HIV COUNSELOR PERSPECTIVES

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HIV OUTREACH WORK

For many people at high risk for HIV infection, it is difficult to access HIV services through private doctors, hospitals, clinics, and other traditional channels. Community outreach programs that bring services to the client’s own environment have proven effective in providing these high-risk populations with appropriate health care and reducing HIV risk behavior. This issue of PERSPECTIVES profiles community health care outreach workers (CHOWs) who provide HIV counseling and testing services. The Implications for Counseling section presents counseling strategies for outreach workers.

Research Update

Some populations at high risk for HIV infection—including sex workers, runaway youth, injection drug users, and homeless people—generally have limited access to health care services and tend to be “hard-to-reach” by conventional prevention strategies. The mission of community health care outreach workers (CHOWs) is to reach these high-risk populations.

HIV outreach work encompasses a variety of services and activities outside of traditional health care settings, including counseling and testing, providing referrals to health care services, and prevention interventions. The models and methods for conducting outreach vary depending on the specific goals of individual programs, which in turn depend on the needs of the community the program intends to serve.

“Street outreach” specifically involves going into the neighborhoods of “target communities” to provide health services, HIV counseling and testing, referrals, linkage, and prevention materials. Other forms of outreach may involve giving lectures at schools or community centers. Some agencies define outreach as “community networking” or “community building” with other organizations, agencies, services, and providers.

CHOWs have unique opportunities to bring hard-to-reach clients into the continuum of health care that includes HIV counseling and testing as well as medical, psychological, legal, financial, and social services. In general, CHOWs work in the target community’s environment and seek to relate to clients and their risk behaviors in a culturally sensitive manner. Some HIV test counselors work in both traditional and outreach settings.

Reaching Hard-to-Reach Clients

Research indicates that street outreach is an effective intervention for high-risk and hard-to-reach populations partly because it enables members of these groups to access health care services. In the process, CHOWs may assist clients in confronting some of the barriers of the health care system, such as the demands of completing paperwork, limited appointment availability, and the expense of transportation to and from service sites. In addition, some staff at traditional health care facilities have limited experience working with hard-to-reach clients or may not understand...
their special needs or circumstances, including homelessness, sex work, or substance use. As a result, clients may not feel comfortable speaking candidly with physicians or nurses about personal issues, such as how they clean their needles or whether or not they use condoms with customers.4

Some members of high-risk populations may also have personal barriers to seeking or receiving care. In a qualitative study of the accessibility of HIV counseling and testing among high-risk heterosexuals—defined as injection drug users, their sexual and injecting partners, and sex workers—many participants said that fear was the primary reason they never tested for HIV. Other reasons not to test included having limited access to testing facilities and perceiving little risk for infection. Some subjects believed they could assess their own HIV status based on their partner’s test results and, therefore, had no need to test. In addition, several injection drug using participants reported being more concerned about finding their next “hit” than about how to adopt safer sex and needle-sharing practices or testing for HIV.5

Based on participant responses, researchers concluded that convenience is a major factor contributing to a person’s decision to test for HIV and that the use of mobile testing vans effectively improves access. Participants suggested increasing the number of mobile testing vans, maintaining regular schedules, and offering vouchers or other incentives for testing.5

In California, the state’s Office of AIDS funds a statewide street outreach project called Neighborhood Interventions Geared to High-Risk Testing (NIGHT). This program funds 21 local health departments to perform HIV counseling and testing outreach work in counties with the highest rates of HIV infection among injection drug users and their needle-sharing and sex partners. The chief goal of NIGHT is to encourage these populations to obtain appropriate HIV counseling, testing, and other services.6

Of the 21 NIGHT projects, 17 have mobile vans to conduct HIV counseling and testing. These vans play an important role in providing HIV services to communities with limited access to care through traditional service providers. The vans are safe, clean, private, and maintain a regular presence within target communities. Seven local health departments have large, mobile health clinic vans, and 10 others use smaller vehicles equipped with partitions, privacy drapes, sinks, tables, and two small rooms to accommodate two clients simultaneously.6

