Trainer's Guide

Family Approach: Index Case Screening

May 2021

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Acronyms and Abbreviations

AERS : The welcoming approach, encourage, watch, listen

ARV: Antiretroviral

VCT: Voluntary Counselling and Testing

CTA : Ambulatory Treatment Center

DHAPP: Department of Defense HIV/AIDS Prevention *Program*

STI : Sexually Transmitted Infections

MER: *Monitoring*, Evaluation *and Reporting*

WHO: World Health Organization

PEP: Post-exposure prophylaxis, normally taken after a blood exposure accident

UNAIDS: Joint United Nations Programme on HIV/AIDS

FP: Family Planning

PMLS: Military AIDS Control Program

PNLIST: National Program for the Control of Sexually Transmitted Infections and HIV/AIDS

PrEP: Pre-exposure prophylaxis, taken to prevent infection in high-risk populations

PMTCT: Prevention of Mother-to-Child Transmission of HIV

PLHIV: Person Living with HIV

AIDS: Acquired Immunodeficiency Syndrome

SMI : Maternal and Child Health

SOP: Standard Operating Procedures

ART/V: Antiretroviral treatment/therapy

TB: Tuberculosis

GBV: Gender-Based Violence

HIV: Human Immunodeficiency Virus

IPV: Intimate Partner Violence

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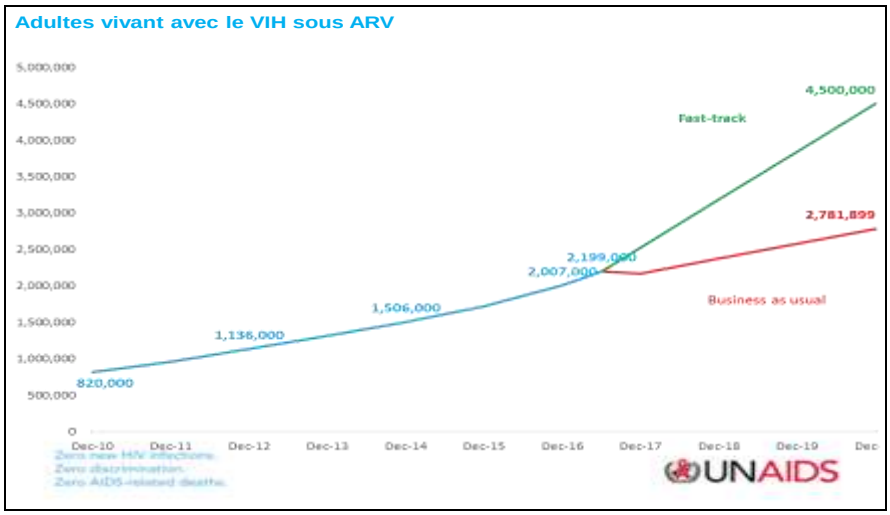
I. C ONTEXT AND RATIONALE

HIV/AIDS is a public health priority in Gabon with a national prevalence of 4.1% (EDSG, 2012) and 51,000 PLWHA (National Report on HIV/AIDS Response, SPECTRUM estimate, 2019).[2] The situation is alarming among adults, where 1,200 new infections were reported in the same year, including 810 among women. The country is committed to achieving the global goals (3X95) by aiming for the elimination of HIV by 2030 through its National Program for the Fight against Sexually Transmitted Infections and HIV/AIDS (PNLIST).

Indeed, the UNAIDS 2019 report shows that remarkable progress has been made toward the 90-90-90 targets: More than two-thirds of all people living with HIV-about 70% [51-84%]-knew their HIV status in 2016. Of these, 77% [57- >89%] had access to antiretroviral treatment and 82% [60- >89%] of them had suppressed their viral load.

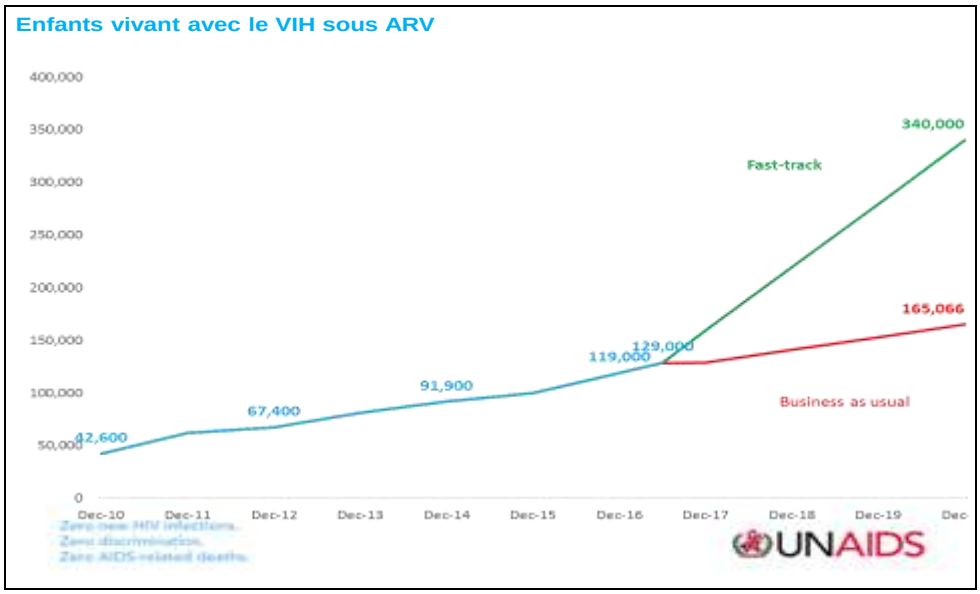
Despite this progress, UNAIDS projections show that if the same approach to testing and treatment is continued, the targets will not be met (Chart 1below).

Chart 1 UNAIDS Projection - Adult ARV Treatment Access with and without Accelerated Efforts



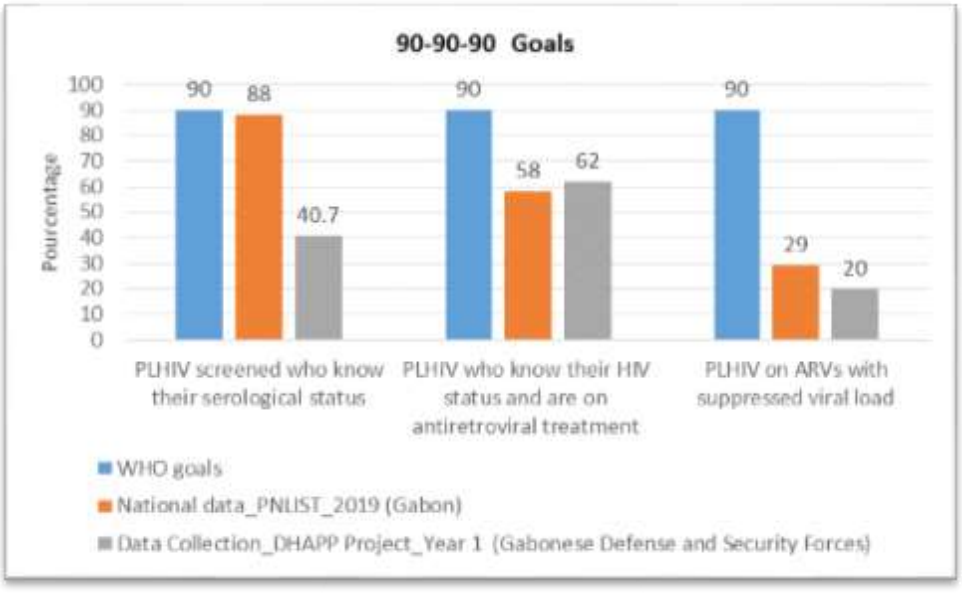
[2] The prevalence is twice as high among women (5.8%) as among men (2.2%).

Chart 2 UNAIDS Projection - Access to ARV treatment for children with and without accelerated efforts



The performance of the Military HIV/AIDS Program (MHAPP) in achieving the 3X90 remains weak. Indeed, information collected during the first fiscal year of the DHAPP project (FY2020) reveals 40% for the first 90, i.e., 60% of PLHIV in the military are unaware of their status and therefore do not have access to ARV treatment; in addition, 80% of those on treatment do not have viral load suppression. However, it is important to specify that the data from this cascade only concern the military health facilities in Libreville and did not include soldiers from the interior of the country and those followed up in public health facilities and others.

Chart 3PMLS 3X90 Performance - 2019-2020 (grey bars)



The PMLS has therefore identified screening of index cases as an appropriate strategy to increase the first 90 and accelerate the achievement of the first 95, thereby improving access to ARV treatment for women, children and key populations. The implementation of this strategy requires a differentiated care approach. It is therefore with this vision that a memorandum of understanding was signed by the stakeholders, namely: MCDI, the Military Health Service (MHS) and the Military HIV/AIDS Program (MHAP) in 2019.

In addition to the capital city of Libreville, where most of the Defense and Security Forces are based, three major military establishments in the interior of the country (in Franceville, Mouila and Port-Gentil) are involved in this project.

We will gradually implement the screening strategy for index cases in the military sites where PLWHIV are treated (adults, children and adolescents, GBV survivors) and PMTCT; this concerns the following sitesOmar Bongo Ondimba Army Training Hospital (HIAOBO), Akanda Army Training Hospital (HIAA), Louembé Infirmary-Hospital (IHL), SMI Ntchoréré, SMI Gros-Bouquet, SMI Toulekima, Mouila Garrison Infirmary, Port-Gentil Garrison Infirmary, Franceville Garrison Infirmary, SMI Garde Républicaine and the Peacekeeping Training Center. This activity is based on cascade training with the training of trainers and then health agents.

II. O BJECTIVES

General Objective: To familiarize PMLS actors with the implementation of Index Case Screening

2.1. Learning Objectives

- Understanding the importance of "first 95" HIV testing;
- Properly perform screening and *counseling;*
- Know the new methods of prevention;
- Respecting the rights of people living with HIV (PLHIV);
- Prevent and control infections through proper handling of medical waste;
- Understand the elements of a comprehensive index case screening approach;
- Create an environment conducive to index case detection and ensure confidentiality;
- Discover how index case screening can be integrated with other referral options to optimize case detection;
- Develop/adapt specific service steps and customer flows;
- Determine the working tools to support index testing in the Gabonese context;
- To provide care for victims of sexual violence and other survivors of gender-based violence (GBV);
- Tailor critical messages to introduce and engage customers in index testing;
- Propose an implementation plan for index case screening.

III. V UE OF THE TRAINING

3.1. Methodology

To achieve the expected objectives, a 5-day workshop that brings together health professionals (doctors, nurses, midwives, counselors and laboratory technicians from the sites represented) involved in the care of PLWHIV, proposes to observe the following steps

The workshop will consist of 15 sessions including plenary sessions, group work, role plays and a planning exercise.

