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WHO Technical Consultation

Scaling up HIV testing and  
counseling as an important  
component of efforts to achieve  
universal access to HIV  
prevention, treatment, care and  
support in the WHO European  
Region

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## List of abbreviations

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral treatment
CIS	Commonwealth of Independent States
DOTS	directly observed treatment, short course
EU	European Union
GFATM	Global Fund to Fight HIV/AIDS, TB and Malaria
HIV	human immunodeficiency virus
HTC	HIV testing and counselling
ICCPR	International Covenant on Civil and Political Rights
MSM	men who have sex with men
MTCT	mother-to-child transmission
NGO	nongovernmental organization
NSP	needle and syringe programmes
OST	opioid substitution therapy
PITC	provider-initiated HIV testing and counselling
PMTCT	prevention of mother-to-child transmission of HIV
STI	sexually transmitted infection
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

## Introduction

HIV continues to pose a major public health challenge in Europe today; 1.5 million adults and children were estimated to be living with HIV in eastern Europe and central Asia in 2008, and 850 000 in Western and central Europe. In 2008, 51 600 HIV cases were diagnosed and reported by 48 of the 53 countries of the WHO European Region<sup>1</sup> and Liechtenstein, more than double the number reported in 2000. The rate of HIV cases varied widely among the three geographical areas, at 179 reported cases per million population in the East, more than double that of the West (72/million) and more than ten times that of the Centre (15/million).

There are important differences in the dominant modes of HIV transmission in the WHO European Region, with a marked increase in diagnoses among men who have sex with men (MSM) in western Europe. MSM account for the largest number of new diagnoses in several countries of central and western Europe. Conversely, in eastern Europe, HIV predominantly affects male injecting drug users, although the proportion of newly-infected women has increased markedly and MSM are also heavily affected. In many countries in the Region, particularly in some migrant and ethnic minority communities in western Europe, HIV infection through heterosexual contact has risen.

Faced with a worsening HIV epidemic and the need to address public health and social challenges, in 2004 government representatives from Europe and central Asia adopted the Dublin Declaration on Partnership to Fight HIV/AIDS in Europe and central Asia, in which they agreed to more effectively tackle the epidemic and its consequences.

A major challenge in reaching universal access to HIV prevention, treatment, care and support and tackling the HIV epidemic is to increase access to and uptake of HIV testing and counselling (HTC) and to decrease the number of people who are unaware of their infection.

It has been estimated that in the European Union around a third of those infected are not aware of their serostatus. In some countries in eastern Europe and central Asia, more than 60% of people with HIV remain undiagnosed. Lack of knowledge of HIV status is a key issue for both individuals and society. HTC can provide an opportunity for timely access to appropriate treatment, care and support; late presenters suffer greater morbidity and mortality than those diagnosed early.

HTC is also important for both primary and secondary HIV prevention. Quality HTC can help prevent HIV infection through counselling to discourage high-risk behaviour and support protective behaviour. People who learn that they are HIV-infected can take steps to decrease the risk of transmitting HIV to injecting and sexual partners. The importance of this for HIV prevention is enhanced in settings where antiretroviral treatment (ART) is available and accessible to all who need it, given its value in reducing viral load and the amount of virus circulating in the community.

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<sup>1</sup> West (23 countries): Austria, Andorra, Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Israel, Italy, Luxembourg, Malta, Monaco, Netherlands, Norway, Portugal, San Marino, Spain, Sweden, Switzerland and United Kingdom; Centre (15 countries): Albania, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, Czech Republic, Hungary, Montenegro, Poland, Romania, Serbia, Slovakia, Slovenia, the former Yugoslav Republic of Macedonia and Turkey; East (15 countries): Armenia, Azerbaijan, Belarus, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan.

Many countries in the WHO European Region have already implemented programmes to increase access to HTC for certain groups (such as pregnant women, those attending sexually transmitted infection clinics and migrants) or more broadly, but the high number of people who continue to be diagnosed late suggests that efforts to scale up HTC can be further improved. Therefore, around the time of the release of the WHO/UNAIDS *Guidance on provider-initiated HIV testing and counselling in health facilities*<sup>2</sup> in 2007, the WHO Regional Office for Europe started a process to develop an HTC policy framework for the WHO European Region, based on evidence, international guidance and local and regional experience and expertise.

Two technical consultations on HTC supported by the WHO Regional Office for Europe were held in 2007 in Yerevan for the Commonwealth of Independent States (CIS)<sup>3</sup> and in Lisbon for NGO/CBOs in the WHO European Region.<sup>4</sup> The focus of these consultations was on scaling up HTC services that are of good quality and respect ethical principles and human rights in the WHO European Region, as many countries in the region, particularly in the CIS, lack a policy environment conducive to scaling up access to quality HTC in the context of broader efforts to reach universal access to HIV prevention, treatment, care and support. In particular, consultation participants made the following observations and recommendations:

