BORDERNET

Work Package 7

Final Report

Period of Activity: 1.1.2005 – 31.12.2007

HIV Voluntary Counselling and Testing (VCT)

Report on survey findings on HIV-test counselling among HIV-test facilities in 5 EU countries

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The authors from SPI Forschung gGmbH would like to thank to all participating partners and institutions:

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- Malgorzata Klys-Rachwalska, DPSZA (Szczecin Public Hospital), Poland
- Sabine Kaschubowski, AIDS-Hilfe Potsdam e.V., Germany
- Joanna Dec, University of Zielona Góra, Poland
- Dr. Helmut Pietschmann, AIDS-Hilfe Wien, Austria
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- Dr. Jean-Pierre Foschia, CRRPS – Regional Centre for Health Promotion, Verona, Italy

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1. Introduction

The role of HIV testing in the global response to AIDS epidemic can unequivocally be highlighted as a major tool for early diagnosis of HIV infection, timely referral to improved treatment and care and to increased quality of life of the affected ones. Its importance becomes greater considering the changing contexts and attitudes towards the HIV epidemic in the last couple of years. A tendency of decrease in attention in Western Europe can be observed due to the successful halt of the increase of HIV spread and to the treatment achievements. Additionally the education and prevention campaigns are often confronted with the fatigue of the targeted audience due to déjà vu experiences. On the other hand worrisome trend of increase of new HIV cases among young people in Eastern Europe against the background tendency of rapid escalation of the epidemic in that region takes alarming dimensions.

In the field of HIV test services an insufficiently high uptake of HIV testing initiated by the clients is observed especially among the group of young people. Besides recent survey's evidence outlined certain discrepancies between utilized HIV test facilities and the quantity and quality of counselling offered by them[1].

Those urged for the adoption of additional approaches in order to expand the access to HIV testing and to complement the client-initiated testing with new models of active recommendation of the HIV test in health facilities, known as provider-initiated HIV testing. Thus several important changes took place in the policy direction in the last couple of years.

The revised guidelines of CDC[2] promote routine HIV testing in all health care settings based on the "opt-out" principle for the groups of adults, adolescents and pregnant women. The HIV test results are reflected in the medical records, separate written consent is not required, but assumed unless the person opts-out. Prevention counselling should also not be required according to this model. This concept of opt-out routine HIV testing has been growingly adopted in practice in USA in controversy to the client-initiated HIV voluntary counselling and testing (VCT)[3].

[1] BORDERNET HIV/AIDS/STIs KAB survey among young people (18 to 25 years old): general hospitals most often attended as HIV testing site, offered most seldom counselling.
[2] CDC. National Centre for HIV/AIDS, Viral hepatitis, STD and TB Prevention (2006). Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health-Care Settings, www.cdc.gov
[3] VCT - Voluntary Counselling and Testing for HIV is the process by which an individual undergoes a counselling enabling her/him to cope with the stress caused by the issue of AIDS and HIV testing and to make an informed choice whether to get tested for HIV or not.

The WHO/UNAIDS promoted last year (May, 2007) new practical guidance for provider-initiated HIV testing in health care settings. They recommend "opt-out" approach to provider-initiated HIV testing and counselling in health facilities, including simplified pre-test information, consistent with the WHO policy options. Those are "recommended 1) for all patients, irrespective of epidemic setting, whose clinical presentation might result from underlying HIV infection; 2) as a standard part of medical care for all patients attending health facilities in generalized HIV epidemics; and 3) more selectively in concentrated and low-level epidemics. "[4].

These changes however do not aim to decrease the importance of VCT: "WHO and UNAIDS strongly support the continued scale up of client-initiated HIV testing and counselling", but respond to the need of adopting various testing approaches.

It is not a task of the survey at issue to carry out assessment of the grade of practical influence and effectiveness of the changes undertaken, considering their novelty. It focused rather on the various dimensions of the practical implementation of the concept of VCT aiming to identify gaps and improvement needs and resources.

Conceptually we depart form the assumption that HIV voluntary counselling and testing with its ***3: "C" columns***: ***confidential***, accompanied by ***counselling***; conducted with informed ***consent*** is of paramount importance to the effective scaling down of the epidemic and to the efficient HIV prevention.

Based on the WHO/UNAIDS definition of VCT good practice standards and recommendations were elaborated for the public health practitioners offering HIV VCT services. Though internationally applied those guidelines have still not been satisfactorily reflected and integrated in the various practice settings in the old and new EC member states, where HIV test is being offered. Problems such as limited offers of free of charge HIV test, insufficient testing among certain target groups (e.g. pregnant women, sex workers, persons without health insurance), lack or insufficient counselling accompanying the test describe the realities in more than one of the BORDERNET project partner countries.

Therefore the need to carry out a further analysis and to identify the gaps and improvement/action priorities faced by the practitioners themselves turns out as a relevant step in the process of synchronization of those services in the border regions.

The current report presents the findings of a small scale comparative survey undertaken among 5 EU countries participating in BORDERNET focusing on the practical implementation of the HIV voluntary counselling and testing.

