

The Basic HIV/HCV Test Counselor Skills 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

© Office of AIDS, California
Department of Public Health, 2020

This project was supported by funds received from the State of California, Department of Public Health, Office of AIDS. Please cite as UCSF Alliance Health Project and Office of AIDS, California Department of Public Health. *The Basic HIV Test Counselor Skills Training–Participant's Manual*. San Francisco: UCSF Alliance Health Project, 2020.

Contributors

Many people have been involved in the development of these trainings over the years since its first publication, and AHP curriculum development is a collaborative process involving the whole training team. Primary author of this revision is Mary Salazar, secondary authors of this revision are Michelle Cataldo, LCSW, Francisco Nanclares and Stephen Scott, MSHSA. Previous authors have included Marcia Quackenbush, MFT; JD Benson, MFT; and Ed Wolf, Bryan Kutner; Francisco Nanclares; Michelle Cataldo, LCSW; and Jen Shockey, MPH.

Additional contributors include: Jena Adams, Fresno County Health Department; Amity Balbutin-Burnham, City of Berkeley HIV Testing Program; Denise Becotte, City of Long Beach, DHHS; Marsha Bollinger, San Luis Obispo HIV Testing Program; Denise Borntrager, San Diego County Health Department; Colleen Brody-Pope, Orange County; Jaklyn Brookman, MFT, Clinical Consultant to AHP and the State Office of AIDS; Pat Coury-Doniger, RN, FNPC, University of Rochester Medical Center; Susan Cowell, RN, NP, University of Rochester Medical Center; Linda Creegan, FNP, CA STD/HIV Prevention Training Center; Ray Ann Cruz, Fresno County; Nettie DeAugustine, Manager, Prevention Health Bureau, City of Long Beach; Linda DeSantis, California STD/HIV Prevention Training Center; Teri Dowling, San Francisco Department of Public Health; Bertell Ferguson, MPH, Los Angeles County Health Department OAPP; Alice Gandelman, MPH, CA STD/HIV Prevention Training Center; Cindy Getty, Team Leader, Training and Development, CDC; Socorro Gutierrez, Santa Cruz Department of Public Health; Karin Hill, HIV Prevention Training Coordinator, HIV Prevention Programs, California Office of AIDS; Lorenzo Hinojosa, Alameda County Health Department; Vanessa Lee, MPH, State Office of AIDS; Willie Lopez, Fresno County Health Department; Brandi Ly, AHP Provider Training and Education Assistant; Fern Orenstein, California STD/HIV Prevention Training Center; Irma Rivera, MPH, Los Angeles County Health Department OAPP; Sandee Renault, Renault and Associates; Mary Salazar, Trainer at UCSF Alliance Health Project, Francis Salmeri, MFT, Clinical Supervisor at the UCSF Alliance Health Project; Corinne Sinclair, Riverside County Health Department; Michael Squires, Los Angeles County Health Department OAPP; and Matthew Willis, HIV Targeted Testing Specialist, Preventions Program Section, HIV Prevention Branch, CA Office of AIDS.

California Department of Public Health Office of AIDS

Sheryl Williams, Interim Chief
HIV Prevention Branch
Chief
HIV Prevention Program Section
Duane Cissna, Chief
Program Implementation Section
Betsie Cialino, Chief
HIV Data to Care Prevention Unit

Jen Rohde-Budz, Chief
HIV High Impact Prevention Unit
Jen Rohde-Budz, Interim Chief
HIV Prevention Operations Unit
Karin Hill, Chief
HIV Prevention Training Unit
Vacant
HIV Prevention Training Coordinator

UCSF Alliance Health Project

James W. Dilley, MD, Executive Director
Lori Thoemmes, LMFT, Director

Jen Shockey, MPH, Provider Training and Education
Manager

Training Staff

Michelle Cataldo, LCSW, Trainer/Curriculum Writer
Francisco Nanclares, Trainer/Curriculum Writer
Mary Salazar, Trainer/Curriculum Writer

Stephen Scott, MSHSA, Trainer/Curriculum Writer
Jen Shockey, MPH, Trainer/Curriculum Writer

Design and Production

Stephen Scott, MSHSA, Trainer/Curriculum Writer

Feedback

To provide feedback on this curriculum, please contact Jen Shockey, Provider Training and Education Manager, at jen.shockey@ucsf.edu or UCSF Alliance Health Project,

Box 0884, San Francisco, CA 94143

Revision - BCST HIV-HCV PM 07/15/2020 v23

TABLE OF CONTENTS

THE PURPOSE AND OBJECTIVES OF THE TRAINING	9
STRATEGIES AND REQUIREMENTS OF TRAINING	10
PARTICIPANT GROUP AGREEMENTS	12
AGENDA DAY ONE	13
AGENDA DAY TWO	14
AGENDA DAY THREE	15
AGENDA DAY FOUR	16
AGENDA DAY FIVE	17
ACTION PLAN: BEFORE I START COUNSELING	18
ORAQUICK ADVANCE RAPID HIV-1/2 ANTIBODY TEST, ORAQUICK HCV RAPID ANTIBODY TEST, AND INSTI HIV-1/HIV-2 ANTIBODY TEST	19
ORAQUICK ADVANCE RAPID HIV-1/2 ANTIBODY TEST.....	20
ORAQUICK HCV RAPID ANTIBODY TEST.....	21
INSTI HIV-1/HIV-2 ANTIBODY TEST.....	22
ACCURACY OF RAPID TESTING	23
QUALITY ASSURANCE REQUIREMENTS.....	24
BASIC UNIVERSAL PRECAUTIONS	27
FINGERSTICK TRAINING AND PROFICIENCY	28
MATERIALS PRESENTATION—5 MICROLITER FINGERSTICK COLLECTION.....	29
MATERIALS PRESENTATION—50 MICROLITER FINGERSTICK COLLECTION.....	34
GENERAL PRINCIPLES	48
DEFINITION OF CONTEXT	49
EXPLORING CONTEXT: WE ALL WANT TO CHANGE SOMETHING.....	49
THE CONCEPT OF CLIENT-CENTERED COUNSELING	50
TOOLS OF THE CLIENT-CENTERED COUNSELOR.....	51

HARM REDUCTION.....	53
REVIEW OF PREP BASICS	57
WHO CAN BENEFIT FROM PREP?.....	58
PEOPLE WHO ARE HIV-NEGATIVE AND AT HIGH RISK OF HIV INFECTION MAY WANT TO CONSIDER PREP AS AN OPTION.....	58
HELPING HIV TESTING CLIENTS OVERCOME BARRIERS TO PREP ACCESS	61
PREP AND NPEP	65
PEP 101.....	66
PEP RESOURCES	67
COUNSELING PROTOCOL: INFORMED CONSENT FOR HIV TESTING	68
COUNSELING CHECKLIST: RISK ASSESSMENT	70
COUNSELING PROTOCOL: RISK ASSESSMENT	71
USEFUL QUESTIONS TO ASK IN A RISK ASSESSMENT SESSION	80
USEFUL QUESTIONS TO ASK REGARDING HEPATITIS C.....	80
GUIDELINES FOR GIVING AND RECEIVING FEEDBACK	83
HEPATITIS C OVERVIEW	88
HEPATITIS C HARM REDUCTION STRATEGIES.....	94
COUNSELING CHECKLIST: HIV-NEGATIVE DISCLOSURE.....	100
COUNSELING PROTOCOL: HIV-NEGATIVE DISCLOSURE	101
IMPLICATIONS OF THE WINDOW PERIOD FOR HIV-NEGATIVE DISCLOSURES	105
COUNSELING CHECKLIST: PRELIMINARY POSITIVE DISCLOSURE.....	107
COUNSELING PROTOCOL: PRELIMINARY POSITIVE DISCLOSURE	108
COUNSELING CHECKLIST: CONFIRMATORY DISCLOSURE SESSION	115
COUNSELING PROTOCOL: CONFIRMATORY DISCLOSURE SESSION.....	116
COUNSELING EVALUATION OUTCOMES	126
EXPANDED VERSION: DETAILED STEPS FOR ORAQUICK ADVANCE RAPID HIV-1/2 ANTIBODY TEST PROCEDURE USING ORAL FLUID.....	130

CHECKLIST VERSION: STEPS FOR ORAQUICK ADVANCE RAPID HIV-1/2 ANTIBODY TEST PROCEDURE USING ORAL FLUID	133
EXPANDED VERSION: DETAILED STEPS FOR ORAQUICK ADVANCE RAPID HIV-1/2 ANTIBODY TEST AND ORAQUICK HCV RAPID ANTIBODY TEST PROCEDURE USING BLOOD	134
CHECKLIST VERSION: DETAILED STEPS FOR ORAQUICK ADVANCE RAPID HIV-1/2 ANTIBODY TEST AND ORAQUICK HCV RAPID ANTIBODY TEST PROCEDURE USING BLOOD	138
CHECKLIST VERSION: DETAILED STEPS FOR INSTI RAPID HIV 1/2 TEST PROCEDURE USING BLOOD	142
OVERVIEW OF HIV TEST DETECTION CAPABILITIES	143
FDA-APPROVED HIV ASSAYS USED FOR SCREENING	144
OVERVIEW OF ACUTE INFECTION	145
OVERVIEW OF THE IMPORTANCE OF EARLY TREATMENT	145
RISK ASSESSMENT AND DISCLOSURE GUIDE (ORAQUICK).....	146
NEGATIVE DISCLOSURE GUIDE (ORAQUICK)	146
PRELIMINARY POSITIVE DISCLOSURE GUIDE (ORAQUICK)	146
RISK ASSESSMENT AND DISCLOSURE GUIDE (INSTI)	147
NEGATIVE DISCLOSURE GUIDE (INSTI)	147
PRELIMINARY POSITIVE DISCLOSURE GUIDE (INSTI)	147
THE TRANSTHEORETICAL MODEL OF BEHAVIOR CHANGE.....	148
ESTIMATED PER-ACT PROBABILITY OF ACQUIRING HIV FROM AN INFECTED SOURCE.....	150
STD OVERVIEW	151
ADDITIONAL RESOURCES FOR HIV AND HCV INFORMATION	153
WINDOW PERIOD DIAGRAM.....	155

DAY ONE

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 and HCV 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. This standard also requires that certified HIV and HCV test counselors be proficient in performing fingerstick blood sample collection, and running and reading the OraQuick ADVANCE Rapid HIV-1/2 Antibody Test, the OraQuick HCV Rapid Antibody Test, and the INSTI HIV-1/HIV-2 Antibody test

OBJECTIVES

Objectives of this training include: increasing the effectiveness of HIV and HCV test counselors in risk assessment and test disclosure settings; training test counselors how to accurately conduct a fingerstick, the OraQuick ADVANCE Rapid HIV-1/2 Antibody Test, the OraQuick HCV Rapid Antibody Test, and the INSTI Rapid test, including relevant quality assurance procedures. 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 either HIV or HCV.
2. Understand the importance of referrals to expanded resources for people who test HIV-positive or HCV reactive, including partner services and linkage to care.
3. Understand the importance of referrals to PrEP for appropriate negative clients and demonstrate a knowledge of PrEP and nPEP.
4. Be able to describe and perform the key elements of a fingerstick and the rapid testing procedure, including quality assurance elements.
5. Complete a proficiency test that will enable them to administer a 5 ml fingerstick, administer a 50 ml fingerstick, the rapid tests, and interpret results for clients coming in for counseling and testing.

STRATEGIES AND REQUIREMENTS OF TRAINING

This training is designed to include a large number of different kinds of learning activities and interactive exercises to improve the technical and counseling skills of beginning HIV and HCV test counselors.

Participants will have multiple opportunities to practice risk assessment and result disclosure sessions throughout the training via a variety of role-play activities, including a final evaluation. Participants will also have the opportunity to practice and complete proficiency exams on both sample collection (via fingerstick) and test operation on the OraQuick ADVANCE Rapid HIV-1/2 Antibody Test, the OraQuick HCV Rapid Antibody Test, and the INSTI Rapid HIV-1/HIV-2 Antibody Test. Client counseling skills, fingerstick proficiency, and test technology proficiency will each be evaluated separately in this training.

Evaluation is an important part of the training. 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.
- Demonstrate an understanding of HCV counseling messages by participating in a short, observed role play.
- Achieve a passing grade of 80 percent on the final written quiz given at the end of the training. The quiz includes questions on information from the Basic Counselor Information Training (BCIT) as well as items addressing the principles and skills discussed and practiced in the training.
- 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 the training, with approval from their supervisor/Local Health Jurisdiction (LHJ) coordinator and the State Office of AIDS.

To successfully complete the 5 Microliter (5µ) OraQuick Loop Fingerstick Proficiency Test, participants will be required to both stick and be stuck during the two practices. In addition, participants will be required to both stick and be stuck during the best one out of two final procedures, including one observation of the process by a trainer.

To successfully complete the 50 Microliter (50µ) INSTI Fingerstick Proficiency Test, participants will be required to both stick and be stuck during the three practices. In addition, participants will be required to both stick and be stuck during the best one out of two final procedures, including one observation of the process by a trainer.

(Note: If you can currently legally draw blood in the state of California, then you do not need to complete the fingerstick proficiency portions of this training. However, you may be asked to complete the fingerstick practices in order to acquaint yourself with the two different test technologies and sample collection methods for each.)

To successfully complete the OraQuick ADVANCE Rapid HIV-1/2 Antibody and OraQuick HCV Rapid Antibody proficiency tests, participants will be required to administer five OraQuick tests and accurately interpret the results, including one observation of the process by a trainer. In addition, participants will be required to successfully interpret the results of 10 test kit photographs.

To successfully complete the INSTI Rapid proficiency test, participants will be required to administer five INSTI Rapid tests and accurately interpret the results, including one observation of the process by a trainer. In addition, participants will be required to successfully interpret the results of 10 test kit photographs.

Participants who are able to meet the criteria above will receive a certificate from the State Office of AIDS stating that they are Certified Rapid HIV/HCV 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: During the counseling portion of the training, 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 use 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.

AGENDA DAY ONE

MORNING

Welcome, Introductions, and Overview

Overview of the OraQuick ADVANCE Rapid HIV-1/2 Antibody Test and OraQuick HCV Rapid Antibody Test

BREAK

Preparing Clients for Fingerstick

Basic Universal Precautions

Materials Presentation and Model Role Play of 5 Microliter fingerstick Collection

LUNCH

AFTERNOON

Paired Practices

Final Questions

Fingerstick Proficiency Test

BREAK

Materials Presentation and Model Role Play of 50 Microliter Fingerstick Collection

Paired Practices

Final Questions

Fingerstick Proficiency Test

Closure and Review of Day

AGENDA DAY TWO

MORNING

Welcome and Overview of Day Two

Window Period Overview

INSTI HIV-1/HIV-2 Antibody Test Review and Trainer Demo

First Practice: INSTI HIV-1/HIV-2 Antibody Test

Second Practice: INSTI HIV-1/HIV-2 Antibody Test

BREAK

Framing the Proficiency Exam

Present the Proficiency Paperwork

Final Questions

INSTI HIV-1/HIV-2 Antibody Test Proficiency Exam

LUNCH

AFTERNOON

OraQuick ADVANCE Rapid HIV-1/2 Antibody Test and OraQuick HCV Rapid Antibody Test Review and Trainer Demo

First Practice: OraQuick ADVANCE Rapid HIV-1/2 Antibody Test

Second Practice: OraQuick HCV Rapid Antibody Test

BREAK

Framing the Proficiency Exam

Present the Proficiency Paperwork

Final Questions

OraQuick ADVANCE Rapid HIV-1/2 Antibody Test and OraQuick HCV Rapid Antibody Test Proficiency Exam

AGENDA DAY THREE

MORNING

Welcome and Overview of Day Three

General Principles

Exploring Context

BREAK

The Concept of Client-Centered Counseling

Spectrum of Risk

LUNCH

AFTERNOON

Harm Reduction

PrEP and PEP

Window Period Double Fishbowl

BREAK

The Risk Assessment Session: Structure and Content

Trainer Model Role Play of a Risk Assessment

The Risk Assessment Session: First Role Plays

Closure and Review of Day

AGENDA DAY FOUR

MORNING

Welcome and Overview of Day Four

Hepatitis C

The Structure and Content of the HIV-Negative Disclosure

BREAK

Trainer Model Role Play of a HIV-Negative Test Disclosure

Second Role Plays: HIV Negative Disclosure

LUNCH

AFTERNOON

Flex Module

Structure and Content for Preliminary Positive Disclosure/Review Partner Services

Trainer Model Role Play of a Preliminary Positive Disclosure with INSTI

BREAK

Third Role-Plays: Risk Assessment and Disclosing an Unknown Result

Closure and Review of Day

AGENDA DAY FIVE

MORNING

Welcome and Overview of Day Five

Risk Assessment Practice

Trainer Evaluations

BREAK

Orientation to Final Fishbowl

Final Quiz

LUNCH

AFTERNOON

Final Fishbowl

BREAK

Final Fishbowl Continued

Closure of Training

ACTION PLAN: BEFORE I START COUNSELING

BEFORE I START COUNSELING

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

7. _____

8. _____

9. _____

10. _____

ORAQUICK ADVANCE RAPID HIV-1/2 ANTIBODY TEST, ORAQUICK HCV RAPID ANTIBODY TEST, AND INSTI HIV-1/HIV-2 Antibody Test

The OraQuick ADVANCE Rapid HIV-1/2 Antibody Test, the OraQuick HCV Rapid Antibody Test, and the INSTI HIV-1/HIV-2 Antibody Test are simple FDA-approved, single-use, rapid, point-of-care, *in vitro*, qualitative tests that detect both HIV-1/2 antibodies in human whole blood, fingerstick blood, or plasma with visual interpretation of test results. CLIA (or Clinical Laboratory Improvement Amendments, a federal law establishing quality standards for all laboratory testing) 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. These are detailed in the California Office of AIDS guidelines for HIV and HCV testing available here:

www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_prev_hivhcv.aspx.

The current package insert (including instructions for operation) for the OraQuick ADVANCE Rapid HIV-1/2 Antibody Test is available at: <http://www.orasure.com/products-infectious/products-infectious-oraquick.asp>.

The current package insert (including instructions for operation) for the OraQuick HCV Rapid Antibody Test is available at: <http://www.orasure.com/products-infectious/products-infectious-oraquick-hcv.asp>.

The current package insert (including instructions for operation) for the INSTI Rapid test is available at: <https://www.fda.gov/media/79719/download>.

The California Quality Assurance Guidelines for HIV antibody/antigen testing are available on the Office of AIDS website at: www.cdph.ca.gov/aids.

More information about rapid HIV testing technology is available on the CDC website at: <https://www.cdc.gov/hiv/pdf/testing/rapid-hiv-tests-non-clinical.pdf>.

The California Quality Assurance Guidelines for HCV antibody testing are available on the OA website at: www.cdph.ca.gov/Programs/CID/DOA/CDPH%20Document%20Library/HCVOraQuickTestingQAGuidelines_ADA.pdf.

More information about hepatitis C is available on the Centers for Disease Control and Prevention (CDC) website at: www.cdc.gov/hepatitis/HCV/index.htm.

For more information, see Appendix—Overview of HIV Test Detection Capabilities.

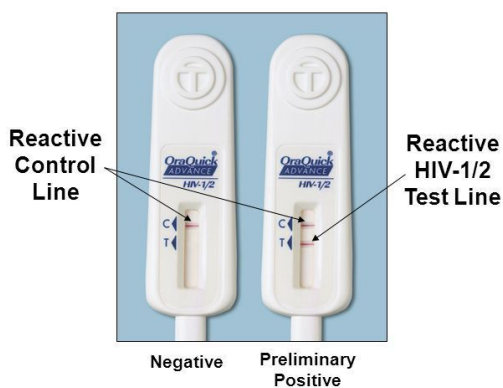
ORAQUICK ADVANCE RAPID HIV-1/2 ANTIBODY TEST



SIMPLE RESULT INTERPRETATION:

One line = NEGATIVE

Two lines = PRELIMINARY POSITIVE



The OraQuick ADVANCE® Rapid HIV-1/2 Antibody Test detects antibodies to HIV-1 and HIV-2 in 20 minutes.

- **Rapid**
Provides results in 20 minutes, enabling patients to learn their status in a single visit and allows HIV positive patients to be connected to care immediately.
- **Accurate**
Greater than 99% agreement with confirmatory Western blot.¹ Detects IgM and IgG antibodies.
- **Easy-to-Use**
CLIA-waived for oral fluid, fingerstick and venipuncture whole blood. Ideal for both clinical and non-clinical settings.

ORAQUICK HCV RAPID ANTIBODY TEST



The first FDA-approved, CLIA-waived rapid HCV test

The OraQuick® HCV test is FDA approved for detecting HCV antibodies in fingerstick and venipuncture whole blood. Our simple platform enables healthcare providers to deliver an accurate diagnosis in 20 minutes.

- **Rapid**
Provides results in 20 minutes, enabling patients to learn their status in a single visit.
- **Accurate**
Greater than 98% accurate
Tests for multiple HCV genotypes
- **Easy-to-Use**
Approved for fingerstick or venipuncture whole blood specimens. Ideal for both clinical and non-clinical settings. CLIA-waived for fingerstick and venipuncture whole blood.

INSTI HIV-1/HIV-2 ANTIBODY TEST

- **Rapid**
CLIA-waived for fingerstick whole blood test in four simple steps with clear results in 60 seconds.
- **Accurate**
Over 99% accuracy with fingerstick blood samples. Detects IgM and IgG antibodies.
- **Easy-to-Use**
Approved for fingerstick or venipuncture whole blood specimens. Ideal for both clinical and non-clinical settings. CLIA-waived for fingerstick and venipuncture whole blood.

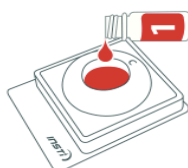


4 Simple Steps...



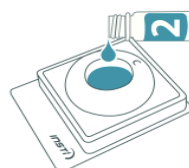
Sample

Collect 50µL of sample and add into Bottle 1.



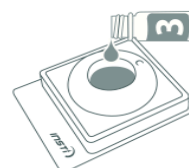
Bottle 1

Pour into Membrane Unit. HIV antibodies, if present, are captured on the test dot by proteins on the membrane.



Bottle 2

Pour into Membrane Unit to generate a blue control dot and a second dot if HIV antibodies are present.



Bottle 3

Pour into Membrane Unit to reduce background color and produce more distinct dot(s).

...to one clear answer in 60 seconds.



Non-Reactive
One Dot



HIV-Reactive
Two Dots:
Control and Test Dots



Invalid
No Dots



Always read results with
INSTI® logo facing you

ACCURACY OF RAPID TESTING

SENSITIVITY

Refers to how well the test detects a positive.

In other words, how sensitive the test is to finding the antibodies it's looking for.

Will rarely have a false negative (outside of the window period).

SPECIFICITY

Refers to how well the test detects a negative.

In other words, how good the test is at not mistaking something else for the antibodies it's looking for.

Will rarely have a false positive.

For preliminary positive HIV screening tests, always run a confirmatory test. For reactive HCV tests, refer clients for testing for the virus itself, usually done in a medical setting.

OVERALL ACCURACY

Sensitivity and specificity together determine the overall accuracy of the test. Avoid discussion of exact numbers with clients. Simply tell clients that this is a "highly accurate test."

Test Technology	Sensitivity		Specificity		Overall Accuracy
OraQuick ADVANCE Rapid HIV-1/2 Antibody Test using fingerstick whole blood	536 Reactive Results / 538 True Positive	99.6%	1,856 Negative Results / 1,856 True Negative	100.0%	99.90%
OraQuick ADVANCE Rapid HIV-1/2 Antibody Test using oral fluid	834 Reactive Results / 840 True Positive	99.3%	3,674 Negative Results / 3,682 True Negative	99.8%	99.60%
OraQuick HCV Rapid Antibody Test using fingerstick whole blood	708 Reactive Results / 723 True Positive	97.9%	923 Negative Results / 937 True Negative	98.5%	98.20%
INSTI HIV-1/HIV-2 Antibody Test using fingerstick whole blood	517 Reactive Results / 517 True Positive	100%	869 Negative Results / 871 True Negative	99.8%	99.90%

QUALITY ASSURANCE REQUIREMENTS

All sites conducting rapid HIV and HCV 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

Test Technology	Perform Test	Test Storage
OraQuick ADVANCE Rapid HIV-1/2 Antibody Test	59° to 99°F	36° to 80°F
OraQuickHCV Rapid Antibody Test	59° to 99°F	36° to 86°F
INSTI Rapid Antibody Test	59° to 86°F	59° to 86°F
Overlap of All Tests	59° to 86°F	59° to 80°F

SPACE FOR UNDISTURBED TEST PROCESSING

Tests cannot be moved while results are developing. There must be no smoking, eating, drinking, chewing gum, applying of makeup (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. The manufacturer of each test produces external controls. They contain human plasma that will test non-reactive or reactive to each of the sensitivities of the test.

