



## Expansion of HIV counseling and testing strategies: technical challenges and ethical-political tensions

Ampliación de las estrategias de consejería y prueba del VIH: desafíos técnicos y tensiones ético-políticas

**Mora Cárdenas**, Claudia Mercedes<sup>1</sup>; **Monteiro**, Simone<sup>2</sup>; **Moreira**, Carlos Otávio Fiúza<sup>3</sup>

<sup>1</sup>Psychologist. PhD in Public Health, Escola Nacional de Saúde Pública, Fundação Oswaldo Cruz, Brazil. claudiamoraca@hotmail.com

<sup>2</sup>Psychologist. Postdoctorate in Public Health. Researcher in Public Health, Head of Laboratory of Environment and Health Education, Instituto Oswaldo Cruz, Fundação Oswaldo Cruz, Brazil. msimone@ioc.fiocruz.br

<sup>3</sup>Bachelor's Degree in Philosophy. PhD in Education. Professor and Researcher in Public Health and Education, Department of Social Sciences, Fundação Oswaldo Cruz, Brazil. otavio@ensp.fiocruz.br

**ABSTRACT** Incentives to provide universal access to antiretroviral therapy in order to control the HIV/AIDS epidemic also encouraged the diversification of HIV testing strategies, as demonstrated by the simultaneous existence of Voluntary Counseling and Testing (VCT) and Provider-Initiated HIV Testing and Counseling (PITC). This paper analyzes the concepts, principles and implementation of the VCT and PITC models regarding counseling, confidentiality and informed consent in Brazil and other countries, based on a literature review of works in the Lilacs, Medline, Sociological Abstracts and Cochrane databases published between 2000 and 2013. According to the literature, PITC increases rates of testing in comparison with VCT, but reduces sexual and reproductive rights and the autonomy of users. These findings suggest technical challenges and ethical tensions between the paradigm of *exceptionalism* and the *normalization* of HIV testing. The necessity to reconcile increased access to HIV tests with the local capacity to offer comprehensive care for people living with HIV/AIDS is highlighted. It is recommended that interdisciplinary studies about the social effects of VCT and PITC be amplified.

**KEY WORDS** AIDS Serodiagnosis; Informed Consent; Confidentiality; Directive Counseling; Review.

**RESUMEN** Los incentivos en el acceso universal a la terapia antirretroviral para el control del VIH-sida, estimularon la diversificación de los modelos de testeo del VIH, que se expresa en la coexistencia del *Voluntary Counseling and Testing* (VCT) y *Provider-Initiated HIV Testing and Counseling* (PITC). Este artículo analiza los conceptos, los fundamentos y la aplicación de los modelos VCT y PITC con respecto a la consejería, la confidencialidad y el consentimiento informado en Brasil y en otros países, a partir de una revisión de la bibliografía en las bases Lilacs, Medline, Sociological Abstracts y Cochrane, publicada entre 2000 y 2013. Según los estudios, el PITC aumenta las tasas de testeo en relación con el VCT, pero reduce los derechos sexuales y reproductivos y la autonomía de los usuarios. Estos resultados señalan los desafíos técnicos y las tensiones éticas entre el paradigma de la *excepcionalidad* y la *normalización* del test. Se destaca la necesidad de conciliar el aumento en el acceso al examen con la capacidad local de cuidado integral a las personas que viven con VIH-sida y se recomienda ampliar los estudios interdisciplinarios sobre los efectos sociales del VCT y PITC.

**PALABRAS CLAVES** Serodiagnóstico del SIDA; Consentimiento Informado; Confidencialidad; Consejo Dirigido; Revisión.

## INTRODUCTION

Over the past ten years the offering of HIV testing has been extended, in line with the commitments made by the United Nations General Assembly Special Session on HIV/AIDS (UNGASS) (1) and thanks to the increased availability of antiretroviral therapy (ART) and the financing of national HIV/AIDS programs, in addition to the possibility of using the treatment as prevention. This situation has promoted the diversification of testing strategies, with two predominant models currently available. One of them, designed in the 1980s, is known as Voluntary Counseling and Testing (VCT) or Client-Initiated HIV testing and Counseling (CITC) by the World Health Organization (WHO) (2). This strategy, hereinafter referred to as *voluntary testing*, seeks to respond to spontaneous user demands regarding their serologic status in services specialized in testing and counseling for HIV and other sexually transmitted infections (STIs). The other model, recently developed in the field of general health services, is called Routine Counseling and Testing (RCT) by the Centers for Disease Control and Prevention (CDC) (3) or Provider-Initiated HIV Testing and Counseling (PITC) by the WHO (4). This model will be referred to as a *diagnostic test*.

The concomitance between voluntary testing and diagnostic test models has raised an international debate founded on two different technical and ethical-political positions. The first position refers to the preservation of the *paradigm of exceptionalism* in the test to detect HIV, which based in the principle of autonomy and human rights seeks to promote preventive actions through counseling and testing. The second position refers to the *normalization of testing*, valuing the collective benefits derived from the access to treatment to the detriment of certain rights like individual autonomy (5).

Faced with the importance of this debate in the planning of STI and HIV/AIDS control and prevention programs, this paper sought to describe the voluntary testing and diagnostic test models with an emphasis on the manner in which the principles of *counseling*, *confidentiality* and *informed consent* have been conceived, based

on a review of international and Brazilian literature. The diversification of the testing strategies within a national context is exemplified through an analysis of studies and discussions developed in Brazil.

