

# Policy Statement on HIV Testing and Counselling for Refugees and other persons of concern to UNHCR



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Division of Programme Support and Management  
United Nations High Commissioner for Refugees  
Case Postale 2500  
1211 Geneva 2, Switzerland  
[www.unhcr.org](http://www.unhcr.org)

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Cover photo: Kenya / Kakuma refugee camp / Blood is taken for an HIV test. Kenya / UNHCR / A. Webster / December 2006

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## I. Background

This Policy Statement examines the role of HIV testing and counselling (HTC) in health facilities in increasing access to HIV prevention, treatment, care and support services for refugees, asylum-seekers, internally displaced persons (IDPs) and stateless persons (see Glossary for definitions). It also identifies specific issues regarding HTC amongst these populations and issues recommendations for future action. This policy statement complements and should be used in conjunction with existing World Health Organization guidance, specifically *Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities* (1) and *Service delivery approaches to HIV testing and counselling (HTC): A strategic policy framework* (2). Information on an enabling environment and training of workers in health care facilities are all found in the above mentioned World Health Organization & Joint United Nations Programme on HIV/AIDS (UNAIDS) guidance. Guidance provides descriptions of HTC service delivery approaches, and HIV testing strategies and algorithms. Recommendations in this document are anticipated to be valid until 2018. At that time UNHCR will review this document and issue its recommendations.

HTC represents the gateway to HIV prevention, care and treatment. Expanded access to voluntary HIV testing and counselling provides important opportunities for:

- ❑ Ensuring universal access to knowledge of HIV serostatus;
- ❑ Enhancing access to HIV prevention services, including:
  - o prevention of mother-to-child transmission (PMTCT),
  - o condoms,
  - o voluntary medical male circumcision (VMMC) for HIV negative men,
  - o management of sexually transmitted infections (STIs),
  - o behavioural interventions
- ❑ Improving early diagnosis of HIV and linkage to appropriate care, support and timely initiation of antiretroviral treatment (ART), in order to improve health of people living with HIV, prevent onward transmission to HIV negative partners, including vertical transmission;
- ❑ Increasing access to ART and simplified delivery of ART through a wide range of settings.

In 2012, WHO issued *Service delivery approaches to HIV testing and counselling: A strategic HIV testing and counselling programme framework* to present a range of options for the provision of HTC (2). This framework is intended to assist countries with strategically selecting HTC delivery models, including facility-based or community-based models and couples/ partners testing, based on the nature of the HIV epidemic, cost-effectiveness, equity of access, and available resources.

Facility-based approaches to HTC include stand-alone clinics that provide voluntary HTC and the provision of HTC in health facilities (e.g., antenatal clinics, tuberculosis services, STI clinics and harm reduction programmes for injecting drug users). HTC in health facilities is voluntary, as all HTC services ought to be. It is generally distinguished from other forms of HTC, where it is often the client who seeks out HIV testing. Since HTC in health facilities is usually initiated by the health care provider, this is referred to also as provider-initiated testing and counselling (PITC). With the advent of rapid diagnostic tests for HIV, HIV testing is increasingly available in community-based settings (e.g. home, workplace, schools/colleges, outreach centres, religious institutions, and sports or entertainment events). Community-based HTC is generally aimed at increasing uptake of HIV testing and reaching populations that may be less likely to access health services or less likely to return for their test results. In June 2013, as part of the revised WHO guidance on the use of antiretroviral drugs for treating and preventing HIV, WHO recommends the adoption of community-based HTC with linkage to care and treatment for generalized epidemics and for key populations in all epidemics (3).

In April 2012, WHO issued guidance to increase the offering of HTC to couples and partners, with support for mutual disclosure (4). WHO also recommends the offering of ART to people living with HIV within serodiscordant couples, irrespective of CD4 count, to prevent transmission to a HIV negative partner. Also in 2013, WHO addressed the needs of adolescents, ages 10-19, by recommending HTC with linkages to prevention, treatment and care services for all adolescents in generalized epidemics and for adolescent key populations<sup>1</sup> in all settings, including low and concentrated epidemics (5).

These guidelines and the UNAIDS/WHO *Policy statement on HIV testing* (6) only briefly address issues related to HTC services for refugees, but does not cover other conflict-affected displaced populations. Therefore, this policy statement addresses the gaps that exists in ensuring appropriate access to voluntary HTC in a manner that mitigates stigma and discrimination related to HIV and AIDS, and protects the human rights of refugees, asylum-seekers, internally displaced persons (IDPs), and stateless persons. This includes upholding the standards of informed consent, confidentiality and non-discrimination (7).

