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Provider-Initiated HIV Testing in Health Care Settings: Should it Include Client-Centered Counseling?

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Abstract

To increase access to HIV-testing the WHO and CDC have recommended implementing provider-initiated HIV-testing (PITC). To address the resource limitations of the PITC setting WHO and CDC suggest that patient-provider interactions during PITC may need to focus on providing information and referrals instead of engaging patients in client-centered counseling as is recommended during client-initiated HIV-testing. Providing HIV-prevention information has been shown to be less effective than client-centered counseling at reducing HIV-risk behavior and STI incidence. Therefore, concerns exist about the efficacy of PITC as an HIV-prevention approach. However, reductions in HIV incidence may be larger if more people know their HIV-status through expanded availability of PITC, even if PITC is less effective than is client-initiated HIV-testing for individual patients. In the absence of an answer to this public health question, adaptation of effective brief client-centered counseling approaches to PITC should be explored along with research assessing the efficacy of PITC.

Keywords

provider-initiated HIV-testing; client-centered counseling; HIV prevention; developing countries

In an effort to increase the number of individuals who know their HIV status, decrease the prevalence of undiagnosed HIV-infection, and to promote early diagnosis of and treatment for HIV-infection, the WHO and CDC have recommended implementing and scaling-up opt-out provider-initiated HIV testing services in both in- and out-patient health care settings (Branson et al., 2006; WHO, 2007). It is also hoped that as more people become aware of their HIV status, HIV transmission risk behaviors will decline, resulting in decreased HIV incidence. Until recently most HIV testing was client-initiated, or opt-in, in which individuals had to actively seek HIV testing at a facility offering HIV testing. In contrast, during provider-initiated HIV testing and counseling (PITC) which is also known as HIV screening or routine HIV testing, a health care provider offers HIV testing to a patient as a standard part of medical care. With opt-out PITC, like other medical procedures such as undergoing diagnostic X-ray examinations, patients must decline to be tested after receiving

information about the test. WHO recommends that PITC be offered to patients in all health care facilities in countries with generalized HIV-epidemics (WHO, 2007) and the CDC recommends that PITC should be offered to patients aged 13-64 in health care settings in the U.S. (Branson et al., 2006). PITC programs are not meant to replace client-initiated HIV testing, in fact, scale-up of such services is also recommended, (Branson et al., 2006; WHO, 2007) but PITC may be an efficient and effective way to provide HIV-prevention services to larger numbers of people. While the recommended scale-up of PITC programs will likely be successful at increasing the number of people who know their HIV status (Creek et al., 2007) and providing important linkages to care and treatment for those who test HIV-positive, changes in the counseling approach recommended during PITC compared to client-initiated HIV testing raises concerns about the effectiveness of PITC as an HIV-prevention approach for those who test HIV-negative as well as those who test HIV-positive.

With the rapid scale-up of PITC in several developing countries, including Uganda and Botswana, PITC may soon over-take client-initiated HIV testing in terms of the number of individuals tested. As such, PITC services hold great promise as a component of HIV-prevention programs because of their ability to reach large numbers of people, and most notably, to reach individuals who have never before had access to HIV testing and prevention services. However, the scale up of PITC programs necessitates that PITC fit within the existing resource and time limitations of health care settings. These resource limitations, especially in developing countries, require that the patient-provider interaction during HIV testing be abbreviated and its contents modified compared to counseling that is offered during client-initiated HIV testing.

Guidelines for counseling during PITC differ from those for counseling during client-initiated HIV counseling and testing. According to CDC and UNAIDS recommendations, counseling during client-initiated HIV testing should be client-centered, meaning that it is a dialogue between the counselor and the client to identify the client's current HIV-risk behaviors, barriers to risk reduction, and to negotiate achievable goals to reduce HIV-risk behaviors (CDC, 1993; UNAIDS, 2000). In contrast, to address the inherent resource limitations in implementing PITC in health care settings, WHO and CDC guidelines suggest that the patient-provider interaction during PITC may need to focus on providing basic HIV-prevention information along with referrals for support and care services instead of engaging patients in client-centered discussions including individualized HIV-risk assessment and risk reduction goal setting, as is recommended during client-initiated HIV testing (Branson et al., 2006; WHO, 2007). Unfortunately, current protocols for client-centered counseling during client-initiated HIV counseling and testing are too lengthy to be implemented in the PITC setting. In Uganda, for example, providing HIV-prevention information and referrals during PITC lasts approximately 5-25 minutes which is much abbreviated compared to the duration of counseling during client-initiated HIV counseling and testing. The WHO and CDC guidelines correctly acknowledge that in order to be viable in a variety of health care settings, the patient-provider interaction during PITC must be brief, but they also inherently assume that in most settings a client-centered counseling protocol cannot be designed to be brief enough to be feasible as part of PITC.

