CHAPTER 23

Counseling, Testing and Psychosocial Support

Rachel Baggaley
Ignatius Kayawe
David Miller
Counseling, Testing and Psychosocial Support

INTRODUCTION
Voluntary counseling and testing (VCT) have become an integral part of HIV prevention and care programs in many industrialized and some developing countries. Besides recognizing the importance of VCT in reducing HIV transmission in those who test seronegative, VCT services have evolved to reflect the changing needs of communities and the changing possibilities in management, treatment and support for HIV-infected people. This chapter offers information on the role of VCT in HIV care and prevention programs as well as practical advice on setting up VCT services.

WHAT IS VOLUNTARY HIV/AIDS COUNSELING AND TESTING?
HIV counseling is defined as “Confidential dialogue between a person and a care provider aimed at enabling the person to cope with stress and make personal decisions related to HIV/AIDS. The counseling process includes an evaluation of personal risk of HIV transmission and facilitation of preventive behavior.”

For the person being tested, HIV testing has consequences that reach far beyond the diagnosis. It may have negative consequences in communities where HIV-infected people are stigmatized.

THE COUNSELING PROCESS
The VCT process begins with raising community awareness of the ways in which VCT is beneficial for HIV prevention and access to appropriate care and support. The process continues with pre-test, post-test and follow-up counseling, which can be adapted to the needs of the client(s).

THE TESTING PROCESS
The diagnosis of HIV has traditionally been made by detecting antibodies against HIV. A wide range of HIV antibody tests are available today, including ELISA-based tests and many newer, simple and rapid tests.
VCT MODELS

Different models of VCT are available, and choice will depend on the needs of the community, seroprevalence of HIV and maturity of the epidemic, attitudes and political and community commitment to VCT, available financing and existing VCT resources.

SETTING UP VCT SERVICES

VCT services will be greatly aided if the following factors are first assured:

- Political commitment and institutional ownership
- Identification of an implementation team
- Awareness of the problem and investment in skills development for health care workers
- Identification of existing resources
- Adequate long-term financing

ORGANIZATIONAL STEPS

The steps required in establishing VCT services include:

- Site choice
- Coordination
- Selecting and training staff
- Counselor monitoring and support
- Record keeping and confidentiality assurance
- Choice of testing strategy
- Organizing a distribution and supply system
- Adapting or developing quality assurance guidelines

COUNSELING FOR PARTICULAR NEEDS

Counseling can be tailored to certain groups with particular needs and issues. These issues should include:

- Prevention
- Premarital counseling and testing
- Couples counseling
- Counseling for children and families
- Adolescents
- Maternal-to-child-transmission (MTCT) interventions and antenatal infant-feeding options
- Tuberculosis preventive therapy (TBPT)
- Vulnerable groups (injection drug users, commercial sex workers and men who have sex with men)
- Bereavement
- Blood donation
INNOVATIVE APPROACHES

Some innovative approaches to VCT have shown success. These include:

- Group information/counseling
- People living with HIV/AIDS (PLHA) support groups
- Home testing

BARRIERS TO VCT

Although VCT is becoming increasingly available in developing and middle-income countries, many people are still to be tested. This is the result of barriers to VCT, which include:

- Stigma
- Gender inequalities
- Lack of perceived benefit

MONITORING AND EVALUATION

Most evaluations have sought to demonstrate that VCT reduces incidence of HIV infection and contributes to prevention efforts. Monitoring and evaluation pose special challenges, because confidentiality is critical. Many of the usual monitoring and evaluation techniques are therefore not applicable.

ETHICAL AND LEGAL CONSIDERATIONS

Ethical and legal considerations often arise around the issue of HIV testing. These include:

- Pre-employment/pre-education HIV testing
- Mandatory HIV testing
- HIV testing following rape
- Testing without counseling
- Discrimination
- Partner notification
LESSONS LEARNED

VCT services have a pivotal role to play as an entry point to HIV prevention and care. Lessons learned in VCT encompass:
- VCT models
- Counselor training
- Counseling content
- Testing methods
- Support services
- Involving hard-to-reach groups
- IEC, awareness and advocacy
- Funding

CASE STUDIES

UGANDA: AIDS INFORMATION CENTRE (AIC)
The AIC philosophy is that knowledge of one’s own HIV infection status is an important intervention and prevention strategy. The organization provides rapid testing with same-day results, syndromic management of other STDs, initiatives to promote VCT and sustain behavior change and special services for couples with discordant HIV results.

MALAWI: MALAWI AIDS COUNSELING AND RESOURCE ORGANIZATION (MACRO)
In late January 2000, MACRO introduced onsite use of simple, rapid, whole-blood, finger-prick testing with immediate confirmation. A prevention counseling protocol was developed, and counselor training conducted for same-day counseling with same-day test results. These new procedures dramatically increased demand for services.
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SUMMARY
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Voluntary counseling and testing (VCT) for HIV have become an integral part of HIV prevention and care programs in many industrialized and some developing countries. While recognizing the importance of VCT in reducing HIV transmission in those who test seronegative, VCT services have evolved and expanded to reflect the changing needs of communities and the changing possibilities in management, treatment and support for HIV-infected people.

The scope and challenges of VCT have changed over the past decade. VCT was initially used mainly to diagnose HIV infection in symptomatic people; testing was promoted as a component of HIV prevention. The development of antiretroviral treatment for people with HIV, less costly interventions to reduce the incidence of HIV-associated infections and relatively cheap and feasible methods to significantly reduce mother-to-child transmission (MTCT) of HIV have made the need to promote VCT for people with asymptomatic infection more compelling. Testing methods have also become simpler and cheaper, making VCT more feasible in many developing countries.
VCT services have a pivotal role to play as an entry point to HIV prevention and care. The advantages of this role are shown in Figure 1.

This chapter provides information on the role of VCT in HIV care and prevention programs and offers practical advice on setting up VCT services.
WHAT IS VOLUNTARY HIV/AIDS COUNSELING AND TESTING?

HIV counseling is defined as, “Confidential dialogue between a person and a care provider aimed at enabling the person to cope with stress and make personal decisions related to HIV/AIDS. The counseling process includes an evaluation of personal risk of HIV transmission and facilitation of preventive behavior.”

For the person being tested, the procedure has consequences that reach far beyond the diagnosis. Although there are many benefits to knowing one’s HIV status, testing may have negative consequences in communities where HIV-infected people are stigmatized. No one should be coerced into being tested. The decision to undergo HIV testing should be entirely voluntary.

Trust is one of the most important factors in the relationship between counselor and client. It enhances that relationship and improves the chances that the individual will act on the information provided. Given the possibility of discrimination, ostracism and personal recrimination that an individual diagnosed with HIV may face, it is all the more important that confidentiality be guaranteed. Confidentiality forbids any reference to, or discussion about, a client, except within a professional relationship, and only then with the consent of the client.

While some health workers are familiar with counseling clients about other issues such as treatment options, death and dying and/or family planning, many are not familiar with HIV/AIDS counseling and related matters. Even when health workers have been trained, professional understanding does not necessarily lead to an appropriate change of attitude or to professional behavior that guarantees confidentiality. Confidentiality must be guaranteed.

THE COUNSELING PROCESS

The VCT process begins with raising community awareness of how the testing is beneficial for HIV prevention and access to appropriate care and support. Without adequate community understanding, acceptance of VCT will probably be poor.

