

GUIDELINES FOR HIV COUNSELLING AND TESTING



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1 Introduction

AIDS Action Europe is a Pan European partnership of non-governmental organisations (NGOs) that aims to work towards a more effective response to the HIV and AIDS epidemic. AIDS Action Europe membership is diverse in terms of size and type of activities. Some of the NGOs focus on treatment; some concern themselves with lobbying for better policies. Some work at the national level, while others work locally or on specific topics.

These guidelines were written following the seminar “Voluntary Counselling and Testing”, organized in Bucharest, on May 30th – 31st, 2008, by ARAS – the Romanian Association Against AIDS. Their purpose is to offer useful information and recommendations on HIV Voluntary Counselling and Testing, both for those already working in the field, but also for those interested in starting such an activity, both for professionals and for clients of the services.

The above-mentioned seminar is part of a series of European best practice seminars that are organised under the project “European Partners in Action on AIDS”. This project aims to strengthen knowledge, capacities, discussion and exchange among HIV-related NGOs in Western and Eastern Europe, in order to encourage concerted action and the acceleration of innovation in their approaches in the fight against HIV and AIDS.

Please visit www.aidsactioneurope.org if you wish to learn more about AIDS Action Europe and the other European best practice seminars.

The seminar included the presentation of the results of a rapid assessment of VCT services in Europe and also of work models in promoting and providing VCT services and in monitoring their quality.

The seminar was made possible by support from the European Commission, the Romanian Ministry of Education, Research and Youth, GlaxoSmithKline's Positive Action Programme and Bristol-Myers Squibb. Furthermore, the project has been carried out with the support of the King Baudouin Foundation and the National Lottery.



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2 Background information

The UNAIDS/WHO Policy Statement on HIV Testing states that:

“Voluntary testing must remain at the heart of all HIV policies and programmes, both to comply with human rights principles and to ensure sustained public health benefits.

The following key factors, which are mutually reinforcing, should be addressed simultaneously:

ensure an ethical process in conducting the testing, including a defined purpose of the test and the benefits to the individuals being tested;

assurances of linkages between the site where the test is conducted and relevant treatment, care and other services, in an environment that guarantees confidentiality of all medical information;

address the implications of a positive test result, including non-discrimination and access to sustainable treatment and care for people who test positive;

reduce HIV/AIDS-related stigma and discrimination at all levels, notably within health care settings; ensuring a supportive legal and policy framework within which the response is scaled up, including safeguarding the human rights of people seeking services;

ensure that the health care infrastructure is adequate to address the above issues and that there are sufficient trained staff in the face of increased demand for testing, treatment and related services.

[.....]

UNAIDS does not support mandatory testing of individuals.

All testing, whether client or provider-initiated, should be conducted under the conditions of the “Three Cs”: involve informed consent, be confidential, and include counselling. “

UNAIDS/WHO Policy Statement on HIV Testing, June, 2004

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3 What is HIV testing?

3.1 Short chronology

1985: ELISA test for HIV becomes available around the world. The World Health Organization (WHO) and the Centre for Disease Control and Prevention, Atlanta (CDC) begin recommending that the test should be accompanied by HIV counselling, as an interactive approach focused on information and education, in order to reduce the risk of HIV infection among beneficiaries after testing.

1986: The first counselling guides for health professionals appear, drawn up by WHO and by CDC Atlanta. These guides are regularly updated and associated with recommendations regarding the quality of services.

1994: CDC publishes guides and pre- and post-HIV test counselling standards, which emphasize client-centred counselling, or, to put it differently, counselling that takes each individual's type of behaviour, circumstances and needs into consideration.

1997: The RESPECT Project (CDC Atlanta, USA) proves the efficiency of working protocols for pre- and post-test counselling in prevention.

2004: UNAIDS/WHO Policy Statement on HIV testing.

2007: Guidance on PITC in Health Facilities.

3.2 Some definitions

The British Association for Counselling and Psychotherapy defines counselling as the use of an interpersonal relationship to facilitate self knowledge, emotional acceptance and personal growth, the optimum development of the beneficiary's personal resources.

The general objective of this approach is to stimulate the client's self-knowledge, personal development and adjustment. It aims for the beneficiary to find him-/herself in a new position, that of an independent and fully responsible person kept in balance.

