# APS SCALE-UP PROJECT TRAINING SCHEDULE

<table>
<thead>
<tr>
<th>DAY 1</th>
<th>DAY 2</th>
<th>DAY 3</th>
<th>DAY 4</th>
<th>DAY 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00am to 10:30am</td>
<td>Introductions: Training objectives</td>
<td>Step-by-step introduction to aPS procedures for Index</td>
<td>Contact tracing: What are partners’ sexual networks, Phone tracing, In-person tracing, Confidentiality</td>
<td>Electronic data collection ODK usage, Technical issue reporting</td>
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<tr>
<td></td>
<td>Justification for aPS: Policy and research: UNAIDS 90:90:90, Passive referral, Contract referral, Provider initiated referral, WHO guidelines, aPS studies</td>
<td>New case report forms, Flow diagram of steps, Oral consents for HIV testing and aPS</td>
<td>Role play and practice Providing aPS to partners, Phone call, In-person tracing</td>
<td>Role play and practice Providing aPS to partners, Phone call, In-person tracing</td>
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<td>Role play and practice Review of client flow chart, Oral consent</td>
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<tr>
<td>11:00am to 1:00pm</td>
<td>National MOH HTS protocol review: Integrating aPS into HTS protocols, HTS guidelines, 3 W’s: When, where, who</td>
<td>Prevention of social harms among clients during aPS Screening for IPV, Management of IPV</td>
<td>Procedures for follow-up contacts in aPS Written consent</td>
<td>Role play and practice Review of aPS procedures and electronic data collection</td>
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<td>National MOH HTS protocol review: Integrating aPS into HTS protocols, HTS guidelines, 3 W’s: When, where, who</td>
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<tr>
<td>2:00pm to 4:00pm</td>
<td>Ethical issues in aPS: Confidentiality, Notification of sexual partners</td>
<td>Role play and practice Introducing aPS to index persons at HTS</td>
<td>Managing resistance &amp; Safety of staff Healthcare worker safety</td>
<td>M&amp;E in aPS Data Management and Control Importance of data integrity, Error reporting</td>
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</table>
Introduction in to Partner Notification Services (aPNS)

Dr. B. Wamuti
Global Map of HIV Prevalence

Adult HIV Prevalence, 2016

Global HIV Prevalence = 0.8%

NOTES: Data are estimates. Prevalence includes adults ages 15-49.
SOURCES: Kaiser Family Foundation, based on UNAIDS, AIDSinfo, Accessed July 2017

36.9 million people living with HIV globally - UNAIDS 2015 estimates
Global HIV Continuum Cascade

- 57% of PLHIV diagnosed
- 46% of PLHIV on ART
- 38% of PLHIV on ART & virally suppressed

43% of PLHIV still remain undiagnosed worldwide.

Source: UNAIDS, 2016 – based on 2015 measure derived from data reported by 87 countries, which accounted for 73% of people living with HIV worldwide; 2015 measure derived from data reported by 86 countries. Worldwide, 22% of all people on antiretroviral therapy were reported to have received a viral load test during the reporting period.
HIV/AIDS in Kenya
1.6 million people living with HIV in Kenya

HIV testing rates increasing

Sub-optimal identification of HIV infected cases

HIV Partner Services are vital
HIV infected individuals unaware of status in Kenya

Kenya: ~53.1% HIV infected individuals unaware of their status
Background: Heterosexual HIV transmission

• Main mode of HIV transmission: Heterosexual
  – Sub-Saharan Africa (SSA) ~70% of incident HIV infections\(^1\)

• Significant proportion of individuals unaware of HIV status
  – Sexual partners of HIV positive individuals are at high risk of HIV acquisition

\(^1\) UNAIDS 2016 estimates
UNAIDS 90-90-90 Strategy
New targets for HIV treatment scale-up by 2020

90% of all living with HIV will know their HIV status
90% of all living with HIV will receive antiretroviral therapy
90% of all receiving antiretroviral therapy will have viral suppression
To achieve the first target, two things are needed:

1. Improved effectiveness of HIV testing services
2. Reach undiagnosed people and link them to care

Meeting the first “90” of the 90-90-90 Strategy

- 90% of all living with HIV will know their HIV status
- 90% of all living with HIV will receive antiretroviral therapy
- 90% of all receiving antiretroviral therapy will have viral suppression
HIV PARTNER SERVICES
Partner Services Conceptual Framework

Index Case

- Interview with HIV+ person
- Sex partner elicitation
- Partner notification
- Strategies:
  - Patient referral (self discloses HIV+)
  - Contract referral
  - Provider referral
- Offer HIV testing
- Linked to care
- New HIV+ sex partner
• **What is “Assisted Partner Notification Services”?**
  - Also known as disclosure or contact tracing; provider referral
  - Opt-out approach
  - Defined as a voluntary process whereby a trained provider asks people diagnosed with HIV about their sexual partners and/or drug injecting partners, and if the HIV-positive client agrees, reach out to these partners and offer HTS

• **Index Case** (Index Client): refers to a person living with HIV whose partners need to be notified

• **Partner**: refers to a person who has been exposed to HIV potentially by the index client
  - Sexual partners, injection drug use partner
  - HIV-exposed infants and children
• Partner Services (PS) in use in US, Europe. Beneficial in:
  – Improving HIV testing
  – Earlier diagnosis, referral and initiation of HIV care

• Few SSA countries implementing PS at program level:
  – Cameroon\(^1\): First program in SSA- PS scalable, effective
  – Malawi\(^2\): First randomized control trial (RCT), PS effective
  – Kenya\(^3\): Cluster RCT – effective, low risk for adverse outcomes
  – Mozambique\(^4\): Small pilot program; acceptable, effective, low risk of adverse outcomes

\(^1\) Henley et al, 2013; \(^2\) Brown et al, 2011; \(^3\) Cherutich et al, 2017; \(^4\) Myers et al, 2016
Cluster RCT of Assisted Partner Services (aPS) in Kenya

- Conducted in 2013-2015
- 18 rural and urban areas in central and western Kenya
- Intervention arm: Immediate aPS
- Control arm: Delayed aPS by 6 weeks
- Results:
  - Partner testing rates increased by 4-fold
  - Rates of first-time HIV testing among men increased by 11-fold
  - Rates of testing HIV positive increased by 3-fold
  - Rates of those enrolled in HIV care increased by 4-fold
  - No intimate partner violence (IPV) cases attributable to intervention
Assisted partner notification services to augment HIV testing and linkage to care in Kenya: study protocol for a cluster randomized trial

Beatrice Muthoni Warnuti, Laura Kelly Erdman, Peter Cherutich, Matthew Golden, Matthew Dunbar, David Bukusi, Barbra Richardson, Anne Ng'ang'a, Rianne Barnabas, Peter Maingi Muniti, Paul Macharia, Mable Jerop, Felix Abuna Otieno, Danielle Poole and Carey Farquhar


Assisted partner services for HIV in Kenya: a cluster randomised controlled trial

Dr Peter Cherutich, PhD, Prof Matthew R Golden, MD, Beatrice Warnuti, MBChB, Prof Barbra A Richardson, PhD, Kristjana H Ásbjörnsdóttir, PhD, Felix A Otieno, Ann Ng'ang’a, BDS, Peter Maingi Muniti, BA, Paul Macharia, MSc, Betsy Sambai, BSc, Matt Dunbar, PhD, David Bukusi, MMed, Prof Carey Farquhar, MD for the aPS Study Group

Understanding Barriers to Scaling Up HIV Assisted Partner Services in Kenya

Marielle Goyette, MPH, Beatrice Muthoni Warnuti, MBChB, MBA, Mercy Owuor, MSc, David Bukusi, MBChB, MMEd, Peter Maingi Muniti, BA, Felix Abuna Otieno, Peter Cherutich, MBChB, MPH, PhD, Anne Ng'ang’a, BDS, MSc, and Carey Farquhar, MD, MPH
National Goal to Achieve the First “90” of 90-90-90 Targets

- 2016 WHO Recommendation:

  Recommendation

  Voluntary assisted partner notification services should be offered as part of a comprehensive package of testing and care offered to people with HIV (strong recommendation, moderate quality evidence).

- Followed by the new international guidelines, Kenya has been in the active role for initiating and scaling up aPS at country-level
  - Started pilot testing aPS at facilities in Homa Bay and Kisumu counties as a way of integrating and implementing aPS into routine HTS
Assisted Partner Notification Services: Approaches used

- **Passive referral**: Index case to notify their partners

- **Provider referral**: an approach where trained healthcare providers confidentially contacts the person’s partner(s) directly and offers them voluntary HTS; done with the consent of the HIV-positive index client

- **Contract referral**: an approach where HIV-positive clients enter into a contract with a trained healthcare providers to notify and refer their partners to HTS within a specific period of time

- **Dual referral (~Couple counselling)**: an approach where trained providers accompany HIV-positive clients and assist with disclosure of HIV status and potential exposure to HIV infection to their partners. The provider also provides HTS to the partner(s) at the same time
TARGETED PARTNER SERVICES: Men

STUDY AIMS
Men are a hard-to-reach population

• Despite the increase in HIV testing in both men and women, programmatic gap still exists in reaching people for HIV testing in Kenya
• Men as a hard to reach population
  – 62% of men noted to be unaware of their status compared to 48% of women
aPS PATH scale-up program

• Collaboration between:
  – Ministry of Health - NASCOP
  – PATH – Kenya
  – University of Washington

• Program goal 1:
  – To determine the effect of integrated aPS on HIV testing and linkage to care, particularly among men, in western Kenya

• Program goal 2:
  – To assess the best mechanism to successfully integrate and scale-up the aPS program nationwide
AIM 1 Evaluate **effectiveness and optimization** of assisted partner services (aPS) when integrated within the existing HIV services by measuring:

1) Rates of first-time HIV testing among men
2) Rates of “new” male HIV infections and HIV-discordant couples
3) Linkage to HIV care and initiation of ART for partners of index cases
4) Suppression of plasma HIV RNA levels among these HIV-infected men
AIM 1: APS Approach

Recruitment of Index Participants in routine aPS
- Eligibility screening
- Informed consent

Baseline Interviews with Index Participants
- Demographic characteristics
- Sexual behavior
- HIV testing history

Provision of Partner Notification Services
- Male partners of index participants
- Female partners of male participants

Follow-up at 12 months with all participants
- HIV Viral load test

Follow-up at 6 months with all participants
- ART initiation

Follow-up at 6 weeks with all participants
- Linkage and engagement in care

Outcome measurements:
- # first-time HIV test recipients
- # newly diagnosed HIV+ participants
- # known HIV+ but not in care
- Rate of linkage to care and ART initiation
- Viral suppression within one year of receiving aPS
Adapt and leverage existing facility instruments to allow complete integration of aPS

- Examples: HTS intake forms, PrEP risk assessment forms, MOH 362 forms

Utilize proven electronic data collection methods using ODK
AIM 2 Determine **fidelity, feasibility, cost and cost-effectiveness** of implementing integrated aPS services by measuring:

1) Implementation elements associated with high uptake of HIV testing, linkage to care and treatment

2) Health facility and individual-level factors that influence **fidelity** to the aPS intervention

3) **Acceptability, demand, and health system requirements influencing feasibility**

4) Impact on health outcomes during and after integration of aPS into existing HIV testing services

5) **Costs and cost-effectiveness** of aPS when integrated into existing HIV testing services
AIM 2: Determine Fidelity, Feasibility, Cost and Cost-effectiveness of Implementing aPS Services

Sites

Using facility-level criterion-based sampling, a subset of study sites will be randomly selected from:

- 9 wards in Homa Bay and Kisumu wards (same as Aim 1)
- Selected sub-county & county administrative offices linked to health facilities
- NASCOP’s national administrative offices in Nairobi

Facility-level selection criteria:

1) aPS service performance levels (high vs. low)
2) Facility patient volume (high vs. low)
Population

Study participants will include:

1) Individuals in leadership positions at the county and national level
2) HIV testing services (HTS) counselors
3) Beneficiaries and non-beneficiaries of the aPS intervention
## AIM 2: Study Approach

<table>
<thead>
<tr>
<th>Data source/participants</th>
<th>Fidelity</th>
<th>Acceptability</th>
<th>Demand</th>
<th>Technical Efficiency</th>
<th>Integration</th>
<th>Cost/C EA</th>
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<tr>
<td>Beneficiary</td>
<td>IDI*, FGD*</td>
<td>IDI, FGD</td>
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<tr>
<td>Non-beneficiary</td>
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<td>O*</td>
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<td>SSI, FGD</td>
<td>O, SSI</td>
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<td>Sub-county AIDS coordinator</td>
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<td>County AIDS coordinator</td>
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<td>HTS counselor logs</td>
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<tr>
<td>Health facility infrastructure</td>
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*O= observations/checklist; FGD=focus group discussion; SSI=Semi-structured interview; Q=questionnaire; DA=data extraction; NASCOP=National AIDS and STI Control Program
AIM 2: Study Approach cont.

Fidelity:
• At 12 months after site activation, aPS advisors will observe 4 HTS sessions per facility, and tracing phone calls, 4 community-based tracing visits per HTS counselor

Acceptability
• 30 in-depth interviews and 10 focus group discussions at 10 selected facilities and safe spaces

Demand
• Documentation of key stakeholders experiences with (provision, administrative oversight, and actual use of) the aPS intervention activities

Integration
• 10 interviews will be conducted in the first 3 months of study initiation

Cost and cost-effectiveness
• Individual-based, stochastic models will be used to estimate the impact of ART on incident cases of averted HIV and HIV deaths
• CEA analyses: ICER per incident HIV case, HIV-related death, and DALY averted will be estimated using the effectiveness estimated in Aim 1
STUDY SITES, POPULATION
APS Identifying HIV+ Partners through Social/Sexual Network and Linking them to Care
Who Are We Recruiting?

Index Case: Women
Partners: Male sexual partners of Index Case
Partners of partners: Female sexual partners of male partners

3 times impact across different populations
Rolling out Integrated APS at Health Facilities

• APS will be *integrated* into the existing HIV services and rolled out in subsets of health facilities in Homa Bay and Kisumu counties
  – To examine the effect of aPS and *how best we can integrate and scale up* at national-level
  – Strong emphasis on provider-referral
Sites for implementation

Table 1. Wards, safe spaces, and health facilities in Homa Bay and Kisumu counties

<table>
<thead>
<tr>
<th>Homa Bay Wards</th>
<th>Kisumu Wards</th>
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<tbody>
<tr>
<td>Homa Bay Central</td>
<td>Kajulu</td>
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<tr>
<td>Homa Bay West</td>
<td>Manyatta B</td>
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<tr>
<td>Homa Bay East</td>
<td>Nyalenda A</td>
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<tr>
<td>Homa Bay Arugo</td>
<td>Kolwa Central</td>
</tr>
<tr>
<td></td>
<td>Kolwa East</td>
</tr>
<tr>
<td><strong>4 safe spaces</strong></td>
<td><strong>5 safe spaces</strong></td>
</tr>
<tr>
<td><strong>14 facilities</strong></td>
<td><strong>24 facilities</strong></td>
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General Population vs. Project Population

- **Study Population**
  - Index Participants:
    - HIV+ girls and women ≥18 yo,
    - HIV +ve girls ≥15 yo and both married
  - Partner Participants:
    - Male partners of index participants
    - Female partners of these male partners

- Exclusion Criteria for Index Participants:
  - Pregnant
  - Reports IPV within the last 1 month
  - <15 years old

- The team will only have access to data collected from who are eligible and willing to participate in the project (follow-up procedures)
STUDY TEAM
APS Project Team

Carey Farquhar
Principal Investigator, Professor, University of Washington, Seattle

Edward Kariithi
Site Principal Investigator, Senior Service Delivery Advisor, PATH, Kenya

Other co-investigators and research personnel:
Peter Cherutich, Deputy Medical Director, Kenya MoH
Sarah Masyuko, Assistant Deputy Director of Medical Services, Kenya MoH and NASCOP
Christopher Okoth Obong’o, Adolescent Health Advisor, PATH, Kenya
Bryan Weiner, Professor, University of Washington, Seattle
Carol Levin, Associate Professor, University of Washington, Seattle
Ruanne Barnabas, Associate Professor, University of Washington, Seattle
Matthew Golden, Professor, University of Washington, Seattle
Barbra Richardson, Research Professor, University of Washington, Seattle
Study Advisory Board (SAB)

Purpose:
• Oversee study procedures to ensure compliance with national HIV testing, care, and treatment guideline
• Provide feedback to address aPS implementation challenges

A total of two SABs
• One SAB per county (7-8 persons)

Meetings will occur every six months

SAB Composition:
• County Director of Health
• Sub-county ASCO (CASCO), Community Focal Person, HRIO
• HTS technical advisors from PATH (Kisumu) and EGPAF (Homa Bay)
• APS Health advisors
• People living with HIV
Strengths & Benefits

• Close collaborations between UW, PATH, MoH, and community
  – In line with NASCOP’s interests of adapting aPS
  – County involvement: Study Advisory Board

• Full picture of aPS integration procedures
  – Leverage existing services to allow complete integration
  – Comparison between years 1-2 and 3-4

• Targeting “hard-to-reach” populations

• Accelerate the process to meet the first “90” target of the UNAIDS 90-90-90 Initiative

• Adaptations by other organizations and countries
Benefits of Partner Notification Services

• Individuals (index and partners)
  o Timely access to ART
  o Increase quality of life, improved life expectancy

• Family
  o Mutual knowledge of HIV status increases trust

• Population
  o Reduced HIV transmission
  o Increased number of people on ART
Potential Risks of Partner Notification Services

- Individual (index and partners)
  - Potential for intimate partner violence (IPV)
  - Risk of stigma with inadvertent disclosure of HIV status

- Family
  - Family separation and marriage dissolution

*Important to retain strict confidentiality to reduce potential social harm of index cases*
Overall Target Population of APS

- Adults

- Key populations: PWID, Commercial sex workers, MSM, AGYW

- Youths and adolescents

- HIV exposed infants and children
Thank you

Questions?
Achieving the UNAIDS 90-90-90 Targets: 
Reaching the Male Populations through 
Partner Notification Services

Introduction to APS
April 2018
Global Map of HIV Prevalence

36.7 million people living with HIV globally
UNAIDS 90-90-90 Strategy

New targets for HIV treatment scale-up by 2020

90% of all people living with HIV will **know their HIV status**

90% of all people with diagnosed HIV infection will **receive sustained antiretroviral therapy**

90% of all people receiving antiretroviral therapy will have **viral suppression**
Global HIV Continuum Cascade

43% of PLHIV still remain undiagnosed worldwide

- 57% PLHIV diagnosed
- 46% PLHIV on ART
- 38% PLHIV on ART & virally suppressed

Source: UNAIDS, 2016 – based on 2015 measure derived from data reported by 87 countries, which accounted for 73% of people living with HIV worldwide; 2015 measure derived from data reported by 86 countries. Worldwide, 22% of all people on antiretroviral therapy were reported to have received a viral load test during the reporting period.
Meeting the First “90” of the 90-90-90 Strategy

To achieve the first target, two things are needed:

1. Improved effectiveness of HIV testing services
2. Reach undiagnosed people and link them to care
1. Improved Effectiveness of HIV Testing Services

- WHO’s essential 5Cs:
  - Consent
  - Confidentiality
  - Counselling
  - Correct test results
  - Connection

- Pre-test information
- Post-test counseling
- Linkage to HIV services
- Quality HIV testing
- Accurate test results and diagnosis
- Coordination with laboratory services for quality assurance
2. Reach Undiagnosed People and Link Them to Care

- Despite an increase in HIV testing in both men and women, a programmatic gap still exists in reaching people for HIV testing in Kenya.
- The gap in HIV testing is bigger for men compared to women.

