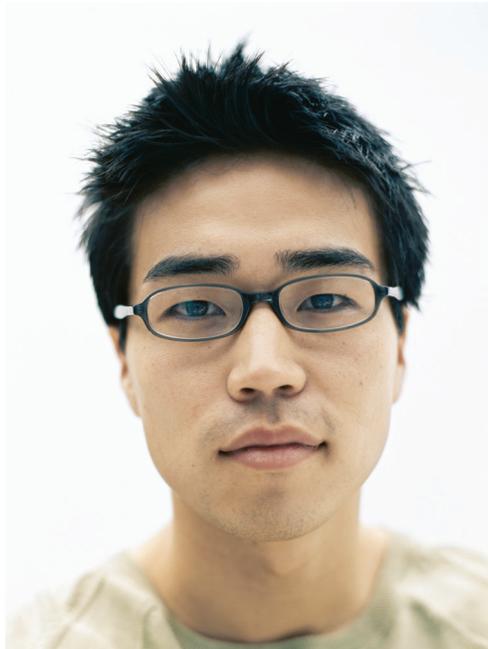
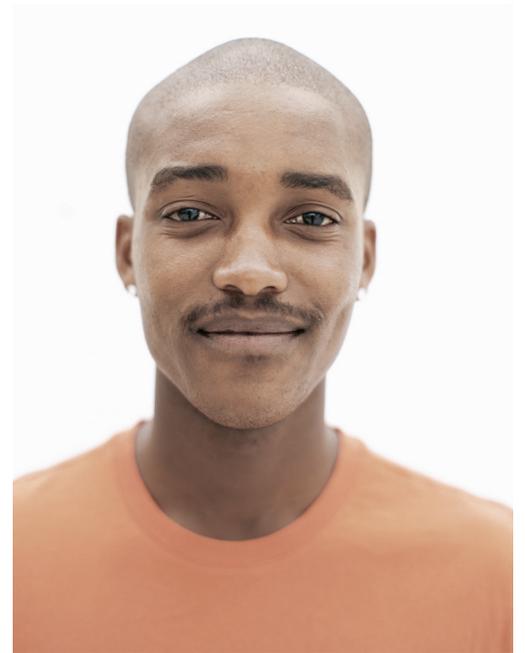


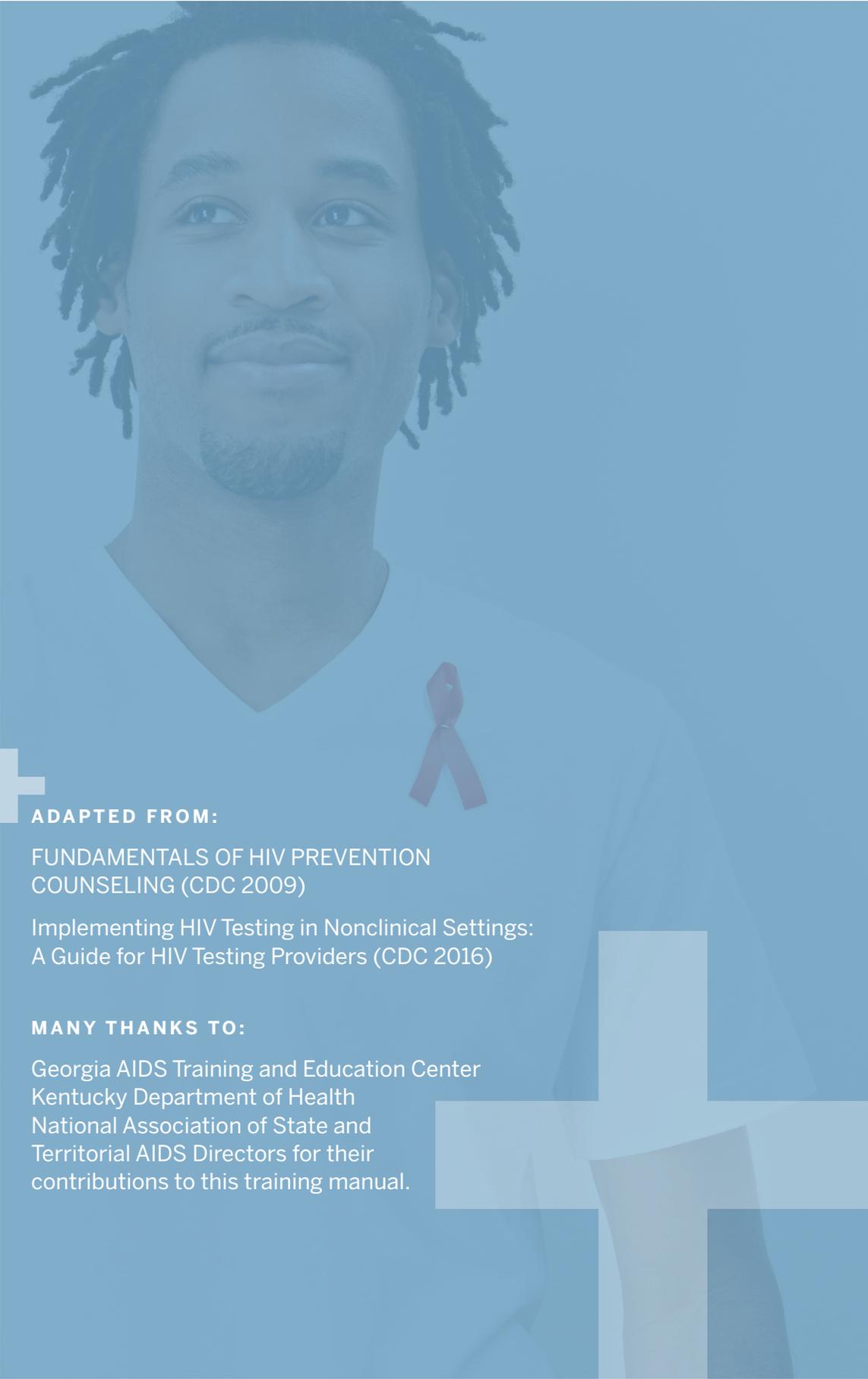


TRAINING MANUAL

Rapid HIV Testing Protocols and Quality Control

Georgia Department of Public Health
Division of Health Protection
Office of HIV/AIDS
HIV Prevention Unit



A man with dreadlocks and a goatee, wearing a white V-neck shirt with a red AIDS awareness ribbon pinned to it. The image is overlaid with a semi-transparent blue filter. On the left side, there are three light blue rectangular shapes of varying sizes, and on the right side, there is a large, light blue cross shape.

ADAPTED FROM:

FUNDAMENTALS OF HIV PREVENTION
COUNSELING (CDC 2009)

Implementing HIV Testing in Nonclinical Settings:
A Guide for HIV Testing Providers (CDC 2016)

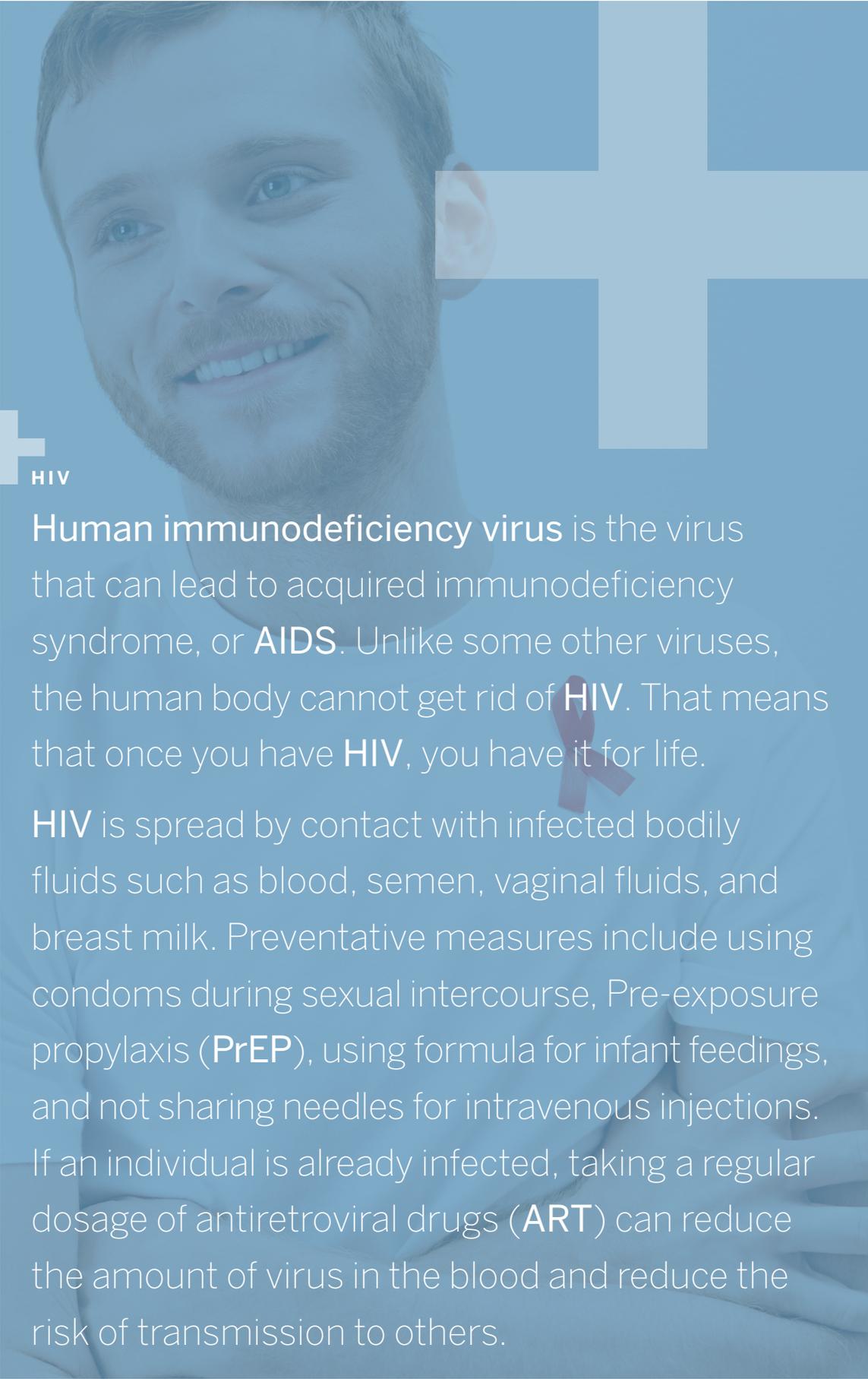
MANY THANKS TO:

Georgia AIDS Training and Education Center
Kentucky Department of Health
National Association of State and
Territorial AIDS Directors for their
contributions to this training manual.



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HIV

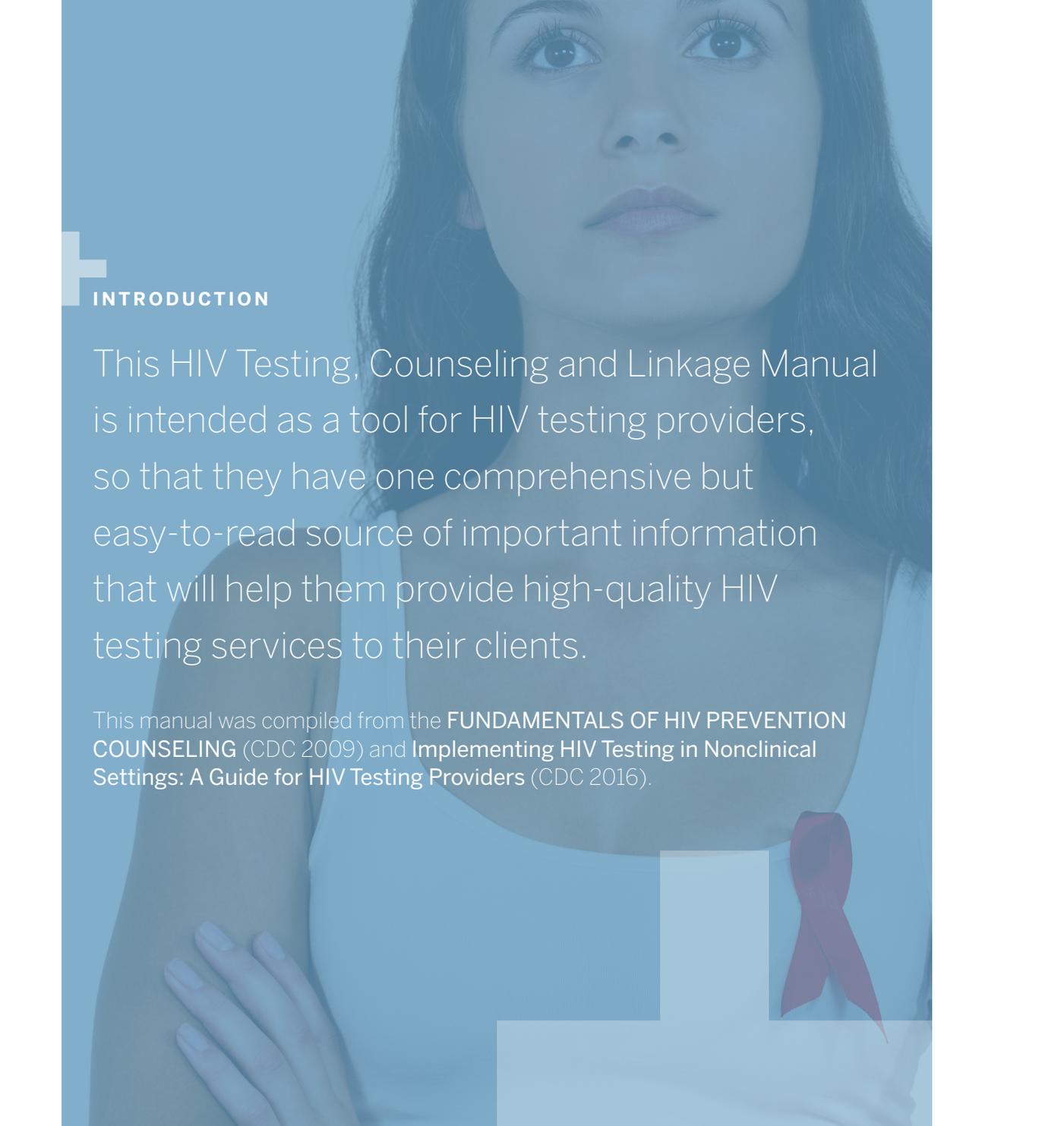
Human immunodeficiency virus is the virus that can lead to acquired immunodeficiency syndrome, or **AIDS**. Unlike some other viruses, the human body cannot get rid of **HIV**. That means that once you have **HIV**, you have it for life.

HIV is spread by contact with infected bodily fluids such as blood, semen, vaginal fluids, and breast milk. Preventative measures include using condoms during sexual intercourse, Pre-exposure prophylaxis (**PrEP**), using formula for infant feedings, and not sharing needles for intravenous injections. If an individual is already infected, taking a regular dosage of antiretroviral drugs (**ART**) can reduce the amount of virus in the blood and reduce the risk of transmission to others.



Acronyms

AIDS	acquired immune deficiency syndrome
ANC	antenatal care
ART	antiretroviral therapy
ARTAS	antiretroviral treatment and access to services
CBA	capacity building assistance
CBO	community-based organization
CDC	U.S. Centers for Disease Control and Prevention
CHTC	couples HIV testing and counseling
CLIA	Clinical Laboratory Improvement Amendments
COP	communities of practice
CPN	CBA providers network
CRIS	CBA Request Information System
DIS	disease intervention specialist
EBI	evidence-based intervention
FDA	Food and Drug Administration
HAART	highly active antiretroviral therapy
HCO	health care organization
HD	health department
HIP	high-impact prevention
HIPAA	Health Insurance Portability and Accountability Act
HIV	human immunodeficiency virus
HNS	HIV navigation services
IPV	intimate partner violence
M&E	monitoring and evaluation
MOA	memorandum of agreement
MSM	gay, bisexual, and other men who have sex with men
NAT	nucleic acid test
NHAS	National HIV/AIDS Strategy
NHM&E	National HIV Prevention Monitoring and Evaluation
nPEP	Non occupational post exposure prophylaxis
OSHA	Occupational Safety and Health Administration
PEP	Post exposure prophylaxis
PII	personally identifiable information
PMTCT	prevention of mother-to-child transmission of HIV
PrEP	Pre-exposure prophylaxis
PS	partner services
PWID	persons who inject drugs
QA	quality assurance
QC	quality control
QI	quality improvement
RNA	ribonucleic acid
SNS	social networking strategy
STD	sexually transmitted disease
TA	technical assistance
TB	Tuberculosis
TEC	Training and Events Calendar



INTRODUCTION

This HIV Testing, Counseling and Linkage Manual is intended as a tool for HIV testing providers, so that they have one comprehensive but easy-to-read source of important information that will help them provide high-quality HIV testing services to their clients.

This manual was compiled from the **FUNDAMENTALS OF HIV PREVENTION COUNSELING** (CDC 2009) and **Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers** (CDC 2016).



Background

CDC recommends that all adolescents and adults get tested for HIV at least once as a routine part of medical care. CDC also recommends more frequent testing (at least annually) for men who have sex with men (MSM), persons who inject drugs (PWID), and other persons at high risk for HIV infection.

Significant advances in HIV testing have been made since the Food and Drug Administration (FDA) approved the first commercial HIV blood test more than 30 years ago, and it is now easier than ever to get tested for HIV. Testing technologies have improved, same-day results are available, testing venues are diverse and readily accessible, information about the importance of testing is clearer and more focused on client risk factors, and testing has become routine for many providers and clients.

Additionally, testing is no longer something that has to be done alone—couples and sex partners can come in and get an HIV test together, supporting one another with a future-focused discussion of joint risk concerns and accessing follow-up services based on their test results and relationship status.

A comprehensive prevention plan through the availability of antiretroviral therapy (ART), barrier protection and, more recently, PrEP have provided new incentives for people to be tested, to take steps to keep themselves and their partners healthy, and to prevent new infections.





Training Objectives

1. To provide participants with the knowledge, skills, and ability to effectively utilize the HIV prevention counseling protocol when conducting rapid HIV testing

2. To provide tools/information/resources support individuals with making behavioral changes that may reduce their risk of acquiring or transmitting HIV.

