

Provider-initiated testing and counselling for HIV – from debate to implementation

A policy space for expanded HIV testing

Recent statements by the new Minister of Health about 'mass voluntary counselling and testing (VCT) campaigns', and references in the latest draft VCT policy to 'provider-initiated VCT', suggest that a policy space is opening up in South Africa for the expansion of HIV testing models beyond the current VCT approach. The existing VCT programme is showing some successes. For example, the Human Sciences Research Council (HSRC) has reported a dramatic increase in the number of 15 - 48-year-olds who report awareness of their HIV status, from 11.9% in 2005 to 24.7% in 2008.¹

Despite increased testing rates and willingness to test, most HIV-positive people do not know their status, do not consider themselves at risk and do not self-initiate testing, even with widespread awareness of and access to VCT services.^{2,3} Barriers associated with VCT uptake include clients having to initiate testing themselves, lengthy pre- and post-test counselling, implementation barriers (organisational management, supervision, human resource and infrastructure limitations), and patient concerns about confidentiality.^{4,5}

Possible strategies for expanding HIV testing include 'provider-initiated HIV testing and counselling' (PITC)⁶ – also referred to as 'opt-out' HIV testing or 'routine offer of HIV testing' – and broad-based testing approaches such as 'mass VCT' campaigns, mobile VCT services, community- and home-based HIV testing initiatives and self-testing.

Provider-initiated HIV testing and counselling: benefits and concerns

In PITC, health providers offer HIV testing to all patients in medical settings, irrespective of their presenting complaint. Patients have the choice to opt out. If they choose to test, informed consent is confirmed verbally (written consent is only obtained if this is a requirement of the health authority) and the rapid test is done immediately. Lengthy pre-test counselling is not a requirement. Post-test counselling is focused on ensuring that patients understand the test result and prevention messages, helping them cope with the associated emotions, and making follow-up arrangements for clinical care, support and prevention services.⁶

The World Health Organization (WHO), the Joint United Nations Program on HIV/AIDS (UNAIDS) and the Centers for Disease Control (CDC) now recommend PITC as a streamlined and cost-effective HIV testing approach to rapidly and massively increase HIV testing rates in medical settings.⁶ The model has a number of advantages. PITC increases HIV testing rates across a range of high-, middle- and low-income settings with absolute increases varying from 5% to as high as 50% (baseline testing rates varied from 6% to 75%).^{4,6,7} Patients also broadly find PITC acceptable, and sometimes preferable to VCT.^{7,8} In South Africa, PITC addresses some health system barriers to testing such as the availability of counsellors and counselling rooms. Finally, PITC potentially normalises

HIV testing for patients and staff, by integrating testing and associated HIV care into standard clinical practice.

PITC can increase HIV testing rates in the South African setting. South African-controlled trials on PITC-type approaches showed significant increases in testing rates compared with VCT (14% in tuberculosis patients⁹ and 13.8% in sexually transmitted infection (STI) patients¹⁰), and a quasi-experimental study showed increased HIV case detection among hospital outpatients.¹¹

The PITC approach raises concerns around informed consent, counselling support, staff workload and access to care for the increased numbers who test positive.^{4,5} The main ethical concern is that testing, especially in resource-constrained settings, will become coercive owing to unequal power relations between patients and providers.^{4,5} The PITC trial with STI patients in Cape Town showed that PITC was feasible to implement in a low resource-setting and that it could be implemented ethically. A proportion of patients who were offered the HIV test by nurses were able to decline testing (26.7% versus 13.5% for VCT), providing indirect evidence of patients exercising their right to decline testing, an indirect marker of the ethical implementation of PITC.¹⁰ Qualitative investigation of informed consent practices found that nurses could apply the basic requirements of informed consent and that patients experienced the testing as voluntary and acceptable.¹²

Recommending PITC

We therefore recommend PITC as an effective, ethical and acceptable method for increasing HIV testing rates in South Africa. However, PITC cannot be the only solution to expanding HIV testing, and there are challenges that will limit its impact and scope. Firstly, the increase in testing rates is not always dramatic. The absolute increases of around 14% (compared with VCT) in the two South African studies are significant but not sufficient to address low testing rates overall. Secondly, although the benefits of early diagnosis and early access to care are known, there are substantial gaps in access to care for those testing HIV positive.¹³ More effort is required to pro-actively link the increased numbers of HIV-positive patients diagnosed through PITC, and more monitoring is required to evaluate this. Finally, PITC implementation faces the same health systems barriers that confront VCT and all other clinical services (organisational, management and human resource difficulties).

Focusing on the ethical implementation of PITC

Maintaining the correct balance between 'normalising' HIV testing and ensuring its continued ethical application is most critical. PITC is not inherently coercive, and we found that it can be performed ethically in a low-resource, primary health care setting, but this does not mean that there is no risk of unethical testing behaviour (such as coercion), especially if

PITC is up-scaled rapidly.^{4,5,8,10,12} Patients' rights are often not well protected in the South African public health service and patients are frequently not empowered to exercise their rights. For example, the PITC study among STI patients in Cape Town, where patients found the service to be both voluntary and acceptable, also showed that from an observer's perspective there was a spectrum in the ethical practice of nurses. For instance, some nurses were more explicit about and facilitative of the patient's right to refuse than others.¹²

The increasing normalisation of HIV testing – whether through PITC or other strategies – requires greater caution to ensure that patients' rights are protected, especially in settings where patient autonomy and participation in decision-making are not strongly embedded. However, debates around unethical practices and PITC should focus on implementation challenges rather than on the inherent qualities of PITC. The task is to balance the 'exceptionalising' impulses (e.g. where HIV testing is a parallel health service with exceptional requirements for test readiness and consent) and the 'normalising' impulses around HIV testing in a way that results in ethical, effective, efficient and sustainable services. The respect for patient

autonomy that is a strong feature of the current VCT approach would be continued by strategies such as brief provider training on PITC that emphasise the importance of ensuring patient informed consent, together with maintaining the requirement for separate written consent. At the minimum, patients need to know the purpose and benefits of HIV testing and that they have the right to refuse testing, and health providers need to know how to motivate for HIV testing, to appreciate the importance of the patient's informed consent, and to convey a HIV-positive result in a supportive manner. Health providers will also need guidance on how to integrate HIV testing and follow-up care efficiently into routine care. If we use this pro-active and inclusive approach to HIV testing, service users (and service delivery) will benefit from increased HIV testing in medical settings and from the associated opportunities for increased and early linkage to HIV care, treatment, and prevention services.

Competing interest. The authors declare that they have no competing interest.

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