

UNIVERSAL TEST AND CONNECT:

BRIEF CONSIDERATIONS

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WHAT IS UNIVERSAL TEST AND CONNECT?

Universal test and connect (UTC) is an intensive community-wide strategy to accelerate HIV epidemic transition in order to rapidly reduce new HIV infections and deaths from AIDS-related illnesses within a specific community. It is an additional, complementary strategy focused on specific communities or subnational areas, with the aim of ensuring rapid impact. UTC relies on a variety of community-based, people-centred approaches to reach people outside of health-care facilities, connect them to quality, respectful and non-stigmatizing HIV services and transform community acceptance and engagement for HIV and health.

The evidence for UTC comes from community trials in Africa that have shown decreased HIV incidence (by approximately 20–30%) and decreased AIDS-related mortality (by approximately 20%) within three years of implementing a community-wide UTC programme, compared with current standard care. There were substantial diagnoses of people living with HIV, including men, and rates of linkage to care and treatment were high in some trials. People living with HIV who were not on treatment were identified and linked to treatment. Retention on HIV treatment (at 12 months) was extremely high, as was virologic suppression (when measured), including for people who elected same-day initiation of HIV treatment at their first clinic visit. These universal test and treat (UTT) randomized controlled trials showed that a combination of interventions can rapidly have an effect on population-level viral suppression—meeting and exceeding the 90–90–90 targets, which translate to 73% of people living with HIV being virally suppressed. Moreover, they did this by reaching and connecting substantial numbers of the people who were most likely to be missed, such as men, young people and others who do not routinely access health facilities, and people who are often not at home during routine community health worker visit hours.

WHAT'S NEW OR DIFFERENT ABOUT UNIVERSAL TEST AND CONNECT?

Although UTC relies on the combination of many existing approaches to HIV prevention, it is not just a new name, such as treat all, for existing approaches, as it includes the critical component of knowledge of the HIV status of an entire population, including the people who are missed by current strategies. It may include community-based outreach, such as door-to-door HIV testing or multidisease health fairs, but it is more wide-reaching than traditional community-based or door-to-door testing or mass HIV testing campaigns, which tend to reach, sometimes repeatedly, the people who are the most available and easy to contact.

Fundamental to UTC is the linkage to, and retention in, quality care for people who test positive for HIV for their overall well-being and the reduction of HIV transmission to partners and infants, while also ensuring a continuum of care for important HIV prevention services for those who test negative in order to ensure their protection from acquiring HIV.

What makes UTC truly different from the business as usual model is that it takes the concept of “universal” from theory to practice—it relies on understanding precisely who in a community has not been reached or has not continued with the services they need and uses community wisdom, data and flexible and iterative service approaches to reach them.

Understanding who is part of the community to be reached, including an estimate of the number of people living with HIV in the selected community, forms the basis of understanding, throughout the implementation of UTC, who has not been reached, while observing all human rights-based approaches. This requires an initial activation of households. Activation consists of providing information, including choices for testing and care and educational materials, and is also a way that keeps people safe, ensuring universality and working through peer respondents and the community.

UTC can be used to increase HIV and health literacy—getting people and households interested in new HIV prevention services, sharing new treatment insights, such as U = U (undetectable = untransmittable), and providing other services, such as hypertension screening and contraception services. Activation needs to also include enumeration—taking a census of the community in each defined geographic area where UTC is implemented in order to ensure that testing services can reach every person and to enable monitoring to identify missing or inadequately served subpopulations. Within the defined geographic area, this involves enumerating each household and individual, such as through door-to-door outreach by community workers. HIV testing and other health interventions can be offered to individuals during enumeration activities, which enhances efficiency.

Effective delivery of UTC builds a standard of quality community-responsiveness and connection across a range of critical services.

More than a checklist of essential services, successful approaches to UTC are coordinated, holistic, people-centred, human rights- and choice-based, gender-responsive and involve organizations with the capacity to deliver high-quality implementation across a range of services—HIV treatment and prevention services and multidisease services that people want and in the ways they want them—at scale in designated areas. UTC is also dynamic and responsive, adaptable and able to meet the needs and expectations during implementation.

