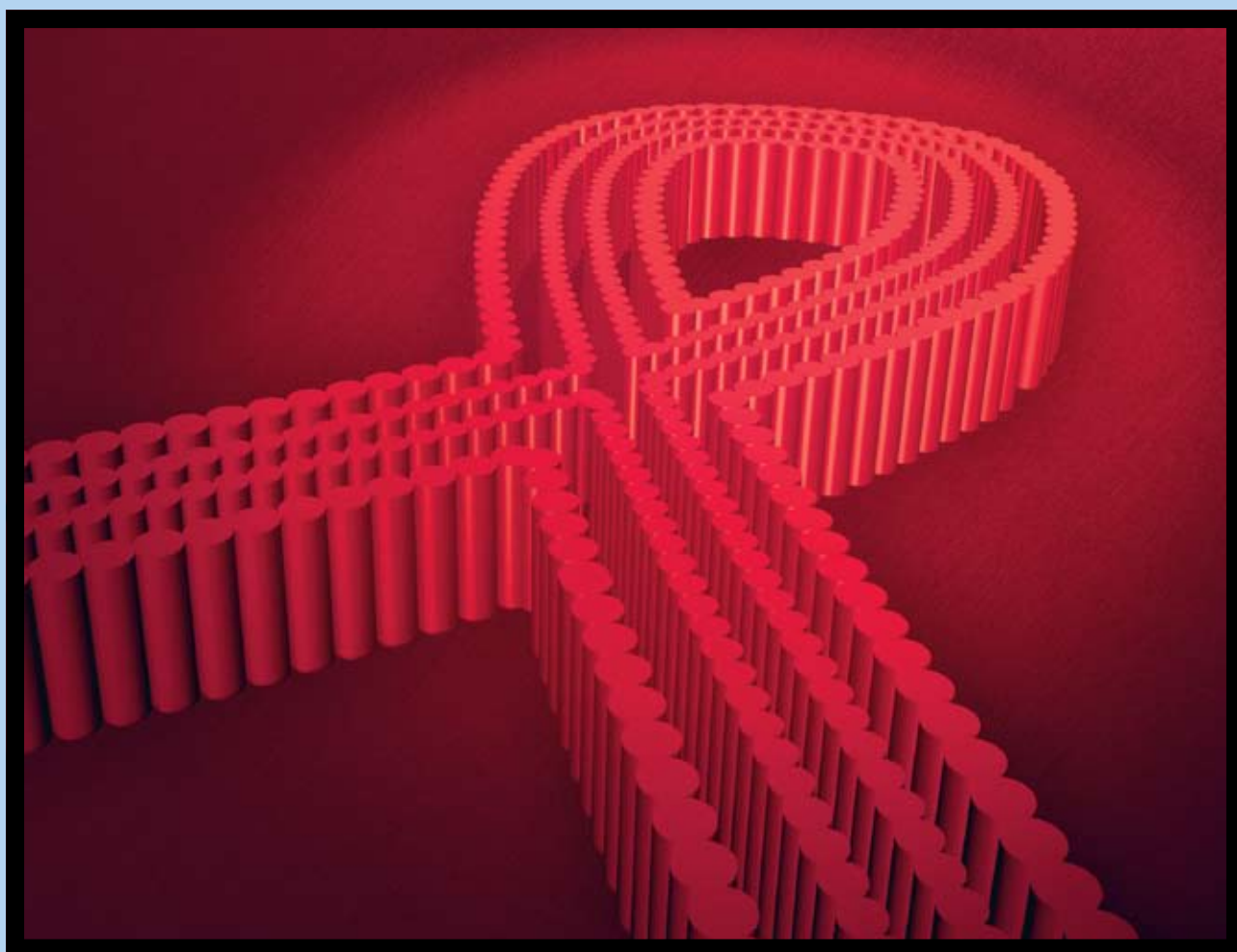


The situation of HIV testing and counselling policies and practices in the Eastern Mediterranean Region



The situation of HIV testing and counselling policies and practices in the Eastern Mediterranean Region

