

Intensified HIV Case Finding through Index Case Testing in Kenya: A Model of Success

June 2020



Photo: Eric Bond, 2019



**Elizabeth Glaser
Pediatric AIDS Foundation**
Fighting for an AIDS-free generation

Points of contact:

Polycarp Musee (pmusee@pedaids.org); Carren Anyango Onyango (conyango@pedaids.org);
Aida Yemaneberhan (aberhan@pedaids.org); Madison Ethridge (methridge@pedaids.org)

Background/Context

There is a global commitment to achieve the UNAIDS 95-95-95 target goals and achieving the first 95 is key to achieving the latter. As countries and programs move closer to attaining the first 95, traditional HIV testing strategies become ineffective in identifying new positive clients. High-quality index case testing, popularly known as assisted partner notification services (aPNS), is an approach in which partners and biological children of an HIV-positive individual (the “index patient”) are solicited and recruited for testing. aPNS has significantly contributed to the increase in the number of people diagnosed with HIV (the goal of the first 95), in countries where EGPAF works. In fact, aPNS is one of the key intensified case finding strategies used to identify people living with HIV at an early stage as well as link them to care and treatment, in addition to also linking HIV-negative individuals at risk for HIV to prevention services. Further, from October 2017 to December 2019, out of 25,801 newly identified HIV-positive cases identified by EGPAF-Kenya, 13,240 (51%) were identified through index testing and 12,493 (91%) were linked to treatment services. Countries such as Kenya have almost achieved their global goals and ability to reach the first 95 due to the efficient strategy of aPNS. Despite existing evidence of the effectiveness of aPNS, many programs and countries struggle to effectively implement this strategy.

aPNS Implementation in Kenya

Before the launch of aPNS in June 2017, EGPAF-Kenya had implemented the family index testing strategy for many years. The team prepared for the launch by conducting a landscape analysis of the family index testing strategy to understand what worked well and what challenges were encountered. Determined to build on good practices while modifying weaknesses, the team empowered the Ministry of Health (MOH), the project team, and the HIV testing services (HTS) providers through data-driven discussions and training. The focus of the sensitization discussions and training for HTS providers was on counseling skills in elicitation and referral approaches as those components are critical to successful aPNS implementation. Additionally, training was conducted in September and October 2019 and experienced counselors in PNS provided peer-to-peer mentorship through experience sharing, quarterly review meetings conducted by HTS providers, and performance-based certification after training.



