Research Update

According to recent data from an ongoing national random telephone survey of health-related information, the proportion of the population who reported ever being tested for HIV increased from 38 percent in 1994 to 48 percent in 2000, and voluntary HIV testing in the prior 12 months increased from 21 percent in 1994 to 23 percent in 2000.1 However, recent research also suggests that about one-third of the 650,000 to 900,000 people living with HIV in the United States do not know they are infected. Factors that may inhibit HIV testing include transportation challenges, scheduling difficulties, lengthy waiting times for appointments, lack of primary health care, lack of case management, having different pre-test and post-test counselors, language barriers, poverty, homelessness, substance use, and HIV stigma.2

According to data from the Centers for Disease Control and Prevention (CDC), the distribution of HIV tests at various publicly funded sites in 1998 was 27.4 percent at STD clinics, 24.2 percent at HIV counseling and testing sites, 11.8 percent at family planning clinics, 9 percent at other health departments (community health clinics, public health clinics, or other health department sites), 7.7 percent at prenatal/obstetric clinics, 5.6 percent at drug treatment facilities, 5.6 percent in correctional facilities, 1 percent at private medical offices or clinics, 0.9 percent in TB clinics, and 6.5 percent at other sites.3

Client Testing Preferences

Researchers in a San Francisco study surveyed client preference for testing venues among several choices. The study found that 63 percent of 354 clients of public testing services chose a public clinic test as their first choice, 24 percent chose a home self-test, 12 percent chose a physician’s office, and 1 percent chose a home specimen collection test. (A home specimen collection test requires mailing the sample to a laboratory for analysis without mailing a sample to a laboratory.)4 Gay and bisexual men were the most likely to choose a public clinic test as their first choice. Non-White respondents, those with lower incomes, and those without health insurance were more likely to test at a physician’s office than were respondents who were White, had higher incomes, or had health insurance. This suggests that some respondents who were least able to afford a test at a physician’s office were more likely to prefer it than those who can afford it.4 The study also evaluated the reasons for client preferences. Eighty-
seven percent of respondents who preferred a public clinic test did so because of anonymity, confidentiality, privacy, or the lack of cost. Fifty-two percent of those who preferred a physician’s test cited accuracy, reliability, trust, or safety as a reason, while 45 percent mentioned professionalism and familiarity. Among those who preferred the home self-test, 92 percent mentioned instant results or convenience as the reason, and 45 percent mentioned anonymity, confidentiality, and privacy.4

A Seattle study examined HIV counseling and testing preferences and barriers to testing among 100 gay and bisexual bathhouse patrons, injection drug-using clients of a needle exchange program, and clients at a public STD clinic. A large number of respondents across all three subsamples reported waiting times for test results and for scheduled appointments as barriers to testing. Participants also mentioned the process of drawing blood as a barrier to testing, especially among injection drug users, for whom it may be difficult to access veins.5

Most participants said they would be more willing to test using a rapid HIV test with same-day results, an oral fluid test, a urine-based test, a home specimen collection kit, or a home self-test instead of the traditional blood test. Among these alternative testing methods, only the home specimen collection kit was widely known among participants.5

The study also assessed factors that participants thought would facilitate HIV testing. Men who have sex with men and injection drug users considered pretest counseling to be repetitive, unnecessary, and in need of new messages. Some injection drug users said they were hesitant to discuss their risk behaviors with counselors, while some STD clinic clients said they appreciated counseling as an opportunity to review their risks. A convenient testing location and a respectful testing environment were also important for participants.5

Anonymous and Confidential

Publicly funded anonymous and confidential counseling and testing sites are similar in that they both tend to follow the guidelines of client-centered counseling, and clients’ identities and test results are not recorded in their primary care medical or insurance files. Confidential sites keep a record of client names, however, allowing for follow-up visits and case management that may integrate HIV testing with other services. In some states anonymous testing is not available because of laws requiring all HIV-positive test results to be reported by name to the state’s department of health in order to track the epidemic. In a Swiss study comparing the clientele of an anonymous test site with an HIV-tested sample from the general population, the anonymous test site sample had higher proportions of younger and single people who were more likely to have had a new sex partner during the prior year. Although the study found that the decision to test came mainly from personal initiative, suggestion from a physician was more frequent in the general population sample while suggestion from a partner or friend was more common among anonymous test site clients.6

