

GUIDANCE ON TESTING AND COUNSELLING FOR HIV IN SETTINGS ATTENDED BY PEOPLE WHO INJECT DRUGS

IMPROVING ACCESS TO TREATMENT, CARE AND PREVENTION



**World Health
Organization**

South-East Asia Region

Western Pacific Region



UNITED NATIONS
Office on Drugs and Crime
Regional Centre for East Asia and the Pacific

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* It is anticipated that the recommendations in this document will remain valid until 2014. The HIV/AIDS and STI Focus, Division of Combating Communicable Diseases, at WHO Western Pacific Regional Office will be responsible for initiating a review of these recommendations at that time.

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Acronyms and abbreviations

AFB	acid-fast bacilli
AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral
CBO	community-based organization
CDC	Centers for Disease Control and Prevention
CITC	client-initiated HIV testing and counselling
DOTS	directly observed treatment, short-course
FBO	faith-based organization
HIV	human immunodeficiency virus
M&E	monitoring and evaluation
MSM	men who have sex with men
MTCT	mother-to-child transmission (of HIV)
NGO	nongovernmental organization
OI	opportunistic infection
OST	opiod substitution therapy
Pap	Papanicolaou (test for cervical cancer)
PEP	post-exposure prophylaxis
PITC	provider-initiated HIV testing and counselling
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission (of HIV)
PWID	people who inject drugs
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	voluntary counselling and testing
WHO	World Health Organization



EXECUTIVE SUMMARY

Executive Summary

INTRODUCTION

This document offers basic operational guidance on HIV testing and counselling in settings attended by people who inject drugs (PWID). It is intended for a wide audience, including policy-makers, HIV/AIDS programme planners and coordinators, care providers, nongovernmental organizations (NGOs) providing services for HIV-related conditions, and civil society groups.

Surveys in the Asia–Pacific region have found that, on average, less than 20% of PWID have been tested for HIV in the previous 12 months and received the results. Greater knowledge of HIV status is critical to expanding access to HIV treatment, care and support in a timely manner, and offers people living with HIV (PLHIV) an opportunity to receive information and the tools to prevent them from transmitting HIV to others.

The World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) strongly support the continued scaling up of asymptomatic client-initiated HIV testing and counselling (CITC). Health and other facilities providing services for PWID represent a key point of contact with people who are in need of HIV prevention, treatment, care and support. With this approach, an HIV test is recommended for all patients whose clinical presentation might result from underlying HIV infection, and as a standard part of medical care for all patients attending specialized health facilities for PWID (provider-initiated testing and counselling [PITC]).

“Settings attended by people who inject drugs” are those extended health-care environments used for the provision of a comprehensive range of HIV prevention and drug treatment activities that focus on PWID. This document recommends a proactive approach to HIV testing and counselling by care providers in these settings. It includes simplified pre-test information consistent with WHO and UNAIDS policy.

Individuals offered an HIV test must specifically accept or decline the test after discussion of their right to decline, the risks and benefits of HIV testing and disclosure, and the social support available. A more detailed counselling approach is required to ensure informed consent for highly vulnerable populations.

Adaptation of this guidance document at country level will require an assessment of the local epidemiology as well as the risks and benefits of a separate HIV testing and counselling approach for settings attended by PWID. Implementation of HIV testing and counselling in PWID settings should be undertaken in consultation with key stakeholders, including civil society groups, PLHIV and PWID themselves.

When recommending HIV testing and counselling to service clients, service providers should always aim to do what is in the best interests of the individual, requiring the provision of sufficient information to make an informed and voluntary decision to be tested, maintaining patient confidentiality, performing post-test counselling, and referring them to appropriate services if needed. This approach to HIV testing and counselling in PWID settings is not an endorsement of coercive or mandatory HIV testing.

OPTIMIZING THE PREVENTION AND CARE ENVIRONMENT

HIV testing and counselling in PWID settings should be accompanied by a recommended package of HIV-related prevention, treatment, care and support services. Although not all the services need necessarily be available in the same facility in which the HIV test is performed, they should be available through local referral. Access to antiretroviral therapy (ART) should not be an absolute pre-requisite for implementation of HIV testing and counselling, but there should at least be an expectation that it will become available to PWID within a reasonable time-frame.

Antiretroviral (ARV) prophylaxis and infant-feeding counselling are important initiatives for the prevention of mother-to-child transmission (PMTCT). These initiatives must be available as part of standard care for pregnant women who are diagnosed HIV-positive through HIV testing and counselling in PWID settings.

At the same time as HIV testing and counselling in PWID settings is being implemented, efforts must be made to ensure that a supportive social, policy and legal framework is put in place to maximize positive outcomes and minimize the potential harm to patients. Such efforts should include: training for health-care providers; codes of conduct for health-care providers and methods for communicating the concerns of patients; engagement of

public security and social/home affairs agencies; and a strong monitoring and evaluation (M&E) system.

Optimal delivery of HIV testing and counselling in PWID settings also requires that laws and policies against discrimination on the basis of HIV status, risk behaviour and gender are in place, monitored and enforced. National policies and codes of ethics should also stipulate the age and/or circumstances in which minors may consent to HIV testing for themselves or for others, and the authorization of sexual/drug-use partner notification in clearly defined circumstances.

PRE-TEST INFORMATION AND INFORMED CONSENT

Depending on local conditions, pre-test information can be provided in the form of individual information sessions or in group health information talks. Informed consent should always be given individually, in private, in the presence of a health-care provider.

When recommending HIV testing and counselling to a patient, the health-care provider should provide the patient with the reasons for the recommendation; the clinical and prevention benefits of testing, the potential risks; the services available in the case of a negative or positive test result, including ART; the mechanisms by which the test result will be treated confidentially by health-care providers directly involved with the patient; the right to decline the test and that declining an HIV test will not affect the patient's access to services; and information that in the event of a positive test result, disclosure to other persons will be encouraged.

Verbal communication is normally adequate for the purpose of obtaining informed consent. Some groups may be more susceptible to being coerced for testing (such as residents of closed settings), so providing additional information about confidentiality provisions and reassurance about the absence of consequences for refusal, beyond the minimum requirements recommended in this document, may be appropriate.

Pre-test information for women who are or may become pregnant should also include: the risks of transmitting HIV to the infant; measures that can be taken to reduce mother-to-child transmission (MTCT) of HIV, including ARV prophylaxis and infant-feeding counselling; and the benefits to the infant of early diagnosis of HIV.

POST-TEST COUNSELLING

Post-test counselling is an integral component of the HIV testing process and all individuals undergoing testing should be counselled when their results are given, regardless of the test result.

Counselling for those whose test result is *HIV-negative* should include: an explanation of the test result, including information about the window period in the case of a recent exposure; basic advice on methods for preventing future HIV transmission, including advice on the use of condoms and safer injecting (if possible, with a supply of condoms, sterile needles/syringes or other commodities as appropriate); and advice on a follow-up test, based on risk assessment and ongoing risk behaviour.

In the case of individuals whose test result is *HIV-positive*, the health-care provider should: inform the client of the result simply and clearly; ensure that the client understands the result and allow the client to ask questions; discuss immediate concerns and assist the client to identify the social network available to offer immediate support; describe available follow-up services; provide information on prevention of transmission of HIV including provision of sterile needles/syringes and condoms, and guidance on their use; provide or refer for provision of prophylaxis for opportunistic infection and, if appropriate, contraception; discuss disclosure of the result – when, how and to whom; encourage testing and counselling of partners and children; assess the client's risk for violence or suicide; arrange a specific date and time for a follow-up visit or referral for treatment; and consider introduction to relevant care team members.

Post-test counselling for a *pregnant woman* whose test result is HIV-positive should also address: childbirth plans; the use of ARV drugs and referral for PMTCT; infant-feeding and support options to facilitate the mother's infant-feeding choice; HIV testing for the infant and the necessary follow up.

FREQUENCY OF TESTING

Recommendations about re-testing in PWID settings will depend on the continued risks taken by the client and the availability of human and financial resources. Re-testing every 6–12 months may be beneficial for individuals at higher risk for HIV exposure. HIV-negative women in high-risk relationships

should be tested as early as possible at the beginning and towards the end of each new pregnancy.

HIV TESTING TECHNOLOGIES

The advantages of using rapid HIV tests for HIV testing in PWID settings include the clear, graphic visibility of the test result and the quick turnaround time. Rapid HIV testing can occur outside laboratory settings, does not require specialized equipment and can be carried out in primary health facilities, mobile clinics or drop-in centres. The reduced waiting times and the rapid availability of test results obviate the need for a return visit, which can be of distinct advantage in PWID settings where lifestyle may interfere with follow-up appointments.

PROGRAMMATIC CONSIDERATIONS

Decisions on how best to implement HIV testing and counselling in PWID settings will depend upon an assessment of the situation in a particular country, including the local epidemiology; available infrastructure, and financial and human resources; available HIV prevention, treatment, care and support; and the existing social, policy and legal frameworks for protection against the adverse consequences of HIV testing, such as discrimination and violence. Where there are high levels of stigma and discrimination, adequate resources should be devoted to addressing these issues during implementation.

MONITORING AND EVALUATION

Monitoring and evaluation are essential for the implementation of HIV testing and counselling in PWID settings, but will need to be supplemented by focused evaluations of various aspects of programming including care provider performance and patient satisfaction.

RECOMMENDATIONS

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

- to all adults, adolescents and children who present to health facilities with signs, symptoms or medical conditions that could indicate HIV infection;
- to all those attending services for sexually transmitted infections (STIs);
- for infants born to HIV-positive mothers, and children presenting with

suboptimal growth or malnutrition and not responding to appropriate nutritional therapy.

In areas with concentrated HIV epidemics¹ among PWID, consideration should be given to recommending HIV testing and counselling in: harm-reduction services; primary care services for PWID; opioid substitution therapy (OST) and other drug dependence treatment services; STI services; other health services for risk populations (sex workers, men who have sex with men [MSM], prisoners/residents of compulsory drug treatment centres); and tuberculosis (TB) services.

¹ HIV has spread rapidly in this defined subpopulation, but is not well established in the general population. This epidemic state suggests active networks of risk within the subpopulation. The future course of the epidemic is determined by the frequency and nature of the links between highly infected subpopulations and the general population. Numerical proxy: HIV prevalence is consistently over 5% in at least one defined subpopulation but is below 1% in pregnant women in urban areas.



1. INTRODUCTION

Introduction

1.1 CONTEXT

This guidance framework responds to a growing country-level need in the Asia–Pacific region for basic operational guidance on HIV testing and counselling in the health services. Such guidance would address the needs of people who inject drugs (PWID) or other key populations at high risk for exposure to HIV in the presence of a concentrated epidemic among those populations. HIV prevention services and primary health-care facilities represent a key point of contact for people who are in need of advice on HIV prevention, and treatment, care and support.

HIV testing and counselling developed as a “voluntary counselling and testing” (VCT) concept of the public health approach in the early years of the HIV epidemic. It was offered in the absence of effective HIV therapy but in anticipation that knowledge of an individual’s status would assist in preventing further transmission of HIV. The critical elements of this approach were that it should be *confidential*, accompanied by *counselling* and conducted only with informed *consent*, meaning that it is both *informed* and *voluntary*. This document remains faithful to these principles and is not an attempt to replace VCT, but to expand and apply the principles of “gold standard” counselling, consent and confidentiality to the “provider-initiated” testing commonly undertaken in this region.

1.2 CHALLENGES AND BARRIERS

VCT has rarely been “client-initiated” in the Asia–Pacific region. It is conceptualized differently from the standard international or United Nations nomenclature – detailed pre- and post-test counselling that is genuinely client-initiated. In reality, most testing and counselling performed is suggested by a provider (doctor, nurse, peer educator, etc.) to a symptomatic or high-risk individual.

WHO and UNAIDS strongly support the continued scaling up of asymptomatic client-initiated HIV testing and counselling (CITC), but recognize the need for additional, innovative and varied approaches.¹

1.3 AIM AND OBJECTIVE

The aim of this document is to recommend a proactive approach to HIV testing and counselling by care providers in the Asia–Pacific region in settings attended by PWID. Such settings are extended health-care environments that provide a comprehensive range of HIV prevention and drug treatment activities that focus on PWID.

The objective is to provide an interim guidance framework for HIV testing and counselling by care providers in settings attended by PWID, based on published international guidance documents and grounded by local expertise. It is not intended to present formal guidelines, and the contents are expected to be valid for a period of approximately five years from publication.

