14th Annual Conference of the
National HIV Nurses Association (NHIVNA)

National HIV Nurses Association

Steven Akehurst

National AIDS Trust

14-15 June 2012, Manchester Conference Centre

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NHIVNA, 15/06/2012

HIV Partner Notification:
sinking without a trace?

Steve Akehurst, NAT

So what is it?

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- **Partner notification (or 'contact tracing'):**

  "...the process of contacting the sexual partners of an individual with a sexually transmitted infection including HIV, and advising them that they have been exposed to infection. By this means, people who are at high risk of STI/HIV...are contacted and encouraged to attend for counseling, testing and other

  prevention and treatment services" – WHO (1999)

- **Should be raised or initiated in the post-test counselling session following a positive diagnosis**

How is it done?

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- **Patient referral - patient informs their own sexual partners themselves; healthcare worker then encourages and follows up with patient**

- **Provider referral – healthcare worker informs patient without disclosing a patient's identity**

- **Contract referral – mixture of the two; patient given period of time before intervention**

Why HIV PN matters – in theory

- Benefits of HIV PN closely linked to benefits of testing and earlier diagnosis

- Diagnosing partners allows them to get on to HIV treatment earlier – with known health benefits

- Preventative effect of treatment, as well as reduction in risk behaviour - can reduce onward transmission of HIV

- Diagnosing partners also allows them to embark on their own PN process

- HIV PN can therefore break up sexual networks through which HIV is transmitted

Proof that HIV PN works – in practice

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Sheffield (2009) – in detail:

- **135 partners from 74 newly diagnosed patients
62% traced**

  32% had already tested
  17% outcome unknown or ongoing
  51% had not tested and did so after notification

- **Of those partners traced and tested, <u>37%</u> were newly diagnosed HIV positive.**

Proof that HIV PN works - in practice

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NAT found an average 'new positive rate' of around 27%. Some more examples:

- **South Yorkshire HIV Network (2010) – 34% of partners traced and tested newly diagnosed as HIV positive**

- **North East (2011) – 34% newly identified HIV+**

- **Dean St (2009/2010) – 26% newly identified HIV+**

- **South Wales (2008) – 25% newly identified HIV+**

- **Manchester (2011) – 26% newly identified HIV+**

In the UK and abroad (e.g US, Denmark), average for HIV PN is about <u>31%</u> of partners traced and tested are newly identified as HIV+

Proof that HIV PN works - in practice

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- **PN more likely than anything else to get MSM tested - 32% for formal PN, next highest was 'as part of regular screening' on 18.2% (Sigma Research 2011)**

- **HIV PN can also get people tested that may not have done before: 22% previously untested attendees only attended as a result of PN (Dean St 2009/2010)**

- **Particularly effective in those recently infected? Higher infectiousness.**

  - Of those traced and tested from a recently infected patient, 62% HIV+ compared to 31% with established HIV infection (Millward et al, 2010)

  - Strong case for integrating RITA within HIV PN process – maybe even prioritising the PN of RITA+ patients? Could help reduce late diagnosis?

So how are we doing? National picture

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- **Not great. In fact, half the problem is we don't even know how bad we are!**

- **HIV PN documentation often inconsistent or incomplete. This is just processes, before we even get to outcomes. Tends to be worse when diagnosed outside of GUM.**

- **Very little auditing of current performance**

Barriers to better HIV PN

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Some barriers inherent to modern world

- **Sex is often anonymous**
- **Globalisation! Sex sans frontier etc.**

Barriers among providers/staff

- **Staff often unconfident or untrained**
- **Ethical dilemmas**
- **No clear guidance on process or outcomes**
- **Notes not getting passed on**
- **Poor practice perpetuates itself**

Barriers to better HIV PN

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Barriers among patients

- **General: HIV stigma, criminalisation**
- **MSM: Quite amenable to process, but still pronounced fears around relationship issues**
- **African: Stigma often worse, fears around asylum issues, complexities around confidentiality (e.g shared phones), faith groups**

So how are we doing? Infectious Disease Units

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- **Despite exceptions - and dedicated staff - there's a sense that ID units particularly struggle with HIV partner notification**

- **Can lead to a 'postcode lottery' when it comes to HIV PN?**

- **ID units rightly focused on medical model (treatment, adherence etc). But PN is a very social practice, can be intimidating and alien to staff.**

- **Many nurses not properly trained to undertake HIV PN interviews – significant factor in lack of confidence**

NAT's recommendations

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General recommendations

- **Nationwide audit - 12 month period of data gathering**

- **Specific outcome standards**

- **Incorporate technologies into HIV PN processes – including online**

- **Specific good practice guidance**

- **Further resources/information for providers around criminalisation**

- **Prioritised within commissioning – local and national**

- **Positive dimensions of PN incorporated within health promotion and HIV prevention messaging for MSM**

NAT's recommendations

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Recommendations aimed at helping nurses with HIV PN

- **Training – wider provision of comprehensive training for CNS's**

- **Standards – all ID units must ensure staff who undertake HIV PN are appropriately trained**

- **Commissioning – must be made clear in every local area who is responsible for HIV partner notification and how it will be paid for**

Where to from here?

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- **We want to see high-quality, consistent and cost-effective HIV partner notification delivered across the UK**

- **Regular and consistent auditing – ideally annually**

- **100% of newly diagnosed HIV+ patients at least offered a discussion about PN, with all outcomes documented.**

- **The key to this is confidence among health advisers AND nurses in undertaking HIV partner notification**

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