

妊婦に関する勧告

今回のガイドラインは現行の妊娠初期における妊婦全員に対する HIV スクリーニングの再確認であるが、スクリーニング過程をできるかぎり単純にし、妊娠中に HIV 感染の有無について知る機会を最大限に広げ、HIV 検査を辞退する機会を確保し、医療および予防において最良の結果を得るために患者医師関係を確実にするためのものである。すべての女性は成人および若年者に対する勧告に基づいた HIV スクリーニング検査の対象となる。HIV スクリーニング検査はすべての妊娠前医療に含まれるべきであり、これによりすべての女性が妊娠に先立ち自分の HIV 感染の有無を知る機会を最大限に広げることが可能となる。さらに、妊娠早期にスクリーニング検査を受けることによって、本人ならびに胎児が時期を逃さず適切な医療を受けることができるようになる。(例: 抗 HIV 治療薬の服用、予定帝王切開、授乳の回避) これらの勧告は妊婦および新生児にかかわる医師および健康政策立案者に対して発表されたものである。

<妊婦とその新生児に対する HIV 検査>

全員に対する Opt-Out スクリーニング

- ・ 米国内のすべての妊婦は HIV スクリーニング検査を受けるべきである
- ・ スクリーニングはすべての妊婦への HIV 検査が推奨されていることを本人に説明し、一般的な妊娠に関する検査項目の中に HIV 検査が含まれており、本人が辞退しない限り実施されることを説明した後に行われなければならない。(Opt-Out スクリーニング)
- ・ HIV 検査は自発的に、また強制されることなく行われなければならない。本人が知らないうちに検査を行ってはならない。
- ・ 妊婦は口頭または文書によって HIV 感染症に関する説明、母子感染を減少させるための方法、検査結果の陽性・陰性の意味に関して説明を受け、質問の機会および検査の辞退の機会も与えられなければならない。
- ・ HIV 検査に当たっては、その他の一般的な妊娠期の検査に用いられる同意書以外の様式を要求されるべきでない。
- ・ 本人が HIV 検査を辞退した場合にはその旨を医療記録に記載する。

検査辞退者への対応

- ・ 医療従事者は HIV 検査辞退の理由について本人と話し合わなければならない。(例: 危険の認知の欠如、疾患への恐怖、パートナーからの暴力・偏見や差別に関する懸念)
- ・ 以前の検査で陰性だったことを理由に検査を辞退する場合には、妊娠のたびに再検査を行う重要性について説明する。
- ・ 物理的な理由による困難(予定が合わないなど)については解決されなければならない。
- ・ 当初 HIV 検査を辞退した女性も本人の懸念について話し合った後に検査を受ける場合がある。HIV 検査を辞退し続ける場合には本人の意思を尊重し、その旨を医療記録に記載する。

検査のタイミング

- ・ 本人に告知し最良の時期に治療を行うために、医療従事者は各妊娠のできるだけ初期に HIV 検査を行うべきである。当初 HIV 検査を辞退した女性に対しても再度検査を勧める。
- ・ 妊娠後期、理想的には 36 週未満に、たとえ有病率が低い地域であっても、再度 HIV 検査を実施することが費用対効果が高く、すべての妊婦に考慮されるべきである。妊娠後期の 2 度目の HIV 検査は以下の項目が 1 つ以上合致する場合には推奨される。
 - 15 歳から 45 歳の HIV および AIDS の発生率の高い地域で医療行為を受ける女性。2004 年には以下の地域が該当した。アラバマ、コネチカット、デラウェア、コロンビア特別区、フロリダ、ジョージア、イリノイ、ルイジアナ、メリーランド、マサチューセッツ、ミシシッピ、ネバダ、ニュージャー

ジー、ニューヨーク、ノースカロライナ、ペンシルベニア、プエルトリコ、ロードアイランド、サウスカロライナ、テネシー、テキサス、バージニア

- ▶ 妊婦の HIV 感染数が 1000 人当たり 1 人以上である医療機関を受診している女性。
- ▶ HIV 感染の危険が高いことがわかっている女性。(静脈麻薬濫用者とその性的接触のパートナー、金銭または麻薬と引き換えに性的接触を行う者、HIV 感染者と性的接触のある者、今回の妊娠の間に新規のもしくは 1 人より多い相手と性的接触のあった者)
- ▶ HIV 急性感染症状を呈する者。急性レトロウイルス感染症候群が疑われる場合には、急性 HIV 感染の診断のために、HIV 抗体検査だけでなく血漿 RNA 検査を行う。

陣痛時の迅速検査

- ・ 陣痛時において過去の HIV 検査の結果が記録にない女性に関しては、本人が辞退しない限り陣痛期間中に迅速検査を行う。(Opt-Out スクリーニング)
- ・ 迅速検査を辞退する場合にはその原因について明らかにする(検査辞退者への対応の項参照)
- ・ 迅速検査で「反応あり」の場合には確認検査の結果を待たずに適切な抗 HIV 治療薬の即時開始を患者に推奨する。

分娩後・新生児検査

- ・ HIV 抗体の陽性・陰性の有無が分娩時に不明の際には、本人が辞退しない限り分娩後直ちに迅速スクリーニング検査を行う。(Opt-Out スクリーニング)
- ・ 母親の HIV 抗体陽性・陰性の有無が不明の場合には、HIV に曝露した新生児に抗 HIV 治療薬の予防投与を勧めるために新生児の迅速検査を直ちに行うことが推奨される。児の HIV 抗体が陽性の場合には母親が感染していることを示すことを母親に通知しなければならない。
- ・ HIV に曝露されているかどうか不明の新生児で里親に養育される場合で、生物学的母親が HIV 検査を受けていない場合には児の HIV の迅速検査が推奨されていることを法的に認められた人物に対して告げ、検査についての同意を得なければならない。
- ・ 新生児の予防的抗 HIV 治療は生後 12 時間以内に実施される場合に最も効果が高いことが知られている。

確認検査

- ・ HIV 感染に関する検査結果が明確でない場合には常に、妊娠に関する選択、抗 HIV 治療、帝王切開またはその他の介入に関する最終決定を下す前に、明確にしておくべきである。
- ・ 分娩前に確認検査の結果が得られない場合には、HIV スクリーニング検査が陰性でないすべての妊婦に対して、児への感染リスクを下げるために直ちに適切な抗 HIV 薬の予防投与が推奨される。

<これまでの妊婦に対する勧告との差異>

これまでの勧告について以下の点では変化はない:

- ・ HIV 検査はすべての妊婦に対して、本人に検査を実施する旨を伝えた後に妊娠初期に実施すべきである。
- ・ HIV 検査は感染リスクの高い妊婦に対しては妊娠後期に再度実施する。
- ・ 医療従事者は本人が検査を辞退する場合、その原因について明らかにしなければならない。
- ・ 妊婦は、通常の妊娠に関する医療の一部として HIV とその感染経路に関して適切な健康教育を受けなければならない。
- ・ HIV 検査結果が陽性の女性に対しては、医療、予防相談、援助事業の提供が最も重要である。

これまでの勧告と異なる点:

- HIV スクリーニング検査は通常の妊娠に関する医療で行われる検査に含め、すべての妊婦に行われなければならない。
- HIV/AIDS の発病率が高い州に居住するすべての妊婦と、年間の HIV 陽性率が 1000 人に対して 1 人以上の医療機関に通院するすべての妊婦は、妊娠後期に再度 HIV 検査を受けることが推奨される。
- 妊娠期間中の HIV 検査結果が不明の場合には、分娩時に全例迅速 HIV 検査を実施すべきである。患者には、本人が辞退しない限りすべての妊婦に HIV 検査が推奨されていることを告げ (Opt-Out スクリーニング) なければならない。迅速 HIV 検査で「反応あり」の場合には、確認検査の結果を待たずに適切な抗 HIV 予防投与の速やかな実施が推奨される。

