

Counselling and Testing

Effective counselling and testing calls for discretion and sensitivity to a nervous or embarrassed client. It is therefore essential that there is an appropriate physical environment for comfort, privacy, and confidentiality; good client reception, greeting and introduction; rapport, respect, interest and empathy; non-judgmental attitude; and engagement of the client in conversation.

Other skills a counsellor requires include active listening (verbal and non-verbal); emotional warmth and support; sensitivity to and accommodation for language barriers; talking about sensitive issues plainly and appropriately to the client; and flexibility to involve partner(s) when appropriate or requested.

HIV Tests

There are currently two main types of HIV tests:

- a) antibody tests (e.g., ELISA, simple/rapid, saliva and urine, and Western blot);
- b) virologic tests (e.g., HIV antigen test, polymerase chain reaction test, and viral culture).

Antibody Tests

HIV antibody tests look for antibodies against HIV; they do not detect the virus itself. When HIV enters the body, it infects white blood cells known as T4 lymphocytes, or CD4 cells. The infected person's immune system responds by producing antibodies to fight the new HIV infection. Presence of the antibodies is used to determine presence of HIV infection.

The most commonly used antibody tests are the enzyme immune assay (EIA) or ELISA, including the rapid HIV test. The less commonly used Western blot antibody test is used mainly in industrialized countries to confirm a prior test. The Western blot is better than other tests at identifying HIV infection, but is more expensive than other tests. In addition, the radioimmunoassay (RIA), a confirmatory antibody test, is used when antibody levels are very low or difficult to detect, or when results of the Western blot are uncertain. RIA is an expensive test and requires time and expertise to perform.

Rapid HIV Testing

Rapid tests usually produce results in five to 30 minutes. Some of these tests do not require a blood sample from the client. HIV tests based on urine or oral fluid samples offer an alternative to blood-based tests.

Testing urine for HIV is not as sensitive or specific as testing blood. Available urine tests include the EIA and the Western blot, which can confirm the EIA results. These tests must be ordered by a physician. Results usually are sent back to the ordering physician or his or her assistant.

Saliva-based tests (e.g., OraSure HIV-1) collect oral fluid, which is tested for the presence of HIV antibodies. A trained specialist usually collects the sample from between the lower cheek and gum. Testing an OraSure HIV-1 specimen for HIV antibodies is accurate, but testing blood is more accurate. When both tests are available, clients may be allowed to choose.

The “Window Period”

In some cases, HIV tests may come back negative, even though the person is infected with HIV. This can happen during the “window period,” the time between initial HIV infection and when the body builds a measurable immunologic (antibody) response to it. During the window period, HIV is not detected by most HIV tests though it is replicating in the blood and lymph nodes. The virus can be detected during this phase only by laboratory tests used to identify the virus itself.

The window period can last from as little as two weeks to as long as six months. Thus, if a person tests negative to HIV antibody tests, one possible explanation is that they are still in the window period, in which their immune system has not yet begun making antibodies to the virus. A person in the window period will only test positive for HIV if a virologic test is used.

Virologic Tests

The antibody tests discussed above are the most commonly used in VCT settings. But under special circumstances (e.g., in a recently infected individual, during the window period, or in the case of a child born to an HIV-positive mother), more direct diagnostic methods may be used. Unlike antibody tests, virologic tests determine HIV infection by detecting the virus itself. There are three virologic (direct) tests:

- Viral antigen detection test (also known as the P24 antigen test);
- Nucleic acid-based tests (specialized tests that look for genetic information on HIV using polymerase chain reaction or PCR);
- Virus culture, which isolates the virus.

Virologic tests are rarely used to diagnose HIV in developing countries since they require sophisticated laboratories. But they may be used to monitor progress of infection or response to therapy (e.g., by measuring viral load).

