

Statement and recommendations on scaling up HIV testing and counselling

Introduction

- 1 On 30 May 2007, WHO and UNAIDS issued guidance on provider-initiated HIV testing and counselling (PITC) in health facilities.² This statement by the UNAIDS Reference Group on HIV and Human Rights is issued in response to the Guidance, recognizing that the Guidance is having a big impact in shaping policy and practice on HIV testing and counselling in countries around the world. It is crucial that HIV testing and counselling be implemented in ways that maximise benefits to individuals and public health and respect, protect, and fulfil human rights.
- 2 The statement is addressed to WHO and UNAIDS, national governments, donors, health care providers, NGOs and others involved or interested in efforts to expand access to HIV testing and counselling as part of global efforts to achieve universal access to HIV prevention, treatment, care and support by 2010.
- 3 The Reference Group welcomes the new WHO/UNAIDS Guidance and calls for rapid action to scale up access to HIV testing and counselling, with full funding and programmatic attention to the protections to patients provided in the Guidance. In this spirit, the Reference Group raises the following concerns, makes a series of recommendations, and urges WHO, UNAIDS, national governments, donors, and others concerned to move quickly to address them.
- 4 Efforts to increase access to HIV testing and counselling are not occurring in a vacuum. Rather, they take place in an environment in which evidence-informed and human rights-based policies and responses to HIV are being widely undermined. Furthermore, even as vastly increased funding for HIV has become available, those most vulnerable to HIV and its impact continue to receive the least access to HIV prevention, care and treatment services.

¹ The UNAIDS Reference Group on HIV and Human Rights is an independent, advisory body, established in 2002 to advise the Joint United Nations Programme on HIV/AIDS (UNAIDS) on all matters relating to HIV and human rights. Its members act in their individual capacity. The views of the Reference Group, including those expressed in this paper, do not necessarily reflect the views or positions of the UNAIDS Secretariat or the Co-sponsors of UNAIDS. This paper results from a collective reflection among members of the Reference Group. It does not necessarily imply the individual agreement of all Members of the Group to all statements in the paper. In particular one member, Mr Anand Grover from the Lawyers Collective in India, expressed much more serious concerns that the WHO/UNAIDS Guidance on PITC could unintentionally legitimate violations of human rights linked to HIV testing that are already widespread in Asia. Since its first meeting in 2003, the Reference Group has actively participated in the debate about HIV testing. In particular, in 2004, it issued a statement on how to ensure a rights based approach to scaling up access to HIV testing and counselling (reproduced in Appendix 1) and in January 2007 provided extensive comments on the draft WHO/UNAIDS guidance on PITC (available via www.unaids.org/en/Issues/Impact_HIV/20070601_reference_group_HIV_human_rights.asp). The Reference Group would like to acknowledge the work on HIV testing undertaken by the Open Society Institute's Public Health Program. Its paper on "Increasing access to HIV testing and counseling while respecting human rights" (available via http://www.soros.org/initiatives/health/articles_publications/publications/routinizing_20061213) and a summary of that paper (submitted for publication) have greatly assisted the work of the Reference Group and have served as the basis for these comments.

² WHO, UNAIDS (2007). Guidance on provider-initiated HIV testing and counselling in health facilities. Available via <http://www.who.int/hiv/en/>

- 5 Most importantly, in many countries there are many abuses around the manner in which HIV testing and counselling are conducted. The Reference Group is concerned that, **if the issues it raises are not addressed, implementation of the Guidance may lead to further abuses, rather than to increased benefits for human rights and public health.**
- 6 This is recognized by the WHO/UNAIDS Guidance itself where it states: “Decisions on how best to implement provider-initiated HIV testing and counselling will depend upon an assessment of the situation in a particular country ... Where there are high levels of stigma and discrimination and/or low capacity of health care providers to implement provider-initiated HIV testing and counselling under the conditions of informed consent, confidentiality and counselling, adequate resources must be devoted to addressing these issues **prior to implementation** (emphasis added).”³
- 7 As elaborated below, the Reference Group asks that UNAIDS/WHO and governments fully honour this part of the Guidance by assessing the situation in country, and where necessary, putting in place sufficient measures prior to and during implementation of provider-initiated testing and counselling to ensure that the three prerequisites, outlined by the Guidance, for provider-initiated testing and counselling are indeed in place:
- access to HIV prevention, care and support services, including a reasonable expectation that access to antiretroviral therapy will become available in the near future as part of a national plan to achieve universal access to antiretroviral therapy
 - sufficient capacity of health care providers to implement provider-initiated testing and counselling under the conditions of informed consent, confidentiality and counselling, and
 - sufficient programmatic attention to protecting people from stigma and discrimination.

