7. Appendices

Appendix A: Systematic review of evidence

A.1 Interventions to prevent disease: evidence searching

Search strategy
The authors of these guidelines searched the databases of MEDLINE, EMBASE and the Cochrane Library to gather evidence for the essential prevention and care interventions related to safe water systems, insecticide-treated nets (ITNs), intermittent preventive treatment in pregnancy (IPTp), vaccines, acyclovir, sexually transmitted infections, azole prophylaxis, and isoniazid preventive therapy. They conducted their searches from July 2005 to May 2006 and retrieved only articles published from 1980 on. All reference lists for major trials, topic reviews, and other guidelines found were reviewed for relevant trials. Experts in each field were contacted for any additional trials and data. All topics were initially searched for randomized controlled trials (RCTs) using the Cochrane RCT search strategy with the appropriate search terms. If no RCTs were identified, the search was broadened to include any evidence from other sources. As well, the authors searched specifically for evidence from studies done in settings with limited resources. Evidence from articles about studies conducted in high income countries was included when data from resource-limited settings were not available.

Search terms
For each intervention, the search terms are included below.

<table>
<thead>
<tr>
<th>Intervention topic</th>
<th>Search terms* (all include “and HIV or AIDS” or equivalent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isoniazid</td>
<td>Isoniazid, tuberculosis, prophylaxis, chemoprevention, treatment</td>
</tr>
<tr>
<td>Fluconazole</td>
<td>Fluconazole, antifungal agents, meningitis, cryptococcal, Cryptococcus, cryptococcosis, Candidiasis, candida</td>
</tr>
<tr>
<td>Itraconazole</td>
<td>Itraconazole, antifungal agents, meningitis, cryptococcal, Cryptococcus, cryptococcosis, Candidiasis, candida</td>
</tr>
<tr>
<td>Insecticide-treated mosquito nets</td>
<td>bedding and linens, malaria, insecticides, anopheles, mosquito control, antimalarials, pyramethamine, sulfadoxine, bednets, curtains, malaria prevention, long-lasting insecticide treated bed nets, mosquito net</td>
</tr>
<tr>
<td>Water, sanitation and hygiene</td>
<td>cholera, diarrhea, health status, water microbiology, water pollution, water supply, hygiene, water vessel, chlorination, chlorine, hand washing, safe water system, water purification, storage, drinking water, point of use, sanitation, sodium hypochlorite, flocculant</td>
</tr>
<tr>
<td>Syndromic treatment of STIs and screening</td>
<td>Syndromic treatment, syndromic management, sexually transmitted diseases treatment, sexually transmitted infections treatment, screening</td>
</tr>
<tr>
<td>Vaccines</td>
<td>Definitions and Uses</td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Acyclovir</td>
<td>Acyclovir, antiviral agents, prophylaxis, chemoprevention, treatment, therapy, herpes simplex virus 1, herpes simplex virus 2, genital herpes, hiv shedding, disease transmission, herpes genitalis, herpesvirus 2, herpesvirus 1</td>
</tr>
<tr>
<td>Pneumococcal vaccine</td>
<td>Pneumococcal vaccination, pneumococcal polysaccharide vaccine, pneumococcal conjugate vaccine, streptococcus pneumoniae, pneumococcal disease, pneumococci, pneumonia</td>
</tr>
<tr>
<td>Influenza vaccine</td>
<td>Influenza vaccination, influenza immunization, influenza vaccine, inactivated influenza vaccine, live attenuated influenza vaccine, influenza virus</td>
</tr>
<tr>
<td>Hepatitis B vaccine</td>
<td>Hepatitis B vaccination, hepatitis B immunization, hepatitis B vaccine, HBV, HIV-HBV, HIV coinfection</td>
</tr>
<tr>
<td>Yellow fever vaccine</td>
<td>Yellow fever vaccination, yellow fever immunization, yellow fever vaccine, yellow fever virus</td>
</tr>
</tbody>
</table>
A.2 Interventions to prevent HIV transmission: evidence searching

