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**XVII International AIDS Conference
Scaling up HIV Testing and Counseling: A Human Rights and
Public Health Imperative
August 5, 2008**

[START RECORDING]

ANA LANGER: Good afternoon everyone. Hola a todos, buenos tardes. We will start on time because we want to have a lot of time for questions and answers.

We have simultaneous translation English/Spanish, and we have a presenter who will speak in French, but his slides are in English and we will help him by translating any questions he may get, and his answers also. [Spanish spoken]

I want to welcome you all to this symposium on scaling up HIV testing and counseling. I am Ana Langer, president of Engender Health, and before taking this position in New York I lived for many years here in Mexico, where I led health research and policy development in this country and the region.

I am very glad to be moderating this session in particular today, because it is a subject that I think about often. And that is because in many ways, it is a new manifestation of a recurrent question in health policy: how do we strike a balance between the good intentions of the public health community with the need to respect and protect individual rights and assure informed consent?

As you know, there are two main approaches to HIV testing right now, and they share a common assumption: that knowing one's status means an individual will access additional counseling and services that can change behavior and/or jumpstart a regimen of life preserving medication. One approach which in recent years has garnered increased attention

follows the WHO recommendation that HIV counseling and testing be administered to everyone with the possibility of opting out.

This is a classic public health approach, based on the assumption that if those in need of treatment can be identified, they will receive services, disease incidence will drop and lives will be extended through proper care.

Surrounding this approach are legitimate concerns about whether real informed consent to opt out of testing is possible in light of the power imbalances between service providers and clients.

The other approach is to rely on voluntary counseling and testing and starts with the assumption that if testing services are known to be available in a community, individuals may decide for themselves whether to be tested. It is not a default component of health care as in the first scenario. Further, the notion is that when people are self-motivated to know their status, they will be that much more inclined to do something about it, whether positive or negative.

So what we have here is the crux of so many public health debates through time, a sweeping effort that includes everyone, or a voluntary approach emphasizing individual choice and rights. A classic example of this debate is mandatory mass vaccination programs, which have contributed to some of the greatest success stories of public health in the last 100 years.

But a critical difference between the decision to commit to mass vaccine programs and the current question of which model of HIV counseling and testing should prevail is that the former was based on very clear evidence that it was a method that worked, and the latter is not, at least so far.

I serve on the world health organization advisory commission on health research, and believe so strongly that health policy must be informed by evidence. And right now, we need to know more about which approach to HIV counseling and testing actually leads to more individuals accessing prevention, care and treatment services, adhering to a regimen of prevention or care and reducing stigma and discrimination.

And so we are here today to examine closely each strategy, the ethical implications of each, and most importantly, the evidence that the desired outcome, life-preserving behavior change, is achievable. Judging by how many of you are here, I know that this is an issue that weighs heavily on many hearts and minds.

To further frame out thinking today, we have four speakers and a discussant. Dr. Ralf Jurgens of the UN AIDS Reference Group on HIV and Human Rights who will talk about the recommendations of the UN AIDS Reference Group to address these questions. Then Aliou Sylla will take us to Mali to see how provider initiated testing and counseling can be done and scaled up while ensuring human rights, informed consent and confidentiality.

Next, Armara Quesada will explain mandatory HIV testing programs that are in place for migrant workers in Asia, and the impact it has on migrants themselves and on their families. Dr. Nduku Kilonzo will report on her program in Kenya that reaches roughly 250,000 individuals a year with various approaches for voluntary counseling and testing, and will examine the gender implications of different approaches.

And then Gracia Violeta Ross of Bolivia will start our discussion of what these programs their approaches and the evidence supporting them, or lack thereof, means as we look ahead. I will now introduce our first speaker, Dr. Ralf Jürgens, and will introduce each of them before their turn.

Just a quick announcement: you may have found evaluation forms on your seats, so please fill them out and give them to a volunteer.

So let me say a few words about Ralf. Ralf is the co-founder of the Canadian HIV and AIDS Legal Network and served as its executive director from 1998 to November 2004. since December 2004, he has worked as a consultant on HIV and AIDS health policy and human right in eastern Europe, central Asia, Africa and Canada.

He is a member of the UN Global Reference Group on HIV and AIDS and Human Rights, and in 2006 co-chaired the policy track at the 16th International AIDS conference in Toronto. A prolific writer on the subjects of legal, ethical and human rights issues related to HIV, he also taught the first course

ever on AIDS and the Law in a Canadian university. Ralf, it's a pleasure to have you here today.

RALF JÜRGENS: Thank you very much, Ana and thank you very much to the organizers of the conference for inviting me to address you today. And thanks to all of you for turning out in such great numbers to this session on HIV testing.

In my presentation, first of all, I would like to acknowledge the Open Society Institute Public Health Program, and some of the people who have worked with me on HIV testing and counseling issues, as well as the members of the UN AIDS Reference Group on HIV and Human Rights, who have helped me organize my thoughts around this issue.

As you know in recent years, there has been a call to not only expand and ensure quality in voluntary counseling and testing services but also to explore other models of testing including provider initiated testing and counseling, which I will now call PITC. As you know, in May 2007, WHO and UN AIDS released guidance on PITC in health facilities.

More recently, separate testing policy statements have been developed of some of the most vulnerable populations such as prisoners and people who use drugs.

One of these UN AIDS UNODC and WHO statements is about to be released in the summarized in a poster that is being presented at the conference today. And you see that poster number on this slide. It is the new policy statement on HIV testing and counseling for prisoners.

Now the World Health Organization and UN/AIDS testing guidance, as you know, strongly supports efforts to scale up testing and counseling services through diverse methods, including client initiated and provider initiated testing and counseling. Under certain circumstances, as Ana said, the guidance recommends that people in health care settings be tested after receiving information about the HIV test unless they specifically decline the HIV test.

While the late 2007 guidance has generally been well-received, concerns have been raised about several aspects of the guidance. In particular, some have raised the question whether it is possible to increase access to HIV testing and counseling and implement the guidance while respecting human rights.

It is important to recognize first that the efforts to increase access to HIV testing and counseling are not occurring in a vacuum. Rather, they take place in an environment in which evidence-informed and human rights-based policies and responses to HIV are being widely undermined.