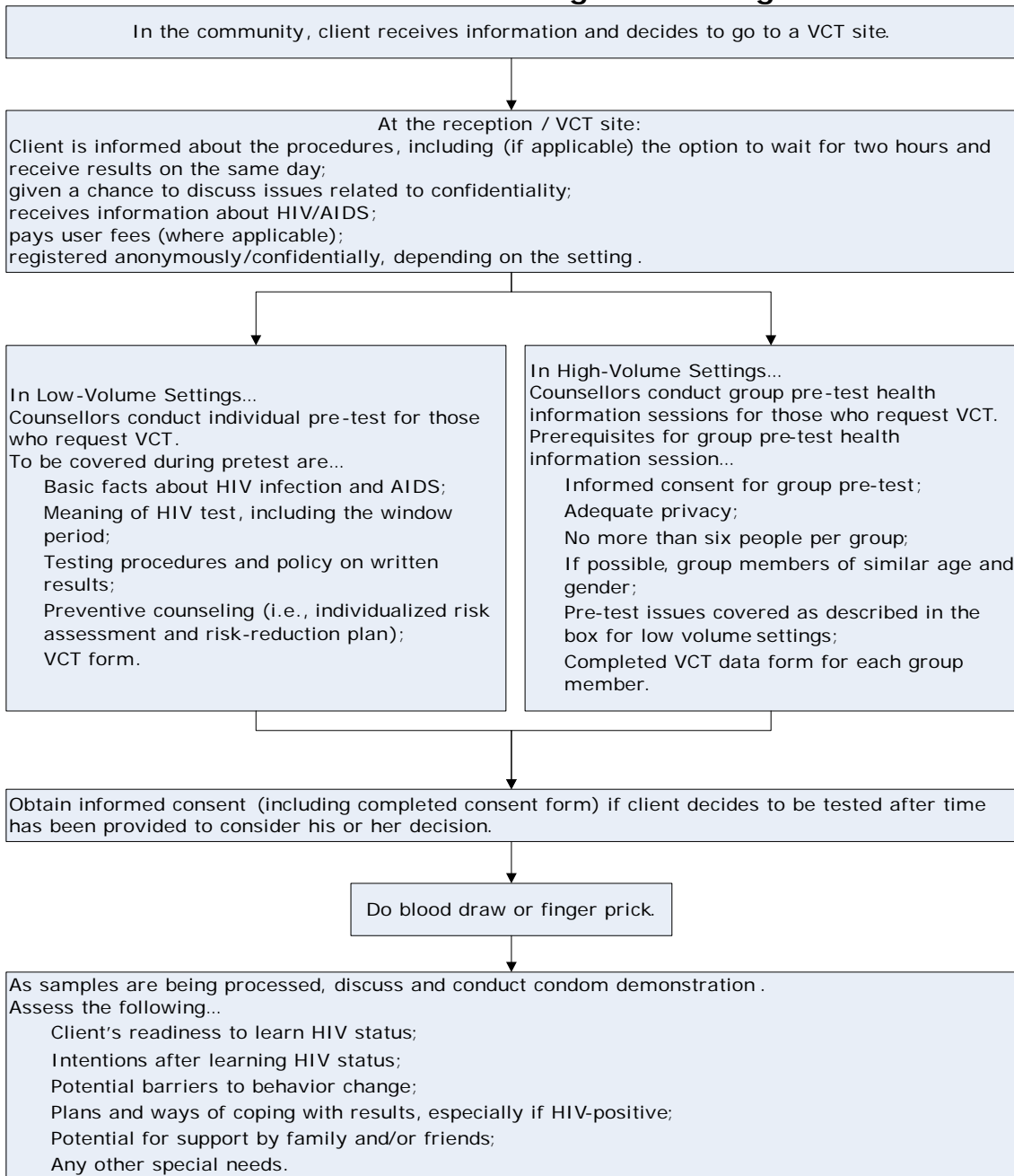
Pre-test Counselling

In pre-test counselling, the counsellor should as much as possible help clients to decide whether or not to be tested and to address the following issues:

- Reason for coming for HIV testing
- Knowledge of HIV and transmission and misconceptions
- Assessment of personal risk profile
- The test process itself
- The meaning of the result and implications (who to inform)
- Coping with test results
- Development of personal risk reduction plan
- Potential needs and available support
- Informed consent/dissent given freely

The flowchart on the following page shows the process of pre-test counselling and testing.

Pre-test Counselling and Testing



Getting Test Results

Results should be given calmly in a quiet and private setting.
Results should be given as soon as possible.
Client should be allowed to express his or her feelings about the test and other concerns.
Client should be given time to ask questions.
Clients should be offered one-on-one or couples counseling, depending on the client's preference.
A family member, friend, or other supportive person should be allowed in the room when the results are given, if the client requests.

HIV Test Results

Negative: A negative test result indicates that no antibodies to HIV were detected in the blood.

This result can have one of two meanings:

- the person may not be infected with HIV.
- the person may be infected with HIV, but his or her body has not had time to produce antibodies to the virus. In this case, the person is in the window period.

A negative test result means that HIV antibodies were not detected in the person's serum sample, either because the person is not infected or because the person is still in the window period. It is imperative that the client understand that a negative result does not mean that the person is uninfected or immune to HIV infection. An HIV-negative person is still vulnerable to HIV infection if he or she engages in risky behavior. A person who tests negative but has practiced safe behaviors during the window period may be (or become) infected with HIV and infectious to others.

