

March 2008

Guidelines for HIV Counselling and Testing

SAY YES TO
KNOWING

HIV Get Tested

Preface

These guidelines for HIV counselling and antibody testing are intended for use by organizations and individuals providing all types of HIV testing in Ontario: anonymous, non-nominal and nominal. They were developed to improve the quality and consistency of HIV pre- and post-test counselling.

They are based on the guidelines for anonymous HIV testing developed in 1992 (when Ontario first opened anonymous test sites) and revised in 1995. As part of the expansion of anonymous HIV testing in Ontario, the Ministry of Health and Long-Term Care is pleased to release these updated guidelines. They reflect 22 years of experience with HIV counselling and testing in Ontario — including 14 years of experience with anonymous HIV testing — and represent current best practice. They are also consistent with the World Health Organization and UNAIDS document, *Guidance on Provider-Initiated HIV Testing and Counselling in Health Facilities*.

Note: Because HIV testing/counselling may be done by a number of different service providers, including social workers, nurses, nurse practitioners, midwives and physicians, these guidelines refer to the professional doing HIV counselling as a “counsellor”.

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What's New in HIV Counselling and Testing?

1. More Anonymous Test Sites

The government of Ontario has recently authorized 24 more sites to provide anonymous testing, bringing the total to 50, and increased the availability of anonymous HIV testing in many parts of the province. Physicians who do not have the time or experience to do HIV testing can refer clients to a public health sexual health clinic or to an anonymous testing program. Contact the AIDS Hotline for locations and phone numbers of anonymous test sites at 416-392-2437 or 1-800-668-2437; French line: 1-800-267-7432.

Where are Ontario's Anonymous HIV Test Sites?

22 in public health units.

16 in community health centres.

4 in midwifery practices (only for use by their clients).

3 in sexual health centres.

5 in other locations — a hospital, a youth agency, two Aboriginal agencies and a family health team.

2. More Flexible Tests

The Ministry of Health and Long-Term Care is making free point-of-care HIV tests available to anonymous test sites, public health sexual health clinics and community health centres that choose to offer this type of testing. With point-of-care testing, people who are negative

will know within a few minutes of being tested. People who test reactive on a point-of-care test must have a confirmatory test done using standard laboratory testing, and will have to wait up to two weeks to obtain their results. (Note: time to receive test results varies across the province.)

In addition, the public health laboratory now routinely performs p24 antigen tests on any test sample where the requisition form indicates the person is in the window period, is symptomatic AND has had a high risk exposure.

3. More Knowledge about Risks

We now know that

- Younger women (i.e., under age 18) are at greater risk of acquiring HIV than older women because the cells of the cervix do not fully develop until age 18.
- The health of the mucosal membrane is affected by the presence of other sexually transmitted infections (STIs), female hormone levels, lack of lubrication and the use of irritating substances.
- A low viral load reduces but does not eliminate the risk of HIV transmission. Antiviral medications do not always reach high enough levels to suppress HIV in the genital tract. The risk increases if the person has another sexually transmitted infection.

- There is a risk of HIV transmission from sharing other drug equipment (besides needles), such as cookers, filters, water, alcohol swabs, tourniquets, crack pipes and glass stems.

4. Greater Understanding of Social Determinants/Risks

The ability of people to negotiate and practise safer sex and drug use is affected by the social determinants of health, such as poverty, housing, power imbalances in relationships, drug or alcohol use, and stigma. The issues that people face often vary with age, sexual orientation, culture and race. Effective prevention counselling must address all these issues. (See Appendix 2 for a brief discussion of population specific issues.)

5. The Importance of Other STIs and Hepatitis C Testing

A significant proportion of people who are at risk of HIV are also at risk of other STIs and hepatitis C. Anyone who presents for HIV testing should also be counselled and assessed for risks of other STIs and hepatitis C, and offered testing.

6. The Time Required for HIV Testing

HIV pre-test counselling can be done in 15 to 20 minutes; however, the time will vary depending on the client's level of knowledge and other needs.

7. Disclose to Future Partners

Over the past few years, a number of people with HIV have been convicted on criminal charges for engaging in sexual activities that pose a significant risk of transmitting HIV without informing their partners of their HIV status. The guidelines include information relevant to the issue of notifying sexual partners.

8. Help with Language Issues

The AIDS Hotline provides information in 18 languages and has staff who can provide translation and interpretation services when

counsellors do not speak the same language as clients. They are very familiar with HIV testing issues and are an excellent resource.

(AIDS Hotline numbers: 416-392-2437 or 1-800-668-2437; French line: 1-800-267-7432.)

9. Help with Partner Notification

The AIDS Bureau is working with the field to develop more detailed guidelines for partner notification that will help counsellors address difficult issues.

10. Other Checklists and Tools

This publication includes a number of tools, such as a pre-test counselling checklist, safer sex guidelines at a glance, counselling tips and advice on providing a positive test result.

In January 2008, the AIDS Hotline provided services in the following languages:

Armenian
Bengali
Cantonese
English
Filipino
French
Gujarati
Hakka
Hindi
Italian
Mandarin
Russian
Sinhalese
Spanish
Swahili
Taiwanese
Urdu
Vietnamese

I. Background

HIV testing is an important part of Ontario's HIV care and prevention programs. Testing and early diagnosis can help people with HIV receive the care and support they need to maintain their health. HIV testing is also an effective part of HIV prevention: it provides an opportunity for one-to-one counselling and prevention education that can help people assess their risk and protect themselves and others from HIV.

Ontario actively encourages people to be tested for HIV; however, the decision to be tested is a difficult one. People who test positive must confront the fact of their infection and its effect on their health and lives. They may also face social consequences, such as stigma and discrimination.

Being tested is stressful and potentially life-altering. That is why pre- and post-test counselling are integral, essential components of HIV testing. According to the HIV/AIDS Legal Network, "Inadequate counselling is not only unethical and poor practice, it is contrary to the legal doctrine that medical interventions require a patient's informed consent."¹

The Goals of Pre- and Post-Test Counselling

For everyone being tested (regardless of HIV status), the goal of pre- and post-test counselling is to provide information about HIV testing, prevention and services that will help people

- Assess their risk.
- Make an informed decision to be tested.
- Know how to take precautions to protect themselves and others from exposure or re-exposure to the virus.
- Know where to go for more information or support.

For people who test positive for HIV, the goals of counselling are also to

- Provide information and support in dealing with an HIV diagnosis.
- Connect them to services that will help them cope with the diagnosis, manage their HIV, prevent the spread of HIV and live healthy, satisfying lives.

How to Use the Guidelines

Counselling is an interactive process: it is an open discussion of risks, feelings, concerns and reactions. This document is intended as a guide. Counsellors are expected to bring their knowledge and skills to the sessions, adapting the information in these guidelines to meet clients' needs. For example, some clients may demonstrate early in the pre-test counselling session that they are well-informed about HIV and may not need as much detailed

¹Canadian HIV/AIDS Legal Network. HIV Testing — Counselling. Information sheet #8. <http://www.aidslaw.ca/Maincontent/issues/testing>

information about HIV transmission. Some clients may need intensive counselling in only one area, such as an irrational fear of being infected despite being assessed as low risk.

Pre-test counselling usually takes 15 to 20 minutes; however the amount of time required depends on the client's risk of infection, understanding of transmission and prevention, attitude towards the possibility of HIV infection, and ability to understand the information the counsellor presents.

The client's culture, language, perception of HIV, self-esteem, attitude towards sex and many other factors will have an impact on how he or she understands and acts on the information discussed during pre-and post-test counselling.

Although counsellors will use their skills and judgement to adapt information to each client's needs, they should ensure that all clients receive consistent messages about the risks of acquiring HIV, prevention strategies, and the benefits of being tested. To help counsellors provide consistent information, these guidelines include a counselling checklist (see Appendix 1) and a series of counselling tips (see Appendix 5).

Referrals and Links to Other Services

Any site that provides HIV counselling and testing should maintain an up-to-date list of agencies offering services clients may need (e.g., support services, mental health services, addiction counselling and treatment, housing, income support, help dealing with violence or abuse, immigration advice), and refer clients appropriately.

The referral list should include

- AIDS service organizations.
- Health units.
- Community health centres.
- HIV outpatient clinics.

Self Care

HIV test counselling can be stressful because it is difficult to give HIV-positive results.

Counsellors and supervisors should be aware of the stress and take positive steps to manage it, such as identifying colleagues or others in their network who can provide support, and developing an internal support process.

II. Pre-Test Counselling

The pre-test counselling session should include a discussion about

- The benefits and risks of HIV testing.
- Timing of testing and the window period.
- Testing options.
- The meaning of test results.
- The client's risks and reasons for testing (i.e., a risk assessment).
- Ways to reduce harm and prevent transmission.
- Preparing for a positive test.
- Informed consent to be tested and/or where to obtain more information and services.

