

MODULE 3 PARTICIPANT MANUAL: Contents

Incorporating HIV Prevention into the Medical Care of Persons Living with HIV. MMWR 2003;52(RR-12). Recommendations of CDC/HRSA/NIH/IDSA-HIVMA

- 1. Website Directory– source for Laws, Regulations and Statutes related to PS, and State and Territorial HIV and STD Directors.**
- 2. Sample Transitional Phrases**
- 3. Defining the 5 Partner Referral Options**
- 4. How Health Department Personnel Protect Confidentiality**
- 5. Article By Golden MR et al**
- 6. References**
- 7. Additional Resources**

Handout 1

National Alliance of State and Territorial AIDS Directors

Founded in 1992, NASTAD is a non-profit national association of state health department HIV/AIDS program directors who have programmatic responsibility for administering HIV/AIDS health care, prevention, education, and supportive services programs funded by state and federal governments

www.nastad.org

Click "About Us"
Click "Resources"
Click "NASTAD Membership Directory"

National Coalition of STD Directors

Founded in 1997, NCSD primary membership represents the nation's state health agency personnel that have programmatic responsibility for administering the 65 sexually transmitted disease (STD) prevention and treatment programs funded by the federal government (fifty states, eight cities and seven US territories).

www.ncsddc.org

Click "Who We Are"
Click "Our Members"
Click "2012-2013 Full Member List"

Council of State and Territorial Epidemiologists

Founded in 1992, CSTE is an organization of member states and territories representing public health epidemiologists. CSTE works to establish more effective relationships among state and other health agencies. It also provides technical advice and assistance to partner organizations and to federal public health agencies such as the Centers for Disease Control and Prevention (CDC).

www.cste.org

Click "About CSTE"
Click "Points of Contact"

Handout 2

Sample Transitional Phrases

You have been given a lot of information today and we've talked about various services available to you, but one service we haven't discussed involves helping you with telling your partners that they may have been exposed to HIV and should receive counseling and testing. **What are your feelings about telling your partners they may have been exposed to HIV?**

or

You've said that you suspected your test would show that you're infected with HIV. You may have given thought to what you'd do when you got this news. **What are your thoughts on letting your partners know they may have been exposed to HIV?**

or

Since you came in for testing because one of your partners expressed concern for you and gave us your name, I'm going to talk with you about your sex and needle-sharing partners. **How do you feel about doing this now?**

or

Now that we have talked about the various ways to keep you healthy, let's talk about ways we can keep your partners healthy. **How do you feel about talking to your partners?**

or

As we discussed, the earlier people know if they do or do not have HIV the greater their opportunity to make important decisions – decisions that may be vital to their health. **How would you feel about talking with other people who may have been exposed to HIV?**

or

You told me earlier that you share needles. About how many people do you think you have shared with in the past year? **How do you feel about letting them know they may have been exposed to HIV?**

Handout 3

Defining the Five Partner Referral Options

Health Department Referral

A trained Partner Services (PS) specialist (usually a disease investigation specialist (DIS) employed by the health department) takes complete responsibility for contacting the partner confidentially and notifying him or her of possible exposure to HIV. Then, the DIS either:

- Counsel located partners about their exposure to infection and provide or refer them to testing, medical care, and other prevention or social services, or
- Counsel partner about their exposure to infection and offers testing on the spot.

Patient Referral

The patient takes responsibility for contacting and notifying the partner of possible exposure to HIV and refers the partner to a facility that offers counseling and testing. The clinical care provider or DIS coaches the patient and provides printed materials as appropriate. The DIS checks back with the patient to see whether they were able to successfully notify the partner, and refer the partner for counseling and testing.

Contract Referral

The DIS negotiates with the patient to establish a timeframe during which the patient agrees to contact and refer the partner. The DIS coaches the patient and gathers full exposure, locating, and identifying information on the partner. If by the contract date, the partner has not come for counseling and testing, the partner is contacted by the DIS (health department).

Third-Party Referral

The clinical care provider (who is not with the health department) notifies the patient's partners. Patient coaching may be needed, but full exposure, identifying, and locating information must be gathered for each partner by the third-party PS provider.

Dual Referral

The HIV infected patient and either the PS provider or clinical care provider inform the partner together. The provider plans with the patient for how the session may go and, if needed, coaches the patient on what to say. Because the patient accompanies the partner in, there is no need to gather full information on the partner.

Handout 4

How Health Department Personnel Protect Confidentiality

In talking with the HIV–infected patient:

- Never reveal whether a partner decided to be tested.
- Never tell client the partners' test results.

