



The Basic HIV Test Counselor Skills Training

Pre-Training Learning Packet

**AIDS Health Project
University of California, San Francisco**

In collaboration with the California Department of Public Health, State Office of AIDS,
HIV Education and Prevention Services Branch

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Section 1: The History of HIV Counseling and Testing

THE NEW DISEASE

In 1981, doctors in New York and Los Angeles reported to the Centers for Disease Control and Prevention that otherwise healthy gay men were developing severe immune system problems, including rare types of pneumonia and a skin cancer called Karposi's sarcoma.

- At that time, the biological cause of infection (the Human Immunodeficiency Virus or HIV) was not yet known.
- The earliest cases of the disease were nearly all diagnosed among gay men, so it was originally called Gay-Related Immunodeficiency Disease (GRID). Injection drug users, people with the blood disease hemophilia, and heterosexuals were soon identified as having the new immune system disease as well. The name was changed to Acquired Immune Deficiency Syndrome (AIDS).
- In 1981, there were only 227 U.S. cases of AIDS reported. Eighty-five percent of U.S. cases that year were diagnosed among gay men. Few suspected that HIV would become a world-wide epidemic.

THE HIV TEST

- In 1984, scientists identified HIV as the virus that causes AIDS.
- By 1985, a simple blood test was available that could detect HIV infection. This was the HIV antibody test, originally developed to protect the blood supply.
- In 1985, the State of California established the first Alternative Test Sites (ATS) providing free, voluntary and anonymous antibody testing to anyone interested.

HIV AND AIDS TODAY

AIDS cases have now been reported in most countries of the world, with devastating concentrations of disease in Africa and in parts of Asia.

- Worldwide, over 42 million people are believed to be carrying the virus. In the U.S., while particular populations have experienced increases or decreases, the overall incidence of AIDS has decreased.
- In California, men who have sex with men continue to account for the majority of diagnoses, but women now account for about 20 percent of the AIDS cases in the U.S.
- National statistics also reflect the disproportionate impact of AIDS on different racial and ethnic groups. According to the CDC's 2005 statistics, Blacks comprise 42.0 percent of people diagnosed with AIDS, Whites comprise 41 percent, Latinos comprise 16.0 percent, Asian/Pacific Islanders and American Indian/Alaska Natives together comprise about 1 percent.

THE ROLE OF COUNSELING IN THE CHANGING HIV EPIDEMIC

The Office of AIDS of the California Department of Public Health (CDPH/OA) develops programs and resources to help people learn their HIV status, to prevent future infection, and to support the health and well-being of people diagnosed with HIV. (Note that once a person comes to a counseling and testing site, we refer to that person as a “client.”)

- For clients diagnosed with HIV, the Office of AIDS funds services that span a continuum of care to help people cope with the medical, psychological and social needs related to living with the virus.
- For people who want to know if they have HIV, the Office of AIDS offers free HIV tests, sometimes with counseling and sometimes without counseling.
- For people whose HIV risk is significant, simply being given an HIV test result is not enough to prevent future infection. For these clients, the Office of AIDS couples the HIV test with behavior change counseling, a mix of HIV education, exploration of client motivations, and realistic support for a client’s prevention efforts.
- Some people have very little chance of exposure to HIV, yet are concerned enough to seek an HIV test. For these clients, the Office of AIDS couples testing with HIV-related health education, without counseling.
- The Basic HIV Counselor Skills Training trains you to work with each of these types of clients, but focuses primarily on working with people who have a significant chance of contracting HIV.
- For more information about the spectrum of services offered to both people living with HIV and people at risk for infection, visit the California Department of Public Health, Office of AIDS web site at: www.cdph.ca.gov/programs/aids.

PREPARATION FOR YOUR ROLE AS A COUNSELOR

This Pre-Training Learning Packet begins the process of your training by exploring information and counseling concepts essential to HIV prevention. Reading through this packet is a requirement for attending the Basic HIV Counselor Skills Training. It may seem like a lot, but the effort to review it now will help you get the most out of the face-to-face training and become the best counselor you can be.

Section 2: HIV and the Immune System

HIV counselors do not need to be immune system experts, but they do need to know basic information about HIV, AIDS and how the immune system operates.

IT STARTS WITH A VIRUS

- HIV (Human Immunodeficiency Virus) is a virus that invades CD4+ cells of the human immune system. Once inside a CD4+ cell, the virus uses the cell to create more virus instead of more cells. In the process, HIV destroys the original cell.

WHAT IS AN ANTIBODY?

- In response to HIV, the body's immune system produces specialized proteins called antibodies. Antibodies help stop or slow down the progress of an infection by removing or destroying the infection.
- The HIV antibody test looks for these antibodies as an indication of HIV infection. We use antibody tests to diagnose HIV, because antibody tests are less expensive than tests that look for the virus itself and, in the case of the rapid HIV antibody test, can deliver a result the same day the sample is collected.
- HIV antibodies fight the disease for a period of time, but eventually weaken. The virus, which had been controlled for a while, begins to spread to new cells rapidly.

WHAT MAKES HIV DIFFERENT FROM OTHER VIRUSES?

- As more and more immune system cells are disabled, the body has a harder time fighting off both HIV and other illnesses.
- Illnesses that would not affect people with healthy immune systems take this opportunity to establish infection. They are called "opportunistic infections."

WHAT IS AIDS (ACQUIRED IMMUNODEFICIENCY SYNDROME)?

- Without medication, most people with HIV develop immune system problems after they have had the infection for many years.
- The earliest signs of impairment usually appear in lab tests of the immune system, often while the individual feels healthy. For example, a low CD4+ cell count shows that CD4+ cells have been destroyed by HIV. A high viral load indicates that the amount of virus in the blood has increased.
- When a person with HIV contracts one of a range of specific opportunistic infections, for example, *Pneumocystis carinii* pneumonia, or when a CD4+ cell count falls below 200, a doctor diagnoses AIDS. It takes an average of six to eight years for a person to develop symptoms and an average of 10 years to develop a disease that indicates an AIDS diagnosis.

The Spectrum Of HIV Disease

Not every person with HIV experiences the same progression toward AIDS. For example, people with HIV may have severe symptoms and an AIDS diagnosis; they may have mild symptoms and no AIDS diagnosis; or they may have no symptoms at all.

- These different manifestations of HIV are often referred to as “the spectrum of HIV disease.”
- Today, medications can and often do delay or completely prevent the progression of HIV to AIDS. With proper medical care, many people with HIV are living long and healthy lives.

Section 3: How HIV Is Transmitted

WHAT BODY FLUIDS CAN TRANSMIT HIV?

- Five human body fluids can transmit HIV: blood; semen; pre-ejaculate (also called precum); vaginal fluids (including cervical secretions); and breast milk.
- HIV can also live in the fluids around organs and joints. These fluids concern health care providers who might come into contact with them when providing care, but do not usually present a risk to others.
- Other fluids (tears, saliva, sweat, sputum, nasal secretion, urine, and feces) are not able to transmit HIV. These substances only present an HIV risk if visible blood is present.
- HIV cannot survive long outside the dark, warm, moist environment of the human body. “Casual contact” (daily contact that does not involve taking any of the five fluids into your body) does not present an HIV transmission risk.

MODES OF TRANSMISSION

- For HIV to pass from one person to another, one of the five fluids containing HIV must enter the bloodstream of an uninfected person.
- Human skin is excellent at protecting against HIV. HIV can only get into the body when the skin is torn or when HIV passes through mucous membranes—wet, soft skin found in the rectum, vagina, and mouth.

This can happen in four ways, called modes of transmission for HIV.

1. Sexual transmission

- ▲ During unprotected anal and vaginal intercourse, HIV-infected fluids can enter the bloodstream through mucous membranes.
- ▲ “Unprotected” means without the use of a latex or polyurethane barrier, such as a condom or dental dam.
- ▲ The State Office of AIDS reports that the risk of HIV transmission through unprotected oral sex is extremely small. Open oral sores or bleeding gums may increase the risk of transmission.

2. Needle and syringe sharing

- ▲ Shared syringes (used for injecting recreational drugs, steroids, hormones, vitamins, insulin or other medications), and shared needles (for tattooing, body piercing, folk healing, or ritual) can transmit infected blood or tissue from one person to another.
- ▲ Other equipment used to prepare drugs, such as spoons, cotton strainers or water used to flush and clean a syringe may also carry HIV-infected blood or tissue.

3. Perinatal transmission (from mother to fetus or newborn)

- ▲ A pregnant woman with HIV can pass the virus to her fetus during pregnancy or delivery.
- ▲ Newborns can also become infected through breast-feeding—particularly if cracked nipples allow blood to pass along with breast milk to the newborn.

4. Blood contact through medical care or occupational exposure

- ▲ This mode of transmission is primarily a concern for health care and emergency workers.
- ▲ Since 1985, the blood supply has been screened for HIV, and the risk of contracting HIV through a blood transfusion in the United States is now very small. There has never been any risk of contracting HIV while donating blood.

RISK BEHAVIOR, NOT “RISK GROUP”

- In the early days of the HIV epidemic, scientists and educators often referred to “risk groups.” These were the groups of people who appeared to be at highest risk of developing AIDS, especially gay men and injection drug users. Using the term “risk group” had a negative effect because those who did not consider themselves to be a part of a particular “risk group” did not consider themselves to be at risk for HIV. In addition, those who were a part of a “risk group” were stigmatized.
- The assessment system devised by the State Office of AIDS uses data based on the relationship between certain behaviors and increased HIV transmission to identify populations most at risk, that is, “risk groups.” This use of data to make broad generalizations helps the State Office of AIDS develop tools and approaches to target limited HIV prevention funding to people who need it most.
- At the same time, when working with individuals, it is not helpful to use the term “risk group.” For example, some men do not identify as gay, but have received semen or pre-ejaculate into their bodies from other men. Therefore, during counseling or information delivery, we talk about “behaviors that are most likely lead to HIV transmission” or “risk behaviors” instead.

Section 4: Counseling Concepts

Counselors clarify information about HIV and support clients in practicing behaviors that reduce the risk of HIV transmission. To do this, counselors must be familiar with the counseling concepts used in HIV prevention.

RELATIVE RISK

- Different behaviors pose different risks for HIV transmission. This concept is often referred to as the “hierarchy of risk.”
- For example, semen has a better chance of entering the bloodstream through the rectum than through the vagina, and much less of a chance through the mouth. (The rectum has one layer of very absorbent skin compared to two self-lubricating layers in the vagina and three layers in the mouth.) Anal sex that allows infected fluids into the rectum is considered a “higher risk” behavior than vaginal sex; the relative risk is higher.
- Keep in mind that HIV can only be transmitted between people when one of them already carries the virus. Unprotected sex or shared injection between people who know for sure they do not carry the virus is not an HIV risk.

CLIENT-CENTERED COUNSELING

- Client-centered counseling is the single most important skill you will develop to work with your clients.
- This style of counseling involves an interactive, highly personalized exchange between client and counselor. There is no preconceived set of points or information to convey. Rather, counselors follow the client’s lead, exploring the client’s concerns about HIV testing and prevention.
- The bulk of the Basic HIV Counselor Skills Training focuses on client-centered counseling through demonstrations and role-play practice.

HARM REDUCTION

- Harm reduction is an approach that encourages clients to envision reasonable and achievable goals for behavior change. Instead of feeling frustrated and discouraged by their failure to give up an HIV-risk behavior “cold turkey,” clients are praised for taking small steps toward healthier behaviors.
- For example, in talking with a counselor, a client may realize he wants to reduce his HIV risk by limiting unprotected anal sex to one partner, adding lubrication to lessen tears during anal sex, or being the insertive rather than the receptive partner. These steps may not eliminate HIV risk, but they will likely reduce the chance of infection. Also, they may be easier to achieve for the client than total elimination of HIV risk.
- When people experience acknowledgement for one small success, they often become more motivated and confident in the pursuit of further change.

THE STAGES OF CHANGE

- HIV prevention relies on psychological research about how people change behavior. The model used is referred to as the Stages of Change (derived from the Transtheoretical Model of Behavior Change).*
- The Stages of Change describe five stages that people go through in relationship to changing a behavior:
 1. **Precontemplative** (not thinking about change): Individuals in this stage have no intentions to change their behavior. They are unaware of HIV risk or deny the adverse outcome that could happen to them. Sometimes clients in this stage are aware of the risk but have made a decision not to change behavior, perhaps because of personal safety or other survival issues. Individuals do not want help finding solutions because they do not really see a problem.
 2. **Contemplative** (thinking about change): People in this stage have formed intentions to change, but have no specific plans to change in the near future. This stage can last for long periods of time.
 3. **Ready for Action** (preparing for change): Someone in this stage plans to change their behavior in the immediate future and may have taken some initial actions.
 4. **Action** (taking steps to change): People in this stage have begun changing their behavior, but the behavior change is relatively recent. This is the most demanding stage with the most visible evidence of change. Relapse to an earlier stage is common.
 5. **Maintenance** (sustaining a change over a long period of time): Someone in this stage has maintained consistent behavior change for an extended period of time and the newly acquired behavior has become a part of their lives.

PRINCIPLES OF CHANGE

- **This is called a Transtheoretical Model**, because it was developed after a review of many different psychological theories of change. Researchers applied it in literally hundreds of studies of human behavior.
- **A person's relationship to changing a behavior is dynamic**: it changes over time. In one session, a client might feel eager to plan how to use condoms. In other words, the client is in the Ready for Action stage. The next week, that same client might hold back from using condoms, unsure about how a new partner will react. In other words, the client is now in the Contemplative stage.
- **The stages of change are not linear**. People tend to move fluidly back and forth between stages. The pace of movement through these stages may vary greatly. For example, some individuals may remain in the contemplative stage for months—even years. Also, once a person initiates a behavior change, that person is naturally vulnerable to relapse at any time.

