



*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

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ACRONYMS

AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ARV	antiretroviral (drug)
CBO	community-based organization
CDC	Centers for Disease Control and Prevention (USA)
CIS	Commonwealth of Independent States
EATG	European AIDS Treatment Group
ECDC	European Centre for Disease Prevention and Control
GP	general practitioner
HAART	highly active antiretroviral therapy
HIV	human immunodeficiency virus
IDU	injecting drug users
MSM	men who have sex with men
MTCT	mother-to-child transmission
NGO	nongovernmental organization
PITC	provider-initiated testing and counselling
PLHIV	people living with HIV
STI	sexually transmitted infection
TB	tuberculosis
T&C	testing and counselling
VCT	voluntary counselling and testing

BACKGROUND

HIV testing and counselling (T&C) form the gateway to prevention, treatment, care and support for all in need. Nonetheless, access to T&C services remains limited in many countries of the WHO European Region. T&C services must be greatly increased in order to ensure that people can know their HIV status and benefit from increased access to prevention, treatment, care and support.

It is a public health imperative that novel and diverse T&C approaches be implemented on a much larger scale. There is an urgent necessity to promote a supportive environment – including legislation – to enable increased T&C services and ensure protection against stigma, discrimination and violence. The further promotion of evidence-based and human rights-based T&C policies, tailored to country needs is crucial. In addition, the expansion of T&C services should address key issues such as T&C ethics, HIV/AIDS-related stigma and discrimination, national programme approaches and related capacities including health care infrastructure and qualified staff. Achieving universal access requires a multisectoral effort, involving all potential stakeholders, linking national realities to Regional and global opportunities.

The technical consultation for the nongovernmental organizations and community-based organizations (NGOs/CBOs) in the WHO European Region held in Lisbon 6-7 June 2007, was the second organized by the WHO Regional Office for Europe supporting Member States' efforts to increase availability of and access to T&C services. The first meeting to review T&C practices and progress made by Commonwealth of States (CIS) countries was held in Yerevan in April 2007 and was attended by ten CIS countries, including representatives of national legislatures, ministries of health, AIDS programmes, NGOs/CBOs, the United Nations, international partners and donor organizations.

The main goals, objectives and expectations of the Lisbon consultations were to:

- review NGO/CBO perspectives on access to and availability of T&C services in the Region;
- address T&C-related stigma and discrimination;
- share experiences on NGO/CBO involvement in T&C service delivery;
- review the draft WHO *Guidance on Provider-initiated HIV Testing and Counselling in Health Facilities*; and
- make recommendations on scaling up T&C services in the Region.

The meeting was attended by participants from 29 WHO European Region Member States, mainly representing CBOs/NGOs, civil society as well as T&C and public health experts, international technical experts, the United Nations and international partners. Service provision and advocacy groups were represented, including organizations of special needs and interest populations. The diversity of representation allowed discussions to reflect the range of European civil society views on T&C. It was an opportunity for civil society and NGO/CBOs to share their vision of the current situation – including the user's perspective – to address demand and to share suggestions regarding T&C policies and practices in Europe.

REPORT OF THE DISCUSSIONS

WHO/UNAIDS Guidance on provider-initiated HIV testing and counselling in health facilities (PITC)

The consultation provided a forum to discuss the recently launched WHO/UNAIDS PITC guidance for countries expanding HIV T&C services.

Representatives of PLHIV backed specific communication guidance and training for medical practitioners in order to advance non-discriminatory behaviour in services to at-risk and vulnerable populations. It also implies the necessity of T&C quality monitoring ensuring that an efficient monitoring and evaluation (M&E) system is in place.

A number of participants suggested that special consideration be given to the needs of prisoners, who are not specifically covered by the PITC document. Informed consent is an issue of particular importance in penal institutions, where it may be difficult to avoid coercion, and it would be preferable to have written consent from prisoners that could be kept on record.

T&C services should be voluntary, whether client- or provider-initiated.

