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Optional Pre-Test HIV Counseling in California: Implications, Applications and Perceptions

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in

Public Health (Epidemiology)

by

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The Dissertation of Mary Jennifer McAnany is approved, and it is acceptable in quality and form for publication on microfilm and electronically:

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ABSTRACT OF THE DISSERTATION

Optional Pre-Test HIV Counseling in California:
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by

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Doctor of Philosophy in Public Health (Epidemiology)

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Required pre-test HIV prevention counseling has been speculated to deter repeat testing among high-risk individuals. The objective of this dissertation was to characterize repeat HIV testers, assess the acceptance of counseling among recent repeat testers (RRTs), and evaluate the acceptability and feasibility of a self-administered client HIV risk assessment survey and optional HIV pre-test counseling for repeat testers from the perspective of clients and clinic staff.

Surveillance data collected from all clients tested for HIV at publicly funded counseling and testing sites throughout California from 2005 to 2006 were analyzed to characterize repeat testers. A subsequent pilot study was conducted allowing RRTs, defined as those receiving HIV testing in the previous year, to opt-out of counseling. After completion of standardized questionnaires by individuals testing between September 2008 and February

2009 at three sites in Orange and Los Angeles Counties, RRTs were compared with non-RRTs to identify correlates of repeat testing. In addition, those accepting counseling were compared to those refusing, to identify correlates of counseling decisions. Finally we applied qualitative and quantitative methods; including quantitative comparison of client responses to assessment options (self- versus counselor-administered), post-visit client satisfaction surveys and qualitative in-depth interviews with clinic staff.

Examination of state testing records found female and heterosexual male RRTs reported higher risk behaviors than non-RRTs, while men who have sex with men (MSM) RRTs did not report higher risk activities than non-RRTs. Of 707 clients surveyed during the pilot study, 202 (28.6%) were RRTs. Compared to non-RRTs, RRTs were more likely to report oral sex in the past 12 months, have high-risk sexual and injection behaviors (all p-values < 0.05). Among 150 RRTs who were eligible to skip counseling, 91 (60.3%) chose to forego counseling. Testing at the STI clinic, being MSM, and having no diagnosis of gonorrhea or syphilis in the past year were significantly associated ($p<0.05$) with accepting counseling in multivariate analysis. Risk assessment survey self-administration and optional counseling for RRTs were well received by counselors and clients.

Our findings suggest that self-administration of surveillance tools and offering RRTs optional pre-test counseling are reasonable and practical additions to the HIV testing process.

INTRODUCTION

HIV is a new disease, or at least a newly identified disease in humans, coming to international attention in 1981. Since that time humans have been scrambling to identify and fight this deadly new challenge to our survival. Resources and capital have been poured into the quest to prevent and cure HIV infection. In the time spent waiting for a vaccine or curative treatment, countless prevention efforts have been enacted to stem the flow of new cases being added to the pool of infected persons.

Though still unable to cure the disease, antiretroviral treatments have changed the prognosis from one of almost certain death to a chronic disease; manageable for decades if not a normal lifetime. Progress has also been made in diagnostics, with the recent advance of an even more rapid, rapid test which provides a result in a few minutes.

Through the progression from standard testing which requires two visits, two weeks apart, to a process which can be completed in less than half an hour, pre- and post-test counseling have been a staple of HIV testing. The requirement for an individual to wait two weeks between specimen collection and receipt of results created a window for risk behavior which required attention and messages to reduce risk behavior (pre-test counseling). Now the window has shrunk to 20 minutes or less, during which time it is doubtful, although not impossible, that an individual could practice behaviors that put them at risk for infection. Changes in testing decrease the importance of pre-test counseling.

Although still a potentially devastating diagnosis, the hope that lies in current treatment eliminates the death sentence nature of an HIV-positive diagnosis. The development of better treatments and diagnostics have changed HIV infection from an unidentifiable specter stalking through populations, to a disease that can be identified in minutes with a few drops of blood and held at bay with minimal interruptions to a normal life.

In 2006 the U.S. Centers for Disease Control and Prevention (CDC) developed new guidelines intended to make HIV testing part of routine health care, more available and in line with other disease testing. The CDC's guidelines acknowledge the progress made in diagnosis and treatment and strive to normalize HIV testing; no longer treating it as an exception. This may help more individuals receive testing or retesting. Those who do not know their own HIV-positive status may be delayed in obtaining timely care and treatment, posing a risk to themselves and others. Getting individuals to test and retest is a priority.

As HIV disease transitions from an unknown condition to an identifiable, treatable disease, prevention efforts in the cause against HIV infection must also keep pace. Therefore an evaluation of required pre-test counseling as part of routine HIV testing is imperative.

This dissertation was undertaken with the goal of better characterizing recent repeat testers in California and fully exploring potential changes to the HIV pre-test counseling procedures, including self-administration of risk assessment forms and optional pre-test counseling among recent repeat testers.

Chapter 1

Literature Review

Importance of HIV testing

Over 1 million Americans are infected with HIV, of which an estimated 21%, or 232,700, are unaware of their HIV-positive status [1]. With estimates of incident HIV infections in the United States recently raised to 56,000 individuals annually, the importance of undiagnosed infection is even greater [2]. Of Americans diagnosed with HIV between 1996 and 2005, 38% received an AIDS diagnosis within 1 year of their HIV diagnosis, representing late HIV testing [3].

Individuals who know their HIV status are able to protect and care for themselves as well as protect those with whom they have sexual contact. Although people should be taking steps to protect themselves from HIV infection and thus their partners and close contacts despite their perceived status, studies have shown that most HIV infection is spread by those unaware of their positive status [4]. Likely the same behaviors that resulted in their infection continue after acquiring the virus, resulting in the spread of infection to uninfected individuals. Although accounting for only 21% of the HIV-positive population, those who are unaware of their status are estimated to account for over 50% of new cases [4]. Those who are unaware are responsible for 3.5 times as much HIV transmission as those who are aware [4].

The reduced HIV transmission by those aware of their status compared to unaware is likely the result HIV-positive individuals making behavior changes to protect others from infection. High-risk sexual behaviors, as defined by unprotected anal and vaginal sex, have been shown to be lower among those who have received their HIV test results [5].

A study among African-American men who have sex with men and women found that those who did not know their HIV status or those who had last tested negative were respectively, 4.7 and 3.9 times more likely to have unprotected sex with their main female partner and 8.5 and 4.2 times more likely to have unprotected sex with their main male partner, compared to those who knew they were HIV-positive [6]. In this instance the men

who had never tested presented the greatest risk because of their increased odds of unprotected sex in conjunction with the increased probability of being positive compared to those who have previously tested negative.

A meta-analysis of 30 studies, with approximately half collecting data in the United States, found that HIV-positive men who have sex with men (MSM) and know their status are more likely to have unprotected anal intercourse with another positive male than with a partner of unknown or negative status [7]. Interestingly, when the partner was of unknown or negative status, the HIV-positive partner was more likely to engage in receptive anal intercourse compared to insertive, but when both partners were positive there was only a 1% difference. This implies that MSM who know their status take steps to protect their partners of unknown or negative status, first through a decrease in unprotected anal intercourse and secondly by making less risky sexual choices such as receptive rather than insertive sexual positioning.

Linking an HIV-positive person with HIV care also has an impact on their HIV risk behavior. Providing referrals and/or linkage services to HIV-positive patients can reduce the odds of unprotected sex by almost half [8]. Passive or active referrals to care after diagnosis and subsequent interactions with health care providers can result in decreased risk behavior, protecting both the individual as well as their contacts.

More directly, patients receiving antiretroviral therapy (ART) are less likely to spread HIV even if their behavior does not change. Among serodiscordant heterosexual couples in Africa, viral load was the prime predictor of the HIV-negative partner seroconverting [9]. Increases in viral load were directly related to increased risk of conversion. Thus those receiving ART, which can successfully decrease viral load, are less likely to spread the infection even if their risk behaviors are not modified. The largest risk factor for spreading the

infection (high viral load) is decreased without necessitating behavior change on the part of the infected individual.

Among Dutch MSM the risk of transmission between serodiscordant couples was 22% if condoms are never used, but when condoms were used unless the HIV-positive partner had an undetectable viral load test in the last six months, the transmission rate was only 3% [10]. This demonstrates the importance of regular medical care in addition to ART as a tool to reduce the spread of infection from those already positive, but can only be received if the individual is aware of their HIV-positive status.

Current recommendations are for non-pregnant individuals to receive ART when their CD4 count drops below 350 cells/mm^3 or when diagnosed with an AIDS defining illness [11]. CD4 cell count can drop below 350 cells/mm^3 before infection with an AIDS defining illness or presentation of disease-specific symptoms. Therefore, an individual is less likely to begin ART at the optimal time if not tested.

Sexually transmitted infections (STIs) increase the risk of both spreading and acquiring HIV infection through mechanisms beyond their shared behavioral risks [12, 13]. Appropriate treatment of STIs among those already HIV infected can decrease the risk of HIV infection among their partners.

Prenatal transmission of HIV is approximately 25% without ART but with treatment it can be lowered to only 1% [14]. In the United States it is recommended that mothers should be tested during prenatal care and/or prior to delivery but this recommendation is not always applied [15]. Although treatment at delivery, or shortly thereafter, can decrease the risk of transmission, it is reduced more when effective treatment is initiated earlier in the pregnancy. Testing during pregnancy can reduce the transmission to the infant but women are better able to make decisions regarding the timing and risk of child-bearing if they accurately know their status before conception.

Barriers to Testing

The estimated 20% of HIV-positive American's unaware of their HIV-positive status is a result of individuals not being tested for HIV or retested after infection [1]. There are multiple reasons a person would not test ranging from personal beliefs and stigma to health care structure [16]. Reasons for not testing cited by injection drug users (IDUs) included fear of a positive result, lack of perceived risk, competing life concerns, faith that they were fine since their partner tested negative, fear of needles, negative perception of staff attitude and lack of an accessible test site [17]. Similarly the 1998 National Health Interview Survey found that those who had not tested listed the top three reasons as "no particular reason," "not at risk for HIV" and "feared adverse consequences" [18]. Among high-risk individuals (MSM, IDUs and STI clinic patients), the top two cited reasons for not testing were low perceived risk of HIV and fear of being positive with MSM more likely to under-perceive their risk [19].

One potential barrier to HIV testing or retesting is pre-test counseling. Clients at an HIV testing site in California were found to present themselves as routine testers and minimize their risks when speaking with a counselor [20]. The lack of frank and forthcoming discussion belays a distrust and/or discomfort with the counseling process.

Among IDUs, those offered HIV testing with optional pre-test counseling were more likely to receive testing than those offered testing with standard counseling, though this difference was not seen among MSM [21]. Among high-risk individuals, those who had never tested compared with those who had delayed testing, were more likely to say they did not want to talk to a counselor [22]. The lack of willingness was more strongly associated with being an IDU. Among young urban MSM, ever testing was significantly associated with knowing a comfortable place to test [23]. Other studies have found that those who are less

likely to have a need for counseling, those with higher motivation to use condoms and greater history of condom use, are the most likely to accept counseling when given the choice [24].

Efficacy of behavior change from counseling

As discussed above, HIV counseling and testing has been shown to be effective at reducing the spread of disease by those who are aware of their status, but the evidence for the effectiveness of counseling in reducing new infections among those testing negative is mixed.

Project RESPECT, a multi-site STI clinic-based study carried out among heterosexual men and women from 1993 to 1996, found that although STI incidence was reduced for all groups in the study, it was significantly lower among those who received counseling, either brief or enhanced as compared to those receiving only educational messages [25]. Additionally self-reported condom use was higher among those counseled when interviewed at 3 and 6 months after intervention, although there was no significant difference at the 9 or 12 months follow-up [26]. At the 9 and 12 month follow-up there was no significant difference in sexual risk behaviors such as report of casual partners or new partners [26]. This study is often cited as showing the efficacy of counseling in the prevention of STIs, and thus likely HIV, but several of the stated aims for behavior change were not accomplished or had only temporary effects.

Evidence of only a transient change of behavior was also found among those who have previously been tested. Compared to those who had tested more than a year before, those who tested more recently had an increase in safer sexual practices and condom use at last intercourse [27]. Although this study likely suffers from selection bias in that those who get tested may be safer in general and the testing may not be causing people to practice safer behaviors.

A study examining MSM repeat testers found that participants receiving standard counseling did not have a significant decrease in unprotected anal intercourse with a partner of unknown or discordant status at 6 months post intervention [28]. Furthermore at 12 months, unprotected anal intercourse was only 1% lower than at baseline in the standard counseling group. A similar study among MSM examining the differences between an enhanced counseling style and standard CDC recommended counseling, found no difference from baseline in unprotected anal intercourse at 6 months among those receiving standard counseling [29]. Conversely, when the followed-up was continued to 12 months there was a significant decrease of unprotected anal intercourse among those receiving standard counseling.

Among repeat testers at an HIV testing facility in San Francisco, repeat testing was found to be associated with higher risk behaviors and higher incidence of HIV [30]. The continued high-risk behavior and HIV seroconversion after receiving testing and counseling implies that certain types of counseling approaches are ineffective at changing the behaviors of those at highest risk.

In a similar study, those who had never tested and those who had tested repeatedly were more likely to have two or more sexual partners, more unprotected and protected vaginal sex and more total unprotected sex, in a comparison of STI clinic patients [31]. Those who were repeat testers were more likely than all other groups to have a previous STI but also a greater percentage of condom use. The finding that multiple repeat HIV testers used condoms more than either one time testers or non-testers, may mean that even though they are participating in higher risk activities, repeat testers in this study were also taking steps to protect themselves.

A meta-analysis of HIV testing research from 1985-1997 found that both HIV-positive patients and serodiscordant couples reduced risk behaviors while those who were

HIV-negative did not change their behaviors any more than those who were untested [32]. In addition another study determined that MSM who have tested three or more times report more unprotected penetrative sex than those who have tested less often [33].

Though practicing higher risk behaviors, repeat testers may be using the testing system as a method of risk reduction. Among MSM, repeat testers tend to be more comfortable and open about their sexual orientation but also more likely to have an HIV-positive partner and be high on drugs during sex, although first time testers are more likely to have unprotected anal intercourse with someone of unknown status [34]. In the Young Men's Survey repeat testers were more likely to acquire HIV and report high-risk sexual behaviors and drug use [34]. Possibly the most risky individuals correctly acknowledge their increased risk, which causes them to pursue HIV testing more frequently than those at lower risk. In fact it has been shown that those at higher risk have higher rates of testing [16, 35].

Mode of Questionnaire Administration

Mode of questionnaire administration can affect the truthfulness and completeness of data collected. Incorrect or incomplete data are collected when the participant cannot remember the correct answer or if there are inconsistencies in questionnaire administration. For example individuals may not be able to recall how many sexual partners they had in the last 5 years, so they either do not complete the question or record their best guess. Beyond incorrect or incomplete answers from an inability to answer the question, some participants are unwilling to disclose their actual behavior. Participants have been found to be most reluctant to report socially undesirable behaviors (MSM behavior, more sexual partners, lower condom use), and over-report socially desirable behaviors (using condoms, getting tested for HIV, telling sexual partners about STI) [36].

Prior to the use of computers for questionnaire administration, the use of self-administered questionnaires, usually by paper and pen/pencil were used in an attempt to provide anonymity and eliminate the influence of an interviewer. Since the responses are captured on paper instead of a microchip, there is still the possibility of the interviewer seeing the responses or opportunity for data entry error. This mode also requires sufficient respondent literacy.

Recently computers have been utilized for questionnaire delivery with the intent of increasing the quality of data collected. There are many methods of data collection using computers, computer assisted self interview (CASI), computer assisted personal interview (CAPI), audio computer assisted self interview (ACASI), and palmtop computer-assisted self interview (PCASI). Computer administered surveys have the advantage of built in skip patterns, range checks and other validity checks to improve the quality of the data. Since CAPI involves an interviewer asking the questions and then entering the responses into a computer, it is substantially different from the other forms of administration which do not require an interviewer to see or hear the participant's responses. As such CAPI will not be addressed further.

Many studies have been carried out to determine whether the use of a form of CASI has an effect on the behaviors reported. In particular sexual behaviors and drug use are of concern to HIV researchers because of their sensitive nature and socially undesirable connotations. In this field of study it is usually assumed that the method producing the highest rate of socially negative behaviors is the most accurate, either when retesting the same individual or testing two comparable groups.

Studies among populations in the United States as well as abroad have found increased reporting of sensitive behaviors, such as MSM, unprotected sex, drug use and non-adherence to ART, through the use of ACASI compared to interview or self-administered

questionnaire [37-47]. One study at an STI clinic in Baltimore which surveyed the same individual by both ACASI and face-to-face (FTF) found multiple partners in the last 30 days, oral-genital exposure, female receptive anal sex, ever having same sex relations, and sex for money or drugs was reported more frequently through ACASI than through FTF [38]. In a public STI clinic in Seattle, patients were surveyed using ACASI followed by a clinician-mediated health history survey, more MSM behavior was reported using ACASI as well as more affirmative answers to sensitive questions among women [39]. As predicted they also found that socially rewarding behaviors were reported more often by clinician-mediated history, and interestingly more symptoms were also reported to the clinician. An early study examining the difference between video-CASI and FTF found that among women attending an STI clinic in New Orleans who had previously been diagnosed with Chlamydia, more socially desirable responses were reported by FTF and more socially undesirable behaviors by video-CASI [48].

Interestingly several studies have found differences by sex between the reporting of risk behaviors by mode of administration [49, 50]. A survey of adolescents within health clinics found that girls reported more alcohol use and marijuana use by ACASI but boys reported more by self-administered questionnaire [50]. An Indian survey of unmarried, 15-19 year olds living at home found girls reporting fewer sexual behaviors to the ACASI but boys reporting more [49]. This could be attributed to the differences by sex and/or cultural dictates of socially desirable and undesirable behaviors.

Some studies have found few or conflicting differences in data reported by mode of administration [40, 42, 51-53]. A household survey conducted in Britain among those aged 16-44 years old found no difference between CASI and pen and paper interview [51]. A study conducted among MSM and IDU participants found that MSM reported more partners of unknown status, fewer HIV-negative partners, more testing outside the study (against study

instructions) and less willingness to join a vaccine study by ACASI, but among IDU almost no differences were found [40]. Few differences were found among women in the behaviors reported by ACASI versus self-administered questionnaire except less unprotected vaginal sex was reported by ACASI and more by self-administered questionnaire [52]. Among syringe exchange clients in four U.S. cities, ACASI elicited higher rates of stigmatizing behaviors but FTF questioning gathered more information on psychological distress [42]. Among attendees of a public STI clinic in Australia, there was no difference found between reported behaviors by ACASI and FTF [53]. Two of these studies involved the comparison of two methods, both of which allowed the participant to keep their answers relatively private (ACASI and self-administered questionnaires), thus potentially accounting for the lack of significant directional results and two of the other studies were conducted outside the United States potentially limiting their generalizability to the U.S. population.

Acceptability of computer assisted questionnaires has been high in diverse populations [40, 47, 53-59]. Populations as diverse as Latinos residing in Washington DC, youths in Mexico, and MSM and sex workers in Kenya found the use of a computer to complete a questionnaire acceptable and comfortable [47, 55, 58]. An early review by Mitchell and Sullivan of data from 1980 to 1997 found some concerns regarding physician use of computers to capture risk and medical data, but the time frame of the review makes its findings less directly relatable to modern testers [60]. The last 14 years have been a time when many more individuals have gained access to personal computers through work and personal time.

In general ACASI has resulted in less skipping of questions, even when the option to skip the question is presented on the screen, compared to FTF or self-administered paper and pencil interview (PAPI) [37, 51]. This is thought to be because of an increased willingness to disclose sensitive responses, but also the inclusion of skip patterns not allowing participants to

see the questions that are irrelevant to their situation based on previous answers. Although in one study where individuals underwent both a FTF survey and an ACASI survey, there was actually more skipping found on the ACASI [38].

The lack of consistent findings on the impact of mode of survey administration calls for further study of data collection methodology, although potentially complicated by each individual's views and behaviors. If someone is not participating in any sensitive behaviors they have nothing to hold back regardless of survey administration method. Similarly if a person is not embarrassed or fearful of the repercussions of their behaviors there also should not be any differences by survey method. Only when an individual feels shame or does not want their behavior known is there the potential for differential reporting of risk behaviors by method of data collection. Therefore the best testing method varies by population as well as behavior type.

California Policy

Legislation introduced on February 22, 2008 by State Assembly Members Portatino and Leno and signed into law by California Governor Schwarzenegger, for the first time allowed state funded HIV tests to be conducted without a 20 minute pre-test counseling session for those at high-risk if they are repeat testers [61]. It further allowed the self-administration of forms where appropriate. The overall purpose was to enable sites to test more individuals. This legislation, though allowing more latitude in how HIV testing is conducted, passed before analysis of impact and implementation could be completed. This study was undertaken to inform and guide the transition from mandatory counseling to optional counseling as well as to determine the validity of self-administered forms.

Conclusion

With a large percentage of the HIV-positive population in the United States unaware of their infection and significant numbers testing late, there is a need for universal testing. Universal testing will require the elimination of barriers to testing such as mandatory counseling. Testing with optional pre-test counseling demands a definition of the client potentially allowed to opt-out of pre-test counseling. Universal testing will also place a greater testing burden on already strained testing sites. To relieve part of this pressure, self-administration of risk assessments needs to be evaluated.

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Chapter 2

Factors Associated with Recent Repeat HIV Testing at Publicly Funded Testing Sites in California, 2005-2006

Abstract

Objectives. The requirement to offer HIV prevention counseling as part of the testing process – a principal tenet of HIV testing programs worldwide – is under debate. In response to growing demand to allow repeat testers to opt-out of pre-test counseling, this study characterizes repeat HIV testers and identifies the optimal definition of repeat testing to help inform HIV testing program planning.

Methods. We analyzed surveillance data collected from all clients tested for HIV in state funded counseling and testing sites throughout California in 2005-2006 at a time when pretest counseling was still universal. Variables included sociodemographics, risk behaviors of clients testing for HIV, and history of prior HIV testing. Analyses were conducted to determine the proportion of clients who would be eligible to opt-out of pre-test counseling, based on changing eligibility criteria (i.e., tested in the past 6 months, past year, past two years), and to characterize HIV-testing clients based on time of last test.

Results. Of 276,143 testing records examined, 200,161 were from unique eligible individuals. Nearly 70% of clients had tested for HIV before the current visit, 43% tested in the last 24 months, 29% in the last 12 months and 14% in the last 6 months. Females and heterosexual males testing in the last year (recent repeat testers [RRTs]) reported more high-risk behaviors than non-RRTs, while men who have sex with men (MSM) RRTs did not report higher risk activities than non-RRTs.

Conclusion. Repeat testers differed little based on time since their last test. Therefore, a practical definition, such as past 12 months, is recommended for distinguishing RRTs who could be eligible to opt-out of HIV prevention counseling. Findings that RRT MSM did not report higher risk than non-RRT suggests that they may be testing more often as a result of recommendations for increased testing among MSM. Heterosexual male and female RRTs may be testing more often because of increased self-perceived risk. Pre-test counseling

options that are tailored for each of these groups are warranted based on the differing risk profiles.

Introduction

Of the more than 1 million Americans infected with HIV, approximately 21% are unaware of their HIV-positive status [1], yet those who are unaware of their status are estimated to account for over 50% of new cases [2]. With approximately 56,000 incident HIV infections in the United States annually, the importance of undiagnosed infection is great [3].

Previously, repeat HIV testing has been found to be associated with higher-risk behaviors such as an increased number of sexual partners, more unprotected sex, more drug use, and increased likelihood of HIV acquisition [4-6]. Though in one study repeat testers were found to have greater condom use [4]. Those at higher risk have been found to test more often [7, 8] than those who are not at higher risk, supporting the possibility that some high-risk individuals understand their increased risk and pursue HIV testing more frequently than those at lower risk.

HIV pre-test counseling was developed at a time when clients had to return two weeks after specimen collection for their test results. Concerns regarding risk behaviors during this two week period, and the reality that not everyone returned to receive their results, made pre-test counseling imperative. Now that rapid tests provide results in 20 minutes or less, few testers fail to receive their results and prevention education can focus on the tester's actual status.

