Reviewer’s report

Title: Evidence for reductions in sexual risk behaviour associated with the use of voluntary counselling and testing services for HIV: observations from a cohort study in rural Tanzania

Version: 1 Date: 28 October 2013

Reviewer: Dermot Maher

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Major compulsory revisions

Title

1. The title may better leave off the first two words (“Evidence for”) and leave the reader to assess the paper and decide if the reported observations constitute evidence of associations between VCT and sexual risk behaviour.

Background

2. The problems with VCT also include the possibility that those most at risk of HIV infection may least use the service, in common with other examples of sexual health service provision, e.g. cervical cancer screening.

Methods

3. Regarding the statement that “HIV prevalence has gradually risen in the study area over time”, what are the actual levels of HIV prevalence which constitute this rise?

4. How do the development and use of measures of sexual behaviour in this long established study reflect efforts to overcome the problems with these measures which the authors have indicated in the Background, going back to 1994 (the year reference 8 was published)?

5. The comment that the rise in HIV prevalence is “partially explained by longer survival and net in-migration of HIV-infected individual” leaves the question hanging unanswered, what else explains the rise?

6. The use of a protocol “based on informed consent without disclosure” requires some explanation and justification, since the standard basis of participation in a survey of a clinically important, treatable condition detected using a reliable test is “informed consent with (of course confidential) disclosure”. On account of ethical grounds, no-one would even think of doing a survey of such a condition (whether noncommunicable, e.g. hypertension, or communicable, e.g. tuberculosis or syphilis) on a basis of “informed consent without disclosure”, so this exceptionalism in the case of a survey of HIV needs explanation and justification. The authors may want to cover this issue in the “Ethics” section, which should not necessarily be confined to a statement of approval of the study
by ethical review committees.

7. It would be useful to have a brief statement of the percentage of study participants who wished to know their HIV status and among those, the percentage who did find out their HIV status.

8. Although the authors exclude “virgins” from the analysis, the authors should comment on the justification, since “virgins” may well have a particular interest in undergoing VCT before deciding on sexual debut, thus representing a group in whom assessing the impact of VCT on sexual behaviour is particularly important. Some of the measures of sexual behaviour change are applicable to people who at a particular survey round had not yet started sexual activity.

9. It’s not clear why the authors haven’t compared changes in sexual behaviour between the survey rounds (1,2 and 3) before VCT was introduced, and the subsequent rounds. The survey rounds before VCT introduction provide a baseline measure against which future changes in sexual behaviour can be assessed after VCT introduction.

Discussion

10. In discussing the possible associations between VCT use and sexual behaviour change among HIV-negative participants, what about the possibility of reverse causality, that those who autonomously change their sexual behaviour may attend VCT to validate the success or otherwise of their behaviour.

11. Regarding the comment that “low levels of condom use could also relate to problems of availability or supply”, it would be useful to know if there were such problems during the study period.

12. In the light of the authors’ explanation that previous findings have not given a consistent picture of the possible associations between VCT and changes in sexual behaviour, it’s not entirely clear if these study findings make a definite difference to establishing a consistent picture.

13. Is it possible that changes in sexual behaviour may occur over a longer time period than that represented in this study?

14. The authors comment on low levels of sexual risk behaviour in this study population, without giving some indication of how this is consistent with the high HIV prevalence in the population, which the authors haven’t stated but is likely to be about 5-6%, i.e. ten times higher than in the general population in nearly all of Europe, for example.

Conclusion

15. The conclusion that “our results support the continued implementation of VCT as part of an HIV prevention strategy” sits uncomfortably alongside the main overall lesson from this study that despite may years of promotion of VCT as part of an HIV preventions strategy, the levels of VCT are so low as to have little if any possible impact on sexual behaviour change and consequent HIV risk. The main study finding of some association between VCT and some measures of sexual behaviour change among HIV-negative participants doesn’t provide very
strong support for the contention that continued implementation of VCT should be part of an HIV prevention strategy. How much information do people get about HIV by which they modify their sexual behaviour from VCT sites compared with other sources? How important is the counselling part of VCT compared with the testing part? By offering HIV testing without disclosure, what message is the researchers sending to the study community about the paramount importance of knowing if one is HIV-positive?

Discretionary revisions

16. The authors' comments on some findings as “encouraging” or “disappointing” seems to bring a degree of subjectivity into the discussion, whereas a more objective account might refer to findings which support or don't support a proposed intervention.