* Adapted from Prochaska JO, DiClemente CC, Norcross JC. In search of how people change: Applications to addictive behaviors. *American Psychologist*. 1992; 47(9):1102-1114.

- **Relapse (or recycling)** to an earlier stage is an important function of the stages of change and illustrates how this model is not a linear process. People may relapse/recycle back to any stage at any time, depending on the unique context within which they find themselves. During counseling, it is helpful to explore what the relapse means to the client and the context within which it occurred. In many instances, relapse is a learning opportunity to revisit the intended change and explore what did and did not work.
- **People are in different stages for different behaviors.** We are all in the process of changing many different behaviors at the same time. Staging a person's behavior with this model is very specific; it describes a person's relationship to changing a particular behavior (not a person's relationship to change in general). For example, it is very useful to recognize that a client who does not want to use condoms is precontemplative about condom use. It would be ineffective, however, to think of this person as simply precontemplative about all behavior change that reduces HIV risk.
- **Because most people make changes in behavior incrementally**—a little at a time—it is not generally realistic for HIV counselors to expect someone to fully change a long-standing behavior after a single intervention. This model helps a counselor first think about a client's stage in relation to a specific behavior and then focus on trying to ease that person towards the next stage.

STAGES AND INTERVENTIONS

- If a counselor can stage a client's current relationship to change, this helps with interventions that can facilitate the client's decision making about HIV prevention.
- Different interventions work better at different stages. One of the most powerful aspects of using this model is that different kinds of interventions tend to work better with different people, depending on what stage they are in.

Stages of Change	Characteristics	Interventions
Precontemplative	Doesn't see it. No! Unaware Defensiveness Resistance	Help them think about it Engagement Trust building Get a reaction, either cognitive or emotional
Contemplative	Maybe, but . . . Ambivalence, unsure Problem awareness Openness to information	Explore pros and cons Help explore ambivalence Explore barriers Pass information
Ready for Action (Preparation)	Decided, Yes! Ready to do Experimentation Coaching; teach skills	Solve it! Encourage, empower, support Emphasize options Focus on developing a step
Action	Doing it! Practice new behaviors Avoiding old behaviors	Help them do it! Support, praise, recognition Focus on rewards Follow-up, reach out Problem-solving
Maintenance	Living it! Sustaining behavior	Live it! Reinforcement Support, praise, recognition Find other supports Become a role model to others

TALKING ABOUT CHANGE

- Through role plays and group discussion, the Basic HIV Counselor Skills Training applies the Stages of Change and explores other counseling concepts in more detail in order to help you think about and practice HIV prevention counseling.
- Until then, keep in mind a few guiding principles for change, adapted from the work of the Harm Reduction Training Institute:
 - ▲ Clients are competent to make choices and changes in their lives.
 - ▲ Change cannot be imposed.
 - ▲ Reward and encouragement are more effective than punishment and judgment.
 - ▲ Change depends on the pros of change outweighing the cons.

Section 5: Preventing HIV

All test counselors should be familiar with the basic steps a person can take to prevent or lessen the chance of HIV transmission.

SEXUAL TRANSMISSION

- People can prevent HIV infection by not taking blood, semen, pre-ejaculate or vaginal secretions into the mouth, vagina or anus. Contact with the eyes, nostrils and open cuts or “weeping” wounds must also be avoided.
- Sexual partners should avoid taking breast milk into their bodies as well, though breast milk is more of an HIV risk for infants.
- The presence of another sexually transmitted disease (STD) increases the risk of HIV transmission.
- HIV risk can be lowered through “safer sex.” Safer sex ranges from activities that completely eliminate HIV risk—like massaging or phone sex—to activities that reduce HIV risk—like oral sex in place of anal sex. Condoms, when used properly, are another highly effective method of “safer sex” that can nearly eliminate the risk of HIV infection during vaginal and anal sex.
- Based on existing research, the risk of HIV transmission from unprotected oral sex is extremely low. If unprotected oral sex is too great a risk for a client, the client might consider using a barrier, not allowing partners to ejaculate into the mouth, or licking the genitals without letting fluids enter the body.
- Contracting HIV is less likely for an insertive partner than for a receptive partner. However, an insertive partner can still become infected. The presence of STDs (for both partners), being uncircumcised (for the insertive partner), or having a high HIV viral load (for the receptive partner) can each increase the chance of the insertive partner contracting HIV.
- For more information about safer sex practices to prevent HIV transmission during sex, refer to *HIV Prevention and Sexual Behavior* in the Online Resources.

SHARED NEEDLES AND INJECTION EQUIPMENT

- To completely eliminate HIV risk, injectors must avoid sharing needles or other equipment exposed to HIV-infected blood.
- Used equipment can be disposed and sterile equipment can be accessed at needle exchanges and some pharmacies, thereby reducing the risk of spreading HIV among injecting partners.
- If syringe access and disposal is not available through these sources, cleaning equipment with bleach can lower HIV risk. Hard liquor, rubbing alcohol and hydrogen peroxide may also lower the chance of infection. If these are not available, soapy water may flush out some residue and reduce the risk of transmission.

- Cleaning injection equipment does not guarantee that HIV is deactivated. However, when injection equipment is cleaned, there is much less risk for HIV transmission. (Cleaning also has yet to be proven to deactivate hepatitis C, another blood-borne virus that is more infectious in blood than HIV. Section 6: Hepatitis C Virus describes hepatitis C in more detail.)
- For more information about the prevention of HIV and hepatitis C during injection drug use, see HIV Prevention and Substance Use in the Online Resources. Information about needle exchange programs can be accessed through the California HIV/AIDS Information Line at 800-367-AIDS.

PERINATAL TRANSMISSION (FROM MOTHER TO FETUS OR NEWBORN)

- For women living with HIV, the risk of having a baby with HIV is about one in four (25 percent).
- Medical treatment during labor or birth reduces this number to as low as 9 percent. Along with prenatal care, the rate has been as low as 1 in 100 (or 0.9 percent).
- These are sensitive issues. Sensitivity and referrals are often the most effective intervention. Remember, however, that the choice to conceive, carry or abort a pregnancy always belongs to the individual woman, not with the HIV counselor.
- For additional information, see *Mother-to-Child HIV Transmission (Perinatal Transmission)* in the Online Resources.

BLOOD CONTACT

- Universal precautions to prevent HIV transmission include wearing gloves, goggles, face masks, and protective clothing when performing certain procedures involving blood; disposing of needles and other sharp equipment; and washing hands after patient contact. These procedures should be followed with every patient, whether or not infection with HIV is known or suspected.
- Precautions should be taken with blood and internal body fluids containing blood, such as those surrounding organs and joints.
- The risk of receiving HIV through a blood transfusion is very low. However, some people arrange to donate and store their own blood before surgery.
- Wearing special protective gear is necessary only when working with blood. Casual contact with clients does not require wearing protective gear.
- For additional information about prevention of HIV from blood exposure, see *Universal Precautions* in the Online Resources.

BIOMEDICAL APPROACHES TO PREVENTION

For those whose prevention intervention fails, for example, the condom breaks, or who believe they have had an exposure that is very likely to lead to transmission, studies have shown that antiviral medications can stop infection after that exposure. Studies are also underway to determine whether taking HIV antiviral medications before exposure might stop transmission even when, for example, a person does not use condoms or clean needles. These approaches are called PEP and PREP:

Post-Exposure Prophylaxis (PEP)

- ▲ If a person has been exposed to HIV (for example, shared injection equipment or had a condom break) within the past 72 hours, that person may be able to access medications to try to keep the exposure from leading to infection.
- ▲ A client may access PEP medications through special programs or research projects, or through their private physicians. For more information, check out www.ucsf.edu/hivcntr or call 888-HIV-4911.

Pre-Exposure Prophylaxis (PREP)

- ▲ Researchers are also studying whether medication administered prior to exposure to HIV can prevent infection.
- ▲ Pre-exposure prophylaxis (PREP) may be a particularly helpful strategy for people who cannot negotiate other prevention methods. Counselors should convey that research has yet to demonstrate which medications and dosages are effective, if at all.

Section 6: Hepatitis C Virus

People who have shared injection drug equipment are at risk for contracting and transmitting other viruses in addition to HIV, including the hepatitis C virus (HCV).

- A demonstration project funded by the State Office of AIDS in 2003 found that HIV testing rates among injection drug users nearly doubled when HIV and hepatitis C counseling and testing were offered together.
- Many counties now offer counseling and testing for HCV alongside HIV counseling and testing.

WHAT IS HEPATITIS C?

- Hepatitis C is a disease caused by hepatitis C virus, which infects the liver and potentially leads to cirrhosis (scarring) and liver cancers, among other conditions.
- Between 15 percent and 40 percent of people who get HCV are able to fight off the virus within six months. Between 60 percent and 85 percent of patients cannot get rid of the virus and develop a long-term, or chronic, HCV infection.
- People with chronic HCV infection will have the disease all of their lives unless they are successfully treated with antiviral medicines. These drugs work for some, but not all patients.
- In California, HCV infection affects approximately 600,000 people, about two percent of population.

SYMPTOMS OF HEPATITIS C INFECTION

- HCV infects the liver, causing swelling and the death of liver cells and tissue, which may lead to cirrhosis of the liver and, in rare cases, to liver cancer.
- Only about 20 percent to 30 percent of people with HCV experience symptoms (jaundice, fatigue, abdominal bloating, and flu-like illness) in the first six months of infection. As a result, most infections go undiagnosed until liver disease develops 20 years to 30 years later.

THE HEPATITIS C AND HIV CONNECTION

- Both HIV and HCV are transmitted by exposure to infected blood.
- While cleaning injection equipment with bleach may help reduce the risk of HIV transmission, bleach has not been proven effective in reducing the risk of HCV infection. (See *HIV Prevention and Substance Use* in the Online Resources.)
- It is estimated that 50 percent to 80 percent of injection drug users who are HIV-positive also have HCV infection.
- Co-infection with both HIV and HCV may result in a faster progression of hepatitis C toward liver damage and can compromise the kinds of medications used to treat HIV.

- Liver disease from HCV is now the leading non-AIDS cause of death in the United States in individuals co-infected with HIV.
- HCV is regarded as an opportunistic infection in people with HIV infection, although it is not considered an AIDS-defining illness.

MODES OF TRANSMISSION FOR HEPATITIS C VIRUS

- People can get HCV if the blood of someone with the virus gets into the bloodstream of someone who does not have the virus.
- The most common cause of transmission is the sharing of needles and other equipment used to inject drugs.
- Less common causes of transmission include: sharing a razor, toothbrush, or nail clipper with an infected person; accidental exposure to infected blood among health care or public safety workers; exposure to non-professional or amateur tattooing or body-piercing instruments that have not been autoclave sterilized; and blood exposure during unprotected anal sex or vaginal sex. In rare cases, hepatitis C can be spread from an infected mother to her child at birth. It cannot be spread by breastfeeding.
- Since 1992, all donated blood is tested for HCV, so there is almost no risk of getting the virus from blood transfusions.

PREVENTING HEPATITIS C INFECTION

- There is no vaccine to prevent HCV infection, so the only way to avoid the disease is to avoid exposure to infected blood.
- Infection can be avoided by not sharing injection equipment. Syringe disposal and access programs—where people can discard old injection equipment and receive new equipment—can prevent both hepatitis C infection and HIV infection. See *HIV Prevention and Substance Use* in the Online Resources.
- Other modes of transmission can be prevented by using universal precautions when exposed to blood at work, using protection during sex that could involve blood exposure, and not sharing personal hygiene items that could carry blood.

HEPATITIS C TESTING

- HCV is screened for by an antibody test, and current HCV infection is confirmed by a viral load test. Both tests rely on blood samples from clients.
- Like HIV testing, HCV testing looks for antibodies to the virus. Even when a person no longer has—that is, “clears”—the hepatitis C infection, that person’s body retains HCV antibodies. For this reason, an HCV-positive antibody result should always be followed by a confirmatory test looking for the virus itself, to find out whether or not the client is currently infected.
- More information about HCV testing is available at test sites that offer HCV counseling and testing.

HEPATITIS C TREATMENT

- Current HCV medications can successfully treat a significant percentage of infected individuals. Individuals co-infected with HCV and HIV may be eligible for services provided through the AIDS Case Management Program or AIDS Medi-Cal AIDS Waiver Program. Clients are provided referrals to specialists who can monitor and treat HCV while also addressing HIV and AIDS.
- Anti-HCV medications have potentially serious side effects. In some patients, the side effects may be so serious that treatment must be stopped. Pregnant women should not be treated with these drugs at all.
- It is important to discuss the pros and cons of HCV treatment thoroughly with a knowledgeable health care practitioner before beginning treatment. Diet and other lifestyle changes may also help prevent the progression of liver disease, even if a person is not ready or able to take hepatitis C antiviral medication.

WHAT SHOULD SOMEONE NEWLY DIAGNOSED WITH HEPATITIS C DO?

- Find a doctor who specializes in the liver; get hepatitis A and B vaccinations to protect against other liver infections; and use only medications and supplements approved by a doctor.
- Eat nutritious meals, avoiding shellfish and foods with high fat contents; get exercise; rest when tired; engage in stress-reduction activities; and avoid or minimize the alcohol and drug use.

HELPFUL HEPATITIS C RESOURCES

- ▲ American Liver Foundation: www.liverfoundation.org
- ▲ Centers for Disease Control and Prevention: www.cdc.gov/idu
- ▲ Chicago Recovery Alliance: www.anypositivechange.org
- ▲ Harm Reduction Coalition: www.harmreduction.org
- ▲ HCV Advocate: www.hcvadvocate.org
- ▲ National Hepatitis C Program, U.S. Veterans Affairs: www.hepatitis.va.gov

Section 7: The Three Options of Counseling and Testing

The Office of AIDS offers three different ways to test for HIV. One way is dedicated to clients with significant HIV risk; the other is dedicated to clients with lower or no HIV risk; and the third is for clients who, regardless of risk level, want a test and no additional counseling.

