

HIV Testing in Europe: A Review of Policy and Practice

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COUNTRY REPORT FOR THE REPUBLIC OF IRELAND

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1. BACKGROUND INFORMATION

The last census established the population of the Republic of Ireland at 3.6million, 1.8m males and 1.8m females. 1.5m are under 25 years of age¹.

Table 1: Demographic Information

Total Population	Male	Female	15 to 24 Years of Age	0-14 Years of Age
3, 626, 087	1,800,232	1,825,855	633,000	859,000

Up to 1993 there was more net emigration than immigration. This has now changed especially in the last few years. In 1998 it was estimated that 21,000 persons emigrated and 44,000 immigrated a net migration of 22,800 persons².

Local ethnic minorities are travellers (gypsies); there are also small communities of Chinese, Italian, and Vietnamese. In recent years there has been an increase in people seeking asylum, applications for 1998 reached 3,885 (a 20% increase on the previous year) bringing the number of people awaiting decision to 6,500. ‘The largest ethnic group is from Nigeria followed by people from Romania and then by Zairians’³.

Legal Situation

Age of Majority

The age of majority is 18. Under 18s are classed as children. Parental or guardian consent is required for medical procedures, including the HIV test. Consultants and doctors can treat 16 to 17 year olds under the new legislation in relation to Non-Fatal Offences against the Person Act. This states “and where a minor has by virtue of this section given an effective consent to any treatment it shall not be necessary to obtain any consent for it from his or her parent or guardian”⁴.

Consent

The age of consent for sex is 17 years for both homosexuals and heterosexuals. Homosexuality was decriminalised in 1993⁵.

Condoms

Condoms are widely available from chemists, shops and dispensers in bars and clubs. Distribution and sale is covered by *the Health (Family Planning) Regulations 1992*. Free condoms may be supplied by health boards and GUM/STI clinics to an individual, if- ‘(a) they are supplied to that person for the purpose of preventing HIV or any other sexually transmitted disease’⁶.

¹ Central Statistics Office 1996.

² Central Statistics Office 1999.

³ Irish Times 5/2/1999 No.45,364 City.

⁴ Section 23-2 Non-Fatal Offences Against The Person Act, 1997.

⁵ Section 1-4 Criminal Law (Sexual Offences) Act, 1993.

⁶ S.I. No. 312 of 1992.

Prostitution

Prostitution is illegal. A new law making soliciting for prostitution (male or female), or brothel keeping illegal was introduced in 1993⁷.

Birth Control

Contraception or other methods of birth control such as condoms are widely available. Health Boards may provide or make available a family planning service comprising comprehensive provision of information, instruction and consultation in relation to various methods⁸.

Abortion

Abortion is illegal. A constitutional referendum to change the Irish Constitution in 1995 allowed access to information on abortion⁹, otherwise women have to go to other countries for the operation. A recent government report on *Women & Crisis Pregnancy* noted that since 1970 over 72,000 Irish women have travelled to England for abortion, 4,950 in 1994¹⁰.

Drugs

Apart from alcohol, nicotine and prescribed drugs, possession of other drugs without proper license is illegal. Alcohol is the main drug used in Ireland. A recent report estimated the economic cost of alcohol misuse for 1995 at £325.6 million (when compared with the real figure for 1994 of £263 million, of which £138 million was borne by the State)¹¹.

A serious heroin problem has existed in Dublin since the 1980s, mainly with intravenous drug use (IVDU) with an increasing number of young heroin smokers in recent years. It is estimated 10,000 IVDUs exist in Dublin alone, mostly in the poorer disadvantaged areas. In 1991 the government issued a strategy document to prevent drug misuse, it stated "in Ireland it is difficult to separate policies dealing with drug misuse from the HIV/AIDS problem"¹². Some of the measures advocated by the committee who drew up the report included, the implementation of community drug teams; co-ordination at health board level of programmes in relation to drug misuse and AIDS; with statutory and NGO involvement and greater role for general practitioners (GPs). Recently therefore the Drugs and AIDS budget (which is linked) has increased dramatically. Leading to, for instance, a growth in needle exchanges and drug treatment centres in the Eastern Health Board area. Enhanced budgets have been granted to other health boards and for NGOs involved in drugs and HIV/AIDS support and prevention.

Health Care

Health care provision is financed by the Department of Health and Children (DOHC). Hospitals and Health Boards work to their respective budget allocation. Public Health services are free. If a patient is employed and with a salary above a certain level, he or she bears the cost for various medical procedures, such as dental or eye treatment etc. and also for attending a general practitioner (GP).

⁷ Section 6-11. Criminal Law (Sexual Offences) Act, 1993

⁸ *Health(Family Planning) Regulations 1992*.

⁹ Bunracht Na hEireann 40.3.3.

¹⁰ Mahon E et al 1998 page 42

¹¹ DOHC (1996) National Alcohol Policy page 22.

¹² DOHC. Government Strategy to Prevent Drug Misuse, page 17. 5/1991.

If a patient is unemployed or low waged they can obtain a medical card, which means all medical services are free including the services of their local General Practitioner (GP).

Private Health insurance is also available.

The capital city, Dublin is the largest centre of population in the country. The Eastern Health Board (EHB) administers the health services covering Dublin City and County, County Kildare and County Wicklow (pop. 1.3 million). Seven other Health Boards administer services to the rest of the Republic of Ireland: South Eastern, North Eastern, Southern, Western, Mid Western, North Western and the Midland.

HIV/AIDS treatment is free and widely available. There are three consultants in infectious diseases, (AIDS/HIV/GUM), one based in Cork, and two in Dublin. A consultant for Pediatrics and infectious Diseases is also based in Dublin. HIV positive patients outside these areas have to travel to Dublin or Cork for treatment.

Infectious Diseases

Mandatory reporting/notification applies for various infectious diseases including TB, Creutzfeldt Jakob Disease, hepatitis, syphilis, gonococcal and other sexually transmitted infections¹³. *This regulation does not include HIV/AIDS*

All pregnant women and those attending GUM/STI clinics are tested for syphilis.

Sexually Transmitted Infections

Sexually Transmitted Infections (STIs) are covered by the Infectious Diseases Regulations, which means they are notifiable and contact tracing must be initiated through the clinics.

Between 1994 - 1996 the rates of STIs increased by an average of 600 cases per year. This is due perhaps to three factors: more availability of GUM/STI clinics, an increase in unsafe sexual practices or increased sexual health awareness via media and prevention campaigns. The new Convenience Advertising campaign run by the Health Promotion Unit of the DOHC includes awareness about STIs other than HIV. Some Non Government Agencies (NGOs) also promote STI awareness. Below are the numbers of reported cases of STIs for the Years 1989, 1994, 1995 and 1996 respectively.

