

A COMMUNITY GUIDE TO WHO HIV TREATMENT GUIDELINES



October 2020

ABOUT ITPC

The International Treatment Preparedness Coalition (ITPC) is a global network of people living with HIV and community activists working to achieve universal access to optimal HIV treatment for those in need. Formed in 2003, ITPC actively advocates for treatment access across the globe through the focus of three strategic pillars:

Treatment education and demand creation (#TreatPeopleRight)
Intellectual property and access to medicines (#MakeMedicinesAffordable)
Community monitoring and accountability (#WatchWhatMatters)

To learn more about ITPC and our work, visit itpcglobal.org.

ABOUT TREAT PEOPLE RIGHT

Treatment education is at the core of ITPC's work to empower people living with HIV and their allies with information about HIV treatment and access issues. People living with HIV and their allies can use our resources to decide what to fight for, why to fight for it and how to fight for it.

ITPC conducts treatment education trainings, and creates and shares resources and tools needed to enable communities and treatment activists to work on the issues that impact their health. Use hashtag **#TreatPeopleRight** to join the conversation online.

ABOUT THIS REPORT

This guide is based on the World Health Organization's **July 2019 Update of Recommendations on first- and second-line antiretroviral regimens**, available at: <https://apps.who.int/iris/bitstream/handle/10665/325892/WHO-CDS-HIV-19.15-eng.pdf>

People living with HIV must be included in the development of policies and guidelines that impact their health and lives - this is known as **GIPA, the greater involvement of people living with HIV/AIDS**.

The guide was written for people living with or at risk for HIV, their communities, networks and allies, with the aim to improve access to and quality of HIV prevention, testing, care and treatment services. To read or download this report from the ITPC Global website, click <https://itpcglobal.org/resource/community-guide-to-who-hiv-treatment-guidelines>

FOR MORE INFORMATION

To learn more about Treat People Right and our community-led monitoring work, send us an email at admin@itpcglobal.org.

ACKNOWLEDGEMENTS

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LIST OF ABBREVIATIONS AND ACRONYMS

AHD	advanced HIV disease
ART	antiretroviral therapy
ARV	antiretroviral
CAG	community adherence group
DSD	differentiated service delivery
DTG	dolutegravir
EDP	event-driven PrEP
EFV	efavirenz
EU	European Union
FDC	fixed-dose combination
HIV	human immunodeficiency virus
GIPA	greater involvement of people living with HIV/AIDS
INSTI	integrase strand transfer inhibitor
ITPC	International Treatment Preparedness Coalition
LMIC	low- and middle-income countries
MSM	men who have sex with men
NGO	non-governmental organization
NTD	neural tube defects
OI	opportunistic infections
PMTCT	prevention of mother-to-child transmission
PrEP	HIV pre-exposure prophylaxis
PWID	people who inject drugs
SRHR	sexual and reproductive health and rights
TB	tuberculosis
TDF	tenofovir
US	United States
WHO	World Health Organization

COMMUNITY ENGAGEMENT

“Nothing for us without us”

Community engagement is a structured, supported, meaningful and accountable process that ensures that people living with HIV have a VOICE in decision-making, planning, implementation, monitoring and evaluation to achieve and maintain access to quality HIV care for all.

CENTRAL PILLARS & PRINCIPLES OF COMMUNITY ENGAGEMENT

PLHIV Centered

No services should be provided without the meaningful participation of recipients of care.

Meaningful

Any engagement should not be tokenistic or in any way use communities for rubber stamping decisions or processes.

Consistent

Should not be haphazard or convenient.

Transparent

Every engagement should be without hidden agendas.

Structured

Engagement must be deliberate, well planned, well organized with clear roles, responsibilities and outcomes.

Equity

All parties should have equal opportunities/ voices at all levels of engagement. There are no lesser people or organizations.

Supported

Resources should be allocated to communities so that they can engage at all levels.

Accountability

All parties, including communities, should be responsible for their action and/or inaction at all levels.

Sustainability

There should be no end to engaging communities.

LEVELS & AREAS OF COMMUNITY ENGAGEMENT

Levels of engagement

- At policy level
- At programming level
- At community level

Areas of engagement at each level

- Design of each level
- Implementation of each level
- Monitoring of each level

Source: *Community Engagement Framework, The CQUIN Recipients of Care Engagement Working Group* (November 2019), available at https://cquin.icap.columbia.edu/wp-content/uploads/2020/01/Community-Engagement-Framework_FINAL.pdf

PROCESS FOR GATHERING COMMUNITY FEEDBACK

This guide was developed by the International Treatment Preparedness Coalition (ITPC Global) and a Technical Review Committee, and perspectives from focus groups, in-depth interviews, and an online community survey.

WORLD HEALTH ORGANIZATION GUIDELINES ON HIV

The World Health Organization (WHO) develops evidence-based guidelines for HIV testing, prevention, care, treatment and service delivery in low- and middle-income countries (LMIC). Community representatives, including people living with HIV, are meaningfully involved in the development of WHO guidelines.