The first two days are devoted to the reminders of international commitments (3X95) for the elimination of HIV/AIDS by 2030, the situational analysis of the fight against AIDS in Gabon, particularly in the military health services. Particular emphasis will be placed on the organization of testing services and the provision of care and support services for PLWHA, PMTCT and pediatric care (testing, psycho-social support, role of counselors and management of ARV drugs).
From the third day, the definition of the concepts of index case and contact case will be introduced, allowing the experiences of other countries to show the evidence. The group work will lead to reflect on the ethical issues related to the screening of index cases and to discuss the issues of confidentiality, security, stigma and legal considerations.

On Day 4 and Day 5, the group activity will give participants the opportunity to reflect on the specific steps of index case testing and identify skills and interventions that may be needed; it will also be an opportunity to reflect on how to reach community contact cases. PHAs who have been invited from the community will lead a roundtable discussion, sharing their experiences with index case testing. Participants will have the opportunity to ask questions and learn from the clients' experiences.

Participants will work in groups to review existing messages in helping clients refer their partners, and/or develop/adapt/revise messages for the local context. Messages will include face-to-face and online modalities to introduce the concept of notification and referral to partners. Participants will learn about the minimum requirements that must be in place to ensure the safety and security of clients from key populations when asking questions about gender-based violence.

Participants will collaborate in plenary (or small groups if appropriate) to develop an index case detection action plan that outlines specific activities.

3.2. Expected results

At the end of the five days, the following results will be obtained:

a) Participants will have a better understanding of international commitments;
b) Participants will have improved their knowledge of the index case screening strategy;
c) Strategies will be proposed for identifying contact cases;
d) An action plan will be proposed by the trainers for the implementation of index case screening: participants will propose a differentiated care approach for the management of PLWHA;
e) Participants will strengthen the referral system for testing and care of PLWHIV.

3.3. Target audience

This training is intended for doctors, nurses, midwives, psychologists, social workers, HIV/AIDS counselors, community health workers and NGOs involved in the fight against AIDS.

IV. OVERVIEW OF SESSIONS

DAY 1		
8 hrs - 8:15 am	• Welcome of the participants	• Stakeholders / Facilitators
8:15 - 9:15 a.m.	• Official Opening/Welcome • Presentation of the PMLS • MCDI Presentation and Training Objectives (definition of index case screening) • Introduction of trainers and participants • Pre-test (30 min)	• Master of Ceremonies • PMLS (Med. Col ANGWE) • MCDI (Mr. NKALA Luc-Armel)
9:15 - 9:30 a.m. 9:30am - 10:00am	**Session I:** • Reminder of the International Commitments to Eliminate AIDS (3X95) by 2030 • Situational analysis of AIDS in Gabon specificity of PMLS (Evolution towards 3X95)	• Col ANGWE Med. • LTCol ADA NKAH
10:00am- 10:15am	COFFEE BREAK	

10:15am - 12:00pm	**Session II**: Provision of screening services • Presentation of existing national standards on HIV/AIDS prevention and testing (30 min) • Questions and answers (15 min) • Voluntary screening service (15 min) • Confidentiality of results (10 minutes) • *Counseling* and psychosocial follow-up (Pre- and post-screening) (20 min) • GBV (30 min)	• Col. MANGOUKA • Col. MANGOUKA • Col. MANGOUKA
12h:00 -13h:00	BREAK - LUNCH	
1:00 pm - 2:00 pm 2:00 - 2:30 pm	**Session II (continued)**: • Operation of the PMLS screening structures • PMLS links with community-based organizations • Questions - Answers	• LTCol ADA NKAH
14:30-15:00	• Summary of the day and closing	
DAY 2		
9:00-9:15 am 9:15am - 9:45am 9:45am - 10:10am 10:10- 10:30 a.m.	• Reminder J1 **Session III**: Provision of services for the care of PLWHIV • Organization of adult care (care structures, antiretroviral treatment protocol, delegation of tasks) • Care for victims of sexual and other gender-based violence • Prevention of Mother-to-Child Transmission Service Offerings	• Col. MANGOUKA • Col. MANGOUKA • Col. MANGOUKA • Col. MANGOUKA
10:30-10:45 am	COFFEE BREAK	
10:45 am - 11:15 am 11:15 am - 12:00 pm	• Pediatric management (including gateways) • Management of key populations - Self-testing practice	• Col. MANGOUKA • Mr. NKALA Luc Armel

12:00 pm - 1:00	LUNCH BREAK	
1:00 pm - 2:00 pm 2:00 pm - 2:45 pm	**Session IV**: Introduction to Index Case Screening - Definition of Concepts **Session V**: Screening of index cases in Gabon - local perspectives	• Mr. NKALA Luc Armel • Col. MANGOUKA
2:45 - 3:00 pm	• Synthesis of the day and closing	
DAY 3		
9:00 am - 9:15 am 9:15-10:15 am	• Reminders J2 **Session VI**: Stages of index case detection • Group work	• Col. MANGOUKA
10:15 - 10:30 a.m.	COFFEE BREAK	
10:30 am - 11:00 am 11h : 00 - 12h : 00	**Session VI**: Stages of index case detection (continued) • Group work **Session VII**: Benefits and Barriers of Index Case Screening • Group work - Brainstorming	• Col. MANGOUKA • Mr. NKALA Luc Armel
12:00 pm - 1:00	LUNCH BREAK	
1:00 pm - 2:30 pm	**Session VII**: Benefits and barriers to index case screening (continued)	• Mr. NKALA Luc Armel
14h:30-15h:00	• Synthesis of the day and closing	
DAY 4		

9:15am - 9:30am	Reminders J3	
9:30am - 10:15am	**Session VIII**: Follow-up tools for index case detection • HTS_INDEX indicator • Monitoring and Evaluation Data Collection Tools • Group work (Exercises)	• Mr. NKALA Luc-Armel • Mr. NKALA Luc-Armel
10:15-10:30 am	COFFEE BREAK	
10:30 a.m. - 12:00 p.m.	**Session IX:** Link and Reference - Sharing Status • Algorithm for notification of sexual partners of the index patient • Group work	• Col. MANGOUKA • Col. MANGOUKA
12:00 - 13:00	LUNCH BREAK	
1:00 pm - 2:30 pm	**Session X**: Case Study - Group Work	• Col. MANGOUKA / Med. • LTCol ADA NKAH / • Mr. NKALA Luc Armel
14:30 - 15:00	• Synthesis and closing	
1:00 - 2:30 pm	**Session XI**: Case Study - Group Work (continued)	• Col. MANGOUKA / Med. • Col ADA NKAH / • Mr. NKALA Luc Armel
14:30 - 15:00	Summary of the day - Closing	
DAY 5		
9:00 am - 9:15 am	• Reminders J4	
9:15-9:45 am	• Post-test	• PMLS/MCDI
9:00 am - 10:15 am	• **Session XII**: Role playing with a client, a community and a service provider	• NGO representatives
10:15 am - 10:30	COFFEE BREAK	
10:30am - 11:00am 11:00am -	**Session XIII**: Developing Messages **Session XIV:** Developing an Action Plan	• Col. MANGOUKA • Col ADA NKAH / • Mr. NKALA Luc Armel
12h:00 -13h:00	LUNCH BREAK	

1:00 - 2:00 pm	**Session XIV**: Developing an Action Plan	• Col. MANGOUKA • Col ADA NKAH / • Mr. NKALA Luc Armel
2:00 pm - 2:30 pm	• Restitution of the action plan	• PMLS / MCDI
14 h30: - 15 :00	• Summary of the workshop • Recommendations and closing	• Col. MANGOUKA • PMLS / MCDI

V. SESSIONS I, II

5.1. Sessions I and II relate to the reminder of international commitments

The first session allows us to understand the challenges of the fight against AIDS in Gabon and internationally. This is based on the reminder of international commitments, particularly access to testing and ARV treatment services. These presentations will highlight the progress towards the 3X90 and 3X95 targets.

They will show that progress can be made towards achieving the targets through the "Test and Treat" and index case screening strategies as outlined in the UNAIDS 2019 report.

They will also describe the service offer in terms of screening, but especially the strategies adopted by Gabon in the management guidelines in terms of screening and ARV treatment in order to increase access to treatment. The PMLS is committed to this approach by adopting, in addition to the "Test and Treat" strategy, the screening of index cases to improve the 90-90-90 and move towards the 95-95-95.

This requires the organization of the service offer (screening strategies, management of adults, pediatric management and management of GBV survivors).

Specifically, the status of military health services in relation to the 3X90 and the organization of screening services and their relationship to the community will be presented. These presentations will be based on the SABERS report which indicates the characteristics of the military's target population by:

- An estimated HIV prevalence of 2.1%;
- An estimated 462 PHAs;
- The sexual multi-partnership, 4-16 partners;
- Low consistent condom use (53.3%);
- A situation that is similar to sexual violence or soldiers (16.3% of men said this against 39.3% of women) had unwanted sexual relations during their enlistment in the army (24.7% said that his attacker was in the army; 63.2% reported that this perpetrator was in the chain of command at the time; 42.1% of perpetrators were of higher rank; 31.6% were of equal rank; 34% of participants did not know the HIV status of their

regular partner at the time of last sexual intercourse). In addition, 75.3% of participants did not know the HIV status of their casual partner;

- Stigma and discrimination against PLHIV: These results indicate that levels of stigma and discrimination against HIV-positive people in the community are generally low.

VI. SESSIONS III, IV, V

These sessions address the different aspects of the organization of care in Gabon and in particular within the Military Health Service. The aim is to present to the participants the organization of the care of PLWHIV adults, children and pregnant women (PMTCT).

The speakers will emphasize:

- Current testing strategies and treatment protocols, as well as ARV drug dispensing arrangements;
- Care for PLHIV in key populations and self-testing;
- TB screening for all PLWH and enrollment in TB preventive treatment for all PLWH;
- Referral links between the different services involved in the care

These sessions will introduce index case screening with the definition of concepts (family approach, index subject, contact cases) and an overview of index screening in Gabon.

6.1. Definition of concepts

a) **Family approach** (in the context of HIV activities): A set of values, attitudes and approaches used by health care professionals (medical or community-based) to bring the spouse and biological children to HIV testing for comprehensive care.

b) **The index case**: a newly diagnosed HIV-positive person and/or an HIV-positive person enrolled in an HIV treatment service

c) **Index case screening**: a voluntary process where counselors and/or caseworkers ask index cases to list all of their: (1) sexual partners or injection drug users in the past year, and (2) their biological children, in order to screen them for HIV

d) All index case screenings must meet the **5** This must be consensual, confidential, and include counseling, correct test results, and connection to treatment or prevention services.

- If the index case agrees, each partner and child listed is: (1) contacted, (2) kept informed that he or she may have been exposed to HIV, and (3) voluntarily tested for HIV.

e) **Benefits of Exposure Screening**

Exposed Subject Screening: Exposed subject screening has benefits for the index subject, partners, and the community.

