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According to the US Centers for Disease Control and Prevention (CDC) (2011), more than one million Americans are living with HIV and approximately one in five do not know it. The World Health Organization (WHO) (2011) reported that there were 2.6 million new HIV infections in 2009 alone, contributing to the current global prevalence of 33.3 million. With the number of new infections worldwide remaining high, some regions previously unscathed experiencing rising incidences of HIV, and the number of patients presenting late at health facilities with advanced HIV/AIDS, there is a growing sense of frustration that global efforts to prevent HIV/AIDS are being outpaced by the spread of the pandemic (Asante, 2007). As a result, calls have been mounting for a more pragmatic approach to containing the disease, with routine and mandatory testing gaining increasing attention. A growing number of religious communities and national and local governments have adopted mandatory premarital HIV testing (PHT) policies. Mandatory PHT, however, remains controversial. While the purpose of this paper is to present the global arguments by the proponents and opponents of mandatory premarital HIV testing and explain why this author supports mandatory PHT, the goal is to stimulate discussion among readers on the merits of introducing the concept as a national strategy in Ethiopia.

Until recently, the primary mode for providing HIV testing and counseling has been client-initiated HIV testing and counseling. Despite the controversy, mandatory PHT has been gaining political and religious support. Countries such as Bahrain, Guinea, United Arab Emirates, and Saudi Arabia have enacted national laws and policies mandating premarital testing. Churches in Burundi, Democratic Republic of the Congo, Ghana, Kenya, Nigeria, Tanzania, and Uganda have also adopted mandatory premarital HIV testing practices. Besides, local governments and legislatures in five Indian states, districts in the Yunnan province of China, Ethiopia, and the Democratic Republic of the Congo have introduced or passed similar laws or regulations (Open Society Foundation, 2010). A global
A review of HIV testing legislation revealed that 27% of the 121 countries evaluated have legislative measures in place mandating HIV testing for vulnerable populations (e.g. commercial sex workers, men who have sex with men, injecting drug users). Other countries have legislation requiring mandatory HIV testing for populations considered potentially vulnerable, such as immigrants (17% of the 121 countries), prisoners (5%), and health personnel (14%) (Li et al, 2007).

One of the arguments for mandatory PHT emanates from benefits for seropositive individuals. Mandatory PHT promotes access to treatment as people get to know their status early and seek treatment thereby prolonging their lives (Uneke et al, 2007). Medical treatment is currently the most important benefit of HIV testing because of the innovation of antiretroviral treatments (ART) that yield dramatic decreases in morbidity and mortality (April, 2010). The benefits have increased over the years with early detection of HIV infection since effective treatment results occur in the early stages (Vermund & Wilson, 2002). This early detection and treatment led to increased survival of seropositive individuals and reduction in HIV transmission to partners and offspring (Marks et al, 2005). The presence of effective ART, therefore, makes HIV screening even more relevant now than ever (Ganczak, 2010, April 2010). According to Ganczak, mandatory PHT might also serve as a forum for health education such as in Arabian Peninsula, where school education regarding HIV/AIDS is focused on the biology without addressing the risk factors. In lieu of the epidemics, non-curability, and high mortality and morbidity rates associated with HIV/AIDS, HIV testing should be considered for inclusion into mandatory screening programs (Alswaidi and O’Brien, 2009). Even though mandatory PHT may expose some diagnosed people to stigma, the negative consequences are likely to be overshadowed by the significant improvements in the health and survival for HIV infected people due to earlier treatment with ART (April, 2010; Asante, 2007; Alswaidi and O’Brien, 2009). One of the concerns, for example by Asante (2007), is that mandatory PHT may not be feasible in some regions such as Africa due to lack of access to ARV therapy, inadequate health workforce, the culture of poor use of health services and widespread stigma and discrimination associated with HIV/AIDS.
Proponents of mandatory PHT argue that premarital testing helps reduce HIV infection rates by containing infection within the population of people living with HIV. It is with the conviction that mandatory PHT will encourage couples to practice moral behavior, such as abstinence before marriage and fidelity after marriage, which in turn can slow the spread of HIV infection (Open Society Foundation, 2010). In line with this argument, a thesis work in Ethiopia showed HIV prevalence significantly (P=000) higher among participants who did not have history of previous HIV test (16.7%) than those who did (2.9%) (Temam, 2008). Moreover, while access to ART is vital, testing and knowledge of one’s HIV status are very important due to the fact that a positive HIV test could activate behavioral change that may reduce the risk of onward transmission of the virus (Asante, 2007). Many also argue that mandatory premarital HIV testing and a ban on discordant marriages can protect women from becoming infected with HIV upon marriage in light of their powerlessness under various cultures (Open Society Foundation, 2010; Arulogun and Adefioye, 2010; Uneke, Alo, & Ogbu, 2007). Its significance for children is also considerable. Mandatory PHT will reduce the number of children that will be orphaned by HIV/AIDS related complications and will be saved from HIV infection if couples are made to undergo HIV testing (Arulogun and Adefioye, 2010).