3. This training will demonstrate the use of HIV prevention counseling in the context of rapid HIV Testing.

This course is an adaptation of the 2009 Fundamentals of HIV Prevention Counseling training. This manual was compiled from the **FUNDAMENTALS OF HIV PREVENTION COUNSELING** (CDC 2009) and **Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers** (CDC 2016)



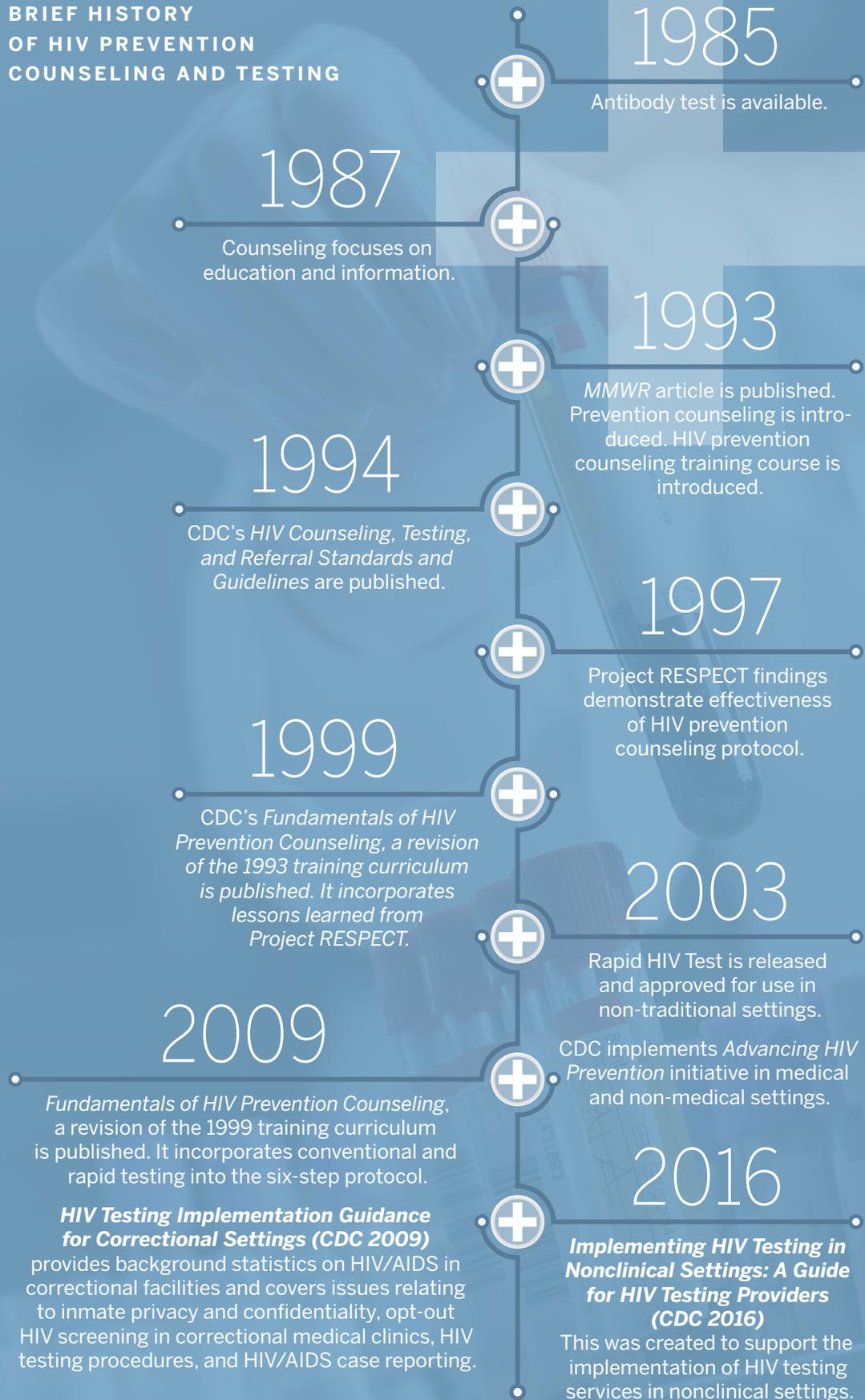
Timeline

HIV testing has evolved rapidly since the onset of the epidemic. As far as testing technology: The first HIV antibody test, developed in 1985 detected IgG antibody and became positive 6 to 12 weeks postinfection. False-positive results occurred; thus, a two-test algorithm was developed using a Western blot test as a confirmatory procedure.

The second-generation HIV test added recombinant antigens, and the third-generation HIV tests included IgM detection, reducing the test-negative window to approximately 3 weeks postinfection.

Fourth- and fifth-generation HIV assays added p24 antigen detection to the screening assay, reducing the test-negative window to 11 to 14 days. The fifth-generation HIV assay provides separate antigen and antibody results and will require yet another algorithm. HIV infection may now be detected approximately 2 weeks postexposure, with a drastically reduced number of false-positive results.

**BRIEF HISTORY
OF HIV PREVENTION
COUNSELING AND TESTING**



DEFINITION OF COUNSELING

Counseling is communication, both verbal and nonverbal, made in response to and in the presence of feelings. It is the work of supporting someone in making decisions when their willingness or ability to act is affected by their feelings. Effective counseling can help a client explore, express, understand, and accept feelings so that a person can make a decision.

Good counseling is client-focused—that is tailored to the behavior, circumstances, and special needs of the person being served.

Counseling is not about solving the client's problem or offering advice.

In the counseling process, the counselor avoids taking on the client's problem or telling the client how to solve their problem. Instead, the counselor helps the client negotiate a risk reduction plan, that will enable the client to reach a better understanding of their risk, and be able to deal with their concerns or attitude about HIV transmission and prevention. The relationship between the counselor and client will enable the counselor to clarify the client's feelings without imposing external feelings or values.

Counseling is different from ongoing therapy. The counseling intervention is focused on an immediate problem related to the services offered by the agency for which the counselor works. Linkages should be made for problems and services that fall outside the scope of the clinic services or the role of the counselor.

ATTACHMENT AND DETACHMENT

Over-attachment occurs when the counselor hands over his or her ego, sense of self, and competence to the client. Healthy detachment is not detachment from our clients but from our own assumptions that our success is defined by our client's actions and behavioral changes.

Offer Suggestions, Not Directives



DEFINITION OF HIV PREVENTION COUNSELING

HIV prevention counseling is a client-centered exchange designed to support individuals in making behavioral changes that will reduce their risk of acquiring or transmitting HIV.

This definition has two critical components:

1. Client-centered mean that counseling is tailored to the behavior, circumstances, and special needs of a person. Being client-focused is an important process in HIV prevention counseling.
2. Equally important is a focus on personal risk assessment and the development of a personalized action plan.

GOAL OF HIV PREVENTION COUNSELING

The goal of HIV prevention counseling is to support individuals in making behavior changes that will reduce their risk of acquiring or transmitting HIV/AIDS.

SOURCES

Fundamentals of HIV Prevention Counseling (CDC 2009)

Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers (CDC2016)

www.gacapus.com

HIV PREVENTION COUNSELING

The focus of HIV prevention counseling is to effectively support clients in:

While helping clients identify their risk behaviors and developing a realistic harm reduction plan is the goal of HIV prevention counseling, counselors should be aware of the factors, relationships, and/or circumstances that influence HIV related behavior change.

- Improving the clients' perception of risks.
- Supporting the client with behavior changes they have made or will attempt.
- Negotiating a workable risk reduction plan.
- Informed decision-making about whether to be tested.
- Coping with their results and taking appropriate steps to protect their health in the future.

LIMITED ROLE OF AN HIV COUNSELOR

When conducting HIV Prevention Counseling, it is important to keep in mind that the HIV counselor has a limited role. The limited time associated with the visit, only gives the counselor a limited amount of time to go in depth and discuss particular issues or concerns the client may have. Because the session time is limited, the counselor may not be able to completely develop a client-centered approach, but quickly establishing rapport and maintaining a client-focused session, can go a long way with the client. The goal of the session is to the guide client through the testing process and link the client to other, more appropriate services.

NOTE: *CDC no longer supports extensive pretest and posttest counseling as part of the HIV testing event. Instead, CDC supports a streamlined model of HIV testing that includes delivering key information, conducting the test, completing brief risk screening, providing test results, and delivering referrals tailored to the client's specific risks.*

COUNSELING CONCEPTS:

1. **Focus on feelings** – The focus is first on how the client feels.
2. **Manage personal discomfort** – It is important to manage our personal values and bias when assisting clients with behavioral changes.
3. **Set boundaries** – Setting boundaries relates to supporting a client's right to making personal choices.

OARS

OARS is a skill-based model of interactions adapted from a client-centered approach used in Motivational Interviewing. These skill-based techniques include verbal and non-verbal responses and behaviors. Both verbal and non-verbal techniques need to be adapted to be culturally sensitive and appropriate.

SOURCE

Fundamentals of HIV Prevention Counseling (CDC 2009)

COMMUNICATION TECHNIQUES OARS

OARS stands for:

O = OPEN ENDED QUESTIONS

A = AFFIRMATIONS

R = REFLECTIONS

S = SUMMARIES

As a health care professional, it is your role to utilize each of these skills with intention.

To be intentional is the rationale for you to choose a specific response at a specific time.

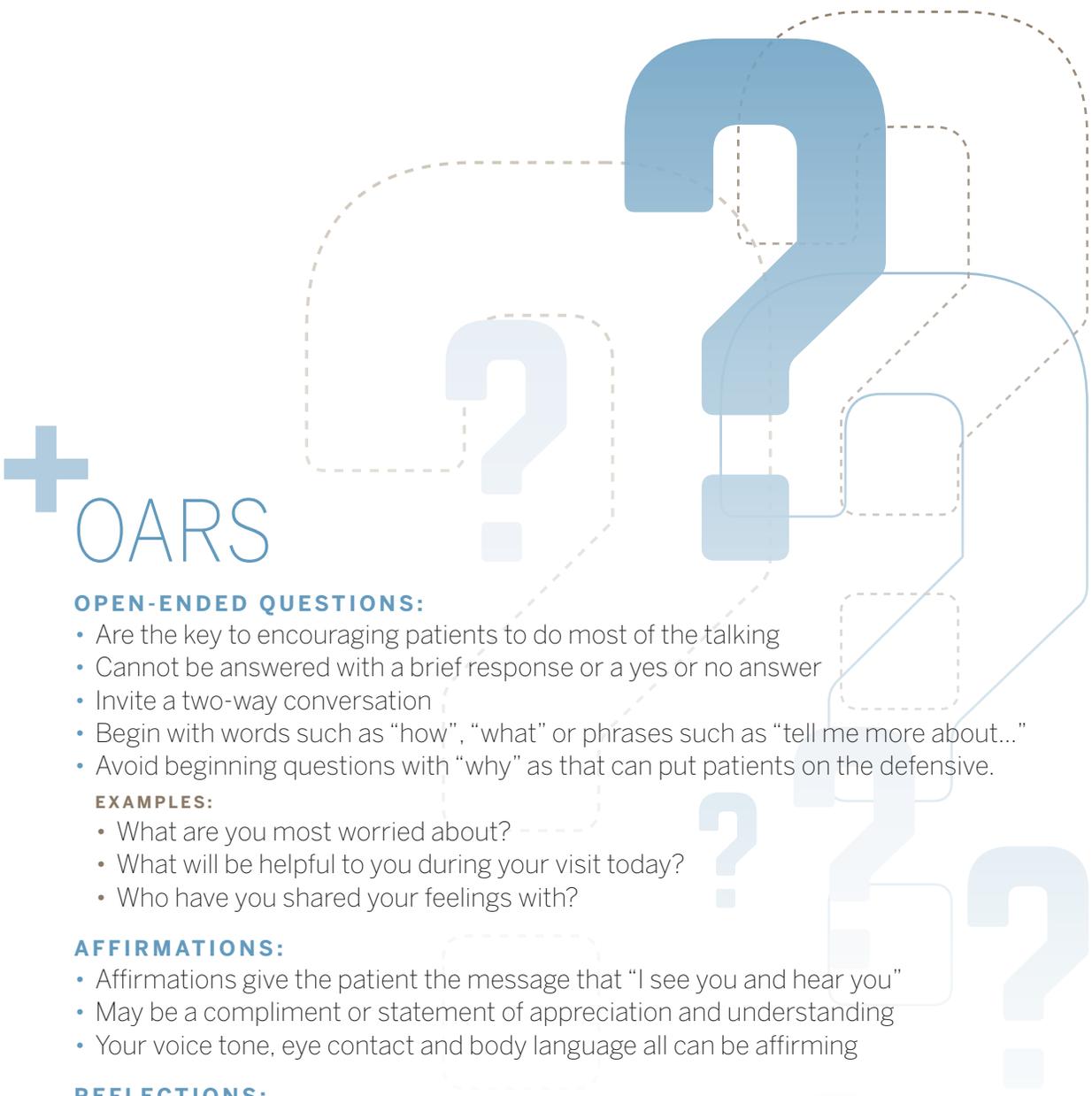
Without intention, the health care professional is having a conversation with the patient, but not a professional interaction or intervention. Three reasons for using these skills are:

- To acknowledge the patient and demonstrate respect which establishes rapport and safety.
- To help the patient explore and gain information and insight.
- To challenge the patient to view his or her situation differently or to take alternative action in their decisions.

NOTE: Using OARS will help to establish an atmosphere of acceptance and trust and aid the patient in exploring their hopes and fears.

REMEMBER: Open-ended questions, Affirmations, Reflections and Summarizing statements are not used in any order and can be used throughout a patient/provider interaction.





+ OARS

OPEN-ENDED QUESTIONS:

- Are the key to encouraging patients to do most of the talking
- Cannot be answered with a brief response or a yes or no answer
- Invite a two-way conversation
- Begin with words such as “how”, “what” or phrases such as “tell me more about...”
- Avoid beginning questions with “why” as that can put patients on the defensive.

EXAMPLES:

- What are you most worried about?
- What will be helpful to you during your visit today?
- Who have you shared your feelings with?

AFFIRMATIONS:

- Affirmations give the patient the message that “I see you and hear you”
- May be a compliment or statement of appreciation and understanding
- Your voice tone, eye contact and body language all can be affirming

REFLECTIONS:

- Reflective listening helps make sure that you understand what the patient is telling you
- You can reflect what is written in a chart, what is said or what you observe
- It helps the patient hear what she or he said and clarifies any misunderstanding
- It may be helpful to remember to use a reflection after the patient answers a question. This avoids falling into the “question-answer trap.”

SUMMARIZING:

- Is a form of reflective listening
- Can be used throughout an interaction to transition from topic to topic
- Can be used at the end of an interaction to review what was discussed
- Ends with an invitation for patient to respond (What did I miss? What else would be helpful today? What other questions do you have?)



SAMPLE QUESTIONS THAT ENCOURAGE PATIENT ENGAGEMENT & PROBLEM SOLVING

- **Questions that raise alternative**
 - What do you see as possibilities?
 - If you had your choice, what would you do?
 - What if you do _____? What if you don't do _____?
- **Questions that encourage evaluation**
 - How would you feel about that?
 - What do you think is best?
 - In 5 years, how do you think you'll feel about it?
- **Questions that encourage looking at the total picture**
 - Tell me a little about your pregnancy.
 - Fill me in on the issues you are currently having in your relationship.
- **Questions that lead to clarification**
 - Help me to understand what you mean.
 - Does all this make sense to you?
 - What feels confusing to you about this?
- **Questions that encourage description**
 - Tell me more about that.
 - What was that like for you?
 - What happened next?
- **Questions that encourage exploration**
 - If you had a choice, what would you prefer to do?
 - What are your options?
- **Questions to identify issues**
 - In what way does this bother you?
 - What's the hardest part for you?
- **Questions that encourage the use of information**
 - What information do you need in order for you to decide?
 - What do you already know about this?
- **Questions that encourage planning**
 - What do you see as the first thing you have to do?
 - What are your next steps?
 - What are some other options available to you?



Offer Options,
Not Opinions



PROGRAM PRINCIPLES

HIV testing programs must strive to provide high-quality services to best meet the needs of their clients and achieve their program objectives. There are certain principles and standards that should be met by all HIV testing programs in order to provide high-quality services.

GUIDING PRINCIPLES

Staff conducting HIV testing should be trained in accordance with state and local requirements before providing services to clients. Please see appendices Three (3) and Four (4) for Georgia's Rapid HIV Testing and Prevention Counseling Quality Assurance Protocols online.

SOURCES

Fundamentals of HIV Prevention Counseling (CDC 2009)

Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers (CDC2016)

www.lexis-nexis.com/hottopics/gacode/default.asp

www.gacapus.com

The following principles guide the provision of HIV testing in nonclinical settings, and HIV testing providers should ensure that these are met:

1. HIV testing is voluntary.
2. Clients give their expressed informed consent to be tested; they clearly understand basic information about HIV and HIV testing, and they provide verbal or written agreement to be tested for HIV.
3. HIV testing can be either confidential or anonymous; although confidential testing is preferred for facilitating linkage to care for newly diagnosed HIV-positive clients, some clients may only test if they can do so anonymously. Clients should understand the benefits of confidential testing compared to anonymous testing, including what measures are in place to protect their confidentiality.

In Georgia, only confidential HIV testing is permitted by DPH funded activities.

FOR MORE INFORMATION CONCERNING GEORGIA'S REGULATIONS -O.C.G.A. § 19-3-35.1 (2016), PLEASE VISIT: WWW.LEXIS-NEXIS.COM/HOTTOPICS/GACODE/DEFAULT.ASP

4. HIV testing services should be client-centered; that is, services should be focused on the client's concerns and situation. Services should also be culturally competent.
5. All clients testing HIV-positive should be referred and linked to care, and these linkages should be tracked to ensure timely linkage and successful enrollment in care.
6. All clients testing HIV-negative should undergo further risk reduction education, retesting, barrier use, pre-exposure prophylaxis (PrEP), etc.

SPECIAL CIRCUMSTANCES FOR CONSENT:

HIV testing agencies should consult with their local health department on the age of consent for HIV testing, and should offer age-appropriate HIV testing services to all persons at or above this age. Some state laws may require permission from a minor's parent or other legally authorized representative. In the state of Georgia, there is no minimum age of consent for an HIV test, nor is consent required from a parent or guardian for a minor to be tested. Anyone under 18 is competent to consent to testing or treatment of a venereal disease, including HIV.

