PARTNER NOTIFICATION:
A HANDBOOK FOR DESIGNING AND IMPLEMENTING PROGRAMS AND SERVICES

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PARTNER NOTIFICATION: A HANDBOOK FOR DESIGNING AND IMPLEMENTING PROGRAMS AND SERVICES

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ACRONYMS

AIDSFree	Strengthening High Impact Interventions for an AIDS-free Generation
ART	antiretroviral therapy
CDC	U.S. Centers for Disease Control and Prevention
CHW	community health worker
HTC	HIV testing and counseling
HTS	HIV testing services
IPV	intimate partner violence
M&E	monitoring and evaluation
MOH	ministry of health
MSM	men who have sex with men
NGO	nongovernmental organization
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission
PN	partner notification
PWID	people who inject drugs
QA	quality assurance
QI	quality improvement
STI	sexually transmitted infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
WHO	World Health Organization

INTRODUCTION

Globally, about 60 percent of people living with HIV (PLHIV) know their status. Comprehensive HIV testing services, including partner notification (PN), are critical links into the HIV and AIDS treatment cascade and essential to achieving widespread testing of those at risk—the first of the 90-90-90 goals,[1] and the more recent 95-95-95 goals, proposed by the Joint United Nations Programme on HIV/AIDS, or UNAIDS (2014; 2016). To reach this goal, the World Health Organization (WHO) recommends a mix of strategies, including partner notification (PN) services (2016).[2]

Partner notification (also referred to as index partner testing or family testing) refers to an overarching approach that delivers HIV testing services (HTS) to sexual partners, drug injection partners, and children who have been exposed to HIV through a person diagnosed with HIV (termed the index patient or index partner). The goal of partner testing is to **provide HTS to undiagnosed persons who are in a relationship with a person diagnosed with HIV.**

The principle of partner testing is to break the chain of HIV transmission by offering HTS to persons who have been exposed to HIV and linking them to:

- HIV treatment as early as possible, if positive
- Prevention services (e.g., voluntary medical male circumcision or pre-exposure prophylaxis), if negative.

PARTNER NOTIFICATION OVERVIEW

Partner notification testing is a voluntary process whereby a trained provider, health worker, or counselor asks the index patient about potential exposures, including sexual partners, drug injecting partners, or the patient's children. PN testing services are offered to persons diagnosed with HIV, also known as the index patient or index partner. It is a voluntary process and program approaches may support

1 By 2020, 90 percent of people living with HIV will be diagnosed, 90 percent of diagnosed people will be on antiretroviral treatment, and 90 percent of people in treatment will be virally suppressed.

2 Note: All definitions used in this document are based on the WHO 2016 guidelines.

notification with disclosure or without disclosing names (anonymously), and may involve an offer of services at different points in time, such as at the time of testing and also at ART enrollment. With the agreement of the index patient, partner HTS may be offered through passive notification (the index patient notifies partners on their own) or through assisted approaches, with the help of a health worker or other trained providers. Detailed descriptions of these approaches follow.

Research has shown that PN is effective. Several studies have demonstrated that index partner testing can: (1) increase uptake of HTS and (2) identify partners with undiagnosed infection (the WHO 2016 guidelines refer to positivity rates as high as 86% among partners of persons with HIV infection.)

KEY PRINCIPLES OF PARTNER NOTIFICATION

All PN testing services should:

- Ensure all services meet WHO's 5 Cs (**C**onsent, **C**onfi entiality, **C**ounseling, **C**orrect test results and **C**onnection to care and treatment), including all index partner testing services. PN should be voluntary and noncoercive.
- Maintain confidentiality. Both the confidentiality of the index client and all named partners and children should be maintained at all times. The identity of the index client should not be revealed and no information about partners should be conveyed back to the index client unless noncoercive consent is obtained from the index partner.
- Ensure that PN is not a one-time event but is offered routinely:
  - Immediately after HIV diagnosis
  - At least annually as part of HIV treatment services
  - After a change in relationship status.
- Minimize intimate partner violence (IPV) risk. PN should take a "do no harm" approach. The initial screening of the index partner should include an assessment for risk of IPV. PN may be contraindicated in those who report IPV or report that they fear IPV or other social harms after disclosure.

TYPES OF PN APPROACHES

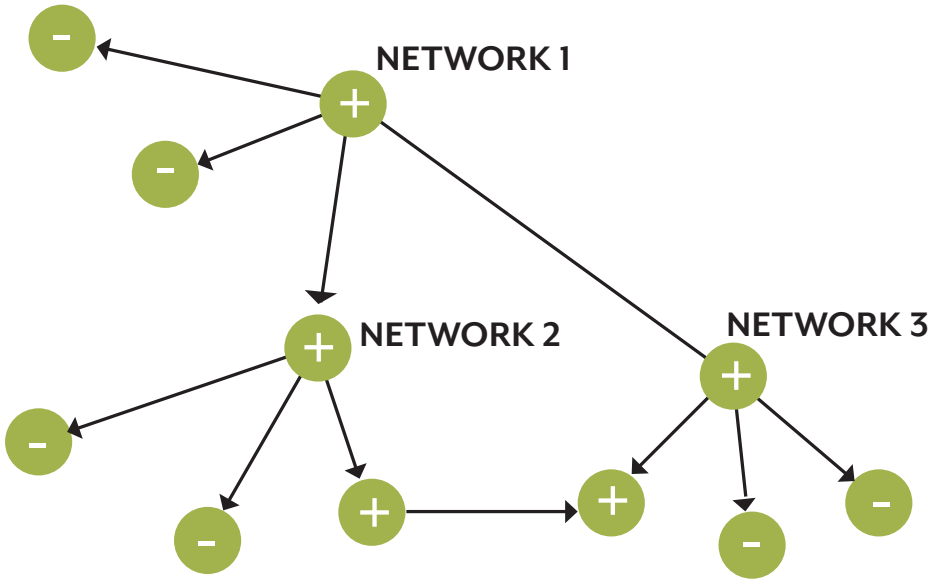
- In **passive** HIV PN services, a trained provider encourages the index patient to disclose their status to their sexual and/or drug injecting partners and suggest HTS to their partners, given their potential exposure to HIV infection. In this model, the index partner is responsible for notifying their partner and referring them to HTS. This is the "standard of care" recommended in the 2015 WHO HTS guidelines.[3]

3 Please refer to the love letter template included in "Tool 9. Sample 'Love Letter'" of this document.

- In **assisted** HIV PN services, a trained provider helps consenting index patients notify their sexual and/or drug injecting partner(s) of the index partner's status and partner's potential exposure to HIV infection. Such notification may occur with disclosure of their identity and HIV status, or anonymously, without disclosure of the identity of the patient. The provider then offers HIV testing to these partner(s). Currently, assisted PN uses provider referral, dual referral, or contract referral, all approaches which are defined below. Assisted approaches include anonymous methods by which the index partner and provider inform partners of potential exposure without disclosing the index partner's status or involvement.
  - **Provider referral**: With the consent of the index partner, a trained provider confidentially contacts the person's partner(s) directly and offers voluntary testing.
  - **Dual referral**: A trained provider accompanies and provides support to the index patient when they disclose their status, and the potential exposure to HIV, to their partner(s). The provider offers voluntary testing to the partner(s).
  - **Contract referral**: The index patient agrees to enter into a contract with a provider to disclose their status and the potential of HIV exposure to their partner(s) by themselves, and to refer their partner(s) for HIV testing within a specified timeframe. If the partner(s) of the HIV-positive individual do not access testing or contact the health provider within that period, then the provider will contact the partner(s) directly and offer voluntary testing.
- **Couples HIV testing services**: Couples HTS is an approach that encourages couples to come for testing together, and to disclose their HIV status to each other during the counseling session. This approach leads to improved outcomes such as linking couples to care, increasing adherence to treatment and uptake of PMTCT services, and reducing IPV and stigma.

PN can serve to identify those at highest risk of HIV, and in some cases, primary partners and contacts lead to the identification of secondary and tertiary networks, as seen in Figure 1.

Figure 1. Partner Notification through a Network Approach of Those with Risk of Exposure from Index Patient



PN services are already a key strategy for identifying HIV cases in the U.S. and Europe, and this approach is growing in use and acceptance in Asia and Africa. Recent studies in Cameroon, Kenya, Malawi, Mozambique, and Tanzania have shown that within HTS at facilities, PN is acceptable, feasible, and effective.[4]

HANDBOOK OVERVIEW

This handbook was developed as a technical update on successful PN programs, offering a synthesis of best practices, models, challenges, and solutions that can be used to develop and implement effective PN programs. Practical steps to implement PN were developed based on this review. The intended audience is policymakers, program managers, health care workers, and trained providers who can use this guide to develop PN policies and implement programs tailored to the country environment.

METHODS USED TO DEVELOP THIS HANDBOOK

This handbook reflects guidance laid out in WHO's *Consolidated Guidelines on HIV Testing Services (2015), and builds on WHO's Guidelines on HIV Self-Testing and Partner Notification: Supplement to Consolidated Guidelines on HIV Testing Services* (2016), which state:[5]

VOLUNTARY ASSISTED PARTNER NOTIFICATION SERVICES SHOULD BE OFFERED AS PART OF A COMPREHENSIVE PACKAGE OF TESTING AND CARE OFFERED TO PLHIV.

This handbook expands on that guidance by including information from a literature review and semi-structured interviews with national HIV program administrators, counselors and other health providers, and administrators of nongovernmental organizations (NGOs). The countries included in this analysis were Côte d'Ivoire, Haiti, Kenya, Mozambique, South Africa, Tanzania, Uganda, and Vietnam, which offer geographic diversity and a variety of PN models. A focus on sub-Saharan Africa was maintained, as that remains the area with the most acute generalized sexual HIV epidemics. Information on the specific policy and implementation environment in these eight participating countries is included within "Appendix 2. Specific Examples from Countries Where Assessment Was Conducted," organized by steps.

