

This toolkit is intended to support clinicians and community-based organizations in providing women-centred care for all people who identify as women living with human immunodeficiency virus (HIV) in Canada. All clinicians who interact with women living with HIV need to practice from a women-centred lens.

Terms used in this toolkit:

- **Women living with HIV** – to refer to all people who are living with HIV and who identify as women, including cis, trans, non-binary who were assigned female at birth, two-spirit and gender-diverse women
- **Clinicians** – to refer to all people involved in providing care for women living with HIV, including family physicians, specialists, nurse practitioners, registered nurses, pharmacists and front-line service providers from community-based organizations

An overview of the toolkit development process can be found at cep.health/hiv. For more information on the Women-Centred HIV Care model, see [page 23](#).

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Section A: Person-centred care

Provide person-centred care by acknowledging each woman as a unique individual and working with them in a participatory model of decision-making to provide holistic care. Person-centred care should be incorporated into every interaction with women living with HIV.

- Establish an honest, trusting, respectful and empowering therapeutic partnership using verbal and non-verbal communication strategies ¹
- Allow adequate time so that discussions do not feel rushed (e.g. book extended appointments when needed) ²
- Personalize the delivery of their care and services by collaborating with each woman to ensure that care is driven from their perspective ^{1,2}
- Engage with each woman as an individual, not a set of diseases or conditions
- Obtain feedback from women living with HIV about their level of satisfaction with a person-centred care approach and use the feedback to improve future care interactions ¹
- Acknowledge and be empathetic to the realities and hardships that women living with HIV face as they navigate the healthcare system
- Providing person-centred care should extend to the front-of-office staff, healthcare porters, custodial staff, lab technicians, and others. Training should be made available to all staff members

Engage with women to understand how their personal circumstances and experiences impact their health, wellness, HIV diagnosis, treatment, retention and self-management, as well as their willingness and ability to engage in their healthcare services. ^{2, 4, 6}

Person-centred care involves understanding each woman as an individual. It involves listening to and discussing a woman's circumstances and experiences in a sensitive and empathic way, including: ¹⁻⁷



Section A: Person-centred care (continued)



Talking points

To start the discussion with women around their circumstances and experiences, ask:

- “Is there anything I should know about your circumstances and experiences that would help me to provide you with better care?”⁸

To discuss social determinants of health, ask women:

- “Do you have enough money and food for yourself and your family?”⁹
- “How is your housing situation?”⁹
- “What is your employment or education status?”⁹

Work collaboratively with women living with HIV

- Empower women’s proactive and meaningful engagement as active partners in their health care
- Engage women in a participatory model of decision-making* to find appropriate solutions^{4,7}
- Listen
- Support women in their various transitions in the health journey^{10,3,1}

* A participatory model is where a clinician and an individual exchange information and make decisions together¹¹

Respect each woman’s autonomy and rights by:^{1,2}

- Providing them with all treatment options
- Accepting and respecting that they may have different views from clinicians about the balance of risks, benefits and consequences of treatments
- Ensuring they know that a second opinion can be requested from another clinician, and if necessary, explain how they do this
- Avoiding situations that force women to disclose their HIV status to others



Avoid verbal and non-verbal stigmatizing language^{1,2,12}

- Avoid words such as:
 - Dirty urine
 - Substance abuse
 - Risky behavior/sex
- Avoid actions such as:
 - Double-gloving
 - Using a tissue to touch paperwork, etc.
- Explore your biases, assumptions and stereotypes
- Consider how your language could stigmatize women from diverse ethno-racial backgrounds, who use substances, who engage in sex work or who are LGBTQ2S+
- Be conscientious when talking with colleagues in front of women living with HIV
- Ensure harm reduction principles or other destigmatizing signage is prominently displayed where women living with HIV enter, to alleviate fear of disclosure⁹

Section B: Trauma- and violence-aware care

Experiences of violence were nearly universal among women living with HIV in Canada, with 79% of women reporting they had experienced a form of violence in adulthood.¹³ This is 13 times higher than the prevalence among the general population of women in Canada.¹⁴ It is therefore recommended to practice trauma- and violence-aware care universally with all women living with HIV. Trauma- and violence-aware care is a strengths-based approach to health care that understands the far-reaching and lasting impacts trauma and violence have on physical, mental and emotional health and wellbeing. Trauma- and violence-aware care acknowledges vast forms of trauma, including single incident, complex, developmental, intergenerational, historical, institutional and stigma trauma, and others. Trauma- and violence-aware care aims to provide women living with HIV with a safe space and equalizes the power imbalances historically inherent in clinician-client relationships. This acknowledges women living with HIV as equal experts in the clinician-client dynamic and prioritizes their control of their narratives and their wishes for any healthcare direction.⁹ Trauma- and violence-aware care must be incorporated into all interactions with women. As a clinician, you do not have to be a trauma and violence expert to practice trauma- and violence-aware care.



Pay attention to signs of a trauma response (e.g. dissociation, flashback, shame) and if a trauma response occurs:

- Pause the conversation and support the woman to connect to the present moment through containment and grounding exercises (e.g. focusing on breathing, focusing on an awareness to one’s feet on the floor or the support of a chair, asking a woman to identify what they see, hear and feel in the current environment)¹⁵
- Explain that trauma reactions are common, expected and part of our survival mechanism

Important notes

- When discussing trauma and violence, remember to use gender-neutral language¹⁵
- Remember that a woman’s cultural beliefs, age, feelings of shame, ability, gender identity or the presence of children may impact their willingness to share their experiences of trauma and violence¹⁵
- There is no mandatory obligation to report violence or trauma to the police. It is the woman’s right to choose if they wish to have police involvement and they must consent to this involvement before a clinician initiates such action. There is however, a mandatory obligation to report trauma or violence (physical, sexual, emotional or abandonment) towards children to local child protective agencies¹⁶⁻¹⁸

Section B: Trauma- and violence-aware care (continued)

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Screening

Women living with HIV should be assessed for:

- Recent trauma or violence (partner violence, child protection involvement or other)
- Lifetime trauma or violence
- The emotional and physical consequences of trauma or violence (e.g. post-traumatic stress disorder, depression, suicidality, substance use, insomnia and chronic pain) ^{7, 19-21}

Screening steps: ¹⁵

1. Ensure screening is done when there is enough time for the disclosure
2. Start by explaining why the questions are being asked by saying, “We understand that experiences of trauma and violence are unfortunately very common for women living with HIV. We want you to know that we care about listening to these experiences if you wish to share them, as such experiences can impact one’s health and wellbeing. Would it be okay if I asked you some questions about experiences you may have had in your past or are currently experiencing?”⁹
3. Then ask specific screening questions, such as “Have you ever had experiences that you feel were violent or traumatic (emotionally, physically or sexually)?”⁹

Alternatively, you can use a validated screening tool such as the [Women Abuse Screening Tool \(WAST\)](#)²²

Environment

Build an environment for women living with HIV that encourages trust and feelings of safety and avoids inadvertently re-traumatizing them. ^{12, 14, 19, 23}

To do this: ^{15, 20, 24}

- Ensure a safe, welcoming and stigma-free environment
Refer to [Women & HIV/AIDS Initiative's Women, HIV & Stigma: A Toolkit for Creating Welcoming Spaces](#)²⁵ for more information on creating a safe, welcoming and stigma-free environment
- Ensure that the physical space provides opportunities for privacy and confidentiality
- Do a ‘walk-through’ with women living with HIV, when possible, using a trauma aware and cultural safety lens. Remove all trauma-related triggers (e.g. ill lit parking lot and sidewalks)
- Acknowledge historical, systemic and current power imbalances and avoid perpetuating them by encouraging empowerment through collaborative decision-making
- Avoid asking women living with HIV to talk about unnecessary details of their experience with trauma or violence
- Encourage women living with HIV to share on their own terms. Display material or wear buttons that inform women of the clinician’s willingness to discuss trauma and violence ¹⁵

Response

If trauma or violence is shared

Respond to disclosure in an empathetic, supportive and non-judgmental way. Offer immediate first-line support. ^{19, 20, 21, 23}

To do this: ^{15, 19}

- Acknowledge and validate what they have shared by saying, “What you have experienced is violence,” “I believe you,” “I’m sorry this happened to you” or “You are resilient”
- Assess immediate health concerns. If a recent sexual assault has occurred, refer the woman for sexual assault care (e.g. physical examination, emergency contraception, post-exposure prophylaxis for sexually transmitted infections)
- Assess immediate safety
- Explore the woman’s immediate priorities and determine a plan of action together
- Refer, with the woman’s consent, to the appropriate resources, including crisis management, safe counselling, safe housing, peer support, cognitive behavioural therapy and justice/advocacy services
- Have a contact list of local violence against women services available

