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Outcomes of the Symposium on HIV Testing and Human Rights

Montréal, 24–25 October 2005

Summary

There are increasing calls by public health authorities and policy-makers to modify or abandon the well-established model of voluntary counselling and testing (VCT) for HIV in favour of models that do not necessarily preserve the elements of informed consent, pre- and post-test counselling and confidentiality of test results. This report summarizes the conclusions of a symposium on the subject of human rights concerns raised by these proposals by a group of people living with HIV, researchers, human rights advocates, service providers, and representatives of international organizations.

Among the key conclusions were the following:

- Informed consent, counselling before and after a test, and confidentiality of test results are all grounded in human rights norms. Forms of HIV testing that omit or significantly curtail these elements are not acceptable.
- There is an urgent need for documentation of the way in which policies of "routine offer" of HIV tests play out on the ground. For example, it is unclear whether these approaches, in practice, allow for informed consent and pre-test counselling.
- The onus is on those who propose modifications to, or elimination of, the VCT model to build a body of evidence to show that new models do not violate the human rights of persons tested in the testing process or contribute, in ways that could be avoided or minimized, to subsequent human rights violations experienced by people who get tested, and particularly those who may test HIV-positive.
- "Routine-offer" approaches may cause an increase in the number of tests given, but that increase may not be the most important outcome. People who are unprepared to be tested and unsupported in dealing with the consequences of disclosure of their HIV status may suffer depression, abandonment, violence and other severe outcomes that may be mitigated by VCT approaches.
- It is unclear whether VCT has failed as a policy approach, as some critics charge, or rather if VCT has not been well supported.

Recommendations for research and action steps are included. Research recommendations particularly highlight the urgent need for a greater understanding of the practical reality of what constitutes "routine-offer" approaches, how informed consent is or is not included, and such factors as what motivates some people to be tested or not. Upcoming efforts on the part of international organizations to revise testing policies provide an opportunity for debate on these questions. The meaningful participation of people living with HIV in these discussions is essential.

Background

HIV testing has long been a focal point of concern for those committed to the struggle against AIDS. During the early years of the epidemic, aggressive calls for punitive, forcible testing sparked widespread concern about the effects of such strategies on individual rights and the spread of the epidemic. Community advocates, human rights activists and public health professionals collectively forged a consensus that voluntary counselling and testing (VCT) was the most effective and rights-based method of encouraging HIV testing.

VCT involved the following elements (often referred to as the 3 Cs): both pre- and post-test counselling, informed consent, and confidentiality of test results. VCT also meant that testing was done on an "opt-in" basis — i.e., that testing would happen upon the positive decision of the person to be tested (either following the person's deliberate decision to seek out HIV testing or, alternatively, in response to an offer or recommendation of testing from another person such as a health care provider).

In the early years, most debates seemed to suggest that the choice was between VCT and some form of compulsory or mandatory testing. "Compulsory testing," also known as "involuntary testing," is defined as testing without a voluntary element — i.e., without informed consent, at the behest of someone or some institution other than the person tested and, sometimes, with neither the fact of having been tested nor the result communicated to the person tested. "Mandatory testing" is defined as testing that would occur as a condition for some other benefit, such as donating blood, immigrating to certain countries, getting married, joining the military or as a precondition of other kinds of employment. Except in the case of donation of blood, organs or other bodily substances, international agencies working on HIV and public health authorities rejected compulsory or mandatory testing as an unethical violation of human rights and as ineffectual in public health terms. Nevertheless, in some countries, compulsory testing still occurs, and mandatory testing continues to be applied to certain groups of people in certain circumstances, such as immigrants, prisoners, sex workers, and the military.

In recent years, there has been increasingly a call for moving away from a sole reliance on the VCT model, particularly in high-prevalence countries. Some public health authorities have stepped up calls for more widespread HIV testing, often suggesting that VCT is too slow or inefficient to help prevent the relentless spread of HIV. Others argue that client-initiated VCT will always have an important role to play in the response to AIDS, but that it needs to be supplemented by some form of provider-initiated testing. The push to extend antiretroviral treatment has also fuelled calls for more aggressive testing measures, including "routine" testing of, or routine offers of HIV testing to, pregnant women to enable the optimum use of tools to prevent mother-to-child transmission.