[4] UNAIDS/WHO (2007) Guidance on Provider-initiated HIV Testing and Counselling in Health Facilities

2. Methodology

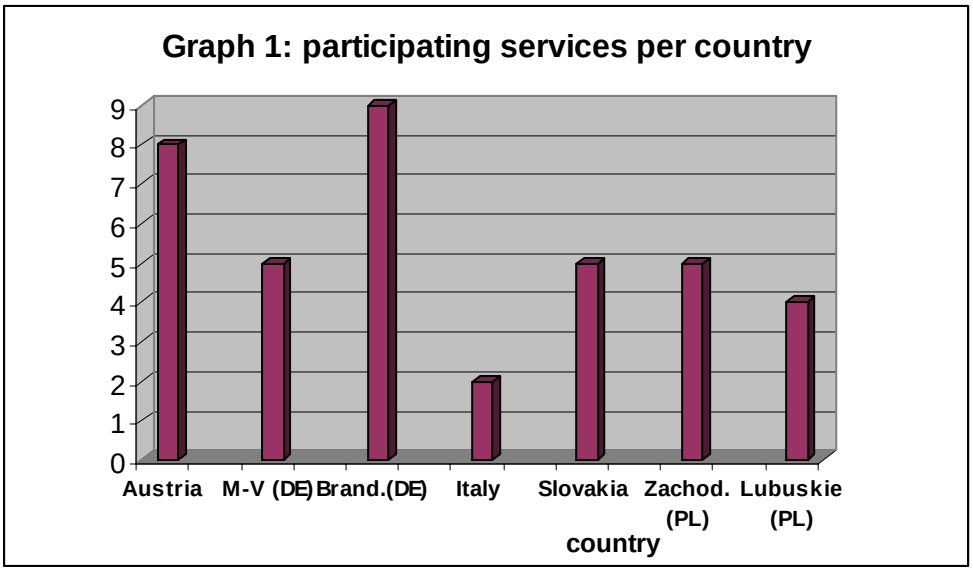
Based on policy papers on VCT (WHO/UNAIDS), practical handbooks and toolkits for VCT counsellors[5] and on theoretical models of counselling a questionnaire was drafted with 24 items, combining multi-choice and open questions. In a consultation process it was circulated among the BORDERNET partners, modified and completed between May and July 2006. Then it was piloted in two structured interviews with HIV/STI counselling and testing points from the public health offices in Berlin. The administration modes comprised both of self-filled questionnairy and of individual or group interviews. In the case of self-administration the regional survey coordinators made a follow up phone call to the respondents clarifying certain aspects of the answers on various items. The survey was conducted between September 2006 and January 2007. Some of the preliminary findings have already been presented in the second interim technical report of BORDERNET in February 2007.

3. Results

3.1. Sample

A total number of 38 services from 5 countries participated in the survey, 14 out of which in Germany, 9 in Poland, 8 in Austria, 5 in Slovakia and 2 in Italy.

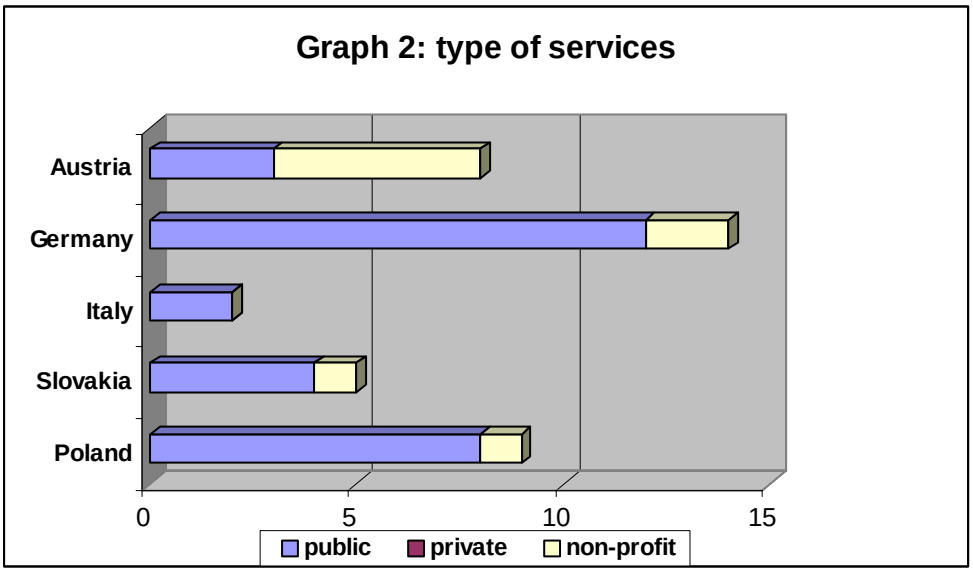
[5] Family Health International (2005) VCT Toolkit. HIV Voluntary Counselling and Testing: Skills Training Curriculum. Facilitator's Guide;



3.2. Type and structure of services

The majority of the participating services are public organisations (29 out of 38). Most of them represent an HIV-testing site, belonging to a health care institution, most often a public health office. Among them there were 5 hospital (in- and outpatient) clinics (2 in Poland, and 1 in each Germany, Italy and Slovak Republic) and 3 specialised services on STIs (1 in Austria, Slovakia and Poland respectively).