Positive: A positive test result indicates that antibodies to HIV were detected in the person's blood. This result indicates the person has been infected with HIV; it does not necessarily mean the person has AIDS. A positive test result means that HIV antibodies were detected in the person's serum sample. It means the person is infected with HIV and that he or she can transmit the virus to others if he or she engages in risky behaviors. It does not necessarily mean the person has AIDS.

Indeterminate: An indeterminate test result means one of the following:

- The person may be infected with HIV and in the process of developing antibodies to it (acute seroconversion).
- The person has antibodies in his or her blood that are very similar to antibodies to HIV. These antibodies are reacting to the HIV test.

An indeterminate test result means that the presence or absence of HIV antibodies could not be confirmed. This means one of three possibilities:

- The person may be in the process of sero-converting.
- The person might have had an earlier inoculation that is cross-reacting with the HIV antibody test (cross-reactivity does not necessarily mean HIV is present).

- The person may have a prior medical condition that is affecting the test (for example, arthritis or autoimmune problems).

HIV tests have been developed to be especially sensitive. Consequently, a positive result may be obtained even when there are no HIV antibodies in the blood. This result is known as a "false positive." Because of this possibility, all positive results must be confirmed by another testing method. False positives have many causes, including:

- technical errors,
- serologic cross-reactivity,
- repeated freezing and thawing of specimens,
- "stickiness" of stored sera in malaria-endemic regions in Africa.

HLA cellular antigens may cross-react and cause a false positive on an ELISA or rapid HIV test. There is risk of false positive results in persons with:

- Rheumatoid arthritis;
- Multiple sclerosis;
- Systemic lupus erythematosus;
- Type I diabetes mellitus;
- Addison's disease;
- Ankylosing spondylitis;
- Chronic hepatitis;
- Cancer (particularly lympho-proliferative malignancies);
- Severe kidney disease.

And in persons who have had a:

- Flu shot within the past 30 days;
- Gamma globulin injection;
- Recent transfusion or organ transplant

Confirmatory tests usually rule out false-positive results. A false negative occurs in an infected person when the blood tested gives a negative result for HIV antibodies, even though it should have showed positive. The likelihood of a false-negative test result must be discussed with clients if their history suggests they have engaged in behavior likely to put them at risk of HIV infection.

Repeated testing over time may be necessary before the client can be reassured that he or she is not infected with HIV. The most frequent reason

for a false-negative result is that the individual is newly infected and is not yet producing HIV antibodies.

The benefits of knowing one's HIV status

At Individual level

- Creates more realistic self-perception of client's vulnerability to HIV;
- Promotes or maintains behaviors to prevent acquisition or further transmission of HIV;
- Alleviates anxiety, and facilitates understanding and coping;
- Facilitates entry to interventions to prevent mother to child transmission of HIV;
- Helps client to plan and make informed choices for the future;
- Leads to early referral to HIV specific clinical care, treatment, and support.

At community level

- Creates peer educators, and mobilizes support for appropriate responses;
 - Reduces denial, stigma and discrimination and normalizes HIV and AIDS.

The most difficult part of learning one's status is deciding whether or not to disclose their status to family, friends, and/or partner(s). There is no right or wrong thing to do. Some individuals disclose while others do not. However, it is important for the client to understand the consequences of his/her decision and the new behavioural limitations s/he will face if the test result is HIV positive.

Post test counselling

The aim of post test counselling is to help clients understand and emotionally accept their test results. During a post-test counselling session with an HIV positive client, the counsellor should address the following:

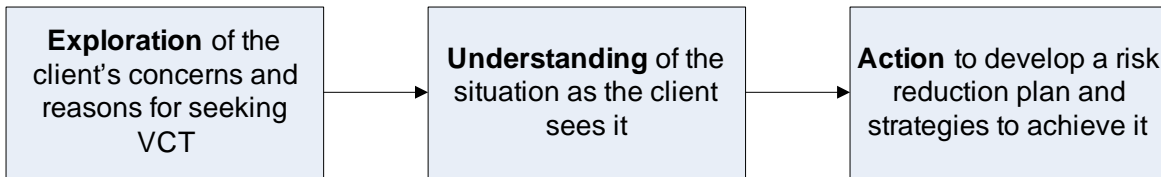
- Referral for follow-up care and support;
- Importance of taking care of ones health and seeing a doctor immediately even for minor illnesses;

- Need to maintain ideal weight by eating a balanced diet, preventing diarrhea diseases, exercising regularly, and taking rest;
- Importance of practicing safer sex to avoid infecting ones partner by (personalized risk reduction plan);
- Importance of protect unborn child if ones partner is pregnant.