New terms have been introduced into the policy arena, such as "routine testing" (i.e., everyone in a given setting or circumstances is tested without regard to individual consent); "opt-out testing" (i.e., the default option in a given situation is to test everyone unless a person clearly opts out, which in some cases may require or give the impression that a person must demonstrate a reason for not being tested); and "provider-initiated testing" (generally understood as synonymous with "opt-out testing"). "Routine offer of testing" is also regularly used, but its meaning is not always clear. There seems to be general consensus that it means everyone in a given setting or circumstance is routinely offered an HIV test, and the term itself suggests that testing remains "opt-in" (i.e., testing proceeds only if consent is expressly given, preferably in a truly voluntary fashion and informed based on quality pre-test counselling). However, sometimes the term "routine offer of testing" is used in ways that suggest that, following the offer, testing proceeds on an "opt-out" basis. It is important to know if "routine offer of testing" means testing in the absence of refusal or testing only with affirmative consent. While these terms are sometimes used without clearly stated definitions, they generally involve departures, to varying degrees, from the VCT model, particularly those approaches to HIV testing that would eliminate or modify individual informed consent, and truncate or eliminate counselling, or restrict counselling solely to post-test counselling tailored to the test result.

The call for a new paradigm in testing is being taken up in many countries by political authorities. In some cases, AIDS experts who previously supported the idea that HIV testing was always to be completely voluntary and feature informed consent and pre-test counselling are supporting measures that do not necessarily preserve these conditions. The proponents of this new paradigm often argue that AIDS should no longer be treated as an exceptional disease with respect to human rights protections in testing.

In light of these developments, on 24–25 October 2005, in Montréal, persons living with HIV, representatives of AIDS service organizations, clinicians, researchers and representatives of development organizations and international agencies working on AIDS attended the Symposium on HIV Testing and Human Rights. Participants came from many countries, both developing and developed. The objectives of the symposium were:

- to review the record of voluntary counselling and testing as a human rights-based HIV prevention and treatment measure;
- to consider from the perspective of researchers, front-line service providers, people living with HIV and other users of health services, and the human rights and public health implications of HIV testing approaches that depart from traditional client-initiated voluntary testing and counselling;
- to consider measures that may enhance human rights protections in all forms of HIV testing and consider their practical feasibility; and
- to articulate research and policy needs related to these questions.

This report provides a summary of the main issues and themes that were identified during the presentations and discussions at the symposium. It also lists the research priorities and issues, the policy issues, and the action steps and opportunities for action identified by participants. The agenda of the symposium and the list of participants can be found at the end of this report.

Main themes and conclusions

This section contains a summary of the main issues raised by participants during the presentations and discussions at the symposium. The issues are grouped under six broad themes or conclusions on which there was wide consensus among the participants.

The "routine" offer of HIV testing raises a number of human rights and other concerns.

In a regime of routine offer of HIV testing, is it possible to retain pre- and post-test counselling, informed consent, and confidentiality, all of which have been seen until now as central to protecting the rights of people tested? There was consensus among all the participants that practices of compulsory, involuntary and "routine" testing without informed consent contravene basic human rights principles. Participants raised the question of whether it is practically possible in provider-initiated, "routine-offer" systems to satisfy the essential conditions of consent, confidentiality and quality counselling. There is an emerging consensus among experts that routine offer of HIV testing will likely lead to a significant decrease in pre-test counselling and in the ability of people being tested to provide informed consent. Indeed, in some settings there are explicit policy statements to the effect that such requirements, well established until now, may be ignored for at least some groups of people (e.g., pregnant women) or in some circumstances (e.g., the patient discloses they have engaged in activities that put them at risk of HIV infection). Group pre-test counselling, which may be used as part "routine-offer" systems, may not be as effective as individual pre-test counselling for some purposes, especially for encouraging patients to ask questions about sensitive issues. In settings where there is a power imbalance between test provider and client, the voluntary nature of HIV testing may be compromised, as the client may feel compelled to "consent" to the provider's "suggestion" or "recommendation." This may particularly be the case where the "offer" of the test is communicated with the information that the test will be performed unless the client refuses. Whereas the practice of provider-initiated, routine offer of testing may not include mentioning the HIV test by name, but rather may include it in a long list of medical tests (or even simply a posted notice in the facility advising that HIV testing will be done unless the patient expressly refuses), "routine offer" may in practice also contravene the basic principle that the offer, and not the testing, should be routine. Health care providers who make the routine offer of testing may not have an appreciation of the importance of informed consent, or standards of what constitutes informed consent may not have been part of their training or culture.

