HIV Partner Counseling and Referral Services

Finally Getting Beyond the Name

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As early as the 18th century, Danish priests collaborated with public health authorities to notify the sex partners of persons with syphilis.[1] Partner notification became a cornerstone of the United States public health efforts to control syphilis in the 1940s, and for many years the Centers for Disease Control and Prevention (CDC) trained and funded a cadre of federally employed public health advisors (PHAs) who were assigned to state and local health departments and staffed or oversaw many partner notification programs. However, direct federal support and oversight for PHAs was sharply curtailed in the 1980s and early 1990s, as federal funding for partner notification was increasingly wrapped into the larger grants that states receive to provide sexually transmitted disease (STD) services. Meanwhile, overall funding for STD control faced widespread cuts in state government budgets.[2] These changes roughly coincided with the emergence of the AIDS epidemic and an associated challenge by some activists and civil libertarians to long-standing public health practices that some believed threatened privacy.[3,4] Partner notification became the "sick man" of public health STD control efforts.[5]

When one does not know what to do about a problem, a common reaction is to change the name. Contact tracing was renamed partner notification, and partner notification morphed into partner counseling and referral services (PCRS). These superficial changes masked the fact that much of the U.S. and Europe simply ignored partner notification as an HIV-prevention strategy. In 2001, fewer than one third of individuals with newly diagnosed HIV in high-morbidity parts of the United States were interviewed by public health officials for purposes of partner notification.[6] San Francisco, New York City, Los Angeles, and many other large cities—epi-centers of the AIDS epidemic in the U.S.—had virtually no partner notification programs for the first 15 years of the epidemic.

The advent of effective antiretroviral therapy, frustration with the failure of public health efforts to stem ongoing HIV transmission, and a general maturing of the AIDS epidemic have led to a widespread reconsideration of the role of traditional public health activities in controlling HIV. The result is a new emphasis on case-finding and treatment as the bedrock of HIV prevention.[7,8] The systematic review published in this supplement to the *American Journal of Preventive Medicine* is part of that reconsideration.[9] The review's main finding, that HIV prevalence is high among the tested sex- and needle-sharing partners of people with newly diagnosed HIV, echoes the results of previous reviews on the subject[10–14] as well as data compiled as part of a national program assessment.[6] Indeed, all but one of the studies included in the current review of PCRS programs were published between 1988 and 1998, highlighting the paucity of recent research in this area.

The pendulum of enthusiasm for HIV partner notification may be swinging too widely. During the first part of the epidemic, many public health departments and other authorities overstated the potential risks of PCRS and neglected the intervention. We may now be at risk for overstating what we know about the effectiveness of public health partner notification programs. Existing evidence somewhat supports the conclusion that PCRS can identify new cases of HIV, but the evidence is not very strong. Only a single published controlled trial has evaluated PCRS. That trial was conducted before the advent of antiretroviral therapy, and enrolled only 74 people.[15] Although it found that significantly more partners were notified and tested among people assigned to receive provider referral than among those assigned to patient referral with back-up provider referral (a strategy called conditional referral), the generalizability of that finding is unknown.

Other data on HIV PCRS effectiveness consist entirely of uncontrolled program evaluations without comparison groups; we do not know how many of the partners notified and tested in the studied populations would have been tested in the absence of any public health intervention, or when they would have been tested. Data collected from men who have sex with men during the early years of the U.S. AIDS epidemic suggest that most people inform their "main" partners, but that few consistently notify other sex partners.[16–18] Randomized trials undertaken in people with other STDs suggest that provider referral is superior to patient referral,[19,20] but these studies were conducted in STD clinics and enrolled almost no women, limiting

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their direct applicability to HIV PCRS undertaken in populations diagnosed primarily in settings other than STD clinics.

The CDC is in the process of drafting new HIV PCRS guidelines. Those guidelines, as well as the review by Hogben et al.[9] in this supplement to *AJPM*, are welcome components of a thoughtful reformation of public health strategies for HIV prevention and control. Several additional steps should be incorporated into this process as it relates to PCRS.

First, we need better evaluations of PCRS and creative efforts to improve the activity. Optimally, this would include randomized controlled trials. As most people with newly diagnosed HIV are not currently interviewed for purposes of PCRS, this should not present an ethical problem, and a study design that employs early versus delayed PCRS interviews should be feasible. Likewise, studies comparing different approaches to PCRS merit consideration. At a minimum, some effort should be made to improve how we evaluate PCRS outcomes. Current efforts typically count only those notifications that can be verified, and fail to distinguish whether partners are notified before or after public health staff interview cases. As a result, assessments include multiple sources of biases and imprecision, some of which under-estimate and some of which over-estimate program effectiveness.

Second, PCRS should be linked to HIV surveillance. While it would be good to have better data on PCRS effectiveness, the desire for better information should not stymie efforts to improve what we are doing. We have very few interventions that we know are effective at preventing HIV, and PCRS is probably better than most of the things that health departments currently fund in the area.[21] Successful PCRS starts with the timely identification of newly diagnosed cases. The only way to ensure widespread application of PCRS is to guarantee that public health programs charged with this activity know about cases as diagnoses occur.

Third, public health staff who provide HIV partner services need improved training and, in many cases, better remuneration and prospects for career advancement.[22] Existing CDC manuals and trainings related to partner notification are antiquated, and poor work conditions impede recruitment and retention of good staff. Fortunately, training materials are currently under revision, and new materials should provide an opportunity to improve training more broadly.

Public health authorities are now engaged in a substantial and long overdue reappraisal of HIV PCRS. This effort should involve a careful reassessment of how PCRS is organized, its components, and its effectiveness. As Hogben et al.[9] show in their review, we have a lot to learn.

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