¹³ Infectious Diseases Regulations 1981 and (Amendment) Regulations, 1996.

Table 2: STI Statistics

Sexually Transmitted Infections	1989	1994	1995	1996
Ano-Genital Warts	505	1,532	1,972	2,286
Candidiasis	688	1,360	1,271	1,321
Chancroid	2	2	3	1
Chlamydia Trachomatis	174	133	245	364
Genital Herpes Simplex	78	173	198	181
Gonorrhoea	27	98	76	83
Granuloma inguinale	0	0	0	1
Lymphogranuloma Venereum	0	0	0	0
Molluscum Contagiosum	31	56	59	34
Non-Specific-Urethritis	600	610	781	823
Pediculosis Pubis	60	69	86	79
Syphilis	12	11	11	17
Trichomoniasis	51	29	60	71
STIs other than those listed	353	391	382	505
Totals:	2,581	4,464	5,144	5,766

* Source: Department for Health & Children. 1998

Hepatitis

Hepatitis testing, and hepatitis A&B Vaccine are available free from all STI/GU clinics, and for a cost from local GPs. Universal Hepatitis B vaccination is not in place at this time. Below are the figures for the years 1992 to 1997. Also included is the provisional number of 119 Hepatitis B positive diagnoses for 1998, a four-fold increase over 1997.

Table 3: Cases reported

Number Reported Each Year	1992	1993	1994	1995	1996	1997	1998 Provisional No.
Hepatitis A	430	389	94	133	313	422	
Hepatitis B	13	11	20	11	10	26	119
Hepatitis UnSpecified	239	189	56	57	63	65	70

*Source: DOHC February 1999.

Testing for Hepatitis C is available from GUM/STI clinics especially for those at risk. The main groups diagnosed Hepatitis C positive are:

- women from contaminated blood product who received Anti D. treatment between 1977 and the early 1990s;
- IVDUs from shared needle use.

The National AIDS Strategy Committee

During a conference marking Worlds AIDS Day 1991 the Minister for Health, Mary O'Rourke stated that the 'diverse nature of the response to deal with the AIDS problem requires by its nature, an inter-sectoral approach at both national and local levels'¹⁴. The National AIDS Strategy Committee (NASC) was set up with members from voluntary and statutory bodies. Also represented on the committee are consultants in HIV/AIDS, a GP representative, the National AIDS Co-ordinator, officials from DOHC and other governmental departments, and two people living with HIV/AIDS. The Minister for Health & Children or Deputy Minister chairs the NASC. The four sub-committees are as follows:

¹⁴ DOHC/AIDS Liaison Forum 1991 report).

- Care and Management of Persons with HIV/AIDS;
- HIV/AIDS Surveillance;
- Education and Prevention Strategies;
- Measures to avoid Discrimination against persons with HIV/AIDS.

The four sub-committees held consultative meetings in 1991/1992, which led to a report being issued and adopted by the main committee in April 1992. This comprehensive report detailed over 60 recommendations in the above sub-committee areas¹⁵. Over the last six years many of the recommendations have been implemented.

The NASC has conducted consultative workshops on various topics; for instance, in 1997/1998, the Department of Health and Children held a series of workshops directly related to HIV testing, namely Partner Notification and Ethical and Counselling guidelines for those dealing with people who are HIV positive. Guidelines for professionals working with HIV positive people are to be published in 2000. The NASC meets about four times per year, though the sub-committees may meet more often. At present it is reviewing the work of the sub-committees and the 1992 recommendations by actively seeking the opinions of all the relevant groups and organisations and from members of the public. A report will be released in the middle of 2000.

¹⁵ NASC Report and Recommendations 1992.

2. OFFICIAL POLICY RE: HIV TESTING

It is not the government's responsibility to issue policy in relation to clinical practice. Local agencies, Consultants and GP's work to their own policy as advised in their publications listed below.

Medical Council Guidelines

The Medical Council of Ireland issued a code of ethics in 1994 in relation to serious infections, testing, confidentiality and informed consent by the client. 'The doctor should discuss the situation fully and completely with the patient laying particular stress, in the case of other medicals or paramedicals, on the need for them to know of the situation so that they may, if required, be able to treat and support the patient. This also applies to the patient's spouse or partners. The doctor should endeavor here also to obtain the patient's permission for the disclosure of the facts to those at risk'. The code goes on to state that 'difficulties may clearly arise if the patient, after full discussion and consideration, refuses to consent to disclosure'¹⁶.

A second guide produced by the Medical Council in 1998 covered Ethical Conduct and Behaviour. In the chapters on confidentiality and consent, the guide reinforces most of the codes outlined in Fitness to Practice. In section 18.12 of the guide on Communicable Diseases the guide states that a doctor must be aware of statutory obligations and risks must be assessed. 'Where others may be at risk if not aware that a patient has a serious infection, a doctor should do his/her best to obtain from the patient permission to tell them...so that they may take appropriate precautions'. Exceptions to confidentiality are listed under four headings: courts or tribunals; to protect the interest of the patient; to protect the welfare of society; to safeguard the welfare of another individual or patient. Section 46.04 covers involvement with the diagnosis and treatment of HIV infection or AIDS stating that the doctor must 'endeavor to ensure that all paramedical and ancillary staff e.g. in laboratories, fully understand their obligations to maintain confidentiality at all times'¹⁷.

General Practitioners

In 1995 the Irish College of General Practitioners (ICGP) produced a booklet 'HIV & AIDS in General Practice'. Chapter 1 under the heading testing for HIV the authors state "although HIV infection is uncommon in most general practice populations, testing for HIV is a procedure with which all GP's need to be familiar, as the majority of tests in this country have been carried out for insurance or visa medicals"¹⁸. In a National survey carried out in 1992, one third of respondents throughout the country had seen one or more patients with HIV infection. The lowest rate was in the North Western Health Board area (10%) and the highest in the Eastern Health Board area (60%). The chapter detailed procedures which all GP's needed to be familiar with:

- label the bottle with initials and date of birth
- avoid putting personally identifying information on the request form.
- identify the specimen as high risk by using a red sticker on the bottle or form

¹⁶ Medical Council of Ireland, "A Guide to Ethical Conduct & Behaviour and to Fitness to Practice" 1994.

¹⁷ Medical Council (1998) A Guide to Ethical Conduct and Behaviour, Dublin.

¹⁸ Irish College General Practitioners (1998) "HIV&AIDS in General Practice", Dublin

- send other samples from the same patient separately (to avoid identification).
- if in doubt about the procedure, check with local laboratory.

Chapter 3 deals with opportunities for prevention in general practice, such as taking a sexual history, giving advice about sexual activity, sexual orientation.