Rather than by providing opiate substitution treatment, for example, ineffective drug treatment remains the norm for many people who are dependent on drugs in many countries in the world. Abstinence based education continues receiving a lot of support, despite its limitations.

In contrast, laws criminalizing exposure to HIV or transmission of HIV are being passed in a large number of

countries, despite a lack of evidence that these laws may have any preventative effect. And at the same time laws protecting women and providing them with equal opportunities and chances linger on legislative agendas in many countries.

Furthermore, even as vastly increased funding for HIV has become available, those who are most vulnerable to HIV continue to receive the least access to HIV prevention, treatment, care and support. In addition, studies have provided evidence that even before new forms of HIV testing were introduced, abuses around the manner in which HIV testing and counseling have been conducted are commonplace.

My presentation is based on work I did for the Open Society Institute Public Health Program and on a statement of recommendations by the UN AIDS reference group on HIV and Human Rights, which was issued in response to the WHO and UN AIDS guidance.

The UN's Reference Group on AIDS and Human Rights, for those who don't know this group, is an independent body which advises UN/AIDS on matters related to HIV and human rights.

The views of the reference group do not necessarily reflect the views or positions of UN/AIDS. I am a member of the reference group and drafted the statement with the help of all members of the reference group. I hope that at the end of the session both the UN Reference Group statement and a short summary of my presentation will be available to all of you as you leave the session.

As part of the work that I have undertaken, I carried out a comprehensive search of the published scientific literature, using electronic databases. I also reviewed conference abstracts and conducted searches on the internet. Particularly I made attempts to obtain as much information as possible from low and middle income countries including through UN country officers and through key informant interviews.

In my presentation I hope I will be able to show that it is not only possible to scale up access to HIV testing and counseling while respecting human rights, but that it is indeed necessary. Scaling up HIV testing without respect for human rights not only leads to human rights infringements but also harms public health efforts.

Indeed, there is a consensus about key aspects of HIV testing and counseling among public health and human rights experts. Overcoming the remaining differences would greatly benefit the efforts to scale up access to not only HIV testing and counseling but importantly also to scale up access to HIV prevention and treatment, care and support. So let me start by pointing out the areas in which there is consensus.

Firstly, there is consensus about the need to scale up access to HIV testing and counseling. AIDS and human rights activists, public health officials, and policymakers all agree about the need for vastly scaled up access to affordable and high quality testing.

There is also near consensus that introduction of provider initiated testing is necessary. Evidence in fact suggests that many opportunities to diagnose and counsel individuals at health facilities are missed when systems rely solely on clients to initiate voluntary counseling and testing. Introducing some form of PITC in health care settings, in some countries at least, is important for many reasons and is widely supported.

While informed consent, counseling and confidentiality remain critical, most also agree that it is justified to relax pre test counseling requirements in some settings. Human rights and public health do not require cumbersome procedures for pre-test counseling, but they do require that regardless of whether persons initiate HIV testing and then counseling themselves or whether they are offered an HIV test in a health care setting, they can seek and receive sufficient information to enable them to give informed and truly voluntary consent to testing. They also require that people receive sufficient post-test counseling, and that confidentiality of test results and of the fact of seeking a test are guaranteed.

However, there are several concerns about the testing guidance or the way it is being implemented, and I will now turn to these concerns. Firstly there are concerns about the fact that WHO and UN/AIDS recommend an approach to PITC under which people are tested unless they specifically decline the HIV test, or "opt out" of the HIV test.

Informed consent is difficult to achieve under any system. It may be even more difficult to achieve when people are tested unless they specifically decline the test. The optimal balance between public health and human rights approaches to HIV testing may lie in routinely offering and recommending HIV testing and counseling, but requiring that clients specifically agree to the test rather than having to decline it. A provider initiated opt-in approach may be especially appropriate for highly vulnerable populations such as sex workers, people who use drugs, and prisoners.

Secondly, there is concern that efforts to scale up HIV testing and counseling fail to devote greater attention to how client-initiated VTC services can be implemented, can be improved and scaled up. VTC is particularly important because large numbers of people do not use formal health services, and these people may need other ways to gain access to HIV testing and counseling.

This is especially true for people living in rural areas poorly served by the health system, mobile populations, and vulnerable communities such as sex workers, gay, bisexual and transgender persons and people who use drugs, who face stigma and discrimination in health settings.

Thirdly, there is concern that efforts to increase access to HIV testing are not always sufficiently linked to larger prevention and treatment, care and support roles.

Efforts to scale up access to HIV testing and counseling should

always be coordinated and integrated with increased efforts to scale up access to ART and to evidence-based prevention.

Many countries are currently far from providing much needed treatment and prevention, and there is concern that the push for increased HIV testing is happening exactly at a time when governments international agencies and funders are stepping back from ambitious goals like the three by five initiative, or universal access by 2010, and are failing to put in place the resources needed to ensure that treatment and prevention are vastly scaled up and become universally available.

There is also concern about the fact that increasing testing and counseling rarely goes hand in hand with establishing strong and enforceable legal frameworks for protection against HIV related discrimination and abuse. In many countries, people who experience breaches of confidentiality, employment discrimination, domestic violence and other abuses following HIV testing enjoy no legal recourse. This can only serve as a disincentive for others to be tested.

There is concern, further, that many of the discussions and assumptions around HIV testing and counseling have occurred in the absence of empirical data, either from studies or from monitoring of existing programs. Particularly outside the prenatal context, evidence about the impact of PITC remains very limited, and deeper research questions beyond simply the number of people getting tested need to be adequately addressed

to ensure that testing and counseling are having their intended effect.

Questions such as the following should be addressed: what is the experience of people being tested as the result of approaches in which HIV testing is more routine? What opt-out approaches to PITC lead to a greater chance of negative consequences, including human rights abuses and particularly against women, than opt-in approaches?

Would such forms of HIV testing normalize HIV and reduce HIV stigma to a greater extent than forms of HIV testing under which people are offered the test, then tested only if they explicitly agree to the test? Would such forms of testing offer a greater or lesser uptake of ART? To what extent is the ability to scale up treatment currently being restricted by a testing gap rather than by other factors? And many other such research questions remain unanswered.

Finally, there is concern that mandatory and compulsory HIV testing continue to occur in many countries and contexts. There is concern that making testing more routine and adopting opt out approaches may in practice result in even more instances of HIV testing without consent.