1.4 TARGET AUDIENCE

The document is intended for a wide audience, particularly policy-makers, national AIDS programme planners and coordinators, health-care providers and nongovernmental organizations (NGOs) involved in the provision of HIV-related services in the Asia–Pacific region. It does not address HIV testing and counselling in general health-care settings in detail, for which guidance already exists and which WHO and UNAIDS strongly support.²

Adaptation of this guidance document at country level will require an assessment of the local epidemiology as well as the risks and benefits of a separate HIV testing and counselling approach for settings attended by PWID. These would include guidance on testing and counselling for HIV in settings attended by PWID; an appraisal of the available resources; prevailing standards of HIV prevention, treatment, care and support; and the adequacy of social and legal protection available for PWID. Implementation of HIV testing and counselling in PWID settings should be undertaken in consultation with key stakeholders, including civil society groups, people living with HIV (PLHIV) and members of the target community of PWID.

Use of this guidance document in closed settings (compulsory residential rehabilitation centres and prisons), while recommended as an interim measure, requires additional training, development of health systems and articulation of the principles of confidentiality, voluntariness and counselling. These principles are often severely compromised or misunderstood in these settings and are

expected to be addressed in the near future in specifically designed guidance documents from the United Nations system.

1.5 METHODOLOGY

Who was involved?

This Guidance was first drafted by Dr David Jacka, currently from the WHO Office in Viet Nam. It is firmly based on the 2007 *Guidance on provider-initiated testing and counselling in health facilities* by the World Health Organization (WHO)/Joint United Nations Programme on HIV/ AIDS (UNAIDS)² with adjustment to ground it in the Asian context of injecting drug-user settings.

A joint WHO/United Nations Children's Fund (UNICEF)/UNAIDS *Technical Consultation on scaling up HIV testing and counselling in Asia and the Pacific* was held in Phnom Penh, Cambodia in June 2007.³ Additional themes and comments were incorporated from this Consultation, and adjustments to adapt the document to the Asian context undertaken in regular consultation with experts in this field in Asia. The outcomes of a final draft document review meeting held in Manila in December 2007 were also incorporated. The meeting was attended by experts, and representatives from the government, nongovernmental organizations (NGOs) and peer groups.

How was the guideline group identified?

The members of the review group comprised interested experts from United Nations agencies, government officials, and NGO and peer representatives working in the field of HIV/AIDS in the Asia-Pacific region. They included: Dr Jose Gerard Belimac (Ministry of Health, Philippines), Ms Kathleen Barbara Casey (Family Health International, Regional Office, Bangkok), Mr Heng Sophea (NGO Korsang, Cambodia), Dr Adeeba Kamarulzaman (Head of the National AIDS Commission, Malaysia), Mr Ananda Pun (International Network of People Who Use Drugs – INPUD), Dr Rosario Jessica Tactacan-Abrenica (Ministry of Health, Philippines), Ms Amala Rahmah (Indonesia HIV Prevention and Care Project), Dr Wang Xiaochun (WHO, Regional Office for the Western Pacific), Dr Hu Yifei (WHO China), Dr Madeline Salva (WHO Philippines), Dr Masami Fujita (WHO Viet Nam), Dr David Jacka (WHO Viet Nam), Mr Gray Sattler (UNODC Regional Office, Bangkok), Ms Gaik Gui Ong (WHO Regional Office for

the Western Pacific), Dr Nguyen Thi Thanh (WHO Regional Office for the Western Pacific) and Dr Fabio Mesquita (WHO Regional Office for the Western Pacific).

The revision of the laboratory content was conducted by Kate Maree Learmonth (WHO Regional Office for the Western Pacific). This document also received inputs from Drs Ying-Ru Lo, Annette Verster and F. Amolo Okero (HIV Department, WHO HQ) and Anita Sands (Health Systems Strengthening, Diagnostics and Laboratory Technology Unit, WHO HQ) and Dr Mukta Sharma (HIV Department, WHO Regional Office for South-East Asia).

What was the original scope of the recommendations?

The focus of the Phnom Penh Consultation in June 2007 was primarily on scaling up HIV testing and counselling in the Asia-Pacific region, as guidance on HIV testing and counselling is not yet well developed and quality systems are lacking. Consultation participants recommended specific actions and measures to ensure that the document contained effective guidance on HIV testing and counselling in the health services to address the needs of PWID or other key populations at high risk for exposure to HIV in the presence of a concentrated epidemic among these populations.

The review meeting in Manila in December 2007 confirmed the need for an updated document on HIV testing and counselling specific to the Asia-Pacific region.

This *Guidance* elaborates upon the 2004 UNAIDS/ WHO *Policy statement on HIV testing*¹ by reiterating:

- revised terminology for HIV testing and counselling (Section 1);
- a description of the enabling environment needed to support implementation, including the recommended HIV services, and the social, policy and legal framework (Section 2);
- guidance on the implementation of HIV testing and counselling in different situations and for different populations, including adolescents (Section 2);
- a description of the processes to be followed for HIV testing and counselling in PWID settings, including the minimum pre-test information, informed consent and information to be provided during post-test counselling (Section 3);

- a brief discussion on the referral processes that need to be established (Section 3);
- a brief discussion on testing technologies (Section 3);
- a brief discussion on adapting this strategy to national and local contexts (Section 4); and
- a brief discussion on recording, reporting, monitoring and evaluation (M&E) (Section 4).

The 2007 meeting in Manila agreed that the guidance framework should not be prescriptive, but should be designed to promote a consistent approach to ensuring quality HIV testing and counselling with the flexibility for adaptation at individual country level. Additional training was recommended for use of the *Guidance* in closed settings.

How was the evidence identified?

From the first draft based on the 2007 *Guidance on provider-initiated testing and counselling in health facilities* by the World Health Organization (WHO)/Joint United Nations Programme on HIV/ AIDS (UNAIDS),² adjustments were made to adapt it to the Asian context of injecting drug-user settings.

There was addition of simplified pre-test information consistent with the WHO policy options developed in 2003,⁴ the 2004 UNAIDS/WHO *Policy statement on HIV testing*¹ and the 2007 WHO/UNAIDS *Guidance on provider-initiated HIV testing and counselling in health facilities*.²

Following the final draft document review meeting held in Manila in December 2007, recommendations of the expert group were incorporated. In addition, a literature search was conducted by the authors using PUBMED, the WHO library database and regional databases. Efforts were made to identify systematic literature reviews and evidence related specifically to the policy and practice of testing and counselling for PWID from developing countries, particularly South-East Asia. Dr David Jacka and Dr Bandana Malhotra helped in conducting the literature search.

How were the recommendations developed, reviewed, revised and finalized?

Additional themes and comments were incorporated from the Consultation on *Scaling up HIV testing and counselling in Asia and the Pacific* held in Phnom Penh, Cambodia in June 2007³ and the revised draft discussed at the final draft review meeting held in Manila in December 2007. The final reviewed draft was thus subjected to an exhaustive review process and suggestions of

international experts, government officials, representatives of peer groups, NGOs and United Nations agencies (WHO, UNODC) were incorporated to tailor the document for use in the Asia–Pacific region.

Participants at the final review meeting included Dr Jose Gerard Belimac (Ministry of Health, Philippines), Ms Kathleen Barbara Casey (Family Health International, Regional Office, Bangkok), Mr Heng Sophea (NGO Korsang, Cambodia) Dr Adeeba Kamarulzaman (Head of the National AIDS Commission, Malaysia), Mr Ananda Pun (International Network of People Who Use Drugs – INPUD), Dr Rosario Jessica Tactacan-Abrenica (Ministry of Health, Philippines), Ms Amala Rahmah (Indonesia HIV Prevention and Care Project), Dr Wang Xiaochun (WHO Regional Office for the Western Pacific), Dr Hu Yifei (WHO China), Dr Madeline Salva (WHO Philippines), Dr Masami Fujita (WHO Viet Nam), Dr David Jacka (WHO Viet Nam), Mr Gray Sattler (UNODC Regional Office, Bangkok), Ms Gaik Gui Ong (WHO Regional Office for the Western Pacific), Dr Nguyen Thi Thanh (WHO Regional Office for the Western Pacific) and Dr Fabio Mesquita (WHO Regional Office for the Western Pacific). Revision of the laboratory content was conducted by Kate Maree Learmonth (WHO Regional Office for the Western Pacific).

Drs Ying-Ru Lo, Annette Verster and F. Amolo Okero (HIV Department, WHO HQ) and Anita Sands (Health Systems Strengthening, Diagnostics and Laboratory Technology Unit, WHO HQ) and Dr Mukta Sharma (HIV Department, WHO Regional Office for South-East Asia) provided valuable inputs. Technical editing was done by Dr Bandana Malhotra under the guidance of Dr Fabio Mesquita and Dr David Jacka.

Declaration of interests

Conflict of interest statements were collected from all of the above major contributors. No conflict of interest has been declared by any contributor to the document.

1.6 INTRODUCTION TO THE GUIDANCE

This document recommends a proactive approach to HIV testing and counselling by care providers in settings attended by PWID. It includes simplified pre-test information consistent with the WHO policy options developed in 2003,⁴ the 2004 UNAIDS/WHO *Policy statement on HIV testing*¹ and the 2007 WHO/UNAIDS *Guidance on provider-initiated HIV*

*testing and counselling in health facilities.*² With this approach, an HIV test is recommended (1) for all patients, irrespective of the type of epidemic, whose clinical presentation might result from underlying HIV infection, and (2) as a standard part of medical care for all patients attending specialized health facilities in areas with concentrated epidemics.

This approach to HIV testing and counselling in PWID settings recommended by WHO and UNAIDS is not an endorsement of “opt-out”, coercive or mandatory HIV testing. WHO and UNAIDS emphatically do not support mandatory or compulsory testing of individuals in general and state that there are no public health grounds to do so.^{1,2}

Surveys in Asia have found that, on average, less than 20% of people who inject drugs (PWID) have been tested for HIV in the previous 12 months and received the results. Greater knowledge of HIV status is critical to expanding access to HIV treatment, care and support in a timely manner, and offers PLHIV an opportunity to receive information and the tools to prevent them from transmitting HIV to others. Increased access to HIV testing and counselling for key populations at high risk for HIV and marginalized groups is essential for working towards universal access to HIV prevention, treatment, care and support, as endorsed by the G8 leaders in 2005⁵ and the United Nations General Assembly in 2006.⁶

Evidence from both industrialized and resource-constrained settings suggests that many opportunities to diagnose and counsel individuals at health facilities are missed, and that provider-initiated HIV testing and counselling (PITC) facilitates diagnosis and access to HIV-related services.^{7,8,9} Concerns about the potential coercion of patients and adverse outcomes of disclosure underscore the importance of adequate training and supervision for health-care providers, and the need for close monitoring and evaluation (M&E) of PITC programmes.

Individuals offered an HIV test must specifically accept or decline the test after discussion of their right to decline, the risks and benefits of HIV testing and disclosure, and the social support available (which may be required for groups especially vulnerable to adverse consequences on disclosure of an HIV test result). A more detailed counselling approach is required to ensure informed consent for highly vulnerable populations.

When recommending HIV testing and counselling, service providers should

always aim to do what is in the best interests of the individual patient. This requires giving an individual sufficient information to make an informed and voluntary decision to be tested, maintaining patient confidentiality, performing post-test counselling, and referring them to appropriate services if needed.

HIV testing and counselling in PWID settings should still be accompanied by the recommended package of HIV-related prevention, treatment, care and support services, and be implemented within the framework of a national plan to achieve universal access to antiretroviral therapy (ART) for all those who need it.

The guidance contained in this document aims for consistency between medical ethics and clinical, public health and human rights objectives. These include:

- enabling individuals with HIV:
 - to know their HIV status in an informed and voluntary manner,
 - to seek and receive HIV prevention, treatment, care and support services,
 - to prevent the transmission of HIV, and
 - to be protected from HIV-related stigma, discrimination and violence;
- improving treatment and prevention outcomes;
- promoting the right to autonomy, privacy and confidentiality;
- promoting evidence-based policies and practices, and an enabling environment for implementation;
- elaborating the roles and responsibilities of care providers in ensuring access to ethical HIV-related testing, counselling and related interventions; and
- providing a structure for PLHIV, caregivers and community-based organizations (CBOs) to assist in the provision of quality HIV testing and counselling services.

1.7 TERMINOLOGY

The terms in this document are used, as much as possible, in a manner agreed upon by a consensus of interested United Nations agencies.

Client-initiated HIV testing and counselling (CITC; earlier known as VCT) involves individuals (clients/patients) who actively seek HIV testing and counselling at a facility that offers these services. CITC usually emphasizes individual risk assessment and management by counsellors,

addressing issues such as the desirability and implications of taking an HIV test, and the development of individual risk-reduction strategies. CITC is conducted in a wide variety of settings, including health facilities, stand-alone facilities outside health institutions, mobile services, community-based settings and even people's homes.