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<sup>1</sup> Key populations were defined as populations at higher risk of contracting HIV: those populations disproportionately affected in all regions and epidemic types, specifically people who inject drugs (PWID), men who have sex with men (MSM), transgender people (TG), people in prisons and closed settings, and sex workers (SW).

*All HIV testing services should always adhere to the “Five Cs”: informed Consent, Confidentiality, Counselling, Correct test results, and Connection or linkage to prevention, care and treatment (8). It should also include sufficient and appropriate information and access to prevention services for individuals who test HIV negative or HIV positive. HTC services should also include referrals to medical and psychosocial support services for people diagnosed as HIV positive. Testing for HIV without informed consent is unethical and violates human rights.<sup>2</sup>*

**UNHCR, WHO and UNAIDS do not support compulsory or mandatory HIV testing of individuals on public health grounds or for any other purpose.**

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<sup>2</sup> Mandatory testing of blood and blood products or organs for transplants is ethical and necessary.

## II. Implications of the Guidance

The WHO *Service delivery approaches to HIV testing and counselling (HTC): A strategic policy framework* (2), UNAIDS/WHO *Policy statement on HIV testing* (6) and the *Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities* (1) provide useful frameworks and contain important principles and recommendations that should guide approaches to expanding access to HTC for all refugees, asylum-seekers, IDPs and stateless persons.

In particular, these documents:

- ❑ Strongly support efforts to scale-up HTC services, including community-based and facility-based testing and counselling in the context of universal access to HIV prevention, treatment, care and support services;
- ❑ Emphasise that, regardless of how HTC is delivered, it should always be voluntary. People need to receive sufficient and appropriate information that will enable them to give informed consent, receive a correct result, have confidentiality regarding their test results, and receive counselling;
- ❑ Mandatory testing is never sanctioned and is opposed by WHO, UNAIDS, and UNHCR;
- ❑ Recognise that emergency-affected populations may be more susceptible to compulsory or mandatory testing and additional means must be taken to ensure informed consent;
- ❑ Recognise that emergency-affected populations may be susceptible to discrimination, violence and abandonment, and other negative consequences upon disclosing their HIV positive status; particular efforts may be needed to protect their privacy and safety;
- ❑ Acknowledge that scaling-up of HTC services must be accompanied by:
  - Informed consent
  - Accurate test results
  - Access to HIV prevention, care, treatment and support services;
  - Referrals and support for effective linkage to services;
  - Supportive social, policy and legal environment for people living with HIV and those most at risk of acquiring HIV infection.

Additional issues related to specific populations and circumstances are described below.

## REFUGEES AND ASYLUM SEEKERS

The HIV status of an asylum-seeker should not constitute a bar to admission to the territory of the country of asylum or to accessing asylum procedures. The right to be protected against *refoulement* is the cornerstone of international refugee law. HIV status is not grounds for any exception to this principle (7). Moreover, an asylum claim should not be denied on the basis of HIV positive serostatus, nor should family reunification be denied.

There is no legal basis for imposing mandatory HIV testing of refugees and asylum seekers in international human rights law. Such testing violates the right to privacy, liberty and security of the person and may lead to a violation of the right to non-discrimination. For example, mandatory testing may be combined with unjust measures restricting the freedom of movement for people living with HIV. However, any restriction on the personal right to liberty, security or freedom of movement based, on the basis of a real or suspected HIV positive serostatus, is discriminatory and cannot be justified by public health concerns.

Examples of mandatory HIV testing amongst refugees and asylum seekers have been identified in a number of countries. This includes mandatory HIV testing, HIV testing without pre- or post-test counselling, nor protection of privacy for refugees who test for HIV. In some countries, this occurs even where national legislation clearly state that all HIV testing should be voluntary, conducted with informed consent, and provided with counselling and privacy. Furthermore, in some situations, refugees and asylum seekers do not have access to affordable HIV prevention and treatment services, (i.e., in some countries, refugees must pay for services that are free to citizens) or only have access to emergency or basic primary health care. It is unacceptable to provide HTC without providing information and access to prevention, care and treatment services.

UNHCR reiterates that a HIV positive serostatus should not adversely affect a person's right to seek asylum, to access protection or to avail oneself of durable solutions.