The process continues with pre-test, post-test and follow-up counseling, which can be adapted to the needs of the clients—whether an individual, a couple, a family and/or children. Counseling content and approach may vary considerably according to the group targeted: young people, gay men, drug users, sex workers, etc. Content and approaches may also reflect specifics of the context of the intervention. Examples include diagnostic HIV counseling (if testing is not available or desired) and counseling associated with specific interventions such as tuberculosis preventive therapy (TBPT) and interventions to prevent MTCT.

Good counseling practice contains certain core elements of content and quality that are important for all counseling sessions, as well as additional subjects that are important in specific circumstances and when specific interventions—such as MTCT and TBPT interventions—are available.

Establishing good rapport by showing respect and understanding will make problem solving easier in difficult circumstances. Reports have shown that the manner in which clients are informed of their HIV serostatus is very important in facilitating adjustment to news of HIV infection.

Important elements in good quality counseling include:

- Discretion and sensitivity to a nervous or embarrassed client
- Appropriate physical environment for comfort, privacy and confidentiality
- Good client reception, greeting and introduction
- Rapport, respect, interest and empathy
- Non-judgmental attitude
- Engagement of the client in conversation
- Active listening (non-verbal and verbal)
- Emotional warmth and support
**Sensitivity to and accommodation for language difficulties**

- Talking about sensitive issues plainly and in a manner appropriate to the culture, educational level and beliefs (spiritual and traditional) of the client
- Prioritizing issues to best use limited time and short contacts
- Techniques to overcome constraints such as time and privacy
- Appropriate management of client’s distress or emotional reactions
- Flexibility to involve partner or significant other, when appropriate or requested

An outline of the key elements in pre- and post-test counseling is shown in Figure 2.6

**Pre-Test Counseling**

During the pre-test session, the counselor will help the client decide whether or not to be tested for HIV. The following areas should be discussed:

- Reason for attending
- Knowledge about HIV and its transmission
- Misconceptions
- Assessment of personal risk profile
- The test itself (process, meaning of possible test results, window period, etc.)
- The meaning of seropositive and seronegative results and possible implications
- Coping with seropositive result
- Development of personal risk-reduction plan.
- Potential needs and available support
- Informed consent/dissent given freely

The client must be given adequate time to ask questions and digest new information. Where “same day” testing is used, clients should be given adequate time to think in the pre-test session.

Some people will defer testing at this stage and return later for the blood draw, after discussing the test with their partner, relatives or friends. If a client is not ready to undergo testing, he/she may wish to discuss VCT with his/her partner or family and return at a later date. When a client has a steady partner, he/she may prefer to return with the partner to be tested together. This approach is beneficial as it allows couples to make decisions together about safer sex.
**POST-TEST COUNSELING**

When simple/rapid tests are used, HIV test results may be available shortly after the specimen (blood, saliva or urine) is taken, or later on the same day. If testing is done at a central laboratory, clients may have to wait as long as two weeks for their test result.

If the client feels unprepared to receive his/her results, he/she should be given a future date to return. It may also be appropriate for him/her to bring a supportive friend or relative.

Whatever the result, post-test counseling should always be given. The two main objectives of the post-test counseling session are (1) support, and (2) prevention of HIV transmission. Post-test counseling accomplishes this through discussion of the result, sharing information and encouraging safer sex practices. Immediate plans, intentions and actions should be reviewed and follow-up plans discussed. In some circumstances, counseling sessions may last only 15 minutes. In view of the emotional consequences associated with giving an HIV test result, it may be necessary to allow up to 60 minutes for post-test counseling for some people.

**Positive results**

The following suggestions can aid counselors (either immediately at the post-test session or during follow-up counseling) when a result is seropositive:

- Give results simply, clearly and humanely.
- Allow time for the result to sink in.
- Discuss the meaning of the result for the client.
- Discuss the personal, family and social implications—including whom, if anyone, to tell.
- Deal with immediate emotional reactions.
- Check that adequate immediate support is available.
- Discuss follow-up care and support, which may include:
  - Ongoing counseling
  - Counseling of other family members and partners
  - Social support
  - Legal advice
  - Referral for screening and treatment of STDs
  - Family planning counseling
  - Special services for pregnant women
  - Medical referral, including TBPT
- Develop a personalized risk-reduction plan, including prevention of HIV transmission to partners who may be uninfected or untested, and use of safer sex practices (these areas may be dealt with in more depth during follow-up counseling).
- Identify options and resources.

Receiving a seropositive test result is often shocking and distressing. The client may be unable to take in large amounts of information at this time. To be supportive, the counselor should concentrate on showing empathy and conveying some measure of hope. The counselor must listen to—and hear—what the client is saying, and encourage him/her to voice his/her thoughts and worries. People's reaction to receiving a positive result will vary. Some may cry; others swear; some remain silent. The counselor may feel uncomfortable if the client starts crying, but can indicate that crying is alright by giving him/her some time to absorb the news. Sometimes, touching the client in a soothing manner can help, such as putting a hand on a client's shoulder for a moment.

The counselor should explore the client's immediate plans, and ensure that he/she will have adequate support. It is often very helpful to have a follow-up session after a few days, when the client has had time to reflect on the implications of the test result, and can discuss future plans, needs and follow-up.
Negative results

Although the client will be relieved to receive a negative test result, it is necessary to discuss repeating the test after three months if he/she has had unprotected sex in the three months before testing. This is the “window” period, during which a test may be negative, even though the client may have contracted HIV. It is also important to discuss sexual partners’ serostatus. If this is unknown or positive, he/she will still be at risk of HIV infection and discussion of safer sex is important. If the client has a steady sexual partner, the benefits of sharing results and testing the partner can be reviewed.

Intermediate/indeterminate results

Any serum that tests seropositive in the first test—but seronegative in the second test—should be retested using the two assays. Concordant results after repeat testing will indicate a positive or negative result. If the results of the two assays remain discordant, the serum is considered indeterminate. Fortunately, indeterminate results are rare. Serum from people with advanced immunosuppression and signs of disease occasionally will give an indeterminate result due to a decrease in antibodies. In these circumstances, a repeat test will usually be unnecessary and a presumed positive result can be given on clinical grounds.

If the person is asymptomatic and has an indeterminate result on initial screening, a second blood sample should be taken after two weeks or more. If the second result is also indeterminate, it should be tested with a confirmatory assay (Western Blot or similar assay). But if this result is also indeterminate, longer follow-up may be required at three, six, or 12 months. This will cover anyone who may have been in the window period. If the result remains indeterminate after one year, the person is considered to be seronegative.

The counselor must discuss the uncertainties associated with an indeterminate result with care and sensitivity. A follow-up plan must be made, explaining when the follow-up blood tests will be taken. Safer sex should be advised with all partners, regardless of their serostatus.

ONGOING COUNSELING AND PSYCHOSOCIAL SUPPORT SERVICES

Some people will require ongoing counseling and support upon learning their HIV status. In a Zambian study, fewer than 30 percent of people who tested seronegative received further counseling sessions, while more than 50 percent of those who tested seropositive sought further counseling.

People turn to different sources for ongoing support after testing. Rather than confiding in their partners, women often turn to female relatives and men to male friends and relatives. Church-based and other religious groups provide spiritual support. This is important for many HIV-infected people in both developing and industrialized countries. In sub-Saharan Africa, many people seek the help of traditional healers, who can work closely with counselors and health workers in providing ongoing support and care for people with HIV.