The Office of AIDS also funds outreach work through its HIV Community Prevention Section (CPS), which provides a wide range of services depending on the goals of the particular intervention and the target population. CPS outreach workers may work on a variety of projects, such as distributing prevention literature, enrolling clients in group therapy, or referring clients to substance abuse treatment services. CPS provides funding to 61 different jurisdictions, which typically consist of one or more counties. Each jurisdiction funds prevention and education outreach for between three and 30 projects through their respective local health departments.7

Related Issue: Contact and Encounter

The relationship between a community health care outreach worker (CHOW) and a client begins with a “point of contact,” a brief interaction during which the CHOW may distribute brochures or condoms and generally make his or her presence known among the client population. The primary objective of a point of contact is to establish rapport and trust with the community. An “encounter” is a longer, more substantial interaction for the purpose of increasing HIV knowledge and decreasing unsafe sex and needle-sharing. The five elements of an encounter are screening, engagement, assessment, service delivery, and follow-up.2

When screening a potential client, the CHOW attempts to determine if the person is receptive to being approached. The engagement consists of starting a conversation with the person and is followed by assessing the client’s HIV and health-related needs, strengths, and skills. To help the client meet his or her needs, service delivery ranges from providing HIV information to making an appointment at a clinic. In the follow-up phase, the CHOW reviews the client’s goals and successes or difficulties in meeting them and develops plans for implementing or maintaining behavior changes. Follow-up also includes evaluating the intervention process with the client.2
Related Issue: Three NIGHT Programs

California’s Neighborhood Interventions Geared to High-Risk Testing (NIGHT) project provides general strategies for conducting HIV outreach work, including the use of mobile testing vans and indigenous outreach staff, but health departments have the flexibility to tailor local programs to fit the individual needs of an area’s target populations. The mostly suburban community of Orange County may have different needs than the more urban populations of Long Beach or the more rural community of Eureka.

The NIGHT program in Long Beach has one mobile testing van and a staff of indigenous outreach workers. Based on data from the Geographical Information System (GIS), a computer database that tracks the geographical prevalence and incidence of sexually transmitted diseases (STDs), the outreach staff concentrates its HIV counseling, testing, and prevention efforts on specific areas with the highest risk. The program evaluates the GIS data on a monthly basis and redirects its outreach effort to meet the changing needs of the population. As incentives, the unit offers $5.00 worth of fast food coupons or movie passes to test and $15.00 cash to return for results. In 1998, the Long Beach mobile testing unit administered more than 1,200 HIV antibody tests. During the first three months of 1999, the unit provided 304 tests, and 86 percent of clients who tested returned for their results. An average of 2 percent of clients who test for HIV receive positive results.

In the rural community of Eureka, two indigenous outreach workers conduct HIV counseling and testing in the downtown area and at local shopping plazas. The program’s target population consists of injection drug users and their sex partners. In 1998, CHOWs working on foot contacted 1,164 clients and administered 104 HIV antibody tests, one of which yielded a positive result. Eureka’s Humboldt County Health Department recently received a mobile testing van for its NIGHT program, which will allow the project to extend its services up to two-and-a-half hours away from downtown Eureka. To avoid being directly associated with HIV, which may deter people from accessing services, the van will be advertised as a mobile health care van and will provide basic medical care and STD screening in addition to HIV testing and counseling. A public health nurse will accompany the two CHOWs in the van to assist with these additional services.

Unlike most other branches of NIGHT, the project in Orange County does not use vans to conduct outreach. The project’s seven CHOWs walk through the communities equipped with coolers and backpacks filled with condoms, bleach kits, test kits, and incentives to test, such as coupons for free food at local fast food restaurants. In 1998, the outreach staff of the 10-year-old program contacted 5,000 people, administered 1,478 HIV tests, distributed 18,000 condoms and 3,000 bleach kits, and provided 1,268 referrals.