## RESETTLEMENT

There are refugees living with HIV who are in need of resettlement to a third country, based on core protection grounds unrelated to their HIV status. Others might be in need of protection and resettlement due to human rights violations related to their HIV status. In both situations, UNHCR believes that HIV status should not adversely affect their right to access social protection and durable solutions. Resettlement countries generally require a medical examination including screening for communicable diseases, including hepatitis B, syphilis and tuberculosis. Additionally, some countries also require a HIV test as part of the medical examination (7).

Any HIV testing in the context of asylum or resettlement should be conducted under the conditions of the "Five Cs": *informed Consent, Confidentiality, Counselling, Correct test results, and Connection or linkage to prevention, care and treatment*, as stated above. UNHCR urges all resettlement countries to have HTC guidelines that call for international standards to be applied and to ensure these standards are monitored and enforced at the country-level.

UNHCR clearly states that HIV status should not adversely affect resettlement opportunities. Whereas States may exclude people, including those living with HIV, who are not self-supporting, if those people also have a legitimate need for asylum, UNHCR stresses that the need for asylum override any concerns about potential costs associated with treatment and care.

In order to address these issues, a Joint UNHCR/IOM/UNAIDS statement on *HIV Testing in the Context of Resettlement* (9) was produced in 2007 which:

- ❑ Notes the obligation of all parties concerned to meet international HTC standards.
- ❑ Calls resettlement countries to ensure resources and quality assurance systems are provided as part of HIV programmes, including prevention, care and treatment services.
- ❑ Calls for activities, including HIV testing and pre- and post- test counselling, for resettlement applicants to follow UNAIDS/ WHO HTC guidelines and UNHCR and IOM resettlement guidelines.

### **INTERNALLY DISPLACED PERSONS**

IDPs should be able to access the same HIV testing and counselling and HIV prevention, treatment, care and support services as other citizens of the country. However, in the emergency phase of a disaster, there is often considerable disruption to services and ensuring continued access ART to avoid potential treatment interruptions is of critical importance.



## III. HIV testing and counselling (HTC)

The following considerations should be made in the provision of HTC services to refugees, asylum-seekers, IDPs and stateless persons:

### 1. Provide Easy Access to HIV Testing and Counselling

UNHCR, WHO and UNAIDS strongly support the continued scale-up of HTC at non-clinical sites and through community-based approaches. HTC should be equally available to displaced persons, where it is available to the surrounding communities.

### 2. Ensure Linkage to and Access to Evidence-based HIV Prevention, Care and Treatment Services

HTC is not a goal in itself, but a gateway to prevention, treatment, and care services.

HTC services should always be combined with evidence-based HIV prevention measures to prevent HIV transmission, including condoms, VMMC for HIV negative men (in the 14 priority countries in East and southern Africa), prompt diagnosis and treatment of STIs, sterile injection equipment, and other harm reduction interventions (10). Antiretroviral drugs for post-exposure prophylaxis (PEP) can be provided to prevent acquisition of HIV from occupational exposure, e.g. health workers, and as part of the care provided to those who have been sexually assaulted (18).

HTC should also be linked to treatment, care and support, including access to antiretroviral treatment. Efforts to increase access to and scale-up HTC in emergency situations and where health services have been disrupted should be made if access to treatment, care and support services is also available. Successful HIV treatment requires the uninterrupted provision of ART, and screening and treatment for tuberculosis and other opportunistic infections (3).

These services should be reflected in national HIV strategies and plans of action.

### 3. Integrating HIV Testing and Counselling with Other Services

HTC should be integrated within a referral network to other services for reproductive health, prevention of mother-to-child transmission (PMTCT), STIs, tuberculosis, post-rape/sexual violence, drug treatment, harm reduction, psychosocial support and social or legal protection.

#### 4. Protection from HIV-related Stigma, Discrimination and Human Rights Violations

People living with HIV often experience stigma, discrimination and human rights violations, which, among other things, can be powerful deterrents to accessing HTC services, as well as to the uptake of prevention, care and treatment. HIV risk behaviours, such as selling sex, injecting drugs and same-sex relationships are often highly stigmatized activities and illegal in many countries (11). Thus, displaced persons living with HIV who also engage in HIV risk behaviour that is criminalized in many settings may require additional protection efforts. Additionally, poorly trained health workers may also demonstrate stigmatizing and judgmental attitudes and require sensitization and further training — especially for key populations (19).

