Module 1: What Is HIV Test Counseling? Why Is It Important?

Module 1: What Is HIV Test Counseling? Why Is It Important? Screen 2 of 11

Introduction

Now that you know how to get around, let's get started!

This course is an introduction to HIV test counseling.

We'll show you what HIV test counselors do, and prepare you to participate and be successful in the Basic HIV Counselor Skills Training.

In the course of this online training, we will meet several HIV test counselors and their clients, and watch what happens in actual test counseling sessions.

Module 1: What Is HIV Test Counseling? Why Is It Important? Screen 3 of 11

What Is HIV Test Counseling?

Most clients come into HIV test sites to find out if they are infected with the virus that causes AIDS. We run that test for them, but HIV test counseling includes other elements too:

We need to make sure that each client understands how HIV is transmitted, how HIV transmission can be prevented, and what the HIV test results mean.

Also—and this might be most important—we hope to have a conversation with clients that encourages them to think about HIV prevention in their lives: what they've tried before, what works, what doesn't, and what they might consider doing in the future.

Module 1: What Is HIV Test Counseling? Why Is It Important?
Screen 4 of 11
What's the Big Deal?

Most other medical tests don't come with counseling. Why do we counsel people who come for an HIV test? The answer lies in the history of HIV and AIDS.

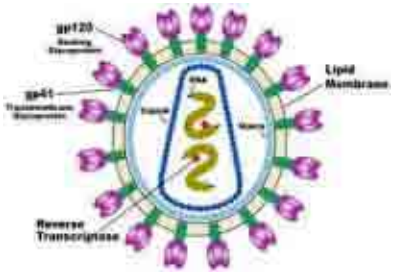
As you may know, HIV is a fairly new disease. In 1981, doctors in New York and Los Angeles suddenly realized that otherwise healthy gay men were developing severe immune system problems, including rare types of pneumonia and a skin cancer called Kaposi's sarcoma. These men, many of them young, became desperately ill and died within weeks or months. No one knew what was causing the illness.

The earliest cases of the disease were nearly all diagnosed among gay men, so it was originally called gay-related immunodeficiency disease (GRID). Before long, injection drug users, people with hemophilia, and others were identified as having the new immune system disease as well, and its name was changed to acquired immune deficiency syndrome (AIDS).

In the beginning, no one knew what caused AIDS or how it was transmitted. There was a lot of panic and terrible prejudice against gay men and others who were infected.

Ask yourself: Can you name 3 important elements of an HIV test counseling session?
If not, reread the last few screens.

Module 1: What Is HIV Test Counseling? Why Is It Important?
Screen 5 of 11
Scientists Discover HIV—the Virus that Causes AIDS



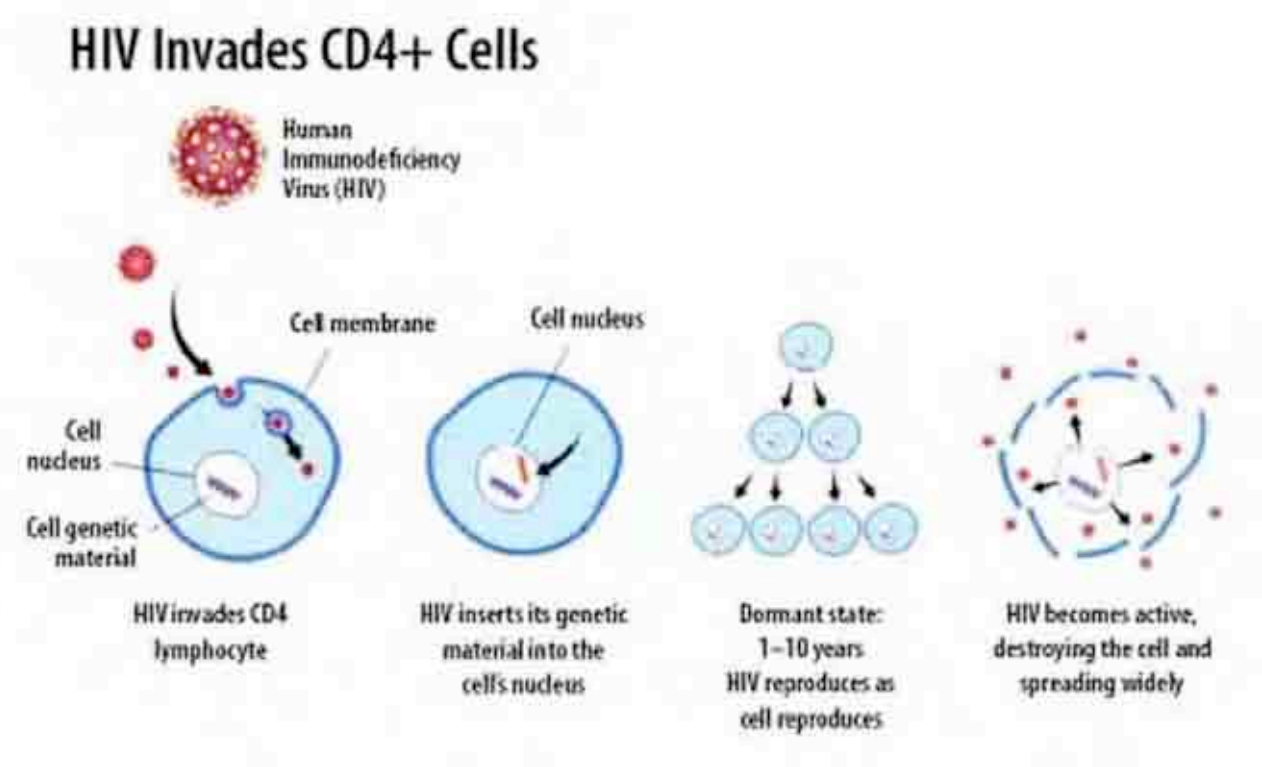
Three years later, in 1984, scientists in France and the United States discovered that AIDS is caused by a virus. They named it the human immunodeficiency virus (HIV).

Soon after, a blood test was developed to detect HIV infection, and we learned how the virus is transmitted from one person to another. (We'll review transmission in Module 5).

Ask yourself: Is AIDS caused by a bacterial infection or a virus?
If you're not sure, reread the last few screens.

Module 1: What Is HIV Test Counseling? Why Is It Important?
Screen 6 of 11
HIV Invades CD4+ Cells

HIV is a virus that invades CD4+ cells, which are a critical part of our immune system. Once inside a CD4+ cell, the virus uses the cell to create more virus. In the process HIV destroys the original cell.



As more and more immune system cells are destroyed, the body has a harder time fighting off both HIV and other illnesses. Illnesses that would not affect people with healthy immune systems take this opportunity to establish themselves. They are called opportunistic infections and conditions. Pneumocystis carinii pneumonia is an example of an opportunistic infection.

Module 1: What Is HIV Test Counseling? Why Is It Important?
Screen 7 of 11
AIDS

Most people don't develop immune system problems until many years after they are infected with HIV. Even though they don't have symptoms, they can infect others with HIV.

When a person with HIV contracts one of the specific AIDS-related opportunistic infections or when their CD4+ cell count falls below 200, a doctor diagnoses AIDS.

Today, medications often can delay or prevent the progression of HIV to AIDS. With proper medical care, many people with HIV are living long and productive lives.

AHP has compiled more information on HIV and AIDS in a PDF that you can download from our Web site:

Frequently Asked Questions in HIV Counseling and Testing

Ask yourself: When does a doctor diagnose AIDS?
If you're not sure, reread the last few screens.

Module 1: What Is HIV Test Counseling? Why Is It Important? Screen 8 of 11

Information Isn't Enough to Stop the Spread of HIV

Once it was clear how HIV was and was not transmitted, there was a huge sigh of relief among medical workers, AIDS activists, and in the communities most affected by the disease. All people needed to do, it seemed, was use condoms and stop sharing needles, and the epidemic would halt.

But changing sexual and social behavior is very, very difficult. Many of the communities most at risk for HIV transmission have long histories of oppression and discrimination that make self-care especially challenging. And when the HIV test was first available, there weren't any of the successful treatments for HIV and AIDS-related complications that exist now. Deciding to test for HIV status was often a difficult choice to make.

In response, AIDS activists and health care workers created an approach to HIV test counseling that combined the medical test with supportive, nonjudgmental counseling about HIV transmission and prevention, as well as about the test itself.

Module 1: What Is HIV Test Counseling? Why Is It Important? Screen 9 of 11

What HIV Test Counselors Do

HIV test counselors try to have a nonjudgmental conversation with clients that clarifies the facts about HIV and engages clients in talking about sex and drug use. By focusing on clients' thoughts and feelings, counselors help them think about what they've done in the past and might want to do in the future to prevent HIV.

This online course offers the information that forms the foundation for the face-to-face Basic HIV Counselor Skills Training you will be attending soon. Both trainings build on 25 years of experience talking with people about stopping the transmission of HIV.

For more information on **the difference between health-related counseling and health education**, see this PDF on AHP's Web site: Comparing Health Education with Client-Centered Counseling

Module 1: What Is HIV Test Counseling? Why Is It Important?
Screen 10 of 11
Who Is Most at Risk in California?

- 76 percent of those who are HIV-positive are men who have sex with men (MSM)
- 28 percent are between 20 and 29 years old; 68 percent are under 40
- 20 percent are African American (7 percent of Californians are African American)
- 28 percent are Latino (36 percent of Californians are Latino)
- Women are the fastest growing demographic for HIV

As you can see, which communities are most affected by HIV is closely tied to the social inequalities in our society: people of color, immigrants, women, gay men, and youth are at highest risk. The reasons are enormously complex. Here are a few examples:

- Unequal access to health care limits the likelihood that people will seek care. This includes lack of medical insurance, distance to clinics, atmosphere of clinics, and attitudes of clinic staff and health professionals.

- Medication trials and studies that focus on the "general population" often do not include adequate representation of these communities and populations.

- Language and attitudes can make people feel judged, unwelcome, and reluctant to seek out preventive health care. Terms that label people rather than opening up a discussion about behavior include: "inmates," "ex-cons," "prostitutes," and "on the down-low."

- Current laws result in long prison sentences for drug use and disproportionate sentences for crack use vs. cocaine use. Incarceration for nonviolent crimes affects not only the incarcerated person but also children, extended family, and community.

Of course, HIV test counseling, no matter how skillful, cannot solve these problems. But being sensitive to the context of your clients' lives, listening empathetically to their experiences, and being aware of the ways we all tend to label or stereotype people can make a big difference. Every site and community is unique, so one thing you will want to do as you prepare to become an HIV test counselor is learn as much as you can about the people in the community you will be serving who are most likely to be at risk for contracting HIV.

Ask yourself: What are two links between HIV and social inequalities?
If you're not sure, reread this screen.

Module 1: What Is HIV Test Counseling? Why Is It Important?
Screen 11 of 11
Module Conclusion

We want to be sure that you have the knowledge and skills to be an excellent HIV test counselor. This online course will give you the background to make good use of the face-to-face Basic Counselor Training.

In the following modules, we will look at what happens in an HIV test counseling session. We want to give you a basic understanding of the structure and goals of a session, HIV tests and results, the principles of test counseling, and HIV transmission and prevention. You will meet some counselors and see them in action.

We have a lot to do, so let's get started!

Module 2: Informed Consent

Module 2: Informed Consent, Screen 2 of 15

Introduction

In this training, we will watch and discuss sections of several counseling sessions. Ou imaginary sites use rapid HIV testing, which means that a lab result is available the same day, often in 20 to 40 minutes. You'll learn more about rapid testing in later modules and in the live training.

Your site might use conventional testing. In conventional testing, the sample collected from the client is sent to a lab and the client returns for results a week or two later. Your site supervisor will explain how to adapt your counseling to the two-session process.

Let me introduce our first counselor, Sylvia, and her client, David.

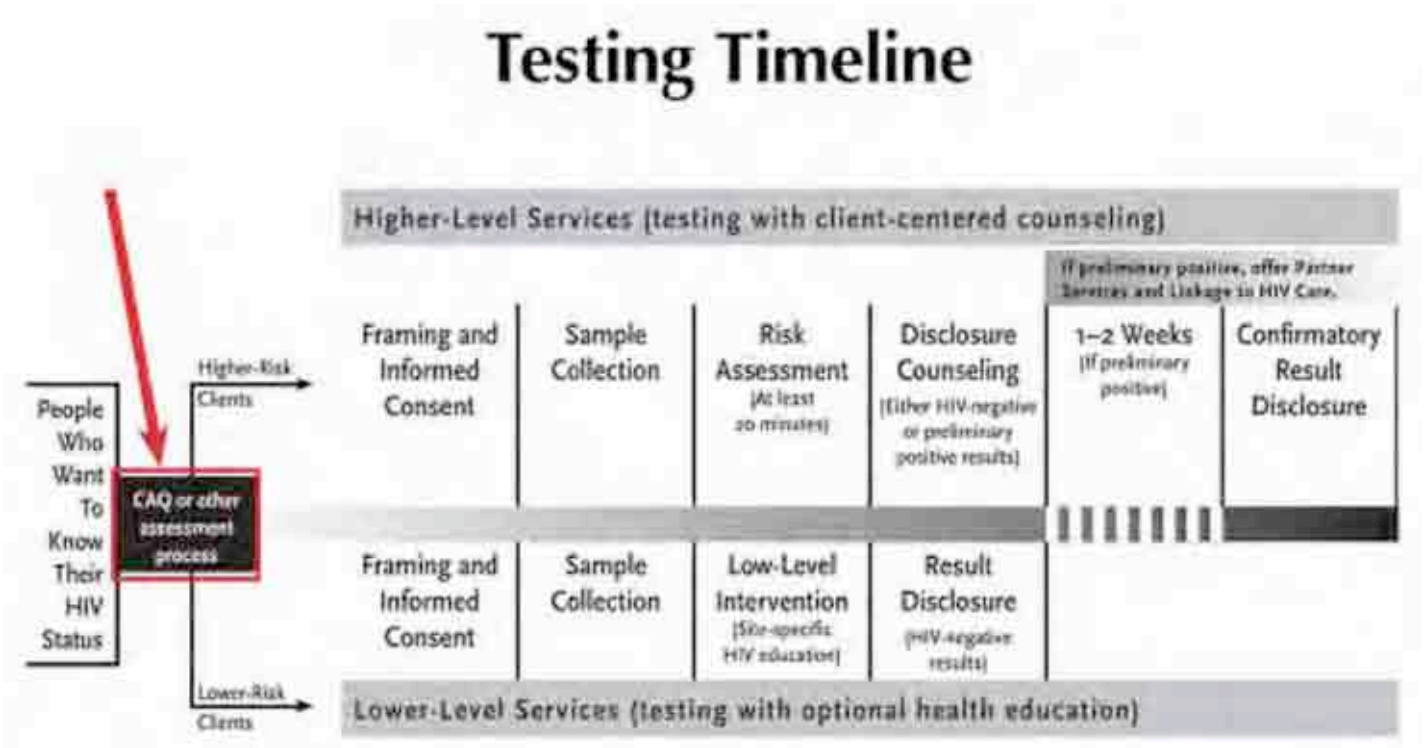
Module 2: Informed Consent, Screen 3 of 15

The Client Assessment Questionnaire

While David waits to talk to Sylvia, he fills out a short form: the Client Assessment Questionnaire, often called the CAQ. The CAQ helps Sylvia assess David's level of risk. At many sites, clients who are at low risk of contracting HIV don't receive counseling services. They are tested and receive a pamphlet or watch a video while they await the results.

At some sites, particularly in big cities, the preliminary screening is done on a PDA, a handheld computer, and the counselor does not see the client's responses.

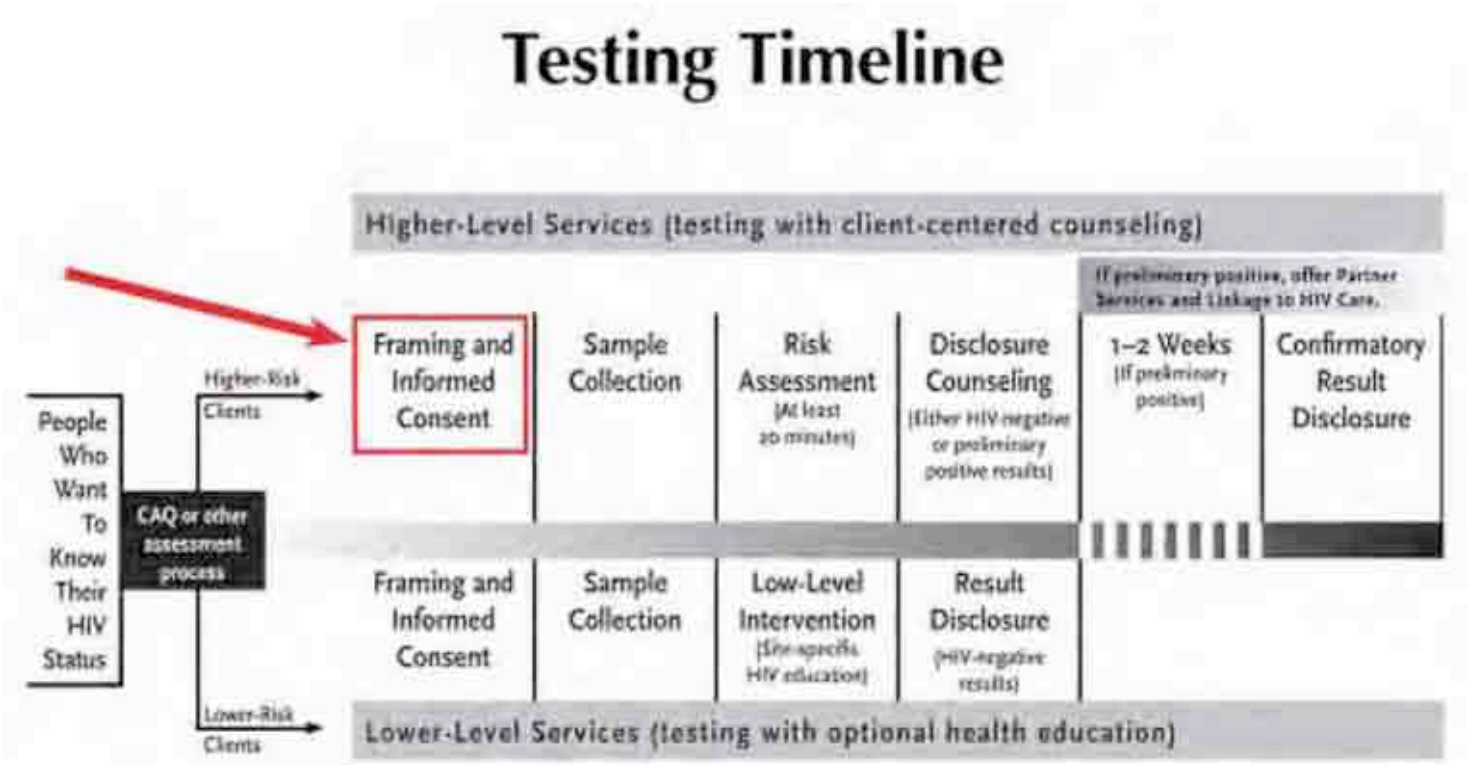
Every site is different, so ask your supervisor what happens at your site.



