



# Community-Based HIV Counseling and Rapid Testing Model with Peer and Lay Outreach Workers

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## **Acronyms**

ART	antiretroviral treatment
BCC	behavior change communication
CAREC	Caribbean Epidemiologic Center
CDC	Centers for Disease Control and Prevention
CHAA	Caribbean HIV&AIDS Alliance
CHART	Caribbean HIV/AIDS Regional Training Network
NAP	National AIDS Program
NAS	National AIDS Secretariat
NGO	nongovernmental organization
UNAIDS	United Nations AIDS Program
USAID	United States Agency for International Development
VCT	voluntary counseling and testing

## Introduction

Globally, the Caribbean is second only to sub-Saharan Africa in its regional HIV burden. Adult prevalence hovers at 1% in the region, although there is tremendous variance from country to country. Countries in the region have both generalized and concentrated epidemics, and half of all infections occur in women. Men who have sex with men, sex workers, and young women are at particularly at risk of HIV infection. According to Joint United Nations Programme on HIV/AIDS (UNAIDS) latest estimates, in some Caribbean countries about a third of all female sex workers and men who have sex with men are living with HIV. Effective HIV prevention requires that all people can access confidential HIV counseling and testing services as well as information about how to protect themselves and their loved ones from infection and, if necessary, HIV treatment and care.

People who are particularly vulnerable to HIV infection often do not have access to health care, information on HIV prevention, including on safer sex and how to use female and male condoms, and HIV counseling and testing. Even when people can access HIV counseling and testing, they may avoid it because they fear: stigma and discrimination, including homophobia; rejection; violence; or financial repercussions. In small Caribbean communities, many people are also concerned about breaches in medical confidentiality. Currently, few people in the Caribbean are seeking HIV tests. Although all countries in the region have guidelines that include HIV counseling and testing as a part of the national HIV/AIDS response, none of these guidelines incorporate non-medical providers in the provision of counseling and testing.

## Use of the Community-Based Counseling and Testing Model

The community-based HIV counseling and rapid testing model is an effective mechanism to facilitate access to the most-at-risk populations and provide MARP-friendly support and services. The model can be adapted and implemented by local, regional and international organizations that support HIV/AIDS programs targeting the most-at-risk populations. For the program to be successful, they should collaborate with Government entities and all stakeholders supporting programs in this area. Key stakeholders might include: local decision makers; leaders from the most-at-risk communities; local community-based, faith-based, and non-governmental organizations; key medical, educational, or professional organizations that may be involved in the training or certification of health workers in HIV counseling and testing; and donors.

Interested organizations could use the model following the steps described in the diagram below. However, it should be noted that these steps may not necessarily be conducted in sequential order i.e. one through twelve. In some cases, they can occur simultaneously.

**Note:** In discussing the model for building this community-based, HIV counseling and rapid testing program, we refer to peer and lay outreach workers. Peer outreach workers refer to people from the most-at-risk communities whereas lay outreach workers refer to people with no formal medical training. Both groups were trained as community health workers, but we will continue to refer to them as peer and lay outreach workers to be clear who to involve in creating similar programs.

## Overview: A Model for Community-Based HIV Counseling and Testing Program with Peer and Lay Outreach Workers

Recognizing that more people in the Eastern Caribbean need to know their HIV status and have access to HIV prevention information and tools and treatment, the International HIV&AIDS Alliance launched an innovative peer-based outreach program, the Eastern Caribbean Community Action Program. The program aimed to make HIV prevention information and community-based voluntary, counseling and rapid testing services more widely available and more widely-used in communities at high-risk of HIV infection. This work was funded by the United States Agency for International Development (USAID)/Barbados and undertaken in partnership with IntraHealth International and University of California, San Francisco. Out of this work, the program has developed a model for using peer and lay outreach workers to reach people at high-risk of HIV infection with community-based HIV counseling and testing and, when needed, referral for other services.