For people who test seropositive in developing countries, the most commonly expressed concerns are medical. Even if asymptomatic, people worry about becoming ill and not having access to medical care. Many have seen HIV-infected friends or relatives suffer painful, undignified deaths, and fear this for themselves. VCT should therefore be linked with health care services such as palliative and home-based care services, and services providing social support. Other common concerns include the need for material support, especially for widows who care for orphans and sick dependents. The AIDS Support Organization (TASO) in Uganda found clients ranked the need for financial and material support higher than ongoing emotional support following VCT.
THE TESTING PROCESS

The diagnosis of HIV has traditionally been made by detecting antibodies against HIV. A wide range of HIV antibody tests are available today, including ELISA-based tests and many newer, simple and rapid HIV tests.

ELISA Testing

The most commonly used HIV-antibody testing method is the enzyme-linked immunosorbent assays (ELISA). The original ELISA tests used single recombinant antigens; with positive specimens usually confirmed using Western Blot technology, which is technically difficult, time-consuming and expensive. WHO has recommended testing strategies that show ELISA alone gives adequate sensitivity and specificity in high-prevalence areas.11

ELISA tests were originally developed for blood screening, and these assays are suitable for batch testing (40 to 90 specimens per run, as many as several hundred specimens per day). This test has become routine in developed countries with centralized blood transfusion services, and has been gradually introduced in many developing countries for screening donated blood. But various elements are essential if ELISA is to perform accurately. Laboratory equipment such as pipettes, microtiter trays, incubators, washers and ELISA readers must be available. A constant supply of electricity and regularly maintained equipment are needed. Validity of the test results depends on skilled technicians who can, for example, pipette with accuracy, operate the equipment and prepare the necessary reagents. Storage at 2-8°C is needed, since ELISAs are vulnerable to temperature fluctuations. Reagents must attain 18-25°C for optimal reaction, but cannot be stored at this temperature, since their activity declines.

Simple/Rapid Tests

More recent advances in technology have led to the development of various rapid tests. Some use the same basic biochemistry, while others use simple agglutination techniques. Most come in a kit form that requires no other reagent or equipment and allows a single test to be performed (as opposed to batch testing). Because they are easy to use, staff can perform these new tests with minimal laboratory training. Some may also be stored at room temperature. Furthermore, their diagnostic performance is comparable with traditional ELISAs.

Advantages of using simple/rapid tests in VCT settings

Several evaluations12 have demonstrated that simple/rapid tests perform similarly to ELISA tests. Errors in HIV antibody testing can be due to specifications in the tests, errors in the laboratory or clerical errors. Operational studies examining the use of simple/rapid tests in developing country settings—such as the AIDS Information Center (AIC) in Uganda—indicate that most errors are clerical and results of the simple/rapid tests are comparable to those of ELISA.13

Although the cost per individual simple/rapid test may appear higher than the cost per ELISA test kit, considerable savings can be achieved in situations where small numbers of tests are made. Often, many of the tests in the multiple ELISA test assays are not used and, when accurate costs are computed, the use of simple/rapid tests is more cost-effective.

Compared with the technically more difficult ELISA tests, the simple/rapid tests are easy to perform and interpret with less chance of error, thereby giving more accurate results overall. The majority of simple/rapid tests will give a preliminary result within a few minutes. Definitive results can also be obtained quickly if alternative simple/rapid tests are used for confirmation (see WHO testing strategies II and III).

All tests should be selected from the list of WHO recommended assays. They should also have been checked by a reputable national research laboratory to
determine performance under local conditions and on local sera. Based on these results, a testing strategy should be specified that clearly states the following:

- After testing with one rapid test, all samples testing negative shall be reported as negative.
- After testing with one rapid test, all those testing positive shall be subjected to a second and different rapid test.
- Those testing positive by the second test shall be reported as positive.
- Those testing negative by the second test (but positive by the first test) shall be subjected to a third test (the tie-breaker).

This strategy must be tested and proven accurate against a “gold standard.” Verification can be carried out by the national research institution. An example of this process was provided by the AIDS Information Center in Uganda.14

It is important to emphasize that although HIV antibody testing is highly sensitive and specific, all seropositive results from one test must be confirmed by an additional, different test.15

VCT MODELS

Different models of VCT are available; choice will depend on the needs of the community, HIV seroprevalence and stage of the epidemic, attitudes and political and community commitment to VCT, available financing and existing VCT resources. Community acceptance of PLHA should also be factored into any decisions.

VCT SITES

VCT is being carried out in various settings in industrialized and developing countries, depending on needs and resources, including:

- Freestanding sites
- Hospital services
- NGOs within the hospital:
  - Integrated into general medical services as part of specialist medical care (STD, dermatology or chest clinic; antenatal and family planning services, etc.)
  - Part of the continuum of care/home-based care (including palliative care services)
  - Health center (urban or rural)
  - Private sector (clinics and hospitals)
  - Workplace clinics
  - Legal requirements: pre-employment, pre-travel, pre-marital
  - Youth and school health services
  - Health services for vulnerable groups:
    - Sex workers
    - Prison populations
    - Refugees
    - Men who have sex with men
    - Children and orphans
  - Self testing/home testing
  - Research project/pilot project:
    - Associated with antenatal services and interventions
    - Associated with tuberculosis service and TB preventive therapy
  - Blood transfusion services

VCT Sites

VCT is being carried out in various settings in industrialized and developing countries, depending on needs and resources, including:

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    - Children and orphans
  - Self testing/home testing
  - Research project/pilot project:
    - Associated with antenatal services and interventions
    - Associated with tuberculosis service and TB preventive therapy
  - Blood transfusion services
SETTING UP VCT SERVICES

A conducive health system and an informed, supportive community are necessary to successfully implement VCT. Community and health system planning are as important as planning for the intervention itself. In setting up VCT services, the following steps lead to success:

- **Ensure political commitment and institutional ownership.** If VCT interventions are being planned, there must be increased awareness about the benefits of knowing one’s serostatus. It is also important that national policy and strategy plans support VCT. Institutions should authorize VCT as an integral part of service provision. In many areas, social mobilization efforts to educate the targeted populations have been shown to be a vital part of implementation; this requires political commitment.

- **Identify implementation team.** A team, or focal point, at the institutional or project level must be identified to develop any implementation, coordinate VCT development, ensure the acceptability of the service among health care staff and provide monitoring and evaluation of services once they are in place. The team may include members from a variety of disciplines, including administrative, VCT staff, spiritual leaders and counselors (such as the hospital pastor), health care staff already involved in counseling, community groups and NGOs assisting HIV care and support. PLHA will also be able to make an important contribution.

- **Raise awareness and invest in skills development for health care workers.** Even health care workers have a poor understanding of the benefits of VCT. They may be reluctant to undergo testing themselves, yet have personal and family worries about HIV. It is essential to provide appropriate training in general and specific counseling skills.

- **Identify existing resources.** When planning VCT services, it will be important to identify existing resources (including physical/infrastructure, personnel and financial resources and existing and support services). There is already a wide range of services in many areas with high HIV prevalence, but coordination and communication between them is often poor. It may be appropriate to use the expertise gained from these existing services in planning a more widely available program. But if a completely new service is planned, the most appropriate models for the community’s needs should be considered. It will also be important to have an inventory of support and care services for referral of seropositive people.

- **Securing adequate long-term financing.** If VCT services have been implemented and are found to be acceptable, demand will be created. Long-term funding must therefore be ensured before services are started. Estimates of the cost of VCT in developing countries range from US$8 to US$29 per client. In poorer countries heavily affected by HIV, it is unlikely that VCT will soon become affordable for all people, or that a significant proportion of the costs can be met by “cost recovery” initiatives. Subsidy schemes may therefore be necessary. In lower-prevalence or middle-income countries, such as those in South America and Asia, partial- or full-cost recovery may be an option. While studies show the main costs of VCT provision relate to labor and infrastructure, VCT has been shown to cost less per HIV and STD case averted than intervention strategies that do not include counseling.