Ask yourself: What is the purpose of the CAQ or other preliminary screening tool?
If you're not sure, reread the last few screens.

Module 2: Informed Consent, Screen 4 of 15

Informed Consent



The first few minutes of the counseling session might be the most important. This is your chance to make sure that your client feels comfortable and respected. Basically, the goals for the first few minutes are:

- Establish rapport
- Find out what brought the client in
- Explain the counseling and testing process
- Ask for questions
- Get informed consent from the client

Informed consent means that the client understands what is going to happen and agrees to the procedure.

Let's see how Sylvia goes about it.

Module 2: Informed Consent, Screen 5 of 15
Sylvia Starts the Test Counseling Session

Sylvia: Hello. My name is Sylvia. I'll be your test counselor today.

David: Hi.

Sylvia: I want to quickly check in with you and ask what brought you to our site today.

David: I came to get an HIV test. I haven't been tested in a while and thought it would be a good idea.

Sylvia: Welcome. We can definitely help you out with that today. You mentioned that you haven't tested in a while. Is that right?

David: It was about two years ago. I went to a clinic near my old apartment. They did that quick test with the oral swab.

Sylvia: And what were the results of that test?

David: It was negative.

Module 2: Informed Consent, Screen 6 of 15
Sylvia Reviews the Rapid Test

Sylvia: OK, I would like to take a minute to talk about what we offer at our site. Is that all right?

David: Sure.

Sylvia: Your last test was a rapid test, which is the kind of HIV test we offer here. What do you remember about that test?

David: I remember that I got my test results that day, which was what I wanted.

Sylvia: You're right. The test takes 20 to 40 minutes to develop. The whole process takes about an hour. Do you have enough time for that today?

David: Yeah, no problem.

Sylvia: Great. While the test is developing, we'll be able to talk about some of the concerns you might have about HIV. Before you leave today we will have your result. Does that sound OK?

David: Yup.

Module 2: Informed Consent, Screen 7 of 15

A Preliminary Positive Result Needs Confirmation

Sylvia: There are a couple of options for how we collect the test sample. You can do an oral swab, or you can go with the finger stick, where we take a small drop of blood from your finger. Do you have a preference for one over the other?

David: I want to do the same one I did last time. I'll go with the oral one.

Sylvia: OK. The test has two possible results. The first is a negative test result. That means that there are no HIV antibodies detected in the sample.

The other test result is preliminary positive. This means that HIV antibodies were very likely detected and, very likely, the person is infected with HIV. When someone tests preliminary positive, we need a second sample to send to the lab to confirm it as a positive result. Would that be OK with you?

David: I thought this test was really accurate. Why does someone need to give a second sample if it's so reliable?

Sylvia: Great question. This is a screening test. Although it is highly accurate, the standard of care for all types of screening tests in the United States is to confirm them with a second sample. No test is 100 percent, and we want to be certain. Does that make sense?

David: Yeah, sure.

Module 2: Informed Consent, Screen 8 of 15

Anonymous vs. Confidential Testing

Sylvia: When you tested last, do you remember if you tested anonymously or confidentially?

David: I don't remember. I'm not sure what the difference is.

Sylvia: At our site, a client can test either way.

In an **anonymous test**, we don't collect any identifying information. We use a code instead of your name. No one except you can connect your test result with who you are.

In a **confidential test**, we ask for your name, address, and other contact information. If you choose the confidential test, we can provide a written result. Some people want that. We can't do that with the anonymous test. Also, if a confidential test is HIV-positive, we forward the result to the health department along with the person's name. The health department's database is very secure and used only to keep track of HIV statistics.

David: Why does the health department need my name?

Sylvia: Let's imagine that someone tested positive at a hospital last year and then came here tomorrow and tested positive again. Without a name, those two results look like two different people. Reporting positive results by name is the simplest way to know how many people actually have HIV so we can direct funding and programs where they are needed the most.

David: That makes sense, I guess. I have a new boyfriend and I'd like to show him my results, so I think I'll go with confidential.

Module 2: Informed Consent, Screen 9 of 15

David Gives Informed Consent

Sylvia: Let me see: I'm hearing that you want the rapid test, you would like to give an oral sample, and you want to test confidentially, not anonymously. Is that right?

David: Yup. That's it.

Sylvia: OK. Since you chose the confidential test, I'm going to ask you to fill in the information here and sign the consent form.

When you sign the consent form, you give us permission to do the rapid test and agree that you understand three things I explained:

- The difference between anonymous and confidential testing.
- The accuracy of the results: They are highly accurate but not 100 percent.
- The process today: You will get your results, and if the test comes back preliminary positive, you agree to give another sample that we can send to the lab for confirmatory testing.

Do you have questions about any of that?

David: I'm good.

Ask yourself: What is the difference between anonymous and confidential testing? If you're not sure, reread the last few screens.

Module 2: Informed Consent, Screen 10 of 15
Sylvia Introduces the Counseling Information Form

Sylvia: OK, I just have two more things to mention. I'm not sure if you remember this Counseling Information Form from the last time you tested. We use it to identify trends in the epidemic.

David: I remember that form. The guy asked me a bunch of questions from it.

Sylvia: I will just set it down next to me and maybe refer to it close to the end of our session. Also, here's a brochure from the people who make the rapid test. You don't have to look at it now, but I want to make sure you have it. Do you have any questions before we head to the lab?

David: No, I'm ready.

Module 2: Informed Consent, Screen 11 of 15
Let's Debrief

ied to create an atmosphere in which David would feel comfortable
g information about his life and thinking about changes he might
o make.

t specific things did you notice Sylvia doing to make David feel
lcome, listened to, and respected?

Module 2: Informed Consent, Screen 12 of 15

Building Rapport

How many of these elements of building rapport did you notice?

Sylvia:

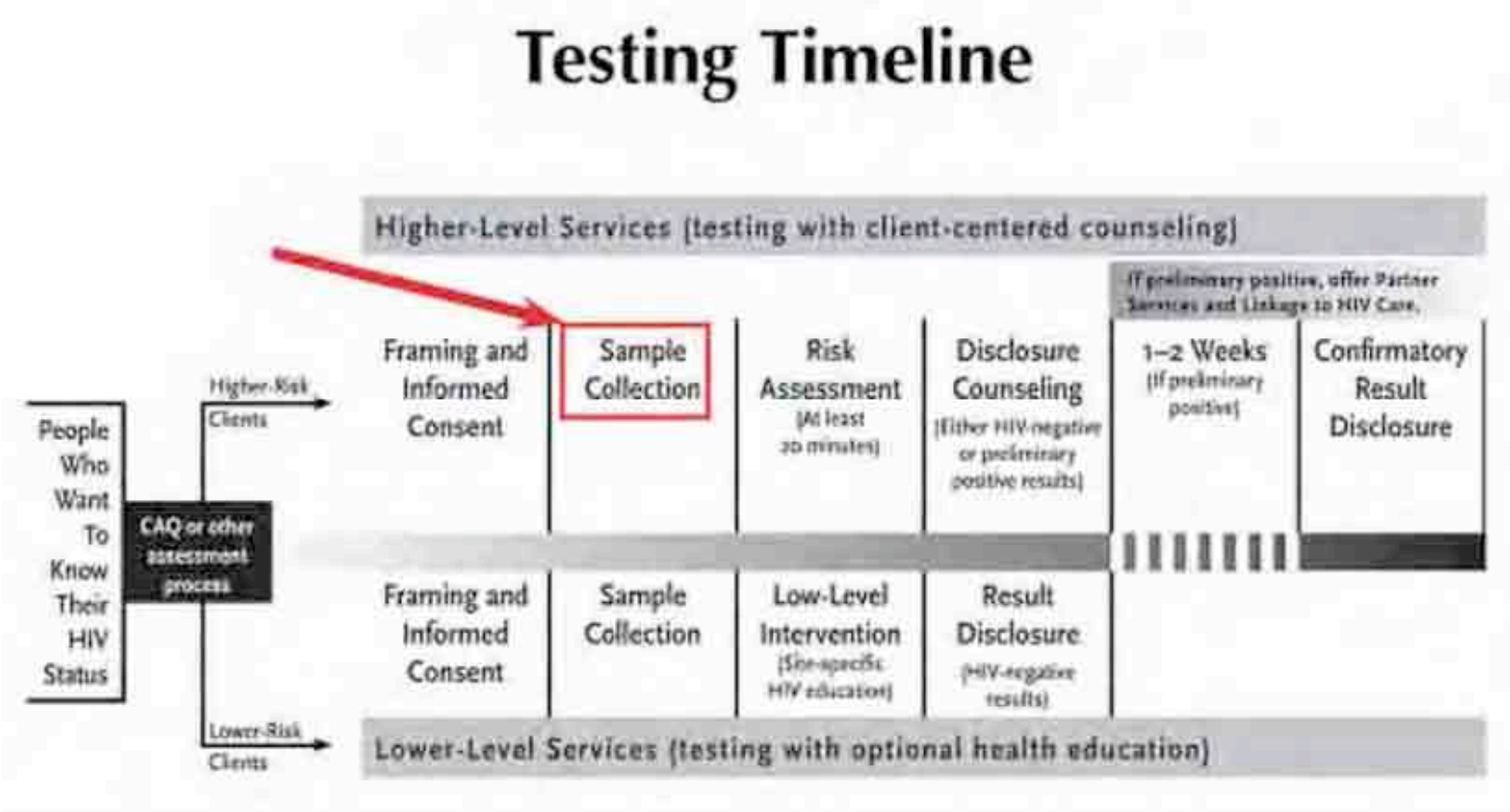
- Introduced herself and welcomed David to the test counseling session.
- Explained exactly what was going to happen.
- Asked David about any previous experience testing.
- Asked David for previous knowledge.
- Asked David for permission before sharing new information and avoided lecturing.
- Checked for understanding and questions.
- Was calm, friendly, and professional.

Module 2: Informed Consent, Screen 13 of 15

The Rapid Test

David had already done a rapid test, so he didn't have many questions about it. But you probably want to know more. Here are some basic facts about the OraQuick ADVANCE Rapid HIV-1/HIV-2 Antibody Test:

1. The test is performed on either an oral sample collected by swabbing along the gums or a blood sample, usually from a finger stick.
2. The rapid test takes between 20 and 40 minutes to develop a result.
3. The test looks for the antibodies that the body creates to fight HIV infection.



Module 2: Informed Consent, Screen 14 of 15

Rapid Test Results

There are three possible rapid test results:

A **preliminary positive** test result means that the test very likely detected HIV antibodies. The individual is very likely infected with HIV. Preliminary positive results must be confirmed. At most sites, this means the client submits a second sample and returns after seven to 14 days to receive the results of the confirmatory test. If the confirmatory test is also positive, it is considered a positive result and the client is HIV-positive.

A **negative** test result means that no antibodies to HIV were detected in the sample. The person is either not infected with HIV, or the person is infected but has not yet produced enough HIV antibodies to show up on the test. The process to produce antibodies takes anywhere from two weeks to six months, and many HIV-positive people have detectable antibodies by the end of three months. This time lag is known as the "window period." We will discuss it in Module 3.

An **invalid** test result is very rare. If it occurs, the test must be redone with a new sample.

At the face-to-face Basic Skills Training, you will learn the rapid test procedure, be evaluated on your ability to conduct the test, and, if you pass the evaluation, be certified to administer, read, and record the test.

Read this PDF to learn more about the OraQuick ADVANCE Rapid HIV-1/HIV-2 Antibody Test.

Ask yourself: What are the three possible results from a rapid antibody test? If you're not sure, reread this screen.

Module 2: Informed Consent, Screen 15 of 15
Let's Review Informed Consent

Just to review, here's what you need to do with your cli
you collect the sample. We call this the Informed Cons
session:

- Establish rapport.
- Explain what will happen during the session and whe
  the client will receive test results. For rapid tests,
  make sure the client knows that a preliminary
  positive result requires a confirmatory test.
- Explain any choices the client has: rapid vs.
  conventional, anonymous vs. confidential, oral
  sample vs. blood sample. Where there is only one
  of these options, explain the option.
- Check for questions and concerns.
- Have client give informed consent to the test (a spok
  consent for anonymous testing, a signed consent fo
  confidential).

That's it! You have completed the first part of the HIV test session. In Module 3, we'll talk about what happens when the client returns from the lab.

For more information about **Informed Consent**

Module 3: Introduction to Risk Assessment

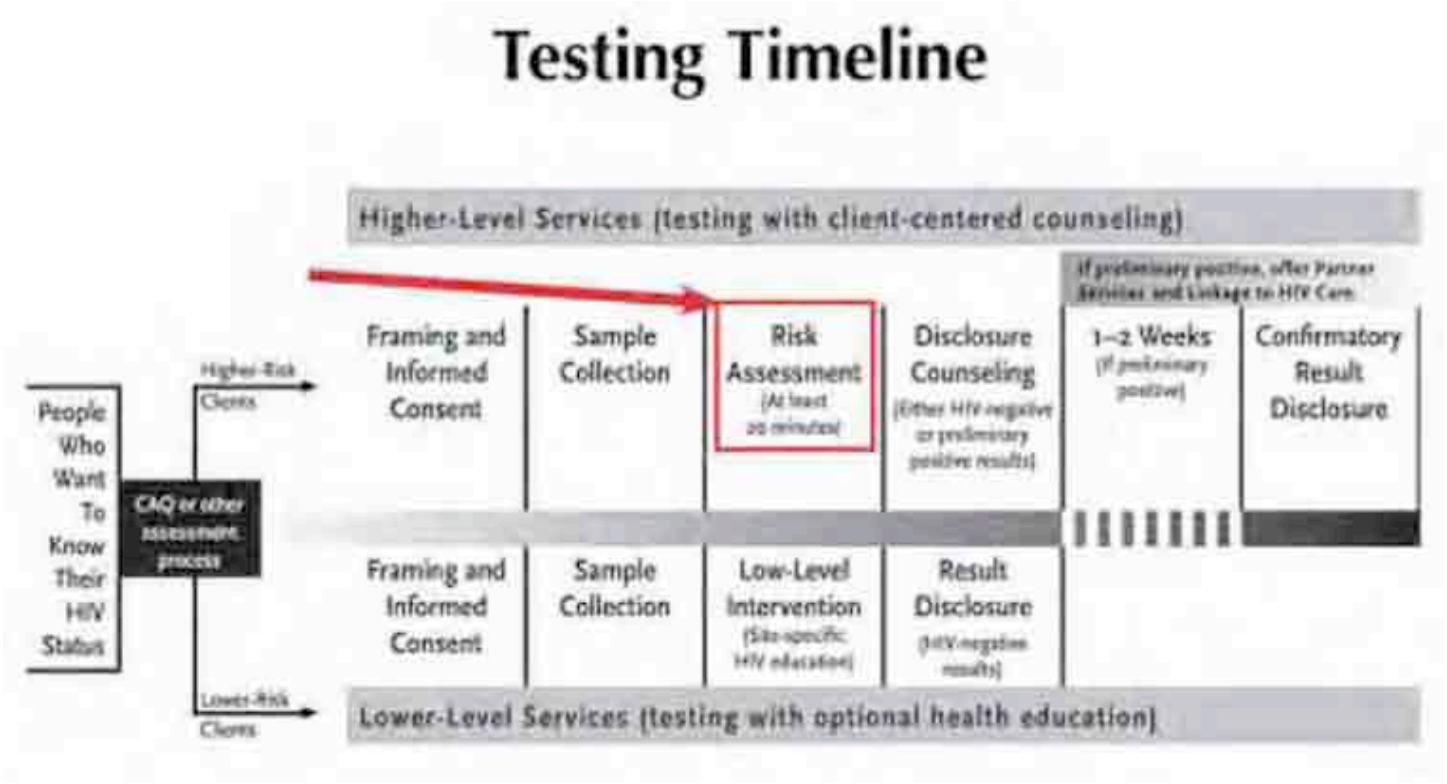
Module 3: Introduction to Risk Assessment, Screen 2 of 12

What Is Risk Assessment?

When the client returns from the lab, we begin the main portion of the counseling session. It is called the Risk Assessment because that is when we gather information to help the client begin to identify activities in their lives that could result in HIV transmission. At most sites, it's also the time when we collect data for the Client Information Form.

The term "risk assessment," however, doesn't tell the whole story. It sounds like a checklist, and the process works best, really, if we have a conversation. Our job is to offer a safe place for our clients to consider the issues in their lives that put them at risk for HIV transmission.

If you can get into a good conversation with your clients, they will feel comfortable sharing and thinking aloud about possible changes in their lives, and you will get most of the information you need without even looking at the form.



Module 3: Introduction to Risk Assessment, Screen 3 of 12

Goals of the Risk Assessment

There are many things we need to accomplish in the risk assessment. At the same time, we want to stay focused on the client's concerns.

Does this sound like a tall order? How are we going to have anything like a conversation that accomplishes all this?