The external control quality control process consists of running a rapid test using a sample obtained from each of the vials in the external controls produced by the manufacturer and obtaining concurrent results.

In other words, each test should return the results that you would expect from a sample taken from each vial.

OraQuick ADVANCE Rapid HIV-1/2 Antibody Test



The white vial should test negative.

The black vial should test preliminary positive for HIV-1.

The red vial should test preliminary positive for HIV-2.

OraQuick HCV Rapid Antibody Test



The white vial should test non-reactive.

The purple vial should test reactive for HCV.

INSTI Rapid Test



The green vial should test negative (Note that this is different than for OraQuick).

The brown vial should test preliminary positive for HIV-1 antibodies.

The white vial should test preliminary positive for HIV-2 antibodies.

WHEN TO RUN EXTERNAL CONTROLS:

- Each newly trained operator prior to performing tests on patient specimens.
- Each new location or if conditions in an existing location have changed significantly.
- When opening a new test kit lot.
- Whenever a new shipment of test kits is received.
- If the temperature of the test storage area falls outside of the acceptable range for the test.
- If the temperature of the testing area falls outside of the acceptable range for the test.
- At periodic intervals as indicated by the user facility.
- Whenever two invalid results in a row are obtained.

BASIC UNIVERSAL PRECAUTIONS

Using “universal precautions” means treating all human blood and certain human body fluids as if they were known to be infectious for HIV, HBV, and other blood-borne pathogens.

1. Wear Gloves

- a. Wear gloves when handling potentially biohazardous fluids, including blood, control units, and proficiency specimens.
- b. Change gloves between clients.
- c. Use gloves whenever handling used test kits or other materials and equipment contacting biohazardous agents.
- d. Wash hands after removing gloves.

2. Properly Dispose of Sharps

- a. Dispose of sharps (fingerstick puncture device or lancet) immediately after use in a red sharps container.
- b. Don't recap, bend, or otherwise manipulate sharps.

3. Properly Dispose of Biohazardous Materials

- a. Dispose of any materials that have touched blood or other infectious fluids in red biohazard containers.
- b. Dispose of used test kits and vials, cotton, gauze, pipettes and, loops, and gloves in red biohazard plastic bags (although these may be put in the biohazard container if there are no biohazard bags available).
- c. Never reuse materials that may have come into contact with biohazardous material.

4. Know Your Site's Protocols

- a. Investigate and read your testing site's protocols and guidelines regarding accidental punctures.
- b. In the event of exposure to blood during the process, follow your testing site's protocols and guidelines.
- c. National Clinicians' Post-Exposure Prophylaxis Hotline (PEPLine) 1-888-448-4911.

FINGERSTICK TRAINING AND PROFICIENCY

The fingerstick training and proficiency meets the requirements set by California Health and Safety Code Section 120917 as amended in 2009 and in 2011. This law allows certified HIV test counselors to perform skin punctures, also known as fingersticks, for the purpose of collecting blood samples for HIV and HCV testing.

WORKING WITH ANXIOUS CLIENTS

Many people get anxious about seeing blood, anticipating pain, or simply having a stranger perform a medical procedure on them. As counselors, we want to help alleviate some of this anxiety as much as possible. Remaining client-centered and attentive to the needs of the client will help clients remain calm and focused as you conduct the procedure.

It is important to take a minute to make sure that your client is ready for what is going to happen. Always check in with your client. Explain the process. Ask how the client is feeling. Ask if the client has any questions.

Here are a few options you might propose to clients who are particularly anxious:

- Breathe from the stomach
- Exhale all the way
- Look away if that feels more comfortable
- Take deep breaths
- Sit in a comfortable position with both feet on the floor
- Try not to tense up

In addition, casual conversation (about anything but the fingerstick procedure) can distract clients.

There are also a few things you want to avoid:

- Don't tell clients that a fingerstick does not hurt or that it will be "quick and painless"
- Don't tell clients it is "very easy"
- Don't "sneak up on" or surprise clients

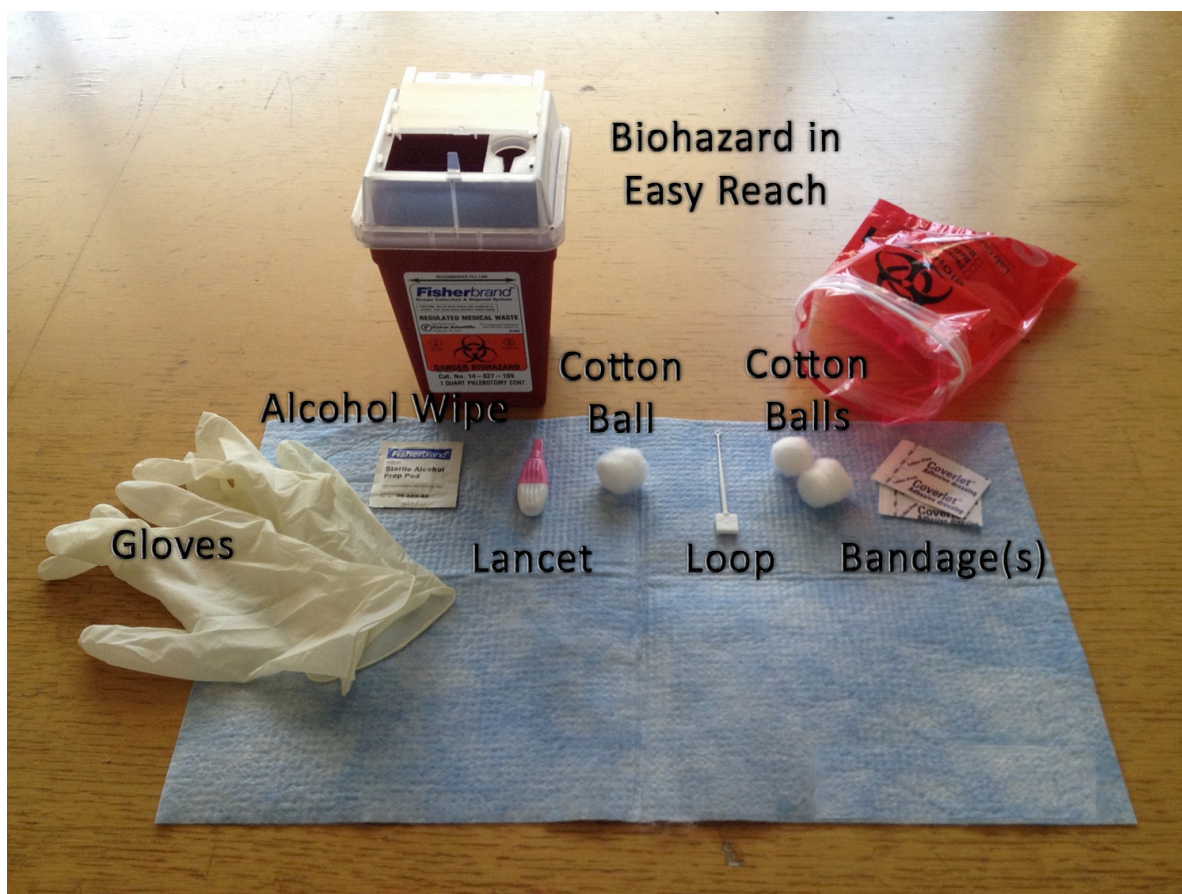
Addressing client anxiety helps create a safe and successful procedure for both client and counselor. In a moment, we will also talk about how to prepare the client's finger for a successful sample collection.

MATERIALS PRESENTATION—5 MICROLITER FINGERSTICK COLLECTION

Before practicing to collect fingerstick whole blood samples with an OraQuick loop you should become familiar with the materials needed to perform a fingerstick. This is an opportunity to see what the lancet (the blade that punctures the skin) looks like and what other materials are involved in collecting a blood sample.

Materials for OraQuick Loop Fingerstick Collection

- Absorbent workspace cover
- Gloves
- Alcohol wipe
- Lancet (also called a “sharp”)
- Cotton balls
- Specimen collection loop
- Bandages
- Sharps container and biohazard bag within easy reach
- Access to a biohazard spill kit



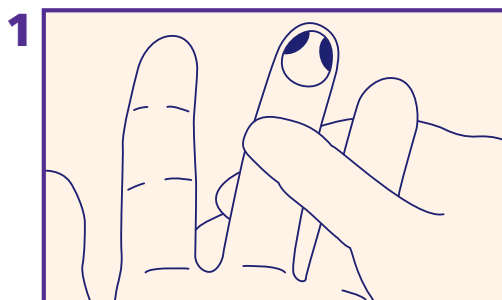


Helping all people
live healthy lives

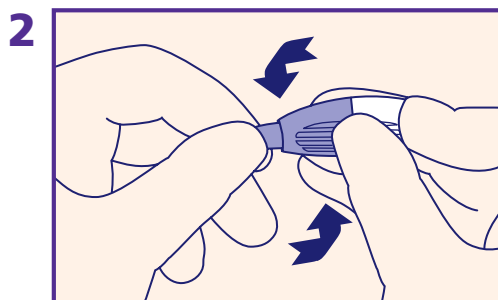
BD Microtainer®

Contact-Activated Lancet

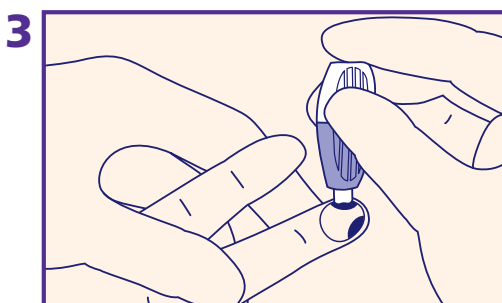
QUICK REFERENCE CARD



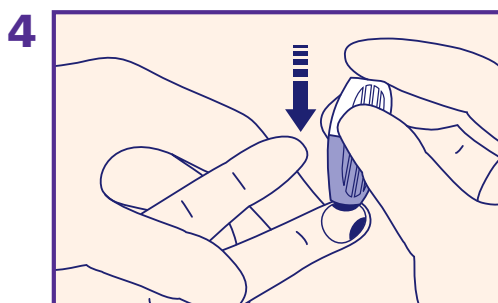
Identify the desired puncture site, (shaded area) and make sure it is properly cleansed according to your facility's established procedures.



Twist off tab to break the seal and discard.



Position safety lancet firmly against puncture site as illustrated. Hold safety lancet between fingers.



To activate, **press** safety lancet firmly against the puncture site. Do not remove the device from the site until an audible click is heard.

5 Discard used safety lancet into an approved sharps container.

Just **Go with the Flow!** BD Microtainer® Contact-Activated Lancets

Designed with a **positive patient experience** in mind

Select the lancet best suited to your needs

Patient condition and warming the puncture site may affect sample volume

Low Flow		Ref: 366592 Depth: 1.5 mm • Needle: 30 G Demonstrates significantly less pain for your patients than comparable products ¹
Medium Flow		Ref: 366593 Depth: 1.8 mm • Needle: 21 G
High Flow		Ref: 366594 Depth: 2.0 mm • Width: 1.5 mm Enables 500µL single puncture collection more consistently ²

¹ BD Clinical Documentation VS7499

² BD Clinical Study

COLLECTION TIPS

See the CLSI guidelines for recommendations for the collection of diagnostic capillary blood specimens.*

*NCCLS 2004 Doc. H4-A5 Vol. 24, No. 21

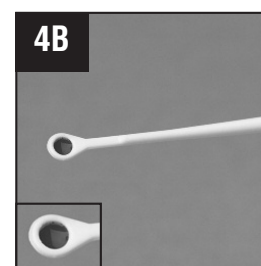
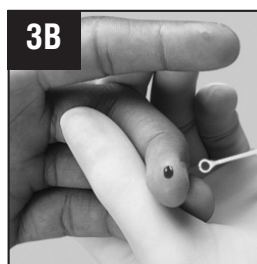
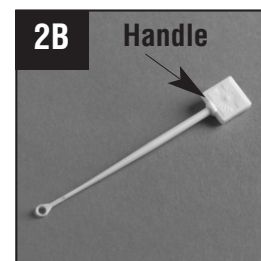
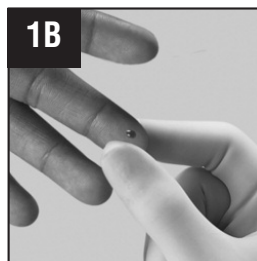
CAUTION: Handle all biologic samples and blood collection “sharps” (lancets, needles, luer adapters, and blood collection sets) in accordance with the policies and procedures of your facility. Obtain appropriate medical attention in the event of any exposure to biologic samples (e.g., through a puncture injury) since samples may transmit viral hepatitis, HIV (AIDS), or other infectious diseases. Utilize any safety-engineered feature if the blood collection device provides one. Discard all blood collection “sharps” in biohazard containers approved for their disposal.

FINGERSTICK WHOLE BLOOD AND VENIPUNCTURE WHOLE BLOOD PROCEDURE**STEP 1: COLLECT**

Whole blood specimens may be collected either by fingerstick (*see Step 1.A*) or by venipuncture (*see Step 1.B*).

STEP 1.A: FINGERSTICK WHOLE BLOOD

1. Using an antiseptic wipe, clean the finger of the person being tested. After cleansing the skin puncture site, allow the area to air dry, so the antiseptic action of the alcohol can take effect. Using a sterile lancet, puncture the skin just off the center of the finger pad. Hold the finger downward. Apply gentle pressure beside the point of the puncture. Avoid squeezing the finger to make it bleed (*see picture 1B*). Wipe away this first drop of blood with a sterile gauze pad. Allow a new drop of blood to form.
2. Pick up an unused Specimen Collection Loop (“Loop”) by the thick “handle” end (*see picture 2B*). Put the “rounded” end of the Loop on the drop of blood (*see picture 3B*). Make sure that the Loop is completely filled with blood (*see picture 4B*). NOTE: If the Loop is dropped or comes in contact with any other surface, discard it in a biohazard waste container. Get a new Loop for the collection of the blood sample.

**SELECT THE SITE**

- Middle or ring finger of non-dominant hand (the hand the client uses less)
- Not too close to nail bed
- Away from center pad of finger

THINGS TO KEEP IN MIND

- Always use the checklist to ensure proper procedure.
- Make sure you have the correct materials available and ready.
- Always use universal precautions.
- Properly dispose of biohazardous materials and sharps.
- Ensure that the client is ready and prepared for the process.
- Do not “sneak up on” or surprise the client when performing a fingerstick.
- Be client-centered.

PREPARE THE FINGER BEFORE STICKING

1. Create a Base for the Finger



Your gloved hand rests on the tabletop, providing a secure base for the finger you will stick.

2. Massage the Finger to Improve Blood Flow



Use your gloved hand to firmly massage the finger you will stick, beginning at the base of the finger, and continuing toward the tip. Your purpose is to draw blood down to the fingertip area. Do not massage an area that has already been cleaned with the alcohol wipe.

3. "Dam" the Finger Before (And While) Sticking



Hold the fingertip firmly to create internal pressure at the fingertip. Maintain this pressure while performing the fingerstick. Doing this reduces the pain that the client feels during the stick, and helps retain blood at the site of the stick, rather than having it flow back into the rest of the finger.

MATERIALS PRESENTATION—50 MICROLITER FINGERSTICK COLLECTION

Before practicing to collect fingerstick whole blood samples with a capillary pipette, you should become familiar with the materials needed to perform a fingerstick. This is an opportunity to see what the lancet (the blade that punctures the skin) looks like and what other materials are involved in collecting a blood sample.

Materials for 50 Microliter Fingerstick Collection

Absorbent workspace cover

Gloves

Alcohol wipe

Lancet (also called a “sharp”)

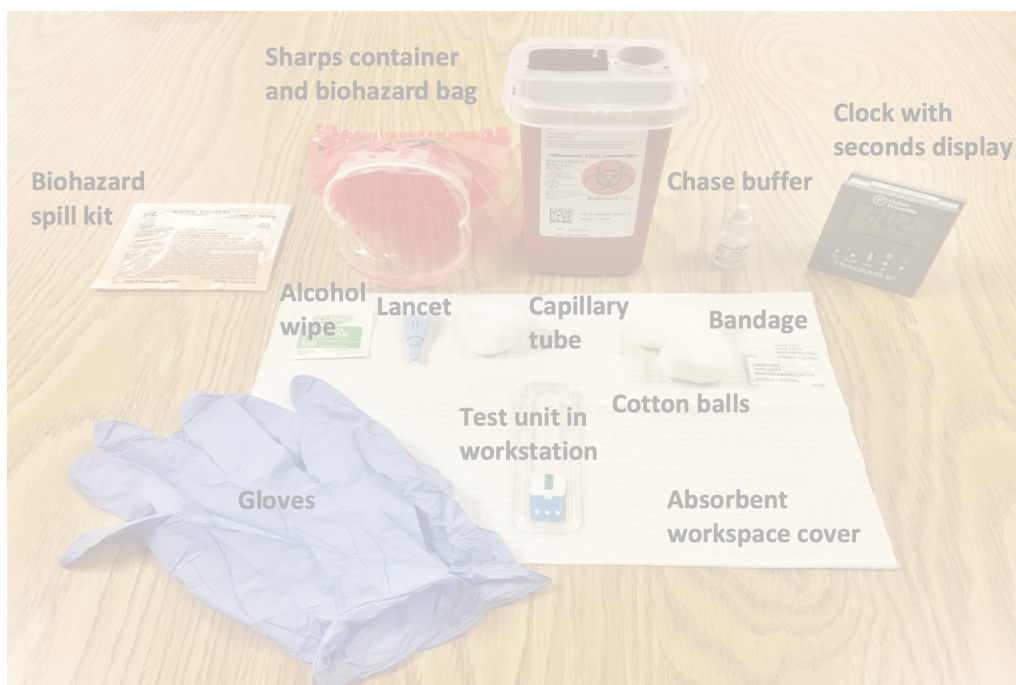
Cotton balls

Capillary pipette

Bandage

Access to a biohazard spill kit

Sharps container and biohazard bag



Guidelines For Obtaining a Fingerstick Sample for an INSTI® Test

Refer to training video for further assistance.
www.insti.com/hiv-test/



- 1 Patient to wash hands thoroughly in warm soapy water or use alcohol pad to clean fingertip. Allow their hands to dry.



- 2 With gloves on, milk fingers towards the tip while observing which finger is optimal—look for the one that has the deepest color for the ultimate blood flow.



- 3 Hold the finger correctly as you use the lancet.



- 4 Angle the capillary tube downwards when collecting the blood sample so capillary action will be assisted by gravity.

Tips

- + Continue to milk the finger.
- + Obtain a good bead of blood before inserting the pipette.
- + Hover pipette in the bead of blood. Avoid direct contact with the skin.

DAY TWO

AGENDA DAY TWO

MORNING

Welcome and Overview of Day Two
Window Period Overview
INSTI Rapid HIV 1/2 Antibody Test Trainer Demo
Practices: INSTI Rapid HIV 1/2 Antibody Test

BREAK

Framing the Proficiency Exam
Present the Proficiency Paperwork
Final Questions
INSTI Rapid HIV 1/2 Antibody Test Proficiency Exam

LUNCH

AFTERNOON

OraQuick ADVANCE Rapid HIV-1/2 Antibody Test and OraQuick HCV Rapid Antibody Test Review and Trainer Demo
First Practice: OraQuick ADVANCE Rapid HIV-1/2 Antibody Test
Second Practice: OraQuick HCV Rapid Antibody Test

OraQuick ADVANCE Rapid HIV-1/2 Antibody Test and OraQuick HCV Rapid Antibody Test Trainer Demo
Practices: OraQuick ADVANCE Rapid HIV-1/2 Antibody Test and OraQuick HCV Rapid Antibody Test Test
Practice Test Result Interpretation

BREAK

Framing the Proficiency Exam
Present the Proficiency Paperwork
Final Questions
OraQuick ADVANCE Rapid HIV-1/2 Antibody Test and OraQuick HCV Rapid Antibody Test Proficiency Exam

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 may 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.

Those six fluids are: Pre-cum (pre-ejaculate), cum (seminal fluid), blood, vaginal secretions, anal secretions, and breast milk (from parent to child).

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.)

Not Every Exposure Leads To Infection

Infection

HIV is now replicating inside the person's body. This means that an HIV-negative person was exposed to HIV (through any of the six fluids), and their immune system was unable to overcome the virus. When someone is infected, we say they are “living with HIV.”

Antibodies

Antibodies are produced by an infected person's immune system to help fight off infectious organisms, like viruses and bacteria. These special proteins are made when parts of the invading organism (called antigens) trigger their production. In the case of HIV, when a person becomes infected, pieces of the virus

called HIV antigen trigger HIV antibodies to be made.

- The window period for detecting HIV antibodies ranges from two weeks to three months.
- Antibodies remain detectable for the life of the person.

Antibodies are only produced after 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 people who have a more long-standing or “chronic” infection.

The following signs and symptoms often characterize acute infection:

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

However, not everyone who is acutely infected with HIV experiences these symptoms. And many people who experience these symptoms may not have HIV. This is one of the reasons that testing specifically for HIV is so crucial.

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 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 had any additional exposures 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 exposures 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, or to further discuss the window period. Counselors must offer a referral to medical care with a provider knowledgeable about HIV.

Find out about the process for delivering, supporting, referring, and confirming Preliminary Positive results at your site, since these vary across sites. Remember that a Preliminary Positive test result will need to be followed by a confirmatory test, either at your site, through the client's medical provider, or at elsewhere. Walk through the process of delivering, supporting, referring, and confirming Preliminary Positive results prior to doing your first shift as a test counselor at your site.

Some clients with little or no risk for acquiring HIV may insist on testing frequently. 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 in the Appendix.

DAY THREE

AGENDA DAY THREE

MORNING

Welcome and Overview of Day Three

General Principles

Exploring Context

BREAK

The Concept of Client-Centered Counseling

Harm Reduction

Spectrum of Risk

LUNCH

AFTERNOON

PrEP and PEP

Window Period Double Fishbowl

BREAK

The Risk Assessment Session: Structure and Content

Trainer Model Role Play of a Risk Assessment

The Risk Assessment Session: First Role Plays

Closure and Review of Day

GENERAL PRINCIPLES

1. **Client-centered counseling:** We focus is on the client's concerns and interests, and we use tools that explore the personal meaning a client gives to the issues being discussed, because we believe that this best serves our clients.
2. **Context:** The session is more effective when counselors explore the ways that HIV is potentially entering the client's life--and the broader physical, social, and emotional circumstances that surround the client's chances of getting HIV.
3. **Individualized sessions:** Counseling has a greater impact 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. Providing information as the sole, or main, intervention is usually not enough to cause a person to successfully change behaviors or to sustain change over time. Other interventions that address the client's motivations for change, capacity to change, and the context of their behaviors, are needed.
5. **Neutral stance:** It is important for counselors to maintain a nonjudgmental manner when discussing sexual practices, substance use, and 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, in terms of time, energy, and expertise. It is often 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 own 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 includes the communities they live in, their cultural influences, the languages they speak, and the impact of poverty and other forms of oppression. Each of these has an impact 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 will:

Start the session by talking 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. Has a genuine curiosity about the client's experiences and perspective.
- c. 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.

“Curiosity” refers to expressing genuine interest in a client's experiences and perspective. When a counselor is appropriately and genuinely curious, it invites greater disclosure by the client. Client-centered counseling 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. As we discuss the tools of client-centered counseling, think about how the counselor's active listening skills can convey this interest and curiosity.

“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. The counselor may use the client's own words and images to reflect their understanding to the client. Although the counselor may disagree with the client's understanding, “starting where the client is,” and attempting to describe the world as the client sees it can be the first step in helping the client find different ways of thinking about a situation. The counselor is constantly trying to understand what experiences and circumstances mean for the client, in order to tailor the session to the client's needs. Similarly, and harm reduction options or referrals offered should make sense within the context of this client's understandings, abilities, values, and situation. If counselors work with clients to develop mutually agreed upon, attainable harm 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 are 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 something that makes you feel uncomfortable, and you want to change it.”