Photo: Eric Bond, 2019

aPNS Implementation in Kenya: A Journey with Many Lessons

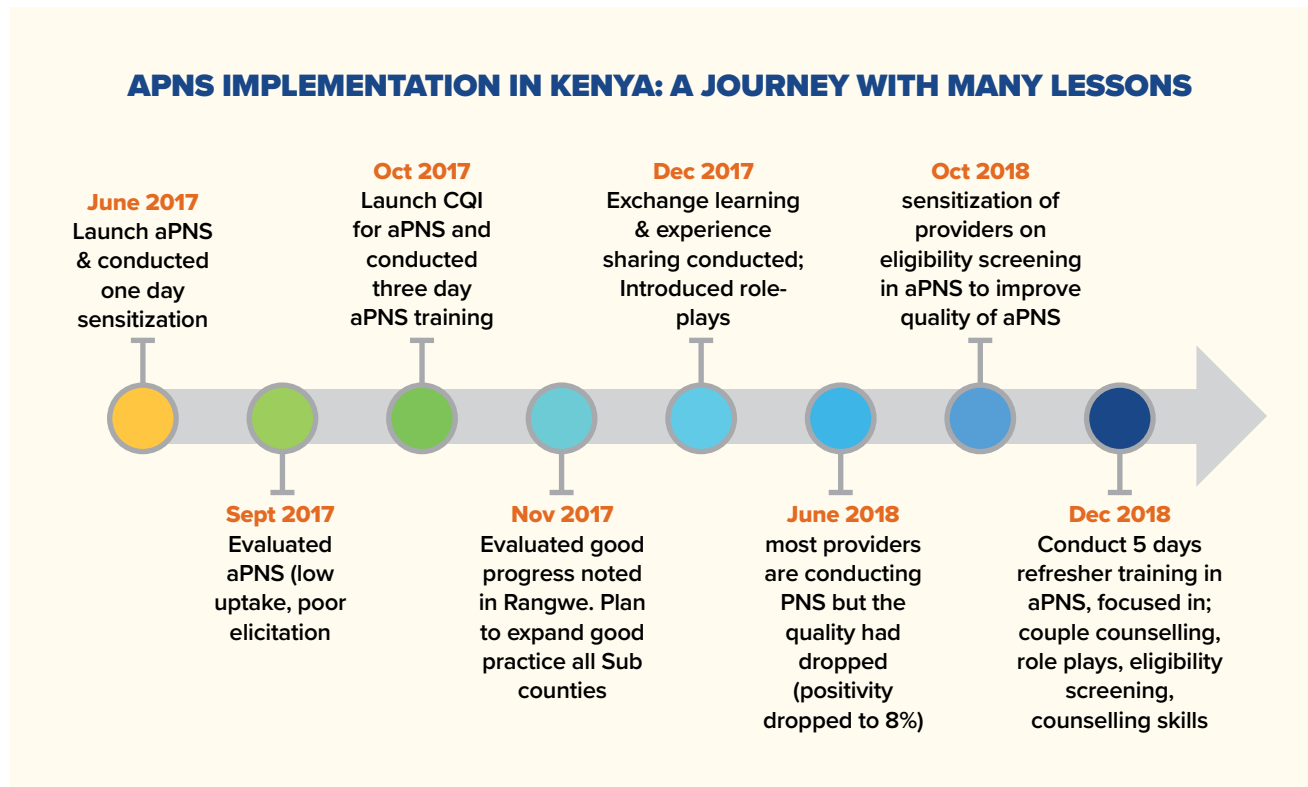


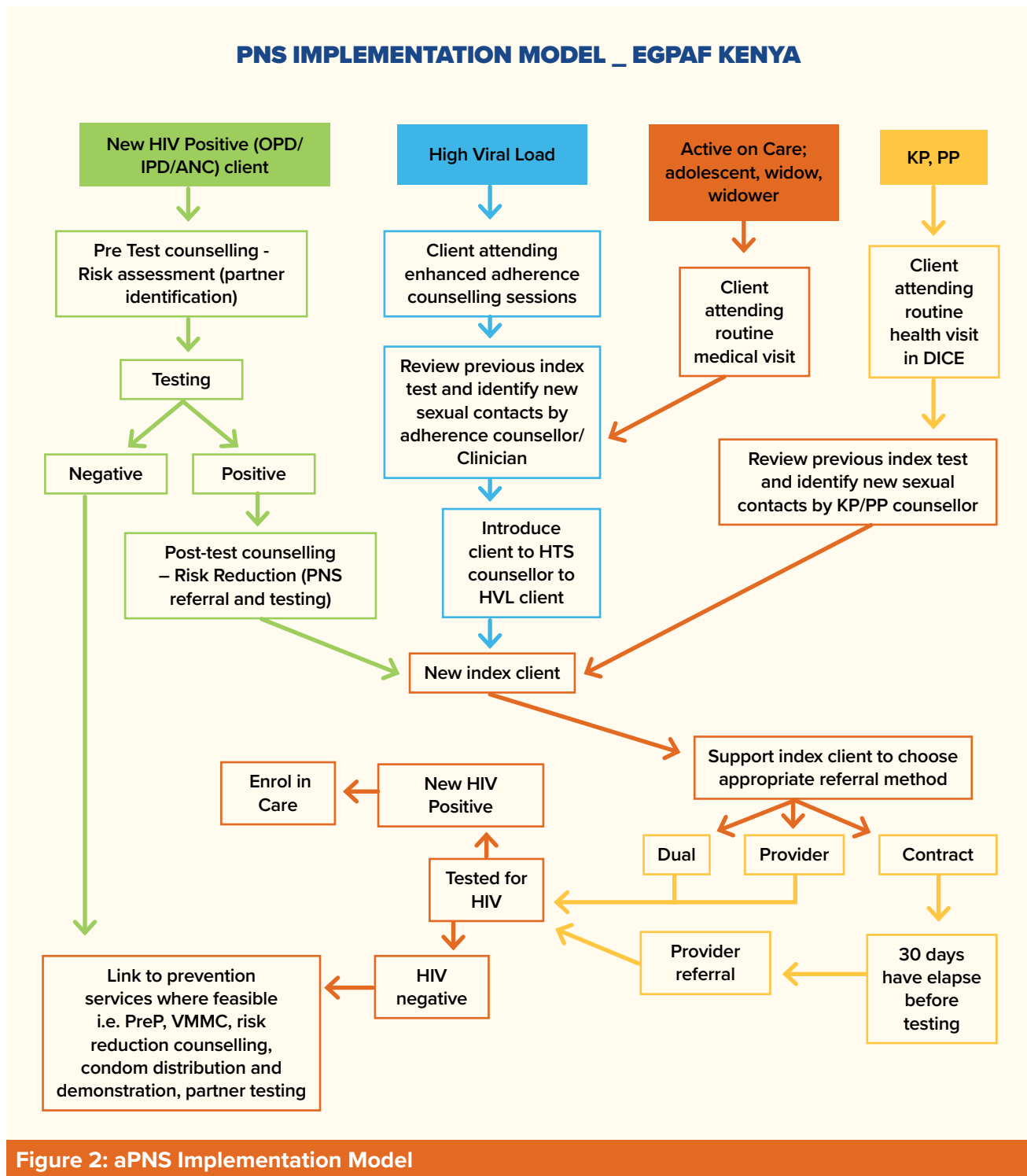
Figure 1: Timeline of aPNS implementation in Kenya



Photo: Eric Bond, 2019

A Model of Success: aPNS Implementation

In response to the slow start implementing aPNS in-country, EGPAF-Kenya developed an aPNS implementation model. The model teaches health care workers (HCWs) implementing aPNS how to clearly introduce and sustain discussion about the index client's sexual life and the impact it has on their health and the health of their loved ones. The goal was to motivate index clients to adopt positive behavior change while supporting their sexual contacts in utilizing HTS.



Operationalization of the aPNS implementation model

I. How to introduce and sustain conversations with new positive clients about their sexual partners

This guidance applies to all clients who are tested in outpatient departments (OPD), inpatient departments (IPD), community outreach, DICE, maternal and child health (MCH), or CCC (these individuals are usually clients with a negative or unknown HIV status). All clients receiving HTS in these departments are treated as potential index clients and therefore, quality-counseling services are offered to elicit sexual contacts. During pretest counseling sessions, PNS is introduced while conducting a risk assessment. The steps below describe the **risk assessment** process.

- Step 1:** HTS provider supports the client in exploring modes of HIV transmission while addressing client misconceptions
- Step 2:** HTS provider supports the client in exploring the risks that might have exposed them to HIV
- Step 3:** Some clients will feel comfortable disclosing their risks, however, the provider may need to employ relevant counseling skills to deal with client ambivalence
- Step 4:** The information acquired during risk assessment is then used during risk reduction counseling, including index testing.



Photo: Eric Bond, 2019

The following steps demonstrate how **risk-reduction counseling in the post-test counseling session links with pretest counseling sessions**:

- Step 1:** HTS provider confirms the client understands what an HIV-positive result means
- Step 2:** HTS provider helps the client understand the importance of starting antiretroviral therapy (ART)
- Step 3:** HTS provider reminds the client of their previous discussion during pretest counseling on exposure and risk (e.g., “in our earlier discussion you had mentioned that you have XX number of sexual partners”)
- Step 4:** HTS provider seeks client’s consent to contact their sexual contacts for an HIV test (e.g., “In our earlier discussion you had mentioned that you have XX number of sexual partners. Now that you are going to benefit from ART, we must work together to support your contacts to access testing so they can also have a chance to benefit from ART if they are positive. If they are negative, you get the chance to help them practice a healthy sex life by utilizing prevention services. Are you willing to work together to test your contacts?”)
- Step 5:** Each sexual contacted listed is screened for intimate partner violence (IPV)
- Step 6:** HTS provider allows the index client to choose the preferred referral method to reach the contacts for an HIV test
- Step 7:** Document in the PNS register



Photo: Eric Bond, 2019

II. How to introduce and sustain a conversation with known positive clients about their sexual partners

This guidance applies to all known HIV-positive clients, both active or inactive on care, and will include defaulters returning to care. It applies to high viral load clients (HVL), adolescents, widows/widowers, key populations, and priority population index clients. Before sitting down with a known positive index client for the elicitation process, the HTS provider reviews their files to have a better understanding of the index clients regarding:

- When they were diagnosed and started on ART
- History of viral load test
- If contacts were previously elicited, tested, etc.

Having this background knowledge of the index clients before sitting down for the elicitation process makes it easy for the HTS provider to know what to ask and what not to ask. While conducting elicitation of sexual contacts for known positive clients, the discussions usually center around ART outcomes and the provider helps the index client understand how sexual contacts with unknown HIV status affect their treatment outcomes. This discussion aims to motivate the known positive client to adopt positive behavior change.

Building skills of HTS providers to effectively implement the aPNS model

It is worth noting that despite the first training and sensitizations that were done across the county, the implementation of aPNS was too sluggish. An assessment was therefore conducted to understand the barriers to implementation—key hindrances include:

- Negative attitude towards aPNS as the providers felt it was an additional responsibility without an increased salary, rather than a strategic initiative enabling them to accomplish their mission.
- Providers felt as though sexual elicitation was trespassing into someone's personal life
- Fear of the unknown—being entangled in the network
- Low capacity in counseling and communication

Counseling and communication skills help the provider to effectively communicate with the client, understand the clients' world as it is experienced by the client, help the client deal with barriers to change, and help the client actualize to their desired state/behavior. A lack of counseling and communication skills may affect the entire counseling process, create more resistance on clients, and leave the client in a worse state than in which they came. Acquisition of these skills requires demonstration by the experts (counselors) and continuous practice by providers under the close supervision of the experts.

Motivational interviewing is a technique used by health care providers to express acceptance to the client and assumes the role of a helper in the behavior change process. The provider helps the client identify the gap between their current state and their desired state, resolving ambivalence that may hinder the achievement of their desired behavior/state. This helps the client elicit self-motivational statements, inspiring them to make small but steady steps towards the desired change. Motivational interviewing stimulates the innate capability of change that exists within a person.

Motivational interviewing training had a personalized approach to help the participating providers identify behaviors in their lives they would want to change, experience the complexities of the change process, and the importance of support. The participants were able to conceptualize the uncertainties of every stage and how to help the clients overcome them by embracing the process, skills, and techniques of motivational counseling.

Clients who are effectively provided with aPNS demonstrate improved adherence and better treatment outcomes.

Results

As previously mentioned, EGPAF-Kenya data from October 2017 to December 2019 showed that of the 25,801-total new HIV-positive cases, 13,240 (51%) were identified through aPNS and 12,493 (91%) were linked to treatment services.

