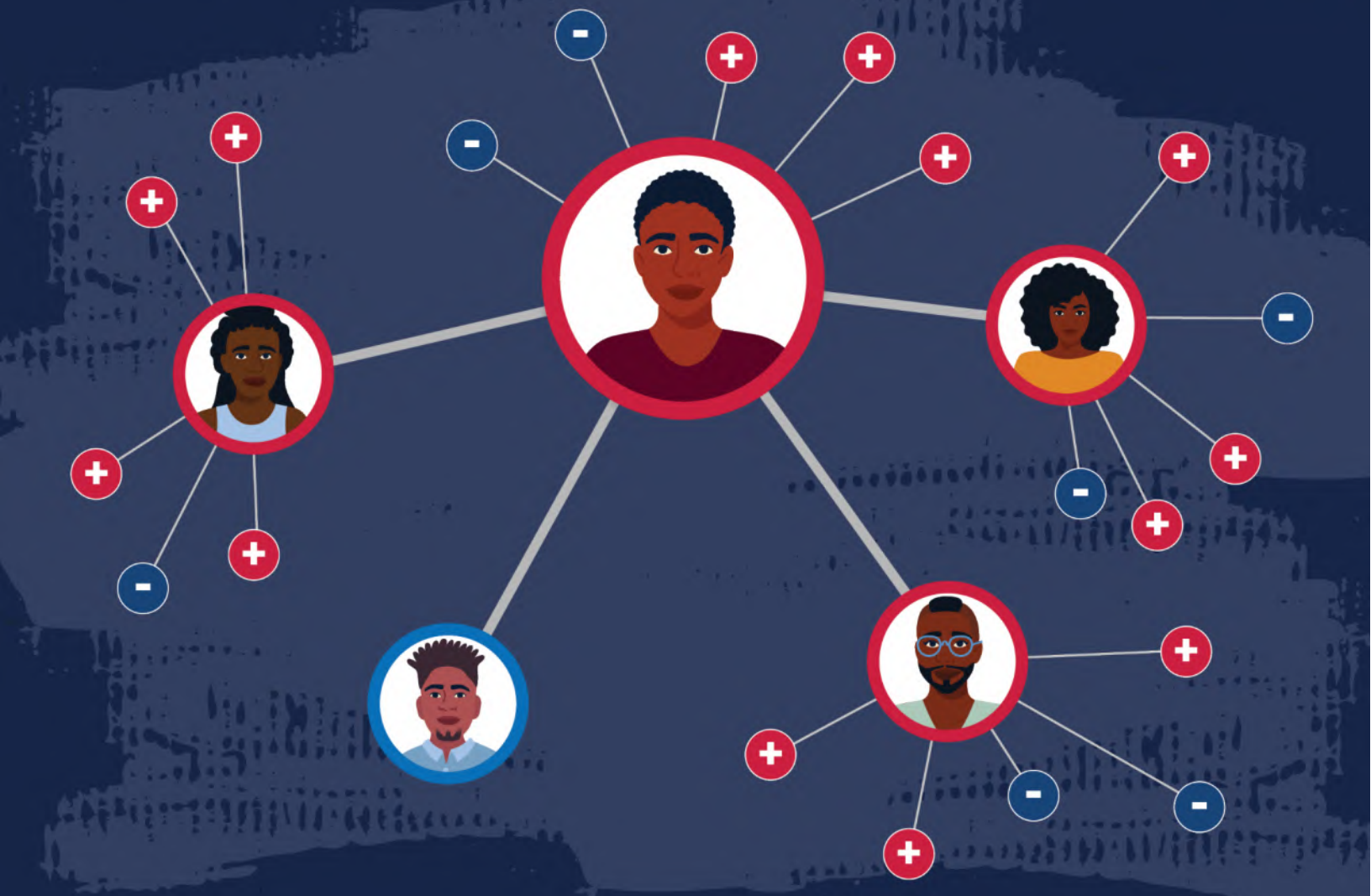
INDEX TESTING AND RISK NETWORK REFERRAL

Program implementation orientation and training

JANUARY 2021

FACILITATORS GUIDE



PEPFAR

USAID FROM THE AMERICAN PEOPLE

EpiC Meeting Targets and Maintaining Epidemic Control

Index testing and risk network referral

Program implementation orientation and training

FACILITATORS GUIDE

January 2021

PEPFAR

USAID
FROM THE AMERICAN PEOPLE

EpiC
Meeting Targets and Maintaining Epidemic Control

Suggested Citation: EpiC. Index testing and risk network referral. Program implementation orientation and training. Facilitators Guide. FHI 360; Durham (NC): 2021.

ACKNOWLEDGMENTS

This curriculum was adapted from a comprehensive training package developed by the Centers for Disease Control and Prevention and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). The curriculum borrows from extensive learning and experience from PEPFAR-supported programs in the field. A number of the tools included in this package can also be found on the PEPFAR Solutions Platform.

The training package was drafted by Daniel Levitt, Danielle Darrow De Mora, Robyn Dayton, and Rose Wilcher. Input and comments of LINKAGES staff and consultants are gratefully acknowledged, with particular thanks to Tiffany Lillie, Chris Akolo, Meghan DiCarlo, and Michael Cassell. It was edited by Suzanne Fischer and Stevie Daniels and designed by Lucy Harber and Jill Vitick with cover art from Design Lab 360.

Finally, we thank the many key-population-led and key-population-serving community-based organizations in all the LINKAGES and EpiC supported countries that contributed to and participated in delivering iterations of this curriculum. Their experiences and feedback helped shape the final version.

This document was made possible by the generous support of the American people through the United States Agency for International Development (USAID) and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). The contents are the responsibility of the LINKAGES and EpiC projects and do not necessarily reflect the views of USAID, PEPFAR, or the United States Government.

Contents

Background

According to UNAIDS, there were approximately 38.0 million people across the globe living with HIV in 2019. While the global rate of infections appears to be slowing, evidence suggests that the epidemic is transforming: in 2019, 62% of all new HIV infections were among key populations (KPs)—sex workers, people who use drugs, gay men and other men who have sex with men, transgender people, and prisoners—and their partners. Approximately 81% of people living with HIV globally knew their HIV status in 2019. The remaining 19% (about 7.1 million people) still need access to HIV testing services.[1]

KPs can benefit from tailored, targeted testing because they are (1) at high risk for HIV infection, (2) at high risk of onward transmission if they are HIV-positive, and/or (3) less likely to routinely access HIV testing services in public sector facilities.[2] In addition, stigma and discrimination impede their access to health care services. Children and sexual and drug-injecting partners of KP members living with HIV also have elevated rates of HIV compared to general populations. However, partners and family members may be unaware that they are at risk.

Index testing (referred to as assisted partner notification by the World Health Organization [WHO]) is an approach that can improve testing coverage and efficiency while also identifying people with undiagnosed HIV infection. It involves systematically identifying children and current and former sexual and drug-injecting partners of individuals newly or previously diagnosed with HIV, and then engaging them in HIV testing services. Testing can be done in a health facility or in the community, according to the services provided by government and community-based counterparts. Various programs and studies have demonstrated index testing's feasibility, acceptability, and high yield. When combined with community-based outreach and risk network referral services, it serves as part of a comprehensive case finding model.

Overview of the training

Purpose

This Facilitators Guide and accompanying PowerPoint slides are for use by HIV programmers who wish to train on and develop, adapt, or revise index texting services for people living with HIV and their children, sexual and drug-injecting partners, and peers in their risk and social networks. The package includes tools that can be readily adapted to the local country context. It also includes guidance at the end of the training on developing and articulating a plan, timeline, and roles and responsibilities related to integrating index testing into HIV programming.

[1] https://www.unaids.org/en/resources/fact-sheet 2020

Participant learning objectives

Participants will:

- Understand the elements of a comprehensive index testing approach
- Explore how to build an enabling environment for index testing and ensure the safety and security of KP clients and their partners
- Learn how index testing can be integrated with other referral options to optimize case finding
- Develop/adapt specific service steps and client flow, and determine the requisite tools and job aids to support index testing in their country context
- Review motivational counseling techniques and their application to the material
- Learn how to ask about and respond to instances of intimate partner violence*
- Adapt critical messages for introducing and engaging clients in index testing
- Practice the provision of index testing services through role plays based on real-life scenarios
- Review basic monitoring and reporting requirements and learn how to gauge the contribution of a local index testing approach to case-finding efforts
- Develop an action plan leading to the implementation of index testing

* *While intimate partner violence is discussed in this training, it is highly recommended that participants engage in separate training about intimate partner violence. PEPFAR and LINKAGES/EpiC offer options. Please contact Robyn Dayton for more information rdayton@fhi360.org.*

Time and preparation requirements

The training will require three full days, not including advance preparation to:

1. Understand how index testing and risk network referral are already being conducted in country
2. Determine what resources to engage throughout the planning and implementation of the training (including who might serve on the client panel of people living with HIV in Day 2—Session 9)
3. Adapt the training to the local context—this will include consolidation and articulation of data for Sessions 2 and 3, expanding or removing parts of the training based on participants' existing skill levels and previous training, identifying relevant laws and policies, developing a list of organizations and agencies to whom program staff can refer clients, and adapting any standard operating procedures (SOPs) that will be introduced during the training (sample SOPs regarding adverse event monitoring, investigation, and response and intimate partner violence identification and response are available)
4. Determine those who should be trained, and identify and train effective facilitators, including KP members as appropriate
5. Identify and prepare a human rights lawyer who can participate in the training

All preparation and implementation should be continually guided by KP members' expertise and experiences and should prioritize KP members' safety.

Training curriculum content and structure

The training includes 15 sessions. Each session contains slides, speaker notes, and activity instructions. In addition, the training package includes handouts to be used for specific activities and instructions for development and/or adaptation of tools during and following the training. A detailed sample agenda is provided at the end of this overview.

KP client perspectives

Throughout the training, participants will have opportunities to explore their personal values and beliefs related to KPs and consider how these affect KP members' access to safety and services. Participants will also hear from KP members during a panel discussion to learn about their experiences with index testing and the kinds of support they prefer.

Index testing in the context of comprehensive case finding for key populations		
Session number	**Title**	**Content/purpose**
1	Introductions	Participants get to know each other and discuss objectives and expectations for the training.
2	Setting the stage	Provides an overview of the history, evolution, and evidence for index testing approaches.
3	Index testing in [COUNTRY]—local perspectives (Optional)	Local stakeholders present on how index testing is already being conducted in the country context.
4	Steps for index testing	Provides an overview of the main steps for index testing, including options clients may choose for partner notification.
5	Core principles and minimum standards	Discusses some of the elements that need to be in place to maintain the safety and security of clients.
6	Tools and flow for index testing	Provides an opportunity for participants to examine commonly used tools and client flow for index testing services. Participants will walk through specific steps and suggest broad adjustments based on the local context.
7	Risk network referral	Introduces the concepts of risk network referral and how it can be integrated with index testing and targeted referral approaches as part of a comprehensive model.
8	Client panel	Includes KP and partner clients living with HIV who have undergone index testing and/or risk network referral who can provide first-hand experience and information on the process to help participants gain a deeper understanding of barriers, risks, and benefits of index testing and referral for KP members.
9	Building a localized index testing and risk network referral approach	Offers participants the opportunity to go into more detail in the development/adaptation of specific models of index testing for their country context, including recommendations on specific tools, and roles and responsibilities of key players.

Index testing in the context of comprehensive case finding for key populations		
Session number	**Title**	**Content/purpose**
10	Motivational counseling	Reviews key motivational counseling techniques and provides realistic scenarios for participants to practice their skills.
11	Asking about and responding to intimate partner violence	Addresses important considerations in asking about and responding to intimate partner violence in the context of KP programming.
12	Messaging	Allows an opportunity to review existing messaging and revise or develop new messaging to introduce index testing approaches catered to KP clients.
13	Practice makes perfect	Provides multiple opportunities for participants to practice using the skills they have learned/reviewed in role plays based on realistic scenarios.
14	Quality assurance, adverse event monitoring and reporting, and index testing MER	Introduces the participants to monitoring and reporting norms for index testing, and how data can be characterized to gauge to what degree index testing approaches are contributing to case finding.
15	Action planning	Guides the development of an action plan including timing and roles and responsibilities for key players.

Intended audience and class size

This curriculum is intended for use by staff who interact with clients on a regular basis (e.g., those actively involved in service delivery). Participants will benefit most if they have prior experience conducting strategic behavioral communication with members of the target population, and at minimum basic training in communication skills and content. Participants also should have at least a basic understanding of sexual health, HIV and AIDS, risk reduction strategies, and/or treatment, depending on their focus.

The training is designed to be highly interactive, with opportunities for participants to share their thoughts in pairs, small groups, and plenary sessions. The more participants, the longer the amount of time needed during activities and discussions to ensure that everyone is fully engaged. We recommend training no more than 25 people at a time.

Training methodology

This training is based on principles of adult education and employs a combination of presentations, small- and large-group discussions, activities, and guided practice/role plays. Key concepts and skills are introduced via PowerPoint (or hand-written slides), facilitator demonstration, and discussion. Participants will have opportunities to participate in or watch demonstrations of skills, and provide feedback to one another to improve performance. Ideally, guided practice should be reinforced with routine field monitoring and mentoring using quality assurance tools that have been modified to incorporate the key skills and concepts covered in this training.

Overview of sessions

A sample agenda is provided below. Following that are session descriptions that include an estimated time for the session, materials required, and notes. Actual times may vary according to the number of participants and any adaptations made to meet their needs, and session times should be revised by the facilitator as required. In addition, some sessions begin with a note on planning ahead. These notes may describe preparation needed for that specific session or preparation required for the workshop overall.

NOTE: The PowerPoint presentations that are part of this training package include detailed notes, some with scripts, for each slide. It is important to review the notes in tandem with the session overviews in this guide while preparing to deliver the training. *Italicized notes* in the PowerPoints are provided as optional scripts. These are meant to be spoken while presenting. Nonitalicized notes in the PowerPoints are instructions or notes for the facilitator. They are not meant to be spoken.

Type of PPT notes	Example
Italicized (spoken)	*In index testing, it is important to note who is involved in the process.*
Nonitalicized (unspoken)	Be sure to revisit the objectives at the end of each day to determine progress and adjust as needed.
Mixed (some spoken, some unspoken)	*The basic steps for index testing include the following* [describe the steps as listed].

SAMPLE TRAINING AGENDA

Day 1: Day, DATE | Index testing						
Start time	**End time**	**Total time**	**Activity**	**Facilitation format**	**Facilitator**	**Session details**
8:45	9:00	0:15	Registration			
9:00	9:15	0:15	Welcome	Presentation: Opening remarks from key stakeholders		Customize for country context
9:15	9:30	0:15	Session 1. Introductions, review agenda and objectives, expectations, and agreements	Presentation and optional activity: Introduction of participants (name, organization, and title); review agenda, with objectives		Facilitator(s) introductions, and facilitation of optional warm-up activity (provided in Facilitators Guide). Participants will get to know each other by providing a round of introductions, followed by a review of the agenda and agreements, and where questions can be tabled for discussion (Parking Lot) if necessary.
9:30	10:00	0:30	Session 2. Setting the stage: History and evolution of index testing, terminology, and evidence	Presentation and Q&A		History of index testing, including key terminology, rationale, and global and local evidence.
10:00	10:20	0:20	**Tea break**			
10:20	10:40	0:20	**OPTIONAL** Session 3. Index testing in [COUNTRY]—local perspectives	Presentation and discussion: Introduces local policy on index testing and role of civil society		Presentation on the index testing strategies conducted in the local context. **NOTE:** Specific steps for index testing will be introduced in the following session.
10:40	11:10	0:30	Session 4. Steps for index testing	Presentation and activity: Overview of the basic steps of index testing		Presentation on the steps of index testing, and an activity to get participants thinking about ways they might be able to reach contacts in the community using targeted testing.
11:10	12:00	0:50	Session 5. Building an enabling environment for index testing	Activity, group work, and presentation: Brainstorming of potential barriers/risks and benefits of index testing; discussion of critical components to ensure safe and effective implementation		Brief plenary quiz to get the group thinking about ethical issues related to index testing, and fast-paced group activity to brainstorm potential enabling elements, and risks/barriers and solutions to address them. Groups will rotate at five different stations to discuss (1) confidentiality, (2) safety, (3) stigma, (4) disclosure, and (5) legal issues. Volunteer facilitators at each station will remain stationary as groups rotate. Discussion will continue with critical elements that need to be in place to ensure ethical/effective implementation.
12:00	13:00	1:00	**Lunch break**			

SAMPLE TRAINING AGENDA

Day 1: Day, DATE | Index testing						
Start time	**End time**	**Total time**	**Activity**	**Facilitation format**	**Facilitator**	**Session details**
13:00	14:10	1:10	Session 6. Tools and flow for index testing	Presentation and activity: Overview of the commonly used tools for index testing; group activity to walk through the specific steps of index testing.		Presentation on the common tools used to document and ensure appropriate services tailored to clients' preferences. Group activity will provide participants the opportunity to think through the specific steps of index testing and to identify skills and interventions that may be required throughout.
14:10	15:15	1:05	Session 7. Risk network referral	Presentation and brief activity: Overview of risk network referral and review of how it can be integrated with index testing and targeted referral.		Participants will be introduced to the basic concepts of risk network referral and how it can help a program reach deeper into social and sexual/drug-injecting networks to find those most at risk. The brief activity will give participants an opportunity to decide what kind of options they might offer to a client based on the client's circumstances and wishes.
15:15	15:30	0:15	**Tea break**			
15:30	16:00	0:30	Review of Day 1 and closing	Plenary discussion and reflections: Day 1.		Plenary discussion, reflections, and Q&A on the issues and steps for index testing discussed throughout the day. Table issues that remain unanswered on the Parking Lot.

Day 2: Day, DATE | Index Testing						
Start Time	**End Time**	**Total Time**	**Activity**	**Facilitation format**	**Facilitator**	**Session details**
9:00	9:15	0:15	Welcome and review of Day 1	Candy quiz: Test your recall of the key points discussed in Day 1.		Participants will have the opportunity to answer questions about key issues and elements discussed on Day 1 (candy prizes provided for accurate answers).
9:15	10:00	0:45	Session 8. Client panel	Panel discussion and Q&A: Real clients from the community provide their reflections and experiences in index testing.		Clients living with HIV who have been invited from the community will conduct a panel discussion, recounting their experiences with index testing. Participants will have the opportunity to ask questions and learn from the clients' experiences.
10:00	10:20	0:20	**Tea break**			

SAMPLE TRAINING AGENDA

Day 2: Day, DATE | Index Testing						
Start Time	**End Time**	**Total Time**	**Activity**	**Facilitation format**	**Facilitator**	**Session details**
10:20	12:00	1:40	Session 9. Building a localized index testing and risk network referral approach	Presentation and activity: Discussion of key considerations and questions related to local adaptation/revision of index testing and risk network referral.		Participants will discuss key considerations and questions relevant to local adaption, revision, and/or implementation of index testing and risk network referral, given the various stakeholders, organizations, and individuals who may be involved. During the group activity, participants will brainstorm answers/solutions to key questions and report back.
12:00	13:00	1:00	**Lunch break**			
13:00	14:30	1:30	Session 10. Motivational counseling	Presentation and activity: Review of key motivational counseling techniques and their relevance to index testing; group activities.		Participants will review key motivational counseling techniques (reflective listening, affirmation, questioning, and ask-tell-ask), and discuss their relevance to index testing. The group activities will help reinforce the importance of the skills as a means of building trust with clients and supporting them to provide information crucial to understanding their perspective, and supporting their own motivations for change.
14:30	15:00	0:30	Session 11. Asking about and responding to intimate partner violence (IPV)	Presentation and activity: LIVES approach for asking appropriate questions and providing requisite services/responses to IPV.		Participants will learn about the minimum requirements that must be in place to ensure the safety and security of KP clients when asking about and responding to violence. They will also learn the LIVES approach for first-line support to ensure that they ask appropriate questions and that clients receive follow-up services.
15:00	15:15	0:15	**Tea break**			
15:15	16:30	1:15	Session 11. Continued			
16:30	16:45	0:15	Review of Day 2 and closing	Plenary discussion and reflections: Day 2		Plenary discussion, reflections, and Q&A on the localized approach and key issues associated with appropriate communication. Table issues that remain unanswered on the Parking Lot.