### Key Strategies for the Model

- **Training peer outreach workers from the most-at-risk populations as well as lay outreach workers from other organizations** as community health workers and counselors to talk to their peers and/or people at high risk of infection about the risks of HIV infection, the availability of HIV counseling, testing, and the availability of treatment and care. By building on the effectiveness of existing peer outreach strategies, peer and other outreach workers are uniquely positioned to discuss sexuality, safer sex, HIV risk behaviors, harm reduction, the impact of stigma and discrimination, informed consent and confidentiality and the need for people to seek HIV counseling and testing. The vulnerability of the client group and therefore trust needs to be developed with the communities. Furthermore, it is important to discuss with target populations how best to offer outreach testing as well as the importance of protecting human rights through informed consent and adequate pre and post-test counseling.
- **Training employees at private laboratories and key local organizations** to provide counseling as an essential, linked component with the rapid HIV tests that may already be available.
- **Employing a community-based approach** that involves community members as full partners and incorporate their feedback from the design phases of the program through the program implementation.
- **Creating a decentralized approach to providing HIV counseling and testing**, which reaches more people including those at high-risk of infection by training and employing lay and community health workers not previously engaged in this work and launching mobile testing units in urban and rural settings.
- **Connecting peer and lay outreach workers with other services and support structures**, by ensuring they are tapped into, and can refer their peers to, existing preventive and clinical services, including those available at government clinics. These personal relationships i.e. bi-directional support and referral are key to ensure most-at-risk populations have better access to culturally and sensitive care and support services.

Whenever possible, peer and lay outreach workers should also collaborate with Ministry of Health staff, health providers, and civil society organizations, ensuring a sustained and institutionalized mechanism for peer-based, community outreach.

- **Using the rapid HIV test**, which shows results in 30 minutes with just a finger prick or oral swab, allowing for same-day diagnosis and eliminating concerns about people not returning for test results.

## 12 Essential Steps to Create a Community-Based HIV Counseling and Testing Program with Peer and Lay Outreach Workers

- 1. Conducting a rapid needs assessment.** Prior to beginning any programmatic work, background research should be conducted to determine whether a given country and community, including MARPs are ready to support and equipped to launch a peer and lay outreach, community-based HIV counseling and rapid testing program. This research should assess: the willingness and ability of local, state, and national governments to support and collaborate with a program; potential support from, and collaboration with, community-based and faith-based organizations; current or potential outreach strategies for reaching high-risk communities; the content of existing guidelines and policies on HIV counseling and testing; the availability of HIV counseling, testing, and treatment services, particularly in communities for high-risk of infection; the ability of existing clinical and laboratory services to support such a program; the availability of relevant record-keeping and referral systems; training curricula, and job aids.
- 2. Planning, organizing and conducting a stakeholder meeting.** A program's success and sustainability often depends on its effectiveness in fostering partnerships with key stakeholders. In developing this type of program, program planners should consult and collaborate with these stakeholders from the program's inception. Key stakeholders might include: local decision makers; leaders from the most-at-risk communities; local community-based, faith-based, and non-governmental organizations; relevant regional and international non-governmental organizations; key medical, educational, or professional organizations that may be involved in the training or certification of health workers in HIV counseling and testing; and donors, which might include USAID, the Centers for Disease Control and Prevention, the Global Fund to Fight AIDS, Tuberculosis and Malaria, etc. .
- 3. Developing an implementation strategy**
  - a. Criteria for selecting collaborating organizations**

When selecting community-based and/or faith-based organizations to launch the program or collaborate with, program planners should consider the diversity of services these organizations offer to the most-at-risk populations. They should also review an organization's client workload, staff and provider capacity, and ability of the organization's infrastructure to accommodate the program needs.