What did it take?

To successfully implement aPNS, buy-in and stakeholder engagement is crucial across all levels. The Human Resources for Health (HRH) Management strategy is one strategy that gathered support at the provider level. The following strategies were implemented to do so:

- Refocus providers to PNS and enhance pre-test elicitation
- Provide logistical support (airtime, transport (\$5 USD) per trip)
- Capacity building and refresher trainings, mentorships (including peer-led), preceptorship, and role plays
- Build skills of project officers
- Attitude change by entire team
- Address self-stigma and lack of self-efficacy by the project team and HTS providers
- Reshuffling of HTS providers

Strategies developed to address barriers, motivate, and equip the providers with the adequate skills to initiate the implementation of aPNS:

- PNS training (revised the mode of delivery to incorporate more practical skills)
- Incorporating PNS in HTS
- Skills and techniques used in aPNS
 - Counselling
 - Communication
 - Motivational interviewing
- Referral methods in aPNS
- Didactic on job training (OJT)
- Mentorship, screening, tracing, testing, and linking
 - Return demos
 - Skills and technique building
 - Exchange visits
 - Peer-to-peer
- Instilling positive attitude and behavioural change towards aPNS among health care workers to conceptualize aPNS and understand how embracing aPNS would be a personal benefit
- Reshuffling: specifically, for those who had stayed in a region for a long time and feared finding themselves in the PNS web as well as those who had become redundant
- M&E: Daily progress monitoring

While the Elizabeth Glaser Pediatric AIDS Foundation makes effort to use photos which accurately depict the actions, topics, or populations referenced, unless specifically indicated, the photographs in this document do not imply program participation, health status, attitude, behavior, or action on the part of persons who appear therein.

www.pedaids.org

Index Case Testing : Modular Description

Points of contact:

Polycarp Musee (pmusee@pedaids.org); Carren Anyango Onyango (conyango@pedaids.org);
Aida Yemaneberhan (aberhan@pedaids.org); Madison Ethridge (methridge@pedaids.org)



Photo: Eric Bond, 2019

Module 1: Basic Counseling Skills

Counseling skills are a collection of techniques and strategies used in counseling sessions to enhance communication within the counselor-counselee relationship. Basic counseling skills are required for the effective implementation of assisted partner notification services (aPNS). Programs should therefore invest in building the counseling skills of their HIV testing services (HTS) providers through trainings (especially around testing protocols, couples counseling, and basic counseling), hosting annual refresher trainings in areas in which HTS providers are weak, conducting several role-plays, mentoring, and coaching. The ability to support and challenge clients are counseling skills that are crucial to the successful implementation of aPNS.

Supportive Counseling Skills

Supportive counseling skills are skills that communicate warmth, unconditional positive regard, and concern for clients. They help the client narrate their story and include attending skills, listening skills, questioning skills, empathy, summarizing, focusing skills, minimal prompts/minimal encouragers, working silence, affirmations, and structuring/contracting.

Attending skills: This enables the provider to be available (in body and mind) and attentive to the client, verbally and non-verbally. It shows the client that the HTS provider is available to them. Attending involves greeting clients, being kind and polite, demonstrating availability, open body posture, tuning oneself into the world of the client, comfortable seating, and minimizing distraction. An acronym commonly used to communicate attending using body language in counseling is **SOLER**:

- S-** Sit squarely
- O-** Open posture
- L-** Lean forward
- E-** Eye contact
- R-** Relax

Listening skills: This is the ability of the HTS provider to capture and understand both the verbal and non-verbal communication as the client narrates their story. The provider should be attentive and listen actively to the client to be able to detect common themes within the client's issues, as well as omissions, discrepancies, experiences, feelings, attitudes, and behaviors. It helps the counselor understand and interpret the client's material correctly.

Questioning skills: This is a process involving making requests to the client to give more information in the area of discussion. The provider should be sensitive to the needs, culture, personality, and the subject of discussion as they inquire more information. There are two types of questions:

1. Closed-ended questions: Do not require further elaboration. The responses to these questions are "yes," "no," or numerical (e.g., "How old are you?" "Do you have children?" "What is your CD4 count?"). Closed-ended questions are prohibited in a counseling session.
2. Open-ended questions: Require further elaboration on the subject. The questions start with "how" or "what" and providers should refrain from asking questions that start with "why" because they may be leading questions. "Why" questions may come off as trying to accuse, label, and blame, which may interrupt the counseling relationship and session. Examples of open-ended questions are: "How do you perceive yourself in your current relationship?" "What stirs up arguments with your partner?" and "Tell me more about your relationship with your partner?"

Paraphrasing: This is a process of rewarding the clients' messages through reflection. The provider re-states or repeats, in their own words, what the clients say, without changing the meaning, to convey their understanding of what the client shared. The provider can demonstrate to the client that they are attentive, present in the session both physically and psychologically, and actively listening. It prompts the client to focus on the important issues and facilitates understanding while validating the client's statements.

Empathy: Involves immersing oneself into the world of the clients to understand their experiences, feelings, and concerns without losing focus. It helps the provider experience the clients' world and therefore understand the client's unique view of the situation and circumstances. A counselor who shows empathy understands and respects the client's point of view, enabling a deeper level of exploration with the client.

Summarizing: This skill is used by the provider to solidify what both the client and the counselor discussed. The service provider will paraphrase what they and the index client have said to illustrate they were paying attention. This skill is used at the end of every stage of counseling and the end of every session. Summarizing iterates to the client that their story is acknowledged because the provider recognizes and validates their experiences, feelings, emotions, and thoughts. This skill also allows the client to add details or additional content previously overlooked.

Focusing skill: This is the act of guiding the client to concentrate on a specific part of their message. The client may bring many issues into the session, however, it is the counselor's duty to help the client understand that all of their issues cannot be addressed in one session. Therefore, it is prudent to choose one issue to address at a time, as it may become easier to tackle issues once the major issues are addressed. Refocusing the conversation can enable the provider to re-direct the client when they deflect from a topic or issue. For example, while discussing the number of sexual contacts the index client has, they may avoid this topic by introducing a slightly different topic such as their child's sickness. The provider will then use focusing skills to respectfully bring the client back to the list of sexual contacts.

Minimal prompts/encouragers: Are verbal and non-verbal tactics to encourage the client to narrate their story and define their concerns through specific experiences, behaviors, and feelings. Minimal prompts/encouragers include non-verbal prompts such as nodding and raising eyebrows, as well as verbal prompts such as "mmh," "yes," "go on," etc. Minimal prompts encourage an individual to continue talking about their issue and confirm the counselor's attentiveness and concern.

Working Silence: Working silence affords clients the uninterrupted time/opportunity for self-exploration by providing the space to process their thoughts and feelings. Processing allows clients to gain clarity on the difficulties they experience and consider possible solutions. The client can have an internal dialogue and communicate strong feelings or emotions to self.

Structuring/contracting: This is a statement the counselor makes to orient the client on the processes, expectations, and potential outcomes of counseling. It enables the client to make an informed decision regarding whether to continue or discontinue the counseling session. Structuring/contracting helps ensure both the counselor and the client have a clear understanding of the session, as well as their roles and responsibilities. During contracting, the client is also informed of PNS and the need to list their sexual and social contacts. Confidentiality is ensured as well.

