POLICY BRIEF

HIV SELF-TESTING AT WORKPLACES: APPROACHES TO IMPLEMENTATION AND SUSTAINABLE FINANCING

MAY 2022

HIV TESTING SERVICES

World Health Organization

International Labour Organization

HIV self-testing at workplaces: approaches to implementation and sustainable financing

ISBN (WHO) 978-92-4-004063-2 (electronic version)
ISBN (WHO) 978-92-4-004064-9 (print version)
ISBN (ILO) 978-92-2-036209-9

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ACKNOWLEDGEMENTS

This policy brief is the result of ongoing collaboration between the World Health Organization (WHO) Department of Global HIV, Hepatitis and STIs Programmes and the International Labour Organization (ILO) Gender, Equality, Diversity and Inclusion Branch that also manages the ILO's programme on HIV and AIDS and the World of Work.

The development of the document was led by the WHO Global HIV, Hepatitis and STIs Programmes, coordinated by **Rachel Baggaley**, **Muhammad Shahid Jamil** and **Cheryl Johnson** under the leadership of **Meg Doherty**. From the ILO Gender, Equality, Diversity and Inclusion Branch, it was led by **Syed Mohammad Afsar** and **Diddie Schaaf**. **Ena Oru**, WHO consultant, contributed to the development of this policy brief and wrote the initial draft.

Joseph Douglas Kutzin and **Matthew Jowett** (WHO Department of Health Systems Governance and Financing) and **Lou Tessier** (ILO Social Protection Department) provided expert review. **Hellen Magutu** (ILO Kenya), **Simphiwe Mabhele** (ILO South Africa), **Theresa Mukeya** (ILO Zambia), **Ida Chimedza** (ILO Zimbabwe), **Syed Mohammed Baqar** (ILO India) and **Anil Singal** (BEST Company, India) provided case studies for the policy brief. Members of the **WHO/UNAIDS Global Men and HIV Technical Working Group** provided guidance and supported external review.

The **Bill and Melinda Gates Foundation** and **Unitaid** contributed to funding this brief.

1. INTRODUCTION

Countries are making progress toward the global goal of 95% of people living with HIV knowing their status by 2025 *(2)*. However, globally, over four million people living with HIV were estimated to be still undiagnosed in 2020 *(3)*. Men in high HIV burden settings and men from key populations in all settings are consistently less likely to know their HIV status than women. Globally, 78% of men ages 15 years and older who are living with HIV are aware of their HIV status, compared with 86% of women with HIV of these ages *(4)*. Men have fewer opportunities to access HIV testing services (HTS), often due to structural barriers such as operating hours or locations that are inconvenient for working men; direct or indirect opportunity costs associated with attending services, such as time lost from work; and gender stereotypes *(5)*.

Offering HTS, including HIVST, at formal and informal workplaces has emerged as an effective, acceptable and feasible approach for reaching men *(6)*. A 2018 World Health Organization (WHO) and International Labour Organization (ILO) policy brief provides key guiding principles for HIVST implementation at workplaces *(7)*. For HIVST to be most impactful and effective, it should be implemented within a policy framework established by the workplace that follows a rights-based approach of consent, confidentiality and non-discrimination, as recommended by the ILO Recommendation concerning HIV and AIDS and the world of work, 2010 (Recommendation No. 200) *(8)*.

HIV self-testing (HIVST) is a process in which a person collects their own specimen (oral fluid or blood) and then, using a simple rapid test, performs an HIV test and interprets the result.

WHO recommendation (2019): HIVST should be offered as an approach to HIV testing services *(1)*.

HIVST does not provide a definitive HIV-positive diagnosis. To confirm the diagnosis, individuals with a reactive test result must receive further testing from a trained provider according to the national testing algorithm.

Building on the 2018 policy brief, this brief captures early experience with HIVST implementation at workplaces and discusses emerging approaches of sustainable financing that can be adapted for HIVST at workplaces. To inform the development of this brief, a desk review of published and grey literature was undertaken; and semi-structured interviews were conducted with key informants in selected countries.

