At a time when HIV prevention efforts increasingly focus on helping HIV-positive people access services such as risk-reduction counseling, disclosure of serostatus and partner counseling and referral services have taken on new significance. Encompassing many activities formerly included within the context of “contact tracing,” “partner notification,” and “partner management,” partner counseling and referral services (PCRS) refer to the process through which a seropositive individual or his or her health care provider informs current and former sexual and needle-sharing partners that they may have been exposed to HIV.1,2 PCRS services include: counseling for both the seropositive client and sexual or needle-sharing partners; free HIV antibody testing for partners; and linking of partners to services such as treatment for HIV, other sexually transmitted diseases (STD), tuberculosis, or substance use. This article further defines PCRS and its approaches, discusses its advantages, and considers some of the more controversial issues surrounding its process. PCRS is particularly relevant now because of two developments. First, advances in treatment and disease monitoring have shown that early detection and treatment of infection may improve prognosis. Second, a refinement in antibody testing—the detuned assay, currently available only as part of a research protocol—offers for the first time information about when a person might have been infected: roughly either within the previous four months or at any time before four months. For people in the second group, the detuned assay does not provide a great deal of information. People in the first group, however, have a far more circumscribed—and more easily identifiable—group of partners to notify because the time period in which they were infected is more recent. In addition, the need to notify partners of people in the first group is more urgent because people at early stages of infection are highly infectious. A third development, however, may actually inhibit PCRS efforts: many states have instituted or are considering reporting the names of all individuals who test HIV antibody positive as a way of tracking the epidemic. Fears about the confidentiality of such systems may lead to reduced testing of at-risk individuals and, consequently, the identification of fewer seropositive people who might be counseled to disclose to their partners. PCRS Guidelines The state of California has responded to these developments by creating a model PCRS Program. The mission of the PCRS Program is to provide seropositive clients identified at publicly funded HIV programs with information, counseling, and resources that will encourage them to notify their sex and needle-sharing partners of the potential risk for HIV infection. Under the program, seropositive clients may choose to inform partners themselves or may request assistance from a public health provider. The program also seeks to ensure that partners who are notified are offered counseling and medical follow-up. PCRS is always confidential, that is, the name of or any other identifying information about the HIV-positive client is never divulged to notified partners. California officials have worked closely with the Centers for Disease Control and Prevention (CDC) in developing both federal and state guidelines. In December 1998, the CDC offered written guidance to help states-plan, implement, and evaluate PCRS. The CDC emphasized several primary principles, namely that PCRS be voluntary on the part
Editorial: Watching Big Brother
Robert Marks, Editor

“Big brother” is a phrase that implies both nurturance and coercion, a warm and fuzzy terror. In the world of HIV, the government is the biggest brother, and no program is so much a combination of good and suspect fraternalism as “partner notification.”

Partner notification—first applied to the older sexually transmitted diseases and now being used for HIV—has sought the ultimate public good: protection from illness. It is the process of partner notification, however, and not its goals, that has raised the specter of a not-so-benevolent Big Brother and concerns about the abridgment of civil rights.

In the early days of the epidemic, partner notification seemed to be a tool to gather information about HIV-infected people and control their actions while offering little benefit to them as individuals. Today, government agencies ranging from local health departments to the Centers for Disease Control and Prevention have reconceived partner notification as “partner counseling and referral,” a new name that suggests a new attitude (rather than simply a new spin). The focus of the new programs is on helping people with HIV consider the benefits of disclosing to past sexual and needle-sharing partners and then helping them undertake these disclosures. With the ultimate goal of notifying partners, the programs also offer the services of providers to undertake notification, within the context of strict confidentiality and the best interests of clients.