WHO Library Cataloguing in Publication Data

World Health Organization. Regional Office for the Eastern Mediterranean

The situation of HIV testing and counselling policies and practices in the Eastern Mediterranean Region /

World Health Organization. Regional Office for the Eastern Mediterranean

p. .- (EMRO Technical Publications Series ; 38)

ISBN: 978-92-9021-790-9

ISBN: 978-92-9021-791-6 (online)

ISSN: 1020-0428

I. HIV Infections – diagnosis - Eastern Mediterranean Region 2. Regional Medical Programs 3. Counseling - methods I. Title II. Regional Office for the Eastern Mediterranean III. Series
(NLM Classification: WC 503.1)

© World Health Organization 2011

All rights reserved.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use.

Publications of the World Health Organization can be obtained from Distribution and Sales, World Health Organization, Regional Office for the Eastern Mediterranean, PO Box 7608, Nasr City, Cairo 11371, Egypt (tel: +202 2670 2535, fax: +202 2670 2492; email: PAM@emro.who.int). Requests for permission to reproduce, in part or in whole, or to translate publications of WHO Regional Office for the Eastern Mediterranean – whether for sale or for noncommercial distribution – should be addressed to WHO Regional Office for the Eastern Mediterranean, at the above address: email: WAP@emro.who.int .

Design, layout and printing by WHO Regional Office for the Eastern Mediterranean, Cairo, Egypt

Contents

Acknowledgements	5
1. Introduction	7
2. Methods	8
3. Findings	8
4. Discussion	12
5. Conclusion	14

Acknowledgements

The situation of HIV testing and counselling policies and practices in the Eastern Mediterranean Region is the product of a collaboration between WHO Regional Office for the Eastern Mediterranean and Family Health International. It was written by Jenny Petrak, Derbyshire Royal Infirmary, Department of Genitourinary Medicine, United Kingdom. The draft was reviewed and revised by Gabriele Riedner and Joumana Hermez, WHO Regional Office for the Eastern Mediterranean. Technical contributions were also received from Mehdi Karkouri, Faculté de Médecine et Pharmacie de Casablanca/Association marocaine de Lutte Contre le Sida; and Cherif Soliman, Karina Shalaby, Doaa Oraby, Sherif Elkamhawi and Rawya Hassan, Family Health International, Cairo.

I. Introduction

Knowing one's HIV status is a prerequisite for access to HIV care and treatment services. However, the vast majority of people living with HIV in the WHO Eastern Mediterranean Region are not aware of their HIV infection and less than 10% of the estimated number of people living with HIV (PLHIV) in need of life-saving anti-retroviral therapy (ART) are receiving it. Knowing one's HIV status by obtaining an HIV test has still not become a viable option for most people at risk of HIV infection in the Region. Limited access to confidential HIV testing services, lack of risk awareness, fear of stigmatization and discrimination in families, communities, at schools and workplaces, including the violation of human rights are all factors contributing to this situation.

WHO and UNAIDS have developed guidance for HIV programmes on how to promote access to and utilization of HIV testing and counselling by getting services out to the communities affected, developing the most appropriate models, involving civil society organizations, and ensuring that it is beneficial for people at risk to know their HIV status. A WHO and UNAIDS HIV testing policy statement¹ emphasizes the importance of HIV testing and counselling as an entry point to HIV prevention, treatment and care services. It also stresses the principles of HIV testing: that it should be voluntary; that it should only be performed with the consent of the client; that it should always be accompanied by counselling; and that the confidentiality of the counselling and the test results should always be observed.

In 2008, the WHO Regional Office for the Eastern Mediterranean commissioned a review of HIV testing and counselling policy and practice in the Eastern Mediterranean Region.

This publication is a brief synthesis of the findings of a literature review on HIV testing and counselling policy and practice in the Region and of case studies on the topic carried out in Egypt, Oman, Pakistan and northern Sudan. The aims and objectives of this review were to: 1) establish an overview of testing and counselling policies and practices in the Region, including voluntary (client-initiated and provider-initiated) and mandatory testing; 2) assess the level of conformity of HIV testing and counselling policies and practices with global recommendations; 3) explore the implications of current HIV testing and counselling policies and practice for beneficiaries, including vulnerable groups and key populations at increased risk of HIV; and 4) document the strengths and weaknesses of current HIV testing and counselling policies and practices in the Region and make recommendations for improvements to increase access to and utilization of testing and counselling services.

