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ETHICS OF MANDATORY PREMARITAL HIV TESTING IN AFRICA: THE CASE OF GOMA, DEMOCRATIC REPUBLIC OF CONGO

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Abstract

Despite decades of prevention efforts, millions of persons worldwide continue to become infected by the human immunodeficiency virus (HIV) every year. This urgent problem of global epidemic control has recently lead to significant changes in HIV testing policies. Provider-initiated approaches to HIV testing have been embraced by the Centers for Disease Control and Prevention and the World Health Organization, such as those that routinely inform persons that they will be tested for HIV unless they explicitly refuse ('opt out'). While these policies appear to increase uptake of testing, they raise a number of ethical concerns that have been debated in journals and at international AIDS conferences. However, one special form of 'provider-initiated' testing is being practiced and promoted in various parts of the world, and has advocates within international health agencies, but has received little attention in the bioethical literature: mandatory premarital HIV testing. This article analyses some of the key ethical issues related to mandatory premarital HIV testing in resource-poor settings with generalized HIV epidemics. We will first briefly mention some mandatory HIV premarital testing proposals, policies and practices worldwide, and offer a number of conceptual and factual distinctions to help distinguish different types of mandatory testing policies. Using premarital testing in Goma (Democratic Republic of Congo) as a point of departure, we will use influential public health ethics principles to evaluate different forms of mandatory testing. We conclude by making concrete recommendations concerning the place of mandatory premarital testing in the struggle against HIV/AIDS.

Keywords

premarital testing; public health; ethics; health policy; Africa; HIV; Democratic Republic of Congo

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INTRODUCTION

In the struggle to control the AIDS epidemic, there is an urgent need to dramatically increase the number of persons who are tested and come to know their HIV status. Of the 24.7 million HIV-positive persons in sub-Saharan Africa, only an estimated 10% are aware that they have the virus.[1] The possibility of behavioral change depends on knowledge of HIV status, and only those known to have HIV can enter into appropriate care and treatment. Clearly, an epidemic of a largely heterosexually transmitted infectious disease cannot be successfully controlled when so few people know whether they are HIV-positive or not. For this reason, the World Health Organization called 2006 the 'Year of Acceleration of HIV Prevention in the African Region', focusing on HIV testing as top priority.

There are different possible ways to 'accelerate' HIV testing and increase the numbers of persons aware of their HIV status. Routine 'opt-out' HIV testing in clinical settings has recently gained the attention of the media, public health professionals and policy-makers after it was adopted by the Botswana Ministry of Health and led to a dramatic uptake in testing acceptance.[2] Routine 'opt-out' testing has also recently been recommended by the Centers for Disease Control and Prevention (CDC) in the United States.[3] The World Health Organization plans to issue new guidelines concerning provider-initiated testing and counseling in early 2007.[4]

One form of 'provider-initiated' testing has been neglected in official HIV prevention policy circles and ethical debates: premarital HIV testing. This may be due to the well-documented failure of premarital HIV testing policies in the early days of the epidemic in the United States. In the late 1980s, Illinois and Louisiana legally mandated premarital HIV testing, but soon abandoned the policy after couples started to marry in neighboring states and very few infections were being detected at a high financial cost.[5]

Despite this adverse experience, premarital HIV testing still has powerful advocates. Kevin De Cock, current director of the Department of HIV/AIDS at the World Health Organization, has written that '[A]lthough premarital HIV testing is not effective where prevalence is low, it is an important preventative practice in regions with generalized epidemics',[6] and that '[F]or ethical and public health purposes, people should be strongly encouraged to learn the HIV status of prospective sex partners, undergo premarital testing, and notify partners of their status.'[7] In 2004, the Global Business Council recommended that HIV testing be required at three points in a person's life: at marriage, before child-birth and upon any visit to the hospital.[8]

This article analyzes key ethical issues surrounding mandatory premarital HIV testing in resource-poor settings with generalized HIV epidemics. We will first briefly mention some mandatory HIV premarital testing proposals, policies and practices worldwide, and offer a number of conceptual and factual distinctions to help distinguish different types of mandatory testing policies. Using premarital testing in Goma (Democratic Republic of Congo) as point of departure, we will evaluate different forms of mandatory testing using influential public health ethics principles. We conclude by making concrete

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recommendations concerning the place of mandatory premarital testing in the fight against HIV/AIDS.