In talking with partners:

- Always confirm identity of partner (visually size up based on age and other descriptors provided).
- Always find a private site and, only then, notify of possible exposure.
- Never identify the HIV –positive client by:
 - name or gender
 - physical description, race or age
 - type of exposure (sex or needle-sharing)
 - dates of exposure or location

In using the telephone:

- Always ensure that you are speaking with the correct person.
- Always verify that the person is in a private setting.
- Always ensure that no one can overhear your end of the conversation.
- The partner is never told of the exposure over the phone.

In handling written records:

- Keep partner names and identifying information locked up.
- Never leave notes or papers with names in your car, home, or other unsafe place.
- Destroy all partner and client information when partner service activities are completed for that partner.

In talking with your own work colleagues:

- Always protect the identity of HIV–positive clients and partners during case reviews.
- Never discuss client or partners unless there is pressing need to do so.

In talking with your family, friends, or others outside the workplace:

- Be mindful of work discussions. Never reveal any identifying features of a client or partner.
- All DIS take on oath of confidentiality.

JAIDS Journal of Acquired Immune Deficiency Syndromes
32:196–202 © 2003 Lippincott Williams & Wilkins, Inc., Philadelphia

Support Among Persons Infected with HIV for Routine Health Department Contact for HIV Partner Notification

*†Matthew R. Golden, †Sharon G. Hopkins, ‡Martina Morris, *King K. Holmes, and
*†H. Hunter Handsfield

**The Center for AIDS and STD and the Division of Infectious Diseases, University of Washington, Seattle, Washington; †Public Health—Seattle and King County, Washington; and ‡Department of Sociology, University of Washington, Seattle, Washington, U.S.A.*

Summary: Public health partner notification (PN) services are provided inconsistently to persons diagnosed with HIV/AIDS in the United States, and some community groups representing persons with HIV/AIDS have opposed widespread application of PN. We surveyed persons with HIV recently reported to our health department and a random sample of HIV-infected persons attending an HIV/AIDS clinic. A total of 95 persons, of whom 76 (80%) were men who have sex with men, completed an anonymous self-administered questionnaire. Eighty-four percent of participants believed the health department should routinely offer everyone diagnosed with HIV help in notifying their partners; 79% indicated they would be somewhat or very likely to provide information to a doctor, case worker, or health department employee for purposes of PN; and 20% indicated they wanted help in notifying a recent sex partner. Seventy-eight percent of participants believed the health department should contact all HIV-infected persons after diagnosis to help them access medical care and social services, and 68% wanted the health department to contact them about the availability of medical or social services. In contrast to common public perceptions, these results suggest that most persons with HIV support health departments routinely contacting people after HIV diagnosis and that many want assistance with PN. **Key Words:** HIV—Partner notification—AIDS.

One of the central goals of the Center for Disease Control and Prevention's recently announced Serostatus Approach to Fighting HIV (SAFE) is to increase the proportion of Americans with HIV who are aware that they are infected (1). One means to realize that goal may be through improved partner notification (PN). However, PN for HIV is controversial (2). Federal law mandates that all states receiving federal support for HIV clinical services ("Ryan White" funds) must have HIV PN programs and requires that "good faith efforts" be made to notify the spouses of persons diagnosed with HIV. In addition, at least 34 states have specific HIV PN laws,

whereas many others have communicable disease laws that apply to HIV PN (3). Nevertheless, many, and perhaps most, persons diagnosed with HIV do not receive PN services from public health agencies (4), and existing data suggest that most private providers do little more than advise their patients to notify their sex and needle-sharing partners themselves (5).

HIV infection in persons without AIDS became reportable in Washington State in 1999. At the time, some community groups, particularly those representing men who have sex with men (MSM), opposed HIV reporting, in part out of concern that reporting would be used to identify persons for PN. Efforts to link named HIV reporting to PN have met similar resistance elsewhere in the United States (6,7). Despite this opposition, there are few data on what people with HIV, particularly MSM,

Matthew Golden is supported by NIH K23 AI01846-02. Address correspondence and reprint requests to Matthew Golden, Harborview Medical Center, Box 359777, 325 9th Avenue, Seattle, WA 98104-2499, U.S.A.; e-mail: golden@u.washington.edu.

196

Copyright © Lippincott Williams & Wilkins. Unauthorized reproduction of this article is prohibited.

Effective Prevention in HIV Care Handout 5

actually think about PN and how the process might be tailored to be most acceptable and effective. To address these issues, we surveyed persons with prevalent HIV diagnoses seen in the HIV clinic of a large public hospital as well as persons with newly diagnosed HIV reported to Public Health–Seattle and King County (PHSKC), the health department serving Seattle and King County, Washington.