The primary audiences for this policy brief are ministries of health and labour, national HIV programmes, employers' organizations, workers' organizations (labour unions), enterprises, implementing partners, including civil society organizations, and health insurance agencies.

2. HIVST IMPLEMENTATION AT WORKPLACES: EMERGING EXPERIENCES

Several countries have conducted pilot projects focused on workplace HIVST, and in some others countries pilot projects are underway or being planned. HIVST is often built on existing VCT@WORK initiatives[1] or similar initiatives at workplaces and focused on male-dominated workplaces in sectors with low access to HTS. Distribution of HIVST through the workplace has proved to be effective. Initial results from workplace HIVST implementation demonstrate potential for reaching men and first-time testers *(9)*. A modelling exercise to measure the impact of an optimized HIVST distribution strategy in South Africa, based on data collected alongside the Unitaid-funded STAR Initiative, showed that workplace HIVST distribution was cost-saving and predicted to have a moderate epidemiological impact *(10)*. Similarly, a cost and cost-effectiveness analysis of HIVST distribution across a range of distribution models in South-Africa suggested that workplace distribution can reach large numbers of workers at relatively low costs *(11)*.

Further, preliminary experiences suggest that building strategic partnerships among the government, employers, workers' unions and other stakeholders is central to success, as is leadership from national programmes. The case studies that follow describe the experience in four high HIV burden countries.

[1] VCT@WORK is ILO's initiative of voluntary HIV counselling and testing of workers.

KENYA

Recognizing that men are being left behind in HIV testing and treatment access, the ILO, under the UN Joint Team on HIV, has been focusing on male-dominated sectors to enhance the uptake of HIV services. Since 2015 the ILO has partnered with the Federation of Kenya Employers, the Central Organization of Trade Unions, the National AIDS Control Council, the National AIDS & STI Control Programme and the Swedish Workplace HIV/AIDS Programme, supporting the Kenya Long Distance Truck Drivers Union and its health arm, Highway Community Health Resource Centre, to establish HIV workplace policy and programmes in 30 transport companies.

The programme provides truckers and sex workers at HIV hotspots along the northern transport corridor with HIV prevention and testing services and linkage to treatment. Advocacy with the management of participating workplaces, conducted by the Federation of Kenyan Employers and the ILO, resulted in the establishment of HIV committees in the workplace or the integration of HIV services into existing occupational safety and health programmes. Campaigns to raise awareness of HIV testing and its benefits for workers, for their families and for enterprises were undertaken. Information on social protection entitlements and support for registration to the National Hospital Insurance Fund were also provided.

Photo © Kenya Long Distance Truck Drivers and Allied Workers Union, Kenya

KENYA *continued*

In 2020 the COVID-19 pandemic posed a challenge, with restrictions leading to a slowdown of HIV interventions. In response to this, the partners designed an integrated programme on COVID-19 prevention and HIVST addressing truckers and sex workers. The programme was initiated because truck drivers who had tested positive for COVID-19 reported facing discrimination and long waiting time in COVID-19 testing and clearance processes. This provided an opportunity for engaging with the drivers on COVID-19 mitigation measures and also on HIV prevention and HIVST. Those who took HIVST kits were offered post-test counselling by telephone. Between June and November 2020, a total of 2995 HIVST kits, over 113 000 condoms, 7000 masks and over 5000 packs of hand sanitizers were distributed to truckers and sex workers.

Source: Hellen Magutu, ILO Kenya, 2020.

SOUTH AFRICA

Building on its long standing VCT@WORK programme, South Africa began its programme of HIVST (known in South Africa as HIV self-screening) at the workplace in 2018 with a focus on the mining, construction and transportation sectors and small businesses, including 176 microenterprises, in two districts. The ILO partnered with Reaction, a nongovernmental organization promoting HIVST, and facilitated partnerships with government and employers' and workers' organizations. The main approaches adopted were collaboration with networks of people living with HIV and with trade unions for distribution of HIVST kits to their workers at dedicated clinics. Between 2018 and 2020, over 160 000 HIVST kits were distributed, nearly two thirds of them to men. Close to half of those reached – 48% – were testing for the first time or had not tested in the past 12 months. Some 4.2% were diagnosed HIV-positive and linked to treatment.