Provider-initiated HIV testing and counselling (PITC) refers to HIV testing and counselling that is recommended by care providers as a standard component of medical care to persons attending health-care facilities. The major purpose of such testing and counselling is to enable specific clinical decisions to be made and/or specific medical services to be offered that would not be possible without knowledge of the person's HIV status.

In the case of persons presenting to health facilities *with symptoms or signs of illness that could be attributable to HIV*, it is a basic clinical and ethical responsibility of health-care providers to recommend HIV testing and counselling as part of the patient's management. This includes recommending HIV testing and counselling to clients/patients with or suspected of having tuberculosis (TB).

In addition, PITC aims to identify unrecognized or unsuspected HIV infection in persons attending health facilities. Care providers may therefore recommend HIV testing and counselling to patients in high-risk settings, even if they *do not have obvious HIV-related symptoms or signs, or overtly stated high-risk behaviours*. In such circumstances, HIV testing and counselling is recommended by the care provider as part of a package of services provided to all patients who undergo clinical interactions in the health facility or its outreach services. A number of possible PITC models can be implemented by doctors:

- The doctor suggests the HIV test and a counsellor provides one-to-one counselling, or group pre-test information and post-test counselling.
- The doctor suggests the HIV test, provides brief information and also gives the result.
- The doctor suggests the HIV test and provides brief information, but a counsellor gives the results.

HIV testing and counselling: This guidance document is designed for use in PWID settings, in situations with a concentrated HIV epidemic, appropriate for the initiation of PITC. In this document, HIV testing and counselling is

recommended in these settings for “diagnostic” purposes (that is, for people with HIV-related symptoms) and to all persons on a regular basis who may, because of their risk behaviours, have HIV but who are not symptomatic. The order of the terms “testing” and “counselling” should not be seen to provide any guidance as to the relative importance of the pre- or post-test components of counselling. HIV testing and counselling should neither be mandatory nor compulsory.

Pre-test information provision is the process by which individuals referred for HIV testing are *provided with sufficient information to ensure informed consent*, perhaps without a full education and counselling session. The minimum amount of information that individuals require in order to be able to provide *informed consent* includes:

- the clinical benefit of undergoing the test, including access to ART and to HIV prevention, care and support services;
- the clear right to refuse the test;
- the follow-up services that will be offered including counselling and referrals; and
- the importance of anticipating the need to inform any persons at ongoing risk who would otherwise not suspect they were being exposed to HIV infection in the event of a positive test result (sexual and drug-using partners).

Post-test counselling is an integral component of the HIV testing process. All individuals undergoing HIV testing must be counselled when their test results are given, with care taken to discuss results and follow-up care in a confidential manner.

Counselling for individuals with HIV-negative test results should include an explanation of the test result, including information about the window period for the appearance of HIV antibodies, basic advice on methods to prevent future HIV transmission and an appropriate time for repeat HIV testing.

The focus of post-test counselling for people with HIV-positive test results is to provide psychosocial support to cope with the emotional impact of the test result; facilitate access to treatment, care and prevention services; prevent HIV transmission; and disclose the result appropriately to sexual and injecting partners.

Confidentiality is the process of ensuring that information provided by the client (including the test result) is accessible only to those authorized to access it, and is one of the cornerstones of HIV testing. Confidentiality also refers to an ethical principle associated with health care in which communication between a person and a health-care professional is “privileged” and may not be discussed or divulged to third parties. In those jurisdictions in which the law makes provision for such confidentiality, there are usually penalties for its violation.

The rationale behind the rule of privilege is that a high level of trust must exist between a physician and patient so that the physician can treat the patient properly. If the patient is fearful of telling the truth to the physician because he or she believes the physician would report such behaviour to the authorities, the treatment process could be rendered far more difficult, or the physician could make an incorrect diagnosis. Practically, the principle of confidentiality requires the training of staff and development of rigorous information management and storage systems to protect an individual’s HIV status (and other sensitive health-related information) from inadvertent disclosure.

PWID are at a perceived high risk of breach of confidentiality in health-care settings because of their marginalization, participation in illegal activities including drug use, and their lack of social power. Health services caring for PWID need to proactively develop guidelines for health-care workers on the management of highly sensitive information divulged by drug users, including their drug use, the identity of their network partners and peers, and their possibly illegal income-generating activities.

A critical feature of an ethical testing process is to ensure that the HIV test is **voluntary**. This means that the individual engages in the testing process of his or her own free will, as an act of choice, freely and without compulsion.

Occupational or accidental exposure to HIV is defined as the occurrence of a risk incident, with potential for HIV transmission, within an occupational setting. This includes, but is not limited to, needle-stick injury, assault and blood or other bodily fluid spatter to the mouth, nose, eyes or an open wound. The implementation of universal precautions should achieve the elimination of many of these work-related incidents and provide for the temporary removal

of health workers with open wounds from clinical settings. The primary mode of response to these incidents is one of re-emphasizing prevention and by providing post-exposure prophylaxis (PEP) (with ART) for any individuals placed at real risk. A well articulated, rapid response system for provision of PEP must be established.

Care providers are trained workers from the broad health sector working in the variety of care settings which make up a modern health-care system; from high-level hospital care to home-based care. Although they are mostly paid professionals, this title is by no means restricted to doctors and nurses, and includes counsellors, peer workers and allied health professionals.

Informed consent is a legal condition whereby a person can be said to have freely given consent based upon an appreciation and understanding of the facts and implications of an action. The individual needs to be in possession of the relevant facts and also of his reasoning faculties, i.e. the individual should not be mentally disabled or ill, or have impaired judgement at the time of consenting. Such impairment may be caused by serious physical illness, drug intoxication or withdrawal, insufficient sleep or other health problems.

HIV testing cannot take place legally in the absence of informed consent. In cases where an individual is considered unable to give informed consent, another person may be authorized to give consent on that person's behalf. Examples of this include the parents or legal guardians of a child or adolescent, and caregivers for the mentally disabled or ill.

Settings for PWID are those extended health-care environments used for the provision of a comprehensive range of HIV prevention and drug treatment activities that provide a focus for PWID. They range from peer educator outreach activities to drop-in centres, drug substitution and voluntary rehabilitation services, and primary care services in communities with high populations of PWID. The purpose of extending the reach so broadly is to include all those individuals at increased risk for HIV through their partners, sexual contacts or early experimental drug use. Closed settings such as prisons and compulsory residential treatment services are also potential settings with a high population of PWID, in which there are additional ethical HIV testing and counselling difficulties.

Referral: The organization of care services and their linkages is an important determinant of successful treatment of PWID. Linking services, such as the provision of ART and directly observed treatment, short-course (DOTS), with treatment for substance dependence improves outcomes in terms of viral suppression and treatment engagement.¹⁰

There are five types of interrelated and linked services which are recommended for the treatment of substance dependence and HIV. These include:

- testing and counselling services, services for the treatment of HIV and opportunistic infections (OIs), and for the prevention of mother-to-child transmission (PMTCT) of HIV;
- general medical care services, and sexually transmitted infection (STI), family planning and tuberculosis (TB) clinics;
- harm-reduction services;
- services for drug-dependence treatment (particularly using opioid substitution therapy [OST]); and
- psychosocial support services.

1.8 TESTING AND COUNSELLING FOR PWID IN THE ASIA–PACIFIC REGION

Of particular importance in this region is the provision of testing and counselling for PWID and the development of an appropriate package of HIV prevention and care services for them.

An HIV test is recommended for all persons whose clinical presentation might result from underlying HIV infection, and for all clients of services designated primarily for PWID and their partners, or those in which PWID are significantly concentrated.^{1,2} Additional discussion of the right to decline HIV testing, the risks and benefits of disclosure, and the social support available will be required for groups and in settings especially vulnerable to adverse consequences upon disclosure of a positive HIV test result. A careful approach to informed consent is warranted in these particular settings.

HIV prevention services and primary health-care facilities represent a key point of contact for people who are in need of advice on HIV prevention, and treatment, care and support. Evidence suggests that there are many missed opportunities at these services to diagnose, counsel and treat individuals with HIV.² In addition to the traditional client-initiated VCT concept, a

more proactive approach to HIV testing and counselling would facilitate increased access to diagnosis and treatment for HIV-related illnesses among traditionally marginalized groups.² Concerns about potential coercion of patients and adverse outcomes of disclosure, however, underscore the importance of careful introduction of these expanded guidelines with adequate training and supervision for all care providers, and the need for close M&E of all HIV testing and counselling programmes.

The key feature of this expanded HIV testing and counselling approach is the development of “front-of-mind” awareness of the desirability of HIV testing among all health-care staff in PWID settings, in order to have HIV testing proactively discussed at all client/patient encounters and according to a recommended re-testing schedule. This philosophy has been well established in other areas of preventive/therapeutic health screening tests, where proactive screening and early intervention are recognized as having benefits for public health and personal treatment outcomes (e.g. Papanicolaou [Pap] cervical smears for sexually active women).

HIV testing and counselling in PWID settings should be accompanied by a recommended package of HIV-related prevention, treatment, care and support services, and implemented within the framework of the national HIV plan to provide access to ART for all who need it. In addition, care providers are encouraged to keep HIV high on the list of possible explanations for presenting symptoms in this high-risk setting in order to detect seroconversion illness and OIs at the earliest possible opportunity.

Implementation of HIV testing and counselling beyond traditional passive VCT should be undertaken in consultation with key stakeholders, including civil society groups and PLHIV. In practice, this guidance document has been developed in an attempt to improve the quality of all testing and counselling services for PWID, recognizing that VCT is often provided in an environment of significant ill-health and where the quality of pre-test counselling and the process of consent are poor.

The development of training curricula for expanded access to HIV testing and counselling for PWID will address, using the principles of interactive adult learning, the development of relationships with PWID and engagement in planning for HIV risk reduction and HIV treatment, of which testing is the

first step. Given the illicit nature and social undesirability of injecting drug use, this training for health service providers should not be regarded as routine or merely an extension of standard VCT courses. Changing the attitudes of service providers and their responses to PWID may be difficult to achieve.

When recommending HIV testing and counselling, service providers should always aim to do what is in the best interest of the individual patient. **This requires giving individuals sufficient information to make an informed and voluntary decision to be tested, maintaining patient confidentiality, performing post-test counselling and referring them to appropriate services.**

WHO and UNAIDS do not support the mandatory or compulsory HIV testing of any individual. Experience has shown that compulsory HIV testing violates ethical principles and the basic rights of consent, privacy and bodily integrity, and has no public health benefits.²

1.9 SPECIAL CONSIDERATIONS FOR PWID

Injecting drug use is an illicit and stigmatized condition associated, in most countries, with marketing of drugs within close networks of drug users. Hence, PWID actively avoid public exposure and law enforcement agencies. Drug use is a pervasive source of stigma and discrimination and is often coupled with a positive HIV status, which results in PWID facing a double stigma and social marginalization. HIV-positive sex workers who inject drugs face discrimination from many quarters. Health services working with PWID therefore need to develop peer outreach networks and innovative approaches to actively attract individuals at behavioural risk for HIV into prevention, testing and care services.

People who are most vulnerable to the impact of poverty and poor health, and lack education and employment are also those most vulnerable to drug use. Many PWID who live on the economic and social fringes may also be rejected by their families. The social problems faced by PWID, stigma and discrimination associated with drug use and being HIV-positive, and the problems their families face may further exacerbate drug use.

Fear of discrimination may discourage drug users from revealing their status or the true level of their drug use to care providers, leading to a risk of misdiagnosis or inappropriate risk assessment. A number of reliable

studies in small surveys in Asia have found that, on average, less than 20% of PWID have been tested for HIV in the previous 12 months and received the results.¹¹ Greater knowledge of HIV status is critical to expanding access to HIV treatment, care and support in a timely manner, and offers PLHIV an opportunity to receive information and the tools to prevent transmitting HIV to others.

The chaotic lifestyle of dependent injecting drug use, with its high pressure for income generation and illicit market access, combined with the poor general and mental health of many PWID, call for expanded health service responses to contact and establish effective relationships with and provide services to this population. In this context, the health sector should attempt to ensure that the human rights of PWID are respected, and that they receive quality services that address their health needs and include ART where available.

In addition, health-care workers should become aware of their own feelings and prejudices, and the effect these may have on their patients and on the successful outcomes of drug treatment and ART. In particular, health-care workers should guarantee the confidentiality of all patients, and refer them to other appropriate services to assist in coping with discriminatory practices, including those concerning education, housing and employment.