In other words, counselling provides the client with a set of abilities that may help him/her in understanding his/her problem, in coping with feelings and worries and in assuming responsibility to evaluate alternatives and make decisions. Thus, the counsellor is not the one who solves the client's problem; he is the one who helps him/her solve it.

Counselling aims at providing active support to clients, so that they may be able to identify and explore their feelings, priority issues and then make appropriate decisions. The essential characteristic of this process is that, according to the needs and the knowledge of the beneficiary, s/he is the one who provides information and determines the content of counselling.

Voluntary HIV counselling and testing represents an essential link between HIV prevention on one hand, and the treatment and support of HIV infected persons on the other.

VCT promotes and encourages behaviour change, providing referrals to services and interventions for the prevention of mother-to-child HIV transmission for the prevention of sexually transmitted infections (STI), facilitating the individual's integration in the health and social care system.

Moreover, VCT improves quality of life and may play an important role in reducing stigma and discrimination.

"Voluntary HIV Counselling and testing represent the process by which an individual receives support in making an information-based decision to take an HIV test, thus having the opportunity to know his/her serological HIV status. The

decision must fully belong to the individual, and s/he must be reassured that the VCT process is confidential.”

(UNAIDS – Voluntary Counselling & Testing (VCT), Technical Update, UNAIDS Best Practice Collection, Geneva, Switzerland, May 2000).

As part of this process, counselling is defined as the professional relationship between a counsellor and a client, based on confidence, listening and mutual respect. Its aim is to support the client/patient in his/her efforts to cope with stress and to make personal decisions in connection with HIV/AIDS.

Within the VCT process, counselling is provided before the HIV testing, called pre-test counselling, and after the testing when the result is announced, called post-test counselling.

In some cases, several counselling meetings may take place before and/or after testing, depending on the client's needs.

Counselling beneficiaries are called “clients” in order to differentiate them with patients (who access a physician to solve their concerns) or assisted persons (who do not always have the opportunity to choose whether they accept a certain service).

Before asking for an HIV test, each individual goes through a decision making process, which is often accompanied by anxiety. Sometimes, appreciations are made on the partner's HIV status (they are compared to infected or sick persons) during this process, the pros and cons of whether one wishes to be aware of the diagnosis are weighed, testing is discussed with friends or partners, and assumptions are made about the possible diagnosis.

When they choose to take an HIV test, people find themselves in a situation in which they have to cope with fears and behaviours from the past.

In this way, some of the clients:

- may consider they are HIV-infected, as they engaged in risk-taking behaviour or were in a situation presenting an infection risk;
- may hope they still were not infected, although they may fear the effects of some risk-taking behaviours/situations from their past;
- may consider they are HIV-negative and want to prove it to themselves;
- may need the result of the test, as required by the partner, physician or employer.

The decision to take an HIV test belongs, in all cases, to the client/beneficiary.

4 Essential elements

4.1 Protecting confidentiality for clients requesting an HIV test

Information about the range of services offered to the client has to remain private and undisclosed to other persons, aside from situations where the client gives his/her consent or where there is a court ruling requiring that the data be revealed.

Another exception is a report sent to the public health authority, of which the client must be informed.

Discussing all aspects related to confidentiality right from the beginning of a counselling relationship is absolutely necessary, as it ensures an atmosphere of confidence between the counsellor and the client.

Ethical limits of confidentiality are also covered, conveying that, in the event counsellors receive a request from the prosecutor's office, they are obliged to

breach client-counsellor privilege.

4.2 Obtaining informed consent regarding HIV testing

Consent with full knowledge of the facts is defined in the laws regarding patient' rights.

Accepting or refusing a test must have no consequence on the quality of the services provided.

4.3 Offering the possibility to take a test anonymously

Anonymous testing (when the coordinates/personal information of the client are/is not recorded) offers important benefits for the individual's health and for public health as well.

The option of confidential testing is applied when the client has not precisely asked for anonymous testing.

The benefit of anonymous testing is its accessibility – the test can be requested also by persons who do not have identity papers, by those without health insurance or those afraid of confidentiality breaching.

4.4 Observance of all legal and ethical provisions regarding counselling and testing

In order that the patients' rights are not violated and quality services are provided, it is necessary:

- to observe regulations regarding the minimal age of consent for testing;
- in the case of legally and mentally challenged persons, that services are provided only in the presence of a family member or of the psychiatrist;
- to provide interpretation for persons who do not speak/understand the language (migrants, for instance), for persons with hearing impairments, etc.