#### 5. Prohibit Mandatory HIV Testing

For public health and human rights reasons, UNHCR, UNAIDS, and WHO strictly oppose mandatory HIV testing of refugees, asylum-seekers, IDPs and stateless persons. It is important that UNHCR staff and partners are aware of what constitutes mandatory testing and monitor this in their programmes. Instances of possible mandatory testing and breach of confidentiality must be investigated and reported.

#### 6. Recommending HTC through Health Services and Health Facilities

Uptake of HTC can be enhanced when they are proactively recommended by health care providers (1). When a health care provider initiates the HIV testing and counselling process, this should adhere to the “5C’s” and include the provision of adequate information, obtaining informed consent, maintaining client confidentiality and providing post-test counselling (2). Health workers should be trained to provide voluntary, confidential, acceptable and non-judgmental services.

Following the WHO/UNAIDS *Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities* (1), provider-initiated testing and counselling is recommended as follows:

- ❑ **In generalised HIV epidemics**, with a supportive social, policy and legal framework, HIV testing and counselling should be *recommended* to all refugees and IDPs, during contact with health care providers, in line with the guidance of the country and where this is available to the surrounding populations.
- ❑ **In concentrated and low level epidemics**, with a supportive social, policy and legal framework, HTC should be *considered* in services for post-rape/sexual violence and STIs, services for key populations (men who have sex with men, transgender people, sex workers and people who inject drugs), antenatal, childbirth and postpartum health services, where country-wide PMTCT programmes offering testing to all pregnant or breastfeeding women, and tuberculosis services.

## 7. HIV Testing and Counselling for Key Populations

Key populations are people who are at increased risk for HIV and stigmatized and discriminated against because of their behavior, including sex workers (SW), men who have sex with men (MSM), transgender people (TG), people who inject drugs (PWID). WHO and UNAIDS advise that HTC should be prioritized for these key populations (12). Key populations may be more susceptible to coerced testing. Therefore, it is important for health care providers to emphasize the voluntary nature of HIV testing and the patient's right to decline. HTC services for key populations should also provide information on HIV, relevant laws and policies, and linked to prevention, care, and treatment services. HIV services will be most effective in settings with supportive social, policy and legal frameworks that protect from stigma, discrimination and prosecution of key populations. It is also a priority for health workers to be trained to provide non-stigmatizing and non-judgemental services, including appropriate HIV prevention messages during counselling, and ensure that adequate referrals for care, treatment and support are offered (12).

## 8. Ensuring Informed Consent

To ensure that informed consent to HIV testing is provided, the following should be in place:

- HIV information and counselling should be available in appropriate languages and be culturally acceptable.
- Health care workers must provide sufficient information in order for clients to fully understand the implications of HIV testing and follow-up procedures. This includes providing an opportunity to ask questions and providing information on:
  - o Why HTC is recommended,
  - o The benefits and potential risks of HTC,
  - o How and where to access follow-up services, if a person receives a positive test result (including whether or not ART is available),
  - o The right to decline HIV testing
  - o Assurance that HIV test results will remain confidential (1).
- Within the resettlement context, counsellors need to inform refugees seeking resettlement that their HIV status will be communicated to the concerned immigration and health authorities of the resettlement countries.

## 9. Recognising the Special Needs of Children, Unaccompanied Minors and Adolescents

Children and adolescents require special attention to ensure the best interest of a child or adolescent are protected. Children and adolescents should not be subjected to procedures such as mandatory HIV testing. The Committee on the Rights of the Child has explicitly stated that States must refrain from imposing mandatory HIV testing on children in all circumstances and to ensure protection against it (13). Some children or adolescents living with HIV may be unaware of their status and in need of treatment (11, 14). It is important to diagnose and provide treatment as early as possible to prevent morbidity and mortality; this includes all children born to women living with HIV (3, 15).

Depending on the age and maturity of the child, HTC is recommended for the child or to their parents or guardians. Pre-test information and post-test counselling should also be provided and access to needed prevention treatment, care and support services should be ensured to all children in need of these and their parents or guardians (5). HTC services should pay attention to the evolving capacity of children and adolescents, as well as to his or her right to be involved in all decisions affecting him or her (14).