9 of the services are non-profit, freestanding HIV testing and counselling sites, 5 in Austria, 2 in Germany and 1 respectively in Poland and Slovakia. 2 of those (in Germany and Slovakia) have mobile units offering HIV-testing services in outreach settings. There was no non-government organisation (NGO) from Italy participating in the survey.

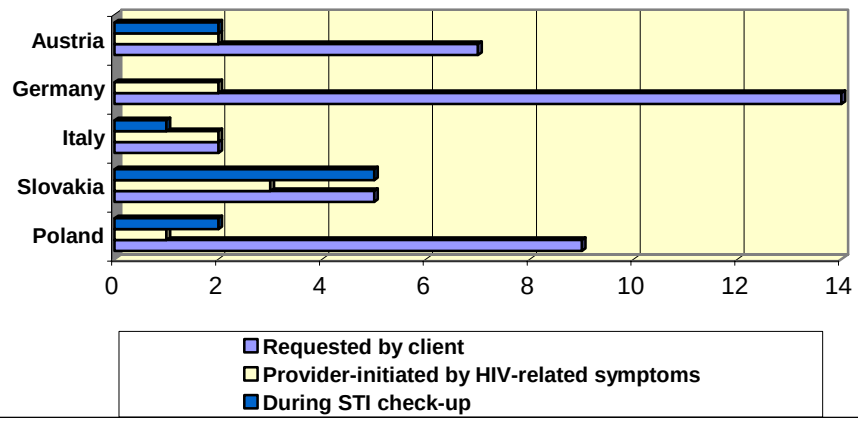


3.3. Types of HIV testing offer

HIV test requested by the client is the most often provided HIV testing offer by almost all services (n=37). 10 services provide in addition HIV test initiated by the health worker upon detection of HIV/AIDS-related symptoms. 10 services (half of them in Slovakia) offer also HIV test in the frame of STI consultations.

The time of survey's administration coincided with the international discussions with regards to the introduction of provider-initiated HIV testing, promoted as routine opt-out HIV test by CDC (September 2006). As far as the guidance of WHO/UNAIDS focusing this issue appeared in May 2007, the survey did not take consideration of those recommendations by the design of research questions. The reported by the HIV test and counselling facilities data on provider-initiated HIV testing does not therefore deliver information on the procedures being applied, whether opt-out (accompanied by pre-test information and informed consent) or voluntary counselling and testing, recommended by the provider.

Graph 3: 3 main types of HIV testing offer



The rest of the HIV testing types are quite underrepresented among the participating services. Thus for instance only 4 services provide HIV test to pregnant women (2 in Italy and 1 in each Austria and Slovakia). There were however no gynaecology practitioners or family planning services among the survey recruits, which might offer an explanation to that data. 2 services provide routine HIV test to surgery patients and 1 (a blood bank in Austria) – exclusively mandatory test to blood donors.

All services but 3 Austrian public organisations offer anonymous HIV test, whereas all of them offer it free-of-charge. Special conditions describe the status of some of the freestanding sites in Germany (AIDS-Hilfe), which offer anonymous and free-of-charge counselling, but are not allowed to perform the HIV test. By 100 % of the services in Poland, Slovakia and Italy the HIV test is both anonymous and free.

The availability of the test can be depicted with a large scale varying from 7 days a week to 1 day a week or in some cases 1 day in two weeks. The country comparison shows in general that Austrian, German and Italian services report higher availability (average of 4-5 days weekly), whereas Polish services range between 1 and 2 days weekly. Important criteria considering the availability are the size of the residential area (rural or metropolitan), the size and scope of reach of the facility.

3.4. HIV testing offer in the antenatal counselling

The HIV testing offer to pregnant women is one of the most important ways of prevention of vertical transmission of HIV (Mother-to-child-transmission, MTCT).

Internationally, the changes in the HIV testing guidelines undertaken in last couple of years, have implications on the testing and counselling offers to pregnant women. Thus the revised recommendations of CDC foresaw that “HIV screening should be included in the routine panel of prenatal screening tests for all pregnant women”. HIV screening is recommended after notification of the test and unless the patient declines (opts-out), test will be performed. No additional written consent is considered necessary.

According to the recently issued by WHO/UNAIDS guidance for provider-initiated HIV testing in health facilities there is no special differentiation made among pregnant women and other general population groups. Thus the recommendations for all HIV epidemic types settings promote HIV testing and counselling as standard of care to “all adults, adolescents or children who present to health facilities with signs, symptoms or medical conditions that could indicate HIV infection.” In generalized HIV epidemics (HIV prevalence is consistently over 1% in pregnant women) the HIV testing and counselling is being recommended to all adults, adolescents and children in all health facilities.