Indigenous Outreach Workers

Outreach work is effective largely because of the use of “indigenous outreach workers,” who come from the communities being targeted for outreach. Indigenous outreach workers are typically former sex workers or injection drug users who are recruited by health agencies to conduct outreach work because they have a personal understanding of the target population’s beliefs, attitudes, norms, and risk behaviors. They are the “front-line interventionists” who make street contacts, disseminate prevention materials and information, and create and maintain stable connections between the community and the outreach program. HIV counseling and testing outreach services administered by local health departments in California are based on the Chicago Indigenous Leader Outreach Model. First developed and implemented by the Chicago AIDS Outreach Intervention Program, the model targets “social networks,” such as people who buy, sell, and use injection drugs together or sex workers from a specific area of a city. The Indigenous Leader Outreach Model has five main objectives: to gain access to target group members, to increase HIV awareness, to conduct individualized risk assessments, to reinforce behavior change, and to encourage members of the target population to advocate for HIV prevention within their communities.

Indigenous outreach workers have multifaceted roles as educators, counselors, and support group leaders. One researcher described the indigenous outreach worker as a combination of ethnographic field assistant and health educator. Because of close relationships with and strong understanding of target communities, indigenous outreach workers are often able to assist in research efforts while providing HIV services.

There are several advantages to using indigenous outreach workers. As former members of the communities they serve, they ensure that the outreach program is culturally competent, they can act as transla-
tors or liaisons between HIV service agencies or researchers and the target population, and they can be positive role models for clients. Indigenous outreach workers’ personal experiences with the specific risk behaviors of a target community provide them with insight, understanding, and empathy to help clients develop realistic risk-reduction strategies. In addition, they have access to the community “grapevine” of information and are able to follow-up with clients and reinforce behavior changes.3

Because outreach work often occurs in economically depressed neighborhoods with relatively high crime rates, CHOWs typically work in teams of two to ensure safety. Teams are also effective because some clients may respond better to different styles or approaches. In addition, team members can provide support for each other, and if one member decides to leave the team, clients continue to have a familiar contact with the program.3

Outreach Effectiveness

Evaluations of the Indigenous Leader Outreach Model conducted by researchers at the Chicago AIDS Outreach Intervention Program found reduced HIV risk behaviors among injection drug-using clients and their sexual partners. At the six-month follow-up of the study, 16 percent of subjects had stopped using injection drugs and 40 percent had decreased their drug use. In addition, needle sharing had decreased by 37 percent, and 57 percent of subjects reported disinfecting their needles with bleach more often than they had before the intervention. The program facilitated the entry of 25 percent of study participants into drug treatment programs. The rate of new HIV infections dropped from 5 percent in 1988 to 1 percent in 1992.3

There is also evidence that outreach work is an effective way of testing high-risk clients for HIV. In a comprehensive evaluation of HIV counseling and testing services in Wisconsin, outreach contacts were 23 percent more likely than clinic-based contacts to test positive for HIV antibodies. The study also found that, statewide, outreach services tested half of injection drug users who tested positive and 22 percent of gay and bisexual men who tested positive.10

In a national survey of staff at 37 HIV prevention projects, 28 percent of respondents rated outreach work, along with conducting small group discussions and training peer educators, as one of the three most effective prevention methods they used to reach high-risk populations. Staff members from 12 of the 37 sites identified eight factors that facilitate a successful prevention intervention, which can be particularly useful for outreach work: designing culturally relevant approaches using the appropriate language, incorporating HIV information into broader contexts, offering incentives to test and return for results, allowing for flexibility within the program’s structure to accommodate clients, promoting community acceptance and integration, repeating HIV prevention messages, providing an open forum for discussion, and inviting members of the target community to participate in the project.11

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Implications for Counseling

Because counselors who work in traditional clinic settings and community health care outreach workers (CHOWs) often have working relationships with one another, it is important for each to understand the other's work. In addition, some clients receive services from both CHOWs and traditional test counseling settings.