Based on the data-gathering process described above, nine key steps for implementing PN were identified, as outlined in Section II. Steps for Implementing Partner Notification. These steps focus on the PN services themselves, as well as on elements of health systems and policies:

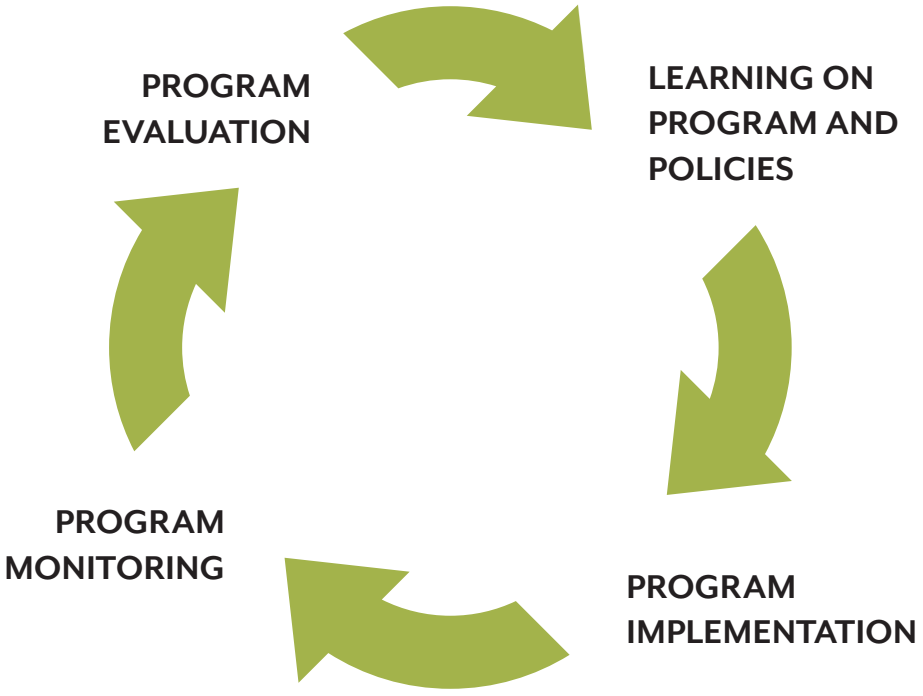
1. Improving the legal and policy environment
2. Selecting PN delivery models
3. Improving human resources and training on PN
4. Deciding on the timing of PN

4 Refer to *WHO Guidelines on HIV Self-Testing and Partner Notification Supplement to Consolidated Guidelines on HIV Testing Services* (2016).

5 Please refer to WHO guidelines relevant to PN included in "Appendix 3. Additional Resources."

5. Selecting specific methods to notify partners
6. Tailoring PN to priority populations
7. Addressing potential adverse outcomes of PN
8. Improving linkage to service
9. Enhancing M&E and quality assurance (QA)

Figure 2. PN Program Cycle



It is recommended that readers use these steps as a checklist when developing a PN program, along with the 2016 *WHO Guidelines on HIV Self-Testing and Partner Notification*. These steps compose the program cycle and cover elements of policy development, program design, program implementation, and M&E (Figure 2). These interrelated components facilitate the use of evidence-informed design with country-specific approaches for each context.

STEPS FOR IMPLEMENTING PARTNER NOTIFICATION

This section synthesizes the available information on each of the nine steps for developing a PN program. For each step, a description, evidence (where available), current practices, and recommendations are provided. Sample tools for implementation are included in "Appendix 1. Tools for Implementing, Documenting, and Monitoring Partner Notification Services." More detailed country examples are included in "Appendix 2. Specific Examples from Countries Where Assessment Was Conducted."

STEP 1. IMPROVING THE LEGAL AND POLICY ENVIRONMENTS

In order to expand effective PN, countries need to consider the effects of the policy environment on the implementation and use of the services. Globally, 67 countries have policies on PN, as described in the WHO 2016 guidelines on self-testing and PN. Existing policies are sometimes not available at the facility level.

CURRENT PRACTICES

Explicit policies and guidelines on PN are currently lacking in many countries. Without clear and consistent national or subnational policies, PN implementation may be inconsistent or poorly implemented. Some countries both require PN to be voluntary and also require PN services to be delivered to partners of PLHIV.

Health workers and HTS providers expressed concerns about the lack of clear guidance in difficult situations. For example, in Uganda, HIV counselors desired more guidance on how to proceed when members of discordant couples refused to reveal their HIV status, leaving partners and/or children at risk of HIV acquisition. Strategies to maintain confidentiality in these situations are urgently needed.

Notably, some current policies can impede national initiatives to address HIV. For example, although the WHO guidelines argue against mandatory PN and criminalization of HIV transmission, sex work, same-sex relations, and drug use, several countries in the assessment both require PN for HIV-positive individuals and criminalize same-sex sexual behaviors, which makes PN more difficult.

Where problematic policies are in place, such as authorization of PN without consent or criminalization of HIV transmission, the quality, quantity, and outcomes of PN services may suffer. Laws criminalizing same-sex sexual behaviors, drug use, and sex work are likely to reduce the willingness of index partners to disclose their status to their partners.

STRUCTURAL BARRIERS TO HIV PARTNER NOTIFICATION SERVICES

- Laws and policies that include any form of mandatory HIV testing
- Laws and policies that include any form of mandatory HIV PN laws and policies that criminalize HIV transmission
- Laws and policies that criminalize behaviors of key populations, such as people who inject drugs (PWID), sex workers, men who have sex with men (MSM), and transgender people
- Lack of confidentiality of medical information
- Lack of anonymity in PN. (WHO 2016)

RECOMMENDATIONS TO IMPROVE THE LEGAL AND POLICY ENVIRONMENT FOR PN

- Countries should review their current legal and policy environments to determine what laws and policies will be required to establish PN standards.
- Policy development should include collaboration and input from all stakeholders, including consumers, clients, and providers of PN services, NGOs, civil society organizations, PLHIV, and relevant government entities at all levels. Clear national policies consistent with the 2016 WHO guidelines are needed. Involvement of legal experts with experience in issues related to confidentiality and PN will also be helpful.
- Consideration should be given to resources necessary to achieve the universal standard practice of voluntary assisted PN, including the human resources (see below), and M&E of programming.
- Policies should be considered to allow well-trained lay counselors, community health workers (CHWs), peer outreach workers, and health volunteers to offer PN services. Careful training in how to maintain confidentiality is essential, along with regular supervision.
- Policies and procedures for HIV PN should consider utilizing established contact tracing procedures for STIs.
- Inconsistencies in law and policy should be addressed and clarified—for example, co-existing laws or regulations requiring PN in all cases but specifying that it must be voluntary.
- Legal frameworks should work towards the reform of laws criminalizing same-sex sexual behaviors, sex work, and HIV transmission, which may reduce the effectiveness of PN.
- Policies should be provided in local languages to support broader understanding and better implementation.

STEP 2. SELECTING PARTNER NOTIFICATION DELIVERY MODELS

A PN program must consider which approach to use, as well as the setting. These models can be implemented as stand-alone activities before or after diagnosis, or as part of other programs such as couples HTS or PMTCT; and can be conducted in a clinical setting, a community gathering, or the index patient's home.

Rather than PN as a stand-alone service, evidence suggests PN programs have more success if implemented in a variety of contexts, including both in the community and the facility. Both passive and active approaches should be considered within these settings. It appears that a well-designed program can be effective in any setting, including health care facilities, PMTCT and antenatal care, stand-alone testing services, or home-based testing. It remains important that regardless of the model, PN should be implemented consistently and systematically, using established methods and standards.

Selection of the delivery model utilized for each case should be based on the needs of index patients as well as their partners, which will differ by country, community, and individual. The specific vulnerabilities of the potential target partner need be considered—barriers for MSM, female sex workers, or minority populations may lead towards one approach over another. Further, programmatic data suggests increased effectiveness in reaching certain populations when specific modalities are used (i.e., providing PN services for hard to reach men through community index partner testing, rather than facility testing). Testing in the home setting has been utilized in many countries. When designing and implementing home-based PN services, the WHO 2012 handbook on home-based HIV testing and counseling will be a very useful tool. This handbook includes guidance on offering home-based HIV testing for couples, adolescents, and children who are part of the family of the index patient. (See "Appendix 3. Additional Resources.")

Each individual index patient may use different delivery models depending upon the targeted partner to be reached. Further, as PN is not a one-time event but rather should be offered repeatedly, delivery models used may also vary based on experiences in the past.

Certain delivery models will require more training and different cadres of service providers or volunteers. Consideration as to the resources required for each modality is essential.

PN should be offered recurrently, including:

- Immediately after HIV diagnosis
- At least annually as part of HIV treatment services
- After a change in relationship status.

CURRENT PRACTICES

In all of the countries assessed, the most commonly used model was a hybrid or combination model implementing passive PN with varying levels and types of provider encouragement or

assistance. Implementation of PN within countries varied by program, locality, and/or priority population. The use of provider referral has been limited by perceived challenges including concerns about confidentiality and costs. Most countries display some key elements of the WHO-recommended model (voluntary PN with some encouragement or assistance from providers), however, systematic and consistent implementation may be lacking. As a result, there is often a suboptimal reach to all PLHIV and their partners.

RECOMMENDATIONS FOR SELECTING PARTNER NOTIFICATION DELIVERY MODELS

- Countries and programs should consider their context and select the PN model(s) best suited to the locations, settings, populations, and preferences of persons who will receive the services.
- PN should be part of a comprehensive package of HIV services, from prevention to testing, treatment, and care.
- Multiple approaches may need to be offered to maximize uptake among different populations and diverse contexts. The goal should be to move from only passive PN approaches towards adoption of voluntary, assisted PN, in accordance with the 2016 WHO guidelines.
- Countries should adopt clear and consistent standard operating procedures (SOPs) for PN, which should inform the design and implementation of their programs. SOPs should emphasize partner identification, disclosure, and testing as a voluntary process. The risks and benefits should be assessed on a case-by-case basis.
- It should be noted that establishment of SOPs does not mean that PN must be implemented in exactly the same way in all circumstances. Standards should spell out how actual PN practice is tailored to different priority groups, settings, localities, and situations.

STEP 3. IMPROVING HUMAN RESOURCES AND TRAINING

The WHO guidance on PN stresses the need to ensure that all HIV-positive persons are linked to treatment and offered PN services and that providers must have training on delivering voluntary PN services sensitively, confi entially, and without judgment. There are, however, human resource shortages for the delivery of PN services. For example, policies that limit the delivery of PN services to certified health care workers may limit the provision of this service.

Interviews with key informants suggest that current service providers for PN are not satisfied with the available training or resources, and they feel ill prepared to address potential adverse outcomes such as IPV. The inconsistent policies that sometimes require both confidentiality and a mandate to inform potentially serodiscordant partners are also a source of concern.

Training should include instruction in effective counseling and documentation of PN services, and should also address the potential for harm in the context of disclosure and referral. Guidance as to how providers can navigate conflicting policies, as well as more granular details into aspects such as transportation assistance for community outreach and expectations for cell phone tracking would be welcomed.

Countries developing PN policies should therefore consider the cadres of health workers available to provide PN and the necery training required to ensure they are adequately prepared to provide the services.

CURRENT PRACTICES

In many contexts, there are inadequate qualified human resources to supply PN services to all who could benefit from PN. In the countries surveyed, PN support, testing, and linkage to care is limited to trained health care workers such as nurses, medical attendants, and doctors, a common situation in countries where mandates allow only credentialed health providers to deliver PN services.