In Germany new instructions[6] were adopted in February 2007, which intend to support the medical practitioners to offer counselling for HIV testing in the frame of the maternity care. According to them HIV test should be offered to all pregnant women, but not on a basis of the routine opt-out screening. The test offer will be utilised only after provision of counselling

[6] Institut für Qualität und Wirtschaftlichkeit im Gesundheitswesen (2007). Erstellung eines Merkblatts für die Schwangere zur Unterstützung des ärztlichen Aufklärungsgespräches über die HIV-Testung im Rahmen der Mutterschafs-Richtlinie des G-BA;

and obtain of the client's informed consent. In a handout to the client these instructions outline the importance of the HIV test and assure the voluntary basis of the decision related to HIV test.

Given the changes described it was of interest to the survey to find out under what circumstances the HIV counselling and test are being offered in the frame of antenatal care. As the results above already have shown that there were no reproductive health practitioners and services (gynaecologist, family planning practices), the HIV testing offer among pregnant women was not very well presented in the study.

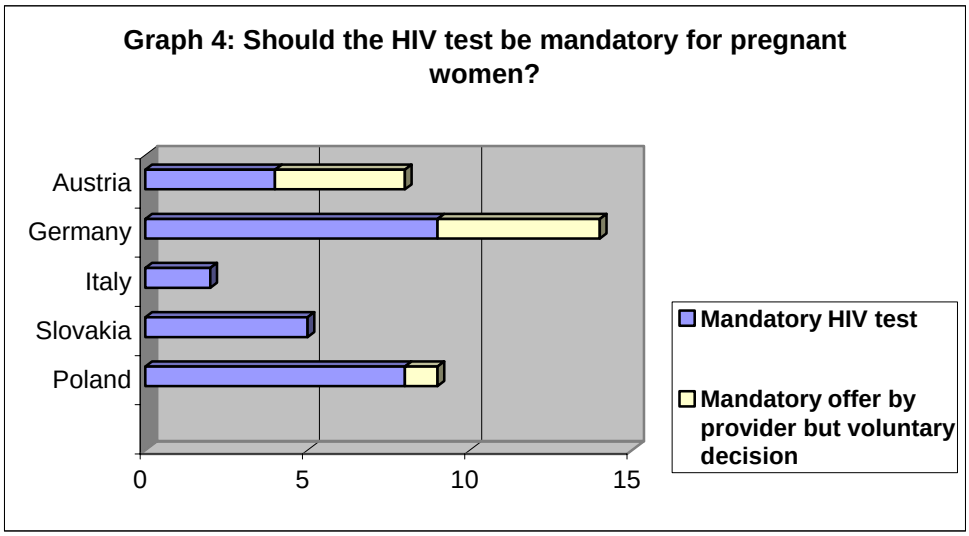
The majority of the services (23 out of 39) offer HIV counselling and testing to pregnant women only if requested by them. Only about a 1/3 (12) of the testing facilities altogether (all 5 Slovak, 5 Polish, and 1 each in Italy and Austria) offer provider-initiated counselling and testing but sporadically. This is evidently dependant on the group of their clients, as pregnant women were not among the usually present clients in the survey's HIV testing facilities.

Nevertheless the findings are worth noting in several regards, as they are indicative for wide spread attitudes of the medical and social professionals toward the HIV testing in pregnant women.

Thus 28 services said they would support the introduction of mandatory HIV test for pregnant women. Such an attitude was most evident among the services in Slovakia, Italy and Poland. The rationale behind is the early diagnosis of HIV infection and the high prevention potential of the treatment during pregnancy minimizing the MTCT risk to below 1 %.

On the other hand the services supporting such attitudes did not point out their view to the right to voluntary counselling and testing and the right to decline HIV test. The introduction of mandatory test dissents from the human rights approach promoted by WHO/UNAIDS in the HIV prevention, treatment and support.

Contrasting opinions were observed among the Austrian and German services, where 9 survey respondents emphasized on the importance of active offer of the HIV test, but moreover on the crucial role of the counselling and on the voluntary decision. According to that viewpoint the HIV test should be a mandatory offer in the antenatal care, but conducted on voluntary basis after HIV test counselling has taken place. The services favouring this position address one of the most sensitive facets of the issue, namely the motivation, competence and readiness of the professionals from antenatal care settings (e.g. gynaecologist, midwives) to offer HIV test counselling to their patients.



3.5. Types of clients

The average number of clients per week who receive HIV counselling and testing ranges from 2 (countryside public health office, small-scope specialised NGO) to 300 (large public STI facility in metropolitan city) and seems incomparable considering the scope of reach of the testing sites. Average 20 clients per week are typically being offered HIV test in Italy, Slovakia and Poland. The survey participants from Germany show threefold lower than that number (average of 7 clients) weekly and the Austrian – more than fourfold higher (average of 88 clients).

The groups of clients who utilise the HIV test and counselling offers differ accordingly. The common ground for all survey participants is that the most usually presented group among the HIV test clients belongs to the general population. Only 2 of the Austrian services have relatively equal proportions of clients belonging to general and to special population groups. The adult men (50 %) have a slight priority against adult women (40%) in almost all services. The usual order of frequency in the German testing sites is adult men, followed by adult women and couples. In Italy and Slovakia teenagers and young people come to the fore (60% of clients in 1 service in each country). Pregnant women are an frequently attended group only in Slovakia.

