Agenda item 3

UNAIDS/PCB (54)/24.5

FOLLOW-UP TO THE THEMATIC SEGMENT FROM THE 53RD PCB MEETING

Testing and HIV

25–27 June 2024 | Geneva, Switzerland
UNAIDS Programme Coordinating Board
Issue date: 14 May 2024

Additional documents for this item: *UNAIDS/PCB (53)/23.35; UNAIDS/PCB (53)/23.36; UNAIDS/PCB (53)/CRP2*

Action required at this meeting—the Programme Coordinating Board is invited to:
See draft decision points in the paragraphs below:

51. *Take note* of the background note (UNAIDS/PCB (53)/23.35) and the summary report (UNAIDS/PCB (54)/24.5) of the Programme Coordinating Board thematic segment on "Testing and HIV";

52. *Request* Member States, in collaboration with community-led HIV organizations and other relevant HIV-related organizations, with the support of the Joint Programme, to fast-track targeted and measurable actions towards the 2025 targets to:

    a. Accelerate the implementation of evidence-based programmes and people-centred differentiated approaches that include facility-based and community-based testing, self-testing and other approaches, focusing on key[1] and other priority populations, as relevant to the national context;

    b. Encourage community-led service provision through the participation and meaningful engagement of community and other civil society organizations in HIV testing services and in increasing demand for testing, and by using community-generated data as a complement to data that are sourced from monitoring and evaluation systems to inform decision-making around service quality improvement;

    c. Update relevant policies to enable and support trained lay-providers, especially people living with HIV and members of key and other priority populations, to perform HIV rapid diagnostic testing;

    d. Ensure quality of testing and testing services to prevent misdiagnoses;

    e. Implement HIV testing programmes as part of a holistic and integrated package that links with prevention, treatment and care services for HIV and other health issues within the framework of primary health care, considering U=U messaging, while continuing scientific research;

    f. As appropriate, revisit legal provisions on the age of consent for HIV testing to ensure that they respond to the needs of adolescents in different country contexts;

    g. Increase efforts to reduce stigma and discrimination associated with HIV and promote service approaches that are led and monitored by key and other priority populations for greatest access and appropriate linkage, and consider mainstreaming gender issues into HIV service delivery;

    h. Close the HIV testing gap, including by addressing gaps in research and quality data;

    i. Use the TRIPS flexibilities to make testing-related health technologies, including diagnostic technologies, more accessible and affordable; and

    j. Increase domestic resource allocations to HIV testing services, including diagnostic, CD4 and viral load testing, as part of essential health services to be included in the national health benefits packages, and enhance programme design and health system functions, including procurement and supply chain management for uninterrupted supply of testing commodities as needed to achieve greater efficiency.

1. As defined in the Global AIDS Strategy 2021-2026.

Cost implications for the implementation of the decisions: none *

Introduction and keynote addresses

1. The thematic segment focused on HIV testing as the gateway to HIV prevention, treatment, care and support services, and on practical approaches to make testing services person-centred, individual and community needs-focused, integrated, functional, effective and sustainable.

2. Angeli Achrekar, Deputy Executive Director at UNAIDS, introduced the thematic segment and handed the floor to Winnie Byanyima, UNAIDS Executive Director, who hailed the strong progress made in expanding HIV testing and treatment services. In 2022, she said, five African countries had reached the 95–95–95 targets ahead of the 2025 timeline and 16 countries, eight of them in Africa, were close to doing so. But major gaps also remained. Globally, 86% of people living with HIV knew their HIV status, but only 63% of children living with HIV had been diagnosed. The diagnosis of HIV infection among key populations also lagged. Undiagnosed people living with HIV were not benefiting from combination prevention and treatment services.

3. Various testing modalities were being used, but not yet at the scale required, Ms Byanyima said, while some policies (e.g. strict age-of-consent requirements) made testing access difficult, as did the criminalization of key populations, and stigma and discrimination in health-care services. Yet, some countries were doing well and had important lessons to share, she said.