- Higher-risk clients get higher-level services: an HIV test coupled with behavior change counseling and referrals.
- Lower-risk clients get lower-level services: an HIV test coupled with health education, without counseling or referrals.
- Clients who are interested in only testing and getting results may opt out of counseling regardless of their CAQ-determined level of risk.
- Even if initially screened as lower-risk, every client who tests preliminary positive or HIV-positive is offered client-centered disclosure counseling and referrals to other services.

CLIENT ASSESSMENT QUESTIONNAIRE (CAQ)

Before a client tests for HIV, your test site determines what option will be applied.

- The Client Assessment Questionnaire (CAQ) is a form with a series of questions that assess HIV-related behavior and HIV risk and is often used to determine which tier of service a client is offered.
- Counselors often receive the CAQ before or at the beginning of the counseling session in order to structure the opening interaction with the client. Check with your supervisor about your site's procedure for administering the CAQ.
- The routing to different types of service is invisible to the client. Clients know only that they are seeing a counselor, not that they are considered to have "higher risk" or "lower risk."
- The CAQ is based on research that associates most HIV infections with 11 categories of "risk." Each category represents either a behavior that is most likely to lead to transmission, for example injection drug use, or a population in which HIV is more common than in other populations, for example, among men who have sex with men.
- The categories are based on research and analysis of trends in the HIV epidemic in California and data from large numbers of counseling and testing clients at Office of AIDS-funded test sites. The categories are very accurate in identifying the likelihood of a client testing HIV-positive.
- As noted earlier, while statistics support labeling men who have sex with men as more likely to have HIV than men who have sex only with women, many individual men who have sex with men use condoms when having anal sex—or do not have anal sex at all—and, as a result, are at very low risk. Likewise, many injection drug users exchange used injection equipment through syringe access and disposal programs, clean their equipment, or do not share works at all; these individuals, too, are at very low risk. These clients would still be directed toward counseling in order to support their continued efforts to stay HIV-negative.

You will get some training about the Client Assessment Questionnaire at your test site. For now, briefly review the form. There are two sides: clients fill out the first side and staff fill out the second side. Below this image, we include a brief review of how the CAQ is “scored.”

CLIENT ASSESSMENT QUESTIONNAIRE

INSTRUCTIONS: Please answer the following questions. Mark or write a number in the boxes for each question. There are no right or wrong answers. All of your answers are completely confidential and will not be shared with anyone. If you need assistance please ask the person who gave you this form.

- 1) What is your sex / gender? (mark one)
 - (1) Male
 - (2) Female
 - (3) Transgender (male to female)
 - (4) Transgender (female to male)
 - (5) Other identity, specify: _____

- 2) What is your race / ethnicity? (mark all that apply)
 - (1) Black / African American
 - (1) American Indian / Alaska Native
 - (1) Asian
 - (1) Native Hawaiian / Pacific Islander
 - (1) Hispanic / Latino(a)
 - (1) White
 - (1) Other race, specify: _____

- 3) What is your birthday / birth date?

		/			/				
Month			Day			Year			

- 4) What is the FIRST LETTER of your LAST NAME?

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- 5) What ZIP code do you live in?

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- 6) What County do you live in? _____

- 7) Which of the following comes closest to your sexual orientation? (mark one)
 - (1) Heterosexual or straight
 - (2) Bisexual
 - (3) Gay, lesbian, queer, same gender loving, or homosexual
 - (4) Other orientation, specify: _____

- 8) Have you had sex with a **woman** in the last year (12 months)? (mark all that apply)
 - (1) Vaginal sex (penis in vagina)
 - (1) Anal sex (penis in anus (butt))
 - (1) Oral sex (mouth on penis, vagina, or anus)
 - (1) I have not had sex with a woman in the last year.

- 9) Have you had sex with a **man** in the last year (12 months)? (mark all that apply)
 - (1) Vaginal sex (penis in vagina)
 - (1) Anal sex (penis in anus (butt))
 - (1) Oral sex (mouth on penis, vagina, or anus)
 - (1) I have not had sex with a man in the last year.

- 10) Have you had sex in the last year with a sex worker or prostitute (whether you paid or not)? (1) Yes (0) No

- 11) Have you had sex in the last year with someone that you know injects drugs? (1) Yes (0) No

- 12) Have you had sex in the last year with someone that you know has HIV or AIDS? (1) Yes (0) No

- 13) If you are **female**, in the last year have you had sex with a man that you know has had sex with another man? (1) Yes (0) No

- 14) Have you used a needle to inject drugs in the last year? (1) Yes (0) No

- 15) Have you used meth, speed, crank, crystal, cocaine, or crack in the last year? (1) Yes (0) No

- 16) Have you received drugs, money, or other items or services for sex in the last year? (1) Yes (0) No

- 17) Has a medical or service provider told you that you have gonorrhea or syphilis in the last year? (1) Yes (0) No

- 18) Has a medical or service provider ever told you that you have hepatitis C? (1) Yes (0) No

- 19) Have you ever used a needle to inject drugs? (1) Yes (0) No

- 20) How many HIV/AIDS tests have you had before today?

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 (enter zero if you never tested before today)

If you have tested before, what is the date of your last test?

		/			
Month			Year		

If you have tested before, what was the last test result you received? (mark one)

 - (1) Negative (No HIV infection)
 - (2) Positive (HIV infection found)
 - (6) Other result, specify: _____
 - (5) I have never received a result

Thank you! Please return this completed form now.

Unique Office of AIDS Client Number

CLINIC USE ONLY					
ADMINISTRATIVE	Data entry initials: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="checkbox"/> (1) Mark <input checked="" type="checkbox"/> if no billing	Agency ID: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<i>(date and initial)</i> Intervention session: Date (mm/dd/yy) Initials (print) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
	CLIENT ASSESSMENT Assessment initials: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Initial intervention: <input type="checkbox"/> (1) LR low-level (<i>indicate transition</i>) <input type="checkbox"/> LR high-level (<i>CIF required</i>) <input type="checkbox"/> HR high-level (<i>CIF required</i>) Transition to high-level? <input type="checkbox"/> Yes (<i>CIF required</i>) <input type="checkbox"/> (0) No Local variance used? <input type="checkbox"/> Yes (<i>CIF required</i>) <input type="checkbox"/> (0) No	Intervention: _____ Intervention ID: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Location ID: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Disclosure session: (<i>same date as intervention for rapid tests</i>) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
HIV test election: (<i>mark one</i> <input checked="" type="checkbox"/>) <input type="checkbox"/> (1) Tested anonymously <input type="checkbox"/> (2) Tested confidentially <input type="checkbox"/> (3) Client declined testing <input type="checkbox"/> (4) HIV test not offered		Reschedule attempt: (<i>for missed HIV confidential disclosures</i>) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
Reschedule attempt outcome: (<i>mark one</i> <input checked="" type="checkbox"/> if no HIV disclosure) <input type="checkbox"/> (1) Unable to locate/contact <input type="checkbox"/> (3) Obtained HIV results elsewhere <input type="checkbox"/> (2) Client declined notification <input type="checkbox"/> (4) Rescheduled but client did not return Note: CIF is required for all preliminary positive rapid tests.					
OTHER TESTING	Referred for hepatitis C testing? (<i>mark one</i> <input checked="" type="checkbox"/>) <input type="checkbox"/> Yes (<i>CIF required</i>) <input type="checkbox"/> No	HIV TEST SUMMARY	Final HIV test result: (<i>mark one</i> <input checked="" type="checkbox"/>) (attach lab slips/ Testing Incident Report) <input type="checkbox"/> (1) Negative <input type="checkbox"/> Positive (<i>CIF required</i>) <input type="checkbox"/> Preliminary positive (<i>CIF required</i>) (<i>no confirmatory sample taken</i>) <input type="checkbox"/> Inconclusive (<i>CIF required</i>) <input type="checkbox"/> Discordant (<i>CIF required</i>) <input type="checkbox"/> (6) Invalid <input type="checkbox"/> Other result, specify (<i>CIF required</i>)	OPTIONAL DATA	Item 1:
	Additional tests this visit: (<i>mark all that apply</i> <input checked="" type="checkbox"/>) <input type="checkbox"/> (1) No additional tests <input type="checkbox"/> (1) Tuberculosis (TB) <input type="checkbox"/> (1) Hepatitis B <input type="checkbox"/> (1) Syphilis <input type="checkbox"/> (1) Gonorrhea <input type="checkbox"/> (1) Chlamydia <input type="checkbox"/> (1) Other STD (<i>other than HIV</i>)		Item 2:		
NOTES _____ _____ _____ _____ _____					
HR = High-Risk Client LR = Low-Risk Client CIF = HIV Counseling Information Form STD = Sexually Transmitted Disease or Infection					
Place additional lab stickers here:	LAB SLIP #2	LAB SLIP #3	LAB SLIP #4	LAB SLIP #5	

Scoring the CAQ

- The CAQ asks clear questions, but the assessment of whether someone is higher- or lower-risk may not always be obvious. Here is a brief review of what answers will lead to the designation as a *higher-risk* client:
- **Gender:** A response of Transgender (male-to-female or female-to-male) or Other to Question 1.
- **Gender and Activity:** The combination of Female in response to Question 1 and yes to anal sex in Question 9 (in the previous year). The combination of Male in response to Question 1 and yes to anal sex or oral sex in Question 9 (in the previous year).
- **Sexual or Drug Using Activities:** The answer of yes to having engaged in any of the following activities or experienced the following events in the previous year:
 - ▲ Question 10: Sex with sex worker or prostitute
 - ▲ Question 11: Sex with someone who injected drugs (but not steroids or vitamins, since only recreational drug injecting is statistically associated with increased rates of HIV)

- ▲ Question 12: Sex with someone who you know has HIV or AIDS
- ▲ Question 13: If female, sex with a man you know had sex with another man
- ▲ Question 14: Used needle to inject drugs (but not steroids or vitamins, since only recreational drug injecting is statistically associated with increased rates of HIV)
- ▲ Question 15: Used methamphetamine (including meth, speed, crank, or crystal) or cocaine (including crack)
- ▲ Question 16: Received drugs, money, or other items or services for sex
- ▲ Question 17: Gonorrhea or syphilis diagnosis (but not other sexually transmitted diseases, since only these are statistically associated with increased rates of HIV)
- **Hepatitis C:** Questions 18 and 19—regarding a hepatitis C diagnosis or ever having used needles to inject drugs—are used to determine whether a client should also be offered hepatitis C testing at test sites that offer this service. These questions do not relate to an assessment of whether a client should receive higher- or lower-level HIV counseling services.

USING NON-JUDGMENTAL LANGUAGE

- The CAQ is a screening tool only. It enables your site to direct clients quickly and easily to the intervention that will serve them best.
- Each client, however, is an individual. It would be imprecise and potentially offensive to describe this “whole” person based on either risk behavior or membership in a group.
- For this reason, we use phrases like “risk behavior” and “risk group” behind the scenes in counseling and testing. These terms are helpful for planning and evaluation of services, but can be off-putting and sound judgmental when used with clients. Instead, rely on the client’s specific concerns, rather than generalizations.

TRANSITIONING FROM HEALTH EDUCATION TO COUNSELING

- If at any time, a client who has been screened as “lower-risk” reveals greater HIV risk—for example, sharing needles, or being the receptive partner during anal sex—transition the client from health education to behavior change counseling.
- Also transition the client to counseling if that client, previously assessed as lower-risk, tests preliminary positive or HIV-positive.

Section 8: Rapid and Conventional HIV Testing

Two HIV-antibody testing procedures are currently available. One is known as the “rapid test,” because the test results are available within 20 to 40 minutes and are generally delivered to clients during a single visit. Counseling is done while the test is processing. The other is known as the “conventional test,” because it is the process originated in 1985. It requires two sessions, one during which the client receives counseling and gives a sample, and another, one to two weeks later, when the counselor discloses the result. In California, 75% of test sites offer rapid testing. For this reason, the training focuses on the rapid test and the counseling that goes along with it.

CONVENTIONAL TESTING

- After informed consent, a swab of the cheek or blood from a vein is sent to a lab.
- The lab performs a simple screening test, called an ELISA or EIA (enzyme-linked immunosorbent assay).
- If the EIA is positive, the test is repeated on the same sample one or two times. If the EIA is positive again, the lab then runs a confirmatory test for a final test result, usually the Western Blot. (In the United States, positive screening tests—like the EIA—must be confirmed with a different, supplemental test.)
- Results come back to the test site 7 to 14 days after the sample is collected. Clients must return to the test site in order to receive their results.
 - ▲ **An HIV-positive test result** means that antibodies to HIV were detected. The client has HIV.
 - ▲ **An HIV-negative test result** means that no antibodies to HIV were detected in the sample. The person is either not infected with HIV, or the person is infected but has not yet produced enough HIV antibodies to show up on the test (a process that usually takes between two weeks and three to six months).
 - ▲ **An inconclusive test result** means the result is neither clearly positive nor clearly negative. This is rare (about 1 in 520 cases), and a new sample usually will provide a clear result.