Among the special population groups' representatives sex workers and MSM are those who present themselves most often for HIV test. More than 80 % of the HIV test clients of one of the Austrian services are sex workers, the majority of whom with migrant background. MSM is most often attended special group in 2 (60% in one of them) of the Italian services and one Slovak service (over 60%). Heterosexual persons with risk behaviour are a special client's

group composing more than 70 % of the HIV test clients in Poland. It ranks at first place in 4 of the Polish testing facilities.

3.6. Counselling process

The survey aimed to outline the strengths and weaknesses of the pre- and post-test counselling conducted in practice and the major difficulties encountered. Beforehand the respondents were invited to reflect on some of the background attitudes (genuineness, non-possessive empathy, unconditional positive regard, acceptance, non-judgmental approach) of the counsellor, derived from the client-centred model of counselling[7]. In a self-evaluating manner they reported on the extent in which each of the attitudes is being considered in their HIV test practice. Almost all services stated that in their daily work they consider either completely or to a great extent all aspects of the counsellor's background stance.

Some aspects of those were however highlighted as especially difficult in the routine counselling work, e.g. the maintenance of authenticity in work under "*time and waiting lists"* pressure. For some counsellors the protection of the personal boundaries becomes a sensitive issue in the process of counselling where highly personal topics are dealt with. Acceptance and non-judgmental stance appear a challenging attitude in the counselling relationships with special clients, as reported by some services, in particular with those who tend to present over and over reiterating problems and who *"do not seem to learn from the counselling".* Refraining from moral argumentation and reproval may become quite a hurdle to some counsellors, who do not share understanding about divergent sexual lifestyles and behaviour patterns of some of their clients.

At this stage the formulated by the respondents difficulties have direct implication to the quality assurance in the counselling process and will be later referred again when discussing the factors, which influence its optimisation.

3.6.1. Pre-test counselling

Reviewing the time frame of the counselling process, the survey respondents offer between 10 minutes to 1 hour for pre-test counselling to their clients. The average amount of time at disposition is about 20 minutes (Italy, Slovakia, Poland). The Austrian professionals dispose at a bit shorter time (15 minutes), whereas some of the German freestanding services

[7] Rogers, Carl. (1959). "A theory of therapy, personality and interpersonal relationships as developed in the client-centered framework.", in (Ed.) S. Koch: *Psychology: A study of a science. Vol. 3: Formulations of the person and the social context.*. New York: McGraw Hill.

(average 30 minutes) dispose at almost 1 hour for each client. As already mentioned above these are services, specialised in counselling, which do not conduct the HIV test. Local practices will here also vary according to the scope of reach of the facilities and the size of clientele attended daily.

Looking at the individual phases and components of the counselling before the HIV test, all services scored rather high on the following aspects: build trust, ensure confidentiality, assess client's knowledge of HIV/AIDS and give information related to HIV/AIDS and HIV test and results, assess of risk exposure and personal sexual behaviour. They are applied as standard components in each pre-test counselling session.

As optional components, integrated only to a small extent or depending on the specific context of the client the services outlined: assess costs and benefits of risk taking for client, identify barriers to risk reduction, explain connection between HIV and STIs and refer to other STI/sexual and reproductive health professionals in case of need.

This data suggests that important predictors for risk exposure might be underestimated in the phase of exploration and risk assessment, which can bear a negative impact on the consecutive determination of risk management strategies. The risk reduction plan and the communication of safer sex practices with the partner were not pointed out as standard component by all services. In addition the assessment of the emotional state of the client with regard to the test is also often skipped from the pre-test topic agenda. Furthermore the omission to especially highlight the interlink between HIV and STIs can significantly diminish the prevention effect of the pre-test counselling avoiding an integrated approach towards risk minimisation.

3.6.2. Post-test counselling

3.6.2.1. In case of HIV-negative result

Generally the time frame of this segment of HIV counselling is rather short, below 20 minutes, whereas in some practices it is reduced to a simple test result delivery (ca. 5 minutes). The prevailing experience, shared by the test facilities is that counselling hardly takes place in this situation, as explicitly formulated by one German service: *"The result giving is not a counselling. One sentence and they are gone".*

The standard practice for all professionals is the discussion of the window period and the re-testing options. The determination of a risk reduction plan is a standard component of the post-test counselling session only for the majority of the Austrian services. Among the rest of the survey respondents only about half of the services in each of Germany, Slovakia and Poland pointed it out as standard component (covered completely or to a great extent).

This finding is concerning considering the prevention potential of the HIV test counselling and the missed opportunities to utilize it as entry gate to promote and support safer sexual behaviour choices.