4.5 Providing services that meet the needs of beneficiaries and communities

Service providers must ensure that their support is wanted and accepted by the client. Also, service providers should be available to adapt the conditions of the services they provide to the client's needs (for instance: working hours, location, materials disseminated, language spoken, interval up to the announcement of the result).

4.6 Providing quality services

Service providers must observe working standards and procedures, develop and implement programmes to guarantee the quality of services and ensure programmes to evaluate the client's level of satisfaction, so as to make sure services respond to the real needs of beneficiaries and of community.

4.7 Focusing and maintaining the session on the idea of reducing HIV infection risk

Each counselling session must address the beneficiary's personal risks of HIV infection and avoid providing a pre-established set of information with no connection to his/her situation or focusing the discussion on the client's other problems.

In order for counselling to be effective, it is important not to make assumptions about the client's sexual behaviour, his/her sexual orientation or on the possibility s/he may be a drug user.

Some clients may not give complete information or may not be willing to discuss their sexual practices or drug use history.

The assumption that a client uses/doesn't use drugs or that s/he has a certain sexual orientation can make the counsellor skip over important information or questions, and this would be to the detriment of the field and also of the client.

Categories of behaviour exposing the client to the risk of infection and the frequency of this behaviour will be identified together with the client, and, at the same time, the discussion will focus on those categories of behaviour, situations and partners that contribute to infection risk.

5 HIV test and counselling

5.1 Pre HIV test counselling

Pre-HIV test counselling uses an approach centred on the client, which aims to support individuals in achieving behavioural changes, so they may reduce risks of HIV transmission.

Client centring represents the essential element of this type of counselling, which means it must be personalized and adapted accordingly to the behaviour, circumstances and the individual needs of the client.

5.2 HIV testing

There are several methods to do the test itself – the most common one is to take a very small sample of blood from a vein in the arm.

This blood is sent to a laboratory where it is processed in order to see if it contains antibodies (the test for HIV is called an HIV antibody test).

If the result is negative, it means that the person is not infected or that he/she is in the immunological window.

If the reaction of the blood is positive, then a second, confirmatory test, is done to check the presence of HIV antibodies.

Standard HIV tests are ELISA.

Rapid tests have been invented, where the result is given almost instantly, but still, this type of test is not approved for use in several countries.

5.3 Post HIV test counselling

Post-HIV test counselling includes the announcing of the HIV test results and the reinforcement of the client's efforts to put into practice the plans for reducing the risks of HIV transmission.

In a post-test counselling, clients:

- will receive the result of the HIV test, accompanied by an interpretation based on their risks of infection and taking into consideration the period of "immunological window";
- will understand the meaning of the result;
- will talk again on and will adopt the risk reduction plan, established during the pre-test counselling.

An essential element in the post-HIV test counselling is the REFERRAL to other services (medical, social, psychological, etc), especially in case of a positive result of the test.

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6 Target groups for VCT services

VCT services are, basically, the same everywhere, nevertheless they can differ from the point of view of their target group.

Some VCT services target the entire population (public VCT services, for instance), some others target specific, vulnerable groups (for example, VCT offered by NGOs in their outreach activities, to groups such as commercial sex workers or intravenous drug users).

We will present here some specific issues related to VCT services for vulnerable groups.

Persons from groups vulnerable to HIV infection are those who are at risk of getting HIV-infected because of socio-economic circumstances, low self-esteem, lack of education or information, necessity of meeting some basic needs, on account of a dependence, of the family conditions, of the pressures made by the circle of friends, etc.

These individuals may:

- explore their own sexuality, when they do not yet have the needed information or abilities to protect themselves;
- practice prostitution for surviving;
- have relationships within which they may not negotiate the practice of safe sex;
- be socially marginalized and discriminated;
- use injecting drugs without knowing/taking harm reduction measures;
- be imprisoned together with other persons with risk-taking behaviours and, possibly, be abused by them;
- have to cope with so many problems, that HIV prevention is not a priority.

In this context, in order to be efficient, the HIV prevention approaches focus on harm reduction – the reduction of the negative consequences of practicing a risk-taking behaviour. More precisely, these approaches rather focus on a gradual change of the behaviour, starting from a small change, towards the reducing of the potential evil, and not necessarily on abstinence (a sure method of averting the HIV infection through sexual practices or drug use).