**Search strategy**
Essential prevention interventions included partner notification, family planning for women with HIV, needle-syringe exchange, psychosocial support, abstinence and abstinence-only and treatment. For testing and counselling interventions, the review was broken into free-standing and provider-initiated testing and counselling. To obtain evidence on disclosure and partner notification, elements of other systematic reviews were used. The systematic review found no evidence, however, on interventions for partner notification in resource-limited settings. Randomized controlled trials and other studies were included if they met the following criteria: 1) study was conducted in a developing country or emerging economy as defined by the World Bank (no US data included); 2) study evaluated the specific intervention being examined; 3) results presented were from pre- and post-assessments, or comparing persons who received the intervention to those who did not; 4) study measured HIV-related intermediate outcomes, or health outcomes such as knowledge, perceptions, attitudes, beliefs, and HIV-risk behaviours; and 5) study was published between January 1990 and December 31, 2004 (reviews of VCT ended April 15, 2005 and treatment ended January 31, 2006).

The databases searched were the U.S. National Library of Medicine’s (NLM) Gateway (including PubMed, MEDLINE and AIDSLine), EMBASE, PsycINFO, Sociological Abstracts, and the Cumulative Index to Nursing and Allied Health Literature (CINAHL). Hand-searches were conducted of four HIV-related journals: AIDS Care, AIDS, AIDS and Behavior, and AIDS Education and Prevention. Additional hand-searching was done of International Journal of Drug Policy for the needle-exchange review and the Journal of AIDS for the VCT review. References of papers included were also searched. Unpublished data and conference abstracts were excluded.

**Search terms**
For each intervention, the search terms are included below.

<table>
<thead>
<tr>
<th>Intervention Topic</th>
<th>Search terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner notification</td>
<td>partner notification, contact tracing, HIV and self-disclosure, interpersonal communication and HIV, HIV partner notification, HIV and partner referral, HIV and partner disclosure</td>
</tr>
<tr>
<td>Family planning for women with HIV</td>
<td>family planning and HIV, fertility and HIV, family planning and counselling and HIV, family planning and developing country</td>
</tr>
<tr>
<td>Needle-syringe programmes</td>
<td>needle exchange and HIV, NEP and HIV, needle distribution and HIV, NESP and HIV, needle sales, syringe sales, syringe distribution and HIV, syringe exchange, SEP and HIV, shooting galleries and HIV, injecting drug users and HIV</td>
</tr>
<tr>
<td>Psychosocial support</td>
<td>support groups and HIV, support groups and AIDS, palliative care and AIDS, palliative care and HIV, ongoing counselling and HIV, ongoing counselling and AIDS, psychotherapy and AIDS, psychotherapy and HIV, HIV counselling and developing country, AIDS counselling and developing country</td>
</tr>
<tr>
<td>Abstinence and abstinence-only</td>
<td>abstinence and HIV, abstinence only and HIV, no sex partners and HIV, no sex partners and intervention and HIV, until marriage and HIV, abstinence only until marriage and HIV, chastity and HIV, virginity and HIV, wait until marriage and HIV, abstinence plus and HIV, born again virgin and HIV, no sex partners and education and HIV, abstinence based interventions and HIV, virginity pledge and HIV, celibacy and HIV, sex can wait and HIV, true love waits and HIV, true sexual freedom and HIV, not me not now and HIV, ABC and HIV, abstain from sex and HIV</td>
</tr>
</tbody>
</table>
A.3 Coding and rigour

Coding

Two coders extracted data from each eligible citation independently using a highly detailed coding form. Data were extracted in 15 content areas: (1) citation information; (2) study inclusion criteria; (3) study methods; (4) study population characteristics; (5) setting; (6) sampling; (7) study design; (8) unit of analysis; (9) loss to follow-up rates; (10) study group (arms or comparison groups) characteristics; (11) intervention characteristics; (12) intervention topic specific questions; (13) outcome measures; (14) eligible outcome results; and (15) additional information (costs; limitations, potential harms, community-acceptance, and other relevant information).