## METHOD

The literature review followed the *scoping review* method (6), focused on the mapping of studies on the diversification of HIV counseling and testing strategies and human rights without prioritizing any specific methodological approach. As the process analyzed has occurred over the last decade, the information gathered from the articles published in the Lilacs, Medline, Sociological Abstracts and Cochrane of Systematic Reviews databases included the 2000-2013 period. The search terms used in each database were the following: "AIDS," "counseling," "ethics," "HIV diagnoses," "HIV screening," "routine testing," "PITC," "VCT," "voluntary testing and counseling," "human rights." Based on the combined used of these terms, 105 references were found. Taking the HIV testing strategies as selection criteria, and after reading all the references, 38 works (Lilacs [5], Medline [18], Sociological Abstracts [14], and Cochrane [1]) were finally selected. This study was complemented by a manual search within the bibliographical references cited in the selected articles, international (UNAIDS, CDC) and Brazilian recommendations (Ministry of Health of Brazil), and chapters from international and Brazilian books on HIV testing strategies principally distributed in Brazil and the USA. From this search, 29 additional studies on the subject were found.

The interpretation of the arguments present in the 67 selected works (38 from the databases and 29 from the additional search strategies) was organized into three themes for analysis. These were: 1) the objectives and impact of and the adjustments to voluntary testing and diagnostic test strategies; 2) the consensuses and controversies arising from the conceptions of *counseling*, *confidentiality* and *informed consent* in each model, and 3) the expansion of HIV testing in Brazil.

## RESULTS

### Counseling and voluntary testing: objectives, impact and adjustments

Industrialized and developing countries adopted the voluntary testing strategy approximately twenty years ago. Considering the social circumstances of users, the model is based on the premise that voluntarily seeking out the diagnosis, along with the option of counseling, will stimulate reflections regarding the prevention of STIs and HIV/AIDS and will encourage adherence to comprehensive health care in those living with HIV/AIDS (7).

This strategy has two complementary stages: the *pre-test*, which consists of a conversation between a counselor (a health care provider, community health agent or person living with HIV/AIDS) and the user, where risk behaviors, the possible test results and their consequences are discussed. This stage includes the use of *informed consent*, which guarantees the user confidentiality and offers an explanation of the risks (physical, social and emotional effects) and benefits of having the test done. The user is entitled to give or refuse his/her consent. The result is delivered in the *post-test* stage in which a professional offers emotional support to the user and discusses the most appropriate risk-reduction strategies. In the event of a positive diagnosis, the counselor may provide guidance to the user regarding communicating the test results to relatives or sexual partners and refer the user to other available health services if necessary (8).

The bibliography that discusses the effects of the voluntary testing strategy reports increased use of condoms, principally among HIV-positive people and serodiscordant couples (2,7,9), as well as a decreased number of sexual partners among patients treated by VCT services (2). However, among women, barriers are observed in negotiating the use of condoms and in sexual decision-making, in both stable heterosexual relationships and sexual intercourse in exchange for goods or money, associated with power inequalities in gender relations (7,9). Studies conducted on the acceptability of and access to voluntary testing in young people indicate that the guarantee of confidentiality added to the communication of test results to relatives are important in this group's adherence to these types of health services (7).

Some authors discuss limitations in evaluating the effectiveness of the voluntary testing strategy, on account of the different instruments used in the studies conducted (7), the imprecision of the indicators (2), and the lack of measurements that allow for more precise comparisons of the positive or negative effects of preventive actions such as VCT, marketing of condoms and peer counseling (10). Considering the lack of debate regarding the primacy of "behavioral changes" as an indicator of the efficacy of these actions, certain authors suggest widening of the scope of expected results, for example to the prevalence of STIs and HIV/AIDS in communities (11), and the inclusion of changes in the internal organization of health care services and the types of counseling approaches offered in impact studies on voluntary testing (2).

Another important aspect refers to the moral and ethical implications of counseling and difficulties associated with the context of the health care services. This perspective is illustrated in an analysis of the interpretation and application of international guidelines among Malawi counselors (12), as well as in a research study conducted in Kenya on the potential emotional, physical and sexual abuse in the VCT service environment, which reflects the gender inequalities existent in that region (13).

The bibliography indicates that one of the main reasons inhibiting test demand is associated with processes of stigma and discrimination reproduced in health care services and in socio-affective relationships (22-25).

As regards the need to make adjustments in the voluntary testing strategy, a set of references describes new modalities that seek to reduce structural and subjective barriers to access, promote positive attitudes towards taking the test, and minimize its negative consequences; these include home-based testing (14,15) and the combination of mobile HIV testing with community mobilization (16). Within this scenario of technical efforts, the participation of pregnant women in the voluntary testing strategy is highlighted due to the effectiveness of prevention of vertical and horizontal transmission of HIV, syphilis and other STIs (17). To mitigate the negative effects of diagnosis in women and to reinforce the relationship in serodiscordant couples, new testing units for couples have been incorporated into prenatal services

(18). The initiative is related to the consequences arising from the disclosure of the diagnosis in women from low-income countries in situations of gender, economic or social inequality, such as physical or sexual violence, abandonment or rupture of affective relationships (19-22).

In accordance with health principles based in human rights, some research studies suggest that the future evaluations of testing programs focus on the criteria of the availability, accessibility, acceptability, quality and scope of the results obtained in population groups according to different regional contexts (26). Regarding the importance of pre-test counseling and informed consent, the research studies also suggest producing evidence regarding the duration and quality of adequate counseling services to guarantee that users' decision-making will be autonomous and voluntary (27).