The arguments for HIV-related partner counseling and referral today are much more compelling than the arguments for partner notification had been. As Catherine Baker and Sandy Schwarz describe in their articles in this issue of FOCUS, two factors make the counseling and referral process easier and its result more useful. First, the detuned HIV antibody assay can considerably make the counseling and referral process easier and its result more useful. First, the detuned HIV antibody assay can considerably reduce the universe of potential past partners, making it easier and more likely that notification could occur. Second, while in the past, the lack of effective treatments left notified partners with few options, burgeoning treatment opportunities offer people who are notified real choices.

Few deny the utility of disclosing HIV status to both past and future sexual and needle-sharing partners. It is the involvement of the government—particularly in the context of new and proposed names-reporting initiatives—that causes many to shy away from what others characterize as sound public health policy. Names reporting, which some suggest is crucial for tracking the epidemic is still felt to be many to be an unnecessary invasion of privacy, and offers another example of a well-meaning bureaucracy dismissing the concerns of marginalized populations.

The ideal situation is for individuals to notify partners themselves, but even this may entail physical and psychological danger. Only programs that make confidentiality paramount and work in a client-centered way will be effective and counter images of a malevolent Big Brother.

of the infected person and his or her partners, that it be confidential and culturally appropriate, and that it be scientifically based, requiring that PCRS providers be trained and skilled in their work. The CDC report also recommended that PCRS be a component of a comprehensive prevention and support services system and that clients have ongoing access to PCRS. In addition, the CDC urged that people who choose to notify their own partners receive counseling and support and that those notified receive assistance in accessing medical evaluation and treatment. Other states, including Washington and New York, are adopting or are likely to adopt these or similar recommendations.

Methods of Notification

According to the current California PCRS guidelines, seropositive clients should be informed that partners could be notified and counseled in at least three ways: self-referral, provider-assisted referral, and provider-only referral. Literature on the subject also describes a fourth method, contract referral. Each method is preceded by a discussion during which counselors review with a client each referral option and its applicability to the client’s partners.

Self-Referral or Client Referral. Clients who choose to notify their partners directly can be “coached” by counselors to prepare for this. Using role-playing, counselors may suggest that clients disclose information about their serostatus and may help clients consider how partners will react and how to deal with reactions. Counselors may also help clients in prioritizing partners in terms of their accessibility, risk for infection, and potential for pregnancy. Finally, counselors may provide follow-up consultation. This process may occur during an HIV counseling and testing disclosure session, a separate visit with a PCRS counselor, a session with an HIV medical treatment program case manager, or other follow-up medical or counseling service.

Provider-Assisted Referral. PCRS counselors, including specially trained HIV test
counselors, providers from HIV early intervention programs, case managers, or outreach workers, may provide direct assistance to their clients by offering "dual counseling" services. Through this process, the client notifies partners about their potential exposure in the presence of the HIV counselor, with the counselor taking on the role of facilitator. Because this option may be the most challenging for the counselor, it is wise that only trained mental health professionals or veteran HIV test counselors with PCRS expertise implement this approach. Similar to the self-referral process, provider-assisted referral also includes working with clients to prioritize the need for and sequence of notifying named partners.

Provider-Only Referral. This model has been used successfully for many years in communicable disease programs such as STD and tuberculosis control. Seropositive clients provide identifying and locating information for their partners and public health representatives conduct notifications and referral while maintaining the original client's anonymity. The CDC has developed standard forms for STD partner management, which many states, including California, have adopted for HIV PCRS.

Contract Referral. This type of referral is a cross between client referral and provider referral. Contract referrals involve a time frame, for example, three days, during which the client commits to contacting and referring partners. If the client is unable to complete the task within the specified time, the PCRS provider has the permission and information necessary to do so him or herself. The provider needs to have honed negotiation skills and a relationship of trust with the client in order to obtain the identifying and locating information (at the time the client first enters into the contract).

Non-Consensual Notification

Under some circumstances, seropositive people do not want partners notified. They may assume their partners already know about HIV risk or they may fear negative consequences if they inform partners. For example, they may fear abandonment by significant others, loss of a place of residence, even violence and abuse. It is important that PCRS providers assess the cause of the client's refusal and offer support and counseling about the benefits to both the infected person and his or her partners. If a client is unwilling to disclose the names of his or her partners, the provider will have to counsel the individual as if he or she is choosing the self-referral approach.

