

UNAIDS Reference Group on HIV and Human Rights

HIV TESTING AND COUNSELLING: New technologies, increased urgency, same human rights

*Statement by the UNAIDS Reference Group on HIV and Human Rights,
fully endorsed by the Global Fund to Fight AIDS,
Tuberculosis and Malaria Human Rights Reference Group*

The UNAIDS Reference Group on HIV and Human Rights was established in 2002 to advise the Joint United Nations Programme on HIV/AIDS on all matters relating to HIV and human rights. The Reference Group speaks with an independent voice; thus, its views do not necessarily reflect the views of the UNAIDS Secretariat or any of the UNAIDS Cosponsors.

The Global Fund Human Rights Reference Group was created in 2013 to advise the Global Fund Secretariat on operationalizing its strategic commitments to protect and promote human rights. The Global Fund Reference Group speaks as an independent expert group, and therefore endorses this statement in its independent capacity.

10 June 2015

The UNAIDS Reference Group on HIV and Human Rights (“UNAIDS Reference Group”) is issuing this statement on HIV counselling and testing with the full endorsement of the Global Fund to Fight AIDS, Tuberculosis and Malaria (“Global Fund”) Human Rights Reference Group (“Global Fund Reference Group”). This statement is informed by three key trends that have emerged since the last statement regarding HIV testing was issued by the UNAIDS Reference Group (in 2007):

1. Proliferation of unjust criminal laws and prosecutions, including the criminalization of HIV non-disclosure, exposure, and transmission;
2. Expanded HIV treatment availability (both geographically and second- and third-line treatments), and evidence supporting the effectiveness of HIV treatment as a means of preventing transmission as well as treating HIV illness (i.e., “treatment as prevention”); and
3. International policy directions focused on greater impact and greater speed in order to “end the AIDS epidemic as a public health threat by 2030,” recognizing that effective interventions need to respond to epidemiological context (in particular, better addressing the needs of youth and key populations), and to the barriers to accessing voluntary HIV testing, prevention services, and sustained treatment faced by key populations.

This statement is issued at a time when UNAIDS and the Global Fund are renewing their strategies for 2016–2021 and 2017–2021, respectively. To support these processes, the Reference Groups offer the following three key messages:

1. There is an ongoing, urgent need to increase access to HIV testing and counselling, as testing rates remain low in many settings. The Reference Groups support such efforts unequivocally and encourage the provision of multiple HIV testing settings and modalities, in particular those that integrate HIV testing with other services.
2. Simply increasing the number of people tested, and/or the number of times people test, is not enough, for many reasons. Much greater efforts need to be devoted to removing barriers to testing

for marginalized and criminalized populations, and to link those tested with prevention and treatment services and successfully keep them in treatment.

3. Public health objectives and human rights principles are not mutually exclusive. HIV testing that violates human rights is not the solution. A “fast-track” response to HIV depends on the articulation of testing and counselling models that drastically increase use of HIV testing, prevention, treatment, and support services, and does so in ways that foster human rights protection, reduce stigma and discrimination, and encourage the sustained and supported engagement of those directly affected by HIV.

Background

The UNAIDS Reference Group on HIV and Human Rights has actively promoted a rights-based approach to HIV testing and counselling since its first meeting in 2003. The Global Fund Human Rights Reference Group, which advises the Global Fund Secretariat on operationalizing its strategic commitments to protect and promote human rights, endorses this statement in its independent capacity.

In 2004, the UNAIDS Reference Group issued its first statement on HIV testing and counselling, outlining the key factors to simultaneously address in order to ensure a rights-based approach to scaling up access to HIV testing and counselling.¹ In 2007, the UNAIDS Reference Group was compelled to issue a further statement and recommendations on HIV testing and counselling in response to a *Guidance on Provider-Initiated Testing and Counselling (PITC) in Health Facilities*, issued by WHO and UNAIDS.²

The 2007 WHO and UNAIDS PITC *Guidance* noted that:

Positive outcomes are most likely when HIV testing ... is confidential and is accompanied by counselling and informed consent, staff are adequately trained, the person undergoing the test is offered and referred to appropriate follow-up services, and an adequate social, policy and legal framework is in place to prevent discrimination.³

The UNAIDS Reference Group welcomed this *Guidance*, emphasizing that HIV testing and counselling must be implemented in ways that maximize benefits to individuals and public health and respect, protect, and fulfil human rights.⁴

In subsequent years, approaches to HIV testing and counselling have continued to evolve, and human rights have remained a central concern. In 2012, WHO and UNAIDS reaffirmed their opposition to mandatory HIV testing.⁵ Also in 2012, WHO issued a policy framework document on service delivery approaches to HIV testing and counselling, which advocated continuing effective and appropriate PITC in healthcare facilities while expanding HIV testing and counselling beyond health-care facilities.⁶ This document reiterated the need for human rights

¹ The statement was published as an appendix to the 2004 UNAIDS/WHO policy statement on HIV testing. It is reproduced as Appendix 1 to this document (page 10).