RAPID TESTING

- After informed consent, the HIV counselor collects and processes an oral or blood sample in a test kit at the test site. The rapid test is a screening test like the EIA mentioned above and is called the OraQuick ADVANCE rapid HIV-1/HIV-2 antibody test.
- The rapid test takes between 20 minutes and 40 minutes to develop a result. During this time, a client receives either health education or HIV counseling. If they opted out of counseling, they may take advantage of a health education video or brochure, if the site has one, or simply wait in the designated area.
 - ▲ **A preliminary positive test result** means that the test very likely detected HIV antibodies. The individual is very likely infected with HIV. Preliminary positive results must be confirmed with a confirmatory test (just as a positive EIA in conventional testing must be confirmed with a Western Blot). This means that a client must submit a second sample and return to the test site after 7 to 14 days to receive the results of the confirmatory test.
 - ▲ **A confirmed positive test result** means that the confirmatory testing has proven that the preliminary positive is accurate and the client is, in fact, HIV-infected. Since the initial rapid test is extremely accurate, in all likelihood, the client's preliminary positive result will be confirmed.
 - ▲ **A negative test result** means the same as a negative result in conventional testing.
 - ▲ **An invalid test result** occurs rarely, when the testing device has been damaged, contaminated, gone out of temperature range, or there is an operator error.

CAN HIV ANTIBODY TESTS DIAGNOSE AIDS?

- The HIV antibody test does not indicate whether or not a person has AIDS. Only a doctor can diagnose AIDS, based on additional tests of the immune system.
- Further testing by a medical provider—either the client's own doctor or a doctor recommended by a counselor—is key to understanding the state of the client's immune system. Initial medical evaluation is one of the next steps for a client who tests HIV-positive.

ACCURACY OF THE TEST

- HIV tests are highly accurate; they are some of the most accurate medical screening tests ever developed.
- Whether using the rapid or the conventional testing procedure, anyone receiving a negative result has been tested once by a test that is very reliable. Anyone receiving a positive result has been tested at least two times—by two different kinds of tests—to be sure the result is accurate.

CONSIDERATIONS ABOUT HIV TEST RESULTS

- Statewide, 98 percent of HIV antibody test results given are negative. Mostly, HIV test counselors are helping people interpret negative results.
- Almost two-thirds of all clients who receive a positive result have previously received at least four HIV-negative results. This means that counselors continue to explore HIV risk reduction even when disclosing a negative result in an effort to prevent people from contracting HIV in the future.
- A person who tests HIV-positive is offered a written referral to medical services, and might appreciate additional referrals to support groups, counseling services, “buddy” programs (where a peer with HIV provides support and understanding), assistance with partner disclosure (also known as Partner Services), or other resources that offer knowledgeable and specialized care. See Section 18: *What Happens After a Client Tests HIV-Positive* for more information.
- In delivering any result, counselors must make individual assessments and link clients to appropriate referrals.

Section 9: The Window Period

WHAT IS THE DIFFERENCE BETWEEN “EXPOSURE” AND “INFECTION”?

- Exposure means that a body substance that can transmit HIV has entered the body or come into contact with a mucous membrane. Only HIV-infected blood, semen, pre-cum, vaginal and cervical secretions, and breast milk are considered capable of transmitting the virus from one person to another through unprotected sex or needle sharing.
- Exposure can lead to an infection. Infection happens when the virus invades a cell or a series of cells and starts to reproduce.
- The activity of HIV varies from person to person. Some people can be exposed to HIV once and become infected; others are exposed multiple times and do not become infected.
- There is no way to predict whether a particular exposure will lead to infection.
- People who have avoided infection, even after repeated exposures, may believe that they are immune from future infection. This belief may seem reasonable, but in fact no one is immune from HIV infection. This means that any person who is exposed to HIV-infected fluids is at risk for getting infected even if that person has not gotten infected yet.

WHAT IS THE “WINDOW PERIOD”?

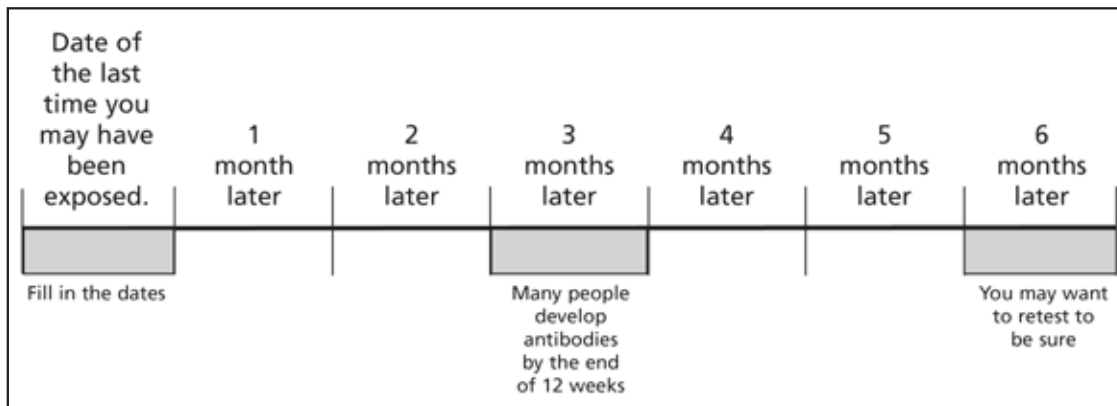
- When a person becomes infected with HIV, the body takes time to develop enough antibodies to show up on an HIV antibody test.
- This period of time when people are infected with HIV, but do not yet have enough antibodies to show up on the test, is called the “window period.”
- People infected with HIV usually develop detectable antibodies between 2 weeks and 6 months after exposure, with many people developing enough antibodies by 12 weeks (3 months). (Outside of California, the window period ends at 3 months; for more information about why California uses an end date of 6 months, see *The Window Period Reexamined* in the Online Resources.)

WHAT ABOUT THE “INCUBATION PERIOD”?

- Incubation is the period of time from initial infection with HIV to the appearance of the first symptom or sign of disease.
- In the context of AIDS, it takes an average of six to eight years for a person to develop symptoms and an average of ten years to develop a disease that indicates an AIDS diagnosis.

HIV TESTING RECOMMENDATIONS, CALIFORNIA STATE OFFICE OF AIDS

- The State Office of AIDS recommends that clients have an HIV antibody test three months to six months after the date of their last possible exposure. If a client tests HIV-negative six months after a possible exposure, the client does not need to test again unless there is a possible exposure again.
- For example, a client says the last time she got someone else’s fluids into her body (her last possible exposure) happened on January 1. She has come to test three months later, on April 1. Her result comes back HIV-negative.



- ▲ Her counselor can recommend she return for another test in early July (six months after the exposure), because some people need six months to develop enough antibodies to show up on the test.
- ▲ If the test in July is negative, and the client has not engaged in any additional HIV risk behavior between the first test in April and the second test in July, she can be confident that she is not infected with HIV.
- ▲ If the test result in July is negative and HIV risk behaviors are ongoing, counseling should focus on helping the client think about how to minimize the chance of future infection and think about when to test again.
- ▲ If the client receives a positive result, there is no need to come back for further HIV antibody testing. Counselors must offer a written referral to medical care with a provider knowledgeable about HIV.

- A client who has no HIV risk does not need to test again for the virus. Still, some clients with no risk for acquiring HIV may insist on testing frequently even in the absence of HIV risk behaviors. If these clients have insurance, the State Office of AIDS recommends that they test through their private medical providers rather than through a publicly funded counseling and testing site.
- A client may be part of a population with high rates of HIV, but the client's individual behavior does not involve exposure to HIV-infected fluids. The counselor would encourage this client to continue to work with HIV prevention counselors in the future to support the ability to maintain lower-risk behaviors.

POST-EXPOSURE PROPHYLAXIS (PEP)

See *Section 5: Preventing HIV* for information about Post-Exposure Prophylaxis, since this also relates to the timing of exposure.

Section 10: The OraQuick ADVANCE Rapid HIV-1/HIV-2 Antibody Test

- The OraQuick ADVANCE device is a rapid test designed to detect HIV-1 and HIV-2 antibodies in 20 minutes.
- Rapid HIV tests allow people to learn test results on the day they are tested. Use of rapid HIV tests substantially increases the number of people who learn of their HIV status. HIV-negative results do not require confirmation; preliminary positive results do require confirmation.
- The test is operated by collecting an oral fluid sample on the porous flat pad of the test kit, or by inserting a drop of whole blood into a vial containing a reagent, and then inserting the test kit into the vial. The specimen and solution flow through the device and results are ready in 20 to 40 minutes.

TESTING YOUR PROFICIENCY WITH THE RAPID TEST

- Anyone collecting a sample, running the test, reading results or supervising someone doing any of these activities must take a proficiency exam during Day One of the Basic I training.
- The exam involves running 5 OraQuick ADVANCE tests in a row using a written checklist. You must correctly follow the steps outlined on the checklist and correctly interpret results of the 5 tests as well as correctly interpret 10 additional pictures of results printed on a handout.
- To prepare you for the proficiency exam, your trainers will first use a test kit to demonstrate the proper use and interpretation of the test. They will then guide you step-by-step in the use of the checklist to practice a rapid test on your own. You will then pair with another participant to practice and observe again. By the time you take the proficiency exam, you will have seen the test administered twice, practiced it twice yourself and been able to ask plenty of questions about the test kit operation and interpretation.
- To pass the proficiency exam, you must score 100 percent. The best way to prepare yourself is to read this section thoroughly and to listen attentively during the training.

BACKGROUND ON THE ORAQUICK ADVANCE RAPID HIV ANTIBODY TEST

- The OraQuick ADVANCE test is a CLIA* waived point-of-care test. This means it can be administered outside of a clinical laboratory. CLIA requires anyone performing a laboratory test classified as waived to follow the manufacturer's instructions contained in the package insert.
- California has additional requirements for quality assurance standards and procedures, some of which will be covered here and others in the Basic I training. Further requirements specific to OraQuick ADVANCE are contained in an addendum detailed in the *California Office of AIDS OraQuick Rapid HIV Testing Guidelines*.

* Clinical Laboratory Improvement Amendments, a federal law establishing quality standards for all laboratory testing.

- The current package insert (including instructions for operation) for the OraQuick ADVANCE test is available on the OraSure Technologies, Inc. website (www.orasure.com).
- The *California Quality Assurance Guidelines* are available on the Office of AIDS website (www.dhs.ca.gov/aids).
- More information about the OraQuick ADVANCE Rapid HIV test is available on the CDC website (www.cdc.gov/HIV/rapid_testing).

COMPARING RAPID AND CONVENTIONAL HIV TESTING

- The OraQuick ADVANCE Rapid Test is very similar to the initial EIA used in conventional testing. Just as in conventional testing, a screening test that develops a negative result does not require confirmation but one that develops a preliminary positive result does.
- Recall from Section 8 that in conventional HIV antibody testing, laboratories use a screening test called the EIA (also known as an ELISA) to look for antibodies to HIV. If no antibodies are found using the EIA, the result is reported as HIV-negative to the client, who may then retest at a later date if the current test falls within the window period. If antibodies are found using the conventional EIA test, the sample is often tested again with another EIA but is always confirmed using a confirmatory test, the Western Blot or IFA, before being designated an HIV-positive result.
- Running the OraQuick ADVANCE is much like running a conventional EIA, except that the OraQuick ADVANCE is even more accurate. The additional accuracy of the OraQuick ADVANCE means we can confidently deliver results from this screening test directly to clients, though preliminary positive results still need to be confirmed using a Western Blot or IFA just as in conventional testing.

ACCURACY OF THE ORAQUICK ADVANCE RAPID TEST

- Accuracy involves two qualities of a test: sensitivity and specificity.

Sensitivity of OraQuick ADVANCE*

- Sensitivity refers to a test's ability to detect a true positive. That is, a test that is extremely sensitive is very unlikely to "miss" a true positive.
- Screening tests like the conventional EIA and OraQuick ADVANCE are selected and designed to be extremely sensitive, so they will not "miss" positives. If there is something there to find, these tests are very good at finding it. (That's why we do NOT need to confirm HIV-negative results.)

The data below from the CDC show that the OraQuick ADVANCE is at least as sensitive as the conventional EIA screening test. Out of 340 samples that were known to be HIV-positive, all of

* These data from the CDC are based on blood samples. Manufacturer data based on oral fluid reflect similar sensitivity (see package insert at www.orasure.com).

them tested positive on the EIA (see the line beginning with “EIA 1”), even when tested a second time (see “EIA RR”).

Test	True Positive	Tested Positive	False Negative	Sensitivity
EIA 1	340	340	0	100%
EIA RR*	340	340	0	100%

- The sensitivity of the EIA was 100 percent. This means that a negative result on the EIA can be confidently reported as HIV-negative to the client. If there had been antibodies present in the client’s sample, the EIA would have found them.
- As you can see from the data below, the sensitivity of the OraQuick ADVANCE test is the same as the EIA. If a client tests negative on the OraQuick ADVANCE, an HIV-negative result is delivered to the client, just as with the conventional EIA.

Test	True Positive	Tested Positive	False Negative	Sensitivity
OraQuick 1	340	340	0	100%
OraQuick RR	340	340	0	100%

- These data reveal two important aspects of accuracy to remember when delivering HIV-negative results:
 - There is no need to confirm an HIV-negative result on the OraQuick ADVANCE. If there were antibodies there to find, this test would have found them.
 - The OraQuick ADVANCE is reliable—when the test was “re-run” it gave the same answer—so we do not need to repeat the test.
 - In addition, the window period is the same for EIA and OraQuick ADVANCE, so clients who receive an HIV-negative result who are still in the window period should be advised to re-test at the appropriate time. (See *Section 9: The Window Period*.)

Specificity of OraQuick ADVANCE**

- Specificity refers to the ability of a test to detect true negatives. A test that is very specific will rarely have false positives. This means that the higher the specificity of a test, the more accurately a preliminary positive result is truly HIV-positive.
- The data below from the CDC demonstrate that the OraQuick ADVANCE is extremely specific to HIV antibodies—its specificity is greater than that of the conventional EIA.

* RR: “repeated reactive.”