KEY POPULATIONS

Key populations are groups of people who are more vulnerable to HIV than the general population. People who are members of key populations often lack access and face high barriers to HIV services. Key populations are:

- **Gay men and other men who have sex with men (MSM)**
- **Prisoners**
- **People who inject drugs (PWID)**
- **Sex workers**
- **Transgender people**

Globally, more than 50% of HIV infections are among people who are members of key populations and their sex partners. WHO has issued recommendations for HIV services for people who are members of key populations, to ensure that HIV services meet their needs. WHO's Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations (2016 update) is available at:

<https://www.who.int/hiv/pub/toolkits/keypopulations-2016-update/en/>

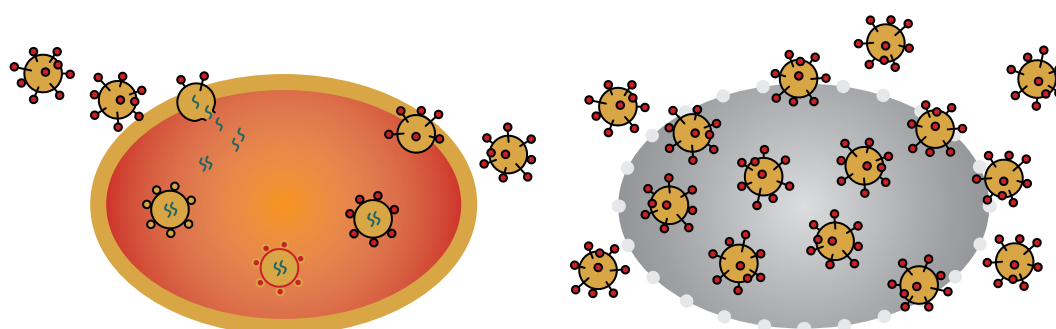
HIV TESTING and CD4 CELL COUNT

Getting tested is the first step towards better health, quality of life and a normal lifespan for people living with HIV. Treatment – called antiretroviral therapy (ART) - can stop HIV from damaging the immune system and allow it to recover. It also prevents HIV from spreading (see U=U and viral load).

Untreated HIV weakens the immune system by taking over CD4 cells, which are white blood cells that help coordinate the body's fight against infections. HIV turns these cells into virus factories. Each CD4 cell can make many new copies of HIV before it dies. After these new copies leave the cell, they go into the bloodstream and enter more CD4 cells. Over time, as this keeps happening, a person's immune system gets weaker.

HIV testing must always be **voluntary** and should be widely **available** in community and healthcare settings. People should get **counseling** before and after an HIV test, and be linked to **healthcare** and **support services** that they need.

FIGURE 1. HIV AND CD4 CELLS



All adults, adolescents and children over age 5 should get a CD4 cell count after they are diagnosed with HIV. A CD4 cell count is used to see how strong a person's immune system is. A normal CD4 cell count ranges from 500 to 1,500 cells/mm³. When the CD4 cell count falls below 200 cells/mm³, people become vulnerable to certain serious illnesses, called opportunistic infections (OI).

ADVANCED HIV DISEASE

Up to half of all people living with HIV do not get tested until they have advanced HIV disease (AHD). People with AHD are at high risk of serious illness and death, because untreated HIV has weakened their immune system.

AHD is defined as a CD4 cell count under 200 cells/mm³ and/or serious HIV-related illness in people over age 5. All children living with HIV who are under age five have AHD.

WHO has special guidelines for treating people with AHD. They include screening, prevention and **treatment for OIs**, and **starting ART** as soon as possible, with counseling and adherence support, available at: <https://apps.who.int/iris/bitstream/handle/10665/255884/9789241550062-eng.pdf>

HIV testing has become quicker, easier and more convenient. Rapid test results can be ready within 20 minutes. In some places, people can do rapid HIV self-testing, with support from telephone hotlines, texting, videos, social media and the Internet. As of 2019, 77 countries had policies that support HIV self-testing.

In places with high HIV rates (over 5%), everyone should be offered HIV testing, and it should be part of all health care services.

In places with low HIV rates (under 5%), testing should be offered to:

- everyone who has symptoms – at any age
- people with tuberculosis (TB) and viral hepatitis
- all pregnant women
- children who have been exposed to HIV
- people who are members of key populations and their partners

HIV testing should also be available to anyone who wants to be tested.

HIV COUNSELING

Before anyone gets an HIV test, they need to get clear information about what the results mean, the risks and benefits of testing, where HIV prevention, care and treatment services are available, and their rights (to ask questions, to refuse testing, and to know that their result - and anything they discuss with the counselor - is confidential) before giving informed consent.