Source: UNAIDS Kenya Narrative Report 2014
Traditional Approach of HIV Testing Services in Kenya

• Client/Patient referral (passive):
  o **WHO Definition**: Passive PNS refers to when HIV-positive clients are encouraged by a trained provider to disclose their status to their sexual and/or drug injecting partners by themselves, and to also suggest HTS to the partner(s) given their potential exposure to HIV infection

  o This method does not involve direct involvement of a trained health provider

• Health provider helps an index client to establish the information to be communicated with the partner(s)
Assisted Partner Notification Services (aPS)

• **What is “Assisted Partner Notification Services”?**
  - Also known as disclosure or contact tracing; provider referral
  - Opt-out approach
  - Defined as a voluntary process whereby a trained provider asks people diagnosed with HIV about their sexual partners and/or drug injecting partners, and if the HIV-positive client agrees, reach out to these partners and offer HTS

• **Index Case** (Index Client): refers to a person living with HIV whose partners need to be notified

• **Partner**: refers to a person who has been exposed to HIV potentially by the index client
  - Sexual partners, injection drug use partner
  - HIV-exposed infants and children
Assisted Partner Notification Services

• Takes an active approach in notifying sexual partners who have been exposed to HIV

• Innovative approaches:
  o **Provider referral**: an approach where trained healthcare providers confidentially contacts the person’s partner(s) directly and offers them voluntary HTS; done with the consent of the HIV-positive index client
  
  o **Contract referral**: an approach where HIV-positive clients enter into a contract with a trained healthcare providers to notify and refer their partners to HTS within a specific period of time
  
  o **Dual referral (“Couple Counseling”)**: an approach where trained providers accompany HIV-positive clients and assist with disclosure of HIV status and potential exposure to HIV infection to their partners. The provider also provides HTS to the partner(s) at the same time
Contact Tracing of Partners

- Using the information given by the index client, trace and notify the partners who may have had contact with HIV

“I think the person should always be contacted and if the person who has the infection does not want to do it then they should be contacted by the clinic. It is not right someone being in danger of having a disease and have it themselves and spread it onto other people unknown that they might have it. It’s a domino effect isn’t it? It can spread really quickly.”

(sexual contact traced by a sexual health adviser)
APS Identifying HIV+ Partners through Social/Sexual Network and Linking them to Care
Evidence from RCT to Guide Policy Decision Making

• WHO reviewed three individually randomized controlled trials (Malawi and U.S) and one cluster randomized controlled trial (Kenya)

• Findings include:
  o Provider or contract referral can increase uptake of HIV testing services among partners of HIV-positive individuals
  o APS can increase the number of people knowing their HIV status (including the unknown HIV+ individuals)
  o APS can increase the number of HIV+ individuals linked to care
  o Rare reported cases of social harm and other aPS-related adverse events in both passive or active referral
Fig 3.3 Time to Presentation at Clinics for Partners of HIV-positive Clients associated with Passive and aPS Methods in Two Trials in Malawi


Source: Rosenberg et al., 2015(7). Reprinted with permission from Elsevier.
Additional Studies Supporting the Impact of APS

HIV partner notification is effective and feasible in sub-Saharan Africa: Opportunities for HIV treatment and prevention

Lillian B Brown, William C Miller, Gift Kamanga, Naomi Nyirenda, Pearson Mmodzi, Audrey Pettifor, Rosalie C Dominik, Jay S Kaufman, Clement Mapanja, Francis Martinson, Myron S Cohen, and Irving F Hoffman

Scale-Up and Case-Finding Effectiveness of an HIV Partner Services Program in Cameroon: An Innovative HIV Prevention Intervention for Developing Countries

Catherine Henley, MPH, Gideon Forgwe, BA, Thomas Welty, MD, Matthew Golden, MD, Adsora Adimora, MD, MPH, Raymond Shields, MD, and Pius T. Muthif, PhD

Assisted partner services for HIV in Kenya: a cluster randomised controlled trial

Dr Peter Cherutich, PhD, Prof Matthew R Golden, MD, Beatrice Wambui, MBChB, Prof Barbra A Richardson, PhD, Kristjana H. Asbjörnsdottir, PhD, Felix A Otieno, Ann Ng’ang’a, BDS, Peter Malangi Mutili, BA, Paul Macharia, MSc, Betsy Sambai, BSc, Matt Dunbar, PhD, David Bukusi, MMed, Prof Carey Farquhar, MD for the aPS Study Group

Improving HIV test uptake and case finding with assisted partner notification services

Shona Dalal, Cheryl Johnson, Virginia Fonner, Caitlin E, Kennedy, Nandi Siegfried, Carmen Figueroa, and Rachel Baggalay
New WHO Guidelines in 2016

• WHO recently published Guidelines on HIV Self Testing and Partner Notification Services:

  **Recommendations**

  HIV self-testing should be offered as an additional approach to HIV testing services (*strong recommendation, moderate quality evidence*).

  Voluntary assisted partner notification services should be offered as part of a comprehensive package of testing and care offered to people with HIV (*strong recommendation, moderate quality evidence*).

• Align with the Kenya Ministry of Health’s interests and focus
Three Meanings of Partner Notification

Partner notification is a highly complex concept. While often simplified to denote the notification of persons who are at risk of becoming infected with a disease, partner notification has at least three distinct, if at times overlapping, meanings:

1. Contact tracing
2. The duty of infected persons to disclose their infection to a sexual partner
3. The duty of health care providers to warn of sexual and other risks to the partners of their infected patients
1. Contact Tracing

- Originated from the regulation of prostitutes in sixteenth century Europe, is characteristically a governmental responsibility undertaken by public health authorities

  - The health department interviews an infected patient, “index case,” who voluntarily discloses the names and locations of past and present sexual partners
  - These contacts are then located—traced—when possible to notify them of their potential exposure to infection
  - The partner is not informed of the name of the index case by health authorities in an attempt to preserve the confidentiality of the index case
  - Medical treatment and personal counseling often are offered to contacts at the time of notification
  - For those persons who are infected, the process is regenerated to determine additional contacts

- It also stems the tide of new infections by medically intervening to treat the disease and by counseling those infected with STDs to reduce the risk of transmission by disclosing their infection to partners and engaging in “protected” sexual activity (e.g., using a condom)
2. The duty of infected persons to disclose their infection to a sexual partner

• What we term “the duty to disclose” is derived from the legal doctrine of the “right to know”
  
  o This “right to know” developed from the social hygiene movement of the early 1900s and likely was influenced by women’s organizations and early principles of feminism
  
  o It developed under tort law that held that a person has a duty of care toward his sexual partner. This duty may entail an obligation to disclose an STD to a sexual partner or to reasonably protect the partner from avoidable health risks
  
  o In some instances, a health department or physician may ask a patient to disclose the STD to his partner, a concept often referred to as “patient referral” since the patient makes the disclosure
3. The duty of healthcare providers to warn of risks to the partners of their infected patients

- Derived from a related legal doctrine known as a “duty to warn”
  - Through conversations with an infected patient, a physician may conclude that certain persons are at risk of contracting the disease
  - Under the “duty to warn,” physicians treating a patient for a sexually transmitted disease have a duty to inform fully foreseeable third parties of their exposure to the infection, regardless of whether the patient consented to such notification or the patient’s identity was protected
  - This practice is sometimes known as “provider referral,” as the health care professional (or public health counselor in contact tracing programs) makes the disclosure
  - Similar to theories of tort law later enacted in statutory law, the duty to disclose and the duty to warn have as their principal objective the protection of unaware individuals from exposure to disease by others who know of their infectious conditions and are in control of their actions
  - The judicial imposition of these duties may have had the unintended result of decreasing the transmission of infectious disease among certain populations
  - The imposition of these duties thus shared a primary goal with contact tracing: the reduction of infectious disease transmission in society
Rationale for Partner Notification Services

• Individuals with asymptomatic infection should be identified and treated to reduce morbidity and duration of infectiousness

• Protect uninfected individuals from acquiring HIV; reduce further transmission of HIV in the network
Principles of Partner Notification Services

- **Client centered** = index partner testing services should be focused on the needs and safety of the index client and his or her partner(s) and child(ren)

- **Client chooses** the most appropriate method for informing each partner based on his/her circumstances

- Delivered in a **non-judgmental manner**

- **Confidential** = 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 explicit consent from all parties is obtained)

- **Voluntary and non-coercive** = index partner testing services should always be voluntary; mandatory or coercive approaches are never justified

- **Accessible and available to all** = partner testing should be available to all index clients regardless of where they are diagnosed (e.g. in a health facility or community setting)

- **Comprehensive and integrative** = partner testing services should include strong referral and linkages to HIV treatment and prevention services
Benefits of Partner Notification Services

• Individuals (index and partners)
  o Timely access to ART
  o Increase quality of life, improved life expectancy

• Family
  o Mutual knowledge of HIV status increases trust

• Population
  o Reduced HIV transmission
  o Increased number of people on ART
Potential Risks of Partner Notification Services

• Individual (index and partners)
  o Potential for intimate partner violence (IPV)
  o Risk of stigma with inadvertent disclosure of HIV status

• Family
  o Family separation and marriage dissolution

*Important to retain strict confidentiality to reduce potential social harm of index cases*
Overall Target Population of APS

• Adults

• Key populations
  – PWID, FSW, MSM, AGYW

• Youths and adolescents

• HIV exposed infants and children
Thank you

Questions?
Ministry of Health’s National HTS Guidelines on Assisted Partner Notification Services
National Goal to Achieve the First “90” of 90-90-90 Targets

• 2016 WHO Recommendation:

  Recommendation

  Voluntary assisted partner notification services should be offered as part of a comprehensive package of testing and care offered to people with HIV (strong recommendation, moderate quality evidence).

• Followed by the new international guidelines, Kenya has been in the active role for initiating and scaling up aPS at country-level
APS Technical Working Group

Technical working group comprised of a group of Kenyan leaders with expertise in HTS and aPS

- Dr. Peter Cherutich
- Dr. Sarah Masyuko
- Dr. David Bukusi
- Dr. Beatrice Wamuti
- Dr. Jonathan Mwangi
- Mary Mugambi
Kenya Policy and Guidance

This is anchored in international, national policy, and legal framework

- HIV Prevention and Control Act 2006:
  - Requires that a person who is aware of the HIV infection status has the **responsibility of informing sex contacts or needle sharing partners of their HIV status**. Furthermore, the same person may request any medical practitioner or any person approved by the Minister under section 16 to inform and counsel a sexual contact of the HIV status of that person. This forms the legal basis for HIV partner services in Kenya. Indeed, **it’s a requirement for a health provider to provide notification services if the said person has not notified their partners after a reasonable duration and has not sought the assistance of the health provider.**
Kenya Policy and Guidance cont.

• The HTS guidelines:
  
  o Proposes **disclosure to sex partners as standard of care and a legal requirement**. However the PNS guidelines are more progressive and would imply **active support to sex partners** to receive HIV testing and linkage to HIV care. It is instrumental to distinguish between disclosure which is a mechanism for HIV infected person to inform family and significant others of their status for the purposes of emotional support. In all these scenarios, **partner services shall be voluntary and client-centered**.
Partner Notification Services in Kenya

• Effective aPS will be delivered within the existing HTS protocol in line with the national HTS guidelines 2016

• APS are guided by the 5C’s of confidentiality, counseling, consent, correct results, and connection to care

• Three main referral approaches implemented in Kenya:
  1. Passive referral
  2. Provider referral
  3. Contract referral
Partner Notification Services Process Flow

**Pre-test counselling session**
- Introduce partner notification services (PNS), its benefits and risks
- Conduct risk assessment – Focus on number of recent sexual partners (at least in past 12 months)

**Testing session**
- Discuss on benefits of disclosure of HIV test results to sexual partners

**Post test counselling session**
- Engage index client in development of a risk reduction plan
- Revisit benefits of disclosure of HIV test results to sexual partners
- Revisit benefits of offering PNS to sexual partners
- Obtain consent for disclosure to sexual partners if provider will conduct the notification
- Obtain sexual partner contact information

**Assessment of other health related conditions**
- Conduct assessment for risk during PNS including intimate partner violence (IPV)
- Assess risk for sexually transmitted infections (STIs) and opportunistic infections that would also require notification

**Referral and linkage to care**
- Offer appropriate and effective referral and linkage to care
- Obtain accurate locator information from the index client (physical location, phone number)
Steps of Partner Notification Services

**Step 1:** Introduce Partner Notification Services (PNS) to the index client
- Use **PNS Talking Points** to introduce PNS to the index client and complete

**Step 2:** Obtain a list of partners in last 12 months
- Use the register to record partner(s) names and contact information

**Step 3:** Screen all named partners for Intimate Partner Violence (IPV)
- Document in the register results of IPV screening and preferred partner notification method.
- Complete each line for each named partner

**Step 4:** Determine the preferred method of partner notification for each named partner and record on PNS register
- **Provider Referral (aPNS):** Initiate partner contact attempts using telephone and home visit scripts.
- **Contract Referral (aPNS):** Provide referral card and disclosure script to index client and agree that client will refer partner for HTS within 30 days.
- **Client Referral:** provide “Tips for Telling Your Partner about HIV” and referral slip
- Complete each line for each named partner

**Step 5:** Contact all named partners using the preferred approach
- Was partner successfully contacted?
- Complete each line for each named partner

**Step 6:** Record partner notification outcomes on the PNS form
- Record successful partner contact (including HIV status) on **PNS register**
- Complete each line for each named partner
- If **Contract Referral**, initiate provider referral after 30 days; otherwise record unusual contact on **PNS register**.
- Complete each line for each named partner
Referral and Linkage

• Kenya Ministry of Health strives to provide all HIV-positive individuals comprehensive referral and linkage to post-test services:
  o Referral and service Information
  o Disclosure of HIV status
  o Addressing barriers to linkage
  o Establishing systems to facilitate linkage
  o Care coordination and Integration

• Prevention interventions will be provided to those who test HIV-negative:
  o PrEP, PEP, VMMC, FP, GBV Care
Considerations for Offering aPS to Index Clients

3 **W**’s:

• When should it be offered?
• Who should offer aPS?
• Where should aPS be offered?
1. When should APS be Offered?

Partner notification is **NOT** a one time event

- Dynamic of sexual relationships and social networks may change over time

APS should be offered:

- Immediately after HIV diagnosis
- At least once a year as part of routine HIV treatment services
- After a change in relationship status
2. Who should Offer APS?

Partner notification services, including partner elicitation, can be delivered by any healthcare provider depends on the setting.

- Healthcare professions include, but not limited to:
  - HTS counselors, nurses, nursing assistants, linkage coordinators, patient navigators, or case managers

All healthcare professionals should be trained on the importance of aPS and how to conduct it appropriately.
3. Where should aPS be offered?

APS should be integrated in:

- All facility-based HIV testing service delivery points
  - Examples: co-located VCT, ANC, TB clinic, VMMC clinic, pediatric wards, nutrition clinic, etc.

- All facility-based HIV treatment sites
  - Examples: PMTCT, CCC, etc.

- As part of community-based HIV testing programs
  - Examples: mobile, home, workplace, drop-in centers, venue-based community-mobilization activities, etc.
Other Things to Keep in Mind

• Improving access
  – Clients should be offered an option of testing for HIV at any of the HIV testing service delivery points, whether it is at a clinic or an off-site venue

• Reducing Stigma
  – Addressing stigma-related concerns and potential breach of confidentiality is critical to increase the uptake of aPS
  – If aPS is offered at home, we could consider offering HIV testing to all households

• HIV-negative pregnant and breastfeeding women in high-burden areas
  – In high prevalence areas, HIV-negative pregnant or breastfeeding women should be offered aPS to reduce risk of HIV acquisition
  – APS would also reduce the risk of mother-to-child transmission from an acute HIV infection during pregnancy or breastfeeding period

• Partner to index
  – When a partner tests HIV-positive, s/he will also receive aPS; partner becomes a new index client
    • DOMINO EFFECT
  – Linking sexual partners of partners to disrupt the HIV transmission cycle
Summary

• APS requires trained personnel to elicit, trace, and notify partners of their exposure to HIV

• APS could be labor and time-intensive but the benefits of reducing new cases and increasing people on care outweighs costs

• Maintaining strict confidentiality is key to success of aPS
Thank you

Questions?
Ethical Concerns related to Assisted Partner Notification Services
Introduction

• Assisted partner notification can be ethically challenging

• Counselors may feel dilemmas as they balance their duty to both the individual patient and their partners

• This can make it difficult to:
  – Respect the autonomy of the individual
  – Do good for everyone concerned
  – Avoid harming anybody
  – Treat all fairly
Discussion Questions

1. Should pressure be applied to clients to accept aPS?

2. What about encouragement? How much pressure is acceptable?

3. What is the difference between encouragement and coercion?

4. Can providers tell lies?

5. If notified partners fail to get tested or linked to care, should providers contact and remind them?

6. Should partners be notified without consent from index clients?
Discussion Questions

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6. Should partners be notified without consent from index clients?
Should pressure be applied to clients to accept aPS?

“The more partners I notify of their exposure, the better it is, right?”

<table>
<thead>
<tr>
<th>In Favor of Applying Pressure</th>
<th>Against Applying Pressure</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Duty to protect partners at risk of significant harm</td>
<td>• Violates autonomy and voluntary participation</td>
</tr>
<tr>
<td>• Duty to protect community from future transmission</td>
<td>• People who feel coerced into giving names or permission may avoid counselor in the future or give false information</td>
</tr>
</tbody>
</table>
Discussion Questions

1. Should pressure be applied to clients to accept aPS?

2. What about encouragement? How much pressure is acceptable?

3. What is the difference between encouragement and coercion?

4. Can providers tell lies?

5. If notified partners fail to get tested or linked to care, should providers contact and remind them?

6. Should partners be notified without consent from index clients?
What about encouragement? How much pressure is acceptable?

HTS Counselors should encourage clients to accept aPS and while:

- Remembering that assisted partner notification services are voluntary
- Staying committed to the autonomy of clients
- Being conscious of their personal attitudes and word choices to minimize coercion
Discussion Questions

1. Should pressure be applied to clients to accept aPS?

2. What about encouragement? How much pressure is acceptable?

3. What is the difference between encouragement and coercion?

4. Can providers tell lies?

5. If notified partners fail to get tested or linked to care, should providers contact and remind them?

6. Should partners be notified without consent from index clients?
What is the difference between encouragement and coercion?

• Encouragement may be justified when the degree of anticipated harm of not accepting aPS is greater
  – For example there may be a greater duty to advocate on behalf of a pregnant partner

• But, there is a fine line between encouragement and coercion
  – Coercion can be bullying, threatening, or blackmailing clients to accept aPS; making patients feel guilty or ashamed for not sharing their partner's names
Discussion Questions

1. Should pressure be applied to clients to accept aPS?

2. What about encouragement? How much pressure is acceptable?

3. What is the difference between encouragement and coercion?

4. Can providers tell lies?

5. If notified partners fail to get tested or linked to care, should providers contact and remind them?

6. Should partners be notified without consent from index clients?
Can providers tell lies?

• Trust depends on public confidence that health providers tell the truth

• Lying may have far reaching consequences

• The need to tell the truth is upheld by most ethical codes because:
  – It's a moral principle
  – It's a condition of autonomy upon moral value tests
  – It's a social convention that is likely to maximize benefits over harm
Can providers tell lies?

• Situations where white lies are justified:
  – When they may protect the client from harm or violence (e.g. contact tracing)

• To prevent suspicion by partners, especially on how providers obtained their information
  – This can be avoided by adopting a telephone manner that assimilates the way a friend or business contact might sound

A justification of these lies is that they honor the overriding duty to protect the person's confidentiality and harm no one
Can providers tell lies?

- Suppose a man, who was diagnosed with HIV some months earlier, promises to bring his partner for testing *only if* the HTS counselor colludes with his story that he is also being tested for the first time on the same day. He agrees he will then tell the partner his result, regardless of his partner's HIV status.

  - A refusal to lie would jeopardize the partner's access to health care if positive or ability to avoid future risk if negative.

  - However, agreeing to lie involves the counselor in serious deceit, if the truth were to emerge in the future the trust between the partner and service may be severely damaged.
Discussion Questions

1. Should pressure be applied to clients to accept aPS?
2. What about encouragement? How much pressure is acceptable?
3. What is the difference between encouragement and coercion?
4. Can providers tell lies?
5. If notified partners fail to get tested or linked to care, should providers contact and remind them?
6. Should partners be notified without consent from index clients?
If notified partners fail to get tested or linked to care, should providers contact and remind them?