3.6.2.1. In case of HIV-positive result

Understandingly the post-test counselling session when the HIV test result is positive was estimated as the most challenging situation in the practice of the counsellors. Generally the amount of time at disposition to an HIV positive client varies between 60 and 120 minutes. Many services reported in addition that they usually offer a second counselling session. The majority of the services confirmed to integrate completely in the counselling process all components crucial to the provision of emotional backup and support to the client. As priority topics in this regard are seen the empathic presence of the counsellor, the ability to convey understanding and to offer crisis intervention if necessary. On the other hand clear indications on medical assistance and treatment options should be delivered and discussed if possible. Counselling should also focus on further psychosocial aspects and support possibilities, self-help groups and should possibly offer referral to existing civil society networks. Considering the high emotional burden in the post-test counselling sessions with HIV positive clients most of the services pointed out that they integrate the aspects of rights and responsibilities and “positive living” only as optional components. Depending on the local resources and the circumstances of the client some services offer several counselling dates before the client is referred to a longer-term medical treatment and a psychosocial care programme.

3.7. VCT standards and quality assurance

The availability and the practical implementation of training guidelines and curricula/training programme for VCT counsellors is an important interface between the international best-practice guidelines and policy papers (WHO/UNAIDS, CDC, ECDC) and the quality of provision of HIV test counselling. They have decisive role in supporting the professionals in the process of development of psychosocial and communication competence needed in the process of counselling. On the one hand these have not yet systematically been developed and integrated into the university study courses of the medical professions, on the other the field of HIV VCT is still prevailingly medicalised in many countries. That fact outlines again the importance of additional further training measures supporting the transfer of skills and competence to the practising medical professionals (doctors, nurses, midwives). There are however growingly more psychosocial professionals engaged in the HIV test counselling

(psychologists, social workers) in the survey's respondents. The majority of them represent though freestanding testing sites (NGOs), which do not belong to medical institutions, whereas the majority of the counsellors in the latter have medical background.

From all survey recruits, only the 9 Polish responded affirming in full consent the question of availability of a training curriculum at national level for training of VCT counsellors they use in their practice. Poland is the only of the 5 survey countries, where nationally adopted VCT training guidelines are currently being applied and monitored by the National AIDS Centre.[8] Only 4 of the German and 3 of the Austrian services (all of them NGOs) confirmed that they use specific counselling guidelines in their HIV-test facilities, in that case, developed by the German and Austrian AIDS-helps. Only 1 of each the Slovak and Italian services referred to available training curricula in their services.

The lack of unified counselling standards and training/certification procedures at national level puts great challenges before the management and quality control of the VCT. Depending on local resources and service's policy the professionals can take part in in-service further training, but those remain also single practices.

Routine training offers and ongoing supervision are prerequisites not only for the quality assurance but for the maintenance of healthy professional profiles of the counsellors. Considering the great extent of pressure and emotional burden the VCT counsellors are exposed to in their daily practice the burn-out risk is a factor with immense impact on the quality of performance and therefore should be thoroughly assessed.

The majority of the survey respondents estimated the burn-out factor in their own VCT practice as considerably high to very high. Various sources of frustration and discontent trouble the daily work of the counsellors. On the one hand there are many structural deficiencies, which are perceived as constraining factors: discrepancy between time resources and work load, exaggerated administrative tasks and paper work, lack of financial security. On the other some dimensions of the nature of counselling process bear significant burn-out potential: lack of recognition for the non-medical performance, routinisation due to the repeating topics and types of clients, high emotional pressure threatening the personal boundaries, lonesomeness. Those result very often in attitudes of apathy, resignation and boredom. Keeping stance of neutrality and protecting the personal boundaries of the counsellors are issues, which can hardly be tackled when team work, intervision and supervision are lacking. Regular upgrading training offers can help to complement the competence of the counsellors and to update the thematic range, but can not solely be

[8] Konieczny G; Lipniacki A; Piasek A; Rogowska-Szadkowska D. Wskazowki dla osob pracujacych w Punktach Anonimowego Testowania. Diagnostyka zakazenia HIV.ISBN 83-87068-19-15

responsible for effective implementation of the professionalism standards in the daily practice of the testing facilities.

3.8. Improvement of HIV VCT current state of arts in the frame of BORDERNET

Following the results and recommendations of the comparative situation analysis several thematic priorities were outlined around which concepts for further training and expert seminars for counsellors were developed. As highest priority the respondents set the advancement of communication skills and competence for counselling interview of medical specialists. Interactive training offers aimed at exchange of experience and models of counselling applied in the everyday practice. Two of the BORDERNET model regions implemented those concepts in the frame of inter/national seminars in the last year of project's duration.

In September 2007 a national seminar VCT – Voluntary Counselling and Testing took place in Linz, Austria, organised by AIDS-HIlfe Wien and AIDS HiIfe Austira. It was attended by 20 participants from HIV testing sites from Austria and Germany, both public health care and NGO testing facilities. The objectives of the seminar were to build new networks with regards to improving the practical standards for VCT and to set priorities considering the future of the HIV test. Communication training was a substantial part of the seminar.

In October 2007 a cross-border symposium on HIV-test counselling took place in Zinnovitz, Germany with participation of more than 40 Polish and German stakeholders from HIV testing points. Objective of the symposium was to clarify which guidelines are being applied in order to ensure quality of counselling, which competences are promoted among the professionals involved and how do the local practices take advantage of them. Alongside to the topic of counselling an important topic of discussion was the exceptional status of the HIV test versus the routine HIV testing according to the opt-out principles.

