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[53] これらの表現の中には、本書の初期の草稿で提案されたものもあり、HIV 検査に関する UNAIDS/WHO 政策声明では「ルーチンとして提示」という表現が用いられていた。政策声明は、本書で用いられる用語を反映すべく改訂される予定である。

[54] 4 番目の流行のシナリオとして、HIV 感染率が 15%を超える国々では HIV プログラムを計画するために、「高度地方流行型の流行 (hyperendemic epidemic)」というものも提案されている。本書に示した一般住民のあいだで HIV が流行している場合の勧告内容は、高度地方流行型の流行にも適用されると思われる。以下を参照 : *Practical guidelines for intensifying HIV prevention: towards universal access*. UNAIDS. 2007.

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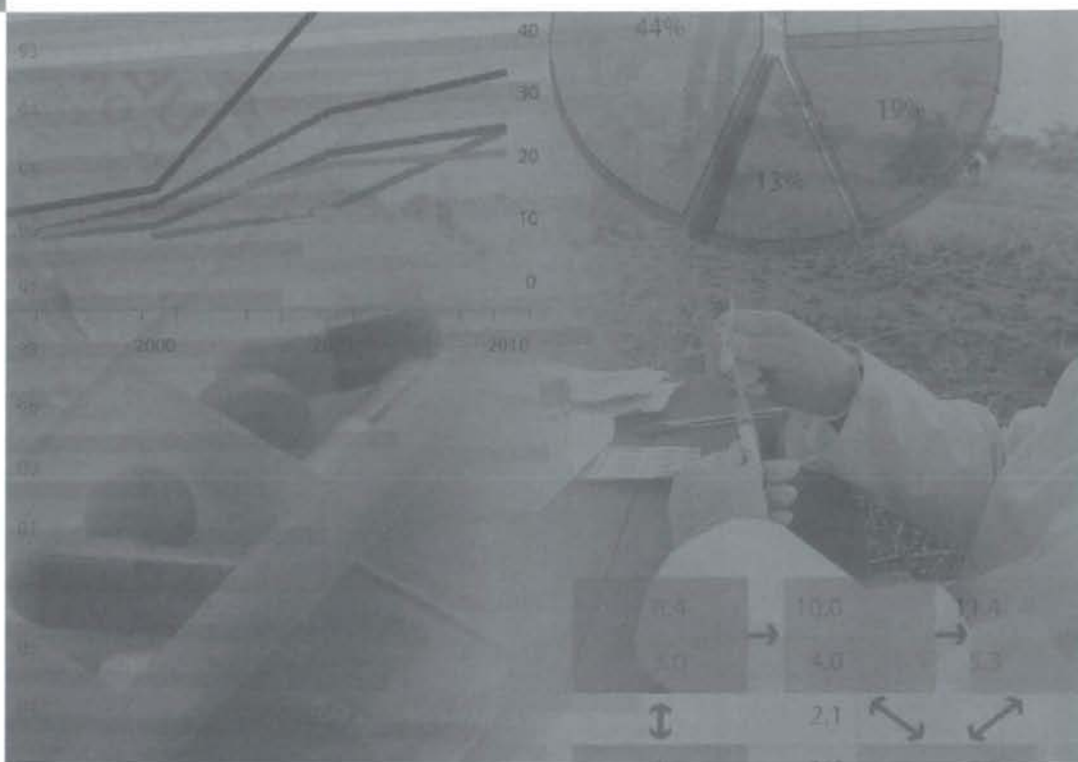

HIV/AIDS Programme

Strengthening health services to fight HIV/AIDS

GUIDANCE ON PROVIDER-INITIATED HIV TESTING AND COUNSELLING IN HEALTH FACILITIES

World Health Organization

UNAIDS

JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

UNHCR UNICEF WFP UNDP UNFPA UNODC ILO UNESCO WHO WORLD BANK

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May 2007

UNAIDS

JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

UNHCR UNICEF WFP UNDP UNFPA UNODC ILO UNESCO WHO WORLD BANK

World Health Organization

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EXECUTIVE SUMMARY

1. INTRODUCTION

This document responds to growing need at country level for basic operational guidance on provider-initiated HIV testing and counselling in health facilities. It is intended for a wide audience including policy-makers, HIV/AIDS programme planners and coordinators, health-care providers, non-governmental organizations providing HIV/AIDS services and civil society groups.

