



What's New in WHO Guidelines?

Key Updates and Future for Testing Services

Dr Cheryl Johnson, Technical Officer, WHO

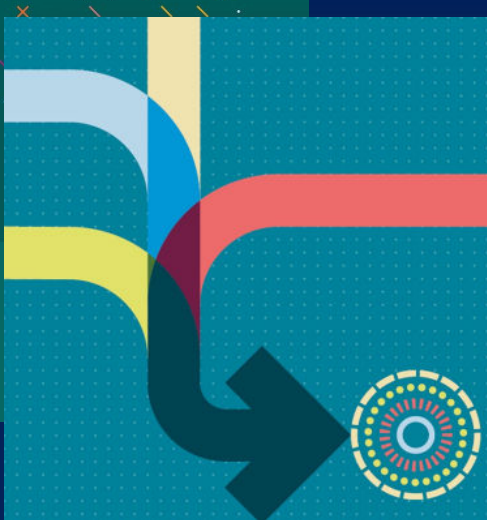
Wednesday, July 10, 2024



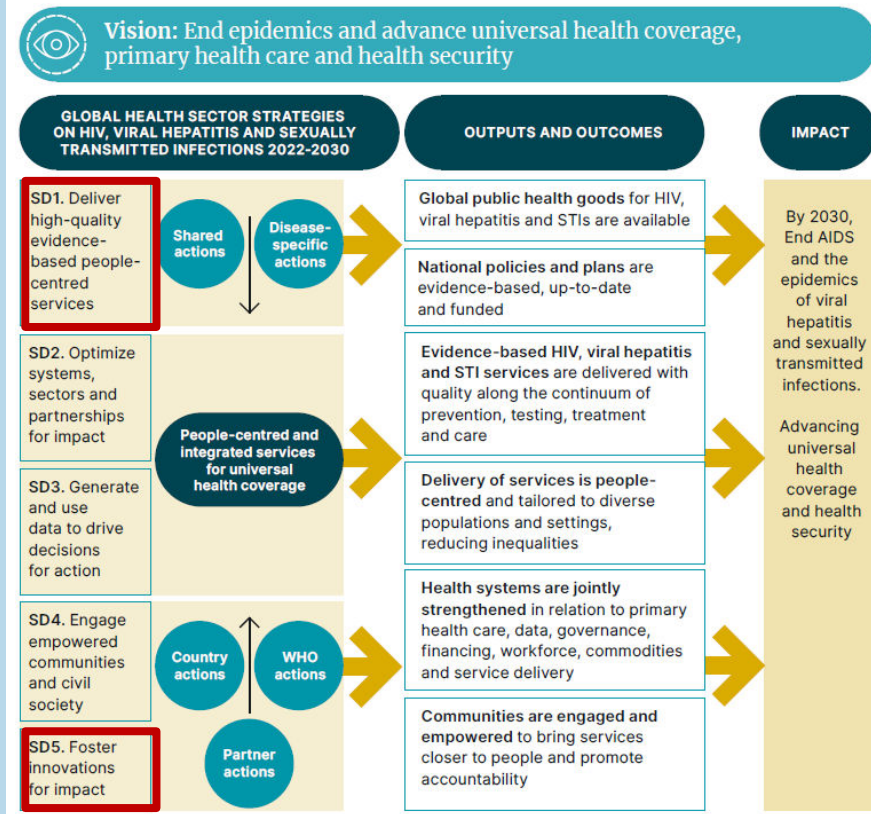
CQUIN dHTS Meeting | July 9 - 12, 2024 – Durban, South Africa

New WHO HIV testing guidance for achieving key targets

Consolidated guidelines on differentiated HIV testing services



Global health sector strategies on, respectively, HIV, viral hepatitis and sexually transmitted infections 2022-2030



The 2022-2030 Global Health Sector Strategies build on the progress achieved during the previous Global health Sector Strategies period from 2016-2021, supported by Member States and partners commitment, community and civil society engagement, and WHO's normative leadership and country support.

Disease area	Impact indicator	Baseline 2020 ^b	2025 target	2030 target
Shared	Reduced incidence	4.5 million	<1.5 million	<500 000
	• Number of new HIV and viral hepatitis cases per year • Number of new cases of syphilis, gonorrhoea, chlamydia and trichomoniasis ^c among people 15-49 years old per year	374 million	< 300 million	<150 million ^d
HIV	Healthy lives – reduced mortality and cancers	2.3 million	<1.7 million	<1 million
	• Number of people dying from HIV, viral hepatitis and sexually transmitted infections ^e per year	1.2 million	<900 000	<700 000
	Number of people newly infected with HIV per year	1.5 million	370 000	335 000
	Number of people newly infected with HIV per 1000 uninfected population per year	0.19	0.05	0.025
	Number of children 0-14 years old newly infected with HIV per year	150 000	20 000	15 000
Number of people dying from HIV-related causes per year	680 000	250 000	<240 000	
Number of people living with HIV dying from TB, hepatitis B and hepatitis C	210 000	110 000	55 000	

