Brief risk-reduction counseling at time of HIV testing does not result in reduction in rate of STIs

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Brief risk-reduction counseling at the time of a rapid human immunodeficiency virus (HIV) test was not effective for reducing new sexually transmitted infections (STIs) during the subsequent 6 months among persons at risk for HIV, according to a study in the October 23/30 issue of *JAMA*.

In the United States, approximately 1.1 million people are estimated to be living with HIV infection. The incidence of HIV infection is considered to have remained steady over the last decade, with about 50,000 new infections occurring annually. About l in 5 people living with HIV is thought to be undiagnosed. The U.S. Preventive Services Task Force recently recommended that all persons age 15 to 65 years be screened for HIV, according to background information in the article. A major issue regarding HIV testing of such a large population is the effectiveness of HIV risk-reduction counseling at the time of testing, because counseling involves considerable time, personnel, and financial costs.

Lisa R. Metsch, Ph.D., of Columbia University's Mailman School of Public Health, New York, and colleagues conducted a trial to assess the effectiveness of counseling in reducing STI incidence among STI clinic patients. From April to December 2010, Project AWARE randomized 5,012 patients from 9 STI clinics in the United States to receive either brief patient-centered HIV risk-reduction counseling with a rapid HIV

test or the rapid HIV test with information only. Participants were assessed for multiple STIs at both the beginning of the study and 6-month follow-up. The core elements of the counseling that the patients received included a focus on the patient's specific HIV/STI risk behavior and negotiation of realistic and achievable risk-reduction steps. The prespecified outcome was a cumulative incidence of any of the measured STIs over 6 months. All participants were tested for *Neisseria gonorrhoeae, Chlamydia trachomatis, Treponema pallidum* (syphilis), herpes simplex virus 2, and HIV. Women were also tested for *Trichomonas vaginalis*.

The researchers found no difference in 6-month composite STI incidence by study group: STI incidence was 250 of 2,039 (12.3 percent) in the counseling group and 226 of 2,032 (11.1 percent) in the information group. This pattern was consistent at all sites. Analyses by age group, race/ethnicity, and sex (for heterosexuals) also demonstrated no effect of counseling on STI rates.

"Despite the historical emphasis on risk-reduction counseling as integral to the HIV testing process, no contemporary data exist on the effectiveness of such counseling. The results of Project AWARE help fill this gap," the authors write.

"Overall, these study findings lend support for reconsidering the role of counseling as an essential adjunct to HIV testing. This inference is further buttressed by the additional costs associated with counseling at the time of testing: without evidence of effectiveness, counseling cannot be considered an efficient use of resources. Posttest counseling for persons testing HIV-positive remains essential, both for addressing psychological needs and for providing and ensuring follow-through with medical care and support. A more focused approach to providing information at the time of testing may allow clinics to use resources more efficiently to conduct universal testing, potentially detecting more

HIV cases earlier and linking and engaging HIV-infected people in care."

"In an era of shrinking resources, clinicians and policy makers cannot ignore data that inform efficient clinical practice," write Jason S. Haukoos, M.D., M.Sc., of the Denver Health Medical Center, and Mark W. Thrun, M.D., of Denver Public Health, in an accompanying editorial.

"Maximizing identification of individuals with undiagnosed HIV infection and reducing viral transmission will require consistent and extensive HIV testing with emphasis, for those identified with HIV infection, on linkage to care, treatment, and adherence. Although utilization of prevention counseling in the context of these post-HIV testing efforts remains to be characterized, results of the AWARE trial support the notion that prevention counseling in conjunction with HIV testing is not effective and should not be included as a routine part of practice."

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