A Cleveland study of 285 adolescents who consented to anonymous HIV testing in an urban clinic found that only 42 percent returned for their test results. The researchers suggest that confidential HIV testing may be more effective than anonymous testing in settings in which return rates are low because it allows for follow-up with clients.7

Counseling Efficacy

Counseling is an integral part of HIV testing in publicly funded anonymous and confidential test sites. A large, five-city study found that brief, two-session counseling interventions, like the ones used in client-centered HIV test counseling, were as effective as longer, four-session counseling interventions at preventing STD infection and more effective than interventions at STD clinics that provided information about HIV and other STD prevention without counseling. The study compared three types of interventions: enhanced counseling, consisting of an introductory 20-minute session and three 60-minute sessions; brief counseling, consisting of two 20-minute sessions modeled after the Centers for Disease Control and Prevention’s (CDC) guidelines for HIV test counseling; and a didactic intervention, consisting of two five-minute sessions that provided prevention information and an opportunity to ask questions.8

Brief counseling interventions resulted in an overall reduction in STD infection of 30 percent after six months and 20 percent after 12 months. At the six-month follow-up, 7 percent of each counseling group had new STD infections, compared with 10 percent of the didactic group. At the 12-month follow-up, 12 percent of each counseling group had new STD infections, compared with 15 percent of the didactic group.8

Physicians’ Offices

A major difference between testing for HIV at a publicly funded site and at a physician’s office is that physicians do not routinely provide client-centered counseling with testing. Research suggests that many physicians are also not effective at assessing patient risk behavior. A 1996 study found that most physicians do not screen their patients for HIV risk behaviors.9 A 1997 study found that physicians initiated HIV screening with 60 percent of at-risk patients and identified an average of only 49 percent of risk behaviors.10
A small 1998 study found that physicians did not elicit enough information to accurately assess a patient’s HIV risk in 73 percent of encounters. Physicians often did not give patients the opportunity to express their concerns. Some physicians reported that feelings of ineffectiveness and strong emotions interfered with their ability to assess HIV risk. However, when reviewing their interactions on videotape, physicians easily recognized the problems in their communication.11

Effective interaction also uncovers the context of risk behavior, acknowledges prior attempts to reduce risk, and assesses motivation to change.12 In effective HIV-related discussions, physicians elicit their patients’ beliefs and concerns first, are organized, use empathy, provide a reason for the discussion, persist through awkward moments, and clarify vague language. Effective interaction also uncovers the context of risk behavior, acknowledges prior attempts to reduce risk, and assesses motivation to change.12

Although half of new HIV infections in the United States occur among people younger than 25, most health care providers report that they do not routinely offer HIV counseling and testing to sexually active young people. According to preliminary findings of a qualitative study using in-depth interviews with more than 50 health care providers and administrators in the Bronx, New York, the greatest barriers to HIV testing by providers include: viewing the process of acquiring informed consent and providing HIV counseling as going beyond routine procedure and taking too much time in a clinical setting; the belief that they lack the training or experience for effective counseling; and relying too much on young people self-reporting their risks, while believing that there is a low incidence of HIV among young people. These findings suggest that it is often not patient refusal but provider concerns that inhibit the routine offering of HIV counseling and testing to young people.13

Prenatal Care

Increased HIV testing of pregnant women and the use of antiviral medications to prevent mother-to-child transmission has reduced the number of infants born with HIV in the United States by 80 percent between 1991 and 2000, according to a recent analysis, leading to a groundswell of support for voluntary HIV testing for pregnant women.