REFLECTIONS

Reflections are usually a guess at the feeling underlying what the client has expressed. They encourage 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. For example, if a client said, “I can’t tell you about that! You’re younger than my kids!” the counselor might reflect: “It’s hard to talk about these things.” A reflection might (but does not have to) start with words such as: “So you feel. . .,” “It sounds like you. . .,” “You’re wondering if. . .,” and “You’re feeling. . ..” Counselors use reflections both to clarify and acknowledge feelings and to move the session forward.

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. . .”).

- **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.
- **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. However, it could potentially 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.

ADDITIONAL TOOLS OF CLIENT-CENTERED COUNSELING

- **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.
- **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.

Using PrEP	Getting treatment for hepatitis C infection
Using Insertive Condoms (on a penis)	Avoiding douching
Using Receptive Condoms (in a vagina or rectum)	Knowing the status of your partners
Testing for and treating STDs	Using less drugs and alcohol before and during sex
Having oral Sex instead of anal or vaginal sex	Staying hydrated and fed when having sex while using drugs
Not ejaculating inside a vagina or rectum, “pulling out”	Keeping genitals clean
Knowing that HIV-positive partners are virally suppressed	Noticing and addressing any changes in genital health
Using adequate lube (avoid oil-based lubricants with condoms)	Being the insertive rather than the receptive partner
Sero-sorting	Having non-penetrative sex (mutual masturbation, sex toys, etc.)
Sero-positioning	
Getting vaccinated for hepatitis A and B	

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 together with other strategies, they can be even more effective at protecting against HIV. Remember that clients are always the expert on their own lives, and they 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 how to do this include:

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

Take PrEP

- Know 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—like swallowing, smoking, and snorting are safer
- Substitute therapies—like methadone, buprenorphine
- Substance use counseling, abstinence, detox, rehab options

This is hardly a complete list. Every client will think of and engage in injection drug use differently. Although many of these strategies work well on their own, when used together with other strategies, they can be even more effective at protecting against HIV. Remember that clients are always the expert on their own lives, and they 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.

ALCOHOL REDUCTION STRATEGIES FOR HIV HARM REDUCTION

Alcohol Reduction Strategies

Avoid drinking alone.

Start off with a non-alcoholic drink.

Alternate usual drinks with alcohol-free or low alcohol drinks.

Drink water while drinking alcohol.

Break the habit of drinking in rounds.

Have at least two alcohol-free days a week and consider increasing the number of alcohol-free days each week. (Note: one to two drinks a day is less harmful for the liver than five drinks in three hours.)

Do not drink when you have had a bad day.

Don't keep alcohol around the home.

Drink slowly.

Substitutes drinking with other activities you enjoy doing.

Avoid situations where there is pressure to drink.

Learn how to say no to drinking alcohol when you are in the company of others who are drinking and may pressure you to do likewise.

Get support for yourself and your family/significant others.

Identify the times of day you are prone to drinking alcohol.

Examine the situations that trigger unhealthy drinking patterns and develop new ways of handling these situations.

Save the money in a separate place that you would spend on alcohol.

Use a worksheet for keeping track of cutting down:

Set an alcohol limit and write it down

Set a goal

Write down the pros and cons of drinking

Celebrate incremental steps in change

A WORD ABOUT U=U

In 2017, the CDC announced that people living with HIV who have been successful (through treatment) at reducing their viral load to a point of being consistently undetectable have almost no risk of transmitting HIV through sex. This concept is called "U=U," or "undetectable=untransmittable." It is also commonly referred to as "treatment as prevention." For people living with HIV and their sexual partners, U=U means reduced shame and anxiety about HIV transmission.

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 on HIV medication, and if their viral loads are known to your client. 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?

PEOPLE WHO ARE HIV-NEGATIVE AND AT HIGH RISK OF HIV INFECTION MAY WANT TO CONSIDER PREP AS AN OPTION.

PrEP is indicated for HIV-negative persons who:

- Have shared injection or drug preparation equipment in the last 6 months;
- Have condomless anal or vaginal sex; and/or
- Had a bacterial STD within the last 6 months.



GETTING PREP'D

Some people may face problems with their insurance covering the costs of Truvada for PrEP. This infographic provides details that may be useful to you. For help with troubleshooting, join **PrEP Facts on Facebook**: [facebook.com/groups/PrEPFacts/](https://www.facebook.com/groups/PrEPFacts/).

LEARN MORE ABOUT PREP

- projectinform.org/prep
- prepfacts.org
- myprepreference.org
- hiveonline.org
- thewellproject.org/hiv-information/prep-women
- whatsprep.org
- pleasepreme.org (CA)



CHECK YOUR INSURANCE PLAN

Your costs

- It's wise to check your insurance plan ahead of time to see what you may have to pay out of pocket while on PrEP.
- Find what your deductible is.
- Find what drug tier that Truvada is on.
- Figure out your total costs for medical visits, routine blood work, and the prescription.
- Ask for help from doctor's office, pharmacist, local case manager, or insurance plan rep.
- Avoid Bronze plans if you can (they generally have higher costs). Silver, Gold and Platinum plans offer better coverage if you can afford them.



FIND A MEDICAL PROVIDER WHO SUPPORTS YOUR DECISION TO PREP

Schedule an appointment

- Approach your medical provider about Truvada for PrEP prescription.
- If s/he will prescribe, GREAT NEWS!
- If s/he doesn't know about PrEP but is willing to prescribe:
 - 1) S/he can consult the US PHS's prescribing guidelines: *Pre-Exposure Prophylaxis for the Prevention of HIV Infection* (www.cdc.gov/hiv/pdf/pepguidelines2014.pdf), and/or
 - 2) Take a copy of the guidelines with you, and/or
 - 3) S/he can consult the CDC's PrEP line at 855-448-7737 during business hours (<http://tinyurl.com/CDCpreline>), and/or
 - 4) S/he can consult NASTAD's *Billing Coding Guide for HIV Prevention* (<http://tinyurl.com/NASTADguide>).
- If s/he isn't willing to prescribe:
 - 1) Read/utilize these resource materials:
 - "Talk to Your Doctor": <http://tinyurl.com/CDCEPbrochure>
 - "Work through Doctor Visit": <http://tinyurl.com/PrEPdocvisit>
 - 2) Ask for a referral, or find another provider on your own:
 - your insurance plan's provider directory
 - public health clinics (<https://findahealthcenterhsa.gov>), STD clinics, Planned Parenthood (<https://tinyurl.com/PPclinics>)
 - local, county and state health depts
 - search engines: pleasepreme.org/prep-locator, preplocator.org, greaterthanorg/get-prep



MEDICAL VISITS, BLOOD WORK

If you encounter uncovered costs related to your medical visits and/or blood work, these options may help:

Public health clinics

- Some public health clinics offer sliding fee scale for medical visits and blood work.

FSAs

- FSAs (Flexible Spending Accounts) are accounts set up with pre-tax dollars to help pay for out-of-pocket health care costs.
- FSAs have an annual limit of \$2,600, available through employers if offered.
- Enrollment is usually annual, so plan ahead.



GET YOUR PRESCRIPTION

Prior authorizations

- Some insurance plans require a prior authorization (PA) for Truvada for PrEP.
- This is a normal process.
- May need extra paperwork.
- Your provider can use the codes found on p29 at www.cdc.gov/hiv/pdf/PrEPprovider-supplement2014.pdf.
- Re-submit paperwork until the PA is approved.

Denials

- Make sure your provider has coded paperwork correctly to insurance carrier. (Same URL as above.)
- Work with your provider's office to submit challenge(s). It may take more than once.

Nurx.co/prep

- Online source may be able to provide a prescription to you without a doctor's visit if you live in California, DC, New York, and Washington.



PICK UP PRESCRIPTION

Pharmacy refills

- Plans vary in what they offer. Your plan may:
 - Vary in how you get meds (at pharmacy, mail order).
 - Provide only 30-day refills
 - Offer 90-day refills
- Make you initiate the monthly refill
- Have an auto-send function for refills
- Offer refills earlier than waiting 30 days

ALSO:

- In-network pharmacies will reduce your cost.
- Apply for Gilead's Co-Pay Card **before** going to pharmacy (URL next column).
- If pharmacy doesn't accept Co-Pay Card, keep pharmacy and sales receipts. Call the number on back of co-pay card, submit paperwork for payment.



PAY FOR THE MEDICATION AND OTHER COSTS

Manufacturer assistance

www.gilead.com/getaccess, 800-226-2056 (18 years or older)

Co-Pay Assistance

- covers up to \$3,600 per calendar year, out-of-pocket costs
- for commercially insured individuals, re-apply annually as needed
- not available for persons with Medicaid, Medicare, VA or other federal/state prescription drug programs

Medication Assistance

- uninsured, insurance declined payment, or no pharmacy benefits
- US resident (SSN not required) and family income <500% FPL (federal poverty level, <http://tinyurl.com/FFIncomes>)
- eligibility confirmed every 6 months

Patient Access Network Foundation

- PAN Foundation has temporarily stopped enrolling new applicants.
- Insured individuals only; family income below 500% FPL
- \$8,000 max per year, may reapply
- Covers co-pays, deductibles and co-insurance
- patientfoundation.org/hiv-treatment-and-prevention, 866-316-7263

Patient Advocate Foundation

- Insured individuals only; family income below 400% FPL
- \$7,500 max per year for co-pay/deductible costs, may reapply
- <https://www.co-pay.org/diseases/hiv-aids-and-prevention>

State assistance programs for residents of:

- Colorado, Illinois, Massachusetts, New York and Washington. Check next page for list of websites.

ARE YOU INSURED TO COVER YOUR COSTS FOR PREP?

YES

(employer, private, insurance marketplace, COBRA, Medicare, Medicaid)

1

Gilead Advancing Access Co-pay Card

gileadcopy.com
877-505-6986

- \$3,600 max/calendar year
- No income restrictions
- Covers co-pays, deductibles and co-insurance
- Re-apply annually as needed
- US resident
- Not available for persons with Medicaid, Medicare, VA or other state/federal prescription drug programs

If pharmacy is unable to process Gilead's Co-pay Card, keep sales and pharmacy receipts. Call number on back of co-pay card. Submit paperwork for reimbursement for all refills. Some restrictions apply: terms, conditions at gileadcopy.com.

2

Patient Access Network Foundation

panfoundation.org/hiv-treatment-and-prevention
866-316-7263

- \$8,000 max/year, re-apply
- Income <500% FPL (\$60,300)
- Based on taxable income (1040 line 7, 1040 EZ line 1)
- Must be insured (as listed under "YES" above)
- Covers co-pays, deductibles and co-insurance
- US resident
- Pharmacies can bill PAN Foundation directly

3

Patient Advocate Foundation (PAF)

<https://www.copays.org/diseases/hiv-aids-and-prevention>

- \$7,500 max/year, re-apply
- Income <400% FPL (\$48,240)
- Based on taxable income (1040 line 7, 1040 EZ line 1)
- Must be insured (as listed under "YES" above)
- Covers co-pays only
- Proof of US residence (utility bill, etc.)
- Case managers available to help resolve medical cost issues (800-532-5274)

These programs may be subject to funding shortfalls, which may limit enrollment.

On Medicaid?

Medicaid should cover medical costs related to PREP. If you encounter barriers to coverage, consult a legal advocate.

FSA (flexible spending account)

If employer offers an FSA, it can help cover up to \$2,550 of out-of-pocket costs.

PROJECT INFORM
projectinform.org/prep-chart
800-822-7422

NO

U.S. RESIDENT?

What's the date?



NOV 1 – JAN 31

Enroll in an insurance marketplace

obamacarefacts.com/state-health-insurance-exchange/
Avoid Bronze plans if you can: they generally have higher costs. Silver plans will offer lower costs for people earning up to 250% FPL (\$30,150). Gold & Platinum plans offer better coverage if you can afford them. Carefully select the right plan for you.

Special enrollment

You can get insurance during the rest of the year for "qualifying life events" such as: pregnancy, loss or change of job, change in household size, change in income, recent move, change in citizenship.

FEB 1 – OCT 31

below 138% FPL / yr
($< \$16,643$)

above 138% FPL / yr
($> \$16,643$)

What's your income?

60,300

below

above

Enroll in the Gilead MAP:
www.truvada.com/truvada-patient-assistance

Retail cost of Truvada

500% FPL
(2017 FPL: \$12,060 taxable income + \$4,180 per dependent, higher FPL in Alaska and Hawaii, 1040 tax form line 7, 1040 EZ line 1)
~ only drug costs ~
<https://tinyurl.com/FPLcomes>

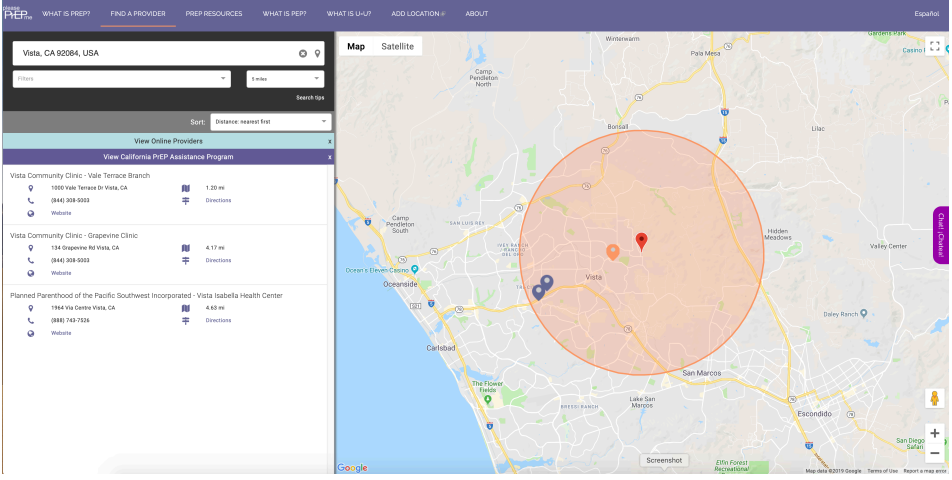
If you're a resident, these state plans may also help:

- COLORADO: <https://tinyurl.com/CoprepAP>
- ILLINOIS: <https://tinyurl.com/ILprepAP>
- MASSACHUSETTS: <https://tinyurl.com/MAPrepDAP> (cost of drug, services)
- WASHINGTON: <http://tinyurl.com/WAPrepDAP> (cost of drug)
- NEW YORK: <http://tinyurl.com/NYprepAP> (cost of services)

UPDATED AS OF
FEBRUARY 10, 2017

Helping HIV Testing Clients Overcome Barriers to PrEP Access

BARRIER	RESOURCES
"I don't know enough about PrEP. Where can I get more information?"	prepfacts.org: http://prepfacts.org. This site is a partnership between the San Francisco AIDS Foundation, the San Francisco Department of Public Health, Gilead, and PrEP activists. It contains information on "PrEP Basics," PrEP research, frequently asked questions on a number of important PrEP-related topics, and information on other biomedical interventions currently being studied. Also available in Spanish. PrEP Watch: http://www.prepwatch.org. This site includes updates on research studies and other news about PrEP, and materials on understanding PrEP, how to access PrEP and what it can cost, and U.S. and worldwide advocacy efforts. Center for Disease Control and Prevention PrEP Page: http://www.cdc.gov/hiv/prevention/research/prep/. This webpage explains what PrEP is, has links to Basic PrEP Questions and Answers, and the CDC's Fact Sheet on PrEP, as well as a host of other resources. and in Spanish at: Información básica sobre la profilaxis de preexposición (PrEP). https://www.cdc.gov/hiv/spanish/basics/prep.html

"I don't know where to get PrEP."	pleaseprepme.org or https://preplocator.org 
"I don't have a way to pay for PrEP"	The Fair Pricing Coalition's website explains what Medication Assistance Programs (MAPs) and co-pay assistance programs are, and explains programs through Gilead, the Patient Access Network, and the Patient Advocacy Foundation. PrEP Cost Analysis for Covered California Health Plans 2017: http://www.californiaaidsresearch.org/files/chrp-funded-reports-publications/Prepcost_UCLA-Report-FINAL-11.7.pdf
"I don't know enough about what other people's experiences have been taking PrEP." "I'm not sure how I'd handle the stigma of taking PrEP."	PrEP Facts: Rethinking HIV Prevention and Sex (Private Facebook Group) PrEP Facts: Women's Sexuality and HIV Prevention (Private Facebook Group) My PrEP Experience: http://myprepexperience.blogspot.com. This website features real stories from people who have chosen to use PrEP for HIV prevention.
"My medical provider doesn't know about PrEP."	UCSF National Clinician's Consultation Line: http://nccc.ucsf.edu/clinical-resources/prep-guidelines-and-resources/ (has links to CDC, aids.gov, and other resources, USPHS. Phone consultation also available: (855) 448-7737 or (855) HIV-PrEP. Monday – Friday, 8 a.m. – 3p.m. PST Start.Truvada.com: http://start.truvada.com and Descovyhcp.com: https://www.descovyhcp.com are Gilead sites that explain Truvada and Descovy for PrEP in clinical/medical provider terms. It explains the safety/side effect information about these PrEP formulations.

	Pre-Exposure Prophylaxis: A Brief Guide for Providers: http://www.sfcityclinic.org/services/PAETC-PrEP-primer-v.1.2016.pdf Helpful primer from the Pacific AIDS Education and Training Center.
"My medical provider doesn't understand why I want PrEP."	How to Get PrEP: A Publication for Understanding How to Navigate the American Healthcare System (booklet by Project Inform) Talk to Your Doctor About PrEP (brochure from the CDC) These can help clients prepare for engaging in and initiating discussions with doctors. Talk to Your Doctor About PrEP includes a list of questions to ask a medical provider, a set of resources, and a list of suggested tasks for clients before, during, and after the doctor's visit. For situations where a client might experience pushback from a doctor about a PrEP request, Project Inform has another helpful publication: PrEP and Working Through a Difficult Doctor Visit. (https://www.health.ny.gov/diseases/aids/general/prep/docs/prep_docvisit.pdf) This booklet helps clients address responses such as "Just use condoms," "I'm not qualified to prescribe PrEP," or "It won't protect you against STDs." People considering or on PrEP can also get tips and support from each other online, at places like MyPrEPExperience and the PrEP Facts Facebook group
"I'm worried about side effects"	Clients will talk with their own prescribers, but they can also review the experiences of other people who have taken PrEP at these websites: PrEP Facts: Rethinking HIV Prevention and Sex (Private Facebook Group) PrEP Facts: Women's Sexuality and HIV Prevention (Private Facebook Group) My PrEP Experience: http://myprepexperience.blogspot.com. In addition, the San Francisco AIDS Foundation webpage—The Questions About PrEP—has a nice summary of side effects at: https://men.prepfacts.org/the-questions/

What PrEP barriers are your clients concerned about?	What resources can help you assist them?
---	---

PrEP AND nPEP

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 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.

PEP 101

(Page 1 is in English, Page 2 is in Spanish)

February 2018

PEP 101

If you may have been exposed to HIV* in the last 72 hours, talk to your health care provider, an emergency room doctor, or your local health department about PEP right away. PEP can reduce your chance of becoming HIV-positive.

What Is PEP?

- PEP, or post-exposure prophylaxis, means taking medicines after you may have been exposed to HIV to prevent becoming infected.
- PEP must be started within 72 hours (3 days) after you may have been exposed to HIV.** But the sooner you start PEP, the better. Every hour counts!
- If your health care provider prescribes PEP, you'll need to take it once or twice daily for 28 days.
- PEP is effective in preventing HIV, but not 100%. Always use condoms with sex partners and use safe injection practices.



Is PEP Right For You?

If you're HIV-negative or don't know your HIV status, and in the last 72 hours you



- May have been exposed to HIV during sex (for example, if the condom broke),
- Shared needles and works to prepare drugs, or
- Were sexually assaulted,



Talk to your health care provider, an emergency room doctor, or your local health department about PEP right away.

Can I Take A Round Of PEP Every Time I Have Sex Without A Condom?



- No. PEP should be used only in emergency situations.
- If you are at very high risk for HIV, ask your health care provider about daily medicine to prevent HIV, called pre-exposure prophylaxis (PrEP).



* People are exposed to HIV by coming into contact with certain body fluids of a person with HIV, including blood, semen, and vaginal fluids. This usually happens through vaginal or anal sex or by sharing needles.

For more information please visit www.cdc.gov/hiv

National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
Division of HIV/AIDS Prevention



Centers for Disease Control and Prevention. PEP 101. Atlanta: U.S. Department of Health and Human Services, 2018.
<https://www.cdc.gov/hiv/pdf/library/factsheets/cdc-hiv-pep101.pdf>. (downloaded 09/06/2018.)

PEP RESOURCES

For Consumers:

Center for Disease Control and Prevention PEP Page: www.cdc.gov/hiv/risk/pep.

This webpage explains what PEP and nPEP are, and discusses federal PEP and nPEP guidelines. It also has links to basic PEP Questions and Answers and the PEP Consultation Service for Clinicians, as well as a host of other resources.

National Institutes of Health PEP Page: www.aidsinfo.nih.gov/education-materials/fact-sheets/20/87/post-exposure-prophylaxis--pep.

A webpage that offers basic questions and answers regarding PEP and nPEP.

Taking PEP: www.takingpostexposureprophylaxis.wordpress.com/blog.

This website documents one user's experience through the 28 days of their nPEP experience.

U.S. Department of Health & Human Services PEP Page: www.aids.gov/hiv-aids-basics/prevention/reduce-your-risk/post-exposure-prophylaxis.

A consumer-friendly webpage that offers basic questions and answers regarding PEP.

For Medical Providers:

CDC 2016 PEP Guidelines: www.cdc.gov/hiv/pdf/programresources/cdc-hiv-npep-guidelines.pdf.

UCSF/AETC National Clinician's Consultation Center: www.nccc.ucsf.edu/clinician-consultation/pep-post-exposure-prophylaxis/ or (888) 448-4911.

Complete consultation on post-exposure management and advice on all aspects of post-exposure prophylaxis (PEP), including:

Assessing the risk of exposure

Selecting the best PEP regimen

Determining the appropriateness of prescribing PEP

Providing follow-up testing

Advice from national experts in exposure management and care, and immediate access to PEP and blood-borne pathogen exposure [information](#). The CDC's consultation and advice on occupational needle sticks, splashes, and other potential exposures to HIV and hepatitis B and C is available over the phone seven days a week. Online PEP Quick Guide is always available to guide urgent PEP decision-making.

COUNSELING PROTOCOL: INFORMED CONSENT FOR HIV TESTING

1. Introductions.

Welcome the client, introduce yourself, and establish rapport by describing what is going to happen during the session. You might begin by asking, “What brings you in today?” and then validate the client’s interest in testing.

“We have some time to talk about your concerns and what brought you in for an HIV test today. Does that sound all right?”

2. Orient the client to the session.

Ask, “What questions do you have about the testing process?”

Inform the client of the basic structure and steps of the session.

Explain the role of the counselor, define the amount of time the client will be in the clinic (check with your supervisor to confirm the amount of time that the process takes at your site), and describe the content of the session.

If performing a rapid test with a 20-minute development time (for example, OraQuick, Alere Determine), say:

“What we’re going to do now is talk a little about how this process works. We’ll collect a sample from you and then we’ll get the test started. We can then talk for about 20 minutes while your test is developing and then at a certain point I’ll go and get your result. Then we can talk about your results, and any next steps that you would want to take. How does all that sound to you?”

If performing an INSTI rapid test, say:

“What we’re going to do now is talk a little about how the process works. First we’ll get your informed consent for the test, called the INSTI test, which takes about 1 minute to develop. We’ll complete any other paperwork, and get a better sense of what your HIV concerns are. After we get a better sense of how HIV could be coming into your life, and what you’d like to do to protect yourself, I will administer the test. I’ll stick your finger for a few drops of blood, and then run the test. The results will come up about a minute after that. Then we can talk about your results, and any next steps that you would want to take.

3. Facilitate informed consent.

Review informed consent, answer client questions, and complete paperwork. Ask questions that will involve the client in this process, confirm the client’s level of knowledge before you embark on long explanations, and treat the client as a partner in the process. For example:

a. Testing history and past results

Ask the client, “Have you tested before? If so, when and what were your results?”

This question gives the counselor some information about the client’s test history and frames the informed consent process, since some information may not have to be repeated, perhaps just reviewed.

b. Client data forms

Introduce and describe the purpose of the client data forms: funding services, directing future HIV prevention and care, and tracking the epidemiology of the epidemic. For example, “I will also refer to this form from time to time. Any information that you share will remain confidential. It helps us understand trends so that we can direct services where they’re most needed. It’s also how we’re able to offer the test for free through the state Department of Public Health. You can always decline answering any questions on this form.” Pause and then ask, “What questions do you have about the form?”

c. Describe the testing process

Depending on the technology to be used, describe the test. Include the fact that the test used is an antibody test, not a test for the virus itself, that it is a highly accurate test, the amount of time that it will take for the test to develop a result, and the method for collecting fluids (likely that a finger stick will be done to obtain a sample) for the test.