METHODS

Study Population

English-speaking persons ≥ 18 years of age whose HIV infections were reported to PHSKC in the 6 months prior to study initiation were eligible if, according to reporting data, their HIV infection was diagnosed in the year preceding their case report. People who were incarcerated, who could not read, or who had been identified by clinical providers as violent or psychologically disabled were excluded. In addition, we excluded patients seen at a single health maintenance organization (HMO) because of that HMO's historical reluctance to participate in public health surveys.

To increase the study's sample and to ascertain opinions about PN among persons previously diagnosed with HIV and receiving medical care, on each working day during June and July 2001, we randomly selected 3 persons with scheduled appointments at the Harborview Medical Center (HMC) HIV/AIDS Clinic and offered them participation in the study. The HMC HIV/AIDS Clinic is affiliated with the University of Washington and is located within King County's public hospital. It provides care to over 1300 persons with HIV and is the largest HIV clinic in the Pacific Northwest. HMC HIV/AIDS patients were excluded from being offered participation in the study if they were < 18 years old, unable to speak English, unable to read the survey, or had previously had an appointment in the clinic during the course of the study. Enrollment at the HIV/AIDS clinic ended when the goal of enrolling of 50 participants was reached.

Identification of Potential Participants from HIV Reporting

Washington law mandates that providers and laboratories report cases of HIV and AIDS by patient name. After 90 days, the names of persons with asymptomatic non-AIDS HIV infection are redacted to a non-name-coded identifier. These codes can be recreated from the reported person's name, birth date, and sex, but the name cannot be reconstructed from the code.

Recruitment and Survey Distribution

In accordance with long-standing public health PN practice in King County, study staff initiated efforts to contact potential participants only after obtaining permission to do so from their reporting clinical provider. To improve participation, providers were given the option of permitting study personnel to contact their patients directly or to distribute the survey to patients themselves, either by mail or when the patient next came to the provider's office for medical care.

Study Instrument

The study instrument was an anonymous, six-page, self-administered questionnaire that included questions about participant demographics, HIV testing history and medical care, sexual behavior, and opinions about PN and public health HIV services.

Questions that asked participants to indicate a preference in how public health services might be provided (e.g., how PN interviews should be conducted) permitted participants to select more than one option if they regarded options as equivalent. All other questions required a single response. Participants were paid a \$10 incentive for completing the survey. The University of Washington Human Subjects Committee approved the survey and all study procedures.

Statistical Analyses

For bivariate analyses, χ^2 tests of association and the Student *t* test with equal variances were used. The Fisher exact test was used if any cell on a bivariate analysis included fewer than five observations. Multivariate tests of association were performed using logistic regression. Only statistically significant variables were included in final multivariate models. Exact logistic regression was employed, using the LogXact program to calculate confidence intervals when no subjects had a characteristic used as an independent variable in a logistic regression model. All other analyses were performed using the SAS system.

RESULTS

Study Population

Between January 2001 and November 2001, 318 persons were reported to PHSKC with HIV, of whom 76 (24%) were ineligible. Reasons for ineligibility included inability to speak English (33), diagnosis at the nonparticipating HMO (21), incarceration (9), death (4), age < 18 years (3), violence or psychosis (4), incorrect HIV diagnosis (1), and blindness precluding the ability to read the survey (1). Of the remaining 242 potentially eligible participants, 62 (26%) were reported by providers to have relocated or had been lost to follow-up and 34 (14%) could not be identified because their names had been removed from PHSKC records and providers could not identify them from their non-name-coded identifier. Of the remaining 146 potential participants, providers did not respond to repeated inquiries about 17 (7%) and refused to allow PHSKC to contact 11 (4%). Thus, permission was obtained to contact 118 persons with newly reported HIV infection: 81% of those persons identified as available for potential participation and 49% of all those reported during the study period. Of these 118 potential participants, 25 (21%) declined to participate, 17 (14%) received surveys but did not return them, and 46 (39%) completed and returned the survey. At the end of the study, 30 (25%) surveys that had been given to providers for their patients had not been distributed to potential participants. Among the 88 patients believed to

Effective Prevention in HIV Care Handout 5

have received the survey, 46 (52%) responded by returning a completed survey.

The 46 persons who returned completed surveys did not differ significantly from the 273 nonparticipants in terms of mean age (37 years vs. 36 years, respectively), race/ethnicity (71% vs. 62% white), HIV risk factor (79% vs. 64% MSM), source of HIV report (67% of both groups reported by private sector providers), or mean CD4 count (491 vs. 424 cells/mm³, respectively).