A study of 1,362 women receiving prenatal care at seven hospitals in four U.S. cities found that 88 percent had received information about HIV and HIV testing and that 70 percent tested for HIV during a prenatal care visit. Women who perceived that providers strongly recommended HIV testing were 2.2 times more likely to test than those who perceived that providers did not recommend testing.15

A California study found lower rates of HIV education among prenatal care recipients. In a study assessing compliance with a state law that requires providers to offer HIV counseling and testing to all women receiving prenatal care, only 47 percent of women surveyed reported receiving counseling, and only 74 percent reported being offered an HIV test. Among those who were offered HIV testing, 90 percent accepted. The study also found that prenatal care providers reported much higher rates of offering HIV counseling and testing to clients: according to a separate survey of 135 providers, more than 90 percent of clients received counseling in 96 percent of practices, and 92 percent of clients were offered testing.16

A study of prenatal clinics and their clients in four California counties found similar discrepancies between prenatal care clients and providers. Eighty percent of women reported being offered an HIV test during a prenatal visit, but only 56 percent reported being told about the risks and benefits of taking an HIV test. At the same time, 98 percent of providers reported offering HIV tests to clients, and 77 percent reported offering counseling to every client. Only one-third of women reported knowing that treatment exists for reducing the risk of prenatal HIV transmission, and 79 percent said they would be more likely to test if they knew about such treatments.17

Substance Abuse Treatment

Offering HIV testing at inpatient substance abuse treatment centers is a controversial topic largely because of the belief that people receiving substance abuse treatment lack the coping skills and social support to receive the difficult news of an HIV-positive diagnosis. However, it may be argued that the availability of effective HIV treatments makes it important to test people at risk for HIV.18

According to a study of state-funded inpatient drug detoxification facilities in New England, 45 percent of facilities in the region did not routinely offer on-site HIV testing to clients, while 97 percent of clients agreed that HIV testing should be available to them. Eighty-nine percent of clients reported that they would cope “about the same” or “better” with an HIV-positive test result while in treatment compared with elsewhere. Reasons given by treatment centers for not offering HIV testing included the brief length of treatment, the lack of testing facilities, the lack of follow-up for test results when HIV testing was offered in the past, and the inability of clients to cope with an HIV test during treatment.18

In a Philadelphia study of return rates for HIV test results among 489 participants drawn from methadone maintenance, detoxification, and
syringe exchange programs, 57 percent of participants who used home-collection test kits obtained test results compared with 45 percent of those who tested at traditional clinics.19

Outreach

In some areas, particularly those with populations at high risk for HIV infection, outreach workers provide HIV counseling and testing and other prevention services. HIV outreach work differs from other testing venues in that the workers bring the HIV testing services to the clients. According to a 1998 review of studies, most research suggests that outreach-based HIV prevention is effective at reducing drug-related and sex-related risk behaviors among injection drug users using clients. Injection drug users regularly reported significant reductions in drug injection, sharing of needles and other injection equipment, and crack use. Research also indicates that outreach interventions promote entry into drug treatment programs. Outreach was also effective at increasing rates of condom use, but most injection drug users still practiced unprotected sex.20

A study of the Neighborhood Interventions Geared to High-risk Testing (NIGHT) program in California, a statewide HIV outreach program targeting high-risk populations, found that in 2000 and 2001, the HIV tests referred by NIGHT accounted for 18 percent of all HIV tests administered in participating areas, an increase from 11 percent in 1997 and 1998. The study concluded that street outreach is particularly effective in increasing HIV testing among drug users, sex workers, and high-risk African Americans.21

Rural Areas

An estimated 7 percent of U.S. AIDS cases occur in rural areas, but the actual number may be higher because rural residents are less likely to test for HIV than people in urban areas. It is common for rural residents to believe that HIV is an urban problem from which their communities are immune. HIV tends to be more highly stigmatized in rural communities than in urban areas, and religious traditions that prohibit condom use, sex education, and honest discussions about sex may play a more influential role.22

Rural HIV rates are often related to the number of residents who travel to urban areas and engage in sexual activity while there. Research also suggests that many people who were born in rural areas and seroconvert after relocating return to their native communities after testing HIV-positive. In addition, overall rates of substance abuse are approximately the same in rural and urban states.23

