UCSF Alliance Health Project

The Counselor Re-Examination Training

Participant's Manual

Alliance 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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THE PURPOSE AND OBJECTIVES OF THE TRAINING

PURPOSE OF TRAINING

The overall purpose of this training is to ensure high standards of care for HIV and HCV testing and prevention services at California Department of Public Health, Office of AIDS-funded testing programs. This standard includes providing accurate, current HIV information relevant to clients. It incorporates the skills of client-centered counseling—that is, active listening and empathic responses to the client's needs and concerns, delivered with compassion and care.

OBJECTIVES

The objective of this training is to increase the effectiveness of HIV test counselors during risk assessment sessions. In this training, participants will:

1. Utilize counseling responses and strategies that will improve the outcome of risk assessment and disclosure counseling for clients testing for.
2. Understand the importance of referrals to PrEP for appropriate negative clients and demonstrate a knowledge of PrEP and nPEP.

STRATEGIES AND REQUIREMENTS OF TRAINING

This training is designed to allow participants an opportunity to demonstrate effective client counseling skills for HIV risk assessment sessions and be evaluated.

To successfully complete the counseling portion of the training, participants will be required to:

Attend the entire training and fully participate to the best of their ability. Anyone who cannot attend the entire training will not get credit for having completed the training.

Demonstrate effective HIV counseling skills. Trainers will evaluate each participant's counseling skills and improvement over the course of the training by observing role plays. Specifically, participants will participate in observed role-play activities during which they will be evaluated on their ability to conduct a short risk assessment. However, please note that participants will be evaluated from the onset of the training and given appropriate feedback to support their success.

Be willing to learn new skills.

Give and receive feedback from both trainers and other participants. Resistance to integrating constructive feedback will generally result in unsuccessful performance during evaluated role plays.

Counselors who are unable to meet the criteria above will be asked to gather more experience at their local site and then repeat all or most of an upcoming Basic Counselor Skills Training (BCST), with approval from their supervisor/Local Health Jurisdiction (LHJ) coordinator and the State Office of AIDS.

Participants who are able to meet the criteria above (and have already passed fingerstick and rapid testing proficiency exams for OraQuick and Alere Determine HIV testing) will receive a letter from the State Office of AIDS stating that they are Certified Rapid Test Counselors.

PARTICIPANT GROUP AGREEMENTS

BE ON TIME: We agree to be here on time at the beginning of each day, and after breaks and lunch.

ATTEND THE ENTIRE TRAINING: We have made a commitment to attend the entire day of each day of the training.

TAKE RISKS, MAKE MISTAKES: We know that some of our best learning comes from mistakes, so we will support each other to take risks and make mistakes.

STRUCTURE: We acknowledge that it is the trainer's task to maintain structure and keep the group on track, and we all share in the responsibility for staying on track.

RESPECTFUL ENGAGEMENT: We agree to be respectful while engaging and interacting with one another throughout the training.

RESPECT PRONOUNS: We agree to respect the pronouns that a participant or trainer states they identify with throughout the course of this training. Examples of pronouns include: she/her/hers, he/him/his, they/them/theirs, ze/zir/zirs, among others.

AGREE TO DISAGREE: We acknowledge individual differences among members of this group. We understand that we will not all agree on everything.

CONFIDENTIALITY: We agree that we will not disclose any personal disclosures by other participants to anyone else; these disclosures will remain confidential.

SUPERVISORS: We understand that in small group activities that involve personal disclosures, we should not be in a small group with someone who supervises us clinically or administratively or, if possible, with a co-worker.

ELECTRONICS: We agree to turn off or silence all personal electronics and to refrain from using cell phones (including for text messaging and email) during the training. There will be breaks and a lunch hour to make and receive calls.

STEP UP, STEP BACK: We acknowledge that some of us like to talk a little more and some of us are more quiet. We will recognize this and share a little more or a little less so all can have the space to join in on the discussions.

DON'T YUCK MY YUM: We agree that in a training that deals extensively with drug use and human sexuality, some participants may have different opinions of many of the activities discussed. We agree to not "yuck" on these activities as other participants may find those same activities "yum."

BE RECEPTIVE TO FEEDBACK: We agree that both participants and trainers will offer us feedback on our performance during both the counseling and technical portions of the training. We will remain open to the feedback and avoid defensiveness as we develop our skills.

THE WINDOW PERIOD

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."

Exposure vs. Infection

Exposure

One or more of the six fluids that can transmit HIV from an HIV-positive person got into an HIV-negative person's body.

Potential Exposure

One or more of the six fluids from a person of unknown status got into an HIV-negative person's body. Or it is unclear if one or more of the six fluids from an HIV-positive person got into an HIV-negative person's body. (For example, a condom broke during sex.)

Infection

An HIV-negative person was exposed to enough HIV, via one of the six fluids, their immune system was unable to overcome the virus, and HIV is now replicating in their body. An infected person is said to be "living with HIV."