All outcome variables reported in a study were noted, but detailed results were only recorded for those outcomes with either a pre/post or between study group arm comparisons. Such eligible outcome results were coded in a structured format. This included: (1) the type of statistical analysis used; (2) the effect size and base rate; (3) the independent variable; (4) catchments and/or follow-up times; (5) the confidence interval and/or p-value; (6) the page number and table where the results are located; and (7) any additional brief information thought to be important. All eligible outcome results were coded, including sub-group presentation of results (such as by gender) even when aggregated results were also presented. Once each of the two coders independently coded the citation, the data were transferred to a statistical database (using SPSS Data Entry software, SPSS™, Chicago, IL).

Inter-coder discrepancies were then resolved to correct for data entry errors, and to identify different interpretations in the presentation of results. A resolution report, containing a comparison of each coder’s textual data fields and highlighting any differences between coders, was generated from the SPSS™ quantitative database. Senior staff resolved any discrepancies in consultation with the study’s principal investigator and other senior collaborators. When needed, attempts were made to contact authors to resolve differences. After resolving the discrepancies, the principal investigator reviewed the final records of each coding form. Detailed records were kept on the reason for discrepancies across coders, and how they were resolved.

Assessing the rigour of studies

The authors analysed the rigour of each study using an eight-point scale developed for the project. This scale descriptively measures adherence to standards for unbiased research, allowing for a standard comparison of rigour across analyses. One point is given for each item. The default value for each criterion is nil, and analyses are only scored on each criterion when data are available to assess the criterion. The rigour scale contains the following items and definitions:

- **Prospective cohort analyses** presented data for a cohort of study participants followed over time, including pre-intervention to post-intervention analyses with or without a control or comparison group. Serial cross-sectional analyses, or post-only comparisons, were not scored on this criterion. Control or
comparison groups were defined as analyses that compare those who received the intervention under study to those who did not, or who received a more-versus-less intensive intervention. These include analyses that compare intervention, control and/or comparison groups, and stratified cross-sectional analyses. This item does not include before-after analyses without stratification.

- **Pre/post intervention outcome data**: These were assessed as it is common for studies to only assess outcome measures in the post-intervention catchments, especially for post-hoc analyses and secondary study aims.

- **Random assignment to treatment groups**: This is defined as when study participants are randomly assigned to treatment groups in multi-arm studies, and includes group-randomized designs. This criterion is nested within a criterion for a control or comparison group to give added weight to designs that include randomization and controls.

- **Random selection of study participants**: The authors of the guidelines assessed whether the quality of data was undermined by selection bias in study enrollment.

- **Attrition**: This was assessed to determine if the follow-up rate was 80% or more at each analysis point.

- **Comparison-group matching** was assessed in multi-arm studies to determine if there were statistically significant differences in socio-demographic measures (such as age) across arms.

- **Comparison-group matching on outcome measures** was also assessed to establish whether studies had statistically significant baseline differences in study outcome measures.
Appendix B: List of participants at WHO expert consultation

The following experts attended the WHO consultative meetings on essential care and prevention interventions for people living with HIV: reviewing the evidence and developing guidelines, June 28-30, 2006, in Montreux, Switzerland (topic groups and roles are given in parentheses):

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HIV/Strategic Information and Research (STIs)

Dr Isabelle **De Zoysa**  
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## Appendix C: WHO clinical staging of HIV/AIDS for adults and adolescents with confirmed HIV infection