In conclusion, far from being opposed to efforts to vastly increase access to HIV testing and counseling, human rights advocates have been among the first to argue that greater access to HIV testing is not only a public health imperative but also a critical aspect of promoting and

protecting the right of the highest attainable standard of health.

I would therefore like to invite those public health experts who have been critical of human rights based approaches to HIV to open their minds and understand that human rights activists are their greatest allies in the fight against HIV, and that promotion and protection of human rights is not only required by law and the right thing to do but also essential to the success of public health efforts.

Those who have attacked human rights activists should consider that it was human rights activists who, faced with much resistance, claimed the human right of millions in low resource countries to HIV treatments including IRVs. They are also the ones who are at the forefront of battles to increase access to evidence-based prevention measures. Human rights activists will be at the side of public health experts and WHO as they scale up HIV testing and counseling, provided the concerns I briefly discussed above are taken into account and addressed.

When necessary, sufficient measures must be put in place prior to and during implementation of PITC to ensure that the prerequisites for PITC are indeed in place: Access to HIV prevention care and support services, sufficient capacity of health care providers to implement PITC under the conditions of informed consent confidentiality and counseling and sufficient

programmatic attention to protecting people from stigma and discrimination.

For additional information, seek out these documents that are available at the websites of UN/AIDS and the Source Foundation and as I mentioned, I hope that at the end of the session these documents will also be available to you in hard copy. Many thanks.

[Applause]

ANA LANGER: Thank you, Ralf. We will hear now from Aliou Sylla from Mali. As I said before, he is speaking French, but his slides are in English, and we will translate for him as needed. Aliou is a physician specializing in community medicine. He established the first Center for Care, Treatment and Support in Mali called CESAC. He was a director of that center for 10 years, and now he is the AIDS director of the Ministry of Health and the president of Agasida [misspelled] and member and cofounder of the International Plus [misspelled?] Coalition Against AIDS. Aliou?

ALIOU SYLLA: [French spoken from 24:58 to 37:11]

ANA LANGER: Merci, Aliou. We will now hear from Amara Quesada, and she is a program officer from Action and Health Initiatives, ACHIEVE, in the Philippines, a position she has held for more than seven years, conducting research examining the HIV vulnerabilities of migrant workers and the impact of HIV on these workers and their families.

Through the Coordination of Action Research on AIDS and Mobility in Asia, CARAM Asia, she has helped set a regional agenda for action and research on mandatory HIV testing, looking specifically that migrant workers' access to information and services. As a trainer Amara has worked with governments, provincial and district hospitals and private medical clinics to improve their HIV services for migrant workers. Amara?

AMARA QUESADA: Thank you, Ana. Good afternoon ladies and gentlemen. Thank you for taking the time to listen to this session. My presentation this afternoon is based largely on the work that we do in Action for Health Initiatives in the Philippines as well as our network, the Coordination of Action Research on AIDS and Mobility in Asia. Although they have been mentioning migrants in general, this presentation focuses on the experience of migrant workers from Asia.

To start off, here is a quote from a Singaporean doctor: "Most HIV positives in our country are migrant workers. You are the ones bringing the virus to our country. So the best thing you could do is to get out of Singapore to avoid transmitting the virus."

I would like to apologize if there are Singaporeans in the audience; I am sure this is not a reflection of every Singaporean's towards migrants living with HIV. But this is a situation that was faced by a migrant domestic worker. He said

this to a migrant domestic worker after telling her that she tested positive for HIV.

The government of Singapore imposes mandatory HIV testing for migrants who want to work or reside there. Spot checks that include HIV tests are also conducted among seafarers whose vessels dock in the country.

To date, there are still 67 countries that require HIV testing as a precondition for granting entry, stay residence or work to foreigners. Many of these countries receive large numbers of migrant workers from Asian countries. Countries in the Middle East, for instance, host the majority of labor migrants coming from south and southeast Asia.

Now we'll take a step back and look at the policies in the origin countries, the countries where most migrant workers come from regarding HIV testing. In a study done by CARAM Asia in 2007 on the state of health of migrants focusing on the mandatory health testing it showed that national AIDS policies in labor-sending countries prohibit mandatory or compulsory testing.

This is true for the Philippines, Cambodia, Nepal, Indonesia and Thailand, to mention a few. These national policies also include provisions to ensure that voluntary HIV tests are conducted with consent, pretest and posttest counseling, and protects confidentiality. HIV-related services, particularly treatment and care are available and accessible in these countries in varying degrees.

This prohibition on mandatory testing also extends to foreigners in most of these countries. Unfortunately, there are some labor sending countries like Bangladesh where deportation might be an option by the government if a foreigner's HIV positive status becomes known.

However, policies that look very good on paper do not necessarily look well in implementation. People who want to migrate for work abroad have to undergo HIV testing, along with a host of other medical tests. Oftentimes these tests are done without knowledge or consent of the pre-departing migrant. When asked, many of the migrants who participated in the study that I just mentioned would just say that they get tested for everything, but do not really know what specific tests are being done.

When you ask them if they know they got tested for HIV, those who say yes know only because their blood was drawn from them, but there is no information regarding how or whether they are tested for HIV. In our experience, migrant workers who test positive for HIV only realize that they were tested after they get the devastating result.

Because these tests are treated as a requirement, there really is no true consent. If you don't want to be tested, you cannot work abroad. Furthermore, the HIV tests that are conducted in these contexts are done generally without pretest or post test counseling.

In Cambodia and in the Philippines, there is post-test counseling but only for those who tested positive for HIV. And this is conducted not by the medical clinics who conducted the tests but the government hospitals where the results are confirmed. Also, results of these tests, including HIV, are disclosed to recruitment agents.

There are isolated cases where HIV positive test results are disclosed exclusively to the patient, but these are rare and does not represent the general practice. There are countries with national AIDS policies that have referral mechanisms for persons who test positive for HIV, but there are still countries where the system is not in place, so migrants who have tested positive for HIV are simply sent home to their villages and communities with no knowledge as to how or where to access services when they need them.

However, the bottom line is that when a prospective migrant has a positive HIV test result, the migrant can no longer migrate for work or residence in the countries that require mandatory HIV testing.

