"E" is for everything else, not least for expanding HIV testing in Europe

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In 2006, the director of the Department of HIV/AIDS in the World Health Organization (WHO) called for moving beyond the hotly debated strategy for the prevention of human immunodeficiency virus (HIV) infection known as "ABC" (for abstain, be faithful, use condoms), with the addition of a "D" for "diagnosis" and an "E" for "everything else".[1] We took this call literally and, together with colleagues from across Europe, in 2007 we cofounded the HIV in Europe initiative, aimed at improving and expanding HIV testing and linkages to earlier care.[2] Fast-forward five years and, in March 2012, HIV in Europe held its third major conference to discuss an array of testing-related issues and ways to take the initiative forward.

Testing rates are unacceptably low everywhere, even in Europe.[3] In some eastern European countries, as many as 60% of those living with HIV are undiagnosed,[4] and in the WHO European Region as a whole, nearly half of the 2.5 million people who are infected with HIV are diagnosed late in the course of their infection. Why do so many people not know that they are infected or get tested too late to obtain optimal care? These are some of the questions we seek to answer. While the 2012 conference reported on concrete study findings, this article explores the elements that should be a part of "E".

Encourage, empower, expand. To scale up testing, groups at higher risk for HIV infection, such as people who inject drugs, sex workers and men who have sex with men, need expanded opportunities and encouragement for HIV testing through targeted information on prevention. Just as importantly, however, they need to be empowered to take control of protecting their own health. Although high-risk populations are typically marginalized, in many parts of western Europe men who have sex with men are less marginalized now than in the past. In this group, HIV infection is on the rise again.[5] Quality counselling on preventing HIV transmission is needed for members of this community and of other groups at risk that are more difficult to reach. Hence, the HIV in Europe initiative will prioritize counselling issues over the next two years.

Ethics. Medical ethics prescribe that health-care providers should do no harm, yet in certain parts of Europe, particularly in the east, they often notify the authorities when people who inject drugs seek HIV testing or care. Fear of incarceration deters drug users from getting tested. Until medical services are fully delinked from law enforcement, or law enforcement and health policymakers begin to work in tandem with HIV organizations, HIV testing will remain infrequent among key risk groups and HIV transmission will continue or increase.

Evidence. A growing body of evidence is accumulating on how to overcome barriers to HIV testing. Since people with HIV infection often have tuberculosis, WHO recommends testing all HIV-positive individuals for tuberculosis and vice versa.[6] It also recommends hepatitis C screening and hepatitis B vaccination among people who inject drugs.[7] Nevertheless, few tuberculosis patients are tested for HIV partly due to stigma involving both the patient and the care provider. While busy providers can be trained and care and referral systems streamlined, stigma can be far more difficult to overcome, particularly when HIV transmission is criminalized.

Evaluation. To build a good evidence base, testing programmes must be rigorously evaluated. All too often, the costs of evaluating, or even monitoring, programme activities are not included in the funding. The resulting lack of reliable national testing data hinders the full evaluation of testing programmes. At the service delivery level, ongoing evaluation can pinpoint inconsistent testing or low testing rates and evaluation research can lead to improved overall programme effectiveness.

Effectiveness. Although HIV testing programme evaluation tends to focus on effectiveness, cost–effectiveness is the criterion most often employed to prioritize interventions, especially in low-resource settings. In 2003 many experts argued that prevention was as much as twenty times more cost–effective than treatment. But what clinician or patient is primarily interested in prevention when faced with advancing disease? Further, the evidence is solid that treatment *is* prevention because reducing the viral load in an individual or community makes transmission decline. What the Copenhagen HIV Programme and colleagues are currently investigating is when to initiate treatment.

The jury is still out on which HIV interventions to prioritize, although initial attempts to define this have been made: WHO has reviewed the published evidence[8] and the Copenhagen Consensus Centre commissioned expert papers on the main interventions, which were ranked in order of cost–effectiveness by a panel of economists.[9] Although antiretroviral therapy ranked fifth and testing and counselling ninth, WHO has called for all interventions to include testing and treatment components, thereby cementing their central position in the response to HIV infection and acquired immunodeficiency syndrome, since testing is a precondition for effective treatment.

If the prevention revolution advocated by the Joint United Nations Programme for HIV/AIDS (UNAIDS) is to materialize, we need the universal access to treatment to which countries have committed themselves. This implies, however, maintaining or increasing funding in the face of competing priorities – a daunting task currently faced by organizations like the Global Fund, UNAIDS and WHO. Otherwise "E" will stand for "empty promises" and "D" for "delayed testing". ■

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