PLEASE SEE THE FOLLOWING LINKS CONCERNING HIV TESTING AND MINORS: [HTTP://WWW.LEGIS.GA.GOV/LEGISLATION/EN-US/DISPLAY/20152016/HB/1058](http://WWW.LEGIS.GA.GOV/LEGISLATION/EN-US/DISPLAY/20152016/HB/1058)

[HTTPS://GOV.GEORGIA.GOV/SITES/GOV.GEORGIA.GOV/FILES/RELATED_FILES/DOCUMENT/HB%201058_0.PDF](https://gov.georgia.gov/sites/gov.georgia.gov/files/related_files/document/hb%201058_0.pdf)



ETHICAL STANDARDS

Agencies should establish an ethical code of conduct for their HIV testing services, which should be read and understood by all testing providers. This code of conduct should clarify that HIV testing providers should not use or be under the influence of alcohol or drugs while on duty; have sex with clients; exchange money with clients; or engage in other inappropriate behavior with clients. Agencies should establish and enforce these boundaries to protect their staff and their clients, and to ensure clients receive high-quality HIV testing services.

USE BEST POSSIBLE TECHNOLOGIES AND APPROACHES

Because one of the goals of HIV testing programs is to identify HIV infection as early as possible after exposure, programs should use testing technologies and specimens that allow for early detection. If possible, persons at highest risk should be tested for acute infection. In general, the tests used for this will be antigen/antibody combination tests used with blood specimens collected from the vein. However, it is not always feasible to have someone trained in collecting blood from a vein at nonclinical HIV testing sites, and so blood collected from a fingerstick is often used. **Blood (whole blood, serum, or plasma) is the preferred specimen for HIV testing because tests conducted with blood are more sensitive for early infection than tests conducted with oral fluid.**

No person shall perform an HIV antibody test on an individual without first obtaining written or verbal consent from the patient or his/her legal representative (general consent for clinical services is sufficient). Specimen collection should **only** take place after the pre-test counseling session and the client has signed the consent form or consent has been noted. The counselor should assess the client's ability to read the consent form and **provide assistance** as needed. Reasonable accommodations should be made for individuals who are blind, deaf, handicapped, and/or speak a language other than English.

WHEN OBTAINING INFORMED CONSENT FROM THE CLIENT, THE COUNSELOR SHOULD EXPLAIN THE FOLLOWING:

- The meaning of “confidential or anonymous” testing and the client's right to the confidential treatment of all information relating to his/her appointment and test session.
- The type of test being administered, specimen being collected, the time frame to receive results, and an explanation of the possible results that can be provided. (ex. positive, reactive, negative, non-reactive, invalid, and indeterminate)
- Explain that HIV testing is voluntary and consent to testing can be withdrawn at any time prior to testing.

Counselors must explain to clients that if they test confidentially, a positive HIV test result is reported to the state and/or local county health department. HIV case reporting allows Health Department staff to offer follow-up to those who test positive; which includes post-test counseling for those who do not return for test results, linkages to medical and psychosocial services, and voluntary Partner Services (PS). Confidential testing can more readily facilitate access into medical care for positive clients and can also assist medical providers in offering more integrated care for other medical conditions clients may have. Referrals to medical and psychosocial services and PS should also be offered to those who test positive anonymously.

POLICIES AND LEGAL CONSIDERATIONS

HIV testing providers should understand and provide services in accordance with their agency policies and state and local policies and laws.

LINKS TO GEORGIA'S RESOURCES:

<http://nccc.ucsf.edu/clinical-resources/hiv-aids-resources/state-hiv-testing-laws/>

http://nccc.ucsf.edu/wp-content/uploads/2014/02/Georgia_Clinicians_HIV_Testing_Law_Reference.pdf

FOR UPDATED REGULATIONS, PLEASE VISIT:

<http://rules.sos.ga.gov/gac/511-2-5>

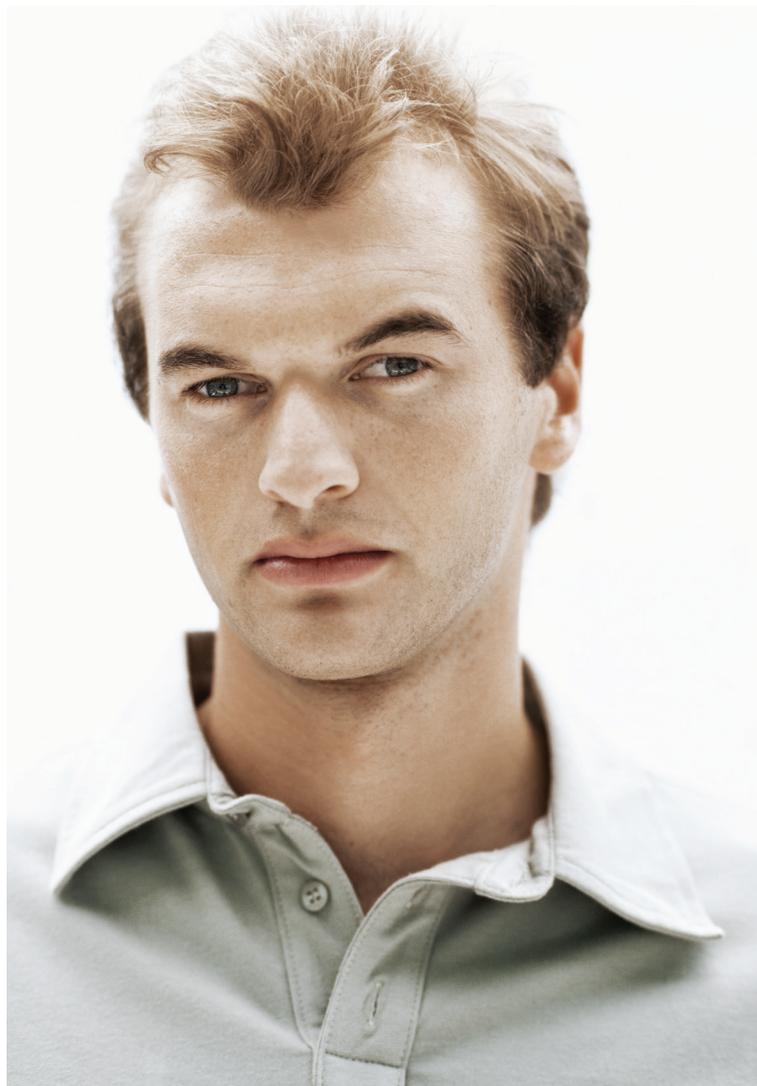
BLOOD BORNE PATHOGEN:

https://gets.sharepoint.com/sites/DPHIntranet/PHIL/FormsAndPolicies/HealthProtection/DPH%2520Guidelines%2520for%2520Standard%2520Precautions%2520and%2520Bloodborne%2520Pathogen_Approved.pdf#search=blood%2520born%2520pathogens

The policies and laws providers should be familiar with include, but are not limited to:

- Authorization for agencies to provide HIV testing
- Provider training and certification to perform HIV testing
- Who can consent to and receive HIV testing (e.g., teenagers or intoxicated persons)
- Record keeping and ensuring confidentiality
- Reporting HIV testing results
- Provision of partner elicitation and notification services
- Laboratory certifications or licensure
- Quality assurance procedures for HIV testing

SOURCE: www.lexis-nexis.com/hottopics/gacode/default.asp



FEDERAL POLICIES THAT APPLY TO ALL HIV TESTING PROGRAMS

<p>Laboratory certificate requirements</p>	<p>Nonclinical HIV testing sites using waived rapid HIV tests must either obtain their own certificate of waiver under CLIA (the Clinical Laboratory Improvement Amendments of 1988), or establish an agreement to work under the CLIA certificate of an existing laboratory. CLIA outlines quality standards for laboratory testing—including rapid HIV testing—to ensure the accuracy, reliability, and timeliness of patient test results. More information about CLIA certification and CLIA-waived tests can be found on CDC’s HIV/AIDS website (http://www.cdc.gov/hiv/testing/lab/clia/). Agencies should contact their state or local health department for more information, including how to apply for a CLIA waiver.</p>
<p>Health information compliance</p>	<p>All health care providers—including HIV testing providers—must comply with federal and state laws that protect patients’ health information, such as those set out in the Health Information Portability and Accountability Act of 1996 (HIPAA). HIPAA provides clients and patients access to their medical records and gives them control over how their health information is used and disclosed. Clients and patients can give permission to share their health information with anyone, including friends, family members, and organizations that provide referral services. This means that couples who wish to be tested and receive their results together may do so under HIPAA if both partners <i>are in agreement</i>.</p>
<p>Data security and confidentiality</p>	<p>All data collected by nonclinical HIV testing sites should adhere to the standards outlined in Data Security and Confidentiality Guidelines for HIV, Viral Hepatitis, Sexually Transmitted Disease, and Tuberculosis Programs. These guidelines provide recommendations related to record keeping, data collection, data management, and data security.</p>
<p>*Universal precautions for employee and consumer safety</p>	<p>The Occupational Safety and Health Administration (OSHA) has established basic precautions designed to keep employees and consumers safe when they might <i>come into contact with</i> blood or other bodily fluids.</p>

SOURCES:

Fundamentals of HIV Prevention Counseling (CDC 2009)

Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers (CDC2016)

www.gacapus.com

QUALITY ASSURANCE

Establishing and implementing Quality Assurance (QA) activities can help ensure that your agencies are delivering accurate test results, meeting program objectives, and delivering services according to established procedures. Each agency should develop a QA plan outlining their agency's QA activities.



QA activities might include:

- Running test kit controls according to the manufacturer's protocols
- Conducting HIV testing data reviews, including medical charts and client data forms
- Conducting role plays with peers, or between supervisors and peers
- Holding team meetings to review activities, discuss problems and concerns, and identify solutions
- Case conferencing to discuss challenging client cases and identify solutions
- Eliciting client feedback through surveys or interviews
- Conducting refresher trainings
- Performing direct observation of HIV testing sessions (with client permission)
- Receiving implementation support from CBA partners
- Reviewing client informational materials to ensure cultural appropriateness and accuracy
- Reviewing community referral and linkage resources, and establishing partnerships

UNIVERSAL PRECAUTIONS

PROVIDER SAFETY

Agencies should establish policies and procedures to keep staff and volunteers safe in HIV testing settings. These policies may include language about the number of staff required to be onsite; service provision hours; emergency preparedness; and staff conduct in outreach sites, mobile testing units, and HIV testing events.

SOURCES

Fundamentals of HIV Prevention Counseling (CDC 2009)

Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers (CDC2016)

www.gacampus.com

Universal Precautions that should be observed:

Wash hands or other skin surfaces immediately before and after handling blood or other body fluids. If soap and water is not available, alcohol-based hand sanitizer may be used.

Use disposable gloves (preferably latex); change gloves between clients.

Do not eat, drink, apply makeup, or handle contact lenses in the testing area.

Do not keep food or drink in refrigerators, containers, shelves, cabinets, or countertops where potentially infectious materials are present.

Dispose of lancets, needles, or other fluid-touched items (e.g., gauze) in proper biohazard containers.

Disinfect all work surfaces and items before and after testing with 10% bleach solution or Environmental Protection Agency-approved disinfectant.

In the context of HIV testing, the **most likely occupational exposure** will be through blood collected via fingerstick or blood draw, needlestick injuries while collecting specimens, or through sharp injuries.

Agencies must protect workers who may come into contact with blood or other body fluids, and make arrangements for safe and proper disposal of all HIV testing waste. If you come into contact with body fluids, report this exposure to your supervisor immediately and seek medical guidance to initiate postexposure prophylaxis (PEP).

Observe Universal Precautions



MONITORING AND EVALUATION

Monitoring and Evaluation (M&E) activities assess the resources that go into a program (e.g., staff, funding), the services provided (e.g., tests provided, referrals provided), and the results of the program (e.g., new HIV diagnoses, successful linkage to care) to determine whether the program is meeting its objectives. Every HIV testing program should conduct M&E activities to assess and track program performance, to identify areas in need of improvement, and to ensure accountability to stakeholders. HIV testing providers play a critical role in M&E activities because they are responsible for the accuracy of client-level data and reporting.

SOURCES

Fundamentals of HIV Prevention Counseling (CDC 2009)

Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers (CDC2016)

M&E begins with establishing HIV testing program targets based on formative work, your agency's capacity for client flow, and requirements established by your funders.

This could be based upon:

NUMBER OF CLIENTS PER MONTH

1. The proportion of clients that represent target population
2. The total number of new HIV diagnoses per month

Once you have established targets for your program, you will need to collect data on each of your clients in order to assess whether you are meeting those targets. This might include:

1. Demographics
2. HIV Risk behavior
3. HIV Test Results
4. Linkage to HIV medical Care (www.gacapus.com)

Again, the **type of data you are required to collect** will be established in advance by your testing agency, health department, CDC, or other funding agencies.

Standard data collection tools (e.g., forms, logbooks) should be used for client-level data collection, they should be reviewed, stored in a secure location, and compiled on a regular basis (e.g., monthly), and trends should be tracked over time. Personally identifiable information should not be disclosed in these aggregate reports.

Reports should be produced and shared with stakeholders, including HIV testing program staff, board of directors, health department, CDC, and other funding agencies.

Including all stakeholders in the process of data sharing and review ensures that everyone has the same understanding of program targets and achievements, and gets everyone involved in identifying solutions for program improvement. Some agencies may wish to appoint a data monitor to be in charge of data quality and reporting, but all staff have a role in ensuring successful M&E.

TESTING ENVIRONMENT

HIV testing should be conducted in a private location where client confidentiality can be ensured and where a specimen can be collected safely and without risk of contamination. Some recommendations for establishing an ideal HIV testing environment included in chart at right.

SOURCES

Fundamentals of HIV Prevention Counseling (CDC 2009)

Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers (CDC2016)

www.gacampus.com

PREPARING THE HIV TESTING ENVIRONMENT	
Room/testing space:	Providers should ensure that the testing space has enough room and seating for all clients to feel comfortable and confident in their HIV testing experience.
Lighting:	There should be enough light to allow providers to perform the test and read results accurately.
Temperature:	Rapid HIV tests should be stored, transported, and conducted within specific temperature ranges specified by the manufacturer.
Surface area:	Rapid HIV tests must be performed on a clean and level surface. HIV testing supplies and controls should be well organized, and no food or drink should be consumed near the testing area
Storage and disposal:	Most rapid HIV tests can be stored at room temperature below 30°C/86°F. However, most controls used for quality assurance and quality control procedures must be stored in a refrigerator with temperature controls. HIV testing providers should maintain an inventory of testing supplies, including lot numbers, date of receipt, storage temperatures, expiration dates, and dates of use.
Equipment:	Laboratory-based tests may require refrigeration of specimens. Refrigerators should have temperature controls, should only be used for the storage of samples and/or testing supplies, and should be labeled as such. A centrifuge will also be needed to prepare laboratory samples for testing.
Prevention Materials:	Condoms, lubricants, and educational materials should be made available to clients in the HIV testing room as well as in the waiting area (or on display if at an outreach or community venue).
Supplies	Staff should have all the supplies, materials, and reference information necessary to provide HIV testing and linkage to care services, including data forms and testing logs; testing supplies and equipment; prevention and educational materials; referral and resource information; and client satisfaction or feedback questionnaires.

HIV TESTING BASICS AND TESTING STRATEGIES

Your agency should have already selected the types of test kits that you will use to perform HIV testing, and if you will be performing HIV testing, you should receive training on how to conduct these tests. This is important information you should know about the different types of HIV test kits that are available, so that you are able to answer questions that your clients might have.

As mentioned previously, agencies are encouraged to use the best possible testing technologies and specimens that allow them to detect HIV infection as early as possible after exposure.

Immediately after infection, during what is referred to as the eclipse period, no HIV test can detect infection. Following this period is the acute infection period, the interval between when HIV ribonucleic acid (RNA) can first be detected using a nucleic acid test and when antibodies can first be detected. Most antibody tests cannot detect acute HIV infection, and persons with acute HIV infection can be highly infectious.

Every test has a window period during which the test cannot detect HIV infection. That period depends on the type of test being used, specimen type, as well as the individual being tested. The window period includes the eclipse period (when no test can detect infection) up through the time when the particular test becomes reactive.

RAPID HIV TESTING TECHNOLOGY

Examples of rapid HIV testing technology available to programs funded or supported by DPH, Office of HIV/AIDS:

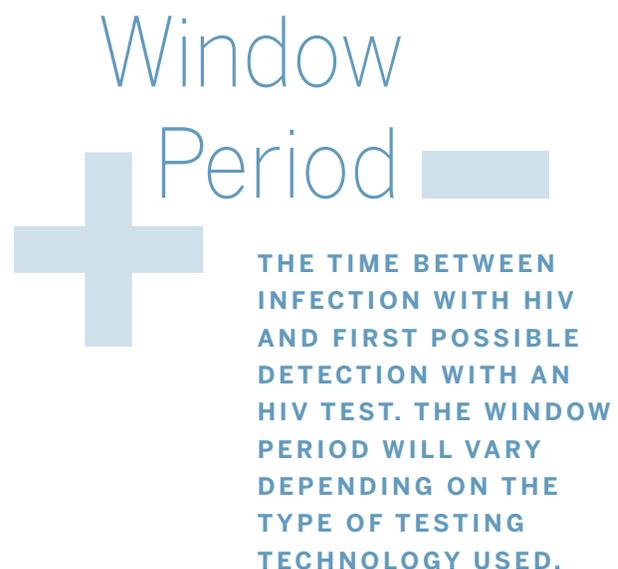
- Sure Check 1/2
- Oraquick Advance 1/2
- INSTI 1/2

SOURCES

Fundamentals of HIV Prevention Counseling (CDC 2009)

Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers (CDC2016)

www.gacapus.com



TYPE OF TESTS

There are 3 types of HIV diagnostic tests:

1. nucleic acid tests (NATs)*
2. antigen/antibody tests
3. antibody tests

*NATs have the shortest window period, followed by antigen/antibody tests, and then antibody tests

- *laboratory only – there is no rapid version of this test*

SOURCES

Fundamentals of HIV Prevention Counseling (CDC 2009)

Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers (CDC2016)

www.gacapus.com

NUCLEIC ACID TESTS (NATS)

NATs can detect the presence of the virus in blood. NATs can detect very early infection, as early as 10 days after infection. NATs are used for HIV testing in many laboratory settings. Additional information is available at CDC's website for U.S. HIV tests (<http://www.cdc.gov/hiv/testing/>).