<table>
<thead>
<tr>
<th>Arguments Against</th>
<th>Arguments in Favor</th>
</tr>
</thead>
<tbody>
<tr>
<td>The clinic has fulfilled its duty by informing the partner, now the individual is responsible for their health</td>
<td>Establishing the reason for non-attendance as a way of making the service more accessible to the individual is important</td>
</tr>
<tr>
<td>Reminders could be perceived as harassment and alienate people and discourage cooperation with HTS counselors</td>
<td>Contacts might need more information about testing or more reassurance about confidentiality</td>
</tr>
</tbody>
</table>
If notified partners fail to get tested or linked to care, should providers contact and remind them?

There is a duty to the community to minimize the incidence if HIV. There is evidence that contacts who attend following reminders have higher rates of infection than contacts who were informed only once (69% vs 49%)
Discussion Questions

1. Should pressure be applied to clients to accept aPS?

2. What about encouragement? How much pressure is acceptable?

3. What is the difference between encouragement and coercion?

4. Can providers tell lies?

5. If notified partners fail to get tested or linked to care, should providers contact and remind them?

6. Should partners be notified without consent from index clients?
Partner notification without Index
Client’s consent

If HTS counselor has the contact information of an exposed partner, should they notify the partner without the client's consent?
Should partners be notified without the consent of the client?

<table>
<thead>
<tr>
<th>Arguments in Favor of Notifying</th>
<th>Arguments Against Notifying</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The partner has the right to know and the counselor has a duty to warn them</td>
<td>• Risk breaching trust and jeopardizing confidentiality in situations where the partner’s only recent partner was the index person</td>
</tr>
<tr>
<td>• There is a greater duty if the partners are also registered patients of the facility as a direct contractual duty of care is invoked</td>
<td>• Client may be put in danger of reprisals, and damage the relationship between the client and clinic, compromising future care.</td>
</tr>
<tr>
<td>• May be regarded as inequitable for some partners to have more rights than others to the same warning</td>
<td>• Long-term damage to public health if and mistrust of services</td>
</tr>
<tr>
<td>• Failure to notify may be seen as a breach of public trust</td>
<td></td>
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</table>
Discussion Questions Overview

• There are complex ethical issues that need to be considered during contact tracing

• It is good practice to discuss difficult choices with colleagues, and document the reasons for the decisions made
WHOs 5 Cs of HIV Testing Services

APS is an HIV testing service and should meet the following criteria within its scope:

- Consent
- Confidentiality
- Counseling
- Correct Test Results
- Connection
WHO's 5 Cs of HIV Testing Services

- Consent
- Confidentiality
- Counseling
- Correct Test Results
- Connection
Consent

• It should never be assumed that a client has accepted aPS services by accepting HIV testing

• As previously mentioned assisted partner notification services are voluntary
  – Patients should continue to receive quality HIV testing and counseling regardless of their decision to accept aPS
WHO's 5 Cs of HIV Testing Services

- Consent
- Confidentiality
- Counseling
- Correct Test Results
- Connection
Confidentiality

• APS services must be confidential

• Discussions held between the HTS counselor and the client should not be disclosed to a third party without consent of the person being tested

• Although confidentiality must be respected, it should never be used to reinforce secrecy, stigma or shame

• Counsellors should always ask clients, who they wish to inform and how they would like this to be done

• HTS counselors should reassure clients that the contact information of they choose to provide will be stored securely
Confidentiality

- HTS counselors should take measures to ensure that partners being notified of their exposure are in a private place and have time to discuss these issues.

- HTS counselors should also take measures to ensure that partners know that only they have been notified of their exposure and no one else.
WHO's 5 Cs of HIV Testing Services

• Consent
• Confidentiality
• **Counseling**
• Correct Test Results
• Connection
Counseling

• Pre-test and post-test counselling should be provided if appropriate

• All persons should have the opportunity to ask questions about aPS if they request it

• All HTS must be accompanied by appropriate and high-quality post-test counselling, based on HIV test results
WHO's 5 Cs of HIV Testing Services

- Consent
- Confidentiality
- Counseling
- Correct Test Results
- Connection
Correct Test Results

- A single reactive self-test result does not provide an HIV-positive diagnosis.
- It should be followed by further testing and confirmation by a trained provider.
- All people who receive a positive HIV diagnosis should be retested to verify their diagnosis before initiation of ART or HIV care.
WHO's 5 Cs of HIV Testing Services

- Consent
- Confidentiality
- Counseling
- Correct Test Results
- Connection
Connection

• Linkage to prevention, treatment and care services should include the provision of effective and appropriate follow-up.

• Providing HTS in situations where there is no access or poor linkage to care, including ART, has limited benefit for those with HIV.
Ethical Considerations from Previous APS Study

- We can anticipate situations we may encounter and ways of dealing with them from past experiences

Understanding Barriers to Scaling Up HIV Assisted Partner Services in Kenya

Marielle Goyette, MPH, Beatrice Muthoni Wamuti, MBChB, MBA, Mercy Owuor, MSc, David Bukusi, MBChB, MMed, Peter Mutiti Maingi, BA, Felix Abuna Otieno, Peter Cherutich, MBChB, MPH, PhD, Anne Ng’ang’a, BDS, MSc, and Carey Farquhar, MD, MPH
Ethical Considerations from Previous APS Study

• Qualitative study:
  o 20 in-depth interviews with clients who declined APS enrollment
  o 9 focus groups with health advisors and HTS counselors and the general HTC client population from aPS RCT
Anticipating Barriers

• “He counseled me and told me not to be scared because I will not be the first or the last to test positive. I gained courage after the talk and tested positive. I asked if my state was so bad and I was about to die, but he told me that I am not doing bad, that I was still very strong. He told me to start medication and make sure I adhere to the doctor’s instructions to the letter, and that I will even bury so many people who will be dying from other diseases not necessarily HIV, and I felt I was calm and ok with the results. So, I am continuing with drugs.” (IDI, female, age 38)
Anticipating Barriers

• "I think it [declining APS] is because of trust. I thought that by giving them the names and contacts of my partners, they would tell them that I am the one who gave their contacts because I tested HIV-positive." (IDI, male, age 30)
Anticipating Barriers

• “I think the main reason [for declining APS] is the one I had mentioned earlier that I had just been found positive and I still had a lot of questions to answer within myself. I was living in denial ...” (IDI, male, age 51)
Anticipating Barriers

• “When I saw the results, I was very shocked, and at that time, I did not want to talk to anyone. My mind was confused that I didn't know what to do and telling my wife or having someone tell her was not in my mind at that time.” (IDI, male, age 30)
Anticipating Barriers

• “He always has problems with me, and this will be a reason for him to accuse me. APS program is good, but what I fear is violence at home as a result of that.” (IDI, female, age 46)
Anticipating Barriers

• “I know I have only one sexual partner and I am told that your sexual partner is positive, of course I will know it is him. This is why you hear of some scandals where someone has been killed ... so, it is good to ask more to establish whether this partner has one partner or more before doing the notification.” (FGD 8, female, age 44, HTC Counselor)
Anticipating Barriers

• “When I test positive, you can just come to my house and pretend that you have never seen me. Don't tell him that I have been to the VCT. Pretend you have never seen me and test us afresh. So, he will see my status and I will also see his.” (FGD 2, female, age 30, General HTC Client)
Anticipating Barriers

• “In my farming job, there are certain things I sell to people, like bananas and vegetables, and being that if the word is out that I am HIV-positive, no one will ever want to buy anything from me.” (IDI, male, age 48)
Anticipating Barriers

• Key Messages:
  – Trust is important
  – Confidentiality is essential
  – Encouragement or pressure should never be coercive
  – HTS counselors should empathize with clients' situations to build trust
Thank you

Questions?
Step-by-Step Introduction to APS Procedures for Index Cases

Standard Operating Procedures
April 2018
Review of Terminology

• Assisted Partner Notification Services (aPS)
  o A voluntary process whereby a trained provider asks people diagnosed with HIV about their sexual partners and/or drug injecting partners, and if the HIV-positive client agrees, reach out to these partners and offer HTS
    o As known as provider referral

• Index Case (Index Client): refers to a person living with HIV whose partners need to be notified

• Partner: refers to a person who has been exposed to HIV potentially by the Index Client
  o Sexual partners, injection drug use partner
  o HIV-exposed infants and children
Objectives of the aPS Scale-Up Project

Goal 1:
To assess effectiveness of integrated aPS on HIV testing and linkage to care, particularly among men, in western Kenya

Goal 2:
To assess the best mechanism to successfully integrate and scale-up the aPS program nationwide
Rolling out Integrated aPS at Health Facilities

- aPS is integrated into the existing HIV services and rolled out in health facilities in Homa Bay and Kisumu counties
  - To examine the effect of aPS and how best we can integrate and scale up at the national-level: utilization of existing tools
  - Strong emphasis on provider referral

Project Sites

- 4 Homa Bay Wards
  - (14 facilities and 4 safe spaces)
- 5 Kisumu Wards
  - (21 facilities and 5 safe spaces)

<table>
<thead>
<tr>
<th>Homa Bay Wards</th>
<th>Kisumu Wards</th>
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<tr>
<td>Homa Bay Central</td>
<td>Kajulu</td>
</tr>
<tr>
<td>Homa Bay West</td>
<td>Manyatta B</td>
</tr>
<tr>
<td>Homa Bay East</td>
<td>Nyalenda A</td>
</tr>
<tr>
<td>Homa Bay Arujo</td>
<td>Kolwa Central</td>
</tr>
<tr>
<td></td>
<td>Kolwa East</td>
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</table>
Leveraging Two Existing Programs

- **APHIAplus**: AIDS, Population and Health Integrated Assistance
  - Mechanism for enhancing HIV care and services in government facilities
  - Supported by the Ministry of Health
  - PATH-led, PEPFAR-funded
  - *Now it is transitioned to USAID Kenya and East Africa HIV Service Delivery Support Activity (HSDSA)*

- **DREAMS**: Determined, Resilient, Empowered, AIDS Free, Mentored and Safe
  - Program aiming to reduce new HIV cases by providing girls and young women at high risk of infection with tailored service; the program also targets clients’ male sexual partners, families, and communities
  - All 9 wards have at least 1 linked DREAMS safe space
  - Safe Spaces hosted in non-clinical settings (educational institutions, churches, etc.)
Current Partner Notification Services

• Rapid implementation of PNS occurred in October 2017
  – Ministry of Health and LVCT

• Project sites are currently providing PNS, which has a few key differences from aPS
  – HTS Counselors are aware and comfortable with providing PNS

• PNS registry is available at each facility
Key Differences Between PNS and aPS

• Eligibility criteria
  – General population vs. more targeted population
  – PNS is currently offered to *all* populations, including pregnant women, sexual partners, needle sharing partners, and children

• Types of referrals provided
  – Client, contract, dual, and provider

• Oral scripts
  – Exposure to HIV

• IPV screening
  – Ever vs. last one month
Who Are We Recruiting for aPS?

Index Case: Women

Partners: Male sexual partners of Index Case

Partners of partners: Female/Male sexual partners of male partners

3 times impact across different populations
Index Case Eligibility Criteria for APS

*Eligibility criteria for Index Case is more stringent than the one for the current PNS activities*

**aPS should be offered to:**
- Adolescent girls and young women who newly test HIV-positive at project sites
- Not in care or on treatment
- ≥15 years old
- Able and willing to provide informed written consent

**aPS should not be offered to:**
- Pregnant based on Client’s self-report
- Clients reporting intimate partner violence (IPV) within the last one month with any identified sexual partner (High risk for IPV)
- <15 years old
Who Should be Provided with aPS?

• Although we are interested in evaluating effectiveness of aPS in a select population, we will provide aPS to all populations just like how PNS has been done until now
  – Importance from the programmatic perspective

• We will distinguish different participants using their program ID (a.k.a. PTID)
aPS Recruitment Overview

• Summary:
  – All clients walking through VCT will be offered to test for HIV as per Kenyan national guidelines
  – If test is seropositive, HTS counselors refer clients for aPS
  – If clients are willing, they will be screened for eligibility (including IPV)

• Materials:
  – HTS Intake Form
  – HIV Test Result Form
  – HIV Refusal Form
  – aPS Willingness Form
  – Written Consent Form
Study Recruitment: Introduction

- Client enters VCT and is greeted by the HTS Counselor
- Client is led to a private room for HIV testing, pre- and post-HIV counseling and screening for aPS
- Once in safe, private environment, HTS counselor will determine client's language preference (English, Swahili or Luo) and proceed with CRFs in appropriate language
Study Recruitment: Introduction

• HTS counselor will record **Client Serial Number** and **HTS Counselor ID** in the "HTS Intake Form"

• HTS counselor will use the barcode to generate **Client Program ID**, called PTID

• HTS counselor will walk through the HTS Intake Form and assess whether s/he is interested in HIV testing

*All clients of VCTs will complete HTS intake form regardless of their decisions to test for HIV*
Step 1: HTS Intake Form

ALL clients enter VCT complete this form

3 sections:
- Introduction
- Demographic information
- HIV testing/treatment history

First few questions in Section 1 allow us to assess whether the client has been notified of potential exposure HIV or not
Step 1: HTS Intake Form

**ALL** clients enter VCT complete this form

3 sections:
- Introduction
- Demographic information
- HIV testing/treatment history

Q8.1 Date of Birth
- We prefer knowing exact DOB, but if not known, there is an option to enter age

Q7 Cell phone number
- If the Client does not have a personal phone number, ask how best counselors should contact the Client. Record this in the comments box
### Step 1: HTS Intake Form

**ALL** clients enter VCT complete this form

3 sections:
- Introduction
- Demographic information
- HIV testing/treatment history

<table>
<thead>
<tr>
<th>SECTION III. HIV TESTING/TREATMENT HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>17. Have you ever tested for HIV before today?</td>
</tr>
<tr>
<td>17.1 What was the date of your last HIV test?</td>
</tr>
<tr>
<td>17.2 What was the result of the last test before today?</td>
</tr>
<tr>
<td>17.3 What motivated you to test for HIV then? (Select all that apply)</td>
</tr>
<tr>
<td>□ Partner is HIV-positive (Go to Q17.4)</td>
</tr>
<tr>
<td>□ Pregnant or partner was pregnant</td>
</tr>
<tr>
<td>□ Starting a new sexual relationship</td>
</tr>
<tr>
<td>□ Symptoms or illness indicative of HIV</td>
</tr>
<tr>
<td>□ Diagnosed with an STI</td>
</tr>
<tr>
<td>□ Sought care and health worker recommended HIV test</td>
</tr>
<tr>
<td>□ Other (specify):</td>
</tr>
<tr>
<td>□ Health Worker told me</td>
</tr>
<tr>
<td>□ Partner told me</td>
</tr>
<tr>
<td>□ Other Source (not Partner or Health Worker), specify:</td>
</tr>
<tr>
<td>17.4 How did you know your partner is HIV-positive?</td>
</tr>
<tr>
<td>18. Have you ever enrolled (registered) at any HIV clinic for HIV care?</td>
</tr>
<tr>
<td>18.1 If yes, when did you enrol (register) in HIV care?</td>
</tr>
<tr>
<td>18.2 Which facility did you enrol?</td>
</tr>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>18.3 Are you currently enrolled in HIV care?</td>
</tr>
<tr>
<td>19. Risk Behaviours in the 12 months prior to testing (Select all that apply)</td>
</tr>
<tr>
<td>□ Sex partner(s) is HIV+ AND:</td>
</tr>
<tr>
<td>□ Sex partner(s) at high risk for HIV and HIV status currently unknown</td>
</tr>
<tr>
<td>□ Not on ART</td>
</tr>
<tr>
<td>□ &lt; 6 months ART use</td>
</tr>
<tr>
<td>□ Poor adherence to ART</td>
</tr>
<tr>
<td>□ Detectable HIV viral load</td>
</tr>
<tr>
<td>□ Couples is trying to conceive</td>
</tr>
<tr>
<td>□ Unknown ART status</td>
</tr>
<tr>
<td>□ Have sex with more than one partner</td>
</tr>
<tr>
<td>□ Ongoing IPV/GBV</td>
</tr>
<tr>
<td>□ Recurrent use of PEP</td>
</tr>
<tr>
<td>□ Recurrent sex under influence of alcohol/recreational drugs</td>
</tr>
<tr>
<td>□ Inconsistent or no condom use</td>
</tr>
<tr>
<td>□ IDU with shared needles/syringes</td>
</tr>
<tr>
<td>□ None of the above</td>
</tr>
<tr>
<td>□ Ever used PrEP</td>
</tr>
<tr>
<td>□ Recurrent sex under influence of alcohol/recreational drugs</td>
</tr>
<tr>
<td>□ Inconsistent or no condom use</td>
</tr>
<tr>
<td>□ IDU with shared needles/syringes</td>
</tr>
<tr>
<td>□ None of the above</td>
</tr>
<tr>
<td>□ Recurrent use of PEP</td>
</tr>
<tr>
<td>□ Recurrent sex under influence of alcohol/recreational drugs</td>
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<td>□ Inconsistent or no condom use</td>
</tr>
<tr>
<td>□ IDU with shared needles/syringes</td>
</tr>
<tr>
<td>□ None of the above</td>
</tr>
<tr>
<td>□ Ever used PrEP</td>
</tr>
<tr>
<td>□ Recurrent sex under influence of alcohol/recreational drugs</td>
</tr>
<tr>
<td>□ Inconsistent or no condom use</td>
</tr>
<tr>
<td>□ IDU with shared needles/syringes</td>
</tr>
<tr>
<td>□ None of the above</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>20. Any referral Services? (at time of testing)</td>
</tr>
<tr>
<td>20.1 Referred to (Name of Facility):</td>
</tr>
<tr>
<td>20.2 Type of Referral (Tick all applicable)</td>
</tr>
<tr>
<td>□ HIV care and treatment Services/CCC</td>
</tr>
<tr>
<td>□ ANC/PMTCT</td>
</tr>
<tr>
<td>□ Male circumcision services</td>
</tr>
<tr>
<td>□ STI services</td>
</tr>
<tr>
<td>□ Family planning</td>
</tr>
<tr>
<td>□ TB services</td>
</tr>
<tr>
<td>□ PLWA support group</td>
</tr>
<tr>
<td>□ Client prefers enrolment at later date</td>
</tr>
<tr>
<td>□ Other (specify):</td>
</tr>
</tbody>
</table>
Step 1: HTS Intake Form

**Section III:**
If the client has history of receiving HIV care, record the CCC number.

Risk behavior categorization adapted from the PrEP screening form:
- Must select all that apply
- Be patient with clients to tell you these information

Based on the information gathered, refer the client to the appropriate referral services.

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have you ever tested for HIV before today?</td>
<td>No (&lt;SKIP Q19), Yes (DONT KNOW)</td>
</tr>
<tr>
<td>Date of last HIV test</td>
<td>MM/YYYY</td>
</tr>
<tr>
<td>Result of last HIV test</td>
<td>Negative (SKIP Q17.3), Positive, Don't know</td>
</tr>
<tr>
<td>What motivated you to test for HIV then? (Select all that apply)</td>
<td>Partner is HIV-positive, Pregnant partner was pregnant, Wanting to conceive, Own health, Sought care and health worker recommended HIV test, Other (specify): ____________</td>
</tr>
<tr>
<td>How did you know your partner is HIV-positive?</td>
<td>Partner told me, Health Worker told me, Other Source (not Partner or Health Worker), specify: ____________</td>
</tr>
<tr>
<td>Have you ever enrolled (registered) at any HIV clinic for HIV care?</td>
<td>No (&lt;SKIP Q19), Yes</td>
</tr>
<tr>
<td>If yes, when did you enrol (register) in HIV care?</td>
<td>MM/YYYY</td>
</tr>
<tr>
<td>Facility did you enrol?</td>
<td></td>
</tr>
<tr>
<td>Name: ____________</td>
<td></td>
</tr>
<tr>
<td>Are you currently enrolled in HIV care?</td>
<td>No (&lt;SKIP Q19), Yes (DONT KNOW)</td>
</tr>
<tr>
<td>Risk Behaviours in the 12 months prior to testing (Select all that apply)</td>
<td>Sex partner(s) is HIV+ AND: Not on ART, &lt; 6 months ART use, Poor adherence to ART, Detectable HIV viral load, Couple is trying to conceive, Unknown ART status, Sex partner(s) at high risk for HIV and HIV status currently unknown, Have sex with more than one partner, Ongoing IPV/GBV, Transactional sex, Recent STI, Recurrent use of PEP, PreP, Recurrent sex under influence of alcohol/recreational drugs, Inconsistent or no condom use, IDU with shared needles/syringes, None of the above</td>
</tr>
<tr>
<td>Any referral Services? (at time of testing)</td>
<td>No (&lt;STOP), Yes</td>
</tr>
<tr>
<td>Type of Referral (Tick all applicable)</td>
<td>HIV care and treatment Services/CCC, ANC/PMTCT, Male circumcision services, STI services, Family planning, TB services, PLWA support group, Other (specify): ____________</td>
</tr>
<tr>
<td>Referred to (Name of Facility):</td>
<td></td>
</tr>
</tbody>
</table>
Step 2: HIV Testing

• In Section 1 of the HTS Intake Form, you have already determined client’s willingness to take an HIV test that day
  – If accepts an HIV test: Complete the HIV TEST RESULT FORM (Same as the HTS Lab Registry format)
  – If declines an HIV test: Complete the HIV TEST REFUSAL FORM

• ODK will prompt you to an appropriate form based on the response on the HTS Intake Form

*Counselor must conduct pre & post test counseling per the NASCOP guidelines;
*Introduction of aPS should begin during the counseling
**Step 2: HIV Testing**

In Section 1 of the HTS Intake Form, you have already determined client’s willingness to take an HIV test that day.
Step 2: HIV Test Form

- If **accepts** an HIV test and **tests positive**, complete Section II: Referral, “Is the client referred to HIV care (CCC) today?”
  - If no, why not?
  - If yes, where?