## **b. Criteria for identifying implementation sites**

When selecting clinical sites, it is important to consider the availability of ART services and health care providers and whether these sites have the necessary infrastructure and equipment to support a program. The ability of the program to connect to referral sites should also be considered in the program planning. This includes how the program will connect participant to treatment, if needed. Laboratories should oversee the certification of rapid testing sites, monitor them, and ensure quality assurance and control. During the planning process, program managers should examine whether collaborating laboratory have the necessary technicians, equipment, and infrastructure to accommodate an increased workflow.

## **c. Criteria for selecting outreach workers**

Finally, it is important to create specific selection criteria for the peer outreach workers, which should include how knowledgeable they are about behavior communication changes strategies, how skilled they are at conveying essential health education information, and their profile and reach into the social networks of the most-at-risk communities. Where the communities in focus speak multiple languages, efforts should be made to select peer outreach workers from each language community so language is not a barrier in implementing the program. All peer outreach workers should be required to sign an oath of confidentiality to keep all information gathered during their services confidential.

- 4. Adapting existing tools and resources** In collaboration with relevant stakeholders and partners such as the Ministry of Health, community-based and faith-based organizations,, program managers should work with government officials to develop, where necessary, or adapt and update national guidelines and training materials on HIV counseling and rapid testing according to changes identified in initial needs assessment analysis. This may require validating rapid testing algorithms, developing voluntary counseling and testing risk assessment forms, and developing record-keeping tools. These guidelines should also detail the certification process for peer-based and lay outreach workers as qualified counselors and rapid testers and how sites are qualified to participate<sup>1</sup>.
- 5. Developing an effective and efficient procurement mechanism** Methods for test kit procurement should align with national guidelines and CDC recommendations, with the objective of maintaining an adequate supply of kits. In developing procurement strategies and protocol, programs planners should also plan to stock other HIV prevention-related commodities such as male and female condoms. An effective procurement system should also provide test sites necessary medical equipment, computers, and software needed for the program. Planning should account for tents

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<sup>1</sup>In terms of involving peer-based and lay outreach workers, our model is that these workers would need to score at least 70% in an examination of their knowledge on voluntary counseling and testing. Furthermore, we suggest requiring that the potential outreach workers score 100% on the Rapid Testing Competency Assessment Exam.

(that can be used at different testing venues e.g. street-based, festival and public events etc.) and other equipment to setup, maintain, and repair. Specific grants to partnering community-based and faith-based organizations can be an effective way to ensure there is support for acquiring these supplies and maintaining the program. Procurement strategies and activities should be undertaken in collaboration with Ministry of Health, national laboratories, private labs, and rapid test kits distributor companies in a way that guarantees a reliable procurement mechanism. The planning and implementation of an inventory management system is one essential element of the procurement mechanism. Membership in the Clinton Foundation Consortium rapid test direct manufacture program is recommended since it allows countries to purchase rapid test kits at a reduced cost (rf. Clinton Foundation Consortium Rapid Test direct manufacturing program).

- 6. Training of peer and lay outreach HIV testing providers.** Built on a train-the-trainers model, this program model requires that master trainers are first taught how to conduct the necessary trainings for peer and lay outreach workers. This initial, master training can be conducted with qualified staff at regional or international NGOs or in collaboration with agencies such as the Centers for Disease Control and Prevention, the World Health Organization, and local organizations charged with overseeing HIV counseling and testing services. The master trainers will then train peer and lay outreach workers on voluntary HIV counseling and testing, rapid HIV testing, harm reduction, combating stigma and discrimination, and informed consent and confidentiality. Additional trainings in Case Management and advanced VCT Monitoring and Evaluation are also recommended. Below is a breakdown of different training modules necessary to launch the program:
  - a. Training of Master Trainers in HIV rapid testing:** This is a five-day training course that grounds master trainers in information about HIV, rapid testing for HIV, testing algorithms, and proficiency testing for trainees. This course also helps master trainers learn how to train, coach, and supervise providers and peer and lay outreach workers in the counseling and testing program. This training should cover the specifics of how to collect blood for an: HIV rapid test including the handling and storage of dried tube specimens, how to do a finger prick and take an oral specimen, quality assurance and safety methods at the HIV rapid testing site, HIV rapid testing algorithms and data collection, and how to test the proficiency of others involved in the program. It is advisable that technical support from CDC be sought in undertaking such training. The curriculum is available from CDC (contact information on Reference List below). Currently, this course does not cover supervision and preceptorship skills.
  - b. Baseline voluntary, HIV counseling and testing background course:** This five-day training is designed to prepare participants, mainly peer and lay outreach workers, in the basics of the recommended protocols for voluntary HIV counseling and for working with clients to focus on a personalized, step-by-step risk reduction plan to prevent HIV infections. The training combines illustrated lectures, group discussions, individual/group exercises, and role plays and relies on the VCT CHART curriculum