Chapter 4 deals with pre- and post- HIV test counselling issues.

Social Workers

In 1992 The Irish Association of Social Workers (IASW) HIV Committee, published practice guidelines for social workers in HIV in its resource pack on HIV¹⁹. The topics included confidentiality and pre and post test counselling.

EHB AIDS/Drugs Service

The Eastern Health Board has a written policy on HIV testing for people in drug treatment. Clients are offered the HIV test and if they refuse, this is indicated on their chart. Counselling may be offered by the doctor, nurse, and if necessary the client may be referred to a specialist HIV counsellor. If the HIV test is declined, the client will be offered the HIV test again every few weeks²⁰. Clients attending the Eastern Health Board's four HIV Testing Clinics for the General Population and the two special drop-in clinics (for men who have sex with men and women in prostitution) are required to take counselling before taking the HIV test, even on a return visit. A consent form is signed by all, stating the client has received counselling and has given permission for testing for HIV, Hepatitis B & C.

GUM/STI Clinics

All of the GUM/STI clinics in Ireland offer some information on testing to clients, although most of them have no written policy. Some of the clinics offer pre-test discussion rather than counselling. GUM/STI clinics outside Dublin do not have counsellors or social workers on the staff. In Dublin social workers are available in St James's, The Mater and Beaumont Hospitals. There are counsellors in the EHB's AIDS/Drugs service. Recently both the GUM clinics in St. James's and the Mater Hospital Dublin have begun to offer the HIV test to all clients on a routine basis. Counselling is not necessarily given, except when suggested by the doctor or client.

Prisons

In 1987 HIV positive prisoners were segregated. Desegregation took place in 1995. HIV testing continues to be available. At present prisoners in the De-Tox unit of Mountjoy Prison Dublin are tested by the attending doctor. Pre-test discussion is offered and the probation and welfare staff provide counselling if requested. A consent form has to be signed by the prisoners. In other areas, prisoners are counselled by the welfare staff and attend an outside clinic for HIV testing. Prisoners are categorised by site rather than risk on the DOHC reports of HIV figures (See section 10, Surveillance).

NGOs and HIV Testing

¹⁹ IASW Committee on HIV (1992) Irish Association of Social Workers, Dublin.

²⁰ Viral Testing Policy No. 14 Drugs/AIDS Unit EHB 1997.

Testing generally has not been promoted, though various AIDS campaigns have led to increased testing. The voluntary sector produced some leaflets about the HIV test. In 1985, the first leaflet by the first AIDS prevention group in Ireland, Gay Health Action²¹ discouraged testing, (primarily due to lack of treatment and fears of discrimination). Recent Gay Health and other NGO publications highlight information on treatments and the benefits of taking the test early. The statutory sector has also produced information leaflets, mentioning testing and the window period. (See section 9).

Legal Situation re HIV Testing

There is no specific law relating to HIV testing.

Notification

Neither AIDS nor HIV is a Notifiable Disease. A system of voluntary reporting exists for AIDS through the Regional AIDS Co-ordinators directly to the National AIDS Co-ordinator in the DOHC. Confirmatory HIV testing results are recorded by the Virus Reference Laboratory, UCD, Belfield Dublin 4.

Window period

It is recognised that most **infected persons** seroconvert within 3 months and many agencies use this as a guide for giving the all clear after a known episode of risk. It is recognised that seroconversion can sometimes take place after 3 months and other agencies use 6 months as a guide.

Confidentiality

Confidentiality is guaranteed in all testing sites. There are no recorded incidents of this being broken.

²¹ AIDS. The HTLV 3 Test, Gay Health Action 12/1985

3. HIV TESTING POLICY/PRACTICE BY POPULATION GROUP AND SITUATION.

HIV Testing began in the Republic of Ireland in 1985, since when, the numbers of people testing has increased. Influences on testing procedures have been the introduction of HIV testing clinics in Dublin, the establishment of the National AIDS Strategy Committee (NASC), the anti-viral treatments and new testing procedures adopted in other countries, (discussion instead of counselling).

The Virus Reference Laboratory (VRL) carries out some of the initial blood tests and all of the confirmatory HIV tests. Some local hospitals and private clinics may do the initial test but send all sero-positives to the VRL for confirmation. The VRL provides anonymous details of positive tests to the Department of Health and Children.

Testing Procedures and Request Form (VRL)

A certificate is issued for all HIV tests carried out by the VRL to the requesting agency. The certificate contains the following information:

- Initials, date of birth, gender, postal code, and risk group category;
- PID Number; Forename
- Surname;
- DOB (age);
- Gender;
- Clinician/Address;
- Specimen date;
- Specimen Type;

The Result Information is printed as follows:

- Serodia test for anti-HIV;
- Murex EIA for anti-HIV1+2;
- INNO-LIA HIV Confirmation Assay: (for confirmatory positive);

Note (The request form from medical staff at the agency must indicate the following details about the client: Name or Initials, DOB, Gender, Risk Group, Postal Area)²².

The Western Blot was used up to 1996 for confirmatory positive test. Since then there has been a decrease in equivocal tests.

Mandatory testing.

There is no mandatory HIV testing in Ireland. Exceptions are: individual requests; entry visa requirements to certain countries; stipulations for insurance when seeking cover or mortgages; blood, sperm bank and organ donation.

²² VRL Specimen Form 1998.

Surgical Procedures

Persons at risk may be asked their HIV status for surgical procedures. As people have to be informed about the possibility of an HIV test, they may refuse it. Infection control policy in all hospitals treat everyone as potentially infected. Staff are requested to adopt universal precautions. Previously some people at risk experienced difficulties when requiring surgical procedures. Incidents such as this were referred to in the NASC report... 'Prisoners were unwilling to be tested in prison and consequently had to forego elective surgery'²³.

A report issued by Body Positive after interviews with 124 people living with AIDS or HIV found that many of the respondents felt they had experienced discrimination, some were refused treatment, or felt discriminated against by health professionals. The report also covers dual marginalisation, IVDU and HIV positivity, Gay and HIV positivity and Women and HIV positivity²⁴.

In January 1998 a survey of 193 members of the Irish Medical Organisation found that '80%(44) of non consultant hospital doctors, 45%(41) of GPs, 29%(6) of consultants and 8%(2) of public health doctors believed it possible they could acquire HIV/AIDS through their occupation'²⁵.

Consent

Individuals must give informed consent before HIV testing. This is practiced by all agencies and health professionals including GPs. In some agencies and practices individuals are asked to sign a consent form. When donating blood, consent is presumed as donated blood is automatically tested.