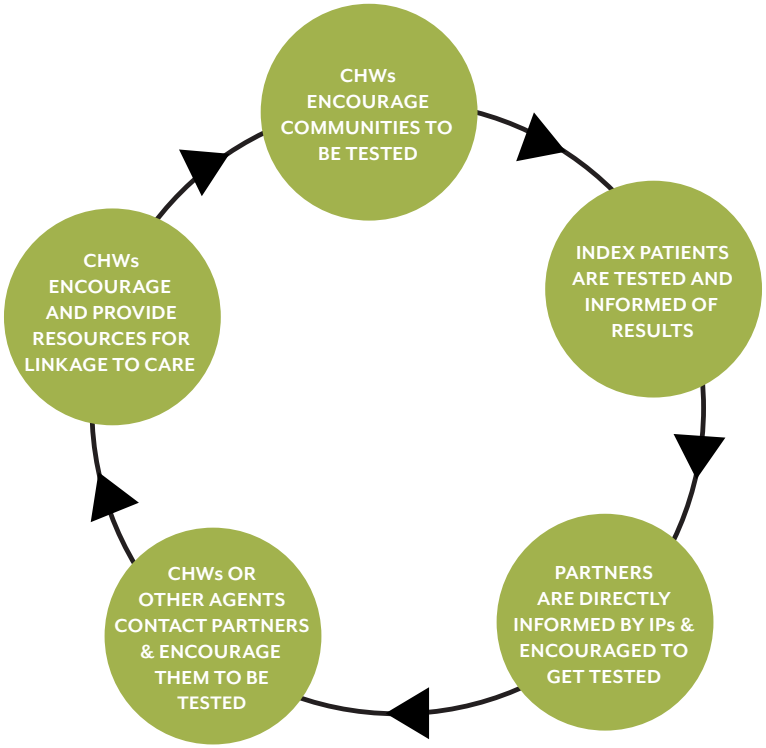
As reported by health workers, it appears that the PN guidelines and training that exist as part of HIV testing programs do not adequately cover all of the challenges reported by PN providers. This assessment found that providers do not feel fully prepared to deal with many issues arising from PN, including IPV, refusal of services, and protecting confidentiality.

Perhaps related to both the shortages of staff, and insufficient training, patient complaints have ranged from the need to travel long distances to clinics, long queues upon arrival, and lack of qualified staff at facilities. Patients across all countries assessed, especially those from poor and rural communities, complained about limited access to providers and expressed fears about the confi entiality of services.

POTENTIAL ROLE FOR COMMUNITY HEALTH WORKERS

In several countries, CHWs have been found to alleviate some of the burden on medical professionals (see Figure 3), but their roles may be limited and vary from country to country. For example, an NGO in *Haiti* uses CHWs to counsel index patients, and in *Mozambique*, CHWs play a critical role in contacting partners. In contrast, in *Kenya*, CHWs can only follow up for linkage to care, while in *South Africa*, CHWs only provide information on HIV testing and general health education. In *Tanzania*, CHWs, peer educators, and volunteer "expert patients" (knowledgeable patients already on treatment and adherent to their regimens) accompany index partners from HIV testing facilities to treatment clinics, but do not conduct PN. Index partners who are sex workers, and MSM, have functioned as expert patients with mobile testing services. Informants from *Mozambique, South Africa*, and *Tanzania* mentioned using community-based approaches (door-to-door and mobile) to reach poor and rural communities. In *Vietnam*, respondents reported that the most successful PN programs were those operated by NGOs that relied on community service providers (similar to community health workers).

Figure 3. Using Community Health Workers for PN



RECOMMENDATIONS TO IMPROVE HUMAN RESOURCES AND TRAINING

- Programs should provide improved PN-specific training for all types of personnel involved in delivering PN. Refresher training may be needed as PN services evolve.
- Programs and countries which have human resource limitations should consider the use of CHWs, volunteers, or peer educators to fill PN service coverage.
- Programs should develop policies to expand the categories of those able to provide PN services, depending on the population, setting, and situation.
- Training of human resources on PN should include:
  - Practical strategies for delivering PN information and services, with methods tailored by context and individual client circumstances.
  - Specific guidelines related to confidentiality, with policies and procedures that should be in place.
  - Guidance for the challenging aspects of PN, including potentially adverse outcomes such as IPV, as well as approaches for index patients who may be reluctant to engage in PN.
- For new providers, "shadowing" of more experienced providers for a period should be considered to improve their skills and competencies.
- Strategies are needed to ensure ongoing supervision and mentoring of community workers.

STEP 4. TIMING THE INTRODUCTION OF PARTNER NOTIFICATION

Giving and receiving HIV diagnoses can be highly complicated and emotional processes. PN is not a one-time event but should be offered repeatedly. PN appears to be most effective at preventing transmission and linking new diagnoses to services if introduced to clients or patients:

- During pretest counseling
- Immediately after diagnosis
- Regularly, as part of HIV treatment services.

Individuals who have already been diagnosed may need to be introduced to PN at least annually as part of HIV treatment services, including during routine services such as ART and PMTCT, and after a change in relationship status.

CURRENT PRACTICES

WHO's HTS guidelines recommend introducing PN prior to diagnosis, such as during pretest counseling and information provision.

The U.S. Centers for Disease Control and Prevention's (CDC) guidelines for PN services recommend that partner elicitation and other partner services be provided "as soon as possible" after new HIV diagnoses, understanding that some patients will need more time than others to adjust to their HIV-positive status (see "Appendix 3. Additional Resources," CDC 2008). Several counseling sessions may be needed for them to move on to partner elicitation and notification.

In Kenya, protocols used by a number of NGOs encourage women to notify partners in antenatal care, antiretroviral therapy (ART), HTS, PMTCT, and STI clinics, but uptake is limited.

RECOMMENDATIONS FOR TIMING THE INTRODUCTION OF PARTNER NOTIFICATION

- Programs and providers should introduce PN during pretest counseling and carry out partner elicitation and notification as soon as possible after diagnosis.
- Programs and providers should allow some flexibility with timing of PN to account for individual variation in response to the diagnosis of HIV.
- PN should be reintroduced as part of routine HIV treatment services such as PMTCT.
- PN should be offered to patients in HIV treatment programs at least annually, as well as after any change in relationship status.
- Countries and programs should monitor implementation and refine guidelines on the timing of PN services.

STEP 5. SELECTING SPECIFIC METHODS TO NOTIFY PARTNERS

WHO guidance recommends offering clients multiple options for notifying partners, and specifies that the options must be voluntary and consensual. Within the overall options of PN available in-country, the specific methods used should be tailored to needs and preferences of the patient or client. Depending upon the population and context, methods of notification have included in-person meeting and phone calls, as well as creative approaches such as letters and text messages. All approaches must respect confidentiality, and include consideration of possible adverse reactions, including IPV, abandonment, neglect, and other negative outcomes.

CURRENT PRACTICES AND MEANS OF COMMUNICATION

The most common way of implementing PN found during this assessment is through face-to-face communication, including one-on-one between index partner and partner, and providers accompanying index partners to notify partners. Notification and communication by letter, telephone, and text messages is also being used, with the method sometimes depending on the demographic group or key population being served. Fairly widespread use of peer educators, CHWs, and health volunteers to support PN was reported.

All PN programs should develop flexible approaches to address the needs of the individual index patients. Strategies to consider include:

- Standard approaches, including the use of referral slips and notices from health facilities (samples are included in "Appendix 1. Tools for Implementing, Documenting, and Monitoring Partner Notification Services")
- Couples counseling
- “Love letters”
- Anonymous PN, or notification to partners without identifying the index patient

Some innovative methods for PN include:

COUPLES COUNSELING

Joint testing of couples, often referred to as couples counseling, has been shown to be an effective way of conducting PN, particularly for index patients who feel uncomfortable about discussing their serostatus with their partner. In this method, the index patient asks their partners to come for joint counseling and testing. This may be conducted as if the index patient had not previously received testing. Pretest and post-diagnosis counseling are conducted so that partners learn their status together, which then may lead to increased trust and understanding. A number of countries have successfully implemented couples counseling, with some evidence showing a preference for this method. In 2012, WHO issued guidance on couples HIV testing; this guidance should be used to help design and implement couples testing.

"LOVE LETTERS"

A successful strategy to improve rates of couples HTS, particularly when an index patient does not want to reveal his or her serostatus, is through the use of "love letters." With this method, implemented in Uganda and other countries, the clinic director sends these letters to identified partners asking them to come in with the named index partner to discuss "matters…of high importance to both of you." To maintain confidentiality, these letters do not mention HIV at all, but serve to encourage the partners to come into the clinic where discussions about testing can take place. Community volunteers and CHWs can help facilitate PN with this approach (see Figure 4). In *Uganda*, an estimated 60 percent of recipients of "love letters" from providers came for testing, demonstrating this technique as effective in reaching many partners (Abt Associates Inc. 2016). A sample love letter template is included in "Tool 9. Sample 'Love Letter.'"

Figure 4. PN Model Using a 'Love Letter'[6]

RECOMMENDATIONS FOR SELECTING SPECIFIC METHODS TO NOTIFY PARTNERS

- Programs should tailor PN methods to prioritize confidentiality and avoid adverse outcomes.
- Programs should consider and select from the array of available delivery methods,including face-to-face communication, letter, telephone, and short message service messages. It will be necessary to use different delivery methods for different clients or situations, and the selected approach should be based on provider assessment and patient preference.
- PN programs must take all appropriate steps to ensure confidentiality, including using anonymous PN when possible or preferred. The information sent to a partner should be nonspecific in case it is seen by someone other than the intended recipient. This is especially important when using SMS or similar messaging services.
- Index patients who choose passive referral and plan to notify their partners themselves should be provided guidance and sample scripts. (See "Tool 10. Guidance for Index Patients to Disclose to Partners.")
- Programs could consider using 'love letters' from providers to partners urging them to come to the health facility with the index partners to discuss an important but unspecified matter.

6 Please refer to the love letter template included in "Tool 9. Sample 'Love Letter'" of this document.

STEP 6. TAILORING PARTNER NOTIFICATION TO PRIORITY POPULATIONS

While PN focuses on delivering HTS to the sexual partners, drug injecting partners, and children who have been exposed to HIV through an index client, programs need to consider the different challenges faced by different subgroups of the population. This can include vulnerable and key populations such as pregnant women, MSM, sex workers and their clients, PWID, children, and rural and poor populations. The available evidence also points to widespread difficulties in reaching men for PN.

All countries have their own set of vulnerable populations, each of which has specific needs that must be addressed for PN to be successful. Programs should adopt PN strategies and approaches to address these specific needs. In 2014, WHO issued guidelines on HIV services for key populations; these guidelines were updated in 2016 and should be used when designing PN services for these populations (see "Appendix 3. Additional Resources").

CURRENT PRACTICES

PN presents an opportunity to engage key populations in HIV services, and effective strategies are a priority. The most effective programs recognize the different challenges faced by different groups and then develop approaches that are responsive to these challenges. Below are outlined some specific approaches used in various countries, to address the specific challenges they faced in reaching MSM, sex workers, PWID, and adolescents and children.

MEN WHO HAVE SEX WITH MEN

MSM communities in various countries reported stigma as a major obstacle keeping index partners from seeking care and participating in PN. For example, in *Kenya*, respondents observed that MSM index patients who are married with children may be unwilling to inform female partners because they do not want to explain how they contracted HIV. To address these issues, the Anova Health Institute in *South Africa* has developed a secure mobile application, Health4Men. This application provides HIV information, including clinic locations and an interface for asking experts questions about HIV and other health concerns.