Remember

Some people can be exposed to HIV many times and not become infected. Other people can be exposed only once and become infected. But in general, the fewer exposures to HIV, the less likely a person will become infected.

Suggestion for Explaining the Window Period

"The test that we're using here today is looking for HIV antibodies—not for the virus itself. Following an infection, the human body can take anywhere from two weeks to three months to develop antibodies. In other words, a negative test result today would mean that, for sure, from the day you were born until three months ago, you were definitely not living with HIV. But it can't tell us for certain about any exposures or potential exposures that occurred in the last three months."

HIV Testing Recommendations from the California Office of AIDS

The State Office of AIDS recommends that clients have an HIV antibody test three months after the date of their last possible exposure.

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 two months later, on March 1. Her result comes back HIV-negative. Her counselor can explain the negative result indicates from birth to three months ago she was definitely not living with HIV, and recommend she return for another test in early April (three months after the exposure), because some people can take as long as three months to develop enough antibodies to show up on the test. If the test in April is negative, and the client has not engaged in any additional HIV risk behavior between January 1 and the second test in April, she can be confident that she is not infected with HIV. If the test result in April 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 referral to medical care with a provider knowledgeable about HIV.

Some clients with little or 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.

The Window Period Diagram

Date of most recent possible exposure to HIV	2 Weeks Later	1 Month Later	2 Months Later	3 Months Later
(Fill in Dates)	The earliest that people show HIV antibodies is 2 weeks after infection			By the end of 3 months, everyone will have HIV antibodies

A larger version of this diagram is available as the last page in this manual.

PROGRESSION OF HIV INFECTION

Antibodies

Proteins produced by the body's immune system to identify and neutralize pathogens by binding to particular antigens that compose viruses, bacteria, and other harmful organisms.

- As the body produces more antibodies, p24 becomes increasingly difficult to detect.
- The window period for detecting HIV antibodies ranges from two weeks to three months.
- Antibodies remain detectable for the life of the person.

Antigen

Any substance, such as the HIV protein p24, that triggers the immune system to produce antibodies against it.

- p24 composes the shell that protects HIV's RNA.
- p24 can be detected by fourth generation tests as soon as two weeks after HIV infection and remain detectable for up to four weeks after HIV infection.

