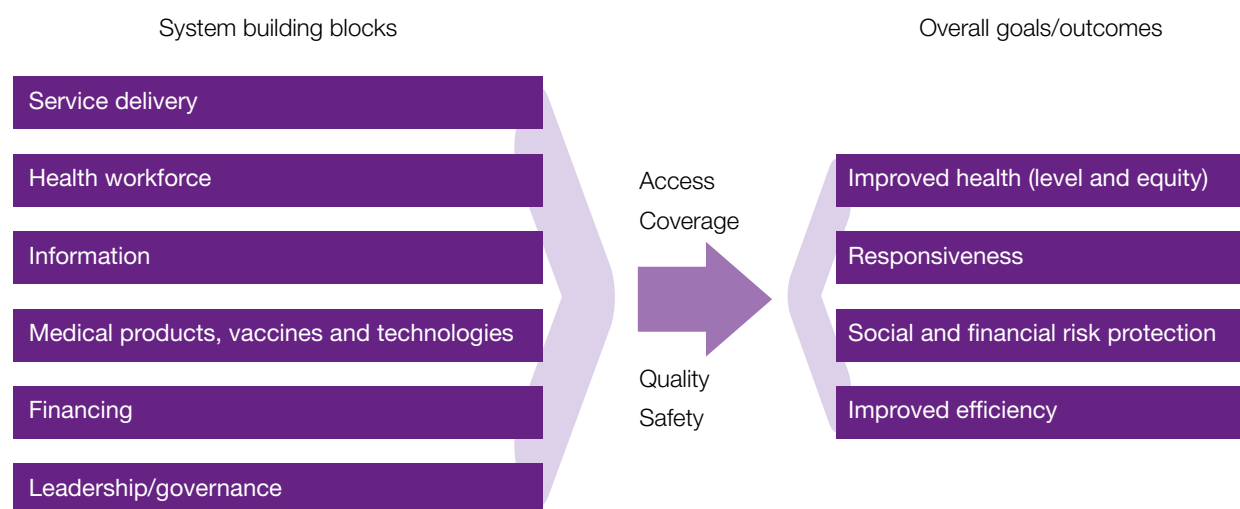
The Sustainable Development Goals (SDGs) launched at the start of 2016 create a vision for leaving no one behind and, in doing so, call for reaching those who are furthest behind first. Women living with HIV in many societies around the world continue to face multiple and intersecting forms of discrimination and are denied their basic human rights, especially in relation to health care. To achieve the SDGs by 2030 and fulfil the commitment to leave no one behind, the health sector – as part of the provision of sexual and reproductive health (SRH) services – must work to eliminate barriers faced by women living with HIV. Drawing on the WHO Health Systems Framework (46), every health system “building block” needs to facilitate an enabling environment for effective services (see Figure 3.1).

This enabling environment can be characterized as follows:

- **Attitudes and behaviours of health workers** need to be inclusive, non-stigmatizing, and promote safety and equality. Health-care providers and managers of health-care facilities should be held accountable when they do not deliver services appropriately or fail to meet standards based on professional ethics and internationally agreed human rights principles. Delivery of care and treatment services should be accomplished in a people-centred and non-judgemental way, allowing women living with HIV to lead the decision-making about their own care in an informed, supported fashion.
- **Necessary medical products and technologies** must be made available to allow health workers to deliver services, implement interventions and to create and maintain the enabling environment.
- **Health management information** should be produced, analysed, disseminated and used in a timely manner, and should capture the wide range of determinants of good SRH for women living with HIV. This information should be available to and used by health workers, women living with HIV and others in the community to address clinical and non-clinical aspects of SRHR. Information gaps should be identified and filled through appropriate research, including community-driven research. Information should be reliable and accurate and it needs to be trusted by patients, who rely on it to support their informed decision-making about their personal health and well-being and about their interactions with health systems.
- **Health interventions** must be available and accessible at the time and place they are needed, and they must also be acceptable and of high quality.
- **Budgetary allocations and financing** strategies need to be recognized as playing a critical role in creating the enabling environment to achieve good health outcomes, universal health coverage and cost-effectiveness of service delivery.
- **Policies, regulations and operational incentives** must take into consideration and must support an enabling environment for SRHR of all women living with HIV, including those who are themselves health workers. Due to the range of determinants of SRHR, creating a supportive environment requires leadership and coalition-building across a range of sectors – including collaboration with and meaningful engagement of the community of women living with HIV. The health system should lead these efforts to ensure a comprehensive approach.



**Figure 3.1: The WHO Health System Framework**



Source: WHO, 2007 (47).

Creating an enabling environment for the SRHR of women living with HIV should embrace the following strategies:

1. **Take a holistic approach:** Making the environment more enabling requires working at multiple levels across the social ecological framework (see section 3.1), including the individual, relationship, community and institutional levels. Some examples of this approach:
  - supporting women’s psychosocial health can decrease internalized stigma on the individual level;
  - continuing HIV education in communities and supporting social protections for all people can decrease stigma in the social settings of women living with HIV;
  - ensuring that health-care facilities do not allow discriminatory practices can reduce institutional stigma;
  - promoting policies and enacting laws that prevent stigma and discrimination can begin to address stigma at its roots.

These are all pieces of a comprehensive approach to an enabling environment for good SRH and realization of the rights of women living with HIV.

2. **Invest in long-term programming:** Examples of this approach include creating SRH and HIV programme plans with a 10–15 year horizon, investing in capacity-building, and working to change destructive social norms, instead of short-term crisis-response activities. Even if plans are concretized in five-year phases, the use of long-term planning strategies and indicators can support long-term goals. Capacity-building among local managers and health-care personnel, along with the training and meaningful engagement of people living with HIV, will support locally owned and locally appropriate, sustainable programmes (48).
3. **Focus on positive messages:** If needs and deficiencies lead the conversation, interventions will not identify or build on strengths that exist among women living with HIV and within the health system. Techniques such as appreciative inquiry (38) allow for the identification of achievements that can serve as a foundation for future progress. Also, an exclusive focus on negative experiences may lead to re-traumatization of women who have had negative experiences, without supporting them to consider ways to move forward, towards recovery, healing and resilience.
4. **Acknowledge the importance of language:** Positive, inclusive language creates new opportunities for advancement and collaboration, instead of exclusively focusing on ending existing problems. For example, discussing “promoting health” instead of “ending disease” can create opportunities to think about the next

steps in health promotion, in addition to responding to concerns of ill health. SRHR programmes should use language that puts people ahead of disease, such as saying “people living with HIV” instead of “HIV-infected people” or “HIV-positive people”. HIV or AIDS should be used instead of HIV/AIDS, thereby disassociating the virus and the clinical syndrome. “Acquire” is a more neutral term than “infected” when referring to the transmission of HIV. Comprehensive prevention of “vertical transmission” can be used instead of saying “mother-to-child transmission” (or MTCT), to reduce possible blame that women living with HIV may experience. This is central to creating an environment that promotes SRHR (13).

5. **Develop interventions in partnership with the end-user communities:** This approach will ensure that services respond to the needs, priorities and realities of the intended beneficiaries.

In the remainder of this chapter, section 3.1 discusses the application of a social ecological framework to defining an enabling environment for the SRHR for women living with HIV, and section 3.2 presents essential strategies for creating and maintaining an enabling environment. This section includes new and existing good practice statements and existing recommendations across eight different topic areas, ranging from the personal (psychological support) to the policy level (supportive laws and policies). It also includes discussion of relevant barriers that compromise access to appropriate, good-quality, rights-based SRH services for women living with HIV, with consideration of women’s own values and preferences in each area, which are drawn from the Global Values and Preferences Survey (GVPS) of women living with HIV (37).

**Taken together, the information in this chapter is intended to support the creation of the enabling environment required for successful achievement of SRHR for women living with HIV.**

### **3.1 Applying a social ecological framework to defining an enabling environment for the SRHR of women living with HIV**

A social ecological framework provides a comprehensive model for understanding the multiple determinants of the SRHR of women living with HIV. This model is widely applied in understanding determinants of a wide range of health behaviours and outcomes. For the purposes of this guideline, in the context of addressing SRHR of women living with HIV, the social ecological framework helps to bring together additional considerations for defining an enabling environment, including interrelated, multi-level factors that affect the capacity of women living with HIV to access relevant and necessary SRH and HIV services, information and products that are key to shaping their SRHR outcomes as well as other aspects of their health and well-being. No single factor determines SRHR outcomes for women living with HIV.

A social ecological framework has four guiding principles. First, it recognizes that **multiple factors influence** health behaviours and outcomes, including factors that operate at the intrapersonal, interpersonal, community and societal levels. Second, it posits that these **influences interact** across these different levels. Third, it requires a **focus on specific health behaviours and outcomes**, identifying which factors are most likely to influence the specific behaviour or outcome at each level of the framework. Last, the framework suggests that interventions that **address factors at multiple levels** are likely to be more effective than those that address only one level.

Applying this framework to SRHR outcomes for women living with HIV means that:

1. At the **individual level**, there is a need to focus on **supporting women living with HIV** to achieve outcomes such as increased self-confidence and personal agency to make and enact decisions that promote their own health, and improved economic and social assets for personal empowerment.
2. At the **relationship level**, there is a need to focus on **partners, families, peers and health worker interactions with women living with HIV** to decrease stigma, discrimination and interpersonal violence, and to promote equality and inclusion.



3. At the **community level**, there is a need to **create positive and equitable social norms and support, including interventions aimed at broader community members and institutions** outside the family unit and within neighbourhoods, schools, health-care settings, places of worship and workplaces, to decrease stigma and the risk of violence, and to promote equality and inclusion.
4. At the **societal level**, there is a need to **promote laws, policies and institutional practices supportive of the SRHR of women living with HIV** in relation to the health, social, economic and educational spheres, and to build broad societal norms and structures to support women living with HIV to realize their full SRHR.

While the health sector is central to the scope of this guideline, successful implementation of actions for a safe and supportive environment for women living with HIV requires collaboration across multiple sectors, such as justice, housing, agriculture, education, welfare and labour. Creating such an environment also requires collaboration across actors including government, civil society and the private sector, as well as the meaningful involvement of the community of women living with HIV in all aspects.

A social ecological understanding of the SRHR of women living with HIV will shape and target interventions that are more likely to succeed in comprehensively addressing the interactive SRHR challenges for women living with HIV and the larger society. An example of the application of the social ecological framework to SRHR for women living with HIV is provided in Box 3.1.

### Box 3.1: How the social ecological framework can guide SRHR service delivery

#### Example: Promoting healthy sexuality for women living with HIV

**Interventions at the individual level:** Provide individual counselling and information to assist women to understand their own rights and SRH options and to help them determine how to go about achieving their aspirations; women may then be better able to achieve their rights and aspirations.

**Interventions at the relationship level:** Ensure that health workers at health-care facilities respect and support women they interact with, instead of judging or stigmatizing them; women may then be better able to access the contraceptive or fertility support services they need in support of their SRH aspirations.

**Interventions at the community level:** Implement interventions to shift social norms relating to violence and stigma; women may then be better able to achieve healthy sexuality if they experience less violence and feel that all their sexual identities are accepted.

**Interventions at the societal level:** Enact law and policy reforms; women may then be better able to exercise their agency if they share power facilitated by the ability to legally inherit wealth and to benefit from health system policies that provide them a wide range of contraceptive options or fertility support services, to help them achieve their fertility desires.

The health system should intervene in matters that influence health outcomes across the levels of the social ecological framework, and consider how they may interact to support women to achieve healthy sexuality.

## 3.2 Essential strategies for creating and maintaining an enabling environment

The components of an enabling environment that need to be addressed across the individual, relationship, community and societal levels to support SRHR for women living with HIV include the following, in the order in which they are addressed in the remainder of this chapter:

1. psychosocial support
2. healthy sexuality across the life course
3. economic empowerment and resource access
4. integration of SRHR and HIV services

5. protection from violence and creating safety
6. social inclusion and acceptance
7. community empowerment
8. supportive laws and policies and access to justice.

Each of these subsections in this chapter presents new and/or existing good practice statements (GPSs) and existing recommendations (RECs) and additional information on these topics, including (i) background information; (ii) barriers; (iii) components of an enabling environment; and, only in the case of the NEW GPSs, (iv) a summary of evidence and considerations of the GDG. The WHO Guideline Steering Group (SG) for development of this guideline identified eight topic areas where **new** RECs or GPSs needed to be developed for this guideline (see Chapter 2, section 2.4). Four of those topics are covered in this chapter (the first four topics listed above) while the other four are covered in Chapter 4. The five new GPSs included in this guideline are presented in the first four subsections of this chapter (and they are labelled as “NEW”). Relevant findings from the Global Values and Preferences Survey (GVPS) of the priorities of women living with HIV are also presented in each sub-section and embedded in the information provided with the new GPSs.

### 3.2.1 Psychosocial support

#### NEW good practice statement on psychosocial support

**GPS A.1: Psychosocial support interventions, such as support groups and peer support, provided by, with, and for women living with HIV, should be included in HIV care.**

##### Remarks

- Psychosocial support interventions are optimally created, delivered and evaluated by, with and for women living with HIV, or in combination with non-specialized health-care providers.
- Among the possible outcomes to address, psychosocial support interventions appear best able to improve coping, self-esteem, social support, depressive symptoms, stress and perceived stigma.
- Interventions should use formative research to ensure that the intervention developed is relevant for the specific population, context and location.

#### i. Background

Many women living with HIV experience psychosocial challenges including stress, depressive symptoms, low self-esteem, and others. A higher proportion of people living with HIV experience depression and anxiety than the general population – with some studies also reporting higher prevalence in females than males – and there is also evidence of a negative impact of psychological distress on quality of life (49–51). In the Global Values and Preferences Survey (GVPS) among women living with HIV, of the 489 women who responded to the optional mental health module, 82% reported depressive symptoms and 78% said they had experienced rejection (37). HIV diagnosis itself can initiate immediate and ongoing mental health challenges. Survey respondents reported that after diagnosis, on average, they experienced 3.5 times the number of mental health issues as they did before diagnosis. However, beyond diagnosis, mental health concerns and issues that many women living with HIV experience – including stigma, fear, discrimination, violence, financial strain and treatment side-effects – interact to limit women’s SRH. Further analysis of the GVPS data showed a positive correlation between mental health problems and “socially disadvantaged identities”, whereby stigma related to identities and behaviours that are subject to social and/or legal sanctions – such as sex work, drug use, same-sex relationships, poverty and non-conforming gender identities, among others – intersects with HIV-related stigma to create multiple layers of disadvantage. Moreover, mental health issues themselves were felt to carry their own stigma, adding yet another layer of difficulty for women when seeking support and services. These interacting issues affect health and well-being in multiple ways: they can create barriers to healthy sexual and intimate relationships, resulting in coping behaviours, such as substance use, which can increase vulnerability and risk; and they can also lead to violations of rights of excluded members of society who are living in the context of the unequal power dynamics associated with both an HIV-positive status and

mental health concerns (52). Psychosocial support “addresses the ongoing psychological and social problems of individuals living with HIV, their partners, families and caregivers” (53).

## ii. Barriers

Stigma and mental health issues, which interact with each other, prevent women from engaging in healthy sexual relationships, and from asserting agency and control in those relationships. Psychosocial challenges can negatively affect the general well-being of women living with HIV, which may create or exacerbate social exclusion and isolation and affect service uptake, or cause further mental health concerns. Among other things, some mental health problems may arise from or be exacerbated by side-effects of some treatments (in particular body dysmorphia, fatigue/sleep problems and loss of libido), and these mental health challenges, in turn, can have an impact on adherence to treatment.

## iii. Components of an enabling environment

HIV can have an impact on mental and emotional well-being, and there is a need for psychological support and counselling that is affordable, accessible, holistic and integrated with other SRH and HIV services.

## iv. Summary of evidence and considerations for the new good practice statement

Despite the high prevalence of psychosocial challenges among women living with HIV, the identified association between psychosocial concerns and SRH outcomes (54, 55), and recommendations to include psychosocial support as a part of HIV care (53, 56), no reviews have looked at the impact of psychosocial support interventions on the SRHR of women living with HIV. Based on findings from the GVPS (see Background above and “Values and preferences” box at the end of this section) and the critical importance of mental health conditions, the Guideline Development Group (GDG) included in the guideline development process a new systematic review of studies evaluating psychosocial support interventions delivered by non-specialized providers to evaluate the impact on outcomes including mental, emotional and/or social well-being and quality of life, as well as SRHR decision-making in women living with HIV (57). In the studies included in the review, providers included those without specialized training in mental health, such as certified health professionals (e.g. doctors and nurses) who were not specialists in psychiatric or psychological care, or lay providers or other persons with or without any training in the provision of psychosocial support services (58). Lay-provider-delivered interventions were included because many psychosocial support interventions are currently delivered by lay providers due to shortages of formally trained health-care providers. This also offers the opportunity for these lay providers to empathize with clients in a unique way; for example, through their shared experience of having HIV, if they are living with HIV and feel able to share their positive status with the client. Among the possible outcomes to address, psychosocial support interventions appear best able to improve coping, self-esteem, social support, depressive symptoms, stress and perceived stigma. However, the reviewed studies did not find statistically significant effects for these outcomes. There were no patterns for significant results for interventions that were delivered in groups versus individually, for different frequency of interventions, or for different primary outcomes or populations (e.g. women seeking antenatal care, mothers or other groups). Guidance related to formal mental health services is provided in WHO’s *Mental health action plan 2013–2020* (59), and mental health is further addressed in Chapter 4, section 4.1.3.

### Values and preferences

Women living with HIV responding to the GVPS expressed a need for: psychological support for disclosure, self-confidence, acceptance and positive body image; ongoing psychosexual counselling, including with partner(s); care for past traumas; support in learning, understanding and believing in rights; and treatment and support for alcohol and drug use as both a symptom and cause of mental health problems. Respondents also articulated the need for: counselling that helps to build a life based on well-being and acceptance; peer support to provide safe spaces where women can talk without being judged; and policies that challenge stigma and promote human rights – including stigma related to mental health problems and to HIV (37).



## 3.2.2 Healthy sexuality across the life course

### a. Puberty and adolescence

#### Existing recommendation on healthy sexuality in puberty and adolescence

**REC A.1: Adolescent-friendly health services should be implemented in HIV services to ensure engagement and improved outcomes.**

*(strong recommendation, low-quality evidence)*

#### Remarks

- This recommendation was integrated into this guideline from WHO's 2016 Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach (7).
- Further information can be found in the original publication, available at: [http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684_eng.pdf)
- See also information on age of consent policies under section 3.2.8 for specific good practice recommendations (GPS A.15 and GPS A.16) on supporting adolescent women with HIV to achieve SRHR.

#### i. Background

Girls going through puberty need information and support to understand the changes taking place in their bodies. They need comprehensive sexuality education (CSE) (25), including information about how pregnancy, STIs and HIV transmission occur, and they need to be equipped with the knowledge and tools – including self-confidence and awareness – to navigate early sexual desires and experiences. As a high proportion of girls' first sexual encounters are forced or coercive (60), girls need to be empowered to recognize, avoid or report violence and coercion if and when they encounter them.

#### ii. Barriers

Adolescent girls and young women living with HIV are often poorly informed about their SRHR. They often lack access to appropriate commodities due to social and legal restrictions on contraceptives and other health services, including restrictions on services for unmarried women (61).

Moralistic attitudes or values and lack of the required competencies often stand in the way of health workers providing adolescents living with HIV with the health services they need. Training, values clarification and ongoing support can enable them to provide the necessary services (62).

In several countries, there are discrepancies between the age of consent for sexual activity, for marriage and for access to services, thus creating barriers for young people needing to access SRH services. It has been documented that adolescents may opt not to seek care because they want to avoid telling their parents about their health problems and sexual activity, while service providers often require parental consent for access to services, particularly SRH services (63). A survey of a nationally representative sample of adolescents in the USA found that 35% avoided contact with health services so as not to have to tell their parents about their health issues, and that girls were more likely than boys to avoid health care in order to prevent their parents from learning about their high-risk behaviour (63). While some laws serve to protect young people, national age of consent laws and social norms can also influence service providers' attitudes and behaviours and create barriers to service access. Thus, it is not surprising that adolescents from key affected populations (e.g. sex workers, men who have sex with men, and people who inject drugs) and vulnerable populations (e.g. incarcerated youth, young women) are even less likely to have access to HIV testing and counselling or care and treatment compared with the general adolescent population (64).

#### iii. Components of an enabling environment

SRH services should support healthy sexuality throughout the life course, including offering accessible and acceptable services to all adolescents living with HIV (65).

As with older women living with HIV, sexual support and counselling programmes should be designed by, with and for young women living with HIV, including those from key affected populations and especially those from vulnerable communities, such as adolescent girls living with HIV who also have other disabilities. To facilitate implementation of the recommendations, providers of SRH and HIV services should receive training, job aids and ongoing supervision in providing supportive counselling specific to SRHR for adolescent girls and young women.

Girls who were born with HIV, or who acquired it in childhood, may require special support as they reach adolescence, enter into sexual relationships, and consider their SRH priorities and rights – including contraceptive advice – for the first time. For girls who acquire HIV during adolescence it is important that they receive accurate and timely information and counselling regarding their SRHR as young women living with HIV, including information and advice on starting/continuing sexual relationships, marriage and fertility choices. Trauma counselling and ongoing psychosocial support may be required for girls and young women who have acquired HIV as a result of rape, incest or sexual violence (for information on adolescent status disclosure, see section 4.2.1: Safe disclosure).

Peers provide many benefits for adolescents. They can be an important source of psychological support, helping to build confidence and resilience and helping to reduce anxiety and promote a sense of belonging. Because of their common experiences, peers can also help adolescents living with HIV to cope with fear, hopelessness, stigma and discrimination, and they can facilitate problem solving. Peers can also be good sources of practical information, motivation and positive reinforcement for adherence to treatment, disclosure, coping with SRH issues, and addressing mental health and substance use concerns (66).

Health-care providers for adolescents living with HIV should make an assessment of sexual activity and provide full and accurate information on available SRH services (67).

WHO's 2011 *Guidelines on preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries* outline specific concerns related to creating an enabling environment for the health and rights of all adolescents, including adolescent girls living with HIV. These include recommendations to prevent early pregnancy by influencing factors such as early marriage, coerced sex, unsafe abortion, access to contraceptives and access to maternal health services for adolescents. These recommendations should be reviewed when creating an enabling environment for young women living with HIV, as for all young women (68).

### Values and preferences

Women living with HIV responding to the GVPS articulated the need for SRHR support for girls and women living with HIV to be available throughout the life course. Social protection mechanisms are perceived as necessary to prevent child sexual abuse, including child and teenage marriages and coerced or transactional sex. Girls and young women living with HIV need access to a full range of information about body changes, menstruation, sexual maturity, sex and sexuality, contraception, and family and pregnancy planning options; this is especially needed by those transitioning from child to adult services – these services should be provided free from judgement, coercion or the need for parental consent. Comprehensive sexuality education (CSE) offered in and out of school for girls and young women should be complemented by behavioural interventions provided by doctors and other care providers, within the context of holistic, woman-centred and culturally-competent care throughout the life course, so that the whole girl or woman is considered, and not just the virus. There is a need for services, including sex and relationships counselling, to be of high quality and unbiased. Unmarried women, lesbian, bisexual and transgender women, as well as those without children, need to be treated in accordance with the same standards of attention and care as those who are married or have children (37).



## b. Ageing, menopause and post-menopause

### NEW good practice statement on ageing and healthy sexuality

**GPS A.2: Women living with HIV in all their diversity should be supported in their choice to have safe and fulfilling sexual relationships and sexual pleasure as they age. Women living with HIV who choose not to be sexually active should also be supported in their choice.**

#### Remarks

- Sexual support and counselling programmes should be designed by, with and for women living with HIV from all age groups, including menopausal and post-menopausal, in conjunction with health-care providers.
- Women living with HIV must be supported in their voluntary choices around sexual relationships 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. This is true for all women, including those beyond their reproductive years.
- To facilitate implementation of the recommendations, providers of SRH and HIV services should receive training, job aids and ongoing supervision in providing supportive counselling specific to sexual health and rights, including for women beyond reproductive age. The training should cover what women are told when they are diagnosed with HIV in relation to their sexuality across the life course, and for their specific life course stage. The health system may need to pay special attention to helping HIV service providers implement these recommendations, given their general focus on treatment adherence and transmission prevention. This could include updating the health worker training curriculum, providing in-service training, supervision and job aids, and the creation of materials with and for women living with HIV.
- Criminalization of non-disclosure, exposure and transmission makes it harder for women to enter into sexual relationships.

### i. Background

Considerations around SRHR for women living with HIV change throughout the life course. The focus of many SRH and HIV programmes is on women in their reproductive years. Evidence relating to post-menopausal women is limited. While some women experience menopause at a young age and require appropriate services at that time, many women have new sexual health priorities and needs at an older age after their reproductive years. In older age, lengthened life expectancies of women – including women living with HIV – mean that many more adults over the age of 50 are acquiring and living with HIV. They will need support for ongoing healthy sexuality and sexual health decision-making.

### ii. Barriers

Research examining sexual relationships and ageing in people aged 50 years and older has largely been conducted with HIV-negative populations. Little is known about supporting SRHR, particularly supporting healthy sexuality, among older women living with HIV. Judgemental attitudes or lack of awareness about the importance of satisfying sexuality for older women can lead to poor care. Similarly, more research is needed into the possible effects of HIV, or HIV treatment, on the menopause. HIV stigma, disclosure, body image concerns and possible loss of libido, among other issues, can inhibit the development of relationships and safer sexual practices among older women living with HIV.

### iii. Components of an enabling environment

SRH services should support healthy sexuality across the life course, including offering accessible and acceptable services to all women living with HIV, including older women.

### iv. Summary of evidence and considerations for the new good practice statement

Based on findings from the GVPs and the lack of existing research on healthy sexuality and older women living with HIV, the GDG used a systematic review of studies that examined the association between ageing and sexual behaviours or experiences of intimacy among women living with HIV (69). The review identified



only four studies that met the inclusion criteria. Overall they showed that while women living with HIV are living longer lives and remaining sexually active in later life, there continue to be significant barriers to being sexually active and maintaining healthy sexual relationships.

### Values and preferences

Women living with HIV – especially older women participating in the GVPS – raised concerns about the impact of living with HIV and long-term adherence to antiretroviral therapy (ART) on the menopause. They also highlighted the dearth of SRHR information and services available to post-menopausal women. They articulated the need for SRHR information and support for women living with HIV to be available throughout the life course, including: information about any known or potential interactions between HIV/use of ART and the menopause; appropriate care and support to women going through the menopause; and training, sensitization and other behaviour change support efforts for doctors and other health-care providers to offer holistic, woman-centred and culturally-competent care to older women. Sex and relationships counselling should be available to women of all ages, including for lesbian, bisexual and transgender women (37).



### 3.2.3 Economic empowerment and resource access

#### NEW good practice statement on food security

**GPS A.3: Comprehensive assessment of food security with linkage to appropriate services is an integral component of the care of women living with HIV.**

#### Remarks

- Food insecurity is often a significant challenge for women living with HIV.
- There are other significant challenges for women living with HIV that are linked to resources, including housing and low socioeconomic status.
- Multidimensional programmes that seek to reduce hunger, poverty, malnutrition and food insecurity, and which enhance women's legal and social rights in conjunction with food assistance and income generation, should be considered part of the HIV response.
- Food access is important. Provision of information regarding sustainable food practices can be a useful and relatively low-cost intervention. It should be accompanied by information on foods that are good for women living with HIV, such as those that help to maintain good nutrition and a healthy weight. Other options may include improving access to overall economic empowerment and social protection interventions or services to support food security and other related needs, such as housing and economic independence. This may include connecting women living with HIV to income-generating opportunities.
- Multisectoral collaboration is essential for delivery of a comprehensive SRH package of care using a rights-based approach.
- In areas with high levels of poverty and food insecurity, the same linkages to services through health-care facilities may need to be made for all individuals to avoid tensions between people living with HIV and those who are not but who also need food, and to avoid incentivizing HIV acquisition. Economic empowerment and services supporting access to resources should consider the overall situation of each woman living with HIV and link her to other appropriate services, as needed.