SEX WORKERS

Sex workers present different challenges to PN, particularly lack of availability during standard clinic hours, and difficulty identifying and informing many of their partners. To address these challenges, night clinics with hours that are more convenient for sex workers have been established in a number of countries. In *Tanzania*, a general network approach is utilized in high-risk populations such as with sex workers. With this approach, members of the network are identified and receive text messages inviting them to receive further texting for HIV services. Mobile clinics are often utilized to reach those who accept the invitation.

PEOPLE WHO INJECT DRUGS

In some contexts, the HIV epidemic can be concentrated in people who inject intravenous drugs. HIV-positive PWID have two potential avenues for partner notification—their sex partners as well as any partners with whom they share drug injection paraphernalia. Findings from some contexts, such as in Vietnam, indicate that PWID index patients who are encouraged to bring their partners in for testing and counseling often have an easier time bringing in their sex partners than their drug injection partners. Providers and policymakers must consider both avenues for PN, and various models may need to be employed.

ADOLESCENTS

Including adolescents in PN services is essential. It is important to consider that receiving information about HIV and potential exposures may be more emotionally challenging for adolescents. Further, the potential loss of social and economic support, or the loss of a partner, may be especially difficult for adolescents, particularly if the partner is older and/or has more power in the relationship. Partners may also be more difficult to locate. Based on their individual circumstances, adolescents may feel especially vulnerable to IPV and abuse. Providers may encounter situations where the age of consent for HIV testing, or for sexual intercourse with adults, is in conflict with national policies. However, the provision of health services to adolescents in a safe environment, without the involvement of law enforcement, is important to enable this vulnerable group to access lifesaving ART if diagnosed HIV-positive or prevention services if HIV-negative (WHO 2016).

CHILDREN

Children are vulnerable populations for HIV, and testing of children should be part of PMTCT or family services in the ART clinic. For example, Tanzania has developed some innovative approaches to reach children, including an approach for family testing for mothers and children. If a child is HIV-positive, the mother is counseled and asked to bring her other children for testing. Referral notes are issued to the mothers which offer the option of a home test for the other children, or incentives to return to the health facility with a refund for transport costs.

WHO has prepared guidelines on testing and care services for children and adolescents. Please see "Appendix 3. Additional Resources" for guidelines related to these groups.

RECOMMENDATIONS FOR TAILORING PARTNER NOTIFICATION TO PRIORITY POPULATIONS

- PN programs should address the needs and concerns of stigmatized and vulnerable groups such as MSM, transgender individuals, PWID, and sex workers. This means providing service venues and procedures that avoid unduly "labeling" clients as members of key populations or PLHIV, to reduce stigma that may be associated with receiving PN and related services.
- Members of priority and vulnerable populations should be actively engaged in the process of program development. This includes consultation about barriers to testing and services and development of appropriate strategies to address these barriers.
- Programs should develop venue-based outreach to reach networks of PWID—for example, at drug injection "hotspots" or other gathering places. Similar strategies may be indicated for sex workers, for example, in establishment and street-based sex work locations.
- Reaching men with PN is a challenge, and barriers specific to each context should be identified. Evening and weekend clinic hours and PMTCT facility-based PN or couples counseling have all had success in different contexts.
- HIV testing for children and adolescents of index patients should be included in PN programs.
- PN for adolescents, whether they are the HIV-positive client or the partner being informed of exposure to HIV infection, requires the provider to engage sensitively and nonjudgmentally in a discussion about sexual partner(s), how to facilitate mutual disclosure, and how to recognize and minimize risks of IPV (WHO 2016).
- Programs should consider trained community volunteers, peer providers, and community and home-based services for reaching rural and remote areas and populations, particularly those with few facilities or credentialed providers available.
- Programs should consider offering incentives in the form of cash payments or transport subsidies to increase rates of partner identification and notification.

STEP 7. ADDRESSING POTENTIAL ADVERSE OUTCOMES

In many contexts, HIV-positive individuals fear that if their status is known, they will face shame, rejection, or violence from partners or family. A serious obstacle for PN services relates to the concern and fear of index patients that PN would harm relationships and might lead to IPV. Gender dynamics also have an impact, and in some settings, women expressed much more concern about notifying male partners than men did about notifying female partners. Fear of IPV should be taken seriously and should be addressed by the health care worker. Other adverse events such as stigma, loss of relationship, loss of support, loneliness, and rejection may occur and should be acknowledged by providers as potential serious adverse outcomes for women, men, and adolescents.

Programs that implement PN must anticipate and develop strategies to provide care and support to women who disclose violence, and address or prevent the potential adverse outcomes of status disclosure. Selecting a PN approach that is sensitive to these concerns and addresses potential adverse outcomes is essential, including not only IPV but also negative social and emotional outcomes and disruption in marital and family relationships.

CLINICAL INQUIRY FOR INTIMATE PARTNER VIOLENCE

In the context of PN, service providers should conduct clinical inquiry (sometimes called routine inquiry) in order to identify potential cases of IPV. In the context of IPV, this refers to the identification of women experiencing violence who present to health care settings, through use of questions based on the presenting conditions, the history and, where appropriate, examination of the patient. These terms are used as distinct from "routine enquiry," which refers to investigating IPV without resorting to the public health criteria of a complete screening program, or "screening," which is the large-scale assessment of whole population groups and is not recommended.

In order to conduct clinical inquiry for IPV in accordance with the WHO guidelines, the following must be in place:

- A protocol or SOP exists for providing gender-based violence services
- A questionnaire, with standard questions where providers can document responses
- Providers offer first-line support[7]
- Providers have received training on how to ask about IPV or sexual violence
- Private setting, confidentiality ensured
- A system for referrals or linkages to other services within the facility is in place

If any of these minimum requirements is missing, or if gender-based violence services are considered inadequate, providers should not conduct a clinical enquiry. In such cases, assistance should be sought in order to develop SOPs, tools, and job aids to ensure site and provider readiness.

There are a number of resources that may be useful in the context of PN. For example, USAID sponsored the development of a step-by-step guide to strengthening sexual violence services in public health facilities. This guide contains tools, job aids, and clinical SOPs to address sexual violence. WHO has also developed a clinical handbook for services for women who disclose violence to health care workers. (See "Appendix 3. Additional Resources.") It is not expected that health care workers who provide PN services should provide a full array of services for persons who

7 First-line support is the immediate care given to a gender-based violence survivor upon first contact with the health or criminal justice system. The WHO defines "first-line support" using the acronym "LIVES": Listening, Inquiring, Validating, Ensuring safety, and Support through referrals.

report sexual violence. However, all health care workers should be knowledgeable about these guidelines and handbooks in the event that an index patient (female or male; adult or adolescent) states reluctance to engage in PN due to fear of violence or other adverse outcomes.

CURRENT PRACTICE

Interviews conducted to develop this handbook indicate that the concern of many index patients that PN would harm relationships and might lead to IPV and other adverse outcomes was the primary obstacle in their willingness to disclose their HIV status to their sexual and drug-using partners. For example, in *Kenya*, informants for the assessment stated that most index partners were unwilling to inform their partners for fear of IPV, stigmatization, loss of relationship, and social exclusion.

In *Côte d'Ivoire*, informants observed that the service providers who encourage PN are held responsible for any negative consequences for the index partner. These negative responses can include verbal abuse, divorce, separation, and cessation of sexual intercourse between the partner and the index partner.

Tanzania uses a five-question IPV screening tool and excludes from tracing any partners for whom index partners' answers suggest the possibility of IPV.

An IPV screening tool, such as the one currently used in some clinics in *Uganda*, may be helpful to providers to select which PN method to use; see below for a sample tool. An extended version of this sample can be found in "Tool 5. IPV Screening Tool."

SCREENING TOOL FOR INTIMATE PARTNER VIOLENCE

Because your safety is very important to us, we ask all clients the following questions:

1. Has [partner's name] ever hit, kicked, slapped, or otherwise physically hurt you?

   ☐ Yes ☐ No

2. Has [partner's name] ever threatened to hurt you?

   ☐ Yes ☐ No

3. Has [partner's name] ever forced you to do something sexually that made you feel uncomfortable?

   ☐ Yes ☐ No

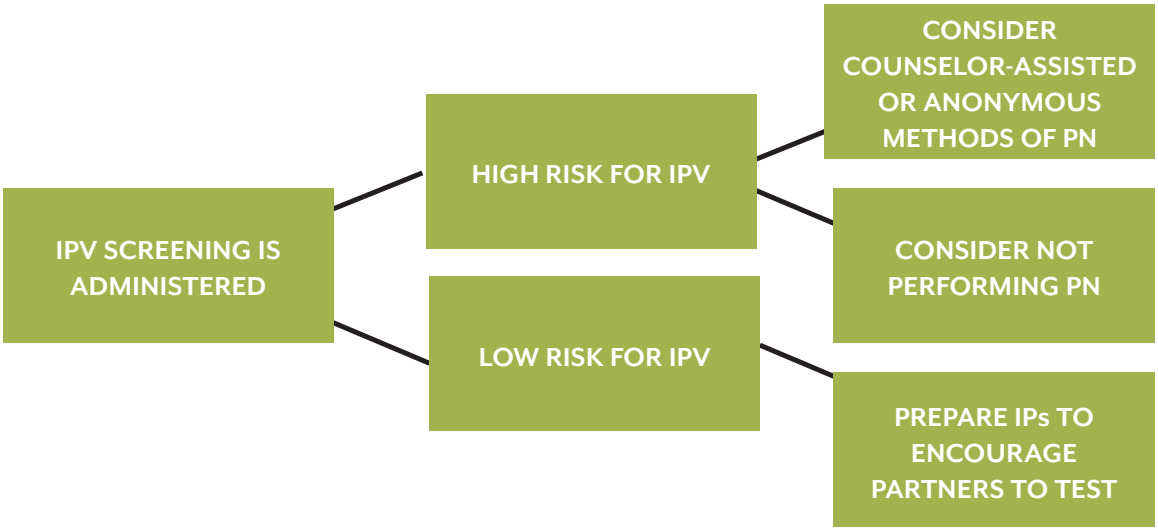
4. Has your partner ever threatened you in other ways, such as divorce, desertion, lack of support, taking away access to your children, or other threats?

   ☐ Yes ☐ No

Once an IPV screening tool such as the one above has been used, the figure below can provide guidance on actions recommended for health workers, HIV counselors, and providers of PN.

All programs will need to develop an IPV risk screening tool appropriate for their context. Below is an example.

Figure 5. Example of an IPV Screening Tool*



*Determination of high versus low risk of IPV will be driven by the individual screening process developed in each country.

RECOMMENDATIONS FOR ADDRESSING POTENTIAL ADVERSE OUTCOMES

- Ensure that all service providers that will be conducting clinical inquiry for IPV in the context of PN are trained to conduct such inquiry per WHO guidelines.
- Map available post-gender-based-violence care services, both clinical and nonclinical, to ensure that women who disclose violence are offered immediate referrals or access to services.
- Attention is also needed to serve male index patients, who may be deterred from PN due to fear of adverse outcomes such as changes in relationships, marital discord, stigma, and economic issues such as job loss.
- Develop clinical inquiry SOPs and job aids per WHO guidelines (see resources section) to ensure that all service providers follow the same protocols.
- Programs should include context-specific interventions to mitigate IPV and other potential adverse outcomes of PN. In cases when adverse outcomes appear more likely, couples counseling may not be appropriate. Other possible options include the use of anonymous notifi ation.