HIV スクリーニングに関する追記事項

<検査結果>

・結果通知に関する問題

医療機関における HIV スクリーニング検査の目的は HIV に感染していることを知り、医療および予防に関するサービスを受けることができる人数を最大限にすることである。検査結果を本人に通知するための確実な方法を確立させる必要がある。陰性の結果に関しては医療従事者との直接の面談なしに告げることも可能である。HIV 感染のリスクの高い者に対しては定期的な再検査の必要性について説明し、予防相談の実施もしくは相談機関の紹介を行う。陽性結果に関しては医師、看護師、カウンセラー、その他技術を持った職員によって秘密厳守の下に個人的に通知されなければならない。英語理解力が十分でない場合には、偏見や差別を助長する危険があるため、家族や友人を陽性結果を伝えるための通訳としてはならない。本人に陽性結果を確実に伝え、治療・相談・予防へつなげるために積極的に話を進めることが重要である。もし検査を実施した医療機関に必要な専門家がいない場合には、別の医療機関、地域の健康局もしくは地域の団体などから必要なサービスを受けることができるよう手配しなければならない。医療従事者は the Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA: 患者情報保護法) が本人の許諾なく HIV 検査結果を含めた健康情報を明らかにすることを禁じていることについて理解していなければならない。

・ HIV 迅速検査

従来の HIV 検査結果は判定するまでに時間を要し、救急部、救急外来や性行為感染症外来など、一度限りの受診となり治療の継続性が望めないような場合には、結果を本人に通知するに当たり手間がかかり困難を伴う。迅速検査の実施は検査結果を知りそびれる人の数を減らし、HIV に感染していることを通知するために費やされる費用を減らすことができる。迅速検査で陽性となった結果は暫定的のものであり、HIV に感染していると診断する前に必ず確認検査を受けなければならない。

・ HIV ワクチン治験参加者

HIV ワクチン治験参加者はワクチンによって作られた抗体を有していることがあり、この場合 HIV 抗体検査が陽性となる可能性がある。ワクチン治験に参加していることが確認された HIV 抗体検査陽性者については、HIV に感染していない可能性があるため、当該者の HIV 感染状態について治験施設と連絡をとり、確認検査を受けるよう説明する。

・ HIV 検査結果の記録

HIV 検査の陽性もしくは陰性の結果は、当該患者の医療に携わる医療従事者すべてが読むことのできる、守秘義務を伴う患者の医療記録に記載されなければならない。妊婦の HIV 検査の結果は新生児の医療記録にも記載する。母親の HIV 検査が陽性の場合には、HIV にさらされた児の出産が予定されていることや可能性のある合併症について小児科医へ連絡する。もし、児の HIV 感染が母親に先んじて明らかになった場合には医療従事者は母親の健康に関して本人と話し合い、治療を受けるための援助を行うことが必要である。

<HIV 感染者への医療>

HIV 感染が判明した者に対しては、当人の健康状態と免疫機能に関して評価を行い、抗 HIV 治療やその他の治療の必要性について判断する。HIV 感染者には直ちに USPHS の HIV 治療指針に従って診療・ケアを提供するか、しかるべき医療機関に紹介すべきである。HIV に曝露した新生児には、出生後可及的速やかに抗 HIV 治療薬の予防投与を行わなければならない。さらに pneumocystis 肺炎の予防のために生後 4-6 週に trimethoprim-sulfamethoxazole 投与を開始する。児はその後 HIV 感染の有無につき臨床観察と検査の実施を必要とする。

＜パートナーの相談と紹介＞

HIV 感染が判明した場合、医療従事者は患者に自分の HIV 感染について、配偶者や現在および過去の性的接触のパートナーに告げることを強く勧め、彼らが HIV 検査を受けることを推奨しなければならない。健康局は患者の個人情報を開示することなく、パートナーへの通知・相談・HIV 検査の実施に関して援助することが可能である。医療従事者は HIV 感染が判明した者に対して、彼らのパートナーへの通知に関して担当官と自発的な面談をもつために健康局へ連絡するよう説明すべきである。

＜若年者に対する特別な配慮＞

通常若年者の医療提供に関しては保護者の関与を求めることが望まれるが、HIV 検査に関する若年者の同意についてはそれを必要としない。しかしながら、HIV に関する同意と守秘義務に関しては州ごとに法律が異なる。公衆衛生に関する法律では未成年者の性行為感染症に関して保護者への通知や同意を必要とせずに検査や治療を行うこと許可しているが、州によっては保護者の同意なしに検査や治療を行えない場合もある。医療従事者は若年者のプライバシー秘匿の意思を尊重しなければならない。HIV 検査は性的接触を行っている若年者すべてに対して話し合い、勧められなければならない。HIV 感染・HIV 検査・感染経路などに関する情報は、プライマリケアの場で若年者に提供される基本的な内容とみなされるべきである。

＜HIV 陰性者に対する予防＞

・ リスクの評価

HIV 検査は当人の行動のリスクに応じて行われるべきものではない。リスクに応じてではなく、HIV とその他の性行為感染症のリスク評価と予防情報の提供は全ての性的にアクティブな者に対し常に通常のプライマリケアに含まれるべきであり、そうすることは HIV 検査の障壁とはならない。リスクに関する情報を求めない場合でも、一般の健康に関する検査として HIV 検査を行うことを患者に知らせることは、当人がリスク行為について知識を得る機会となり、HIV 感染とその予防について話し合う機会を提供することとなる。MSM、複数の性的接触パートナーを有するもの、最近性感染症を罹患した者、金銭や麻薬と引き換えに性的接触を行う者、麻薬濫用者など感染リスクについて明らかになった者や、行動変容のための援助を必要とする者に対しては HIV 感染リスク軽減の支援業務の提供もしくはその事業への紹介を行う。(例: 薬物治療、性行為感染症の治療、予防相談など)

・ 予防相談

医療機関においては、予防相談を HIV 検査に関連付ける必要はない。しかしながら、HIV 検査を受けの際に HIV および自身の感染リスクについて考える者も少なくないので、検査実施時は、HIV 感染リスクの軽減が可能となる行動変容の援助や予防相談の実施、もしくは予防相談の予定を組むのに理想的な機会となる可能性がある。HIV 感染のリスクの高い患者が受診する医療機関および HIV 感染のリスクの高い行動についての情報が継続的に提供される機関(例: 性行為感染症外来)では、予防相談の実施、もしくは予防相談を実施する機関への紹介を行うべきである。

＜HIV/AIDS サーベイランス＞

・ HIV 感染者のリスクファクターを確定する

CDC は医療提供者に対して、すべての HIV 感染のリスクファクターについて明らかにし記録を残すことを推奨する。医療提供者は州もしくは地域の健康局の HIV/AIDS 調査専門官から、リスクファクター確定のために作成された資料を得ることができ、また調査のために定められたリスクファクターについてのガイダンスを受けることができる。このリスクファクターに関する情報は、とりわけ予防と医療に関し医療機関・地域・州・国レベルでの公衆衛生政策決定の見地から重要である。

・ HIV/AIDS 症例報告

すべての州は AIDS 症例および HIV 感染が判明した個人に関して、医療従事者による州もしくは地域の

健康局への報告を義務付けている。報告書式は各州および地域の健康局で入手できる。

・ HIV に曝露した小児の報告

CDC と全米州および地域疫学専門家審議会は米国のすべての州と地域において分娩時の HIV への曝露に関する調査を行っており、報告を受けた後に医療従事者に対して当該新生児の HIV 感染の有無についての追跡調査を行っている。その内容には母親の HIV 検査実施日時、妊娠期の医療受診、母親および新生児の抗 HIV 治療薬服用の有無、分娩様式、授乳状況が含まれ、小児 HIV/AIDS 症例報告書式を用いる。

<継続観察と評価について>

スクリーニング検査を推奨する基準は米国医療機関における未診断の HIV 感染症有病率の推測値に根拠を求めて定められるが、この推測値に関する近年の正確なデータは存在しない。再検査の最良の頻度は未だ確立されていない。HIV 検査に関する費用対効果のパラメーターは、現存するプログラムモデルに応じて定められており、これには相談業務に関する費用は含まれていたが、スクリーニング検査によってもたらされる二次感染の回避による効果は含まれていなかった。成人および若年者のスクリーニング検査あるいは妊婦の再検査の実施基準を改め、そしてその継続的効果を明らかにするために、スクリーニング検査事業は新規診断の効率、モニター費用を追跡し、HIV 感染が判明した患者が医療機関に紹介され受診を継続しているかについて継続観察を行わなければならない。検査結果に関する情報システムにわずかに手を加えることによって、臨床医に対し、HIV 検査を受けた彼らの患者の HIV 有病率を確定する実効性の高い方法を提供することが可能となる。