In a study comparing HIV risk perceptions and practices of 571 low-income African American women living in rural areas with those living in urban areas, rural women were more likely to report not receiving HIV counseling during pregnancy and having a sex partner who had not tested for HIV. Rural women were also more likely to report not using condoms, having no preferred method of HIV prevention because they did not worry about STD infection, and believing that their sex partners were HIV-negative, despite their lack of testing.24

Related Issue: Rapid Testing

In May 2002, OraSure Technologies Inc. received conditional approval from the U.S. Food and Drug Administration (FDA) for its OraQuick Rapid HIV antibody test. The rapid test is a finger stick blood test that provides results within 20 minutes. OraSure expects to receive final approval by the end of 2002. No other rapid test has received FDA approval.25 A recent study found that most current rapid HIV tests detected HIV infection as reliably as standard EIA tests and provided results in 20 minutes or less.26

According to preliminary results of a large study comparing rapid HIV tests, which provided one counseling session, with standard HIV testing, which provided a risk assessment and result disclosure counseling session, more than 95 percent of the rapid test group received their test results, compared with 68 percent of the standard test group. However, there were 22 percent more new STD infections in the rapid test group six months after testing and 12 percent more STD infections 12 months after testing, suggesting that the standard two-visit counseling protocol is more effective at reducing STD risk behavior than one-visit rapid tests.27

A Minneapolis study of various outreach settings found that a greater percentage of African American clients learned their HIV test results with the single use diagnostic system (SUDS) rapid urine test (99.9 percent) than with the OraSure oral mucosal transudate test (82.2 percent). However, the convenience of OraSure was more acceptable to clients. The number of clients tested per month increased from 50 with SUDS to 77 with OraSure, and the cost per person learning their results was $66.56 with SUDS, compared with $47.48 with OraSure. The study results suggest that a rapid HIV test that collects an oral sample would be the most cost-effective way to maximize the number of people who test for HIV and learn their results.28
Implications for Counseling

There are many different settings for HIV antibody testing, and each testing venue has its own unique circumstances, features, and challenges. Confidential test sites keep records of client name and contact information. At locations that provide anonymous testing with counseling, it is impossible to follow-up with clients who do not return for their test results because they do not provide any identifying information. Outreach or mobile testing brings HIV counseling and testing to targeted populations via settings such as street fairs, needle exchange sites, and sex clubs. Some testing locations, including medical offices, provide HIV testing but do not routinely offer risk assessment or disclosure counseling.

Anonymous and Confidential Testing

After the first HIV antibody test was licensed to screen the nation’s blood supply in 1985, free and anonymous HIV testing was quickly established at alternative test sites (ATS) because of concerns that people would flock to blood donation centers as a way to test for HIV. Part of the reason it was important to divert people from testing at blood banks was fear that the window period of infection would result in an increased number of cases of HIV infection related to blood transfusions. It was also this fear that led to the establishment of the counseling and testing protocol, which provided an opportunity to educate clients about the window period and other HIV prevention information. This marked the first time a medical test became available outside of a medical setting, implemented instead by trained counselors and health educators. It also differed from the established model of sexually transmitted disease (STD) surveillance, which required clients to provide their names, personal contact information, and contact information of sex partners who might have been exposed. One obstacle to HIV testing that anonymous testing relieved was fear that insurance companies or the government would obtain client names, potentially leading to discrimination based on HIV infection status.

Some people are still concerned about government access to the names of people who test HIV-positive, but the main goal of collecting such data is tracking information about HIV to anticipate trends in the epidemic and to allocate resources. In an effort to preserve anonymity, some states gather information about HIV infection trends by using unique client identifier codes rather than identify clients by name. California recently adopted such a policy.

Confidential counseling and testing sites gather information about each client and record it with the client’s name, which makes it possible to follow-up with clients if they do not return for test results; anonymous sites gather and record client information without identifying the client. Agencies that provide HIV testing in addition to other services tend to be confidential sites because this allows them to maintain ongoing relationships with clients and allows counselors to direct clients to other services in the agency. This is especially useful for high-risk clients and clients testing HIV-positive. Confidential testing is also more appropriate for clients who want a record of their test results, which they may need, for example, for immigration purposes, to show sex partners, or to obtain services if they test HIV-positive.