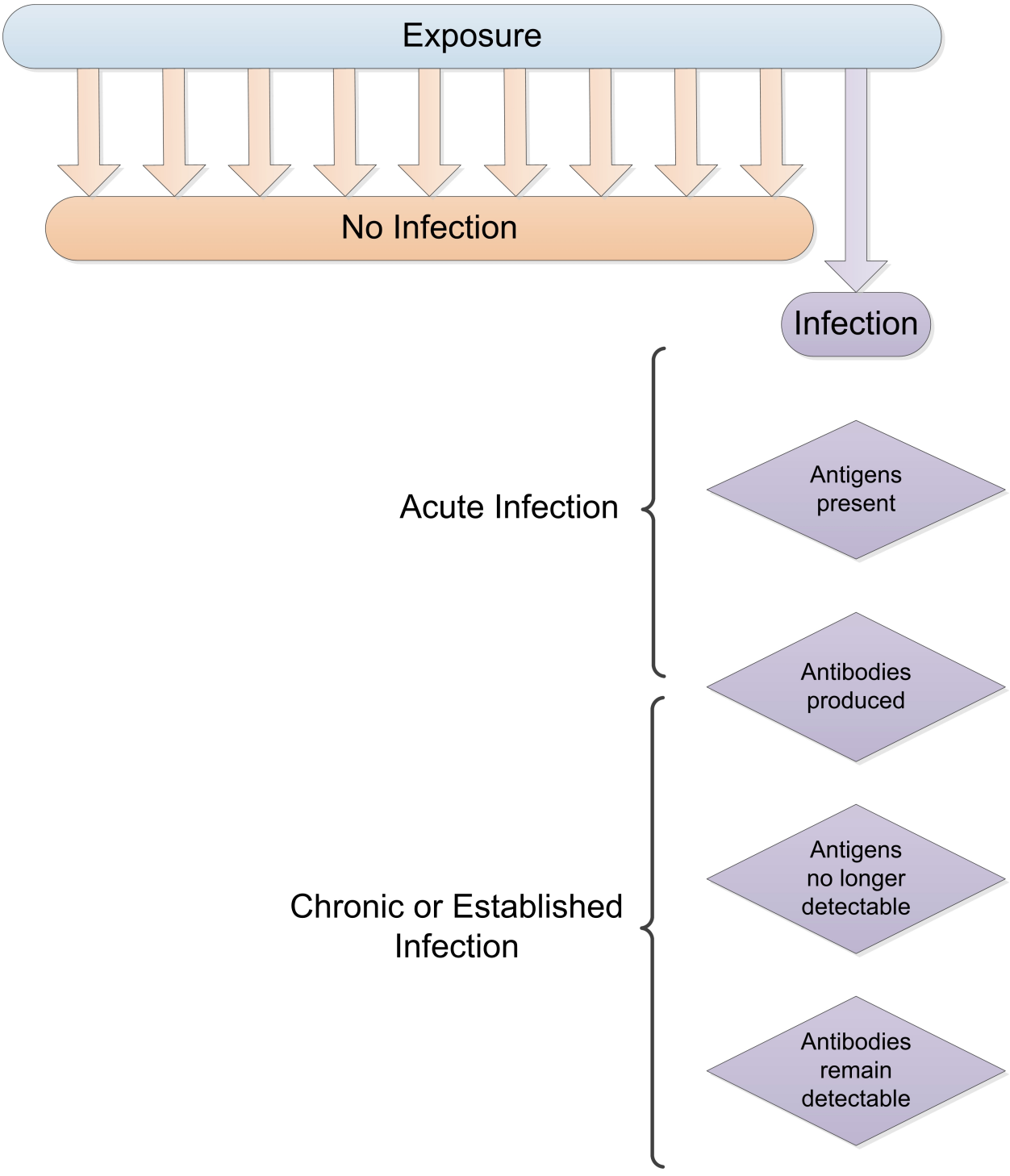
Acute Infection

Also called "primary infection," acute infection is the period between infection with the virus and the body's production of antibodies. During acute infection, HIV replicates at very high rates producing large amounts of virus and destroying a large number of CD4+ cells, which are crucial to the health of the immune system. Because of this high rate of replication, individuals in the acute stage of HIV infection are much more likely to transmit HIV to sexual or needle-sharing partners than other individuals with a more long-standing or "chronic" infection.

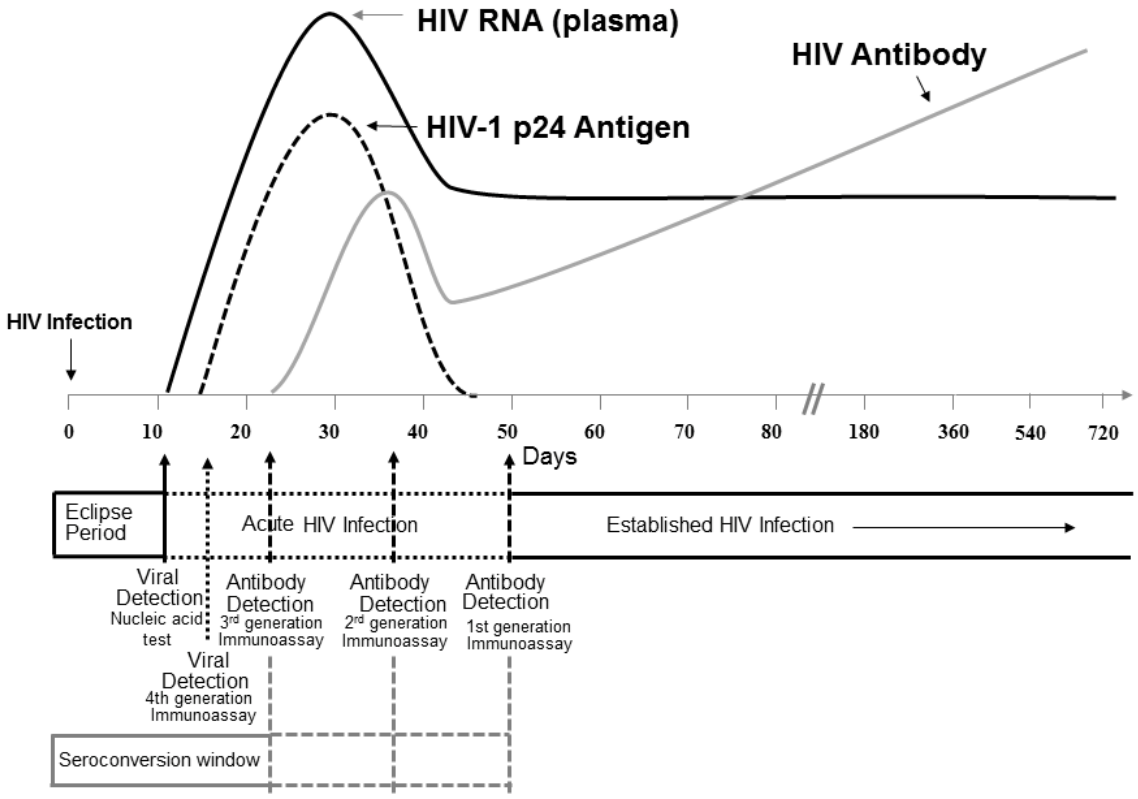
The following signs and symptoms often characterize acute infection:

- Fever
- Fatigue
- Swollen lymph nodes or tonsils
- Sore throat
- Joint and muscle aches
- Diarrhea
- Rash

These signs and symptoms can begin a few days after infection and usually last for about 14 days, although they can last for several months. (Note, however, that HIV is not diagnosable by symptoms alone. Many of these symptoms are common to other viral infections as well.) The acute infection stage is followed by the more established (or chronic) infection stage.


