Technical Guidance Note for Global Fund HIV Proposals

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Testing and counselling

Rationale for including testing and counselling in the proposal

The number of men, women, adolescents and children in the general population who know their human immunodeficiency virus (HIV) status remains inadequate. Significant expansion in the availability of, and equity of access to, HIV testing and counselling is required in order to meet universal access goals to treatment and care. The result of low coverage and uptake of HIV testing and counselling, and low levels of knowledge of HIV status, is that many people living with HIV access HIV testing and counselling only when they already have advanced clinical disease.

Where antiretroviral therapy is available, maximum benefit in terms of reduced morbidity and mortality is obtained when HIV is diagnosed early. Additional benefits of HIV testing and counselling include improved access to interventions such as antiretroviral prophylaxis for the prevention of mother-to-child transmission, and an entry point for men in high-burden countries to medical male circumcision. Earlier diagnosis also presents an opportunity to provide people living with HIV with information and tools to prevent HIV transmission to their partners and others. For HIV-negative people, HIV testing and counselling can facilitate the adoption of preventive behaviours.

Elements to be considered in the situation analysis

- Prevalence of HIV infection in the general population and in specific subpopulations (important to identify whether it is a generalized, concentrated or low-level epidemic).
- Availability of HIV testing and counselling services.
- Coverage and use of HIV testing and counselling services, including an understanding of the groups that are not being reached by available services (e.g. young people, key populations) and barriers and facilitators to access to testing.
- Existing policies regarding HIV testing and counselling and particular social and legal factors that may impede access.
- Availability of financial and personnel resources.

Examples of programme objectives

- To expand availability of HIV testing and counselling services, including a focus on key populations and communities that are hard to reach, particularly in countries with concentrated and missed epidemics.
- To increase the number of people who know their HIV status from *x*% to *y*%.
- To assure the quality of HIV testing and counselling services.[1]
- To assure the existence and quality of effective and efficient referral and linkage systems.

Focus populations

Populations to be focused for HIV testing and counselling services include the following:

- Adults and adolescents wishing to have an HIV test.
- In generalized epidemics, all adults, adolescents and children attending clinical services.
- In concentrated and low-level epidemics, all adults, adolescents and children who present in clinical settings with signs and symptoms or medical conditions that may indicate HIV infection.

1 *Handbook for improving HIV testing and counselling services.* Geneva, World Health Organization, 2010 (http://www.who.int/hiv/pub/vct/9789241500463/en/index.html).

- In all epidemics, all adults attending services for sexually transmitted infections (STIs), family planning and tuberculosis (TB).
- In all epidemics, all pregnant women first presenting for antenatal care. In addition, in high-prevalence generalized epidemics, retesting of pregnant women in the third trimester, or during labour or postpartum if the HIV status has not been determined, is recommended.[2]
- All children born to women living with HIV.[3]
- Parents of unknown HIV status who have children living with HIV.
- People identified as members of, or attending services for, key populations (people who inject drugs, sex workers, men who have sex with men).[4,5,6]
- Men presenting for circumcision for HIV prevention (re male circumcision guidelines).
- Couples.[7]

HIV testing and counselling can be either client- or provider-initiated, and provided at the individual or couple level.

Couples voluntary testing and counselling

Couples HIV testing and counselling provides test results and counselling to two or more partners simultaneously, and gives an opportunity for mutual disclosure, the provision of support to couples and the development of a mutual HIV risk management plan. Couples HIV testing and counselling can be provided within health facilities, including antenatal clinics, and through home-based testing. The World Health Organization (WHO) recommends the increased offering of couples HIV testing and counselling in generalized epidemics.

Facility-based testing

Client-initiated testing and counselling

This approach, also known as voluntary counselling and testing, entails an individual or couple actively seeking HIV testing and counselling from a standalone facility offering the service. Voluntary counselling and testing sites can be free-standing or integrated into health facilities, educational institutions or workplaces.

Provider-initiated testing and counselling

In this approach, an HIV test is recommended by health-care providers (i) for all patients, irrespective of epidemic setting, whose clinical presentation may result from underlying HIV infection; (ii) as a standard part of medical care for all patients attending health facilities in generalized HIV epidemics; and (iii) more selectively in concentrated and low-level epidemics.

