The Impact of New York's HIV Reporting and Partner Notification (HIVRPN) Law:

General Findings Report

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Impact of New York's HIV Reporting and Partner Notification Law

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New York State (NYS) has long been the center of the AIDS epidemic in the United States, continuing to lead the nation in the *number* of AIDS cases and second only to the District of Columbia in the *rate* of AIDS cases, with over 160,000 cases diagnosed through 2003. Prior to 2000, public health surveillance of the HIV epidemic in NYS was carried out exclusively through AIDS reporting. AIDS case surveillance, however, is no longer able to monitor the current status of the overall HIV epidemic. Because it takes several years for persons to progress from HIV to AIDS, AIDS surveillance data reflect disease transmission patterns in the distant past, rather than recent experience. The advent of highly active antiretroviral therapy (HAART) has significantly slowed progression to AIDS in many persons with HIV, further reducing the value of AIDS data in tracking the HIV epidemic and obtaining information to guide prevention and care programming.

NYS passed its HIV Reporting and Partner Notification (HIVRPN) law to address the deficiency of AIDS surveillance as a mechanism to track the HIV epidemic. Effective June 1, 2000, the HIVRPN law requires the reporting of persons with HIV infection, HIV-related illness, and AIDS, by physicians, other health care providers, and by laboratories performing diagnostic tests. The law also requires reporting known contacts of persons with HIV or AIDS and contact notification, when merited, to protect the public's health. In addition, the legislation requires that a domestic or intimate partner violence (IPV) screen be applied to each identified partner, with notification being deferred in cases where a risk of violence exists. Finally, the law retains an anonymous HIV counseling and testing option in NYS.

The HIVRPN Law Impact Study

This study, funded by a three year grant (2000-2003) from the Centers for Disease Control and Prevention (CDC) Public Health Practice Program Office (PHPPO), assessed the impact that the HIVRPN law and its implementation have had on the ability of NYS to document and identify HIV-positive individuals. In addition, several of the potential benefits and negative consequences of the law were evaluated. This was accomplished through a multi-disciplinary research design, which included six primary study components.

1. An analysis of data from the NYS HIV/AIDS Surveillance and Partner Notification System. Data examined included:

   - The number of new cases of HIV infection, HIV-related illness, and AIDS;
   - The number of partners named per index case;
   - The number/percentage of named partners who are notified;
   - The distribution of partner notification methods used to notify partners;
   - The percentage of HIV-positive individuals with an identified risk of IPV from one or more partners.

2. An analysis of publicly-funded HIV counseling and testing program and Medicaid data to measure aggregate changes in HIV testing levels after the implementation of the HIVRPN regulations.

3. Focus groups with HIV-positive individuals, HIV service providers, and PartNer Assistance Program (PNAP) staff regarding the partner notification aspects of the HIVRPN legislation.

4. Re-administration of a modified version of the CDC-funded HIV Testing Survey to high-risk populations. The intent of this survey was to measure, among other things, knowledge and perceptions of New York's HIVRPN law and regulations, HIV testing experiences, and reasons for delaying or not testing;

5. Administration of a survey to a probability sample of HIV counseling and testing providers in NYS to measure the perceived impact of the HIVRPN law and regulations from an agency and HIV test counselor perspective.

6. Administration of a modified version of CDC's Sexually Transmitted Disease Clinical Observation Notification Tracing and Control Techniques (STD-CONTACT) survey to a stratified random sample of physicians likely to diagnose and treat STDs. The intent of the survey was to examine physician knowledge, attitudes, and practices around HIV/STD reporting, partner notification and intimate partner violence screening.

Highlights from each study component are presented below.

Component 1: New York's HIV Reporting and Partner Notification Reporting System

Newly Diagnosed HIV and AIDS Cases

Nearly 30,000 cases of HIV or AIDS were diagnosed and reported from January 2001 through December 2003. NYC's HIV/AIDS epidemic is concentrated in New York City (NYC), among males, among those over the age of 30, and among minorities. These groups accounted for 83%, 65%, 84%, and 81% of newly diagnosed HIV/AIDS cases, respectively. The sex and racial/ethnic distribution of newly diagnosed HIV cases closely resembles that of AIDS cases, suggesting that the HIV epidemic has not been trending disproportionately by gender or race/ethnicity in NYS.

The ratio of AIDS to HIV cases was also examined. There were 1.4 newly diagnosed AIDS cases for every newly diagnosed case of HIV infection reported over the three-year period. While this ratio is difficult to interpret by itself (i.e., since the bolus of HIV cases were being captured during the initial reporting period), examining this ratio within demographic and risk-related subgroups may be meaningful. Interestingly, the ratio of AIDS to HIV cases was higher among cases diagnosed outside NYC (1.7) than it was among NYC cases (1.3). This ratio also varied slightly by gender, with males exhibiting a higher ratio (1.5) than females (1.3). As expected, the ratio of AIDS to HIV cases increased sharply with age, reflecting the fact that HIV infection often takes several years to develop into an AIDS-defining condition. Whites, African

Americans, and Hispanics exhibited identical AIDS to HIV ratios (1.4). Finally, there was sharp variation in this ratio by transmission category: IDUs (2.0) and MSM/IDUs (2.0) exhibited much higher AIDS to HIV ratios than MSM (1.1) and those contracting the virus through heterosexual (1.4) or other/unknown (1.4) methods.

Partner Notification Activities

As discussed, NYS's HIV reporting law specifically requires the reporting of partners known to, or elicited by, the diagnosing health care worker. Although there were over 8,000 partners reported to the system over the three-year period, two-thirds of reported cases identified no partners, while an additional one-quarter identified just one partner. Moreover, a significant increase in the percentage of cases naming no partners was observed after the first year.

Partner notification rates among identified partners remained stable across the period at about 65%. Notification rates were higher among cases residing outside NYC (73%) than they were among NYC cases (63%). The most common methods of partner notification were by index patients directly (25%) and through reports of partners already knowing their own HIV-infected status (22%). There were differences in notification methods between NYC and non-NYC clients, with the largest difference attributable to the higher level of utilization of the NYS PNAP program. In fact, for non-NYC clients, PNAP staff was the most common source of notification (29%), followed by direct patient notification (17%) and partners already knowing their own HIV-positive status (10%). Finally, although 35% of identified partners were classified as "not notified", this does not necessarily mean that notification did not occur. This simply means that the notification could not be verified at the time these data were compiled. Surprisingly, just 3.1% of partners (n=145 across all three years) were not notified due to concerns about risk of IPV.

Limitations

We had initially hoped that NYS's HIVRPN system would permit the tracking of data on the relationship between method of partner notification and partner testing outcomes, and on the number of newly identified HIV-positive individuals resulting from partner notification efforts. However, this information is generally available only for the subset of identified partners who are actually notified and/or tested by the PNAP or CNAP programs.

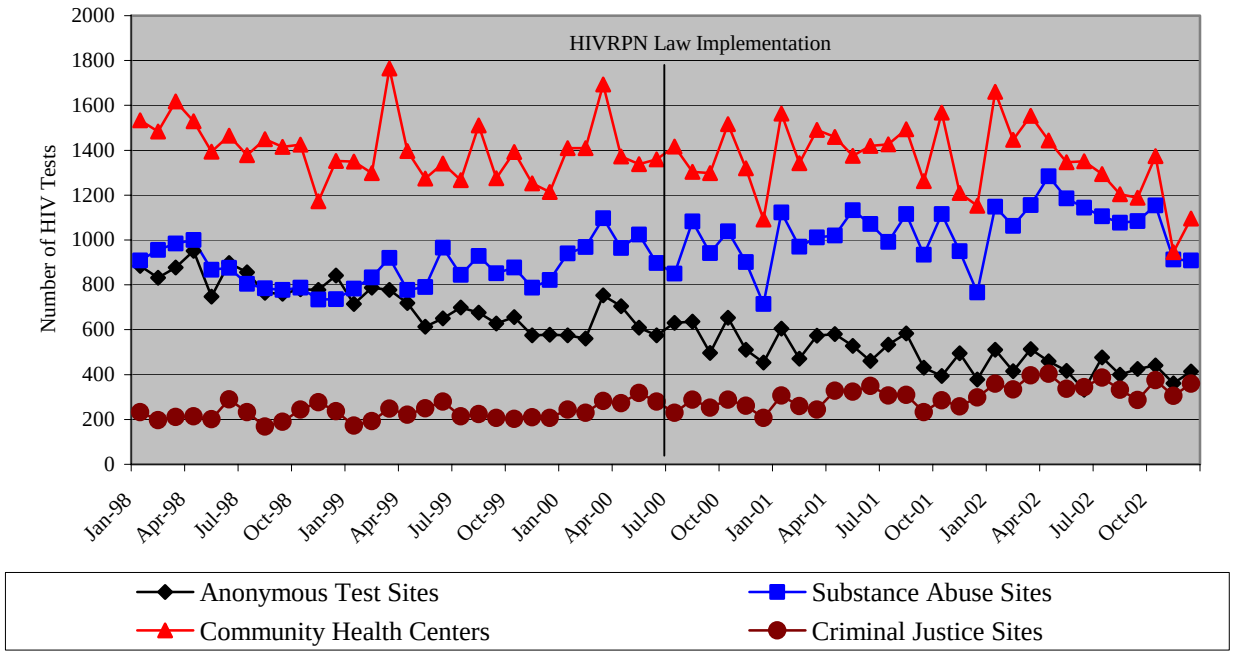
Component 2: HIV Testing Trends in NYS Before and After the HIV Reporting and Partner Notification (HIVRPN) Legislation

One concern with NYS's HIVRPN law was that it would cause individuals to avoid HIV testing. This component of the grant assessed, through the application of an interrupted time series design, the impact of NYS's HIVRPN law on the HIV testing trends of publicly funded counseling and testing sites. More specifically, sets of interrupted time-series analyses measuring the impact of the HIVRPN legislation on HIV testing levels and post-test counseling rates were estimated for the total sample, within HIV testing setting, and then within categories of sex, race/ethnicity, age, and HIV risk factor.

HIV Testing Levels

The figure below displays the total number of HIV tests per month over the study period for each testing setting. Implementation of the HIVRPN law is indicated by the vertical line. Once existing trends and/or seasonality in testing levels were controlled statistically, post-HIVRPN law changes were not statistically significant in 3 out of the 4 testing settings. There was a statistically significant change in testing levels in criminal justice settings only, with levels of testing actually increasing by about 70 tests per month in the post-HIVPRN law period. Discussions with program staff suggest that this increase was likely due to increases in the amount of staff time spent in correctional facilities over the study period.

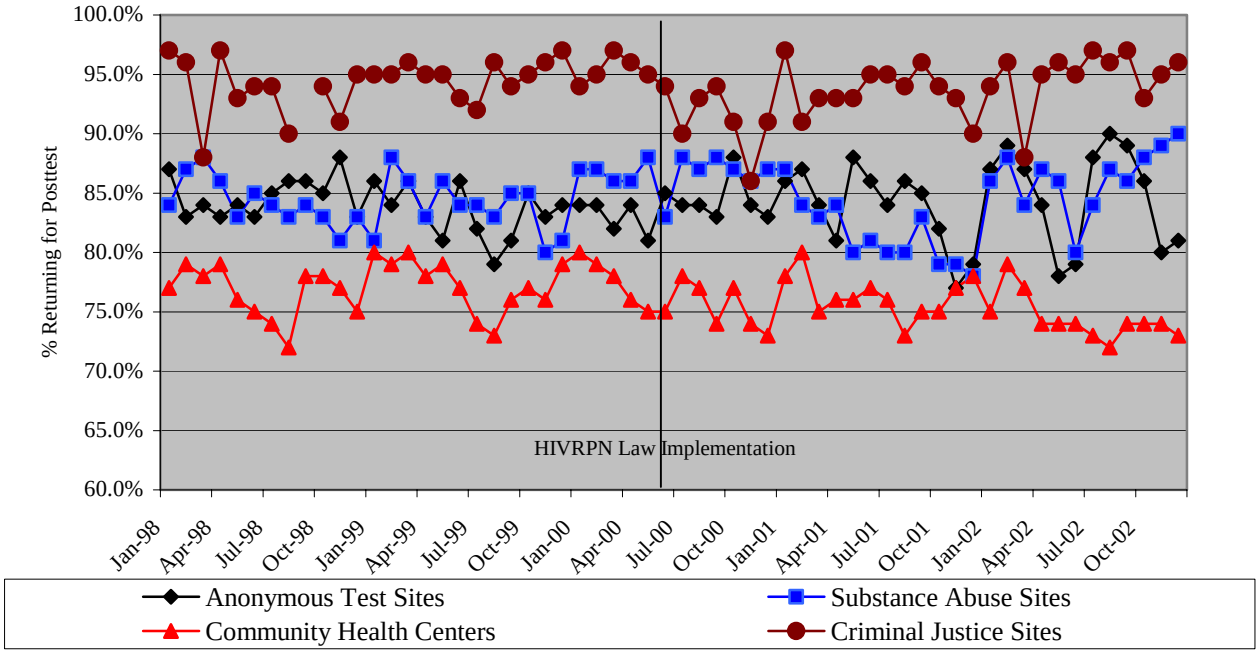
Figure 1: Total HIV Tests by Month and Year
NYS HIV Counseling and Testing (CTS) Data System



HIV Post-test Counseling Rates

Rates of HIV post-test counseling are displayed in the figure below. There is no indication that the rate of HIV post-test counseling decreased following the HIVRPN law in any of the 4 testing settings: Post-test counseling rates fluctuated around 95% throughout the study period in criminal justice testing settings, 85% in anonymous and substance abuse testing settings and around 75% in community health center settings. Time series modeling confirmed these findings, as post-HIVRPN law changes were not statistically significant in any of the testing settings.

Figure 2: HIV Post-Test Return Rates by Month and Year
NYS HIV Counseling and Testing (CTS) Data System



Subgroup Analyses

Separate time series models were estimated in each of the 4 testing settings by client demographic and HIV-related risk factors. This was done for HIV testing levels and for rates of post-test counseling. Subgroup results were consistent with the overall results, providing no support for a differential HIV testing impact on certain demographic or HIV risk-related subgroups.

Conversions from Anonymous to Confidential Status

Clients testing HIV-positive with anonymous HIV testing providers have the option of converting their anonymous test result to confidential status at the post-test counseling session. Doing so allows the individual to access HIV health care services without having to retest. The percentage of HIV-positive individuals converting from anonymous to confidential HIV status in anonymous counseling and testing settings did not decrease following the implementation of NYS's HIVRPN law.

Analyses of Medicaid Data

Because publicly funded counseling and testing sites do not make up the universe of HIV counseling and testing options in NYS, the same methodology was used to examine trends in HIV pre- and post-test counseling in the NYS Medicaid Program. Time series modeling of Medicaid data also failed to detect an effect from the HIV reporting legislation. This was true for overall levels and for subgroup analyses separated by gender, age group, and region of NYS (HIV risk factor data were not available in the Medicaid dataset).

Limitations

The primary limitation of this study component was the fact that testing site-specific changes in policies and procedures during the course of the study period could not be accounted for. To minimize the impact of changes in counseling and testing sites over time, we included only those sites submitting data throughout the study period. However, other factors, such as changes in staffing, funding levels, hours of operation, area-specific HIV testing media campaigns, etc. could not be controlled. Another limitation is that the publicly funded HIV testing data used in this study do not represent the universe of HIV testing performed in NYS. Trends in non-Medicaid based HIV testing through private physicians was not captured by this study.

Component 3: Partner Notification Under New York's HIVRPN Law - Focus Groups With HIV-positive Individuals, HIV Service Providers, and PartNer Assistance Program Staff

NYS's HIVRPN law changed the process by which HIV partner notifications are conducted in NYS. The legislation affects those who test HIV-positive and must consider the issue of partner notification (PN), those who conduct HIV testing and must offer advice on how to notify partners, and those who assist clients in conducting PN. Focus groups were held with HIV-positive individuals, HIV service providers, and PN assistance program staff in order to gather their input on how NYS's HIVRPN law has affected the PN process. The focus groups with HIV-positive individuals and HIV service providers were designed to explore knowledge of, experience with, and attitudes toward the HIVRPN law in the context of PN, from both the consumer and provider perspectives. The focus groups with staff from the State's PartNer Assistance Program (PNAP) were conducted to explore how the law has impacted the jobs of those responsible for assisting HIV-positive individuals in conducting partner notification.

Focus Groups with HIV-positive Individuals

Participants were selected by convenience sampling from several NYC and upstate community based agencies. Selection was conducted to ensure the following groups were represented in the sample: Men who have sex with men (MSM); African Americans; Latinos/Latinas; current or former injection drug users (IDUs); and women. Separate focus groups were conducted with each of these consumer groups, in order to increase the comfort level of participants and the likelihood of honest, uninhibited responses. Efforts were also made to match focus groups and facilitators based on the characteristics of race, ethnicity, and gender.

HIV-positive individuals had limited knowledge of the HIVRPN law, or awareness of "partner notification" as a legal concept. Individuals who did know the law tended to be those who were engaged in the health care system. Participants reported little awareness or usage of the partner notification assistance programs operated by the NYC and NYS Departments of Health. However, the few individuals who had used the programs found them to be helpful.

Participants had mixed feelings about whether or not outside individuals should be involved in the notification of their partners. However, once educated that assisted notification under the HIVRPN law was voluntary, most believed the PN aspect of the law to be beneficial. While most participants felt responsible to inform their partners of their possible HIV exposure,

they did not consider PN when they were first diagnosed. In addition, it became clear that participants felt responsibility toward notifying sexual partners, but did not feel the same responsibility toward needle-sharing partners. Individuals preferred to notify their current partners personally, but embraced the idea of assisted notification for notifying past partners.

Finally, participants indicated that intimate partner violence (IPV) was a potential consequence of notifying partners. They described specific acts that had been committed both against them and by themselves when they were told of their own exposure risk. Importantly, participants did not feel that the HIVRPN law increased the risk of IPV. Additionally, participants reported little awareness of any formal screening mechanism regarding their risk for IPV when undergoing HIV testing or beginning PN. It is important to note, however, that the vast majority of focus group participants were initially diagnosed with HIV prior to implementation of the HIVRPN law.

