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Analysis of the arguments for and against routine antenatal testing for HIV of all pregnant women in Australia.

As recently as July 2005 calls for universal screening of pregnant women, for HIV have been reported in the Australian media¹.

Since 1999 and most recently in August 2004, when an editorial by Dr. Nick Graves and Associate Professor John Ziegler appeared in the Medical Journal of Australia² there have been calls for universal screening of all pregnant women in Australia.

This paper will address the arguments put forward for routine testing by Dr. Graves and A. Professor Ziegler in their MJA editorial. Statements from the editorial will follow bolded and italicized.

Summary

While antenatal HIV testing is recommended for all pregnant women only in NSW, Qld and the Northern Territory, reports to PLWHA organizations, AIDS Councils, NAPWA and AFAO indicate that routine screening of pregnant women for HIV has been carried out on an ad hoc and often non consensual basis in many locales across Australia.

A/Professor Ziegler and Dr. Graves support routine HIV testing of pregnant women without acknowledging the fact that across the board screening of low risk populations has been proven to be epidemiologically and practically ineffective. Heterosexual women in Australia unlike their sisters in Africa and some areas of North America are considered to be at very low risk of HIV infection.

AFAO's particular concern with routine HIV testing is that where it becomes one of a collection of routine tests without investigation of patient risk factors, that it may easily become separated from any form of pre and post test counseling and specific informed consent. This is particularly likely in

¹ Sydney Morning Herald 5.7.05 HIV Tests recommended for pregnant mums.

² The time to recommend antenatal HIV screening for all pregnant women has arrived. J Ziegler, N Graves, Medical Journal of Aust. Volume 182 Number 3, 2 Aug 2004

practices and settings where resources and HIV knowledge and experience are low.

The routine testing argument runs that in order to prevent vertical transmission

- All women presenting for an initial antenatal examination be offered and encouraged to undergo a test for HIV along with other regular ante natal tests

and

- That all tests should be accompanied by pre and post test counseling and
- That the pre test counseling must include an assessment of risk

The difference between this argument and that presented by AFAO, NAPWA etc against routine testing is...

- That after discussion of possible risk factors for HIV infection and in the case of there being no discernible risk factor for HIV present in the patient's history

And

- That after explanation of HIV risk factors the patient declines to be tested

...that no test for HIV should occur and that testing of women who present with no possible risk factors for HIV infection and no concerns regarding HIV is ineffective and inefficient health resource management.

AFAO maintains a clear position on the necessity of obtaining informed consent prior to all HIV testing.

One particular area of HIV testing where it is reported that informed consent is frequently not being obtained is that of the testing of pregnant women.

It is customary for a doctor at the time of an initial antenatal examination to take blood and order a number of "routine" tests. It has become practice by many doctors to also order tests for HIV antibodies as part of this routine.

It is important for Doctors ordering tests to differentiate between routine tests for conditions, which carry very little impact, for example iron deficiency, and those with potentially more drastic outcomes such as testing for HIV infection.

AFAO advocates that HIV testing in any circumstance must follow the guidelines laid out in the ANCARD HIV Testing policy³. These guidelines explicitly call for an exploration of possible risk factors and an explanation of possible results and outcomes.

“Despite the ready availability of prevention strategies, it appears that a small number of Australian babies continue to acquire HIV infection

³ ANCARD/IGCARD HIVtesting policy Sept 1998

unnecessarily. The solution to this calamity is to prevent HIV infection in women and, when it does occur, to identify it before or during pregnancy.”

Given that the percentage of babies born, in Australia, to mothers whose HIV-positive status is unknown has become very low it is difficult to comprehend what advantage routine testing would have over a thorough implementation of an evaluation of risk of HIV infection discussion in initial antenatal interviews.

“The ability to interrupt perinatal transmission of HIV is, of course, only possible if the mother’s status is known”

Discussions of antenatal screening of pregnant women for HIV continue in the developed world with several test programs, most notably in France being introduced.

In the case of the French program where it became mandatory to offer serological screening for HIV to pregnant women it has been reported in the Journal of Acquired Immunodeficiency Syndromes and Human Retrovirology that at least five cases of transmission had occurred through “failure of the screening policy”⁴. It was reported that in all five cases, in which the mother had declined to be tested, that “the parents had risk factors which could have been identified during the history taking” but that due to the cursory nature of the history taking as part of routine testing that the risk factors were not detected.

The implications of this outcome are that a thorough “history taking” process to identify and discuss risk factors for HIV infection must be carried out as a process separate from that of other routine screening and testing associated with initial antenatal examinations.

In order to ***“interrupt perinatal transmission of HIV”*** rather than supporting the introduction of routine HIV screening AFAO encourages the adoption and implementation across Australia of a policy of comprehensive evaluation of risk factors (for HIV infection) and counseling, where appropriate, of expectant mothers at the time of their first antenatal examination, with HIV testing being recommended as a result only when indicated.