#### i. Background

A positive HIV status may be linked to livelihood insecurity, increased poverty and a lack of resources to meet key needs and expenses. This leads to greater vulnerability and poor SRHR outcomes. Therefore, interventions focused on economic empowerment, poverty reduction and resource access, such as housing and food support, have the potential to bolster the status of women living with HIV within their families,



improve access to health care, and improve their health outcomes. Similarly, legal barriers associated with gender or marital status limit wealth acquisition by women through limits on property ownership, inheritance from family or partners who have died, and other means. Also, socioeconomic vulnerabilities can make it difficult for women living with HIV to exercise their sexual and reproductive rights, such as in situations where women are dependent on violent or abusive partners, or transactional sex, to ensure that their and/or their children's basic needs are met.

## **ii. Barriers**

Women living with HIV report experiencing livelihood insecurity as a result of abandonment, widowhood, loss of work or income as a result of workplace stigma and discrimination, mental or physical ill health, intimate partner violence, and negative treatment side-effects. Economic dependence can force women to remain in violent relationships and deter them from accessing treatment, and can thus have a negative impact on the mental health of women living with HIV.

HIV treatment can increase the need for food security, as women living with HIV may not only need food for nourishment and the maintenance of health, but also to support ART initiation and adherence, and to manage ART side-effects. Studies also show that some women engage in transactional sex to ensure food access (61).

## **iii. Components of an enabling environment**

Economic and legal empowerment interventions could strengthen vocational skills, provide mentorship, bolster self-esteem, provide a sense of solidarity, and build skills in communication and negotiation with sexual partners among women living with HIV. Such interventions may also enhance women's ability to claim property and inheritance rights so they may not be forced to rely on others for economic and food security.

## **iv. Summary of evidence and considerations for the new good practice statement**

### ***Food insecurity***

Food insecurity refers to the lack of access to adequate nutrition. Among people living with HIV, food insecurity has been linked to increased vulnerability to HIV transmission, more rapid disease progression, and incomplete HIV viral load suppression. Several studies have identified food insecurity as a motivation for women to engage in transactional sex in exchange for food and/or other resources, or to engage in sex work. Food insecurity is one of a number of significant challenges for women living with HIV that are linked to resources including housing and low socioeconomic status. The GDG considered the systematic review of studies that examined the impact of food insecurity on sexual risk behaviours and ART adherence among women living with HIV (70), which was conducted in support of the development of this guideline. The review identified five studies that met the inclusion criteria, including qualitative and quantitative data from Africa and North America in the peer-reviewed literature. Four major themes were identified in relation to food insecurity: sex as a means of survival (i.e. sex work and transactional sex); lack of control in relationships; a barrier to ART initiation and adherence; ART adherence and women's health.

### ***Housing***

Housing services can also be particularly important. Housing can enhance quality of life by creating a safe home, a safe setting for women trying to leave violent relationships, and a setting where a woman can store and take her medication, including ART. Enhancing inheritance and property rights for women who are widowed (especially due to HIV) can also support similar beneficial outcomes. It is critical that receipt of food and other services does not stigmatize women living with HIV or put women at risk of unintentional disclosure of their HIV status.

There is increasing evidence on the role of social protection in the response to HIV (71). HIV-sensitive social protection means not exclusively focusing on people living with or affected by HIV. Through an HIV-sensitive approach, people living with HIV and other key populations are served together so as not to exclude equally underserved groups. Social protection has been defined as “all public and private initiatives that provide income or consumption transfers to the poor, protect the vulnerable against livelihood risks and enhance the social status and rights of the marginalized with the overall objective of reducing the economic and social vulnerability of the poor, vulnerable and marginalized groups” (71).

Economic empowerment of people living with HIV in support of their basic needs, including food, housing and nutrition, and increasing the effectiveness of HIV treatment for prolonged and improved quality of life are key components of a typical combination of HIV and social protection instruments (71).

While supporting empowerment and resource access can improve individual well-being, at a structural level, poverty is linked to HIV and to challenges of maintaining wellness and SRHR. To facilitate the SRHR of women living with HIV and others, health-care providers should support actions and policies and build coalitions with social protection actors to reduce poverty and increase resource access.

### Values and preferences

Throughout their responses to the GVPS, women living with HIV emphasized the challenges of poverty and its resulting strains on mental, physical and sexual health. The greatest single issue (raised by 67% of respondents) was lack of employment opportunities for women living with HIV. The survey also revealed a number of issues linking economic insecurity to the SRHR of women living with HIV. For example, violence against women living with HIV – including denial of property and inheritance rights in the event of widowhood – creates and exacerbates poverty and financial vulnerability; economic dependence can force women to stay in violent relationships, and also creates a lack of negotiating and decision-making power within the relationship, including in relation to sex and child-bearing. Financial stability also bears on whether and when women living with HIV decide to have or not have children, including the ability to access private fertility services and private, safe abortion services. Financial insecurity may have a bigger impact on more marginalized women living with HIV, such as sex workers and other women with multiple vulnerabilities. Poverty emerged as a major concern for women growing older with HIV, especially for women who do not have children, are widowed or without a partner, or who have no access to insurance or pensions. Women want affordable health care, including for HIV testing, counselling, treatment and care, for SRH and for mental health. To achieve this, respondents highlighted the need for: increasing the number of health centres offering HIV treatment and care and SRH services in rural areas; enabling access to health insurance; offering affordable fertility treatment; and ensuring that transport and childcare costs are not barriers to accessing services. The intersecting nature of the challenges experienced by women living with HIV calls for multidisciplinary teams, including peer mentors, able to work across sectors relevant to HIV needs (37).



### 3.2.4 Integration of SRHR and HIV services

#### Existing recommendations on integration of services

**REC A.2:** In generalized epidemic settings, ART should be initiated and maintained in eligible pregnant and postpartum women and in infants at maternal and child health care settings, with linkage and referral to ongoing HIV care and ART, where appropriate.

*(strong recommendation, very low-quality evidence)*

**REC A.3:** Sexually transmitted infection (STI) and family planning services can be integrated within HIV care settings.

*(conditional recommendation, very low-quality evidence)*

#### Existing recommendations on decentralization of services

**REC A.4, A.5, A.6:** Decentralization of HIV treatment and care should be considered as a way to increase access to and improve retention in care:

- **initiation of ART in hospitals with maintenance of ART in health facilities**  
*(strong recommendation, low-quality evidence)*
- **initiation and maintenance of ART in peripheral health facilities**  
*(strong recommendation, low-quality evidence)*
- **initiation of ART at peripheral health facilities with maintenance at the community level**  
*(strong recommendation, moderate-quality evidence)*

#### Existing recommendations on task shifting and task sharing

**REC A.7:** Trained and supervised lay providers can distribute ART to adults, adolescents and children living with HIV.

*(strong recommendation, low-quality evidence)*

**REC A.8:** Trained non-physician clinicians, midwives and nurses can initiate first-line ART.

*(strong recommendation, moderate-quality evidence)*

**REC A.9:** Trained non-physician clinicians, midwives and nurses can maintain ART.

*(strong recommendation, moderate-quality evidence)*

**REC A.10:** Trained and supervised community health workers can dispense ART between regular clinical visits.

*(strong recommendation, moderate-quality evidence)*

#### Remarks

- These existing recommendations were integrated into this guideline from WHO's 2016 *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach, second edition (7)*.
- It is important to ensure that providers have appropriate training as outlined in the guideline, as their work relates to special considerations for women living with HIV.
- Further information can be found in the original publication, available at: [http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684_eng.pdf)

## NEW good practice statements on integration of services

**GPS A.4: Women living with HIV should have access to integrated and tailored comprehensive\* sexual and reproductive health (SRH) and HIV services.**

**GPS A.5: Women living with HIV should be included in the design and delivery of these services.**

\* As defined in WHO's 2004 *Reproductive health strategy to accelerate progress towards the attainment of international development goals and targets*, comprehensive SRH services include the following: improving antenatal, perinatal, postpartum and newborn care; providing high-quality services for family planning, including infertility services; eliminating unsafe abortion; combating sexually transmitted infections including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; and promoting sexual health (65).

### Remarks

- Both on-site care models and enhanced referral models of integration have demonstrated positive outcomes. Thus, the model of integration used should be driven by the care setting and should reduce existing barriers to access.
- A full range of family planning and STI services can be provided regularly throughout the course of routine HIV care, rather than exclusively at enrolment or treatment initiation.
- Service integration needs to consider the context of women's lives, including services related to gender-based violence (GBV) and other health concerns.

## i. Background

Integrating SRH and HIV services may improve women's SRHR outcomes. Such integration recognizes the importance of empowering people to make informed choices about their own SRH, and recognizes the vital role that sexuality plays in people's lives (72).

Comprehensive, rights-based family planning (FP) services are a core component of an integrated SRH and HIV services package, which enables women with HIV to pursue their fertility goals, including planning for safer pregnancies, spacing desired pregnancies and preventing unintended pregnancies.

A list of essential SRHR services for women living with HIV is detailed in Box 3.2. The provision of ART to women living with HIV is also a part of effective clinical management of HIV among women seeking FP services (7). Strengthening service access or quality may not suffice to improve health outcomes in the absence of a safe and supportive enabling environment, necessitating the inclusion of screening and management of GBV and prevention of stigma as a part of FP service delivery. It is never acceptable for a provider to coerce or force a woman to prevent conception if she does not want to do so. A woman should be counselled on the full range of healthy pregnancy planning and contraceptive options, to support her in making voluntary choices. Integrating FP services with HIV services has been one approach to make both services more accessible to women and couples living with HIV.

The importance of linking SRH with HIV and AIDS responses is now widely recognized. Linkages need to be broad-based, addressing not only the health sector and the direct impact on health, but also the structural and social determinants affecting both HIV and SRH. There is international consensus around the need for effective linkages between responses to HIV and SRH, including recommendations for specific actions at the levels of policy, systems and services (73).

### Box 3.2: Essential SRHR services for women living with HIV

- Information and counselling to support women's rights to make decisions about reproduction, including planning desired pregnancies and preventing unintended pregnancies
- Effective clinical management of HIV to improve health irrespective of pregnancy intention
- Rights-based family planning counselling and services, including contraceptives and infertility screening and services
- Sexually transmitted infection (STI) screening and management
- Gender-based violence (GBV) response
- An environment free of stigma and discrimination.

Source: The Inter-agency Task Team for Prevention and Treatment of HIV Infection in Pregnant Women, Mothers, and their Children, 2012 (74).

#### ii. Barriers

Women living with HIV who seek HIV care may be unable to consistently access or utilize SRH services due to barriers, including lack of awareness, distance, timing, discrimination, GBV and others. This may increase negative SRH outcomes, including unplanned, undesired or inadequately spaced pregnancies, untreated STIs, and others. The vertical nature of HIV services in many countries may create a barrier to the provision of FP methods within HIV-focused settings due to lack of provider training or skills, lack of supplies, or lack of health information systems to connect services.

#### iii. Components of an enabling environment

Ensuring access to the full range of choice of SRH services delivered in a respectful, supportive environment is critical for women living with HIV to achieve optimal SRHR outcomes. Health-care facilities can create a supportive environment that facilitates good SRH.

#### iv. Summary of evidence and considerations for the new good practice statements

While prior WHO guidelines included the integration of HIV into SRH services (6), in the development of the current guideline two reviews were undertaken to characterize the range of models of integration of SRH services (STI and FP services, respectively) into HIV treatment that have been evaluated using a comparison group, and to synthesize the evidence on their positive and negative outcomes. In the context of these two reviews, SRH and HIV integration was considered at the service-delivery level, as opposed to the policy or other levels. Integrated SRH and HIV health services could include (i) STI services, such as testing, treatment and syndromic management of STIs; (ii) FP services, including information, education and communication (IEC), behaviour change communication (BCC), counselling and assessment; and/or (iii) commodity provision, either on-site or through referrals. The reviews included a wide range of outcomes. In the review on integration of FP and HIV services (75), primary outcomes reported by the reviewed studies included changes in unmet need for FP, use of modern contraceptive methods, use of more effective methods, use of dual modern method with condoms, use of any contraceptive, and rates of unintended pregnancy. Secondary outcomes included knowledge about contraceptive methods and attitudes towards their use, cost-effectiveness and client satisfaction with services. Modern methods of contraception included hormonal injectable contraceptives, oral contraceptives (pills), intrauterine devices (IUDs), implants, female or male sterilization, and consistent use of male or female condoms. More effective contraceptive methods include all modern methods except condoms. In the review on integration of STI and HIV services (76), outcomes included uptake of STI services, STIs (re-infection), client satisfaction and service quality, and provider knowledge and attitudes about STI services for women living with HIV.

Based on review of this evidence, the GDG reached consensus on new good practice statements GPS A.4 and GPS A.5.

Health care for women and girls living with HIV, including those from key affected populations, should be accessible, affordable and available, with provision of integrated SRH services. Services need to uphold the human rights of women living with HIV in the integration and delivery of services to ensure that their informed consent is respected, that they are accorded a full range of ART treatment options, and that they are not subjected to coerced termination of pregnancy, coerced sterilization or pressure to start treatment (77).

Special considerations for the SRHR of young women living with HIV who inject drugs are presented in Box 3.3.

### Box 3.3: Special considerations for the SRHR of young women living with HIV who inject drugs

#### Integration and service access:

- Separate services for TB, HIV, viral hepatitis, SRH and for other aspects of harm reduction make it difficult for young people who inject drugs to access care to address all their needs (78).
- As reported by the Youth RISE consultation, young women who inject drugs in Kyrgyzstan said that SRH services were important to them, but they felt stigmatized when accessing them (78).
- Pregnant women who inject drugs are less likely than non-injecting pregnant women to have access to antenatal care and services for the prevention of perinatal transmission of HIV, thus they face an increased risk of passing HIV to their newborns (79).
- Negative experiences with health services – such as judgemental attitudes of providers, disrespectful treatment of young people or perceived lack of privacy and confidentiality – discourage young people who inject drugs from seeking the services they need. In some countries, a conservative social climate makes it harder for young people, especially girls and young women, to access SRH services.

#### Overarching considerations for services for young adolescents who inject drugs:

- Primary consideration should be given to the best interests of the young adolescents and children in the design and delivery of all programmes and services for children who inject drugs (including HIV and SRH services), in accordance with the Convention on the Rights of the Child (80; Article 1) and other relevant international treaties.

#### Values and preferences

Women living with HIV responding to the GVPS articulated that health care for women and girls living with HIV should be accessible, affordable and available, with provision of integrated SRH services. Respondents reported negative experiences with regard to contraceptive choice: many have been told by service providers that they may only use condoms; others have been coerced or forced into using long-acting or permanent contraceptive methods. Additionally, these methods are sometimes given as a condition for receiving other services, such as safe abortion and post-abortion care or ART. Furthermore, only around half of women surveyed reported receiving practical support for safe conception or for realizing their fertility desires, despite these topics being discussed during contact with health-care providers 70% of the time. Experiences of violence were also reported as barriers to optimal SRHR outcomes.

Women living with HIV stated that compassionate, holistic, unconditional care and support and informed choice should be provided to all women living with HIV in the context of services related to pregnancy and fertility desires, and the enjoyment of healthy sexuality. Survey respondents expressed the need for pregnancy and childbirth among women living with HIV – as well as the right to enter into sexual relationships and marriage – to be “normalized” at the level of the health services and within the community at large, instead of being seen as deviant and dangerous. Women want to be able to choose whether and when to disclose their status to their partners, and to be supported to do so if and when they want to.

Women living with HIV recommended peer learning, sharing and counselling to enable access to information, training and awareness relating to risks (of onward transmission), safety and sexual pleasure (for themselves and their partners), and to promote self-acceptance and self-confidence. Women living with HIV need access to male and female condoms, lubricants and other safe-sex-enhancing commodities, and skills to negotiate their use (37).



### 3.2.5 Protection from violence and creating safety

#### Existing recommendations on protection from violence and creating safety

**REC A.11: Women who disclose any form of violence by an intimate partner (or other family member) or sexual assault by any perpetrator should be offered immediate support. Health-care providers should, as a minimum, offer first-line support\* when women disclose violence. If health-care providers are unable to provide first-line support, they should ensure that someone else (within their health-care setting or another that is easily accessible) is immediately available to do so.**

*(strong recommendation, indirect evidence)*

\* Note: First-line support includes:

- being non-judgemental and supportive and validating what the woman is saying
- providing practical care and support that responds to her concerns, but does not intrude
- asking about her history of violence, listening carefully, but not pressuring her to talk (care should be taken when discussing sensitive topics when interpreters are involved)
- helping her access information about resources, including legal and other services that she might think helpful
- assisting her to increase safety for herself and her children, where needed
- providing or mobilizing social support.

Providers should ensure:

- that the consultation is conducted in private
- confidentiality, while informing women of the limits of confidentiality (e.g. when there is mandatory reporting) (81).

**REC A.12: Health-care providers should ask about exposure to intimate partner violence when assessing conditions\*\* that may be caused or complicated by intimate partner violence, in order to improve diagnosis/identification and subsequent care.**

*(strong recommendation, indirect evidence)*

\*\* Note: Examples of clinical conditions associated with intimate partner violence (IPV):

- symptoms of depression, anxiety, post-traumatic stress disorder (PTSD), sleep disorders
- suicidality or self-harm
- alcohol and other substance use
- unexplained chronic gastrointestinal symptoms
- unexplained reproductive symptoms, including pelvic pain, sexual dysfunction
- adverse reproductive outcomes, including multiple unintended pregnancies and/or terminations, delayed pregnancy care, adverse birth outcomes
- unexplained genitourinary symptoms, including frequent bladder or kidney infections or other
- repeated vaginal bleeding and sexually transmitted infections
- chronic pain (unexplained)
- traumatic injury, particularly if repeated and with vague or implausible explanations
- problems with the central nervous system – headaches, cognitive problems, hearing loss
- repeated health consultations with no clear diagnosis
- intrusive partner or husband in consultations (81).



## Existing recommendations on protection from violence and creating safety (continued)

**REC A.13:** In-service training and training at pre-qualification level and in first-line support for women who have experienced intimate partner violence and sexual assault should be provided to health-care providers (in particular doctors, nurses and midwives).

*(strong recommendation, very low-quality evidence)*

**REC A.14:** Pregnant women who disclose intimate partner violence should be offered brief to medium-duration empowerment counselling (up to 12 sessions) and advocacy/support, including a safety component, offered by trained service providers where health-care systems can support this. The extent to which this may apply to settings outside of antenatal care, or its feasibility in low- or middle-income countries, is uncertain.

*(conditional recommendation, low-quality evidence)*

**REC A.15:** Care for women experiencing intimate partner violence and sexual assault should, as much as possible, be integrated into existing health services rather than as a stand-alone service.

*(strong recommendation, very low-quality evidence)*

**REC A.16:** Mandatory reporting of intimate partner violence to the police by the health-care provider is not recommended. However, health-care providers should offer to report the incident to the appropriate authorities (including the police) if the woman wants this and is aware of her rights.

*(strong recommendation, very low-quality evidence)*

### Remarks

- These existing recommendations were integrated into this guideline from the 2013 publication, *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines (81)*.
- Further information relating to all of the above existing recommendations can be found in the original document, available at: [http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf)

## Existing good practice statements on protection from violence and creating safety

**GPS A.6:** Violence against people from key populations should be prevented and addressed in partnership with key population-led organizations. All violence against people from key populations should be monitored and reported, and redress mechanisms should be established to provide justice.

**GPS A.7:** Health and other support services should be provided to all persons from key populations who experience violence. In particular, persons experiencing sexual violence should have timely access to comprehensive post-rape care in accordance with WHO guidelines.

**GPS A.8:** Law enforcement officials and health- and social-care providers need to be trained to recognize and uphold the human rights of key populations and to be held accountable if they violate these rights, including perpetration of violence.

### Remarks

- These existing good practice statements were integrated into this guideline from WHO's *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations – 2016 update (10)*.
- Key populations include women living with HIV.
- Further information on all of the above existing good practice statements can be found in the original publication, available at: <http://apps.who.int/iris/bitstream/10665/246200/1/9789241511124-eng.pdf>

## **i. Background**

Violence against women living with HIV can take various forms, including physical, sexual and psychological abuse and controlling behaviours by an intimate partner (60). Studies suggest that violence is strongly associated with HIV; violence and HIV interact, resulting in multiple negative outcomes. Importantly for this guideline, violence may be associated with a woman's HIV-positive status (82). According to WHO estimates, women with HIV are at least 1.5 times more likely to experience violence than other women, which could be because violence preceded HIV acquisition or because HIV acquisition and disclosure resulted in violence (83). In addition, reported rates of violence against sex workers and transgender women living with HIV are high (10), and these rates are likely to be underreported, particularly where certain populations or activities are criminalized, or – in the case of transgender persons – where legal protections are lacking. Violence may also challenge the ability of a woman living with HIV to make and enact health-promoting decisions related to her sexual and reproductive life, or to access and utilize SRH and HIV services, including ART, or to adhere to treatment regimens. Further, the negative psychological outcomes of violence may inhibit self-care (82). Violence may also be experienced in health-care settings, including physical abuse experienced by women living with HIV, aggressive attitudes of health workers, and institutional use of violence such as coerced or forced sterilization or exclusion from other desired health services, such as fertility support.

During the scoping meeting in January 2015, the GDG decided to review violence-specific questions related to safe disclosure (see RECs B.4–B.10, presented in Chapter 4, section 4.2.1), but decided not to review other existing recommendations on related issues since they were considered to be current and relevant. Key existing recommendations (RECs A.11–A.16) and good practice statements (GPSs A.6–A.8) for creating safety for women living with HIV are included in the boxes at the beginning of this subsection, and other related recommendations and guidance are available in the referenced documents.

## **ii. Barriers**

Violence against women living with HIV is fuelled by the imbalance in the power dynamics of gender, and by prejudice and discrimination against women living with HIV and women from other key affected populations. Also, multiple other structural factors influence vulnerability to violence, including discriminatory or harsh laws and policing practices, and cultural and social norms that legitimize stigma and discrimination (10, 60). At the interpersonal level, women living with HIV experience violence from intimate partners or family members when disclosing their HIV status (see also section 4.2.1), and violence from health workers, such as aggressive attitudes and behaviours, and forced sterilization (84).

## **iii. Components of an enabling environment**

Efforts to address violence against women living with HIV must involve other sectors along with the health sector. Together, they must create an enabling environment to promote physical, sexual and emotional well-being and safety. Critical components of an enabling environment include: mechanisms for documenting and monitoring violence; training women living with HIV, health-care workers and other stakeholders to understand human rights; fostering the accountability of law enforcement officials and health-care professionals to prevent and respond to violence and infringements of human rights; and addressing the structural elements that facilitate violence, such as gender inequality in decision-making and resource access, social norms, unfair laws and policies, and stigma and discrimination (84). In some settings, violence is pervasive for many women. While appropriate action around violence could help improve SRHR for all women, special attention should be paid to women who may be more vulnerable to stigma and exclusion, including women living with HIV as well as lesbian, bisexual and transgender women, women who use drugs and women engaged in sex work.

Certain core values should accompany interventions to create safety for women living with HIV and thereby foster improved SRH and realization of their rights. The following will help to create an enabling environment for safety for women living with HIV:

- taking a human rights approach;
- putting women's safety first and ensuring confidentiality;

- ensuring that, at a minimum, efforts do no harm – that these efforts take into consideration and prevent any possible backlash that could result when violence is addressed among women’s partners, families and communities;
- promoting gender equality;
- treating all people with respect; and
- facilitating the meaningful participation of women living with HIV in efforts to end violence and create safety (84).

### ***Prevention of violence against women living with HIV***

It is critical that whenever possible, as for all women, violence against women living with HIV is prevented and safety is promoted. This includes implementing community interventions to transform gender norms; conducting training for health workers on economic and gender issues and HIV; promoting laws and policies to support gender empowerment; and integrating motivational interviewing and counselling interventions into efforts for HIV risk reduction and HIV testing and counselling (see Box 3.4) (84).

With regard to the role of law and policy reforms to better protect the rights and safety of all women, including women living with HIV in all their diversity, this can include:

- advocacy to increase awareness of reporting mechanisms and disciplinary action;
- conducting sensitization workshops for people with pivotal roles in the community (e.g. government officials, police, media, health workers and religious leaders);
- creation of safe spaces;
- creation of early warning and rapid response mechanisms with the involvement of women living with HIV, health workers and law enforcement officials.

Integrating community representatives into these efforts also helps to create channels of communication among women living with HIV, civic officials and police (10). Unfortunately, law enforcement practices can increase the risk of violence faced by women living with HIV, especially those involved in activities that are criminalized or subject to legal sanctions, such as sex work or drug use. Indeed, law enforcement officers themselves can be perpetrators of violence. Work with law enforcement officers can involve training on the human rights of women living with HIV as well as promoting accountability for rights-based law enforcement (10).

In the context of this guideline, which is aimed at the health sector, incidents of disrespect and abuse of women living with HIV should be tackled through strategies to eliminate any form of violence.

#### **Box 3.4: Addressing violence against women in the context of HIV: a programming tool**

For specific ideas to foster an improved supportive environment by addressing violence, see the programming tool: *16 Ideas for addressing violence against women in the context of the HIV epidemic* (84). It presents ideas for:

- integrating violence against women and HIV services
- empowering women
- transforming cultural and social norms
- promoting and implementing laws and policies.

### ***Support for persons experiencing violence***

All women living with HIV who experience either sexual violence or intimate partner violence (IPV) and who disclose this to a health-care provider in an SRH or HIV service-delivery setting should receive first-line support in line with WHO guidelines for responding to IPV and sexual violence (81). In addition, women who experience sexual assault should be offered post-rape care that includes: emergency contraception; safe abortion and post-abortion care as needed, to the fullest extent of the law; post-exposure prophylaxis for HIV (PEP) and screening/testing and treatment for STIs; hepatitis B immunization; and psychosocial care and support. Where necessary, they should be referred to or offered medico-legal care, including forensic examination, in accordance with WHO guidelines (85, 86).

In HIV testing and counselling services, and especially for women who test positive, health-care providers should ask about their risk of IPV. Those who disclose IPV should be treated for their most immediate clinical needs including any injuries, offered first-line support, offered psychosocial support, assessed for mental health conditions and provided with mental health care in accordance with WHO clinical and policy guidelines for responding to IPV and sexual violence (81) and the WHO Mental Health Gap Action Programme (mhGAP) recommendations (87).

It also is important to monitor and document incidents of violence, both as evidence for advocacy and to inform programme design. Documenting the levels of violence faced by women living with HIV is often the first step in creating awareness. Documentation of such violence must be undertaken ethically with women's consent and with care to maintain confidentiality so as to not compromise their safety.

### Values and preferences



The single most prominent finding of the GVPS was that women living with HIV experience high levels of violence – which many of them termed “intolerable”. The vast majority of survey respondents, 89%, reported that they had experienced violence or fear of violence in one or more settings before, since or because of their diagnosis. HIV diagnosis acts as a specific trigger for IPV and/or violence from family and community members, and exposes women to new “sites” of violence as well, in particular within the health-care setting. The survey revealed frequent experiences of violence and rights violations within health-care settings among women living with HIV. These included confidentiality breaches, where health workers disclosed a woman’s HIV-positive status, or women themselves were forced to disclose their status, particularly in the context of antenatal care. These types of incidents constitute rights violations in and of themselves, and also put women at risk of IPV/ domestic violence. Women also experience reduced access to SRH services, including contraception, maternity and obstetric care, fertility treatment and adoption services. Many women who participated in the survey reported limited or no support for violence they had experienced, and/or “secondary victimization” or blame when they tried to access services for support or redress.