ORGANIZATIONAL STEPS

**Choice of site**

The choice of VCT site will depend on existing facilities and available resources.

**Coordination**

A system must be established to ensure coordination between VCT and HIV care and support services, so that each is informed of the other’s needs and problems and confidential information-sharing about treatment is assured.
Selecting and training staff

Organization of training and ongoing counselor support must be arranged. Initial training courses typically last from one to two weeks. To manage psychological issues arising from VCT, counselors need courses that equip them with:

- Thorough knowledge of HIV/AIDS and information on how to get updates.
- Familiarity with the logic and content of pre-test and post-test counseling processes.
- Skills to break bad news, and contain the immediate and mid-term consequences.
- Ability to work with families in crisis.
- Discussion of “taboo” topics, such as sex, death and bereavement, anticipatory planning, etc.
- VCT management in the context of ongoing work.
- Ability to identify and manage psychological sequelae of risk recognition—anxiety, depression, suicidal thinking, grief, etc.
- Information for linking with local and national community resources in ongoing care and support.

Such courses may be intensive sessions or involve regular seminars on a part-time basis. Experience has shown that role-playing, active participation in discussion, feedback and case study examples are essential to assist trainee counselors in identifying and working through the key issues that arise in counseling management.

Counselor monitoring and support

Regular case monitoring or supervision in difficult situations and cases is critical to ensure counseling quality and identify needed training and support. Guidelines for evaluating VCT implementation, skills, content and level of supervision and counselor support have recently been successfully field-tested and published by UNAIDS.

Work stress and burnout are inevitable among HIV/AIDS health workers of all disciplines in poor or resource-constrained areas, or when caseloads are very high and mounting. Under the same conditions, attrition of health staff is high. Access to supporting supervision and burnout prevention techniques are vital for the sake of the counselor and client.

Record keeping and ensuring confidentiality

Clients may be seen by different counselors for pre- and post-test counseling and ongoing emotional and health care. A system must be in place to ensure that health care workers who need access to test results and case notes have it, while ensuring that confidentiality is not breached. Otherwise, clients’ needs may not be met. Adequate liaison and cross referral should be planned and encouraged between health care workers and counselors.

Choice of testing strategy

Consideration must be given to the most appropriate testing strategy—always ensuring that a quality-control system is in place. All seropositive tests are confirmed before a definitive result is given.

Organizing a distribution and supply system

A system for distribution and supply of both HIV test kits and reagents (if required) and consumables such as syringes, gloves, vacutainer bottles, disposable pipettes, etc., should be organized. Regular supply, secure storage, distribution and accounting must be ensured.

Record-keeping systems must be designed to ensure confidentiality of HIV-related data.

Adapting or developing guidelines on quality assurance

Guidelines to ensure the quality of the HIV testing strategy and the counseling content will need to be adapted for the particular setting.
COUNSELING FOR PARTICULAR NEEDS

Counseling for Prevention

VCT has been shown to help people change their sexual behavior to prevent HIV transmission.20-26 In some high-prevalence countries, people often assume that they must already be infected and therefore do not bother using safer sex practices. But even in these areas, the majority of people will test seronegative, presenting an important opportunity for counseling on safer sex and HIV prevention. In these cases, VCT can play an important role in the prevention of HIV transmission.

Premarital Counseling and Testing

Several countries in Asia and sub-Saharan Africa have proposed that couples undergo VCT prior to marriage. A voluntary program already exists in some of these countries, and many church groups and religious organizations support premarital VCT. Premarital VCT can help in future planning and decision-making about having children. Those who test seropositive should not be discriminated against. Both partners should undergo testing voluntarily, understand the implications of the test and decide what they will do whatever the outcome.

Couples Counseling

Some countries have promoted counseling couples together to facilitate disclosure and safer sex behavior. Although this has been shown to be successful in reducing HIV transmission, counselors should be aware of barriers to couples counseling and worries about the fate of seropositive women. (Couples counseling is also discussed in the sections on MTCT and barriers to testing.)

Some people do not want to be tested with their partners and may not come forward for testing. While couples counseling should be encouraged, counseling approaches should be flexible and respectful of different needs.

Disclosure of one’s HIV status increases both practical and emotional support for those who test seropositive.27 Sharing one’s HIV status with one’s sexual partner is important in order to make appropriate changes in sexual behavior to reduce HIV transmission. Revealing serostatus often takes time, and disclosure to spouses or partners can be problematic for a number of reasons—including fear of reprisals, stigma or loss of economic and emotional support. Special counseling and support are needed to explore these barriers to disclosure and facilitate communication between couples.

Many couples will have discordant results. This is often not understood; partners may believe that both should have the same result. Counseling discordant couples poses special challenges. These include assisting the couple to cope with their emotional reactions, helping them develop a plan to not only protect the seronegative partner, but also to help the HIV-positive partner live with the infection. Family planning must be discussed.

Types of Couples Counseling

- Premarital
- Couples counseling associated with MTCT and other interventions
- Married couples or regular partners
- Serodiscordant couples
- Same-sex couples

Disclosure of one’s HIV status increases both practical and emotional support for those who test seropositive.27 Sharing one’s HIV status with one’s sexual partner is important in order to make appropriate changes in sexual behavior to reduce HIV transmission. Revealing serostatus often takes time, and disclosure to spouses or partners can be problematic for a number of reasons—including fear of reprisals, stigma or loss of economic and emotional support. Special counseling and support are needed to explore these barriers to disclosure and facilitate communication between couples.

Many couples will have discordant results. This is often not understood; partners may believe that both should have the same result. Counseling discordant couples poses special challenges. These include assisting the couple to cope with their emotional reactions, helping them develop a plan to not only protect the seronegative partner, but also to help the HIV-positive partner live with the infection. Family planning must be discussed.
Counseling for Children and Families

HIV testing of infants must be considered carefully, because diagnosis is difficult in children under 16 months, and there are implications for the mother and the rest of the family.

All children born to HIV-positive mothers will have maternal antibodies for HIV at birth. They will test seropositive using ELISA or simple/rapid testing, but are not necessarily HIV-infected. The mother’s antibodies start to disappear when the baby is nine months to 15 months old. HIV antibody testing is therefore recommended after 16 months. Testing that identifies viral components (such as polymerase chain reaction [PCR] or viral culture) can detect HIV infection in an infant four to six weeks old. More than 90 percent of perinatally infected infants will have a positive DNA PCR by the time they are four weeks old, and by six months, PCR has a sensitivity of approximately 99 percent. But these techniques are expensive and difficult to perform; they require technical expertise and complex laboratory equipment. They are not widely available in developing countries, but may be available in the private sector or research institutions.

Counseling and testing children born to HIV-infected mothers

When known seropositive mothers are given interventions to prevent MTCT, up to 10 percent of children will be infected despite the intervention. (See Chapters 17 and 18 for in-depth discussion of MTCT.) In this situation, the mother will already know her seropositive status and may have already shared this with the baby’s father. Even if a mother has received antenatal counseling, she may still need support to deal with many outstanding anxieties and problems. These issues may need to be addressed over the weeks and months following testing.