Focus Groups with HIV Service Providers

A snowball sampling technique was used to select the sample for the provider focus groups (first locating a knowledgeable informant who was a member of the target group and asking them to identify additional participants who would be appropriate for the focus group). Emphasis was placed on inviting participants who had direct client contact in HIV counseling and testing situations, and who could contribute information relevant to the HIV PN regulations and their implementation. Two groups were convened, one in an upstate New York community, and one in NYC.

As expected, providers were well informed about the HIVRPN law in general. There was confusion over specific details of the law however, most notably those addressing the issue of whether giving partner information was voluntary for the HIV-positive client. Providers demonstrated mixed attitudes regarding the effectiveness of the law, but most felt that their initial concern that the law would deter HIV testing was unwarranted. They did express concern that focusing on PN during post-test sessions with newly diagnosed HIV-positive individuals detracts attention from the immediate needs of the client.

Providers discussed several beneficial effects of the law. They indicated that the law highlights the need to approach partner notification together with the client, which, in turn, helps create an initial relationship between the provider and the client. Additional benefits included increasing the likelihood that clients who have trouble notifying their partner(s) will receive help in doing so, increasing the number of partners getting tested, and increasing client and partner access to support and care systems.

There was a strong consensus among providers that they always screen their clients for the risk of intimate partner violence (IPV) and defer notification when indicated. However, providers noted that IPV in relation to PN is complex and they expressed the need for additional training. For example, many providers indicated that if there is an IPV risk, they do not report that partner's name to the Department of Health as required, because they do not want to risk the safety of their client in any way (i.e., by PN staff inadvertently notifying these partners). This

practice, if widespread, may be contributing to IPV deferrals being underreported in the HIVRPN system.

Focus Groups with HIV PartNer Assistance Program (PNAP) Staff

PNAP staff was sampled after contacting the supervisors at each regional PNAP office and asking that they invite as many PNAP staff as possible for participation in the focus groups. Five groups were held with 27 PNAP staff from Buffalo, Rochester, Syracuse, Westchester and Long Island.

PNAP staff indicated several ways in which their jobs had changed since the implementation of the HIVRPN law. The first had to do with the mechanism by which PNAP staff received new cases: Implementation of the HIVRPN system initiated the era of electronic case assignments. The major complaint about this change related to the speed of the electronic system, which was very slow initially, but later upgraded to allow for faster connections subsequent to these focus groups. The second major change resulting from implementation of the HIVRPN system was that the physical office space of PNAP workers was altered in order to accommodate new issues involving the confidentiality of data. For some this meant minor changes, but for others this involved more significant changes, including the complete reconstruction of their office space.

The most frequently questioned change for PNAP staff was the requirement that they contact the diagnosing medical provider before proceeding with the PN process. In the past, contact with the diagnosing physician prior to contact with the newly diagnosed individual was engaged in on an "as needed" basis. Under the new system PNAP staff must attempt to verify all information with the medical provider and get the provider's permission to proceed with the elicitation of his/her patient. PNAP staff felt this new requirement slowed down the notification process and was inconsistent with their procedures for conducting PN for other sexually transmitted diseases.

Barriers to efficient partner notification under the HIVRPN law were also identified. The electronic case reports generated to date had insufficient locating information, requiring PNAP staff to spend additional time tracking down the information from the labs or provider offices before locating the partner. In addition, PNAP staff disagreed with imposing differential procedures for HIV-related PN. PNAP staff felt strongly that differences between HIV PN and PN for other STDs make locating and notifying partners of HIV-positive individuals more difficult and also increases the potential window of disease exposure.

Benefits to the way in which partner notification is conducted under the HIVRPN law were also identified. PNAP staff believed that the law, as implemented, ensures more confidentiality than the previous system. While some staff indicated that this was a barrier to effective notification, most agreed that the additional safeguards were important. Because the law specifically addresses PN, staff felt that it provides tremendous opportunities to educate medical providers and the broader community about PNAP, potentially increasing utilization of their program.

PNAP staff made suggestions for improving the partner notification system in New York, including more extensive front-line staff involvement in future changes to the system, better coordination between partner notification staff throughout the state, more extensive promotion of PNAP, and the provision of additional training opportunities to PNAP staff.

Component 4: HIV Testing Attitudes and Practices Survey (H-TAPS)

Introduction

The HIV Testing Attitudes and Practices Survey (H-TAPS) is a follow-up to the Centers for Disease Control and Prevention's HIV Testing Survey (HITS). As with the HITS survey, H-TAPS assesses respondents' demographic characteristics, HIV testing experiences, knowledge of HIV testing policies and testing methods, sexual behavior, drug use histories, and HIV prevention practices. Additional questions were included in the H-TAPS survey instrument to assess participants' knowledge and attitudes towards, and experiences with, NYS's HIVRPN legislation.

The H-TAPS survey was administered in four Upstate NY cities: Buffalo, Rochester, Syracuse and Albany. Primary enrollment occurred in three venues: injection drug users in syringe exchange programs (SEP), high-risk heterosexuals in sexually transmitted disease clinics (STD), and men who have sex with men (MSM) in gay bars. Because the STD clinics in Syracuse and Albany had limited hours of operation, and because there were no SEPs in these cities, H-TAPS was administered exclusively to MSM in Syracuse and Albany.

The H-TAPS survey was anonymous and administered as a face-to-face interview. Interviews were conducted in Spanish and English in the SEPs and in English only in the other locations. The total sample was comprised of 761 respondents, including 362 participants interviewed in gay bars, 198 interviewed in STD clinics, and 201 interviewed in SEPs. Seventy-two individuals were known to be HIV-positive.

Results: HIV Risk

The H-TAPS venue-based sampling methodology was successful in enrolling people at high risk of acquiring HIV: Just 12% of the sample reported no sexual partners within the past year, and most of these individuals were interviewed in syringe exchange programs, where injection drug use was a risk factor. The gay bar sample had the most sexual partners, with 20% of the sample reporting more than 10 sexual partners in the past year. Less than one-in-five people reported always using condoms during vaginal and anal sex. Despite the fact that HIV-positive individuals reported consistent condom use at much higher rates than other H-TAPS respondents, more than half of all positive individuals admitted to inconsistent or no condom use during vaginal and anal sex. One-fourth of the sample reported injecting drugs within the past year. One in five injection drug users admitted to using a needle previously used by someone else, and 70% of these individuals further admitted not always cleaning shared needles prior to use.

Results: HIV Testing Experiences

The H-TAPS sample was experienced with HIV testing. More than one-half of the sample had tested for HIV within the twelve months leading up to their interview, while an additional 30% had last tested more than a year ago. HIV testing history differed by venue, with over one in four STD clinic respondents never testing for HIV. The most common reasons for HIV testing centered around concerns about health and medical treatment, or about possible HIV exposure through sexual or drug using behaviors. Reasons for HIV testing also differed by sampling venue, with many differences expected given the risk behaviors and characteristics of people interviewed at each venue.

Results: Knowledge and Impact of New York's HIVRPN Law

Our examination of H-TAPS data revealed virtually no support for the possibility that the HIV testing behaviors of H-TAPS respondents were negatively impacted by the HIVPRN law. In fact, less than one in five respondents even knew that HIV-positive test results are reported by name in NYS. More to the point, just 5% of respondents cited concern about their name being reported to the government as a reason for avoiding or delaying HIV testing, with just one person citing this as the most important reason. There was also no evidence that high-risk individuals were moving away from confidential HIV testing in favor of anonymous testing options: The percentage of respondents who reported that their last HIV test was anonymous prior to the HIVRPN law was similar to the percentage testing anonymously after the law.

Results: Knowledge and Experience with HIV Partner Notification

Knowledge about New York's PN policy, including the voluntary nature of naming sexual and needle sharing partners, the availability of PN assistance programs and the confidentiality of PN, was greater than knowledge of named HIV reporting. Where differences existed by venue, persons interviewed in gay bars were most knowledgeable, while STD clinic respondents were least knowledgeable. Those who had ever been HIV tested were more likely to be aware of PN assistance programs than those who had never tested, indicating that this basic message is being conveyed in test counseling sessions. However, those who tested after the law went into effect were no more knowledgeable that naming partners is voluntary, perhaps indicating that discussion of named reporting and PN during pre- and post-test counseling is confusing to some clients, or that this specific information is not being conveyed at all.

H-TAPS respondents expressed mixed feelings about the desirability and efficacy of PN in general, and about assisted notification programs in particular. Most agreed that PN helps reduce the spread of HIV, and that assistance programs make it easier to notify partners and are safer than direct notification. However, respondents exhibited concerns about the potential for physical harm resulting from notifying partners, and about assistance programs being too impersonal, violating privacy, and being unable to protect the anonymity of the index client. Attitudes toward PN varied greatly by venue, with STD clinic respondents being most concerned about the potential for violence resulting from PN, and gay bar respondents being the most skeptical of assisted notification programs.

Results: Experience with Intimate Partner Violence (IPV)

The vast majority of participants reported that they had, at some point in their lives, experienced physical violence. Despite statistically significant differences by both venue and gender, *lifetime* IPV levels were high among respondents from all sampling venues, although females were much more likely to report injuries resulting from IPV. Rates of IPV were comparable between HIV-positive and HIV-negative/unknown status respondents. This study found little evidence that disclosure of one's HIV status is a specific trigger for violence: Physical abuse was anticipated as a likely outcome of HIV disclosure by less than 10% of HIV-negative or unknown HIV status respondents, while 4 out of 72 HIV-positive individuals reported being physically injured by a past or current partner as a result of testing positive for HIV.

Limitations

The H-TAPS component was successful at surveying individuals at elevated risk for acquiring STDs, including HIV. However, because this component did not utilize probability sampling methods to conduct the surveys, the extent to which the findings can be generalized to high risk New Yorkers in general is unknown. In addition, we were not able to sample in all the venues called for by the HITS study methodology in Albany and Syracuse, due to an inability to reach sufficient numbers of the target populations in these smaller cities.

Component 5: HIV Counselors' Attitudes and Practices Survey (H-CAPS)

The HIV Counselors' Attitudes and Practices Survey (H-CAPS) sought to identify NYS HIV counseling and testing (C&T) providers' current knowledge, practices and training needs regarding HIV pre- and post-test counseling, reporting of HIV-positive results, notification of partners and IPV screening. H-CAPS included two components; a survey of supervisors of agencies that conduct HIV C&T (Agency Survey) and a survey of individuals performing HIV C&T services in those agencies (Counselor Survey).

The Agency Survey was sent to 163 randomly selected agencies that conducted HIV C&T in NYS. Completed Agency Surveys were returned from 110 agencies, yielding a response rate of 68%. One hundred and eleven of the 163 agencies sampled for the Agency Survey agreed to distribute the Counselor Survey to their HIV test counselors. Six hundred eighty counselor surveys were distributed. Two hundred eighty four Counselor Surveys were completed, yielding a response rate of about 43% (after 16 ineligible cases were excluded).

Results: Agency Survey

HIV C&T services were of high priority in most of the agencies surveyed. C&T services were most commonly provided by nurses and nurse practitioners, followed by dedicated HIV test counselors and then mental health/case management workers. Nearly half (44%) of agency directors reported that the demand for HIV C&T services increased since the HIVRPN law took effect, however most agency supervisors did not attribute the increase in demand to the HIVRPN legislation. In fact, 91% of agencies reported that New York's HIVRPN law had no impact on its

demand for HIV C&T. Nearly all agency directors reported that their staff had received training on the major aspects of the HIVRPN legislation. Common sources of training included the agency itself, followed by local or state health departments and regional training centers. Most agencies were familiar with NYS guidelines for integrating IPV screening into HIV counseling and testing activities and over 80% reported using those guidelines to develop or modify its own IPV screening protocols.

Results: Counselor Survey

HIV C&T providers rated themselves as proficient at various partner elicitation and notification tasks. Likewise, perceived proficiency in conducting IPV screening was also relatively high. Despite high rates of training and perceived proficiency, knowledge of many of the specifics of the HIVRPN law was still relatively low. Just one-half of counselors surveyed were able to correctly identify how HIV-positive test results are reported in NYS. Respondents were particularly confused with the PN and IPV aspects of the law. For example, approximately one-third of the sample was unaware that naming partners was not mandatory for those testing HIV-positive, while about one-half did not realize that they are required to report known contacts of HIV-positive clients, even if the client does not disclose these contacts to the provider. Similarly, less than half the sample knew that IPV screening results must be reported to the state, while one-third did not realize that a referral to a licensed service provider is required for those with an identified risk of IPV.

C&T providers believed that clients delayed or avoided testing primarily because they didn't want to know that they were HIV-positive. Fear of named reporting was commonly chosen as a possible reason for their clients to delay or avoid testing, however very few providers thought this to be the most important reason.

Finally, less than one-quarter of the sample had ever had contact with partner notification assistance programs operated by the NYC and NYS Health Departments. While contact with the programs was low, perceptions of the programs were positive.

Limitations

Surveys were returned directly to the Department of Health, which regulates HIV reporting and partner notification activities. In addition, data were obtained through self-report. Both of these factors could have resulted in socially desirable responses. Finally, there was no listing of specific individuals engaged in HIV C&T activities in NYS. This fact necessitated that we rely on C&T agency supervisors to distribute surveys and follow up with C&T staff. The resulting response rate of 43% was relatively low.

Component 6: STD-CONTACT - Survey of Physicians in NYS

Given the expanded role of physicians in HIV reporting and partner notification in NYS, it was deemed important to assess their knowledge, attitudes and practices surrounding the new law. The CDC had conducted its national STD-CONTACT survey in 1999 to examine the STD

clinical practices of private physicians. This survey took place before New York's HIVRPN was enacted in June 2000. A modified version of the STD-CONTACT survey was conducted by the NYS Department of Health in early 2003, approximately 2.5 years after enactment of New York's HIVRPN law. The sampling frame for both surveys consisted of physicians practicing in one of the five specialties believed to provide 85% of STD care. The timing of these surveys provided a natural comparison to examine the impact of the HIVRPN legislation on physician knowledge, attitudes and practice.

The CDC provided NYS-specific data from its 1999 survey to use for a baseline comparison. The CDC data included 295 physicians practicing in NYS. This survey had a national response rate of 70%, however, information on state-specific response rates was not available. The 2003 survey conducted by the NYS Department of Health had a total of 835 respondents, and a response rate of 61%.

Results

Knowledge of New York's HIV reporting requirement increased significantly after the law took effect. Prior to the HIVRPN law, physicians had very low levels of knowledge regarding whether physicians were required to report HIV to the Department of Health (they were not required to report prior to June, 2000). Physicians who were surveyed after the HIVRPN law went into effect were fairly knowledgeable about their roles in HIV reporting, with 76% correctly responding that physicians are required to report. However, physicians surveyed after the law went into effect were considerably less knowledgeable about the PN and intimate IPV screening components of the law than they were about the named reporting component.

The majority of physicians had diagnosed HIV during their careers and of those, the majority had reported it at some point. However, approximately two-thirds of both samples indicated that they do not routinely screen their asymptomatic patients for HIV. There was no significant difference between the pre- and post-law surveys on this practice, overall or by patient gender or pregnancy status. Additionally, less than one-half of physicians completing the post-law survey indicated that they always report HIV infections to the State.

There was little change in physicians' PN practices between the pre- and post-law surveys. Physicians felt strongly that discussing partner notification with their patients diagnosed with an STD or HIV was a worthwhile activity. However, physicians were much less likely to report that their staff actually collects partner information and contacts partners themselves.

Physicians who participated in the post-law survey were asked specifically about their experiences with partner notification assistance programs. The majority of physicians reported no direct contact with their health department's PN program. Physicians were supportive of local partner/contact notification assistance programs, however, despite having limited contact with them.

Physicians surveyed after the law were asked to rate their proficiency in conducting partner elicitation and notification for HIV. Nearly half of physicians felt moderately proficient

in conducting partner elicitation and notification. As expected, physicians who had experience diagnosing HIV or STDs felt more proficient than physicians who did not diagnose HIV or STDs. Less than one-half of physicians expressed interest in receiving additional training on partner elicitation and notification.

Physicians' knowledge, attitudes and practices concerning NYS's policies on IPV screening during HIV counseling and testing were assessed in the post-law survey only. Physicians' knowledge of the screening and partner reporting process was relatively low. Although most physicians acknowledged that IPV is a serious problem for their patient population, very few physicians reported regular IPV screening of their patients. Physicians identified safety and time-related barriers to conducting IPV screening with patients. Finally, while approximately half of physicians rated their proficiency in conducting IPV screening as good/excellent, most indicated that they had never actually received training on how to do it.

Limitations

The 2003 STD-CONTACT surveys were returned by the physician directly to the Department of Health, which regulates HIV reporting and partner notification activities. In addition, data from both surveys were obtained through physician self-report. Both of these factors could have resulted in socially desirable responses. The response rate for the post-law survey of 61%, while moderately acceptable, may preclude generalizing results to the targeted physician population in NYS. In addition, for both surveys, only the five specialties believed to provide 85% of STD care were sampled. Finally, the two samples, although similar, did differ slightly on physician, patient and primary practice characteristics. It is not known the extent to which these differences between the samples affected the study's results.

Conclusion and Discussion

Results from multiple components of this grant indicate no support for a deterrent effect of HIV reporting and partner notification policies on testing behavior in NYS. In fact, there appears to be limited awareness of the details of the HIVRPN law, at least among high-risk individuals. H-TAPS respondents were largely unaware of the specifics of the HIVRPN law, and virtually nobody cited concern about their name being reported to the government as a reason for avoiding or delaying HIV testing. This finding from H-TAPS should be made widely available to HIV test counselors throughout NYS, since fear of named reporting was commonly cited as a possible reason for their clients to delay or avoid testing, although very few providers thought that this was the most important reason. Analysis of publicly funded counseling and testing program data clearly indicated that levels of HIV testing did not decrease following the NYS HIVRPN law. Similarly, post-test counseling rates, and rates of conversion from anonymous to confidential status among individuals testing HIV-positive, also remained stable after the HIVRPN law. These results were also echoed in focus groups with HIV/AIDS service providers and in responses from HIV counseling and testing providers.