The Benefits and Risks of HIV Testing

Because HIV is a slow-acting virus, people can be infected for many years without symptoms. The ministry estimates that about 30 per cent of Ontarians who are infected with HIV do not know their HIV status and, therefore, are

If language is an issue . . .

If the counsellor does not speak the same first language as the client and is concerned that the client may not understand what is being said in the pre-test counselling session, an interpreter should be used.

If an interpreter is not available, contact the AIDS Hotline (416-392-2437; 1-800-668-2437; French line: 1-800-267-7432), which provides service in 18 languages and is able to assist with HIV counselling.

not receiving early treatment and may not be taking steps to prevent the spread of the virus.

Benefits

For individuals, the benefits of HIV testing may include

- Relieving anxiety related to not knowing their HIV status.
- The opportunity to receive accurate information, care, treatment and support.
- Better long-term health.
- Information and support to protect themselves and others from exposure or re-exposure to the virus.

For the community, the benefits of HIV testing include

- An effective way to provide education and prevent the spread of HIV.
- An effective way to promote harm reduction.
- An increase in the number of people who know their status and are able to take steps to prevent HIV transmission.
- Lower incidence of HIV.

Risks

For individuals, the risks of HIV testing include

- The stress of coping with a life-threatening illness.
- Possible stigma and rejection by family, friends or employers.

For certain communities (e.g., gay men, the African and Caribbean community, immigrant women), the risks of HIV testing can include an increase in stigma, discrimination and fear if a large proportion of their members are infected

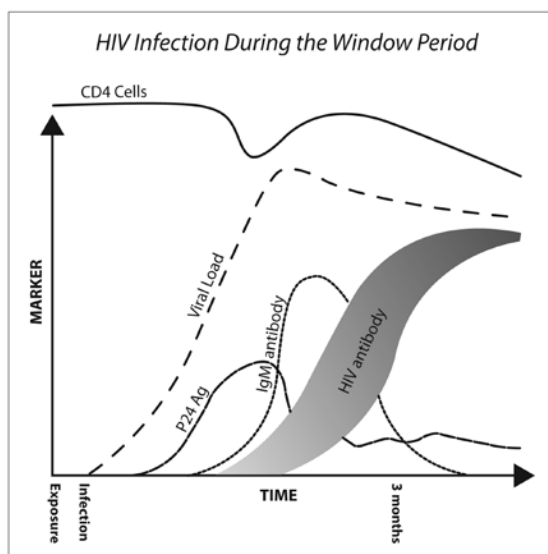
with HIV. Counsellors should be aware that the risks within communities evolve over time.

Other Considerations

As part of pre-test counselling, clients should also be informed that AIDS is a reportable disease in Ontario. All positive HIV tests are reported to public health and efforts are made to contact partners (without disclosing the client's name) so they can be tested and take steps to protect their own health. People who know they have HIV should also be aware of the importance of disclosing their HIV status to future partners and of the legal risks they face if they engage in activities that pose “a significant risk” of transmitting HIV without disclosing their HIV status.

Timing of Testing and the Window Period

The tests most commonly used to diagnose HIV detect antibodies to HIV, not the virus itself. As the figure below illustrates, it may take up to three months after an exposure to HIV (i.e., 12 weeks) for a person who has been infected to develop detectable antibodies (i.e., seroconvert). The time between infection and seroconversion is called the window period.



The window period for HIV infection refers to the period between the time a person becomes infected with HIV (which takes only a matter of hours or days after exposure) and the time he or she seroconverts or develops antibodies to HIV that are detectable with current tests.

The Process of HIV Infection

- Not everyone who is exposed to HIV will become infected; however, those who do will become infected within a few hours or days of exposure.
- Once a person is infected with HIV, the virus begins to replicate, infecting a few cells (lymphocytes) that produce virus that infect more cells (lymphocytes and CD4 cells). This process leads to a rise in viral load and p24 antigen and a drop in CD4 cells.
- From the time the virus begins to replicate, the person is infectious. A person is actually most infectious during this early acute stage of HIV infection — before he or she has developed antibodies.
- During the initial period of infection, most people will have some symptoms of acute HIV infection such as fever, myalgia, night sweats, nausea, diarrhea and rash.

Seroconversion/Developing Antibodies

- In response to HIV infection, the body produces antibodies. However, it takes a few days for the body to produce enough virus to stimulate the immune system and a few more days for the immune system to produce large amounts of antibodies that can be detected through testing.
- The immune system produces different types of antibodies at the beginning of an infection than in later stages. For example, with HIV, the body starts by producing IgM antibodies and only later starts to produce the other types of HIV antibodies detected through standard HIV testing.

- Once the body produces enough of these antibodies, they partially neutralize the virus and it goes into a more latent state. The CD4 cells rebound, the p24 antigen levels drop and the viral load stabilizes.

Average Time to Seroconversion

The average time between exposure/infection with HIV and when tests can detect HIV antibodies has been scientifically documented to be 22 days (Busch et al). It used to be much longer but, with better tests, we are now able to detect HIV antibodies earlier.

The window period used in Ontario is three months because more than 99 per cent of infected individuals will develop detectable antibodies within three months after their exposure. The only exceptions include people who have underlying immune system problems or who have artificially altered the course of HIV infection (e.g., by taking post-exposure prophylaxis).

Testing During the Window Period

Clients who present for testing during the window period (i.e., within 12 weeks of a possible exposure) should not be refused testing. They should be offered HIV antibody testing at the time. If they test negative, they should be encouraged to return after the 12 week window period to be retested.

During the early stages of infection, when viral load is high and before antibodies develop, it is possible to use another test that detects p24 antigens (part of the viral particle) to diagnose HIV infection.

The public health laboratory will routinely do a p24 antigen test for clients who meet the following criteria:

- The possible exposure was at least seven days ago.
- The client is still in the window period.
- The client is experiencing symptoms (i.e., flu-like symptoms).

- The client has had a high risk exposure (e.g., condom break during sex with a positive partner, sexual assault).

NOTES:

- To obtain a p24 antigen test for someone who meets the criteria, it is important to provide all the information on the test requisition form.
- It takes a few extra days to receive the results of a p24 antigen test.
- A positive p24 antigen indicates that someone is infected with HIV but a negative p24 antigen result does NOT mean the person is not HIV infected. The person should still be tested at the end of the window period for HIV antibodies to rule out HIV infection.
- If you have any questions about p24 antigen testing, contact the public health laboratory.
- As long as p24 antigen testing has been discussed with the client as part of pre-test counselling, a separate consent is not required.

For clients who have had a high risk exposure, post-exposure prophylaxis (PEP) may prevent infection if administered within 72 hours of exposure. Although sexual assault treatment centres provide PEP free of charge to their clients, PEP is not universally available in other settings.

The public health laboratory will routinely do a p24 antigen test for clients who meet the following criteria:

- *The possible exposure was at least seven days ago.*
- *The client is still in the window period.*
- *The client is experiencing symptoms (i.e., flu-like symptoms).*
- *The client has had a high risk exposure (e.g., condom break during sex with a positive partner, sexual assault).*

Testing After the Window Period

All individuals who have had an exposure to HIV should have an HIV antibody test three months after their last known exposure. If that test result is negative, that rules out HIV infection from the exposure that occurred three months earlier — unless they have a compromised immune system or have taken post-exposure prophylaxis that altered the course of possible HIV infection.

Clients should be counselled not to donate blood until they receive a negative test result after the 12-week seroconversion period.

HIV Testing Options

Counsellors should explain that the HIV testing and reporting options in Ontario are designed to maximize the benefits of HIV testing for the individual and community, while reducing potential harms.

HIV tests can be ordered by physicians, nurse practitioners and midwives.

Anonymous, Non-nominal and Nominal

People have three testing and reporting options:

1. Anonymous testing: the name or identity of the person being tested is not requested, recorded or reported. The test is ordered using a code known only to the person being tested. Epidemiological information (i.e., age, sex, risk factor for HIV infection) is collected and reported.
2. Non-nominal testing: the practitioner ordering the test knows the name or identity of the person being tested, but orders the test using a code. If the test is positive, the laboratory is required to report the result to the local medical officer of health.
3. Nominal testing: the practitioner orders the test using the person's name. If the test is positive, the laboratory is required to report the result to the local medical officer of health.

In 2004, a total of 372,792 HIV tests were done in Ontario. Of those, 89% were ordered nominally, 8% were ordered non-nominally and 3% were done anonymously. Although a smaller number of people are tested anonymously, a larger proportion of them test HIV positive. The positivity rates vary quite dramatically by type of testing (e.g., in 2004, .28% of nominal tests were positive, .80% of non-nominal tests and 1.16% of anonymous tests). This indicates that people at risk of being infected with HIV are more likely to choose non-nominal or anonymous testing.