Survey respondents articulated that safety for women living with HIV, including those from key affected populations, is paramount and needs to be embedded throughout all the systems and structures of the HIV response, including policies and guidelines. Specifically, these women called for:

- a protective legal environment, economic empowerment and financial security;
- greater awareness of their rights and the different forms of GBV so that they are able to identify, name and report violence when it happens;
- greater sensitization of health workers and law enforcement officials in relation to the rights of women living with HIV;
- greater access to good-quality support services for all women who experience GBV;
- effective complaints and redress mechanisms;
- stigma reduction and human rights protection within health services including for women living with HIV from key affected or vulnerable populations (see also section 3.2.6);
- an end to rights violations including mandatory testing, involuntary disclosure and forced/coerced sterilizations;
- health staff to reach out beyond the clinic to promote and provide links to community-based programmes;
- support to address interpersonal violence; and
- options for treatment and support, such as safe houses, income-generating opportunities, and others (37).

### 3.2.6 Social inclusion and acceptance

#### Existing good practice statement on anti-stigma, anti-discrimination and protective policies

**GPS A.9: Policy-makers, parliamentarians and other public health leaders should work together with civil society organizations in their efforts to monitor stigma, confront discrimination against key populations and change punitive legal and social norms.**

##### Remarks

- This existing good practice statement was integrated into this guideline from WHO's *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations – 2016 update* (10).
- In addition, a relevant “critical enabler” should be noted: “Countries should work towards implementing and enforcing antidiscrimination and protective laws, derived from human rights standards, to eliminate stigma, discrimination and violence against people from key populations” (10).
- Further information on the above good practice statement and critical enabler can be found in the original publication, available at: <http://apps.who.int/iris/bitstream/10665/246200/1/9789241511124-eng.pdf>

#### Existing good practice statements on providing friendly services

**GPS A.10: Health-care workers should receive appropriate recurrent training and sensitization to ensure that they have the skills, knowledge and understanding to provide services for adults and adolescents from key populations based on all persons' right to health, confidentiality and non-discrimination.**

**GPS A.11: It is recommended to make contraceptives affordable to all, including adolescents, and that law and policy support access to contraception for disadvantaged and marginalized populations.**

##### Remarks

- These existing good practice statements were integrated into this guideline from WHO's *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations – 2016 update* (10).
- Key populations include women living with HIV.
- Further information can be found in the original publication, available at: <http://apps.who.int/iris/bitstream/10665/246200/1/9789241511124-eng.pdf>

#### i. Background

Women living with HIV often experience and/or fear violence in the form of stigma, discrimination and negative attitudes from their families, communities and health workers. Such stigma is common in many communities of health professionals, health-care facilities and law enforcement services. Often such stigma and discrimination persists with impunity due to lack of national laws and policies against discrimination and/or by-laws that criminalize and impose sanctions on particular behaviours, actions or occurrences, such as same-sex practices between consenting adults, personal drug use, sex work, and HIV transmission or exposure.

#### ii. Barriers

The effects of such HIV-related stigma and discrimination against women living with HIV can lead to poor uptake of SRH and HIV services, and create challenges for adherence to ART (88, 89).

While stigma often manifests at the relationship level, within and beyond the health sector, stigma and discrimination can take many forms. The lack of understanding among health workers about the needs, priorities, rights, health issues and appropriate interventions for women living with HIV leaves providers ill-equipped to address important health concerns and priorities, and it perpetuates stigmatizing and discriminating practices, even to the point of health workers refusing to provide services. Policies that promote or do not prevent stigmatizing practices can normalize discrimination. For example, instead of

limiting the FP options of women living with HIV who wish to prevent pregnancy, programmes should instead offer the full available range of contraceptive options and support women to select their preferred, optimal method.

For women living with HIV, there is often an intersection between stigma related to HIV and stigma related to other socially disadvantaged identities, such as identifying as lesbian, bisexual or transgender, having mental health issues, using drugs or being engaged in sex work. This can result in further marginalization of women living with HIV from these communities, and complex layers of stigma, discrimination and violence (52).

### **iii. Components of an enabling environment**

Efforts to reduce stigma and discrimination at a national level, such as promoting anti-discrimination and rights-protective policies for all women living with HIV, can foster a supportive environment at a community and interpersonal level, particularly within the health-care and justice systems (90). Policies are most effective when they simultaneously address individual, organizational and public policy factors that enable or allow stigma and discrimination (91). Programmes both within and outside the health sector need to institute pro-safety-related responses, including anti-stigma and anti-discrimination policies and codes of conduct, as well as raising awareness among service providers and community members about human rights issues. Monitoring and oversight are important to ensure that standards are implemented and maintained. Additionally, mechanisms should be made available to women living with HIV to anonymously report occurrences of stigma, negative attitudes, or offensive language or questions, and/or other forms of discrimination when they try to obtain health services.

#### ***Providing friendly services to women living with HIV***

It is important to make health services available, accessible and acceptable to women living with HIV, based on the principles of medical ethics, avoidance of stigma, non-discrimination and the right to health (22), and to tailor these services to their needs and priorities (90). Interventions and services for women living with HIV should adopt woman-centred, patient-friendly and rights-based principles, paying particular attention to accessibility and the expertise and attitudes of staff members.

The meaningful involvement of peer educators in service provision may help to create a safer environment for women living with HIV from different communities to access services. Peer and community support strategies can promote treatment readiness, uptake, adherence and lifelong retention in care; reduce stigma and discrimination; and mitigate potential violence stemming from HIV disclosure (77).

Social norms and taboos related to sexual orientation, sexual identity, gender, sexual health, sexuality and reproductive health create a culture of shame, blame and silence. Women living with HIV in such contexts can feel isolated and may internalize negative perceptions, leading to mental health problems such as depression and the neglect of self-care. In addition, the lack of confidential and non-judgemental health care services is a barrier for women living with HIV to obtain information and commodities, and to feel supported in expressing their SRH needs and concerns. Safe spaces (both within health-care facilities and social services) and confidential and stigma-free environments can encourage women living with HIV to access the services they need (10). Further information on training and sensitizing health workers is provided in Box 3.5.



### Box 3.5: Training and sensitizing health workers

Creating inclusive health services requires sensitizing and educating providers and other staff members in health care and social services. This can be done in both pre-service and in-service training, through on-the-job support and supervision, and by creating an organizational norm of inclusiveness and non-discrimination.

**Attitudes:** Health-care providers working with adults or adolescents from key populations should be non-judgemental, supportive, responsive and respectful, and should understand the issues faced by women living with HIV. Training, with the involvement of key population representatives and groups, can be developed to sensitize and educate health workers on issues specific to women living with HIV, non-discriminatory attitudes and practices, and key populations' rights to health, confidentiality, non-coercive care and informed consent.

**Skills:** It is important that health workers are able to respond to the specific needs of key populations and provide quality services, know what interventions, tools and materials are available to provide information, can advise on HIV risk-reduction strategies, and know how to support treatment adherence and retention in care.

Improving and maintaining providers' attitudes and skills is a continual process consisting of multiple components, such as formal training events, job aids, supportive supervision, training follow-up and mentorship. Multidisciplinary training and work environments can strengthen linkages to community-based providers so that referrals and adequate follow-up are more available. Particularly where there are workforce shortages, it is important that all providers receive adolescent-specific training, including lay counsellors, to enable task shifting.

Source: WHO, 2016 (10).

### Values and preferences

Women and girls with HIV from key affected populations – including sex workers, women who use/inject drugs, lesbian, bisexual and other women who have sex with women, transgender women, and women with disabilities (among others) – face many of the same challenges that women and girls in general who are living with HIV face, based on gender inequality, assumptions and HIV-related stigma, discrimination and violence. However, gender norms and other societal perceptions and values may also play out within the specific context of their lives to create additional layers of social and structural barriers to accessing services and claiming human rights. Actions to support the rights of these women from key populations should include:

- sensitizing health workers and other service providers about the specific needs and rights of women living with HIV of all ages, and in particular those who use drugs, engage in sex work, and/or are lesbian, bisexual, transgender or intersex, in order to eliminate stigma and discrimination on the basis of HIV status, drug use, sex work, sexuality, gender identity or age;
- ensuring continuity of treatment and holistic care for women in prison or detention;
- increasing access to harm reduction services for women who use drugs;
- repealing laws that criminalize HIV transmission and exposure, and those that criminalize personal drug use, sex work and same-sex practices;
- ensuring that people in authority see it as a part of their duty and role to remove barriers to SRH access for women living with HIV in all their diversity (37).





## 3.2.7 Community empowerment

### Existing recommendations on women living with HIV who are health workers

**REC A.17:** Provide free HIV and TB treatment for health workers in need facilitating the delivery of these services in a non-stigmatizing, gender-sensitive, confidential, and convenient setting when there is no staff clinic and/or their own facility does not offer ART, or where health workers prefer services off-site.

*(strong recommendation, weak evidence)*

**REC A.18:** Introduce new, or reinforce existing, policies that prevent discrimination against health workers with HIV or TB, and adopt interventions aimed at stigma reduction among colleagues and supervisors.

*(strong recommendation, moderate-quality evidence)*

#### Remarks

- These existing recommendations were integrated into this guideline from the 2010 publication, *Joint WHO/ILO policy guidelines on improving health worker access to prevention, treatment and care services for HIV and TB* (92). These guidelines address important aspects of ensuring that the SRHR guidance applies to women living with HIV who are also health workers.
- In this same publication, it is also noted that “although health workers are at the frontline of national HIV programmes, they often do not have adequate access to HIV services themselves” (92).
- Further information can be found in the original publication, available at: [http://apps.who.int/iris/bitstream/10665/44467/1/9789241500692\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/44467/1/9789241500692_eng.pdf)

### Existing good practice statement on community empowerment

**GPS A.12:** Programmes should be put in place to provide legal literacy and legal services to key populations so that they know their rights and applicable laws and can receive support from the justice system when aggrieved.

#### Remarks

- This existing good practice statement was integrated into this guideline from WHO’s *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations – 2016 update* (10).
- Key populations include women living with HIV.
- Further information can be found in the original publication, available at: <http://apps.who.int/iris/bitstream/10665/246200/1/9789241511124-eng.pdf>

### i. Background

Community empowerment refers to the process of enabling communities to increase control over their lives (84). Some women living with HIV are leaders in promoting SRHR for women living with HIV. Several peer-support programmes have been successful in providing life skills and safe spaces for women living with HIV, ensuring safety, building assets, and connecting women with a social network of mentoring and positive role models, which are seen by women living with HIV as essential to improving their SRHR outcomes. Similarly, empowerment of women living with HIV, including an active role in decision-making about their own health, is critical to good SRHR outcomes. Communities play an important role in both developing evidence-informed policies, through sharing evidence from the community, and ensuring effective implementation of national policies and uptake of services.

## ii. Barriers

Women living with HIV often have little or no control over SRH risk factors that are driven by their legal, political and social environment and the context of their personal lives. For instance, they may not have the power to negotiate consistent condom use to prevent an unintended pregnancy or STI. This lack of empowerment is exacerbated if women are unaware of their legal and human rights, specifically their right to health, and unaware of what to do if these rights are violated.

## iii. Components of an enabling environment

Community empowerment is a collective process that enables women living with HIV to address the structural constraints to health, human rights and well-being; make social, economic and behavioural changes; and improve access to health services. Community empowerment can foster the wider reach and greater effectiveness of services for women living with HIV, and have positive outcomes across a broad range of concerns, such as living conditions, developing strategies for SRH interventions and redressing violations of human rights. Community empowerment can take many forms, such as meaningful participation in: designing, decision-making, implementation and monitoring of services; peer education; implementation of legal literacy and service programmes; and in fostering peer-led groups, programmes, research and service delivery (10).

Women living with HIV form a very diverse and heterogeneous community. Therefore, to be effective, health-care interventions must account for this diversity as well as the legal, political, social and health environments in which women with HIV are living. This flexibility, responsiveness, adaptability and sustainability are also essential to community empowerment initiatives.

Policies on access to health services and information need to be improved. Ensuring that women living with HIV are aware of their legal and human rights as individuals – specifically that their right to health includes the right to information – can increase their access to health services. Since women living with HIV are often the target of exploitation, marginalization, criminalization, stigma and discrimination, programmes are particularly needed to ensure that women living with HIV know their legal and human rights, including applicable protective laws and where and how to obtain legal services and report violations. Health literacy, sexuality education and support programmes can help improve awareness (93). If better informed, networks of women living with HIV can better organize to advance their rights and raise awareness of their rights, priorities and the policies and legal issues that critically affect them (90, 94, 95). More information on supportive laws and policies is provided in section 3.2.8.

### Values and preferences

Survey respondents repeatedly referred to the benefits of connecting with other women living with HIV as fundamental to their ability to accept their HIV diagnosis and serostatus, disclose it to others, deal with mental health issues, understand their rights, enjoy sexual relationships and make positive decisions about pregnancy and childbirth, among other things. Peer support was also cited as important in identifying and seeking redress for experiences of violence and other human rights violations. Respondents articulated the need for investment in networks and organizations of women living with HIV to provide peer support, safe spaces and counselling, as well as training for leadership and advocacy to challenge structural barriers, including gender inequality, stigma, discrimination and cultural norms (37).



### 3.2.8 Supportive laws and policies and access to justice

#### Existing good practice statements on decriminalization and sentencing related to HIV

**GPS A.13:** Countries should work towards decriminalization of behaviours such as drug use/injecting, sex work, same-sex activity and nonconforming gender identities, and towards elimination of the unjust application of civil law and regulations against people who use/inject drugs, sex workers, men who have sex with men and transgender people.

**GPS A.14:** Countries should work towards developing non-custodial alternatives to incarceration of drug users, sex workers and people who engage in same-sex activity.

#### Remarks

- These recommendations apply to women living with HIV who use/inject drugs, are sex workers, engage in same-sex activity and who are transgender. They were integrated into this guideline from WHO's *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations – 2016 update (10)*.
- Further information can be found in the original publication, available at: <http://apps.who.int/iris/bitstream/10665/246200/1/9789241511124-eng.pdf>

#### Existing good practice statements on age of consent policies and laws for adolescents

**GPS A.15:** Countries are encouraged to examine their current consent policies and consider revising them to reduce age-related barriers to HIV services and to empower providers to act in the best interest of the adolescent.

**GPS A.16:** It is recommended that sexual and reproductive health services, including contraceptive information and services, be provided for adolescent girls without mandatory parental and guardian authorization/notification.

#### Remarks

- These existing good practice statements, which are relevant to adolescent girls living with HIV, were integrated into this guideline from WHO's *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations – 2016 update (10)*.
- Further information can be found in the original publication, available at: <http://apps.who.int/iris/bitstream/10665/246200/1/9789241511124-eng.pdf>

#### Existing good practice statements on transgender people

**GPS A.17:** Countries should work toward developing policies and laws that decriminalize same-sex behaviours and nonconforming gender identities.

**GPS A.18:** Countries should work towards legal recognition for transgender people.

**GPS A.19:** For transgender people, the legal recognition of preferred gender and name may be important to reduce stigma, discrimination and ignorance about gender variance. Such recognition by health services can support better access, uptake and provision of HIV services.

#### Remarks

- These existing good practice statements, which are relevant to transgender women living with HIV, were integrated into this guideline from WHO's *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations – 2016 update (10)*.
- Further information can be found in the original publication, available at: <http://apps.who.int/iris/bitstream/10665/246200/1/9789241511124-eng.pdf>

## **i. Background**

Many countries have made legally binding commitments to a number of international agreements and consensus documents to protect the needs and rights of people living with HIV. However, in practice, many laws and policies are not in line with international human rights norms and standards. For example, many countries criminalize unintentional HIV transmission, or do not have laws to protect women living with HIV from sexual violence. Moreover, even where good laws exist, they need to be implemented through political commitment, adequate resource allocation, capacity-building of those responsible for upholding and enforcing the law, and the creation of systems of accountability when laws are violated.

## **ii. Legal barriers**

Often, instead of facilitating access for women and girls living with HIV, laws and policies at the national level restrict access and in some cases impose punitive sanctions. Sixty per cent of countries report having laws, regulations or policies that are barriers to effective HIV services for many women living with HIV (96). In particular, over 100 countries criminalize some or all aspects of sex work (96).

Although living with HIV is not itself indicative of sexual transmission of the infection, individuals are often discriminated against for their HIV-positive status based on a presumption of sexual activity that is often considered socially unacceptable (23). Criminalization of HIV non-disclosure, HIV exposure and HIV transmission make it more difficult for women living with HIV to enter into healthy sexual relationships (97). HIV transmission has been criminalized in various ways and women are particularly affected by these laws since they often learn that they are HIV-positive before their male partners do, given that they are more likely to access health services. Human rights bodies have called on states to ensure that a person's actual or perceived health status, including HIV status, is not a barrier to realizing human rights. When HIV status is used as the basis for differential treatment with regard to access to health care, education, employment, travel, social security, housing and asylum, this amounts to restricting human rights and it constitutes discrimination (98).

Additionally, transgender people are not legally recognized in many countries and face restrictive policies that regulate their gender identity and expression (96). In many settings, punitive drug use policies call for harsh penalties for the possession of small amounts of drugs for personal use, and in some settings policies mandate compulsory detention as “treatment” for people who use or inject drugs (96). For women living with HIV in many prisons and other closed settings, SRH and HIV services are substandard or entirely lacking.

While laws vary, adolescents under 18 years of age are classified legally as minors in many settings or jurisdictions, and are therefore often required to have parental consent for medical care, including SRH and HIV-related services. Such laws and policies can be barriers to or can discourage adolescents from seeking services (64). These restrictions may create complex dilemmas for providers who endeavour to act in the best interests of their clients but who may have concerns about their own legal liability and about the safety of their young clients.

## **iii. Components of an enabling environment**

Laws and policies can help to protect the human rights of women in relation to HIV – both those living with HIV and those at risk of acquiring HIV. Legal reforms – such as decriminalizing drug use and sexual practices, including sex work and sex between consenting adults, and legal recognition of transgender status and of the evolving capacity of children/adolescents – are critical enablers that can change a hostile environment for women living with HIV into a supportive environment. Specific consideration should be given to such legal reforms as part of any revision of policies or programmes for women living with HIV. For example, in many countries, possession, use and sale of clean needles and syringes or possession of condoms remains justification for arrest. Where this is the case, this warrants review.

Laws and policies that do not criminalize HIV are critical to supporting SRHR of women living with HIV, and indeed, all people living with and most impacted by HIV.

Supporting the health and well-being of women living with HIV whose sexual practices, drug use, gender expression or perceived sexual orientation are currently criminalized may require changing legislation and adopting new policies and protective laws in accordance with international human rights standards. Without protective policies and decriminalization of HIV transmission and exposure, sex work, possession of drugs and same-sex practices, barriers to essential health services will remain; many women living with HIV may fear that seeking health care will expose them to adverse legal consequences (99).

### ***Improve access to justice and legal support for women living with HIV***

Policies and procedures are needed to ensure that women living with HIV can safely report rights violations, such as discrimination, violations of informed consent, violations of medical confidentiality and denial of health services. For example, women living with HIV can be trained as paralegals or a network of women living with HIV can serve as a third-party reporter of complaints (10). For violence against women and other rights violations, the most important consideration in facilitating women's access to justice should be safety, confidentiality, choice and autonomy in terms of whether or not a woman wants to report her experience of violence to the police. Health-care providers should facilitate access to justice by offering to support the woman should she wish to report to the police, and to refer her for forensic examination and evidence collection as appropriate and in line with WHO guidance (84, 100). However, they should not be mandated to do so.

### ***Law enforcement***

Law enforcement can play an important role by ensuring that the human rights of women living with HIV are not violated. Police should receive continual training on ways to support – or at least not to impede – access to essential health services. Systems to promote good policing practices and to provide safe avenues for reporting human rights violations will help ensure that police are protecting both the public health and the human rights of all persons. As mentioned previously, unfortunately, law enforcement practices and personnel can also harm women living with HIV. Law enforcement work should promote the human rights of women living with HIV as well as internal accountability for rights-based law enforcement (10).

### ***Access to SRH and HIV services for women living with HIV in prison or detention***

There are more than 10 million men and women in prisons and other closed settings, with an annual turnover of around 30 million moving between prison and the community. Globally, the prevalence of HIV, other STIs, hepatitis B and C, and TB in prison populations is estimated to be 2–10 times higher than in the general population. In addition to HIV risk behaviours in prison (e.g. unsafe sexual activities, injecting drug use and tattooing), factors related to the prison infrastructure, prison management and the criminal justice system contribute to increased risk of HIV, hepatitis B and C, and TB in prisons. Due to the conditions of imprisonment, including overcrowding, sexual violence, drug use and lack of access to HIV prevention commodities such as condoms and lubricants, transmission risk is very high. In some settings, HIV prevalence rates are higher among women in prisons than among men, and much higher than among women in the general population (10).

Access to HIV treatment and care programmes is often poor in prisons and other closed settings. Few countries implement comprehensive HIV programmes in prisons. Not only are such services needed in prison and other closed settings, but linkages to HIV services in the community are also needed to maintain continuity after a person is released from prison.

## Values and preferences



Women living with HIV who responded to the GVPS reported that laws that criminalize certain practices act as a disincentive to getting tested for HIV and seeking SRH and HIV services, and also undermine the efforts of women living with HIV to protect their own and others' health. They articulated that a supportive legal environment enhances the ability of women living with HIV to access services that advance their own health and rights, and which also enable them to protect their partners and children from onward transmission of HIV. Conversely, punitive laws and policies that criminalize HIV exposure and transmission, drug use, sex work and same-sex activities between consenting adults not only stand in the way of women's access to SRHR and HIV services, but also position them as a threat to others and something to be feared, thereby entrenching existing stigma and discrimination at the community level. Survey respondents called for the decriminalization of HIV exposure/transmission as well as of sex work, drug use and same-sex activity. At the same time, they called for a strengthening of laws to protect *all* women – including women living with HIV – from all forms of violence, including date and marital rape, as well as laws and policies to protect and uphold the rights of people living with HIV.

Laws, policies and practices should be reviewed and, where necessary, revised by policy-makers and government leaders, with meaningful engagement of women living with HIV, to allow and support their increased access to services (37).

# Chapter 4. Health interventions: recommendations and good practice statements

This chapter covers health interventions related to the sexual and reproductive health and rights (SRHR) of women living with HIV, grouped into six types of services, in the order in which they are presented in the remainder of this chapter:

1. sexual health counselling and support services
2. violence against women services
3. family planning and infertility services
4. antenatal care and maternal health services
5. safe abortion services; and
6. sexually transmitted infection (STI) and cervical cancer services.

Each of these sections in this chapter presents new and/or existing recommendations (RECs) and existing good practice statements (GPSs) as well as background information on each type of service. In the case of the NEW RECs, a summary of evidence and considerations of the GDG is also presented. The WHO Guideline Steering Group (SG) for development of this guideline identified eight topic areas where new RECs or GPSs needed to be developed for this guideline (see Chapter 2, section 2.4). Four of those topics are covered in this chapter – under topics 1, 2, 4 and 5 as listed above – while the other four are covered in Chapter 3. The six new RECs included in this guideline are presented in four sub-sections of this chapter (and labelled as “NEW”): 4.1.1 Empowerment and self-efficacy; 4.2.1 Safe disclosure; 4.4.1 Caesarean section; and 4.5.1 Safe abortion. Relevant findings from the Global Values and Preferences Survey (GVPS) of the priorities of women living with HIV are also presented in each sub-section and embedded in the information provided with the new RECs.



## 4.1 Sexual health counselling and support

### 4.1.1 Empowerment and self-efficacy

#### NEW recommendation on empowerment and self-efficacy

**REC B.1: WHO recommends that for women living with HIV, interventions on self-efficacy and empowerment around sexual and reproductive health and rights should be provided to maximize their health and fulfil their rights.**

*(strong recommendation, low-quality evidence)*

#### Remarks

- These interventions should meaningfully engage women living with HIV throughout the development, implementation and evaluation process, include consultations and involvement during the planning, design, delivery and monitoring of the interventions. This will increase the relevance, acceptability and, likely, the accessibility and effectiveness of the interventions. However, the responsibility for the provision of these interventions lies with the health system and does not fall solely on women living with HIV.
- Women living with HIV, including those from key populations, may need further special considerations to overcome additional layers of disempowerment, marginalization and exclusion resulting from intersecting forms of stigma, discrimination and violence – often legitimated by laws that criminalize or fail to protect them.
- The power imbalances and inequalities that cause women living with HIV to be unable to exercise their sexual and reproductive rights operate on multiple levels. Not only should women be supported at the individual level to develop self-efficacy and empowerment, but interventions should also be considered at the interpersonal, community and societal levels to shift these norms. Supporting women to gain access to improved economic, food, housing and other resources may support their ability to make decisions and exercise their rights. Chapter 3 of the guideline discusses economic empowerment (see section 3.2.3).
- Further ideas for empowering women living with HIV are available in the programming tool: *16 Ideas for addressing violence against women in the context of the HIV epidemic* (84).

#### i. Background

Women living with HIV often experience inequitable gender norms and power imbalances that prevent them from being able to achieve their sexual and reproductive health (SRH) goals and exercise their rights. The barriers they face can include limited access to health services, limited agency within health systems, and disempowerment in their interactions with their sexual partners and other members of their community. Women living with HIV often face multiple layers of disempowerment, including gender norms that prevent women from participating in decision-making, as well as stigma and marginalization that can accompany their HIV-positive status. These challenges influence the SRH behaviours and choices of women living with HIV. Health-care services and health workers can support women to achieve good SRHR outcomes through empowerment and self-efficacy interventions. Strategies that focus on women's empowerment have the potential to impact positively on their quality of life, their autonomy, their health and the health of their children and families.

#### ii. Summary of evidence and considerations for the new recommendation

At the scoping meeting in January 2015, the Guideline Development Group (GDG) decided that interventions that improve self-efficacy and empowerment should be reviewed. The PICO question (population, intervention, comparator, outcome) was: **What interventions improve self-efficacy and empowerment around safer sex and reproductive decision-making for women living with HIV?** Self-efficacy is defined as “an individual's belief in his or her capacity to execute behaviours necessary to produce specific performance attainments” (101). Empowerment is defined as “the process of increasing the capacity of individuals or groups to make choices and to transform those choices into desired actions and outcomes” (102). The relevant systematic review conducted in support of the development of this guideline included studies with comparison groups, drawn from a search of the peer-reviewed and grey literature for women living with HIV

aged 10 years and older. Outcomes of interest included: self-efficacy; empowerment or other measures of a woman's ability to make her own decisions around SRH; SRH behaviours; and SRH outcomes, such as sexually transmitted infections (STIs), pregnancy and others (103).

### **Results**

The review found 20 studies (17 randomized controlled trials [RCTs], 2 quasi-experimental studies and 1 matched case-control study) evaluating 10 interventions and international adaptations of interventions from five countries: Nigeria, South Africa, the USA, Zambia and Zimbabwe. The interventions were administered to individuals or small groups, during discussion or counselling sessions with one computer module-based intervention. The content and delivery of the interventions varied across the studies. The interventions included 2–11 sessions and covered topics such as: gender pride; supportive social network use; HIV transmission risk behaviours; communication and safe sex negotiation; condom use; managing abusive relationships; goals and values; prevention of perinatal transmission; nutrition; and adherence. Interventions were each grounded in a theoretical framework or approach including: cognitive behavioural stress management; social cognitive theory; the theory of gender power; the theory of reasoned action; motivational interviewing; and stages of change. Intervention providers included nurses, psychologists and peer educators.