In implementing testing and counselling services, particular attention needs to be given to issues such as testing and counselling for infants, children and adolescents, and their families and caregivers, and couples testing and counselling.

2 *Delivering HIV test results and messages for re-testing and counselling in adults.* Geneva, World Health Organization, 2010 (http://www.who.int/hiv/pub/vct/hiv_re_testing/en/).

3 *WHO recommendations on the diagnosis of HIV in infants and children.* Geneva, World Health Organization, 2010 (http://www.who.int/hiv/pub/paediatric/diagnosis/en/index.html).

4 *Prevention and treatment of HIV and other sexually transmitted infection among men who have sex with men and transgender people.* Geneva, World Health Organization, 2011 (http://www.who.int/hiv/pub/guidelines/msm_guidelines2011/en/index.html).

5 *Guidance on testing and counselling for HIV in settings attended by people who inject drugs: Improving access to treatment, care and prevention.* Geneva, World Health Organization, 2005 (http://www.who.int/hiv/pub/idu/iduguide/en/index.html).

6 *HIV testing and counselling in prisons and other closed settings.* Geneva, World Health Organization, 2009 (http://www.who.int/hiv/pub/idu/tc_prisons/en/index.html).

7 *Couples HIV testing and counselling and antiretroviral therapy for treatment and prevention in serodiscordant couples.* In press.

In all types of HIV epidemics, health-care providers should recommend HIV testing and counselling as part of the standard of care to:

- all adults, adolescents and children who present to health facilities with signs, symptoms or medical conditions that may indicate HIV infection; these include, but are not necessarily limited to, TB and other conditions specified in the WHO HIV clinical staging system;
- infants born to women living with HIV as a routine component of the follow-up care for these children – early infant diagnosis is recommended;
- children presenting with suboptimal growth or malnutrition in generalized epidemics, and under certain circumstances in other settings such as when malnourished children do not respond to appropriate nutritional therapy;
- men seeking circumcision as an HIV prevention intervention.

In **generalized epidemics** where an enabling environment is in place and adequate resources are available, including a recommended package of HIV prevention, treatment and care, health-care providers should recommend HIV testing and counselling to all adults, adolescents and children seen in all health facilities. This applies to medical (including maternal and child health services) and surgical services, public and private facilities, inpatient and outpatient settings, and mobile and outreach medical services.

HIV testing and counselling should be recommended by health-care providers as part of the normal standard of care provided to the patient, regardless of whether the patient shows signs and symptoms of underlying HIV infection or the patient's reason for presenting to the health facility.

Resource and capacity constraints may require a phased implementation of provider-initiated HIV testing and counselling. The following settings and services should be considered priorities for the implementation of provider-initiated HIV testing and counselling in generalized epidemic settings:

- medical inpatient and outpatient facilities, including TB clinics;
- antenatal, childbirth and postpartum health services – in these settings, couples HIV testing and counselling is recommended;
- health services and other services for key populations;
- services for children;
- surgical services;
- services for adolescents;
- reproductive health services, including family planning;
- STI services.

For **concentrated and low-level HIV epidemics**, health-care providers should not recommend HIV testing and counselling to all people attending all health facilities, since most people will have a low risk of exposure to HIV. In such settings, the priority should be to ensure that HIV testing and counselling is recommended to all adults, adolescents and children who present to health facilities with signs and symptoms suggestive of underlying HIV infection, including TB, and to children known to have been exposed perinatally to HIV.

If data show that HIV prevalence in people with TB is very low, then the recommendation of offering HIV testing and counselling to people with TB may not be a priority.

Decisions about whether and how to implement provider-initiated HIV testing and counselling in selected health facilities in low-level and concentrated epidemics should be guided by an assessment of the epidemiological and social context. Consideration may be given to the implementation of provider-initiated HIV testing and counselling in the following health facilities or services:

- STI services;
- health services for key populations;
- antenatal, childbirth and postpartum services;
- TB services.

