

Models of service delivery

A range of models of 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 prior to HIV testing, and individual post-test counselling. Couple 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.
2. *In an antenatal care clinic*, HIV testing can support interventions that address maternal health and prevention of HIV transmission to infants and young children. Clients, however, may not have considered the risk of HIV, may not be ready to undergo testing and may have misgivings about confidentiality procedures. Low uptake of HIV testing has been observed in many antenatal care settings that use an opt-in strategy for HIV testing, in which clients are offered counselling and then asked whether they wish to be tested. To increase uptake, opt-out strategies, as used in Thailand, are an alternative approach to HIV testing; using this strategy, all clients are offered HIV testing, though they may decline (and thus opt out) during the informed consent procedure. In some programmes, post-test counselling of HIV-negative women is not carried out, in order to save time and resources, though this may result in a missed opportunity for prevention counselling.
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 curtailed 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 or treatment plan.
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.

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 desire for information about their HIV infection status before entering a new sexual partnership) in certain settings (such as free-standing VCT sites or sexual health clinics). The various aspects of the VCT model are important components of any HIV-testing process. The configuration and emphasis of these components, however, may vary in different circumstances. The participants at the meeting called for innovative *additional* models for the provision 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 (such as HIV prevention in vulnerable groups, prevention of HIV transmission to infants, and access to care, treatment and support). For ethical reasons, however, all models should ensure that informed consent is obtained before proceeding with HIV testing and that high-quality counselling is offered to all people who test positive.

WHO will soon be conducting a wider consultation to define in more detail strategies for increasing access to knowledge of HIV status, to specify the essential requirements of the informed consent procedure, and to describe models of service delivery that meet current priorities.

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WORLD HEALTH ORGANIZATION

Increasing access to knowledge of HIV status: conclusions of a WHO consultation, 3-4 December 2001



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 or transmitting 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 provision 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.

Knowledge of HIV status: a key entry point to prevention and care

People need to have access to voluntary HIV testing and counselling so they can find out about their HIV status and thus make the most of interventions for prevention and care. HIV testing and counselling provide essential knowledge and support: they enable uninfected people to remain so 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 long-term treatment of people living with HIV. It is also the main entry point for interventions that prevent HIV infections in infants and young children. HIV-infected women who know their serostatus are able to make informed choices about their reproductive lives and, if pregnant, to access specific interventions, such as antiretroviral 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.

HIV testing and counselling

HIV testing and counselling enable people to learn whether they are infected, understand the implications of their serostatus, and make more informed choices for the future. HIV testing is the process by which blood or body fluids are tested for the presence of antibodies or antigens associated with HIV infection. HIV testing of individuals should be undertaken only with their informed consent and should be entirely voluntary. In this context, HIV counselling is a confidential process that enables individuals to examine their knowledge and behaviour in relation to their personal risk of acquiring or transmitting HIV infection, that helps them decide whether or not they should be tested and that provides them support when they receive their test result.

Benefits of increasing access to knowledge of HIV status

Wider access to knowledge of HIV status would

enable individuals to:

- initiate or maintain behaviours to prevent acquisition or further transmission of the virus
- gain early access to HIV-specific care, treatment and support
- access interventions to prevent transmission from mothers to their infants
- better cope with HIV infection
- plan for the future

enable communities to:

- reduce denial, stigma and discrimination that surround HIV/AIDS
- mobilize support for appropriate responses

At this time, the availability of testing and counselling services is very uneven, and only a small proportion of people living in developing countries know their serostatus. In most resource-constrained settings with high HIV prevalence, investment in testing and counselling services is inadequate, medical and laboratory infrastructures remain insufficient, and trained staff are scarce. Furthermore, in areas where testing and counselling services are available, the uptake of these services has remained low, because of widespread denial, stigma and discrimination. Until recently, many people believed there were few benefits to knowing their serostatus. This is now changing, due to improved access to antiretroviral drugs for treatment and for use in preventing mother-to-child transmission of HIV. Demand for HIV testing and counselling services is now increasing in many places. The provision of these services will need to be scaled up dramatically in the future in order to reach the goals for prevention and care that have been set at the 2001 United Nations General Assembly Special Session on HIV/AIDS.