Challenging skills: These skills stimulate client's thought processes, enabling them to look critically inward at their perceptions towards their circumstances, self, experiences, feelings, and emotions. Challenging skills are effective after the therapeutic relationship has been achieved. These skills offer clients a perspective that is different from theirs, therefore stimulating them to reconsider their current position. These skills include:

- Confrontation
- Self-disclosure
- Immediacy
- Concreteness/firmness
- Reflection of feeling/mirroring

Confrontation: This is an action initiated by the counselor based on their understanding of the client's behavior and their belief that the client's story may contain discrepancies. The counselor brings the discrepancy to the client's awareness for re-examination and evaluation. For example, the counselor may say to the client, "You say you are happy in your marriage yet the tone of your voice depicts some level of dissatisfaction," or, "You say you are not infected with HIV yet you are on HIV care and treatment." This skill helps reduce ambiguities and

incongruences in the client's experience and motivates personal growth. If the client responds with persistent denial, however, the counselor must let the issue go.

Self-disclosure: The counselor willingly reveals their feelings, attitudes, and opinions to the client. The personal information the counselor reveals should be relevant to the discussion at hand and the counselor should have overcome any conflict to comfortably share it. The counselor appropriately talks about themselves to manifest solidarity and humanize themselves as someone who similarly manages difficulties in their personal lives. This facilitates exploration and encourages the client to be more courageous and confident in confronting painful issues, leading to therapeutic growth.

Immediacy: This skill is used to deal with the immediate discrepancies in the feelings and behavior of the client. The counselor brings such discrepancies to the client as soon as they notice them as failure to immediately bring up the discrepancy may lead to the client denying their display of what the counselor claims to have observed/noted. For example, the counselor may say to the client, "As you narrate your story, I realized you clenched your fist and shook your head, may I know what is going on in your mind as you narrate this story?" This skill affords the client the opportunity for deep internal reflection to assess their intra- and interpersonal relationships.

Concreteness/firmness: This is the counselor's ability to be realistic and practical, without resorting to theoretical obstructions. This keeps communication specific and focused on facts, experiences, and feelings that are of relevant concerns in the counseling session. Concreteness helps:

- Keep the counselor's response close to the client's feelings and experiences
- Foster accurate understanding by the provider
- Encourage the client to attend to the specific problem areas

Reflection of feelings: This is when the counselor restates the content of the conversation (both verbal and non-verbal) back to the client with the intent of helping the client hear their thoughts and listen to their feelings. This skill helps the client fully understand their feelings and leads the client into deeper self-exploration. This skill uses two techniques:

1. **Mirroring:** The provider repeats a keyword or the last words spoken by the client. It is important to not over mirror as it can be irritating to the client.
2. **Paraphrasing:** The counselor reflects feelings and emotions through paraphrasing to stir the client into self-exploration.

Motivational Interviewing by William Miller and Stephen Rollnick

Motivational interviewing is a collaborative, goal-oriented style of communication that places particular attention on the language of change. It is designed to strengthen personal motivation and commitment to a specific goal by eliciting and exploring one's reasons for change within an atmosphere of acceptance and compassion (Miller, William R.; Rollnick, Stephen P. 2012).

It is a semi directive, client-centered counseling style to elicit behavior change by helping the client explore and resolve ambivalence. It is focused, goal-directed, and facilitates and engages intrinsic motivation within the client. Motivational interviewing focuses on the present and helps clients to cultivate intrinsic motivation to change a particular behavior that is not consistent with the client's values. The counselor helps the client critically look at their current behavior against their values (Miller, William R.; Rollnick, Stephen P. 2012). To foster therapeutic gains, it is prudent for the counselor to employ certain conditions in a counseling session such as empathy, unconditional positive regard (UPR), and genuineness.

According to Miller, motivation to change is influenced by a person's self-esteem. Providers should therefore positively affirm clients experiencing low self-esteem so they can feel accepted, thus creating an environment for growth.

Motivational interviewing is at the center of index partner testing and biological children index testing. Effective interviewing can only happen when good communication skills are used. Further, motivational interviewing is a useful tool to overcome barriers and resistance to the aPNS process.

The motivational interview consists of the following components known as PACE (partnership, autonomy, compassion, evocation):

- **Partnership/Collaboration:** The provider should provide support and avoid the expert role, confrontation, arguing, and persuading. This leads to the client having a better understanding of their experience and the anticipated behavior and allows the provider to see the circumstances from the client's point of view.
- **Acceptance/Autonomy:** The provider respects the client's autonomy, potential, strength, perfection, and decision-making ability.
- **Compassion:** The provider keeps the client's interest in mind
- **Evocation:** The provider shares information about HIV prevention, emphasizing the importance of testing contacts to trigger the change process. The best ideas come from the client, therefore, the provider should ensure the client has enough information to influence change.

Principals of Motivational Interviewing

The therapist creates a conducive atmosphere that will promote change by employing the five principles below:

- **Express Empathy**
Empathy is a core condition of the person-centered theory that motivational interviewing embraces. It helps to set the right therapeutic environment that enables change. The provider gets into the client's world to gather an understanding of the client's struggles, issues, and barriers to change. The provider also wins the confidence of the client by demonstrating a non-judgmental attitude.
- **Develop Discrepancy**
The provider should help the client reflect on their current situation, especially the consequences of being entangled in that current situation, compared to their desired situation and the benefits attached to achieving that desired situation. The provider also helps the client explore the gap between their current behavior and the desired behavior by asking a series of relevant questions to lead the client to the change they desire. For example, the provider may first say to the client, "Having looked at the modes of HIV transmission, which one may have exposed you to HIV?" and if the answer is, for instance, sexual interaction, the provider would lead the client to talk more about their sexual interactions. For example, the provider may continue the conversation by saying, "tell me more about your sexual interactions and how they may expose you to HIV?" followed by, "What would you want to do to protect yourself from being infected with HIV?"
- **Avoid Arguments**
The provider should avoid arguments for change that awaken resistance in the client. Trying to convince a client they have a problem or need to change will elicit argumentative behavior and resistance. This will not help the client build adequate motivation for change. Therefore, it is important to recognize arguments are counterproductive.
- **Dealing with Resistance**
The provider should accept the reality of ambivalence and invite the client into the problem-solving process without manipulating or coaxing them. The provider should understand change is a process, levels of resistance are likely to be experienced, and they should therefore try to understand the client's point of view.
- **Support self-efficacy**
Self-efficacy is one's belief they are endowed with the capacity to accomplish given tasks or resolve bothersome situations. The provider helps the client review previous successful problem-solving tasks to strengthen their self-esteem, enabling them to handle the present circumstance/issue. This cultivates the client's ability to conceptualize change as a real possibility.

Therapeutic Process of Motivational Interviewing

The therapeutic relationship between the provider and the client is empathic and supportive. According to Miller and Rose (2009), counselors should start the session by building trust and guiding the client through empathic, reflective listening.

Engaging establishes a therapeutic relationship by employing trusting, mutual, and respectful liaising by attuning to your client, aligning to your client, and joining with your client. This makes the client feel welcome, comfortable, and aware of mutual goals.

Focusing allows the provider to guide the client to the desired behavior by assisting in agenda setting, goal/priority consideration, and setting a direction.

Evoking and reinforcing a client's internal resources facilitate the natural change process that is inherent by eliciting change talk and motivational statements.

Providers can elicit change talk by exploring the following:

- What makes you want to want to change?
- What are the reasons for this change?
- What are the benefits of change?
- How do you intend to go about this change?
- What would be your first step towards change?