<table>
<thead>
<tr>
<th>SECTION IV. REFERRAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>ONLY complete this section if test positive</em></td>
</tr>
</tbody>
</table>

11. Is the client referred to HIV care (CCC) today?  
- [ ] NO (COMPLETE ONLY Q11.1)  
- [ ] YES (COMPLETE ONLY Q11.2)  

11.1 If no, why not?  
- [ ] NOT ENOUGH TIME  
- [ ] CLIENT REFUSED  
- [ ] CLIENT WASN’T EMOTIONALLY READY  
- [ ] CLIENT LEFT UNEXPECTEDLY  
- [ ] OTHER, SPECIFY: ________________________________________________

11.2 If yes, where?  
- (check all that apply)  
- FACILITY NAME: ________________________________________________

12. CLIENT HTC REGISTER NO (MOH362): ___ ___ / ___ ___ ___ ___
Step 2: HIV Test Refusal Form

• If declines an HIV test: complete the HIV Test Refusal Form
  – Take note of reasons for refusal
  – Refer accordingly

• Especially important during partner tracing:
  – Are they declining because they already know they are HIV+?
  – If so, are they in care?
  – Complete “Known HIV+ Partner Form”
Pre- and Post-Test Counseling

• Don’t forget to conduct pre- and post-test counseling as per the national HTS guidelines

• Pre-test counseling: after completing INTAKE FORM

• Post-test counseling: after HIV testing

*Introduction of aPS should begin during the counseling*
Step 3: APS Procedures
Client Flow of APS

APS INTERVENTION FLOWCHART: AT VCT

- Client comes to clinic (Everyone)
  - Complete HTS INTAKE FORM + Link Log (Name and PTID)
    - Pre-test counseling
      - ORAL CONSENT FOR HIV TESTING
        - Client agrees to test for HIV
          - Client test positive
            - Complete REFERRAL & LINKAGE FORM and INDEX LOCATOR FORM
              - Complete KNOWN HIV+ PARTNER FORM
                - Record HIV result in MOH HTS Register if test HIV+
                  - See below: “If client tests HIV+”
          - Client test negative
            - Client declines to test for HIV
              - If client is partner and declining HIV test because he already knows he’s HIV+
                - Complete KNOWN HIV+ PARTNER FORM

If client tests HIV+:

- Complete APS WILLINGNESS FORM
  - Client agrees to receive aPS
    - Complete APS SCREENING FORM
      - Client eligible
        - Complete PARTNER TRACING FORM & SEXUAL HISTORY FORM
          - HTS counselor reaches out to identified sexual partners
      - Client not eligible
        - Complete PERTHER TRACING FORM & SEXUAL HISTORY FORM
          - HTS counselor reaches out to identified sexual partners

- Client declines to receive OR HTS counselor did not offer aPS
  - WRITTEN CONSENT FOR FOLLOW-UP PROCEDURES
aPS Procedures

• aPS referral and provision happen right after post-test counseling for HIV+ Clients

• Same HTS Counselors are responsible for conducting aPS and eliciting sexual partners of HIV+ Clients
  – Inform the Client that:
    • The clinic is offering aPS to assist the Client with anonymously notifying their partners of their exposure to HIV
      – Accelerate the HIV testing process and help them link to care if test positive
    • The service is offered because we know disclosure of HIV status to partners can be difficult

• aPS Health Advisors are available to answer any technical questions related to aPS
Consent for APS

• aPS is being implemented as part of the national HTS guidelines

• Written consent is needed for routine aPS services

• While obtaining written consent, HTS Counselors will:
  o Explain the importance of aPS
  o Discuss benefits and potential risks of aPS
  o Discuss how, when, and where their sexual partners might be informed
  o Answer any questions Index Case might have
  o Reinforce confidentiality and privacy measures taken
Written Consent Form for Routine APS

Assisted Partner Notification Services Written Consent Form

We are asking you to participate in the assisted partner notification services (APS) that are now part of the routine HIV testing services (HTS). The purpose of this consent is to give you the information to help you decide if you want to take part. Read the form carefully. You may ask questions about the purpose and procedures of APS, the possible risks and benefits, your rights as a volunteer, and anything else about the services or this form that is not clear. You will decide whether you want to receive APS or not. This process is called 'informed consent.'

Purpose of APS Intervention: Disclosure of HIV status to partners can be difficult. Therefore, the clinic is now offering APS as part of routine HTS to assist newly diagnosed HIV-positive clients to anonymously contact their partners and provide voluntary HTS. The goal of APS is to stop further HIV transmission by offering HTS to all persons who have been exposed to HIV.

Routine APS Procedure: HTS counselors will ask you to list the names of all sexual and/or needle sharing partners in the past 3 years if you test HIV-positive. You will also be asked to name your children who may need an HIV test. With your consent, HTS counselors will contact the partner(s) either by phone or in-person to let them know they might have been exposed to HIV and should be tested. The counselors will not reveal your identity to the partner(s) while contacting them. If the partner tests positive, they will be offered APS and referred to HIV treatment and care services. If test negative, they will be referred to HIV prevention services.

Risks, Stress or Discomfort: Answering questions about your sexual relationships, including stressful. You may feel some pain from where blood sample is taken. Although your identity contacting your partners, in some cases it may be possible for them to figure out who referred.

Benefits: There is no money for receiving APS. Counseling referrals and HIV treatment are

Other information: You are not obliged to receive APS. Your decision not to receive APS will

Problems or questions: If you ever have any questions about this service or your rights, Hospital Ethics and Research Committee, at 272630E Ex. 44102

Introduction to APS Scale-Up Study: There is a research study that is embedded in this routine HTS/APS program. The research team will abstract HTS/APS program data to evaluate 1) how well APS increases the uptake of HIV testing in the communities and 2) how best can APS be scaled-up nationwide. Study participants will be contacted at 6 weeks, 6 months, and 12 months to assess ART initiation, linkage-to-care, and viral suppression. If you are interested in participating in the study, you will be referred for eligibility screening. Your decision not to be part of the study will not affect your APS or other care services at this clinic.

Subject's statement 1: APS procedures have been explained to me and I volunteer to receive APS. I have had a chance to ask questions. If I have questions later about APS, or if I have been harmed by participating in APS, I can contact the HTS counselor who has signed this form. I give my consent to receive APS as described in this consent form. I will receive a copy of this form.

Printed name of client: ___________________________ Signature of client: ___________________________ Date: ___________________________

Printed name of clinic staff obtaining consent: ___________________________ Signature: ___________________________ Date: ___________________________

Subject's statement 2: The objectives and procedures of APS Scale-Up Study have been explained to me. I give my consent to be referred for the study eligibility screening. I will receive a copy of this form.

Printed name of client: ___________________________ Signature of client: ___________________________ Date: ___________________________

Printed name of clinic staff obtaining consent: ___________________________ Signature: ___________________________ Date: ___________________________
Key Differences with the Current PNS

• Currently PNS does not involve notifying partners of their exposure to HIV

• Counselors must be explicit in that they are contacting the partner(s) because of the potential exposure to HIV
  – Written consent is essential

• Emphasis on provider referral
Study Recruitment: APS Willingness Screening

Reasons for refusal:
- **Client**
- **Provider**

Information on this form is important for fidelity and acceptability assessments of Aim 2: How best can we implement and scale-up aPS nationwide?

### ASSISTED PARTNER NOTIFICATION WILLINGNESS FORM

**ONLY for clients who were tested HIV+ today. End data collection if Client does not accept aPS**

| CLIENT HTC REGISTER NO (MOH362): | / | / |
| CLIENT PROGRAM ID: |  |  |
| HTS COUNSELOR ID: |  |  |
| TODAY’S DATE: | DD/MM/YYYY |

**SECTION I. ASSISTED PARTNER SERVICES STATUS**

1. Do you give consent to receive assisted partner services (aPS) today?
   - [ ] NO (COMPLETE 1.1)
   - [ ] YES
   - [ ] aPS NOT OFFERED

   1.1 If no, why?
   (check all that apply):
   - [ ] NOT EMOTIONALLY READY
   - [ ] FEAR THAT MY PARTNER WILL FIND OUT
   - [ ] FEAR OF INTIMATE PARTNER VIOLENCE (IPV)
   - [ ] WOULD RATHER INFORM THEM MYSELF
   - [ ] DID NOT HAVE SEX WITHIN THE PAST 3 YEARS
   - [ ] ALL MY SEXUAL PARTNERS LIVE OUTSIDE THE COUNTY
   - [ ] ALL MY SEXUAL PARTNERS LIVE OUTSIDE KENYA
   - [ ] OTHER, SPECIFY:

2. HTS counselors only: Was assisted partner services (aPS) offered today?
   - [ ] NO (COMPLETE 2.1)
   - [ ] YES

   2.1 If no, why?
   (check all that apply):
   - [ ] NOT ENOUGH TIME
   - [ ] CLIENT LEFT UNEXPECTEDLY
   - [ ] CLIENT REFUSED TO RECEIVE aPS
   - [ ] IPV (STOP HERE: DO NOT GO ON WITH aPS PROCEDURES)
   - [ ] OTHER, SPECIFY:
Study Recruitment: APS Willingness Screening

Reasons for refusal:
- Client
- Provider

Information on this form is important for fidelity and acceptability assessments of Aim 2:
How best can we implement and scale-up aPS nationwide?
aPS Eligibility Screening

• Exclusion criteria:
  – Unable and/or not willing to provide informed written consent
  – History of intimate partner violence (IPV) in the past 1 month
  – Currently pregnant
  – <15 years old

• A series of questions are asked to determine the risk level for IPV
  – Exclude those who are in the high risk category
## APS Eligibility Screening

**Section I:**

- **IPV Questions**
  - History of intimate partner violence (IPV) in the past 1 month
  - Currently pregnant

### Section I: Intimate Partner Violence (IPV) Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No (SKIP TO Q2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you ever been in a relationship with a person who has physically hurt you?</td>
<td>Yes</td>
<td>No (SKIP TO Q2)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No (SKIP TO Q3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Have you been in a relationship with a person who threatens, frightens, or insults you, or treats you badly?</td>
<td>Yes</td>
<td>No (SKIP TO Q3)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No (SKIP TO Q4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Have you been in a relationship with a person who forces you to participate in sexual activities that make you feel uncomfortable?</td>
<td>Yes</td>
<td>No (SKIP TO Q4)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Are you pregnant? (Ask only if Female)</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

### Section II: IPV Risk Category

6. What IPV risk category is the client in? (Refer to Q1, Q2 and Q3. Choose the first category, top to bottom, with matching criteria.)

- HIGH (any ticked “past 1 month”)
- MODERATE (any ticked “Ever”)
- LOW (all ticked “Never”)
**APS Eligibility Screening**

Section II:
- IPV Risk Category
  - Exclude those who are in the high risk category

---

### ASSISTED PARTNER NOTIFICATION INTERVENTION SCREENING FORM

**Partners: those who came in for testing after being notified of HIV exposure by health advisor**

<table>
<thead>
<tr>
<th>CLIENT SERIAL NO:</th>
<th>CLIENT PROGRAM ID:</th>
<th>HTS COUNSELOR ID:</th>
<th>TODAY'S DATE: DD/MM/YYYY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Facility/Venue Reporting:</td>
<td>MFL Code:</td>
<td>County:</td>
<td>Sub-County:</td>
</tr>
</tbody>
</table>

#### SECTION I. INTIMATE PARTNER VIOLENCE (IPV) QUESTIONS

"I would like to ask you some questions about your current and past relationships. We want to make sure you are safe."

1. Have you ever been in a relationship with a person who has physically hurt you?
   - No (SKIP TO Q2)
   - Yes

2. Have you been in a relationship with a person who threatens, frightens, or insults you, or treats you badly?
   - No (SKIP TO Q3)
   - Yes

3. Have you been in a relationship with a person who forces you to participate in sexual activities that make you feel uncomfortable?
   - No (SKIP TO Q4)
   - Yes

4. Do you think any of these things could happen to you if you decide to receive assisted partner notification services?
   - No
   - Yes

5. Are you pregnant? (Ask only if Female)
   - No
   - Yes

#### SECTION II. IPV RISK CATEGORY

6. What IPV risk category is the client in?
   - HIGH (any ticked “past 1 month”)
   - MODERATE (any ticked “ever”)
   - LOW (all ticked “Never”)
APS Eligibility Screening

Section III, IV, and V:
- Eligibility
- Monitoring Plan
- Follow-up

If client is at high risk of IPV:
- IPV monitoring and follow-up for those with moderate risk of IPV

Automatically determined

**SECTION III. ELIGIBILITY**

7. Is the client eligible to receive assisted partner notification services? (Tell the subject if their eligible. If not eligible, tell them why.)
   - No
   - Yes

8. HTS Counsellor only: Is the client eligible for the study?
   - No
   - Yes

**SECTION IV. IPV MONITORING PLAN**

**ALL High or Moderate IPV Risk Subjects, regardless of aPS eligibility**

9. Was client referred?
   - No (Go to Q10)
   - Yes (Go to Q11)

10. Why was client not referred? (Tick one)
    - Not in a relationship
    - Refused
    - Other
    - Specify: ____________________________

11. Where was client referred to?

**SECTION V. IPV MONITORING FOLLOW-UP**

**ONLY APS-Eligible, Moderate IPV Risk Subjects who are Referred**

12. Client prefers follow up at: (Tick one)
    - Phone: ____________________________
    - Home
    - Clinic
    - Other: ____________________________

13. Next follow-up contact scheduled for:
    - DD / MM / YYYY
    - (date must be within next 10 days)
Elicitation of Sexual Partners

• When determined eligible for aPS, elicitation of sexual partner begins

• HTS Counselor will record the information for each named sexual partner in 2 forms

  – Addresses and contact information are filled in “PARTNER CONTACT FORM” (Paper-form)

  – Data collected using the "SEXUAL HISTORY WITH PARTNERS FORM" (eCRF on ODK)
Elicitation of Sexual Partners

Partner Contact Form

• Ask for the number of partners in the last 3 years
  – Name most recent partners if none in the last 3 years

• Sex includes oral, anal and vaginal sex

Please name all people you have had sex with in the LAST 3 YEARS starting with the most recent sex partner.

Sex with a partner includes: oral, anal, and vaginal sex.

A. Write names and contact information.
B. If the index person names no partners or only one partner in the last three years, ask them to name their most recent prior sexual partner and STOP.
C. If more than 4 partners named, put information on separate sheet.

Q.1 How many people have you had sex with in the past 3 years?

_________ Partners

<table>
<thead>
<tr>
<th>PARTNER A</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner's Client Program ID:</td>
<td>__ - _____ - ____ - ____ - ____</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nicknames:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is this a current partner?</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Where can we find them?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Directions to place:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone #1:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone #2:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PARTNER B</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner's Client Program ID:</td>
<td>__ - _____ - ____ - ____ - ____</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nicknames:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is this a current partner?</td>
<td>☐ No ☐ Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Elicitation of Sexual Partners

Partner Contact Form

• Name partners in the last 3 years
  – Name most recent partners if none in the last 3 years
• Sex includes oral, anal and vaginal sex
• Encourage client to be detailed in description of place and directions to locate partners
• If client is hesitant, encourage her to provide information on the most recent partner

Please name all people you have had sex with in the LAST 3 YEARS starting with the most recent sex partner.

Sex with a partner includes: oral, anal, and vaginal sex.

A. Write names and contact information.
B. If the index person names no partners or only one partner in the last three years, ask them to name their most recent prior sexual partner and STOP.
C. If more than 4 partners named, put information on separate sheet.

Q.1 How many people have you had sex with in the past 3 years? _______ Partners

<table>
<thead>
<tr>
<th>PARTNER A</th>
<th>PARTNER B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>Partner’s Client Program ID:</td>
<td>Partner’s Client Program ID:</td>
</tr>
<tr>
<td>Nicknames:</td>
<td>Nicknames:</td>
</tr>
<tr>
<td>Is this a current partner:</td>
<td>Is this a current partner:</td>
</tr>
<tr>
<td>Where can we find him/her?</td>
<td>Where can we find him/her?</td>
</tr>
<tr>
<td>Directions to place:</td>
<td>Directions to place:</td>
</tr>
<tr>
<td>Telephone #1:</td>
<td>Telephone #1:</td>
</tr>
<tr>
<td>Telephone #2:</td>
<td>Telephone #2:</td>
</tr>
</tbody>
</table>

CLIENT HTC REGISTER NO (MOH362): ___/___/____
CLIENT PROGRAM ID: ___/___/___/___/___
HTS COUNSELOR ID: ___/___/___/___/___
TODAY’S DATE: DD/MM/YYYY
**Sexual History with Partners Form**

- Go through Section II for every sexual partner identified.
- Complete all questions for each section:
  - Names, nicknames
  - Program ID
  - Age, sex, relationship
  - Occupation
  - Lived with partner?
  - First/last sexual interaction
  - Condom use
  - Partner HIV status

---

**SEXUAL HISTORY WITH PARTNERS FORM**

- **CLIENT HTC REGISTER NO (MOH362):**   
- **CLIENT PROGRAM ID:**   
- **HTS COUNSELOR ID:**   
- **TODAY’S DATE: DD/MM/YYYY**

**Name of Facility/Venue Reporting:**
- **MFL Code:**   
- **County:**   
- **Sub-County:**   
- **Ward:**

**SECTION I. TOTAL NUMBER OF SEXUAL PARTNERS** *(Sex with a partner includes: oral, anal, and vaginal sex)*

1. How many sexual partners have you had in the past 3 years? 
   - Partners
   - NOTE: *If no sexual partner in the past 3 years, ask about the most recent sexual partner from >3 years ago.*

**SECTION II. SEXUAL HISTORY PER PARTNER** *(Go through this section for every sexual partner identified)*

2. Name of partner:   
   - Nickname of partner:

3. Sex of partner
   - Male
   - Female

4. 1. Is this the Index Client?   
   - No
   - Yes (Sean Index Client’s barcode)

4.2 Partner Code: __________

5. Age of partner: 
   - _______ years old

6. How would you describe your relationship to this partner? 
   - Wife/husband
   - Girlfriend/boyfriend
   - Someone I had sex with for fun
   - Someone who pays or gives me things to have sex with him/her
   - Someone who receives things from me to have sex with him/her
   - Someone who forces me to have sex with him/her

7. What is the occupation this partner? (Select all that apply) 
   - UNEMPLOYED
   - MILITARY
   - TRADER
   - HEALTHCARE WORKER
   - HOUSEWIFE
   - TEACHER
   - HAIR DRESSER
   - SMALL BUSINESS OWNER/SELF-EMPLOYED
   - STUDENT
   - FARMER
   - SECRETARY
   - OTHER SPECIFY:

8.1 Have you lived with this partner? 
   - No (GO TO Q9.1)
   - Yes (GO TO Q8.2)

8.2 If yes, are you currently living with this partner? 
   - No
   - Yes

9.1 Is this person a current sexual partner? 
   - No
   - Yes

9.2 When was the first time you had sex with this partner? 
   - DD/MM/YYYY

9.3 When was the last time you had sex with this partner? 
   - DD/MM/YYYY

10. Did you use a condom last time you had sex with this partner? 
   - No
   - Yes
Go through Section II for every sexual partner identified.