Inevitably, given the large geographical size of the Region and the low levels of published information on HIV testing and counselling policies and practice, the findings and recommendations presented in this report may not be representative for all countries in the Region. There has been considerable progress in the development of HIV prevention and control programmes in the Region in the past few years. Interventions are continually being adapted in response to advances in technology and to better understanding of local contexts and needs. Recommendations are therefore, inevitably, general, subject to change, and may already reflect some countries' programmes and practice. It is hoped that the findings of this review can be used as the basis for further discussion, enhanced HIV country responses and scale up of programmes.

¹ *UNAIDS/WHO policy statement on HIV testing*. Geneva, WHO/UNAIDS, 2004. Available at www.who.int/hiv/pub/vct/statement/en.

2. Methods

The review synthesizes data obtained through systematic search of published literature and unpublished literature. The findings from the literature review were complemented by information collected through four country case studies. Countries were selected with the intention of reflecting as much as possible the variations across the Region in terms of epidemic level, economic status, social and cultural contexts and maturity of the health system. Sudan and Pakistan are low-income countries and have the highest estimates of PLHIV in the Region. Oman is an upper-middle income country whose policies are agreed jointly with other member countries of the Gulf Cooperation Council. Egypt has many similarities with other Arab countries. The four countries reflect generalized, concentrated and low-level epidemic stages, respectively.

Information was collected on HIV testing carried out for different purposes, in various settings and through different modalities, including voluntary (client-initiated and provider-initiated) testing, blood screening for blood safety, mandatory testing and surveillance testing. In each country visit, the experience of key informants was documented. Key informants include Ministry of Health, National AIDS Programme, WHO and UNAIDS representatives, health service providers, nongovernmental organizations, people living with HIV/AIDS, and those accessing HIV testing services where possible. Programme documents, facility reports, interviews, site visits and observations were used to address the key question of how people learn about their HIV status and what barriers exist to accessing HIV testing and counselling.

3. Findings

Findings from this review suggest that there is wide variability in HIV testing and counselling practice, including voluntary client-initiated and provider-initiated models of HIV testing, with and without counselling, and mandatory screening or testing of certain populations. Many countries have established national policies which conform to global recommendations on ethical practice of HIV testing, treatment and care (Table 1), but these policies are not always being fully implemented.

Coverage of people at risk of HIV with HIV testing and counselling is still low across all the countries of the Region. In contrast, there is widespread mandatory HIV testing occurring, particularly for migrants. HIV testing of migrants accounts for a high number of the HIV tests being performed, and is second only in number to HIV testing of blood products. Key populations at increased risk of HIV, namely sex workers, men who have sex with men and injecting drug users have limited access to HIV testing and counselling services, resulting in tiny proportions of members of those populations groups being reported to be tested for HIV. This situation is aggravated by limited availability of HIV prevention services, and care and treatment tailored to the needs of those population groups. Progress is being made in particular where political leadership is supportive of national AIDS programmes, and where public sector and civil society partnerships are fostered. The key features of the HIV testing and counselling services are summarized as follows.

1. Access to voluntary (client-initiated and provider-initiated) HIV testing and counselling is low.

Most countries report low levels of client- and provider-initiated access to HIV testing and counselling. According to the WHO Universal Access Progress report 2010, the coverage

Table 1. National HIV testing and counselling policies in the Eastern Mediterranean Region