Module 3: Introduction to Risk Assessment, Screen 4 of 12

The General Principles of HIV Test Counseling

It's easier than you might think. There are six principles that lay the foundation for having a productive, supportive conversation with clients:

- **Client-Centered Counseling**
- **Context**
- **Support All Positive Changes**
- **Individualized Session**
- **Information Alone Does Not Change Behavior**
- **Neutral Stance**
- **Limited Role**

Let's take a look at these principles one by one.

Module 3: Introduction to Risk Assessment, Screen 5 of 12

Counselors Define Client-Centered Counseling

We asked some participants in a training like this one for definitions of client-centered counseling. Here is what they said:

Focus on the client's needs, not the counselor's needs.

Listen more, talk less.

Clients are more important than paperwork.

Feelings come first.

Module 3: Introduction to Risk Assessment, Screen 6 of 12
Client-Centered Counseling Ideas

All of those ideas are part of client-centered counseling. You can think of centered counseling in terms of two big ideas:

1. **Express unconditional positive regard for the client**: Demonstrate your respect for the client's feelings and concerns. You might have very different ideas and feelings yourself, but you will be most effective if clients feel you are on their side, trying to see the situation from their perspective.

2. **Frame the session in the clients' terms**: Work within the "frame" of your clients' concerns and experiences, not your own. For example, start with why they came in for testing, not with the first question on the CIF.

Ask yourself: What is client-centered counseling?
If you're not sure, reread the last few screens.

Module 3: Introduction to Risk Assessment, Screen 7 of 12
Context

Risk factors do not happen independently; they are influenced by the context of our lives. Context sets the scene for the choices we make, including those that can affect our risk for HIV. Our life context might include such factors as our sexual partners, families, jobs, and communities, as well as the impact of racism, sexism, homophobia, poverty, and other forms of oppression.

To explore context, use open-ended questions, and listen carefully to what clients tell you about their lives and how the risk for HIV transmission fits into this larger picture.

Module 3: Introduction to Risk Assessment, Screen 8 of 12
Individualized Session

Because client-centered counseling occurs within the framework of the client's concerns, each session will be different. Even though there are many things you need to cover by the end of the session, how that happens can vary widely. For example, some clients test regularly and know all about the window period, while others have never heard the term. Some clients are used to talking about sex with a counselor, while for others, this is a huge challenge.

For new counselors especially, it is tempting to use the CIF to structure the session. The most effective counseling sessions, however, are based in an individualized conversation—not a preset checklist—that follows the client's lead and explores client concerns.

Module 3: Introduction to Risk Assessment, Screen 9 of 12
Information Alone Does Not Change Behavior

If a counselor tells a client who smokes, "Smoking causes cancer," that person is probably not going to stop smoking as a result. The information might change the client's feelings but, alone, it will not change the client's behavior. The client may feel more inclined to avoid the counselor than to avoid cigarettes.

Similarly, telling a client, "Unless you use a condom, you are putting yourself at risk for HIV," will probably not be enough to get that client to decide to practice safer sex.

Remember context: We all have reasons for what we do, including the things that put us at risk for HIV or other health hazards. We and our clients are most likely to change when we feel supported in thinking about the changes we want to make ourselves, not when we feel lectured or judged by others.

Module 3: Introduction to Risk Assessment, Screen 10 of 12
Neutral Stance

Remember when we talked about unconditional positive regard as one of the key ideas of client-centered counseling? Neutral stance is related to unconditional positive regard.

Neutral stance means being supportive and nonjudgmental—showing respect for the client's perspective without agreeing or disagreeing.

It doesn't help to argue or lecture about a client's behavior or ideas, even if they seem misguided or dangerous. But we also don't want to cheerlead for a specific change they are considering. Neutral stance means leaving space for clients to work out how they feel and what they want to do for themselves.

Remember, the client—not the counselor—ultimately decides on which changes to make and how to make them. As much as it may be tempting to corral a client toward an understanding or decision, behavior change simply does not work that way. A neutral stance says that you trust the counseling session to offer the client the information and support to make the best decisions.

Module 3: Introduction to Risk Assessment, Screen 11 of 12
Limited Role

Sometimes HIV risk is only one of many serious problems in a client's life. At some sites, many clients face overwhelming survival issues. As caring people, it's hard for counselors not to want to help.

HIV test counselors, however, have a **limited role**: Our job is to assess risk for HIV transmission and guide clients toward changes that will lower that risk.

As you will see in a later module, giving referrals for additional services is part of the HIV test counseling session. Your site supervisor will help you become familiar with the referrals for other services in your area.

Module 3: Introduction to Risk Assessment, Screen 12 of 12

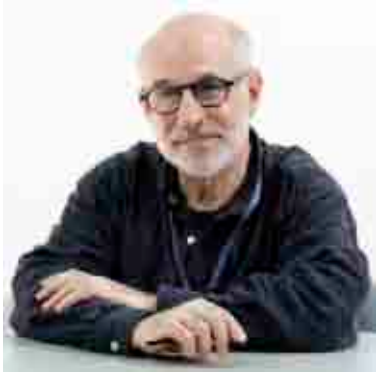
Conclusion

In this module, we defined the Risk Assessment portion of the counseling session, and discussed the Six General Principles of HIV Test Counseling.

In the next module, we'll watch a Risk Assessment and see those principles in action.

Ask yourself: What are the six General Principles of HIV test counseling?
If you're not sure, reread the last few screens.

Module 4: Risk Assessment Session



Module 4: Risk Assessment Session, Screen 2 of 10

Introduction

Now that you know the General Principles, let's watch an actual session.

First, I'd like to introduce Paolo. Paolo is an HIV test counselor who works in a mobile test site, a van that parks outside gay bars, public cruising areas, and homeless encampments.

Paolo's client is Greg. Paolo and Greg have already completed the Informed Consent section of the counseling session. Paolo also collected a finger stick blood sample from Greg and started the rapid test developing. Now the pair are back in the van's counseling area with time to talk.

Module 4: Risk Assessment Session, Screen 3 of 10

Paolo Begins the Risk Assessment

Paolo: So, now we have about 20 minutes to talk while the test is developing. You mentioned when you first came in that you were worried. Tell me a little about that.

Greg: I know about HIV. I've tested a lot before. But I still don't use a condom a lot of the time. It's kind of stupid.

Paolo: Tell me what's going on.

Greg: I just think to myself, "Why did I do that?"

Paolo: You're not sure why this is happening.

Greg: Right. I know better—I want to use condoms, but I don't—and that's about it.

Module 4: Risk Assessment Session, Screen 4 of 10

Everyone Knows Greg Is Gay

Paolo: That must be frustrating. I wonder if there's a specific time when this happened recently.

Greg: A month ago. I met this guy at a party. It was sort of obvious that he wanted to go home with me.

Paolo: Uh huh.

Greg: I was flattered. But you know something? By the time we got to my place, I already knew I wasn't gonna use a condom with him.

Paolo: You knew beforehand.

Greg: That's right. I knew I wasn't going to.

Paolo: How did you know that?

Greg: It's embarrassing. I feel like people see me and assume things. When people meet me, they see this big queen. They instantly know I'm gay.

Paolo: And you don't like that.

Module 4: Risk Assessment Session, Screen 5 of 10

Greg Starts to Explain

Greg: Well, I do and I don't. It means I don't have to come out to anyone, ever. It's because I'm kind of effeminate. I mean, I'm fine with the way I am. I've done a lot of work to accept myself. But—

I don't know.

[Paulo pauses before speaking.]

Paolo: I think you're saying this has something to do with sex, too.

Greg: [Sighs] Yeah.

Paolo: And this guy from a month ago? You said you knew you weren't going to use a condom with him.

Greg: I knew this guy would think that he was going to top me. Guys just look at me and think that.

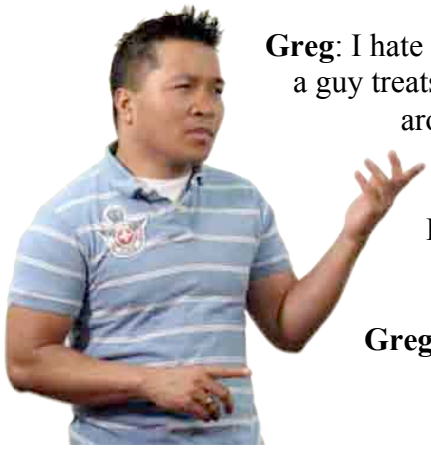
Paolo: They assume that you're only a bottom.

Module 4: Risk Assessment Session, Screen 6 of 10

Paolo Listens Carefully

Greg: Yeah. I knew this guy—Joe—was expecting that he'd top me. I know I'm not all that masculine. Guys take one look at me and think, "Oh, he's a bottom." Even my friends joke about it. But the truth is that I like both. I'm not just one thing.

Paolo: That must be frustrating.



Greg: I hate it. Then I feel like I have to prove a point. If a guy treats me that way, I have to switch things around and end up on top.

Paolo: Like you have something to prove.

Greg: Exactly. And then it's harder to, uh, keep it up.

Module 4: Risk Assessment Session, Screen 7 of 10
Greg Feels Trapped

Paolo: I think I understand, but can you explain what you mean?

Greg: I can't stay hard if I'm concentrating on proving something. I get nervous.

Paolo: I see now.

Greg: I get nervous and then I can't stay hard. And I worry that a condom will make it worse, so I don't use one.

Paolo: That's why you didn't use a condom with Joe.

Greg: Yeah.

Paolo: Earlier, you said you weren't sure why there are times you don't use condoms. Then you voiced a really compelling reason: You think guys see you as only a bottom. You don't want to be labeled, so you end up topping without a condom to prove that you're not just a bottom.

Greg: I hate that the most, feeling like I have to prove a point. It feels so stupid.

Paolo: This is really bothering you.

Module 4: Risk Assessment Session, Screen 8 of 10
Paolo Expresses Unconditional Positive Regard

Greg: Yeah, but you know, it's not always that way. I almost always use a condom when I'm on the bottom or when it's someone who knows me and knows what I like. It's weird. I end up not using condoms with guys I don't know that well, just to show them. And I don't end up liking the sex that much.

Paolo: This is complicated. And you're trying really hard to work it out. I wonder—

Maybe it's upsetting because you wish there were another way to deal with this "prove a point" thing.

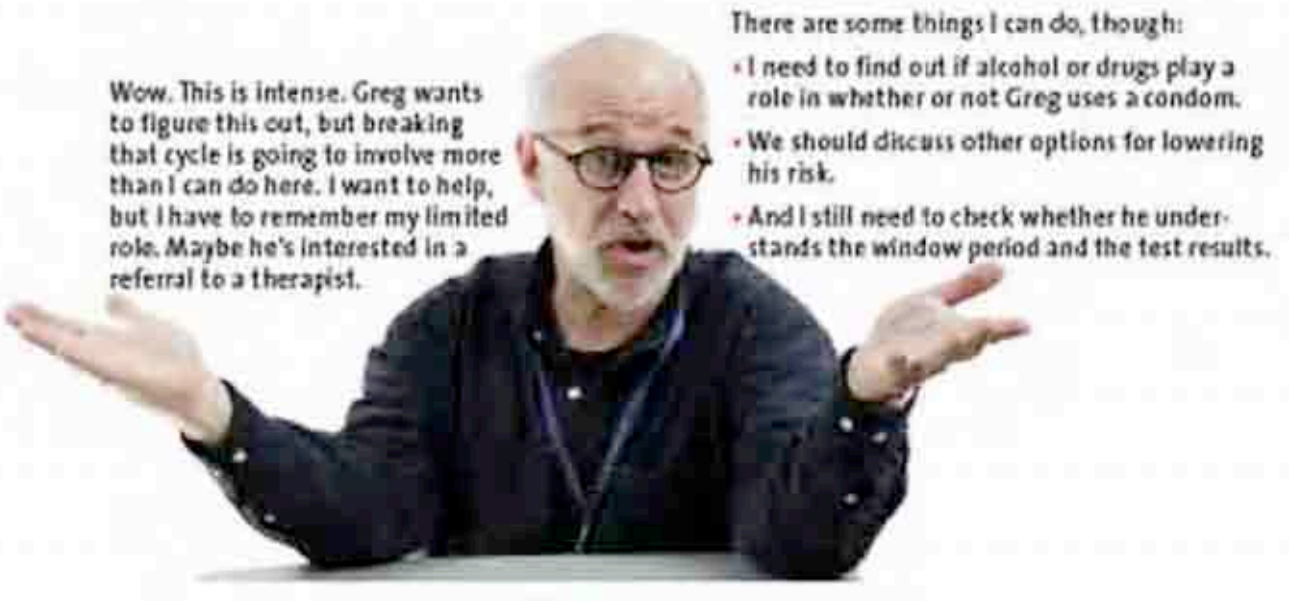
Greg: I do.

Paolo: This is important to you. What have you thought about doing, if anything?

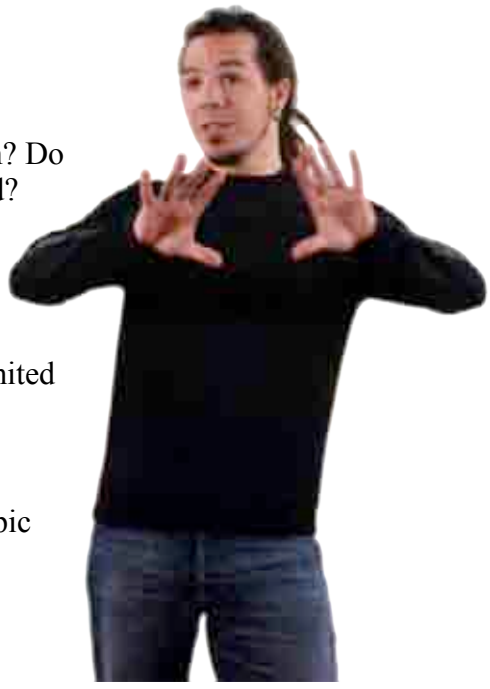
Module 4: Risk Assessment Session, Screen 9 of 10
The Session So Far

Paolo started the session by asking Greg about his immediate concerns. Then, using open-ended questions and a supportive, nonjudgmental manner, Paolo learned quite a bit about the context of Greg's risk for HIV transmission.

Now Paolo needs to figure out how to guide the session forward from this point. If we could see his thoughts, they might look like this:



Module 4: Risk Assessment Session, Screen 10 of 10
Conclusion



What do you think about Paolo's approach to the rest of the session? Do you have additional questions or another idea about how to proceed?

There is more than one way to have an effective counseling session. The key is to stay rooted in the General Principles: client-centered counseling, context, individualized session, information alone does not change behavior, neutral stance, and limited role.

Although counselor approaches may vary, we all need a firm grounding in HIV transmission and prevention. We'll cover this topic in the next module. Then we'll rejoin Paolo and Greg's session.

Module 5: HIV Transmission and Prevention

Module 5: HIV Transmission and Prevention, Screen 2 of 18

The Five Body Fluids that Can Transmit HIV

This module explores the basics of how HIV passes from person to person. We'll focus on sexual transmission and prevention. In Module 6 we'll look more at drugs and injection drug use.

Let's start with the five body fluids that can transmit HIV:

- **Blood**
- **Semen**
- **Precum (pre-ejaculate)**
- **Vaginal Fluid**
- **Breast Milk (for infants)**

Other body fluids (tears, saliva, sweat, sputum, nasal secretions, urine, and feces) do **not** transmit HIV. Sharing food or drink, hugging and kissing, sharing a classroom or work environment—the U.S. National Institutes of Health and the U.S. Centers for Disease Control and Prevention have found that none of these are ways that people contract the virus.

Module 5: HIV Transmission and Prevention, Screen 3 of 18

HIV Transmission and Prevention

For HIV to pass from one person to another, one of the five fluids containing HIV has to enter the bloodstream of an uninfected person. HIV can't survive long outside the human body, and human skin is excellent at protecting against infection.

HIV can only get into the body when the skin is torn or compromised in some way, or when HIV passes through mucous membranes (for example, the wet, soft skin in the rectum and vagina).

There are four ways, called modes of transmission, that HIV can enter the body:

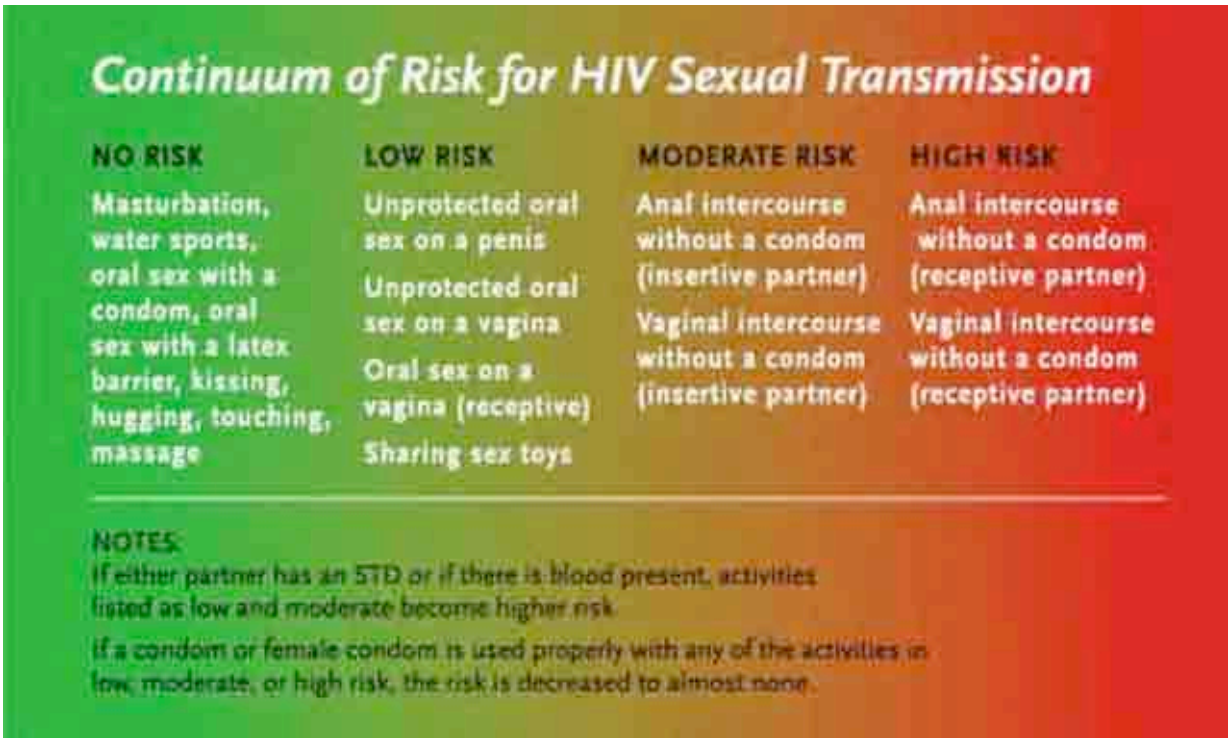
- During unprotected anal and vaginal intercourse sex, and possibly, under very specific conditions, oral sex
- While sharing injection equipment, most often needles
- During pregnancy, birth, or breastfeeding, from mother to fetus or newborn
- Through contact with blood during health care or other occupational exposure

Ask yourself: What are the five fluids that can transmit HIV? If you're not sure, reread the last few screens.