Table 4: Consent by Group

Group	Consent
IVDU	Informed consent
Gay/Bisexual Men	Informed consent
Pregnant Women	Informed consent
Haemophiliacs	Informed consent
Blood Donors	Presumed consent

*Blood and organs for donation are tested for HIV.

Blood Transfusion, Donations

The Blood Transfusion Services Board (BTSB) is the statutory body for blood transfusions, and blood donations which people give on a voluntary basis for non-payment. All donated blood is tested. The BTSB discourage members of the public from using the BTSB as a testing site for HIV. There are restrictions for people giving blood; they are asked to self-select and a leaflet is given to the individual to read before blood is taken. The following are asked not to donate blood:

- if someone is HIV positive, Hepatitis B or C infectious;
- a man who has had sex with another man, (even 'safer sex' using a condom);
- someone working or who has previously worked in prostitution;
- a current or ex injecting drug user.

²³ NASC Report, page 76, 1992

²⁴ Facing the Reality, Living with HIV or AIDS, Body Positive 1993.

²⁵ Irish Medical Journal Vol 91 No.6. 1998.

There is also a restriction of a year on donations from the following persons:

- a female who has had sex with a man who has had sex with another man;
- a person who has had sex with a prostitute;
- a person who has sex with an IV drug user;
- a person with Haemophilia or related clotting disorder;
- anyone of any race, who has been sexually active in Africa in the past year (apart from Morocco, Algeria, Tunisia, Libya or Egypt)²⁶.

If a donor's blood tests positive for HIV he or she is contacted by letter and asked to attend the BTSB, where they receive counselling and give another blood sample for testing. This blood sample is sent to the Virus Reference Laboratory. A spokesperson for the BTSB acknowledged the discriminatory aspects of the leaflet and they were aware of the changing aspects of HIV risk groups, with the increase of HIV among heterosexuals.

Table 5: Procedure by Agency

Agencies	Routinely Offered	Mandatory	Given Results
St James Hospital STI/GUM Clinic, Dublin 8.	Yes	No	Yes
Mater Hospital STI/GUM Clinic, Dublin 7.	Yes	No	Yes
Infectious Disease Clinic, Beaumont Hospital, D 9.	Yes	No	Yes
Gay Men's Health Project, (EHB), Dublin 4.	Yes	No	Yes
Women's Health Project,(EHB), Dublin 4.	Yes	No	Yes
Asling Clinic (EHB), Dublin 10.	Yes	No	Yes
Baggot St. Clinic (EHB), Dublin 4.	Yes	No	Yes
City Clinic, (EHB), Dublin 3.	Yes	No	Yes
Domville House, Dublin 9.	Yes	No	Yes
Drug Treatment Satellite Clinics (EHB)	Yes	No	Yes
Drug treatment Center, Trinity Court, Dublin 2.	Yes	No	Yes
STI/GUM Clinic, Limerick General Hospital. Co. Limerick.	Yes	No	Yes
STI/GUM Clinic, Ennis General Hospital, Co. Clare	Yes	No	Yes
STI/GUM Clinic, Regional Hospital, Nenagh, Co. Tipperary	Yes	No	Yes
STI/GUM Clinic, Regional Hospital, Clonmel, Co. Tipperary.	Yes	No	Yes
STI/GUM Clinic, Victoria Hospital, Cork City. Co. Cork.	Yes	No	Yes
STI/GUM Clinic, Galway University Hospital, Galway City.	Yes	No	Yes
STI/GUM Clinic, General Hospital, Castlebar, Co. Mayo	Yes	No	Yes
STI/GUM Clinic, Regional Hospital, Waterford City.	Yes	No	Yes
STI/GUM Clinic, Sligo Regional Hospital, Sligo, Co Sligo	Yes	No	Yes
Maternity Hospitals, Antenatal clinics	Yes	No	Yes

Testing By Group

From 1999 all pregnant women will be routinely tested at all antenatal clinics (see below). People known to be at risk are usually encouraged to consider the HIV test, by the GUM/STI clinical staff, drug treatment agency, general practitioner (GP) or voluntary group such as Gay Health Network.

IV Drug Users

²⁶ BTSB Leaflet BT136 May 1996.

Since HIV testing began, people using IV drugs form the largest group infected with HIV. This has changed in the last number of years as numbers continue to fall. There is discussion that this fall may be due to the introduction of outreach, needle exchanges, more drug treatment centres, and prevention and education. In the Eastern Health Board for instance there are 12 needles exchanges and over 40 treatment centres²⁷ most of which make available the HIV test. In the last number of years the EHB has increased the number of outreach workers and counsellors to provide services in the community. The government has also funded “Drug Task Forces” in local communities. Many NGO’s have also employed support workers for IV and other drug users. A high percentage of the IV drug users have Hepatitis C. The EHB has recently appointed a specialist in Hepatitis C.

Gay, Bisexual Men & Other Men Who Have Sex with Men

Since HIV testing began many gay/bisexual men have been tested and comprise the second largest group of those infected. The only study available is the EHB 1992 survey of gay and bisexual men in Dublin: of the 481 who responded 47% knew their HIV status. Only 32% had had an STI screen, and 14% had had the Hepatitis B Vaccine²⁸. As a result of this study, the Gay Men’s Health Project (GMHP) was established, the only gay targeted GUM/STI clinic in Ireland. It provides a drop-in and outreach service, HIV Testing, Hepatitis B Vaccine, and an STI screening, including counselling and support. Of the 354 new attendees for 1998, 80% had the HIV test. (*Gay Men’s Health Project, 1998 Report & Developments*)²⁹. The other GUM/STI clinics and HIV testing sites throughout Ireland report a constant number of gay and/or bisexual men testing for HIV.

The DOHC figures show that the numbers of gay/bisexual men testing HIV positive continues to grow. It is also suggested that some of the unspecified HIV Positives may be men who have had sex with other men and not identified this at testing.

Sex Workers/Men and Women in Prostitution

Prostitution occurs in many of the big cities in Ireland. One targeted project for women in prostitution in Dublin provides drop-in and outreach services. The Women’s Health Project, Dublin, established 1991 works solely with women in prostitution. They operate a drop-in clinic one evening per week, with an afternoon clinic opening soon. The project has produced many reports and is the EUROPAP co-ordinator for Ireland. A recent report published in the International Journal of STD & AIDS detailed the services offered between 1991-1997. Of the 150 women attendees studied, 119 women (79%) had the HIV Test, and 3 were positive. 124 women (83%) tested for Hepatitis B and 6 were positive³⁰.