In November 2007 a panel session in the frame of the evaluation conference of the BORDERNET project in Zielona Gora, Poland focused on the challenges of HIV VCT in European context. Main topics of presentation and discussion were the components of the counselling integrated in the training of medical and social professionals, the quality assurance criteria (supervisions, national monitoring etc.) and the application of VCT in unusual counselling contexts. Outreach prevention settings and their role as entry gate to specific vulnerable groups have influence on the HIV test offers, outlining the rapid HIV tests as a preferable option. Herewith the professionals face the shortcomings of the counselling as main information and prevention tool, as the context givens most often do not allow for more than a delivery of short information. Thus the HIV testing offers in the age of rapid HIV

test pose a challenge to the process of VCT or in other words highlight the importance of the networking and referral among services, in order to bridge the information provision to prevention counselling.

4. Conclusions

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 stimatizing 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 wit 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 VCT in diverging testing settings and for better comparability of their outcomes.

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6. Annexes

6.1. Questionnaire on HIV VCT

Questionnaire

I. Types of HIV testing sites

1. Your service is *(please select only one option*):

- ❒ A public organisation
- ❒ A private/profit organisation
- ❒ A Non-governmental/non-profit organisation (NGO)

2. The structure of your service is:

- ❒ Freestanding HIV testing and counselling site - not associated with other health care institution*;*
- ❒ HIV testing and counselling site, which is part of a health care institution *(e.g. public health office, hospital, university clinic etc.)*;

❒ Sexually transmitted infections (STIs) service *(stationary/ambulatory dermato-venerological, urological etc. centre*);

❒ Family planning centre *(stationary/ambulatory gynaecological or sexual health centre)*

❒ Private medical practice – a GP, gynaecological, dermato-venerological, urological,

❒ Mobile clinic– van, during outreach services

II. Types of HIV testing offered **(according to UNAIDS/WHO)**

3. Which of the following testing types are provided by your service?

	Yes	**No**
HIV test requested by the client	❒	❒
HIV test initiated by health worker after detection of HIV/AIDS-related symptoms	❒	❒

		Yes	No
HIV test during an STI consultation	:	❒	❒
HIV test for pregnant women:		❒	
❒			
Routine HIV test for surgery patients		❒	
❒			
Mandatory HIV screening for blood donors		❒	❒

4. Who carries out the HIV counselling?

- ❒ Gynaecologist
- ❒ Dermato-venerologist
- ❒ GP
- ❒ Doctor with other specialization, which?_____
- ❒ Nurse
- ❒ Psychologist
- ❒ Social worker
- ❒ Other: _____

5. Is it possible to be tested for HIV anonymously in your service?

❒ yes ❒ no

6.Is the anonymous HIV test free-of-charge?

❒ yes ❒ no

6.1. What is the proportion of the free-of-charge HIV tests in comparison to the paid one?

□□□ %

7. How many days in the week is the HIV test and counselling provided? □ **days**

7.1. How many hours a day? □□
hours

III. Types of clients of VCT

8. Which of those groups are most usually presented among your HIV test clients?

What is their approx. proportion in percentage?

❒ General population

- ❒ teenagers
- ❒ adult men;
- ❒ adult women;
- ❒ pregnant women;
- ❒ couples

❒ Special population groups

- ❒ MSM;
- ❒ sex workers (male and female);
- ❒ clients of sex workers;
- ❒ drug addicts;
- ❒ partners of PLWHA
- ❒ heterosexuals with risk behaviour

❒ Migrants

9. How many clients per week in average receive HIV counselling and testing?

□□□

IV. Specific VCT offer in the antenatal counselling (prevention of Mother-To-Child-Transmission (MTCT) of HIV)

10. When/under what circumstances is voluntary counselling and HIV test offered to pregnant women?:

- ❒ If requested by the woman;
- ❒ Offered by the health worker (gynaecologist, midwife, nurse etc.)

11.. In your opinion, should the HIV test it be mandatory for pregnant women?

❒ yes ❒ no

V. VCT – The Counselling Process

Counselling is not or better lot more than just giving information and advice. The VCT concept is based on the client-centred model of counselling.

12. Are there guidelines on how to carry out and provide HIV counselling that you follow?

❒ yes ❒ no **(please continue with Q 13)**

12.1 If yes, please indicate which (title):_____

12.2. If yes, provide by:

❒ Ministry of Health

❒ Local health institutions

❒ Scientific society

❒ WHO/UNAIDS

❒ Other, specify:_____

A. Client-centred model of counselling (according to the Humanistic Psychology of Carl Rogers):

13. In how far are the following background attitudes reflected in the counselling model of your HIV test practice?

completely	to a great extent	to a small extent	not at all	
❒	❒	❒	❒	Being genuine with the client
❒	❒	❒	❒	Showing non-possessive empathy and warmth
❒	❒	❒	❒	Showing unconditional positive regard
❒	❒	❒	❒	Showing complete acceptance of the client
❒	❒	❒	❒	Being non-judgemental of the client
❒	❒	❒	❒	Others:_____