If trauma or violence isn’t shared

Honour the woman’s autonomy and rights to choose to disclose their trauma. Provide general information about trauma and violence and the impact it has on their health and safety. Revisit the discussion at a future appointment. ¹⁵

Foundation

Ensure that trauma- and violence-aware values are built into the organizational foundation, including physical setting, activities and relationships, to ensure effectiveness and sustainability. ¹⁴

To do this: ²⁰

- Ensure a commitment to trauma- and violence-aware care is built into the organizational mandate and a clearly written policy statement
- Ensure a commitment to trauma- and violence-aware care at the organizational leadership level
- Incorporate trauma- and violence-aware care into job descriptions and interview questions during hiring practices
- Train staff on the provision of trauma- and violence-aware care
- Provide staff with clinical supervision during screening appointments from a colleague who is knowledgeable in trauma- and violence-aware care

Section C: HIV care

Provide effective, ongoing treatment for HIV, including prevention, screening and management of concurrent conditions, to improve a woman's overall health, longevity and quality of life.

Terms used in Section C:

- **Combination antiretroviral therapy (cART)** – a combination of antiretroviral medications (either in one pill or multiple pills) that are the standard of care for people living with HIV

i. Steps for HIV care

The following sub-section outlines the steps-for-care for a woman after confirmation of their HIV diagnosis. These steps can be shared across all clinicians involved in the woman's care.

Initial care ^{7, 10, 26}

- Reassure women that HIV care has come a long way and that excellent therapy is now available
- Initial care (which can be done across multiple visits) should include the following:
 - Medical history
 - Physical and mental health history
 - Family history
 - Medication history (including prescription medications, herbals, recreational substances and other non-prescribed medications)
 - Evaluation of sexual and reproductive health
 - Physical exam (including screening for co-morbid conditions)
 - Review of extended lab tests* (lab tests are ideally done before the first appointment)
 - Counselling on general information about HIV (see [Counselling](#))

Start cART ^{7, 10, 27, 28}

cART is the standard of care for all women living with HIV regardless of CD4 count, and should ideally be started within 4 weeks of the initial care appointment (however, it is important to start as early as possible considering a woman's readiness).

- Ensure that women have the information on benefits and risks they need to decide about cART, while respecting their voice and choice

♥ Benefits ²⁹

- Prolongs survival
- Slows disease progression
- Decreases viral replication
- Prevents/reverses immunologic impairment
- Prevents opportunistic infections
- Delays/prevents emergence of drug-resistant strains of HIV
- Lowers the risk of transmission of HIV
- Improves quality of life

! Possible risks ²⁹

- Metabolic complications
- Reduced bone mineral density
- Drug-drug interactions
- Side effects (check the drug monograph for medication specific side effects)
- Increased risk of chronic kidney disease
- Increased risk of cardiovascular events

Arrange additional appointments and assessments ²⁶

Arrange the following for women after diagnosis and then assess regularly (i.e. annually at minimum):

- Social priorities assessment (ask women, "Do you have enough money and food for yourself and your family? How is your housing situation?"⁹) → if needs are present, ensure that an appointment with a social worker, peer support worker or peer navigator is arranged to assess and help with housing, food security and other social factors
- If a woman is ill → arrange an appointment with a clinician to assess for clinical signs of immune suppression and other critical diagnoses within 48 hours
- Trauma and violence assessment (see [Section B: Trauma- and violence-aware care](#))
- Appointments to get vaccinations (see [Section C: HIV care](#))
- Screening appointments for concurrent conditions including Pap testing (see [iii. Prevention, screening and management of concurrent conditions](#) section)
- Assessment of reproductive goals and discussion of healthy sex life (see [Section D: Women's health care](#))
- Mental health assessments (see [Section E: Mental and emotional health care](#))
- Connection with local peer support, leadership and capacity building opportunities if a woman expresses interest (see [Section F: Peer support, leadership and capacity building](#))

- When selecting an appropriate cART regimen, consider: comorbid conditions, pregnancy/preconception planning, allergies (ensure that HLA-B*5701 is conducted to rule out a hypersensitivity to abacavir), the results of a genotype, the use of other prescription medications, over the counter medications, vitamins, supplements, complementary and alternative medications or recreational substances, medication coverage and irregular schedules (e.g. work nights, travel for work)



Consult provincial/local guidelines or the [U.S. Department of Health and Human Services' Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV](#) ³⁰ for information on the most up-to-date recommended cART regimens.



cART should be combined with treatment or prophylaxis for major opportunistic infections. Always consult a reputable drug interaction reference (e.g. [HIVClinic.ca](#)³¹) or the product monograph before prescribing cART when the woman is currently on or starting another medication.

Search [HIV411](#)³² for HIV services located in women's communities.

*Extended lab tests = complete blood count, lytes, creatinine, urine albumin creatinine ratio, aspartate aminotransferase, alanine aminotransferase, bilirubin, lipids, hemoglobin A1C, hepatitis A immunoglobulin G, hepatitis B surface antigen, hepatitis B core antibody, hepatitis B surface antibody, hepatitis C antibody, HIV viral load, CD4 count, beta human chorionic gonadotropin (if indicated), ferritin and vitamin B12 (if indicated), serum phosphate, HLA*B5701 and a genotype, syphilis as well as urine for chlamydia and gonorrhoea

Section C: HIV care (continued)

Follow-up and ongoing care ²⁶

Follow-up clinician appointments and targeted lab tests** should be scheduled every 1-2 months*** after starting cART to ensure that there is no organ toxicity (particularly liver and renal toxicity). Repeat every 1-2 months*** until the woman is clinically stable (i.e. viral load is suppressed to below the level of detection) and psychosocially stable.



Is the woman clinically and psychosocially stable?

YES: clinician appointments and follow-up lab tests can be reduced to every 3-6 months***

NO: clinician appointments and follow-up lab tests should ideally be monthly to encourage adherence and help with barriers to taking cART

Retention in care ^{7, 26}

- Regularly discuss with a woman the importance of medication and care adherence, the potential barriers to adherence and equip the woman with resources/supports that can improve adherence (e.g. contact information of a clinician to call with questions, access to a clinician with experience in adherence support, peer support, community-based counsellors)
 - Importance of adherence: non-adherence to therapy promotes the emergence of drug-resistant HIV strains and is an important challenge in the management of HIV infection ²⁹
- Establish a regular system to review a woman's adherence, as well as their circumstances and experiences, including prompts for when they are no longer retained-in-care and strategies for re-engaging them
 - If a woman living with HIV does not have lab tests done every 6 months (or decided upon duration), they are considered not retained-in-care
 - A confirmed rebound in viral load can indicate non-adherence (or treatment failure) ²⁹
- Encourage re-engagement in care through multiple and repeated means (e.g. phone calls, text message, email, leaving a letter with their pharmacy or outreach workers) and attempt to determine if they have decided to seek care from a new clinician
 - Confirm with a woman living with HIV their preferred follow-up strategy (e.g. phone calls, text message and/or email reminders)

**Targeted lab tests = complete blood count, creatinine, aspartate aminotransferase, alanine aminotransferase, bilirubin, HIV viral load, CD4 count (optional, no need to do if the CD4 count is consistently >350 cells / μ L)

*** Due to a woman's circumstances or geographic location, less frequent follow-up clinician appointments and targeted lab tests may be more feasible.



