

Appendix 1:

WHO COUNSELLING GUIDELINES FOR HIV TESTING

COUNSELLING BEFORE HIV TESTING OR SCREENING

Undergoing a test for HIV infection is likely to be an important step in a person's life, and should always be accompanied by pre-test and post-test counselling.

■ THE AIM OF PRE-TEST COUNSELLING

Counselling before the test should provide individuals who are considering being tested with information on the technical aspects of screening and the possible personal, medical, social, psychological, and legal implications of being diagnosed as either HIV-positive or HIV-negative. The information should be given in a manner that is easy to understand and should be up to date. Testing should be discussed as a positive act that is linked to changes in risk behaviour.

A decision to be tested should be an informed decision. Informed consent implies awareness of the possible implications of a test result. In some countries, the law requires explicit informed consent before testing can take place; in others, implicit consent is assumed whenever people seek health care. There must be a clear understanding of the policy on consent in every instance, and anyone considering being tested should understand the limits and potential consequences of testing.

Testing for HIV infection should be organized in a way that minimizes the possibility of disclosure of information or of discrimination. In screening, the rights of the individual must also be recognized and respected. Counselling should actively endorse and encourage those rights, both for those being tested and for those with access to the records and results. Confidentiality should be ensured in every instance.

■ ISSUES IN PRE-TEST COUNSELLING

Pre-test counselling should focus on two main topics: first, the client's personal history and risk of being or having been exposed to HIV; secondly, assessment of the client's understanding of HIV/AIDS and previous experience in dealing with crisis situations.

■ ASSESSMENT OF RISK

In assessing the likelihood that the person has been exposed to HIV, the following aspects of his or her life since about 1980 should be taken into account:

- Frequency and type of sexual behaviour: specific sexual practices, in particular, high-risk practices such as vaginal and anal intercourse without use of condoms, unprotected sexual relations with prostitutes;
- Being part of a group with known high prevalence of HIV infection or with known high-risk life-styles, for example, users of injecting drugs, male and female prostitutes and their clients, prisoners, and homosexual and bisexual men;
- Having received a blood transfusion, organ transplant, or blood or body products;
- Having been exposed to possibly non-sterile invasive procedures, such as tattooing and scarification.

■ ASSESSMENT OF PSYCHOSOCIAL FACTORS AND KNOWLEDGE

The following questions should be asked in assessing the need for HIV testing:

- Why is the test being requested?
- What particular behaviour or symptoms are of concern to the client?
- What does the client know about the test and its uses?
- Has the client considered what to do or how he/she would react if the result is positive, or if it is negative?
- What are the client's beliefs and knowledge about HIV transmission and its relationship to risk behaviour?
- Who could provide (and is currently providing) emotional and social support (family, friends, others)?
- Has the client sought testing before and, if so, when, from whom, for what reason, and with what result?

The initial counselling should include a discussion and assessment of the client's understanding of (a) the meaning and potential consequences of a positive or a negative result, and (b) how a change in behaviour can reduce the likelihood of infection or transmission to others.

Pre-test counselling should include a careful consideration of the person's ability to cope with the diagnosis and the changes that may need to be made in response to it. It should also encourage the person being counselled to consider why he or she wishes to be tested and what purpose the test will serve. When asking about personal history, it is important to remember that the client:

- may be too anxious to absorb fully what the counsellor says;
- may have unrealistic expectations about the test; and

- may not realize why questions are being asked about private behaviour and therefore be reluctant to answer.

During pre-test counselling, it is also important that the client be told that current testing procedures are not infallible. Both false-positive and false-negative results occur occasionally, although supplementary (confirmatory) tests are very reliable if an initial test is positive. These facts must be clearly explained, together with information about the “window” period during which the test may be unable to assess the true infection status of the person.

■ IF TESTING IS NOT AVAILABLE

There may be locations where reliable facilities for testing are not readily available. Where this is so, every effort should be made to emphasize prevention counselling, especially the need for changes in behaviour among people who have engaged in high-risk activities, and the reinforcement of appropriate behavioural changes. Counselling, education, information and support are the crux of behaviour change.

COUNSELLING AFTER HIV TESTING OR SCREENING

Counselling after testing will depend on the outcome of the test, which may be a negative result, a positive result, or an equivocal result.