Special Consideration When Counseling and Testing Children

- Future medical care of child
- Emotional support of the child, including dealing with his/her illness and parental illness or death
- Anxieties about other children in the family who may be infected
- What and when to tell the child
- What to tell siblings and other family members
- Coping with stigma and discrimination at school and in the community
- Future plans—what to do if the child’s mother or father becomes ill or dies
- Provision for the child’s future. Making a will and dealing with issues around “property grabbing”

Testing children as “index cases”

The possibility of infection in a child may be the first indication that HIV is a problem in the family. If an infant tests positive, his/her mother will almost always be infected too—and the father will probably also be infected. Siblings may also be infected, leading to worries for future children. If older children are found to be seropositive, there may be anxieties about child sexual abuse, especially if the mother is seronegative.

Adolescents

HIV-infected adolescents may have become infected during infancy or childhood, in a number of ways. Some children who were infected with HIV at birth or through breastfeeding survive into their teens. In countries where antiretroviral (ARV) therapy is available, some HIV-infected children have reached
adulthood and had children of their own. Other children may become infected through tainted blood products, surgical procedures, sexual abuse and incest. Many young people also begin sexual relationships with their peers—or older sexual partners—in their early teens. Young girls are particularly vulnerable to HIV infection: immaturity of their reproductive tract facilitates HIV transmission. In some settings, poverty necessitates exchanging sex for food or school requisites. (Chapter 26 focuses on care and protection programs for vulnerable children.)

A child (defined in most countries as younger than 15 years of age) or adolescent (less than 18 years) will usually require parental or guardian consent before testing. While legal requirements vary, counselors must protect the rights of adolescents by ensuring that they have freely agreed to VCT, fully understand the meaning of the HIV test and its implications and that appropriate post-test support will be available. Counseling adolescents poses particular challenges due to their age, the sensitive nature of adolescent sexuality and the need to guarantee voluntary informed consent. (See Chapter 7 for more information about youth intervention programs.)

In some sub-Saharan African countries where children and adolescents have been tested as part of an HIV prevention campaign or blood-donor recruitment, teachers have given consent. This practice may not be considered appropriate or ethical, and is not supported by UNAIDS. Wherever children test seropositive, they should not be discriminated against, either at school or at home, and should be given adequate ongoing emotional support.

### Special Considerations When Counseling and Testing Adolescents

- Parental consent may be required
- Diagnosis and treatment of other STDs
- Potential history of child sexual abuse
- Particular vulnerabilities and emotional needs of adolescents
- Stigma and discrimination at school and home
- Lack of support groups/services available for young people

### MTCT Interventions and Antenatal Infant-Feeding Options

**ARV interventions for preventing MTCT**

Antiretroviral (ARV) therapy interventions are being implemented at pilot sites in many countries in sub-Saharan Africa, and are more widely in Asia and Latin America. If ARV is available, and if a pregnant woman must decide whether she needs it, she must first know and understand her HIV status. VCT is therefore considered an essential element of services for women in antenatal clinics.

Although pregnant women will require the same information as other people in pre- and post-test counseling sessions, additional areas must be explored. These special considerations include:

- **Disclosure.** Sharing results with the baby’s father/her partner and close family members requires sensitive counseling. Interventions to reduce MTCT may involve changing infant-feeding methods that will make it difficult to conceal a seropositive status. Sharing HIV results during pregnancy should be encouraged if women have adequate emotional support.
Reinforcing safer sex messages to all women and their partners. Even in high HIV-prevalence areas, the majority of women tested during pregnancy will be seronegative; this is an opportunity to reinforce safer sex messages. Women who become HIV infected during pregnancy or during breastfeeding are at increased risk of transmitting HIV to their babies, due to the high viral load associated with acute infection.30

Promotion of couples counseling and testing. Where MTCT interventions are available, antenatal testing should always be offered to couples. If women are tested alone, if their partners refuse to be involved in the VCT process, or if they feel unable to disclose their serostatus to their sexual partner, it becomes harder for women to take full advantage of the benefits of VCT. They will have difficulties making decisions about using safer sex practices, planning for their own and their families’ futures, accessing care and support and making informed infant feeding choices. But most women do test alone in MTCT pilot projects, and disclosure to partners occurs infrequently. Testing women individually should be the exception (at the women’s request), and not the rule. But the decision to test as a couple should always rest with the woman.

Infant feeding counseling
Thirty percent to 35 percent of MTCT occurs through breastfeeding. It is therefore important that even in settings where ARV interventions are not available for pregnant women—but where they have access to VCT—they be advised of all available infant-feeding options. Even in the highest prevalence areas, the majority of women will test seronegative. It will be important that the positive aspects of breastfeeding are reinforced to this group, and not diluted by the promotion of non-breastfeeding options. It also must be emphasized that, although they are seronegative at the time of testing, they may still be vulnerable to HIV if they do not know the serostatus of their partners (up to 25 percent of couples have discordant results) or if their partners have other sexual partners and do not use condoms. If they become infected during the antenatal period or during breastfeeding, they have a high risk of passing the infection on to their infants. (See Chapter 19.)

The decision whether or not to be tested must always be informed and voluntary. Some women will choose not to know their status. This decision must be respected and supported. If a woman is unaware of her status, she should usually be encouraged to breastfeed her infant.

Counseling for Tuberculosis Preventive Therapy (TBPT)
In many countries, TB is the leading cause of death in people with AIDS. In countries where TB is common, many people will have been infected, sub-clinically, during childhood and adolescence. If they then become infected with HIV, a reactivation of this latent TB infection can occur causing clinical disease (active TB). It has been shown that tuberculosis preventive therapy (TBPT) can reduce the incidence of clinical TB in people with HIV by 50 percent.31 It is, however, important to screen people for clinical TB before TBPT is given. WHO and UNAIDS recommend that TBPT (with daily dose of isoniazid for six months) should be offered to HIV-positive people following VCT.32 Other preventive therapies can also be offered during the post-test counseling session, such as cotrimoxazole (Septrin/Bactrim) prophylaxis, which is routinely given to people with CD4+ counts of less than 200 in industrialized countries for prevention of pneumocystis carinii pneumonia (PCP). In developing countries, prophylactic administration of cotrimoxazole may prevent common bacterial infections in people with symptomatic HIV disease. Initial promising results from Côte d’Ivoire have shown that cotrimoxazole prophylaxis may reduce morbidity and mortality.
in HIV-infected people. Specific information about adherence to therapy and possible drug interactions and adverse effects should be discussed with clients during the post-test counseling session. (Chapter 25 provides information about management of HIV and its complications.)

VULNERABLE GROUPS

Injection drug users (IDUs)

HIV prevention and care for IDUs already infected is complicated by discrimination and marginalization of this group. Their VCT services are poorly developed, often with great resistance to testing because of fear of discrimination, a lack of voluntarism, and confidentiality. (See Chapter 22 for in-depth information about risk reduction in IDUs.)

Problems Associated With VCT for IDUs

- Seen as a low priority and lack of political will
- Lack of acknowledgment of HIV as a problem among IDU population
- Lack of resources and services available
- Illegality of IV drug use
- “Hard to reach” population
- Psychosocial problems frequently associated with IDU
- Punitive rather than prevention and care approach to IDU
- Needs of IDUs in prisons ignored
- Mandatory testing before medical and psychosocial treatment or entry to prison

Commercial sex workers (CSWs)

In many countries, directing care and support to CSWs has been considered an important approach in HIV prevention. Offering VCT, STD screening and treatment, group discussions about prevention and free condoms for HIV-negative sex workers can help increase condom use and reduce the incidence of HIV and other STDs. (Chapter 8 focuses on reducing HIV risk in sex workers and their clients.)

Special Considerations When Offering VCT to CSWs

- Avoid blame and stigma among CSWs.
- Offer comprehensive STD as well as family planning services.
- Target clients of CSWs.
- Ensure ongoing support for HIV-positive CSWs.