Explain that HIV-negative results do not need to be confirmed, but may involve a discussion of the window period, which you may need to describe briefly.

“The test that we’re using here today is an HIV antibody test. It’s a highly accurate test and you’re able to get your results in as little as [state the amount of time, depending on test being used]. I’ll be collecting a blood sample from you today.”

Check in with the client, since by this point, you have offered lots of information.

d. Consent forms, if applicable

After reviewing all this material, present consent forms (if those are used by your site) as a way of summarizing the informed consent discussion. Ask the client to confirm consent.

e. Subject information pamphlet for the test technology used. Clients do not need to take these forms with them, but the counselor must offer them.

Ask client if they have any questions before proceeding.

4. If using a rapid-test with a 20-minute development time, (for example, OraQuick ADVANCE Rapid HIV-1/2 Antibody or Alere Determine HIV-1/2 Ag/Ab Combo test), Collect sample and begin the HIV test following the appropriate checklist.

If using the INSTI Test, skip this step for now, and proceed to conducting the Risk Assessment. Running and reading the INSTI Test will occur between the Risk Assessment and the Results Disclosure Sessions, as Figure X: "Counseling Protocol for One-Minute Rapid Test" shows.

COUNSELING CHECKLIST: RISK ASSESSMENT

6. Begin a conversation with the client with the goal of understanding how HIV could be entering their life: Help them have an accurate understanding of their risk.
7. Listen for and identify behaviors that put the client at highest risk for HIV.
8. Assess the client's understanding of the window period as it relates to the last date of exposure.
9. Assess the client's level of concern about having or acquiring HIV, STDs, and/or hepatitis C.
10. Discuss the client's HIV testing history and behavioral changes in response to results.
11. Discuss the specifics of the most recent risk behavior by exploring context: the who, what, where, when, and how of what happened.
12. Assess the level of risk that is acceptable to this client.
13. Assess communication of HIV, STD, and hepatitis C concerns with partners.
14. Identify circumstances or situations that contribute to the risk behavior.
15. Assess the client's patterns of risk behavior.
16. Identify harm reduction successes and obstacles.
17. Explore triggers and situations that increase the likelihood of higher-risk behaviors.
18. Reassess the client's level of acceptable risk and consider a PrEP referral.
19. Summarize the risk behavior and risk patterns.
20. Explore behaviors that the client feels most motivated or capable of changing in order to negotiate a harm reduction step.
21. Problem-solve any obstacles in achieving the harm reduction step.
22. Identify sources of support and provide referrals.
23. Assess client's readiness to receive their result.
- 24: **FOR 20-MINUTE RAPID TESTING (OraQuick; Alere Determine): End of Risk Assessment--Now retrieve client's results and prepare to disclose them.**

FOR INSTI TESTING: Obtain sample, conduct test. Prepare to obtain results and disclose in less than 5 minutes.

COUNSELING PROTOCOL: RISK ASSESSMENT

Discuss the client's concerns while the results develop. If the client is anxious about awaiting the results, offer validation and support.

Specific to a rapid test with a 20-minute development time:

"We have about 20 minutes while the test develops. Remind me what brought you in for an HIV test today."

"What concerns do you have that we could address while we are waiting for the test to develop?"

Specific to an INSTI test:

"What concerns do you have that we could address before we start the test?"

Establish rapport and stay open to cues from about their concerns. Paying attention to nonverbal cues will help you to follow the client's lead, and allow clients the opportunity to discuss things they might ordinarily opt not to talk about.

"We can use this time however you'd like to. We can talk for all of it, or part, or none. It's up to you."

"Now that we've started the test, we have about 20 minutes before a result will develop. I'm curious how you would like to spend that time." (This is specific to a rapid test with a 20-minute development time)

If you need to get info for the client data forms, you can frame your request this way:

"This form is what helps us keep offering this service for free and helps us track who we serve. Do you mind if I ask you a couple questions?"

6. Begin a conversation with the client with the goal of understanding how HIV could be entering their life: Help them have an accurate understanding of their risk.

The focus of the counseling session is on developing prevention steps and strategies with the client, rather than simply providing information. Find out why the client has come in for HIV testing.

"What brought you in for an HIV test today?"

"What brings you in for HIV counseling and testing today?"

Find out what the client already knows about HIV.

"What do you know about how HIV is passed from one person to another?"

"Tell me what you know about how HIV is transmitted."

“Earlier, you mentioned oral sex. May I clarify what kinds of sex are more and less likely to transmit HIV?”

“What do you know about the window period for HIV?”

7. Listen for and identify behaviors that put the client at highest risk for HIV.

All HIV prevention counseling must be “client-centered.” Counseling should be interactive, allowing the counselor to recognize and respond to each client’s needs.

Establish a sense of the client’s most recent sexual risks, needle-sharing risks, and alcohol or other drug use. Help the client understand risks where appropriate. This client-centered approach is attempting to focus the client’s attention on their behavior and the corresponding risk for HIV.

Use open-ended questions frequently. Keep your tone genuine and be interested without seeming intrusive or judgmental.

"How could any of those six fluids we talked about be getting inside your body?"

“How do you think you could have been exposed to HIV?”

“When was the last time one of the six fluids that can transmit HIV entered your body?”

Sexual risk:

“Tell me about the sex you have.”

“Who do you have sex with?”

“Tell me about your partners.”

“How do you like to protect yourself now?”

“Tell me what you know about STDs?”

“You mentioned that you only have sex with HIV-negative partners. Tell me more about how you find out that a person is negative.”

“What has been your experience with STDs?”

Alcohol or other drug use:

"Tell me about the role of drugs and alcohol in your life."

“Sometimes when people are a little drunk or high, it can be harder for them to protect themselves. What's different about your ability to protect yourself when you're using from when you're not?”

“Tell me about your experience with drugs or alcohol.”

“What’s the relationship, if any, between drugs and alcohol and what happens sexually?”

Injection drug use:

“Since you mentioned sharing your rig and your equipment, I’m wondering what you’ve heard about HIV or hepatitis C?” If the client reported injection drug use on the client data forms and

your test site does not offer hepatitis C testing, be sure to offer a referral for testing.

“I’m interested in knowing more about your needle use practices.”

“What’s been your experience with needle exchange programs?”

“Tell me about sharing your works with other people.”

“How do you protect yourself when you're injecting?”

“What does injecting safely mean to you?”

“Walk me through how you like to inject. Maybe we can go step by step.”

“What steps have you taken to protect yourself [from HIV, STDs, and/or hepatitis C?] How is it going?”

“Lots of people share needles. When does that happen for you?”

8. Assess the client’s understanding of the window period as it relates to the last date of exposure.

Ask what the client already knows about the window period. For clients who already understand the window period, ask them to consider how this test result will relate to their most recent, compelling risk incident.

“What have you heard about the window period?”

“What’s your understanding of the window period?”

“Your biggest concern happened two months ago. Let’s think about what that means for today’s results.”

For clients who are new to HIV testing or who are unsure of the window period, offer a thorough explanation, using the dates of their most recent compelling risk incident, if possible. Pause throughout your explanation to allow the client to digest the information and to ask questions.

“When someone becomes infected with HIV, their body responds by building antibodies—little cells that try to fight the infection. If someone has HIV, then the antibodies will eventually show up on a test. They may start to show up as early as two weeks after someone gets infected, but people often take longer to develop detectable antibodies. For some people, it takes as long as three months.”

“This means that if today’s test comes back negative, what it will tell us is that from the day you were born until three months ago, you definitely weren’t living with HIV. But it can’t tell us for certain about any exposures in the last three months.”

If available and appropriate (a likely exposure within the previous 72 hours), offer clients a referral to a PEP program.

“You mentioned that the sex you were concerned about happened last night. There is a special medication that can help prevent you from contracting HIV. And the sooner you start the more effective it is. Would you like to spend some time talking about this?”

If your site offers viral load testing (also called “PCR” or “RNA” testing) or makes referrals to this kind of testing, inform your clients:

“You may also be able to test for HIV using a viral load test, which looks for HIV, not antibodies to HIV. That test can often detect HIV infection sooner than antibody tests. Before you leave today, I can give you a referral to get that test if you’re interested.”

9. Assess the client’s level of concern about having or acquiring HIV, STDs, and/or hepatitis C.

Based on what you have heard, begin to assess the client’s level of concern about their risk(s) for HIV/STDs/hepatitis C.

“Which behaviors concern you most?”

“How important is it for you stay HIV-negative?”; Follow up: “Tell me about that.”

Consistently provide positive reinforcement for changes or steps already achieved or attempted.

“This is a hard topic to discuss. I can appreciate how courageous it is for you to be here now.”

“HIV is an important concern for you.”

“Clearly, you have already been thinking about ways to protect yourself from HIV.”

“You’ve taken the first step by being here today.”

“You’ve taken a big step by talking to your partner(s) about HIV.”

“You’ve made a commitment to your health and that of your partner(s) by using condoms (or PrEP, or needle exchange).”

10. Discuss the client’s HIV testing history and behavioral changes in response to results.

Inquire about the client’s past testing experience and what it has meant to them.

“Have you ever been tested before?” (If yes) “What was that experience like for you?”

“What were your results the last time you tested?”

“About how often do you test?”

“How did the counseling and test results affect how you feel about HIV?”

“How do you decide that it’s time to retest?”

If the client has a previous negative HIV test result, you might ask:

“When you were tested before, how did getting a negative test result affect you?”

“How have you protected yourself since your last negative test?”

11. Discuss the specifics of the most recent risk behavior by exploring context: the who, what, where, when, and how of what happened.

Each client is different, so each client’s risk behavior requires exploring the specifics of their sex and needle-sharing HIV risk behaviors.

“Tell me more about your biggest concern.”

“This happened three weeks ago. Tell me more about what happened.”

“You said earlier that you’re coming in for testing because (name the reasons). Tell me about the last time you could have been exposed to HIV.”

“When was the last time one of the six fluids that transmit HIV could have gotten into your body?”

“You’ve clearly given this a lot of thought. How would you like to see things change?”

“When was the last time that you were exposed to HIV?”; Follow up: “What happened?”

“Tell me about a partner or partners that concern you particularly?”

“Tell me about a particular night or event that you’re more concerned with than others?”

“Tell me a little bit about your partners?”

“How do you meet your partners?”

“I wonder if this sort of thing has happened before.”

“Tell me about where you go to inject.”

12. Assess the level of risk that is acceptable to this client.

It will be important to understand the level of concern that the client has about their potential risk behavior. For example:

“What are your concerns about HIV?”

“What are your concerns about having unprotected sex?”

“What are the situations in which you are most likely to be exposed to HIV?”

“What concerns do you have about having sex or sharing needles with this person?”

“We talked about how sharing syringes is a way that we see folks getting HIV. How comfortable do you feel with that possibility?”

13. Assess communication of HIV, STD, and hepatitis C concerns with partners.

Exploring how clients talk to their partners can be an important part of creating a realistic harm reduction step. Assess clients’ abilities to negotiate with their partners.

“What kinds of conversations have you had with your partners about HIV?”

“Before you have sex or inject drugs with a new person, do you ever have a conversation about HIV?”

“What discussions have you had about reducing HIV transmission?”

“I’m wondering whether you talk about HIV with your partners.”

“How would knowing your partner’s HIV status affect sex or the sharing of injection equipment?”

14. Identify circumstances or situations that contribute to the risk behavior.

Explore further the context of a client's behavior. For example:

"What would you like to tell me about what happened?"

"Have you noticed a difference between the times you do use condoms and the times you don't?"

"Tell me about a time where you were able to negotiate condom use with a new partner?"

"You mentioned that you usually use condoms. How was this time different?"

"Tell me how you like to protect yourself from HIV and STDs"

15. Assess the client's patterns of risk behavior.

In order to review the client's previous harm reduction experiences, it will be important to assess the client's patterns of HIV risk behaviors. It may also be important to establish the number and type of partners, etc. For example:

"How are things different with your primary partner than with your casual partners?"

"How many different sex and injection-sharing partners have you had in the past three months?"

"How often do you practice safer sex or inject safely?"

"I wonder if any of the events you mentioned have happened before."

"How do you usually meet your potential partners?"

"What do conversations around HIV status look like with partners before you have sex or inject drugs with them?"

16. Identify harm reduction successes and obstacles.

Ask the client how they have protected themselves in the past. Then identify obstacles to future attempts at behavior change.

"How do you usually like to protect yourself?"

"Tell me about a specific time when you chose to do something, either sexually or when injecting, were able to protect yourself from for HIV, STDs, or hepatitis C? How was it? What made it work for you?"

"You mentioned that you are interested in taking PrEP to prevent HIV. What do you think might help you to be successful in that? What do you think might get in the way of it working for you?"

"Tell me about a time when you were able to negotiate condom use? How did that go?"

"What do you think would work for you in terms of protecting yourself more often?"

"Where have you had the greatest success in protecting yourself from HIV, STDs and HCV risks?"

"Which type of partners make it easier to negotiate safe sex or safe needle use with?"

17. Explore triggers and situations that increase the likelihood of higher-risk behaviors.

“Some people feel like there are times or situations when they are more likely to take someone’s fluids into their body. What do you think about that, for you?”

“Tell me about anything that might be going on in your life that could be increasing your chances of becoming infected with HIV, STDs, or hepatitis C.”

“What is the difference between the times you are safer and the times you are not?”

“What effect do drugs and alcohol have on the types of sex you’re having?” “What role do they play when you’re choosing not to use protection?”

“Are there particular people you find it easier to ask for safer sex/safer injection with than others?”

“When you have brought your HIV/STD/hepatitis C concerns up with your partners how did the discussion go? Who brought it up and how did you feel about it?”

“What do you and your friends talk about concerning HIV?”

18. Reassess the client’s interest in harm reduction options, and consider a PrEP referral.

“You’ve mentioned a couple of ways that HIV could be coming into your life. “How do you feel about talking about some other ways to further protect yourself from HIV?”

“How would you like to protect yourself?”

“On one hand, it sounds like you enjoy sex without condoms. On the other hand, you also want to avoid HIV infection. I wonder if you have heard about a new HIV-prevention medication called PrEP?”

19. Summarize the risk behavior and risk patterns.

Summarize the information the client has shared with you. Retell the client’s story by highlighting the reasons the client has mentioned not wanting to change and wanting to change. Make connections between issues and situations, summarizing the key arguments for change identified by the client.

“I appreciate all that you’ve told me today. Here’s how I understand your main concerns for HIV. (Then retell the client’s story).”

“You’ve taken the first step today in protecting yourself—talking about and trying to figure out ways to reduce your chances of getting HIV.”

“Several things seem to have been going on in your life lately that affect how you have sex and/or share injection equipment: [List issues you have learned from the client].”

It seems like you feel most able to protect yourself when [state what the client has told you]. It’s more difficult in situations where [state what the client has told you]. What might make it easier to protect yourself in those situations?

“Are these your main concerns about HIV?”

“Is this how you see HIV potentially coming into your life?”

“Did I miss anything or would you like to add other issues that need to be talked about?”

20. Explore behaviors that the client feels most motivated or capable of changing in order to negotiate a harm reduction step.

Rely on the Stages of Change to help the client prioritize a harm reduction step that the client feels is realistic and doable.

“Now that we’ve looked at what’s been happening and how you feel about it, what do you think you’ll do next?”

“Can you tell me what you want to address most?”

“Given what we’ve talked about, what situation would make it most likely for you to get HIV or STDs?”

“How would you most like to reduce your risk for HIV and STDs?”

“What do you believe you could reasonably do to reduce your risk?”

If the client selects an “always” or “never” for an activity:

“It sounds like you really want to eliminate your risk. We know that change usually occurs in small steps. What could be the first step that might work for you?”

“This could be challenging. See if you can take it in small steps—small change is the beginning of a larger change.”

If the client is at a loss for how to reduce risk:

“Some people have told me that [offer some options] has worked for them. What would work for you?”

“Could you think of one small step you could take to make it harder to get HIV?”

Once the client identifies something, help them break it down into specific concrete steps.

“Now that you’ve identified going on PrEP as something you’d like to do, how could you make it happen?” “How can our PrEP Navigator help you?”

“What do you think you need to do first, second, third? When would it make sense to start?”

21. Problem-solve any obstacles in achieving the harm reduction step.

Assist the client in exploring obstacles to the harm reduction step.

“What could make it more difficult for you to complete this step?”

“How will you handle it if something gets in the way of your trying this step? What would be a good backup plan?”

“If you hit an obstacle in obtaining PrEP, who will you call?”

If appropriate, role-play the plan with the client.

“Would you like to practice how you’ll handle this?”

“Imagine that I am one of your partners. What would you say? Let’s switch roles.”

“What would help you make this plan easier for you? Who would be supportive of you trying this?”

“When you complete this step, how do you think you will feel?”

“How comfortable are you with the plan? Does it seem realistic to you? How does it feel? If we need to, we can rework the plan.”

22. Identify sources of support and provide referrals.

Assess the client’s support system.

“Who in your life do you feel is supportive of you?”

“Who knows that you’re here testing today?”

“Who do you usually talk to about your feelings and concerns?”

“Who are the people who feel closest to?”

“Your plan seems like it could really work for you. And we’ve talked about some important issues that may contribute to your chances of getting HIV, STDs, and hepatitis C. Would it be helpful to seek out professional help or other support with these issues?”

“You said that you think your drug and alcohol use is putting you at risk for HIV, and you want to make a change. What would you like to do?”

“Have you ever sought assistance, such as counseling, going to a support group or substance use treatment?”

“Some people find treatment really helpful. What would work for you?”

“How interested would you be in getting a referral for services to help you deal with this issue?”

“Is there a particular type of support or service you would consider using?”

“Here is the name and phone number of the service you could call to get assistance. I understand you are not sure yet whether you want to call, which is fine. It’s really whatever you feel would be most helpful.”

23. Assess client’s readiness to receive their result.

Assess client’s concerns related to receiving their result. for example:

“Do you have any questions before we go on?”

“Is there anything you’d like to talk about before I get your result?”

If using INSTI: “Is there anything you’d like to talk about before I get started on your test?”

USEFUL QUESTIONS TO ASK IN A RISK ASSESSMENT SESSION

"What brought you in for an HIV test today?"

[If the client says, "I test routinely," you might ask, "Is there a particular partner or event that you're more concerned about than others?"]

"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?"

"Tell me about the role drugs and alcohol play in your life."

"How do you like to protect yourself from HIV and STDs?"

"What have you heard about the WP?"

[In talking about closing WP] "How would you like to do that?" [HR step]

USEFUL QUESTIONS TO ASK REGARDING HEPATITIS C

"What have you heard about hepatitis C?"

"Have you ever been tested for hepatitis C?"

"You mentioned that sometimes in the past you have shared injection equipment. When was the last time you were tested for hepatitis C?"

"What concerns do you have about hepatitis C?"

"What are some of the ways you try to reduce the chances of hepatitis C being transmitted when you share injection equipment?"

"How would you like to protect yourself against hepatitis C?"

"What was the follow up testing like for your past hepatitis C reactive result?"

[If yes: "Did you end up going on any kind of medication to fight the hepatitis C?"

"Where have you had the greatest success in protecting yourself from HIV, STDs and HCV risks?"

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

FREQUENTLY ASKED QUESTIONS

WHAT IF CLIENTS DON'T WANT TO TALK?

At some point, it is likely that you will have a client who does not seem interested in counseling services. On the one hand, counseling is a voluntary service, and it's not appropriate to try to force someone to engage in it. On the other hand, many skillful counselors can find ways to engage clients who initially seem reluctant. Keep in mind that the purpose of your counseling time with the client is for the client to understand how HIV could be coming into their life, and what they would like to do about it. A counselor might say something like, "We have about 20 minutes while the test is developing a result *[if that is the case]*. How could we best use that time?" Oftentimes people who have tested many times before may feel they have "heard it all before." In this case, an acknowledgement of their expertise can go a long way toward developing rapport. It is also fine for a counselor to "let go" of an explicit focus on risk reduction in order to explore the larger context of a client's relationship with HIV. For example, if a client said "I know the drill. I've been testing for 25 years. There's nothing new you can tell me," a skilled counselor might ask: "How has living through the epidemic affected you?" or "What's it like to have stayed HIV-negative all this time?"

HOW DO I COUNSEL CLIENTS AT VERY LOW RISK FOR HIV?

Counseling clients with low or no risk for HIV can sometimes feel like a challenge, since a counselor may feel like there is very little to do during the 20-minute risk assessment. Remember that some clients have very low HIV risk because they have successfully shifted from higher-risk behaviors to lower-risk ones. Use stage-appropriate interventions for the Action and Maintenance stages—acknowledgment, affirmation, problem-solving, future planning—can help a client maintain change over time. Remember that "Action" is the stage during which people are most susceptible to "recycling" to previous stages, so a realistic exploration of recent changes may help maintain new desired behaviors.

HOW DO WE KNOW THAT A CLIENT IS TELLING US EVERYTHING?

We don't. The questions that counselors ask will, hopefully, engage the client in sharing their experience. Some clients may not feel comfortable disclosing everything to a counselor for a variety of reasons. Some settings, like jails, prisons, and others, get in the way of privacy. Counselors who maintain a neutral stance and express empathy during the risk assessment increase the chances that a client will have engage. Normalizing how difficult it is to share can increase comfort. Using "third-personing" to share information about harm reduction can help clients consider options without having to openly acknowledge behaviors that are difficult to share.

WHAT ABOUT ORAL SEX?

The risk for contracting HIV through oral sex is extremely low. In general, this is not a way that we see HIV being transmitted. Open oral sores or bleeding gums may increase the risk of transmission, so the counseling message is that that HIV is very unlikely to be transmitted this way, but not impossible.

You may encounter clients who only have oral sex. Risk reduction with these clients may feel like a challenge, because oral sex is already a low-risk activity. Keep in mind that clients may want to think about screening for other STDs, since these are more easily transmitted than HIV, often have no symptoms, and would elevate the transmission risk from oral sex. Also bear in mind that some clients may only feel comfortable telling you about having oral sex, not other kinds of sex.

WHERE CAN I GO WHEN I NEED TO TALK?

During the counseling session, the focus is on the client. But after the session, it is important to find ways to take care of your emotions, and to get feedback on how to handle challenging situations that arise. Sharing both your successes and challenges with other experienced test counselors (or your supervisor) can help you grow as a counselor and brainstorm different strategies and approaches when you are working with similar clients in the future. Finding appropriate, empathic people to share your counseling experiences with (without violating confidentiality) is a key part of both your personal and professional self-care.

GUIDELINES FOR GIVING AND RECEIVING FEEDBACK

GIVING FEEDBACK

1. Start with something the counselor did well in the role play.
 - For example: "I liked the way you asked some open-ended questions at the beginning. It made me feel like talking more about what was going on with me."
2. Select one or two areas of focus.
 - For example: "When you asked me how I like to protect myself, it made me realize that there are things that I do to prevent HIV. And then when you asked how I wanted to protect myself going forward, it made me realize that I'm the one in charge."

or

 - For example: "When we were talking about the different drugs I do, you stayed neutral--you seemed like you wanted to hear more about it, not to tell me I should stop. And you got a lot of context about how I use."
3. Give feedback that is specific and concise.

For example: "The way that you summarized halfway through made me realize how much we had covered, and also helped me figure out my harm reduction step."

4. Discuss an aspect that could be improved, with a concrete example of how to make it better.

For example: It's great that you asked about drugs and alcohol, and it would be more helpful if you ask in an open-ended way. I think you said, 'Do you do any drugs?' and it would be more helpful to say, 'What kinds of substances do you use?' or 'What role do drugs and alcohol play in your life?'"

5. Describe the behavior, rather than interpreting it.

For example, instead of saying, "You kept looking at your paper, but you were probably just nervous," say something like "I felt like you were really following my story, but then when you would look down at your notebook it kind of broke the connection."

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.