- The 2007 WHO/UNAIDS guidance is a good starting point for efforts to scale up access to HTC, but particular efforts are needed to ensure that testing is only done when people consent to it. Clearer language should be used to explain that PITC means that providers offer (and sometimes recommend) HIV testing, but that individuals must consent to the test.
- In the CIS (and other countries in the WHO European Region), the HIV epidemic is at a low-level or concentrated stage, and the HTC services should reflect the scope and scale recommended for this stage of the epidemic.
- Increased access to HTC should not be a goal in and of itself, but should always lead and be linked to prevention, antiretroviral treatment and other treatment and care. Therefore, it should always be seen as one of several components “of the comprehensive strategy to achieve universal access to HIV/AIDS prevention, treatment, care and support”.
- A variety of settings should be taken into account when planning to scale up HTC services, as HTC takes place in multiple settings and is delivered by different providers, including penitentiary institutions. Access to HTC services will be significantly improved by the wide involvement of civil society organizations, and civil society should feed into the HTC policy-making.
- HTC that is acceptable, affordable, safe and reliable should be available to all in need in every country. Quality of HTC services should be of paramount importance, highlighting the need for training of those undertaking HTC.

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<sup>2</sup> WHO/UNAIDS. *Guidance on provider-initiated HIV testing and counselling in health facilities*. Geneva WHO, 2007.

<sup>3</sup> World Health Organization. Technical consultation for the Commonwealth of Independent States. Scaling up access to quality testing and counselling services – the important prerequisite in moving towards universal access to HIV/AIDS prevention, treatment, care and support. Yerevan, Republic of Armenia, 18–20 April 2007. Copenhagen: WHO Regional Office for Europe, 2007.

<sup>4</sup> World Health Organization. Technical consultation for NGOs/CBO in the WHO European Region. Challenges and opportunities for scaling-up access to quality testing and counselling services – the NGO/CBO perspectives. Lisbon, 6–7 June 2007.

- HTC should reflect and respond to the needs of diverse populations. Particular efforts should be made to reach population groups most at risk of and vulnerable to HIV. This may require “bringing services to them.”
- Tailoring services to the needs of clients is essential, so efforts should be made to promote client-centred health services, and a client-based and human rights-based approach should be the cornerstone of HTC policies and practices.
- Health system aspects of HTC should be taken into consideration, by promoting wide integration and incorporation of HTC services within the existing health systems to ensure sustainability and effective functioning.
- Legal aspects play a significant role in scaling up access to quality HTC services. Evidence-based and human rights-based approaches are essential when developing HTC-related national legislation, policies and practices. Hence, countries should develop strong legal instruments, regulations and normative documents on HTC to ensure that rights-based and evidence-based principles and approaches “are declared, granted and followed in practice.” In particular, “confidentiality should be maintained for all information given by clients to counsellors regardless of HIV status and should be protected by law.”
- Financial and economic aspects of HTC should be given serious consideration. An increase in state allocations to deliver HTC services is essential. Limited resources should be targeted towards “the most effective interventions.”
- HTC services need to be appropriately monitored and evaluated.

Generally, participants felt that the development of a European HTC policy framework would be an important step in assisting countries in the WHO European Region, and particularly CIS countries, in further scaling up access to quality, ethical HTC services. The document would help “avoid confusion and duplication of efforts” and facilitate “partnership and close collaboration across the WHO European Region,” which “need to be promoted.”

Based on these recommendations, the WHO Regional Office for Europe engaged a consultant to write a first draft of a regional HTC framework and organized a technical consultation to discuss the draft and obtain further input on how best to scale up HTC in the Region. The consultation was held in Ljubljana, Slovenia, from 8 to 10 June 2009.

The main goals, objectives and expectations of the consultation were to (see Annex 1 for the full programme of the consultation):

- review current HTC policies and practice in the WHO European Region, addressing major scaling up related needs, existing challenges and opportunities;
- discuss whether major issues influencing HTC scaling up are reflected in the draft regional HTC policy framework;
- review the input on the regional HTC policy framework draft received from consultation participants, national and international technical and public health experts, NGO/CBO, civil society, international partners prior to the meeting;
- suggest changes to be made to the draft regional HTC policy framework taking into consideration the feasibility of implementation of the recommended policy interventions;
- discuss further steps in the development of the final version of the regional HTC policy framework, including ways for broader input from stakeholders in the WHO European Region, as well as dissemination and implementation of the final document.

The consultation was attended by national and international HTC and public health experts, policy-makers, managers of national HIV/AIDS programmes, representatives of national and international CBOs/NGOs, people living with HIV, members of communities at high risk of HIV, United Nations and donor organizations (see Annex 2 for a list of all participants).