#### **10. Building Capacity of Staff Providing HIV Testing and Counselling Services**

Any introduction and scale-up of HTC services for refugees, asylum seekers, IDPs and stateless persons should ensure that health care workers, professional and lay people, are properly trained to provide these services. This calls for assessment of the effectiveness and quality of existing testing and counselling services and the capacity of staff providing such services to people from different ethnic groups and socio-cultural backgrounds, or those with special needs, such as children and adolescents. The counselling skills of all staff providing HTC should be strengthened, as well as their capacities to obtain informed consent, protect confidentiality and ensure they do not discriminate. Ongoing monitoring, mentoring and supervision of staff providing HTC services can help ensure quality services, reduce errors and support the workforce. Adequate lab capacity (for confirmatory testing), sufficient stock of test kits and supplies, effective supply chain management systems, medical waste management and external quality assurance are also critical to HIV testing capacity (16). WHO currently recommends two standardized HIV testing strategies to improve accuracy of HIV test results in low-prevalence and high-prevalence settings (i.e. above 5% in the population to be tested) (2).

#### **11. Ensuring Adequate Monitoring, Evaluation and Research**

To improve the effectiveness, acceptability and quality of HTC services, as well as further creating an enabling environment that protects from stigma discrimination, violence or refoulement, services need to be appropriately monitored and evaluated. Programmes should monitor both the process of conducting HTC and outcomes of HTC. In addition to the collection and reporting of routine programmatic data on uptake and coverage of services, specific evaluations should be made on the quality of counselling through direct observation and assessment of client satisfaction, programme effectiveness, reliability and accuracy of HIV testing, and assessment of positive health and social outcomes. Programmes providing HTC should provide and track linkage to prevention, care and treatment services. WHO provides clear guidance for establishing quality assurance systems for HIV testing and outlines key indicators for the monitoring and evaluation of HIV testing programmes (17). Systems for redress are needed for violations, including implementation of mandatory testing or breaches of confidentiality.

## Summary of Recommendations

1. UNHCR, WHO and UNAIDS oppose all forms of compulsory or mandatory HIV testing on human rights and public health grounds. Countries should review and, if necessary, change their laws, regulations, policies and practices to prohibit mandatory or compulsory HIV testing of persons of concern to UNHCR, including children and adolescents.
2. Efforts to scale-up access to HIV testing and counselling should be part of a comprehensive HIV programme aimed at achieving universal access to HIV prevention, treatment, care and support.
3. All HIV testing services should always adhere to the “Five Cs”: informed Consent, Confidentiality, Counselling, Correct test results, and Connection or linkage to prevention, care and treatment. It is essential to ensure confidentiality of results and, for those people living with HIV, the respect and protection of their human rights.
4. All persons should have access to information related to HIV prevention and treatment in local languages, including information about voluntary HIV testing and counselling programmes.
5. **In generalised HIV epidemics**, with a supportive social, policy and legal framework, HIV testing and counselling should be *offered* to *all* persons of concern to UNHCR during contact with health care providers, in line with the guidance of the country and where this is available to the surrounding populations.
6. In **concentrated and low level** epidemics, with a supportive social, policy and legal framework, *recommendation* of HIV testing and counselling should be *considered* in sexually transmitted infections services, services for key populations, antenatal, childbirth and postpartum health services, where country-wide prevention of mother-to-child transmission programmes offering testing to all pregnant women exists, tuberculosis services and as part of harm reduction services for people who inject drugs, in line with the guidance of the country and where this is recommended to the surrounding national populations.
7. All health care workers conducting HIV testing and counselling should be trained to obtain informed consent, ensure confidentiality, pre-test information and post-test counselling and how to recommend HIV testing. Health care workers providing HIV testing and counselling in the context of resettlement should be informed of resettlement criteria in relation to HIV so that they can adequately inform applicants.
8. Establish monitoring mechanisms to ensure that all HIV testing conducted amongst persons of concern to UNHCR is conducted in a confidential manner, with informed consent in accordance with agreed standards on testing and counselling and with positive health and social outcomes.
9. National HIV programmes should ensure that refugees and other persons of concern to UNHCR are an integral part of national efforts to scale up access to HIV testing and counselling, and more broadly, achieve universal access to HIV prevention, treatment, care and support.

## Glossary

### **Refugee**

The 1951 Convention relating to the Status of Refugees describes refugees as people who are outside their country of nationality or habitual residence, and have a well-founded fear of persecution due to their race, religion, nationality, membership of a particular social group or political opinion.

### **Asylum-seeker**

Individuals who have sought international protection and whose claims for refugee status have not yet been determined.

### **Internally Displaced Person (IDP)**

People or groups of individuals who have been forced to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violation of human rights or natural- or human-made disasters, and who have not crossed an international border.