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7 Specific situation

7.1 Pre- and post- HIV test counselling for individuals involved in commercial sex (prostitution)

We can define prostitution as the practice of sexual relationships with the purpose of gaining a material reward – that may consist in money or products, including drugs. Many people may consider that only women are involved in prostitution, but the male prostitution should also be taken into consideration, including the bisexual or transsexual persons.

Moreover, many other persons are often involved in the prostitution networks – those who mediate the relations or those who assure protection against possible aggressions or abuses.

In order to be able to provide counselling services to persons involved in prostitution, it is essential that we are able to understand their practices and the circumstances under which they carry out their activity, that is:

- the places where commercial sexual relations are practiced – in a brothel, in the street, in hotels, in bars, in apartments;
- the price of a sexual contact – with significant differences between those in hotels and those in the street;
- the socio-economic statute (level of school-based education, family to support, the existence of a legal workplace, etc.);
- the terms of their work: they prostitute themselves occasionally or daily, receive money or other goods in exchange, can decide who the clients are, may negotiate the sexual practices;
- whether they are trafficked persons or not / dependent on other persons (pimps) or independent;
- whether prostitution is associated to drug use (including alcohol) and/or trafficking;
- the sexual behaviour – chosen or forced;
- the perception of the risk – for example, it is possible that, for some of the persons involved in sex work, the risk of not having access to drugs or of being assaulted is considered much higher than the risk of getting infected with HIV or with other sexually transmitted disease;
- the access to medical and social services.

Since legislation penalizes prostitution, the persons involved may receive with reserve both the abuse denunciation and the accessing of medical and social services, which is of a nature to restrict the efficiency of HIV prevention programmes.

Stigma and discrimination related to commercial sex constitute an additional barrier to preventing HIV infection, as well as to preventing prostitution and to integrating persons willing to change their life style.

At the other end stands the counsellor or other personnel offering services to persons involved in sex work. They sometimes find themselves in the situation to “fight” with the wish to help the beneficiaries, by offering them solutions that may solve the problem.

Whereas the prostitution is illegal and implies high risks of HIV infection, the obvious (and also moral) solution – in certain counsellors’ opinion – is to recommend giving up this “occupation”.

Although this suggestion may suit some individuals, to others it is unacceptable and may be perceived as a critical attitude and therefore rejected.

The choice of a proper manner (adapted to the situation) of risk reduction has to belong to the person in question and must be done being aware of its advantages and disadvantages – by following the principle “I do what I want, but I know what I do!”, a slogan of one of the HIV prevention campaign developed by Population Services International in 2001.

The HIV counselling and testing need to lay their foundation on an uncritical attitude and respond to the needs of the persons involved in sex work.

All the stages of the pre- and post-test counselling must be treated with even more attention:

- an informed consent, in full knowledge of the problem;
- a strict confidentiality – both regarding the result and the content of the counselling;
- the completion of the knowledge on the HIV infection, a self-assessment of the infection risks and the elaboration of a realistic and feasible plan for reducing these risks;
- the preparation for a potentially positive result;
- the referral to other services – which, in turn, are welcoming and friendly, and include treatment for the sexually transmitted diseases (if they are not treated, these may facilitate the HIV infection).

The essential factors to reduce the HIV transmission to the persons involved in sex work are:

- the information and education of the population, including the clients of the persons involved in sex work;
- an increased access to condoms (both male and female condoms, where possible, as well as the promotion of the use of dental dams (latex barriers for use in the oral sexual intercourse);
- the discrimination and stigma reduction – both of the HIV infected persons, and of those who are socially vulnerable.

7.2 Pre- and post- HIV test counselling for the injecting drug users (IDUs)

When working with the IDUs, a fact must be accepted from the very beginning, which is that no counsellor can make a drug user give up drugs, unless the latter has an inner motivation to adopt an abstinence behaviour.

The counsellor may assist, facilitate and support the process towards abstinence or towards a „controlled“ use.

The context and the practices related to drug use vary from one person to another, from one community to another and, therefore, the counsellor must know:

- the type of drug(s) used by the population targeted;
- the ways drug is administrated;
- the injecting equipment used;
- the HIV prevalence within the population concerned;
- the practices of sharing syringes;
- specific treatments, support treatments, detoxification, post-cure or other existing services for the drug users.