The above questions should elicit the following reactions or motivational statement that the provider should affirm:

- Cognitive recognition of the problem (“I am realizing that this problem is bigger than I anticipated”)
- Effectively expressing concern of the circumstance (“My situation bothers me”)
- Implicit or explicit statements about the client's intention to change (“HIV prevention for my family and sexual contacts starts with me, otherwise I will lose my loved ones”)
- Optimism about change (“I am the expert and driver of the change I desire”)

Planning helps the client develop a specific change plan the client agrees to implement, a commitment to change, and a SMART plan.

Transtheoretical Model (Stages of Change Model)

The transtheoretical model/stages of change model was developed by James Prochaska and Carlo DiClemente to help people quit smoking and is effective in changing problem behavior. This model demonstrates behavioral change as a gradual process requiring small steps towards a goal but acknowledges this can sometimes end in relapse. In the early stages of this model, people are usually adamant, unwilling, and resistant to change; however, they gain momentum later.

Making a sustainable change in behavior requires motivation, commitment, effort, and the right emotions and attitude.

STAGES OF CHANGE	CHARACTERISTICS	STRATEGIES
PRE-CONTEMPLATION	<ul style="list-style-type: none"> • Denial • Ignorance of the problem behavior • No intention of changing behavior • Feelings of lack of control over the behavior 	<p>Help the client:</p> <ul style="list-style-type: none"> • See their problem behavior • Get into self-assessment through introspection and evaluation of the behavior • Understand the consequences of the behavior and assess how prepared they are to handle the consequences
CONTEMPLATION	<p>Aware of the problem behavior but not certain whether they want to make the change (ambivalence)--thus can stay in this stage for a long time</p>	<p>Help the client cross-examine themselves regarding:</p> <ul style="list-style-type: none"> • Why they want the change • How to get the change • What they need to change • Identify barriers to change
PREPARATION	<ul style="list-style-type: none"> • Makes smaller changes towards the larger change • Equips oneself with information relevant to change 	<p>Help the client:</p> <ul style="list-style-type: none"> • Develop SMART goals • Develop a plan of action • Identify intrinsic motivation towards the change • Develop inspiring statements towards the change • Link to support groups
ACTION	<p>Takes actions to accomplish their goals</p>	<p>Help the client:</p> <ul style="list-style-type: none"> • Develop means of reinforcement—clients should learn to applaud themselves for their achievements • Develop a strong will power to drop problem behavior and embrace the anticipated behavior • Review motivation, resources, and progress made • Develop strategies against temptations and relapse
MAINTENANCE	<ul style="list-style-type: none"> • Sustains the new behavior • Avoids relapse 	<ul style="list-style-type: none"> • Help the client avoid temptations • Encourage the client to reward themselves for the changes
RELAPSE	<ul style="list-style-type: none"> • Returns to older behavior • Feelings of failure, disappointments, and frustration 	<p>Help the client:</p> <ul style="list-style-type: none"> • Review every achievement they have accomplished during the process to help them develop a sense of self-efficacy • Identify what triggered the relapse • Assess their support system and resources • Reaffirm strategies in the preparation stage • Develop plans that will counter future relapse

Relevance to PNS/ICT

How motivational counseling appears in aPNS

Assisted partner notification services (aPNS) is a strategy used in the health sector to locate individuals who could be infected with an illness as a result of being in contact with an infected patient. PNS helps curb the spread of HIV by identifying contacts early and initiating treatment. While 90% of HIV transmission is through sexual activity, 83.9% of HIV-infected Kenyans living in married or cohabiting households are unaware of their HIV status (KENPHIA, 2018).

Incorporating motivational interviewing in HTS/aPNS helps clients address risky behaviors that can result in infection, including adopting behavior that will prevent them from acquiring HIV.

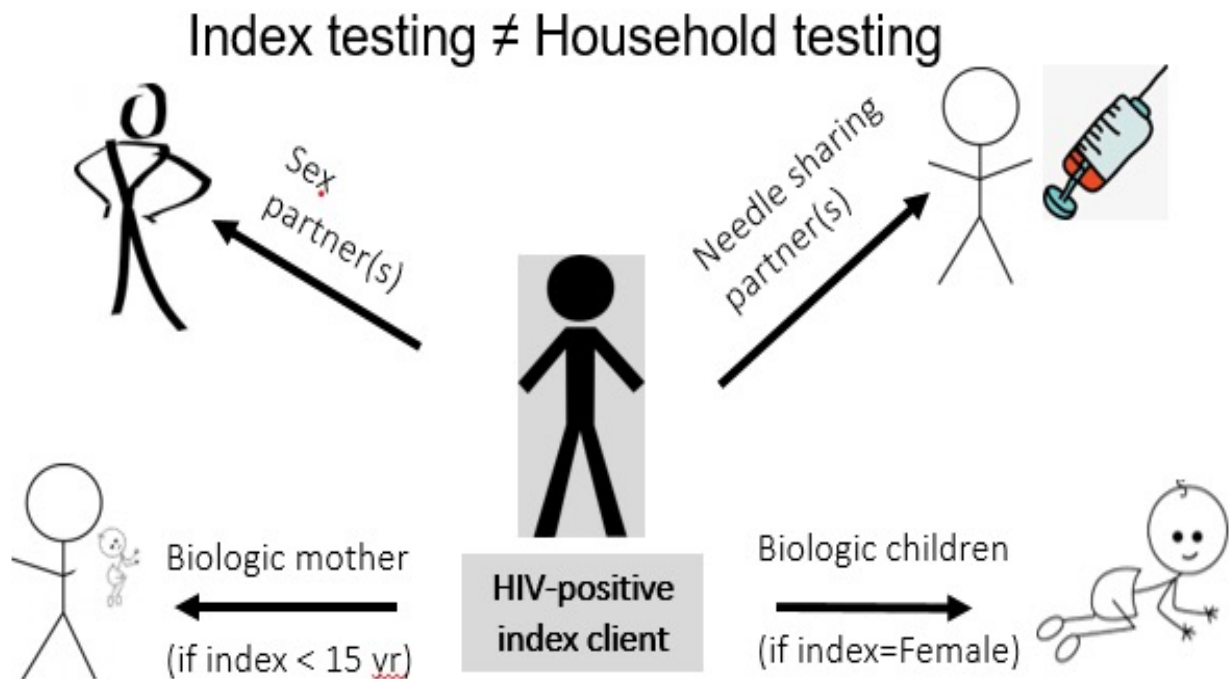
Motivational interviewing is highly recommended in HIV prevention, care, and treatment to help the client build their consistency to change. It triggers change in behaviors that lead to the spread of HIV and venereal diseases.

These approaches also ensure health care workers (HCWs) are empathetic and remain non-judgmental, thus gaining a patient's trust. It further helps HCWs deal with ambivalent and resistant clients.

Module 2:

Elicitation of Sexual Contacts And Biological Children

In aPNS, counselors elicit individuals who had a sexual relationship with the index client for a period not exceeding one year. Other elicited individuals are those who shared a needle with the index client, as well as the biological children of female index clients.



Source: PEPFAR solutions platform

It is important to note that successful elicitation of sexual contacts may be influenced by the quality of counseling, the elicitation environment, and the questioning technique (timing of a particular question, how questions are asked/framed, the types of question that are asked, how the contracting of the session was done, etc.). The HTS provider's body language, attitude towards aPNS and their role in HIV prevention, as well as their skills, all contribute to the success of the elicitation of sexual contacts.