** These data from the CDC are based on blood samples. Manufacturer data based on oral fluid reflect similar sensitivity (see package insert at www.orasure.com).

- In the first set of data shown below, the EIA resulted in 25 false positives when 467 known negative samples were tested (see “EIA 1”). When repeated with the same samples, the number of false positives fell to 4 out of 467 known negative samples (see “EIA RR”). This is why even in conventional testing, all positive results on the EIA must be confirmed with a Western Blot or IFA before being reported to the client as HIV-positive.

Test	True Negative	Tested Negative	False Positive	Specificity
EIA 1	467	442	25	94.7%
EIA RR*	467	463	4	99.1%

- In comparison, the data below show that OraQuick testing resulted in only 1 false positive when 464 known negative samples were tested. These results were consistent when the samples were tested again.

Test	True Negative	Tested Negative	False Positive	Specificity
OraQuick 1	464	463	1	99.8%
OraQuick RR	464	463	1	99.8%

- These data reveal two important aspects of accuracy to remember when delivering preliminary positive results:
 - The OraQuick ADVANCE is more specific than the conventional EIA; it is much more acceptable to deliver a preliminary positive OraQuick ADVANCE result because we know it will almost always be confirmed.
 - The OraQuick ADVANCE is reliable—when the test was “re-run” it gave the same answer—so we do not need to repeat the test, even for preliminary positive results.
- These CDC data show that the OraQuick ADVANCE test is very specific to HIV antibodies, and rarely results in false positives. However, it is the standard of care in the United States to confirm preliminary positive results from screening tests to rule out false positives and to ensure that clients receive the correct result. Recall that confirmatory testing is done on positive EIA samples, too—it just happens at the lab before the result returns to the test site.
- Either blood or oral fluid may be used for confirmatory testing, but blood is preferred whenever possible.
- The counseling aspects of delivering preliminary positive results will be dealt with in your Basic I training. Know that delivering preliminary positive results is already in practice, and clients are responding fine to the need for confirmatory testing.
- Any screening test, including OraQuick ADVANCE, will sometimes have a false positive result. The package insert lists some of the co-factors that were present when OraQuick ADVANCE resulted in a false positive. This happens so rarely that there is not enough data to conclude which combination of factors may cause this effect.

* RR: “repeated reactive.”

Additional Data on the Accuracy of OraQuick ADVANCE

- Additional data testing people of unknown status reveals similar sensitivity and specificity to previous data. When testing 780 people of unknown status, OraQuick ADVANCE correctly identified all participants who were truly HIV-negative (100% sensitivity). Of the participants who tested preliminary positive, only one result was a false positive (99.9% specificity).

CDC Clinical Trial: Test performed on 780 persons of unknown serostatus; 35 proved to be HIV-positive.	
Sensitivity	100%
Specificity	99.9%

- Data from the manufacturer, Orasure Technologies, Inc. reflects similar overall accuracy, though the sensitivity and specificity were slightly different. These differences are reasonable to expect in any test, and nonetheless reflect the very high level of accuracy when using OraQuick ADVANCE.

Manufacturer Data		
Sensitivity	536/538	99.6%
Specificity	1856/1856	100%
Overall Accuracy	2392/2394	99.9%

- When discussing OraQuick ADVANCE with clients, emphasize that the test is “extremely accurate” or “highly accurate” and de-emphasize statistics and percentages. Clients who would like additional information about the accuracy of the test may refer to the Subject Information Flyer designed to answer questions about the OraQuick ADVANCE.

QUALITY ASSURANCE

- Inaccuracies in test results are exceedingly rare. When they do happen, they often involve human error in the operation or interpretation of the test kit. For this reason, the Office of AIDS requires very strict adherence to quality assurance guidelines.
- Quality assurance refers to planned processes that provide confidence in a product’s suitability for its intended purpose. The following are the key points to remember about quality assurance requirements for OraQuick ADVANCE. They are compiled from the manufacturer’s information.
- Remember that small mistakes can lead to major errors, such as a client receiving an inaccurate test result. With conventional testing, California’s public health labs conduct these and more quality assurance procedures. During rapid testing, it is up to test sites to follow quality assurance guidelines and ensure that ALL clients receive accurate test results.

BRIEF QUALITY ASSURANCE OVERVIEW

- All sites conducting rapid HIV testing are required to meet specific quality assurance requirements designed to ensure that every client receives an accurate test result. In addition to training requirements for personnel operating the test, sites must have:

Adequate Lighting

- Full or bright light to read test device lines. In some cases, a stationary task light will be necessary.

Temperature Control

- Perform test: 59 to 99 degrees Fahrenheit (or as indicated in current package insert)
- Store test: 35 to 80 degrees Fahrenheit (or as indicated in current package insert)

Space for Undisturbed Testing Process

- Space separate from the counseling area where tests may sit undisturbed for at least 20 minutes. There must be no smoking, eating, drinking, applying of make-up (including lip balm), etc., in the testing area.

External Controls

- Sites must also ensure that the test kits are working properly by running external controls under specific circumstances. An external quality control unit consists of three vials of clear fluid made from human plasma. One vial contains fluid that will test negative; a second vial contains fluid that will test HIV-1 positive; a third vial contains fluid that will test HIV-2 positive. Although the two positive results will not look any different in the test kit window, two separate positive control vials are needed to determine that the test kits are able to detect both HIV-1 and HIV-2.
- The external quality control process consists of running three OraQuick ADVANCE tests and using a drop of fluid from each of the control vials, to ensure that the tests are obtaining the proper result.

When to Run External Controls

- By each new operator prior to performing testing on patient specimens;
- In each new setting or whenever conditions in a setting have changed significantly;
- When opening a new test kit lot or when a new shipment of test kits is received;
- If the temperature of the test storage area falls outside of acceptable 35 to 80 degrees Fahrenheit range;
- If the temperature of the testing area falls outside of acceptable 59 to 99 degrees Fahrenheit range;

- At periodic intervals as dictated by the user facility;
- Whenever two invalid results in a row are obtained.
- More details about quality assurance requirements and procedures are available in the Office of AIDS OraQuick Rapid HIV Testing Guidelines at www.dhs.ca.gov/aids.

IMPORTANT NOTES ON QUALITY ASSURANCE

- There should be at least two separate spaces in which to provide rapid testing: one room or location for counseling and another for the test to develop.
- External controls allow us to determine if the OraQuick ADVANCE is working properly. For example, if the operation temperature falls out of range (below 59 or above 99 degrees Fahrenheit), then external controls are used to make sure the test kits are still working properly. Do your best to memorize when to run external controls.
- The “new operator” requirement comes from the manufacturer. By the end of the Basic I, you will have run tests using the HIV-negative and the HIV-1 external controls. Back at your test site, you will need to run the HIV-2 external control prior to conducting OraQuick ADVANCE testing with clients.
- If you will be administering the test using finger stick blood samples, you will have to go through separate training to become certified to perform finger sticks. Further information will be available from your supervisor.

Section 11: Informed Consent

Counselors need to know some required elements of informed consent to help clients choose the testing process that will best suit their individual needs.

ANONYMOUS OR CONFIDENTIAL TESTING

- OA-funded test sites provide either anonymous or confidential HIV testing. Some sites are able to offer clients a choice of either testing process; others offer only one type.
- Counselors need to convey a clear understanding of both systems of testing and be able to explore the personal advantages and disadvantages for each client. In particular, a client who comes in for one type of testing may, upon learning the advantages of the other type, request a referral to a program that offers that type.

Anonymous Testing

- An individual choosing anonymous testing is given a code number that is linked to the test result and lab slip.
- The person never gives any contact information, such as name, telephone number or address. The test result cannot be linked in any way to the individual's identity.

Confidential Testing

- An individual choosing confidential testing provides identifying information and contact information.
- Special laws in the State of California protect this result from being disclosed to anyone but the client.
- OA-funded test sites employ an even higher standard to protect confidential records than is required by law. In general, people working in HIV services share this strong commitment to protection of privacy and confidentiality.

THE MAIN DIFFERENCES BETWEEN ANONYMOUS AND CONFIDENTIAL TESTING

- **Consent Forms:** In confidential testing, clients sign a consent form. In anonymous testing, counselors sign the forms, not the client.
- **Follow-Up:** In a confidential setting, counselors have contact information and can follow-up with clients on referrals or for further services. No follow-up is possible in anonymous testing.
- **Written Results:** In confidential testing, clients can receive a written result with their name. If anonymous test sites give clients a written result, no name is attached.
- **Identifiers:** In confidential testing, a result is linked to that person's name in a confidential record. In anonymous testing, sites never know the name of a client.

- **HIV Reporting by Name:** In a confidential setting, whenever a client’s test results indicate HIV infection—a confirmed positive antibody test or a viral load test—that person’s full name and full social security number (if provided) will be forwarded to the local health department, and eventually to the CDPH/OA. Anonymous testing never involves HIV reporting by name because no name is ever given during the testing process. [Note: Legislation is pending that would add another test used in HIV care, CD4+ cell count test, to HIV reporting requirements.]

THE COUNSELING INFORMATION FORM (CIF)

- The Counseling Information Form (CIF) records important demographic information about the client as well as the test results, though the client’s name is never recorded on the form. (The CIF is used for higher-risk clients; for lower-risk clients, the CAQ suffices.)
- Completed forms are used by public health scientists as well as program and policy planners to learn more about HIV trends throughout the State. The form is also a link to the client’s lab number, to ensure that clients receive the appropriate results.
- Counselors must explain the purpose of the CIF and its relevance to the counseling session as part of informed consent. The needs and concerns of the client are always foremost. In some cases, it may be most appropriate to leave the form out of a session entirely, or to leave out some questions.

CONFIRMING INFORMED CONSENT

- In order to test, clients should be at least 12 years old (13 years old if using the OraSure sample collection device), fully understand the risks and benefits of the HIV test and alternatives to the test, demonstrate mental capacity to understand this information, and freely agree— without being forced—to have the test performed.

Each client must specifically be informed of:

- The difference between anonymous and confidential testing, especially as they relate to current HIV reporting laws.
- The difference between conventional and rapid HIV testing. This includes explaining the different sample collection procedures, when results will be ready, and the meaning of possible test results (including the collection of a second sample for confirmatory testing after receiving a preliminary positive result on the rapid test).
- The purpose and relevance of the CIF to the counseling session, if the client is receiving higher-level services.
- If a client chooses confidential testing, the client and counselor can then complete appropriate paperwork. With an anonymous test, the client consents verbally, and only the counselor completes the paperwork.

Section 12: Common Questions About the HIV Test*

Test yourself by responding to these common questions about HIV testing. You should know the answers to these questions before you attend the Basic HIV Test Counselor Skills Training.

Section 2: HIV and the Immune System

1. What is an antibody?
2. Why do you test for an antibody instead of the virus itself?

Section 8: Rapid and Conventional HIV Testing

3. Why do I have to wait seven to 14 days for a conventional test or confirmatory positive test result?
4. Can you tell me if I have AIDS?
5. What's the difference between conventional testing and rapid testing?
6. What does a positive test result mean?
7. What does a negative test result mean?
8. What does an inconclusive test result mean? Is an invalid test result the same thing?
9. What does a preliminary positive mean?

Section 9: The Window Period

10. If I test negative, then I don't have anything to worry about, right?
11. What is the window period?
12. How often should I come back for testing?

Section 11: Informed Consent

13. What is the difference between anonymous and confidential testing?
14. How sure can I be that the system you have in place is completely confidential?

If you would like further practice responding to common questions that clients ask in counseling and testing, see *Frequently Asked Questions about HIV Counseling and Testing* in the Online Resources.

* The questions in this section were developed with the help of Catherine Baker and Katie Villegas, California Department of Public Health Office of AIDS.

Section 13: Why Are People Still Contracting HIV?

Information alone does not usually change behavior. Human behavior is complex and many factors influence why a person has unprotected sex or shares injection equipment.

BEHAVIOR CHANGE IS DIFFICULT

Beliefs, psychological needs, life experiences, and social circumstances influence why a person continues to engage in HIV risk.

Beliefs	The people I share needles with wouldn't have HIV.	HIV is not the danger people say it is.	HIV only affects gay men.	If I do get HIV, a cure will be available long before I need it.
Psychological Needs	I feel alive when I take a risk.	I want to learn how sex feels without a condom.	It feels powerful to be secretive and do things that are forbidden.	If I push too hard about condoms, my partner will hurt me.
Experiences	We don't know anyone with HIV or anyone who talks about HIV.	My last boyfriend rejected me after I said we should clean our needles.	Sex without condoms feels better. It's more intimate.	Drugs make sex more wild and exciting.
Social Needs or Circumstances	I get paid more money for not using a condom.	I've lost so many people to AIDS that I don't care anymore if I get HIV.	When I have sex without a condom, the messed up stuff disappears.	I've tried so many times and given up so many times, no one believes I can do it.

THE SOCIOCULTURAL CONTEXT MODEL

- The individual behavior of people is intimately tied to the larger contexts in which people live.
- The impact of oppressive sociocultural factors is essential to understanding HIV risk. The “sociocultural context” model describes how homophobia, family loyalty, sexual silence, racism, poverty, violence, and sexual abuse contribute to HIV risk behavior.
- These broader sociocultural issues result in individual psychosocial issues such as loneliness, low self-esteem, internalized homophobia and internalized racism, low perceptions of sexual control, and hopelessness in regards to HIV infection. These individual psychosocial issues then contribute to HIV risk.
- People most likely to have lower risk behaviors have found ways to counter oppressive sociocultural factors. Some of these “resiliency” factors include strong social networks, a high degree of sexual satisfaction, positive role models, and family acceptance.
- Successful prevention work must include an understanding of the ways in which each client's life and sense of self are affected by these factors.

WHAT CAN WE DO AS HIV COUNSELORS?