Source: Simphiwe Mabhele, ILO South Africa, 2020.

ZAMBIA

Workplace HIVST started in Zambia in 2018 with support from Unitaid's STAR Initiative[1] with a focus on mining, agriculture, transport, tourism professions and parts of the informal economy. The project reached out to working men and women, with emphasis on young men in workplaces that are distant from other HIV testing services.

In 2019 a total of 191 peer educators and workplace champions from 60 workplaces were trained, and 11 000 HIVST kits were distributed. Operational costs were supported by funding from WHO to the National AIDS Council (NAC) and the Ministry of Health. The ILO provided technical support to the trainings. The STAR Initiative provided the test kits.

Building upon this, in 2020, the ILO provided financial and technical support to the Zambia Congress of Trade Unions to implement workplace HIVST in North Western and Lusaka provinces. The NAC, the Ministry of Health and the ILO trained 60 peer educators. The companies provided a forum where awareness raising activities and counselling sessions (group as well as individual) were held and HIVST kits were distributed.

Peer educators, working closely with employers, distributed 2500 HIVST kits provided by the Ministry of Health. In 2021 the HIVST at workplaces programme was scaled up considerably, and the programme is now being implemented in 15 companies by the Zambia Federation of Employers and the Zambia Congress of Trade Unions in collaboration with the NAC and the ILO.

Source: Theresa Mukeya, ILO Zambia, 2021.

[1] HIV Self Testing Africa (STAR) is a Unitaid-funded initiative to catalyze the global market for HIVST, generate evidence for global guidance and create an enabling environment for HIVST scale-up.

ZIMBABWE

In Zimbabwe the workplace HIVST programme focuses on industries with high numbers of workers and rapid turnover, such as the mining, agriculture, manufacturing, fast-food processing and energy sectors. The programme began by training peer educators and medical staff from 10 companies. Starting in May 2019, over 47 000 employees received education and information on workplace HIVST, and 12 780 HIVST kits were distributed. The majority of kits (72%) were distributed to men. Of those tested, 548 (4.3%) tested positive, and 281 of these (51%) started treatment during the six months follow-up period. Encouraged by this experience, 10 more companies have joined the HIVST initiative in 2021, which the ILO is facilitating in partnership with the Ministry of Health and Child Care (MoHCC).

Like other programmes, this was a collaborative effort involving a public–private partnership, among the MoHCC, the ILO, WHO, Population Services International (PSI) and the private sector. The STAR Initiative provided HIVST kits. The NAC, the ILO and the private sector implemented the programme.

Source: Ida Chimedza, ILO Zimbabwe, 2021.

KEY ENABLERS FOR SUCCESSFUL WORKPLACE HIVST PROGRAMMES

Based on the experience of workplace HIVST programme implementation and stakeholder interviews, several key enablers of the success of workplace HIVST programmes emerge. These include:

- presence of a non-discriminatory HIV workplace policy demonstrating commitment to respect for confidentiality, protection of jobs and non-discrimination;
- presence of an existing workplace HIV programme such as VCT@WORK;
- partnership and collaboration among key stakeholders including government, national programme, employers, employees and implementing partners;
- ownership and buy-in from employers' organizations, trade unions and their leadership;
- training of staff, community health workers and workplace peer educators to support mobilization, HIVST kit distribution and linkage to post-test services;
- financing through a range of sources, for example, provision of HIVST kits by partners/ministry of health, resources contributed by the ILO and employers, and the use of existing workplace facilities and programmes, such as clinics and occupational safety and health and wellness programmes;
- a focus on communication and advocacy highlighting the benefits of testing and HIVST.