Module 5: HIV Transmission and Prevention, Screen 4 of 18

Continuum of Risk

As you can see in this illustration, different activities pose different risks for HIV. If you look at the continuum, anal or vaginal intercourse with someone who has the virus risks infection much more than, say, oral sex.



When you're counseling, you might use the concept of a continuum of risk to help clients think of small, incremental steps to reduce the chance of infection. For example, if a client is not going to use a condom, substituting oral sex for anal intercourse is a step that dramatically reduces the client's chance of contracting or transmitting the virus.

Let's look at two specific examples of options for reducing the risk of HIV infection.

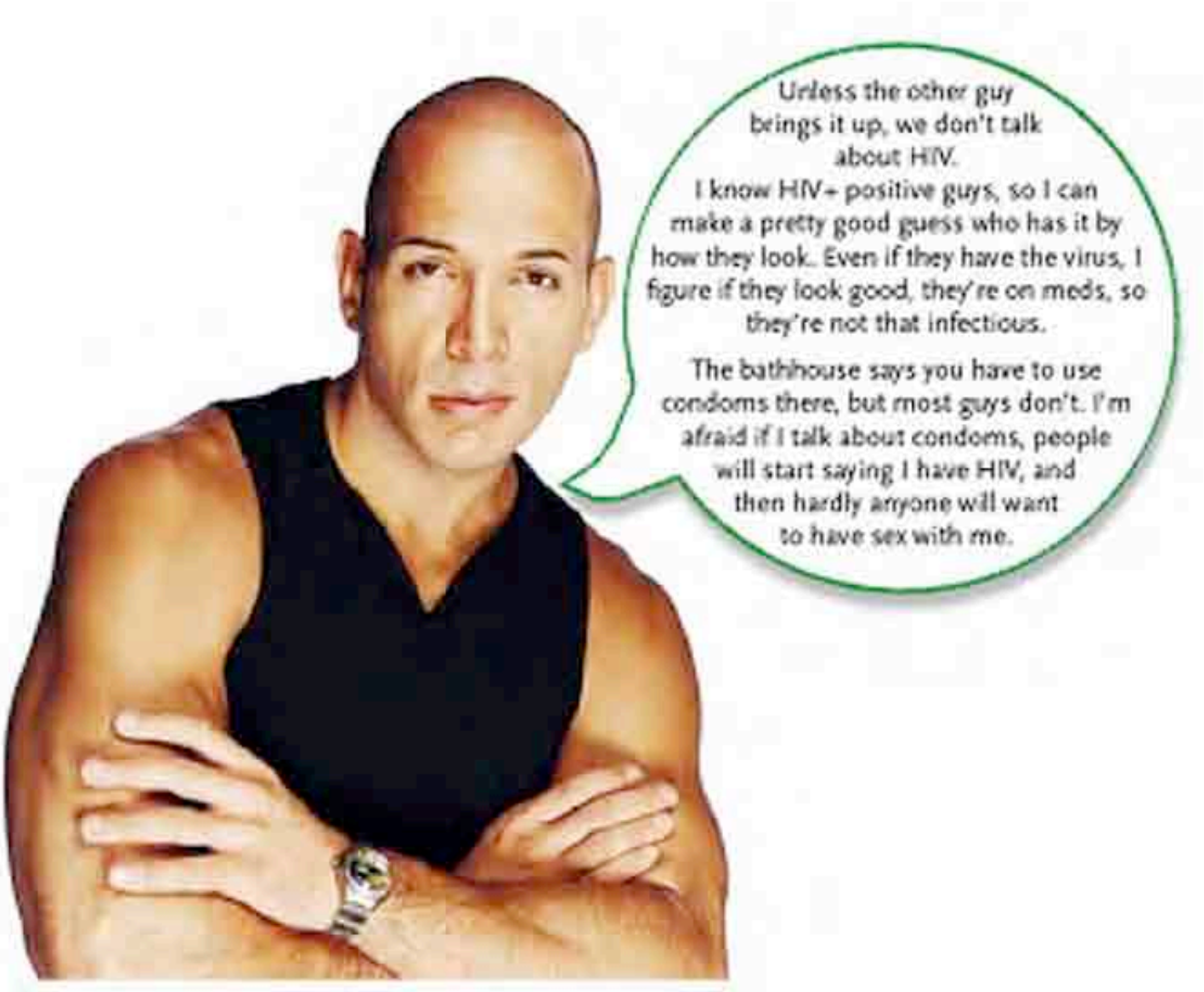
Ask yourself: Can you name three activities that are high risk for HIV transmission?

If you're not sure, reread the last few screens.

Module 5: HIV Transmission and Prevention, 5 of 18

What Are Bill's Risks for Transmitting HIV?

This is Bill. Bill is in his 30s and identifies as a gay man. He is testing today because he has been having sex with men he meets online. He signs on in the afternoons and makes dates to meet some of these men at the local bathhouse. Here's how Bill explains his situation to the counselor:



What are some risk reduction options for Bill?

Module 5: HIV Transmission and Prevention, Screen 6 of 18

Risk Reduction Options for Bill

It's not going to work to tell Bill how dangerous unprotected sex is. Instead, the counselor could ask Bill if he is interested in talking about options to reduce the chances of transmitting HIV, and if he has any ideas for options that might work for him. Here is some framework for thinking about options:

Bill is not necessarily opposed to using condoms. Since he arranges his encounters online, one thing he could do is tell guys he's chatting with online which sexual activities he likes—but only with a condom—and which activities won't require condoms. Those men who are not interested in using condoms at all will probably just pass on meeting up with him.

Another thing Bill could do is try to "serosort": only have sex with men of the same HIV status. He could post his HIV status on the forum and say he is only interested in having sex with other negative men. Or, he could choose to only have anal sex with men who state they are negative, but have oral sex and/or mutual masturbation with men of any status.

Bill could also reduce his risk of HIV transmission by increasing the amount of lube he uses with his partners. Or he could reduce the amount of anal sex, both insertive and receptive, and increase oral and other kinds of sex.

Module 5: HIV Transmission and Prevention, Screen 7 of 18

What Are Linda's Risks for HIV Transmission?

Let's look at one more example. Linda is a woman in her mid-40s. She has been married for 15 years. Her husband does not know that she is testing. They both stopped using crystal about three years ago. Let's see what Linda has to say:

What can Linda do to reduce the risk of transmission of HIV?

Module 5: HIV Transmission and Prevention, Screen 8 of 18

Risk Reduction Options for Linda

Linda does not want to tell her husband about her drug use, her STD, (relationship with Brad, so she won't tell her husband to wear a condor doesn't want to use a condom when he has sex with Linda because he maintain an erection. It seems clear that condoms are not an option rig What options to reduce risk might work for Linda?

Once she and Brad no longer have gonorrhea, Linda could increase th amount of oral sex and decrease the amount of intercourse in both relationships. (Oral sex decreases the risk of HIV transmission, but gonorrhea can be transmitted orally. If another STD is present, the risk for HIV transmission is also higher.)

With Brad, she could suggest starting with intercourse and finishing with oral sex or a hand job. While precum (pre-ejaculate) can transmit HIV, it is less risky than cum (ejaculate). She could also try a Reality (female) condom with Brad. She can wear this condom when they have intercourse to protect herself from HIV and other STDs.

Linda could also use lots of lube with both partners. A water-based lubricant will decrease the amount of friction during sex and reduce the chances of HIV transmission.

Ask yourself: Other than using condoms, what are a few ways people can reduce their risk for HIV? If you're not sure, reread the last few screens.

Module 5: HIV Transmission and Prevention, Screen 9 of 18

Comfort Asking About Sex

Some of us come from families and environments in which sex is discussed openly and neutrally. But many of us—and many of our clients—come from backgrounds in which these conversations are taboo.

Silence surrounding sex often hides what people are actually doing and, consequently, it hides whether we understand their HIV risk from sex. Whether it's our own discomfort with the topic or a client's discomfort, silence can lead to assumptions about what people do and how they can prevent HIV while doing it.

People might think Terri is bisexual. But it would be a mistake to jump to that conclusion, just as it would be a mistake to assume we already know what her HIV risk is. There are a lot of possibilities here:

- Maybe Terri identifies as a lesbian, and only has sex with men to pay her bills. She always uses condoms for oral, vaginal, and anal sex with men because she doesn't want to bring anything home to her partner. Her partner accepts Terri's HIV risk from sex work as minimal, so they don't use protection with one another.

- Maybe Terri limits her sex with men to being a professional dominatrix, occasionally masturbating men but never coming in direct contact with precum or semen. She doesn't like labels, so she doesn't identify as lesbian, bisexual, or heterosexual. She and her partner inject heroin together, which helps her cope with her work.

- Maybe Terri identifies as bisexual. She always uses condoms for vaginal and anal sex with her male clients. Terri's partner is HIV-positive, but they don't use protection for oral sex and use separate sex toys for each another. Terri had a condom break recently with one of her male clients.

There could be a lot more to Terri's sex life than we might assume at first glance. The more context we hear, however, the easier it is to let go of our assumptions and see what's really going on for Terri.

Module 5: HIV Transmission and Prevention, Screen 10 of 18
Don't Make Assumptions

As you can see, we can't assume much looking through a narrow window into someone's sexual behavior. The main thing to remember is that we need to keep our own assumptions in check, otherwise we risk making it more difficult for clients to tell us what they're doing.

We don't have to know everything there is to know about sex in order to do HIV counseling. We do, however, need to know some of the basic approaches people use to prevent contracting the virus.

Module 5: HIV Transmission and Prevention, Screen 11 of 18
Basic Ways to Prevent HIV During Sex

People can prevent HIV infection during sex by not taking blood, semen, pre-ejaculate, or vaginal secretions into the mouth, vagina, or anus. Condoms nearly eliminate the risk of HIV transmission during anal and vaginal intercourse. However, not all clients you'll see will be ready, willing, or able to use condoms or to use them 100 percent of the time.

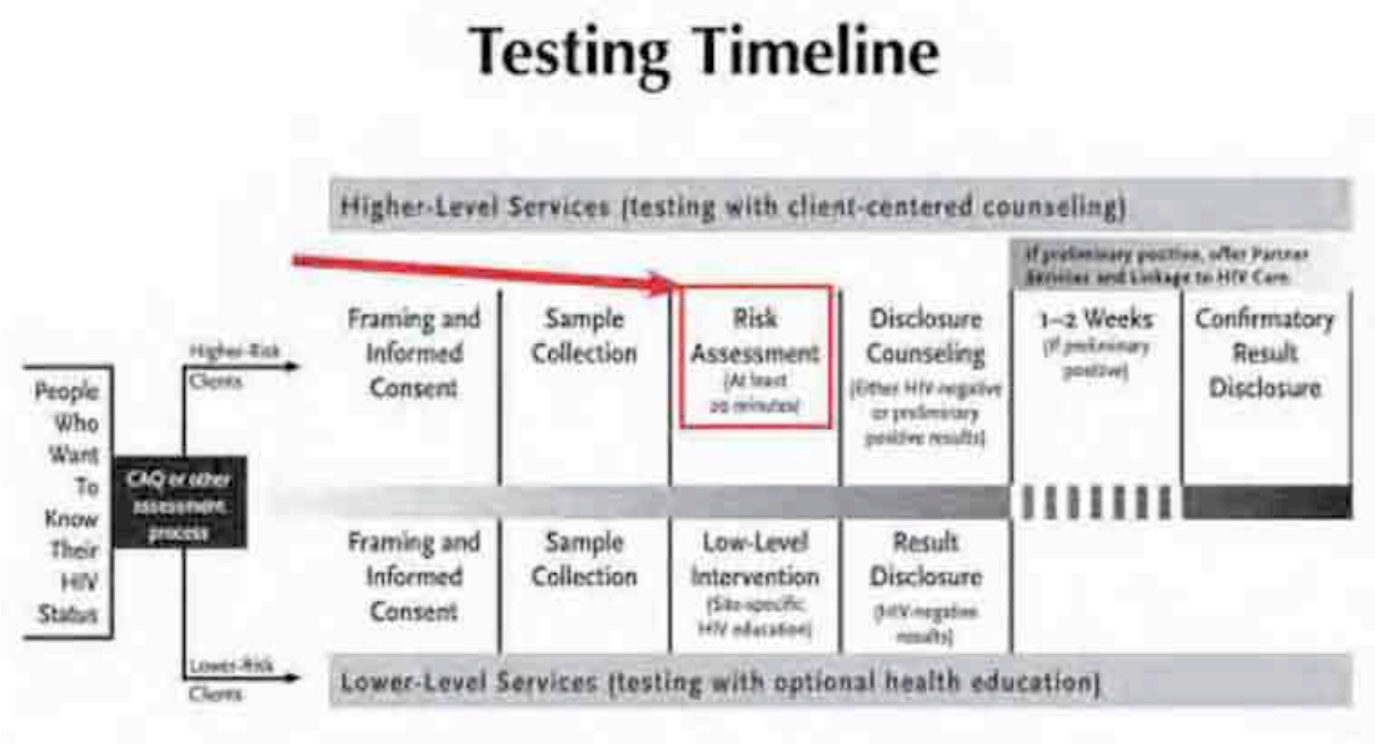
If someone isn't going to use a condom, here are some other options that might lessen the chance of infection during sex:

Use more lube for vaginal and anal sex. Lubrication helps prevent tears in mucous membranes and lowers the risk of transmission.	**Test for and treat STDs.** Treating other sexually transmitted infection (STDs) reduces the chance of infection with HIV.
Replace intercourse with oral sex. The risk of HIV transmission from oral sex is extremely low. However, the presence of cuts, bleeding gums, or an STD elevates this risk. Options for lowering the risk of HIV transmission during oral sex include using a barrier like a condom or dental dam. If a client does not want to use condoms, not allowing partners to ejaculate into the mouth offers some protection.	**Serosorting.** HIV transmission is possible only if at least one partner is HIV-positive. Some people make a practice of disclosing their own HIV status and asking potential partners about theirs. Then they make decisions about safer sex based on that information. This is called serosorting. The advantages and limitations of serosorting can be a rich topic of conversation during a counseling session.

Ask yourself: Why is it important not to make assumptions about clients' sex lives? If you're not sure, reread the last few screens.

Module 5: HIV Transmission and Prevention, Screen 12 of 18

We Return to Paolo and Greg



Now let's rejoin Paolo and Greg. As you may remember, Paolo had just summarized the discussion so far, and reflected back to Greg that he seemed to want to do something about his need to "prove a point" by topping without a condom.

What have you thought about doing, if anything?

Module 5: HIV Transmission and Prevention, Screen 13 of 18

Paolo Suggests a Referral

Greg: I've been thinking—maybe I should talk to someone, like a therapist.

Paolo: That's often helpful in a situation like this. Before you go, I can give you referrals to a couple of therapists.

Greg: Thanks.

Paolo: We still have some time before the result is ready. Would you be OK with us focusing on prevention a little more specifically?

Greg: What do you mean?

Paolo: To start, there's a question I wanted to ask you: Does drinking or other drugs play a role in whether or not you use condoms?

Greg: No, not really.

Module 5: HIV Transmission and Prevention, Screen 14 of 18

Paolo Asks Greg About Realistic Options

Paolo: OK. It's helpful to get a picture of everything that's happening.

I know you're interested in talking with a therapist. In the meantime, though, if you find yourself in a situation similar to the one that happened last month, what do you think you might do?

Greg: I guess I could try to use a condom.

Paolo: You mentioned that you use them when you bottom.

Greg: I didn't tell you everything before. If I don't use a condom as a top, guys just assume I'm into raw sex as a bottom, too. So, sometimes it goes both ways. I know, I know. I should just use condoms—or not have sex at all.

Paolo: Sometimes you don't feel you can use a condom and, at the same time, you want to protect your health.

Module 5: HIV Transmission and Prevention, Screen 15 of 18

Paolo Helps Greg Explore His Feelings

Greg: That's true. Well, there is one thing I already do. I don't let guys come inside me.

Paolo: That does lower the risk of HIV transmission. It's just that you seem to be so worried about HIV. Even though that reduces the chances, I wonder if you feel it's enough for you.

Greg: I'm not sure. Sometimes it feels too difficult to change. And, honestly, when everything goes OK, I like the feeling of raw sex. But it's sort of a death wish, isn't it? That's why I'm thinking about seeing that therapist.

Paolo: You think there's something more to this than just pleasure.

Greg: Definitely.

Paolo: I'm going to take a stab at summing up what you're saying, because I want to make sure I really get what's going on. Sometimes you use condoms, sometimes you don't. The times you don't are a mix of the "proving a point" thing and "it feels better." Either way, though, you feel that something needs to change. You're thinking about seeing a therapist, and you already make sure guys don't come inside you when you bottom. You're not sure what else you might do.

Greg: I've been thinking about switching to more oral sex. I could do that for a while.

Paolo: Switching to oral sex would decrease the chance of transmitting HIV a lot.

Greg: Because oral sex isn't such a big deal for HIV, right?

Paolo: There's still a small risk with oral sex, but it's way below bottoming or topping raw.

Module 5: HIV Transmission and Prevention, Screen 16 of 18

Paolo Offers a Couple of Risk Reduction Options

Greg: I could try that.