## **HIV testing and counselling in the WHO European Region: policy, practice and evidence**

Participants agreed with the summary of HTC policies and practices in the WHO European Region provided in the draft of the regional policy framework, which highlighted that the availability of HTC services, and their accessibility, affordability and acceptability for the people most in need of them, varies significantly across the Region:

- Most countries report having national guidance on HTC. In eastern and central Europe, laws often govern HTC policies. Guidance or legislation was issued in the early 1990s in some countries, while others have updated their guidance more recently.
- In the vast majority of countries in the Region, HIV testing is routinely offered by health-care providers *in certain settings*, most often to pregnant women in prenatal settings, sexually transmitted infection (STI) clinic patients and TB patients. In many countries, HIV testing is also routinely offered by health-care providers *to people belonging to high risk groups*, most often to people who inject drugs, prisoners, sex workers, and MSM. In a smaller number of countries, testing is also routinely offered to immigrants, hospital patients, and people under the age of 25.
- Some countries have policies of provider-initiated “opt-out” HTC (defined as testing unless the patient declines), mainly for antenatal settings, but sometimes also for other settings and/or populations. However, there continues to be some confusion as to what exactly the term provider-initiated “opt-out testing” means.
- Mandatory or compulsory testing in situations other than blood donations still exists in some countries.
- HTC is accessed through a variety of health care settings – STI clinics, hospitals, antenatal clinics etc. A large number of countries offer HTC through HIV centres, while in fewer countries tests are available through general practitioners, private laboratories, NGOs and TB services. Access to HTC through primary care is somewhat variable across the Region. A few countries have a testing strategy that primarily operates through general practitioners, while in other countries, general practitioners are not at all or only marginally involved in HTC services.
- A few countries provide specific places for testing certain populations.
- A growing number of countries provide outreach interventions in at-risk communities for HTC. Key at risk communities that are relatively wider served are people who inject drugs, where HIV testing services are sometimes combined with harm reduction programmes, and sex workers. Most interventions involve awareness-raising and distribution of information materials, sometimes combined with rapid testing. Outreach work is generally conducted by NGOs.
- Data suggest that only a small percentage of HIV tests are conducted anonymously.

- Many countries declare that HIV tests are available free of charge. However, this might mean that they are free of charge only in a limited number of settings such as anonymous testing centres.
- In a growing number of countries, HIV testing using rapid diagnostic tests is offered, mostly in a limited number of facilities or in outreach services for people who inject drugs, sex workers, and MSM.
- Data from surveys suggest that informed consent is not always obtained and that not all HIV tests are performed on a truly voluntary basis.
- All countries state that they have a policy to ensure confidentiality in HTC centres, but concerns over confidentiality have been reported, mostly in central and eastern Europe.
- People living with HIV frequently report having been tested without pre- or post-test counselling.
- Voluntary partner notification efforts are carried out in most countries, while partner notification is compulsory in a small number of countries.

Participants then heard about the current policy and practice in some countries that have recently increased efforts to scale up access to and uptake of HTC, but taken different approaches: some countries have emphasized the quality of HTC and the creation of HTC sites for “specific populations in need” such as MSM and migrants from high prevalence countries; some have seen a dramatic increase in the number of people tested for HIV since the introduction of rapid testing; and some adopted new national HIV testing guidelines.

Participants agreed that efforts to increase access to and uptake of HTC in each country in the WHO European Region must address the specific factors that create barriers to HTC, by undertaking efforts to remove patient-related and structural barriers to HTC, and take advantage of approaches that have shown to increase utilization of HTC services. They further agreed that, in practice, this requires moving towards evidence-based and rights-based HTC policy and practice, which recognizes that respect and protection of human rights and ethical principles (e.g. the right to privacy, confidentiality, informed consent, the duty to do no harm) facilitates acceptance, implementation and success of HTC programmes and HIV prevention, treatment, care and support measures. On the other hand, participants agreed that approaches that erode human rights and ethics and create an environment of fear, intolerance and coercion undermine efforts to scale up HTC and public health interventions that aim to encourage disclosure and partner notification.

## **Ensuring a supportive social, policy and legal frameworks for HTC scale up**

Participants noted that uptake of HTC is influenced by a complex set of factors including a supportive social, policy and legal environment (and the availability of treatment – see below). They agreed with the draft paper that, consistent with the 2007 WHO/UNAIDS Guidance, highlighted the importance of ensuring coordination and integration of countries’ efforts to scale up (1) access to HTC, treatment and evidence-based prevention and (2) legal and human rights protections for people living with, affected by or vulnerable to HIV and AIDS.

They noted that stigma and discrimination and other abuses of the human rights of people living with HIV and those at greatest risk of infection remain a major problem in many countries of the WHO European Region, and that in many countries effective protections against such abuses are not provided. Only few countries have conducted a critical review of existing legislation, policies and legislation to audit legislation, policies and practices for their promotion and protection of the rights of people living with HIV and affected communities. While most countries have laws in place to protect the rights of people living with HIV, there is a broad lack of protection for the communities most affected by HIV, most notably prisoners, people who use drugs and sex workers, but also ethnic minorities, disabled people and MSM. Experience has shown that it is difficult to take advantage of rights protections that do exist, and a “massive gulf yawns between protection on the books and practices on the ground”.

After some discussion, participants agreed with the following wording regarding the need for ensuring supportive social, policy and legal frameworks: “At the same time as efforts to increase access to, and uptake of, HTC are undertaken, 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 harms to people testing for HIV. If the following elements are not in place, efforts to increase access to quality HTC are unlikely to succeed. Countries need to assess their situation in terms of these elements and address any problems as they plan for expanded HTC.”