SAMPLE TRAINING AGENDA

Day 3: Day, DATE | Index Testing						
Start Time	**End Time**	**Total time**	**Activity**	**Facilitation format**	**Facilitator**	**Session details**
9:00	9:15	0:15	Welcome and review of Day 2	Candy quiz: Test your recall of the key points discussed in Day 2.		Participants will have the opportunity to answer questions about key issues and elements discussed on Day 2 (candy prizes provided for accurate answers).
9:15	10:15	1:00	Session 12. Messaging	Group Activity: Development/adaptation of key messages and scripts to provide in person and online (as appropriate).		Participants will work in groups to review existing messaging in supporting clients to refer their partners, and/or develop/adapt/revise messaging for the local context. Messages will include face-to-face and online-mediated modalities for introducing the concept of partner notification and referral, including the four types of index testing, risk network referral, and targeted referral.
10:15	10:30	0:15	**Tea break**			
10:30	12:30	2:00	Session 13. Practice makes perfect	Role plays to practice index testing skills and messaging developed/adapted.		Participants will break into groups of three (client, counselor, and observer) to practice a series of role plays. Groups will have a chance to report back after each role play to comment on experiences and observations.
12:30	13:30	1:00	**Lunch break**			
13:30	14:00	0:30	Session 14. Monitoring and reporting on index testing	Presentation and discussion on potential ways that programs can represent and analyze data to monitor partner referral and testing interventions.		Participants will learn about ways in which programs have represented and analyzed program data to gauge the effectiveness and contribution of index testing toward case finding and enrollment in treatment.
14:00	15:00	1:00	Session 15. Action planning	Development of action plans in plenary to clarify **who** will do **what**, **when**, and **where.**		Participants will collaborate in plenary (or smaller groups if relevant) to develop an index testing and risk network referral action plan that outlines specific activities/support/TA/resources necessary to achieve results. Areas of focus could include a) staffing and task shifting; b) tools for counselors/providers and partners; c) documentation and monitoring and evaluation tools/processes; d) planning for the increased case load (linking people living with HIV to treatment, support, referral to pre-exposure prophylaxis [PrEP]); and e) programmatic steps for implementation.
15:00	15:15	0:15	**Lunch break**			
15:15	15:30	0:15	Review of Day 3 and closing	Key findings and agreed-upon next steps reviewed and final Q&A; closing remarks		Facilitator will review relevant findings from the role plays, and agreed upon steps from the planning session.

Session descriptions

DAY 1

Welcome

Time: 5–15 minutes depending on opening remarks by key stakeholders

Materials:

- Training PowerPoint—Day 11 (with adaptations as needed)

Objectives: By the end of this session, participants will have:

- Been introduced to key stakeholders and learned about why index testing is a priority for them

1. Project the title slide for the **Day 1** presentation.

   Introduce yourself, welcome the participants to the room, and thank them for attending Day 1 of the training on index testing and risk network referral.

   Note that you will be doing full group introductions shortly.

   Before beginning, ask if everyone is comfortable with the room temperature and seating arrangements, or if anything needs to be adjusted.

2. *We will be covering a lot over the next three days.*

   While the focus of the training is on index testing, we will also be discussing risk network referral, an approach that complements index testing, and how the approaches, along with targeted testing, fit into the larger treat and test model.

   On Day 2, we will start the day off with a panel discussion with clients who are living with HIV, who have experienced index testing, and who can help us learn from their experiences. We will then adapt the approaches we will discuss today to the [COUNTRY] context and learn about (or review) key motivational counseling skills to support these approaches. Finally, but importantly, we will learn how to ask about and respond to intimate partner violence.

   On Day 3, we will begin by adapting key messages to be used in our index testing approaches. Then we will spend a considerable amount of time practicing index testing in role plays. Afterward, we will discuss how we can examine some basic data from our program to monitor the effectiveness of our index testing efforts in improving case finding. Finally,

we will spend the last session creating a plan of action so that we are all clear on next steps, who will lead and support, and their timing.

Session 1. Introductions, review agenda and objectives, expectations, and agreements

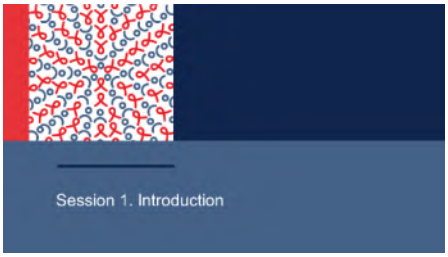
Time: 15 minutes

Materials:

- Training PowerPoint—Day 1 (with adaptations indicated in PowerPoint file)
- Flipchart and markers
- List of categories and options (if icebreaker Option 1 below is chosen)
- Ball (if icebreaker Option 2 below is chosen)

Objectives: By the end of this session, participants will have:

- Gotten to know each other by providing a round of introductions
- Reviewed the agenda and agreements
- Discussed and understood where questions can be tabled for discussion (Parking Lot) if necessary



3. *In this introductory session, we will be introducing everyone in the room, discussing the objectives for this training, going over training agreements, and conducting a brief exercise to mentally put aside anything that may be causing us stress*.

4. Prepare a locally relevant welcome slide.

   Introduce yourself (the facilitator), if appropriate, and have the participants briefly introduce themselves.

   Optional: Lead an interactive, physical activity to introduce each of the participants. Choose from one of the three options below.

   Option 1. Four corners of the room. Identify a category (e.g., favorite color), and list four options, identifying each option with a corner in the room. Ask the participants to go to the corner that represents their preference. Repeat 5–10 times with other categories and options (e.g., foods, hobbies, dream vacations). Options can also be constructed as "what would you rather," or as statements (e.g., I prefer to work: a)

with a team, b) alone, c) sometimes with a team and sometimes alone, d) not to work at all). After a few rounds, have participants each introduce their name, organization, role, and why they are in that "group/category" per their answer to the question/theme.

Option 2. Ball toss. Ask participants to form circle. Toss the ball to someone and then tell them something about yourself that they didn't know (could be anything, from your favorite food to what kitchen appliance/item you would be and why.) Continue until all participants have introduced themselves.

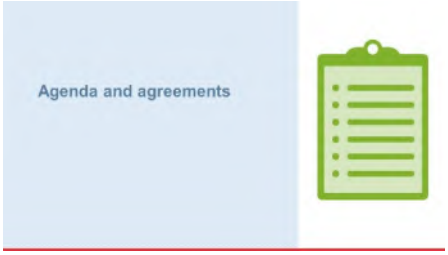
Option 3. Line up. Identify a category and have participants line up in order (e.g., height, birthday month, number of years working in HIV). Then have each participant introduce themselves.

5. Introduce the general purpose of the training: to orient participants on current practices in index testing and risk network referral to improve HIV testing uptake among those who are at highest risk in order to accelerate and achieve epidemic control.

   Summarize the intended learning and skills-building objectives and ask participants if they have any questions or different expectations (adjust as needed before the training).

   Refer to the "Parking Lot" flipchart where important comments and questions that are outside the workshop's immediate focus/objectives will be recorded and addressed by the end of the workshop.

   Be sure to revisit the objectives at the end of each day to determine progress and adjust as needed.



6. Briefly review the agenda (focus on start times, breaks, meals, and plans for ending the day on time).

   Brainstorm with participants about what group agreements they would like to incorporate into the training, and record them on a whiteboard or flipchart paper.

   These might include respecting start, end, and break times; ensuring that cell phones and computers are only used outside of the workshop room; honoring other people's opinions with respect; avoiding sidebar conversations, etc.

Ask if everyone feels comfortable with the agreements.

Ask participants if they are comfortable if you (the facilitator) adjust the agenda as needed to accommodate the natural pace and learning of the group (the agenda is a guide). Respond to questions or concerns.

Ask if there are any specific goals or expectations the group has outside of the training and include them on the "Parking Lot" flipchart page.

7. .**Optional**: Ask participants to think about something that is weighing down on them, or causing stress or distraction.

   Ask each person to take a minute or two to write down on a piece of paper or notecard whatever issue(s) may be concerning them.

   After everyone has finished writing down their issue(s), ask them to fold their paper in half or quarters, and place it somewhere in their bag to be saved for later.

   There is no specific follow-up for this activity, which can serve as a way of helping people turn their attention to the training.

Session 2. Setting the stage: History and evolution of index testing, terminology, and evidence

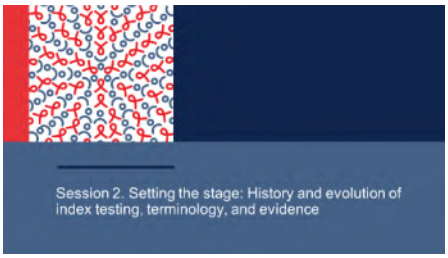
Time: 15 minutes

Materials:

- Training PowerPoint—Day 1 (with adaptations indicated in PowerPoint file)
- Flipchart and markers

Objectives: By the end of this session, participants will:

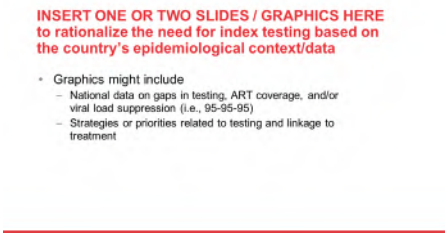
- Understand the history, evolution, and evidence for index testing approaches



8. *In this session, we will briefly introduce index testing, and discuss the origin, terminology, and evidence supporting the approach.*

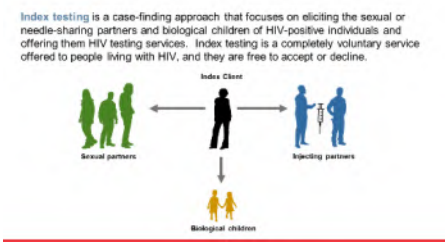
9. *It is important to note that index testing and risk network referral are not new concepts, as we will discuss shortly.*

   The intention of this workshop is to build on existing experience in case finding, and introduce or improve approaches that prioritize and protect people living with HIV while promoting case finding and linkage to care and treatment. The ultimate goal of these approaches is to help achieve epidemic control



10. Using available national data, demonstrate existing gaps in testing, antiretroviral therapy (ART) coverage, and viral suppression, to help set the stage/rationale for an approach designed to improve case finding.

    Note that because HIV testing is the entry point into the continuum of HIV services, programs will need to innovate and/or employ new evidence-based approaches to address these gaps. One way of doing this is to engage directly with existing clients who are living with HIV.



11. *Based on the PEPFAR definition, index testing is a case-finding approach that focuses on eliciting the sexual or needle-sharing partners and biological children* of HIV-positive individuals and offering them HIV testing services. Index testing is a completely voluntary service offered to people living with HIV and they are free to accept or decline.*

    **Per COP20, PEPFAR is prioritizing the scale-up of index testing of biological children, including children of mothers living with HIV and, if the mother's status is unknown, children of biological fathers.*

    NOTE: Highlight key words such as "voluntary," "elicit," and "refer," and ask why sexual and injecting partners and biological children might be the focus of index testing.

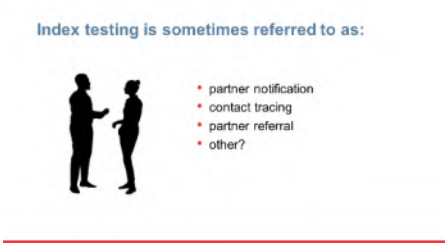
By "elicit," we mean allowing the index client to voluntary consent to provide the names and contact information (if available) of all individuals that fit the criteria as sexual partners, injecting partners, and/or biological children. We will discuss later in the training what to do with contacts who may pose a risk of violence for the client.

By "refer," we mean either disclosing to those individuals that they may have been exposed to HIV infection and referring them for testing, or working with someone such as a provider who can provide individuals that information and offer them a test.

The goal of index testing is to break the chain of HIV transmission by offering testing to anyone who has been exposed to HIV and linking them to HIV treatment, if positive, or prevention services including PrEP, condoms, and circumcision (where relevant), if negative.

Note that index testing should include biological children of mothers living with HIV as a way to diagnose children who were not identified through prevention of mother-to-child transmission (PMTCT) or early infant diagnosis (EID).

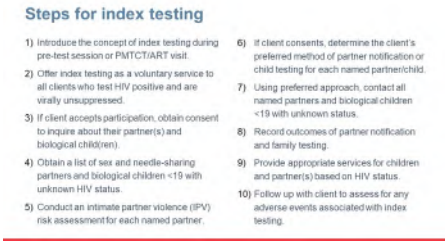
We will talk in detail about the specific approaches recommended in this training.



12. *There are a number of different terms used to refer to the process of working with existing HIV-positive clients to notify their partners of HIV exposure and encourage them to test.*

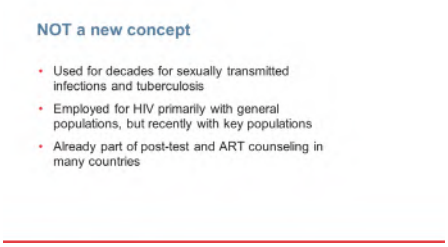
    In [NAME OF COUNTRY/REGION WHERE YOU ARE TRAINING], *it is often referred to as* [LOCAL TERM].

    In order to avoid any confusion, we can take some time now to ensure that everyone feels comfortable with the term index testing, and what it means. What is the best way to refer to index testing here in [COUNTRY]?



13. *These are the 10 basic steps for index testing. We will go into detail about each of these steps as we progress through the training, including the different ways that a client might decide to notify a potential partner who may have been exposed to infection.*

    The basic steps for index testing are as follows [describe the steps as listed].



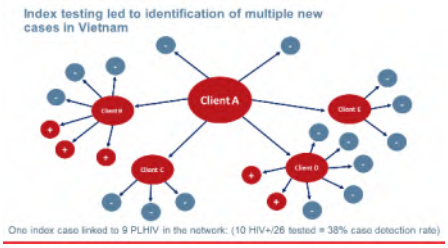
14. *Although it might seem like index testing is a new concept, it has been a public health approach for many years, including for tracking sexually transmitted infections and individuals who may have been exposed to tuberculosis.*

    More recently, given reduced resources and the need to achieve higher yields, programs have employed index testing to focus HIV testing on those most at risk, including sexual and drug-injecting partners of clients living with HIV, and their children.

    Many countries already have index testing as part of their national HIV testing and treatment protocols, but the language and guidance may not be tailored to key populations.

    [Ask the participants why key populations might need tailored guidance. Avoid spending too much time on this discussion because there will be a group activity to explore special considerations for KPs and index testing later in the day.]

15. *There have been several scientific studies showing that index testing—when done correctly—can lead to more timely case detection, but much of the research has focused on the general population. There are also some studies showing that index testing is safe, acceptable, and effective among KPs.*



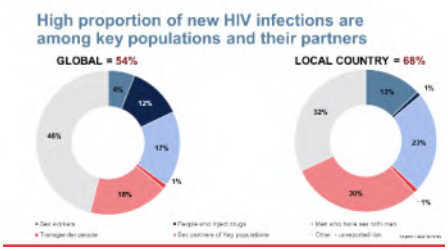
16. *This graphic from a program in Vietnam shows how a client who agreed to index testing services (Client A in the center) helped the program identify four more individuals who had injecting or sexual contact with the client and were also living with HIV (Clients B through E).*

    Each one of the four partners also agreed to index testing services, and as a result, an additional five individuals living with HIV were identified.

    In all, including the first client, a total of 26 people agreed to a test. Ten were living with HIV, which represents a 38% yield.

What might be the advantage of referring sexual and drug-using contacts of the index clients who end up testing negative?

[Those individuals are practicing high-risk behaviors through their contact with the index client, and therefore, will benefit from prevention services and being part of the program.]



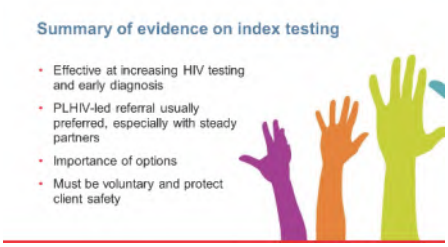
17. **NOTE:** The purpose of this slide is to help demonstrate quantitatively the need for testing and linkage to treatment among KPs in the country where you are training. The pie chart on the right should be edited to reflect data from local country where the training is taking place. The percentage in RED will also need to be adjusted. The pie chart on the left may need to be adjusted if UNAIDS has more recent data.

    So why might there be a strong push for index testing here in [NAME OF COUNTRY]?

    The chart on the left, based on 2019 UNAIDS data, shows that globally, over half of new infections are among members of KPs and their sexual partners.

    In [NAME OF COUNTRY], *that statistic is* ***XX***%.

    Donors, policymakers, and implementing partners—including people living with HIV and KP-led groups—are searching for more effective and efficient case-finding strategies, especially among populations who are most at risk of infection.



18. *In summary, current findings suggest that while index clients prefer to contact their partners themselves (compared to having the provider contact the partner), provider-led referral is more effective at bringing in partners for HIV testing.*

    Note that you will talk later about the different kinds of assisted index testing approaches.

    As we will repeat frequently throughout this training, index testing must be voluntary and informed.

    No client should ever be forced or coerced into identifying and referring their partners or disclosing their HIV status.

Session 3. Index testing in [COUNTRY]—local perspectives (OPTIONAL)

Time: 20 minutes

Materials:

- Presentation slides provided by local presenter
- Flipchart and markers

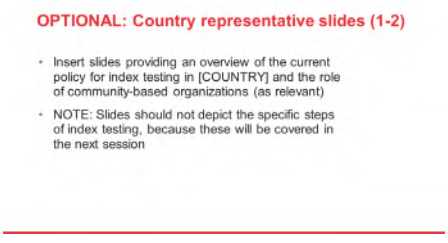
Objectives: By the end of this session, participants will have:

- An understanding of how index testing is being conducted in the country context

19. *The purpose of this session is to help orient you to index testing policies in practice in [COUNTRY].*

    We will be discussing the specific options for index testing over the next few days.