■ COUNSELLING AFTER A NEGATIVE RESULT

It is very important to discuss carefully the meaning of a negative result (whether this was anticipated or not). The news of being uninfected is likely to produce a feeling of relief or euphoria, but the following points should be emphasized:

- Following a possible exposure to HIV, there is a “window” period during which a negative test result cannot be considered reliable. This means that, in most cases, at least three months must have elapsed from the time of possible exposure before a negative test can be considered to mean that infection did not occur. A negative test result carries greatest certainty if at least six months have elapsed since the last possible exposure.
- Further exposure to HIV infection can be prevented only by avoiding high-risk behaviour. Safer sex and avoidance of needle-sharing must be fully explained in a way that is understood and permits appropriate choices to be made.
- Other information on control and avoidance of HIV infection, including the development of positive health behaviour, should be provided. It may be necessary to repeat explanations and for the counsellor and the person being counselled to practise methods of negotiating with others in order to assist the client in introducing and maintaining new behaviour.

■ COUNSELLING AFTER A POSITIVE RESULT

People diagnosed as having HIV infection or disease should be told as soon as possible. The first discussion should be private and confidential, and then the client should be given time to absorb the news. After a period of preliminary adjustment, the client should be given a clear, factual explanation of what the news means. This is *not* a time for speculation about prognosis or estimates of time left to live. It is a time for acknowledging the shock of the diagnosis and for offering and providing support. It is also a time for encouraging hope – hope for achievable solutions to the personal and practical problems that may result. Where resources are available, it may also be justifiable to talk of possible treatments for some symptoms of HIV infection and about the efficacy of anti-viral treatments.

How the news of HIV infection is accepted or incorporated often depends on the following:

1. The person's physical health at the time. People who are ill may have a delayed reaction. Their true response may appear only when they have grown physically stronger.
2. How well the prepared the person was for the news. People who are completely unprepared may react very differently from those who were prepared and perhaps expecting the result. However, even those who are well prepared may experience the reactions described in the following pages.
3. How well supported the person is in the community and how easily he or she can call on friends. Factors such as job satisfaction, family life and cohesion, and opportunities for recreation and sexual contact may all make a difference in the way a person responds. The reaction to the news of HIV infection may be much worse in people who are socially isolated and have little money, poor work prospects, little family support, and inadequate housing.
4. The person's pre-test personality and psychological condition. Where psychological distress existed before the test result was known, the reactions may be either more or less complicated and require different management strategies than those found in persons without such difficulties. Post-result management should take account of the person's psychological and/or psychiatric history, particularly as the stress of living with HIV may act as a catalyst for the reappearance of earlier disturbance.

In some cases, news of infection can bring out previously unresolved fears and problems. These can often complicate the process of acceptance and adjustment and will need to be handled sensitively, carefully, and as soon as possible.

5. The cultural and spiritual values attached to AIDS, illness, and death. In some communities with a strong belief in life after death, or with a fatalistic attitude towards life, personal knowledge of HIV infection may be received more calmly than in others. On the other hand, there may be communities in which AIDS is seen as evidence of antisocial or blasphemous behaviour and is thus associated with feelings of guilt and rejection.

Counselling and support are most needed when reactions to the news of HIV infection and disease appear. Some reactions may initially be very intense. It is important to remember that such responses are usually a normal reaction to life-threatening news and as such should be anticipated.

■ PSYCHOLOGICAL ISSUES

The psychological issues faced by most people with HIV infection or disease revolve around uncertainty and adjustment.

With HIV infection, uncertainty emerges with regard to hopes and expectations about life in general, but it may focus on family and job. An even more fundamental uncertainty may concern the quality and length of life, the effect of treatment, and the response of society. All these are relatively unpredictable in terms of their long-term outcome. They need to be discussed openly and frankly, but care should always be taken to encourage hope and a positive outlook.

In response to uncertainty, the person with HIV must make a variety of adjustments. Even the apparent absence of a response may, in itself, be an adjustment through denial. People start to adjust to news of their infection or disease from the time they are first told. Their day-to-day lives will reflect the tension between uncertainty and adjustment. It is this tension that causes other psychosocial issues to assume more or less prominence and intensity from time to time.