There is no specific services for men in prostitution. The GMHP produced a report on a pilot study of ‘Men in Prostitution in 1997’ (with support from EUROPAP). Of the 27 men interviewed 17(63%) had had an HIV test. Only 8 men had ever had a screen for other STIs or the Hepatitis B test. In relation to the men’s sexual orientation, 59% identified as gay, 22% as

²⁷ Eastern Health Board Annual Report 1998.

²⁸ Quinlan M, Wyse D et al (1992) Sexual & HIV Risk Behaviour of Gay & Bisexual Men, GMHP/EHB Dublin

²⁹ Quinlan M, Wyse D, Keating S Dr., Mulcahy F. Dr. Eastern Health Board GMHP 1999.

³⁰ McDonnell P et al International Journal of STD & AIDS 1998; 9: 485-488.

bisexual and 19% as heterosexual. Currently the GMHP is expanding its Outreach work with these men and is the Irish section co-ordinator for the European Network Male Prostitution.

Heterosexuals

Many heterosexuals have had the HIV test since 1985 especially in the EHB's HIV testing centres and the GUM/STI clinics. As in other countries there has been an increase in HIV positives among this category in the last three years (see the tables in the Surveillance section). The ratio of new positives of women to men is approximately one and a half to one. Over the last number of years some studies have taken place in relation to young people, students and their sexual practices.³¹ Some NGOs have highlighted that there is a sense of complacency among heterosexuals in relation to AIDS, who believe that the infection concerns only those who are gay or IVDUs.

Ante-natal HIV testing

An unlinked Anonymous HIV Testing programme for pregnant women was established in October 1992. As a result of discussion with the National AIDS Strategy Committee (NASC), the Department of Health and Children has just issued a report on unlinked HIV testing³², which shows a total of 287,009 tests of which 64 (0.02%) were positive.

Table 6:

Year	Tests Undertaken	Negative Tests	Tests Confirmed Positive	% Confirmed Positive
1993*	53,480	53,467	13	0.02
1994	51,118	51,112	6	0.01
1995	56,081	56,075	6	0.01
1996	62,008	61,996	12	0.02
1997	64,412	64,385	27	0.04
Total	287,099	287,035	64	0.02

* Includes the 4th Quarter of 1992

37(57.8%) of the 64 positive results were in the EHB region where 100,035 women tested, (34.8% of the overall number testing), increasing the percentage of confirmed positives in the EHB region to 0.04% or 37 per 100,000.

Pregnant women tested between the ages of 20-29 numbered 122,083 of which 41 were positive.

The average rate of HIV positives per 100,000 tests was 22.9.

In its conclusion the report highlights the fact that though the number of HIV positives is low it is increasing, particularly in 1997, double the number for previous years. The rate from the EHB remains significantly higher, while the relatively low prevalence nationally seems to be increasing, 'coinciding with and supporting the view that heterosexual transmission of HIV infection is increasing in Ireland'. It also suggested that the development of a unique patient identifier would clearly be important as a strategy to avoid duplication.

³¹ Alliance the Centre for Sexual Health, "What on Earth are They Doing" Cork 1998

³² Anonymous Unlinked Ante-Natal HIV Screening In Ireland, Results from the 4th Quarter 1992 to 4th Quarter 1997.

As a result of these figures and particularly with the development of new anti-retroviral drugs and the reduction of mother-to-child transmission, with intervention the DOHC has decided to launch linked routine HIV testing for all pregnant women. This began in 1999 in Dublin and will expand to other parts of the country. A number of training courses has been established for midwives and others working with pregnant women. All pregnant women will have to give informed consent and they may refuse the HIV test if they wish. The report commented on this aspect stating where 'a small number of women refused (where linked HIV testing has begun), and some of those have actually agreed after counselling/discussion'. The DOHC has produced leaflets (in three languages) highlighting the issues for the women testing³³. There is also a Consent form to Antenatal blood tests, which includes all particular instructions from the patient.

³³ 1. Blood tests at your first antenatal visit 2. HIV antibody testing & pregnancy, DOHC 1999.

4. CLIENT-INITIATED TESTING

The HIV test is available to anyone via local GPs, GUM/STI clinics, HIV Testing Clinics and certain projects (Dublin). The test is free (though the individual pays the GP for the consultation). Some private clinics offer the HIV test on a payment basis on referral from a GP or Embassy.

Generally clients initiate the HIV test, except when visiting a GUM/STI clinic, where a person considered to be at risk may be encouraged to consider the test.

Table 7: Availability of HIV Testing

Availability	Named Testing	Anon Testing	Accessibility	Named Testing	Anon Testing
Not Available			not accessible		
Available only in the Capital City			accessible only in the Capital City		
Available in the main urban areas			Accessible only in the main urban areas		
Available in most or all urban areas			Accessible in most or all urban areas		
Available in all urban areas and outside urban areas	Yes		accessible in all urban areas and outside urban areas	Yes	

Reasons for not testing

As the test is free the main reasons that people might not take the test are ignorance of local testing sites, fear of meeting others in the clinic, and fear of discrimination, especially in smaller cities or towns. Many people travel from these areas to larger cities especially Dublin.

An unpublished part of the GMHP 1992 study of gay and bisexual men found that of the 481 respondents 174 had not tested for various reasons:³⁴

- **scared/did not want to know (40%) 68;**
- **no reason/unclear (21%) 36;**
- **not worried; (18%) 30;**
- **always safe/no risks (10%) 17;**
- **decided not to go after counselling (6%) 10;**
- **no need i.e. fewer relationships (3%) 6;**
- **stress/insurance/confidentiality(3%) 5;**

At a consultative meeting on HIV testing and partner notification John Williams of POZ Ireland highlighted the concerns for people testing positive: ‘discrimination, no mortgage protection policies, no medical and holiday insurance, no life assurance, employment discrimination, social exclusion, homophobia’ etc. In its publication, “POZ Ireland” anonymous HIV testing is

³⁴ Quinlan M, Wyse D et al. GMHP/EHB 1992.

advocated³⁵. Concerns about the HIV test and possible discrimination were also commented on in many other publications between 1985 and 1994.

The cost of the HIV test is paid for by central government through local health authorities.

Testing sites

There are at least 17 sites (GUM/STI and HIV testing services) throughout the Republic of Ireland, offering the HIV test free. A client can initiate the HIV Test voluntarily. Dublin City has 10 sites some offering an evening drop-in service. (See listing chart). GPs can also refer an individual to a local hospital for the test.

Length of time for test result

HIV test results are usually available within one week, although rapid testing can take place if considered necessary. Private clinics (not counted above) offer same day or 24-hour service, for a fee. It is anticipated that improvements will occur in rapid, same day testing within the next two years.

5. HOME SAMPLING AND HOME TESTING

Not available.

³⁵ Williams J. POZ Ireland 1998.