Recent initiatives by WHO (2007) and some countries considering opt out option instead of opt in for HIV testing is an outstanding instance how the current system of voluntary testing and counseling has failed to cope with the growing HIV infection throughout the world. According to WHO (2007), uptake of client-initiated HIV testing and counseling (opt in) has been limited by low coverage of services, fear of stigma and discrimination, and the perception by many people that they are not at risk. In light of this limited uptake, WHO released guidelines recommending expanding testing to all adults accessing health care facilities in settings with high HIV prevalence unless they explicitly opt out. This was initiated because of increasing evidence that opt out approach can increase uptake of HIV testing, improve access to health services for people living with HIV, and may create new opportunities for HIV prevention. Taking it further, April (2010) makes a case that it would be an
effective public health response for communities devastated by the HIV epidemic such as sub-Saharan Africa. In light of the pandemic nature of HIV and limited success of the opt in testing, some international associations (e.g. Bill Clinton HIV Initiative and the United Nations AIDS program) have suggested that HIV screening be mandatory in countries with prevalence of 5% or more (April, 2010; Alswaidi and O’Brien, 2009). Sub-Saharan Africa accounts for 67% of people living with HIV and for 75% of deaths due to AIDS. It is estimated that fewer than one in five HIV infected Africans know their serostatus As a result, while the availability of life extending ART has dramatically increased, low levels of testing have been barriers to expansion of treatment (April, 2010).

There are increasing attempts to make HIV a routine test in the healthcare setting and switch from opt in to opt out testing policies due to the inadequacy of the current system of voluntary testing. The U.S. Centers for Disease Control and Prevention (2011) recommends routine HIV testing in healthcare settings. In Canada, pregnant women who seek antenatal care are offered opt out/opt in options. The outcomes from these provisions demonstrated that opt out approach resulted in a marked increase in prenatal testing. Provinces using opt out approach showed almost universal uptake; whereas testing rates in provinces using opt in was only 50% to 60%. In Alabama, uptakes increased from 75% to 88% after a switch from opt in to opt out testing (Schuklenk & Kleinsmidt, 2007).

The seroprevalence and extent of risk behavior engaged by some age groups are sources of concerns for many community and public health leaders. The seroprevalence among individuals referred from faith-based organizations in south-eastern Nigeria, due to mandatory PHT requirement, was reported to be 7.8% compared to the national average of 5.0% (Uneke, Alo & Ogbru, 2007). The findings also showed that the highest prevalence of HIV infection (8.9%) was recorded among individuals in the 21 - 30 years age category, which constituted the age at which most adolescents and adults seek marriage. The individuals in these age categories are also classified as the most sexually active and hence the highest-risk group for sexually transmitted infections such as HIV infection (Uneke, Alo & Ogbru, 2007). In a survey of attitudes of unmarried youths towards mandatory PHT in
Ibadan, Nigeria, Oyedunni & Adefioye (2010) reported that the majority (82.0%) of the participants supported mandatory PHT as one of the ways religious institutions could use to protect their members from HIV infection. Overall attitude towards mandatory PHT was positive. Khebir et al (2007) evaluated a premarital screening program in Johor State, Malaysia, over 3 years. Their findings showed increased number of marriage applications and public awareness of HIV improving the chances of early detection.