Men who have sex with men (MSM)

VCT services for men who have sex with men (MSM) are well established in Europe and North America, but few services for these men are available in developing countries. In many resource-constrained countries, homosexuality is either not acknowledged or illegal; the need for VCT among MSM is therefore ignored. (See Chapter 11 for more information about HIV prevention activities targeting MSM.)

Bereavement Counseling

Counseling for partners and families following the death of a loved one is often overlooked in developing countries. The death of a person from AIDS may give rise to new problems for surviving friends and family members. Counseling can help the bereaved person to discuss and reflect on the changes brought about by loss, mourn appropriately and enable him/her to look to the future. Partners and parents of a child who dies from AIDS may have unresolved fears and concerns for themselves or other family members, and can be helped to make decisions about testing.
The process of grieving may last many months or years. But some people find that a single counseling session can clarify their thoughts and feelings, and reassure them that they are coping as best they can under the circumstances. This is particularly true for people who have other emotional supports, such as family, friends and church or spiritual support. For others, several sessions may be helpful. Some people never completely come to terms with a loss, particularly if it is the loss of a child. In high HIV-prevalence developing countries, grieving may be more difficult when there have been multiple losses of friends and relatives due to AIDS.

**Blood Donor Counseling**

Counseling blood donors about HIV is different from VCT in other settings, because the first concern is safeguarding the blood supply. Furthermore, blood donation counseling is not ongoing; one pre-donation session is usually the rule. This session focuses on providing information; however, some personal risk questions should be asked. Given the limited time of these sessions, this requires tact and skill for the counselor. Some countries have established systems whereby blood donors who test seropositive may be referred for further VCT and needed care. But the practice of using blood-screening services to learn HIV serostatus should be discouraged.

**Innovative Approaches**

**Group Information/Counseling**

In situations with limited resources and few counselors, group counseling can increase the number of people having access to VCT. Group counseling can provide pre-test information to women in antenatal settings, couples and groups of people who seek services. This may be more aptly described as “group interaction,” where people learn details about HIV transmission, risks, testing and interventions, as “group education” rather than counseling. The counselor who leads the group session will need skills similar to those required for individual counseling, and will also need to cope with the complex dynamics that may arise in a group.

Although group work has been used successfully as part of pre-test preparation, it should not replace individual pre-test counseling; everyone undergoing an HIV test should have the opportunity to receive individual pre-test counseling. Informing patients of their test results and post-test counseling should always be conducted on an individual basis. It may be very difficult for individuals to discuss personal issues and fears in a group setting, and people may feel swayed by the opinion of the group and need time to discuss their own circumstances. Individual counseling should always be available to participants who wish it.

There are many examples of post-test groups where people gain mutual support from others’ VCT experiences. Again, this should not replace post-test and ongoing counseling—which should be available to all people following VCT.

**PLHA Support Groups**

People living with HIV/AIDS (PLHA) describe feeling empowered by support groups, and state that the group approach helps them to overcome fears that can accompany a seropositive result. Support groups offer a forum for problem solving in areas such as coping with stigma and discrimination, relationships, sexual concerns, care of partners with HIV and issues related to children and dependents. By sharing their experiences, group members can give each other new
perspectives. Some groups provide practical support and advice on income generation, legal issues and writing wills. For HIV-positive people in low-prevalence countries, where there is little understanding about HIV in the community, support groups can play an important role in overcoming feelings of isolation. These groups may or may not be facilitated by a trained counselor.

**HOME TESTING**

Several self-test kits are now available, allowing people to test themselves for HIV at home. Although there are advantages to using home collection and self-testing kits—they offer privacy and may provide a service for people who do not seek testing at VCT sites—they should be used with caution. Users must understand the need for a confirmatory test and be informed about the “window” period. Regulations must be in place to ensure their quality, and self-test kits should contain clear instructions and be easy to use.

There are also concerns that people using self-test kits receive no pre-test counseling or access to follow-up care and support, and that some may be coerced into testing.

But there are special groups who could benefit from home testing. These include health care workers who may be reluctant to be screened for HIV after occupational exposure because they fear they may already be infected, and people who may wish to self-test before mandatory testing for travel abroad or issuance of a work permit.

**BARRIERS TO VCT**

Although VCT is becoming increasingly available in developing and middle-income countries, many people are still greatly reluctant to be tested. This reluctance is the result of barriers to VCT, which are discussed below.

**STIGMA**

HIV is highly stigmatized in many countries, and HIV-infected people may experience social rejection and discrimination. In low-prevalence countries, or places where HIV is seen as a problem of marginalized groups, rejection by families or communities may be a common reaction. Fear of rejection or stigma is a common reason for declining testing. Linking testing with ongoing care and support services, as well as HIV education and awareness in the community, can reduce stigma and may contribute to wider acceptance of VCT. VCT may also be seen as an important way of overcoming stigma and—as more people become aware of their HIV serostatus—of normalizing the disease.

**GENDER INEQUALITIES**

In many countries, women worry that they would suffer shame and discrimination if they were known to be HIV-infected. Many women are particularly vulnerable, and risk violence, abandonment, rejection or even loss of their homes and children if their seropositive status becomes known. The need for protection and support of vulnerable women who test seropositive must be considered when developing VCT services.

**LACK OF PERCEIVED BENEFIT**

Lack of perceived benefit is another common barrier to testing. In poorer high-prevalence areas, many people do not want VCT. They may be afraid that little help will be available to them if they learn they are infected, and therefore it is better not to know their serostatus. Linking VCT with comprehensive care and support services and improving acceptance of the HIV-infected in the community can reduce this barrier to testing. Offering interventions to prevent MTCT once status is known is another major benefit of VCT.
**MONITORING AND EVALUATION**

Most evaluations of VCT have sought to demonstrate that VCT reduces incidence of HIV infection and contributes to prevention efforts. VCT efficacy reports have therefore largely concentrated on outcomes, such as the role of VCT in modifying sexual behavior. But VCT services in developing countries are often new interventions, with monitoring limited to attendance reports, coverage and return rates.

The quality of VCT counseling determines service outcome. Poor-quality counseling can result in misunderstanding and even resistance to change.

VCT monitoring and evaluation poses special challenges because confidentiality is a critical element; many of the usual assessment techniques are therefore not applicable. While some measures are presented in the box below, additional guidance on monitoring and evaluation of VCT can be found in recent UNAIDS guidelines cited in the reference list.

One critical difficulty with the evaluation of VCT is the complexity of variables influencing pre-test and post-test behavior. It may be unreasonable to expect that a few counseling sessions will significantly affect sexual behavior in the context of gender inequality and disempowerment. Future counseling evaluation strategies may need to be less linear if the added value of counseling in VCT is to be appropriately revealed.

**OPERATIONAL MONITORING AND EVALUATION**

In operational settings it is important to monitor and evaluate the services, both at an individual and community level.

### OUTCOME MEASURES

#### Individual
- Reduction in cases of HIV transmission (either by direct sero-incidence studies or by proxy indicators, such as rates of STDs or sexual practices (condom use with regular and casual partners, number of partners, etc.)
- Partner/family disclosure
- Uptake of partner testing
- Uptake of care and support services by people testing seropositive
- Long-term follow-up of people undergoing testing and their families and children (social consequences of testing, long-term coping with HIV infection and future planning, use of safer sex practices over time, uptake of family planning and pregnancy rates, morbidity and mortality, etc.)

