**HIV Testing: Entry to the UNAIDS 90-90-90 target**

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Benefits of early antiretroviral therapy for the individual and society are well-established (1, 2). A necessary first step to realising these benefits is HIV status awareness, followed by accessing and maintaining HIV treatment. UNAIDS/WHO’s ambitious target notes 90% of people living with HIV knowing their status, 90% of HIV-positive people on ART and 90% of people on ART virally suppressed (3). However, in sub-Saharan Africa (SSA), men and young people in particular, HIV testing rates are modest, ART uptake limited and subsequently poor virological suppression common (4).

To improve HIV testing rates, Geoffrey and colleagues (ref) examined the effectiveness of door-to-door HIV testing in reaching youth and men in 57 villages in rural Malawi, with an average of 284 individuals per village enumerated for the study. Of 16,200 enumerated, 15,401 (95%) individuals aged 2 years and above were eligible for HIV testing, of whom 13,783 (90%) accepted HIV testing , similar across all age groups. The overall testing rate was 85% (90% of 95%) or 90% of those seen in the home, more men than women were testing for the first time (77% vs 59%); 65% of those who tested were aged less than 24 years. Overall HIV prevalence was 4%, higher in females than males (5% vs. 2%) with a steep increase in prevalence in individuals over the age of 25 years.

Men were more difficult to reach than women, similar to experience in other settings (5), which could have been due to testing activities being restricted to 10am-3pm weekdays. About 800 people were enumerated but not offered testing, nearly 1400 were unreachable and 215 refused; it is unknown whether these 15% would be more or less likely to be HIV infected. It was also difficult to establish the number of individuals in villages not reached by the intervention where households were not enumerated and the average population per household could thus not be estimated. Mulanje, where the study took place, has a population of 670,000, average of 1160 individuals per village, substantially higher than in the study. Nevertheless, findings here are in line with experience elsewhere showing that community HIV testing approaches are known to reach hard-to-find groups like men and young individuals with the added advantage of earlier HIV diagnosis (6).

In many parts of SSA HIV testing has remained largely facility-based with community testing promoted by non-governmental organisations as part of implementation research. Poor HIV testing uptake would make it difficult to achieve the 73% (90% of 90% of 90%) target of all HIV-positive individuals being virally suppressed by 2020 (3), and systemic factors that affect one step of the cascade are likely to affect the other steps as well, linkage to care has proved to be even more of a challenge than HIV testing (7).

To achieve and sustain high HIV testing rates, especially for men and young people, combination HIV testing that incorporates facility-based HIV testing, work-place testing, community testing and self-testing should become part of routine HIV testing services supported by government HIV programmes. However, this needs to be followed by improving community-based linkage to care.

**References**

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