There is a consensus that ART is a vital prerequisite when scaling-up T&C. Efforts to increase testing should be made concurrently with increasing access to treatment and care. While not everyone testing positive is in immediate need of ART, monitoring should be in place to evaluate eligibility and initiate it when needed. Augmented access to T&C services would motivate people to seek needed services, and eventually a majority of those tested may need ART. Access to ART is considered an absolute prerequisite for T&C scale-up.

Some examples from eastern Europe suggested that client-initiated T&C (CITC) is usually rare; testing is mainly recommended by service providers. There are few if any campaigns promoting HIV testing that increase awareness and motivation for people to learn their HIV status. International support, especially GFTAM grants, has been a stimulus to increased VCT access in some countries.

While epidemiological data should be used to guide policy, the quality of the data should be given serious consideration when deciding whether to initiate PITC. Implementing broader PITC may in fact uncover a higher HIV prevalence than found in a given target population. Decisions should always be based on solid evidence using quality data.

There is some scepticism about the positive effects of replacing pre-test counselling with pre-test information, on the grounds that without asking relevant questions during pre-test counselling, the clients' behaviour – particularly risky behaviour – will be unknown. Therefore pre-test counselling should be considered an integral part of T&C services.

It should be noted that PITC is just one approach in a comprehensive augmenting of T&C efforts. A large portion of vulnerable and at risk populations do not have access to medical settings as sites of T&C. The challenge is how to reach these populations and elaborate novel approaches to facilitating their access. Active involvement of NGO/CBOs and civil society in T&C and their collaboration with health care settings are important courses to pursue.

Counselling and testing issues to be addressed by national legislation

A supportive legal basis is vital for scaling up T&C services in order to maximize positive outcomes and minimize potential harm. Approaches adhering to the respect, protection and promotion of human rights as stated in the Dublin Declaration are fundamental for:

- preventing transmission of HIV;
- reducing vulnerability to infection;
- dealing with the impact of HIV/AIDS; and
- empowering individuals and communities to respond to HIV.

Core issues that should be addressed by national legislation are:

- confidentiality, counselling and consent (the three Cs)
- disclosure
- reporting and maintenance of a registry
- medical records
- protection against stigma and discrimination
- referrals to appropriate services
- the role and responsibilities of health care providers.

Broader issues for legislation include:

- regulation of HIV related goods, services and information
- employment
- compensation
- insurance
- education
- HIV and social welfare
- HIV and the right to asylum.

Who initiates T&C, who provides services, and in what settings T&C takes place should also be addressed. While there may not be any institutional pressure in the case of CITC, there may be pressure from inter alia families, partners or friends. Potential pressures in PITC may stem from timing and power relations between the patient and providers

Other important issues for regulation include:

- the responsiveness of health care providers
- guaranteed equal access to T&C and confidentiality
- the interests of the individual patient
- the information offered
- whether defined T&C are to be free or paid
- private or public providers, or both
- to allow NGO/CBO the T&C service provision
- frequency of testing, especially for most-at-risk groups
- lay or certified personnel, type and mode of qualification, issuing authority
- the right to refuse test results
- the scope of testing for research purposes
- the scope of compulsory testing.

Despite officially free HIV testing in some countries, people are at times asked to “donate” money to some fund, cause or other, thus making fees a precondition of access to T&C services and creating a barrier to those in need. Mandatory testing is still widespread in some

countries (mainly in the eastern part of the Region) and in some countries people may be tested for HIV without their knowledge. Human rights-based policies must be adopted and monitored for compliance.

The major questions that arose in relation to verbal informed consent were whether related information should be recorded on medical records and how to prevent forgery of medical documentation and fraudulent IC. It could also occur that T&C are offered by a provider and declined by a patient without the refusal being entered into the medical record, due to local regulations. Anecdotes showed that this scenario can create negative consequences for health care personnel. National legislation should take this into account and encompass protective measures.

It can be very difficult for patients to decline *an offer* of testing and even more difficult if testing is *recommended* by a health care provider. Sociocultural norms, traditions and education often play important roles in provider–patient dynamics. True voluntary testing, without explicit or implicit coercion, would require education and training on both sides and take a great deal of time, with national variances.

Clarity, common understanding and consensus on terminology and specific or general consent are necessary. An issue for local determination is whether only specific consent (as opposed to general) be required for HIV testing. There is consensus that informed consent issues should be clearly defined by national legislation and/or regulations.