Surveys in sub-Saharan Africa have shown that a median of just 12% of men and 10% of women had been tested for HIV and received the results. Greater knowledge of HIV status is critical to expanding access to HIV treatment, care and support in a timely manner, and offers people living with HIV an opportunity to receive information and tools to prevent HIV transmission to others. Increased access to HIV testing and counselling is essential in working towards universal access to HIV prevention, treatment, care and support as endorsed by G8 leaders in 2005 and the UN General Assembly in 2006.

WHO and UNAIDS strongly support the continued scale up of client-initiated HIV testing and counselling, but recognize the need for additional, innovative and varied approaches. Health facilities represent a key point of contact with people with HIV who are in need of HIV prevention, treatment, care and support. Evidence from both industrialized and resource-constrained settings suggests that many opportunities to diagnose and counsel individuals at health facilities are being missed and that provider-initiated HIV testing and counselling facilitates diagnosis and access to HIV-related services. Concerns about the potential coercion of patients and adverse outcomes of disclosure underscore the importance of adequate training and supervision for health care providers and the need for close monitoring and evaluation of provider-initiated HIV testing and counselling programmes.

The document recommends an "opt-out" approach to provider-initiated HIV testing and counselling in heath facilities, including simplified pre-test information, consistent with WHO policy options developed in 2003 and with the 2004 UNAIDS/WHO Policy Statement on HIV Testing. With this approach, an HIV test is recommended 1) for all patients, irrespective of epidemic setting, whose clinical presentation might result from underlying HIV infection; 2) as a standard part of medical care for all patients attending health facilities in generalized HIV epidemics; and 3) more selectively in concentrated and low-level epidemics. Individuals must specifically decline the HIV test if they do not want it to be performed. Additional discussion of the right to decline HIV testing, of the risks and benefits of HIV testing and disclosure, and about social support available may be required for groups especially vulnerable to adverse consequences upon disclosure of an HIV test result. An "opt-in" approach to informed consent may merit consideration for highly vulnerable populations.

Provider-initiated HIV testing and counselling should be accompanied by a recommended package of HIV-related prevention, treatment, care and support services described in Section 5 and implemented within the framework of a national plan to achieve universal access to antiretroviral therapy for all who need it. Simultaneous with implementation of provider-initiated HIV testing and

counselling, efforts must be made to ensure that a supportive social, policy and legal framework is in place to maximize positive outcomes and minimize potential harms to patients.

Adaptation of this guidance at country level will require an assessment of the local epidemiology as well as the risks and benefits of provider-initiated HIV testing and counselling, including an appraisal of available resources, prevailing standards of HIV prevention, treatment, care and support, and the adequacy of social and legal protections available. Implementation of provider-initiated HIV testing and counselling should be undertaken in consultation with key stakeholders, including civil society groups and people living with HIV/AIDS.

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

Endorsement of provider-initiated HIV testing and counselling by WHO and UNAIDS is not an endorsement of coercive or mandatory HIV testing. WHO and UNAIDS do not support mandatory or compulsory testing of individuals on public health grounds.

2. RECOMMENDATIONS

Guidance on provider-initiated HIV testing and counselling in this document is categorized according to the following HIV epidemic types:

1. Low-level HIV epidemics

Although HIV may have existed for many years, it has never spread to substantial levels in any sub-population. Recorded infection is largely confined to individuals with higher risk behaviour: e.g. sex workers, drug injectors, men having sex with other men. Numerical proxy: HIV prevalence has not consistently exceeded 5% in any defined sub-population.

2. Concentrated HIV epidemics

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

3. Generalized HIV epidemics

HIV is firmly established in the general population. Although sub-populations at high risk may contribute disproportionately to the spread of HIV, sexual networking in the general population is sufficient to sustain an epidemic independent of sub-populations at higher risk of infection. Numerical proxy: HIV prevalence is consistently over 1% in pregnant women.

- **Recommendations for all epidemic types**

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

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

- **Recommendations for generalized epidemics**

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

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

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

- Medical inpatient and outpatient facilities, including tuberculosis clinics.
- Antenatal, childbirth and postpartum health services.
- Health services for most-at-risk populations.
- Services for younger children (under 10 years of age).
- Surgical services.
- Services for adolescents.
- Reproductive health services, including family planning.