While there was a wide range of outcomes of interest for this topic (see Annex 3), including the relevant outcomes reported in the studies were STI incidence, condom use, contraceptive use, condom use negotiation self-efficacy, sexual communication self-efficacy, and the balance of power within the relationship. STI incidence was measured in two studies using the same set of interventions, adapted for different settings. Statistically significant decreases were seen for chlamydia, gonorrhoea and trichomoniasis. Results for bacterial vaginosis were not significant. Studies used varying measures for condom use but generally found an increase or no change, with high baseline rates of reported use. While the evidence was inconsistent, several studies found improvements in condom use and negotiation self-efficacy, as well as improvements in the balance of power within the relationship.

Harms from the interventions were not evaluated. The primary objective of many of the interventions was sexual risk reduction, but empowerment or self-efficacy was often included as a secondary objective or as the approach to achieve the primary objective. This highlights the need for more comparative studies evaluating interventions focusing on empowering women living with HIV to achieve good SRH, which includes healthy sexuality, family planning, antenatal care, avoiding STIs and unsafe abortion, and freedom to exercise sexual and reproductive rights.

### **Quality of the evidence for the recommendation**

The quality of the evidence is low. The GDG downgraded the evidence due to inconsistency, as studies showed mixed results for condom and other contraceptive use, and imprecision, because of the low number of events included in the studies. The variations in intervention topics, providers, timing and objectives may explain the variation in estimates. It was not possible to assess consistency for all outcomes, as some were measured by only one study.

### **Rationale for the strength and direction of the recommendation**

While evidence is limited, self-efficacy and empowerment is of critical importance to women living with HIV, as indicated by the findings of the Global Values and Preferences Survey (GVPS) (37). There are arguments from multiple fields of enquiry that power dynamics affect health outcomes, particularly for vulnerable groups, and therefore a high value was placed on self-efficacy and empowerment by the GDG. The GDG discussed whether to make REC B.1 a strong or conditional recommendation. In order to gain an initial indication of GDG members' views on this, the methodologist asked participants to raise their hands in support of each separate option. This was not a formal vote, but a decision-making aid to allow the methodologist and chairs to gauge

the distribution of opinion and subsequently work towards consensus through further discussion. The final adoption of REC B.1 as a strong recommendation was confirmed by unanimous consensus among all GDG members.

### **Feasibility**

There were 10 different programmes with multiple, international adaptations studied in five countries, indicating initial feasibility. Some health workers, such as peer educators, may be better able to implement the interventions than others, based on training and resources.

### **Values and preferences**

Women living with HIV responding to the GVPS raised a number of issues relating to gender equality and social justice. Respondents said that women's and girls' agency and autonomy around SRHR-related decision-making is affected by a range of cultural, economic, social/structural and legal factors, including gender norms and power relations, religious and cultural beliefs, stigma and discrimination related to HIV and/or a range of other demographic factors (e.g. age, gender, sexuality, ethnicity and race, class, disability). Other factors influencing their agency and autonomy include access to information and services, and the existence of laws that either uphold or erode the rights of women living with HIV in all their diversity. Women living with HIV reported widespread difficulty in decision-making around when, how and with whom to have sex, and whether and when to have children. They also reported difficulty in decision-making around condom use, negotiating safer sex and, in particular, identified achieving a pleasurable and satisfying sex life as a challenge. Financial inequality and lack of formal economic opportunities for women were raised repeatedly by survey respondents in relation to decision-making around their sex life, fertility desires, and accessing and utilizing SRH services. They also reported that financial insecurity or hardship had a severe impact on their mental health. Women articulated that social relations predicated on gender inequality can severely limit women's ability to exercise agency in relation to SRH, and to claim and realize their human rights. They argued that SRH and human rights for all women, including women living with HIV and women from key populations, must be embedded in a framework of gender equality and social justice. Women reported that severe stigma and discrimination experienced by women living with HIV from key affected populations, especially women who are lesbian, transgender or sex workers, negatively affects their self-efficacy for SRH decision-making (37). Cultural and gender norms that perpetuate poor knowledge and access to resources (such as comprehensive sexuality education [CSE] and SRH services for girls and young women) and legal barriers (such as age of consent laws and restriction of access to safe abortion and post-abortion care) limit their ability and self-efficacy to make SRH decisions.



## 4.1.2 Brief sexuality communication (BSC)

### Existing recommendations and good practice statement on BSC

**REC B.2: BSC is recommended for the prevention of sexually transmitted infections among adults and adolescents in primary health services.**

*(strong recommendation, low- to moderate-quality evidence)*

**REC B.3: Training of health-care providers in sexual health knowledge and in the skills of BSC is recommended.**

*(strong recommendation, low- to very low-quality evidence)*

**GPS B.1: Health policy-makers and decision-makers in health-care professional training institutions need to ensure that, where BSC is introduced, it respects, protects and fulfils clients' human rights.**

#### Remarks

- These existing recommendations and good practice statement were integrated into this guideline from the 2015 WHO publication, *Brief sexuality-related communication: recommendations for a public health approach* (25).
- As stated in WHO's 2015 BSC recommendations, "The implementation process should be based on STI/HIV epidemiology as well as the local context of the epidemic, in line with national STI control and prevention strategies, and it should be inclusive of all national stakeholders" (25). Providers will need to consider the enabling environment for women living with HIV, as outlined in Chapter 3 of this document, and the specific situation of each woman to ensure the protection of rights and promotion of SRH.
- Further information can be found in the original publication, available at: [http://apps.who.int/iris/bitstream/10665/170251/1/9789241549004\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/170251/1/9789241549004_eng.pdf)

### i. Background

One service-delivery approach to promote sexual well-being is brief sexuality communication (BSC). In BSC, the provider – whether a nurse, doctor or health educator – uses counselling skills to address sexuality and related personal or psychological issues, as well as to promote sexual well-being. BSC takes into account the psychological and social dimensions of sexual health and well-being along with the biological ones (25).

#### Values and preferences

Survey respondents emphasized the importance of: access to information relating to positive sexuality and sexual pleasure (including addressing gender norms and sexual taboos); access to psychosexual counselling; trust between intimate partners and also between clients and SRH providers; provision of support with regard to disclosure; and access to SRH providers who are sensitized and well informed about the SRH needs of women in same-sex relationships and transgender women (37).



### 4.1.3 Mental health

No new or existing recommendations or good practice statements were identified or developed for this topic. However, mental health remains a key area for women living with HIV and an important part of attainment of SRHR of women living with HIV. Existing comprehensive WHO mental health guidance is discussed below.

#### i. Background

HIV is a catalyst for mental health issues such as depression, feelings of rejection and insomnia.

Comprehensive guidelines on mental health exist in the 2015 edition of the *WHO mhGAP Intervention Guide* (mhGAP-IG) (87), the update to the first version of that guide, which was published in 2010 (104). As such, at the scoping meeting in January 2015, to avoid duplication, the GDG chose not to develop specific recommendations for mental health of women living with HIV but to reference the existing guidance, as many of the approaches for addressing issues of depression, anxiety and post-traumatic stress disorder (PTSD) that women living with HIV may face as a result of trauma and stress are similar to those that would apply to all women. The mhGAP-IG presents guidance on providing integrated management of priority conditions using protocols for clinical decision-making (87). The priority conditions included in the mhGAP-IG are: depression, psychosis, bipolar disorders, epilepsy, developmental and behavioural disorders in children and adolescents, dementia, alcohol use disorders, drug use disorders, self-harm/suicide, and other significant emotional or medically unexplained complaints.

The full guidance should be utilized for each woman as appropriate for her specific situation, with special attention to how the recommendations may need to be implemented to support a woman living with HIV and her associated needs, situation and concerns (87). Further guidance is available from the 2014 *Guidelines for the identification and management of substance use and substance use disorders in pregnancy* (105).

The mhGAP-IG outlines the principles of essential care for all people seeking health care, including those with mental, neurological and substance use (MNS) conditions, and their carers. It aims to “promote respect for the privacy of people seeking care for MNS conditions, foster good relationships between health care providers, service users and their carers, and ensure care is provided in a non-judgmental, non-stigmatizing, and supportive manner” (87).

Furthermore it outlines the following general principles and essentials of mental health clinical practice.

General principles:

1. Use effective communication skills: Using effective communication skills allows health-care providers to deliver good-quality care to adults, adolescents and children with MNS conditions.
2. Promote respect and dignity: Persons with MNS conditions should be treated with respect and dignity in a culturally appropriate manner. As a health-care provider, make every effort to respect and promote the will and preference of people with MNS conditions and support and engage them and their carers in the most inclusive way. Persons with MNS conditions are often more vulnerable to human rights violations. Therefore, it is essential that in the health-care setting, providers promote the rights of people with MNS conditions in line with international human rights standards, including the UN Convention on the Rights of Persons with Disabilities (CRPD).

Essentials of mental health clinical practice:

1. Assess physical health: Persons with MNS disorders are at higher risk of premature mortality from preventable disease and therefore must always receive a physical health assessment as part of a comprehensive evaluation.
2. Conduct an MNS assessment: First, the presenting complaint is explored, then a history is obtained including asking about past MNS issues, general health problems, family MNS history, and psychosocial history. Observe the person (Mental Status Exam), establish a differential diagnosis, and identify the MNS condition.
3. Manage MNS conditions: Once the assessment is conducted, follow the management algorithm in mhGAP-IG to manage the MNS disorder (87).

## Values and preferences



Women living with HIV who responded to the GVPS described a complex nexus of HIV diagnosis, violence and other stress factors including livelihoods and treatment side-effects, which impact on individuals' mental health, which can in turn have a negative effect on their ability to enjoy their SRHR. Ways in which mental health disorders affect the SRHR of women living with HIV include: loss/lack of libido or sex drive, or increased need for sexual intimacy; lack of assertiveness in sexual relationships, including inability to negotiate condom use; secrecy in relationships in relation to HIV disclosure; difficulty in committing to sexual relationships, lack of trust, or choosing to stay with violent or abusive partners; anxiety-related sleep disorders and pain; and alcohol or drug dependence, which can prevent the formation of close, intimate relationships. Key factors identified by women in the survey that can support them with mental health issues include: peer counselling and support; access to support groups by and for women living with HIV (see also section 3.2.1); access to holistic health services that include support for/attention to mental health issues; safety; and a supportive legal and policy environment. From the clinical side, access to ongoing stigma-free counselling/psychosocial care is paramount (37).

## 4.2 Violence against women services

### 4.2.1 Safe disclosure

#### NEW recommendations on safe disclosure

**REC B.4: WHO recommends that policy-makers and service providers who support women living with HIV who are considering voluntary HIV disclosure should recognize that many fear, or are experiencing, or are at risk of intimate partner violence.**

*(strong recommendation, low-quality evidence)*

**REC B.5: WHO recommends that interventions and services supporting women living with HIV who are considering voluntary HIV disclosure should include discussions about the challenges of their current situation, the potential associated risk of violence, and actions to disclose more safely, and facilitate links to available violence prevention and care services.**

*(strong recommendation, low-quality evidence)*

#### Remarks

- Disclosure of HIV status is a process, not a single event for women living with HIV. Women must have informed choice about to whom they disclose, for whom they disclose, and when, where and how they disclose. Women living with HIV would benefit from support to consider the possible benefits of disclosure, such as support from family, friends and members of the community of women living with HIV to take antiretroviral therapy (ART). They would also benefit from support as they consider the possible challenges this disclosure may present, particularly related to the reactions of sexual partners, family members and friends – or others, such as employers or clients – which could possibly lead to increased stigma, violence or reduced access to resources.
- An important way to support women and to ensure that they can exercise their human rights is to ensure that the women themselves are leading their disclosure decisions with support from others, including health workers, and are not forced to disclose or have their status disclosed on their behalf.
- Counselling should include information for women about the risk of violence and should take into consideration the high prevalence and risk of violence experienced by women living with HIV.
- In countries where HIV transmission is criminalized, safe disclosure may not be possible. Furthermore, many women face violence independent of the disclosure of their status. Violence related to disclosure and otherwise is covered further in Chapter 3 of this guideline (see section 3.2.5).



## Existing recommendations on safe disclosure

**REC B.6: Adolescents 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.**  
(conditional recommendation, very low-quality evidence)

### Remarks

- This existing recommendation was integrated into this guideline from the 2013 WHO publication, *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* (64).
- Further information can be found in the original publication, which is also available as an online interactive tool, *Adolescent HIV testing, counselling and care: implementation guidance for health providers and planners* (67), available at: <http://apps.who.int/adolescent/hiv-testing-treatment/>

**REC B.7: HIV testing services for couples and partners, with support for mutual disclosure, should be offered to individuals with known HIV status and their partners.**  
(strong recommendation, low-quality evidence for all people with HIV in all epidemic settings; conditional recommendation, low-quality evidence for HIV-negative people depending on the country-specific HIV prevalence)

### Remarks

- This existing recommendation was integrated into this guideline from WHO's 2012 *Guidance on couples HIV testing and counselling including antiretroviral therapy for treatment and prevention in serodiscordant couples: recommendations for a public health approach* (106).
- Further information can be found in the original publication, available at: [http://apps.who.int/iris/bitstream/10665/44646/1/9789241501972\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/44646/1/9789241501972_eng.pdf)

**REC B.8: Initiatives should be put in place to enforce privacy protection and institute policy, laws and norms that prevent discrimination and promote tolerance and acceptance of people living with HIV. This can help create environments where disclosure of HIV status is easier.**  
(strong recommendation, low-quality evidence)

**REC B.9: Children of school age should be told their HIV positive status; younger children should be told their status incrementally to accommodate their cognitive skills and emotional maturity, in preparation for full disclosure.**  
(strong recommendation, low-quality evidence)

**REC B.10: Children of school age should be told the HIV status of their parents or caregivers; younger children should be told this incrementally to accommodate their cognitive skills and emotional maturity.**  
(conditional recommendation, low-quality evidence)

### Remarks

- These three existing recommendations have been integrated into this guideline from WHO's 2011 *Guideline on HIV disclosure counselling for children up to 12 years of age* (107).
- It should be noted that in that document, school-age children are defined as those with the cognitive skills and emotional maturity of a normally developing child of 6–12 years (107).
- Further information can be found in the original publication, available at: [http://apps.who.int/iris/bitstream/10665/44777/1/9789241502863\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/44777/1/9789241502863_eng.pdf)



## i. Background

For women living with HIV, status disclosure can facilitate access to health services, including antiretroviral therapy (ART) for prevention of perinatal transmission, as well as access to social support and opportunities for future planning with partners (108, 109). However, HIV status disclosure can also bring risks. A systematic review of rates, barriers and outcomes of HIV serostatus disclosure among women living with HIV found reported disclosure rates in peer-reviewed articles and conference abstracts ranged from 17% to 86% (110). Following disclosure, between 4% and 15% of women reported a violent response from their partner (110). Women may be hesitant to disclose their status due to potential negative outcomes such as violence, abandonment, relationship dissolution, stigma, and loss of their children and/or their home (111). A recent study shows the health sector can play a preventive role by sensitizing health-care providers to the potential risks for partner violence following disclosure and by ensuring that every decision of women living with HIV to disclose is fully informed and voluntary (112).

HIV testing services must be confidential, meaning that what the provider and the client discuss will not be disclosed to anyone else without the expressed consent of the person being tested. Confidentiality should be respected, but it should not be allowed to reinforce secrecy, stigma or shame. Counsellors should discuss, among other issues, whom the person may wish to inform and how they would like this to be done. Shared confidentiality with a partner or family members – trusted others – and health-care providers is often highly beneficial (11).

As stated in a UNAIDS/WHO guidance publication (2000):

UNAIDS and WHO encourage beneficial disclosure. This is disclosure that is voluntary; respects the autonomy and dignity of the affected individuals; maintains confidentiality as appropriate; leads to beneficial results for those individuals, and for their families and sexual and drug-injecting partners; leads to greater openness in the community about HIV/AIDS; and meets the ethical imperatives of the situation where there is need to prevent onward transmission of HIV" (113).

It is critical to support women living with HIV in accessing a full range of SRHR services and social support opportunities while ensuring their well-being and safety. In 2006, WHO issued a meeting report on addressing violence against women (VAW) that occurs during HIV testing and counselling services. The report called for operational research to assess counselling, communication and referral tools to support women through the disclosure and risk-reduction planning processes.

## ii. Summary of evidence and considerations for the new recommendations

At the scoping meeting for the current guideline, in January 2015, the GDG decided that interventions to facilitate safer disclosure of HIV status for women living with HIV should be reviewed for this guideline. The PICO question was: **What interventions facilitate safe disclosure of HIV status for women living with HIV who fear violence or disclose currently experiencing violence?** The review included studies with comparison groups, and used definitions for violence, intimate partner and other relevant topics from the WHO 2013 guidelines on intimate partner violence (IPV) and sexual violence (81). The PICO question included all populations of women living with HIV, all lengths of time of living with HIV, and all types of violence. Current violence was defined as violence that occurred within the past 12 months or another definition that indicated present risk of violence; it does not include a risk or experience of violence from long ago that is no longer present. More information on the review can be found in the Web supplement to this guideline.<sup>2</sup>

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2. Available at: [www.who.int/reproductivehealth/publications/gender\\_rights/srhr-women-hiv/en/](http://www.who.int/reproductivehealth/publications/gender_rights/srhr-women-hiv/en/)

## **Results**

The evidence on interventions that facilitate safer disclosure of HIV status is limited. Only two studies, both RCTs, were identified from a systematic review of the peer-reviewed and grey literature. Both studies identified in the review concerned disclosure to partners, as opposed to other people in the family, community, health system or other setting. Further, both studies evaluated interventions that integrated screening for IPV into HIV testing and counselling, and trained counsellors to facilitate discussions about disclosure based on a woman's risk of violence. Counselling included structured questionnaires to help women assess their risk of harm following disclosure. Counsellors were then trained to explore women's risk of disclosure-related violence and to explore alternative options when indicated. Additional intervention components included community mobilization activities to counteract violence, support groups and on-site legal aid services. Outcomes included in the studies were: disclosure, physical violence, sexual violence, emotional violence. Neither study provided clear evidence for the effectiveness of a safer disclosure intervention as they were not designed to isolate the contribution of the safer disclosure components from the broader multiple-component interventions. The evidence suggests, however, that women who disclose their status are more likely to be in non-violent relationships. Findings from the studies also "suggest that while IPV continues to be a significant barrier to disclosure for women who fear violence, it has not been adequately addressed in current approaches related to provision of HIV testing, treatment and care services in health care settings" (111). Future studies need to examine other disclosure relationships (i.e. other than disclosure to partners) and comparative effectiveness between interventions, including possible interventions in both clinic and community settings. This may help underscore the potential contribution of peer support, and may thus reduce the health-care resources needed for the intervention.

## **Quality of the evidence for the recommendation**

The quality of the evidence was low to very low, with downgrades for serious indirectness, as outcomes were measured for all women living with HIV rather than just for those receiving the safe disclosure interventions, and for inconsistency, as the two studies showed different results.

## **Rationale for the strength and direction of the recommendation**

The GDG determined that the strength of the recommendation was strong despite the low-quality evidence. This decision was based on (i) the very high value placed on safety during and after disclosure for women living with HIV; (ii) the potential for great benefit to individuals, partners, families and communities; and (iii) the understanding that implementation of the intervention would improve equity. The GDG discussed at length the additional demands that this recommendation would place on the health worker, but agreed that in general health workers wish to support the health, well-being and rights of their patients and, as such, acceptability for this recommendation would be high within feasibility constraints.

## **Feasibility**

The GDG considered the feasibility of the intervention to be uncertain. This was partially due to the additional demands on health workers and the health system if this recommendation is adhered to, given the high prevalence of VAW, with 35% of women aged 15 years and older experiencing physical or sexual violence worldwide (114). The GDG was also concerned about the required resources for implementation. Community-based as well as clinic-based interventions may be needed to manage strategies and address resource-related concerns. The GDG discussed the need to ensure that disclosure is always voluntary. If a woman decides to disclose, however, she should be supported and safe. Laws and policies that require disclosure would make these recommendations unfeasible.

## Values and preferences



In the GVPS, women articulated that safety for women living with HIV is paramount. The single most prominent finding of the survey was that women living with HIV experience high levels of violence – which many of them termed “intolerable” – with 89% of respondents reporting that they had experienced violence or fear of violence, before, since or because of their diagnosis. Women reported that HIV diagnosis acts as a specific trigger for violence. Some respondents feared disclosure to a partner.

Respondents called for safety in health-care settings, at home and in the community. Support to address interpersonal violence was viewed as key. Women articulated that health care for women and girls living with HIV should be accessible, affordable and available, with provision of integrated care and support for both SRH and gender-based violence (GBV). Women reported experiences of involuntary disclosure within health services, as well as breaches of privacy or confidentiality, pressure or coercion to disclose to partners or other family members, and stigma, discrimination or judgemental attitudes from service providers themselves. Respondents highlighted that health services should be safe places for women to go without fear of these experiences or attitudes. They articulated that women newly diagnosed with HIV should be offered peer counselling and support. Women living with HIV reported a need for women experiencing violence or fear of violence in connection with disclosure to have health staff reach out beyond the clinic setting to promote and provide links to community-based programmes. They would like health staff to provide or refer them to care and support options for women experiencing IPV (mental and/or physical violence), such as safe houses and income-generating opportunities, among others (37).

## 4.3 Family planning and infertility services

### 4.3.1 Strategies for achieving safe and healthy pregnancy

#### Existing recommendations on strategies for achieving safe and healthy pregnancy

**REC B.11: In countries where HIV transmission occurs among serodiscordant couples, where discordant couples can be identified and where additional HIV prevention choices for them are needed, daily oral PrEP (specifically tenofovir or the combination of tenofovir and emtricitabine) may be considered as a possible additional intervention for the uninfected partner.**

*(conditional recommendation, high-quality evidence)*

#### Remarks

- This existing recommendation was integrated into this guideline from WHO’s 2012 *Guidance on oral pre-exposure prophylaxis (PrEP) for serodiscordant couples, men and transgender women who have sex with men at high risk of HIV: recommendations for use in the context of demonstration projects* (115).
- Further information can be found in the original publication, available at: [http://www.who.int/hiv/pub/guidance\\_prep/en/](http://www.who.int/hiv/pub/guidance_prep/en/)

**REC B.12: ART should be initiated in all adults living with HIV, regardless of WHO clinical stage and at any CD4 cell count.**

*(strong recommendation, moderate-quality evidence)*

#### Remarks

- This existing recommendation was integrated into this guideline from WHO’s 2016 *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach* (7).
- Further information can be found in the original publication, available at: [http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684_eng.pdf)

## i. Background

There are several key principles that should underpin the design and provision of fertility care for women living with HIV. Family planning counselling tailored to women living with HIV is important for good SRHR. Counselling is a way for health-care providers to communicate with a client to identify fertility desires and to help advise a woman living with HIV, or a couple, about fertility and pregnancy. The WHO's 2012 publication, *Reproductive choices and family planning for people living with HIV counselling tool*, guides providers to move through a process with the client to assess, advise, agree, assist and arrange (116). In delivering counselling, it is important that providers uphold equality of access to resources to enable informed decision-making about reproductive choices, to create environments that reduce stigma associated with HIV and infertility, and environments that encourage safe, voluntary disclosure of HIV and fertility status to partners (117).

There are several options identified to support achieving pregnancy safely for women living with HIV in serodiscordant relationships. These include: antiretroviral therapy (ART) use by the woman living with HIV to suppress her viral load; use of oral pre-exposure prophylaxis (PrEP) by the partner who does not have HIV; use of condoms when the woman is not at peak fertility; screening and treatment of STIs in both partners; voluntary medical male circumcision to reduce HIV transmission; and manual insemination. Fertility screening and management is important for all couples that experience fertility problems (117). It is currently not possible to develop definitive guidance on how best to deliver daily oral PrEP to the HIV-negative partners (male or female) in serodiscordant couples; demonstration project research is needed and ongoing.

Additional relevant WHO guidelines are in development on infertility and on safer conception strategies.

### Values and preferences

Women living with HIV responding to the GVPS reported experiencing negative reactions from health-care providers when they expressed the desire or intention to have a child (whether or not they already had other children). These reactions included discouragement, disapprobation, pressure to terminate the pregnancy if already pregnant, misinformation about the potential or likely health outcomes for the child, verbal abuse, and mistreatment and/or neglect during antenatal care and labour. Women living with HIV who have been engaged in sex work were sometimes treated especially poorly by health-care providers during pregnancy and labour. Cases of women living with HIV being forced or coerced into being sterilized have been documented; this practice is now widely considered a violation of the human rights of women living with HIV and an act of institutional GBV. In some countries, women living with HIV reported being denied fertility treatment.

Women living with HIV expressed a desire to be given advice on a full range and choice of appropriate and safe conception techniques, and on pregnancy and childbirth, and to have equitable access to fertility treatment if needed, as well as access to legal adoption services. They articulated a need for access to accurate, up-to-date information on the risk of transmission to partners during conception as well as on the risk of perinatal transmission to children. Survey respondents emphasized the importance of support from trusted doctors and other health-care providers in realizing their fertility desires – to have children born free of HIV – and of peer support from other women living with HIV who have had children (37).



## 4.3.2 Contraception

### Existing recommendation on contraception

**REC B.13: The correct and consistent use of condoms with condom-compatible lubricants is recommended for all key populations to prevent sexual transmission of HIV and STIs.**

*(strong recommendation, moderate-quality evidence)*

#### Remarks

- This existing recommendation was integrated into this guideline from WHO's *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations – 2016 update (10)*.
- Key populations include women living with HIV.
- Further information can be found in the original publication, available at: <http://apps.who.int/iris/bitstream/10665/246200/1/9789241511124-eng.pdf>

### Existing recommendations on medical eligibility criteria (MEC) for hormonal contraceptive use

Note: MEC categories (118):

1. A condition for which there is no restriction for the use of the contraceptive method. A condition where the advantages of using the method generally outweigh the theoretical or proven risks.
2. A condition where the theoretical or proven risks usually outweigh the advantages of using the method.
3. A condition which represents an unacceptable health risk if the contraceptive method is used.
4. These categories are provided in the source document in place of strength of recommendation information.