² WHO/UNAIDS, *Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities*, 2007. Available at http://whqlibdoc.who.int/publications/2007/9789241595568_eng.pdf.

³ *Ibid.*, at page 30.

⁴ UNAIDS Reference Group on HIV and Human Rights, “Statement and recommendations on scaling up HIV testing and counselling,” 2007. Available at http://www.hivhumanrights.org.vs2.korax.net/commitmenttohumanrights/wp-content/uploads/downloads/2012/03/20070905_rghr_statement_testing_en.pdf.

⁵ WHO/UNAIDS, “Statement on HIV testing and counselling: WHO, UNAIDS re-affirm opposition to mandatory HIV testing,” 28 November 2012. Available at http://www.who.int/hiv/events/2012/world_aids_day/hiv_testing_counselling/en/index.html.

⁶ WHO, *Service delivery approaches to HIV testing and counselling (HTC): A strategic policy framework*, July 2012. Available at http://www.who.int/hiv/pub/vct/htc_framework/en/.

protection, regardless of the testing model and how testing is offered; emphasized the fact that the “5 Cs” (i.e., consent, confidentiality, counselling, correct test results, and connection to care) of good testing practices continue to be relevant and should always be guaranteed; stressed that testing must always be voluntary; and noted that testing should not be promoted in situations where a positive test result could lead to discrimination, or where choosing to test is treated as indicating criminal behaviour.

Amidst calls to “normalize” testing and target interventions in order to increase impact, the UNAIDS Reference Group refocused on HIV testing and counselling issues at its fifteenth meeting in December 2013. The Reference Group considered new developments such as “treatment as prevention” and increased testing settings and modalities as they relate to maximizing the benefits to individuals, communities, public health, and human rights protection.⁷

The Reference Groups endorse these fundamental messages about increasing access to voluntary HIV testing and safeguarding human rights that it has consistently advanced. We strongly support efforts to expand access to voluntary HIV testing as part of a continuum of care — from prevention to sustained treatment. The Reference Groups also believe that addressing barriers to voluntary HIV testing is both an integral element of the HIV testing scale-up agenda and critical to meeting the objective of increasing the number of people who know their status in order to link to care those who are living with HIV. Barriers include, but are not limited to: laws and policies, including those relating to age of consent and confidentiality, that hinder access to HIV testing, particularly for adolescents; inadequate HIV testing policies that violate informed consent, privacy, and confidentiality, or that restrict the availability and uptake of innovative or client-controlled HIV testing models; lack of legal services (for gender-based violence, property-rights abuses, discrimination in housing and employment, and criminalization of homosexuality, sex work, drug use, and HIV non-disclosure, exposure, and transmission); insufficient care and support services (including for opportunistic infections, antiretroviral therapy [ART], and for other conditions such as tuberculosis [TB], hepatitis C virus [HCV], drug dependency, etc.); and widespread HIV-related stigma and discrimination.

The UNAIDS Reference Group is issuing this updated statement on HIV counselling and testing to reiterate its position on HIV testing, which is fully endorsed by the Global Fund Reference Group. This statement is informed by three key trends that have emerged since the UNAIDS Reference Group issued its last statement on HIV testing in 2007:

1. Proliferation of unjust criminal laws and prosecutions, including the criminalization of HIV non-disclosure, exposure, and transmission;
2. Expanded HIV treatment availability (both geographically and second- and third-line treatments), and evidence supporting the effectiveness of HIV treatment as a means of preventing transmission as well as treating HIV illness (i.e., “treatment as prevention”); and
3. International policy directions focused on greater impact and greater speed in order to “end the AIDS epidemic as a public health threat by 2030,” recognizing that effective interventions need to respond to epidemiological context (in particular, better addressing the needs of youth and key populations), and to the barriers to accessing voluntary HIV testing, prevention services, and sustained treatment faced by key populations.