COMBINATION ANTIGEN/ANTIBODY TESTS

Combination antigen/antibody tests detect both the antibody to HIV and the antigen “p24”—a protein that is part of the virus itself. Because the p24 antigen can be detected before antibodies appear, combination tests can identify very early infections. These tests—used with blood specimens collected from the vein—are recommended by CDC as the first test in the laboratory testing algorithm. Combination antigen/antibody rapid tests can be used for point-of-care testing, but detect infection several days later than the laboratory-based combination tests. The evidence is inconclusive about the ability of combination antigen/antibody rapid tests to accurately detect the p24 antigen on whole blood specimens, and CDC has not provided recommendations about the use of these tests.

ANTIBODY TESTS

HIV antibody tests detect the presence of antibodies against HIV, which typically develop within 2 to 8 weeks after exposure to the virus. An antibody test can be conducted on a sample of blood or oral fluid. Many antibody tests are rapid tests, which means results can be returned on the same day, or within the same hour, or even within minutes. Oral fluid antibody tests have been shown to detect infection a month or more later than blood based tests because there is a lower concentration of HIV antibodies in oral fluid than in blood. **Oral fluid is not ideal for identifying early HIV infection**, but may also be appealing in outreach settings because collecting oral fluid does not involve a finger stick or venipuncture to perform the test. No antigen/antibody or nucleic acid tests are available for use with oral fluid. Blood-based rapid HIV antibody tests are widely available in most nonclinical HIV testing sites, and blood (whole blood, serum, or plasma) is the preferred specimen for HIV testing because tests conducted with blood are more likely to detect early infection than those conducted with oral fluid. **If your organization must use oral fluid for testing, then you should inform HIV testing clients and patients of the limitations of this type of specimen for testing.**

TESTING APPROACHES

Laboratory-based testing

SOURCES

Fundamentals of HIV Prevention Counseling (CDC 2009)

Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers (CDC2016)

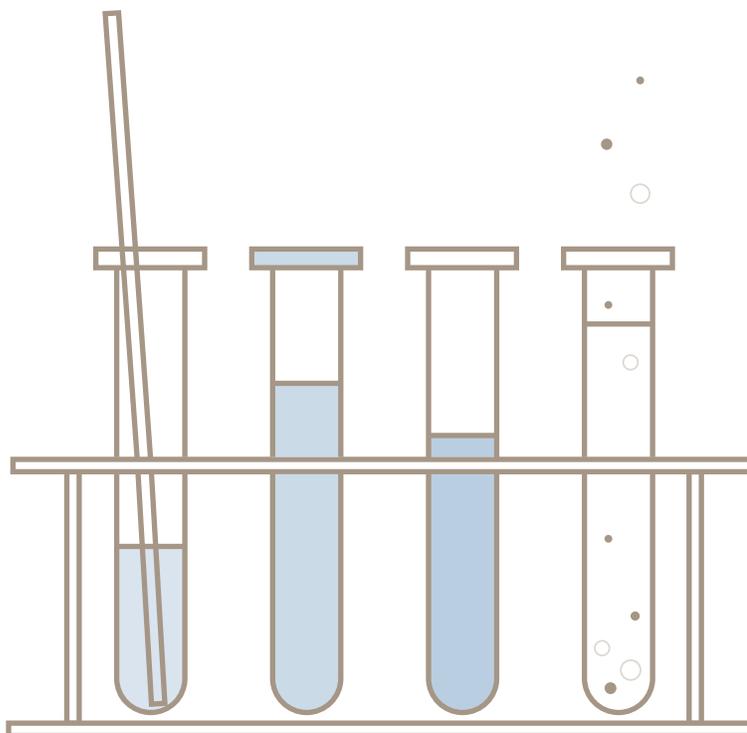
LABORATORY-BASED TESTING

If a blood specimen is drawn for the laboratory, all testing can be conducted using the initially drawn specimen. For blood specimens sent to a laboratory, CDC and the Association of Public Health Laboratories recommend the use of an antigen/antibody combination assay for the first test, and—if reactive—additional testing with a HIV1/2 differentiation assay and NAT when needed.

Some nonclinical HIV testing sites work closely with laboratories to process the site's HIV tests and send back the test results. In this type of arrangement, your agency will collect and prepare blood samples from your clients and ship them to the laboratory where the HIV tests will be performed.

If your testing site is conducting laboratory-based HIV testing on blood samples, you will need to follow the appropriate sample collection and preparation procedures as defined by the laboratory doing the testing. It is very important that you follow these procedures precisely to ensure an accurate test result. Each laboratory has procedures that dictate the type and minimum size of sample collection tubes to be used, shipping requirements, temperature requirements, preparation of the samples, timeframes associated with processing the test, and reporting results.

More information on laboratory-based HIV tests is available at <http://www.cdc.gov/hiv/testing/lab/guidelines/>.



TESTING APPROACHES

Some products utilize a self-collected sample that is mailed to a lab for testing. Results are provided over the phone by a qualified counselor. Other products allow the consumer to collect the sample, conduct the test and determine the results themselves. Again, telephone counseling and support is available for this type of home test.

SOURCES

Fundamentals of HIV Prevention Counseling (CDC 2009)

Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers (CDC2016)

www.gacapus.com

POINT-OF-CARE TESTING

Most rapid HIV testing performed in nonclinical settings is considered “point-of-care” or “point of-contact” because the test is processed onsite where the client is receiving services. Results of rapid tests are often provided in less than 1 hour or even within minutes.

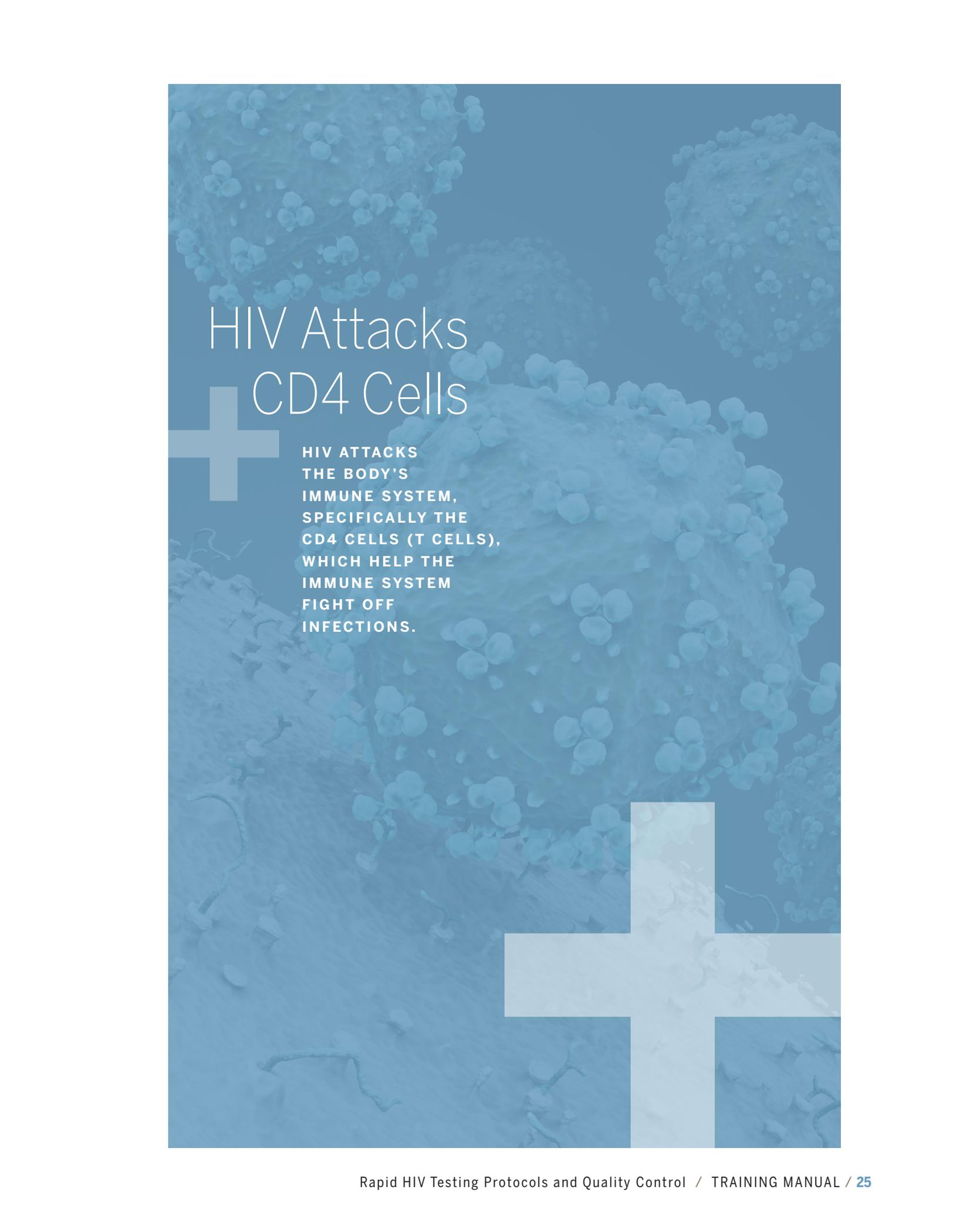
This testing may be called “rapid HIV testing” or “CLIA-waived rapid HIV testing.” CLIA establishes criteria for rapid HIV tests based on 3 different levels of complexity: waived, moderate complexity, and high complexity. CLIA-waived rapid HIV antibody tests are the most common type of tests used in nonclinical HIV testing settings, although some nonclinical settings are also starting to incorporate CLIA-waived combination antigen/antibody rapid tests. CLIA-waived rapid HIV tests can be used in many different settings and are typically used in nonclinical settings because of their ease of use and fast test results. A list of CLIA-waived rapid HIV tests is available at <http://www.cdc.gov/hiv/testing/nonclinical/>.

Instructions for specimen collection, preparation, and performance of rapid HIV tests are provided by the manufacturer in the test kits. If there are any questions about the test kits or how to perform the test, you should call the manufacturer’s customer service number, which is provided on the product insert.

All HIV testing providers should be trained in how to conduct rapid HIV tests, including the specimen collection approach that is used at their testing site (i.e., venipuncture, fingerstick, or oral fluid).

HOME TESTS

Home HIV testing is an emerging area of interest among consumers and HIV testing providers because it can be an effective method for reaching people who are not otherwise getting tested. This approach may also be helpful in reaching couples and persons in sexual relationships. Some nonclinical HIV testing sites are finding opportunities to engage with home testing clients by being available for follow-up counseling or by **actually distributing** the tests and serving as a resource for clients who have completed testing and interpreted their results. Strategies for engaging persons who test positive with a self-test should be explored so they can be linked to medical care quickly.

The background of the page is a microscopic image of cells, likely CD4 cells, rendered in shades of blue. A large, semi-transparent white plus sign is positioned on the left side of the page, partially overlapping the text.

HIV Attacks CD4 Cells

**HIV ATTACKS
THE BODY'S
IMMUNE SYSTEM,
SPECIFICALLY THE
CD4 CELLS (T CELLS),
WHICH HELP THE
IMMUNE SYSTEM
FIGHT OFF
INFECTIONS.**

TESTING ALGORITHMS

noun

A self-contained sequence of actions to be performed.



HIV TESTING ALGORITHMS

Most HIV testing conducted in nonclinical settings will include an initial HIV test and, if the initial HIV test is reactive, a follow-up HIV test. Both the initial and follow-up tests are considered part of the same testing event for reporting purposes for CDC funded programs.

An initial HIV test will either be an antibody test or combination antigen/antibody test. It may involve sending blood or oral fluid to a laboratory or obtaining blood or oral fluid for a rapid test.

Follow-up testing (sometimes referred to as “supplemental testing” or “confirmatory testing”) is performed if the initial test result is positive. HIV tests are generally very accurate, but follow-up testing is important to be sure of the diagnosis of HIV infection.

<https://stacks.cdc.gov/view/cdc/23446>

LABORATORY TESTING ALGORITHM

In 2014, CDC published new recommendations for the HIV testing algorithm in laboratory settings (<http://www.cdc.gov/hiv/pdf/HIVtestingAlgorithmRecommendation-Final.pdf>). The updated recommendations outline a new testing algorithm that begins with a combination antigen/antibody test that detects both HIV-1 and HIV-2 antibodies. This algorithm has many advantages over previous ones:

- follow-up testing does not rely on the Western blot, which does not detect early infections
- accurate diagnosis of HIV-2
- potential for earlier diagnosis of HIV-1

NOTE: *The recommended HIV testing algorithm cannot be used with oral fluid specimens. Some laboratories still allow submission of oral fluid specimens, but these specimens are not part of CDC's recommended algorithm. Testing oral fluid in the lab requires a different testing algorithm that includes the Western blot, which does not detect infection as early as the more sensitive blood tests recommended in the new algorithm.*

POINT-OF-CARE TESTING ALGORITHM

Unlike laboratory testing, CDC has no published guidelines for point-of-care testing algorithms. However, there are several sources of information that highlight possibilities for point-of-care algorithms.^{38, 39, 40} Point-of-care rapid HIV testing may follow 1 of 3 testing algorithms. The benefits and drawbacks of each algorithm are addressed in the Program Manager Guide and separately in a 2009 report from the Association of Public Health Laboratories and CDC.⁴¹

THE 3 ALGORITHMS THAT ARE COMMON TO NONCLINICAL HIV TESTING SETTINGS ARE:

1. Single rapid test with immediate linkage to clinical provider if initial test is reactive; if initial test is nonreactive, client is presumed to be HIV-negative.
2. Single rapid test followed by laboratory-based follow-up testing if initial test is reactive; if initial test is nonreactive, client is presumed to be HIV-negative with recommended additional education.
3. Single rapid test immediately followed by a second rapid test on-site if initial test is reactive.
 - A. If initial test is nonreactive, client is HIV-negative with recommended additional education.
 - B. If both tests are reactive, provide immediate linkage to HIV care.
 - C. If second test is nonreactive but first test is reactive, refer to laboratory or clinical provider for follow-up testing. Agencies should use the algorithm mandated by their state or local health department. If there are options, agencies should choose an algorithm that allows them to detect HIV as early as possible after exposure. Agencies should also consider other factors, such as feasibility of implementation, likelihood of being able to follow-up with the client, and cost.

SPECIMEN COLLECTION AND PREPARATION

Regardless of the HIV testing method you are using, you should perform specimen collection and preparation correctly and consistently to ensure the accuracy of your clients' test results.

GA DPH BLOOD BORNE PATHOGEN EXPOSURE INFORMATION:

https://gets.sharepoint.com/sites/DPHIntranet/PHIL/FormsAndPolicies/HealthProtection/DPH%2520Guidelines%2520for%2520Standard%2520Precautions%2520and%2520Bloodborne%2520Pathogen_Aproved.pdf#search=blood%2520born%2520pathogens

SOURCES

Fundamentals of HIV Prevention Counseling (CDC 2009)

Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers (CDC2016)

www.gacampus.com

All HIV testing providers should be trained in the specimen collection procedure that is used at their agency—whether venipuncture, fingerstick, or oral fluid.

Practical hands-on training should be available through your local health department. CDC's Rapid HIV Testing Online Course also provides some of this information, and can be accessed at <http://effectiveinterventions.cdc.gov/en/HighImpactPrevention/PublicHealthStrategies/CTR.aspx>.

Every test kit also has a product insert, which should be readily available to all persons conducting the HIV test. This insert should be consulted to ensure accurate procedures. However, although job aids such as the test kit insert are helpful, they should not be relied on as the sole source of information for conducting tests. All agencies should have HIV testing policies and procedures that describe instructions for accurate specimen collection and preparation, as well as safety precautions and a biohazard disposal protocol to protect clients and testing personnel. For more information, see "Universal precautions for employee and consumer safety"



GIVING RESULTS

Guidelines for Giving HIV Test Results

SOURCES

*Fundamentals of HIV Prevention
Counseling (CDC 2009)*

*Implementing HIV Testing
in Nonclinical Settings:
A Guide for HIV Testing
Providers (CDC2016)*

www.gacapus.com



The CDC has identified guidelines for all counselors when providing HIV test results.

When giving any test result, counselors should:

- Assess client readiness to receive test results.
- Provide test results promptly.
- Provide the results in a clear and concise manner.
- Interpret result for client, and ensure that s/he understands what the results mean.
- Negotiate, reinforce or re-negotiate the risk-reduction plan.
- Keep the message simple.
- Provide resources and linkages as appropriate. (www.gacapus.com)

Additional points when giving results:

- Use counseling concepts and skills
- Remain non-judgmental and avoid value statements. Think before touching (i.e hugging the client). Position the chairs so both counselor and client have access to the door.
- Make sure back-up support is available if needed

INTERPRETING RESULTS

In order to deliver an accurate message about the meaning of HIV test results, you should be familiar with the testing algorithm used by your agency. Remember to use simple and clear language to explain test results to clients.

Plain language makes it easier for everyone to understand and use health information. Although plain language is a familiar idea, many organizations don't use it as often as they should. **The Plain Writing Act of 2010** (<http://www.plainlanguage.gov/>) requires federal agencies to train staff and use plain language when they communicate with the public.

We provide examples of this language for each type of result, to the right.

Possible HIV Test Results

Conventional HIV Test Results	
RESULT	INTERPRETATION
Non Reactive	Negative
Reactive	Positive
Indeterminate/ inconclusive	Uncertain

Rapid HIV Test Results	
RESULT	INTERPRETATION
Non Reactive	Negative
Reactive	Preliminary positive
Invalid	Not a result. Unable to interpret

- Assess the client's readiness to receive the result
 - Ask the client if they have any questions or anything they would like to discuss before receiving their result.
 - **For example:** "What questions or concerns would you like to discuss before we proceed?"
 - **Follow the client's lead as to when to disclose.** In general, clients will be anxious to move ahead. Give the test result when you think the client is ready to receive them.
- Explain the meaning of the reactive test result.
 - State the result in a direct but neutral tone.
 - **For example:** "Your test result is reactive which means this a preliminary positive result".
 - **Take a pause after providing the test result.** This will give the client time to respond to the result. You may need to take 15 to 30 seconds (or longer) before speaking again.

Follow the
Client's Lead



REACTIVE RESULTS

When testing with either conventional or rapid testing, a reactive test result means that HIV antibodies have been detected in the client's sample.

- **Conventional testing**
reactive test result is interpreted as positive.
- **Rapid testing**
the test result is interpreted as reactive.

NOTE: A confirmatory test **must** be conducted for a **reactive or Positive** test result. However, the confirmatory test should not delay or impede initiation of the linkage to care process.