STEP 8. IMPROVING LINKAGE TO SERVICES

The WHO guidelines recommend offering PN as part of a comprehensive package of testing and care. Facilitating linkage to care remains a priority, and PN services should facilitate patient enrollment in services by aiding in the identification of patients. Index partners, newly diagnosed partners, and previously diagnosed partners who are out of care should be linked to treatment services, while partners who test HIV-negative should be linked to available prevention services.

PN also serves to improve linkage to care by means of disclosure, which evidence shows to be associated with higher uptake of services and retention to care (WHO 2012). To ensure optimal linkage, PN should not be considered a separate program, but rather incorporated into existing care services, where linkage to care can be strengthened.

CURRENT PRACTICE

Linkage of HIV-positive patients to ART is a priority, and obstacles include the initial identification of such patients, as well as the distance to and inconvenience of obtaining care at facilities. PN has been shown as a way to help overcome some of these barriers by facilitating identification of high-risk patients through index partner testing. Further, countries such as *Mozambique, South Africa*, and *Vietnam* include PN as part of service packages within testing and treatment facilities, increasing the likelihood of linkage to care when index partner and partners are identified. Programs in *Mozambique, South Africa*, and *Tanzania* have addressed problems of distance to facilities through community-based testing approaches, including mobile and door-to-door services.

USE OF MOBILE PHONES

Many countries have begun using mobile phones to follow up with named partners and invite them to come for testing. However, this approach is limited by unreliable mobile phone systems in some countries or incorrect phone numbers given by the index partner. Each country will need to assess whether it is appropriate to use mobile phones for this purpose, and funding may be needed to support the use of mobile phones by providers.

LINKAGE THROUGH PARA-PROFESSIONAL STAFF

In some countries, official policy limits those able to conduct PN to trained medical professionals. To alleviate the human resource burden that PN can place, some countries have turned to CHWs as essential partners. In *Kenya* and *Mozambique*, for example, CHWs are used to ensure critical follow up to both partners and index partners and to facilitate their linkage to care (see Figure 6). In *Uganda*, many PN programs have staff, such as village health teams, dedicated to linkage of care once notification and testing occur.

Figure 6. CHWs and Linkage to Services

PMTCT PARTNER ENGAGEMENT

In Tanzania, women who are newly diagnosed with HIV and are receiving PMTCT services are encouraged to inform their partners and bring them to the facility for testing. This passive strategy includes having village officials write letters to partners urging them to come for testing, and offer priority access to services for women who bring their partners.

RECOMMENDATIONS TO IMPROVE LINKAGE TO SERVICES

- PN programs should establish formal plans to link all persons receiving HTS to appropriate services. All HIV-positive patients should be linked to treatment services, and all HIV-negative persons should be linked to prevention services.
- To improve referral and linkage, countries should include PN programs as a part of an overall package of services for HIV prevention, testing, treatment, and care.
- Programs should include PN services in community-based testing approaches that have been effective in rural and poor communities.
- Programs should consider strategies that overcome their specific barriers to linkages, such as:
  - Co-locating services which previously were in distinct geographic locations
  - Employing mobile technology such as text messages
  - Maximizing the use of trained and supervised community-based providers, including both professional and para-professional workers.
- Self-testing protocols should include linkage components with identification of the closest and most convenient facilities or resources based on client profiles.

STEP 9. ENHANCING MONITORING & EVALUATION AND QUALITY ASSURANCE

WHO recommends systematic, confidential monitoring of PN services that includes the number and percentage of HIV-positive persons offered and accepting PN, partners identifi d per index partner, partners notified, testing positive, and enrolled in treatment, and adverse events affecting index partners following notification. WHO defines monitoring as routine tracking of services using information collected on an ongoing basis, such as client records, patient medical records, programmatic reports, and so forth. (See "Appendix 3. Additional Resources" for the WHO handbook on monitoring and evaluation [M&E] of HTS.) These measurements help evaluate program outcomes and impact and inform program strategies leading to improved results. The WHO handbook includes many recommended indicators for couples and partner testing, as well as for male partners of pregnant women. Additional indicators relating to PN should be tailored to the specific national and subnational context.

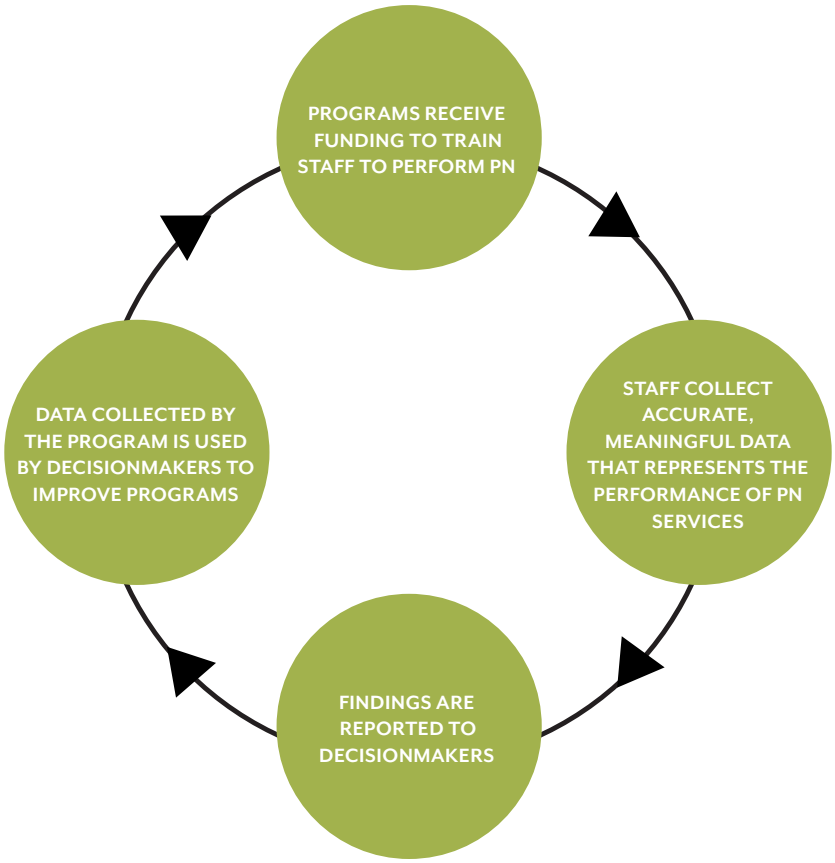
WHO defines evaluation as the episodic (not routine) assessment of changes in results that may be attributed to program activities, such as HTS. Suggestions on evaluation of HTS are included in the 2012 WHO handbook; these suggestions may help guide evaluation of PN services. Quality assurance is of great importance in an intervention like PN, with an increased potential for adverse outcomes when adherence to SOPs may be inconsistent. The 2012 document also includes methods to ensure quality assurance in testing programs PN services require similar methods.

CURRENT PRACTICE

The evidence base to inform PN is limited and is currently based on a small number of studies. There are few M&E systems which track routine performance of PN services outside of research studies. Most PN-related data tracking is derived from the main services such as HIV testing, ART, and PMTCT. In some instances, patients referred for PN services come to facilities and are tested and documented, but no information is recorded as to the referral being part of the PN services.

Within this assessment, there were not adequate trained personnel available to collect and use M&E data on PN programs. This gap appears to be due largely to a lack of funding and supportive policies. Also, as programs develop their PN strategies and training systems, they may consider implementing the learning-based M&E system (see Figure 7) to track its progress.

Figure 7. Learning-Based M&E System



RECOMMENDATIONS TO ENHANCE MONITORING & EVALUATION AND QUALITY ASSURANCE

- Programs should establish M&E systems to accurately track progress and the achievement of desired outcomes for the PN delivery models, focusing on ensuring systematic implementation as well as performance and outcomes.
- Quality assurance systems should be established to ensure that PN delivery methods are implemented as designed.
- Program M&E and QA should align with global best practices as much as possible.
- Service providers and PN program administrators should be trained to collect, compile, report, learn, and apply learning from the data collected in the M&E system.
- When necessary, programs should conduct research to better understand the results of the program and share lessons learned.

APPENDIX 1. TOOLS FOR IMPLEMENTING, DOCUMENTING, AND MONITORING PARTNER NOTIFICATION SERVICES

This appendix includes the following sample tools:

- **Tool 1.** Talking points for introducing partner testing services to index clients or patients
- **Tool 2.** Index patient information form (used to collect data on each index patient)
- **Tool 3.** Partner elicitation or identification form (used to identify partners of the index patient or client)
- **Tool 4.** Partner information form (used to collect more detailed information about each identified partner)
- **Tool 5.** Intimate partner violence screening tool
- **Tool 6.** Options and plan for partner testing
- **Tool 7.** Sample referral slip
- **Tool 8.** Sample scripts for use by health workers or HIV testing providers
- **Tool 9.** Sample "love letter"
- **Tool 10.** Guidance for index patients or clients to assist with disclosure to partners
- **Tool 11.** Outcomes of partner testing services form
- **Tool 12.** Testing form for HIV-exposed children

These tools may be adapted and modified in line with each country's policies, legal environment, specific programmatic issues, and the preferences of program managers. Each tool is on a separate page for ease of use and duplication.

Using the same (or similar) tools consistently will strengthen national PN services monitoring.

TOOL 1. TALKING POINTS FOR INTRODUCING PARTNER TESTING SERVICES TO INDEX CLIENTS OR PATIENTS

DURING PRETEST INFORMATION/COUNSELING, PROVIDERS SHOULD:

- Explain the importance of ensuring that all partners get tested for HIV.
  - HIV-positive partners can start on HIV treatment to keep them healthy and reduce risk that they will pass HIV to other sex partners and/or children.
  - HIV-negative partners can access HIV prevention services to help them remain HIV-negative, including condoms, pre-exposure prophylaxis, and male circumcision.
- Inform the index client that:
  - The clinic is offering partner testing services to assist the client to contact their partners so that these partners can learn their HIV status.
  - The service is offered because we know disclosure of HIV status to partners can be difficult.
  - You will be asking the client to list the names of all persons they have had sex with, including people they may have only had sex with once. If there are also persons the client has shared needles with, you will also ask for their names.
  - You will also be asking for the names of any child(ren) who may need an HIV test.

DURING POST-TEST COUNSELING AND/OR COUNSELING IN THE HIV CLINIC:

- Remind the client of the importance of partner testing using information from above.
  - Inform the client that there are three options for contacting their partners
    - Client can contact them to let them know they should be tested for HIV
    - Client can contact them within a certain time period, after which the provider will offer assistance if the partner hasn't been tested
    - The health care providers can contact the partners directly, without telling them the client's name (this will be done anonymously).
- Options for approaches such as use of "love letters" or couples counseling should be mentioned if offered.
- If the client chooses option two, they will have four weeks to bring in or refer their partner for HTS.
  - If the partner does not come in for HTS after four weeks, then the provider will contact the index client for permission to contact the partner.
- Inform the index client that:

- All information will be kept confidential. This means that:
  - Partners will NOT be told the index client's name or test results.
- The index client will NOT be told the HIV test results of their partner(s) or whether their partner(s) actually tested for HIV.
- You will NOT contact the partner without first contacting them to get their permission.
- They will continue to receive the same level of care at this health facility regardless of whether they choose to participate in PN services.
- Answer any questions that the index client might have and obtain verbal consent to continue.