■ FEAR

People with HIV infection or disease have many fears. The fear of dying and, particularly, of dying alone and in pain is often very evident. Fear may be based on the experiences of loved ones, friends or colleagues who have been ill with, or died of, AIDS. It may also be due to not knowing enough about what is involved and how the problems can be handled. As with most psychological concerns, fear and the pressures such fear creates can often be managed by bringing them clearly and sensitively into the open. They should be discussed in the context of managing the difficulties, including with the help of friends and family or with the counsellor.

■ LOSS

People with HIV-related disease experience feelings of loss about their lives and ambitions, their physical attractiveness and potency, sexual relationships, status in the community, financial stability, and independence. As the need for care increases, a sense of loss of privacy and control over life will also be experienced. Perhaps the most common loss that is felt is the loss of confidence. Confidence can be undermined by many aspects of life with HIV, including fear for the future, anxiety about the coping abilities of loved ones and care-givers, by the negative and/or stigmatizing actions of others. For many people, recognition of HIV infection will be the first occasion that forces them to acknowledge their own mortality and physical vulnerability.

■ GRIEF

People with HIV infection often have profound feelings of grief about the losses they have experienced or are anticipating. They may also suffer the grief that is projected on to them by close family members, lovers, and friends. Often these same people are supporting and taking care of them on a day-to-day basis, and watching their health decline.

■ GUILT

A diagnosis of HIV infection often provokes a feeling of guilt over the possibility of having infected others, or over the behaviour that may have resulted in the infection. There is also guilt about the sadness the illness will cause loved ones and families, especially children. Previous events that may have caused pain or sadness to others and remain unresolved will often be remembered at this time and may cause even greater feelings of guilt.

■ DEPRESSION

Depression may arise for a number of reasons. The absence of a cure and the resulting feeling of powerlessness, the loss of personal control that may be associated with frequent medical examinations, and the knowledge that a virus has taken over one's body are all important factors. Similarly, knowing others or about others who have died or are ill with HIV-related disease, and experiencing such things as the loss of potential for procreating and for long-term planning may contribute to depression.

■ DENIAL

Some people may respond to news of their infection or disease by denying it. For some people, initial denial can be a constructive way of handling the shock of diagnosis. However, if it persists, denial can become counter-productive, since people may refuse to accept the social responsibilities that go with being HIV-positive.

■ ANXIETY

Anxiety can quickly become a fixture in the life of the person with HIV, reflecting the chronic uncertainty associated with the infection. Many of the reasons for anxiety reflect the issues discussed above and concern the following:

- prognosis in the short and long term
- risk of infection with other diseases
- risk of infecting others with HIV
- social, occupational, domestic, and sexual hostility and rejection
- abandonment, isolation, and physical pain
- fear of dying in pain or without dignity
- inability to alter circumstances and consequences of HIV infection
- how to ensure the best possible health in the future
- ability of loved ones and family to cope
- availability of appropriate medical/dental treatment
- loss of privacy and concern over confidentiality
- future social and sexual unacceptability
- declining ability to function efficiently
- loss of physical and financial independence.

■ ANGER

Some people become outwardly angry because they feel they have been unlucky to catch the infection. They often feel that they have been, or information about them has been badly or insensitively managed. Anger can sometimes be directed inwardly in the form of self-blame for acquiring HIV, or in the form of self-destructive (suicidal) behaviour.

■ SUICIDAL ACTIVITY OR THINKING

People who are HIV-infected have a significantly increased risk of suicide. Suicide may be seen as a way of avoiding pain and discomfort or of lessening the shame and grief of loved ones. Suicide may be active (i.e., deliberate self-injury resulting in death) or passive (i.e., concealing or disregarding the onset of a possibly fatal complication of HIV infection or disease).

■ SELF-ESTEEM

Self-esteem is often threatened early in the process of living with HIV. Rejection by colleagues, acquaintances, and loved ones can quickly lead to loss of confidence and social identity, and thus to reduced feelings of self-worth. This can be compounded by the physical impact of HIV-related diseases that cause, for example, facial disfigurement, physical wasting, and loss of strength or bodily control.

■ HYPOCHONDRIA AND OBSESSIVE STATES

Preoccupation with health and even the smallest physical changes or sensations can result in hypochondria. This may be transient and limited to the time immediately after the diagnosis, or it may persist in people who find difficulty in adjusting to the disease.

■ SPIRITUAL CONCERNS

Concern about impending death, loneliness, and loss of control may give rise to an interest in spiritual matters and a search for religious support. Expressions of sin, guilt, forgiveness, reconciliation, and acceptance may appear in the context of religious and spiritual discussions.