<医療機関以外の場所で行われる一次予防と HIV 検査について>

今回の改訂版の勧告は医療機関における HIV スクリーニング実施を増やすために作成されたものである。しかしながら、最も感染のリスクの高い集団は通常の医療提供システムを最も受けにくい人々をしばしば含んでいる。一次予防活動を継続させ、予防事業が有効と思われる HIV 感染のリスクの高い個人を明らかにし、医療機関以外で HIV 感染リスクの高い個人に対して HIV 検査を実施することの必要性はこれまでと同様に高いままである。新しいアプローチ(例:社会的もしくは性的接触の場、または薬物濫用の場でのネットワークから HIV 感染者および HIV 感染のリスクの高い非感染者を発見し、相談、検査、医療機関への紹介につなげる)はこれまで HIV 感染を知らなかった個人にその感染を明らかにする効果をあげている。

<規則および法的問題について>

今回の公衆衛生的勧告は最良の医療の実践に基づき説明と同意の倫理的原則に十分に対応するものである。HIV/AIDS に関する法律はすべての州およびコロンビア特別区で立法化されており、説明と同意および検査前の相談についての要請は州によって異なる。州や地域、機関によっては辞退がない限り検査を実施する Opt-Out 検査に障害となる法律や規則を有しており、相談、同意文書、確認検査や HIV 結果伝達において、今回の勧告と矛盾する場合がある。このような場合には、管轄者は現行の枠内で勧告を最も良好に実効させる方法を考慮し、この勧告との矛盾を解消するための方策を考慮すべきである。

<その他のガイドライン>

今回の勧告に含まれなかった問題に関しては USPHS のガイドラインに含まれている(表 1)。HIV 診療に関する概念はすぐに変化するので USPHS は勧告を定期的に改訂している。現行の改訂版は国立健康研究所(NIH) <http://AIDSinfo.nih.gov> にて入手可能である。その他のガイドラインには CDC、U.S. Department of Health and Human Services、Office for Civil Rights などから発行されたものなどがある(表 2)。

表 1. HIV 治療に関する最近の米国公衆衛生事業ガイドライン

- HIV に感染している成人および若年者に対する抗 HIV 治療薬使用に関するガイドライン
- HIV に感染している小児に対する抗 HIV 治療薬使用に関するガイドライン
- HIV に感染している妊婦に対し母体の健康および HIV 母子感染予防のための抗 HIV 治療薬に関する推奨

表 2. その他のガイドライン及び勧告

- CDC: 職業的 HIV 曝露および曝露後予防に関する米国公衆衛生事業ガイドライン改訂版. MMWR 2005; 54 (No.RR-9):1-17
- CDC: 米国における性的接触・経静脈麻薬その他非職業的 HIV 曝露後予防ガイドライン: 米国保健社会福祉省 (DHHS) 勧告. MMWR 2005; 54 (No.RR-2):1-20
- CDC: HIV 予防の HIV 感染者治療への組み込み: CDC, 保健研究局 (HRSA), 米国感染症学会 HIV 治療部会推奨. MMWR 2003; 52 (No.RR-12):1-24
- 米国保健社会福祉省 (DHHS), 市民権局: 個人健康情報保護に関する米国基準.
<http://www.hhs.gov/ocr/hipaa>
- 米国保健社会福祉省 (DHHS), 市民権局: 英語が十分に熟練していない者への出身地に基づく差別禁止 (Title VI prohibition) に関する連邦政府経済援助受益者へのガイドライン.
<http://www.hhs.gov/ocr/lep/revisedlep.html>

Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings

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Summary

These recommendations for human immunodeficiency virus (HIV) testing are intended for all health-care providers in the public and private sectors, including those working in hospital emergency departments, urgent care clinics, inpatient services, substance abuse treatment clinics, public health clinics, community clinics, correctional health-care facilities, and primary care settings. The recommendations address HIV testing in health-care settings only. They do not modify existing guidelines concerning HIV counseling, testing, and referral for persons at high risk for HIV who seek or receive HIV testing in nonclinical settings (e.g., community-based organizations, outreach settings, or mobile vans). The objectives of these recommendations are to increase HIV screening of patients, including pregnant women, in health-care settings; foster earlier detection of HIV infection; identify and counsel persons with unrecognized HIV infection and link them to clinical and prevention services; and further reduce perinatal transmission of HIV in the United States. These revised recommendations update previous recommendations for HIV testing in health-care settings and for screening of pregnant women (CDC. Recommendations for HIV testing services for inpatients and outpatients in acute-care hospital settings. MMWR 1993;42[No. RR-2]:1-10; CDC. Revised guidelines for HIV counseling, testing, and referral. MMWR 2001;50[No. RR-19]:1-62; and CDC. Revised recommendations for HIV screening of pregnant women. MMWR 2001;50[No. RR-19]:63-85).

Major revisions from previously published guidelines are as follows:

For patients in all health-care settings

- HIV screening is recommended for patients in all health-care settings after the patient is notified that testing will be performed unless the patient declines (opt-out screening).
- Persons at high risk for HIV infection should be screened for HIV at least annually.
- Separate written consent for HIV testing should not be required; general consent for medical care should be considered sufficient to encompass consent for HIV testing.
- Prevention counseling should not be required with HIV diagnostic testing or as part of HIV screening programs in health-care settings.

For pregnant women

- HIV screening should be included in the routine panel of prenatal screening tests for all pregnant women.
- HIV screening is recommended after the patient is notified that testing will be performed unless the patient declines (opt-out screening).

The material in this report originated in the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (proposed), Kevin A. Fenton, MD, PhD, Director, and the Division of HIV/AIDS Prevention, Timothy D. Mastro, MD, (Acting) Director.

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- Separate written consent for HIV testing should not be required; general consent for medical care should be considered sufficient to encompass consent for HIV testing.
- Repeat screening in the third trimester is recommended in certain jurisdictions with elevated rates of HIV infection among pregnant women.

Introduction

Human immunodeficiency virus (HIV) infection and acquired immunodeficiency syndrome (AIDS) remain leading causes of illness and death in the United States. As of December 2004, an estimated 944,306 persons had received a diagnosis of AIDS, and of these, 529,113 (56%) had died (1). The annual number of AIDS cases and deaths declined substantially after 1994 but stabilized during 1999–2004 (1). However, since 1994, the annual number of cases among blacks, members of other racial/ethnic minority populations, and persons exposed through heterosexual contact has increased. The number of children reported with AIDS attributed to perinatal HIV transmission peaked at 945 in 1992 and declined 95% to 48 in 2004 (1), primarily because of the identification of HIV-infected pregnant women and the effectiveness of antiretroviral prophylaxis in reducing mother-to-child transmission of HIV (2).

By 2002, an estimated 38%–44% of all adults in the United States had been tested for HIV; 16–22 million persons aged 18–64 years are tested annually for HIV (3). However, at the end of 2003, of the approximately 1.0–1.2 million persons estimated to be living with HIV in the United States, an estimated one quarter (252,000–312,000 persons) were unaware of their infection and therefore unable to benefit from clinical care to reduce morbidity and mortality (4). A number of these persons are likely to have transmitted HIV unknowingly (5).

Treatment has improved survival rates dramatically, especially since the introduction of highly active antiretroviral therapy (HAART) in 1995 (6). However, progress in effecting earlier diagnosis has been insufficient. During 1990–1992, the proportion of persons who first tested positive for HIV <1 year before receiving a diagnosis of AIDS was 51% (7); during 1993–2004, this proportion declined only modestly, to 39% in 2004 (1). Persons tested late in the course of their infection were more likely to be black or Hispanic and to have been exposed through heterosexual contact; 87% received their first positive HIV test result at an acute or referral medical care setting, and 65% were tested for HIV antibody because of illness (8).

These recommendations update previous recommendations for HIV testing in health-care settings (9,10) and for screening of pregnant women (11). The objectives of these recommendations are to increase HIV screening of patients, including pregnant women, in health-care settings; foster earlier detection of HIV infection; identify and counsel persons with unrecognized HIV infection and link them to clinical and prevention services; and further reduce perinatal transmission of HIV in the United States.

Single copies of this report are available free of charge from CDC's National Prevention Information Network, telephone 800-458-5231 (Mondays–Fridays, 9:00 a.m.–8:00 p.m. ET).

Background

Definitions

Diagnostic testing. Performing an HIV test for persons with clinical signs or symptoms consistent with HIV infection.

Screening. Performing an HIV test for all persons in a defined population (12).

Targeted testing. Performing an HIV test for subpopulations of persons at higher risk, typically defined on the basis of behavior, clinical, or demographic characteristics (9).