### Diagnostic test: objectives, impact and adjustments

A systematic review of the diagnostic test in low- and middle-income countries illustrates the diversification of the offering of testing by health care services, such as family planning, prenatal, obstetric, and pediatric care, tuberculosis prevention and care, and STI treatment including methadone maintenance therapy (28). This wider approach to testing is based on routine testing models (RCT) (3) and on the counseling and testing strategy initiated by health care professionals (PITC) (4). Both models consider the benefits of early access to ART in terms of individual well-being and reduced HIV virus transmission.

Within the framework of RCT, it is argued that pre-test counseling and informed consent represent barriers to the test and increase user anxiety (3). Based on the criticisms the RCT initiative received, given that *test normalization* reflects a less complex approach to the epidemic, the PITC model recommendations underwent ethical-political debates among academics, activists and organizations such as the Human Rights Watch in an attempt to reconcile text expansion with the WHO/UNAIDS commitment to human rights (5). With respect to informed consent, the recommendations consider two different approaches: *opt-in*, which consists of the verbal or written consent of

the users, especially among the most vulnerable communities; and *opt-out*, applied in health care service users from countries with a generalized epidemic, unless users express their disagreement. A few basic pieces of information to be provided to participants before being tested were also defined, such as the clinical and preventive benefits of the test, health care referral services and the right to reject the test (4).

The research studies indicate that the diagnostic test models (RCT and PITC) are strategically relevant to progress in the early detection of infection and the start of treatment, and therefore in reduced AIDS mortality. Apart from contributing significantly to increased test coverage, there is evidence that the diagnostic test positively impacts patient's preventive practices (reduction in the number of sexual partners and increased use of condoms). However, negative impacts are also observed (discontinued use of contraceptive pills). Faced with heterogeneous results and a reduced counseling process, caution in the implementation of diagnostic tests on a large scale is suggested (28).

In relation to the impact obtained, a set of articles deals with the role of health care professionals in the implementation of the diagnostic test. Due to the communicative limits and moral biases involved in the evaluation of user risk, a research study conducted in Vietnam highlights the pertinence of recommending the test to all those who attend health services (29). In other contexts, it was observed that acceptance in pregnant women was related to more emphasis placed on the benefits to the fetus and less questioning regarding moral aspects related to the women's sexual history (21).

Other texts describe the ethical and legal aspects of routine testing in the USA and the potential contradictions between CDC recommendations and constitutional principles, such as the right to privacy, state laws and the professional code of practice, among others. This discordance is considered to reduce the principle of justice and equality with respect to performing the HIV diagnosis (30). According to another study, emergency services professionals consider it important to discuss the ethical and preventive implications of routine testing. The search for a balance between users' wishes and needs is another aspect to be examined (31). Furthermore, in relation to the role

of nursing professionals in sub-Saharan Africa, it is suggested that in order to comply with the objectives touted in the diagnostic test strategy, the conditions for training and work processes organization must be guaranteed (32).

Other research studies, developed in African and Asian countries and in the USA, show that the decision to use the routine testing strategy derives from the evaluation of the epidemic circumstances (generalized or concentrated), from local beliefs attributed to the fact of living with the HIV virus, and from questioning the universality of values essential to the paradigm of *exceptionalism* (33). Studies on the implications of implementing prenatal diagnosis were also found in the countries mentioned above. Although mandatory HIV testing has not been connected to CDC or WHO/UNAIDS recommendations, authors explain that these tests (either explicitly or implicitly), apart from reinforcing discrimination, stunt such irrevocable rights as the right to privacy and the right to dignity (24,34,35).

In summary, although the implementation of diagnostic test policies have not interfered with users returning to health services, as observed in Uganda, Democratic Republic of Congo and Botswana (21), reservations exist regarding the potential individual and collective benefits of diagnostic testing, considering its inconsistency with respect to human rights and impact on the reduction of new infections (11-20). It is highlighted that the systematic offering of the test must correspond with ART and comprehensive health care availability (11), given that limited support (social, psychological, and care-related aspects) may put diagnostic testing objectives at risk both in terms of adherence to treatment and in terms of the general wellbeing of people living with HIV/AIDS (36).

## Research arising from the coexistence of voluntary testing and the diagnostic test

### *Updating the paradigm of exceptionalism or promoting the normalization of the test?*

The value placed in voluntary testing (paradigm of exceptionalism) is based on the offer of counseling and its contribution to the prevention of

HIV transmission. The contemplation of individual and sociocultural characteristics reinforces the confidence of HIV seropositive people in ART and contributes to voluntary testing being perceived as sensitive and responsive to communities, with long-term benefits (37). However, the impact of voluntary testing depends on the quality of health care services. Providing care in cases of spontaneous demand through the administration of a test, in health care systems with scarce resources, is restricted by structural conditions (limited time and facilities, overworked professionals and inadequate training to provide appropriate care to the most vulnerable communities) as well as limited in its actions (motivation of professionals and the value placed in professional practice) (21,37,38). In addition to improving counseling quality and diversifying healthcare services, it is also important to promote diagnosis and other preventive strategies (19,20).

Additionally, because of inadequate control of the epidemic in Africa, a type of test aligned with the paradigm of *normalization* was proposed in 2002 (39). From that perspective, priority is given to diagnostic efforts in women who are pregnant or lactating, STI carriers, and so on, and universal testing to all healthcare service users (40). Prevention and care efforts are based on the serological status of individuals, notifying sexual partners and widespread dissemination of HIV/AIDS-related information.