Recent recommendations by the U.S. Centers for Disease Control and Prevention calling for routine HIV testing in clinical care settings without a counseling requirement [9] has stimulated discussion about eliminating pre-test counseling for repeat testers as a cost-saving measure in publicly funded testing sites. Since the level of HIV risk, and consequential

need for counseling, could differ between those who test more or less frequently, a definition is needed for recent repeat testing that determines who should and should not be allowed to opt-out of pre-test counseling.

Previous research utilizing California Department of Public Health, Office of AIDS (CDPH-OA) Counselor Information Form (CIF) data to compare differences between those testing in the past year (recent repeat testers [RRTs]) and those not testing in the past year (non-RRTs) in the San Francisco Bay and Los Angeles areas found that risk behavior varied by sexual orientation and geographic location [10]. Both areas in the study were predominantly urban with high HIV prevalences, and potentially have different HIV testing and risk behaviors than those in the state as a whole. As such, we sought to determine the most appropriate definition of RRT and better understand the characteristics of repeat HIV testers at publicly funded HIV testing sites through-out California.

Methods

Prior to 2009, completion of a CIF by the HIV counselor was required for HIV tests performed in California State funded counseling and testing sites. We analyzed CIF data to characterize repeat testers and determine the proportion of testers who would be eligible to opt-out of pre-test counseling based on varying lengths of time between the current and most recent past HIV test (i.e. tested in the past 6 months, past year, past two years).

Data Collection

Using the CDPH-OA CIF database, we extracted data for HIV test visits occurring between January 1, 2005 and December 31, 2006 in California. This was the most recent complete data file at the time this study was undertaken. The CIF is used to record information about the client for use during HIV pre-test and post-test counseling, as well as for reimbursement purposes.

Variables of interest included: sociodemographics (date of birth, race, gender, self-identified sexual orientation), risk behaviors (number of sex partners, HIV-positive sex partner, condom use, condom use with high-risk partner, sex work, drug use with sex, injection drug use (IDU), needle sharing), a recent STI diagnosis (i.e., in the past two years), an HIV-positive test result, and date of last test. Sexual behaviors and drug use were recorded for the last two years. Since HIV testing rates have been found to be associated with local HIV prevalence, publically available county-level HIV prevalence surveillance data was correlated with county of residence reported.

Sexual orientation was determined by self-identified sexual orientation and reported sexual behaviors. Participants were categorized as MSM, if they self-identified as MSM or if they reported any MSM behaviors regardless of their self-identification. Having a high-risk sex partner was defined as having a sex worker partner, injection drug using partner or HIV-positive partner, and for women, a male sexual partner who has sex with men. Stimulant drug use was defined as reporting crack, methamphetamine, or cocaine use in the past two years. County HIV prevalence was dichotomized into those with HIV prevalence above (high) and below (low) the statewide median.

Sample Selection

The dataset included records from all HIV tests conducted at publicly funded sites over a two year period, so there was the possibility that clients could have multiple records because of repeated visits during the time period. Though client names were not gathered, the CDPH-OA method for creating a unique identifier for each client based on a series of demographic variables was used to identify people who tested more than once during the time period. The dataset also included clients from testing sites that were not affected by changes in counseling requirements (detention facilities, alcohol/drug treatment facilities and TB clinics), so they were excluded from the analysis. Since this study focused on pre-test counseling as

HIV prevention, repeat testers with a previous positive or inconclusive test result were excluded. Those younger than 15 years old were excluded to eliminate adolescents and potential cases of perinatal transmission.

Data Analysis

Data were analyzed to compare the proportion of testers considered repeat testers using four self-reported HIV testing time-points: 1) ever previously tested; 2) tested within past 24 months; 3) tested within past 12 months; and 4) tested within past 6 months. Five broad risk measures were compared across the four testing time-points: never versus ever used condoms, any versus no drug use with sex, any versus no high-risk partners, any versus no injection drug use, and HIV status at the current visit. The denominators for 'never use condoms' and 'drug use during sex' were restricted to those reporting sexual partners.

Since HIV-associated risk factors are known to differ significantly by sexual orientation, further analyses were stratified into three categories: MSM, males not reporting any MSM activity (heterosexual males), and females. Females were not subdivided into categories based on sexual preference as numbers were not large enough to allow for meaningful comparisons. Likewise, transgender and other gender identifying groups were not further compared because of small numbers. Within each category, univariate and then multivariate logistic regression was carried out. All variables found to be significant at $\alpha < 0.10$ were included in a full model, and removed in a step-wise fashion based on significance of $\alpha < 0.05$, and the strength and direction of associations among the variables remaining in the regression. Because the correlation between the variables of injection drug use and sharing injection equipment, only injection drug use was entered in the initial multivariate model if significant.

All analyses were conducted using Predictive Analytics SoftWare (PASW 17.0).

Results

Definition of Recent Repeat Tester

A total of 276,143 HIV tests were conducted and recorded from 2005 through 2006 in the CIF database. Excluding those testing at a detention facility, alcohol/drug treatment program, or TB clinic, those with a previous positive or inconclusive HIV test result, under 15 years old, reporting gender other than male or female, missing sexual orientation, not responding to HIV testing history or identified as a potential duplicate record; a final sample of 200,161 test records was used for this analysis (Figure 2.1). Almost 70% of the testing population had ever previously tested for HIV, 43% last tested within the past 24 months, 29% in the last year and 14% in the last 6 months (Table 2.1).

As the RRT definition became more stringent (e.g. fewer months since last test), the prevalence of having a high-risk sex partner increased slightly and the prevalence of never using a condom decreased (Figure 2.2). The prevalence of drug use during sex, injection drug use and testing HIV-positive did not differ by time since last test. Though statistically significant when treated as mutually exclusive categories (data not shown), the differences in reported behavior found between the different cut-points for the definition of RRT were not clinically significant.

Comparing HIV Testers by Recent Repeat Testing Status

Given the lack of clinically significant differences in self-reported risk factors by time since last HIV test, the 12 month interval was chosen for our subsequent analysis because of policy recommendations, expected recall and ease of use.

Among heterosexual men, RRTs were more likely to be Black than those who have not tested for HIV in the past year (Table 2.2). They were also slightly older and were more likely to report no sexual partners, having an HIV-infected partner, sex work, IDU, a recent STI diagnosis, drug use during sex, stimulant use, and living in a high-prevalence county.

Heterosexual male RRTs were less likely to have shared needles and more likely to have used condoms than heterosexual males who had not tested in the last year.

Among MSM, RRTs were more likely than non-RRTs to be White, slightly younger, report fewer sexual partners, having an HIV infected partner, a recent STI diagnosis, and living in a high HIV prevalence county. RRTs were less likely to report sex work, IDU, drug use during sex, stimulant use or test positive for HIV, though they were more likely to report condom use and condom use with a high-risk partner more often.

Female RRTs were more likely than non-RRTs to be Black or White, report fewer sexual partners, having an HIV infected partner, sex work, IDU, a recent STI diagnosis, drug use during sex, stimulant use, and living in a high HIV prevalence county, though they also reported more condom use and condom use with a high-risk partner more often.

In multivariate analysis, RRTs despite sexual orientations or gender were more likely to report fewer partners in the past 2 years, having an HIV-positive partner, living in a high prevalence county, and less likely to report never using a condom (Table 2.3). Heterosexual male RRTs were older than non-RRTs, but MSM RRTs were significantly younger. MSM RRTs were less likely to report sex work, while female RRTs were more likely. Similarly showing increased risk, heterosexual male and female RRTs were both more likely to report injection drug and stimulant use, but MSM RRTs were less likely to have used stimulants.

Discussion

We found that there were no clinically significant differences in risk behaviors based on the cut-points used to define RRTs, suggesting that changes in the cut-point used to define RRTs would not change the overall make-up of the RRT population with respect to risk behaviors. Therefore, other factors such as recall of behaviors could be used to determine a

practical definition of recent repeat testing, allowing the simple operational definition of RRT to be set as testing within the last 12 months.

When analyzing differences between RRT and non-RRT stratified by sexual orientation, among females and heterosexual males, RRTs reported significantly higher risk behavior (e.g. IDU and stimulant use) than non-RRTs. RRTs were also significantly more likely to report condom use and among MSM, more condom use with high-risk partners. Among MSM, results were mixed, with some risk behaviors reported more often among RRTs (having an HIV-positive partner, recent STI diagnosis) and others reported more often among non-RRT MSM (sex work, IDU and stimulant use). This could be the reason that only among MSM was there a significant difference between RRT and non-RRT in testing positive for HIV, with non-RRTs more likely to test positive.

These findings from a statewide sample are consistent with a prior study that included only two major metropolitan areas, except that in the statewide results show more similarities to the San Francisco Bay area among females and heterosexual males and more similarities to the Los Angeles area among MSM [10]. Among all groups statewide, RRTs are more likely to use condoms, have a recent STI diagnosis, and have an HIV infected partner. These findings suggest that RRTs may be using more frequent HIV testing as part of a risk reduction strategy.

The finding that those at higher risk for HIV, at least among females and heterosexual males, are more likely to be RRTs is consistent with previous research suggesting that those at higher risk are more likely to get tested [7, 8]. Our analysis supports the finding of higher risk behaviors among RRTs [11] when limited to females and heterosexual males, but MSM RRTs in our study were not generally at higher risk and no group of RRTs had a higher incidence of HIV infection than non-RRTs in contrast to the findings of other studies [6, 11].

Because of differences found in risk behavior, different counseling options may be needed to best meet each group's needs. Heterosexual male and female RRTs may be in need of more targeted prevention messages about injection drug use, sex work, and drug use with sex. These groups could be linked with services such as drug treatment options through HIV testing. Among all groups, counseling and testing options which address precautions surrounding having an HIV-positive partner would be especially valuable for RRTs.

Additionally, for all groups, testing numbers were greater in high prevalence counties compared to low prevalence counties. Although their risk of exposure to HIV may be greater because of the high prevalence of cases among potential sexual and drug sharing partners, testing options should be examined in low prevalence areas, since their low prevalence may be an artifact of low testing.

These findings should be interpreted with the following limitations in mind. Some risk behaviors may not place the individual at increased risk for HIV acquisition depending on other unmeasured behaviors. For example, a person who did not report any condom use may be having sex with only one faithful and mutually tested partner. Though necessary, assumptions about risk behavior are a limitation. Another limitation was the dependence on self-reported behavior. Clients may have reported more socially desirable behaviors and fewer socially undesirable behaviors because of the pressure to report their behaviors to an interviewer. This lack of privacy and potential desire to be seen favorably may have biased our findings.

A strength of this study was its use of all HIV tests conducted at publicly funded sites throughout California over a two year period. The large sample size and uniform quality of data provides results that are generalizable to all of California's public testing sites.

Overall, the prevalence of any one risk factor was fairly low among HIV testers with only a few exceptions. This finding held true using four different definitions for RRT; thus,

prior HIV testing within the last year was selected for practical reasons. RRTs were perhaps more likely to report certain risk behaviors, such as injection drug use or having a high-risk sex partner, but did not appear to be necessarily higher risk within this context. For example, among these risk stratifications, RRTs were not at higher risk when taking further risk behavior into consideration (i.e. sharing needles and using condoms with high-risk sex partners). Using RRT as an eligibility criterion for opting out of pre-test counseling does not appear to systematically allow the highest risk groups of clients the opportunity to refuse counseling. Further studies are needed to determine whether there are differences in those repeat testers who do and do not opt-out of HIV prevention counseling when given the opportunity to do so.

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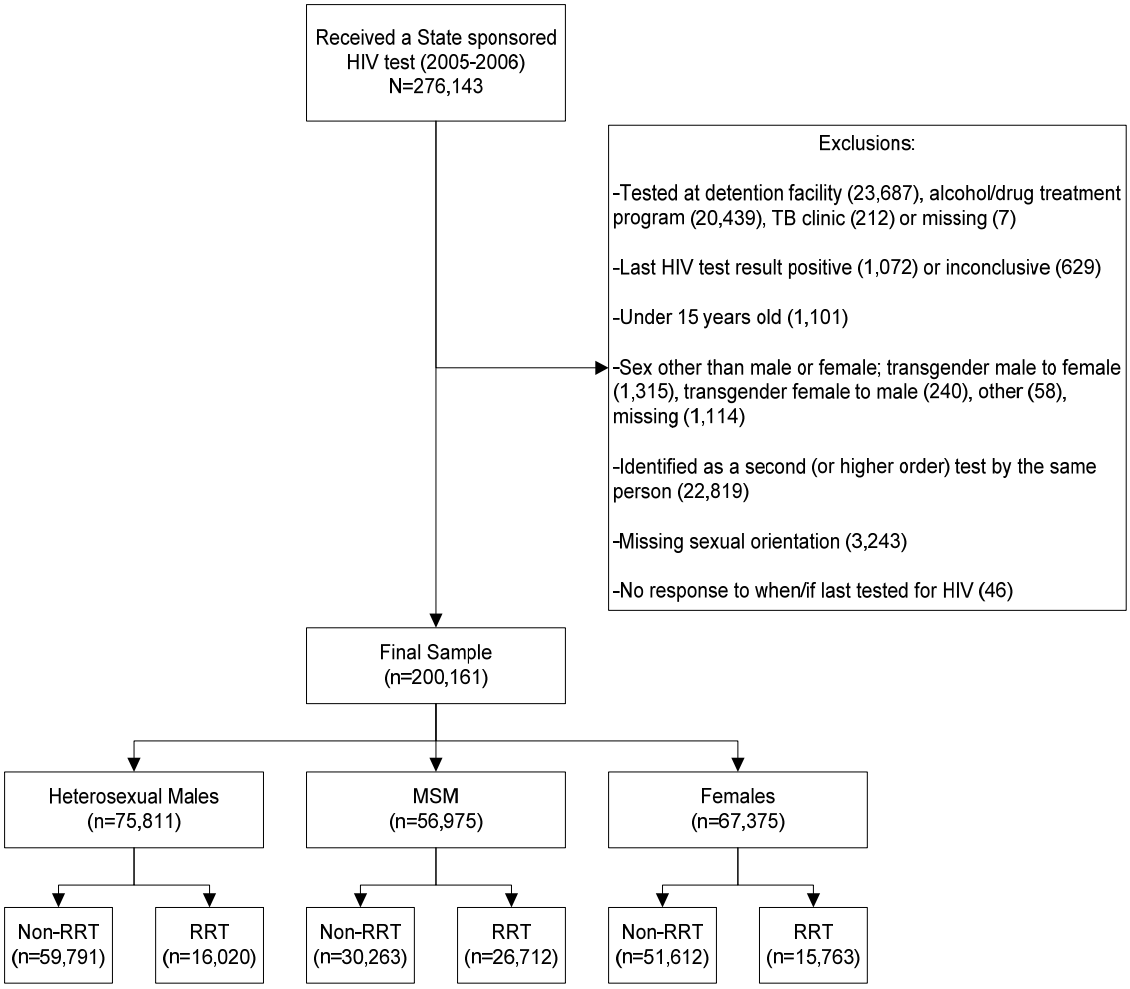

Figure 2.1 Study inclusion criteria and sample composition among clients of publicly funded HIV counseling and testing sites in California, 2005-2006

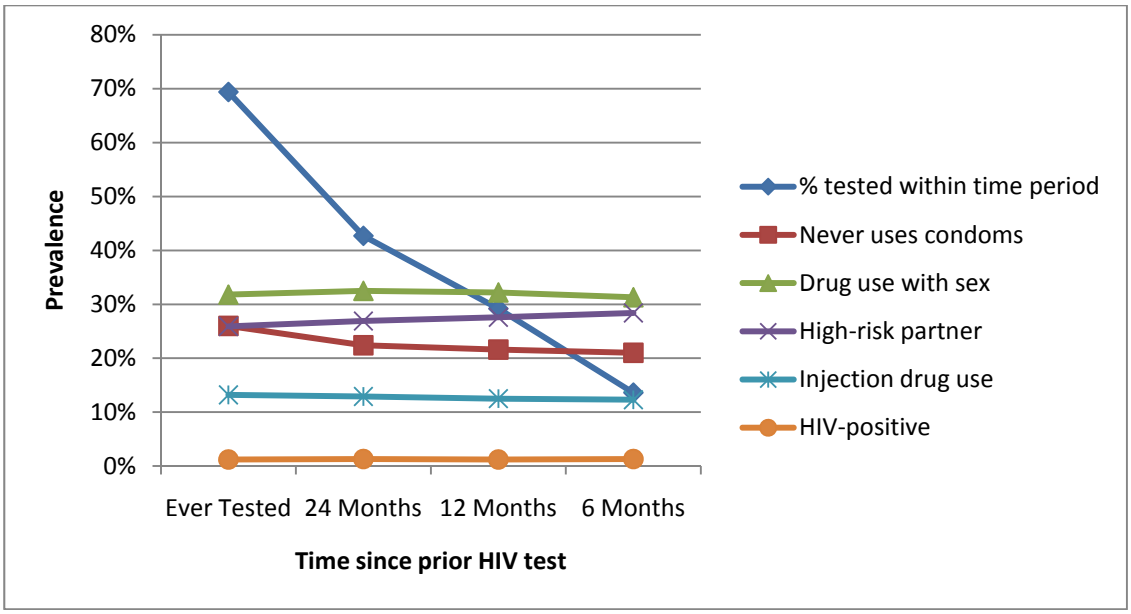

Figure 2.2 Self-reported risk behaviors by history of prior HIV testing among clients of publicly funded HIV counseling and testing sites in California, 2005-2006

Table 2.1 Demographics and risk factors by different definitions of a recent tester in California 2005-2006

	Ever Tested for HIV n= 135,774 (69.4%)	**HIV Tested within the past 24 Months** n=85,506 (42.7%)	**HIV Tested within the Past 12 Months** n=58,495 (29.2%)	**HIV Tested within the Past 6 Months** n=27,252 (13.6%)
Mean Age (SD)	35.4 (11.7)	34.4 (11.6)	34.2 (11.6)	33.8 (11.6)
Gender				
Male	92,210 (67.9)	60,814 (71.1)	42,732 (73.1)	20,214 (74.2)
Female	43,564 (32.1)	24,692 (28.9)	15,763 (27.0)	6,885 (26.9)
Race				
Black – Non-Hispanic	23,994 (17.9)	15,548 (18.4)	10,377 (17.9)	4,863 (17.8)
Hispanic	35,795 (26.6)	22,488 (26.6)	15,239 (26.3)	6,886 (25.3)
White – Non-Hispanic	58,764 (43.7)	35,974 (42.5)	24,807 (42.8)	11,626 (42.7)
Asian	8,635 (6.4)	5,990 (7.1)	4,192 (7.2)	1,973 (7.2)
Other	7,216 (5.4)	4,698 (5.5)	3,328 (5.7)	1,633 (6.0)
Never Uses Condoms	35,306 (26.0)	19,151(22.4)	12,609 (21.6)	5,730 (21.0)
Drug Use with Sex	43,140 (31.8)	27,758 (32.5)	18,858 (32.2)	8,534 (31.3)
High-Risk Sex Partner	31, 828 (25.9)	20,931 (26.9)	14,651 (27.6)	6,936 (28.4)
Injection Drug Use	13,693 (13.2)	8,604 (12.9)	5,726 (12.5)	2,591 (12.3)
HIV-Positive	1,641 (1.2)	1,074 (1.3)	727 (1.2)	362 (1.3)

Table 2.2 Demographics and risk behaviors by sexual orientation among current HIV testing clients who had an HIV test in the past 12 months (RRT) and clients who have not had an HIV test in the past 12 months (non-RRT), California, 2005-2006

	Heterosexual Males			**MSM**			**Females**		
	Non-RRT n=59,791 n (%)	RRT n=16,020 n (%)	p-value	Non-RRT n=30,263 n (%)	RRT n=26,712 n (%)	p-value	Non-RRT n=51,612 n (%)	RRT n=15,763 n (%)	p-value
Race/ethnicity			**<0.001**			**<0.001**			**<0.001**
Black	9.183 (15.5)	3,929 (24.8)		3,075 (10.3)	2,388 (9.0)		9,754 (19.2)	4,060 (26.1)	
Hispanic	21,050 (35.6)	4,347 (27.4)		10,005 (33.5)	7,099 (26.8)		15,755 (30.9)	3,793 (24.3)	
White	22,669 (38.3)	5,861 (37.0)		12,952 (43.4)	13,138 (49.6)		18,803 (36.9)	5,808 (37.3)	
Asian	3,347 (5.7)	774 (4.9)		2,616 (8.8)	2,513 (9.5)		3,769 (7.4)	905 (5.8)	
Other	2,896 (4.9)	939 (5.9)		1,219 (4.1)	1,374 (5.2)		2,828 (5.6)	1,015 (6.5)	
Age: mean (std)	34.3 (12.8)	35.9 (12.5)	**<0.001**	35.2 (12.2)	34.7 (11.0)	**<0.001**	32.3 (12.3)	32.3 (11.3)	0.496
Sex partners			**<0.001**			**<0.001**			**<0.001**
0	6,833 (11.4)	2,933(18.3)		4,314 (14.3)	4,987 (18.7)		6,265 (12.1)	2,398 (15.1)	
1	12,467 (20.9)	3,413 (21.3)		3,248 (10.7)	2,915 (10.9)		16,243 (31.5)	4,559 (28.9)	
2-3	19,996 (33.4)	4,893 (30.5)		6,645 (22.0)	5,599 (21.0)		16,651 (32.3)	4,957 (31.5)	
4-9	13,896 (23.2)	3,217 (20.1)		7,808 (25.8)	6,444 (24.1)		8,129 (15.8)	2,323 (14.7)	
10+	6,588 (11.0)	1,560 (9.7)		8,240 (27.2)	6,760 (25.3)		4,308 (8.3)	1,537 (9.8)	
HIV+ partner	756 (1.4)	404 (2.8)	**<0.001**	3,571 (13.4)	5,075 (21.1)	**<0.001**	1,145 (2.5)	744 (5.2)	**<0.001**
Traded sex	1,622 (3.4)	627 (4.8)	**<0.001**	2,520 (11.5)	1,526 (8.0)	**<0.001**	3,888 (9.9)	2,004 (15.8)	**<0.001**
IDU[†]	6,549 (14.3)	2,616 (20.9)	**<0.001**	1,877 (7.8)	1,167 (5.4)	**<0.001**	3,834 (10.9)	1,943 (16.8)	**<0.001**
Shared needles*	4,146 (68.9)	1,458 (59.6)	**<0.001**	867 (51.2)	519 (50.9)	0.990	2,404 (69.3)	1,230 (67.8)	0.272
Positive HIV test	244 (0.4)	61 (0.4)	0.628	1,008 (3.3)	625 (2.4)	**<0.001**	180 (0.3)	41 (0.3)	0.089

Table 2.2 Demographics and risk behaviors by sexual orientation among current HIV testing clients who had an HIV test in the past 12 months (RRT) and clients who have not had an HIV test in the past 12 months (non-RRT), California, 2005-2006, Continued

	Heterosexual Males			**MSM**			**Females**		
	Non-RRT n=59,791 n (%)	RRT n=16,020 n (%)	p-value	Non-RRT n=30,263 n (%)	RRT n=26,712 n (%)	p-value	Non-RRT n=51,612 n (%)	RRT n=15,763 n (%)	p-value
Partner but no condom use	17,857 (29.9)	4,099 (25.6)	**<0.001**	6,760 (22.3)	3,813 (14.3)	**<0.001**	18,519 (35.9)	4,697 (29.8)	**<0.001**
High-risk sex partner but no condom use	5,176 (9.5)	1,584 (10.9)	**<0.001**	3,249 (12.1)	2,526(10.4)	**<0.001**	4,360 (9.4)	1,613 (11.2)	**<0.001**
Recent STI‡	1,980 (3.3)	611 (3.8)	**0.002**	2,146 (7.1)	2,688 (10.1)	**<0.001**	1,515 (2.9)	661 (4.2)	**<0.001**
Sex w drug use	19,578 (32.7)	5,840 (36.5)	**<0.001**	9,735 (32.2)	7,923 (29.7)	**<0.001**	13,196 (25.6)	5,095 (32.3)	**<0.001**
Stimulant use	14,109 (23.7)	4,463 (28.0)	**<0.001**	6,534 (21.7)	4,736 (17.8)	**<0.001**	9,684 (18.8)	4,128 (26.3)	**<0.001**
Prevalence**			**<0.001**			**<0.001**			**<0.001**
Low	34,755 (61.0)	7,913 (52.0)		11,776 (40.9)	8,593 (33.4)		28,734 (58.2)	7,757 (51.5)	
High	22,251 (39.0)	7,299 (48.0)		17,051 (59.1)	17,173 (66.6)		20,639 (41.8)	7,319 (48.5)	

†injection drug user

*among injection drug user

‡sexually transmitted infection

**HIV prevalence of county of residence. County prevalence dichotomized into those with HIV prevalence above (high) and below (low) the statewide median.