<table>
<thead>
<tr>
<th>Stage 1</th>
<th>Asymptomatic, Persistent generalized lymphadenopathy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 2</td>
<td>Unexplained moderate weight loss (&lt;10% of presumed or measured body weight)</td>
</tr>
<tr>
<td></td>
<td>Recurrent respiratory tract infections (sinusitis, tonsillitis, bronchitis, otitis media, pharyngitis)</td>
</tr>
<tr>
<td></td>
<td>Herpes zoster</td>
</tr>
<tr>
<td></td>
<td>Angular cheilitis</td>
</tr>
<tr>
<td></td>
<td>Recurrent oral ulceration</td>
</tr>
<tr>
<td></td>
<td>Papular pruritic eruptions</td>
</tr>
<tr>
<td></td>
<td>Seborrhoeic dermatitis</td>
</tr>
<tr>
<td></td>
<td>Fungal nail infections</td>
</tr>
<tr>
<td>Stage 3</td>
<td>Unexplained severe weight loss (&gt;10% of presumed or measured body weight)</td>
</tr>
<tr>
<td></td>
<td>Unexplained chronic diarrhoea for longer than one month</td>
</tr>
<tr>
<td></td>
<td>Unexplained persistent fever (above 37.5°C intermittent or constant, for longer than one month)</td>
</tr>
<tr>
<td></td>
<td>Persistent oral candidiasis</td>
</tr>
<tr>
<td></td>
<td>Oral hairy leukoplakia</td>
</tr>
<tr>
<td></td>
<td>Pulmonary tuberculosis</td>
</tr>
<tr>
<td></td>
<td>Severe presumed bacterial infections (e.g., pneumonia, empyema, pyomyositis, bone or joint infection, meningitis, bacteraemia)</td>
</tr>
<tr>
<td></td>
<td>Acute necrotizing ulcerative stomatitis, gingivitis or periodontitis</td>
</tr>
<tr>
<td></td>
<td>Unexplained anaemia (&lt;8 g/dl), neutropenia (&lt;0.5 x 10⁹ per litre) and/or chronic thrombocytopenia (&lt;50 x 10⁹ per litre)</td>
</tr>
<tr>
<td>Stage 4</td>
<td>HIV wasting syndrome</td>
</tr>
<tr>
<td></td>
<td>Pneumocystis pneumonia</td>
</tr>
<tr>
<td></td>
<td>Recurrent severe bacterial pneumonia</td>
</tr>
<tr>
<td></td>
<td>Chronic herpes simplex infection (orolabial, genital or anorectal of more than one month's duration or visceral at any site)</td>
</tr>
<tr>
<td></td>
<td>Oesophageal candidiasis (or candidiasis of trachea, bronchi or lungs)</td>
</tr>
<tr>
<td></td>
<td>Extrapulmonary tuberculosis</td>
</tr>
<tr>
<td></td>
<td>Kaposi's sarcoma</td>
</tr>
<tr>
<td></td>
<td>Cytomegalovirus infection (retinitis or infection of other organs)</td>
</tr>
<tr>
<td></td>
<td>Central nervous system toxoplasmosis</td>
</tr>
<tr>
<td></td>
<td>HIV encephalopathy</td>
</tr>
<tr>
<td></td>
<td>Extrapulmonary cryptococcosis, including meningitis</td>
</tr>
<tr>
<td></td>
<td>Disseminated non-tuberculous mycobacteria infection</td>
</tr>
<tr>
<td></td>
<td>Progressive multifocal leucoencephalopathy</td>
</tr>
<tr>
<td></td>
<td>Chronic Cryptosporidiosis</td>
</tr>
<tr>
<td></td>
<td>Chronic Isosporiasis</td>
</tr>
<tr>
<td></td>
<td>Disseminated mycosis (extrapulmonary histoplasmosis or coccidiomycosis)</td>
</tr>
<tr>
<td></td>
<td>Recurrent septicaemia (including non-typhoidal Salmonella)</td>
</tr>
<tr>
<td></td>
<td>Lymphoma (cerebral or B-cell non-Hodgkin)</td>
</tr>
<tr>
<td></td>
<td>Invasive cervical carcinoma</td>
</tr>
<tr>
<td></td>
<td>Atypical disseminated leishmaniasis</td>
</tr>
<tr>
<td></td>
<td>Symtomatic HIV-associated nephropathy or symptomatic HIV-associated cardiomypathy</td>
</tr>
</tbody>
</table>

### Appendix D: Presumptive and definitive criteria for recognizing HIV/AIDS-related clinical events in adults (15 or older) with confirmed HIV infection