Under the *Health Protection and Promotion Act*, the medical officer of health and his/her designates are legally obligated to safeguard the person's confidentiality and to ensure the person's sexual and drug use partners are notified. With both nominal and non-nominal testing, the medical officer of health (or designate) will request the names of the person's contacts and follow up with the practitioner to ensure that contacts are notified that they may have been exposed to sexually transmitted infection (without disclosing the person's name) and encouraged to go for testing.

Standard HIV Antibody Testing and Point-of-Care Testing

HIV antibody testing can be done in two ways: standard HIV testing or point-of-care HIV testing.

- Standard HIV testing is done by the public health laboratory, using a two-part test. The first test, a screening test, is very sensitive. Any sample that tests reactive on the screening test is screened a second time. If the second screen is also reactive, then the sample is tested again using a confirmatory test (the Western Blot) that rules out

everything except HIV. It takes up to two weeks to receive test results.

- Point-of-care HIV testing is done on site at the time of testing and includes only a screening test. Results are available within a few minutes. When clients test reactive on the point-of-care test, then standard HIV testing must be ordered from the public health laboratory to confirm the results.

NOTE: the ministry is making free point-of-care tests available to anonymous test sites, public health sexual health clinics and community health centres that are able to offer this service to the public.

Helping Clients Make an Informed Choice

Counsellors working in sites that offer point-of-care HIV testing can help clients make an informed choice between standard HIV testing and point-of-care HIV testing.

Meaning of Test Results

A negative test result from both standard HIV antibody testing and point-of-care testing means the client had no antibodies to HIV when he/she was tested. Anyone who is tested during the window period should be tested again when the window period is over.

An indeterminate test result from standard HIV antibody testing means the results were not conclusive and the client must be tested again.

A positive test result from standard HIV antibody testing means the person is infected with HIV.

A reactive test result from point-of-care testing means the person may be infected and must be tested again using standard HIV testing.

Assessing Risk

1. Counsellor Preparation

Counsellors should have a clear understanding of

- How HIV is transmitted.
- Biological and social/cultural factors that may affect risk.

HIV Transmission

HIV transmission can only occur when body fluids that have high concentrations of virus, such as blood, pre-ejaculate, semen, vaginal fluid and breast milk, enter another person's bloodstream — usually through small breaks

Other More Specialized HIV Diagnostic Tests

The DNA PCR test is used to test babies born to HIV-positive mothers. It is also occasionally used in other situations, such as testing health care workers who have a need-lestick injury. This test is usually ordered by clinicians in HIV clinics or hospitals, not by testing sites. Special samples of whole blood are required for the DNA PCR. Special arrangements must be made with the public health laboratory to order this test.

The PCR viral load test is used to measure viral load. It should only be ordered after a client is diagnosed with HIV (i.e., to provide baseline information on the stage of infection) and then again at regular intervals to see how actively the virus is reproducing. Viral load testing in conjunction with CD4 testing provides information that can help determine when to start treatment. It is also used to monitor the effectiveness of antiretroviral therapy. The viral load test can be used to diagnose HIV but is not currently used that way in Ontario. It is not normally available through HIV testing centres. Viral load testing is NOT to be ordered until a confirmed test result report is received from the Central Public Health Laboratory.

or tears in the vagina, anus, mouth or skin, or through contact with blood in the uterus. Other body fluids, such as saliva, sweat, tears and urine, do not carry enough virus to transmit HIV.

HIV transmission can occur

- During unprotected anal or vaginal sex (high risk).
- During unprotected oral sex (low risk).
- By sharing uncleaned sex toys.
- When using contaminated needles to inject substances or for piercing/tattooing.
- When sharing other drug equipment, such as crack pipes, cookers, filters, burners, cotton and water.
- During pregnancy, childbirth or breastfeeding.

HIV is NOT spread by mosquitoes, by touching or hugging someone who is HIV-positive, or by living, working or having any casual (i.e., non-sexual) contact with someone who is HIV-positive.

Biological Factors that Affect Risk of HIV Transmission

Certain factors can increase or decrease the risk of HIV transmission, including

- Frequency, duration and type of exposure. The risk of HIV transmission increases with the number of times people are exposed, the duration of the exposure, and the type of exposure. In sexual transmission, the receptive partner is at greater risk than the penetrative partner — although BOTH are still at risk.
- Development/health of the mucosal membrane. When the mucosal membrane in the anus, vagina or mouth is broken, inflamed or infected, the risk of HIV transmission is much greater. The health of the mucosal membrane is affected by age (i.e., cells in the cervix do not fully develop until age 18), the presence of other sexually transmitted

When providing pre- and post-test counselling, counsellors should be prepared to describe in detail how transmission occurs with specific sexual, drug use and other activities; however, they should only go into detail with clients who need the information. It is important to avoid being “mechanical” when discussing HIV transmission and prevention. Counsellors should

- *Focus on information relevant to the client’s risk history.*
- *Present information in a relaxed, non-judgmental way that will help clients feel comfortable when discussing personal information.*
- *Use simple lay terms to describe risk activities and prevention strategies.*
- *Avoid making assumptions (e.g., anal sex is not a risk for women).*

infections, lack of lubrication and the use of irritating substances.

- Hormone levels. The presence of female hormones during the menstrual cycle or from hormonal contraceptives, in particular depo-medroxyprogesterone, can make women more susceptible to HIV infection.
- Viral load. A low viral load may reduce the risk of HIV transmission, but it does not eliminate it. When taken as prescribed, highly active antiretroviral therapy (HAART) for HIV can significantly decrease the viral load in blood but it may not reduce the viral load in semen. Antiviral medications do not always reach high enough levels to suppress HIV in the genital tract, which may contain resistant strains of HIV that are not present in blood.² Even when viral load is low, the person is infected and the virus can spread.

The risk of transmission increases if the person has another sexually transmitted infection.

Social/Cultural Factors that Affect Risk of HIV Transmission

Certain cultural factors can lead to behaviours and practices that increase the risk of HIV transmission, including

- Female genital mutilation and other cultural practices that cut or damage skin or membranes, which make people more susceptible to HIV infection.
- Body piercing (e.g., tongue, lips, scrotum), which can be done with contaminated needles or cause breaks in the skin — both of which can make people more susceptible to HIV infection.
- Power imbalances in relationships (including financial dependence), which can affect an individual's ability to negotiate safer sex.
- Alcohol and drug use, which can affect people's ability to practice or negotiate safer sex and drug use.

See Appendix 2: Population-Specific Counselling Issues.

For more information, see *HIV Transmission: Guidelines for Assessing Risk*, developed by the Canadian AIDS Society.

2. Client's Reasons for Testing

Counsellors should explore the client's reasons for being tested. This will help the counsellor understand the client's information and counselling needs. Possible reasons include

- Fears and anxieties about HIV/AIDS (i.e., people looking for reassurance).
- Sexual assault.

- Pregnancy or planning a pregnancy (in this case, counsellors should advise that both partners be tested).
- Concern about high-risk activity (e.g., having had unprotected sex, condom breakage).
- Concern about symptoms that may be related to HIV.

Counsellors should not make assumptions about clients' sexual or substance use activities or practices. Some clients may be unwilling to discuss their practices; however, to do an accurate risk assessment, it is important for counsellors to know "who put what where." When taking a risk history, counsellors should ask direct questions, such as

- *Are your sexual partners women, men, transgendered?*
- *When you have sex with men, do you ever have anal sex?*
- *Have you ever shared sex toys?*
- *Have you ever used a needle to inject substances?*
- *Have you ever smoked crack?*
- *Are you concerned about high-risk activity (e.g., having had unprotected sex, condom breakage)?*
- *Are you concerned about symptoms that may be related to HIV?*
- *Have you been notified of a possible exposure?*

- Having been notified of a possible exposure.

3. Client's Risk History

Once clients understand how HIV is transmitted and the factors that affect risk, counsellors should review their risk history

² Kalichman et al. AIDS Research and Human Retroviruses, 2001.

and help them to identify and understand their risks. The assessment is designed to gather information on

- The client's HIV testing history. Has the client been tested before? When? What was the result? If the person is being re-tested that should be noted on his/her chart.
- Sexual health history, including sexual activities and practices, and whether the client has been diagnosed with other sexually transmitted infections or other blood-borne diseases, such as hepatitis C.
- Any history of violence or sexual assault.
- Substance use history.
- His/her partners' sexual or drug use history.
- Any symptoms he/she may be experiencing.

For more detailed information on the risks associated with different types of drug equipment, see Appendix 3.

When discussing sexual history, counsellors should ask clients about both regular and occasional partners to ensure that clients do not rule out partners they assume are not infected. It is not necessary to review every partner; it is more important to get a general idea of how often clients engage in risky activities.

Based on the risk history, the counsellor and client will then assess the client's overall level of risk, and the client's ability or willingness to change practices or behaviours in order to reduce their risk.