PROPOSALS, POLICIES AND PRACTICES WORLDWIDE

Premarital HIV testing lives a somewhat shadowy global existence. These policies are often implemented at regional or local levels by churches and religious groups, and often there is little formal or publicly accessible documentation of their procedures. For this reason, premarital HIV testing policy is a relatively neglected subject, particularly in the scientific literature, though there are regular reports in the media.

Asia and Southeast Asia

On World AIDS Day in 2005, the Indian government declared its intention to make premarital testing mandatory. After a public outcry, the government retracted its intention, though the local government of Goa continues to pursue premarital testing policies in collaboration with local churches, a move condemned by human rights organizations.[9] The government in the state of Andhra Pradesh also intends to implement a mandatory premarital testing policy.[10] As of January 2006, Muslim couples in the northeastern Malaysian state of Kelantan are required to bring their HIV test results to mandatory marriage preparatory classes.[11] Similar measures are in effect in the states of Johor and Perlis, though it is not Malaysian national policy. The government of Yunnan, one of the provinces in China hardest hit by HIV/AIDS, decided in late 2006 to make HIV tests part of mandatory premarital health screening.[12] Premarital HIV testing is said to have become ‘a tradition’ in Phayao, a northern province of Thailand.[13]

Europe

In 2004, the Republic of Albania considered a draft amendment to its Family Code, which would require premarital HIV testing and bar those found with HIV/AIDS from marriage.[14] The amendment, strongly opposed by national and international legal and humanitarian organizations, did not pass.

North America

In the early 1990s, seven of Mexico’s 32 states made HIV testing part of their mandatory premarital screening, despite opposition from local NGOs.[15] The state of Missouri in the United States has premarital HIV testing on its statute books, allowing for the promulgation of rules for mandatory premarital HIV testing if the Centers of Disease Control and Prevention so indicates.[16]

Africa

Since the late 1990s, mandatory premarital HIV testing was introduced in most Orthodox and Pentecostal churches in Nigeria,[17] as was the case with number of churches in Ghana, before the latter changed to voluntary premarital testing after pressure from civil society groups.[18] In March 2006, the Roman Catholic Church in Burundi instructed its priests only to conduct wedding ceremonies if the couples first present an HIV test.[19] According to news reports, premarital testing policies in the southern Burundian province of Bururi were

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initiated by the Catholic Church in 1989.[20] The influential Ecumenical Council of Churches has conceived premarital HIV testing in Africa as integral to marriage as a holy union.[21]

This list is not exhaustive. Given that the policies and practices are typically implemented at a local level, there may be much more mandatory premarital testing taking place worldwide than indicated here.

DISTINGUISHING PREMARITAL TESTING POLICIES

Health policies and their implementation in practice can take different forms, each of which may raise different ethical issues. Recent debates concerning 'routine HIV testing' have made clear the importance of making conceptual distinctions between types of testing policies. Ambiguous use of terms such as routine testing, routine offers of testing, opt-in and opt-out testing, mandatory and compulsory testing have lead to confusion about the policies and practices to which they refer and their ethical significance.[22] Therefore, some basic distinctions need to be made prior to a discussion of the ethics of premarital HIV testing.

An important initial distinction should be made between (1) ways in which HIV testing is offered and obtained from prospective clients and (2) the relationship between the HIV test result (however obtained) and the institution of marriage. In regard to HIV testing, the terms 'voluntary' and 'compulsory' refer to ways of offering testing, producing test results, and informing clients of the results. The term mandatory refers, in this context, to the relationship between HIV testing and marriage. HIV testing can be voluntary in its way of being offered – such as a client-initiated voluntary testing and counseling model – while possession of the test result can be mandatory in view of getting married. Failing to make these distinctions can, for example, lead to the false impression that 'mandatory premarital testing' involves forcing couples who plan to marry to undergo an HIV test. There are examples of mandatory premarital testing being called *compulsory* testing in the scientific literature[23] and in the popular press.[24] This misnomer can obviously influence ethical evaluation of the policy.