Post-test counseling for people with a negative test result includes explaining the result, giving information about, and referral to HIV prevention services, encouraging partner testing, recommending repeat testing for people at recent risk – and testing every 6-12 months for people at ongoing risk.

Post-testing for people with a positive test result includes explaining the result, answering questions and addressing concerns (including who can support them, their physical safety and mental health, and how to tell partners and family members) as well as information about HIV prevention, benefits of ART, and where to find these and other medical and support services. People may start ART right away or make an appointment to do so.

Post-test counseling for pregnant women with a positive test result includes talking about childbirth plans and prevention of mother-to-child transmission (PMTCT), information about nutrition, follow-up testing for infants and choices for feeding them.

Post-test counseling for people with a positive test result who are members of key populations should include linking them with the services they need, such as harm reduction programs and peer support.

Post-test counseling for adolescents with a positive test result should include links to the age-based medical and support services they need, including peer support and help with disclosure, and information on confidentiality and their rights and responsibilities.

HIV PRE-EXPOSURE PROPHYLAXIS

“This information should reach everybody, and it needs to be packaged in a simple way that is understandable and also removes the stigma.”

HIV pre-exposure prophylaxis (PrEP) is a once-daily pill that is part of HIV prevention. In studies, when PrEP was taken every day, it lowered the risk of getting HIV from sex by over 95%. PrEP should be offered to people who are at risk for HIV, with information and support for adherence (meaning taking it as directed so that it works).

PrEP is made up of the same drugs (tenofovir with lamivudine or emtricitabine) that are used as part of HIV treatment. PrEP can be used by men, cisgender women (including with hormonal contraceptives, during pregnancy and breastfeeding), transgender women and adolescents who weigh more than 35kg who are at risk for HIV. PrEP does not prevent other sexually transmitted infections.

Although access to PrEP is increasing, it is not available everywhere or to everyone who needs it. Communities need to share information about PrEP to increase demand and to make sure that people know how to use it. Cisgender and transgender women need to take PrEP every day for it to work. Men who have sex with men (MSM) can use PrEP before and after they have sex; this is called event-driven PrEP (EDP). Studies of EDP reported that it reduced the risk of getting HIV from sex among MSM by 86-97%. For more information about event-driven PrEP, see ***What’s The 2 +1 +1? Event-Driven Oral Pre-Exposure Prophylaxis to Prevent HIV for Men Who Have Sex With Men: Update to Who’s Recommendation on Oral Prep*** (July 2019): <https://apps.who.int/iris/bitstream/handle/10665/325955/WHO-CDS-HIV-19.8-eng.pdf>

FIGURE 2. EVENT-DRIVEN PrEP



HIV TREATMENT

“ [I would start treatment]... immediately, because I know the research shows that is better - but if it actually happened, I might have a different response.”

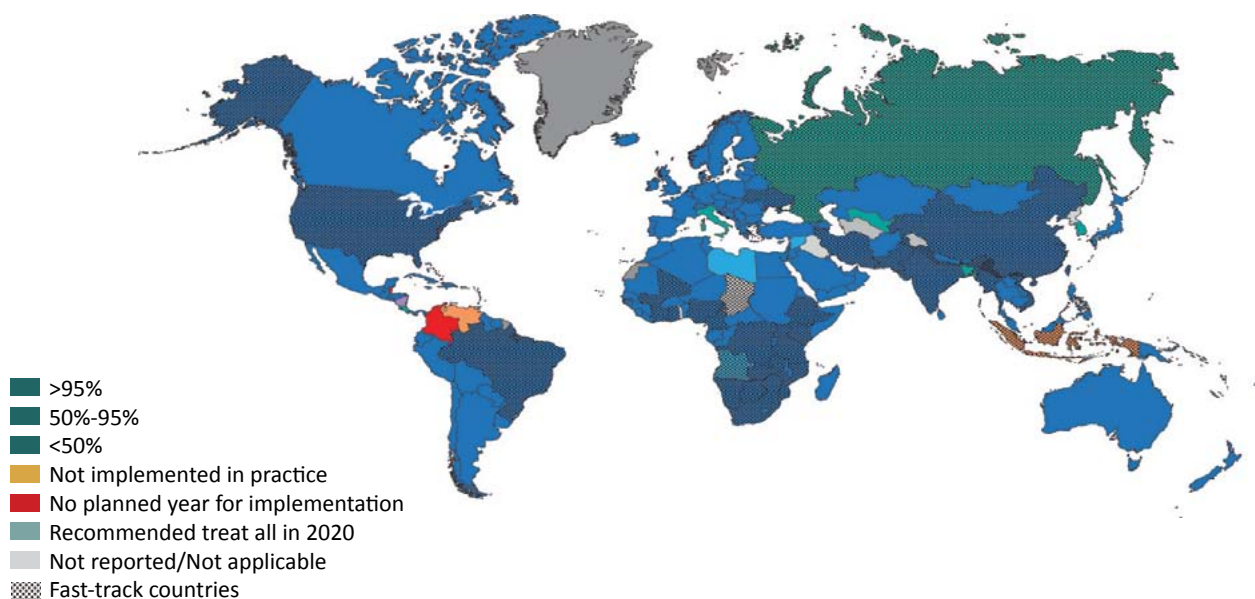
Since 2015, WHO has recommended ART for everyone living with HIV – babies, children, adolescents and adults. This is called ‘treat-all’. Starting ART as soon as possible can keep people living with HIV healthy and prevent HIV transmission, by keeping the amount of virus in a person’s body very low, called viral suppression. (see U = U).