In particular, participants noted that:

- public information campaigns should be conducted to raise awareness about HIV, promote the rights of those living with HIV and most-at-risk populations and the benefits of knowing one’s HIV status;
- facilities providing HTC should have codes of conduct for providers and methods of redress for patients whose rights are infringed;
- countries need to provide real protection – in practice, and not just on paper – from HIV-related discrimination and abuse for people living with HIV and members of most-at risk and vulnerable populations;
- countries must undertake efforts to cost, budget and implement national programmes that will secure legal and human rights protections for people living with, affected by or vulnerable to HIV and AIDS, including legal support for people living with HIV and members of vulnerable and marginalised groups; legal audits and law reform programmes that examine all existing relevant laws and the impact these laws have on the quality of the response to the HIV epidemic, and reform laws as necessary; “know your rights” (and redresses) campaigns that empower those affected by HIV to know their rights in the context of the epidemic HIV and inform them about redresses available to them; human rights training for key professions (including health-care workers, police, judges and prosecutors);
- ethical partner notification policies and procedures should be in place in every country.

Participants noted that some of these elements of a supportive social, policy and legal framework for HTC may not be in place before efforts to increase access to HTC are undertaken, but should be addressed as part of national plans to scale up HTC and achieve universal access to HIV prevention, treatment, care and support. They agreed that optimal delivery of expanded HTC requires removal of regulatory barriers and the presence of supportive laws and policies.

Participants heard presentations from several countries about the experience with efforts to scale up access to and uptake of HTC, and about the social, policy and legal environments in the countries. They highlighted the differences that exist in these countries with regard to the social, policy and legal frameworks for HTC, but also the need for moving towards a framework that, while recognizing differences, asserts the need for evidence-based and human-rights based approaches in each country.

Participants also heard a presentation about criminalization of HIV exposure/transmission, which they agreed can be a barrier to uptake of HTC. They noted that therefore countries need to review the use of criminal laws and prosecutions against conduct carrying the risk of HIV transmission to ensure that overbroad application of criminal sanctions does not undermine efforts to increase access to and uptake of quality HTC and HIV prevention, treatment, care and support services

Participants then discussed mandatory/compulsory testing practices and policies/laws. They noted that in some countries in the Region, HIV testing is required by legislation or policy for certain people, in certain situations; and that, in other cases, it is officially voluntary, according to the law, regulation or policy, but people are more or less subtly coerced into it. Participants agreed with the recommendation in the draft framework that countries should review, and change as necessary, their laws, regulations, policies and practices to eliminate any forms of non-voluntary HIV testing (with the exception of HIV screening for blood, blood products and before all procedures involving transfer of bodily fluids or body parts). They further agreed that, instead, countries should adopt legislation and policy providing for expanded access to free, voluntary and confidential HTC.

## **Ensuring increased access to and uptake of quality HTC for different populations**

Participants highlighted that various models for offering HTC are currently used in the Region – some based on the primary care sector, some based on the secondary care sector and others operating through dedicated AIDS centres or with the support of NGOs. They all agreed that countries not only need to expand models of HTC service delivery, but ensure that their efforts to increase access to and uptake of HTC are tailored to different settings, populations, and client needs.

## **Implementing PITC for symptomatic patients and those with suspected primary HIV infection, and in selected health facilities**

Recognizing that many opportunities for diagnosis and counselling at health facilities are missed when systems rely primarily on individuals to initiate HTC, participants agreed that implementing provider-initiated forms of HTC is essential in countries in the WHO European Region, under certain circumstances and in some health care settings. Participants had a lively debate about whether, throughout the Region, where HIV is mainly concentrated among key populations at risk, widespread use of PITC in all health-care settings would be appropriate. While some of the participants felt that this should be the case in their own countries, participants agreed in the end that in most countries in the Region, most people have a low risk of exposure to HIV and that recommending HTC to all persons attending all health care facilities may not be feasible, necessary or appropriate.

Participants agreed that PITC for symptomatic patients should be prioritized and felt strongly that HTC should also be recommended to anyone presenting at health facilities with symptoms of primary HIV infection or seroconversion illness. They recognized that this may be the only clinical opportunity to detect HIV before advanced immunosuppression years later and also represents a unique opportunity to prevent onward transmission. They highlighted that implementation of PITC for those with suspected primary HIV infection will require a major effort to educate health-care providers about the typical features of primary HIV infection and the benefits of discussing HIV risk and recommending HTC to people presenting with these symptoms.

In addition, participants agreed that countries should consider implementing PITC in facilities providing services for STIs, TB, most-at-risk and vulnerable populations and antenatal, childbirth and postpartum services. They agreed that decisions should be made based on the local epidemiology, the availability of and access to comprehensive, evidence-based HIV-related prevention and treatment (including ART), care and support to all who need it, and the presence of supportive social, policy and legal environments to maximize positive outcomes and minimize potential harm to patients.