Voluntary premarital testing refers to a range of ways of conducting HIV tests among men and women intending to marry. Any offer of HIV testing to couples who are not (yet) married is in a sense 'premarital testing', but voluntary premarital testing generally refers to voluntary testing and counseling (VCT) services accommodating the specific needs of couples with marriage plans. How voluntary testing is offered has many variations, such as client-initiated 'opt-in' or more provider-initiated 'optout' approaches. The key ethical idea, however, is that being tested remains a matter of informed and uncompelled choice. As centuries of philosophizing on free will attest, the concept of 'voluntary' is notoriously slippery and difficult to define. In this context, we understand voluntary HIV testing as a process in which a person, free from undue controlling influences, decides to come to know his/her own HIV status, and authorizes others to gain this information, primarily in order to plan his/her own health care or protect the health of others. Voluntary testing in this sense stands in contrast to *compulsory HIV testing*, defined as a person being tested for HIV without his or her consent or knowledge. Compulsory premarital testing would, for example, involve drawing blood to be tested from couples against their will, or screening their blood

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for HIV without their knowledge and prior consent. Legal prohibitions exist in some countries against compulsory HIV testing as a violation of the right to privacy,[25] with possible exceptions made for compulsory testing of sexual offenders,[26] though compulsory HIV testing of other groups (such as convicted injection drug users and sex workers) occurs in some parts of the world.[27]

Mandatory premarital testing refers to policies that make HIV testing a necessary condition for civil and/or religious marriage. Mandatory HIV testing in general is defined as the requirement for persons to be HIV tested in order for them to access some perceived benefit or good. Policies requiring HIV testing before immigration to certain countries, joining the military or gaining employment are all forms of mandatory testing. Since ‘mandatory’ here refers to the relationship between HIV testing and marriage, it should be contrasted not with voluntary or compulsory testing policies but with the alternative of simply not having to be tested for HIV in order to get married. When a mandatory premarital testing policy is in effect, HIV testing is still (unlike compulsory testing) a matter of choice, although choosing not to be tested means (unlike voluntary testing) having to forego marriage.

Arguably, marriage is so important to people that making HIV testing mandatory for marriage may seem tantamount to making it compulsory, that is, that couples may feel they have ‘no real choice’ but to get tested. This is a significant ethical concern, and suggests that policy-makers should be sensitive to how mandatory premarital testing is experienced by those subject to it. However, it does not undermine the distinction between compulsory and mandatory in regard to premarital testing policies. Feeling as if one has no choice, due to deep commitment to the value of marriage, is ethically different than being tested for HIV against one’s will or without one’s knowledge. In the former case, choice is constrained; in the latter case, choice is eliminated.

The labels mandatory, voluntary and compulsory are only rudimentary ways of distinguishing premarital testing policies. Policies can be further differentiated in response to the following four key questions:

Who is responsible for oversight and enforcement of the policy, and what kinds of marriage are involved?

Premarital HIV testing policies are typically implemented by religious authorities, civil authorities or both. In the case of China, for example, premarital health examinations have long been seen as an opportunity to address various population health concerns; religious groups are not involved in the practice of offering HIV testing as part of premarital screening in China.[28] In Ghana, premarital HIV testing was initiated when church leaders felt that the HIV/AIDS epidemic was showing no signs of diminishing; there seems to be little state involvement.[29] In Nigeria, clinics, hospitals or health centers are contracted by faith-based organizations to perform the tests, and while the Nigerian government endorses the practice, there is no national legislation regarding premarital HIV testing and no HIV test required for civil marriage.[30]

What is done with positive HIV testing results in regard to the planned marriage?

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In some cases, couples may be given the choice whether or not to marry regardless of test results, while in other cases church leaders may actively counsel against marriages of serodiscordant couples and/or couples of whom both test positive; it is also possible to have a policy that only permits HIV negative couples to marry. For example, in 2001, Johor state in Malaysia implemented an Islamic religious decree (*fatwa*) requiring Muslim couples to test for HIV, but couples were permitted to marry whatever the result.[31]

How is the information about the HIV status of the couple treated during the process of premarital testing?