⁷ The issue paper “HIV testing: The way forward” and the Summary Report and Recommendations of the Reference Group’s Fifteenth Meeting can be accessed via <http://www.hivhumanrights.org/meetings/fifteenth-meeting/>.

Key Trends

a) Proliferation of unjust criminal laws, including the criminalization of HIV non-disclosure, exposure, and transmission

The criminalization of HIV non-disclosure, exposure, and transmission is not a new phenomenon, but the vigour with which governments have pursued criminal responses to alleged HIV exposures — at the same time as our understanding of HIV prevention and treatment has greatly advanced, and despite evidence that criminalization is not an effective public health response — causes considerable concern to HIV and human right advocates.⁸ In the last decade, many countries have enacted HIV-specific laws that allow for overly broad criminalization of HIV non-disclosure, exposure, and transmission. This impetus seems to be “driven by the wish to respond to concerns about the ongoing rapid spread of HIV in many countries, coupled by what is perceived to be a failure of existing HIV prevention efforts.”⁹ In some instances, particularly in Africa, these laws have come about as a response to women being infected with HIV through sexual violence, or by partners who had not disclosed their HIV status.¹⁰

Emerging evidence confirms the multiple implications of the criminalization of HIV non-disclosure, exposure, and transmission for HIV testing and counselling.¹¹ For example, HIV criminalization can have the effect of deterring some people from getting tested and finding out their HIV status. The possibility of prosecution, alongside the intense stigma fuelled by criminalization, is good reason for some to withhold information from service providers or to avoid prevention services, HIV testing, and/or treatment. Indeed, in jurisdictions with HIV-specific criminal laws, HIV testing counsellors are often obliged to caution people that getting an HIV test will expose them to criminal liability if they find out they are HIV-positive and continue having sex. They may also be forced to provide evidence of a person’s HIV status in a criminal trial. This creates distrust in relationships between people living with HIV and their health care providers, interfering with the delivery of quality health care and frustrating efforts to encourage people to come forward for testing.

Alongside the criminalization of HIV non-disclosure, exposure, and transmission, we also see vigorous criminalization of LGBTI people, sex workers, and people who use drugs in many parts of the world. This sort of criminalization is stigmatizing, drives key populations away from testing and services, and can make HIV testing a life-endangering rather than life-saving act. It is critical to consider this harsh context when devising interventions to scale up HIV testing and counselling.¹²

⁸ See Edwin Bernard, *Advancing HIV justice: A progress report on achievements and challenges in global advocacy against HIV criminalisation* (GNP+ and HIV Justice Network), 2013, for an overview.

⁹ Open Society Institute, *10 Reasons to Oppose Criminalization of HIV Exposure or Transmission*, (2008) (page1). Available at http://www.opensocietyfoundations.org/sites/default/files/10reasons_20081201.pdf.

¹⁰ Ibid.

¹¹ Studies documenting these negative effects on HIV prevention and justice are emerging from different parts of the world, reinforcing policy recommendations. See, for example, C. Dodds et al. “Keeping Confidence: HIV and the criminal law from service provider perspectives,” *Sigma Research*, 2013; CL Gallety and SD Pinkerton, “Conflicting messages; How HIV criminal disclosure laws undermine public health efforts to control the spread of HIV,” *AIDS and Behaviour*, 2006, 10: 451–461; E. Mykhalovskiy, “The problem of ‘significant risk’: Exploring the public health impact of criminalizing HIV non-disclosure,” *Social Science & medicine*, 2001, 1663–1671; and P. O’Byrne, A. Bryan and C. Woodyatt, “Nondisclosure prosecutions and HIV prevention: Results from an Ottawa-based gay men’s sex survey,” *Journal of the Association of Nurses in AIDS Care*, 2013, 24(1): 81–87.

¹² For example, in a number of countries, condoms are used as evidence in the arrest and prosecution of sex workers. See OSF, <http://www.opensocietyfoundations.org/sites/default/files/criminalizing-condoms-20120717.pdf>. On the criminalization of key populations and HIV risk, see, for example: K. Shannon et al., “Global epidemiology of HIV among female sex workers: influence of structural determinants” *The Lancet* Volume 385, No. 9962, p55–71, 3 January 2015; Mathers et al., “The global epidemiology of injecting drug use and HIV among people who inject drugs: a systematic review,” *The Lancet*, 2008, 372(9651): 1733–1745; and UNAIDS, “Homophobia and punitive laws continue to threaten HIV responses and human rights,” 28 August 2012.