Diagnostic innovation is highlighted as key for achieving goals across strategy

South Africa

1

Expanding self-testing

- **Self-testing is safe, effective and empowering**

- Recommended across conditions and diseases including HIV, hepatitis C and syphilis – including dual HIV/syphilis self-tests
- Affordable and WHO prequalified self-tests increasingly available (\$1)
- ST used in facilities, communities, pharmacies and through partners, peers and networks in more than 100 countries

RECOMMENDED



- **HIVST now recommended more broadly in facilities**

- Increases coverage when needed
- Replaces risk-based screening tools which miss too many undiagnosed PLHIV
- Insufficient evidence on caregiver assisted testing with HIVST due to low uptake, performance, limited impact and high costs

RECOMMENDED

UNCERTAIN

- **HIVST now recommended for expanding prevention access**

- PEP delivery – at start and completion
- Initiation, re-initiation and continuation of PrEP (oral & ring w/ ongoing research needed for LA-PrEP)
- Greater access, many benefits, lower costs
- No risks of increasing drug resistance at population-level
- Oral and blood-based ST both acceptable

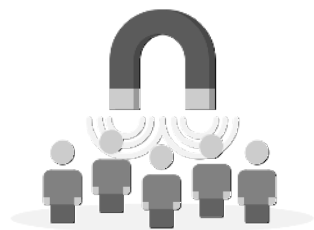


RECOMMENDED

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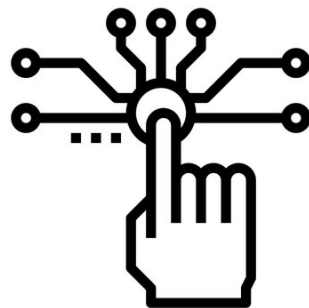
Rapid uptake of WHO HIVST-supported guidance

As of May 2024, WHO mapped country uptake of the new recommendation on HIVST-supported PrEP identified the following country reports (work ongoing).



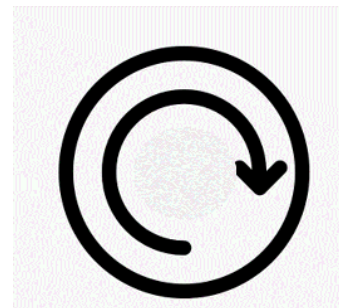
**HIVST for
PrEP demand creation**

Nepal, Zimbabwe,
Kazakhstan, Ghana, South
Africa, Eswatini, Viet Nam



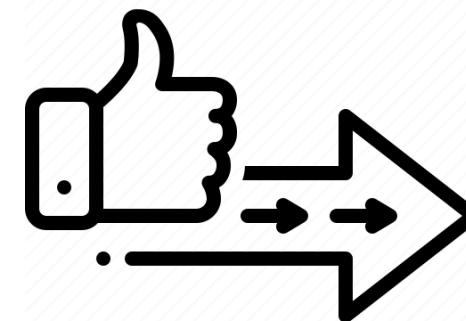
**HIVST for
PrEP initiation**

Philippines, Eswatini
& Thailand



**HIVST for
PrEP re-initiation**

Brazil



**HIVST for
PrEP continuation**

Zambia, Spain,
Mozambique, Kenya,
South Africa, Viet Nam*

2 Reaching children and adolescents

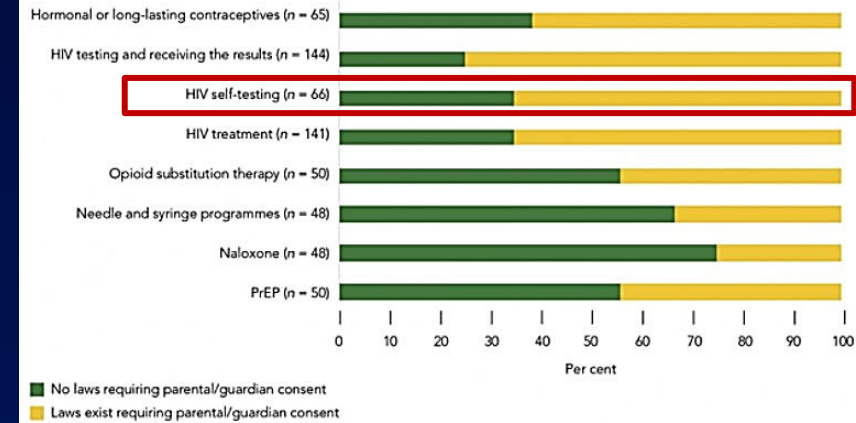
Time to focus on scaling-up evidence-based approaches

- Facility entry points
- Screening in/nudging tools to reduce missed opportunities
- Broader network-based testing emphasized (see next slide)
- Review and revise age-of-consent policies and support provider training (align across testing, self-testing, prevention, ART)
- Self-testing for adolescents and young people – safe, accurate, effective

Priorities moving forward

- Reviewing evidence from PEPFAR-funded programs and strategies, e.g. “hot spots”, KP-focused, zero-dose communities, populations in closed settings/migrants
- Develop tools for paediatric case finding audits
- Revise strategies for mature and less developed PMTCT programmes
- Differentiate testing focused on sick children from routine testing

Countries with requirements for parental/guardian consent for adolescents (under age 18 years) to access services, global, 2021



Source: UNAIDS National Commitments and Policy Instrument, 2017–2021.