OBSERVING THE TRAINER MODEL ROLE PLAY

Write down your thoughts and observations regarding the model role play. Specifically, we'd like you to focus on:

1. What was done well in this session?

2. What might you do differently when you are the counselor??

3. What are some of the circumstances that affect how HIV could be coming into the client's life?

4. What stage-appropriate interventions was the counselor able to make?

5. Which of the tools of client centered counseling did you see demonstrated in the role play?

DAY FOUR

AGENDA DAY FOUR

MORNING

Welcome and Overview of Day Four

Hepatitis C

The Structure and Content of the HIV-Negative Disclosure

BREAK

Trainer Model Role Play of an HIV-Negative Test Disclosure

Second Role Plays: HIV Negative Disclosure

LUNCH

AFTERNOON

Flex Module

Structure and Content for Preliminary Positive Disclosure/Review Partner Services

Trainer Model Role-Play of a Preliminary Positive Disclosure

BREAK

Third Role Plays: Risk Assessment and Disclosing an Unknown Result

Closure and Review of Day

HEPATITIS C OVERVIEW

Hepatitis C Virus (HCV) infection is caused by HCV and is the most common blood-borne infection in the United States. Approximately 3.5 million (1.1 percent) people in the United States are chronically infected with hepatitis C. National estimates indicate that there are approximately 400,000 people living with chronic HCV in California. HCV is a leading reason for liver transplant in the United States. Approximately 25 percent of those infected with HIV are co-infected with HCV. It is estimated that less than half of people with HCV are aware of their infection.

Clinical features

Most (70–80 out of 100) people with recent HCV infection do not experience any symptoms and are often unaware of their infection. Of every 100 people infected with HCV, approximately 75–85 will go on to develop chronic infection; 60–70 will go on to develop chronic liver disease; 10–20 will go on to develop cirrhosis over a period of 20–30 years; and, without timely detection and treatment, 1–5 will die from the consequences of chronic infection (liver cancer or cirrhosis). Out of 100 people infected with HCV, 15–25 will clear the virus on their own, typically within the first six months of infection. HIV infection can lead to more rapid liver disease progression and higher risk of cirrhosis, end-stage liver disease, liver cancer, and liver-related death in people with HCV. It is not clear whether HCV speeds HIV progression.

Diagnosis

A combination of tests is required to diagnose HCV. HCV antibody (anti-HCV) indicates either past or present infection. A nucleic acid test (NAT)—also called a ribonucleic acid (RNA) or polymerase chain reaction (PCR) test—detects the presence of HCV in the blood, and is needed to diagnose current HCV infection.

Transmission

HCV is a blood-borne pathogen and is transmitted primarily by exposure to blood through the skin, such as through sharing contaminated injection equipment. Prior to 1992, many individuals were infected with HCV by blood transfusions or organ transplants. HCV is not efficiently transmitted between long-term monogamous heterosexual partners. However, having HIV increases a person's risk for sexual transmission of HCV. HCV can be transmitted from mother to child during childbirth and is more likely if the mother is co-infected with HCV and HIV.

Transmission of HCV has also occurred in health care and emergency response settings through accidental needle sticks or through failure to follow standard precautions and other infection control guidelines. There are very limited epidemiologic data to suggest additional risks from non-injection (snorted or smoked) cocaine use, but these risks are difficult to differentiate from risks associated with injection drug use and sex with HCV-infected partners.

There is little evidence that getting tattoos in licensed, commercial facilities spreads HCV. Whenever tattoos or body piercings are given in informal settings or with non-sterile instruments (such as in prison), transmission of HCV and other blood-borne infectious diseases is possible, and transmission in state prisons via sharing injection or tattoo equipment has been documented. An estimated 10 to 15 percent of people with HCV have no known risk factors.

Prevention

Currently there is no vaccine for HCV; however, researchers are working to develop one. Key HCV prevention messages include practicing safer injection by only using new syringes, cookers, cottons, or other injection equipment; following infection control guidelines in health care settings; and not sharing personal items that might have blood on them such as razors, toothbrushes, nail clippers, and blood glucose monitors. However, access to safe injection equipment varies by geographic area in California. Many counties do not have an authorized syringe exchange program, but all pharmacies may sell sterile syringes over the counter without a prescription. For people with opioid use disorders, maintenance medication assisted treatment (MAT) with buprenorphine or methadone has been shown to reduce hepatitis C transmission rates by 50 percent. MAT and safe injection practices can also play an important role in preventing reinfection among people with hepatitis C who have been treated and cured of their infection. People with chronic HCV infection should be advised to reduce or eliminate intake of alcohol and other substances toxic to the liver.

Screening: The USPSTF Recommendation

In 2020, the United States Preventative Services Task Force recommended that all adults between the ages of 18 to 79 be tested for hepatitis C. Their statement is below:

Hepatitis C virus (HCV) is the most common chronic blood-borne pathogen in the US and a leading cause of complications from chronic liver disease. Hepatitis C virus infection is associated with more deaths than the top 60 other reportable infectious diseases combined, including HIV. The most important risk factor for HCV infection is past or current injection drug use. In the US, an estimated 4.1 million persons have past or current HCV infection (ie, they test positive for the anti-HCV antibody). Of these persons who test positive for the anti-HCV antibody, approximately 2.4 million have current infections based on testing with molecular assays for HCV RNA. The estimated prevalence of chronic HCV infection is approximately 1.0% (2013 to 2016). An estimated 44,700 new HCV infections occurred in the US in 2017. Cases of acute HCV infection have increased approximately 3.8-fold (2010 to 2017) over the last decade because of increasing injection drug use and improved surveillance. The most rapid increase in acute HCV incidence has been in young adults aged 20 to 39 years who inject drugs, with increases in both sexes but more pronounced in men. Rates increased especially in American Indian/Alaskan Native and non-Hispanic white populations.

At-Risk Groups

The Centers for Disease Control and Prevention (CDC) has identified the following groups to be at risk for HCV:

Adults should be tested once (without prior ascertainment of HCV risk factors)

HCV testing is recommended for those who:

- Currently inject drugs

- Have ever injected drugs, including those who injected once or a few times many years ago

- Have certain medical conditions, including persons:

 - Who received clotting factor concentrates produced before 1987

 - Who were ever on long-term hemodialysis

 - With persistently abnormal alanine aminotransferase levels (ALT)

 - Who have HIV infection

- Were prior recipients of transfusions or organ transplants, including persons who:

 - Were notified that they received blood from a donor who later tested positive for HCV infection

 - Received a transfusion of blood, blood components, or an organ transplant before July 1992

HCV testing based on a recognized exposure is recommended for:

- Health care, emergency medical, and public safety workers after needle sticks, sharps, or mucosal exposures to HCV-positive blood

- Children born to HCV-positive women

Note: For persons who might have been exposed to HCV within the past six months, testing for HCV RNA or follow-up testing for HCV antibody is recommended.

In public health settings, CDPH recommends prioritizing hepatitis C testing for people who have ever injected drugs and for people with HIV, as well as prioritizing offering testing to people in settings with high hepatitis C prevalence, such as jails, drug treatment programs, and syringe exchange programs.

Treatment

The main goal of HCV treatment is to achieve a sustained virological response (SVR), which is defined as undetectable HCV in the blood 12 weeks after the end of treatment. If someone does not have hepatitis C virus in their blood 12 weeks after they have completed hepatitis C treatment, they are considered cured of their hepatitis C infection. Direct-acting antiviral medications can cure hepatitis C infection in more than 95 percent of cases in eight to 12 weeks.

There are a variety of different medications made by different manufacturers. (For more information on medications available for treating hepatitis C, visit the University of Washington Hepatitis C Online website at www.hepatitisc.uw.edu/page/treatment/drugs.) The most important thing for HIV test counselors to know is that “new treatments have changed the game.” Pegylated interferon, which only worked about half the time and caused serious side effects, is no longer used, and new direct-acting antiviral regimens are highly effective and have shorter durations with fewer side effects.

Hepatitis C treatment guidelines are available from the American Association for the Advanced Study of Liver Diseases and the Infection Diseases Society of America at www.hcvguidelines.org. Treatment is recommended for all people with hepatitis C, except for those with a life expectancy of less than 12 months and people who are pregnant or too young for medications currently approved for hepatitis C treatment by the U.S. Food and Drug Administration (FDA). Currently, available hepatitis C treatment medications are currently approved for treating hepatitis C infection in people 12 years of age and older. Treatment is not currently recommended during pregnancy because ribavirin, which is still used in some treatment regimens, is known to cause birth defects, and because the effects of other hepatitis C medications on a developing fetus are unknown.

Combined Hepatitis C and HIV Window Period

The window period for HCV is different from that of HIV. The earliest that people can develop HCV antibodies following an infection is six weeks, with everyone having detectable antibodies by three months.

Date of most recent possible exposure to HIV or hepatitis C	2 weeks later	6 weeks later	3 months later
Fill in dates	The earliest people show HIV antibodies is 2 weeks after exposure	The earliest people show HCV antibodies is 6 weeks after exposure	By the end of 3 months, everyone who was infected will have HIV and/or HCV antibodies

Hepatitis C Progression



Of 100 people acutely infected with hepatitis C



Approximately 20 people clear the virus within 6 months



Approximately 80 people remain chronically infected



Of the 80 chronically infected people



28 will not suffer significant liver damage or symptoms



52 will get some symptoms of liver damage over a period of 10 to 25 years



Of these 52 people with some liver disease



36 will not develop serious liver disease



16 will develop cirrhosis



Of the 16 with cirrhosis



12 will have slowly progressive cirrhosis



4 will have liver failure or cancer within 5 to 10 years

Hepatitis C Antibody Test Results & Disclosure Key Points

“Non-Reactive” Result



- A line at the “C” and no line at the “T.”
- Using the OraQuick HCV test, this is a “non-reactive” result.
- No HCV antibodies were found at this time.
- Check to see if the client could be in the window period.
- If the client has passed their window period, this means that they have never been infected with HCV.
- Check in about harm reduction steps to keep “non-reactive” results coming.

“Reactive” Result



- A line at the “C” and a line at the “T.”
- Using the OraQuick HCV test, this is a “reactive” result.
- HCV antibodies were found.
- At some point in their life, the client was infected with HCV.
- They might still be infected, *or they might not*.
- Further testing, for the HCV virus itself, is needed.
- Refer to a medical provider for further testing.
- Check in about harm reduction steps to keep from potentially spreading HCV to others and how to protect their own health (like avoiding or limiting alcohol).
- If it turns out they have HCV, more and better treatment options are now available.
- Their doctor can help them decide if, when, and how to start treatment.

HEPATITIS C HARM REDUCTION STRATEGIES

From the Hepatitis C Counseling Best Practices Manual, Hepatitis C Harm Reduction Coalition Project

People Who Inject Drugs

Messages

Hepatitis C is more easily transmitted via blood than HIV.

Hepatitis C can be present in very small amounts of blood.

Blood can be present on any injecting equipment, even though it may not be visible (syringe, cooker, cotton, hands, in used water, etc.).

Questions

Do you inject drugs alone or with others?

How do you set up to inject with others?

Are there any of your works or area that could have contact with blood?

How do you prepare your shots?

Do you divide your drugs?

What sorts of things could you do to avoid contact with others people's blood?

Strategies

Discuss safe injecting 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 (ESAP)

- Prescribed by doctor

Bleach kits as last resort, have a kit available and if no clean equipment is available

Reduce injecting 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

Sexual Transmission

Messages

Hepatitis C is primarily found in blood.

Sexual transmission is not common but can occur; especially when blood is present during sex.

Risk is heightened if you have multiple sexual partners.

Risk is probably higher with certain sex activities that involve blood, like unprotected vaginal or anal sex.

Risk is probably higher if STDs/HIV or skin tears present and when a woman is menstruating or pregnant.

If in long-term monogamous sexual relationship, the risk of transmission is very low—you may not need to change behavior, but may wish to discuss the use of barrier precautions.

Questions

Can you think of times when blood may have been present when having sex?

What sort of things could you do to prevent blood-to-blood contact when having sex?

How do you think it would go if you brought up condom use with your partners?

Do you know whether your partner has hepatitis C or HIV?

Strategies

Sexual transmission is uncommon. If there is concern of hepatitis C transmission, use condoms to reduce your risk.

Avoid high-risk practices, modify how the practices are performed.

e.g., use plenty of lubrication when having anal or rough vaginal sex, use condoms during pregnancy and menstruation.

Explore reasons why condoms may not be used when risk factors are known and present.

Have STDs treated.

Discuss availability and adequate supply of condoms and water-based lubrication.

Household Contact

Messages

Only household items contaminated with blood can transmit hepatitis C—e.g., razors, toothbrushes, nail clippers, snorting straws.

Reinforce that hepatitis C cannot be spread by casual contact:

- Coughing or sneezing

- Hugging or kissing

- Food or beverages

- Sharing eating utensils or cups

- Breast feeding (unless nipples are cracked or bleeding)

Questions

Are there items in your house that you think may have contact with blood that others might use?

What sort of things could you do to avoid blood-to-blood contact from your own personal items?

Strategies

Have your own toothbrush and razor clearly identified.

If blood is present in your mouth, have dental problems attended to if possible.

Encourage participant to discuss hepatitis C transmission with other members of household.

Tattooing/Body Piercing

Messages

Only sterile or new equipment should be used.

Inkpots should be for single use only and should not be shared by others.

Questions

Have you ever had tattooing or piercing done where you could have had contact with other people's blood?

If you are having a tattoo or piercing done when sterile equipment was not available, how could you ensure your own needle and ink supply?

Strategies

Only have tattooing or piercing done if sterile equipment and new single-use inkpots are used.

If non-professional/unsafe tattooing or piercing occurs:

- Dispose of implements once used.

- Ensure own/marked equipment is used for tattooing or piercing

- Ensure own inkpot is available

- Bleach equipment if no sterile or new equipment is available

Alcohol

Messages

Alcohol is a potent toxin to the liver.

If you have hepatitis C and drink alcohol, the risk of liver damage is increased.

If alcohol consumption is moderate to high and the participant is hepatitis C-positive, then strategies to reduce consumption should be discussed. It is unclear if rare or low levels of alcohol consumption are harmful.

Questions

Are there ways that alcohol causes problems in your life—e.g., relationship, financial, health?

How do you think you could reduce or stop drinking alcohol?

Where are you in terms of reducing your drinking?

Strategies

Refer to appropriate substance use counseling:

Substance use counselor

Alcoholics Anonymous (AA)

Detox/rehab, substitute therapies—e.g., naltrexone, medical management

Discuss the current social & personal supports the client has or can access. Explore how this support can be used to help them to reduce or stop alcohol use.

Assess and discuss underlying issues that may lead to drinking—e.g., mental illness or depression.
Refer to appropriate service.

Alcohol Reduction Strategies

Avoid drinking alone.

Start off with a non-alcoholic drink.

Alternate usual drinks with alcohol-free or low alcohol drinks.

Drink water while drinking alcohol.

Break the habit of drinking in rounds.

Have at least two alcohol-free days a week and consider increasing the number of alcohol-free days each week. (Note: one to two drinks a day is less harmful for the liver than five drinks in three hours.)

Do not drink when you have had a bad day.

Don't keep alcohol around the home.

Drink slowly.

Substitutes drinking with other activities you enjoy doing.

Avoid situations where there is pressure to drink.

Learn how to say no to drinking alcohol when you are in the company of others who are drinking and may pressure you to do likewise.

Get support for yourself and your family/significant others.

Identify the times of day you are prone to drinking alcohol.

Examine the situations that trigger unhealthy drinking patterns and develop new ways of handling these situations.

Save the money in a separate place that you would spend on alcohol.

Use a worksheet for keeping track of cutting down:

- Set an alcohol limit and write it down

- Set a goal

- Write down the pros and cons of drinking

- Celebrate incremental steps in change

COUNSELING CHECKLIST: HIV-NEGATIVE DISCLOSURE

25. Read test result, dispose of test, complete relevant paperwork.

26. Disclose HIV-negative test result.

- a. State result in a direct, neutral tone.
- b. Wait for client's response before proceeding

27. Assess client's emotional state and counseling needs.

28. Explore feelings about the result.

Acknowledge client's feelings in response to negative result.

29. Explore information and thoughts about result.

- a. Assess client's understanding of test result and clarify misconceptions.
- b. Assess need for retest based on window period and recent risks.

30. Explore behavior.

Reassess client's harm reduction step that was discussed earlier in the session.

31. Explore interpersonal issues.

Assess client's support network and disclosure-related issues.

32. Evaluate HIV risk behavior.

33. Identify sources of support for the harm reduction step.

Assess strength of social support for client's intended harm reduction step.

34. Revisit referrals from risk assessment.

Reassess client's harm reduction step that was discussed earlier in the session.

35. Express confidence in the client's ability to complete the step.

36. Close the session but not the door.

COUNSELING PROTOCOL: HIV-NEGATIVE DISCLOSURE

Goal of the Session: Integration of test result in a meaningful and productive manner, which includes the following: discussion of the window period, continued conversation about harm reduction, and negotiation of a realistic, incremental step to prevent HIV.

25. Read test result, complete appropriate paperwork.

The particular paperwork, referral, and disclosure issues, which are specific to your site, will be reviewed by your supervisor.

26. Disclose HIV-negative test result.

Proceed directly, but without seeming rushed, through this part of the session.

State the result in a direct, neutral tone.

“Your test result is negative.”

Wait for client’s response before proceeding.

You may need to wait for 15 seconds (or longer) before speaking after delivering the result. Do not rush the client. Let the client respond to the result in their own way and at their own pace.

27. Assess client’s emotional state and counseling needs.

Based on the client’s response to the test result, make some decisions about this client’s needs.

Keeping in mind the limited time available in the session, think about helping the client integrate their test result in four key areas: feelings, information and thoughts, behavior, and interpersonal issues.

28. Explore feelings about the result.

Assess and acknowledge client’s feelings in response to their negative result. Open-ended questions may be helpful here:

“What does an HIV-negative result mean to you?”

“How are you feeling about this result?”

“What impact do you imagine this will have on your life?”

You may also find it more effective to use reflections because they allow clients to continue experiencing their feelings without a sense of interruption.

“You look relieved.”

“You seem surprised.”

“I can see this is big news for you.”

“I can’t tell how you’re feeling about this.”

Provide validation and support for clients who appear distressed at the negative result, explore survivor guilt and other issues.

29. Explore information and thoughts about the result.

Assess client's understanding of the test result, and clarify misconceptions as necessary. Describe the meaning of the test result.

“What does this test result mean to you?”

“Is this result what you thought it would be?”

“Remember when we talked about the fact that you're in the window period? What does that mean to you?”

Assess need for retest based on the window period and recent risks, and provide other information as appropriate.

30. Explore behavior.

Reassess client's harm reduction step, which was discussed earlier in the session. Help client to clarify their ongoing commitment to behavior change.

“Now that we know this result, what do you think about the harm reduction step you mentioned earlier?”

“What steps do you see yourself taking in the future to protect yourself from HIV infection?”

“How would you like to keep those negative results coming?”

“What do you feel ready to do to remain HIV-negative, if anything more than you've already mentioned?”

“We can think again about ways to protect yourself from HIV now, if you feel like that would be helpful.”

31. Explore interpersonal issues.

Assess client's social support network, plans for disclosure, and the impact of any disclosures. Identify and strengthen social support network. Explore disclosure issues: who to tell, whether to tell, when, and how. Develop plan to maximize support and minimize negative consequences of disclosure.

“Have you thought about who you will discuss your result with?”

“What impact will your test result have on your partner(s)?”

“Earlier you mentioned someone in your life and what this result might mean for that relationship. What do you think now?”

32. Evaluate HIV risk behavior.

If the client reports ongoing participation in higher-risk behavior, evaluate strategies for more in-depth support. Use summaries to explain the limitations of this session, express genuine concern, and encourage follow-through on referrals.

“There are a lot of complex reasons people continue to be at risk for HIV. I know we don't have time in this session to fully cover what these might be for you. You deserve more attention and time than I

can give you here, and [name the resource] may be helpful in working with your plans and helping you protect yourself from HIV.”

If client reports participation in only lower-risk behaviors, depending on the client’s reason for testing, consider offering the client referrals for other support.

“I see that you are relieved that your test was negative. Since your result was negative today and you said you have had no exposures in the last three months, we know that at this moment you are truly not infected with HIV. There is no need for you to retest in the future unless you have an exposure to the fluids we talked about earlier. At the same time, if it seems that coming to test is helping you prevent HIV, let’s talk about when you think you’d like to come back or if there’s anything else you might need other than testing.”

33. Identify sources of support for the harm reduction step.

Emphasize the importance of the client discussing with a trusted friend or relative the intention and content of the harm reduction step they developed during the risk assessment.

“Since we may not see each other again, it might be useful for you to share your plan with someone who can support you in your efforts to change. What do you think about talking with a supportive person in your life?”

“Who in your life is supportive of you?”

“Could you talk to them about your plan?”

“Who do you usually talk with about changes you’re making in your life?”

34. Revisit referrals from risk assessment.

If a referral was given during the course of the risk assessment, revisit the client’s ability to follow up with it. Reassess willingness and ability to follow up with sources of support in the client’s life.

“We talked earlier about you accessing the needle exchange. Would you still like me to get you their information?”

“We were talking about PrEP and you said you might want to meet with our PrEP navigator. Would you like for me to help set you up with an appointment?”

35. Express confidence in the client’s ability to complete the step.

Ask the client to reflect on the strengths and weaknesses in their step as they try it out and let them know you have confidence in them.

“When you try this step, think about what feels good and works for you and which parts are hard or uncomfortable.”

“Remember that trying to do something differently is sometimes awkward, but it gets easier with practice.”

“Changing behavior takes time and practice. Be patient with yourself.”

“This is a strong plan you’ve come up with. It sounds like something that you think you can do.”

Remember to revise the plan if you need to in order to make it work better for you.”

“Just so you know, if you come back in a few months and we see one another, I want you to know that you can talk about this again with me or another counselor here—or not. It’s really up to you and what you think would be most helpful. I just don’t want you to leave feeling like you have to ‘report back’ to me about how things go.”

36. Close the session, but not the door.

Acknowledge the client’s strength in taking charge of their health. Tell them not to hesitate to call or come by if they have any HIV, STD, or hepatitis C concerns in the future.

IMPLICATIONS OF THE WINDOW PERIOD FOR HIV-NEGATIVE DISCLOSURES

HIV-NEGATIVE DISCLOSURE COUNSELING MESSAGES

Review the protective behaviors that have helped the client avoid infection with HIV and reinforce the client's step to remain uninfected.

Ensure that the client is aware that, as is true of any antibody test, the negative HIV test result may not reflect their current HIV status if there has been a recent exposure or possible exposure. Specifically, the client needs to be informed that after a person is infected with HIV, it takes time (two weeks to as long as three months) before antibodies can be detected by the test.

Some clients with recent exposures or possible exposure may want to be retested after enough time has passed since their most recent exposure.

FOLLOW-UP TESTING IN CLIENTS WITH HIV-NEGATIVE TEST RESULTS

A negative HIV test usually indicates the absence of HIV infection. Because recent infection, however, cannot be excluded without follow-up testing, providers should consider the following factors related to individual client needs when recommending the timing and frequency for follow-up HIV testing:

- Timing of the last potential exposure

- Probability of HIV infection given the type of exposure

- Presence or likelihood of ongoing risk behavior

- Likelihood of returning for follow-up HIV testing, prevention counseling, and referral

- Client anxiety

- Provider and client relationship

- Resource constraints

RECENT EXPOSURE

Follow-up testing might be appropriate for clients who test negative but who haven't had time to develop detectable antibodies after a recent sexual or needle-sharing exposure. The timing of follow-up testing should provide assurance that the exposure did not lead to infection. Follow-up testing should be conducted in a timely manner so clients identified as HIV-positive can receive appropriate treatment, prevention, and support services as soon as possible.

SINGLE POSSIBLE OR KNOWN EXPOSURE

People living with HIV will develop detectable HIV antibodies within three months of exposure. If the initial negative HIV test was conducted within the first three months after exposure, repeat testing should be considered three months after the exposure occurred to account for the possibility that the body had not produced detectable antibodies by the time of the first test. If the follow-up test at three months is also

negative, and no new exposures have occurred since the initial exposure, the client is not living with HIV.

ONGOING EXPOSURES

In some settings, clients with ongoing risk represent a substantial proportion of those receiving HIV counseling, testing, and referral. In most circumstances, follow-up testing should be recommended periodically for clients with ongoing risks. Follow-up testing would monitor the client's HIV status, but also promote continued client contact and provide opportunities for HIV prevention counseling and referral to additional preventive and support services.

COUNSELING CHECKLIST: PRELIMINARY POSITIVE DISCLOSURE

Goal of the Session: Integration of test result in a meaningful and productive manner, which includes the following: collection of a second sample and scheduling an appointment for a confirmatory result disclosure session, including linkage to medical care. Think about helping the client integrate the test result in four key areas: feelings, information and thoughts, behavior, and interpersonal issues.