### **Stateless Person**

Someone who is not considered as a national by ANY state (de jure stateless); or possibly someone who does not enjoy fundamental rights enjoyed by other nationals in their home state (de facto stateless). Unlike the other groups outlined here, they may have never moved away from the country where they were born, however some stateless people are also refugees.

### **HIV Testing and Counselling (HTC)**

WHO recommends that voluntary HTC be available through a wide range of service delivery models and defines five key principles to adhere to—the five Cs: informed Consent, Confidentiality, Counselling, Correct test results, and Connection to care, treatment and prevention services.

## Abbreviations


<b>AIDS</b>	Acquired Immuno-Deficiency Syndrome
<b>ART</b>	Antiretroviral Therapy
<b>IDP</b>	Internally Displaced Person
<b>HIV</b>	Human Immunodeficiency Virus
<b>UNAIDS</b>	UN Joint Programme on AIDS
<b>UNHCR</b>	United Nations High Commissioner for Refugees
<b>WHO</b>	World Health Organization

## References

1. *Provider-initiated testing and counselling guidelines*. Geneva: World Health Organization, 2007.  
Available from: [http://whqlibdoc.who.int/publications/2007/9789241595568\\_eng.pdf](http://whqlibdoc.who.int/publications/2007/9789241595568_eng.pdf)
2. *Service delivery approaches to HIV testing and counselling (HTC): a strategic HTC programme framework*. Geneva, World Health Organization, 2012.  
Available from: [http://www.who.int/hiv/pub/vct/htc\\_framework/en/index.html](http://www.who.int/hiv/pub/vct/htc_framework/en/index.html)
3. *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach*. Geneva: World Health Organization, 2013.  
Available from: <http://www.who.int/hiv/pub/guidelines/arv2013/en/>
4. *Guidance on couples HIV testing and counselling including antiretroviral therapy for treatment and prevention in serodiscordant couples*. Geneva: World Health Organization, 2012. Available from: [http://apps.who.int/iris/bitstream/10665/44646/1/9789241501972\\_eng.pdf](http://apps.who.int/iris/bitstream/10665/44646/1/9789241501972_eng.pdf)
5. *Guidance for HIV Testing and Counselling (HTC) for Adolescents and Treatment and Care for Adolescents Living with HIV: Recommendations for a Public Health Approach*. Geneva: World Health Organization, 2013.
6. *Policy statement on HIV testing*. Geneva: Joint United Nations Programme on HIV/AIDS, 2004.
7. *Note on HIV/AIDS and the Protection of refugees, IDPs and Other Persons of Concern*. Geneva: United Nations High Commission for Refugees, Joint United Nations Programme for HIV/AIDS, 2006.
8. *Statement on HIV testing and counselling: WHO UNAIDS re-affirm opposition to mandatory HIV testing*. Geneva: World Health Organization, 2012.
9. *Joint Statement on HIV Testing in the Context of Resettlement*. Geneva: United Nations High Commission, Joint United Nations Programme on HIV/AIDS, International Organization for Migration, 2007.
10. *Practical Guidelines for Intensifying HIV Prevention: Towards Universal Access*. Geneva: Joint United Nations Programme on HIV/AIDS, 2007.
11. *Global report: UNAIDS report on the global AIDS epidemic*. Geneva: Joint United Nations Programme on HIV/AIDS, 2013.
12. *Consolidated Key Population Guidelines*. Geneva: World Health Organization, 2014.
13. *CRC Comment No. 3 "HIV/AIDS and the rights of the Child"*. 2003.  
Available from: <http://www.refworld.org/docid/4538834e15.html>

14. Doyle AM, et al. The sexual behaviour of adolescents in sub-Saharan Africa: patterns and trends from national surveys. *Tropical Medicine & International Health*, 2012, 17(7):796-807.
15. *March 2014 supplement to the consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection, recommendations for a public health approach*. Geneva: World Health Organization, 2014.
16. *HIV assays operational characteristics: HIV rapid diagnostic tests (detection of HIV-1/2 antibodies) Report 17*. Geneva: World Health Organization, 2013.
17. *Guide for monitoring and evaluating national HIV testing and counselling (HTC) programmes*. Geneva: World Health Organization, 2011.
18. *Post-exposure prophylaxis to prevent HIV infection: Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection*. Geneva: WHO/ILO, 2007.  
Available from: <http://www.who.int/hiv/pub/guidelines/PEP/en>
19. *Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations*. Geneva: World Health Organization, 2014. Document pending on website - July, 2014.





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