Different disclosure mechanisms obviously have different implications for the protection of confidentiality. Does the agency administering the tests forward test results to civil or religious authorities? Do the married couples bring a copy of their HIV test result to the authorities themselves? Who, in practice, can come to know the HIV status of the persons involved in the premarital testing process?

Is partner-notification built into the premarital testing process or are the couples expected to disclose to each other without third party involvement? How are family members or physicians involved?

What services are offered and accessible for those who receive a positive result in the course of premarital HIV testing?

In some settings, men and women who receive a positive test result could be referred to affordable health services that offer something like the World Health Organization's 'universal access package' of HIV interventions: antiretroviral treatment including adherence support, prevention counseling, psychosocial and nutritional support, opportunistic infection prophylaxis, and tuberculosis and STI detection and interventions. In other settings, some or no such services may be available, or they may be available but unaffordable for the majority, or they may be available and affordable but of low quality. The ethics of premarital HIV testing policy is partly dependent on the benefits of the policy for individuals, and therefore it is important to know how premarital policies link with local standards of care for HIV positive persons.

THE CASE OF GOMA, DEMOCRATIC REPUBLIC OF CONGO

Goma lies on the northern shore of Lake Kivu in the eastern part of the Democratic Republic of Congo (DR Congo). Administratively, it is composed of two communes (named Goma and Karisimbi) with a combined population of roughly half a million people. Although the region is known for its natural beauty, it is also marked by a history of armed conflict, invasion by neighboring countries, human rights abuses and poverty. The region also has a high HIV prevalence (4.5–10%) relative to the estimated national figures.[32]

The DR Congo has no national policy regarding mandatory premarital HIV testing. The *Programme National de Lutte contre la SIDA* (PNLS), the national AIDS control program in the DR Congo, recommends the promotion of voluntary premarital testing[33] and has permitted pilot voluntary premarital testing programs in the country, funded by Family

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Health International (FHI) and run by local nongovernmental organizations (NGOs) Femme Plus and Amo-Congo.[34] The *Facultés Catholique de Kinshasa*, one of the most influential academic institutions in the country, recommended that its Faculty of Canon Law reflect on the issue of premarital HIV testing during its 24th National Episcopal Conference in 2005. No final recommendations have been issued to date.

In Goma, mandatory premarital HIV testing was initiated about 10 years ago by some local churches, particularly the Communauté des Eglises Baptistes au Centre de l'Afrique (CBCA) and has subsequently been adopted by the mayor of Goma for civil marriages since 2004. There are currently two ways of being married in Goma – civil or religious – and both involve different forms of mandatory HIV testing. The PNLS does not seem to cooperate with the premarital HIV testing practices of religious or civil institutions in Goma, nor has it officially spoken out against them.

For religious marriage, couples must declare their intention to be married to the church committee, led by the head pastor. During the (mandatory) preparatory education given by the church, the couple is told that they each must submit HIV test results. Both the tests of the man and woman must be performed within the same week. In the case of CBCA, the results are often sent, in a sealed envelope, from the laboratory or clinic to the pastor of the church, who convenes the committee meeting of his church to open the envelope and learn the results. The couple is then invited to a meeting where the test results are disclosed to the couple and a decision is made about marriage. If either of the couple tests positive for HIV, the marriage is forbidden by the church.

For civil marriage, the couple must declare their intention to be married to the mayor or the head of the commune. The mayor or head of the commune then demands an HIV test certificate from the couple. Couples can obtain an HIV test and certificate from local clinics or the Red Cross. Civil authorities, however, do not require details about the test result itself in order for the couple to marry, and there is no requirement for tested couples to disclose HIV status to each other.[35] In principle, serodiscordant or HIV positive couples can be married in civil ceremonies.