3. EMERGING FINANCING APPROACHES AND THEIR SUSTAINABILITY

To date, workplace HIVST has been implemented on a small scale, as pilot projects, often building on existing programmes such as VCT@WORK and/or through catalytic donor investments by Unitaid, the US President's Emergency Fund for AIDS Relief (PEPFAR) or the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). In recent years donor financing for HIV response has either remained flat or declined *(12)*. At the same time, domestic financing for HIV programmes has increased in a number of countries.

Most government schemes raise funds through domestic revenues, primarily taxes, and provide a universal basic set of health care services.

Some countries raise HIV-specific national funds – for example, through earmarked taxes or levies or debt conversion.

For HIV-related services at the workplace broadly, countries have used four financing approaches through public or private financing:

- financing from general government revenues
- social/national health insurance
- private health insurance
- company-led workplace programmes.

These financing approaches, with relevant case examples, are presented below.

3.1 Public financing

3.1.1 General government revenues

Government health spending as a share of total government spending reflects the public priority of health. The average shares in 2018 were 5.6% in low-income countries, 7.3% in lower-middle-income countries, 11.6% in upper-middle income countries and 14.3% in high-income countries. Funding for HIV/AIDS in both low- and middle-income countries continues to rely more on external aid than on domestically generated government revenues *(13)*.

Still, government financing for health is central to national HIV programmes. Government health schemes are often universal, available to all citizens or residents, or sometimes applied with some restrictions, for a specific segment of the population such as the poor or those with certain health conditions or for specific health interventions. The amount of coverage, budgetary allocation and other characteristics of government health schemes differ markedly from country to country.

An example of HIV-specific revenues for national budgets is HIV and AIDS levies on airplane tickets, beverages and alcohol sales. The Zimbabwe AIDS levy is a 3% tax on profits of all employers and trusts. It raises the equivalent of over US$ 35 million annually and signals an important commitment by the country. At least half of these funds are used to buy antiretroviral (ARV) medications, and the remainder goes to administration and capital costs, HIV prevention, and monitoring and evaluation *(14)*.

Another example is the Debt2Health programme, managed by the Global Fund, which converts debt repayments into life-saving investments in health. Under individually negotiated "debt swap" agreements, an implementing country agrees to invest part or all of the freed-up resources into a national Global Fund-supported programme. The investment is made through the Global Fund according to the systems and principles that it regularly uses to disburse grants. In return, a creditor country cancels an equivalent amount of debt owed by the implementing country. From its inception in 2007 through September 2020, eight implementing countries – Cameroon, Côte d'Ivoire, Democratic Republic of Congo, El Salvador, Egypt, Ethiopia, Indonesia and Pakistan – have invested nearly US$ 140 million in domestic health programmes through this mechanism. In return, Australia, Germany and Spain have cancelled debt in those implementing countries *(15)*.

Government financing for workplace HIV testing has been used in all VCT@WORK programmes to complement the ILO's resources. In the United Republic of Tanzania, for example, the Dodoma City Council, the President's Office Public Service Management and the Tanzania AIDS Commission led the mobilization of public service employees' HIV testing in 24 national ministries and ministerial departmental agencies. Between June 2018 and June 2019, 265 785 people were tested from the workplaces. The leadership of the prime minister was key. He set the example by testing himself using a self-test, and played an important role in mobilizing the various ministries and partners.

Government financing for health in low- and middle-income countries often does not cover HIVST. There is potential for considerable benefit through expanding such financing to include HIV testing, including workplace HIVST. Such spending is likely to be highly cost-effective. As HIVST at workplaces is a means to enable more men to test, countries may prioritize HIVST for workers in selected economic sectors, such as those with many mobile and migrant workers, uniformed personnel and workers in remote sites, far from health centres. Also, this approach will reduce the burden on over-crowded health facilities and health service providers.