4. Misperceptions of Risk

Some clients may have a realistic assessment of their risk; others may over or underestimate their risk. Misperceptions may be due to a number of factors, including

- Incorrect or conflicting information.
- Negative attitudes to sex, including homophobia and internalized homophobia.
- Guilt and fear over past actions.
- Irrational fear of disease.

- Inability to see a long-term partner as being a risk.
- Inability to cope with stressful life situations.

To be able to assess their risk more accurately, some clients may need more information or help to understand the reason for either unfounded fears or for their inability to accept that they are putting themselves at risk. Some clients may need referrals for more extensive counselling to deal with underlying issues.

Providing Harm Reduction and Prevention Education

Counsellors should stress that harm reduction and prevention is extremely important, regardless of clients' HIV status. Using the client's risk history as a guide, counsellors and clients will discuss strategies that clients can use to reduce their risk and prevent the spread of HIV.

Harm reduction and prevention education includes

Counsellors should be sex positive and promote healthy sexuality (i.e., have sex, have fun, but do it safely).

- Discussing with clients the safer sex practices they are using now and their confidence in them.
- Providing detailed information on safer sex practices, including how to use dental dams and clean sex toys, if relevant for the client.
- Offering condoms to clients.
- Showing clients how to use condoms properly to minimize breakage.
- Explaining safer drug use practices, stressing that using a needle once and discarding it safely (i.e., single use) is best practice and that cleaning and reusing needles is not safe.
- Providing the location of needle exchange programs.

- Discussing any factors that may affect clients' ability to reduce their risk (e.g., unwillingness/inability to negotiate safer sex and/or drug use with partners, problems getting partners to agree, safety/violence issues, lack of self-esteem, the impact of culture on their ability to negotiate safer sex or drug use, self-destructive behaviours, unrealistic attitudes).
- Discussing the clients' willingness to take risks.
- Working with clients to develop a harm reduction plan.
- Offering clients referrals to addiction counselling and treatment that support a harm reduction approach.

Everyone has a different perception or understanding of risk. Some people are more willing than others to take risks and, over time, a person's actual risk and perception of risk can change.

See Appendix 4: Safer Sex Guidelines at a Glance.

Helping Clients Prepare for Positive Test Results

Counsellors should help clients prepare for a positive test result by discussing the possibility and helping to normalize it. This includes

- Discussing with clients how they think they will react to a positive test result (e.g., reactions can range from anger to fear to relief).
- Reassuring them about the treatments now available for HIV, and the fact that many people who are HIV-positive are still healthy 20 years after being infected.
- Reminding them that early detection can lead to better health outcomes, and not knowing does not mean they are not infected.
- Asking them about their support systems (e.g., friends, primary care provider, counselling services). If your test result is positive, who will be supportive? Is there someone you can talk to?

- Discussing the support they may need to notify partners or disclose their HIV status to family and friends.
- Reassuring them that there are professional counselling services that can help them cope with a positive diagnosis.

NOTE: When using point-of-care HIV testing, counsellors must obtain informed consent for the point-of-care test and again if standard laboratory confirmatory testing is required.

Obtaining Informed Consent

Before any blood is taken, counsellors will ensure clients have understood the information about HIV transmission, harm reduction and prevention, and antibody testing, and have made an informed decision to be tested.

Under the *Health Care Consent Act 1996*, anyone capable of giving informed consent can be tested. If an adolescent asks to be tested and is considered to be capable of giving consent, the counsellor should document his/her capacity and provide testing. Counsellors should be sensitive to requests made by parents to have children tested. If the child or adolescent seems to have been coerced, the counsellor should not provide testing, and refer the family to an appropriate agency. Only agencies/providers that are equipped to provide comprehensive follow-up care for children should offer HIV testing for children.

The Health Care Consent Act 1996 does not require written consent. Under the Act, consent to treatment may be expressed or

NOTE: When using point-of-care HIV testing, counsellors must obtain informed consent for the point-of-care test and again if standard laboratory confirmatory testing is required.

implied. A person's participation in counselling implies informed consent.

III. Post-Test Counselling

Post-test counselling includes:

- Communicating the test result.
- Assessing the client's understanding of the test result.
- Referring the client for medical treatment and follow-up care and support.
- Reinforcing the importance of harm reduction and prevention.

The goal of post-test counselling is not simply to provide test results; it is also to provide support for people who test positive and to reinforce safer behaviours and practices with clients who test either negative or positive.

Therefore, post-test counselling should be done in person and by the same person who did the pre-test counselling whenever possible. Appointments for post-test counselling should be made at the end of the pre-test counselling session.

Exceptions can be made for people who live a long distance from the testing site (e.g., another town), and/or who are unable to return for the result and who are likely to be HIV-negative and/or have adequate support when they receive the test result. If a client will receive test results by phone, arrangements should be made for the call during the pre-test counselling session.

A Negative Test Result

For clients who test negative on either point-of-care or standard HIV testing, counsellors will use the post-test counselling session to reinforce the importance of harm reduction and prevention.

Counsellors will

- Discuss the window period for seroconversion and determine whether the client should be retested in a few weeks time.
- Review harm reduction and prevention information.
- Discuss the specific activities/factors that have put the client at risk in the past.
- Talk with clients about specific strategies they will use to reduce risk in the future.
- Encourage those who reported problems with alcohol, drugs, abuse, violence or other factors to seek appropriate support.

If clients continue to be anxious after receiving a negative test result, counsellors should refer them for more in-depth counselling.

A Positive Test Result

For clients who test positive, counsellors will help them express their emotions and provide immediate support. It is not appropriate to try to work through their reactions, as this is a longer-term process.

Initial reactions can range from extreme anxiety to relatively calm acceptance. Common reactions include

- Disbelief.
- Shock.
- Anger at the person from whom they acquired the virus.
- Anger at the person giving the test result.
- Guilt about being infected.
- Fear and uncertainty about their future health.
- Relief that there is finally an explanation for symptoms or health problems they are experiencing.
- Anxiety about the health of their partners or children.

What to say when a client tests positive

According to professionals who have been giving positive tests for a number of years

- *Be direct: for example, “It’s not the news we hoped for. You have tested HIV-positive.”*
- *Be aware that clients often hear nothing except the diagnosis so encourage them to make another appointment and return after they have had time to process the information.*
- *Stress the fact that there are treatments, and that people can stay healthy and lead full lives with HIV.*
- *Reassure clients that it takes some time to come to terms with the diagnosis, but in six months’ time they will feel more in control of their lives again.*
- *Ask the client how he/she will get home.*

Counsellors should

- Reassure clients that these are normal responses. Talking about how others have responded to testing positive may offer reassurance and give them insight into their own mixed feelings.
- Reinforce that HIV is a slow-acting, treatable virus — remind clients that early detection can lead to better health outcomes and that people with HIV can remain healthy and productive for decades.
- Discuss the client’s health and other needs (e.g., does the client need a referral to the local AIDS service organization to help find a physician experienced with HIV or deal with other issues, such as social support and housing?).
- Check that clients have understood and retained the harm reduction and prevention information covered during pre-test counselling and are aware of the steps they

can take to continue enjoying a healthy sex life without putting themselves or others at risk.

- Discuss the client’s ability to take steps to address health issues and reduce the harm associated with certain behaviours (e.g., alcohol or drug use) that can have negative effects on their health and on disease progression.
- Ensure that clients have a supportive person to talk with after the counselling session. If not, the counsellor may spend more time with the client.
- Encourage clients to return for a follow-up visit in a few days or refer them to an appropriate support service.

For more detailed advice on giving positive test results, see Appendix 6.

An Indeterminate (standard HIV testing) or Reactive (point-of-care testing) Test Result

For clients who test indeterminate with standard HIV testing or reactive with point-of-care testing, counsellors will

- Explain that the test was indeterminate or reactive, that more testing will be required to determine the person’s HIV status, and that a new blood sample must be sent to the public health laboratory for standard HIV testing.
- Explain that some people who screen indeterminate do test negative on the confirmatory test; however, for people who are at risk of HIV, a reactive point-of-care test is a good indicator that they are infected.
- Reinforce the importance of returning for the final test results, and make an appointment for the client to come back to receive the results.
- Review harm reduction and prevention information.
- Reinforce strategies to reduce risk.
- Discuss ways for the client to cope with anxiety while waiting for the results of the confirmatory test.

IV. Disclosure Issues

Notifying Past and Current Partners

Partner notification is part of effective HIV/AIDS prevention and management. Partners of people who are infected with HIV should be notified of their possible HIV exposure, if at all possible, and have the opportunity to assess their own risk, be counselled and tested and, if necessary, receive appropriate support and treatment.

Partner notification raises some difficult issues for counsellors. The Ministry of Health and Long-Term Care is working with the field to develop guidelines for partner notification, which will be available in 2008.