Country	National policy document on HIV testing and counselling exists	Consent to HIV test	Policy requires Confidentiality of HIV test result	Testing to be accompanied by counselling	Promote the use of rapid HIV tests	Policy (same document, other document or unwritten) requiring mandatory testing exists
Afghanistan	Yes	Yes	Yes	Yes	Yes	No
Bahrain	Yes	No	Yes	Yes	No	Yes
Djibouti	Yes	Yes	Yes	Yes	Yes	No
Egypt	Yes	Yes	Yes	Yes	Yes ^b	Yes
Islamic Republic of Iran	Yes	Yes	Yes	Yes	Yes ^b	No
Iraq	Yes	Yes	Yes	Yes	No	Yes
Jordan	Yes	Yes	N/A	Yes	No	Yes
Kuwait	yes	yes	yes	No	No	Yes
Lebanon	Yes	Yes	Yes	Yes	Yes ^b	Yes
Libyan Arab Jamahiriya	Yes	Yes	Yes	Yes	No	Yes
Morocco	Yes	Yes	Yes	Yes	Yes ^b	Yes ^c
Oman	Yes	Yes	Yes	Yes	No	yes
Pakistan	Yes	Yes	Yes	Yes	Yes ^b	No
Occupied Palestinian territory	Yes	Yes	Yes	No	Yes	Yes
Qatar	No	Yes	Yes ^a	Yes	Yes ^b	Yes
Saudi Arabia	Yes	Yes	Yes	Yes	Yes	Yes
Somalia	Yes	Yes	Yes	Yes	Yes	No
Sudan	Yes	Yes	Yes	Yes	Yes	Yes
Syrian Arab Republic	Yes	Yes	Yes ^a	Yes	No	Yes
Tunisia	Yes	Yes	Yes	Yes	Yes ^b	Yes
United Arab Emirates	In process	No	In process	In process	No	Yes
Yemen	Yes	Yes	Yes	Yes	Yes ^b	Yes

^a Except for mandatory partner notification

^b Initial screening test only; if positive should be referred to laboratory for ELISA and/or Western Blot

^c For military only to establish fitness

of HIV testing in the Eastern Mediterranean Region is only 3.6 tests per thousand adult population, including those tests conducted without counselling. The findings from this review suggest that the reasons for this are multi-factorial and complex but not necessarily insurmountable. High levels of stigma among both the general public and local communities and, notably, among health care workers, political sensitivities and cultural constraints consistently emerge as barriers to accessing HIV prevention and care services in the Region.

This has particular impact on marginalized and criminalized populations at risk, such as injecting drug users, men who have sex with men and sex workers. High levels of stigma and discrimination among health care workers were reported in the case studies. Information on locating HIV testing and counselling services is also lacking within countries. Within many countries low levels of literacy and health-care seeking in populations is found.

2. Mandatory HIV testing of some population groups is widespread in most countries.

It is difficult to determine the extent of mandatory HIV testing (sometimes also termed compulsory testing) of populations in the Region although the practice is common particularly as set by regulations of host countries for migrant workers. The practice of HIV testing for immigration purposes, pre-recruitment and periodic medical assessment does not appear to conform to WHO/UNAIDS recommendations that such testing should only be conducted with the knowledge and consent of the individual tested and that individuals found to be HIV positive should be counselled and referred to medical and psychosocial services.

3. HIV testing for blood safety varies, with different levels of compliance with international guidance.

There is considerable international guidance on the standards necessary to ensure a safe nationally coordinated blood transfusion service with collection of blood only from voluntary non-remunerated blood donors from low-risk populations. Universal screening of all donated blood is carried out in the majority of countries. However, in some countries with poor health system infrastructure blood is still transfused unscreened. Case studies revealed variability in practice with, for example, family/replacement donor systems continuing to be prevalent in Egypt, Sudan and Pakistan and with the latter also having a significant commercial or paid donor system. In addition, there is variability in how the blood screening for HIV is practised and whether donors who test positive for HIV or other infectious disease are guaranteed confidentiality and anonymity (e.g. in Oman and Egypt donors are contacted and informed of positive HIV test results whereas in Sudan donors are anonymous and the blood units deferred). In addition information gained

from case studies suggests relatively high rates of infectious disease are being detected in deferred units of blood suggesting difficulties in assessment of donor risk.

4. Many private hospitals and laboratories conduct HIV testing.

Use of private facilities (private laboratories or private hospitals and clinics) for HIV testing seems to be widespread. Regulation of HIV testing practice in private facilities is a challenge for some countries and private providers often do not conform to national policies on voluntary HIV testing and counselling. The four country case studies showed that information, education and communication material is usually not on display and counselling for risk reduction is usually not available in private facilities.