ETHICAL EVALUATION OF MANDATORY PREMARITAL HIV TESTING

Nancy Kass has proposed a six-step ethical framework for evaluating public health policies.[36] In what follows, we will bring this ethical framework to bear on HIV testing policy in Goma, with an eye to evaluating mandatory premarital HIV testing in low-resource countries in sub-Saharan Africa in general.

What are the public health goals of the proposed policy?

The general goal of any public health policy or program, according to Kass, is the reduction of population mortality or morbidity, although there may be proximate goals and other incidental benefits. Given that premarital HIV testing in Goma has been initiated by religious and civil institutions, independent of collaboration with public health authorities, one may question whether the policy has a public health goal rather than being driven by ulterior motives. Historical precedents of using public health rationale for moralizing ends

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are well documented.[37] In Ghana, church authorities regarded premarital HIV testing as a means of promoting premarital abstinence and reinforcing the traditional religious prohibition against sex outside of marriage.[38] Of course, a policy aiming to reduce population mortality and morbidity has no less a public health goal if it concurrently reinforces religious norms. But, for a policy to be ethically evaluated in public health terms, it must have a distinct public health goal.

In Goma, the civil and religious premarital HIV testing policies have emerged from two basic concerns: (1) that the policies could detect HIV infections in those planning to marry and help prevent transmissions to potential spouses and future children and (2) that especially religious authorities would be complicit in wrongdoing if they married persons of unknown serostatus. Although not expressed in explicitly population-level public health terms, (1) expresses the aim of using premarital HIV testing to help reduce HIV transmission, and hence HIV-related morbidity and mortality. The formulation of the goal at an individual rather than public health level may be due to lack of communication between religious, civil and public health authorities in Goma (such as the PNLS) in establishing, designing or publicizing their policies. Nevertheless, the policies in Goma appear to have a distinct, though limited, public health goal. In Goma as elsewhere, premarital testing policy is intended to be only one means of controlling HIV transmission within a comprehensive prevention strategy.

How effective is the policy in achieving its stated goals?

If the public health goal of premarital testing in Goma is to help reduce HIV-related morbidity and mortality at a population level, there are number of assumptions at work. The major assumptions are: (1) knowledge of serostatus will positively alter sexual behavior, particularly among those found HIV positive, (2) that the rate of marriage will not decline as couples fear being testing for HIV, (3) Goma couples will not circumvent premarital HIV testing by getting married outside the Goma region, (4) Goma couples will not circumvent the policy by using forged HIV-negative test certificates, (5) the test results generally reflect true HIV status, that is, there will be few cases of false positive and false negative results, (6) the policy will deter unprotected premarital sexual contacts, (7) the policy will help people access available HIV treatment and help the public health sector monitor their care, and (8) the policy will be cost-effective (in this low-resource context) relative to other interventions with the same goal. The religious premarital testing policy has an additional assumption, (9) forbidding marriage when one or both members of a couple will help reduce HIV transmission more than the civil policy where the negative test results are not required for a marriage license. To answer the central question of effectiveness, the above assumptions have to be supported by credible evidence.

This raises a general problem with premarital HIV testing policies, especially in regard to developing countries. The policies are commonly recommended on largely intuitive claims of effectiveness, and once the policies are implemented there are often few evaluation and monitoring mechanisms to measure their effectiveness. A major exception to this rule is premarital HIV testing in Illinois – where the policy was revealed to be neither cost-effective nor efficacious in terms of epidemic control. In Goma, if premarital HIV testing

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increases knowledge of serostatus, then it is plausible to believe that some new infections will be averted through behavioral change. Associations between knowledge of HIV status and behavioral change have been noted in developed countries,[39] while the strength of the association within developing world settings is less well known. How many new infections will be averted will depend on how many couples agree to be married in Goma and submit a genuine HIV test (assumptions 2, 3 and 4). There are reports of a market in fraudulent HIV negative test certificates in Goma being used by couples for civil marriage[40] and it is reasonable to believe that such certificates may also be used in religious marriages. In Goma, there is also no reliable baseline data from which to judge increases or decreases in rates of premarital sex. In regard to assumption 5, the accuracy of the tests depends on the testing technology available in Goma, the current laboratory conditions and the expertise of staff in producing and interpreting results. Given that laboratories in the region face challenges in regard to sample handling, storage and the quality of reagents, there may be heightened potential for false negative and false positive results.