New York successfully implemented its HIVRPN system during the first year of name-based reporting, and now has detailed information on both HIV and AIDS cases diagnosed across the state. As in other states, minorities are disproportionately affected by the HIV/AIDS

epidemic in New York. African Americans represented just 16% of New York's population in 2000, yet they accounted for over 50 percent of newly diagnosed HIV and AIDS cases occurring between 2001 and 2003. People of Hispanic origin were also overrepresented, accounting for 15% of the population but 27% of HIV and AIDS cases. The gender and racial/ethnic distribution of newly diagnosed HIV cases resembled that of newly diagnosed AIDS cases, suggesting that the relative impact of the HIV epidemic by gender and race/ethnicity may have stabilized in NYS. There is some evidence that New York's HIV epidemic may be trending towards a higher percentage of MSM cases, however the large percentage of missing data on HIV risk exposure category necessitates further exploration of this finding.

The PN component of New York's HIVRPN law offers potential to prevent future infections by identifying, notifying, and testing the partners of HIV infected individuals. Much of that potential has remained untapped during the early years of the HIVRPN law, however, as two-thirds of reported HIV and AIDS cases failed to identify even a single partner, while an additional 25% identified just one partner. Moreover, the utilization levels of the PN assistance programs operated by the NYC and NYS Departments of Health have not increased subsequent to the law. Multiple factors that likely contribute to the low volume of PN include the complexity of the law, incomplete knowledge of the law, low awareness of state- and city-operated PN programs, and lack of proficiency in addressing PN-related issues among those diagnosing HIV. Fortunately, strategies to address each of these factors are possible.

Continued targeted education and training on the partner notification and IPV-related aspects of New York's HIVRPN law is necessary. Despite high rates of general training, knowledge of many of the specifics of the HIVRPN law among providers was relatively low. Approximately one-third of HIV counseling and testing providers were unaware that naming partners was not mandatory for those testing HIV-positive, while about one-half did not realize that they are required to report known contacts of HIV-positive clients, even if the client does not disclose these contacts to the provider. Similarly, less than half knew that IPV screening results must be reported to the state, while one-third did not realize that a referral to a licensed service provider is required for those with an identified risk of IPV. Physician knowledge of the IPV-related aspects of the law was also much lower than their knowledge of the reporting aspects. Although most physicians acknowledged that IPV is a serious problem for their patient population, very few reported regular IPV screening of their patients. Thus, even though counseling and testing providers report almost always discussing HIV reporting, PN and IPV risk during the pre- and post-test counseling sessions, it is uncertain what is actually being conveyed to clients. This, coupled with the low rates of IPV deferrals being reported to the State, underscores the importance of ongoing promotion of existing training. Both physicians and other HIV counseling and testing providers expressed at least some interest in receiving additional training on PN and IPV aspects of the law.

Given that research has shown that assisted notification can be more productive than self-notification (i.e., result in more partners being notified and tested), efforts are also needed to increase the number of provider-assisted notification occurring in NYS. In addition to the confusion surrounding the specifics of the PN component of the law noted above, another reason for NYS's low assisted notification rates may be that too much of the burden to address PN is being placed on HIV counseling and testing providers. The HIVRPN system data clearly

indicate relatively few provider-assisted notifications are being reported. Yet focus group and interview data from this study, coupled with positive experiences in other states, indicate that high-risk individuals would consider using assisted notification options, particularly for notification of past partners. While dedicated HIV counseling and testing providers (i.e., those agencies/individuals funded primarily to offer HIV testing) may have the capacity to be actively involved in PN activities, it may be unrealistic to expect physicians to become proficient in this role.

Current awareness of the NYS and NYC PN programs appears low. Focus groups revealed little awareness in the general community about formal PN assistance programs, and a minority of HIV counseling and testing providers and physicians reported ever working with the PNAP (NYS) or CNAP (NYC) programs. While contact was low, perceptions of these programs were positive. Given this, attempts at increasing communication between these programs and HIV testing providers would likely be well received.

Although several of the barriers to effective PN within the state-operated PNAP program were resolved, the requirement that PNAP staff verify information with the medical provider and get the provider's permission to proceed with the elicitation of his/her patient before proceeding with the PN process should be reevaluated in light of the PNAP focus group findings. PNAP staff felt that this requirement slows down the notification process and is inconsistent with their procedures for conducting PN for other sexually transmitted diseases.

The three sampling venues utilized in the H-TAPS component of this study proved useful at reaching three distinct groups of high-risk individuals. The inconsistent use of condoms and/or multiple sexual partners by many H-TAPS respondents indicate a sizable risk for acquiring HIV through sexual practices among people sampled across all three venues. Despite the fact that HIV-positive individuals reported consistent condom use at much higher rates than other H-TAPS respondents, nearly half of all positive individuals admitted to inconsistent or no condom use during vaginal and anal sex. Somewhat alarming was the finding that 1 in 5 injection drug users admitted to using a needle previously used by someone else, and 70% of these individuals further admitted not always cleaning shared needles prior to use. This is surprising since the vast majority of these individuals were SEP participants, where access to sterile syringes is not a problem. It is possible that some of these individuals were reporting risk behaviors that predated their enrollment in the SEP, or that they are sharing less often as a result of SEP utilization. These findings stress the continued need to aggressively promote evidence-based HIV/AIDS prevention messages and interventions to targeted communities, including both high-risk and HIV-positive individuals.

Introduction

Background of HIV Reporting in New York State

New York State (NYS) has long been the center of the AIDS epidemic in the United States, continuing to lead the nation in the number of AIDS cases and second only to the District of Columbia in the rate of AIDS cases, with over 160,000 cases diagnosed through 2003.[1,2,3] In the early years of the epidemic and again now, men having sex with men accounted for the majority of new AIDS cases each year, however intravenous drug use has also been an important risk behavior associated with new cases. Similarly, while white men were formerly predominant among reported AIDS cases, minority populations are now over-represented among persons reported with AIDS. Women, formerly only a minor fraction of reported AIDS cases, now account for approximately one-third of newly diagnosed cases.

Between 1983 and 2000, public health surveillance of the HIV epidemic in NYS was carried out through the reporting of persons meeting the national surveillance case definition for AIDS to the NYS and to the New York City Departments of Health. This system provided fairly complete and high quality data on the characteristics of persons with AIDS, the end stage of HIV infection. AIDS surveillance data have been used to track changes in the epidemic in minority communities, women and injection drug users, to classify geographic areas by level of risk for HIV to better target prevention and treatment programs, and to determine NYS's share of federal AIDS funding.

AIDS case surveillance, however, cannot monitor the current status of the overall HIV epidemic. Because it takes several years for persons to progress from HIV to AIDS, AIDS surveillance data reflect disease transmission patterns in the distant past, rather than recent experience. The advent of highly active antiretroviral therapy (HAART) has significantly slowed progression to AIDS in many persons with HIV, further reducing the value of AIDS data in tracking the HIV epidemic and obtaining information to guide prevention and care programming.

NYS's HIV Reporting and Partner Notification (HIVRPN) Law

Due to the deficiency of AIDS surveillance as a mechanism to track the HIV epidemic, and because NYS's voluntary partner notification programs were significantly underutilized, the state legislature passed Chapter 163 of the Laws of 1998, which was signed into law by the Governor in July 1998. The new law required the reporting of persons with: 1) HIV infection; 2) HIV-related illness; and 3) AIDS, by NYS physicians and other medical providers who make diagnoses, and by laboratories performing diagnostic tests. The law also requires reporting of known contacts of persons with HIV, HIV-related illness or AIDS and contact notification when merited to protect the public's health. A significant requirement of the HIVRPN legislation is a screen for domestic violence. In situations where a risk of domestic violence has been identified, reasonable arrangements must be made to minimize risk before notification can proceed. Regulations implementing the HIVRPN law took effect June 1, 2000.[4]

Those supporting passage of an HIV reporting law pointed to potential public health benefits for the people of NYS, among them collection of data needed to track the HIV epidemic and protection of spouses, sexual and needle sharing partners and other contacts of persons testing positive for HIV. However, the possibility of the new law also raised concern, particularly among those in the advocate community, that implementation would have counterproductive public health effects, would compromise confidentiality, and would further erode civil liberties.

Literature Regarding the Impact of HIV Surveillance

Much of the debate surrounding HIV surveillance can be classified into one of three general areas: 1) The impact of HIV reporting on testing behavior; and 2) the need to maintain anonymous HIV counseling and testing; and 3) the role of HIV surveillance in HIV partner notification. The following sections represent a brief overview of the literature in each of these three areas.

The Impact of HIV Reporting on HIV Counseling and Testing

One concern with HIV name-based reporting has been that such policies would cause individuals to avoid or delay HIV testing or medical care. There has been a fair amount of research into this issue, with conflicting findings being reported. Some of this inconsistency can be attributed to differences in the timing of the research, differences in the populations studied, and differences in the research methods employed. Most early surveys of at-risk populations asking about self-reported reasons for not testing, or asking about testing intentions under hypothetical conditions of mandatory HIV reporting, found strong support for a deterrent effect of HIV reporting.[5, 6, 7, 8] In addition to measuring intention rather than actual testing behavior, much has changed in the years since these studies were conducted. Changes include decreasing stigma associated with HIV/AIDS and the availability of effective therapies to treat HIV infection.

More recent studies have found lesser deterrent effects. The HIV Testing Survey (HITS), which was conducted in nine states with differing HIV reporting policies, utilized a non-probability sample consisting of approximately equal numbers of men who have sex with men (MSMs) (recruited from gay bars), IDUs (recruited from street outreach) and sexually active heterosexuals (recruited from sexually transmitted disease clinics).[9] Results indicate that only a minority of HITS respondents were familiar with whether their state had an HIV reporting policy.[10] This held true for respondents in both HIV reporting and non-HIV reporting states.[9,10] Concern about names being reported to the Health Department was given as a reason for not testing by 19% of respondents, while 17% of respondents who had been tested cited this as a reason for delaying testing. However, this was cited as the *main* reason for not testing or delaying testing by just 2% of respondents.[9] The HITS study in New Mexico found that after implementation of named-based reporting, significantly fewer untested participants indicated that they avoided testing due to a fear of named reporting (4% compared to 23% prior to named reporting).[12] People who lived in states with name-based HIV reporting were more likely to *delay* HIV testing due to concern about named reporting. However, there was no association between living in a state with name-based HIV reporting and *avoiding* HIV testing due to

concern about named reporting.[10] The HITS survey did uncover a larger concern about name-based reporting among the subgroup of MSM, particularly in states that had name-based reporting in place. Among those who had not been tested, 38% of MSM cited concern about their name being reported as a reason they did not test, compared to 13% of at-risk heterosexuals and 18% of injection drug users. Thirty-five percent of MSM in name-based reporting states cited this as a reason for not testing, compared to 11% of MSM in states without name-based reporting.

More recent articles based on multi-state HITS data have reported similar results: a low awareness of states' reporting laws among high-risk individuals in general and little evidence that HIV testing decisions are being strongly influenced by a concern about named HIV reporting.[10,11,12] Also consistent with initial HITS study results, although not a major worry, was that concern about name-based reporting was slightly higher in states with name-based HIV reporting policies, particularly among IDU and MSM subsamples.

A few studies have addressed the issue of prenatal HIV testing in relation to named-based HIV surveillance and found no evidence that rates of HIV testing in prenatal care settings are affected by the initiation of name-based HIV reporting policies.[13,14] One of these studies specifically addressed (in limited geographic settings) NYS 's HIVRPN.

The Multistate Evaluation of Surveillance for HIV (MESH) project represents a probability based sample of AIDS patients in 8 states (5 with name-based HIV reporting and 3 without).[15] The purpose of the study was to determine the effect of HIV testing type and HIV surveillance policy on the timeliness of testing and the receipt of medical care. Interviews were completed with 1,913 people (68% response rate). Results indicated that most participants initiated medical care soon after receiving a positive test result, and the percentages of study participants obtaining timely medical care differed only slightly in states with and without name-based HIV reporting. Fear of being reported to the Health Department was given as a reason for delaying care by just 9% of respondents, with none citing this as the main reason.

Another method of determining the impact of HIV reporting policies is to examine HIV testing levels before and after the introduction of HIV reporting. This methodology was employed in a 1998 study by Nakashima et al., which examined HIV testing trends in publicly funded HIV testing sites in six states.[16] The study analyzed trends in routinely reported counseling and testing data for a period of 12 months before and after each state began HIV reporting. Results indicated no significant decreases in the total number of HIV tests reported after HIV reporting took effect in any state (in fact, testing levels increased in four states). However, statistically significant but inconsistent changes in testing levels were found among select HIV risk and demographic groups across states. For example, the number of HIV tests among injection drug users decreased 34% in Michigan, while it increased 19% in Nevada. The study also examined trends in anonymous and confidential tests in two of the states. A decrease in both the number and proportion of total HIV tests that were anonymous was found in Louisiana after HIV reporting, while the opposite trend was uncovered in Nebraska. Among white MSMs in Nebraska, the number of anonymous HIV tests increased 42% after HIV reporting while the number of confidential tests decreased 17%.

The authors of the Nakashima study concluded that "Confidential HIV reporting by name did not appear to affect use of HIV testing in publicly funded counseling and testing programs" and that "…the impact of surveillance on those seeking HIV testing will be small and should not hinder HIV prevention efforts". These conclusions, as well as the methodology of the Nakashima et al. study, have been criticized for: Not employing a comparison group of states without HIV reporting,[17,18] failing to use data from states with high HIV prevalence;[19] not measuring changes in the level of high risk behavior among those testing; failing to control for potentially confounding effects from other variables,[19,20] and not focusing on the sub-group differences that were uncovered in their study.

The Value of Anonymous HIV Counseling and Testing

NYS's HIVRPN Law retains an anonymous HIV counseling and testing option. This was done to offset the potential deterrent effects that HIV reporting might have on the HIV test-seeking behavior of some residents. This policy is consistent with Centers for Disease Control and Prevention (CDC) guidelines for HIV case surveillance, which recommends that all states and territories conduct HIV case surveillance as an extension of their current AIDS surveillance activities, but that anonymous counseling and testing options be retained.[21]

Several previous studies have addressed the need for anonymous HIV counseling and testing. Early studies suggested that anonymous counseling and testing was an important component to HIV prevention, especially for certain subgroups. For example, in the three months following the introduction of anonymous counseling and testing in Oregon in 1986, the demand for HIV testing increased 50%, with a 125% increase observed among MSM.[22] Among 251 HIV-positive men in St. Louis, Missouri (1991-1994), men who chose to be tested anonymously were more likely to be white or have had sex with men and less likely to have injected drugs compared to men who tested confidentially.[23]

A study of a pilot anonymous counseling and testing program in Colorado, conducted from 1990 to 1992, revealed a higher percentage of first-time testers and a higher seropositivity rate in anonymous versus confidential sites, however the effects were temporary.[24] A statistically significant increase in HIV testing levels was observed among MSM and injection drug users in the five months following the introduction of anonymous HIV counseling and testing in Arizona in 1989.[25] Two North Carolina studies assessed the impact of removing the anonymous HIV testing option in some counties. Although HIV testing levels increased in all North Carolina counties following the change, the rate of increase was lower in counties without anonymous counseling and testing than it was in counties that retained the anonymous testing option.[26,27] The HITS study in New Mexico found that participants were more likely to test anonymously after the implementation of name-based HIV reporting than before.

A recent probability sample of 835 AIDS cases chosen across six states found that those individuals tested anonymously had sought HIV testing and medical care sooner than those who tested confidentially.[28] However the possibility that it was the characteristics of the individuals rather than the testing method that produced the differences could not be ruled out. Alternatively, HIV-positive men (n= 251) in St. Louis who tested anonymously were less likely to accept HIV care coordination than those who tested confidentially.

The Role of HIV Surveillance in HIV Partner Notification

The HIV partner notification component of the HIVRPN law was deemed necessary because it had been difficult to document the extent to which HIV partner notification was occurring in NYS. Utilization of NYS and City HIV partner notification programs had been small relative to the estimated number of newly-infected persons in the state, and it was feared that many individuals were not being made aware of exposure.

A review of the literature on HIV partner notification permits the following general statements:

- Client self-notification appears less effective than provider-assisted methods of notification (including notification by health department officials);
- Many HIV-infected individuals will agree to assisted methods of partner notification;
- Partners of HIV infected persons are receptive to being notified and are willing to seek HIV testing;
- Assisted notification appears to be an effective way to identify new cases of HIV infection.