- Assess how the client is coping with the reactive test result.
 - Based on the client's response to the test result, make some decisions about the client's most immediate needs.
 - Assess and acknowledge client's feelings in response to a reactive/positive test result.
 - **For example:** "How are you feeling about this result?" or "Take your time, we have plenty of time to talk about the result".
- Emphasize the importance of a confirmatory test to verify the reactive/positive result. Further testing is required to confirm a reactive/positive test result.
- Emphasize the importance of taking precautions to avoid the possibility of transmitting infection to others while awaiting results of confirmatory testing.
- Reemphasize the high level of accuracy of the initial screening and prepare the client to receive a confirmed reactive.

After providing reactive/positive result...

- Determine protocol at counselor's organization for obtaining sample for confirmatory testing.
- Initiate procedures for confirmatory testing.
- Initiate procedure for linking the client to HIV medical care.
- Schedule a follow-up visit to provide confirmatory test result.
- If the organization does not collect the sample for confirmatory test, link the client to an organization that can conduct the confirmatory test and document follow-up.
- After obtaining a positive confirmatory result, continue linkage to care protocol and link client to partner services and prevention (i.e. mental health, substance abuse, housing, etc. www.gacapus.com)

NONREACTIVE RESULTS

Conventional testing
the test result is interpreted as **negative**.

Rapid testing
the test result is interpreted as **non-reactive**.

When using either conventional or rapid testing, a non-reactive or negative test result means that no HIV antibodies have been detected in the client's sample.

- Before providing results, ask the client if he or she has any questions or concerns.
- State the results in a direct, neutral tone. Explain that a non-reactive (negative) HIV test results mean that HIV antibodies are not present in the client's sample.
- Review window period with the client (Refer to the window period chart).
 - If the client is not in the window period, you can clearly state that the client does not have HIV. For example, you could say, "Based on what you've shared with me today and the result of the test, you do not have HIV".
 - Re-testing the client may be required if the client is in the window period or has ongoing risky behaviors.
 - Be sure to explain to the client that there is no need for further testing unless his or her HIV risk behaviors change. For example, say, "The behaviors you've shared with me are considered to carry little or no risk for contracting HIV. Unless something changes in the future or differs from what you've shared with me, you do not need to seek follow-up testing".
- Negative/Non-reactive rapid and conventional HIV test results do not require a confirmatory test.
- Provide other information on a comprehensive prevention plan (pamphlets, condoms, PrEP, nPEP, etc...) and linkage to prevention services as appropriate: www.gacapus.com
- Close the session by reinforcing positive actions that the client has already taken. Let the client know that you have confidence in his or her ability to remain HIV-negative.
- Inform the client that quality assurance measures are in place to ensure the accuracy of the test.
- Continue to assess the client's reaction.

INVALID RESULTS

An invalid test is different than an indeterminate test result.

An invalid test occurs when there is either a problem related to the sample, the device, or the testing procedure.

The rapid test result cannot be interpreted, therefore the test is considered invalid, and repeat testing should be administered.



REPORTING AN INVALID RAPID TEST:

The counselor should take the following steps if a client's rapid test result is invalid:

- Inform the client that the test could not be interpreted.
- Explain that the test must be repeated. For invalid tests, it is necessary to collect a new sample and run a new test.
- Tell the client the general reason(s) why the test could not be interpreted. Invalid tests occur because there is a problem with the process of collecting the specimen or with the test kit.
- Provide other information on a comprehensive prevention plan (pamphlets, condoms, PrEP, nPEP, etc...) and linkage to prevention services as appropriate. www.gacapus.com
- Assess the client's emotional state. Be prepared to acknowledge feelings and answer questions.

PROVIDING AN INDETERMINATE RESULT

An indeterminate test result means that the test could not determine HIV infection. The result of the confirmatory test (negative) was incongruent with the result of the initial HIV test (positive). Indeterminate test results usually refer to confirmatory testing.

An indeterminate test should be repeated according to the program protocol.

- An indeterminate test result means that the HIV test did not show clearly **whether or not** the client is infected.
- Only confirmatory HIV tests can be considered indeterminate.
- Indeterminate test results should be given to the client **in a clear and concise way** that he or she can understand.
- Assess the client's emotional state. Be prepared to acknowledge feelings and answer questions.



LABORATORY TESTING RESULTS

What to say when delivering the result:

REACTIVE RESULTS

You might say to clients:

"The test result shows that you are infected with HIV."

NONREACTIVE RESULTS

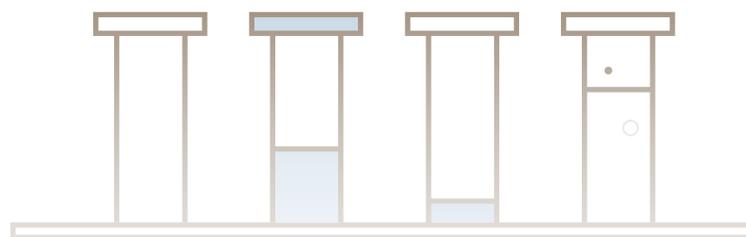
You might say to clients:

"The test result shows that there is no evidence of HIV infection. If you've had a recent exposure, it may be too early to tell if you are infected. You should be retested in _____ weeks."

INDETERMINATE RESULTS

You might say to clients:

*"Your test result is indeterminate, which means that the test cannot tell **whether or not** you have HIV. Because you have been recently exposed to HIV, I am going to refer you to _____ for additional testing."*



REACTIVE RESULTS

If the results from the CDC-recommended laboratory algorithm indicate HIV infection, clients should be linked to HIV medical care (i.e. mental health, substance abuse, housing, etc. (www.gacapus.com)) and referred to partner services (PS) and/or other prevention services. If the laboratory algorithm results indicate an acute infection, **linkage to care should be expedited, if possible, due to the increased risk of transmission to partners.** In addition, it is beneficial for clients to be counseled to assist them in adopting risk-reduction strategies.

NONREACTIVE RESULTS

A nonreactive test result indicates no evidence of HIV infection and can be interpreted as HIV negative. Depending on the window period associated with the test that you are using, clients that report recent known or possible exposure to HIV can be advised that, because of their recent exposure, it is possible the test did not detect HIV antibodies **at this time.** You should recommend retesting at an appropriate interval based on the client's risk and the type of test used. Also, provide other information on a comprehensive prevention plan (pamphlets, condoms, PrEP, nPEP, etc...) and linkage to prevention services as appropriate. (www.gacapus.com)

INDETERMINATE RESULTS

On occasion, confirmatory tests will yield indeterminate results. These test results may be related to recent infection, infection with HIV-2, concurrent infection with other viruses or diseases, vaccination (e.g., HIV vaccine trial participants), or problems with the sample or testing procedure. In this case, laboratories should conduct further testing to rule out the possibility of acute HIV infection. Sometimes, the laboratory may request an additional. If the laboratory used by your agency cannot perform a more definitive test, the client must be referred to a provider that has access to such technology. Also, provide other information on a comprehensive prevention plan (pamphlets, condoms, PrEP, nPEP, etc...) and linkage to prevention services as appropriate. (www.gacapus.com)

CLIA-WAIVED RAPID HIV TESTING

REACTIVE

NONREACTIVE

INVALID

In rare cases, an initial rapid HIV test will be reactive and a follow-up test will be nonreactive. If this happens when follow-up testing is done at a clinical provider or laboratory, it will either be resolved before your agency receives the follow-up test results, or your agency should receive guidance about how to deliver these results and the next steps. However, if this happens when you are conducting a second rapid HIV test onsite, you may need to incorporate language about what this means and what the next steps are.

You might say to clients:

“The first test was reactive, and we ran a second test, which was nonreactive. Since those 2 tests gave us different results, we can’t be sure about your HIV status. We are sending the blood we drew to an offsite lab for confirmation. We’ll make an appointment for you to come back and get those results in 1 week.”

REACTIVE INITIAL RESULTS

If the initial rapid HIV test is reactive, this indicates that HIV antibodies or antigen have been detected. The result is interpreted as a preliminary positive test result and follow-up testing is required to confirm the diagnosis.

In most cases, clients who are reactive on their initial rapid HIV test are true positives; that is, they are likely to be reactive on a follow-up test as well and should be prepared to receive a confirmed positive result.

For this reason, it is preferable to immediately link clients who have preliminary positive test results to HIV medical care and to PS if follow-up testing cannot be conducted onsite. It is also important to counsel clients and to assist them with risk-reduction strategies while awaiting their follow-up test results.

Follow-up testing should be arranged according to the algorithm your agency uses for rapid testing, which might include 1 of 3 possible options:

- 1.** Make a referral to a clinical provider that can perform follow-up testing and immediate linkage with HIV medical care. The client may also return back to you to be linked with other services, as appropriate.
- 2.** Collect a sample and send it to a laboratory for follow-up testing, while initiating linkage with HIV medical care and other services, as appropriate.
- 3.** Conduct a second rapid HIV test onsite, deliver the confirmatory result, and link the client with HIV medical care or other services, as appropriate.

You might say to clients:

“The test result was reactive, which means it is very likely that you have HIV. We need to do a second test to confirm the results.”

Once you have the results of the follow-up test (whether received from a laboratory or from your second rapid HIV test conducted onsite), you should deliver these as confirmed results. In most cases the results of the follow-up test will match the results of the initial test; that is, they will also be reactive and you will confirm the client’s HIV-positive status.

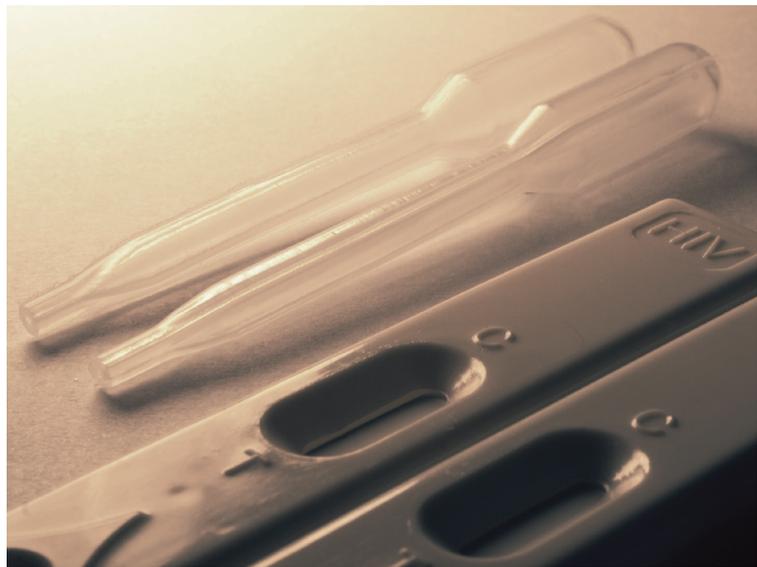
You might say to clients:

“The results of your follow-up test were also reactive, which means you have HIV. I’d like to link you with a medical provider who will do some additional testing and get you enrolled in medical care.”

CLIA-WAIVED RAPID HIV TESTING

For a nonreactive result, you might say to clients:

"The test result does not show signs of HIV infection. However, since you mentioned that you've recently had sex without a condom with someone whose HIV status you don't know, I'd like to recommend that you get retested in _____ weeks."



NONREACTIVE RESULTS

If the result of a rapid test is nonreactive, the test result is interpreted as HIV-negative. Depending on the window period associated with the test that you are using, clients that report recent known or possible exposure to HIV can be advised that, because of their recent exposure, it is possible the test did not detect HIV antibodies **at this time**. You should recommend retesting at an appropriate interval based on the client's risk and the type of test used.

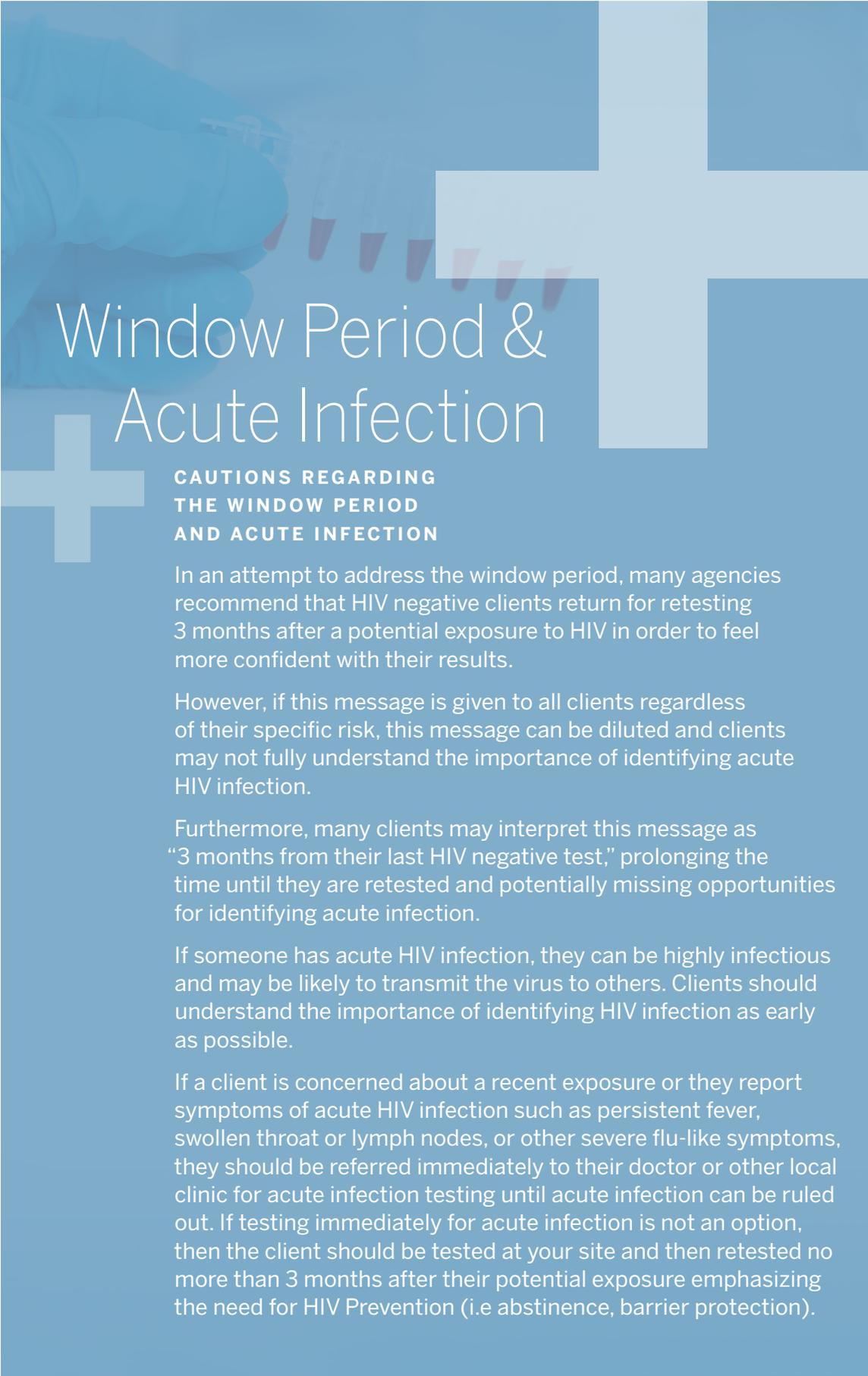
Also, provide other information on a comprehensive prevention plan (pamphlets, condoms, PrEP, nPEP, etc...) and linkage to prevention services as appropriate.

websites: www.gacampus.com, PrEP toolkit, etc.

INVALID RESULTS

If a rapid test produces an invalid result, it cannot be interpreted. Invalid results are often the result of user error, which means you may have conducted the test incorrectly. You should repeat the HIV test on a new sample obtained from the client, and may wish to call in a supervisor or other experienced HIV testing provider to assist with the test. Also, provide additional information on a comprehensive prevention plan (pamphlets, condoms, PrEP, nPEP, etc...) and linkage to prevention services as appropriate (www.gacampus.com).

For additional information on invalid rapid test results, refer to the package insert provided with the test kit by the manufacturer.



Window Period & Acute Infection

CAUTIONS REGARDING THE WINDOW PERIOD AND ACUTE INFECTION

In an attempt to address the window period, many agencies recommend that HIV negative clients return for retesting 3 months after a potential exposure to HIV in order to feel more confident with their results.

However, if this message is given to all clients regardless of their specific risk, this message can be diluted and clients may not fully understand the importance of identifying acute HIV infection.

Furthermore, many clients may interpret this message as “3 months from their last HIV negative test,” prolonging the time until they are retested and potentially missing opportunities for identifying acute infection.

If someone has acute HIV infection, they can be highly infectious and may be likely to transmit the virus to others. Clients should understand the importance of identifying HIV infection as early as possible.

If a client is concerned about a recent exposure or they report symptoms of acute HIV infection such as persistent fever, swollen throat or lymph nodes, or other severe flu-like symptoms, they should be referred immediately to their doctor or other local clinic for acute infection testing until acute infection can be ruled out. If testing immediately for acute infection is not an option, then the client should be tested at your site and then retested no more than 3 months after their potential exposure emphasizing the need for HIV Prevention (i.e. abstinence, barrier protection).

Cautions



CAUTIONS

FALSE-NEGATIVE AND FALSE-POSITIVE TEST RESULTS

**Please note:*

The median window period for third-generation tests was 22 days (19-25) and 18 days (16-24) for fourth-generation tests. The probability of a false negative result is 0.01 at 80 days' post-exposure for third-generation tests and at 42 days for fourth-generation tests. https://www.unbound-medicine.com/medline/citation/25033879/Probability_of_a_false_negative_HIV_antibody_test_result_during_the_window_period:_a_tool_for_pre_and_post_test_counselling_

SOURCES

Fundamentals of HIV Prevention Counseling (CDC 2009)

Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers (CDC2016)

www.gacampus.com

FALSE-NEGATIVE TEST RESULTS

False-negative test results occur when someone who is infected with HIV receives an HIV-negative test result. This scenario has been documented in persons on ART and in some persons receiving PrEP. However, additional data are needed to determine the extent to which test performance is affected by these factors. HIV testing providers may wish to ask clients if they are currently using ART, nPEP/PEP, or PrEP, **in order to** determine if additional testing is necessary to rule out a false negative result. False-negative results may occur for other reasons as well, such as test design, improper test procedures, or mislabeling of the specimens.