<table>
<thead>
<tr>
<th>Clinical stage</th>
<th>Clinical event</th>
<th>Clinical diagnosis</th>
<th>Definitive diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Stage 1</strong></td>
<td>Asymptomatic</td>
<td>No HIV-related symptoms reported and no signs on examination</td>
<td>Not applicable</td>
</tr>
<tr>
<td></td>
<td>Persistent generalized lymphadenopathy</td>
<td>Painless enlarged lymph nodes &gt;1 cm in two or more non-contiguous sites (excluding inguinal nodes) in the absence of known cause, and persisting for three months or more</td>
<td>Histology</td>
</tr>
<tr>
<td><strong>Clinical Stage 2</strong></td>
<td>Moderate unexplained weight loss (&lt;10% of body weight)</td>
<td>Reported unexplained involuntary weight loss; in pregnancy failure to gain weight</td>
<td>Documented weight loss &lt;10% of body weight</td>
</tr>
<tr>
<td></td>
<td>Recurrent upper respiratory tract infections (current event plus one or more in last six-month period)</td>
<td>Symptom complex, such as unilateral face pain with nasal discharge (sinusitis), painful inflamed eardrum (otitis media) or tonsillopharyngitis without features of viral infection (such as coryza or cough)</td>
<td>Laboratory studies where available, such as culture of suitable body fluid</td>
</tr>
<tr>
<td></td>
<td>Herpes zoster</td>
<td>Painful vesicular rash in dermatomal distribution of a nerve supply, does not cross the midline</td>
<td>Clinical diagnosis</td>
</tr>
<tr>
<td></td>
<td>Angular cheilitis</td>
<td>Splits or cracks at the angle of the mouth, not due to iron or vitamin deficiency, usually respond to antifungal treatment</td>
<td>Clinical diagnosis</td>
</tr>
<tr>
<td></td>
<td>Recurrent oral ulcerations (two or more episodes in last six months)</td>
<td>Aphthous ulceration, typically painful with a halo of inflammation and a yellow-grey pseudomembrane</td>
<td>Clinical diagnosis</td>
</tr>
<tr>
<td></td>
<td>Papular pruritic eruption</td>
<td>Papular pruritic lesions, often with marked post-inflammatory pigmentation</td>
<td>Clinical diagnosis</td>
</tr>
<tr>
<td></td>
<td>Seborrhoeic dermatitis</td>
<td>Itchy scaly skin condition, particularly affecting hairy area (scalp, axillae, upper trunk and groin)</td>
<td>Clinical diagnosis</td>
</tr>
<tr>
<td></td>
<td>Fungal nail infections</td>
<td>Paronychia (painful red and swollen nail bed) or onycholysis (separation of the nail from the nail bed) of the fingernails (white discoloration—especially involving proximal part of nail plate— with thickening and separation of the nail from the nail bed)</td>
<td>Fungal culture of the nail or nail-plate material</td>
</tr>
<tr>
<td><strong>Clinical Stage 3</strong></td>
<td>Unexplained severe weight loss (more than 10% of body weight)</td>
<td>Reported unexplained involuntary weight loss (&gt;10% of body weight) and visible thinning of face, waist and extremities with obvious wasting or body mass index &lt;18.5 kg/m²; in pregnancy the weight loss may be masked</td>
<td>Documented loss of more than 10% of body weight</td>
</tr>
<tr>
<td>Clinical event</td>
<td>Clinical diagnosis</td>
<td>Definitive diagnosis</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>--------------------</td>
<td>---------------------</td>
<td></td>
</tr>
<tr>
<td>Unexplained chronic diarrhoea for longer than one month</td>