People at high risk of HIV believe that they are capable of notifying their partners on their own. According to a survey of people attending New York City STD clinics for pre-HIV test counseling between January 20 and May 31, 2000 (n=1,372), most MSM (76%), women who had sex with men (93%) and men who only had sex with women (88%) said that they would be able to contact all partners with whom they had unprotected anal or vaginal sex in the past 2 months if they wanted to.[29] Despite this, there is evidence to suggest that few HIV-positive individuals inform all partners on their own, and that the efficacy of self-notification may be lower among some population subgroups.[30,31,32,33,34,35,36,37,38] For example, a survey of 250 HIV-positive individuals in case managed substance abuse and community health center settings conducted by the NYS Department of Health AIDS Institute found that just 35% of clients had notified all past partners, while 60% had notified all of their current partners.[39]

Landis et al., (1992) conducted one of the few studies that directly compared provider-assisted notification with self-notification. In a randomized controlled study in North Carolina, 50% of partners were successfully located by provider notification whereas only 7% of partners were successfully located by self-notification.[40] A study of 132 partners of HIV-positive individuals located through health department notification found that 87% thought the Health Department did the right thing in telling them about their exposure, and 92% thought that the Health Department should continue to notify persons exposed to HIV.[41]

Data from surveys with HIV-infected individuals in NYS, however, suggest that only a very small percentage utilize formal assisted methods of HIV partner notification.[42] A more recent analysis (2001) of partner notification data in North Carolina revealed that notification of partners of 1,379 HIV-positive individuals resulted in HIV testing of 65% of partners who previously tested HIV-negative and 64% of partners who had never HIV tested. Partner notification and testing led to 125 newly diagnosed cases of HIV, yielding a rate of 1 newly

diagnosed case per 11 index patients. Results from other studies also suggest that health department or provider assisted methods of HIV partner notification can be effective in identifying HIV-positive individuals.[33,43,44,45,46] A study of a voluntary and confidential HIV partner notification program in a rural section of South Carolina found that, among 290 contacted partners of HIV-positive individuals, 280 (97%) agreed to HIV testing and 49 (18%) were HIV-positive. Only 3 of the 49 HIV-positive individuals had previously been HIV tested.[47] Similarly, a 1990 study of 365 HIV-positive index patients in Sweden found that, among 350 located and tested contacts, previously unknown seropositivity was diagnosed in 53 individuals.[48]

While assisted notification may represent the gold standard for partner notification, it is not always feasible for individual providers to participate in the notification process. Health care providers who diagnose HIV must frequently place the burden of partner notification on their patients. According to qualitative analysis of data collected during interviews with 24 HIV test providers (15 HIV test counselors and 9 physicians), test providers felt that PN of sexual partners was necessary but usually encouraged self-notification of partners.[49] A national survey of physicians found that most physicians who had diagnosed HIV within the past year always instructed their newly diagnosed patients to inform their partners of the exposure and told them to seek care for diagnosis and treatment.[50] Physicians do not typically get involved with partner notification. Only small percentages of physicians always sent partner information to the Health Department or had their office contact patients' partners. Among a small group of physicians who diagnosed HIV in Syracuse, New York, nearly two-thirds (64%) of physicians were familiar with NYS's Partner Notification Assistance Program, but none conducted partner notification themselves.[51]

Literature Regarding HIV Partner Notification and Intimate Partner Violence

NYS's HIVRPN legislation requires that a domestic or intimate partner violence (IPV)[a] screen be applied to each identified partner, with notification being deferred in cases where a risk of violence exists. While the implementation of IPV screening in the context of partner notification appears to reflect good public health practice, with a few limited exceptions, it has yet to be established as a routine measure in any state.

According to the National Family Violence Surveys (1975, 1985, 1992), it has been estimated that 1 out of 6 US couples had experienced at least one episode of IPV in the previous year.[52] In a more recent study of a representative sample of 1,635 US couples, an estimated 8% to 22% of the study subjects recalled at least one act of IPV in the previous year.[53] IPV is especially problematic for certain segments of the population, although actual prevalence varies between studies. For instance, it has been estimated that over 30% of women experience IPV during their lifetime.[54,55] A study of over 1,400 women seeking medical care in family practice clinics, 55% of the women interviewed had experienced some type of partner violence in a current or a past relationship with a male partner.[56] According to the National Violence against Women Survey (a random digit dialing survey), women were more likely than men to have ever

[a] The terms Intimate Partner Violence (IPV) and Domestic Violence (DV) are used interchangeably in this report. New York's HIVRPN law refers specifically to DV, which represent conventional terminology. IPV is becoming the current convention, however, given its perceived broader applicability.

experienced physical or sexual violence (17.6% compared to 5.9%).[57] A study of female STD client patients indicated that 11% of women had experienced IPV within the past year and 24% had ever experienced IPV.[58]

Until recently, violence involving intimate partners among gay, lesbian, bisexual, and transgender (GLBT) individuals had received limited attention in the literature. A review of selected prevalence studies by the National Coalition of Anti-Violence Programs indicates that between 25% to 33% of GLBT persons are abused by their partners, comparable to the rate of IPV occurring in heterosexual relationships.[59] Another review of 19 prevalence studies corroborates this observation and also indicates that the correlates of same-sex partner abuse are very similar to those identified in heterosexual relationships.[60]

Victims of IPV are also at increased risk of HIV infection. Threats of physical abuse undermine efforts of the abuse victims to negotiate or practice HIV risk reduction measures such as condom use.[61] The linkage between IPV and HIV risk has been found among diverse segments of the population, including African American and Hispanic women,[62,63,64 65] American Indian women,[66] female STD clinic patients, [58] Latino gay men,[67] and heterosexual couples.[68]

It has been argued that the disclosure of HIV status may trigger acts of violence by intimate partners against HIV-infected individuals,[69] especially among those who are already in abusive relationships.[70,71] Approximately 3% of women offered HIV testing in an STD clinic, whose partner(s) had been notified of STD exposure, were physically harmed by that partner as a result of the notification.[72] Despite the low level of actual violence resulting from notification, one-quarter of the women who had a primary partner in the past three months reported that they would be afraid to tell their partner if they had HIV. IPV and fear of violence were not associated with refusing HIV testing. However, injury resulting from IPV in the past year was marginally associated with refusal to be HIV tested. Such concerns notwithstanding, there have been few systematic investigations of how the disclosure of one's HIV status may lead to victimization by current or former intimate partners.[73]

There are indications that the threat of violence is a major concern among HIV-infected individuals[74] and their health care providers.[75] However, there are several studies that cast doubt on the argument that disclosure itself contributes to violence against people living with HIV/AIDS. For instance, earlier research on the consequences of disclosure among HIV-positive gay and bisexual males viewed disclosure as both a stressor and a positive coping strategy.[76,77,78] Gielen et al. reported that while two-thirds of HIV-infected women had been afraid to disclose their HIV status, only 6% of the study sample indicated that they were actually verbally or physically assaulted.[79] In fact, three-quarters of the women received supportive and understanding responses to their disclosure. Among 142 HIV-infected STD patients in three urban centers, 6% were abandoned because of their HIV status but only 1% had been assaulted because of disclosure.[80] In a study of 129 HIV-infected primary care patients, women were found to be more likely to reveal their serostatus to sexual partners than men, contrary to the expectation that women are less likely to disclose for fear of violence victimization.[81]

There are two key issues in the literature that may obscure the relationship between IPV and disclosure of HIV status. First, there is a lack of reliable estimates of the prevalence of IPV against people living with HIV/AIDS. Second, most existing studies fail to provide empirical evidence that notification or disclosure has indeed triggered violent responses by intimate partners. Few prevalence estimates of HIV-induced domestic violence are based on large probability samples. One notable exception is the study by Zierler et al.[82] Using a nationally representative sample of 2,864 HIV-infected adult patients, the prevalence estimates of domestic violence *since* HIV diagnosis among women, men who have sex with men, and heterosexual men are estimated to be 20.5%, 11.5% and 7.5%, respectively. When asked whether "being physically hurt" was related to one's HIV infection, 40% to 50% of DV victims across the three sub-samples believed their infection was the cause of the violence. While the high rates of violence, especially against women and MSM, are alarming, the authors caution that they "did not detect a particular high-risk period for physical harm after HIV diagnosis".

Study of the Impact of the HIVRPN Law

The current study, funded by a three-year grant from the CDC Public Health Practice Program Office (PHPPO), assessed the impact that the HIVRPN law and its implementation have had on the ability of NYS to document and identify HIV-positive individuals. In addition, several of the proposed benefits and projected negative consequences were evaluated. This was accomplished through a multi-disciplinary research design, which included the following major study components.

1. An analysis of data from the NYS HIV/AIDS Surveillance and Partner Notification System. Data examined included:

   - The number of new cases of HIV infection, HIV-related illness, and AIDS;
   - The number of partners named per index case;
   - The number/percentage of named partners who are notified;
   - The distribution of partner notification methods used to notify partners;
   - The percentage of HIV-positive individuals with an identified risk of domestic violence from one or more partners.

2. An analysis of publicly-funded HIV counseling and testing program and Medicaid data to measure aggregate changes in HIV testing levels after the implementation of the HIVRPN regulations.

3. Focus Groups with HIV-positive individuals, HIV service providers, and PartNer Assistance Program (PNAP) staff regarding the partner notification aspects of the HIVRPN legislation.

4. Re-administration of a modified version of the CDC-funded HIV Testing Survey (HITS) to high-risk populations. The intent of this survey was to measure, among other things, knowledge and perceptions of NYS's HIVRPN law and regulations, HIV testing experiences, and reasons for delaying or not testing;

5. Administration of a survey to a probability sample of HIV counseling and testing providers in NYS to measure the perceived impact of the HIVRPN law and regulations from an agency and HIV test counselor perspective.

6. Administration of a modified version of CDC's Sexually Transmitted Disease Clinical Observation Notification Tracing and Control Techniques (STD-CONTACT) survey to a stratified random sample of physicians likely to diagnose and treat STDs. The intent of the survey was to examine physician knowledge, attitudes, and practices around HIV/STD reporting, partner notification and intimate partner violence screening.

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Component 1

New York's HIV Reporting and Partner Notification (HIVRPN) Reporting System

Summary of Data On:
1. Newly Diagnosed HIV and AIDS Cases
2. Partner Notification Activities

Office of Program Evaluation and Research
New York State Department of Health AIDS Institute
CDC Grant: R06/CCR218723

Introduction

Expanded reporting of HIV infection permits more accurate epidemiologic surveillance of the HIV/AIDS epidemic and provides the basis for targeted planning, resource allocation and evaluation of public health initiatives. Enhanced partner notification allows more exposed individuals to learn their HIV status and receive early diagnosis and treatment if infected. The partner notification process also increases the opportunities for patient education regarding HIV risk reduction education to prevent future transmission.

Operationally, HIV/AIDS surveillance activities are the sole responsibility of the New York State (NYS) and New York City (NYC) Departments of Health (DOH), while partner notification activities are conducted by a combination of NYS, NYC, and county Health Department staff. The regulations indicate that all newly diagnosed cases of HIV infection and any known contacts reported by physicians merit priority consideration for partner notification. Cases outside of NYC are referred for partner notification evaluation to the 13 participating county health commissioners and NYSDOH regional PartNer Assistance Program (PNAP) staff. NYC cases are transferred to the NYC HIV/AIDS Surveillance Program.

HIV/AIDS Surveillance

During the first year of implementation, state-of-the-art computer systems were developed to receive, process and transfer HIV/AIDS reports in a highly confidential and secure manner. All NYS, NYC, and other local DOH personnel were trained in handling highly confidential information. Office renovations were made and other security precautions were taken to comply with the strict security standards of the federal Centers for Disease Control and Prevention (CDC) and the NYSDOH.

By January 2001, all 74 clinical laboratories performing HIV related tests in NYS were transmitting HIV/AIDS reports to the NYSDOH. Since HIV infected individuals in care may receive up to four CD4 and HIV viral load tests a year, the majority of reports received are duplicate reports for the same individuals. These duplicate reports ensure a complete case count but necessitate the development of matching procedures to identify newly reported cases for assignment to State and City surveillance staff for field follow-up. This follow-up involves chart reviews to gather the required surveillance information in order to confirm a case as HIV, HIV-related illness or AIDS.

Partner Notification

In all areas outside of NYC, PNAP staff, who are a mix of state and participating county staff, routinely contact the health care provider regarding reports of newly diagnosed HIV infection for the purpose of offering voluntary partner notification assistance. Initially this was done upon receipt of the provider report, even if the provider did not specifically request PNAP assistance on the Provider Report Form. In 2003, policy changed to initiate PNAP follow-up with the provider on receipt of the laboratory report, in order to offer assistance in development of partner elicitation and partner notification plans soon after diagnosis. In NYC, the surveillance staff initially referred to CNAP only those cases (small minority) where the provider specifically asked for CNAP assistance on the provider report form. Given the continuing high number of cases with no partners, the NYSDOH worked with NYC to promote use of the CNAP program,

and to revise its policies to refer many additional cases (where no partners are named, plans are in progress, etc.) to CNAP for follow-up. The results of this expanded follow-up (formalized in an MOU between the State and City Health Departments in 2004) are not yet known.

In addition to partner notification activity generated by medical provider and laboratory reports, both PNAP and CNAP staff continue to receive requests for partner notification assistance not related to HIV reporting directly from NYS providers and out-of-state providers whose patients have partners in NYS. PNAP staff also contact providers by telephone to follow up on laboratory reports of newly diagnosed infections for which a Provider Report Form has not been received. In NYC cases, HIV Surveillance program staff hand deliver letters to providers who are late in completing Provider Report Forms.

Newly Diagnosed HIV and AIDS Cases

Table 1 presents summary information on newly diagnosed HIV and AIDS cases from January 2001 through December 2003. Although HIV reporting officially began in June 2000, data from the first six months of the program were incomplete due to a variety of system startup-related issues. As a result, data from June 2000 through December 2000 are excluded from this report. Table 1 reveals that nearly 30,000 cases of HIV or AIDS were diagnosed and reported during the three-year period. Table 1 further indicates that the HIV/AIDS epidemic in NYS is concentrated in NYC, among males, among those over the age of 30, and among minorities. These groups accounted for 82.9%, 65.4%, 83.9%, and 81.0% of newly diagnosed HIV/AIDS cases, respectively. The risk-related data are harder to interpret, since over 40% of newly diagnosed cases did not have a documented risk factor at the time of this report.

Of note in Table 1 is the fact that, with the anticipated exception of age, the sex and racial/ethnic distribution of newly diagnosed HIV cases closely resembles that of AIDS cases[1]. Assuming HIV cases reflect the current face of the epidemic, this suggests that the HIV epidemic has not been trending disproportionately by gender or race/ethnicity in NYS. Although the risk-related information is highly incomplete, the percentage of total cases attributable to MSM is higher among newly diagnosed HIV (26.1%) versus AIDS (21.4%) cases, while the percentage of IDU cases is lower (11.7% of total HIV cases versus 16.6% of AIDS cases). Further investigation of yearly trends in HIV/AIDS cases by risk factor provided additional support for this possibility: The percentage of total HIV cases attributable to MSM increased from 23.7% in 2001 to 29.7% in 2003, while the percentage of HIV cases attributable to IDU decreased from 14.8% to 8.6% during this same timeframe (data not shown).

[1] It often takes several years to progress from HIV to AIDS. Therefore it is expected that the average age of those diagnosed with HIV would be younger than the average age of those being diagnosed with AIDS.

Table 1: Newly Diagnosed HIV and AIDS Cases by Demographic and Primary Risk Factors: January 2001 - December 2003*

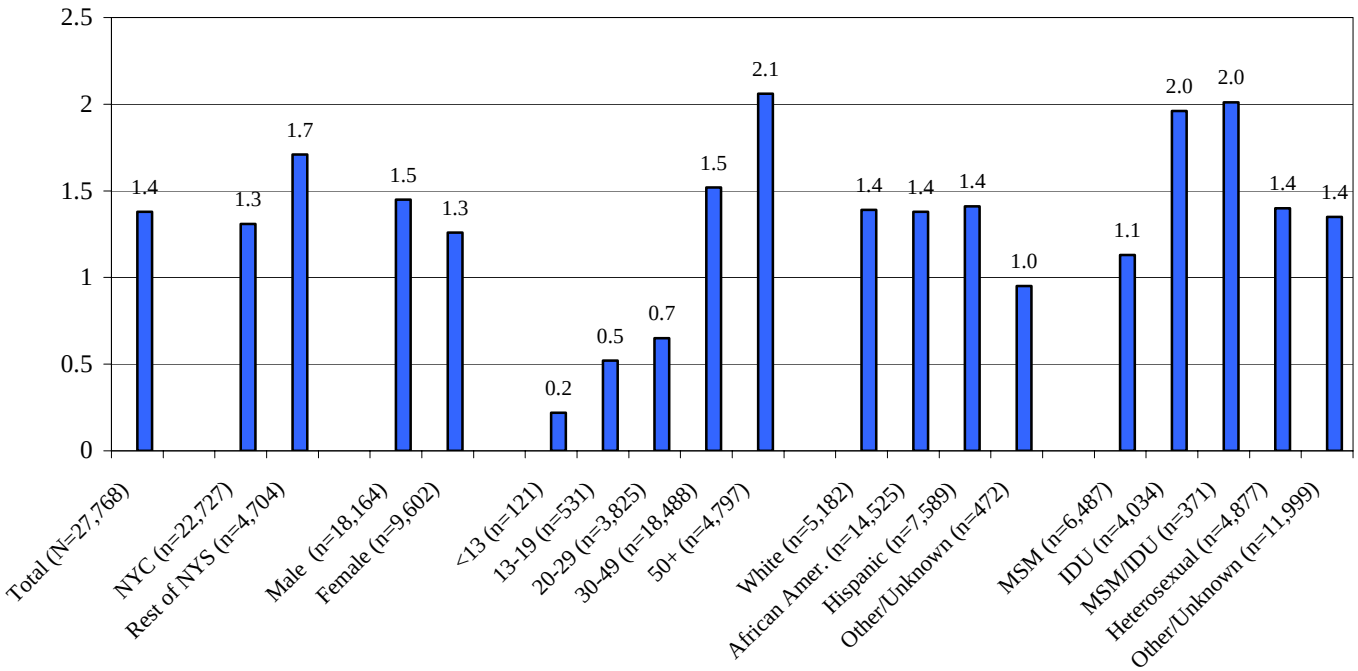
	January 1, 2001 – December 31 2003					
	New HIV cases		New AIDS cases		Total cases	
	n	%	n	%	n	%
Total	11,671	100.0%	16,097	100.0%	27,768	100%
Region						
NYC	9,838	85.0%	12,889	81.3%	22,727	82.9%
Rest of NYS	1,737	15.0%	2,967	18.7%	4,704	17.1%
Missing	96	----	241	----	337	----
Gender						
Male	7,415	63.5%	10,749	66.8%	18,164	65.4%
Female	4,254	36.5%	5,348	33.2%	9,602	34.6%
Missing	2	----	0	----	2	----
Age						
<13	99	0.9%	22	0.1%	121	0.4%
13-19	350	3.0%	181	1.1%	531	1.9%
20-29	2,325	19.9%	1,500	9.3%	3,825	13.8%
30-49	7,323	62.8%	11,165	69.4%	18,488	66.6%
50+	1,568	13.4%	3,229	20.1%	4,797	17.3%
Missing	6	----	0	----	6	----
Race/ethnicity						
White	2,172	18.6%	3,010	18.7%	5,182	18.7%
African American	6,104	52.3%	8,421	52.3%	14,525	52.3%
Hispanic	3,153	27.0%	4,436	27.6%	7,589	27.3%
Asian/Pacific Isl.	158	1.4%	179	1.1%	337	1.2%
Native American	29	0.3%	31	0.2%	60	0.2%
Other/Unknown	55	0.5%	20	0.1%	75	0.3%
Risk						
MSM	3,042	26.1%	3,445	21.4%	6,487	23.4%
IDU	1,365	11.7%	2,669	16.6%	4,034	14.5%
MSM/IDU	123	1.1%	248	1.5%	371	1.3%
Heterosexual	2,032	17.4%	2,845	17.7%	4,877	17.6%
Other/Unknown	5,109	43.8%	6,890	42.8%	11,999	43.2%

* Includes 2003 cases reported and confirmed in 2004. 2003 data are incomplete due to lag in reporting. Source: NYS Department of Health Bureau of HIV/AIDS Epidemiology.