Informed consent. A process of communication between patient and provider through which an informed patient can choose whether to undergo HIV testing or decline to do so. Elements of informed consent typically include providing oral or written information regarding HIV, the risks and benefits of testing, the implications of HIV test results, how test results will be communicated, and the opportunity to ask questions.

Opt-out screening. Performing HIV screening after notifying the patient that 1) the test will be performed and 2) the patient may elect to decline or defer testing. Assent is inferred unless the patient declines testing.

HIV-prevention counseling. An interactive process of assessing risk, recognizing specific behaviors that increase the risk for acquiring or transmitting HIV, and developing a plan to take specific steps to reduce risks (13).

Evolution of HIV Testing Recommendations in Health-Care Settings and for Pregnant Women

In 1985, when HIV testing first became available, the main goal of such testing was to protect the blood supply. Alternative test sites were established to deter persons from using blood bank testing to learn their HIV status. At that time, professional opinion was divided regarding the value of HIV testing and whether HIV testing should be encouraged because no consensus existed regarding whether a positive test predicted transmission to sex partners or from mother to infant (14). No effective treatment existed, and counseling was designed in part to ensure that persons tested were aware that the meaning of positive test results was uncertain.

During the next 2 years, the implications of positive HIV serology became evident, and in 1987, the United States Public Health Service (USPHS) issued guidelines making HIV counseling and testing a priority as a prevention strategy for persons most likely to be infected or who practiced high-risk behaviors and recommended routine testing of all persons seeking treatment for STDs, regardless of health-care setting (15). "Routine" was defined as a policy to provide these services to all clients after informing them that testing would be conducted (15).

In 1993, CDC recommendations for voluntary HIV counseling and testing were extended to include hospitalized patients and persons obtaining health care as outpatients in acute-care hospital settings, including emergency departments (EDs) (10). Hospitals with HIV seroprevalence rates of >1% or AIDS diagnosis rates of >1 per 1,000 discharges were encouraged to adopt a policy of offering voluntary HIV counseling and testing routinely to all patients aged 15–54 years. Health-care providers in acute-care settings were encouraged to structure counseling and testing procedures to facilitate confidential, voluntary participation and to include basic information regarding the medical implications of the test, the option to receive more information, and documentation of informed consent (10). In 1994, guidelines for counseling and testing persons with high-risk behaviors specified prevention counseling to develop specific prevention goals and strategies for each person (client-centered counseling) (16). In 1995, after perinatal transmission of HIV was demonstrated to be substantially reduced by administration of zidovudine to HIV-infected pregnant women and their newborns, USPHS recommended that all pregnant women be counseled and encouraged to undergo voluntary testing for HIV (17,18).

In 2001, CDC modified the recommendations for pregnant women to emphasize HIV screening as a routine part of prenatal care, simplification of the testing process so pretest counseling would not pose a barrier, and flexibility of the consent process to allow multiple types of informed consent (11). In addition, the 2001 recommendations for HIV testing in health-care settings were extended to include multiple additional clinical venues in both private and public health-care sectors, encouraging providers to make HIV counseling and testing more accessible and acknowledging their need for flexibility (9). CDC recommended that HIV testing be offered routinely to all patients in high HIV-prevalence health-care settings. In low prevalence settings, in which the majority of clients are at minimal risk, targeted HIV testing on the basis of risk screening was considered more feasible for identifying limited numbers of HIV-infected persons (9).

In 2003, CDC introduced the initiative Advancing HIV Prevention: New Strategies for a Changing Epidemic (19). Two key strategies of this initiative are 1) to make HIV testing a routine part of medical care on the same voluntary basis as other diagnostic and screening tests and 2) to reduce perinatal transmission of HIV further by universal testing of all pregnant women and by using rapid tests during labor and delivery or postpartum if the mother was not screened prenatally (19). In its technical guidance, CDC acknowledged that prevention counseling is desirable for all persons at risk for HIV but recognized that such counseling might not be appropriate or feasible in all settings (20). Because time constraints or discomfort with discussing their patients' risk behaviors caused some providers to perceive requirements for prevention counseling and written informed consent as a barrier (12,21–23), the initiative advocated streamlined approaches.

In March 2004, CDC convened a meeting of health-care providers, representatives from professional associations, and local health officials to obtain advice concerning how best to expand HIV testing, especially in high-volume, high-prevalence acute-care settings. Consultants recommended simplifying the HIV screening process to make it more feasible and less costly and advocated more frequent diagnostic testing of patients with symptoms. In April 2005, CDC initiated a comprehensive review of the literature regarding HIV testing in health-care settings and, on the basis of published evidence and lessons learned from CDC-sponsored demonstration projects of HIV screening in health-care facilities, began to prepare recommendations to implement these strategies. In August 2005, CDC invited health-care providers, representatives from public health agencies and community organizations, and persons living with HIV to review an outline of proposed recommendations. In November 2005, CDC convened a meeting of researchers, representatives of professional health-care provider organizations, clinicians, persons living with HIV, and representatives from community organizations and agencies overseeing care of HIV-infected persons to review CDC's proposed recommendations. Before final revision of these recommendations, CDC described the proposals at national meetings of researchers and health-care providers and, in March 2006, solicited peer review by health-care professionals, in compliance with requirements of the Office of Management and Budget for influential scientific assessments, and invited comment from multiple professional and community organizations. The final recommendations were further refined on the basis of comments from these constituents.

Rationale for Routine Screening for HIV Infection

Previous CDC and U.S. Preventive Services Task Force guidelines for HIV testing recommended routine counseling and testing for persons at high risk for HIV and for those in acute-care settings in which HIV prevalence was $\geq 1\%$ (9,10,24). These guidelines proved difficult to implement because 1) the cost of HIV screening often is not reimbursed, 2) providers in busy health-care settings often lack the time necessary to conduct risk assessments and might perceive counseling requirements as a barrier to testing, and 3) explicit information regarding HIV prevalence typically is not available to guide selection of specific settings for screening (25–29).

These revised CDC recommendations advocate routine voluntary HIV screening as a normal part of medical practice, similar to screening for other treatable conditions. Screening is a basic public health tool used to identify unrecognized health conditions so treatment can be offered before symptoms develop and, for communicable diseases, so interventions can be implemented to reduce the likelihood of continued transmission (30).

HIV infection is consistent with all generally accepted criteria that justify screening: 1) HIV infection is a serious health disorder that can be diagnosed before symptoms develop; 2) HIV can be detected by reliable, inexpensive, and noninvasive screening tests; 3) infected patients have years of life to gain if treatment is initiated early, before symptoms develop; and 4) the costs of screening are reasonable in relation to the anticipated benefits (30). Among pregnant women, screening has proven substantially more effective than risk-based testing for detecting unsuspected maternal HIV infection and preventing perinatal transmission (31–33).

Rationale for New Recommendations

Often, persons with HIV infection visit health-care settings (e.g., hospitals, acute-care clinics, and sexually transmitted disease [STD] clinics) years before receiving a diagnosis but are not tested for HIV (34–36). Since the 1980s, the demographics of the HIV/AIDS epidemic in the United States have changed; increasing proportions of infected persons are aged <20 years, women, members of racial or ethnic minority populations, persons who reside outside metropolitan areas, and heterosexual men and women who frequently are unaware that they are at risk for HIV (37). As a result, the effectiveness of using risk-based testing to identify HIV-infected persons has diminished (34,35,38,39).

Prevention strategies that incorporate universal HIV screening have been highly effective. For example, screening blood

donors for HIV has nearly eliminated transfusion-associated HIV infection in the United States (40). In addition, incidence of pediatric HIV/AIDS in the United States has declined substantially since the 1990s, when prevention strategies began to include specific recommendations for routine HIV testing of pregnant women (18,41). Perinatal transmission rates can be reduced to $<2\%$ with universal screening of pregnant women in combination with prophylactic administration of antiretroviral drugs (42,43), scheduled cesarean delivery when indicated (44,45), and avoidance of breast feeding (46).