In most cases, clients will be willing to inform their sexual and drug use partners about a possible exposure to HIV; however, telling partners is difficult, particularly if clients fear that partners may react with anger or violence, or withdraw emotional or financial support. Counsellors should

- Discuss how important it is for partners to know they may have been exposed to HIV so they can be tested and receive care and treatment.
- Help clients identify partners and contacts.
- Work with clients to develop strategies to inform partners while protecting themselves.
- Tell clients about some of the options available to them, such as mailing a card to their contacts or asking public health for assistance in notifying partners.

- Explain to clients that public health staff are required by law to protect their confidentiality and will not use their name when partners are contacted.

Disclosing to Future Partners

Counsellors should work with clients to help them understand the importance of practising safer sex with current and future partners, and of informing partners. Some people with HIV who did not tell a partner before having unprotected sex have been charged with aggravated sexual assault or similar charges because they were deemed to have engaged in activities that posed a “significant risk” of harm to their partners. Some have received serious sentences, including prison time.

The law is not yet completely clear on what poses a “significant risk” of harm for partners. For legal advice or information on recent rulings, counsellors and/or clients can contact the HIV & AIDS Legal Clinic (Ontario) (416-340-7790; 1-888-705-8889; www.halco.org).

The following is a summary of the Canadian HIV/AIDS Legal Network understanding of the law as of June 2007:³

What poses a significant risk?

- Unprotected sexual intercourse. The law is clear. People with HIV must tell their sexual partners that they have HIV before having unprotected vaginal or anal sex — otherwise, the partner’s consent to have sex is not valid and the person with HIV could be charged with aggravated sexual assault.

³ Email communication between the Canadian HIV/AIDS Legal Network and the AIDS Bureau, May 18, 2007.

- Sharing drug equipment. There has not been a ruling on this yet; however, sharing drug equipment carries a significant risk of transmitting HIV. People with HIV are probably required by law to tell a partner before sharing equipment.
- Sex with a condom. It is not legally clear whether people with HIV have to tell their sexual partners if they are using condoms for vaginal or anal sex. Properly used, condoms greatly reduce the risk of transmitting HIV from one person to another during sex; however, it is still possible that people with HIV could be charged with a crime for having sex without telling their partner they have HIV, even if a condom is used.
- Oral sex. It is not legally clear whether people with HIV have to tell their sexual partners before oral sex (with or without a condom or some other protection). Oral sex carries a low risk of transmitting HIV but there is still a risk, so they may have to tell.

Even in cases where someone with HIV might not be criminally charged for having sex without revealing their HIV status, their partners could still sue the person if they learn, after having sex, that the person has HIV. It is not the role of the counsellor to provide legal advice but to provide information about HIV and the law. If clients want legal advice, refer them to the HIV & AIDS Legal Clinic Ontario (HALCO).

Refer clients who want more information about the legal requirement to disclose their HIV status to HIV & AIDS Legal Clinic (Ontario) (HALCO) for confidential legal information and advice: 416-340-7790; 1-888-705-8889; www.halco.org.

Disclosing to Non-Partners

For people who are HIV-positive, disclosing their HIV status to people other than sexual or drug partners (e.g., family members, friends, colleagues) is a complex and difficult process. Who people decide to tell, and when and how they tell them, is a personal decision.

When clients are first diagnosed, they are vulnerable. Some may react by wanting to tell everyone; others will want to tell no-one.

Most clients will be anxious about telling others of their HIV status. Counsellors should help clients explore this anxiety and explain that most people, such as employers, co-workers, day care providers and friends, do not need to know, and that there is no need to tell them. This advice is particularly important for clients who, in need of support, disclose their status too easily without considering the implications (e.g., stigma, discrimination).

Counsellors should help clients start to work through the process of deciding how to tell the people who need to know, such as close family and friends who can provide support.

Pre-Test Counselling Check List

Date: _____

AT Number:* _____

Date blood drawn: _____

Code Word: _____

Information about HIV Testing:

Review:

- Pros and cons of being tested.
- How the HIV antibody test is done.
- How long it will take to get test results (point-of-care test or laboratory testing).
- Window period (three months).
- Meaning of a negative test result.
- Meaning of a positive test result.
- Meaning of a reactive test result (with point-of-care testing).
- Meaning of an indeterminate test result (with standard HIV testing).
- Who has access to test results.
- Informed consent.
- How to obtain test results (i.e., results will not be given over the phone; the client has to return to receive them unless special arrangements are made).
- If special arrangements are made, how to get results over the phone (e.g., code word).

Client History/Risk Assessment:

- Reasons for seeking testing.
- HIV 101 – how HIV is transmitted, risk factors.
- AIDS anxiety.

Have you been tested before for HIV?

- Yes
- No
- Date of last test _____

Do you have?

- One regular partner
- A number of different partners
- Both

Does your sexual partner have?

- One regular partner
- A number of different partners
- Both
- Unsure

Are your usual sex partners?

- Male
- Female
- Both
- Transgendered

* For anonymous testing sites only

Do you have (check all that apply)?

- Oral sex
- Vaginal sex
- Anal sex
- Other

What type of STI protection do you use?

- None
- Male condom
- Female condom
- Dental dam
- Other: _____

How often do you use condoms/other STI protection?

- All the time
- Most times
- Sometimes
- Never

Has a condom ever broken during use?

- Yes
- No
- Unsure

Have you had sex with someone from a country where HIV is endemic?

- Yes
 - No
 - Unsure
- (e.g., sub-Saharan Africa, the Caribbean)

Have you ever shared sex toys?

- Yes
- No
- Unsure

Do you use street drugs (e.g., cocaine, heroin, crystal meth)?

- Yes
- No
- Unsure

Do you share needles?

- Never
- Sometimes
- Most times
- All the time

Do you share pipes, straws or other works?

- Never
- Sometimes
- Most times
- All the time

Do(es) your sex partner(s) share needles, pipes, straws or other works?

- Yes
- No
- Unsure

Do you have any of the following risks?

- Tattoos
- Body piercings

Do you ever cut/slash yourself?

- Yes
- No
- Unsure

Have you had a workplace exposure (e.g., needle-stick injury)?

- Yes
- No
- Unsure

Have you had any of the following infections?

- | | |
|--|---|
| <input type="checkbox"/> Chlamydia | <input type="checkbox"/> Gonorrhea |
| <input type="checkbox"/> Urethritis | <input type="checkbox"/> Herpes |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Molluscum |
| <input type="checkbox"/> Genital warts/HPV | <input type="checkbox"/> Trichomonas |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Yeast infections |
| <input type="checkbox"/> Bacterial Vaginosis | <input type="checkbox"/> Parasites |

When were you last tested for sexually transmitted infections? _____

Have you received?

Hepatitis A vaccination:

- Yes
- No

Hepatitis B vaccination:

- Yes
- No

How would you assess your risk of getting HIV?

When (approximately) was your most recent possible exposure to HIV?

- Less than 3 months ago
- 3 to 6 months ago
- 6 to 12 month ago
- More than 12 months ago

Do you have any of the following symptoms?

- Diarrhea
- Fever
- Night sweats
- Yeast infections
- Infections
- Rash
- Weight loss
- Other: _____

For women only:

- Repeated abnormal pap smears
- Recurring vaginal yeast infections
- Pain and/or bleeding during sexual intercourse
- Counsellor's assessment of client's risk:

Harm Reduction

Provide client-specific risk reduction counselling, which may include (depending on client's needs):

- How the assumptions the client makes about sexual partners affect risk.
- Safer sex, including how to use a condom (male and female), lubricant and dental dam.
- Strategies to manage partner pressure and negotiate safer sex.
- The importance of being tested regularly for HIV if client continues to engage in risky activities or has no control over/cannot negotiate safer sex or drug use.
- The importance of being tested and treated for other STIs and hepatitis C.
- Safer drug use and needle and syringe exchange.
- Safe tattooing, piercing, cutting.
- The importance of not donating organs, blood or sperm if the client is involved in risk activities.

Preparing for a Positive Test Result

- How do you think you would react to a positive test result?

Do you have a supportive person you can talk to if you test positive?

- Yes
- No

Is client at risk for suicide?

- Yes (If yes, defer testing and refer for counselling)
- No

Is client at risk for violence (i.e., from partner)?

- Yes (If yes, defer testing and provide counselling resource)
- No

Do you have a family doctor or nurse practitioner?

- Yes
- No

Will you feel comfortable discussing HIV-positive results with your family doctor/ NP?

- Yes
- No

(Provide counselling and referral if needed)

Discuss partner notification, including

- The importance of informing past and current sexual and drug partners if client tests positive

- The assistance available to help the client with partner notification

Who will be responsible for notifying partner?