4. Kevin Fenton, Regional Director for London in the Department of Health and Social Care's Office for Health Improvement and Disparities (OHID)in the United Kingdom's Department of Health and Social Care, briefly described the HIV epidemic in England, where the 95–95–95 targets had already been reached. He told the meeting that new HIV diagnoses had decreased markedly since their peak in 2005 and had fallen by 33% between 2019 and 2021. However, the rate of decline was now slowing and there were signs of increasing HIV diagnoses among people of colour and young men who have sex with men.

5. Strong community engagement had been crucial for the achievements, along with strong political commitment to end AIDS across all political parties, Mr Fenton explained. In 2019, three large national charities had set up a participatory HIV commission, which developed a strategic plan for England. The Government created an HIV oversight group which worked with the Department of Health to deliver the HIV Action Plan, which was launched in 2021. The Plan focused on achieving equitable access to HIV prevention; scaling up testing; optimizing rapid access to treatment; addressing stigma; and improving the quality of life for people living with HIV. The Action Plan was being led by a national implementation steering group, with a community advisory group providing additional input.

6. An example of a successful testing approach, Mr Fenton said, was the scale up of HIV and hepatitis C virus (HCV) testing in emergency departments in London hospitals, using an opt-out approach. This had doubled HIV testing capacity in the city and had identified 934 previously undiagnosed people living with HIV and 3,000 people living with hepatitis C. HIV-related stigma remained a key challenge, however, even though data from the United Kingdom showed it continued to decline due to actions taken. The Action Plan included interventions such as additional training for health-care workers and partnering with communities to reduce stigma. Ultimately, though, communities had to be at the centre of the response, Mr Fenton said, with committed leadership, clear governance and strong accountability the other crucial factors for a successful HIV testing strategy.

7. Daughtie Ogutu, Programme Manager at GNP+ in Kenya, credited her survival as a

mother living with HIV to being able to access HIV testing and regular viral load testing. But many people lacked access to HIV testing, she said, even though it was the first line of defence against HIV; each person who takes an HIV test helps break the chain of HIV transmission. It was vital for people living with HIV to know that they cannot transmit HIV once their viral loads are undetectable, she added. Ms Ogutu also underscored the need for timely diagnosis and treatment of cryptococal meningitis (the second-leading cause of death among people living with HIV), and called for easier access to CD4 testing and relevant screening.

8. The necessary testing technologies had to be available to all, Ms Ogutu insisted, but testing kits were lacking in some countries. As well, social, economic and cultural barriers still blocked access, and stigma and discrimination kept many people away from life-saving services. Testing services had to be culturally sensitive, inclusive and respectful. Community-based testing was highly acceptable, including for key and other priority populations, and studies showed that community-led testing can help diagnose people with HIV at early stages after infection and link them to treatment. Access to testing was not a privilege, but a fundamental right, she said and called for greater inclusivity (including of key populations and young people in all their diversity); letting communities lead testing; and more funding for community-led testing.

Session overview

9. Meg Doherty, Director of the Global HIV, Hepatitis and STI Programmes at the World Health Organization, presented a summary of the background note. She said new data showed that testing access had increased and that the number of new HIV infections were declining overall. New HIV testing innovations, when used widely, were boosting progress towards global HIV targets. However, large numbers of people remained at high, ongoing risk for HIV, and were not being reached with high impact HIV prevention services: knowledge of HIV status was only 60–67% across different key populations, for example. Testing services were also missing the partners of people living with HIV, and people with other sexually transmitted infections (STIs), and there were gaps in testing and treatment for children, and for pregnant and breastfeeding women. Syphilis testing rates in ANC were suboptimal and lagging behind. Men generally were underserved by testing and treatment services (about 83% of men living with HIV knew their HIV status compared with 90% of women). If treatment access in sub-Saharan Africa were equal for men and women, new HIV infections in women could be reduced by 50% or more, Ms Doherty said, citing recent study evidence.

10. In addition, she warned, CD4 testing levels were declining and two point-of-care CD4 test manufacturers had exited the market. Yet it was vitally important to know whether a person diagnosed with HIV had advanced HIV disease: up to 50% of cases of advanced HIV disease would be missed in the absence of CD4 baseline testing. Point-of-care viral load testing access had also stalled during and after the COVID-19 pandemic, though multiplex testing platforms can be leveraged to improve access. Stigma and discrimination also continued to hinder people from using and benefiting from HIV testing and treatment services, she said.