Table 2.3 Adjusted analysis of factors associated with HIV recent repeat testing, California, 2005-2006

	Heterosexual Males		**MSM**		**Females**	
	Odds Ratio	95% C.I.	Odds Ratio	95% C.I.	Odds Ratio	95% C.I.
Race/ethnicity						
Black	Ref		Ref		Ref	
Hispanic	0.52	0.49-0.56	0.79	0.73-0.86	0.65	0.61-0.71
White	0.63	0.59-0.66	1.180	1.09-1.28	0.75	0.70-0.80
Asian	0.54	0.49-0.61	1.00	0.90-1.11	0.63	0.56-0.71
Other	0.78	0.71-0.87	1.26	1.12-1.45	0.95	0.85-1.07
Age	1.01	1.004-1.007	0.99	0.99-0.99		
Sex partners						
0	Ref		Ref		Ref	
1	0.80	0.74-0.87	0.95	0.87-1.04	0.97	0.88-1.07
2-3	0.69	0.64-0.746	0.83	0.77-0.89	0.87	0.80-0.95
4-9	0.60	0.56-0.65	0.75	0.70-0.81	0.74	0.67-0.81
10+	0.56	0.52-0.62	0.72	0.67-0.77	0.62	0.55-0.69
HIV+ partner	1.56	1.34-1.80	1.80	1.69-1.92	1.61	1.40-1.83
Traded sex			0.75	0.69-0.81	1.26	1.16-1.36
IDU†	1.30	1.22-1.39			1.42	1.31-1.54
Tested HIV+			0.66	0.58-0.75		
Never condom	0.80	0.75-0.85	0.66	0.62-0.70	0.75	0.71-0.80
High-risk sex partner but no condom use	1.14	1.05-1.23	0.83	0.77-0.90		
Recent STI‡			1.42	1.31-1.53	1.18	1.04-1.34
Stimulant use	1.12	1.06-1.18	0.80	0.75-0.84	1.28	1.40-1.36
Prevalence**						
Low	Ref		Ref		Ref	
High	1.23	1.17-1.28	1.28	1.22-1.34	1.21	1.15-1.28

†injection drug user

‡sexually transmitted infection

**HIV prevalence of county of residence. County prevalence dichotomized into those with HIV prevalence above (high) and below (low) the statewide median.

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Chapter 3

Factors Associated with Recent Repeat HIV Testing and Acceptance of Prevention Counseling at Publicly Funded Testing Sites in Southern California

Abstract

Objectives. Required pre-test HIV prevention counseling has been speculated to deter repeat testing among high-risk individuals. The objective of the study was to assess the prevalence and correlates of recent repeat testing overall and acceptance of counseling among recent repeat testers (RRTs) who reported HIV-associated risk factors.

Methods. A pilot study allowing RRTs, defined as those receiving HIV testing in the previous year, to opt-out of counseling was conducted in two California counties. Individuals seeking HIV testing between September 2008 and February 2009 at a sexually transmitted infection (STI) clinic in Orange County, a mobile testing van or stand-alone testing center in Los Angeles County completed standardized questionnaires at the time of testing. RRTs were compared with non-RRTs to identify correlates of repeat testing. Second, among RRTs, those accepting counseling were compared to those refusing, to identify correlates of their counseling decisions.

Results. Of 707 clients surveyed, 202 (28.6%) were RRTs. Compared to non-RRTs, RRTs were more likely to report oral sex in the past 12 months, have high-risk sexual and injection behaviors, and there was a higher prevalence of RRTs at the STI clinic (all p-values <0.05). Among 150 RRTs who were eligible to skip counseling, 91 (60.3%) chose to forego counseling. Testing at the STI clinic, being MSM, and not having a diagnosis of gonorrhea or syphilis in the past year were significantly associated ($p<0.05$) with accepting counseling in multivariate analysis.

Conclusion. RRTs reported HIV risk more often than non-RRTs, and among eligible participants, those accepting counseling were less likely to have a recent STI diagnosis but were not statistically different in any modifiable risk factor from those opting-out. While many high-risk RRTs accepted counseling, alternative interventions are needed for those who refuse counseling.

Introduction

Of the more than 1 million Americans infected with HIV, approximately 21% are estimated to be unaware of their HIV-positive status [1]. Though accounting for a minority of the HIV-positive population, those who are unaware of their status are estimated to account for over 50% of new cases [2]. Those who are unaware are responsible for 3.5 times as much HIV transmission as those who are aware [2].

In order to reduce transmission by those unaware and to reach HIV infected individuals before they have symptoms, the CDC published guidelines in 2006 recommending routine HIV testing of individuals in healthcare settings without necessitating pre-test counseling [3]. The guidelines did not suggest changes to sites where people seek HIV testing, though an aspect of HIV testing which may discourage testing or retesting is obligatory 20 minute pre-test counseling. Clients at an HIV testing site in Northern California stated their reason for testing as wanting a "routine test" and did not readily admit to behaviors that put them at risk when speaking with a counselor [4]. A lack of frank and forthcoming discussion may increase distrust and/or discomfort with the counseling process. Among IDUs, those offered HIV testing with optional counseling were more likely to test than those offered testing with mandatory counseling [5]. Among high-risk individuals, those who had never tested compared with those who had delayed testing, were more likely to report not wanting to talk to a counselor [6].

Previous studies have found that those who are less likely to have a need for counseling, those with higher motivation to use condoms and greater history of condom use, are the most likely to accept counseling when given the choice [7]. Other testers see HIV testing as part of regular care [8] and between 1998 and 2002 the percentage of those receiving an HIV test during a regular check-up increased to 25% [9]. A propensity of those most at risk to avoid counseling and the predisposition of repeat testers with safer practices to

accept counseling leads to questioning the need for repeated HIV prevention counseling among regular HIV testers.

Though HIV counseling and testing has been shown to be effective as a secondary prevention tool to reduce risk behaviors among those testing HIV-positive, the evidence for the effectiveness of counseling as a primary prevention effort among those testing negative is mixed. Project RESPECT, found the incidence of STIs was significantly lower among those who received counseling, either brief or enhanced, compared to those receiving only educational messages [10]. Several studies found only a transient change in behavior among those receiving counseling [11, 12] and other studies among MSM have found that participants did not significantly decrease unprotected anal intercourse after receiving counseling [13, 14]. These studies raise questions about the effectiveness of HIV pre-test counseling to promote meaningful behavior changes in the risk behavior of repeat testers.

Repeat testing is associated with higher-risk behaviors such as increased number of sexual partners, more unprotected sex, more drug use, and increased likelihood of HIV acquisition [15-17]. Though in one study repeat testers were found to have greater condom use [15]. It has been demonstrated that those at higher risk test more often [18, 19], supporting the possibility that the most risky individuals understand their increased risk resulting in their pursuing HIV testing more frequently than those at lower risk.

A change in Californian legislation in 2009 allowing state funded HIV tests to be conducted without a 20 minute pre-test counseling session for repeat testers [20], afforded our study team the opportunity to assess whether high-risk recent repeat testers (RRTs) would choose to opt-out of prevention counseling and to identify correlates of counseling acceptance. As the State transitions to new HIV testing policies including optional counseling and self-administration of risk assessment forms, this study was undertaken to determine the potential impact of new HIV testing policies on the populations currently presenting for HIV testing.

Methods

A pilot program comprised of offering optional pre-test counseling was conducted at two sites in Los Angeles County (a mobile testing van and stand-alone testing center) and one site in Orange County (a county-run STI clinic). The mobile testing van circulates throughout South Los Angeles, administering approximately 400 tests per month to an ethnically/racially diverse, though primarily female client population. The stand-alone HIV testing center, conducts approximately 250 tests per month and serves a largely MSM population. The STI clinic tests approximately 500, predominately monolingual Spanish-speaking, clients a month. HIV testing was free of charge at all sites.

We conducted a cross-sectional study between September 2008 and February 2009 to describe client characteristics and counseling choices at these sites. Upon arrival, clients were given a Client Assessment Questionnaire (CAQ) to determine the clients' risk level and prior HIV testing history. The questionnaire was available in both English and Spanish at all sites and collected demographics, risk behavior information, the number of previous HIV tests, as well as the month and year of the last HIV test received. Clients in LA used computer assisted self interview (CASI) on handheld (Palm) computers while OC clients used paper forms to self-administer the CAQ. Clinic staff used the CAQ to determine the clients' risk level and date of last HIV test. Those who reported HIV risk and had tested in the last year (RRTs) were given the option to forgo pre-test counseling. All HIV-positive participants were provided post test counseling even if they chose to skip pre-test counseling.

High-risk was defined as a participant reporting any of the following in the last year: injection drug use; MSM identification or behavior; sex with a sex worker; trading sex for money, drugs, services or other items; gonorrhea or syphilis diagnosis; sexual partner who was an MSM or IDU with an HIV status that was positive or unknown; or was transgender. High-risk clients were also asked supplemental risk behavior questions using the California

Office of AIDS Supplemental Risk Information Form (RIF). These questions immediately followed the CAQ for participants using handheld computers in LA, and were administered during face-to-face interviews with HIV testing staff in OC.

We had an opportunity to assess the reliability of self-administered questionnaires compared to counselor-administered interviews, by comparing the self-administered CAQ to counselor gathered data on a subset of participants. Since data collection methods differed between LA and OC, we analyzed the sites separately. Questions compared from the LA sites included vaginal or anal sex by partner gender, oral sex by partner gender, injection drug use in the last year, HIV risk factors among sex partners and HIV testing history. Comparable questions from OC included gender of reported partners and injection drug use.

Double data entry and reconciliation was carried out on all paper forms. The Institutional Review Boards of the University of California, San Diego, California Department of Public Health, the County of Orange Health Care Agency and AIDS Healthcare Foundation approved the protocol.

Statistical Analysis

We conducted separate analyses involving two outcomes, recent repeat testing and counseling acceptance. The first analysis identified correlates of recent repeat testing while the second analysis identified correlates of counseling acceptance among those high-risk RRTs who were eligible to skip counseling.

Descriptive statistics and chi-square tests were carried out to identify associations between client characteristics and recent repeat testing status or counseling acceptance. Multivariate logistic regression was utilized to determine the significance of demographic and risk behaviors on recent repeat testing and counseling choice. All variables found to be significant at $\alpha < 0.10$ were included in a full model, and removed in a step-wise fashion based on significance of $\alpha < 0.05$, and the strength and direction of associations among the variables

remaining in the regression. Since several covariates varied significantly by site, the first multivariate analysis controlled for site and a second analysis, without site, was run to determine if site was masking important associations.

The kappa test statistic was utilized to determine the agreement between the questions that were repeated on self-administered and interviewer-administered forms. The analysis of a socially desirable behavior, previous HIV testing, in addition to sensitive behaviors, was used to determine whether clients were answering questions differently because of the inability to understand the self-administered format or a differential willingness to disclose sensitive behaviors.

Results

Overall

A total of 707 participants enrolled in the study, of which 461 (65.2%) were recruited from the STI clinic site in Orange County, 104 (14.7%) at the stand-alone testing center and 142 (20.1%) at the mobile testing van. Most participants were male (73.1%) and Hispanic (51.3%). Overall, five (0.8%) participants tested HIV-positive, all testing at the STI clinic. The majority reported practicing oral sex (78.4%) and vaginal or anal sex (84.9%) in the last year; 84.6% of those who had sex, participated in unprotected sex. Prior HIV testing was reported by 447 (63.2%) clients; 202 (28.6%) tested in the last year thereby meeting our definition of RRT.

Forty-four percent of the population met the definition of high-risk, and 22.5% were high-risk and also tested in the last year, making them eligible to skip counseling. Of those testing at the stand-alone testing center, 46.2% were eligible, while at the STI clinic and mobile testing van, 21.9% and 7.0% were eligible, respectively (Table 3.1).

Factors associated with recent repeat testing

Among all participants, variables significantly associated with recent repeat testing in univariate analysis included sex at birth, race, site tested, sexual orientation, oral sex, vaginal/anal sex, gonorrhea or syphilis in the last year, high-risk behavior, more male or less female partners, an HIV-positive partner, and knowledge of partner's positive status before sex (Table 3.2). Since the definition of high-risk behaviors included MSM, the full model did not include sexual orientation. Interactions between site tested and variables of interested were tested, but dropped from the full model due to lack of significance or impact on other variables. The first full model including all significant associations with recent repeat HIV testing included oral sex (adjusted odds ratio [aOR]=2.9, p=0.001), practicing high-risk behaviors (aOR=7.8, p=<0.001) and site tested (aOR=0.27, p=<0.001 for mobile testing van versus STI clinic). The second full model, excluding the site variable included oral sex (aOR=2.6, p=<0.01), vaginal or anal sex (aOR=3.5, p=0.02) and practicing high-risk behaviors (aOR=7.6, p-value=0.001).

Factors associated with accepting pre-test counseling among recent repeat testers

Among the 151 high-risk RRTs eligible to forgo counseling, 78.1% were MSM, 7.3% were IDUs and 16.6% had used stimulants in the past year. Univariate analysis found acceptance of counseling was associated with testing at the STI clinic, being MSM, having fewer female partners, not having an HIV-positive partner and no use of erectile dysfunction drugs (male participants) in the last year (Table 3.3). In the first multivariate logistic regression model, participants who tested at the STI clinic (aOR=6.5, p<0.001), were MSM (aOR=7.1, p=0.014), and had not been diagnosed with gonorrhea or syphilis in the past year (aOR=5.6, p=0.01) were significantly more likely to accept counseling. Interactions between site tested and variables of interest were tested, but dropped from the full model due to lack of

significance or impact on other variables. In the second multivariate logistic regression model excluding the site variable, participants who were MSM (aOR=8.7, p=0.01), shared injection equipment (aOR=16.9, p=0.02), and did not have an HIV-positive partner (aOR=5.0, p=0.01) were significantly more likely to accept counseling.

Comparability of self-report with counselor administered

At the LA sites there was only moderate agreement between the self-administered and counselor-administered forms (Table 3.4). The question, "have you had an HIV test before today?" had the highest agreement with a kappa score of 0.66. The next highest kappa was for having vaginal or anal sex with a female, which had a kappa score of 0.61. Though not consistent for all variables, more high-risk behaviors were reported on interviewer-administered questionnaires (oral, vaginal, or anal sex with a man, vaginal or anal sex with a woman, an MSM partner, and an IDU partner) than on self-administered questionnaires, although having an HIV-positive partner or using injection drugs was reported more often when using the computer-administered questionnaire.

At the STI clinic site kappa scores ranged between 0.78 and 0.93. Sexual partners of either gender were reported more often by interview than self-administration, though injection drug use was reported less often.

Discussion

In this study, personal characteristics differed between RRTs and non-RRTs, but we found few differences between those accepting counseling and those choosing to skip counseling. We also found moderate agreement between self-administered and interviewer-administered questionnaires.

This is consistent with previous studies that found that repeat testers were more likely to report high-risk behaviors [17-19]. High-risk behavior as defined in this study includes both

modifiable behaviors such as unprotected sex but also personal characteristics such as MSM. MSM is not a modifiable behavior but there are steps that can be taken to reduce the risk of HIV transmission. Although not necessarily higher risk depending on their moderating behaviors, MSM behavior was used to categorize an individual as high-risk to reflect California Department of Public Health, Office of AIDS categories designed for program planning because this population is most affect by the HIV epidemic in the United States. Although RRTs were significantly more likely to participate in some high-risk behaviors, they were not significantly different from those who had tested more than a year ago or not at all, when comparing HIV rate, unprotected sex, sharing injection equipment, either paying or being paid for sex or stimulant use. Although RRTs were more likely to report vaginal or anal sex, they were also more likely to report oral sex. Since participants did not report the frequency of sexual behaviors it is possible that the higher reporting of oral sex was the result of choosing oral sex in place of vaginal or anal sex in some situations as a risk reduction strategy. RRTs may be using HIV testing as a prevention strategy and not be at greater risk for HIV than those who do not repeat test. Other studies have found that those not testing for HIV think they are at lower risk [21] while those testing perceive themselves to be at higher risk or actually have higher risk behaviors [22, 23]. Some high-risk individuals have stated that HIV testing is a part of self-care and a means of control [8].

Among the high-risk RRTs eligible to skip counseling, significant associations with counseling acceptance were found by site, sexual orientation, and recent STI diagnosis. When site was excluded significant differences were also found among those sharing injection equipment and those with an HIV-positive partner. It is of interest that we found MSM more accepting of counseling in both models, since in previous studies MSMs were more likely not to fully disclose risk to a counselor [24]. The site differences may be attributed to the very different structure, wait time and primary function of each location. The STI clinic

experienced long wait times which counselors hypothesized may have made participants more willing to accept counseling in order to avoid returning to the waiting room while their test developed or they waited to be called to see a nurse for the next step in their STI appointment. Differences in counseling acceptance could also be a function of the mode of data collection, since both the testing center and the mobile testing unit used CASI while the STI clinic used paper forms. Mode of questionnaire administration can affect the truthfulness and completeness of data collected with more socially desirable responses given to an interviewer and more socially undesirable responses more likely with an anonymous form of data collection such as CASI [25-35].

Given that differences were seen in risk behavior reporting by mode of administration, different methods may need to be employed to elicit the most honest responses in different settings. Based on our findings, a self-administered questionnaire may be more effective in settings with high injection drug use. Other studies among populations in the United States as well as abroad have found increased reporting of sensitive behaviors, such as MSM, unprotected sex, drug use and non-adherence to ART, through the use of CASI compared to interview or self-administered questionnaire [25-35], although some studies have found little difference or conflicting differences [28, 30, 36-38]. Similar to previous studies the socially undesirable behavior of IDU was reported most often by self-report. Interestingly, sexual behaviors were reported more often to an interviewer. These differences may be a function of differing levels of question sensitivity and legality, since the socially desirable behavior of having a previous HIV test was also reported more often to an interviewer. Individuals may have differing levels of sensitivity disclosing sexual behaviors while IDU can have more serious repercussions including jail time.

One limitation of this study is its cross-sectional nature, which does not allow the differentiation between correlation and causation. Another limitation we encountered was the

inability to query those who had never received an HIV test or did not retest because of the pre-test counseling requirement. Those who refuse to test because of the counseling would not present themselves to be tested during our study. Therefore it is not possible to directly measure the individuals who do not present for testing because of the barrier of mandatory pre-test counseling, but we are able to infer information about them from those who did seek testing but then decided to skip counseling when given the option. If similar to those who presented to be tested during this study, those who are not testing because of the counseling, are more likely to be heterosexual males, have a recent STI diagnosis and test at a non-STI clinic site. The higher proportion of STI infection among these individuals indicates that they are practicing behaviors that put them at risk for sexual transmission of HIV. As such they should receive testing even if not accompanied by counseling.

Other limitations include different data collection methods and lack of consistency in questions used across sites for assessment of data reproducibility. Also, the risk behavior questions we report were limited to the state approved risk assessment, and some important client characteristics were not asked. For example, two variables that would have been advantageous to measure on the CAQ are separate vaginal and anal sex questions and a stimulant drug use question. These questions would have allowed a better definition of high-risk. Despite these limitations, this study provides unique information about differences between RRTs and non-RRTs, as well as those who are more comfortable foregoing counseling and just receiving an HIV test.

The large percentage of participants who accepted counseling (40%), suggests that some clients desire counseling and should receive it, but alternative interventions are needed for those who refuse counseling. Additionally, those who did not choose counseling were not significantly riskier than those who did, therefore those most at risk were not systematically missing out on an opportunity for counseling. This study was important as the first

implementation of new pre-test counseling options. We were able to determine what people choose when given the option surrounded by the actual pressures and constraints faced daily by testers and counselors. As such we were able to determine the impact of recent and potential future policies on individuals presenting for testing.

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Table 3.1 Demographic characteristics of participants from three Southern Californian HIV testing sites

	STI clinic n=461 n (%)	Testing center n=104 n (%)	Mobile testing van n=142 n (%)	p-value
Demographics				
Male	347 (75.3)	88 (84.6)	82 (57.7)	< 0.001
Female	114 (24.7)	16 (15.4)	60 (42.3)	
Median age (range)	29.6 (18-72)	32.9 (19-83)	32.7 (18-71)	0.01
Black	17 (3.8)	23 (11.5)	58 (42.6)	< 0.001
Hispanic	281 (62.7)	21 (20.2)	51 (37.5)	
White	103 (23.0)	59 (56.7)	22 (16.2)	
Asian	36 (8.0)	4 (3.8)	3 (2.2)	
Other	11 (2.5)	8 (7.7)	2 (1.5)	
Heterosexual male	239 (51.8)	19 (18.3)	69 (48.6)	< 0.001
MSM	108 (23.4)	69 (66.3)	13 (9.2)	
Female	114 (24.7)	16 (15.4)	60 (42.3)	
HIV positive	5 (1.1)	0 (0.0)	0 (0.0)	-
Sexual behavior last year				
Oral Sex	361 (78.8)	98 (94.2)	93 (65.5)	< 0.001
Vaginal or anal sex	410 (88.9)	92 (88.5)	98 (69.0)	< 0.001
Unprotected vag/anal sex	347 (76.1)	69 (66.3)	72 (50.7)	< 0.001
Traded sex	10 (2.2)	7 (6.7)	13 (9.2)	< 0.01
Sex with sex worker	49 (10.7)	17 (16.3)	29 (20.6)	< 0.01
Gonorrhea/syphilis	19 (4.1)	3 (2.9)	1 (0.7)	0.12
Injection drug use last year				
Injected any illegal drugs	18 (4.0)	4 (3.8)	4 (2.9)	0.73
Shared injection equipment	8 (1.8)	2 (1.9)	1 (0.7)	0.57
Testing history				
Ever tested for HIV	278 (60.3)	88 (84.6)	81 (57.0)	< 0.001
Tested in last year	139 (30.2)	48 (46.2)	15 (10.6)	< 0.001
High-risk*	183 (39.7)	82 (78.8)	47 (33.1)	< 0.001
Eligible to opt-out of counseling**	101 (21.9)	48 (46.2)	10 (7.0)	< 0.001

*High-risk tester defined as reporting being transgender; MSM behavior or identification; or in the past year having sex with a prostitute, trading sex for money, drugs, services or other goods, injecting illicit drugs, having gonorrhea or syphilis, having sex with an MSM or IDU partner of unknown or HIV-positive status.

**Participants were eligible to skip counseling if they were both high-risk and had previously tested within the last year.