<td>Chronic diarrhoea (loose or watery stools, three or more times daily) reported for longer than one month</td>
<td>Three or more stools observed and documented as unformed, and two or more stool tests reveal no pathogens</td>
<td></td>
</tr>
<tr>
<td>Unexplained persistent fever (intermittent or constant and for longer than one month)</td>
<td>Fever or night sweats for more than one month, either intermittent or constant with reported lack of response to antibiotics or antimalarial agents without other obvious foci of disease reported or found on examination; malaria must be excluded in malarious areas</td>
<td>Documented fever &gt;37.5°C with negative blood culture, negative Ziehl-Nielsen stain, negative malaria slide, normal or unchanged chest X-ray, and no other obvious focus of infection</td>
<td></td>
</tr>
<tr>
<td>Oral candidiasis</td>
<td>Persistent or recurring creamy white curd-like plaques that can be scraped off (pseudomembranous), or red patches on tongue, palate or lining of mouth, usually painful or tender (erythematous form)</td>
<td>Clinical diagnosis</td>
<td></td>
</tr>
<tr>
<td>Oral hairy leukoplakia</td>
<td>Fine white small linear patches or corrugated lesions on lateral borders of the tongue that do not scrape off</td>
<td>Clinical diagnosis</td>
<td></td>
</tr>
<tr>
<td>Pulmonary tuberculosis (current)</td>
<td>Chronic symptoms: (lasting more than two-to-three weeks) cough, haemoptysis, shortness of breath, chest pain, weight loss, fever, night sweats, and no clinical evidence of extrapulmonary disease</td>
<td>One or more sputum smear positive for acid-fast bacilli and/or radiographic abnormalities consistent with active tuberculosis and/or culture positive for Mycobacterium</td>
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</tr>
<tr>
<td>Discrete peripheral lymph node M. tuberculosis infection (especially cervical) is considered a less severe form of extrapulmonary tuberculosis</td>
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<tr>
<td>Severe bacterial infection (e.g., pneumonia, meningitis, empyema, pyomyositis, bone or joint infection, bacteraemia and severe pelvic inflammatory disease)</td>
<td>Fever accompanied by specific symptoms or signs that localize infection and response to appropriate antibiotic</td>
<td>Isolation of bacteria from appropriate clinical specimens (usually sterile sites)</td>
<td></td>
</tr>
<tr>
<td>Acute necrotizing ulcerative gingivitis or necrotizing ulcerative periodontitis</td>
<td>Severe pain, ulcerated gingival papillae, loosening of teeth, spontaneous bleeding, bad odour, and rapid loss of bone and/or soft tissue</td>
<td>Clinical diagnosis</td>
<td></td>
</tr>
<tr>
<td>Unexplained anaemia (&lt;8 g/dl), neutropenia (&lt;0.5 x 10^9 per litre) or chronic (more than one month) thrombocytopenia (&lt;50 x 10^9 per litre)</td>
<td>No presumptive clinical diagnosis</td>
<td>Diagnosed on laboratory testing and not explained by other non-HIV conditions; not responding to standard therapy with haematinics, antimalarial agents or other anthelmintic agents as outlined in relevant national treatment guidelines, WHO Integrated Management of Adult Illness guidelines or other relevant guidelines</td>
<td></td>
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</tbody>
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**Clinical Stage 4**