11. Turning to possible solutions, Ms Doherty said HIV self-testing was a big opportunity, but it was being introduced at scale mainly in sub-Saharan and was relatively scarce in Asia and the Pacific, and in the Caribbean. In Zambia, "one-stop-shop" men's clinics were using self-testing approaches to achieve high testing yields with strong linkage to care. Workplace testing for men was also performing well. Social network testing was increasing among key populations, though it was important to see how it could be scaled up while avoiding any risk of harm to members of key populations. Viral load testing could be scaled up by making full use of diagnostics networks and by using

available testing platforms more efficiently, she added.

12. Looking ahead, Ms Doherty highlighted three areas of improvement: mobilize and create demand for testing; use accessible and acceptable service delivery approaches; and ensure linkage to post-test services. She urged countries to pick the most appropriate options; use a strategic mix of differentiated testing approaches; and ensure that testing services are of a high quality to avoid misdiagnosis.

13. Speaking from the floor, participants thanked the Secretariat for staging the segment and preparing the background note, and thanked the panelists for sharing their knowledge and experiences. Several speakers described the testing and prevention services that were available in their countries and reiterated that HIV testing was an entry point for the prevention and treatment of HIV and other infections, and for realizing people's sexual and reproductive health and rights.

14. Speakers stressed the importance of integrating testing services with broader sexual and reproductive health services within a primary health care approach. Also needed was public education about HIV testing, including through comprehensive sexuality education. Testing services should be available at low-threshold services for people who use drugs and who sell sex, they added, and people who take an HIV test must receive and fully understand their test results.

15. The meeting was reminded that, although HIV testing science had improved a great deal, the world had not yet reached the target of having 95% of people living with HIV know their HIV status. Discrimination and criminalization were major obstacles and the pushback against human rights and gender equality was aggravating the situation. Community-led organizations needed the space, resources and capacity to play their full roles in bringing HIV testing to everyone who needed it. Health system weaknesses were also undermining testing and treatment. In addition to financial support, successful testing strategies required enabling legal and policy environments; the elimination of stigma and discrimination; increased HIV literacy; sustainable supply chains; and strong leadership, speakers said.

16. Innovative approaches to self-testing could be used to reach populations who were being missed. Speakers highlighted the work of Unitaid, which had helped develop and distribute self-testing kits, as well as facilitate price decreases and the adoption of self-testing policies. However, it was noted that the persistence of late diagnoses of HIV infection had implications for the use of rapid self-testing to improve testing and treatment uptake and outcomes. In Brazil, for example, about 30% of people diagnosed with HIV were found to be in WHO clinical stage 3 or 4. Loss to follow-up was another persistent problem.

17. Responding to remarks from the floor, Mr Fenton said the uptake of opt-out testing was very high (>90% in London) and that people who declined the offer typically already knew their HIV status. The opt-out approach was also highly acceptable to health-care workers. He said HIV programmes should attempt to test at the scale needed to achieve their population-level goals. The introduction of opt-out testing in England had doubled the testing capacity, which meant that hundreds of thousands more people got an HIV test. No single testing method or approach was appropriate for everybody, however. Programmes should discover which kind of testing works best for whom—and communities were best-placed to answer those questions.

18. Ms Ogutu also stressed the need for inclusivity and for letting communities lead. She called for greater investment in community-led testing and monitoring, which would also boost retention in treatment and care. Unfortunately, HIV self-testing was not yet a realistic option for many people in many places, she noted: it was not available

everywhere and remained expensive in many countries. Ms Ogutu urged that self-testing be made affordable and accessible, especially for communities who are hard to reach. Agreeing, Ms Doherty also noted that linkage to care remained a challenge, partly because it required additional testing for confirmation. More public education about the benefits of HIV testing, including self-testing, was needed. She acknowledged concerns about social networking testing approaches, but said they could be addressed.

Panel 1: Testing for HIV—HIV testing modalities

19. This panel focused on different modalities of HIV testing, including community engagement and the use of lay-providers; facility-based testing and integration at primary health care facilities; and testing for ending paediatric AIDS.