= Use the **Tool 2: Index Patient Information Form** to record contact information for the index client.

TOOL 2. INDEX PATIENT INFORMATION FORM

Instructions: Complete this form while interviewing the HIV-positive index client who has verbally agreed to receive index partner testing or partner notification services.

***Complete one form per index client**

Date form completed (dd/mm/yyyy: _____ /_____ /_____

Name of person completing form: _____

Name of health facility or HIV testing site: _____

INFORMATION ABOUT THE INDEX CLIENT OR PATIENT

Index client's name (last, first, middle): _____

DOB: (dd/mm/yyyy): _____ **Age**: _____yrs.

Gender: ☐ Male ☐ Female ☐ Transgender (Male to Female) ☐ Transgender (Female to Male)

Marital status: ☐ Single ☐ Engaged to be married ☐ Married/cohabitating-monogamous
☐ Divorced ☐ Widow/er ☐ Married-polygamous: # wives _____

Client's personal mobile number: _____

Alternate contact number (if available): _____

Address (including any landmarks, e.g., "next to the church"):

_____

_____

Date of HIV diagnosis: (dd/mm/yyyy): _____

Is the index client currently enrolled in an HIV treatment program? ☐ Yes ☐ No

If yes, name of health facility _____

If yes, list the index client's ART enrollment number: _____

For women: How many children age 12 or under does the index client have?

_____ # children age 12 and under

TOOL 3. PARTNER ELICITATION OR IDENTIFICATION FORM

***Complete one form for each index client**

Instructions: Ask the index client to tell you the names of all the people they have had sex with in the past 12 months, including both main/married partners and casual/unmarried partners. If the client injects drugs, ask them to also tell you the names of their injecting drug use partners. You may wish to start with the main sex partner (or injecting drug use partner) and then ask about other partners, or you may wish to start by asking about the most recent partner and working backward in time.

LIST NAME(S) OF PARTNERS (TICK ☐ IF NAME IS UNKNOWN)	PHONE NUMBER	ALTERNATIVE PHONE NUMBER
1. ☐	_____ ☐ Unknown	_____ ☐ Unknown
2. ☐	_____ ☐ Unknown	_____ ☐ Unknown
3. ☐	_____ ☐ Unknown	_____ ☐ Unknown
4. ☐	_____ ☐ Unknown	_____ ☐ Unknown
5. ☐	_____ ☐ Unknown	_____ ☐ Unknown
6. ☐	_____ ☐ Unknown	_____ ☐ Unknown
7. ☐	_____ ☐ Unknown	_____ ☐ Unknown
8. ☐	_____ ☐ Unknown	_____ ☐ Unknown

TOOL 4. PARTNER INFORMATION FORM

***Complete one form for each partner named by the index client.**

Instructions: Ask the client to give you as much information as they can about each of the partners they named on the partner elicitation form.

Write "N/A" for any information not available.

After completing a separate form for each contact, file all completed forms in the client's folder or medical chart. Be sure to observe measures to maintain confidentiality of this information.

Partner's name (last, first, middle): _____

Partner's nickname: _____

Partner's DOB (dd/mm/yyyy): _____ Partner's age: _____ yrs.

Partner's gender: ☐ Male ☐ Female ☐ Transgender

Partner's physical description: _____

Partner's address (including any landmarks, e.g., "next to the church"):

_____

_____

_____

How would you describe your relationship to this partner?

☐ My wife/husband/fiancée ☐ We live together but are not married

☐ My girlfriend/boyfriend ☐ Someone I had sex with for fun

☐ Someone who pays me or gives me things to have sex with her/him

☐ Someone I paid to have sex with

Do you currently live with this partner?

☐ Yes ☐ No ☐ Declines to answer

As far as you know, has this partner ever tested positive for HIV?

☐Yes ☐ No ☐ Don't know ☐ Declines to answer

If known HIV-positive partner: is this partner currently taking medications for HIV?

☐ Yes ☐ No ☐ Don't know ☐ Declines to answer

TOOL 5. INTIMATE PARTNER VIOLENCE SCREENING TOOL

SCREENING TOOL FOR INTIMATE PARTNER VIOLENCE

Use this screening tool for all clients or patients who participate in PN services. Use one form for each partner identified by the client or patient. If the client or patient responds "yes" to any of these questions, consider options for partner notification that the index patient or client feels safe to use. Figure 5 on page 25 of this document illustrates a method to decide on PN methods based on the response to the intimate partner violence screening tool.

Please state to the client or patient:

Because your safety is very important to us, we ask all clients the following questions:

1. Has [partner's name] ever hit, kicked, slapped, or otherwise physically hurt you?

   ☐ Yes ☐ No

2. Has [partner's name] ever threatened to hurt you?

   ☐ Yes ☐ No

3. Has [partner's name] ever forced you to do something sexually that made you feel uncomfortable?

   ☐ Yes ☐ No

4. Has [partner's name] ever threatened you in other ways, such as divorce, desertion, lack of support, taking away access to your children, or other threats?

   ☐ Yes ☐ No

TOOL 6. OPTIONS AND PLAN FOR PARTNER TESTING

DECIDE ON A PLAN FOR PARTNER TESTING

Instructions: Show the "Options for Getting Your Partner Tested" card to the index client or read this to them if there are any challenges with literacy. Review the three options. Ask the client which option they would prefer and record their chosen option below. If the client chooses "contract referral," record the date (30 days from today's date) by which the partner should come for HIV testing services.

INDEX CLIENT'S PLAN FOR NOTIFYING THIS PARTNER:

☐ **Client Referral:** Index client will notify partner.

☐ **Provider Referral:** Health care providers will notify the partner.

☐ **Contract Referral:** Both the index client and health care provider will notify the partner.

The index client will first t y notifying the partner no later than _____/ _____ / _____ .

After which the provider will contact the partner (with permission from the index client).

☐ No partner testing needed, partner is known positive.

☐ Partner testing is not recommended at this time due to safety concerns.

TOOL 7. SAMPLE REFERRAL SLIP

Date: _____

HIV is a serious disease in our community. It is important that you come for an HIV test at _____ [name of health facility]_____ so that you can learn your HIV status. If you are HIV-negative, we can give you information on how you can remain free from HIV. If you are HIV-positive, we can give you medicines to treat your HIV. These medicines will help you stay healthy and reduce your chance of passing HIV onto others.

HIV testing services are available Monday–Friday from 8:30 in the morning until 5:00 in the evening. We hope you will come for an HIV test at your earliest convenience.

Please bring this referral slip with you.

Signature of Health Care Provider: _____

TOOL 8. SAMPLE SCRIPTS FOR USE BY HEALTH WORKERS OR HIV TESTING PROVIDERS

SCRIPT FOR PARTNER TESTING SERVICES: PHONE CALL

Good day. My name is _____ and I am a counselor/health care provider at _____[name of health facility]_____. Am I speaking with _____[partner's name]_____?

[IF NOT]: Is _____[partner's name]_____ available?

[If partner is not available]: Thanks. I'll try back later.

[If YES]: I have some important information for you. Is now a good time to talk?

[If NO]: When would be a better time for me to call you?

[If YES]: Before we begin, I just need to confirm that I am speaking with the right person. Can you please tell me your date of birth and home address?

If the person is unable or unwilling to confirm their date of birth and home address, ask them to come to the health facility for the information. Do not proceed with the notification until you can confirm their identity.

[After confirming date of birth and address]: "We have recently learned that you may have been exposed to HIV. It is important that you come to _____ [name of health facility]_____ for an HIV test so that you can learn your HIV status. If you are HIV-negative, we can give you information on how you can remain free from HIV. If you are HIV-positive, we can give you medicines to treat your HIV. These medicines will help you stay healthy and reduce your chance of passing HIV onto others.

HIV testing services are available Monday–Friday from 8:30 in the morning until 5:00 in the evening. Alternatively, we can send a counselor out to your home for an HIV test. Which option would you prefer?

[FACILITY TEST]: What day would you like to come in for an HIV test?

[HOME TEST]: What date and time would you prefer for the counselor to come to your home for an HIV test?

SCRIPT FOR PARTNER TESTING SERVICES: VOICE MAIL

Good day. My name is _____ and I am a counselor/health care provider at _____ [name of health facility]_____. I am trying to reach _____ [partner's name]_____ with some important health information. My phone number is XXX-XXX-XXXX. I will also try back later. Thank you and good-bye.

SCRIPT FOR PARTNER TESTING SERVICES: TEXT MESSAGES

Messages should be clear, concise, and professional.

SAMPLE FIRST MESSAGE

"Hello. My name is _____ and I am with the [name of health department, facility, or community organization]. I have important information about your personal health. Please call me as soon as possible at XXX-XXX-XXXX."

IF THE PERSON DOES NOT RESPOND TO YOUR FIRST MESSAGE WITHIN 24 HOURS, SEND A SECOND MESSAGE URGING THE PERSON TO CALL YOU

"This is _____ again with the (insert name of Health Department, Facility, or Community Organization). This is my second attempt to contact you. I have urgent health information for you. Please call me at XXX-XXX-XXXX."

IF THE PERSON DOES NOT RESPOND TO EITHER OF YOUR FIRST TWO MESSAGES A FINAL TEXT MAY BE SENT

"Hello. This is _____. I have been trying to contact you about important health information. Please call me at XXX-XXX-XXXX. This is my last attempt to contact you."

IF THE PERSON RESPONDS WITH A TEXT MESSAGE REQUESTING YOU TO SEND MORE INFORMATION

"I am not able to give health information through a text message. This is urgent and needs your immediate attention. Please call me at XXX-XXX-XXXX."

SCRIPT FOR PARTNER TESTING SERVICES: HOME VISIT

Good day. My name is _____ and I am a counselor/health care provider at _____[name of health facility]_____. I am looking for _____[partner's name]_____.
Is he/she around?

[IF NOT]: Ok, thanks. Do you know when he or she will be back?

[Once the partner is in front of you]: Is there a private place that we can talk?

[Once you are in private area where others cannot overhear]: I have some important information for you. We have recently learned that you may have been exposed to HIV. It is important that you get tested for HIV so that you can learn your HIV status. If you are HIV-negative, we can give you information on how you can remain free from HIV. If you are HIV-positive, we can give you medicines to treat your HIV. These medicines will help you stay healthy and reduce your chance of passing HIV onto others.

I can test you for HIV right now. Or, if you prefer, you can go to _____ [name of health facility]_____ for an HIV test. HIV testing services are available Monday–Friday from 8:30 in the morning until 5:00 in the evening. Which option would you prefer?

[HOME TEST]: Provide pretest counseling, informed consent, and post-test counseling according to national HTS guidelines.

[FACILITY TEST]: What day would you like to come to the health facility for an HIV test?