25. Read test result, dispose of test if appropriate, complete relevant paperwork.

26. Disclose preliminary positive test result.

- a. State result in a direct, neutral tone.
- b. Wait for client's response before proceeding.

27. Assess client's emotional state and counseling needs.

28. Explore feelings. Acknowledge client's feelings in response to a preliminary positive result.

29. Explore information and thoughts. Assess client's understanding of test result and clarify misconceptions.

30. Explore behavior and previously discussed harm reduction step.

31. Explore interpersonal issues, including partner notification and disclosure assistance.

- a. Assess strength of social support for this client.
- b. Explore plans for and potential consequences of disclosure to others.
- c. Evaluate partner notification concerns.

32. Describe collecting a second sample and the scheduling of the next appointment.

- a. Describe collecting a second sample.
- b. Explain the importance of returning for the confirmatory result.

33. Discuss medical follow-up, including linkage to care. If the client is ready, willing, and able, link the client to medical care using your site's protocol.

34. Review strategies for coping. Discuss the waiting period for the confirmatory result and client's strategies for coping.

35. Present reasons that will encourage clients to return for confirmatory result. Emphasize benefits of receiving the confirmatory result, especially those that might enlist follow-through for this client.

36. Facilitate client empowerment. Empower client to follow through on immediate and long-term planning.

37. Provide additional referrals. Close the session, not the door. Provide adequate linkage to additional community-based referrals before bringing the session to a close.

COUNSELING PROTOCOL: PRELIMINARY POSITIVE DISCLOSURE

Goal of the Session: Integration of test result in a meaningful and productive manner, which includes the following: collection of a second sample and scheduling an appointment for a confirmatory result disclosure session, including linkage to medical care. Think about helping the client integrate the test result in four key areas: feelings, information and thoughts, behavior, and interpersonal issues.

Key Concepts:

Be attentive and genuine. Respectful pausing and silence is OK.

Use techniques to build hope, self-advocacy skills, and empowerment.

Validate and normalize the client's feelings and experience.

Engage in ongoing assessment of the client's feelings and ability to integrate the information.

Try to think about helping the client integrate the test result in four key areas: feelings, information and thoughts, behavior, and interpersonal issues. Remember that each client will be different and you will be able to accomplish different things with different clients.

25. Read test result, dispose of test if appropriate, complete relevant paperwork.

The particular paperwork, referral, and disclosure issues, which are specific to your site, will be reviewed by your supervisor.

26. Disclose preliminary positive test result.

Proceed directly, but without seeming rushed.

State the result in a direct, neutral tone.

“Your test result came back preliminary positive.”

Wait for client's response before proceeding. You may need to wait for 15 seconds (or longer) before speaking after delivering the result. Do not rush the client. Let the client respond to the result in their own way and at their own pace.

27. Assess client's emotional state and counseling needs.

Based on the client's response to the test result, make some decisions about this client's needs. Keeping in mind the limited time available in the session, think about helping the client integrate test result in four key areas: feelings, information and thoughts, behavior, and interpersonal issues.

28. Explore feelings.

Many clients who have received a preliminary positive result report that once the counselor delivers the result, they are not able to recall a lot of what was said during the rest of the session. Thus, the primary goal here is to support, validate, and normalize the client's emotional reaction.

Assess and acknowledge client's feelings in response to a preliminary positive result.

Picking up on the client's feelings and using reflection can be particularly useful.

"I want to give you some time; I'm right here when you're ready to talk."

"I can see this is a lot to take in right now."

"You seem surprised by this result."

"You seem to not be surprised."

"What are you feeling right now?"

"You seem relieved. I'm wondering what's going on for you?"

Provide validation and support.

"Take your time. We have plenty of time to talk about the result."

"It seems like this is difficult for you."

"I can see that this is very upsetting to you. What can I do right now to be helpful?"

Normalize feelings.

"Many people I've talked with have expressed similar feelings when they learn they have a preliminary positive result."

Help client cope with anxiety or despair.

"You may need to take time to adjust to this. Many clients say that it gets easier once they get over the initial shock. With proper medical and social support, many people with HIV can expect to lead very productive, full lives."

"I can see this is a hard moment for you. Can you think of anything you can do to take care of yourself just for now—during this session and after you leave here today?"

29. Explore information and thoughts.

Assess client's understanding of the test result, and clarify misconceptions as necessary.

"What does this test result mean to you?"

"Let's make sure we're both on the same page about what this means."

Confirm the meaning of the preliminary positive test result.

"We will want to verify this result with a follow-up test."

"It is very likely that you are infected with HIV. After we collect a sample today and receive a confirmatory result next week, you will know for sure."

"This test result is extremely accurate in most cases and it is very likely that you are infected with HIV. When we have a confirmatory result next week, you will know for sure."

Describe the meaning of the result and provide other information.

“It is highly likely that you are infected with HIV, but we need a follow-up test to get a definite result. Once we get that result, we will know for sure if antibodies are present.”

For some clients, it may be appropriate to talk about the accuracy of the test.

“It is a highly accurate test. And we will confirm it to be sure.”

Provide other information as appropriate.

“This test tells us that it is very likely that you have antibodies to the virus, which would mean that you are living with HIV. But it doesn’t tell us anything about your health. A doctor can help you find out more about that.”

30. Explore behavior and previously discussed harm reduction step.

When appropriate, refer back to client’s harm reduction step.

“If you’re willing to talk about this now, what does this mean for the harm reduction step we discussed earlier?”

“How do you think you could protect yourself from STDs and hepatitis C going forward?”

“There are different ways to be sexually intimate and close without transmitting HIV. We now know that when a person living with HIV is undetectable that they have almost no risk of transmitting HIV through sex. What does that mean for you?”

Where possible and appropriate, identify a step toward reducing risk for future transmission.

“Now might be a good time for us to think about how this result might affect how you have sex or inject drugs.”

“Can you think of one small step that you could take to reduce the risk of transmitting HIV to others?”

“If you like, we can discuss ways to inject without risking HIV transmission. Have you ever used a needle exchange program?”

31. Explore interpersonal issues, including partner notification and disclosure assistance.

Assess client’s social support network, plans for disclosure of result to others, and concerns about the potential impact of any of these disclosures.

“Have you thought about who you will discuss your result with?”

“Who can be supportive of you in dealing with this?”

“Some people want to tell someone they trust, someone who will keep their confidence.”

Explore whether the client is able to talk about the implications of their preliminary positive result with their sexual or injection-sharing partners. Evaluate partner notification concerns and clarify how partner services can be of assistance once the preliminary positive result is confirmed.

“How might you bring up your preliminary positive result with your sexual or needle-sharing partners?”

“If you’re not sure how or if you want to tell your partner(s), we have some more support we can offer. (Describe partner services, if the client is ready.)

Explore disclosure issues: who to tell, whether to tell, when, how, etc. Assess the client’s personal situation and assist in determining their timing of disclosure.

“What do you think about talking to them about your result?”

“What impact will your test result have on your relationships?”

Encourage client to think about who should be informed and how. Inform them that their local health jurisdiction’s partner services program can assist them in notifying their partners once their preliminary test result has been confirmed. Reassure them that this notification service is free and voluntary, is always confidential, and client names are never disclosed.

“Who do you believe may need to know about your result? Are there any particular partners that you want to inform?”

“Are there people that you think might want to get tested themselves?”

Develop a plan to maximize support and minimize negative consequences of disclosure.

“Have you discussed with your partners what it would mean if you were infected with HIV? How do you think they would react?”

“It’s essential that you understand that your test result does not necessarily indicate what the result of your partner(s) will be. Your partner may not be infected.

32. Discuss collecting a second sample and scheduling an appointment for the confirmatory test.

Describe the procedure for collecting a second sample and scheduling an appointment for the confirmatory test result.

“Before you leave today, we will be collecting a second sample to confirm the result you have just received. Let’s talk about what will work for you to return for your confirmatory result.”

Explain the importance of the second sample and the need for the confirmatory result.

33. Discuss medical follow-up, including linkage to care.

While this result is preliminary positive and has yet to be confirmed, some clients may be ready to seek medical care. Explain the importance of medical follow-up, even for people who feel quite healthy or who feel overwhelmed by learning they have HIV. Describe benefits of seeing a knowledgeable health care provider for HIV medical advice and offer linkage to care.

Describe standard interventions for people with HIV, including immune system monitoring; screening for other STDs, tuberculosis (TB), and hepatitis C; preventive (prophylactic) treatments; prenatal care for pregnant women; and so on.

Keep descriptions brief and offer written materials for later reference by client.

“This test result means that it is highly likely that you are living with HIV. While we wait for the confirmatory test result, you may want to talk with a doctor. When someone has HIV, it’s important to receive medical follow-up, in order to understand options and the next steps to take. Could we walk through some of the ways I can help connect you to medical care?”

If the client does not have a medical provider, offer to connect the client to medical care.

Whether or not the client has a medical provider already, try to make an appointment on-the-spot.

If the client is not interested in medical care, ask if your test site might 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.

“It sounds like now is not the time to think about this. Would it be OK if we check in with you later? We’d just contact you to see if you might be interested in medical care or other support services. If that sounds helpful to you, when and how would you like us to get in touch with you?”

34. Review strategies for coping.

Ask client to think about what the waiting period for the confirmatory result will be like.

“What do you think the waiting period for your confirmatory result will be like for you?”

“How have you handled stressful situations in the past?”

“Is there a supportive person in your life you can talk to about this?”

35. Present reasons that will encourage clients to return for confirmatory result.

Acknowledge that sometimes clients might hesitate to return for their confirmatory result, and validate that this is a normal feeling. Emphasize benefits of receiving confirmatory result, especially those that might encourage follow-up for this client.

Knowing that you are HIV-positive opens the door for early interventions.

Knowledge about your body and your health can be empowering.

Relieves the anxiety of “not knowing,” which may be more stressful than knowing one way or the other about one’s HIV status.

Understanding your result can reinforce commitments to practice safer behaviors.

Enables protection of partners or spouses from infection and guarantees the safety of future children.

Offers opportunity to give important information to past, current, or future sexual or needle-sharing partners.

The counselor will be able to provide linkage to support services that are personalized to the client’s needs.

36. Facilitate client empowerment.

Empower client to follow through on immediate and long-term planning.

“We’ve talked about a lot. Would it be helpful to prioritize the steps you might take to get the care you need?”

“What is most important for you to deal with first?”

Offer realistically hopeful statements without discounting client’s feelings.

“I can tell that this is hard news to hear and that you’re upset about it. I want you to know there are reasons to be hopeful. With proper care, people are living long healthy lives with HIV.”

“There is a lot of support available for you.”

Encourage client’s active participation in addressing health needs and concerns.

“It’s important to see a doctor soon, but ultimately it’s your decision. What do you think you might do?”

“How can I help make it easier for you to connect with care?”

Build skills in decision-making.

“Let’s talk about some of the decisions you might want to make, now that you know this result.”

“Tell me what you know about U=U or treatment as prevention?”

“We now know that when a person living with HIV is undetectable that they have almost no risk of transmitting HIV through sex. What does that mean for you?”

37. Provide additional referrals. Close the session, not the door.

Provide specific, appropriate, written referrals with adequate linkage. This may include the following:

Program staff for assistance and support with linkage to care services.

Hotlines or other services available in the county in which the client resides.

Support programs for newly diagnosed people.

Select referrals based on your assessments, keeping in mind the client’s identified needs.

Keep the number of referrals limited. Don’t overwhelm the client. Instead, enlist client feedback regarding prioritizing referrals.

Explore with client where they are going immediately after the session. Assist client to become more grounded before they leave the test site by asking them where they are going next, how they are getting there, and who will be there.

“It can be difficult dealing with the likelihood that you’re infected with HIV. How are you doing?”

“Let’s think through a few next steps together, if you’re ready for that. What will you do after this

session? What will you do tonight? Who can you talk to about what you've learned here today?"

"I can see that this is hard news to hear and that you are upset about it. I want you to know that there are many treatment options available for people living with HIV."

COUNSELING CHECKLIST: CONFIRMATORY DISCLOSURE SESSION

Essential goal of session: Integration of test result in a meaningful and productive manner, and linkage to medical and psychosocial support.

- 1. Review the client data forms and results before meeting with client.** Make a preliminary plan for the session. Keep plan flexible.
- 2. Welcome and assess client's readiness for result.**
- 3. Disclose confirmatory test result.**
 - a. Ask client if they have any questions or concerns before disclosing the result.
 - b. Follow client's lead as to when to disclose.
 - c. State result in a direct, neutral tone.
 - d. Wait for client's response before proceeding.
- 4. Assess client's emotional state and counseling needs.**
- 5. Explore feelings.** Assess and acknowledge client's feelings in response to their confirmatory result.
- 6. Explore information and thoughts.** Assess client's understanding of test result and clarify misconceptions.
- 7. Explore behavior and previously discussed harm reduction step.**
- 8. Explore interpersonal issues, including partner notification and disclosure assistance.**
 - a. Assess strength of social support for this client.
 - b. Explore plans for and consequences of disclosure to others.
 - c. Evaluate partner notification concerns.
- 9. Review strategies for coping.**
- 10. Discuss medical follow-up and linkage to care.**
- 11. Facilitate client empowerment.**
- 12. Provide referrals and closure.** Provide adequate linkage and grounding to client before they leave the session.

COUNSELING PROTOCOL: CONFIRMATORY DISCLOSURE SESSION

Goal of the Session: The essential goal of this part of the session is to help the client integrate their test result in a meaningful and productive manner. A client who integrates results will be better able to take appropriate steps to seek medical care and social support, and will also be better prepared to avoid transmission of HIV to others. Counselors will use a variety of techniques and skills throughout the session to accomplish this.

Key Concepts:

Be attentive and genuine. Respectful pausing and silence is OK.

Use techniques to build hope, self-advocacy skills, and empowerment.

Validate and normalize the client's feelings and experience.

Engage in ongoing assessment of the client's feelings and ability to integrate the information.

Try to think about helping the client integrate the test result in four key areas: feelings, information and thoughts, behavior, and interpersonal issues. Remember that each client will be different and you will be able to accomplish different things with different clients.

1. Review the client data forms and results before meeting the client.

Retrieve confirmatory results, look over the information on the client data forms, and make a preliminary plan for the session and whatever referrals might be appropriate. Keep plan flexible, depending on client's expressed needs and concerns.

2. Welcome and assess the client's readiness for result.

Welcome the client, and introduce yourself. Be attentive, genuine, and neutral. Assess the client's readiness to receive their result. Find out how the past week or two has been since the client was last at the site.

"How are you? How has the last week been?"

Do not rush to the result, but follow the client's lead and move directly to results if that is the client's preference.

3. Disclose confirmatory test result.

Assess the client's readiness to receive their result. Ask the client for any questions or anything they would like to talk about before disclosing the result.

"Are there any questions or concerns you'd like to talk about before we go on?"

Follow client's lead as to when to disclose. In general, clients will be anxious to move ahead. Proceed directly, but without seeming rushed, through this part of the session.

State the result in a direct, neutral tone.

"Your test result is HIV-positive."

Wait for client's response before proceeding.

You may need to wait for 15 seconds (or longer) before speaking after delivering the result. Do not rush the client. Let the client respond to the result in their own way and at their own pace.

4. Assess client's emotional state and counseling needs.

Based on the client's response to the confirmatory test result, make some decisions about this client's needs. Keeping in mind the limited time available in the session, think about helping the client integrate test result in four key areas: feelings, information and thoughts, behavior, and interpersonal issues.

5. Explore feelings.

Some clients who receive a confirmed positive result report that once the counselor delivers the results, they do not remember the rest of the session. The primary goal here is to be supportive, validating, and normalizing when responding to the client's emotional reaction.

Assess and acknowledge client's feelings in response to the confirmatory positive result.

"How are you feeling about this result?"

"It's been a week or two since you found about your first result. Now that you know for sure, what are you feeling?"

"What impact do you imagine this will have on your life?"

"What does this mean for you?"

Provide validation and support.

"Take your time. We have plenty of time to talk about the result."

"It seems like this is difficult for you."

"I'm wondering what's going on for you."

"I can see that this is very upsetting to you. What can I do right now to be helpful?"

Normalize feelings.

"Many people I've talked with have expressed similar feelings when they learn they have a positive result."

Help cope with anxiety or despair.

"You may need to take time to adjust to this. Many clients say that it gets easier once they get over the initial shock. With proper medical and social support, people with HIV can expect to lead very productive, full lives."

"I can see this is a hard moment for you. Can you think of anything you can do to take care of yourself just for now—during this session and after you leave here?"

6. Explore information and thoughts.

Assess client's understanding of the test result, and clarify misconceptions as necessary.

"How do you understand this result?"

"Is this result what you thought it might be?"

Explore the meaning of the confirmed positive test result.

"What does this test result mean to you?"

Describe the meaning of the result and provide other information.

"This test result is positive, which means you are infected with HIV. What does that mean to you?"

For some clients, it may be appropriate to talk about the accuracy of the test.

"This confirmatory result is extremely accurate. You have now tested positive twice on two very accurate tests: the OraQuick ADVANCE Rapid Test or the INSTI Rapid Test, and again on this confirmatory test."

Provide other information as appropriate.

7. Explore behavior and previously discussed harm reduction step.

When appropriate, refer back to client's harm reduction step.

"If you're willing to talk about this now, what does this mean for your harm reduction step we discussed when you were last here?"

"Can you tell me how you plan to protect yourself from STDs/hepatitis C and protect your partners from HIV?"

"How would you like to protect yourself from STDs/hepatitis C? How would you like to protect your partners from HIV?"

Where possible and appropriate, identify a step toward reducing risk for future transmission.

"Now might be a good time for us to think about how this result might affect how you have sex or inject drugs."

"Can you think of one small step that you could take to reduce the risk of transmitting HIV to others?"

"If you like, we can discuss ways to inject without risking HIV transmission or exposing yourself to hepatitis C. Have you ever used a needle exchange program?"

8. Explore interpersonal issues, including partner notification and disclosure assistance.

Assess client's social support network, plans for disclosure of result to others, and concerns about the potential impact of any of these disclosures.

"Since you were last here, have you discussed your result with anyone in your life?"

“Have you thought about who you will discuss your result with?”

“Who can be supportive of you in dealing with this?”

“Some people want to tell someone they trust, someone who will keep their confidence.”

Explore whether the client is able to talk about the implications of their confirmed HIV positive result with their sexual or injection-sharing partners. Evaluate partner notification concerns and clarify how partner services can be of assistance once the preliminary positive result is confirmed.

“I wonder if you’ve thought about telling anyone about your result, since your first result.”

“How might you bring up your confirmed HIV positive result with your sexual or needle-sharing partners?”

“If you’re not sure how or if you want to tell your partner(s), we have some more support we can offer. (Describe partner services, if the client is ready.)

“Since you were last here, is there anyone you need help letting know that they may need to get an HIV test themselves?”

Explore disclosure issues: who to tell, whether to tell, when, how, etc. Assess the client’s personal situation and assist in determining their timing of disclosure.

“What do you think about talking to them about your result?”

“What impact will your test result have on your relationships?”

Encourage client to think about who should be informed and how. Inform them that their local health jurisdiction’s partner services program can assist them in notifying their partners. Reassure them that this notification service is free and voluntary, is always confidential, and client names are never disclosed.

“Who do you believe may need to know that they may have been exposed? Perhaps there are particular partners you’re worried about.”

“Who do you feel you need to tell because they need to be tested themselves?”

Develop a plan to maximize support and minimize negative consequences of disclosure.

“Have you discussed with your partner(s) what it would mean if you were infected with HIV? How do you think they would react?”

“It’s essential that you understand that your test result does not necessarily indicate what your partner(s) result will be. Your partner may not be living with HIV.

9. Review strategies for coping.

It’s important to help clients think about how they will receive support now that they know they have HIV.

“Learning that you have HIV and living with HIV is a challenge. It may be really important that you take care of yourself both physically and emotionally in a different way. What kinds of support

do you currently have in your life?”

“How have you handled stressful situations in the past?”

“What would be the hardest thing about seeking support for HIV?”

“What kind of social support network do you have right now? Is there someone you feel you can talk to who would treat your discussion confidentially and supportively?”

10. Discuss medical follow-up and linkage to care.

Now that the preliminary positive result has been confirmed, some clients may be ready to seek medical care. Explain the importance of medical follow-up, even for people who feel quite healthy or who feel overwhelmed by learning they have HIV. Describe benefits of seeing a knowledgeable health care provider for HIV medical advice.

Describe standard interventions for people with HIV, including immune system monitoring; screening for other STDs, tuberculosis (TB), and hepatitis C; preventive (prophylactic) treatments; prenatal care for pregnant women; and so on.

Keep descriptions brief and offer written materials for later reference by client.

“This test result means that you have HIV. You may want to talk with a doctor. When someone has HIV, it’s important to receive medical follow-up, in order to understand options and the next steps to take. Could we walk through some of the ways I can help connect you to medical care?”

If the client has already seen a medical provider since receiving a preliminary positive result, check in with the client:

“It sounds like you’ve already seen a doctor. Could we talk a little bit about how that went, and what else do you feel like you might need?”

If the client does not have a medical provider, offer to connect the client to medical care.

Whether or not the client has a medical provider already, try to make an appointment on the spot.

If the client is not interested in medical care, ask if your test site might 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.

“It sounds like now is not the time to think about this. Would it be OK if we check in with you later? We’d just contact you to see if you might be interested in medical care or other support services. If that sounds helpful to you, when and how would you like us to get in touch with you?”

For clients testing anonymously, explain that you can still help them connect to care. They will eventually have to switch to confidential services in order to receive medical services—either at their private doctor’s office or at any other referral to medical care. Clients testing anonymously may, for this reason, wish to transition from anonymous to confidential testing, in order to ensure a timely linkage to medical care and support services.

11. Facilitate client empowerment.

Empower client to follow through on immediate and long-term planning.

“We’ve talked about a lot. Would it be helpful to prioritize the steps that you might take to get the care you need?”

“What is most important for you to deal with first?”

Offer realistically hopeful statements without discounting client’s concerns.

“I can tell that this is hard news to hear and that you’re upset about it.”

Encourage client’s active participation in addressing health needs and concerns.

“Who do you plan to see for medical care? When do you expect to make your first appointment?”

Build skills in decision-making.

“Let’s talk about some of the decisions you may want to make now that you know you have HIV.”

“Tell me what you know about U=U or treatment as prevention?”

“We now know that when a person living with HIV is undetectable that they have almost no risk of transmitting HIV through sex. What does that mean for you?”

12. Provide referrals and closure.

Because clients returning for their confirmatory result have had some time to reflect on their preliminary positive result, they may be more open to referrals. Provide specific, appropriate, written referrals with adequate linkage. This may include referrals to post-disclosure counseling, outreach workers or other prevention staff, care case management, hotlines, or other services available in the county in which the client resides. Be sure to include a medical referral and assist with partner notification where appropriate. Select referrals based on your assessments, keeping in mind the client’s identified needs and consideration of cultural similarities or differences between client and referral.

“How interested would you be in getting a referral for services to help you live with HIV?”

Keep number of referrals limited—one or two is enough. Don’t overwhelm client. Instead, enlist client feedback regarding prioritizing referrals.

Explore with client where they are going immediately after the session. Assist client to become more grounded before they leave the test site by asking them where they are going next, how they are getting there, and who will be there to support them.

“It can be difficult dealing with living with HIV. How are you doing?”

“I can see this is difficult and that you’re upset about it. I want you to know that there are many treatment options available for people living with HIV.”

“Let’s think through a few of the next steps together, if you’re willing. What will you do after this counseling session? Where will you go? How will you get there? Who will be there?”

DAY FIVE

AGENDA DAY FIVE

MORNING

Welcome and Overview of Day Five

Risk Assessment Practice

Trainer Evaluations

BREAK

Orientation to Final Fishbowl

Final Quiz

LUNCH

AFTERNOON Final Fishbowl

BREAK

Final Fishbowl Continued

Closure of Training

COUNSELING EVALUATION OUTCOMES

Pass

- You have demonstrated sufficient beginning counseling skills to start conducting counseling sessions with clients.
- You are allowed to conduct counseling sessions with clients.
- Please request and read your evaluation form and note any remaining areas of growth.
- We strongly recommend that you shadow experienced, certified HIV/HCV Test Counselors for at least two sessions at your site, and be shadowed by an experienced counselor for your first two sessions with a client.