A human rights and public health imperative: The need to expand access to both client and provider-initiated HIV testing and counselling

- 8 The Reference Group recognizes that vastly expanded access to voluntary, affordable and high-quality HIV testing and counselling is essential for an effective global response to HIV, and is both a public health and a human rights imperative.
- 9 Scaling up access to HIV testing and counselling and providing appropriate provider-initiated HIV testing and counselling, in addition to scaled-up client-initiated voluntary counselling and testing (VCT) services, is likely to have many benefits, as long as people who test HIV positive:
- can benefit from treatment, care and support, including antiretroviral treatment (ART)
 - have access to evidence-based prevention measures that enable them to reduce the risk of transmission to their partners, and
 - are protected from stigma, discrimination and violence through a supportive social and legal environment.

³ WHO/UNAIDS Guidance, at 45.

Human rights and the “Three Cs”: counselling, informed consent, and confidentiality

- 10 In order to make it feasible for health-care providers to offer HIV testing and counselling to all their patients, in some settings it may be justified to relax, to some extent, pre-test counselling requirements. Human rights and public health do not require cumbersome procedures for pre-test counselling. But human rights – and public health imperatives – require that, regardless of whether persons are routinely offered an HIV test in a health care setting or whether they initiate HIV testing themselves, they can seek and receive sufficient information to enable them to give informed and truly voluntary consent to testing. They also require that people receive post-test counselling and that confidentiality of test results and of the fact of seeking a test are guaranteed.
- 11 WHO and UNAIDS, in their Guidance on PITC, acknowledge that patients need to be able to make a voluntary and informed decision about whether to be tested or not, and specify the minimum information for informed consent that health care providers should provide patients when recommending HIV testing and counselling.⁴ However, the Reference Group remains concerned that adoption of an “opt-out” approach to testing (under which people are tested unless they clearly opt out and refuse to be tested), as recommended by WHO and UNAIDS,⁵ may in practice result in a greater number of people being tested without their informed and voluntary consent. In settings where there is a power imbalance between test provider and client, the voluntary nature of HIV testing may be compromised, as the client may feel compelled to consent to the provider’s offer.
- 12 One way of rapidly scaling up access to HIV testing that may be as effective as a matter of public health and more respectful of human rights would be to routinely offer and recommend “opt-in” HIV testing and counselling, rather than “opt-out” testing. With an “opt-in” approach, testing is initiated by the provider, who *offers* an HIV test as a routine part of discussions with all patients in a given setting or meeting certain criteria (e.g., all pregnant women, all patients using STI health services), but the client must specifically agree to the test, rather than merely not decline it. With “opt-out”, the default is testing; with “opt-in”, the default is no testing. This is an important distinction that the Guidance fails to make by in some places equating provider-initiated testing and counselling with “opt-out” testing. Where implementation of an “opt-in” approach is adequately supported, it may be as successful or nearly as successful in increasing the number of people who test for HIV as adopting an “opt-out” approach. It also has the potential to have an impact on access to care and treatment, prevention, and stigma similar to that of PITC using an “opt-out” approach.⁶

Recommendation 1

National governments that consider introducing provider-initiated HIV testing and counselling in (some) health-care settings should consider adopting an “opt-in” rather than “opt-out” approach.

⁴ Ibid, at 36-37.

⁵ Ibid, at 5.

⁶ Jürgens R (2007). *Increasing access to HIV testing and counseling while respecting human rights*. New York: OSI Public Health Program.