Anonymous testing provides only verbal test results. An advantage for counselors is that anonymous testing requires relatively little paperwork that may take time away from the already short counseling session. An advantage for some clients is that they may feel more comfortable divulging personal information about risks such as injection drug use, anal sex, or hiring sex workers if they can do so anonymously.

Some testing venues are more appropriate for either anonymous or confidential testing. For example, HIV testing in a sex club or at a needle exchange site is more compatible with anonymous testing. Medical clinics or hospitals may be more suited for confidential testing where clients may be directed into ancillary programs and where counselors may have access to office space and other resources for completing paperwork.

Urban and Rural Settings

One of the challenges for HIV test counselors in rural areas is the potential threat to anonymity or confidentiality because of mutual familiarity among the residents of small communities. Counselors at anonymous test sites who already know

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A Counselor’s Perspective

“I’ve always thought that counseling was an essential part of the HIV testing process. I was surprised to learn that some people test with their doctor because they can get their results without having to deal with counseling.”

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A Counselor’s Perspective

“I am fortunate to have worked at both a clinic site and a mobile test site. I find the different environments and clients stimulating and fascinating.”
their clients face ethical, and possibly legal, dilemmas. If this happens, a counselor must refer the client to another counselor or test site, explaining that he or she cannot work with the client because it would compromise the client’s anonymity. This creates an ethical problem if it is the only site in the area the client can access. It is important to consult with a supervisor in these situations. Similarly, people may be reluctant to test at a site where they know the staff to avoid being identified as someone who is at risk for HIV.

In urban settings, testing in one’s own neighborhood poses a similar risk of compromising anonymity as in small rural communities because clients may know counselors. However, it is often relatively easy for clients in urban areas to travel to a different neighborhood.

Urban areas also offer clients more opportunities to work with counselors who are a better match for their own demographics. Typically, urban centers fund neighborhood agencies to provide HIV testing services targeting specific populations that are at risk for HIV, such as African American gay men or male-to-female transgendered clients. These organizations tend to employ trained peer counselors from the targeted groups. Many clients feel more comfortable talking about their sexual, needle-using, and other risk behaviors with counselors who they feel can relate to their experiences.

### Outreach and Mobile Testing

In some areas, HIV counseling and testing services are also available through street outreach workers, who usually target high-risk populations in a street setting, for example, injection drug users or sex workers.

Working in a street setting makes

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**References**


Case Study

Judy is a 24 year-old, sexually active, heterosexual woman. She tested for HIV a year ago at her physician’s office after testing positive for chlamydia. Judy says that her friend, a gay man, recently told her that he tests for HIV once a year at an anonymous test site and finds the counseling to be a helpful reminder to stay safe. Judy is now testing anonymously at a local public health clinic and says that she is beginning to think more about safer sex and testing regularly for HIV.

Counseling Intervention

Begin by framing the session for Judy by explaining what will happen in the session. Use open-ended questions to assess Judy’s knowledge of HIV, her sexual practices and partners, and her reasons for testing. Educate her, as necessary, about relevant HIV risks. If she is well informed, validate her knowledge, and ask her how she thinks she is placing herself at risk.

If Judy becomes uncomfortable, use active listening techniques and statements such as, “Many people are often uncomfortable discussing sex. I’m wondering if there is anything I can do to help you feel more comfortable.” If Judy says she was not prepared to talk in such detail about sex, follow her lead by asking what her expectations were. If her expectations were based on her experience with her physician, who did not provide counseling, explain the reasons for including HIV counseling with testing, for example, by saying, “Physicians often do not have the time or the training to provide in-depth HIV prevention counseling. By talking about sex, I can help you assess your risks and find ways to reduce them. I know this may be uncomfortable for you, but I’m wondering if it’s something you might be willing to try to talk about.”