Other models of testing and counselling service delivery

Where HIV testing and counselling is facility-based, there are various structural, logistic and social barriers to access. The provision of HIV testing and counselling services at the community level can remove these barriers, thereby improving equity of access and uptake of services. The provision of HIV testing and counselling services at the community level can also contribute to reducing the stigma and discrimination associated with HIV testing and counselling and HIV where community mobilization is conducted alongside the promotion of community-based HIV testing and counselling services. Treatment 2.0 advocates for strengthened community mobilization to promote access to and use of HIV testing and counselling services.

National testing campaigns

National campaigns can be delivered at the national, regional or district level. They can be integrated with other disease-prevention campaigns, including for malaria and diabetes. National campaigns can be implemented in many different ways, with differing coverage and quality outcomes. Although national campaigns have the potential to reach a large number of people, depending on how the model is implemented, many of the people reached may be repeat testers.

In **generalized epidemics**, national campaigns may be appropriate, but they require careful analysis of the availability of services and a high level of planning. Careful consideration of the most appropriate approach, whether facility- or community-based, should be accompanied by ongoing monitoring of the coverage and quality of services.

Home-based testing and counselling

There are two models of home-based testing and counselling. In **door-to-door home-based testing and counselling**, HIV testing and counselling is offered door to door to all consenting household members. In **index patient testing and counselling**, HIV testing and counselling is offered to household members of a person known or suspected to have TB or HIV, with consent being obtained from the person before the household visits are conducted.

In **generalized epidemics**, door-to-door home-based testing and counselling can be offered to all households in high-prevalence and high-density settings where HIV testing coverage is low. Index patient testing and counselling can also be considered, as this achieves high systematic coverage and can provide services to first-time HIV testers. Home-based testing and counselling should be provided at the couple level.

In **concentrated epidemics**, home-based testing can be offered to household members of a person known or suspected to have TB or HIV, with consent being obtained from the person before the household visits are conducted.

Mobile/outreach testing and counselling

Mobile HIV testing and counselling provides HIV testing and counselling services through semi-mobile or fully mobile vans or trucks. This model can also provide services in temporary sites, such as community buildings and school classrooms, and can be delivered through sporting, music and other entertainment events.

Mobile HIV testing and counselling improves access for key populations, including men, young people, sex workers, men who have sex with men, people who inject drugs, people in rural populations, and people in lower-income and lower-education populations.

In **generalized epidemics**, mobile HIV testing and counselling can be implemented in high-prevalence areas where testing coverage is low. It can also be targeted at key populations that are hard to reach, such as rural populations underserved by the formal health system, adolescents and young people.

In **concentrated epidemics**, this model of delivery of HIV testing and counselling has the potential to provide access to services for populations that are hard to reach, such as sex workers, men who have sex with men, and people who inject drugs. The delivery model can be promoted through venues and events and can be delivered in settings that are convenient and accessible to the target population, including needle-exchange settings.

Workplace- and school-based testing and counselling

Individuals in formal employment or full-time education may have limited access to testing services, whether facility- or community-based, due to the opportunity cost associated with seeking these services. Providing HIV testing and counselling services at workplaces and schools can remove economic barriers associated with access, but for school-based testing there are many ethical and operational issues that must be considered.

In **generalized epidemics** in areas of high prevalence where testing coverage is low, this model of testing can be considered. As with other models of HIV testing and counselling, confidentiality must be assured; coercion, whether intentional or unintentional, must be prevented.

Suggested activities

The main activities to be considered in scaling up testing and counselling services include the following:

- **Development and review of guidelines:** National policies and strategies regarding testing and counselling may need to be developed or updated in the light of emerging guidance from WHO and UNAIDS on HIV care, particularly on treatment and diagnostics. Revisions may have to be made to national policies on testing and counselling and related protocols and implementation guidelines. Particular attention should be given to the incorporation of provider-initiated testing and counselling in ongoing health services.
- **Training of involved personnel on how to conduct HIV testing and counselling, including training on couples testing and counselling in generalized epidemics:** This also includes training for laboratory personnel, other health personnel such as nurses and doctors, lay counsellors, outreach workers, reception staff, and others involved in the process of providing prevention and care services.
- **Procurement of commodities and supplies:** This is to ensure adequate availability of test kits, reagents and consumables. It should cover procurement, storage and distribution of the supplies.
- **Improving testing and counselling facilities:** This may involve renovation of existing facilities to create environments that are more conducive to testing and counselling, with an emphasis on ensuring confidentiality. It may also involve acquiring transportation such as motorcycles and other vehicles for home-based or mobile testing and counselling services.
- **Community mobilization and advocacy:** This could involve advocacy with and involvement of decision-makers, people living with HIV, local communities and the general public to educate on and promote uptake of testing and counselling services. Social mobilization should also aim to reduce stigma and discrimination, which are usually the main barriers to use of testing and counselling services.
- **Strengthening referrals and linkages:** As testing and counselling serves as an entry point to other HIV prevention, treatment and care services, it is important that referral linkages between the involved services are established and operational. This may involve location of the services, transfer of referral information and communications.