Exposure
No Infection
Infection
Acute Infection
Antigens present
Antibodies produced
Chronic or Established Infection
Antigens no longer detectable
Antibodies remain detectable

Markers of HIV Infection



COMBINED HIV ANTIGEN AND ANTIBODY WINDOW PERIOD

Rapid HIV Test	Marker	Time Following Infection		
		2 weeks	4 weeks	3 months
OraQuick ADVANCE Rapid HIV-1/2 Antibody Test	HIV Antibody (Ab)	Earliest HIV Antibodies can be detected		HIV Antibodies are detectable for everyone
Alere Determine HIV-1/2 Ag/Ab Combo Test	HIV Antigen (Ag)	Earliest HIV Antigens can be detected	HIV Antigens may no longer be detectable	
	HIV Antibody (Ab)	Earliest HIV Antibodies can be detected		HIV Antibodies are detectable for everyone

Suggestion for Explaining the Combined Window Period

"The test that we're using today is looking for HIV antibodies and antigen—not for the virus itself. If an exposure resulted in an infection, the human body can take anywhere from two weeks to three months to develop antibodies and antigen. This period, during which antibodies or antigen might not be detected, is called the 'window period.'

"A negative test result today means that from the day you were born until three months ago, you were definitely not living with HIV. But it can't tell us for sure about any exposures or potential exposures that occurred in the last three months."

GENERAL PRINCIPLES

1. **Client-centered counseling**: The clients we see will be best served by client-centered counseling, where the focus is on the client's concerns and interests. These techniques explore the personal meaning a client gives to the issues being discussed.
2. **Context**: The impact of counseling will be improved when counselors are able to explore and assess the physical, social, and emotional circumstances under which a client's life, and consequently that client's HIV risk behavior, takes place.
3. **Individualized sessions**: The impact of counseling will be improved when counselors tailor sessions based on the specific needs and situation of each individual client.
4. **Information alone does not lead to behavior change**: Behavior change is a complex process that requires interventions based on a client's personal circumstances. Providing information as the sole, or main, intervention is generally not sufficient to lead a person to successfully change behaviors or to sustain change over time.
5. **Neutral stance**: It is appropriate for counselors to take a neutral stance and to maintain a nonjudgmental manner when discussing sexual practices, substance use, or other personal behaviors. This is particularly important when addressing ambiguous or controversial information.
6. **Limited role**: There are limits to how much a counselor can offer a client. It will often be appropriate for counselors to make referrals to additional sources of support or information.
7. **Harm Reduction:** In essence, it is "about moving a person toward (any) positive change." This strategy works best as long as counselors are asking the questions that allow our clients to come up with the options that fit their self-set risk reduction goals and what they believe they can change.

DEFINITION OF CONTEXT

Context refers to the broader circumstances surrounding a client's potential risk behaviors. These may include their sexual partners and behaviors, substance use, physical environment, their emotional state, peer influences, personal history, motivations for participating in the behaviors, and so on. A client's social environment can have a large complex set of co-factors that might include the communities they live in, their cultural influences, the languages they speak, and the impact of poverty and other forms of oppression on their ability to initiate and be supported in risk reduction.

EXPLORING CONTEXT: WE ALL WANT TO CHANGE SOMETHING

In this exercise, you will get a chance to play both the "counselor" and the "client."

The "client" is going to talk about something they would like to change about themselves—a behavior or habit—but for some reason have not yet changed.

When you're the "counselor," please follow these directions:

The counselor will:

Listen carefully with the goal of understanding.

Give no advice!

Ask these four open-ended questions:

1. What motivates you to make this change?
2. How might you go about it to succeed?
3. On a scale of 0 to 10, how important is it to make this change?

   (0 being not important at all and 10 being the most important thing in your life)
4. How come you're at a ___ and not a zero?

Give a short summary of the client's motivations for change.

Then ask: "So, what do you think you'll do?"

Just listen with interest.

THE CONCEPT OF CLIENT-CENTERED COUNSELING

In client-centered counseling, the **focus is on the client's concerns and interests**. Counseling techniques explore the personal meaning a client gives to issues discussed.

A simple way to understand the concept of client-centered counseling is to see it as a counseling process in which the counselor:

a. Expresses unconditional positive regard for the client.

b. Frames the session in the client's terms.

"Unconditional positive regard" refers to the counselor's respect for, and not necessarily approval of, the client's feelings and concerns. If a counselor feels quite differently from a client regarding a significant issue, it is imperative that the counselor detaches from their own perspective in order to communicate effectively with the client.

"Framing the session in the client's terms" refers to the counselor's effort to work within the "frame" of a client's life experience and the client's description of that life experience. Clients often feel that they understand their concerns, and the counselor may use the client's own words and images to reflect back that understanding to the client. Although the counselor may disagree with the client's understanding, client-centered framing techniques can help the client begin to reframe their concerns. This reframing can help the client clarify reality-based issues and risk-taking in ways that the client finds valuable and usable. Helping the client to do their own reframing is the primary objective of client-centered counseling. If facts are presented, the counselor discovers what implications these facts have in the client's life. If options or referrals are suggested, they are designed to be relevant to the client's philosophy, lifestyle, and resources.