B. Components of the VCT counselling process:

Pre-test Counselling

14.How much time do you spend for the pre-test counselling? ☐☐ minutes

15. To what extent are the following components of the counselling process integrated in your practices?

15.1. Building trust

completely	**to a great extent**	**to a small extent**	**not at all**	
❒	❒	❒	❒	introduction, greeting, ensure confidentiality

15.2 Assessing/Exploring/Understanding

completely	**to a great extent**	**to a small extent**	**not at all**	
❒	❒	❒	❒	Assess client's knowledge about HIV/AIDS and (other) STIs;
❒	❒	❒	❒	Give information related to HIV/AIDS, explain the HIV test and the results;
❒	❒	❒	❒	Explain connection between STIs and HIV risk exposure;

❒ ❒ ❒ ❒ Personal Sexual Behaviour and Risk Assessment, including:

❒ ❒ ❒ ❒ a) *determine client's risk taking behaviour*

❒ ❒ ❒ ❒ b) *assess costs and benefits of risk taking*

❒ ❒ ❒ ❒ c) *identify barriers to risk reduction*

❒ ❒ ❒ ❒ d) *assess past successes and failures*

❒ ❒ ❒ ❒ Assess client's emotional state with regards to the test

❒ ❒ ❒ ❒ Discuss window period

❒ ❒ ❒ ❒ Refer to further STI/sexual and reproductive health specialists in case of need

15.3. Determining action

completely	to a great extent	to a small extent	not at all	
❒	❒	❒	❒	Pre-test risk reduction plan, incl. partner communication and condom negotiation
❒	❒	❒	❒	Obtain informed consent about HIV tes
❒	❒	❒	❒	Offer HIV Test

POST-TEST COUNSELLING

16. How much time do you spend for the post-test counselling?

a) By "HIV- negative" result ☐☐ minutes

16.1.By "HIV-negative" result

completely	to a great extent	to a small extent	not at all

❒	❒	❒	❒	Assess client's readiness to get result and give them the result
❒	❒	❒	❒	Discuss window period and re-testing options
❒	❒	❒	❒	Risk reduction plan by HIV-negative result

b) By "HIV-indeterminate" result ☐☐ minutes

16.2.By "HIV-indeterminate" result

completely	**to a great extent**	**to a small extent**	**not at all**	
❒	❒	❒	❒	Explain the term "indeterminate result";
❒	❒	❒	❒	Avoid stress and confusion;
❒	❒	❒	❒	Discuss window period and re-testing options;
❒	❒	❒	❒	Motivate to retest in 3 months;

❒	❒	❒	❒	Give information how to protect in the meantime;
❒	❒	❒	❒	Explain the obligation to be excluded from the register of blood donors;

c) By "HIV-positive" result ☐☐ minutes

16.3. By "HIV-positive "result

completely	**to a great extent**	**to a small extent**	**not at all**	
❒	❒	❒	❒	Assess client's readiness and emotional state to get result and give them the result
❒	❒	❒	❒	Give emotional support
❒	❒	❒	❒	Give clear indication on how to get medical assessment on treatment for HIV
❒	❒	❒	❒	Counsel on psychosocial referral
❒	❒	❒	❒	Counsel on rights and responsibilities
❒	❒	❒	❒	Counsel on positive living

VI. VCT Counsellors

A. Training:

17.Is there a training curriculum/guidelines for training of VCT counsellors you use in your practice?

❒ yes ❒ no **(please continue with Q 19)**

18. Who carries out the training?

❒ Ministry of Health/National AIDS Programme

❒ University

❒ Regional/Local health authorities

❒ Private training organisations

❒ NGOs (AIDS Help groups, Red Cross, etc.)

❒ Other, specify: _____

19. Who can be trained?

❒ Doctor

❒ Nurse

❒ Psychologist

❒ Social worker

❒ Other: _____

20. To what extent should the following aspects (according to Family Health International) be integrated in the VCT training?

	completely	**to a great extent**	**to a small extent**	**not at all**
-self-awareness:				
- objectivity	❒	❒	❒	❒
- non-judgmental				
- attitudes	❒	❒	❒	❒
-handling sexuality:				
- personal boundaries				
- and neutrality,	❒	❒	❒	❒
- terminology, slang	❒	❒	❒	❒
- handling personal issues –				
- too emotional topics,	❒	❒	❒	❒
- too high intervention demand,	❒	❒	❒	❒
- balance between paternalism				
- and non-directive counselling	❒	❒	❒	❒
- other aspects:_____	❒	❒	❒	❒

B. Supervision and quality ensuring

21. How do you estimate the extent of the burn-out risk factor in the routine practice of the VCT counsellors?

very high	considerably high	rather low	very low
❒	❒	❒	❒

22.. What are 3 the major burn-out risks? Please range them, marking the highest with 1 and the lowest with 3:

❒ _____

❒ _____

❒ _____

23.. What are the 3 coping strategies, you use and would recommend to other professionals?

❒ _____

❒ _____

❒ _____

24. If a further training offer will be organised in the frame of BORDERNET, which is the most relevant topic according to you?

_____