The differences between the two scenarios described, due to the different weight assigned to individual autonomy and the protection of collective interests, lead to reflections on the relationship between ethics and public health. A study that analyzes the right to privacy (41) as the basis for AIDS prevention considered that the guarantee of individual and collective interests should bring together the principles of human dignity and equality, articulating apparently opposing interests such as communal vs. liberal or autonomy vs. justice. The author reiterates that the concepts of voluntary and consensual in the HIV test are based in the principles of equal respect for life (principle of non-maleficence) and equal opportunities (principle of justice) (41). However, a critical review of the implications of the two types of tests (42) discusses whether it is possible to formulate policies based on a universal proposition

that balances individual and collective interests, showing the potential contribution studies on population and public health ethics might have in addressing this issue.

Within the framework of the existing strategies, there are voids when it comes to guaranteeing the principles of equality and justice in the access of the most vulnerable populations to the test. The scope of the diagnostic test is relative to the degree of accessibility of the different social sectors to the health care system as a whole, and the variations in seeking care according to gender, class, generation, among other social markers, even within relatively homogeneous conditions of access (37).

The debate around re-updating the paradigm of *exceptionalism* or shifting towards the *normalization of the test*, largely sustained by moral arguments that praise or criticize each view, may be better clarified by theoretical and empirical advances that support an ethical framework aligned with individual and collective interests (42).

#### ***Separating the HIV test from prevention?***

The fragmented conception of counseling in the diagnostic test model reduces the possibilities of promoting and maintaining care and prevention efforts in the long term (37,43) and limits the expression of the subjective and objective implications of test results (44). Those limits are related to the context of practices, to the extent that in the clinical environment individualizing actions are prioritized and rarely do professionals take into account the users' interpretation of the information provided. Therefore, it is expected that key issues in connection with STI or AIDS prevention, such as sexuality or drug use, will likely not be addressed in depth (19). Thus, the importance of counseling in prevention as opposed to the mere act of performing a test is highlighted.

The *opt-out* approach has been criticized due to its legal, ethical and clinical implications (30,45). The justification for this approach has been questioned as it has been shown that the elimination of counseling and informed consent does not in fact help to reduce user anxiety (27). Mass prevention of new infections through the early commencement of treatment has also been questioned since in the period of highest infectivity

(eight weeks after having been infected with the virus) seeking prevention through the exam is not frequent and people living with HIV may continue with their sexual activity (protected or not) (19). At the same time, the offering of pre-test counseling in a primary health care context is valued, and it is suggested that this procedure become optional in order to respect participant autonomy (46). However, this point of view is not unanimous; another author considers that in gynecological and sexual and reproductive health care services, counseling should be done systematically (47).

The virtual separation of the HIV test from counseling and the emergence of new preventive technologies stimulate the reformulation of STI and AIDS prevention strategies and therefore the discourse on sexual health care.

#### ***What implications do the diagnostic test models have for sexual and reproductive rights?***

In the diagnostic test model autonomy in the acceptance of the test is relativized due to factors such as scarcity of services, user submission to the authority of health professionals, and social inequality in general (5,28). In addition, the mere recommendation to get tested may promote the idea that tests are mandatory or subject to medical prescription (36,47). Broadly speaking, the reproduction of practices of care and prevention that reduce the rights and responsibilities of both health professionals and users may be extended to other health care practices, contradicting a principle of clinical practice: the participation of patients in their therapeutic plan (48,49).

Within the context of reproductive and sexual health policies, some countries such as Great Britain and Brazil included the offer of HIV testing as part of prenatal care, under the principle of the test being voluntary. Taking into account the implications of early detection of the virus in pregnant women, some authors highlight the importance of managing this population through the *opt-out* approach (40,50). Others, conversely, state that the adherence of the female population to actions for reducing the vertical transmission of the virus depends on the approach and acknowledgement of the rights to autonomy, body integrity, non-discrimination and privacy (48). Global networks of people living with HIV-AIDS claim that coercive

actions lead to pregnant women not returning to seek care, interruption of treatment and delays in the diagnosis of newborns (22).

Another significant point in the bibliography is the right to the confidentiality of the information and to the consent of the person before communicating the diagnosis to his/her partner (51). As professionals do not know about these rights, inappropriate revelations of the diagnosis within the clinical context is possible (30). Additionally, perspectives in connection with AIDS prevention based on the right and responsibility to take care of one's sexual health and that of one's sexual partners suggest testing among partners as a protective measure (52). This situation can contribute to the criminalization of vertical and horizontal HIV exposure and transmission, in contexts of gender violence and in countries that have a specific legislation on the matter (20,53,54).

Taking into account the arguments presented, some authors recommend that managers observe the gaps and contradictions between ethical principles and operational recommendations in the international guidelines (5), verify potential faults related to the principle of least infringement upon the population (27), and promote strategies for universal access to the test with an emphasis on gender equality in national policies (42). These measures, along with the election of an adequate preventive approach, may help make it so that testing initiatives do not to reinforce social inequalities.