Paolo: That would be much safer. I have a couple of other ideas, if you're interested.

Greg: What are they?

Paolo: Using more lube can reduce tearing, in either your rectum or the other guy's.

Greg: OK. So more lube.

Paolo: Right. And getting checked out for other infections—like gonorrhea, chlamydia, and syphilis—would also help. Those diseases often don't show symptoms, but they make it easier to become infected with HIV. And they are treatable.

Module 5: HIV Transmission and Prevention, Screen 17 of 18

Paolo Summarizes Greg's Options

Greg: I haven't been checked out for other stuff in a while.

Paolo: OK, I'll give you a phone number and a Web site if you need one.

Greg: Yeah, please. Aren't my results ready yet?

Paolo: I bet they are.

Before I go look, let me just quickly review: I'm going to give you a referral to a couple of therapists and a referral for STD testing. In the meantime, you are already doing some important things to prevent HIV transmission: You don't let partners come in you when they're not wearing condoms and you sometimes use condoms when you bottom. Now you're thinking about trying more oral sex instead of anal sex and using more lube if you do have anal sex without a condom. Is that right?

Greg: Yup.

Paolo: OK. Do you have any other questions before I go check on your results?

Greg: No, I just want to know.

Paolo: OK. I'll be a few minutes.

Module 5: HIV Transmission and Prevention, Screen 18 of 18

ı-ended questions and reflections to guide Greg
ıssion about his feelings about his sexual activities
.e might want to make to prevent HIV transmission.

icited safer sex ideas from Greg, and offered
ional options only after Greg had put several
ons on the table.

ow do you think that session went? Do you think
reg will put any of his new options for safer sex
nto practice?

Module 6: HIV, Drugs, and Injection Drug Use

Module 6: HIV, Drugs, and Injection Drug Use, Screen 2 of 14

Introduction

Greg's risk for HIV transmission isn't related to drinking or drugs, but often alcohol and drug use are important factors to consider. It isn't just a question of injection drug use. For many people, drinking or using drugs influences sex in ways that elevate the risk for HIV transmission. So it's important to talk to every client about substance use.

In this module, however, we will be focusing on the basics of injection drug use.

Module 6: HIV, Drugs, and Injection Drug Use, Screen 3 of 14

The Territory of Drug Use

To be effective as an HIV test counselor, you have to feel comfortable discussing injection drug use with clients. Some of us already have lots of experience doing that. But for others, this is new territory.

The focus of this module is on harm reduction and how it can prevent the spread of HIV. Charles is a counselor who speaks eloquently about this challenge.

"I didn't realize it, but my attitude used to be: "I'm not comfortable talking about drugs, so you need to stop using them. I want our discussion to focus on things I'm comfortable talking about." Once I realized that was my attitude, I was more willing to go out of my comfort zone. I started to have equal enthusiasm for counseling about drug behavior as sexual behavior."

Module 6: HIV, Drugs, and Injection Drug Use, Screen 4 of 14

What Is Harm Reduction?

Here's how the Harm Reduction Coalition defines harm reduction:

- **Harm reduction is any effort to reduce drug-related harm to an individual, their family, or their community.**

In other words, harm reduction aims to reduce the harmful consequences of drug use without necessarily reducing someone's drug use.

Many people use substances to cope with a variety of personal and interpersonal stressors. Harm reduction interventions meet people who use drugs "where they're at" and encourage these folks to make any positive change.

Although the concept of harm reduction was developed by substance users and their counselors, the principles are applicable to many other kinds of activities. For example, Greg and Paolo's discussion of switching to more oral sex and less anal sex could be seen as an example of harm reduction.

Module 6: HIV, Drugs, and Injection Drug Use, Screen 5 of 14

Developing Harm Reduction Approaches

Here are some suggestions, adapted from the Harm Reduction Coalition and Training Institute, for working with clients on harm reduction:

- Maintain a policy of respect for all clients: Recognize and set aside judgments about drugs, drug use, and drug users.
- Focus on a client's strengths and abilities.
- Support all positive changes.
- Don't assume that all the problems in the life of someone who uses drugs are related to drug use. Let people identify and set their own priorities.
- When asked, provide accurate and honest information about the possible harms of drug use, both in general and specifically in terms of the client's life.

Ask yourself: Can you name three examples of harm reduction?
If you're not sure, reread the last few screens.

Module 6: HIV, Drugs, and Injection Drug Use, Screen 6 of 14
Basics of Injection Drug Use

As part of the discussion of harm reduction options, we want to review the basics of injection drug use and ideas for harm reduction. The activity on the following screens lets you go as fast or slow as you want, depending on your level of knowledge. Feel free to go at your own pace. Or skip around if you already know some of the information.

Keep in mind that your clients may do things differently. It is always important to ask your clients how they inject and then individualize the session to their specific situation and needs.

Module 6: HIV, Drugs, and Injection Drug Use, Screen 7 of 14
Injection Safety: Steer Your Own Course

When you click on any of the boxes below, you will see a "card" with information about that aspect of injection drug use. When you click on the grey card, the card will flip over to show harm reduction steps that reduce the risk of HIV (and hepatitis C transmission).

PHYSICAL SETTING

There is an enormous variation in where people inject drugs, from the dining room table in their home to behind a dumpster or in a public bathroom. Because the drugs they inject are illegal, clients often have little control over where they shoot up, especially if they are homeless, living in a shelter or halfway house, or trying to hide their drug use from housemates. Safety and comfort are critical factors for harm reduction. Someone who is scared, in a rush, or without access to clean water is going to have a difficult time putting harm reduction options to work.

HARM REDUCTION FOR PHYSICAL SETTING

Find a safer location for injecting.
Some characteristics to look for:

- The space is clean, dry, warm, and well lit
- The chances of getting caught by the police are minimal
- The chances of being interrupted by unwanted observers are low
- You can take as much time as you need
- There is enough space for you and your equipment
- There is access to soap and a sink

Wash surfaces and hands with soap and water before making a shot.
Wipe in one direction or in an outward moving spiral. Otherwise, you just end up spreading dirt and germs around.

Prepare for injection on a clean section of a newspaper or a center page of a pad of paper.
If soap and water aren't available, using a relatively clean surface is better than a dirty one.

SOCIAL SETTING

The social setting is an important factor for harm reduction. Injecting with other people can provide a safety net, and is especially important to reduce the risk of overdose. However, the social setting can increase the risk of HIV and hepatitis C transmission.

Some questions to consider: Does the client inject alone or in a group that remains fairly constant over time? What is the HIV and hepatitis C status of members of the group? Is the client dependent on someone else to do the injecting?

Is there a power dynamic involved? For example, is a woman client dependent on a male partner who controls the drugs and injects her?

HARM REDUCTION FOR SOCIAL SETTING

- **Learn how to prepare and safely inject drugs on your own**. Having to rely on someone else makes you vulnerable.
- **Assess your mood**. It can be hard to make good decisions if you are feeling panicked or sick. Take a few deep breaths, reconsider your plan, or try sniffing or smoking a little of your drug first.
- **Keep your own works, and expect other people to do the same.**
- **Talk about HIV and hepatitis with people you know.**
- **Watch out for other people and try to choose fellow injectors who will watch out for you.**

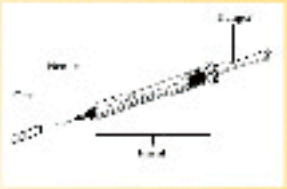
WORKS

The equipment used to inject drugs is often called "works." It usually includes following:

- A tourniquet (also called a "tie") to enlarge veins and bring them to the surface of the skin
- Water to dissolve solid drugs so they can be injected
- A spoon or bottle cap (also called a "cooker") to hold the water and drug mixture
- Ascorbic acid—vitamin C powder—to break down crack, and some kinds of heroin, into a form that will mix with water
- A source of heat—a lighter, candle, or match—to cook the drugs in water, which helps dissolve solid drugs into a liquid
- A cotton filter or some other material to filter lumps and impurities out of the liquefied drug before injecting it
- Alcohol swabs to clean hands and injection sites
- A needle and syringe to draw the dissolved drug up from the cooker and inject it
- Gauze or cloth to stop the bleeding after injection

HARM REDUCTION FOR WORKS

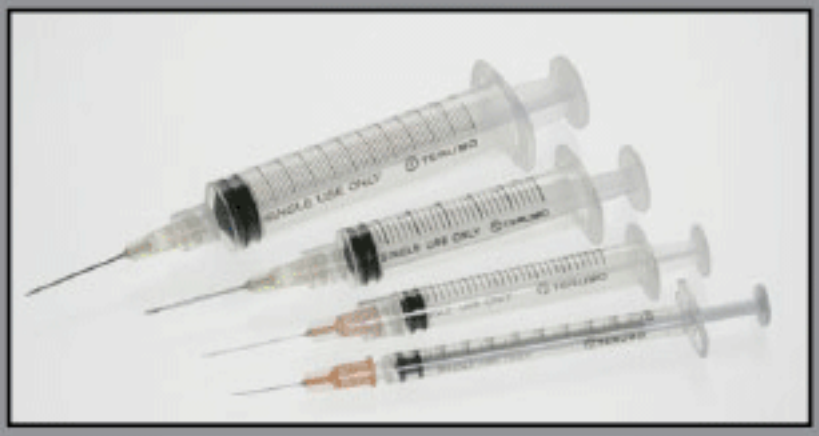
- **Use your own works.** Any part of the equipment could come in contact with blood during injection, and even a small, invisible amount of blood can transmit hepatitis B, hepatitis C, and HIV.



- **If you inject in a group, clearly label equipment** and keep it within reach to prevent sharing by mistake. One way to keep everything labeled is to buy color-coded equipment or to mark equipment with a name, a piece of tape, or a distinctive scratch mark.
- **If there is a needle exchange in your area, all of these supplies should be available there.** Call the AIDS Hotline at 1-800-367-AIDS or go to *www.aidshotline.org* to locate the closest needle exchange.
- **If you must share or reuse works, rinse syringes and cookers in cold water, fill with bleach and leave at least two minutes, then rinse with water again.** This process prevents HIV and hepatitis B transmission, but be aware: It will not necessarily kill hepatitis C. Filters cannot be cleaned.

SYRINGES AND NEEDLES

Needle size is described by "gauge": the higher the gauge number, the thinner the needle. For example, a 30-gauge needle is as thin as a thread, while a 16-gauge needle is as thick as the wire of a large paperclip. The right needle size depends on the drug being used, where on the body a person is injecting, and how the shot is prepared.



HARM REDUCTION FOR SYRINGES AND NEEDLES

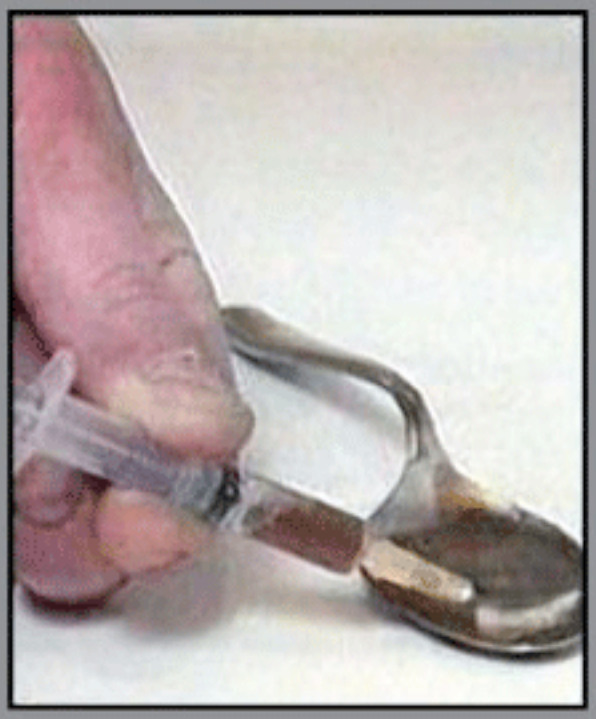
- **Use a new, sterile syringe for each shot to avoid sharing HIV, hepatitis B, hepatitis C, and other diseases.** Also, needles *may* become blunt after just one use, and blunt needles can damage your veins.

- **Find a reliable source for syringes.** If there is a needle exchange in your area, take advantage of it. You can locate the closest needle exchange by contacting the AIDS Hotline at 1-800-367-AIDS or www.aidshotline.org. If there is no needle exchange, see if you can purchase sterile syringes at drugstores in your area. If you must buy syringes on the street, clean them before using. Sometimes used syringes are repackaged and sold as "new."

- **If you must share works, bleach your equipment.** Rinse syringes and cookers in cold water, fill with bleach and leave at least two minutes, then rinse with water again. This process prevents HIV and hepatitis B transmission, but be aware: It will not necessarily kill hepatitis C.

SPLITTING DRUGS TO SHARE

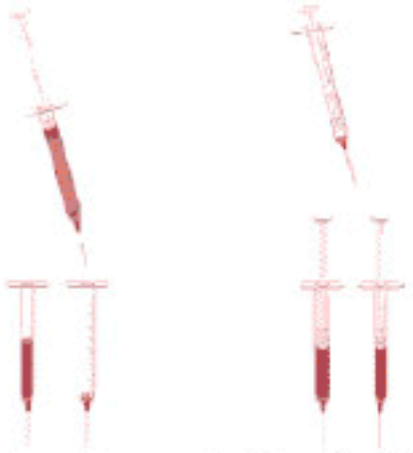
Drugs are often shared by two or more people. Frequently, the powder or solid is dissolved in water and heated in the cooker first; then individuals take turns drawing up their portion into their syringe. Unless the cooker, cotton, and all syringes are sterile, splitting wet drugs is very likely to transmit HIV, hepatitis B, and hepatitis C.



HARM REDUCTION FOR SPLITTING DRUGS TO SHARE

- **Split drugs when they're dry, not wet.** Divide the powder (cocaine), rock (crack cocaine), or tar (heroin) into separate cookers. Then each person can prepare their own drugs with their own water and equipment.
- **If you only have one set of sterile works, you can backload.** Cook the drug in a sterile cooker. Then use a sterile cotton and a sterile syringe—the designated "splitter"—to draw up equal amounts of the drug and carefully squirt it into the back of each person's syringe after the plunger has been removed.

BACKLOADING (PIGGYBACKING)



Remove the plungers from two syringes. Using a third, sterile syringe, draw up the hit and empty half into each of the syringes.

Carefully replace both plungers.

WATER

The availability of clean water is central to the safety of an injection. Water is used to:

- Clean the work surface before the drug is prepared
- Wash hands before preparing the drug, and before and after injecting
- Dissolve powdered and solid drugs so they can be injected

- Clean the skin at injection sites if alcohol is not available
- Rinse injection equipment if it is going to be reused or shared

HARM REDUCTION FOR WATER

- **Don't reuse water**. Water can transmit viruses. If you have one container of clean water, divide the water before it touches anyone's equipment.

- **Use sterile water**. You can get it at a needle exchange or buy it at a drugstore. As a next best option, boil water for 10 minutes. If sterile or boiled water is not an option, use cold tap water or other bottled water. As a last resort, use the water from a toilet tank, but never from the bowl.

COOKING DRUGS

Applying heat helps some drugs dissolve, which reduces the likelihood of injecting undissolved particles. Heat also kills some bacteria and helps prevent infections that can cause abscesses.

Liquid drugs, like hormones and injectable morphine, don't need to be "cooked." Cocaine and methamphetamines need only to be combined with water. Crack and brown heroin need, in addition to heat, to be "acidified" with ascorbic acid in order to dissolve well.

HARM REDUCTION FOR COOKING DRUGS

- **Use your own cooker and be sure that every syringe and cotton coming in contact with the cooker is sterile.** Shared cookers can transmit HIV and hepatitis C and B.
- **If you must use someone else's cooker, bleach it. First, rinse it with water.** Then fill it with bleach and let the bleach sit for at least two minutes. Then rinse with water again. This process prevents HIV and hepatitis B transmission, but be aware: It will not necessarily kill hepatitis C.
- **Use powdered ascorbic acid to help dissolve heroin or crack.** Don't use lemon juice, which can cause serious eye infections.

FILTERING

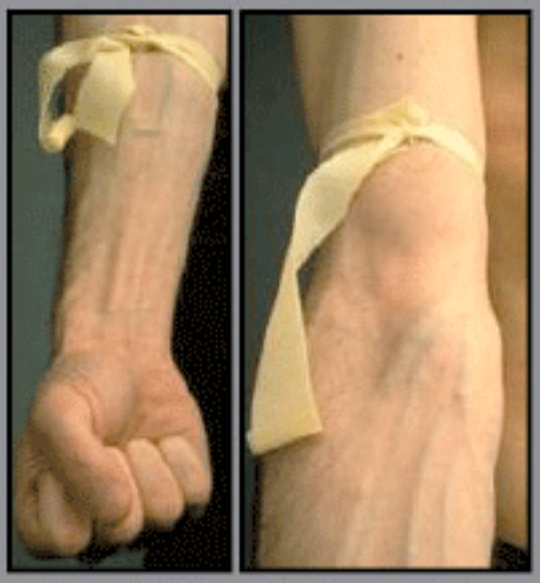
Liquefied drugs must be filtered before drawing them into the syringe to keep solid particles from clogging the needle and entering the body. The ideal filter is sterile, requires no manipulation to get it to be the right size, and has fibers that do not easily break off or carry poisons. The best filters are cotton pellets, typically available at needle exchanges. Since they are pre-sized, they don't need to be shaped by hand.

HARM REDUCTION FOR PREPARING FILTERS

- **Never share a filter or reuse an old one.** Hepatitis C can live in filters for up to four days, and bacteria can quickly grow in filters. Instead, get and keep new, clean filters in a plastic zip bag, and throw out filters immediately after using them.
- **Use filters that don't need shaping.** The filters in the bottom row of the image—a tampon, a cigarette filter, a cotton ball, and a Q-tip—all need handling to make them the right size and shape. The pre-sized filters in the top row are from a needle exchange and are ready to go. If you must shape your filter, wash your hands with soap and water before handling.
- **Don't use cigarette filters or tampons,** which may be the most dangerous of all potential filters. The fibers break off, carry small particles and poisons into the body, and can cause infections and obstructions.

