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Dr Richard Steele
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AD25-52-1

Dear Richard

Re: "Normalisation" of Medical HIV Testing

In recent years a number of new policies and strategies have been introduced to help address the changing pattern of HIV infection in New Zealand. These include the November 2005 implementation of HIV testing of immigrants and the commencement of the antenatal HIV testing programme pilot in the Waikato region in March 2006. In addition, there has been significant improvement in the range of funded antiretrovirals now available for treating patients with HIV infection in New Zealand.

For some years now HIV testing has been in a position of "exceptionalism" which has required adherence to a policy that recommends pre-test counselling takes place before blood testing is performed. The original Ministry of Health (the Ministry) policy guidelines for HIV testing of adults were established in 1987.

At its meeting on 16 November 2006 the Ministry's AIDS Medical and Technical Advisory Committee (AMTAC) discussed the need to promote more frequent HIV testing, and particularly to "normalise" the protocols around HIV testing where such testing is being performed in a medical context. The attached November 2006 AMTAC document, "*Updated Recommendations for HIV Testing of Adults in Healthcare Settings*" contains recommendations to the Ministry with respect to the "normalisation" of medical testing. It is important to note that these guidelines are not intended to modify current recommendations concerning HIV testing and counselling of persons at high risk of HIV infection who are being tested in the non-clinical setting, for example, community based testing by the New Zealand AIDS Foundation.

The Ministry acknowledges that circumstances surrounding HIV infection in New Zealand are now such that the need exists to "normalise" the protocols around HIV testing along the lines recommended by AMTAC. Accordingly, the Ministry has distributed this document to relevant professional bodies to seek their endorsement of these updated guidelines. A copy of the document has also been sent to the New Zealand AIDS Foundation.

Please indicate whether or not your organisation endorses the recommendations regarding "normalisation" of HIV testing in the medical context.

Thank you in anticipation.

Yours sincerely

Dr Don Matheson
Deputy Director General
Public Health Directorate

AIDS MEDICAL AND TECHNICAL ADVISORY COMMITTEE

UPDATED RECOMMENDATIONS FOR HIV TESTING OF ADULTS IN HEALTHCARE SETTINGS

Prepared by AMTAC Thursday 16th November 2006

The original Ministry of Health guidelines for HIV testing of adults were established in 1987. At that time testing was performed in the context of (1) acknowledged high risk behaviour for transmission of HIV, (2) lack of effective treatments for HIV, and (3) recognition of the need to promote safe behaviours as the primary means of preventing HIV transmission. The guidelines emphasized the value of both pre and post test counselling, and whilst defining issues that needed to be addressed at some stage during the counselling process, recommended that testing proceeded in the context of significant counselling component. The measures recommended were:

1. The patient should be aware that a test for HIV was recommended.
2. Oral consent to proceed with testing was required.
3. Further written information would be available if requested.
4. The test result should be provided in person, face-to-face, not by telephone message or mail, and
5. Extensive pre and/or post-counselling (lasting 30-45 minutes) was recommended, focused around modification of high-risk behaviours.

AMTAC recognises there have been changes in HIV management since these measures were first proposed. There are now highly effective treatments for HIV infection that can delay progression to AIDS for many years. HIV/AIDS epidemiology is slowly shifting from a gay/bisexual predominance towards a mixture of gay/bisexual and heterosexual spread. It is estimated in New Zealand at least 25% of currently HIV infected persons do not know that they are infected. Internationally there is now increased emphasis on widespread testing to identify such persons and provide appropriate clinical care as early as appropriate. Persons established on antiretroviral therapy who are virally suppressed show improvements in immune functioning over time, and where their viral load is below 500 copies they have been shown to be unlikely to transmit HIV to their sexual partners (NEJM 2000; 342: 921).

The need for special "pre testing counselling" is perceived by many as a barrier to testing, inhibiting some clinicians who think that an HIV test may be of value. AMTAC considers that the continued increase in cases of HIV/AIDS in New Zealand means that there is a need to encourage more widespread and frequent testing of persons with risky behaviours. AMTAC further recognises that HIV testing is becoming part of "routine" medical care.

