

## Routine HIV-testing policies

The recommendation by Rennie & Behets in the January 2006 issue<sup>1</sup> urging policy-makers and health workers to reflect on the ethical significance of routine testing policies for people where protection against discrimination and stigma-related violence does not exist is well taken but, in certain ways, overstated.

If the testing policy outpaces our capacity to meet the stipulated or implicit ethical preconditions (strict confidentiality, informed consent, competent pre-test and post-test counselling, ensuring that human rights are protected and that negative consequences of being tested are minimized by appropriate social and institutional support services), they argue, “the claim that new HIV-testing practices have a human rights basis [or that human rights are at the heart of the policy] could fail to reflect the reality”.

If this is a correct analysis of the ethics of – using their example – Botswana’s routine offer of HIV testing, we must react conscientiously. Either the policy was irresponsibly optimistic from the beginning, and should perhaps be recalled on ethical grounds, or we must revise the stipulated ideal preconditions of the policy in order to take better account of implementation realities. (It could also be viewed as a call to service.)

Beyond the ideal preconditions stipulated in the WHO Policy Statement on ensuring a rights-based approach to routine offers of HIV testing,<sup>2</sup> which are suspected to be unevenly present if not occasionally ignored altogether in practice, Rennie & Behets are particularly concerned with the threat to human rights posed by stigma-related and gender-based violence and discrimination. In search of practical moorings and consistency, it should be noted that: (i) voluntary counselling and testing (VCT) is ethically suspect for the same reasons, since the essential factor is informed consent, or genuine voluntariness; (ii) gender-based violence is a problem quite apart from the risk associated with testing; (iii) we are morally

obliged to consider also the human rights of others who are affected by the claimed right not to know; and (iv) the effort to address the human rights-based concerns is ongoing though admittedly imperfect because it is overburdened.

Rennie & Behets also stress the need for rapid testing as well as affordable testing and availability of treatment. Because resource-poor countries are suspected to be unable to ensure social and medical infrastructures adequate for safeguarding the human rights of people seeking services, in which case the testing should not be routinely offered, it is odd to insist on quicker results to tests that they oppose in principle. Though testing should be linked to “accessible and relevant treatment,” there are other sufficiently compelling reasons to test even if antiretroviral therapy is unavailable: preventing further infection, normalizing the disease and managing the disease with alternative forms of treatment. Access to informed treatment is but one benefit of testing.

Public health policies are imperfect compromises between the moral mandate to attack the removable causes of disease and the ethical duty to protect individual human rights. Erring on the side of protecting individuals against HIV-related discrimination and threat of violence, advocates of an exceptionally vigilant human rights-based approach to HIV testing oppose the application of standard methods of disease control. Failure to apply these standard methods, it is argued, undermines society’s ability and responsibility to control the epidemic.<sup>3</sup> De Cock et al. argue that the emphasis on human rights in HIV/AIDS prevention has reduced the importance of public health and social justice.<sup>4</sup> Beyond public health and social justice, there is also the very personal issue concerning the human rights of seronegative husbands, wives, partners and neonates: these vulnerable people should be at the very heart of a sound human rights-based approach to HIV-testing policies and legislation.

Kwame Ampomah, UNAIDS Coordinator in Botswana, posed an arresting question in June 2003 in relation to the issue of “normalizing” the disease: “Has there been a case in history where a major public health catastrophe was

effectively managed and brought under control by placing individual rights above collective rights as public interest?”<sup>5</sup> Botswana’s voluntary HIV testing programme enrolment numbers are climbing, not exponentially but steadily, and health officials estimate that up to 35% of the population now know their status.<sup>6</sup>

Is it ethically obligatory to insist on human rights protections and other policy implementation ideals at all costs, even in health emergencies? Rennie & Behets worry that advocates of expanded testing “sometimes downplay the social consequences of an HIV-positive status for women and girls in low-income countries to make the policy look more attractive or at least less contentious,” and they also wonder whether certain individuals might have been channelled into testing. Though useful, this ethical thought experiment is not yet an argument: routine testing policies are hardly responsible for introducing gender inequalities, domestic abuse, stigmatization or overburdened and underfunded health clinics. While routine testing policies could conceivably exacerbate the situation in certain ways, unwittingly or unintentionally, they also raise awareness, reduce stigma, prevent transmission, expand treatment and empower individuals.

Refusing to be tested (opting out) is ethically equivalent to affirmative consent (opting in) only if the refusal is adequately informed and if the patient has sufficient liberty to say no, according to Rennie & Behets, but they would also concede that even affirmative consent in VCT may fail to meet the ethical preconditions they enumerate. Surely we need to understand more about what conditions are required to ensure that the patient has sufficient liberty not to opt out? Rennie & Behets suggest that it would be premature for us to assume that “voluntariness,” which is said to be at the very heart of routine HIV-testing policies, occurs in practice. Empowered voluntariness is elusive in any setting, be it high or low in resources; if a decision is voluntary only when one is fully and equally aware of the benefits and risks, informed consent and robust voluntariness are rare achievements in most health-care

settings. Further, whereas not opting out during a routine HIV test may demonstrate a certain disempowerment, the decision to opt out might be determined by an equally worrisome form of disempowerment or involuntariness. ■