- If a counselor tells a client who smokes, “Smoking causes cancer,” that person probably is not going to stop smoking as a result. The client may feel more inclined to avoid the counselor than to avoid cigarettes.
- Smoking, while seemingly a simple act of lighting a cigarette and inhaling, is a complex process that is not shifted by a single piece of information.
- Similarly, telling a client, “Unless you use a condom every time you have intercourse, you are putting yourself at risk for HIV,” will not be enough for that client to use a condom all of the time. While the information may be a necessary part of counseling, it is not enough to lead to behavior change.
- Through client-centered, harm reduction counseling based on an understanding of the personal as well as sociocultural context of HIV risk behavior, counselors explore a client’s sex and drug use in ways that motivate positive change, as defined by the client.
- Not every client will be ready, willing, or able to completely avoid HIV risk, but most will feel encouraged and supported to move in that direction.
- When the counselor can listen and “meet” a client where they actually are in the process of making—or thinking about making—changes, the counseling session often has long term, positive effects. For more on this topic, see *Understanding the Model of Behavior Change* in the Online Resources.

Section 14: HIV and Substance Use*

CONNECTIONS BETWEEN SUBSTANCE USE AND HIV

- Sharing of contaminated syringes and other injection equipment is linked to 19 percent of all reported AIDS cases in the state, either directly through the sharing of needles, or indirectly through sexual transmission with an injecting partner or from an injection-infected mother to her child during pregnancy or during delivery.
- In California, this link is particularly strong for women and people of color.
- California data suggests that more than 1,500 new syringe-sharing HIV infections occur annually.
- One reason people use drugs is to experience or enhance sexual arousal. Increased desire combined with an altered perception of reality may make safer sex more difficult or less attractive in a moment of sexual excitement.
- Some drugs, like stimulants, increase heart rate and respiration and dilate blood vessels, creating an easier route for HIV to enter the body if a person is exposed to the virus.
- Because many substances can heighten a person's pain threshold, users may engage in more vigorous sex under the influence, sometimes leading to bleeding or other tissue trauma. Bleeding or abrasions heighten the risk of HIV transmission by compromising the body's first line of defense, skin.
- Chemical dependence may lead some users to survive by exchanging sex for drugs, which may lead to an increased chance of contracting a sexually transmitted disease, including HIV.

CHEMICAL DEPENDENCE

- Generally, people use substances—at least to start with—because they enjoy the change in perceptions, feelings or sensations experienced while under the influence of the drug. They may feel more relaxed, more powerful, or more comfortable socially.
- Some people also like experimenting with the varied experiences of new and different drugs. Those with chronic health problems and pain, or are suffering from untreated mental health problems, may use street drugs to self medicate.
- Over time some people develop physical and/or psychological dependence on a substance. Chemical dependence can occur in as little as a few days, a few weeks, or even over a longer period, such as months or years. The pleasure in use may decrease over time, while the urgency to use increases.

* Robin Ortiz-Young contributed substantially to this section.

PHYSICAL VERSUS PSYCHOLOGICAL DEPENDENCE

- Physical dependence on an addictive drug means that a person's body needs the substance to function, and ending use will cause specific physical symptoms, called withdrawal.
- Withdrawal from some drugs, particularly alcohol, can be extremely dangerous—even life threatening—and should be supervised by medical providers.
- Psychological dependence occurs when a user becomes so accustomed to a substance that use is necessary to reach a level of functioning, or to achieve any feeling of wellbeing.

WHAT'S THE HIV COUNSELOR'S ROLE?

- In HIV counseling and testing, if a client describes a pattern of substance use associated with HIV risk, a counselor's job is to explore that pattern to clarify the client's concerns and offer harm reduction that reduces HIV risk.
- Counselors may need to be particularly sensitive to their own biases about substance use and people who use substances. Substance using clients may be particularly good at perceiving that they are being judged, or they may have concerns about a counselor's motives for gathering information about substance use, and discomfort about the consequences of answering questions honestly.
- HIV test counselors who are not specially trained in drug counseling and assessment should not be determining whether a client is chemically dependent.
- A skillful test counselor will look for signs of problems, understand how to discuss these problems in a non-judgmental way with the client, and have appropriate referrals on hand for clients interested in more in-depth counseling.
- An effective counseling intervention involves a harm reduction approach to reduce HIV risk, but it is not an HIV test counselor's role to determine if a client is chemically dependent.

Section 15: Human Sexual Behavior*

A WIDE RANGE OF HUMAN SEXUAL BEHAVIORS

- While HIV counseling clients will often talk about oral sex, vaginal or anal intercourse and masturbation, people engage in many other sexual activities.
- The full variety of human sexual behaviors is limited only by human imagination. There is no “right” way to have sex or “right” way for people to feel during sexual activity.
- People also feel a great variety of emotions during sexual activities, including gratification, love, frustration, anger, shame, sadness, fear, embarrassment, anxiety, delight, happiness and accomplishment.

SEXUALITY, RISK AND JUDGMENT

- Because everyone has different feelings about sexuality, it is natural that counselors might sometimes feel judgmental responses.
- If the client senses the counselor is judgmental about certain sexual behaviors (especially if they pose HIV-related risks), the client may never reveal those risks. The counselor will be unable to make an adequate risk assessment, and the client may leave the session without the necessary counseling and information to practice harm reduction.
- Human sexual drives are very complex. These behaviors that HIV counselors call “risk behaviors” are natural and motivated by powerful desires and experiences. If behavior change were simple, HIV would not present an ongoing risk to so many people.
- As counselors build greater familiarity with human sexual practices, they tend to experience fewer episodes of discomfort or judgment with clients who make sexual choices or express attractions different from their own.

CLEAR LANGUAGE: A KEY TO EFFECTIVE RISK ASSESSMENT

- In conversations about sexuality, people tend to use vague words to describe sexual behavior.
- For example, someone might mention “anal sex.” Is the person referring to anal intercourse (penis in anus), fingers in the anus, a dildo in the anus, or a tongue in the anus (rimming)?
- Counselors can explain that terms like “normal sex,” “anal sex,” and “vaginal sex” mean different things to different people, and then ask the client to explain in more detail what they mean.

* Francis Salmeri LMFT, Clinical Supervisor/Volunteer Coordinator at the UCSF AIDS Health Project, contributed substantially to this section.

SEXUAL ORIENTATION, SEXUAL IDENTITY, AND HIV RISK

- Many clients assume that gay men continue to be the primary population at risk for AIDS. This assumption has unfortunately caused many people who do not identify as gay men to feel a false sense of safety, permitting themselves to think they could not become infected while engaging in sex that poses a high risk for HIV transmission.
- Sexual orientation describes a person's attractions as a sexual being.
- The most important determinant of sexual orientation is self-description—how the individual identifies desire.
- Common ways people express sexual orientation are: heterosexual or straight (men who are interested in women as partners; women interested in men as partners); bisexual or bi (interested in male and female partners); and gay and lesbian (men interested in male partners, women interested in female partners).
- Sexual identity, as distinct from sexual orientation, expresses a broader spectrum of a person's sense of sexual self. This includes a person's gender identity (male, female, transgender), and also encompasses the gender a person feels attracted to, fantasizes about, and has had sex with historically and currently.

TRANSGENDER PEOPLE

- Transgender is a term that refers to people who live in a manner transcending traditional gender roles.
- For example, a person born male but who feels and identifies as female, or vice versa, may identify as a transsexual. Some transsexuals have sex-change surgery, and some do not. Transsexuality is an example of being transgender.
- Some people do not identify as solely male or female, but as a blending of both genders. People may refer to themselves as “intersex,” “two-spirit,” or simply “trans.”
- Transgender individuals also express a range of sexual orientations. There are, for example, male-to-female transsexuals who are lesbian-identified, some who are straight or bi-identified. There are also female-to-male transsexuals who are straight identified and some who are bi or gay-identified.
- It is also important to note that the umbrella term “transgender” may have different meaning in different geographical or regional communities. Not knowing all the facts is okay, if the counselor can be open, ask respectfully, and demonstrate compassion and caring.

SEXUAL ORIENTATION AND SEXUAL BEHAVIOR

- Sexual behavior describes what a person actually does sexually. This is not necessarily clear from a person's stated sexual orientation.
- For example, a heterosexual man might engage in sex with another man and maintain his heterosexual identity. A lesbian might perform oral sex on a gay identified man while remaining firm in her identity as a lesbian.
- Focusing on actual sexual behaviors rather than sexual orientation is key to any HIV risk assessment.

PERSONAL HISTORIES AND SEXUAL VIOLENCE

- Counselors discussing sexual histories and practices should keep in mind the possibility that clients might have unpleasant associations related to experiences of rape, incest, or molestation.
- Frank and open discussions of sexual behavior may be particularly uncomfortable.
- Skillful HIV counselors will respond sensitively to clients' clues that they are coping with painful histories, and invite them to discuss these concerns further, validate their reactions, and offer referrals for more in-depth counseling if appropriate.

A QUALITY OF OPENNESS, INTEREST, AND ACCEPTANCE

- HIV counselors can never know everything about human sexuality. People are far too resourceful and creative for anyone, even a specially trained sex counselor, to predict all possible feelings, behaviors, and motivations for people's sexual behaviors.
- The most important qualities counselors can bring to counseling sessions are openness, interest, and acceptance.
- The client who feels a genuine presence and interest from a counselor is probably going to offer a more complete history and more background information about sexuality.

Section 16: Sexually Transmitted Diseases and HIV*

HIV counselors should be familiar with the names and symptoms of sexually transmitted diseases (STDs) other than HIV. Many STDs are more easily transmitted than HIV and often go unnoticed and untreated. Yet the presence of an STD may increase, sometimes significantly, the risk of both contracting and transmitting HIV, and can be a serious health complication for people living with HIV.

BACKGROUND ON COMMON STDs

- Common sexually transmitted diseases are caused by bacteria, viruses, and parasites (such as protozoa).
- Most STDs are asymptomatic (show no symptoms), which means that the only way to know if someone has an STD is to test (or “screen”) for the infection.
- Some STDs can be treated and usually cured. Others can be treated, but not cured. Untreated STDs can lead to complications, such as pelvic inflammatory disease (PID), infertility, cervical or anal cancer, liver damage, or problems with the circulatory and nervous systems.
- STDs and HIV are both transmitted by sexual behaviors and respond to similar risk reduction strategies. Condoms, for example, reduce the risk of both HIV and most other STDs.

CONNECTIONS BETWEEN STDs AND HIV

- If someone has a risk for HIV, that person likely also has a risk for STDs. Many STDs are transmitted in the same way as HIV is transmitted.
- STDs can facilitate both the acquisition of HIV and the transmission of HIV from someone who is also HIV-positive.
 - ▲ Many STDs cause sores or break down cell layers in the skin. This creates an easier entry point into the body for HIV. Sores and compromised skin also provide an easy exit for HIV out of the body.
 - ▲ White blood cells sent by the body’s immune system go to the site of an STD infection to try to fight the infection. As these cells come closer to the skin’s surface, they increase the chance that HIV will find a host cell to infect during sex. If someone with HIV has another STD, HIV-infected white blood cells around the STD site also increase the risk of HIV exiting the body and infecting other people during sex.
 - ▲ STDs alter conditions in the vagina that provide natural defenses against infection. For example, STDs may change pH (acidity or alkalinity), levels of hydrogen peroxide, or the amount of good bacteria. STDs also increase the concentration of HIV in semen.
 - ▲ While HIV is not easily transmitted through oral sex, STDs in the throat and mouth may increase the chance of HIV infection during oral sex.

* Developed from materials provided by the CA STD/HIV Prevention Training Center, www.stdhivtraining.org.

- **As is true for HIV, the only way to know if a person has an STD is to test for the range of STDs.** Most STDs are asymptomatic, and even with STDs that may cause lesions, warts, or sores, these signs are often hidden in the vagina or rectum.
- **HIV and STDs require medical attention for diagnosis and treatment.** As with HIV, home remedies or over-the-counter medications do not get rid of an STD.
- **STD and HIV co-infection may worsen each condition** and further compromise the immune system. HIV-positive clients, in particular, should seek STD testing.

STDs AND HIV: WHAT ARE THE DIFFERENCES?

In the United States there are about 40,000 new cases of HIV—and 19 million new cases of STDs—each year. Likewise, while there are between 1 million and 1.25 million people living with HIV in the United States, there are 100 million people living with an STD.

- Most STDs are much more infectious than is HIV. Therefore they are also much more common than HIV.
- STDs are more easily acquired than HIV. Some STDs can be passed by direct skin-to-skin, lesion-to-skin, or lesion-to-mucous-membrane contact. These STDs do not require contact with blood, semen, or vaginal secretions.
- Oral sex is considered a low risk for HIV, but it is a high risk for other STDs.

THE ROLE OF HIV TEST COUNSELORS

Stick to basic STD information: assess a client's risk for STDs, enhance the client's perception of risk between HIV and STDs, and make referrals.

- Referrals between HIV and STD clinics are critical to HIV prevention. People seeking HIV testing often have an underlying risk for other STDs.
- For people who test HIV-negative, STD prevention is an important strategy in HIV prevention. Even if all clients do is screen and treat for STDs, they will be reducing their HIV risk.
- For people who test HIV-positive, STD screening is one important next step. Evaluation for other STDs should be part of a newly diagnosed client's medical work-up.

RECOGNIZING COMMON SIGNS AND SYMPTOMS OF STDs

The most common sign of STD infection is to have NO signs. However, if signs or symptoms are present, they may include:

- Itching or burning during urination
- Open sores or lesions (with urination or defecation or without pain)
- Discharge (from genitals/anus)
- Warts (on or around genitals/anus)

- Rash (body, palms, soles)
- Blisters
- Abdominal pain
- Abnormal bleeding
- Diarrhea, gas cramping, bloating
- Painful intercourse
- Swelling of or around genitals

If a client describes any of the above symptoms, do not try to diagnose the STD. Instead, refer the client to a medical provider or clinic for the appropriate tests.