Client-centered counseling involves an interactive, highly personalized exchange between client and counselor. Counselors working with clients in a client-centered manner will not be wedded to a preconceived set of points or checklist. Rather, they will engage in a dialogue that encourages the client to do most of the talking. It is important that counselors be genuinely interested in each client, seeing each person as a unique individual with needs and concerns related to HIV risk as well as to those outside the realm of HIV. If counselors work with clients to develop mutually agreed upon, attainable risk reduction steps, clients may initiate or sustain behavior changes that reduce their risk.

TOOLS OF THE CLIENT-CENTERED COUNSELOR

In order to get to the issues and motivations that are most important to the client, counselors should employ active listening skills. Active listening skills are counseling techniques that engage and respond to the client based on something they have expressed, either in words, actions, or manner. These include the following:

OPEN-ENDED QUESTIONS

Open-ended questions are questions that are not easily answered with a one-word response ("yes" or "no") and do not assert the counselor's values or objectives. Open-ended questions are useful when counselors seek information about the context in which behaviors occur and when counselors explore attitude, culture, and economic or social factors that may play a role in the client's continued behavioral risk. Open-ended questions invite further client disclosures and help to build rapport and trust by giving the client space to elaborate, at the same time demonstrating the counselor's unconditional positive regard for the client and a genuine interest in knowing how the client feels.

AFFIRMATIONS

Affirmations seek to affirm, appreciate, and reinforce a client's strengths, including attributes and actions, in particular—past successes and efforts to improve situations; attitudes, including future hopes, struggles, and desires; and the humanity and character of the client. Try to avoid making statements like "I'm glad you came in for testing today," which is about the counselor's feelings, or "It's so great that you came in," unless they are specifically tied to something the client has said. For example, if the client had to take a series of buses to get to the testing site, think about what that says about the client: "You're determined to take care of your health." Avoid giving compliments such as "I think you're really smart" and instead use "you" language to highlight why the counselor thinks the client is really smart. For example, "You recognize the issue, a situation that makes you feel uncomfortable, and you want to take steps to change it."

REFLECTION

Reflections have the effect of encouraging the client to elaborate, amplify, confirm, or correct. Unlike a question, a reflection is a statement, so it involves the voice inflection going down at the end. A reflection can start with words such as: "So you feel. . . ," "It sounds like you. . . ," "You're wondering if. . . ," and "You're feeling. . . ."

SUMMARIES

Summaries refer to the technique of highlighting the most important aspects of the session as a way of ensuring that both counselor and client have a common understanding of what they discussed. The best HIV test counseling summaries highlight the language a client uses to describe how they feel about or perceives the situation. Further, summarizing for information ("You did x, y, and z. . .") can be helpful and necessary, but summarizing for motivation is crucial ("You're not sure why you did x, y, and z, but now you're thinking that it might have been because. . .").

- **Curiosity** refers to expressing genuine interest in a client's circumstances and thereby inviting further disclosure. Much of the skill in using curiosity as a technique is in the counselor's own expressiveness. The words must be backed up by a genuine quality of interest in tone and manner.
- **Attending** refers to the counselor's ability to communicate listening through frequent and varied eye contact, facial expressions, and other forms of nonverbal communication. This includes sitting in a relaxed posture, leaning forward occasionally, and using natural hand and arm movements that are responsive and encouraging. Counselors also need to be aware of nonverbal communications in the client's demeanor, since nonverbal cues are important forms of communication.
- **Repeating** (or parroting) means repeating the client's words exactly. When used sparingly, this technique can help the client feel heard.
- **Paraphrasing** refers to rewording the content of what the client has said in similar but fewer words. This can help the counselor clarify the basic message expressed in the verbal content of the client's communication. Paraphrasing neither expands nor builds on the topic, but is a way to help the client feel heard and build rapport.
- **Reframing** refers to offering an alternative way of looking at something that the client has just said, usually one that is more constructive and positive.
- **Process comments** are counseling techniques that are useful when sessions seem stuck in some way. A comment is made about what is going on in the session, rather than the content of the discussion. A process comment may help move the session along if the counselor has a sense that the client is not fully present or distracted for a reason unknown to the counselor. The result may be that the client will reveal more about the original issue and what makes it difficult to move on.
- **Third-Personing** is a counseling technique that reflects on a client's experience by referring to someone outside the session. Third-person statements often include the words "many people," "a lot of folks," or "other clients," as in "Many other clients have shared similar concerns with me." Third-personing is also a way to offer harm reduction strategies or retesting strategies in a neutral way, as in "A lot of people have been learning more about whether PrEP is right for them."
- **Minimizing Self-Disclosure** is a reminder that when a counselor shares some personal information, they are self-disclosing to the client. Counselors should ask themselves first: "Why do I want to disclose?" "Will it benefit the client?" "Will it further the session?" Self-disclosure may further the sense of connection and rapport in a counseling session. It may also take the focus off the client and shift it, inappropriately, onto the counselor. In this type of situation, it is often more effective to use third-personing rather than self-disclosure.
- **Pausing** provides an opportunity for clients and counselors to digest material and to make room for feelings or thoughts to emerge. Giving the client some time to experience the moment by allowing silence to happen is a sign of respect for the power of the client's thoughts and feelings. Sometimes a counselor's discomfort with silence can interrupt the client's process. Remember that silence is also a form of communication.