    NOTE TO FACILITATOR: This is optional and can be facilitated by a representative of the Ministry of Health, AIDS Commission, or other governmental or civil society group familiar with current index testing status and policy in the country. The training facilitator can also review the information directly (based on local input). Work with the local government or other representative in advance to ensure that their presentation does not go into detail about the methods and approaches to index testing, because this information will be covered in later sessions. This session allows local representatives to help assure participants that there is a policy/platform for the skills/approaches they will be learning, or that one will be developed along with the adaption of global models for this country.



20. Insert slides providing an overview of the current policy for index testing in [COUNTRY] and the role of community-based organizations (as relevant).

    NOTE: Slides should not depict the specific steps of index testing, because these will be covered in the next session.

Session 4. Steps for index testing

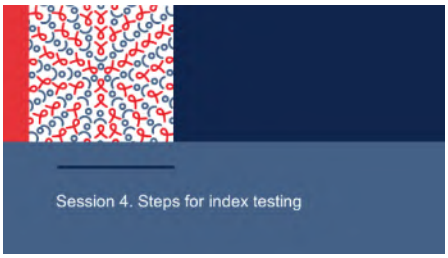
Time: 30 minutes

Materials:

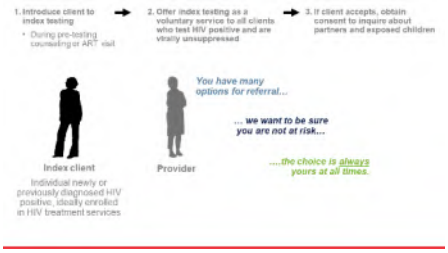
- Training PowerPoint—Day 1 (with adaptations indicated in PowerPoint file)
- Flipchart and markers

Objectives: By the end of this session, participants will have:

- An understanding of the main steps for index testing, including options clients may choose



21. *The purpose of this session is to help orient you to the four options for index testing and to address some important considerations in offering these services.*



22. **NOTE:** Advance the animation in the slide as appropriate while using the talking points below.

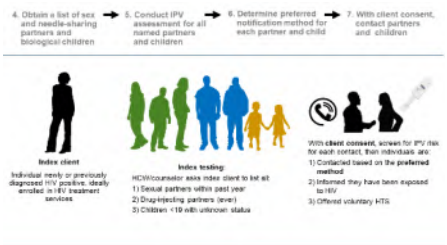
    In index testing, it is important to note who is involved in the process.

    We begin with the index client, who is either newly diagnosed HIV positive, or who is currently living with HIV and may or may not be enrolled in treatment services.

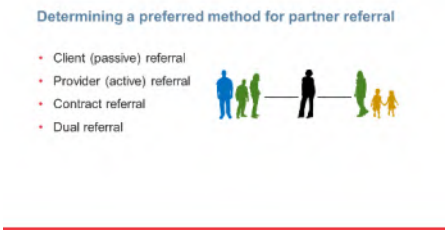
    As noted previously, we take advantage of a variety of opportunities to invite the client to refer all:

    - *Sexual partners within the past year*
    - *Drug-injecting partners (ever)*
    - *Children*

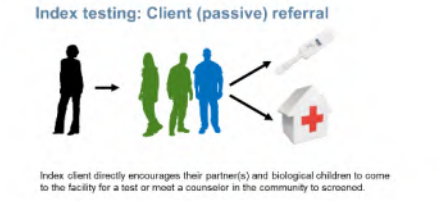
    Informed consent is critical and must be received from the client to participate in the index testing process. We will talk more about consent and confidentiality in Sessions 5 and 6.



23. *If the client consents, each individual on the client's list is contacted, informed that they have been exposed to HIV, and offered testing services. Testing can take place in whatever form is available, including at a facility, in the community, and/or using assisted or unassisted self-testing approaches.*



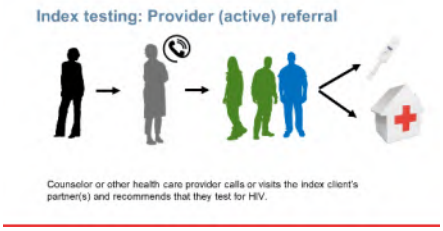
24. *Clients can choose from four options for partner referral in index testing: client referral (which is also sometimes called passive referral), provider referral (sometimes called active referral), contract referral, and dual referral.*



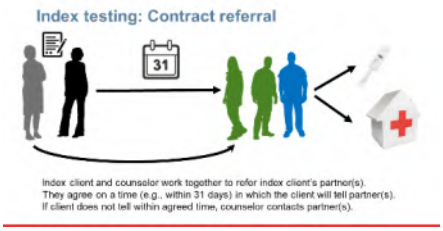
25. *Some clients prefer to disclose to sexual and/or drug-using partner directly. In this case, they agree to notify those individuals themselves, and encourage them to test. They might need coaching on how to disclose, depending on the type of partner. Other clients may invite their partner for testing without disclosing their own status. Disclosure is not required. For example, the client could invite the partner for couples testing and counseling.*

    What are some options for accessing testing?

    NOTE: Elicit responses based on all available testing options in country and be sure to include community-based or self-testing options if available.

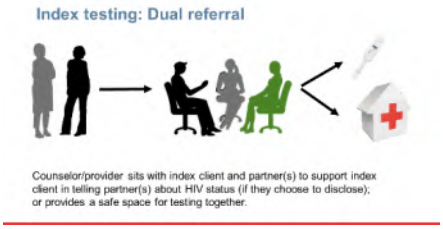


26. *In some cases, a client may prefer not to disclose directly to a partner. This may be because they are too nervous or afraid of that contact's response. They may have concerns about potential harm that this person could cause them. In provider/active referral, the provider agrees to call or visit the index client's partner and then either refer them to testing or provide it directly. Unless the client consents to be referenced, the provider must not disclose the client's name or HIV status.*



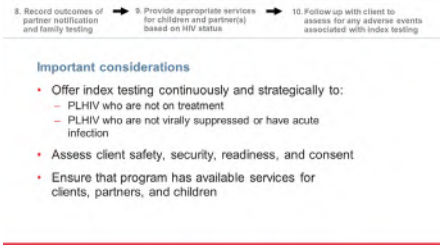
27. *You may have a client who is nervous about disclosing to a partner, and just needs some time. One option is to come to an agreement with your client. With the contract referral option, you and the client agree on a certain amount of time (such as one month) that your client can take to come to terms with disclosing to their partner(s). The client then has that amount of time to make the disclosure. As part of the contract, if the client does not disclose to their partner(s) by the end of the contract period, then the provider (you) has the right to contact the partner directly.*

    However, if at any time the client indicates that they do not want you to contact the partner, especially in potential cases where violence can result, you must maintain the client's confidentiality, safety, and security.



28. *Dual referral allows for in-person support for the client to disclose to their partner(s). In this case, the provider and client agree when and where the provider will join the client and their partner to discuss the client's HIV status, and the implications for the partner. The provider can then either refer the partner or provide testing services at that time, if the partner chooses.*

    Before we move on, do you have any questions about these different options?



29. *It is important to note that index testing is not a one-time event. Each person living with HIV processes and accepts their diagnosis at a different pace, and their readiness to discuss with and/or refer their partners and others who may be at risk will differ.*

    Introducing index testing during outreach and at pre-test counseling will help orient beneficiaries to the service and may increase the likelihood that they opt in.

    Repeating the offer of index testing when a client is diagnosed with HIV, at ART initiation, and during follow-up visits (without coercion) will increase opportunities to promote index testing, and also offer clients a chance to decide for themselves when they are ready. It may increase the chances of successful referrals.

    Not all individuals referred will be members of key populations. It will be important to consider how many people might be referred as a result of index testing and where they can go for support, including accessing free HIV testing, and prevention, care, and treatment services.

Session 5. Minimum standards for safe and ethical index testing

Time: 50 minutes

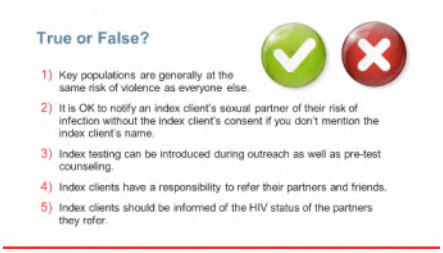
Materials:

- Training PowerPoint—Day 1 (with adaptations indicated in PowerPoint file)
- Five flipchart sheets with headings as described in the notes below
- Flipchart and markers

Objectives: By the end of this session, participants will have:

- An understanding of some of the elements that need to be in place to maintain the safety and security of clients and the referred partners

30. *In this session, we will discuss some of the benefits and potential risks and barriers to implementing index testing services for key populations. We will also discuss the critical elements of an index testing approach that ensure the safety and security of key population clients and their partners.*



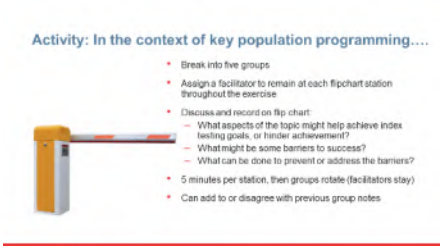
31. **NOTE:** Begin with a short quiz/energizer to get the participants thinking about ethical considerations in conducting index testing.

    Ask the participants to stand up. Explain that you will read five statements and for each statement, you would like the participants to decide if the statement is true or false.

    If they think it is true, they should go to the left side of the room [point], and if they think it is false, they should go to the right side of the room [point]. Note that it's ok if they are not sure, and if they prefer, they can stay in the middle.

    Read each statement one by one as you advance the slide with each bullet, and give the participants time to decide (with their feet). Then ask the participants to return to their seats and advance to the next slide.

    You do not need to discuss the answers now, because you will conduct the quiz again at the end of the session to see if the group understood the messages in this session.



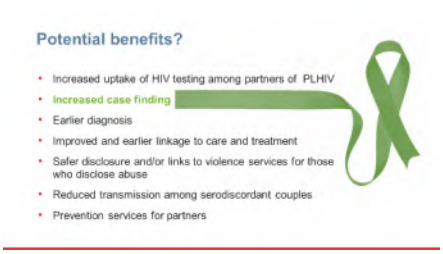
32. **NOTE:** Prepare five flipcharts in advance of this session and label the flipcharts separately with the following: (1) Confidentiality, (2) Safety, (3) Stigma, (4) Disclosure, (5) Legal issues. Place the flipcharts in different parts of the room. (Note, as an alternative, topics can be solicited from participants).

    The purpose of this activity is to get the participants thinking about the special considerations for index testing among key populations in order to help ensure the safety, security, and confidentiality of the clients they serve.

    Divide the participants into five groups.

    Ask each group to meet under a different flipchart, and then explain that they will be spending about 5 minutes per station responding to the three questions on the slide. They are welcome to add to or disagree with any of notes written by the previous group.

    Allow the groups 25 minutes to get through all five flipcharts, prompting them to rotate every 5 minutes. Then ask them to return to their seats.



33. **NOTE:** Before advancing the bullets in this slide, ask the participants to share what they think the benefits of index testing are.

    Use the bullets on the slide to add any additional points that participants didn't mention.

34. **NOTE:** Before advancing the bullets in this slide, ask participants to share what they think could be the potential risk of index testing.

    Emphasize that there is no such thing as zero risk; all HIV testing programs involve some risk.

    Ask participants what they would suggest to mitigate/reduce these risks. Look for suggestions such as: integrate violence screening and referral; link clients to disclosure counseling if necessary; use motivational counseling techniques to create a supportive and safe space for the client to make an educated decision.

Then ask the group what they think are the three or four most critical barriers to implementing index testing.

Use the bullets as necessary to fill in any gaps.

Follow up by asking what they think are some possible solutions to address those barriers.

Ask what might need to be done to plan for and implement controls to maximize positive outcomes and reduce risk.

ADDITIONAL POSSIBLE BARRIERS:

- Trauma due to diagnosis
- Fear reaction of partner(s)
- Guilt about having put partner or children at risk
- Doubts about confidentiality; think partner(s) will know that he/she gave the information
- Anger over probable source of infection
- Lack information about index testing services and ways to tell exposed individuals
- Ignorance of the benefits of index testing services
- Poor communication skills
- Unwillingness to spend time, money, and energy to tell partner(s)
- Don't care about past partners (angry, depressed, unwilling to notify – infidelity)

Display the list after several ideas have been shared.

Ask the participants if they have any questions or comments (avoid lengthy debate on specific topics as you will go into further detail in subsequent slides).

35. *In response to community and client concerns about safe index testing, PEPFAR suspended index testing among key populations and conducted a thorough and participatory review and revision of index testing minimum standards. PEPFAR required all sites implementing index testing to complete a survey (RedCap) to assess compliance with minimum standards and to identify areas for improvement.*

Index testing approaches must be voluntary, confidential, ensure the safety and security of all clients, and be comprised of options that are based on the client's preferences. We

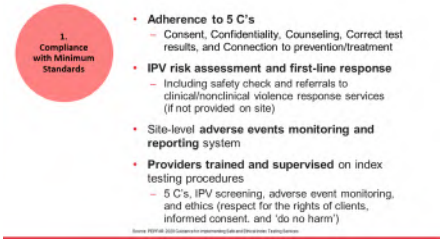
must also protect the safety and confidentiality of referred partners.

All PEPFAR-supported programs should take steps to implement safe and ethical index testing services by:

1. *Monitoring site and provider-level compliance with minimum standards for index testing*
2. *Obtaining informed consent prior to the elicitation interview and before contacting partners*
3. *Conducting an IPV risk assessment for each named partner and providing appropriate services for clients experiencing violence*
4. *Implementing a robust mechanism for detecting, monitoring, reporting, and following up on any adverse events associated with index testing services*
5. *Utilizing quality assurance and accountability to remediate any gaps in the provision of index testing services*

Having options is critical, because beneficiaries will be more likely to use index testing services if they have choices that meet their needs and circumstances. This makes sense if you think about your own expectations when you go to a restaurant, choose a pair of shoes, or travel.

We will discuss in a later session the different kinds of options clients will have for index testing.



36. In response to feedback from community-based organizations and stakeholders working in HIV, the U.S. Government's Office of the Global AIDS Coordinator at PEPFAR established a set of minimum standards for safe and effective delivery of index testing services. It is important that providers know and understand the 5 C's.

NOTE: The use of 5 C's may not translate well in a language other than English, and the script here may need to be adjusted for the local context. It is more important that the participants understand the concepts, as opposed to trying to maintain the English language equivalents.

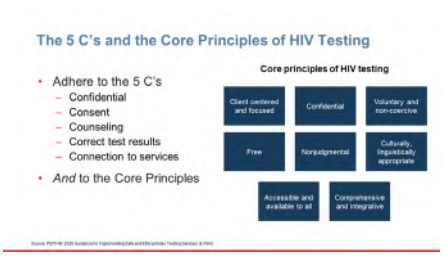
All programs should ensure that providers are able to adhere to the 5 C's, and that they have the capacity and resources to

ask about potential violence and respond appropriately, including referral to essential services.

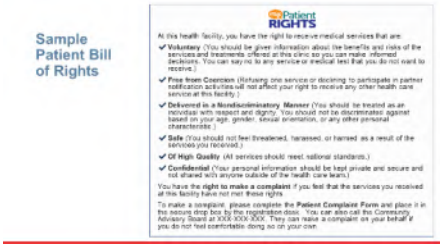
We will talk more about intimate partner violence (IPV) and adverse events in Session 11.

Finally, we must ensure that all providers who will conduct index testing have been thoroughly trained on:

- *The provision of intimate partner violence screening and adverse event monitoring*
- *Ethics, including respecting the rights of clients, obtaining informed consent both for provision of partner contact information and for the method in which those individuals are reached—the key principles of 'do no harm'.*



37. **NOTE:** Go through each of the bullets on this slide one by one and ask if anyone has any questions. Note that you will discuss each of these in detail when you adapt the index testing approaches in a later session.



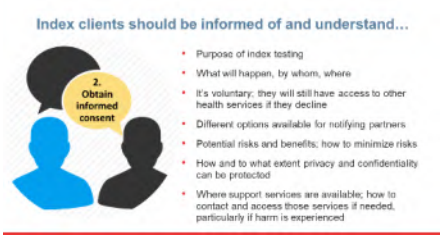
38. *One way of helping providers, administrative staff, and clients know, remember, and uphold clients' rights is to post a 'patient bill of rights' in large print at a place where clients and providers can easily see it within the site or facility. On the right of this slide is an example of a bill of rights.*

What rights do you see are emphasized in bold?

Allow the respondents a few moments to respond.

It is important that teams providing services, including receptionists, custodial staff, and guards, fully understand these rights. At minimum, site leadership should hold a meeting for all staff to review them, ensure they are understood, discuss possible scenarios, address any questions, and ultimately have each staff member sign a statement agreeing to uphold them.

An example of a confidentiality statement and this sample patient bill of rights are provided with this training package.



39. *What do we mean by informed consent, and why is it important?*

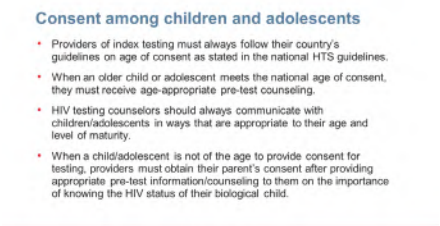
Allow the participants a few moments to respond to the question.

Then go through the bullets on the slide sequentially to explain what clients should be aware of. Note that you will discuss each of these in detail when you adapt the index testing approaches in a later session.

Emphasize that consent (yes/no) is not enough; the client needs to make an informed decision based on sufficient information and understanding.

Examples of language per referral method include:

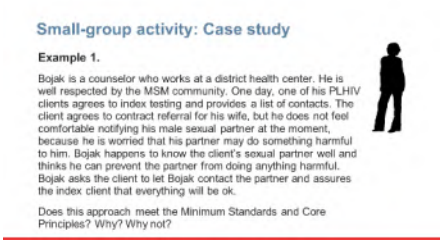
- Contract referral, "I plan to tell my partner about my HIV and refer him (or her) to this facility (or site) for HIV testing within 14 days of today's date. If I am unable to do this within 14 days, I give permission for the counselor to telephone my partner and offer them an HIV test. I understand that while all services are confidential and my partner will not be given my name, there is a risk of accidental disclosure or that my partner will attempt to guess my identity."
- Provider referral, "I give consent for the counselor to telephone (or visit) my partner and offer them an HIV test. I understand that while all services are confidential and my partner will not be given my name, there is a risk of accidental disclosure or that my partner will attempt to guess my identity."



40. *There are special considerations for obtaining consent from children and adolescents that are influenced by local law and policy as well as culture and social norms.*

Review the considerations and ask participants if they have additional points or if they have questions or concerns about any of the bullets on the slide.

Refer participants to the resource "Maximizing Coverage of Index Testing among Biological Children of Mothers Living with HIV: Standard Operating Procedures" prepared by the Pediatric and OVC Interagency Team at PEPFAR.



41. *Let's look at a couple of case studies to explore these issues further. Please find a partner near you, read the case study together, and spend about 3 minutes discussing the questions on the slide.*

    Allow the groups to work together for about 5 minutes.

    Based on this example, do you think that Bojak's approach meets the Minimum Standards of index testing and the Core Principles of HIV testing? Why, or why not?

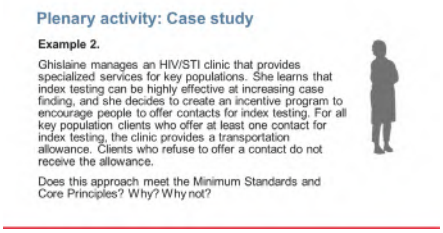
    Allow the participants a few moments to respond.