In some cases, the provider already knows the identity of a partner at risk even though the seropositive client has not identified that partner. In California and some other states, laws allow physicians and local health officers to contact people "reasonably believed" to be sexual or needle-sharing partners of HIV seropositive individuals without a client's consent, provided certain conditions are met. Some of these conditions are: the result must be confirmed; the notification must be for the treatment of the notified person; and the physician must offer education and counseling to the seropositive patient and inform him or her of the intention to notify without consent. The law also requires that physicians refer all notified third parties for appropriate care, counseling, and follow-up."

Skills and Training of PCRS Counselors

Public health officials throughout the country agree that effective PCRS requires client cooperation and expert staff skills. PCRS counseling employs the same abilities needed for any client-centered counseling: strong listening, attending, and focusing skills, and the ability to remain clear on the value of PCRS work while at the same time being sensitive to the client's emotional process. PCRS counselors must be able to foster ongoing relationships with clients in which they develop rapport and support incremental behavior change. They must possess strong assessment skills to explore barriers, such as a client's fear of losing a relationship, that might keep a client from notifying partners. Patience and tenacity regarding the importance of notification are crucial attributes for PCRS counselors.

PCRS can be challenging for counselors on a personal level. For instance, consider the scenario of a married couple in which the woman is pregnant. Upon HIV and STD testing, the couple's provider discovered that the man was positive for chlamydia and HIV and the woman was positive only for chlamydia. The husband acknowledged having sex outside the marriage, but did not want his wife to know of this relationship or of his serostatus. Working over the course of several sessions with the husband, the provider explained to him the importance of disclosing to his wife, who, while apparently uninfected at the time of testing, might have, in fact, been in the infection "window period" (a time following infection but pre-


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Clearinghouse: Partner Notification

References

PCRS has the potential to identify exposed and infected people early in the course of HIV disease, enabling them to take advantage of early treatment and preventing the further spread of HIV infection. While other HIV prevention efforts continue to target individuals and groups at high risk, efforts to increase the availability and use of PCRS may well prove worthwhile given the ability of PCRS to deliver HIV prevention services to individuals at maximum risk.

Conclusion

PCRS has the potential to identify exposed and infected people early in the course of HIV disease, enabling them to take advantage of early treatment and preventing the further spread of HIV infection. While other HIV prevention efforts continue to target individuals and groups at high risk, efforts to increase the availability and use of PCRS may well prove worthwhile given the ability of PCRS to deliver HIV prevention services to individuals at maximum risk.
A New HIV Test to Detect Recent Infections
Sandy Schwarcz, MD, MPH

HIV antibody testing is one of the key diagnostic and prevention strategies for monitoring HIV infection. Since the first serologic test for HIV infection became widely available in 1985, strategies to improve HIV testing have been a major focus of research. Currently available tests can identify HIV antibody from serum, oral fluids, and urine. Current testing strategies include specimen collection in both professional offices or formal test sites or using home collection kits. New testing technology, however, is broadening both the process of and the information available from antibody testing, and many test sites, formally limited to antibody testing alone, are beginning to offer other sorts of testing.

One of the changes that may have the most far-reaching effect is the introduction of the detuned assay, a testing technique that can distinguish between recent and long-standing infections. Developed by the Centers for Disease Control and Prevention (CDC) in Atlanta and the Blood Centers of the Pacific in San Francisco, this assay relies upon a “dual test algorithm” in which seropositive specimens are retested using a less sensitive form of the standard antibody test—the enzyme-linked immunosorbent assay (ELISA or EIA). Since people who are recently infected—those who have seroconverted within the prior four months—have lower levels of antibody than those who have long-standing infections, those who have seroconverted sometime beyond the prior four months—will have antibody levels sufficiently high to test positive on both of the assays.