It allows to:

Subject index	Partners/ children of the index subject	The community
Provide support to PLHIV to help them test their partner(s) and child(ren) for HIV Remove in case of index The responsibility to notify partners of their exposure	Maximize the number of partners/children aware of their exposure to HIV and children to be screened Access ARV treatment and reduce HIV-related illness and mortality	An effective case-finding strategy with better performance than other strategies in reducing transmission rates through early diagnosis and treatment of HIV-positive partners

f) **Screening of biological children of index cases**

This intervention is essential to provide care for HIV-positive children because:

- Without treatment, most children living with HIV will die before the age of 5.
- Initiation of ART after diagnosis can reduce the mortality rate of HIV-infected infants by up to 75%.

It is therefore extremely important to identify children who have been exposed to HIV during pregnancy, delivery or breastfeeding and to ensure that these children are tested for HIV.

Index cases meeting the following criteria should be prioritized for screening of their biological children:

- All HIV-positive women with biological children under 18 (e.g., PMTCT/ANC, ART entry points)
- HIV-positive men who report that the child's biological mother is: HIV-positive, deceased, or whose HIV status is unknown
- HIV-positive infants with biological siblings under 18 years of age with unknown HIV status

6.2. Case Index Screening Approach (Traditional vs. Assisted Approach)

a) **Passive notification**: the index subject takes responsibility and encourages the partner(s) to be tested, usually by using an invitation letter or notification slip. Partners may take the opportunity to disclose their HIV status to their partner(s).

Assisted approaches :

b) **Appointment-based notification:** The index subject enters into a "contract" with the counselor and/or health service provider, whereby he or she agrees to notify his or her partner(s) by offering to test within a specified time frame. This often includes disclosure. If the partner(s) do not get tested within this time

period, counselors/providers can contact the partner(s) directly, informing them that they may have been exposed to HIV.

Counselors/providers offer voluntary testing to the partner(s) while maintaining the confidentiality of the index subject.

c) **Provider notification**: With the consent of the HIV-positive index subject, the counselor/provider directly contacts the index subject's partner(s), informs them that they have been exposed to HIV, and offers them voluntary testing while maintaining the confidentiality of the index client.

d) **Joint notification**: A trained provider sits down with the HIV-positive client and his or her partner(s) to provide support when the client discloses his or her HIV status. The provider also offers voluntary testing to the

6.3. Country experiences on index screening

Please see Appendix 3 to learn more about the experiences in Malawi, Zimbabwe, Kenya, and Côte d'Ivoire. You can present them in PowerPoint or distribute the case studies to small groups to read and present to the rest of the training group.

6.4. Confidentiality

Confidentiality is defined as the protection of personal information. It is essential.

- You need to assure your client that what is said will be confidential (that it will remain a secret between you and the client) because unless you can do this, the client is unlikely to open up to you;
- It is our duty to never reveal information that clients entrust to us without their consent;
- Confidentiality of the index case and all designated partners and children must be maintained at all times;
- The identity of the index client must never be revealed to the partner(s);
- The status of the index subject should not be shared with the child(ren);
- And no partner information should be returned to the index case (unless explicit consent is obtained from all parties).

Personal information is kept confidential; it is:

- Information that would allow others to identify the index subject
- Their name, date of birth, address, telephone number, etc.
- Their HIV diagnosis and treatment plan
- Anything they said during their interview and/or clinical examination

Confidentiality of patient information is maintained in :

- **A secure physical environment**: Information and data related to partner services should be kept in a secure physical environment (e.g., locked filing cabinets).

- **A secure technical environment**: Electronic data for partner services must be maintained in a technically secure environment, with the amount of data stored and authorized access by individuals kept to a minimum (e.g., password protected computers).
- **Individual responsibility:** Service personnel at the individual partner authorized to access case-specific information and data are responsible for protecting it (e.g., by having staff sign patient confidentiality agreements).

In the interest of the patient confidentiality may be :

- **Shared**

a) Sometimes two organizations, such as a health care facility and a community delivery partner, may share a client's personal information in order to provide care.
b) For example, the facility may interview the index case to obtain the name of the partner. The facility then shares the partner's name with the community-based organization that visits the partner's home and provides HIV testing services.
c) Both the facility and the community partner must "share confidentiality" of client information.
d) They should have a data sharing agreement that includes a description of how they will maintain the confidentiality of customer information.

- **Raped** (examples)

a) Your client, Alice, names two partners "John" and "Isaac". When you contact "Isaac," he demands to know which of his partners gave his name. You say, "By law, I am not allowed to provide that information."

- You are counseling Thomas, *who has just learned that he is infected with HIV. Thomas has agreed to receive counseling and names Sarah as his partner. You recognize Sarah's description and recall that she has already been tested for HIV. You tell the patient not to worry; this partner "has already been taken care of. Is this a violation?*

When are these services to be provided?

- Present the concepts and benefits of basic partner/family screening services during post-counseling information for the index case OR during PMTCT or ART visits
- Partner screening is not a one-time event but should be offered continuously:
- Immediately after diagnosis of HIV
- At least once a year as part of HIV treatment services
- After a change in relationship status
- Familial screening tests are intended for biological children of index subjects with "unknown" status

- Providing HIV-positive clients with incomplete documentation of family tree status
- Children without current or new HIV exposure do not need to be re-screened, if status is known.
- ***Victoria,*** *a pregnant woman in the PMTCT program, gives you the name of her partner. You test him at home and find that he is HIV-positive. The next time Victoria comes in for her prenatal appointment, she asks you if you tested her partner and what the result was. You remind her of the strict confidentiality policies at the clinic and tell her that you cannot reveal her partner's HIV status.*
- **You are trying to contact a partner** of an index client. You reach the person's voicemail and leave a message that says, "My name is Amy from Kanyama Clinic and I have important and urgent health information to discuss with you." You include your contact information and close by asking her to contact you as soon as possible.

6.5. The procedures

The implementation of index screening requires appropriate organization and measures:

a) **Exposure testing services** require trained staff and resources to conduct index patient interviews, partner and biological child notification, testing, and linkage; the human and financial costs of partner testing services must be considered to ensure that they are adequately resourced.

b) **Appropriate** security and confidentiality **procedures** should be in place prior to initiating testing of partners and family members to protect the safety of the index subject, all partners/children, and providers of testing of exposed subjects.

c) As with all HIV testing services, exposed subject services should create **strong notification links** with:
- HIV treatment programs for HIV-positive people.
- **HIV prevention services (**including condoms, male circumcision, and pre-exposure prophylaxis) for HIV-negative people**.**

Who are the index cases and HIV-exposed individuals?

HIV-positive adults (men and women) and adolescents are index cases.

Their exhibited topics are:

- All sexual or injection drug partners in the past year
- All of their biological children (0-18 years) if the mother is HIV-positive OR the father is HIV-positive and reports that the child's mother is HIV-positive, deceased, or her status is unknown, OR The biological brother is HIV-positive

Procedures for index case screening of exposed individuals are:

- Exposed subject identification can be performed by **an HIV testing services counselor**, **nurse or nurse's assistant, liaison coordinator, patient navigator**, or **case manager;** these individuals should be trained

in how to conduct exposed subject testing services where exposed subject testing per index case should take place; these are:

- All facility-based HIV testing service delivery points (e.g., VCT, ANC, TB, etc.);
- All health facilities focused on HIV treatment (e.g., PMTCT, ART, etc.);
- Community-based HIV testing programs (e.g., mobile, home, place of worship);

6.6. Other considerations

In addition to the above, consider the following:

a. **To improve access to care,** partners and biological children of index subjects should have the opportunity to come to the health center for an HIV test or see a counselor/health worker who will screen the partner and children in the community (through **home or mobile testing**).

b. **To address issues of stigma** and to avoid breaching the confidentiality of the index subject, consider offering testing to all households surrounding the client's household. Inform these households that you are offering home testing because of the high burden of HIV in the community. Remember: For follow-up assessment **report only screenings of exposed partners or** "exposed" **biological children** and other screenings returning under "other community."

c. **In high-prevalence areas**, you may want to consider offering notification services to HIV-negative pregnant and lactating women because of the high risk of mother-to-child transmission associated with HIV infection. At-risk couples should continue to receive the full range of care offered to all participants in antenatal care (ANC).

d. When a partner is HIV-positive, he or she becomes an index case and the process begins again.

6.7. Resources and Implementation

a. **Exposure testing services** require trained staff and resources to conduct index patient interviews, partner and biological child notification, testing, and linkage; the human and financial costs of partner testing services must be considered to ensure that they are adequately resourced.

b. **Appropriate** security and confidentiality **procedures** should be in place prior to initiating testing of partners and family members to protect the safety of the index subject, all partners/children, and providers of testing of exposed subjects.

c. As with all HIV testing services, exposed subject services should create strong notification links with:

d. **HIV treatment programs** for HIV-positive people.

e. **HIV prevention services (**including condoms, male circumcision, and pre-exposure prophylaxis) for HIV-negative people**.**

6.8. Disclosure and Partner Testing

a. Partner notification does not require the index case to disclose their HIV status to the partner(s);
b. In cases where the index client does not immediately wish to disclose their HIV status to the partner;
c. The provider's communication with the partner of an index case will be done anonymously while maintaining the identity of the index case;
d. The provider notifies the partner that he or she may have been exposed to HIV and offers an HIV test;
e. Community health workers direct their services to the households or neighborhoods where the partners live.

6.9. How to prioritize screening services for exposed individuals

Sometimes we may have more index subjects to the point where we have to work with our existing staff to find them; Suggestions for prioritizing partners/children to find first:

a. The index case is acutely infected and/or has a high viral load;
b. The index case or the partner is pregnant or nursing;
c. The index case or the partner is a teenager;
d. Large age difference between partners (especially for adolescent girls);
e. Index case indicates high-risk sexual behavior:
    - Recent unprotected sex with a partner;
    - Large number of sexual partners (e.g., biological children/FSW partners).

VII. SESSIONSVI, VII, VIII, IX

These sessions are divided into 4 parts:

I- Stages of index screening,
II- Communication
III- Benefits and barriers of index screening
IV- Follow-up tools for index case detection (data collection, monitoring and evaluation)

7.1. Steps in case detection Index

Step 1: Present the need for screening of individuals exposed to the index case

The provider informs the index client that:

All information will be kept confidential; This means that:

- **Partners** will not know the name of the index client or the results of the test;
- **The index client** will not be informed of the results of the HIV test of his/her partner(s) or if his/her partner(s) has (have) actually been tested for HIV;
- Testing services and results for children will not be shared with others;
- **You will not contact** the partner(s) without their permission;
- **They will continue to receive** the same level of care at this health care facility, regardless of whether they choose to participate in Exposure Screening. Answer any questions the index client may have and obtain verbal consent to proceed. Use the index client information sheet to record contact information for the index client.

Step 2: Obtain a list of sexual partners/people with whom you share needles.