FALSE-POSITIVE TEST RESULTS

False-positive test results occur when someone who is not infected with HIV receives an HIV-positive test result. This scenario is not frequent, but can occur in clients who are participating in HIV vaccine trials. HIV vaccine-induced antibodies can cause a rapid HIV antibody test to give a positive result, even though the person does not have HIV. All clients who receive an HIV-positive test result and who are also HIV vaccine trial participants should contact the vaccine trial site for evaluation or to receive a referral to HIV medical care for further evaluation and/or testing. False-positive test results also occur in people who have not received the HIV vaccine in the study trial. The number of clients who received false positive test results will vary based on the type of tests you use and the HIV prevalence in your setting. False-positive results may also occur for other reasons such as those mentioned under false-negative results.

DELIVERING TEST RESULTS

*WRITTEN RESULTS

Delivering Test Results
Your agency should have clearly defined protocols for delivery of HIV test results. These protocols can be described in your agency's HIV testing policies and procedures. Although there are pros and cons to the different approaches for delivering HIV test results, (e.g., face-to-face, telephone, or Internet), it is most important that clients do receive their results, as well as referrals to and linkage with appropriate follow-up services. If you use laboratory testing as either the initial HIV test or for follow-up testing after a reactive rapid HIV test result, you will need to schedule a second encounter with the client **in order to** deliver their confirmed results. However, if rapid HIV testing is performed, the **vast majority** of clients will receive their test results on the same day during the testing encounter.

**Written results should not be provided when conducting anonymous HIV testing. It is important to address provision of written test results in your agency's policies and procedures.*

FACE-TO-FACE DELIVERY

Delivering results face-to-face allows you to have some engagement with the client, to assess their reaction to their test results, and to link them with HIV medical care or prevention services, if indicated, or to other appropriate follow-up services. For most nonclinical sites conducting rapid HIV testing, results can be delivered face-to-face during the same visit at which the client was tested. If laboratory testing was conducted, you may still wish to schedule a return visit for the client to deliver their results face-to-face at your site. When possible, it is recommended that HIV-positive results be delivered face-to-face.

INTERNET DELIVERY/MESSAGING SERVICE

At times, agencies use telephone/messaging service or Internet (video chat, or other secure HIPAA compliant messaging service) to deliver a client's HIV test results. This approach may be beneficial for clients who are not likely to return to the testing site for their results. Although this approach is not ideal for delivering HIV-positive test results, if it is the only way a client will receive their results, then it should be supported. Agencies who deliver results should make a concerted effort to ensure clients have all the information and support they need to access HIV medical care or prevention services, as indicated, and other appropriate follow-up services. Some agencies have had success with video chat for returning results, since it allows for some personal engagement of the client. This can be particularly useful for agencies supporting home-based HIV testing, for following up with clients and supporting linkage to care, as appropriate.

WRITTEN RESULTS

Clients sometimes request written copies of their test results. If you are delivering written HIV negative test results, the results should be accompanied by a clear statement about the meaning of the test results, relative to the window period of the test used. It may also be useful to indicate when the client should return for retesting and provided additional information on a comprehensive prevention plan (pamphlets, condoms, PrEP, nPEP, etc...) and linkage to prevention services as appropriate. If your agency is providing written test results they should be provided on your agency letterhead or a similar form and should clearly state the following:

- The name of your agency and the date the test was conducted
- The test result (positive, negative or indeterminate)
- Explanation of the result relative to the window period and/or date for retesting

STEPS FOR CONDUCTING HIV TESTS WITH INDIVIDUALS

All HIV testing sessions in nonclinical settings will generally follow the same overall structure, regardless of where they are being conducted or who is being tested. That is, a person will conduct certain steps before delivering the results (called “pre results steps”), and certain steps after delivering results (called “post results steps”). This chapter will review these steps, outline essential tasks for each step, and present additional considerations for your HIV testing session with individual clients

REDUCED COUNSELING APPROACH

**CDC no longer supports extensive pretest and posttest counseling. Instead, HIV testing providers should conduct brief, information-based sessions tailored to their clients, as outlined below. CDC has found this strategy to be more effective in a rapid HIV testing environment. The most widely recommended intervention pairing HIV prevention counseling and HIV testing, Project RESPECT, was originally conceived as involving traditional HIV tests that required clients to return for their test results several days after testing. Because of the changed HIV testing environment, CDC no longer supports the RESPECT intervention or the HIV prevention counseling protocol that is based on the RESPECT model*

INCORPORATING HIV TESTING INTO HIV PREVENTION COUNSELING PRE-RESULTS AND POST- RESULTS STEPS

RAPID HIV TESTING 10–20 minute read time	INSTANT HIV TESTING ~1 minute read time	NONRAPID HIV TESTING Laboratory
PRE RESULTS STEPS	PRE RESULTS STEPS	PRE RESULTS STEPS, INITIAL VISIT
– STEP 1 – Introduce and orient client to session	– STEP 1 – Introduce and orient client to session	– STEP 1 – Introduce and orient client to session
– STEP 2 – Prepare for and conduct initial rapid HIV test (10–20 minute read time)	– STEP 2 – Conduct brief risk screening	– STEP 2 – Conduct brief risk screening
– STEP 3 – Conduct brief risk screening	– STEP 3 – Prepare for and conduct initial instant HIV test (~1 minute read time)	– STEP 3 – Prepare for test and collect sample to send to laboratory
Post Results steps	Post Results steps	Post Results steps, return visit (ideally, no more than 1 week after initial visit)
– STEP 4 – Provide results of initial rapid HIV test and follow your agency’s protocol for conducting follow-up confirmatory testing	– STEP 4 – Provide results of initial instant HIV test and follow your agency’s protocol for conducting follow-up confirmatory testing	– STEP 4 – Check in with client
– STEP 5 – Develop care, treatment, and prevention plan based on results	– STEP 5 – Develop care, treatment, and prevention plan based on results	– STEP 5 – Provide confirmed result
– STEP 6 – Refer and link with medical care, social and behavioral services	– STEP 6 – Refer and link with medical care, social and behavioral services	– STEP 6 – Develop care, treatment, and prevention plan based on results

STEPS FOR CONDUCTING HIV TESTS WITH INDIVIDUALS

The steps for individual HIV testing will vary slightly depending on the type of test kit and testing algorithm that is being used. We present three scenarios below—one for sites using 10–20 minute rapid tests, one for sites using ~1 minute “instant” tests, and one for sites that draw a specimen for laboratory testing or “nonrapid” testing.

As you can see, the steps are more or less the same for all three scenarios, with minimal modifications. In the rapid testing scenario, the HIV test is conducted as step 2 and then while the test is developing you will conduct a brief risk screening. However, in the instance of nonrapid testing scenarios, you will conduct a brief risk screening and then conduct the instant test or collect the sample. The nonrapid scenario also presents the steps in two visits, not just one. Following this approach, the return visit should ideally not occur more than 1 week after the initial visit, in order to ensure return for results and linkage.

Pre Results Steps

THERE ARE 3 PRE RESULTS STEPS FOR INDIVIDUAL HIV TESTING:

STEP 1: Introduce and orient the client to the session

STEP 2: Prepare for and conduct the rapid HIV test

STEP 3: Conduct brief risk screening

Post Results Steps

The additional step in this scenario is to simply check in with the client before delivering their results, since some time will have passed since you last saw them.

THE 3 POST RESULTS STEPS FOR INDIVIDUAL HIV TESTING ARE:

STEP 4: Deliver results

STEP 5: Develop a comprehensive care, treatment, and prevention plan based on results (i.e. provide information on a comprehensive prevention plan (pamphlets, condoms, PrEP, nPEP, etc...) and linkage to prevention services as appropriate.

STEP 6: Refer and link with medical care, social and behavioral services (i.e. mental health, substance abuse, housing, etc.)

If you are conducting laboratory testing, remember that you will include 1 additional step before delivering results. When the client returns to your site for his or her result (ideally no more than 1 week after the initial visit), you should first take a moment to check in with the client to address any HIV risk concerns or issues since the last visit. Then proceed with delivering results.

PRE RESULTS STEPS

STEP

1.

INTRODUCE AND ORIENT THE CLIENT TO THE SESSION

The first thing you will do when conducting an individual HIV testing session is introduce yourself and orient the client to the session. Conducted in 5-10 minutes.

SOURCES

Fundamentals of HIV Prevention Counseling (CDC 2009)

Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers (CDC2016)

www.gacapus.com

Key Tasks For Step 1:

*Introduce yourself and describe your role.
Provide a brief session overview, including:*

HOW LONG THE SESSION WILL TAKE
PROCESS FOR CONDUCTING THE TEST
HOW RESULTS ARE RETURNED

(i.e., same day or return for results)

OBTAIN CONCURRENCE TO PROCEED WITH THE SESSION

(This step is important for building rapport and establishing client expectations for what will happen during the HIV testing session. Generally this step will take about 1–2 minutes)



**PREPARE FOR
AND CONDUCT
RAPID HIV TEST**

In step 2, you will provide the client with basic information about the HIV test. Use simple, clear language that the client can understand. Provide information in a language and at a reading level appropriate to the client. Information can be presented verbally, written, or through videos, computers, or other electronic technology.

SOURCE

www.gacapus.com

Key Tasks For Step 2:

Explain the process of conducting the HIV test, including:

- Type of test used (rapid vs. nonrapid; antibody vs. combination antibody/antigen test)
- Sample collected (blood vs. oral)
- Time until test results are ready

Explain the meaning of HIV-negative, HIV-indeterminate and HIV-positive test results, including:

- Need for retesting if HIV-negative
- Provide information on a comprehensive prevention plan (pamphlets, condoms, PrEP, nPEP, etc...) and linkage to prevention services as appropriate.
- Need for and process of conducting follow-up testing if HIV-positive
- Possibility of invalid result

Obtain consent to test (oral or written)

Distribute test kit information booklet (required for CLIA-waived tests)

Collect specimen and conduct rapid HIV test

You may conduct the test in the same room where the entire session is taking place, or you may take the client to an onsite laboratory where all testing is performed. If you conduct the test in the same room where the session occurs, it may be useful to set the test kits to the side while they are developing, or set up a screen to block the client's view so that the client does not get distracted or anxious watching the test develop. If the test is conducted in an onsite laboratory—or, in the case of mobile or outreach testing, in a central location where one person is responsible for doing multiple tests—you must ensure client confidentiality and accuracy of test results. Tests should always be performed according to the directions outlined in the test kit insert, and test kits should be clearly labeled to ensure that the correct results are given to the correct client.

PRE RESULTS STEPS

STEP

3

RISK SCREENING

While you are waiting for the test results take a few moments to conduct brief risk screening to better understand the client's HIV risk. You may use your agency's data collection tools to guide the risk screening, or you may engage the client in a brief discussion of their immediate risk concerns. You may start by asking the client how they decided to be tested, and then listening and probing for additional information about immediate, recent, or ongoing risk. If the client needs to be referred immediately for other services such as nPEP, acute infection testing, or medical care, make linkages with those services at this point.

SOURCES

Fundamentals of HIV Prevention Counseling (CDC 2009)

Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers (CDC2016)

Key Tasks For Step 3

Ask how the client decided to be tested; listen and probe for previous testing history and indicators of increased risk including:

- Potential exposure in last 24–72 hours (to indicate need for nPEP)
- Potential exposure in last 3 months (to indicate need for acute infection testing)
- Symptoms (to indicate need for acute infection testing and accessing medical care)
- Ongoing risk behavior or key population (MSM, PWID, partner with unknown or known HIV-positive status, transgender woman)

Address indicators of increased risk and make immediate referrals to other services (i.e. nPEP, acute infection testing, or medical care) as indicated. Please see www.gacapus.com for additional resources)

Assess the client's knowledge of HIV transmission, provide accurate information as needed

Prepare for possible test results



POST RESULTS STEPS

STEP

4

DELIVERY OF RESULTS

If you are conducting a CLIA-waived rapid HIV test, after following the manufacturer's instructions and allowing for the appropriate time for the test to process, you will read the test device and interpret the result. If the test was conducted by another staff at your agency or outside the room where the client is waiting, obtain the result and return to the client. If the client was in the waiting room, call him or her back to the HIV testing room to receive their result. If the test result is preliminary and must be confirmed with a follow-up test, you will indicate this to the client and follow your agency's procedures (as outlined above) for follow-up testing.

Key Tasks For Step 4:

The 2 key steps for delivering results are:

- Confirm the client's readiness to receive their result
- Provide a clear explanation of the client's result

Most clients will confirm that they are ready to receive their result because they came to you specifically for this purpose. Their confirmation is also an indication that you have done a successful job preparing them to receive their result during the pre results steps.

On very rare occasions, clients may change their mind about receiving their result. If clients state that they are not ready to hear their result, engage them in a discussion about reasons they do not feel ready. Provide motivation and support for clients by reminding them of the importance of knowing their status and making decisions for their health based on their status. Once the client has a chance to talk about his or her concerns, they may be ready to hear their result.

If the client still refuses, respect his or her decision, discuss options for getting the result **at a later date**, and make arrangements to follow-up with the client.

Specific tasks For Step 5:

(For clients testing HIV-negative)

- Explore client's reaction to result
- Discuss need for retesting based on window period of test used and client's risk
- Emphasize key risk reduction strategies that will help the client remain HIV-negative:
 - Choose less risky sexual behaviors
 - Get tested for HIV together with partner(s)
 - Use condoms consistently and correctly
 - Reduce number of sex partners
 - Talk to doctor about PrEP (as indicated, according to PrEP screening indicators)
 - Talk to doctor about nPEP (as indicated, within 3 days following a specific exposure to HIV)
 - Get tested and treated for other STDs and encourage partners to do the same
 - Provide condoms

POST RESULTS STEPS

STEP

5

PLAN DEVELOPMENT

Develop a care, treatment, and prevention plan with the client based on their HIV test results and risk issues identified during the brief risk screening.

After receiving their test result, whether HIV-negative or HIV-positive, clients may have a hard time absorbing lots of information so it may be most effective to identify key referral services, make linkages with those services, and schedule follow-up visits if the client has additional concerns.

Alternatively, another provider, such as a linkage coordinator or patient navigator, can also address the client's concerns during follow-up visits.

Specific tasks For Step 5: (For clients testing HIV-positive)

- Explore client's reaction to result Advise on next steps for follow-up testing
- Discuss disclosure and inform about processes for partner services
- Advise to access care and treatment for HIV
 - Treatment can help people with HIV live long, healthy lives and prevent transmission
 - Treatment as Prevention (TasP 96% reduction in transmission/extend life to near normal lifespan)
 - Other health issues can be addressed
- Emphasize key risk reduction strategies that will prevent transmission
- Choose less risky sexual and drug-using behaviors
- Get tested together with their partners
- Use condoms consistently and correctly
- Reduce number of sex partners
- Encourage partners to be tested
- Provide condoms
- If pregnant, maternal viral load suppressed to <50 copies/mL near delivery, use of combination ART during pregnancy has reduced the rate of perinatal transmission of HIV from approximately 20% to 30% to 0.1% to 0.5%.

<https://aidsinfo.nih.gov/guidelines/html/1/adult-and-adolescent-arv-guidelines/10/initiation-of-antiretroviral-therapy>

Clients receiving an HIV-positive result for the first time might also experience a wide range of emotions, including shock, grief, or other strong feelings. While exploring the client's reaction to his or her result, you can effectively use silence to express empathy and give the client space to absorb this new information. Attend to the client's immediate needs before moving on with the other tasks. Advise the client on their next steps for follow-up testing to confirm the HIV-positive test result.

POST RESULTS

STEP

6

REFER AND LINK WITH MEDICAL CARE, SOCIAL, AND BEHAVIORAL SERVICES

Throughout the HIV testing session, you will receive information from clients that will help you determine what additional services they need in order to stay healthy, safe, and prevent HIV transmission or acquisition. Before you close the session, you will identify the necessary medical, social, and behavioral services that are appropriate for the client, and then provide the client with referrals and link them to these services. Some of these services may be provided by your agency; for others, you will need to refer outside your agency.

PLEASE CHECK

www.gacapus.org for additional information on service related issues

The 3 tasks For Step 6: (For clients testing HIV-negative)

- Identify necessary medical, social, and behavioral referral services
- Make referrals as indicated
- Track linkage to HIV medical care

For clients who test HIV-negative, some of the services you might refer them to include:

- nPEP and PrEP
- Partner or couples HIV testing
- Retesting for HIV
- Screening and treatment for STDs, hepatitis, and/or TB
- High-impact behavioral interventions that can reduce their risk of acquiring HIV
- Reproductive health services
- Counseling and services for mental health, substance abuse, and/or domestic violence
- Insurance navigation and enrollment
- Housing
- Other social and behavioral services

For clients who test HIV-positive, some of the services you might refer them to include:

- HIV care and treatment
- Partner services
- Medication adherence services
- Partner or couples HIV testing
- Screening and treatment for STDs, hepatitis, and/or TB
- High-impact behavioral interventions for newly diagnosed HIV-positive persons
- Reproductive health services
- Counseling and services for mental health, substance abuse and/or domestic violence
- Insurance navigation and enrollment
- Housing
- Other social and behavioral services

COUPLES HIV TESTING AND COUNSELING (CHTC)

Couples HIV testing and counseling (CHTC), or **Testing Together**, is an approach to HIV testing, whereby 2 or more persons who are in—or are planning to be in—a sexual relationship are tested for HIV together.

Couples go through the entire process together, and receive their results together. **Testing Together** is different from individual testing because it is not focused on past risk behavior, but rather supports couples to address their joint risk concerns with a focus on the present and the future.

Couples are only separated if there is suspicion of coercion or to confirm information collected on individual data forms. **Testing Together** is voluntary, and couples may decide at any time during the session that they prefer to be tested separately.

SOURCES

Fundamentals of HIV Prevention Counseling (CDC 2009)

Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers (CDC2016)

www.gacapus.com



DIFFERENCES FROM INDIVIDUAL TESTING

Testing Together follows a very similar structure to individual HIV testing but with some key differences.

These are outlined below:

INDIVIDUAL HIV TESTING	TESTING TOGETHER
Clients learn their individual HIV status alone.	Clients learn their own HIV status as well as that of their partner(s).
Clients must disclose to their partner on their own, or use PS.	Counselor-facilitated mutual disclosure among partners is immediate and 100%.
Clients deal with issues of tension and blame on their own	Provider is there to help ease tension and diffuse blame.
Individual risk screening is based on past risk behavior.	Couple's joint risk concerns are discussed with a focus on the present and the future.
Focus is on health education.	Skill building is focused on couple's communication and sexual agreements.
Referrals and linkage are based only on client's HIV status and needs.	Referrals and linkage are tailored to the results and needs of both partners.