Paucity of data hampers evaluation of any ‘deterrent effect’ of premarital HIV testing policies contributing positively to HIV-related morbidity and mortality in the region (assumption 6). One study in Nigeria indicates that those who were HIV tested in preparation for religious marriage under a mandatory premarital policy had a higher prevalence than the national average, weakening the case for a potential ‘deterrent effect’.[41] In regard to assumption 7, the information available does not support claims of effectiveness. If there were supportive health care systems in Goma, those found HIV positive via premarital testing could access treatment, care and psychological support services that could also contribute to the reduction of HIV-related morbidity and mortality. But country-wide in DR Congo, only 6% in need of antiretroviral treatment have access,[42] only 1% of the national budget was allocated to health care in 2002,[43] and, furthermore, the health care system in Goma is rudimentary at best. In regard to assumption 8, the cost of implementing the policies, relative to the number of HIV infections detected, has not been calculated by civil or religious authorities in Goma. In the Illinois case, estimates of the cost of averting a single HIV infection ranged between US$312,000 and US$900,000.[44] Advocates rightly claim that in high-prevalence settings, premarital HIV policies are likely to be more cost-effective than the Illinois case.[45] However, little is known about the cost-effectiveness of such policies in high HIV-prevalence regions relative to other prevention interventions, and this is a crucial point where resources for HIV prevention are very limited.

Is the church policy of forbidding marriage to HIV-positive persons justified by its contribution to the reduction of HIV-related morbidity and mortality (assumption 9)? The underlying logic seems to be: if a couple is married, and one or both are HIV positive, they will eventually have unprotected sex, particularly if they desire children. Prohibition of marriage is preferable to transmission risks. Again, the question is how many new HIV infections the prohibitive aspect of the policy is likely to avert. Those unable to be married by the church can still be married by the state; those unable to be married by the state can still engage in unprotected sex; and those married by the church may engage in unprotected extramarital sex later on. In regard to the last point, the common Congolese custom of a man

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having a mistress ('*deuxieme bureau*') is a social reality that may also erode the effectiveness of the policies. Exchange of sex for food or other benefits between men and women are common in the DR Congo.[46] One could argue premarital testing policies do not aim to reduce HIV-related morbidity and mortality by preventing extramarital sex after marriage, and should not be criticized on these grounds. However, premarital HIV testing is often promoted to reinforce marital fidelity,[47] and fidelity is widely promoted as a way of preventing HIV transmission. If premarital HIV testing does not help reduce unprotected extramarital sex via fidelity, this can be another way of questioning policy effectiveness.

In short, there is little data to evaluate the public health effectiveness of premarital HIV testing in Goma, and where there is available data, the current case for effectiveness seems weak.

What are the known or potential burdens of the policy?

The most obvious known burden of the church's policy is its restriction on the 'right to marriage'. In the United States, the right to marriage is regarded as a basic liberty founded on the right to privacy, where it is understood as the right of individuals to pursue their own life goals (including the decision to marry) without external interference. However, basic liberties are not absolute and can be restricted if, under the legal standard of strict judicial scrutiny, there are compelling public interests. Some legal experts in the United States argue that mandatory HIV testing policies – especially those that bar HIV positive persons from marrying – do not pass the test of strict judicial scrutiny, because the policy does not convincingly contribute to the reduction of HIV infection, and may therefore be unconstitutional.[48] This may be also relevant to the case of Goma. In 2006, the DR Congo adopted a new constitution in which Article 40 reads, 'Every individual has the right to marry with the person of his or her choice, of the opposite sex, and to establish a family.' (Tout individu a le droit de se marier avec la personne de son choix, de sexe opposé, et de fonder une famille.) Freedom of religion and separation of church and state under the new constitution may legally permit religious premarital testing policies barring HIV positive persons, though the legal status of the church's policy will only emerge as legal infrastructure of the country is rebuilt. From an ethical view, however, the burden of barring HIV positive persons from religious marriage seems unjustified when the public health effectiveness of the policy remains unclear.