Counseling

Throughout the HIV care process, encourage women living with HIV to ask questions and ensure that they receive ongoing counselling from clinicians and peer support on the following topics (resources for women are provided below each item):

- HIV 101
 - Refer to [CATIE's HIV Basic Facts](#) ³³
- Living well with HIV (including self-management and reducing modifiable risk factors for comorbid illness and drug interactions)
 - Refer to [Canadian AIDS Treatment Information Exchange's \(CATIE\) Practical Guide to a Healthy Body for People Living with HIV](#) ³⁴
- Benefits and risks of cART (as well as the importance of medication adherence, scheduling of medications and initiating treatment as soon as possible)
 - Refer to [CATIE's Guide to HIV Treatment](#) ³⁵
- Possible side effects of medications
 - Refer to [CATIE's Practical Guide to HIV Drug Side Effects](#) ³⁶
- Knowing their rights including sexual and reproductive rights
 - Refer to [United Nations' Information Series On Sexual And Reproductive Health And Rights](#) ³⁷
- Preventing HIV horizontal and vertical transmission by adherence to cART (U=U; undetectable=untransmittable)
 - Refer to [Women & HIV/AIDS Initiative's Living in the Asterisk resource](#) ³⁸
- Benefits, risks and requirements of voluntary HIV disclosure
 - See [Disclosure](#)



Talking points

Ask women about their medication adherence:

"We understand that many women on HIV medications find it difficult to take them regularly and often miss doses. We won't be surprised if you have missed doses. We would like to know how many doses you have missed. Can you provide your best guess about how much medication you have taken in the last month on a scale where: 0% means you have taken no medication, 50% means you have taken half your medication, and 100% means you have taken every single dose of your medication. We would be surprised if this was 100% for most women." ³⁹


Section C: HIV care (continued)


ii. Disclosure⁴⁰⁻⁴³

HIV disclosure is a crucial topic for women living with HIV. HIV disclosure is the process of sharing one's HIV status with another person.

Discuss with women the benefits and risks of disclosure within the context of the public health or legal requirements. Avoid interpreting requirements or pressuring women to disclose. **It is important for women to know that the majority of the time there is no need to disclose and often the risks outweigh the benefits.** For women who express interest in disclosing, support them through the disclosure process on their terms and timelines. Connect them with peer support if they are interested (see [Section F: Peer support, leadership and capacity building](#)) and refer them to a local HIV legal service provider to discuss the current status of the disclosure requirements in their jurisdiction.

Benefits and risks to disclosure⁴⁴

 Connectedness to the person the woman is disclosing to⁴⁴

 It can lead to rejection, violence or abuse
It can be a traumatizing, isolating and painful experience⁴⁴

Disclosure requirements

Women do not have to disclose their HIV status to:

- Casual contacts, such as employers, teachers, coworkers, sport coaches, roommates, family members or friends
- Sexual partners if a woman maintains a low viral load (i.e. <1,500 copies/ml) and uses a condom*
- A clinician at a walk-in clinic, unless a woman's reason for accessing the clinic is HIV-related**

It is recommended that women disclose their HIV status to:

- Dentists**
- All other clinicians (e.g. emergency room clinicians)**

Public health and the law require women to disclose their HIV status to:

- Sexual partners, if a woman does not maintain a low viral load (i.e. <1,500 copies/ml) and does not use a condom***
- Previous sexual partners following a woman's diagnosis
- Drug use partners before a woman shares injection equipment
- Clinicians who care for a woman during pregnancy, childbirth and if they choose to breastfeed

Women do not have to disclose how HIV was transmitted to them.

*Even if a woman's viral load is low, telling their partner about their HIV status may be important to them.

**Although women do not have to disclose their HIV status to all their clinicians, it is often recommended so that clinicians can be well informed and as a result provide more tailored care.

***This is a legal requirement in Canada. The law is far behind the research that supports U=U. Even though the risk of transmitting HIV to a sexual partner when a person's viral load is low is unlikely, the law requires people to use a condom during sexual activity. Individuals are working to change the law.

Other important information about HIV disclosure:

- Laws for HIV disclosure are changing and differ by province and territory.
- A woman's provincial or territorial public health authority will be informed of their HIV status after they are diagnosed. The public health authority will contact the woman to get a list of their past sexual partners. The woman will be given the option to contact their past sexual partners or to have their public health authority contact them for them (they will not disclose the woman's name).^{41,45}
- If a woman is applying for permanent residence in Canada, they will need to have a medical exam that includes an HIV test. Their results will be shared with Immigration, Refugees and Citizenship Canada (IRCC). This is not grounds for refusal of their application, however if IRCC estimates that their annual health care costs including medication are more than \$19,812 (i.e. 3 times the cost of the average Canadian's annual health care costs), and they do not have private health insurance, they may not be able to obtain permanent resident status. Also their HIV status may be disclosed to their sponsor if they are in the Family Class or Dependent Refugee Class.⁴¹

Disclosure and travel:

- Some countries have restrictions on travel for those who are HIV positive. Women can still travel living with HIV, but it helps to know which countries have restrictions and what types.





Refer to the [Women's Health in Women's Hands Community Health Centre's Negotiating Disclosure website](#)⁴⁴ for information on guiding women through the disclosure process. Refer to the [Canadian HIV/AIDS Legal Network's website](#)⁴⁶ for information on the evolving legal disclosure requirements.

Section C: HIV care (continued)

iii. Prevention, screening and management of concurrent conditions

The following sub-section outlines important information on supporting women living with HIV to prevent, identify and manage the development of concurrent conditions. These steps can be shared across all clinicians involved in the care of women living with HIV.

General physical health prevention strategies	
Diet	<p>Discuss the importance of a healthy and balanced diet. Ask women about food insecurities and barriers experienced in accessing healthy food</p> <ul style="list-style-type: none"> A healthy and balanced diet = eating plenty of vegetables, fruits, whole grain foods and plant-based protein foods, drinking plenty of water and limiting (as much as possible) saturated fat, processed food and sugary drinks ⁴⁷ <p> Refer women to Canada's Food Guide Healthy Eating on a Budget⁴⁸</p>
Exercise	<p>Discuss the importance of regular exercise and which types of exercise works for them</p> <ul style="list-style-type: none"> Regular exercise = 150 minutes of moderate- to vigorous-intensity aerobic physical activity per week, in bouts of 10 minutes or more; muscle and bone strengthening activities using major muscle groups, at least 2 days per week ⁴⁹
Sleep hygiene	<p>Discuss the importance of sleep hygiene</p> <ul style="list-style-type: none"> Sleep hygiene = women having difficulty with sleeping can try to implement techniques (and decide what works best for them) such as, having a regular sleep and exercise schedule - even on weekends, going to bed only when tired, using their bedroom only for sleep and sexual activity, avoiding large meals and exercise just before bedtime, limiting caffeine, alcohol and nicotine, keeping their bedroom dark and quiet, avoiding daytime or evening napping, removing their bedroom clock from sight, avoiding light-emitting devices or bright lights in the hours before bedtime (e.g. e-books, cell phones, television) ⁵⁰ <p> Refer women to free resources such as Sleepwell.ca ⁵¹</p>
Smoking cessation	<p>All efforts should be made to help women living with HIV to reduce smoking at every visit. Ask questions to explore reasons for smoking, past attempts to stop (what worked, vs. what did not), and offer non-pharmacologic and pharmacologic assistance to support them when they are ready to quit ²⁶</p>
Weight management	<p>Discuss the importance of trying to manage weight through diet and exercise to stay in a healthy Body Mass Index range</p> <ul style="list-style-type: none"> Healthy Body Mass Index range = 18.5—24.9 ⁵²
Bone health	<p>Discuss the importance of participating in weightbearing exercises and ensure that their diet contains adequate amounts of calcium and vitamin D. Suggest a supplement if their dietary intake is inadequate</p> <ul style="list-style-type: none"> Daily calcium requirement = 1,000 mg/day for women ≤50 years of age and 1,200 mg/day for women >50 years of age ^{53,54} Daily vitamin D requirement = 400—1,000 IU/day for women ≤50 years of age and 800—2,000 IU/day for women >50 years of age ^{53,54} <p>Avoid prescribing certain cART medications that may cause higher rates of bone density diminishing in women with low bone density or osteoporosis ^{53,55}</p>
Oral care	<p>Discuss with women the importance of maintaining oral health if feasible (i.e. brushing teeth for 2 minutes twice a day, flossing daily, avoiding tobacco and seeing an oral health professional on a regular basis) to prevent tooth decay and gum disease ⁵⁶</p>

Section C: HIV care (continued)

Vaccinations ^{7, 57, 58, 59}

Ensure that women living with HIV are offered (or have previously received) the following vaccinations. Requirements for follow-up vaccinations should be assessed at least once a year, perhaps easiest around flu vaccination season. ²⁶ Live vaccines should not be given when the CD4 count is <200 cells/ μ L or if pregnant.