HTS providers can create a conducive environment for successful elicitation of sexual contacts by ensuring clients are comfortable, safe, supported, and in control. There are small things a counselor can do to create a conducive environment for index clients to freely disclose their sexual contacts. First, the counselor should welcome their clients warmly into a counseling session. For clients to freely disclose their sexual contacts, ensure friends, spouses, and relatives are excluded. The counselor should aim to conduct themselves professionally by introducing themselves, determining the language the client is comfortable with, addressing any concerns, and assuring confidentiality. For the counselor to have a successful contracting process and counseling session, they should sharpen their counseling skills, mind the best practices they learned, and reflect on their practices. This will make it easier for the counselors to elicit sexual contacts from clients.

It is not advisable to elicit sexual contacts when conducting couples counseling. Clients may not always be honest with the counselor in the presence of their intimate partner, and if a client is honest, it could lead to intimate partner violence. Counselors should always keep in mind the two core principles of couples counseling: (1) Do not conduct risk assessments during couples counseling and (2) a couple should start and complete counseling sessions together—do not separate the couple to elicit sexual contacts from the HIV-positive partner. This means that during couples counseling, the HTS providers should defer the elicitation process to another day.

“Resistant” and Ambivalent Index Clients

Many counselors report being unable to elicit sexual contacts beyond official sexual partners and that some clients are resistant to freely divulging their list of sexual partners. A key question is, what will make index clients resistant to disclosing their sexual contacts to an HTS counselor but open to disclosing to other sexual contacts?

An index client will “resist” disclosing their sexual contacts to the HTS provider due to the uncondusive environment created by the HTS provider. An uncondusive environment may be a result of an HTS provider’s negative attitude towards aPNS and the entire counseling process. Counselors who do not believe there are people in their community who have multiple sexual partners will not conduct quality risk assessment counseling to elicit sexual contacts from all of the clients they serve. At the same time, counselors who do not feel confident offering aPNS will find every client they serve to be “resistant.” Furthermore, aPNS implementation requires HTS providers to adhere to HTS protocol and take adequate time to conduct quality counseling.

HTS providers may experience resistance from index clients while conducting eligibility screenings because they have inadequate counseling skills. HTS providers with inadequate counseling skills will be unable to navigate the barriers created by index clients protecting their privacy. It is normal for an individual to guard their privacy, especially when it comes to issues around multiple sexual partners. The role of an HTS provider, however, is to navigate the barriers the index client erects around them to make the client feel more comfortable disclosing their sexual contacts. The tools HTS providers need to do this are the counseling skills mentioned in the first module. HTS providers with inadequate counseling skills will feel as though index clients are resistant to naming their sexual partners beyond their official sexual partners.

Index clients may resist disclosing their sexual contacts when they feel unsafe. This feeling may be compounded by a lack of assurance of confidentiality or a counseling environment that does not ensure confidentiality.

How to Minimize Resistance

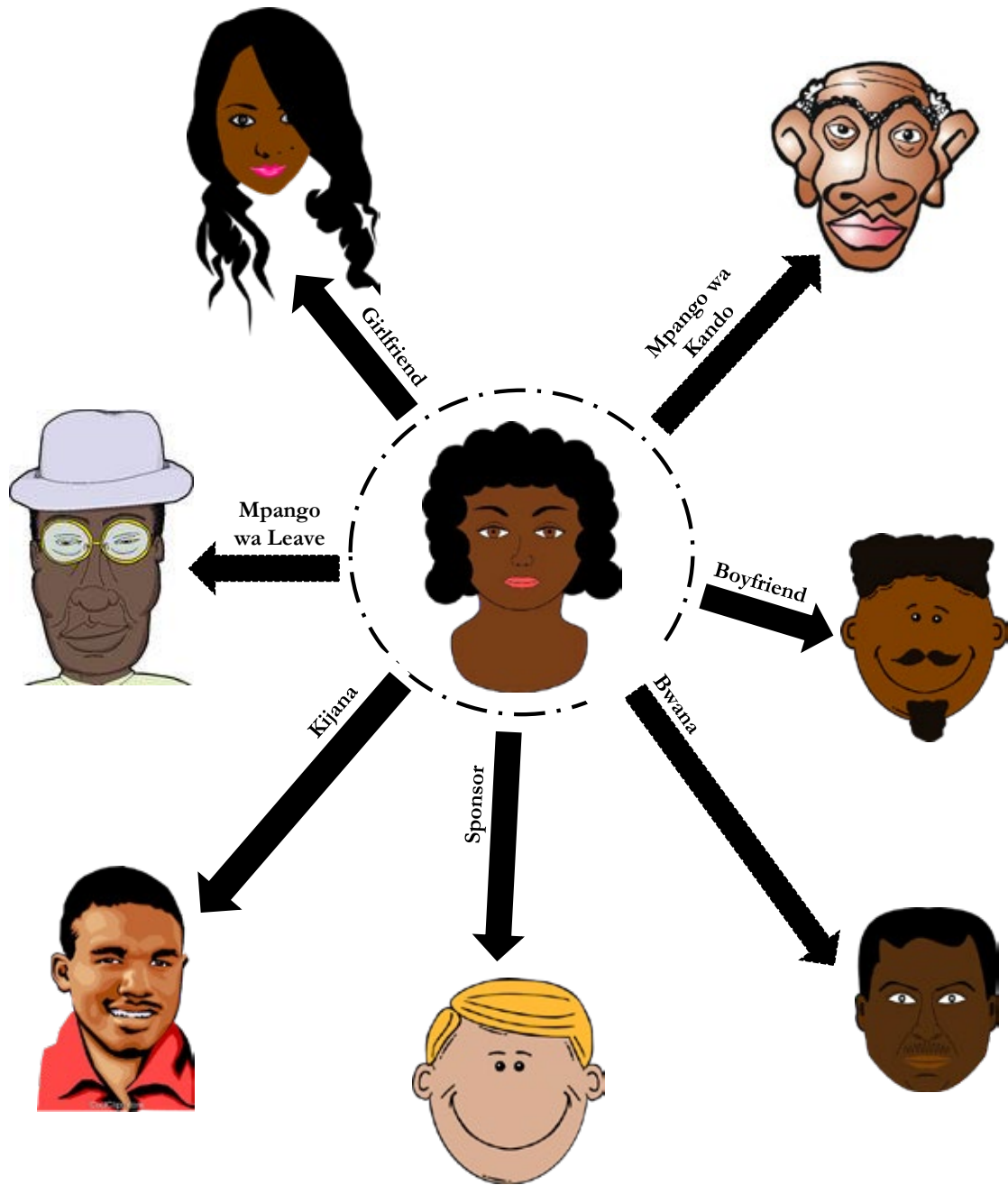
The first step to minimizing resistance is supporting HTS providers to develop a constructive attitude towards aPNS that acknowledges the reality of their communities. For example, the provider should acknowledge:

- Men and women (single, married, widowed, adolescents, students) in their community have multiple sexual partners
- The factors that drive different groups of people to have multiple sexual partners (e.g., economic reason, basic needs, etc.)
- The cultural practices that promote risky behavior

