

*Letter to the Editor*

## **The Role of HIV Counseling and Testing in CDC's HIV Prevention Efforts**

**To the Editor:** Darrow and colleagues (1998) have made a useful contribution to our understanding of the potential for HIV transmission by HIV-seropositive men who have sex with men (MSM). Unfortunately, however, they have inadvertently misrepresented the role of HIV counseling and testing in the current HIV prevention efforts of the Centers for Disease Control and Prevention (CDC) and have failed to adequately support their conclusion that "counseling and testing is ineffective as a measure for promoting behavior change among HIV-positive MSM in South Beach" (p. 115).

Although HIV counseling and testing is an important part of HIV prevention efforts in the United States, the CDC does not require state or local health departments to provide a specific level of support for this intervention. Since 1994, the allocation of funds for prevention activities has been the responsibility of local HIV prevention community planning groups (CDC, 1998; Valdiserri *et al.*, 1995). Each of these groups has developed its own HIV prevention plan that addresses local epidemiologic trends and prevention needs. In 1997, CDC provided \$253 million to allow health departments to implement the HIV prevention plans developed by their community planning groups. Roughly 36% of these funds were allocated by local communities for counseling, testing, referral, and partner notification activities (CDC, 1998). CDC does, however, provide funding to support targeted prevention services that address the needs of communities at greatest risk of HIV infection and transmission. This year, for example, CDC has provided funds to strengthen the efforts of minority community-based organizations to address high-priority HIV prevention needs of African-American and Latino communities and to support five demonstration projects to reduce HIV transmission by persons living with HIV.

We disagree with Darrow and colleagues' suggestion that the goals of counseling and testing programs conflict with those of primary prevention. Some studies of counseling and testing have provided

support for its effectiveness and others have not (Higgins *et al.*, 1991; Wolitski *et al.*, 1997). Many of the early studies were not specifically designed to test the effectiveness of counseling and testing and suffered from considerable methodological weaknesses (Higgins *et al.*, 1991; Phillips and Coates, 1995; Wolitski *et al.*, 1997). For example, the single study of counseling and testing cited by Darrow and colleagues (Otten *et al.*, 1993) has been the subject of considerable debate and criticism (Chamot *et al.*, 1995; Hirano *et al.*, 1994).

A recent review of the HIV counseling and testing literature that was conducted by CDC staff found that more than half of the studies indicated that these programs motivated individuals to adopt risk-reducing practices (Wolitski *et al.*, 1997). Furthermore, the authors of this review reported "studies that examined the relationship between HIV serostatus and risk behavior typically found that persons who learned that they were HIV seropositive were more likely to have adopted risk-reducing practices than were those who were HIV-seronegative" (p. 64). More recent findings provide additional evidence regarding the ability of counseling and testing to change risk behavior. Findings from a five-city randomized controlled trial (Project RESPECT) found a significant differential decrease in new STDs and an increase in condom use at 6-month and 1-year follow-ups among persons receiving HIV testing (with either two or four sessions of counseling) compared with those receiving HIV testing and only minimal risk-reduction education (Kamb *et al.*, 1996, 1998).

We are uncertain as to how Darrow and colleagues came to the conclusion that HIV counseling and testing is ineffective in South Beach. The analysis they presented does not assess pre-post changes in risk behavior following HIV counseling and testing nor does it compare risk practices of men who had previously received counseling and testing with those who had not. The only evidence offered to support their conclusion appears to be the proportion of

HIV-seropositive MSM (39.2%) reporting unprotected anal intercourse in the prior year. Although the percentage of men reporting unprotected sex is clearly cause for concern, the extent to which this figure represents a failure of counseling and testing to motivate reductions in risk practices cannot be ascertained from the data presented by Darrow and colleagues. First, because the authors used a cross-sectional design, the extent to which respondents' risk behavior changed after receiving HIV counseling and testing is not known. Second, some participants learned that they were HIV-seropositive during the 1-year recall period for which respondents were asked to describe their risk behavior. In fact, 17 of the 51 HIV-seropositive men did not know that they were infected at time of interview. Third, those men who had previously tested HIV-seropositive had known their status for as little as 3.5 months and as long as 11.9 years. Thus, the risk behavior reported by some of these men included the period of time prior to their first (or first HIV-seropositive) HIV-antibody testing and counseling experience. Finally, one must question the value of an analysis that attempts to evaluate the effectiveness of an intervention that occurred on average more than 5 years ago. Is this a reasonable standard for any single prevention program to be held to?

Despite the concerns we've raised regarding their report, we strongly agree with Darrow and colleagues' suggestion that "more effective social and behavioral interventions must be developed, implemented, and evaluated" (p. 115). Like all other HIV prevention interventions, counseling and testing does not motivate behavior change among all participants. It would be unreasonable to expect 100% adherence as a response to *any* intervention. Furthermore, brief interventions like counseling and testing are not well suited to maintaining behavior change over an extended time period. It is clear that a wide range of interventions at the individual, social group, community, and policy level are necessary in order to bring about sustained behavior change among persons at risk for acquiring or transmitting HIV. The CDC has a long history of supporting these types of interventions in partnership with local communities. In addition, the CDC actively promotes the adoption of effective risk reduction programs and funds research to develop new primary prevention programs for at-risk populations including young MSM, persons living with HIV, and incarcerated youth.

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