TREATING STDs

- **STDs caused by bacteria or protozoa are curable.** This means that medical treatment can remove these STDs from the body.
- **STDs caused by viruses are incurable.** No medical treatment will be able to remove these STDs completely from the body.

Bacterial STDs	Protozoal STDs	Viral STDs
<ul style="list-style-type: none"> ■ chlamydia ■ gonorrhea ■ NGU/NSU ■ shigella ■ syphilis 	<ul style="list-style-type: none"> ■ cryptosporidium ■ entamoeba ■ giardia ■ trichomonas 	<ul style="list-style-type: none"> ■ hepatitis A (HAV) ■ hepatitis B (HBV) ■ hepatitis C (HCV) ■ herpes (HSV) ■ HIV ■ human papilloma virus (HPV)

- Even though viral STDs are not curable, they are treatable. Medications can eliminate or reduce symptoms. Treatment may also reduce the amount of virus in the body and therefore the risk of transmission to other people.
- Some viruses (like human papilloma virus, hepatitis A, and hepatitis B) ordinarily resolve with medication. These “acute” infections last less than six months.
- Other viruses (like herpes, hepatitis C and HIV) are chronic. These STDs can remain in the body, affecting organs, tissues, and cells for a long time. Some viral STDs, like herpes and human papilloma virus, may have acute symptoms that come and go, but the infection itself is chronic.
- Vaccinations for hepatitis A virus and hepatitis B virus can prevent infections. (There is no vaccine for hepatitis C virus, although hepatitis A and B vaccinations are recommended for anyone living with hepatitis C.)

MODES OF STD TRANSMISSION

- While HIV and many STDs are often transmitted in similar ways, STDs can also be passed in ways that HIV cannot. STDs are passed from person to person in three ways:
 - 1. Skin-to-Skin:** An open sore, lesion or wart comes in contact with another person's skin or mucous membrane during oral, anal, or vaginal sex, or while bodies rub one another. (It is in the moist, genital area or other mucous membranes like the mouth, where this "rubbing" can pass STDs.) Breaks in the skin do not necessarily have to be present for skin-to-skin transmission to occur. For example, herpes and HPV can be transmitted by skin-to-skin contact, even without visible warts or sores.
 - 2. Sexual Fluids/Discharge/Blood:** Infected sexual fluid, discharge or blood comes in contact with a mucous membrane during oral, anal, or vaginal sex. In other words, transmission can happen the same way that HIV transmission can happen.
 - 3. Fecal/Oral:** Infected bits of feces are taken into the mouth through cunnilingus, anilingus, fellatio, vaginal intercourse, anal intercourse, digital sex, fisting, and sharing of sex toys. The organism must enter the mouth and be swallowed in order to infect.

RESOURCES AND REFERRALS

- Every test site should have a local referral list. For out of area referrals, counselors can access information about state programming through the California STD Control Branch website (www.cdph.ca.gov/programs/std) which offers a link to www.hivtest.org, a search engine for HIV/STD testing based on zipcode. Additional sites may be listed through www.inspot.org.
- Counselors can also call the National CDC Hotline 24 hours a day, seven days a week to find further resources beyond California: 800-CDC-INFO (800-232-4636), and TTY for the Deaf and Hard of Hearing (888-232-6348).
- For a more thorough description of specific STDs, check out the CDC's web site and fact sheets at <http://www.cdc.gov/std/default.htm>.
- CA STD Control Branch website, which is available under www.cdph.ca.gov/programs/std. They offer a link to www.hivtest.org, which provides STD testing locations based on zipcode search.

MODES OF TRANSMISSION CHART

STDs	Skin-to-skin contact with a lesion, sore, or wart	Skin-to-skin contact with infected tissue, even without a visible lesion, sore or wart	Exposure to infected semen, vaginal or anal secretions	Exposure to discharge (pus)	Exposure to infected blood	Ingestion of organism via feces
Bacteria						
Chlamydia			•	•		
Gonorrhea			•	•		
NGU/NSU			•	•		
Shigella						•
Syphilis	•				•*	
Protozoa						
Cryptosporidium						•
Entamoeba						•
Giardia						•
Trichomonas			•	•		
Viruses						
Hepatitis A						•
Hepatitis B			•		•	
Hepatitis C					•**	
Herpes (HSV)	•	•				
HPV	•	•				
HIV	•***		•	•***	•	

*Syphilis may be passed through blood-to-blood contact (i.e. shared needles) only during a very small and specific time period during infection. Blood-to-blood transmission is not common.

**Hepatitis C virus is not commonly transmitted via sex, unless blood is present. This may occur if warts or abrasions lead to bleeding, or if intercourse is prolonged without lubrication.

***In an HIV-positive person co-infected with another STD, HIV may be passed through open lesions and/or discharge from the STD infection.

Section 17: Domestic Violence*

Abuse in a relationship, or domestic violence, is any pattern of behavior used to dominate, coerce, or control another person.

- Domestic violence occurs in all communities, regardless of race, class, ethnicity, ability/disability, age, sexual orientation, religion, education, or lifestyle.
- Domestic violence is a complex issue to address. The primary role of an HIV counselor when addressing domestic violence is to provide useful and sensitive referrals to specialized counseling, shelters, and other resources.

PREVALENCE OF DOMESTIC VIOLENCE

- In California, in 2002 alone, there were nearly a quarter of a million domestic violence related calls for assistance to law enforcement agencies.
- It is estimated that every year, spousal assault occurs in one out of six families in the United States. Approximately 1.3 million women and 835,000 men are physically assaulted by an intimate partner annually in the United States.

DOMESTIC VIOLENCE AND HIV

- Domestic violence affects many aspects of counseling, including a client's ability to practice or even discuss HIV prevention. A client may express this experience in several ways, for example:
 - ▲ "I'm not sure it's safe for me to tell my counselor what's really happening."
 - ▲ "If I bring up condoms or going to needle exchange, he'll think I'm cheating and hit me even harder."
 - ▲ "My girlfriend will yell at me and say I'm stupid if I ask her to get an HIV test. I won't even tell her I was here."
 - ▲ "I have bigger things to worry about than HIV, like making sure he doesn't start hitting the kids."
 - ▲ "He'd kill me if he found out I talked about this."
- Violence may also occur when a lover, family member, or roommate finds out about a person's HIV status. The abuser may threaten to reveal the client's HIV status to others, threaten to leave a client who is sick, refuse to wear a protective barrier during sex, force or withhold sex based on the client's HIV status, or humiliate or blame the client for HIV infection.

* This material has been adapted from California Alliance Against Domestic Violence, www.caadv.org/know_the_facts.html#facts.

THE IMPORTANCE OF ASSESSING DOMESTIC VIOLENCE

- Asking about domestic violence allows clients an opportunity to discuss how abuse influences HIV risk behavior, and likewise influences how you approach discussing risk reduction and referrals, like partner notification.
- For example, a client may not consider straightforward prevention options to be realistic (e.g., notifying the partner if the client tests HIV-positive, or feeling like using sterile needles or condoms is really a “choice”).
- If the client is at risk for being a victim of severe abuse, an appropriate referral could save the client’s life.
- The client may also be a perpetrator of domestic violence and be receptive to getting help. Counseling may be an opportunity to refer the client to a batterer treatment program.

GUIDELINES FOR COUNSELING BATTERED AND ASSAULTED CLIENTS

- All clients who participate in HIV prevention counseling should be asked about their ability to talk to their sex and/or needle-sharing partners about their HIV concerns.
- In assessing the impact of an individual’s HIV status on violence in a relationship, consider: the abuse survivor’s knowledge and feelings about his or her own HIV status; the abuser’s knowledge and feelings about his or her HIV status; the health status of the abuse survivor; and the health status of the abuser.
- If clients feel they cannot talk to their partners, counselors should then assess for the risk of domestic violence and/or sexual assault. For example:

To Assess, Ask:

- Are you in a relationship with a person who threatens or physically hurts you?
- Is your partner hurting or abusing you, verbally or physically?

If the Client is Pregnant or Doesn’t Have a Current Partner, Ask:

- Within the last year, have you been hit, slapped, kicked or otherwise physically hurt by someone?
- Since you have been pregnant, have you been hit, slapped, kicked or otherwise physically hurt by someone?
- Within the last year, has anyone forced you to engage in sexual activities?

Then, If the Client Says “Yes”:

- Domestic violence is against the law and no one deserves to be physically assaulted.
- Would you like to talk about what has happened to you? (If client says “no,” she or he may not feel ready to talk, or may not feel safe enough.)

If There is Risk of Violence:

The client should be given referral information and the counselor should document the abuse. If the client's life is possibly in danger, then ask questions about a plan for safety (especially if the client tests preliminary or HIV-positive!):

- Is it safe to go home?
- Are the children/other dependents safe?
- Is there a need for a safe place to stay? Are there friends or family to stay with? (If immediate need for place to stay, refer to shelter).
- Is there an urgent need for crisis counseling? (Assess for lethality.) Refer to domestic violence hotline and also to other shelters and domestic violence agencies that provide counseling services.

The counselor should assess lethality and offer the client a safety plan:

- Has your partner ever threatened to kill you, your children, your relatives, or him or herself?
- Are there weapons in the house?
- Does your partner abuse alcohol or use drugs?
- Is your partner violent outside the home?
- Does your partner hurt the family pets?
- Has the violence increased in frequency or severity over the past year?

If abuse is indicated or situation is potentially dangerous, partner notification should never be done without the client's consent.

GUIDELINES TO ASSESS POTENTIAL PERPETRATORS

- Do you ever have trouble with anger?
- Have you ever done anything when you were angry that you later wished you hadn't done?
- Has your anger ever gotten you in trouble?
- Have you ever thought about doing something about your anger?
- Get indication of how he/she responds to provoking situations.
- Consider referral to batterer groups.

RESOURCES

- A written referral could risk greater violence if discovered by a perpetrator. Instead of a written referral, give a verbal referral, for example to the National Domestic Violence Hotline, 1-800-799-SAFE, which offers resources throughout the country and is easy to remember.
- The Basic HIV Counselor Skills Training will not cover domestic violence counseling in depth. You can prepare yourself to assess and address domestic violence within your limited role by taking the Domestic Violence Continuing Education Training through the HIV/STD Prevention Training Center (www.stdhivtraining.org).

Section 18: What Happens After a Client Tests HIV-Positive?

People react in a wide range of ways to their HIV status. While it is not possible to know exactly how someone will respond to an HIV diagnosis, we do know that one of most important next steps for a newly diagnosed person is to meet with a medical provider.

- Early intervention is key, before the onset of symptoms or while symptoms are mild. Testing the immune system will help to determine when and how to treat HIV.
- Other steps that people consider are informing past partners that they may want to test for HIV, or initiating prevention steps so that they can continue to have emotionally healthy lives, for example, by continuing to have sex in safe ways.

THE IMPORTANCE OF MEDICAL CARE

- Today's HIV medications can slow or stop the virus from reproducing. For many people, HIV has become a chronic, manageable disease. In addition, a wide range of treatment options exist for people living with HIV even when a patient develops a severe illness.
- By taking “prophylactic,” that is, preventive, treatments, a person with HIV may be able to avoid opportunistic infections altogether.
- Illnesses that once might have led to significant disability and even death are usually manageable and only mildly disabling when treatment is accessible.
- The efficacy of treatments varies. Some people do not respond, while others respond initially but over time experience a “breakthrough” as the virus regains its ability to replicate. The long-term effects of these medications is not yet known.

VERIFIED MEDICAL VISIT AND SERVICES (VMV)

- When a person tests HIV-positive in an Office of AIDS-funded test site, counselors must always offer a written, medical referral for HIV care. A medical provider can offer a person with HIV insight into the wide range of medical options available to the client. If the client chooses to take antiviral treatment, this treatment can slow the progression and reduce the severity of HIV disease, its symptoms, and related complications. Medical care can also open the path toward other services along the continuum of care and improve the client's quality of life.
- Medical care can also have an impact on HIV prevention, since it can reduce HIV viral load and the infectivity of HIV. Further, a medical provider can continue to offer clients prevention counseling.
- The Office of AIDS encourages test sites to verify that clients who test HIV-positive receive a referral to a medical provider, get an appointment with that provider, and actually go to the appointment. The Office of AIDS calls this process of “linkage” Verified Medical Visit and Services (known as VMV).

- During VMV, counselors give their HIV-positive clients a release of information form to hand to their medical provider. This form allows the test site to know when the client has entered medical care. For a client testing anonymously, the form would include the CIF code; for a client testing confidentially, the form would include the client's name. Whether a client tests anonymously or confidentially, counselors must document the VMV process on the CIF.
- Whether or not the client has a medical provider already, counselors should try to help the client make an appointment on-the-spot. If the client is not interested in medical care, test sites can offer to check-in with the client at a later date, to see if there is any additional support—either medical or psychosocial—that interests the client.
- The VMV process is intended to help HIV-positive clients transition from the counseling and testing experience to the next step in their HIV care. Not every client will be ready, willing, and able to discuss medical care immediately after receiving an HIV diagnosis. Sensitivity to following the client's lead will, of course, be the best way to support the client in taking whatever next step feels most appropriate.

PARTNER SERVICES (PS)

- When clients test preliminary positive or HIV-positive, they may want to consider informing sexual and needle-sharing partners of their HIV status or of their partners' HIV risk.
- The next section, *Partner Counseling and Referral Services*, describes the process by which the Office of AIDS supports clients in their efforts to inform past and present, sexual and needle-sharing partners of their HIV risk. Partner Services can also be a source of support for considering general issues of disclosure, for example, for disclosing to friends or family.