It was also pointed out that some health care professionals in several countries do not understand the importance of confidentiality; consequently, breaches of confidentiality are widespread. There should be a code of conduct for service providers, with clear guidance on T&C in the general framework of the “3C’s” principle.

Meeting participants felt strongly that in case the age of consent for an HIV test differs from the age of legal majority, it could be set at the national legal age for consensual sex. This potentially could result in different ages of consent across the region.

Role of quality counselling in HIV counselling and testing services delivery

The availability and quality of counselling remain sensitive issues in many countries. Experience from WHO Regional Office-supported pre-and post HIV test counselling workshops in a number of countries shows that it is important to start such workshops with an introduction of basic counselling skills and techniques, especially in countries where counselling is new. Counsellors’ self awareness, self-understanding and listening skills are the most important matters to be addressed and promoted. It was suggested that allowing clients to talk whatever they need to, including sexual issues, is very important. Counsellors need to be cautious about giving too much information and talking too much, which could potentially confuse and stifle the client, and fail to achieve the desired results. The main mentioned counselling skills are:

- getting clients to ask questions
- listening to what clients have to say
- sensitivity to issues raised by the client.

Supervision – an integral element of ensuring quality counselling – was a new concept for many consultation participants. Unfortunately, supervision is a worrying concept for many new to counselling, as it is often mistaken for penal investigation, whereas it is an opportunity to receive support from colleagues and external people, discuss their professional concerns and to find solutions while continuing to develop counselling skills. Experience also showed that many counsellors had no or limited experience in counselling PLHIV. Counsellors definitely need to know what it means to live with HIV infection and its psychosocial consequences in order to provide high quality counselling services to PLHIV. It is also important to involve PLHIV in counselling.

The distinction between pre-test counselling and pre-test information must be emphasized. Consideration should be given to the impact of replacing pre-test counselling with pre-test information.

NGOs are involved in HIV testing in a number of countries. The public should be made aware that testing is available in both health care settings and NGOs. Counselling in NGO settings is usually provided by psychologists and/or social workers. Counsellor training in these countries is mainly provided by large NGOs, universities (usually psychology departments), state health care departments, etc. Also, rapid tests are used in some places and there is a close collaboration with laboratories and health centres to ensure high quality testing.

The introduction of mobile units and rapid tests in some countries increased the number of people tested and the frequency of post-test counselling. Some countries had negative experiences associated with mobile units. While mobile testing services were made available for IDUs and FSW, there were a high number of false negative results and poor counselling services.

Some countries reported that pre-test counselling is hardly available. Such circumstances, for instance, exacerbated difficult situations in which women learned of their HIV status during pregnancy and there was no crisis, couple or family counselling available. Provision of unified counselling services without considering individuals' needs should also be avoided.

Training, including refresher courses, is important in maintaining high-quality counselling, and monitoring tools must be in place for overall quality assurance. However, it was suggested that the creation of a new profession – counsellor – should be avoided. This issue is of particular importance for some countries in eastern Europe that have strict rules requiring all services to be firmly legislated and regulated. A possible solution could be allowing a variety of providers to offer counselling services in addition to their other roles. This may entail officially recognizing them as counsellors by certifying or licensing them, as appropriate in the country, without establishing a separate profession of counselling.

Discussions that take place during counselling should be included under confidentiality protection laws. Regulation should prohibit the disclosure of the client's HIV status, information related to possibly criminal risk behaviour for HIV infection and any other information given by the client. If information received during counselling is not protected under confidentiality laws, the question arises whether a counsellor is obliged to report any or all information to authorities. Such counselling issues should be addressed by national legislation or regulations.

The successes and challenges of HIV testing in the United Kingdom

The epidemic in the United Kingdom is mainly MSM-driven. It is significant that testing rates are increasing in this population, but so is infection incidence, as opposed to sustained low prevalence among IDUs and in the general population. The epidemic remains concentrated mostly among MSM. High ART coverage has been maintained. The majority of new infections have been acquired through heterosexual transmission, which has changed the epidemiological profile in the United Kingdom. In addition, the prevalence among women from sub-Saharan groups giving birth in England is above 2%.