    CONSIDERATIONS:

    - Bojak sounds like a hard-working nurse/counselor who wants the best for his client. He has offered to go out of his way to help make sure that his client is safe. However, what if something goes wrong, beyond Bojak's control?
    - While this approach is well meaning, it is not entirely focused on the client's wants and needs, and further, it has the potential for causing harm. The client is much more likely to understand his own risks from his male partner than Bojak.
    - It is critical for index testing services to be client centered, voluntary, and non-coercive.

    What could Bojak have done differently?

    Allow the participants a few moments to respond and affirm answers that are in line with the Minimum Standards and Core Principles.



42. **NOTE:** Ask one of the participants to read the example on the slide or have them read it on their own for a minute.

    Based on this example, do you think that Ghislaine's approach meets the Minimum Standards of index testing and the Core Principles of HIV testing? Why, or why not?

    Allow the participants a few moments to respond.

    CONSIDERATIONS:

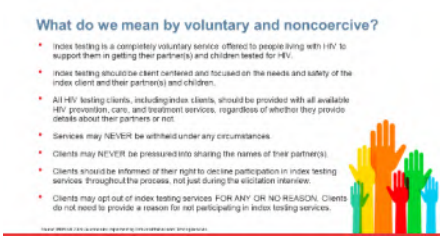
    This is a challenging question. One could argue that risk-network referral rewards people who refer individuals within their risk networks to HIV testing, including people with whom they may have had sexual contact or shared needles. However, referring someone for testing is different

than agreeing to have someone contacted who may be at risk for HIV infection because of their relationship to the index client. In this example, Ghislaine's approach does not entirely embrace the principles of being voluntary, noncoercive, and nonjudgmental because clients may feel pressure to list contacts or otherwise lose possible benefits, and/or experience stigma/judgment from their providers or from themselves.

43. *Here are a couple of examples of what a client could say, or read and sign, that would constitute consent for a provider to contact their partner through contract or provider referral.*

    Ask a participant to read the first paragraph on the slide, and then ask another participant to read the other.

    Ask if the participants have any questions.

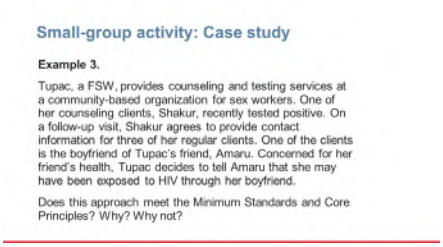


44. **NOTE:** Before advancing the bullets, ask the question in the script below. Then, review the points on this slide if they have not yet been discussed in this session.

    What do we mean when we say that index testing services should be voluntary and noncoercive?

    Allow the participants some time to provide answers. Then advance the bullets using the script if the points have not already been discussed.

    It is important for index testing to be client centered and focused on the needs and safety of the index client and his or her partner(s) and children.



45. *Please go back into your pairs, read the case study, and spend about 3 minutes discussing the questions on the slide.*

    Allow the groups to work together for about 5 minutes maximum.

    Based on this example, do you think that Tupac's actions meet the Minimum Standards of index testing and the Core Principles of HIV testing? Why, or why not?

    Allow the participants a few moments to respond.

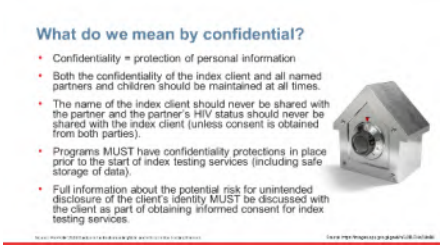
    CONSIDERATIONS:

    Tupac clearly wants to take care of her clients and her friends, and to help reduce HIV transmission in the

community. She is right to be concerned about Amaru's health and well-being. But what could the potential harms be if she informs Amaru that her boyfriend may have given her HIV? What if Amaru's boyfriend decides to harm Shakur in some way?

What could Tupac have done differently?

Allow the participants a few moments to respond and affirm answers that are in line with the Minimum Standards and Core Principles.



46. **NOTE:** Before advancing the bullets, ask the question in the script below. Then, review the points on this slide if they have not yet been discussed in this session.

What do we mean when we say that services must be confidential?

Allow the participants a few moments to respond, then advance the bullets as you move through the script below.

Confidentiality means protection of personal information.

It is important to note that confidentiality extends beyond the index client and must include all partners or children named as well.

As providers (and other staff working at sites that offer index testing), we also need to ensure that index client names are never shared with partners who are notified, and that partner HIV status is never shared with index clients (unless consent is obtained from both parties).

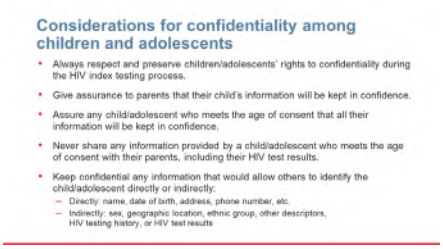
How can we ensure that this happens?

Allow the participants a few moments to respond.

All programs must have confidentiality protections in place prior to the start of index testing services. These may include specific policies, standard operating procedures for protection including measures to store client information, and procedures for responding to breaches of confidentiality (which might include legal and/or disciplinary measures, among others).

Providers will need to discuss the potential risk for unintended disclosure of the client's identity as part of obtaining informed consent for index testing services.

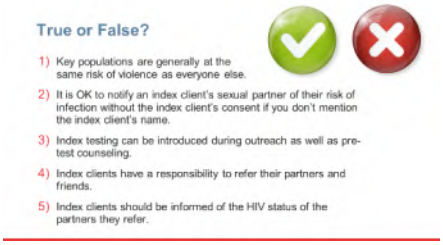
- *Whenever possible, names of contacts other than biological children (e.g., sex and needle-sharing partners) should be kept separate from the names of index clients to prevent accidental breaches in confidentiality.*
- *One method for doing this is to assign all index clients a unique ID number. This number can be written in the "comments" section of the HTS register.*
- *This ID number can then be used in place of the client's name in the index testing register.*
- *Programs may also consider having separate index testing registers for family testing (spouse and biological children) and partner notification (extramarital partners, same-sex partners, needle-sharing partners, etc.)*
- *Under NO circumstances should the name of the index client be shared with community organizations notifying partners out in the community.*
- *Only information required to contact the partner should be shared with these organizations.*



47. *Just as we discussed special considerations for obtaining consent among children and adolescents, so too must we identify the unique aspects of confidentiality.*

    Ask participants to brainstorm how confidentiality among children and adolescents differs from adults. Inquire about participants' experiences.

    Refer participants to the resource "Maximizing Coverage of Index Testing among Biological Children of Mothers Living with HIV: Standard Operating Procedures" prepared by the Pediatric and OVC Interagency Team at PEPFAR.



48. Run the quiz that opened this session one more time.

    Ask the participants to stand up. Remind them that as you read each statement, if they decide it is true, they should go to the left side of the room [point], and if they think it is false, they should go to the right side of the room [point].

    Read each statement one by one as you advance each bullet, and give the participants time to decide (with their feet). Then ask the participants to return to their seats, and advance to the next slide.

Session 6. Tools and flow for index testing

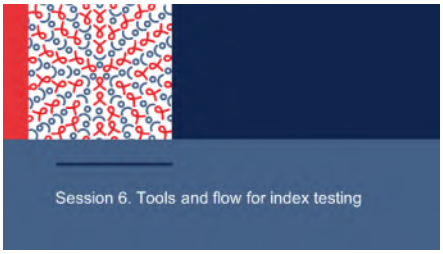
Time: 70 minutes

Materials:

- Training PowerPoint—Day 1 (with adaptations indicated in PowerPoint file)
- Client Flow Game Cards (one set per breakout group; print from separate PowerPoint file)
- Optional: Handouts including sample tools associated with the various steps along the index testing process
- Flipchart and markers

Objectives: By the end of this session, participants will have:

- Reviewed commonly used tools and client flow for index testing services
- Walked through specific steps and suggested broad adjustments to the index testing process, based on the local context



49. *The purpose of this section is to introduce you to some of the tools that are commonly used to support, monitor, and follow up on index testing and associated referral services.*

    While this may seem like a lot of tools, they are important for ensuring client confidentiality and safety, while also helping to determine the effectiveness of index testing in achieving epidemic control. We will not be going through the tools in detail, but just reviewing them for now so that you are aware of them. Your teams will introduce the tools soon so that you can practice the skills you learn in this training while recording important information.

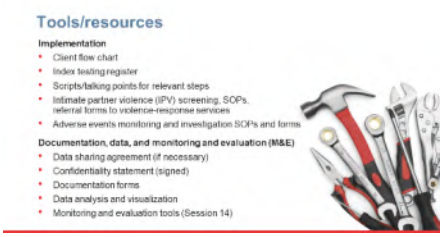
    NOTE: If possible, determine in advance if the program has already developed or will shortly be developing tools for tracking/monitoring index testing. Ideally, program staff (such as those present in this training) will have the opportunity to practice using the tools and provide feedback before they are finalized.

    While it might seem ideal to integrate the tools with practice sessions in this training, it may be a lot of information for people to take on in a single training. FHI 360 recommends that participants first learn the index testing options, flow, and counseling skills before practicing those skills with the tracking logs/forms.

    You may wish to include a packet of handouts with draft versions of the tools so participants can review them

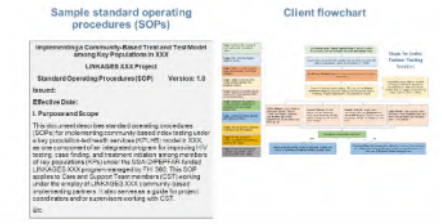
between sessions, or it may make sense to hold off on providing drafts until you are preparing to train on their use.

Finally – each of the boxes in the slides can be edited and replaced with the local language (or other language).



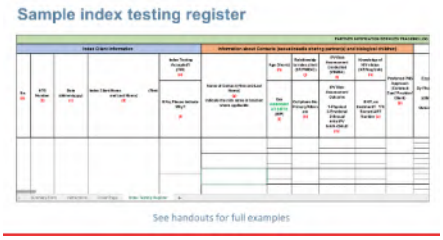
50. *As noted when we introduced this session, we will be going through each of the kinds of tools that are likely to be included in our locally adapted index testing program. This is not intended to overwhelm you, as we will have a separate opportunity to go through each of these in detail once the draft versions have been finalized.*

    For now, it is important for you just to know what they might look like, and why we need them. We will go through the steps for index testing in detail, and you will have an opportunity to determine where you might need to incorporate these tools along the way.



51. *Most programs use some form of standard operating procedures—referred to as 'SOPs'— to guide service steps and follow-up actions for providers and other members. SOPs help orient people who are new to your program and who may not have attended a training like this.*

    In addition, many people appreciate having a visual flowchart to help them understand what possible options or specific steps might take place based on an individual client's choices or circumstances. We will be developing a client flowchart later in this session for the [COUNTRY] *context*.

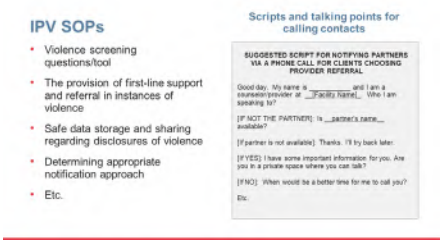


52. *It is important to track index testing service provision for all clients who are offered the service, and ensure tracking of intimate partner violence (IPV) risk, contact notifications, and outcomes.*

    This process will also help you track reasons why clients declined index testing, which will be discussed in a later session.

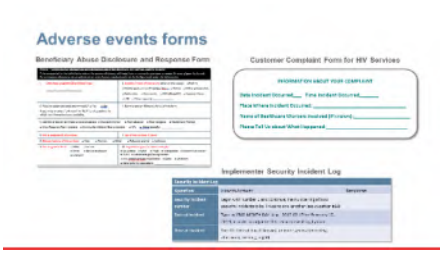
53. *The program will also provide you with specific scripts for introducing index testing to your clients. It is critical to follow closely to these scripts, as they were developed with considerable input from the communities they were designed to serve. You will have a chance to practice using these scripts [during this training] or [during a follow-up session on the forms required for index testing service provision and monitoring].*

    NOTE: It will be important to know in advance if there will be time during the training or during a follow-up session on-site to go through each of the forms. As noted previously, it may be most effective first to ensure participants understand the main concepts from start to finish and have a chance to work through some of the practice scenarios, before providing a full script to learn/guide them.



54. *Our session on Core Principles and Minimum Standards for index testing revealed a number of potential harms that can result from or surface through index testing counseling. It will be important for the team to have SOPs that direct members on what to do to screen for violence, determine if disclosure can be safe, decide on the right approach for notifying a partner based on the safety determination, plan for safe disclosure, and counsel and/or refer in instances of violence, among other procedures. We will have a separate module on intimate partner violence and adverse events.*

    It will also be important to have specific scripts that support you to contact and discuss potential exposures with your clients' partners, and in counseling sessions with index clients. We will have a chance tomorrow to review, revise, and/or develop specific messages that you can use in your sessions.

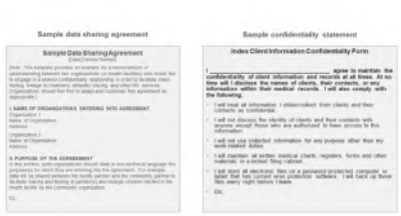


55. *We introduced the concept of adverse events back in Session 5. Can anyone define what an adverse event is?*

    NOTE: An adverse even is an incident that results in harm to the client as a result of their participation in index testing services.

    We will discuss adverse events in more detail in Session 11. It will be important for teams to work together to ensure that reported adverse events are documented in addition to specific actions taken to follow up or provide support. It is also important to document any complaints clients have based on

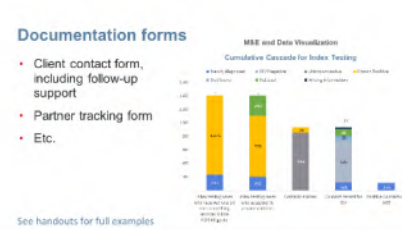
their experience at the service provision site, such as concerns about stigma or discrimination, confidentiality, or consent, among others. Incidents will also need to be recorded in a log to ensure appropriate tracking and follow-up.



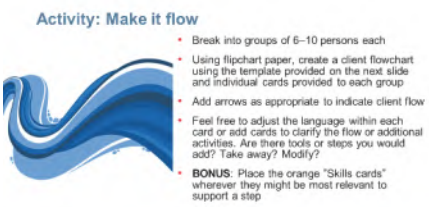
56. *We have already noted the importance of maintaining the confidentiality, safety, and security of each of our clients throughout the partner notification and index testing process.*

    We may need to develop a data sharing agreement between facilities to ensure they can communicate directly to track clients as they make referrals or request support for referrals, and to ensure that we have followed up with appropriate services.

    Having the names and contact information of individuals who may be at risk of HIV infection is a serious matter. If that information mistakenly or purposefully got into the hands of individuals who are not part of our services continuum, it could put either our clients or their contacts at risk. If you have not already signed a confidentiality statement, you may be asked to sign one as part of this program.

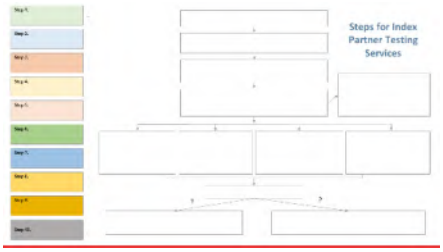


57. *We will need to document client contact information, tracking of partners, and follow-up. We will need to consider how we will track data on index testing, and standardize data visualizations so that we can have conversations about what is working and what might need improvement.*

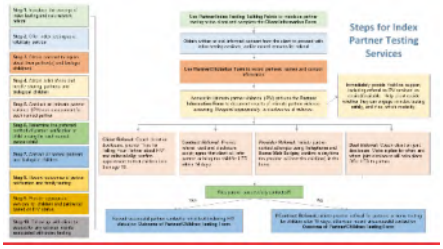


58. **NOTE:** Print a sufficient number of flowchart card sets in advance based on the number of breakout groups.

    Go through the instructions on the slide. Explain that they will be provided with a template (shown on the next slide) to help them with the task.



59. Show this slide after ensuring that the participants fully understand the instructions for the activity as outlined on the previous slide.



60. Use this slide to review the steps if needed. You can also choose one of the flowcharts created by one of the groups instead.

Session 7. Risk network referral

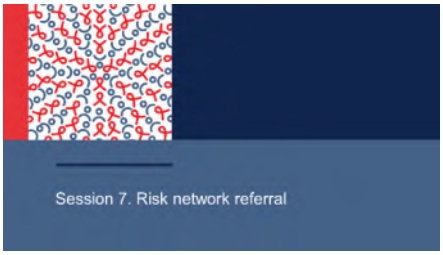
Time: 65 minutes

Materials:

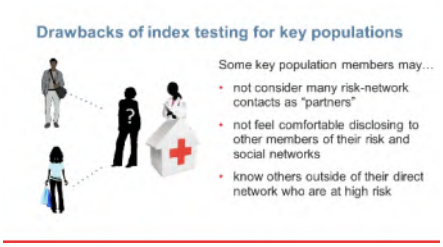
- Training PowerPoint—Day 1 (with adaptations indicated in PowerPoint file)
- Flipchart and markers

Objectives: By the end of this session, participants will have:

- Reviewed the concepts of risk network referral and how it can be integrated with index testing and targeted referral approaches as part of a comprehensive model.



61. *The purpose of this session is to introduce you to a referral chain recruitment approach that can complement index testing and targeted referral to increase reach into social risk networks and improve case finding.*



62. *In the standard approach for index testing, an individual presents at a testing facility or at community-based testing event and, after being diagnosed with HIV, is counseled by a counselor/provider using one of the four methods previously described to encourage sexual and drug-injecting partners and potentially exposed children to come for testing.*

This approach, however, may miss opportunities to dig deeper into the index case's sexual, drug injection, and social risk networks.

Some clients may prefer not to notify their partners. What issues concerns may make it more challenging for a member of a key population to notify their partner(s)?

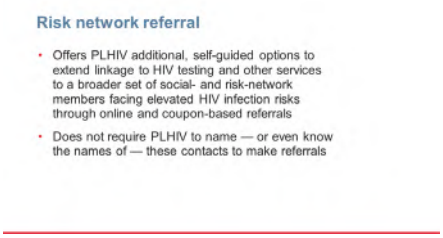
Allow for the participants to provide their thoughts.

Some members of key populations may not consider many of their risk-network contacts to be "partners."

Some may not feel comfortable disclosing their status to other members within their risk and social networks, in part because of concerns about confidentiality in small key population communities.

In addition, a client may be aware of other people in their social network who are not necessarily sexual contacts but who are practicing high-risk behaviors.

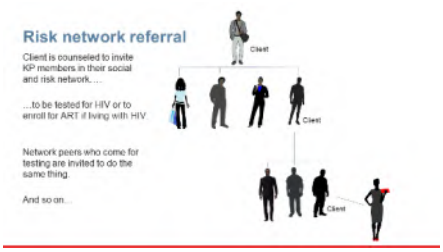
What can be done to ensure we are efficiently and effectively reaching everyone we can with testing and treatment services?