20. Jemma Samitpol, clinic supervisor at the Tangerine Clinic in Thailand, said the clinic provides holistic health services for transpeople, including hormone-replacing treatment and support; HIV and STI testing; pre- and post-exposure and prophylaxis; HIV treatment; vaccination for human papilloma virus; and mental health screening. The clinic also runs testing kit delivery and collection services. The difficulties were related mainly to funding, which led to high staff turnover. More funding would enable the clinic to scale up its services to other key populations and to neighbouring countries. She stressed that people needed attractive and relevant testing choices, which required constant consultation with communities.

21. Stephen Watiti, Executive Director of the Community Health Alliance in Uganda, said he had been living with HIV for 35 years and had survived numerous coinfections. Despite fears or misgivings about taking an HIV test, most people tended not to refuse a test when offered one, he said. HIV testing had to be demystified—people should think about an HIV test in the same way they may think of testing for malaria—and everyone who may benefit from an HIV test should be offered one. The main barrier was HIV-related stigma, which was based on myths and misconceptions and which could be overcome if people had accurate information about HIV and the benefits of testing (beyond HIV). That, in turn, required HIV-competent service providers.

22. Loyce Maturu, Policy and Advocacy Advisor at Zvandiri in Zimbabwe, said the world had the tools and know-how to ensure that no child was born with HIV and no mother died while giving birth. Ending paediatric AIDS required repackaging the ways in which prevention of mother-to-child transmission messages and services are delivered, she told the meeting. HIV literacy for young mothers was vital because it empowered and gave women the confidence to use services and discuss their situations with partners.

23. Access to HIV treatment had to be available affordably and consistently for all women who need it, Ms Maturu said, and quality services for pregnant and breastfeeding mothers had to be readily available at health-care facilities. In reality, though, HIV tests were often out of stock, due to supply chain problems. Social, cultural and religious beliefs also made it difficult for people to take the right steps, and stigma remained a major problem. Evidence-based, differentiated service delivery and community-based support were vital. She shared examples of successful interventions such as young mentor mother projects and community adolescent treatment support projects. It would also be helpful to have overnight shelters for rural women who have to travel long distances to benefit from HIV and other health services. A great deal had been achieved in reducing paediatric AIDS and improving maternal and child health care, Ms Maturu said, but there was still a long way to go.

24. Speaking from the floor, participants noted with concern that significant proportions of

people were starting treatment with advanced HIV disease. Access to HIV diagnostics was still inequitable across the world and in countries, they said, and decreasing funding was affecting countries' abilities to offer effective testing and related services, and reduce stigma and discrimination. In Kenya, for example, in 2022, approximately 1,700 children aged 0-4 years were dying each year due to AIDS-related causes because its HIV systems and programmes were operating without sufficient resources. Greater investment in HIV testing and in new HIV technologies was needed.

25. Speakers described some of their experiences and achievements in rolling out testing and treatment services in their countries (including in Botswana, India and the Russian Federation). They emphasized the use of comprehensive approaches, rather than a narrow focus on facility-based testing. including combining traditional methods such as facility-based testing with community-based screening, self-testing, partner testing and index testing. Also mentioned was the value of easy-to-understand and accurate information; initiatives such as integrated testing campaigns in rural areas and for specific populations; and the importance of providing diagnostic and treatment services for HIV, viral hepatitis and other STIs free of charge.

26. While the achievements in many countries merited celebration (including Botswana, where uptake of prevention of mother-to-child transmission services stood at 98%), speakers warned against complacency about the challenges that remained, including obstructive legal and policy environments, weak health systems and counter-productive social norms. It was especially concerning that awareness of HIV status was far below the 95% target among key populations in most countries. Speakers stressed the roles of community organizations in making testing more accessible and said community-led health-care providers had to be fully funded. Enabling environments were also needed so communities could deliver testing services widely and effectively. Countries were urged to decriminalize consensual same-sex relations and to provide full protection to everyone, including LGBTI people.

Panel 2: Testing for HIV—meeting the differentiated testing, prevention and treatment needs of populations left behind

27. This session focused on practical ways to deliver testing services for key populations, including social network testing and community mobilization; HIV testing for adolescents and young people; and testing for men.