- Client
- Counsellor and client together
- Refer to Public Health

Discuss disclosure to non-partners

- The implications of disclosing HIV status
- How to decide whom to tell and when
- Strategies for disclosing.

Referrals provided to community resources

1. _____
2. _____
3. _____
4. _____

Counsellor's notes:

* RESULT: Positive Negative Indeterminate Reactive (point-of-care test)

* Result Given

Appendix 2

Population-Specific Counselling Issues

Every population affected by HIV faces unique issues and will have distinct counselling needs. The following information may help counsellors provide more culturally sensitive services.

Gay Men/Men Who Have Sex with Men

Homophobia can be an issue in providing HIV testing services for gay men. Gay men may be more reluctant to disclose sexual activities due to their experience of homophobia. Counsellors may be uncertain how to talk to gay men about their sex lives because of their own discomfort or desire not to offend. To provide effective HIV testing and counselling services, programs should

- Ensure counsellors are comfortable with gay sex and the sexual habits and lifestyles of gay clients (i.e., open, warm and friendly; able to use humour in an appropriate way; able to signal in some way that they are comfortable with the client and with talking about gay sex).
- Normalize what clients are doing sexually, reassuring them that other guys are doing it too (e.g., “Several guys have talked about ..., Do you ...?”).
- Create a safe, gay-affirming, gay sex positive environment where the client feels comfortable talking openly about his sex life and his anxieties.
- Affirm gay men’s efforts to reduce their risk, even when that does not include condoms but involves other strategies (regardless of their efficacy).

When counselling men who self-identify as gay and men who report having sex with men, counsellors should explore some of the issues that may affect their ability to practise safer sex, including

- The assumptions they make about their partners. Some men decide whether or not to use condoms based on false assumptions such as “being on top is not risky;” “guys who are HIV-positive will disclose their status;” “guys who have the same ethnic background as I do will not have HIV” (i.e., for men from non-Caucasian ethnocultural backgrounds); “only gay guys have HIV so bisexual men and straight or married men are safe;” and “you can tell by looking at someone if they have HIV” (i.e., healthy looking men do not have HIV).
 - Their comfort using condoms. Some gay men feel that condoms are a barrier to intimacy or pleasure, or affect their ability to maintain an erection.
 - Life experiences that may increase the risk of unsafe sex, such as the end of a relationship, death of a partner or family member, loss of a job or income, or general depression.
 - Whether they are in a long-term relationship. Most unsafe sex with gay men happens in relationships. The riskiest time for most gay men is when they are dating or first enter a relationship. Some gay men adjust their condom use, especially early on in a relationship, as a sign of trust, respect and budding love.
- When a gay man is in a mutually understood open relationship, the counsellor should
- Be affirming, particularly of the rules or strategies that the couple have developed to enjoy sex with others while avoiding HIV and maintaining their emotional comfort and intimacy.
 - Suggest the client and his partner get tested.
 - Ensure the client understands the window period.
 - Explain that love and trust are not uncommon motivators for gay men to drop condoms, but this decision requires thought and planning to do so as safely as possible.

- Explain the importance of open, ongoing communication as a means of minimizing risk if the couple has dropped condoms within their relationship.

When a gay man is in a monogamous relationship, the counsellor should

- Acknowledge and normalize the challenge many men experience being monogamous.
- Find out whether the client is just assuming the relationship is monogamous or has actually discussed it with his partner.
- Encourage men to discuss their perceptions of monogamy with their partner to make sure they both have the same understanding.
- Discuss strategies the client can use to avoid HIV transmission if he is having sex with others and is not prepared to inform his partner.

Sample Counselling Questions for Gay Men

- Did you do anything to reduce your risk of HIV when you had unsafe sex with your sexual partner?
- When you have unsafe sex, what do you do to reduce your risk of HIV?
- Did you feel that the sex you had was relatively safe, even though you did not use a condom?
- How did you know it was safe?
- How do you feel about using condoms?
- Are condoms a barrier to safer sex?
- Do you have difficulty getting or maintaining an erection when using condoms?
- Do you use the condom for the entire sex act? (Ontario research shows that many gay men are delaying the application of a condom — that is, penetrating for a while, then withdrawing, adding the condom, and going back in to ejaculate. This practice is leading to new infections.)

- Do you ever not use condoms to avoid losing an erection?
- Do you become anxious or worry about using a condom before or during sex?
- Are you in a relationship or are you dating someone new?
- Is the relationship monogamous?
- Are you using condoms?
- Have you and your partner discussed sex outside the relationship?

Aboriginal People

Some Aboriginal people may seek HIV testing outside Aboriginal-specific agencies/services because of concerns about stigma and to safeguard their privacy and confidentiality. To provide effective HIV testing and counselling services for Aboriginal people, non-Aboriginal programs should consider the following

- A physical environment (e.g., location, waiting room/area) that is affirming and includes visible signs that Aboriginal people are respected and welcomed (e.g., posters, Aboriginal staff).
- Links and relationships with Aboriginal communities and service providers.
- Education sessions for counsellors on Aboriginal cultures and approaches to health and healing.
- A more holistic approach that incorporates HIV testing into a broader assessment of the client's physical, mental, spiritual and emotional health and well-being, and integrates HIV testing with regular testing for other STIs.
- The use of positive language.
- Referrals to other services that are welcoming and sensitive to the needs of Aboriginal people, as well as support in following through with those referrals.

African and Caribbean People Living in Canada

When working with people from Africa and the Caribbean (i.e., countries where HIV is endemic), counsellors should keep in mind the following

- The low rates of HIV testing among Ontarians from Africa and the Caribbean and the importance of affirming the person's decision to seek testing.
- The high rates of HIV prevalence among these populations, which increases the risk of being exposed to HIV, and the importance of prevention.
- The role of stigma and discrimination in increasing risk and keeping people from seeking testing.
- The importance of creating an anti-racist and anti-oppression environment, of making clients feel welcome, valued and respected, and of challenging any stigmatizing attitudes or statements.
- The need to train staff to identify racism and other forms of discrimination.
- The role of religion in the community and the impact of religious beliefs (e.g., people who are saved cannot acquire or transmit HIV, HIV is a punishment) on a client's response to HIV or willingness to be tested.
- Gender inequities that make it difficult for women to negotiate safer sex, even though they may be able to negotiate other aspects of their lives.
- Immigration requirements, which can limit women's access to social benefits and force them to stay in abusive or dangerous relationships, as well as other immigration issues, such as the way migration has disrupted family relationships.
- Sexual violence.
- The role of heterosexism and homophobia, which causes many to view HIV as a "gay disease" and not recognize that they are at risk.

- The perception that the risk of acquiring HIV in Canada is negligible.
- Cultural attitudes towards talking about sex and sexual health education for youth (e.g., sex is a taboo subject).
- Cultural attitudes towards multiple sex partners (e.g., in many cultures it is acceptable for men to have many partners — women, men or transgendered).
- Cultural practices that can affect risk, such as the ritual of male circumcision, where all young men may be circumcised using the same knife, and female genital mutilation.
- The tendency for African and Caribbean men to think that they are "clean" (i.e., do not have HIV or other STIs) and to choose partners that they assume are also "clean" — rather than use condoms.
- HIV-related stigma within the community, and the lack of support for people who do test positive and who often feel they must keep their status secret.

When working with men in the African and Caribbean community, counsellors should

- Never assume that men are exclusively either heterosexual or gay.
- Discuss the risks associated with unprotected sex with multiple sex partners.
- Discuss the full range of HIV prevention options without making assumptions about the client's sexual activities.
- Reinforce that being in a relationship does not protect against HIV.
- Explain that, in heterosexual relationships, men are twice as likely to transmit HIV and other STIs to their female partners than vice versa, and the risk is always greater for the receiving partner, whether female, male, or transgendered.
- Highlight that men can play a unique and valuable role in HIV prevention in their

communities by educating themselves and other men.

- Listen carefully to any objections to HIV testing and prevention and help overcome any barriers (recognizing that this is an ongoing process).
- Encourage clients to select and use HIV prevention methods (e.g., using condoms, reducing number of partners, engaging in non-penetrative sex), even if they are in long-term relationships, to protect current and future partners from any risks associated with sexual activity outside the relationship.
- Help them develop a contingency plan in case they engage in sexual behaviour outside their primary relationship.
- Recommend regular HIV and other STI testing (e.g., once a year and when partner(s) change).

This information has been excerpted from *Service Providers' HIV Prevention Guidelines for African and Caribbean Communities Living in Canada*, African and Caribbean Council on HIV/AIDS in Ontario (ACCHO), 2006.

Youth

To provide youth-friendly services, testing sites may have to make some changes to the environment, such as

- Being in a convenient location (e.g., on a bus route).
- Displaying posters on the wall that picture youth, and having magazines that appeal to youth.
- Hiring reception staff who are open, friendly and respectful of youth.