available from the Caribbean HIV/AIDS Regional Training Network (CHART), CHAA and IntraHealth International (EC-CAP Training Materials and Tools CD).

- c. **Advanced training in administering HIV counseling and rapid testing in the most-at-risk communities:** Participants in this course must first complete the basic voluntary HIV counseling course. This five-day, advance course builds on the basic course by offering providers, peer and lay outreach workers, and lab technicians practical skills in rapid HIV testing such as how to correctly conduct fingerpick testing. Participants also complete a practicum experience on HIV testing at the health facility. This course teaches participants about how to employ a risk-reduction, client-centered counseling approach with people from high-risk communities. The curriculum, which is still in field-testing stages, was developed by and is being piloted globally by the CDC (rf. contact information on Reference List).
- d. **Harm reduction and substance abuse training:** This two-day course teaches providers and peer and lay outreach workers about association between injection drug use, including illicit drugs, and the risk of HIV and Hepatitis B and C infections as well as other blood-borne illnesses. Participants learn about patterns of drug use in the Caribbean; principles and practices of harm reduction and their application in the Caribbean; and the social and policy contexts of harm reduction in the Caribbean and how this influence the use of harm reduction strategies in HIV counseling and testing programs. When possible, this course should be conducted in collaboration with local harm reduction organizations. In the case of the Eastern Caribbean Community Action Program, this training was undertaken in partnership with the Caribbean Vulnerable Communities and the Caribbean Harm Reduction Coalition. The Caribbean Harm Reduction Coalition is in the process of developing a harm reduction and substance abuse training curriculum.
- e. **Training on stigma and discrimination:** This two-day course is designed to deepen providers' and peer and lay outreach workers' understanding of how most-at-risk communities experience stigma and discrimination, including how it is associated with HIV. The course helps participants examine professional and personal attitudes and values related to these communities and aims to build the necessary skills to offer client-centered counseling and testing services for all clients. The original curriculum for this course was developed by the International HIV&AIDS Alliance and funded by USAID. It was then adapted for this course by the American Foundation for AIDS Research, Caribbean Vulnerable Communities, and the Caribbean Harm Reduction Coalition. The curriculum is available at CHAA and IntraHealth International (rf. to EC-CAP Training Materials and Tools CD).
- f. **Consent and confidentiality training:** This one-day course is designed to teach participants about their obligations to keep all health information collected during the program confidential and private. It also teaches participants about the importance of ensuring clients give informed consent before receiving any HIV or AIDS-related services. The curriculum for this course is available from the Caribbean

HIV/AIDS Regional Training Network, CHAA and IntraHealth International (rf. to EC-CAP Training Materials and Tools CD).