**REC B.14: Women living with asymptomatic or mild HIV clinical disease (WHO stage 1 or 2) can use the following hormonal contraceptive methods without restriction: combined oral contraceptive pills (COCs), combined injectable contraceptives (CICs), contraceptive patches and rings, progestogen-only pills (POPs), progestogen-only injectables (POIs, DMPA and NET-EN), and levonorgestrel (LNG) and etonogestrel (ETG) implants (MEC Category 1). Women living with asymptomatic or mild HIV clinical disease (WHO stage 1 or 2) can generally use the LNG-IUD (MEC Category 2). (MEC Part I, section 12b)**

*(moderate- to very low-quality evidence)*

**REC B.15: Women living with severe or advanced HIV clinical disease (WHO stage 3 or 4) can use the following hormonal contraceptive methods without restriction: COCs, CICs, contraceptive patches and rings, POPs, POIs (DMPA and NET-EN), and LNG and ETG implants (MEC Category 1). Women living with severe or advanced HIV clinical disease (WHO stage 3 or 4) should generally not initiate use of the LNG-IUD (MEC Category 3 for initiation) until their illness has improved to asymptomatic or mild HIV clinical disease (WHO stage 1 or 2). However, women who already have an LNG-IUD inserted and who develop severe or advanced HIV clinical disease need not have their IUD removed (MEC Category 2 for continuation). LNG-IUD users with severe or advanced HIV clinical disease should be closely monitored for pelvic infection. (MEC Part I, section 12c)**

*(moderate- to very low-quality evidence)*

**REC B.16: Women taking any nucleoside/nucleotide reverse transcriptase inhibitor (NRTI) can use all hormonal contraceptive methods without restriction: COCs, contraceptive patches and rings, CICs, POPs, POIs (DMPA and NET-EN), and LNG and ETG implants (MEC Category 1). (MEC Part I, section 12d)**

*(low- to very low-quality evidence)*

**REC B.17: Women using ART containing either efavirenz or nevirapine can generally use COCs, patches, rings, CICs, POPs, NET-EN and implants (MEC Category 2). However, women using efavirenz or nevirapine can use DMPA without restriction (MEC Category 1). (MEC Part I, section 12d)**

*(low- to very low-quality evidence)*

**REC B.18: Women using the newer non-nucleoside/nucleotide reverse transcriptase inhibitors (NNRTIs), etravirine and rilpivirine, can use all hormonal contraceptive methods without restriction (MEC Category 1). (MEC Part I, section 12d)**

*(low- to very low-quality evidence)*

## Existing recommendations on medical eligibility criteria (MEC) for hormonal contraceptive use (continued)

**REC B.19:** Women using protease inhibitors (e.g. ritonavir and ARVs boosted with ritonavir) can generally use COCs, contraceptive patches and rings, CICs, POPs, NET-EN, and LNG and ETG implants (MEC Category 2), and can use DMPA without restriction (MEC Category 1). (MEC Part I, section 12d)

(low- to very low-quality evidence)

**REC B.20:** Women using the integrase inhibitor raltegravir can use all hormonal contraceptive methods without restriction (MEC Category 1). (MEC Part I, section 12d)

(low- to very low-quality evidence)

**REC B.21:** Intrauterine device (IUD): Women using ARV medication can generally use LNG-IUDs (MEC Category 2), provided that their HIV clinical disease is asymptomatic or mild (WHO stage 1 or 2). Women living with severe or advanced HIV clinical disease (WHO stage 3 or 4) should generally not initiate use of the LNG-IUD (MEC Category 3 for initiation) until their illness has improved to asymptomatic or mild HIV clinical disease. However, women who already have an LNG-IUD inserted and who develop severe or advanced HIV clinical disease need not have their IUD removed (MEC Category 2 for continuation). LNG-IUD users with severe or advanced HIV clinical disease should be closely monitored for pelvic infection. (MEC Part I, section 12d)

(low- to very low-quality evidence)

### Remarks

- These existing recommendations were integrated into this guideline from WHO's 2015 publication, *Medical eligibility criteria for contraceptive use, fifth edition (118)*.
- Further information can be found in the original publication, available at: [http://apps.who.int/iris/bitstream/10665/181468/1/9789241549158\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/181468/1/9789241549158_eng.pdf)

ARV: antiretroviral; CIC: combined injectable contraceptive; COC: combined oral contraceptive; DMPA: depot medroxyprogesterone acetate; ETG: etonogestrel; IUD: intrauterine device; LNG: levonorgestrel; MEC: *Medical eligibility criteria for contraceptive use* (a WHO publication [118]); NET-EN: norethisterone enanthate; NNRTI: non-nucleoside reverse transcriptase inhibitors; NRTI: nucleoside reverse transcriptase inhibitors; POI: progestogen-only injectable contraceptive; POP: progestogen-only pill.

## Existing good practice statement on third-party authorization requirements for contraceptive services

**GPS B.2:** It is recommended that third-party authorization requirements be eliminated, including spousal authorization requirements for women living with HIV for obtaining contraceptives and related information and services.

### Remarks

- This existing good practice statement was integrated into this guideline from WHO's *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations – 2016 update (10)*.
- The term “recommended” is included in the text because this was originally termed a “good practice recommendation”; but it is not a GRADE-based WHO recommendation – it is a good practice statement.
- Further information can be found in the original publication, available at: <http://apps.who.int/iris/bitstream/10665/246200/1/9789241511124-eng.pdf>

## i. Background

As stated in a 2014 interagency statement:

Human rights standards recognize that women living with HIV have a right to contraception and other reproductive health services on the same grounds as all other women. These standards state that safe and affordable means of contraception should be available and that women should have the right to freely choose or refuse family planning services (including sterilization services). They require that health-care providers should be non-coercive and respectful of autonomy, privacy and confidentiality, and that reproductive freedom should not be restricted as part of a family planning, HIV prevention or other public health agenda (28).



Voluntary use of contraception by women living with HIV who wish to prevent pregnancy is important for upholding their reproductive rights. It also continues to be an important strategy for reducing perinatal HIV transmission (74). The fifth edition of WHO's *Medical eligibility criteria for contraceptive use* (the MEC), published in 2015, prioritized the availability of a wide range of contraceptive options (118).

Because there may be interactions between certain methods of hormonal contraception and certain antiretroviral medicines (ARVs), health-care providers need to refer to the recommendations on ARV interactions (available in the MEC) when counselling women living with HIV on contraceptive efficacy. A woman living with HIV and using ARVs should discuss the potential impact of particular ARVs on contraceptive efficacy with her health-care provider, as recommendations differ for women who are at different stages of HIV (118). This underscores the need for the availability of a comprehensive range of contraceptives, informed choice and supportive doctors and other health-care providers, so that women living with HIV feel that they can explore their options in depth. The updated third edition of WHO's *Selected practice recommendations for contraceptive use* (the SPR), published in 2016, provides guidance for how to use contraceptive methods safely and effectively once they are deemed to be medically appropriate (119). The SPR serves as a companion document to the MEC guidance, which focuses on who can use contraceptive methods safely, providing guidance on the safety of various contraceptive methods in the context of specific health conditions and characteristics. According to the MEC, women with asymptomatic HIV infection and women with AIDS can safely and effectively use most methods of contraception (118).

Condoms remain a key component of high-impact HIV prevention programmes, but are also a critical component in a comprehensive and sustainable approach for combination prevention against STIs and unintended pregnancy (120). Consequently, male and female condoms are also important for women living with HIV to protect themselves. To ensure safety, efficacy and effective use, condoms must be manufactured according to the international standards, specifications and quality assurance procedures established by WHO, UNFPA and the International Organization for Standardization (ISO) (121, 122) and they must be made available either free or at an affordable price. People in low-resource settings are more likely to use condoms when they can access them at no cost or at subsidized prices (120).

Many young women and girls, especially those who are married or in long-term relationships and those who are sex workers, do not have the power or agency to negotiate the use of condoms, as men are often resistant to using condoms and they generally hold more of the power in these relationships. Within relationships, the suggestion to use condoms may be taken to signal a lack of trust or intimacy.

Counselling is a way for health-care providers to communicate with a client to identify fertility desires and to share information about the full range of contraceptive options, if a woman voluntarily wants to avoid pregnancy. The WHO's 2012 *Reproductive choices and family planning for people living with HIV* counselling tool guides providers through a process with the client to assess, advise, agree, assist and arrange (116). Family planning counselling tailored to the needs and rights of women living with HIV is essential to advance their SRHR. Where HIV and family planning services are provided through separate vertical programming, women need to be supported to connect to the services they may need (see section 3.2.4).

Box 4.1 presents further information on contraceptive guidance tools, and Box 4.2 presents key considerations on contraception for women living with HIV from key populations.



### Box 4.1: Contraceptive guidance tools

Family planning is essential to promoting the well-being and autonomy of women, including women living with HIV, their families and their communities. Ensuring quality of care in contraceptive services is paramount for achieving high standards of health for all. In order for health workers to provide high-quality contraceptive services, contraceptive programmes need to include certain elements, such as:

- choice among a wide range of contraceptive methods;
- evidence-based information on the effectiveness, risks and benefits of different methods;
- technically competent, trained health workers;
- provider–user relationships based on respect for informed choice, privacy and confidentiality; and
- an appropriate constellation of services available at the same locality.

The following WHO tools can help health-care providers, together with their clients, to identify the best contraceptive options based on each client’s current health status:

- *Medical eligibility criteria wheel for contraceptive use – 2015 update (123).*
- *Medical eligibility criteria for contraceptive use, fifth edition (the MEC, 2015).* This publication includes tables summarizing guidance for women at different stages of HIV progression (118).
- *Selected practice recommendations for contraceptive use, third edition (the SPR, 2016) (119).*

### Box 4.2: Key considerations on contraception for women living with HIV from key populations

- It is important that contraceptive services are free, voluntary and non-coercive for all people from key populations.
- It is important that prison health services offer contraception to women in closed settings.
- It is important to counsel transgender women who use oral contraceptive pills for feminization about the higher risk of thrombotic events with ethinyl estradiol than with 17-beta estradiol.
- Female sex workers should be offered contraceptive counselling to explore pregnancy intention and should be offered a range of contraceptive options, including dual protection.
- It is important that health-care providers in contact with women who use drugs offer contraception, including hormonal contraceptives, as part of a standard package of care.

Source: WHO, 2016 (10).

### Values and preferences

Women living with HIV responding to the GVPS reported that they are sometimes only offered a limited range of contraceptive options and they are sometimes forced or coerced into accepting long-term or permanent contraceptive methods. Women living with HIV reported male condoms as both an enabler and challenge to having a safe and pleasurable sex life. The majority reported very limited access to or experience with using female condoms.

Some survey respondents reported that within health-care settings they are denied a full range of choice of contraceptives, with service providers pushing them to use condoms for the sake of reducing the risk of onward transmission. Given the difficulty many women living with HIV experience in negotiating and consistently using either male or female condoms, restricting their choice of contraceptives to those that rely on partner cooperation may put them at risk of unintended pregnancy.

Nearly 60% of GVPS respondents had experienced an unplanned pregnancy. Only 40% said they had accessed family planning services. Participants in some settings revealed a very low level of understanding, awareness and education on sexuality, pregnancy and pregnancy prevention (37). This is true for many women, including young women and adolescents, and women from key populations, including sex workers. It is important to note that gender dynamics play a key role in decision-making around accessing and using contraception, and in decision-making about the number and spacing of children.



## 4.4 Antenatal care and maternal health services

### 4.4.1 Caesarean section

#### NEW recommendation on caesarean section

**REC B.22: WHO recommends that elective caesarean section (C-section) should not be routinely recommended to women living with HIV.**

*(strong recommendation, low-quality evidence)*

#### Remarks

- The benefits and risks of different modes of delivery should be discussed with women living with HIV, including vaginal delivery, and elective and non-elective C-section.
- When indicated for other medical or obstetric reasons, C-section should still be offered, as for all women.
- Wide communication of this recommendation through policy briefs and other means will be important, as many health-care providers continue to believe that C-section is best for women living with HIV, which leads to coerced delivery decisions and practices.
- Women undergoing C-sections are also sometimes sterilized without their consent. Coerced or forced sterilization is never acceptable (28).
- In many settings with a high burden of HIV, women who need C-sections do not have access to them, especially in rural areas. When C-section is medically indicated, it should be available, accessible, affordable and safe.

#### i. Background

Caesarean section (C-section) before onset of labour and before rupture of membranes (“elective C-section”) has been suggested as an intervention for the prevention of perinatal HIV transmission. For all women, when medically justified, a C-section can effectively prevent maternal and perinatal mortality and morbidity. However, there is no evidence for the benefits of caesarean delivery for women or infants who do not require the procedure. As with any surgery, C-sections are associated with short- and long-term risks, which can extend many years beyond the current delivery and affect the health of the woman, her child and future pregnancies. In addition, while C-section is sometimes a medically necessary and life-saving intervention, in settings with limited local capacity and skills to perform C-section and treat potential complications, it can be dangerous and can sometimes lead to maternal death. These risks may be heightened for women with compromised immune systems, such as women living with HIV, and for women with limited access to comprehensive obstetric care. Therefore, unnecessary C-sections should be avoided, and C-sections should only be performed for standard obstetric indications (124).

For women living with HIV, as for all women, the decision on whether or not to have an elective C-section must take into account the range of potential risks as well as benefits for both the mother and the infant. These risks and benefits vary depending on the underlying risk of perinatal transmission during delivery, which is associated with disease stage and ART use, as well as on the underlying risks of C-section compared with vaginal delivery for both the mother and infant.

#### ii. Summary of evidence and considerations for the new recommendation

At the scoping meeting in January 2015, the GDG agreed to examine the modes of delivery related to the best maternal and child outcomes for women living with HIV. The PICO question was: **What modes of delivery result in the best maternal and perinatal outcomes for women living with HIV?** Reviewed studies each included a comparison group of women living with HIV who underwent a mode of delivery other than C-section. Outcomes included: (a) morbidity and mortality among women (e.g. febrile morbidity,

endometriosis, haemorrhage, severe anaemia, pneumonia, urinary tract infections); (b) HIV in infants; (c) other morbidity and mortality among infants (e.g. respiratory morbidity, skin lacerations); and (d) breastfeeding (success or timing of initiation and continuation). More information on the methods and findings of the review can be found in the Web supplement.

### **Results**

The review included 31 articles but far fewer studies, due to multiple publications on a small number of multicountry studies (125). Only one was an RCT and all others were observational studies (cohort or case-control). Most of the studies had been conducted in the USA or Europe (10 countries) and others were from Argentina, the Bahamas, Brazil, India, Jamaica, Mexico, Nigeria, Peru and South Africa. Almost all of the studies measured infant HIV, while fewer measured maternal health outcomes and only one measured child health outcomes. Most outcomes were measured immediately after birth, providing no information on distal morbidities. Despite a significant number of studies, there were few recent studies that focused on women who were on ART and/or who were virally suppressed. Low- to very low-quality evidence suggests that elective C-section appears to reduce infant HIV acquisition but increase maternal and infant morbidity. Very low-quality evidence suggests that, in the context of ART use, differences in both infant HIV acquisition and maternal and infant morbidity are less pronounced between modes of delivery.

### **Quality of the evidence for the recommendation**

The available evidence is low to very low. It was downgraded for a serious risk of bias due to a high likelihood of multiple other confounders, and for imprecision for all outcomes, and for inconsistency for the outcome of “any morbidity”.

### **Rationale for the strength and direction of the recommendation**

The GDG discussed this recommendation at length and determined that it should be strong despite low-quality evidence for the following reasons: (i) the potential harms (e.g. sepsis, haemorrhage) of providing C-sections outweigh the benefits; (ii) C-sections are difficult and not feasible to perform in many settings with high HIV prevalence in the general population; (iii) C-sections can be costlier than vaginal births, which is a possible deterrent to optimal SRH for women living with HIV who have limited means, and which can create barriers to future health seeking. The GDG agreed that it was key that C-sections not be recommended routinely for all women living with HIV simply because they were living with HIV, but noted that it was essential to provide C-section to women living with HIV when medically indicated, as for all women.

### **Feasibility**

C-sections are difficult and potentially harmful to perform in many settings. They are expensive, require equipment that may be limited, and may have adverse outcomes, such as sepsis. Not performing routine C-sections would be more feasible than routine C-sections. It is important to support medical practitioners with correct and current information on best practices, and to inform and empower women so that they can decide with confidence to avoid unnecessary C-sections. There can be financial incentives for health-care providers to perform C-sections; however, they should only be performed when medically indicated for the health of the mother and baby (28).

### **Values and preferences**

Women living with HIV who responded to the GVPS reported experiencing a routine lack of inclusion in decision-making and lack of choice about their own SRH care, including modes of delivery. They clearly articulated that principles of human rights need to be embedded in all health-care policies, practices and training programmes, and that coercion of any kind is never acceptable (37).



## 4.4.2 Labour and delivery

No new or existing recommendations or good practice statements were identified or developed for this topic. Recommendations for all women, including women living with HIV (but none that are specific to these women), can be found in the following two 2015 WHO publications: *Pregnancy, childbirth, postpartum and newborn care: a guide for essential practice, third edition (127)*, and *Recommendations for prevention and treatment of maternal peripartum infections (128)*.

### i. Background

Human rights violations experienced by women living with HIV include “being dissuaded from having children, mistreatment while pregnant [such as being neglected during child birth] and forced or coerced sterilization” due to their HIV-positive status (82). Many women experience disrespectful, abusive or neglectful treatment during childbirth in health-care facilities worldwide. Such treatment not only violates the rights of women to respectful care, but can also threaten their rights to life, health, bodily integrity and freedom from discrimination (26). Such practices may have direct adverse consequences for both the mother and infant (26).

Reports of disrespectful and abusive treatment during childbirth in facilities have included outright physical abuse, profound humiliation and verbal abuse, coercive or forced medical procedures (including sterilization), lack of confidentiality, failure to get fully informed consent, refusal to give pain medication, gross violations of privacy, refusal of admission to health-care facilities, neglecting women during childbirth – a time when they may suffer life-threatening, avoidable complications – and detention of women and their newborns in facilities after childbirth due to an inability to pay (26, 126). Among others, adolescents, unmarried women, women of low socioeconomic status, women from ethnic minorities, migrant women and women living with HIV are particularly likely to experience disrespectful and abusive treatment during childbirth (26, 126).

To achieve a high standard of respectful care during childbirth, health systems must be organized and managed in a manner that ensures respect for women’s SRH and human rights (26).

In order to prevent and eliminate disrespect and abuse during facility-based childbirth globally, the following actions should be taken:

1. Secure greater support from governments and development partners for research and action on disrespect and abuse.
2. Initiate, support and sustain programmes designed to improve the quality of maternal health care, with a strong focus on respectful care as an essential component of quality care.
3. Emphasize the rights of women to dignified, respectful health care throughout pregnancy and childbirth.
4. Generate data related to respectful and disrespectful care practices; systems of accountability and meaningful professional support are required.
5. Involve all stakeholders, including women, in efforts to improve quality of care and eliminate disrespectful and abusive practices (26).

### Values and preferences

Women living with HIV who participated in the GVPS highlighted labour and delivery as a time of potential neglect and discriminatory care, due to health worker perceptions about HIV. Respondents emphasized the needs (i) to educate families, friends, communities and health-care providers on the rights of women living with HIV; (ii) to normalize “positive” pregnancy and childbirth; and (iii) to ensure that women have the right to care and support, which is not conditional on disclosure to partners. The women also strongly acknowledged that health workers can be very supportive and helpful in labour and delivery, particularly when women living with HIV are, themselves, well informed about their choices as a result of having access to relevant, up-to-date and trustworthy information on HIV, pregnancy and transmission. Self-awareness and trust in one’s own decisions was also an important factor (37).



### 4.4.3 Prevention and treatment of postpartum haemorrhage (PPH)

#### Existing recommendation on prevention and treatment of PPH

**REC B.23: Late cord clamping (performed approximately 1–3 minutes after birth) is recommended for all births while initiating simultaneous essential newborn care.**

*(strong recommendation, moderate-quality evidence)*

#### Remarks

- This existing recommendation was integrated into this guideline from the 2012 publication, *WHO recommendations for the prevention and treatment of postpartum haemorrhage (129)*.
- The recommendations in the 2012 publication apply to all women, including women living with HIV. Considerations for women living with HIV are included in the document. Only the recommendation given above, on late cord clamping, includes dedicated comment with reference to women living with HIV, as follows: “Late cord clamping is recommended even among women living with HIV or women with unknown HIV status”.
- Further information can be found in the original publication, available at: [http://apps.who.int/iris/bitstream/10665/75411/1/9789241548502\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/75411/1/9789241548502_eng.pdf)

#### i. Background

As described in the 2012 publication, *WHO recommendations for the prevention and treatment of postpartum haemorrhage*, early cord clamping and cutting was previously considered to be a key component of active management of the third stage of labour for prevention of PPH (129). But this and other key components of this approach (administration of prophylactic uterotonic after delivery, controlled cord traction and uterine massage) have been reviewed and revised, and the 2012 publication contains the current recommendations, including REC B.23 presented above.

Some health-care professionals working in areas of high HIV prevalence have expressed concern regarding delayed cord clamping as part of management of the third stage of labour. These professionals are concerned that during placental separation, a partially detached placenta could be exposed to maternal blood and this could lead to a micro-transfusion of maternal blood to the baby.

It has been demonstrated that the potential for maternal-to-child transmission of HIV can take place at three different points in time: (a) micro-transfusions of maternal blood to the fetus during pregnancy (intrauterine HIV transmission), (b) exposure to maternal blood and vaginal secretions when the fetus passes through the birth canal in vaginal deliveries (intrapartum transmission), and (c) during breastfeeding (postnatal transmission). For this reason, the main intervention to reduce perinatal transmission is the reduction of maternal viral load through the use of ARV medicines during pregnancy, childbirth and the postnatal period. There is no evidence that delaying the cord clamping increases the possibility of HIV transmission from the mother to the newborn. Maternal blood percolates through the placental intervillous space throughout pregnancy with a relatively low risk of maternal–fetal transmission before delivery. It is highly unlikely that separation of the placenta increases exposure to maternal blood, and is highly unlikely that it disrupts the fetal placental circulation (i.e. it is unlikely that during placenta separation the newborn circulation is exposed to maternal blood). Thus, the proven benefits of a delay of at least 1–3 minutes in clamping the cord after delivery of the baby outweigh the theoretical, and unproven, harms (129).

#### Values and preferences

In order to improve safe childbirth and delivery outcomes, women living with HIV who responded to the GVPS emphasized the need for the normalization of “positive” pregnancy and childbirth. They suggested education on the rights of women living with HIV for families, friends, communities and health-care providers, and highlighted the need to ensure that women have the right to care and support, which is not conditional on disclosure to partners (37).



#### 4.4.4 Prevention of perinatal transmission of HIV

##### Existing recommendations on initiation of antiretroviral therapy (ART)\*

**REC B.24: ART should be initiated in all adolescents living with HIV, regardless of WHO clinical stage and at any CD4 cell count.**

*(conditional recommendation, low-quality evidence)*

**REC B.25: As a priority, ART should be initiated in all adolescents with severe or advanced HIV clinical disease (WHO clinical stage 3 or 4) and adolescents with a CD4 count  $\leq$  350 cells/mm<sup>3</sup>.**

*(strong recommendation, moderate-quality evidence)*

##### Remarks

- These existing recommendations were integrated into this guideline from WHO's 2016 *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach* (7).
- Further information can be found in the original publication, available at: [http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684_eng.pdf)

\* See also REC B.12 in section 4.3.1.

##### Existing recommendation on perinatal transmission of HIV

**REC B.26: ART should be initiated in all pregnant and breastfeeding women living with HIV, regardless of WHO clinical stage and at any CD4 cell count, and continued lifelong.**

*(strong recommendation, moderate-quality evidence)*

##### Remarks

- This existing recommendation was integrated into this guideline from WHO's 2016 *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach, second edition* (7).
- Further information can be found in the original publication, available at: [http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684_eng.pdf)

##### Existing recommendation and good practice statement on HIV and infant feeding

**REC B.27: Mothers living with HIV should breastfeed for at least 12 months and may continue breastfeeding for up to 24 months or longer (similar to the general population) while being fully supported for ART adherence.**

*(strong recommendation, low-quality evidence for 12 months, very low-quality evidence for 24 months)*

**GPS B.3: Mothers living with HIV and health-care workers can be reassured that ART reduces the risk of postnatal HIV transmission in the context of mixed feeding. Although exclusive breastfeeding is recommended, practising mixed feeding is not a reason to stop breastfeeding in the presence of antiretroviral (ARV) drugs.**

##### Remarks

- This existing recommendation and good practice statement were integrated into this guideline from the 2016 WHO and UNICEF publication, *Guideline: updates on HIV and infant feeding: the duration of breastfeeding, and support from health services to improve feeding practices among mothers living with HIV* (130).
- Further information can be found in the original publication, available at: <http://apps.who.int/iris/bitstream/10665/246260/1/9789241549707-eng.pdf>



## Existing recommendations on augmentation of labour

### **REC B.28: The use of amniotomy alone for prevention of delay in labour is not recommended.**

*(weak recommendation, very low-quality evidence)*

Note: It is stated in the 2014 recommendations that: "As early amniotomy may increase the risk of perinatal HIV transmission, this recommendation could be strengthened in settings where HIV infection is prevalent and women may present in labour with unknown HIV status".

### **REC B.29: The use of amniotomy and oxytocin for treatment of confirmed delay in labour is recommended.**

*(weak recommendation, very low-quality evidence)*

Note: It is stated in the 2014 recommendations that: "There is a need to exercise caution among women with HIV".

#### Remarks

- These existing recommendations were integrated into this guideline from the 2014 publication, *WHO recommendations for augmentation of labour (131)*.
- These recommendations include specific guidance on when the recommendations vary for women living with HIV, as detailed in the notes above. Other recommendations on the augmentation of labour do not differ between women living with HIV and other women.
- Further information can be found in the original publication, available at: [http://apps.who.int/iris/bitstream/10665/112825/1/9789241507363\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/112825/1/9789241507363_eng.pdf).

## i. Background

Perinatal transmission of HIV, also known as vertical transmission and mother-to-child transmission of HIV, refers to transmission of HIV from a woman living with HIV to her infant during pregnancy (intrauterine), labour and delivery (intrapartum), and during breastfeeding (postpartum). Prevention of perinatal transmission focuses mainly on interventions to prevent intrauterine and intrapartum transmission, as well as on early initiation of ART in the woman and on assuring the woman's health.

The following four components of a comprehensive strategy for prevention of perinatal transmission are recommended (74):

1. Primary prevention of HIV acquisition among women of childbearing age
2. Prevention of unintended pregnancies among women living with HIV
3. Prevention of HIV transmission from women living with HIV to their infants
4. Provision of appropriate treatment, care and support to mothers living with HIV, their children and families.

In the third component, which focuses on direct interventions to prevent vertical transmission, the preventive interventions consist of a cascade of services: HIV testing and counselling, ART, safe delivery, safer infant feeding, infant prophylaxis, postpartum interventions in the context of ongoing ART, early infant diagnosis and final diagnosis for HIV-exposed infants, and, finally, linkage of both the mother and child to appropriate care and treatment (fourth component) (10).

The global community has committed itself to eliminating perinatal transmission of HIV and syphilis as a public health priority. The initiative to eliminate mother-to-child transmission (EMTCT) of HIV and syphilis focuses on a harmonized approach to improving health outcomes for women and children. This integrated approach is necessary to improve the efficiency and quality of maternal and child health services and to offer women more comprehensive primary care services (132).

It is essential to note that in the context of efforts to prevent perinatal transmission, the SRHR of women living with HIV must be upheld by maintaining a focus on the health, autonomy and human rights for women and babies alike (see Box 4.3).



### Box 4.3: A human rights-based approach to antiretroviral therapy (ART)

All ART should be prescribed using a human rights-based approach. This means that the pregnant or breastfeeding woman receives full information and medical guidance that is appropriate to her situation, and is supported to make voluntary choices around medical therapy initiation, continuation and adherence/retention in care, as applicable. Health workers must help women to appropriately address their health-care needs and those of their children.

To achieve all four components of the approach to avoid perinatal transmission of HIV, this section works together with section 4.3.1: Strategies for achieving safe and healthy pregnancy, and with section 4.3.2: Contraception, for women who do not want to conceive. As with all areas of this guideline, the recommendations emphasize both equity and a rights-based approach to implementation. This means that all women should have access to the required resources for all four components and should be empowered to make an individual informed choice about family planning and HIV treatment.

Constructive male engagement, in cases where women living with HIV have male partners, can support good health outcomes for women, children and families. Male involvement can support improved communication between men and women, more equal sharing of the responsibility for family health, and improved child-feeding and mortality outcomes. However, women should always be consulted about whether and how they wish their partners to be involved – male partner engagement should never be a condition to accessing services, nor should women be punished in any way for presenting for health-care interventions without a male partner. Gender inequalities can negatively affect prevention of perinatal transmission. More information on gender transformative programming to improve equality and involvement can be found in the 2012 WHO publication, *Male Involvement in the prevention of mother-to-child transmission of HIV* (133).

Additional implementation considerations to support components 3 and 4 are available in the 2013 publication, *Toolkit: expanding and simplifying treatment for pregnant women living with HIV: managing the transition to Option B/B+* (134). Implementation considerations for a national health system include:

- rapid assessment of prevention of mother-to-child transmission (PMTCT) progress;
- agreement on the choice of the PMTCT ART regimen;
- exploration of the acceptability of the choice among women;
- identification of policies, procedures and resource requirements necessary to adopt option B+;
- preparing the health system staff, infrastructure, procurement and supply chains for optimal service delivery;
- monitoring, evaluation and quality assurance;
- point-of-care early infant diagnosis; and
- implementation driven by community involvement, including women living with HIV.