The IDU counselling must take into consideration the provision of information on the risk-free injecting practices and on those allowing the drug user client to reduce effects associated to drug consumption:

- the development of a new type of behaviour: “a new syringe, used just once” (one syringe, one injection!);

- the use of sterile injecting equipments (needles, syringes, filters, distilled water, etc.);
- information related to correct injecting (alternation of the two arms, the change of the injecting spot, areas of the body that an IDU must not inject, etc.);
- information related to the care of the lesions/wounds emerged following the latest injections (the use of heparine-based ointments for the recovery of the destroyed veins, treatment of abscesses, etc.);
- information on HIV/AIDS, B and C hepatitis – ways of transmission, prevention procedures, the protection of the other members of the group or of the sexual partners.

In order to have an efficient counselling, the counsellor must not make appeal to moral judgements regarding the client's behaviour as a drug user.

In many cases, the client might have already faced discrimination and rejection, from the medical staff and from the family as well, or those promoted at the societal level.

Hence, the counsellor will not confirm or statute such attitudes!

Moreover, the counsellor will listen to what the client has to say: which is, from the client's viewpoint, his/her most important problem, which is the information the client needs the most.

Even though the long term objective is abstinence, both the counsellor and the client must have an approach as realistic as possible of this fact. It rarely happens that a drug user decides to give up drug use and also to manage to do it from his/her first attempt. If the objectives proposed exceed the individual's real possibilities and are not adapted to the context, they may demobilize the client, who will not feel able to reach them in a near future and will feel even more helpless: "it's too hard for me, I can't do it!".

The counsellor who works with the IDUs, either carrying out his/her activity in a centre of needle-exchange or in an outreach programme, may provide the client with information that may help him/her avert the risks associated to the drug use:

- changing the way of administration: by smoking cigarette, by thin sheet, or sniffing;
- passing to a substitution treatment: methadone;
- using only sterile, single use injecting equipment;
- including him/her in a needle-exchange programme;
- not using in common, within the injecting group, any of the drug administration equipments (to use one's own sterile syringe is not enough if filters, ampoules, the needle for extracting the prepared drugs are shared).

7.3 Pre- and post- HIV test counselling for the partners of injecting drug users

Many pre- and post- HIV test counsellors may find themselves in the situation to (incorrectly) suppose that a person who has only one partner and doesn't take drugs is not at risk of HIV infection. However, the cases in which the client is the partner of an injecting drug user or of an alcohol user are quite numerous.

Many of the injecting drug users' partners are at a very high risk of HIV infection, as they do not know the drug use behaviour (maybe not even the fact that their partner uses drugs), and this ignorance makes them adopt sexual behaviours which do not involve protection.

The negotiation of the type of sexual practices with a partner who is under the (legal or illegal) drug influence may be a tough one. In addition to this, drug users often invite their partners to join them in taking drugs. On the other hand, even if drug use is stigmatized by the society, there are subcultures which value it.

Practicing unprotected sexual intercourse may be also influenced by the strong relationships within a couple which is often built on the basis of a socio-economic dependence.

In these situations, the pre-test counselling must include:

the assessment of the risk of HIV infection and of B and C hepatitis:

“Sometimes, when a partner of an individual is a drug user, that individual finds it very hard to talk about that”;

“Do you know that women are more exposed to HIV infection risk than men?”;

“Somebody I know found out s/he is HIV-infected after having a relationship with someone who used to be a drug user. He didn’t know he was infected and she didn’t either.”

In order to identify the type of relationship between the partners, questions like the following may be used:

“Do you talk with your partner about the sexual intercourse?”

or:

“How do you decide what kind of sexual practices you adopt?”.

The fact that the client might use drugs (which makes even more complicated the adoption of prevention practices within a couple) or that there may be other drug-related problems (among which the need for money to procure drugs) must be taken into consideration as well;

the risk reduction, including plans regarding abstinence from drug use for the partner, keeping him/her on methadone or changing the sexual practices – practice of protected sexual contacts –, offering new needles and syringes to the partner, cleaning them, persuading the partners to use drugs at home, individually.

8 Access to VCT services

One very important condition for VCT services is that they should be easily accessible, in order to ensure that the relevant target groups have access to these services.