63. *We have been discussing the importance of providing our clients with options.*

Risk network referral is one way of offering our clients additional options for referring people with whom they have had sexual or drug-using contact, or that they know practice risky behaviors within their network.

Clients do not have to name these individuals and can even refer people using a coupon system without knowing their names.



64. *Risk network referral usually starts with a client who is part of our program (either a client we are providing ongoing prevention services to or someone living with HIV – such as an index case). In other words, anyone regardless of their status can refer their peers.*

The client is oriented to the referral process and…

[ADVANCE]

…offered the chance to invite peers within their social and risk networks to come for a test or to enroll in treatment for PLHIV who have not yet started or who have stopped treatment. We can offer a small incentive for each person who is successfully tested. A coupon system is used to keep track of who referred whom to ensure people are provided appropriate incentives.

Each person who agrees to meet with a program team member, such as an outreach worker, a navigator, or a counselor, to conduct a risk assessment and test (if eligible) can also be offered the chance to serve as a mobilizer.

[ADVANCE]

And the process continues with everyone who is eligible.

[ADVANCE]

65. **NOTE**: Practice advancing the animation on this slide to suit your preferred way of explaining showing how you can reach deeper into various social networks through this approach. Some language is provided below.

Here is another way of looking at it.

Our "peer mobilizer," a client living with HIV, might refer four individuals he knows who are either sexual contacts or people who practice risk behaviors within his social network.

[ADVANCE]

They, in turn, refer nine more people.

[ADVANCE]

And so on.

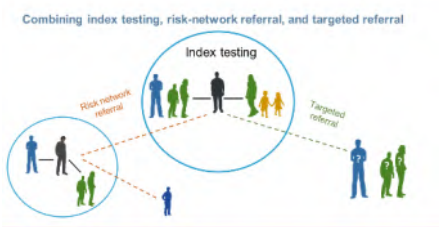
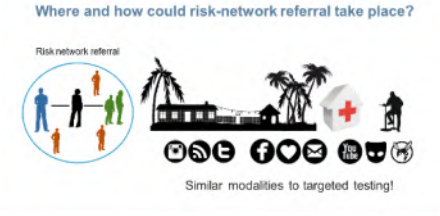
[ADVANCE]

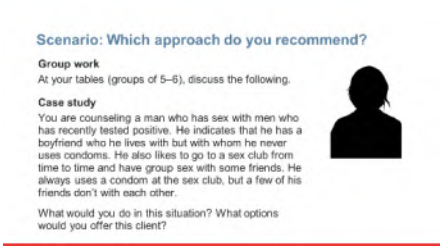
And so on.

[ADVANCE].

Through a process that does not require us to develop contracts with and supervise a large staff…

[ADVANCE]

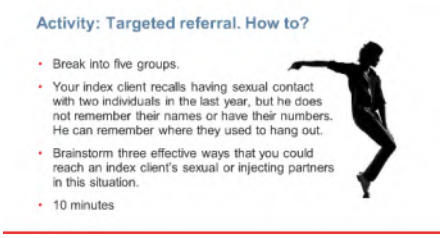
	…we have reached various social networks that would have been challenging to break into if we relied solely on a peer educator or outreach worker's social network.
	66. *This slide shows how risk network referral can be integrated as part of a comprehensive approach that includes various options for clients.* *Risk network referral extends the scope of referrals beyond clients who would usually be considered (and counted as) part of a traditional index testing approach.* *In targeted referral, the client may recall someone with whom they had a risk contact, but they may not know their name or number. We will discuss ways in a moment for how we might be able to reach those individuals.*
	67. *And this slide helps show how these approaches can be combined.* *The index client in the central circle refers a number sexual and drug-injecting partners and his children for testing using one of the partner-notification options we have already discussed.* *In addition, he uses a risk network referral approach to refer a peer with whom he either had sexual contact (but does not want to disclose to) or knows practices high-risk behaviors (orange dashed line). That person is then invited to choose from the same set of options.* *The original index client might also tell the counselor about a person he knows who may be at risk, but for whom he does not have a contact name or number. Perhaps he met that person at a bar, and he feels comfortable telling the counselor the name and location of the bar.*
	68. *So where might risk network referral take place?* [Allow a moment for participants to brainstorm and provide responses. Then advance as appropriate one at a time to show the various venues through which peers can be referred. They include in the community, at a health center, at a café or restaurant, or through any of the popular social media and dating apps that might be commonly used in this country.]



69. Introduce this group work session by asking participants to form groups of 5–6 or work at their tables (if the tables are about that size).

    Have a participant read through the case study and then read the questions. Ask if there are any questions and then allow the group 5 minutes to consider.

    After 5 minutes, ask for volunteers from any of the groups to provide their thoughts (briefly), and after each response, ask if anyone has anything new to add.



70. Ask the participants to break into five groups or remain at their tables in groups if appropriate or preferred.

    Ask a volunteer to read the scenario and instructions, and allow the groups 10 minutes to brainstorm.

    At the end of 10 minutes, ask for a group to volunteer to report back, and limit the report to 2 minutes. Ask if any groups had different ideas, and allow them to fill in any ideas not yet stated (avoid having groups report back on the same ideas).

    Advance to the next slide to assist you with filling in any gaps not mentioned in the discussion.

71. Use this slide to fill in any possible approaches that may not have been discussed in the brainstorm session described in the activity on the previous slide.

    Avoid repeating what has already been said by the groups to save time and honor the contributions of the participants.

72. Wrap-up Day One with participant summaries and review content for Day Two.

END OF DAY 1

DAY 2

Welcome and review of Day 1

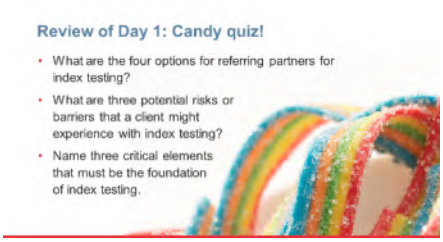
Time: 5-15 minutes

Materials:

- Candy Quiz (Training PowerPoint Day 2, Slide 2)
- Candy prizes

Objectives: By the end of this session, participants will have:

- Had the opportunity to answer questions about key issues and elements discussed in Day 1 (candy prizes provided for accurate answers)

	1. Project the title slide for the **Day 2** presentation. Welcome the participants and thank them for coming to Day 2 of the training. Ask if they are comfortable with the temperature of the room before you begin. As you will be conducting a short quiz in the next slide, you can wait until after the quiz to ask them if they have any questions before beginning with the Day 2 sessions.
	2. *Is everyone ready for a candy quiz?* [You can conduct this quick in plenary format. Advance one question at a time and award individuals who answer correctly with a piece of candy (or other prize).] Before moving to the next session, ask if the participants have any questions about the material covered in Day 1. Where possible, ask participants to provide their thoughts to help answer the questions before providing your own thoughts. When the group is ready, advance to the next session.

Session 8. Client panel (OPTIONAL)

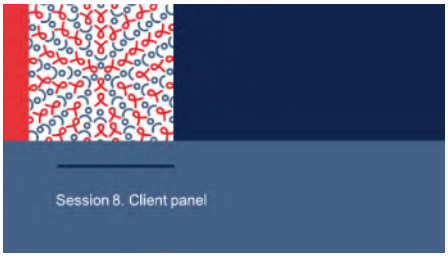
Time: 45 minutes

Materials:

- Room set up for panel discussion (table, chairs as needed)
- Name tags if needed
- Training PowerPoint—Day 2 (with adaptations indicated in PowerPoint file)

Objectives: By the end of this session, participants will have:

- Had the opportunity to learn from a panel of clients living with HIV about their index testing and risk network referral experiences, and ask questions
- Gained empathy for the process of undergoing index testing



3. **THIS SESSION IS OPTIONAL:** Invite a panel of actual clients living with HIV from the community to talk about their specific experiences working with index testing and risk network referral. Ideally, some among them will have undergone index testing and risk network referral and had positive experiences.

   OBJECTIVE: The purpose of this exercise is to give participants the opportunity to learn from the experiences that clients had when offered and followed through with index testing and risk network referral options, and any tips they have to ensure the process is successful. This session will help orient participants to the challenges clients may face, as well as challenges providers may have when conducting index testing. It also offers a safe space to ask questions before practicing the skills.

4. The session can be run like a panel discussion. Facilitator(s) can invite a maximum of four clients to sit at the front of the room or within a circle among the participants. Each client can be provided about 5 minutes to speak. Talk with clients in advance about what you hope they can bring to the discussion (a description of their experiences being offered and opting in for index testing and/or risk network referral).

   Possible subjects to cover:

   - How did they feel?
   - What aspects of the counseling approach used by the provider helped them make a decision?
   - What were their concerns, and how did they overcome them?

- What were the outcomes?

Allow 10 minutes for Q&A, and then thank the clients and move to the tea break. Ideally, the clients will stay for tea, providing participants more opportunities to approach them if they have additional questions.

Session 9. Building a localized index testing and risk network referral approach

Time: 100 minutes

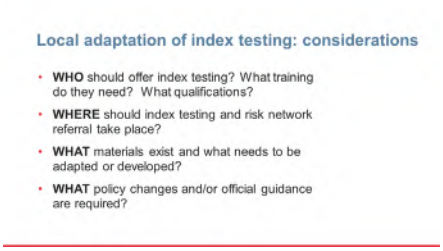
Materials:

- Training PowerPoint—Day 2 (with adaptations indicated in PowerPoint file)
- Optional: Printouts of Slide 8 (index testing steps) for breakout sessions
- Flipchart and markers

Objectives: By the end of this session, participants will have:

- Developed and/or adapted specific models of index testing for their country context, including recommendations on specific tools, and roles and responsibilities of key players.

5. *In this session you will have the opportunity to consider how to adapt index testing and risk network referral for the [COUNTRY] context. We will return to the flowcharts you worked on in Session 6 and then, employing several key questions, construct a step-by-step design.*



6. *When considering how best to adapt an index testing approach for the [COUNTRY] context, it will help us to consider some familiar overarching questions first.*

   Who will be the key players to offer clients index testing? Where will they provide these services, and what qualifications and training will they need to conduct index testing effectively?

   What might need to be adapted to complete our toolkit?

   Are there any policies that will need to be developed or modified to ensure the right people can implement in the most appropriate places?

7. *Let's take some time to address these questions and others in small groups.*

   Ask the participants to break into groups of 8–10 individuals. This might involve combining people from one table to another, so that you have two or three groups total.

   Explain that you will be showing several questions on the following slide that follow the key steps of index testing discussed in Session 6. The purpose of this session is to divide the steps by groups and address the questions to the extent possible within the time provided (about 75 minutes). Given the amount of time, groups should be encouraged to go into as much detail as possible, while staying on track to respond to all questions.

   Ask if there are any questions, and then advance to the next slide. You may also choose to print out this slide in advance so that each group (or all participants) have a copy.

8. **NOTE:** You may wish to print out copies of this slide in advance for each group or for all participants to assist them during the activity.

   Based on the number of participants and breakout groups, divide the steps by group accordingly. For example, if there are three groups, you might divide as follows:

   Group A: Steps 1–3

   Group B: Steps 4–6

   Group C: Steps 7–10

   Note that you will ask a volunteer from each group to report back for no more than 5 minutes, and a prize will go to the group that is most creative and concise.

   Before beginning the activity, say the following:

   I would like to note that, for Step 5, disclosures of violence should also help inform decision-making about the appropriateness of index testing; ultimate decisions rest with the service user.

   Therefore, a disclosure of violence in Step 5 does not make someone ineligible to engage in index testing. However, the disclosure of violence must be taken into account when determining whether and which modality should be used.

   Allow the groups about 70-75 minutes to conduct their work. If you find that a group has finished very early, visit with them to see what they have done and consider how

much detail that have provided in their notes. If relatively limited, encourage them to go into greater detail (i.e., specific service steps, names of organizations/agencies/departments, specific documents or policies needed, etc.). If the group has the capacity, you may also ask them to start considering the specifics of the job aids or SOPs they are recommending. What is already existing that might need to be modified? Who might be responsible for adapting, revising, or developing new guidance. What might be realistic in terms of timing? Etc.

Bring the groups back together with at least 25 minutes remaining, and ask each group to have one reporter explain what they discussed in 5 minutes or less. If you like, you can time each session and give the reporter a 1-minute warning. Allow all groups to present, and then facilitate a discussion about the steps with the remaining time.

Don't forget to give a prize to the group with the clearest and most concise report (you can have the groups vote or decide for yourself).

Ask if there are any questions, and then move on to the next session.

Session 10. Motivational counseling

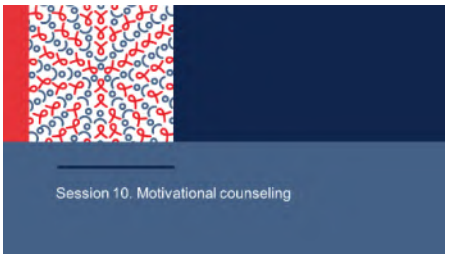
Time: 90 minutes

Materials:

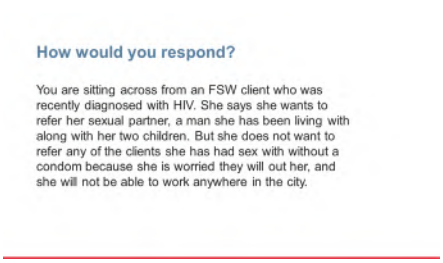
- Training PowerPoint—Day 2 (with adaptations indicated in PowerPoint file)
- Ball (for Reflections Ball Toss – Slide 16)
- Flipchart and markers

Objectives: By the end of this session, participants will have:

- Reviewed key motivational counseling techniques and practiced their use in realistic scenarios

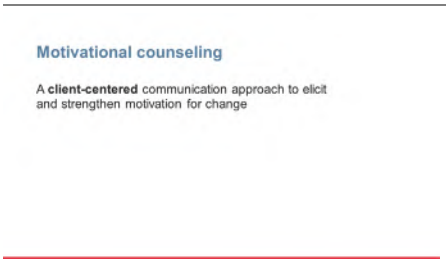


9. *In this session, we will discuss some techniques you can use to help your clients find their own motivations for making healthy decisions for themselves, their loved ones, and partners. You will also have several opportunities to practice the techniques. Even if you have been in motivational counseling training before, the exercises in this session will help you refresh your skills and support your peers to learn and/or practice them.*



10. Ask a volunteer to read the scenario on the slide.

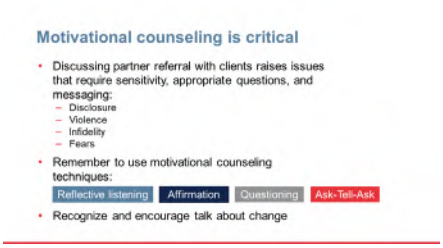
    Elicit some responses from the group on how they might respond, and then advance to the next slide.



11. Ask a volunteer to read the definition of motivational counseling. Then advance to the next slide.

12. *Why might a client-centered communication approach to elicit and strengthen motivation for change be important in the context of index testing and risk network referral?*

    Allow the participants a few moments to respond to the question, and then advance to the next slide.



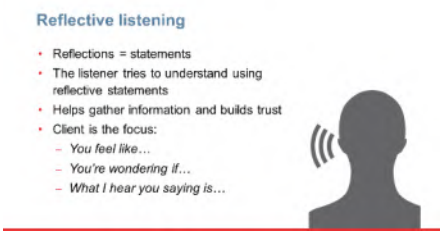
13. *Several issues may come up when you are discussing partner referral with your clients.*

    Some clients may have experienced violence or are afraid that disclosing could lead to violence. They may be grappling with having to tell someone who loves them that they have not been faithful in the relationship and that they have exposed them to HIV infection. It is not uncommon for clients to experience fear, shame, and ambivalence about what to do.

    It is important to use motivational counseling techniques at all stages. These include:

    [NAME EACH SKILL AS YOU ADVANCE THEM ONE BY ONE ON THE SLIDE].

    It is also important for you to recognize when your clients talk about changes they are thinking of making that favor positive outcomes, and encourage them.



14. Ask the participants what they think "reflective listening" is.

    Allow them to respond.

    Reflections are statements – not questions – that can be used to gather information and to help you better understand your client.

    There are some verbal cues that can be used when one is making a reflection. For instance:

    - *"So you feel…"*
    - *"What I hear is that you…"*
    - *"You're wondering if…"*
    - *"It sounds like…"*

    These don't have to be used, but they can be helpful, especially for someone who is just starting to use reflections.

    Have participants practice the basic idea of reflections by feeding them a few statements, and see if they can reflect the statements back to you:

    - "People always talk about HIV, but I'm young and fit, so I don't really worry about it."
    - "I know I should tell my wife, but I just don't know what I'd do if she and the kids left me."
    - "If I ask my boyfriend to use condoms, he's going to think I've been sleeping around."

15. **Reflections Ball Toss**: Ask the participants to go to a part of the room where the entire group can stand in a circle and see each other. Bring a ball that can be easily thrown and caught (this can be made with paper and tape if needed). Explain that you will make a statement about yourself. You might suggest a theme for the group—such as "Something I like about myself" or "Something I am working on"—whatever is appropriate for your participants.

    Example: *I love to travel for my work, but I feel like I don't have enough time to spend with friends and family.*

    Explain that after you make your statement, you will make eye contact with someone in the circle and toss the ball to them when they look ready to receive it. Their job is first to reflect on what you said, then say a statement about themselves, then toss the ball to someone else.

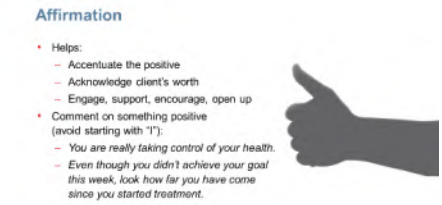
    Note: this requires that participants pay attention to one another. Continue until everyone has had at least one turn – if it Is going well, you might continue for an additional

round, but with a different theme. Try to avoid participants passing the ball to the person next to them – the idea is for all participants to be listening and thinking, since they never know if they might be next.

When the activity is over, ask participants how they felt. What was easy about reflecting? What was difficult?

Expect to hear that it was hard to stay focused and keep up with everything that was being said.

Explain that *to be able to reflect your client's statements effectively, you need to be able to listen closely and watch your client for verbal and nonverbal cues AND think carefully about your client's meaning. Rather than being concerned with what you want to tell your client, your first concern should be understanding what they are trying to tell you*.



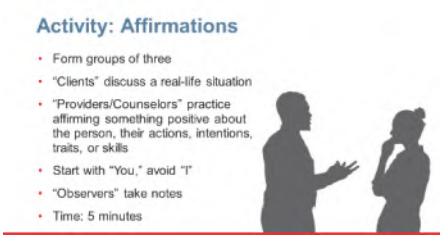
16. Ask participants if anyone can explain what an affirmation is.

Offering affirmation means highlighting the positive things about our clients. Many educators/counselors may spend the majority of time focusing on their clients' "bad" behaviors, and rarely acknowledge their positive choices, changes, or intentions. Affirming can help build a positive rapport with our clients (it can be exhausting if someone is always telling you what you can do better). Affirming can also decrease clients' defensiveness and make them more open to constructive critical feedback in the future. At its core, affirming is about empathy – because it shows that we are recognizing the value in every person, even those who don't practice ideal behaviors consistently, if ever.