## Values and preferences



Women living with HIV responding to the GVPS emphasized the need for women living with HIV themselves to know that it is possible to have children born HIV-free through access to programmes for prevention of vertical transmission, which include advice and support on delivery and infant feeding options, and access to fertility treatments, if needed. Respondents recommended that guidelines for the prevention of perinatal transmission should address mental health, and that health workers thus need to be trained to provide relevant services. Women living with HIV have experienced violence in health-care settings, particularly in relation to mandatory testing and disclosure in antenatal care settings. Further, many women living with HIV continue to experience discouragement from health-care providers with regard to conceiving a child or carrying a pregnancy to term (whether or not they already have children from earlier pregnancies) to the point of judgemental and abusive language and pressure to terminate an existing pregnancy.

Women articulated that, as with all SRHR interventions, Option B+ should be offered in the context of a human rights-based approach. Women should be given choices about initiating antiretroviral therapy (ART) and the length of ART maintenance after the birth of their child. Lifelong maintenance of ART, while offered as an option for pregnant and breastfeeding women living with HIV, should be decided upon with the woman. A great many survey respondents articulated experiencing side-effects from antiretroviral (ARV) medicines, ranging from relatively mild to severe, which have a negative impact on several areas of their lives, including their ability to work and enjoy their full SRHR. Some respondents also raised a number of actual or potential problems associated with achieving undetectable viral load. These included ceasing to take medication in the belief that they are “cured” and increased challenges to practicing safer sex with partners who perceive them to be “non-infectious” (37).

## 4.5 Safe abortion services

### 4.5.1 Safe abortion

#### NEW recommendations on safe abortion services

**REC B.30: WHO recommends that safe abortion services should be the same for women living with HIV who want a voluntary abortion as for all women.**

*(strong recommendation, very low-quality evidence)*

**REC B.31: WHO suggests that women living with HIV who want a voluntary abortion can be offered a choice of medical or surgical abortion, as for all women.**

*(conditional recommendation, very low-quality evidence)*

#### Remarks

- Abortion services should be free of coercion and offered in a respectful and non-judgemental manner.
- Health workers offering abortion, as with all health workers, must respect the rights of the women living with HIV by (a) providing access if desired and (b) ensuring women make the choice for themselves.
- If only one type of abortion (medical or surgical) is offered in a specific setting, women living with HIV should have access to that option. Limited options for all women should not result in women living with HIV having less access than other women.

## i. Background

Eliminating unsafe abortion is one of the pillars of SRH. In 2012, WHO issued guidance for safe abortion that covers clinical care guidelines in a variety of situations (32). The 2012 guidance used the following definitions:

**Medical methods of abortion (medical abortion):** Use of pharmacological drugs to terminate pregnancy. Sometimes the terms “non-surgical abortion” or “medication abortion” are also used.

**Surgical methods of abortion (surgical abortion):** Use of transcervical procedures for terminating pregnancy, including vacuum aspiration and dilatation and evacuation.

Additional detail on each type of abortion method is provided in WHO’s 2012 publication, *Safe abortion: technical and policy guidance for health systems* (32). Further information is also available in the 2014 *Clinical practice handbook for safe abortion* (135). Guidelines on who can provide safe abortion care are available in the 2015 document, *Health worker roles in safe abortion care and post-abortion contraception* (136).

The GDG also considered it important to note the following:

- a. Women living with HIV have been coerced or forced into involuntary abortion due to stigma, discrimination and misconceptions around conception, pregnancy and childbirth for women living with HIV; they often still face hostility in relation to realizing their fertility desires (28). Women living with HIV have been given sterilization consent forms to sign under pressure or without proper discussion of the form, and have had family members asked to provide consent on their behalf (28). Abortion should never be coerced or forced.
- b. Safe abortion should also include post-abortion care, as described in the following excerpt from WHO’s 2012 publication, *Safe abortion: technical and policy guidance for health systems*:

Following an induced or spontaneous abortion, women should receive appropriate post-abortion care. For those women whose abortions were performed unsafely, post-abortion care is used as a strategy to attenuate the morbidity and mortality associated with complications, including uterine aspiration for incomplete abortion; offer of contraception to prevent future unintended pregnancies; and linking women with other needed services in the community. Following safe, induced abortion, post-abortion care may not require a follow-up visit if the woman has adequate information about when to seek care for complications and has received any needed supplies or information to meet her contraceptive needs. All women should receive contraceptive information and be offered counselling for and methods of post-abortion contraception, including emergency contraception, before leaving the health-care facility (32).

While guidelines exist for abortion for the general population, they do not specify any clinical care issues that may be particular to women living with HIV. While medical and surgical abortion methods are both recommended as safe for the general population, concerns have been raised that they may have different clinical outcomes among women living with HIV. Women living with HIV may be at greater risk for anaemia and bleeding as a result of surgical abortion, and vomiting caused by medicines used for medical abortion may reduce the efficacy of ARVs for HIV treatment (137).

## ii. Summary of evidence and considerations for the new recommendations

At the scoping meeting in January 2015, the GDG decided that risks and outcomes for women living with HIV for each type of abortion should be examined. The group developed a PICO question to address the topic: **Do outcomes of medical and surgical abortion among women living with HIV differ from outcomes among HIV-uninfected women?**

To address this question, studies were included in a systematic review if they had comparison groups of legal abortion outcomes for all women living with HIV, including efficacy (complete abortion), serious adverse events (death, hospitalization, blood transfusion, major operative intervention [e.g. laparotomy], etc.), other adverse events (e.g. haemorrhage not requiring blood transfusion, vomiting) and patient satisfaction, and if they were published in a peer-reviewed journal or presented as an abstract at a scientific conference (138). The review used the WHO 2012 definitions presented above. The review built on a 2012 review, by Manski et al., of clinical outcomes of surgical and medical abortion among women living with HIV (137). It expanded on that review by

updating the search using a rigorous systematic review process that included reviewing articles in languages other than English, searching conference abstracts, and contacting authors for unpublished data on women living with HIV. More information on this new systematic review can be found in the Web supplement.

### **Results**

The 2012 review by Manski et al. included peer-reviewed articles published through 2011 and found few studies on surgical abortion and no studies on medical abortion (137). The studies identified in that review mostly covered illegal or non-specified abortion but suggested no significant differences in complications by HIV status. In addition, gynaecological procedures similar to or more invasive than abortion reportedly showed no differences in complications by HIV status. Changes in haemoglobin levels due to blood loss from medical abortion where anaemia is prevalent, and frequency and duration of vomiting due to medical abortion drugs are relatively minor concerns. Based on the limited data available, the authors concluded that both medical and surgical abortions are safe and appropriate for women living with HIV.

The updated review identified one conference abstract on complications of medical abortions for women living with HIV that met the criteria and concluded that this extremely limited evidence base is due at least in part to the illegality of abortion in many settings with a high burden of HIV (138). However, indirect evidence from other gynaecological and health procedures suggests no clear reason to suspect that health outcomes of medical or surgical abortion differ by HIV status.

### **Quality of the evidence for the recommendations**

The quality of the evidence for both of the new recommendations (REC B.30 and REC B.31) was judged to be very low. It was downgraded twice for indirectness, as there was no comparison of women living with HIV to women without HIV, or of medical versus surgical abortion. Inconsistency was not applicable, as the review included only a single study. It was also downgraded for imprecision due to the limited number of events in the study.

### **Rationale for the strength and direction of the recommendations**

Given the low quality of the evidence, the GDG considered not making any recommendations on safe abortion for women living with HIV. In order to gain an initial indication of GDG members' views on this, the methodologist asked participants to raise their hands in support of making recommendations on this. This was not a formal vote, but a decision-making aid to allow the methodologist and chairs to gauge the distribution of opinion and subsequently work towards consensus through further discussion. It was decided by unanimous consensus among all members that the GDG would make recommendations. This was based on there being no major concerns about harms, and the fact that existing WHO guidelines on safe abortion do not recommend anything specific in terms of the type of clinical abortion recommended for women living with HIV. By a similar process, it was unanimously agreed to make REC B.30 strong and REC B.31 conditional. The rationale for making REC B.30 strong is based on the findings of the GVPS, which identified this as an important human rights and equity topic for women living with HIV (37). Given that there is no current evidence to suggest an optimal mode of abortion for women without HIV, the GDG agreed to make REC B.31 conditional, with women living with HIV having the same choices as women without HIV.

### **Feasibility**

The recommendations were judged to be feasible, as they direct existing safe abortion services to be provided to women living with HIV if requested by the woman.

As stated in the 2012 WHO publication, *Safe abortion: technical and policy guidance for health systems*:

An enabling regulatory and policy environment is needed to ensure that every woman who is legally eligible has ready access to safe abortion care. Policies should be geared to respecting, protecting and fulfilling the human rights of women, to achieving positive health outcomes for women, to providing good-quality contraceptive information and services, and to meeting the particular needs of poor women, adolescents, rape survivors and women living with HIV (32).

## Values and preferences



Women living with HIV participating in the GVPS indicated having limited access to safe abortion; financial stability influenced access to private safe abortion services. Survey participants recommended that free and safe abortions and post-abortion care should be included as part of a holistic and comprehensive package of rights-based integrated SRH and HIV services for women living with HIV, and as part of comprehensive post-rape care.

Respondents described a routine lack of inclusion or choice in decision-making about their own SRH care and care pathways, and recommended that principles of human rights need to be embedded in all health-care policies, practices and training. In particular, women should never be pressured or coerced into any course of action (especially pregnancy termination), whether explicitly without consent or even unwittingly (37).

## 4.6 Sexually transmitted infection and cervical cancer services

### 4.6.1 Sexually transmitted infections (STIs)

#### Existing recommendation on STI services

**REC B.32: Sexually transmitted infection (STI) and family planning services can be integrated within HIV care settings.**

*(conditional recommendation, very low-quality evidence)*

#### Remarks

- This existing recommendation was integrated into this guideline from WHO's 2016 *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach* (7).
- Further information can be found in the original publication, available at: [http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/208825/1/9789241549684_eng.pdf)

#### i. Background

STI care includes screening for and comprehensive case management of STIs and reproductive tract infections (RTIs) including: syphilis, chancroid, herpes, ulcer, bacterial vaginosis and trichomoniasis leading to vaginal infection, vaginal candidiasis, human papillomavirus (HPV), cervical cancer, gonorrhoea, chlamydia and pelvic inflammatory disease (PID).

Appropriate and prompt case management of STIs reduces the risk of associated reproductive tract and obstetric complications. Although the presentation and response to treatment of some STIs – in particular genital herpes and chancroid – may be altered in women living with HIV, standard treatment protocols are effective (6).

The main existing WHO guidelines related to STI management include the 2003 *WHO Guidelines for the management of sexually transmitted infections* (139), the 2005 *Sexually transmitted and other reproductive tract infections: a guide to essential practice* (140), and the updated modules for four specific infections, published in 2016: *WHO guidelines for the treatment of Chlamydia trachomatis* (141), *WHO guidelines for the treatment of Treponema pallidum (syphilis)* (142), *WHO guidelines for the treatment of Neisseria gonorrhoeae* (143) and *WHO guidelines for the treatment of genital herpes simplex virus* (144). Given that the latter four STI treatment guidelines were already in the process of being updated, the GDG chose not to review the existing

STI-related recommendations and other current guidance (see Box 4.4) for the purposes of this guideline. In reference to HIV, all four of the new WHO STI treatment guidelines state the following:

Both ulcerative and non-ulcerative STIs are associated with a several-fold increased risk of transmitting or acquiring HIV. Infections causing genital ulcers are associated with the highest HIV transmission risk; in addition to curable ulcer-causing STIs (e.g. syphilis and chancroid), highly prevalent HSV-2 infections substantially increase that risk. Non-ulcerative STIs, such as gonorrhoea, chlamydia and trichomoniasis, have been shown to increase HIV transmission through genital shedding of HIV. Treating STIs with the right medicines at the right time is necessary to reduce HIV transmission and improve sexual and reproductive health. Efforts should therefore be taken to strengthen STI diagnosis and treatment (141–144).

#### **Box 4.4: Guidance specific to the dual morbidity of HIV and an STI or reproductive tract infection (RTI)**

**Genital ulcers and HIV:** In chancroid, atypical lesions have been reported in individuals living with HIV. The lesions tend to be more extensive, or multiple lesions may form that are sometimes accompanied by systemic manifestations such as fever and chills. Reports of rapidly aggressive lesions have been noted by some clinicians. This emphasizes the need for early treatment, especially in individuals living with HIV. There is evidence to suggest that HIV infection may increase rates of treatment failure in chancroid, especially when single-dose therapies are given. More research is needed to confirm these observations. In immunosuppressed individuals, herpes simplex lesions may present as persistent multiple ulcers that require medical attention, as opposed to the self-limiting vesicles and ulcers which occur in immunocompetent individuals. Thus, herpes antiviral treatment is particularly important in such instances, to be given therapeutically or prophylactically to offer comfort to the patient. Adequate education needs to be given to the patient as well, to explain the nature and purpose of treatment and in order to avoid false expectations of cure (139).

**Syphilis and HIV:** There is an increase in vertical transmission of HIV among pregnant women coinfecting with syphilis and HIV (142). The treatment recommendations for syphilis, as provided in the 2016 *WHO guidelines for the treatment of Treponema pallidum (syphilis)*, apply to all adults and adolescents (10–19 years of age), including pregnant women, people living with HIV, people who are immunocompromised and key populations, including sex workers, men who have sex with men (MSM) and transgender persons (142).

**Herpes and HIV:** Herpes simplex virus type 2 (HSV-2) is of particular concern due to its epidemiological synergy with HIV infection and transmission. People with HSV-2 are approximately three times more likely to acquire HIV, and people with both HIV and HSV-2 are more likely to transmit HIV to others. In addition, infection with HSV-2 in people living with HIV is often more severe and can lead to serious, although rare, complications, such as brain, eye or lung infections (144). The treatment recommendations for genital herpes simplex virus, as provided in the 2016 *WHO guidelines for the treatment of genital herpes simplex virus*, apply to all adults, adolescents (10–19 years of age), pregnant women, people living with HIV, people who are immunocompromised and key populations, including sex workers, MSM and transgender persons. Suggested dosages are provided in the publication for people living with HIV and people who are immunocompromised for recurrent clinical episodes of genital HSV. Suppressive therapy for HSV-2 should be considered in areas with high HIV prevalence. Immunocompromised patients, including those with HIV, generally have more frequent recurrences with more severe symptoms. Recurrent ulcers can cause significant physical and psychological morbidity (144).

**Vulvo-vaginal candidiasis and HIV:** Candidiasis at several sites, including the vulva and vagina, is an important correlate of HIV infection. It is often quite severe and frequently relapses. Prolonged treatment is generally required and chronic suppressive therapy is frequently employed (139).

**Gonorrhoea and HIV:** The treatment recommendations for sexually transmitted gonococcal infections, as provided in the 2016 *WHO guidelines for the treatment of Neisseria gonorrhoeae*, apply to all adults and adolescents (10–19 years of age), including people living with HIV and key populations, including sex workers, MSM and transgender persons and pregnant women (143).



According to information in WHO's *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations – 2016 update*, "Screening, diagnosis and treatment of STIs should be offered routinely as part of comprehensive HIV prevention and care for key populations", including for women living with HIV. Furthermore, "STI management should accord with existing WHO guidance and be adapted to the national context. Also, it should be confidential and free from coercion, and patients must give informed consent for treatment" (10). Further information on STIs for women living with HIV from key populations is presented in Box 4.5.

#### Box 4.5: Key considerations on STIs for women living with HIV from key populations

- Screening, including periodic screening of people from key populations for asymptomatic STIs, diagnosis and treatment of STIs are crucial parts of a comprehensive response to HIV; this includes services for key populations. STI management should accord with existing WHO guidance and be adapted to the national context. Also, it should be confidential and free from coercion, and patients must give informed consent for treatment.
- In the absence of laboratory tests, symptomatic people from key populations should be managed syndromically in line with national STI management guidelines.
- Periodic presumptive treatment (PPT) for asymptomatic STIs should be offered to female sex workers in settings with high prevalence and limited clinical services, but PPT should be implemented only as a free, voluntary, confidential, short-term measure as part of comprehensive sexual health services and while HIV/STI services are being further developed in settings where STI prevalence is high, e.g. > 15% prevalence of *N. gonorrhoeae* and/or *C. trachomatis* infection.
- Health-care providers should be sensitive to and knowledgeable about the specific health needs of transgender people. In particular, genital examination and specimen collection can be uncomfortable or upsetting whether or not the person has undergone genital reconstructive surgery.

Source: WHO, 2016 (10).

#### Values and preferences

Survey participants described a number of challenges around decision-making with regard to when and how to have sex, and how to achieve a healthy and satisfying sex life. Intimate partner violence (IPV), unequal gender-power relations, economic dependence and mental health challenges all pose a threat to women's sexual agency and bodily autonomy. For younger and older women, among others, legal and social sanctions can act as barriers to accessing information and counselling on safer sex and relationships (including STI prevention), on how to communicate with sexual partners about pleasure, and on how to build trust and negotiate shared decision-making. GVPS respondents indicated that they want access to a full range of services for STIs and HIV, and access to quality services for STI and HIV prevention, diagnosis, treatment and care. They expressed a need for access to male and female condoms and lubricants – and the skills to use them – as well as information, training and awareness around sexual risks, safety and pleasure, including through peer learning, counselling and sharing. Women from key populations, including women who are lesbian, bisexual and transgender, sex workers and women with disabilities, all need tailored information from non-judgemental service providers who are sensitized to their specific needs for STI prevention, including their greater vulnerability to violence (37).





## 4.6.2 Cervical cancer

### Existing recommendation on the HPV vaccine for girls

**REC B.33:** WHO recommends the HPV vaccine for girls in the age group of 9–13 years. Girls receiving a first dose of HPV vaccine before the age of 15 years can use a two-dose schedule. The interval between the two doses should be six months. There is no maximum interval between the two doses; however, an interval of no greater than 12–15 months is suggested. If the interval between doses is shorter than five months, then a third dose should be given at least six months after the first dose. Immunocompromised individuals, including those who are living with HIV, and females aged 15 years and older should also receive the vaccine and need three doses (at 0, 1–2, and 6 months) to be fully protected.

(Strength of recommendation and quality of evidence: information not provided, but original source indicates use of GRADE methodology [145]).

#### Remarks

- This existing recommendation was integrated into this guideline from the 2014 WHO publication *Comprehensive cervical cancer control: a guide to essential practice* (146).
- Further information can be found in the original publication, available at: [http://apps.who.int/iris/bitstream/10665/144785/1/9789241548953\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/144785/1/9789241548953_eng.pdf)

### i. Background

Cervical cancer is the second most common cancer in women living in low- and middle-income countries. Deaths from cervical cancer are unnecessary because cervical cancer is preventable and curable if detected and treated early. Women living with HIV are more likely to develop persistent HPV infections with multiple high-risk HPV types at an earlier age and to have more rapid progression to pre-cancer and cancer than women not living with HIV. Women living with HIV are at 4–5 times greater risk of developing cervical cancer, which is a defining illness of AIDS in women with HIV (146).

Women living with HIV are at increased risk for HPV and HPV-related tumours, including cervical intraepithelial neoplasia (CIN) grade 2 or 3, and invasive cervical carcinoma. The prevalence of HPV and CIN has been reported to increase with increasing immunosuppression. ART does not seem to improve cervical cancer outcomes (146).

The above points strongly suggest the need to develop specific cervical cancer vaccination, screening and treatment protocols for women living with HIV and for all women living in countries or regions with a high prevalence of HIV. This could include cervical screening, treatment of precancerous lesions, and management of invasive cancer. Existing protocols are based on experience, and studies are ongoing to determine whether or not these protocols include the best possible practices (146).

The 2014 WHO publication *Comprehensive cervical cancer control: a guide to essential practice* provides the following additional guidance relevant to women and girls living with HIV (146), and these points were considered by the GDG to be essential components of a complete approach to SRHR for women living with HIV:

Screening and treatment of cervical pre-cancer:

- Screening for cervical pre-cancer and cancer should be done in women and girls who have initiated sexual activity as soon as the woman or girl has tested positive for HIV, regardless of age; these women and girls living with HIV should be re-screened 12 months after treatment for pre-cancer, or within three years after negative screening results.
- Any of the three screening tests for cervical cancer (visual inspection with acetic acid [VIA], HPV testing or cytology) can be used for women living with HIV, as can cryotherapy and loop electrosurgical excision procedure (LEEP) treatments.
- Cervical cancer screening and treatment should be done with informed choice and informed consent.
- Women living with HIV whose screening results are negative (i.e. no evidence of precancer is found) should be rescreened within three years.

- Women living with HIV who have been treated for cervical pre-cancer should receive post-treatment follow-up after 12 months.
- Management of abnormalities, including colposcopy and biopsy, should not be modified on the basis of a woman's HIV status. During the healing process after any procedure, women living with HIV might have increased viral shedding. In counselling, it is very important for the provider to stress that the patient should discuss this with her partner(s) and abstain from intercourse until healing has occurred (146).

Managing cervical cancer in women living with HIV:

- Because there are no well-designed or longitudinal studies on the treatment of cervical cancer in women living with HIV, there are no evidence-based guidelines on this subject to include in this guide. In their absence, this section presents some practices that are commonly used in the international and national arenas.
- It is best for women living with HIV who have cervical cancer to be fully diagnosed, staged and treated at a tertiary-level institution with the appropriate expertise. Most institutions treating women living with HIV use multidisciplinary teams; each woman will be evaluated individually and an assessment made of her overall health and the existence of other chronic illnesses that may further compromise her immune system and her ability to tolerate immunosuppressive anti-cancer therapy (e.g. tuberculosis).
- Both radiotherapy and chemotherapy are immunosuppressive therapies and surgery requires women to be relatively healthy in order to avoid complications such as postoperative sepsis, bleeding or wound problems. Therefore, a baseline CD4 count is a key element of care for women living with HIV and should be one of the initial evaluative tests obtained, regardless of the extent of the cancer. CD4 counts will also be needed to monitor the patient's immune status throughout treatment. If the CD4 count is or becomes low during therapy, she may be started on ART, which may delay treatment to allow for recovery of her immune system (146).

Further information, including information on screen-and-treat strategies for women with HIV-positive status or unknown HIV status in areas with high endemic levels of HIV, can be found in the 2014 WHO publication *Comprehensive cervical cancer control: a guide to essential practice* (146).

Box 4.6 presents key considerations for transgender men living with HIV in relation to cervical cancer.

#### Box 4.6: Key considerations on cervical cancer for transgender men living with HIV

- Transgender men who retain their female genitalia often miss out on cervical screening and other sexual health services, as they may not seek out or may be excluded from those services. As a result, they face increased risk of ovarian, uterine and cervical disease.
- Following total hysterectomy, if there is a history of high-grade cervical dysplasia and/or cervical cancer, a Papanicolaou test of the vaginal cuff can be performed annually until three normal tests are documented, and then every two to three years.
- Following removal of ovaries, but where the uterus and cervix remain intact, WHO cervical screening guidelines for natal females can be followed. This may be deferred if there is no history of genital sexual activity. It is important to inform the pathologist of current or prior testosterone use, as cervical atrophy can mimic dysplasia.

Source: WHO, 2016 (10).

#### Values and preferences

Women respondents participating in the GVPS articulated that cervical cancer screening for women living with HIV should be included in a standardized package of holistic, quality, woman-friendly, confidential, non-discriminatory and integrated HIV and SRH services, including in resource-limited and rural settings, and in restricted settings, such as prisons and detention centres (37).



# Chapter 5. Service delivery and guideline implementation

## 5.1 Overview

The ultimate goal of this guideline and its recommendations and good practice statements is to improve the quality of health services and sexual and reproductive health and rights (SRHR) outcomes for women living with HIV. The respect, protection and fulfilment of internationally recognized human rights, such as the right to the highest attainable standard of health and the right to non-discrimination (14, 15), require that all people have access to high quality and affordable health services. An effective process for developing and implementing a national or subnational response to the SRHR of women living with HIV should follow a woman-centred approach and the guiding principles of human rights and gender equality, as outlined in Chapter 1 (section 1.4) and also the strategies described in Chapter 3. This process involves both an ethical and rights-based approach, and coordination among all key stakeholders, including meaningful participation of women living with HIV. Ensuring that the needs and rights of women living with HIV in relation to sexual and reproductive health (SRH) are supported requires meeting standards with regard to the availability, accessibility, acceptability and quality of health-care facilities, supplies and services. Specifically, in addition to other health system strengthening initiatives, investment is urgently needed in areas such as training of health-care providers. Such investment should be considered a top priority because quality SRH care and support of rights for women, including women living with HIV, has far-reaching benefits for individuals, families, communities and countries affected by HIV.

The recommendations and good practice statements for creating an enabling environment and for health interventions presented in Chapters 3 and 4, respectively, form part of a comprehensive package of interventions that are specific to women living with HIV. Many other SRHR considerations and interventions are the same as for the general population, and recommendations related to those areas can be found in a range of WHO guidelines, including many of those cited in Chapters 3 and 4. Contextual factors influencing implementation of the recommendations and best practices for the SRHR and well-being of women living with HIV are addressed in Chapter 3.

Action on the recommendations in this guideline requires a strategy that is informed by evidence, appropriate to the local context, and responsive to the needs and rights of women living with HIV. Programmes should aim to achieve equitable health outcomes, promote gender equality, and deliver the highest-quality care efficiently at all times. The current chapter focuses on the optimal approaches for delivery of health services and implementation of the recommendations and good practice statements in this guideline to best support women living with HIV in all their diversity. The guiding principles for these efforts are outlined in Box 5.1.

Putting these guiding principles into operation, while taking a woman-centred approach underpinned by the principles of human rights and gender equality (as outlined in Chapter 1, section 1.4) means that:

- The needs, priorities and perspectives of women, their families and communities are central to the provision of care, and to the design of programmes and services.
- Women are recognized and supported as active participants in, as well as beneficiaries of, trusted health systems that respond to their priorities, rights and aspirations in humane and holistic ways.
- The promotion of gender equality is central to the achievement of SRHR for all women including women living with HIV and requires recognition and taking account of existing imbalances in power between men and women, practices that exclude transgender women, and the prevalence of gender-based violence (GBV). The intersection of issues that women living with HIV who are from marginalized communities or key populations may face includes multiple layers of stigma, discrimination and/or violence. Promoting gender

equality means that women are empowered to make and enact decisions in all aspects of their lives including in relation to gender, sexuality and reproduction, and to participate in their own health care – which should be organized around their own health needs and expectations rather than around disease management and control.

- The interactive influences on SRHR from across the individual, relational, community and societal levels are acknowledged and, hence, the creation of an enabling environment for women living with HIV to achieve optimal SRHR outcomes is critical.
- An integrated approach to health and human rights is necessary, including care linkages to ensure the dignity and well-being of women living with HIV.