As of 2019, 93% of all LMIC were ‘treating-all,’ and 5% more were scaling up.

Communities fought for affordable, generic ARVs, which has made ‘treat-all’ possible. Competition between generics producers has forced prices for HIV treatment down to affordable levels.

Communities play a vital role in sharing information about HIV and ART. Knowing about newer ARVs with fewer side effects is very important for people who do not feel ill from HIV, since ART is lifelong.

FIGURE 3. COUNTRIES THAT HAVE IMPLEMENTED WHO ‘TREAT-ALL’ RECOMMENDATION (July 2019)



ART: What It Does and What It Is

The goal of ART is to prevent HIV from multiplying and destroying CD4 cells. This allows the immune system to recover and stay strong.

ART is usually made up of a combination of three drugs, from at least two different classes, or families. They stop the HIV life cycle in different places so the virus cannot make more of itself. It’s the same idea as preventing a house robbery by locking the front door, the back door and the windows instead of locking only one or two of these.

TABLE 1. WHO-RECOMMENDED ARVs, BY CLASS

CLASS	DRUG NAMES	WHAT THEY DO
Integrase strand transfer inhibitors (INSTI)	Dolutegravir (DTG) Raltegravir (RAL)	INSTI stop HIV from getting inside and controlling the CD4 cell’s information center, called DNA
Non-nucleoside reverse transcriptase inhibitors (nNRTI)	Efavirenz (EFV) Nevirapine (NVP)	nNRTI attach themselves to part of HIV to prevent it from copying itself - just like having someone block your doorway so you cannot get out
Nucleoside/tide reverse transcriptase inhibitors (NRTI)	Abacavir (ABC) Emtricitabine (FTC) Lamivudine (3TC) Tenofovir (TDF) Tenofovir alafenamide (TAF)* Zidovudine (AZT)	NRTI work as fake building blocks –just like adding a false link to a gold chain to weaken it so it breaks
Protease inhibitors (PI)	Atazanavir/ritonavir (ATZ/r)** Darunavir/r (DRV/r)** Lopinavir/ritonavir (LPV/r)**	PI stop a part of HIV that works like a scissor so it cannot cut up new copies of itself

*TAF is a different form of tenofovir. It is used at a much lower dose (25 mg versus 300 mg). TAF can cause excessive weight gain when used with DTG. TAF cannot be used with TB treatment. Until there is more information on TAF during pregnancy, WHO recommends TAF only for people who have severe kidney disease and weakened bones - or as an alternative ARV for children.

