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▶ Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations.

World Health Organization.
World Health Organization, 2014.
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Consolidates WHO guidance on HIV prevention, diagnosis, treatment and care for key populations including prisoners and people who inject drugs. Strongly advocates universal access of injectors to needle exchange and of dependent opioid users to indefinite, high dose methadone and buprenorphine maintenance.

SUMMARY In these new consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations, the World Health Organization (WHO) brings together all existing guidance relevant to five key populations – men who have sex with men; people who inject drugs; people in prisons and other closed settings; sex workers; and transgender people – and updates selected guidance and recommendations. These guidelines aim to: provide a comprehensive package of evidence-based HIV-related recommendations for all key populations; increase awareness of the needs of and issues important to key populations; improve access, coverage and uptake of effective and acceptable services; and catalyze greater national and global commitment to adequate funding and services.

The risk behaviours and vulnerabilities of key populations result in their being disproportionately affected by HIV in all countries and settings. These disproportionate risks reflect both behaviour common among members of these populations and specific legal and social issues that increase their vulnerability. Yet HIV services for key populations remain largely inadequate. In many settings, HIV incidence in key populations continues to increase, even as incidence stabilises or declines in the general population.

To date WHO has developed guidance separately for each of the five key populations, but in general, guidance has not adequately addressed overarching issues relating to key populations. Similarly, the WHO global HIV guidance, including the 2013 consolidated antiretroviral guidelines, did not specifically consider issues relating to key populations. The new guidelines aim to address these gaps and limitations, addressing the issues and elements for effective HIV service delivery common to all key populations, as well as those specific to one or more groups.

General recommendations

The following recommendations apply to all key groups including drug users.

The correct and consistent use of condoms with condom-compatible lubricants is recommended to prevent sexual transmission of HIV and sexually transmitted infections.
Post-exposure prophylaxis should be available to all eligible people from key populations on a voluntary basis after possible exposure to HIV.
Voluntary medical male circumcision is recommended as an additional, important strategy for the prevention of heterosexually acquired HIV infection in men, particularly in settings with hyperendemic and generalised HIV epidemics and low prevalence of male circumcision.
Voluntary HIV testing and counselling should routinely be offered to all key populations both in the community and in clinical settings. Community-based HIV testing and counselling for key populations, linked to prevention, care and treatment services, is recommended, in addition to provider-initiated testing and counselling.
Key populations living with HIV should have the same access to antiretroviral therapy and to its management as other populations.
All pregnant women from key populations should have the same access to services for prevention of mother-to-child transmission and follow the same recommendations as women in other populations.
Key populations should have the same access to tuberculosis prevention, screening and treatment services as other populations at risk of or living with HIV.
Key populations should have the same access to hepatitis B and C prevention, screening and treatment services as other populations at risk of or living with HIV.
Routine screening and management of mental health disorders (depression and psychosocial stress) should be provided for people from key populations living with HIV in order to optimise health outcomes and improve their adherence to antiretroviral therapy. Management can range from co-counselling for HIV and depression to appropriate medical therapies.
Screening, diagnosis and treatment of sexually transmitted infections should be offered routinely as part of comprehensive HIV prevention and care for key populations.
People from key populations, including those living with HIV, should be able to experience full, pleasurable sex lives and have access to a range of reproductive options.
Abortion laws and services should protect the health and human rights of all women, including those from key populations.
It is important to offer cervical cancer screening to all women from key populations.
It is important that all women from key populations have the same support and access to services related to conception and pregnancy care, as women from other groups.

Recommendations related to drug use

The package of interventions required to respond effectively to HIV among key populations in general is essentially the same for people who inject drugs. It is important that countries where injecting drug use occurs prioritise immediate implementation of needle and syringe programmes and opioid substitution therapy. Implementation of these essential harm reduction services should facilitate and enhance access to HIV-specific services, such as HIV testing and counselling and antiretroviral therapy, and improve adherence to treatment. Harm reduction interventions for people who use drugs but who do not inject are also important. They should include evidence-based drug dependence treatment and provision of non-injecting drug use paraphernalia as appropriate to the local context and patterns of drug use.

Needle and syringe programmes

Once HIV is introduced in a population of people who inject drugs and commonly share syringes and injecting equipment, prevalence rates can reach epidemic proportions very quickly. Distributing free or low-cost sterile injecting equipment to injectors facilitates the use of clean needles and syringes and reduces the number of injections with used needles and syringes. Needle and syringe programmes substantially and cost-effectively reduce HIV transmission among injectors and may also reduce transmission of other

blood-borne viruses, such as hepatitis B and C. At the same time, programmes do not encourage drug use or injecting.

Needle and syringe programmes may serve as an important point of entry to other services. Aiming to engage their clients repeatedly on a regular basis, they have multiple opportunities to facilitate access to other health services such as opioid substitute prescribing and other drug dependence treatment, HIV testing and counselling, and treatment of HIV, tuberculosis and viral hepatitis. Programmes may also offer basic health care and address other specific issues that commonly affect drug injectors, such as wound care and overdose prevention.

