Connecting with Hard-to-Reach Clients
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For a variety of reasons, many people who are at risk for HIV disease do not seek HIV testing. Connecting with these hard-to-reach individuals has always been a challenge.

In response, outreach programs that provide education, HIV counseling and testing, and related services outside typical HIV counseling and testing settings are invaluable. They can provide a bridge to clients, making HIV testing a less mysterious and less forbidding process, the concept of HIV more personally relevant, and the possibility of being infected less shameful.

This issue of the FOCUS Supplement examines the role of outreach in HIV counseling and testing programs and the difficulties and opportunities it presents. A separate case example illustrates the experience of a client in an outreach counseling and testing session.

At Risk and Not Getting Services

There are many reasons people may be at risk for infection but not be served by traditional HIV counseling and testing programs. Some people who want to test would never walk through the doors of an HIV agency, a sexually transmitted disease (STD) clinic, or a substance abuse program—places where counseling and testing services typically exist but which are not part of the daily experience of most people. For many people, finding a telephone to call a testing service and ensuring the privacy of that call can be onerous. For others, the thought of talking about personal behaviors such as sex or alcohol or drug use is inconceivable.

People who have considered testing may feel discouraged because of uncertainty about the confidentiality of testing services, the meaning of a positive result, or the services available if they test seropositive. In rural areas, testing may be particularly forbidding if it is available only at a single physician’s office or at a small satellite facility of the county health department: a client may encounter a neighbor, friend, relative, or business associate.

Because of societal stigmas that still adhere to HIV and its risk behaviors, many potential clients remain hidden. For instance, for some men who have sex with men but do not identify as gay, acknowledging or even admitting that they engage in risk behaviors requires overcoming shame. Other clients who feel the need to keep sexuality or substance use a secret will be unlikely to acknowledge and disclose risk behaviors.

By meeting clients where they are most comfortable, outreach can mitigate these obstacles. Counseling and testing outreach programs take many forms, including venue-based education and counseling, where providers may make referrals to testing services, and mobile testing programs where providers actually perform HIV counseling and testing.

Street and Community Outreach

Street and community—or venue-based—outreach entails a one-on-one interaction between an outreach worker and a client. Ideally, a pair or small team of outreach workers work within the same venue at the same time. Outreach may occur in a variety of locations, including in homes, dance clubs, churches, temples, synagogues, schools, sporting events, gyms, county fairs, sex-video stores, sex clubs, the street, and substance abuse residential treatment facilities. Interaction with clients may include distribution of prevention materials such as condoms; assessment of a client’s needs; behavioral risk assessments; health education and risk reduction information; and referrals and
dialogue about a client’s HIV-related concerns. Venue-based outreach may involve one-time interventions or be part of a long-term relationship between counseling and testing programs and at-risk communities. Venue-based outreach is most effective when it is consistent, continuous, and performed by someone who is a member of the targeted community. This last factor is particularly important in developing trust, and can occur whether an outreach worker has lived and worked in the community or received extensive training regarding a particular community. Over the length of this consistent interaction, clients come to understand that even though they may not be ready to talk in their first, second, or third contact with an outreach worker, they will have another chance.

Creating such a presence in the community is a powerful prevention tool. When counselors and service providers deliver services to clients, clients receive the message that they are important enough for the providers to reach out to them. For many clients, this may be the first time someone else has done something that communicates to them that they and their health are valued. Venue-based outreach also offers clients who test seronegative the chance to assess their behaviors and, possibly for the first time, talk with someone about behavior change plans, harm reduction strategies, alcohol and other drug use, and issues of sexuality.

Mobile Testing
Mobile testing, which has grown in popularity in recent years, makes HIV counseling and testing services particularly visible and accessible by bringing them directly into the communities hardest hit by the epidemic. The UCSF AIDS Health Project (AHP), which has conducted counseling and testing services for the city and county of San Francisco since HIV testing began in 1985, conducted its first mobile testing event in 1990 at the Castro Street Fair, a large neighborhood event at the geographical center of the city’s lesbian, gay, and bisexual community. AHP tested 240 clients at that event and has run a mobile testing site at that fair each year since. AHP’s mobile testing program also provides counseling and testing services at a minimum of five other community events each year.

Mobile testing is particularly effective if it is implemented consistently at annual events, offering time savings and other efficiencies for administrators and a sense of reliability and trust for clients. Some clients report that they test each year at street fairs and at no other site.