6. COUNSELLING/GIVING RESULTS:

Post-test

Practice for giving results varies in STI/GUM clinics. Medical doctors give the positive results, while social workers/counselling or nursing staff give the negative results. In the EHB clinics the doctors give both negative and positive results.

Counselling and support for the HIV positive person is available in many cities both from the social workers/counsellors in the clinics or from local NGO. Apart from GP surgeries most agencies have counselling guidelines and procedures. All people diagnosed HIV positive are referred to the nearest consultant physician.

Pre-test

In 1992, the NASC report recognised the importance of counselling/social work services in non-hospital and hospital settings so that people could deal with a wide range of issues relating to HIV/AIDS. 'These issues would include pre and post test counselling medical information; dealing with sexuality and safer sex practices; issues relating to the prevention of transmission of the virus and with sustaining of adapted safer sex practices'³⁶. In 1995 a study by a senior social worker in St. James's hospital the case was made for pre-test counselling. 'Pre test counselling is time limited, focused discussion which sets out to assess the person's actual risk of having the virus; to educate, to promote behaviour change and prevent further transmission, to facilitate the person to think through the consequence of testing positive and to explore the social, psychological and practical implications of a positive result'³⁷.

Also the International Federation of Social Workers in its International Policy on Strategies for Responding to HIV/AIDS state that the "WHO/GPA has indicated that counselling in relation to HIV must be an integral and essential component of an overall National AIDS prevention and control programme. Adequate counselling and support services must complement national information education strategies. Social work is seen as one of the key professions to undertake these tasks"³⁸.

General practitioners also provide the HIV test and the ICGP's guidelines commented not all patients, undergoing testing, had counselling or information. "A number of people have tested positive without having had counselling and this has had adverse psychological effects as well as delaying medical follow up"³⁹ The authors maintained that as GPs often knew their patients well, counselling need not be time consuming. It advised that some issues needed to be discussed with the patient; the need for a HIV test, risk activity, time of last risk, advantages and disadvantages and dealing with a positive result. With *all* patients who are having a HIV test, and the most important principle is not to assume a particular outcome. It is recommended that HIV test results should be given in person and not by telephone.

³⁶ NASC Report & Recommendations April 1992

³⁷ Foreman M et al, Irish Social Worker Journal Vol. 11. No.1. 1995.

³⁸ IASW 1992.

³⁹ ICGP 1995.

In HIV testing sites/GUM clinics there are different methods in relation to pre-test counselling. Some of this is due to staffing levels, as many clinics around Ireland may have only doctors and nurses. In Dublin, the Mater, Beaumont and St James's Hospitals employ social workers, while the EHB AIDS/Drugs service employ both HIV and outreach counsellors. In Cork and Dublin three STI/GUM clinics employ health advisors for contact tracing and health advice for sexually transmitted infections.

Recently two GUM clinics in Dublin, St. James's and the Mater Hospitals have changed their procedures. Clients are routinely offered the HIV test, but counselling is offered only when requested by the client or if thought necessary by the doctor. Apart from the drug treatment centres and satellite clinics all the other testing sites in the EHB provide counselling to everyone seeking the HIV test, and this is indicated on a consent form. Most of the GUM/STI clinics outside Dublin also routinely offer the test and where possible discussion/counselling is offered.

Training

Local agencies provide training or journal clubs in relation to HIV testing. The GUM clinical staff in St. James's Hospital run courses for nurses and other health disciplines. The EHB staff in the AIDS/Drugs service receive training and supervision in relation to HIV counselling. The course includes treatment issues, sexuality, confidentiality, homophobia, etc. The DOHC Education & Prevention Committee of the NASC has held talks and workshops on treatments and issues for people from statutory and voluntary agencies.

Many of the GUM/STI staff commented that it was mainly nursing or counselling staff who took advantage of training. In some cases doctors attend courses both in Ireland and abroad.

7. PARTNER NOTIFICATION/CONTACT TRACING

There is no law to require partners of HIV positive people to undergo testing. Counselling staff will encourage the HIV positive person to tell their partner themselves. Among health professionals generally it is felt that this procedure is working well at present. As mentioned in Chapter 1 the National AIDS Strategy Committee is producing a document later in 1999 on the issues involved in this topic.

8. TREATMENT AND WELFARE-RELATED ASPECTS OF TESTING POSITIVE

Treatment is available free to all HIV positive people who are Irish and EU nationals or refugee/asylum seekers. A Non Irish or EU National can receive treatment if paid for or covered by insurance. The particular type of anti-viral treatment is dependent on the state of the individual's health and other related issues such as IVDU drug use infection with hepatitis or other illness/disease.

Table 8. Criteria for placement in treatment.

Recommendations	Clinical criteria for placement in treatment	Biological criteria (CD rate)	Biological criteria (Viral Load)
Medical consensus	Seroconversion stage B-C	CD4<300-500	VL<10 000-20 000

(Source DOHC & Consultants)

There are over 600 patients receiving anti-retroviral treatment.

Every Irish and EU National including refugees/asylum seekers, if unemployed, receives social welfare payments (and dietary allowance if recommended).

In Dublin, Galway, Limerick, Cork and Donegal non-government agencies provide specific support for HIV positive people, partners and family, including housing and drop-in services (See listings). A self-support group for gay men with HIV/AIDS used to meet in Dublin, but due to the improvements from treatment experienced by individuals, the group stopped meeting in late 1998. There is a project in Dublin for women living with HIV/AIDS as part of the International Community of Women Living with HIV/AIDS Group⁴⁰. An independent treatment directory is produced and distributed regularly by POZ Ireland. In 1995, a lobbying group MALAIDS, was set up, consisting of men and women living with HIV/AIDS, two of whom are representatives on the National AIDS Strategy Committee.

In the statutory sector, the Eastern Health Board provides support through their local community HIV counsellors, who are based in local clinics and who work closely with the client and relevant health care staff in the Hospitals. Respite care is available via EHB Cherry Orchard Hospital, St. James's and Mater Hospitals units. Both the Mater and James's Hospitals have social workers on the staff who also provide support. There is respite and hospice care for the terminally ill in Galway, Dublin and Cork. Persons diagnosed HIV positive in urban/rural areas are referred to consultants in Cork or Dublin. Those from the North Western Health Board Area may be referred to the GUM Consultant from Belfast Royal Victoria Hospital, who covers the Sligo Regional Hospital's GUM/STI clinic or to the Altnagelvin Hospital Derry, Northern Ireland (this is a reciprocal arrangement between the NWHB and the WHB. NI.)