Explain that there are different ways to affirm.

Ask the participants for examples of things they might affirm about a client (or friend/family member/partner).

- You can make a positive comment about a person's intentions or actions
- You can comment on positive traits or skills
- You can even reframe a negative as a positive – i.e., *"You haven't been able to quit smoking yet, but you keep trying, because you really care about your health."*



17. Ask participants to turn to a partner at their table (everyone should be in groups of two or three if necessary). Tell the participants that the purpose of this exercise is to take a few minutes practicing affirmations with each other. Ask the participants to think of a real-life situation they are currently dealing with that they feel comfortable sharing with their partner(s). Then, in turn, each person should tell the listener briefly about the issue they are working on, and what they are doing to overcome challenges they are facing with it.

    Encourage participants who are serving as listeners to provide affirmations where appropriate, making sure to start with "you" in their statements (avoid starting with "I"), and to focus on something positive about the person, their actions, intentions, traits, or skills

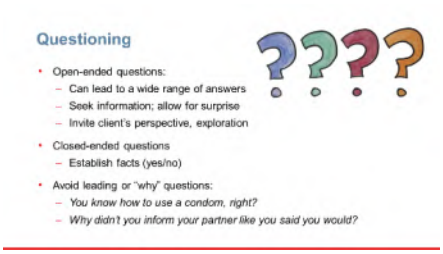
    Allow about 5 minutes for the exercise, then discuss in plenary reactions and observations from the activity.

    How did it feel receiving an affirmation? How did it feel giving an affirmation? How could this potentially help the client-provider relationship in conducting index testing and risk network referral?

    If there is time, ask participants what the difference is between affirmation and praise.

    Affirmation is not the same thing as praise. To affirm is to state something as a fact – to recognize the goodness, the value within our client, or their behaviors or their intended behavior. That goodness exists whether we choose to acknowledge it or not – it simply is. To praise, on the other hand, is to establish the outreach worker or counselor as a judge of what is good or bad, what has value and what does not. This places them in a position above the client.

    In practice, this means making affirmations that focus on "you" (the client) rather than "I" (the outreach worker). Think about the difference between "You really want to protect yourself" and "I think you're trying very hard." In the first example, the focus is on the client; in the second, the focus is on the outreach worker, and his or her evaluation of the client.

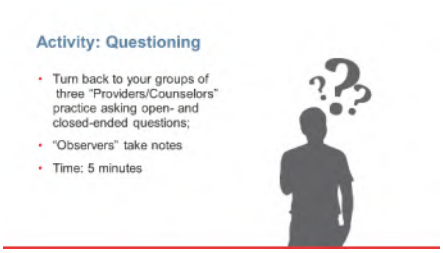


18. Ask the participants to help you define the difference between the different kinds of questions one might use:
    - Open-ended question
    - Closed-ended question
    - Leading or "why" question

    Have participants give examples of each.

    Discuss what types of questions would generally be better to use with clients, and when one would use the different kinds of questions:
    - Open: Allows you to probe deeply, while keeping the conversation focused on the client. Helps build rapport and maintain flow.
    - Closed: Useful for establishing facts, understanding behavior, but one can fall into the "assessment trap" whereby the client simply responds to a list of questions.

    What could be the danger of using leading or "why" questions that start with why?
    - Leading question: Generally inappropriate as you don't know if the client is telling you the truth, or telling you what you want to hear.
    - "Why" question: Always inappropriate. Loaded questions are a form of blaming the client, and they are inconsistent with sound behavior change communication.



19. Ask the participants to turn back to their groups of three and return to the discussions they were just having.

    This time, have one participant start by asking a question to elicit more information about the situation discussed in the last exercise (individuals can switch roles if there was not enough time to do so in the previous session). Providers/counselors should be encouraged to use both open- and closed-ended questions to learn more about the client's perspective, experiences, etc.

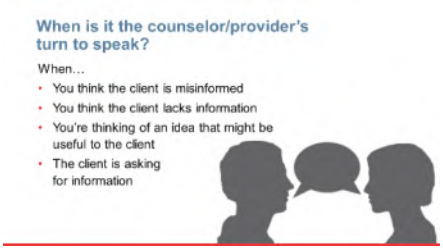
    Observers should observe what kinds of information the different questioning approaches yield, and how the conversation flows as a result. They should also be on the lookout for leading questions or questions that start with "why," and take note. Time permitting, individuals can switch roles.

Hold a brief plenary discussion after the exercise to get observations and thoughts from the group.

When is the right time to use an open-ended question versus a closed-ended question?

Open questions, as opposed to closed questions, help you engage and gain a deeper understanding of your client because they keep the focus on the client, rather than on you. These are generally the best way to begin a conversation when you are still creating rapport with your client. That doesn't mean you should never use closed questions – sometimes closed questions are necessary to obtain specific or precise information, or to clarify a point.

If you have a list of specific yes or no questions for which you need answers (for instance, for data collection purposes), it is best to save them for later. You may find you get the answers you need without having to ask those specific questions.

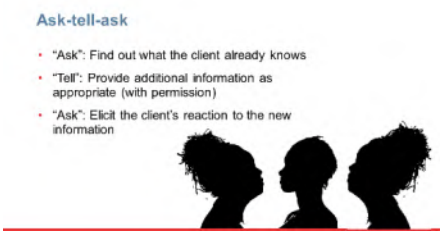


20. Brainstorm some of the situations in which it is important for counselors/providers to take the lead:

- If the client lacks information or is misinformed
- If you have an idea or suggestion that might help the client
- If the client is asking for information or assistance
- Others?

When it is your turn to provide information, it can be hard to do so without seeming like you are the expert and the client is dependent on you for information. What could be the risk of playing the expert as opposed to being a collaborator?

Playing the expert may be faster, but it ignores the knowledge/experiences that the client may already have. This may send a message to the client that we really aren't interested in them as a person. It also means we may not be addressing the client's most relevant challenges, since we did not ask what those were. Finally, even though clients may half-heartedly accept our suggestions as experts, they may not be truly committed to change.

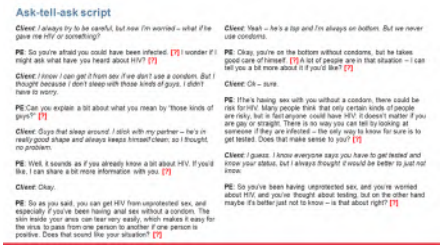


21. *We want to be able to provide information and guidance to our clients, but we want to do this in a collaborative way.*

    This is where "Ask-Tell-Ask" comes into play:

    - ***Ask** the client what they already know about the topic at hand.*
    - ***Tell** the client additional information. (And only the relevant information. There is no need to repeat what clients already know, and we should avoid overwhelming them with details.)*
    - ***Ask** the client for their reaction to the new information you have provided.*

    Asking clients what they already know and how they interpret what information we they share with them is something we practice any time we want to provide new information or suggestions to our client – it reinforces the client's autonomy.

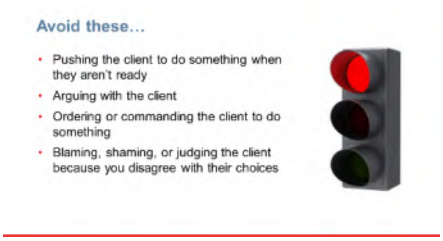


22. Ask for two volunteers who will help you act out the script on the slide. If the training group is large, you may want to print the slide in advance and hand out copies before the activity begins.

    Before the two readers begin, explain that one will serve as the client and the other as a counselor.

    Explain that the question marks in red (on the slide) in the script are markers that follow one or more of the skillsets discussed in this session. As the two volunteer readers move through the script, participants are welcome to raise their hands or call out the skill used just before each question mark.

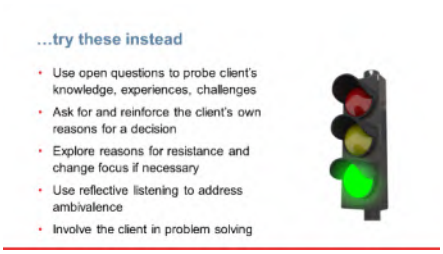
    Ask the volunteer readers to pause at each red question mark to allow participants time to guess. Use the answer key in the notes of the slide to guide participants.



23. *Regardless of which strategy you use in communicating with your clients, it is important to avoid certain communication approaches that, while they may be well intended, are likely to encourage clients to resist change.*

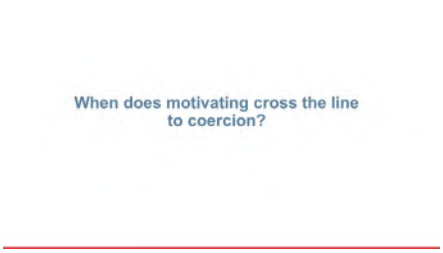
    These include the ones on this slide. Would someone like to read these on the slide?

    Have a volunteer read the examples.



24. *In place of the approaches on the previous slide, you can try using these approaches instead. Would someone like to read from the slide?*

    Have a volunteer read from the slide.



25. *Can anyone tell me what motivation is? What are other words you would use to describe it? How does it relate to index testing?*

    Capture participants' comments on flipchart paper.

    Now can anyone tell me what coercion is?

    Capture participants' comments on flipchart paper. Highlight when there is any similarity between words used to describe motivation and coercion.

    When does motivating cross the line to coercion? Let's do a short exercise to see what you think.

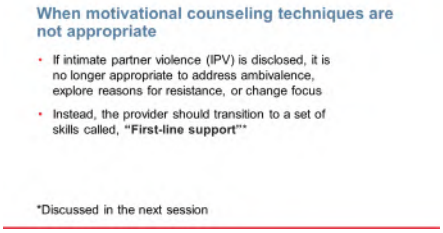
    Ask the group to stand up. They will need to be able to walk to one side of the room or the other, or stay in the middle for this exercise. Alternatively, they can stay in their seats and raise their hands.

    Call out the following examples and ask participants to vote with their body and/or their hands to indicate if it is motivation, coercion, or a little of both:

    1. *To increase index testing results, Clinic A is paying PLHIV $10 for every partner they refer, and an extra $5 if the partner tests positive.*
    2. *A PLHIV client arrives to pick up her ART. The counselor tells her she can't get the medicine unless she refers at least two partners for HIV testing.*
    3. *A mother living with HIV is hesitant to bring her biological children for HIV testing. You pair her with a peer mother who can share her own experience with referring her children.*

    COERCION: the practice of persuading someone to do something by using force or threats.

    Remind the participants that noncoercion is a core principle of HIV testing before moving on.



26. *Motivational counseling helps clients and providers form a relationship in which sensitive information is likely to be shared. In the context of index testing, that information may involve violence from one of the index client's partners.*

    Disclosures of IPV cannot be treated like other causes such as ambivalence or other reasons for resistance. Engaging a violent partner through partner notification can cause extreme harm to the index client. If a client does not feel comfortable engaging a partner because of violence or the threat of violence, then it should not be pursued further.

    At the same time, a client who discloses IPV has now shared important information that can affect their treatment adherence, viral load, and overall well-being.

    It should be addressed immediately.

    When violence disclosures occur, the conversation about index testing should be paused and the provider should shift to offering first-line support. First-line support will be explored in detail in the next session.

Session 11. Asking about and responding to intimate partner violence

Time: 120 minutes

Materials:

- Training PowerPoint—Day 2 (with adaptations indicated in PowerPoint file)
- Flipchart and markers

Objectives: By the end of this session, participants will have:

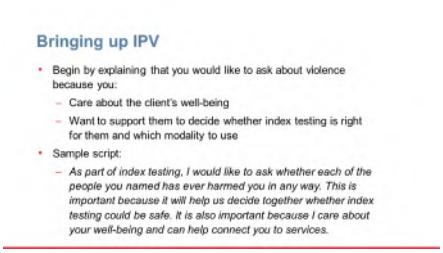
- Addressed important considerations in asking and responding to intimate partner violence in the context of key population programming

27. *In this session, we will discuss some of the minimum requirements that must be in place before asking about violence, and learn recommended ways to ask about and respond to intimate partner violence.*

28. *We've touched several times on violence throughout this training. In this session, we will be discussing how to ask about violence and what to do when it is disclosed.*

    Before staff members in a program can ask about violence—thus, before the program can implement index testing—several elements must be in place. While providers are not responsible for many of these (such as developing SOPs), it is important for you to know what kinds of support should be available to you as you engage in this important work.

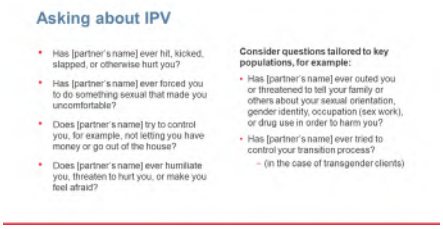
    The two requirements that we will cover in detail in this session are outlined in red on the slide.



29. *Many clients will not understand why an HIV counselor would want to talk about their experiences of violence. Therefore, it is important to begin with explaining that you would like to ask about violence because you care about their well-being and want to support them in making a decision about whether index testing is right for them and which modality to use.*

    You might consider using the script provided here on the slide. Would someone like to volunteer to read it?

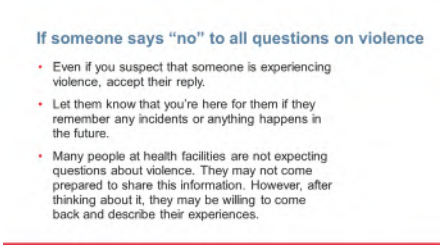
    Have a participant read the lines and ask if there are any questions.



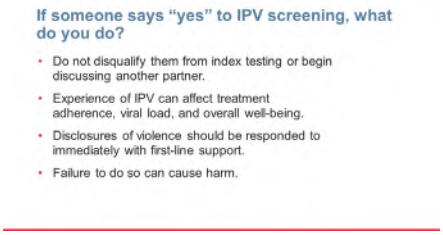
30. *When you ask about intimate partner violence, it is important to use questions that have been standardized. This ensures that each provider is not relying on their own interpretation of violence and that a broad range of violence is explored.*

    The questions on the left are validated for cisgender women. They are useful with key populations as well, but will not address 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.



31. So, what should you do if someone says no to all of your questions?



32. *If someone says "yes" to IPV screening, what do you do?*

    It is important not to disqualify them from index testing or begin discussing another partner.

    A client who discloses IPV has shared important information that can affect their treatment adherence, viral load, and overall well-being. It should be addressed immediately.

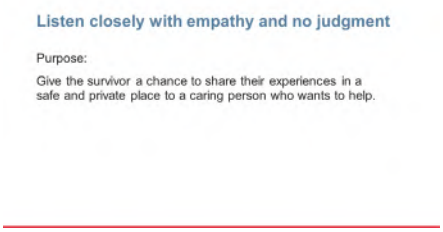
    Disclosures of violence should be responded to with first-line support. Failure to do so can cause harm.

33. *First-line support is also known as psychological first-aid.*

    It can be easily remembered using the LIVES acronym in contexts where English is spoken.

    Review the contents of the table.

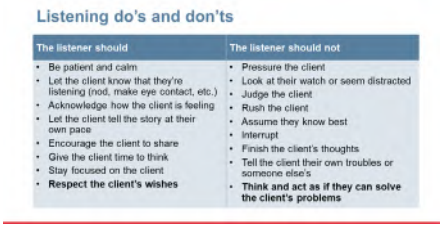
    You can see from the image that WHO recommends health care workers use LIVES when women disclose violence. It can also be used with key population members who are male or transgender.



34. *We will now go over each of the skills in outlined in the LIVES acronym.*

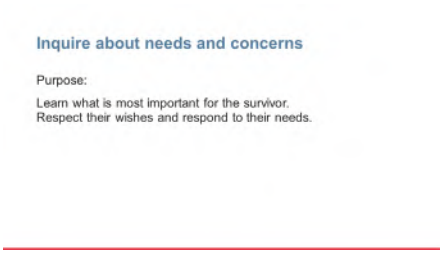
    The first is listening without judgement and with empathy.

    Remember that it can be difficult to share about an experience of violence; making it clear that you are interested and empathetic can encourage a client to open up.



35. *We discussed the importance of reflective listening in Session 10. However, an important difference between motivational counseling and using the LIVES approach in instances of disclosed violence is that you, as the provider, do not have a behavioral goal for the client. Your role is simply to listen to the client to understand what they wish to do without attempting to direct them toward a specific choice.*

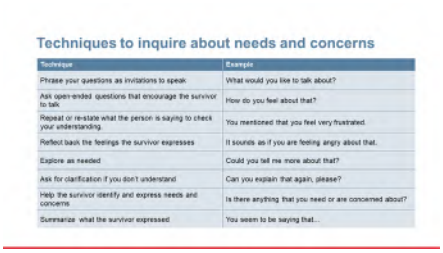
    It is also important to remember that IPV is a complex and personal issue and that it is not your role to solve your client's problems. LIVES provides a platform in which you give the client options and let the client know that you will support any choice that they make.



36. *The next skill is inquiring about needs/concerns.*

    The purpose of this step is to learn what is most important for the survivor.

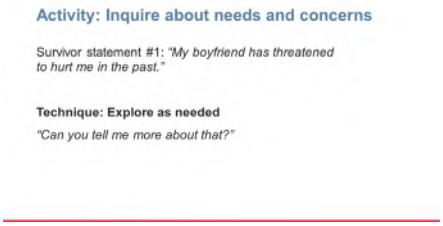
    It is important to respect their wishes and respond to their needs.



37. *There are many techniques to help you inquire about needs and concerns.*

    Ask the participants to review the options on the table and choose a few of these that they think they could do.

    As necessary, remind them that many of these skills are also used in motivational counseling.



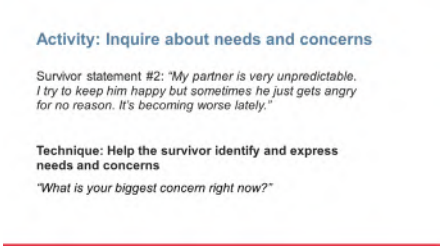
38. *Let's try practicing some of the techniques.*

    Suppose that you are with one of your clients, and you ask about violence and the client says, "My boyfriend has threatened to hurt me in the past."

    What could you say to get the survivor to provide more information?

    Allow the participants to provide a few answers, then advance.

    Explain that it can be as simple as saying "Can you tell me more about that?"



39. *Let's do another statement.*

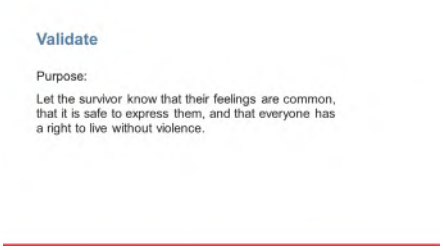
    Imagine that an index client is asked if they are ever hit and they respond with this statement:

    "My partner is very unpredictable. I try to keep him happy but sometimes he just gets angry for no reason. It's becoming worse lately."

    Let's try to help the survivor identify and express needs and concerns by reflecting back what you're hearing.

    Ask participants to share some ideas for what the provider could say and then advance to show the example.

    Note that the provider is trying to name the need so that this can be addressed later.