The main arguments against mandatory PHT include human rights concern, confidentiality, stigmatization, counseling and treatment inadequacy. According to human rights advocates, mandatory PHT infringes the right to marry and start a family by requiring that people be HIV negative in order to marry. They further argue that mandatory PHT disregards the need for informed consent, confidentiality, and access to HIV counseling and treatment, breaching upon basic human rights to bodily integrity, privacy, and information (Salkeld & McGeehan; 2010; Open Society Foundation, 2010; April, 2010; Durojaye & Balogun, 2010; Schuklenk & Kleinsmidt, 2007; Pinheiro, 2002; Turnock & Kelly, 1989). In some countries such as the Arabian Peninsula, the results are not kept confidential (Ganczak, 2010). In some cases, medical professionals disclose premarital test results directly to religious leaders. In Malaysia, for instance, Muslim couples submit certificate of HIV test result to state religious departments when applying for a marriage license. Confidentiality is also compromised in cases where serodiscordant marriages are discouraged. Considering the impact of various cultures, mandatory PHT may have a far-reaching social impact, especially for people planning to marry. It extends beyond individuals and couples in certain communities where values may clash with the concept of premarital HIV testing (Luginaah, Yiridoe, & Taabazuing, 2006). It can be very difficult to keep mandatory PHT results confidential in many communities where marriage is arranged between families (Open Society Foundation, 2010; Ganczak, 2010).

People who test positive for HIV face increased stigmatization and discrimination in nearly every aspect of life, including employment and societal and family life. As the basis of mandatory
PHT, it is recommend that guidelines for the management of seropositive individuals and serodiscordant couples and the safeguarding of confidentiality should be developed; and training and capacity building for religious leaders, to appropriately manage social issues associated with HIV/AIDS be instituted (Asante, 2007; Uneke, Alo & Ogbu, 2007). Expanding on these recommendations, Alswaidi and O’Brien (2009) underscore that marital programs are most successful when social, religious, ethnic and cultural factors are all addressed (Alswaidi and O’Brien, 2009). In a meta-analysis of studies of HIV/AIDS related stigma in developing countries, a review on outcomes of disclosure of HIV seropositive status of women to their partners found that 16.7% - 87% of the women chose not to disclose their status. However, majority of the reviewed studies reported positive outcomes to their disclosure such as receiving kindness, understanding or acceptance following disclosure. Besides, the study found that much-feared negative community or partner responses are far less common than women assume (Medley, Garcia-Moreno, McGill & Maman, 2004). Likewise, Indian investigators reported that actual stigma experienced by women with HIV infection is lower (reported by 26% of women) than the fear of stigma (reported by 97%) (Thomas, et al, 2005). These findings suggest that many women are probably overly concerned about stigma and that, in reality, their likelihood of being stigmatized is substantially smaller than they think it is (Schuklenk & Kleinsmidt, 2007). Even under increasing stigma, the negative consequences are likely to be overshadowed by the significant improvements in health and survival of HIV infected people due to earlier treatment with ART (April, 2010).

The other point of contention is the cost of mandatory HIV testing. Arguing against mandatory PHT in Nigeria, Durojaye & Balogun (2010) wonder, “How will the already over-burdened health-care institutions manage the logistics of implementing this policy?” Early on, Petersen and White (1990) evaluated premarital HIV seroprevalence in eight areas of the US and concluded that mandatory premarital screening would be more expensive than other HIV prevention programs. Turnock and Kelly (1989) evaluated mandatory PHT in Illinois and concluded that the mandatory tests were not
cost-effective way to control HIV infection. Other studies, however, showed mandatory premarital testing to be cost-effective; in the US, McKay and Phillips (1991) predicted savings of $70,000 to $127,000 for every case of HIV infection prevented. One can discern these cost-benefit analyses were done two decades ago. Thus, the lower HIV prevalence during that period as opposed to the epidemics we have now could underestimate the benefits from prevention programs such as mandatory PHT.