There is a need for more evidence on how routine offer of HIV testing is playing out on the ground. It was clear, including from the questions raised above, that there is inadequate evidence on which to judge the practical reality of the routine offer of testing. Policy-makers, governments, and many international organizations and funders are not seriously addressing deeper research issues beyond simply the numbers of people getting tested. What is the experience of people being tested as a result of routine-offer approaches? Are people tested as a result of a routine offer as likely to seek and gain access to treatment as those who initiated testing themselves? What is the impact of rapid point-of-care testing on counselling and the consent process? Under what conditions is the routine offer of testing likely to deter patients seeking care (including antenatal care)? Do the jurisdictions that have adopted routine-offer, opt-out testing have universal or even good access to treatment, condoms and other prevention measures? Participants emphasized that **the onus should be on those who propose routine-offer testing to make the case for it,** and that the case has not yet been made in research or experiential accounts. A body of evidence should be built, but the fundamental ethical principle of "do no harm," and respect for human rights (including bodily integrity and freedom from coerced medical procedures) must be dominant in policy discussions on HIV testing with or without that body of evidence.

It is not surprising that numbers of people tested rise under regimes in which HIV testing is routinely offered and/or HIV testing is conducted on an opt-out basis, but the number of tests is not an adequate indicator of benefits. If people are unprepared for testing or for disclosure of their status, and are inadequately counselled at the time of testing, adverse consequences of testing — for which some persons tested will be unprepared — will likely also rise along with numbers tested. Among these potential consequences are abandonment by family members, violence, abuse and psychological depression. Simply measuring the number of people tested does not capture either the experience of HIV testing or that of people who may be at risk of adverse outcomes. In addition, the move toward routine testing and the increasing availability of antiretroviral therapies have coincided. Therefore, any increase in HIV testing may not be due entirely to shifting from client-initiated VCT to more routine approaches to testing. In many cases, more research is needed on what accounts for higher testing numbers and on the extent to which greater numbers of people tested are gaining access to health services (including treatment) and support. The frequently made assertion that treatment scale-up is curtailed by inadequate numbers of people knowing their serostatus also has yet to be demonstrated in research.

Policies on HIV testing should not be considered in isolation from such factors as discrimination and access to prevention, care, treatment and support services.

Discrimination is widespread, especially in health care settings; this has affected VCT and will also affect the routine offer of HIV testing. Current examples of discrimination include breaches of confidentiality, surgeons refusing to operate on people who are HIV-positive, pregnant women being denied insurance because they have had an HIV test, and people being tested without their consent. It is also of concern that many HIV-positive women may be offered a short course of antiretrovirals to reduce the risk of mother-to-child transmission, but not longer-term treatment and care, which may sometimes be the result of discrimination. In addition, symposium participants returned several times to the conclusion that **imposing routine offer, particularly if testing is then done on an opt-out basis, in places where treatment, care, support and other prevention services are unavailable raises serious ethical and human rights questions.** HIV testing is not done for its own sake. It is not always clear what services (if any) are available to a person who has tested HIV-positive.

The debate on more routine approaches to testing has occurred in an environment in which evidence-based and human rights-based policies and programs are being widely undermined.

The push for more routine approaches to HIV testing is happening in a larger political context. There is a mix of motivations behind the push for moving away, to varying degrees, from the VCT model. Some of the people behind this push have the best of intentions. But this policy shift is happening in a larger political context, a context which includes the undermining of evidence-based prevention measures, impediments to scaling-up treatment, and coercive and punitive responses to AIDS. Other policy shifts could occur following the move to making HIV testing more routine, such as more coercive approaches to partner notification.

Is it legitimate to "normalize" HIV and end "AIDS exceptionalism"? HIV-related disease is not (yet) a "normal" illness. Is it putting the cart before the horse to propose normalization through approaches to a single intervention (i.e., HIV testing) that may come at a high cost to people living with HIV, the burden of which will be borne disproportionately by certain groups of people living with HIV (e.g., women)? Could other approaches to destigmatizing HIV — such as appropriate social marketing of testing, support for people living with HIV, and leadership by political leaders as well as people living with HIV — be more appropriate and effective? Is normalization a way to introduce a return to a more traditional notion of infectious disease control, in which the broader concerns of individuals affected by HIV are seen as unimportant and thus need not be addressed by HIV programs or governments? Or is normalization a recognition that the risk-benefit ratio has evolved with the advent of antiretroviral treatment (ART)? Should more routine approaches to HIV testing necessarily be linked to ART access or is it enough on the risk-benefit scale if those who test HIV-positive may not have immediate ART access but have access to quality services providing care and support, including, nutritional counselling and support, and psychosocial support through health services and community-based mechanisms?