This means:

- good opening hours = late opening hours are preferred
- good, easily accessible location = a place that can be ideally reached from all corners of the city
- discretion = it is preferable not to have a huge banner on the building stating what is going on inside...
- ideally, it should be a location that offers several services, so that people who come for testing benefit from other services at the same time (ex: social assistance, primary medical care, etc)

According to a research made by the Czech AIDS Help Society, VCT services offered by non-governmental institutions are preferred to services offered by state institutions, because of:

- a better connection with prevention services (distribution of leaflets and condoms, possibility to discuss longer on prevention measures to be taken after the test)
- better adapted programmes: afternoon and evening hours
- a friendlier approach of vulnerable groups (in many cases referred by outreach teams who work in partnership with the VCT services)
- lower threshold services
- positive and less discriminative attitudes toward PLWHA
- better support for persons who find out they are HIV+ (referrals and accompanying to other services).

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9 Data protection and anonymity

As mentioned above, the anonymity must be guaranteed in all VCT services and all VCT services should have clear protocols that regulate the data management.

As in many other situations, VCT is also a matter of human rights, therefore it should be treated as such, with certain elements to be kept in mind:

- confidentiality
- anonymity
- stigma and discrimination
- informed consent

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10 VCT intervention models

A high quality VCT service must observe the following:

- international recommendations regarding HIV testing and counselling
- development of national policies regarding HIV testing and counselling
- national legal provisions regarding VCT services and their quality
- in place work standards and procedures
- monitoring and evaluation system for services

Several intervention models, including all above-mentioned items, were presented during the VCT seminar held in Bucharest. All of them took into account the discrimination and stigmatization people living with HIV must face, and also the increased efficiency of ARV treatment. The presentations stressed the importance of increasing access to HIV testing and counselling for the population, and especially for vulnerable populations.

Vulnerability is defined both on grounds of social situation (including migrant status) and/or behaviour.

An in depth analysis of all materials regarding virtual resources on counselling and testing (<http://www.who.int/hiv/topics/vct/elibrary/en/index.html>) reveals the fact that some countries have specific, national policies and recommendations.

Also, some countries have developed advocacy and policy guidelines, uptake of testing, implementation, acceptability, effectiveness, operational issues, supply and management of commodities, training, etc.

In cases like UK and Ukraine, there are national policies and standards regarding HIV testing and counselling.

10.1 VCT service providers

- in several countries (for instance, France and Spain), local authorities are involved in providing counselling and testing services and even in supporting them financially
- local authorities also promote on their own web pages the centres where HIV test is free of charge and/or anonymous, accompanied by counselling
- HIV services are generally provided by public institutions, in specialized centres or in institutions that offer integrated services (STI services, family planning, TB, hospitals)
- in some cases, private clinics or NGOs provide these services in HIV testing and counselling centres, which are easily accessible for vulnerable groups, or in the framework of outreach services for vulnerable populations.

The rapid assessment ARAS carried prior to the VCT seminar included a survey of NGOs' opinions regarding VCT services in Europe, whose results show that:

“Based on information provided by more than one third of the European countries (32 people from 18 countries), the survey reveals that in the field of HIV voluntary counselling and testing services it is important to continue improving the social policies and mostly the implementation into practice.

Although legal provisions regarding counselling, testing services, working standards and protocols exist, the study shows that in most of the countries (especially in Eastern Europe) an HIV test is accompanied by counselling only in an estimated 10% of the cases. On the other hand, it is good that some of the countries estimated that the proportion of HIV tests accompanied by counselling is as high as 50% to 80%.

The data analysis also shows that there are countries where an HIV test is a condition for being hired in the following sectors: medical field (5), hair dressing (2), police (4) and army (4). Further situations where HIV tests are compulsory include entering a children/elderly home (2), hospitalization (3) or marriage (2). These situations might represent a violation of civil rights.

The access to VCT services is influenced by whether the test is free or whether the services are geographically close to the people who need it. The respondents stated that the test is free of charge for anyone asking for it in 15 countries. However, only in 13 of these countries legal provisions in this regard exist. Respondents often mentioned the test to be free of charge for some particular social subgroups considered to be most at risk. This might suggest barriers to considering free accessibility of HIV tests for any person opting for a test. The HIV test is available in VCT centres and general medical settings in most of the countries (14 out of 18). The services are provided by public institutions, private medical cabinets and NGOs.

Apart from the barriers related to price and location, other barriers still exist. Barriers to VCT services include the existence of discrimination, fear of breaking confidentiality, lack of information on test issues and test locations, and a minimum age to test without parental approval.