Mandatory HIV testing not only stimulates arguments between controlling the spread of HIV infection and preservation of individual rights, but also raises the issue of protecting the individual rights and common goods. At the population level, some support mandatory PHT for protecting many at the cost of possibly harming a few, especially in regions with a serious HIV/AIDS epidemic. Public health officials agree that it is in the interest of the public to test for HIV infection and to identify seropositive individuals (Li et al., 2007). Arguing of the bioethical issue surrounding the mandatory test, Redden (2002) said, “Bioethical issues such as mandatory HIV testing for pregnant women and newborns require a delicate and difficult balance between public health interests and respect for individual privacy. The stigma attached to HIV positive status is grave and vilifying. This makes the privacy of individuals of paramount importance... But this concern for individuals and their privacy - as a means of preserving their freedom - does not amount to a workable strategy for the welfare of a community”. This argument was supported by Etzioni (1997) who wrote, "It should be noted... that privacy is not an absolute value, and does not trump all other rights or concerns of the common good...”

To sum up, despite the human rights issues and potential sociocultural negative implications of mandatory PHT, and cognizant of the justifications provided for mandatory PHT, this writer supports the idea of mandatory PHT as a public policy to control HIV/AIDS. Reasons for supporting this policy include:

- Increasing HIV prevalence, and associated morbidity and mortality. In the presence of close to 33.3 million HIV positive people globally and in view of low rate of voluntary HIV testing coupled with
the socioeconomic and health burden to individuals and nations caused by the disease, mandatory PHT should be consider as one tool to control HIV infection. Making HIV screening mandatory in some regions such as Africa may not be feasible now due to lack of access to ARV therapy, inadequate health workforce, and culture of poor use of health services and stigma associated with HIV/AIDS. However, concomitant effort should be in place to address the obstacles while implementing the mandatory PHT instead of turning back on such tough but potentially successful strategy to combat the problem. Africa cannot afford to wait more while it shoulders more than the two-third of the HIV infection.

- Benefits to individuals, women, children and society. Early detection and treatment of HIV has been proven to be a successful way to improve not only the survival but also the quality of life of HIV positive patients. Mandatory PHT prevents the person at the receiving end of the HIV mainly women, it reduces prenatal infection, and helps reduce orphanage due to lose of parents for HIV/AIDS associated complications. While policies that can concurrently satisfy both individuals and the public are preferred, the common good should get primacy in light of the pandemic nature of HIV infection. It is an infection that can inflict harm to every member of the society. This is not an issue that remains a private matter and can be ignored. It is contagious and needs to be viewed in terms of its impact for the society. Hence, mandatory PHT should be considered as one of the tools to redress this public concern.

- This writer agrees mandatory PHT may not be a good policy if it is employed by governments for the sake of testing. Mandatory PHT should be a part of a grand strategy to address the problem of HIV infection. The strategy should include a reasonable treatment and public awareness campaign that involves community, church, and political leaders. Some are concerned with the problem of stigma in regions such as Africa. This could be in the past. What about now and in the future? What is the extent? Some of the reviews presented in this paper have shown that the fear is by far higher than the real stigma. Most families from the sub-Saharan region have either known a close
friend, a relative or family member who is an HIV seropositive or has died because of it. Even in the presence of stigma, many have come to witness the benefits of early detection which eventually may help lessen the stigma.

- In light of the push for opt out instead of opt in HIV testing by many prominent institutions and leaders, and the success stories highlighted in this paper are encouraging. The fact that the initiative originated from a frustration with the status quo and the need to devise a policy intervention that can improve the intake for HIV testing accentuates the need for more pragmatic policy such as mandatory PHT.
References Cited