There have been many challenges in implementing VCT, but it is not clear that these add up to the "failure" of VCT.

Even where VCT is the policy, elements of the VCT model may not be well implemented. VCT means that HIV testing should be voluntary (i.e., done only with the informed consent of the individual), that it should be accompanied by adequate pre- and post-test counselling, and that the test results should be confidential. What is happening on the ground often falls short of this standard. In many countries, VCT is available only in urban centres. VCT is often under-resourced, and counsellors may be overworked and unable to spend sufficient time with those being tested. Many counsellors are not adequately trained. In many countries, there is a lack of commitment to VCT. In China, for example, there is no counselling, and people often receive the results of their HIV test over the phone. The availability of VCT is often not well publicized; in some countries, many people learn about VCT only after they have already been informed of their HIV-positive status. Confidentiality is often breached. Frequently, those conducting testing and counselling are not devoted to these tasks full-time and have other duties to perform. There are many situations where the consent to be tested provided by the individual is not really informed and the concept of informed consent is even not understood. **Given these challenges, can one conclude that the VCT model has been given a fair chance?** Moreover, if respecting and protecting human rights is so challenging where VCT is the stated policy, would it not be even more so when policy and programs start from the premise that HIV testing should be made more routine?

Critics of VCT often fail to acknowledge that in many settings VCT has not been adequately funded or promoted. It is unlikely that any move to make HIV testing more routine will address the real or perceived deficiencies of VCT. The major case against VCT has been that it is resource-intensive and time-intensive and thus impedes bringing testing to scale, which in turn is said to impede efforts to scale up treatment (even though it is not clear that increased testing will be matched by increased access to treatment in many settings). There have been no serious investigations about how to streamline VCT in order to address these issues. It may be possible to ensure confidentiality, consent and counselling in alternative models of VCT, rather than only seeing these components as barriers. This is also not to say that if confidentiality, consent and counselling were protected in more routine approaches where providers initiate testing, those approaches would necessarily be acceptable as a matter of ethics and human rights.

Measures need to be taken to deal with the ongoing problem of inadequate or poor-quality counselling and testing. There is a need to develop and implement guidelines and training for testing providers (and health care workers more generally) about how to provide quality counselling and testing (including the use of rapid tests), and how to manage confidentiality and disclosure issues. It would be useful to put into place some basic principles, perhaps in the form of international minimum guidelines that could be adapted in each country to address cultural and contextual realities. There is a need to simplify information for both test providers and people being tested, while still ensuring that adequate information is provided for informed consent. There is a need to ensure, possibly through laws and regulations (combined with adequate monitoring and enforcement of those standards), that the quality of counselling and testing provided by test providers, whether public or private, is adequate. It is also urgently necessary to provide greater support to those providing testing and counselling. **The delivery of VCT also needs to be better coordinated with other health services.** Better links are required between VCT and health services such as those provided for STIs and other sexual and reproductive health, and for directly observed therapy for TB. Consideration should be given to one-stop sexual health services; this would help to reduce stigma or at least minimize the degree to which HIV-related stigma may impede access to HIV testing and health services if these are delivered through separate, identifiable sites.

Different populations may require different HIV testing approaches.

The needs of different populations — e.g., people who use drugs, sex workers, men who have sex with men, women and girls, migrant populations — are not identical. Many people in vulnerable communities do not use formal health services, so they may need other ways to gain access to HIV testing. Refugees and immigrants face a particular set of problems, particularly if their immigration status is unclear. What is the best way to promote HIV testing to men who, for a variety of reasons may not be seeking out VCT, and who would still have lower testing rates even where HIV testing is offered routinely and/or is done on an opt-out basis, because they have less contact with health services? Younger women and girls have special needs and may require specialized testing centres.

More information is needed on the real-life experiences of people being tested under both VCT and other testing policies.

There is limited evidence regarding the counselling-testing-disclosure process as to what works and what doesn't. There is limited comparability among studies on disclosure and the consequences of disclosure. More research is needed on

(a) perceptions of risk by both test providers and those people getting tested;
(b) understanding of, and reasons for, seeking or not seeking HIV testing;
(c) the real experiences of counselling and testing under different approaches (e.g., how counselling unfolds, how informed and voluntary the decision is);
(d) understanding by those seeking testing of the concept of informed consent, as well as the concept's relevance in different cultural contexts;
(e) the experiences of people who have been tested when they were really not ready for testing;
(f) the barriers to HIV testing; and
(g) the real experiences of a diagnosis of HIV and disclosure of HIV-positive status.