Figure 1 presents the information from Table 1 in a slightly different way. Figure 1 reports the simple ratio of AIDS to HIV cases among each demographic and risk-related subgroup from Table 1. Overall, there were 1.4 newly diagnosed AIDS cases for every newly diagnosed case of HIV infection reported over the three-year period. While this ratio is difficult

to interpret by itself (i.e., since the bolus of HIV cases were being captured during the initial reporting period), examining this ratio within demographic and risk-related subgroups may be meaningful. Interestingly, the ratio of AIDS to HIV cases was higher among cases diagnosed outside NYC (1.7) than it was among NYC cases (1.3). This ratio also varied by slightly by gender, with males exhibiting a higher ratio (1.5) than females (1.3). As expected, the ratio of AIDS to HIV cases increased sharply with age, reflecting the fact that HIV infection often takes several years to develop into an AIDS-defining condition. Whites, African Americans, and Hispanics exhibited identical AIDS to HIV ratios (1.4). Finally, Figure 1 reveals sharp variation in this ratio by transmission category: IDUs (2.0) and MSM/IDUs (2.0) exhibited much higher AIDS to HIV ratios than MSM (1.1) and those contracting the virus through heterosexual (1.4) or other/unknown (1.4) methods.

Figure 1: Ratio of AIDS to HIV Cases by Demographic and Risk-Related Factors: Newly Diagnosed HIV/AIDS Cases - January 2001-December 2003



Partner Notification Activities

As discussed, NYS's HIV reporting law specifically requires the reporting of partners known to, or elicited by, the diagnosing health care worker. Table 2 presents information on the number of partners identified per index case from January 2001 through December 2003. Yearly data are presented in the first three columns, while the final column summarizes data across the three-year period. Data are also reported for NYS as a whole, and then separately for NYC and the rest of NYS. It is important to note that a direct comparison between the HIV/AIDS reporting data reported in Table 1 and the data reported in the remaining tables in this report is not possible. There are a few reasons for this. PNAP assignments are made (and usually completed) before surveillance is initiated on the case. Subsequent surveillance may result in identifying some reported cases as duplicates, different stage of illness, counted in another

jurisdiction (e.g., NYC case), etc. In addition, PNAP assignments are made based on the address of the reporting provider or lab, and will include partner follow-up on cases where the patient is actually a NYC resident. Another reason why partner notification data do not directly match HIV/AIDS data involves the fact that partner notification data are tied temporally to the date the case was assigned from the reporting system, not the date the index case was diagnosed. As a result, some partners of HIV/AIDS index cases diagnosed late in one year are assigned to the following year.

Table 2 reveals that, across the three-year period, two-thirds of reported cases identified no partners at the time all follow-up was completed, while an additional 26% identified just one partner. Moreover, a significant increase in the percentage of cases naming no partners was observed after the first year (from 52.9% in 2001 to 72.6% in 2003). Table 2 also reveals that NYC cases were more likely to result in no partners being identified after all follow-up was completed than were cases diagnosed in other areas of NYS.

Table 2: Number of Partners Per HIV/AIDS Case
January 1, 2001 to December 31, 2003

Number of partners per reported case[1]	1/1/01 – 12/31/01		1/1/02 – 12/31/02		1/1/03 – 12/31/03		1/1/01 - 12/31/03	
	n	%	n	%	n	%	n	%
New York State Total								
0	3,723	52.9%	5,851	74.6%	4,909	72.6%	14,483	66.9%
1 or more	3,316	47.1%	1,994	25.4%	1,857	27.4%	7,167	33.1%
Total	7,039		7,845		6,766		21,650	
New York City								
0	3,294	54.8%	4,730	76.5%	3,880	74.4%	11,904	68.4%
1 or more	2,714	45.2%	1,454	23.5%	1,333	25.6%	5,501	31.6%
Total	6,008		6,184		5,213		17,405	
Rest of New York State								
0	429	41.6%	1,121	67.5%	1,029	66.3%	2,579	60.8%
1 or more	602	58.4%	540	32.5%	524	33.7%	1,666	39.2%
Total	1,031		1,661		1,553		4,245	

1. Includes partners listed on provider reports and partners for cases identified with PNAP/ CNAP assistance in follow-up.
Source: Bureau of STD Control, NYSDOH

Table 3 reports on the notification status of identified partners. There were over 8,000 partners reported to the system over the three-year period, with the number of reported partners dropping sharply after the first year of reporting (from 3,793 in 2001 to 2,320 in 2002). The higher number in 2001 may be partially due to delayed deployment of the newly developed PNAP tracking system in some localities, that resulted in partners from 2000 cases (first year of HIV reporting) not assigned “electronically” until 2001 (these were called out for follow-up by the respective localities until the electronic assignment system was functional).

Table 3: Notification Status of Partners of HIV/AIDS Cases Reported or Referred to the NYS or NYC DOH: January 1, 2001 to December 31, 2003

	1/1/01 – 12/31/01		1/1/02 – 12/31/02		1/1/03 – 12/31/03		1/1/01 - 12/31/03	
	n	%	n	%	n	%	n	%
New York State Total								
PNAP/CNAP initiated partners[1]	3, 793	100.0%	2,320	100.0%	2,107	100.0%	8,220	100.0%
Total notified partners	2, 490	65.6%	1,602	69.1%	1,295	61.5%	5,387	65.5%
Notified by provider	140	3.7%	189	8.1%	192	9.1%	521	6.3%
Notified by patient	984	25.9%	650	28.0%	449	21.3%	2,083	25.3%
Partner already knows own HIV+ status	744	19.6%	432	18.6%	374	17.8%	1,550	18.9%
Notified by DOH	493	13.0%	251	10.8%	184	8.7%	928	11.3%
Other confirmed Notifications	129	3.4%	80	3.4%	96	4.6%	305	3.7%
Partners not notified	1,303	34.4%	718	30.9%	812	38.5%	2,833	34.5%
New York City								
CNAP initiated partners[1]	2,978	100.0%	1,659	100.0%	1,536	100 %	6,173	100.0%
Total notified partners	1,891	63.5%	1,121	67.6%	878	57.2%	3,890	63.0%
Notified by provider	64	2.1%	144	8.7%	133	8.7%	341	5.5%
Notified by patient	816	27.4%	552	33.3%	365	23.8%	1,733	28.1%
Partner already knows own HIV+ status	658	22.1%	375	22.6%	316	20.6%	1,349	21.9%
Notified by DOH	299	10%	17	1 %	24	1.6%	340	5.5%
Other confirmed Notifications	54	1.8%	33	2 %	40	2.6%	127	2.1%
Partners not notified	1,087	36.5%	538	32.4%	658	42.8%	2,283	37.0%
Rest of New York State								
PNAP initiated partners[1]	815	100.0%	661	100.0%	571	100.0%	2,047	100.0%
Total notified partners	599	73.5%	481	72.8%	417	73.0%	1,497	73.1%
Notified by provider	76	9.3%	45	6.8%	59	10.3%	180	8.8%
Notified by patient	168	20.6%	98	14.8%	84	14.7%	350	17.1%
Partner already knows own HIV+ status	86	10.6%	57	8.6%	58	10.2%	201	9.8%
Notified by DOH	194	23.8%	234	35.4 %	160	28 %	588	28.7%
Other confirmed notifications	75	9.2%	47	7.1 %	56	9.8%	178	8.7%
Partners not notified	216	26.5%	180	27.2 %	154	27.0%	550	26.9%

1. For data comparability, 2001 data have been adjusted to drop those contacts included in the initial data report that do not meet the CDC definition of a contact (262 total partners in NYS: 57 in NYC, 205 in Rest of New York State) due to insufficient information to initiate for Partner Counseling and Referral Services (PCRS). Subsequent year reports (2002, 2003) reports did not include these partners.

Source: Bureau of STD Control, NYSDOH

Table 3 reports that 65.5% of partners were notified statewide across the three-year period, with notification rates remaining fairly stable across each year. Notification rates were lower among NYC cases, however: 63% of NYC-based partners were notified versus 73.1% of partners residing outside NYC.

Table 3 also reveals that, statewide, the most common methods of partner notification were by index patients directly (25.3%) and by already knowing one's own HIV-infected status

(21.9%). The majority of those were reported as patient self-notification unconfirmed by the provider. There were differences in notification methods between NYC and non-NYC clients, with the largest difference attributable to the higher level of utilization of the NYS PNAP program. In fact, for non-NYC clients, PNAP staff was the most common source of notification (28.7%), followed by direct patient notification (17.1%) and partners already knowing their own HIV positive status (9.8%).

Finally, Table 3 indicates that 34.5% of identified partners were classified as "not notified". Importantly, this does not necessarily mean that notification did not occur. This simply means that the provider and/or PNAP/CNAP staff could not verify that notification had occurred at the time these data were compiled. There were several reasons for notifications not occurring, the most common reasons being investigations or notifications that were still in progress, partners being lost to follow-up and partners dying or moving out of state. Interestingly, just 5.1% of partners (n=145 across all three years) were not notified due to concerns about risk of intimate partner violence (IPV) (data not displayed).

Conclusion

Nearly 30,000 individuals living with HIV or AIDS were identified during the first three years of NYS's HIVRPN law. African Americans represented just 15.9% of NYS's population in 2000[2], yet they accounted for over 50 percent of newly diagnosed HIV and AIDS cases occurring in NYS between 2001 and 2003. People of Hispanic origin were also overrepresented, accounting for 15.1% of the population but 27% of NYS's HIV and AIDS cases. The gender and racial/ethnic distribution of newly diagnosed HIV cases resembled that of newly diagnosed AIDS cases, suggesting that the relative impact of the HIV epidemic by gender and race/ethnicity may have stabilized in NYS. There is some evidence that NYS's HIV epidemic may be trending towards a higher percentage of MSM cases, however the large percentage of missing data on HIV risk exposure category necessitates further exploration of this finding.

The partner notification component of NYS's HIVRPN law offers tremendous potential to prevent future infections by identifying, notifying, and testing the partners of HIV-infected individuals. Much of that potential has remained untapped during the early years of the HIVRPN law, as two-thirds of reported HIV and AIDS cases failed to identify even a single partner, while an additional 25% identified just one partner. Moreover, the reporting of partners was highest during the first year of the HIVPRN law, dropping sharply thereafter. More effort at strengthening the linkages between providers and health department partner notification programs (who employ specially trained disease intervention specialists) to facilitate close cooperation in supporting patients to develop and implement comprehensive and effective partner notification plans, appears warranted.

Data on the notification status of over 8,000 partners of newly identified HIV positive individuals reveals that 65% had evidence of being notified (or already knowing their status). An examination of the methods used to notify partners reveals that the HIVRPN law has not increased the utilization levels of the partner notification assistance programs operated by the NYC and NYS DOH. In fact, the number of notifications being performed by NYC-based

[2] Source: US Census Bureau at http://quickfacts.census.gov/qfd/states/36000.html

CNAP staff fell sharply in 2002 and 2003. It appears that a significant amount of effort, especially in NYC, was initially placed on working with providers to document partner notification activities, rather than on following up with partners to conduct notifications.

Given that a variety of research has shown that assisted notification can be more productive than self-notification (i.e., result in more partners being notified and tested), efforts are needed to increase the actual amount of HIV-related partner notifications being conducted by the NYS and NYC partner notification assistance programs. Toward this end, NYS PNAP staff has begun to follow-up directly with providers upon receipt of the initial lab report, in order to offer their consultation early in the partner elicitation process. Within NYC, the DOH has modified policies to require CNAP follow-up on cases where the partner notification plan is incomplete, in process or has not been finalized. These activities should result in increased utilization of the State and City assisted notification programs.

Finally, the HIVRPN system uncovered very few deferrals of partner notification due to risk of IPV. This is somewhat surprising given the findings from the literature and the other components of this grant, suggesting high levels of IPV risk among at-risk and HIV-infected individuals. Accounts based on interviews and focus groups with HIV/AIDS service providers suggest one possible reason for this discrepancy: Partners screening positive for IPV risk may be excluded from the Provider Report Forms due to concern about the safety of index patients. Index patients may also be reluctant to name abusive partners.

Limitations

We had initially hoped that NYS's HIVRPN system would permit the tracking of data on the relationship between method of partner notification and partner testing outcomes, and on the number of newly identified HIV-positive individuals resulting from partner notification efforts. However, this information is generally available only for the subset of identified partners who are actually notified and/or tested by the PNAP or CNAP programs.

Component 2

HIV Testing Trends in New York State Before and After the HIV Reporting and Partner Notification (HIVRPN) Legislation

General Findings Report

Office of Program Evaluation and Research
NYS Department of Health AIDS Institute
CDC Grant: R06/CCR218723

Introduction

As discussed, one concern with New York State's (NYS) HIV Reporting and Partner Notification (HIVRPN) law was that it would cause individuals to avoid HIV testing. Existing research into this issue has produced conflicting findings, attributable, at least in part, to differences in the timing of the research, differences in the populations studied, and differences in the research methods employed. More recent studies have found lesser deterrent effects. NYS's HIVRPN Law retains the anonymous HIV counseling and testing option. This was done to offset the potential chilling effects that HIV reporting might have on the HIV test-seeking behavior of some residents.

This component of the grant assesses, through the application of an interrupted time series design, the impact of NYS's HIVRPN law on the HIV testing trends of publicly funded counseling and testing sites.

Data and Methods

Data

All Centers for Disease Control and Prevention (CDC) funded HIV counseling and testing providers in NYS are required to complete individual-level data on each HIV test performed. Information collected includes the date of the HIV test, client demographic information (sex, age, race/ethnicity), HIV-risk related behavior(s) of the person testing, and the type of testing site (i.e., anonymous test center, community health center, substance abuse treatment center, prison/jail). Data from each provider are sent to central offices in Albany, where an HIV Counseling and Testing System (CTS) database is maintained.

Clients testing HIV positive with anonymous HIV testing providers have the option of converting their anonymous test result to confidential status at the post-test counseling session. Doing so allows the individual to access HIV health care services without having to retest. The decision to convert from anonymous to confidential status is also collected on the individual-level CTS form.

Publicly-funded HIV counseling and testing providers do not make up the universe of HIV testing options for NYS residents. Residents may also test, among other places, with private doctors or in private clinics. NYS Medicaid Claims were also used to capture some of this other testing activity. Medicaid billing codes were used to collect, for the Medicaid population, similar data to that being gathered for publicly-funded HIV testing clients.

Research Questions

The primary outcome variables for this study component are 1) the number of HIV tests conducted; 2) the percentage of HIV tests with post-test counseling; and 3) the percentage of HIV positive test results converted from anonymous to confidential status (anonymous HIV testing sites only). As discussed, prior research has not consistently established an overall deterrent effect of HIV reporting policies on HIV testing intentions

or behaviors, although there is some evidence that certain sub-groups may be more impacted than others. Although no a-priori hypotheses were being proposed, three distinct impact patterns were examined against this study's null hypothesis, which states that the HIVRPN legislation has no effect on HIV counseling and testing activity, the percentage of HIV tests with post-test counseling, or decisions to convert HIV positive test results from anonymous to confidential status. Alternative hypotheses examined in this study include:

> Abrupt, Temporary Negative Impact: The HIVRPN legislation has an initial negative impact on HIV testing levels, post-test counseling, and conversion rates immediately after implementation, followed by an eventual recovery to pre-intervention levels.
>
> Abrupt, Permanent Negative Impact: The HIVRPN legislation has an initial negative impact on HIV testing levels, post-test counseling, and conversion rates, which is maintained throughout the study period.
>
> Abrupt, Temporary Positive Impact**:** The HIVRPN legislation creates a surge of testing episodes shortly ***before*** implementation, most likely followed by a sharp decline after implementation occurs.

In addition, we tested for differential impact by testing type in order to investigate the possibility that the HIVRPN legislation had created a bifurcating pattern on testing levels – a concurrent decline in confidential testing and an increase in anonymous testing after implementation. Finally, we investigated whether or not there was a differential impact on testing levels by subgroup. That is, whether or not the HIVRPN legislation had differential effects based on the sex, race/ethnicity, age group, and/or HIV risk group of those testing. These impact patterns are not mutually exclusive, nor are they exhaustive. They simply represent some of the most commonly suggested effects of HIV reporting set forth in the literature.

Methods

To ensure an adequate amount of pre- and post-intervention data, the study period began in January of 1998 and ran through December of 2002, providing 29 months of pre- and 30 months of post-intervention data. In addition, in order to minimize the impact of changes in counseling and testing sites over time, we included only those sites submitting data throughout the entire study period. Monthly data served as the unit of analysis. It should be noted that analyses were also performed using weekly data as the unit of analysis. Weekly data had the advantage of being able to detect more subtle changes in testing patterns and pinpoint more precisely when those changes occurred, however there was not a sufficient volume of testing activity occurring to produce stable estimates, particularly among the models being estimated for the subgroups defined above.