During this stage you should:

a) Ask the index client to give you the names and contact information of all people with whom they have had sex in the past 12 months;
b) Begin by asking the index client to name his or her primary sexual partner. Then ask if there are any other partners with whom he or she can remember having sex in the past 12 months;
c) You can start by asking about the most recent sexual partner and work down (e.g., who was the last person you had sex with? Who was the person you had sex with before?) ;
d) Encourage the client to list the names and contact information of the primary partner(s), as well as casual partners, even if they have had sex only once;
e) If the client injects drugs, ask for the names and contact information of people with whom they have shared needles;
f) Use the Partner Identification Form to record all partner names (Appendix 1);
g) Complete a Partner Information Sheet for each designated partner;
h) Use this form to record partner contact information, filter the IPV, and establish a plan for how each partner will be contacted.

Step 3: Screening a victim of intimate partner violence

Our first duty as healthcare providers is to do **no harm**. To protect the safety of the index client, **partners who are at risk for IPV may be excluded from partner notification services**. Each designated partner must be screened for intimate partner violence using the three screening questions on the partner information sheet.

a) If the client answers "yes" to any of the screening questions, discuss further and assess the risk of harm to the client**. Use the LIVES approach** to provide front-line psychological support.

b) Screening of the index case's partner may be pursued unless you have good reason to believe that notification of the partner could result in physical harm to the index client.

c) If the security of the index customer cannot be assured, it may not be appropriate to contact this partner at this time.

Explore alternatives to partner notification with the index client. For example:

- Community-based screenings in the area where the partner lives;
- Couples screenings, where both partners learn their status together, and a counselor is available to help manage any potential tension;
- Notify the customer of VPI services, where available.

In the case of sexual violence, the index client must be treated with PEP kits that contain ARV treatment according to the national protocol, STI treatment and the morning-after pill (emergency contraception). This management takes place within 48 hours of the sexual violence.

In addition, psychological support is provided to the client as well as legal support if the client wishes.

Providers play an important role in screening for GBV because they are on the front line and can provide a "first line response" to victims of IPV. To do this, it is important that they are trained in these two requirements that start the IPV management process:

a) How to ask and answer questions about violence.

b) Provide front-line support using the LIVES approach.

Many clients do not understand why an HIV counselor or provider might want to talk about violence. Therefore, it is best for the provider to begin by explaining that he or she wants to ask about violence because he or she cares about the client's well-being and wants to help the client make a decision about whether to have index testing and which modality to use.

Sample script: As part of the index case screening, I would like to ask if each of the people you named has ever harmed you in any way. This is important because it will help us decide together if the screening process can be safe. It is also important because I care about your well-being and can help you find services.

After giving an explanation, the provider can ask questions about IPV. When providers ask questions about violence, it is important **to use questions that have been standardized**. This ensures that each provider does not rely on his or her own interpretation of violence and that a broad spectrum of violence is explored.

These questions are:

1- Has [partner's name] ever bullied you, insulted you, threatened to hurt you, or tried to control you (for example, by not letting you leave the house)?
2- Has [partner's name] ever hit, kicked, slapped, or physically hurt you?
3- Has [partner's name] ever forced you to have sex or forced you to have sexual contact that you did not want?

These questions are generally used for cis-gender women. They are also useful for key populations, but do not take into account the unique forms of IPV they may experience. Consider adding questions, such as those on the right, or creating other relevant questions, based on the characteristics of IPV in your context.

For example:

1. *[For men who have sex with men, transgender women, sex workers]:* Has your partner ever insulted you or threatened to expose you?

2. *[For men who have sex with men and transgender women]:* Has your partner ever criticized your sexual performance, clothing, or asked you to act more masculine?

3. *[For transgender clients]*: Has your partner tried to control your transition process? *or* Has your partner ever told you that no one else would want to be with someone like you because you are transgender?

If someone answers **NO** to all three questions:

- Even if the provider suspects that a person is being abused, the provider must accept the client's response.
- The provider can let them know they are available if the client remembers an incident or if something happens in the future.
- Many people in health care settings do not expect to be asked about violence. They may not be ready to share this information. However, after thinking about it, they may be willing to come back and describe their experiences.

If someone answers **YES** to one or more questions:

- The provider should not disqualify them for the indexing test or start talking about another partner.
- Because the experience of IPV can influence treatment adherence, viral load, and overall well-being, disclosures of abuse should be responded to immediately with frontline support using LIVES.

How to provide front-line support using the LIVES approach

First line support is also considered psychological first aid. It can be easily remembered by using the acronym LIVES in English.

It is **important to remind the provider that there is a difference between counseling** and using the **LIVES** approach. The provider's role is simply to listen to the client to understand what he or she wants to do without trying to steer him or her toward a specific choice.

It is also important to remind participants that IPV is a complex and personal issue and that the provider's role is not to solve the client's problems. LIVES provides a platform in which the provider gives the client options and lets them know that they will support any choice they make.

To understand the LIVES approach, review each step with participants and practice the corresponding communication skills.

LIVES APPROACH		
STEP	**OBJECTIVE**	**COMMUNICATION SKILLS TO PRACTICE WITH PARTICIPANTS**
L :*Listen/* Écouter	Listening without judgment and with empathy gives the survivor a chance to share her experiences in a safe, private place with a caring person who wants to help. Remind participants that it can be difficult to talk about an abusive experience; making it clear that they are interested and empathetic can encourage a client to confide.	Practice active listening. Remind participants of the key points of good listening (such as being fully present, encouraging by asking open-ended questions) and poor listening (such as pressuring or judging the client).
I: *Inquire/* Enquire	Find out what is most important to the survivor. Respect their wishes and meet their needs.	Practice asking open-ended questions, summarizing, clarifying and reflecting the survivor's thoughts.
V: *Validate/* Valider	Let the survivor know that her feelings are normal, that it is safe to express them and that everyone has the right to live without violence.	Provide validation messages. Also include messages to avoid.
E: *Enhance/* Améliorer	Helps assess the survivor's situation and develop a plan for future safety. While the provider cannot guarantee the survivor's safety, they can try to help the survivor stay safer.	Practice asking questions about safety. If the client does not feel safe or is unsure of their safety, conduct a risk assessment. If it is determined that the

		client is at risk, explore safety strategies.
S: Support	This step recognizes that the provider is only an entry point to services and cannot meet all of the victim's needs. The goal of this step is to connect the victim with other resources to meet their medical, social, legal and justice needs, as these needs are usually beyond what can be provided in a health care facility.	Let participants know that they can also help the client identify and use their existing support networks by asking questions such as "Who has helped you in the past? Can they be helpful now?" Let participants know how the orientation process should work as described in the SOP that is being developed for this training.

Suggested practical exercises:

1- **Helping an IPV survivor develop a future safety plan**:

Let's say a client has just disclosed that her partner is abusive to her. While you are supporting her using the LIVES approach, she admits that she feels unsafe. You need to help her develop a safety plan. In pairs, with one person being the survivor and the other being the health worker, develop a safety plan together that considers the following categories: safe places to travel, child safety, transportation, things to take with you, financial issues, and support from available friends or family.

Take 3 minutes to develop this plan. When you are finished, reverse the roles. Once each person has played their role, discuss how you felt as a survivor and as a health worker.

2- **Screening for violence against women and formulating an intervention plan**

Here is a brief five-question questionnaire that you can ask a patient and, based on the answers, develop a safe and appropriate HIV disclosure plan for immediate, delayed, or mediated action, or decide with the woman that non-disclosure is the most prudent option. In pairs, one person in the woman's role and one person in the provider's role, review the questionnaire.

1- Does your partner know that you will be tested for HIV and that you will receive your test results? (Yes/No)
2- If you told him/her that you tested positive for HIV, do you think he/she would react positively? (Yes/No)
3- Are you afraid of how your partner will react if you tell him or her your HIV test results? (Yes/No)
4- Has your partner ever physically hurt you? (Yes/No)

5- Do you think your partner could physically harm you if you were tested for HIV and tested positive? (Yes/No)

Together, establish an appropriate communication plan for immediate, delayed, or mediated notification of action, or decide with the woman that non-disclosure is the most prudent option.

3- Scenarios for dealing with the risk of violence

Helping women find ways to negotiate safer sex is essential. In the following cases, discuss with a partner a plan you can develop to help a woman negotiate safer sex with her partner. The first scenario is provided as an example. Find out what a woman might say for the next four scenarios, and then add an example that you have encountered or imagine you might encounter, based on your experience.

If a woman's partner says...	**She can say...**
If you don't have sex with me without a condom, I will force you	A respectable man cannot force his partner to have sex. I respect you and you should respect me. Let's talk about this calmly
Because we are married, I have the right to have sex with you without a condom	
You want to use a condom? You are cheating on me!	
I paid the dowry for you. You must have sex with me. You owe it to me.	
You are already pregnant, so we don't need to use a condom anymore	
Write your own example here	

Step 4: Determine the partner screening plan

This step consists of:

a) Review the 4 partner notification options using the "Options for Referring Index Case Partners to Screening" card;

b) Document the chosen method of reporting for each partner listed on the Partner Information Sheet;

The options for referring the index case partners are:

Direct Referral = You tell your partner about your HIV status and encourage him or her to go to a health center for an HIV test.

Provider Referral = A counselor or other health care provider will call or visit your partner to offer an HIV test.

Contractual Reference = You and the consultant will work together to notify your partner. You will have 30 days to notify your partner, at which time the consultant will contact your partner.

Double Referral = The counselor/provider will talk with you and your partner. He/she will support you when you talk to your partner about your HIV status.

Step 5: Contact partners

If the client opts for the contractual reference, it is necessary to:

a) Follow the same steps as for the direct referral (by the customer) of partners;
b) Review the "Tips and Scripts for Talking to Your Partner about HIV Testing;
c) Ask the client to give the reference sheet to their partner(s);
d) Identify a time frame of 30 days from today's date and agree with the client that he/she will invite his/her partner(s) or bring his/her child(ren) for HIV testing before that date;
e) Note the date on the partner information sheet;
f) Remind the client that if their partner(s) do not come in for an HIV test by this date, you will need to call to get their permission to contact the partner(s) directly;
g) After 30 days, call the index client and verify that the partner(s) have been screened;
h) Otherwise, obtain client authorization to: 1) contact the partner(s) and follow the provider's referral methods.

If the client does not provide permission to contact their partner(s), note this result on the partner test results form.

If the index case chooses the double reference :

a) Identify where the client and their partner would like to meet with the provider: in the health care facility or at home?
b) If he/she prefers to do it in the establishment, set up an appointment for the client to come with his/her partner;
c) Give the invitation letter to the client to share with their partner, inviting them to the facility for health services;
d) If he/she prefers to do it at home, set up a time when you will visit the patient and his/her partner at home.

Step 6: Record the results of the screening services

a) It is important to keep a written record of the results of all partner screening attempts on a Partner Screening Services Results sheet.
b) Indicate the type of partner screening services, the date and method used when contact was attempted, and whether the partner was successfully contacted.