These successes contrast with a relative lack of progress in preventing sexual transmission of HIV, for which screening rarely is performed. Declines in HIV incidence observed in the early 1990s have leveled and might even have reversed in certain populations in recent years (47,48). Since 1998, the estimated number of new infections has remained stable at approximately 40,000 annually (49). In 2001, the Institute of Medicine (IOM) emphasized prevention services for HIV-infected persons and recommended policies for diagnosing HIV infections earlier to increase the number of HIV-infected persons who were aware of their infections and who were offered clinical and prevention services (37). The majority of persons who are aware of their HIV infections substantially reduce sexual behaviors that might transmit HIV after they become aware they are infected (5). In a meta-analysis of findings from eight studies, the prevalence of unprotected anal or vaginal intercourse with uninfected partners was on average 68% lower for HIV-infected persons who were aware of their status than it was for HIV-infected persons who were unaware of their status (5). To increase diagnosis of HIV infection, destigmatize the testing process, link clinical care with prevention, and ensure immediate access to clinical care for persons with newly identified HIV infection, IOM and other health-care professionals with expertise (25,37,50,51) have encouraged adoption of routine HIV testing in all health-care settings.

Routine prenatal HIV testing with streamlined counseling and consent procedures has increased the number of pregnant women tested substantially (52). By contrast, the number of persons at risk for HIV infection who are screened in acute-care settings remains low, despite repeated recommendations in support of routine risk-based testing in health-care settings (9,10,15,34,53,54). In a survey of 154 health-care providers in 10 hospital EDs, providers reported caring for an average of 13 patients per week suspected to have STDs, but only 10% of these providers encouraged such patients to be tested for HIV while they were in the ED (54). Another 35% referred patients to confidential HIV testing sites in the

community; however, such referrals have proven ineffective because of poor compliance by patients (55). Reasons cited for not offering HIV testing in the ED included lack of established mechanisms to ensure follow-up (51%), lack of the certification perceived as necessary to provide counseling (45%), and belief that the testing process was too time-consuming (19%) (54).

With the institution of HIV screening in certain hospitals and EDs, the percentage of patients who test positive (2%–7%) often has exceeded that observed nationally at publicly funded HIV counseling and testing sites (1.5%) and STD clinics (2%) serving persons at high risk for HIV (53,56–59). Because patients rarely were seeking testing when screening was offered at these hospitals, HIV infections often were identified earlier than they might otherwise have been (29). Targeted testing programs also have been implemented in acute-care settings; nearly two thirds of patients in these settings accept testing, but because risk assessment and prevention counseling are time-consuming, only a limited proportion of eligible patients can be tested (29). Targeted testing on the basis of risk behaviors fails to identify a substantial number of persons who are HIV infected (34,35,39). A substantial number of persons, including persons with HIV infection, do not perceive themselves to be at risk for HIV or do not disclose their risks (53,56,59). Routine HIV testing reduces the stigma associated with testing that requires assessment of risk behaviors (60–63). More patients accept recommended HIV testing when it is offered routinely to everyone, without a risk assessment (54,56).

In 1999, to increase the proportion of women tested for HIV, IOM recommended 1) adopting a national policy of universal HIV testing of pregnant women with patient notification (opt-out screening) as a routine component of prenatal care, 2) eliminating requirements for extensive pretest counseling while requiring provision of basic information regarding HIV, and 3) not requiring explicit written consent to be tested for HIV (12). Subsequent studies have indicated that these policies, as proposed by IOM and other professional organizations (12,64,65), reflect an ethical balance among public health goals, justice, and individual rights (66,67). Rates of HIV screening are consistently higher at settings that provide prenatal and STD services using opt-out screening than at opt-in programs, which require pretest counseling and explicit written consent (52,68–74). Pregnant women express less anxiety with opt-out HIV screening and do not find it difficult to decline a test (68,74). In 2006, approximately 65% of U.S. adults surveyed concurred that HIV testing should be treated the same as

screening for any other disease, without special procedures such as written permission from the patient (75).

Adolescents aged 13–19 years represent new cohorts of persons at risk, and prevention efforts need to be repeated for each succeeding generation of young persons (63). The 2005 Youth Risk Behavior Survey indicated that 47% of high school students reported that they had had sexual intercourse at least once, and 37% of sexually active students had not used a condom during their most recent act of sexual intercourse (76). More than half of all HIV-infected adolescents are estimated not to have been tested and are unaware of their infection (77,78). Among young (aged 18–24 years) men who have sex with men (MSM) surveyed during 2004–2005 in five U.S. cities, 14% were infected with HIV; 79% of these HIV-infected MSM were unaware of their infection (56). The American Academy of Pediatrics recommends that clinicians obtain information from adolescent patients regarding their sexual activity and inform them how to prevent HIV infection (79). Evidence indicates that adolescents prefer to receive this information from their health-care providers rather than from their parents, teachers, or friends (80). However, fewer than half of clinicians provide such guidance (81). Health-care providers' recommendations also influence adolescents' decision to be tested. Among reasons for HIV testing provided by 528 adolescents who had primary care providers, 58% cited their provider's recommendation as their reason for testing (82).

The U.S. Preventive Services Task Force recently recommended that clinicians screen for HIV all adults and adolescents at increased risk for HIV, on the basis that when HIV is diagnosed early, appropriately timed interventions, particularly HAART, can lead to improved health outcomes, including slower clinical progression and reduced mortality (24). The Task Force also recommended screening all pregnant women, regardless of risk, but made no recommendation for or against routinely screening asymptomatic adults and adolescents with no identifiable risk factors for HIV. The Task Force concluded that such screening would detect additional patients with HIV, but the overall number would be limited, and the potential benefits did not clearly outweigh the burden on primary care practices or the potential harms of a general HIV screening program (24,83). In making these recommendations, the Task Force considered how many patients would need to be screened to prevent one clinical progression or death during the 3-year period after screening. On the basis of evidence available for its review, the Task Force was unable to calculate benefits attributable to the prevention of secondary HIV transmission to partners (84). However, a

recent meta-analysis indicated that HIV-infected persons reduced high-risk behavior substantially when they became aware of their infection (5). Because viral load is the chief biologic predictor of HIV transmission (85), reduction in viral load through timely initiation of HAART might reduce transmission, even for HIV-infected patients who do not change their risk behavior (86). Estimated transmission is 3.5 times higher among persons who are unaware of their infection than among persons who are aware of their infection and contributes disproportionately to the number of new HIV infections each year in the United States (87). In theory, new sexual HIV infections could be reduced >30% per year if all infected persons could learn their HIV status and adopt changes in behavior similar to those adopted by persons already aware of their infection (87).

Recent studies demonstrate that voluntary HIV screening is cost-effective even in health-care settings in which HIV prevalence is low (26,27,86). In populations for which prevalence of undiagnosed HIV infection is $\geq 0.1\%$, HIV screening is as cost-effective as other established screening programs for chronic diseases (e.g., hypertension, colon cancer, and breast cancer) (27,86). Because of the substantial survival advantage resulting from earlier diagnosis of HIV infection when therapy can be initiated before severe immunologic compromise occurs, screening reaches conventional benchmarks for cost-effectiveness even before including the important public health benefit from reduced transmission to sex partners (86).

Linking patients who have received a diagnosis of HIV infection to prevention and care is essential. HIV screening without such linkage confers little or no benefit to the patient. Although moving patients into care incurs substantial costs, it also triggers sufficient survival benefits that justify the additional costs. Even if only a limited fraction of patients who receive HIV-positive results are linked to care, the survival benefits per dollar spent on screening represent good comparative value (26,27,88).

The benefit of providing prevention counseling in conjunction with HIV testing is less clear. HIV counseling with testing has been demonstrated to be an effective intervention for HIV-infected participants, who increased their safer behaviors and decreased their risk behaviors; HIV counseling and testing as implemented in the studies had little effect on HIV-negative participants (89). However, randomized controlled trials have demonstrated that the nature and duration of prevention counseling might influence its effectiveness (90,91). Carefully controlled, theory-based prevention counseling in STD clinics has helped HIV-negative participants reduce their risk behaviors compared with participants who received only a didactic prevention message from health-care providers (90).

A more intensive intervention among HIV-negative MSM at high risk, consisting of 10 theory-based individual counseling sessions followed by maintenance sessions every 3 months, resulted in reductions in unprotected sex with partners who were HIV infected or of unknown status, compared with MSM who received structured prevention counseling only twice yearly (91).

Timely access to diagnostic HIV test results also improves health outcomes. Diagnostic testing in health-care settings continues to be the mechanism by which nearly half of new HIV infections are identified. During 2000–2003, of persons reported with HIV/AIDS who were interviewed in 16 states, 44% were tested for HIV because of illness (8). Compared with HIV testing after patients were admitted to the hospital, expedited diagnosis by rapid HIV testing in the ED before admission led to shorter hospital stays, increased the number of patients aware of their HIV status before discharge, and improved entry into outpatient care (92). However, at least 28 states have laws or regulations that limit health-care providers' ability to order diagnostic testing for HIV infection if the patient is unable to give consent for HIV testing, even when the test results are likely to alter the patient's diagnostic or therapeutic management (93).

