

## New guidance on recommended HIV testing and counselling

After a series of meetings, open internet-based reviews, and consultations over a year, WHO and UNAIDS recently released guidance on HIV testing and counselling initiated by health providers.<sup>1</sup> Those not engaged in this exercise might not fully appreciate the evolution of thinking represented by this final document, nor the role played by active debate between constituencies with diverging views on key issues. Among these issues was whether HIV testing should be included in the panoply of routine tests given in health settings on the initiative of the clinician, unless the patient specifically opted-in by asking to be tested for HIV or opted-out by refusing the test, despite not having been prompted to consent to it. Many found the ideas confusing<sup>2-4</sup> and questioned the underlying assumption of this approach—ie, that patients who signed off on admission forms when consulting or being admitted to a care facility de-facto agree to any diagnostic test found necessary by the treating doctor. Concerns were raised that, unlike other tests, in view of prevailing stigma, discrimination, and risks of violence attached to an HIV-positive result in many settings, particularly for women, specific individual agreement to the test remained necessary.<sup>5,6</sup>

As the WHO/UNAIDS guidance evolved towards its now final form, despite some reference to opting-in and opting-out, liberal use of this language was dropped and replaced with ideas more reflective of sound public health, medical ethics, and human rights. Specifically, the ambiguous notion that providers would initiate testing (with lack of clarity about whether this testing is with or without expressed consent) has shifted to a model in which providers recommend testing (thus proceeding with the test only after consent has been

given by the patient). The WHO/UNAIDS guidance continues to use the term provider-initiated testing, but provider-recommended testing is now what the guidance advocates. The crucial difference here is that doctors are now encouraged to recommend a test, and not simply to test without securing the patient's specific agreement. In many ways, the WHO/UNAIDS document is far clearer and better anchored in evidence than the rather confusing 2006 guidelines of the US Centers for Disease Control and Prevention (CDC), to which it refers supportively several times.<sup>7</sup> The CDC guidelines use terms inconsistently, and thereby create (deliberately or not) a wide space for doctors to do HIV tests on patients with or without express consent. The strength of the WHO/UNAIDS document lies in its attention to specific elements to be considered when formulating or reformulating HIV-testing policies according to various environments, epidemic types, health settings, clinical presentations, and testing practices. Yet, several issues will require attention while this guidance is implemented, including the rather vague approach to monitoring and evaluation, even as WHO is under stress to anchor its guidelines more strongly in evidence.<sup>8</sup> Critical indicators, sources of information, and means of measurement could have been suggested to set groundwork for risk-management and further revisions of this guidance. The more-than-elusive description of how the guidance is to be adapted to specific country settings is another area that needs attention. This description will require rapid pre-emptive measures by WHO/UNAIDS and others, such as development of methods to facilitate adaptation process, failing which adaptation might go astray on the initiative of those who believe that widespread HIV testing is an effective response to the epidemic. A further issue is the lack of reference to how this form of testing will intersect with the trend towards criminalisation of HIV transmission,<sup>9</sup> in particular when a previous record of a positive HIV test could be interpreted to mean that a person knowingly transmitted HIV to others, whether deliberately or negligently.

Policymakers may now opt-in to the guidance and model policies, and practice can proceed along the lines proposed, even though there will be substantial differences in how this change is made. Some policymakers will no-doubt opt-out, holding that the guidance is insufficient and does not respond to local realities. Clinicians, other health



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practitioners, and civil society will have to be vigilant in their attention to the uses and abuses of HIV-testing policies as the policies are reformulated and, just as importantly, to the observed gaps between public-health goals, policy, and practice.

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We declare that we have no conflict of interest. Both authors are members of the UNAIDS Reference Group on HIV and Human Rights, which commented on earlier drafts of the guidance.

- 1 WHO/UNAIDS. Guidance on provider-initiated HIV testing and counselling in health facilities. Geneva, Switzerland: World Health Organization, 2007. [http://www.who.int/hiv/who\\_pitc\\_guidelines.pdf](http://www.who.int/hiv/who_pitc_guidelines.pdf) (accessed June 18, 2007).
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- 9 UNAIDS Reference Group on HIV and Human Rights. Criminalization of HIV transmission. Feb 12–14, 2007; [http://data.unaids.org/pub/BaseDocument/2006/070216\\_HHR\\_3\\_Criminalization.pdf](http://data.unaids.org/pub/BaseDocument/2006/070216_HHR_3_Criminalization.pdf) (accessed Jun 18, 2007).

## Lancet International Fellowships 2007 and 2008

We are delighted to announce the winners of our International Fellowship scheme for 2007—Dr Jennifer Cuellar-Rodríguez, an infectious diseases researcher at the Instituto Nacional de Ciencias Médicas y Nutrición Salvador Zubirán in Mexico City, Mexico, and Dr Macky Natha, a specialist registrar in genitourinary and HIV medicine at St George's Hospital in London, UK.

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- The names and addresses (including e-mail addresses and telephone numbers) of three referees.

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