3.1.2 Social/national health insurance

Social health insurance is characterized by mutual support. The level of the contribution is not related to individual risk but rather to the ability of the persons covered to contribute. Contributions to social insurance schemes are calculated on the principle of collective equivalence between income and expenditure, and contribution levels are graduated according to ability to contribute *(16)*.

Many countries have introduced social or national health insurance schemes as a supplementary mechanism to raise and pool funds to finance health services, including at workplaces. Generally, but not always, the wealthy contribute more than the poor, and contributions do not vary with health status, thus advancing equity *(16)*. This approach can be used to finance workplace HIVST programmes, although the challenge will be to enhance coverage of insurance for workers in the informal economy, especially in low- and middle-income countries.

Social protection includes both access to health care and income security. Although significant progress has been made towards increasing the coverage of social health protection, over four billion people, more than half of the global population, remain entirely unprotected by any social protection benefits, according to the ILO's 2021 *world social protection report (17)*. Yet, regional differences remain; for example, the percentage of the population covered by a social protection scheme in sub-Saharan Africa is only 15.7%, while in South Asia it is 23.4%. The COVID-19 pandemic has further exacerbated the social protection gap between countries with high- and low-income levels.

For those covered by health insurance, barriers to accessing health care take the form of high out-of-pocket payments, distance to services, limitations in the range, quality and acceptability of health services, long waiting times, as well as opportunity costs such as lost working time. The COVID-19 pandemic has highlighted the inadequacy of benefits in many schemes and the need to reduce out-of-pocket payments. The ILO report notes that the financing gap (the additional investment required to ensure at least minimum social protection for all) has increased by approximately 30% since the start of the COVID-19 pandemic.

HIV care package integrated into universal health coverage in Thailand

In Thailand the Universal Coverage Scheme (UCS) was launched in 2002 to achieve 100% health insurance coverage for all citizens. The UCS has made access to health care a fundamental right. Hence, it is the duty of the government to facilitate standard medical care services for everyone. In 2006 Thailand integrated the HIV care package into the UCS, including support for HIV testing and ARV treatment. The National AIDS Programme in Thailand is coordinated by the Ministry of Public Health. The National Health Security Office acts as purchaser and system manager in the health system and is responsible for providing HIV treatment and care, HIV testing services and HIV prevention. General government taxation funds the UCS *(18, 19)*.

Integrating HIV into the social health insurance of Viet Nam

In Viet Nam social health insurance and donor funding finance the HIV response. The social health insurance package covers both inpatient and outpatient services, including rehabilitation services, screening, diagnostics and, in poor and mountainous areas, transportation. The annual premium is the equivalent of approximately US$ 30 but is subsidized for people with HIV *(20)*.

Social health insurance is an important financing mechanism ensuring the sustainability of the HIV response. For example, in Hanoi the scheme raises funds through progressive taxation; persons classified as poor or near poor are exempted from contributions, while those who earn higher incomes pay for a portion (up to 20%) of care received. As of 2019, approximately 46% of people with HIV used social health insurance for their health care. In Viet Nam 25% of total spending in health flows through the government budget and 21% through SHI *(21)*.

3.2 Private financing

3.2.1 Private health insurance

Private health insurance packages can complement public health financing mechanisms within the national context and policies. Private health insurance refers to any health insurance package provided by a private entity. In the context of the workplace, this insurance is typically purchased by employers and offered to their employees. Private insurance packages that cover prevention, testing and screening services are beneficial for employers as they avoid or reduce the long-term costs of treatment and rehabilitation.

In some countries people with pre-existing conditions including HIV are denied private insurance. For example, a recent study by the ILO and the Malaysian AIDS Foundation found that health insurance companies in Malaysia exclude people living with HIV from their coverage package because they are unaware of the advances in ARV treatment, which make possible longer life expectancy and general gains in the health of people living with HIV *(22)*.

Inclusion of HIV and HTS in private insurance

Kenya's Jubilee Insurance, a major private health insurance provider, has included HIV testing, care and other services in its coverage since 2004. Like most private health insurance programmes, Jubilee is open to the public – individuals, families, small- and medium-sized enterprises and large corporate organizations.