Table 3.2 Analysis of factors associated with recent repeat testing among Southern Californian HIV testers

	Recent Repeat Tester			**Model 1***		**Model 2****	
	YES n=202 n (%)	**NO** n=505 n (%)	p-value	aOR	p-value	aOR	p-value
Site			**< 0.001**				
STI clinic	139 (68.8)	322 (63.8)		Ref.			
Testing center	48 (23.8)	56 (11.1)		0.88	0.61		
Mobile testing van	15 (7.4)	127 (25.1)		0.27	**< 0.001**		
Demographics							
Male	174 (86.1)	343 (67.9)	**< 0.001**				
Female	28 (13.9)	162 (32.1)					
Age: mean (std)	32.5 (9.5)	33.7 (11.8)	0.15*				
Black	18 (9.1)	63 (14.1)	**0.02**				
Hispanic	95 (48.0)	258 (52.7)					
White	58 (29.3)	126 (25.7)					
Asian/Other	27 (13.6)	37 (7.6)					
Heterosexual male	50 (24.8)	277 (54.9)	**< 0.001**				
MSM	124 (61.4)	66 (13.1)					
Female	28 (13.9)	162 (32.1)					
HIV positive	3 (1.7)	2 (0.5)	0.16†				
Homeless	5 (3.6)	7 (6.4)	0.32				
Incarcerated past year	13 (9.4)	15 (13.8)	0.29				
Sexual behavior last year							
Oral sex	186 (92.1)	366 (72.9)	**< 0.001**	2.9	**0.001**	2.6	**0.002**
Vaginal or anal sex	190 (94.1)	410 (81.2)	**< 0.001**			2.3	**0.016**
Unprotected [a]	143 (71.9)	345 (68.6)	0.40				
Traded sex	11 (5.5)	19 (3.8)	0.31				
Sex with sex worker	31 (15.3)	64 (12.8)	0.38				
Gonorrhea or syphilis	16 (7.9)	7 (1.4)	**< 0.001**				
Injection drug use last year							
Injected any illegal drugs	12 (6.0)	14 (2.8)	**0.04**				
Shared injection equipment	6 (3.0)	5 (1.0)	0.05				
High-risk[b]	159 (78.7)	153 (30.3)	**< 0.001**	7.8	**< 0.001**	7.6	**<0.001**
Partners							
Male (mean [std])	12.2 (47.8)	2.4 (4.8)	**0.01**‡				
Female (mean[std])	0.7 (1.9)	1.7 (3.0)	**< 0.01**‡				
MSM (among females)	4 (23.5)	4 (19.0)	1.00†				
IDU	13 (8.5)	13 (8.7)	0.96				
HIV +	25 (16.1)	9 (6.0)	**< 0.01**				
Knew HIV+ partner status[c]	11 (7.2)	1 (0.7)	**< 0.01**				

Table 3.2 Analysis of factors associated with recent repeat testing among Southern Californian HIV testers, Continued

	Recent Repeat Tester			**Model 1***		**Model 2****	
	YES n=202 n (%)	**NO** n=505 n (%)	p-value	aOR	p-value	aOR	p-value
Substance use last year							
No alcohol or drug use	33 (21.6)	44 (34.4)	**0.02**				
Alcohol	112 (73.2)	77 (60.2)	**0.02**				
Marijuana	30 (19.6)	30 (23.4)	0.44				
Methamphetamine	16 (10.5)	16 (12.5)	0.59				
Cocaine	16 (10.5)	13 (10.2)	0.93				
Crack	4 (2.6)	7 (5.5)	0.22				
Heroin	7 (4.6)	8 (5.2)	0.53				
Pain killers/tranquilizers	14 (9.2)	9 (7.0)	0.52				
Ecstasy	13 (8.5)	10 (7.8)	0.84				
GHB	8 (5.2)	3 (2.3)	0.21				
Ketamine	5 (3.3)	0 (0.0)	0.07†				
Viagra, Cialis or Levitra	13 (8.5)	7 (5.5)	0.33				
Poppers	18 (11.8)	7 (5.5)	0.07				
Stimulant use	26 (17.0)	24 (18.8)	0.70				

*Adjusted odds ratio from full model, including only those significant at the <0.05 level.

** Adjusted odds ratio from full mode, excluding site and including only those significant at the <0.05 level.

[a]Reported having vaginal or anal sex without a condom in the last year compared to those who did not reported vaginal or anal sex without a condom in the last year.

[b]High-risk was defined as defined as reporting being transgender, MSM behavior or identification, and in the past year sex with a prostitute, trading sex for money, drugs, services or other goods, IDU, gonorrhea or syphilis, and/or reporting sex with an MSM or IDU partner of unknown or HIV positive status.

[c]Knew their HIV-positive partner's status prior to having sexual relations with them.

‡Equal variances not assumed

† Calculated with Fisher's exact test due to small numbers.

Table 3.3 Analysis of factors associated with HIV prevention counseling acceptance among high-risk recent repeat testers in Southern California

	Accepted Counseling			**Model 1***		**Model 2****	
	YES n=60 n (%)	**NO** n=91 n (%)	p-value	aOR	p-value	aOR	p-value
Site			**< 0.001**				
STI clinic	49 (81.7)	44 (48.4)		6.5	<0.001		
LA sites[α]	11 (18.3)	47 (51.6)		Ref.			
Demographics							
Male	55 (93.2)	80(88.9)	0.38				
Female	4 (6.8)	10 (11.1)					
Age: mean (std)	31.9 (9.2)	33.2 (9.4)	0.45				
Hispanic	32 (56.1)	34 (37.8)	0.07				
White	13 (22.8)	35 (38.9)					
Black/Asian/Other	12 (21.1)	21 (23.1)					
Heterosexual male	3 (5.0)	16 (17.6)	**0.04**	Ref.		Ref.	
MSM	53 (88.3)	65 (71.4)		7.1	<0.01	8.7	0.01
Female	4 (6.7)	10 (11.0)		3.6	0.17	3.1	0.28
HIV positive	1 (1.9)	2 (2.5)	1.00[†]				
Sexual behavior last year							
Oral sex	56 (94.9)	85 (93.4)	1.00[†]				
Vaginal or anal sex	55 (93.2)	85(94.4)	0.74[†]				
Unprotected	36 (62.1)	66 (75.0)	0.10				
Traded sex	5 (8.5)	6 (6.7)	0.69				
Sex with sex worker	8 (13.6)	22 (24.2)	0.11				
Gonorrhea or syphilis	3 (5.1)	12 (13.3)	0.10	0.2	0.01		
Injection drug use last year							
Injected any illegal drugs	6 (10.3)	5 (5.6)	0.34[†]				
Shared injection equipment	4 (6.9)	1 (1.1)	0.08[†]			16.9	0.02
Homeless	2 (4.2)	3 (3.8)	1.00[†]				
Incarcerated past year	5 (10.4)	7 (8.6)	0.76[†]				
Partners last year							
Male (mean [std])	22.1 (77.4)	6.7 (11.3)	0.14[‡]				
Female (mean[std])	0.3 (0.9)	1.0 (2.2)	**0.02**[‡]				
MSM (among females)	1 (14.3)	3 (30.0)	0.60[†]				
IDU	4 (7.0)	8 (9.3)	0.76[†]				
HIV +	5 (8.8)	20 (22.7)	**0.03**			0.2	0.01
Knew HIV+ partner status[b]	2 (3.5)	9 (10.5)	0.20[†]				

Table 3.3 Analysis of factors associated with HIV prevention counseling acceptance among high-risk recent repeat testers in Southern California, Continued

	Accepted Counseling			**Model 1***		**Model 2****	
	YES n=60 n (%)	**NO** n=91 n (%)	p-value	aOR	p-value	aOR	p-value
Substance use last year							
No alcohol or drug use	9 (16.7)	22 (24.7)	0.26				
Alcohol	42 (77.8)	62(69.7)	0.29				
Marijuana	9 (16.7)	21 (23.6)	0.32				
Methamphetamine	3 (5.6)	12 (13.5)	0.13				
Cocaine	6 (11.1)	10 (11.2)	0.98				
Crack	1 (1.9)	3 (3.4)	1.00†				
Heroin	3 (5.6)	4 (4.5)	1.00†				
Pain killers/tranquilizers	6 (11.1)	7 (7.9)	0.56†				
Ecstasy	3 (5.6)	10 (11.2)	0.37				
GHB	3 (5.6)	5 (5.6)	1.00†				
Ketamine	1 (1.9)	4 (4.5)	0.65†				
Viagra. Cialis or Levitra	1 (1.9)	12 (13.5)	**0.02**†				
Poppers	7 (13.0)	10 (11.2)	0.76				
Stimulant use	7 (13.0)	18 (20.2)	0.27				

*Adjusted odds ratio from full model, including only those significant at the <0.05 level.

** Adjusted odds ratio from full mode, excluding site and including only those significant at the <0.05 level.

α LA sites include both the testing center and mobile testing unit

† Calculated with Fisher's exact test due to small numbers.

‡Equal variances not assumed

bKnew their HIV-positive partner's status prior to having sexual relations with them.

Table 3.4 Agreement in factors reported on self-administered questionnaire and during counselor interviews at the same testing visit among HIV testers in Southern California

	Self-Administered %	Interviewer-Administered %	kappa
Stand-alone and Mobile testing van (n=77)			
Sensitive Questions			
Oral sex with a male partner	31.2	42.9	0.53
Vaginal or anal sex with a male partner	32.5	53.2	0.44
Oral sex with a female partner	37.7	37.7	0.50
Vaginal or anal sex with a female partner	40.3	51.9	0.61
MSM partner	9.1	13.6	0.33
IDU partner	6.7	12.0	0.38
HIV+ partner	2.7	1.4	-0.02
Injected drugs	4.1	2.7	-0.03
Less Sensitive Question			
Have you had an HIV test before today?	58.7	64.0	0.66
STI clinic (n=353)			
Gender of sex partners			
male	45.6	46.7	0.93
female	53.0	55.2	0.83
Injection drug use	4.0	2.6	0.78

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Chapter 4

A Pilot Study to Determine Implementation Feasibility and Acceptability of New Client-Centered Options Introduced During Routine HIV Testing in Southern California

Abstract

Objectives. In this study we evaluated the acceptability and feasibility of two client-centered HIV-testing conditions; a self-administered client HIV risk assessment (versus counselor-administered) and optional HIV pre-test counseling for repeat testers as part of routine HIV testing in three clinics in Southern California.

Methods. Clinic staff and clients tested during the implementation of the new testing procedures were invited to provide feedback. We utilized surveys with qualitative and quantitative components to gather information from site administrators, staff and clients on their experiences and opinions regarding the two new testing conditions.

Results. Survey information was gathered from three sites involving three administrators, 10 counselors and 299 clients. The self-administration option was well received by counselors and clients, although some Spanish-speaking clients had difficulty completing the assessment. Optional counseling for recent repeat testers was well received by counselors and clients.

Conclusion. Our study indicated overall good acceptability from both clinic staff and clients of self-administered risk assessment and optional counseling for repeat testers. We observed that implementation of these changes was feasible. Changes creating more flexibility in the counseling and testing process were well received by clients, staff and administrators. Overall, the increase in client-focused options gave counselors the tools to better meet each client's individual needs while making good use of reduced HIV prevention resources.

Introduction

Efforts to expand HIV testing in the United States are a critical part of engaging HIV-positive persons into care and stemming the transmission of HIV [1]. Opportunities to enhance client-centered approaches to testing by allowing client self-administration of HIV risk-assessment forms (versus counselor-administered) and optional pre-test counseling for repeat HIV testers have the potential to get more persons to come in for testing and reduce testing costs.

Doing the most good with limited resources requires evidence-based decisions. Knowledge of HIV status has been shown to dramatically decrease sexual risk behaviors among those who test HIV-positive, thus protecting others [2, 3]. Although there is strong evidence of behavior change as a function of knowledge of HIV-positive status and post-test counseling [2-5], the evidence of behavior change after pre-test counseling among those testing HIV-negative is mixed [2, 6-9]. Those who have never tested are more likely to cite speaking with a counselor as an obstacle to testing than those who have delayed testing [10]. Also, prior studies suggest that those most at risk are less likely to accept counseling when offered [11].

Opportunities to receive HIV testing without pre-test counseling, especially among those who have previously received counseling, has been suggested to improve clinic responsiveness to client HIV testing needs and result in cost savings; however, research is lacking on the feasibility and acceptability of such an approach. From a healthcare utilization perspective, clinic responsiveness to client testing preferences (e.g., optional pre-test counseling) may influence both use of testing services and satisfaction with the HIV testing process [12, 13]. Client-centered changes such as allowing self-administration of risk assessment forms and allowing recent repeat testers to forgo counseling may increase use of and satisfaction with testing services, although research is lacking in this area. The purpose of

this pilot study was to assess the feasibility and acceptability of expanding patient-centered options to clients undergoing HIV testing from the perspective of clinic administrators and staff and clients themselves.

Methods

Study Population

The study was conducted at three publicly funded sites that offered free and confidential HIV counseling and testing in Southern California. Two sites in Los Angeles (LA) County participated (a mobile testing van and stand-alone testing center) and one site in Orange County (OC), California (a county-run STI clinic).

The mobile testing van administered approximately 400 tests a month to a racially and sexually mixed client population. Approximately three people staffed the mobile van at all times for a total of about six different individuals in a given week. The stand-alone HIV testing center had one full-time employee and conducted 250 tests per month, while serving a mostly men who have sex with men (MSM) population. The OC STI clinic tested approximately 500 clients a month, with a staff of six counselors, two administrative assistants and one site supervisor. Over 50% of the clients testing at the OC site were monolingual Spanish speakers.

Procedures

We used qualitative and quantitative methods to assess the feasibility and acceptability of implementing self-administration of risk assessments and optional pre-test counseling

The Client Assessment Questionnaire (CAQ) was developed based on the current standard California Department of Public Health Office of AIDS (CDPH-OA) data collection instruments and was available in English and Spanish. Prior to implementation of the new

testing procedures counselors would complete the survey during pre-test counseling; gathering surveillance data as required by the State of California. Self-administration modalities for the CAQ included handheld computers (used by LA sites) and paper forms (used by the OC site).

Clients who reported HIV risk on the CAQ and had tested in the last year (recent repeat testers) were given the option to skip pre-test counseling. CAQ data and counseling choices were analyzed as part of a separate analysis [14]. Upon completion of HIV testing, clients were asked to complete a Client Satisfaction Survey (described below).

The Institutional Review Boards of the University of California, San Diego (UCSD), the CDPH-OA, the County of Orange Health Care Agency and AIDS Healthcare Foundation approved the study.

Survey measures

Three separate surveys were conducted to obtain information about self-administered CAQs and optional pre-test counseling from the perspectives of the clinic administrators (Clinic Process Survey), site staff (Frontline Staff Survey), and the clients (Client Satisfaction Survey). A team of researchers from the CDPH-OA, UCSD, AIDS Healthcare Foundation, County of Orange Health Care Agency, County of Los Angeles Department of Public Health Office of AIDS Programs and Policy developed the surveys.

Clinic Process Survey

Trained staff from UCSD and CHPH-OA conducted the Clinic Process Survey with clinic site coordinators to evaluate the overall implementation of the two new testing process options. Interviews were conducted at three time points: before testing changes were implemented, during implementation and after completion of the pilot. The Clinic Process Survey is semi-structured and comprised of 30 questions. Baseline questions were used to determine the clinic flow, normal operating status and procedures. Additional questions, were added for subsequent time point measures to determine potential roadblocks, issues and fears

surrounding implementation of the options. During and after implementation, coordinators were asked to comment on best and worst practices based on their experience with the testing process. The purpose of this survey was to capture site level issues, concerns and impact of implementing new HIV testing procedures.

Frontline Staff Survey

The purpose of the Frontline Staff Survey was to evaluate the impact of implementing the new testing assessment and counseling options on clinic operations. It queried counselors regarding their own opinions as well as their perception of clients' reactions to the new program. The survey was self-administered after the completion of the pilot by counselors responsible for the day-to-day pilot implementation at each site.

The survey included 13 questions with multiple prompts for comments throughout. Background questions included:

"Which counseling and testing services have you provided during the pilot?"

"Before the pilot began, did you have experience with HIV test counseling?"

"If yes, how long?"

Questions specific to the pilot study included:

"How would you rate the overall CAQ and supplemental data collection process?"

"How would you rate the process for determining client risk level based on CAQ responses?"

Response options were on a likert scale 1 ("not at all well") to 5 ("very well").

"How hard was it for you to answer client's questions about the CAQ?

Response options were on a likert scale 1 ("not at all hard") to 5 ("very hard").

Client Satisfaction Survey

Upon completion of their HIV testing visit, all HIV-negative clients were asked to complete a brief, self-administered paper questionnaire that included 16 questions about their satisfaction with the counseling and testing process. To allow the pilot process to stabilize at the participating sites, the Client Satisfaction Survey was first offered to clients two to three weeks after initiation of the new procedures and continued to the end of the pilot program. This questionnaire was available in both English and Spanish. Questions included:

"When you were answering the questions [CAQ], were you worried that someone sitting near you might be able to see your answers?"

"Did a staff person give you the option to skip counseling today?"

"Where did you have your last HIV test?"

Data analysis

All quantitative analyses were conducted using Predictive Analytics SoftWare (PASW 17.0). We generated descriptive statistics of quantitative responses to the Frontline Staff Survey and the Client Satisfaction Survey. Chi-square tests and analysis of variance were carried out on demographic characteristics of those completing the Client Satisfaction Survey. Univariate logistic regression was also used among repeat testers to determine differences by site of client perceptions of current HIV testing experience compared to their last experience. Comparisons were carried out between "this time was better" and "about the same." Due to small numbers "last time was better" was dropped from the analysis. An $\alpha < 0.05$ was considered significant.

Qualitative analysis of the Clinic Process Survey was conducted by first reviewing all qualitative responses and identifying similarities and differences between clinic sites.

Results

Nine Clinic Process Survey interviews were conducted and 6 OC and 4 LA staff members completed Frontline Staff Surveys. A total of 299 Client Satisfaction Surveys were obtained: 112 from OC, 141 from the stand-alone clinic and 46 from the mobile van (Table 4.1). Client age did not differ significantly with the mean age ranging from 32 to 35 years old. There were significantly more men who have sex with men (MSM) tested at the LA stand-alone testing center. There were also significant differences in the percentage of clients taking the survey in English. At the stand-alone clinic almost all (99%) took the satisfaction survey in English but at the mobile van (80%) and OC (71%) significantly fewer took the survey in English.

Self-administration of data

Counselors at sites using handheld computers to gather CAQ data rated the process as at least "okay", with half the counselors stating it went "very well". One counselor summarized the process:

> "Handheld was a great time-saving tool. For repeat testers, it provides a great way for them to feel comfortable with going through the process of being aware of their status without having to be annoyed by one-on-one counseling involving the same questions they had endured once before."

Most counselors at sites using handheld computers (LA sites) stated that only a few clients (0% to 5%) needed help completing the CAQ using the computer. However, one counselor estimated that 50% needed help, stating "some clients would say 'What do I do here?' or 'What do I do next?'"

Most counselors at the OC site rated the paper-based CAQ administration as only "okay" (5 out of 6 counselors) and the other counselor rated it "less than okay." One stated, "Still have to check in to make sure they answered correctly. Also, had to help many clients finish filling out the CAQ." The general rates of assistance needed were higher with the paper-based survey, ranging from 5% to 50%. One counselor specified that only 1%-2% of English-

speaking clients needed assistance to complete the CAQ, but 90% of the Spanish-speaking clients required assistance although the form was available in Spanish. Since a majority of clients at this site spoke Spanish, the counselor said, “the burden was significant.”

Clients expressed little concern that others would see their answers at any site, with 95% of OC clients and 96% of LA clients reporting they were “not at all worried” that someone near them might see their answers while completing the CAQ. Similarly high rates reported no trouble answering the questions (93% in OC and 90% in LA). Of those who reported trouble answering the questions, only one participant at OC reported “a lot of trouble”, while the rest reported “a little bit of trouble.” Compared to OC (16%), more clients in LA (24%) were not sure what some of the questions meant, but most of those who asked for help at the LA sites also reported that they got the assistance they needed (97%).

Most clients at LA sites viewed the use of computers for self-administering the CAQ positively, as reflected in the following comments:

“I loved the new Dell computer that is now used to take the survey.”

44 year old, White male

“The new PDA system is a plus!”

25 year old, White male

One of the potential benefits and reasons for piloting self-administration was a predicted decrease in counselor workload. This was noted at LA sites, which utilized computers for the self-administration, but not at the OC clinic. The computers were programmed to display the client’s risk status when they completed the questionnaire; whereas counselors using the paper CAQ had to review responses in several places on the form to manually determine the client’s risk status. As such, time savings for the counselors was noted at both LA sites using computers, but not at the OC site where the paper CAQ was used.

At sites using computers for self-administration of forms, clinic staff noted that maintaining interpersonal contact with the client during the process was important. For example, at the mobile testing van, an outreach worker stayed outside the van, welcoming the clients and instructing them on how to complete the CAQ on the handheld computer. This outreach worker was a trained HIV counselor and tester, which the sites thought was advantageous for answering questions as the client waited. At the stand-alone clinic, it was also noted that having staff available during administration of the computer CAQ was desirable. Sites using technology had no data available for counselor review. At these sites counseling was seen as slightly more difficult.

Optional pre-test HIV counseling

From the counselors' perspective in OC, recent repeat testers responded between "okay" and "mostly positively" when offered the option to skip counseling. One counselor mentioned that those offered the option "seemed to appreciate the option of not discussing their risk behaviors [because they] want [to] just get a test result," but two other counselors mentioned that clients then felt a little like they should skip counseling to ease the burden of the busy counselor.

Three of the four counselors in LA said that clients reacted mostly positively to being offered the option to skip counseling with two mentioning that repeat testers enjoyed having the option. On counselor stated, "they felt it saved time; and was more efficient than having to be counseled again."

Four of the six OC counselors commented that they liked having the option of letting repeat high-risk clients skip counseling:

"It is a nice option to offer if available for the future."

"It's a nice option for clients who had tested several times before and only want their results."

> "For those who come in for testing but are really closed off to having a conversation with the counselor it did make it easier for myself because if they qualified for opt-out I didn't feel like I have […] to pry answers out of them."

Clients also completed questions regarding their opinion of acceptability of the opt-out process. Only 2 (<1%) out of 299 clients reported that they do not like talking with counselors or that counseling does not change their behaviors, and no client agreed with the statement that counseling was a "waste of time." The most common response to why they skipped counseling was that they "already understand their HIV risk" (17%), with the next most common responses of "I am a routine tester" (12%), and "I already know how to stay safe" (11%). Write-in responses for why they skipped counseling included; "appreciate it but had it at last test" and "I already received counseling."

While some repeat testers appreciated being able to skip counseling, there was still a desire for counseling among some clients, with 18% stating that they "always learn something new" and 15% stating they "need to better understand their HIV risk". Thirteen percent stated they "like talking to a counselor."

At all sites, most clients felt that the testing services provided were at least as good as the last test they received, but the clients at LA sites were significantly more likely to report that the information they received about HIV "this time was better" than the last time they tested compared to "about the same" (Table 4.2). Those testing at the sites in LA were also significantly more likely to report that the amount of time spent with the counselor, total amount of time spent getting tested, information was collected better, the counselor focused on their needs more and the overall experience was better than last time.

Given that clients may test at other sites, an OC counselor brought up the point that just because a client has tested recently does not necessarily mean they received counseling recently. One counselor stated they "would also like to see some kind of question if they have received education or counseling for HIV in the past." Among those who completed the client

satisfaction survey, 18% had last been tested at an alcohol or drug treatment program, jail, prison, doctor's office or hospital, all of which are less likely to provide counseling as part of the testing procedure.

Other concerns included:

> "My only fear with opt-out is that prevention work will be lost and there will be long term consequences because high risk folks will be easily tested but nothing (behaviors) will ever change so eventually these repeat testers will most likely turn HIV[-positive]."
>
> "I'm worried about the clients that just test but continue to put themselves at risk all the time."

We noted variability in how counselors interacted with clients. For example, even among those eligible to skip counseling, the counselor often asked what brought them in for testing or if they had any questions, to ensure that they were not overlooking clients' needs. This dialogue resulted in some eligible clients receiving counseling without being presented the option to skip. At OC, possibly because of up to three hour wait-times, some clients showed an unwillingness to leave the counseling room when given the option. The counselors believed this unwillingness was because of a fear that if they left the room they would have to wait a long time to be seen for their results. Other clients seemed to think they were doing the counselor a favor by choosing to forgo counseling, thus presumably freeing the counselor for another person.

At all sites, counselors mentioned that it was advantageous to be able to give recent repeat testers the option to accept or skip counseling. Since the OC testing site offered testing and treatment for STIs in addition to HIV, not every client who attended the facility was there to be tested for HIV. As such, this site had at least one recent repeat tester in for syphilis treatment who received testing only because they did not have to sit through pre-test counseling. That client tested positive for HIV.

Discussion

Our evaluation of two client-centered HIV-testing conditions, a self-administered client HIV risk assessment (versus counselor-administered) and optional HIV pre-test counseling for repeat testers as part of routine HIV testing revealed that overall, creating more flexibility in the counseling and testing process is feasible and acceptable to HIV testing clients, counselors and sites administrators. Although some problems were noted, overall, empowering clients by allowing repeat-testers to opt-out of pre-test counseling appears to promote high client satisfaction with testing, while decreasing counselor burden. These particular issues have not been studied previously and provide insight into the counseling and testing process.