For individuals who test HIV-positive, knowledge of their status, when accompanied by an individualized HIV-transmission risk assessment and HIV-risk reduction goal setting, has been shown to be effective at reducing HIV-transmission risk behavior (Marks, Crepaz, Senterfitt, & Janssen, 2005). However, it is unknown if knowledge of HIV-positive status in the absence of such client-centered counseling is equally effective at reducing HIV-transmission risk behavior. The current recommendations for the structure of the patient-provider interaction during PITC include providing referrals for follow-up counseling, partner and family member HIV testing, and support, care, and treatment services as

applicable (Branson et al., 2006; WHO, 2007). While opportunities may exist to provide individualized HIV-transmission risk assessment and HIV-risk reduction goal setting to those who test HIV-positive during follow-up clinical care it is unknown what percentage of those who test HIV-positive during PITC seek follow-up services. Reports from the U.S. indicate that one-third to nearly half of individuals diagnosed with HIV during client-initiated HIV testing delay entry into care for more than 1 year (Glynn, 2005; Samet et al., 1998). Similar rates of delayed access to care have been observed in developing countries with universal access to HIV care and treatment (Kumar, Kilaru, Kumari, Forde, & Waterman, 2008; Louis, Ivers, Smith Fawzi, Freedberg, & Castro, 2007).

Furthermore, opportunities for follow-up individualized HIV risk-reduction counseling may not exist for those who test HIV-negative—creating a missed opportunity to provide effective counseling to help these patients adopt behaviors to reduce their risk of HIV-acquisition. Providing HIV prevention information during HIV testing has been shown to be less effective than client-centered counseling at reducing HIV-risk behavior and STI incidence in the U.S. (Kamb et al., 1998). For individuals who test HIV-negative the absence of an individualized HIV risk assessment and risk-reduction goal setting may enable them to assume incorrectly that their current behavior poses little to no risk for HIV-infection even when their behavior may pose significant risk (Glick, 2005). Such a conclusion may lead individuals who test HIV-negative to maintain or increase their current level of HIV-risk behavior. Therefore, abandoning the potential HIV-preventive value of client-centered risk reduction counseling during the “teachable moment” of HIV testing may create a missed opportunity to provide effective HIV-prevention services to individuals who may not otherwise have access to these services.

Achieving optimal HIV-prevention outcomes from PITC programs may depend upon receipt of supplementary referrals for HIV-risk reduction counseling as part of clinical care services following HIV-positive test results. As PITC programs proliferate, research is needed to determine what percentage of patients seek follow-up counseling, support, and care services, and to identify the enabling and impeding factors associated with accessing follow-up services. Such knowledge, in combination with data regarding the efficacy of PITC at reducing HIV-risk behavior among those testing HIV-negative and HIV-positive, would provide empirical support for the WHO and CDC recommendations for moving away from client-centered counseling during PITC in health care settings, or designing of interventions to address gaps in the current procedures.

In the absence of such data, it is also worth considering that it may be possible to create a brief client-centered HIV risk reduction counseling approach that stays within the limited time and resources available for PITC in health care settings. Brief client-centered counseling has been shown to be effective in several contexts. Most notably, client-centered counseling lasting less than 30-minutes during PITC among STD clinic patients who tested HIV-negative in the U.S. was effective at reducing STI incidence and HIV-risk behavior through 12-month follow-up (Kamb et al., 1998). Similarly, two brief (5-15 minute) client-centered counseling sessions demonstrated effectiveness at reducing unprotected sexual behavior among HIV-positive patients in clinical care in the U.S. (Fisher et al., 2006) and South Africa (Cornman et al., 2008). A single session of client-centered counseling has also been shown to be effective at changing other health-related behaviors even when the counseling duration is 15 minutes or less (Rubak, Sandbaek, Lauritzen, & Christensen, 2005).

Given that client-initiated HIV counseling and testing programs have reached such a small percentage of people who need access to HIV testing, one wonders whether reductions in HIV incidence may be larger if more people know their HIV status through expanded

availability of PITC, even if PITC is less effective than is client-initiated HIV counseling and testing at reducing HIV-transmission risk behavior for individual patients. An answer to this question requires knowledge about: (1) the HIV-transmission likelihood among patients receiving PITC compared to those receiving client-initiated HIV testing, (2) if awareness of HIV-positive or negative status in the absence of individualized prevention counseling is sufficient to achieve optimal reductions in HIV-transmission risk behavior, (3) how effective PITC is at reducing HIV-transmission risk behavior and at linking patients to follow-up care, and (4) how effective prevention during follow-up care is at reducing HIV-transmission risk behavior. In the absence of a definitive answer to these public health questions, adaptation of what is known about brief-client centered counseling from other contexts to the PITC setting should be explored. If an effective client-centered counseling approach including an individualized HIV-risk assessment and HIV-risk reduction goal setting can be tailored to the time and resource constraints of the public health sector in resource-limited settings, then the scale up of PITC programs could achieve even greater reductions in HIV incidence than they might otherwise.

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