Travel

There are no restrictions on HIV positive people entering the Republic of Ireland. In 1990 the private secretary for the Minister for Foreign Affairs wrote to the Irish Frontliners Organisation

⁴⁰ Reed L 1996.

to confirm that: ‘The Irish Government oppose any restrictions on the movement of HIV positive travellers on the grounds that; It adds to the potential for stigmatisation and discrimination; HIV persons do not represent a risk to other people; such measures cannot prevent the introduction and spread of HIV’⁴¹.

Legislation

The NASC 1992 report covered many issues in relation to primary care of persons with HIV/AIDS. Legislation in relation to persons living with AIDS or HIV protection in the workplace was passed in 1998⁴². This Act covers equality of employment and protection in the workplace on gender, sexual orientation, race, religion and disability (which is felt covers HIV/AIDS)

A code to protect HIV positive persons in employment in the public and civil service was passed in 1988.

PEP

Occupational Post Exposure Prophylaxis (PEP) treatment is available in all hospitals. Generally someone attends the A&E and is referred on to the GUM/STI specialist or nearest HIV consultant. Hospitals have a protocol for treatment especially for needle-stick injuries. St James’s Hospital Dublin produced a document on needle-stick protocol⁴³. There is also a national guidance relating to PEP published by the Department of Health and Children’s Advisory Group’s report on the prevention of Transmission of Blood Borne Diseases in the Health Care Setting (1997 & 1999).

Non Occupational Post Exposure Prophylaxis treatment. In some GUM/STI clinics, PEP might be implemented for a concerned person after unprotected sexual intercourse with an infected person.

Vertical Transmission

In Ireland the vertical transmission rate (VTR) prior to introduction of maternal antiretroviral therapy (ART) was 14%. The routine use of ART in pregnancy, labour, and to the infant post delivery, was introduced in November 1994. As of February 1997, most HIV positive pregnant women received combination therapy. The use of caesarean section is individualised based on maternal disease status, treatment history and viral burden. As of 1999, anti-natal screening for HIV is routinely offered to all pregnant women. Between November 1994 and August 1999 there have been 34 deliveries to mothers managed with this approach and the VTR is 0 thus far⁴⁴.

⁴¹ The Frontline Sept. 1990.

⁴² Employment Equality Act 1998.

⁴³ St James’s Hospital February 1998.

⁴⁴ Dr Karina Butler, Consultant Pediatrics and Infectious Diseases (interview) 1999.

9. PROMOTION OF HIV TESTING THROUGH PUBLIC EDUCATION

There has been no concerted general public campaign by NGO's around promoting the HIV test. In 1998, Gay Health Network published a leaflet, 'HIV test information for men who have sex with men', which promoted the benefits of taking the test. They also produced posters and placed adverts in the gay paper, (It will be evaluated in 1999). Previously, HIV prevention campaigns did not promote the HIV test *per se*, although some NGO campaigns dealing with AIDS awareness did mention the test. Those who provided specific testing leaflet information suggested caution. Beginning with the first leaflet published on the test by Gay Health Action (1985) entitled AIDS: The HTLV3 Test), revised (1986/1987) and Southern Gay Health Project (1995). Some publications mentioning the test were produced by the following groups; Women and AIDS (1990), AIDS Action Alliance (1988), Dublin AIDS Alliance (1991), Students AIDS Action (1992), Lesbian and Gay Health Caucus & Union of Students in Ireland (1992). Various publications produced by IV drug users, ex users and drug workers. Drugs Workers Forum (1992) and C.I.E.S.T (1997 & 1998).

A number of articles in the Gay Community News promoted safer sex awareness and the HIV test, such as 'Going Bareback' which highlighted the issue of gay men not using condoms, especially those in a steady relationship who had stopped using condoms, or had not used them in the first place. Based on the Australian (ACON) campaign 'Talk Test Talk Test', it detailed the following procedures: talk to each other, discuss the type of relationship wanted, and testing issues; talk to a counsellor; test together. If both partners test negative, they should continue safer sex for 12 weeks, continue to talk and visit the counsellor again before re-testing. If both test negative they should talk again before deciding to stop using condoms⁴⁵. In another article 'Testing Times' Bill Foley, (Senior Social Worker, Mater Hospital) and member of Gay Health Network, discussed the benefits of testing early, as those who recently diagnosed were perhaps already too ill to avail fully of the new treatments. His article encouraged men who felt they were at risk to go for the HIV test. In this same piece a leading consultant physician was quoted as supporting the move to routine testing in STI/GUM clinics and other places⁴⁶.

The statutory agencies such as the Health Promotion Unit, or the DOHC mention the HIV test in publications on HIV/AIDS information booklet and the STD information leaflet, advising people who have put themselves at risk of infection with HIV to be tested. The Eastern Health Board published the 'Test or not to Test' leaflet (1991 and 1994). The Rotunda Hospital (Maternity) also published 'HIV Test yes or no' and St. James's Hospital, 'HIV testing'(1998). Both leaflets highlight the benefits of testing. During events such as World AIDS Day and Irish AIDS Day clinics report an increase in numbers of people seeking the HIV test. Throughout Ireland the 4 AIDS Information telephone services and 6 gay information lines provide information, advice or counselling on HIV testing.

⁴⁵ Quinlan M, GCN 1/1998 Issue 104.

⁴⁶ Foley B. GCN 2/1999 Issue 114.

10. HIV SURVEILLANCE

The Virus Reference Laboratory, UCD, Belfield, Dublin has recently changed its format for reporting HIV figures. The system is being updated at present and will provide a more detailed report every six months. Figures for HIV (and AIDS) are issued twice yearly. The latest figures for HIV and AIDS are set out in the tables below.

Table 9: HIV Antibody Results in the Virus Reference Laboratory to 31st December 1998. Cumulative Total Samples Tested in the VRL for HIV Antibodies (1986 to Date)

Category	Total Tests	Positive Individuals
Intravenous Drug Users: Male	9,530	628
IVDU: Female	4,505	202
IVDU Unknown Gender	158	14
Children at Risk	2,163	149
Homosexuals	6,588	458
Haemophiliacs	1,268	114
Haemophiliac Contacts	76	3
Hospital Staff, Occupational Hazard, Needlestick	7,606	4
* Transfusion	826	4
*Blood Donors (specimens referred by BTSB)	3,771	28
* Organ Donors	6,203	0
* Visa Requests	12,777	2
* Insurance	41,355	1
* Prisoners	1,656	26
Heterosexuals/Risk Unspecified	54,197	353
Total	152,679	1,986

Notes: This does not include specimens tested in unlinked anonymous surveillance programme.

The above figures, which are produced by the VRL, relate to categories of persons as identified either by patients themselves or by their clinicians. * Categorised by site reason rather than risk.

