Practicing provider-initiated HIV testing in high prevalence settings: consent concerns and missed preventive opportunities

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Abstract:

Background: Counseling is considered a prerequisite for the proper handling of testing and for ensuring effective HIV preventive efforts. HIV testing services have recently been scaled up substantially with a particular focus on provider-initiated models. Increasing HIV test rates have been attributed to the rapid scale-up of the provider initiated testing model, but there is limited documentation of experiences with this new service model. The aim of this study was to determine the use of different types of HIV testing services and to investigate perceptions and experiences of these services with a particular emphasis on the provider initiated testing in three selected districts in Kenya, Tanzania, and, Zambia. Methods: A concurrent triangulation mixed methods design was applied using quantitative and qualitative approaches. A population-based survey was conducted among adults in the three study districts, and qualitative data were obtained from 34 focus group discussions and 18 in-depth interviews. The data originates from the ongoing EU funded research project “Response to Accountable Priority Setting for Trust in Health Systems” (REACT) implemented in the three countries which has a research component linked to HIV and testing, and from an additional study focusing on HIV testing, counseling perceptions and experiences in Kenya. Results: Proportions of the population formerly tested for HIV differed sharply between the study districts and particularly among women (54% Malindi, 34% Kapiri Mposhi and 27% Mbarali) ($p < 0.001$). Women were much more likely to be tested than men in the districts that had scaled-up programmes for preventing mother to child transmission of HIV (PMTCT). Only minor gender differences appeared for voluntary counselling and testing. In places where, the provider-initiated model in PMTCT programmes had been rolled out extensively testing was accompanied by very limited pre- and post-test counselling and by a related neglect of preventative measures. Informants expressed frustration related to their experienced inability to ‘opt-out’ or decline from the provider initiated HIV testing services. Conclusion: Counselling emerged as a highly valued process during HIV testing. However, counselling efforts were limited in the implementation of the provider-initiated opt-out HIV testing model. The approach was moreover not perceived as voluntary. This raises serious ethical concerns and implies missed preventive opportunities inherent in the counselling concept. Moreover, implementation of the new testing approach seem to add a burden to pregnant women as disproportionate numbers of women get to know their HIV status, reveal their HIV status to their spouse and recruit their spouses to go for a test. We argue that there is an urgent need to reconsider the manner in which the provider initiated HIV testing model is implemented in order to protect the client’s autonomy and to maximise access to HIV prevention