Many young people seek testing because they are concerned about another issue (e.g., a health problem, violence or abuse, uncertainty about their sexual orientation) and they may require education and information more than

testing. It is important for the counsellor to explore the reasons why the young person wants to be tested.

The traditional risk/history-taking format used with adults is often not useful with adolescents. It is usually more effective to use a more functional and less abstract approach, and to structure the counselling questions around home, education and other activities.

Home

- Where do you live?
- Whom do you live with?
- How much time do you spend at home?
- What do you and your family argue about?
- Can you go to your parents with problems?
- Have you ever run away from home?

Education

- What grade are you in?
- What grades are you getting? Have they changed?
- Have you ever failed any classes or been kept back a grade?
- Do you ever cut classes?
- Have you ever been teased or attacked at school?
- Do you work after school or on weekends?
- What are your career/vocational goals?

Activities

- What do you do for fun?
- What activities do you do during and after school?
- Are you active in sports? Do you exercise?
- Who do you do fun things with?
- Who are your friends?
- Whom do you go to with problems?
- What do you do on weekends? Evenings?

Drugs

- Do you drink coffee or tea?
- Do you smoke cigarettes? Have you ever smoked one?
- Have you ever tried alcohol? When? What kind and how often?
- Do any of your friends drink or use drugs?
- Have you ever injected steroids or drugs?
- What drugs have you tried?
- When? How often do you use them?
- How do you get money to pay for drugs?
- Are drugs used or available in places where you hang out?

Sexual Activity/Identity

- Do you feel you are ready for sex?
- Have you chosen to remain abstinent?
- Have you ever had sex?
- How many sexual partners have you had?
- How old were you when you first had sex?
- How old was your partner?
- Have you ever had sex with men? Women? Both?
- Do you think you might be lesbian, gay, bisexual or transsexual?
- Do you think you need to have sex to find out if you're lesbian, gay, bisexual or transsexual?
- Do you want to become pregnant? Have you ever been pregnant?
- Have you ever had an infection as a result of sex?
- Do you use condoms and/or another form of contraception to prevent STIs and HIV?
- Have you ever had sex unwillingly?
- Have you ever tried sex for money, drugs, clothes or a place to stay?
- Have you ever been tested for HIV? Do you think it would be a good idea to be tested?

Suicide/Depression

- How do you feel today, on a scale of 0 - 10 (0 = very sad, 10 = very happy)?
- Have you ever felt less than a 5? How long did that feeling last?
- What made you feel that way?
- Does thinking you may be lesbian, gay or bisexual make you feel that way?
- Did you ever think about hurting yourself or that life isn't worth living, or hope that when you go to sleep you won't wake up?

Adapted by the Adolescent AIDS Program with permission, from Goldering JM, Cohen EH: Getting into an adolescent's H.E.A.D.S. Contemporary Pediatrics 1998; 5:7, and Ryan C, Futterman D. Lesbian and Gay Youth: Care and Counseling. Columbia University Press. 1998.

Appendix 3

Risks Associated with Drug Equipment

While the risk of HIV transmission from contaminated needles is well known, many counsellors and clients may not be aware of the risks associated with other drug equipment. The following information is excerpted from *Ontario Needle Exchange Programs: Best Practice Recommendations* (March 2006).

Cookers

Data from international studies document the high frequency of re-using or sharing cookers among people who use injection drugs who tend to

- Retain and reuse cookers longer than either filters or rinse water .
- Share cookers more frequently than other drug preparation equipment .
- Share cookers even when they use a sterile needle to inject.

This means there may be greater opportunity for cookers to be contaminated with HIV and HCV than other drug equipment.

Filters

People who use injection drugs often use cotton or cotton wool as a filter. There are anecdotal reports that tampons, rolling paper, cotton buds and cigarette filters are also commonly used. Although these filters may prevent large particles getting into the syringe, they may not be clean and will not prevent the entry of small organisms like viruses. Data from international studies document that people who use injection drugs frequently re-use filters; however, less is known about how often they inject washes from filters previously used by another person who uses injection drugs.

Water

Studies have shown that using a common water container and/or untreated water (e.g., rain water) to rinse injection equipment (i.e., needles, cookers, filters) and to dissolve drugs into a solution for injection can pose health risks (e.g., HIV, HCV, bacterial infections); however, these risks are often overlooked. When a water container is shared or used by more than one person, small amounts of blood from another injection drug user can be deposited into the water. Non-sterile or shared water can also be contaminated with bacteria and lead to other health problems such as skin abscesses and infections such as endocarditis. These bacterial infections can have serious health implications and lead to death.

Alcohol Swabs

People who use injection drugs use alcohol swabs to clean the injection site before injection and to remove any blood from the injection from their fingers and other surfaces. People who use injection drugs who inject other users also use a swab to clean their thumb before and after injection. Reusing or sharing alcohol swabs increases the risk of HIV and HCV transmission.

Tourniquets

There is a risk of HIV and HCV transmission from sharing tourniquets, which are hard to clean when they are spattered with blood.

Crack Pipes/Glass Stems

Devices to smoke crack or other drugs are often crudely constructed from metal such as pop cans and glass materials, which can lead to cuts from sharp edges and lip burns. Contaminated blood may be transmitted between users if they share devices used to smoke crack or other drugs and have open wounds on their hands and mouths, putting them at risk of HIV and hepatitis C.

Appendix 4

Safer Sex Guidelines at a Glance

NOTE: this section is based on the Canadian AIDS Society HIV Transmission, Guidelines for Assessing Risk (2005). It is intended for use by counsellors; NOT as a handout for clients.

To help clients assess the risk of their sexual activities, counsellors should understand how transmission of HIV occurs. Risk reduction and prevention are important for all clients, regardless of whether they test positive or negative. Clients who test positive will want to know how to continue to enjoy sex and intimacy while avoiding passing HIV to their sexual partners. Clients who test negative will use information about risk to help develop strategies to stay negative.

Counsellors who maintain an open, positive attitude about the infinite variety of sexual activities will find it easier to discuss a client's risk behaviours and options. Having consistent and accurate information on hand can help clients make choices that are right for them.

Conditions of HIV Transmission

The science is clear: HIV transmission can occur when there is a sufficient level of virus in blood, semen or vaginal fluids to enter the bloodstream of a sexual partner, usually through small breaks or tears in the vagina, anus, mouth or skin. Unprotected vaginal and anal intercourse and sharing insertive sex toys that have not been cleaned/disinfected represent the highest risk of sexual transmission of HIV. Other sexual activities represent lower levels of risk.

Categories of Risk

Sexual activities can be classified into the following categories of risk for HIV transmission, based on scientific evidence:

- **High risk:** High potential of transmission because activities involve exchange of semen (including pre-ejaculate), vaginal fluids, blood or breast milk. A significant number of scientific studies confirm association of these activities with HIV infection.
- **Low risk:** Potential for transmission because activities may involve exchange of semen, vaginal fluids, blood or breast milk. A few isolated reports of infection have been attributed to these activities, usually in individual case studies or anecdotal reports.
- **Negligible (or no real) risk:** Potential for transmission because exchange of semen, vaginal fluids or blood is involved, but conditions reduce the efficiency of transmission. No confirmed reports of infection.
- **No risk:** No potential for and no evidence of transmission.

The following table provides a quick summary of the level of risk of individual episodes of different sexual activities. Note that some activities, such as anilingus, may not be high risk for HIV transmission but are high risk for other STIs.

LEVEL OF RISK FOR HIV TRANSMISSION	SEXUAL ACTIVITY
No Risk	<ul style="list-style-type: none"> • Wet or dry kissing — no exchange of blood • Masturbation by partner with or without latex glove • Receiving unshared insertive sex toys • Sadoomasochistic (S/M) activities using universal precautions • Urination on the body • Contact with feces on unbroken skin
Negligible (no real) Risk	<ul style="list-style-type: none"> • Oral sex (fellatio) — performing or receiving with a condom • Oral sex (fellatio) — receiving without a condom • Oral sex (cunnilingus) — performing with a barrier • Oral sex (cunnilingus) — receiving with or without a barrier • Oral sex (anilingus) — performing with or without a barrier • Oral sex (anilingus) — receiving with or without a barrier • Vaginal or anal fingering — performing with or without latex glove • Vaginal or anal fingering — receiving with or without latex glove • Fisting — performing or receiving, with or without a latex glove • Giving insertive sex toys, with or without condom • Receiving shared or disinfected insertive sex toys, with condom • S/M activities, not using universal precautions • Contact with feces, open cuts, lesions, ulcers, burns, rashes • Urination into the body • Vulva-to-vulva rubbing, either during or not during menses • Docking (foreskin over penis of partner followed by masturbation)
Low Risk	<ul style="list-style-type: none"> • Wet kissing — with exchange of blood (from bleeding gums, cuts, ulcers) • Oral sex (fellatio) — without a barrier, taking semen/ pre-ejaculate in mouth • Oral sex (cunnilingus) — performing without a barrier, either during or not during menses • Penile-vaginal intercourse — insertive or receptive with condom • Penile-anal intercourse — insertive or receptive with condom
High Risk	<ul style="list-style-type: none"> • Penile-vaginal intercourse — insertive or receptive without condom • Penile-anal intercourse — insertive or receptive without condom • Receiving shared insertive sex toys without condom

Source: *HIV Transmission: Guidelines for Assessing Risk*, Canadian AIDS Society (Fifth Edition, 2005)

For more detailed information on safer sex and assessing risk, see *HIV Transmission: Guidelines for Assessing Risk*, developed by the Canadian AIDS Society (fifth edition, 2005), available online at <http://www.cdnaids.ca/web/repguide.nsf/pages/cas-rep-0307>.