Many of these and other concerns will appear or become more pronounced when a diagnosis of AIDS is made. The appearance of new infections, cancers, and periods of severe fatigue all have a significant emotional and psychological impact. The effect is likely to be even greater if the person with AIDS has been rejected by family or friends and has withdrawn from normal social relationships.

OTHER COUNSELLING ISSUES

HIV infection often highlights other issues critical to quality of life.

■ SOCIAL ISSUES

Environmental and social pressures, such as loss of income, discrimination, social stigma (if the diagnosis becomes commonly known), relationship changes, and changing require-

ments for sexual expression, may contribute to post-diagnosis psychosocial problems. The patient's perception of the level and adequacy of social support is of vital concern and may become a source of pressure or frustration.

■ MEDICAL MANAGEMENT

The type of counselling support usually required and requested is often influenced by the person's experiences with other forms of health care related to the infection. Where the patient or loved ones feel that medical management has been insensitive or has been conducted without sufficient regard for privacy, counselling may be all the more necessary in order to persuade the patient to comply with recommended treatment programmes.

Counselling may also involve helping the person gain access to appropriate medical care and participate more fully in decisions about treatment. If there is any evidence of neurological disease, day-to-day management of the patient may be complicated, and special emphasis will have to be given to counselling of family, loved ones and care-givers.

At this stage, counsellors may need to co-ordinate a range of health and social services. Many people with HIV will also seek care from traditional or complementary healers: this may first be revealed in the context of supportive counselling. Where this is the case, counselling can help patients talk about their perceived needs and their satisfaction with these care-givers.

■ COUNSELLING AFTER AN EQUIVOCAL TEST RESULT

If the result of the HIV test is equivocal, the counsellor has particular responsibilities to provide information. In particular, there are two main issues to cover:

1. The person should be given a clear explanation of what such a test result means. The first test most commonly used on all samples is the enzyme-linked immunosorbent assay (ELISA). The ELISA has levels of sensitivity and specificity approaching 99.5%, meaning that a non-reactive result with this technique can be regarded as a definite indicator that the person is not infected, except for tests during the "window period". However, a reactive result suggests the possibility of HIV infection. The usual procedure in that case is to perform a second test using the ELISA; if the second ELISA test is also positive, supplementary testing is required, for example using the Western blot test. The results of such supplementary testing may be positive (indicating HIV infection), negative (indicating no infection), or indeterminate (giving an equivocal result). Where the result of supplementary testing is indeterminate (which may be the case in up to 10% of samples in some areas), the reason may be one of the following:
 - the test is cross-reacting with a non-HIV protein (usually, the protein reaction is simulating the reaction associated with p24 core protein).
 - there has been insufficient time for full seroconversion to occur since the person was exposed to HIV.

When presented with an indeterminate result, the options are to:

- Use other methods to try to achieve a reliable result. Combinations of laboratory techniques may be needed to exclude false-positive results.
 - Refrain from further testing for the moment. If the result is indeterminate and further testing is not possible, the person cannot reliably be considered HIV-infected. The counsellor should advise the person to come for repeat testing in three months. It is important to remember that the risk of finding a false-positive result in the ELISA is higher in areas with a low level of HIV infection than where the background rates of HIV infection are high. Thus, in places where there are many people with AIDS in the community, it is more likely that a reactive or positive result in the ELISA is accurate.
2. Prevention and support while waiting for an unequivocal result. The period of uncertainty following an equivocal test result may be three months or longer. It is important for counsellors to stress essential messages related to prevention of transmission, regarding sexual activity, drug use, donation of body fluids or tissues, and breast-feeding. Just as importantly, however, the uncertainties associated with this period may lead to acute and severe psychosocial difficulties, and the counsellor must be prepared to assess and manage such issues or to make appropriate referrals, if possible.