Hepatitis A	2 doses 6 months apart
Hepatitis B	3 or 4 double doses, and post-immunization monitoring of anti-HBs titres recommended with booster dose if the titre is <10 IU/L
Herpes zoster (shingles)	Women \geq 50 years of age may receive 2 doses 8 weeks apart; it is not covered for those <65 years of age in most jurisdictions (live vaccine is contraindicated if CD4 <200 cells/ μ L)
Haemophilus influenzae type b (Hib)	1 dose regardless of prior history of vaccination and at least 1 year after any previous dose
Human papillomavirus (HPV)	3 doses to be given at 0, 2 and 6 months for those who have not received any dose by 15 years of age up to the age of 45 years (not covered in all provinces or territories) ⁶⁰
Influenza (flu)	1 dose annually of inactivated vaccine (live vaccine contraindicated)
Measles-mumps-rubella (MMR)	1 dose for women who have received MMR, if born in or after 1970 (contraindicated if CD4 <200 cells/ μ L or if pregnant) Women living with HIV should not receive the vaccine for measles-mumps-rubella together with varicella as it is not authorized for use in adults
Meningococcal conjugate	2 doses, 8 weeks apart starting at diagnosis; booster doses required every 3-5 years; quadrivalent conjugate meningococcal vaccine recommended (not covered in all jurisdictions)
Pneumococcal conjugate 13-valent	1 dose followed 8 weeks later by 1 dose of pneumococcal polysaccharide 23-valent vaccine (see row below); administer at least 1 year after any previous dose of polysaccharide 23-valent vaccine
Pneumococcal polysaccharide 23-valent	1 dose provided as a follow-up 8 weeks after the pneumococcal conjugate 13-valent vaccination (see row above); 1 re-immunization 5 years after the first dose; if the most recent dose was administered <65 years of age, then administer an additional 1 dose when \geq 65 years of age and at least 5 years after the last dose
Tetanus, diphtheria, pertussis (whooping cough), polio	1 dose of a combination tetanus, diphtheria, pertussis and polio vaccine followed by a combination tetanus and diphtheria booster every 10 years; 1 dose of a combination tetanus, diphtheria and pertussis during each pregnancy
Varicella zoster (chicken pox)	Women aged <50 years of age without contraindications and who do not meet the definition for varicella immunity may receive 2 doses of univalent varicella vaccine 4 weeks apart (contraindicated if CD4 <200 cells/ μ L or if pregnant)
Travel vaccines	Depending on place of travel, the following vaccines are recommended: <ul style="list-style-type: none"> • Cholera • Travellers' diarrhea • Japanese encephalitis • Rabies • Typhoid (only provide inactivated vaccine; live vaccine contraindicated) • Tick-borne encephalitis • Yellow fever (contraindicated if CD4 <200 cells/μL)

Legend: black = as recommended or as indicated in the general population, orange = special consideration for women living with HIV, red = contraindication

Notes: anti-HBs = antibody to hepatitis B surface antigen



Consult provincial/local guidelines or the [Public Health Agency of Canada's Canadian Immunization Guide](#)⁵⁷ for recommended immunization schedules for immunocompromised individuals

Section C: HIV care (continued)

Screening	
Ensure that all women living with HIV are screened for the following concurrent conditions.	
Bone health	Screen premenopausal women living with HIV ≥ 40 years of age for fragility fractures and low bone mineral density using the Fracture Risk Assessment tool ⁶¹ ; refer postmenopausal women or women identified as higher risk for fragility fractures (using the tool) for a bone density scan (e.g. dual-energy x-ray absorptiometry) ⁵³
Breast cancer	Refer women living with HIV > 50 years of age for a mammogram every 2-3 years (unless they are at high risk of breast cancer, then more frequent screening should initiate at the age of 30) ^{7, 62, 63}
Cardiovascular disease	Assess women living with HIV for cardiovascular risk using the Framingham Risk Score tool at minimum every 5 years when < 40 years of age, and annually when ≥ 40 years of age or peri- or post-menopausal ^{64, 65}
Cervical cancer	Refer women living with HIV of all ages for annual Papanicolaou testing ⁶⁶
Colorectal cancer	Refer women living with HIV between 50-74 years of age for a fecal immunochemical test every 2 years (the use of colonoscopy as a screening test is not recommended) ^{67, 68}
Diabetes	Assess women living with HIV of all ages for diabetes risk annually using the Canadian Diabetes Risk Assessment Questionnaire (CANRISK) , and send women ≥ 40 years of age or those identified as high risk for FPG and A1C lab tests (a 75g OGTT may also be considered) every 3 years ⁶⁹
Dyslipidemia	Send women living with HIV of all ages for lipid testing every 1-2 years (TC, LDL-C, HDL-C, TG, non-HDL-C)
Hepatitis B	Send women living with HIV 15-65 years of age for HBsAg and anti-HBc and anti-HBs lab tests at diagnosis and repeat appropriate tests annually ⁷⁰
Hepatitis C	Send women living with HIV 15-65 years of age for HCVAb serologic testing at diagnosis, and if positive, conduct follow-up hepatitis C viral load test. If negative, repeat HCVAb annually if continued risk ⁷⁰
Hypertension	Assess the blood pressure of women living with HIV of all ages at minimum annually ^{71 - 73}
Kidney impairment	Send women living with HIV of all ages every 6 months for serum creatinine, eGFR and urinary protein excretion lab tests ⁷³
Liver impairment	Send women living with HIV of all ages every 6 months for AST, ALT and bilirubin lab tests
Neurocognitive issues	Assess and monitor women living with HIV, within 6 months of diagnosis, for neurocognitive changes, including HIV-associated neurocognitive conditions and dementia, using the Montreal Cognitive Assessment test ⁷⁴ , particularly among those with low CD4 counts or with rising viral loads and when indicated thereafter based on symptoms ^{7, 75}
Other sexually transmitted infections	Screen all sexually active women living with HIV at diagnosis for chlamydia, gonorrhea, syphilis and trichomonas and annually after that (more or less frequent screening might be appropriate depending on the sexual history) ⁷⁰
Tuberculosis	Send women living with HIV of all ages at diagnosis for latent tuberculosis testing using tuberculin skin testing or interferon-gamma release assay. Send women with positive results for a chest x-ray. For women with negative results, redo tuberculosis skin test or interferon-gamma release assay annually if at high risk. Send women who have a history of screening positive and/or were treated for latent or active tuberculosis for a chest x-ray (do not repeat a tuberculosis skin test) ^{7, 9, 76}

Legend: black = as recommended or as indicated in the general population, orange = special consideration for women living with HIV

Notes: ALT = alanine transaminase, AST = aspartate transaminase, A1C = glycated hemoglobin, anti-HBc = antibody to hepatitis B core antigen, anti-HBs = hepatitis B surface antibody, eGFR = glomerular filtration rate, FPG = fasting plasma glucose test, HBsAg = hepatitis B surface antigen, HCVAb = hepatitis C antibody, HDL-C = high-density lipoprotein cholesterol, LDL-C = low-density lipoprotein cholesterol, non-HDL-C = non-high-density lipoprotein cholesterol, OGTT = oral glucose tolerance test, TC = total cholesterol, TG = triglycerides

Section C: HIV care (continued)

