UCSF Center for AIDS Prevention Studies
AIDS Research Institute

what is the role of counseling and testing in HIV prevention?

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why is C&T important?

HIV counseling and testing (C&T) is an important part of a continuum of HIV prevention and treatment services. C&T is one of the main times when a comprehensive individual risk assessment is taken, making it the best opportunity for accurate referrals to more intensive services. C&T is also one of the primary entry points into prevention and other services. C&T uses short, client-centered counseling that can be effective in increasing condom use and preventing sexually transmitted diseases (STDs).[1]

Knowing one's HIV status, whether HIV- or HIV+, is key to preventing the spread of HIV and accessing counseling and medical care. It is estimated that one-fourth of all HIV+ persons in the US do not know they're infected.[2] A survey of young men who have sex with men (MSM), found that 14% of young Black MSM were HIV+. Among those, 93% were unaware of their infection, and 71% reported it was unlikely they were HIV+.[3]

Recently, the Centers for Disease Control and Prevention (CDC) announced an initiative aimed at expanding C&T in the US.[4] Their Strategic Plan for 2005 strives to decrease by 50% the number of people who don't know their HIV status.[5] If this goal is met by 2010, an estimated 130,000 new HIV infections may be prevented, saving over $18 billion.[6]

how is C&T done?

C&T has three distinct components: risk assessment and counseling before the blood or oral sample is taken, testing of the sample, and counseling and referral with the test results.[7] C&T can be confidential—a person's name is recorded with the test results—or anonymous—no name is recorded with the test. Publicly funded HIV C&T takes place in testing centers, community health clinics, community-based organizations, outreach programs, mobile vans, STD and family planning clinics and local health departments, among other venues.

Although public health workers are trained in C&T procedures, most HIV testing in the US occurs in private doctors' offices. Many people prefer being tested as part of a routine check-up, instead of public health sites. However, testing in private venues does not offer anonymity, and patients who get tested as part of routine medical care may not receive adequate counseling or referrals.[8]

Other venues also test for HIV, such as emergency rooms, jails/prisons, military recruitment sites and Job Corps. HIV testing in the US is mandatory to get some insurance and medical benefits, apply for some jobs, join the military, give blood or enter the US as an immigrant. HIV testing is compulsory for federal prison inmates and sex offenders in some states.

what about rapid testing?

The standard testing method for the past 20 years has been a needle blood draw. In the past 10 years, a mouth swab (OraSure) that tests cells from inside the cheek has also been available. Results are sent to a lab for the ELISA test and a Western Blot to confirm an initially positive result, with an average wait of 1-2 weeks between sample collection and the provision of results. With this method, many persons don't return for their test results, and nationally 31% of persons who test HIV+ don't return to find out their results.[4]

Rapid testing is now available with a finger stick (OraQuick). With this method, results are known in 20 minutes, eliminating the need for a return visit for results. However, if a client's tests is reactive, he receives a preliminary positive result. A second blood test (needle draw or OraSure) is required to confirm the result with a standard Western Blot. Final confirmation still takes 1-2 weeks. National data indicate that with rapid testing, 95% of clients who received a preliminary positive result returned for their confirmatory results.[9]

Rapid testing will change the way C&T is conducted, although clients can still opt to get their results later. Because the client needs to wait for 20 minutes for the results, the counselor takes the blood early in the session and has a "captive audience" for risk assessment and counseling. Test counselors can conduct the blood test themselves, or a separate staff person can do the finger stick and read results. Counseling with rapid testing can be more intense and client-focused due to the immediacy of getting results. It is hoped that rapid testing will dramatically increase the number of persons who know their results.

Says who?

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what makes good C&T?

Good C&T depends on counselors who are properly trained and have enough experience. Counselors must protect the confidentiality of client information, obtain informed consent before testing and provide effective counseling services and appropriate referrals. Counselors should establish relationships with key service agencies to make sure the referrals they give clients reflect their needs, priorities, culture, age, sexual orientation and language. C&T counselors should be evaluated regularly to assure quality and be provided with support and ongoing training.[7]

With rapid testing, counselors need different training as they can be both the counselor and the lab. Rapid testing requires stable temperatures, adequate lighting, and careful attention to detail. Also, rapid testing is not rapid counseling. Counselors need to work closely with clients to develop a reasonable risk reduction step and to make sure their clients are actually ready to receive the test results. It is also important to obtain a second blood sample for confirmation if a client tests positive.[10]

what's being done?

The Department of Public Health (DPH) in Florida made a deliberate effort to improve their C&T services and increase the number of people who know they are HIV+. State funded testing sites targeted venues with high-risk persons, including CBOs, prisons/jails and outreach settings. They also began using OraSure for testing in the field. In 2002, the DPH reported a 2% seropositive rate for blood draws and 3.2% for OraSure. In jails they found a 3.6% seropositive rate. They also used partner counseling and referral services (PCRS) and in 2002, 80% of HIV+ people gave names of partners, 64% of partners were located and counseled, and 13% of partners who tested were HIV+.[11]

In Minneapolis, MN, rapid testing was offered at a variety of agencies serving primarily African American clients. Venues included drug treatment programs, homeless shelters, teen clinics, sex offender groups and halfway houses. Almost all (99.7%) of clients received their test results and counseling, and 95% reported they would rather have a finger stick than a blood draw.[12]

Wisconsin's AIDS/HIV Program wanted to increase the number of high-risk persons accessing testing. In the early 90s, tests jumped from 6000 per year to between 20,000-30,000. The number of high-risk persons tested, however, remained the same while seroprevalence rates dropped from 3.5% to 0.5%. In the late 90s, the program shifted its philosophy from one of public education to case finding. Publicly funded sites were reduced from 126 to 55 serving the greatest percentage of high-risk persons and persons of color. In one year, the seroprevalence rate improved to .75%, the number of low-risk persons tested decreased 42%, high-risk persons tested increased 6%, and testing among persons of color improved 18%.[13]

what is the future of C&T?

As rapid testing becomes more widely used, it is hoped that the number of people not returning for their test results will decrease. Rapid testing can allow for more targeted outreach to communities and persons at risk, as C&T occurs in venues that are more accessible and acceptable. Rapid testing should be implemented carefully to allow time for agencies to gain experience and clients to understand the new testing process.

Greater efforts may be necessary to refer clients to effective services. Behavior change is a slow and difficult process, and many persons make changes incrementally. Linkages to other services and follow-up with clients may substantially increase the impact of the initial counseling. While training and quality assurance has traditionally centered on counseling in C&T, referrals may be the weakest part and need most improvement.

Simply increasing the number of persons who know they are HIV+ will not slow the HIV epidemic sufficiently. As more persons in the US discover their HIV status, it is crucial to ensure that more prevention, social and treatment services are available both to HIV+ and HIV- persons. In addition to primary HIV prevention interventions, these should include access to quality drug and alcohol treatment, housing and employment services, STD testing and treatment, syringe exchange programs, quality medical care and adherence support to insure effective use of AIDS medications.

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