In the HMC HIV/AIDS clinic, a total of 52 patients were offered study participation, of whom 50 (96%) agreed to participate in the study and returned a survey. One survey was returned without being completed.

Thus, 95 persons returned completed surveys and were included in the analysis. For purposes of final analysis, subjects were classified as having a new HIV diagnosis if their survey results indicated that they first tested HIV-positive within 18 months of study participation and as having an old HIV diagnosis if they first tested positive more than 18 months prior to participation. The 18-month cutoff was used because subjects recruited through HIV reporting included those reported within 6 months of the beginning of the study who were diagnosed in the year preceding that report. Table 1 presents data on the sociodemographic characteristics, sexual orientation, and HIV testing and medical care history of study participants.

Sexual Behavior and Drug Use

Participants reported a mean of 3.2 anal or vaginal sex partners (median = 1.0, range: 0–60) in the 6 months prior to completing the survey. Thirty-one participants (33%) reported meeting at least 1 sex partner in a public sex venue or via the Internet or a telephone chat line. Among these persons, 20 met a partner in a bathhouse, 7 in a park, 14 over a telephone chat line, and 10 on the Internet. Twenty-seven (29%) participants reported using poppers (amyl nitrate), and 24 (25%) reported using amphetamines. Forty participants (42%) reported having unprotected anal or vaginal sex in the preceding 6 months.

Opinions About Partner Notification

Table 2 presents participants' responses to statements about HIV PN and other public health services. Eighty-four percent of respondents strongly or somewhat agreed with the statement, "The health department should offer everyone with HIV help notifying their partners as long as it is completely voluntary and confidential" (Table 2). Age, race, being a man who has sex with other men,

TABLE 1. Demographic characteristics, education, income, sexual orientation, and HIV testing and medical care history among 95 study participants

	Total (N = 95)
Age (years)	
<30	11 (11)
30–34	25 (26)
35–39	26 (27)
≥40	33 (35)
Race	
White	62 (65)
African American	15 (16)
Hispanic (not African American)	11 (12)
Other	5 (5)
Gender & sexual orientation	
Male	89 (94)
MSM	76 (86)
Heterosexual	12 (14)
Female	6 (6)
History of injection drug use	22 (23)
Education	
High school graduate or less	37 (40)
Some college	33 (35)
College graduate or more	24 (25)
Annual income	
<\$15,000	50 (53)
\$15,000–\$30,000	18 (19)
\$30,001–\$50,000	18 (19)
>\$50,000	8 (8)
Site of HIV diagnosis	
Sexually transmitted disease clinic	24 (25)
Other public health clinic	17 (18)
Private provider or hospital	54 (58)
Anonymous HIV testing	37 (39)
Time since HIV diagnosis	
<1 year	37 (39)
1–5 years	17 (18)
>5 years	41 (43)
Receiving case management	74 (78)
Taking antiretrovirals	62 (67)
Recruited through HIV reporting	46 (48)

Data missing: race (2), education (1), sexual orientation (1), taking HIV meds (1), income (1).
MSM, men who have sex with men.

income level, diagnosis outside of a public health testing site, anonymous HIV testing, and receiving HIV care at the HMC HIV clinic were not significantly associated with support or opposition to offering PN assistance (data not shown).

Participants were also asked about how PN might best be organized. Thirty-six (38%) subjects believed MSM should conduct PN, whereas 45 (48%) had no preference regarding a PN worker's sex or sexual orientation. Among MSM, 34 (45%) preferred that MSM provide PN services, whereas 33 (44%) had no preference. Fifty-eight respondents (64%) believed people should be contacted about PN as soon as possible after their diagnosis of HIV, whereas 12 (13%) believed contact should be delayed 1 to 2 weeks and 8 (9%) supported delaying

JAIDS Journal of Acquired Immune Deficiency Syndromes, Vol. 32, No. 2, February 1, 2003
Copyright © Lippincott Williams & Wilkins. Unauthorized reproduction of this article is prohibited.