Management	
Arrange care of identified concurrent conditions for women living with HIV.	
Bone health	<ul style="list-style-type: none"> Ensure women living with HIV, especially those identified as higher risk for fragility fractures and all postmenopausal women are consuming adequate amounts of calcium (1,000 mg/day for women ≤50 years of age and 1,200 mg/day for women >50 years of age) and vitamin D (1,000 IU/day). Suggest supplements if dietary intake is inadequate^{53, 54} Discontinue prescribing certain cART that may cause higher rates of bone density loss in women with low bone density or osteoporosis^{53, 55} Initiate antiosteoporosis therapy for women living with HIV >50 years of age, with evidence of osteoporosis⁵³
Breast, cervical and colorectal cancer	<ul style="list-style-type: none"> Refer women living with HIV with breast, cervical or colorectal cancer for appropriate cancer treatment <div style="border: 1px solid orange; padding: 5px;"> <p>! Pharmacokinetic interactions between antiretrovirals and systemic anticancer therapy should be checked before administration, and those who require chemotherapy or radical radiotherapy should receive concomitant cART and opportunistic infection prophylaxis unless contraindicated.⁵⁹</p> </div>
Cardiovascular disease	<ul style="list-style-type: none"> Encourage and support women living with HIV to engage in routine lifestyle interventions (e.g. diet, exercise, smoking cessation)²⁶ Ensure that women living with HIV and cardiovascular disease are monitored and treated for (if applicable) diabetes, dyslipidemia and hypertension
Diabetes	<ul style="list-style-type: none"> Encourage and support women living with HIV to engage in routine lifestyle interventions (e.g. diet, exercise, weight management) and self-management programs^{69, 73} Treat women living with HIV and diabetes with appropriate pharmacologic glycemic management⁶⁹
Dyslipidemia	<ul style="list-style-type: none"> Encourage and support women living with HIV to engage in routine lifestyle interventions (e.g. diet, exercise and smoking cessation)⁷³ Treat women living with HIV and dyslipidemia with lipid-lowering or statin therapy if lifestyle interventions are ineffective^{65, 73}
Hepatitis B	<ul style="list-style-type: none"> Treat women living with HIV and hepatitis B with a combination HIV and hepatitis B therapy^{30, 59} Send women for HBsAg, HBeAg, HBeAb, HBV-DNA, AST and ALT lab tests every 3-6 months Order a liver ultrasound to rule out hepatocellular carcinoma every 6 months
Hepatitis C	<ul style="list-style-type: none"> For women living with HIV and hepatitis C, start combination antiretroviral therapy first. Once the HIV is virologically suppressed, promptly initiate hepatitis C virus treatment^{30, 59} Antiretroviral therapy regimens should be selected with careful consideration of potential drug-drug interactions with the hepatitis C treatment regimen³⁰
Hypertension	<ul style="list-style-type: none"> Support women living with HIV to engage in routine lifestyle interventions (e.g. sodium-restricted diet, reduction of alcohol consumption, regular exercise, weight management, reduction in intake of non-steroidal anti-inflammatory drugs)^{72, 73} Treat women living with HIV and hypertension as per guidelines (e.g. diuretics, ACE or ARBs, calcium channel blockers)^{72, 73}
Kidney impairment	<ul style="list-style-type: none"> Refer women living with HIV and kidney impairment to a nephrologist for appropriate treatment⁷³
Liver disease	<ul style="list-style-type: none"> Refer women living with HIV and liver disease to a hepatologist if required
Neurocognitive issues	<ul style="list-style-type: none"> Encourage and support women living with HIV and neurocognitive issues to engage in physical exercise and brain fitness exercises to mitigate or manage mild neurocognitive losses⁷
Other sexually transmitted infections	<ul style="list-style-type: none"> Provide women living with HIV and sexually transmitted infections with routine treatment for identified chlamydia, gonorrhea, syphilis or trichomonas⁷⁰
Tuberculosis	<ul style="list-style-type: none"> Refer women living with HIV and tuberculosis for appropriate tuberculosis treatment <div style="border: 1px solid orange; padding: 5px;"> <p>! cART should not be withheld until completion of tuberculosis treatment. However, caution should be exercised when initiating cART early for women living with HIV and tuberculosis due to multidrug adherence demands, drug-drug interactions, overlapping side effect profiles and the development of immune reconstitution inflammatory syndrome (although primarily a concern for those with lower CD4 cell counts). If a woman has central nervous system tuberculosis, delay cART by 2 weeks after initiation of tuberculosis treatment.^{30, 59}</p> </div>



Always consult a reputable drug interaction reference (e.g. HIVClinic.ca³¹) or the product monograph before prescribing a medication when a woman is currently on cART or using recreational substances. Some combinations are contraindicated and can lead to serious drug-drug interactions.

Legend: black = as recommended or as indicated in the general population, orange = special consideration for women living with HIV

Notes: ACE = angiotensin converting enzyme inhibitors, ALT = aminotransferase, ARB = angiotensin receptor blockers, AST = aspartate aminotransferase, HBeAb = hepatitis B e antibody, HBeAg = hepatitis B e antigen, HBsAg = hepatitis B surface antigen, HBV-DNA = hepatitis B virus DNA

Section D: Women's health care

Offer comprehensive and holistic care to women living with HIV that addresses and prioritizes their sexual and reproductive choices and rights. This section offers information on sexual and reproductive health across the life course as well as age- or stage-appropriate recommendations. For information on sexual health (e.g. cervical and breast cancer, human papillomavirus, sexually transmitted infections and diseases), please see [iii. Prevention, screening and management of concurrent conditions.](#)



For more information specific to the health care of trans women, please refer to the [Rainbow Health Ontario website](#).⁷⁷

Terms used in Section D:

- **Sexual and reproductive health rights (SRHR)** - is the concept of human rights applied to women's sexuality and reproduction
- **SOGIE** - sexual orientation, gender identity and expression
- **Pre-exposure prophylaxis (PrEP)** - antiretroviral medicines taken daily by people who are at risk of getting HIV to prevent becoming infected
- **Post-exposure prophylaxis (PEP)** - antiretroviral medicines taken by people after being potentially exposed to HIV to prevent becoming infected



This toolkit promotes and operationalizes the principles and recommendations of the [World Health Organization Consolidated Guideline on Sexual and Reproductive Health and Rights of Women Living with HIV](#).¹² This guideline was built on the findings of [Salamander Trust's Global Values and Preferences Survey](#)⁷⁸ and offers evidence-based recommendations and good practice statements for providing comprehensive SRHR-related services and support for women living with HIV. Particular emphasis is placed on the creation of an enabling environment to support the health and rights of women living with HIV, and taking a "holistic, women-centred con(tra)ception-to-old-age approach to sexual and reproductive healthcare" as outlined in [Salamander Trust's Building a Safe House on Firm Ground](#)⁷⁸ report.

Refer to the [Implementation Checklist](#)⁷⁹ to effectively implement the World Health Organization Consolidated guideline on sexual and reproductive health and rights of women living with HIV. This is important given that uptake of the guideline includes the meaningful engagement of women living with HIV in all their diversity.

i. Sexuality and sexual rights

- Reassure women living with HIV that they can have a safe, healthy and fulfilling sex life
- Acknowledge the sexual rights of women living with HIV of all ages and support women to live healthy sexual lives, as defined by them⁹



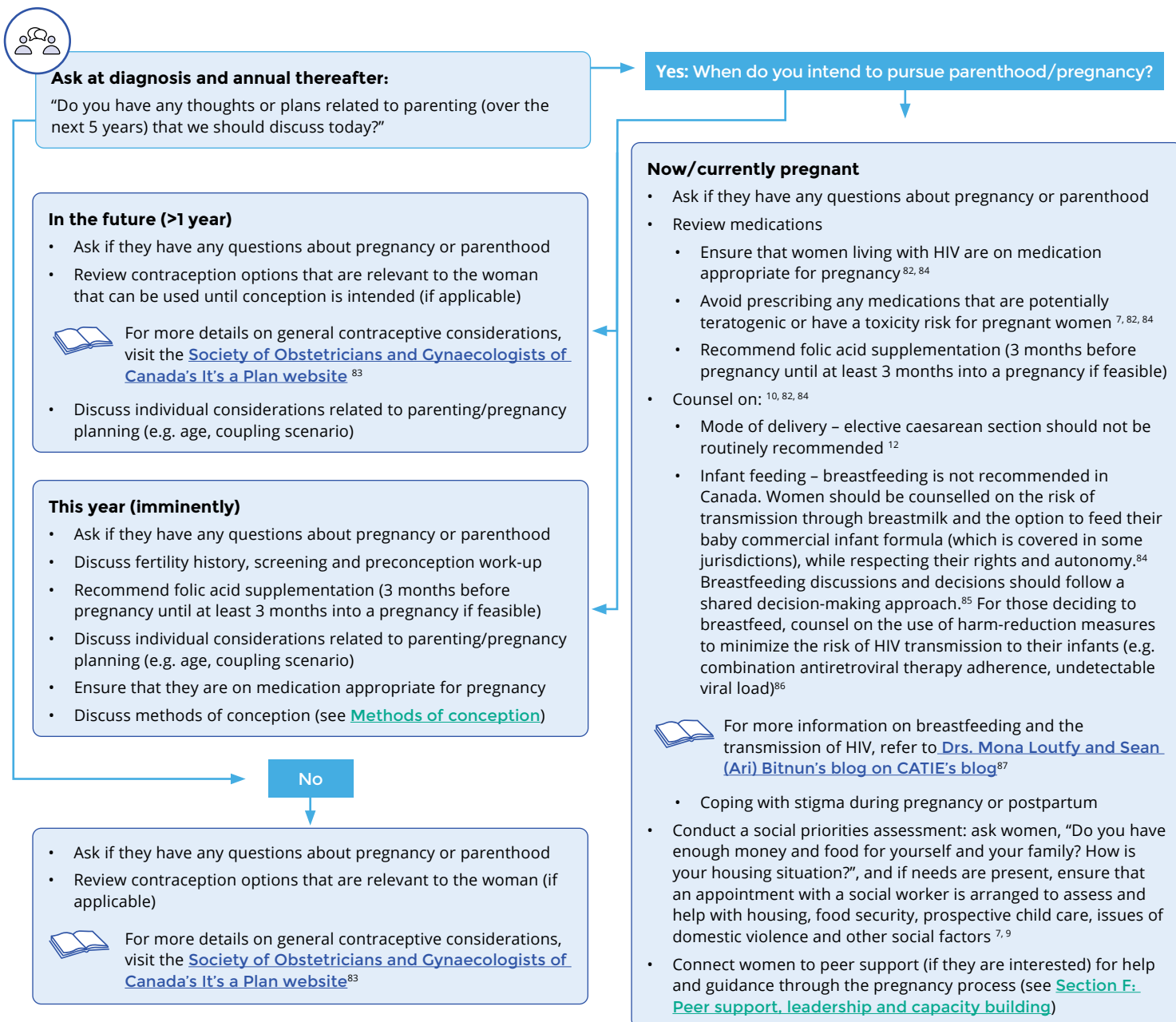
Direct to sex-positive resources, such as the [Life and Love with HIV website](#)⁸⁰