5. Models of client-initiated HIV testing and counselling services (or VCT services) are diverse, however the number of services available is limited.

Most countries make voluntary HIV testing and counselling services available to people who wish to know their personal HIV status. There is a shortage of VCT services in some countries and service quality has rarely been assessed. In some countries VCT is available within hospitals and health facilities, often integrated in tuberculosis, family planning, sexually transmitted infections and antenatal care clinics. VCT services are provided either at fixed site locations or through mobile services (e.g. VCT vans), at some nongovernmental organizations centres, and in some cases within university locations. Some VCT centres are linked to a hotline. The wide range of facilities where HIV testing is conducted has the potential benefit of choice for those seeking testing. However, linkages and referral to HIV treatment, care and support are less developed.

Quality and sustainability of voluntary HIV testing and counselling are also significant issues. Few countries have guidelines or

standard operating procedures specific to implementation of HIV testing and counselling and practice varies within and between countries. While some countries advocate for anonymous testing and counselling, most countries require identification of those accessing such services and reporting of individuals who test HIV-positive to national authorities. In some countries sexual contacts of HIV-positive clients of VCT are proactively contacted. Registration as HIV-positive with national authorities is a requirement to access ART in some countries. Channels of reporting often constitute a breach of confidentiality.

Generally documentation and information on models of voluntary testing and counselling targeting primarily people at increased risk of HIV are lacking, with the exception of the Islamic Republic of Iran's programme for injecting drug users and the programmes of Lebanon and Morocco for men who have sex with men and sex workers.

6. Provider-initiated testing and counselling is still rarely implemented. In some cases it is confused with mandatory testing

Information gained from case studies in this review suggests that provider-initiated approaches to HIV testing are being applied, however this is still rare. The practice of provider-initiated testing and counselling is varied, and there is low familiarity with the model articulated by WHO. In some cases the model is being implemented, but programme managers and service providers do not perceive it as that. For example, most people in Sudan access HIV testing and counselling linked to hospital sites based on referral if they are suspected of having HIV-related symptoms. However, while Sudan does not currently use the term provider-initiated testing and counselling, HIV testing and counselling services generally follow principles of informed consent, counselling

and confidentiality. Information on how widely provider-initiated testing and counselling is available within antenatal care settings as a component of prevention of mother-to-child transmission is limited. In many other countries, HIV testing may be provider-initiated but not involve consent, as evidenced by high rates of mandatory or compulsory testing for persons with tuberculosis, sexually transmitted infections or persons undergoing surgery (pre-operative screening).

7. National HIV testing protocols may require multiple confirmatory HIV testing of reactive tests by national laboratories and can result in a “long journey” to diagnosis.

Many countries require specimens to be sent to national referral laboratories for confirmation of all HIV test results. Three of the four countries in the case studies require further confirmation of all reactive HIV test results using complex laboratory techniques rather than simple rapid HIV tests. This can result in delayed results and poses a significant barrier. For example, community services may be prohibited from providing HIV positive test results until blood results are sent to the central laboratory and returned; or initial reactive rapid test results may require persons to attend public or private health sites for further HIV testing and counselling with associated costs of travel.

8. PLHIV organizations and networks do not exist in some countries, or if they do, they require strengthening.

The case studies revealed that the involvement and mobilization of PLHIV is varied. Pakistan seems to have relatively active PLHIV organizations. Oman has no established PLHIV organization. Sudan has a national organization for PLHIV which appears to be in great need of capacity-building. While Egypt has an established PLHIV organization, The Friends of Life, the difficulties associated with being

open about one's HIV status within the country context was emphasized. Other countries have also reported varying degrees of involvement of PLHIV. It is not clear how representative these findings are of the entire Region but they do at least suggest that challenges lie ahead for ensuring the full involvement of PLHIV in advocacy and services.