The design of UTC relies on an initial round of services, with subsequent services adapted and delivered in response to who is left to reach or who would benefit from repeated or more intensive services. For example:

- ▶ After activation/enumeration, the first round of services aims to blanket the community with HIV testing, with the goal of knowledge of HIV status of everyone who does not know their status. People living with HIV who have not engaged in care or have fallen out of care are connected to HIV treatment through a personalized approach (peer navigators, immediate welcoming from

clinic staff, offer of same-day treatment initiation, etc.) and people at risk of HIV infection are connected to primary HIV prevention (condoms, voluntary medical male circumcision, education, pre-exposure prophylaxis (PrEP)), all based on the needs of the individual. Linkage to services and support beyond health, such as social support and protection, domestic and gender-based violence counselling and other health services, can strengthen community uptake.

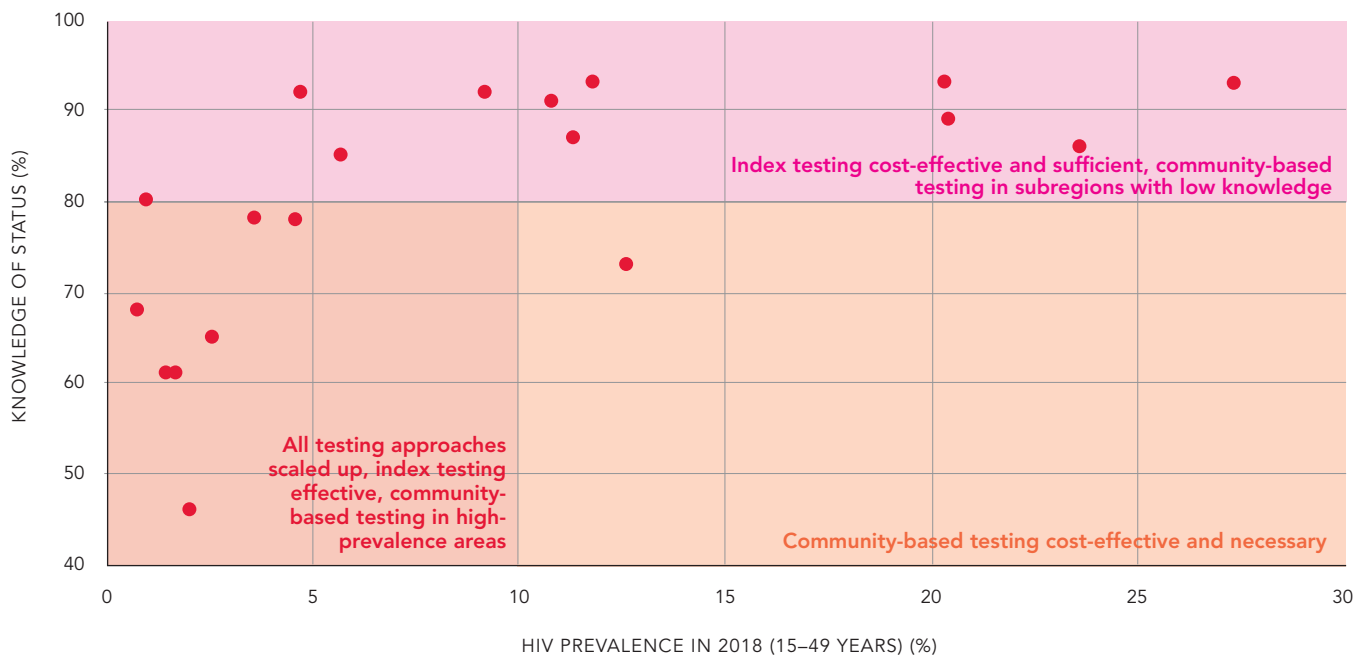
- ▶ Follow-up rounds of services are tailored to the needs of individuals, families and communities, and are data-driven. They may include a more targeted approach to reach people and populations not reached in the first round and a greater focus on relinkage and retention in HIV care, including the offer of community antiretroviral therapy delivery. Follow-up rounds could also include HIV retesting of people who are most at risk of HIV acquisition. Community leaders are critical to helping to understand and mobilizing to reach the missing people and populations and for continuous adaptation of the interventions between rounds.
- ▶ Dynamic and adaptive approaches to reach people can include the use of various multidisease strategies (for hypertension, diabetes, sexual and reproductive health, maternal and child health services, etc.), visiting specific households on evenings or weekends, the availability of male-friendly clinics and holding youth-friendly discussions on relationships and sex.
- ▶ UTC is complementary and synergizes with current in-facility approaches by reaching people who may avoid traditional health systems and engaging them in client-centred and human rights-based systems.