The counseling and testing process at mobile sites is similar to that at fixed sites. The site itself ranges in size from 300 square feet—three times the size of a typical street-fair booth space—to 1,000 square feet. Clients are seen on a first-come, first-served basis. Ideally, the number of counselors should exceed the number of counseling spaces, giving individual counselors time between clients to finish paperwork or obtain supervision. If phlebotomists are drawing blood, a single booth space should accommodate two phlebotomists. This allows greater booth space for counseling and ensures phlebotomists are in close proximity to assist each other, for example, should a client faint. Staff schedule clients for appointments to receive their results at fixed sites, using appointment cards to note location, day, and time, and a telephone number to the HIV counseling and testing program in case clients have questions or need to change their appointment.

A variation on this theme is mobile testing on the street in mobile vans. Mobile vans provide space for HIV counseling and testing at night in high-risk communities, for example, outside dance clubs or in public parks, or on streets, for instance, where sex workers commonly congregate. Mobile vans can also be set-up outside health fairs, near street fairs, and at community college events, rodeos, and county fairs.

Other mobile testing approaches include counseling and testing within the offices of agencies that provide other health care services, including HIV-related services. An outside HIV counseling and testing program can offer the clients of the host agency risk assessment and testing and schedule disclosure sessions at the same site or at one of the HIV counseling and testing program’s stationary sites. In this scenario, the host agency would not have access to a client’s test result unless the client chose to disclose the result and request this in writing. This model of mobile testing is particularly valuable because it offers host programs high quality counseling and testing and offers clients direct linkage to services such as HIV treatment, family planning, employment training, or substance abuse treatment.
Outreach and Testing Made Easier

New technologies in HIV testing have improved the ability to make HIV testing a part of outreach programs. For example, oral HIV testing—which does not require drawing blood—enables counseling and testing programs to enlist the help of smaller agencies, who can reach out to their clients, collect specimens, and provide test results without trained phlebotomists.

Oral testing was introduced in 1996 with the OraSure HIV-1 oral specimen collection device.* The OraSure test detects HIV antibodies by inserting a pad in the mouth, which then draws in fluid from the lining of the lower gum between the teeth and cheek. As with blood samples, this fluid undergoes analysis using ELISA, IFA, and Western Blot assay. Studies have shown the OraSure test to be 99.9 percent accurate, a similar rate to that achieved with blood specimens.

OraSure, which is not sold over-the-counter, is intended for use in physicians’ offices, private testing sites, public health departments, community-based health services, and AIDS service organizations. OraSure offers several benefits: prior to laboratory testing, specimens can be stored for 21 days without refrigeration; a person performing the test need not be a phlebotomist, and local health departments can train and certify test counselors to obtain the specimen; and the test itself, once the pad is placed between the cheek and gum, takes less than five minutes. The waiting period for results varies among laboratories, but it is usually the same as that for the blood collection method. The OraSure testing kit is more expensive than traditional blood draw testing, but OraSure achieves cost savings by reducing the amount of medical supplies and labor required. It is also safer for test-site staff and clients since it does not involve a needle.

Outreach Challenges

Outreach and mobile testing efforts present many systems and counseling challenges. These relate to cost, time, space, staffing, anonymity, return rates, peer pressure, and drug and alcohol use.

Setting up mobile sites is expensive. Space rental at street fairs typically ranges from $75 to $150 per space, and the rental and delivery of a physical booth can cost as much as $150. Staffing can be difficult because outreach is often done at night and on weekends. Staff safety is also a concern, especially when services are provided at night in public spaces.

While the provision of counseling and testing services in a public venue delivers services directly to clients, clients may experience anxiety regarding anonymity. At street fairs, the chance a client will see someone he or she knows increases. This increases the possibility that a client will be associated with HIV disease by others in his or her community and stigmatized for this association.

Clients who receive risk assessment counseling and either a blood draw or an oral test at a mobile site may need to return to a different site to receive their results. Providers need to plan ahead and know where their clients will be sent for results. In some ways, the requirement that clients receive results at a site separate from the original mobile site contradicts the purpose of the mobile site: to reach clients “where they are.” But, this approach does provide a bridge for clients to come to host agencies or other agencies that provide more comprehensive prevention or care support services.

Return rates for mobile sites are lower than at stationary sites. Reasons for this include the fact that clients may need to go elsewhere to receive results, or that clients who are visiting an area may get tested at a street fair but not be able to return to the area for results. At the time they test, these clients may believe they will return for their results, but then have second thoughts when the time arrives for them to do so. Similarly, clients testing at residential substance abuse treatment facilities or homeless shelters may no longer be at these sites when disclosure is scheduled to occur.