CHOOSING A VEIN: INJECTION SITES

Intravenous injection ("mainlining")—injecting a drug directly into a vein—is one of the fastest ways to deliver a drug into the bloodstream. It is also the method most likely to cause an overdose. Heroin, cocaine, and amphetamines are commonly mainlined.



Usually, a tourniquet (tie) is used to make veins bigger and easier to access. People who inject drugs often have one or two favorite places to inject: veins that are easy to find and where they get a clean "hit" on the first try. But veins that are used repeatedly can become seriously infected, collapse, or scar if they don't have time to heal.

People also inject drugs into muscle ("muscling") or just beneath the skin ("skin-popping").

HARM REDUCTION FOR CHOOSING A VEIN: INJECTION SITES

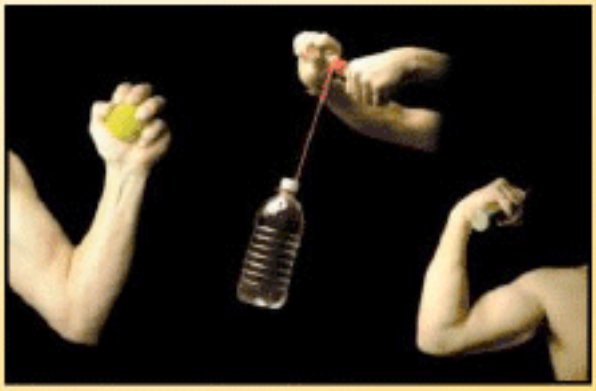
- **Learn how to safely inject drugs on your own.** Having to rely on someone else makes you vulnerable. Experienced injectors are often positive for hepatitis C (and sometimes HIV as well) and "hit doctors" frequently inject one person after another with the same works.

- **Change injection sites frequently and give your veins a chance to heal.**

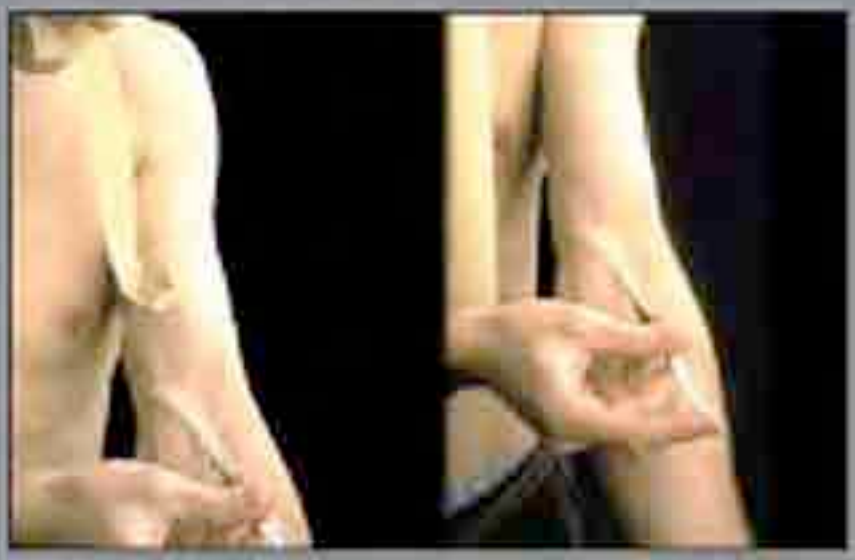
- **Once you choose an injection site, clean the skin in one direction or in a spiral.** Rubbing in a circle just pushes the dirt around; it does not remove it from the injection site.

- **Clean off an alternative patch of skin in case your first choice doesn't work.**

- **Don't muscle or skin-pop speed.** Speed (meth, methamphetamine, crank) is often cut with chemicals that are particularly hard for the body to absorb if the shot misses a vein. Muscling or skin-popping speed is extremely painful and may cause an abscess.



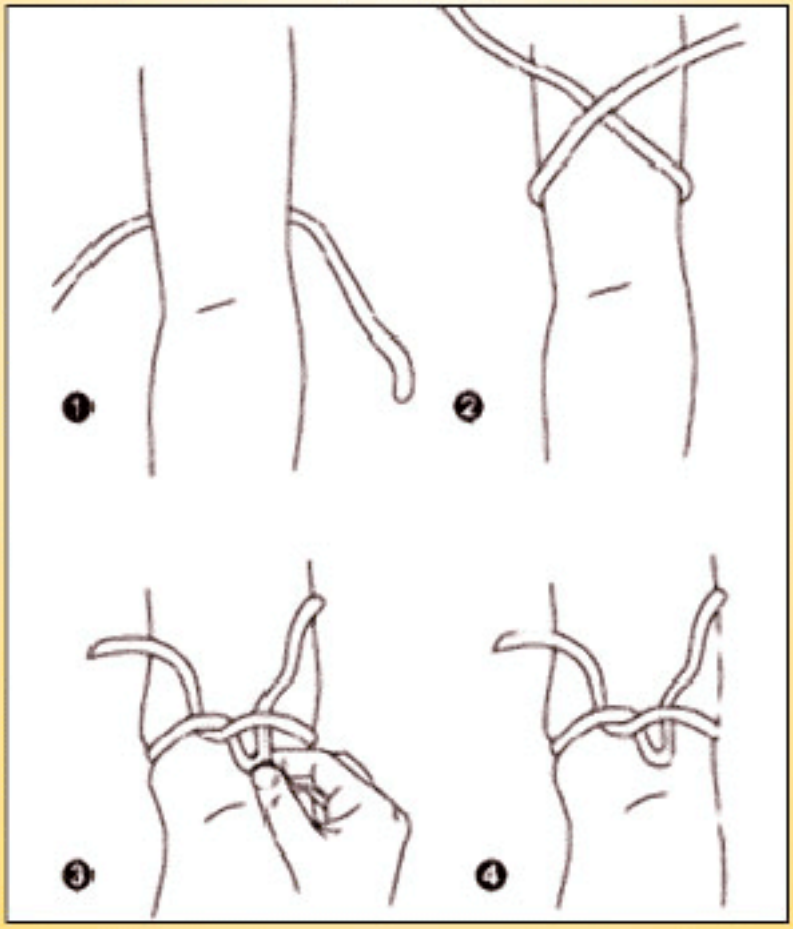
GETTING A HIT



In the picture above, the person on the left has inserted a syringe and is pulling back a little on the plunger, to see if visible blood enters the barrel. When blood appears, it indicates a register or a "hit," confirming that the needle is positioned inside a vein. On the right, the person pulls the tie with his mouth to release the tie, and then injects the drug.

HARM REDUCTION FOR GETTING A HIT

- **Tie with a slipknot so you can release it with a slight tug.** This reduces leakage of drug and blood outside the vein.
- **"Taste" the shot.** Injecting only a little bit at first enables the user to "taste" the shot—to feel its effects and stop injection or proceed based on how strong the drug is.

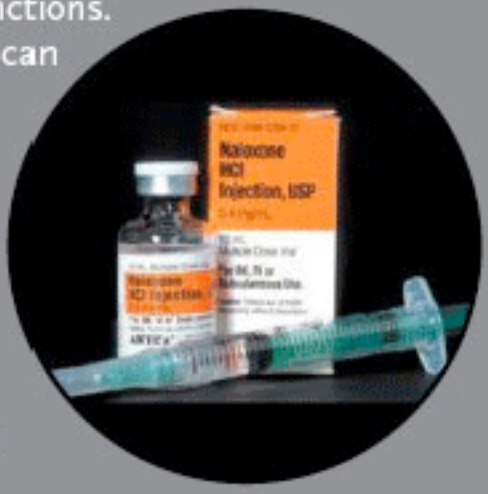


OVERDOSES

An overdose happens when a person takes more of a drug or a combination of drugs than the body can handle. The amount of a drug that causes an overdose varies, and it depends on the person's tolerance to that drug, body chemistry, the purity of the drug, and whether it's combined with other drugs.

Depressant drugs, like heroin and alcohol, slow down the body's functions. Symptoms of overdose typically include slow, shallow, or no breathing, extreme drowsiness, and unconsciousness.

Stimulant drugs such as cocaine and amphetamines speed up the body's functions. Symptoms of overdose can include cardiac arrest, seizure, disorientation, and collapse from exhaustion.



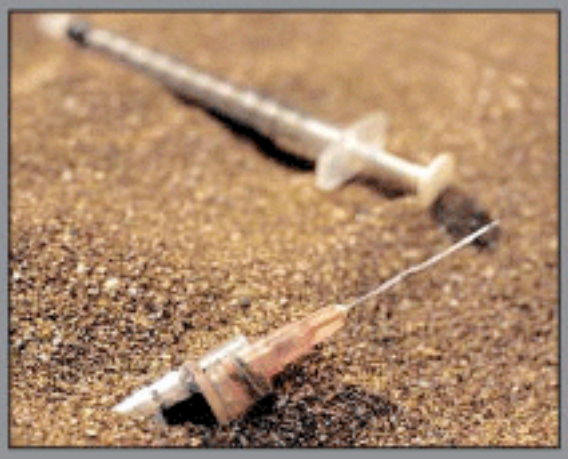
For many clients, overdose is a more pressing life threat than hepatitis C or HIV.

HARM REDUCTION FOR OVERDOSE

- **If someone has symptoms of an overdose, call 9-1-1.**
- **Check for the person's breathing.**
- **If they are breathing, put the person in the recovery position (see illustration).**
- **If they aren't breathing, try rescue breathing.** Tilt the head back, lift the chin, pinch the nose, and administer one breath every five seconds until the person starts breathing or help arrives. To learn more about rescue breathing, check out the Harm Reduction Coalition's website.
- **If the person is overdosing on heroin or another opiate, administer naloxone.** Some needle exchanges distribute naloxone and a quick training in how to use it. For more information about naloxone and training to administer it, contact the DOPE Project (Drug Overdose Prevention Project at the Harm Reduction Coalition).

DISPOSING OF USED WORKS

All used syringes should be treated as if they are potentially contaminated and should never be thrown on the ground or in the trash, or flushed down the toilet. Needle exchanges and pharmacies distribute sharps containers. Coffee tins and thick plastic containers such as empty laundry detergent bottles are good alternatives. Needle exchanges and some pharmacies accept these containers and properly dispose of them.



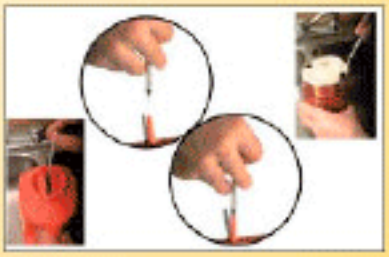
HARM REDUCTION FOR DISPOSING OF USED WORKS

- **Dispose of your works carefully**. Use a sharps container or thick plastic container with a screw-top lid. In some parts of California, people can dispose of used equipment and receive new, sterile equipment through needle exchange programs.

- **Avoid trying to recap a needle—especially a needle someone else has used.** If recapping is necessary because there isn't a sharps container, put the cap against a surface, as shown in the image below, to minimize the risk of getting stuck by it. And then label the syringe as used.

- **If you collect used needles from other people, ask them to put them in the container for you or give them to you in a puncture-proof container.**

- **Bleach equipment if you don't have access to sterile needles.** Clean needles, syringes, and cookers in cold water. Soak in bleach for at least two minutes, then rinse well with water. This process prevents HIV and hepatitis B transmission, but be aware: It will not necessarily kill hepatitis C. Cottons cannot be cleaned.



Module 6: HIV, Drugs, and Injection Drug Use, Screen 8 of 14

When Both Sex and Drugs Are Risk Factors

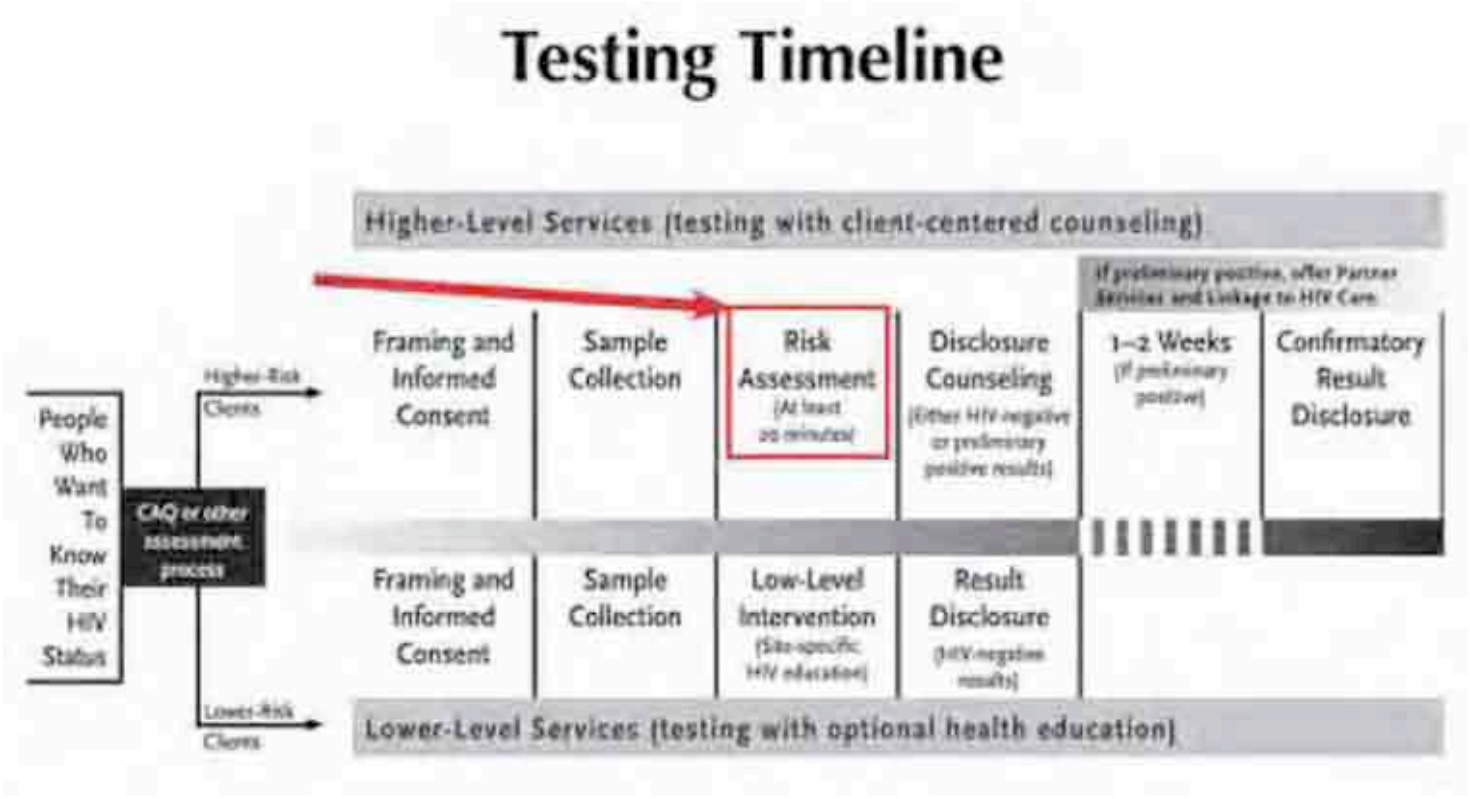
That was a lot of information, wasn't it? Don't worry. The most important aspect is feeling comfortable with harm reduction as an approach.

Now that we've explored some facts and ideas about injection drug use, let's look at how injection-related risks might come up in a counseling session.

We're going to pop in for part of a session with Ingrid and Laurie. Ingrid is a counselor at a drop-in health clinic that serves many injection drug users.

Module 6: HIV, Drugs, and Injection Drug Use, Screen 9 of 14

Ingrid Asks Laurie What She Knows About HIV Transmission



Ingrid: Laurie, I don't want to tell you things you know. So would you tell me what you already know about how HIV is transmitted from person to person?

Laurie: The basics—like you get it from sex and from sharing needles, right?

Ingrid: That's right. Can I add a little, to make sure we're on the same page?

Laurie: Sure.

Ingrid: HIV is transmitted through five fluids: blood, cum, precum—the stuff that comes out before cum, vaginal secretions, and breast milk. If you get any of those fluids into your body from someone who has HIV, you could get HIV yourself.

Laurie: That's what I thought.

Ingrid: OK. So knowing that, how might you have come into contact with the virus?

Laurie: Well, if I got it, it'd be from sex.

Ingrid: What kind of sex?

Module 6: HIV, Drugs, and Injection Drug Use, Screen 10 of 14
Ingrid Asks Laurie to Explain

Laurie: Well, I have sex with my boyfriend. Sometimes I also have sex with guys to get money. I don't really like it, but it pays the bills, if you know what I mean.

Ingrid: Tell me about that.

Laurie: Well, dope is expensive. When me and my boyfriend are desperate, I'll give a hand job or a blow job for 20 bucks. But I don't let them go inside me. I only do that with my boyfriend.

Ingrid: So you don't let guys go inside your vagina or ass, if I understand you right.

Laurie: That's right.

Ingrid: How do you and your boyfriend feel about condoms?

Laurie: He's not into using condoms. But I tell him not to come inside me and usually he doesn't.

Ingrid: Not coming inside does lower the risk for HIV. Not as much as condoms, though. Has your boyfriend been tested for HIV?

Module 6: HIV, Drugs, and Injection Drug Use, Screen 11 of 14
Ingrid Uses Open-Ended Questions

Laurie: He tested last week because they were giving out vouchers. He tested negative, so that was a relief.

Ingrid: You mentioned earlier that you and your boyfriend use dope. Can you tell me about that? What do you use and how do you use it? That kind of thing.

Laurie: Different stuff, but I guess what you're asking about is heroin. We shoot up, but mostly it's just him and me.

Ingrid: Tell me more about that.

Laurie: I got into it about a year ago when I met him. He fixes me first, then shoots up afterward.

Ingrid: Using the same syringe?

Module 6: HIV, Drugs, and Injection Drug Use, Screen 12 of 14

Ingrid Asks for Clarification

Laurie: Sometimes. We don't do that if we can get to a needle exchange, but since we travel, it's hard to get to a good exchange.