There are similarities and differences between counseling and testing performed in outreach environments and in traditional clinic settings. Counselors in both settings assess client risks, work with clients to reduce risks, provide referrals, and distribute condoms, lubricant, and other risk-reduction materials. Issues of trust, boundaries, confidentiality, and privacy are important in both settings, but aspects of each of these may differ, largely because the counselor-client relationship is different in each setting. While counselors in traditional settings have short-term relationships with clients who seek HIV counseling and testing services, CHOWs often establish ongoing relationships with clients, many of whom had not been actively seeking services. These relationships occur closer to the client’s living environment, and CHOWs provide a variety of services in addition to HIV counseling and testing.

Trust and Relationships

More than test counselors in any other setting, the CHOW’s ability to build trust depends on being able to relate to and work with people in specific communities. CHOWs must fully understand the values, beliefs, behaviors, and norms of these communities.

Being consistent is important in developing trust. A CHOW may have contact with a client several times before the client is willing to discuss his or her concerns, accept HIV risk reduction information or materials, or consider testing for HIV. CHOWs can facilitate this process by being consistent in their messages and by directly addressing any inconsistencies that arise. It is also important for CHOWs and their testing vans to maintain a consistent schedule.

Because outreach clients may view government and other institutions with distrust, it is sometimes important for CHOWs to avoid conveying any institutional affiliation. For instance, CHOWs who drive as part of their job should not use cars marked as being part of a city or county’s fleet of vehicles. CHOWs should avoid or limit contact with police officers because this may imply affiliation with the police, who clients may see as adversarial. Similarly, CHOWs generally should not wear photo identification badges, which convey outsider status and institutional association to clients and also make it clear to onlookers that the client is having contact with an outsider.

Incentives can be an effective way of developing trusting relationships with clients, but more importantly, they can be an effective way of convincing clients to test for HIV. Cosmetics, toiletries, hair ties, and alcohol swabs are among the items that can be used in establishing contact. Helping clients obtain food or clothes also may be part of a CHOW’s work. As incentives to test, some CHOWs provide vouchers for fast-food restaurants or supermarkets.

To encourage clients not simply to test, but to also return for results, CHOWs should provide vouchers both for risk assessment and disclosure sessions. All CHOWs within an agency should distribute incentives of the same value and in the same quantities to all clients. Otherwise, clients may wait until receiving greater incentives before testing.

Counselors in traditional settings often instruct clients who are in the window period of infection to return for testing at the end of the window period, but the transient nature of some outreach programs may not allow for this continuity. In addition, many clients who have contact with CHOWs frequently place themselves at risk for HIV, and, therefore, may always be in the window period. As a result, regular testing may be important for some clients. CHOWs should always explain where clients can go to test regularly, whether it is in outreach or traditional test site settings. Because clients may move to different areas, it is important to provide resource information cards with local or toll-free telephone numbers of agencies that can provide information about testing services. CHOWs can also help clients build skills to locate testing services, such as by consulting local telephone directories.

A Counselor’s Perspective

“When I began to do outreach work, I thought of myself as being similar to my clients in many ways, and I became too involved emotionally. With the help of my supervisor, I’m more effective in my work because I can now appropriately detach myself, and I’m better able to take care of myself.”
Confidentiality and Privacy

Conducting HIV counseling and testing in outreach settings can pose unique challenges to establishing and maintaining confidentiality and privacy. When counseling and testing occurs on streets or other public places, it is important for CHOWs to maximize privacy by trying to find or create a space to interact without being overheard or interrupted. CHOWs should make clients aware that privacy in such environments cannot be assured and assess the extent to which clients are comfortable with the level of privacy that exists.

