



JOINT WHO/UNICEF/UNAIDS TECHNICAL CONSULTATION ON SCALING UP HIV TESTING AND COUNSELLING IN ASIA AND THE PACIFIC

Phnom Penh, Cambodia
4-6 June 2007

CONCLUSIONS AND RECOMMENDATIONS

Along with 73 participants from 12 countries, representatives from the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the Joint United Nations Programme on HIV/AIDS (UNAIDS), Secretariat of the Pacific Community (SPC), South Asia Association for Regional Cooperation (SAARC), and civil society, met during 4 to 6 June 2007 in Phnom Penh, Cambodia, to discuss critical actions required to scale up access to HIV testing and counselling in Asia and the Pacific towards Universal Access. Participants reviewed HIV testing and counselling policies and practices in different settings and contexts in Asia and the Pacific.

The aim of the meeting was to discuss how to scale up HIV counselling and testing services, discuss core public health methods, ethical principles and human rights values for scaling-up HIV testing and counselling, and identify and agree on key actions for follow-up at the regional and country level for policy and programme implementation, and the role of the recently released provider initiated testing and counselling (PITC) guidance was considered.

Encouraging progress in preventing HIV transmission has been made in several countries with decreasing HIV prevalence such as Cambodia, Tamil Nadu State in India, and Thailand. Regionally, 19% of people living with HIV in need of antiretroviral therapy (ART) were receiving it by the end of 2006. Most countries in Asia and the Pacific are providing client initiated and provider initiated HIV counselling and testing services or a mix of both approaches. Yet, less than 10% of persons living with HIV are aware of their status.

Some countries face substantial human and financial constraints, weak health infrastructures, in particular at the community level, inadequate use of HIV testing technologies, limited knowledge on HIV in the community and among health care workers, combined with stigma and discrimination. Commonly, laws and policies inhibit the implementation of interventions targeting people most at risk such as sex workers and their clients, injecting drug users and men having sex with men. Different countries have different experiences of HIV testing and counselling in closed settings such as rehabilitation centres, prisons, camps and juvenile institutions. These include mandatory HIV testing on entry, release, or during the period of detention while voluntary counselling and testing remains exceptional and is usually not accompanied by access to appropriate prevention or care-related services.

Mandatory and other coercive forms of HIV testing do not serve a legitimate public health goal and jeopardize access to health services, reduce health-seeking behaviours and increases stigma and discrimination.

Participants recognized and agreed there is an urgent need to scale up access to HIV counselling and testing in countries of the Region as a means of enhancing access to comprehensive HIV prevention care and treatment. Existing models of voluntary counselling and testing need to be strengthened, scaled up and complemented by approaches that build on the potential of health services to offer HIV counselling and testing. Such an approach to HIV testing, initiated by health providers, should be accompanied by counselling, confidentiality and be conditional upon the person's informed consent (the "3 Cs"). WHO and UNAIDS published guidance on this in May 2007 provides a useful framework which now needs to be considered by every country.

In order to scale up voluntary HIV counselling and testing and achieve universal access to prevention treatment and care services, participants recommended:

1. Countries need to review national HIV testing policies, and approaches and practices to embrace existing guidance on voluntary counselling and testing (VCT), and consider the new provider initiated testing and counselling (PITC) guidance.

2. National consideration needs to be a participatory and transparent process (appropriate next steps are detailed in the meeting report).
3. HIV counselling and testing, irrespective of settings, must be accompanied and linked to a nationally agreed minimum package of defined services and linked to HIV prevention, including harm reduction services, treatment and care including ART.
4. Additional attention is required to clearly define terms used locally, and to reinforce the voluntary nature of HIV testing and the requirements of consent, counselling and confidentiality ("3 Cs").
5. Countries need to optimize the use of newer HIV testing technologies, including rapid tests, to allow same day access to results, and virological testing for infants.
6. Countries will need to define, revise and apply standards, guidelines and training tools for HIV testing and counselling, including internal and external quality assurance schemes to support quality service delivery.
7. Countries need to review and amend laws and policies which criminalize practices like sex work, drug use, and sex between men, with a view to facilitating access to HIV counselling and testing, prevention, treatment care and support (including ART and harm reduction).
8. Countries need to review laws, policy and practice to prohibit mandatory testing of persons in closed settings (such as rehabilitation centres, prisons, detention centres, immigration lock-ups) to facilitate access to voluntary HIV testing and counselling, prevention, care and treatment and support (including ART and harm reduction).
9. Countries should ensure increased access to HIV testing and counselling, HIV prevention, treatment and care, including ART for infants, children and adolescents.
10. Countries should prioritize where and how testing services should be scaled up based on national and subnational epidemiological patterns and at risk populations (including the need for HIV counselling and testing in sexually transmitted infections (STI), tuberculosis (TB) and antenatal care (ANC) services). This should be reflected

in agreed benchmarks and targets.

11. In order to scale up quality accessible, equitable, acceptable HIV testing and counselling services, countries will need to revise existing costed plans and mobilize additional resources.
12. Scaling up community response requires broad-based advocacy, greater collaborative interactions between community and health facilities and specific steps to support and facilitate referrals.
13. Codes of conduct and mechanisms for receiving, examining and responding to complaints are needed for HIV services, including HIV testing and counselling in health facilities, closed settings and in context of labor and migration.
14. Countries need to review and revise national policies and laws to prohibit mandatory HIV testing for migrant workers and ensure access to HIV prevention, treatment, care support and referral services in both home and host countries, and advocate for the same through regional and intergovernmental mechanisms.
15. Simplified national monitoring mechanisms should be put in place and adapted to reflect progress towards achieving set targets, (meeting report to discuss principles of one national Monitoring and Evaluation system and duplicate reporting systems).
16. A working group should be established at the regional level (comprising civil society, people living with HIV/AIDS, global and regional partners, and technical experts) to support the process of scaling up voluntary HIV counselling and testing to secure access to care and prevention at the national level and to monitor progress against these recommendations.
17. Technical support should be extended to countries by global and regional partners to implement the above recommendations.