The VCT services focus on informing the beneficiaries instead of changing behaviours. Be aware that respondents of 5 countries indicated that informed consent in the structure of the pre- and post HIV test counselling is not included, and 3 of them say that there are legal provisions regarding informed consent. According to the respondents, the counselling services are provided by medical personnel, specialized counsellors and peer educators. It has been noted that specialized training sessions for this personnel exist.”

HIV COUNSELLING AND TESTING SERVICES IN EUROPE Results of a European Survey, Pre seminar report, ARAS

Another report was presented during the seminar: HIV Voluntary Counselling and Testing (VCT) - Report on survey findings on HIV-test counselling among HIV-test facilities in 5 EU countries, realised in the framework of BORDERNET WORK project, by Tzvetina Arsova Netzelmann, SPI Forschung, Berlin.

One of the important conclusions of this report was that:

“The importance of HIV test to the prevention of spread of the HIV epidemic has been

repeatedly emphasized in the international guidelines. According to the WHO/UNAIDS, greater knowledge of HIV status is critical to expanding access to HIV treatment, support and care both in post-industrial and resource-constrained societies. Therefore the scale-up of HIV testing (both client- and provider-initiated) plays a major role of entry gate to primary and secondary prevention.

The issue at stake is if prevention can not do without HIV test, can HIV test do without prevention-counselling? The focus of this report and its finding is to emphasize the role of counselling in the frame of the VCT concept. Hence the response is not as much whether counselling should be an intrinsic part of the HIV testing offer, but how to constantly optimise and assure its quality in the various practice settings.

Several considerations seem conclusive at this point:

- *Special efforts should be promptly undertaken to safeguard the wide coverage and quality of counselling considering the constraints of the public health services. Additionally, the low threshold HIV-testing offers*

should be made better known through intensive public awareness work and targeted information campaigns;

- *Secondly, it is important to conduct risk assessment in a non stigmatizing manner in order to avoid discrimination of particular target groups in the testing settings;*
- *Thirdly, an actual challenge to the counsellors is the promotion of behaviour change and risk management over a short-term interaction. An ability of crucial importance is to accompany the dynamic process of stepwise progress and relapses in behaviour change adopting a client-centred perspective;*
- *Fourthly, balance should be sought for between public health benefits and responsibility on the one hand and human rights, individual autonomy and confidentiality on the other when considering the various HIV testing approaches. Otherwise, the efforts to reduce the stigma associated to the HIV test will fail in reducing the stigma associated to the HIV positive status.*
- *Lastly, addressing groups exposed to higher risks with routine HIV testing offers without ensuring the enabling environment of risk assessment and prevention counselling can increase eventually the gap among those groups and the health care settings.*

Summing up the conclusions, regardless of the testing approach being recommended, be it client or provider-initiated HIV test, the counselling has an indispensable role in the whole process of HIV testing.

Therefore, the competence required for its delivery should be promoted and assured at multilevel. Internationally synchronized standards of pre- and post-test counselling, unified training curricula at national level and provision of ongoing supervision on local level are seen as appropriate recommendations for improvement of the quality of HIV voluntary counselling and testing in diverging testing settings and for better comparability of their outcomes.”

An interesting model of intervention presented during the seminar was that implemented by Checkpoint Amsterdam:

“The objective of Checkpoint is to familiarise the Dutch market with the HIV rapid test. The testing method is offered to anyone who has run a risk of becoming infected with HIV, regardless of his/her sex or sexual preference. The testing takes place in the context of thorough pre- and post-test counselling. With this method, Checkpoint wants to contribute to a more active testing policy in the Netherlands. The expertise gained with regard to this method is being analysed and will eventually be transferred structurally to primary health care facilities and interested parties.

Checkpoint has introduced a new formula: an HIV rapid test administered under expert supervision.

To begin with, the person being tested discusses all the ins and outs of the test with a healthcare worker (doctor or nurse).

Then a drop of blood is taken, followed by a quarter of an hour’s wait.

If the test result is HIV negative, there is a brief discussion about that result, and the procedure comes to an end.

If the test result is HIV positive, blood is drawn for a confirmation test. The client needs to return for the result of that test a week later, and in 99.7% of the cases it will confirm the earlier result. If the client is HIV positive, the centre will offer him/her the many forms of support and information that it provides. The entire

testing procedure lasts about 25 minutes, not including the 15-minute wait for the test result, and costs €15.”