Appendix 5

Counselling Tips

- Hold counselling sessions in a comfortable private area, where clients feel at ease.
- Tailor the counselling session to the client's personal risks. Certain counselling techniques, such as open-ended questions, role-play scenarios, attentive listening and a nonjudgmental approach can help clients focus on ways to reduce their risk of acquiring or transmitting HIV.
- Provide information in a way that is sensitive to the client's culture, language, sex, sexual orientation, age and developmental level.
- Consider using pamphlets, brochures and/or videos to help communicate key harm reduction/prevention information.
- Acknowledge and provide support for any steps the client is already taking to reduce risks (e.g., coming for testing). This will encourage clients to believe that they can take other steps.
- Identify any critical misconceptions clients may have about their risk or behaviour and then clarify the risks associated with specific activities (e.g., drug-using clients may think that HIV can be spread only by sharing needles; they may not understand the risks from sharing cookers, cotton or water; clients may think that oral sex is a no-risk activity).
- Focus on helping clients to negotiate concrete, achievable changes that will reduce their risk (e.g., identify barriers and supports for a specific change; ask clients to write down the one or two goals that would reduce their risk most).
- Avoid a "one-size-fits-all" prevention message.
- Help clients identify and practise problem-solving strategies they can use to reduce their risk (e.g., role-playing, talking about safer sex with partners, using condoms properly).

- Use the session for counselling and not data collection. Using a lot of forms during the session can limit effectiveness (e.g., lack of eye contact, missing verbal and visual cues). Complete paperwork at the end of the session.
- At the post-test counselling session, give the test results at the beginning of the session in clear explicit language.

Appendix 6

Giving Positive Test Results

Taken from a presentation by Dr. Lindy Samson, Children's Hospital of Eastern Ontario at the HIV Testing Conference, February 26, 2007, sponsored by the AIDS Bureau, Ministry of Health and Long-Term Care. Her presentation was adapted from the "SPIKES" Framework for Discussing Results. Oncologist 2000 5(4): 302-11.

Learning difficult test results leads to a cognitive, behavioural or emotional deficit in the person receiving the news, which persists over time. How clients are given an HIV-positive test result affects how they move forward and engage in ongoing care, treatment and support. Giving a positive test result is different each time...and it should be. It is important to keep learning and modifying.

Goals

- Make people feel valued and understood.
- Convey enough information but do not overwhelm.
- Provide hope.
- Enable connection with treatment, care and support services.

Setup — Preparation

- Where will you have the conversation? Giving a positive test result over the phone is not appropriate unless there are extenuating circumstances.
- Was there pre-test counselling? Did you do it?
- Have a plan in mind based on what you know about the situation.
- What supports is the client likely to have?
- Consider your own emotions and/or biases. If necessary, discuss them with colleagues so you are aware of how they might interfere with your encounter with the client.

Perception — Throughout

- Find out the client's perception of the situation.
- What has the client been told about the infection?
- Correct any misconceptions or misunderstandings.

Invitation

- Find out how much detail the client wants at this initial discussion.

Knowledge

- Use language that matches the client's level of education: be direct and avoid using jargon.
- Give a warning that bad news is coming: for example, "I have some serious news to tell you." This will allow the client to prepare psychologically.
- After giving the news, stay quiet. Resist the urge to tell the client how to feel and give the client time to absorb the information and respond.

Empathy

- Watch the client's reaction.
- Use empathic statements to respond to the client's emotions.
- Resist the temptation to make things better. This is usually a reaction to your own sense of helplessness and perhaps failure.
- Ask if the client has questions or concerns and keep asking until he or she says, "No."
- Offer your personal reflection on how others in the same situation have reported feeling after six to 12 months.

Summary and Strategy

- Summarize the information, making a joint plan with concrete steps.
- Check on the client's understanding of what has been discussed.
- Describe care options (e.g., large clinic vs. primary care).
- Make a follow-up plan: find the best way to contact the client over the next few days.
- Ask if the client knows what he/she is going to do right now.
- Give contact information so the client can contact you.
- Offer referrals to community agencies or for individual counselling.
- Find out what the client's immediate needs are and act on them.

Discussion about Disclosure

- Affirm that the client is entitled to control disclosure of his/her HIV status.
- Acknowledge that deciding when and how to disclose may be difficult and that ongoing counselling may help.
- Examine any potential benefits of disclosing HIV status, particularly to the client's support network, including partner, family and friends.

- Acknowledge the potential for discrimination and other social harms of disclosure to certain people or institutions (e.g., employers, schools, insurers), and other disclosures that may stem from disclosure of status (e.g., coming out issues due to sexual orientation, immigration status, drug use).

Cultural Considerations

Some cultures have different views on whether people should be told about a life-threatening illness. Some cultures believe that discussing death can bring death closer. To explore a client's cultural beliefs, consider asking the following questions:

- What do you think might be going on?
- If we need to discuss a serious medical issue, how would you want to handle it?
- Would you want to receive the information and make the decisions, or should that be done by someone else in the family?

Pitfalls/Common Barriers to Good Communication

- Feeling you are responsible for the information being given.
- Ignoring your own feelings.
- Making assumptions about what the patient knows and does not know.
- Talking too much.

Pearls/Ideas to Facilitate Giving Difficult Test Results

- Elicit the client's immediate concerns to help him/her feel heard, and make a plan. It helps identify concerns and barriers to ongoing care and treatment.
- Be empathic, interested and affirming. These are powerful verbal techniques that clients recognize as demonstrations of your support.
- Help your clients hope for the best while preparing them for the worst. This gives you the opportunity to explore hopes and concerns, and signals that you are willing to discuss both.

- Individualize the way you give the result to match the client's needs.
- Keep in mind that clients who receive an HIV-positive diagnosis remember few details from the initial visit.
- Have the results with you to show the client.
- Giving results can only be as good as the pre-test counselling. There should be no surprises other than the test result itself. The same counsellor should do both the pre and post-test counselling whenever possible.
- Do not do anything other than give results and support (e.g., no data gathering).
- Know what supports the client has and strategize together about how to take advantage of them.
- Give the results alone.
- Be prepared to spend as much time as the client needs.
- Plan a follow-up connection. Ask permission to contact the client in the next few days. Make a follow-up appointment ASAP.

Appendix 7

Public Health Agency of Canada
List of Countries where HIV is Endemic

The “endemic countries” risk category for HIV infection has traditionally referred to countries in Africa and the Caribbean, where the rates of HIV infection are high. In October 2007,

the Public Health Agency of Canada updated the list of endemic countries to reflect new information on rates of infection in different parts of the world. While most “endemic countries” are still in Africa and the Caribbean, the list now includes some countries in Central/South America and Asia.

Africa	Mozambique	Dominican Republic
Angola	Namibia	Grenada
Benin	Niger	Guadeloupe
Botswana	Nigeria	Haiti
Burkina Faso	Rwanda	Jamaica
Burundi	Senegal	Martinique
Cameroon	Sierra Leone	Montserrat
Cape Verde	Somalia	Netherlands Antilles
Central African Republic	South Africa	St. Lucia
Chad	Sudan	St. Kitts and Nevis
Congo	Swaziland	St. Vincent and the Grenadines
Djibouti	Tanzania	Trinidad and Tobago
Equatorial Guinea	Togo	Turks and Caicos Islands
Eritrea	Uganda	U.S. Virgin Islands
Ethiopia	Zaire	Central/South America
Gabon	Zambia	French Guiana
Gambia	Zimbabwe	Guyana
Ghana	Caribbean	Honduras
Guinea	Anguilla	Suriname
Guinea-Bissau	Antigua and Baruda	Asia
Ivory Coast	Bahamas	Cambodia
Kenya	Barbados	Myanmar/Burma
Lesotho	Bermuda	Thailand
Liberia	British Virgin Islands	
Malawi	Cayman Islands	
Mali	Dominica	

AIDS Hotline

416-392-2437 or 1-800-668-2437

French: 1-800-267-7432

www.health.gov.on.ca/HIV

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