TOOL 9. SAMPLE "LOVE LETTER"

Mr/Mrs/Miss_____

REQUEST TO COME WITH YOUR PARTNER AT [FACILITY NAME], [FACILITY LOCATION]

We send our greetings to you Sir/Madam and thank you for all the work that you do.

In efforts to improve health outcomes in our households, you are requested to come with your partner, Mr/Mrs/Miss _____ at _____ [name of health facility] _____ on _____ [date]_____ at _____[time]_____. Matters of discussion are of high importance to both of you.

We look forward to seeing you then.

Yours in service:

Name: _____ **Signature:** _____

Head of [Facility Name]

TOOL 10. GUIDANCE FOR INDEX PATIENTS OR CLIENTS TO ASSIST WITH DISCLOSURE TO PARTNERS

MAKE A PLAN:

- Many people are afraid of telling their partner that they have HIV. It is helpful to make a plan for how and when you will tell your partner.
- Think about how you would like to be told, if your partner was disclosing to you.
- Choose a day and a time when you and your partner will have time to talk.
- You also want to pick a time when your partner is not stressed or angry, and has not been drinking alcohol.
- Pick a private place where you feel comfortable and safe. You may want to have someone in the next room to help and support you, if needed.

ANTICIPATE REACTIONS:

- Think about how your partner may react. Your partner may:
  - Offer you support or comfort you
  - Not believe it's true
  - Feel confused or sad
  - Feel angry
  - Accuse you of bringing HIV into the relationship or household.
- Think about how you will respond to these reactions.
- What questions may your partner ask you? How will you answer these questions?

START THE CONVERSATION:

- "I went to the clinic for a check-up the other day [or for xyz reason] and the doctor/nurse was encouraging people to get tested for HIV. So I got tested and learned that I have HIV. I wanted you to know so that you could also get an HIV test. There are medicines now for treating HIV that can help us stay healthy."
- "HIV is a very serious disease in our community. I decided to go for an HIV test. It turns out that I am HIV-positive. I already started on treatment. I think it is important that you also get tested for HIV so you can know your HIV status."

ENCOURAGE YOUR PARTNER TO GET TESTED FOR HIV:

- Give your partner the Referral Slip.
- Tell your partner that it is important they get tested for HIV. If they are HIV-positive, they can get medicines to treat their HIV. These medicines can help patients stay healthy and reduce the chance they will pass HIV onto others.
- If they are HIV-negative, there are things they can do to help them remain negative like use condoms, take pre-exposure prophylaxis, or get circumcised (if they are male).
- Offer support because this is difficult news for someone to hear. “We can work on this together. I will support you.”

PRACTICE FIRST!

Practice what you will say and do ahead of time. You can do that now with your health care provider or later by yourself in your home. This will help you feel comfortable on the day you tell your partner.

TOOL 11. OUTCOMES OF PARTNER TESTING SERVICES FORM

INDEX CLIENT INFORMATION

Name: _____

HTS/ART Clinic Number: _____

Gender: ☐ Male ☐ Female ☐ Transgender **Date of Birth:**_____/_____/_____

***Complete additional forms if index client has more than three partners.**

PARTNER 1	**PARTNER 2**	**PARTNER 3**
Gender: ☐ Male ☐ Female ☐ Transgender	Gender: ☐ Male ☐ Female ☐ Transgender	Gender: ☐ Male ☐ Female ☐ Transgender
Date of Birth: ___ /____ / ___	Date of Birth: ___ /____ / ___	Date of Birth: ___ /____ / ___
Type of Partner Testing: ☐ Client ☐ Provider ☐ Contract, date _____	Type of Partner Testing: ☐ Client ☐ Provider ☐ Contract, date _____	Type of Partner Testing: ☐ Client ☐ Provider ☐ Contract, date _____
Date/Method of 1st Contact Attempt: _____ /____ / ____ Phone Home	Date/Method of 1st Contact Attempt: _____ /____ / ____ Phone Home	Date/Method of 1st Contact Attempt: _____ /____ / ____ Phone Home
Date/Method of 2nd Contact Attempt: _____ /____ / ____ Phone Home	Date/Method of 2nd Contact Attempt: _____ /____ / ____ Phone Home	Date/Method of 2nd Contact Attempt: _____ /____ / ____ Phone Home
Date/Method of 3rd Contact Attempt: _____ /____ / ____ Phone Home	Date/Method of 3rd Contact Attempt: _____ /____ / ____ Phone Home	Date/Method of 3rd Contact Attempt: _____ /____ / ____ Phone Home
Was partner contacted? ☐ Yes ☐ No If yes, who contacted partner? ☐ Client ☐ Provider ☐ Client + Provider	Was partner contacted? ☐ Yes ☐ No If yes, who contacted partner? ☐ Client ☐ Provider ☐ Client + Provider	Was partner contacted? ☐ Yes ☐ No If yes, who contacted partner? ☐ Client ☐ Provider ☐ Client + Provider
Outcome of Partner Testing Services: ☐ Partner received an HIV test ☐ Partner refused an HIV test ☐ Partner known to be HIV-positive ☐ Other: _____	Outcome of Partner Testing Services: ☐ Partner received an HIV test ☐ Partner refused an HIV test ☐ Partner known to be HIV-positive ☐ Other: _____	Outcome of Partner Testing Services: ☐ Partner received an HIV test ☐ Partner refused an HIV test ☐ Partner known to be HIV-positive ☐ Other: _____
Partner's HIV status (if tested):, ☐ HIV-positive ☐ HIV-negative	Partner's HIV status (if tested):, ☐ HIV-positive ☐ HIV-negative	Partner's HIV status (if tested):, ☐ HIV-positive ☐ HIV-negative
Is the partner on ART (if HIV-positive)? ☐ Yes ☐ No	Is the partner on ART (if HIV-positive)? ☐ Yes ☐ No	Is the partner on ART (if HIV-positive)? ☐ Yes ☐ No

TOOL 12. TESTING FORM FOR HIV-EXPOSED CHILDREN

INDEX CLIENT INFORMATION

Name: _____

HTS/ART Clinic Number: _____

Gender: ☐ Male ☐ Female ☐ Transgender _____ **Date of Birth:** ____ /___ /___

No. of Children: _____

CHILD 1	**CHILD 2**	**CHILD 3**	**CHILD 4**
Name: _____	Name: _____	Name: _____	Name: _____
Gender: ☐ Male ☐ Female	Gender: ☐ Male ☐ Female	Gender: ☐ Male ☐ Female	Gender: ☐ Male ☐ Female
Date of Birth: ___ /___ /__	Date of Birth: ___ /___ /__	Date of Birth: ___ /___ /__	Date of Birth: ___ /___ /__
Child's HIV Status:	Child's HIV Status:	Child's HIV Status:	Child's HIV Status:
☐ HIV-positive	☐ HIV-positive	☐ HIV-positive	☐ HIV-positive
☐ HIV-negative	☐ HIV-negative	☐ HIV-negative	☐ HIV-negative
☐ Unknown	☐ Unknown	☐ Unknown	☐ Unknown
If tested HIV-positive,	If tested HIV-positive,	If tested HIV-positive,	If tested HIV-positive,
ART Start Date:	ART Start Date:	ART Start Date:	ART Start Date:
_____ / _____ / _____	_____ / _____ / _____	_____ / _____ / _____	_____ / _____ / _____
ART Client Number	ART Client Number	ART Client Number	ART Client Number
_____	_____	_____	_____

Instructions:

- Complete this testing form for all biologic children of the index client. If the index patient has more than four children, complete additional forms as needed so that all children are recorded.
- If the index HIV patient is a child, complete the form for all the child's of siblings and their biological parents.
- Children of male index clients do not need HIV testing unless their biological mother is HIV-positive, deceased, or her HIV status is unknown/not documented.
- This form should be reviewed and updated at least annually.

APPENDIX 2. SPECIFIC EXAMPLES FROM COUNTRIES WHERE ASSESSMENT WAS CONDUCTED

STEP 1. IMPROVING THE LEGAL AND POLICY ENVIRONMENT: EXAMPLES FROM THE ASSESSMENT

Many countries have policies or laws relating to PN. For example, a study in *Malawi* (Obermeyer 2013) observed that counselors *Côte d'Ivoire, Tanzania*, and *Vietnam* have laws requiring PLHIV to inform their partners and spouses of their status, but do not mandate any services to help them do so.

Under *Côte d'Ivoire* law, the provider must ensure that the partner(s) of PLHIV are informed and that "psychosocial" care is provided for the index partner and partners. However, providers appear to take a less formal approach and do not consistently follow up to ensure that partners are informed.

In *Tanzania*, PN is required by the national HIV/AIDS Prevention and Control Act of 2008; however, PN is also required to be voluntary in Tanzania, representing a policy inconsistency. Tanzania has made PN a part of standard practices for HIV testing as reflected in the Ministry of Health's (MOH) Comprehensive Guidelines. The policies are not currently available in local languages, which makes compliance difficult.

In *Vietnam*, PN is mandated in the National HIV/AIDS Law (2006), and HIV transmission is also punishable as an administrative violation. There are no national operational policies or guidelines on PN, although several local NGOs have developed guidelines for their own programs.

Kenya has no stand-alone PN laws or policies, but their MOH have issued guidelines on HIV testing that include PN. Some NGOs also have guidelines on PN. However, some legal language remains that allows PN without index partners' consent.

In *South Africa*, the National HIV Testing Guidelines (2015) encourage PN, and the MOH is developing national PN guidelines. However, confidentiality is entrenched in the Constitution; therefore, PN without the consent of the index partner is prohibited.

Uganda previously had a legal mandate for PN, but this was dropped, and currently there is no clear policy other than the statement in the HIV Prevention Act that health providers must notify partners if index partners fail to do so. The circumstances and procedures for such provider notification are unclear in the law.

STEP 2. SELECTING PARTNER NOTIFICATION DELIVERY MODELS: EXAMPLES FROM THE ASSESSMENT

PASSIVE APPROACHES TO PARTNER NOTIFICATION

In *Haiti*, passive PN is the most commonly used model. Some assistance—such as dual referral by the local NGO SEROvie reaching lesbian, gay, bisexual, and transgender people—is available from peer educators, support groups, and CHWs. Provider referral is not permitted in *Haiti* because of concerns of confidentiality.

In *Côte d'Ivoire*, there is no standard PN model prescribed, but passive referral with some provider assistance is most common. In *South Africa*, PN is primarily by passive referral and is strictly voluntary. In both *Tanzania* and *Vietnam*, the most common model is passive referral with some provider encouragement.

MIXED APPROACHES TO PARTNER NOTIFICATION

In *Kenya*, PN is practiced in most clinics and through home-based HTS and community outreach programs. Each organization decides on the model to use, but the most common is initially passive referral, then provider assistance (peer educator, counselor, or community health worker), if the index partner is unable or unwilling to notify his or her partners.

In *Mozambique* there is no national policy, and PN is limited to couples HTS in standard of care operations like PMTCT, where women are encouraged to bring their partners for testing and counseling and other ART services. Index patients report being urged to get their families involved in support of their adherence to treatment. PN takes place through various models, including passive PN as well as assisted notification.