Effective Prevention in HIV Care Handout 5

TABLE 2. Opinions about partner notification

	Total (N = 95)
The health department should offer everyone with HIV help notifying their partners as long as it is completely voluntary and confidential.	
Agree strongly	42 (48)
Agree somewhat	31 (36)
Disagree somewhat	6 (7)
Disagree strongly	8 (9)
Would want help notifying at least one partner from the last 6 months	18 (20)
The health department should contact everyone after they are diagnosed with HIV to make sure that they know how to get medical care and social services if they want them.	
Agree strongly	50 (53)
Agree somewhat	24 (25)
Disagree somewhat	5 (5)
Disagree strongly	15 (16)
I want the health department to contact me to help me find out how to get medical care or other social services like housing, insurance or counseling.	
Agree strongly	39 (42)
Agree somewhat	24 (26)
Disagree somewhat	6 (6)
Disagree strongly	23 (25)

Data missing: health department should contact for PN (2), wants help with PN (2), health department should contact for medical and social services (1), health department contact me (3).

contact for 4 weeks or more. Given options about how interviews might best be conducted, 50 respondents (54%) preferred face-to-face interviews, 30 (32%) preferred to be interviewed by telephone, 13 (14%) stated a computer-assisted interview would be preferable, and 12 (13%) indicated they would not give anyone information about their partners regardless of how an interview was conducted (totals exceed 100% because some participants indicated several choices were equivalent).

The survey also asked participants how likely they would be to provide information to facilitate contacting their sex partners to various different types of health care and social service providers. Fifty-nine (64%) stated they would be somewhat or very likely to give such information to their doctor, 57 (62%) to a social worker or case worker, 42 (48%) to someone from the health department, and 40 (45%) to someone from a gay men's community group. Among the 93 participants who responded to questions soliciting their preference about who should provide PN services, 78 (84%) indicated they would be somewhat or very likely to give information to at least one type of clinical or social service provider. When asked about specific factors that might influence their decision to provide names of sex partners for PN, 47 (50%) respondents stated they would be "much more

likely" to provide names if their partners could be tested anonymously, 38 (42%) stated they would be "much more likely" to do so if they could provide the information anonymously, and 22 (24%) indicated they would be "much more likely" to do so if they were paid \$20.

Opinions About Ongoing Partner Notification

Sixty-three respondents (67%) agreed it is a "good idea to periodically contact people with HIV and offer them help making sure that their partners are tested." Despite support in principle for this approach, only 26 persons (28%) indicated they would like to be so contacted, although 41 (44%) responded that they would be "willing to be contacted." Of the 86 participants (77%) who indicated a preference about who should offer them ongoing PN assistance, 50 (58%) preferred that their doctor do so, 37 (43%) preferred that a social worker or case worker provide the service, 17 (20%) wanted the health department to do it, and 13 (15%) preferred that PN services be provided by a community group representing MSM (responses were not mutually exclusive).

Among 91 participants who responded to a question asking how many partners they would like assistance in notifying, 18 (22%) wanted assistance in notifying at least 1 partner (range: 0–10); combined, these participants reported wanting assistance in notifying 41 partners. Participants were more likely to want assistance with PN if they had unprotected anal or vaginal sex in the preceding 6 months, had a new HIV diagnosis, or somewhat or strongly agreed that the health department should offer everyone with HIV help with PN (Table 3). MSM were less likely than others (17% vs. 25%, $P = 0.36$) and injection drug users (IDUs) were more likely than others (27% vs. 17%, $P = 0.31$) to report wanting assistance in notifying a partner(s), although these differences were not statistically significant. On multivariate analysis, persons who reported having unprotected sex in the preceding 6 months were significantly more likely to request assistance with PN (OR = 5.1, 95% CI: 1.5–20.8), and persons who strongly or somewhat agreed that the health department should offer everyone help with PN were borderline statistically significantly more likely to want help with PN (OR = 6.1, 95% CI: 0.84 to infinity).

HIV Social Services

Because persons receiving PN services in King County are typically offered help in accessing social and medical services (e.g., assistance with housing, food,

JAIDS Journal of Acquired Immune Deficiency Syndromes, Vol. 32, No. 2, February 1, 2003

Copyright © Lippincott Williams & Wilkins. Unauthorized reproduction of this article is prohibited.

TABLE 3. Factors associated with participants wanting HIV partner notification (PN) assistance^a