Data show that large groups of late presenters are missed by general practitioners, who consequently do not offer testing. Data also shows that about 11% are presenting with full blown AIDS, quite disproportionately male heterosexuals infected abroad. Despite strong educational efforts among MSM, one in five presents late.

The United Kingdom responded at the start of the epidemic with dedicated funds, needle and syringe exchange programmes, targeted interventions for risk groups, dedicated HIV and STI services and specific targeted health promotion messages. The strategies have responded to the changing environment, demonstrating the importance of having an effective monitoring and evaluation system in place.

The uptake of HIV testing in genito-urinary medicine (GUM) clinics and antenatal settings among heterosexuals increased from 30% to more than 80%. There has also been a decrease in the number of people going undiagnosed when offered testing though it still occurs. MSM show a similar 80% uptake, and more than 80% accept testing in antenatal settings. Data are poor for the number of tests performed in general and in other settings.

Despite successes there are still challenges, such as high prevalence among MSM, a large increase of prevalence in ethnic minority groups, late diagnosis, high mortality rates among HIV-infected people and lack of diagnosis of probably a third of HIV-infected people. Testing patterns are very important as late diagnosis contributes to high mortality. Moreover, the undiagnosed portion of HIV infections is an additional reason to address testing.

Areas that still need to be addressed include:

- decreasing the number of people undiagnosed
- decreasing late presentations
- promoting testing policies ensuring that the major departments – TB , dermatology and others – have testing policies and recommendations.

Improving access to testing and counselling services for IDUs –recent experiences from Portugal

Increased access to HIV testing opened doors for boosting access to prevention, treatment, care and support services in Portugal. The major remaining barriers are:

- failure to target people testing negative for repeat testing;
- some prefer not to know test results because of different reasons, including that solutions proposed are not the most suitable for them;
- lack of knowledge of one's own risk factors; and
- lack of access to health services for certain population groups, such as IDUs.

In order to increase the efficiency of T&C services it is crucial to know what works and what does not, taking local and regional circumstances into account. The Portuguese National AIDS Programme experience shows that the use of simple rapid tests has made a large impact on screening programmes and also highlighted some related issues, such as the lack of infrastructure. Rapid tests are important in areas where people are hesitant to approach health care settings. Moreover, experience has demonstrated that outreach and peer approaches are effective in reaching IDUs. Data suggest that while there is a decrease in incidence among IDUs, the expected decrease in AIDS has not followed. There is some doubt about whether doctors are correctly identifying and reporting data on transmission routes that may be influencing data on transmission patterns in Portugal. The lack of a decrease in AIDS cases may be a reflection of IDUs not using services or accessing them too late for early treatment. People also need to travel long distances to hospital; in southern Portugal, for example, it may be up to 300 km. The long-distance travel is also prompted by fear of stigma and discrimination. Data from a large hospital in northern Portugal show a decrease in the number of infected people in that region, especially among IDUs, attributed harm reduction efforts including NSEP, substitution therapy and assisted injection facilities under a programme in place since 1998. A mathematical model has been developed to forecast the number of cases that could be avoided, but it has not yet been evaluated.

Special surveys were implemented in the country's two largest prisons, where data suggest that almost all IDUs are HCV positive, all PLHIV are also HCV-positive, but not all those tested positive for HCV are also HIV positive. Prevalence is especially high among those sharing injecting paraphernalia. The approach used for the Portuguese IDU population in general has been to ensure that whenever a user is in touch with a drug treatment setting or outreach programme, HIV testing is offered. During the first visit qualitative information is obtained via a specific questionnaire, then pre-test counselling is conducted by a nurse or psychologist, followed by an HIV rapid test. Results of about 25 000 tests indicated that the test refusal rate is quite low. Only one centre had high refusal rates, due to personnel reporting refusals in order to decrease their work loads. This demonstrates the importance of monitoring and evaluation once again. A financial analysis showed that using rapid tests requires just 1/5 of funds that would have been needed to perform an ELISA. This cost-benefit permitted reallocation of saved funds and their use for other important activities.