Another potential burden of the policy is loss of confidentiality and stigmatization of persons living with HIV/AIDS. Confidentiality is understood here as the right to control information regarding oneself (especially sensitive information) from non-consensual divulgation and public scrutiny. Premarital testing policies open many possible routes for involuntary disclosure of HIV status, and the negative social consequences of such disclosure can be significant in a context where HIV/AIDS remains highly stigmatized. When couples who have announced their intention to marry abandon their plans, members of their family or community may suspect them of being HIV positive. Those who undergo HIV testing for civil marriage in Goma do not run the risk of having their results seen by a bureaucracy of government personnel, but confidentiality is not guaranteed if testing is done in official testing sites, and those who seek fraudulent HIV testing certificates may also be

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suspected of being HIV positive when they simply fear the test. The risks of lost confidentiality are higher in the church's policy, where HIV testing results may be seen by a number of church officials belonging to the same congregation as the tested individuals.

Another potential burden is what Kass calls 'a risk to justice'. According to Kass, it is appropriate to ethically evaluate health policies as to whether they alleviate, entrench or exacerbate existing racial, ethnic, gender or socio-economic inequalities due not to chance or poor individual choices, but due instead to structural forces and power arrangements in society. Under the church's policy, HIV positive persons are treated very differently than those believed to be HIV negative; the former can enjoy the privilege of religious marriage, the latter cannot. Given that marriage as a union before God has a strong appeal and central importance in the lives of many people, restriction of freedom to marry must have a very compelling justification. When the public health effectiveness of premarital HIV testing policy is questionable, however, barring HIV positive persons from marriage seems discriminatory. In connection with this issue, it should be noted that in the eastern region of DR Congo, a significant number of women are HIV-infected as a result of sexual violations.[49] Barring these women from marriage may increase their vulnerability and marginalization in society.

Can the burdens be minimized? Are there alternative approaches?

The burdens of the church's policy could be minimized by not barring HIV positive persons from marriage and protecting confidentiality by requesting HIV test certificates, but not test results. This would make the religious policy similar to the civil one. But the burdens of the civil policy itself could also be reduced by making premarital HIV testing voluntary rather than mandatory. As Kass states, whenever the burdens of a health policy can be minimized without greatly reducing policy effectiveness, it is ethically obligatory to do so. Given that there is no compelling evidence that a mandatory premarital testing policy is more effective in reducing HIV-related morbidity and mortality than voluntary approaches, the latter should be adopted, at least until there is more evidence in support of mandatory testing. This does not mean promotion of HIV testing among couples is unimportant. Programs and services offering HIV testing to couples, including couples planning to marry, should be strongly promoted. But couples testing should not take the form of making HIV testing mandatory in order to be married or making the possibility of marriage contingent on the test results. These approaches impose burdens that seem to outweigh the public health benefits.

Is the policy implemented fairly?

This part of the ethics framework expresses a concern about distributive justice, that is, the fair distribution of benefits and burdens of the policy among persons and groups in society. Since this is a policy applied to couples and aimed at the control of a largely sexually transmitted disease, it is appropriate to focus on the issue of gender. Is the mandatory HIV testing fair from a gender perspective? Some argue that not only is mandatory HIV testing policy fair, but that it can be empowering for women. Women are currently more tested for HIV than men because they more often present at health clinics. Making premarital testing mandatory at least forces men, who want to get married, to get tested; women are often in no

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position to demand this from their partners. In Senegal, in 2003, women's groups advocated mandatory premarital testing in order to allow women to know the HIV status of their prospective husbands, and to protect themselves accordingly.[50] However, an HIV testing policy that is equitable or empowering in theory may produce unfairness in practice due to the policy's engagement with existing social inequalities. In the case of the church's policy in Goma, the question is who is the most likely not to afford reliable HIV testing (or a fraudulent test certificate), who is most likely to test positive for HIV, and who is unable to access care and treatment if found HIV-positive. Women in Goma, often infected by their stable partners or through survival sex and sexual violence, have fewer resources than men if they are found to be HIV positive through premarital testing, and are more vulnerable to stigmatization by the community and exclusion from their family networks. Life prospects in Goma are different for a man who tests HIV-positive through mandatory premarital testing and a woman who does the same. If the ethics of a public health policy are to be partly judged on its potential to lessen social inequalities impacting on health, the church's mandatory testing policy does not fare well.