The Food and Drug Administration (FDA) is currently reviewing applications for approval of the detuned assay. However, the AIDS Health Project of the University of California San Francisco, which runs the large-scale anonymous HIV Counseling and Testing Service for the city of San Francisco, offers the detuned assay as part of a research demonstration project in collaboration with the San Francisco Department of Public Health and the CDC. (Another research study is being conducted in Seattle.) In San Francisco, antibody test clients receive an information sheet that explains the detuned assay, its research nature, and its risks and benefits. Clients are then asked if they wish to have the detuned assay performed should their antibody test result be seropositive. So far, the assay has been widely accepted; nearly 100 percent of clients have agreed to undergo it.

The detuned assay represents the first indicator that can offer clear evidence of the date of a person’s HIV infection. Despite its limitations—those who have been infected beyond four months prior to testing have no indication of whether they were infected one year ago or 10 years ago—the detuned assay has significant implications for HIV prevention, in particular, the identification and notification of previous sexual and needle-sharing partners. It also may have implications for medical treatment and has applications for HIV epidemiological surveillance.

Partner Management and Treatment
Current research suggests that treatment during early HIV infection is impor-
Data from detuned assay studies can help target prevention efforts. In San Francisco, research found that recent infection was associated with unprotected anal sex and having more than 10 sex partners in the prior year.


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Conclusion
The detuned assay is just one new test that will be available at antibody test sites throughout the country. Other tests—including viral load and CD4+ cell count, subtyping (which determines the strain of HIV) and drug-resistance testing (which determines the antiviral drugs to which a strain of HIV is resistant), and testing for other types of sexually transmitted diseases—may also become more common at government-funded test sites. At the same time, referral for prevention and social services becomes an even more crucial component of the counseling and testing process. This array of testing can provide both seropositive and seronegative clients with information to take further steps to improve their health and the health of others, but only if they have clear options for follow-up care or counseling.

Comments and Submissions
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Drug Users and Partner Management

Focus group interviews revealed that although drug users are critical of partner management programs, they recognize the importance of such interventions and said they would participate as long as the process was voluntary. HIV and substance abuse counselors agreed that interventions should be voluntary and stressed the importance of implementing partner management as part of other comprehensive HIV services.

The New York study consisted of focus group interviews with 25 in- and out-of-treatment drug users, 23 counselors, and nine experts in the fields of partner management and substance abuse prevention and treatment. Researchers recruited the substance users from a street outreach HIV prevention program and a hospital-based methadone maintenance treatment program. The majority were unemployed, heterosexual, African American men between the ages of 20 and 40. The counselors who participated were also predominantly African American; more than half of this group were women. The nine experts had a wide range of expertise and were also predominantly female and African American. All the subjects participated in either an interview session with researchers or one of two focus groups, one for active substance users or one for the in-treatment substance users.

In general, both counselors and clients viewed notifying needle-sharing partners as being logistically difficult and traumatic to clients.

The in-treatment substance abusers were willing to inform sexual partners for several reasons, including to stop the spread of the disease, to protect health, and to allow their partners a chance to receive medical treatment. Yet 50 percent of this group declined to participate in a program in which counselors released this information to their sexual partners. Most subjects argued that it was important to include the client as well as a counselor in the notification process.

In general, active drug users did not want to inform their former or current sexual partners. Many said that they wanted to maintain trust within their relationships, but they were also concerned about being “too honest” with partners.

In-treatment substance users said they would prefer to notify their sexual partners right away, “before they got sick and wondered why, and when you don’t add so much stress when people are sick.” The majority of active users, however, said they needed time to deal with their own emotions first and would wait at least six months before notifying their partners. In addition, some users said they would wait until they began to have HIV symptoms or when they were near death in order to gain sympathy or minimize their partner’s anger.

Perceptions of Partner Management
Fenton KA, Peterman TA. HIV partner notification: Taking a new look. AIDS. 1997; 11(13): 1535-1546. (University College London Medical School; Centers for Disease Control and Prevention.)