### **Expansion of HIV counseling and testing strategies in Brazil**

Brazil adopted the voluntary test model starting in 1998, with the implementation of the *Centros de Testagem e Aconselhamento* (CTA) – services specialized in counseling and testing for HIV and other STIs – which in the year 2012 had 515 units in the country. In the last decade, the policy of test decentralization along with the implementation of HIV diagnosis through rapid testing were promoted (55). The guidelines for testing in the CTA and in primary health care units have a common ethical base that provides for counseling, informed consent and confidentiality (8,56). However, the bibliography indicates

that full compliance with those precepts has not yet been achieved. A cross-sectional study on attitudes and practices (carried out between 1998 and 2005) identified an increase in HIV testing among women of reproductive age, except among women who had had more than four sexual partners in the last five years or who perceived themselves as being at high risk. In relation to the guarantee of human rights, it was observed that counseling was scarcely provided and that autonomy with respect to the option to receive testing had been overstepped, especially among pregnant women. The systematic inaccessibility of counseling and testing was also observed among young (aged 16 to 19 years), illiterate, low-income people living in the North and Northeast of Brazil (57). An ethnographic study illustrates the processes of social and regional vulnerability when describing how people in conditions of extreme inequality and social exclusion avoided learning their serologic status, despite perceiving themselves to be at risk, for fear of social stigmatization (58). It is worth adding that it is necessary to expand the network of counseling and HIV testing especially in municipalities of priority and it is necessary to include the injecting drug users, sex workers and men who have sex with men (59).

In relation to preventive actions and the compliance with UNGASS goals in Brazil, the need to improve the quality of counseling through the training and accompaniment of the professionals involved is suggested (60). Ethnographic studies emphasize that the counseling practice must be effectively oriented by an approach centered on the person. Faced with the symbolic and social elements brought up by AIDS and sexuality, it is understood that actions of prevention and diagnosis must address, within their objectives and practices, the demands and motivations of users, thus minimizing the distances between the discourses and representations of health professionals (counselors) and those of users (61,62).

Based on reflections regarding prevention policies in Brazil, one challenge is to translate the discourse of vulnerability into new psychosocial intervention technologies and to develop models to evaluate these practices (63,64). Part of this challenge involves reviewing health care practices by acknowledging their technical dimension, circumscribed to formal knowledge,

and their care dimension, derived from the knowhow of professionals in the intersubjective encounter with users (65).

Changes observed in response to the epidemic both at the national and international level, such as the depoliticization of prevention and the radicalization of normative approaches, contribute to the invisibility of prevention strategies (66). Therefore, it is considered equally relevant to understand the effects of the optimism generated by new preventive technologies, such as HIV prophylaxis post-exposure, and to document the structural and community interventions developed in Brazil (63).

Indeed, the offering of diagnostic testing is an important strategy in the control of the epidemic, which should be adequate and appropriate to each country's policies, including variations among population and regions. However, to avoid the unnoticed re(production) of scenarios of programmatic vulnerability, it is relevant to pay attention to the current debates in the international arena on the implications of the flexibilization of the principles of counseling, informed consent and confidentiality (57). Given the interdependence of these principles, motivations to take the test and its potential repercussions in users cannot be disregarded, in either the voluntary test or in the diagnostic test scenarios.

## FINAL CONSIDERATIONS

Based on the critical review of the international bibliography, this work describes the strategies and principles of the global models of counseling and HIV testing and highlights some ethical and technical questions regarding their coexistence. Since it consisted of a mapping of secondary sources, this review has limitations related to the specific period chosen for the bibliographical sources. However, the references analyzed allowed for a characterization of the process of HIV testing expansion based on different approaches (empirical studies, evaluations, systematic reviews, essays), fields of knowledge (public health, bioethics, law, nursing) and national contexts (Asian and African countries, USA and Brazil). It is worth mentioning the lack of

literature reviews on the context of change in HIV counseling and testing policies in Latin America and the Caribbean, and the importance of conducting studies in that direction given the need to define testing policies according to specific local requirements.

In addition, it is recommended that the debate regarding the paradigms of *exceptionality* and *normalization* in testing be broadened and clarified with the help of interdisciplinary empirical approaches and the tools of public health ethics (42). It may also be convenient for the debate to include studies on the new ways of applying confidentiality and informed consent in regional and local practices (21) as well as the monitoring and evaluation of diagnostic and voluntary test strategies (2,19,28).

Some authors warn that, due to the persistence of processes of discrimination and stigmatization present in social and health practices and their consequences (related to psychosocial, work-related, affective, reproductive aspects, physical well-being, and so on), *test normalization* may bring about serious harm to human rights, especially for women living with or without HIV (47,49,67). In addition, a lack of empirical analysis on the relationship between testing models and AIDS-related stigmatization is observed (42).

In summary, the critiques of researchers, managers and people living with HIV/AIDS with respect to the diagnostic test model, focused on the scarce recognition both of user autonomy in health care services and of sexual and reproductive rights, will have to be evaluated by the international organizations. Likewise, the diversification of the voluntary test model raises the challenge of renewing its scope (individual, social, structural), objectives, and discourse, in order to overcome barriers to access in counseling and HIV testing services.

This review also identified a lack of studies on counseling principles and practices, particularly regarding the central elements that promote long-term transformations in sexual health care (7,10,21). The construction of this practice based on a sociocultural approach to sexuality, that includes gender relationships, diversity and the significance of sexual trajectories may contribute to amplifying primary and secondary preventive actions (62). The training of counselors must also include the implementation of ethical aspects



involved in the test (49) as well as a reflection on the moral aspects implied in counseling (68).

Although the expansion of testing in Brazil and the consolidation of effective strategies such as the prevention of vertical HIV transmission has been widely recognized (63), it is important to understand the distances between professional practices and the national recommendations with respect to counseling and informed consent.