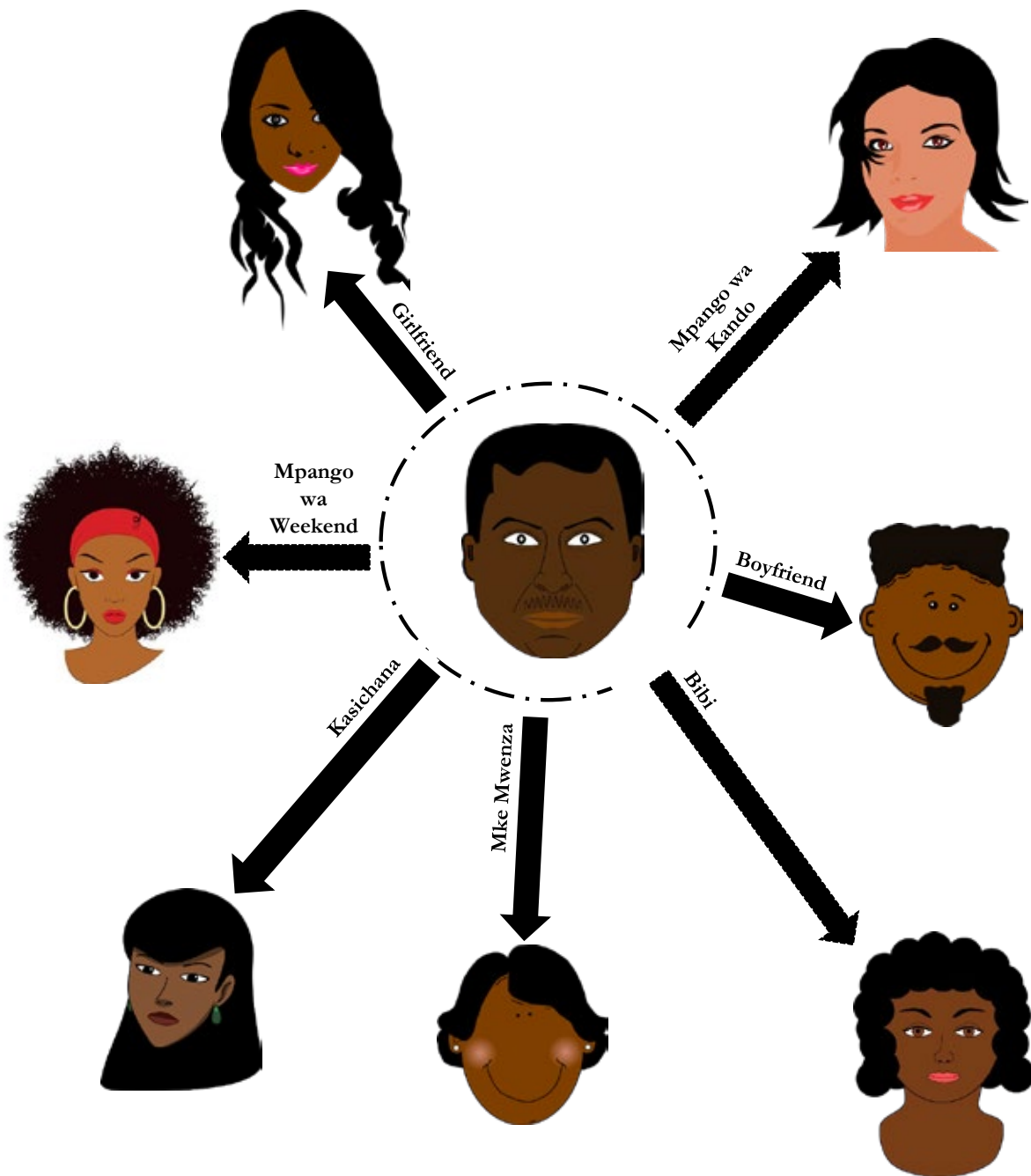
After acknowledging these factors, HTS providers will need to understand that if nothing is done, then the HIV epidemic will not be controlled. As HTS providers, they play a pivotal role in identifying undiagnosed HIV-positive people, people at risk of being infected with HIV, and linking everyone to prevention services.

Additionally, HIV/HTS programs need to invest in building the counseling skills of HTS providers so they can navigate the defensive barriers erected by index clients. Programs are encouraged to use different capacity-building strategies such as a three-day training, role-plays, peer-to-peer mentorship, preceptorship, and learning visits.

HTS providers need to also normalize discussion of sexual relationships in their communities. To do this, HTS providers need to give examples of sexual relationships that exist in the community and the reasons driving such relationships. Country programs can also develop pictorial diagrams like the one below to help normalize the discussion of sexual relationships.



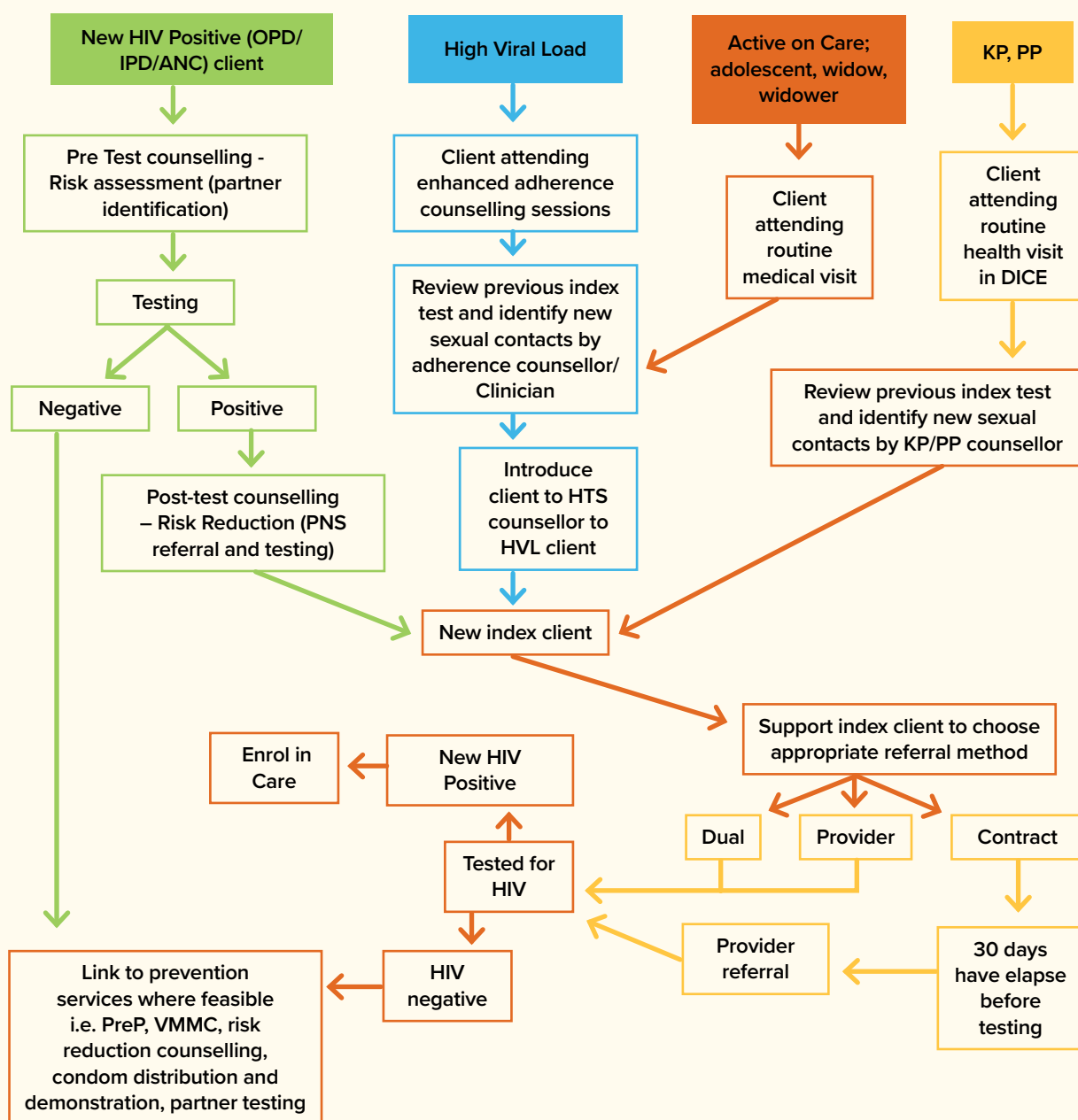
Adopted from ICAP program in Western Kenya



Adopted from ICAP program in Western Kenya

Lastly, elicitation of sexual contacts should not be a one-off event. Elicitation is a process that should take several weeks or months. On the first day, an index client may disclose one or two sexual contacts; however, the number of sexual contacts elicited may increase with continuous discussion with the client. Programs should encourage HTS providers to maintain a therapeutic relationship with index clients for up to six months. As clients come for their monthly ART refills, HTS providers should make a point of meeting them, strengthening adherence messages, and inquiring if there are additional sexual contacts the client wishes to list. A therapeutic relationship between an index client and an HTS provider helps soften defensive barriers erected by index clients and allows for the elicitation of more sexual contacts.