Outreach activities, particularly those involving trained peers, have been found to be particularly effective in contacting PWID and, when combined with needle/syringe programmes, in reducing the use of contaminated injecting equipment. They are also effective in attracting PWID into other HIV prevention activities and drug-treatment services. These peer/outreach worker services provide an ideal first-line approach to attracting PWID into HIV testing and counselling services. The role of the outreach worker is to not only contact and educate PWID on HIV prevention, but to also encourage appropriate HIV testing and counselling and, if required, to accompany them to a testing site.

This system of outreach, contact and subsequent accompanying as a “buddy” or navigator to the health services has features in common with the provision of services to other hidden populations such as sex workers, men who have sex with men (MSM), transgender persons, illegal immigrants and homeless

individuals. The level of subsequent counselling involved prior to actual HIV testing will depend on the training and trust invested in the outreach workers. Care needs to be taken to provide incentives or encouragement to outreach workers for this recruitment of PWID to prevent them from bringing emotional or even financial duress to bear on PWID.



2. RECOMMENDATIONS FOR HIV TESTING AND COUNSELLING FOR PWID

Recommendations for HIV testing and counselling for PWID

In settings attended by PWID, the priority should be to ensure that those individuals with recognized risk behaviours receive timely and regular testing to enhance their access to HIV prevention, care and treatment services. Care providers should not, however, recommend HIV testing and counselling to all persons attending all such health facilities. The priority should be to ensure that, in addition to individuals with recognized risk behaviours and their partners, 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 to HIV perinatally.

2.1 SUPPORTIVE SOCIAL, POLICY AND LEGAL FRAMEWORK

Reduction of stigma and discrimination towards drug users is an important component of the testing and counselling strategy – it is widely acknowledged that many PWID experience serious barriers to care (particularly to ART) access and they are often not treated with dignity and respect as human beings or as part of the wider community. At the same time as a strategy for HIV testing and counselling for PWID is implemented, equal efforts must be made to ensure that a supportive social, policy and legal framework is created to maximize positive outcomes and minimize potential harms to clients.

Optimal delivery of HIV testing and counselling for PWID in the long term requires that laws and policies against discrimination on the basis of HIV status, risk behaviour and gender are in place, monitored and enforced. Because UNAIDS and WHO encourage voluntary disclosure of HIV status and ethical partner notification and counselling, national policies and codes of ethics should be developed to authorize official partner notification, but only in clearly defined circumstances.

In addition, because of the special issues associated with the young age of many PWID, governments need to develop and implement clear legal and policy frameworks that stipulate the specific age at and/or circumstances in which minors may consent to confidential HIV testing and counselling for themselves or for others.

2.1.1 Basic framework elements

The following components of a social, policy and legal framework should be in place to support the implementation of HIV testing and counselling in PWID settings.

Community preparedness and social mobilization

Public information campaigns should be conducted to raise community awareness about HIV and AIDS; promote the rights of PLHIV, and the benefits of knowing and disclosing one's HIV status; and provide information about the available services for HIV testing, prevention, care and support. PLHIV and affected communities should be involved in the formulation, implementation and monitoring of such campaigns.

Because of the critical role played by public security and social affairs ministries in the region, it is imperative that HIV prevention and health services be fully engaged in the area of confidentiality and participation by PWID. High-level advocacy should be undertaken to achieve adaptation of the national or local law enforcement environment so that PWID are encouraged to participate in the development of comprehensive HIV prevention and care services, and access them when needed.

Adequate resources and infrastructure

Policy-makers and planners should anticipate the additional resources required for implementation of expanded HIV testing and counselling in PWID settings, including funding for training and the purchase of commodities such as HIV test kits and other supplies. An adequate clinical infrastructure must also be available, including adequate private consulting rooms and lockable storage for medical records. Resources allocated for HIV testing and counselling should not be diverted from other needed services, including more general community approaches to HIV testing and counselling. Additional resources may be needed to assist CBOs in providing follow-up counselling, support and other services.

WHO and UNAIDS recommend that, to the extent possible, HIV testing should not involve any additional costs for clients/patients at the point of service delivery.²

Training for expansion of testing and counselling

A major part of the investment required for HIV testing and counselling in

PWID settings is likely to be spent on training, and ongoing supervision of care providers and administrators. Training programmes for personnel who will perform HIV testing and counselling in health facilities, as well as for other staff who deal with clients in the health services, should be developed and implemented well in advance of the implementation or expansion of HIV testing and counselling.

A redistribution of health worker responsibilities (task-shifting) in health facilities may help to overcome chronic staff shortages. Appropriately skilled lay personnel who can receive training can also be identified and remunerated to carry out HIV testing and counselling activities under the supervision of health-care professionals with more expertise. PLHIV, AIDS service organizations, and other CBOs and civil society groups can be potentially important sources of appropriately skilled lay personnel. In some facilities, this would involve expanding the types of health workers who are authorized to carry out HIV counselling (e.g. outreach workers).

Training should be based on protocols which address the following key areas:

- ***Obtaining informed consent***

Guidance and ongoing supervision must be provided to care providers on the process of obtaining informed consent. Clients must receive adequate information on which to base a personal and voluntary decision regarding whether or not to consent to the test. They must also be given an explicit opportunity to decline a recommendation of HIV testing and counselling without coercion. More detailed guidance on the process of obtaining informed consent is given in Section 3.

- ***Confidentiality and privacy***

Training must emphasize that care providers have a responsibility to maintain the confidentiality of HIV test results. Clinical care can be undermined by not recording HIV results or not communicating results to other care providers responsible for patient care. The fact that a client has provided informed and voluntary consent for an HIV test and the test result should be documented in the client's record, and systems established to protect this information.

Medical records, including test results, should be shared only with health-care professionals who have a direct role in the ongoing management of the client. These principles apply to both verbal and written communications.

Clients should be offered advice on the safe-keeping of client-held records, such as antenatal care (ANC) cards and child health cards.

Privacy must also be ensured. For example, informed consent should be sought and given in a private setting. Similarly, post-test counselling for an HIV-positive client and other communication relating to HIV status should take place away from other persons or staff not involved with that person's care.

Medical records administrators may need to receive specific training in the appropriate handling of medical records in clinical settings where HIV testing and counselling is performed.

- *Stigma and discrimination*

People living with or who are suspected of having HIV frequently report mistreatment and/or discrimination on the part of health-care providers. The implementation of HIV testing and counselling in settings attended by PWID provides an opportunity to raise awareness about HIV/AIDS and human rights issues among care providers and administrators, and to reinforce their adherence to appropriate standards of practice.

Staff working in PWID settings should receive specific training and ongoing supervision to address the needs of individuals living with or at risk for HIV. It should be standard practice to treat all clients decently, with respect and without discrimination on the basis of HIV status or risk behaviours, and to help such people address the potential negative social consequences of HIV testing. Involving PLHIV, members of at-risk populations and their advocates in training sessions for care providers on these issues is strongly recommended.

- *Client referral*

Care providers need to become familiar with the referral needs of clients and patients, their partners and family members, as well as the services that are available locally to provide follow up and support, including the availability of additional counselling services.

Care providers should take an active role in the development of local referral processes to maintain HIV care and treatment for, and meet the practical needs of, those PWID who are transferred to or leaving “closed

settings”. Providers should also understand the mechanisms that are in place for referral to prevention, care and support services provided by CBOs and civil society groups.

- *Principles of harm reduction*

For appropriate and effective post-test counselling, care providers should become familiar with and accept the principles of harm reduction.¹²

As respected members of their community, it is vital that health-care workers have a solid understanding of the public health philosophy and research underpinning harm reduction.¹³ The effectiveness of wider HIV prevention efforts depends on their ability to do so and communicate their understanding to others.

- *Performance of HIV testing*

To maintain high quality on-site testing, staff requires initial and subsequent in-service training including appropriate mechanisms to integrate quality assurance systems into testing protocols.

Codes of conduct for care providers and methods of redress for clients

Health facilities should develop codes of conduct for care providers and methods of redress for clients whose rights are infringed. Consideration should be given by each service to identify and appoint an independent “patient advocate” or “client representative” with whom breaches of HIV testing and counselling protocols and codes of conduct can be discussed.

A strong monitoring and evaluation system

A system that monitors the implementation and scaling up of HIV testing and counselling should be developed and implemented concurrently with efforts to engage client and family groups in assisting with the evaluation of service quality. This is discussed in more detail in Section 4.

2.1.2 Other measures

Although the following measures may not be prerequisites for the implementation of HIV testing and counselling in PWID settings, they should be addressed as part of national plans to scale up HIV testing and counselling and achieve universal access to HIV prevention, treatment, care and support.

Social and legal initiatives

Optimal delivery of HIV testing and counselling in the long term requires that laws and policies against discrimination on the basis of HIV status, risk behaviour and gender are in place, monitored and enforced. These include legal and social measures that protect privacy, autonomy and gender equality. Implementing these broad social and legal protections is the responsibility of diverse stakeholders, including parliamentarians, ministries of the interior, health and justice, and civil society groups, emphasizing the need for multisectoral commitment to scaling up of HIV testing and counselling.

Discussions should be held regarding the most appropriate local law enforcement responses to drug use and the carrying of needles, syringes and condoms, in the interests of maintaining the engagement of PWID with HIV prevention, care and treatment services. Self-disclosure of PWID status to care providers should not lead to notification to or arrest by law enforcement agencies.

Voluntary disclosure and ethical partner notification and counselling

UNAIDS and WHO encourage voluntary disclosure of HIV status and ethical partner notification and counselling. This may require national policies and public health legislation authorizing partner notification in clearly defined circumstances, as well as the promotion of professional codes of ethics among health-care and social service providers. While beyond the scope of this document, these issues are comprehensively addressed in UNAIDS publications including: *Opening up the HIV/AIDS epidemic: guidance on encouraging beneficial disclosure, ethical partner counselling and appropriate use of HIV case-reporting*.¹⁴

2.2 HIV TESTING AND COUNSELLING FOR PWID IN HEALTH AND OTHER FACILITIES

HIV testing and counselling needs to be established at health services for key populations at higher risk of HIV exposure. These include needle/syringe programmes, drop-in centres, drug treatment and recovery services, OST programmes or other health services (e.g. TB clinics). The specific population groups that are at higher risk for HIV exposure include sex workers and their clients, PWID, MSM, prisoners, migrant workers and refugees. These populations often suffer worse health problems than the general population, are stigmatized and have difficulty in accessing quality health services. The

availability of integrated services will remove some of the perceived barriers to testing and counselling, as a variety of services for PWID will be housed under the same roof as the testing and counselling service.

HIV testing and counselling should be recommended to all clients/patients who attend facilities or services that focus on PWID unless this is politically unacceptable. Staff at these services require training to enable them to enquire sensitively about risk behaviours and recognize the early symptoms of HIV-related disease. All care providers need training to destigmatize drug use, develop skills in recognizing risk factors and learn sensitive enquiry techniques. In addition, they should be trained to understand the necessity of generating trust and maintaining the confidentiality of the information obtained. Plans for HIV testing and counselling in such settings should prioritize the implementation of a supportive social, policy and legal framework.

Strategies need to be developed to increase access to and uptake of HIV testing and counselling and treatment among members of groups at highest risk for HIV exposure, particularly through evidence-informed approaches such as peer outreach, harm-reduction programmes or innovative services delivered through mobile clinics and other community settings. Prisoners and others in closed settings should be able to access confidential HIV testing and counselling at any time during their incarceration without being subject to mandatory HIV testing.

Efforts to expand access to HIV testing and counselling in settings attended by PWID should include social mobilization and education initiatives in those networks to encourage people with high-risk behaviours or their contacts to learn their HIV status and access services. Because of their special health needs, PWID and other populations at higher risk for HIV are more likely to attend specific health services, such as acute primary care, STI clinics, needle/syringe programmes or drug-dependence treatment services. Recognizing the illicit nature of injecting drug use and the marginalized, unhealthy and impoverished state of many PWID is important in understanding their issues in accessing “mainstream” services, and in designing quality health-care services to meet the needs of these “hidden” and stigmatized populations.

Experience has demonstrated that special efforts need to be undertaken to ensure that HIV services are especially “friendly” to youth and female PWID

to ensure access by these additionally marginalized HIV risk subpopulations.¹⁵ Adolescence is a particularly critical time for undertaking initiatives in individuals, and provides opportunities to embed safer drug-use behaviours and to instil the sense of self-efficacy to “stay negative”.

PWID may often be more susceptible to coercion, discrimination, violence, abandonment, incarceration or other negative consequences upon disclosure of an HIV-positive test result. Care providers will usually require special training and supervision to maintain standards of informed consent and confidentiality for these populations. Additional discussion may be required with service providers about the right to decline HIV testing, the risks and benefits of HIV testing and disclosure, and social support needs after the test results are given.