How can the benefits and the burdens of the policy be fairly balanced?

Given that the public health benefits of mandatory premarital HIV testing are unclear, 'fair balance' in this case entails minimizing the burdens of the policy to the greatest extent possible. How can the burdens of the policy be maximally minimized, while keeping it mandatory? One way is to better protect the confidentiality of the individuals tested. The mechanisms of the church's policy in Goma increase the vulnerability of couples by escalating potential for disclosure of HIV status. Only those with a 'need to know' should have access to the couple's HIV testing results. The disclosure of HIV status should be conducted in a sensitive way by persons with experience in HIV counseling. The church should follow the recommendation of the Oecumenical Council of Churches in assuring psychosocial support of those testing HIV positive.[51] In fact, the church should go further. When a research study excludes prospective participants who test positive for HIV, there is an expectation that some care be provided to those 'screened out'.[52] The church should similarly assure a decent standard of care for HIV positive persons it has excluded from religious marriage.

Ultimately, however, the only real way to ethically balance the burdens and benefits of premarital HIV testing policies in a setting such as Goma is to make them voluntary instead of mandatory, because current policies impose significant burdens on individuals while being based on unsubstantiated claims to public health effectiveness. However, this raises an interesting hypothetical question: would mandatory premarital HIV testing be acceptable in high-prevalence, low-income settings if it *did* appear to reduce HIV incidence? The answer could be 'yes', depending on the details of how the policy was formulated and implemented in practice, for example, if there were sufficient safeguards protecting confidentiality and if civil and religious authorities only required HIV test certificates, rather than (negative) test results, to marry couples. Another hypothetical question concerns the possibility of a slippery slope: if mandatory premarital HIV testing might be ethically justified, why not move on to *compulsory* premarital HIV testing? In our view, there are substantial consequentialist and non-consequentialist reasons precluding compulsory premarital HIV

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testing. The policy would be unlikely to work, because it would be found unacceptable by communities, and it would be found unacceptable by communities because such an underhanded approach to HIV prevention would violate basic respect for persons. Even in sub-Saharan countries hardest hit by the HIV/AIDS epidemic, there have been no calls for compulsory premarital HIV testing, and in countries with new democratic constitutions and strong traditions of political activism (such as South Africa), there is little chance of such a policy getting off the ground.

CONCLUSION AND RECOMMENDATIONS

On the basis of the foregoing analysis, we conclude with three key recommendations:

1. Voluntary couple testing and voluntary premarital HIV testing should be strongly encouraged by local civil authorities, public health institutions and the church. Voluntary approaches could raise knowledge of HIV status while avoiding some of the burdens connected with mandatory testing. Churches and civil institutions could recommend or give referrals for couple testing prior to marriage short of making testing mandatory for marriage, while the government could establish VCT centers catering to the needs of couples and promote them in the media.
2. Premarital testing policies, particularly in developing countries, should be the object of increased scientific study. Research should be quantitative, qualitative, descriptive and normative, focusing on the public health effectiveness of different policy approaches, the details of how they are implemented and experienced by community members, and the various ethical challenges and concerns the policies raise.
3. Major public health policy-makers, particularly the World Health Organization and UNAIDS, should take a clear policy position on mandatory premarital HIV testing. Mandatory premarital testing is taking place in some parts of the world, and is being contemplated in others. While increasing knowledge of HIV status is crucial to the control of HIV/AIDS, the World Health Organization and UNAIDS have always tied their testing policies to human rights concerns. We urge these influential bodies to publicly state, in regard to mandatory premarital testing, whether they still stand behind their joint 2004 policy statement:

> UNAIDS/WHO does not support mandatory testing of individuals on public health grounds. Voluntary testing is more likely to result in behavioral change to avoid transmitting HIV to other individuals.[53]

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