WHERE SHOULD THE UNIVERSAL TEST AND CONNECT STRATEGY BE CONSIDERED?

UTC is appropriate for subnational/local geographic areas for accelerated epidemic transition:

- ▶ In countries with a high HIV prevalence, efforts should be focused on subnational areas with an especially high HIV prevalence and incidence and with a residual unsuppressed community viral load. Other considerations may include low knowledge of HIV status, and/or low linkage to or retention in care. Note that UTC trials were effective in both urban and rural settings, including in areas with good overall performance of 90–90–90 but with specific populations (including young people and men) who were disproportionately missed by current standard programmes.
- ▶ In countries with medium or low HIV prevalence, especially where the HIV burden is concentrated among members of key population and their partners in urban areas, it may be possible to identify specific neighbourhoods, areas or types of venue within a city where people living with or at higher risk for HIV may be more likely to be. Designs that saturate this area, rather than target only certain people within the area, and include a social network snowball or outreach component to invite people connected to but not living in the neighbourhood could be considered. It could also include mapping to identify specific times and locations at which to intervene, in particular for non-residents.
- ▶ UTC should not be applied everywhere. It is not appropriate, and there are not enough resources, to offer this approach in focused epidemics and in low HIV prevalence and incidence settings. Areas where UTC should be applied should be identified through an analysis of several factors, including knowledge of HIV status, HIV prevalence (see Figure 1) and community levels of unsuppressed viral load and in locations where population-level viral suppression is low and AIDS-related mortality is high.

FIGURE 1. KNOWLEDGE OF HIV STATUS AND HIV PREVALENCE



● Red dots represent knowledge of HIV status and HIV prevalence for 19 countries in sub-Saharan Africa (Angola, Botswana, Cameroon, Cote d'Ivoire, Democratic Republic of the Congo, Eswatini, Ethiopia, Ghana, Kenya, Lesotho, Malawi, Mozambique, Namibia, Nigeria, South Africa, the United Republic of Tanzania, Uganda, Zambia and Zimbabwe).

Source: Avenir Health, 2019.

WHAT CRITICAL POLICIES, PRACTICES AND SERVICES MUST BE IMPLEMENTED FOR UNIVERSAL TEST AND CONNECT TO SUCCEED?

UTC relies on the rapid adoption of people-centred and human rights-based HIV best practices and global HIV service recommendations. The uptake of HIV testing, initiating HIV treatment and staying on treatment should be a personal choice, with ongoing support provided as needed. In areas where UTC will be implemented, it is strongly advised that the following policies and practices be put in place locally, even if they have not yet been fully adopted or implemented at the national scale:

- ▶ Lay provider HIV testing, age of consent for HIV testing to be less than 15 years of age, HIV self-testing and quality and client-supportive index and social network testing, with consent and without coercion.
- ▶ Same-day HIV treatment initiation, differentiated (multimonth) and patient-centred service delivery, accessible viral load testing, regimen optimization/ dolutegravir transition and the removal of user fees for HIV services.
- ▶ Special consideration should be given to the availability of, and access points for, combination HIV prevention services, including information and comprehensive sexuality education, male and female condoms, reproductive health services, including contraceptives, screening for, and management of, sexually transmitted infections, voluntary medical male circumcision and PrEP.
- ▶ The effective collection of data to provide real-time information on coverage and gaps, which supports timely course correction and problem-solving.

HOW DO CURRENT AND POSSIBLE FUTURE COVID-19 CONTEXTS PROVIDE DIFFERENT OPTIONS FOR ADAPTING OR INCLUDING ELEMENTS OF UNIVERSAL TEST AND CONNECT?

COVID-19 has changed the context of community health, and the future new normal may be substantially different. Already, there are some suggestions that multidisease strategies that address COVID-19 but also hypertension, diabetes, HIV and other comorbidities could help to more effectively reach the most vulnerable people and also help to de-stigmatize the conditions. Elements that are part of UTC—activation/enumeration of households or people, personalized approaches to ensuring follow-up and linkage to the right services and especially the engagement of community leaders and stakeholders on reach and progress—may be quite relevant to COVID-19 responses in certain settings.