Where testing uptake is low, there is a need to understand why this is so. There is a need for more research on the experiences of HIV testing in settings other than health care facilities (e.g., community-based settings, organizations of persons living with HIV). (See also the research recommendations below.)

There is limited evidence on the experiences of particular populations. Currently, too much of the data on numbers tested or experiences of testing is not disaggregated by population subgroups. Research is needed into the experiences with HIV testing of populations such as women (including pregnant women), people who use drugs, men who have sex with men, sex workers and youth. More information is needed on the HIV testing experiences of men who have sex with women.

Next steps: research, policy and action

At the symposium, participants developed lists of research priorities and other issues, actions that should be considered by policy- and decision-makers, and actions and opportunities that HIV and human rights activists should consider.

Research priorities

Participants agreed that research is urgently needed on the following topics:

- Health-seeking behaviours, including the behaviours of people in vulnerable populations: Who comes to health facilities (before, during and after testing)? Who is not coming? What factors contribute to testing readiness?
- The nature of informed consent: How do community and providers understand "consent"? What are the real-life ways of obtaining consent, and how might these be made more appropriate?
- Existing models of testing and counselling, including community-based and provider-initiated models: How do these play out in reality? How are they experienced by people who might be socially marginalized, uneducated, stigmatized or subordinated?
- Links between HIV testing and primary and secondary prevention, and between HIV testing and treatment; process, clinical and behavioural outcomes; and disclosure and effects of disclosure.

Other issues

Participants agreed that research is also needed on the following topics:

- Stigma and discrimination against those people who refuse testing;
- The impact of the criminalization of HIV exposure on seeking testing;
- How policies are interpreted and adapted;
- The status of the legal framework on HIV testing and related issues; and
- The policies currently in place concerning partner notification and other questions related to disclosure.

In addition:

- More action research is needed where research "subjects," that is, people living with HIV and those at risk of HIV infection, particularly those who are part of vulnerable populations, are real partners in the design and conduct of research.
- More research is needed on how HIV testing policies are interpreted and adapted.

Actions for policy-makers

Symposium participants identified a number of factors that ideally should accompany any attempt to increase HIV testing through policies or practices that make it more routine, including providers initiating testing. These conditions would also provide optimal support for those seeking testing and should be seen as central to developing comprehensive programs for HIV testing. Participants recognized that realistically these elements may take a long time to establish but nonetheless wished to emphasize that they are crucial to effective and humane HIV testing:

- Anti-discrimination laws are in place and are enforced;
- Pre-test counselling and information (group or individual) is available;
- The health professionals involved are comfortable talking about sex and drug use;
- Women are screened for potential negative outcomes (e.g., don't proceed with HIV testing for women at risk of violence, abandonment or other abuse, in the absence of ensuring explicit informed consent clearly given voluntarily);
- Comprehensive care and treatment, and evidence-based HIV prevention, are available and accessible;
- The offer of an HIV test is in a form that makes it clear that refusal is acceptable, and avoids placing pressure on the person to accede to the "offer," "suggestion" or "recommendation";
- A training program for health workers that involves community representatives is in place; and
- Community education on HIV testing and counselling is in place.

Participants identified the following additional actions and policy considerations:

- Testing and counselling should be accessible to all and free of charge. This should be a central policy goal. Anonymous testing and counselling should be available. Confidentiality should be respected in all models of counselling and testing.
- Support should be provided for providers of testing and counselling, including (a) training and the provision of clear guidelines, (b) adequate remuneration, and (c) recognition, where applicable, of their professional status.
- Human rights-based policies on testing and counselling of adolescents and minors should be developed.
- Human rights-based policies should be developed on the testing and counselling of people in vulnerable populations, especially criminalized persons (e.g., people who use drugs, sex workers, men who have sex with men, illegal migrants and others). These policies should provide protection from compulsory or mandatory testing. Access to testing and counselling should be ensured even if HIV transmission or exposure is criminalized.
- People living with or vulnerable to HIV should be involved in the development of policy related to testing and counselling, as should those providing testing and counselling.
- NGOs should be allowed by law to offer testing and counselling services.
- Private and public sector providers of HIV testing should be regulated; there may be a need in some settings for particular measures to ensure that private sector providers are adequately regulated.
- Health literacy is a key component of ensuring that people understand their rights to treatment and prevention services as well as the human rights that underlie the right to informed consent and confidentiality. A comprehensive response to AIDS should include health literacy programs for people living with HIV and communities at risk.