<table>
<thead>
<tr>
<th>Clinical event</th>
<th>Clinical diagnosis</th>
<th>Definitive diagnosis</th>
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</thead>
<tbody>
<tr>
<td>Unexplained involuntary weight loss (&gt;10% baseline body weight), with obvious wasting or body mass index &lt; 18.5 PLUS unexplained chronic diarrhoea (loose or watery stools, three or more times daily) reported for longer than one month OR reports of fever or night sweats for more than one month without other cause and lack of</td>
<td>Documented weight loss &gt;10% of body weight PLUS two or more unformed stools negative for pathogens OR documented temperature of &gt; 37.5°C with no other cause of disease, negative blood culture, negative malaria slide and normal or unchanged chest X-ray</td>
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</table>

*Appendices to Guidelines on Prevention Interventions for PLHIVs, April 18, 2007 / 13*
<table>
<thead>
<tr>
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<th>Clinical diagnosis</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Pneumocystis pneumonia</strong></td>
<td>Dyspnoea on exertion or nonproductive cough of recent onset (within the past three months), tachypnoea and fever AND chest X-ray evidence of diffuse bilateral interstitial infiltrates AND no evidence of bacterial pneumonia; bilateral crepitations on auscultation with or without reduced air entry</td>
<td>Cytology or immunofluorescent microscopy of induced sputum or bronchoalveolar lavage or histology of lung tissue</td>
</tr>
<tr>
<td>Recurrent severe presumed bacterial pneumonia</td>
<td>Current episode plus one or more previous episodes in the past six months; acute onset (two weeks) of severe symptoms (such as fever, cough, dyspnoea, and chest pain) PLUS new consolidation on clinical examination or chest-X-ray; response to antibiotics</td>
<td>Positive culture or antigen test of a compatible organism</td>
</tr>
<tr>
<td>Chronic herpes simplex virus infection (orolabial, genital or anorectal) of more than one month or visceral of any duration</td>
<td>Painful, progressive anogenital or orolabial ulceration; lesions caused by recurrence of herpes simplex virus infection and reported for more than one month. History of previous episodes. Visceral herpes simplex visura requires definitive diagnosis</td>
<td>Positive culture or DNA (by polymerase chain reaction) of herpes simplex virus or compatible cytology or histology</td>
</tr>
<tr>
<td>Oesophageal candidiasis</td>
<td>Recent onset of retrosternal pain or difficulty on swallowing (foods and fluids) together with oral <strong>Candida</strong></td>
<td>Macroscopic appearance at endoscopy or bronchoscopy, or by microscopy or histology</td>
</tr>
<tr>
<td>Extrapulmonary tuberculosis</td>
<td>Systemic illness (such as fever, night sweats, weakness and weight loss). Other evidence for extrapulmonary or disseminated tuberculosis varies by site, such as pleura, pericardia, meninges, mediastinum or abdominal Discrete peripheral lymph node <strong>Mycobacterium tuberculosis</strong> infection (especially cervical) is considered a less severe form of extrapulmonary tuberculosis</td>
<td><strong>M. tuberculosis</strong> isolation or compatible histology from appropriate site or radiological evidence of military TB (diffuse uniformly distributed small military shadows or microucles on chest X-ray)</td>
</tr>
<tr>
<td>Kaposi sarcoma</td>
<td>Typical gross appearance in skin or oropharynxx of persistent, initially flat, patches with a pink or violaceous colour, skin lesions that usually develop into plaques or nodules</td>
<td>Macroscopic appearance at endoscopy or bronchoscopy, or by histology</td>
</tr>
<tr>
<td>Cytomegalovirus disease (other than liver, spleen or lymph node)</td>
<td>Retinitis only: may be diagnosed by experienced clinicians. Typical eye lesions on fundoscopic examination: discrete patches of retinal whitening with distinct borders, spreading centrifugally, often following blood vessels, associated with retinal vasculitis, haemorrhage and necrosis</td>
<td>Compatible histology or cytomegalovirus demonstrated in cerebrospinal fluid by culture or DNA (by polymerase chain reaction)</td>
</tr>
<tr>
<td>Central nervous system toxoplasmosis</td>
<td>Recent onset of a focal nervous system abnormality consistent with intracranial disease</td>