PREVENTION WITH POSITIVES

- People with HIV are living longer and healthier lives in which sex and drug use may be an integral part of their sense of health.
- Clients may be concerned about disclosure; wondering about medication; dealing with depression and isolation; or considering other HIV-related issues.
- Counselors may have an ongoing relationship with clients who test HIV-positive and may want to learn more about these psychosocial issues related to living with HIV and the skills a provider can offer to support HIV-positive people. To learn more about prevention counseling for people living with HIV, go to the California STD/HIV Prevention Training Center's web site at www.stdhivtraining.org.

STATE SPONSORED PROGRAMS FOR PEOPLE LIVING WITH HIV

- For a complete description of programs, call 916-449-5900 or visit the Office of AIDS web site at www.dhs.ca.gov/AIDS and click on "OA Program Fact Sheets": <http://www.cdph.ca.gov/programs/AIDS/Pages/OAProgramFactSheets.aspx>.

The AIDS Drug Assistance Program (ADAP)

- The AIDS Drug Assistance Program (ADAP) provides HIV drugs to people who have no prescription insurance coverage or limited financial means. More information about ADAP is available from at 888-575-ADAP.

Early Intervention Programs (EIP)

- The California Early Intervention Program (EIP) provides comprehensive services to HIV-infected individuals and their at-risk sex and/or needle-sharing partners.
- In some locations, test counselors can arrange for an EIP staff person to be available to meet with a newly HIV-positive client, so that linkage with EIP is immediate.

Section 19: Partner Services*

WHAT IS PARTNER SERVICES?

- When a client tests positive, the question of whether, or how, to notify a partner or partners of possible exposure often becomes part of an HIV counseling session.
- Partner Services (formerly known as Partner Counseling and Referral Services or PCRS) helps people living with HIV consider whether or not and how to inform sexual and needle-sharing partners about their exposure to the virus. In some parts of California, Partner Services is also a service that helps HIV-positive people think through considerations about disclosure in general, for example, to family, friends, or future partners.
- The Office of AIDS places a high value on a client's right to privacy. Participation in Partner Services is voluntary.
- Special laws also protect a person's confidentiality if he or she becomes involved with Partner Services.
- Partner Services has succeeded in reaching people who may not test for HIV on their own, especially needle-sharing partners of injection drug users and female partners of men who also have sex with men.
- During a confirmatory test disclosure session, every HIV-positive client should be offered Partner Services. HIV prevention counselors must be able to describe Partner Services as it works at their local health jurisdictions and facilitate a referral for clients who request provider assistance.

HOW PARTNER SERVICES NOTIFICATION WORKS

The notification part of Partner Services involves telling sexual or needle-sharing partners about their possible exposure to HIV. This can happen in three ways:

- **Self-Notification:** a provider can “coach” clients who decide to contact their partners on their own.
- **Dual-Notification:** a Partner Services counselor can be present, while clients disclose to partner(s) themselves.
- **Provider-Only Notification:** a Partner Services worker can locate partners, arrange to meet privately, and inform them of their HIV exposure.
- Choosing to notify one's partners through Partner Services is voluntary. HIV-positive clients are never forced to provide marital or other partners' names or locating information.
- All records related to the interview of the original client, the elicitation of partner names and contact information, related field activities, and resulting dispositions must be retained

* For more information, see Kutner B, Cataldo M. HIV Status Disclosure. HIV Counselor PERSPECTIVES. 2007; 16(1): 1–8. You can access this publication at <http://www.ucsf-ahp.org/HTML2/archivesearch.html>.

in a confidential manner. No Partner Services documentation can ever be compelled to be presented in a criminal or civil trial.

MAIN ELEMENTS OF PARTNER SERVICES

- **Confidentiality of the Index Client:** Identifying information about the index client (the original HIV-positive client) is never divulged to partners.
- **Free Counseling and Testing:** All partners are offered voluntary HIV prevention counseling and testing services (and follow-up prevention counseling if appropriate). Testing may be either anonymous or confidential.
- **Referrals:** Partners are offered referrals to other appropriate services for treatment of HIV, STDs, tuberculosis, or other conditions.

WHO IS ELIGIBLE?

- Partner Services is available to individuals with confirmed HIV-positive test results, whether the client tested anonymously or confidentially. The original positive clients' identity does not need to be known in order for partners to be informed of exposure.
- Disclosure is a sensitive topic. Partner Services counselors never identify the original client to people being informed through the service, and make sure to think through with the original client whether or not informing partners is appropriate.
- Disclosure is an ongoing process. Partner Services is available throughout the continuum of care, not only at the time a person is diagnosed with HIV. Clients can access Partner Services through test sites, case managers, doctors' offices, and anywhere else they receive HIV services.

OTHER TYPES OF NOTIFICATION

- Each local health jurisdiction has its own partner management services for STDs, which counselors can learn about through their test site supervisors or by contacting their local coordinators, who work with the STD Control Branch on the process of PS and the training providers. The process for PS and training for PS occurs through the STD Control Branch. The November 2009 Prevention Guidance contains documentation regarding the PS process. Counselors should speak to their supervisors or coordinators about the PS procedures for their area.
- Non-consensual, or mandatory, notification is currently not required by law. It is, however, permitted under certain circumstances. Health officers who are also physicians may choose to notify partners of potential exposure to HIV. This is not considered part of Partner Services but is a form of partner notification possible under California law.

Section 20: Elements Of Effective Closure

HIV counseling can involve an intense exchange between counselor and client. Ending a session involves making a smooth transition into closing the session, not the door.

SUMMARIZE CONTENT

- Re-state the general content of the session: where the client has been, where the client is now: “From our conversation, you seem very committed to using condoms, even more now after receiving this negative result.”
- Review essential new information and provide written material for backup: “We talked about the effect of STDs on HIV. It sounds like you want to get checked out for those as well.”

CONFIRM NEXT STEPS

- Review steps the client has expressed interest in taking: “Since this result is HIV-negative, you said you’d like to come back in two months, just to be sure.”
- Broader support issues: “You mentioned going to needle exchange, and that you could talk to a friend about her experience there.”

PROVIDE EFFECTIVE REFERRALS

- Make sure referrals are carefully selected, limited in number, and relevant to the client’s needs.
- Offer referrals in written form, with a contact name and reference, whenever possible.
- Invite feedback from the client: “How does this sound to you? Is it realistic?”
- Assess and respond to possible obstacles to follow-through, especially as it pertains to returning for confirmatory results.

EXPLORE RETURNING FOR CONFIRMATORY RESULTS

- “What would make it easier for you to return here? Who might be able to come with you? What will you need over the next few days?”

CLOSE THE SESSION, BUT NOT THE DOOR

- Let the client leave feeling there are specific and appropriate steps to take in the present, and options for further follow-up in the future (either at your agency/site or through some other resource).

Section 21: Legal and Ethical Issues

There are more laws written about HIV than any other disease. Over the years, counselors and policymakers have also developed a number of ethical guidelines.

WHAT'S THE DIFFERENCE BETWEEN LEGAL AND ETHICAL ISSUES?

- Legal standards are legislated, developed by government agencies, or established by courts. Violating laws can result in penalties such as fines or imprisonment.
- Ethics are essentially about “doing the right thing,” whether or not this is what is required by law. Ethical standards are driven by considerations of the specific moral obligations and choices made by an individual or profession.

ASPECTS OF LAW AFFECTING HIV COUNSELORS

HIV counselors have an individual responsibility to uphold three basic laws:

Informed Consent

- Clients must be 12 years or older (13 if using the OraSure specimen collection device).
- Clients must be capable of understanding the information, and must choose to test freely, without being forced.

Anonymity/Confidentiality

- Counselors should not disclose any information identifying clients of test sites or their results, either to other providers outside the test site or in any social situation.
- Releasing information can only occur with the written approval of a client, consistent with Office of AIDS policies and local, state, and federal laws.

Limited Role of the HIV Counselor

- In a confidential test, counselors must abide by certain reporting laws. For example, if a client discloses child abuse, domestic violence, or an intention to harm oneself or others, the counselor should consult with his or her supervisor. The test site may then be required to report the incident to police or other parties.
- Although counselors need to be aware of these requirements, they may not be carried out without the involvement of a supervisor.
- In an anonymous test, counselors should involve supervisors, but there is no mandated reporting. Anonymity supercedes any reporting.

ETHICAL VERSUS LEGAL ISSUES

Sometimes there is a gray area between laws and ethics. For example, clients do not show evidence of their age, so how does a counselor know if a client is at least 12 years old? These kinds of gray areas are best explored onsite with your supervisor or coordinator.

Section 22: Policy and Forms

The State Office of AIDS has produced a manual addressing policies and guidelines for counseling, recommendations for referrals, samples of lab slips and data gathering forms, and policies concerning training of HIV prevention counselors. These state policies are to be followed in all OA-funded test sites.

CDPH/OA POLICIES AND GUIDELINES

- Ask your supervisor or site administrator where the state guidelines manual is stored (California Department of Public Health–Office of AIDS (CDPH/OA) HIV Counseling and Testing Guidelines–Policies and Recommendations [1997] plus a 2003 supplement on rapid testing). Refer to the manual in responding to the following questions.
 - ▲ A television reporter wants to do a story on your HIV test site. What can you tell the reporter about test site guidelines concerning media contacts?
 - ▲ An HIV-positive client wants help telling his old girlfriend about her potential exposure to HIV. He cannot make this contact himself. What could you offer this client?
 - ▲ A father comes to the test site with his 14-year old son, requesting an HIV test for the youth. What response is appropriate from the test site?

SITE-SPECIFIC POLICIES

- Ask your supervisor or site coordinator about your site’s policies and guidelines regarding the following procedures and issues:
 - ▲ Client flow (how are appointments made; who matches clients with counselors; how are clients identified; how follow-up appointments are made; how a client is “transitioned” to a Counselor II).
 - ▲ Low-level interventions (how they are administered; where they are administered; the kinds of interventions—brochures, videos, group education—that are used).
 - ▲ Record keeping (what records are kept on clients; where are test results recorded; how does a counselor match the correct test results to each client).
 - ▲ Counselor responsibilities (setting appointments or work times; lines of responsibility; relationship with other counselors; calling in sick; reporting time worked; general duties and behavior at the test site).
 - ▲ Crisis intervention (what policies and practices are in place to respond to clients who are potentially violent or suicidal).
 - ▲ Referrals and resources (what kind of resource guide for referrals is available; what pamphlets or other educational material is available to give to clients).

IF A QUESTION REMAINS UNANSWERED

- Counselors can ask their supervisors or test site coordinators to contact the State Office of AIDS directly for further assistance at <http://www.cdph.ca.gov/programs/aids>.

ONLINE RESOURCES

Maintaining your skills as an HIV test counselor is an ongoing process. For this reason, after the Basic I course, you will have the opportunity to continue your training at your test site, for example, observing test counseling sessions, role-playing with other counselors, and doing test counseling with a more experienced test counselor or your supervisor.

We also believe that it may help to nurture your skills if you have access to other written materials. We have posted, on the AIDS Health Project web site, a variety of resources directly related to this training. These resources will support your continued growth as test counselors. To review the current resources, go to:

<http://www.ucsf-ahp.org/HTML2/trainingresources.html>.

We have divided these Online Resources for the Basic I into nine sections. Be aware that these resources may evolve and grow over time and, if you return to the web site, they may look different from this listing:

1. HIV Prevention and Substance Use [Pre-Training Resources Included in This Section]

- How to Clean Your Rigs [Pre-Training Resource]
- Syringe Disinfection for Injection Drug Users [Pre-Training Resource]
- Alcohol
- Cocaine
- Crack Cocaine
- Ecstasy (Methylenedioxymethamphetamine)
- GHB (Gammahydroxybutyrate)
- Heroin, Opiates, and Narcotics
- Poppers and Other Inhalants
- Ketamine
- LSD and Other Hallucinogens
- Marijuana
- Methadone
- Mushrooms and Psilocybin
- Speed and Methamphetamine
- Viagra

2. HIV Prevention and Sexual Behavior [Pre-Training Resources Included in This Section]

- Using Condoms: Information about Latex and Polyurethane Condoms [Pre-Training Resource]
- Reality Condom [Pre-Training Resource]
- Using Latex Dams [Pre-Training Resource]
- HIV Risk from Topping [Pre-Training Resource]

3. Behavior Change Theory and Counseling

- What Is the Role of Theory in HIV Prevention?
- Understanding the Model of Behavior Change
- Comparing the Health Educator Model with the Client-Centered Counseling Approach

4. HIV Prevention and Mother-To-Child Transmission [Pre-Training Resources Included in This Section]

- Mother-to-Child HIV Transmission (Perinatal Transmission) [Pre-Training Resource]

5. HIV and Testing 101

- Frequently Asked Questions about HIV Counseling and Testing
- The Window Period Reexamined

6. Rapid HIV Antibody Testing

- Step-by-Step Instructions for OraQuick Rapid HIV-1 Antibody Test

7. Burnout Prevention

- Suggested Strategies for Coping with Stress

8. State Office of AIDS and San Francisco AIDS Office Guidelines and Forms

- Universal Precautions
- HIV Partner Counseling and Referral Services (PCRS) [in San Francisco, DAPS]
- Instructions for completing HIV Test Lab Slips and the Counseling Information Form (CIF)

9. Legal and Ethical Issues and Guidelines

- HIV Reporting Laws: Anonymous versus Confidential
- HIV Reporting Laws: Points for Clients and Counselors to Remember
- HIV Reporting Laws in California: Questions and Answers
- Legal and Policy Information for HIV Counselors: Informed Consent
- Legal and Policy Information For HIV Counselors: Confidentiality and Anonymity
- Legal Information For HIV Counselors: At Risk Sex and Needle-Sharing Partners