To ensure a standardized approach and quality testing and counselling, documents have been produced for counselling, testing, referrals, confidentiality and other related topics. A manual has also been prepared on ways to promote testing, condom use, etc. Part of the strategy included training on the use of the manual and other documents.

The major challenge in Portugal is to reach as many IDUs as possible, especially those who most probably would not initiate the contact with health care providers. There are efforts to shorten the time between diagnosis and hospital admission to a maximum of 7 days. People still come late for diagnosis and for treatment initiation and care interventions. While the national programme is addressing the quality of treatment by closing small units, providing additional training including periodic refresher courses, quality treatment and care remain a challenge.

Logistical issues, transport and other topics that are often given little attention despite their essential importance were discussed. At present, with positive results being shown, the national programme is about to be expanded to other groups.

The treatment data monitoring perspective

The HIV Monitoring Foundation in the Netherlands follows patients in 24 treatment sites in the country and monitors national trends of the epidemic, data on new diagnoses, what happens between HIV diagnosis and AIDS, data on death and what happened between diagnosis of AIDS and death. Initiation of HAART in 1996 made a major impact reducing the number of people developing of and dying from AIDS. It is estimated that about 18 000 people are infected in the Netherlands, and the epidemic is driven by MSM transmission. There is data suggesting a clear correlation between time of diagnosis, treatment patterns and outcomes. At the moment there are about 8000 patients under treatment, 2000 others are infected and not under treatment because, in accordance with national guidelines, they are not currently eligible for treatment. A majority of patients respond well at start of treatment, about 20% fail for a variety of reasons and out of them about 80% show resistance. Resistance has been found in about 65% new infections and seems stable. Subsequent to the initiation of HAART there was a decrease in infections, but there has since been an increase, mainly among MSM. Despite some suggestions that this may have been caused by an increase in testing due to awareness of the availability of treatment, newly tested people have shown high CD4 counts, indicating recent infection. This confirmed that the number of infections among MSM was increasing and was comparable to the beginning of the epidemic in 1980's. In order to figure out what happened a mathematical model was employed and estimates made. The main uncertainty was establishing the time from infection to diagnosis. In the model issues such as risk behaviour patterns after diagnosis as well as access to treatment were analysed. Viral load also influences transmission patterns and needed to be considered. An increase in risk behaviour caused more than 2000 new cases of infection. Detection of infection within one year can significantly affect the epidemic. It is crucial that T&C focus on high-risk behaviour, with effective referrals for ART, care and support services. T&C services have to be of high quality. Augmenting availability of and access to T&C services means early access to testing to increase awareness of people's serostatus and their access to quality counselling for behaviour change and obtain timely treatment that ultimately will have an impact on the epidemic. While treatment reduces transmission, the virus and risk of transmission remain, so raising awareness and trying to influence behavioural continues to play a major role. Quality counselling is an important instrument in the overall efforts of preventing and controlling the epidemic.

General Discussion and Conclusions:

T&C are essential for HIV/AIDS prevention and improving treatment outcomes. Increasing access to T&C services for all in need is a public health imperative. It was suggested that increasing T&C services without access to ART is unethical. Early testing and diagnosis is crucial for PLHIV if they are to live long, good quality lives.

The situation in prisons was given special attention. Some country representatives said that many prisoners prefer to be ill, as it may give them a chance for early release, so they refuse to be tested and refuse ART. This should be taken into consideration by policy-makers and programme planners. Prisoners, just like other European citizens, should have the right to know or not to know their HIV status and make an independent decision to be treated or not. The same public health norms and approaches should be applied in prisons as in general public health settings.

In some eastern European countries, T&C services are declared free of charge, but are not really. The AIDS phobia in these countries, even among health professionals, was mentioned a factor in mandatory testing. Doctors in private clinics are reportedly interested in treating PLHIV for private income, while some public medical personnel are not interested, as the increased work load is not reflected in their salary. Some advocate additional remuneration for dealing with HIV/AIDS as “exceptionally dangerous diseases”. These issues should be addressed by international guidelines.

