

APPROACHES FOR ENHANCING HIV SCREENING WITHIN STOP HIV PILOT PROJECT SITES

Recommendations from the HIV Testing Strategies Subcommittee

January 2011

SUBCOMMITTEE MEMBERS:

VCH: Dr. Réka Gustafson, Meaghan Thumath

NHA: Dr. Susan MacDonald, Kathy MacDonald

Providence/BCCFE: Scott Harrison, Julie Kille, Dr. Rolando Barrios, Dr. Kate Heath, David Moore, Caitlin Johnston

BCCDC: Dr. Mark Gilbert (Chair), Dr. Gina Ogilvie, Dr. Malcolm Steinberg, Elizabeth Elliot

PHSA Labs: Dr. Mel Krajden

BCPWA: Elgin Lim, Glyn Townsend

PAN: Katrina Jensen

Renewing our Response: Heidi Standeven

Central Interior Native Health Society: Sam Milligan

BACKGROUND

- The primary objective of the HIV Testing Strategies Subcommittee is to identify strategies for HIV screening and understand their application within the BC context, in order to recommend approaches to enhancing HIV screening across both pilot project sites as part of STOP HIV
- This document includes the first set of recommendations to enhance HIV screening identified by the Subcommittee. As additional strategies are reviewed this recommendations document will be updated

DEFINITIONS

Provider-initiated HIV testing: This refers to HIV testing which is recommended by health care providers to persons attending health care facilities/settings as a standard component of medical care to:

- Enable specific clinical decisions to be made and/or specific services to be offered that would not be possible without knowledge of the person's HIV status, or
- Identify unrecognized or unsuspected HIV infection in persons attending health facilities in order to provide these services.

PIHT is sometimes equated with *opt-out* testing but is recognized by the WHO to also include *opt-in* testing. PIHT can either be implemented for specific target populations or clients/patients or alternatively can be offered routinely to everyone attending a specific health care setting (***routine offer of HIV testing***).

Client-initiated HIV testing: This is also known as voluntary testing and counselling (VCT) and involves individuals actively seeking HIV testing and counselling at a facility that offers these services. Client-initiated HIV testing and counselling emphasizes individual risk assessment and client centered counselling.

PROCESS TO DATE

- Brainstorming of potential screening strategies for consideration
- Prioritization of strategies
- Development of evidence/discussion documents for strategies under consideration

- Development of criteria for evaluation of strategies and forming recommendations

RECOMMENDATIONS

1. **Continue the current expansion of point-of care testing, supported by the provincial Point of Care (POC) HIV Testing program currently under development.**

Summary of discussion/rationale:

POC HIV testing is highly acceptable to persons undergoing testing and may result in increased uptake and volume of HIV testing, and receipt of test results. Current provincial guidelines recommend that POC HIV tests are most appropriately used in clinical scenarios where there is an urgent need to determine HIV status, and in targeted voluntary HIV counseling and testing (i.e., client-initiated HIV testing) settings: where have client populations with high HIV prevalence, where not returning for test results is common among high risk clients, or where provision of a POC HIV test will improve public health follow-up or connection to HIV clinical care. Expansion of POC HIV testing in Vancouver and Prince George within these indications has been rolled out or is underway. PHSA is establishing a provincial POC HIV testing program (funded through STOP HIV) that will support the POC HIV testing activities occurring through STOP HIV.

2. **Support and expand provider-initiated HIV testing by recommending providers routinely offer HIV testing:**

i) To persons having a greater individual likelihood of HIV infection:

- Signs and/or symptoms suggestive of HIV infection or opportunistic infections characteristic of AIDS
- Individuals who are seeking testing for, or are diagnosed with sexually transmitted infections, hepatitis C, or tuberculosis
- Individuals with a past history of a sexually transmitted infection
- Anyone who requests an HIV test

ii) To members from population groups that are disproportionately affected by HIV (e.g., higher expected prevalence/incidence of HIV infection):