Self-administration of data

We found that self-administered risk assessments were feasible and in some instances preferred over counselor-administered forms. Depending on the audiences' literacy, different formats may be more or less appropriate. Self-administration was most advantageous when coupled with technological features that allowed the participant to be truly anonymous when reporting their behaviors and allowed counselors to handle less paperwork. Although cutting the counselors paperwork, clients utilizing computers did need more assistance with self-administration which might offset staff time gains. This may be a matter of counselors and clients becoming familiar with a new process that long-term may become a less time-intensive process. However future studies would be needed to determine the net time gain or loss.

Without the inclusion of computers for self-administration, the paperwork at the OC clinic was burdensome for counselors and difficult for clients to complete. The process ran more smoothly and efficiently at the sites using computers than at the site using paper forms. Though important this may have been confounded by client attributes that differed by site, such as primary language and clients' comfort with computers. The OC testing site had a

higher proportion of Spanish-language dominant clients who reported difficulty with the self-administered risk assessment.

Optional pre-test HIV counseling

Although a larger study will be needed, our pilot study findings indicate that optional pre-test counseling may be the best option to meet clients testing needs but still provide a service to those who desire it. During this study an HIV-positive client tested and received their result because they had the option to skip pre-test counseling. This person is now able to take steps to protect themselves and others. Eliminating the barrier of counseling did result in at least this individual becoming aware of their HIV-positive status.

Further staff training may improve the process because some counselors noted difficulty presenting the option to skip counseling in such a way that clients do not feel pressured to reject counseling to help the counselors have more time or accept counseling because they do not want to wait in a busy waiting room. This training may involved working with counselors to develop standardized scripts or messages they could use with repeat testers.

Based on our evaluation, clinic staff perceived that the option for recent repeat testers to choose to go to counseling or not, served both the clients' testing needs and helped ensure that the time counselors spent with clients was not stymied by uncooperative and/or possibly already-educated clients. It allowed counselors to address the needs of each client individually rather than applying the same prevention approach to everyone.

Limitations

This study has limitations that should be considered. The number of sites and participants within the sites were small, thereby limiting our ability to make generalizations to other settings, locations and clients. Additionally, the sites were not chosen randomly, but rather by their willingness and ability to implement the pilot program and may not represent the varied nature of HIV testing sites. The differences seen in the sites provide insight into

sites at different levels of preparedness and ability to implement the two changes in the testing and counseling process, since one site was not prepared to implement a computer option. Another limitation was that we could only assess clients who presented for testing and our sample may not represent individuals who would have come for testing had they known that about optional counseling. The clients of greatest concern are those who are not currently presenting for testing but we were unable to reach them in the current study.

In addition problems were noted with the Spanish translation of the forms. Certain ideas such as sexual orientation were not translated in a culturally relevant way. Many Hispanic men entered "hombre" or man into the other category at the OC site. Prior to subsequent use, the self-administered forms will need to undergo additional review to ensure appropriate and relevant translation.

Slight deviations in protocol also occurred. Counselors did not "get the chance" to give some clients the option to skip counseling, because they were already so engaged with the participant in counseling. It is likely these same clients would have chosen to accept counseling, but without giving them the option, it is not possible to know. Counselors often mentioned that they still asked clients who had the option to skip counseling "what brought them in today" in an attempt to make sure the participant was given the best service possible. This changes the study design slightly, as ideally the participant would not be engaged prior to being given the option not to receive counseling.

Although not ideal in one sense, these deviations allow us to observe what implementation of these standards (self-administered CAQs and optional counseling for repeat testers) may actually look like. Counselors may be unwilling/unable to give every eligible participant the option to skip counseling. As such, counselor workload may not be reduced as drastically as expected from the percentage of eligible clients presenting.

Although we are able to hypothesize how clients' responses fit into a healthcare utilization model, we are unable to truly model behaviors and how they would differ based on these changes. Those who were presenting for testing have already overcome all potential barriers to testing as evident by their presence. The overall high approval of the process in comparison to their previous test does indicate that the outcome of satisfaction with care has been increased or at least not damaged by the measures piloted.

Implications

Legislation introduced in the California State Assembly in 2006 proposed requiring the California Office of AIDS to restructure its counseling policy. The bill was tabled until the completion of an evaluation of the potential impact of the changes, allowing legislation to be based on scientific evidence. This multi-phase study was designed and implemented, but before completion of the study, in January 2009 another bill was passed and implemented restructuring the California Office of AIDS policy, allowing self-administered CAQs as well as optional counseling for repeat HIV testers. Further restructuring of HIV testing and counseling has arisen because of the current economic situation. At this time, most pre-test counseling has been defunded on the state level in California.

In California, the change in HIV testing policy was prompted by economic factors rather than empirical data. However, our findings support the move to a more client-centered approach to collecting risk assessment information and HIV prevention counseling, and could provide insight into potential issues and implications for other states. Our study indicated that for sites whose staff and patient populations are comfortable with computer technology, implementation of a computer-aided self assessment tool is both feasible and acceptable. Although options for pre-test counseling are now dictated by fewer resources, we also found that patient-centered options are by and large welcome by most patients.

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Table 4.1 Demographic characteristics of those who completed the Client Satisfaction Survey.

	Los Angeles Stand-Alone n=141 n (%)	Los Angeles Mobile Van n=46 n (%)	Orange County STI Clinic n=112 n (%)	p-value
Mean age (std)	34.7 (9.9)	33.7 (12.4)	31.9 (9.4)	0.11
Sex at birth				<0.01
Male	82 (73.2)	16 (57.1)	88 (83.8)	
Female	30 (26.8)	12 (42.9)	17 (16.2)	
MSM	63 (56.3)	3 (10.7)	45 (42.9)	<0.001
Race*				<0.001
Hispanic	20 (17.9)	14 (51.9)	54 (51.9)	
White	65 (58.0)	3 (11.1)	29 (27.9)	
Black	17 (15.2)	9 (33.3)	8 (7.7)	
Asian	3 (2.7)	1 (3.7)	9 (8.7)	
Other	7 (6.3)	0 (0.0)	4 (3.8)	
English survey	139 (98.6)	37 (80.4)	79 (70.5)	<0.001

*In analysis, race was combined to Hispanic, White and Other due to small numbers.

Table 4.2 Client perceptions of current HIV testing experience compared to their last experience among repeat testers with self-reported risk factors for HIV infection at Los Angeles and Orange County testing sites.

	Last time was better*		This time was better		About the same		
	Los Angeles n (%)	Orange County n (%)	Los Angeles n (%)	Orange County n (%)	Los Angeles n (%)	Orange County n (%)	p-value
Information about HIV/AIDS	5 (4)	4 (5)	72 (54)	29 (37)	56 (42)	46 (58)	0.02
Amount of time spent with counselor	5 (4)	3 (4)	80 (61)	32 (41)	47 (36)	44 (56)	<0.01
Total amount of time spent getting tested	3 (2)	9 (11)	80 (59)	30 (38)	52 (39)	40 (51)	0.02
I felt safer sharing personal information	3 (2)	3 (4)	73 (54)	34 (43)	59 (44)	43 (54)	0.12
I felt more comfortable with clinic staff	2 (2)	2 (3)	79 (59)	39 (50)	52 (39)	37 (47)	0.21
I felt my own needs were better met	2 (2)	1 (2)	68 (54)	24 (44)	55 (44)	29 (54)	0.22
Information about me was collected better	2 (2)	1 (2)	76 (61)	21 (39)	47 (38)	32 (59)	<0.01
The counselor focused more on my needs	3 (2)	1 (2)	76(61)	23 (43)	45 (36)	30 (56)	0.02
Overall the experience was better	2 (2)	2 (3)	94 (70)	23 (47)	38 (28)	30 (51)	<0.01

*Comparisons carried out between "this time was better" and "about the same." Due to small numbers "last time was better" was dropped from analysis.

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Chapter 5

Overall Conclusions and Discussion

This dissertation was undertaken with the goal of better characterizing recent repeat testers in California and fully exploring potential changes to the HIV pre-test counseling procedures, including self-administration of risk assessment forms and optional pre-test counseling among recent repeat testers.

Although recent repeat testers were found to be participating in some high-risk behaviors, they are also practicing moderating behaviors which lessen the potential negative consequences. Counseling was accepted by 40% of those eligible to choose, some of whom were at increased HIV risk. Optional counseling is a potential way to decrease barriers to HIV testing and still provide a valuable service to those who desire it. Utilizing recent repeat testing status to determine eligibility to receive optional counseling is a viable solution with few drawbacks.

Repeat testers

From analysis comparing risk behaviors by different cut-point used to define a recent repeat tester (RRT), testing within the past year was determined to be the best definition for practical reasons. Overall care must be taken to distinguish between repeat testers and RRTs. Repeat testers have simply tested before while RRTs have tested in the past year indicating a pattern of regular and repeated testing. When examining differences between those testing in the last year and more distantly, there were significant differences but none of clinical importance.

In analyses of California State data, risk behaviors varied among RRTs by sexual orientation. Among females and heterosexual males, RRTs reported significantly more high-risk behavior (e.g. IDU and stimulant use) than non-RRTs. RRTs were also significantly more likely to report condom use and among MSM, more condom use with high-risk partners. Among MSM, results were mixed, with some risk behaviors reported more often among RRTs

(having an HIV-positive partner and a recent STI diagnosis) and others reported more often among non-RRT MSM (sex work, IDU and stimulant use). Only among MSM was there a difference between RRTs and non-RRTs in testing positive for HIV, with non-RRTs more likely to test positive. This follows from the pattern of more protective and fewer high-risk behaviors among MSM RRTs than among female and heterosexual RRTs.

When examining data from the pilot study, RRTs were significantly more likely to report high-risk behaviors. The California Department of Public Health, Office of AIDS definition of high-risk behaviors was used. It is design to target those most at risk for HIV and includes MSM behavior. This is not a modifiable behavior, but the potentially associated behavior of unprotected anal sex can be a target of behavior change. The other behaviors that result in an individual being categorized as high-risk also have potentially moderating behaviors which reduce the potential risk. For example sex with a prostitute is risky but consistent and correct condom use decreases the risk.

Statewide findings are closely aligned with those from previous regional analysis carried out in California, but show more similarities to the Los Angeles area among MSM and the San Francisco Bay area among females and heterosexual males [1]. Among all groups statewide, RRTs were more likely to use condoms, have a recent STI diagnosis, and have an HIV infected partner. Although RRTs in the pilot study were more likely to report high-risk behaviors, they were also more likely to report oral sex. This suggests that regular testing may be used as part of a risk reduction strategy, since oral sex is a less risky alternative to vaginal or anal sex.

The finding that those at higher risk for HIV are more likely to be RRTs is consistent with previous research suggesting that those at higher risk are more likely to get tested [2, 3]. Our analyses support previous findings of higher risk behaviors among RRTs [4] but no group

of RRTs had a higher incidence of HIV infection than non-RRTs, inconsistent with previous findings [4, 5].

Differences found in recent repeat testing by sexual orientation could be due to testing recommendations and the risk profiles of each group. Current national testing guidelines suggest at least annual testing for people practicing high-risk behaviors. Men who have sex with men are a high-risk group. MSM are disproportionately affected by the HIV epidemic in the United States. Although they account for only a small percentage of the population, they make up over 50% of the HIV-positive population. Even a low-risk MSM is a high-risk individual. Overall the MSM population is testing disproportionately to their percentage of the population but not to their percentage of the HIV epidemic.

In contrast testing recommendations for high-risk individuals only apply to females and heterosexual males who are practicing a risk behavior beyond their sexual identity. They are not at higher risk due to their sexual preferences. Finding higher risk behaviors such as stimulant use and sex work among RRTs is consistent with testing recommendations that these groups should test more often.

Recent repeat testing individuals are practicing behaviors that put them at risk for HIV, such as having an HIV-positive partner, sex work, injection drug use and stimulant use. It is possible that although they are aware of the increased risk of acquiring HIV through these behaviors, they are unwilling to stop practicing them at this time. So instead of changing their primary HIV risk behavior, they are taking steps to make the behavior less risky. For example, although RRTs are more likely to have an HIV-positive partner and use injection drugs, they are not different in condom use or sharing injection equipment. In some instances they practice higher condom use and less equipment sharing. A part of their risk reduction plan could even be their repeated HIV testing.

Self-administration

We found that most sexual risk behaviors were reported more often to a counselor than during survey self-administration. This may have been because participants did not fully realize the importance of disclosing their behaviors until speaking with the counselor. Participants in another study expressed not understanding why risk behavior data are collected and/or not thinking it was important [6]. Participants in this study may not have realized the significance of accurate reporting until they spoke with the counselor. Once they realized the significance they may have been more willing to disclose their actual behaviors.

The generally higher reporting of risk behaviors during the interview is in contrast to many previous studies in the United States as well as abroad that have found increased reporting of sensitive behaviors, such as MSM, unprotected sex, drug use and non-adherence to ART, through the use of CASI than interviewer or self-administered questionnaire [7-17], but some studies have found few or conflicting differences [10, 12, 18-20].

In contrast to our findings regarding sexual behavior disclosure, but in line with previous studies, injection drug use was reported more often on self-administered questionnaires at all testing sites. This could be because injection drug use can have serious criminal repercussions. Clients may have been fearful that if they disclosed injection drug use to a counselor the behavior would be reported to law enforcement officials. The number of clients reporting injection drug use was so small that it is difficult to draw firm conclusions.

Given differential reporting by mode of administration different methods may need to be employed to elicit the most honest responses in different settings. Based on our findings, a self-administered questionnaire may be more effective in settings with high levels of illegal activity, while an interviewer may be best able to elicit sexual risk behavior disclosure.

The site difference found in counseling acceptance (those at the STI clinic were 6.5 times more likely to accept counseling) also may be a function of the mode of data collection,

since both the testing center and the mobile testing van used CASI while the STI clinic used paper forms. Although we found that more sexual risk behaviors were reported to the counselor despite method of self-administration, the perceived anonymity provided by the computer may have been an incentive for clients to skip counseling and maintain their privacy. At the STI clinic, the counselor was already privy to risk behaviors through review of the paper form, so there may not have been an incentive to skip counseling and maintain privacy among those participants.

Through querying site administrators, counselors and clients we found that self-administered risk assessments were feasible and in some instances preferred over counselor-administered forms. Self-administration was most advantageous when coupled with technological features that allowed the participant to be truly anonymous when reporting their behaviors and allowed counselors to handle less paperwork. Clients are able and willing to self-complete risk behavior surveys, but may not disclose as many sexual behaviors as they would through counselor-administered forms.

Optional pre-test HIV counseling

Although a larger study will be needed, our findings indicate that optional pre-test counseling may be the best option to meet clients testing needs while still providing a service to those who desire it. Based on our evaluation, clinic staff perceived that the option for RRTs to choose to go to counseling or not, served both the clients' testing needs and helped ensure that the time counselors spent with clients was not stymied by uncooperative clients. It allowed counselors to address the needs of each client individually rather than applying the same prevention approach to everyone. Although some problems were noted, empowering clients by allowing RRTs to opt-out of pre-test counseling appears to promote high client satisfaction with testing, while decreasing counselor burden.

Counseling acceptance among high-risk RRTs was 40%. We found in both multivariate models of counseling acceptance that MSM clients were over 7 times as likely to accept counseling as compared to heterosexual males. This is interesting given that previous studies found men practicing MSM behaviors more likely not to fully disclose risk to a counselor [6].

It is promising that those who share injection equipment are significantly more likely to accept counseling in a multivariate model. These individuals are at higher risk for HIV acquisition but they are willing to be counseled. During counseling they received knowledge that they can put into practice to reduce their risk even if they continue injection drug use. These individuals likely are aware of their increased risk and were still willing to discuss their behaviors with a counselor even when given the option to remain silent.

It is of concern that those with an HIV-positive partner are significantly less likely to accept counseling. They are practicing a behavior that puts them at very high-risk of HIV acquisition but they are unwilling to speak with a counselor. There is the possibility that they are fully aware of their risk and do not want to justify their choices to a counselor. In addition to their own behavior modifications, hopefully these individuals are being protected by their HIV-positive partners since other studies have found that those who are aware of their HIV-positive status take steps to protect their partners from infection.

The fact that no other risk behavior was significantly associated with counseling acceptance is promising. Those who rejected counseling did practice a behavior that put them at increased risk but most likely are aware of the risk. Ideally all individuals practicing high-risk behaviors would accept counseling, but the lack of significant differences between those accepting and rejecting counseling can be viewed positively. Those who are at higher risk are not systematically rejecting counseling. Therefore at least among those currently receiving testing, counseling is not a significant barrier to their repeated testing. Offering an option for

testing without counseling for those with an HIV-positive partner may increase the number of people with an HIV-positive partner testing, since counseling appears to be especially unwelcome among these individuals.

Implications

Although a California State Assembly Bill was passed in 2009 allowing self-administration of data and optional counseling for repeat testers, the bill was vaguely worded. Information from these studies will be invaluable as testing sites look for guidance on the appropriateness of self-administered risk behavior assessments and a functional definition of repeat HIV tester. Additionally financial concerns are affecting much of the United States and these studies can be a tool for sites making difficult decisions regarding funding uses. Self-administration of risk behavior surveys and optional counseling are both potential cost saving measures.

Optional testing in our study was based on the assumption that RRTs have received counseling in the previous year as part of an HIV test. The finding that 18% of those completing the Client Satisfaction Survey had last tested at a site unlikely to provide counseling raises a larger concern. The concern is that clients could test repeatedly without ever receiving prevention messages and risk reduction information. The premise behind optional pre-test counseling was that those who already understood their risks and are unwilling or unable to change their behaviors should be given the opportunity to forgo counseling. The potential result would be more testing by the individuals at highest risk. The fact that individuals allowed to skip counseling may not be aware of their personal risk is concerning. Although an individual is free to make decisions regarding their personal behaviors, from a public health perspective it would be advantageous (if not imperative) that

they are at least aware of the risks and the possible risk reduction strategies applicable to their behaviors.

The concern that individuals are unaware of their risk and risk reduction strategies has larger implications as counseling is defunded on the state level. Potentially other modes of education can be administered at the time of testing, such as videos and brochures in the waiting room. Another possibility is the use of risk reduction advertisements on internet sites, especially sites used to facilitate high-risk behaviors such as anonymous MSM partnering.

Limitations and Strengths

One limitation was that we were only able to gather data on those who received testing. We are unable to reach the population of most interest, those who are not testing or retesting. By definition those we sampled received an HIV test and know their status. They all overcame any barrier that existed in their lives to receiving an HIV test. The real challenge is to reach those that are not currently testing; those who do not know their status. It is not possible given our data to determine why they are not testing.

This is somewhat ameliorated by our ability to compare RRTs and those who are non-RRTs. Although we cannot measure directly their motivations and personal barriers, we were able to look at their reported behaviors and among RRTs their counseling preferences.

The cross-sectional nature of our analyses also limits our ability to determine causation. Instead we are only able to determine correlations between outcomes and behaviors, but we are unable to suggest a causal pathway.

Additionally sites were invited to participate in the pilot study based on previous relationships and their stated willingness. These sites may not represent other HIV testing sites since they were willing and able to participate. The small number of sites and limited geographic distribution also limits the generalizability to all testing sites in California or the

U.S. The sites did vary in the populations served by demographics as well as computer familiarity. They also varied in their ability to implement computer self-administration. These differences and challenges do give us a perspective of implementation and improve generalizability.

The small number of participants included in some analyses of the pilot study is a limitation. Although 151 individuals were offered optional counseling, only 58 were eligible from either LA site and only 11 of those 58, choose counseling. From the stand-alone testing site and the mobile testing van, there were only 77 participants with both a self-administered survey and an interviewer administered survey to compare. This means that some behaviors were reported by fewer than five individuals. These small numbers limit the strength of the findings and the generalizability. This is balanced by the much larger samples which participated in the pilot study as a whole as well as the analysis of statewide data from a two year period.

All behaviors were measured by self-report. There can be differences in what a person is willing to disclose and how they actually behave. We did not perform confirmatory tests of biomarkers to determine the veracity of their reported behaviors and some behaviors such as condom use are inherently difficult to verify. The only possible verification of behavior we had was their HIV test result. The statewide data did seem to confirm client self-report in that MSM RRTs reported fewer high-risk behaviors than non-RRTs and they in fact were significantly less likely to test HIV-positive.

These data may suffer from response bias as a function of the clients' willingness to disclosure behaviors to an interviewer, since all statewide data from 2005-2006 were gathered by counselors during pre-test counseling. There is no direct way to determine the truthfulness of the reported data, but in the pilot study clients were actually more likely to report sexual risk behaviors to a counselor than on self-administered surveys.

Another limitation were data lost because of a supply run-out at the mobile testing van. The site ran out of identification number stickers, which are generated and dispersed by the State, because of a combination of factors, including a fire that shut down their receiving office. In an effort to continue, the staff at this site used a "unique" identification number created from the client's birthday and initials. Unfortunately the identification number was not uniform across the multiple forms, so an identification number on a Client Satisfaction Survey did not necessary match an identification number entered into the computer for the CAQ. An arduous process of hand matching the identification numbers was undertaken, but data from over 100 participants were not able to be used because it could not be matched.

Even when fully supplied there were slight derivations from the study plan as designed. At OC the counselors thought the addition of a stimulant question was necessary on the CAQ to fully capture all high-risk individuals. For a short time period, until stopped by the site coordinator, the counselors were adding the question to the questionnaire and utilizing a positive response as qualification to be considered high-risk. In data analysis this was handled through the reclassification of individuals on their ability to opt-out based on the predefined criteria, and the elimination of those who should not have been defined as high-risk but were.

More generally at all sites there was resistance among counselors not to at least ask what brought a client in today, even if they were eligible to opt-out. The client should have been given the option to skip counseling and not engaged in discussion prior to their agreement to be counseled. The engagement of everyone meant that some were not given the option to skip counseling even though they were eligible. Although their concern for their clients is admirable it is not ideal as a study methodology.

A strength of this study was the ability to offer RRTs the option to skip counseling and then measure their actual responses, given the experiences they had that day. In previous

studies RRTs were asked what they would do if given the choice and focus groups were queried as to their responses to such an option, but we were able to implement the process change and see what happened.

Conclusions

Repeat testers may practice more HIV risk behaviors than non-repeat testers, but within the context of their behavior they are taking steps to minimize the negative outcomes of their behaviors. One step may in fact be their repeated HIV testing. Therefore repeat HIV testers are good candidates for optional pre-test counseling. Self-administration of required surveillance data and optional pre-test counseling were found to be feasible and acceptable, providing evidence that new procedures which may cut cost and reduce barriers to HIV testing are options worth further consideration and study.

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Appendix

Reason using paper version: (*check one*) Time administered:_____

☐ Problem with hand-held ☐ All hand-helds in use

☐ Client had difficulty using hand-held ☐ Other, specify:_____

California Department of Public Health, Office of AIDS

Unique Office of AIDS Client Number

CLIENT ASSESSMENT QUESTIONNAIRE

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

1.) What was your sex at birth?

☐ (1) Male ☐ (2) Female ☐ (3) Other, specify:_____

2.) What sex do you currently consider yourself?

☐ (1) Male ☐ (2) Female ☐ (3) Other, specify:_____

3.) What is your race/ethnicity? *(mark all that apply "x")*

☐ (1) Black/African American
☐ (1) American Indian/Alaska Native
☐ (1) Asian
☐ (1) Native Hawaiian/Pacific Islander
☐ (1) Hispanic/Latino(a)
☐ (1) White
☐ (1) Other, specify: _____

4.) What is your birthday / birth date? *(mm/dd/yy)*

☐☐/☐☐/☐☐

5.) What is the FIRST letter of your LAST name? ☐

6.) What ZIP code do you live in?

☐☐☐☐☐

7.) Which of the following comes closest to your sexual orientation? *(mark one "x")*

☐ (1) Heterosexual or straight
☐ (2) Bisexual
☐ (3) Gay, lesbian, queer, same gender loving, or homosexual
☐ (4) Other orientation, specify:

8.) Have you had sex in the past 12 months with a sex worker or prostitute? *(whether you paid or not)*

☐ (1) Yes ☐ (0) No

9.) Have you received drugs, money, or other items or services for sex in the last year?