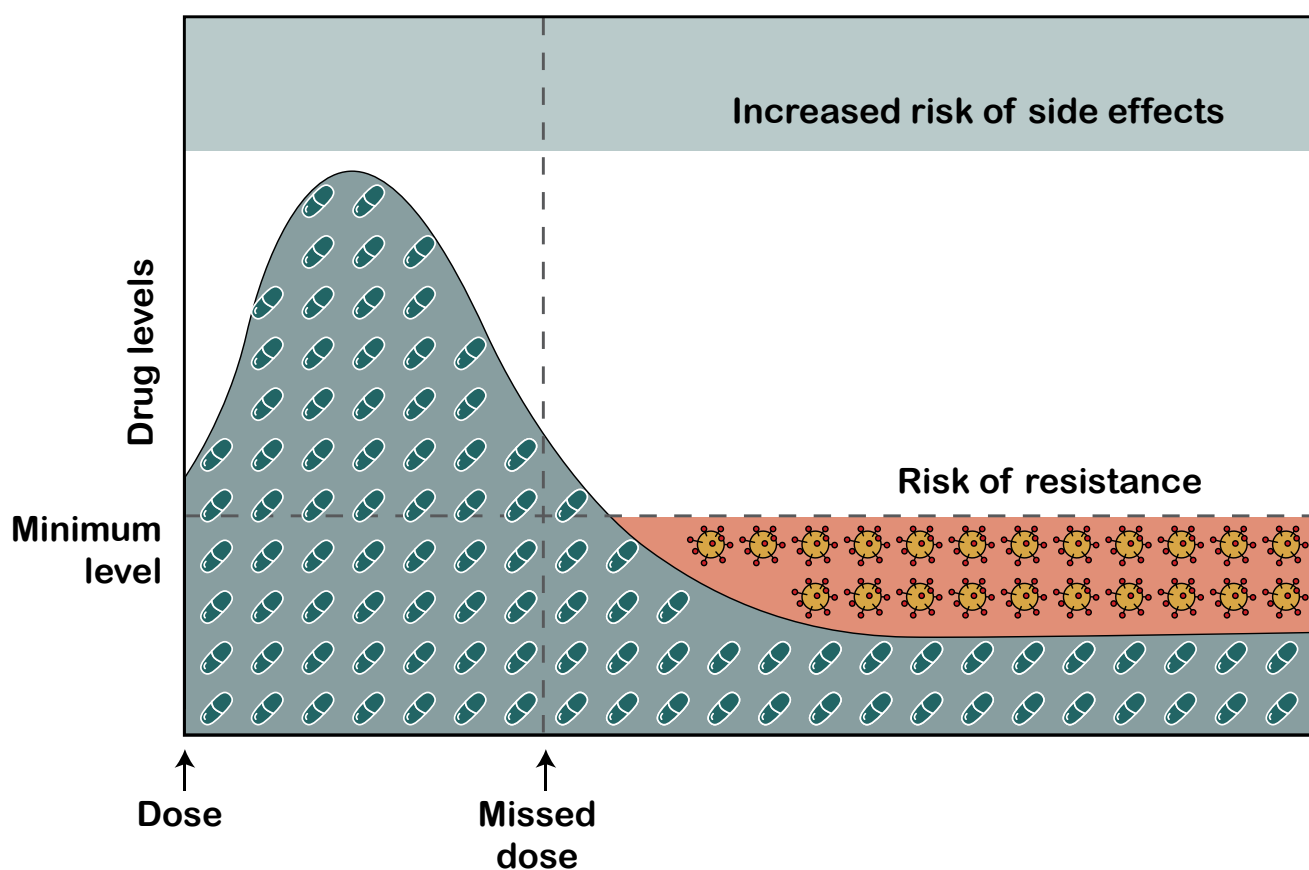
** Ritonavir (r) increases the amount of other drugs in the bloodstream - it is used with other PI as a “booster” to lower the number of pills a person takes.

Adherence and Resistance

To work, ART needs to be taken every day. This is called adherence. Adherence support is very important for people living with HIV – figuring out how they can fit ART into their lives, what helps them remember to take it and who can help them to take it. Some people join Community Adherence Groups/Community ART Groups (CAGs), which decongest clinics and empower people. CAG members take turns going to pick up ARVs – while getting blood work and other care- then distribute them to the group. CAG members usually meet at one member’s home to discuss their own health issues and other challenges and to give each another adherence and social support.

When a person misses ART doses, HIV has a chance to make more copies of itself. Some of these copies may have changes that can stop ART from working. When the person takes their ART again, it will not be able to stop the HIV that has these changes from making copies of itself. This is called drug resistance. Some people have HIV that has developed drug resistance to one or more ARVs because they have not been able to take their ART regularly, and some people get a form of HIV that is already resistant to some ARVs. They will need to switch to other ARVs.