- Do not make assumptions or judgments about SOGIE or number of partners⁹
- Ensure that services are able to accommodate women living with HIV in all their diversities including their SOGIE, experiences, preferences, desires, occupations, social and cultural norms, values and networks⁹

Section D: Women's health care (continued)

ii. Reproductive health^{81, 82}

Self-efficacy and empowerment interventions around reproductive health and rights should be provided to women living with HIV to maximize their health and fulfill their rights.¹² Reassure women living with HIV that having a safe and healthy pregnancy is possible and that you will support their pregnancy planning priorities and preferences.



Section D: Women's health care (continued)

Methods of conception

General recommendations:

- Ensure that the partner(s) with HIV has/have been on combination antiretroviral therapy for at least 3 months with a maintained suppressed viral load (defined as 2 viral loads <200 copies/ml at least 1 month apart) ideally for 6 months before attempting conception ^{82,84}
- Offer HIV PrEP to the HIV-negative partner when confirmation of adherence and viral suppression for the partner living with HIV cannot be made ⁸²
- If a woman/couple has attempted a recommended conception method for 6-12 months without success, refer them to a gynaecologist, fertility clinic or someone who specializes in fertility ^{82,84}

Methods: ⁸²

- Condomless sex timed with ovulation (recommended method of conception) – requires partner(s) with HIV to be on cART with a maintained suppressed viral load (defined as 2 viral loads <200 copies/ml at least 1 month apart), and sexual intercourse without a condom to occur 1-3 days before and on the day of ovulation, or if menses are irregular, every other day around ovulation (e.g. day 12, 14, 16)
- Condomless sex – requires partner(s) with HIV to be on cART with a maintained suppressed viral load (defined as 2 viral loads <200 copies/ml at least 1 month apart) and sexual intercourse without a condom
- Home sperm insemination with syringe – requires the collection of sperm from a partner or donor in a sterile container or a condom and the insertion of the sperm via a needleless syringe into the vagina as close to the cervix as possible 1-3 days before and on the day of ovulation
- Sperm washing with intrauterine insemination – requires a referral to a fertility clinic or a care provider who specializes in fertility. It involves the collection of sperm from a partner or donor, which is then centrifuged to separate live sperm (which do not carry HIV) from seminal plasma and non-germinal cells (which may carry HIV) and inserted into the uterine cavity with a catheter 1-3 days before the day of ovulation and on the day of ovulation
- Other – in vitro fertilization, intracytoplasmic sperm injection, sperm donation, egg donation or surrogacy, adoption



For more information on pregnancy planning for women living with HIV, please refer to the [Canadian HIV Pregnancy Planning Guidelines' HIV Pregnancy Planning website](#). ⁸⁸

iii. Tailoring the delivery of care across the continuum of aging

Acknowledge the fluidity of age and apply discretion based on each woman when tailoring the delivery of care to their position across the life course. It is important to remember that due to advances in cART, women living with HIV are living longer and healthier lives. The information and evidence in this area are still emerging.



- Support younger women in the transition from pediatric to adult care
- Remember that some younger women will have been born with HIV while others will have acquired it
- Ask in private whether they wish anyone else to be present at their visits ⁸⁹
- Offer more frequent appointments to support retention ⁷
- Respect that younger women living with HIV have different priorities ¹⁹
- Use language and communication strategies that work for them (e.g. email, text message) ⁸⁹
- Be sensitive to any issues women living with HIV face related to changes in sexuality and intimacy and address these issues through discussion, counselling, appropriate medication and referrals ⁷
- Help women living with HIV to improve coping skills, stay active in their communities, arrange social engagements and enhance perceptions of self-worth to reduce their risk of social isolation and mental health problems ^{5,7}
- Counsel women living with HIV about the changes they can expect including menopause (see [Menstruation and menopause](#)) and increased risk of concurrent conditions, such as reduced bone health, cardiovascular disease, cancers, diabetes, dyslipidemia, hypertension, as well as kidney and liver impairment (see [iii. Prevention, screening and management of concurrent conditions](#))
- Provide comprehensive care to help minimize cumulative burden of multiple conditions ⁷
- Work closely with pharmacists and others in a woman's referral networks to address complications related to polypharmacy and drug-drug interactions ⁷
- Offer telecare options if applicable to increase access to care for women living with HIV and mobility challenges ⁵
- Engage caregivers if appropriate
- Counsel women about geriatric care, including long-term care, palliative care, and end-of-life planning if appropriate ^{5,9}
- Support women living with HIV through integrated care that offers continuity between geriatric and existing primary care, community and social services ⁷
- Counsel women living with HIV to complete a durable power of attorney for health care and an advance directive medical instruction form, including their views on preferred care settings during advanced disease ⁷

Section D: Women's health care (continued)

iv. Menstruation and menopause

Menstruation

- Abnormal uterine bleeding has been found to be more common among women living with HIV⁹⁰
- Having HIV and the use of cART have been associated with abnormal uterine bleeding and menstrual irregularities in women living with HIV⁹⁰
- Management of irregular menstruation:
 - Obtain a complete menstrual history, including the age of onset, amount, duration, frequency, recent changes, pregnancy test as well as the presence of pain, weight change, concurrent condition and the use of new contraception or medication
 - Refer women with irregular menstruation to a clinician with gynecologic expertise for evaluation and management

Menopause

- In Canadian women living with HIV, the average age of menopause is 48 years, which is three years younger than in the general population⁹¹
- Women living with HIV experience higher rates of early menopause and premature menopause (also known as premature ovarian failure) as compared to women without HIV⁹¹
- A possible explanation for this increased risk is multifactorial and includes the combined effects of an HIV infection itself and possible effects of cART, as well as other sociodemographic factors, such as a history of substance use, smoking or hepatitis C co-infection⁹¹
- Provide women living with HIV of approximately 40 years of age and older, counselling on menopause, peri-menopause and premature menopause, including a discussion of physiologic symptoms and management options⁹³

Definitions of terms for irregular menstrual bleeding⁹²

Condition	Definition
Amenorrhea	Cessation of bleeding for ≥ 3 months
Polymenorrhea	Menstrual bleeding occurs < 21 days after prior menses
Oligomenorrhea	Menstrual bleeding occurs > 35 days after prior menses
Menorrhagia/hypermenorrhea	Regular cycles with excessive flow (> 80 ml) or duration (> 7 days)
Metrorrhagia	Irregular bleeding or bleeding between periods ("breakthrough bleeding")
Menometrorrhagia	Bleeding that is both heavy and irregular
Post-menopausal bleeding	Bleeding > 1 year after cessation of menses
Post-coital bleeding	Bleeding after intercourse
Mid-cycle spotting	Light bleeding around the time of ovulation

Phases and definitions related to menopause

Phase	Definition ⁹⁴	Possible symptoms ⁹⁴
Perimenopause	The time period leading up to menopause during which hormone levels begin to change	Hot flashes and irregular menstruation for up to 8 years
Premature menopause	When menopause occurs < 40 years of age	Hot flashes, night sweats, pounding/racing heart, sleep disturbances, anxiety attacks, difficulty concentrating, fatigue, irritability, memory loss, mood swings, weight gain, joint aches and pains, skin changes, urogenital symptoms (e.g. vaginal dryness and discomfort, incontinence and decrease/loss of libido), changes in eye and oral health and increased risk of co-morbidities, such as osteoporosis and cardiovascular disease
Early menopause	When menopause occurs < 45 years of age	
Menopause	The point in time when a woman has had no menstrual period for 12 consecutive months after the age of 45 (and they are not pregnant and are not on male transitioning hormone therapy or opioid replacement therapy)	