As the UNAIDS Reference Group stated in 2007:

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.¹³

This comment is even more relevant today and requires intensifying advocacy with governments and donors to decriminalize, fund legal support services, provide training to criminal justice system actors, and ensure the privacy and safety of those who seek HIV testing as a prerequisite to massively scaling up HIV testing or implementing new testing modalities. This criminalized context is critical to understanding HIV testing and counselling today.

b) Expanded HIV treatment availability and “treatment as prevention”

The HPTN 052 clinical trials, which examined the impact of highly active antiretroviral therapy (HAART) treatment on the transmission of HIV in sero-discordant couples, confirmed that the use of HAART decreased HIV transmission by at least 96%.¹⁴ Additionally, the study showed that starting HAART earlier was associated with more than a 40% reduction in the rate of disease progression. The findings of HPTN 052 confirmed those previously reported by Montaner et al.¹⁵

This ground-breaking research, and subsequent studies, support important new opportunities and public health, economic, and human rights arguments for expanded and improved integration of treatment and prevention efforts. The “treatment as prevention” discovery is comparable to other historic turning-points in the epidemic, such as the development of a test to detect HIV antibodies (1985), antiretroviral therapy to prevent perinatal HIV transmission (1991), and highly active antiretroviral therapy to suppress viral replication, significantly reducing AIDS-related morbidity and mortality (1996).

As when each of these milestones which created a paradigm shift in how HIV policies and programmes were developed, prioritized, funded, and implemented, the “treatment as prevention” revolution requires a careful examination of the scientific evidence, programmatic structures, and the importance of protecting and promoting human rights. How one goes about achieving equity, empowerment, protection from discrimination, and accountability must correspondingly shift.¹⁶

As noted by the UNAIDS Reference Group co-chairs and an additional author in a commentary on this issue:

Successful HIV prevention and use of ART, for either prevention or treatment, both depend upon the ability of individuals and affected communities to seek out services and then use those services over the course of a lifetime. While increasing rates of HIV testing utilization is one important component, it is not the numbers of tests performed that, in and of itself, will lead to increased demand for and successful use of prevention and treatment services. HIV testing is not a goal, but a tool. It is a tool that can only be valuable if the conditions are in place to put the information one receives from testing to use. Those conditions include the availability of sustained and high-quality health-care and prevention

¹³ UNAIDS Reference Group on HIV and Human Rights, “Statement and recommendations on scaling up HIV testing and counselling,” 2007 (para 23). Available at http://www.hivhumanrights.org.vs2.korax.net/commitmenttohumanrights/wp-content/uploads/downloads/2012/03/20070905_rghr_statement_testing_en.pdf.

¹⁴ M. Cohen et al., “Prevention of HIV-1 Infection with Early Antiretroviral Therapy,” 365 *New England Journal of Medicine* 2011: 493–505.

¹⁵ J. Montaner, “Treatment as prevention—a double hat-trick,” 378 *The Lancet* 2011: 208–209. Available at [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(11\)60821-0/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)60821-0/fulltext).

¹⁶ D. Barr, J. Amon, and M. Clayton, “Articulating a Rights-based Approach to HIV Prevention and Treatment Interventions,” 9 *Current HIV Research* 2011: 396–404. Available at <http://www.eurekaselect.com/94789/article>.

services, including ART, along with policies and programmatic approaches that connect people to services and protect them from human rights abuses.

While testing is crucial, knowing one's status is often not enough. Even where treatment is free, countries have reported large gaps between numbers of people who test positive and those who start, and are able to maintain, treatment. Much more needs to be done to bridge the gap between testing and treatment, and to keep people on treatment. There is still very little research on the factors that affect whether or not people choose to start treatment, but it is clear that the biomedical argument (regarding the benefit of ART in reducing morbidity and mortality) is not always sufficient motivation for people to start ... An environment of safety in which people at risk for HIV can demand and use services without fear of stigma, discrimination, and abuse of their human rights is a necessary prerequisite for implementation of all HIV treatment services, including those for prevention. Without sufficient human rights protection, seeking HIV services can often be more immediately dangerous than HIV itself.¹⁷

The Reference Groups believe that these considerations should also be paramount throughout the Global Fund processes, including concept note development, grant making, and implementation. They are reflected in five minimum human rights standards that are incorporated into Global Fund grant agreements. In particular, the grant agreements state: "Programs supported by the Global Fund are expected to: ... d) respect and protect informed consent, confidentiality and the right to privacy concerning medical testing, treatment or health services rendered."¹⁸ Individuals who experience or witness a violation of this standard in Global Fund-financed services are encouraged to use the Global Fund Office of the Inspector General Whistle-blower hotline to file a complaint.