- Complete all questions for each section:
  - Partner HIV care
  - Partner risk assessment

Determine preferred PNS
- Emphasis on Provider Referral

### Sexual History with Partners Form

11. Is this partner HIV+?
   - [ ] No (Go to Q13)
   - [ ] Yes (Go to Q11.1)
   - [ ] Don’t know (Go to Q13)

   11.1 How did you learn that this partner was HIV+?
   - [ ] Partner told me (tested HIV+ less than 2 months ago)
   - [ ] Partner told me (tested HIV+ over 2 months ago)
   - [ ] Health Provider told me
   - [ ] Other source (neither Partner nor Health Provider). Specify: ______

12. Is this partner receiving medical services for HIV?
   - [ ] No
   - [ ] Yes (Go to Q12.1)
   - [ ] Don’t know

   12.1 If HIV+ and enrolled in care, what is the CCC number of the partner? ______

13. Risk assessment of this partner (select all that apply)
   - Partner is HIV+ but not on ART
   - Partner is HIV+ and on ART but not virally suppressed
   - Never or rarely use condoms (Complete Q13.1)
   - I want to conceive a baby
   - Not applicable
   - Partner exchanges money or other material gain for sex
   - Partner injects drugs
   - None of the above

### SECTION III. PARTNER NOTIFICATION

14. What is your preferred method of notifying this partner?
   - [ ] Provider referral
   - [ ] Contract referral (complete Q14.1)
   - [ ] Dual referral
   - [ ] Client referral
   - [ ] Couple testing
   - [ ] Refusal

14.1 If contract referral
   - [ ] Index case will notify this partner by: DD/MM/YYYY
   - [ ] Counsellor will follow-up with partner after DD/MM/YYYY
   - [ ] Counsellor will attempt to notify this partner by DD/MM/YYYY
Sexual History with Partners Form

- **Section III: if contact referral, select one and specify date:**
  - Index case will notify
  - Counselor follow-up with partner
  - Counselor will attempt to notify partner

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Is this partner HIV+?</td>
<td>Yes (Go to Q11.1)</td>
</tr>
<tr>
<td>11.1 How did you learn that this partner was HIV+?</td>
<td>Partner told me (tested HIV+ less than 2 months ago)</td>
</tr>
<tr>
<td></td>
<td>Health Provider told me</td>
</tr>
<tr>
<td>12. Is this partner receiving medical services for HIV?</td>
<td>No</td>
</tr>
<tr>
<td>12.1 If HIV+ and enrolled in care, what is the CCC number of the partner?</td>
<td>Partner is HIV+ but not on ART</td>
</tr>
<tr>
<td></td>
<td>Never or rarely use condoms (Complete Q13.1)</td>
</tr>
<tr>
<td></td>
<td>Not applicable</td>
</tr>
<tr>
<td></td>
<td>Partner injects drugs</td>
</tr>
<tr>
<td>13. Risk assessment of this partner (select all that apply)</td>
<td>Provider referral</td>
</tr>
<tr>
<td></td>
<td>Dual referral</td>
</tr>
<tr>
<td></td>
<td>Couple testing</td>
</tr>
</tbody>
</table>

**SECTION III. PARTNER NOTIFICATION**

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>14. What is your preferred method of notifying this partner?</td>
<td>Index case will notify this partner by: DD/MM/YYYY</td>
</tr>
<tr>
<td></td>
<td>Counsellor will follow-up with partner after DD/MM/YYYY</td>
</tr>
<tr>
<td></td>
<td>Counsellor will attempt to notify this partner by: DD/MM/YYYY</td>
</tr>
</tbody>
</table>
Partner Notification Circumstances

- Needle Sharing Partners
- Children
- Known HIV+ Partners
Partner Notification Services of Needle Sharing Partners

- Form for clients who use injectable recreational drugs:
  - Complete form
  - Identify if client shares needles with anyone
  - Identify information per partner and assess risk
 Partner Notification Services of Children

- **Form for clients with children:**
  - Determine if client has children
  - If client does have children, identify their HIV testing status and eligibility

**PARTNER NOTIFICATION SERVICES OF CHILDREN**

<table>
<thead>
<tr>
<th>Section I: Total Number of Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have biological children or children in your care (legal guardian)?</td>
</tr>
<tr>
<td>☐ No (FINISH THIS FORM) ☐ Yes</td>
</tr>
<tr>
<td>2. If yes, how many children do you have who are 15 years or younger? _________ Children</td>
</tr>
</tbody>
</table>

**Section II: Information Per Child** (Go through this section for each child identified)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. What is this child’s HIV status?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Child never tested for HIV (GO TO Q6)</td>
</tr>
<tr>
<td>☐ Child ever tested positive for HIV</td>
</tr>
<tr>
<td>☐ Child tested negative for HIV</td>
</tr>
<tr>
<td>☐ Tested negative during PMTCT or while breastfeeding, but did NOT have any tests after they finished breastfeeding (GO TO Q8)</td>
</tr>
<tr>
<td>☐ Tested negative AFTER they finished breastfeeding (Skip to next child)</td>
</tr>
<tr>
<td>☐ Don’t know (GO TO Q8)</td>
</tr>
<tr>
<td>☐ Other: specify: __________ (Skip to next child)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. Is this child receiving care for HIV?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Currently on ART</td>
</tr>
<tr>
<td>☐ In care at CCC but not on ART</td>
</tr>
<tr>
<td>☐ Not linked to HIV care/defaulted care/lost to follow up (LTFU)</td>
</tr>
<tr>
<td>☐ Don’t know</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>8. If eligible for HTS, what is the age of this child?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Date of Birth: MM/DD/YYYY ☐ Unknown</td>
</tr>
<tr>
<td>8.2 If DOB is unknown, ________ years ________ months</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9. Where is this child currently staying?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ With me, at home, but attend boarding school</td>
</tr>
<tr>
<td>☐ With me, at home, and attend day school</td>
</tr>
<tr>
<td>☐ With me, at home, but does not attend school</td>
</tr>
<tr>
<td>☐ With their other parent, not at my home, and I have contact with them</td>
</tr>
<tr>
<td>☐ With their other parent, not at my home, but I do not have contact with them</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10. What is your relationship to this child?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Biological parent</td>
</tr>
<tr>
<td>☐ Family member, but not biological parent</td>
</tr>
<tr>
<td>☐ Aunt/uncle</td>
</tr>
<tr>
<td>☐ Grandparent</td>
</tr>
<tr>
<td>☐ Cousin</td>
</tr>
<tr>
<td>☐ Other relative, specify: __________</td>
</tr>
<tr>
<td>☐ Unrelated Guardian</td>
</tr>
</tbody>
</table>
Things to Keep in Mind

• When collecting data, it is important NOT to skip any questions unless you are prompted to

• Consequences of missing data:
  – Puts more burden on HTS Counselors/aPS Health Advisors/Data Managers to go back and refill the blank spaces in the data
  – Compromises program findings/results
Summary

- Newly diagnosed clients may still need some time to digest the new information even after post-test counseling — “Patience is a virtue”

- It is important to give full information about aPS

- Although provider-referral is highly recommended, clients may choose other options

- HTS Counselors’ attitude is very important to maximize the impact of aPS
Thank you

Questions?
Prevention of Social Harms among Index Clients during Assisted Partner Notification Services

Potential Social Harms and Prevention Strategies
Definition of Social Harms in HIV Testing

**WHO Definition:**
Any intended or unintended cause of physical, economic, emotional or psychosocial injury or hurt from one person to another, a person to themselves, or an institution to a person, occurring before, during or after testing for HIV
Potential Risks of Partner Notification Services

• In PNS, we are mostly concerned about intimate partner violence (IPV)

• IPV: Physical, sexual, or psychological harms caused by a current or former partner or spouse
  – IPV can happen in any kind of relationship, and it does not require sexual intimacy
  – IPV varies in frequency and severity

• Key populations, including adolescent girls and young women, face greater risk of IPV due to their unique circumstances
What Constitutes Intimate Partner Violence?

1. Physical Violence

Intentional use of physical force or restraints that may cause injury, disability, or even death

- **Examples**: Slaps, punches, kicks, assaults with a weapon, homicide
- Also includes pushing, grabbing, chocking, shaking, shoving, scratching, biting, burning
What Constitutes Intimate Partner Violence?

2. Sexual Violence

Any completed or attempted sexual act that was done against a person’s will (unwanted) with a use of physical force, verbal threats, weapons, or harassment

• Perpetrator could be anyone regardless of their relationship to the victim

• **Examples:** rape, sexual abuse of children and mentally or physically disabled people, unwanted touching or physical advance, forced marriage/abortion, forced participation in pornography or commercial sex, denial of right to use contraception
What Constitutes Intimate Partner Violence?

3. Threats of physical or sexual violence

Use of verbal/physical threats (words, gestures, behaviors, etc.), or weapons to communicate the intent to cause death, disability, injury, or physical harm
What Constitutes Intimate Partner Violence?

4. Psychological Violence

Intentional use of verbal/physical acts or coercive tactics to cause psychological trauma, such as anxiety, depression, post-traumatic stress disorder

- Also known as emotional abuse and mental abuse
- **Examples**: belittling, humiliating, denial of right to work or see friends/family, withholding resources (basic needs or money) or information, confiscating earnings
Why does IPV Exist?

• IPV stems from deep-rooted gender inequalities that still exist in many cultures.

• Violence against women and other vulnerable populations is a gross violation of human rights and a public health problem.
IPV in Partner Notification Services

- Reported cases of social harm or other adverse events associated with PNS have been very rare

- Nonetheless, we must be sensitive to potential risk of IPV, and closely monitor IPV events followed by PNS
  - Ensure safety of index clients
Screening for IPV at Baseline

• After providing verbal consent for aPS, women are interviewed to screen for their risk of IPV prior to partner elicitation

• Interviews are conducted by trained HTS Counselors and Health Advisors using the intervention screening form
## ASSISTED PARTNER NOTIFICATION INTERVENTION SCREENING FORM

**Partners: those who came in for testing after being notified of HIV exposure by health advisor**

| CLIENT HTC REGISTER NO (MOH362): |  |  |  |
| CLIENT PROGRAM ID: |  |  |  |  |  |  |
| HTS COUNSELOR ID: |  |  |  |

**TODAY’S DATE: DD / MM / YYYY**

### Name of Facility/Venue Reporting: ____________________________

### MFL Code: ___________ County: ___________ Sub-County: ___________ Ward: ___________

### SECTION I. INTIMATE PARTNER VIOLENCE (IPV) QUESTIONS

“I would like to ask you some questions about your current and past relationships. We want to make sure you are safe.”

<table>
<thead>
<tr>
<th>Question</th>
<th>Timeframe</th>
<th>1.1a Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you ever been in a relationship with a person who has physically hurt you?</td>
<td>No (SKIP TO Q2)</td>
<td>□ More than 6 months ago</td>
</tr>
<tr>
<td>□ Yes</td>
<td>□ In the past 6 months</td>
<td>□ In the past 1 month</td>
</tr>
<tr>
<td>□ No (SKIP TO Q3)</td>
<td>□ Not in the past 1 month</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Timeframe</th>
<th>2.1a Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Have you been in a relationship with a person who threatens, frightens, or insults you, or treats you <strong>badly</strong>?</td>
<td>No (SKIP TO Q3)</td>
<td>□ More than 6 months ago</td>
</tr>
<tr>
<td>□ Yes</td>
<td>□ In the past 6 months</td>
<td>□ In the past 1 month</td>
</tr>
<tr>
<td>□ No (SKIP TO Q4)</td>
<td>□ Not in the past 1 month</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question</th>
<th>Timeframe</th>
<th>3.1a Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Have you been in a relationship with a person who forces you to participate in sexual activities that make you feel uncomfortable?</td>
<td>No (SKIP TO Q4)</td>
<td>□ More than 6 months ago</td>
</tr>
<tr>
<td>□ Yes</td>
<td>□ In the past 6 months</td>
<td>□ In the past 1 month</td>
</tr>
<tr>
<td>□ No (SKIP TO Q5)</td>
<td>□ Not in the past 1 month</td>
<td></td>
</tr>
</tbody>
</table>

| Question                                                                 |  |  |
| 4. Do you think any of these things could happen to you if you decide to receive assisted partner notification services? | No | Yes |

| Question                                                                 |  |  |
| 5. Are you pregnant? (Ask only if Female)                              | No | Yes |
IPV Risk Category

IPV risk category is based on history of IPV

**HIGH RISK:** History of IPV within the last one month

**MODERATE RISK:**
Determined by two components:
1. History of IPV during their *lifetime (ever)* either from a current or past partner
2. Fear of IPV from receiving aPS

**LOW RISK:** No history of IPV and do not have fear of IPV
Recap: APS Eligibility Criteria

- 4 exclusion criteria: <15 years, high IPV risk, currently pregnant, fear of IPV due to aPS
What to Do if a Client is at High or Moderate Risk of IPV?

- Set up an IPV monitoring plan regardless of aPS eligibility
- IPV monitoring plan includes referral and management services:
  - GBV Counseling
  - Post-rape care (PEP, emergency contraception, etc.)
  - Rape prevention
  - Community hotlines

<table>
<thead>
<tr>
<th>SECTION IV. IPV MONITORING PLAN **ALL High or Moderate IPV Risk Subjects, regardless of eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Was client referred?</td>
</tr>
<tr>
<td>[ ] No (Go to Q9)</td>
</tr>
<tr>
<td>[ ] Yes (Go to Q10)</td>
</tr>
<tr>
<td>9. Why was client not referred?</td>
</tr>
<tr>
<td>[ ] Relationship ended (Tick one)</td>
</tr>
<tr>
<td>[ ] Refused</td>
</tr>
<tr>
<td>[ ] Other</td>
</tr>
<tr>
<td>Specific:</td>
</tr>
<tr>
<td>(End Form)</td>
</tr>
<tr>
<td>10. Where was client referred to?</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
IPV Monitoring for Eligible Clients Receiving aPS

• IPV and other adverse events will be monitored at 6 weeks, 6 months, and 12 months for all clients with either low or moderate risk of IPV

• Those in the moderate risk group will receive special monitoring by HTS Counselors and Health Advisors
Special Monitoring

• Includes one additional home/off-facility visit by the HTS Counselor or Health Advisor within 10 days after aPS

• Activities at this visit include:
  – Interviews of all clients (index and contacts) for IPV
  – Individual and couple counseling
  – Referrals for additional care/counseling as needed
  – Scheduling of additional monitoring visits as needed

• All monitoring visits are documented in the IPV Monitoring Log and reported to the Program Coordinator at the end of each week

• If any IPV event is reported, Program Coordinator will immediately report to the Safety Monitoring Board
Decisions on Additional Monitoring Visits

• Additional monitoring visits within 10 days after the first visit is made by:
  – HTS Counselor/Health Advisor during the visit
  – Program Coordinator after reviewing the weekly report
  – Safety Monitoring Board at any time
During the Follow-Ups

• If clients report IPV since the last follow-up contact, immediately refer the clients to IPV-related services

• IPV management plan will be created for them

• HTS Counselors and Health Advisors will immediately report IPV episodes to Program Coordinator, who will inform the Safety Monitoring Board
Summary

• APS should be offered appropriately and safely
• Be mindful of potential risk of IPV among clients
• Be friendly and build trust
• Communicate with Program Manager if any concerns arise
Thank you

Questions?
Principles of Contact Tracing
Assisted Partner Notification Services

Standard Operating Procedures
Contact Tracing of Partners

- Using the information given by the index client, trace and notify the partners who may have had contact with HIV

“I think the person should always be contacted and if the person who has the infection does not want to do it then they should be contacted by the clinic. It is not right someone being in danger of having a disease and have it themselves and spread it onto other people unknown that they might have it. It’s a domino effect isn’t it? It can spread really quickly.”

(sexual contact traced by a sexual health adviser)
Contact Tracing is a Voluntary Process

• When a client tests HIV positive, an HTS counselor offers aPS to index clients and their partner(s)
  – It is up to them to decide whether they want to receive aPS and provide contact information of their sexual partner(s)

• Contact tracing should be done as part of the comprehensive HIV testing package, not in isolation

• Index clients and partner(s) get different options for referral approaches:
  o Patient-initiated (passive)
  o Provider-initiated (active)
  o Contract (combination)
When does Contact Tracing Occur?

Index Case

- Interview with HIV+ person
- Sex partner elicitation

Partner notification

- Offer HIV testing
- Linked to care
- Strategies
  - Patient referral (self discloses HIV+)
  - Contract referral
  - **Provider referral (assisted partner services[aPS])**

New HIV+ sex partner
Important Components of Contact Tracing

• Confidentiality, confidentiality, and confidentiality!
  – Maintaining strict confidentiality of index clients (source of information) are critical in this intervention
  – Other ethical issues associated with breach of confidentiality (e.g. stigma, discrimination, IPV, etc.)

• Attitudes of healthcare professionals conducting contact tracing
  – Must be delivered in a non-judgmental, culturally appropriate, and sensitive matter

• Contact tracing provides an opportunity to deliver HIV testing and care services at each stage of the continuum of care

• Counseling and support should also be available for those who choose to do client-referral (passive)
Achievement of the Intervention

Publication/ dissemination of information
1. Presentation at the ICASA conference – 2008 Dakar Senegal
2. Presentation at IAS conference – 2009 Cape Town South Africa
3. Presentation at IAS conference – 2010 IAS Vienna Austria

International Recognition/partnerships
1. Bill and Melinda Gates Foundation
2. University of North Carolina funding
3. University of Washington
4. CHEF
PN outcome Aug 1, 2007 to April 30, 2012

- Index persons interviewed: 9196
- Contact persons identified: 10340 (70%)
- Contact persons traced/notified: 7244 (70%)
- Contact persons consenting for HIV testing: 5320 (73%)
- Contact persons with HIV positive results: 2850 (54%)
- Contact persons linked to Care and treatment: 1197 (42%)

CBC Health Services
Partner Tracing as a Successful Intervention

News

Partners of people living with HIV more likely to test when encouraged by health worker

30 June 2017

Research findings on ‘voluntary assisted HIV partner notification’ inform new WHO testing guidelines.

WHO RECOMMENDS ASSISTANCE FOR PEOPLE WITH HIV TO NOTIFY THEIR PARTNERS

DECEMBER 2016
Partner Tracing as a Successful Intervention in Kenya

Effectiveness of Partner Services for HIV in Kenya: A Cluster Randomized Trial

Peter Cherutich, Mathew R. Golden, Beatrice Wamuti, Barbra A. Richardson, Kristjana H. Ásbjörnsdóttir, Felix A. Otieno, Betsy Sambai, Matt Dunbar, Carey Farquhar; for the aPS Study Group

HIV NEWS: Communities deliver HIV partner notification services in Kenya

Kenya has a high HIV burden, but is recognized for its successful national HIV programme. One of the country’s key achievements has been improved and decentralized HIV testing services (HTS), from health clinics to communities.
Successful Intervention: Newly Testing

NNTI: Number Needed to Interview

Western: NNTI=3.55

- P=0.143

Rural: NNTI=2.25

- P=<0.001

Nairobi/Central: NNTI=3.22

Peri-Urban/Urban: NNTI=3.55

3.3 index cases to find...

...1 partner newly testing
Successful Intervention: Testing Positive

NNTI: Number Needed to Interview

Western NNTI=3.34

Rural NNTI=2.95

Nairobi/Central NNTI=4.77

Peri-Urban/Urban NNTI=4.29

4.2 index cases to find...

...1 partner test positive

P=<0.001

P=0.02
Challenges of Contact Tracing

• Inadequate telephone network coverage in some areas making it impossible to trace contacts in such localities

• Mobility and change of address and residence leading to lost to follow-up

• Verbal threats by contact persons on the health advisors

• Suspicion

• Health Advisors do contact tracing along side other assignments
How to Actually Conduct Partner Tracing?