	Number (%) that want PN assistance for at least one partner	OR 95% CI
HIV diagnosis in last 18 months	12/42 (28)	2.9 (1.0–8.5)
HIV diagnosis >18 months	6/49 (12)	
MSM	12/72 (17)	.43 (.14–1.4) ^b
IDU not MSM	2/10 (20)	
Female not IDU	1/4 (25)	
Other	3/5 (60)	
Annual income		.39 (.13–1.2) ^c
<\$15,000	6/47 (13)	
\$15,000–\$30,000	7 (18)	
\$30,001–\$50,000	5/18 (28)	
>\$50,000	0/8	
Age (years)		.41 (.12–1.4) ^d
<30	2/10 (20)	
30–34	2/24 (8)	
35–39	7/25 (28)	
≥40	7/32 (22)	
Diagnosed in public health HIV site	8/41 (20)	.92 (.33–2.6)
Diagnosed outside public health system	10/48 (21)	
HMC HIV/AIDS clinic	9/59 (15)	.46 (.16–1.3)
Private sector HIV clinic	9/32 (28)	
Education		1.3 (.41–3.6) ^e
High school graduate or less	8/36 (22)	
Some college	6/31 (19)	
College graduate or more	4/23 (17)	
Unprotected anal/vaginal sex in last 6 months	13/37 (35)	5.3 (1.7–16.6)
No unprotected anal/vaginal sex in last 6 months	5/54 (9)	
Somewhat or strongly agrees health department should offer everyone assistance with PN	17/70 (24)	5.42 (.84–infinity)
Somewhat or strongly disagrees that health department should offer everyone assistance with PN	0/13 (0)	

^a Based on responses from 91 participants.

^b MSM vs. other.

^c <\$15,000 vs. all other.

^d Age <35 vs. >34.

^e High school education or less vs. more than high school.

MSM, men who have sex with men; IDU, injection drug user; HMC, Harborview Medical Center.

substance abuse treatment, and health care) at the time of PN contact, we asked respondents about their need for these services and their interest in receiving assistance in procuring them. Among all respondents, 78% strongly or somewhat agreed that “the health department should contact everyone after they are diagnosed with HIV to make sure that they know how to get medical care and social services if they want them,” and 68% strongly or somewhat agreed that the health department should contact them personally about the availability of social services (Table 2). Persons diagnosed in settings other than public health clinics were less likely to have spoken with a social worker or case worker since their HIV diagnosis than those diagnosed in public health clinics (65% vs. 93%, $P = 0.002$). Participants who reported never having spoken to a social worker or case worker were asked if they would want to speak to such an individual as a question with yes or no responses. Persons diagnosed outside of the public health system were more likely to

report wanting to speak to a social worker about the availability of medical and social services (49% vs. 29%, $P = 0.20$), a difference that was most pronounced among those with incomes below \$30,000 per year (67% vs. 27%, $P = 0.04$). Among all persons with incomes below \$30,000, 3 (23%) of 13 diagnosed in public health clinics and 12 (67%) of 18 diagnosed in the private sector indicated that they would like to speak to a social worker or case worker ($P = 0.03$, Fisher exact test).

DISCUSSION

Partner notification services are not universally provided to persons diagnosed with HIV in the United States (4). One factor that has probably contributed to restricting the scope of PN has been a widespread belief that many people with HIV, particularly MSM, oppose public health PN efforts. To our knowledge, however, no published data exist to support this belief.

JAIDS Journal of Acquired Immune Deficiency Syndromes, Vol. 32, No. 2, February 1, 2003

Copyright © Lippincott Williams & Wilkins. Unauthorized reproduction of this article is prohibited.

Effective Prevention in HIV Care Handout 5

We surveyed persons with both new and established HIV diagnoses to assess the acceptability of HIV PN and to explore ways that the PN process might be modified to maximize its acceptability and usefulness to people with HIV. In a population composed primarily of MSM (80%), we found that 84% of HIV-infected persons believe PN should be provided routinely, that 79% would be willing to speak to health care or public health provider about PN, and that a significant minority (20%) would personally want assistance in notifying 1 or more partners were that assistance offered.

Our finding that most HIV-infected persons support PN is consistent with formative research conducted among IDUs (8,9). The fact that many of our participants, including 17% of all MSM and 28% of MSM who had engaged in unprotected anal sex in the preceding 6 months, wanted assistance with PN for specific partners is likewise consistent with the reported experience in some states where HIV PN is associated with HIV reporting (10,11) but is at odds with a recent study conducted in San Francisco reporting that 97% of people with newly diagnosed HIV infection seen at public health testing sites refused to meet with a PN counselor (12). We cannot say whether the marked disparity in the reported experience with HIV PN reflects differences in the populations served or differences in how PN services are offered. Nevertheless, our findings suggest that the universal rejection of HIV PN reported from San Francisco would not necessarily apply to Seattle, depending on how PN was organized.

Our findings also suggest that the failure of public health departments to contact persons with newly diagnosed HIV on a routine basis may deprive some people with HIV of referral for social services they desire. In King County, persons diagnosed at public health testing sites are routinely offered referral for medical and social services after HIV diagnosis. These referrals are part of a package of medical, social, and preventive services, of which PN is one component. In contrast, persons diagnosed with HIV outside of public health testing sites are not routinely contacted. We found that over one third of persons diagnosed outside of the public health system had never spoken to a social worker or case worker about available HIV social services, although almost half (49%) wanted to do so. The unmet need for social services appeared to be most acute among low-income persons diagnosed outside of the public health system. Although expanding outreach for social services need not include PN, providing PN in the context of other services will likely improve its acceptability and is consistent with the approach envisioned in SAFE (1).