Informed consent should always be obtained as there is no situation where consent is not required. Test results should always be given to the person concerned, according to the indicate mode (in person, telephone, letter). The age of consent for an HIV test or other medical care could be the same as the legal age for consensual sex if the latter differs from the age of legal majority. Each country should decide on the age threshold as it would be too difficult to achieve consensus at the Regional level. In countries where home testing is available, regulations should ensure that kits are of high quality, include correct and complete information including the implications of the results and available sources of support. Recommendations on home testing are needed.

NGO delivery of certain types of T&C services should be encouraged, especially in some eastern European countries where governments are still reluctant to allow the nongovernmental sector to perform HIV/AIDS related duties. Active involvement of NGOs /CBO/civil society in prevention and care is imperative, since they have established access to some of the groups most at risk. Civil society has a particular role in rectifying these sorts of issues.

Significant resources are being spent on counselling training and education with highly experienced trainers, but this is not leading to higher-quality counselling services. Pre- and post- test counselling are often done by doctors in health care facilities as there is rarely dedicated staff for the purpose. Doctors’ willingness to provide counselling is low as it requires additional skills, takes time away from other medical duties (standard time recommended for counselling by some national protocols can reach 40 minutes, as opposed to 20 minutes for general check-ups), and there are no additional incentives given for counselling service provision. Staff trained in counselling may at times refuse to deliver services after realizing there is no additional salary for the new services they are to provide. Besides the lack of T&C services, resources have been wasted on training that is not put to use.

In some countries testing and counselling services are delivered at separate sites, in some cases in different parts of town; consequently, clients may be less inclined to go for testing after a pre-test counselling session, or after receiving test results may disregard the post-test counselling session.

Health care structures, especially in central and eastern Europe, may not allow people to fully use the knowledge and skills acquired in T&C training sessions. In some countries there is a monopoly of AIDS centres, so doctors caring for patients with TB, STI or other conditions are not involved in HIV-related services, including conveying test results to patients. This, too, hampers access to T&C. In these circumstances, the use of rapid tests is usually not permitted. Breaking down such monopolies and moving towards evidence-based policies and practices are imperative if the goals of universal access are to be met.

Continuous education and refresher courses are necessary to ensure that knowledge and skills are kept up-to-date. Quality control measures are needed to monitor T&C services and to retain qualified staff. This is of particular importance even if difficult to undertake and maintain in the long run. GPs also need training to offer quality T&C services, considering their important role in early detection of HIV infection. The integration of HIV into STI health services was recommended, along with STI testing in VCT centres.

In some countries partner notification is regulated by law. The major question is whether people realize the value of disclosure and the risk of non-disclosure. If an active testing policy is in place, partners will probably be picked up without active partner notification. Partner notification should be seen as a very useful strategy to promote. There are concerns about it being used as a method of compulsory testing. The effect of prosecution on partner notification and the relationship of criminalization to the willingness to be tested need to be investigated. Partner notification, especially in eastern Europe, has often been done in a repressive manner.

There remain serious concerns regarding data confidentiality. In some countries there are no consequences of negative results, whereas positive results lead to personal data entering a central register. The full name, address and other information collected at the facility level may maintain confidentiality but there is no explanation for this information being collected or sent to regional or national levels. Maintaining data confidentiality is of utmost importance and must be guaranteed. While duplication may be a concern, it can be avoided by using a coding system. Even if there is duplication, its impact is not comparable to the importance of protecting confidentiality.

Clear, non-controversial and specific recommendations must be developed for achieving universal access in the European Region by 2010.

Participants were encouraged to provide input for and participate in the international meeting Working Together for optimal Testing and early Care, in Brussels, November 2007

RECOMMENDATIONS

1. WHO European Region Member States have subscribed to international declarations securing human and individual rights for which there should be no distinction among Member States in terms of legal principles/framework related to T&C.
2. Countries should develop strong legal instruments, regulations and normative documents on T&C to ensure that right- and evidence-based principles and approaches are declared, granted and followed in practice.
3. Sustained political commitment, implementation of rights- and evidence-based policies, approaches and interventions on the scale required in each country are required to ensure the impact needed.