Statistical Methods and Analysis

Statistical Package for the Social Sciences (SPSS) (PC version 11.0) was used to analyze all data associated with this study. Sets of interrupted time-series analyses measuring the impact of the HIVRPN legislation on each outcome variable were estimated for the total sample, within each type of testing setting, and then within categories of sex, race/ethnicity, age, and HIV risk factor. More specifically, the intervention analysis developed by Box and Taio based on the Box-Jenkins autoregressive, integrated, moving average (ARIMA) time-series modeling technique was employed.[1,2]

The models reported below utilized the HIVRPN law's June 2000 implementation date as the sole intervention point. It is important to note that additional intervention points were also included in each model, representing initial passage of the HIVRPN legislation, passage of the regulations implementing the legislation, and the timing of known post-implementation training campaigns. Since these intervention points did not serve to affect the results, the final models utilized the June 2000 implementation date as the sole intervention point.

Finally, the models reported below present the results of analyses specifically testing the "Abrupt, Permanent Negative Impact Hypothesis" detailed above. We also estimated models for the Abrupt, Temporary Negative Impact and the Abrupt, Temporary Positive Impact hypotheses. Since these models produced similar conclusions, only the Abrupt, Permanent Negative Impact models are presented in this report.

Results

HIV Testing Levels

Figure 1 displays the total number of HIV tests per month over the study period for each testing setting, while Table 1 presents a summary of the ARIMA time series models for HIV testing levels in each setting. Implementation of the HIVRPN law is indicated by the vertical line in Figure 1. There is no apparent (visual) change in HIV testing levels following the HIVRPN law among community health centers. Levels of HIV testing increased gradually over time in substance abuse treatment settings, although this trend appears to have begun prior to implementation of the HIVRPN law. Testing levels also increased in criminal justice testing settings, from about 200 tests per month for most of the pre-implementation period, to approximately 400 tests per month by the end of the study period. Finally, levels of testing in anonymous testing sites decreased throughout the entire study period, from over 800 tests per month in January 1998, to about 400 tests per month by the end of the study period. However, Table 1 indicates that, once existing trends and/or seasonality in testing levels were controlled statistically, post-HIVRPN law changes were not statistically significant in 3 out of the 4 testing settings. There was a statistically significant change in testing levels in criminal justice settings only, with levels of testing actually increasing by about 70 tests per month, rather than decreasing in the post-HIVPRN law period. Discussions with program staff suggest that this

increase was likely due to increases in the amount of staff time spent in correctional facilities over the study period.

Figure 1: Total HIV Tests by Month and Year
NYS HIV Counseling and Testing (CTS) Data System

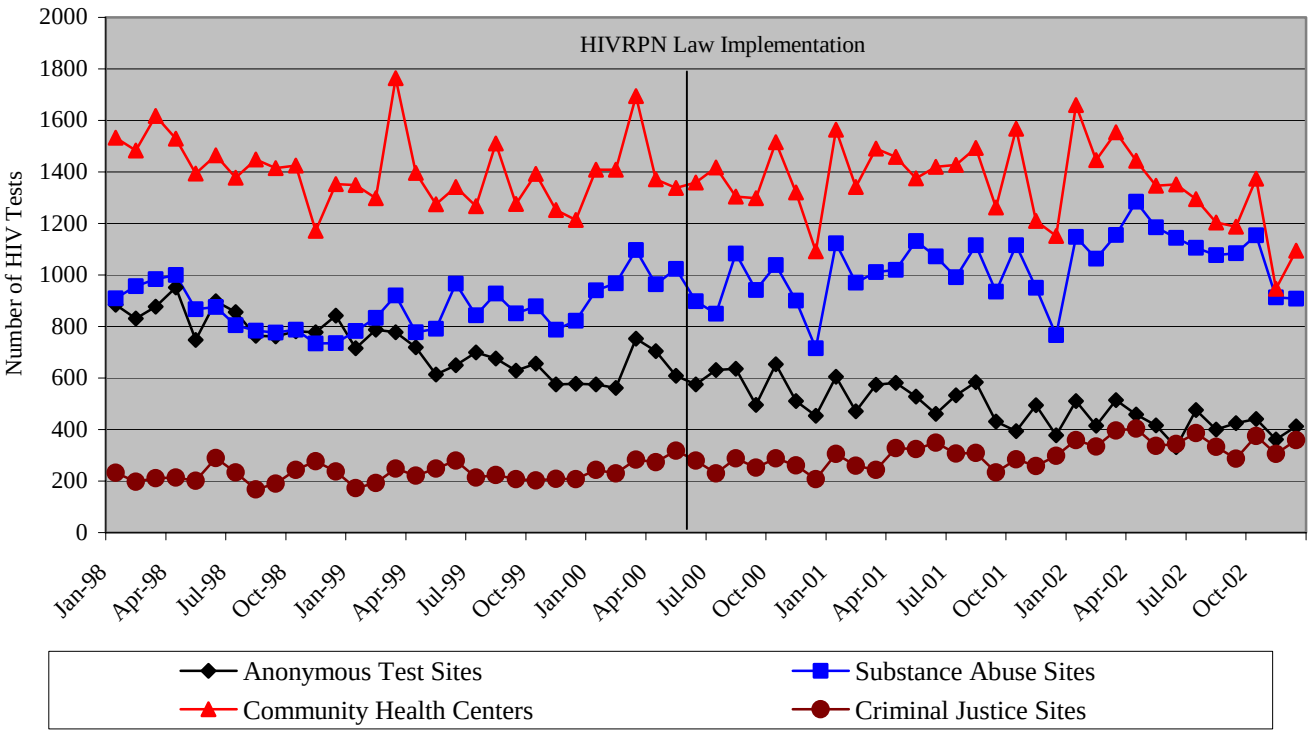


Table 1: Summary of ARIMA Time Series Models for HIV Testing
NYS HIV Counseling and Testing (CTS) Data System

Testing Venue	ARIMA Model	Mean Tests/ Month Before HIVRPN Law	Change in Tests/Month After Law[1]	% Change in Tests/Month After Law[1]
Anonymous	(2,0,0)	733	Not Sig.	No Change
Substance Abuse Treatment	$(1,0,0)(1,0,0)_{12}$	875	Not Sig.	No Change
Community Health Center	$(0,0,0)(1,0,0)_{12}$	1,406	Not Sig.	No Change
Criminal Justice	(1,0,0)	230	+ 70.5**	+ 30.6%

* p<.05 ** p<.01

[1] Reflects the change in testing levels after controlling for autocorrelation as specified in "ARIMA Model" column

HIV Post-test Counseling Rates

Figure 2 displays the rate of HIV post-test counseling throughout the study period for each testing setting, while Table 2 presents a summary of the ARIMA time series models for post-test counseling rates in each setting. Once again, implementation of the HIVRPN legislation is indicated with the vertical line in Figure 2. There is no indication that the rate of HIV post-test counseling decreased following the HIVRPN law in any of the 4 testing settings:

- The rate of post-test counseling fluctuated around 95% throughout the study period in criminal justice testing settings.
- Similarly, the post-test counseling rate varied throughout the period at around 85% in anonymous and substance abuse testing settings.
- Finally, the monthly rate of post-test counseling varied around 75% in community health center settings throughout the 5 year study period.

Once existing trends and/or seasonality in post-test counseling rates were controlled statistically, post-HIVRPN law changes were not statistically significant in any of the testing settings (Table 2).

Figure 2: HIV Post-Test Return Rates by Month and Year
NYS HIV Counseling and Testing (CTS) Data System

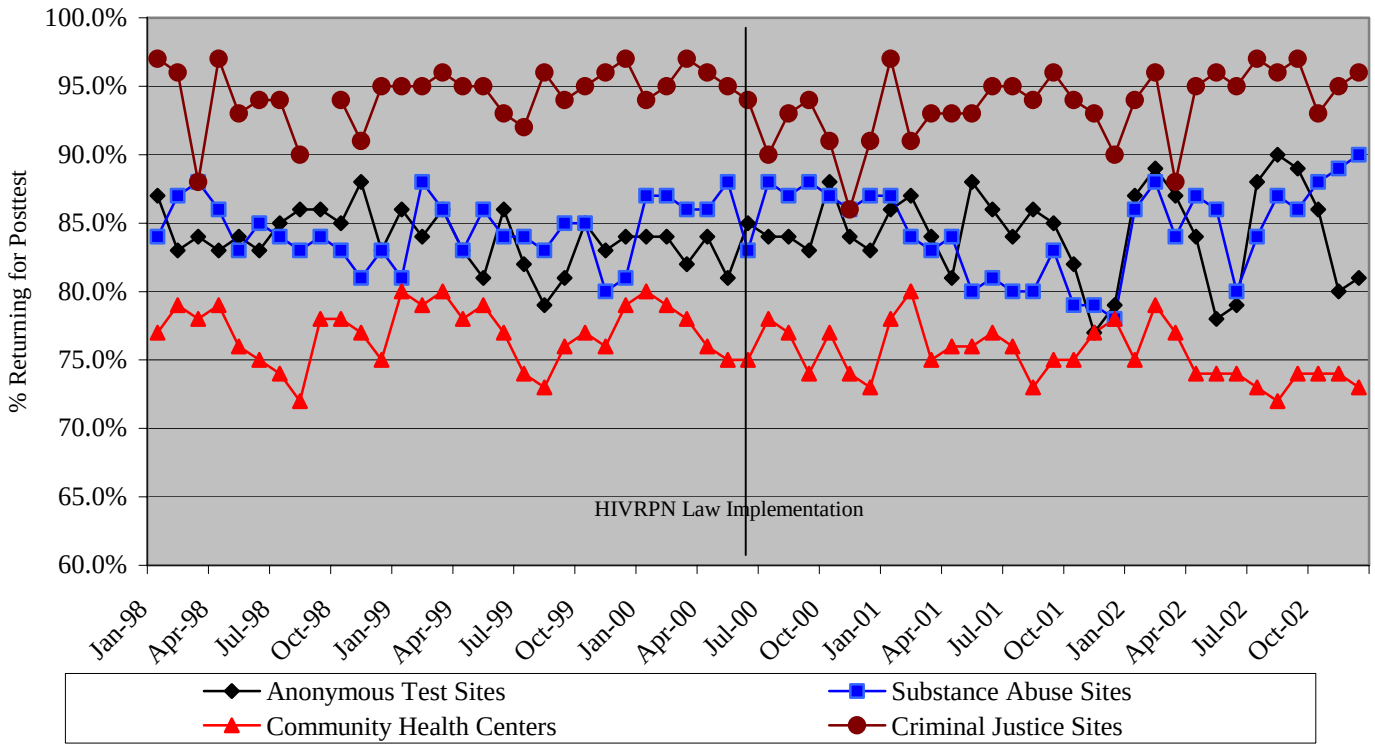


Table 2: Summary of ARIMA Time Series Models for Post-Test Counseling
NYS HIV Counseling and Testing (CTS) Data System

Testing Venue	ARIMA Model	Mean Post-tests/ Month Before HIVRPN Law	Change in Post-test/Month After Law[1]	% Change in Post-tests/Month After Law[1]
Anonymous	(0,0,0)	85%	Not Sig.	No Change
Substance Abuse Treatment	(1,0,0)	84%	Not Sig.	No Change
Community Health Center	(1,1,0)	77%	Not Sig.	No Change
Criminal Justice	(0,0,0)	94%	Not Sig.	No Change

[1] Reflects the change in post-test counseling levels after controlling for autocorrelation as specified in "ARIMA Model" column

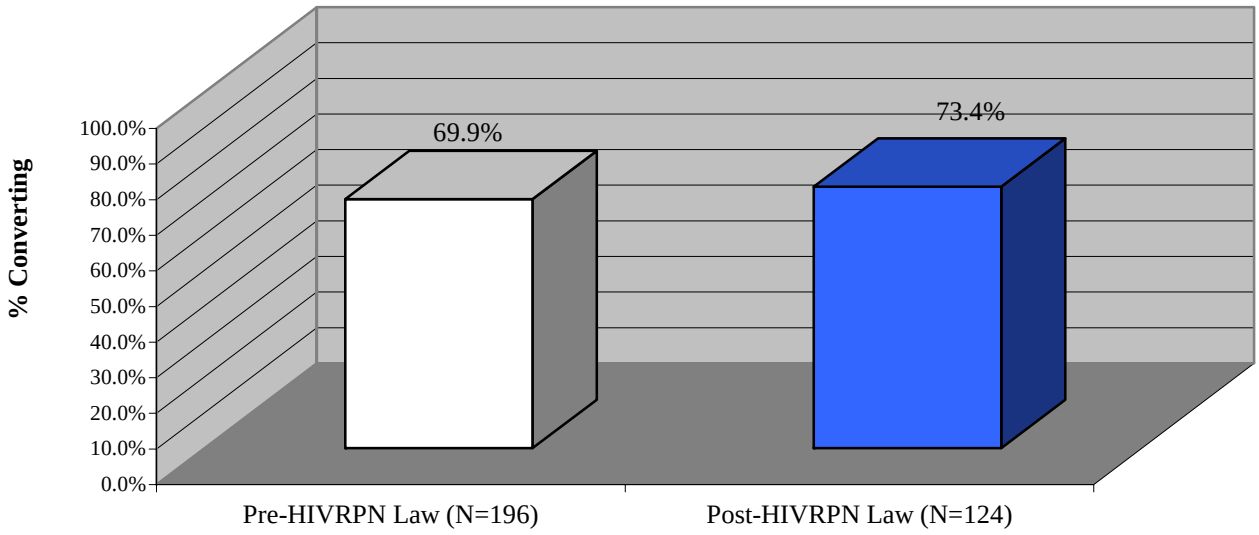
Subgroup Analyses

Separate ARIMA time series models were estimated in each of the 4 testing settings by client demographic (sex, age group, race/ethnicity) and HIV risk-related factors (injection drug use, men who have sex with men, and heterosexual). This was done for HIV testing levels and for rates of post-test counseling. The vast majority of subgroup models were not statistically significant, indicating that HIV testing levels and rates of post-test counseling did not change subsequent to the HIVRPN law. Where significant post-HIVRPN changes were found, there were no clear patterns to these changes: HIV testing levels and post-test counseling rates did not consistently increase or decrease and trends were not consistently observed in specific demographic or HIV risk-related subgroups. Because many individual subgroup models were estimated (over 100 models in total), some statistically significant results were expected based on chance alone.

Conversions from Anonymous to Confidential Status

Figure 3 displays the percentage of HIV-positive individuals converting from anonymous to confidential HIV status in anonymous counseling and testing settings. Rates of conversion were actually higher following the implementation of NYS's HIVRPN law, although the difference was not statistically significant.

Figure 3: Rates of Conversion From Anonymous to Confidential Status Among HIV Positive Individuals in Anonymous Testing Settings*

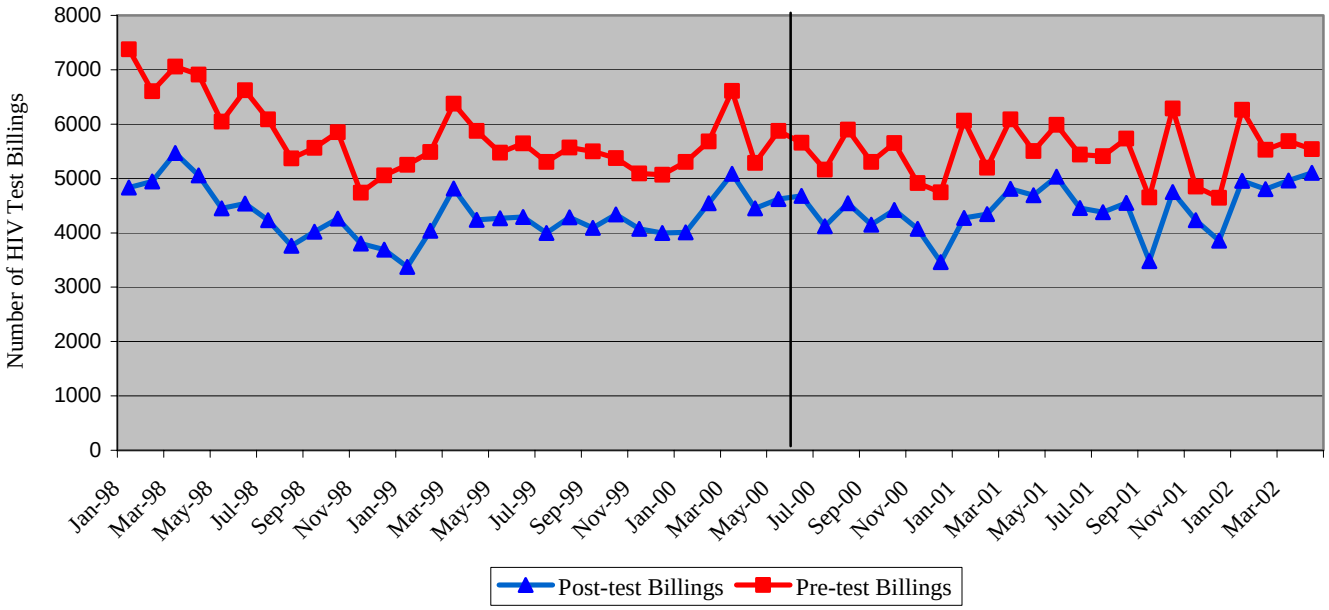


* Conversion rates based on HIV+ individuals posttest counseled. Pre-post law differences not statistically significant.

Analyses of Medicaid Data

Because CTS data were not designed to support a rigorous study of HIV testing trends (discussed below), and because publicly-funded HIV counseling and testing providers do not make up the universe of HIV testing options for New York State residents, we also examined trends in HIV pre- and post-test counseling in the NYS Medicaid Program. The same methodology was used to examine HIV pre-test and HIV post-test Medicaid billings for a similar time period to that examined with CTS data (Medicaid data were only complete through the spring of 2002 at the time these data were analyzed, however). ARIMA time series modeling of Medicaid data also failed to detect an effect from the HIV reporting legislation (results not displayed in tabular format in this report). This was true for overall levels (those displayed in Figure 4 below) and for subgroup analyses separated by gender, age group, and region of NYS. It was not possible to investigate racial/ethnic or HIV risk-related differences in HIV testing levels using Medicaid data, since risk factor data are not collected and race/ethnicity is not consistently reported in the Medicaid system.