Priority settings for COVID-19 that are also relevant to HIV may include mobile populations and informal settlements, slums and high-density suburbs in countries with a high HIV prevalence. COVID-19 activities to be considered may include COVID-19 tracing and outreach, future COVID-19 antibody surveys of specific communities and COVID-19 vaccine community preparation and delivery. The types of team needed for UTC, those with strong community–facility linkages and coordinated project management skills, may be highly effective in delivering services for COVID-19.

WHAT IT TAKES TO GET IT DONE: STRONG MANAGEMENT AND SHARED ACCOUNTABILITY

A strong management structure that includes both community and health services leadership for treatment and prevention is critical for success. Building community readiness, HIV treatment literacy and ongoing community-based support is also important.

For UTC to have impact, it is essential to strengthen partnership between communities and the health leadership, to link community services and facility services, to raise commitment to people-centred and human rights-based quality improvement and to ensure dynamic and regular sharing of data and results in order to mobilize efforts towards the people who need to be reached. This is an intensive and responsive management and communication set-up that requires leadership support and investment.

WHAT IS THE BACKGROUND EVIDENCE FOR UNIVERSAL TEST AND CONNECT?

UTC is grounded in the experience and results of four UTT trials as well as intensive experience from programmes such as the Mbongolwane project, supported by Médecins Sans Frontières. Although the trials and programmes were of diverse designs and interventions, common understandings and experiences were clear. In December 2019, a consultation was held to further delve into the broader issues and implications of implementing UTT programmatically, which included key stakeholders comprised of representatives of the four UTT trials, modellers, health economists, the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), the United States President's Emergency Plan for AIDS Relief (PEPFAR), the World Health Organization, a civil society representative and national government officials. The results were reviewed and detailed implementation experiences were discussed and will be developed into a broader considerations position paper, which is intended to help guide and inform countries on the practical implementation of the UTC package of interventions.

FUNDING CONSIDERATIONS

The implementation of UTC approaches may not end up costing more money than alternative approaches. Better co-ordination, communication and dynamic changes within the current funding framework will make this feasible and sustainable. It is recommended to complete a bundled plan and budget that covers all boosted service and management elements required to implement UTC in the geographic areas identified and to discuss them with funding partners, including the Global Fund and/or PEPFAR.

Strategies that include community health workers and multidisease screening could include cofunding from universal health coverage and other health funds. Note that due to the iterative and responsive nature of implementation, reporting and accountability mechanisms may need to be negotiated in order to ensure flexibility and the shifting of services throughout implementation. Like all innovative strategies, there are no a priori guarantee of funding, and it is expected that early implementers will need to work closely with funders to achieve successful buy-in.

FURTHER INFORMATION

Countries considering implementing UTC at the subnational level are strongly urged to draw upon the technical support available through UNAIDS. This technical support facilitates direct engagement with the UTT Trials Consortium (UT³C), which is comprised of key members of the four UTT trial teams on which UTC is based. A UTT team will help to identify experts to provide support at both the consideration phase and once a country has decided to move forward if it needs assistance in planning and implementing the UTC package of interventions. This technical assistance brings detailed implementation experience that is not found in published articles alone. If you are interested in requesting technical assistance or would like to learn more, please contact Julianna Hills at hillsj@unaids.org. The following summaries of the UTT trials are available:

- ▶ Havlir DV et al. What do the universal test and treat trials tell us about the path to HIV epidemic control? *J Int AIDS Soc.* 2020;23(2):e25455 (<https://doi.org/10.1002/jia2.25455>).
- ▶ Hayes RJ et al. Effect of universal testing and treatment on hiv incidence—HPTN 071 (PopART). *N Engl J Med.* 2019;381:207–218 (<https://www.nejm.org/doi/full/10.1056/NEJMoa1814556>).
- ▶ Havlir DV et al. HIV Testing and treatment with the use of a community health approach in rural Africa. *N Engl J Med.* 2019;381:219–229 (<https://www.nejm.org/doi/full/10.1056/nejmoa1809866>).
- ▶ Iwiji CC et al. Universal test and treat and the HIV epidemic in rural South Africa: a phase 4, open-label, community cluster randomised trial. *Lancet HIV.* 2017;5(3):E116–E125 ([https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018\(17\)30205-9/fulltext](https://www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(17)30205-9/fulltext)).
- ▶ Makhema J et al. Universal testing, expanded treatment, and incidence of HIV infection in Botswana. *N Engl J Med* 2019; 381:230–242 (https://www.nejm.org/doi/full/10.1056/NEJMoa1812281?query=recirc_curatedRelated_article).