HARM REDUCTION

Any effort a client makes to reduce drug-related and HIV-related harm.

Harm reduction approaches meet clients "where they are," encouraging people to envision and define positive change for themselves, with the understanding that improvements in health can occur even without the total elimination of drug use or HIV/HCV risk.

Harm reduction interventions also recognize that oppressive social factors—such as racism, heterosexism, misogyny, transphobia, trauma, poverty, sexual abuse, and violence—affect both vulnerability to, and resources for effectively dealing with, HIV/HCV transmission.

Adapted by the UCSF Alliance Health Project from the Harm Reduction Coalition.

SEXUAL HARM REDUCTION FOR HIV

There are a lot of ways that people can have fulfilling sexual lives and still protect themselves from HIV. Some examples of ways to do so are listed here.

Condoms

Testing and treatment for STDs

Oral Sex instead of anal or vaginal sex

Not ejaculating inside, aka "pulling out"

Non-penetrative sexual activities (mutual masturbation, sex toys, etc.)

PrEP

Viral suppression of positive partners

Lubrication (avoid oil-based lubricants with condoms)

Sero-sorting

Sero-positioning

Getting vaccinated for hep A and B

Getting treatment for HCV infection

Avoid douching

Knowing the status of your partners

Using less drugs and alcohol before and during sex

Staying hydrated and fed when having sex while using drugs

Using good genital hygiene

Being the insertive rather than the receptive partner

Insertive condoms

This is hardly a conclusive list and each client will think of and engage in sexuality differently. Although many of these strategies work well on their own, when used in conjunction with other strategies they can become even more effective at protecting themselves from HIV. Remember that the client is always the expert in their own lives and will have the best ideas of how to protect themselves from HIV.

Asking questions about what has worked well for the client in the past or what strategies they've thought about using before can be a great way to start the conversation.

HIV HARM REDUCTION FOR PEOPLE WHO INJECT DRUGS (PWID)

There are a lot of ways that people can inject drugs and still protect themselves from HIV. Some examples of ways to do so are listed here.

- Practice safe injection practices
  - Prepare your own drugs and inject yourself whenever possible
  - Mark your own injection equipment
  - Clean the surface areas you use to prepare drugs before and after use
- Encourage adequate supply of new syringes and other injecting supplies
  - Availability, Syringe Exchange Program
  - Purchase from pharmacies (Expanded Syringe Access Programs (ESAP))
  - Prescribed by doctor
- Knowing the status of their injection partners
- Bleach kits as last resort, have a kit available if no clean equipment is available
- Reduce injection drug use
  - Take drugs in other ways—e.g., swallowing, smoking, and snorting are safer
  - Substitute therapies—e.g., methadone, buprenorphine
  - Substance use counseling, abstinence, detox, rehab options

This is hardly a conclusive list and each client will think of and engage in injection drug use differently. Although many of these strategies work well on their own, when used in conjunction with other strategies they can become even more effective at protecting themselves from HIV. Remember that the client is always the expert in their own lives and will have the best ideas of how to protect themselves from HIV.

Asking questions about what has worked well for the client in the past or what strategies they've thought about using before can be a great way to start the conversation.

A WORD ABOUT U=U

In 2017, the CDC announced that after reviewing a consensus statement endorsed by 700 organizations from nearly 100 countries, that the research agreed that undetectable = untransmittable, or "U=U" as it's been commonly called. In other words, if a person living with HIV is taking antiretroviral medications (ARV) and has been successful at reducing their viral load test to a point of being undetectable, they have effectively no risk of transmitting HIV to their HIV-negative sexual partners. As revolutionary as this information is, it alas is still largely unknown by much of the community, despite several campaigns to heighten awareness. This concept is also commonly referred to as "treatment as prevention." This obviously has a lot of ramifications for people living with HIV, particularly around shame and fear of sexual transmission to their partners. In addition, this gives the sexual partners of people living with HIV assurance that their partner could not possibly infect them as long as they stay virally suppressed and that they can conceive children with less than 1 percent chance of passing HIV to a child. This messaging is an unprecedented opportunity to transform the way the community thinks of HIV and transform the lives of millions of people.

During counseling sessions with clients who have one or more partners who are living with HIV, it can be helpful to ask them if these partners are undetectable or whether they are on ARVs or not. While it may seem counterintuitive, many times the highest risk partners of our clients might well be the partners who think they're negative, not their partners living with HIV. Information on U=U can also be helpful when disclosing a preliminary or confirmed positive result for clients who express concerns about passing the virus on to others.