Figure 4: Number of Medicaid HIV Pre-Test and Post-Test Billings by Month of Service



Conclusions

Results from these analyses indicate little support for an overall deterrent effect of HIV reporting and partner notification policies on testing behavior. Levels of HIV testing did not decrease in confidential testing settings and they did not increase in anonymous settings following the NYS HIVRPN law. Similarly, the rates at which people returned for their post-test counseling sessions did not change subsequent to the law. Rates of conversion from anonymous to confidential status among individuals testing HIV-positive also remained stable after the HIVRPN law. Subgroup analyses also failed to uncover any consistent patterns in testing levels or in post-test counseling return rates based on sex, age group, race/ethnicity, or HIV risk-related factors. Finally, CTS results were partially replicated using Medicaid data.

Limitations

Because CTS data were not designed to support a rigorous study of HIV testing trends, a number of inherent limitations in CTS data need to be mentioned. First, each HIV testing provider is unique and changes in policies and procedures during the course of the study period could have affected results. In order to minimize the impact of changes in counseling and testing sites over time, we included only those sites submitting data throughout the entire study period. However, other factors could not be controlled. For example, CTS data do not capture changes in staffing, funding levels, hours of operation, area-specific HIV testing media campaigns, and changes in the availability of other HIV testing options in each community.

Another limitation is that the publicly funded HIV testing data represent the number of HIV tests performed, not the unduplicated number of individuals tested (i.e., there is no way to identify repeat testers). Because this limitation is present throughout the study period, unless the propensity to repeat test interacts with other study variables, this limitation should not affect the ability to assess the impact of the HIVRPN legislation. Moreover, this limitation was not present in the Medicaid data, where duplicate testers were eliminated prior to analysis. Finally, the publicly funded HIV testing data used in this study do not represent the universe of HIV testing performed in New York State. Non-Medicaid based HIV testing through private physicians was not captured in this study.

Literature Cited

1. Box GEP, Taio G. Intervention analysis with applications to economic and environmental problems. *Journal of the American Statistical Association.* 1975;70:70.

2. Box GEP, Jenkins, GM. *Time Series Analysis: Forecasting and Control*. Holden Day. San Francisco, CA; 1975.

Component 3

Partner Notification Under New York's HIV Reporting and Partner Notification (HIVRPN) Law

Summary of Focus Groups With:
1. HIV-positive Individuals
2. HIV Service Providers
3. PartNer Assistance Program Staff

Office of Program Evaluation and Research
New York State Department of Health AIDS Institute
CDC Grant: R06/CCR218723

Background

New York State's (NYS) HIV Reporting and Partner Notification (HIVRPN) law changed the process by which HIV partner notifications are conducted in NYS. This impacts several groups of people. Most importantly, the new legislation affects: 1) those who test HIV-positive and must consider the issue of partner notification (PN); 2) those who conduct the HIV test and must offer advice on how to notify partners; and 3) those who assist clients in conducting PN. Under the new law, providers are required to report all known contacts (sexual or needle sharing partners) of a newly diagnosed individual. In addition, they are encouraged to elicit additional partners from the newly diagnosed individual. The newly diagnosed person is not required to name partners. If a partner is named, an intimate partner violence (IPV) screen is conducted to determine if notifying the partner might place the newly diagnosed patient at risk of harm. If the screen is positive for risk of severe violence, the notification is deferred. The screen is repeated upon subsequent visits to determine whether or not the risk of violence has diminished. If the screen is negative, the index patient has a variety of options for conducting the notification: 1) The patient can notify the partner(s) directly; 2) the provider (e.g., physician, test counselor, notification staff) and index patient can work together to notify the partner(s); and 3) State or local HIV partner notification staff can notify the partner(s) without participation from the patient or provider. Because HIV was being reported for the first time in NYS in June, 2000, it was expected that there would be an influx of new cases, thus increasing the workload of HIV PN assistance program staff throughout the state.

In 1999, prior to implementation of the HIVRPN law, the NYS Department of Health (NYSDOH) AIDS Institute conducted a series of focus groups to gather input from HIV/AIDS service providers and consumers regarding the HIVRPN Law. The primary objectives of the focus groups were threefold: to assess individual perceptions of how current and newly-enacted regulations would affect HIV reporting and partner notification (PN); to determine barriers to effective implementation of the law; and to discuss effective methods of communicating the new regulations to people in NYS. The focus groups identified three major concerns: 1) fear of stigma attached to being HIV-positive or having AIDS and possible discrimination and prejudice; 2) fear that the government would have private information; and 3) fear of losing confidentiality. The anxiety level was rated high in the groups and positive responses were slow to emerge. There was confusion over the concepts of confidentiality, voluntary participation and distinguishing between the issues of HIV reporting and those of PN.

As part of this grant and as a follow up to the 1999 focus groups, additional focus groups were planned with HIV-positive individuals, HIV service providers and PN assistance program staff in order to gather their input on how HIVRPN has affected the PN process. The first series of focus groups were conducted with HIV-positive individuals and HIV service providers. The groups conducted with HIV-positive individuals were designed to explore their knowledge of, experience with, and attitudes toward the HIVRPN law in the context of PN. The groups conducted with HIV service providers were designed to get at the same issues from the provider perspective. The second round of focus groups were conducted with staff from state and county Departments of Health who are responsible for assisting HIV-positive individuals in conducting partner notifications. The staff comprises NYS's PartNer Assistance Program (PNAP). The groups were conducted in order to explore how the law has impacted the jobs of PNAP staff.

Methods

Participants

HIV-Positive Individuals

Participants were selected by convenience sampling from several New York City and upstate community based agencies. Selection was conducted to ensure the following groups were represented in the sample: Men who have sex with men (MSM); African Americans; Latinos/Latinas; current or former injection drug users (IDUs); and women. Separate focus groups were conducted with each of these groups, in order to increase the comfort level of participants and the likelihood of honest, uninhibited responses. Efforts were also made to match focus groups and facilitators based on the characteristics of race, ethnicity, and gender.

Table 1 contains demographic information on the HIV-positive sample. Sixty percent of participants were male. Fifty-two percent of the sample identified themselves as straight or heterosexual, while 27% self-identified as gay or lesbian, and 20% as bisexual. The largest reported race/ethnicity category was African American/Black (42%), followed by Latino/a (30%), and Caucasian (21%). Sixty-two percent of participants had a high school education or less, and 64% of participants had monthly household incomes of $1,000 or less. Notably, while efforts were made to recruit participants who had been diagnosed with HIV after the implementation of HIVRPN, 84% percent of participants had received their first HIV-positive test result prior to the implementation of the new law in June of 2000 (data not reported in Table 1). This was due to the fact that the groups took place in the fall of 2001, just one year after the law was implemented.

Table 1. Characteristics of HIV-Positive Sample (n=45)

Variable	n*	%	Variable	n*	%
Gender			Education		
Male	17	37.8%	Less than high school	18	22.2%
Female	27	60.0%	High school or GED	18	40.0%
Transgender	1	2.2%	Some college, no degree	8	17.8%
			Associate degree or higher	9	20.0%
Sexual orientation			Monthly household income		
Straight/heterosexual	23	52.3%	Less than $1,000	27	64.3%
Gay/lesbian	12	27.3%	$1,000 - $3,999	9	21.5%
Bisexual	9	20.5%	$4,000 or More	6	14.3%
Race/ethnicity					
African American/black	18	41.9%			
Latino/a	13	30.2%			
Caucasian/white	9	20.9%			
Other race/ethnicity	3	6.9%			
* Totals for each variable may not equal 45 due to missing responses from some participants.					

HIV Provider Sample

The sample for the provider focus groups was selected using a snowball sampling method. This consisted of first locating a knowledgeable informant who was a member of the target group and asking them to identify additional participants (in this case additional HIV/AIDS service providers) who would be appropriate for the focus group (Patton, 1990). Emphasis was placed on inviting participants who had direct client contact in HIV counseling and testing situations, and who could contribute information relevant to the HIV PN regulations and their implementation. Two groups were convened, one in an upstate New York community, and one in New York City.

Table 2 displays the characteristics of the participants in the two provider focus groups. Demographic and work-related information was submitted by 14 of the 16 focus group participants. The provider groups consisted of an equal number of men and women, and included representation from each of the three major racial/ethnic groups. Just over three-quarters of the sample conducted HIV test counseling as part of their job and the remainder were supervisors or administrators. There was over-representation of Upstate (64%) versus New York City (36%) providers.

Table 2. Characteristics of Provider Sample (n=14)

Variable	n*	%	Variable	n*	%
Gender			HIV counseling		
Male	7	50.0%	Do HIV counseling**	10	76.9%
Female	7	50.0%	Do not do HIV counseling	3	23.1%
Race/ethnicity			Primary work setting		
African American/black	5	35.7%	CBO/community agency	5	41.7%
Latino/a	4	28.6%	Health department	3	25.0%
Caucasian/white	4	28.6%	Other clinic	3	25.0%
Other race/ethnicity	1	7.1%	HIV testing site	1	8.3%
Education			Primary occupation		
Some college, no degree	3	21.4%	Counselor/HIV test counselor	7	53.9%
Associate degree	1	7.1%	Administrator	3	23.1%
Bachelors degree	2	14.3%	Outreach worker	2	15.4%
Graduate degree	8	57.1%	Case manager	1	7.7%
Region					
Work in NYC	5	35.7%			
Work outside of NYC	9	64.3%			

* Totals for each variable may not equal 14 due to missing responses from some participants.
** HIV counselors reported counseling an average of 14 clients per week (n=8).

Partner Notification Assistance Program Staff Sample

PNAP staff was sampled after contacting the supervisors at each regional PNAP office and asking that they invite as many PNAP staff as possible for participation in the focus groups. Five groups were held with 27 PNAP staff from Buffalo, Rochester, Syracuse, Westchester and Long Island. There were not enough staff members in the Albany office to convene a focus group. The 27 PNAP staff interviewed comprise nearly half of the 60 PNAP staff operating across New York State. Efforts were also made to conduct groups with staff from the Contact

Notification Assistance Program (CNAP), New York City's PNAP-equivalent, but it was not possible to convene CNAP groups during the timeframe of this study.

Characteristics of the PNAP sample are included in Table 3. PNAP focus group participants were fairly evenly split among males and females, with representation from each of the three major racial/ethnic groups. Most participants (about 75%) were direct service staff and the vast majority held 4-year college degrees or higher (Table 3).

Table 3. Characteristics of New York State PNAP Staff Sample (n=27)

Variable	n*	%	Variable	n*	%
Gender			Age		
Male	13	48.1%	29-39	10	43.5%
Female	14	51.9%	40-49	8	34.8%
			50 and over	5	21.7%
Race/Ethnicity			Education		
African American/Black	11	42.3%	Some college/ associate degree	2	7.4%
Latino/a	3	11.5%	Bachelors degree	15	55.6%
Caucasian/white	12	46.2%	Graduate degree	10	37.0%
Job Description			Location of Focus Group		
NYSDOH PNAP staff	12	44.4%	Rochester	7	25.9%
County DOH PNAP staff	8	29.6%	Syracuse	7	25.9%
Supervisor of PNAP staff	4	14.8%	Westchester	5	18.5%
Other	2	11.1%	Buffalo	4	14.8%
			Long Island	4	14.8%

* Totals for each variable may not equal 27 due to missing responses from some participants.

Focus Group Procedures

Several trained facilitators, provided with a semi-standardized question format, led all focus groups (one to two facilitators per group). The focus group questions were developed by the study team in consultation with a focus group consultant. The content of the focus group questions for HIV-positive individuals and for HIV/AIDS service providers was similar, seeking to gather input on awareness of the HIVRPN law and its impact and effectiveness, with an emphasis on the PN and IPV violence components of the law. The PNAP groups focused on the perceived barriers and benefits of PN under the new law, with an emphasis on the impact of the law on the jobs of PNAP workers.

One staff member from the study team attended each group as a focus group monitor. The focus group facilitator began each group by reading a statement of informed consent and asking participants to sign if they agreed to be a part of the group. Each group had anywhere from 4 to 10 participants and lasted one to two hours. All focus group participants were asked to complete a two-page anonymous demographic survey after their focus group was completed. The groups were held at HIV service agencies that served the populations of interest (HIV-positive individuals) and in conference rooms at regional NYSDOH agency offices (for HIV/AIDS service providers and PNAP staff). The participants of each group were provided with a meal and those in the HIV-positive groups received a $25 money order. Service agencies

hosting the HIV-positive groups were compensated $300 for recruiting and hosting the focus groups.

The focus groups were audiotape recorded and professionally transcribed. Once the transcripts were cleaned and data were verified, a content analysis was conducted to identify, code and categorize the primary themes in the data. Two independent coders analyzed each focus group interview. The demographic data were analyzed using SPSS for Windows, Release 10.0 (SPSS Inc., Chicago, Illinois).

Results

Focus Groups with HIV-positive Individuals

Awareness of the Law

HIV-positive individuals had limited knowledge of the HIVRPN law, or awareness of "partner notification" as a legal concept. Individuals who did know the law tended to be those who were engaged in the health care system. Participants reported little awareness or usage of the partner notification assistance programs operated by the NYC and NYS Departments of Health, however, the few individuals who had used the programs found them to be helpful. In addition, once educated about these programs, most agreed that the idea of assisted notification was a useful one.

Perceived Efficacy of the PN Component of the Law

Initially, participants had mixed feelings about whether or not outside individuals should be involved in the notification of their partners. Once educated that assisted notification under the HIVRPN law was voluntary and existed primarily as a service available to infected individuals, most believed the PN aspect of the law to be beneficial. While most participants felt responsible to inform their partners of their possible HIV exposure, they did not consider PN when they were first diagnosed, as they were emotionally overwhelmed by the information. In addition, when discussed in more detail, it became clear that participants felt responsibility toward notifying sexual partners, but did not feel the same responsibility toward needle-sharing partners. Finally, individuals preferred to notify their current partners personally, while they liked the idea of assisted notification for notifying past partners.

Risk of Intimate Partner Violence

Participants indicated that IPV was a very real consequence of notifying partners. They described specific acts that had been committed both against them and by themselves when they were told of their own exposure risk. Even those who did not experience violence discussed how real the threat was. Importantly, participants did not feel that the HIVRPN law increased the risk of IPV. Participants reported little awareness of any formal screening mechanism regarding their risk for IPV when undergoing HIV testing or beginning PN. It is important to reiterate that the vast majority of focus group participants were initially diagnosed HIV-positive prior to implementation of the HIVRPN law.

Focus Groups with HIV Providers

Awareness of the Law

As expected, HIV/AIDS providers were well informed about the HIVRPN law in general. Somewhat surprising, however, was the finding that there was confusion over specific details of the law, most notably those addressing the issue of whether giving partner information was voluntary for the HIV-positive client.

Perceived Efficacy of the PN Component of the Law

Providers demonstrated mixed attitudes regarding the effectiveness of the law, however, most felt that their initial concern that the law would deter HIV testing was unwarranted. They did express concern that focusing on PN during post-test sessions with newly diagnosed HIV-positive individuals detracts attention from the immediate needs of the client.

Providers discussed several beneficial effects of the law. They indicated that the law highlights the need to approach partner notification together with the client, which, in turn, helps create an initial relationship between the provider and the client. Additional benefits were also cited, including increasing the likelihood that clients who have trouble notifying their partner(s) will receive help in doing so, increasing the number of partners getting tested, and increasing client and partner access to support and care systems.

Risk of Intimate Partner Violence

Under the HIVRPN law, providers are supposed to elicit partner names and then conduct an IPV screen for each partner, reporting all names and IPV screening results to the Department of Health. There was a strong consensus among providers that they always screen their clients for the risk of IPV and defer notification when indicated. However, providers noted that IPV in relation to PN is complex and they expressed the need for additional training. For example, many providers in these groups indicated that if there is an IPV risk, they do not report that partner name to the Department of Health, because they do not want to risk the safety of their client in any way (i.e., by PNAP staff inadvertently notifying these partners). This practice, if widespread, may be contributing to IPV deferrals being underreported in the HIVRPN system. At the other extreme, a minority of providers expressed a belief that partners possess a universal right to be made aware of their exposure risk, notwithstanding a positive screen for IPV. It is important to note that even these providers reported a universal application of the required IPV screening process, including deferrals when warranted.

Focus Groups with PNAP Workers

How Have Jobs Changed Since the HIVRPN?

PNAP staff indicated several ways in which their jobs had changed since the implementation of the HIVRPN law. The first had to do with the mechanism by which PNAP

staff received new cases. Implementation of the HIVRPN system initiated the era of electronic case assignments. In the past, PNAP staff received new cases via telephone from the Central Office staff in Albany. The major complaint about this change related to the speed of the electronic system, which was very slow initially. It is important to note that the speed of the system has been upgraded to allow for faster connections subsequent to these focus groups.

The second major change resulting from implementation of the HIVRPN system was that the physical office space of PNAP workers was altered in order to accommodate new issues involving the confidentiality of data. All office spaces containing computers capable of accessing the HIVRPN system had to be secured so that individuals who were not specifically trained on the system could not access it. For some (those who already had private, lockable offices), this meant minor changes, but for others this involved more significant changes, including the complete reconstruction of their office space.

The third major change to job tasks, and the one most frequently questioned, was the new requirement that PNAP staff contact the diagnosing medical provider before proceeding with the PN process. In the past, contact with the diagnosing physician prior to contact with the newly diagnosed individual was engaged in on an "as needed" basis. Under the new system PNAP staff must attempt to verify all information with the medical provider and get the provider's permission to proceed with the elicitation of his/her patient (PNAP staff may ultimately proceed in the absence of provider approval, but only after attempts at approval are made). PNAP staff felt this new requirement slowed down the notification process and was inconsistent with their procedures for conducting PN for other sexually transmitted diseases.