■ SELF-HELP GROUPS

In some places, the counsellor can call on peer-support or self-help groups, part of a growing network of non-governmental AIDS service organizations (ASOs). These can provide a type of personal care and peer-based psychosocial support that may not be available elsewhere. If no such groups exist, the counsellor may be able to encourage clients to form one. Where this is not possible, the counsellor may be able to put clients in touch with each other on an individual basis, at the discretion of the counsellor and with the express consent of the individuals and on a confidential basis. Matters that are often best dealt with through self-help groups, but which need to be raised by the counsellor in any event, include the following:

1. Learning to live with HIV infection. Self-help groups are often in a good position to address this because many of the people involved may have already gone through the process. They can describe the medical and psychological problems they have experienced and the interventions they have found most useful.
2. Helping care-givers and loved ones handle the pressures of living with sick or distressed people on a daily basis, especially where this involves managing bleeding, vomiting, incontinence, disposal of dressings, etc., and advice regarding sexual relations.
3. Reducing stress and avoiding conflict. The need to overcome anxiety, depression and other possible challenges to sustained health has to be handled on a practical, “I did this...” basis.

4. Deciding how best to talk about HIV/AIDS. Fears of disclosing a diagnosis of HIV or AIDS to loved ones, family, friends, and colleagues need to be examined and solutions sought, including what to say, to whom, when, and how.
5. Dealing with feelings of loneliness, depression, and powerlessness. Self-help or peer-support groups can provide help and mutual support. Advice from people who have themselves gone through such feelings may be more meaningful than advice provided on a second-hand or theoretical basis.
6. Managing the implications of adopting and maintaining safer sex behaviour. Peer-support groups can organize discussions and training that can be far more relevant than advice provided through formal health care programmes. Peer commitment to safer sex also helps make these practices socially acceptable, attractive and thus sustainable.

The essence of peer-support group activity is a feeling of group cohesion, a sharing of experiences and mutually supportive activities. At times, such groups may need help in getting started and in maintaining regular activities. They will all look to the counsellor for help in identifying medical services and care-givers. Providing legal advice and, in some cases, financial support may also become issues in establishing such groups and giving them operational legitimacy.

Appendix 2:

CONSENSUS STATEMENT FROM THE WHO/UNICEF CONSULTATION ON HIV TRANSMISSION AND BREAST-FEEDING

In view of the importance of breast milk and breast-feeding for the health of infants and young children, the increasing prevalence of human immunodeficiency virus (HIV) infection around the world, and recent data concerning HIV transmission through breast milk, a Consultation on HIV Transmission and Breast-feeding was held by WHO and UNICEF from 30 April to 1 May 1992. Its purpose was to review currently available information on the risk of HIV transmission through breast milk and to make recommendations on breast-feeding.

Based on the various studies conducted to date, roughly one-third of the babies born worldwide to HIV-infected women become infected themselves, with this rate varying widely in different populations. Much of this mother-to-infant transmission occurs during pregnancy and delivery, and recent data confirm that some occurs through breast-feeding. However, the large majority of babies breast-fed by HIV-infected mothers do not become infected through breast milk. Recent evidence suggests that the risk of HIV transmission through breast-feeding (a) is substantial among women who become infected during the breast-feeding period, and (b) is lower among women already infected at the time of delivery. However, further research is needed to quantify the risk of HIV transmission through breast-feeding and determine the associated risk factors in both of these circumstances.

Studies continue to show that breast-feeding saves lives. It provides impressive nutritional, immunological, psychosocial and child-spacing benefits. Breast-feeding helps protect children from dying of diarrhoeal diseases, pneumonia and other infections. For example, artificial or inappropriate feeding is a major contributing factor in the 1.5 million annual infant deaths from diarrhoeal diseases. Moreover, breast-feeding can prolong the interval between births and thus make a further contribution to child survival, as well as enhancing maternal health.

It is therefore important that the baby's risk of HIV infection through breast-feeding be weighed against its risk of dying of other causes if it is denied breast-feeding. In each country, specific guidelines should be developed to facilitate the assessment of the circumstances of the individual woman.