Ingrid: Are there other people, too?

Laurie: Basically just him. I mean we've shot up with other people sometimes, but he and I keep our stuff together. We don't share.

Ingrid: Meaning you don't share needles, cookers, cottons, or anything else except with your boyfriend?

Laurie: I guess sometimes when we've been high—but not usually.

Ask yourself: What is a harm reduction step Laurie could take to reduce her HIV risk?
If you're not sure, reread screens 7–12.

Module 6: HIV, Drugs, and Injection Drug Use, Screen 13 of 14

Ingrid Considers What She Has Learned

Ingrid has learned a lot about Laurie. She knows that some of Laurie's activities put her at high risk for HIV transmission. She has also learned that Laurie is doing some important things to protect herself.

Let's sneak a look at what Ingrid is thinking right now:

Module 6: HIV, Drugs, and Injection Drug Use, Screen 14 of 14

Conclusion

Ingrid has some great ideas for options that would reduce Laurie risks—everything from more lube during intercourse to urging L to learn how to inject herself to brainstorming ways to increase Laurie's use of the needle exchange.

But Ingrid knows that making one suggestion after another probably won't work. She's tried that before. Clients usually say "Yes, but …" and then explain why that option won't work for them. Both Ingrid and her client end up feeling frustrated. Ingrid knows that lecturing Laurie or trying to scare her won't work either.

What will work?

In the next module, we're going to explore the Stages of Change Understanding those stages will help Ingrid have a supportive an effective discussion with Laurie about changes she might want t make.

Module 7: The Stages of Change and Risk Reduction Steps

Module 7: The Stages of Change and Risk Reductio
Screen 2 of 11
Introduction

Have you ever tried to stop smoking, lose weight, get more exercise, or stop nagging your children? If you have ever tried make a major change in your behavior, you know how hard it i

You probably went through several stages, starting with not wanting to change at all. Maybe later you considered the pros and cons of changing for a long time. Perhaps you had a few unsuccessful attempts before you succeeded in making a change, or maybe you're still thinking about whether you want to try.

That's totally normal. Two researchers, James Prochaska and Carlo DiClemente, discovered that there is a series of Stages o Change that almost everyone goes through when faced with changing an ingrained behavior.

As HIV test counselors, understanding the Stages of Change can be important. The more we adapt our discussion with a client to the client's stage, the more likely we are to be effective. Let's look at those stages.

Module 7: The Stages of Change and Risk Reduction Steps, Screen 3 of 11

The Stages of Change

According to Prochaska and DiClemente, there are five stages of change:

- **Precontemplation**
- **Contemplation**
- **Preparation (Ready for Action)**
- **Action**
- **Maintenance**

On the following screens, we'll look at each stage one at a time.

Module 7: The Stages of Change and Risk Reduction Steps, Screen 4 of 11

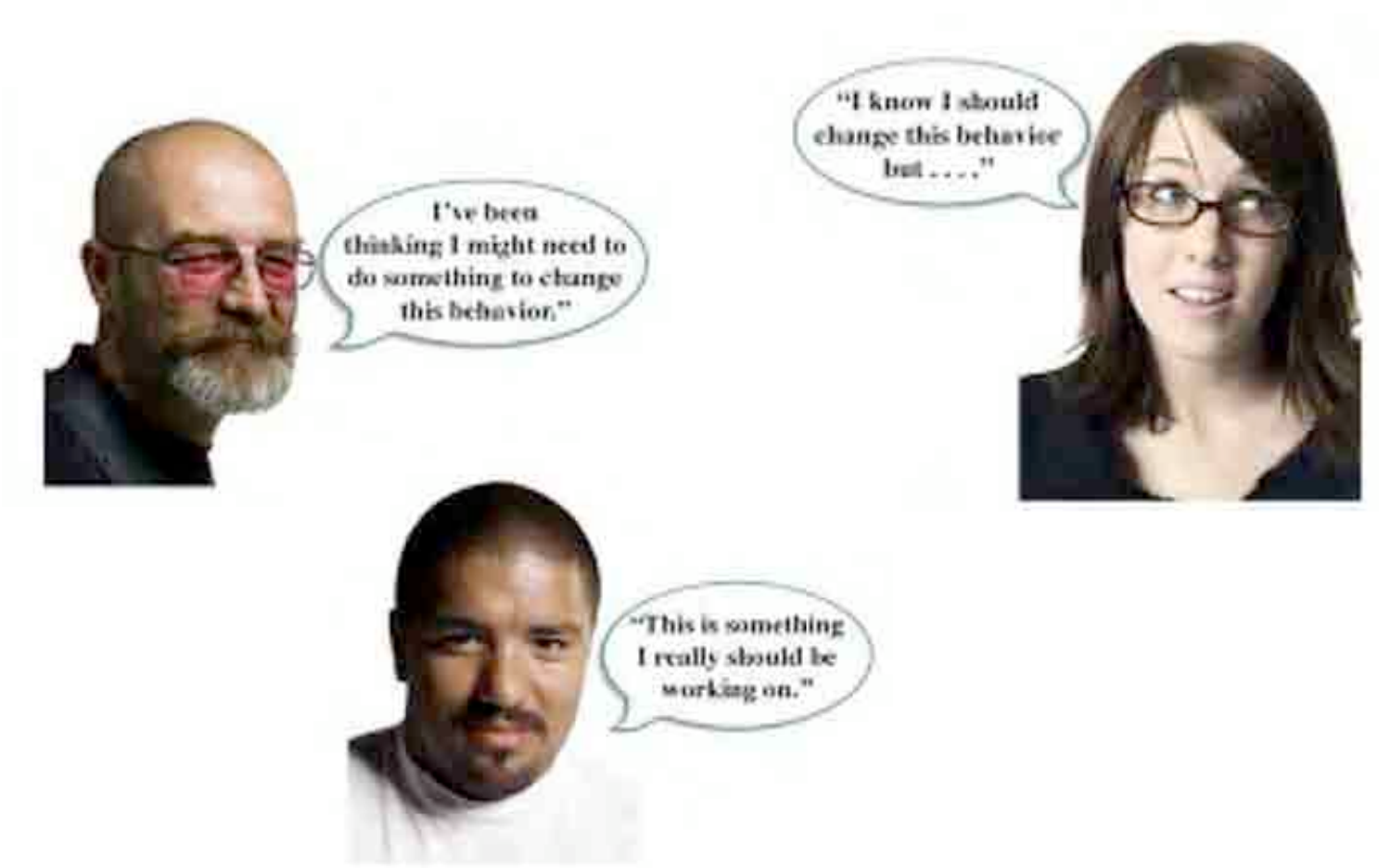
Precontemplation

Prochaska and DiClemente's research classified people as precontemplative if they had no serious intention to change the problem behavior. People in this stage are often unaware of the problems presented by their behavior--they are not having difficulty in finding solutions, but instead in seeing that a problem exists in the first place. People in the precontemplation stage often seek social services or HIV counseling because of external pressures, for example, from family members, the courts, and employers.

Module 7: The Stages of Change and Risk Reduction Steps, Screen 5 of 11

Contemplation

During the contemplation stage, a person recognizes that a problem exists and is seriously thinking about changing a behavior, but has not yet committed him or herself to taking action. Prochaska and DiClemente's research classified people as contemplative if they indicated they were seriously considering changing their behavior within the next six months.



In one of Prochaska and DiClemente's studies of smokers, the most common outcome among 200 contemplators was no progression to the next stage of change over the two years of the study. The contemplation stage can last for long periods of time. The person in this stage knows where he or she wants to go but is not ready to do what is necessary to get there. Contemplators spend considerable effort weighing the pros and cons of the problem and its solutions. The hallmark of this stage is the serious consideration of change without adequate motivation to endure the effort of change and sustain the loss that change requires.

Module 7: The Stages of Change and Risk Reduction Steps, Screen 6 of 11

Preparation

During the preparation stage, a person brings together the intention to change and the preliminary behavioral efforts to make the change. Prochaska and DiClemente's research classified people as preparing if they intended to take action within the next month or had unsuccessfully taken action in the past year.

Preparation might include, for example, someone who wants to stop smoking and has actually cut back the number of cigarettes he or she smokes each day. It might also include someone who had quit completely smoking for two months, relapsed and started smoking again, and intends to quit again within a month.

Module 7: The Stages of Change and Risk Reduction Steps, Screen 7 of 11

Action

During the action stage, a person makes adaptations in order to change his or her attitudes, behaviors, or environment. Prochaska and DiClemente's research classified people in the acting stage if they had successfully altered their behavior for a period ranging from one day to six months. The researchers defined "success" using criteria such as complete abstinence from smoking or drug use. The action stage demands considerable time and energy and is notable for overt and visible changes in behavior.

While action can be a dramatic and rewarding stage, merely acting is not the same as successfully achieving and maintaining behavior change. In addition, people in the action stage are particularly susceptible to relapse to an earlier stage: for example, an individual may give up heroin use completely for three months and then use again; or someone may have been consistent about using a condom for every act of anal intercourse for a month and then may slip and have unsafe sex.

Module 7: The Stages of Change and Risk Reductio Screen 8 of 11

Maintenance

During the maintenance stage, a person's efforts focus on susta change in behavior, preventing relapse to the behavior, and consolidating the gains of the action stage. Prochaska and DiClemente's research classified people as "maintaining" if th had successfully sustained their behavior change for six month or longer.

Maintenance was once considered static, as represented by the statement, "Once you're there, you've arrived." It is now viewed as the continuation of change, rather than its absence, as represented by the statement, "Once you're there, there is st plenty of work to do." Relapse to an earlier stage is always possible.

Module 7: The Stages of Change and Risk Reduction Steps, Screen 9 of 11

Matching Interventions to Stages

The following table illustrates the kinds of interventions that may be most effective for clients in each stage of behavior change. To find more information on the stages of change, including examples of interventions and information on eliciting self-motivational statements, go to the following article: **Harm Reduction and Motivational Interviewing**

STAGING AND INTERVENTIONS GRID

STAGE OF READINESS TO CHANGE	OVERALL STRATEGY OR APPROACH
Precontemplative (PC) Unaware — Doesn't see it. Denial — No!	Get a reaction, either cognitive or emotional. Help them think about it!
Contemplative (C) Ambivalence — maybe? Unsure — Sees it, but	Explore pros and cons. Help to weigh pro side. What are their barriers?
Ready for Action (RFA) Decided — Yes!	Encourage. Empower. Coaching — teach skills. Focus on developing a step. Solve it!
Action (A) Doing it!	Support — Praise and Recognition. Focus on rewards. Problem-solving. Do it!
Maintenance (M) Living it!	Support — Praise and Recognition. Find other supports. Become a role model to others. Live it!

Ask yourself: Why won't suggesting a risk reduction option help a client who is contemplative? If you're not sure, reread the last few screens.

Module 7: The Stages of Change and Risk Reduction Steps, Screen 10 of 11

Precontemplative and Contemplative—Practice Exercise

While it is important to be familiar with each of the stages of change, research has shown that 85 percent of people who come in to test at California state-funded HIV test sites are in either the pre-contemplative or the contemplative stage. Sometimes it can be difficult to tell the difference between these two stages, but it is important to understand the difference, since the interventions will be very different for each stage.

Read the statements below in the left column, then click and drag the statement to the column you feel is the appropriate state of change. If you dragged the statement to the correct column, then you'll get the thumbs up. If incorrect, you'll get a thumbs down. Either way, you will see the correct answer on the far right with the reason why it is either precontemplative or contemplative.

Don’t worry: there are no grades for this game. I just want you to feel comfortable with understanding the differences between the two stages.

Module 7: The Stages of Change and Risk Reduction Steps, Screen 11 of 11

Conclusion

How does what we learned about the Stages of Chang Laurie and Ingrid? Laurie is doing at least two things at risk for HIV transmission: She's having unprotecte intercourse with her boyfriend, who is in the window she's sharing needles and works with him and someti other people, too, when they can't get to the needle exchange.

Ingrid needs to use open-ended questions to find out how Laurie feels about changing either of these situations. If Laurie is precontemplative, it won't do any good for Ingrid to offer lots of good options, because Laurie won't be interested in changing.

If Laurie is contemplative, helping her think about th pros and cons of changing—in a nonjudgmental way- could be supportive and effective.

If Laurie is in the preparation stage, then Ingrid migh to find out if Laurie has ideas for how she could chan and whether Laurie is interested in more options.

In the next module, we'll see more of Ingrid and Lau counseling session.

Module 8: Preparation for Test Results

Module 8: Preparation for Test Results , Screen 2 of 9

Introduction

We have watched Ingrid do some effective counseling:

- Ingrid helped Laurie feel safe enough to share experiences that put her at risk for HIV transmission.
- Ingrid explored the context of Laurie's HIV transmission risk as well as specific activities.

While we were learning about the Stages of Change, Ingrid used open-ended questions and her understanding of the Stages of Change to help Laurie think about changes she might want to make to prevent HIV transmission.

Laurie decided she is ready to have a conversation with her boyfriend about using condoms. On the other hand, she is not sure she wants to cl about how she and her boyfriend use heroin. She's going tc that more.

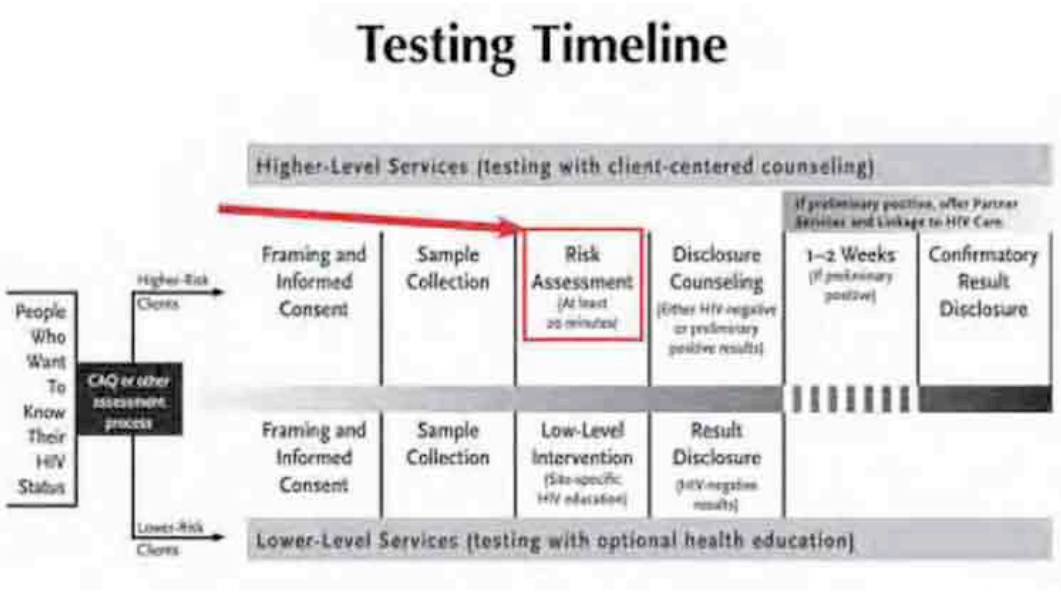
Before she goes to retrieve Laurie's test results, Ingrid nee sure that Laurie understands what the results will mean. Th explaining:

- The window period.
- The meaning of a negative test result.
- The meaning of a preliminary positive test result.

Let's watch her do that in the next few screens.

Module 8: Preparation for Test Results , Screen 3 of 9

Ingrid Summarizes Laurie's Talk About Change



Ingrid: Laurie, I want to review what I heard. Please tell me if I missed anything. You are already doing important things to protect yourself from HIV: When you have sex for money, you don't have intercourse, just blow jobs and hand jobs. Your boyfriend doesn't like condoms, but you try to get him to withdraw before he comes. In terms of shooting up, you and your boyfriend get clean works at the needle exchange when you can, and he injects you first. You don't share needles or works with people besides him.

Now you're thinking you might want to do even more. You want to talk with your boyfriend about using condoms. And you're not sure, you need to think about it more, but you might be willing to consider changing how you shoot up. Is that right? Did I miss anything?

Laurie: That's right. I don't want HIV, that's for sure. But I think I'm gonna be negative. My boyfriend tested negative last week, so that must mean I don't have anything either.

Ingrid: It's more complicated than that. Can I explain what I mean?

Module 8: Preparation for Test Results , Screen 4 of 9

Ingrid Explains HIV Antibodies

Laurie: OK.

Ingrid: Stop me if I'm saying stuff you already know. When HIV infects someone's body, the body tries to fight it off by building antibodies, kind of like soldiers that try to fight off HIV.

Laurie: Yeah, I remember hearing something about this.

Ingrid: What do you remember?

Laurie: That those antibodies can't fight HIV all that well, which is why people get sick.

Ingrid: That's right. The rapid test is looking for these antibodies. It's looking for the body's reaction to HIV. But it takes a while for the body to build up enough antibodies so that they will show up on the test.

Ask yourself: What is an antibody?
If you're not sure, reread the last few screens.

Module 8: Preparation for Test Results , Screen 5 of 9

HIV Antibodies and the Window Period

Ingrid: Here's something really important: If the test finds antibodies, that person very likely has HIV.

If the test doesn't find antibodies, it means either that person doesn't have HIV or that it just hasn't been long enough since the person got infected for those antibodies to have accumulated enough to show up.

Laurie: Wait a second. Does that mean my boyfriend could have HIV even though he tested negative?

Ingrid: That's true.

Laurie: Really?

Ingrid: That's the important part: Just because he tested negative last week doesn't mean he doesn't have HIV. Or that you don't. This is a lot to hear. How do you feel about this?

Laurie: Like I need to call my boyfriend right now. If this test can't find the antibodies, then what's the point?

Ingrid: The test is actually really good at finding antibodies. If someone has HIV, then the antibodies will eventually show up on a test. They may show up as early as two weeks after someone gets infected, but people often take longer to develop detectable antibodies. Many people with HIV show the antibodies at the end of three months. The longest it would take is six months.

Laurie: I think I follow you, but I'm not sure.