PNS IMPLEMENTATION MODEL—EGPAF



How to Conduct Elicitation of Sexual Contacts from Newly-Positive Clients

This guidance applies to all clients who are tested in outpatient departments (OPD), inpatient departments (IPD), outreach, drop-in centers (DICE), maternal and child health (MCH), and comprehensive care clinic (CCC). These clients are usually individuals with a negative or unknown HIV status. All clients receiving HTS in departments should be treated as potential index clients and therefore, quality-counseling services should be offered with an aim of eliciting sexual contacts.

During pretest counseling sessions, aPNS will be introduced jointly with the risk assessment. **The steps below describe the risk assessment process:**

- Step 1:** Explore with the client modes of HIV transmission (let the client mention modes of HIV transmission and fill in the gaps later)

- Step 2:** Explore the risks the client has engaged in that might have exposed them to HIV (e.g. “when we test you, you will either be positive or negative. Supposing you are positive, which risks have you engaged in that might have exposed you to HIV”)
- Step 3:** Some clients will deny engaging in any risky behavior, therefore, providers should use counseling skills to break down barriers
- Step 4:** The information acquired during risk assessment will be used during risk reduction counseling, including index testing.

Please note that during risk exploration, avoid asking leading questions that will hinder a client’s willingness to be forthcoming. For example, asking a client if they are married, have a wife or husband, will limit the number of sexual contacts the client lists.

The information gathered during pretest counseling will then be used by the provider when conducting risk reduction.

These steps below describe risk reduction counseling:

- Step 1:** Confirm the client has understood what an HIV-positive result means
- Step 2:** Discuss with the client the importance of starting treatment immediately and the benefits of ART to them and their family
- Step 3:** Remind the client of the exposure to risk they shared during pretest counseling (e.g., “In our earlier discussion, you had mentioned that you have XX number of sexual partners”)
- Step 4:** Seek the client’s approval to contact their sexual contacts for an HIV test (e.g., “In our earlier discussion, you had mentioned you have XX number of sexual partners. Now that you are going to benefit from ART, we must work together to ensure your contacts also receive access to testing and ART. If they are negative, you get a chance to support their health and sex life by helping them utilize prevention services. Are you willing to work together to test your contacts?”)
- Step 5:** Conduct intimate partner violence (IPV) screening for each sexual contact listed
- Step 6:** Discuss the preferred contact referral method with the index client (e.g., “How can we get [contact] to test for HIV?)
- Step 7:** Document in the aPNS register

Module 3:

Referral, Tracking, and Testing of Elicited Contacts

There should be an agreement between the HTS provider and the index client regarding the appropriate referral method used to reach each contact elicited. This agreement should be in place before the client leaves the counseling/elicitation room. Providers should ensure the preferred referral method and the date the elicited contact will be contacted are documented in the aPNS/index testing register before terminating the counseling/elicitation session. For successful implementation of aPNS/index testing, HTS providers should consider reaching and testing the elicited contacts within 30 days. Programs should also procure airtime for communication and reimburse transport costs incurred while tracking the contacts for testing to ensure HTS providers can effectively track and test contacts.

There are four referral methods for PNS including:

- **Contract referral:** Index clients commit to directing their contacts to HTS within a specified period. When that period elapses, the HCW and the index client will agree on the next cause of action, which may include provider referral
- **Dual referral:** HTS provider and index client agree to collaborate on directing the elicited contact to take up HTS within a specified period
- **Provider referral:** The index client permits the HTS provider to track and test elicited contacts. The HTS provider will therefore develop innovative scripts based on the profile of the contact elicited that will enable them to reach the contact with an HIV test
- **Client referral:** Index clients commit to directing their contacts to HTS at their own time. Client referral differs from contract referral in regard to the time period.

How to Use the Provider Referral Method to Reach Sexual Contacts With an HIV Test

As much as possible, providers should understand the sexual contacts they want to reach. The index client should help providers profile sexual contacts so providers have information regarding, where the sexual contacts live, work, socialize; who they are; how they react to strange phone calls and bad news; when they are free/available; what makes them happy; etc. Based on the sexual contact's profile, the HTS provider can decide to either call the sexual contact or visit them in-person at home, their place of work, a social place in the community, etc.

Phone Call

Based on the sexual contacts' profile and what the contact would be the most receptive to, the HTS provider may call the contact and introduce themselves as either a service provider, an acquaintance to a common friend, a client, a person in need of their help, etc. During the call, the HTS provider should assess whether it is appropriate and feasible to invite the contact to the facility for HTS or whether to arrange for a meeting outside the facility.

In-person Visits

Based on the sexual contact's profile, the HTS provider may go directly to the sexual contact and introduce HTS or they may employ the one-by-two testing strategy.

When the HTS provider decides to go directly to the sexual contacts, they may introduce themselves as a service provider, an acquaintance to a common friend, a client, a person in need of their help, etc., depending on the sexual contact's profile. During the visit, the HTS provider should assess the environment to determine if it is appropriate to introduce HTS. If it is not appropriate, the HTS provider can excuse themselves and try to reach out at a different time.

In the one-by-two strategy, the counselor will aim to test the entire household while still targeting the sexual contact that was elicited. To avoid stigmatization of that household, the HTS provider will test two other households.

REFERENCE

Brown, J. M., & Miller, W. R. (1993). Impact of motivational interviewing on participation and outcome in residential alcoholism treatment. *Psychology of Addictive Behaviors*, 7(4). 211-218.

Feltham, C. (1995). *What is Counseling?* London: Sage

Feltham, C. (1999). *Understanding the counseling relationship*. London Sage.

Hammond, D.C., Hepworth, D.H & Smith, V.G. (2002). *Improving Therapeutic Communication: A guide for developing Effective Techniques*, 2nd Ed. New York: Jossey-Bass.

MacDougall, C. (2002). Roger's person-centered approach: consideration for use in multicultural counseling, *Journal of Humanistic Psychology*, 42, 48-65.

McLeod, J. (2009). *An Introduction to Counseling (Fourth Edition)*. McGraw-Hill, England.

Miller, W. R. (1994). Motivational interviewing: III. On the ethics of motivational intervention. *Behavioral and Cognitive Psychotherapy*, 22. 111-123.

Miller, W. R. (1995). The ethics of motivational interviewing revisited. *Behavioral and Cognitive Psychotherapy*, 23, 345-348.

Miller, W. R. (1996). Motivational interviewing: Research, practice, and puzzles. *Addictive Behaviors*, 21 (6). 835-842.

Miller, W. R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York: Guilford Press.

Miller, W. R., & Rose, G. S. (2009). Toward a theory of motivational interviewing. *American Psychologist*, 64(6)