- 13 Ultimately, any form of PITC – whether opt-in or opt-out – will have to be carefully monitored and evaluated to ensure that, in practice, providers offer and recommend testing, and that patients give informed and voluntary consent to the test.⁷ In this context, the Reference Group notes with concern that more detailed guidance on monitoring and evaluation, while being developed by WHO, is not available at this point.
- 14 In addition, for the same reason, training programmes for personnel who will perform HIV testing and counselling in health facilities, as well as for other staff who deal with clients in health services, will have to be developed and implemented well in advance of the implementation of provider-initiated HIV testing and counselling.

Recommendation 2

WHO and UNAIDS should develop (a) a model code of conduct for health care providers undertaking HIV testing and counselling; (b) guidance on the content of training on informed consent, confidentiality and counselling; and (c) minimum standards for training and accrediting trainers. In addition, they should assist countries in implementing and overseeing such a code, in training health care personnel, and in securing the resources necessary for the training and implementation of the code of conduct.

Recommendation 3

Health facilities should adopt the code of conduct for health care providers undertaking HIV testing and counselling (after adaptation to local circumstances, if required) and work with national governments to provide effective methods of redress for patients whose rights are infringed.

Recommendation 4

WHO and UNAIDS should ensure that more detailed guidance on monitoring and evaluation of HIV testing and counselling, including provider-initiated testing and counselling, will become available soon. Such guidance should include clear indicators by which to monitor and evaluate the implementation of testing scale-up efforts, including indicators sensitive to human rights concerns and to the linkages between testing and counselling and prevention, care and treatment services.

Recommendation 5

National governments, donors, and health facilities should ensure that monitoring and evaluation form an essential and ongoing part of programmes to implement provider-initiated HIV testing and counselling. Formal and routine engagement of civil society, including community-based organizations and networks of people living with HIV in monitoring and evaluation should be considered as one important strategy.

- 15 As the amount of data collected through routine monitoring will always be limited, routine monitoring should be complemented with targeted evaluations, as appropriate to various settings. This is particularly important because many of the discussions and assumptions (e.g. that greater knowledge

⁷ Tarantola D, Gruskin S (2007). New guidance on recommended HIV testing and counselling. *The Lancet*, 370 (3583): 202-203.

of status reduces stigma and discrimination) around HIV testing and counselling have occurred in the absence of empirical data, either from studies or from monitoring of existing programmes. Particularly outside the prenatal context, evidence about the impact of provider-initiated testing and counselling remains limited, and deeper research questions beyond simply the numbers of people getting tested need to be adequately addressed to ensure that testing and counselling are having their intended effect. Questions such as the following should be addressed: What is the experience of people being tested as a result of approaches in which HIV testing is more routine? Would “opt-out” approaches to provider-initiated testing and counselling lead to a greater chance of negative consequences including human rights abuses, particularly against women, than “opt-in” approaches, or than increased investment in VCT and anti-stigma campaigns? Would such forms of HIV testing “normalize” HIV and reduce HIV-related stigma to a greater extent than forms of HIV testing under which people are offered the test, but tested only if they opt in? Would such forms of testing result in greater or lesser uptake of ART? Under what conditions are such forms of testing likely to deter patients seeking care? Would such forms of testing increase the number of people who are tested for HIV significantly more than routine offer of testing and, if so, would this extra margin be prepared to know their HIV status, disclose it to their partner(s) and engage in positive behaviour change? To what extent is the ability to scale up treatment currently being restricted by a “testing gap” rather than by other factors? What effect do routine forms of testing have on the preventive value of testing and counselling, and would any potential negative effect be offset by the greater number of people who may take up testing? What is the impact of rapid point-of-care testing on counselling and the consent process? Do the jurisdictions that have adopted an “opt-out” approach have universal or even good access to treatment and prevention?

Recommendation 6

WHO and UNAIDS should encourage and support targeted evaluations, as appropriate to various settings, to assess whether increased uptake of testing allows countries to achieve prevention and treatment goals, providing information about the number of people who obtain their test results, disclose their HIV status, ultimately change their sexual and/or drug using behaviours, and access care and treatment, including ART. Research is also needed to capture the experience of HIV testing and that of people who may be at risk of adverse outcomes.