#### Societal/community responses
- Acceptance of HIV in the community and measure of stigma associated with HIV infection
- Attitudes toward VCT in the community

### OPERATIONAL FACTORS

#### At the VCT Sites
- Uptake and acceptability of VCT
- Quality of counseling
- Reliability of testing strategy (including external quality control)
- Stress and burnout among counselors/health care workers

#### In the community
- Attitudes toward VCT in the community
- Uptake of VCT
- Availability and quality of community care and support services
**Examples of Possible Indicators**

<table>
<thead>
<tr>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td>People accepting VCT.</td>
<td>All people invited for VCT.</td>
</tr>
<tr>
<td>People returning for test result.</td>
<td>All people tested.</td>
</tr>
<tr>
<td>People sharing result with partner.</td>
<td>All people receiving test result.</td>
</tr>
<tr>
<td>HIV-positive people accessing care and support services.</td>
<td>All HIV-positive people requiring services.</td>
</tr>
</tbody>
</table>

**Ethical and Legal Considerations**

**Pre-Employment/Pre-Education HIV Testing**

The intention and result of pre-employment testing is to exclude those who test seropositive. Such testing is, therefore, an abuse of human rights, but some employers continue to test job applicants or employees before sending them for further studies. Some countries insist on testing people before allowing them entry to take up a job or studies. Pre-employment testing is often carried out without adequate pre-test counseling and informed consent—sometimes without the knowledge of the person undergoing the medical examination, who may be unaware that his/her blood is being taken for HIV testing. (Chapter 27 explores issues related to HIV and human rights; Chapter 9 looks at HIV prevention in the workplace.)

**Mandatory HIV Testing**

Mandatory testing has been applied to many groups, including immigrants, migrant workers, refugees, prisoners, CSWs, IDUs, military recruits and pregnant women. Mandatory testing has no advantages over VCT, and several disadvantages.

- Mandatory testing without informed consent or counseling does not help people change their sexual behavior to reduce HIV transmissions to others.
- Testing without counseling and follow-up support can be devastating for those who test seropositive. It may lead to depression and irresponsible actions, including violence to self and others.
- Mandatory testing may lead to a false sense of security. For example, it is illogical to require mandatory testing of surgical patients to “protect” health care staff, as universal precautions should be applied to all patients. In addition, patients who test seronegative may be in the “window” period.
- Insisting on testing new employees or military recruits will not insure that they are HIV free, as they may acquire HIV infection during their employment or military service. It would be better to use resources to offer care and support to those with HIV and provide comprehensive HIV prevention and education programs for employees.
- The need to provide evidence of a negative test result has led to anecdotal reports of health workers selling negative certificates to untested people.
- Mandatory testing in health care settings, such as antenatal clinics, may lead to mistrust by clients and discourage them from seeking health care.
HIV Testing Following Rape

There is a more convincing argument for mandatory testing of rapists, as provision of ARV therapy to rape victims can prevent HIV transmission. But in the majority of cases it is impossible to test the rapist, as he is rarely apprehended. The rape victim should receive counseling in order to get tested for all STDs including HIV, and to determine pregnancy.

Testing Without Counseling

There may be circumstances in which people specifically request or decline pre-test counseling—for example, when they have had previous tests, or say that they already have enough information. In these circumstances, people should not be refused testing and should receive post-test counseling.

Discrimination

An HIV seropositive test result has led to deportation, or incarceration in some countries. HIV testing may also be mandatory before receiving a visa or pursuing further studies (with a seropositive result precluding foreign travel and/or education). UNAIDS/WHO opposes mandatory testing under any circumstance.

Partner Notification

India and several other countries now require that seropositive persons inform their partners of their status before marriage. A resolution from the Southern African Development Community (SADC) Health Sectors meeting in April 1999 proposed that partner notification and notification of close family members of people with AIDS (although at this point not HIV) should be compulsory. Supporters argue that AIDS notification is necessary to create greater openness about HIV, and that it will protect sexual partners and caregivers from becoming infected with HIV. But this proposal has been criticized within sub-Saharan Africa and by international human rights and activist groups, who charge that it will limit people’s rights to privacy and confidentiality. UNAIDS and its co-sponsors are currently developing policy options for governments considering broader notification strategies.

Lessons Learned

VCT Models

All VCT models have both benefits and disadvantages. It is important to support existing VCT services and help health care structures include VCT among their services. Advantages of particular programs may be specific for individual sites, though some generalizations can be made. Cross-referral between VCT services should also be considered—for example, couples can be referred from MTCT interventions to free-standing sites for counseling together; symptomatic clients can be referred from free-standing VCTs to clinic-based services for appropriate medical interventions. Other VCT models such as peer and community counseling should also be considered.

Training of Counselors

The type and length of training required to provide high-quality counseling is still under debate.

Counseling training programs may be as long as four weeks (the Kenya association of professional counselors) or as short as three days (some VCT programs associated with MTCT interventions argue that VCT training can be achieved in this time period.). Those who propose longer training maintain that counselors who receive inadequate training cannot handle the complex behavioral aspects of counseling that may lead to behavior change.

An alternative approach suggested is a cadre of “health educator/counselors” for routine pre- and post-test counseling and “expert counselors” to lend support with difficult cases and provide support and supervision.

There is, however, clear agreement that ongoing support, supervision and training are essential. Without these, staff motivation, morale and counseling quality will likely deteriorate.

It is also important to develop minimum standards of counselor training. In most VCT sites, monitoring and evaluation of counseling services consists of counting uptake and return rates—but more critical assessments are needed to monitor counseling quality. These standards may vary, depending on the backgrounds of trainees.
Counseling Content

There should be a greater emphasis on client-centered counseling. The driving force behind VCT has been its usefulness as a determinant of effective medical interventions, such as MTCT. This focuses counseling on a particular aspect of VCT, and may lead to neglect of the clients’ real needs and concerns.

HIV Testing Methods

New simple/rapid (S/R) technology should be embraced. S/R using finger prick whole blood allows testing anywhere, including home-based care. Algorithms using either initial testing of all samples with two S/R tests and a third as a tiebreaker, or initial screening and re-testing of all seropositives can be considered. All services employing S/R have reported an increase in demand and return rate, with satisfaction of both clients and counselors. Some individuals will still decline to be tested or defer testing after having their blood sample taken. This choice should be respected.

Saliva- and urine-based HIV tests are good alternatives to blood tests. Both fluids contain HIV antibodies, the presence of which allows for HIV detection. They do not require needles, so health care workers collecting the specimen are at very low risk of contracting HIV. These samples are also well suited for people who do not like having their blood drawn, people with difficult veins, hemophiliacs and those taking medications that affect coagulation. Although they are about as accurate as blood-based tests, saliva- and urine-based HIV tests are not yet widely used, in part because of their cost.

Support Services

VCT services should allow referral for ongoing support. The following services could be considered:

- Emotional support/ongoing counseling
- Social support
- Medical support
- Pre-test and TB preventive therapy (TBPT)
- Cotrimoxazole
- Family planning
- Home-based care (HBC)
- Legal counseling/support
- Family counseling

Involvement of Hard-to-Reach Groups

When developing VCT services, particular consideration should be given to providing accessible and appropriate services for groups such as:

- Men (in MTCT interventions)
- Adolescents
- Couples
- Sex workers and their clients
- Injection drug users (IDUs)

IEC, Awareness and Advocacy

Although knowledge about HIV among most age groups in most communities is very good, there has been little emphasis on the benefits of VCT. Improved and appropriate advertising and awareness raising are needed. Special emphasis on messages for young people, couples, sex workers and their clients and other groups must be considered. The metaphors of HIV must also change, making the messages softer and more supportive. Stigma remains the most important challenge.