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Consequently, testing should move from the current position of being "exceptional" to becoming part of "normal" medical practice, similar to testing for other treatable conditions, but without any relaxation of the need for consent and confidentiality. Clinicians should maintain a high level of alertness for the acute retroviral syndrome which presents with features commonly referred to as "glandular fever-like syndrome" with negative tests for EBV. Persons presenting in this fashion should be considered for an HIV test. Testing should also be performed on all sexually active persons presenting with signs or symptoms suggesting a sexually transmitted infection. This advice applies to persons presenting to STI Clinics or primary healthcare providers. In busy clinical settings, there is a need to promote more frequent testing by simplifying the current counselling process.

AMTAC recommends that in future:

a) Testing should remain voluntary and only undertaken with the patient's knowledge and understanding that an HIV test is recommended.
b) Oral consent is obtained before the test is performed.
c) The clinician requesting the test should continue to discuss the patient's risk behaviour that has led to the recommendation for testing, eg unprotected sexual exposure, and engage in a brief dialogue as to how such risk behaviour could be managed in the future.
d) The clinician requesting the HIV antibody test should discuss with the person how the results of the tests are to be provided and,
e) Written information should be provided if requested.

Where the need to modify risky behaviour has been clearly identified, the clinician should be prepared to explore strategies for change with the patient or alternatively refer the patient to another agency, eg STI Clinic, or AIDS Foundation Clinic, that have specific skills in this regard. Such referral should not be an impediment to proceeding with the test.

These guidelines are not intended to modify current recommendations concerning HIV testing and counselling of persons at high risk of HIV who are being tested in the non-clinical setting eg community based testing at AIDS Foundation or drug treatment clinics.

HIV positive results should continue to be communicated confidentially by means of direct (ie face-to-face) personal contact between the testing clinician and patient, in a supportive clinical environment, and not conveyed over a phone. AMTAC recognizes that negative results do not need to be provided face-to-face, and in many situations can be delivered by phone or other agreed means.

AMTAC recommends HIV testing for:

a. all persons with a history of unprotected sexual exposure that could result in HIV transmission, including especially men who have sex with men (MSM).
b. all persons with a history of injecting drug use that involves the sharing of drug injecting equipment, needles, syringes, spoons, filters etc.
c. all persons seeking assessment for sexually transmitted infections,
d. all pregnant women
e. all persons with recently diagnosed tuberculous infection,
f. persons with sexual contacts from countries where transmission of HIV infection is common, eg Africa, Thailand or other Asian countries,
g. prospective partners in a new sexual relationship

h. any person whose blood or body fluids is the source of an occupational exposure for a healthcare provider.

AMTAC further recommends that persons with ongoing behaviours that place them at risk for HIV infection should be offered testing at least annually. This includes men who have sex with men (MSM) who themselves or whose partners have had one or more new sexual partner(s) since their most recent test; sexual partners of HIV infected persons; injecting drug users who share injecting paraphernalia; persons who exchange sex for money or drugs, heterosexual persons with multiple sex partners. Persons who are known to have high risk behaviours for HIV transmission should be advised of the need for periodic retesting and offered prevention counselling as appropriate to their circumstances.

The use of rapid HIV tests in episodic care settings, eg Emergency Departments, urgent care clinics, STD or drug clinics, where continued relationships with patients typically do not exist, could substantially reduce the number of persons who fail to learn of their test results. If rapid HIV tests are performed, all positive results should be considered preliminary, and must be confirmed by conventional testing methods before the diagnosis of HIV infection is considered established.

Positive or negative HIV results should be documented in the patient's confidential medical record, and should be readily available to other healthcare providers involved in the patient's clinical management.

When HIV infection is diagnosed, healthcare providers should make strenuous efforts to encourage infected persons to disclose their HIV status to their spouses, current sexual partners, previous sexual partners within the last 6-12 months, and that all of these sexual partners should be offered testing for HIV infection.

These recommendations are in accord with recently published US Guidelines in the Morbidity Mortality Weekly Report (MMWR) "Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Healthcare Settings", MMWR September 22 2006 Vol 55 No. RR-14.

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Chairman AMTAC