*Within 1 week of index case enrollment, HTS Counselors will:*

1. Contact partners using mobile numbers Index Case provided
   - Partner Contact Form

2. Record all attempts (up to 3) to contact partners
   - Client Tracking Form

3. When successfully traced, use oral scripts to discuss aPS with partners
<table>
<thead>
<tr>
<th>Function of Forms and Scripts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Partner Tracing Form</strong></td>
</tr>
<tr>
<td>- Record when partners were contacted and how</td>
</tr>
<tr>
<td>- Date, outcome, reasons not located, methods</td>
</tr>
<tr>
<td>- Record clear and detailed comments about contact attempts</td>
</tr>
<tr>
<td>- Re-scheduled calls or visits</td>
</tr>
<tr>
<td><strong>Partner Contact Form</strong></td>
</tr>
<tr>
<td>- Provide contact information for partners</td>
</tr>
<tr>
<td>- Address, phone number, directions</td>
</tr>
<tr>
<td><strong>Oral Script</strong></td>
</tr>
<tr>
<td>- Guide attempts to notify and actual notification</td>
</tr>
<tr>
<td><strong>Voicemail Script</strong></td>
</tr>
<tr>
<td>- Guide failed attempts to contact</td>
</tr>
<tr>
<td><strong>In-Person Script</strong></td>
</tr>
<tr>
<td>- Guide in person notification attempts</td>
</tr>
<tr>
<td><strong>Written Consent</strong></td>
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</table>
How to Actually Conduct Partner Tracing?

1. Contact partners using information Index Case provided using:
   - Partner Contact Form
   - Sexual History with Partners Form
Please name all people you have had sex with in the LAST 3 YEARS starting with the most recent sex partner.

Sex with a partner includes: oral, anal, and vaginal sex.

A. Write names and contact information.

B. If the index person names no partners or only one partner in the last three years, ask them to name their most recent prior sexual partner and STOP.

C. If more than 4 partners named, put information on separate sheet.

Q.1 How many people have you had sex with in the past 3 years?

______ Partners

<table>
<thead>
<tr>
<th>PARTNER A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: ________________________________</td>
</tr>
<tr>
<td>Partner’s Client Program ID: __ __ - __ __ __ __ __ __ - __ __ - __ __</td>
</tr>
<tr>
<td>Nicknames: __________________________</td>
</tr>
<tr>
<td>Is this a current partner: ☐ No ☐ Yes</td>
</tr>
<tr>
<td>Where can we find him/her? ________________</td>
</tr>
<tr>
<td>Directions to place ____________________</td>
</tr>
<tr>
<td>Telephone #1: __________________________</td>
</tr>
<tr>
<td>Telephone #2: __________________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PARTNER B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name: ________________________________</td>
</tr>
<tr>
<td>Partner’s Client Program ID: __ __ - __ __ __ __ __ __ - __ __ - __ __</td>
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• Preferred Method and date:
  – Contact partners based on agreed upon conditions with Index client
How to Actually Conduct Partner Tracing?

1. Record all attempts (up to 3) to contact partners
   - Client Tracing Form
Client Tracing Form

Client Tracing Form will be used throughout the entire tracing process.

### CLIENT TRACING FORM

**CONTACT ATTEMPT 1**

<p>| | |</p>
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<thead>
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<tr>
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</tr>
<tr>
<td>3.</td>
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</tr>
<tr>
<td>4a.</td>
<td>Was client located? □ No □ Yes □ Yes, but re-scheduled</td>
</tr>
<tr>
<td>4b.</td>
<td>Why was client not located or re-scheduled?</td>
</tr>
<tr>
<td>4c.</td>
<td>How was client located? □ By telephone □ In person</td>
</tr>
<tr>
<td>Comment:</td>
<td></td>
</tr>
</tbody>
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**CONTACT ATTEMPT 2**

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**CONTACT ATTEMPT 3**

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<td>Comment:</td>
<td></td>
</tr>
</tbody>
</table>
**Client Tracing Form**

### Contact Attempt Section

- For each attempt record:
  - Partner ID
  - If client is index or partner
  - Date of attempt
  - Outcome of attempt
  - Reasons not located or re-scheduled
  - Method used (phone or in-person)

#### CONTACT ATTEMPT 1

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</table>

4a. Was client located? □ No (Go to Q4b) □ Yes (Go to Q4c-e) □ Yes, but re-scheduled (Go to Q4d)

4b. Why was client not located or re-scheduled? □ By telephone □ In person

4c. How was client located? □ By telephone □ In person

4d. Which facility would the client go to for HIV testing?

4e. When would the client go for HIV testing? Day: ___ Month: ___ Year: ___

Comment: __________________________________________________________

#### CONTACT ATTEMPT 2

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4b. Why was client not located or re-scheduled? □ By telephone □ In person

4c. How was client located? □ By telephone □ In person

4d. Which facility would the client go to for HIV testing?

4e. When would the client go for HIV testing? Day: ___ Month: ___ Year: ___

Comment: __________________________________________________________

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4c. How was client located? □ By telephone □ In person

4d. Which facility would the client go to for HIV testing?

4e. When would the client go for HIV testing? Day: ___ Month: ___ Year: ___

Comment: __________________________________________________________
**Client Tracing Form**

**Contact Attempt Section**

- If 3 phone contact attempts fail, an in-person tracing will be scheduled.

*Contact attempts should be on different days and times*
Lost to Follow-up

• How many attempts to trace a partner?
  – 3 initial phone tracing
  – 1 in-person tracing
  – 2 additional tracing either by phone or in-person

• If all these attempts fail, then the contact will be classified as lost to follow-up
How to Actually Conduct Partner Tracing?

3. Use the following tools to discuss APS once you have successfully contacted the client:
   
   • **Oral Script**
   • In-Person Script
   • Written Consent
Oral Script for partners:

• Confirm person you are speaking to is correct
• Introduce yourself
• Ask if it is a good time to talk privately

Oral Script for Partners

Script is for partners exposed to HIV – Phone Contact Tracing

Hello, am I speaking with Ms/Mr._________?

[IF NOT] Is Ms/Mr._________ available?

[If Partner is not available] Thank you. I will try again later.

[If YES] I am ___________, a counselor/healthcare provider in ___________. As a public health service, the reason for the call is to focus on your health and to also give you some important information. This will not take long and I assure you that our discussion will be confidential. Is now a good time to talk?

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

[If YES] We have recently learned that you might have been exposed to HIV. HIV is a primarily sexually transmitted infection but this does not mean you are infected. It just means that you have been exposed to HIV and will need to test yourself soon to see what your status is. We cannot disclose how we learned about the exposure due to the need to maintain confidentiality. 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 live a long life and reduce your chance of passing HIV onto others.

HIV testing services are available at health facilities 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] Which facility would you like to go for an HIV test? What day would you like to come?

[Off-facility Test] What date and time would you prefer for the counselor to come to your home for an HIV test?

Thank you.
Oral Script for partners:

- Not a good time to speak privately:
  - Re-schedule a phone call
  - Record in the **Partner Tracing Form**

**Oral Script for Partners**

Script is for partners exposed to HIV – Phone Contact Tracing

Hello, am I speaking with Ms/Mr.__________?

[IF NOT] Is Ms/Mr.__________ available?

[If Partner is not available] Thank you. I will try again later.

[If YES] I am ____________, a counselor/healthcare provider in __________ County. As a public health service, the reason for the call is to focus on your health and to also give you some important information. This will not take long and I assure you that our discussion will be confidential. Is now a good time to talk?

**[IF NO] When would be a better time for me to call you?**

[If YES] We have recently learned that you might have been exposed to HIV. HIV is a primarily sexually transmitted infection but this does not mean you are infected. It just means that you have been exposed to HIV and will need to test yourself soon to see what your status is. We cannot disclose how we learned about the exposure due to the need to maintain confidentiality. 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 live a long life and reduce your chance of passing HIV onto others.

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[Off-facility Test] What date and time would you prefer for the counselor to come to your home for an HIV test?

Thank you.
Oral Script for partners:

- **Good time to speak privately:**
  - Notify them of their exposure
  - Assure them that their exposure does not mean they are HIV positive, but it does mean they need to get tested.

**Oral Script for Partners**

Script is for partners exposed to HIV – Phone Contact Tracing

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[Off-facility Test] What date and time would you prefer for the counselor to come to your home for an HIV test?

Thank you.
Oral Script for partners:

- If partner inquires how their contact information was acquired, inform them you are not allowed to disclose that information.

*If partner insists or threatens you inform them that it was obtained from a NASCOP database*
Oral Script for partners:

- If partner agrees to come to the clinic for an HIV test let them know your availability and name.

- Record in the **Partner Tracing Form**
  - *tick yes for "was partner located?"*

---

**Oral Script for Partners**

*Script is for partners exposed to HIV – Phone Contact Tracing*

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Thank you.
How to Actually Conduct Partner Tracing?

3. Use the following tools to discuss APS:
   - Oral Script
   - **In-Person Script**
   - Written Consent
In-Person Contact Tracing

If a partner was not notified successfully after 3 times begin in-person tracing:

- Use the partner contact information to locate their address
- Use Introduction Script to Partners once you have arrived

**Introduction Script to Partners – In-Person Contact Tracing**

Hello, I am looking for Ms/Mr.___________. Is he/she around?

[IF NOT] Okay, thank you. Do you know when he/she will be back?

[Once Partner is in front of you] My name is ____________, and I am a counselor/healthcare provider in ____ (County). Is there a private place that we can talk?

[IF YES] I have some important health information for you. We have recently learned that you might have been exposed to HIV. This does not mean you are infected. It just means that you have been exposed to HIV and will need to test yourself soon to see what your status is. We cannot disclose how we learned about the exposure due to the need to maintain confidentiality. 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 live a long life and reduce your chance of passing HIV onto others.

I can test you for HIV right now. Would you like to do the test today?

[IF YES] **Provide pre-test counseling, obtain informed consent, and do post-test counseling according to national HTS guidelines.**

[IF NO] If you prefer, you can come to ____ [Facility Name] ____ for an HIV test. HIV testing services are available Monday - Friday from 8:30 in the morning until 5:00 in the evening. Would you like to go today? If so, I can accompany you to the clinic. If not, what day would you like to come to the health facility for an HIV test? I advise that you do the test at your earliest convenience. Please look for me when you get to ____ [Facility Name] ____ for an HIV test.

If you test positive on your HIV test, I will also provide assisted partner notification services. As the first part of the service, we will ask you to share with us the contact information of your sexual partners from the past three years. Then, either HTS Counselors or Health Advisors will attempt to contact these partners by phone or off-site visit to tell them they may have been exposed to HIV. We will keep your identity confidential while telling your sexual partners of their possible exposure. This means they will not tell your sexual partners how or who may have exposed them to HIV. However, in some cases it may be possible for them to figure out who referred them. If your partner(s) decide they want to take an HIV test and test positive, we will help them linked to care. Assisted Partner Services are important so that your partners can know their HIV status and take preventive measures accordingly to live a healthy life.

Do you have any questions? Would you like to receive aPS if you test positive?

[Off-Facility Test] **Provide pre-test counseling, obtain informed consent, and do post-test counseling according to national HTS guidelines**

Thank you.
In-Person Contact Tracing

If the partner is not home, ask when he/she will be back.
In-Person Contact Tracing

Once the partner is in front of you, notify them of their possible exposure to HIV
• Offer them testing

Introduction Script to Partners – In-Person Contact Tracing

Hello, I am looking for Ms/Mr.___________. Is he/she around?

[IF NOT] Okay, thank you. Do you know when he/she will be back?

[Once Partner is in front of you] My name is__________, and I am a counselor/healthcare provider in ______(County)__. Is there a private place that we can talk?

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Do you have any questions? Would you like to receive aPS if you test positive?

[Off-Facility Test] **Provide pre-test counseling, obtain informed consent, and do post-test counseling according to national HTS guidelines

Thank you.
In-Person Contact Tracing

If they accept HIV testing

- Provide pre-test counseling
- Obtain informed consent
- Provide post-test counseling

*According to national HTS guidelines*
In-Person Contact Tracing

If they decline HIV testing at the moment

- Refer them to HIV testing services
- Provide them with facility schedule
In-Person Contact Tracing

Inform them that if they test positive on their HIV test at the facility:

- They will be provided with aPS
- Explain aPS
- Answer any questions they may have
- Ask if they would like to receive aPS if they test positive

Introduction Script to Partners – In-Person Contact Tracing

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Thank you.
How to Actually Conduct Partner Tracing?

3. Use the following tools to discuss APS:
   - Oral Script
   - In-Person Script
   - **Written Consent**
Written Consent Form Guide

For cases newly diagnosed with HIV

• Use Consent Script to guide written consent for aPS

• Remember consent is informed and voluntary

• Answer any questions they may have

Script is for index cases newly diagnosed with HIV

1. Per your HIV test result, I would like to discuss with you “Assisted Partner Notification Services” and see if you would be interested in receiving this service.

2. First, I’ll tell you some information about this service. You can ask questions at any time.

3. Assisted partner notification services are provided to people who test HIV-positive.

4. As the first part of the service, we will ask you to share with us the contact information of your sexual partners from the past three years.

5. Either HTS Counselors or Health Advisors will attempt to contact these partners by a phone call or off-site visit to tell them they may have been exposed to HIV. We will keep your identity confidential while contacting your sexual partners. This means they will not tell your sexual partners how or who may have exposed them to HIV. However, in some cases it may be possible for them to figure out who referred them.

6. If your partner(s) decide that they want to take an HIV test and test positive, we will help them link to care and receive HIV services.

7. You will not benefit directly from this study. However, you may benefit indirectly by having your partner notified and tested for HIV.

8. Do you have any questions now?
Written Consent Form Guide

For cases newly diagnosed with HIV

• Reassure them aPS is confidential
• Reassure them they are not obliged to accept the service
• Provide them with the written consent form

9. We will keep all your records and data confidential; no information that could identify you will be available to people who are not part of providing this service.

10. If you have any questions about the service, you can contact Kenyatta National Hospital Ethics and Research Committee, at 2726300 Ext. 44102.

11. You can decline this service at any time and this will not be a problem for you.

12. The decision not to accept this service will not affect your care at this clinic. You are not obliged to accept this service. The decision to accept Assisted Partner Notification services is yours to make.

13. Please review the Assisted Partner Notification Services Written Consent Form, this document explains Assisted Partner Notification Services in further detail and asks for your written informed consent. Thank you.
Assisted Partner Notification Services Written Consent Form

We are asking you to participate in the assisted partner notification services (aPS) that are now part of the routine HIV testing services (HTS). The purpose of this consent is to give you the information to help you decide if you want to take part. Read the form carefully. You may ask questions about the purpose and procedures of aPS, the possible risks and benefits, your rights as a volunteer, and anything else about the services or this form that is not clear. You will decide whether you want to receive aPS or not. This process is called ‘informed consent.”

Purpose of APS Intervention: Disclosure of HIV status to partners can be difficult. Therefore, the clinic is now offering aPS as part of routine HTS to assist newly diagnosed HIV-positive clients to anonymously contact their partners and provide voluntary HTS. The goal of aPS is to stop further HIV transmission by offering HTS to all persons who have been exposed to HIV.

Routine APS Procedure: HTS counselors will ask you to list the names of all sexual and/or needle sharing partners in the past 3 years if you test HIV-positive. You will also be asked to name your children who may need an HIV test. With your consent, HTS counselors will contact the partner(s) either by phone or in-person to let them know they might have been exposed to HIV and should be tested. The counselors will not reveal your identity to the partner(s) while contacting them. If the partner tests positive, they will be offered aPS and referred to HIV treatment and care services. If test negative, they will be referred to HIV prevention services.

Risks, Stress or Discomfort: Answering questions about your sexual relationships, including recent history of IPV, may be stressful. You may feel some pain from where blood sample is taken. Although your identity will be kept confidential while contacting your partners, in some cases it may be possible for them to figure out who referred them to HTS.

Benefits: There is no money for receiving aPS. Counseling referrals and HIV treatment are free.

Other information: You are not obliged to receive aPS. Your decision not to receive aPS will not affect your care at this clinic.

Problems or questions: If you ever have any questions about this service or your rights as a participant, Kenyatta National Hospital Ethics and Research Committee, at 2726300 Ext. 44102
Introduction to APS Scale-Up Study: There is a research study that is embedded in this routine HTS/APS program. The research team will abstract HTS/APS program data to evaluate 1) how well aPS increases the uptake of HIV testing in the communities, and 2) how best can aPS be scaled-up nationwide. Study participants will be contacted at 6 weeks, 6 months, and 12 months to assess ART initiation, linkage-to-care, and viral suppression. If you are interested in participating in the study, you will be referred for eligibility screening. Your decision not to be part of the study will not affect your aPS or other care services at this clinic.

Subject’s statement 1: APS procedures have been explained to me and I volunteer to receive aPS. I have had a chance to ask questions. If I have questions later about aPS, or if I have been harmed by participating in aPS, I can contact the HTS counselor who has signed this form. I give my consent to receive aPS as described in this consent form. I will receive a copy of this form.

Printed name of client          Signature of client          Date

Printed name of clinic staff obtaining consent          Signature          Date

Subject’s statement 2: The objectives and procedures of APS Scale-Up Study have been explained to me. I give my consent to be referred for the study eligibility screening. I will receive a copy of this form.

Printed name of client          Signature of client          Date

Printed name of clinic staff obtaining consent          Signature          Date
How to Actually Conduct Partner Tracing?

Record all attempts (3) to contact partner and attempt to discuss APS using:

- **Client Tracing Form**
- Oral Script
- In-Person Script
- Written Consent
Once partner is located, then move on from Contact Attempt Section to Partner Notification Section

<table>
<thead>
<tr>
<th>PARTNER NOTIFICATION - Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Date completed:</td>
</tr>
<tr>
<td>2. Is partner still alive?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>3a. Did you notify partner of their exposure to HIV?</td>
</tr>
<tr>
<td>3b. Reason not notified:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>4a. Method of notification (Tick one):</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>4b. Where was partner notified?</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>5. Had partner already been notified of their HIV exposure?</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Comments: ___________________________
Reminders and Tips

• Be detailed in your contact attempts
• Be friendly and build trust first
• Answer any questions partners may have
• When notifying a partner of their exposure assure them that their exposure does not mean they are HIV positive, but it does mean they need to get tested
Summary

• Contact tracing is an important component of aPS

• May seem time and labor-intensive, but has a significant impact long-term

• Need commitment and same vision from trained providers for successful contact tracing
Thank you

Questions?
Procedures for Follow-Up Contacts in Assisted Partner Notification Services

Standard Operating Procedures
Follow-up Contacts in aPS

• Significance:
  – Although aPS increases HIV testing, not much evidence is available to assess its long-term effect

• Three follow-up contacts:
  – At 6 weeks, 6 months, and 12 months
  – First two contacts are done over the phone; the last contact is done in-person
Setting Up Follow-Up Contacts with Clients

• Occurs upon completion of partner elicitation and before clients leave the clinic

• HTS counselors will ask clients whether they would be willing to schedule follow-up interviews to assess their HIV care, safety (IPV), and partner notification status
  – Two calls, one in 6 weeks, one in 6 months
  – 12 month visit to assess viral suppression

• If client is interested, HTS counselors will obtain written consent from clients
Why Written Consent?

• Although follow-up contacts are a critical part of aPS to monitor and evaluate program impact, they may not be scalable at nation-level.

• Since follow-up contacts are not part of routine care, written consent is needed.
Written Consent Procedures

• Written consent is brief (1 page)
  – Should only take ~10 minutes per client

• HTS Counselors will walk through each section in written consent form and explain:
  – Purpose of research
  – Program procedures
  – Client’s rights as a volunteer
  – Possible risks and benefits

• HTS Counselors will take time and answer any remaining questions that Clients might have
Written Consent Procedures

• After reviewing the consent form, HTS Counselors ask Clients if they understood everything. If yes, ask Clients to sign and date the Signature Page.

• If the Client is illiterate, thumb print may substitute signature.