28. Sergey Dugin, General Director of the Humanitarian Action Fund in the Russian Federation, said HIV testing used to be performed by nurses at state facilities, but it became clear that people often had multiple health problems and that some were uncomfortable engaging with health institutions. It was decided to offer a greater range of testing and services to key and marginalized populations via smaller medical centres, which operate as a community service. This made services more accessible, especially to people who lacked the requisite documentation to obtain services in state institutions. Testing services had been provided to over 1000 people in the previous year, he said, and coverage was increasing among people who inject drugs. Some 2,000 refugees and migrants had also received medical assistance, including for hepatitis C, in the previous two years.

29. Youba Darif, founder of Roots Lab for Gender and Development in Morocco, described his background and described some of the challenges faced by young members of key populations, including a lack of awareness and knowledge about HIV, about the benefits of testing, and about prevention options. Stigma and discrimination were persistent barriers and health facilities could be unwelcoming, he told the meeting. Confidential HIV services were scarce in many regions of his country, while legal and

policy barriers, including age-of-consent restrictions, made service access even more difficult. Young people needed better knowledge about HIV and services had to be made more easily accessible and affordable to all. Inclusive policies and compassionate health-care services were vital and service providers should train health-care staff to be sensitive to the needs of young key populations. This could be done if countries and donors invested in grassroots youth and key population leaders: let young communities lead, Mr Darif said.

30. Mohammad Afsar, Senior Technical Specialist at the International Labour Organization (ILO), described the ILO's VCT@work programme. He said reluctance among workers to take HIV tests was mostly due to stigma and discrimination; a fear that they would be denied work due to their HIV status; opportunity costs (loss of wages), especially for workers in the informal economy; and low health-seeking behaviour. The ILO had designed the VCT@work programme with those concerns in mind, he explained. The programme focused on protecting rights; partnerships (including with workers' organizations and employer associations); advocacy and communication; and ensuring linkage to treatment and care. Support for accessing social protection services was also being integrated with testing programmes. HIV workplace policies were being prioritized and a sectoral approach was being used to reach men who are at high risk of HIV, Mr Afsar explained. The programme leveraged existing resources such as peer educators, workplace clinics, wellness programmes, occupational safety and health services, and technical assistance was provided when needed.

31. These approaches were reaching more men, many of whom were first-time testers or men who had not recently taken an HIV test. Self-testing was being introduced in several countries, including Nigeria, where a qualitative study on self-testing showed it was highly acceptable, less stigmatizing and easy to use. If the cost of self testing kits could be reduced further, uptake would increase even more, Mr Afsar said. Lessons learnt included the value of engaging workplace leaders and clearly communicating the benefits of HIV testing to workers. If public-private partnerships could leverage additional resources, workplaces could help close the testing gap for men, he said, adding that the data from these programmes should be integrated into national data systems.

32. Mohammed Majam, Director of Medical Technology at the University of the Witwatersrand, South Africa, described a project which focused on promoting HIV testing at taxi ranks in Johannesburg. Volunteer workers used mobile phones to collect data from commuters, while trained field workers distributed HIV self testing kits and assisted individuals with linkage and follow-up support. Acceptability was high, he said. The project reached some 60% of men aged 20–39 years, a large percentage of whom were first-time testers. HIV prevalence was 9% and 54% of the men who tested positive using a self-testing kit had confirmatory testing, with 66% of the latter starting antiretroviral therapy. Tailored services helped reduce stigma and discrimination, he said.

33. In discussion, speakers called for greater progress on HIV testing for children and adolescents. Many HIV-exposed infants were not receiving HIV tests within the recommended time frame, they said. Test results (including for viral load tests) often took weeks or months to be returned to patients or health-care providers, which undermined linkage to treatment and care. UNAIDS was asked to advocate for greater access to rapid diagnostics, including simple, cost-effective tools for use in clinics and community settings. Asked which changes they would prioritize, the panelists singled out more comprehensive testing services; greater involvement of young people; and more effective actions to end HIV-related stigma and discrimination.

Panel 3: Testing for people living with HIV—comprehensive testing and diagnostic services

34. This session focused on viral load and CD4 testing, planning and implementation; integration of HIV testing services with other disease programmes; and public health laboratory systems for quality assurance and drug resistance monitoring.