REFERRAL, LINKAGE AND NAVIGATION

A primary goal of HIV testing is to identify clients with undiagnosed HIV infection and link them to HIV medical care as soon as possible. Additionally, HIV testing providers may play a role in the reengagement of previously diagnosed HIV-positive persons who are not currently engaged in care

ADDITIONAL RESOURCES

www.gacapus.com

SOURCES

Fundamentals of HIV Prevention Counseling (CDC 2009)

Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers (CDC2016)

www.gacapus.com

Defining Referral, Linkage and Navigation

Referral is the process by which you actively provide clients with information and assistance in accessing medical care, social, and behavioral services.

The referral process includes conducting an initial assessment of the client's needs, identifying and prioritizing those needs based on this assessment, identifying barriers to accessing referral services, developing a plan for accessing referral services with the client, and facilitating his or her access to these referral services.

Linkage is the outcome verifying the successful completion of your referral by the client. Linkage includes following up with either clients or providers to confirm linkage and documenting the results. For example, when you confirm and document that a client made it to the first medical appointment within 30 days following the initial diagnosis, this is considered successful linkage.

Navigation is the overarching system that includes referral and linkage, but which may also extend beyond these steps to include continuous engagement with clients or patients to ensure they remain engaged in HIV medical care, social, and behavioral services for as long as necessary to support viral suppression and HIV prevention.

HIV navigation services are intended to serve both clients living with HIV as well as HIV-negative individuals who are at risk of acquiring HIV. The objectives of HIV navigation services are twofold: **(1)** to provide direct assistance to clients in accessing services, and **(2)** to support clients in building the knowledge and skills necessary to access and use the system on their own. This process may require contacting clients or patients on a regular basis to identify and address their barriers to staying engaged in care. Navigation often extends beyond the HIV testing encounter.

TARGETING AND RECRUITMENT

Targeting and recruitment is the process by which persons from your focus population are located, engaged, and motivated to access HIV testing services. Regardless of whether HIV testing providers are directly involved in targeting and recruitment, they should be aware of how their HIV testing services are messaged in the community and how clients reach them for testing.

SOURCES

Fundamentals of HIV Prevention Counseling (CDC 2009)

Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers (CDC2016)

www.gacapus.com

Defining Targeting

Targeting is the process for defining how you will direct your HIV testing services to identify persons who are unaware of their HIV status and who are at greatest risk for HIV infection. Appropriately targeting your HIV testing services to these highest-risk populations is necessary for maximizing resources, and for identifying undiagnosed HIV-positive persons in need of HIV medical care, treatment, and prevention services. Targeting can also help you identify high-risk HIV-negative persons needing important HIV prevention services, such as PrEP, nonoccupational postexposure prophylaxis (nPEP), and other social and behavioral interventions.

In nonclinical settings, it is important to target your services to identify high-risk individuals who do not access health care services or who may not otherwise have access to HIV testing in clinical settings—these are the persons who may benefit most from HIV testing services in nonclinical settings, and so these are the persons you should attempt to recruit into your program.

Additionally, in defining your focus population and how to reach them, your program should consult multiple data sources, including local epidemiologic and surveillance data, recent programmatic monitoring and evaluation data, and your health department's Comprehensive HIV Prevention Jurisdictional Plan. Members of your focus population, agency staff, and other service providers can also be important sources of information for identifying high-risk populations, where they congregate in the community, and the best ways of reaching them. Key informant interviews, which are brief interviews to obtain feedback from these groups, can be used for this purpose. Each agency will need to define or segment their focus populations, which should include both their primary focus population and their secondary focus population (or subpopulation). **In order to** narrow your overall focus population to reach persons most at risk for HIV infection, you will need to know what high-risk behaviors and other factors are related to increased risk in your community, who is engaging in these behaviors or is affected by these factors, and where to identify these populations. This will help you tailor your messages and services in a way that resonate with your focus population and plan for how to reach them.

TARGETING AND RECRUITMENT

The 6 primary categories of recruitment strategies are the following:

1. Street-based and venue-based outreach
2. Internet outreach
3. Social marketing
4. Internal referrals
5. External referrals
6. Social networking

SOURCES

Fundamentals of HIV Prevention Counseling (CDC 2009)

Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers (CDC2016)

www.gacapus.com



Defining Recruitment

Recruitment begins once you have defined your focus population and identified where and how to reach them (i.e., targeting).

Community assessment or formative evaluation can provide valuable information on recruitment, given the dynamics of different communities, and the potential for certain strategies to work better than others with high-risk groups. Your agency should develop a recruitment plan that outlines when, where, and how recruitment of the focus population should be done.

Once you have defined the recruitment strategies you will use to engage your focus population and outlined these in your plan, you should pilot these strategies and make refinements based on your results. Even after you begin implementing your recruitment strategies, you should routinely monitor your HIV testing services to determine if you are meeting your targets, and make adjustments to your recruitment strategies as needed.

RECRUITMENT STRATEGIES

IMPLEMENTING RECRUITMENT

In order to achieve the best results, your agency should employ multiple recruitment strategies to reach the focus population. You may even choose to use all 6 recruitment strategies because they each have their own benefits and potential for reaching different subgroups of the focus population. When selecting your recruitment strategy, your agency should consider staff safety, agency capacity, and availability of resources. Recruitment of the focus population is essential to the success of your high-impact HIV testing program.

SOURCES

Fundamentals of HIV Prevention Counseling (CDC 2009)

Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers (CDC2016)

www.gacapus.com

Recruitment Strategies

INTERNAL REFERRALS

Internal referrals **means** accessing the focus population through other services offered at the HIV testing agency, such as syringe services programs, substance abuse programs, mental health services, evidence-based HIV prevention interventions, sexually transmitted disease (STD) testing and treatment programs, and HIV medical care (for partners of people already in care). This approach can be successful, but persons with high-risk behaviors may not access these services independently, so additional recruitment strategies should also be used.

EXTERNAL REFERRALS

External referrals **means** that persons from the focus population are referred to HIV testing services by agencies outside the HIV testing program. External agencies may include syringe services programs, substance abuse programs, mental health services, evidence-based HIV prevention interventions, STD testing and treatment programs, HIV medical care, and homeless shelters. These offsite programs identify high-risk clients who are accessing their services and send them to your agency for HIV testing. Building strong partnerships with external agencies that tend to serve high-risk clients is important, as is sharing information with them about how to make appropriate referrals to your program. The Georgia CAPUS Resource Hub offers external referrals for those individuals within the state of Georgia looking for additional assistance such as housing, medical care, and overall information concerning HIV/AIDS. The mission of this Resource Hub is to serve as a one-stop information source for all things HIV/AIDS within the state of Georgia.

GA CAPUS RESOURCE HUB: www.gacapus.com

RECRUITMENT STRATEGIES

Agencies should aim to deliver strategic, culturally competent, community-based recruitment strategies that engage the focus population and motivate them to access HIV testing services. Organizations should collaborate with other organizations that have a history of working with and recruiting the focus population. They should seek input from community stakeholders, such as the Community Advisory Board, to select the most appropriate program promotion and recruitment strategies. Community stakeholders can also be useful for crafting recruitment messages, which may focus on increasing public awareness of the agency's services, destigmatizing HIV and HIV testing, and providing key information about HIV and HIV testing.



STREET-BASED AND VENUE-BASED OUTREACH

Street-based and venue-based outreach are done by engaging the focus population in their own environment, such as a **particular street**, neighborhood, hot spot, or venue (e.g., a bar, hotel, or community center). Outreach workers, who may include HIV testing providers, aim to reach the focus population with key messages about HIV and HIV testing. HIV testing services may also be offered in conjunction with street- and venue-based outreach, if appropriate, and some agencies will bring a mobile testing unit, such as a van or tent, to provide HIV testing for the focus population. Internet outreach

INTERNET OUTREACH

Internet outreach involves reaching the focus population through online venues, such as chat rooms, social networking sites, hook-up sites, and mobile applications. Agencies can promote HIV testing services including couples or partner testing through these approaches; provide information about HIV prevention, care, and treatment; or schedule appointments for clients seeking HIV testing. Internet-based outreach may be especially useful for reaching young people and MSM who do not identify as gay or who cannot be found in traditional outreach settings.

RECRUITMENT STRATEGIES

SNS

Social Networking Strategy (SNS)

PLEASE SEE

www.effectiveinterventions.org
for more information about SNS
and other public health strategies

SOURCES

Fundamentals of HIV Prevention Counseling (CDC 2009)

Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers (CDC2016)

www.gacapus.com

SOCIAL MARKETING

Social marketing is the use of media (e.g., flyers and brochures, posters, print advertisements, radio and television advertisements, or Internet advertisements) to recruit clients into HIV testing programs. Organizations can develop their own social marketing campaigns but are encouraged to use existing resources, such as those available from CDC, and tailor them to their jurisdiction's specific requirements.

CDC'S ACT AGAINST AIDS CAMPAIGN MATERIALS CAN BE ACCESSED AT <http://www.cdc.gov/actagainstaids/> and additional materials are available at <http://effectiveinterventions.cdc.gov/>.

SOCIAL NETWORKING

Social Networking Strategy (SNS) is a peer-driven approach to recruitment that involves identifying HIV-positive or high-risk HIV-negative persons from the community to serve as "recruiters" for your agency. Recruiters deliver key messages and encourage HIV testing among high-risk persons in their social, sexual, or drug-using networks.

They may use coupons or invitations as a way of documenting that they have delivered these messages to potential clients. The recruiters are trained or "coached" on the best approaches to reach their peers, including who should be reached through this approach and what messages can motivate their peers to be tested for HIV. Partner referral is a type of social networking that involves recruiters referring their sexual partners to an HIV testing program. Recruiters may refer their sexual partners to be tested alone, or recruiters may accompany their partners and be tested together in Couples HIV Testing and Counseling

In order to have an effective and innovative program, resources should be dedicated to carrying out your recruitment plan. You may have the most success if you

- hire and train specific recruitment staff who are separate from HIV testing staff
- build partnerships in the community to ensure multidirectional referrals and expand your reach
- use innovative approaches for reaching the focus population through Internet and social media
- offer incentives to reach previously unreached populations, generate interest in new services, or obtain buy-in for testing at high-risk venues (e.g., bathhouse or bar) where clients might need extra motivation to access HIV testing

CULTURAL RESPONSIVENESS AND HIV COUNSELING

A person's cultural background may influence how an individual views a health problem or risk. It also determines how symptoms and concerns are expressed, as well as, what type of treatment is provided. Knowledge and understanding of cultural perceptions of health and wellness is important in providing HIV prevention services to diverse populations.

SOURCES

Fundamentals of HIV Prevention Counseling (CDC 2009)

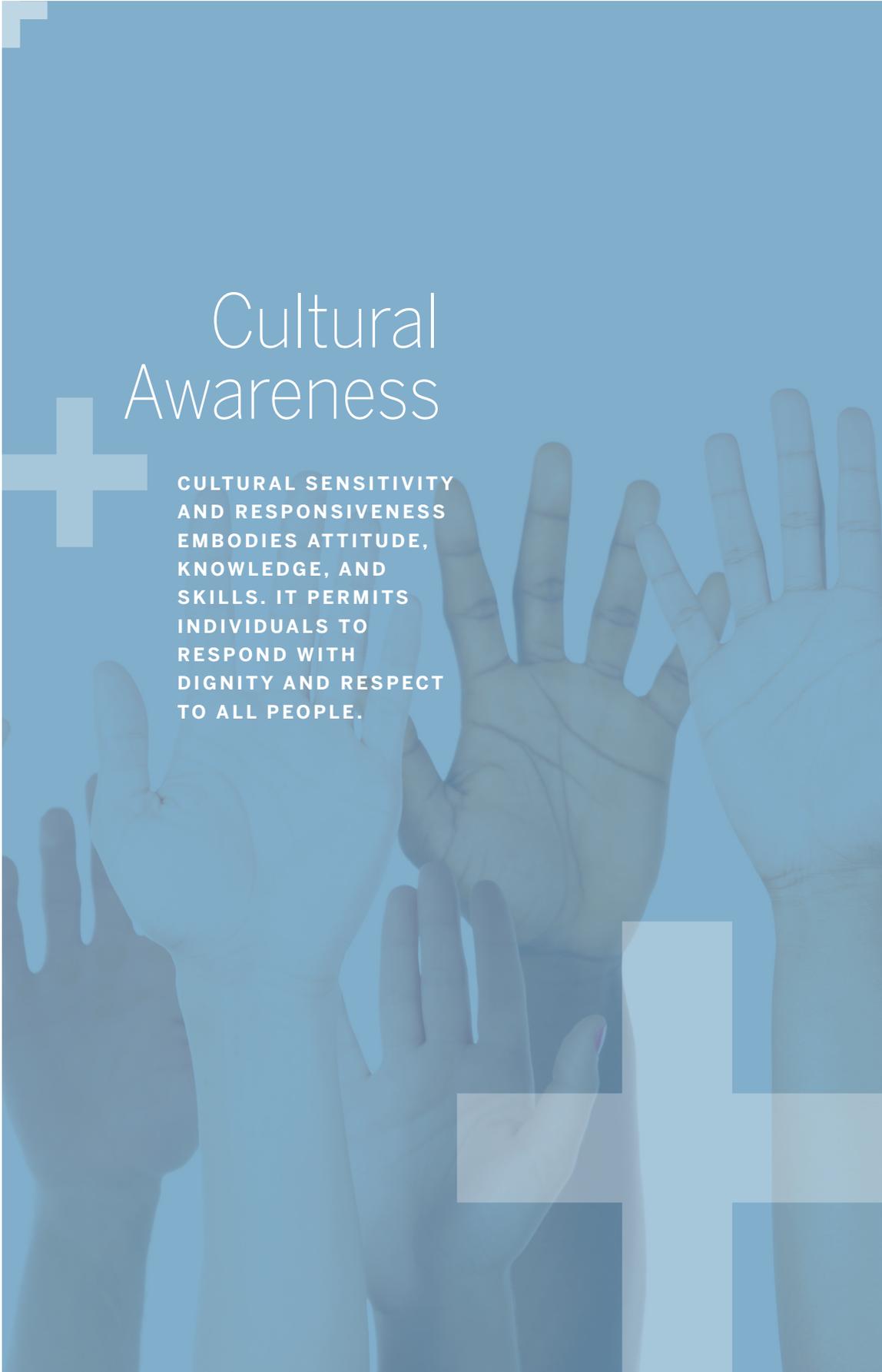
Implementing HIV Testing in Nonclinical Settings: A Guide for HIV Testing Providers (CDC2016)

www.gacapus.com



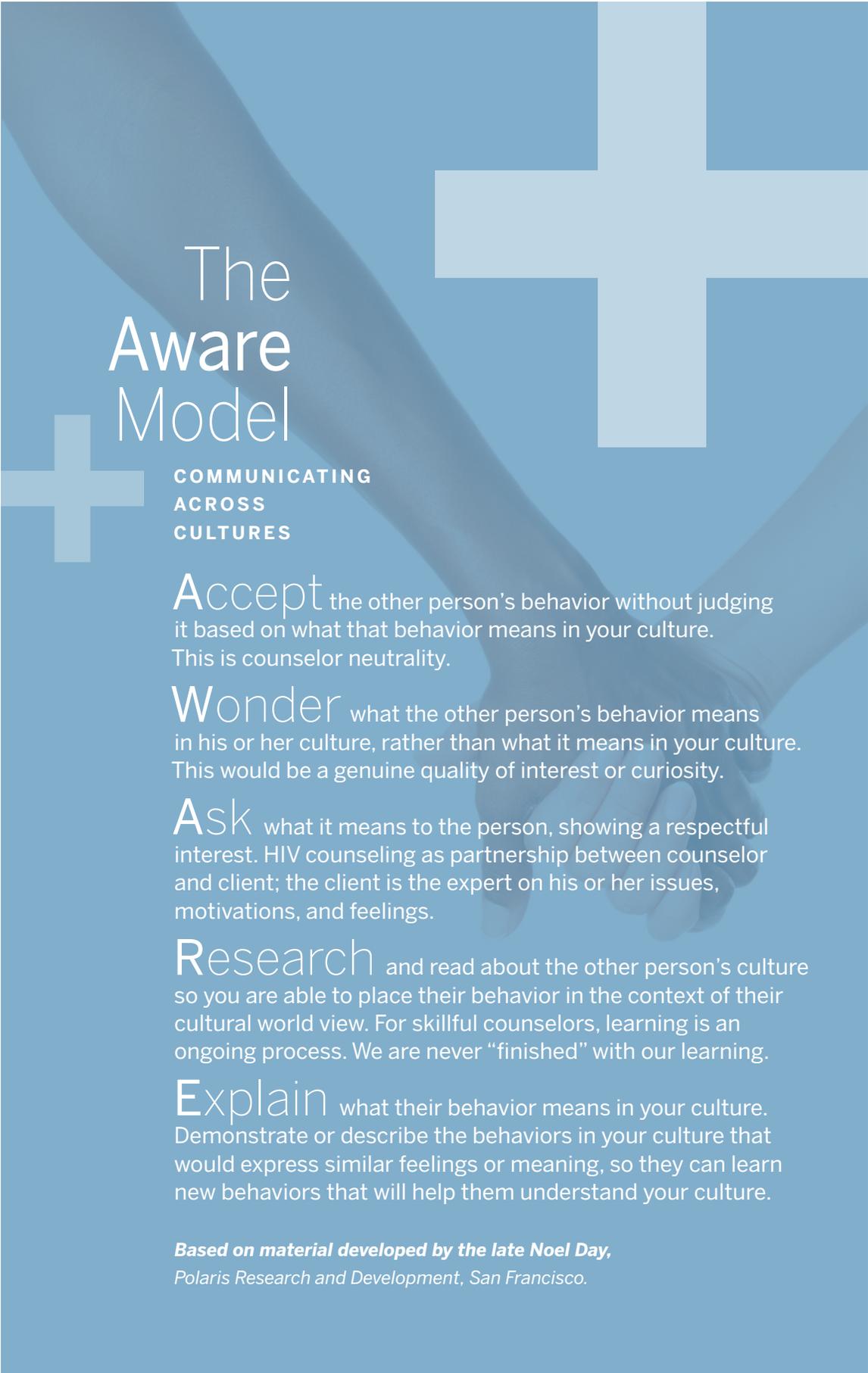
CULTURAL RESPONSIVENESS AND HIV COUNSELING

CULTURE INCLUDES	ELEMENTS OF CULTURE
Thoughts Communications <i>(verbal, nonverbal, literary)</i> Actions Customs Beliefs Values Institutions	Created through interactions Passed through generations Learned Not frequently discussed Provides further explanations Dynamic Difficult to change Source of emotional responses
CULTURAL FACTORS	VARIATIONS WITHIN CULTURAL GROUPS
OBJECTIVE The visible aspects of culture <i>(food, clothing, art, music, dance)</i> SUBJECTIVE The less tangible aspects of culture <i>(values, norms, expectations, beliefs)</i>	Ethnicity Age Socioeconomic status Religion Education Language Gender Sexual Orientation Length of time in the U.S. Urban vs. Rural Contact with elders Urban vs. Rural Contact with elders



Cultural Awareness

CULTURAL SENSITIVITY AND RESPONSIVENESS EMBODIES ATTITUDE, KNOWLEDGE, AND SKILLS. IT PERMITS INDIVIDUALS TO RESPOND WITH DIGNITY AND RESPECT TO ALL PEOPLE.