With regard to most-at-risk and vulnerable populations, participants agreed that expanding sources of safe, voluntary and accessible HTC outside the health system, offered or recommended to them in a peer-driven and non-judgmental manner, should be the priority (see below). However, participants recognized that, because of their special health needs, populations most at-risk for HIV may be more likely to attend health services such as acute care or drug dependence treatment. Therefore, in addition to expanding innovative approaches to HTC outside the health system, they felt that countries should consider adopting policies to offer HTC to all patients attending those facilities or services, if epidemiologically appropriate and socially acceptable. Participants heard from some of the presenters, particularly those representing people living with HIV and NGOs/CBOs, how in many countries in the Region, people who inject drugs, sex workers, migrants and mobile populations are marginalized and/or criminalized and suffer from a history of stigma and discrimination. As a consequence, they are often denied access to comprehensive and evidence-based HIV prevention. They are also more susceptible to coercion, discrimination, violence, abandonment, incarceration or other negative consequences upon disclosure of an HIV-positive test result. Participants therefore concluded that, before PITC can be introduced in services for these populations, special training and supervision for health care providers to uphold standards of informed consent and confidentiality is required. Finally, they noted the importance of involving representatives and advocates of these populations in the development of HTC protocols and monitoring and evaluation of PITC programmes.

Whether or not PITC should be implemented in all antenatal, childbirth and postpartum services in the Region was one of the more contentious issues at the meeting. All participants recognized that there are clear advantages in determining the HIV status of pregnant women before delivery, with the risk of transmission of the virus nearly eliminated implementing the evidence-based interventions. Some participants suggested that it is time to adopt PITC in all antenatal clinics across the Region, while others pointed out that there may be areas where the HIV prevalence is so low that this strategy would not be cost-effective. In the end, participants agreed that all countries in the Region should adopt a comprehensive approach to prevention of mother-to-child transmission of HIV (PMTCT), including:

- preventing HIV infection among women of child-bearing age and their partners

- preventing unintended pregnancies among HIV-infected women
- preventing HIV transmission from infected women to their babies
- providing care and support to HIV-infected women, their infants and families.

Participants highlighted that ultimately decisions about whether to make PITC part of such services will have to be based on an assessment of local resources and the epidemiological and social context. They agreed that many countries will have the resources to implement PITC as part of a broader PMTCT plan, whereas in others it may be necessary to scale up other elements of the comprehensive PMTCT plan before it is possible to adopt a policy of PITC for all pregnant women. In particular, they emphasized that measures need to be in place to ensure that PITC leads not only to increased uptake of HTC, but also of the interventions required to reduce the risk of MTCT and benefiting HIV-positive mothers, including ART. Finally, they noted that measures also need to be in place to reduce HIV transmission to women in the first place, in particular to women most at risk of HIV infection.

### **Improving access to HTC for most-at-risk and vulnerable populations**

As noted above, participants agreed that increasing and improving access to HTC is particularly important for the populations that are most at risk and most vulnerable including people who inject drugs, MSM, sex workers, migrants and mobile populations and ethnic and national minorities. They noted that many in these socially marginalized communities rarely use the health system and require sources of safe, voluntary and accessible HTC outside the health system, offered or recommended to them in a peer-driven and non-judgmental manner. Examples include services by mobile clinics, community settings or other outreach, for example by empowering nongovernmental, community-based organizations to provide HIV tests to their peers “where they are”. For people who use drugs, HTC may be offered or recommended at needle and syringe programmes and other harm-reduction services, drop-in centres or outreach programmes. One participant presented the results of a community-based HTC centre. Participants noted that establishing such services acknowledges that many individuals may prefer to test in non-medical settings or may not be registered with primary care. They were encouraged by studies showing that such services are acceptable and feasible and may encourage potentially high-risk and vulnerable individuals who would not otherwise have accessed HIV testing through conventional services. They noted that in some countries, establishing such new options may require changes to laws and policies, including allowing non-health-care professionals, including those in NGOs, to offer or recommend and perform HTC.

### **Meeting the needs of prisoners, detainees and people in other closed settings**

Participants discussed the special needs of prisoners, detainees and people in other closed settings. They agreed with the recommendations in the HTC guidance specifically developed for these populations by WHO and UNODC.<sup>5</sup>

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<sup>5</sup> UNODC, WHO. HIV testing and counselling in prisons and other closed settings (Technical paper). New York, United Nations, 2009; UNODC, WHO. HIV testing and counselling in prisons and other closed settings (Policy Brief). New York, United Nations, 2009.

## **Providing rapid testing, where appropriate**

Participants discussed the issues related to the introduction of rapid HIV tests. They noted the many advantages of these tests and recommended that they should be used, where appropriate, to support efforts to increase access to and uptake of HTC.

## **Ensuring that HIV testing is done with consent, counselling, confidentiality and referral**

Participants recognized that HIV testing must be voluntary and that informed choice is central to creating a climate of confidence and trust between the person being tested and the service providers. They heard presentations from several countries about various aspects of the three principles of HIV testing (the “three Cs”)

- counselling and information about HIV/AIDS before and after the test;
- consent to be tested given in an informed, specific and voluntary way by the person to be tested; and
- confidentiality of test results and of the fact of seeking a test.