Although our results support the notion that PN is more acceptable than widely believed, we also identified important barriers to widespread PN. Most respondents preferred to give information about partners to their clinical provider or a social worker rather than to a health department employee or even a representative of a community agency. This preference was particularly strong when people were asked about their willingness to receive ongoing PN services after HIV diagnosis. Traditionally, PN in the United States has been conducted by disease intervention specialists (DIS), professional public health workers who specialize in PN. Very little information exists on how physicians confront the need to notify the partners of their patients with HIV, but existing data suggest that most do little more than tell patients they should notify their partners themselves (5), and some may oppose public health PN efforts either out of concern for their patients' privacy or misperceptions about how the process is conducted. Our findings suggest that people with HIV want PN to be integrated into their care and not imposed from without. Addressing this preference may require a new approach to PN in which either a DIS becomes part of the team of people involved in patient care or existing medical and social service personnel take on new prevention roles, perhaps as part of prevention case management.

Our study has limitations. First, our sample size was small, and we were not able to survey most people with newly reported HIV in King County. This limitation attests to the difficulty that we as well as others are likely to confront in expanding HIV PN services beyond public health testing sites. However, our survey respondents did not significantly differ from nonrespondents in demographics, HIV risk profile, or stage of disease as indicated by CD4 lymphocyte count. Moreover, our central finding, that HIV PN is widely supported by people with HIV, including MSM, was seen among persons identified through HIV reporting as well as among those recruited at the HMC HIV/AIDS clinic, where 94% of a random sample provided data for the study. As a result, we believe our findings accurately reflect the opinions and attitudes of HIV-infected persons in King County. Although opinions and attitudes might differ in other parts of the United States or in other industrialized nations, this type of survey can be readily conducted in other settings to inform PN procedures.

Another limitation is that we measured opinions and intentions rather than actual PN outcomes. Although two studies conducted in the early 1990s that included people with HIV seen outside of public health venues endorsed the efficacy of PN (10,11), our recent experience in King County has been discouraging. Interviews conducted

JAIDS Journal of Acquired Immune Deficiency Syndromes, Vol. 32, No. 2, February 1, 2003

Copyright © Lippincott Williams & Wilkins. Unauthorized reproduction of this article is prohibited.

Handout 5

202

GOLDEN ET AL.

with 338 persons diagnosed with HIV almost entirely at public health testing sites from 1999 through 2001 resulted in only 9 verified new cases of HIV infection being identified through PN, 6 of which were actually referred by index patients themselves. An additional 48 contacts were known to have tested HIV-negative. Our survey findings do not address the efficacy of PN, and more research in this area is needed on the operational aspects and outcomes of PN for HIV.

In summary, we found that most people with HIV, including MSM, support the universal provision of confidential and voluntary public health PN services and that the restriction of PN programs to public health sites deprives some patients of services they desire. In light of this observation, clinical providers, community-based organizations, and health departments should reassess whether narrowly focusing PN services on persons testing at public health sites really reflects patient preferences. Efforts to improve PN should concentrate on greater integration of the process into the provision of the medical and social services patients already receive.

Acknowledgments: The authors thank the many clinical providers in King County who facilitated access to their patients as well as the study participants themselves. They also thank Nicole Woodruff, Rusty Myers, Carol Glenn, and Mark Fleming for assistance with data collection; Tim Tyree for help with data management; and John Peppert for providing data on HIV PN outcomes in King County.