In *Uganda* the most commonly implemented model is passive referral with encouragement and assistance. One NGO, The AIDS Support Organisation, which provides care, support and treatment for PLHIV, reports using a variant of a contract referral model in which index patients are given two weeks to notify their partners. If they fail to do so on their own, then providers work with index partners to develop notification strategies.

In *Tanzania*, index partners' willingness to identify and disclose their HIV status to partners is reportedly mixed, and PN is attempted through several models. In most cases, after an index partner is tested and identifies his or her partners, the provider's assessment determines the most appropriate PN approach. Most commonly, the first step is passive notification where the index partner, often without revealing that he/she has been tested, encourages their partners to come to the clinic for testing. Contract referral exists in *Tanzania*, but is not yet widely implemented. Community-based approaches in rural areas are also being implemented on a trial basis.

STEP 3. IMPROVING HUMAN RESOURCES AND TRAINING ON PN: EXAMPLES FROM THE ASSESSMENT

In *Côte d'Ivoire*, PN programs rely on health care provider training that does not include any specialized training on PN issues or strategies. In *Mozambique*, PN providers include professionals and para-professionals, with follow-up by CHWs and counselors. In *Uganda*, medical professionals, as well as community volunteers, local leaders, and peer educators are involved in PN. In *Vietnam*, provider training in PN has been conducted by community organizations.

STEP 4. DECIDING ON THE TIMING OF PN: EXAMPLES FROM THE ASSESSMENT

In many countries, policies and laws suggest that PN should occur very soon after the initial diagnosis, though specific time frames may be lacking. The index patient is often encouraged to notify partners in many different settings. For example, in *Kenya*, protocols used by a number of NGOs encourage women to notify partners in antenatal care, ART, HTS, PMTCT, and STI clinics, but uptake is limited.

STEP 5. SELECTING SPECIFIC METHODS TO NOTIFY PARTNERS: EXAMPLES FROM THE ASSESSMENT

All countries surveyed in this assessment demonstrated a range of PN approaches and means of communication:

- In *Kenya*, PN most commonly takes place through a telephone call or letter; or face-to-face, with a provider usually accompanying the index partner to meet the partner during a home visit.
- In *Mozambique,* mobile telephone communication is the most common channel for PN.
- In *South Africa*, PN is most commonly supported by trained counselors and CHWs within larger HIV testing programs.
- In *Tanzania*, most PN is face-to-face with referral cards provided to partners. Some programs also offer couples counseling and use text messages with neutral language for anonymous PN, such as encouragement for testing without identifying index partners.
- In *Uganda*, PN programs employ face-to-face and telephone communication, but only rarely use text messaging.

STEP 6. TAILORING PN TO PRIORITY POPULATIONS: EXAMPLES FROM THE ASSESSMENT

Many countries tailor PN methods to their own priority populations. For example, in *Tanzania*, the Tanzania Youth Alliance offers follow-up services for young girls and boys, adolescent mothers, as well as vulnerable populations of all ages, including sex workers, MSM, and heavy drinkers. In *Vietnam*, PN services are tailored to MSM and PWID, as well as their family members.

In *Kenya*, respondents observed that MSM index partners who are married with children may be unwilling to inform female partners because they do not want to explain how they contracted HIV. To address these issues, the Anova Health Institute in *South Africa* has developed a secure mobile application, Health4Men (www.h4m.mobi). This application provides HIV information, including clinic locations and an interface for asking experts questions about HIV and other health concerns.

STEP 7. ADDRESSING POTENTIAL ADVERSE OUTCOMES OF PN: EXAMPLES FROM THE ASSESSMENT

In *Uganda*, researchers found that HIV counselors wanted more guidance on how to proceed when members of discordant couples refused to reveal their HIV status, leaving partners or children at risk (Obermeyer 2013). Providers in *Uganda* also expressed concerns about not having strategies for maintaining confidentiality. Patients in *Uganda* observed that counselors and health workers bent the rules if they believed that family members or partners should know an index partner's HIV status, despite guidelines that should have protected index partners' privacy. Finally, the patients mentioned that providers could be rude and act as an additional barrier to quality service (Abt Associates Inc. 2016).

A study in *Malawi* (Obermeyer 2013) observed that counselors bent the rules if they believed that family members or partners should know an index partner's HIV status, despite guidelines that should have protected index partners' privacy.

STEP 8. IMPROVING LINKAGE TO SERVICE: EXAMPLES FROM THE ASSESSMENT

In many of the countries assessed, including *South Africa, Uganda, Kenya* and others, PN services are an integral component of universal "test and treat" approaches. Partners found to be HIV-positive are encouraged to enroll in care; this is emphasized when index patients are told about the importance of PN.

STEP 9. ENHANCING MONITORING, EVALUATION, AND QUALITY ASSURANCE: EXAMPLES FROM THE ASSESSMENT

In the eight countries assessed, there are few formal procedures for QA and quality improvement PN services.

In *Côte d'Ivoire*, data collection tools are in place to monitor and evaluate the PN program; such tools include fields related to PN and family screening. This assessment indicated that service providers do not receive adequate training to fill in the forms correctly, and informants observed that these fields are left blank on "almost all" patient files.

In *Tanzania*, the *National Comprehensive Guidelines for HIV Testing and Counseling of 2013* cover quality of testing, but do not address the quality of PN services. Similarly, in South Africa, there are currently no quality assurance policies on PN, though routine HTS QA activities exist and could be used to support PN services.

APPENDIX 3. ADDITIONAL RESOURCES

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APPENDIX 4. EVIDENCE BASE RELATED TO PARTNER NOTIFICATION

The following evidence is available on the effectiveness of PN.

FEASIBILITY OF PN

- A randomized controlled trial at STI clinics in Lilongwe, *Malawi* found that PN was feasible and effective. Newly diagnosed patients with HIV at a central hospital and outpatient STI clinics in Lilongwe were randomized to one of three methods of PN: passive referral or assisted referral, contract referral, or provider referral. Among locatable partners, 107 (24%) returned for HIV counseling and testing in the passive referral arm, compared with 51 percent in both the contract referral arm and the provider referral arm. Among the returning partners, 64 percent were HIV-positive and 81 percent of these were newly diagnosed. This study provided the first evidence of the greater effectiveness of active over passive PN in sub-Saharan Africa (Brown et al. 2011).
- A cross-sectional study in *Tanzania* led by Kahabuka (2017) demonstrated that an approach taken in three high-testing volume hospitals that offered index partners different options for PN (passive, contract, and provider referrals) reached 57 percent of the sexual partners identified by 390 index partners; 96 percent of those partners were tested, with 62 percent testing positive, all of whom were new diagnoses.

EFFECTIVENESS OF ASSISTED PARTNER NOTIFICATION

- The International Training and Education Center for Health implemented an *assisted partner service* program in *Mozambique*. The evaluation found that after four weeks, 206 index partners, 72 of whom (35%) were known to be in HIV-serodiscordant relationships, had notified 193 (73%) of 266 identified partners. CHWs directly notified 22 additional partners and tested 83 (39%) of the total 215 notified partners. The testing identified 43 new HIV-positive individuals (Feldacker et al. 2015).
- Armbruster et al. (2011) demonstrated that *provider referral* could be an effective method in a highly concentrated population—in this case a remote island in *Malawi*, with an estimated prevalence of <10 percent. In populations with higher prevalence, provider referral is an effective approach for the

spouses of index partners, and a complement to passive notification and generalized HIV testing campaigns using community-based approaches.

- Henley et al. (2011) found that *provider referral* was an effective model in *Cameroon*. A total of 1,462 index partners identified 1,607 sexual partners, of whom health advisors notified 1,347 partners (83.8%) and 900 (66.8%) were tested, with 451 (50.1%) testing HIV-positive and 386 (85.6%) enrolling in HIV care.

APPENDIX 5. METHODOLOGY OF THE ASSESSMENT TO DEVELOP THIS HANDBOOK

The handbook is based on information collected from policymakers and program implementers through semi-structured interviews in the eight countries, additional focused literature review, and review of policy and program documents and current guidelines and practices on PN in the United States and the United Kingdom.

This handbook is intended to complement WHO's guidelines and serve as a technical resource on successful approaches to PN. This technical resource focused on documentation of different models of PN and best practice in field implementation of these models.

STEP I: REVIEW EXISTING LITERATURE

The AIDSFree team conducted a rapid review of the peer-reviewed literature and reports that informed the entire activity, including the priority topics of the handbook and designing the data collection tool, a guide for a semi-structured interview. Primary attention was given to conducting interviews with key informants including program implementers and evaluators. In short, our focus was on obtaining and synthesizing the voices from the field with less reliance on the results of formal studies and trials.

STEP 2: IDENTIFY COUNTRIES AND KEY INFORMANTS

The handbook uses interviews with key informants across a range of countries to identify and discuss PN models. The countries were selected based on three main criteria: diversity of PN models, country diversity, and feasibility.

Regional diversity was considered with an emphasis on sub-Saharan Africa, where much of PEPFAR's investment in HIV and AIDS is focused. This included countries with unique policy challenges and programming contexts based on disease burden (HIV prevalence and related indices) as well as countries at different income levels (as this may influence program priorities) and technical guidance in HIV prevention services and a diversity of PN models. Countries were also included that presented different ways of addressing the general population and key populations because key populations may be less willing to disclose (Passin 2006) and may have a different approach. Countries with a range of experience and opportunity to implement the Partnership Framework Implementation Plan were also selected.

Lastly, practical and feasibility considerations influenced the selection of countries. These criteria included the availability of affiliated staff and programs in-country, and the potential to leverage those relationships to identify key informants and countries that have already studied HIV partner testing services—e.g., the countries included in the first literature review. The countries selected were: *Côte d'Ivoire, Haiti, Kenya, Mozambique, South Africa, Tanzania, Uganda, the United States*, and *Vietnam*.

In each country, country teams identified consultants based on their past work and potential access to the anticipated informants, such as individuals involved in the design, implementation, and evaluation of HTS and programs. Informants were identified using a purposeful approach, starting with selection of participants based upon the understanding of country programs, and emphasizing persons who are intimately involved in managing and supervising HTS within a given country program. Additional sources included MOH and national AIDS program officials, referenced authors from the literature review, and conference/webinar speakers. We maximized key relationships within the AIDSFree consortium, which includes USAID implementing partners, USAID, and our knowledge of local country experiences in HIV programming, to generate the list of key informants. The interview list was refined through discussion with local in-country collaborators, the consultants hired to interview the informants, and the Abt team. The study team also used snowball sampling, asking the initial set of respondents to refer them to other potential informants. Many individuals were contacted, and several organizations were represented by multiple individuals. Ultimately, informants were selected based on their knowledge of the programs and organizations involved in PN.

The Abt teams, staff, and consultants involved in the collection of data underwent a training via webinar on basic research methods. This one- to two-hour training ensured that all the persons conducting the interviews had a good grasp of the skills necessary to complete the work. This training also ensured that the data collection tool could be used consistently and correctly across several different countries and with individuals from different types of organizations.

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APPENDIX 6

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