## **Informed consent and pre-test information or counselling**

Participants recognized that in some settings providing pre-test information – rather than more extensive pre-test counselling (including HIV prevention counselling) – may be justified in order to make pro-actively offering HTC feasible. They noted that human rights and public health do not require cumbersome procedures for pre-test counselling or that informed consent be recorded in writing, but highlighted that they do require that people be given adequate information on which to base informed and truly voluntary consent to HIV testing.

## **Special considerations for adolescents**

Participants noted that, in most countries, the median age for the onset of sexual activity is earlier than the age of legal majority. Many adolescents do not have independent access to HIV prevention services. They agreed that clear legal regulations and policies should stipulate the age and/or circumstances in which minors may consent to HIV testing, and how the assent of and consent for adolescents should best be assessed and obtained. They further agreed that sufficiently mature adolescents should be permitted to give their own informed consent to HIV testing.

## **Post-test counselling**

Participants agreed that post-test counselling must remain an integral component of the HIV testing process. Everyone undergoing HIV testing must be counselled when their test results are given, regardless of the result.

## **Ensuring confidentiality, privacy, and security of data**

Participants stressed the importance of ensuring confidentiality, privacy and security of data in the HTC process. They agreed that countries should have nationally approved privacy, confidentiality and security definitions, guiding principles and recommendations for HIV-related data, with relevant capacities for their maintenance. Privacy and confidentiality laws should be in place and be reviewed and known by everyone accessing health data.

## **Ensuring referral to services**

Finally, participants emphasized the importance of ensuring referral to services. In practice, this means that the HIV test results must be communicated to the person tested with an explanation of the available prevention, treatment (including ART), care and support services. At minimum, referral should include information about whom to contact as well as where, when and how to obtain the services required. Participants noted that patient referral works best if the health care provider makes contact in the presence of the patient and schedules an appointment, making note of the contact and the organization in the patient's file.

## **Key programmatic considerations and health systems strengthening needs**

In this fifth and final panel discussion, participants heard some country presentations and discussed several of the broader considerations and needs related to HTC scale up.

## **Linking HTC scale up with broader efforts to achieve universal access to HIV prevention, treatment, care and support**

At the outset, participants recognized that HTC is never a goal in itself, but is motivated by HIV prevention and treatment, care, and support goals. Consequently, they noted that the efficacy of HTC policies and programmes is co-determined by the availability of comprehensive HIV prevention, treatment, care and support programmes. Importantly, people who access HTC should always:

- have the benefit of treatment (including ART), care and support as needed;
- have access to comprehensive, evidence-based HIV prevention services that enable those testing negative to avoid infection and those testing positive to reduce the risk of transmission to their partners (or, if pregnant, to their babies), as well as the risk of being re-infected.

They noted with concern that in many countries in the Region access to evidence-based HIV prevention and/or treatment (including ART), care and support is far from universal. In particular, while significant progress in increasing access to ART has been achieved, in many countries in the Region many of those who need ART do not have access to it. The lack of access to ART is particularly acute for marginalized populations. Access to opioid substitution therapy (OST), an important component of strategies for retaining people who inject drugs in ART programmes, also remains very limited in many countries, particular in central and eastern Europe, and is not provided at all in some countries. Participants further noted that in many

countries and in many settings, essential HIV prevention measures are not provided. For example, in many countries in the Region with HIV epidemics fuelled by injecting drug use, access to needle and syringe programmes (NSP) and OST is limited by legal frameworks and prevailing attitudes. In most countries in the Region, prisoners also have inadequate access to HIV prevention measures, although condom provision, OST and NSP have been successfully introduced in some prison systems and proved to be effective at preventing the spread of HIV. Sex workers, migrants, ethnic minorities and MSM may also face barriers to accessing HIV prevention, either because services targeting them are insufficient or they avoid services due to widespread violence, stigma and discrimination.

Because HTC is motivated by HIV prevention and treatment, care and support goals, participants agreed that it should not be done without assured referral for all tested to HIV prevention, care and support and the earliest possible access to ART and other treatments as needed. Therefore, they emphasized that efforts to scale up HTC must be linked to broader efforts to achieve universal access to comprehensive, evidence-based HIV prevention, treatment (including ART), care and support. In particular, they noted that:

- in countries with insufficient or inequitable access to ART, efforts to improve access to ART must be vastly scaled up at the same time as access to HTC is increased;
- special efforts are needed to ensure equitable access for members of most-at-risk and vulnerable populations;
- countries with no or limited access to OST must make immediate plans to introduce it or to scale it up.

## **Resources, infrastructure and training**

Participants emphasized that policy-makers and planners need to anticipate the additional resources required for implementation of expanded HTC, including training, purchasing commodities and adequate clinical infrastructure; and added that additional resources may be needed to assist nongovernmental, community-based organizations to offer HTC and/or provide follow-up services.