Suggested key indicators

The list of indicators in the table below is not exhaustive. The *WHO Guide for Monitoring and Evaluating National HIV Testing and Counselling (HTC) Programmes* (http://www.who.int/hiv/pub/vct/9789241501347/en/index.html) should be consulted.

Availability	Coverage	Outcome/impact
Number of HIV testing and counselling sites in the country	Number of people who receive testing and counselling services for HIV and receive their test result (prevention indicator HIV-P8b disaggregated by age groups <15 years and >15 years)	Percentage of people aged 15–49 years who know their HIV status (from Demographic and Health Survey)
Percentage of health facilities that provide HIV testing and counselling services (universal access indicator #A1)	Percentage of women and men aged 15–49 years who received an HIV test in the past 12 months and who know their results (prevention indicator HIV-P8a/UNGASS#7)	
Percentage of health facilities that provide virological testing services (e.g. polymerase chain reaction) for infant diagnosis on site or through dried blood spots	Percentage of sexually active young men and women aged 15–24 years who received an HIV test in the past 12 months and who know their results (prevention indicator HIV-P10/ additional recommended indicator #5)	
	Percentage of pregnant women who were tested for HIV and who know their results (prevention indicator HIV-P11/ additional recommended indicator #7)	
	Percentage of pregnant women who attended antenatal clinics and whose male partner was tested for HIV	
	Percentage of infants born to women living with HIV who receive an HIV test within 12 months of birth (disaggregated into virological testing at <2 months or 2–12 months, or antibody testing at 9–12 months) (prevention indicator HIV-P13/additional recommended indicator #8)	
	Percentage of most-at-risk populations who received an HIV test in the past 12 months and who know their results(prevention indicator HIV-P9/UNGASS#8)	
	Percentage of people with TB who had an HIV test result recorded in the TB register	

Linkages with other interventions/programmes

Testing and counselling is linked with all other HIV-specific service delivery areas (Figure 1).