Scaling up voluntary counselling and testing (VCT)

- 16 Efforts to expand access to HIV testing and counselling, which currently focus on provider-initiated testing and counselling in formal health settings, need to devote greater attention to how client-initiated VCT services can be improved and scaled-up, particularly for socially marginalized groups.
- 17 A large body of research demonstrates the effectiveness of VCT as part of comprehensive prevention, treatment and care strategies. VCT services that are responsive and sensitive to the communities served need to be adequately supported by resources and promoted and scaled up. Research studies undertaken in many countries and settings suggest ways in which uptake and acceptability of VCT can be increased.
- 18 Scaling up access to VCT is particularly important because large numbers of people do not use formal health services and may need other ways to gain access to HIV testing and counselling, especially if

they live in rural areas poorly served by the health care system, are mobile, or belong to vulnerable communities who face stigma and discrimination in health settings.

Recommendation 7

WHO and UNAIDS should support strategies to increase access to and uptake of HIV testing and counselling through client-oriented VCT services, including by:

- documenting best practice
- updating existing guidance on VCT
- providing technical support to countries investing in greater access to VCT services
- continuing to emphasize the importance of VCT services and advocating for increased funding for them.

Recommendation 8

National governments should ensure that efforts to increase access to HIV testing and counselling include efforts to increase access to client-initiated VCT services and that these efforts form an essential part of achieving universal access to HIV prevention, care and support.

Meeting the needs of most-at-risk populations

- 19 In their Guidance, WHO and UNAIDS do recognize that “strategies are needed to increase access to and uptake of HIV testing and counselling” for most-at-risk populations, “particularly through innovative client-initiated approaches such as services delivered through mobile clinics, in other community settings, through harm reduction programmes or through other types of outreach”.⁸ However, the Guidance also says that “consideration should be given to recommending HIV testing and counselling to all patients who attend [specific health services, such as acute care, STI or drug dependence treatment services]”.⁹
- 20 The Reference Group is concerned that implementation of provider-initiated testing and counselling in such settings may lead some people to avoid seeking care. In many countries, people belonging to most-at-risk populations have been routinely subject to abuse in health care settings and may not feel that they have the power to decline a recommendation to be tested. The Guidance recognizes these concerns and makes several recommendations aimed at addressing them, including that “additional discussion”¹⁰ take place in these settings of the right to decline HIV testing and of the risks and benefits of HIV testing; and that “health care providers will usually require special training and supervision to uphold standards of informed consent and confidentiality for these populations”.¹¹ The Guidance concludes that “an ‘opt-in’ approach to informed consent may merit consideration for highly vulnerable populations”¹² and suggests that, where provider-initiated testing and counselling is implemented, most-at-risk populations

⁸ WHO/UNAIDS Guidance, at 24-25.

⁹ Ibid, at 25.

¹⁰ Id.

¹¹ Id.

¹² Id.

and their advocates should be involved in the development of HIV testing and counselling protocols and in the monitoring and evaluation of provider-initiated testing and counselling programmes.

- 21 Nevertheless, concerns remain that, unless dedicated financial and technical resources are devoted to ensuring that these recommendations can be implemented in practice, members of most-at-risk populations will continue avoiding health services or experiencing abusive treatment within such services.

Recommendation 9

WHO, UNAIDS, and other UN agencies should specifically support scale-up of innovative client-initiated VCT services for populations at risk.¹³

Recommendation 10

National governments should devote particular efforts to ensuring that members of most-at-risk populations are not left out of, or adversely affected by, efforts to increase access to HIV testing and counselling, and should ensure that they have easy access to innovative, client-initiated VCT services.

Recommendation 11

Recognizing that there is a need for more detailed guidance about the additional training and supervision required by health care providers working with most-at-risk populations, WHO and UNAIDS should develop and provide such guidance. For countries that consider adopting an “opt-out” approach to HIV testing in certain health settings serving these populations despite the concerns raised above, such guidance should specify what exactly the “additional discussion” of the right to decline HIV testing should entail.