☐ (1) Yes ☐ (0) No

10.) Has a medical or service provider told you that you have gonorrhea or syphilis in the last year?

☐ (1) Yes ☐ (0) No

11.) Has a medical or service provider ever told you that you have hepatitis C?

☐ (1) Yes ☐ (0) No

12.) In the past 12 months, have you had oral sex with a female? *(mouth on penis, vagina, or anus)*

☐ (1) Yes ☐ (0) No

13.) In the past 12 months, have you had oral sex with a male? *(mouth on penis, vagina, or anus)*

☐ (1) Yes ☐ (0) No

14.) In the past 12 months, have you had vaginal or anal sex with a male?

☐ (1) Yes ☐ (0) No *(if no, skip to question 16)*

15.) In the past 12 months, have you had vaginal or anal sex with a male without a condom?

☐ (1) Yes ☐ (0) No

16.) In the past 12 months, have you had vaginal or anal sex with a female?

☐ (1) Yes ☐ (0) No *(if no, skip to question 18)*

17.) In the past 12 months, have you had vaginal or anal sex with a female without a condom?

☐ (1) Yes ☐ (0) No

18.) In the past 12 months, have you had sex with:

a.) An HIV positive person... *(mark all that apply "x")*

...Who injects drugs ☐ (1) Yes ☐ (0) No
...Who injects drugs w/out a condom ☐ (1) Yes ☐ (0) No
...Who was a male who has sex with men ☐ (1) Yes ☐ (0) No
...Who was a male who has sex with men w/out a condom ☐ (1) Yes ☐ (0) No

b.) A person whose HIV status you did not know... *(mark all that apply "x")*

...Who injects drugs ☐ (1) Yes ☐ (0) No
...Who injects drugs w/out a condom ☐ (1) Yes ☐ (0) No
...Who was a male who has sex with men ☐ (1) Yes ☐ (0) No
...Who was a male who has sex with men w/out a condom ☐ (1) Yes ☐ (0) No

19.) In the past 12 months, have you used injection drugs?

☐ (1) Yes ☐ (0) No *(if no, skip to question 21)*

20.) In the past 12 months, have you shared injection equipment?

☐ (1) Yes ☐ (0) No

Please continue on page 2 of this form.

21.) Have you had a HIV/AIDS test before today?

☐ (1) Yes ☐ (0) No *(if no, continue with questions 22-27)*

If you have been tested before, how many tests have you had before today?

☐☐

If you have been tested before, what is the date of your last test? *(mm/yy)*

☐☐☐☐

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

☐ (1) Negative (No HIV infection)
☐ (2) Positive (HIV infection found)
☐ (3) Other result, specify:_____
☐ (4) I have never received a result
☐ (5) I do not remember the result
☐ (6) I prefer not to disclose the result

(if you have tested before, continue with questions 28-33)

22.) Have you ever had vaginal or anal sex with a male?

☐ (1) Yes ☐ (0) No *(if no, skip to question 24)*

23.) Have you ever had vaginal or anal sex with a male without a condom?

☐ (1) Yes ☐ (0) No

24.) Have you ever had vaginal or anal sex with a female?

☐ (1) Yes ☐ (0) No *(if no, skip to question 26)*

25.) Have you ever had vaginal or anal sex with a female without a condom?

☐ (1) Yes ☐ (0) No

26.) Have you ever used injection drugs?

☐ (1) Yes ☐ (0) No *(if no, skip to End)*

27.) Have you ever shared injection equipment?

☐ (1) Yes ☐ (0) No

(End)

28.) Since you last tested for HIV, have you had vaginal or anal sex with a male?

☐ (1) Yes ☐ (0) No *(if no, skip to question 30)*

29.) Since you last tested for HIV, have you had vaginal or anal sex with a male without a condom?

☐ (1) Yes ☐ (0) No

30.) Since you last tested for HIV, have you had vaginal or anal sex with a female?

☐ (1) Yes ☐ (0) No *(if no, skip to question 32)*

31.) Since you last tested for HIV, have you had vaginal or anal sex with a female without a condom?

☐ (1) Yes ☐ (0) No

32.) Since you last tested for HIV, have you used injection drugs?

☐ (1) Yes ☐ (0) No *(if no, skip to End)*

33.) Since you last tested for HIV, have you shared injection equipment?

☐ (1) Yes ☐ (0) No

(End)

Thank you! Please return this completed form now.

Reason using paper version: (*check one*) Time administered:_____
☐ Problem with hand-held ☐ All hand-helds in use
☐ Client had difficulty using hand-held ☐ Other, specify:_____

Estado de California - Agencia de Salud y Servicios Humanos
Departamento de Salud Pública de California, Oficina de SIDA

Oficina Única de SIDA
Número de cliente

CUESTIONARIO DE EVALUACIÓN DEL CLIENTE

INSTRUCCIONES: Por favor, conteste las siguientes preguntas. Marque con una "x" o escriba un número en la caja correspondiente para responder cada pregunta. No hay respuestas correctas o incorrectas. Todas sus respuestas son totalmente confidenciales y no se le revelarán a nadie. Si necesita ayuda, por favor, solicítesela a la persona que le entregó este formulario.

1.) ¿Cuál fue su sexo al nacer?
❑ (1) Hombre ❑ (2) Mujer ❑ (3) Otro
(especificar):_____

2.) ¿Cuál es su sexo en la actualidad?
❑ (1) Hombre ❑ (2) Mujer ❑ (3) Otro
(especificar):_____

3.) ¿Cuál es su fecha de nacimiento/cumpleaños?
(mm/dd/aa)
☐☐☐☐☐☐

4.) ¿Cuál es la PRIMER letra de su APELLIDO?
☐

5.) ¿Cuál es el código POSTAL de su domicilio?
☐☐☐☐☐

6.) ¿Cuáles de las siguientes opciones es la más cercana a su orientación sexual? (marque con una "x")
❑ (1) Heterosexual
❑ (2) Bisexual
❑ (3) Gay, lesbiana u homosexual
❑ (4) Otra orientación (especifique):_____

7.) Durante el último año, ¿tuvo relaciones sexuales con un(a) trabajador(a) del sexo o con un(a) prostituto/-a?
(ya sea que haya pagado o no)
❑ (1) Sí ❑ (0) No

8.) ¿Ha recibido drogas, dinero u otros elementos o servicios a cambio de sexo durante el último año?
❑ (1) Sí ❑ (0) No

9.), ¿Algún proveedor médico le dijo que tiene gonorrea o sífilis durante el último año?
❑ (1) Sí ❑ (0) No

10.) ¿Alguna vez le dijo un proveedor médico que usted contrajo hepatitis C?
☐ (1) Sí ☐ (0) No

11.) En los últimos 12 meses, ¿tuvo sexo oral con una mujer(es)?
(boca sobre el pene, la vagina o el ano)
☐ (1) Sí ☐ (0) No

12.) ¿En los últimos 12 meses, tuvo sexo oral con algún hombre/hombres?
(boca sobre el pene, la vagina o el ano)
❑ (1) Sí ❑ (0) No

13.) ¿En los últimos 12 meses, ha tenido sexo vaginal o anal con algún hombre?
❑ (1) Sí ❑ (0) No *(Si contesto No, pase a la pregunta 15)*

14.) ¿En los últimos 12 meses, tuvo sexo vaginal o anal sin condón con algún hombre?
❑ (1) Sí ❑ (0) No

15.) ¿En los últimos 12 meses, tuvo sexo vaginal o anal con alguna mujer/mujeres?
❑ (1) Sí ❑ (0) No *(Si contesto No, pase a la pregunta 17)*

16.) ¿En los últimos 12 meses, tuvo sexo vaginal o anal sin condón con alguna mujer?
❑ (1) Sí ❑ (0) No

17.) En los últimos 12 meses, ¿ha tenido sexo con...
a.) alguna persona que sea VIH positivo... (marque con una "x" todas las que correspondan)
...que se inyecta drogas? ❑ (1) Sí ❑ (0) No
...que se inyecta drogas y no utiliza condón? ❑ (1) Sí ❑ (0) No
...un hombre que tiene relaciones sexuales con hombres? ❑ (1) Sí ❑ (0) No
...un hombre que tiene relaciones sexuales con hombres sin utilizar condón? ❑ (1) Sí ❑ (0) No

Por favor, continúe en la página 2 de este formulario

En los últimos 12 meses, ¿ha tenido sexo con...

b.) Una persona que usted no sepa que tiene el VIH...

...que se inyecta drogas? ❑ (1) Sí ❑ (0) No

...que se inyecta drogas y no utiliza condón? ❑ (1) Sí ❑ (0) No

...hombre que tiene relaciones sexuales con hombres? ❑ (1) Sí ❑ (0) No

...hombre que tiene relaciones sexuales con hombres sin utilizar condón? ❑ (1) Sí ❑ (0) No

18.) En los últimos 12 meses, ¿se ha inyectado drogas?
❑ (1) Sí ❑ (0) No *(Si contesto No, pase a la pregunta 20)*

19.) En los últimos 12 meses, ¿compartió con alguien su equipo de inyecciones?
❑ (1) Sí ❑ (0) No

20.) ¿Se hizo un examen del VIH/SIDA antes que hoy?
❑ (1) Sí ❑ (0) No
(Si contesto No, continúe con las preguntas 21-26)

¿Cuantos exámenes del VIH se ha hecho antes que hoy?
☐☐

Si se hizo un examen antes de hoy, ¿cuál fue la fecha del último examen? *(mm/aa)*
☐☐☐☐

Si se ha hecho exámenes antes de hoy, ¿cuál fue el último resultado que recibió?
(Marque con una "x".)
❑ (1) Negativo (Sin infección del VIH)
❑ (2) Positivo (Se halló infección del VIH)
❑ (3) Otro resultado (especificar):_____
❑ (4) Nunca recibí un resultado.
❑ (5) No recuerdo el resultado
❑ (6) Prefiero no informar el resultado.

(Si se ha hecho algún examen antes de hoy, continúe con las preguntas 27-32)

21.) ¿Alguna vez tuvo sexo vaginal o anal con hombres?
❑ (1) Sí ❑ (0) No *(Si contesto No, pase a la pregunta 23)*

22.) ¿Alguna vez tuvo relaciones sexuales vaginales o anales con un hombre sin condón?
❑ (1) Sí ❑ (0) No

23.) ¿Alguna vez tuvo sexo vaginal o anal con una mujer?
❑ (1) Sí ❑ (0) No
(Si contesto No, pase a la pregunta 25)

24.) ¿Alguna vez tuvo relaciones sexuales vaginales o anales con una mujer sin condón?
❑ (1) Sí ❑ (0) No

25.) ¿Alguna vez se inyectó drogas?
❑ (1) Sí ❑ (0) No
(Si contesto No, pase al fin del cuestionario)

26.) ¿Alguna vez compartió equipo de inyección con otras personas?
❑ (1) Sí ❑ (0) No

27.) Desde su último examen del VIH, ¿tuvo sexo vaginal o anal con un hombre?
❑ (1) Sí ❑ (0) No
(Si contesto No, pase a la pregunta 29)

28.) Desde su último examen del VIH, ¿ha tenido sexo vaginal o anal con hombres?
❑ (1) Sí ❑ (0) No

29.) Desde su último examen del VIH, ¿ha tenido sexo vaginal o anal con mujeres?
❑ (1) Sí ❑ (0) No
(Si contesto No, pase a la pregunta 31)

30.) Desde su último examen del VIH, ¿ha tenido sexo vaginal o anal con mujeres sin condón?
❑ (1) Sí ❑ (0) No

31.) Desde su último examen del VIH, ¿alguna vez se inyectó drogas?
❑ (1) Sí ❑ (0) No
(Si contesto No, pase al fin del cuestionario)

32.) Desde su último examen del VIH, ¿alguna vez compartió equipo de inyección con otras personas?
❑ (1) Sí ❑ (0) No

(Fin)

¡Gracias! Por favor, devuelva este formulario completo.

State of California - Health and Human Services Agency

California Department of Public Health, Office of AIDS

OFFICE OF AIDS RISK INFORMATION FORM

Unique Office of AIDS Client Number

Data entry initials: ☐☐☐☐

Mark "x" if no billing ☐ (1)

Homeless? *(currently)* ☐ (1) Yes ☐ (0) No ☐ (*) D/R

Incarcerated? *(last 12 months)* ☐ (1) Yes ☐ (0) No ☐ (*) D/R

Health insurance coverage: *(mark all that apply "x")*

☐ (1) No coverage
☐ (1) Private
☐ (1) Medi-Cal (Medicaid)
☐ (1) Medicare
☐ (1) Military
☐ (1) Indian Health Service
☐ (1) Other public, specify: _____

SEXUAL BEHAVIOR

GENDER OF PARTNERS *(last 12 months)*

Male sex partner(s): *(mark one "x")*

☐ (1) Yes ☐ (0) No ☐ (*) D/R

# of partners *(1-999)* ☐☐☐

Sexual Activity:		Condom use frequency: Never	Sometimes	Usually	Always
Oral	☐ (1) Yes ☐ (0) No	☐ (1)	☐ (2)	☐ (3)	☐ (4)
Vaginal receptive	☐ (1) Yes ☐ (0) No	☐ (1)	☐ (2)	☐ (3)	☐ (4)
Anal insertive	☐ (1) Yes ☐ (0) No	☐ (1)	☐ (2)	☐ (3)	☐ (4)
Anal receptive	☐ (1) Yes ☐ (0) No	☐ (1)	☐ (2)	☐ (3)	☐ (4)

Female sex partner(s): *(mark one "x")*

☐ (1) Yes ☐ (0) No ☐ (*) D/R

# of partners *(1-999)* ☐☐☐

Sexual Activity:		Condom use frequency: Never	Sometimes	Usually	Always
Oral	☐ (1) Yes ☐ (0) No	☐ (1)	☐ (2)	☐ (3)	☐ (4)
Vaginal insertive	☐ (1) Yes ☐ (0) No	☐ (1)	☐ (2)	☐ (3)	☐ (4)
Anal insertive	☐ (1) Yes ☐ (0) No	☐ (1)	☐ (2)	☐ (3)	☐ (4)

Transgender sex partner(s): *(mark one "x")*

☐ (1) Yes ☐ (0) No ☐ (*) D/R

# of partners *(1-999)*

Male to female: ☐☐☐

Female to male: ☐☐☐

Sexual Activity:		Condom use frequency: Never	Sometimes	Usually	Always
Oral	☐ (1) Yes ☐ (0) No	☐ (1)	☐ (2)	☐ (3)	☐ (4)
Vaginal insertive	☐ (1) Yes ☐ (0) No	☐ (1)	☐ (2)	☐ (3)	☐ (4)
Vaginal receptive	☐ (1) Yes ☐ (0) No	☐ (1)	☐ (2)	☐ (3)	☐ (4)
Anal insertive	☐ (1) Yes ☐ (0) No	☐ (1)	☐ (2)	☐ (3)	☐ (4)
Anal receptive	☐ (1) Yes ☐ (0) No	☐ (1)	☐ (2)	☐ (3)	☐ (4)

SEX IN EXCHANGE *(last 12 months)*

Have received...	Yes	No	Sexual Activity: *(mark all that apply "x")* Oral	Vaginal	Anal ins.	Anal rec.	Partner's gender: *(mark all that apply "x")* Male	Female	Trans.	Condom use frequency: *(for vaginal & anal sex only)* Never	Sometimes	Usually	Always
Money or other items or services for sex	☐ (1)	☐ (0)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
Drugs for sex	☐ (1)	☐ (0)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (2)	☐ (3)	☐ (4)

SEX PARTNER TYPE *(last 12 months)*

Had sex with...	Yes	No	Sexual Activity: *(mark all that apply "x")* Oral	Vaginal	Anal ins.	Anal rec.	Partner's gender: *(mark all that apply "x")* Male	Female	Trans.	Condom use frequency: *(for vaginal & anal sex only)* Never	Sometimes	Usually	Always
Male partner(s) known to have had sex with a male *(if client is female)*	☐ (1)	☐ (0)	☐ (1)	☐ (1)		☐ (1)	■			☐ (1)	☐ (2)	☐ (3)	☐ (4)
Sex worker partner(s)	☐ (1)	☐ (0)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
Partner(s) who inject drugs	☐ (1)	☐ (0)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (2)	☐ (3)	☐ (4)
HIV-positive partner(s)	☐ (1)	☐ (0)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (1)	☐ (2)	☐ (3)	☐ (4)

Did client know partner's HIV+ status prior to sexual contact? ☐ (1) Yes ☐ (0) No

State of California - Health and Human Services Agency | California Department of Public Health, Office of AIDS

SUBSTANCE USE

PSYCHOACTIVE SUBSTANCES *(last 12 months) (mark all that apply "x")*

	Injected: Yes	Injected: No	Had sex while high or intoxicated: Yes	Had sex while high or intoxicated: No
(*) D/R				
(1) No alcohol or drug use				
(1) Alcohol	(1)	(0)	(1)	(0)
(1) Marijuana *(pot, grass, weed, hash)*			(1)	(0)
(1) Methamphetamine *(crystal, meth, speed, crank, tina)*	(1)	(0)	(1)	(0)
(1) Cocaine *(powder)*	(1)	(0)	(1)	(0)
(1) Crack *(rock)*	(1)	(0)	(1)	(0)
(1) Heroin *(dope, junk, skag, smack, H)*	(1)	(0)	(1)	(0)
(1) Pain Killers/Tranquilizers *(e.g., Oxycontin, Percocet, Morphine, Codeine, Ativan, Phenobarbital, Valium)*	(1)	(0)	(1)	(0)
(1) Ecstasy *(MDMA, E, X)*	(1)	(0)	(1)	(0)
(1) GHB *(liquid ecstasy, gina, G)*	(1)	(0)	(1)	(0)
(1) Ketamine *(special K, K)*	(1)	(0)	(1)	(0)
(1) Other drug, specify: _____	(1)	(0)	(1)	(0)

SYRINGE/NEEDLE USE *(complete if injected)*

How often...*(last 12 months)*	Never	Sometimes	Usually	Always	Shared with known HIV+ partner? Yes	No
Shared syringes/needles	(1)	(2)	(3)	(4)	(1)	(0)
Cleaned syringes/needles	(1)	(2)	(3)	(4)		
Shared other works *(cooker, cotton, spoon, water)*	(1)	(2)	(3)	(4)	(1)	(0)
Cleaned other works	(1)	(2)	(3)	(4)		

Source of brand-new (sterile) syringes: *(Indicate most recent timeframe "x")*

	Never	Last 30 days	Last 12 months	Last 2 years
Syringe exchange program (SEP)	(1)	(2)	(3)	(4)
Secondary exchange	(1)	(2)	(3)	(4)
Pharmacy/drug store	(1)	(2)	(3)	(4)
Friend, diabetic, or sex partner	(1)	(2)	(3)	(4)
Other source, specify: _____	(1)	(2)	(3)	

Disposal method of syringes: *(last 30 days) (mark all that apply "x")*

(1) No disposal; (1) Gave away; (1) Sold them; (1) Thrown in trash; (1) Flushed in toilet; (1) Hospital/clinic; (1) Police confiscation; (1) Pharmacy/drug store; (1) Syringe exchange (SEP); (1) Left in public place *(park, street)*; (1) Other, specify: _____

SEXUAL ENHANCEMENT DRUGS *(last 12 months)*

	Used with sex: Yes	No
(1) Viagra, Cialis, or Levitra *(includes generic brands)*	(1)	(0)
(1) Poppers *(nitrites/nitrates, rush)*	(1)	(0)

OTHER SUBSTANCES INJECTED AND SHARED *(last 12 months)*

Injected hormones, steroids, vitamins, insulin, etc. and shared syringes/needles *(include if shared)* (1) Yes (0) No

OTHER RISK HISTORY

STDs & HEPATITIS *(last 12 months) (mark all that apply "x")*

(1) No STDs/hepatitis; (1) Syphilis *(syph, the pox, lues)*; (1) Gonorrhea *(GC, clap, drip)*; (1) Chlamydia; (1) Trichomoniasis *(trich)*; (1) Human papilloma virus (HPV); (1) Genital Herpes (HSV); (1) Hepatitis A (HAV); (1) Hepatitis B (HBV); (1) Hepatitis C (HCV); (1) Other, specify: _____

VIRAL STDs & HEPATITIS *(lifetime history over 12 months ago) (mark all that apply "x")*

(*) No lifetime viral STDs/hepatitis; (1) Human papilloma virus (HPV); (1) Genital Herpes (HSV); (1) Hepatitis A (HAV); (1) Hepatitis B (HBV); (1) Hepatitis C (HCV)

HEPATITIS VACCINATION *(lifetime history)*

Completed hepatitis A (HAV) vaccination series? (1) Yes (0) No

Completed hepatitis B (HBV) vaccination series? (1) Yes (0) No

DEFINITIONS: **Oral:** mouth on penis, vagina, or anus; **Vaginal insertive:** penis in partner's vagina; **Vaginal receptive:** partner's penis in vagina; **Anal insertive:** penis is partner's anus; **Anal receptive:** partner's penis in anus; **STD:** Sexually Transmitted Disease; **D/R:** Client Declined/Refused

Place additional lab stickers here:	LAB SLIP #2	LAB SLIP #3	LAB SLIP #4	LAB SLIP #5

Estado de California - Agencia de Salud y Servicios Humanos — Departamento de Salud Pública de California, Oficina de SIDA

FORMULARIO SUPLEMENTARIO DE INFORMACIÓN DE RIESGOS DE VIH

Para Uso Clínico Exclusivamente

Iniciales de persona de datos: ☐☐☐☐

Marque con una "x" si no se factura ☐(1)

Aseguranza medica: *(Marque con una "x" todas las que correspondan)*

☐(1) Sin Aseguranza
☐(1) Aseguranza Privada
☐(1) Medi-Cal (Medicaid)
☐(1) Medicare
☐(1) Militar
☐(1) Indian Health Service (Servicio de salud indígena)
☐(1) Otro de carácter público, (especificar): _____

¿Sin hogar? *(actualmente)* ☐(1) Sí ☐(0) No ☐(*) R/R

¿Encarcelado? *(Últimos 12 meses)* ☐(1) Sí ☐(0) No ☐(*) R/R

COMPORTAMIENTO SEXUAL

SEXO DE LAS PERSONAS QUE A TENIDO RELACIONES SEXUALES *(Últimos 12 meses)*

Hombres: *(Marque con una "x")*

☐(1) Sí ☐(0) No ☐(*) R/R

N° de parejas *(1-999)* ☐☐☐

Actividad sexual:			Frecuencia de uso de condones:			
			Nunca	*Algunas veces*	*Generalmente*	*Siempre*
Oral	☐(1) Sí	☐(0) No				
Vaginal receptiva	☐(1) Sí	☐(0) No	☐(1)	☐(2)	☐(3)	☐(4)
Anal insertiva	☐(1) Sí	☐(0) No	☐(1)	☐(2)	☐(3)	☐(4)
Anal receptiva	☐(1) Sí	☐(0) No	☐(1)	☐(2)	☐(3)	☐(4)

Mujeres: *(Marque con una "x")*

☐(1) Sí ☐(0) No ☐(*) R/R

N° de parejas *(1-999)* ☐☐☐

Actividad sexual:			Frecuencia de uso de condones:			
			Nunca	*Algunas veces*	*Generalmente*	*Siempre*
Oral	☐(1) Sí	☐(0) No				
Vaginal insertiva	☐(1) Sí	☐(0) No	☐(1)	☐(2)	☐(3)	☐(4)
Anal insertiva	☐(1) Sí	☐(0) No	☐(1)	☐(2)	☐(3)	☐(4)

Transexual(es): *(Marque con una "x")*

☐(1) Sí ☐(0) No ☐(*) R/R

N° de parejas *(1-999)*
Hombre a mujer: ☐☐☐ Mujer a hombre: ☐☐☐

Actividad sexual:			Frecuencia de uso de condones:			
			Nunca	*Algunas veces*	*Generalmente*	*Siempre*
Oral	☐(1) Sí	☐(0) No				
Vaginal insertiva	☐(1) Sí	☐(0) No	☐(1)	☐(2)	☐(3)	☐(4)
Vaginal receptiva	☐(1) Sí	☐(0) No	☐(1)	☐(2)	☐(3)	☐(4)
Anal insertiva	☐(1) Sí	☐(0) No	☐(1)	☐(2)	☐(3)	☐(4)
Anal receptiva	☐(1) Sí	☐(0) No	☐(1)	☐(2)	☐(3)	☐(4)

