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Journal Discussion

HIV Policy: Does Most Effective Equal Best?

Public health policies must not only demonstrate a concern for the general public but also respect individual patient privacy and confidentiality.

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When AIDS was first diagnosed in this country the diagnosis was a death sentence. For women, the diagnosis came with recommendations from the Centers for Disease Control and Prevention (CDC) and the American College of Obstetrics and Gynecology (ACOG) to avoid spreading HIV to an unborn child by not getting pregnant [1].

The 1994 finding that the antiretroviral drug zidovudine could reduce by 2/3 the likelihood that a woman with HIV would pass on the virus to an unborn child promised to expand reproductive options for women with HIV and change the face of pediatric AIDS cases [2]. (Without intervention approximately 1 in 4 women who are HIV-positive will pass on the deadly virus to their infant either in utero or during labor and delivery) [3].

The Public Health Service (PHS) then created practice guidelines calling for clinicians and other prenatal caregivers to counsel all pregnant women about the benefits of HIV testing and to offer voluntary HIV testing. These guidelines were quickly endorsed by ACOG as well as the American Academy of Pediatrics (AAP) and other organizations [4].

Later discoveries of combination antiretroviral therapies reduced HIV vertical transmission rates to as low as 1.5 percent [5-7] and even as low as 1 percent when cesarean delivery was coupled with ziodiuvine therapy [8,9]. Changes in standard clinical practice have resulted in a sharp decline in the number pediatric AIDS cases attributable to perinatal HIV transmission from its peak at 954 cases in 1992 to just 101 cases in 2001 [10]. The CDC currently estimates that about 300 babies contract HIV from their mothers every year [11].

As of 2000, 35 states (including Puerto Rico and the District of Columbia) offered voluntary HIV testing but had no specific laws governing the testing during pregnancy; 11 states required health care professionals to offer an HIV test to pregnant women; 4 states required caregivers to test the woman for HIV unless she refused testing. In 2 states (New York and Connecticut) it is mandated that a newborn be tested for HIV when its mother's HIV status is not known [12].

In 1997 Amy E. Lovvorn, Sandra C. Quinn, and David H. Jolly analyzed various strategies for preventing perinatal HIV transmission that they found in range of policies, from those that did not specify advice during pregnancy to those that proposed mandatory testing of all pregnant women. The Lovvorn et al analysis was based on 4 criteria: avoidance of stigma, right to privacy, effectiveness, feasibility, and 2 that the authors called vertical equity and horizontal equity. They defined vertical equity as treating people in different circumstances differently, usually in an attempt to improve their circumstances, eg, affirmative action or providing special HIV education for groups at high risk for contracting the virus. Horizontal equity was seen as the equal treatment of individuals in similar circumstances, eg, the equal treatment of all pregnant women [13].

Based on these criteria the authors believed the most acceptable policy was counseling all pregnant women about risks of perinatal HIV transmission and the importance of HIV testing. The only criterion this policy failed to satisfy, in the minds of the authors, was vertical equity because those at higher risk received no special attention. But because all pregnant women would be counseled, Lovvorn et al suggested that this policy would be an effective means of

thwarting perinatal HIV transmission.

In April 2003 the CDC released new HIV prevention recommendations, which call for HIV testing to become a routine part of medical care for all individuals including the prenatal care of pregnant women. In instances where the woman's HIV status is unknown at delivery, the CDC recommends HIV testing of the newborn [10].

The policy analyzed by Lovvorn et al that most closely resembles the policy now being recommended by the CDC was labeled "test pregnant women unless" meaning all pregnant women would be tested for HIV unless they refused. Lovvorn found that this type of policy would satisfy horizontal equity in that it would treat all pregnant women the same, and it would be both feasible and effective. Lovvorn et al objected to this policy, and would presumably object to the current recommendations of the CDC, because it puts the burden of refusing HIV testing on the woman, a move the authors see as a mild form of coercion. They posit that this coercion might compromise the patient-physician relationship and trust. The authors further objected to this type of policy because they think it stigmatizes pregnant women and does not guarantee their rights to privacy. It would seem that the CDC's current recommendations address the stigmatization criticism by calling for routine HIV testing of all people, not just pregnant women.

Although society does have an interest in the health of the unborn and in preventing the spread of the virus, as Lovvorn et al point out, state policies must recognize not only women's rights to privacy and confidentiality but also their parental interest in protecting their infants' well-being. Laws that mandate HIV testing during pregnancy deny women the right to privacy and deny them the opportunity to assert, voluntarily, their parental role as the health care decision-maker for their unborn child.

There is concern that if laws mandate HIV testing, be it for the population at large, among pregnant women, or for all newborns, some patients may not seek needed medical care so that they can avoid being tested for HIV. Lovvorn, Quinn, and Jolly rightly point out that the policy that best identifies HIV-infected women and reduces the number of perinatally transmitted HIV infections may not be the most acceptable policy overall.

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