If the partner was contacted, indicate who notified the partner and the outcome of the partner's testing service (e.g., whether or not the partner was tested for HIV). If the partner was tested for HIV, indicate the result of the test. If the test is positive, indicate whether the partner has been put on ARVs.

Step 7: Provide appropriate services to HIV-concordant/different partners or work on disclosure support.

Appropriate services...

To the HIV-positive couple:

- ARV therapy and adherence counseling;
- PMTCT (if woman is HIV positive);
- Harm reduction counseling and condom promotion;
- STI Screening and Treatment;
- Family planning services, including preconception counseling

To the serodivergent couple:

- ART and adherence counseling for the HIV-positive partner;
- PrEP for the HIV-negative partner (until viral load suppression in the HIV-positive partner);
- Male circumcision (if the man is HIV negative) or PMTCT (if the woman is HIV positive);
- Repeat HIV test of negative partner;
- Harm reduction counseling and condom promotion;
- STI testing and treatment and family planning services, including preconception counseling.

Disclosure

Screening of biological children of the index case

Step 1.1: Present the need for screening of individuals exposed to the index case

Children: Inform the patient that there are three options for testing all biological children < 18 years of age with unknown biological status using the "HIV Testing Options for Biological Children:

- **At home** = A counselor or other health care provider will come to your home to meet with you and your child(ren), explain the need for HIV testing and test the child(ren) for HIV.
- **At the facility** = You bring your child(ren) to the center for HIV testing. The counselor/caregiver will sit down with you and your child(ren) to inform your child(ren) of the need to know their status and to have the child(ren) tested for HIV.

Contractual Reference = You will have 30 days to bring your child(ren) to the facility for screening. After this time, a community screening counselor will attempt to reach your child(ren) at home or in the community for their screening.

Step 1.2: Make a list of biological children

- Ask the index client to give you the names of all their biological children and list them on the "Biological Child Screening Results" sheet.
- If the index client is a child, complete the form for all siblings and biological parents of the child

Step 1.3: Determine the child screening plan

If the subject chooses screening within the facility:

a) Explain the benefits of screening children, even if they appear healthy;

b) If the child is HIV-positive, he or she will receive early treatment for HIV;

c) If the child is HIV-negative, he or she can take steps to stay HIV-free as he or she grows;

d) Discuss with the index subject their fears or concerns;

e) Involuntary disclosure of their own status, fear of stigmatization or suffering of the child, disclosure of the child's status;

f) Discuss the logistical barriers the subject must overcome to bring the child(ren) ;

g) *Optional:* Explain that a transportation incentive will be provided for the client to return with the child(ren) for screening, or that the client will be given a referral slip to go to the front of the line when returning with the child(ren) ;

h) Schedule an appointment for the subject to bring his/her child(ren).

Step 1.4: Determine the child screening plan

The customer chooses

The option of a contractual reference:

a) Follow the same procedure as in the in-house screening option;

b) Set a time limit of 30 days from that day, and agree with the client that he or she will bring his or her child(ren) in for HIV testing within that time;

c) Enter the date on the partner/child(ren)'s information sheet;

d) Remind him/her that if his/her child(ren) do not come for an HIV test on that date, you will call him/her to get permission to visit his/her home;

e) After 30 days, call the index subject and determine if the child(ren) have been screened;

f) If not, get permission to send a counselor to screen the child(ren) at home;

g) If the subject does not give permission to go home, record this result on the Biological Child Screening Results Sheet.

The home screening option:

The provider must then:

a) Explain the benefits of screening children, even if they appear healthy;
b) If the child is HIV-positive, he or she will receive early HIV treatment;
c) If the child is HIV-negative, he or she can take steps to stay HIV-free as he or she grows;
d) Discuss all fears and concerns with the index subject;
e) Involuntary disclosure of their own status, fear of stigma or suffering of the child, disclosure of the child's status;
f) Schedule a time for a health care worker to visit the client and child(ren) at home;
g) Note the date of the required home visit, or a day of the week and time of day that is appropriate for the index subject;
h) Confirm cell phone numbers and home address (including landmarks).

Step 1.5: Record the results of biological child screening services

It is important to:

a) Record the results of all child screening attempts on the Biological Child Screening Results sheet ;
b) Record the type of screening services, date and method of contact attempts, and whether the child(ren) were successfully screened;
c) If the child has been tested for HIV, indicate the result;
d) If the test result is positive, indicate if he/she has been put on antiretroviral treatment

7.2. Communication

Basic principles

Communication is the key to successful index case screening. The interview is central to the screening of the index subject's partners and family, and an effective interview can only take place when good communication skills are used.

Good communication relies on:

1. Appropriate non-verbal messages
2. Appropriate verbal messages
3. Effective listening

Communicate appropriately with our patients (AERS approach)

- Welcoming your customers;
- Encourage your customers to talk;
- Look at your customers;
- Listen to your customers;

10 communication skills:

1) Demonstrate professionalism;
2) Reporting;
3) Effective Listening;
4) Use open-ended questions;
5) Communicate at the patient's language level;
6) Provide factual information;
7) Solicit patient response;
8) Use reinforcement ;
9) Offer options, not directives;
10) Use appropriate non-verbal communication.

Conducting an interview with index patients requires certain skills. Consider training your most experienced counselors to handle partner and biological child screening services for index patients.

Good communication relies on:

1. Appropriate non-verbal messages;
2. Appropriate verbal messages;
3. Effective listening

a) Be professional;
b) Sit in front of the patient and maintain good eye contact.
c) Provide an objective, non-judgmental view of the patient's behavior;
d) Maintain professional relationships with patients, partners and social contacts.

Build rapport and listen effectively.

Relationship = sympathetic relationship

Build rapport, show respect, empathy and sincerity to patients in a variety of ways:

a) Introduce yourself;
b) Be polite;
c) Seek and help address a patient's concerns;
d) Listen effectively;
e) Don't interrupt the customer unnecessarily;
f) Answer the questions appropriately;
g) Paraphrase (repeat what the patient has expressed either verbally or through their emotions);
h) Use basic encouragement to keep the patient talking ("uh-huh", "yes");
i) Let the patient know that his or her concerns are normal by using third-person statements ("Many people feel this way");

j) Ask open-ended questions.

Empathetic communication is the most important skill in providing index patient-based screening services.

- Ask questions that cannot be answered with a "yes" or "no". They start with words like "Who", "What", "When", "Where" and "How".
- They can also be polite commands such as "Tell me about...", "Explain..." or "Describe...".
- Be careful when asking questions using "why". They may appear judgmental and cause defensiveness.

Communicate clearly at the patient level:

- Avoid technical terms, jargon, or words the patient may not understand;
- Clearly explain medical and technical terms as appropriate;
- Provide accurate STI/HIV information;
- Correct the patient's misconceptions;
- After giving factual information, use open-ended questions to make sure the patient understands what you just said;
- Offer options, not directives.
  Instead of saying, "I will inform all your partners that they need an HIV test."
  Say, "You can tell your partners on your own, or I can do it while remaining anonymous, or you can tell him while I am there to support him."

7.3. Overcoming obstacles

How do we address barriers to screening HIV-exposed individuals from an index case?

- You should not be surprised or discouraged when patients show resistance when you offer index patient-centered screening services;
- Being infected with HIV is already scary for many clients;
- They are already concerned about the various changes they will have to undergo as a result of these results;
- Your approach, skills and commitment to your work will greatly affect your success rate in index screening services.

What are the potential obstacles?

a) Diagnostic Trauma;
b) Partner(s) fear reaction;
c) Guilt for putting a partner or children at risk;
d) Doubts about confidentiality; the idea that the partner(s) will know that he/she has given the information;
e) Anger at the likely source of the infection;
f) Lack of information about index screening services and ways to inform those exposed;

g) Ignorance of the benefits of index subject focused screening services;
h) Poor communication skills;
i) Refusal to spend time, money and energy to notify partner(s);
j) Not caring about former partners (angry, depressed, unwilling to inform - infidelity).

Potential barriers from the index client's point of view?

a) The index subject believes that he/she does not have enough information;
b) The index subject provides incomplete data;
c) The index subject believes that the contact person is not involved;
d) The index subject has strong views on who may be the source of the infection;
e) The index subject cannot be persuaded to inform a regular partner;
f) The index subject does not show interest in the welfare of the ex-partner;
g) The index subject believes that the contact person will not respond or take it seriously;
h) The index subject believes that the contact person is already aware of their status.

Useful techniques for overcoming obstacles

- Develop a sense of familiarity by "vetting" the contact and making that person as real as possible. This can be done by asking a series of questions that range from the superficial (age, appearance) to speculation about circumstances, personality, values and aspirations;
- Foster a sense of relationship by focusing on the interactions between them (how they met, what attracted them to each other, how they got along, how they broke up) ;
- Strengthen the sense of belonging by identifying social connections through mutual acquaintances;
- Empathy can be elicited by asking the patient to imagine how they would feel if the situation were reversed and the contact had not notified them;
- See the guide entitled Managing Barriers to HIV Testing of Index Case Subjects in the Index Case Supplementary Materials booklet.

7.4. Monitoring, data collection, monitoring and evaluation forms and tools

Suggested indicators for monitoring index subject screening services:

- Number of index patients offered index subject focused screening services;
- Number of index patients accepting index subject focused screening services;
- Number of partners/children listed per index patient;
- Number of partners notified (disaggregated by method of notification: by client, by appointment, by provider and jointly);

- Number of known HIV-positive partners/children at time of contact;
- Number of partners/children tested for HIV after contact;
- Number of partners/children diagnosed with HIV ;
- Number of HIV-positive partners/children put on HIV treatment;
- Number of HIV-negative partners who have adopted prevention measures (condoms, PrEP, voluntary circumcision)

Example of the index subject register

How to use the "Registry" in Appendix 1:

- Include all partners and children eligible for screening in the client registry;
- Complete the test results section after the referred client has been tested;
    - A quick review of the client registry will tell you how many clients have not yet been screened, creating a pool of unscreened partners and children eligible for screening.
- This allows for a list of unscreened people to be kept;
- This approach allows for the use of a monitoring and evaluation tool (i.e., the Subject Registry or Partner Identification Form) for reporting through the cascade of index subject screening:
    - # of partners/children identified
    - # Partners/children screened and outcomes
    - # Partners/children put on HIV treatment