REVIEW OF PREP BASICS

In 2016, California Governor Jerry Brown signed Assembly Bill 2640 into law. It states that medical providers and other people who are administering HIV tests have a special responsibility to their clients who test HIV-negative and are at high risk for HIV infection. As a test counselor, it is your responsibility to inform these clients about the safety and effectiveness of the variety of HIV-prevention methods that are available—including PrEP (pre-exposure prophylaxis) and PEP (post-exposure prophylaxis). Since you are such an important source of information about PrEP and PEP, it is important to be ready to talk about these and other prevention options.

Think about what you have learned about PrEP, either from the Basic Counselor Information Training that you took online, or from other sources. Use the space below to jot down notes as the group reviews this information. When appropriate, remember to discuss PrEP as a possible HIV-prevention option with your clients.

What is PrEP? _____

_____

Who is PrEP for? _____

_____

How is PrEP taken? _____

_____

What's new about PrEP? _____

_____

What's the difference between PEP and PrEP? _____

_____

Additional information about PrEP that I want to remember: _____

_____

_____

_____

WHO CAN BENEFIT FROM PrEP

Who Can Benefit From PrEP?

People who are HIV-negative and at high risk of HIV infection may want to consider taking PrEP

In particular, the CDC recommends PrEP as an option for:

Gay and Bisexual Men who:

- have an HIV-positive partner.
- have multiple partners, a partner with multiple partners, or a partner whose HIV status is unknown—and who also
- have anal sex without a condom, or
- recently had a sexually transmitted disease (STD).

Heterosexuals who:

- have an HIV-positive partner.
- have multiple partners, a partner with multiple partners, or a partner whose HIV status is unknown—and who also
- don't always use a condom for sex with people who inject drugs, or
- don't always use a condom for sex with bisexual men.

People who inject drugs who:

- share needles or equipment to inject drugs.
- recently went to a drug treatment program.
- are at risk for getting HIV from sex.

PrEP AND nPEP

UCSF Alliance HEALTH PROJECT
SERVICES FOR THE LGBTQ AND HIV COMMUNITIES

PrEP (Pre-exposure prophylaxis) *vs* nPEP (non-occupational Post-exposure prophylaxis)

PrEP

What is PrEP?

Pre-exposure prophylaxis (PrEP) is a new HIV prevention method. People who are on PrEP use anti-HIV medications ***before (as well as after)*** they are exposed to HIV, in order to prevent infection.

What's In It?

Currently, PrEP is a single drug (Truvada) that combines two anti-HIV medications: tenofovir disoproxil fumarate and emtricitabine. In the future, there will also likely be other drug options.

Is PrEP for Me?

PrEP is for people who expect to be at ongoing risk of HIV infection ***in the future***.

You must be able to take a pill every day, and to stay in regular medical care.

The CDC recommends considering PrEP for many HIV-negative people who:

- Have sexual partners who are or might be HIV-positive
- Have sex without condoms with partners who might have HIV
- Have had STDs, injected drugs, or shared equipment in the last 6 months.

How Well Does PrEP Work?

Studies suggest that PrEP can reduce a person's chances of getting HIV by as much as 92%—if it is taken consistently. It is ***much*** less effective if it isn't taken consistently. It's not a guarantee that you won't get infected. Your chances of avoiding HIV go way up if you use other prevention methods too—like condoms, and if you test for and treat STDs.

But Is It Safe?

The FDA approved Truvada for PrEP use in 2012, and and it has been used to treat people living with HIV since 2004. No serious side effects were observed in PrEP clinical studies. Some people had an upset stomach, or loss of appetite or got headaches. Some had slight, temporary changes in kidney function and bone mineral density. We don't know the side-effects of taking PrEP for 20 or 30 years. You'll be tested for HIV before starting PrEP, because PrEP doesn't work (and could cause harm such as drug-resistance) in HIV-positive people.

How Long Would I Have to Take It?

You can stop taking PrEP at any time, but for the best protection against HIV, it's recommended that you take it for about 3 weeks before any HIV exposures, and about one month after. Talk with your doctor about what's right for you.

Where Can I Find It?

Truvada can be prescribed by your doctor. It is covered by many insurance programs and the ACA, but may require pre-authorization from a doctor. Patient assistance programs are also available. Many agencies also have "PrEP Navigators" who can help. Talk to your doctor to see if PrEP should be part of your HIV prevention toolkit.

nPEP

What is nPEP?

Post-exposure prophylaxis (PEP) uses anti-HIV medication as an emergency measure to help prevent HIV within 72 hours ***after*** an exposure to the virus. nPEP refers to ***non-occupational*** (outside of work) exposure—it is for people who were exposed, for example, through sexual contact or shared injection equipment.

What's In It?