The Aware Model

COMMUNICATING ACROSS CULTURES

Accept the other person's behavior without judging it based on what that behavior means in your culture. This is counselor neutrality.

Wonder what the other person's behavior means in his or her culture, rather than what it means in your culture. This would be a genuine quality of interest or curiosity.

Ask what it means to the person, showing a respectful interest. HIV counseling as partnership between counselor and client; the client is the expert on his or her issues, motivations, and feelings.

Research and read about the other person's culture so you are able to place their behavior in the context of their cultural world view. For skillful counselors, learning is an ongoing process. We are never "finished" with our learning.

Explain what their behavior means in your culture. Demonstrate or describe the behaviors in your culture that would express similar feelings or meaning, so they can learn new behaviors that will help them understand your culture.

*Based on material developed by the late Noel Day,
Polaris Research and Development, San Francisco.*

CULTURAL RESPONSIVENESS AND HIV COUNSELING

POINTS TO REMEMBER ABOUT CULTURE

1. An awareness of one's own cultural values and beliefs and recognition of how they influence our attitudes and behaviors.
2. Feelings of apprehension, loneliness, and lack of confidence are common when visiting another culture.
3. When people talk about cultures, they tend to describe the differences not the similarities.
4. An understanding of the cultural beliefs and values of others and how they are influenced by them.

Understanding another culture is an ongoing process.

Cultural sensitivity and responsiveness embodies attitude, knowledge, and skills.

It permits individuals to respond with dignity and respect to all people. It is a continuum that encompasses several stages. Becoming culturally sensitive or responsive is not an overnight process. It is a process that takes time, attention, and self-awareness.

Cultural responsiveness should occur in both individuals and organizations. It is the state of being capable of functioning effectively **in the midst of cultural differences**. It is being sensitive enough not to impose our personal views on someone else because they are different. It is the ability to establish relationships with people **in the midst of diversity**.

Cultural awareness is not:

- Being politically correct
- A bandage on the problem
- Memorizing beliefs, knowledge, and practices of cultural groups
- Forcing one's own cultural practices and beliefs onto another group
- Adopting another's cultural values and beliefs
- The same as Equal Employment Opportunity and Affirmative Action.

Lack of cultural awareness leads to:

- Clients receiving poor care
- Lack of trust
- Lack of client compliance
- Lack of client satisfaction
- Lack of community support
- Worsening health status of the clients.

Culturally aware counselors are more effective because they understand and respond to the needs of the populations served. Being culturally sensitive or competent does NOT mean knowing everything about every culture. It is instead respect for differences, eagerness to learn, and a willingness to accept that there are many ways of viewing the world.

WORKING WITH SPECIAL POPULATIONS

Many clients are members of certain population groups who are involved in particular activities or circumstances that can present special challenges when providing HIV prevention services. Knowledge and effective communication with clients from these special populations is important when supporting behavior change for HIV risk reduction.

Special populations that may be encountered during your counseling and testing sessions are as follow:

Pregnancy

Domestic Violence

Homeless Population

Incarcerated Population

Transgender Population

Adolescent Population

Pregnancy

Women with HIV who are pregnant may pass the HIV virus on to their fetus or newborn. This is referred to as perinatal transmission (it occurs in the perinatal period, which spans from the point of conception through delivery and then into the first few weeks of life). Avoidance of breastfeeding has been and continues to be a standard, strong recommendation for HIV-infected women in the United States, because maternal ART dramatically reduces but does not eliminate breastmilk transmission. Further, safe infant feeding alternatives are readily available in the United States. It is important to address possible barriers to formula feeding beginning during the antenatal period. Similarly, there are risks of HIV transmission via pre-mastication (pre-chewing) of infant food. After birth, a child given pre-chewed (pre-masticated) food or who breastfeeds could also contract HIV if the mother carries the virus. HIV counselors should be aware of these important facts about perinatal transmission when working with this special population. After birth, a child who breastfeeds could also contract HIV if the mother carries the virus.

Pregnant women who are infected with HIV need special prenatal care to prevent perinatal transmission. A mother's risk for transmitting HIV to her unborn child decreases if the woman is provided medication during her pregnancy, labor, and delivery (maternal viral load

PREGNANCY

THE GEORGIA HIV/SYPHILIS PREGNANCY SCREENING ACT OF 2015 STATES:

“Every physician and health care provider who assumes responsibility for the prenatal care of a pregnant woman during gestation and at delivery shall be required to test such pregnant woman for HIV and syphilis except in cases where the woman refuses the testing. Additionally, every physician and health care provider who provides prenatal care of a pregnant woman during the third trimester of gestation shall offer to test such pregnant woman for HIV and syphilis at the time of first examination during that trimester or as soon as possible thereafter, regardless of whether such testing was performed during the first two trimesters of her pregnancy”.

OFFICIAL CODE OF GEORGIA

Section 31-17-4.2(a).



suppressed to <50 copies/mL near delivery, use of combination ART during pregnancy has reduced the rate of perinatal transmission of HIV from approximately 20% to 30% to 0.1% to 0.5%). Offering prevention and treatment information to pregnant women is important so they can make informed decisions during pregnancy. HIV counselors should encourage HIV positive women to seek prenatal care from a medical provider who has specific knowledge about perinatal HIV. There has been major success with protecting newborn babies from contracting HIV from their mother, **if and when** the mother knows her status. A woman's HIV status is not the most important factor to influence decisions to conceive. These decisions can be based on many other factors, including family and social relationships, cultural and religious beliefs, economic circumstances and childbearing history. Some women consider child bearing to be an important factor of their life. They may not feel that having HIV is a reason to give up plans for conceiving a pregnancy. As counselors, we **have to** remember that the only person who can fully evaluate both the benefits and the disadvantages of conceiving is the woman herself.

Your role as the HIV counselor when working with pregnant women is to offer basic information, provide linkages to medical and social support services, and to support your client with making decisions. Counselors should not impose their personal values when guiding the session; they might interfere with the client making decisions. Counselors should not make recommendations about whether a client should continue or terminate a pregnancy.

DOMESTIC VIOLENCE

Domestic abuse is a pattern of behaviors used to establish power and control over an intimate partner, often leading to the threat or use of violence. Abuse is any controlling, hurtful act, word, or gesture that injures another's body or emotions.

Domestic abuse takes many forms and may escalate in severity. These forms demonstrate themselves as acts of domestic abuse and generally fall into one or more of the following categories:

Psychological abuse may include emotional, verbal, and financial abuse and may be experienced as intimidation, terrorizing, name-calling, jealousy, destroying property, eliminating access to finances, threats directed toward other family members, children, or household pets.

Sexual abuse may include denying privacy, forcing performance of sexual acts that are not comfortable, unwanted sexual touching, and/or partner rape.

Physical abuse may include pushing, slapping, biting, kicking, hitting with objects, restraining, and/or the use of a weapon.

Domestic Violence

ASSESSING THE CLIENT FOR DOMESTIC ABUSE

Domestic abuse can have a definite effect on a client's decision to test for HIV, access partner notification, and the ability to adopt safer sexual practices. It is the role of the HIV counselor to identify **whether or not** a client is a victim of domestic abuse because it can impact many aspects of the counseling session. Being a victim of domestic abuse can impact whether the client will be open and truthful with the counselor, whether the client is in more imminent danger-due to domestic abuse-than from contracting HIV. This is an opportunity for the counselor to provide useful referral information for counseling or shelter services.

When screening clients for domestic violence, the goal is to validate and empower the abuse survivor while attending to the immediate health concerns. Counselors should: Routinely screen, in a confidential manner, all clients for domestic violence. Domestic violence affects people from all backgrounds, income levels, and races.

PHRASE QUESTIONS IN A NONJUDGMENTAL WAY

To assess you could ask:

- "What does your partner do when he or she loses their temper?"
- "How do you think your partner will react if the results come back positive?"
- "Are you in a relationship with a person who verbally threatens or physically hurts you"?
- "Are you afraid of your partner?"

Provide an atmosphere where patients feel respected and taken seriously.

Focus on prevention goals that will not risk violence from and abusive partner.

The appearance of possible abuse may warrant a different approach to the counseling session. However, the questions should be asked in a careful manner, so that the client will not become defensive.

Remember that while screening for domestic violence is important, actual counseling related to domestic violence, which may include such topics as leaving abusive relationships, involves skills that require special training. The most dangerous time for a person in a violent relationship is often when they attempt to leave their partner.

HOMELESS POPULATION

HUD USES THE FOLLOWING CATEGORIES TO DEFINE HOMELESSNESS:

Literally Homeless

*Sheltered Homeless lives in emergency shelter, transitional housing for homeless persons, or a hotel or motel with the stay being paid for by an organization

*Unsheltered Homeless lives in a car, park, abandoned building, encampment, dilapidated building, on the sidewalk, or similar location

Imminently Homeless

is facing loss of housing within two weeks, has no subsequent residence identified, and lacks the resources or support networks needed to obtain other permanent housing

Other Homeless

is in jail, a hospital, or a detox program, but would otherwise have been homeless



Homeless Population

HIV is an issue that affects the homeless population. Immediate survival is often the main concern for people experiencing homelessness. HIV prevention or even treatment may be secondary to accessing food or shelter. Interventions with this population often require numerous linkages with additional services. Involvement in activities such as alcohol, injection drug use, prostitution, and unprotected sexual activity, are all factors that add to this population's increased risk for HIV infection. Furthermore, homeless people often suffer from other co-infections (e.g. Tuberculosis, Hepatitis B and C) chronic and mental health problems that will also need to be addressed in order to promote behavior change. The presence of multiple conditions and issue can complicate the session when working on a risk reduction plan.

HIV counselors should be knowledgeable about local resources that assist the homeless and should be prepared to provide linkages and referrals. Counselors should be familiar with information pertaining to local shelters within their county or district. Additionally if other conditions are apparent at the time of the counseling session, linkages/referrals should be made to address other health and psychosocial services as appropriate. Due to the transitory nature of this population, rapid testing should be offered. HIV counselors should make great efforts to obtain the most effective locating information for the client. This information could be the address for the shelter where the client usually stays or the address for a relative or friend. Ask them to provide a phone number where they can be contacted.

INCARCERATED POPULATION

Incarcerated populations are susceptible to contracting HIV/AIDS due to certain high-risk behaviors that are usually prevalent to the correctional facilities.

Incarcerated Population

A majority of the individuals who are infected with HIV in the correctional facilities were most likely positive prior to incarceration. Some individuals engage in high-risk activities that can lead to HIV infection during their incarceration. Some inmates continue to engage in high-risk activities such as tattooing, and unprotected sexual activities. A history of other conditions such as injection drug use, substance dependency, and mental health issues can increase the likelihood of sexual risk-taking behaviors.

Counselors should be aware of the incarceration history of their clients' and information about the client's sexual partners. This information can be important for counseling and testing strategies with the client and the clients sexual and needle sharing partners. It is especially important when determining the window period of infection.

Due to strict policies in the correctional facilities, certain harm reduction techniques such as the use of condoms or sterilizing tattooing instruments may be limited or non-existent. It may be important for the counselor to focus on the unsafe behaviors the client is engaging in and help the client to figure out a way to reduce his/her risks with the resources that he/she has.

The prevention counseling messages should include discussion on the benefits of early diagnosis and education regarding repeat testing, especially if the client will continue engaging in the high risk behaviors.

Partner services should be an important component in the counseling session as well. If possible, HIV testing and post-test counseling prior to release should be strongly encouraged with the incarcerated populations. Counselors should have the availability of linkages/ referrals for the incarcerated population if requested.

Other concerns for inmates may be denial, fear of illness, and confidentiality about diagnosis with other inmates and facility staff (i.e., guards). Counselors should make a great effort to overcome these barriers, and help the inmate with moving forward in their testing and care process. Given the short duration of time many inmates spend in jails, rapid testing should be used whenever applicable.



TRANSGENDER POPULATION

A transgender (trans) person is someone who has a different sex, gender identity, and/or gender expression than the one assigned to them at birth, regardless of their sexual orientation (Cabral, 2007; Sausa, Keatley, & Operario, 2007). Due to assumptions and/or discomfort among health professionals to ask questions about gender identity, trans people are either completely missed and not accurately counted in surveillance methods, or miscounted as MSM (often trans women are incorrectly counted as MSM). In addition, many funders, health departments and government agencies do not even allow for the reporting of trans people as clients and patients, as if they don't even exist.

Transgender Population¹

A recent meta-analysis of 29 studies specifically focused on trans people underscored the alarming rate of HIV prevalence among trans people in the U.S. (Herbst et al., 2008). Overall, 28% of trans women tested positive for HIV, though when asked about their HIV status only 12% self-reported living with HIV. This highlights the extraordinary high rate (about 1 in 4) of trans women living with HIV. The high rate of trans women who are undiagnosed or unaware that they are infected is more than twice the national average (57% vs. 27%) (CDC, 2008; Glynn & Rhodes, 2005; Herbst et al., 2008). The same meta-analysis reported a rate of 2-3% (about 1 in 50) among trans men, though few studies accounted for or focused on the growing number of trans men who have sex with gay and bisexual men (Sevelius, 2007). With regards to incidence of new HIV infections, when data are gathered and reported, incidence percentage rates (adjusted for population size and number of persons testing) among trans women are often the highest rate reported among any population group and in many cases twice that of gay and bisexual men (San Francisco Department of Public Health (SFDPH), 2005 & 2008; Herbst et al., 2008).

Despite these high rates of HIV infection reported among trans women, there is also a concurrent lack of knowledge, comfort, and skills among health and social service providers who work with trans clients and patients (Clements, Wilkinson, Kitano & Marx, 2001; Hussey, 2006; Grossman & D'Augelli, 2006; Nemoto, Sausa, Operario, & Keatley, 2006; Shaffer, 2005). This lack of provider competency has resulted in many trans people avoiding health care services for preventive and urgent/life-threatening conditions (Shaffer, 2005), and trans people having a lower adherence to their HIV medication (Melendez et al., 2005; SFDPH, 2008).

¹Center for Excellence for Transgender Health (transhealth.ucsf.edu)

ADOLESCENT POPULATION

In 2014, youth aged 13 to 24 accounted for an estimated 22% of all new HIV diagnoses in the United States. Most of those occurred among young gay and bisexual males. Young black/African American and Hispanic/Latino gay and bisexual males are especially affected. Youth with HIV are the least likely out of any age group to be linked to care. Addressing HIV in youth requires that we give youth the tools they need to reduce their risk, make healthy decisions, get treatment and care if needed, and communicate effectively with others.

SOURCE

<https://www.cdc.gov/hiv/group/age/youth/>

Adolescent Population

PREVENTION CHALLENGES

Inadequate Sex Education. The status of sexual health education varies substantially throughout the United States and is insufficient in many areas according to CDC's 2014 School Health Profiles. In most states, fewer than half of high schools teach all 16 critical topics that CDC recommends for inclusion in curriculums. Specifically, many curricula do not include prevention information that relates to the needs of young gay and bisexual men. In addition, sex education is not starting early enough: in no state did more than half of middle schools meet goals put forth by CDC. Finally, sex education has been declining over time across the country. The percentage of US schools in which students are required to receive instruction on HIV prevention decreased from 64% in 2000 to 41% in 2014.

2013 data from the Youth Risk Behavior Surveillance System (YRBS), which monitors health risk behaviors that contribute to the leading causes of death and disability among youth reveal:

LOW RATES OF TESTING

LOW RATES OF CONDOM USE

SUBSTANCE USE

High rates of sexually transmitted diseases (STDs). Some of the highest STD rates are among youth aged 20 to 24, especially youth of color. The presence of another STD greatly increases a person's likelihood of getting or transmitting HIV.

Stigma around HIV. In a 2012 Kaiser Family Foundation survey, 84% of youth aged 15 to 24 said there is stigma around HIV in the United States, which means they may not be comfortable discussing their status with others and agreeing on measures to protect themselves and their partners. For gay and bisexual youth who are just

Rapid Testing Technology for Adolescents and Minors must be used according to Manufacturers' directions. Many of the rapid testing devices have only been evaluated on youth of a certain age range.

OTHER CONSIDERATIONS

In the Guidelines for Mandatory Reporting of Suspected Child Abuse for Public Health Personnel that takes into account recent changes in the mandatory reporting statute:

“Sexual abuse” shall not include consensual sex acts between minors who are at least fourteen years old, or between a minor and an adult who is not more than four years older than the minor.

Under **Code Section 31-17-7(b)**, clinical staff may, but are not obligated to, notify the parent or legal guardian of a minor who is receiving or who needs treatment for HIV. However, with regard to any other venereal disease, the minor’s medical information may not be shared without the minor’s consent.

beginning to explore their sexuality, homophobia can pose obstacles to HIV testing and treatment.

Feelings of isolation. Gay and bisexual high school students may engage in risky sexual behaviors and substance abuse because they feel isolated and lack support. They are more likely to experience bullying and other forms of violence, which can lead to mental distress and engagement in risk behaviors that are associated with getting HIV.





TRAINING MANUAL

Rapid HIV Testing Protocols and Quality Control

*Thank you for participating in this
HIV Rapid Testing Protocols and Quality Controls training.*

FOR INFORMATION ABOUT OTHER TRAINING OPPORTUNITIES
PROVIDED BY THE OFFICE OF HIV/AIDS,
PLEASE CONTACT US AT:

**GEORGIA DEPARTMENT OF PUBLIC HEALTH
DIVISION OF HEALTH PROTECTION
OFFICE OF HIV/AIDS
HIV PREVENTION UNIT**



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