Taking into account the leadership that this country has shown in addressing the HIV/AIDS epidemic, from a health care and human rights approach, an important challenge today is that of articulating within its local HIV testing policies international recommendations, new preventive technologies, and technologies centered on people.

---

## ACKNOWLEDGEMENTS

To Professor Kenneth Camargo (IMS-UERJ) for his contributions after reading the first version of this article. To the Programa de Estudantes-Convenio de Pós-Graduação (PEC-PG) of the Coordenação de Aperfeiçoamento de Pessoal de Nível Superior, Conselho Nacional de Desenvolvimento Científico Tecnológico (CAPES-CNPq) of Brazil for the scholarship offered to the first author (2010-2014)

---

## REFERENCES

1. Organização das Nações Unidas. Declaração de Compromisso sobre o VIH/SIDA. Sessão extraordinária da Assembleia Geral sobre o VIH/SIDA. Portugal: ONU; 2001.
2. Fonner VA, Denison J, Kennedy CE, O'Reilly K, Sweat M. Voluntary counseling and testing (VCT) for changing HIV-related risk behavior in developing countries. *Cochrane Database of Systematic Reviews*. 2012(9):CD001224. DOI: 10.1002/14651858.CD001224.pub4.
3. Branson BM, Handsfield HH, Lampe MA, Janssen RS, Taylor AW, Lyss SB, Clark JE. Revised recommendations for HIV testing of adults, adolescents, and pregnant women in health-care settings. *Morbidity and Mortality Weekly Reports*. 2006;55(RR14):1-17.
4. World Health Organization. Guidance on provider-initiated HIV testing and counselling in health facilities. Geneva: WHO/UNAIDS; 2007.
5. Bayer R, Edington C. HIV testing, human rights, and global AIDS policy: exceptionalism and its discontents. *Journal of Health Politics, Policy and Law*. 2009;34(3):301-323.
6. Arksey H, O'Malley L. Scoping studies: Towards a methodological framework. *International Journal of Social Research Methodology*. 2005;8(1):19-32.
7. Joint United Nations Program on AIDS. The impact of voluntary counseling and testing: A global review of the benefits and challenges. Geneva: UNAIDS; 2001.
8. Ministério da Saúde. Diretrizes dos Centros de Testagem e Aconselhamento (CTA): manual. Brasília: Ministério da Saúde do Brasil; 1999.
9. Weinhardt LS, Carey MP, Johnson BT, Bickman NL. Effects of HIV counseling and testing on sexual risk behavior: A meta-analytic review of published research, 1985-1997. *American Journal of Public Health*. 1999;89:1397-1405.
10. Bollinger L, Cooper-Arnold K, Stover J. Where are the gaps?: The effects of HIV-prevention interventions on behavioral change. *Studies in Family Planning*. 2004;35(1):27-38.
11. Yeatman SE. Ethical and Public Health considerations in HIV counseling and testing: policy implications. *Studies in Family Planning*. 2007;38(4):271-278.