Knowledge of HIV status

A study conducted in Zambia in 1995 - 1996 found that only 7% of the people surveyed, mainly living in urban areas, reported that they had previously undergone HIV testing¹. A more recent study estimated that less than 1% of the sexually active urban population in Africa had been tested². This proportion was even lower in rural populations. Furthermore, this study estimated that only 0.5% of pregnant women attending urban health facilities had been counselled, tested and had received their test results, and that this proportion was even lower in rural health facilities.

1 FYLKESNES, K. ET AL. HIV counselling and testing: overemphasizing high acceptance rates a threat to confidentiality and the right not to know. *AIDS*, 13: 2469–2474 (1999).

2 KUMARNAYAKE, L. & WATTS, C. Resource allocation and priority setting of HIV/AIDS interventions: addressing the generalised epidemic in sub-Saharan Africa. *Journal of international development*, 13: 451–466 (2001).

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 convened a small consultative 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 for individuals seeking 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 included 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 antenatal care clinics in Thailand, many pregnant women are now undergoing HIV testing with an intervention model that comprises provision of information in groups, individual-level discussion and informed consent prior to HIV testing and individual post-test counselling, with enhanced counselling for HIV-infected women.

Major challenges to the large-scale implementation of VCT include the limited availability of staff who are familiar with client-centred counselling – and who are trained in pre- and post-test techniques – and the heavy work demands placed on staff in busy health-care settings. To respond to these challenges, the VCT model may need to be tailored in some settings to make it more suitable as an entry point to new life-saving interventions, as well as make it more feasible and affordable when scaled up.

Informed consent for HIV testing

In this context, informed consent is an autonomous authorization, based on adequate understanding, given by a patient or client to a health-care provider to undergo an HIV test. The health-care provider and client relationship is unequal in terms of knowledge and experience. 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.

Informed consent

While knowledge of serostatus may lead to many benefits, it may also lead to problems. The client and the provider need to be aware of (and prepared for) the potential for negative social and psychological outcomes of HIV testing. In particular, the harmful consequences of a positive test result may be far reaching. Emotional stress and psychological disturbances may be observed. Stigma and discrimination in many forms are commonly encountered, limiting access to key services – such as health care, employment and housing – for those who live with HIV. Violence, especially against women, can also follow disclosure of HIV status. For these reasons, the meeting participants reaffirmed that informed consent is required before an HIV test is performed and that mandatory testing is not acceptable. Strong links to support services that can help mitigate the impact of any such negative outcomes should also be available.

The key elements of the informed consent process, however, may not be quite the same in all settings. They have received greatest attention in situations where clients voluntarily seek an HIV test, as in many free-standing VCT centres. Other challenges arise in situations where, at the outset, clients do not express their intention to learn about their serostatus – for example, when they seek medical attention for severe illness, or when they attend antenatal care services.

On the other hand, it may also be that the demanding procedures inherent in the VCT approach may now inadvertently draw a high level of attention to HIV in a way that impedes the “normality” of seeking and accepting HIV testing. Current approaches to voluntary HIV testing may ironically perpetuate the stigma associated with HIV and HIV testing, and limit its availability. This in part may be due to an overemphasis on secrecy, rather than an appropriate use of confidentiality. Nonetheless the special status accorded to HIV testing, as compared with other medical tests, may now be less relevant. Under the current guidelines, there is limited flexibility for adapting informed consent procedures in ways that could better meet client needs and reduce the time and resources required. In some settings, it may be appropriate to offer HIV testing with an informed consent procedure that provides key information and checks on knowledge about risks and benefits, but that does not mandate in-depth pre-test counselling. Post-test counselling, however, should always be offered, and is especially important in the case of a positive HIV test result.