The UNAIDS Reference Group analyzed the human rights issues related to "treatment as prevention" at its thirteenth meeting in December 2011. Recommendation 4.4 of that meeting reads:

The Reference Group recognizes the need to further increase access to HIV testing and counselling, but **urges WHO and UNAIDS Secretariat to carefully analyze the human rights risks and benefits from new approaches to testing**, such as community testing and home testing.¹⁹

The potential impact of "treatment as prevention" does not alter this recommendation. The added prevention value of antiretroviral therapy only heightens the need to find successful approaches to improved HIV service delivery *and* human rights protection. Similarly, ethical issues relating to prioritizing treatment for prevention purposes, particularly in contexts where treatment may not be available for all of those who require it for their own health, must be given appropriate consideration.²⁰

c) The drive to end the AIDS epidemic as a public health threat by 2030

Despite so many changes, the barriers to testing remain largely unchanged. The "more, better, faster" approach to HIV will not end AIDS as a global public health threat without addressing these barriers. The desired scale-up of voluntary HIV testing will not be achieved if the barriers to access to voluntary HIV testing, prevention services, and sustained treatment faced by vulnerable and most at-risk populations are not addressed.

As UNAIDS, together with its co-sponsors, partners, and allies, strives to re-energize and redefine the HIV response in order to face some of the most challenging aspects of the epidemic that have yet to be resolved, the

¹⁷ Ibid.

¹⁸ Global Fund Grant Regulations (2014), Article 6(2)(1).

¹⁹ UNAIDS Reference Group on HIV and Human Rights, "Thirteenth Meeting, 14–16 December 2011: Summary and Recommendations." Available at http://www.hivhumanrights.org.vs2.korax.net/commitmenttohumanrights/wp-content/uploads/downloads/2012/04/HRRefGrp-13thMtg_Rec-ENG-1.pdf.

²⁰ D. Barr, J. Amon, and M. Clayton, "Articulating a Rights-based Approach to HIV Prevention and Treatment Interventions," *Current HIV Research* 2011: 396–404. Available at <http://www.eurekaselect.com/94789/article>.

UNAIDS Reference Group notes with approval the analysis presented in *The Gap Report*.²¹ The report identified twelve groups who are being left behind:

- People living with HIV;
- Adolescent girls and young women;
- Prisoners;
- Migrants;
- People who inject drugs;
- Sex workers;
- Gay men and other men who have sex with men;
- Transgender people;
- Children and pregnant women living with HIV;
- Displaced persons;
- People with disabilities; and
- People aged 50 years and older.

As such, the agenda is set, the priorities are identified. The race towards the end of AIDS will be indefinitely stalled until these key groups are included in all HIV-related planning and programming, and the legal and human rights issues that hinder their access to and uptake of HIV and other health services are addressed.

Concretely, to scale up HIV testing and counselling while protecting human rights, the Reference Groups suggest that the following issues must be urgently addressed:²²

- A well-defined, well-resourced, and consistently applied strategy for meaningful involvement of people living with HIV and key populations in designing, implementing, and monitoring testing and treatment programmes is required.
- Law, policy, and practice reform is required to create an enabling and non-discriminatory environment in which a legal and policy framework ensures respect for and protection of the right to health (including the right to information, access to testing and treatment, and other related socio-economic rights), as well as civil and political rights such as autonomy, privacy, the right to be protected from violence, the rights to speech and assembly, and access to justice for people living with HIV and vulnerable to HIV infection.
- Laws and policies that can act as barriers to access to HIV testing and treatment services, such as those which criminalize same-sex relationships, sex work, and drug use, should be repealed.
- Access to justice for people whose rights have been violated must be strengthened.
- Human rights training for health care workers focusing on informed consent, confidentiality, non-discrimination, duty to treat, and universal precautions is essential, as is the training and sensitization of law enforcement agents on HIV and the human rights of vulnerable populations, particularly in terms of supporting access to services, non-discrimination, non-violence, and freedom from harassment, arbitrary arrest, and detention.
- Programmes to promote the rights of women in the context of HIV are essential. These programmes

²¹ UNAIDS, *The Gap Report*, 2014. Available at <http://www.unaids.org/en/resources/campaigns/2014/2014gapreport/gapreport>.