Checkpoint includes pre- and post-test counselling and the use of the reliable Abbott Determine HIV-1/2 test. A positive result is confirmed using an Elisa and Western Blot.

Checkpoint wanted to prove that a one-hour procedure would motivate men who have sex with men at high risk to take an HIV test. As a control, we used statistics from the Amsterdam Health Department, where a one-week wait after an HIV test is standard. Minimal public relations efforts were necessary for Checkpoint to be fully booked every week. 4909 tests were taken. MSM and straight people came in equal proportions. The majority of the visitors (67%) chose Checkpoint because of its rapidity.

The average prevalence (2.8%) and the prevalence among MSM (5.2%) were higher than those in the control group (respectively 1.1% and 3.8%). There were no false positives. Detailed profiles of the high (MSM) and low prevalence groups have been obtained.

This procedure is persuasive for those at risk who refrain from or postpone HIV testing. This method can be applied without a laboratory infrastructure in outreach settings to reach high-risk groups. Good pre- and post-test skills are required.

For more information, visit::

http://www.hivnet.org/index.php?option=com_content&task=view&id=4145&Itemid=343

11 Conclusions

The different VCT models presented during the seminar (both the research results and the service presentations) proved once more the high importance of providing ACCESSIBLE and QUALITATIVE services, that respect ANONIMITY AND/OR CONFIDENTIALITY.

Service providers can be very different, as seen during the seminar – from voluntary basis services (Checkpoint, the Netherlands), to state run (France) or NGO run VCT centres. Another model was a VCT service fully initiated by a NGO and then partially taken over by public institutions (Romanian Angel Appeal, Romania).

An important conclusion of the seminar is that intervention models are still very little compared to the need for VCT and cannot cover all geographic areas or answer all groups of populations.

It is obvious that, before organising a VCT service, it is highly necessary to determine the population/populations we want to target and to adapt the service to its/their specificities and needs.

Eastern European countries are still facing problems of non-observance of the legal provisions regarding informed consent and confidentiality in VCT services.

Voluntary counselling and testing services have consistently improved lately, still service providers should continue to work on developing monitoring and evaluation systems for their activity. The results these systems could offer are a valuable resource for improving the existing services and for starting new ones on very good grounds.

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12 Annexes

12.1 Basics when starting an HIV VCT activity

Starting a VCT service can be very challenging and difficult, but it can also be extremely rewarding.

Here are some hints about what you should not forget when thinking about this type of service:

- 1 check the national legal framework
 - does it allow the opening of private VCT services?
 - what are the conditions you have to fulfil (legal, hygienic, etc)
 - what is the process to be taken before opening the service (documents to prepare, certifications, how to arrange the place where the service will be, etc)
- 2 check already existing services – both public and private
 - see what you can learn from them, both in good and bad
 - see who comes there
 - what do they offer?
 - how do they offer it?
- 3 try to adapt your service to the population you want to reach firsthand
 - do you want to make a low threshold service, for vulnerable groups?
 - do you plan to open it for the general public?
 - what is the level of discrimination against vulnerable groups in your country?
Ex: if it is high, and you want to have a service open for all groups, you risk facing discrimination against persons belonging to vulnerable persons
 - do you intend to offer services to migrants? plan an interpreter and specific hours for this group
- 4 prepare a database and make connections with other institutions, both public and private, that offer services in the field of HIV/AIDS and where you can refer clients
 - ARV and treatment for opportunistic diseases, Hepatitis, STIs
 - psychological, social, financial support for PLWAs and their families
 - legal support
 - HIV/AIDS prevention
 - support for persons using intravenous drugs
 - housing facilities
 - Et cetera

12.2 Sources of information

www.aidsactioneurope.org

www.hivnet.org

<http://www.aidsmap.com>

<http://www.eatg.org>

<http://www.i-base.info>

<http://www.fhi.org/en/index.htm>

<http://hivinsite.ucsf.edu/InSite.jsp?page=kbr-07-01-04>

<http://www.youandaids.org/Themes/voluntarycounseling.asp>

<http://www.healthsystems2020.org/content/resource/detail/1893/>

<http://www.ihp.org/training/aidsvct.html>

<http://www.eurosurveillance.org/ViewArticle.aspx?ArticleId=8024>

<http://www.bhiva.org/files/file1031097.pdf>