The French study supports the view that routine offering of HIV testing without an adequate exploration and explanation of risk factors by the health care worker combined with a lack of understanding of risk factors by the patient will lead to the offer of HIV testing being declined.

“Unfortunately, national policies on antenatal screening are flawed. The Australian National Council on AIDS and related Diseases recommends that ”pregnant women found to be at higher risk of HIV...should be

⁴ Duval, Michelet ai, Failure of Paediatric AIDS Prevention Despite Maternal Screening in Paris, France, J.Acquir Immune Defic Syndr 1999; 20:100

encouraged to undergo HIV screening.” but does not explain the term “higher”.

The current ANCARD guidelines indicate the following as indicating a higher risk of exposure to and possible HIV infection.

- Unprotected male to male intercourse
- Shared reuse of injecting equipment
- Receipt of blood products or donor tissue of any kind prior to 1985
- People originating from countries of high HIV prevalence
- Being the sexual partner of a person with HIV infection
- Being the sexual partner of a person fitting into any of the above groups.

AFAO believes that the current ANCHARD HIV testing policy clearly states the factors for higher risk of exposure to HIV⁵. As the Guidelines are due to be reviewed and updated any perceived deficiency in this area may be addressed when this process occurs.

“Until further information becomes available, HIV antibody testing should be offered to and encouraged for all women presenting for ante natal care.”

“Prevalence of HIV in pregnant women in Australia is unknown though is likely to be low, probably between 1:10,000 and 1:2,000”⁶

“Available prevention strategies have the potential to prevent 20-30 perinatal infections in every hundred HIV positive pregnancies.”

A policy of routine screening for HIV, of pregnant women, would have significant resource implications through the costs associated with

- an increase in tests
- verifications and retesting of initial positive results
- pre and post test counseling
- HIV/AIDS training for practitioners.

It has been demonstrated, in trials of routine HIV testing of large, low risk populations both in Australia and overseas, that it is not a statistically or cost effective method of identifying people infected with the virus.

For example St. Vincent’s Hospital in Sydney ran a five-month trial in 1991 where they tested (with consent) all casualty patients, for HIV. In addition to testing, a patient’s likelihood of being infected with HIV was assessed through a questionnaire.

⁵ ANCARD/IGCARD HIV Testing Policy 1998 Pg 10. 1.4.2 Clinical screening and case detection

⁶ Antenatal screening for HIV: Why it should now be routinely recommended. A/Prof John Ziegler Noahs Ark Vol. 10 No 4.

The questionnaire contained questions relating to participation in risk behavior linked to HIV transmission. Of 1,300 patients tested, only one was identified as HIV positive who (from the questionnaire) was not already known to be HIV positive or at high risk of being infected with the virus.

The chief of surgery at St. Vincent's Professor Lord commenting on the results said that he believed they indicated that people were generally willing to disclose their HIV status or high risk behavior status and that this was a more efficient and cost effective means of obtaining information than routine screening.⁷

In the setting of antenatal examinations where risk factors are explored and the possible benefits to mother and child of awareness of HIV status are made clear, cooperation and candidness could be expected to be optimum.

ANCARD has published the following in relation to the cost and benefits of routine antenatal testing for HIV.

“assuming 10,000 tests would have to be performed to find one HIV-infected woman and there is a %50 chance that the woman will decide to terminate her pregnancy, 20,000 tests would have to be done to prevent the birth of one seropositive baby.

On the basis of a HIV test costing \$12 and the associated counseling \$27, the cost of preventing the birth of one HIV infected baby would be \$3,120,000.”⁸

While the number of identified women with HIV has increased slightly since this evaluation was made the costs of testing and counseling have also increased.

“There are quite reasonable concerns that routine testing might result in a degree of coercion and the conduct of testing without proper pre and post test counseling. Clearly, any recommendations to offer testing to all pregnant women would need to be accompanied by systematic strengthening of counseling and consent procedures.”

Given that the majority of women participating in an initial antenatal examination will do so with their GP, who in most cases will have received no specific training in HIV, risk factors for HIV and possible outcomes of receiving a HIV positive diagnosis or counseling skills it is difficult to imagine that negative outcomes would not arise from the introduction of a system of routine testing for HIV.

While providing the necessary training in these issues for all GP's would be desirable it is difficult to imagine the cost not being seen as prohibitive by the Australian government.

⁷ AIDS Risks and Rights, 3rd report of the committee on The risk of HIV transmission in health care and other settings and the rights of infected and non-infected persons. Parl. Of SA.

⁸ Australian National Council on AIDS Bulletin No. 8 July 1992