Module 8: Preparation for Test Results , Screen 6 of 9

The Window Period

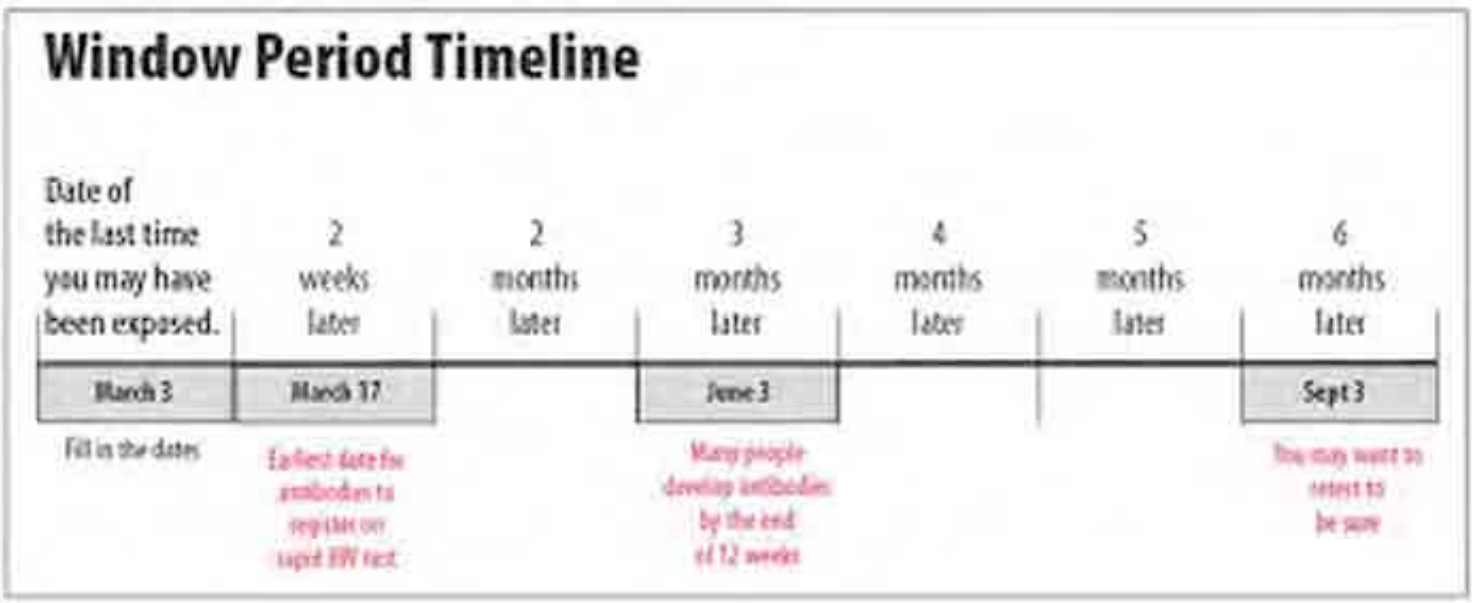
Ingrid: Let's use this diagram. Sometimes it helps me understand something better if I see it. When was the last time you got someone else's blood, cum, precum, or vaginal secretions into your body?

Laurie: Uh, we're talking precum. So last night.

Ingrid: OK. Let's fill this out. Today is March 4, so that would be March 3.

Ingrid: So if by any chance you got HIV last night, then the earliest you'd test positive would be in two weeks—March 17—but it could take as long as three months—June 3—or even six months—September 3. To be absolutely sure about last night, you'd need to retest around September 3.

The period of time between when someone gets HIV and when the antibodies show up on the test is called the window period. It's called that because that is the period when the window is open for antibodies to develop and accumulate enough to be detected by the test.



Module 8: Preparation for Test Results , Screen 7 of 9

Why Test Now?

Laurie: Then what's the point of me testing today?

Ingrid: It does tell you something important. If the test comes back negative today, that means that up until six months ago, you didn't get HIV. And since your boyfriend tested negative last week, that means that up until six months ago, he didn't have HIV either.

Laurie: Yeah, so?

Ingrid: It's possible that you or he could have HIV but still test negative for a few more months. That means you could pass HIV on to one another, even after testing negative, unless you protect yourselves.

There could be a silver lining to the window period. Maybe when you and your boyfriend are talking about some of the ideas you mentioned for lowering the chance of HIV transmission, you could decide to try them out for the six months of the window period. Then, at the end of six months, it might help you decide what to do next.

Laurie: Yeah, but I can't see him going for that.

Ask yourself: What's the earliest antibodies might show up on a test? What's the longest? If you're not sure, reread the last few screens.

Module 8: Preparation for Test Results , Screen 8 of 9

Review of Negative and Preliminary Positive Results

Ingrid: That's definitely up to the two of you. Before I go get your results, I want to review what I told you about the possible results. OK?

Laurie: I already know. Negative means I don't have HIV, at least I don't have the antibodies showing today. Positive means I've got it.

Ingrid: That's basically it. A negative result would mean either you don't have HIV, or you're in the window period and your body hasn't yet manufactured enough HIV antibodies to show up on the test.

A preliminary positive result would mean that you very likely are infected with HIV. To be absolutely sure, we would ask for a blood sample to send to the lab and we'd ask you to return in a week for final results.

How are you feeling about all this?

Laurie: I get it. I'm pretty much talked out. I just want my results.

Ingrid: I understand. (Ingrid glances at CIF form). I just need to ask one or two quick questions for my paperwork, and then I'll go get those results for you. Would that be OK?

Ask yourself: What does a negative test result mean? What does a preliminary positive test result mean?
If you're not sure, reread the last few screens.

Module 8: Preparation for Test Results , Screen 9 of 9

Conclusion

When Ingrid looks at the CIF form, she realizes that there are only tv three questions that she needs to ask Ingrid directly. Answers to mos of the questions emerged naturally during their discussion. So Ingrid is just about done with the Risk Assessment section of the session.

There are only a few remaining steps:

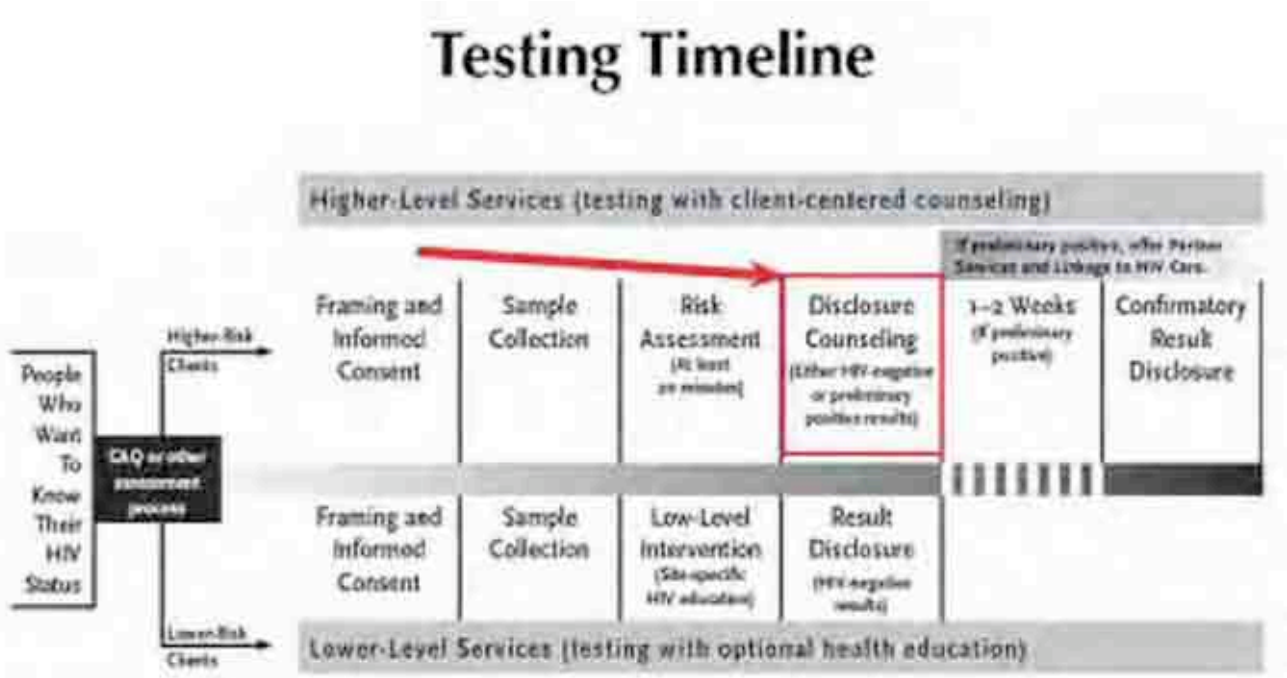
Ask any remaining questions from the CIF.
Ask if the client has questions before you retrieve the results.

Tell the client you will be gone a few minutes so the client won't needlessly worry about how long you are gone.

Go retrieve the results.

Module 9:
Disclosing Negative Test Results

Module 9: Disclosing Negative Test Results, Screen 2 of 11
Introduction



In this module, we'll watch Paolo deliver a negative HIV test result. Thinl of this as a preview of the face-to-face Basic Counselor Skills Training, which will include a significant focus on delivering test results. There, yo will watch an experienced counselor disclose negative and preliminary positive test results. You will learn about the components of the disclosure sessions and have a chance to practice both negative and preliminary positive test disclosures.

Most new HIV test counselors worry about delivering preliminary positive results. That is totally normal. We will have a chance to discuss this in the Basic Counselor Skills Training. But remember that the overwhelming majority of test results you deliver will be HIV-negative. A negative disclosure session is an important opportunity to work with yo client on HIV prevention.

Module 9: Disclosing Negative Test Results, Screen 3 of
Goals of HIV-Negative Disclosure Session

Here are the basic elements of a HIV-negative disclosure session:

- Make sure the client is ready to hear the results.
- Share the results.
- Allow the client to react to the results.
- Make sure the client understands the results.
- Support the client in processing thoughts and feelings.
- Review behavior change decisions and plans (if any) from the Risk Assessment.
- Make referrals if needed.

Module 9: Disclosing Negative Test Results, Screen 4 of 11
Paolo Gives Greg His Test Results

Let's see what that looks like by joining Paolo and Greg as Paolo returns to the counseling room with the test result.

Paolo: OK, Greg, let's match up the numbers: 7-5-3-4-2-1-0. They're the same.

Your result is negative.

Module 9: Disclosing Negative Test Results, Screen 5 of 11
Greg Hears His Test Result

Greg listens to this test result. To see his reaction go to the next screen.

Module 9: Disclosing Negative Test Results, Screen 6 of 11
Greg Reacts

Greg: OK—

Paolo: You look … surprised.

Greg: I am. I expected—

Paolo: —a different result.

Greg: Yeah. I mean, I'm relieved, but it might be easier just to know already.

Paolo: [Pauses]

Greg: I still need another test in a few months.

Paolo: That's right.

Module 9: Disclosing Negative Test Results, Screen 7 of 11

Paolo Reflects Greg's Feelings

Greg: I think it's going to be positive next time.

Paolo: You sound convinced.

Greg: I've been lucky so many times before. I'm worried that my luck is going to run out.

Paolo: It's a lot to be carrying this feeling that you're eventually going to get HIV.

Greg: I really don't want to get it.

Paolo: And it's complicated.

Greg: Yeah.

Paolo: Can I go out on a limb and suggest something?

Greg: Yeah. What is it?

Module 9: Disclosing Negative Test Results, Screen 8 of 11

Paolo Summarizes Greg's Talk About Change

Paolo: You said some things today that clearly communicate a drive for things to be different, to make a change. You're interested in seeing a therapist to work through how you want to respond when someone stereotypes you as a bottom. In the meantime, you're thinking about trying more oral and less anal sex—and more lube if you do have anal sex without a condom. And you mentioned getting checked out for STDs.

Do I have this right?

Greg: Yeah. But now it feels like a lot to tackle.

Paolo: How do you feel about that?

Module 9: Disclosing Negative Test Results, Screen 9 of 11

Paolo Offers Referrals

Greg: Kind of overwhelmed, but when you play it back like you did, it does sound like I don't want to get sick.

Paolo: I was just repeating what you said earlier. It's your own internal pep talk.

Greg: I guess you're right. And I do want to talk to a therapist.

Paolo. Here are numbers for two therapists. If neither of these works out for any reason, call us back at this number on my card and we'll help you find someone else. And here's the information on STD testing, if that's something you want.

Do you have any more questions or anything you'd like to add?

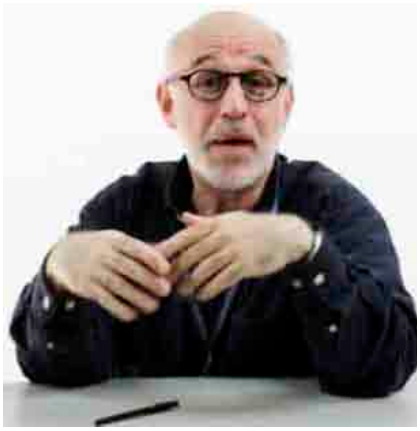
Greg: No. I'm good. Thanks a lot.

Module 9: Disclosing Negative Test Results, Screen 10 of 11

Paolo and Greg Reflect on the Session

Let's see how Greg and Paolo are feeling about the session:

Greg: That was okay. It was hard to say that stuff about sex out loud, but I feel better now that I did. Paolo was pretty easy to talk to. I'm going to call one of those therapists this afternoon before I lose my nerve.



Paolo: It upsets me when clients wish they were positive. I have to work hard to stay neutral and let them say how they feel. I think I did okay with that this time. I should have asked Greg to summarize the changes he decided to make before I jumped in. I'm going to work on that next time.

Module 9: Disclosing Negative Test Results, Screen 11 of 11

Conclusion

nber: this was just a first look at a negative disclosure session. You'll learn › during the Basic Counselor Skills Training. As we mentioned in the nning of this module, you will have a chance to watch and practice both ative and preliminary positive disclosure sessions.

Module 10: Conclusion

Module 10: Conclusion, Screen 2 of 5

HIV Test Counselor Basic Training

Thank you for all your hard work. We have covered a lot of material in this online pretraining course. By now you are well prepared for the Basic Counselor Skills Training.

The Basic Counselor Skills Training is an intense, hands-on learning experience. It includes opportunities to discuss counseling issues and practice skills. You will watch experienced counselors model the Risk Assessment and Disclosure portions of the HIV counseling session. You will have opportunities to practice specific sections of the counseling session and to get feedback. You will be trained and certified to administer and read the OraQuick ADVANCE Rapid HIV-1/HIV-2 Antibody Test.

This online training has given you the background to be a knowledgeable and engaged participant in the live training. We hope you feel confident and committed to participating actively in that training. It will help you be an effective HIV test counselor.

Module 10: Conclusion, Screen 3 of 5

What We Learned

Before we get to the final Mastery Test, let's take a look back at the objectives of this course. If you're not sure about any of the topics, use the links to go back and review.

Objectives

- Explain the rationale and goals of HIV test counseling **[Module 1]**
- Describe each of the components of informed consent **[Module 2, Screens 4 and 12]**
- Explain rapid testing **[Module 2, Screens 6–7]**
- Explain basic information about the OraQuick test and know where to find more detailed information **[Module 2, Screens 13–14]**
- Define the General Principles of HIV test counseling:
    - Client-centered counseling **[Module 3, Screen 5–6]**
    - Context **[Module 3, Screen 7]**
    - Individualized sessions **[Module 3, Screen 8]**
    - Information alone doesn't change behavior **[Module 3, Screen 9]**
    - Neutral stance **[Module 3, Screen 10]**
    - Limited role **[Module 3, Screen 11]**
- Explain how HIV is transmitted and how to prevent transmission **[Module 5, Screens 2–5, 11]**
- Demonstrate a basic understanding of the range of human sexuality and its relationship to HIV transmission **[Module 5, Screens 6–10]**
- Define harm reduction in relation to HIV transmission **[Module 6, Screens 4–5]**
- Demonstrate a basic understanding of injection drug use and its relationship to HIV transmission **[Module 6, Screen 7]**
- List a variety of harm reduction options **[Module 5, Screen 11; Module 6, Screen 7]**
- Demonstrate a basic understanding of the Stages of Change and the implications for HIV test counseling **[Module 7, Screens 3–10]**
- Explain the window period **[Module 8, Screen 4–8]** |
- Explain the meaning of negative, preliminary positive, and positive HIV test results. **[Module 2, Screen 7; Module 2, Screen 14; Module 8, Screens 5–9; Module 9, Screen 3]**

Module 10: Conclusion, Screen 4 of 5

References and Resources

This is a list of the most important links and images from the Online BCIT. In addition to the links here, you'll find even more information in our Online Resources. Thanks for going through the Online BCIT.

See you in the live training, the Basic Counseling Skills Training!

Module 1: What is HIV Test Counseling? Why Is it Important?

4. Frequently Asked Questions in HIV Counseling and Testing
5. Comparing Health Education with Client-Centered Counseling

Module 2: Informed Consent

The OraQuick ADVANCE Rapid HIV Test
Informed Consent

Module 5: HIV Transmission and Prevention

Continuum of Risk for Sexual Transmission of HIV
Sexually Transmitted Diseases and HIV link
Sexuality CET

Module 6: HIV, Drugs, and Injection Drug Use

Injection Safety: Steer Your Own Course

Module 7: The Stages of Change and Risk Reduction Steps

Stages of Change
Matching Interventions to Stages
Understanding the Stages of Change
Harm Reduction and Motivational Interviewing

Module 10: Conclusion, Screen 5 of 5

Concluding the Training

You have now completed the training and are ready for your Course Mastery Test. This test will reflect important information you have learned throughout this training. You must score at least 80 percent on this test to be eligible to take the Basic Counselor Skills Training. If you do not achieve this score, you will see only the questions you answered incorrectly and we will give you the chance to review that information. Then you can retake the test. Completing the quiz digitally is highly preferred. But if for some reason you cannot do so please email us at ahptrainings@ucsf.edu and we will send you a PDF version of the quiz to print.

Contact Us

If you have any questions about anything in the course or the course process, please feel free to contact us. Here are a few different contacts to help you with specific types of problems.

For general questions contact:
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Web Site: www.ucsf-ahp.org
Now that you have read all this technical information, we are ready to start the training.