- **Options for concentrated and low-level HIV epidemics**

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

If data show that HIV prevalence in patients with tuberculosis is very low, the recommendation of HIV testing and counselling to these patients may not remain a priority.

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

- STI services
- Health services for most-at-risk populations
- Antenatal, childbirth and postpartum services
- Tuberculosis services.

3. ENABLING ENVIRONMENT

Provider-initiated HIV testing and counselling should be accompanied by a recommended package of HIV-related prevention, treatment, care and support services shown in Section 5. Although not all the services need necessarily be available in the same facility as where the HIV test is performed, they should be available through local referral. Although access to antiretroviral therapy should not be an absolute prerequisite for the implementation of provider-initiated HIV testing and counselling, there should at least be a reasonable expectation that it will become available within the framework of a national plan to achieve universal access to antiretroviral therapy for all who need it.

Antiretroviral prophylaxis and infant feeding counselling are important interventions for the prevention of mother-to-child transmission. These interventions must be available as part of the standard of care for pregnant women who are diagnosed HIV-positive through provider-initiated HIV testing and counselling.

At the same time as provider-initiated HIV testing and counselling is implemented, equal efforts must be made to ensure that a supportive social, policy and legal framework is in place to maximize positive outcomes and minimize potential harms to patients. This includes:

- Community preparedness and social mobilization
- Adequate resources and infrastructure
- Health care provider training
- Health care provider codes of conduct and methods of redress for patients
- A strong monitoring and evaluation system.

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

Governments may also need to develop and implement clear legal and policy frameworks that stipulate 1) the specific age and/or circumstances in which minors may consent to HIV testing for themselves or for others, and 2) how the assent of and consent for adolescents should best be assessed and obtained.

4. PRE-TEST INFORMATION AND INFORMED CONSENT

Depending on local conditions, pre-test information can be provided in the form of individual information sessions or in group health information talks. Informed consent should always be given individually, in private, in the presence of a health care provider. When recommending HIV testing and counselling to a patient, the health care provider should at a minimum provide the patient with the following information:

- The reasons why HIV testing and counselling is being recommended
- The clinical and prevention benefits of HIV testing and the potential risks, such as discrimination, abandonment or violence
- The services that are available in the case of either an HIV-negative or an HIV-positive test result, including whether antiretroviral treatment is available
- The fact that the test result will be treated confidentially and will not be shared with anyone other than heath care providers directly involved in providing services to the patient
- The fact that the patient has the right to decline the test and that testing will be performed unless the patient exercises that right
- The fact that declining an HIV test will not affect the patient's access to services that do not depend upon knowledge of HIV status
- In the event of an HIV-positive test result, encouragement of disclosure to other persons who may be at risk of exposure to HIV
- An opportunity to ask the health care provider questions.

Patients should also be made aware of relevant laws in jurisdictions that mandate the disclosure of HIV status to sexual and/or drug injecting partners.

Verbal communication is normally adequate for the purpose of obtaining informed consent. Jurisdictions that require consent to be given in writing are encouraged to review this policy.

Some patient groups may be more susceptible to coercion to be tested and to adverse outcomes of disclosure of HIV status such as discrimination, violence, abandonment or incarceration. In such cases, providing additional information beyond the minimum requirements defined in this document may be appropriate to ensure informed consent.

Pre-test information for women who are or may become pregnant should also include:

- The risks of transmitting HIV to the infant
- Measures that can be taken to reduce mother-to-child transmission, including antiretroviral prophylaxis and infant feeding counselling
- The benefits to infants of early diagnosis of HIV.

Special considerations apply in the case of children and adolescents who are below the legal age of majority (usually 18 years of age). As minors, children cannot legally provide informed consent. However, they have the right to be involved in all decisions affecting their lives and to make their views known according to their level of development. Every attempt should be made to inform and involve the child and to obtain her/his assent. Informed consent from the child's parent or guardian is required. More detailed discussion of consent for children and adolescents is considered in Section 6.1.3.

Declining an HIV test should not result in reduced quality or denial of services that do not depend on knowledge of HIV status.

