

Rapid Review Response: Provider-Initiated HIV Testing and Counseling

Question: What are the actual and perceived advantages and disadvantages of provider-initiated HIV testing and counseling (PITC) procedures?

The Issue and Why It's Important

Timely HIV testing is an effective treatment and prevention strategy. The earlier people with HIV are diagnosed, the sooner they will receive care, which improves health outcomes. When people with HIV know their status, they are also more likely to reduce risk activities and prevent further transmission of HIV (1).

To increase the number of people being tested for HIV, the World Health Organization (WHO) and the US Centers for Disease Control and Prevention (CDC) currently recommend provider-initiated HIV testing and counseling (PITC), which is also known as “routine” or “opt-out” testing or screening. These new testing guidelines differ from earlier recommendations, which suggested targeting high risk groups and implementing comprehensive client-centered pre-test counseling. Because of the nature of PITC (i.e., everyone tested as part of routine health care/annual physicals), counseling tends to be much shorter (e.g., seven minutes) than in targeted testing programs, where counseling takes at least 15 minutes.

A number of studies have investigated the practical implementation of PITC, the efficacy of abbreviated counseling as well as various structural, provider and patient barriers.

Key Take Home Messages

- Very few studies have comprehensively investigated patient perceptions of PITC. There are no data currently available on the sustainable effects of PITC on: reducing HIV incidence (i.e., the long-term impact of the counseling received); or increasing earlier entry into care (2).
- There are varied opinions on the efficacy of abbreviated counseling procedures in reducing HIV risk behaviours (3).
- Patients and providers generally support opt-out testing, but recommend that this testing include effective communication of HIV and testing information, as well as a client-centered counseling approach (4;5).
- PITC with rapid tests in general health care settings has mostly been shown to be economically feasible in the US (6).

What We Found

Widespread implementation of PITC is relatively new. Therefore, data on the effects of national PITC rollout on actual reduction of HIV incidence, increased and earlier entry into care, and long-term risk behaviour change is not yet available (2). However, a number of recent studies have examined the practical implications of the new WHO and CDC guidelines, as well as provider and patient perceptions.

There are some concerns about the counseling procedures recommended with PITC. The WHO and CDC guidelines recommend that counseling focus on providing HIV prevention information and referrals, as opposed to previously recommended client-centered counseling, which involves a back-and-forth communication process between the provider and the client about risk behaviors and risk reduction strategies. The effects of this abbreviated counseling strategy have not been well-researched; however there are concerns that current counseling recommendations for PITC may not be as effective at reducing HIV risk behaviours as a client-centered approach and that the number of new diagnoses expected with PITC should not detract from the number of HIV infections that could have been prevented with client-centered counseling (3;7). An alternative approach that has been suggested is to adopt a much shorter client-centered counseling strategy that works within the resource constraints of health care settings. Although this approach has not yet been well-researched under the new WHO and CDC guidelines, previous studies that have examined the efficacy of a shorter (less than 30 minutes) client-centered counseling session at reducing other health risk behaviours yielded encouraging results (3). Feedback from the patients and providers at Veterans' Affairs Medical Centers in the US also suggested that PITC include patient-centered communication strategies in order to mitigate concerns regarding confidentiality and stigma (4).

A study that looked at abbreviated versus standard pre-test counseling in the prenatal setting found that the abbreviated counseling approach did not have a negative effect on patient decision making or HIV testing satisfaction. This study did acknowledge, however, that this approach results in slightly lower HIV knowledge as opposed to the standard counseling approach (8). Other prenatal studies revealed that women generally support routine testing, although they stressed the importance of effective communication of HIV and testing information by the provider (5). Their other concerns included: confidentiality, ensuring appropriate referrals and access to services, and a focus on reducing stigma and discrimination (9).

Some alternative counseling strategies that have been investigated include the use of computer-assisted interviewing to enhance pre-test counseling at HIV testing sites. Although the costs and lengths of the tests varied, most studies showed that computer-assisted interviewing was successful and, in some cases, better at identifying risk behaviours than provider counseling and interviewing (10-12).

One criticism of routine testing for HIV is that the number of previously unreported HIV infections is low compared to the resources required to conduct routine testing in general health care settings (13). A previous Rapid Response found that universal testing programs are not cost-effective; however, cost-effectiveness is not the only factor to consider in policy development and resource allocation (14). The scope of this Rapid Response is only concerned

with feasibility and studies have shown that PITC with rapid tests in general health care settings is economically feasible (6).

Some barriers to successfully implementing HIV testing by US physicians include policy, logistical/resource and educational barriers, which much be addressed in order to ensure successful implementation of PITC (15). It has been suggested that family physicians and other primary care clinicians approach HIV prevention, testing and disease management as they would other chronic diseases under the new PITC guidelines (16).

Another major criticism of PITC guidelines is that they do not require written consent by the patient. Many state laws are not congruent with the new counseling and consent guidelines, which may have serious practical implications on universal rollout of PITC in the US (17).

PITC has also recently been implemented in European health care settings. Although there is some literature that looks at various barriers to testing and counseling, including perceptions of low-risk, accessibility of services and human resources issues, there is a scarcity of research that looks specifically at the perception of patients as barriers to HIV testing (18). Two studies from the Netherlands reported that an opt-out strategy increased the uptake of HIV testing over time. The Netherlands studies also identified specific groups who were more likely to opt-out (e.g., men who have sex with men), which indicates that opt-out testing may not be reaching those at highest risk. That research suggested that focused counseling among high-risk groups is an important strategy to decrease the number of high risk patients who opt-out of HIV testing (19;20). A study on universal HIV screening of pregnant women in Australia, and another on migrant populations in Belgium, echoed this concern, noting the importance of tailoring counseling to specific groups and settings (21;22).

Factors That May Impact Local Applicability

The majority of available research is from the US and Europe and may not be directly applicable to the Canadian health care setting. Furthermore, there have been numerous studies on opt-out testing strategies in various developing countries around the world where the HIV epidemic is generalized. This review was limited to developed Western countries, however, for greater comparability to the HIV epidemic in Canada.

What We Did

To identify any systematic reviews we hand searched the Cochrane HIV/AIDS review group and Health-Evidence.ca under the 'Acquire Immunodeficiency Disorder' and 'HIV' categories. In addition, we searched the Cochrane Library and Medline (using the optimized search hedge for reviews) using the following combination of search terms: (HIV or Acquired Immunodeficiency Syndrome) [entered as MeSH terms] AND (testing) AND (counseling OR counselling) [entered as text terms]. Search results were limited to the last 10 years. 1,597 titles and abstracts were generated. Only those that referred to developed Western countries were reviewed to identify articles for this summary.

Suggested Citation:

Rapid Response Service. *Provider-initiated HIV testing and counseling: Rapid Review Response*. Toronto, ON: Ontario HIV Treatment Network; 2010

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