Recommendation 12

Before rolling out “opt-out” provider-initiated testing and counselling in certain health facilities serving most-at-risk populations, national governments should undertake pilot projects incorporating additional discussion of the right to decline, as well as additional training and supervision, and carefully monitor and evaluate them.

¹³ In July 2007, UNODC and WHO commissioned a background paper to inform discussions about how to scale up access to HIV testing and counselling for members of two most-at-risk populations: people who use drugs and prisoners. By doing this, they acknowledged that – while the WHO/UNAIDS Guidance briefly addresses issues related to these populations – there is a need for more in-depth discussion and analysis of the specific issues related to HIV testing and counselling for people who use drugs and prisoners. Consultations on issues specific to HIV testing and counselling for prisoners and for people who use drugs are planned for September/October 2007. The aim of the consultations will be to come up with official policy statements on HIV testing and counselling of people who use drugs and of prisoners.

The Reference Group supports this initiative, which recognises that scaling up access to HIV testing and counselling among these populations raises particular public health and human rights issues and challenges, and looks forward to providing input into the policy statements.

HIV testing cannot be implemented in isolation

Universal access to HIV prevention, treatment, care and support

- 22 The Reference Group recognizes that access to ART should not be an absolute prerequisite for the implementation of provider-initiated testing and counselling, but underlines that HIV testing should never be done without assured links for each individual testing to prevention, care and support and to as early access to treatment as possible. Consequently, the efficacy of testing policies and programmes is, in turn, co-determined by the availability of effective prevention, care, treatment and support programmes. The Guidance provides for this in its assertion that provider-initiated testing and counselling must be linked to the provision of a package of HIV prevention, treatment, care and support services (which are spelled out in detail in the Guidance¹⁴). This means that efforts to scale up access to HIV testing and counselling need to be coordinated and integrated with efforts to scale up access to ART and to evidence-based prevention. Furthermore, many countries have poor or non-existent patient-tracking and referral modalities. Thus, there is no way to monitor whether patients who are tested and counselled in one setting ever receive the prevention, treatment, care and support they need. In such situations, one cannot assess whether expanded access to testing and counselling is resulting in positive health outcomes.

The need for serious and much greater investment in protection from discrimination and abuse

- 23 Increasing HIV testing and counselling must also go hand in hand with much greater investment in real protection – in practice, and not just on paper – from HIV-related discrimination and abuse, particularly for women, children and adolescents, sex workers, men who have sex with men, people who use drugs, and prisoners. In the Guidance, WHO and UNAIDS recognize that “equal efforts must be made to ensure that a supportive social, policy and legal framework is in place to maximize positive outcomes and minimize potential harm to patients”.¹⁵ Furthermore, the Guidance provides that where stigma and discrimination are high and capacity to implement the “Three Cs” is low, efforts to address these issues and build necessary capacity should take place before, as a precondition, to efforts to expand provider-initiated HIV testing and counselling.¹⁶
- 24 Yet in general, there have been few efforts to cost, budget and implement national programmes that would secure legal and human rights protections for people living with, affected by, or vulnerable to HIV and AIDS. Despite vastly increased funding for global AIDS programmes, there has been little investment in legal reform and legal support services, know your rights campaigns, campaigns against violence against women, and other initiatives to provide protection from stigma, discrimination and other human rights abuses. Nor does it appear that in the context of expansion of provider-initiated testing and counselling governments are assessing their situations in terms of levels of stigma and discrimination and health-worker capacity, and where problematic, taking steps to address any problems **before** expanding testing and counselling.

¹⁴ WHO/UNAIDS Guidance, at 30-31.

¹⁵ Ibid, at 32.

¹⁶ Ibid, at 45.

Recommendation 13

WHO and UNAIDS should highlight that increased access to HIV testing and counselling should never be a goal in itself and strongly advocate for the coordination and integration of countries' efforts to scale up:

- access to HIV testing and counselling
- access to treatment
- access to evidence-based prevention; and
- legal and human rights protections for people living with, affected by, or vulnerable to HIV and AIDS.