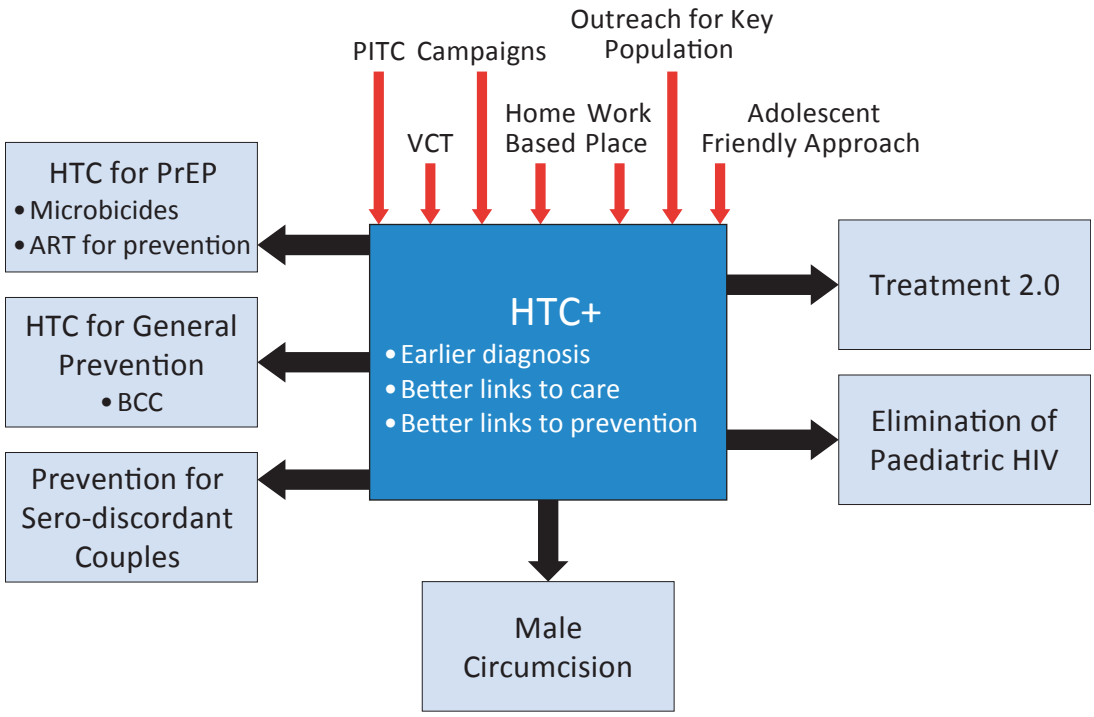

Figure 1. Universal HIV testing and counselling for universal prevention and treatment (HTC+)

Addressing gender, human rights and equity

The promotion of a rights-based approach to HIV testing and counselling services helps to normalize the services in health facilities and communities and is critical for improving people's perceptions about the benefits of HIV testing and counselling; this has a direct impact on the uptake of services.

A rights-based approach to HIV testing and counselling means that:

- people have a right to know their HIV status;
- HIV testing must be voluntary, with the decision to test or not test being based on the individual's understanding of accurate, objective and relevant information;
- HIV testing must be accompanied with post-test counselling services;
- HIV testing services must be of a high quality, with quality-assurance mechanisms in place to support the delivery of the correct result;[8]
- individuals have a right to be provided with or linked to good-quality HIV services;
- confidentiality must be protected;
- non-discrimination in service delivery is critical;
- testing and counselling must be scaled up, eventually leading to universal access.

8 For practical suggestions for the improvement of HIV testing and counselling services, see *Handbook for improving HIV testing and counselling services*. Geneva, World Health Organization, 2010 (http://www.who.int/hiv/pub/vct/9789241500463/en/index.html).

Most countries are signatories to international legal instruments, declarations and guidelines that are vital components of the rights-based approach to HIV testing and counselling services. These countries are required to adhere to the principles laid down in the instruments that form a framework of rights and give countries a basis for formulating their local laws, policies and practices. International instruments provide standards that facilitate the creation of an enabling environment for HIV testing and counselling.

Approach to costing

In its Investment Framework, UNAIDS assumes a gradual move from voluntary testing and counselling modalities to community testing approaches (hence a decline over time in the number of people tested through voluntary testing and counselling and an increase in the number of people tested through community mobilization). The overall cost for provider-initiated testing and counselling in the Investment Framework for low- and middle-income countries is assumed to increase from about US$ 400 million in 2011 to US$ 590 million in 2015, while voluntary testing and counselling as a social enabler will decline from US$ 3.8 billion in 2011 to US$ 816 million in 2015.

The median unit costs of counselling and testing per client in 2009 were reported by UNAIDS as follows:

Sub-Saharan Africa	US$ 14.87
East Asia and the Pacific	US$ 26.00
South and South-East Asia	US$ 14.66
Eastern Europe	US$ 15.58
North Africa and the Near East	US$ 20.15
Latin America and the Caribbean	US$ 14.53

These costs were very sensitive to the number of people tested in individual facilities and to the coverage of testing in the population, and they are expected to decrease significantly in the years to come. Planners need to be aware that there is an expectation not only to improve the coverage of testing and counselling but also to improve the efficiency of the offer of their services so that costs can be contained.

Key implementing partners to be considered

- Government service providers (including local authorities).
- Nongovernmental organizations (local and international) and faith-based organizations.
- Health facilities.
- Employers.
- Networks of people living with HIV.
- Professional organizations of health-care workers.

Technical assistance that may be required during implementation

Technical assistance may be required in the following areas:

- reviewing/updating policies and guidelines;
- developing training programmes;
- evaluating testing and counselling availability, coverage and quality of services.

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