Different medications can be used in nPEP (usually includes a combination of two or three anti-HIV drugs). Currently, two NRTIs (nucleoside analogue reverse transcriptase inhibitors) are used, and sometimes a third NRTI or protease inhibitor is as well.

Is nPEP for me?

nPEP can only work if started within 72 hours after exposure. You must be able to take HIV medications every day for four weeks, and have your care monitored by a doctor. nPEP may be a good choice for people who have had ***an exposure that is unusual for them*** (unprotected sex, needle sharing, sexual assault, or another one-time exposure). If you have ongoing risk for HIV, the CDC recommends PrEP as a better choice.

How Well Does nPEP Work?

Although it works in many cases, there is less evidence for the effectiveness of nPEP in preventing HIV infections after an exposure than there is for PrEP preventing HIV before one. The sooner a person starts nPEP, the better the chances HIV will be prevented from making copies of itself in the body.

Is It Safe?

The medicines in nPEP often cause more and stronger side effects than PrEP does, such as diarrhea, nausea, vomiting, and fatigue. nPEP may cause drug-resistance in people who do become HIV-positive from their exposure. You'll be tested for HIV before starting nPEP.

How Long Would I Have to Take It?

For the best protection against HIV, you would need to start nPEP within 72 hours after an exposure (but even sooner than that is better) and take it for 28 days. Talk with your doctor about what's right for you.

Where Can I Find It?

You can ask your doctor, your local emergency room, urgent care, or HIV medical clinic about nPEP. The medical provider there will ask questions to assess if nPEP could be the right choice for you. Some insurance plans cover nPEP, and some patient assistance programs also exist.

USEFUL QUESTIONS TO OPEN A RISK ASSESSMENT SESSION

What brought you in for an HIV test today?

Have you ever had an HIV test before?

Tell me what you know about how HIV is transmitted? (6 fluids)

How could any of those fluids be getting into your body?

When was the last time any one of those fluids got into your body?

What have you heard about the window period?

How would you like to protect yourself going forward?

Is there a particular partner or event that you're more concerned about than others?

QUESTIONS TO ENCOURAGE DISCUSSION OF HEPATITIS C

What do you know about hepatitis C?

Have you ever been tested for hepatitis C?

When was the last time you were tested for hepatitis C?

Have you thought about getting tested for hepatitis C?

What concerns do you have about hepatitis C?

What would be your response if you found out you have hepatitis C?

When you were previously tested and found that you were hepatitis C reactive, did you have any questions about what sort of hepatitis you had?

When you were previously tested and found that you were hepatitis C reactive, did you have further tests to confirm that you were currently infected?

Do you have contact with a health service that could do further monitoring of your hepatitis C status?

Adapted from the Harm Reduction Coalition Hepatitis C Project, Hepatitis C Best Practices Manual

GUIDELINES FOR GIVING AND RECEIVING FEEDBACK

GIVING FEEDBACK

1. Start with something the counselor did well in the role play.
2. Select one or two areas of focus.
3. Give feedback that is specific and concise.
4. Discuss an aspect that could be improved, with a concrete example of how to make it better.
5. Describe the behavior, rather than interpreting it.

RECEIVING FEEDBACK

1. Seek clarification if the feedback is not clear. Ask for specific examples if these are not given.
2. Avoid defensiveness. Stop and check with yourself to see if you can find any truth in the feedback.

RISK ASSESSMENT AND DISCLOSURE GUIDE

Risk Assessment	**The goal is to enhance a client's self-perception of risk**
ASK . . .	What brings you in for an HIV test today?
EXPLORE . . .	the client's knowledge of HIV transmission and concerns about exposure
GATHER CONTEXT . . .	about exposures, partners, sex, substances, past testing and harm reduction attempts
EXPLAIN . . .	the window period (if applicable)
SUMMARIZE . . .	throughout the session as needed to clarify what's been said or to help you regroup with what to explore next
REVIEW . . .	previous test and past attempts at behavior change
NEGOTIATE . . .	realistic risk reduction step, and troubleshoot that step
IDENTIFY . . .	sources of support
CLOSE . . .	explain that it is time to retrieve the result

HIV-Negative Disclosure

RETRIEVE . . .	the result
DISCLOSE . . .	the result and pause
ASSESS . . .	emotional state and needs
EXPLORE . . .	feelings and thoughts, behavior, interpersonal issues
IDENTIFY . . .	sources of support
REVIEW . . .	harm reduction steps, coping strategies
PROVIDE . . .	support, referrals, and closure
CLOSE . . .	the session, not the door

Preliminary Positive Disclosure

RETRIEVE . . .	the result
DISCLOSE . . .	the result and pause
ASSESS . . .	emotional state and needs
EXPLORE . . .	feelings and thoughts, behavior, interpersonal issues
IDENTIFY . . .	sources of support
LINK . . .	to medical care
FACILITATE . . .	client empowerment
REVIEW . . .	harm reduction steps, coping strategies
PROVIDE . . .	referrals and closure
CLOSE . . .	the session, not the door

WINDOW PERIOD DIAGRAM