When reasonable privacy and confidentiality is not available, CHOWs who are performing counseling and testing must offer clients the option of testing elsewhere, such as at a traditional counseling and testing site, and explore how the client feels about this. The CHOW can then escort a willing client to the test site.

Disclosure sessions raise particular challenges to confidentiality, especially when HIV test results are positive. Because HIV-positive disclosure sessions are commonly longer than HIV-negative ones, a long disclosure session—even when it occurs in a private room—may, in effect, reveal the test result.

While clients in traditional counseling and testing settings generally leave the site after receiving a result, the outreach setting, by its nature, may be a place where people congregate. This is true, for instance, when counseling and testing outreach work occurs in residential substance abuse treatment facilities where other residents know who is testing for HIV. After completing a session in such a setting, a client must also face peers who are aware that he or she has tested, and, because of the rules of the program, the client might not be able to leave this environment. If a client tests positive for HIV, his or her options may consist of either denying this result or unwillingly disclosing it. When providing outreach counseling and testing services in residential programs, CHOWs can work with program staff to provide clients with the option of temporarily leaving the facility in order to receive HIV-related support services or to receive follow-up counseling with the outreach worker.

Challenges for CHOWs

A personal connection to the community allows CHOWs to understand the community, to be accepted by it, and to share personal stories as a part of the process of establishing trust and connections with clients. But because CHOWs may have ongoing relationships with clients, they may have difficulty setting and maintaining boundaries. The investment that indigenous outreach workers often have in the well-being of communities they serve can cloud their objectivity and lead them to expect too much from clients. For example, CHOWs may begin to consider risk elimination, rather than risk reduction, to be the only viable option for clients. This can lead some outreach workers to become judgmental of client behavior or desires and to overlook the nuances of risk taking and decision making, ultimately alienating the client. In addition, CHOWs who have experiences in common with clients may fail to recognize that there are

A Counselor’s Perspective

“I’ve found that the key to developing relationships in outreach settings is patience. It is a process that occurs over time.”

References

also differences and incorrectly believe that they fully understand all of a client’s issues and concerns. Because of the array of challenges CHOWs face, including the fact that they may have limited contact with other outreach workers, supervision and structured contact with other staff members is important. In supervision, CHOWs can explore how their work affects them professionally and personally, including possibilities of burnout and recidivism. Indigenous outreach workers are at increased risk for returning to previous risk behaviors, such as substance abuse and sex work, especially when encountering peers and environments in which they previously engaged in these behaviors. It is also important for supervisors to discuss safety strategies with CHOWs, including regularly notifying other staff of their whereabouts, avoiding entering new areas alone, and making themselves and their purpose known to local law enforcement officials so their presence is not seen as suspicious. To understand outreach work, supervisors should occasionally accompany CHOWs into the field.

**Mutual Understanding**

The links between traditional clinic settings and outreach programs are crucial. It is especially important for outreach services that do not include testing to link clients to HIV test sites.

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**Case Study**

*Michael is a 26-year-old substance user who has never taken an HIV test. Carla is an outreach worker who has talked with Michael several times at a street corner where Michael often “hangs out.” Over the course of several informal conversations, Michael has told Carla that he has a history of injection drug use, and he has repeatedly told her not to tell anybody about anything he discusses with her. Michael states that he would like to take an HIV test, but he is afraid to do so. After explaining that testing is available in a van parked nearby, Carla leads Michael to the van for a counseling and testing session. After entering the van, Carla begins to record information about Michael on a risk assessment form. Michael expresses concern about the confidentiality of the session, because of the form and the fact that Carla knows some of the same people that Michael knows. Carla begins by explaining that a test counseling session is confidential and that its purpose is for her to learn more about his risks as well as for him to ask questions about HIV risks or the testing process. Carla explains that although she may know some of the same people that Michael knows, she will not disclose to anyone the content of their discussion, the fact that he tested, or even that they have ever talked.