• Put the signed consent form in a binder and securely store it in the lockable cabinet.
Written Consent for APS Scale Up

Assisted Partner Notification Services Scale-Up — Written Consent Form
Kenya National AIDS & STI Control Programme, PATH, University of Washington

<table>
<thead>
<tr>
<th>Researchers:</th>
<th></th>
<th></th>
<th>Telephone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Position</td>
<td>Department</td>
<td></td>
</tr>
<tr>
<td>Carey Farquhar</td>
<td>Principal Investigator</td>
<td>Professor, Departments of Medicine, Epidemiology, Global Health, University of Washington, Seattle, USA</td>
<td>011-206-543-4278</td>
</tr>
<tr>
<td>Edward Kariithi</td>
<td>Site Principal Investigator</td>
<td>Regional HIV/TB Service Delivery Advisor, PATH, Kenya</td>
<td>254-20-387-7177</td>
</tr>
<tr>
<td>Christopher Obong’o</td>
<td>Co-investigator</td>
<td>Adolescent Health Advisor, PATH, Kenya</td>
<td></td>
</tr>
<tr>
<td>Peter Cherutich</td>
<td>Co-investigator</td>
<td>Deputy Medical Director, Ministry of Health, Kenya</td>
<td>072-192-4030</td>
</tr>
<tr>
<td>Sarah Masyuko</td>
<td>Co-investigator</td>
<td>Assistant Deputy Director of Medical Services, National AIDS and STI Control Program, Ministry of Health, Kenya</td>
<td></td>
</tr>
</tbody>
</table>

Investigators' statement: We are asking you to be part of research that is embedded in a health program. The purpose of this consent is to give you the information to help you decide if you want to take part. Read the form carefully. You may ask questions about:

- The purpose of the research
- What we would ask you to do
- The possible risks and benefits
- Your rights as a volunteer
- Anything else about the research or this form that is not clear

You will decide whether you want to be part of the research or not. This process is called ‘informed consent.’

Purpose of the Research: APS is now part of routine care in Kenya. By following up with clients who receive aPS, we want to know how much aPS increases the number of people testing for HIV, receiving care, and with viral suppression. We also want to know the best way to implement aPS nationwide. The information we obtain from this program would allow us to stop further spread of HIV.
Written Consent for APS Scale Up

**Program Procedure:** There will be three follow-up contacts made by trained providers if you decided to participate. The first two will happen over the phone at 6 weeks and 6 months from enrollment. We will ask you questions about sexual behaviors, HIV care or treatment, recent history of intimate partner violence (IPV), and whether you have disclosed your HIV status to anyone. The last follow-up will be done in-person at the clinic at 12 months from enrollment. At this visit, we will ask you the same questions and also get a blood sample to test your HIV viral load. To do so, a small needle will be used to make a puncture in the skin. The blood will be put onto filter paper and a dried blood sample will be made. The sample will be sent to a lab in Kisumu. All follow-up procedures will take less than 30 minutes.

**Risks, Stress or Discomfort:** Answering questions about your sexual relationships, including recent history of IPV, may be stressful. You may feel some pain from where blood sample is taken.

**Benefits:** There is no money for participating in this program. Counseling referrals and HIV treatment are free.

**Other information:** The data will be kept private and there will be no identifying links to you. Being in this study is voluntary. You do not have to be in this study if you don’t want to.

**Problems or questions:** If you ever have any questions about this research, or if you have a research-related injury you should contact Dr. Edward Karini at 254-0722620666. If you have questions about your rights as a participant, contact the Kenyatta National Hospital Ethics and Research Committee, at 2726300 Ext. 44102

<table>
<thead>
<tr>
<th>Printed name of study staff obtaining consent</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

**Subject’s statement:** This study has been explained to me. I volunteer to take part in this research. I have had a chance to ask questions. If I have questions later about the research, or if I have been harmed by participating in this study, I can contact one of the researchers listed on the first page of this consent form. If I have questions about my rights as a research participant, I should contact the Kenyatta National Hospital Ethics and Research Committee, at 2726300 Ext. 44102. I give permission to take a dried blood spot sample as described in this consent form. I will receive a copy of this form.

<table>
<thead>
<tr>
<th>Printed name of subject</th>
<th>Signature of subject</th>
<th>Date</th>
</tr>
</thead>
</table>
Appointment Card

• After obtaining written consent, HTS Counselors set up appointments for the 6-week, 6-month, and 12-month follow-up contacts

• Date and time must be mutually agreed by both parties: Clients and Counselors

• HTS Counselors record the appointment times and dates on the Appointment Card and inform Clients that they will be receiving calls from them
Appointment Card

- The Appointment Card will be given to the Client before they leave the Clinic
Phone Follow-Up Contacts

• Use the ODK Form to indicate whether the client was reached

• HTS Counselors may attempt to contact clients via phone up to 3 times

• If the client indicates it is not a good time to talk, HTS Counselor will reschedule a phone call at the time the Client suggests

• If all three attempts are not successful, an off-site in-person visit will be conducted within a week

Second attempt must be done the next day and third attempt must be done within one week of the first attempt
Missed Visit Form

- Use to record missed visits at 6-week, 6-month, or 12-month follow up
- State reasons and attempts

---

**APS SCALE-UP STUDY MISSED VISIT FORM**
*For both Index Clients and Partners*

<table>
<thead>
<tr>
<th>CLIENT PROGRAM ID:</th>
<th>_______ • _______ • _______ • _______ • _______ • _______</th>
</tr>
</thead>
<tbody>
<tr>
<td>HTS COUNSELOR ID:</td>
<td>_______ • _______ • _______ • _______ • _______ • _______</td>
</tr>
<tr>
<td>TODAY'S DATE:</td>
<td>DD/MM/YYYY</td>
</tr>
</tbody>
</table>

**Name of Facility/Venue Reporting:**
MFL Code: ______________ County: ______________ Sub-County: ______________ Ward: ______________

**SECTION I.**

1. **CLIENT PROGRAM ID:**

2. **Which follow-up contact did the client miss?**
   - [ ] 6-week follow-up
   - [ ] 6-month follow-up
   - [ ] 12-month follow-up

3. **What was the scheduled date of this missed visit?**
   DD/MM/YYYY

4. **How many attempts have been made to reach this client?**
   ____________ Attempts

5. **What was the reason for missing this client?**
   - [ ] Client relocated
   - [ ] Changed phone number
   - [ ] Deceased
   - [ ] Traveling; not at home
   - [ ] Very sick; hospitalization
   - [ ] Other, specify: ____________________

**Comments:**

**HTS Counsellor**

<table>
<thead>
<tr>
<th>Name:</th>
<th>____________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signature:</td>
<td>____________________</td>
</tr>
<tr>
<td>Today's Date (dd/mm/yy):</td>
<td><strong>/</strong>/____</td>
</tr>
</tbody>
</table>

---
12 Month In-Person Follow-Up at Facility

- Use the “Client Tracing Logbook” to indicate whether the client was reached.

- On the eve of the clinic visit, HTS counselors will call the client to remind them of the appointment.

- If the client does not show up for the appointment, the HTS counselor may attempt to contact clients via phone up to 3 times.

- If all three attempts are not successful, an off-site in-person visit will be conducted within a week.

- At the end of the visit, HTS counselors thanks the client for the cooperation, sets up a plan for continuation of care, and reviews the importance of ART adherence.
Follow-Up Form

**INDICATE THE FOLLOW-UP VISIT NUMBER AND CCC NUMBER**

**SECTION I. FOLLOW-UP INFORMATION**

1. Which follow-up contact is this?  
   | 6-week follow-up  | 6-month follow-up  | 12-month follow-up |

2. Was this follow-up done in-person or via phone?  
   | In-person  | Phone |

**SECTION II. NOTIFICATION INFORMATION**

4. Did you notify any of your current or past partners of their exposure to HIV since your last follow-up visit?  
   | No (Go to Q6)  | Yes |

5. If so, which partner(s) did you notify?  
   | A  | B  | C  | D  | E  | F  | G  | H |

6. Did you find out that any of your current or past partners received assisted partner notification services since your last follow-up visit?  
   | No (Go to Q7)  | Yes |

6.1 If so, which partner(s)?  
   | A  | B  | C  | D  | E  | F  | G  | H |

7. Did any of your current or past partners get tested for HIV since your last follow-up visit?  
   | No (Go to Q8)  | Yes |

7.1 If so, which partner(s)?  
   | A  | B  | C  | D  | E  | F  | G  | H |

8. Have you shared your HIV status with anyone other than a current or past partner?  
   | No (Go to Q9)  | Yes |

8.1 If so, with whom? Enter number of people in each category you shared your HIV status with:

   - Parent(s)
   - Sibling(s)
   - Religious leader(s)
   - Other friend(s)/acquaintance(s)
   - Husband/wife
   - Children
   - Boyfriend/girlfriend
   - Other(s) (specify:___________)
   - Employer(s)
   - Health provider(s)
Follow-Up Form

### SECTION III. HIV HISTORY QUESTIONS

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No (Go to Q10)</th>
<th>No (Go to Q11)</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Have you enrolled (registered) at any HIV clinic for HIV care since your last follow-up?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.1 If so, which clinic did you enroll (register) in HIV care? If you have enrolled in multiple clinics, where are you currently getting HIV care?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.2 When did you first enroll (register) in HIV care at this HIV clinic?</td>
<td>Day ___ Month ___ Yr. ___ ___</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.3 What is client’s CCC number?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Have you taken antiretrovirals for your HIV since your last follow-up? (Not for prevention of mother-to-child transmission)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.1 When did you first start taking antiretrovirals for your HIV?</td>
<td>Day ___ Month ___ Yr. ___ ___</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Are you currently taking antiretrovirals for your HIV?</td>
<td></td>
<td>No (Go to Q12)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.1 When did you stop taking antiretrovirals?</td>
<td>Day ___ Month ___ Yr. ___ ___</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Have any of your relationships ended since your last follow-up?</td>
<td></td>
<td></td>
<td>No (Go to Q13) □ Yes</td>
<td></td>
</tr>
<tr>
<td>12.1 If so, why did your relationship end?</td>
<td></td>
<td>Client learned his/her status</td>
<td>Client learned partner’s status</td>
<td>Other reason (Specify: ____ )</td>
</tr>
</tbody>
</table>

### ONLY FOR 12-MONTH FOLLOW-UP VISIT

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Was the blood drawn for the client for an HIV viral load?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Did you get a filter paper for blood sample?</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
| 15. What is the viral load result?                                      |     | ___ copies/mL

□ RECEIVED BUT DO NOT REMEMBER  □ DID NOT RECEIVE VIRAL LOAD RESULT
Follow-Up Form

• Ensuring Client safety is the upmost importance of success of aPS:

<table>
<thead>
<tr>
<th>ONLY FOR 12-MONTH FOLLOW-UP VISIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Was the blood drawn for the participant?</td>
</tr>
<tr>
<td>14. Did you get a filter paper for blood sample?</td>
</tr>
</tbody>
</table>

SECTION IV. IPV QUESTIONS  
“I would like to ask you some questions about your current and past relationships. We want to make sure you are safe.”

| 15. Are you in a relationship with a person who has physically hurt you? | □ Yes, since the last follow-up call |
| 16. Are you in a relationship with a person who threatens, frightens, or insults you, or treats you badly? | □ Yes, since the last follow-up call |
| 17. Are you in a relationship with a person who forces you to participate in sexual activities that make you feel uncomfortable? | □ Yes, since the last follow-up call |

Comments:

HTS Counsellor

Name: __________________________
Signature: ______________________
Today’s Date (dd/mm/yy): _____/_____/______

At each follow-up contact, HTS Counselors will closely monitor whether the client has experienced intimate partner violence since receiving aPS.
Importance of Minimizing LTFU

• Maintaining a high retention rate is critical in research to assess the program impact

• All staff involved in aPS must be familiar with proactive and reactive retention methods to successfully follow up with Clients
  – **Proactive retention**: Measures taken to ensure a client’s continued and persistent success at attending scheduled appointments within their target dates
  – **Reactive retention**: Efforts made to reschedule Clients who have missed their follow-up visits or contacts

• Detailed information is available in SOPs
Summary

• All clients receiving aPS will be invited to participate in follow-up procedures

• Written consent will be obtained from all clients receiving follow-up contacts

• It's Important for all staff to work together to maintain a high retention rate
Thank you

Questions?
Managing Resistance to Assisted Partner Notification Services

Adapted from CBC Health Services Training Slides
April 2018
What is Resistance in APS?

Resistance in aPS refers to a client or partner refusing to receive any procedure related to aPS for one reason or the other.
Potential Reasons for Resistance

• Lack of trust in providers or government
• Fear of social harms
• Fear of stigma
• Breach of confidentiality
• Types of relationship (casual vs. stable)
• Blame shifting and ventilation
Potential Reasons for Resistance

• Knowing these potential reasons for resistance will make it easier for health advisors to identify and manage resistance
• We will explore various ways of managing different types of resistance
Resistance

Index case does not believe s/he has sufficient information about the sexual partner(s)

Management:
• Communicate that any information can be useful
• Most people are able to give a first name, estimated age, physical description, and where they met
• Some may even know the area where they live, occupation, state or condition of relationship at present
• Even if it not enough to trace the contact, it may allow the person to be recognized and managed appropriately if they attend clinic spontaneously
  – (The potential for this is greater in small clinics, where a Health Advisor is more likely to be aware of the majority of attendees)
Resistance

Index case has substantial details like name and date of birth but believe that they need a full address

Management

• Explain that more information can be obtained from other medical records
• Find out if the patient may be willing to seek more missing information from mutual acquaintances
Resistance

Index case believes partner was not exposed because they used a condom

Management

• Outline the risk of exposure despite condom use, due to unprotected genital contact
• Explore the benefits of notifying and testing early
Resistance

Index case has a fixed view on the likely source of infection and is unwilling to notify previous contacts.

Management

• Emphasize the difficulty of being certain about the duration of the infection
• Explore the benefits of notifying and testing early
• Remind him/her of the fact that testing is the only way to know someone’s sero-status
Resistance

Index case cannot be persuaded to inform a regular partner

Management
• Encourage Index person to explore ways of going for VCT with partner.
• Invite both for general health counseling if feasible and then include education on HIV and AIDS.
• In case the index case says the contact already did the test, it is worth advising repeat tests if unprotected sexual contact is resumed
Resistance

Index case is hostile towards the partner

Management

• Where there is risk of violence, delaying provider referral until the patient is in a place of safety may be acceptable.
• However the negative consequences of not notifying partners should be emphasized.
• For example, the index person may become re-infected, or may eventually be confronted by a contact person who has realized s/he could have been notified earlier, thus preventing complications and further transmission.
Resistance: Case Study

NY feared disclosure outcomes and silently started a new relationship, after first partner neglected and abandoned her infected baby. Within first two months of this new relationship, she could no longer conceal clinic visits and cards. Boyfriend in the course of searching for a towel from her travelling bag, discovered clinic cards and antiretroviral drugs!

It was a terrible, horrible night as I struggled to resolve conflict by phone. Crisis between this couple and partner violence has been a concern as feelings of bitterness, distrust remains a challenge. Boyfriend tested positive but holds to the fact NY infected him since she failed opening up to him initially.
Resistance

Index case fears angry confrontation

Management

- The index case may be able to reduce the risk of angry confrontation by selecting an appropriate time and place, speaking calmly, resisting blame or guilt and focusing on the need for medical care rather than speculating about the source.
Resistance

Management
• If the index case is given the opportunity to explore these feelings with the support and understanding of the health advisor, anger may eventually reduce sufficiently for them to reconsider.
• Stressing the frequent absence of symptoms can challenge false beliefs that may be fueling resentments, such as the assumption that the partner has knowingly passed on an infection.
• Equally, the patient may assume the infection has been recently acquired, and that therefore a partner has been unfaithful.
Resistance

Management

• Emphasize the serious consequences of untreated infection as may stir enough concern or conscience to override depression

• If the patient is still not ready to co-operate, further discussion may be postponed
Resistance

Index case is indifferent to the partner's welfare

Management
- Indifference is often a barrier, particularly towards casual partners where there is insufficient familiarity or sense of connection to provoke empathy, concern or obligation.
DP had numerous contact persons but was not willing to consider their welfare and bitterly claimed that “... make any man hear for yi kanda”. She refused taking responsibility for past risky behaviour and finally got lost to tracing after revealing few partners.
Resistance

Index case believes that the contact will not respond or take notification as a joke

Management
• Patients who have previously failed to persuade a partner to attend may see no point in trying again.
• Exploring the reasons why the contact is unwilling to attend may suggest solutions.
• A contact who does not believe s/he has been at risk may be persuaded by a hospital letter; a contact wanting to avoid acquaintances who work at the clinic may be willing to visit the GP.
Resistance

Index case believes that the partner is aware of his/her status already

Management
• It is important to challenge the assumption that the contact will be symptomatic
• It is more like for someone who already knows their status to cooperate and test again
Resistance

Index case is afraid of the potential consequences

Management

- Partner notification is not without risk for the index person, who may fear:
  - Loss of relationship
  - Verbal abuse
  - Damaged reputation and rejection
  - Physical violence
  - Stigma and Discrimination
  - Separation or Divorce

- The health adviser may help to reduce risks or fears by providing a supportive environment where anxieties can be explored: this may enable the index person to reassess fears and manage risks effectively.
Resistance

Index case is afraid the contact will know who gave their name, be angry, end relationship or tell others.

Management

• Examine and possibly challenge it: for example, confidence may be enhanced by reassurances about confidentiality, or by considering the possibility that the contact person may be more grateful than angry.

• The patient may be able to reduce the risk of angry confrontation by selecting an appropriate time and place, speaking calmly, resisting blame or guilt and focusing on the need for medical care rather than speculating about the source.
Resistance

Index case is afraid of a clash, compromising confidentiality and risking confrontation

Management

- The health advisor may be able to prevent this by booking appointments personally, at ‘safe’ intervals.
Staff Safety

• If the resistance is very high, staff safety may be at risk

• Safety concerns for staff during off-facility contact tracing include, but not limited to:
  
  – Partner(s) threatening to hurt the health provider if s/he does not disclose who provided their contact information and potential exposure to HIV

  – Partner(s) not wanting to take an HIV test and threatens the health provider to leave the premise immediately
How to Minimize Potential Harm

- Staff should always introduce themselves first and be friendly
- Maintain confidentiality:
  - Ensure you are in a private and secure environment with partner(s) before discussing HIV and testing
- Tell partner(s) that their contact information and potential exposure to HIV were obtained from the NASCOP database
- Engage in a conversation first and show empathy before doing an HIV test
- Carry your work ID card
- Engage chiefs, administrators, CHVs/CHWs of the community if possible
- Building trust is key
- Listen to your gut feeling
In Cases of Violence:

• Calm down, do NOT panic or respond immediately
• Call Health Advisors or Study Coordinator
• Immediately leave the premise
• Document in-detail what happened
• Report to Study Coordinator

Case-by-case precaution measures must be taken

Decisions on how to follow-up with that specific partner will be made by Study Coordinator and Safety Monitoring Board
Safety Monitoring Board

• An independent advisory capacity to monitor safety of clients and staff

• Members include experts around the world

• Responsibilities include:
  – Oversee intervention conduct and progress to protect the safety of clients and staff
  – Review IPV monitoring data and discuss reported cases
  – Review and monitor data to ensure confidentiality of clients and address concerns regarding stigma related to HIV and testing
  – Monitor potential threats posed on staff when conducting off-facility services
Summary

• Healthcare provider should be able to identify a resistant case and select a technique of managing it
• Remember to make use of every information that the patient gives
• A successful technique used in Case A may not always be applicable in Case B
  – You have to be *flexible* in your approach
• Avoid unsafe circumstances when conducting partner tracing
Thank you

Questions?
Electronic Data Collection in Assisted Partner Notification Services

Standard Operating Procedures for ODK Use
Day 3
April 2018
Benefits of Electronic Data Collection

Traditionally, medical, and M&E data were collected using paper-based forms in Kenya.