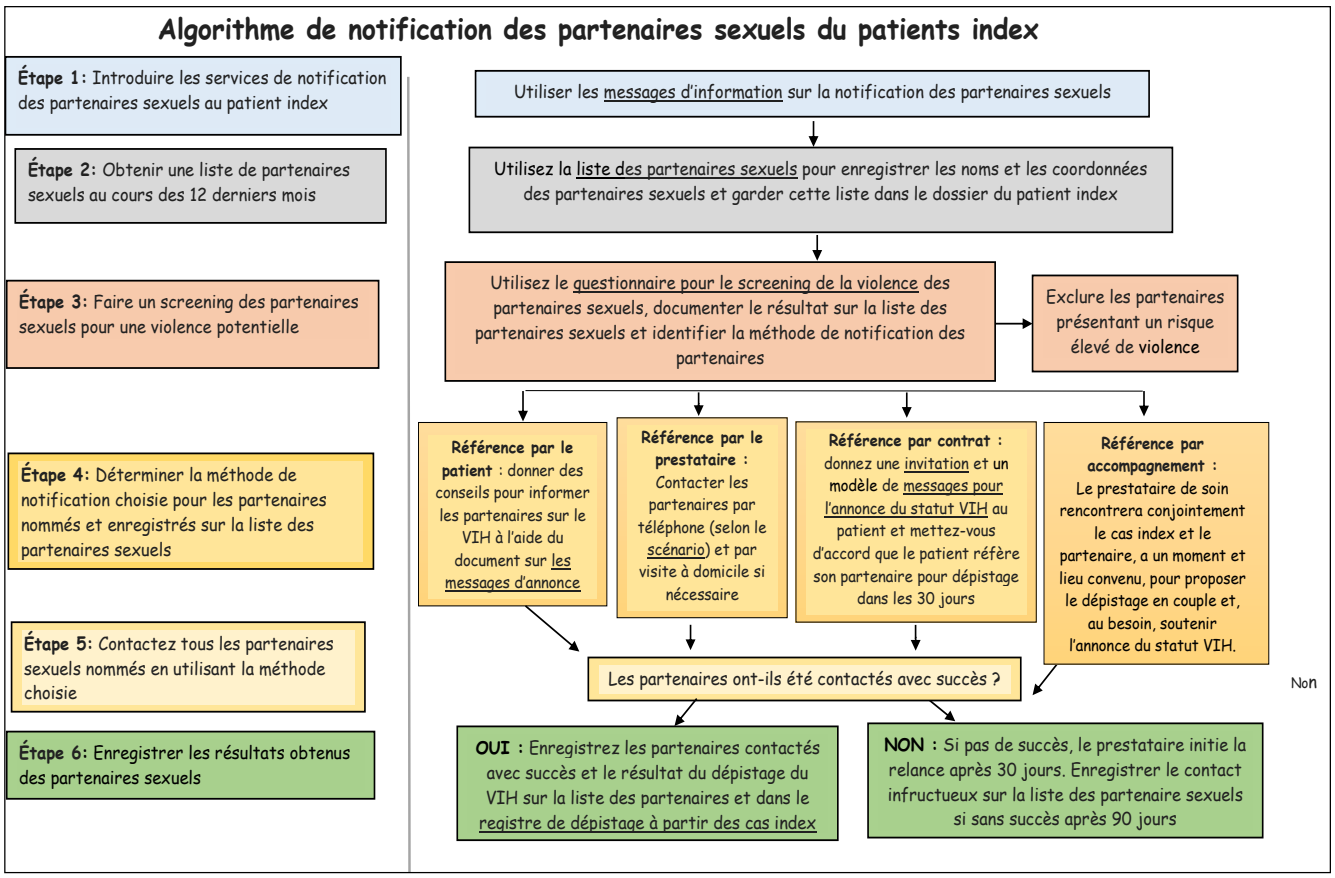
Index case screening is considered a high-yield testing strategy. This means that a higher proportion of index case contacts are likely to be positive than the general public. The yield of index testing is calculated using the number of identified contacts as the denominator and the percentage of positive cases detected as the numerator.

VIII. SESSIONS X, XI

Session X: Follow-up tools for index case detection (Data collection and evaluation)

Please refer to Appendix 1 for the paper versions of the reporting tools, which are also available in SANTIA.

Session XI: Algorithm for notification of sexual partners of the index patient



IX. SESSION XII, XIII, XIV, XV

This session includes four parts with:

I. Case studies that take place in group work
II. Role plays involving a client, a community and a service provider
III. Develop messages: in group work and from existing models, propose messages taking into account the local context;
IV. Development of an action plan

The training of trainers leads to a planning session that allows the implementation of the index case screening by all stakeholders. The observations and recommendations made during the various sessions are taken into account. Taking into account that the goal of index case screening is to increase the first 90 and reach the 3 X90 or even the 3X95 to consider the elimination of HIV by 2030.

Index case screening is therefore integrated into the set of ongoing strategies, such as: test and treat, targeted screening and differential management.

These different strategies therefore require the establishment of an organization of services for care (links between prevention and treatment services), the management of ARV drugs and the carrying out of viral load tests. This organization will be based on the active file at the PMLS level. It is therefore a question of examining the results relating to the achievement of the 3X90.

Planning could be summarized in seven steps:

1. Why are you organizing this activity? List the objectives.
2. Who will need to be involved to successfully implement this activity?
3. When and where do you plan to implement this activity?
4. What types of tools, materials, products, etc. do you need to successfully implement this activity? Index Test - Facilitator's Guide Page | 76
5. How will you ensure the success of the activity in terms of services, finances, M&E, etc.?
6. What technical assistance will you need to successfully implement this activity?
7. Timeline: indicate the steps, with a timeline, on how you will implement your activity

In the case of the PMLS, from the examination of the graphs and the exchanges during the training, the following bottlenecks can be identified, from which it is necessary to conduct the causal analysis and propose corrective actions; these are

- Inadequate screening;
- From the High Number of Lost to Sight;
- Inadequate retention of PLHIV in care;
- Insufficient viral load suppression;
- Lack of appropriate services for GBV;
- Inadequate training of staff for the implementation of Index Testing.

In addition, it is necessary to reinforce :

- The reference links between the Military Hospital, the CTAs, the AIDS Information Centers and the infirmaries (Scheme defined during the preparation of the workshop, toll-free number);
- The Monitoring and Evaluation Mechanism.

To carry out this activity, the following tools could be proposed in group work:

1-Causal analysis matrix for bottlenecks

Screening Case Index

Bottlenecks	**Immediate causes**	**Intermediate causes**				**Actions to be implemented**		
						Central level	**Intermediate level**	**Peripheral level**
Insufficient screening								
Inadequate retention of PLHIV in care								
Insufficient viral load suppression								
Lack of services for GBV								

X. References

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12- WHO-Unified Guidelines on HIV Testing Services July 2015 HIV Testing Services. 5C: CONSENT, CONFIDENTIALITY, COUNSELING, CORRECT RESULTS AND CONNECTION
13- **WHO-CDC-PEPFAR-USAID-IAS**. Key considerations for differentiated delivery of antiretroviral therapy to special populations: children, adolescents pregnant or lactating women and key populations. 2017
14- **WHO-** Resources_WHO_DocsComplementary-IndexTraining. May 2018

Appendix 1: Registry for Index Case Screening

CLINICAL TESTING: PARTNER IDENTIFICATION FORM

Name and surname of the index subject :		Unique Identification Number :		Date of registration :
Telephone contacts:	Year of birth:	Age :	Gender:	

No order	Date dd / mm / yy	Name and surname of the contact subject	Phone number et Geographic address	Age (In months if Age < 24 months)	Genre			Type of contact	HIV status at registration	Potential risk of violence by the sexual partner	Outreach strategy for HIV testing	HIV Testing			HIV test result	Putting on ARVs		Observations
					H	F	Transgender	1. Spouse2. Other sexual partner3. Biological child <18 ans 4. Brothers/Sisters < 18 years (froml' index < 18 ans) 5.Father/Mother	1. HIV +2. HIV -3. I nconnu	1. Yes2. No	1. By the index2. By the provider3. Contracted4. Accompanied	1. Known HIV positive status2. Tested HIV3. Retested HIV	(If 2 or 3) date dd/mm/yy	Screening code	1. Positive2. Negative	Date dd/mm/yy	Unique identification number	

								(from index < 18 ans)										

COMMUNITY INDEX CASE REGISTRY

Name and surname of the index subject :		Unique Identification Number :		Date registration
Telephone contacts:	Year of birth:	Age:	Gender:	Date started

Order number	Date dd / mm / yy	Name and surname of the contact subject	Telephone number and geographical address	Age (In months if Age < 24 months)	Type			Type of contact					HIV status at registration			Was the index patient a victim of sexual partner violence?		Reporting method chosen by the index patient				HIV Testing		HIV test result		Does the co support ser	
					H	F	Transgender	Biological children	Spouse	Siblings under 15	Father / Mother of	Injection drug	Negative	Positive	Unknown	Yes	No	By the index	By the provider	By Contract	Accompanied	Date	Screening code	Negative	Positive	Date dd/mm/yy	

Appendix 2: SOP for GBV Service Integration

- Identifying and responding to intimate partner violence in the context of index case screening
- Standard Operating Procedure-May 2021

Contents:

Abbreviations and acronyms

STI	Sexually Transmitted Infection
WHO	World Health Organization
PEP	Post-exposure prophylaxis
SOP	Standard Operating Procedure
PVI	Intimate Partner Violence
GBV	Gender-based violence
HIV	Human Immunodeficiency Virus

Definitions

Gender - refers to the classification of people as male, female, intersex or other sex, based on a combination of sexual and reproductive organs, chromosomes and hormones.

Gender - social ideas about acceptable traits, roles, responsibilities and behaviors for people born with female or male biological characteristics. Social definitions of what it means to be male or female vary across cultures and change over time.

Gender identity - refers to a person's sense of being male, female, non-binary, or other gender, which may or may not correspond to the sex assigned at birth.

Gender-based violence (GBV) - any harmful act perpetrated against a person's will and based on socially ascribed differences (i.e. gender) between men and women; used to maintain and reinforce gender-based power differences.

Intimate Partner Violence (IPV) - a form of gender-based violence that refers to any behavior within an intimate relationship that causes physical, psychological, or sexual harm to people in that relationship. It includes:

- Physical aggression (slapping, hitting, kicking or beating)
- Emotional/psychological abuse (insults, belittling, constant humiliation, intimidation, threats of harm, threats to kidnap children)
- Sexual violence (unwanted sexual comments or advances; forcing someone to have sex or perform sexual acts when they don't want to; non-consensual sexual touching; non-physical sexual acts such as sexting; hurting someone during sex; forcing or pushing someone to have sex without protection from pregnancy or infection).
- Economic abuse (using money or resources to control a person; blackmail; denial of the right to work; confiscation of earnings; withholding resources as punishment).
- Other controlling behaviors (including isolating a person from family or friends, monitoring a person's movements, or restricting access to financial, information, education, medical care, or other resources).
- IPV includes violence committed by former partners and individuals in romantic relationships. IPV also includes harmful practices such as female genital mutilation/cutting, early and forced child marriage, and dowry-related killings. IPV occurs in all settings and among all socioeconomic, religious, and cultural groups. The vast majority of IPV victims are cisgender women and girls; however, IPV also affects transgender women and cisgender and transgender men. Lesbians, gays, bisexuals, and transgender people are particularly vulnerable to IPV.