Table 10: New HIV Positives Cases. 1st January 1998 to 31st December 1998

Category	Male	Female	Unknown	Total
Intravenous Drug Users	16	10		26
Children at Risk	11	8	1	20
Homosexuals	37			37
Haemophiliacs	-	-	-	-
Haemophiliac Contacts	-	-	-	-
Hospital Staff/Occupational Hazard /Needlestick	-	-	-	-
*Transfusion	-	1 [^]	-	1
* Blood Donors	1	1	-	2
* Visa Requests	-	-	-	-
* Insurance	-	-	-	-
* Prisoners	3	-	-	3
Heterosexual	23	18	-	41
Risk Unspecified	5	1	-	6
Total	96	39	1	136

*Numbers Categorised by site rather than risk. [^] Acquired outside Ireland. (DOHC 1999)

The number of new HIV positive cases for the last year has reduced somewhat for IVDU whereas it has increased for Heterosexuals, while the figures for gay/bisexual continue at a

steady number. 110 of the new positive cases were living in the EHB area. Below is a list of the AIDS cases and deaths up to 31st December 1998⁴⁷.

Table 10a: Revised list of AIDS cases up to 31st December 1998

Cases 650	Male	Female	Total
Homosexuals/Bisexuals	224		224
IV Drug Users	200	66	266
Homo/Bisexual IVDU	9		9
Haemophiliacs	33		33
Heterosexuals	43	40	83
Children born to IV Drug Users	7	6	13
Other Children	1	8	9
Undetermined	9	1	10
Transfusion recipient	2	1	3
TOTAL	528	122	650

Table 10b: Revised list of AIDS related Deaths up to 31st December 1998

Deaths-332	Male	Female	Total
Homosexual/Bisexuals	109		109
IV Drug Users	109	39	148
Homo/Bi VDU	6		6
Haemophiliacs	25		25
Heterosexuals	16	16	32
Children Born to IV Drug Users	4	4	8
Undetermined	3	1	4
	272	60	332

(DOHC) 1999

⁴⁷ DOHC 1999.

11. IMPACT OF HIV TESTING (RESULTS AND EFFICACY OF THE SYSTEM)

Various international and Irish studies have commented on the effects of the HIV test and a HIV positive result and the needs and concerns of the individual, (including NGOs working directly with HIV positive persons or Body Positive groups themselves). The social work team in the GUM clinic in St. James's Hospital have some studies available. At present the EHB's Gay Men's Health Project is assembling information from the counselling profile forms in relation to perceived changed behaviour.

Many people living with HIV or with AIDS continue to have social difficulties, such as homelessness and access to drug treatment, poverty, long term care (especially those with brain impairment due to HIV infection)⁴⁸. For many there are added psychological issues such as long term survival with a chronic condition, readjusting from a position of being terminally ill to recovery, pregnancy hopes increased due to treatment for the child. Treatment issues include the fact that it is not effective for all. Compliance, which many feel, is "a terrible word, being treated like a child"⁴⁹ is an issue for both those on treatment and health providers. Many of those on treatment feel under great pressure. The failure rate needs closer examination with publicity on "side effects, depression, anger, time of regime" etc.

⁴⁸ Foreman M. St. James's Hospital 1999

⁴⁹ Reed L. 1997

12. Concerns

During the compilation of this report, many health service staff and those in NGOs interviewed expressed concerns in relation to HIV testing, in particular to routine testing, positive results, treatments and discrimination. It is felt that due to anti-viral treatments and the change in progression of HIV, the medical profession are taking control and streamlining the testing procedures to exclude counselling. Budgetary concerns are considered a factor, i.e. counselling/social work staff levels within a unit.

The introduction of routine testing without counselling is subject of concern especially if counselling is not also routinely offered before the test. Doctors and nurses may not have the time or training to counsel the client. It is generally agreed that some discussion is necessary, especially in relation to the window period. HIV negative clients may feel there is no need to have a follow up test.

Preparing a person for a possible positive result is important so that the individual is able to deal with the shock. The possibility of discrimination and marginalisation needs to be highlighted especially in relation to the impact upon an individual's provision, his or her partner, family, and workplace. The effects on Insurance cover.

Sexuality and safer sex advice are issues which need to be discussed with all persons considering testing.

Pre-test counselling should be seen as an important method to encourage behaviour change and provide treatment information which needs be revised regularly so that it is up to date.

13. Conclusion

HIV Testing has existed in Ireland since 1985. Overall the approach to HIV testing in the Republic of Ireland seems to be successful.

There are no official recorded cases of discrimination or of confidentiality breaches. In some studies respondents did experience discrimination and were suspicious of the testing procedures. In general, however, there is a lack of concise information on HIV testing and its effects especially on behaviour change.

The studies of GPs and their perception of risk shows that training needs to be promoted and would include issues relevant to the target groups including up to date treatment information.

Where the consensus approach has previously provided safeguards to those seeking the HIV test, it may soon be outweighed by increased medical control and promotion of routine HIV testing, particularly in light to new treatments, longevity and a lower mortality rate.

Routine HIV testing and its effects need to be closely monitored especially if counselling is not being carried out.

Pre test counselling needs to be widely available, promoted and advertised (such as the St. James's Hospital GUM's clinic leaflet) where the HIV test is available.

Counselling with clients to include topics such as those recommended in the NASC 1992 report (see chapter 6 this report).

Close monitoring of treatment figures and deaths is needed especially if deaths begin to increase again as is happening in other countries⁵⁰.

Clear written HIV policies and testing procedures are needed especially in relation to the Freedom of Information Act (1998). This would also empower the client to choose when to test or where to go to receive counselling before the test.

Information campaigns on treatments and their benefits or possible side effect are recommended.

There is a need for prevention campaigns aimed specifically at heterosexuals at risk.

With the beginning of the millennium perhaps it is time for fuller discussion between agencies, organisations and HIV positive individuals of the issues and strategies needed to provide a comprehensive approach to HIV testing. The development of strategies similar to the recent procedures held with and for the gay community could enable those at risk to develop appropriate responses⁵¹. Perhaps the debate needs to begin with an understanding of what the HIV test means to health professionals, NGOs, people living with HIV or AIDS, and the Department of Health and Children: to recognize that the HIV test is not prevention and is part of the process to improve knowledge of HIV status. A positive or negative result still means the individual has to practice safer sex or safe needle use. The question is how to encourage and maintain this behaviour.

Whatever the outcome, it is hoped that this report will encourage discussion and help with finding the best policy, practice and procedures for HIV testing, that will continue to support and protect those who are considering the HIV test and who are HIV positive.

⁵⁰ Positive Nation HIV Magazine Issue 39 2/1999.

⁵¹ DOHC/Nexus/GLEN 1997.

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