Electronic medical records are collected using mobile devices, such as tablets and smartphones:
  - Time efficient
  - Easy to coordinate
  - Higher data quality with fewer missing data
APS Scale-Up Project

• Will utilize Samsung tablets for data collection

• Each facility will have 1-2 tablets available

• All case report forms (i.e. HTS intake form, lab results, aPS screening, enrollment, and follow-up) will be completed using a tablet
    – Except LINK LOG, PARTNER CONTACT FORM, and WRITTEN CONSENT FORMS

• Health Advisors must be proficient in ODK and tablet use to provide technical support to HTS counselors
Open Data Kit (ODK)

• Open-source mobile device application

• Used to develop data collection tools (e.g. survey), collect and extract data for analysis

• Data can be sent to the server on a daily basis; enable real-time data monitoring and evaluation
Rules for Mobile Device Usage

• Tablets are the property of the aPS program; they may not be used for personal and/or non-study activities

• Inappropriate usage include, but not limited to:
  – Calling and texting friends or family
  – Non-study related internet searching/browsing
  – Playing games
  – Social media (e.g. Facebook, Twitter, and Instagram)
How to Use ODK?

• Step-by-step procedures
  o Downloading a new, blank form
  o How to navigate different eCRFs
  o Understanding skip patterns
  o Data transfer to server
Steps for ODK Error Reporting

If encounter any technical problems related to ODK:

1. Contact Data Manager or Research Coordinator

2. Take a screenshot of the page with the error message, and send it to Data Manager via WhatsApp or other channel

3. Data Manager will provide solutions to HTS Counselors/Health Advisors if it can be resolved easily

4. If the problem cannot be resolved remotely, HTS Counselor will get a backup tablet to complete the interview

5. The problematic tablet will be sent to Data Manager at the end of the day

6. Data Manager will troubleshoot; the tablet will be returned to the facility once resolved
Version Update/Control

• When CRFs require updating, the device will be returned to Data Manager

• Data Manager is responsible for updating the forms and/or device
Handling of Mobile Devices

• Tablets are handheld computers

• All staff involved in aPS delivery must make every effort to protect them from theft or damage

• Tablets will be securely stored inside a locked cabinet at the facility

• Tablets must be connected to a charger whenever not in use to ensure it has enough battery during data collection
Client Identification Number (PTID)

• This is different from HTS registry no.

• Barcode will be used to generate the first part of PTID
  – Barcode will have a two-digit site number and 4-digit index number
  – Use tablets to scan a barcode
  – Each facility will have pre-generated barcodes available before the start of the project
Thank you

Questions?
Basic Counselling & Communication Concepts in HTS & aPNS

SESSION 4
Communication is key to the success of index testing services

• Communication is at the center of aPNS, and effective communication can only happen when good communication skills are used.

• Good communication depends on:
  1. Appropriate non-verbal messages
  2. Appropriate verbal messages
  3. Effective listening
Basic Communication Skills

1. Demonstrate Professionalism
2. Establish Rapport
3. Listen Effectively
4. Use Open-Ended Questions
5. Communicate at the Patient’s Level
6. Give Factual Information
7. Solicit Patient Feedback
8. Use Reinforcement
9. Offer Options, Not Directives
10. Use Appropriate Nonverbal Communication
The communication process

1. Sender has an idea
2. Sender encodes idea in message
3. Message travels over channel
4. Receiver decodes message
5. Feedback comes back to the sender
6. Possible additional feedback to receiver
Counselling skills useful in aPNS
Group 1
- Define counselling
- What are the attributes of a good counselors

Group 2
- Discuss counseling skills and how they can be used in the context of aPNS
Definition of Counselling

- Is a ‘professional’ relationship between a trained counselor and a client

- Counselling helps clients to understand/clarify their views to make informed choices

- Gives the client an opportunity to explore, discover, and clarify ways of living more satisfyingly and resourcefully
Counselling Skills

- **Structuring/contracting:** counsellor establishes to the client what the session will cover and the boundaries of the service
  - counsellor and the client have a clear understanding about the session and what roles and responsibilities each party plays
  - It's during contracting that the client is informed of PNS and listing of sexual and social contacts.

- **Attending skills:** Attending skill refers to the counsellor’s ability to pay close attention to the client as the process of counselling progresses. **Attending involves:** SHOVLER
SHOVLER

S – Face the other squarely
H – Head nods
O -- Adopt a open posture
V – Verbal following
E – Speech patterns and volume
L – Lean toward the other
E – Make eye contact
R – Be relatively relaxed
Counselling Skills Cont..

- **Listening skill**: ability to actively listen to the client when they are talking in order to know client issues, reveal omissions and clients experience, behaviour, or feelings.

- **Questioning skills**: There are two types of question; Open ended and close ended questions.

- **Paraphrasing**: Paraphrasing is the skill where the counsellor re-states or repeats the client’s words in their own words in order to convey their own understanding of what the client has shared.
Counselling Skills Cont..

- **Empathy:** Empathy refers to the ability of the counsellor to tune into the world of the client or “to get into the clients shoe”

- **Summarizing:** Summarizing is a skill that the counsellor uses to concretize what both; the client and the counsellor have said.

- **Focusing skill:** Focusing involves re-directing the client when they deflect from the topic of issue. It is asking the client for priorities of exactly what he/she would want to tackle at a particular time.
### Minimal prompts/minimal encouragers:
Act of encouraging an individual to continue talking about their issue and it also demonstrates attentiveness and concern of the counsellor.

- Non-verbal prompts include: nodding, raising eyebrows etc.
- Verbal prompts include: mmh, yes, yah, go on, etc.

### Working silence:
No verbal communication is taking place and at the same time the counsellors is there for the client: Helps the client to have dialogue with him/herself, allows the client to communicate a strong feeling or emotion to self.
Counselling Skills Cont..

- **Affirmation**: encourages the counsellor to praise, appreciate the client for the efforts they have put in place already in their lives.
  - HIV testing and deciding to reduce risk of getting to be infected is a huge step and affirming the client goes a long way in motivating them to do prevention
  - PNS requires high level of trust towards the provider hence acknowledging the steps to lists their sexual and social contacts makes the client feel less anxious
Counselling Skills

Counselling skills are divided into two categories; Supportive skills and Challenging skills.

**Supportive skills:** These are skills that communicate warmth, unconditional positive regard and concern for clients (above skills are supportive).

**Challenging skills:** These are skills communicating what you have heard and picked up in the counselling sessions for example, inconsistencies, goals consistently not achieved or challenging current beliefs, thinking and values.

(This skills are only used in context of empathy, unconditional positive regard and genuiness)

Below there are examples of challenging skills.
Counselling Skills Cont..

- **Concreteness/firmness:** Concreteness is an aspect of counselling that means that the counselor should be specific, definite, and vivid rather than vague and general.
- It keeps the therapist’s response close to the client's feelings and experiences;
- It fosters accurateness of understanding in the therapist, allowing for early client corrections of misunderstanding; and
- It encourages the client to attend to specific problem areas.
**Counselling Skills Cont.**

- **Self disclosure:** involves the counsellor appropriately disclosing or talking about oneself, or sharing personal experiences, emotions, attitudes with another.

  - The careful use of self-disclosure in helping sessions can facilitate client growth and exploration. Use the skills only when the provider has already successfully dealt with the issue they want to disclose.

- **Immediacy:** ability of the counsellor to use the immediate situation to invite the client to look at what is going on between them in the relationship.
**Confrontation**: counsellor uses to help the client reflect on contradiction and incongruence’s that they express during the process of counselling.

- It also helps the client to identify his/her blind spots.
Counselling Theoretical Framework informing PNS Service Delivery

Session 5
- Group 1: Humanistic/Person Centered Approach
- Group 2: Solution Focused Brief Therapy
- Group 3: Cognitive Behavioral/Rational Emotive Behavioral approaches

- Key figure(s) (founder)
- Basic assumptions
- Key concepts
- Techniques utilized
- How to use this in PNS
Solution Focused Brief Therapy

By Steve de Shazer and Insoo Kim Berg
Basic Assumptions

- It is based on solution-building rather than problem-solving.

- The therapeutic focus is on client’s desired future rather than on past problems or current conflicts.

- No problem happens all the time.

- Provider help clients find alternatives to current undesired patterns of behavior, cognition, and interaction that are within the clients’ repertoire or can be co-constructed by therapists and clients as such.
Key Concepts in SFBT

- Solution-Focused Brief Therapy is a competency-based model, which **minimizes emphasis on past failings and problems**, and instead **focuses on clients’ strengths and previous successes**.

- SFBT helps clients develop a **desired vision of the future** wherein the problem is solved, and explore and amplify related client exceptions, strengths, and **resources to co-construct a client-specific** pathway to making the vision a reality.
Thus each client finds his or her own way to a solution based on his or her emerging definitions of goals, strategies, strengths, and resources.

The solution focused approach provides providers with a framework for exploring and utilizing clients’ existing resources; their strengths, support networks, ideas and theories of how change occurs.
Basic Assumptions cont..

- Clients are encouraged to increase the frequency of current useful behaviors.
- It is asserted that small increments of change lead to large increments of change.
- Clients’ solutions are not necessarily directly related to any identified problem by either the client or the provider.
SFBT Techniques

Miracle Question:

• The miracle question requests clients to make a leap of faith and imagine how their life will be changed when the problem is solved.

  ▪ This is not easy for clients. Most clients need time and assistance to make that shift.

  ▪ The question is best asked deliberately and dramatically. In PNS one can ask “if a miracle was to happen right now, how would it be easy to disclose your status to your partner(s) in order to facilitate them take an HIV test too…?"
Exception Questions

• Having created a detailed miracle picture, the counsellor begins to gain some understanding of what the client hopes to achieve and the provider and client can begin to work towards these solutions.

• This is achieved through highlighting exceptions in a client’s life that are counter to the problem.

• This helps empower clients to seek solutions. Exception questions provide clients with the opportunity to identify times when things have been different for them.

• “Tell me about times when you were able to disclose a very hard issue to a significant other.”
SFBT Techniques cont...

Coping questions

• Coping questions can help demonstrate to client in therapy that they are resilient and that they are a number of ways in which they are capable of coping with challenges in their lives.

• An example of a coping question might be, “How do you manage, in the face of such difficulty, to fulfill your daily obligations?”

• This can help people recognize their skills in coping with adversity.
Scaling Questions

- Scaling questions invite clients to perceive their problem on a continuum.
- Scaling questions ask clients to consider their position on a scale (usually from 1 to 10, with one being the least desirable situation and 10 being the most desirable).
- Scaling questions can be a helpful way to track clients’ progress toward goals and monitor incremental change.
Affirmation/Compliments

- Affirmation or compliments are essential part of solution focused brief therapy.
- Validating what clients are already doing well, and acknowledging how difficult their problems are encourages the client to change while giving the message that the therapist has been listening (i.e., understands) and cares.
- Compliments in therapy sessions can help to punctuate what the client is doing that is working.
- Compliments are often conveyed in the form of appreciatively toned questions of “How did you do that?” that invite the client to self-compliment by virtue of answering the question.
Limitations and Concerns of SFBT

- Seems to simply discard or ignore information deemed important by other treatment modalities.
- For example, in this type of therapy a relationship between the adverse issues people face and the changes necessary to foster improvement is not assumed.
- Any underlying reasons for maladaptive thoughts and/or behaviors are not explored in atypical SFBT session.
- Individuals wishing to explore these reasons may find it more helpful to seek a type of therapy that addresses these concerns, though they may do so while also receiving SFBT.
Cognitive Behavioral/Rational Emotive Behavioral approaches

By Albert Ellis (1913-2007)
Basic Assumptions of REBT

- REBT is based on the assumption that cognitions, emotions, and behaviors interact significantly and have a reciprocal cause-and-effect relationship.
- REBT has consistently emphasized all three of these modalities and their interactions, thus qualifying it as an integrative approach.
- Our emotions stem mainly from our beliefs, evaluations, interpretations, and reactions to life situations.
Basic philosophies of REBT Cont…

- Human beings have three basic musts (or irrational beliefs) that we internalize that inevitably lead to self-defeat:
  - “I must do well and win the approval of others for my performances or else I am no good.”
  - “Other people must treat me considerately, fairly, kindly, and in exactly the way I want them to treat me. If they don’t, they are no good and they deserve to be condemned and punished.”
  - “I must get what I want, when I want it; and I must not get what I don’t want. If I don’t get what I want, it’s terrible, and I can’t stand it.”
Basic assumptions

- The focus is on working with thinking and acting rather than primarily with expressing feelings.
- Therapy is seen as an educational process.
- The therapist functions in many ways like a teacher, especially in collaborating with a client on homework assignments and in teaching strategies for straight thinking; and the client is a learner, who practices the newly learned skills in everyday life.
- Individuals tend to incorporate faulty thinking which leads to emotional and behaviour disturbance.
Basic assumptions Cont…

• Cognitions are the major determinant of how we feel and act.
• Therapy is primarily oriented towards cognitive and behaviour and its stresses the role of thinking, deciding, questioning, doing and redoing.
• It is based on a psycho educational model, which emphasizes therapy as learning new ways of thinking and acquiring effective ways of coping with problems.
Goals of therapy REBT

- Challenging client to confront faulty beliefs with contradictory evidence that they gather and evaluate
- Helping the client seek out dogmatic beliefs and vigorously minimize them.
- Helping clients become aware of automatic thoughts and changes them for better living
- Reducing tendency to blame oneself or others and learning ways of dealing with difficulties
Techniques of therapy

• Therapist uses a variety of cognitive, emotive and behavioral techniques; diverse methods are tailored to suit individual clients.

Debating irrational beliefs - Consists of the provider actively disputing clients’ irrational beliefs and teaching them how to do this challenging on their own. Clients go over a particular “must,” “should,” or “ought” until they no longer hold that irrational belief, or at least until it is diminished in strength.
Techniques cont…

• **Psychoeducational methods** – It is based on a psychoeducational model, which emphasizes therapy as learning new ways of thinking and acquiring effective ways of coping with problems. Therapists educate clients about the nature of their problems and how treatment is likely to proceed. They ask clients how particular concepts apply to them.

• **Changing one’s language** - REBT contends that imprecise language is one of the causes of distorted thinking processes.
Techniques cont...

- **Rational Emotive Imagery** - Clients imagine themselves thinking, feeling, and behaving exactly the way they would like to think, feel, and behave in real life

- **Using humor** - REBT contends that emotional disturbances often result from taking oneself too seriously. It fosters the development of a better sense of humor and helps put life into perspective
• **Role playing** - Role playing has emotive, cognitive, and behavioral components. Clients can rehearse certain behaviors to bring out what they feel in a situation. The focus is on working through the underlying irrational beliefs that are related to unpleasant feelings.

• **Shame-attacking exercises** - This exercise helps people reduce shame over behaving in certain ways. We can stubbornly refuse to feel ashamed by telling ourselves that it is not catastrophic if someone thinks we are foolish.
Techniques cont…

• **Carrying homework assignment** - Homework assignments are a way of tracking down the absolutist “shoulds” and “musts” that are part of their internalized self-messages. Part of this homework consists of applying the A-B-C model to many of the problems clients encounter in daily life.

• **Use of force and vigor** - Use of force and energy as a way to help clients go from intellectual to emotional insight. Clients are also shown how to conduct forceful dialogues with themselves in which they express their unsubstantiated beliefs and then powerfully dispute them. Force and energy are a basic part of shame-attacking exercises.
Humanistic/Person Centered Approach

by Carl Rogers (1902–1987)
Basic philosophy and assumptions

- Human beings are basically good. Humans have a natural self-actualizing tendency.
- Client experiences feelings that were denied or distorted and becomes self-aware, then self-actualizing.
- The client’s potential is maximized and the client moves towards growth—awareness, spontaneity, trust in self and inner directedness.
Key concepts

- Clients have the potential to gain insight in their issues and can resolve them.
- The therapist is not an expert and does not direct or interpret issues for the client.
- Mental health is viewed as a congruence of the ideal and the real self, and maladjustment is a discrepancy between the two.
- Focus is on the here-and-now and on experiencing and expressing feelings.
Key concepts Cont...

Therapeutic relationship

- The relationship is the therapy. Important qualities for the therapist are genuineness, accurate empathy, non-possessive warmth and caring, and the ability to communicate these attitudes to the client.

- The client is able to transfer their learning to other relationships.
Techniques

Few techniques are used, as stress is on the therapist’s attitude. The therapist uses self as an instrument.

- Basic techniques are empathy, genuineness and unconditional positive regard shown through active listening, reflection of feelings and being available for the client.
- No diagnostic testing, interpretation, history taking, probing or questioning are done or are minimal.
Benefits and limitations

- Using humanistic counselling theories enables the client to be the expert and to make decisions. Humanistic counselling empowers the client.
- Sometimes, it may be hard to believe clients are good and are striving towards self-fulfilment, if their lifestyle appears destructive.
- As with psychoanalytic theory, humanistic therapy may take a long time to achieve change.
Wheel of Change (Self-Awareness Exercise)

Session 6

Video on Wheel of change (Utilize the Marshall Goldsmith Model)

https://www.youtube.com/watch?v=RBv92BfVTG4
The Wheel of Change
Becoming the Person that We Want to Become

- Creating
  - Adding
  - Improving
  - Maintaining
  - Making Peace
- Eliminating
  - Inventing
  - Eradicating
  - Reducing
  - Delaying

- Preserving
- Accepting

KEEP
1. **Preserving** -(Positive elements )
   - What have I learned about my practice that is having a positive impact on those around me?
   - How can I keep doing those things in the current context?
   - What do I need to make sure I don’t lose focus on? How can I leverage the things that are working?

2. **Creating** -(Positive elements )
   - What is one behaviour I could add to my tool kit that I believe / have been told will have a positive impact on those around me?
3. Eliminating - (Negative elements)

- What is an act or behaviour I need to stop doing – even something I like doing or am good at? (eg Where do I need to let go – let others get their ‘hands dirty’ so they can learn and grow?)

4. Accepting - (Negative elements)

- This is often the hardest option to reflect on. What about myself do I need to accept?
- As the saying goes…“Grant me the serenity to accept the things I cannot change, the courage to change the things I can, and the wisdom to know the difference.”
The 4 perspectives in this simple model are very powerful as they help offer a realistic – and importantly – balanced view of behaviour change: helping to not let us forget the less sexy things (those to preserve) in pursuit of the new and shiny ‘me’ (those to create.)

They help us to make choices about what we need to remove or what might be holding us back (eliminate) and importantly facilitate a realistic perspective by also accepting that we will never be the perfect specimen.

Just a better one on the journey towards becoming ‘the best we can be’.
Sexual Partners, Networks and Social Contacts within the context of PNS

Session 7
Definition of a Sex Partners and Sex Network

- Two or more partners involved in a sexual relationship
- These may be between individuals of the same sex or opposite sex
- The sexual partners may be involved romantically or are just casual sexual partners without any plans to get involved in a long term romantic or intimate relationship)
Types of sexual networks

1. Casual relationships – these are individuals who are involved in an ongoing or intermittent sexual relationships for whatever reason which includes transactional sex.
Dynamics of Casual Relationship

• When there is HIV infection, the partners are not responsible for each other in terms of providing long term support
• Partners may also subject each other to stigma and discrimination
• Violence may also be pervasive
• Contact tracing for the partner(s) may be hard and also may take longer hence requiring patience by the HTS provider
• In PNS- the safety of the provider should be paramount especially how the partners are approached. The provider must be ready for any eventualities and also must enquire about any concerns that may arise.
Steady relationships

- Individuals who are involved in a relationship that is well defined and may or may not be exclusive.
- The partners in this relationships are however more committed to each other and may have romantic or intimate feelings towards each other.
- They may be married, planning to be married, living together/cohabiting, dating one another, may have children etc. Jealousy may be a huge factor.
Dynamics In Steady Relationships

• If HIV infection is present, there is a higher likelihood that the partners may provide support to each other.
  ▪ Contact tracing for the partner(s) may be easy and also may take shorter to trace and test
  ▪ Counsellor supported disclosure maybe easier than in the casual relationships
Family members and Social Contacts within the context of PNS
Family members

- Individuals that are immediately related to the client in the following way;
  - Children (blood) of a female index client
  - Children of a deceased mother whose death was AIDS related or may have been ascertained
  - Children of a male index client who’s partner is either a known positive or of unknown HIV status
Social contacts

- These constitutes individuals that are not related either sexual or by family (children) to the index client but needs to be targeted for aPNS
- Siblings of the index client where due cause has been demonstrated beyond reasonable doubt that HIV testing is paramount i.e. Sharing sexual partners
- Known to have high risk behaviors to HIV or are vulnerable to HIV
- Individuals sharing injecting drug paraphernalia
- Key population clients (MSM, FSW and PWIDs) sharing either a hot spot or clients