Involving key populations at higher risk of HIV exposure and their advocates in the development of HIV testing and counselling protocols and in the M&E of HIV testing and counselling programmes in PWID settings will help to ensure that the most appropriate and acceptable practices are followed.

2.2.1 STI services in PWID settings

The presence of an STI can increase the risk of acquiring and transmitting HIV and is a *de facto* marker of unprotected sex and hence past sexual risk for HIV. STI clinics are important venues for increasing knowledge of HIV and awareness of HIV status among men and women who are sexually active, and for increasing access to HIV prevention, treatment and care.

Accordingly, HIV testing and counselling should be recommended to all persons presenting at sexual health/STI services or who present at other types of health services with an STI. Persons diagnosed with an STI should be encouraged to propose STI treatment and HIV testing and counselling to their partners.

2.3 ENABLING ENVIRONMENT

HIV testing and counselling in PWID settings should be implemented with the objective of maximizing the health and well-being of individuals through the timely detection of HIV, prevention of HIV transmission and subsequent access to appropriate HIV prevention, treatment, care and support services. Implementation must include measures to prevent compulsory testing and

unauthorized disclosure of HIV status, and the potential negative outcomes of knowing one's HIV status. Potential negative outcomes include discriminatory attitudes of care providers; legal problems or arrest; a financial burden associated with testing; and/or unauthorized disclosure of an individual's HIV status, resulting in discrimination or violence, or loss of employment. Women may be more likely than men to experience discrimination, violence, abandonment or ostracism when their HIV status becomes known, and measures must be taken to prevent this.

Positive outcomes are most likely when HIV testing is confidential and is accompanied by counselling and informed consent, staff are adequately trained, the person undergoing the test is offered or referred to appropriate follow-up services, and an adequate social, policy and legal framework is in place to prevent discrimination.

2.3.1 HIV-related services

HIV testing and counselling in PWID settings should be accompanied by a recommended package of HIV-related prevention, treatment, care and support services, as given below. Not all the HIV-related services need necessarily be available in the same facility in which the HIV testing and counselling is performed, but they should be available through local referrals.

Access to ART should be a pre-requisite for the implementation of HIV testing for PWID, under the principle that to achieve universal access is to provide ART for all who need it. Work with mainstream providers of ART may be necessary to ensure access by PWID to the full range of treatment, care and support services. Provision of appropriate peer support at such services can enhance access for newly referred individuals from marginalized populations.

ARV prophylaxis and infant-feeding counselling are important interventions for PMTCT. These interventions must be available as part of standard care for all pregnant women who are diagnosed HIV-positive through HIV testing, including PWID, in keeping with the guidelines for PMTCT.

Recommended components for implementation of HIV testing and counselling in PWID settings

1. Individual or group pre-test information
2. Basic prevention services for persons diagnosed HIV-negative:
 - Post-test HIV prevention counselling for individuals or couples, which includes information about prevention services
 - Promotion and provision of condoms
 - Needle and syringe access and other harm-reduction interventions, including OST
 - PEP, where indicated.
3. Basic prevention services for persons diagnosed HIV-positive:
 - Individual post-test counselling by a trained provider, which includes information about and referral to prevention, care and treatment services, as required
 - Support for disclosure to partner(s) and couples counselling
 - HIV testing and counselling for partners and children
 - Safer sex and risk reduction counselling, with promotion and provision of condoms
 - Needle and syringe access and other harm-reduction interventions for PWID
 - PMTCT for pregnant women, including ARV prophylaxis
 - Reproductive health services, family planning counselling and access to methods of contraception.
4. Basic care and support services for persons diagnosed HIV-positive:
 - ART, where required
 - Education, psychosocial and peer support for management of HIV-related disease
 - Clinical and/or CD4 staging and periodic reassessment
 - Management and treatment of common OIs
 - Co-trimoxazole prophylaxis for those with CD4 counts <350/mm³ or WHO stage 2, 3 or 4 disease
 - Screening and treatment for TB, when indicated; preventive therapy, when appropriate
 - Prevention and treatment of malaria, where needed
 - Management and treatment of STI
 - Palliative care and symptom management

- Advice and support regarding other prevention measures, such as safe drinking water
- Advice on nutrition
- Infant-feeding counselling.

2.4 LINKAGES BETWEEN HIV AND PWID SERVICES

The development of relationships between HIV testing and counselling services and the variety of health and other services that come in contact with PWID will largely determine the pace and success of implementation of this expanded HIV testing, counselling and treatment strategy.

The range of services for PWID with which it is possible to establish fruitful linkages and referral systems is very broad and, as listed elsewhere, includes community health services; outreach and peer education activities; needle and syringe programmes; drug-use treatment programmes including OST; TB and STI services; family planning services; PMTCT services; voluntary or coerced residential rehabilitation; detoxification services; prisons; psychiatric services; pharmacies; peer support groups; and relapse prevention counselling services.

It should be noted that services for PWID are often regarded as being outside the mainstream and even outside health care, so additional efforts may be required to engage them in a linkage dialogue. Regular meetings of representatives from HIV testing and counselling services with representatives of all PWID-related services at the community level, and clear referral processes will of great assistance in fostering functional referral relationships.



3. PROCESS AND ELEMENTS

Process and elements

3.1 PRE-TEST INFORMATION AND INFORMED CONSENT

Pre-test information may be provided in a number of ways:

- One-to-one, face-to-face, etc.
- group information + brief individual risk assessment
- group information only
- couples + individual
- couples together
- de-linked community counselling (in PWID settings, encouraging self-referral), or
- phone link/hotline pre-test counselling in the community linked to a testing laboratory.

Providers of HIV testing and counselling typically conduct an education session and a risk assessment, with a primary focus on prevention counselling for clients both prior to and after receiving their test results. This approach to testing and counselling in PWID settings attempts to find a balance between complicated and overdrawn counselling sessions and rapid, intense education/information transfer. While it is accepted that detailed counselling is vital in certain circumstances, it is felt that in most settings attended by PWID it can be substantially shortened.

Because the objective of HIV testing and counselling in PWID settings is the timely detection of HIV and access to health-care services, pre-test information in particular can be simplified. For example, individual risk assessment and risk reduction plans can be covered during post-test sessions, rather than in the pre-test information session, and tailored to the patient's HIV status.

Depending on local conditions, pre-test information can be provided in the form of individual information sessions, as couples or in group health information talks, with provision of appropriate printed materials. Informed consent should always be given individually, in private, in the presence of a care provider.

When recommending HIV testing and counselling to a client attending

services for PWID, the care provider should, at a minimum, provide the client with the following information:

- The reason(s) the test is being recommended (symptoms or the presence of risk behaviour)
- The clinical benefits of testing (access to ART, OI prophylaxis) and the potential risks (discrimination or abandonment)
- The services available in the case of negative and positive results (including the availability of ART)
- That the result will be treated confidentially and shared only with involved care providers
- That the person has the right to decline the test
- That declining an HIV test will not affect the person's access to other services
- That, if the test result is positive, disclosure to the person's contacts who may be at risk is encouraged.

An opportunity should then be provided for the client to ask the care provider questions and the client given time to make a decision about consenting to the test. Clients should also be made aware of any relevant laws in jurisdictions that mandate the disclosure of HIV status to sexual and/or drug-injecting partners.

Drug and alcohol use are commonly underreported and can be missed if the client is not directly asked about their use. The HIV counsellor should become aware of the pattern of a client's drug use so that appropriate information and advice can be provided on reducing any associated risks. It is important that a drug use assessment be carried out during HIV test counselling as part of the risk assessment and reviewed in any behaviour change counselling session or supportive post-diagnosis counselling sessions.

Verbal communication is normally adequate for the purpose of obtaining informed consent. Those institutions or jurisdictions that require consent for testing to be given in writing are encouraged to review their policy.

Some populations, such as those at higher risk of HIV transmission and women, may be more susceptible to being coerced for testing and to the previously discussed adverse outcomes, such as discrimination, violence, abandonment or incarceration. Alternatively, individuals may be subjected to

pressure to be tested in environments where treatment for OIs or HIV is not available. In such situations, additional measures to ensure informed consent may be appropriate, beyond the minimum requirements defined in this document. The care provider may need to particularly emphasize the voluntary nature of the test and the client's right to decline it.

Summary of core content of pre-test counselling session

- Reason for testing
- Imparting basic information on HIV, including on HIV transmission
- Personal risk assessment
- Feedback of possible results in relation to individual risk assessment
- Assessment and discussion regarding capacity to cope with potential positive result
- Assessment of potential support requirements
- Development of a personal risk reduction plan
- Provision of HIV test information
- Informed consent
- Follow-up arrangements for collection of results and other referrals, e.g. STI treatment

3.1.1 Pre-test individual risk assessment

The risk assessment is undertaken to understand the nature and time course of behavioural risks. It is important for clients to understand that the HIV test only screens for HIV and not the other pathogens associated with the risks of injecting drug use or unprotected sex, such as hepatitis B, C or syphilis. Clients should be advised of the routine blood and other tests that are offered and informed consent obtained for them. Often, care providers focus only on HIV transmission associated with unsafe injecting practices and neglect the other transmission risks, such as unprotected intercourse, tattooing and the additional risks for female drug users, including MTCT.

3.1.2 Pre-HIV test information in a group

Individual pre-test counselling is considered to be the most effective pre-test counselling strategy. However, this may not be possible where routine testing and counselling results in large numbers of individuals requiring pre-test

information. In many settings the demand for VCT is high and resources are limited. Often, clients are kept waiting in busy waiting rooms for long periods of time. The information components of pre-test counselling could be provided in a group setting, while issues specific to the individual could be discussed on an individual level in a briefer, individual session. Informed consent for testing should be always taken on an individual basis.

<p>SUITABLE FOR GROUP INFORMATION</p>	<ul style="list-style-type: none"> • The confidentiality and privacy that can be offered to clients • What HIV is – the virus and the infection • Basic information about HIV transmission and HIV risk reduction • Demonstration of and discussion on condom use • The benefits and potential issues related to testing • The procedures for testing and provision of results • General information about reproductive health
<p>INDIVIDUAL COUNSELLING (PRE- OR POST-TEST)</p>	<ul style="list-style-type: none"> • Personal risk assessment and feedback of individual risk • Informed consent

3.1.3 Additional information for women who are or may become pregnant

In addition to the information given above, pre-test information for women who are or may become pregnant should include:

- the risks of transmitting HIV to the infant;
- the special risks associated with acquiring HIV during pregnancy;
- measures that can be taken to reduce MTCT, including ARV prophylaxis and infant-feeding counselling; and
- the benefits to infants of an early diagnosis of HIV
- advice on contraception if they do not want to become pregnant.

3.1.4 Addressing the special needs of sex workers, MSM and transgender PWID

In addition to the recommendations above, it must be recognized that clients from these populations are vulnerable to additional stigma and discrimination, and may have lifestyles that complicate their access to HIV or other health services during normal working hours. Testing and counselling services wishing to provide comprehensive or quality services to these subpopulations of PWID must therefore consider service adjustments (in place and service hours) to facilitate access and provide a welcoming environment, and meet any special needs.

The development of rapid HIV testing technologies will decrease the waiting times for HIV results and may thereby improve the rate of return for results among these clients. Additional support from peer outreach workers and innovative reminder strategies (e.g. mobile phone SMS) may also increase the chances of completing testing and counselling.

Referral of high-need drug users to specialist drug treatment services and OST should be a high priority to provide the opportunity to substantially improve their quality of life and contribute to the additional stability required to undertake appropriate testing and counselling, and subsequent HIV treatment.

3.1.5 Special considerations for adolescents

In most countries, the median age for the onset of sexual activity is earlier than the age of legal majority. Many adolescents do not have independent access to HIV prevention services. With regard to information on sexual and reproductive health, including that on family planning, the Committee on the Rights of the Child has stated in General Comment “4” (Adolescent Health and Development) that governments “should ensure that adolescents have access to appropriate information regardless of their marital status and whether their parents or guardians consent”, and should remove all barriers to health services, including those relating to HIV prevention (such as condoms).¹⁶ For these reasons, WHO and UNAIDS encourage countries to provide adolescents with independent access to HIV prevention, treatment, care and support services.²

Adolescents are not easy to engage in mainstream or even PWID services, as they have additional reasons for attempting to avoid detection of their risk

behaviours. Health services need to pay special attention to orienting HIV prevention and care programmes to their needs and adjusting programmes to the behavioural issues generated by adolescents.

National and local laws may not stipulate precisely the age of majority for independent access to health services. The age at which adolescents are allowed to give their own consent may vary for different procedures. Many countries make allowances for adolescents designated as “mature” or “emancipated minors” (e.g. those who are married, pregnant, sexually active, living independently or who are themselves parents), which will enable them to provide consent by themselves for some services.