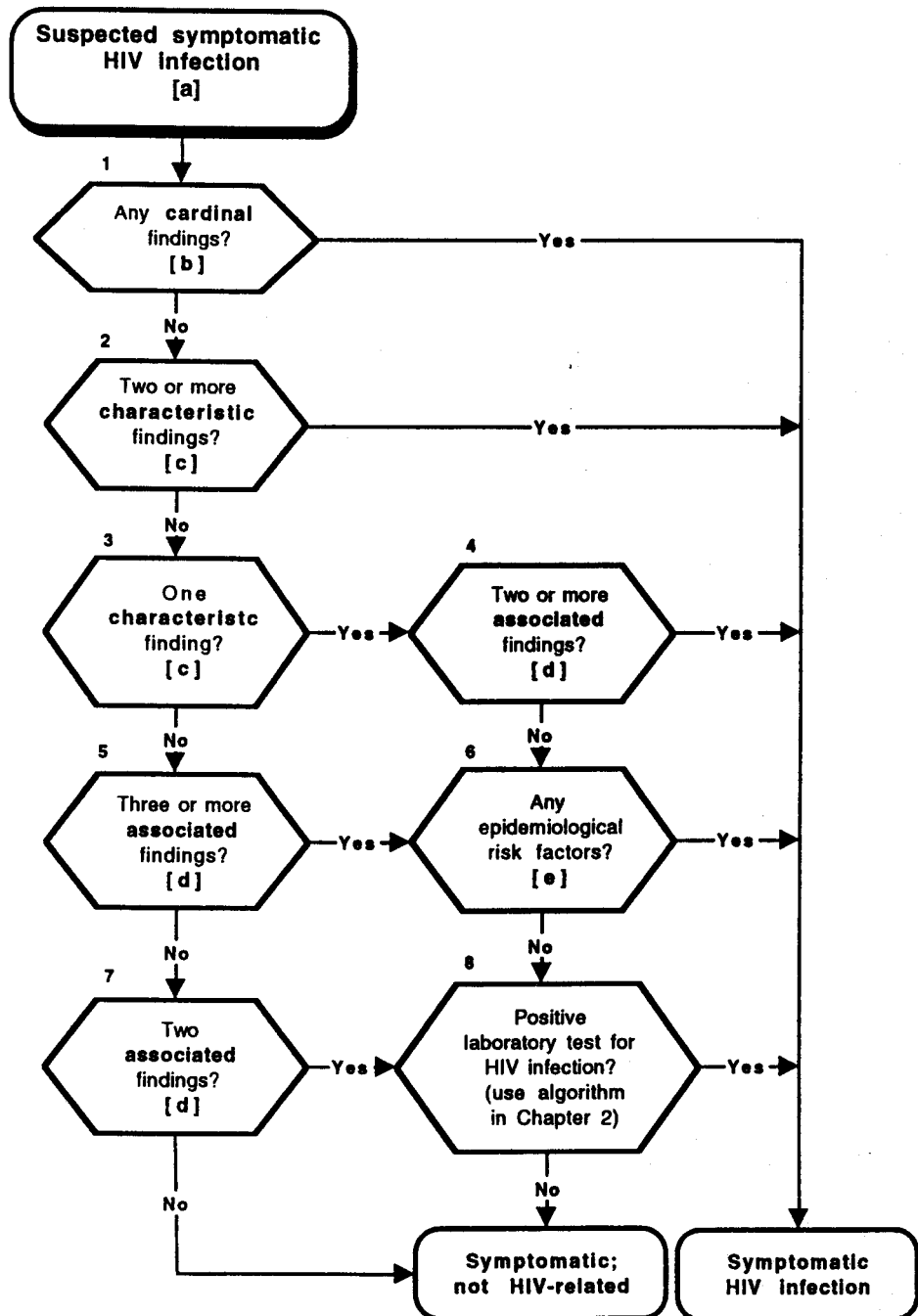
■ RECOMMENDATIONS

1. In all populations, irrespective of HIV infection rates, breast-feeding should continue to be protected, promoted and supported.
2. Where the primary causes of infant deaths are infectious diseases and malnutrition, infants who are not breast-fed run a particularly high risk of dying from these conditions. In these settings, breast-feeding should remain the standard advice to pregnant women, including those who are known to be HIV-infected, because their baby's risk of becoming infected through breast milk is likely to be lower than its risk of dying of other causes if deprived of breast-feeding. The higher a baby's risk of dying during infancy, the more protective breast-feeding is and the more important it is that the mother be advised to breast-feed. Women living in these settings whose particular circumstances would make alternative feeding an appropriate option might wish to know their HIV status to help guide their decision about breast-feeding. In such cases, voluntary and confidential HIV testing accompanied in all cases by pre- and post-test counselling could be made available where feasible and affordable.
3. In settings where infectious diseases are not the primary causes of death during infancy, pregnant women known to be infected with HIV should be advised not to breast-feed but to use a safe feeding alternative for their babies. Women whose infection status is unknown should be advised to breast-feed. In these settings, where feasible and affordable, voluntary and confidential HIV testing should be made available to women along with pre- and post-test counselling, and they should be advised to seek such testing before delivery.
4. When a baby is to be artificially fed, the choice of substitute feeding method and product should not be influenced by commercial pressures. Companies are called on to respect this principle in keeping with the International Code of Marketing of Breast-milk Substitutes and all relevant World Health Assembly resolutions. It is essential that all countries give effect to the principles and aim of the International Code. If donor milk is to be used, it must first be pasteurized and, where possible, donors should be tested for HIV. When wet-nursing is the chosen alternative, care should be taken to select a wet-nurse who is at low risk of HIV infection and, where possible, known to be HIV-negative.
5. HIV-infected women and men have broad concerns, including maintaining their own health and well-being, managing their economic affairs, and making future provision for their children, and therefore require counselling and guidance on a number of important issues. Specific issues to be covered by counselling include infant feeding practices, the risk of HIV transmission to the offspring if the woman becomes pregnant, and the transmission risk from or to others through sexual intercourse or blood. All HIV-infected adults who wish to avoid childbearing should have ready access to family planning information and services.
6. In all countries, the first and overriding priority in preventing HIV transmission from mother to infant is to prevent women of childbearing age from becoming infected with