²² Most of these are elaborated on more fully in Barr, Amon, and Clayton, *supra* n. 14.

include interventions to change laws, policies, and practices that discriminate against women, including those that restrict women's economic opportunities, property, and inheritance rights, inadequately criminalize or punish violence against women, and perpetuate harmful and inequitable gender norms.

- In many countries, the legal age for consent to testing denies sexually active youth access to HIV testing. These restrictions must be removed.
- Social, cultural, and legally-based inequalities between men and women and high levels of gender-based violence often make it difficult for women to access HIV testing. Gender analysis and principles of equality must be applied to all testing interventions and every effort must be made to reduce gender-based violence and inequality globally.
- Alternative testing options should be provided at the point where testing is being offered. This allows people to “save face” when declining testing (i.e., they are not saying “no,” just “later,” or “at another place”) and make the best decision for their own situation. Providing alternatives helps address the power differentials inherent in patient-provider settings, and improves informed consent and confidentiality.
- Programmes to reduce stigma and discrimination are essential for the creation of a social environment which facilitates access to prevention and treatment services. These should address their underlying causes — ignorance, fear, myths, and social judgment.
- Change must also be promoted from the ground up. People affected by HIV must be supported to know their rights in the context of the epidemic, to formulate concrete demands for access to services and non-discrimination on the basis of HIV and other social status, and to have the information and support necessary to make and follow through on testing and treatment decisions and implement behaviour change to improve health.
- There is a need to strengthen local, community-based, and peer-based networks and organizations as a mechanism to support testing and treatment preparedness.
- Empowerment and mobilization approaches to service delivery are essential to the success of expanded testing and treatment access. Legal protection alone will not end stigma. Ultimately, the reduction of stigma will depend on the willingness and ability of individuals to seek out health services. Service provision based on principles of community mobilization and empowerment can provide the sustained engagement in care necessary for a lifetime of treatment adherence.

In the context of the Global Fund concept note development and grant making process, the Reference Groups note the specific guidance from the Global Fund on the inclusion of a package of interventions to address these issues under the Removing Legal Barriers Module, which includes interventions to strengthen community systems for community-led human rights monitoring and advocacy to enhance social accountability.²³ The Global Fund Human Rights Reference Group underscores that these interventions are essential to achieving impact in HIV testing, counselling and treatment.

²³ The package of interventions includes: legal environment assessment and law reform; legal literacy and legal services; training for officials, police, and health workers; community-based monitoring, policy advocacy, and social accountability. Reference may be made to the *Global Fund Information Note on Human Rights For HIV, TB, Malaria and HSS Grants* (<http://www.theglobalfund.org/en/fundingmodel/support/infonotes/>) for more information on those interventions.

Conclusion

As UNAIDS and the Global Fund renew their respective strategies, this is a critical time in the response to HIV and AIDS. Bold new targets for prevention, treatment, and non-discrimination will lead the world on a “fast-track” towards the end of AIDS. *Now more than ever*, UNAIDS and the Global Fund can lead the health and human rights response to HIV.

To support UNAIDS and the Global Fund in this undertaking, the Reference Groups offer the following three key messages:

1. There is an ongoing, urgent need to increase access to HIV testing and counselling, as testing rates remain low in many settings. The Reference Groups support such efforts unequivocally and encourage the provision of multiple HIV testing settings and modalities, in particular those that integrate HIV testing with other services.
2. Simply increasing the number of people tested, and/or the number of times people test, is not enough, for many reasons. Much greater efforts need to be devoted to removing barriers to testing for marginalized and criminalized populations, and to link those tested with prevention and treatment services and successfully keep them in treatment.
3. Public health objectives and human rights principles are not mutually exclusive. HIV testing that violates human rights is not the solution. A “fast-track” response to HIV depends on the articulation of testing and counselling models that drastically increase use of HIV testing, prevention, treatment, and support services, and does so in ways that foster human rights protection, reduce stigma and discrimination, and encourage the sustained and supported engagement of those directly affected by HIV.

Appendix 1: UNAIDS Reference Group on HIV and Human Rights Statement on HIV Testing (2004)

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 the 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; and
5. Ensuring that the healthcare infrastructure is adequate to address the above issues and that there are sufficiently-trained staff in the face of increased demand for testing, treatment, and related services.