Section D: Women's health care (continued)**iv. Menstruation and menopause (continued)**

Menopause management	
Management strategy	Details
Lifestyle interventions	Using a fan, dressing in layers, drinking cold drinks, meditation, exercise, quitting smoking and losing weight can all help lessen hot flashes and night sweats ⁹⁵
Hormone replacement therapy	<p>For the management of vasomotor symptoms, prevention of bone loss, premature hypoestrogenism and genitourinary symptoms: ⁹⁶</p> <ul style="list-style-type: none"> • <60 years – for women living with HIV <60 years of age or who are within 10 years of menopause onset and have no contraindications, the benefit-risk ratio is most favorable for treatment with menopause hormone replacement therapy for bothersome vasomotor symptoms and for those at elevated risk for bone loss or fracture • ≥60 years – for women living with HIV who initiate menopause hormone replacement therapy more than 10-20 years from menopause onset or are ≥60 years of age, the benefit-risk ratio appears less favorable because of the greater absolute risks of coronary heart disease, stroke, venous thromboembolism and dementia <p>Contraindications for hormone replacement therapy: Unexplained vaginal bleeding; severe active liver disease; prior estrogen-sensitive breast or endometrial cancer; coronary heart disease; stroke; dementia; personal history or inherited high risk of thromboembolic disease, porphyria cutanea tarda, or hypertriglyceridemia, with concern that endometriosis might reactivate, migraine headaches may worsen, or leiomyomas may grow ⁹⁶</p> <p>It is not well known how hormone replacement therapy interacts with cART</p>
Venlafaxine, paroxetine and fluoxetine, gabapentin or clonidine	May be used to manage hot flashes and night sweats ⁹⁵
Iron replacement	May be offered to women living with HIV in perimenopause who are experiencing heavy and irregular menstrual periods resulting in anemia ⁹
Low-dose vaginal estrogen therapy	May be offered to women living with HIV with bothersome urogenital symptoms not relieved with over-the-counter medications and who may not have indications for use of menopause hormone replacement therapy ⁹⁶
Bioidentical hormone therapy	Government-approved bioidentical hormone therapy may be offered to women living with HIV to manage the symptoms of menopause. However, compounded hormone therapy should be avoided (due to minimal government regulation and monitoring, risk of overdosing or underdosing, presence of impurities and lack of sterility, scientific efficacy, safety data and label outlining risks) and only considered if a woman cannot tolerate a government-approved bioidentical hormone therapy due to allergies to ingredients or for a dose or formulation not currently available in government-approved therapy ⁹⁶

Section E: Mental and emotional health care

Women living with HIV are almost twice as likely to experience mental health conditions than women living without HIV.⁹⁷ Provide frontline prevention, screening and treatment for mental health conditions using a biopsychosocial approach for all women living with HIV.

i. General mental health promotion strategies

General promotion strategy	Details
Stabilize physical and social priorities	Support women living with HIV to stabilize their physical and social priorities (e.g. safe and secure housing, food security, healthy relationships and other social factors)
Exercise	<p>Discuss the importance of regular exercise and which types of exercise works for them</p> <ul style="list-style-type: none"> Regular exercise = 150 minutes of moderate- to vigorous-intensity aerobic physical activity per week, in bouts of 10 minutes or more; muscle and bone strengthening activities using major muscle groups, at least 2 days per week ⁴⁹
Sleep hygiene	<p>Discuss the importance of sleep hygiene</p> <ul style="list-style-type: none"> Sleep hygiene = women having difficulty with sleeping can try to implement techniques (and decide what works best for them) such as, having a regular sleep and exercise schedule - even on weekends, going to bed only when tired, using their bedroom only for sleep and sexual activity, avoiding large meals and exercise just before bedtime, limiting caffeine, alcohol and nicotine, keeping their bedroom dark and quiet, avoiding daytime or evening napping, removing their bedroom clock from sight, avoiding light-emitting devices or bright lights in the hours before bedtime (e.g. e-books, cell phones, television) ⁵⁰ <p> Refer women to free resources such as Sleepwell.ca ⁵¹</p>
Mindfulness meditation	<p>Encourage women living with HIV to practice mindfulness meditation</p> <p> Refer women to free resources such as UCLA Mindful Awareness Research Center's guided meditation app ⁹⁸</p>
Community involvement	Encourage women living with HIV to become engaged in organizations and communities that connect them with people who they share identities with (e.g. spiritual, religious, race, ethnicity, heritage, SOGIE, age, location)
Self-care	Encourage women living with HIV to participate in activities that they enjoy and to prioritize their needs and interests (e.g. going for walks, engaging in hobbies, spiritual activities)
Peer support	Encourage women living with HIV to participate in peer support opportunities (see Section F: Peer support, leadership and capacity building)

Section E: Mental and emotional health care (continued)

ii. Screening and management

Use a stepped-care approach to screen for and select the most effective interventions for common mental health conditions.⁹⁹ An overview of the stepped-care approach is presented as well as a detailed overview of the approach for some common mental health conditions. Engage a psychiatric professional if needed to manage a mental health condition not listed below.

Overview of the stepped-care approach:⁹⁹

- **Step 1** – Proactively screen women living with HIV using a validated assessment tool
- **Step 2** – Offer women living with HIV, who are identified as having a potential mental health condition, brief counselling and treatment as well as connect them to a low-intensity treatment intervention and recommend general prevention strategies (see [i. General mental health prevention strategies](#)). Clinicians must consider a woman's lifestyle and life circumstances when choosing an intervention
- **Step 3** – Refer women living with HIV for higher-intensity interventions if condition symptoms do not respond to low-intensity interventions

Stepped-care approach for common mental health conditions:

Proactively screen women:

Proactively screen women living with HIV for possible mental health conditions using the [Patient Health Questionnaire \(PHQ\)](#)¹⁰⁰ validated assessment tool. Once the presenting condition is identified, follow the condition-specific steps below.

Depression:^{99, 101}

Step 1 – screen women living with HIV and symptoms of depression using the 9-item [Patient Health Questionnaire \(PHQ-9\)](#)¹⁰²

Step 2 – for women with confirmed symptoms of depression, connect them with low-intensity interventions such as, peer support, individual facilitated self-help, online cognitive behavioural therapy, structured group physical activity, self-help and support groups, nondirective counselling delivered at home

Step 3 – for women who do not respond to low-intensity interventions, provide or refer them for higher-intensity interventions such as, [pharmacotherapy](#)¹⁰³ (e.g. escitalopram, sertraline) and cognitive behavioural therapy, inter-personal psychotherapy, behavioural activation, behavioural couples therapy (if applicable)

Generalized anxiety disorder and panic disorder:⁹⁹

Step 1 – screen women living with HIV and symptoms of generalized anxiety disorder and panic disorder using the 7-item [Generalized Anxiety Disorder scale \(GAD-7\)](#)¹⁰⁴

Step 2 – for women with confirmed symptoms of generalized anxiety disorder and panic disorder, connect them with low-intensity interventions such as, peer support, individual non-facilitated and facilitated self-help, psychoeducational groups

Step 3 – for women who do not respond to low-intensity interventions, provide or refer them for higher-intensity interventions such as, cognitive behavioural therapy, applied relaxation, [pharmacotherapy for anxiety disorder](#)¹⁰⁵ or [pharmacotherapy for panic disorder](#)¹⁰⁶ (e.g. sertraline, venlafaxine) self-help and support groups

Post-traumatic stress disorder:⁹⁹

Step 1 – screen women living with HIV and symptoms of post-traumatic stress disorder using the 5-items [Primary Care PTSD Screen \(PC-PTSD\)](#)¹⁰⁷

Step 2 – for women with confirmed symptoms of post-traumatic stress disorder, connect them with low-intensity interventions such as, peer support, trauma-focused cognitive behavioural therapy or eye movement desensitization and reprocessing

Step 3 – for women who do not respond to low-intensity interventions, provide or refer them for higher-intensity interventions such as, trauma-focused cognitive behavioural therapy, eye movement desensitization and reprocessing, [pharmacotherapy](#)¹⁰⁸ (e.g. sertraline)

Substance use disorder and addiction:

Step 1 – screen women living with HIV and symptoms of substance use disorder and addiction using the 10-item [National Institute on Drug Abuse-Modified Alcohol, Smoking and Substance Involvement Screening Test \(NM-Modified ASSIST\)](#)¹⁰⁹

Step 2 – for women with confirmed symptoms of substance use disorder and addiction, connect them with low-intensity interventions such as, peer support and offer a single, brief, individualized session (typically 5–30 minutes) about ceasing or reducing the use of the substance

Step 3 – for women who do not respond to low-intensity interventions, provide or refer them for higher-intensity use disorder specific interventions (see below)

Alcohol use disorder¹¹⁰

Step 3 – for women who do not respond to low-intensity interventions, connect them with higher-intensity interventions such as, local self-help, support groups and rehabilitation or detox programs, and provide or refer them for cognitive behavioural therapy for alcohol use disorder, behavioural therapy focused on alcohol-related problems, social network and environment based therapies, behavioural couples therapy (if applicable), [pharmacotherapy](#)¹¹¹ (e.g. naltrexone, acamprosate)

Opioid use disorder¹¹²

Step 3 – for women who do not respond to low-intensity interventions, provide or refer them for higher-intensity interventions such as, [pharmacotherapy](#)¹¹³ (e.g. methadone, buprenorphine/naloxone) and contingency management, recommend local self-help and support groups

Other substance use disorders¹¹⁴

Step 3 – for women who do not respond to low-intensity interventions, connect them with higher-intensity interventions such as, local self-help and support groups, and provide or refer them for contingency management, cognitive behavioural therapy, psychodynamic therapy, or behavioural couples therapy (if applicable)



Always consult a reputable drug interaction reference (e.g. [HIVClinic.ca](#)³¹) or the product monograph before prescribing medication when a woman living with HIV is already on cART.

Important notes

- Remember that women's cultural beliefs, age, feelings of shame, ability, gender identity or the presence of children may impact their willingness to share their experiences of mental health conditions
- Be harm reduction aware and practice proactive harm reduction

Section F: Peer support, leadership and capacity building

Women living with HIV have the right to participate in their health care as active and equal participants and should be meaningfully involved in its design, delivery and evaluation.¹¹⁵ As part of clinical care, clinicians should identify and make women aware of local peer navigation programs and peer capacity building and leadership opportunities. The engagement of peers in women's care and engaging women in peer opportunities have been shown to improve health and wellbeing outcomes for women living with HIV.¹¹⁵⁻¹¹⁷ It should be acknowledged that not all women living with HIV will want peer support initially following diagnosis or at any point in their life.

Terms used in Section F: ¹¹⁸

- **Peers** – to refer to individuals who have lived experiences that are similar to those of another individual, and therefore can understand their life circumstances
- **Peer support** – to refer to individuals who have lived experiences that are similar to those of another individual, and who can provide them with emotional, cultural and social support
- **Peer navigators** – to refer to individuals who have lived experiences that are similar to those of another individual, and can help guide, connect, refer, educate and accompany them throughout their journey in the healthcare systems
- **Peer leadership** – to refer to women living with HIV who take roles that recognize and use their knowledge and expertise about HIV

i. Peer support

Peer support can be delivered one-on-one or in groups. Peer support can happen in-person, on the phone, over text, over email or through the internet. Peers can help women by sharing information, providing mutual social support and helping them feel empowered.¹¹⁹ As mentioned throughout this toolkit, peer support can also help women cope with their HIV diagnosis, trauma and violence, disclosure and stigma.

If peer support or peer navigator programs are not available in a woman's community:

- Engage outreach workers, public health nurses and community-based organizations



To find a community-based organization, search [HIV411](#)³² or the [Canadian AIDS Society's membership website](#)¹²⁰

- Encourage or help women to find informal support through:
 - Other women living with HIV
 - Online support
 - Online or local support communities (HIV or non-HIV specific)
- Consider starting a program



Refer to [CATIE's Practice Guidelines in Peer Health Navigation for People Living with HIV](#)¹¹⁸ for information on developing, implementing and strengthening peer health navigation programs

ii. Peer navigators

Make women living with HIV aware of the support that peer navigators can offer them.

Peer navigators can support women living with HIV by offering:⁹

- Practical assistance
- Advocacy support to ensure a woman's voice is heard during healthcare appointments and in the community
- Healthcare appointment support
- Emotional, cultural and social support based on a common understanding of the experience of living with HIV
- Education and information
- Referral support
- Healthcare system navigation support as well as support with transportation, housing, financial assistance, child/elder care, and other services that can facilitate optimal engagement in health care
- Relationship development support with clinicians and other health professionals
- Immigration system navigation support
- Encouragement to take an active role in their health care and self-care maintenance
- Sharing aspects of their lived experience in a manner that is helpful to the peer by inspiring hope for recovery

Section F: Peer support, leadership and capacity building (continued)

iii. Leadership and capacity building

Identify and make women living with HIV aware of peer leadership and capacity building opportunities in their community. Recognizing the contribution people living with HIV can and do make in response to HIV/ AIDS is called GIPA (Greater Involvement of People living with HIV/AIDS) and MEWA (Meaningful Engagement of Women living with HIV/AIDS).



For more info on GIPA/MEWA, refer to the [Pacific AIDS Network's Meaningful Involvement of People with HIV](#) webpage¹²¹

Peer leadership

- Women living with HIV are experts in their experiences, and they have valuable insights regarding potential barriers and stigmatizing behaviours¹²²
 - For optimal outcomes, it is best to engage women living with HIV from the beginning of the process¹²²
- Women living with HIV should be encouraged and supported in leadership roles on boards or steering committees, as mentors, peer navigators, peer group or program coordinators, organization leaders, advocates or in research
- Women living with HIV should be encouraged and supported to join local, regional, national and international health committees to help shape robust, high quality services of care that are based on safety and evidence⁷⁸
- Refer women to programs that support women living with HIV to realize their leadership potential and increase their capacity to participate meaningfully in community life:



[Pacific AIDS Network's Positive Leadership Development Institute](#)¹²³

[Ontario AIDS Network's Positive Leadership Development Institute](#)¹²⁴

Capacity building

- Women living with HIV need to be empowered through training, resources and compensation. Providing them with opportunities is not enough. Women living with HIV need to be given the opportunity to build on their skills, making it possible for them to succeed in other opportunities^{117, 125}
- Mentorship relationships may need to precede or coincide capacity building to begin equalizing power dynamics¹²²
- Capacity building includes assisting women living with HIV to develop the skills needed to contribute and create opportunities that allow them to participate meaningfully in decisions (in environments that have traditionally not been accessible to them)

If no leadership or capacity building opportunities are available, consider making some available in your organization (e.g. peer navigator, peer advisory councils).⁹

Important considerations when putting in place leadership or capacity building opportunities:

- Fair hiring process and clear role definition
- Fair compensation
- Adequate and ongoing training
- Supervision, support and mentorship
- Monitoring and evaluation of programs
- Barriers to meaningful involvement and leadership
- Involuntary HIV disclosure
- Confidentiality and legal policies
- Conflict resolution
- Stigma reduction
- Safety, appropriate/healthy boundaries and self-care
- Agency and empowerment
- Power dynamics and existing hierarchies
- GIPA and MEWA principles

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The model is in the shape of a 'house' to represent safety and stability – essential aspects for care delivery. Trauma- and violence- aware care is the 'foundation' to acknowledge the alarming high rates of violence, trauma and intersecting oppressions* women living with HIV face. Person-centred care with attention to social determinants of health and family make up the 'first floor'. For many women, ensuring their family is cared for is essential to their wellbeing as is ensuring adequate housing and livable income as well as other social determinants of health. The 'second floor' contains three rooms: competent HIV care is integrated with women's health [including sexual and reproductive health and rights (SRHR)] and mental health and addiction care; this is important as many women living with HIV do not see any other clinicians other than their HIV clinician. The 'roof' contains peer support, leadership and capacity-building which are integral to the model.

The woman herself is the most essential component of the model and emphasizes the shared-care decision-making principle of person-centred care. The woman is often supported by a peer to enter the house and together the women are holding up the glowing piece about peer support. Importantly, the model is meant to be provided to all women, in all their diversity. Finally, women will be of different ages at different stages of their lives, so all components of women-centred HIV care are to be delivered across the life course.

*Intersecting oppressions refers to disadvantages experienced by an individual based on their multiple and overlapping social identities including gender, race, ethnicity, class, sexuality, and HIV status. These identities are also shaped by history including colonization and slavery, and impact many aspects of one's life, including health status and wellbeing.

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