12. Angotti N. Working outside of the box: how HIV counselors in Sub-Saharan Africa adapt Western HIV testing norms. *Social Science & Medicine*. 2010;71(5):986-993.
13. Hamilton C, Okoko D, Tolhurst R, Kilonzo N, Theobald S, Taegtmeier M. Potential for abuse in the VCT counselling room: service provider's perceptions in Kenya. *Health Policy and Planning*. 2008;23(6):390-396.
14. Fylkesnes K, Sandøy IF, Jürgensen M, Chipimo PJ, Mwangala S, Michelo C. Strong effects of home-based voluntary HIV counselling and testing on acceptance and equity: a cluster randomised trial in Zambia. *Social Science & Medicine*. 2013;86:9-16.
15. Jürgensen M, Sandøy IF, Michelo C, Fylkesnes K. Effects of home-based voluntary counselling and testing on HIV-related stigma: findings from a cluster-randomized trial in Zambia. *Social Science & Medicine*. 2013;81:18-25.
16. Kawichai S, Celentano D, Srithanaviboonchai K, Wichajarn M, Pancharoen K, Chariyalertsak C, Visrutaratana S, Khumalo-Sakutukwa G, Sweat M, Chariyalertsak S. NIMH Project Accept (HPTN 043) HIV/AIDS community mobilization (CM) to promote mobile HIV voluntary counseling and testing (MVCT) in rural communities in Northern Thailand: modifications by experience. *AIDS and Behavior*. 2012;16(5):1227-1237.
17. Hong H, Xu G, Zhang D. Voluntary counseling and testing services for HIV and sexually transmitted infections among pregnant women in China. *International Journal of Gynecology & Obstetrics*. 2012;116(2):173-174.
18. Mlay R, Lugina H, Becker S. Couple counselling and testing for HIV at antenatal clinics: views from men, women and counsellors. *AIDS Care*. 2008;20(3):356-360.
19. Kippax S. A public health dilemma: A testing question. *AIDS Care: Psychological and Sociomedical Aspects of AIDS/HIV*. 2006;18(3):230-235.
20. Tarantola D, Gruskin S. New guidance on recommended HIV testing and counseling. *The Lancet*. 2007;370:202-203.
21. Obermeyer C, Osborn M. The utilization of testing and counseling for HIV: A review of the social and behavioral evidence. *American Journal of Public Health*. 2007;97(10):1762-1774.
22. Bell E, Mthembu P, O'Sullivan S, Moody K. Sexual and reproductive health services and HIV testing: perspectives and experiences of women and men living with HIV and AIDS. *Reproductive Health Matters*. 2007;15(29):113-135.
23. Hossain MB, Kippax S. Stigmatized attitudes toward people living with HIV in Bangladesh: Health care workers' perspectives. *Asia-Pacific Journal of Public Health*. 2011;23(2):171-182.
24. Durojaye E, Balogun V. Human Rights implications of mandatory premarital HIV testing in Nigeria. *International Journal of Law, Policy and the Family*. 2010;24(2):245-265.
25. MacPhail CL, Pettifor A, Coates T, Rees H. "You Must Do the Test to Know Your Status": Attitudes to HIV voluntary counseling and testing for adolescents among South African youth and parents. *Health Education & Behavior*. 2008;35(1):87-104.
26. Gruskin S, Tarantola D. Health and Human Rights: overview. In: Heggenhougen K, Quah S. *International Encyclopedia of Public Health*. Vol 3. San Diego: Academic Press; 2008.
27. Pierce MW, Maman S, Groves AK, King EJ, Wyckoff SC. Testing public health ethics: Why the CDC's HIV screening recommendations may violate the least infringement principle. *The Journal of Law, Medicine & Ethics*. 2011;39(2):263-271.
28. Kennedy CE, Fonner VA, Sweat MD, Okero A, Baggaley R, O'Reilly KR. Provider-initiated HIV testing and counseling in low- and middle-income countries: a systematic review. *AIDS and Behavior*. 2013;17(5):1571-1590.
29. Oosterhoff P, Hardon AP, Nguyen TA, Pham NY, Wright P. Dealing with a positive result: routine HIV testing of pregnant women in Vietnam. *AIDS Care*. 2008;20(6):654-659.
30. Hanssens C. Legal and ethical implications of opt-out HIV testing. *Clinical Infectious Diseases*. 2007;45(S4):S232-S239.
31. Waxman MJ, Popick RS, Merchant RC, Rothman RE, Shahan JB, Almond G. Ethical, financial, and legal considerations to implementing emergency department HIV screening: a report from the 2007 conference of the National Emergency Department HIV Testing Consortium. *Annals of Emergency Medicine*. 2011;58(S1):S33-S43.
32. Evans C, Ndirangu E. The nursing implications of routine provider-initiated HIV testing and counselling in sub-Saharan Africa: A critical review of new policy guidance from WHO/UNAIDS. *International Journal of Nursing Studies*. 2009;46(5):723-731.

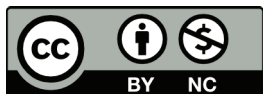
33. Heald S. Abstain or die: The development of HIV/AIDS policy in Botswana. *Journal of Biosocial Science*. 2006;38(1):29-41.
34. Alswaidi F, O'Brien S. Premarital screening programmes for haemoglobinopathies, HIV and hepatitis viruses: review and factors affecting their success. *Journal of Medical Screening*. 2009;16(1):22-28.
35. Luginaah IN, Yiridoe EK, Taabazuing M. From mandatory to voluntary testing: balancing human rights, religious and cultural values, and HIV/AIDS prevention in Ghana. *Social Science & Medicine*. 2005;61(8):1689-1700.
36. Heywood MJ. The routine offer of HIV counseling and testing: A human right. *Health and Human Rights*. 2005;8(2):13-19.
37. Tarantola D. HIV Testing: Breaking the deadly cycle. *Health and Human Rights*. 2005;8(2):37-41.
38. Du J, Lombardi C, Evans E, Jiang H, Zhao M, Meng YY. A mixed methods approach to identifying factors related to voluntary HIV testing among injection drug users in Shanghai, China. *International Journal of Infectious Diseases*. 2012;16(7):498-503.
39. De Cock KM, Mbori-Ngacha D, Marum E. Shadow on the continent: Public health and HIV/AIDS in Africa in the 21st century. *The Lancet*. 2002;360(9326):67-72.
40. De Cock KM, Marum E, Mbori-Ngacha D. A serostatus-based approach to HIV/AIDS Prevention and Care in Africa. *The Lancet*. 2003;362(9398):1847-1849.
41. Luque R. Derecho a la intimidación: Fundamento preventivo en la epidemia global de SIDA. In: Viveros M. Saberes, culturas y derechos sexuales en Colombia. Bogotá: CLAM/CES; 2004.
42. Knight R, Shoveller J, Greyson D, Kerr T, Gilbert M, Shannon K. Advancing population and public health ethics regarding HIV testing: a scope review. *Critical Public Health*. 2014;24(3):DOI: 10.1080/09581596.2013.800188.
43. The Voluntary HIV-1 Counseling and Testing Efficacy Study Group. Efficacy of voluntary HIV-1 counselling and testing in individuals and couples in Kenya, Tanzania, and Trinidad: a randomised trial. *The Lancet*. 2000;356(9224):103-112.
44. Macklin R. Scaling up HIV Testing: Ethical Issues. *Health and Human Rights*. 2005;8(2):27-30.
45. Fraser J. Ethics of HIV testing in general practice without informed consent: a case series. *Journal of Medical Ethics*. 2005;31(12):699-700.
46. Frith L. HIV testing and informed consent. *Journal of Medical Ethics*. 2005;31(12):699-700.
47. Ahmed A, Hanssens C, Kelly B. Protecting HIV-positive women's human rights: recommendations for the United States National HIV/AIDS Strategy. *Reproductive Health Matters*. 2009;17(34):127-134.
48. Rennie S, Behets F. Desperately seeking targets: the ethics of routine HIV testing in low-income countries. *Bulletin of the World Health Organization*. 2006;84(1):52-57.
49. Fields L, Kaplan C. Opt-out HIV testing: an ethical analysis of women's reproductive rights. *Nursing Ethics*. 2011;18(5):734-42.
50. Bennett R. Routine antenatal HIV testing and informed consent: an unworkable marriage? *Journal of Medical Ethics*. 2007;33(8):446-448.
51. Shapiro K, Ray S. Sexual health for people living with HIV. *Reproductive Health Matters*. 2007;15(29):67-92.
52. Dixon-Mueller R. The sexual ethics of HIV testing and the rights and responsibilities of partners. *Studies in Family Planning*. 2007;38(4):284-296.
53. Juergens R, Cohen J, Cameron E, Burris S, Clayton M, Elliott R, Pearshouse R, Gathumbi A, Cupido D. Ten reasons to oppose the criminalization of HIV exposure or transmission. *Reproductive Health Matters*. 2009;17(34):163-172.
54. Csete J, Pearshouse R, Symington A. Vertical HIV transmission should be excluded from criminal prosecution. *Reproductive Health Matters*. 2009;17(34):154-162.
55. Ministério da Saúde. Política brasileira de enfrentamento da Aids: Resultados, avanços e perspectivas. Brasília: Ministério da Saúde do Brasil; 2012.
56. Ministério da Saúde. Oficina de Aconselhamento em DST HIV Aids para a Atenção Básica. Brasília: Ministério da Saúde do Brasil; 2005. Série Manuais n°66.
57. França Jr I, Calazans G, Zucchi EM. Mudanças no âmbito da testagem anti-HIV no Brasil entre 1998 e 2005. *Revista de Saúde Pública*. 2008;42(S1):S84-S97.