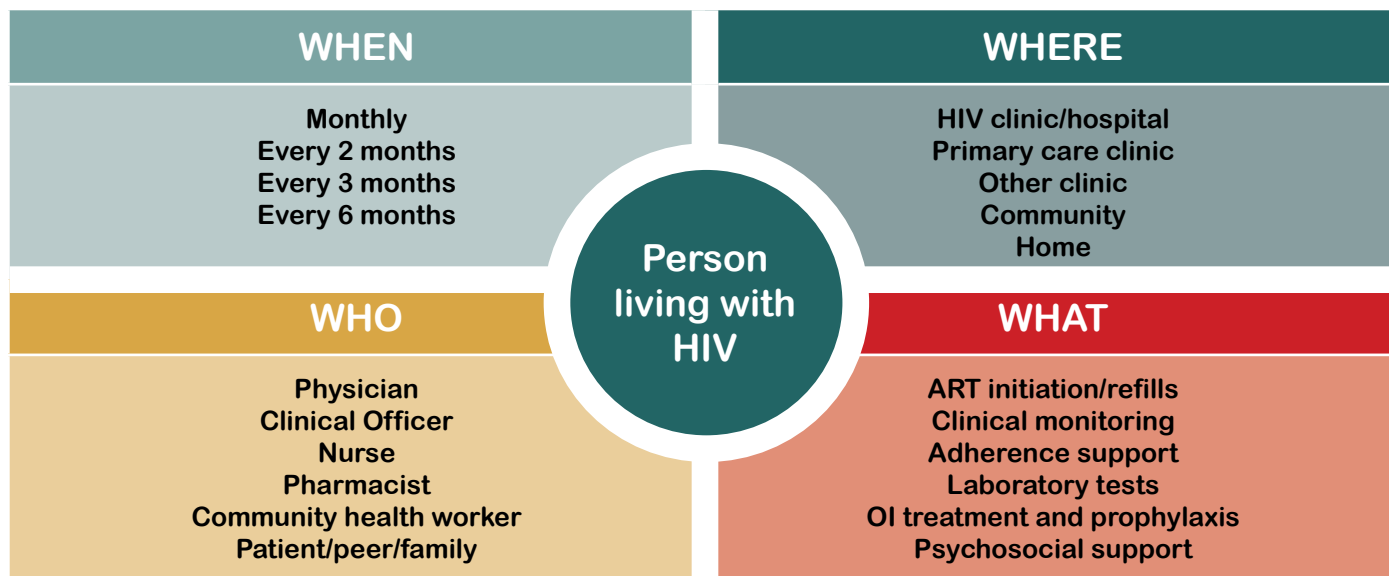
FIGURE 4. HIV DRUG RESISTANCE



DIFFERENTIATED SERVICE DELIVERY AND HIV TREATMENT*

Differentiated service delivery (DSD) is a way to provide HIV care and treatment that puts the person at the center by fitting services to what people who are living with HIV want and need. DSD covers the what, the where, the when and the who.

FIGURE 5. DIFFERENTIATED SERVICE DELIVERY



As examples, with DSD, sometimes people may need to see a healthcare provider more often, such as when they are starting ART, if they have fallen ill with an OI, or if they need support to help them adhere to treatment. Children, adolescents and pregnant women may need more frequent healthcare than a person who is healthy and doing well on ART.

DSD allows healthcare workers to focus on people with the most need, which improves the quality of care – and is more efficient.

Covid-19 has a huge impact on the world, including on HIV service delivery. People may be afraid to visit health centers, but they should not go without their ARVs or other important medical care. DSD is flexible; people should get multi-month ARV refills, from community distribution points, pharmacies, food stores, vending machines, by the post office or the internet to avoid waiting in crowded clinics.

Models of Differentiated ART Delivery

There are four main models for differentiated ART delivery:

- Clinic-based, one-on-one model – when a person living with HIV goes to pick up their own ART refills without adherence counseling or medical visit
- Out-of-facility-based, one-on-one model – when a person living with HIV goes to pick up their own ART refills somewhere that is not a clinic or medical facility
- Healthcare worker-managed group model/adherence group – People living with HIV receive their ART refills at a group run by a healthcare worker.
- Self-managed group – people living with HIV receive their ART refills at a self-managed group

* To learn more about DSD, see ***Differentiated Care For HIV: A Decision Framework for Antiretroviral Therapy Delivery***, available at https://www.differentiatedcare.org/Portals/0/adam/Content/yS6M-GKB5EWs_uTBHk1C1Q/File/Decision%20Framework.pdf

FIRST-LINE ART

First-line treatment, the ARVs that people begin with, are once-daily, and usually come as a fixed-dose combination (FDC) - meaning all the drugs are in one pill. It works well, has few side effects, is safe during pregnancy and breastfeeding and while a person is being treated for tuberculosis (TB). Many people can stay on their first-line treatment for years.

TABLE 2. WHO FIRST-LINE TREATMENT

AGE	FIRST-LINE	ALTERNATIVE
Newborns (up to 4 weeks old)	AZT + 3TC + RAL (2 NRTI + INSTI)	AZT + 3TC + NVP (2 NRTI + nNRTI)
Children (age up to 10 years)	ABC + 3TC + DTG* (2 NRTI + INSTI)	ABC + 3TC + LPV/r (2 NRTI + PI) ABC + 3TC + RAL (2 NRTI + INSTI) TAF + 3TC or FTC + DTG (2 NRTI + INSTI)
Adolescents and Adults	TDF + 3TC or FTC + DTG (2 NRTI + INSTI)	TDF+ 3TC+ EFV ₄₀₀ mg (2 NRTI + nNRTI)

* with approved DTG dosing

What is Dolutegravir (DTG)?

“DTG is dolutegravir, a new ART drug introduced to replace efavirenz.”

“I heard that DTG wasn’t safe for young women in their reproductive age but recently it is confirmed to be safe for all ages and for both men and women.”

DTG is a newer ARV. It is very effective, and likely to work for a long time – even if people miss doses once in a while. For most people, DTG has fewer side effects than efavirenz (EFV), and is easier to take with other common medicines.

FIGURE 6. DTG TIMELINE

- 2013** DTG, a new INSTI, is approved in the United States (US).
- 2014** DTG is approved in the European Union (EU).
- 2015** WHO recommends DTG as an alternative first-line ARV; it is not a preferred ARV because there is not enough information about using it during pregnancy and with TB treatment.
- 2018** WHO recommends DTG as a preferred first-line ARV.