40. *The next letter is V for validate.*

    The purpose of validating is to let the survivor know that their feelings are common, that it is safe to express them, and that everyone has a right to live without violence.

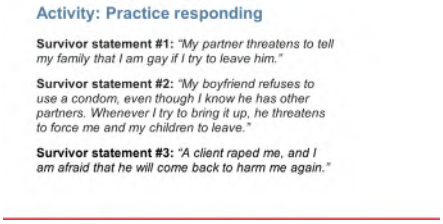
41. *These messages validate the survivor and make it clear that they are not to blame and that you believe them.*

    They also explain that the survivor is not alone.

    You don't have to use all of these. Choose those that feel most natural to you.

    Write down at least two that you'd like to use as we will do an activity in just a moment.

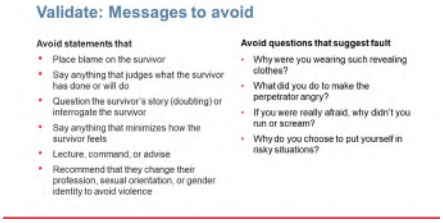
    Allow the participants a few moments to write down the ones they may want to use.



42. *Let's practice using some validating statements (using the ones that you wrote down a moment ago).*

    Read each survivor statement and have participants share some of the validating statements they recorded.

    There are no wrong answers assuming they use the statements suggested.

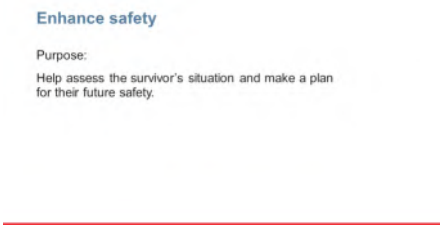


43. *There are also important messages, including questions, to avoid.*

    Ask a volunteer to read the statements in the column on the left.

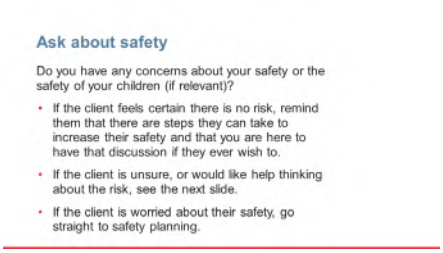
    Then ask another volunteer to read the statements on the right.

    These statements and questions can intentionally or accidentally make it seem that the violence is the fault of the survivor. This is damaging to the survivor and allows perpetrators to act with impunity.

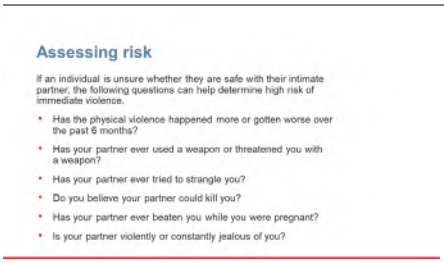


44. *The letter E in LIVES stands for enhance safety.*

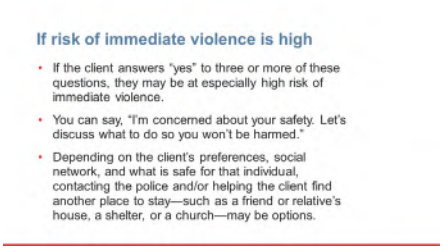
    While we cannot guarantee the survivor's safety, we can try to help them stay safer.



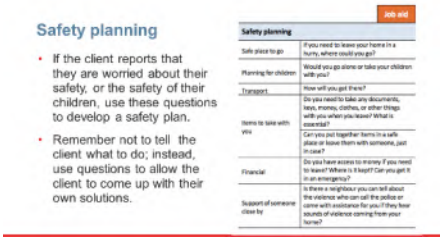
45. *Not everyone feels unsafe. The first step is to ask the person if they currently feel safe and, as relevant, if they have concerns about their children.*



46. *As we said, you can help them assess their current risk if they are unsure whether they are safe.*



47. If they answered three or more of those questions with "yes" then there may be an especially high risk of immediate violence.



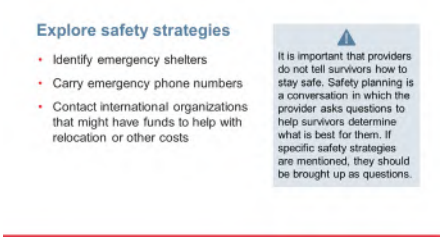
48. When someone does not feel safe or you've assessed their risk to be high, you want to help them make a safety plan.

    There are specific questions to ask to help someone come up with a safety plan. You are not responsible for telling them how to stay safe but should ask questions that help the survivor brainstorm what they can do.

    Turn to a partner at your table, (or adapt for virtual) and in pairs, decide who will be the survivor and who will be the provider. The provider should then practice, for 3 minutes, asking some of the questions on the table in this slide, and supporting the survivor as they provide answers. After 3 minutes, switch.

If the survivor doesn't have an answer, you can skip a question and move to the next.

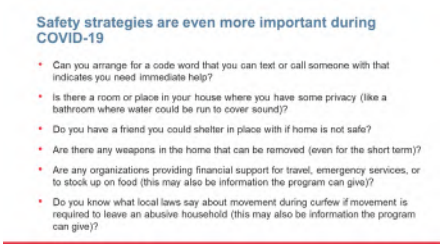
Allow the participants about 7 minutes to conduct this activity, and then advance to the next slide.



49. *These safety strategies may also be good to mention.*

    However, they should not be proposed as solutions.

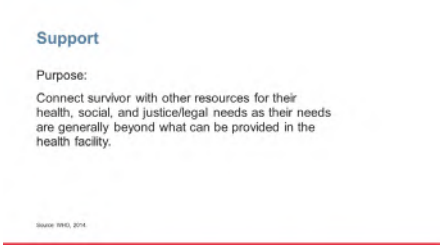
    Instead, you can ask the survivor if the survivor thinks it might be helpful to carry emergency phone numbers, for example.



50. *We know that COVID-19 has made safety planning even more important, especially when people are forced to be in the same location as an abusive partner. Here are some strategies that can be useful, even if someone is forced to be in the same place as their abuser.*

    Review slide.

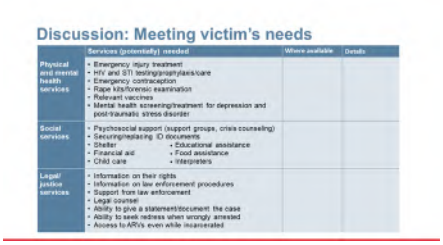
    The last two bullets are also questions that the health care worker or counselor can help the victim answer. If you know of places to get support for food/travel or other emergency services, share this information. You can also be a source of information about local laws regarding movement.



51. *Lastly, the S in the LIVES acronym stands for support.*

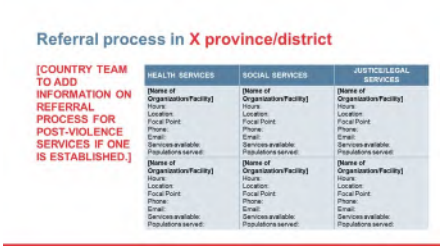
    This step recognizes that the provider is just an entry point into services and cannot provide for all the survivor's needs.

    The purpose of this step is to connect the survivor with other resources for their health, social, and justice/legal needs as their needs are generally beyond what can be provided in a health facility.



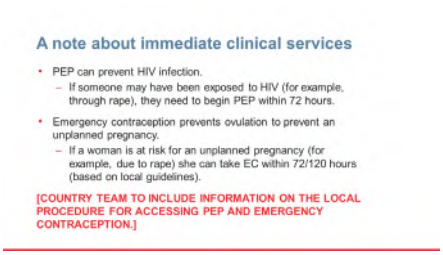
52. *Before we move on, let's talk about what you can link a survivor to. Your facility should have a service directory that lists information about the services available to victims of violence.*

    If the training is being done in person, fill in this table in small groups or present an already prepared service directory.

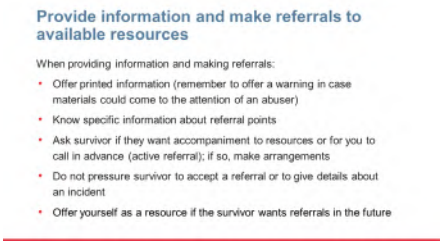


53. *Here is the information you should make available about each violence response service that you may refer an individual to. You, as the provider, want to know that you're sending your client to a place that will support them and will be open. There are many horror stories of victims of violence going to get help only to find no one there. In some cases, they don't seek help again. It's also the case that a victim may go to a service only to be told that they are not the population for whom the service is intended. We can imagine this happening to a transgender woman seeking shelter at a women's shelter. Make sure you know who the service is ready to serve in a nonstigmatizing way before sending someone there.*

If you have a service directory, present it here. If all of this information is not part of that directory, talk with HCWs about how you will adapt/revise the directory.



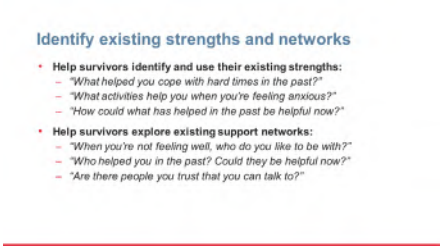
54. *If the victim has experienced sexual violence, please remember there are services that are immediately necessary.*



55. *There are ways to refer that make it more likely that someone will actually complete the referral.*

When providing information and making referrals, it is important to:

- *Offer printed information (remember to offer a warning in case materials could come to the attention of an abuser)*
- *Know specific information about referral points*
- *Ask the survivor if they want accompaniment to resources or for you to call in advance (also called active referral); if so, make arrangements*
- *Do not pressure survivor to accept a referral or to give details about an incident*
- *Offer yourself as a resource to access other services*



56. *As part of referral, help survivors identify their own strengths and networks. This can also be done via questions.*

    To help survivors identify and use their existing strengths, you can ask questions like:

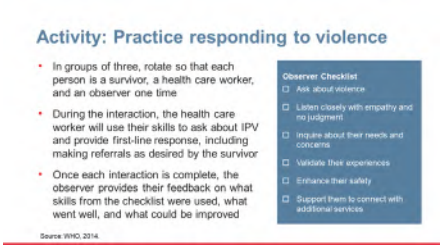
    - "What helped you cope with hard times in the past?"
    - "What activities help you when you're feeling anxious?"
    - "How could what has helped in the past be helpful now?"

    To help survivors explore existing support networks, you can ask questions like:

    - *"When you're not feeling well, who do you like to be with?"*
    - *"Who helped you in the past? Could they be helpful now?"*
    - *"Are there people you trust that you can talk to?*

    Remember, it is not your job to "save" the person. You are helping return control to the survivor by giving them options and letting them know that you will support them in their decision-making.

    It is also true that an individual may not be ready to seek help beyond talking to you. This is OK and the survivor will know that they can come back to you for information or to connect with services as needed.



57. *Now let's put it all together.*

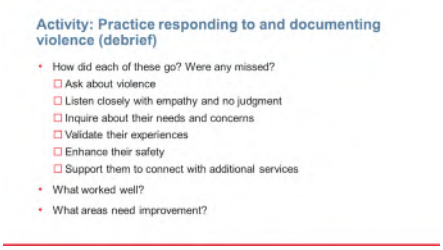
    Review the instructions on the slide and pass out printed versions of the case studies for this session.

    Give 8 minutes per case study (25 minutes in total for the activity).

    Scenario 1: A 28-year-old mother of three children says that her husband beats her whenever he has been drinking.

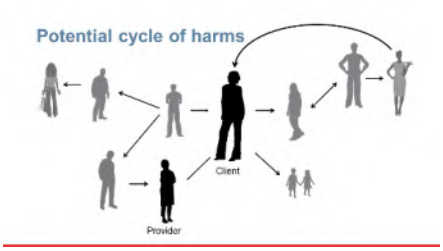
    Scenario 2: A 22-year-old gay man says that his boyfriend will not let him visit his parents or friends and controls who he can speak to on the phone. When the client asks his boyfriend to wear a condom, the boyfriend becomes verbally abusive and calls the client harmful names.

    Scenario 3: An 18-year-old transgender woman is living with an older man. Recently, he has begun to force her to have sex with his friends, who pay the older man. The older man tells her that it is to pay her living costs.



58. **NOTE**: Use the questions on this slide to debrief on the activity conducted in the previous slide.

    After the debriefing has ended, proceed to a review discussion about what was covered during the day, and any other business before closing for the day.



59. **NOTE:** Use the animation in this slide to help participants understand how index clients, their partners and children, and associated individuals including the provider can potentially experience harm associated with disclosure – especially disclosure that is not implemented according to the core principles and minimum standards.

    It's also important to emphasize that anyone can experience harms as results of index testing. There have been documented instances of cases where the contacts who were referred by a client experienced violence after they were contacted by a provider. So, we need to be especially careful about respecting the core principles and minimum standards, and ensuring we have all the resources available to respond if something happens.

    In this animated slide, you can see how index clients, their partners and children, and associated individuals including the provider can potentially experience harm associated with disclosure – especially disclosure that is not implemented according to the core principles and minimum standards. Adherence to the standards and core principles can help minimize these harms.

60. Wrap-up Day Two with participant summaries and review content for Day Three.

END OF DAY 2

DAY 3

Welcome and review of Day 2

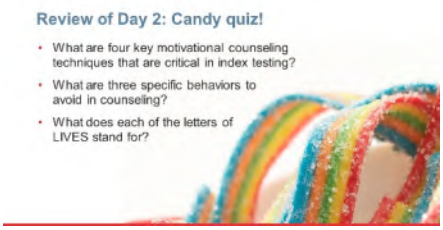
Time: 5-15 minutes

Materials:

- Candy Quiz (Training PowerPoint Day 3, Slide 2)
- Candy prizes

Objectives: By the end of this session, participants will have:

- Had the opportunity to answer questions about key issues and elements discussed in Day 2 (candy prizes provided for accurate answers)

	1. Project the title slide for the **Day 3** presentation. Welcome the participants and thank them for coming to Day 3 of the training. Ask if they are comfortable with the temperature of the room before you begin. As you will be conducting a short quiz in the next slide, you can wait until after the quiz to ask them if they have any questions before beginning with the Day 3 sessions.
	2. *Is everyone ready for a candy quiz?* Advance one at a time and award individuals who answer correctly. When the group is ready, advance to the next session.

Session 12. Messaging

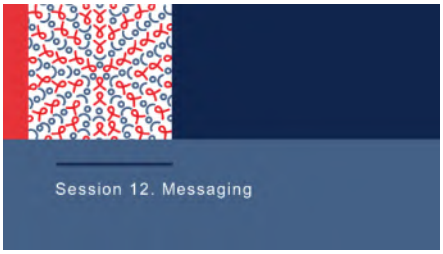
Time: 60 minutes

Materials:

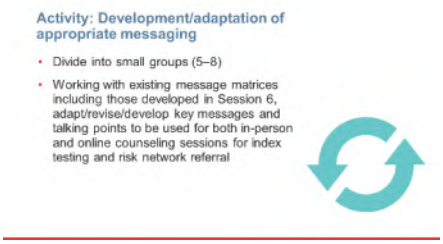
- Training PowerPoint—Day 3 (with adaptations indicated in PowerPoint file)
- Optional: Printouts of existing messaging matrices (as relevant)
- Flipchart and markers

Objectives: By the end of this session, participants will have:

- Reviewed existing messaging, and revised or developed new messaging to introduce index testing approaches catered to key population clients.



3. *In this session, we will spend some time adapting appropriate messaging for index testing to the [COUNTRY] context.*



4. **NOTE:** It will be helpful to have a set of messages (e.g., a message matrix) available before conducting this session. Messaging might be found in SOPs for outreach, testing, and/or counseling, or available as part of local national guidance. In the absence of an official source of messages, it may still help to provide examples of messages from another country with a similar context.

   Have the participants divide into small groups of about 5–8 people each.

   Explain to the participants that, using existing message matrices or an example of messaging from a similar country context (pasted in the next slide), and they will have about 45 minutes to develop key messages that match the country context in the provision of index testing services.

   You can design this session based on the need for the program, and break up the responsibility among the participants to fill in different messages along the index testing flow chart.

   For example, you can focus specifically on developing messages/scripts for:

   - Introducing the four index testing options in a counseling session for a recently diagnosed individual
   - Offering risk network referral options for contacts or individuals the client knows
   - Responding to common concerns that clients are likely to raise in the sessions

   It may help to brainstorm these in advance of the training with representatives from the program/health sector/community partners to ensure that the time is used effectively.

   Be sure to save what the groups produce (it can be faster if they draft directly into laptops). Their inputs can be used later to design SOPs and job aids.

   Allow 50 minutes for the exercise, and 10 minutes to report back any challenges or interesting findings.

5. Follow instructions on the slide.

Session 13. Practice makes perfect

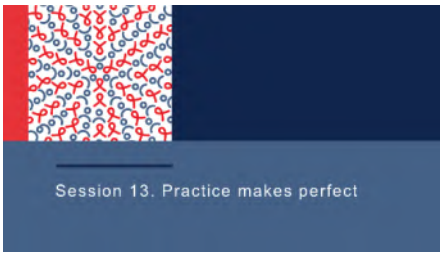
Time: 120 minutes

Materials:

- Training PowerPoint—Day 3 (with adaptations indicated in PowerPoint file)
- Flipchart and markers

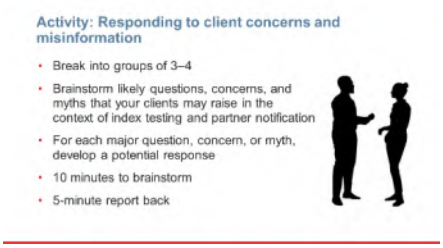
Objectives: By the end of this session, participants will have:

- Practiced using the skills they have learned/reviewed in role-plays based on realistic scenarios.



6. *This is session is perhaps one of the most important sessions we will conduct in this training. While we have had many exercises that have given you a chance to play different roles, the activities and role-plays this morning will give you the opportunity to combine all of the skillsets you have learned so far. By no means should this be the last time you practice these skills in a safe setting. It is important to refresh these skills regularly with support from your supervisor and peers who have championed the skills. Practice makes perfect.*

   NOTE: This session includes roughly 105 minutes of exercises and Q&A. The total time allotted for the session is 120 minutes. This is to allow for a couple of minutes of excess time for each exercise if needed. While it is not essential to get through every scenario, it is important to observe and provide support throughout by walking around the room, listening, and gauging to what degree the material from the training has been adopted. As this is new material, some participants may fall back on old habits that are inconsistent with new recommended approaches.

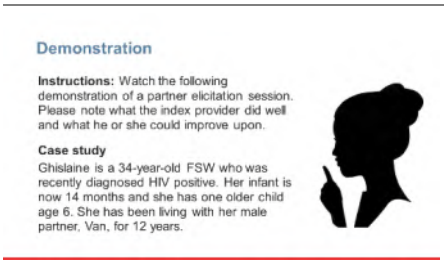


7. *Ask the participants to break into groups of 3–4 (they may be able to stay with the same groups at their tables if the size is right).*

   Ask them to think about likely questions, concerns, and myths that their clients may raise in the context of index testing and partner notification.