Funding Issues

Adequate long-term funding is essential to provide high quality service and maintain staff morale.
CASE STUDIES

“In countries where HIV prevalence is high and where there are numerous deaths attributed to AIDS, it is common for many to develop feelings of hopelessness and a misperception that behavior change is futile. In these settings, the power of positive behavior change messages may be reinforced by effective HIV counseling and testing services.”39

UGANDA: AIDS INFORMATION CENTRE (AIC)

The HIV/AIDS epidemic arrived early in Uganda and hit the country hard. It came in the midst of devastation from civil strife and economic hardship. By the late 1980s, Uganda had the highest rates of infection in the world. Today, Uganda is recognized for its effective response to the epidemic. This success is thought to have resulted from several factors, among them: (1) An assertive and open response from the government; (2) Prevention programs implemented by both the government and NGOs; (3) An active role for PLHA; (4) Involvement of religious organizations; and (5) A sustained, high level of support by the donor community.40 VCT was one of the early programs implemented.

Many Ugandans wanted to know their HIV serostatus after awareness campaigns began in 1986. At that time, few HIV testing services were available and even fewer provided counseling. This placed an enormous burden on the national blood bank, where individuals interested in knowing their serostatus went to donate blood. The blood bank was not equipped to provide counseling and support, and blood donated under these circumstances proved to be a costly misuse of the blood banking services.

Several organizations met and discussed the need for anonymous and voluntary counseling and testing. As a result, the AIDS Information Centre (AIC) opened in February 1990, with the philosophy that knowledge of one’s HIV infection status is an important intervention and prevention strategy.41

AIC originally offered well-planned VCT services with informed consent and a referral system for more comprehensive care and support. This referral system was developed in consultation with other NGOs, community-based organizations, hospital directors, PLHA organizations and various other service providers.

Today, AIC provides a wide range of services: VCT using rapid testing with same-day results, syndromic management of other sexually transmitted diseases (STDs), condom education and distribution, tuberculosis education and referral, family planning information, psychosocial and medical services through the post-test club, initiatives to promote VCT and sustain behavior change, food supplementation, peer support through the post-test club and special services for couples with discordant HIV results. In addition, AIC offers training for a variety of service needs, including integration of rapid testing with prevention counseling into other clinical services.

Since it began operations a little over a decade ago, the AIC has served more than 500,000 clients.

Lessons learned

- VCT services utilizing rapid test are feasible, cost beneficial and acceptable to clients and counselors.
- Rapid testing and counseling increase availability and demand for VCT services.
- Counseling should be prevention-focused and include risk-reduction planning.
- Ongoing support through a post-test club helps HIV-positive clients cope with infection and helps HIV-negative clients adopt and maintain safer behavior.
- Active referral systems can be established and maintained to provide additional support and care services by prevention and care partner organizations.
- Monitoring is essential to maintain quality control for counseling and testing services.
- VCT services should be part of a comprehensive HIV prevention program.
- When first establishing services, anonymity is important; confidentiality is always critical in assuring trust and creating demand.
Integrating other services—such as treatment for STDs and education and referral for tuberculosis diagnosis and treatment—are feasible and well received by VCT clients.

A computerized information management system is crucial for monitoring services and helps quality control and evaluation activities.

**Malawi: Malawi AIDS Counseling and Resource Organization (MACRO)**

Perhaps fewer than 10 percent of African PLHA are aware of their infection. This lack of knowledge limits access of infected individuals to supportive care and prevention therapies, and is an important factor in the spread of AIDS. In Malawi, VCT has been available in Lilongwe since 1992 and in Blantyre since 1994 through the Malawi AIDS Counseling and Resource Organization (MACRO), an NGO supported by the Ministry of Health and donor organizations.

VCT use remained very low from 1992 to 1999. During 1999, 5,663 clients received VCT services—but only 69 percent received their test results and additional counseling. Thus, the problem of low utilization was compounded by a low rate of return for test results. Off-site testing in a central laboratory resulted in delays in receiving test results. These problems are not unique to Malawi or to Africa: In the United States, fewer than 70 percent of clients tested return for HIV test results in most settings.

In addition to these problems, supplies of test kits at the Malawi laboratory were inconsistent and inadequate. Even returning clients sometimes could not receive their results, because laboratories lacked enough supplies to conduct tests.

The Ministry of Health and MACRO, in collaboration with the U.S. Agency for International Development (USAID) and the Centers for Disease Control and Prevention (CDC), in late January 2000 introduced the onsite use of simple, rapid, whole-blood, finger-prick testing with immediate confirmation for HIV. A prevention counseling protocol was developed, and counselor training conducted for same-day counseling with same-day test results.

Almost overnight, demand for services increased dramatically. By the end of December 2000, testing increased fourfold to more than 21,400 clients. The number of clients receiving their test results and additional prevention counseling increased sixfold. More than 99 percent received their test results with additional prevention counseling.

**Lessons learned**

- An HIV rapid, whole-blood, two-different-test algorithm conducted onsite provides results equivalent to ELISA testing with confirmation conducted in a reference laboratory.
- This test algorithm provides confirmed results for both HIV-negative and HIV-positive clients on the same visit, eliminating the need to return two weeks later for test results and post-test counseling.
- Quality prevention counseling can be provided; both clients and counselors attest to the improved service delivery of the new strategy.
- HIV rapid testing with counseling promotes both prevention and earlier access to care and support.
- The test used in this algorithm is simple and rapid, requires no electricity to process, no refrigeration for storage, has a long shelf life and can be conducted by a trained counselor.
- A computerized information management system is crucial for monitoring services and aiding quality control and evaluation efforts.

This VCT strategy can dramatically increase access to and use of VCT services throughout Africa and the rest of the world—especially in rural areas—even in such developed countries as the United States.
SUMMARY

VCT serves as a cornerstone and vital entry point for early access to prevention, care and support services. Testing should not be considered or implemented as a separate program, but as a key component in a comprehensive HIV/AIDS prevention strategy.

The public health need for a rapid HIV testing algorithm with prevention counseling is as important in the United States and other developed countries as it is in Africa. VCT use must be increased for HIV prevention, care and treatment. But slow results cause low return rates, with their impact on care and treatment. The Uganda and Malawi VCT approach offers the rest of the world a successful strategy in our war against HIV/AIDS.

These case studies were written by Carl Campbell, Senior Public Health Advisor, Chief, Voluntary Counseling and Testing Activity, Global AIDS Program, Centers for Disease Control and Prevention.

RELEVANT CHAPTERS

Chapter 7  Youth Intervention Programs
Chapter 8  Reducing HIV Risk in Sex Workers, Their Clients and Partners
Chapter 9  HIV/AIDS Programs in Private Sector Businesses
Chapter 11  Reaching Men Who Have Sex with Men
Chapter 18  Reducing the Risk of Mother-to-Child Transmission of HIV During Pregnancy and Delivery
Chapter 19  Mother-to-Child Transmission of HIV Through Breastfeeding: Strategies for Prevention
Chapter 22  HIV Risk Reduction in Injection Drug Users (IDU)
Chapter 25  Management of HIV Disease and Its Complications in Resource-Constrained Settings
Chapter 26  Orphans and Other Vulnerable Children: Approaches to Care and Protection Programs
Chapter 27  HIV/AIDS, Health and Human Rights

REFERENCES


42. Msowoya K, Marum E, Barnaba A, et al. Whole blood rapid HIV tests and same day counseling results in Malawi. Poster presentation (paper on this work is in draft for publication). XIIIth International AIDS Conference, Durban, July 2000.

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**Recommended Reading**