Routine investigation - an approach to identifying IPV cases among all clients who present for specific services, without using the public health criteria of a comprehensive screening program. For populations likely to be at higher risk of violence, routine investigation is recommended in services such as prenatal care, HIV care and treatment, and pre-exposure prophylaxis (PrEP) services.

Clinical Inquiry - an approach to identifying IPV by staying alert to clinical clues and other possible signs and asking questions about the abuse if you notice these clues. Clinical clues include ongoing stress, anxiety, or depression; substance abuse; thoughts, plans, or acts of self-harm or (attempted) suicide; repeated or poorly explained injuries; repeated instances of sexually transmitted infections (STIs); and unwanted pregnancies.

Frontline support - the minimum level of support (primarily psychological) and validation of their experience that all clients who disclose violence to a health care (or other) provider should receive. Frontline support includes five tasks, summarized by the acronym "LIVES" (listening, inquiring about needs and concerns, validating, reinforcing safety, and supporting).

Cis-gender - refers to people whose gender identity corresponds to the sex they were assigned at birth.

Transgender - describes people whose gender identity is different from the sex they were assigned at birth.

Context

This standard operating procedure (SOP) is intended to be adapted and used in the context of index case detection. The purpose of this procedure is to guide programs to:

1) prepare their clinics to ask and answer questions about violence
2) identify clients who are victims of intimate partner violence (IPV),
3) provide appropriate violence response services.

There is evidence that gender-based violence is a barrier to HIV services. In addition, it is possible that violence may result from index testing. In order to link survivors of violence to violence response services and avoid adverse events related to testing, it is important to conduct a routine IPV survey of all clients who test. After conducting a routine IPV survey, staff should then provide appropriate support and referral to violence response services.

WHO clinical guidelines state that the following minimum conditions must be in place before providers can ask clients about violence:

- A protocol/operating procedure for conducting a routine investigation.
- Providers trained in how to ask questions about IPV.
- A standard set of questions to which providers can document the answers.
- Providers who are able to provide front-line support when abuse is disclosed. Frontline support refers to the minimum level of support (primarily psychological) and validation of the survivor's experience that should be received "by those who disclose violence to a health care or other provider. WHO uses the acronym LIVES to assist providers in providing first-line support:
    - Listening with empathy
    - Inquire about the client's immediate needs and concerns
    - Validate the customer experience
    - Assessing and assisting Improving the safety of the person
    - Connect the client to other support services
- A private setting where confidentiality is assured and providers can ask questions about VPI.
- A process for providing referrals or links to other services.

Objective

This SOP defines procedures for using routine investigations to identify index clients who are victims of IPV and for providing clients who disclose abuse with appropriate front-line support, referral, and follow-up.

This SOP defines procedures for using routine investigations to identify index clients who are victims of IPV and for providing clients who disclose abuse with appropriate front-line support, referral, and follow-up.

Scope of application

This procedure applies to all program staff involved in index case screening services (including health care providers, clinical support staff, and outreach workers who collaborate with the index screening site) as well as to staff involved in supporting, referring, or following up with clients who report IPV (including counselors). This SOP covers creating an environment conducive to conducting a routine investigation, taking steps to identify abused individuals, and then providing "front-line support" to those who disclose abuse. The final step in front-line support is appropriate referral to clinical and non-clinical services.

Responsibilities

The PMLS, in collaboration with the HIV Prevention Committee, is responsible for:

- Ensure that all staff members who screen index cases or supervise staff members who screen understand and apply this SOP;
- Maintain the reference network that was validated during the technical sessions in preparation for the training on index cases;
- Ensure that program staff conducting index case screening are trained to conduct routine IPV investigations and provide front-line support;
- Ensure that all program staff who interact directly with clients, including [counselors, clinicians, clinic support staff, and community workers] are trained to provide front-line support to clients who spontaneously disclose abuse ;
- Monitor and evaluate the quality and effectiveness of routine investigations, identification of IPV and provision of front-line support, and implementation of the referral system; collaborate with program staff to improve strategies to provide clients with the best possible violence support

Procedures

1- Routine IPV survey in the context of index case detection

- During the screening process, the health care provider who requests contact cases and obtains the client's consent to participate in index case screening should ask the client whether each named partner has committed violence against him or her.
    - This can only be done if the client is alone or if the accompanying children are under the age of 2.
    - Program staff must communicate to each client any limitations on confidentiality, such as mandatory reporting requirements, before asking about abuse.[3]

[3] In Gabon reporting is not currently mandatory, but if that changes, if the client shares an experience that requires mandatory reporting, the provider must follow all local procedures and let the client know what those procedures entail.

- When addressing the issue of violence, the provider should explain that questions about violence are asked - 1) out of concern for the client's well-being, 2) because of the effects of violence on HIV outcomes, and 3) to ensure that testing can be done safely. The provider should also explain that these questions are asked of everyone and that many people experience problems at home.
    - The following script can be used: As *part of the index testing, I would like to ask if each of the people you have named has ever harmed you in any way. This is important because it will help us decide together if the testing process can be safe. It is also important because I care about your well-being and can help you find services.*

- Use a standard set of questions to ask each named partner, one at a time, about violence. Use the questions below:
    1. Has [partner's name] ever bullied you, insulted you, threatened to hurt you, or tried to control you (for example, by not letting you leave the house)?
    2. Has [partner's name] ever hit, kicked, slapped, or physically hurt you?
    3. Has [partner's name] ever forced you to have sex or forced you to have sexual contact that you did not want?
- If you are working with key population members, use questions tailored to their experiences.
    1. [For men who have sex with men, transgender women, sex workers]: Has your partner ever insulted you, called you names, or threatened to expose you?
    2. [For men who have sex with men and transgender women]: Has your partner ever criticized your sexual performance, clothing, or asked you to act more masculine?
    3. [For transgender clients]: Has your partner tried to control your transition process? or Has your partner ever told you that no one else would want to be with someone like you because you are transgender?
- If the abuse is not disclosed, remind the client that you and other staff members are there to provide support if the abuse occurs in the future or if the client remembers an event that he or she wishes to share later. Also, inform clients who do not disclose abuse of existing intervention services so they understand that help is available if they ever need it.
    - If the client does not disclose abuse, but you suspect abuse or the person is simply reluctant to talk about it at this time, tell the client that the conversation can continue at subsequent visits. You may also decide to offer an additional visit in the near future so that the client can return sooner rather than later for further clinical services.
    - However, do not pressure someone to disclose abuse, even if you think it is happening.
- If the abuse is disclosed, after following the steps in Section 3 below, recommend that the client not proceed with initiation of index case testing. If the client wishes to proceed with testing and the provider believes it can be done safely, choose a testing method that does not require disclosure.

- When the client returns for his or her own HIV care after testing, if the provider caring for him or her is the same person to whom he or she disclosed the abuse, the provider should adapt his or her counseling to reflect knowledge of this additional barrier to HIV services.
    - For example, the provider may ask if the client needs help thinking of a safe place to hide ARVs from a partner who may become physically abusive, or the provider may ask if the client anticipates difficulties getting to future appointments, as may occur with a controlling partner.

2- Providing front-line support to clients who disclose abuse

- If the client discloses abuse during a routine investigation, program staff should provide first-line support. WHO defines "frontline support" using the acronym "LIVES" in English, which includes the following elements:

Listen/ Ecouter	Listen to the client carefully, with empathy, and without judgment.
Inquire about needs and concerns/ Enquérir sur les besoins et préoccupations	Assess and address various client needs and concerns - emotional, physical, social, and practical (e.g., child care).
Validate/ Valider	Show the client that you understand and believe them. Assure the client that he or she is not to blame for the abuse.
EnhanceSafety/ Améliorer la sécurité	Discuss a plan to protect against further problems if the violence occurs again.
Supporter/ Supporter	Support the client by helping them find information, services and social support.

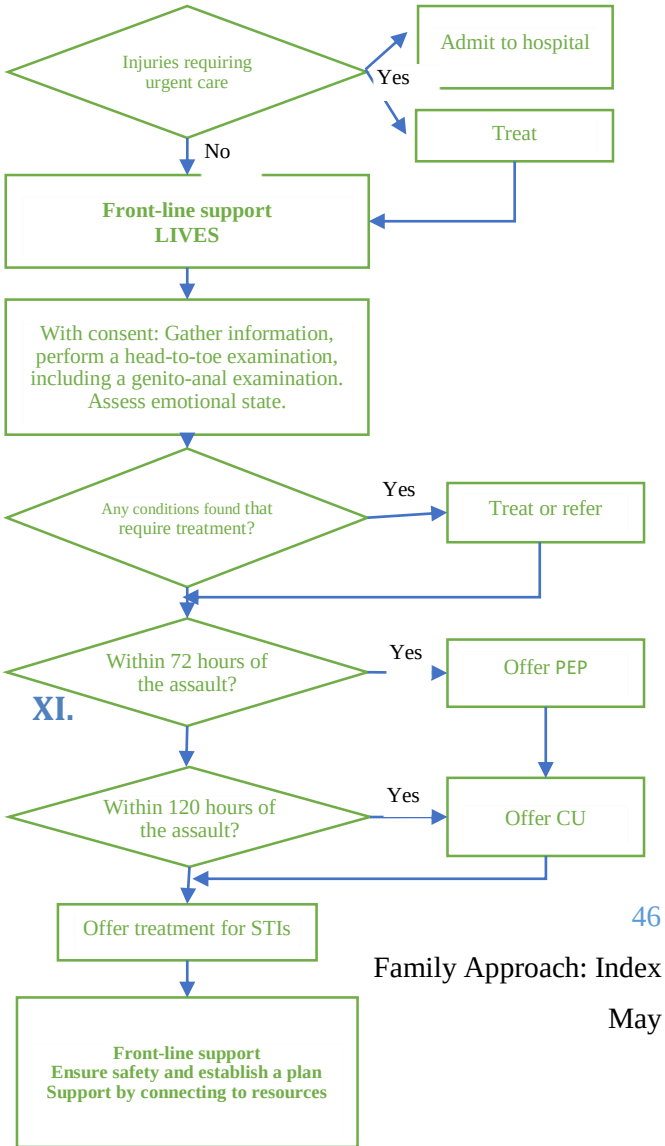
- This front-line support must be offered at all levels including AIDS information centers, MCHs, military infirmaries, military hospitals, and military CTAs.

- **Referrals**: Each site must define a referral process for services provided within the facility and those provided outside the facility. The referral process should prioritize services that are time-limited - such as PEP and emergency contraception - if they are relevant and desired by the survivor refer to the "*index case testing diagram*" for where to refer the client.