Soon afterwards, Botswana’s Tsepamo study, which follows pregnant women on ART, reports a higher rate of neural tube defects (NTD; when the spine and brain do not develop normally) among babies born to women taking DTG at conception and during the first 12 weeks of pregnancy. This information led WHO to maintain efavirenz (EFV) as part of first-line ART for women of childbearing age – including pregnant women, based on its well-known safety and effectiveness. DTG could be considered if used with consistent, reliable contraception - and if other first-line ARVs were not useable. As a result of this recommendation, some countries prohibited women from receiving DTG. Women living with HIV were not involved in these decisions, which stopped them from being able to choose their own ART.

“We want to exercise choice, this is not a ‘one dress fits all’ situation!”

— Martha Akello, International Community of Women Living with HIV.

What happened with DTG shows how much meaningful engagement and participation of people living with HIV matters, and how important community-based HIV treatment information is. Communities need information so they can join conversations about their values and preferences, and to ensure that they are included in making policies and guidelines that impact their health and lives.

2019 DTG became a preferred first-line (and second-line) ARV, including pregnant women, adolescents and children.

- More babies have been born to women who took DTG at conception and the first 12 weeks of pregnancy. The rate of NTDs is much lower than it seemed to be based on the initial results of Tsepamo study. The risk for NTDs among babies born to women using DTG is similar to other ARVs, and balanced with DTG’s benefits. Based on benefits of DTG (lower rates of maternal death, mother-to-child HIV transmission, and sexual transmissions, and higher rates of viral suppression) with this new safety information, and consultations with an advisory group of women living with HIV, WHO updated its recommendation in July, 2019, stressing the importance of a woman-centered approach in which women make informed choices about their treatment.
- New information comes out on DTG and weight gain - especially among women and people using TAF - from two African studies. Although it is common to gain weight after starting ART, sometimes because people become healthier, gaining too much weight can cause health problems such as diabetes.

2020 US FDA approves DTG 5 mg tablets for infants who are at least four weeks old and weigh at least 3 kg, but it is not known when it will be available globally. Older children, who weigh at least 20 kg, can take the 50 mg tablet of DTG. More information is needed about weight gain and the potential risk for obesity, diabetes and other health problems from DTG-based treatment in children.

In the meantime, WHO recommends raltegravir or lopinavir/ritonavir (LPV/r) for infants, which is more likely to be available in LMIC. Solid formulations of LPV/r (such as pellets or granules) are better than the liquid, which has a foul taste and high alcohol content, but was the only available formulation for infants and young children until very recently.

What is EFV₄₀₀?

“I felt dizzy while taking EFV₆₀₀ but after changing [to] EFV₄₀₀ the side effect is not found.”

Efavirenz (EFV) has been part of first-line treatment since 2010. It is safe and effective, once daily, and can be used during pregnancy and with TB treatment. But it has side effects, which have led some people to stop taking it. Researchers have studied a lower dose of EFV – 400 mg a day (vs. 600 mg), which works just as well but causes fewer side effects, so it is recommended as an alternative for first-line treatment.

ART is not a cure, since it cannot reach all the HIV in a person’s body – but it gives people living with HIV longer, healthier lives.

Sexual and Reproductive Health and Rights (SRHR)

WHO endorses women-centered health care, which is based around what women, their families and communities want and need; it promotes gender equality and human rights. Women-centered healthcare recognizes a woman's right to the knowledge she needs for making informed decisions about her healthcare, and the right to make such decisions.

Sexual and reproductive health care for women should be fully integrated into HIV services – and widely available.

SRHR Resources

WHO's *Consolidated guideline on Sexual and Reproductive Health and Rights of Women Living with HIV* (2017) is available at: <https://apps.who.int/iris/bitstream/handle/10665/254885/9789241549998-eng.pdf>

WHO has also published a checklist for community engagement in implementing the SRHR Guideline, *Translating Community Research into Global Policy Reform for National Action*, is available at: <https://apps.who.int/iris/bitstream/handle/10665/325776/9789241515627-eng.pdf>

Although more than half of all people living with HIV worldwide are women and girls, there is much less information about ART in women than men. Women and girls may have different- or worse- side effects than men. Women have been under-enrolled and under-represented in HIV clinical trials everywhere, especially women of different races and ethnicities - and Black African women. When trials of new ARVs do not produce enough information about their safety or side effects in women, especially during pregnancy, observational studies of 'real-life' use and data from programmes are used to identify any concerns.

Treatment Checklist for Women Living with HIV

We know that ART works well for women and girls, but we know less about its safety during pregnancy (especially during the first three months, when a baby's organs are forming and the risk for birth defects is greatest).

Women of childbearing potential may have concerns about the safety of HIV treatment, such as whether ARVs can be taken with contraceptives, how it fits with their plans to have children, how it protects the baby from HIV, and concerns about ARV side effects – for themselves and their children.

Am I pregnant?

Do I plan to become pregnant?

Do I have access to contraception?

Did I get enough information about my options for contraception?

Did I get enough information about HIV treatment?

