

The licencing of home-testing IVDs for HIV would be of primary benefit for two populations of individuals; those who do not test or delay testing; and those who are regularly exposed to HIV and do not test with optimal frequency.

The first population are often described as 'hard to reach', but this phrase masks great diversity. There are some few populations who geographically are far from easy access to clinical and health care services; remote aboriginal communities may be a case in point. But for many other groups they could be better described as 'hard to test'. Once again this phrase covers a diversity of issues.

Some groups may find it confronting to attend health services for the purposes of testing – again Aboriginal and Torres Strait Islanders may be especially concerned about the lack of privacy and anonymity associated with health services close to where they live, especially Aboriginal Medical Services, where relatives and friends may work.

Others for whom a positive test result would be confronting include migrants and temporary visa holders, where a positive diagnosis could affect employment status, residence, and other areas of life. Further, the lack of affordable and accessible treatment for these groups, should they test positive, is a disincentive to test at all. Other occupational groups such as sex workers are also at risk of losing rights and benefits should they test positive. The consequences of testing positive in a clinical setting, and the prospect of having a notifiable disease could be significant barriers to testing at all. It is important to recognise that these barriers to testing within the health system are predominately about the perception of risk and consequences rather than the legislative and procedural reality in the relevant jurisdiction.

For all these groups, the prospect of personal home based testing, with the anonymity and confidentiality that such testing brings, should be reassuring. Accessible home based testing could certainly address the identified barriers for those who are HIV positive, but who, for the reasons specified above, are unlikely to access testing in a clinical setting. The most obvious risk in home-based testing for this population would be the lack of adequate support should they test positive. It is important to recognise however, that for these groups, the alternative would be no testing or late diagnosis. Those in these groups who choose to undertake home testing will have already recognised the possibility of a HIV positive status and the decision to test may reduce uncertainty and anxiety.

The second population who would benefit from the ease and time effectiveness of home base testing would be those who are regularly potentially exposed to HIV and do not test with optimal frequency for early diagnosis and optimal treatment.

Two groups fit this criterion. The first are the presumptive negative sexual partners of HIV positive people – sero-discordant couples. For these people very regular testing is essential given repeated potential exposure. The costs, time and procedural fatigue associated with attending a clinic for an HIV test could reduce the frequency of testing.

The other group regularly potentially exposed to HIV would be gay men who engage in unprotected anal intercourse with casual partners on a semi-regular basis. Whilst these men are likely to test, they are

unlikely to test as frequently as might be necessary to allow for early detection and treatment of acquired HIV. Home base testing would allow for regular, quick, efficient and timely testing. These groups – sero-discordant couples and gay men at regular risk will likely already be testing, but not as frequently as desirable.

In terms of risk associated with home testing for these populations it has been argued that it is essential that there be discussion prior to HIV testing, both to prepare for a positive result and as a health promotion intervention. It is now widely recognised that for those undergoing regular testing the efficacy of pre-test discussion is minimal. Both the populations described above would be highly likely to be well informed about HIV and HIV positivity in both informational and social domains. These days the pre-test discussion is largely around information provision and safe sex messages – which can be readily conveyed in text associated with the testing kit. In particular, pre-test discussions are unlikely to be relevant to groups who are testing regularly (but not frequently) as for someone testing for the first time. In the most recent HIV Futures survey¹, participants who had tested HIV positive post 2010 reported low rates of pre- test discussion or counselling (22%) but high levels of satisfaction with this situation (71%). Those who received pre-test counselling were most likely to have been tested as part of routine health screenings. Post-test counselling was reported by 74% of these participants with 81% reporting satisfaction. These findings would indicate that for recently tested HIV positive individuals, pre-test discussion is unlikely to play a significant role in either their understandings of HIV or their experience of testing. Given the necessity of follow-up clinical confirmation of a positive home test result, the availability of post-test counselling is unlikely to be compromised. In fact many clinicians report greater effectiveness of post-test discussion in a consultation some time after that involving the giving of a positive diagnosis, rather than at a time when patients are in shock. Home based testing would allow patients to prepare themselves for a clinical discussion.

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¹ J Grierson, M Pitts, R Koelmeyer (2013) HIV Futures Seven: The Health and Wellbeing of HIV Positive People in Australia, monograph series number 88, The Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne, Australia