HIV in the first place. Priority activities are (a) educating both women and men about how to avoid HIV infection for their own sake and that of their future children; (b) ensuring their ready access to condoms; (c) providing prevention and appropriate care for sexually transmitted diseases, which increase the risk of HIV transmission; and (d) otherwise supporting women in their efforts to remain uninfected.

Appendix 3:

RECOGNITION OF SYMPTOMATIC HIV INFECTION



■ ANNOTATIONS

[a] The aim of this appendix is to help the health care provider to recognize the patient with symptomatic HIV infection, as an aid to clinical management.

Although symptomatic HIV infection can be recognized without laboratory testing, wherever HIV testing is available and affordable it can be used to substantiate the clinical suspicion.

[b] Cardinal findings:

- Kaposi sarcoma¹
- *Pneumocystis carinii* pneumonia
- *Toxoplasma* encephalitis
- oesophageal candidiasis
- cytomegalovirus retinitis.

[c] Characteristic findings:²

- oral thrush (in patient not taking antibiotics)
- hairy leukoplakia
- cryptococcal meningitis (may be a cardinal finding in Africa)
- miliary, extrapulmonary or noncavitary pulmonary tuberculosis³
- herpes zoster, present or past, particularly multidermatomal, age < 50 years
- severe prurigo
- Kaposi sarcoma (other than as cardinal finding)
- high-grade B-cell extranodal lymphoma.

[d] Associated findings:²

- weight loss (recent, unexplained) of more than 10% of baseline body weight, if assessable³
- fever (continuous or intermittent) for more than 1 month³
- diarrhoea (continuous or intermittent) for more than 1 month
- ulcers (genital or perianal) for more than 1 month
- cough for more than 1 month³
- neurological complaints or findings⁴

¹ Kaposi sarcoma is a cardinal finding only when: (1) intraoral lesions are present; (2) lesions are generalized; or (3) lesions are rapidly progressive or invasive.

² If no other obvious cause of immunosuppression is present.

³ The combination of fever, weight loss and cough is characteristic of both tuberculosis and AIDS.

⁴ Neurological complaints or findings associated with HIV infection include seizures (especially focal), peripheral neuropathy (motor or sensory), focal central motor or sensory deficits, dementia, and progressively worsening headache.

- generalized lymphadenopathy (extrainguinal)
- drug reactions (previously not seen), e.g. to thiacetazone or sulfonamides
- skin infections (severe or recurrent), e.g. warts, dermatophytes, folliculitis.

[e] Epidemiological risk factors:

1. Present or past high-risk behaviour:
 - drug injecting
 - multiple sex partners
 - sex partner(s) with known AIDS or HIV infection
 - sex partner(s) with known epidemiological risk factor or from an area with a high prevalence of HIV infection
 - males having penetrative sexual intercourse with males.
2. Recent history of genital ulcer disease.
3. History of transfusion after 1975 of unscreened blood, plasma or clotting factor; or (even if screened) from an area with a high prevalence of HIV infection.
4. History of scarification, tattooing, ear piercing or circumcision using non-sterile instruments.



00040681