An estimated 70% to 80% of corporate clients (employer-based groups) buy the optional HIV and AIDS coverage. Jubilee holds educational sessions, inviting medical specialists to advise members on how to achieve the most cost-effective treatment to maximize their insurance benefits and improve health outcomes. Jubilee has learned that, due to heightened awareness about HIV testing campaigns, people living with HIV are diagnosed earlier, which contributes to lower treatment costs for those who proactively manage their conditions. In contrast, other chronic conditions, such as cancer, which are covered by insurance, often remain undiagnosed or are diagnosed late, leading in some cases to higher long-term treatment costs compared with those of HIV. Thus, the gains made in HIV awareness and testing have a positive impact on the actuarial costs of treating HIV and AIDS *(23)*.

National policy and legislation can play a crucial role in motivating insurance companies to expand coverage for HIV and AIDS. For example, in Kenya the National AIDS Control Policy on non-discrimination towards people living with HIV motivated Jubilee Insurance to expand coverage for HIV and AIDS.

Contributions to private health insurance, often called premiums, are usually not related to income or economic status but rather to individual health condition and risks. Private insurance premiums are calculated on the basis of individual equivalence, which means that the insurance policy must be equal for all individuals. Private health insurance schemes can involve subscribers' co-payments. Pre-existing conditions may not be covered, and a health examination to identify pre-existing conditions may be required upon entry into the scheme *(16)*.

There is certainly an economic case for inclusion of HIV coverage in private insurance, based on experiences of companies and the advances in antiretroviral treatment, which enables people living with HIV to live long and productive lives.

3.2.2 Company-led workplace programmes

In this financing approach, employers use their own resources, such as workspace (for example, on-site clinics, occupational safety and health infrastructures) and human resources (such as nurses, doctors, health officers and trained peer educators) to directly provide health care to their workforce. Through this approach, employers can provide access to HIVST at workplaces and facilitate linkage to ART and other post-test services that are usually provided free of charge by national governments. Several companies or organizations can undertake joint ventures with a common procurement plan to obtain large volumes of HIVST kits at a lower price.

A workplace programme led by employers, under the company's health and wellness or HIV workplace policy, uses a company's financial and human resources to promote the health and well-being of workers.

Company-led integrated HIV and TB workplace programme – an example from India

Brihanmumbai Electric Supply and Transport (BEST), a major public sector company in Mumbai, India, employing over 40 000 people, provides a good example of a company-led HIV and tuberculosis (TB) programme. Since 2005 the company has conducted regular awareness programmes on HTS and provided confidential and voluntary testing for HIV, TB and other conditions. To reduce stigma related to HIV testing, several employees serve as peer educators, and HIV testing is performed along with other health screening tests.

BEST spends 1% of its annual budget, around US$ 81 000, on the health and welfare of its employees. BEST has been implementing its workplace HIV and AIDS programmes in collaboration with the ILO and has developed a workplace policy on HIV and TB that guides its programme. BEST has developed a memorandum of understanding (MOU) with Mumbai District AIDS and TB Control Society (MDACS/MDTCS) and the National AIDS Control Organization (NACO) of the Ministry of Health and Family Welfare. Under this MOU, MDACS/MDTCS and NACO support awareness and training. The company trains peer educators at its three training centres. Between 2019 and 2021, over 100 peer educators in different departments and levels of the company have been trained to raise awareness of HIV and TB among employees. Two dedicated ART clinics and one clinic for offering short course of directly observed treatment for TB (DOTS) are linked with BEST. For specialized or in-patient care that is not available at these clinics, BEST covers the cost for its employees.

Photo © BEST Company, India

Building over years of successful integrated HIV and TB programme, BEST has also started piloting HIVST under the action research project initiated in India in 2021.