Of the 40,000 persons who acquire HIV infection each year, an estimated 40%–90% will experience symptoms of acute HIV infection (94–96), and a substantial number will seek medical care. However, acute HIV infection often is not recognized by primary care clinicians because the symptoms resemble those of influenza, infectious mononucleosis, and other viral illnesses (97). Acute HIV infection can be diagnosed by detecting HIV RNA in plasma from persons with a negative or indeterminate HIV antibody test. One study based on national ambulatory medical care surveys estimated that the prevalence of acute HIV infection was 0.5%–0.7% among ambulatory patients who sought care for fever or rash (98). Although the long-term benefit of HAART during acute HIV infection has not been established conclusively (99), identifying primary HIV infection can reduce the spread of HIV that might otherwise occur during the acute phase of HIV disease (100,101).

Perinatal HIV transmission continues to occur, primarily among women who lack prenatal care or who were not offered voluntary HIV counseling and testing during pregnancy. A substantial proportion of the estimated 144–236 perinatal HIV infections in the United States each year can be attributed to the lack of timely HIV testing and treatment of pregnant women (102). Multiple barriers to HIV testing have been identified, including language barriers; late entry into prenatal care; health-care providers' perceptions that their patients are at low risk for HIV; lack of time for counseling

and testing, particularly for rapid testing during labor and delivery; and state regulations requiring counseling and separate informed consent (103). A survey of 653 obstetrical providers in North Carolina suggested that not all health-care providers embrace universal testing of pregnant women; the strength with which providers recommended prenatal testing to their patients and the numbers of women tested depended largely on the providers' perception of the patients' risk behaviors (21). Data confirm that testing rates are higher when HIV tests are included in the standard panel of screening tests for all pregnant women (52,69,104). Women also are much more likely to be tested if they perceive that their health-care provider strongly recommends HIV testing (105). As universal prenatal screening has become more widespread, an increasing proportion of pregnant women who had undiagnosed HIV infection at the time of delivery were found to have seroconverted during pregnancy (106). A second HIV test during the third trimester for women in settings with elevated HIV incidence (≥ 17 cases per 100,000 person-years) is cost-effective and might result in substantial reductions in mother-to-child HIV transmission (107).

Every perinatal HIV transmission is a sentinel health event, signaling either a missed opportunity for prevention or, more rarely, a failure of interventions to prevent perinatal transmission. When these infections occur, they underscore the need for improved strategies to ensure that all pregnant women undergo HIV testing and, if found to be HIV positive, receive proper interventions to reduce their transmission risk and safeguard their health and the health of their infants.

Recommendations for Adults and Adolescents

CDC recommends that diagnostic HIV testing and opt-out HIV screening be a part of routine clinical care in all health-care settings while also preserving the patient's option to decline HIV testing and ensuring a provider-patient relationship conducive to optimal clinical and preventive care. The recommendations are intended for providers in all health-care settings, including hospital EDs, urgent-care clinics, inpatient services, STD clinics or other venues offering clinical STD services, tuberculosis (TB) clinics, substance abuse treatment clinics, other public health clinics, community clinics, correctional health-care facilities, and primary care settings. The guidelines address HIV testing in health-care settings only; they do not modify existing guidelines concerning HIV counseling, testing, and referral for persons at high risk for HIV who seek or receive HIV testing in nonclinical settings (e.g., community-based organizations, outreach settings, or mobile vans) (9).

Screening for HIV Infection

- In all health-care settings, screening for HIV infection should be performed routinely for all patients aged 13–64 years. Health-care providers should initiate screening unless prevalence of undiagnosed HIV infection in their patients has been documented to be $< 0.1\%$. In the absence of existing data for HIV prevalence, health-care providers should initiate voluntary HIV screening until they establish that the diagnostic yield is < 1 per 1,000 patients screened, at which point such screening is no longer warranted.
- All patients initiating treatment for TB should be screened routinely for HIV infection (108).
- All patients seeking treatment for STDs, including all patients attending STD clinics, should be screened routinely for HIV during each visit for a new complaint, regardless of whether the patient is known or suspected to have specific behavior risks for HIV infection.

Repeat Screening

- Health-care providers should subsequently test all persons likely to be at high risk for HIV at least annually. Persons likely to be at high risk include injection-drug users 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.
- Health-care providers should encourage patients 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 judgment.
- Unless recent HIV test results are immediately available, any person whose blood or body fluid is the source of an occupational exposure for a health-care provider should be informed of the incident and tested for HIV infection at the time the exposure occurs.

Consent and Pretest Information

- Screening should be voluntary and undertaken only with the patient's knowledge and understanding that HIV testing is planned.
- Patients should be informed orally or in writing that HIV testing will be performed unless they decline (opt-out screening). Oral or written information should include an explanation of HIV infection and the

meanings of positive and negative test results, and the patient should be offered an opportunity to ask questions and to decline testing. With such notification, consent for HIV screening should be incorporated into the patient's general informed consent for medical care on the same basis as are other screening or diagnostic tests; a separate consent form for HIV testing is not recommended.

- Easily understood informational materials should be made available in the languages of the commonly encountered populations within the service area. The competence of interpreters and bilingual staff to provide language assistance to patients with limited English proficiency must be ensured.
- If a patient declines an HIV test, this decision should be documented in the medical record.

Diagnostic Testing for HIV Infection

- All patients with signs or symptoms consistent with HIV infection or an opportunistic illness characteristic of AIDS should be tested for HIV.
- Clinicians should maintain a high level of suspicion for acute HIV infection in all patients who have a compatible clinical syndrome and who report recent high-risk behavior. When acute retroviral syndrome is a possibility, a plasma RNA test should be used in conjunction with an HIV antibody test to diagnose acute HIV infection (96).
- Patients or persons responsible for the patient's care should be notified orally that testing is planned, advised of the indication for testing and the implications of positive and negative test results, and offered an opportunity to ask questions and to decline testing. With such notification, the patient's general consent for medical care is considered sufficient for diagnostic HIV testing.

Similarities and Differences Between Current and Previous Recommendations for Adults and Adolescents

Aspects of these recommendations that remain unchanged from previous recommendations are as follows:

- HIV testing must be voluntary and free from coercion. Patients must not be tested without their knowledge.
- HIV testing is recommended and should be routine for persons attending STD clinics and those seeking treatment for STDs in other clinical settings.

- Access to clinical care, prevention counseling, and support services is essential for persons with positive HIV test results.

Aspects of these recommendations that differ from previous recommendations are as follows:

- Screening after notifying the patient that an HIV test will be performed unless the patient declines (opt-out screening) is recommended in all health-care settings. Specific signed consent for HIV testing should not be required. General informed consent for medical care should be considered sufficient to encompass informed consent for HIV testing.
- Persons at high risk for HIV should be screened for HIV at least annually.
- HIV test results should be provided in the same manner as results of other diagnostic or screening tests.
- Prevention counseling should not be required as a part of HIV screening programs in health-care settings. Prevention counseling is strongly encouraged for persons at high risk for HIV in settings in which risk behaviors are assessed routinely (e.g., STD clinics) but should not have to be linked to HIV testing.
- HIV diagnostic testing or screening to detect HIV infection earlier should be considered distinct from HIV counseling and testing conducted primarily as a prevention intervention for uninfected persons at high risk.

Recommendations for Pregnant Women

These guidelines reiterate the recommendation for universal HIV screening early in pregnancy but advise simplifying the screening process to maximize opportunities for women to learn their HIV status during pregnancy, preserving the woman's option to decline HIV testing, and ensuring a provider-patient relationship conducive to optimal clinical and preventive care. All women should receive HIV screening consistent with the recommendations for adults and adolescents. HIV screening should be a routine component of preconception care, maximizing opportunities for all women to know their HIV status before conception (109). In addition, screening early in pregnancy enables HIV-infected women and their infants to benefit from appropriate and timely interventions (e.g., antiretroviral medications [43], scheduled cesarean delivery [44], and avoidance of breastfeeding* [46]). These

* To eliminate the risk for postnatal transmission, HIV-infected women in the United States should not breastfeed. Support services for use of appropriate breast milk substitutes should be provided when necessary. In international settings, UNAIDS and World Health Organization recommendations for HIV and breastfeeding should be followed (46).

recommendations are intended for clinicians who provide care to pregnant women and newborns and for health policy makers who have responsibility for these populations.