9. Very few countries provide targeted services for key populations at increased risk of HIV.

While there is a lack of published evidence of good practice in voluntary HIV testing and counselling in the Region this does not mean that examples do not exist. With regard to reaching most-at-risk populations with HIV testing and counselling services some interesting examples of successful approaches were found, particularly among nongovernmental organizations in Egypt, Pakistan and Sudan. These countries are working to increase access to voluntary HIV testing and counselling and prevention interventions focusing on populations such as injecting drug users, men who have sex with men, sex workers and prisoners. Notably the national AIDS control programme in the Islamic Republic of Iran has developed a pioneer national comprehensive approach to harm reduction for injecting drug users inside and outside prisons. Through a model called triangular clinics, injecting drug users are provided with a combination of VCT, HIV care and support, care for sexually transmitted infections and harm reduction services. The case studies found that where such targeted services for key populations at increased risk exist, their level of coverage with HIV testing and counselling remains largely unknown and record keeping and monitoring of service utilization require strengthening.

4. Discussion

Information gained from the review and case studies suggests that the practice of HIV testing and counselling and linkages to treatment, care and support in the Region vary. It should be borne in mind that policies and practices are never static. Policies across the 22 countries under consideration may be either under development or being updated, and practices are being adapted and enhanced as new guidance emerges. Table 1 presents a summary of country policies relating to HIV testing and counselling. Most countries also have, or are developing, specific HIV testing policies that either exist in addition to or are integrated within national AIDS control programmes and strategic plans. Most of those support voluntary HIV testing and counselling and mention strategies for reaching populations at increased risk. However, substantial gaps remain in service provision and implementation of policy. Often parallel policies exist that promote mandatory testing of certain population groups.

Strategic information is vital to inform and monitor national responses to the HIV epidemic and this repeatedly emerges as an area requiring strengthening. However, there is a distinct lack of published evidence on successful programmes which include voluntary HIV testing and counselling and prevention initiatives. Generally limited data is available on the HIV epidemic in the Region with large amounts of missing information in major global epidemic reports. More recent information on the HIV epidemic emerged during the writing of this report from the Middle East and North Africa (MENA) HIV/AIDS Synthesis Project, providing potentially the first major overview of HIV transmission trends and dynamics in the Region from a number of data sources. However, the report states that most data available in the Region lack accuracy and are not based on

representative samples of the populations they refer to. Similarly, very few programmes in countries collect monitoring and evaluation data on the HIV response and consequently, there is very little published information on levels of coverage, outcomes and impacts of the different interventions. It is not clear how many countries have specific policy and guidance on monitoring and evaluation aspects of HIV testing and counselling although it is likely that it is needed.

Expanded HIV testing efforts in the Region have led to increasing numbers of reported cases. However, availability and utilization of voluntary testing and counselling services remain low. Across the Region mandatory testing accounts for the majority of tests being performed. Migrant and foreign workers are by far the group most subjected to mandatory testing. Some PLHIV interviewed during the country visits have reportedly been deported from their host countries abroad, when they were mandatorily tested for HIV and found positive. One interviewee reportedly was deported without even knowing why, and without knowing the HIV test result. This practice has ethical implications as well as negative consequences for the health of the individual and for the family and community s/he is returning to since HIV can be transmitted unknowingly. There is no evidence to support the practice of mandatory HIV testing on public health grounds and it is not an effective use of health care resources. This practice does not conform with WHO and UNAIDS guidelines on human rights and HIV. Resources would be more effectively used if HIV testing and counselling were linked to targeted interventions for most at-risk populations.

The findings from this review suggest that the route towards accessing HIV testing and finding out the result is often problematic and disjointed. Barriers to accessing HIV testing include difficulties in addressing the sensitive

content of HIV prevention, including sex outside marriage and same-sex behaviour, the limited availability of services targeting key populations at increased risk of HIV, and high levels of stigma and discrimination in health care settings and among the general public.

There is little information available on the extent of provider-initiated testing and counselling in antenatal care, tuberculosis and sexually transmitted infections service settings. The review has established that access to HIV testing in antenatal care settings was found to be low. Strategies for expanding coverage of provider-initiated testing and counselling within the countries of the Region need to take into consideration the particular epidemic and country contexts. WHO promotes provider-initiated HIV testing and counselling for all pregnant women for prevention of mother-to-child transmission. How widely provider-initiated testing and counselling for tuberculosis patients should be implemented will depend on local HIV prevalence in this group. Nevertheless, training on provider-initiated testing and counselling and in particular linked to the broader programme of prevention, treatment, care and support could be initiated within health care settings and programmes.