Despite having national policies that prohibit mandatory HIV testing, migrants still go through it because it is a requirement of the destination countries, because most destination countries demand for the fittest migrant workers, and HIV test is one of the criteria to determine fitness to work. Mandatory HIV tests for migrants who apply for work residence or student visas again are done by destination

countries, particularly in the middle east and some destination countries in southeast and east Asia. These mandatory tests are repeated at regular intervals, like when a migrant renews her or his contract or decides to change employers.

Just like the conduct of actual HIV tests in origin countries, HIV tests in the destination countries are done in violation of internationally accepted guidelines on HIV testing. There is no information, no consent, no counseling and the result is also disclosed to the authorities even before migrants are informed of it.

And because having an HIV positive result leads to deportation, migrant workers are not referred to services and there have been stories of migrants who have been simply picked up by the police and brought to detention centers without any explanation.

Like the case of Jerry. He underwent HIV testing in Dubai as part of his application for work visa. When he tested positive for HIV, he was detained for more than a month in a hospital ward that was guarded by the police. Nobody told him why he was there.

It was only when he was about to be deported that his prospective employer told him why he was being sent back to his country. And when it came time for Jerry to be sent home, he was handcuffed and escorted by the police to the airport like a common criminal.

It should be noted that the nationals of these countries which impose mandatory testing on migrants are not treated this way. As reflected in the attitude of the Singaporean doctor that was in the quote earlier, the blame is for the migrants as carriers of disease and should therefore be expelled from their lands.

There are two reasons why these countries continue to impose mandatory HIV testing. According to them, they are simply safeguarding their public's health and preventing the spread of HIV among the local population. They also refuse to allocate resources for the health of migrants.

This stark manifestation of discrimination not only traumatizes the migrants who are affected but also creates a false sense of security on the part of the nationals of those countries, believing that as long as they get rid of the migrants who bring in HIV, it will not spread among the local population. There is simply a great denial of the fact that HIV is already in these countries, and deporting migrants who are HIV positive will in no way lessen the spread of HIV.

In fact, these punitive and discriminatory measures only serve to force migrants who may suspect their HIV status to become undocumented, to hide their condition in order to keep working and earning for their families back home. Going underground leaves them unable to access information and services that may lead to higher chances of unknowingly infecting others.

Which then brings us to a concern when we look at the framework of scaling up HIV testing and counseling. Of course there is a need to scale up and to make testing and counseling widely available as long as it protects the rights of people, is utilized as a gateway for prevention through proper counseling, and leads to treatment and services.

What worries us is that public health as an imperative that fuels scaling up testing and counseling is also the rationale for some of the countries that impose mandatory HIV testing. In the context of mandatory testing as conducted among migrants, the problem is not that there are no available testing services. In fact, testing is made available and migrants have no real choice but to utilize them. The problem in this context is that there is no respect, no promotion and no protection of migrants' human rights every time they undergo mandatory HIV testing.

Especially problematic is the fact that deportation practices go hand in hand with mandatory HIV testing policies in many countries. There is no room for counseling, no interest to provide it in the first place, and definitely no chance to access services.

Destination countries that deport migrants based on HIV status also do not do referral to service providers in origin countries. The impact is a complex psychological, physical and emotional trauma brought on by an abrupt loss of opportunity to

work aggravated by the experience of detention, deportation and discrimination.

What we all want is a human rights based HIV counseling and testing that is a true gateway for prevention and leads to services. We in CARAM therefore propose the following: that along with a campaign to scale up human rights based HIV testing and counseling there is an urgent need to call for removal of all mandatory testing policies and practices for migrants. Detention, deportation and other punitive practices in relation to HIV status should be eliminated.

Instead, there is a need to scale up HIV preventive education, and CARAM calls for the institutionalization of migrant friendly testing policies and practices that ensure that all HIV tests are voluntary and that they abide by international guidelines for testing.

Most importantly, testing must always, always, always lead to access to treatment, care, and support services wherever and whenever they are needed. Thank you so much.

[Applause]

ANA LANGER: Thank you so much, Amara. Our final presenter in this session is Nduku Kilonzo. Nduku is the director of the Liverpool Voluntary Counseling Testing Care and Treatment, a Kenyan National nongovernmental organization comprising more than 250 staff who provide VCT services to approximately 250,000 individuals each year as well as HIV treatment to more than 16,000 Kenyans.

The organization also conducts operations and formative research on HIV service delivery. Nduko's own research has looked at the links between section virals in HIV and among other things has provided evidence for the development of integrated post-rape care services, currently offered in 15 public health facilities in Kenya.

Nduku has served as a technical adviser to the WHO including their committees on HIV Counseling and Testing and Violence against Women. She's also a member of the coordinating group of the sexual violence research initiative. Nduku.

NDUKU KILONZO: Good afternoon, ladies and gentlemen. I'm going to be talking specifically— okay. Sorry, I'm trying to get this to work.

I'm going to be looking at the gender dimensions of HIV and having a discussion around what the issues are, what the new approaches are and what they mean to scaling up counseling and testing, what they mean for gender, and finally I'll look at the opportunities we have for responding and make a couple of recommendations on the way forward.

To start off, I would like to start by looking at the numbers with regard to gender and HIV in Kenya. This is just to give a backdrop, and enough for you of some of the discussions that I'm going to be having. And I will base my discussion on the challenges the issues and the experiences of our organization.

HIV prevalence is twice amongst females that of males. Women who are 15 to 24 years are four times more likely to be HIV infected, and increasing HIV prevalence in rural areas is what is seen in Kenya. Now, about 70-percent of Kenyan population lives in the rural areas. But more important, 84-percent of this population is of women in rural areas. While male HIV prevalence has been related to education, it is significantly women's' low education is significantly associated with HIV prevalence.

And the rates of infection are higher among men. There is higher discordance and the polygamous unions are more likely to be HIV infected. This data is from the Kenya AIDS Indicator Survey, which was released last week in Kenya.

We have the numbers. What do we see? First I would like to say that when we talk about sexual practices and sexual behavior in the context of counseling and testing, we need to realize that discussing practices around sexual behavior, that is when who how and where I should have sex are really determined by the individual but are framed within cultural norms. And women are less likely to have or— let me not say are— were less likely to have access to VCT in Kenya around 2005. And males have more decision making power.

Now it is very clear as many parts of Africa perhaps in the world today that we are seeing additional epidemic around gender-based violence, intimate partner violence, sexual violence. And that has implication. Because it is very

blurred boundaries between sex between coerced, consensual and forced sex. And the perceptions of risk amongst women, particularly amongst married women is that they know.