Recommendation 14

In particular, because these efforts have been neglected in the past, WHO and UNAIDS should support efforts by countries to cost, budget and implement national programmes that would secure legal and human rights protections for people living with, affected by, or most at risk for HIV. These programmes should include legal reform and legal support services, know your rights campaigns, campaigns against violence against women, and other initiatives to help create a supportive social, legal and policy environment in which people can seek HIV testing and counselling with adequate protections against stigma, discrimination and other human rights abuses.

Recommendation 15

Countries adapting the WHO/UNAIDS Guidance to their local conditions should assess their situations in terms of levels of stigma and discrimination and health-worker capacity, and where problematic, take steps to address any problems before expanding testing and counselling.

Recommendation 16

Countries should coordinate their efforts to scale up access to HIV testing and counselling with, and integrate them into, national plans to (a) achieve universal access to prevention, treatment, care and support; and (b) create a supportive social and legal environment for people living with and at risk for HIV. As part of these efforts, countries should cost, budget and implement national programmes that would secure legal and human rights protections for people living with, affected by, and most at risk for HIV.

Recommendation 17

Countries should build referral, patient-tracking and follow-up mechanisms into HIV testing and counselling programmes, to ensure tested patients receive prevention, treatment, care and support.

The need for increased human, technical and financial resources

- 25 Scaling up HIV testing and counselling will require significant human, technical and financial resources. Yet there currently is a lack of resources to roll out the Guidance under appropriate conditions and more broadly, to scale up access to HIV testing and counselling. As a result, countries may fail to scale up access to HIV testing and counselling, may implement PITC without creating the enabling environment necessary to maximise the benefits of testing and minimize its potential harms, or may divert resources from other essential efforts, such as increasing access to evidence-based prevention, antiretroviral treatment, and human rights interventions. If scale up of HIV testing and counselling is to reach its objectives, new and additional resources will have to be found, not only for increased testing and counselling, but also for the conditions that will make testing and counselling successful.
- 26 *With regard to human resources*, a redistribution of health worker responsibilities (task-shifting) in health facilities may help to overcome chronic staff shortages in some settings. This may entail identifying appropriately skilled lay personnel who can receive training and remuneration to carry out HIV testing and counselling activities under the supervision of health care professionals with more specialized expertise. People living with HIV, AIDS service organizations and other community-based organizations and civil society groups can provide an important source of skilled lay personnel for delivery of testing and counselling services, for patient-tracking and referral services and for monitoring and evaluation. In some settings, expanding the types of health workers who are authorized to carry out HIV testing and counselling may require amendments to laws and regulations.

Recommendation 18

Countries should review and, if necessary, amend policies, laws and regulations in order to allow: (a) task-shifting in health facilities; and (b) lay personnel to carry out HIV testing and counselling and monitoring and evaluation, after receiving adequate training.

- 27 *With regard to technical resources*, WHO and UNAIDS could greatly assist countries considering implementing provider-initiated testing and counselling by providing simple tools that will assist countries in operationalizing the Guidance. In particular, such tools would assist countries to expand access to HIV testing and counselling in ways that ensure that (a) it is linked to access to prevention, care and support and early treatment; (b) there is sufficient capacity in health care settings and among health care staff to implement informed consent, counselling and confidentiality, and (c) sufficient programmes have been put into place to protect people living with or vulnerable to HIV from stigma, discrimination and other human rights abuses.

Recommendation 19

WHO and UNAIDS should follow up on the release of the Guidance by providing simple tools that will assist countries in operationalizing the Guidance. These tools should allow countries to easily understand what they need to do before and during implementation of provider-initiated testing and counselling.