HIV Screening for Pregnant Women and Their Infants

Universal Opt-Out Screening

- All pregnant women in the United States should be screened for HIV infection.
- Screening should occur after a woman is notified that HIV screening is recommended for all pregnant patients and that she will receive an HIV test as part of the routine panel of prenatal tests unless she declines (opt-out screening).
- HIV testing must be voluntary and free from coercion. No woman should be tested without her knowledge.
- Pregnant women should receive oral or written information that includes an explanation of HIV infection, a description of interventions that can reduce HIV transmission from mother to infant, and the meanings of positive and negative test results and should be offered an opportunity to ask questions and to decline testing.
- No additional process or written documentation of informed consent beyond what is required for other routine prenatal tests should be required for HIV testing.
- If a patient declines an HIV test, this decision should be documented in the medical record.

Addressing Reasons for Declining Testing

- Providers should discuss and address reasons for declining an HIV test (e.g., lack of perceived risk; fear of the disease; and concerns regarding partner violence or potential stigma or discrimination).
- Women who decline an HIV test because they have had a previous negative test result should be informed of the importance of retesting during each pregnancy.
- Logistical reasons for not testing (e.g., scheduling) should be resolved.
- Certain women who initially decline an HIV test might accept at a later date, especially if their concerns are discussed. Certain women will continue to decline testing, and their decisions should be respected and documented in the medical record.

Timing of HIV Testing

- To promote informed and timely therapeutic decisions, health-care providers should test women for HIV as early as possible during each pregnancy. Women who

decline the test early in prenatal care should be encouraged to be tested at a subsequent visit.

- A second HIV test during the third trimester, preferably <36 weeks of gestation, is cost-effective even in areas of low HIV prevalence and may be considered for all pregnant women. A second HIV test during the third trimester is recommended for women who meet one or more of the following criteria:
 - Women who receive health care in jurisdictions with elevated incidence of HIV or AIDS among women aged 15–45 years. In 2004, these jurisdictions included Alabama, Connecticut, Delaware, the District of Columbia, Florida, Georgia, Illinois, Louisiana, Maryland, Massachusetts, Mississippi, Nevada, New Jersey, New York, North Carolina, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, Tennessee, Texas, and Virginia.[†]
 - Women who receive health care in facilities in which prenatal screening identifies at least one HIV-infected pregnant woman per 1,000 women screened.
 - Women who are known to be at high risk for acquiring HIV (e.g., injection-drug users and their sex partners, women who exchange sex for money or drugs, women who are sex partners of HIV-infected persons, and women who have had a new or more than one sex partner during this pregnancy).
 - Women who have signs or symptoms consistent with acute HIV infection. When acute retroviral syndrome is a possibility, a plasma RNA test should be used in conjunction with an HIV antibody test to diagnose acute HIV infection (96).

Rapid Testing During Labor

- Any woman with undocumented HIV status at the time of labor should be screened with a rapid HIV test unless she declines (opt-out screening).
- Reasons for declining a rapid test should be explored (see Addressing Reasons for Declining Testing).
- Immediate initiation of appropriate antiretroviral prophylaxis (42) should be recommended to women on the basis of a reactive rapid test result without waiting for the result of a confirmatory test.

[†] A second HIV test in the third trimester is as cost-effective as other common health interventions when HIV incidence among women of childbearing age is ≥ 17 HIV cases per 100,000 person-years (107). In 2004, in jurisdictions with available data on HIV case rates, a rate of 17 new HIV diagnoses per year per 100,000 women aged 15–45 years was associated with an AIDS case rate of at least nine AIDS diagnoses per year per 100,000 women aged 15–45 years (CDC, unpublished data, 2005). As of 2004, the jurisdictions listed above exceeded these thresholds. The list of specific jurisdictions where a second test in the third trimester is recommended will be updated periodically based on surveillance data.

Postpartum/Newborn Testing

- When a woman's HIV status is still unknown at the time of delivery, she should be screened immediately postpartum with a rapid HIV test unless she declines (opt-out screening).
- When the mother's HIV status is unknown postpartum, rapid testing of the newborn as soon as possible after birth is recommended so antiretroviral prophylaxis can be offered to HIV-exposed infants. Women should be informed that identifying HIV antibodies in the newborn indicates that the mother is infected.
- For infants whose HIV exposure status is unknown and who are in foster care, the person legally authorized to provide consent should be informed that rapid HIV testing is recommended for infants whose biologic mothers have not been tested.
- The benefits of neonatal antiretroviral prophylaxis are best realized when it is initiated ≤ 12 hours after birth (110).

Confirmatory Testing

- Whenever possible, uncertainties regarding laboratory test results indicating HIV infection status should be resolved before final decisions are made regarding reproductive options, antiretroviral therapy, cesarean delivery, or other interventions.
- If the confirmatory test result is not available before delivery, immediate initiation of appropriate antiretroviral prophylaxis (42) should be recommended to any pregnant patient whose HIV screening test result is reactive to reduce the risk for perinatal transmission.

Similarities and Differences Between Current and Previous Recommendations for Pregnant Women and Their Infants

Aspects of these recommendations that remain unchanged from previous recommendations are as follows:

- Universal HIV testing with notification should be performed for all pregnant women as early as possible during pregnancy.
- HIV screening should be repeated in the third trimester of pregnancy for women known to be at high risk for HIV.
- Providers should explore and address reasons for declining HIV testing.
- Pregnant women should receive appropriate health education, including information regarding HIV and its transmission, as a routine part of prenatal care.

- Access to clinical care, prevention counseling, and support services is essential for women with positive HIV test results.

Aspects of these recommendations that differ from previous recommendations are as follows:

- HIV screening should be included in the routine panel of prenatal screening tests for all pregnant women. Patients should be informed that HIV screening is recommended for all pregnant women and that it will be performed unless they decline (opt-out screening).
- Repeat HIV testing in the third trimester is recommended for all women in jurisdictions with elevated HIV or AIDS incidence and for women receiving health care in facilities with at least one diagnosed HIV case per 1,000 pregnant women per year.
- Rapid HIV testing should be performed for all women in labor who do not have documentation of results from an HIV test during pregnancy. Patients should be informed that HIV testing is recommended for all pregnant women and will be performed unless they decline (opt-out screening). Immediate initiation of appropriate antiretroviral prophylaxis should be recommended on the basis of a reactive rapid HIV test result, without awaiting the result of confirmatory testing.

Additional Considerations for HIV Screening

Test Results

- **Communicating test results.** The central goal of HIV screening in health-care settings is to maximize the number of persons who are aware of their HIV infection and receive care and prevention services. Definitive mechanisms should be established to inform patients of their test results. HIV-negative test results may be conveyed without direct personal contact between the patient and the health-care provider. Persons known to be at high risk for HIV infection also should be advised of the need for periodic retesting and should be offered prevention counseling or referred for prevention counseling. HIV-positive test results should be communicated confidentially through personal contact by a clinician, nurse, mid-level practitioner, counselor, or other skilled staff. Because of the risk of stigma and discrimination, family or friends should not be used as interpreters to disclose HIV-positive test results to patients with limited English proficiency. Active efforts are essential to ensure that HIV-infected patients receive their positive

test results and linkage to clinical care, counseling, support, and prevention services. If the necessary expertise is not available in the health-care venue in which screening is performed, arrangements should be made to obtain necessary services from another clinical provider, local health department, or community-based organization. Health-care providers should be aware that the Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits use or disclosure of a patient's health information, including HIV status, without the patient's permission.

- **Rapid HIV tests.** Because of the time that elapses before results of conventional HIV tests are available, providing patients with their test results can be resource intensive and challenging for screening programs, especially in episodic care settings (e.g., EDs, urgent-care clinics, and STD clinics) in which continuing relationships with patients typically do not exist. The use of rapid HIV tests can substantially decrease the number of persons who fail to learn their test results and reduce the resources expended to locate persons identified as HIV infected. Positive rapid HIV test results are preliminary and must be confirmed before the diagnosis of HIV infection is established (111).
- **Participants in HIV vaccine trials.** Recipients of preventive HIV vaccines might have vaccine-induced antibodies that are detectable by HIV antibody tests. Persons whose test results are HIV positive and who are identified as vaccine trial participants might not be infected with HIV and should be encouraged to contact or return to their trial site or an associated trial site for the confirmatory testing necessary to determine their HIV status.
- **Documenting HIV test results.** Positive or negative HIV test results should be documented in the patient's confidential medical record and should be readily available to all health-care providers involved in the patient's clinical management. The HIV test result of a pregnant woman also should be documented in the medical record of her infant. If the mother's HIV test result is positive, maternal health-care providers should, after obtaining consent from the mother, notify pediatric care providers of the impending birth of an HIV-exposed infant and of any anticipated complications. If HIV is diagnosed in the infant first, health-care providers should discuss the implications for the mother's health and help her to obtain care.