35. Alisson Bigolin, Head of the Diagnostics Division in Brazil's Ministry of Health, described the provision of HIV diagnostic and treatment services in Brazil's health system. He explained that the national Ministry of Health defined the technical features of HIV tests to be procured, while the federal health services determined the anticipated demand and arranged for the transportation of samples, amongst other aspects. Several platforms existed for viral load and CD4 testing, both in larger reference laboratories and in smaller, point-of-care laboratories. Those platforms were also used for molecular testing for TB and for viral hepatitis testing. Mr Bigolin also described diagnostic service suppliers' roles and obligations (including for training and quality assurance), and the systems used to reimburse them. Ministry of Health technical teams monitored productivity and equipment maintenance, and investigated incidents. Between January and September 2023, some 791 000 viral load tests and 342 000 CD4 tests had been conducted across Brazil, he said. It was possible to identify care gaps by cross-referencing data from the various systems. A diagnostic network strategy was being implemented to optimize and integrate as many tests as possible. The aim was to expand point-of-care testing platforms to at least 50% of HIV referral services by 2027.

36. Maxwell Mumba, UNITAID Community Board delegation member, Zambia, said testing systems were not yet serving everyone's needs, especially young people. Health-care workers often lacked understanding of young people's realities and concerns, and tended to be judgmental. Youth-friendly spaces were needed, Mr Mumba said, and digital technologies could be used more effectively to encourage and enable people to take HIV tests. He called for a comprehensive approach for youth that recognizes the interconnected nature of their health and other needs. That would include using a variety of venues where young people can be reached, as well as linking various services they might need, such as mental health, nutrition, and sexual and reproductive health services. He also advised the use of friendlier outreach methods and awareness campaigns, and said information should be presented in accessible ways and in people's preferred languages. HIV testing had to be normalized for young people, he urged. Other proposed improvements included offering context-specific testing services; promoting self-testing; advocating for lowering the age of consent; using inclusive and gender-sensitive approaches; decentralizing testing services; and involving young people actively in providing services.

37. Jin Cong, Deputy Director of the National HIV/AIDS Reference Laboratory at the Chinese Center for Disease Control and Prevention, described the HIV testing laboratory network in China, which includes 36 000 rapid test sites, 13 400 screening laboratories, 800 confirmatory laboratories, 35 central confirmatory laboratories, and a national reference laboratory (which provides technical guidance and support). She said testing quality was assured by applying national guidelines, conducting training courses on testing techniques and laboratory management, and subjecting HIV testing laboratories to regular quality evaluations and proficiency tests. Quality assurance was also applied at the provincial level through similar processes, organized by the provincial or prefectural centres for disease control. Reference laboratories conducted post-market surveillance of commercial HIV diagnostic reagents to determine the accuracy of tests in use. China also operated 69 drug-resistance testing laboratories, Ms Cong said, with most of them located at centres for disease control. She

emphasized the need to monitor drug resistance: transmitted drug resistance (TDR) prevalence was 7.8% and had increased over the past two decades.

38. Speaking from the floor, participants said that large numbers of new HIV infections in all regions were among key populations, including young key populations, making it important to channel testing services through community-led organizations and to make greater use of community-led monitoring. Communities wanted to work with and support government programmes, but they needed systems and approaches that allowed them to collaborate productively, speakers said. It was important to include access to sexuality education and to remove age-of-consent barriers so more young people, especially adolescent girls, can know their HIV status.

39. The meeting was told that research was showing the value of linking social protection and HIV testing and that simple adaptations could be made to ease people's access to social protection (including people belonging to key populations). For example, the UN Development Programme and ILO had created a check list for social protection. Studies suggested that members of key populations who accessed economic empowerment and employment support tended to be more likely to use HIV testing and related services. Some participants described how their HIV testing services served as entry points for prevention and treatment services.

40. Asked to identify the most important changes that could be introduced, the panelists emphasized scaling up testing through point-of-care services; treating young people as stakeholders, not just beneficiaries; and achieving strong quality assurance of HIV, viral load and CD4 testing.

Panel 4: Enablers for testing services – ethics, policy and systems

41. This session shared country experiences regarding age-of-consent regulations for HIV testing; human rights and gender issues in promoting testing; and procurement and supply chain management.