Service delivery models include distribution at fixed sites such as pharmacies, automatic dispensing machines or vending machines, and mobile and outreach services. Additionally, given the high incarceration rates of people who inject drugs, access to sterile injecting equipment and needle and syringe programmes are important components of prison health services.

Recommendations

The featured guidelines strongly recommended that all individuals from key populations who inject drugs should have access to sterile injecting equipment through needle and syringe programmes.

They also suggested that programmes provide low dead-space syringes along with information about their preventive advantages, and that injecting equipment should be appropriate to the local context, taking into account such factors as the type and preparation of drugs commonly injected.

Opioid substitution therapy

Effective treatments for drug dependence can reduce illicit drug use and hence the frequency of injection, as well as improve health and social functioning. For people dependent on opioids, treatments which substitute other opiate-type drugs (opioid substitution therapy) for those the patient has become dependent on are highly effective in reducing injecting behaviours that risk HIV. Such treatments can reduce opioid use and improve retention in HIV treatment. Access and adherence to these treatments can improve health, reduce overdoses and resulting mortality, reduce crime, improve psychosocial outcomes and decrease risk to pregnant women dependent on drugs and to their infants. Methadone and buprenorphine, both of which are on WHO's list of essential medicines, are the most commonly used substitute medications.

To achieve optimal coverage and treatment outcomes, opioid substitution therapy should be provided free or via public health-care insurance and should be accessible to all those in need, including those in prison and other closed settings. It should not be compulsory; patients must give informed consent. To be most effective, therapy should be provided as maintenance treatment for sufficient duration and at adequate doses. Programmes should create supportive environments and relationships to facilitate coordinated treatment of co-morbid mental and physical health issues and address relevant psychosocial factors.

Recommendations

The guidelines strongly recommended that all people from key populations who are dependent on opioids should be offered opioid substitution therapy in keeping with WHO guidance, including those in prison and other closed settings.

The guidelines added that:
To maximize safety and effectiveness, policies and regulations should encourage flexible dosing structures, without restricting dose levels or duration of treatment. Usual methadone doses should be 60–120mg per day, and average buprenorphine doses should be at least 8mg per day. Take-home doses can be offered when the dose and social situation are stable and when there is little risk of diversion for illegitimate purposes.
Opioid substitution therapy is most effective as a maintenance treatment for longer periods of time (treatment for years may be necessary). Detoxification or opioid withdrawal (rather than maintenance treatment) results in poor outcomes in the long term. However, patients should be helped to withdraw from opioids if it is their informed choice to do so.
Rather than attempting detoxification, opioid substitution therapy should be used for the treatment of opioid dependence in pregnancy.
Psychosocial support should be available to all opioid-dependent people, in association with pharmacological treatments of opioid dependence. At a minimum this support should include assessment of psychosocial needs, supportive counselling and links to family and community services.
For opioid-dependent people with tuberculosis, viral hepatitis B or C or HIV, opioid medications should be administered in conjunction with medical treatment. There is no need to wait for abstinence from opioids to start treatment for these conditions.
Treatment services should offer hepatitis B vaccination to all opioid-dependent patients, whether or not they are in substitute prescribing programmes.
Care settings that provide substitute prescribing should initiate and maintain antiretroviral therapy for eligible people living with HIV.
Countries should affirm and strengthen the principle of providing treatment, education and rehabilitation as an alternative to conviction and punishment for drug-related offences.
Prison authorities in countries where opioid substitution therapy is available in the community should urgently introduce these programmes and expand them to scale as soon as possible.
Care should be taken to see that people on opioid substitution therapy before entering prisons or other closed settings can continue without interruption while imprisoned and when transferred between settings, and can be linked to community-based therapy on release. Providing opioid substitution therapy before release can help reduce overdose-related mortality.
In the early phase of treatment, administration of methadone and buprenorphine doses should be directly supervised. Take-home doses can be recommended when the dose and social situation are stable and when there is a low risk of diversion for illegitimate purposes.
Involuntary discharge from treatment is sometimes justified to ensure the safety of staff and other patients, but failure to follow programme rules alone should not generally be a cause of involuntary discharge. Before involuntary discharge, reasonable measures to improve the situation should be taken, including re-evaluating the treatment approach.

Other drug dependence treatments

Drug dependence treatment aims to achieve and maintain physical, psychological and social wellbeing by reducing the risktaking associated with drug use, reducing levels of drug use, or by promoting abstinence. Because of the chronic, relapsing nature of drug dependence and the need to address social and psychological dimensions, achieving abstinence, if desired, is often a lengthy and difficult process. Providing 'stepping stones' or 'stabilising strategies' – short-term, more achievable goals – can help to define and structure progress. It can also help to reduce drug-related harms, one of which is the transmission of blood-borne viruses such as HIV and hepatitis B and C.

Containing the spread of HIV is more successful where there is a comprehensive and varied range of evidence-based services for drug dependence treatment. Drug dependence treatment helps to prevent HIV by reducing injecting drug use, the sharing of injecting equipment, and sexual risk behaviours, and by creating opportunities for HIV education and medical care.