### Box 5.1: Guiding principles for a response to the SRHR of women living with HIV

The way in which services are provided has long been recognized as a crucial determinant of whether, and to what extent, people seek health services when needed. An effective process for developing and implementing a national or subnational response to the SRHR of women living with HIV follows these guiding principles:

- **Ethics and rights:** An ethical and rights-based approach should inform all decision-making. The planned response, and the decision-making process itself, should be non-discriminatory and accountable to women living with HIV in all their diversity, respecting and upholding their autonomy and rights. Principles of fairness and equity should be followed. This can include gender-transformative approaches to health service delivery which take into account, address and challenge the norms and structures that can act as barriers to women's access to, and utilization of, services (147).
- **Meaningful participation of women living with HIV:** This is critical to ensure that the decisions made, the plans formulated and the programmes developed are acceptable to community members, equitable, and responsive to community needs. Representatives of women living with HIV in all their diversity, including from key population constituencies, should be involved at all stages, from designing the response through its implementation, to monitoring and evaluation (M&E) (10). Successful community empowerment develops the capacity of community members and organizations to participate in these processes in a meaningful way. Community-led organizations play a crucial role in delivering services that best meet the needs and priorities of women living with HIV.
- **Involvement of all stakeholders:** Addressing SRHR among women living with HIV requires a multisectoral response. Accordingly, planning of the response needs to involve multiple sectors.
- **Coordinated approach:** The national HIV programme manager, an appropriate body such as a national HIV/AIDS commission, the national reproductive health programme manager and an appropriate focal point within the ministry of health should take joint responsibility for managing the overall planning process and facilitating the participation of stakeholders and community members. Designating individuals to work specifically on developing and coordinating services may facilitate this. In large and diverse countries, developing a national programme requires formulating strategies at the local and subnational levels as well, with central guidance and coordination at the national level.
- **Openness and transparency:** The evidence and rationale for decisions should be publicly available, including information on expected effectiveness, anticipated risks, and the distribution of health benefits and burdens for women living with HIV.
- **Evidence-based:** Policies, interventions and approaches should be based on sound evidence or experience.
- **Equity:** Programmes should aim to achieve equitable health outcomes across all populations and settings and to promote gender equity.
- **Efficiency and sustainability:** Programmes should seek to deliver effective services most efficiently and to ensure that they are sustainable over the long term.
- **Quality:** Services should deliver the highest quality care at all times. Quality may be a process, requiring ongoing review of service delivery and outcomes.

As defined in the WHO *Framework on integrated people-centred health services* (IPCHS), “Integrated people-centred health services means putting the comprehensive needs of people and communities, not only diseases, at the centre of health systems, and empowering people to have a more active role in their own health”.<sup>3</sup> This Framework, which was adopted by Member States at the World Health Assembly in May 2016 (148), provides broad guidance on implementing a people-centred approach where everyone has access to health services that (i) respond to their preferences; (ii) are coordinated around their needs; and (iii) are safe, effective, timely, efficient and of an acceptable quality. This vision promotes a continuum of care that meets each individual’s health needs, in an integrated way, throughout their life course. This will allow health services to be more effective and equitable, and to meet the fundamental challenges faced by today’s health systems. To support implementation of this guideline, it will be important to update or develop implementation tools and to include the community of women living with HIV in the development process.

## 5.2 Key service-delivery reforms

Based on evidence and experience, WHO recommends three overarching reforms to improve HIV service delivery: (1) integration; (2) decentralization; and (3) task shifting (149). These reforms, separately or in combination, can improve access to care. Community-led and community-based approaches are integral to implementing these reforms, particularly for women living with HIV. To support women living with HIV in all their diversity, with varying SRHR needs and preferences, and with the range of social and epidemiological contexts in which they live, these strategies are best implemented based on a situational assessment and undertaken in consultation with the community of women living with HIV and health-care providers. Relevant specific recommendations and good practice statements to be implemented were presented in Chapter 3, section 3.2.4.

### 5.2.1 Integration of services

The goal of programme planning should be to create delivery systems that best facilitate access to holistic care, which takes a woman-centred, gender-sensitive approach, considering women’s needs, aspirations and priorities beyond HIV. WHO recommends integrating SRH services with a range of HIV interventions as well as other relevant clinical services, such as those for violence against women (VAW), tuberculosis (TB) and drug-dependence treatment (7). Integration of services facilitates provision of comprehensive and consistent care. It also allows individuals to attend to their various health-care needs at the same time and in the same location. Collaboration between programmes at every level of the health system is therefore important to the success of SRH services, HIV services and other related health and social services. Aspects of coordination that need consideration include mobilizing and allocating resources; training, mentoring and supervising health workers; procuring and managing medicines and other medical supplies; and M&E.

Integrated health services are managed and delivered in a way that ensures people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation and palliative care services, at the different levels and sites of care within the health system, and according to their needs throughout the life course (150). This includes SRH as well as other services that women living with HIV may utilize. Linking SRH and HIV interventions recognizes the vital role that sexuality plays in people’s lives, and the importance of empowering people to make informed choices about their SRH. SRH linkages and integration are defined in Box 5.2.

#### Box 5.2: Defining SRH linkages and integration

**Linkages:** The policy, programmatic, service and advocacy synergies between SRH and HIV.

**Integration:** The different kinds of SRH and HIV services and/or operational programmes that can be joined together to ensure collective outcomes. This would include referrals from one service to another. It is based on the need to offer comprehensive services.

Source: WHO, UNFPA, IPPF, UNAIDS, IPPF, 2005 (151).

3. This definition appears on the WHO web page for the Framework on IPCHS: <http://www.who.int/servicedeliverysafety/areas/people-centred-care/en/>

An updated *Integrated EMTCT commodities framework* has been developed; this work involved collaboration among UNFPA, WHO and several other partners, including communities of people living with HIV (152). This framework will enable programme and supply chain management to understand the full range of commodities that should be made available to support comprehensive integration of programmes delivering SRHR services through the reproductive, maternal, newborn and child health (RMNCH) and family planning platforms. It brings together a number of existing commodities packages, including those that make up a comprehensive four-component service for elimination of mother-to-child transmission (EMTCT) of HIV, and commodities for family planning, sexually transmitted infection (STI), GBV, maternal, newborn and child health (MNCH) and HIV.

For WHO tools that can help guide implementation of other HIV-related services, refer to Box 5.3, and for tools offering guidance on how to link SRH with HIV, see Box 5.4.

### Box 5.3: WHO guidance on HIV-related service delivery approaches

The 2016 publication, *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach, second edition (7)* and the 2015 publication, *Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV (153)* provide broad guidance in essential operational and service delivery areas:

- Offering antiretroviral therapy (ART), assisting with initiation of ART and providing adherence support
- Retention of clients living with HIV in care, across the continuum of care
- Service integration and linkage, and decentralization of HIV care and treatment
- Human resources, including task shifting
- Laboratory and diagnostic services
- Commodity procurement and supply management systems.

### Box 5.4: Tools offering guidance on how to link SRH with HIV

- *Sexual and reproductive health & HIV/AIDS: a framework for priority linkages*, 2005 (151)
- *SRH & HIV linkages resource pack*, 2012 (154)
- *Integrating HIV voluntary counselling and testing services into reproductive health settings: stepwise guidelines for programme planners, managers and service providers*, 2004 (155)
- *Reproductive choices and family planning for people living with HIV: counselling tool*, 2012 (116)
- *Rapid assessment tool for sexual and reproductive health and HIV linkages: a generic guide*, 2009 (73).

## 5.2.2 Decentralization of services

Decentralization aims to deliver SRH and HIV services at sites that are more local to the client. While decentralization can take many forms, such as deconcentration, delegation or devolution, the focus here is on the outcome of decentralization for antiretroviral therapy (ART) and access to SRH services (specific recommendations on this are presented in Chapter 3, section 3.2.4). Decentralizing access to these services can be a key reform for women living with HIV since it may improve access to services, care-seeking behaviour and retention in care (7). In many settings, transport costs and long waiting times at central hospitals are significant barriers to service access and retention in care. Particularly in rural areas, decentralization can reduce the difficulty and cost of travel and shorten waiting times. If carefully planned and implemented – with due consideration for confidentiality and high-quality care – decentralization may provide safer, more accessible and discreet health-care options, particularly for women living with HIV. Potential and/



or actual clients of these services should be involved in the planning and development of the decentralization efforts, as well as in monitoring and evaluation to ensure that services are acceptable and appropriate. Decentralizing HIV care and treatment for women living with HIV can also further strengthen community engagement and link community-based interventions with health-care facilities.

- **Community-based approaches** to service delivery can increase accessibility and acceptability for key populations. Outreach, mobile services, drop-in centres and venue-based approaches are useful for reaching those with limited access to, or underserved by, formal health-care facilities. These approaches allow for critical linkages and referrals between the community and health-care facilities, and they support decentralization. Community-based programmes can also refer to programmes that are led and delivered by women living with HIV who are also members of key population communities. Staff members, including peers, involved in community-based approaches need to be appropriately supported in terms of training, counselling, supervision and management, and also incentives and remuneration.
- **Community-led services** are interventions designed, delivered and monitored by community members. They enable community members to address structural barriers to the exercise of their rights and empower them to change social norms, thus reducing vulnerabilities that go beyond HIV. For example, their roles include:
  - providing adequate and reliable access to commodities (condoms, lubricants and temporary contraceptives) and clinical services through outreach and referrals and community-based distribution (156);
  - responding to violence against women living with HIV and implementing other structural interventions; and
  - offering formal and informal means for the community to provide feedback on the quality of services and to engage with services beyond the SRH or HIV programme.

### 5.2.3 Task shifting and sharing delivery of services

Task shifting involves the rational redistribution of tasks among health workers and lay providers. Where appropriate, tasks are reassigned from highly qualified health workers to those with shorter training and fewer complementary qualifications (7). Many countries face a shortage of health workers; task shifting can increase the effectiveness and efficiency of available personnel, enabling the existing workforce to serve more people. Community-led organizations can also play important roles in reaching women living with HIV, engaging with them, linking them to services and providing ongoing care and support, thereby supporting the tasks of health promotion. Specific recommendations on task shifting and task sharing in relation to ART are presented in Chapter 3, section 3.2.4.

WHO's 2012 publication, *Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting (OptimizeMNH)* recommends tasks that can be shifted to specific cadres based on a review of existing evidence (58). Many recommendations in that document have relevance for SRHR of women living with HIV although they are not specific to women living with HIV. These recommendations can be accessed in that publication, available at: [http://apps.who.int/iris/bitstream/10665/77764/1/9789241504843\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/77764/1/9789241504843_eng.pdf). Additional information on task shifting that can be considered with additional evidence reviews, as well as tasks that are recommended not to be shifted, are also included in that publication.

In addition to this, peer-to-peer models are effective prevention and treatment strategies to reach women and girls living with HIV. Several programmes have shown, for instance, the potential to significantly increase HIV testing uptake, and success in providing peer support for ART adherence.

- **Peer interventions** – also termed peer-based or peer-driven interventions – are an important method for delivering services and exchanging information and skills that promote safer behaviours to individuals or networks of women living with HIV. Beyond providing services, peers can act as role models and offer non-judgemental and respectful support that may contribute to reducing stigma, enhancing trust between the community and health workers, facilitating access to services, and improving their acceptability and potential sustainability.



## 5.3 Key considerations when providing services for women living with HIV

Programmes need to provide equitable services that are (1) people-centred, (2) accessible, (3) acceptable and (4) affordable. Furthermore, women living with HIV need to be made aware of and empowered to avail themselves of services. Directed support may help those women who experience extreme challenges in receiving care. Such women may include: transgender women, who might not be considered eligible to access “women’s services” in some settings; sex workers, for whom standard health service opening times might present barriers; and women with disabilities, who might have problems with access. It is important that their SRHR are supported, as they should be for all women. It is recommended that these women receive non-stigmatizing, gender-sensitive, confidential services in a convenient setting, and that interventions are adopted to prevent discrimination and reduce stigma (92). It is important to remember that health workers themselves may also be women living with HIV.

### 5.3.1 People-centred

People-centred health services represent an approach to care that consciously adopts the perspectives of individuals, families and communities, and sees them as participants in – as well as beneficiaries of – trusted health systems that respond to their needs and preferences in humane and holistic ways. This approach requires that people have the education and support they need to make decisions and participate in their own care. It is organized around the health needs and expectations of people rather than diseases (157)<sup>4</sup>.

To meet the fundamental challenges faced by today’s health systems, the *WHO Framework on integrated people-centred health services* (IPCCHS) proposes five interdependent strategic directions that need to be adopted in order for health-service delivery to become more people-centred and integrated (148):

- empowering and engaging people through providing opportunities, skills and resources;
- strengthening governance and accountability;
- reorienting the model of care so that efficient and effective health-care services are purchased and provided through models of care that prioritize primary and community care services and the coproduction of health;
- coordinating services around the needs of people at every level of care, as well as promoting activities to integrate different health-care providers and create effective networks between health and other sectors; and
- creating an enabling environment that brings together the different stakeholders to undertake the transformational change needed.

Interventions in specific country contexts need to be developed and negotiated locally. In each context the exact mix of strategies to be used will need to be designed and developed taking account of local conditions, values and preferences (157).

### 5.3.2 Accessible

**Address age barriers:** Age-of-consent laws should be examined to determine their effects on access to services. Countries may consider revising age-of-consent policies and creating exceptions to age limits (i.e. mature minor status; early child marriage). Countries may also consider how best to assess adolescents’ capacity to consent.

**Make services convenient:** Programmes may consider offering mobile and/or drop-in services, and weekend- and/or night-service times that facilitate access. Outreach, including venue-based, digital health interventions via mobile phone and home-visiting services, can also increase access.

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4. Available at: <http://www.who.int/servicedeliverysafety/areas/people-centred-care/fullframe.pdf>

**Decentralize services:** Shifting services from centralized locations to community-based and/or mobile outreach (i.e. using a vehicle) and peripheral health-care facilities can increase access. For example, school-based sexuality education, peer counselling and community-level activities can disseminate behavioural messages, promote follow-up on referrals to services, improve adherence to treatment and increase people's participation in their own health care.

**Invest in creating an enabling environment:** Countries can support access to services by women living with HIV, including those from key populations, by investing in critical enablers such as integrated treatment, programmes to improve literacy on human rights, legal services, programmes to reduce stigma and discrimination, and training for health workers and law-enforcement personnel.

### 5.3.3 Acceptable

**Train health-care providers:** Health-care providers (including community workers, peer outreach workers, support staff and management) should receive sensitization and education on issues specific to women living with HIV, including those from key populations, and on non-discriminatory, gender-sensitive practices and eliminating stigma. This can be achieved through pre-service and in-service training, job aids, supportive supervision and training follow-up. Where possible, training should involve women living with HIV.

**Create a safe and supportive environment:** Safe spaces (for provision of both health care and social services) and confidential and stigma-free environments can encourage access by women living with HIV. For example, providing separate and well lit entrances or locating services in an appropriate setting can decrease barriers to access. Similarly, confidentiality must be respected, avoiding unintentional disclosure of status through differences between how or where women living with HIV access health care compared with others. Inclusion of women living with HIV in planning access to services may improve the effectiveness of services. This also includes women living with HIV who are themselves health workers.

**Provide high-quality services:** Services should be acceptable and of high quality. One way to assess quality is to monitor clients' experience using national and global indicators.

**Assure voluntary and informed consent:** Programmes must promote individuals' right to decide on their own treatment and must accept their right to refuse services. All services should be voluntary, without any sense of coercion or conditional requirements for obtaining services or commodities. Information on services and treatment should be clear, explicit and in the appropriate language, and also provided in a way that is accessible for women with limited or no literacy. Information for adolescents needs to be appropriate to their developmental stage.

**Ensure confidentiality:** Attention should be devoted to protecting privacy and confidentiality – for example, by closing the consultation room door or finding a private place to talk. Clients should be reassured of confidentiality, and permission should be sought before disclosing information to other health-care providers. Programmes should address the complexities of maintaining confidentiality, particularly in community-based, outreach and peer approaches. Ensuring that medical records are kept confidential is one step that health-care providers can take to increase trust between health services and women living with HIV.

**Engage women living with HIV:** Women living with HIV, including those who are members of various key populations, should be involved in the design of programmes, including planning, implementation and M&E, and also should be invited to take part as service providers and advocates. Such involvement can increase the community's sense of ownership, thereby enhancing programme success.

### 5.3.4 Affordable

**Ensure monetary resources:** Countries should use timely, appropriate and reliable strategic information to prioritize resource allocation, evaluate responses and inform accountability processes, given that government commitment and funding are important. This includes investment and support to civil society, including

networks of people living with, at risk of and affected by HIV, scaled up to enhance their essential role in the response.

**Minimize or eliminate fees:** Wherever possible, services should be provided free of charge or at a reduced price. Insurance or health subsidies should cover any fees for services.

**Reduce costs:** Costs to the health system and the user can be reduced through the integration and decentralization of services, including community-based and community-led approaches, using convenient locations, while ensuring quality and confidentiality. Costs to the individual can be reduced by shortening waiting times at health-care facilities through flexible appointment systems and by separating clinic consultation visits from picking up medicines.

### 5.3.5 Special considerations for the SRHR of young transgender women living with HIV

Human rights bodies have also called on states to ensure timely and affordable access to good quality health services, including for adolescents, delivered in a way that ensures informed consent, respects dignity, guarantees confidentiality, and is sensitive to people's needs and perspectives (158). However, many young transgender women living with HIV are particularly stigmatized and discriminated against. Refusal to make clinic appointments, refusal to treat, or treatment with gross disrespect, violation of medical privacy, private shaming and public disparagement are among the discriminatory practices and abuses that have been reported, along with hurried and inferior care (159). The remainder of this subsection highlights special considerations for the SRHR of young transgender women living with HIV relevant to a range of issues affecting provision of services for these women. More information on young transgender people and HIV is available in the 2015 publication, *Technical brief: HIV and young transgender people* (160).

#### Service delivery

The difficulty of negotiating the tension between a desire to express one's identity and the fear of being stigmatized for doing so often has a negative impact on the emotional well-being of transgender adolescents and may deter them from seeking guidance and information about gender identity as well as SRH and HIV (160).

Participants in UN community consultations identified discrimination by health-care providers as one of the most significant barriers to accessing testing, treatment and care (evidence from the HIV Young Leaders Fund [HYLF] consultation and UNFPA consultation [160]). Young transgender people may fear having their gender identity divulged to others by health-care providers. Those who are open about their gender identity may be denied health services. Some patients report being refused HIV treatment by doctors who clearly disapproved of their transgender identity (161).

Where services are available, providers often do not have experience of working with young people, or the knowledge needed to deal with health issues specific to transgender people (162). Some transgender women are frustrated to find their SRH concerns conflated with those of men who have sex with men, or feel that they must educate health-care providers about their needs. They also express concern about the lack of guidance from health-care professionals regarding interactions between HIV treatment and hormone therapy (160).

Studies conducted in the United States have shown that transgender people who have had negative experiences with health-care providers tend to avoid accessing health care in the future (163). Services that are not acceptable to transgender people fail to provide effective HIV prevention, treatment and care to this population.

#### SRH service uptake

Young transgender people in relationships, like non-transgender people, may use condoms less frequently with their main partners than with casual or commercial partners (160).

Barriers to health care among transgender people have been significantly associated with depression, economic pressure and low self-esteem, which may reduce rates of condom use (164).

### **Commercial sex work**

Evidence suggests that a significant proportion of young transgender women sell sex in some settings, often as a result of social exclusion, economic vulnerability and difficulty in finding employment (165, 166).

### **Considerations for programmes and service delivery**

- Ensure that young transgender people have access to appropriate SRH information, regardless of their marital status and without any requirement for consent of parents/guardians (167), and that medical treatment without parental/guardian consent is possible and effectively considered when in the best interests of the individual.
- Prevent all forms of physical, emotional and sexual violence and exploitation, whether by law enforcement officials or other perpetrators, and promote community-led response initiatives.

### **Considerations for law and policy reform**

- Examine current consent policies to consider removing age-related barriers and parent/guardian consent requirements that impede access to HIV and STI testing, treatment and care. Address social norms and stigma around sexuality, gender, gender identities and sexual orientation through age-appropriate comprehensive sexuality education in schools, supportive information and parenting guidance for families, training of educators and health-care providers, and non-discrimination policies in employment (10, 168).

## **5.4 Understanding local HIV and STI epidemiology**

Development and implementation of an evidence-based plan requires understanding the characteristics of the populations of women living with HIV who are affected; the physical, social and political environments that influence risk and vulnerability; the needs and priorities of women living with HIV, and any factors that might enable or hinder efforts to address those needs and priorities; and the health systems and community infrastructure.

While many SRHR risks, needs and aspirations may be common to all women, some factors will differ among women living with HIV, and some will be specific to a particular group or context. Accordingly, for a local response to be appropriate, acceptable and effective, these risks, needs and aspirations must be examined locally, and local communities, networks and women living with HIV in all their diversity must be consulted and actively involved in the situational analysis.

Those most at risk are likely to be people who could be considered members of more than one key population. For example, some transgender women living with HIV may also be engaging in sex work and be facing high levels of violence and discrimination, or have additional health or welfare needs related to their HIV status, their gender identity and/or their engagement in sex work. Also, women living with HIV in resource-constrained settings may be homeless and/or may experience mental health conditions or fear violence.

It is critical that information-gathering processes, and the information itself, serve to protect, and not put at risk, the safety and privacy of women living with HIV. At all times, ethical principles must be observed, and the human rights of women living with HIV must be protected. In some circumstances, determining population size or mapping the SRHR needs of women living with HIV can unintentionally endanger community members or subject them to increased stigma or violence by identifying them as living with HIV and/or as being from key population groups. When undertaking information-gathering exercises, it is important to maintain strict privacy, confidentiality and security of the information collected. If the safety and human rights of women living with HIV cannot be protected, collection of certain data, such as identifying locations of women living with HIV, is better avoided.

In addition, the SRHR needs of women living with HIV change over time, as do various contextual and environmental factors. Ongoing M&E will identify changing parameters and make it possible to refine or refocus the response. A situational analysis will identify gaps in knowledge and an agenda for further research can address these gaps, some of which are outlined in Chapter 6, Table 6.1.

# Chapter 6. Developing the research agenda

## 6.1 Defining priority research considerations to strengthen the evidence base

The evidence base was limited for many of the questions addressed by new recommendations in this guideline. The reasons for this included: (i) few rigorous studies related to the topics of interest have been published in peer-reviewed journals; (ii) there was little geographic diversity between the studies; and (iii) few outcomes of interest were included in the studies. The certainty of evidence was rated as “low” or “very low” for a number of interventions evaluated. According to the Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology (9), where the certainty of evidence is “low” or “very low” for important outcomes, this implies that further research on these interventions is likely to have an impact on future certainty and subsequent recommendations related to these interventions. The quality of the evidence was also generally low and was commonly affected by imprecision (small sample size) and indirectness. In many cases, the available evidence was not exclusive to women living with HIV within the context of the intervention, and in other cases the evidence lacked an appropriate comparison group against which to measure the intervention. Data were particularly limited around the following interventions: mode of abortion, self-efficacy and empowerment, sexual satisfaction, support for voluntary disclosure, and entrenchment of human rights.

During the guideline development process, the Guideline Development Group (GDG) identified important knowledge gaps that need to be addressed through further primary research. Table 6.1 lists these identified gaps, but this is not intended to be a comprehensive list and many other topics may also merit further research (169).

**Table 6.1: Priority questions for further research on the sexual and reproductive health and rights (SRHR) of women living with HIV**

Topic	Priority research questions to address gaps
<b>A. Creating and maintaining an enabling environment</b>	
<b>Ageing and sexual health</b>	<ul style="list-style-type: none"> <li>• How can services best support healthy sexuality among older women living with HIV, including heterosexual, lesbian, bisexual and transgender women?</li> <li>• What are the possible effects of HIV and HIV treatment during post-menopause?</li> </ul>
<b>Protection from violence during adolescence</b>	<ul style="list-style-type: none"> <li>• What are the protective and risk factors associated with the transition of adolescent girls to adulthood in the context of violence and other barriers to good SRHR?</li> <li>• What are the best interventions to support healthy outcomes?</li> </ul>
<b>Hard-to-reach populations</b>	<ul style="list-style-type: none"> <li>• How can services for women living with HIV incorporate the concerns of women who are hard to reach and serve them more effectively?</li> <li>• How can positive social norms help to address stigma and discrimination?</li> <li>• How can adequate, tailored health and psychosocial services be delivered to young transgender people (aged 10–24 years)?</li> </ul>



Topic	Priority research questions to address gaps
<b>A. Creating and maintaining an enabling environment (continued)</b>	
<b>Health workers who are women living with HIV</b>	<ul style="list-style-type: none"> <li>• What levels of support, confidentiality and attitudes prevail within the health system towards women living with HIV who are health workers?</li> <li>• What is health-care leadership currently doing with regard to access to services for these women?</li> <li>• What is the prevalence of gender-based violence (GBV), including intimate partner violence (IPV) and work-based GBV, experienced by health workers who are also women living with HIV?</li> </ul>
<b>Human rights and health</b>	<ul style="list-style-type: none"> <li>• How can we effectively integrate human rights into health care and health-care systems?</li> <li>• How can human rights techniques be used to improve health outcomes?</li> <li>• What are the ongoing human rights abuses within the health-care system and what can be done to prevent them?</li> </ul>
<b>HIV treatment services</b>	<ul style="list-style-type: none"> <li>• What are the long-term effects of antiretroviral (ARV) medicines on the quality of life of women living with HIV?</li> <li>• What are the mental health, psychosocial, physical, relational and other implications of life-long treatment?</li> <li>• How treatment-literate are women, and how can that be improved if it is low?</li> <li>• How can the new treatment guidelines be best implemented to support good overall health, acknowledging risks such as violence and other challenges?</li> <li>• How can continued access to HIV treatment services be best supported as funding models transition from external donor support to local support, including the use of health insurance?</li> </ul>
<b>Integration of SRHR and HIV services</b>	<ul style="list-style-type: none"> <li>• How does funding influence service integration, particularly when donor priorities and metrics differ from those of national programmes and other donors?</li> <li>• What are the effects of integrated service delivery of HIV and SRH care on health workers' service-delivery capacity, and what are the impacts on clients?</li> </ul>
<b>B. Health interventions</b>	
<b>Empowerment and self efficacy</b>	<ul style="list-style-type: none"> <li>• What is the best way to promote equality and empowerment of women living with HIV for healthy and enjoyable sexuality?</li> </ul>
<b>Safe disclosure</b>	<ul style="list-style-type: none"> <li>• What are the best methods for HIV status disclosure? Options that require further research may include: assisted partner notification and other methods to support disclosure; methods of HIV testing and safe disclosure that could explain why people prefer not to disclose and innovatively address the barriers; functional support associated with disclosure (e.g. safe houses), particularly in environments of high levels of other barriers to good SRH, such as violence; wrap-around services with disclosure support.</li> </ul>
<b>Brief sexuality communication</b>	<ul style="list-style-type: none"> <li>• What are the most effective interventions to support safe, pleasurable sexual relationships for women with HIV who choose to engage in them, based on evidence on healthy sexuality and sexual dysfunction among women living with HIV?</li> </ul>
<b>Caesarean section</b>	<ul style="list-style-type: none"> <li>• What are the C-section-associated morbidities for women living with HIV compared with those not living with HIV?</li> </ul>

Topic	Priority research questions to address gaps
<b>B. Health interventions (continued)</b>	
<b>Labour and delivery</b>	<ul style="list-style-type: none"> <li>• What is the impact of an HIV diagnosis during pregnancy?</li> <li>• How can women who are diagnosed during pregnancy be best supported to manage negative associated outcomes?</li> <li>• What proportion of women are tested for HIV outside of pregnancy?</li> <li>• How are HIV testing and pregnancy care related?</li> <li>• How can breastfeeding women be retained in HIV care?</li> <li>• What is the association between antiretroviral therapy (ART) and pre-eclampsia? It should be noted that WHO's 2011 recommendations for prevention and treatment of pre-eclampsia and eclampsia are not specific to women living with HIV (170).</li> </ul>
<b>Safe abortion</b>	<ul style="list-style-type: none"> <li>• Do outcomes of medical and surgical abortion among women living with HIV differ using mifepristone and misoprostol? It should be noted that an important research gap is that the included studies looked only at abortions using misoprostol instead of the recommended mifepristone and misoprostol (32).</li> </ul>
<b>Mental health</b>	<ul style="list-style-type: none"> <li>• What is the association between post-traumatic stress disorder in women living with HIV and their experiences of HIV diagnosis, their experiences of violence and other common HIV-related experiences?</li> </ul>

## 6.2 Towards an appropriate approach to research on SRHR

### 6.2.1 Women living with HIV as equal partners in research

Research about women living with HIV should be conducted with, by and for women living with HIV, as equal research partners. Research that is pursued and funded in this area should include justification for why it is important to women living with HIV.