- 28 *With regard to financial resources*, there is concern about the lack of resources to roll out the Guidance

and scale up access to HIV testing and counselling under appropriate conditions. In particular, there is concern that national governments and donors may provide additional funds only or primarily for the implementation of provider-initiated testing and counselling, while neglecting to provide adequate funds for training, monitoring and evaluation, client-initiated voluntary testing and counselling, and the creation of supportive social, policy, and legal frameworks that should be pre-conditions to or complement provider-initiated testing and counselling. There is also concern that increased funding for HIV testing and counselling will not be accompanied by increased funding for prevention and treatment.

Recommendation 20

National governments and donors should provide increased funding for all components necessary to ensure that access to HIV testing and counselling are implemented in ways that maximise benefits to public health and respect, protect, and fulfil human rights. In particular, this requires adequate funding for creating the conditions necessary to roll out the WHO/UNAIDS Guidance under appropriate conditions, increased funding for client-initiated voluntary counselling and testing, and increased funding for prevention, treatment, care and support and human rights interventions.

The need to step up the fight against compulsory and mandatory testing

- 29 As was recently highlighted at the Joint WHO/UNICEF/UNAIDS Technical Consultation on Scaling up HIV Testing and Counselling in Asia and the Pacific,¹⁷ mandatory and compulsory HIV testing occurs in many countries and contexts, in violation of ethical principles and basic rights of consent, privacy, and bodily integrity. With the exception of HIV screening for blood, blood products, and before all procedures involving transfer of bodily fluids or body parts, compulsory or mandatory testing is ineffective for public health purposes and a violation of human rights.

Recommendation 21

WHO and UNAIDS need to take concrete and sustained action against policy and practice that require or permit mandatory and compulsory testing, including by assisting governments to revise existing laws or policies requiring such testing and by supporting the empowerment of the UN human rights mechanisms as well as civil society to monitor such practices and challenge them.

¹⁷ WHO, UNICEF, UNAIDS (2007). Joint WHO/UNICEF/UNAIDS Technical Consultation on Scaling up Testing and Counselling in Asia and the Pacific. Phnom Penh, Cambodia, 4-6 June 2007. Conclusions and Recommendations.

APPENDIX 1: UNAIDS Reference Group on HIV and Human Rights. Statement on HIV Testing, 2004

Since its first meeting in 2003, the UNAIDS Reference Group on HIV and Human Rights (then called the UNAIDS Global Reference Group on HIV/AIDS and Human Rights) has actively participated in the debate about HIV testing. In particular, in 2004, the Reference Group issued a statement on how to ensure a rights based approach to scaling up access to HIV testing and counselling (reproduced below)¹⁸ and in January 2007 provided extensive comments on the draft WHO/UNAIDS Guidance on PITC.¹⁹

Ensuring a rights based approach

The global scaling up of the response to AIDS, particularly in relation to HIV testing as a prerequisite to expanded access to treatment, must be grounded in sound public health practice and also respect, protection, and fulfilment of human rights norms and standards.

The voluntariness of testing must remain at the heart of all HIV policies and programmes, both to comply with human rights principles and to ensure sustained public health benefits. The following key factors, which are mutually reinforcing, should be addressed simultaneously:

1. Ensuring an *ethical process for conducting the testing*, including defining the purpose of the test and benefits to the individuals being tested; and assurances of linkages between the site where the test is conducted and relevant treatment, care and other services, in an environment that guarantees confidentiality of all medical information;
2. Addressing the *implications of a positive test result*, including non-discrimination and access to sustainable treatment and care for people who test positive
3. Reducing *HIV/AIDS-related stigma and discrimination* at all levels, notably within health care settings;
4. Ensuring a supportive *legal and policy framework* within which the response is scaled up, including safeguarding the human rights of people seeking services;
5. Ensuring that the *healthcare infrastructure* is adequate to address the above issues and that there are sufficient trained staff in the face of increased demand for testing, treatment, and related services.

UNAIDS Global Reference Group on HIV/AIDS and Human Rights

¹⁸ The statement was published as an appendix to the 2004 UNAIDS/WHO policy statement on HIV testing (<http://www.who.int/hiv/pub/vct/statement/en/index.html>).

¹⁹ These comments are available via http://www.unaids.org/en/Issues/Impact_HIV/20070601_reference_group_HIV_human_rights.asp.