INTERCAMBIO SEXUAL

(Últimos 12 meses)

¿Ha recibido…	Sí	No	Actividad sexual: *(Marque con una "x" todas las que correspondan)* Oral	Vaginal	Anal ins.	Anal rec.	Sexo de la otra persona: *(Marque con una "x" todas las que correspondan)* Hombre	Mujer	Trans.	Frecuencia de uso de condones: *(Sólo para sexo vaginal y anal)* Nunca	Algunas veces	Generalmente	Siempre
dinero u otros elementos o servicios a cambio de sexo?	☐(1)	☐(0)	☐(1)	☐(1)	☐(1)	☐(1)	☐(1)	☐(1)	☐(1)	☐(1)	☐(2)	☐(3)	☐(4)
drogas a cambio de sexo?	☐(1)	☐(0)	☐(1)	☐(1)	☐(1)	☐(1)	☐(1)	☐(1)	☐(1)	☐(1)	☐(2)	☐(3)	☐(4)

TIPO DE PERSONA CON QUE TUVO SEXO *(Últimos 12 meses)*

Tuvo sexo con...	Sí	No	Actividad sexual: *(Marque con una "x" todas las que correspondan)* Oral	Vaginal	Anal ins.	Anal rec.	Sexo de la otra persona: *(Marque con una "x" todas las que correspondan)* Hombre	Mujer	Trans.	Frecuencia de uso de condones: *(Sólo para sexo vaginal y anal)* Nunca	Algunas veces	Generalmente	Siempre
Hombre(s) que usted sabe que ha(n) tenido relaciones sexuales con hombre(s) *(Si la clienta es mujer)*	☐(1)	☐(0)	☐(1)	☐(1)	☐(1)	☐(1)	■			☐(1)	☐(2)	☐(3)	☐(4)
Alguien que es trabajador sexual (prostituta)	☐(1)	☐(0)	☐(1)	☐(1)	☐(1)	☐(1)	☐(1)	☐(1)	☐(1)	☐(1)	☐(2)	☐(3)	☐(4)
Alguien que se inyecta(n) drogas	☐(1)	☐(0)	☐(1)	☐(1)	☐(1)	☐(1)	☐(1)	☐(1)	☐(1)	☐(1)	☐(2)	☐(3)	☐(4)
Alguien que es VIH positivo(s)	☐(1)	☐(0)	☐(1)	☐(1)	☐(1)	☐(1)	☐(1)	☐(1)	☐(1)	☐(1)	☐(2)	☐(3)	☐(4)

¿Sabía el cliente cuál era la condición de la pareja con respecto al VIH antes del contacto sexual? ☐(1) Sí ☐(0) No

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USO DE JERINGAS/ AGUJAS *(Complete si se ha inyectado)*

¿Con qué frecuencia... *(últimos 12 meses)*	Nunca	Algunas veces	Generalmente	Siempre	¿Las compartió con alguna persona que, según se sabe, es VIH +? Sí	No
...compartió jeringas/ agujas?	❑(1)	❑(2)	❑(3)	❑(4)	❑(1)	❑(0)
...limpió jeringas/agujas?	❑(1)	❑(2)	❑(3)	❑(4)		
...compartió otro equipo? *(cocinador, algodón, cuchara, agua)*	❑(1)	❑(2)	❑(3)	❑(4)	❑(1)	❑(0)
...limpió los otros equipos?	❑(1)	❑(2)	❑(3)	❑(4)	❑(1)	❑(0)

Fuentes de jeringas nuevas (estériles): *(Indique con una "x" el período más reciente)*	Nunca	En los últimos 30 días	En los últimos 12 meses	En los últimos 2 años
Programa de intercambio de jeringas (SEP, por sus siglas en inglés)	❑(1)	❑(2)	❑(3)	❑(4)
Intercambio secundario	❑(1)	❑(2)	❑(3)	❑(4)
Farmacia	❑(1)	❑(2)	❑(3)	❑(4)
Amigo, diabético o compañero sexual	❑(1)	❑(2)	❑(3)	❑(4)
Otra fuente (especifique):	❑(1)	❑(2)	❑(3)	❑(4)

Método de desecho de las jeringas: *(Últimos 30 días) (Marque con una "x" todas las que correspondan)*

❑(1) No se desecharon — ❑(1) Se arrojaron a la basura — ❑(1) Las confiscó la policía — ❑(1) Se dejaron en lugares públicos *(barque, calle)*

❑(1) Se regalaron — ❑(1) Se arrojaron al retrete — ❑(1) Farmacia — ❑(1) Otro (especifique):

❑(1) Se vendieron — ❑(1) Hospital/clínica — ❑(1) Intercambio de jeringas (SEP)

DROGAS DE POTENCIA SEXUAL *(Últimos 12 meses)*

	Usadas con el sexo:	
Viagra, Cialis o Levitra *(Incluso marcas genéricas)*	❑(1) Sí	❑(0) No
Poppers *(nitritos/nitratos, rush)*	❑(1) Sí	❑(0) No

OTRAS SUSTANCIAS/DROGAS INYECTADAS Y COMPARTIDAS *(Últimos 12 meses)*

Hormonas, esteroides, vitaminas, insulina, etc. inyectados y jeringas/agujas compartidas *(Especifique si se compartió)* ❑(1) Sí ❑(0) No

USO DE LAS DROGAS

DROGAS PSICOACTIVAS *(Últimos 12 meses) (Marque con una "x" todas las que correspondan)*	Se inyectó: Sí	Se inyectó: No	Tuvo sexo estando drogado/a o hebreo/a: Sí	Tuvo sexo estando drogado/a o hebreo/a: No
❑(*) R/R				
❑(1) Sin uso de alcohol ni drogas	❑(1)	❑(0)	❑(1)	❑(0)
❑(1) Alcohol	❑(1)	❑(0)	❑(1)	❑(0)
❑(1) Marihuana *(hierba, pasto, maría, hachís)*	❑(1)	❑(0)	❑(1)	❑(0)
❑(1) Metanfetamina *(cristal, meta, speed, vidrio, tina)*	❑(1)	❑(0)	❑(1)	❑(0)
❑(1) Cocaína *(polvo blanco)*	❑(1)	❑(0)	❑(1)	❑(0)
❑(1) Crack *(rock)*	❑(1)	❑(0)	❑(1)	❑(0)
❑(1) Heroína *(paste, junk, polvo blanco, goma, H)*	❑(1)	❑(0)	❑(1)	❑(0)
❑(1) Calmantes/tranquilizantes *(ej.: oxicontina, Percocet, morfina, codeína, Ativan, fenobarbital, Valium)*	❑(1)	❑(0)	❑(1)	❑(0)
❑(1) Éxtasis *(MDMA, E, X)*	❑(1)	❑(0)	❑(1)	❑(0)
❑(1) GHB *(éxtasis líquido, gina, G)*	❑(1)	❑(0)	❑(1)	❑(0)
❑(1) Ketamina *(K especial, K)*	❑(1)	❑(0)	❑(1)	❑(0)
❑(1) Otra droga, especifique:_____	❑(1)	❑(0)	❑(1)	❑(0)

OTRO HISTORIAL DE RIESGO

ETS Y HEPATITIS *(Últimos 12 meses) (Marque con una "x" todas las que correspondan)*

❑(1) Sin ETS/hepatitis — ❑(1) Herpes genital (HSV)

❑(1) Sífilis *(gran viruela)* — ❑(1) Hepatitis A (HAV)

❑(1) Gonorrea *(GC, blenorragia, purgaciones)* — ❑(1) Hepatitis B (HBV)

❑(1) Clamidia — ❑(1) Hepatitis C (HCV)

❑(1) Tricomoniasis — ❑(1) Otro (especifique):

❑(1) Virus papiloma humano (HPV) _____

ETS VIRALES Y HEPATITIS *(Historial de toda la vida anterior a los últimos 12 meses) (Marque con una "x" todas las que correspondan)*

❑(1) Sin ETS/hepatitis viral en toda la vida

❑(1) Virus papiloma humano (HPV)

❑(1) Herpes genital (HSV)

❑(1) Hepatitis A (HAV)

❑(1) Hepatitis B (HBV)

❑(1) Hepatitis C (HCV)

VACUNA CONTRA LA HEPATITIS *(Historial de toda la vida)*

¿Completó la serie de vacunas contra la hepatitis A (HAV)? ❑(1) Sí ❑(0) No

¿Completó la serie de vacunas contra la hepatitis B (HBV)? ❑(1) Sí ❑(0) No

DEFINICIONES: **Oral:** boca sobre pene, vagina o ano — **Vaginal insertiva:** pene en la vagina de la otra persona — **ETS:** Enfermedad de transmisión sexual

Anal insertiva: pene en el ano de la otra persona — **Vaginal receptiva:** pene del compañero en la vagina — **Anal receptiva:** pene de la otra persona en el ano — **R/R:** El cliente rechazó la pregunta/se rehusó a responder

Coloque aquí los auto-adhesivos de laboratorio adicionales:	FICHA DE LABORATORIO N° 2	FICHA DE LABORATORIO N° 3	FICHA DE LABORATORIO N° 4	FICHA DE LABORATORIO N° 5

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State of California - Health and Human Services Agency

California Department of Public Health, Office of AIDS

HIV TEST RESULT AND SERVICES RENDERED FORM

Unique Office of AIDS Client Number

ADMINISTRATIVE

Data entry initials: ☐☐☐☐

Mark "x" if no billing ☐ (1)

Agency ID: ☐☐☐☐

Intervention: _____

CLIENT ASSESSMENT

Assessment Initials: ☐☐☐☐

Intervention ID: ☐☐☐☐☐

Intervention opt-out:
Eligible ☐ (1) Yes ☐ (0) No
Opted out ☐ (1) Yes ☐ (0) No

Location ID: ☐☐☐☐☐

Initial intervention:
☐ (1) LR low-level *(indicate transition)*
☐ (2) LR high-level
☐ (3) HR high-level

HIV test election: *(mark one "x")*
☐ (1) Tested anonymously
☐ (2) Tested confidentially
☐ (3) Client declined testing
☐ (4) HIV test not offered

Transition to high-level? ☐ (1) Yes

Local variance used? ☐ (1) Yes (0) No

(date and initial)	Date *(mm/dd/yy)*	Initials *(print)*
Intervention session:	☐☐☐☐☐☐	☐☐☐☐
Disclosure session: *(same date as intervention for rapid tests)*	☐☐☐☐☐☐	☐☐☐☐
Transition to high-level: *(enter high-level counselor initials if transitioned from a low-level only counselor)*		☐☐☐☐
Confirmatory disclosure: *(rapid positive confirmatory results)*	☐☐☐☐☐☐	☐☐☐☐
Reschedule attempt: *(for missed HIV confidential disclosures)*	☐☐☐☐☐☐	☐☐☐☐

Reschedule attempt outcome: *(mark one "x" if no HIV disclosure)*

☐ (1) Unable to locate/contact
☐ (2) Client declined notification
☐ (3) Obtained HIV results elsewhere
☐ (4) Rescheduled but client did not return

HCV result disclosure: *(may be same date as HIV disclosure)* ☐☐☐☐☐☐ ☐☐☐☐

OTHER TESTING

Hepatitis C test offered: *(mark one "x")*
☐ (1) Not offered
☐ (2) Yes, client accepted *(indicate HA kit & result)*
☐ (3) Yes, client declined

HCV test result: *(mark one "x")*
☐ (1) Negative
☐ (2) Positive
☐ (3) Inconclusive

Additional tests this visit: *(mark all that apply "x")*
☐ (1) No additional tests
☐ (1) Tuberculosis (TB)
☐ (1) Hepatitis B
☐ (1) Syphilis
☐ (1) Gonorrhea
☐ (1) Chlamydia
☐ (1) Other STD *(other than HIV)*

Home Access test kit used? ☐ (1) Yes ☐ (0) No

COUNSELING TOPICS

Risk reduction plan developed? ☐ (1) Yes ☐ (0) No ☐ (*) D/R *Briefly describe:* _____

Testing and transmission
☐ Testing process/meaning of results
☐ How HIV is transmitted
☐ HIV's impact on immune system
☐ Window period/follow-up test

Substance Use
☐ Prevention/harm reduction w/ IDUs
☐ Demonstrate needle cleaning
☐ Drugs w/ sex as co-factor for risk
☐ Explore treatment & recovery

Sexual Health
☐ Discuss continuum of risk
☐ Demonstrate condom/barrier use
☐ Obstacles to condom/barrier use
☐ Partner risks related to client's risk
☐ Discussing HIV status w/ partners
☐ Negotiating safety w/ partners

Other Topics
☐ Cultural/peer influences
☐ Domestic violence
☐ Sexual assault
☐ Other, specify: _____

State of California - Health and Human Services Agency | California Department of Public Health, Office of AIDS

REFERRALS

Referrals: *(mark all that apply "x")* ☐ (1) No referrals provided

Risk/harm reduction

- ☐ (1) Comprehensive risk counseling (CRCS)
- ☐ (1) HIV education & prevention services
- ☐ (1) Follow-up HIV counseling
- ☐ (1) Prevention skill development
- ☐ (1) Prevention support group
- ☐ (1) Individual psychotherapy/counseling

Substance use services

- ☐ (1) Alcohol/drug treatment *(detox, methadone, outpatient, or residential)*
- ☐ (1) Abstinence self-help *(12-step or other: AA, NA, CA, CMA, etc.)*
- ☐ (1) Harm reduction services
- ☐ (1) Syringe exchange program

HCV positive referral

- ☐ (1) HCV medical services

Other referrals

- ☐ (1) Post-exposure prophylaxis (PEP)
- ☐ (1) Hepatitis testing/vaccination
- ☐ (1) STD testing & treatment
- ☐ (1) TB testing & treatment
- ☐ (1) Reproductive health services
- ☐ (1) Non-HIV/HCV medical services
- ☐ (1) Social services
- ☐ (1) Other HIV testing
- ☐ (1) Other referral, specify: _____

HIV TESTING

Final HIV test result: *(mark one "x")*
(attach lab slips/Testing Incident Report)

- ☐ (1) Negative
- ☐ (2) Positive
- ☐ (3) Preliminary positive *(no confirmatory sample taken)*
- ☐ (4) Inconclusive
- ☐ (5) Discordant
- ☐ (6) Invalid
- ☐ (7) Other result, specify: _____

HIV POSITIVE

HIV positive medical referrals: *(mark all that apply "x" for positive & preliminary positive results)*

- ☐ (1) No referrals provided
- ☐ (1) HIV case management
- ☐ (1) Early intervention program (EIP)
- ☐ (1) Prenatal care
- ☐ (1) HIV medical services *(care, evaluation, treatment)*
- ☐ (1) Client plans to use their own physician/health plan
- ☐ (1) Referrals provided but client declined referrals
- ☐ (1) Other medical referral, specify: _____

Medical visit verified by client? ☐ (1) Yes ☐ (0) No
Medical visit verified by data? ☐ (1) Yes ☐ (0) No
Medical visit verified by provider? ☐ (1) Yes ☐ (0) No

Medical visit date: *(mm/dd/yy)* ☐☐ ☐☐ ☐☐

PCRS

Partner Counseling & Referral Services (PCRS) discussed/offered to client? *(mark one "x")*

- ☐ (1) No, PCRS not discussed
- ☐ (2) Yes, client declined services
- ☐ (3) Yes, PCRS referred out
- ☐ (4) Yes, PCRS activities this session *(initial and indicate activities)*

PCRS initials *(if activities)* ☐☐☐☐

PCRS activities: *(mark all that apply "x") (attach Partner Information Forms)*

Number of partners:

- ☐ (1) Skill building with client for self notification *(indicate # of partners)* ☐☐☐
- ☐ (1) Anonymous third party notification *(indicate # of partners & attach partner forms)* ☐☐☐
- ☐ (1) Dual client/partner session *(indicate # of partners & attach partner forms)* ☐☐☐

DEFINITIONS:

LR: Low-Risk Client
HR: High-Risk Client
D/R: Client Declined/Refused
STD: Sexually Transmitted Disease

Place additional lab stickers here:	LAB SLIP #2	LAB SLIP #3	LAB SLIP #4	LAB SLIP #5

APPENDIX III

Recruitment Scripts

Client Satisfaction Survey Recruitment Script

"We are asking select clients to fill out a survey as part of a research study to help us evaluate the HIV counseling and testing process and, as someone tested for HIV today we would like to invite you to give us your feedback. Participation is completely voluntary. If you don't wish to participate, or if you decide to stop at any point, there will be no penalty, nor will there be any loss to or change in the benefits or services you normally receive at our site, today or in the future. The survey will take about 10 minutes. Would you be interested in participating?"

"Le estamos pidiendo a los clientes seleccionados de por favor llenar una encuesta que será parte de un estudio de investigación que nos ayudara a evaluar los servicios de conserjería y de la prueba del VIH y como alguien que se a hecho los exámenes ahora nos gustaría invitarlo que nos de su observaciones. La participación es totalmente voluntaria. El no participar en la encuesta no afectara de ninguna manera los servicios que usted recibe aquí hoy o en el futuro, ni causara ninguna pérdida de beneficios a las cuales usted está autorizado. La encuesta tardara aproximadamente 10 minutos en terminar. Interesa a participar?"

Data Validity Sub-Study Recruitment Script

"Though you are eligible not to have pre-test counseling and have chosen this option, we are asking select clients to fill out a survey with a counselor as part of a research study to help us evaluate the HIV counseling and testing process. Participation is completely voluntary. If you don't wish to participate, or if you decide to stop at any point, there will be no penalty, nor will there be any loss to or change in the benefits or services you normally receive at our site, today or in the future. The survey will take about 15 minutes, and you will receive a $10 voucher for your time. Would you be interested in participating?"

"Aunque usted tiene derecho optar por no tener una sesión de consejería de 20 minutos antes de la pruebe de VIH, le estamos pidiendo los clientes de por favor llenar una encuesta con un consejero por un estudio de investigación que nos ayudara a evaluar los servicios de consejería y de la prueba de VIH. La participación es totalmente voluntaria. El no participar en la encuesta no afectara de ninguna manera los servicios que usted recibe aquí hoy o en el futuro, ni causara ninguna pérdida de beneficios a las cuales usted está autorizado. La encuesta tardara aproximadamente 15 minutos en terminar. Interesa a participar?"

University of California, San Diego
Consent to Act as a Research Subject

Informing the opt-out option: formative research on client perspectives and characteristics of repeat HIV testers

CLIENT SATISFACTION SURVEY

1. Purpose, Participation, and Procedures

   You are being invited to participate in a research study that includes filling out a brief survey about the services you received today. The purpose of this research is to better understand client satisfaction with the services they receive, including how the services you received today compares to services you received in the past. You were selected because you received HIV testing services today. There will be approximately 500 people in this research study.

   The survey is being carried out by Dr. Richard Garfein, PhD, from the University of California, San Diego (UCSD) in partnership with the California Department of Public Health, Office of AIDS, the AIDS Healthcare Foundation (AHF), LA County Public Health, and the County of Orange Health Care Agency. If you have questions about the research study, you can contact Dr. Garfein (ph: 858-822-3018). If you have questions about your rights as a research participant, you can contact the Human Research Protection Program at UCSD (ph: 858-455-5050).

   You will be asked to fill out a brief survey that asks 16 questions at most. These questions will ask about the level, quality, and benefit of services you received today. You will not be asked the survey questions by a counselor or researcher. You will complete the survey on your own. A counselor will be available to answer questions you may have or help you if any issues should come up.

2. Description of Risks

   While your name is not recorded, your research record will contain your birthdate, race/ethnicity and zip code, as well as your HIV test result from today's test, and there is therefore a risk for loss of confidentiality. Given the sensitive nature of the information collected, a loss of confidentiality could have an impact on employability, insurability or ability to travel to some foreign countries. The possibility for a breach of confidentiality is very low.

3. Confidentiality

All study materials will be securely stored and electronic files will only be used on secure UCSD workstations with firewall and password protection. Any written reports or publications will contain general information about all study participants, and will not be presented in a way that could allow individual participants to be identified. As we are not collecting your name anywhere on the forms used in this research, we are not asking you to give your name and sign a consent form. Completion of the research survey indicates that you agree to allow the researchers to use the information for the purpose of evaluating possible changes to the HIV counseling and testing system. Your information will not be used or disclosed for any other purpose. Only study staff (Dr. Garfein, project coordinator and statistician), and the UCSD Institutional Review Board, which is responsible for monitoring the ethical conduct of research, will have access to the research records. Research records will be kept confidential to the extent allowed by law.

4. Description of Benefits

There will not be any direct benefit to you from this research today. The investigator and the Office of AIDS, however, may learn more about how an option to opt-out of pre-test counseling would work.

5. Alternative Procedures

There are no alternative procedures related to participating in this research project. Your participation is completely voluntary.

6. Compensation

The research project should take you about 10 to 15 minutes to complete. You will not receive compensation for participating in this research project.

7. Treatment for Injury

Participation in this research project presents little to no risk of injury. Treatment will not be provided should any injury occur as a result of participating in this research project.

8. Potential Conflict of Interest and Funding

This research is funded by the California Department of Public Health, Office of AIDS. The researchers working on this project do not have any personal financial interests or other personal interests that could impact the results of this research.

9. Questions

If you have questions about the research study, you can contact Dr. Garfein (ph: 858-822-3018). If you have questions about your rights as a research participant, you can contact the Human Research Protection Program at UCSD (ph: 858-455-5050). You can also contact the California Committee for the Protection of Human Subjects (ph: 916-326-3660).

10. Voluntary Participation

Participation in this research is completely voluntary and you have the right to stop participating at any time. Refusal to participate or stopping your participation in the research will in NO WAY affect the services you receive here today or in the future, or cause any loss of benefits to which you are entitled.

11. Research Participant's Bill of Rights

You have been asked to participate in a research study. Any participant in a research study has the right to:

(a) Be told the nature and purpose of the study.

(b) Be given an explanation of what will happen during the study and of how the research participant is expected to participate.

(c) Be given an explanation of any risks or discomforts that may be experienced as a result of participating in the study.

(d) Be given an explanation of any benefits that may be expected from participation in the study.

(e) Be told of other appropriate choices that may be better or worse than being in the study, and be told of the risks and benefits of those other choices.

(f) Have the opportunity to ask questions about the study or about your participation in it, both before agreeing to participate in the study and during the course of the study.

(g) Be told that you may withdraw your consent and participation in the study at any time, and that your withdrawal will not affect your services.

(h) Be told that you may refuse to answer any question.

(i) Be given a copy of the signed and dated consent form.

(j) Be free of pressure when considering whether to consent to, and participate in, the study.

(k) Be informed, upon request, about the results of the study.

12. Consent Statement

I have been given adequate time to consider my participation in this study. At this time, all of my questions have been answered to my satisfaction, and I understand that I have the right to ask more in the future. As we are not collecting your name anywhere on the forms used in this research or on the counselor's form, we are not asking you to give your name and sign a consent form. Completion of the survey indicates that you agree to allow the researchers to use the information for the purpose of evaluating possible changes to the HIV counseling and testing system. Your agreeing to participate in this research project and your providing information in response to the survey indicates that you have read and understand this form.

You may request a copy of this consent document to keep in addition to the California Research Participant's Bill of Rights.

Human Research Protections Program
(858) 455-5050
(858) 455-9540 (FAX)

University of California, San Diego
9500 Gilman Drive, Mail Code 0052
La Jolla, CA 92093-0052

EXPERIMENTAL SUBJECT'S BILL OF RIGHTS

The faculty and staff of the University of California, San Diego and the Veteran's Affairs San Diego Healthcare System wish you to know:

Any person who is requested to consent to participate as a subject in a research study involving a medical experiment, or who is requested to consent on behalf of another, has the right to:

1. Be informed of the nature and purpose of the experiment.

2. Be given an explanation of the procedures to be followed in the medical experiment, and any drug or device to be used.

3. Be given a description of any attendant discomforts and risks reasonably to be expected from the experiment.

4. Be given an explanation of any benefits to the subject reasonably to be expected from the experiment, if applicable.

5. Be given a disclosure of any appropriate alternative procedures, drugs, or devices that might be advantageous to the subject, and their relative risks and benefits.

