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In clinical care settings, the focus is on making a diagnosis and deciding about a treatment. In the presence of suspected HIV infection, current practices and appropriate standards and procedures to meet these needs in resource-constrained settings are not well described, and few protocols exist. The attending health care worker usually initiates the request for HIV testing and counselling, and informed consent procedures are often cutaneous or ignored. A possible tension between establishing a diagnosis and treatment plan, on the one hand, and attending to the patient’s psychosocial needs, on the other hand, may occur in such cases, the health care worker may not be well equipped to address these diverse demands. Both medical and psychosocial considerations should be included in a comprehensive care package.

In sexual and reproductive health care settings, HIV testing and counselling are still rarely provided, except in clinics for the treatment of sexually transmitted infections. HIV considerations play a critical role in family planning and reproductive health counselling, with HIV testing and counselling enable people to learn whether they have HIV, and that provides them support for prevention and care. HIV testing and counselling provide essential knowledge and support; they enable uninfected people to remain and enable those infected with HIV to plan for the future and prevent HIV transmission to others. Those who are infected can also benefit from available care, treatment and support services. Knowledge of HIV infection is a prerequisite to initiating antiretroviral therapy for the many who need it and who may be infected with HIV. It is also the main entry point for interventions that prevent HIV infections in infants and young children. Infected women who know their serostatus are able to make informed decisions about their reproductive lives, and if pregnant, to access antenatal and delivery services, such as antenatal drugs and infant-feeding counselling and support, which can significantly reduce the risk of mother-to-child transmission of HIV. Currently, the majority of HIV-infected people are unaware of their serostatus and are therefore unable to make informed decisions and receive the services they need.

WHO is developing strategies to rapidly scale up access to HIV testing and counselling services, in order to enhance people’s ability to reduce their risk of acquiring HIV, to access HIV-specific care, treatment and support, and to better plan for the future.

This will require the implementation of innovative, ethical and practical approaches for the prevention of testing and counselling services, recognizing that programmes need to be adapted to the populations to be reached, the service delivery settings and the main outcomes sought.

Conclusions and recommendations

Increased access to knowledge of serostatus is urgently required to serve new imperatives, such as the provision of specific services for people living with HIV/AIDS, for their care, treatment and support, and for the prevention of HIV transmission to infants and young children. WHO is committed to public health policies that will foster the rapid expansion of HIV testing and counselling services while protecting the rights of those affected by HIV.

At the consultative meeting held in December 2001, there was unambiguous endorsement of the standard VCT service delivery model as the way to meet certain needs (such as an individual’s need for information about their HIV infection status before entering a new sexual partnership) in certain settings (such as face-to-face VCT sites or sexual health clinics). The various aspects of the VCT model are important considerations for ensuring that HIV testing and counselling services are effective, efficient and sustainable. The configuration and emphasis of these components, however, may vary depending on the local context.

Models of service delivery

A range of models for service delivery for HIV testing and counselling is now in place, including free-standing services (as exemplified by walk-in, anonymous VCT centres), integrated services (for example, in maternal and child health programmes) and outreach services for vulnerable groups. In all these models, the greatest variation is observed in approaches to HIV counselling. Pre- and post-test counselling are often carried out in individual sessions, though other approaches are common, such as giving information to a group, followed by individual-level informed consent for HIV testing, and individual post-counselling. Couples counselling and testing is encouraged in many settings.

A closer examination of four of the most common scenarios in the provision of HIV testing provides some insights into the diverse issues to be considered in planning and implementing testing and counselling services.

1. In a free-standing VCT service, the client generally initiates the demand for HIV testing. Informed consent is still critical, however, as clients may not be as well informed as they appear to be or may have been coerced to seek HIV testing (for example, by a partner or an employer). In the case of couple counselling and testing, informed consent should be obtained separately from each partner. Also, counselling services should emphasize HIV prevention goals, as the potential for behaviour change is generally high.

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3. In clinical care settings, the focus is on making a diagnosis and deciding about a treatment. In the presence of suspected HIV infection, current practices and appropriate standards and procedures to meet these needs in resource-constrained settings are not well described, and few protocols exist. The attending health care worker usually initiates the request for HIV testing and counselling, and informed consent procedures are often cutaneous or ignored. A possible tension between establishing a diagnosis and treatment plan, on the one hand, and attending to the patient’s psychosocial needs, on the other hand, may occur in such cases, the health care worker may not be well equipped to address these diverse demands. Both medical and psychosocial considerations should be included in a comprehensive care package.

4. In sexual and reproductive health care settings, HIV testing and counselling are still rarely provided, except in clinics for the treatment of sexually transmitted infections. HIV considerations play a critical role in family planning and reproductive health counselling services. The counselling process in this setting needs to address sexual and reproductive health care needs, as well as HIV prevention and care issues.

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Purpose of the meeting

WHO is exploring innovative, ethical and practical ways to increase access to knowledge of serostatus in resource-constrained settings. To this end, WHO conducted a small consultaive meeting in December 2001, to discuss approaches to service delivery for different purposes and settings. The participants included experts in the following key areas: ethics, human rights, law, health systems and voluntary counselling and testing services.

Issues discussed

The “VCT model” of service delivery

Voluntary counselling and testing, or VCT, was developed in the mid-1980s as the standard of care in settings where individuals sought to know their infection status. Its core components have been codified in guidelines developed by various health agencies, including WHO. The voluntary nature of HIV testing ensures that the process is free from coercion. Counselling should be client-centred and focused on ensuring informed consent to testing, providing HIV-related information, assisting clients in developing a risk reduction plan, and discussing strategies for disclosure and social support. The goals of testing are to ascertain the client’s serostatus and to contribute to promoting motivation, increasing knowledge to support risk reduction, and planning for the future. Counselling has been closely linked to testing, to ensure that informed consent is achieved and to maximize the benefits of the intervention. The sequence followed is pre-test counselling, HIV testing and post-test counselling.

The standard VCT model places a strong emphasis on its contribution to meeting HIV-prevention goals. Studies have shown that VCT can be a cost-effective intervention in developing country settings. Nonetheless, the adoption of VCT has generally been slow in most developing countries, with a few exceptions – notably Uganda and Thailand, where VCT has been successfully introduced as a key element of HIV prevention and care programmes.

However, since the inception of VCT as a model of service delivery, the benefits of knowing one’s HIV status have evolved, primarily through increased access to antiretroviral drugs for the treatment of HIV disease and for the prevention of mother-to-child transmission of HIV. The need for voluntary HIV testing is growing in a number of settings. There is often the presumption that VCT is a package that must always be provided in a uniform way (whether the HIV test is sought in free-standing centres, in antenatal care or in clinical care settings). In practice, however, diverse models of service delivery have emerged in response to various needs. For example, in many pregnant women clinics in Thailand and South Africa, VCT is considered to be less relevant, due to the availability of antiretroviral drugs and for use in preventing mother-to-child transmission.

In this context, informed consent is an essential component, based on adequate understanding, given by a patient or client to a health-care provider for undertaking an HIV test. The health-care provider and client relationship is unequal in terms of knowledge and power. It is important therefore to provide information that the client regards as relevant, such as client-specific information about the risks and benefits that they face and the options that they have. Only then can an informed choice be made. Informed consent for an HIV test is always required as HIV infection is a life-threatening condition which may result in harmful consequences for the client.