And finally with regard to counseling and testing, while many people say that they would not test or that they had not taken an HIV test is because my partner's results are mine. So if my partner is tested, I don't need to test. Also background for VCT in Kenya: Think about coming to a space where— not only in Kenya, but VCT as a model of service delivery— where we protected stigmatized persons around the 80s and 90s has confidentiality. Human rights— and I say watch out, public health approach with caution, for the simple reason that it seems that there has been a discussion or a discourse that has pitted human rights and a human rights imperative against the public health imperative, which I think in my opinion should be "and" rather than "or."

And again, counseling was meant to support copy [misspelled?], particularly in the context where we did not have treatment. Responsibility for HIV prevention rested on individuals where, we had a range of models. VC and so on. And visiting models, one was centrally located. And they were premised on individualized health care seeking behavior, individualized sexual decision making capacity, and really, levels of monogamy. If you go to a VCT service it was really counseling and testing for years individual and your plan,

your individual plan, was about you changing your sexual behavior.

Now, Kenya's history around counseling and testing. There were four VCT care treatment started, the first three VCT sites in 1998. And currently Kenya has well over 1000 sites. And as an organization, we have tested about 940,000 people.

In 2006 Kenya developed approaches or new models of counseling and testing to be able to deliver new services and to scale up coverage and knowledge of HIV status including mobile provider-initiated, community-based HIV counseling and testing, which has commonly been referred to as "door to door." And Kenya is committed to universal access and testing, with a goal of 80 percent coverage of knowledge of HIV status by 2010.

So, what have these approaches meant for uptake of counseling and testing services? One: Why do we need people to know their HIV status? It is necessary for care and treatment, it is a right for all. I really believe that when we talk about HIV prevention, treatment and care, everyone has a right to treatment, everyone has a right to care, everyone also has a right to know their HIV status.

The questions around the data and evidence for prevention are currently quite conflicting. Now, this is data from the DHS in Kenya in 2003, and the AIDS Indicator Survey in 2007. And you can see clearly that there was a huge increase or uptake of counseling and testing among females over the last, and it has been linked to the new testing approaches:

mobile VCT, community-based counseling and testing and provider-initiated counseling and testing that actually deliver the service to the client.

I just drew on our data as an organization. We looked at static VCT sites, which includes the provider-initiated testing and counseling. And again, you can see clearly that the female uptake has increased between— this is better from June 2007 to 2008. And we find these high numbers of women uptaking counseling and testing.

So what are the gender issues that emerge and how do we begin to deal with them? One, I think we need to rethink the models of HIV counseling and testing. They've been based on very individualized counseling, individualized risk reduction, risk assessment, individualized forward planning, individualized testing and delivery of results. Yet we know sexual practice is socially defined.

Multiple partnerships is something that has been associated with increased risk of HIV and high prevalences. However, we also need to be cognizant that multiple partnerships are largely sanctioned, at least in the Kenyan community, and this is amongst men and I would almost say increasingly amongst women because it is the same communities that sanction multiple partnerships amongst men that expect men to actually have those partners from somewhere, and that is the women.

And we have limited sexual decision making power among women. Yet in the counseling and testing models, you are providing counseling and testing and planning for the way forward with an individual and expecting them to go back to wherever it is that they come from and to be able to make decisions about changing sexual behavior.

The second issue I want to speak to, around models, is reconceptualizing risk. We have for a long time used a model framework that looks at, you should have only one partner, these strategies— that is really monogamy-based. Yet polygamy is an accepted way of life. I come from an extended family where most of my relatives are polygamous. And that is an accepted way of life.

So while there is a need to change the social and gender norms, which takes a long while, how are we dealing with HIV and being able to provide counseling and testing in this context? What is the understanding of risk, by gender? Women say that they are at low risk, married women, yet from the Kenya survey data, what is very clear is that the highest risk is among married couples. And I shall talk about disclosure and discordance briefly in a short while.

And then also, the risk that we talk about in the VCT context assumes that sex is consensual. It does not take into context gender based violence. It does not take into context coercive sex, particularly in intimate partner relationships.

Further, assumptions of heterogeneity amongst women. It almost is like all the protocols of counseling and testing are really standardized across the world. I am pretty sure it would be information, assessment, testing, post-test counseling. It actually assumes that one size fits all, counseling and testing.

There is not messaging that is directed or particularly gender desegregated, nor do we have targeted prevention or messaging for women by age, yet we know that, for instance, women who are 15 to 24, particularly in Kenya, are more likely to be at risk of HIV infection. We do not have targeted messaging by HIV risk.

Secondly, part of counseling and testing really focuses on being able to provide and care. And it appears to be gender blind in the sense that uptake of counseling and testing, uptake of care and treatment services thereafter, and ability to be able to be retained in the health care system based on the report by the social determinants of health are gender based.

And finally, current definitions of couples. Current definitions of couples as monogamous are problematic. Because polygamy, one, is acceptable. Two, with the question of serial monogamy, what— how do they know, the knowledge of couples HIV status at the point at which they engage? Also women's agency in the context of counseling and testing does not seem to be taken into account.

And finally, the definition of couples. You seem to be missing or seem to be lacking. Because we don't talk about youth couples. How is that defined? And yet, that's a high risk group.

Consent? What is consent? For what? For information? For testing? For results? Who asks for consent, from whom? Consent in health provider client relationships is problematical, has been shown to be contextual. Depending on who asks, depending on the language that is used, depending on the potential consequences of giving or not giving consent.

And then perceptions of consent by providers and general populations and human rights activists seem to differ. If I draw on lessons of anonymity and confidentiality in Kenya, for VCT, we actually found that people were less worried about having their names written on VCT cards than health providers and human rights advocates thought for a very long time.

And again, we seem to have double standards. If it is VCT for PMTCT, in reproductive health settings, do you require the same consent? And for what are you asking consent? Vis a vis VCT delivered in a supply driven section or in a demand driven section such as VCT.

Finally, disclosure of sexual practice is socially constructed. And disclosure—intended disclosure is higher than actual disclosure. And supported disclosure has been an issue that is very highly contested. However, we do know why

it has been highly contested, around experiences of violence. But we also know that women are being largely supported.