CRE (Counseling Re-examination Eligible)

- You have demonstrated some beginning counseling skills. However, you have not met the minimum standards to conduct counseling sessions with clients.
- You are not allowed to conduct counseling sessions with clients.
- Please request and read your evaluation form and note areas of growth.
- Request to shadow experienced, certified HIV/HCV Test Counselors at your site and practice the skills noted on your evaluation form with experienced counselors.
- Ask your supervisor to register you for an upcoming Counseling Re-Examination Training (CRE) or the counseling portion of an upcoming Basic Counseling Skills Training (BCST). Whichever option you choose, please ask your supervisor to sign you up for the relevant upcoming training.

Not Pass

- You have not demonstrated sufficient counseling skills to conduct counseling sessions with clients.
- You are not allowed to conduct counseling sessions with clients.
- Please request and read your evaluation form and note areas of growth.
- Request to shadow experienced counselors at your site and practice the skills noted on your evaluation form with experienced counselors.
- If you want to pursue certification, ask your supervisor to register you for the counseling portion of an upcoming Basic Counseling Skills Training (BCST). Many people who take the BCST a second time are successful.

APPENDICES

EXAMPLE OF INFORMED CONSENT PAPERWORK



CONFIDENTIAL CONSENT FOR SERVICES

Please Initial
Each Statement

_____ I understand that the tests that I will receive are confidential and that the names of all individuals who test positive for any of these tests will be forwarded to the San Francisco Department of Public Health and the California Department of Public Health. Names are protected under Federal and California laws pertaining to confidential medical information.

_____ I understand that blood may be collected to test for HIV, Hepatitis C, or Syphilis. I understand that an oral and/or self-collected rectal swab may be collected to test for Gonorrhea and Chlamydia.

_____ I understand the HIV and Hepatitis rapid tests will take up to 20 minutes.

_____ I understand that recent infections may not be detected by these rapid tests and I understand the window period of these tests.

_____ I understand that the accuracy of these rapid tests is over 98%.

_____ I understand that if any of my rapid tests is reactive, my blood will be sent to an off-site laboratory for additional tests.

_____ I understand that if I test positive for any of these tests, I may be contacted by a Partner Services/Linkage Specialist who will help me get into medical care and help me inform my partners.

_____ After I leave today, I understand that I will only be contacted if any of my additional results are not negative. It can take up to 10 working days to process these test results.

Today, __/__/__, I consent to the following tests: ☐ HIV Rapid - Yes ☐ Hepatitis C ☐ Oral – GC/CT
☐ HIV Rapid - No ☐ Syphilis ☐ Rectal – GC/CT
☐ Hep A Vaccine ☐ Hep B Vaccine

By signing below, I acknowledge that I have been given information regarding testing services and have had a chance to ask questions which were answered to my satisfaction.

Name: _____ Date of Birth: __/__/__

Address: _____ City: _____ Zip Code: _____

Phone: (____) ____-____ OK to Leave a Message: ☐ Yes ☐ No

Email: _____

Signature: _____

Security Question (CIRCLE ONE AND ANSWER):

What is the name of your childhood best friend OR favorite pet OR elementary school? _____

EXPANDED VERSION: DETAILED STEPS FOR ORAQUICK ADVANCE RAPID HIV-1/2 ANTIBODY TEST PROCEDURE USING ORAL FLUID

1. Gather and arrange materials.

- a. Instructions (this checklist)
- b. Absorbent workspace cover
- c. Biohazard bag (within easy reach)
- d. Biohazard spill kit (available)
- e. Gloves
- f. Good lighting
- g. Test kit pouch
- h. Test kit stand
- i. Clock and thermometer
- j. Pen
- k. Client ID stickers
- l. Quality Assurance (QA) Log
- m. Client Encounter Form

2. Examine test kit pouch. It must be

- a. Unopened to protect the absorbency of the test kit pad.
- b. Be at room temperature, between 59 and 99 degrees Fahrenheit. (If test kits are stored refrigerated, allow test kit to come to room temperature before using. If the storage temperature was outside the 35 to 80 degrees Fahrenheit range, external controls must be run prior to resuming testing.)
- c. Gently shake the side of the pouch with the test kit device in it to ensure that it contains an absorbent packet (desiccant). If not, dispose of the entire pouch and use a new test kit

pouch.

3. Record Test Provider ID and Date on the QA Log (if first entry).

If this is the first entry on a new QA log, record your test provider ID and date on the top of the QA log.

4. Record Test Name on the QA Log.

Check the OraQuick HIV box in the column labeled “Test Name” on the QA log.

5. Record Lot Number on the QA Log.

The lot number is stamped on the outside of the test kit pouch. Omit leading zeros and record this number on the QA log in the column labeled “Lot Number”.

6. Record Expiration Date on the QA Log.

The expiration date is stamped on the outside of the test kit pouch. While the expiration date is printed as YYYY-MM-DD, you will record this number as MM-DD-YYYY on the QA log in the column labeled “Expiration Date”.
NOTE: Do not use test kit if today’s date is past the expiration date.

7. Open test kit pouch and remove vial of reagent.

- a. Feel the pouch to determine which side contains the round vial of reagent.
- b. Open only that side of the pouch. Remove the vial of reagent and set the rest of the pouch aside.

8. Affix client ID sticker to vial of reagent.

- a. Affix client number sticker to the back of the vial of reagent vertically in the area left empty by the manufacturer's sticker, ensuring that the number will be visible when the vial is inserted into the test kit stand.
- b. Leave enough space uncovered at the bottom of the vial to be able to see the fluid.

9. Affix client ID stickers to the Client**Encounter Form and QA Log.**

From the same sheet of client number stickers, affix a sticker to the Client Encounter Form over the space labeled "OA unique ID" and the QA log in the column labeled "Client ID". Affix additional stickers to any other paperwork that is associated with this client. (e.g., informed consent forms, research paperwork, etc.)

10. Open vial of reagent and place in test kit stand.

- a. Open the vial of reagent by gently rocking the lid back and forth. The lid does not unscrew.
- b. Insert the vial into the test kit stand by sliding the vial in from the top. Do not "snap" the vial in from the front.
- c. Ensure that the vial is fully seated in the test kit stand with the client number sticker clearly facing you.

11. Put on gloves.

Universal precautions require that all health care providers use gloves and other protective

gear as appropriate when dealing with potentially infectious fluids, blood samples, control vials, proficiency specimens, used test kits, and other materials that may have come into contact with potentially infectious fluids.

12. Collect Specimen.

- a. Open the other side of the test kit pouch and remove the test kit device without touching the absorbent pad.
- b. Collect, or direct the client to collect, the oral fluid sample on the flat pad by placing the flat pad above the teeth against the outer gum. Gently swab completely around both the upper and lower outer gums using the flat pad, avoiding the roof of the mouth, the teeth, the inside of the cheek, or the tongue. Both sides of the flat pad may be used during the collection process.

13. Insert test kit device into vial of reagent.

- a. Carefully insert the test kit device into the vial of reagent.
- b. Ensure that the absorbent pad is touching the bottom of the vial and that the test kit window is facing you.

14. Remove gloves and put them in the biohazard bag.

Remove the gloves by grasping the cuff and pulling them off so that the glove turns inside out, in order to safely contain any biohazardous agents and dispose into a biohazard container.

15. Record Begin Test Time on the QA Log.

Record the current time in the column labeled “Begin Test Time/ Begin Test Temp.”, marking the AM or PM box as appropriate.

16. Record Begin Test Temperature on the QA Log.

Record the current temperature in Fahrenheit in the column labeled “Begin Test Time/ Begin Test Temp.”.

Test must develop for at least 20 minutes and not more than 40 minutes.

17. Record Result on the QA Log.

Carefully examine the test kit result window and mark the result on the QA log in the column labeled “HIV Result”.

- i. If there is a line in the control and a line in the test area, the result is “Preliminary Positive (Ab only)”.
- ii. If there is a line in the control and no line in the test area, the result is “Negative”.
- iii. Any other result would be considered

“Invalid” and a new test procedure would need to be conducted.

18. Record End Test Time on the QA Log.

Record the current time in the column labeled “End Test Time/ End Test Temp.”, marking the AM or PM box as appropriate.

19. Record End Test Temperature on the QA Log.

Record the current temperature in Fahrenheit in the column labeled “End Test Time/ End Test Temp.”.

20. Put on gloves again and dispose of test kit device into a biohazard bag. Then dispose of gloves into a biohazard bag.

- a. Put on a new pair of gloves and dispose of the test kit device and workstation into a biohazard container.
- b. Remove the gloves by grasping the cuff and pulling them off so that the glove turns inside out, in order to safely contain any biohazardous agents and dispose into a biohazard container.

CHECKLIST VERSION: STEPS FOR ORAQUICK ADVANCE RAPID HIV-1/2 ANTIBODY TEST PROCEDURE USING ORAL FLUID

1. Gather and arrange materials.

- a. Instructions (this checklist)
- b. Absorbent workspace cover
- c. Biohazard bag (within easy reach)
- d. Biohazard spill kit (available)
- e. Gloves
- f. Good lighting
- g. Test kit pouch
- h. Test kit stand
- i. Clock and thermometer
- j. Pen
- k. Client ID stickers
- l. Quality Assurance (QA) Log
- m. Client Encounter Form

2. Examine test kit pouch. It must be unopened, be between 59°F and 99°F, and contain an absorbent packet (desiccant).

3. Record Test Provider ID and Date on the QA Log (if first entry).

4. Record Test Name on the QA Log.

5. Record Lot Number on the QA Log.

6. Record Expiration Date on the QA Log.

7. Open test kit pouch and remove vial of reagent.

8. Affix client ID sticker to vial of reagent.

9. Affix client ID stickers to the Client Encounter Form and QA Log.

10. Open vial of reagent and place in test kit stand.

11. Put on gloves.

12. Collect Specimen.

13. Insert test kit device into vial of reagent.

14. Remove gloves and put them in the biohazard bag.

15. Record Begin Test Time on the QA Log.

16. Record Begin Test Temperature on the QA Log.

Test must develop for at least 20 minutes and not more than 40 minutes.

17. Record Result on the QA Log.

18. Record End Test Time on the QA Log.

19. Record End Test Temperature on the QA Log.

20. Put on gloves again and dispose of test kit device into a biohazard bag. Then dispose of gloves into a biohazard bag.

EXPANDED VERSION: DETAILED STEPS FOR ORAQUICK ADVANCE RAPID HIV-1/2 ANTIBODY TEST AND ORAQUICK HCV RAPID ANTIBODY TEST PROCEDURE USING BLOOD

1. Gather and arrange materials.

- a. Instructions (this checklist)
- b. Absorbent workspace cover
- c. Biohazard sharps container and biohazard bag (within easy reach)
- d. Biohazard spill kit (available)
- e. Gloves
- f. Good lighting
- g. Alcohol wipe
- h. Lancet
- i. Cotton balls
- j. Bandage
- k. Test kit pouch
- l. Test kit stand
- m. Specimen collection loop
- n. Clock and thermometer
- o. Pen
- p. Client ID stickers
- q. Quality Assurance (QA) Log
- r. Client Encounter Form

2. Examine test kit pouch. It must be

- a. Unopened to protect the absorbency of the test kit pad.
- b. Be at room temperature, between 59 and 99 degrees Fahrenheit. (If test kits are stored refrigerated, allow test kit to come to room temperature before using. If the storage

temperature was outside the 35 to 80 degrees Fahrenheit range for HIV test kits or 36 to 86 Fahrenheit range for HCV test kits, external controls must be run prior to resuming testing.)

- c. Gently shake the side of the pouch with the test kit device in it to ensure that it contains an absorbent packet (desiccant). If not, dispose of the entire pouch and use a new test kit pouch.

3. Record Test Provider ID and Date on the QA Log (if first entry).

If this is the first entry on a new QA log, record your test provider ID and date on the top of the QA log.

4. Record Test Name on the QA Log.

Check the OraQuick HIV or OraQuick HCV box in the column labeled “Test Name” on the QA log as appropriate.

5. Record Lot Number on the QA Log.

The lot number is stamped on the outside of the test kit pouch. Omit leading zeros and record this number on the QA log in the column labeled “Lot Number”.

6. Record Expiration Date on the QA Log.

The expiration date is stamped on the outside of the test kit pouch. While the expiration date is printed as YYYY-MM-DD, you will record

this number as MM-DD-YYYY on the QA log in the column labeled “Expiration Date”.

NOTE: Do not use test kit if today’s date is past the expiration date.

7. Open test kit pouch and remove vial of reagent.

- a. Feel the pouch to determine which side contains the round vial of reagent.
- b. Open only that side of the pouch. Remove the vial of reagent and set the rest of the pouch aside.

8. Affix client ID sticker to vial of reagent.

- a. Affix client number sticker to the back of the vial of reagent vertically in the area left empty by the manufacturer’s sticker, ensuring that the number will be visible when the vial is inserted into the test kit stand.
- b. Leave enough space uncovered at the bottom of the vial to be able to see the fluid.

9. Affix client ID stickers to the Client

Encounter Form and QA Log.

From the same sheet of client number stickers, affix a sticker to the Client Encounter Form over the space labeled “OA unique ID” and the QA log in the column labeled “Client ID”. Affix additional stickers to any other paperwork that is associated with this client. (e.g., informed consent forms, research paperwork, etc.)

10. Open vial of reagent and place in test kit stand.

- a. Open the vial of reagent by gently rocking

the lid back and forth. The lid does not unscrew.

- b. Insert the vial into the test kit stand by sliding the vial in from the top. Do not “snap” the vial in from the front.

- c. Ensure that the vial is fully seated in the test kit stand with the client number sticker clearly facing you.

11. Put on gloves.

Universal precautions require that all health care providers use gloves and other protective gear as appropriate when dealing with potentially infectious fluids, blood samples, control vials, proficiency specimens, used test kits, and other materials that may have come into contact with potentially infectious fluids.

12. Perform a finger stick.

- a. Select the site
 - i. Use the lateral aspect of the fingertip.
 - ii. Do not use the center pad of the fingertip.
 - iii. Middle and ring finger of the non-dominant hand are preferred. In other words, if the client is right-handed, use their left hand, if the client is left-handed, use their right hand.
 - iv. If the direction of the blade is known, the puncture should be made across the ridges of the fingerprint to assist with blood droplet formation.
- b. Cleanse the puncture site with an alcohol wipe and allow to dry. Do not blow on the site

- to accelerate drying.
- c. Activate lancet at proper site.
- d. Immediately dispose of lancet into a sharps container.

13. Collect specimen.

- a. Wipe away first drop of blood.
- b. Touch loop to second drop of blood until filled.
- c. Examine loop to make sure it is completely filled with no bubbles.

14. Press clean cotton ball against the puncture site.**15. Stir loop into vial of reagent, then dispose of loop into the biohazard bag.****16. Examine vial to make sure fluid is pink.**

Carefully examine the vial to ensure that the fluid in the vial appears pink. If not, discard all test kit materials and start over. (If the fluid is not pink, it means that the sample did not enter the reagent.)

17. Insert test kit device into vial of reagent.

- a. Open the other side of the test kit pouch and remove the test kit device without touching the absorbent pad.
- b. Carefully insert the test kit device into the vial of reagent.
- c. Ensure that the absorbent pad is touching the bottom of the vial and that the test kit window is facing you.

18. Place bandage on puncture site.

- a. Remove the cotton ball from the puncture site.

- b. Ensure that no cotton is left on the finger.
- c. Bandage the finger at the puncture site.

19. Dispose of any remaining biohazardous material.

Discard any other materials that could have come into contact with any potentially infectious agents (such as alcohol wipes or cotton balls) into the appropriate biohazard containers.

20. Remove gloves and put them in the biohazard bag.

Remove the gloves by grasping the cuff and pulling them off so that the glove turns inside out, in order to safely contain any biohazardous agents and dispose into a biohazard container.

21. Record Begin Test Time on the QA Log.

Record the current time in the column labeled “Begin Test Time/ Begin Test Temp.”, marking the AM or PM box as appropriate.

22. Record Begin Test Temperature on the QA Log.

Record the current temperature in Fahrenheit in the column labeled “Begin Test Time/ Begin Test Temp.”.

Test must develop for at least 20 minutes and not more than 40 minutes.

23. Record Result on the QA Log.

- a. **For HIV** - Carefully examine the test kit result window and mark the result on the QA log in the column labeled “HIV Result”.
 - i. If there is a line in the control and a line in the test area, the result is

“Preliminary Positive (Ab only)”.

ii. If there is a line in the control and no line in the test area, the result is

“Negative”.

iii. Any other result would be considered “Invalid” and a new test procedure would need to be conducted.

b. **For HCV** - Carefully examine the test kit result window and mark the result on the QA log in the column labeled “HCV Result”.

i. If there is a line in the control and a line in the test area, the result is

“Reactive”.

ii. If there is a line in the control and no line in the test area, the result is “Non-Reactive”.

iii. Any other result would be considered “Invalid” and a new test procedure would need to be conducted.

24. Record End Test Time on the QA Log.

Record the current time in the column labeled “End Test Time/ End Test Temp.”, marking the AM or PM box as appropriate.

25. Record End Test Temperature on the QA Log.

Record the current temperature in Fahrenheit in the column labeled “End Test Time/ End Test Temp.”.

26. Put on gloves again and dispose of test kit device into a biohazard bag. Then dispose of gloves into a biohazard bag.

a. Put on a new pair of gloves and dispose of the test kit device and workstation into a biohazard container.

b. Remove the gloves by grasping the cuff and pulling them off so that the glove turns inside out, in order to safely contain any biohazardous agents and dispose into a biohazard container.

CHECKLIST VERSION: DETAILED STEPS FOR ORAQUICK ADVANCE RAPID HIV-1/2 ANTIBODY TEST AND ORAQUICK HCV RAPID ANTIBODY TEST PROCEDURE USING BLOOD

1. Gather and arrange materials.
 - a. Instructions (this checklist)
 - b. Absorbent workspace cover
 - c. Biohazard sharps container and biohazard bag (within easy reach)
 - d. Biohazard spill kit (available)
 - e. Gloves
 - f. Good lighting
 - g. Alcohol wipe
 - h. Lancet
 - i. Cotton balls
 - j. Bandage
 - k. Test kit pouch
 - l. Test kit stand
 - m. Specimen collection loop
 - n. Clock and thermometer
 - o. Pen
 - p. Client ID stickers
 - q. Quality Assurance (QA) Log
 - r. Client Encounter Form
2. Examine test kit pouch. It must be unopened, be between 59°F and 99°F, and contain an absorbent packet (desiccant).
3. Record Test Provider ID and Date on the QA Log (if first entry).
4. Record Test Name on the QA Log.
5. Record Lot Number on the QA Log.
6. Record Expiration Date on the QA Log.
7. Open test kit pouch and remove vial of reagent.
8. Affix client ID sticker to vial of reagent.
9. Affix client ID stickers to the Client Encounter Form and QA Log.
10. Open vial of reagent and place in test kit stand.
11. Put on gloves.
12. Perform a finger stick.
13. Collect specimen.
14. Press clean cotton ball against the puncture site.
15. Stir loop into vial of reagent, then dispose of loop into the biohazard bag.
16. Examine vial to make sure fluid is pink.
17. Insert test kit device into vial of reagent.
18. Place bandage on puncture site.
19. Dispose of any remaining biohazardous material.
20. Remove gloves and put them in the biohazard bag.
21. Record Begin Test Time on the QA Log.
22. Record Begin Test Temperature on the QA Log.
Test must develop for at least 20 minutes and not more than 40 minutes.
23. Record Result on the QA Log.
24. Record End Test Time on the QA Log.
25. Record End Test Temperature on the QA Log.
26. Put on gloves again and dispose of test kit device into a biohazard bag. Then dispose of gloves into a biohazard bag.

EXPANDED VERSION: DETAILED STEPS FOR INSTI RAPID HIV 1/2 ANTIBODY TEST PROCEDURE USING BLOOD

1. Gather and arrange materials.

- a. Instructions (this checklist)
- b. Absorbent workspace cover
- c. Biohazard sharps container and biohazard bag (within easy reach)
- d. Biohazard spill kit (available)
- e. Gloves
- f. Good lighting
- g. Cotton balls
- h. Bandage
- i. Test kit pouch
- j. Clock and thermometer
- k. Pen
- l. Client ID stickers
- m. Quality Assurance (QA) Log
- n. Client Encounter Form
- o. Lancet (optional)

2. Examine test kit pouch. It must be:

- a. Unopened
- b. Be at room temperature, between 59 and 86 degrees Fahrenheit. (If the storage temperature was outside the 59 to 86 degrees Fahrenheit range, external controls must be run prior to resuming testing.)

3. Record test provider ID and date on the QA log (if first entry).

If this is the first entry on a new QA log, record your test provider ID and date on the top of the QA log.

4. Record test name on the QA log.

Check the INSTI HIV in the column labeled “Test Name” on the QA log.

5. Record lot number on the QA log.

The lot number is stamped on the outside of the test kit pouch on the back side. Record this number in the column labeled “Lot Number” on the QA log

6. Record expiration date on the QA log.

The expiration date is stamped on the outside of the test kit pouch on the back side. While the expiration date is printed as YYYYMMDD, you will record this number as MM-DD-YYYY in the column labeled “Expiration Date” on the QA log. (NOTE: Do not use test kit if today’s date is past the expiration date.)

7. Open test kit pouch and remove all of the contents.

Open test kit pouch and remove all contents from pouch including membrane unit pouch, 3 bottles, lancet, capillary pipette, and alcohol wipe.

8. Line up the three reagent solutions in order with the numbers facing you.

9. Tear open the membrane unit pouch and carefully remove the membrane unit.

Use the pre-cut edge to carefully open the membrane unit pouch. Remove the membrane unit without touching the center well.

10. Place the membrane unit on the absorbent workspace cover, being careful not to touch the well and making sure the tab of the unit is pointing towards you.

11. Affix client ID sticker to the tab of the membrane unit.

12. Affix client ID stickers to the Client Encounter**Form and QA Log.**

From the same sheet of client number stickers, affix a sticker to the Client Encounter Form over the space labeled “OA unique ID” and in the column labeled “Client ID” on the QA log. Affix additional stickers to any other paperwork that is associated with this client. (e.g., informed consent forms, research paperwork, etc.)

13. Open bottle #1.

Open bottle #1, the sample diluent, and retain the cap. Do not open the other bottles at this time.

14. Put on gloves.

Universal precautions require that all health care providers use gloves and other protective gear as appropriate when dealing with potentially infectious fluids, blood samples, control vials, proficiency specimens, used test kits, and other materials that may have come into contact with potentially infectious fluids.

15. Perform a fingerstick.

- a. Select the site
 - i. Use the lateral aspect of the fingertip.
 - ii. Do not use the center pad of the fingertip.
 - iii. Middle and ring finger of the non-dominant hand are preferred. In other words, if the client is right-handed, use their left hand, if the client is left-handed, use their right hand.
 - iv. If the direction of the blade is known, the puncture should be made across the ridges of the fingerprint to assist with blood droplet formation.
- b. Cleanse the puncture site with an alcohol wipe and allow to dry. Do not blow on the site to

accelerate drying.

- c. Activate lancet at proper site.
- d. Immediately dispose of lancet into a sharps container.

16. Collect specimen.

Wipe away the first drop of blood with a cotton ball. Holding the capillary pipette horizontally, touch the tip of the capillary pipette to the blood sample. Maintain the horizontal position until the flow of the sample has reached the fill line and stopped.

17. Press clean cotton ball against the puncture site.**18. Add the contents of the capillary pipette to bottle #1 and dispose of capillary pipette to biohazard.****19. Recap bottle #1 and mix by gentle inversion.**

Recap bottle #1 and gently invert bottle 3-5 times.

20. Open bottle #1 and pour the contents into the center of the membrane unit well.**21. Dispose of bottle #1 to biohazard and wait until all the liquid from bottle #1 has been absorbed.****22. Mix bottle #2 by gentle inversion.**

Gently invert bottle #2, the color developer.

23. Open bottle #2 and pour the contents into the center of the membrane unit well.**24. Place bandage on puncture site.**

- a. Remove the cotton ball from the puncture site.
- b. Ensure that no cotton is left on the finger.
- c. Bandage the finger at the puncture site.

25. Dispose of bottle #2 to biohazard and wait until all the liquid from bottle #2 has been absorbed.**26. Open bottle #3 and pour the contents into the center of the membrane unit well.**

Open bottle #3, the clarifying solution, and pour the contents into the center of the membrane unit well.