Caregiver-Assisted Testing with HIV Self-Test Kits for Children 18 Months and Older: A GRADE Systematic Review

16 Pages · Posted: 29 Jan 2024

Kathleen McGee
Independent

Muhammad Jamil
World Health Organisation (WHO) - Global HIV, Hepatitis and STI Programme
More...

Abstract

Background: Caregiver-assisted testing using HIV self-test (CG-HIVST) kits has been proposed to enhance paediatric HIV/AIDS case finding and contribute toward ending paediatric HIV/AIDS by 2030. We conducted a systematic review to assess the risks and benefits of CG-HIVST.

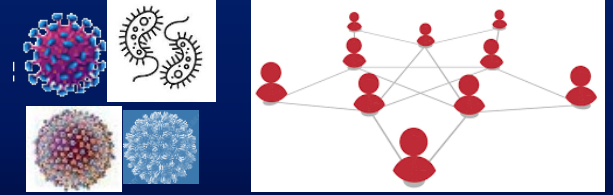
Methods: We searched nine electronic databases and consulted experts to identify relevant articles through 5 February 2022. Studies comparing CG-HIVST to other testing services among children over 18-months, or to no intervention were included. Outcomes included uptake, acceptability, diagnostic accuracy, feasibility, HIV positivity, linkage to care, social harm, values and preferences, costs, and cost-effectiveness. Risk of bias was assessed using relevant Cochrane tools and certainty of evidence was evaluated with GRADE.

Findings: Among 2203 screened articles, nine observational studies from sub-Saharan Africa were included. In one non-randomized intervention study of 6082 children, overall CG-HIVST uptake was lower than other standard testing services offered (3.30% vs. 56.73%). In the same study, HIV positivity following CG-HIVST appeared lower or comparable to standard testing (RR = 0.44; 95% CI: 0.05, 3.20). Two single-arm studies reported high linkage to confirmatory testing (97.48%) and treatment initiation (97.7%) among children reported positive with CG-HIVST. Pooled positive predictive value was 36.72% across three non-randomized intervention studies. Reported social harms were rare, and acceptability appeared to be high among caregivers taking up the intervention, but feasibility was unclear as some reported anxiety in relation to reactive results. Evidence was appraised to be of very low certainty. Average CG-HIVST costs varied widely and were consistently higher than standard testing services.

Interpretation: CG-HIVST may be acceptable, but feasibility remains uncertain with potential higher costs. Current evidence favours standard testing for uptake and positivity. Low positive predictive values raise concerns about false positives and potential harm. Programmes should prioritize evidence-based approaches for paediatric case-finding, while research to fully evaluate this approach continues.

Source: [McGee 2023](#), WHO 2024. Zhang AIDS 2024

WHO tool kit in development
and release Q1 2025



Partner services

- RECOMMENDED**
- New recommendation on STI partner services
 - Provider-assisted partner services should be encouraged as still most effective strategy
 - Provide options based on client needs (partner referral, provider-assisted, expedited partner therapy*)
 - Services must always be voluntary

Social network testing now for all with risk (not only key populations KP)

- RECOMMENDED**
- ST, community-led, multiple rounds, virtual or in-person
 - Do not need incentives or in-depth training

Prioritize and integrate services

- RECOMMENDED**
- Prioritize and integrate based on capacity and resources
 - Strategic opportunities with ANC, male partners, KP
 - Consider dual HIV/syphilis RDT/ST and HBV within family and household outreach

What are network-based testing services?

Range of approaches (Partner services, social network, family/household testing) that extend testing by supporting individuals to disclose to, refer for testing, and/or distribute self-tests to partners, families, and other members of their social networks.

Recommended across HIV, viral hepatitis and STIs

**EPT is only an option for curable STIs*

Recency testing in routine HTS

NOT RECOMMENDED

Guidance recommends **against** recency testing in routine HTS

Findings from evidence review:

- No study showed evidence of effectiveness or clinical benefit
- Variable acceptability, with many finding intervention unacceptable
- Effects on social harm were uncertain.
 - Concerns about social harms such as stigma, conflict among community members, dissatisfaction with services and increased intimate partner violence were reported by providers and clients.
- Need to prioritize limited HTS resources toward impactful approaches
 - Very limited feasibility due to requirements for substantial resources, time, planning, training and monitoring.
 - High costs as does not replace diagnostic testing and requires additional tests and service costs (test kits, VL, implementation).
 - Concerns about reduced equity due to diversion of funds

What is recency testing?

Assay used within an algorithm to estimate if HIV infection occurred in past 1-year

No WHO PQ recency assays

Guidance on recency for surveillance still supported and guidance unchanged

**Thank you to all those who supported
these guidelines!**

**For more information on
HIV testing services**

**WHO HIV Testing Services
Dashboard**

**WHO 2024
HTS GL**

Questions?

Contact: Cheryl Johnson johnsonc@who.int