6. Be informed of the avenues of medical treatment, if any, available to the subject after the experiment if complications should arise.

7. Be given an opportunity to ask any questions concerning the experiment or the procedures involved.

8. Be instructed that consent to participate in the medical experiment may be withdrawn at any time, and the subject may discontinue participation in the medical experiment without prejudice.

9. Be given a copy of a signed and dated written consent form when one is required.

10. Be given the opportunity to decide to consent or not to consent to a medical experiment without the intervention of any element of force, fraud, deceit, duress, coercion, or undue influence on the subject's decision.

If you have questions regarding a research study, the researcher or his/her assistant will be glad to answer them. You may seek information from the Human Research Protections Program - established for the protection of volunteers in research projects - by calling (858) 455-5050 from 8:00 a.m. to 4:30 p.m., Monday through Friday, or by writing to the above address.

Client Satisfaction Survey

Unique Office of AIDS Client Number

The State Office of AIDS and this clinic are interested in improving the quality of services offered with HIV testing. Please take a few minutes to answer the following questions. Your opinions will help us improve this service. This survey is voluntary and all answers are confidential.

When you arrived at the testing site, you got a paper or computer questionnaire about your risk behaviors.

1) Did you have any trouble answering the questions?
   - ❑(1) No, not at all
   - ❑(2) Yes, a little bit of trouble
   - ❑(3) Yes, a lot trouble

2) When you were answering the questions, did you need to ask clinic staff any questions to be sure you understood?
   - ❑(1) No, everything was very clear
   - ❑(2) I wasn't sure what some questions meant, but I didn't ask about them.
   - ❑(3) I asked about some questions, but still didn't understand.
   - ❑(4) I asked about some questions, and got answers that helped me understand.

3) When you were answering the questions, were you worried that someone sitting near you might be able to see your answers?
   - ❑(1) No, not at all worried
   - ❑(2) Yes, a little bit worried
   - ❑(3) Yes, a lot worried

After completing the sheet of questions, a counselor may have given you the option to not get counseling today.

4) Did a staff person give you the option to skip counseling today? *(check one)*
   - ❑(1) Yes
   - ❑(2) No ⟶ **(GO TO QUESTION 9)**

5) Would you have been more comfortable if the option to skip counseling was given to you on the computer, instead of by a counselor? *(check one)*
   - ❑(1) Yes
   - ❑(2) No

6) Did you decide to get counseling today?
   - ❑(1) Yes
   - ❑(2) No ⟶ **(GO TO QUESTION 8)**

7) Why did you decide to get counseling today? *(check all that apply)* **(GO TO QUESTION 9 WHEN DONE)**
   - ❑(1) I like talking with counselors
   - ❑(1) I just needed to talk with someone
   - ❑(1) I needed to better understand my HIV risk
   - ❑(1) I needed to know how to stay safe
   - ❑(1) I needed to know about or get a referral to other HIV, medical or support services
   - ❑(1) I always feel better after talking to someone
   - ❑(1) I always learn something new
   - ❑(1) Other, specify _____

8) Why did you decide to skip counseling today? *(check all that apply)*
   - ❑(1) I don't like talking with counselors
   - ❑(1) Counseling does not change my behavior
   - ❑(1) I already understand my HIV risk
   - ❑(1) I already know how to stay safe
   - ❑(1) Counseling never focuses on me, it is always just a 'checklist' of risk behaviors
   - ❑(1) Counseling is a waste of my time
   - ❑(1) I just want to know my HIV status
   - ❑(1) I never learn anything new from counseling
   - ❑(1) I am not really at 'high risk' for getting HIV
   - ❑(1) I am a routine tester
   - ❑(1) Other, specify _____

9) Thinking about the information you got today, which statement do you agree with? *(check all that apply)*
   - ❑(1) Not counting my test result, I already knew all of the information I got
   - ❑(1) The information doesn't apply to me
   - ❑(1) The information will help me avoid getting HIV
   - ❑(1) I learned something new about HIV/AIDS

10) What do you think about the **amount** of information you got about HIV and AIDS today?
   - ❑(1) I didn't get enough information
   - ❑(2) I got just the right amount of information
   - ❑(3) I got too much information

11) Did you get all of the referrals today that you needed?
   - ❑(1) Yes, I did get the referrals that I needed
   - ❑(2) No, I did not get a referral that I needed

(Continued on next page)

12) Do you think the **time** it took to complete the counseling and testing process today was:
- ❑(1) Too short
- ❑(2) Too long
- ❑(3) Just right

13) Do you think you will get tested again for HIV in the future?
- ❑(1) No, I understand how to avoid HIV
- ❑(2) Yes, I prefer to test once in awhile, even though I'm not at high risk
- ❑(3) Yes, I prefer to test regularly, even though I'm not at high risk
- ❑(4) Yes, I test regularly because I am at high risk

14) Have you ever tested for HIV before?
- ❑(1) Yes
- ❑(2) No ⟶ ***(Stop, you are done with this survey. Go to the comments section below)***

15) Where did you have your last HIV test?
- ❑(1) This site
- ❑(2) Anonymous testing site
- ❑(3) Family planning clinic
- ❑(4) STD clinic
- ❑(5) Alcohol or drug treatment program
- ❑(6) Jail or prison
- ❑(7) Doctor's office or hospital
- ❑(8) Community center
- ❑(9) County health clinic
- ❑(10) Mobile van or street outreach
- ❑(11) Other site, please specify:

16) Compare your experience the last time you received counseling and testing to your experience this time. In the categories below, which testing session did you think was better? *(check one box for each aspect)*

	Last Time Was Better	This Time Was Better	About the Same
Information about HIV and AIDS was better	❑	❑	❑
Amount of time spent with counselor was better	❑	❑	❑
Total amount of time spent getting tested was better	❑	❑	❑
I felt safer sharing personal information	❑	❑	❑
I felt more comfortable with clinic staff	❑	❑	❑
I felt my own needs were better met	❑	❑	❑
Information about me was collected better	❑	❑	❑
The counselor focused more on my needs	❑	❑	❑
Overall experience was better	❑	❑	❑

If you have anything else that you would like to tell us about your counseling and testing experience today, please write it in the space below.

_____

_____

_____

_____

_____

_____

_____

Thank You!

For staff use only

Client End Time for Today's Clinic Activities: Hr Hr : Min Min

Universidad de California, San Diego
Consentimiento para actuar como sujeto en un estudio

Información de la opción de exclusión: investigación formativa sobre las perspectivas y características de los clientes que actúan como sujetos de exámenes repetitivos del VIH

ENCUESTA DE SATISFACCIÓN DEL CLIENTE

1. Propósito, participación y procedimientos

   Se le invita a participar en un estudio que incluye responder a una encuesta breve sobre los servicios que recibió hoy. El propósito de este estudio es comprender mejor la satisfacción de los clientes respecto a los servicios que reciben, incluyendo el modo en que usted recibió los servicios hoy en comparación con esos recibidos en ocasiones anteriores. Usted ha sido seleccionado porque hoy recibió servicios de examen del VIH. En este estudio participarán aproximadamente 500 personas.

   El estudio lo realiza el Dr. Richard Garfein, PhD, de la Universidad de California, San Diego (UCSD), en asociación con el Departamento de Salud Pública de California, Oficina de SIDA; AIDS Healthcare Foundation (AHF, por sus siglas en inglés); el Departamento de Salud Pública del Condado de Los Ángeles, Oficina de Programas y Pólizas del SIDA (OAPP), y la Agencia de Atención Médica del Condado de Orange. Si tiene alguna pregunta sobre el estudio, puede comunicarse con el Dr. Garfein (tel.: 858-822-3018). Si tiene preguntas sobre sus derechos como participante en el estudio, puede comunicarse con el Programa para la Protección de Investigaciones en Humanos de la UCSD (tel: 858-455-5050).

   Se le solicitará que complete una encuesta breve de no más de 16 preguntas. Dichas preguntas se referirán al nivel, la calidad y el beneficio de los servicios que recibió hoy. Las preguntas de la encuesta no se las hará un consejero. Usted completará la encuesta solo. Habrá un consejero disponible para responder las dudas que usted tenga o ayudarle si se le presenta alguna dificultad.

2. Descripción de los riesgos

   A pesar de que no se registrará su nombre, su registro del estudio contendrá su fecha de nacimiento, raza/etnia y código postal, así como también el resultado de su examen del VIH de hoy; por lo tanto, hay un riesgo de pérdida de la confidencialidad. Dada la naturaleza delicada de la información recogida, la pérdida de confidencialidad podría afectar la capacidad de obtener empleo, contratar seguros o viajar a determinados países extranjeros. La posibilidad de un incumplimiento de la confidencialidad es muy baja.

3. Confidencialidad

Todos los materiales del estudio se guardarán de manera segura y los archivos electrónicos sólo se utilizarán en estaciones de trabajo seguras de la UCSD con protección mediante para seguridad y contraseñas. Los informes y publicaciones escritos contendrán información general sobre todos los participantes del estudio y no se presentarán en absoluto de ningún modo que permita la identificación de los participantes en forma individual. Como no documentamos su nombre en ningún lugar de los formularios que se utilizan en este estudio, no le pediremos que dé su nombre ni que firme un formulario de consentimiento. Al completar el estudio de investigación, usted indica que está de acuerdo en permitir a los investigadores que utilicen la información con el propósito de evaluar posibles cambios en el sistema de asesoramiento y examen del VIH. Su información no se utilizará ni divulgará con ningún otro propósito. Sólo el personal del estudio (Dr. Garfein, coordinador del proyecto y especialista en estadísticas) y la Junta Revisora Institucional de la UCSD, responsable de supervisar la conducta ética del estudio, tendrán acceso a los registros. Los registros se guardarán de forma confidencial hasta el máximo grado permitido por la ley.

4. Descripción de los beneficios

Usted no obtendrá ningún beneficio directo de este estudio. Sin embargo, ésta les permitirá al investigador y a la Oficina de SIDA saber más acerca de cómo funcionaría una opción de optar por la exclusión del asesoramiento previo al examen.

5. Procedimientos alternativos

No hay procedimientos alternativos relacionados con la participación en este proyecto de estudios. Su participación es completamente voluntaria.

6. Compensación

Completar el proyecto de estudios lleva aproximadamente de 10 a 15 minutos. No recibirá ninguna compensación por participar.

7. Tratamiento por lesiones

El riesgo de sufrir lesiones por participar en este estudio es bajo o ninguno. Si se produjera alguna lesión causada por participar en este proyecto, no se proveerá tratamiento.

8. Conflicto de intereses potencial y financiamiento

Este estudio es financiado por el Departamento de Salud Pública de California, Oficina de SIDA. Los investigadores que trabajan en este proyecto no tienen intereses financieros personales ni otros intereses personales que pudieran afectar los resultados del estudio.

9. Preguntas

Si tiene alguna pregunta sobre el estudio, puede comunicarse con el Dr. Garfein (tel.: 858-822-3018). Si tiene preguntas sobre sus derechos como participante en el estudio, puede comunicarse con el Programa para la Protección de Investigaciones en Humanos de la UCSD (tel.: 858-455-5050). También puede comunicarse con el Comité de California para la Protección de Sujetos Humanos (tel.: 916-326-3660).

10. Participación voluntaria

La participación en este estudio es totalmente voluntaria y usted tiene derecho a dejar de participar en cualquier momento. El hecho de rehusarse a participar o dejar de participar posteriormente NO afectará EN ABSOLUTO los servicios que recibirá hoy o en el futuro ni causará la pérdida de los beneficios a los cuales usted tiene derecho.

11. Declaración de consentimiento

Se me ha dado suficiente tiempo para considerar mi participación en este estudio. Se le dará una copia de este documento de consentimiento, además de la Declaración de derechos de los participantes en estudios de California.

Declaración de Derechos de Participantes en Estudios No-Medicos

Se le ha pedido que participe en un estudio de investigación. Cualquier participante en un estudio de investigación tiene el derecho a:

a) Que se le diga la naturaleza y el propósito del estudio.

b) Que se le dé una explicación de lo que ocurrirá durante el estudio y de que manera se espera que participe el participante en una investigación.

c) Que se le dé una explicación de todos los riesgos o molestias que pueden ocurrir como resultado de la participación en el estudio.

d) Que se le dé una explicación de todos los beneficios que se pueden recibir de la participación en el estudio.

e) Que se le diga de otras alternativas apropiadas que pudieran ser mejores o peores que la participación en el estudio, y que se le diga de los riesgos y beneficios de esas otras alternativas.

f) Que tenga la oportunidad de hacer preguntas acerca del estudio o acerca de su participación en el estudio, antes de participar en el estudio y durante la duración del estudio.

g) Que se le diga que puede retirar su consentimiento y participación en el estudio en cualquier momento, y que su retiro no le afectará sus servicios.

h) Que se le diga que puede rehusarse a contestar cualquier pregunta.

i) Que se le dé una copia firmada y fechada de la forma de consentimiento.

j) Estar libre de presiones al momento de decidir si da su consentimiento para participar en el estudio.

k) Obtener información, en cuanto usted lo pida, acerca de los resultados del estudio.

Oficina Unica de SIDA
Numero de cliente

Encuesta de Satisfacción del Cliente

La Oficina del Estado para la prevención del SIDA (State Office of AIDS) y esta clínica desean mejorar la calidad de los servicios ofrecidos con los exámenes de VIH. Por favor, dedique unos minutos a responder las preguntas siguientes. Su opinión nos ayudará a mejorar este servicio. Esta encuesta es voluntaria y todas las respuestas son confidenciales.

Cuando usted llegó al lugar de los exámenes, recibió un cuestionario de papel o cuestionario por la computadora sobre sus comportamientos del riesgo.

1) ¿Tuvo algún problema para responder las preguntas?
   - ❑(1) No, ninguna
   - ❑(2) Sí, algún problema
   - ❑(3) Sí, muchos problemas

2) Mientras respondía las preguntas, ¿necesitó consultar al personal de la clínica acerca de las preguntas para ser seguro que usted entendía?
   - ❑(1) No, todo era muy claro
   - ❑(2) No estaba seguro del significado de algunas preguntas, pero no consulté sobre ellas.
   - ❑(3) Me informe acerca de algunas preguntas, pero continué sin comprender.
   - ❑(4) Me informe acerca de algunas preguntas y las respuestas que recibí me ayudaron a comprender.

3) Mientras respondía las preguntas, ¿Le preocupaba que alguien que estuviera sentado cerca a usted pudiera ver sus respuestas?
   - ❑(1) No, no me preocupé en absoluto.
   - ❑(2) Sí, me preocupé un poco.
   - ❑(3) Sí, me preocupé mucho.

Luego de completar la hoja de preguntas, un consejero le podría dar la opción de no recibir consejería hoy.

4) ¿ Un consejero le dio la opción de no recibir consejería hoy? *(marque una)*
   - ❑(1) Si
   - ❑(2) No ⟶ **(VAYA A PREGUNTA 9)**

5) ¿Se hubiera sentido mas comodo(a) si la opción de no recibir conserjería fuera ofrecida por computadora y no consejero? *(marque una)*
   - ❑(1) Si
   - ❑(2) No

6) ¿Usted decidió recibir consejería hoy?
   - ❑(1) Si
   - ❑(2) No ⟶ **(VAYA A PREGUNTA 8)**

7) ¿Por qué usted decido recibir consejería hoy? *(marque todas las que correspondan)* **(VAYA A PREGUNTA 9 CUANDO ESTE COMPLETO)**
   - ❑(1) Tengo gusto platicar con consejeros
   - ❑(1) Necesitaba platicar con alguien
   - ❑(1) Necesitaba entender mejor mi riesgo del VIH
   - ❑(1) Necesitaba saber como permanecer seguro
   - ❑(1) Necesitaba saber o conseguir información sobre otros servicios de VIH, soporté o médicos
   - ❑(1) Siempre me siento mejor después de hablar con alguien.
   - ❑(1) Siempre aprendo algo nuevo
   - ❑(1) Otro, especifica_____

8) ¿Por qué decidió no recibir consejería hoy ? *(marque todas las que correspondan)*
   - ❑(1) No me gusta hablar con consejeros
   - ❑(1) Consejería no cambia mi comportamiento
   - ❑(1) Entiendo mi riesgo del VIH
   - ❑(1) Ya se como protegerme contra el VIH
   - ❑(1) Consejería nunca se enfoca en mí, siempre es una lista de comportamientos del riesgo
   - ❑(1) Consejería siempre es una perdida de mi tiempo
   - ❑(1) Solamente quiero saber mi resultado de VIH
   - ❑(1) Nunca aprendo nada nuevo de conserjería
   - ❑(1) No estoy realmente en el riesgo elevado para contraer el VIH
   - ❑(1) Hago exámenes rutinarios
   - ❑(1) Otro, especifica_____

9) Teniendo en cuenta la información que recibió sobre el VIH/SIDA, ¿con cuáles de las siguientes declaraciones está de acuerdo? *(marque todas las que correspondan)*
   - ❑(1) Sin contar con mi resultado del examen, ya conocía toda la información que recibí
   - ❑(1) La información no corresponde a mi caso
   - ❑(1) La información me ayudará a evitar contraer el VIH
   - ❑(1) Aprendí algo nuevo sobre el VIH/SIDA

(Continué en la próxima página)

10) ¿Qué opina acerca de la **cantidad** de información que recibió hoy sobre el VIH y el SIDA?
- ❑(1) No recibí suficiente información
- ❑(2) Recibí la cantidad correcta de información
- ❑(3) Recibí demasiada información

11) ¿Recibió toda la información que usted necesitaba hoy?
- ❑(1) Si, recibí toda la información que necesitaba
- ❑(2) No recibí toda la información que necesitaba

12) Con respecto al **tiempo** que le llevó realizarse el examen de VIH hoy, usted considera que fue:
- ❑(1) Demasiado cortó
- ❑(2) Demasiado largo
- ❑(3) Adecuado

13) ¿Cree que en el futuro se realizará otro examen de VIH?
- ❑(1) No, comprendo cómo evitar el VIH
- ❑(2) Sí, prefiero realizarme un examen de vez en cuando, aunque no tengo un alto riesgo
- ❑(3) Sí, prefiero realizarme un examen periódico, aunque no tengo un alto riesgo
- ❑(4) Sí, me realizo un examen periódicamente porque tengo un alto riesgo

14) ¿Se ha realizado alguna vez un examen de VIH?
- ❑(1) Sí
- ❑(2) No ⟶ ***(Deténgase aquí, ha completado esta encuesta. Vaya a sección de comentas abajo.)***

Si desea comentarnos algo más acerca de su experiencia de examen de hoy, por favor escríbalo en el espacio que aparece a continuación.

_____

_____

_____

15) ¿Dónde se realizó su último examen de VIH?
- ❑(1) En este lugar
- ❑(2) En un lugar de exámenes anónimos
- ❑(3) En una clínica de planificación familiar
- ❑(4) Clínica de ETS (enfermedades de transmisión sexual)
- ❑(5) Programa de tratamiento de alcoholismo o drogadicción
- ❑(6) Cárcel o prisión
- ❑(7) Consultorio de un médico u hospital
- ❑(8) Centro comunitario
- ❑(9) Clínica de salud del condado
- ❑(10) Unidad móvil o de difusión en la calle
- ❑(11) Otro lugar. Por favor, especifique:

_____

16) Compare la última vez que se realizó el examen con esta vez. En las categorías siguientes, ¿cuál sesión de examen le pareció mejor? *(marque una caja para cada aspecto)*

	Última vez	Esta vez	Similar
La información sobre el VIH y el SIDA fue mejor	❑	❑	❑
La cantidad de tiempo con el asesor fue mejor	❑	❑	❑
La cantidad total de tiempo que me llevó realizarme el análisis fue mejor	❑	❑	❑
Sentí mayor seguridad al dar mi información personal	❑	❑	❑
Me sentí más cómodo con el personal de la clínica	❑	❑	❑
La experiencia en general fue mejor	❑	❑	❑

_____

_____

_____

_____

¡Gracias!

For staff use only

Client End Time for Today's Clinic Activities: Hr Hr : Min Min

Frontline Staff Survey

Site Name _____

Thank you for participating in our pilot study to determine best practices in a potential new model for HIV Counseling and Testing. The Office of AIDS is interested in hearing about your experiences providing services to clients requesting HIV testing. Please answer the following questions on the basis of your personal knowledge and experience during this pilot. Feel free to skip questions that are not applicable, and to write in comments as you see fit. Thanks again for your help in this process.

1) Which counseling and testing services have you provided during the pilot? *(mark all that apply)*
- ❑(1) Distribute the CAQ to clients
- ❑(1) Administer handheld or kiosk surveys
- ❑(1) Answer client questions about the CAQ
- ❑(1) Answer client questions about handhelds/kiosks
- ❑(1) Assess risk-level of client from CAQ answers
- ❑(1) Assess opt-out eligibility
- ❑(1) Offer opt-out of counseling to eligible clients
- ❑(1) Provide informed consent
- ❑(1) Provide low-level intervention
- ❑(1) Provide high-level intervention
- ❑(1) Provide negative test result disclosure
- ❑(1) Provide positive or preliminary positive test result disclosure
- ❑(1) Conduct OraQuick rapid test
- ❑(1) Complete services rendered checklist
- ❑(1) Other _____

Before the pilot began:

2) Did you have experience with HIV test counseling?
- ❑(1) Yes – how long? _____
- ❑(2) No
- ❑(3) Not applicable

3) Did you have experience using rapid HIV test kits?
- ❑(1) Yes – how long? _____
- ❑(2) No
- ❑(3) Not applicable

4) How experienced were you using computers?

not at all experienced		OK		Very experienced
1	2	3	4	5

If you were involved in the CAQ and/or supplemental data process, please answer the following questions:

5) How would you rate the **overall CAQ and supplemental data collection process**? *(Circle a number on the scale below)*

	Not at All Well		OK		Very Well	
Paper-based Version	1	2	3	4	5	N/A
Handheld Version	1	2	3	4	5	N/A
Computer Kiosk Version	1	2	3	4	5	N/A

Please provide comments below:

6) How would you rate the **process for determining client risk level** based on CAQ responses? *(Circle a number on the scale below)*

	Not at All Well		OK		Very Well	
Paper-based Version	1	2	3	4	5	N/A
Handheld Version	1	2	3	4	5	N/A
Computer Kiosk Version	1	2	3	4	5	N/A

Please provide comments below:

7) Of all the clients you saw, about what percentage **needed help completing the CAQ**?

Paper Version: _____%

Handheld Version: _____%

Computer Kiosk Version: _____%

Please describe the kinds of questions clients had about completing the CAQ:

8) How hard was it for you to **answer client's questions about the CAQ**? *(Circle a number on the scale below)*

	Not at All Hard		OK		Very Hard	
Paper-based Version	1	2	3	4	5	N/A
Handheld Version	1	2	3	4	5	N/A
Computer Kiosk Version	1	2	3	4	5	N/A

Please provide comments below:

9) Of all the clients you saw, about what percentage **needed help using the handhelds or kiosks**?

Handhelds: _____%

Computer Kiosks: _____%

Please describe the kinds of questions clients had about using handhelds or kiosks:

10) How hard was it for you to **answer client's questions about using the handhelds or kiosks**? *(Circle a number on the scale below)*

	Not at All Hard		OK		Very Hard	
Paper-based Version	1	2	3	4	5	N/A
Handheld Version	1	2	3	4	5	N/A
Computer Kiosk Version	1	2	3	4	5	N/A

Please provide comments below:

11) How would you rate the **process overall for determining client eligibility to opt-out of counseling**? *(circle a number on the scale below)*

not at all well		OK		Very well	N/A
1	2	3	4	5	6

❑(0) I did not do this activity

Please provide comments below:

12) How would you rate **client reaction to being offered the option to skip counseling**? *(Circle a number on the scale below)*

Mostly Negative		OK		Mostly Positive	N/A
1	2	3	4	5	6

Please provide comments below:

13) How would you rate **the impact of not collecting risk data during counseling on the quality of the intervention**? *(Circle a number on the scale below)*

Mostly Negative		OK		Mostly Positive	N/A
1	2	3	4	5	6

Please provide comments below:

14) If you have anything else you would like to tell us about the pilot, the training, or your experience providing services to clients, please write it in below:

Thank you!