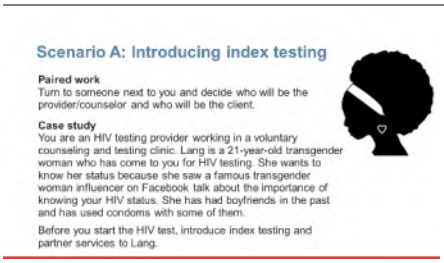
   For each major question, concern, or myth, they should develop a potential response.

   Allow them 10 minutes to brainstorm, and then provide 5 minutes total for volunteers to report on their observations from the session.



8. **NOTE**: Facilitators should prepare this demonstration in advance. If there is only one facilitator, then you may wish to choose a participant member in advance to go over the scenario and agree on roles and how it will play out. The purpose is to allow the participants to see an example of behaviors that are encouraged in index testing and behaviors to avoid. Facilitators/volunteers should agree on what will be examples of appropriate messaging/behavior, and what is inconsistent with recommended approaches.

   Take about 8-10 minutes to conduct the role-play, then allow a few minutes for the participants to provide comments and observations (5 minutes).

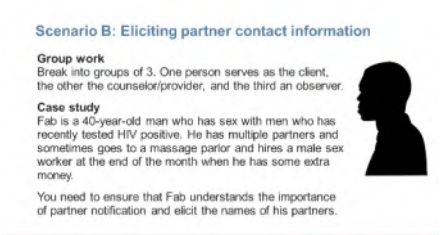


9. Ask for a volunteer to read the instructions and the case study.

   Allow the pairs 10 minutes to conduct the role-play.

   Ask the groups how it went, and if they have any questions (5 minutes).

   Provide answers as appropriate, and advance to the next slide.



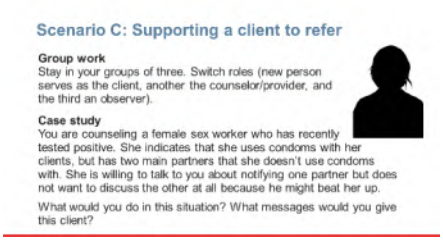
10. Ask the groups to break into trios. Explain that one person will serve as the client, another the counselor/provider, and the third an observer.

    Ask for a volunteer to read the case study.

    Allow the trios 10 minutes to conduct the role-play.

    Ask the groups how it went, and if they have any questions (5 minutes).

    Provide answers as appropriate, and advance to the next slide.



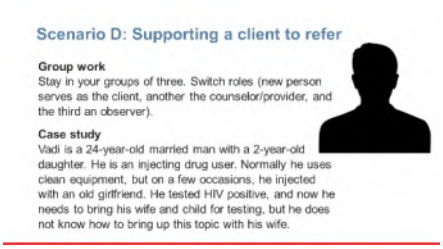
11. Ask the groups to stay in their trios, and to rotate roles (a new person serves as the client, another the counselor/provider, and the third an observer).

    Ask for a volunteer to read the case study.

    Allow the trios 10 minutes to conduct the role-play.

    Ask the groups how it went, and if they have any questions (5 minutes).

    Provide answers as appropriate, and advance to the next slide.



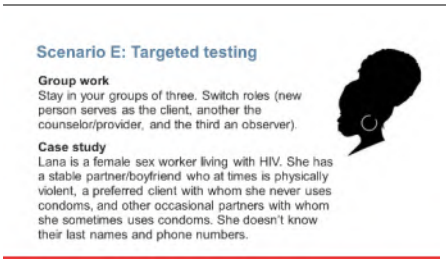
12. Ask the groups to stay in their trios, and to rotate roles (a new person serves as the client, another the counselor/provider, and the third an observer).

    Ask for a volunteer to read the case study.

    Allow the trios 10 minutes to conduct the role-play.

    Ask the groups how it went, and if they have any questions (5 minutes).

    Provide answers as appropriate, and advance to the next slide.



13. Ask the groups to stay in their trios, and to rotate roles (a new person serves as the client, another the counselor/provider, and the third an observer).

    Ask for a volunteer to read the case study.

    Allow the trios 10 minutes to conduct the role-play.

    Ask the groups how it went, and if they have any questions (5 minutes).

    Provide answers as appropriate, and advance to the next slide.

Session 14. Quality assurance, adverse event monitoring and reporting, and monitoring and evaluation of index testing efforts

Time: 30 minutes

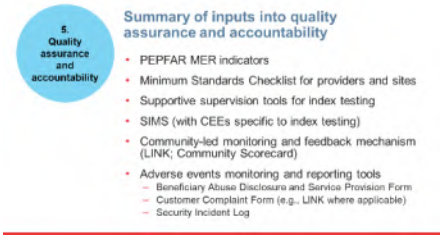
Materials:

- Training PowerPoint—Day 3 (with adaptations indicated in PowerPoint file)
- Flipchart and markers

Objectives: By the end of this session, participants will have:

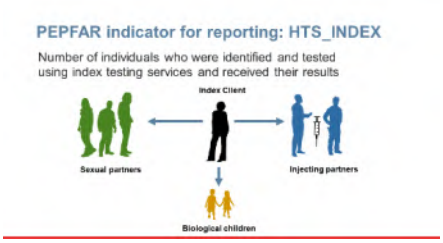
- A basic understanding of monitoring and reporting norms for index testing, and how data can be characterized to gauge to what degree index testing approaches are contributing to case finding

14. *In this session we will briefly touch on some of the important ways we will be measuring the degree to which index testing is contributing to overall case-finding efforts. We will also look at how the program will report index testing service provision to PEPFAR.*



15. *Continuous quality monitoring and improvement are critical for ensuring that index testing efforts help achieve targets and epidemic control. They are also critical for ensuring that teams are effectively screening for potential violence and other risks, reporting instances of violence or adverse events, and following up appropriately. As we will discuss later in this session, monitoring includes efforts led by implementing partners and sites, as well as community representatives and clients themselves.*

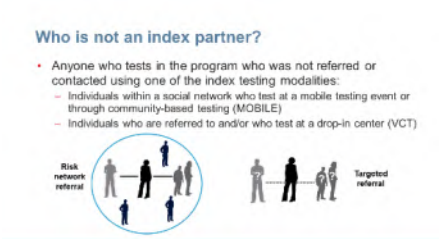
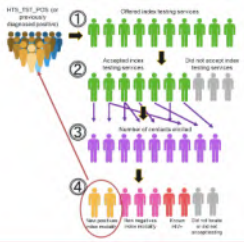
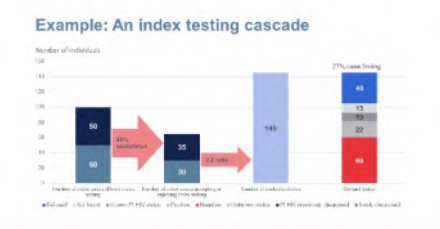
This slide lists the inputs and tools that can and should be used with a PEPFAR-supported index testing program.



16. *Who "counts" as an index partner?*

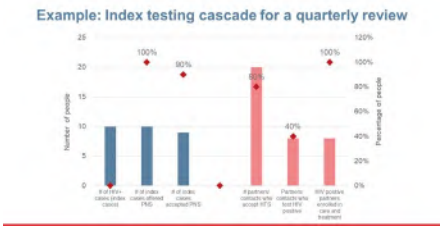
An index partner is anyone who is referred through an index testing modality who is a:

- *Current or past sexual partner(s), biological children/parents (if index case is child), or anyone with whom a needle was shared.*
- *Biological child of an HIV-positive mother. Children of **male** index clients (fathers) should be included when the biological mother is HIV positive, deceased, or her HIV status is not known or not documented.*

	If the index client is a child, his/her mother should be tested; if mother is HIV positive or deceased, father and all known sexual partners should be tested.
	17. *Remember that we also discussed various ways that index clients (and other beneficiaries) can refer people for services. These included risk network referral and targeted referral.* *While these approaches are critical complements to index testing and should be offered as part of our menu of options, when someone tests in our program who has not been referred via an index testing partner notification option, we cannot count them as index cases.* *They still count as HTS_TST when they test.*
	18. *This graphic helps clarify how individuals are classified within an index testing program.* *We begin with a cohort of previously diagnosed PLHIV. All of them are offered index testing services (1).* *Among them, some will accept, and some will not (2). We hope that the majority will accept, based on the use of motivational counseling approaches and in the absence of the threat of violence.* *From those who accept, we expect to see a cohort of individuals come for testing (the contacts provided by the index case) (3).* *Among those, some will agree to test, and some will not (4). Of those who test, some will be positive, and can be offered index testing services. Among those who are negative, we can still offer risk network referral and targeted referral options.*
	19. *This is an example of an index testing cascade which helps us analyze the performance of index testing.* *The first bar represents the total number of index clients who were offered the service. In this case, 100 people. It disaggregates index clients who were newly diagnosed (50) and PLHIV already diagnosed and on treatment TX_CURR and those living with HIV but not on treatment, (50).* *The second bar shows the number clients who accepted the service (in this case, 65 of the 100, or 65%).*

The third bar shows the number of contacts provided by the index clients; 145 which is about 2.2 contacts per index client.

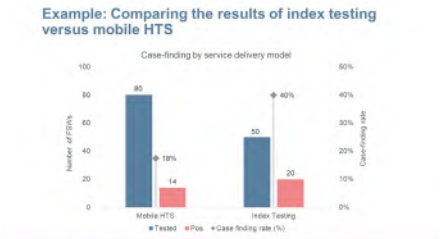
The last bar shows the outcomes of the contact referrals, it includes 40 people who refused HIV testing, 13 who were not found, 10 who were known PLHIV, 22 who agreed to testing and were diagnosed with HIV (27% case finding) and 60 who agreed to testing but were negative.



20. *This graph shows an example of how a program might display data for a quarterly review to see how effective the program is at supporting clients to accept index testing (here shown as PNS – partner notification services), and the case-finding and linkage rates for the contacts of the index clients.*

    As you can see on the left in blue, 100% of all cases were offered index testing, and 90% accepted. That's pretty good, though we are always aiming for 100%.

    On the right are the individuals referred through index testing by the clients on the left. 80% of those contacted accepted index testing, among whom 40% were diagnosed living with HIV, and 100% of them were linked to treatment. This is an example of a successful index testing intervention. We see high rates of acceptance and high case-finding and linkage rates as well.

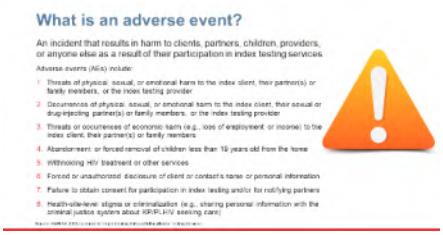


21. *In this graph, we can see how a program might compare two different modalities for case finding.*

    On the left you see data for mobile HTS. While the approach reached 80 people during the period, and achieved an 18% yield, index testing approaches resulted in fewer people tested but resulted in a higher yield and even more cases.

    This graph is not meant to suggest that we should put all of our resources into index testing. In fact, community-based approaches for reaching and recruiting still found 14 cases in this example. But it should help convince you that implementing both approaches will effectively increase our chances of epidemic control.

    If resources are highly limited, increasing focus on index testing and reducing the number of mobile outreach events may save costs and still result in case-finding rates that are on par with local or national targets.



22. **NOTE:** *The term adverse event may be confusing for some people, especially if translated into another language. While it is important for programs to understand what language is being used globally, it may help to agree on a local term for 'adverse events' that all participants can understand, and that can be used throughout this training and beyond.*

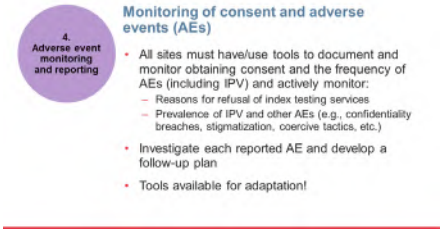
    We previously introduced the concept of adverse events in Session 5. Can anyone remind the group what an adverse event is?

    Allow a few moments for the participants to respond.

    It's important for providers to be aware of the potential for adverse events, types of adverse events, and how to respond.

    Adverse events include threats or occurrences of harm, including physical, sexual, or economic. These can be toward the index client, their partners, family members and/or children, a provider, or anyone else.

    There are also some adverse events that may not seem like obvious harms, but that could have severe consequences. These include withholding of treatment or other services, which can be life threatening or cause harm, and forced or unauthorized disclosure of names or personal information (as discussed on the previous slide).



23. *Why might it be important to monitor the provision of client consent and adverse events?*

    Allow the participants a few moments to respond, and use the bullets in the slide to fill in any answers that might not have been suggested.

    It is important for all sites to have a method for obtaining consent and documenting who among its clients has provided consent. As discussed previously, clients can provide either oral or written consent, depending on national guidelines. Either way, it will be the provider's responsibility to document if the client has provided consent, and for site leaders to monitor if consent has been obtained both for listing clients and for methods chosen for notification.

    Sites also will need to document reasons for refusal of index testing services and occurrences and prevalence of adverse events. For each reported adverse event, sites will need to investigate and develop a follow-up plan. This training package provides all the resources needed for tracking and guidance for response.

24. *Have a look at the graphic on this slide. What might we mean by including community monitoring and client feedback as part of an adverse event monitoring system? What is the difference between community monitoring and client feedback? Aren't they the same thing?*

    Allow the participants a few moments to respond.

    An adverse event monitoring system expands beyond the site alone. At the site level, it's important to employ standardized tools to guide supervision and ensure quality, including a Minimum Standards Checklist, supportive supervision checklists, and SIMS checklists.

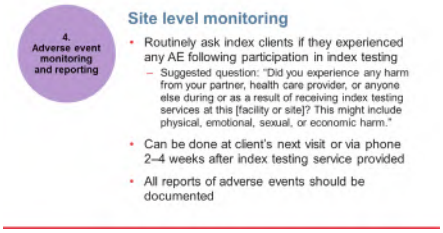
    Sites also need to incorporate monitoring and reporting tools, including:

    - *Beneficiary Abuse Disclosure and Service Provision Form*
    - *Customer Complaint Form (using LINK where applicable)*
    - *Security Incident Log*

    At the client level, sites should incorporate tools/approaches for gauging client satisfaction with services, such as paper- or web-based surveys (using LINKS), comment boxes, and client exit interviews.

    It's also important that community organizations have platforms for monitoring and providing feedback to ensure that services meet the Core Principles and Minimum Standards, including being catered to individual client needs. These can include Community Scorecard approaches, whereby community representatives work with site leadership and providers to assess quality and accessibility of services and develop recommendations together that are then implemented and assessed again. This approach has demonstrated considerable success in a variety of contexts.

    Local organizations and facility leaders can also form community advisory boards that consolidate feedback from the community and provide recommendations to improve quality and accessibility.



25. *At the site level, providers should routinely inquire about any adverse events. This can be done in various ways, including in person during a visit or by phone.*

    The script in this slide offers one way of asking about harms.

26. **NOTE:** Use the animation in this slide to follow with the suggested script below.

    Why do we want to ask about and track the reasons that clients decline index testing services?

    Allow the participants a few moments to respond, then advance one bullet.

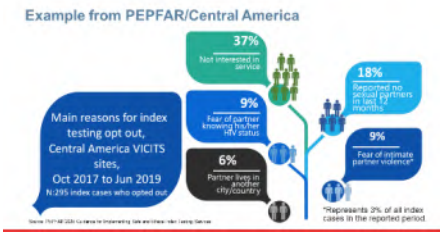
    What might be reasons that clients decline index testing services?

    Allow the participants a few moments to respond, then advance one bullet.

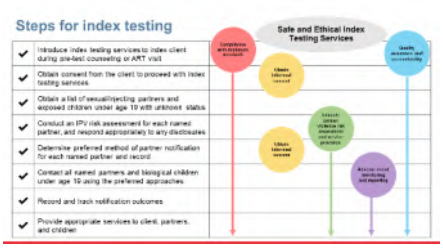
    As you noted, there are a number of reasons that clients might decline index testing services. It will be helpful to track these reasons in order to develop solutions to address whatever may be in your power to address.

    Advance to show the table on the right.

    Here are a few examples of solutions for the reasons listed in the table on the left.



27. *As pictured in this slide, you may wish to develop a visualization that quantifies reasons for decline to allow site leadership, providers, and implementing partner staff to develop and prioritize solutions. Using continuous quality improvement measures, you can then gauge over time if changes in service provision have led to changes in uptake.*



28. *To summarize, this slide shows all the steps for index testing we have discussed in this training. While we did not have specific slides for Step 8, you discussed various referral services available here in* [COUNTRY] *in Sessions 6 and 10. The slide also shows how and when to ensure that the steps for safe and ethical index testing are applied. Compliance with minimum standards and continuous quality improvement are applied from the very first step. Consent is obtained first before proceeding with the client interview to obtain contacts, and for each contact and mode for partner notification where a provider is engaged (contract or client referral). And, adverse event monitoring is conducted throughout the client's care after index testing services have been provided on subsequent visits (i.e., within 2–4 weeks of the index interview).*

Session 15. Action planning

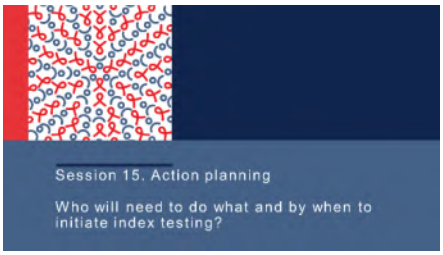
Time: 30 minutes

Materials:

- Training PowerPoint—Day 3 (with adaptations indicated in PowerPoint file)
- Flipchart and markers

Objectives: By the end of this session, participants will have:

- Developed an action plan including timing and roles and responsibilities for key players that will guide preparation for and initiation of index testing.



29. This session should be customized according to the local context, who is in the room during this training, and what effectively can be accomplished in a planning session. For example, if the participants include government, and nongovernment (i.e., community-based) stakeholders who are all new to index testing, this session can be an effective means of planning **who** will do **what** to develop tools, job aids, and define the roles and responsibilities of each agency, department, donor, etc., with a specific date in mind for initiating implementation.

    As there are significant sensitivities around notifying partners, including the potential for violence, it is important to have processes and guidance in place, as well as supportive services, before implementing the approach.

    Regardless, this session can be used at minimum to make clear the role of the facilitating agency, or provide a platform for the government to make commitments to a national timeline. The following slide serves as an example of the kind of table that can be used for this planning process.

30. Action planning could incorporate the use of the 7-step planning tool, which outlines specific activities/support/technical assistance/resources necessary to achieve results.

    The questions in the 7-step planning tool include:

    - Why are you organizing this activity? List objectives.
    - Who will need to be involved to successfully implement this activity?
    - When and where are you planning to implement this activity?
    - What kind of tools, materials, commodities, etc., do you have/need to successfully implement this activity?

	▪ How will you ensure the successful delivery of the activity in terms of services, finances, M&E, etc.? ▪ What technical assistance will you need to successfully implement this activity? ▪ Timeline: List the steps, with time frame, on how you will implement your activity. Areas of focus could include: staffing and task shifting; tools on introducing index testing to both the index case and sexual partners; M&E tools and constructing a cascade; planning for the increased case load (linking PLHIV to treatment, support, referral to PrEP); and constructing the programmatic steps for implementation.
	31. Wrap-up Day Three with participant summaries. Thank participants. .

END OF TRAINING