Key factors that make the BEST's programme sustainable are: management commitment, allocation of an annual budget, the existence of a supportive HIV and TB workplace policy and the systematic monitoring of its policy, the engagement of trade unions, MOUs with national government programmes, a focus on regular capacity building of peer educators and reviews every six months of the work plan by a joint working group.

Source: Anil Singal, BEST Company, 2021.

4. CONCLUSION

Early experiences and emerging evidence on workplace HIVST highlight its potential for reaching people who do not otherwise have access to HTS and linking them to services for confirmatory testing and ART. HIVST at workplaces is particularly useful for reaching men and first-time testers. Also, HIVST makes use of existing workplace resources such as health and wellness clinics, occupational safety and health infrastructures and employers' budgets for HIV programmes. Engagement of trade unions helps greatly in mobilizing workers to use HIVST.

Key elements that make a successful HIVST workplace programme include:

- effective engagement of all stakeholders and commitment and ownership from the management
- supportive workplace policy on HIV that protects the human rights of workers, demonstrates commitment to non-discrimination and respect for confidentiality, and assurance of continued employment for those diagnosed HIV-positive
- buy-in from staff and workers and use of well-trained peer educators
- leveraging existing workplace programmes, workplace resources and effective linkage to post-test services.

Countries and workplaces can build on existing HTS programmes and initiatives, such as VCT@WORK, to implement and scale up HIVST in workplaces. Some countries begin by introducing workplace HIVST on a small scale, often with catalytic donor investments and partnerships, as with the Unitaid STAR initiative, the Global Fund, PEPFAR and the ILO. These pilot initiatives are helpful in setting up the necessary systems in collaboration with the national governments and enabling countries to learn lessons that can inform scale-up decisions.

The COVID-19 pandemic has further highlighted the need for investment in social protection systems. Investments need to be made keeping in mind the principle of leaving no one behind so that all members of society, including people living with HIV are covered. Collective financing, broad risk pooling and rights-based entitlements are essential for effective access to health care for all.

Despite limited direct experience and models for sustainable financing of workplace HIVST programmes, there are several approaches that have been used for HTS and other HIV services. These approaches can be considered and adapted to support workplace HIVST. National legislation, appropriate social protection and workplace policies are needed to promote adequate coverage for HIV services in health financing approaches. Further implementation of innovative approaches is needed to understand the different financial approaches for workplace HTS programmes in general and workplace HIVST programmes in particular, including for those working in the informal economy.

REFERENCES

1. Consolidated guidelines on HIV testing services 2019. Geneva: World Health Organization; 2019 (https://apps.who.int/iris/handle/10665/336323, accessed 23 September 2021).

2. Seizing the moment: tackling entrenched inequalities to end epidemics. Global AIDS Update 2020. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2020 (https://www.unaids.org/sites/default/files/media_asset/2020_global-aids-report_en.pdf, accessed 23 September 2021).

3. 2021 UNAIDS Global AIDS update — confronting inequalities — lessons for pandemic responses from 40 years of AIDS. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2021 (https://www.unaids.org/en/resources/documents/2021/2021-global-aids-update, accessed 23 September 2021).

4. AIDSinfo [database]. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2021 (https://aidsinfo.unaids.org/, accessed 2 July 2021).

5. Makusha T, van Rooyen H, Cornell M. Reframing the approach to heterosexual men in the HIV epidemic in sub-Saharan Africa. J Int AIDS Soc. 2020;23.

6. Improving men's uptake of HIV testing and linkage to services. Geneva: World Health Organization; 2021 (https://apps.who.int/iris/handle/10665/339620, accessed 23 September 2021).

7. World Health Organization and International Labour Organization. HIV self-testing at the workplace. Policy Brief. Geneva: World Health Organization; 2018 (https://www.ilo.org/wcmsp5/groups/public/---dgreports/---gender/documents/publication/wcms_651792.pdf, accessed 23 September 2021).

8. International Labour Conference. Recommendation 200: Recommendation concerning HIV and AIDS and the world of work. Geneva: International Labour Organization; 2010 (https://www.ilo.org/ilc/ILCSessions/previous-sessions/99thSession/texts/WCMS_142613/lang--en/index.htm, accessed 23 September 2021).