Governments should be encouraged to develop and implement clear legal and policy frameworks that stipulate: (i) the specific age and/or circumstances in which minors may consent to HIV testing for themselves or for others (as in the case of child-headed households); and (ii) how the assent of and consent for adolescents should best be assessed and obtained. Efforts to expand HIV testing and counselling in PWID settings should include training and supervision for care providers on laws and policies governing consent for minors to access clinical services, including when they can and cannot recommend an HIV test to an adolescent independent of the consent of the adolescent’s parent or legal guardian.

Where the law does not allow a sufficiently mature adolescent to give his or her own informed consent to an HIV test, the care provider should provide the adolescent with the opportunity to assent to HIV testing and counselling in private, without the presence or knowledge of his or her parents or legal guardians. Pre-test information should be adapted to the patient’s age, developmental stage and literacy level. If the adolescent provides assent, indicating that he or she understands the risks and benefits of HIV testing and would like to receive the test, then the care provider should seek the informed consent of the parent or legal guardian.

In some situations, a parent or legal guardian may not be available to give consent on the adolescent’s behalf, and the care provider may need to assess whether an adolescent can request and consent to testing alone. The provider must always work within the framework of local or national laws and regulations, be assisted by consultation with professional colleagues and be guided by the best interests of the patient.

3.1.6 Seriously ill patients

Many individuals undergoing HIV testing in PWID settings have been ill for some time and, for a variety of reasons, delayed seeking definitive health care. Many have their own expectation of the outcome of a positive test result. HIV testing services in PWID settings should build strong support services for these individuals to complete the testing process, rapidly establish an extended support network, and facilitate referral to appropriate health services for the investigation and treatment of OIs and initiation of ART. Any delay in or failure of the referral process at this advanced stage of HIV infection can markedly shorten the patient's life.

Critically ill or unconscious patients may not be able to provide informed consent for HIV testing and counselling. In such circumstances, consent should be sought from the patient's next-of-kin, guardian or other caregiver. In the absence of such a person, care providers should act according to the best interests of the patient.

3.1.7 Follow up where a test is declined

Declining an HIV test following counselling should not result in reduced quality or denial of services, coercive treatment or breach of confidentiality, nor should it affect a person's access to health services that do not depend on knowledge of their HIV status. Individuals declining the test should be offered assistance to access HIV testing and counselling in the future.

The individual's decision to decline the HIV test should be noted in the medical record so that, at subsequent visits to the health facility, a discussion about HIV testing and counselling can be re-initiated.

3.1.8 Preparation to return for results

Clients should be advised in advance that they will not be provided with their results if they present to the facility under the influence of drugs or alcohol, or experiencing the effects of withdrawal from such substances. Counsellors should explain the rationale for this policy and advise clients to control their drug or alcohol use before returning for their results.

Where there are concerns about an individual's ability to fully participate in counselling, informed consent for testing or receiving the results, it should be discussed with him or her in a supportive and non-threatening way. It is important to acknowledge that the stress of the situation is understandable,

but that it is not possible to proceed if the person is unable to participate fully. This may simply mean allowing the person to wait in a supervised area or come back later in the day.

3.2 POST-TEST COUNSELLING

Post-test counselling is an integral component of the HIV testing process. All clients undergoing HIV testing must be counselled when their test results are given, regardless of the test result. Given that many inpatient and outpatient facilities are crowded, care should be taken to discuss results and follow-up care in a confidential manner. The results should be given to clients in person by care providers or trained lay personnel. Ideally, post-test counselling should be provided by the same care provider who initiated the HIV testing and counselling. Results should not be given in group settings.

PWID who are regular drug users will be at additional risk for recreational or self-harming drug overdose after receiving their HIV test results. This additional component should be specifically addressed during counselling in an attempt to identify those at high risk for suicide if the risk of positive or recreational overdose is negative. Coping strategies are particularly limited in such clients and peer support mechanisms may be helpful.

It is not acceptable practice for health-care providers to recommend HIV testing and counselling to clients and to subsequently withhold or fail to convey the test results. Although clients can refuse to receive or accept the results of any test or investigation, health-care providers should make every reasonable attempt to ensure that clients receive and understand their test results in a confidential and sympathetic manner.

Counselling for those whose test result is *HIV-negative* should include the following minimum information:

- an explanation of the test result, including information about the window period for the appearance of HIV antibodies and a recommendation to re-test in case of a recent exposure;
- basic advice on methods to prevent HIV transmission, including avoiding the use of non-sterile needles, syringes or other injecting equipment;
- access to drug dependence treatment and its effectiveness, particularly OST where it is available;

- guidance on the use of condoms, safe injecting advice (if possible, an appropriate supply of condoms, sterile needles/syringes and other commodities should be provided); and
- the appropriate time for a follow-up test, based on the risk assessment and ongoing risk behaviour.

The care provider and the client should jointly assess whether there is a need to be referred for more extensive post-test counselling or additional prevention support including OST.

Counsellors need to assist all clients in preventing unplanned pregnancies by providing adequate information on barrier contraception such as the use of condoms, especially during periods of potential exposure to HIV or suspected acute infection. It is also important that partners of pregnant women are screened and that they are aware of the risk of transmission to unborn children and the heightened risk of transmission during seroconversion.

For those clients whose test result is *HIV-positive*, the care provider should:

- inform the client of the result simply and clearly, and give time to consider it;
- ensure that the client understands the result;
- allow the client to ask questions;
- assist the client in coping with the emotions arising from the test result;
- discuss immediate concerns and assist the client in determining what social network may be acceptable and available to offer immediate support;
- describe follow-up services that are available in the health facility and in the community, paying special attention to OI/HIV treatment, PMTCT, and care and support services;
- provide information on how to prevent the transmission of HIV, including provision of sterile needles, syringes and condoms, and guidance on their use;
- provide information on other relevant preventive measures, such as good nutrition, use of co-trimoxazole prophylaxis and, if appropriate, insecticide-treated bednets, and OST;
- discuss disclosure of the result – when and how this may happen, and to whom (*see below*);
- encourage testing and counselling of partners and children;

- provide advice on other pathological tests that may be appropriate (such as for liver function, hepatitis B and C serology, pregnancy, X-ray, sputum for acid-fast bacilli [AFB]);
- assess the risk of violence, drug overdose or suicide, and discuss possible measures to ensure the physical safety of clients, particularly women, who are diagnosed HIV-positive;
- arrange a specific date and time for follow-up visits or referrals to treatment, care, counselling, support and other services, as appropriate (e.g. screening for and treatment of TB, prophylaxis for OIs, STI treatment, contraception, antenatal care, OST, hepatitis B and C screening, and access to supplies of condoms and sterile needles/syringes); and
- consider introducing the client to relevant team members who may be involved in future care.

Post-test counselling for *pregnant women* whose test results are *HIV-positive* should also address the following routine measures:

- childbirth plans;
- the use of ARV drugs for the client's own health when indicated, and for PMTCT;
- maternal nutrition, including iron and folic acid supplements;
- infant-feeding options and support options to facilitate the mother's infant-feeding choice;
- HIV testing for the infant and the follow up that will be necessary; and
- partner testing (*see below*).

There is a need for counsellors to increase client awareness of the impact of continued substance use on the unborn or breastfed child and to consider referral to drug treatment services, particularly those providing OST.

When pregnant women or their partners are identified as HIV-positive, it is essential that they are referred to specialist PMTCT programmes and that good communication is facilitated between the counselling and testing service, drug treatment services and the PMTCT programme. Counsellors can facilitate this process by getting client consent for information-sharing between service providers.

For those clients whose test result is *HIV-indeterminate*, the care provider should:

- explain to the client what this means;

- specifically enquire about recent symptoms suggestive of a seroconversion illness;
- ask the patient to return for re-testing in three months; and
- reaffirm the necessity for safer sexual practices with all partners in the absence of a negative result.

3.2.1 Disclosure of positive HIV test results to partners

Disclosure of a positive result to sexual or injecting partners is a complex and sensitive issue, with a variety of options available to clients for its successful completion. Counsellors should support the client's decision-making process by providing a list of potential disclosure mechanisms and facilitating a discussion of the advantages and disadvantages of each. The client and counsellor can even rehearse the act of disclosure to develop the client's skills in managing his or her partner's potential response. Options include:

- The client discloses the status.
- The client brings the partner to the clinic for self-disclosure in the presence and with the support of the counsellor.
- The client brings the partner to the clinic and the counsellor discloses in the presence of the client.
- The client authorizes the counsellor to disclose to the partner in the absence of the client.
- The client discloses to a key trusted family member who discloses to the partner.
- The client hands out referral cards for testing and counselling to sexual/injecting partners.

3.3 REFERRAL SYSTEMS

HIV test results should be communicated with an explanation of the prevention, treatment, care and support services available to the client. Linkages between programmes for other chronic illnesses (such as TB, hepatitis C) and community-based HIV prevention, care, support and treatment services are especially important, as is establishing and maintaining collaborative referral and communication mechanisms with them. Care providers should undertake a formal or informal screening for comorbid physical and mental illness to facilitate all appropriate referrals as early as possible in the care cycle.

At a minimum, referral should include providing the client with information about whom to contact as well as where, when and how to contact them.

Client referral works best if the care provider makes the contact and schedules an appointment in the presence of the client, making a note of the contact and the organization in the client's file.

Effective referral involves:

- communicating with the client about the referral process;
- consent for information transfer to referral services (shared confidentiality);
- supporting the client in getting to the referral services (strategies, treatment “buddies”, etc.); and
- tracking referrals (following up – did the client get there?).

As stated above, services relevant to the management of HIV illness should be integrated into a local network of care providers who meet regularly to discuss problems, referrals and mechanisms to strengthen HIV care. Relevant services include those for harm reduction, diagnosis and treatment of TB and STI, reproductive health, PMTCT, palliative care and HIV home care/ support. Staff within the referral network need to routinely inform each other of changes in personnel or processes which could impact on the referral of clients. In settings attended by PWID, the intrinsic stigma displayed toward or perceived by PWID presents a significant barrier to normal referral processes and hence access to services.

Useful strategies employed in PWID settings to overcome these barriers include:

- the provision of “buddies” or navigators to negotiate the referral process with the referred individual;
- identified peers based at the referral site to welcome and familiarize new clients with the services at the referral site; and
- specialist or treatment service visits to the PWID setting to provide personal “bridges” across the services.

3.4 FREQUENCY OF TESTING

Care providers should subsequently recommend testing and counselling to all HIV-negative patients likely to be at high risk for HIV, based on individual risk assessment. This should be conducted at least annually for:

- PWID and their sex partners;
- persons who exchange sex for money or drugs;
- sex partners of HIV-infected persons; and
- MSM or heterosexual persons who themselves or whose sex partners have had more than one sex partner since their most recent HIV test.

Re-testing every six months may be beneficial for individuals at a particularly high risk for HIV exposure, such as sex workers, men who have unprotected sex with men, PWID who report using unsterile injecting equipment, and sex partners of PLHIV. This more frequent testing provides an added opportunity to emphasize the need for such individuals to practise safe behaviours. It is important that regular HIV testing does not become a substitute for prevention behaviours, and care providers should use the post-test counselling session to emphasize safer behaviours.

Health-care providers should encourage individuals and their prospective sex partners to be tested before initiating a new sexual relationship.

Repeat screening of persons not likely to be at high risk for HIV should be performed on the basis of clinical judgement.

Unless recent HIV test results are immediately available, any person whose blood or body fluid is the source of an occupational exposure for a care provider should be informed of the incident and asked to consent to testing for HIV infection at the time the exposure occurs.

Additional research is needed in diverse settings with varying HIV epidemiology to determine the optimum interval between HIV tests for specific populations.

Risks of HIV transmission to an infant are very high if the mother acquires HIV during pregnancy or while breastfeeding. HIV-negative women should be tested as early as possible in each new pregnancy, particularly in the case of women who are at high risk for HIV exposure. Repeat testing late in

pregnancy is recommended to HIV-negative women exposed to ongoing risk through their own behaviour or that of their partner who injects drugs.

3.5 HIV TESTING TECHNOLOGIES

3.5.1 Factors to consider

The advantages of using rapid tests for HIV testing and counselling in PWID settings, particularly for health facilities where laboratory services are weak or in peripheral and rural settings where traditional laboratory infrastructure does not exist, include the visibility of the test and the quick turnaround time, which increases confidence in the results and helps to avoid clerical errors.