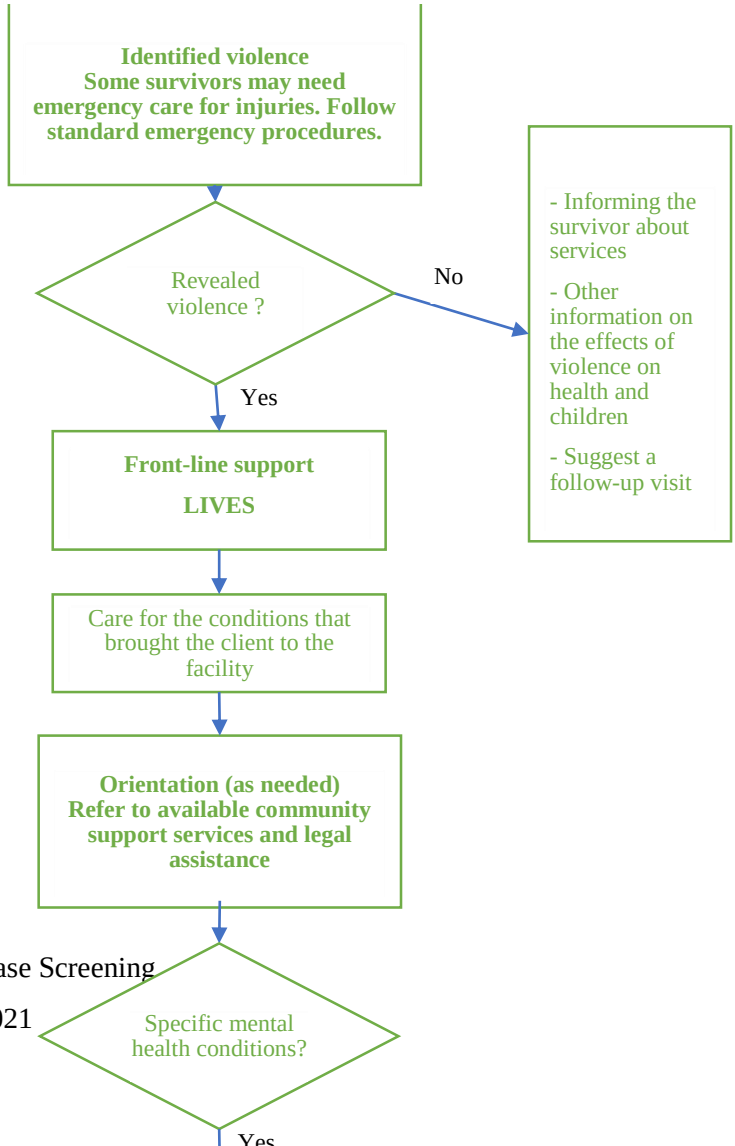
- AIDS Information Centres can refer clients to MCHs or military infirmaries for additional services;
- Provide the referral facility with a referral letter that includes a detailed description of the referral (only if the client authorizes the inclusion of this information in the referral letter). Offering this option to the client is important because it can help the referral facility learn about the client's general situation and needs without the client having to recount his or her experiences of abuse;
- Offer to help the client make an appointment by calling for him or her (ask in advance what information about his or her experience or needs should be shared with the referral facility), call with him or her, or offer a private place for him or her to call. Offer the client a completed referral letter (see Appendix D) to give to the referral agency. In this situation, the reason for the referral should be general (e.g., something like "client is referred for additional psychosocial counseling and support") to reduce the risk of danger if someone else finds the letter.

- MCHs, military infirmaries, military hospitals, and military ATCs must use the must use the following pathway to provide violence-related services.

WHO Care Pathway for Sexual Violence



WHO Care Pathway for Intimate Partner Violence



XI.

3- Staff experiences with trauma

- Working with survivors of violence may increase the risk of health care workers experiencing burnout and vicarious trauma. Health care workers' thoughts and beliefs may change as a result of their empathy for and/or repeated engagement with survivors of violence. For example, staff may begin to believe that no relationship can be healthy. This is of particular concern for staff who have experienced violence themselves. Each facility is advised to have a plan in place to deal with such situations. This support may take the form of:
    - Periodic debriefing sessions to discuss client experiences (without naming them) and the staff/facility's ability to respond. One goal of these sessions is to identify lessons learned and potential improvements that can be made to the response. If participants mention difficult situations, these debriefing sessions can also include time to discuss the well-being of staff members involved in the case.
    - Supportive Supervision: Those who supervise staff working with survivors should check in with staff at regular supervision meetings. Supervisors should inquire about the well-being of their team and their feelings about working with survivors and ensure that staff are aware of available services if they would like additional support.
    - Provide additional support to staff working with survivors by referring them to services that can provide psychological support
    - Additional paid time off. If possible, provide additional paid time off for staff members who experience vicarious trauma.

4- Documentation

- Document the reporting of IPV in the index case registry. The registry should note whether IPV management occurred and what the outcome was.
- Treat information about abuse with the same procedures as other medical information to ensure confidentiality. Keep in mind the following:

- All staff members understand the importance of confidentiality and secure record keeping, and staff members who regularly deal with abused women have been trained in secure record keeping.
- A woman's identifying information, including her name and contact information, is not visible or accessible to anyone who is not caring for that patient.
- Staff members do not leave documents in view of the patient (unless requested by the patient), accompanying persons, or any other person. Staff members do not carry open files or place them on shared desks or counters.
- When collecting information from women about their experiences of violence, staff members avoid asking for or writing this information on records in a public place.
- Staff members do not write a note indicating intimate partner violence or sexual violence on the front page of a file, which is more likely to be seen if it is opened.
- Staff members use a code, such as an abbreviation or symbol, to indicate cases of intimate partner violence or sexual violence on the charts (recommended option). They do not write "SUSPECTED DOMESTIC VIOLENCE" or "VIOLENCE" or any other explicit wording in large letters on the chart. Some countries use a color-coded system on medical records that is known only to the health staff involved.

Appendix 3: Country Experiences

MALAWI - COTE D'IVOIRE - KENYA - ZIMBABWE

Family screening: an index case finding strategy to fill gaps in pediatric HIV diagnosis. Simon KR, Flick RJ, Kim MH, Sabelli RA, Tembo T, Phelps BR, Rosenberg NE, and Ahmed S. *JAcquir Immune DeficSyndr*. 2018 Aug15; 78 Suppl 2(Suppl 2):S88-S97.	Despite substantial improvements in the delivery of the EID and PITC programs, gaps in pediatric HIV diagnosis persist and children infected with HIV remain undiagnosed. Children of HIV-infected adults are at higher risk of infection, but many do not have access to HIV testing services. Family screening is an index case finding strategy in which children, siblings, and parents of HIV-infected patients are targeted for testing by asking known HIV-infected patients about family contacts. The yields of familial testing are high and often several times higher than the PITC or the estimated age-specific prevalence. Some studies report low test use among contacts of index patients, and future work is needed to better understand the barriers. Family screening is better implemented with a systematic approach to screening, referral, and linkage to care that is repeated at each ART clinic visit and supported by pragmatic tools, SOPs, and counseling By adopting family-based testing, national HIV programs have the opportunity to help close the pediatric case detection gap and ensure that HIV-infected children have rapid access to antiretroviral treatment.
Approaches to notification of sexual partners and children of human immunodeficiency virus index cases in Côte d'Ivoire. Marie-Huguette K A Kingbo , Petros Isaakidis , Arielle Lasry, Kudakwashe C Takarinda , Marcel Manzi , John Pringle , Flore Adjoua Konan, Jules N'Draman, Nathalie Krou Danho, Armand K Abokon , Nicole Isabelle L Doumatey. *Sex Transm Dis*. 2020 Jul;47(7):450-457.	There were 1089 sexual partners and 469 children out of 1089 newly diagnosed index cases. About 90% of the children were contacted through client referral: 85.2% were tested and 1.4% were positive. Ninety percent of the children were from female cases. • The provider's referral attracted 56.3% of sexual partners, 97.2% of whom were tested for HIV. • The client referral attracted 30% of sexual partners, of whom only 81.5% had been tested for HIV. • The percentages of HIV positivity were 75.5% and 72.7%, respectively, for the 2 approaches. Male index cases helped reach twice as many HIV-positive sexual contacts outside the household (115) as female index cases (53). Contract and double referrals were not preferred by index cases. Conclusions: Referral to a provider is a successful and acceptable strategy for bringing in sexual partners for testing. Client referral is preferred for children.

Timeliness of HIV testing among sexual contacts identified by HIV-positive index clients in Siaya County, Kenya. Wekesa P , Kataka J, Owuor K, Nyabiage L, Miruka F, Wanjohi S, Omondi S.	A study was conducted to assess time to test since notification among identified sexual contacts of index HIV-positive clients using program data in Siaya County and Kenya.Cette study involved 117 health facilities. They sought to determine the time to HIV testing by contact characteristics after identification to inform targeted testing interventions. Of the 6,845 contacts included in this analysis, 3,858 (56.4%) were male. Most were between the ages of 25 and 34 years (3,209 [46.9%]). • Median time to contact test was **14.5 days**. • Les contact subjects aged 18 to 24 years had less time for HIV testing than those aged 35 to 44 years. • Married polygamous contacts had a shorter time to HIV testing than monogamous married contacts. • Non-spousal sexual contacts had more time for HIV testing than spouses This study recommends enhanced differentiated partnership services targeting the elderly, monogamous married persons, and sexual contacts between spouses to facilitate early diagnosis, same-day treatment, and prevention in western Kenya and sub-Saharan Africa in general.
High and sustained HIV testing through indexed testing and partner notification services: experiences in three provinces in Zimbabwe. Mahachi N, Muchedzi A, Tafuma TA, Mawora P, Kariuki L, Bazghina-Werq S , Bateganya MH, Nyagura T, Ncube G, Merrigan MB, Chabikuli ON, Mpofu M. *J Int AIDS Soc*. 2019 Jul;22 Suppl 3 (SupplSuppl 3):e25321	Several southern African countries have made significant progress toward the Joint United Nations Programme on HIV/AIDS goal of having 90% of people living with HIV know their status. In Zimbabwe, progress toward the first 90 was estimated at 73% in 2016. To reach the remaining people living with HIV who have not been diagnosed with infection, the Zimbabwean Ministry of Health and Child Welfare has promoted index testing and partner notification services (PNS). We describe the implementation of index testing and PNS in the Zimbabwe HIV Care and Treatment (ZHCT) project and the resulting uptake rate, HIV status, and linkage to HIV treatment is implemented since March 2016, covering a total of 12 districts in three provinces. The results obtained show: • Un average HIV-positive rate increased from 10% in the first six months of implementation to over 30% in August 2016 and remained above 30% through May 2018. • Un The high rate of HIV seropositivity was 31.3% for men and 33.7% for women. • A mean monthly ZHCT HIV positivity rate from the index test (32.6%) was significantly higher than that achieved through provider-initiated testing and counseling and other facility-based HIV testing modalities (4.1%, p <0.001). Conclusions: The ZHCT project demonstrated success in implementing index testing and partner notification services (PNS) by achieving a sustained high rate of HIV positivity during the study period.

Any opinions, findings and conclusions or recommendations expressed in this document are those of the author(s) and do not necessarily reflect the views of the *Defense Health Agency*.