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References

1. Rennie S, Behets F. Desperately seeking targets: the ethics of routine HIV testing in low-income countries. *Bull World Health Organ* 2006; 84(1):52-7.
2. UNAIDS/WHO policy statement on HIV testing. Geneva: WHO; 2004: Appendix 1. Available at: [http://www.who.int/ethics/topics/en/hivtestingpolicy\\_who\\_unaids\\_en\\_2004.pdf](http://www.who.int/ethics/topics/en/hivtestingpolicy_who_unaids_en_2004.pdf)
3. Frieden TR, Das-Douglas M, Kellerman SE, Henning KJ. Applying public health principles to the HIV epidemic. *N Engl J Med* 2005; 353:2397-402.
4. De Cock KM, Mbori-Ngacha D, Marum E. Shadow on the continent. 2002; 360:67-72. Available from: [www.thelancet.com](http://www.thelancet.com)
5. Botswana *Guardian* 20 June 2003; quoted in: Heald S. Abstain or die: the development of HIV/AIDS policy in Botswana. *J Biosoc Sci* 2006; 38:29-41 (e-publication 3 November 2005).
6. United Nations Office for the Coordination of Humanitarian Affairs Integrated Regional Information Network (IRIN), January 2006. Review of policies and legislation related to HIV and AIDS in Botswana available from: <http://www.bonela.bw> and <http://www.policyproject.org>

**Routine HIV testing: the right not to know versus the rights to care, treatment and prevention**

In their article “Desperately seeking targets: the ethics of routine HIV testing in low-income countries” published in the *Bulletin* in January 2006, Stuart Rennie & Frieda Behets explore some of the ethical challenges of routine (“opt-out”) HIV testing in low-income countries.<sup>1</sup> They argue that such testing policies violate human rights since patients do not have sufficient liberty to say “no”. In response, we would like to draw attention to the high unmet demand for HIV testing, share our experiences in providing routine HIV testing and counselling (RTC) and discuss the ethical balance between the

right not to know one’s serostatus and the rights to care and prevention.

HIV counselling and testing are vital: they provide an opportunity to reduce the risk of individuals becoming infected; while those who are already infected can receive care and be supported to avoid transmitting the virus. After two decades of voluntary counselling and testing, over 90% of the HIV-infected individuals worldwide are unaware of their serostatus. Only 15% of Uganda’s population has accessed HIV counselling and testing, although 70% desire to be tested. We must change our approach to challenge this situation.

RTC is not a departure from “voluntariness”, because patients can opt-out. In Mulago and Mbarara hospitals in Uganda, we have been providing RTC since 2004. Health-care providers routinely offer HIV testing to patients but emphasize their right to opt-out. Care for HIV-positive patients is initiated at the time of diagnosis. The majority of individuals offered testing (over 95%) accept and receive their results,<sup>2</sup> with over 90% reporting that they feel relieved after being tested.

Patients’ rights are emphasized throughout Rennie & Behets’s article but only in relation to opting-out of HIV testing. While all rights are important, the ethical balance between the right not to be tested and the rights to care and prevention is weighted towards the latter. Many people in low-income countries desire to be tested and would do so voluntarily if an HIV test were offered to them.<sup>3,4</sup>

Gender-related violence is common in low-income countries. However, HIV counselling and testing programmes are not the root cause of such violence. For example, in Uganda one such programme that implemented testing of couples was not associated with any increases in domestic violence.<sup>5</sup>

Rennie & Behet stress anti-retroviral therapy but do not highlight prevention and other forms of care. For HIV-infected people, knowledge of their serostatus can reduce risky sexual behaviour by 65%.<sup>6</sup> Provision of co-trimoxazole (trimethoprim–sulfamethoxazole) prophylaxis reduces HIV-related mortality by 50% at minimal cost.

Rather than discouraging use of routine HIV testing and counselling, we should find ways of addressing the issues that Rennie & Behets raise; otherwise, we will miss an opportunity to diagnose, treat and stop the spread of HIV infection. ■

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References

1. Rennie S, Behets F. Desperately seeking targets: the ethics of routine HIV testing in low-income countries. *Bull World Health Organ* 2006; 84(1):52-7.
2. Wanyenze R, Kanya M, Mayanja-Kizza H, Nawavvu C, Mayanja B, Walusimbi M et al. Routine HIV counseling and testing at Mulago and Mbarara University Teaching Hospitals: feasibility, acceptability and lessons learned. *Third International AIDS Society Conference on HIV pathogenesis and treatment*, Rio de Janeiro, Brazil, July 2005. Available at: [www.ias-2005.org/planner/Presentations/ppt/3468.ppt](http://www.ias-2005.org/planner/Presentations/ppt/3468.ppt)
3. De Cock KM, Bunnell R, Mermin J. Unfinished business — expanding HIV testing in developing countries. *N Engl J Med* 2006; 354:440-2.
4. Wanyenze R, Kanya M, Liechty CA, Ronald A, Guzman DJ, Wabwire-Mangen F et al. HIV counseling and testing practices at an urban hospital in Kampala, Uganda. *AIDS Behav* 2006;10:361-7.
5. Apondi R, Bunnell R, Awor A, Wamai N, Bikaako-Kajura W, Solberg P et al. Home-based antiretroviral care is associated with positive social outcomes in a prospective cohort in Uganda. *Fourth Uganda AIDS Conference*, April 2005.
6. Crepez N, Hart TA, Marks G. Highly active antiretroviral therapy and sexual risk behavior: a meta-analytic review. *JAMA* 2004;292:224-36.

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