- g. **IntraHealth supportive supervision training:** This three-day course builds supervisors knowledge and skills in offering supportive supervision to staff and peer and lay outreach workers in the program to ensure high-quality counselling and rapid testing services. The curriculum is available at IntraHealth international and CHAA (rf. EC-CAP Training Materials CD).
- 7. Piloting the program prior to scale up** Prior to launching the full-scale program, a small pilot program should be launched in fewer than five sites and should be continued for at least six months to understand the feasibility and acceptability of the program. The pilot sites should be different types of locations to test the program's feasibility in different settings e.g. clinics, private labs, businesses etc. Lay and peer outreach workers should offer HIV counseling and rapid testing services according to the national guidelines and under the supervision of certified technical staff or a master trainer. The outreach workers should be regularly accompanied by a manager or other technical staff member. The pilot program offers an opportunity to make the program technically sound in delivering services and creating a working program structure that allows for the expansion and the replication of the model. Peer and lay outreach workers will perform tests according to valid national algorithm and to ensure quality control. The pilot program is also an opportunity to develop a strong referral system for people who test HIV-positive and ensure they can get the adequate treatment and care they require, in accordance with national guidelines.
- 8. Implementing mobile testing activities Mobile** Among other outreach testing activities, mobile testing drives have proven to be an important component of a decentralized model for community-based HIV counseling and rapid testing, particularly in the most-at-risk communities. These events should be a key part of the implementation plan and can be conducted in both urban and rural communities in collaboration with government organizations and public and private sector partners, e.g., businesses, NGOs, and FBOs.
- 9. Linking with clinical, treatment and other adjunct services** HIV counseling and testing can be very stressful for both client and the counselor. It is, therefore, essential that the program builds in a mechanism during the training period and for the life of the program to ensure that all outreach workers have access to supervised psychosocial support sessions to address any concerns raised during counseling sessions and alleviate counsellor burn-out.
- 10. Linking with psycho-social and other care and support services** All HIV counseling and rapid testing services in community and clinical settings need to be coupled with a strong referral system that guarantees that HIV-positive clients are referred to the clinical and non-clinical services they need, including psychosocial support, counseling, nutritional guidance, and palliative care. This requires that the program build collaborations with other local organizations, including associations and networks of people living with HIV/AIDS, NGOs, as well as local community and religious leaders.

## 11. Monitoring and evaluation

- a. **Supportive supervision through observation:** As one step towards ensuring the program offers high-quality services, program managers should develop and use a supportive supervision system that requires a master trainer or other certified staff member to observe counseling and testing sessions and rate the outreach worker using an observation checklist. This type of quality control mechanism should also be built in for laboratory staff. The tool can be adapted from the counseling and rapid testing training manual or the national rapid testing guidelines.
- b. **Develop a recordkeeping system of the outreach workers' contacts:** The outreach workers sessions should be tracked using bi-directional referral forms, registers, and monthly report forms. In addition, the program should employ a referral linkage card that can track clients who are referred by outreach workers when they access other services.
- c. **Create a tracking system to report on key indicators:** A system should be in place to aggregate and compile data on key program indicators e.g. manually or software system can be developed. For example:
  - # of individuals trained to provide counseling and testing according to national or international standards
  - # of individuals who received counseling and rapid testing for HIV and received their results; # of individuals who test HIV-positive
  - # of sites that provide counseling and rapid testing according to national or international guidelines
  - # of individuals who received pre-test counseling and testing at counseling and rapid testing sites
  - # of HIV-positive individuals who were referred for services from counseling and rapid testing sites.

**12. Sustainability** While one of the immediate goals of the program is to extend HIV counseling and testing to the most-at-risk communities, it is also important that in the initial program planning and implementation, program managers take steps to ensure the program's longer-term sustainability. This can be done by building strong relationships with local governments, NGOs, and community-based and faith-based organizations as well as other local bodies. It is important to consider how additional grants towards these organizations may further support the sustainability of the program as will the integration of the peer and lay outreach workers into health system in more formal ways.