27. Take a mental note of the start time and start temperature.

After pouring all the contents of bottle #3 into the center of the membrane unit well, take a look at the start time and the start temperature. Ensure that the temperature is with the 59 to 86 degrees Fahrenheit. Make a mental note of the start time to ensure that the test is result is read no later than 5 minutes from the start time.

28. Once all the liquid from bottle #3 has been absorbed, immediately read the result.

29. Dispose the test membrane unit and any remaining biohazardous material.

Discard any other materials that could have come into contact with any potentially infectious agents (such as alcohol wipes or cotton balls) into the appropriate biohazard containers.

30. Remove gloves and put them in the biohazard bag.

Remove the gloves by grasping the cuff and pulling them off so that the glove turns inside out, in order to safely contain any biohazardous agents and dispose into a biohazard container.

31. Record Result on the QA Log.

Mark the result in the column labeled “HIV Result” on the QA log.

- If there is a single dot in the upper control area the result is “Negative.”
- If there is a dot in the upper control area and a dot in the lower test area the result is “Preliminary Positive (Ab only).”
- Any other result would be considered “Invalid” and a new test procedure would need to be conducted.

32. Record End Test Time on the QA Log.

Record the current time in the column labeled “End Test Time/ End Test Temp.” on the QA log, marking the AM or PM box as appropriate.

33. Record End Test Temperature on the QA Log.

Record the current temperature in Fahrenheit in the column labeled “End Test Time/ End Test Temp.” on the QA log.

CHECKLIST VERSION: DETAILED STEPS FOR INSTI RAPID HIV 1/2 TEST PROCEDURE USING BLOOD

1. **Gather and arrange materials.**
 - a. Instructions (this checklist)
 - b. Absorbent workspace cover
 - c. Biohazard sharps container and biohazard bag (within easy reach)
 - d. Biohazard spill kit (available)
 - e. Gloves
 - f. Good lighting
 - g. Cotton balls
 - h. Bandage
 - i. Test kit pouch
 - j. Clock and thermometer
 - k. Pen
 - l. Client ID stickers
 - m. Quality Assurance (QA) Log
 - n. Client Encounter Form
 - o. Lancet (optional)
2. **Examine test kit pouch to ensure it is unopened and between 59 and 86 degrees Fahrenheit.**
3. **Record test provider ID and date on the QA log (if first entry).**
4. **Record test name on the QA log.**
5. **Record lot number on the QA log.**
6. **Record expiration date on the QA log.**
7. **Open test kit pouch and remove all of the contents.**
8. **Line up the three reagent solutions in order with the numbers facing you.**
9. **Tear open the membrane unit pouch and carefully remove the membrane unit.**
10. **Place the membrane unit on the absorbent workspace cover, being careful not to touch the well and making sure the tab of the unit is pointing towards you.**
11. **Affix client ID sticker to the tab of the membrane unit.**
12. **Affix client ID stickers to the Client Encounter Form and QA Log.**
13. **Open bottle #1.**
14. **Put on gloves.**
15. **Perform a fingerstick.**
16. **Collect specimen.**
17. **Press clean cotton ball against the puncture site.**
18. **Add the contents of the capillary pipette to bottle #1 and dispose of capillary pipette to biohazard.**
19. **Recap bottle #1 and mix by gentle inversion.**
20. **Open bottle #1 and pour the contents into the center of the membrane unit well.**
21. **Dispose of bottle #1 to biohazard and wait until all the liquid from bottle #1 has been absorbed.**
22. **Mix bottle #2 by gentle inversion.**
23. **Open bottle #2 and pour the contents into the center of the membrane unit well.**
24. **Place bandage on puncture site.**
25. **Dispose of bottle #2 to biohazard and wait until all the liquid from bottle #2 has been absorbed.**
26. **Open bottle #3 and pour the contents into the center of the membrane unit well.**
27. **Take a mental note of the start time and start temperature.**
28. **Once all the liquid from bottle #3 has been absorbed, immediately read the result.**
29. **Dispose the test membrane unit and any remaining biohazardous material.**
30. **Remove gloves and put them in the biohazard bag.**
31. **Record Result on the QA Log.**
32. **Record End Test Time on the QA Log.**
33. **Record End Test Temperature on the QA Log.**

OVERVIEW OF HIV TEST DETECTION CAPABILITIES

HIV antibody tests, generally referred to as ELISA (enzyme-linked immunosorbent assay) or, alternatively, EIA (enzyme immunoassay), are tests that detect HIV antibodies, which the body starts producing between two weeks and three months after becoming infected with HIV. Current HIV antibody tests can detect antibodies that are present as early as two weeks after exposure, which is faster than the antibody tests that were common early in the epidemic. Current HIV antibody tests are often grouped according to their detection abilities; capable of detecting IgG antibodies, capable of detecting both IgM and IgG antibodies, or capable of detecting both HIV IgM and IgG antibodies and the p24 antigen, which comes directly from the HIV virus. The OraQuick ADVANCE test is capable of detecting IgG antibodies and demonstrates some IgM detection ability.

Regardless of what detection capabilities a test has, all preliminary positive HIV antibody test results must be confirmed with a Western blot, a rapid test of a different brand from the initial test, or an HIV viral load test. In addition, a confirmatory test would need to have the same detection capabilities as the initial screening test.

The capability of detecting both HIV IgM and IgG antibodies and the p24 antigen (i.e. Alere Determine) can possibly result in the ability to detect HIV during the highly infectious acute infection stage. This can help with channeling clients into care at an earlier stage of infection, improving health and prevention outcomes, and facilitating more targeted partner services.

FDA-APPROVED HIV ASSAYS USED FOR SCREENING

Advantages and Disadvantages of FDA-Approved HIV Assays Used for Screening, by test category											
Test Category *	HIV Screening Tests	Run Time	Instrument	Report Ag and Ab separately	Detects IgG	Detects IgM	Uses whole blood (WB) specimens	Uses oral fluid (OF) specimens	Uses dried blood spot specimens	Least complex ³ CLIA category	External quality control not required in each run
Nucleic acid laboratory test	Aptima HIV-1 RNA Qualitative Assay ²	>3 hours	semi-automated							high	
Ag/Ab laboratory test	ADVIA Centaur HIV Ag/Ab Combo (CHIV) Assay	<1 hour	automated		✓	✓				moderate	✓
	ARCHITECT HIV Ag/Ab Combo Assay	<30 mins	automated		✓	✓				moderate	✓
	BioPlex 2200 HIV Ag-Ab	45 mins	automated	✓	✓	✓				moderate	✓
	Elecsys HIV combi PT	27 mins	automated		✓	✓				moderate	✓
	GS HIV Combo Ag/Ab EIA	>3 hours	semi-automated		✓	✓				high	
	VITROS HIV Combo Test	48 mins	automated		✓	✓				moderate	✓
Ag/Ab rapid test	Determine HIV-1/2 Ag/Ab Combo	20 mins	single-use	✓	✓	✓	✓			waived	✓
Ab laboratory test	ADVIA Centaur HIV 1/O/2 Enhanced (EHIV) Assay	< 1 hour	automated		✓	✓				moderate	
	Avioq HIV-1 Microelisa System	>3 hours	semi-automated		✓	✓		✓	✓	high	
	GS HIV-1/2 Plus O	>3 hours	semi-automated		✓	✓				high	
	VITROS Anti-HIV 1+2	< 1 hour	automated		✓	✓				high	✓
Ab rapid test	DPP HIV-1/2 Assay	10 mins WB/ 25 mins OF	single-use		✓		✓	✓		waived	✓
	HIV 1/2 STAT-PAK	15 mins	single-use		✓		✓			waived	✓
	INSTI HIV-1/HIV-2 Antibody Test	<2 mins	single-use		✓	✓	✓			waived	✓
	OraQuick ADVANCE Rapid HIV-1/2 Antibody Test	20 mins	single-use		✓	✓	✓	✓		waived	✓
	Reveal G4 Rapid HIV-1 Antibody Test	<2 mins	single-use		✓		✓			moderate	✓
	SURE CHECK HIV 1/2 Assay	15 mins	single-use		✓		✓			waived	✓
	Uni-Gold Recombigen HIV-1/2	10 mins	single-use		✓	✓	✓			waived	✓

Centers for Disease Control and Prevention. Advantages and disadvantages of FDA-approved HIV assays used for screening. *HIV/AIDS*. Atlanta: U.S. Department of Health and Human Services, 2018. https://www.cdc.gov/hiv/pdf/testing/hiv-tests-advantages-disadvantages_1.pdf. (downloaded 02/14/2019.)

OVERVIEW OF ACUTE INFECTION

Acute infection refers to the first couple of months of HIV infection during which the viral load (the concentration of HIV in the blood) is very high. During this period, HIV is replicating very quickly—and destroying a large number of CD4+ cells—because the body hasn’t yet started to produce antibodies to fight the virus and slow its replication.

A person with acute HIV infection will likely have a very high viral load that can make transmission of the virus to sexual and needle-sharing partners more likely. In fact, during acute infection, HIV viral load and the likelihood of transmitting the virus to others may be the highest they will ever be during an HIV-positive person’s life.

Because HIV is so infectious during acute infection, treatment during this period can have a significant impact. Treating HIV at this point will both improve the body’s ability to fight the effects of HIV and increase the capacity to protect sexual and needle-sharing partners.

In addition, since antigen detection suggests a more recent infection, a person who wishes to participate in partner services may be better able to target their disclosure of status to fewer people if they choose to notify past sexual or needle-sharing partners about their status.

OVERVIEW OF THE IMPORTANCE OF EARLY TREATMENT

Treatment of early HIV infection with antiretroviral therapy (ART) improves laboratory markers (various tests used to estimate prognosis in patients with HIV infection) of disease progression. Treatment of early HIV infection may also reduce the severity of acute disease, lower the viral set point, reduce the size of the viral reservoir, delay disease progression, enhance CD4 T lymphocyte (CD4) cell recovery, and decrease the rate of viral mutation by suppressing viral replication and preserving immune function. Early HIV infection is often associated with high viral loads and increased infectiousness. ART use by HIV-infected individuals reduces transmission to uninfected sexual and needle-sharing partners. Therefore, treatment during early HIV infection is expected to substantially reduce the risk of HIV transmission. In addition, although data are limited and the clinical relevance unclear, initiating ART during early HIV infection may preserve mucosal Th17 cell function and mitigate the profound loss of gastrointestinal lymphoid tissue that occurs during the first weeks of infection. Many of the potential benefits described above may be more likely to occur with treatment of acute infection, but they also may occur if treatment is initiated during recent HIV infection.

RISK ASSESSMENT AND DISCLOSURE GUIDE (ORAQUICK)

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
EXPLAIN . . .	the window period (if applicable)
SUMMARIZE . . .	throughout the session as needed
REVIEW . . .	previous test and past attempts at behavior change
NEGOTIATE . . .	realistic harm reduction step, and troubleshoot that step
IDENTIFY . . .	sources of support for the harm reduction step
CLOSE . . .	explain that it is time to retrieve the result

NEGATIVE DISCLOSURE GUIDE (ORAQUICK)

RETRIEVE . . .	the result, do any paperwork
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 GUIDE (ORAQUICK)

RETRIEVE . . .	the result, do any paperwork
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

RISK ASSESSMENT AND DISCLOSURE GUIDE (INSTI)

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
EXPLAIN . . .	the window period (if applicable)
SUMMARIZE . . .	throughout the session as needed
REVIEW . . .	previous test and past attempts at behavior change
NEGOTIATE . . .	realistic harm reduction step, and troubleshoot that step
IDENTIFY . . .	sources of support for the harm reduction step
CLOSE . . .	explain that it is time to conduct the test

NEGATIVE DISCLOSURE GUIDE (INSTI)

READ . . .	the result, do paperwork
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 GUIDE (INSTI)

READ . . .	the result, do paperwork
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

THE TRANSTHEORETICAL MODEL OF BEHAVIOR CHANGE

Stages of Change

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.

Staging 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	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	- Decided, Yes! - Ready to do experimentation - Emphasize options	- Solve it! - Encourage, empower, support - Coaching; teach skills - 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

ESTIMATED PER-ACT PROBABILITY OF ACQUIRING HIV FROM AN INFECTED SOURCE

Type of Exposure	Risk per 10,000 Exposures
Receptive Anal Intercourse	138
Needle-Sharing During Injection Drug Use	63
Percutaneous (Needle-Stick)	23
Insertive Anal Intercourse	11
Receptive Penile-Vaginal Intercourse	8
Insertive Penile-Vaginal Intercourse	4
Receptive Oral Intercourse	Low
Insertive Oral Intercourse	Low

* Factors that may increase the risk of HIV transmission include sexually transmitted diseases, acute and late-stage HIV infection, and high viral load. Factors that may decrease the risk include condom use, male circumcision, antiretroviral treatment, and pre-exposure prophylaxis. None of these factors are accounted for in the estimates presented in the table.

Patel P, Borkowf CB, Brooks JT. Et al. Estimating per-act HIV transmission risk: a systematic review. AIDS. 2014. doi: 10.1097/QAD.0000000000000298.

STD OVERVIEW

COMMON STDs FACT SHEET

	GENITAL HERPES			SYPHILIS	HEPATITIS B VIRUS (HBV)	HIV
WHAT IS IT?	A viral infection of the genital areas. It can also infect the area around the mouth.			An infection caused by bacteria that can spread throughout the body.	A viral infection affecting the liver-HBV can be acute (mild illness lasting for a short time) or chronic (a serious life-long illness).	The human immunodeficiency virus (HIV) is the virus that causes AIDS.
HOW MANY PEOPLE GET IT IN THE US?	An estimated 1 million new infections each year, with about 45 million people already infected.			About 46,000 new cases reported each year.	An estimated 40,000 new cases each year (most of which are acquired through sex). Up to 1.2 million people are already infected with chronic HBV.	About 56,000 new infections each year, with an estimated 1.1 million people already living with HIV.
SYMPTOMS	Most people have no symptoms. Herpes 1 typically causes cold sores and fever blisters on the mouth; Herpes 2 typically causes genital sores or blisters. But both viruses can cause sores in either area. A herpes outbreak can start as red bumps and then turn into painful blisters or sores. During the first outbreak, it can also lead to flu-like symptoms (like a fever, headaches, and swollen glands).			Symptoms vary based on the course (timing) of infection—beginning with a single, painless sore (called a chancre) on the genitals, anus, or mouth. Other symptoms may appear up to 6 months after the first sore has disappeared, including a rash. However, there may be no noticeable symptoms until syphilis has progressed to more serious problems (see below).	Many people don't have any symptoms, especially adults. People may experience tiredness, aches, nausea & vomiting, loss of appetite, darkening of urine, tenderness in the stomach, or yellowing of the skin and the whites of the eyes (called jaundice). Symptoms of acute HBV may appear 1 to 6 months after exposure. Symptoms of chronic HBV can take up to 30 years to appear, although liver damage can occur silently.	Many people who are infected with HIV do not have any symptoms and feel healthy. Symptoms don't usually develop until a person's immune system has been weakened. The symptoms people experience are usually related to infections and cancers they get due to a weakened immune system. On average it takes about 10 years from initial HIV infection to develop AIDS.
HOW IT'S SPREAD	Through vaginal, oral, or anal sex. It can also be passed through skin-to-skin sexual contact, kissing, and rarely, from mother to child during childbirth.			Through vaginal, oral, or anal sex. It can also be passed through kissing if there is a lesion (sore) on the mouth, and from mother to child during childbirth.	Through vaginal, oral, or anal sex. Also through childbirth if the baby does not get vaccinated against HBV; sharing contaminated needles or razors; or exposure to the blood, bodily fluids (like cum) or saliva of an infected person.	Through vaginal, oral, or anal sex. Also by sharing contaminated needles or drug works; and from mother-to-child during pregnancy or breast-feeding. The chance of getting it through kissing is very low.
TREATMENT	There is no cure for herpes—the virus stays in the body and may cause recurrent outbreaks. Medications can help treat symptoms, reduce the frequency of outbreaks, and reduce the likelihood of spreading it to sex partners.			Antibiotic treatment can cure syphilis if it's caught early, but medication can't undo damage already done. Both partners must be treated and avoid sexual contact until the sores are completely healed.	Most often, acute HBV is treated with rest, eating well, and lots of fluids. Chronic HBV is treated through close monitoring by a doctor and anti-retroviral medications.	There is no cure for HIV or AIDS. Anti-retroviral treatment can slow the progression of HIV disease & delay the onset of AIDS. Early diagnosis & treatment can improve a person's chances of living a longer, healthier life.
POSSIBLE CONSEQUENCES (IF LEFT UNTREATED)	Increased risk for infection of other STDs, including HIV. Some people with herpes may get recurrent sores. Passing herpes from mother to newborn is rare, but an infant with herpes can become very ill.			Increased risk for infection of other STDs, including HIV. Untreated, the symptoms will disappear, but the infection stays in the body and can cause damage to the brain, heart, and nervous system, and even death. Syphilis in women can seriously harm a developing fetus during pregnancy.	Increased risk for infection of other STDs, including HIV. Chronic, persistent inflammation of the liver and later cirrhosis or cancer of the liver. Babies born to infected women are likely to develop chronic HBV infection if they don't get needed immunizations at birth (including HBV vaccination).	Increased risk for other life-threatening infections and certain cancers. By weakening the body's ability to fight disease, HIV makes an infected person more vulnerable to infections that they wouldn't otherwise get. HIV can also cause infections that anyone can get, such as other STDs and pneumonia, to be much worse. Left untreated, HIV infection is a fatal disease.

COMMON STDs FACT SHEET

	CHLAMYDIA	TRICHOMONIASIS (TRICH)	GONORRHEA	GENITAL HUMAN PAPILOMAVIRUS (HPV)
WHAT IS IT?	A bacterial infection of the genital areas.	A parasitic infection of the genital areas.	A bacterial infection of the genital areas.	A viral infection with over 40 types that can infect the genital areas, including types that cause warts and cancer.
HOW MANY PEOPLE GET IT IN THE US?	About 1.2 million new cases reported each year. The highest rates are among adolescent women.	An estimated 5 million new cases each year.	About 650,000 new cases reported each year. The highest rates are among women aged 15 to 19 and men aged 20 to 24.	An estimated 6.2 million new cases each year, with at least 20 million people already infected.
SYMPTOMS	Often there are no symptoms. For women who do experience symptoms, they may have abnormal vaginal discharge, bleeding (not their period), and/or burning and pain during urination. For men who do experience symptoms, they may have discharge or pain during urination, and/or burning or itching around the opening of the penis.	Often there are no symptoms. For women who do experience symptoms, they may notice a frothy, smelly, yellowish-green vaginal discharge, and/or genital area discomfort. Men who have symptoms may temporarily have a discharge from the penis, slight burning after urination or ejaculation, and/or an irritation in the penis.	Most infected people have no symptoms. For those who do, it can cause a burning sensation while urinating, abnormal white, green, and/or yellowish vaginal or penile discharge. Women may also have abnormal vaginal bleeding and/or pelvic pain. Men may also have painful or swollen testicles.	Most infected people have no symptoms. But some HPV types can cause genital warts – small bumps in and around the genitals (vagina, vulva, penis, testicles, and anus, etc.). If they do occur, warts may appear within weeks or months of having sex with an infected partner. Cancer-causing HPV types do not cause symptoms until the cancer is advanced.
HOW IT'S SPREAD	Through vaginal, oral, or anal sex. It can also be passed on from mother to child during childbirth.	Through vaginal sex.	Through vaginal, oral, or anal sex. It can also be passed on from mother to child during childbirth.	Through vaginal, oral, or anal sex. It can also be passed on during skin-to-skin sexual contact, and in rare cases, from mother to child during childbirth.
TREATMENT	Oral antibiotics cure the infection. Both partners must be treated at the same time to prevent passing the infection back and forth. Both partners should abstain from sex until the infection is gone.	Antibiotics can cure the infection. Both partners must be treated at the same time to prevent passing the infection back and forth. Both partners should abstain from sex until the infection is gone. It is common for this infection to recur (come back again).	Oral antibiotics can cure the infection. Both partners must be treated at the same time to prevent passing the infection back and forth. Both partners should abstain from sex until the infection is gone.	There is no cure for HPV (a virus), but there are ways to treat HPV-related problems. For example, warts can be removed, frozen off, or treated through topical medicines. Even after treatment, the virus can remain and cause recurrences (warts come back).
POSSIBLE CONSEQUENCES (IF LEFT UNTREATED)	Increased risk for infection of other STDs, including HIV. In women, chlamydia can cause pelvic inflammatory disease (PID) which can lead to infertility and tubal (ectopic) pregnancy. Men may develop pain and swelling in the testicles, although this is rare. Babies born to infected women can develop eye or lung infections.	Increased risk for infection of other STDs, including HIV. In women, trich can cause complications during pregnancy.	Increased risk for infection of other STDs, including HIV. In women, gonorrhea can cause pelvic inflammatory disease (PID) which can lead to infertility and tubal (ectopic) pregnancy. Men may develop epididymitis, a painful condition which can lead to infertility. Babies born to infected women can develop eye infections.	Genital warts will not turn into cancer over time, even if they are not treated. Babies born to women with genital warts can develop warts in the throat. Cancer-causing HPV types can cause cervical cancer & other less common cancers (like anal cancer) if the infection lasts for years. Cervical cancer is rare in women who get regular Pap tests.

ADDITIONAL RESOURCES FOR HIV AND HCV INFORMATION

AIDS Office, San Francisco Department of Public Health: HIV prevention information, research, services, and resources for San Francisco; www.sfhiv.org.

The Body: The Complete HIV/AIDS Resource: Information and resources designed to lower barriers between patients and clinicians, demystify HIV and its treatment, improve patients' quality of life, and foster community through human connection; www.thebody.com.

Harm Reduction Coalition: Provides training, conferences, community organizing, policy development, and resources to promote the health and dignity of individuals and communities that are impacted by drug use; www.harmreduction.org.

Hepatitis Central: Information about living with hepatitis C, including the latest news about infection, transmission, symptoms, treatment breakthroughs, and medical progress; www.hepatitiscentral.com.

HIV/AIDS Nightline: Call (415) 434-2437 or (800) 628-9240 Nationwide. Responds to calls from people newly diagnosed with HIV, living with HIV, those concerned about HIV risk, and caregivers. Open 24 hours a day, 7 days a week. People can also engage with counselors via text at (415) 200-2920.

HIVandHepatitis.com: Online publication that provides timely online information about treatment, management, and prevention of HIV, hepatitis B and C, HIV/HBV and HIV/HCV co-infection, and related conditions; www.hivandhepatitis.com.

Kaiser Family Foundation: Media briefings about HIV as well as information and resources about HIV for each U.S. state and for countries around the world; www.kff.org.

National Domestic Violence Hotline: A national hotline offering referrals throughout the country; 1-800-799-SAFE; 1-800-787-3224 (TTY for hearing impaired).

Office of AIDS, California Department of Public Health: Programs, services, and activities relating to HIV: the assessment and prevention of HIV transmission and provision of care to HIV-positive Californians; <https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OAmain.aspx>

Partner Services: For California guidelines on Partner Services; https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_prev_partnerservices.aspx

For training opportunities from the CDC; <https://www.cdc.gov/hiv/effective-interventions/diagnose/partner-services/index.html>

A national hotline offering referrals through

Please PrEP Me: Provides an interactive map that will search for nearby PrEP providers by zip code; www.pleaseprepme.org.

PrEP and Working Through a Difficult Doctor Visit: For situations where a client might experience pushback from a doctor about a PrEP request, Project Inform has a publicationbooklet that helps clients address responses such as “Just use condoms,” “I’m not qualified to prescribe PrEP,” or “It won’t protect you against STDs.”;

PrEP Locator: A national directory of providers of HIV Pre-Exposure Prophylaxis (PrEP) in the U.S.; <https://prelocator.org/about-us>.

San Francisco AIDS Foundation: Direct services, information about HIV treatment and related issues, and policy advocacy for HIV; www.sfaf.org.

San Francisco City Clinic: A wealth of information on HIV and STDs for consumers and providers as well as sexual health education; www.sfcityclinic.org.

San Francisco Sex Information: A free information and referral switchboard providing anonymous, accurate, nonjudgmental information about sex; www.sfsi.org; 415-989-7374.

UCSF Alliance Health Project: For more than 30 years, AHP has produced publications for service providers, researchers, and public health planners. Our library offers practical guides to counseling techniques and lesbian, gay, bisexual, transgender, and queer (LGBTQ) and HIV-related mental health information. Also provides information about HIV test counselor training and other services; <https://alliancehealthproject.ucsf.edu>

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