Clinical Care for HIV-Infected Persons

Persons with a diagnosis of HIV infection need a thorough evaluation of their clinical status and immune function to determine their need for antiretroviral treatment or other therapy. HIV-infected persons should receive or be referred for clinical care promptly, consistent with USPHS guidelines for management of HIV-infected persons (96). HIV-exposed infants should receive appropriate antiretroviral prophylaxis to prevent perinatal HIV transmission as soon as possible after birth (42) and begin trimethoprim-sulfamethoxazole prophylaxis at age 4–6 weeks to prevent *Pneumocystis pneumonia* (112). They should receive subsequent clinical monitoring and diagnostic testing to determine their HIV infection status (113).

Partner Counseling and Referral

When HIV infection is diagnosed, health-care providers should strongly encourage patients to disclose their HIV status to their spouses, current sex partners, and previous sex partners and recommend that these partners be tested for HIV infection. Health departments can assist patients by notifying, counseling, and providing HIV testing for partners without disclosing the patient's identity (114). Providers should inform patients who receive a new diagnosis of HIV infection that they might be contacted by health department staff for a voluntary interview to discuss notification of their partners.

Special Considerations for Screening Adolescents

Although parental involvement in an adolescent's health care is usually desirable, it typically is not required when the adolescent consents to HIV testing. However, laws concerning consent and confidentiality for HIV care differ among states (79). Public health statutes and legal precedents allow for evaluation and treatment of minors for STDs without parental knowledge or consent, but not every state has defined HIV infection explicitly as a condition for which testing or treatment may proceed without parental consent. Health-care providers should endeavor to respect an adolescent's request for privacy (79). HIV screening should be discussed with all adolescents and encouraged for those who are sexually active. Providing information regarding HIV infection, HIV testing, HIV transmission, and implications of infection should be regarded as an essential component of the anticipatory guidance provided to all adolescents as part of primary care (79).

Prevention Services for HIV-Negative Persons

- **Risk screening.** HIV screening should not be contingent on an assessment of patients' behavioral risks. However, assessment of risk for infection with HIV and other STDs and provision of prevention information should be incorporated into routine primary care of all sexually active persons when doing so does not pose a barrier to HIV testing. Even when risk information is not sought, notifying a patient that routine HIV testing will be performed might result in acknowledgement of risk behaviors and offers an opportunity to discuss HIV infection and how it can be prevented. Patients found to have risk behaviors (e.g., MSM or heterosexuals who have multiple sex partners, persons who have received a recent diagnosis of an STD, persons who exchange sex for money or drugs, or persons who engage in substance abuse) and those who want assistance with changing behaviors should be provided with or referred to HIV risk-reduction services (e.g., drug treatment, STD treatment, and prevention counseling).
- **Prevention counseling.** In health-care settings, prevention counseling need not be linked explicitly to HIV testing. However, because certain patients might be more likely to think about HIV and consider their risks at the time of HIV testing, testing might present an ideal opportunity to provide or arrange for prevention counseling to assist with behavior changes that can reduce risks for acquiring HIV infection. Prevention counseling should be offered or made available through referral in all health-care facilities serving patients at high risk for HIV and at facilities (e.g., STD clinics) in which information on HIV risk behaviors is elicited routinely.

HIV/AIDS Surveillance

- **Risk-factor ascertainment for HIV-infected persons.** CDC recommends that providers ascertain and document all known HIV risk factors (115). Health-care providers can obtain tools and materials to assist with ascertainment and receive guidance on risk factors as defined for surveillance purposes from HIV/AIDS surveillance professionals in their state or local health jurisdiction. This risk-factor information is important for guiding public health decisions, especially for prevention and care, at clinical, local, state, and national levels.

- **HIV/AIDS case reporting.** All states require that health-care providers report AIDS cases and persons with a diagnosis of HIV infection to the state or local health department. Case report forms are available from the state or local health jurisdiction.
- **Pediatric exposure reporting.** CDC and the Council for State and Territorial Epidemiologists recommend that all states and territories conduct surveillance for perinatal HIV exposure and contact providers after receiving reports of exposed infants to determine the infant's HIV-infection status. Information concerning dates of maternal HIV tests, receipt of prenatal care, maternal and neonatal receipt of antiretroviral drugs, mode of delivery, and breastfeeding is collected on the pediatric HIV/AIDS case report form (115).

Monitoring and Evaluation

Recommended thresholds for screening are based on estimates of the prevalence of undiagnosed HIV infection in U.S. health-care settings, for which no accurate recent data exist. The optimal frequency for retesting is not yet known. Cost-effectiveness parameters for HIV screening were based on existing program models, all of which include a substantial counseling component, and did not consistently consider secondary infections averted as a benefit of screening. To assess the need for revised thresholds for screening adults and adolescents or repeat screening of pregnant women and to confirm their continued effectiveness, screening programs should monitor the yield of new diagnoses of HIV infection, monitor costs, and evaluate whether patients with a diagnosis of HIV infection are linked to and remain engaged in care. With minor modifications, laboratory information systems might provide a practical alternative for clinicians to use in determining HIV prevalence among their patients who are screened for HIV.

Primary Prevention and HIV Testing in Nonclinical Settings

These revised recommendations are designed to increase HIV screening in health-care settings. Often, however, the population most at risk for HIV includes persons who are least likely to interact with the conventional health-care system (47,116). The need to maintain primary prevention activities, identify persons at high risk for HIV who could benefit from prevention services, and provide HIV testing for persons who are at high risk for HIV in nonclinical venues remains undiminished. New approaches (e.g., enlisting

HIV-infected persons and HIV-negative persons at high risk for HIV to recruit persons from their social, sexual, and drug-use networks for counseling, testing, and referral) have demonstrated considerable efficacy for identifying persons who were previously unaware of their HIV infection (117).

Regulatory and Legal Considerations

These public health recommendations are based on best practices and are intended to comply fully with the ethical principles of informed consent (67). Legislation related to HIV and AIDS has been enacted in every state and the District of Columbia (118), and specific requirements related to informed consent and pretest counseling differ among states (119). Certain states, local jurisdictions, or agencies might have statutory or other regulatory impediments to opt-out screening, or they might impose other specific requirements for counseling, written consent, confirmatory testing, or communicating HIV test results that conflict with these recommendations. Where such policies exist, jurisdictions should consider strategies to best implement these recommendations within current parameters and consider steps to resolve conflicts with these recommendations.

Other Guidelines

Issues that fall outside the scope of these recommendations are addressed by other USPHS guidelines (Box 1). Because concepts relevant to HIV management evolve rapidly, USPHS updates recommendations periodically. Current updates are available from the National Institutes of Health at <http://AIDSinfo.nih.gov>. Additional guidelines have been published by CDC and the U.S. Department of Health and Human Services, Office for Civil Rights (Box 2).

BOX 1. Recent U.S. Public Health Service HIV treatment guidelines

- Guidelines for the use of antiretroviral agents in HIV-infected adults and adolescents
- Guidelines for the use of antiretroviral agents in pediatric HIV infection
- Recommendations for use of antiretroviral drugs in pregnant HIV-1-infected women for maternal health and interventions to reduce perinatal HIV-1 transmission

SOURCE: National Institutes of Health, Bethesda, Maryland. Available at <http://AIDSinfo.nih.gov>.

BOX 2. Other guidelines and recommendations

- CDC. Updated U.S. Public Health Service guidelines for the management of occupational exposures to HIV and recommendations for postexposure prophylaxis. *MMWR* 2005;54(No. RR-9):1–17.
- CDC. Antiretroviral postexposure prophylaxis after sexual, injection-drug use, or other nonoccupational exposure to HIV in the United States: recommendations from the U.S. Department of Health and Human Services. *MMWR* 2005;54(No. RR-2):1–20.
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