And there are some additional concerns around disclosure that we do not talk about generally. One is children and families, and extended families.

Why doing the disclosure? If you look at that graph, it actually tells us. And this is from CARAM's data, that 45-percent of people in marriage relationships are in discordant relationships.

So to finalize, how do we respond to these issues? What are the opportunities that exist and how can we utilize them? I think there is one thing to say is that the question can no longer be a question of whether we scale up counseling and testing, but it can only be a question of how we make it responsive.

This is the total number of Kenyans who need cotrimoxazole currently but do not even know their HIV status. These are the people who need CTX and are currently on prophylaxis. That is 12 percent. And this here is the people who need prophylaxis, know their status, but are not on prophylaxis.

This 84 percent must be reached. Let us all remember that the highest infection prevalence is amongst women. In conclusion, we need gender-responsive counseling and testing. We need to reengage counseling to ensure that opportunities for

counseling facilitate discussion amongst couples and families. And that we are no longer talking about individuals.

We need to engage supportive disclosure and partner notification. We can not continue to run away from that. And we need options. Because it provides an options support negotiation and knowledge of partner status.

We need to be able to redefine risk and knowledge of partner status because currently our understanding of risk is based on empathy frameworks about one partner, yet the question of risk actually seems to be way outside that given the current data.

And we need to be able to develop gender audits for counseling and testing programs and evaluate counseling and testing programs, develop quality assurance programs that do counseling and testing but look at the implications of counseling and testing whether it is provider initiated door to door or it is VCT from the perspective of the implications for men and women. Messaging needs to be gender targeted and we need to refocus our main object of counseling and testing. Thank you very much.

[Applause]

ANA LANGER: Thank you to all presenters for their wonderful speeches. We will now start our Q and A session with some reflections by Gracia Violeta Ross-Cordoba. Violeta is an anthropologist by training, and she is a human rights activists for people living with HIV and Aids.

She currently is the Latin American Caribbean NGO representative on the UN/AIDS board. From that capacity, she participates in the Second Independent Evaluation of UN/AIDS, and she is a member of the search committee for the executive director of UN/AIDS.

She has helped establish Redbol [misspelled?], the Bolivian Network of People Living with HIV, which she led as executive director from 2005 to 2007, and is an active member of international community of women living with HIV AIDS. Violeta has been honored on many occasions for her tireless work and commitment. Thank you Violeta.

GRACIA VIOLETA ROSS: Thank you, good afternoon. Thank you to all the speakers for your presentations, I really learned a lot myself in this session, although I read the presentations in advance.

Just to tell you one more thing about me which I believe is the most important. I was a rape victim in 1998 and in 2000 I tested HIV positive without my consent, and this was not the government or any migration office who took me there, it was my loved sister, my older sister.

Because of the situation of rape and because I was not feeling so well, she really wanted me to make this test. And after coming back home from a trip, she realized that I was not feeling well, so we assumed I had yellow fever. And we went to the lab of my uncle, and we said okay, make the yellow fever test and anything else.

And she said, without my consent, "Also do the HIV test, because she has been a victim of rape." And by that night she already knew that I was HIV positive and I did not know. Next day, she said, I will go with you to collect those tests. And I said, why?

When they gave me those tests, I can not explain what I felt. Because really I was not expecting that situation. I did not have any idea of how I had been at risk of HIV because the message that I received was gay men, drug users, sex workers. Those are at risk, not you, a regular woman in the world.

And because of that, I did not believe those tests were real. I thought my sister and somebody else were playing a joke for me. And you know, I went in complete denial. And my sister just walked after me from the center, because she knew I was about to kill myself that very moment. I went to a bridge which is very famous in La Paz for suicide. And I think I was going to do it. She actually forced me and took me into the taxi and took me home.

Because of that, I was angry at her for a year. You know, because she didn't ask my permission. I was not ready to receive that news at that moment. I felt she took away my freedom to enjoy life. And then maybe this is part of the testing when it does not happen with consent.

And imagine what happens when you are vulnerable for any situation. From what the speakers said, I can say on my

reflections that any approach for testing that will test people whose human rights are undermined, all the people who are in situations of vulnerability, are migrant, are men who have sex with men, or a pregnant woman or a rape survivor a young person, any person who is in a situation of vulnerability that testing will be taken as an intrusion in your intimacy, and will not help.

And after when I am working in the Bolivian Network of People Living With HIV/AIDS, we saw that people who were taken to test without their consent, the impact in their lives is like a boomerang. They don't acknowledge they are living with HIV. They don't adhere to the medicines. They don't accept the fact that they are HIV positive. And some people even go and engage in more risk behavior.

So maybe my question to you is, whose rights do we need to protect in testing for HIV? Those of the individual, those of the government, those of a country that doesn't want to receive migrants, or those of the baby, those of the husband? And whose ability to decide are we honoring in these approaches of testing? That of the health minister? That of any agency? Or that of individuals? I don't think any approach that does not consider a gender approach, a human rights approach, and a continuation of service from testing to care and support would not be successful and I just wanted to say this to you now and follow your discussions. Thank you.

[Applause]

ANA LANGER: Okay, we have a little over 15 minutes for questions and answers. I understand that there are some volunteers with cards on which you can write your questions. Is that right? If not, we will just use the microphones.

Well, apparently there are no cards, so if whoever wants to ask a question could— sorry? Could— yes. Yes. Line behind the mikes, please, and I wonder if we could turn on the lights? Not these lights, but the room. And— [Spanish spoken]. Anyway, please. I will take a few questions, and then ask the speakers to respond.

TERRY FORD: Hi, I'm Terry Ford from the AIDS Healthcare Foundation. I want to thank you for all your presentations, especially from Kenya. I thought that was a fantastic presentation.

There is no possibility for universal access to treatment without universal access to testing. And we put the cart before the horse. We have one minute HIV tests now that require no refrigeration. We have pretest counseling, and mobile tests have never been more mobile. What we are missing is the will.

We are calling for 1 million tests on World AIDS Day around the world. There is no way we are going to stop this virus without 1 billion tests a year. We need to do 1 million HIV tests this World AIDS Day Week.

You can sign up at 229 because the ultimate human right is the right to life. As you said from Kenya, public health

and human rights are not adversaries. We need to unite them. This is a public health issue. And we need to do 1 million tests around the world. World AIDS Day. We're calling on everybody to sign up for that.