Rapid HIV testing can occur outside laboratory settings, does not require specialized equipment and can be carried out in primary health-care facilities by appropriately trained non-laboratory personnel, including counsellors. However, trained laboratory supervisors are required for supervision and provision of quality assurance measures, including external quality assessment, regular quality control for testing and biosafety. The tests selected should be of assured quality.²

Enzyme-linked immunosorbent assay (ELISA) may be preferable in settings where large numbers of tests need to be performed, where immediate provision of test results is less important (such as for hospital inpatients) and in reference laboratories. ELISA tests require specialized laboratory equipment and staff. Decisions on whether to use HIV rapid tests or ELISA for HIV testing and counselling in PWID settings should take into account such factors as:²

- the setting in which testing is proposed;
- cost and availability of the test kits, reagents and equipment;
- available staff;
- the available resources and infrastructure;
- the laboratory expertise and personnel available;
- the number of specimens to be tested;
- specimen collection and transport mechanisms;
- the ability and likelihood of individuals to return for the results.

In the environment of services for PWID, the use of rapid HIV tests provides a particular advantage for those clients with high mobility experiencing a “brief window of opportunity” for access to testing or a widely fluctuating enthusiasm for HIV diagnosis and treatment.

3.5.2 Diagnostic testing strategies

HIV testing should follow strategies recommended by WHO and the Centers for Disease Control and Prevention (CDC).¹⁷ A testing strategy refers to a generic testing approach for specific needs (for example, transfusion and transplant safety, surveillance or diagnosis of HIV infection) and a testing algorithm refers to the combination in sequence of specific HIV testing assays used within a given HIV testing strategy. Both the selection of test kits and the order in which the assays are used are of the utmost importance for the final outcome of the testing algorithm.

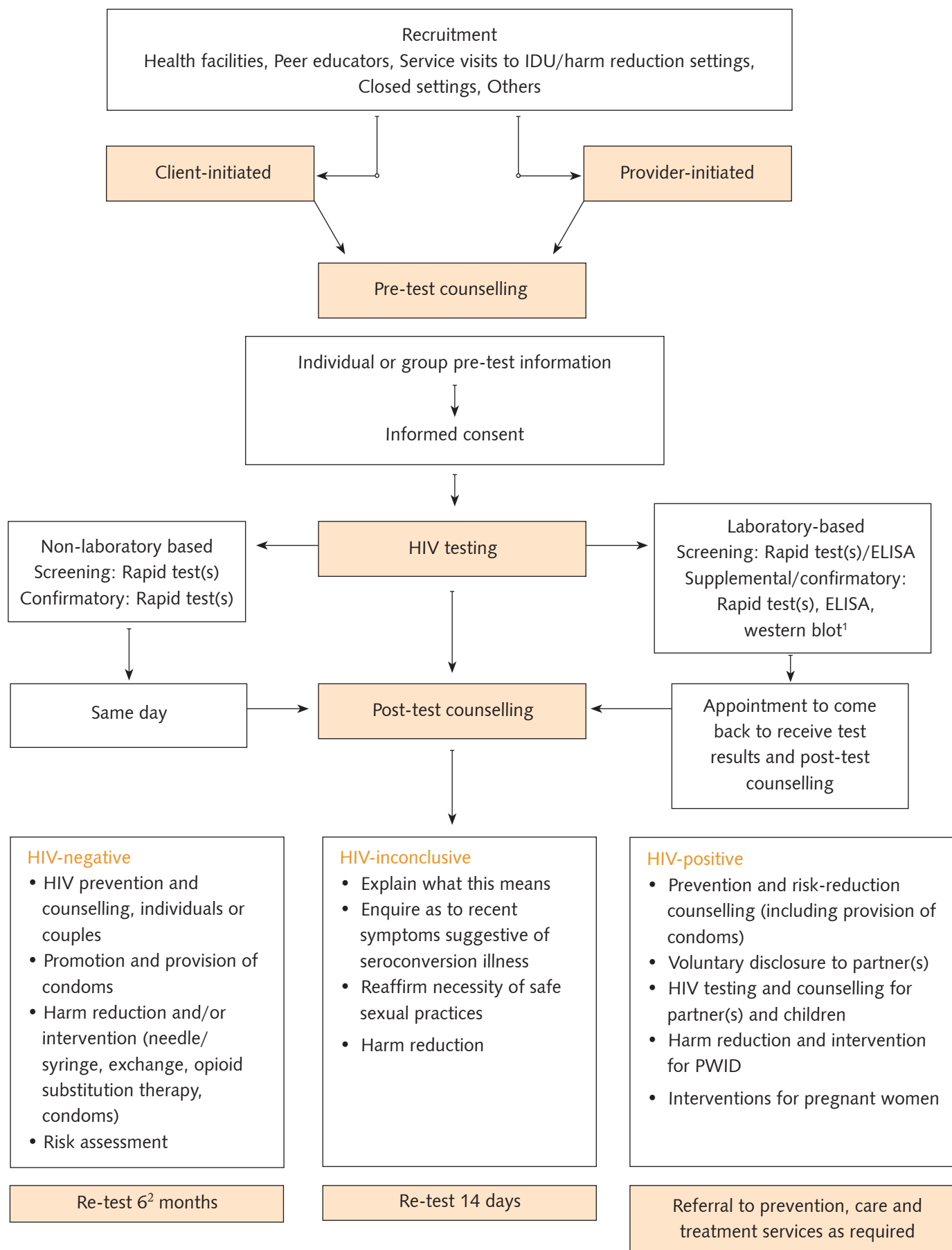
The number of algorithms should be limited in order to streamline procurement procedures and facilitate standardization and ease of training.

It is of the utmost importance that assay combinations should always be validated in the context in which they will be used before widescale implementation. All HIV assays used in a particular HIV testing algorithm should have at least a sensitivity and specificity of 99% and 99%, respectively.¹⁸ The current recommended HIV testing strategies are in the process of being reviewed and so this document will not go into detail except to emphasize that testing strategies should only be applied to validated testing algorithms.¹⁹

A testing algorithm must be nationally validated for its intended use. At the country level, the choice of testing strategy and the choice of HIV assays for use in a particular testing algorithm should be determined by:¹⁸

1. the objective of the testing to be performed and the type of HIV epidemic;
2. the performance characteristics of the tests (i.e. sensitivity and specificity), the positive predictive value of the testing algorithm and costs;
3. the availability of the assays, reagents and equipment including considerations of shelf-life and storage conditions;
4. aspects related to implementation such as resources and infrastructure, existing laboratory expertise and personnel, daily specimen throughput, specimen collection and transport methods, the setting in which testing will take place, how they work together as a system, and the convenience and ability of individuals to return for results.

HIV TESTING ALGORITHM



¹Gold standard of HIV testing ²Dependent on risk assessment



4. PROGRAMMATIC CONSIDERATIONS

Programmatic considerations

Decisions on how best to implement HIV testing and counselling in settings attended by PWID will depend on an assessment of the situation in the particular country, including the local epidemiology; the available infrastructure, financial and human resources; the available standard of HIV prevention, treatment, care and support; and the existing social, policy and legal frameworks for protection against the adverse consequences of HIV testing, such as HIV-related discrimination and violence.

Offered proper support, PWID can achieve the same levels of adherence to and clinical benefit from ART as other patients with HIV.¹⁷ However, where there are high levels of stigma and discrimination and/or low capacity among care providers to implement HIV testing and counselling under the conditions of informed consent, confidentiality and counselling, greater resources and training must be devoted to addressing these issues prior to implementation.

Decisions around implementation should be made in consultation with all relevant stakeholders, including civil society groups, PWID and PLHIV. The steps that may need to be taken to adapt the general recommendations in this document to national and local conditions are given below.

4.1 NATIONAL AND LOCAL CONSULTATION, AND ADAPTATION ACTIVITIES TO IMPLEMENT HIV TESTING AND COUNSELLING IN PWID SETTINGS

1. In countries considering the implementation of HIV testing and counselling in PWID settings, the Ministry of Health may convene a national consultation to plan an implementation strategy, including adaptation of this guidance document to local conditions. It is suggested that participants include:
 - national-level programme managers for HIV prevention and care, TB and other clinical services, and drug dependence treatment services;
 - ministries of justice, welfare, interior and finance;
 - ministries responsible for prisons, drug treatment and rehabilitation;
 - care providers;
 - regulatory bodies and associations of health professionals;
 - CBOs and faith-based organizations (FBOs), including women's organizations;

- key populations at higher risk for HIV, particularly PWID representatives;
 - PLHIV;
 - human rights advocates;
 - private sector representatives; and
 - representatives of legal and social support services.
2. Existing social, legal and policy frameworks should be assessed and reviewed to facilitate implementation of HIV testing and counselling in PWID settings and protect the rights of clients, and should include advocacy and communication campaigns, and social and legal support services.

Adequate resources must be planned and made available for implementation, including funding for testing-related commodities, care-provider training, community preparedness and social mobilization.
 3. It is recommended that operational guidelines, protocols and codes of conduct for care providers, as well as training tools and education materials, be developed or adapted. These should be based on HIV epidemiology, available resources, ethical and human rights principles, and legal and sociocultural contexts.
 4. For countries choosing to implement HIV testing and counselling in PWID settings in a phased manner, priorities should be set for initial and subsequent scaling up.
 5. Care providers should be identified and trained. There are particular issues involved in providing services for PWID. Taking blood specimens from the damaged veins of some PWID will require the recruitment of more experienced and empathetic staff, as well as additional training.
 6. HIV testing and counselling in PWID settings should be incorporated into existing supervision, quality assurance and M&E systems.
 7. Civil society should be engaged in the process of ongoing M&E of all HIV testing and counselling services.
 8. At facility level, linkages should be strengthened between services to facilitate entry into HIV-related services following HIV testing and counselling, including community-based prevention, treatment, care and support services.

4.2 PROGRAMME IMPLEMENTATION IN HEALTH FACILITIES FOR PWID

Many settings with a high burden of HIV face substantial human and financial constraints that limit the feasibility of implementing new health service activities on a large scale. It may be necessary to prioritize particular health facilities for the introduction of HIV testing and counselling for PWID, depending on the local context and available resources. Services require standards and accreditation procedures, including the identification of approved teaching sites.

Coordinated planning, training and procurement are important to ensure synergies between all HIV testing and counselling providers, and will help to facilitate referral between different types of health services. Training on stigma and discrimination is recommended, as is the accreditation of staff following training.

4.3 PROGRAMME IMPLEMENTATION IN HARM-REDUCTION SETTINGS

The above HIV testing and counselling approach in PWID settings is part of the natural continuum of harm-reduction services and should be readily incorporated into the knowledge base of harm-reduction workers in all services. The purpose of the harm-reduction approach is to reduce the risk of acquiring and transmitting HIV and other bloodborne viruses, among other harms. Harm reduction is a natural entry point for PWID and their partners to HIV testing, counselling and care services.

The addition of an HIV testing and counselling strategy to HIV prevention services follows a pragmatic understanding that avoidance of risk is not always possible, and that HIV testing and counselling should be readily available to provide the earliest possible entry to HIV care (if required) and the knowledge to avoid acquiring HIV (if not).

Harm-reduction workers will, of course, require special attention for the implementation of expanded HIV testing and counselling services, so that they incorporate appropriate messages into their daily contact with and education activities for PWID. Particular attention should be paid to the development of linkages to other services, such as TB and STI and, in the longer term, to comprehensive services for PWID.

4.4 PROGRAMME IMPLEMENTATION IN CLOSED SETTINGS

Planning and development of an expanded HIV testing and counselling strategy is at its most vulnerable and complex in custodial or compulsory rehabilitation settings. Health-care staff in closed settings are often insufficiently separated from the management at the centres to provide balanced counselling advice or adequate assurances of the confidentiality of HIV testing. Compulsory or mass HIV screening is not supported by WHO or UNAIDS and has no evidence base on public health grounds.²

The issue of informed consent is particularly problematic in an environment of significant deprivation of liberty and basic rights, including health care. As previously noted, HIV testing and counselling in PWID settings is a strategy proposed primarily in those settings where HIV care and treatment, including investigation and treatment for OIs and provision of ART, are or will soon be available.

Group and individual counselling in these contexts is particularly problematic because of compromised confidentiality. Knowledge on harm reduction and access to prevention methodologies for STI/bloodborne viruses (condoms, sterile needles/syringes) should be routinely included in the counselling content. The high risk of exposure to HIV in a custodial environment and the lack of access to prevention methodologies (condoms, sterile needles/syringes, OST) increase the concern regarding the premature introduction of expanded HIV testing and counselling for PWID in this particular environment without adequate training and access to ART.

The routine referral to community care services of patients diagnosed and commenced on an HIV care continuum while in custody may prove problematic on their release into the community. With the introduction of HIV testing, counselling and care in closed settings comes the requirement for establishing excellent community linkages and systems that will provide for the seamless connection of patients on OI, ART or OST to community agencies in a position to continue that care.