Finally, clients testing at venues such as sex clubs often are testing because they feel responsible and health conscious at the time they first come in contact with counseling and testing services, only to feel distant from this experience when it is time to receive their results. In addition, clients may be with friends or peers who are testing and may take the test because “everyone else is.” In fact, such clients may not have made a truly informed decision to test, and often will not return for results.

Conclusion

By being aware of the different types of possible outreach, all counselors, whether or not they are in outreach settings, can develop a greater understanding of the process by which clients “get” to the test site. This awareness can prompt useful discussions with clients about these difficulties and lead to a greater likelihood that clients will return for results. By discussing various issues such as sexuality, perception of risk, lack of autonomy in a

*OraSure is manufactured by SmithKline Beecham Consumer Healthcare.

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community, and lack of peer support, counselors can help facilitate the first steps clients need to take to explore the factors that contribute to their HIV risk. In addition, outreach efforts enable providers to create a natural bridge between a client’s personal life and the support that is available to help the client take care of him or herself. Situating HIV counseling and testing in the lives of clients often helps them begin to address the perception that they are “far away” from HIV risk when it is often quite close.

Mobile Testing in Action

Mike is a counselor at a mobile test site that has been set up in collaboration with a local community college’s Health Awareness Fair. Jesse, a 20-year-old Latino man, walks up to the testing booth with several friends—men and women between 18 and 23 years old who are laughing and appear to be enjoying the event.

Mike notices that they all stop in front of the counseling and testing booth and talk among themselves, then they all decide to test. As Mike brings Jesse into the private counseling area, Jesse remarks to his friends that “There’s no reason for me to do this, but hey why not.” When counseling begins, Jesse asks where private the booths are and what will happen to the information he discloses during the session. Mike explains anonymity and confidentiality regulations and procedures. Jesse repeats to Mike that he does not need to test but that because everyone else has tested, he might as well. Jesse does not look directly at Mike and seems preoccupied with ensuring that the booth is private and that people cannot see into it.

Peer Pressure

Mike may take a few different approaches with Jesse, depending on Jesse’s response. Mike acknowledges to Jesse that this type of counseling and testing site is different from a normal clinic setting. Mike also follows up on Jesse’s assertion that he need not test, wondering out loud whether Jesse can say more about why he is testing. Mike also says that he noticed Jesse had come to the site with a group of people and asks Jesse if possibly he felt pressured to test by his friends.

Jesse acknowledges sheepishly that he did feel a little pressure, and whispers that his friends assumed that Jesse was as sexually active as they were and therefore would want to test. Jesse has been too embarrassed to say that he doesn't sleep around that much, telling his friends only that he doesn’t need to test because he sleeps with “safe” people; he’s also experienced a little with bisexuality and is terrified that his friends will find out.

After a little more probing by Mike, Jesse admits that, nonetheless, he has been wanting to test for some time, but not with this group of friends nearby. He says he is concerned that they will hear him or see his risk assessment information. Mike reinforces that the discussion is confidential, and also asks Jesse if he would feel more comfortable coming to a different site and seeing him at a different time. Jesse asks for the location of other sites, and the hours these are open, and says he’d like to go to a site where Mike works. He says he is concerned about his availability to test because he has a job with irregular hours. Mike gives Jesse the information, acknowledges that Jesse does want to test, and validates Jesse's concerns about privacy with his friends so close to the process.

Mike explains that Jesse can test at one of the other test site locations and they can exit the booth today just as if Jesse had tested. In this way, Jesse has not lost face with his friends and has gained information as to where he can comfortably and safely test and discuss his concerns. Jesse agrees to this plan. Mike asks Jesse if he would like any other referral numbers before he gets to the clinic site, or any other information until then. Jesse says he does not need anything and they exit the booth.

Mobile Testing as One Step

Mike gave Jesse some important support in this session. He acknowledged that Jesse did want to test for his own reasons and also wanted to show his friends that he was being “responsible” and testing just as they were. He also acknowledged that Jesse felt uncomfortable with this type of mobile site and that a different site would feel safer for him. Mike has made a connection with Jesse that can now continue at a stationary clinic site.

The mobile site in this case served the purpose of going into a community and attracting people there who would not normally test. For Jesse, this was a beginning step in his understanding of his personal risks for HIV and of resources that might help him obtain other services and support. Even though Jesse did not test at this site, this interaction would not have occurred had the site not come to the community college that Jesse attended.
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