5. POST-TEST COUNSELLING

Post-test counselling is an integral component of the HIV testing process. All individuals undergoing HIV testing must be counselled when their test results are given, regardless of the test result. Counselling for those whose test result is *HIV-negative* should include the following minimum information:

- An explanation of the test result, including information about the window period for the appearance of HIV-antibodies and a recommendation to re-test in case of a recent exposure
- Basic advice on methods to prevent HIV transmission
- Provision of male and female condoms and guidance on their use.

The health care provider and the patient should then jointly assess whether the patient needs referral to more extensive post-test counselling session or additional prevention support.

In the case of individuals whose test result *is HIV-positive*, the health care provider should:

- Inform the patient of the result simply and clearly, and give the patient time to consider it
- Ensure that the patient understands the result
- Allow the patient to ask questions
- Help the patient cope with emotions arising from the test result
- Discuss any immediate concerns and assist the patient to determine who in her/his social network may be available and acceptable to offer immediate support
- Describe follow-up services that are available in the health facility and in the community, with special attention to the available treatment, PMTCT, and care and support services
- Provide information on how to prevent transmission of HIV, including provision of male and female condoms and guidance on their use
- Provide information on other relevant preventive health measures such as good nutrition, use of co-trimoxazole and, in malarious areas, insecticide-treated bed nets
- Discuss possible disclosure of the result, when and how this may happen and to whom
- Encourage and offer referral for testing and counselling of partners and children.
- Assess the risk of violence or suicide and discuss possible steps to ensure the physical safety of patients, particularly women, who are diagnosed HIV-positive
- Arrange a specific date and time for follow-up visits or referrals for treatment, care, counselling, support and other services as appropriate (e.g. tuberculosis screening and treatment, prophylaxis for opportunistic infections, STI treatment, family planning, antenatal care, opioid substitution therapy, and access to sterile needles and syringes).

Post-test counselling for pregnant women whose test result is HIV-positive should also address the following:

- Childbirth plans
- Use of antiretroviral drugs for the patient's own health, when indicated and available, and to prevent mother-to-child transmission
- Adequate maternal nutrition, including iron and folic acid
- Infant feeding options and support to carry out the mother's infant feeding choice
- HIV testing for the infant and the follow-up that will be necessary
- Partner testing.

6. FREQUENCY OF TESTING

Recommendations about re-testing will depend on the continued risks taken by the patient, the availability of human and financial resources and HIV incidence in the setting. Re-testing every 6-12 months may be beneficial for individuals at higher risk of HIV exposure.

HIV-negative women should be tested as early as possible in each new pregnancy. Repeat testing late in pregnancy should also be recommended to HIV-negative women in generalized epidemic settings.

7. HIV TESTING TECHNOLOGIES

The advantages of using rapid HIV tests for provider-initiated HIV testing and counselling – particularly for health facilities where laboratory services are weak – include visibility of the test and quick turn-around, increasing confidence in results and avoidance of clerical errors. Rapid HIV testing can occur outside laboratory settings, does not require specialized equipment and can be carried out in primary health facilities.

ELISA tests may be preferable in settings where large numbers of tests need to be performed, where immediate provision of test results is less important (such as for hospital inpatients) and in reference laboratories. However, ELISA tests require specialized laboratory equipment and staff.

Decisions on whether to use HIV rapid tests or ELISA for provider-initiated HIV testing and counselling should take into account factors such as the setting in which testing is proposed; cost and availability of the test kits, reagents and equipment; available staff, resources and infrastructure; the number of samples to be tested; sample collection and transport and the ability of individuals to return for results.

Virological testing, while more complex and expensive, is recommended for diagnosing HIV in children less than 18 months old.

8. PROGRAMMATIC CONSIDERATIONS

Decisions on how best to implement provider-initiated HIV testing and counselling will depend upon an assessment of the situation in a particular country, including local epidemiology; the available infrastructure, financial and human resources; the available standard of HIV prevention, treatment, care and support, and the existing social, policy and legal frameworks for protection against adverse consequences of HIV testing, such as HIV-related discrimination and violence. Where there are high levels of stigma and discrimination and/or low capacity of health care providers to implement provider-initiated HIV testing and counselling under the conditions of informed consent, confidentiality and counselling, adequate resources should be devoted to addressing these issues prior to implementation. Decisions around implementation should be made in consultation with all relevant stakeholders, including civil society groups and people living with HIV/AIDS.