Do I have access to DTG and EFV₄₀₀?

Am I ready to make the best choice for myself?

ARV for Children and Adolescents

In 2018, an estimated 1.7 million children and adolescents (age up to 14 years) were living with HIV. Just over half of them (54%) were receiving ART. As with adults, children and adolescents need to take ARVs every day or they won't work. Children have fewer choices in ARVs than adults or adolescent, because development and approval of new ARVs for children takes years. Adolescents do not always get the services and counseling, especially from peers, that is right for them.

Viral Load Testing

"...in the absence of the use of VLT ... we will continue fighting HIV in the dark!"

People need a test, called viral load, to know whether their HIV treatment is working. When ART is working, it stops HIV from multiplying. The amount of HIV in a person's bloodstream becomes so low that a viral load test cannot find it – this is called undetectable. An undetectable viral load keeps people healthy, since HIV is not able to enter CD4 cells and make more of itself. An undetectable viral load also protects a person's sex partners, since people who have an undetectable viral load do not transmit HIV to their sex partners.

WHO has recommended viral load testing since 2013. Access to viral load testing is very important. A person should be able to get a viral load test at 6 and 12 months after starting ART, and then every 12 months, if they are healthy and stable. But many people still do not know about or have access to viral load testing. Sometimes, people have a viral load test but don't get their results back – or don't know what their results mean.

U=U

"It gave me a piece of my womanhood back that was stolen by this disease... No more shame, no more stigma self-inflicted. A renewed sense of hope and a new desire to love. Thank you, U=U!"

A global campaign, called U=U (UNDETECTABLE = UNTRANSMITTABLE), began in 2016 to share this information. The concept of Undetectable = Untransmissible lessens stigma, and can encourage people to start and stay on ART, remain in care and fight for access to – or have, routine viral load testing to see if their ART is working.

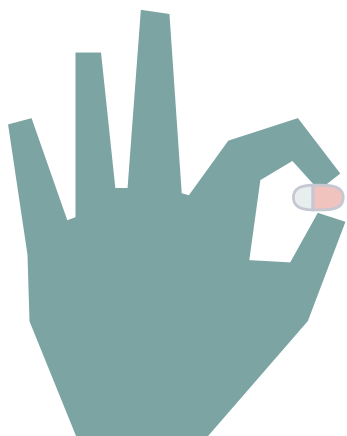
SECOND-LINE ART

If viral load testing shows that ART has stopped working (when viral load is above 1,000 copies/ml on two tests within three months), or a person has serious side effects, they can switch to second-line treatment. Second-line treatment needs to work when first-line treatment fails, so it is based on what was used for first-line treatment. Second-line treatment includes an ARV from a new class, or family that someone has not used before. Sometimes, second-line treatment is taken twice a day, and/or people may need to take more than one pill.

TABLE 3. WHO SECOND-LINE TREATMENT RECOMMENDATIONS

AGE	Switch from	Second-line, preferred	Second-line, alternative
Infants and Children (age up to 10 years)	ABC + 3TC + DTG (2 NRTI + INSTI)	AZT+ 3TC + LPV/r (or ATV/r) (2 NRTI + PI)	AZT + 3TC + DRV/r (2 NRTI + PI)
	ABC (or AZT) + 3TC + LPV/r (2 NRTI + PI)	ABC (or AZT) + 3TC + DTG (2 NRTI + INSTI)	AZT (or ABC) + 3TC + RAL (2 NRTI + INSTI)
	ABC (or AZT) + 3TC + EFV (2 NRTI + nNRTI)	AZT (or ABC) + 3TC + DTG (2 NRTI + INSTI)	AZT (or ABC) + 3TC + LPV/r (or ATV/r) (2 NRTI + PI)
	AZT + 3TC + NVP (2 NRTI + nNRTI)	ABC + 3TC + DTG (2 NRTI + INSTI)	ABC + 3TC + LPV/r (or ATV/r or DRV/r) (2 NRTI + PI)
Adolescents and Adults	TDF + 3TC (or FTC) + DTG (2 NRTI + INSTI)	AZT + 3TC + ATV/r (or LPV/r) (2 NRTI + PI)	AZT + 3TC + DRV/r (2 NRTI + PI)
	TDF + 3TC (or FTC) + EFV (or NVP) (2 NRTI + nNRTI)	AZT + 3TC + DTG (2 NRTI + INSTI)	AZT + 3TC + ATV/r (or LPV/r or DRV/r) (2 NRTI + PI)
	AZT + 3TC + EFV (or NVP) (2 NRTI + nNRTI)	TDF + 3TC (or FTC) + DTG (2 NRTI + INSTI)	TDF + 3TC (or FTC) + ATV/r (or LPV/r or DRV/r) (2 NRTI + PI)

Third-line treatment is used when second-line treatment no longer works; it is based on what a person has already used in first- and second-line treatment.



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