Work is needed to ensure that human rights are actively and effectively integrated into health service planning and the provision of health care. Similarly, SRHR researchers should aim to incorporate human rights considerations and associated outcome measurements into their study designs and should ensure that the language they use is appropriate to the SRHR context.

Research on broader research questions should include women living with HIV in the study population, and should present subgroup analyses to show how the findings may be specific to this group. For example, the larger research agenda around violence prevention, including stigma, could examine the role of HIV in marginalized populations such as sex workers, without focusing exclusively on HIV. These linkages may provide important insights for future action for all women, not only those living with HIV.

Research should be respectful of the unique situations of participants. For example, key considerations for conducting research with women who have experienced violence are outlined in the 2016 publication, *Ethical and safety recommendations for intervention research on violence against women. Building on lessons from the WHO publication: Putting women first: ethical and safety recommendations for research on domestic violence against women (171)*.

A potentially empowering, action-oriented research approach is participatory action research (PAR). Women HIV activists have called this respectful engagement with, and learning from, communities “MIWA” – meaningful involvement of women living with HIV and AIDS. The approach taken in the development of this guideline and the engagement of communities of women living with HIV reflects a large breadth and depth of engagement, with comprehensive research results and detailed positive feedback that acknowledges that it is possible to achieve the MIWA principles of participation, diversity and ethics (40). When it is properly

facilitated, PAR can help to change mindsets and spur change (172). A useful tool for planning PAR is the 2014 publication, *Participatory action research in health systems: a methods reader* (172).

### 6.2.2 Study design

To increase the evidence base for making recommendations, studies should use the most rigorous design possible to answer the research question. For questions on the effectiveness of particular interventions, randomized controlled trials (RCTs) and other comparative designs should be used. However, it is critical to note that context is required to understand what is truly being tested in an RCT, to enable accurate interpretation of the results, and to support potential transferability of the findings to other populations or settings. Therefore, qualitative and quantitative process documentation should accompany these trials.

More implementation science and demonstration research would provide information on how to – and how not to – implement recommended practices effectively, in addition to addressing a wide range of other potentially relevant research questions (173). Research should be designed and implemented not only to answer relevant research questions but also to facilitate possible future action based on the research findings. Research questions and discussions of findings should take into consideration future implementation actors, contexts and resources. Adoption of implementation research as a valid method to deliver robust results is key to addressing this (174).

Researchers should contextualize their research within the range of relevant existing health services, resources and actors, the relationships between actors, and the variety of influences across the social ecological framework that may need to be addressed to facilitate beneficial outcomes (175). While not every study can cover all elements of a topic, studies should endeavour to consider both clinical and behavioural elements of SRHR and HIV and, at a minimum, to consider the limitations of their work in the absence of either. In writing up the research, the authors should fully describe the interventions and the context in which they operate so that they can be transferred to other settings, with appropriate adaptations as needed to ensure the highest probability of success.

When it is more appropriate to use qualitative or non-comparative study designs to answer a research question, researchers should be explicit about their methods to ensure the robustness of their results. For example, the theoretical grounding, hypotheses used, level of engagement of the researcher, sampling approach and analysis techniques should be elucidated. This will both improve the rigour of studies and allow for easier translation of findings into effective action.

It is important that research identifies achievements, strengths and platforms upon which to build as well as challenges (38). Strength- and asset-based approaches and paradigms should be used when planning, conducting and analysing research studies (150). The Global Values and Preferences Survey (GVPS) referenced in this guideline is an example of a positive approach to understanding important health topics, both through study leadership coming from the affected community and through surveys identifying positive practices that can be built upon for action (37).

### 6.2.3 Funding

One underlying reason for the limited evidence base on women living with HIV is that these women are often excluded from participation in research. Discouraging the use of HIV-positive status as a criterion for exclusion from study participation is important in order to build the evidence base. Funders should ensure that they support studies that include women who are living with HIV and who voluntarily agree to participate. They should ensure that these women are supported in understanding the research and that research results are reported back to these participants. In addition, the financial precarity which many women living with HIV face needs to be acknowledged and addressed when meaningfully engaging communities of women living with HIV, as their time and involvement is often not compensated.

# Chapter 7. Dissemination, applicability and updating of the guideline and recommendations

## 7.1 Dissemination

This guideline will be available online for download and also as a printed publication. Online versions will be available via the websites of the WHO Department of Reproductive Health and Research (RHR) and the HIV/AIDS Department and through the WHO Reproductive Health Library (RHL).<sup>5</sup> Print versions will be distributed to WHO regional and country offices, ministries of health and national AIDS control partners, WHO collaborating centres, NGO partners and professional associations, and communities of people living with HIV. Technical meetings will be held jointly with the WHO Departments of RHR and HIV to share the recommendations and derivative products, which will include implementation tools for the new recommendations and good practice statements. For the recommendation on safe disclosure of HIV status, for example, WHO is developing a module aimed at health-care providers, particularly providers of HIV testing and counselling services, to help women at risk of or experiencing intimate partner violence to make decisions on disclosure that take safety into account. This module will have to be used in conjunction with the WHO clinical handbook *Health care for women subjected to intimate partner violence or sexual violence*, which provides overall “how to” guidance for health-care providers in caring for women experiencing violence, including practical tips and job aids (176). Two sets of evidence briefs will also be developed – one set for policy-makers and programme managers and the other for health-care professionals – highlighting the recommendations and implementation-related contextual issues.

Should finances allow, the dissemination plans will also include workshops and briefings with different stakeholders at the global and regional levels. It is expected that detailed plans for development of the evidence briefs and implementation tools, as well as for dissemination and implementation of the guideline, will be formulated in collaboration with implementing partners, national stakeholders and communities of women living with HIV, and will allow for derived products to be tailored to the needs in different national contexts.

The executive summary and recommendations from this publication will be translated into the six UN languages for dissemination through the WHO regional offices and during meetings organized or attended by staff of the WHO Departments of RHR and HIV, among others.

The guideline will be launched on the website of the RHR Department and in “HRP News”, the monthly electronic newsletter<sup>6</sup>. HRP News currently has over 3000 subscribers including clinicians, programme managers, policy-makers and health-service users worldwide. This guideline will also be shared through several knowledge-sharing platforms, including the Implementing Best Practices (IBP) initiative<sup>7</sup> and on the website of the Interagency Working Group on SRH & HIV Linkages;<sup>8</sup> both groups reach key partners working in the field of SRHR and HIV. In addition, a number of articles will be published presenting the systematic and literature reviews that were conducted for the development of this guideline (see Annex 4) and presenting the

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5. Available at: <http://apps.who.int/rhl/en/>

6. Please see the “What’s new?” page of the RHR/HRP website, which includes a link to subscribe to HRP News: <http://www.who.int/reproductivehealth/news/en/>

7. For further information, see: <http://www.ibpinitiative.org/>

8. For further information, see: <http://srhhivlinkages.org/>

recommendations and key implementation considerations, in compliance with WHO's open access and copyright policies.

In an effort to increase the dissemination of WHO guidelines on SRHR, a search function with the ability to search the database of WHO guidelines and recommendations has been created and recently launched by the Department of RHR. The recommendations of this guideline will be made available via this new search function.<sup>9</sup>

## 7.2 Applicability

### 7.2.1 Anticipated impact of the guideline

Effective implementation of the recommendations and good practice statements in this guideline will likely require reorganization of care and redistribution of health-care resources, particularly in low- and middle-income countries (LMICs). The potential barriers to implementation include the following:

- lack of human resources with the necessary expertise and skills to implement, supervise and support recommended practices, including client counselling;
- lack of infrastructure to support the intervention;
- lack of physical space to conduct individual or group counselling;
- lack of physical resources, such as equipment, test kits, supplies, medicines and nutritional supplements;
- lack of effective referral mechanisms and integrated SRH/HIV services and care pathways for women identified as needing additional care (e.g. for TB or malaria);
- lack of understanding of the value of newly recommended interventions among health-care providers and health system managers;
- lack of health management information systems (HMISs) designed to document and monitor recommended practices (e.g. client cards, registers).

Given the potential barriers noted above, a phased approach to adoption, adaptation and implementation of the guideline recommendations may be prudent. Various strategies for ensuring that the woman-centred approach and guiding principles of human rights and gender equality that underpin this guideline are operationalized, and for addressing these barriers and facilitating implementation, have been suggested in the list of considerations in Chapter 5, section 5.1.

### 7.2.2 Monitoring and evaluating the impact of the guideline

It is critical that monitoring and evaluation (M&E) systems are practical, not overly complicated, and collect information that is current, useful and can be readily applied. The implementation and impact of these recommendations will be monitored at the health service, regional and country levels, based on clearly defined criteria and indicators that are associated with locally agreed targets, and with the involvement of women living with HIV, where possible.

WHO and UN partner agencies have developed frameworks for monitoring the health care and health system response to HIV and SRHR in the general population and for people living with HIV. Selected examples of these frameworks are listed in Box 7.1, and each of these recommends a set of national-level indicators or actions. Some also provide recommended indicators or actions at the global, subnational and community levels. These indicators assess key factors related to the enabling environment; measure the availability, coverage and quality of specific interventions; and examine the outcomes and impacts of the interventions. In addition, the Interagency Working Group on SRH & HIV Linkages and several M&E experts, including country, donor, UN agency and civil society representatives, undertook a collaborative process to identify and assess existing indicators and tools, and provide recommendations for a compendium of indicators that can be used to measure SRH and HIV integration and linkages at policy, systems and service-delivery levels, as well as at

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9. Available at: [search.optimizemnh.org](http://search.optimizemnh.org)

output, outcome and impact levels. The results of this process were published in the 2014 *SRH and HIV linkages compendium: indicators and related assessment tools* (177). Building upon this, the *SRHR and HIV Linkages Index* has been developed with publication expected in 2017;<sup>10</sup> this Index provides the first ever composite score for measuring country progress towards linking SRHR and HIV in 60 countries using 30 indicators. The Index can be used to support advocacy to improve SRHR and HIV linkages, to guide decision-making for focused programming, and to measure progress on SRHR and HIV linkages. Together, the indicators measure how well a country is progressing at linking/integrating SRHR and HIV, including for people living with HIV.

In collaboration with the M&E teams of the WHO Departments of RHR and HIV, data on country- and regional-level implementation of the recommendations will be collected to evaluate their short-to-medium term impact on national policies of individual WHO Member States.

### Box 7.1: Selected frameworks for monitoring the health care and health system response to HIV and SRHR

Frameworks and further information, including recommended indicators and actions, can be found in the following publications:

- *Tool to set and monitor targets for HIV prevention, diagnosis, treatment and care for key populations*, 2015 (178)
- *Consolidated strategic information guidelines for HIV in the health sector*, 2015 (179)
- *Monitoring & evaluation framework for antiretroviral treatment for pregnant and breastfeeding women living with HIV and their infants (IATT Option B/B+ M&E Framework)*, 2015 (180)
- *A tool for strengthening gender-sensitive national HIV and sexual and reproductive health (SRH) monitoring and evaluation systems*, 2016 (181)
- *Ensuring human rights within contraceptive service delivery: implementation guide*, 2015 (30).

## 7.3 Updating the guideline

In accordance with the concept of WHO's GREAT Network (Guideline-driven, Research priorities, Evidence synthesis, Application of evidence, and Transfer of knowledge), which employs a systematic and continuous process of identifying and bridging evidence gaps following guideline implementation (182), this guideline will be updated five years after publication unless significant new evidence emerges that necessitates earlier revision. The WHO Steering Group will continue to follow the research developments in the area of SRHR of women living with HIV, particularly as there are many areas for which no evidence was found or that are supported by low-quality evidence, where new recommendations or a change in the published recommendation, respectively, may be warranted. Any concern about the validity of a recommendation will be communicated promptly, and plans will be made to update the recommendation as needed.

As the guideline nears the end of the proposed five-year validity period, the responsible technical officer (or another designated WHO staff person), in conjunction with the WHO Steering Group, will assess the currency of the recommendations and the need for new guidance on the topic. This will be achieved by performing a scoping exercise among people living with HIV, technical experts, health-care professionals and researchers to identify controversial or priority areas where further evidence-based guidance may be needed.

All technical products developed during the process of developing this guideline – including full reports of systematic reviews, corresponding search strategies and dates of searches – will be archived in the

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10. Information will be available soon at: [toolkit.srhivlinkages.org](http://toolkit.srhivlinkages.org)

departmental shared folder for future reference and use. Where there are concerns about the validity of a particular recommendation based on new evidence, the systematic review addressing the primary question will be updated. To update the review, the search strategy used for the initial review will be applied, either by the same systematic review team or by another team if the initial review team is no longer available. Any new questions identified following the scoping exercise at the end of five years will undergo a similar process of evidence retrieval, synthesis and grading in accordance with the standards in the *WHO handbook for guideline development* (39).

The guideline development process identified a fair number of knowledge gaps, which are highlighted in Chapter 6 (Table 6.1). WHO aims to develop further guidance around topics that would be likely to promote equity, be feasible to implement, and contribute to improvements in SRHR of women living with HIV, so that the appropriate recommendations can be included in a future update of this guideline.



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## Annex 2. Summary of declarations of interest from the Guideline Development Group (GDG) members and how they were managed

Name	Expertise	Disclosure of interest	Conflict of interest and management
<b>GDG members</b>			
Prof. Pascale Allotey	Midwifery, delivery of care, implementation science, sexual and reproductive health and rights (SRHR), HIV, migration, conflict and health, implementation research, health systems, research, gender and equity	None declared	Not applicable
Dr Elham Atalla	Clinical sexologist, sexual health, women's health, policy, mental and behavioural disorders among vulnerable populations including women living with HIV	None declared	Not applicable
Dr Susan Bewley	Academic, obstetrician, normative guidance, research, violence during pregnancy, maternal health, HIV, delivery of care	Provided advice on the development of the Global Values and Preferences Survey (GVPS).	The conflict was not considered serious enough to affect GDG membership or participation in the Technical Consultation.
Prof. Shalini Bharat	Social science research, HIV/AIDS, stigma, discrimination, social drivers of HIV, women's health, health vulnerabilities	None declared	Not applicable
Prof. Elizabeth Bukusi	Sexually transmitted infections (STIs), reproductive health, HIV prevention, youth programmes, training, socio-behavioural, biomedical and implementation research	None declared	Not applicable
Dr Caroline Phiri Chibawe	Public health specialist, maternal and child health, HIV clinician, implementation research, communications and advocacy, family planning	None declared	Not applicable
Ms Sophie Dilmitis	Woman living with HIV, advocacy, SRHR/HIV, community training, comprehensive sexuality education, youth programmes	Funded by the Women4Global Fund, UN Women Global treatment access review Group; funded through UNAIDS for the GBV/HIV Working Group.	The conflict was not considered serious enough to affect GDG membership or participation in the Technical Consultation.



Name	Expertise	Disclosure of interest	Conflict of interest and management
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Dr Chisale Mhango	Obstetrics and gynaecology, SRHR, maternal health	None declared	Not applicable
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Dr Rejoice Nkambule	National policy, primary health care, HIV/AIDS including HIV prevention, prevention of vertical transmission, ART programmes, education, training and counselling, SRHR/HIV linkages and tuberculosis (TB)	None declared	Not applicable
Prof. Vera Paiva	SRHR/HIV, mental health, psychology, researcher, policy adviser, community interventions, youth programmes, implementation science	None declared	Not applicable
Ms Quach Thi Thu Trang	Gender-based violence (GBV), gender, sexuality, reproductive health, research, monitoring and evaluation (M&E), training delivery, clinician, work with minority and vulnerable populations, including lesbian, gay, bisexual and transgender (LGBT) people and people living with HIV	None declared	Not applicable
Prof. Paul Van Look	Research, SRHR, policy, SRH/HIV linkages, programme director	None declared	Not applicable
Prof. Alice Welbourn	Woman living with HIV, SRHR, HIV, community participation, intimate partner violence, communication, advocacy, research	Received funds through the Salamander Trust to lead the GVPS, but received no personal fee for this work.	The conflict was not considered serious enough to affect GDG membership or participation in the Technical Consultation.

Name	Expertise	Disclosure of interest	Conflict of interest and management
Dr Anandi Yuvaraj	Woman living with HIV, GBV, HIV prevention, community and public health, advocacy and communication, human and financial resources for health	None declared	Not applicable

**Consultants who attended the GDG meeting**

Dr Caitlin Kennedy	Systematic reviews, qualitative evidence, SRH and HIV	Leading systematic reviews	
Ms Laura Beres	Systematic reviews, qualitative evidence, SRH, HIV, community health	Support for systematic reviews	
Dr Nandi Siegfried	Methodologist, clinical epidemiologist	Guideline methodologist	

# Annex 3. Priority questions and outcomes for the interventions identified for this guideline

PICO: P = Population; I = Intervention; C = Comparator; O = Outcomes

PICO questions (P–I–C)	Priority outcomes (O)
<p><b>PICO question 1</b> What interventions improve self-efficacy and empowerment around safer sex and reproductive decision-making for women living with HIV?</p> <p><b>P:</b> Women living with HIV (WLHIV) <b>I:</b> Interventions to address gender and power imbalances and increase self-efficacy and empowerment around safer sex and reproductive decision-making <b>C:</b> No intervention or standard of care</p>	<ol style="list-style-type: none"> <li>1. Self-efficacy, empowerment or other measure of ability to make one’s own decisions around safer sex, pregnancy termination, birth spacing, childbearing and other aspects of sexual and reproductive health</li> <li>2. Sexual or reproductive health behaviours (condom use, contraceptive use, etc.)</li> <li>3. Sexual or reproductive health outcomes (sexually transmitted infections [STIs], pregnancy, etc.)</li> </ol>
<p><b>PICO question 2</b> What interventions facilitate safe disclosure of HIV status for women living with HIV who fear violence or who disclose that they are currently experiencing violence?</p> <p><b>P:</b> WLHIV who fear violence or who disclose that they are currently experiencing violence <b>I:</b> Interventions to facilitate safe disclosure of HIV status <b>C:</b> No intervention</p>	<ol style="list-style-type: none"> <li>1. Disclosure</li> <li>2. Violence (physical, sexual, emotional)</li> <li>3. Fear of violence</li> <li>4. Other adverse events (relationship dissolution, abandonment, job loss, loss of children, loss of access to services, etc.)</li> <li>5. Positive outcomes (feelings of individual empowerment, safety, partner involvement, better physical health, HIV care and treatment engagement, adherence to antiretroviral therapy, etc.)</li> </ol>
<p><b>PICO question 3</b> What modes of delivery result in the best maternal and perinatal outcomes for women living with HIV?</p> <p><b>P:</b> WLHIV and their children <b>I:</b> Elective caesarean section (C-section) <b>C:</b> Other modes of delivery (non-elective C-section, vaginal delivery)</p>	<ol style="list-style-type: none"> <li>1. HIV infection in children born to WLHIV (efficacy of prevention of vertical transmission)</li> <li>2. Morbidity and mortality among WLHIV (including febrile morbidity, endometriosis, haemorrhage or severe anaemia, pneumonia and urinary tract infections)</li> <li>3. Morbidity and mortality among infants born to WLHIV (respiratory morbidity [respiratory distress syndrome and transient tachypnea of the newborn] and skin lacerations)</li> <li>4. Breastfeeding (success or timing of initiation and continuation)</li> </ol>
<p><b>PICO question 4</b> Do outcomes of medical and surgical abortion among women living with HIV differ from outcomes among HIV-uninfected women?</p> <p><b>P:</b> Women seeking an abortion <b>I:</b> Medical abortion among WLHIV <b>C:</b> Medical abortion among HIV-uninfected women</p>	<ol style="list-style-type: none"> <li>1. Efficacy (complete abortion)</li> <li>2. Serious adverse events (death, hospitalization, blood transfusion, etc.)</li> <li>3. Other adverse outcomes and side-effects (haemorrhage not requiring blood transfusion, vomiting, etc.)</li> <li>4. Patient satisfaction</li> </ol>

# Annex 4. Systematic and literature reviews

For each review, the team leader is indicated by \*

## Systematic reviews conducted for development of the new good practice statements (GPSs)

### Psychosocial support (NEW GPS A.1)

Beres LK, Narasimhan M, Robinson JL, Welbourn A, Kennedy CE\*. Non-specialist psychosocial support interventions with women living with HIV: a systematic review. *AIDS Care*. 2017 (under review).

### Healthy sexuality across the life course (NEW GPS A.2)

Narasimhan M\*, Payne C, Caldas S, Beard JR, Kennedy CE. Ageing and healthy sexuality among women living with HIV. *Reprod Health Matters*. 2016;24(48):43–51. doi:10.1016/j.rhm.2016.11.001.

### Economic empowerment and resource access (NEW GPS A.3)

Chop E, Duggaraju A, Flignor A, Burke V, Caldas S, Yeh PT, Narasimhan M, Amin A, Kennedy C\*. Food insecurity, sexual risk behaviour and adherence to antiretroviral therapy among women living with HIV: a systematic review. *Health Care Women Int*. 2017 (under review).

### Integration of SRHR and HIV services (NEW GPSs A.4 and A.5)

Kennedy CE, Haberlen SA, Narasimhan M\*. Integration of sexually transmitted infection (STI) services into HIV care and treatment services for women living with HIV: a systematic review. *BMJ Open*. 2017 (in press).

Haberlen S, Narasimhan M, Beres LK, Kennedy CE\*. Integration of family planning services into HIV care and treatment services: a systematic review. *Stud Family Plann*. 2017. doi:10.1111/sifp.12018.

## Systematic reviews conducted for development of the new recommendations (RECs)

### Empowerment and self-efficacy (NEW REC B.1)

Robinson JL, Narasimhan M, Amin A, Morse S, Beres LK, Yeh PT, Kennedy CE\*. Interventions to address unequal gender and power relations and improve self-efficacy and empowerment around sexual and reproductive health decision-making for women living with HIV: a systematic review. *PLoS One*. 2017 (under review).

### Safe disclosure (NEW RECs B.4 and B.5)

Kennedy CE, Haberlen S, Amin A, Baggaley R, Narasimhan M\*. Safer disclosure of HIV serostatus for women living with HIV who experience or fear violence: a systematic review. *J Int AIDS Soc*. 2015;18(6 Suppl 5):20292. doi:10.7448/IAS.18.6.20292.

### **Caesarean section (NEW REC B.22)**

Kennedy CE\*, Yeh PT, Pandey S, Betrán AP, Narasimhan M. Elective caesarean section for women living with HIV: a systematic review of risks and benefits. *AIDS Care*. 2017 (under review).

### **Clinical care for women living with HIV undergoing abortion (NEW RECs B.30 and B.31)**

Saleem H, Kennedy CE\*, Ganatra B, Narasimhan M. Medical and surgical abortion for women living with HIV: a systematic review. *Cochrane Database Syst Rev*. 2017 (in press).

## **Literature reviews and other papers prepared in the development of the guideline**

### **Literature reviews on human rights:**

Kumar S, Gruskin S\*, Khosla R, Narasimhan M. Human rights and the sexual and reproductive health of women living with HIV – a literature review. *J Int AIDS Soc*. 2015;18(Suppl 5):20290. doi:10.7448/IAS.18.6.20290.

Khosla R\*, Van Belle N, Temmerman M. Advancing the sexual and reproductive health and human rights of women living with HIV: a review of UN, regional and national human rights norms and standards. *J Int AIDS Soc*. 2015;18(Suppl 5):20280. doi:10.7448/IAS.18.6.20280.

### **Literature review on the social ecological approach:**

Saleem H, Narasimhan M\*, Denison JA, Kennedy CE. Achieving pregnancy safely for HIV-serodiscordant couples: a social ecological approach. *J Int AIDS Soc*. 2017;20(Suppl 1):21331. doi:10.7448/IAS.20.2.21331.

### **Methodological paper on the use of GRADE:**

Siegfried N\*, Narasimhan M, Kennedy C, Welbourn A, Yuvaraj A. Using GRADE as a framework to guide research on the sexual and reproductive health and rights of women living with HIV – a methodological paper. *AIDS Care*. 2017 (in press).

# Annex 5. Guideline Development Group (GDG) judgements related to the new recommendations

Recommendation	REC B.1	REC B.4	REC B.5
Intervention	Empowerment and self-efficacy	Safe disclosure	Safe disclosure
<b>Certainty of the evidence</b>	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input checked="" type="checkbox"/> Low <input type="checkbox"/> Very low	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input checked="" type="checkbox"/> Low <input type="checkbox"/> Very low	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input checked="" type="checkbox"/> Low <input type="checkbox"/> Very low
<b>Values and preferences of women living with HIV</b>	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options
<b>Resource use</b>	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options
<b>Equity</b>	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options	<input type="checkbox"/> Favours this option <input checked="" type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options
<b>Acceptability</b>	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options
<b>Feasibility</b>	<input type="checkbox"/> Favours this option <input checked="" type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options
<b>Balance of benefits versus disadvantages</b>	<input checked="" type="checkbox"/> Benefits outweigh disadvantages <input type="checkbox"/> Benefits and disadvantages are balanced <input type="checkbox"/> Disadvantages outweigh benefits	<input checked="" type="checkbox"/> Benefits outweigh disadvantages <input type="checkbox"/> Benefits and disadvantages are balanced <input type="checkbox"/> Disadvantages outweigh benefits	<input checked="" type="checkbox"/> Benefits outweigh disadvantages <input type="checkbox"/> Benefits and disadvantages are balanced <input type="checkbox"/> Disadvantages outweigh benefits
<b>GDG decision</b>	<input checked="" type="checkbox"/> Recommended <input type="checkbox"/> Conditional <input type="checkbox"/> Not recommended	<input checked="" type="checkbox"/> Recommended <input type="checkbox"/> Conditional <input type="checkbox"/> Not recommended	<input checked="" type="checkbox"/> Recommended <input type="checkbox"/> Conditional <input type="checkbox"/> Not recommended



Recommendation	REC B.22	REC B.30	REC B.31
Intervention	Caesarean section	Safe abortion	Safe abortion
<b>Certainty of the evidence</b>	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input checked="" type="checkbox"/> Low <input type="checkbox"/> Very low	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input checked="" type="checkbox"/> Very low	<input type="checkbox"/> High <input type="checkbox"/> Moderate <input type="checkbox"/> Low <input checked="" type="checkbox"/> Very low
<b>Values and preferences of women living with HIV</b>	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options
<b>Resource use</b>	<input type="checkbox"/> Favours this option <input checked="" type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options
<b>Equity</b>	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options
<b>Acceptability</b>	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options
<b>Feasibility</b>	<input type="checkbox"/> Favours this option <input checked="" type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options	<input checked="" type="checkbox"/> Favours this option <input type="checkbox"/> Neither favours this option or other options <input type="checkbox"/> Favours other options
<b>Balance of benefits versus disadvantages</b>	<input checked="" type="checkbox"/> Benefits outweigh disadvantages <input type="checkbox"/> Benefits and disadvantages are balanced <input type="checkbox"/> Disadvantages outweigh benefits	<input checked="" type="checkbox"/> Benefits outweigh disadvantages <input type="checkbox"/> Benefits and disadvantages are balanced <input type="checkbox"/> Disadvantages outweigh benefits	<input checked="" type="checkbox"/> Benefits outweigh disadvantages <input type="checkbox"/> Benefits and disadvantages are balanced <input type="checkbox"/> Disadvantages outweigh benefits
<b>GDG decision</b>	<input checked="" type="checkbox"/> Recommended <input type="checkbox"/> Conditional <input type="checkbox"/> Not recommended	<input checked="" type="checkbox"/> Recommended <input type="checkbox"/> Conditional <input type="checkbox"/> Not recommended	<input type="checkbox"/> Recommended <input checked="" type="checkbox"/> Conditional <input type="checkbox"/> Not recommended



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