9. HIV self-testing at workplaces in Zimbabwe [webpage]. In ILO/HIV and AIDS/VCT@WORK. Geneva: International Labour Organization; 2019 (https://www.ilo.org/global/topics/hiv-aids/vct/WCMS_735379/lang--en/index.htm, accessed 23 September 2021).

10. Jamieson L, Johnson LF, Matsimela K, Sande LA, d'Elbée M, Majam M et al. The cost effectiveness and optimal configuration of HIV self-test distribution in South Africa: a model analysis. BMJ Glob Health. 2021;6:e005598.

11. Matsimela K, Sande LA, Mostert C, Majam M, Phiri J, Zishiri V et al. The cost and intermediary cost-effectiveness of oral HIV self-test kit distribution across 11 distribution models in South Africa. BMJ Glob Health. 2021;6:e005019.

12. Kates J, Wexler A, Lief E, Joint United Nations Programme on HIV/AIDS. Donor government funding for HIV in low-and middle-income countries in 2021. San Francisco: Kaiser Family Foundation (KFF); 2021 (https://www.kff.org/global-health-policy/report/donor-government-funding-for-hiv-in-low-and-middle-income-countries-in-2020/, accessed 23 September 2021).

13. Global spending on health: weathering the storm. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/337859, accessed 23 September 20212).

14. Bhat N, Kilmarx PH, Dube F, Manenji A, Dube M, Magure T. Zimbabwe's national AIDS levy: a case study. SAHARA J. 2016;13:1-7.

15. Innovative finance [webpage]. Geneva: The Global Fund to Fight AIDS, Tuberculosis and Malaria; 2021 (https://www.theglobalfund.org/en/innovative-finance/, accessed 9 July 2021).

16. Social protection spotlight. Towards universal health coverage: social health protection principles. ILO Brief. Geneva: International Labour Organization; 2020 (https://www.ilo.org/secsoc/information-resources/publications-and-tools/Brochures/WCMS_740724/lang--en/index.htm, accessed 23 September 2021).

17. World Social Protection Report 2020–22. Social protection at the crossroads – in pursuit of a better future. Geneva: International Labour Organization; 2021 (https://www.ilo.org/global/publications/books/WCMS_817572/lang--en/index.htm, accessed 23 September 2021).

18. The journey of universal access to antiretroviral treatment in Thailand. South–south cooperation on universal health coverage: a road to equitable and health society. Bangkok: United Nations Development Programme 2017 (https://eng.nhso.go.th//assets/portals/1/files/10%20The%20Journey%20of%20Universal%20ART%20Thailand.pdf, accessed 23 September 2021).

19. Thailand integrates HIV response into UHC [webpage]. Bangkok: National Health Security Office; 2020 (https://eng.nhso.go.th/view/1/DescriptionNews/Thailand-integrates-HIV-response-into-UHC-/155/EN-US, accessed 23 September 2021).

20. Todini N, Hammett TM, Fryatt R. Integrating HIV/AIDS in Vietnam's Social Health Insurance Scheme: Experience and Lessons from the Health Finance and Governance Project, 2014–2017. Health Systems & Reform, 2018 (https://doi.org/10.1080/23288604.2018.1440346)

21. Health financing in Viet Nam. In: WHO/Health financing [webpage]. Geneva: World Health Organization; 2021, accessed 23 September 2021).

22. A study on medical insurance coverage for people living with HIV in selected multinational insurance companies in Malaysia. Geneva: International Labour Organization; 2021 (https://www.ilo.org/global/topics/hiv-aids/publications/WCMS_789866/lang--en/index.htm, accessed 23 September 2021).

23. Talib A, Hatt L. Expanding Private Health Insurance Coverage for HIV and AIDS in Sub-Saharan Africa. 2013. Brief. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Assoc.

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POLICY BRIEF

HIV TESTING SERVICES