I actually do not have a question. I am just saying, we really need to commit to the will to create the testing that will create the treatment. And as we know, now treatment is prevention. Treatment suppresses the virus enough that it is one of the most important parts of prevention today. Thank you.

ANA LANGER: Thank you very much. But if you could, make very pointed questions, please?

DIEDERICH LOHMAN: Hello, my name is Diederich [misspelled?] Lohman and I work for Human Rights Watch. I have a question for Ralf. Ralf, you talked about on the one hand VCT, and on the other hand provider initiated testing in healthcare settings. But what we are seeing across southern Africa is a proliferation of other models.

For example, we have done research on the know your status campaign in Lesotho, where several thousand lay counselors were trained and then sent into villages to do testing in peoples' homes in the communities. And I wonder if you have also looked at the human rights implications of those kinds of approaches. Thank you.

GABRIELLE: Hi, my name is Gabrielle. I'm from Canada and I'm with an NGO, the World Youth Alliance.

ANA LANGER: Can you speak up a little, please?

GABRIELLE: Sorry. I'm with the World Youth Alliance. And I was just wondering— this is just a general question— what are being done to promote voluntary couples testing to empower both a man and a woman in the relationship? Because often women are stigmatized or abused because of their diagnosis. What is being done to promote couples testing? Thank you.

ANA LANGER: Thank you.

HILLARY HULLMANS: Hello, my name is Hillary Hullmans, and I just really wanted to make a comment rather than a question, and that is that UNHCR has also been looking at these issues in relation to humanitarian populations of concern and find that in many countries though populations of concern are being tested, in refugee camps are being tested, children, unaccompanied minors are being tested before being placed in orphanages, and we have numbers of examples. And for those reasons I would like to commend the work that Ralf is talking about and just to let people know that UNHCR has also developed some draft guidance in response, and in addition, complementary to the PITC guidance.

ANA LANGER: Thank you.

ALEX DORIAN: Hi, my name is Alex Dorian, I work with a company called Vista Gard Franson [misspelled?] based in the regional Africa office in Nairobi. I just had an open question to the panel. I think that there is a consensus that testing and counseling needs to be scaled up rapidly, and that you need

specific testing and counseling such as gender specific for different contexts.

Now there has been some studies of incentivized testing and counseling, not so much to coerce people into testing and counseling but to compensate them for the costs of attending the testing facilities. So I would just like to ask the panel what is the opinion on that issue. Thank you.

ANA LANGER: Thank you.

IMA ALFARO: Hi. My name is Ima Alfaro and I work for a private sector partnerships project in Guatemala. I would like to ask the panel, and I would like to ask the audience as well, if any of you have had experience that you can share in terms of voluntary counseling and testing models adequate for the private sector providers? Our project is focusing on physicians and clinical laboratories who offer private services, and I would like to know if you have any experience to that effect so that you can share.

And I would also like to mention that I have brought with me some CDs that I can share on voluntary counseling testing events and a tool kit for implementers which I can share if someone is interested at the end of the session. Thank you.

ANA LANGER: Thank you. While more people line up I would like to give the panelists a chance to respond. Ralf, you got a specific question, and you all got three open questions, and please volunteer to answer them.

RALF JÜRGENS: Yes. Maybe I'll start with the comment that there is no possibility of universal access without universal access for testing. That is of course is true, and it is also true that we are missing the will to scale up HIV testing and counseling adequately.

However I disagree with the fact that we need to or should scale up access to HIV testing without that being linked to increasing access to prevention access to treatment and increased stigma discrimination and human rights programs. I do not think we have evidence at all that simply increasing the number of tests will automatically lead to increased access to HIV treatment and increased prevention and decreased stigma. There is some kind of link, of course, but there is not a direct link. And that means that we need to— there needs to be a will to do all of the above rather than singling out one and focusing only on one.

Secondly, Diederich, yes, we have also had issues related to home-based testing and of course there are specific concerns related to that. And they are addressed in part in the paper. I talk about but because of lack of time I was not able to talk about that in much detail.

As with all these new types of testing, there are good aspects about that, promising aspects— it is promising that this will lead to increased access to HIV testing. But there are also some concerns. And as with all the other aspects of HIV testing, those concerns need to be addressed. And maybe I

will leave some of the other panelists to address some of the other questions.

ANA LANGER: Nduku? Amara?

NDUKU KILONZO: I hope you can hear me. I think I will speak to two of the questions. The first is providing voluntary couples HIV testing and counseling. There are approaches that have begun to look at couples in Kenya. We have begun using faith based organizations as an avenue for targeting couples, because we do know that a lot of couples are engaged with churches or other faith-based programs.

The other option that we are looking at is the question, and I think that Ralf has just talked about, home based counseling and testing. If you looked at the data on the graph that I showed, it was the only program that seemed to have a certain and almost balanced number of men and women and it is because we are targeting couples and families. I think that questions from the engaging the human issues so that there is consent, there is not coercion.

There are lots of guidance around coercion for women and violence, work that has been done by the outreach or that we have adopted as methods of being able to look at the ways in which we shall see whether or not women will be affected.

The second issue is around the models for private sector. Yes, there are models for private sector. There is a private public partnership currently running in Kenya between a couple of organizations in the private sector and Liverpool is

one of the counseling and testing providers, and what we have is we are able to provide counseling and testing mobile to work places and we are able to link people who are in to gain treatment anonymously, to treatment programs for those who want anonymity within workplaces, because that is still an issue around stigma in workplaces.

ANA LANGER: I would like to give a chance to— yes. A few more questions? If you could respond quickly?

AMARA QUESADA: I would like to respond to two questions, first on our opinion regarding giving incentives to people who go for testing. I think it is a very interesting question, and looking the context in my country for instance where most very health seeking behavior among Philippines and there is an attitude where they fear knowing their HIV status plus the cost of testing and treatment as deterrents to why they would voluntarily go for testing.

I think it would be interesting to provide incentives, however foremost is that we should never ever forget that whatever tests we conduct, it should always look at access to treatment and services. And in certain contexts like my country where access to treatment and services for people living with HIV are limited, we are not in the position to actually be providing incentives just so people will come for tests.