Actions for HIV testing activists

Participants identified a number of action steps that the organizations represented at this symposium, and other HIV and human rights activists, should consider, which are as follows:

- Develop a succinct, human rights-based analysis of arguments for, and policies implementing, more routine approaches to HIV testing, including opt-out testing, written in plain language and translated into various languages. This response could be distributed for sign-on as widely as possible as a consensus document of the consortium of organizations represented at the symposium. (The Canadian HIV/AIDS Legal Network has agreed to draft this response.)
- Provide international support for advocates in Botswana who are seeking to investigate and monitor the reality of the "routine HIV testing" policy in that country from the perspective of human rights. It would be useful to ask the World Health Organization (WHO) for an independent evaluation of the impact of the policy (link to care and prevention, social factors, etc.), an evaluation that would include community input.
- Call on UN agencies to provide more detail on their HIV testing policy recommendations, including operational guidance on their implementation, and to directly address the ethical and human rights concerns at stake with moving to more routine approaches to HIV testing.
- Identify ways to increase the capacity to document human rights violations related to HIV testing and counselling, to bring complaints, and to assess whether existing mechanisms provide adequate redress in the event of human rights being infringed. Local groups of people living with HIV should have the resources needed to document human rights violations and do follow-up advocacy; this should be part of the Global Fund to fight AIDS, Tuberculosis and Malaria and other grants. International and regional human rights organizations should be encouraged to work on HIV testing and related human rights protections.
- Organize in early 2006 a meeting with the incoming director of the WHO Department of HIV/AIDS to discuss concerns about the push for more routine HIV testing.
- Bring the consensus points on research from this symposium to the attention of national research bodies.
- Look for ways to raise HIV testing issues in the country progress reports that are prepared in response to the United Nations General Assembly (UNGASS) Declaration of Commitment on HIV/AIDS. It may also be possible to prepare shadow reports.
- Advocate for resources to be made available in-country to allow for workshops to prepare the UNGASS-related reports.

Other opportunities

Participants identified several opportunities for action for the organizations represented at this symposium and other HIV and human rights activists. The opportunities are as follows:

- The WHO has a training manual for provider-initiated testing and counselling; it will circulate the manual for comment.
- UNAIDS and the WHO plan to update the UNAIDS/WHO HIV Testing Policy Statement (www.unaids.org). Operational guidance for implementation of the recommendations will be developed in consultation with stakeholders, including civil society and human rights activists.
- The WHO is planning to prepare a draft policy for Lesotho, and will circulate the draft for comments; this may lead to a model policy that may be promoted elsewhere by the WHO and others.
- The WHO is organizing a meeting on violence and disclosure; it may be possible for some of the participants from this symposium to participate in the WHO meeting. The WHO is also organizing a meeting in 2006 on HIV testing and counselling policy. (Participants said that in any WHO or UNAIDS consultations, the reality of users of testing and counselling services should be represented.)
- Organizations and individuals interested in HIV testing issues can communicate with each other by using the contact list from this symposium; by providing feedback on the WHO model policy (Lesotho) and training package on provider-initiated testing and counselling; by circulating widely the report of this symposium; and by making a conscious effort to share documents.
- Get HIV testing issues on the agenda of the Strategic Technical Advisory Committee (STAC) of the WHO.

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About the Canadian HIV/AIDS Legal Network

The Canadian HIV/AIDS Legal Network (www.aidslaw.ca) promotes the human rights of people living with and vulnerable to HIV/AIDS, in Canada and internationally, through research, legal and policy analysis, education, and community mobilization. The Legal Network is Canada's leading advocacy organization working on the legal and human rights issues raised by HIV/AIDS.

About the Center for Health and Gender Equity

The Center for Health and Gender Equity (CHANGE) is a U.S.-based non-governmental organization focused on the effects of U.S. international policies on the health and rights of women, girls, and other vulnerable populations in Africa, Asia, and Latin America. We believe that every individual has the right to the basic information, technologies, and services needed to enjoy a healthy and safe sexual and reproductive life free from coercion and preventable illness.

About the Gay Men's Health Crisis

Gay Men's Health Crisis (GMHC) is a not-for-profit, volunteer-supported and community-based organization committed to national leadership in the fight against AIDS. Our mission is to reduce the spread of HIV disease, help people with HIV maintain and improve their health and independence, and keep the prevention, treatment and cure of HIV an urgent national and local priority. In fulfilling this mission, we will remain true to our heritage by fighting homophobia and affirming the individual dignity of all gay men and lesbians.

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