

HIV TESTING: Breaking the Deadly Cycle

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In many developing countries, uptake levels of anti-retroviral therapy (ART) remain below set targets, reflecting a vicious — and deadly — cycle of adverse events constraining access to HIV/AIDS treatment and care. This cycle starts with low demand for HIV testing and moves to the shortage of HIV testing services with established pre- and post-test counseling and then to inadequate referral to treatment facilities when an HIV-infection status is suspected or confirmed. The cycle then leads to the low capacity of these services to provide comprehensive and quality HIV/AIDS treatment and care in a sustainable and socially acceptable manner, to the failure to treat HIV/AIDS as a “normal” disease — which would encourage people to come forward for testing — and, then, back into the cycle, to the failure to generate greater demand for testing. Contributing significantly to the destructive impact of this cycle is the fact that each of these events often occurs within an oppressive atmosphere of persistent social stigma and discrimination — ensuring the continuation of this lethal cycle.

Ethical and human rights norms applied to HIV testing thus far have required that HIV testing be voluntary and confidential and both be preceded and followed by counseling and referral to a source of care if needed. To impose any biomedical test on people without their explicit, informed consent amounts to a restriction of rights. Restrictions can, of course, be justified through due process establishing that the measure taken that restricts the right is necessary and effective.

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tive and has been applied without discrimination in the interest of public health.¹ The burden of proof is on the authorities who hold legal power to enact and apply the laws needed to legitimize this restrictive action. Comparing the efficacy of “routinely practiced” versus “voluntary” HIV testing in a controlled environment would naturally necessitate a carefully designed study protocol that is respectful of ethical and human rights principles.

As treatment schemes are being rolled out, some practitioners have promoted the concept of making HIV testing a “routine” practice performed on people during their first contact with a health service or when symptoms suggest the possibility of HIV infection.² This “routine testing,” when performed without the explicit, informed consent of those subjected to the test, is carried out on the assumption that care seekers are sufficiently informed to enable them to “opt out” of the testing. In turn, this assumes that people who are about to be submitted to a test are fully informed about its systematic practice, aware of the implications of test results, able to express their objection to the testing, and free to reject the test without undue pressure or penalty applied to them by care providers. Among the motivations for practitioners to adopt this practice is their legitimate desire to scale up treatment promptly. They may also hope that greater use of testing will, in time, lead to HIV/AIDS’ being seen as a chronic, treatable condition like many others, eventually diminishing the stigma associated with HIV and stimulating demands for HIV testing more broadly.

Leaving aside other possible trivial motivations such as the anxiety of project managers fearful of failing their project targets as a result of low treatment uptake, the reality is that it is as difficult to build and sustain an effective counseling and testing capacity that engages people with the health system over time as it is to put people on a treatment regimen. Unless renewed efforts are made in the health care setting to enable people to make an informed choice about HIV tests that are about to be performed on them, systematically imposed HIV testing masquerading as a “routinely practiced HIV test with possible opting-out” remains a short-sighted public health practice with counter-productive consequences.

Emphasis has begun to be placed on a so-called strategic shift from a “client-initiated” HIV test to “care provider-initiated” HIV test. Presented as an innovative response to the low demand for HIV testing, this shift brings into renewed focus health providers’ responsibilities to offer — not impose — a test to potential users. In fact, to proactively offer an HIV test to clients in the health care setting was already the approach of choice almost 20 years ago when the global strategy on HIV/AIDS was launched by WHO. It was an early component of tuberculosis control and was further emphasized in the mid-1990s when studies established the effectiveness of chemoprophylaxis against certain other opportunistic infections. Although loaded with good intentions and great expectations, the approach yielded poor results as the expansion of counseling and testing was constrained by staff insufficiently trained in counseling competency, lack of funding, and a focus on creating discrete “VCT services” rather than VCT capacities integrated in prevention and care practices.

The approach itself was not the major factor in low HIV testing uptake, however. The problem was in its poor implementation and the fact that treatment options were few and inadequately applied. The prevention and management of opportunistic infections through the use of simple and cheap drugs, even before the advent of ARV therapy, had been shown to impact significantly on the duration and quality of life of people living with HIV. Yet, no developing country established such schemes on a national scale, and successful projects remained few and with limited outreach.

While promised access to ART therapy has changed this situation considerably, adopting the short-sighted view that the rapid introduction of ART will stimulate HIV testing, without paying appropriate attention to how the testing itself is performed, threatens to jeopardize efforts to scale up access to treatment and runs the risk of further undermining the trust of communities in health practitioners and services.

In recent months, “routine HIV testing” has begun to lose some of its popularity as a result of reported abuses and objections from community-based groups, HIV/AIDS advocacy and service organizations, as well as the UNAIDS

Reference Group on HIV and Human Rights and human rights organizations. Building or rebuilding trust to ensure that people come forward for testing and treatment requires at least three important lines of action. First, counseling and testing facilities that are responsive and sensitive to the communities served need to be scaled up. To enhance this capacity is neither easy nor inexpensive, but doing so has been shown to be highly cost-effective with potential long-term public health benefits.³

Thus far, the human and financial resources required to scale up testing that is sensitive to community concerns have been largely underestimated in national or international programs. The time has come to bring this essential element of health practice into focus.

Second, building trust necessitates ensuring that people who are diagnosed as living with HIV have access to quality care and treatment services that are responsive to their needs. Crucial to engendering trust is making sure that this is done in a manner that is sensitive to their individual, social, and cultural environments and is sustained over time.

Third, building trust requires that people diagnosed as living with HIV are protected against discrimination, not just on paper, but also in practice, and that their human rights and dignity are recognized and protected. Unfortunately, low use of HIV testing is also largely understood to result from individuals' fears of the health and social consequences of a positive diagnosis. Incidents of social rejection, loss of employment, family disruption, and violence continue to fuel these fears, as they have since the beginning of the epidemic.⁴

Until treatment can be offered consistently to those diagnosed as HIV-infected, and in the absence of effective protection against discrimination, imposing an HIV test by law — or worse, without legal backing — amounts to unsound public health practice. If mechanisms and means are in place to provide quality services and an environment protective of the rights of those who seek testing, there is every reason to expect that the voluntary demand for testing and care will grow steeply.

More efficient use of existing resources and greater investments could within a short time provide the necessary

structures, equipment, supplies, and skills to support the expansion of counseling, testing, and access to care and treatment in ways that are both effective and compliant with ethical and human rights principles.

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