42. Anne Cécile Zoung-kani Bisseck, Director of Operational Health Research in Cameroon's Ministry of Health, discussed some of the legal, psychosocial and other obstacles that made it difficult for adolescents to know their HIV status and receive HIV treatment. She said adolescents in Cameroon had to be accompanied by their parents or have their explicit consent to start HIV treatment. The civil code set the age of majority at 21 years, which meant that people younger than 21 years needed parental consent to access certain health services. Yet large proportions of adolescents were sexually active: about 21% of 15–19-year-old girls were mothers and the average age of first sexual contact for girls was 16 years. It was important to make it easier for adolescents to use testing services, she said. Adolescents were also highly reluctant to discuss sexual matters in the presence of their parents. A recently promulgated law sought to ease access to testing services, she explained. Even though it still contained several restrictions, it offered some opportunities to circumvent the age-of-consent limitations. It was also important for health-care workers to receive training so they can properly obtain consent from adolescents, Ms Bisseck said.

43. Aditia Taslim, from the INPUD/UNITAID Communities Delegation, Indonesia, said he had been diagnosed with HIV at 18 years. Because drug use was criminalized he could not disclose his drug use, which blocked his access to other services he needed, including harm reduction services. Many people who use drugs still faced the same problems, he said: legal obstacles kept them away from services that could benefit them. The evidence showed that behavioural interventions to stop people from using drugs were not effective for reducing HIV incidence among drug users, Mr Taslim told the meeting. In addition, very few service providers had the training to protect women

who use drugs, many of whom may also have experienced sexual violence. He directed participants to a recently published HIV monitoring tool for women who use drugs and emphasized the need to mainstream gender issues into all aspects of HIV service delivery and to create gender-specific safe spaces.

44. Community-led services could fill many of the gaps, even in conflict-affected areas, Mr Taslim said. It was important to position people who use drugs at the centre of those services, not just as outreach workers, and to meaningfully involve them in all stages of the design, implementation and monitoring of services. Peer-led services would improve testing, treatment initiation and retention, but peer workers should be properly paid and recognized within the health system, he added. Stigma and discrimination, including the pathologization of drug use, must be eliminated and laws that criminalize people who use drugs and other key populations should be repealed. Mr Taslim urged the Joint Programme to also focus on the 10–10–10 and the 30–80–60 targets.

45. Sarah Mayuni, lead pharmacist in the Department of HIV, STI and Viral Hepatitis in Malawi's Ministry of Health, said that diagnostics, laboratories and test kits absorbed about 25% of the HIV commodities budget in Malawi. The annual number of tests conducted in her country varied and but the positivity yield was declining. She described the information management system which was used to track service reports from the almost 870 public and private testing sites, including for HIV and syphilis, along with steps taken to shift commodities between facilities when shortages emerged, using "scan flow" technology. The latter system was working well and had been rolled out in 70% of facilities, she said. Strong quality assurance and logistics data were important for efficient management of diagnostic systems, she added. A reliable long-term budget model (working on a three-year grant cycle) made it possible to plan ahead and negotiate better prices for commodities with suppliers. Domestic resource mobilization was slowly increasing and public-private partnerships were enhancing the effectiveness of testing services, Ms Mayuni said.

46. Speaking from the floor, participants said equitable access to testing was vital for ending AIDS by 2030. Some speakers (including Australia and Germany) shared reflections on their domestic experiences and emphasized the importance of reducing stigma and discrimination; building stronger supply chains; bringing new technologies into the market; and changing policies and practices that block access to services (e.g. removing legal and policy barriers, including age-of-consent requirements and restrictions). They noted the importance of community-led services for reducing the number of late diagnoses.

47. Citing a new systematic review[1], speakers emphasized that a person with an undetectable viral load had zero risk of transmitting HIV, while a person with a viral load of less than 1000/ml[3] had an almost-zero risk of transmitting HIV. Speakers warned that groups opposed to gender equality and sexual and reproductive health and rights were mobilizing to further restrict adolescents' access to testing, treatment and prevention services. New alliances and compelling messages were needed to counter those efforts. Winnie Byanyima, Executive Director of UNAIDS, thanked the panelists and said her experience from Uganda suggested that public knowledge about HIV appeared to be low. She asked whether the counseling aspect of HIV testing was still being prioritized.

