

ROUTINE HIV TESTING: A View from Botswana

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Following an announcement in October 2003 by President Festus Mogae, routine testing for HIV (RHT) was introduced in Botswana in January 2004. It was assumed that RHT would reduce the stigma associated with the “exclusivity” of HIV testing, enable earlier testing, allow more timely access to treatment, and ultimately reduce the rate of infection.¹⁻³

Botswana’s first year of RHT has shown an increase in the accessibility of HIV testing and, consequently, in the number of people who have chosen to test. For RHT to be implemented in a manner that makes this increase meaningful, however, it needs to be positioned within a well-designed strategy, including timely and thorough training in the health care sector. Although RHT was introduced in January 2004, guidelines were not introduced until the end of February; and at the beginning of 2005, both the training of health care practitioners and the development of training materials were still ongoing. Anecdotal reports and consultation with medical practitioners indicate that there is still confusion around key issues such as who should be offered RHT, what information or counseling should precede testing, and — most worrisome — what constitutes informed consent in the RHT context. The concern raised prior to the announcement of RHT that the “concepts of compulsory, routine, and mandatory testing have been used interchangeably” also continues to be reflected in anecdotes relating to the differences in how testing is handled at different testing sites.⁴ These reported inconsistencies indicate

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a need for a broad-based public education campaign, which ideally should have preceded the introduction of RHT.

While the human rights of life and health are the principle rights cited as justifying routine testing, the right of autonomy is the most frequently cited concern with regard to its implementation.^{5,6} In the case of implementation of RHT in Botswana, it was decided that “standard” pre-test counseling would not be required and that pre-test information, including “public service announcements, group sessions, [and] videos,” would be acceptable alternatives.⁷ Consent also reversed from an “opt-in” system in which patients indicate that they want to test, to an “opt-out” system in which patients must indicate that they do not want to test. Major concerns exist, however, that pre-test education, in some instances limited to written or audiovisual material, in combination with an “opt-out” policy in a culture where patients are generally uncomfortable declining the recommendation of a medical practitioner, may not meet the threshold of informed consent.

If the end goal of RHT is to test a larger proportion of the population, it has succeeded. Ultimately, however, the objective should be improved public health, including a lower rate of infection and greater rates of participation in and adherence to the national anti-retroviral (ARV) program. Too often, it is stated that testing alone will cause positive behavioral changes that will result in these goals. There is nothing magical, however, in the act of drawing blood and testing it for antibodies. Behavioral change is the product of understanding and ownership of one’s health and a sense of responsibility to protect the health of others. These changes occur not from the act of testing blood, alone, but from the pre-test counseling, the information given, and the informed and voluntary consent that accompany them. For RHT to be successful in Botswana and elsewhere in its public health goals, it must not dilute the participation of patients in their own health care or neglect individuals’ rights to autonomy, dignity, and information.

References

1. P. Mazonde, Ministry of Health, *HIV Testing from a Public Health Perspective* (Presented at a seminar on "Routine or Compulsory Testing in Botswana?" convened by the Botswana Lawyers' Taskforce on HIV/AIDS and the Botswana Network on Ethics, Law, and HIV/AIDS [BONELA].) (Gaborone, Botswana, September 13, 2003).
2. Ministry of Health, *Guidelines on Routine HIV Testing* (Gaborone, Botswana: February 29, 2004), p. 6.
3. Dr. Mazonde commented that RHT was necessary to prevent a "health crisis" and to "arrest the spread of infection." (See note 1).
4. *Routine or Compulsory Testing in Botswana?* Seminar Report, Botswana Lawyers' Taskforce on HIV/AIDS and BONELA (Gaborone, Botswana, September 13, 2003).
5. Mazonde (see note 1); Landman, *Ethical Considerations in Testing for HIV/AIDS*; B. Mguni, *HIV Testing from a Government Lawyer's Perspective* (Presented at "Routine or Compulsory Testing in Botswana?" convened by the Botswana Lawyers' Taskforce on HIV/AIDS and the Botswana Network on Ethics, Law, and HIV/AIDS [BONELA].) (Gaborone, Botswana, September 13, 2003).
6. Landman (see note 5). D. Boko, *HIV Testing from a Human Rights Perspective* (Presented at "Routine or Compulsory Testing in Botswana?" convened by the Botswana Lawyers' Taskforce on HIV/AIDS and the Botswana Network on Ethics, Law, and HIV/AIDS [BONELA].) (Gaborone, Botswana, September 13, 2003).
7. See note 2, p. 8.