- Gay, bisexual and other men who have sex with men
- People with a current or lifetime history of use of injection drugs, and their sex partners
- People with a current or lifetime history of use of non-injection drugs, and their sex partners
- Individuals who trade sex for money or drugs/sex workers, and their clients
- Aboriginal people
- People with mental health disorders
- People from HIV-endemic countries and their sex partners
- Sexually active adolescents seeking care

iii) In settings with a higher expected prevalence of HIV:

- Sexual health services/STI clinics
- Reproductive health services
- Youth clinics
- Addictions and mental health services
- Harm reduction services

- Corrections
- Additional settings where individuals may be expected to have a higher prevalence of HIV (e.g., select acute care settings, clinics, dentist offices, pharmacies)

iii) To all pregnant women as part of routine prenatal care.

Summary of discussion/rationale:

Providers may not recognize or elicit a history of risk factors for HIV infection in their clients, and clients themselves may be unaware that they have been exposed to HIV. To expand HIV screening providers need to expand testing offer beyond clients with identified risk factors for infection (e.g., unprotected sex or sharing of injection-related or other drug paraphernalia) . Screening all individuals in health care settings for HIV is generally considered to be cost-effective when the prevalence of *undiagnosed* HIV infection exceeds 0.1%. Hence the initial immediate priority for expanding provider-initiated HIV testing is based on routine offer to individuals and within settings as per the recommendations above, where resources to support providers to expand testing may be best utilized. Substantial gaps currently exist in BC with respect to these recommendations (e.g., approximately 50% of persons with a new HCV diagnosis who are not known to be previously HIV positive have an HIV test within 3 months).

3. As STOP HIV affords the opportunity to evaluate new approaches to HIV testing, support and expand provider-initiated HIV testing by recommending providers routinely offer HIV testing within the following expanded parameters (for a defined period of time, with evaluation of impact):

- To all individuals who have ever been sexually active and who have not had an HIV test in the previous year
- To all individuals presenting for care within defined health care facilities where routine offer of HIV testing can be feasibly implemented and with high client volumes (e.g., urgent care, acute care settings)

Summary of discussion/rationale:

While recommending that providers routinely offer HIV testing to all clients presenting for care (i.e., as per CDC 2006 guidelines) would result in identification of new infections, a review of the evidence suggests that the overall yield of this approach in identifying new infections is likely to be low at a regional level, and it is unlikely to be cost-effective or sustainable in the long-term. For these reasons, a standing recommendation to providers to test all patients for HIV may not be readily adopted (for example, this approach is currently not recommended by the US Task Force for Preventive Health Care for these reasons). However, we do not currently have Canadian data regarding the impact of this strategy, and STOP HIV affords the opportunity to test this strategy within defined parameters, for a defined period of time (i.e., six months, one year). This would also need to be accompanied by a summative evaluation of the impact of this strategy, which would guide further recommendations (i.e., to maintain and expand this strategy, or to discontinue the strategy).

4. Develop resources and guidelines to support both streamlined and comprehensive models for pre- and post-test counselling.

Summary of discussion/rationale:

Increasing provider-initiated HIV testing in health care settings such as emergency departments or physicians' offices will require more concise and less time-consuming pre- and post-test processes that

continue to maintain voluntary and informed consent, client-centred care, and the human rights of clients. In the literature, pre-test counselling has been found to have limited success as a primary prevention strategy for reducing behaviours that may increase transmission in HIV negative persons. However, post-test counselling is a successful secondary prevention strategy for newly diagnosed HIV positive clients, as are other strategies for positive prevention. Streamlining pre-test counselling (and post-test counselling, if HIV negative), requires identifying minimum standards for information required by clients undergoing testing (e.g., voluntary and informed consent, confidentiality and reporting of results), and may include provision of written information. Outreach, specialized sexual health and community-based settings working with populations with a greater incidence and prevalence of HIV and in situations of client-initiated testing continue to benefit from more in-depth pre and post-test counselling processes. Current pre- and post-test guidelines and training curricula developed by BCCDC are currently under revision to reflect this continuum of care (streamlined, comprehensive).