Positive clients should be encouraged to make a short term coping plan, share it with a spouse or partner and return to discuss it with the counsellor. Positive clients are encouraged to make a risk reduction plan as well.

Clients should be asked to make a risk reduction plan.

- The counsellor asks the client to propose some ideas about how to reduce his or her risk of HIV exposure.
- The counsellor may initiate a discussion of risk reduction by listing several alternative risk reduction strategies for the client to consider.
- For each risk-reduction behavior, the counsellor assesses internal and external obstacles to change, perceived efficacy in enacting the new behavior, readiness to change, and availability of resources to support change.
- In supporting a client to enact his or her personalized risk-reduction plan, the counsellor acknowledges and supports the client's strengths (e.g., social support, self-efficacy, previous success in changing behavior) and assists problem solving in areas of concern or expected difficulty.
- If condom use is part of the risk-reduction plan, the counsellor asks the client to tell what he or she knows about condoms and invites the client to practice putting a condom on a penis/vagina model before the counsellor conducts the condom demonstration.
- If the client does not mention condoms, the counsellor may introduce the subject, whether or not the client is planning to use them.
- The counsellor elicits a commitment from the client to try to implement specific behavioral changes before the next counselling session.



Post-Test Counselling for the Sero-negative Client

Post-test counselling for an HIV negative client should address the following:

- The challenges of remaining negative
- Negotiation and persuasion skills to encourage the partner(s) to go for VCT and to practice safer sex
- The promotion and advocacy of the female condom if appropriate.
- The importance of being tested periodically.

Negative clients should be encouraged to return for testing. Clients whose results are indeterminate should be told to practice safe sex and prevent the transmission of the virus in case they have it.

Voluntary Counselling and Testing with Special Groups

There are two types of counselling services: Counselling for particular needs; and counselling for particular population groups. Counselling for particular needs include a range of services from prevention; PMTCT interventions and infant feeding; TB preventive therapy; bereavement; blood donation; psychosocial support; positive living; spiritual counselling; to family planning. Counselling for particular population groups may focus on commercial sex workers (CSW); intravenous drug users (IDU); children; youth; and men having sex with men (MSM).

Special considerations need to be taken when offering VCT to CSWs. These include avoiding blame and stigma among CSWs and their partners; offering comprehensive STD as well as family planning services; targeting clients of CSWs; and ensuring ongoing support for HIV-positive CSWs.

HIV tests and children

Diagnosis of HIV in infants is problematic because babies born to HIV-positive mothers test positive for antibodies acquired from their mothers for as long as 15 months after birth, due to maternal-fetal transfer of antibodies during pregnancy, delivery, or breast-feeding. A positive result on an antibody test only identifies infants who have been exposed to the mother's antibodies to HIV; these children may not be infected with the virus itself. For this reason, identifying infected and uninfected infants born to HIV positive women is difficult. Only virologic tests, such as PCR, viral culture, and P24 antigen testing, will prove whether an infant is infected. Clinical evaluation with repeated testing over at least the first two years of life has been the primary means of establishing a diagnosis in these children.

Special considerations are needed when counselling and testing children. These may include among others future medical care of child; emotional

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support; anxieties about siblings that might 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 community; future plans- what to do if parent(s) becomes ill or dies; who should provides consent for testing; and disclosure (i.e. whether the child should be told his/her own HIV status or parents HIV status).

Young People

Young people aged 10-24 account for more than 50% of all HIV infection world-wide (excluding perinatal cases). Cultural, biological and

environmental factors place young people, especially adolescent girls (10-19), at increased risk for HIV infection. Yet, few VCT services exist for young people. A number of issues need to be considered when counselling and testing young people. These include:

- vulnerabilities and emotional needs of adolescents (immaturity); disclosure to parent/guardian, family, sexual partner(s);
- consent (legal and ethical considerations);
- availability of ongoing emotional and support services; confidentiality (anonymous vs. confidentiality);
- VCT outside formal health settings; and
- vulnerabilities of young women (biological and social vulnerability, sex work/abuse, barriers to testing and behaviour change).

Others include stigma and discrimination at school and home; access to medical care (preventive therapies, PMTCT interventions, STI screening and treatment, contraception); linkages with youth support groups; access to condoms (male and female); pre-marital counselling (legal and religious requirements); involvement of and support from religious groups; peer counsellor support (prevention of burnout); counsellors' capacity to undertake VCT for youth; and the need to consider mobile/outreach services to ensure accessibility.

So far data on young people and VCT is quite limited for a number of reasons: a good number of young people actively seek VCT services but have concerns about confidentiality; costs; lack of trust in sexual partners; lack of support for young people with HIV.