Further experience and training is required locally to develop implementation strategies for the successful and effective development of ethical, voluntary and confidential HIV testing and counselling in various types of closed settings. In all likelihood, special guidance documents and training materials with a

particular emphasis on consent and confidentiality will be required for each of the different closed settings and their staff.

4.5 RECORDING AND REPORTING

Routine data collection systems, while absolutely protecting client privacy and confidentiality (regarding risk behaviours and HIV test results), should be established in all services offering HIV testing and counselling. These should be designed and used to monitor service workloads, demand for testing and consolidated results.

Standardized and simple data collection tools will enable comparability between sites and reduce the burden on health-care personnel. Additional mechanisms are needed, in the presence of confidential data collection, to avoid duplicate counting of patients in prevention and care services. Appropriate training in data collection should be provided to care providers and administrators.

The highly emotive issue of name-based reporting of HIV and ART data requires extensive discussion to avoid becoming a deterrent for patients considering testing and counselling. Name-based reporting is not required for national epidemiological data collection and a number of mechanisms exist for the generation of unique personal codes to maintain patient confidentiality and avoid double registration.

These data, once consolidated, should be forwarded to national HIV planning authorities and district/provincial managers to facilitate the planning of HIV prevention, treatment and care services. Consolidated reporting of HIV testing and counselling activities should be used to reflect on the access of risk groups to testing, counselling and treatment, and circulated to all HIV prevention and treatment services in the form of periodic or annual reports.

4.6 MONITORING AND EVALUATION

M&E of HIV testing and counselling services are essential but may need to be supplemented by focused evaluations of specific aspects of programming to allow programme managers:

- to monitor progress in implementation, including procedures for obtaining informed consent, ensuring confidentiality and providing counselling;
- to identify problems, and refine and adapt implementation strategies;

- to assess the effectiveness and impact of this guidance document on HIV testing and counselling in PWID settings in terms of:
 - increasing access to HIV testing and counselling, and to test results,
 - increasing access to and uptake of HIV-related prevention, treatment, care and support services,
 - decreased morbidity and mortality,
 - increased HIV awareness and treatment literacy; and
 - social impact (e.g. on rates of disclosure, stigma and discrimination, and adverse outcomes);
- to assess cost-effectiveness and sustainability;
- to assess the quality of related laboratory services;
- to assess the reasons that HIV testing and counselling is being recommended; and
- to assess client satisfaction, inform service planning and follow up.

Additional attention should be paid to routinely assessing the barriers to health-seeking behaviour for drug users and other populations at higher risk of acquiring HIV, and recommending how these can be addressed.

Planning for M&E should aim, where possible, to utilize existing structures or mechanisms for collecting relevant indicators, rather than setting up independent systems. Standardized and simple data collection tools will enable comparability between sites and reduce the burden on health-care personnel. Health-care providers and administrators should receive appropriate training in data collection.

As the amount of data in routine monitoring will always be limited, it is recommended that routine monitoring be complemented by focused evaluations of specific aspects of implementation. For example, quality assurance should be undertaken at the health facility level. Regular evaluations of health-care provider performance and patient satisfaction (testing processes, pre-test information, consent process, post-test counselling) can help improve the effectiveness, acceptability, and quality of HIV testing and counselling services.

Health facilities are encouraged to partner with NGOs and civil society groups for monitoring and evaluating HIV testing and counselling to ensure service quality and acceptability, including maintenance of high ethical standards and human rights norms.

The formation of client resource groups to inform the development and performance of PWID services is essential for effective service quality and access. For reasons of discrimination, legality and behaviour, this task is characteristically complex. Involvement of PWID mobilized from these resource groups as “professional patients” in HIV testing and counselling training activities should be regarded as routine.

A comprehensive evaluation of this broader HIV testing and counselling approach should be undertaken a reasonable time after implementation to ensure that the aims of the testing and counselling strategy are being achieved. These include access to testing by PWID, provision of sufficient information to make an informed and voluntary decision to be tested, maintenance of patient confidentiality, provision of adequate post-test counselling, and referral to appropriate HIV prevention and care services.

More detailed guidance on the M&E of HIV testing and counselling is being developed by WHO and should be available in the near future.

Additional resources

A broad selection of tools and guidance for implementing HIV testing and counselling in different settings may be found on the WHO HIV Testing and Counselling Online Toolkit. This website is periodically updated with the latest HIV testing and counselling resources available including:

Scaling-up HIV testing and counselling services – a toolkit for programme managers. Geneva, WHO, 2005

(<http://who.arvkit.net/tc/en/index.jsp>; http://whqlibdoc.who.int/publications/2005/924159327X_eng.pdf).

Guidance on provider-initiated HIV testing and counselling in health facilities. Geneva, WHO/UNAIDS, 2007

(http://whqlibdoc.who.int/publications/2007/9789241595568_eng.pdf).

HIV counselling trainer's manual for VCT, PITC and care counselling for the Asia Pacific Region. Paris, UNICEF (and others), 2008 (in press).

The following documents and internet sites may also be useful resources for planning, implementing and scaling-up HIV testing and counselling services:

Antiretroviral therapy and clinical care

Antiretroviral therapy for HIV infection in adults and adolescents: towards universal access – recommendations for a public health approach. Geneva, WHO, 2006 revision (<http://www.who.int/entity/hiv/pub/guidelines/artadultguidelines.pdf>).

Antiretroviral drugs for treating pregnant women and preventing HIV infection in infants: towards universal access – recommendations for a public health approach. Geneva, WHO, 2006 version (<http://www.who.int/hiv/pub/guidelines/pmtctguidelines2.pdf>).

Antiretroviral therapy for HIV infection in infants and children: towards universal access – recommendations for a public health approach. Geneva, WHO, 2006 (<http://www.who.int/hiv/pub/guidelines/paediatric020907.pdf>).

WHO ARV toolkit. A public health approach for scaling up antiretroviral (ARV) treatment —a toolkit for programme managers. Geneva, WHO, 2003

(<http://www.who.int/hiv/toolkit/arv/en/index.jsp>; <http://whqlibdoc.who.int/hq/2003/9241591161.pdf>).

WHO. *Integrated management of adolescent and adult illness (IMAI) and integrated management of childhood illness (IMCI)*. Various documents (<http://www.who.int/hiv/pub/imai/en/>).

Ball A, Kazatchkine M, Rhodes T, eds. HIV treatment and care for injecting drug users. *International Journal of Drug Policy*, 2007, 18:241–332.

Open Society Institute. *Breaking down barriers: lessons on providing HIV treatment to injection drug users*. New York, International Harm Reduction Development Program, Open Society Institute, 2004 (http://www.soros.org/initiatives/health/focus/ihrd/articles_publications/publications/arv_idus_20040715/Breaking_Down_Barriers.pdf).

Legal and policy issues

Policy statement on HIV testing. Geneva, UNAIDS and WHO, 2004 (http://data.unaids.org/una-docs/hivtestingpolicy_en.pdf).

HIV/AIDS and human rights – international guidelines. Geneva, UNAIDS and OHCHR, 1996 (<http://whqlibdoc.who.int/publications/1998/9211541301.pdf>).

International guidelines on HIV/AIDS and human rights. Geneva, UNAIDS and OHCHR, 2006 consolidated version (http://data.unaids.org/Publications/IRC-pub07/jc1252-internguidelines_en.pdf).

Handbook for legislators on HIV/AIDS, law and human rights. Geneva, UNAIDS and IPU, 1999 (http://whqlibdoc.who.int/unaid/1999/UNAIDS_99.48E.pdf).

Beneficial disclosure and partner counselling

Opening up the HIV/AIDS epidemic: guidance on encouraging beneficial disclosure, ethical partner counselling and appropriate use of HIV case-reporting. Geneva, UNAIDS, 2000 (UNAIDS Best Practice Collection, Key Material) (http://whqlibdoc.who.int/unaid/2000/UNAIDS_00.42E.pdf).

HIV testing in women and girls

Addressing violence against women in HIV testing and counselling—a meeting report. Geneva, WHO, 2007

(http://www.who.int/gender/documents/VCT_addressing_violence.pdf).

Testing and counselling for prevention of mother-to-child transmission of HIV (TC for PMTCT). Support tools. Geneva, CDC, WHO, UNICEF, USAID and PMTCT implementing partners, 2005

(<http://www.who.int/hiv/pub/vct/tc/en/index.html>).

Briefing note: HIV and infant feeding. Conference on Retroviruses and Opportunistic Infections. Los Angeles, 25–28 February 2007.

(<http://www.who.int/hiv/mediacentre/Infantfeedingbriefingnote.pdf>).

Sexual and reproductive health of women living with HIV/AIDS. Geneva, WHO and UNFPA, 2006

(http://whqlibdoc.who.int/publications/2006/924159425X_eng.pdf).

Prevention of mother-to-child transmission of HIV: generic training package. Atlanta, WHO and CDC, 2004.

(<http://www.cdc.gov/nchstp/od/gap/PMTCT/>).

Nutrition counselling, care and support for HIV-infected women. Geneva, WHO, 2004

(<http://whqlibdoc.who.int/publications/2004/9241592125.pdf>).

HIV testing and counselling in TB clinical settings

Tuberculosis care with TB–HIV co-management. Geneva, WHO, 2007

(http://www.who.int/hiv/pub/imai/TB_HIVModule23.05.07.pdf).

HIV testing and counseling in TB clinical settings tools. Atlanta, CDC and WHO, 2007 (http://www.cdc.gov/nchstp/od/gap/pa_hiv_tools.htm).

Evidence for Action Technical Papers. Policy guidelines for collaborative TB and HIV services for injecting drug users. An integrated approach. Geneva, WHO, 2008

(http://whqlibdoc.who.int/publications/2008/9789241596930_eng.pdf)

Most-at-risk populations

Toolkit for targeted HIV/AIDS prevention and care in sex work settings. Geneva, WHO, 2005

(<http://who.arvkit.net/sw/en/index.jsp>; http://www.who.int/entity/hiv/pub/prev_care/sexworktoolkit.pdf).

Evidence for Action Technical Papers. Interventions to address HIV in prisons. HIV care, treatment and support. Geneva, WHO, UNODC, UNAIDS, 2007 (http://www.who.int/hiv/idu/oms_ea_hiv_treatment_df.pdf).

Prevention, treatment and care for injecting drug use and prisons. Available at: (<http://www.who.int/hiv/idu/en/index.html>).

Priority interventions HIV/AIDS prevention, treatment and care in the health sector. Geneva, WHO, 2008 (http://www.who.int/hiv/pub/priority_interventions_web.pdf70).

Strategies for involvement of civil society in HIV testing within context of “3 by 5”: focus on marginalized communities. Geneva, UNAIDS, 2004 (Issue Paper) (http://data.unaids.org/Topics/Human-Rights/hr_refgroup3_06_en.pdf).

HIV testing and children

Convention on the rights of the child. New York, United Nations, 1989 (<http://www2.ohchr.org/english/law/pdf/crc.pdf>).

HIV/AIDS and human rights international guidelines. Revised guideline 6: access to prevention, treatment, care and support. Geneva, OHCHR and UNAIDS, 2003 (<http://whqlibdoc.who.int/publications/2002/9291730254.pdf>)

Convention on the rights of the child. General comments No 3 and 4: HIV/AIDS and the rights of the child. New York, United Nations, 2003 ([http://www.unhchr.ch/tbs/doc.nsf/\(symbol\)/CRC.GC.2003.3.En?OpenDocument](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/CRC.GC.2003.3.En?OpenDocument); [http://www.unhchr.ch/tbs/doc.nsf/\(symbol\)/CRC.GC.2003.4.En?OpenDocument](http://www.unhchr.ch/tbs/doc.nsf/(symbol)/CRC.GC.2003.4.En?OpenDocument)).

Integrated management of childhood illnesses (resources)

(http://www.who.int/child_adolescent_health/topics/en/; http://www.who.int/child_adolescent_health/documents/en/).

Testing technologies

HIV rapid testing: training package. Atlanta, CDC and WHO, 2006
(<http://www.phppo.cdc.gov/dls/ila/hivtraining/default.aspx>).

Guidelines for assuring the accuracy and reliability of HIV rapid testing: applying a quality system approach. Geneva, CDC and WHO, 2005
(http://www.who.int/diagnostics_laboratory/publications/HIVRapidsGuide.pdf).

Revised recommendations for the selection and use of HIV antibody tests.
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11. United Nations Office on Drugs and Crime. *Scaling up HIV testing and counselling for injecting drug users and in prison settings*. IHRA Conference 2008. (http://www.ihra.net/uploads/downloads/Conferences/Archive/Barcelona2008/2008_Monday_DoubleConcurrent_Higgins.pdf).
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