If Judy says she is willing to try, validate her effort and let her know that she can stop the session at any time. This may give her a greater sense of control over the session and her anxiety. Check in often during the discussion to see how she is feeling. Include an explanation about how sexually transmitted diseases (STDs) can increase vulnerability to infection with HIV. Ask Judy how she thinks she contracted chlamydia. Use open-ended questions to help her explore what she realistically do to reduce her risks for HIV and other STDs. After providing appropriate referrals, ask Judy what this experience was like for her.

Other Settings

Unlike outreach environments, a typical public clinic environment looks like a small office. Clinic sites usually have receptionists who seat clients and direct them to the testing area. Sessions are private, without distractions, and generally conducive to in-depth discussions.

Private medical offices usually do not offer counseling with HIV testing. This may appeal to clients who want to test for HIV without counseling. Clients who have tested multiple times may be resistant to counseling because they may believe that they have nothing left to learn about HIV. However, client-centered counseling consists of more than information. It is an exploration of the psychological and social factors that influence risk taking as well as a discussion of feelings and thoughts about how clients perceive their risks. Counselors are trained to take this discussion further by exploring feasible steps clients can take to reduce risk.

When working with a client who is reluctant to receive counseling, a counselor may say, “I don’t want to waste your time. This won’t be a lecture, and I won’t tell you things you already know. Instead, I’d like to talk with you about what you think is going on in your life which places you and your partners at risk for HIV.”

Home specimen collection tests offer an accessible, private, and convenient way to test for HIV. Test results and counseling are provided by telephone. Although face-to-face counseling is more effective because it allows for the communication of nuance and body language, telephone counseling can also be effective with proper counselor training. One possible advantage of telephone counseling is the increased anonymity for clients when talking about their sexual and drug-using practices.
Test Yourself

Review Questions

1. Which proportion of people living with HIV in the United States do not know they are infected? a) one-tenth; b) one-quarter; c) one-third; d) one-half.

2. True or False: Confidential counseling and testing sites do not record the name of the client testing for HIV.

3. True or False: Research suggests that brief, two-session counseling interventions, like the ones used in client-centered HIV test counseling, are as effective as longer, four-session counseling interventions at preventing STD infection.

4. True or False: HIV testing at physician’s offices usually does not include counseling.

5. Increased HIV testing of pregnant women and the use of antiviral medications to prevent mother-to-child transmission has reduced the number of infants born with HIV in the United States by how much between 1991 and 2000? a) 10 percent; b) 25 percent; c) 50 percent; d) 80 percent.

6. True or False: Offering HIV testing at inpatient substance abuse treatment centers is a controversial topic largely because of the belief that people receiving substance abuse treatment lack the coping skills and social support to receive the difficult news of an HIV-positive diagnosis.

7. Research indicates that injection drug-using clients of HIV outreach interventions regularly reported significant reductions in which of the following risk behaviors? a) drug injection; b) sharing of needles and other injection equipment; c) crack use; d) all of the above.

8. True or False: Overall rates of substance abuse are approximately the same in rural and urban states.

Discussion Questions

1. What are some of the advantages and disadvantages of anonymous and confidential counseling and testing sites?

2. What are some reasons a client may choose to test for HIV at a physician’s office rather than at a confidential or anonymous site?

3. What are some of the ethical or legal issues that may arise at rural counseling and testing sites?

4. What are some of the challenges to providing mobile testing or street outreach?

5. What are some good ways to work with clients who have tested repeatedly and do not want to receive counseling?

6. What are some advantages and disadvantages of rapid HIV testing?

Answers

1. c.
2. False. Confidential counseling and testing sites keep records with client names, but these records are kept confidential within the agency.
3. True.
4. True.
5. d.
6. True.
7. d.
8. True

Using PERSPECTIVES

PERSPECTIVES is an educational resource for HIV test counselors and other health professionals. Each issue explores a single topic. A Research Update reviews recent research related to the topic. Implications for Counseling applies the research to the counseling session. Also included are a Case Study and two sets of questions for review and discussion.

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