A comprehensive review of studies on HIV partner management suggests that at least half of notified partners agree to test for HIV antibodies and receive related counseling. In addition, 10 percent to 35 percent of notified partners who test for HIV receive a positive result for the first time.

The main goal of partner management is to reduce the likelihood of infected partners transmitting HIV and of uninfected partners from acquiring HIV. According to a South Carolina study, notified sex and needle-sharing partners decreased the number of their sex partners by 82 percent in a six-month period if they tested seropositive and by 54 percent if they tested negative. In addition, condom use increased by 80 percent among HIV-infected men after notification and by 69 percent among uninfected men. Another study found that 87 percent of 132 notified partners who completed anonymous questionnaires agreed that the health department did the right thing in telling...
them about their exposure, and 92 percent agreed that the health department should continue to notify people exposed to HIV.

For infected clients, partner management is generally acceptable only if they maintain confidentiality. In a New Jersey study of 25 HIV-infected women, 68 percent were willing to reveal the names of their sexual partners as long as their own identities remained confidential. Only 20 percent said they would participate if their names were disclosed to partners.

A North Carolina study comparing partner management methods found that “provider referral,” in which a health care worker notifies partners of HIV-infected clients, was more effective than “patient referral,” in which HIV-infected clients notify their partners about possible exposure without the direct involvement of a health care worker. The provider referral method successfully located and notified 50 percent of partners, while patient referral only notified 7 percent.

There are drawbacks, however, to provider referral, in particular, and partner management in general. Research consistently indicates that provider referral is the most expensive method of partner management: the estimated cost is between $33 and $373 for each partner notified and between $810 and $3,205 for each infected partner identified. Possible complications of notifying partners include loss of confidentiality, domestic violence, stress, stigmatization, discrimination, and emotional trauma.

Logistics of Partner Management

In a large study of HIV partner management, available information was sufficient to initiate a search for only 15 percent of 8,633 total partners within the preceding year. Of the 590 located partners who agreed to be tested, 22 percent were seropositive.

The study sample included newly diagnosed clients from three STD clinics in Broward County and Tampa, Florida and Paterson, New Jersey. The majority of participants were African American heterosexual men between the ages of 25 and 34. Forty-seven percent of clients reported having one or two partners during the previous year, 33 percent had between three and 10 partners, and 9 percent had 11 or more partners.

Disease intervention specialists located 80 percent of the 1,290 targeted partners. Twenty-four percent of the 1,035 located partners had previously tested positive for HIV antibodies, 54 percent agreed to test, 7 percent refused to test, and 15 percent were located but not notified.

Taking into account the amount of time the disease intervention specialists spent working with each client and locating and contacting the clients’ partners, the specialists’ salaries, and transportation and overhead expenses, the average cost of the process was $251 per client, $427 per partner notified, and $2,200 per partner discovered to be infected with HIV.

The study’s original objective of comparing the cost and effectiveness of four strategies for partner notification—“patient referral,” “contract referral,” “provider referral, field blood”—was unsuccessful and inconclusive because there was crossover among partners who were named by multiple clients and, therefore, were notified using more than one strategy. Researchers eliminated the “patient referral” intervention group and combined both “provider referral” groups with “contract referral” for further analysis of a generalized provider referral partner management strategy.

Next Month

While it is clear that certain substances contribute both to HIV-related risk among uninfected people and to HIV progression among seropositive individuals, there has been less clarity about the effects of alcohol and poppers. In the March issue of FOCUS, Kendall J. Bryant, PhD, of the National Institute on Alcohol Abuse and Alcoholism reviews the data on the interactions of alcohol and HIV, focusing in particular on the ways in which alcohol affects partner dynamics and heightens risk.

Also in the March issue, Hank Wilson, Chair of the Committee to Monitor Poppers of ACT-UP Golden Gate, discusses the role of poppers in HIV disease. He looks at how an understanding of the use of poppers has evolved over time and how it stands now.
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