Recommendations

Evidence on the impact of other forms of drug dependence treatment on HIV incidence is less compelling than that for opioid substitution therapy and needle and syringe programmes. Still, these other interventions are recommended where non-opioid drugs such as amphetamine-type stimulants, cocaine, sedatives and hypnotics are widely used, and where opioid substitution therapy

remains unavailable.

All key populations with harmful alcohol or other substance use should have access to evidence-based interventions, including brief psychosocial interventions involving assessment, specific feedback and advice.
Prisoners should have access to the same evidence-based treatment options for substance dependence as people in the community.
To reduce over-incarceration and prison overcrowding, which increase the risk of HIV infection, it is important that countries review their laws and policies that criminalise people for their consumption of alcohol or drugs

Opioid overdose prevention and management

Worldwide, drug overdose is the leading cause of death among people who inject drugs and a common cause of non-HIV-related deaths among people with HIV. An estimated 69,000 people die from drug overdoses each year. Opioid overdose is both preventable and, if witnessed, treatable. Opioid substitution therapy provides the most effective prevention among people dependent on opioids. Opioid overdose is treatable by respiratory support and via the short-acting opioid antagonist [blocks the effects of opiate-type drugs] naloxone. Naloxone has a long clinical history of successful use for the treatment of opioid overdose. The medication has no effect if opioids are absent and has no potential for abuse. Naloxone is included in WHO's list of essential medicines.

While naloxone has long been widely used by medical staff and in health-care facilities, a number of countries in several regions have recently started community-based distribution – allowing distribution and administration by people dependent on opioids and their peers and family members as well as by first-responders such as police and emergency services. Greater availability of naloxone through community-based distribution could help reduce the high rates of opioid overdose, particularly where access to essential health services is limited for people who inject drugs.

Recommendations

People likely to witness an opioid overdose should have access to naloxone and be instructed in its use for emergency management of suspected opioid overdose.
Naloxone is effective when delivered by intramuscular, intranasal, intravenous and subcutaneous routes. Persons administering naloxone should select the route based on formulation available, skills in administration, setting and local context.
In suspected opioid overdose, first-responders should focus on maintaining an airway, assisting ventilation and giving naloxone.
After successful resuscitation following administration of naloxone, the affected person's level of consciousness and breathing should be closely observed, where possible, until they have fully recovered.

Outreach

Community-based outreach is not listed as a separate intervention, but is an effective way to reach people, particularly those who face barriers to obtaining mainstream services, as is often the case for the key populations. Outreach is a highly effective means of delivering HIV prevention interventions such as needle and syringe programmes, condom programmes and targeted communication, as well as a useful access point for referral to opioid substitution therapy and antiretroviral therapy. Hence, outreach is an essential component of all HIV-related programmes.

Critical enablers

The following were seen as critical to enabling implementation of the report's recommendations.

Laws, policies and practices should be reviewed and, where necessary, revised by policymakers and government leaders, with meaningful engagement of stakeholders from key population groups, to allow and support the implementation and scale-up of health-care services for key populations.
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.
Health services should be made available, accessible and acceptable to key populations, based on the principles of medical ethics, avoidance of stigma, non-discrimination and the right to health.
Programmes should work toward implementing a package of interventions to enhance community empowerment among key populations.
Violence against people from key populations should be prevented and addressed in partnership with key population-led organisations. All violence against people from key populations should be monitored and reported, and redress mechanisms should be established to provide justice.

Developing a national response

Apart from the chapters dealing with key groups and interventions, in chapter 7 the guidelines offer guidance on developing a national response to HIV prevention including: guiding principles such as inclusiveness, human rights and equity; understanding the situation, including key population size and distribution and risk profiles; planning and implementing the response, including targeting risk groups, selecting interventions and required resources; monitoring and evaluating the response; and ongoing planning and development of the response.

FINDINGS COMMENTARY Where these guidelines run most obviously counter to recently developed UK government policy is in their insistence that indefinite, high dose methadone and buprenorphine maintenance should be the dominant and first-line response to addiction to drugs like heroin. Though this (except for reticence about high doses) has been the practice in the UK, the dominance of these approaches is challenged by government policy which now seeks to "ensure that open-ended substitute prescribing in the community is only used where absolutely necessary" and favours recovery from addiction in the form of abstinence, social reintegration and treatment exit.

This policy runs counter to the characteristics thought to make methadone and allied programmes effective public health tools in the prevention of infection: a widely provided and easily accessible frontline treatment rather than one reserved for the "absolutely necessary" and provided long-term without expecting early or even any termination. An expert group acting on behalf the British government has sought to reconcile this dilemma, allying a recovery orientation with continued long-term methadone prescribing for those who need it, but there are concerns that the public health achievements of recent years will be jeopardised by the new policy focus. For more see this hot topic entry on the longstanding controversy over prescribing opiates to opiate addicts.

These consolidated WHO guidelines reiterate and incorporate earlier guidance from WHO specific to medication-based treatments for opioid dependence.

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