The other question I would like to respond to is regarding working with the private testing centers, private

sectors. My organization, in collaboration with the Department of Health in my country actually had a series of trainings for medical testing centers that conduct tests for migrant workers who leave the country. We trained their staff to conduct pretest and post test counseling. We have reached more than 80 testing centers.

Unfortunately, the challenges are more daunting. One, the volume of migrants that are tested daily is just too much for counseling to be given on an individual or even group basis, and I would like to respond to the woman who has a campaign on having one million tests a year. I would like to inform you that just last year, the Philippines registered one million migrant workers leaving the country. Which means that we tested one million migrants.

Unfortunately, these are all mandatory tests. So please do not ever forgot that the kind of tests that are being conducted and the implications that they have on the people who are being tested. Thank you.

ANA LANGER: Thank you. [Applause]

Ralf, do you want to answer one of the questions now? If you could just take one minute, because there are—

RALF JÜRGENS: I just wanted to add to something about the other testing statements that are being developed, because so many of you are not aware of this. As I said, there is a testing statement, a policy statement that has been developed by WHO, UN ODC and UN/AIDS on testing specifically for

prisoners and another one is being developed on testing specifically for people who use drugs.

And there were two reasons behind the development of these specific additional policy statements. The first one was that there was a concern that the PITC guidance would be misinterpreted by people providing HIV testing in prisons or by legislatures to make testing of prisoners routine and to keep testing of people who use drugs routine.

The second concern, however, was that these populations would continue to be as they are, specifically () to prisoners, left out of efforts to scale up access to testing and treatment. So look out for those specific statements, one of which as I said will be available very shortly.

FATIMA HASSAN: Thank you. Fatima Hassan from the Treatment Action Campaign and AIDS Law Project South Africa. There are two groups that we are trying to figure out mechanisms to scale up testing for in South Africa and I think in the rest of Africa as well, and that is new born babies. Because we have an increasing infant mortality problem where if we do not diagnose early enough, we can not put them on treatment early enough. And that is a group that probably because of time has not been addressed here, but what are the issues in other countries, and what is the position of human rights activists to the routine PCI testing of all newborn babies, particularly where the status of the mother is unknown.

And the second where we have a particular problem with is actually men. We are able to identify many women through a number of our family planning, contraception, antenatal, a number of clinics, TB, where women seek treatment earlier and seek testing earlier. But men are coming into the system too late.

And I worry— and as a feminist and a gender activist I do worry— that we not targeting men early enough, and that the only time we do target men is in couple testing, couple counseling. So those are my two questions. Thanks.

ANA LANGER: Unfortunately, we will be able to take only one more question. Sorry, what is that? Oh, there is somebody lining up already. Okay.

MALE SPEAKER: Okay, I just would like to ask you if there is any study of cost effectiveness of provider initiated counseling and testing. Because we know the percentage of people testing positive in VCT services is high, usually is higher than the prevalence in the country. So they are very cost effective, these kinds of services.

And by the other way, with provider initiated, we will make lots of tests and many tests will be negative. And also the quality of the counseling will be very low. We usually see people testing positive in VCT services that have already been tested in a routine fashion by any doctor in any other services. So he or she was tested in an un-useful and very costly manner. That is what I wanted to ask.

ANA LANGER: Thank you.

FEMALE SPEAKER: I am the executive director of an NGO in Uganda called the Uganda [inaudible] HIV/AIDS. I just wanted briefly to share with participants another model we have been using we have adopted in my organization in Uganda is to provide VCT services during our training. We are an HIV AIDS/human rights organization, and we have been surprised when we introduced VTC services whatever provide training for human rights and HIV aids.

The uptake has been very high; people freely consent to testing. They receive their results and the point I wanted to share here is that those who are pushing for testing without consent, they need to reexamine why people are not taking up VCT services otherwise. When we have inquired from the people we have trained why they have not tested, quite often people raise issues like distance, fear, and "You know? I never thought about it," or discrimination.

But when you give them this opportunity— others also mention the barrier of cost, like a charge that is placed before they can take the test. Now when you remove all these barriers— we have been very surprised that the uptake for VCT is very high, 80-percent. All the people want to take up their results and the men of particular also are coming up. They test.

So we need to challenge some of the data out there that says that people are not willing to come out to take voluntary

testing and counseling, particularly outside those care services. I think there are many more reasons which you have not explored, and I think we may be applying a diagnosis for a problem we have not properly identified.

ANA LANGER: Thank you very much. Just in one minute, if someone wants to answer one of the last questions we've had? Violeta?

GRACIA VIOLETA ROSS: About the newborns, I do not know if we have a position on this, because in the Network of Women Living with HIV I have seen two positions. Some are demanding voluntary counseling and testing of course, but then I met another group of women in South America in a particular country who are mothers and their babies are dead by the time. And they are advocating for mandatory testing for all pregnant women, because they are saying, if I were tested when I was pregnant, my baby maybe was not going to be dead by now.

And in the same discussion, the feminist advocates who were not HIV positive were saying, you can not do that with the pregnant women. And they were saying, if you lost your baby you would say yes, do that. So I did not find a unified position among these two groups of women so loved to my heart.

And myself, I do not know what to say as a woman who wants to get pregnant today. But I think that we have to protect the health of the babies and the mothers at the same time.

ANA LANGER: Okay, we will give Ralf the last word.

RALF JURGENS: Yes. Just to say that studies show that when HIV testing and counseling is routinely offered to pregnant women, and it is recommended to them, the vast majority— and we are talking here 95 to 98-percent of women will understand that the HIV test is beneficial to them and to the baby. And the very few women who did not accept the testing in some studies they talked very eloquently why they feel they simply can not do it because of fear of violence or other issues.

So I think there is a clear answer, we shall not any more compare VCT as it was done 10 years ago of pregnant women. We shall talk about routinely offering women, pregnant women the test and explaining to them why the test its beneficial to them and to the child, and then let women make the decision for them and their babies.

[Applause]

ANA LANGER: Just for your information, very quickly, there are at least three session tomorrow and Thursday on a similar topic. One is the satellite session you got an announcement of. There is also a session called Optimizing HIV Testing Interventions tomorrow from 11 to 12:30 in Room 5, and another one, HIV Testing: New Models Shattering the Barriers To Universal Access to Treatment on Thursday from 6:30 to 8:30 in room 9. Thank you. Gracias.

[END RECORDING]