In particular, they noted that, if HTC scaling-up is to reach its objectives, new and additional financial resources will have to be found in each country, not only for expanded HTC, but also for the conditions that will make it successful – in particular, scaled up HIV prevention, treatment (including ART), care and support and human rights interventions. Finally, they emphasized that expanding access to HTC will also require a major investment in human resources. They noted that people living with HIV, AIDS service organizations and other community-based organizations can be important sources of skilled lay personnel for service delivery, follow-up, referrals, monitoring and evaluation. In some settings, expanding the types of providers authorized to carry out HTC may require amending laws and regulations.

## **Undertaking consultations to plan for scaled-up HTC**

Participants emphasized that, while a policy framework on HTC would offer much-needed guidance for policy-making and practice in countries across the WHO European Region, decisions on how best to increase access to and uptake of HTC will ultimately depend on assessments in the particular countries. They agreed that implementation decisions should be made in consultation with relevant stakeholders, including civil society groups, persons living

with HIV and representatives of most-at-risk and vulnerable populations; and highlighted the importance of involving targeted individuals and communities in the development, policy formulation, programme planning and implementation and monitoring and evaluation of HTC policies and programmes.

Participants recognized that some countries face substantial human and financial constraints to implementing large-scale health service activities. They noted that it may therefore be necessary to prioritize particular activities for the expansion of HTC, depending on the local context and resources. They stressed that, as such decisions are made, human rights and ethical principles need to be taken into account, and the needs of populations most at risk and most vulnerable should be prioritized.

## **Monitoring and evaluation**

Participants heard a presentation about monitoring and evaluation by an expert working for WHO. They agreed that, beyond setting targets for scaled-up HTC and documenting the number of people being tested, efforts to increase access to and uptake of HTC will have to be carefully monitored and evaluated to ensure that, in practice people have unproblematic access to free or affordable, high-quality HTC; are not coerced into testing, but give informed, voluntary consent; are diagnosed earlier; are referred and obtain access to needed services, particularly ART for those testing HIV- positive; and do not suffer exclusion or any other negative consequences.

They agreed that routine monitoring should be complemented with targeted evaluations and research.

## **Conclusions and recommendations**

After a lively debate in the plenary sessions and in some working group sessions, participants reached consensus on most issues addressed in the draft paper before them and gave clear instructions on where and how the paper needed to be changed to address points raised in the discussion that the draft did not, or did not adequately, address. Some of the main points of agreement included:

- scaling up HTC in the WHO European Region must be linked to broader efforts to achieve universal access to comprehensive, evidence-based HIV prevention, treatment, care and support;
- efforts to scale up HTC and, in particular, the implementation of PITC, must include measures to prevent compulsory testing and unauthorized disclosure of HIV status, and potential negative outcomes of knowing one's HIV status;
- positive outcomes are most likely when an adequate social, policy and legal framework is in place;
- non-voluntary forms of HTC are unethical and not justified from a public health perspective, and existing laws and policies authorizing or allowing such testing should be changed;
- efforts to increase access to and uptake of HTC requires different approaches for different populations in different settings;

- particular efforts are needed to meet the needs of most-at-risk and vulnerable populations;
- regardless of where and how HTC is done, it must always be voluntary and with the informed consent of the person being tested, adequate pre-test information or counselling, post-test counselling, protection of confidentiality and referral to services;
- scaling up HTC requires moving from episodic, short-term action on HTC to a long-term, sustainable national commitment to providing access to quality HTC as part of broader efforts to reach universal access to evidence-based HIV prevention, treatment, care and support, and legal protections.

It was agreed that the final draft of the policy framework should reflect these conclusions and, more broadly, the discussions at the meeting. It was also agreed that the policy framework should be short and accessible, no longer than 20 pages, but that it should be accompanied by a revised version of the first, longer draft, as a comprehensive background document. It was further agreed that another draft of the policy framework should become available by the end of the year and shared across the region for final input, if any. After that, the policy framework should be finalized and widely disseminated, preferably in the first quarter of 2010. Participants said they were confident that the document would play an important role in supporting national HTC scale up efforts.

## ANNEX 1. PROGRAMME OF THE TECHNICAL CONSULTATION

**DAY 1, 8 June 2009**

<b>Subject</b>	<b>Presenter/facilitator</b>
<b>Registration</b>	
Plenary session	
Welcoming remarks	S. Matic, WHO EURO Ministry of Health, Slovenia
Objectives and expectations of the Consultation	WHO EURO
Presentation of the draft document and general feedback (including a brief overview of comments received to date)	R. Jürgens – WHO consultant

### **Discussion points:**

- |  |                  |
|--|------------------|
| <ul style="list-style-type: none"> <li>a) What do you particularly like about the draft?</li> <li>b) What don't you like about the draft?</li> <li>c) What is missing in the draft?</li> </ul> | All participants |
|--|------------------|

### **Panel discussion I.**

**HIV T&C in the WHO EURO Region: current policy, practice, and evidence**

#### **Co-Chairs/Co-Facilitators:**

Slovenia (TBC)

### **Discussion points:**

- a) What do we know about current policy and practice regarding HIV T&C in the region?
- b) In our experience over the last years, what approaches have worked to increase not only access to and uptake of HIV T&C, but also maximize the benefits of T&C, including access to ART and comprehensive prevention?