4. T&C policies should ensure public health benefits while being directed to the benefit of individual patients.
5. In order for policy-makers to be well informed, international bodies need to coordinate their responses when drafting policy statements, guidance, recommendations and other normative tools to avoid confusion and duplication of efforts.
6. It is vital for civil society to feed into the T&C policy-making.
7. Partnership and close collaboration across the WHO European Region need to be promoted.
8. Services meant for specific population groups need to be brought to them.
9. Sufficient T&C venues offering equal access to acceptable, affordable, safe and reliable services should be available to all in need in every country.
10. Sustained, comprehensive, effective health promotion campaigns including T&C should be undertaken.
11. A variety of service providers should be permitted to provide counselling services. They should be well trained, certified/licensed in accordance with country regulations and based on country needs and circumstances
12. Confidentiality should be maintained for all information given by clients to counsellors regardless of HIV status and should be protected by law.

ANNEX 1: LIST OF PARTICIPANTS

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ANNEX 2: PROGRAMME

DAY 1: JUNE 6th

- 08.30 - **Registration**
09.00
- 09.00– Welcoming remarks
09.30 **S. Matic** WHO EURO Regional Adviser for STI/HIV/AIDS; **N. Dedes** EATG;
Ton Coenen Aids Action Europe & Co-chair EU Civil Society Forum on HIV/AIDS
- Objectives of the Consultation
Major points for discussion:
- What are the key concerns of civil society, NGOs and PLWHA in relation to HIV T&C?
 - More specifically, how can the following be ensured:
 - ✓ *Voluntary, anonymous/confidential, free, quality HIV T&C services are available, affordable, acceptable and equal access is guaranteed/secured*
 - ✓ *Increased availability of and access to HIV T&C services is not a goal in itself but are followed by their increased uptake and lead to improved access to prevention, treatment, care and support services*
 - ✓ *Call for scaling up of HIV Testing is not perceived/understood as a promotion of mandatory testing and does not lead to increased human rights' violation, stigma, discrimination and violence*
 - ✓ *National legislation address HIV T&C related aspects in a rights based manner and protection against stigma, discrimination and violence is granted*
 - ✓ *T&C data are protected. Disclosure is voluntary. Human rights' based approach is a basis for partner tracing*
 - ✓ *Resource constraints are not stopping T&C promotion and cost effectiveness issues are not influencing public health values*
 - Which main issues should be addressed/ discussed in a European T&C Policy brief that WHO EURO plans to develop in collaboration with national and international partners?
- 9:30 – HIV T&C and Universal Access to HIV Prevention, treatment, care and support, **S. Matic**
10:00 WHO EURO
- 10.00– Overview of the recently developed WHO/UNAIDS draft “Guidance on Provider-initiated HIV
10.30 Testing and Counselling in Health Facilities **A. Okero** WHO HQ
- Questions & Discussion
- 10.30 - Coffee break**
11.00
- 11:00 – Questions & Discussion (*cont'd*)
12:00
- 12.00 -1 Lunch**
3.00
- 13.00– T&C issues to be addressed by national legislation ensuring right-based approach. **K. Turkovic**
14.00 Zagreb Law School, Croatia
- Questions & Discussion
14. 00 – Role of quality counselling in T&C services delivery, **L. Schonnesson** Karolinska Institute,
15.00 Sweden
- Questions & Discussion
- 15.00– **Coffee break**
15.30
- 15.30 – Successes and challenges of HIV testing in the UK, **V. Delpech** Health Protection Agency, UK
16.30 Questions & Discussion

16.30 – General discussion
17.00

DAY 2; JUNE 7th

09.00- Improving access to T&C services for IDUs: what works/ what does not – most recent
09.45 experience from Portugal Questions & Discussion, **H. Barros** National HIV/AIDS Coordinator, Portugal

09.45- Scaling up T&C as it looks from treatment data monitoring perspectives: the applied research
10.30 outcomes and the policy implications it generates – Dutch experience, **F. de Wolf**, HIV Monitoring Fdt. Foundation The Netherlands
Questions & Discussion

10.30 - **Coffee break**
10.45

10.45 - **General Discussion:**

13.00 - Recommendations

Next steps and Closing remarks, **S. Matic WHO EURO**