58. Biehl J. Will to live: Aids therapies and the politics of survival. Princeton: Princeton University Press; 2007.
59. Grangeiro A, Escuder M, Veras M, Barreira D, Ferraz D, Kayano J. Voluntary counseling and testing (VCT) services and their contribution to access to HIV diagnosis in Brazil. *Cadernos de Saúde Pública*. 2009;25(9):2053-2063.
60. Paiva V, Rivero L, Barboza R. The right to prevention and the challenges of reducing vulnerability to HIV in Brazil. *Revista de Saúde Pública*. 2006;40(Supl):S1-S10.
61. Souza V, Czeresnia D, Natividade C. Aconselhamento na prevenção do HIV: olhar dos usuários de um centro de testagem. *Cadernos de Saúde Pública*. 2008;24(7):1536-1544.
62. Monteiro S, Brandão E, Vargas E, Mora C, Soares P, Daltro E. Discursos sobre a sexualidade em um Centro de Testagem e Aconselhamento (CTA): diálogos possíveis entre profissionais e usuários. *Ciência e Saúde Coletiva*. 2014;19(1):137-146.
63. Bastos F, Hacker M. Pesquisas brasileiras psicossociais e operacionais face às metas da UNGASS. *Revista de Saúde Pública*. 2006;40(Supl):S42-S51.
64. Ayres JRCM. "Prevenção e estratégias" Políticas de prevenção e estratégias adotadas no país [Debate]. In: Pimenta MC, Raxach JC, Terto Jr. V. Aprimorando o debate II: respostas frente à Aids no Brasil. *Anais do Seminário Prevenção das DSTs/AIDS: novos desafios*. Rio de Janeiro: ABIA; 2010. p. 19-20.
65. Ayres JRCM. Cuidado: tecnologia ou sabedoria prática? [Debate]. *Interface (Botucatu)*. 2000;4(6):117-120.
66. Parker R. "Prevenção e estratégias" Políticas de prevenção e estratégias adotadas no país [Debate]. In: Pimenta MC, Raxach JC, Terto Jr. V. Aprimorando o debate II: respostas frente à Aids no Brasil. *Anais do Seminário Prevenção das DSTs/AIDS: novos desafios*. Rio de Janeiro: ABIA; 2010. p. 21-22.
67. Ekstrand ML, Bharat S, Ramakrishna J, Heylen E. Blame, symbolic stigma and HIV misconceptions are associated with support for coercive measures in urban India. *AIDS and Behavior*. 2012;16(3):700-710.
68. van Rooyen H, Durrheim K, Lindegger G. Advice-giving difficulties in voluntary counselling and testing: a distinctly moral activity. *AIDS Care*. 2011;23(3):281-286.

#### CITATION

Mora Cárdenas CM, Monteiro S, Moreira COF. Expansion of HIV counseling and testing strategies: technical challenges and ethical-political tensions. *Salud Colectiva*. 2014;10(2):253-264.

Received: 16 July 2013 | Accepted: 15 November 2013



Content is licensed under a Creative Commons.

Attribution — You must attribute the work in the manner specified by the author or licensor (but not in any way that suggests that they endorse you or your use of the work).

Noncommercial — You may not use this work for commercial purposes.

The translation of this article is part of an interdepartmental collaboration between the Undergraduate Program in Sworn Translation Studies (English < > Spanish) and the Institute of Collective Health at the Universidad Nacional de Lanús. This article was translated by Patricia De Souza Martínez and Pamela López, reviewed by María Pibernus and modified for publication by Vanessa Di Cecco.