### **Panelists:**

1. The Swiss experience in T&C scaling up – R. Staub
2. Update from Portugal –H- Barros
3. In what settings an HIV test should be considered and what indicator could be used for guidance - UK experience V. Delpech
4. Civil society perspectives –T. Coenen

### **Questions & Discussion**

### **Panelists:**

**Panel discussion II:**

**Ensuring a supportive social, policy & legal  
framework for T&C scale up**

**Co-Chairs/Co-Facilitators:**

R. Staub, V.Ilic

**Discussion points:**

- a) Why is a supportive social, policy & legal framework a prerequisite to efforts to scale up access to T&C?
- b) What is the situation in countries in the region with regard to providing such a framework?
- c) How can existing frameworks be improved?
- d) How can mandatory/compulsory testing practices and policies/laws be ended?
- e) What are priority actions?

**Panel discussion II cont'd**

1. Experience from Russian Federation (TBC )
2. Danish perspective – S. Cowan
3. Systematic HIV testing practices: epidemiological perspectives – B. Zhussupov
4. Affected communities perspectives from Ukraine – S. Moroz

**Panelists:**

1. Addressing criminalization of HIV exposure/transmission as a barrier to testing – M.Weait
2. Community mobilization around HIV testing – experience from Kyrgyzstan – B. Estebesova
3. Priority actions to form supportive legal environment – K. Turkovic
4. *Role of supportive legal framework and programmatic action on human rights (TBC)*

**DAY 2, 9 June 2009**

**Panel discussion III**

**Ensuring increased access to and uptake of quality T&C for different populations**

**Co-Chairs/Co-Facilitators:**

T. Coenen, S. Cowan

**Discussion points:**

- a) How can existing barriers be removed and access to and uptake of quality T&C services scaled up ?
- b) Why is a combination of different, complementary approaches needed for different settings & different populations?
- c) How can countries best scale up optimal approaches and innovative T&C service delivery models for most-at-risk and vulnerable populations?
- d) What should be the priority actions to scale up HIV T&C in different settings and for different populations
- e) Has the time for home self-testing come, or not yet?

**Panel discussion III cont'd**

**Panelists:**

1. "HIV Europe" perspectives – H. Arildsen
2. HIV testing and counseling in the context of pregnancy: issues and policies in Eastern Europe and Central Asia - UNICEF
3. Experience from Kazakhstan – N. Amanzolov
4. Community based testing facility : experience from Spain – M. Meulbroek

**Panelists:**

1. Polish experience – A. Marzec-Boguslawska
2. Italian perspectives – G. Rezza
3. "Let's not opt out of our rights" Eastern European Harm Reduction network - K. Jiresova

**Questions & Discussion**

### **Panel discussion IV**

**Ensuring that HIV testing is done with consent, counselling, confidentiality, and referral**

#### **Co-Chairs/Co-Facilitators:**

K. Turkovic, H. Arildsen

#### **Discussion points:**

1. How can informed and truly voluntary consent be obtained? What does it mean for pre-test counseling (or pre-test information)?
  2. Should young people be able to consent to HIV T&C?
  3. How can counseling capacity best be scaled up?
  4. What needs to be done, in policy and practice, to protect confidentiality and secure medical information?
1. Addressing different forms of consent – N. Mladenovic (TBC the title)
  2. Experience from Romania – M. Stefanescu
  3. Ensuring data confidentiality and protection: experience from Spain – M. Diez Ruiz-Navarro
  4. Scaling up counselling capacities – L. Nilsson-Schonnesson

### **Questions & Discussion**

### **Panel discussion V**

**Key programmatic considerations and health systems strengthening needs.**

#### **Co-Chairs/Co-Facilitators:**

A. Marzec-Boguslawska, M. Diez Ruiz-Navarro

#### **Discussion points:**

- a) What are key programmatic considerations?
  - b) What are key health systems' strengthening needs?
1. Ensuring that efforts to scale up T&C are linked to and coordinated with efforts to achieve UA to comprehensive HIV prevention, treatment, care and support - experience from Bulgaria – H. Taskov
  2. Role of clinical settings in T&C scaling up and a demand for follow up service provision - J. Begovac
  3. Ensuring adequate resources and infrastructure; consultation with and involvement of most-at-risk and vulnerable populations and civil society into policy development, program planning,

### **Panelists:**

- c) Why is it essential to ensure that efforts to scale up access to T&C are linked and coordinated with efforts to scale up access to comprehensive HIV prevention & treatment, care & support?
- d) What are priority actions?
- implementation, M&E - experience from Moldova – S. Georgitha
4. Ensuring adequate monitoring and evaluation – M. Sabin

### **Questions & Discussion**

### **DAY 3, 10 June 2009**

#### **Introduction to Working Group session :**

#### **Working Group session:**

**Facilitators:** WHO

Participants will be asked to divide into 3 groups

#### **Working Groups' presentations**

#### **Co-Chairs/Co-Facilitators**

V. Delpech, S. Georgitha

### **Questions & General Discussion**

#### **General Discussion**

#### **Next steps**

#### **Closing remarks**

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