REFERENCES

1. Janssen RS, Holtgrave DR, Valdiserri RO, et al. The serostatus approach to fighting the HIV epidemic: prevention strategies for infected individuals. *Am J Public Health* 2001;91:1019–24.
2. Fenton KA, Peterman TA. HIV partner notification: taking a new look. *AIDS* 1997;11:1535–46.
3. Wasserman S. Issue brief: health policy tracking service HIV/AIDS: Partner notification programs. March 15, 2000. Available at: <http://stateserv.hpts.org/public/pubhome.nsf>.
4. Golden MR, Hogban M, Handsfield HH, et al. Partner notification: a survey of health departments in high morbidity areas. Presented at the 2002 National STD Prevention Conference, San Diego, 2002.
5. Dye TD, Knox KL, Novick LF. Tracking sexual contacts of HIV patients: a study of physician practices. *J Public Health Manage Pract* 1999;5:19–22.
6. Johnson R. GMHC decries passage of HIV partner notification bill. 1998;2002. March 8, 2002. Available at: <http://www.thebody.com/gmhc/pr/jun1998.html>.
7. San Francisco AIDS Foundation. HIV surveillance: HIV reporting and partner notification in California. 2000; February 19, 2000. Available at: http://www.sfaf.org/policy/partner_notification.html.
8. Rogers SJ, Tross S, Doino-Ingorsol J, et al. Partner notification with HIV-infected drug users: results of formative research. *AIDS Care* 1998;10:415–29.
9. DePhilippis D, Metzger DS, Woody GE, et al. Attitudes toward mandatory human immunodeficiency virus testing and contact tracing. A survey of intravenous drug users in treatment. *J Subst Abuse Treat* 1992;9:39–42.
10. Pavia AT, Benyo M, Niler L, et al. Partner notification for control of HIV: results after 2 years of a statewide program in Utah. *Am J Public Health* 1993;83:1418–24.
11. Spencer NE, Hoffman RE, Raevsky CA, et al. Partner notification for human immunodeficiency virus infection in Colorado: results across index case groups and costs. *Int J STD AIDS* 1993;4: 26–32.
12. Schwarcz S, McFarland W, Delgado V, et al. Partner notification for persons recently infected with HIV: experience in San Francisco. *J Acquir Immune Defic Syndr* 2001;28:403–4.

Handout 6

References

Slide 7:

- a. Hogben et al. (2007). The effectiveness of HIV partner counseling and referral services in increasing identification of HIV-positive individuals. *American Journal of Preventive Medicine*, 33(2s), S89-S100.

Slide 8:

- a. Marks et al. (2006). Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA. *AIDS*, 20(10), 1447-1450.
- b. Campsmith et al. (2010). Undiagnosed HIV prevalence among adults and adolescents in the United States at the end of 2006. *Journal of Acquired Immune Deficiency Syndromes*, 53(5), 619-624.
- c. Centers for Disease Control and Prevention (CDC). *HIV in the United States* [Factsheet]. <http://www.cdc.gov/hiv/resources/factsheets/us.htm>

Slide 10: Golden et al. (2003). Support among persons infected with HIV for routine health department contact for HIV partner notification. *Journal of Acquired Immune Deficiency Syndromes*, 32, 196-202.

Slide 15: Centers for Disease Control and Prevention (CDC) (2008). Recommendations for Partner Service Programs for HIV infection, Syphilis, Gonorrhea, and Chlamydial Infection. *MMWR*, 57(#RR-9), 1-92. <http://www.cdc.gov/mmwr/PDF/rr/rr5709.pdf>

Slide 16: Centers for Disease Control and Prevention (CDC). (2003). Incorporating HIV prevention into the medical care of persons living with HIV: Recommendations of CDC, the Health Resources and Services Administration, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. *MMWR*, 52(#RR-12), 1-24. <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm>

Handout 7

Additional Resources

- MMWR 2008; 57 (No. RR-9): Recommendations for Partner Services Programs for HIV Infection, Syphilis, Gonorrhea, and Chlamydial Infection. <http://www.cdc.gov/nchhstp/partners/Recommendations.html>
- CDC Fact Sheet on Partner Services: <http://www.cdc.gov/nchhstp/partners/FAQ-public.html>
- MMWR 2003; 52 (No. RR-12): Incorporating HIV prevention into the medical care of persons living with HIV. <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5212a1.htm>
- National HIV/AIDS Strategy. <http://www.whitehouse.gov/administration/eop/onap/nhas>
- High-Impact HIV Prevention: CDC's Approach to Reducing HIV Infections in the United States. <http://www.cdc.gov/hiv/strategy/index.htm>
- CDC 2010 STD Treatment Guidelines. <http://www.cdc.gov/std/treatment/2010/default.htm>
- CDC Division of STD Prevention. <http://www.cdc.gov/std>
- CDC Division of HIV/AIDS Prevention. <http://www.cdc.gov/hiv/dhap.htm>
- AIDS Education and Training Centers (AETC). <http://www.aidsetc.org>
- National Network of STD/HIV Prevention Training Centers (NNPTC). <http://www.nnptc.org>
- Interactive online STD cases. <http://www.stdcases.org>
- Practitioner's handbook for the management of STDs. <http://www.stdhandbook.org>
- National Alliance of State and Territorial AIDS Directors (NASTAD) – <http://www.nastad.org>
- National Coalition of STD Directors – <http://www.ncsddc.org>