<td>Positive serum toxoplasma antibody AND (if available) single or multiple</td>
</tr>
<tr>
<td><strong>Clinical event</strong></td>
<td><strong>Clinical diagnosis</strong></td>
<td><strong>Definitive diagnosis</strong></td>
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<tr>
<td>HIV encephalopathy</td>
<td>Disabling cognitive and/or motor dysfunction interfering with activities of daily living, progressing over weeks or months in the absence of a concurrent illness or condition, other than HIV infection, which might explain the findings</td>
<td>Diagnosis of exclusion: and (if available) neuroimaging (computed tomography or magnetic resonance imaging)</td>
</tr>
<tr>
<td>Extrapulmonary cryptococcosis (including meningitis)</td>
<td>Meningitis: usually subacute, fever with increasing severe headache, meningism, confusion, behavioural changes that respond to cryptococcal therapy</td>
<td>Isolation of <em>Cryptococcus neoformans</em> from extrapulmonary site or positive cryptococcal antigen test on cerebrospinal fluid or blood</td>
</tr>
<tr>
<td>Disseminated non-tuberculous mycobacterial infection</td>
<td>No presumptive clinical diagnosis</td>
<td>Diagnosed by finding atypical mycobacterial species from stool, blood, body fluid or other body tissue, excluding the lungs</td>
</tr>
<tr>
<td>Progressive multifocal leukoencephalopathy</td>
<td>No presumptive clinical diagnosis</td>
<td>Progressive nervous system disorder (cognitive dysfunction, gait/speech disorder, visual loss, limb weakness and cranial nerve palsies) together with hypodense white matter lesions on neuroimaging or positive polyomavirus JC polymerase chain reaction on cerebrospinal fluid</td>
</tr>
<tr>
<td>Chronic cryptosporidiosis (with diarrhoea lasting more than one month)</td>
<td>No presumptive clinical diagnosis</td>
<td>Cysts identified on modified Ziehl-Nielsen stain microscopic examination of unformed stool</td>
</tr>
<tr>
<td>Chronic Isosporiasis</td>
<td>No presumptive clinical diagnosis</td>
<td>Identification of <em>Isospora</em></td>
</tr>
<tr>
<td>Disseminated mycosis (such as coccidiomycosis, histoplasmosis, or penicilliosis)</td>
<td>No presumptive clinical diagnosis</td>
<td>Histology, antigen detection or culture from clinical specimen or blood culture</td>
</tr>
<tr>
<td>Recurrent non-typhoid <em>Salmonella</em> bacteraemia</td>
<td>No presumptive clinical diagnosis.</td>
<td>Blood culture</td>
</tr>
<tr>
<td>Lymphoma (cerebral or B-cell non-Hodgkin)</td>
<td>No presumptive clinical diagnosis</td>
<td>Histology of relevant specimen or, for central nervous system tumours, neuroimaging techniques</td>
</tr>
<tr>
<td>Invasive cervical carcinoma</td>
<td>No presumptive clinical diagnosis</td>
<td>Histology or cytology</td>
</tr>
<tr>
<td>Visceral leishmaniasis</td>
<td>No presumptive clinical diagnosis</td>
<td>Diagnosed by histology (amastigotes visualized) or culture from any appropriate clinical specimen</td>
</tr>
<tr>
<td>HIV-associated nephropathy</td>
<td>No presumptive clinical diagnosis</td>
<td>Renal biopsy</td>
</tr>
<tr>
<td>HIV-associated cardiomyopathy</td>
<td>No presumptive clinical diagnosis</td>
<td>Cardiomegaly and evidence of poor left</td>
</tr>
<tr>
<td>Clinical event</td>
<td>Clinical diagnosis</td>
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<td>Ventricular function confirmed by echocardiography</td>
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</tbody>
</table>

Appendix E: WHO guidelines and links

Antiretroviral Therapy


Co-trimoxazole


Clinical staging


Nutrition

  http://www.who.int/nutrition/publications/Content_nutrient_requirements.pdf


- WHO technical papers prepared for the April 2005 WHO Consultation on HIV/AIDS and Nutrition in Durban, South Africa, as well as the Participants’ Statement from the consultation, and the December 2005 Report on HIV/AIDS and Nutrition to the WHO Executive Board.  
  Participants' Statement [pdf 137kb]
Sexually transmitted infections


Tuberculosis


Malaria


**Family planning**


**Safe water**


Testing and counselling

• Guidelines on Provider-initiated HIV Testing and Counselling in Health Facilities (in draft).

Vaccines


Other WHO references

• WHO Integrated Management of Adolescent and Adult Illness http://www.who.int/hiv/pub/imaia/en/

• WHO List of Essential Medicines
http://www.who.int/topics/essential_medicines/en/


Other guidelines