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Good and Bad Sides of HIV Voluntary Counseling and Testing

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When people who are inexperienced in the subject read about voluntary counseling and testing for HIV in Malawi, they are usually amazed at how far the intervention programs have gone and how many people have been tested. There should be no doubt on the success of HIV prevention, and support and mitigation programs on the African continent. A country like Malawi, with an estimated 1 million of the 13 million population infected with the virus, has so far enrolled 250 000 people in its HIV treatment programs. Knowledge on HIV and AIDS is almost universal among adults. This is certainly a major achievement for a nation that has lost a considerable number of its nurses via emigration to developed nations and was among the 10 poorest nations in the world until 2004, when it became the second fastest growing economy in the world.

What does voluntary counseling and testing actually entail in practice? The answer is simple: many things. Its basic tenet, however, is that individuals, couples, or families choose to be tested for HIV without being forced by anyone or any circumstance. It is assumed that the people who choose to be tested will then go on to make better choices, whether they are found to be HIV infected or not. In the case of treatment, it is often believed that individuals who are tested positive for HIV will also make the decision to be assessed by a trained clinician to evaluate if they are eligible for antiretroviral therapy.

For non-governmental organizations and many African governments, the focus is to raise the number of tests among people who present for HIV counseling and testing. Often, there is no meaningful effort to find out who the people presenting for testing are, why they are coming, or what lifestyles they lead. To be fair, there are several articles on the profiles and subsequent reported sexual and other behaviors of people who had received HIV testing. However, these data are from people who presented for testing in surveys or local rather than national programs. The data obtained within such limited context, though valuable, may not be representative of the whole country or even just parts of the country. Also, individuals participating in surveys may not be representative of persons presenting for routine HIV testing in voluntary counseling and testing programs.

I have no information that voluntary counseling and testing is offered anywhere under non-voluntary conditions. The counseling part is variable and so is the testing. Many testing programs use antibody-based test kits, meaning that only individuals who have been infected for 6 or more weeks may test positive. Those people who have a more recent infection (acute infection) will be missed by these tests. Tests based on the RNA or other HIV antigens will be required to detect acute HIV infection. This means that the majority of HIV voluntary counseling and testing does not have the capability to detect HIV infection when the viral load is very high but antibodies are still undetected. Individuals with acute HIV infection are especially likely to transmit infection if they engage in high-risk sexual and other risk behaviors with HIV uninfected but susceptible individuals.

The HIV testing units that I know of operate using the simple biomedical model of practice and with little regard to public health interest. The person coming in for testing is, rightly or wrongly, treated as an autonomous individual, with no consideration to any other people with whom he or she may have shared "body fluids." Tracing individual's sexual and injecting drug use contacts is, in general, not a feature of many of the voluntary counseling and testing programs in southern Africa and other resource-limited settings. Secondly, testing is largely anonymous. This is intentional, as a way to encourage more people to present at the testing. Since testing is anonymous, it is not clear how many people have been tested once or more times. The numbers from national HIV testing programs, therefore, show people who have been tested for the first time and those tested for an n-th time. We could argue that for

people who have been tested negative once, having a repeat test is a good idea. After all, antibody-based tests are used for the majority of the testing programs and these are largely unable to detect a recent infection. An individual, therefore, with a recent HIV infection and a negative HIV test may test positive at a subsequent test. Again, it does not really matter whether an individual has been tested once, twice, or many times. As long as each test facilitates their making responsible decisions, then our goal is attained. Although such thinking may be justified, we may be fooling ourselves if we concluded that the reach of services was improving only based on the data from national anonymous programs.