Carla acknowledges Michael’s previous concerns about anyone else finding out what he has disclosed to her and asks him how he feels about this and the idea of discussing his risks further. Michael says he feels reasonably comfortable, but he emphasizes the importance of Carla respecting his privacy about two issues in particular: that he once injected drugs and that he is testing for HIV. She reassures him that she will not tell anyone, affirms the value he places on confidentiality, and asks him if there are any particular reasons he singled out those two points. “Because I don’t want my girlfriend to know that I ever used,” Michael answers, “and I don’t want anybody to use it against me.” Carla explains that she is asking questions only to better understand his risk behavior in order to help him reduce his HIV risks.

Carla and Michael continue by discussing his risk behaviors. He says that he engages in unprotected sex with his girlfriend and that he is aware of the risk for HIV transmission. Carla and Michael explore his willingness to consider changing his risk behaviors. Michael promises not to have sex with his girlfriend until he receives his test result, and Carla commends him on his commitment, but she explores with him how realistic it is.

Carla sets an appointment with Michael for his disclosure session. She also tells Michael her schedule in the neighborhood, and they agree to discuss his risks further in the future. She concludes the session by again emphasizing its confidentiality.

Counselors in traditional clinic settings should assess if clients who have limited access to health care services are interested in receiving outreach services. A client may not be familiar with the term “outreach worker,” but he or she may know CHOWs as “friends” who work for a particular agency, or as “people who give me supplies,” which may include condoms or clean needles in exchange for used needles. When these relationships do not exist, test counselors can offer referrals to agencies that provide outreach services. Counselors should contact agencies to learn about their outreach services and how clients can be linked to these services.*
Test Yourself

Review Questions

1. CHOWs target which of the following high risk, hard-to-reach populations? a) sex workers; b) injection drug users; c) homeless people; d) all of the above.

2. True or False: Research suggests that using indigenous outreach workers, who are former members of target communities, is a successful strategy for providing HIV counseling and testing to hard-to-reach populations.

3. True or False: HIV outreach work is intended to serve low-risk clients who receive comprehensive health care services.

4. True or False: In outreach work, an “encounter” is the same thing as a “point of contact.”

5. True or False: The use of mobile testing vans is an effective way of eliminating most access barriers to health care for populations at risk.

6. True or False: All local health departments that participate in the NIGHT street outreach project use the same methods despite their individual needs.

7. Which of the following are advantages to using indigenous outreach staff? a) they ensure that the outreach program is culturally sensitive; b) they have access to the community “grapevine” of information; c) they have first hand experience with the risk behaviors of the target population; d) all of the above.

8. True or False: Some staff at traditional health care facilities have limited experience working with hard-to-reach clients or may not understand their special needs or circumstances.

Discussion Questions

1. What strategies can CHOWs employ to establish rapport and trust with clients?

2. How can CHOWs deal with issues of mistrust that clients may have of institutions or, conversely, of someone providing services outside the context of an institution?

3. In what ways is it important for counselors who work in traditional clinic settings and CHOWs to work together?

4. How can CHOWs set and maintain appropriate boundaries in their relationships with clients?

5. How can CHOWs maximize privacy when talking with clients in public settings?

6. How can CHOWs increase the likelihood of clients returning to receive their HIV test results?

Answers to Test Yourself

1. d.

2. True.

3. False. The goal of HIV outreach work is to serve high-risk populations who have limited access to health care services and are “hard-to-reach” by conventional prevention strategies.

4. False. A “point of contact” is the initial brief interaction between a CHOW and a client. An “encounter” is a longer, more substantial interaction.

5. True.

6. False. California’s Neighborhood Interventions Geared to High-Risk Testing (NIGHT) project provides general guidelines for conducting outreach work, but local health departments have the flexibility to tailor their programs to best fit their needs.

7. d.

8. True.
DID YOU KNOW?

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