HIV testing algorithms which support rapid testing and which, by providing results on the same day, are less invasive and enhance follow-up to care, are also needed. Much progress has been made in the past few years in increasing access to HIV testing and counselling in the Region and now the challenge is to ensure the approaches used are ethical, sustainable, available and of best quality. As access to HIV testing and counselling is expanded, and in particular made more accessible to mobile and at-risk populations, it will be crucial to ensure that HIV test results are available on the spot.

5. Conclusion

Despite the challenging sociocultural context in the Region, there are many opportunities to effectively address this issue. High levels of political commitment, increased public awareness of HIV, and increased community-based involvement are required as a minimum to ensure that levels of stigma are reduced. Much can be achieved to overcome stigma associated with HIV with access to services that are confidential, non-judgmental, and non-discriminatory. Health care workers can be trained and codes of practice developed and implemented to ensure that people living with HIV/AIDS are treated with the same dignity, care and respect as any other persons accessing health care.

The public health benefits of voluntary HIV testing and counselling are well-established. As countries are encouraged to scale-up their HIV testing programmes, there is equally a need to ensure user involvement in their design and to ensure that PLHIV organizations and networks are established to meet the support needs of increasing numbers of people testing HIV positive. Advocates for people living with HIV/AIDS have always played a leading role in fighting HIV stigma and ensuring that human rights are protected. Such advocates are needed in the Region as human rights are not always protected with stories emerging of, for example, forced HIV testing of various population groups. PLHIV support organizations and networks would also benefit from further capacity-building to provide home-based care and treatment adherence support. It is important that key stakeholders, including programme managers, health care providers, PLHIV and civil society organizations, work in collaboration to increase understanding and to address the challenges and barriers faced by people living with HIV/AIDS in accessing comprehensive services in the Region. There is also a need to strengthen linkages between

outreach services, voluntary HIV testing and counselling services, and treatment and care.

Experiences around the world suggest that confidentiality and, in some cases, anonymity of HIV testing and counselling may be particularly important for increasing access for high-risk populations (e.g. men who have sex with men, sex workers, and injecting drug users) who may fear censure or even arrest as well as high levels of stigma and discrimination. Comprehensive HIV prevention approaches which support confidential and voluntary HIV testing and counselling should be promoted for those groups.

In conclusion, countries and their technical partners should focus their efforts on ensuring the following.

1. Location and delivery of HIV testing and counselling, along with other health care services, near to the populations most affected.
2. Development of models of provider-initiated testing and counselling in health facilities for antenatal care, tuberculosis, sexually transmitted diseases and other hospital and clinic populations in the Region. Rolling-out provider-initiated testing and counselling, however, will require particular attention in order to address the high levels of stigma and discrimination within health care settings.
3. Exploration of reasons for low access to and utilization of client-initiated testing and counselling. Findings should be used to enhance programme responses in each country to increase access to client and provider-initiated HIV testing and counselling and highlighting the benefits of knowing one's HIV status.
4. Application of a mix of models for client-initiated and provider-initiated HIV testing and counselling with a view to increasing access to and utilization by all

- relevant population groups and addressing their diverse needs.
5. Encouraging private hospitals and laboratories conducting HIV testing to make practice accountable to national policies.
 6. Closer involvement of civil society organizations in the provision of targeted services to at-risk populations including injecting drug users, men who have sex with men and sex workers across the Region.
 7. Strengthening PLHIV organizations and other civil society groups through capacity-building and greater involvement in national and regional policy and programmes.
 8. Updating and simplifying HIV testing algorithms to include the option of rapid testing for confirming HIV reactive tests. This would allow same-day delivery of test results by public health and/or qualified community-based services in a quality assured manner. Countries which are implementing national algorithms incorporating rapid testing (e.g. Sudan) are encouraged to share their findings with other countries in the Region in order to address concerns such as quality assurance and specificity of test results.