## Community-Based HIV Counseling and Rapid Testing Model with Peer and Lay Outreach Workers

<b>1</b>   Rapid needs assessment	<p>Conduct back ground research and determine feasibility of launching a counseling and rapid testing program</p> <ul style="list-style-type: none"> <li>• Desk review and readiness assessment</li> <li>• Conduct RT, CBCRT site visit i.e. Best Practice in region</li> </ul>	<b>7</b>   Pilots	<p>Launch small scale pilot of HIV counseling and rapid testing services</p> <ul style="list-style-type: none"> <li>• Conduct pilots in different settings (i.e. clinic, offices, NGO, CBO) to support decentralized RT/CBCRT roll out in terms of logistic, QA, QC</li> </ul>
<b>2</b>   Stakeholder meetings and consultation	<p>Involve key stakeholders from different areas in assessment, design, and implementation</p> <ul style="list-style-type: none"> <li>• Agreement with MOH/CDC/CHAA/IntraHealth i.e. MOU or Letter of Support</li> <li>• Input from MARPS stakeholders</li> </ul>	<b>8</b>   Mobile testing activities	<p>Employ mobile testing drives with peer outreach workers and lay community workers</p> <ul style="list-style-type: none"> <li>• Conduct mobile testing in different settings to support decentralized RT/CBCRT roll out i.e. urban and rural</li> </ul>
<b>3</b>   Implementation strategy	<p>Draft implementation strategy that details the criteria for selecting collaborating organizations, sites for launching the program, and the peer outreach workers in collaboration with relevant stakeholders</p> <ul style="list-style-type: none"> <li>• Selection of RT, CBCRT sites and community animators</li> <li>• Contacts with regional and international organizations (CHART, CDC, etc.)</li> </ul>	<b>9</b>   Clinical services	<p>Provide support services for lay and peer outreach workers</p> <ul style="list-style-type: none"> <li>• Provide psycho-social clinical support to animators/CBCRT partners i.e. government, NGO, CBO and private sector</li> </ul>
<b>4</b>   Adaptation	<p>Develop, adapt, or update national and state guidelines on HIV counseling and testing protocols</p> <ul style="list-style-type: none"> <li>• Adaptation/validation of RT algorithms, reference manual, RT competency assessment, VCT risk assessment tools/EPI INFO data base and other standardized record - keeping forms</li> </ul>	<b>10</b>   Palliative care and support	<p>Create a mechanism for referring clients for other care and support services, including palliative care</p> <ul style="list-style-type: none"> <li>• Award grants for care and support, buddy system, and ART adherence</li> <li>• Clinical Care Coordinator</li> <li>• One stop shopping for animators/bi-directional referrals</li> </ul>
<b>5</b>   Strategic trainings	<p>Train master trainers and peer and lay outreach workers on relevant topics and skills needed for the counseling and testing program</p> <ul style="list-style-type: none"> <li>• RT TOT training, Atlanta</li> <li>• CHART VCT training</li> <li>• CHART advanced VCT/ME</li> <li>• Advanced VCT/RT MARPS training</li> <li>• Harm reduction training</li> <li>• S&amp;D training</li> <li>• Supportive Supervision</li> <li>• Consent &amp; Confidentiality</li> <li>• Case Management</li> </ul>	<b>11</b>   Monitoring and evaluation	<p>Develop a system for quality assurance and monitoring and evaluating the program evaluation</p> <ul style="list-style-type: none"> <li>• Monthly and quarterly reports</li> <li>• Supportive supervision through observation</li> <li>• Conduct Case Study</li> </ul>
<b>6</b>   Procurement	<p>Plan for acquiring an adequate supply of HIV test kits and other necessary supplies</p> <ul style="list-style-type: none"> <li>• ID pharmaceutical supply company – local/regional</li> <li>• Stock Management System</li> <li>• Clinton Foundation Consortium</li> </ul>	<b>12</b>   Sustainability	<p>Collaborate with local governments and organizations to build a sustainable community-based HIV counseling and rapid testing program</p> <ul style="list-style-type: none"> <li>• Build strong relationship with government and community partners</li> <li>• Community Organizing</li> <li>• Secure additional funding i.e. private and government grants</li> </ul>

\* **Note:** The essential steps are not necessarily conducted in sequential order 1-12 and in some cases occur simultaneously.

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