48. In reply, the panelists said public knowledge about HIV appeared to be less than ideal and suggested that this might be related to changes in the ways in which people sought and received information. Programmes had to make greater use of social

[1] Broyles LN, Luo R, Boeras D, Vojnov L. The risk of sexual transmission of HIV in individuals with low-level HIV viraemia: a systematic review. Lancet. 2023;402(10400):464–471.

media platforms to disseminate relevant information. Asked to single out the most important lessons learnt, panelists said programmes had to become better at exploiting the loopholes and gaps in obstructive laws and should remember that laws evolve through precedent and use. They said it was not a matter of people being hard to reach, but rather that the right people were needed to reach them—which well-trusted community-led organizations could achieve. Donors should not be afraid to provide funding to organizations of people who use drugs, they said.

Conclusions and the way forward

49. Christine Stegling, Deputy Executive Director for Policy, Advocacy and Knowledge at the UNAIDS Secretariat, thanked the panelists and participants and said HIV testing remained the first line of defense against the AIDS pandemic. The advances in testing technologies and approaches were increasing people's choices. She summarized the discussions, using the right to health as the reference point. The right to health, she explained, had four elements—availability, accessibility, affordability and quality—and the discussions had focused on each of them.

50. Discussions had underscored the importance of access, especially for youth and key populations, and of the obstacles posed by barriers such as age-of-consent requirements. The meeting had heard compelling examples of the value of differentiated testing services that offer people a variety of appropriate options. Also emphasized was the importance of the 10–10–10 targets and of continuing to invest in HIV education and awareness. Affordability remained an issue, Ms Stegling added. Some countries were still applying user fees for HIV testing and many still struggled to achieve reliable supply chains for diagnostics. The meeting had heard examples from China on quality assurance for HIV testing, including for ensuring that services were confidential and accurate, and that they reached the right people with appropriate and acceptable testing services. Several speakers had stressed that people living with HIV had to be part of the design and implementation of testing models. Ms Achrekar thanked the panelists, participants and organizers of the thematic segment.

Proposed Decision Points

The Programme Coordinating Board is invited to:

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52. *Request* Member States, in collaboration with community-led HIV organizations and other relevant HIV-related organizations, with the support of the Joint Programme, to fast-track targeted and measurable actions towards the 2025 targets to:

    a. Accelerate the implementation of evidence-based programmes and people-centred differentiated approaches that include facility-based and community-based testing, self-testing and other approaches, focusing on key[2] and other priority populations, as relevant to the national context;

    b. Encourage community-led service provision through the participation and meaningful engagement of community and other civil society organizations in HIV testing

[2] As defined in the Global AIDS Strategy 2021-2026.

services and in increasing demand for testing, and by using community-generated data as a complement to data that are sourced from monitoring and evaluation systems to inform decision-making around service quality improvement;

c. Update relevant policies to enable and support trained lay-providers, especially people living with HIV and members of key and other priority populations, to perform HIV rapid diagnostic testing;

d. Ensure quality of testing and testing services to prevent misdiagnoses;

e. Implement HIV testing programmes as part of a holistic and integrated package that links with prevention, treatment and care services for HIV and other health issues within the framework of primary health care, considering U=U messaging, while continuing scientific research;

f. As appropriate, revisit legal provisions on the age of consent for HIV testing to ensure that they respond to the needs of adolescents in different country contexts;

g. Increase efforts to reduce stigma and discrimination associated with HIV and promote service approaches that are led and monitored by key and other priority populations for greatest access and appropriate linkage, and consider mainstreaming gender issues into HIV service delivery;

h. Close the HIV testing gap, including by addressing gaps in research and quality data;

i. Use the TRIPS flexibilities to make testing-related health technologies, including diagnostic technologies, more accessible and affordable; and

j. Increase domestic resource allocations to HIV testing services, including diagnostic, CD4 and viral load testing, as part of essential health services to be included in the national health benefits packages, and enhance programme design and health system functions, including procurement and supply chain management for uninterrupted supply of testing commodities as needed to achieve greater efficiency.

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