Barriers to PN under HIVRPN

PNAP staff identified barriers to efficient partner notification under the HIVRPN law. One barrier reported by staff was that many of the electronic reports generated to date had insufficient locating information, requiring PNAP staff to spend additional time tracking down the information from the labs or provider offices before locating the partner. PNAP staff disagreed with imposing differential procedures for HIV-related PN. With other STDs, staff typically receive the assignment within a week of the diagnosis and can proceed directly with the notification without contacting the medical provider. With HIV, it can take up to three months to receive the assignment[1] and the provider must be contacted before the notification is initiated. Staff reported that providers were not always well educated about the law and, as a result, were often hesitant to provide them with the information necessary to proceed with the notification. Although this contact can be a good time to educate providers about the specifics of the law, PNAP staff felt strongly that differences between HIV PN and PN for other STDs make locating and notifying partners of HIV-positive individuals more difficult and also increases the potential window of disease transmission.

Benefits to PN Under the HIVRPN

[1] Since the time of the focus groups, efforts have been made to decrease the length of time between diagnosis and case assignment.

In addition to barriers, staff acknowledged benefits to the way in which partner notification is conducted under the HIVRPN law. PNAP staff acknowledged that the law as implemented ensures more confidentiality than the previous system. While some staff indicated that this was a barrier to effective notification, most agreed that the additional safeguards were important. Staff members also felt that the law increased the potential for use of PNAP. Because the law and its implementation specifically address PN, it provides tremendous opportunities to educate medical providers and the broader community about PNAP. As a result, PNAP staff felt the law had the potential to greatly increase utilization of their program.

Suggestions for Improvements to the HIVRPN System

PNAP staff were asked to make suggestions to improve the partner notification system. The overwhelming response from frontline staff was that they wanted more extensive involvement in the decision making process regarding future changes to the system. Although frontline staff input was sought when the system was being developed, staff did not believe that they contributed substantively to the process. Staff also expressed a desire to network with other PNAP (and NYC CNAP) staff throughout the state in order to share best practices. Participants indicated that the PNAP program could benefit from more extensive promotion to medical providers and to its targeted populations. Staff felt that there was relatively low awareness of their services and that they could be more effectively utilized if more individuals and providers were educated about PNAP. Finally, staff indicated that they would like additional training opportunities for PNAP staff on topics such as: evaluation of the safety of a notification site (to avoid violence); self-defense; helping notified individuals (in general) cope with news of HIV exposure or diagnosis; and dealing with mentally ill clients.

Discussion

Each targeted focus group population confirmed that there is little awareness in the general community about the HIVRPN law or about formal partner notification assistance programs. Those who did have experience with the programs found them to be useful. Broader promotion of available PN services was recommended.

The results from the HIV-positive and HIV service provider groups suggest that ongoing contact between health care providers and HIV-positive clients on issues relating to partner notification is necessary. This may allow the client a chance to absorb the meaning of their new diagnosis before tackling the issue of notifying all current and past partners. The importance of notifying past partners should be emphasized in post-test counseling and follow-up sessions as clients indicated a tendency to focus primarily on the notification of current partners. In addition, efforts should be made to notify needle-sharing partners as well as sexual partners.

The needs of providers should be monitored on an ongoing basis in order to develop and maintain effective training and support programs. Specific efforts should be made to provide additional training on how to handle cases involving IPV risk. Finally, continued efforts need to be made to inform consumers about the HIVRPN law and in particular, partner notification assistance programs.

While PNAP staff had several complaints about the effect of HIVRPN on their jobs, they did acknowledge that it is a new system and with time, most of these kinks will likely be worked out. Generally speaking, they were supportive of the idea of including PN in the HIV reporting legislation and felt very positively about the work that they do. However, substantive involvement of frontline staff in future modifications to the system and its procedures would likely increase acceptance of the system among PNAP staff.

References

Patton MQ. *Qualitative Evaluation and Research Methods* (2nd Ed). Sage Publications: Thousand Oaks, CA; 1990.

Component 4

HIV Testing Attitudes and Practices Survey (H-TAPS)

General Findings Report

Office of Program Evaluation and Research
NYS Department of Health AIDS Institute
CDC Grant: R06/CCR218723

Overview

The HIV Testing Attitudes and Practices Survey (H-TAPS) is a follow-up to the Centers for Disease Control and Prevention's HIV Testing Survey (HITS). As with the HITS survey, H-TAPS assesses respondents' demographic characteristics, HIV testing experiences, knowledge of HIV testing policies and testing methods, sexual behavior, drug use histories, and HIV prevention practices. Additional questions were included in the H-TAPS survey instrument to assess participants' knowledge and attitudes towards, and experiences with, New York State's (NYS) HIV Reporting and Partner Notification (HIVRPN) legislation, enacted in June 2000. This report presents primary findings from H-TAPS, and also includes an analysis of trends occurring between the baseline implementation of HITS and the post-law implementation of H-TAPS.

Methods

Description of the venues and participant recruitment

The H-TAPS survey was administered in four Upstate NY cities: Buffalo (2001-2002), Rochester (2002-2003) and Syracuse and Albany (2003-2004). In Buffalo and Rochester, enrollment occurred in three venues: injection drug users in syringe exchange programs (SEP), high-risk heterosexuals in sexually transmitted disease clinics (STD), and men who have sex with men (MSM) in gay bars. The target sample size for the syringe exchange programs and STD clinics in Buffalo and Rochester was 100. The target sample size in the bars was 100 in Rochester and 140 in Buffalo (due to a purposive over sampling of MSM of color). As with the HITS, venues were chosen based on the belief that these locations attract individuals at high risk for acquiring HIV.

Because the STD clinics in Syracuse and Albany had limited hours of operation, and because there were no SEPs in these cities, H-TAPS was administered exclusively to MSM in Syracuse and Albany. The targeted sample size was 100 bar-based interviews in each city, although less than 50 interviews were actually completed in the Albany bar-based venue. Alternative sampling venues were also explored in Albany and Syracuse. Interviews were conducted with MSM frequenting: a bathhouse in Albany (n=49); a gay, lesbian, bisexual and transgender community center in Albany (n=39); a non-alcoholic café in Syracuse (n=16); and two highway rest stops near Syracuse (n=11). In order to maintain methodological comparability with the baseline HITS data, these 115 cases are not included in the analyses utilized in this report. The alternative venue cases will be the subject of a future venue-specific report.

Individuals were eligible to be interviewed if they were at least 18 years of age and resided in New York State. Target populations by venue were as follows:

1) Bars, bathhouse, community center, and café, rest stops;
2) Syringe Exchange Programs (SEPs); and
3) STD clinics: Additional eligibility criteria included: Individuals who were attending the clinic for a new, suspected STD and who had not been at the clinic within the past 90 days.

Individuals were given a $20 money order as an incentive for participation, regardless of whether or not their responses were ultimately deemed eligible for inclusion.

Description of the survey instrument

This survey was anonymous and administered as a face-to-face interview. Interviews were conducted in Spanish and English in the SEPs and in English in the other locations. The survey instrument was divided into 8 sections: Sociodemographics; HIV testing experiences; knowledge of HIV testing policies; knowledge of and attitudes towards HIV testing methods; perceptions of HIV and partner notification (PN); sexual behavior; partner relations (i.e. intimate partner violence (IPV)); and drug use history. Additional detail for each section is provided below, when section-specific results are presented.

Data entry and analysis

Survey data were entered into SPSS Data Entry, version 3.03 (SPSS Inc., Chicago, Illinois) and analyzed using SPSS for Windows, version 11.01 (SPSS Inc., Chicago, Illinois). Pearson's χ^2 and Fisher's exact tests were used for comparison of categorical variables. Analyses of variance were conducted to compare the means of continuous variables between different strata. All tests of significance were two-sided and assessed against an alpha level of 0.05.

Contents of this Report

This report presents general findings from H-TAPS. Most sections of this report present survey responses by sampling venue only. As noted below, there are large demographic differences in survey respondents by sampling venue (i.e, Hispanics are overrepresented among SEP participants, there are no females in the bar sample, etc.). As a result, sub-group differences in study outcomes, while occasionally important to note, are difficult to assign meaning to at the bivariate level. In-depth investigations into demographic, risk-related, and attitudinal variations in survey responses are ongoing, and will be the subject of separate publications.

Results

I. Description of Sample

Table 1 presents basic information regarding the H-TAPS sample. The total sample is comprised of 761 respondents, including 362 participants interviewed in gay bars, 198 interviewed in STD clinics, and 201 interviewed in SEPs. As noted above, this report excludes 115 MSMs sampled in alternative venues. There were similar numbers of respondents interviewed in each venue in Buffalo and Rochester, with Syracuse and Albany contributing to the bar sample only. As expected, the majority of H-TAPS survey respondents were male (79.5%), although the STD clinic venue, consistent with sampling protocol, drew approximately equal numbers of male and female respondents. Race/ethnicity also varied greatly by venue, with African American (52.8%) and Hispanic (46.6%) respondents comprising large percentages of the total STD clinic and SEP samples, respectively. Finally, Table 1 reveals that the SEP sample was older and had a higher proportion of minority participants than the gay bar and STD clinic samples. Participants ranged in age from 18 to 67 years for gay bar participants (mean=32.4), 18 to 64 for STD clinic participants (mean=29.5) and 18 to 76 for SEP participants (mean=40.4).

Table 1: Basic Description of the Sample

	Total (n=761)		Gay bar (n=362)		STD clinic (n=198)		SEP (n=201)	
	n	%	n	%	n	%	n	%
City								
Buffalo	337	44.3%	138	38.1%	99	50.0%	100	49.8%
Rochester	292	38.4%	92	25.4%	99	50.0%	101	50.2%
Albany	45	5.9%	45	12.4%	0		0	
Syracuse	87	11.4%	87	24.0%	0		0	
Gender								
Male	605	79.5%	357	98.6%	101	51.0%	147	73.1%
Female	150	19.7%	0	.0%	97	49.0%	53	26.4%
Transgender	6	0.8%	5	1.4%	0	.0%	1	0.5%
Race/Ethnicity								
Hispanic	150	20.5%	37	10.8%	23	11.8%	90	46.6%
Non-Hispanic white	241	33.0%	151	44.2%	47	24.1%	43	22.3%
Non-Hispanic black	253	34.7%	98	28.7%	103	52.8%	52	26.9%
Non-Hispanic other	86	11.8%	56	16.4%	22	11.3%	8	4.1%
	Mean	**Range**	**Mean**	**Range**	**Mean**	**Mean**	**Range**	**Range**
Age	33.7	18-76	32.4	18-67	29.5	18-64	40.4	18-76

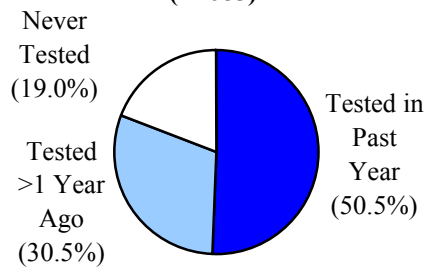
II. HIV Testing Experiences

The HIV testing experiences section assessed whether or not respondents had ever HIV tested, their reasons for HIV testing, their experiences during their last HIV test, and their reasons for delaying or avoiding testing.

HIV Testing History

The vast majority of participants reported testing for HIV at some time in the past (81%), with 51% of the total sample reporting testing during the past 12 months (Figure 1).

Figure 1: HIV Testing History (n=685)*



*Excludes HIV-positive participants

Table 2 clearly indicates that the SEP sample was the most experienced with HIV testing, with nearly three-quarters of respondents reporting testing within the past 12 months, and just 4.1% reporting that they had never tested for HIV. The STD clinic sample was the least experienced, with 26.8% reporting no previous HIV testing experience. There were no differences in HIV testing history by sex, however, differences by city, race/ethnicity, and age group were found. Rochester survey respondents were more likely to report testing in the past year (61.1%) compared to those interviewed in Buffalo (45.0%), Albany (37.8%) and Syracuse (39.4%). Hispanics, who were overrepresented in the SEP sample, were the most tested group, with nearly 70% reporting HIV testing in the past year. Not surprisingly, there was an inverse relationship between age and HIV testing experience, with respondents aged 18-24 years being most likely to have never tested for HIV (36.4%) (Table 2).

Table 2: HIV Testing History by Venue and Client-Specific Characteristics*

	HIV Testing History			
	Tested in Past Year	**Tested > 1 Year Ago**	**Never Tested for HIV**	**Pearson X^2 p-value**
Total Sample (n=685)	50.5%	30.5%	19.0%	NA
Venue				<0.01
Gay Bar (n=320)	47.2%	30.6%	22.2%	
STD Clinic (n=194)	37.1%	36.1%	26.8%	
SEP (n=171)	71.9%	24.0%	4.1%	
City				<0.01
Buffalo (n=302)	45.0%	35.8%	19.2%	
Rochester (n=275)	61.1%	24.7%	14.2%	
Albany (n=37)	37.8%	37.8%	24.3%	
Syracuse (n=71)	39.4%	26.8%	33.8%	
Sex				Not Significant
Male (n=542)	48.7%	31.2%	20.1%	
Female (n=138)	56.5%	28.3%	15.2%	
Race/Ethnicity				<0.01
Non-Hispanic white (n=227)	44.1%	30.8%	25.1%	
Non-Hispanic black (n=215)	47.4%	39.1%	13.5%	
Hispanic (n=133)	65.4%	23.3%	11.3%	
Non-Hispanic other (n=82)	53.7%	22.0%	24.4%	
Age Group				<0.01
18-24 (n=165)	35.2%	28.5%	36.4%	
25-34 (n=243)	59.3%	28.8%	11.9%	
35-44 (n=169)	51.5%	34.3%	14.2%	
45+ (n=106)	51.9%	32.1%	16.0%	

* Excludes 72 HIV-positive respondents. Numbers within subgroups may not add to total cases due to missing data.

Reasons for HIV Testing

Table 3 classifies the top reasons for HIV testing provided by respondents, overall, and by venue. The percentage of respondents indicating each reason for HIV testing is provided, as is the percentage that indicated each reason as being the *most important* reason for testing. Overall, respondents reported HIV testing because they "wanted to know where they stood", chosen by 85.9% of respondents as a reason for testing and by 39.4% as the most important reason. More concrete reasons for HIV testing were also given, including the desire to get medical care if HIV-positive (61.9%), and the concern that exposure to HIV may have occurred through sex (57.4%) or drug use (32.2%).

Reasons for HIV testing differed significantly by venue, with substantive differences anticipated given the characteristics of persons interviewed at each venue. For example, gay bar respondents were more likely test due to concern about sexual exposure to HIV (65.2%) or because they knew someone who had HIV or had died from AIDS (44.8%). Similarly, STD clinic respondents were more likely to have tested as part of an STD or medical checkup (65.5%), and SEP participants were more likely to test due to concern about contracting HIV through drug use (83.2%) (Table 3).

Table 3: Reasons for HIV Testing by Venue*

Reason and Most Important Reason for HIV Testing		Total Sample (n≈627)	Venue**		
			Gay Bar (n≈289)	STD Clinic (n≈144)	SEP (n≈194)
Wanted to know where you stood	A Reason:	85.9%	82.7%	96.5%	82.7%
	Most Imp. Reason:	39.4%	33.2%	41.0%	47.2%
Wanted to get medical care if you had HIV	A Reason:	61.9%	49.3%	81.9%	65.8%
	Most Imp. Reason:	3.6%	2.2%	4.9%	4.7%
Might have been exposed to HIV through sex	A Reason:	57.4%	65.2%	58.5%	45.1%
	Most Imp. Reason:	16.8%	23.1%	15.3%	8.8%
Knew someone (including partner) HIV-positive or died from HIV/AIDS	A Reason:	34.8%	44.8%	26.8%	25.9%
	Most Imp. Reason:	8.8%	16.2%	4.9%	1.0%
Might have been exposed to HIV through drug use	A Reason:	32.2%	5.9%	16.8%	83.2%
	Most Imp. Reason:	10.1%	2.2%	4.2%	25.9%
Part of a STD or routine medical check-up	A Reason:	34.0%	27.6%	65.5%	20.1%
	Most Imp. Reason:	3.1%	4.0%	3.5%	1.6%

* Includes only participants who had ever HIV tested and got the results.
** Differences by venue significant at $p<0.05$ for each reason, and at $p<0.05$ for Most Important reason.

Experiences During Last HIV Test

Participants who had HIV tested were asked if their last test was anonymous or confidential. They were also asked if someone had discussed whether or not their name would be reported to the State Health Department if they tested HIV-positive. Although this was an appropriate topic of discussion even prior to the HIVRPN, this should have been incorporated into HIV pre-test counseling sessions following implementation of the law.

Results presented in Table 4 indicate that discussions of HIV name-based reporting increased subsequent to the law, for those tested in both anonymous and confidential settings. Overall, 60.3% of respondents testing anonymously after the HIVRPN law indicated that their HIV counselor had discussed whether or not their name would be reported to the State Health Department if they tested HIV-positive. This was substantially higher than the rate reported by respondents who tested anonymously prior to the law (34.6%). A similar overall trend was observed among those last testing confidentially: Fifty-nine percent reported a discussion of name-based reporting subsequent to the law, compared to just 26.7% prior to the law. Table 4 further details that the most dramatic increases were observed in the gay bar and SEP venues, while the smallest gains were reported among STD clinic respondents.

A less obvious finding from Table 4 is that the percentage of respondents who reported that their last HIV test was anonymous prior to the HIVRPN law (26/101=25.7%) was very similar to the percentage testing anonymously after the law (121/379=31.9%). This difference was not statistically significant. If name-based reporting was negatively impacting a persons' HIV testing decisions, then we would expect either a decrease in HIV testing subsequent to the law, or at least a move towards higher rates of anonymous HIV testing. The results from Table 4 provide no support for the latter of these hypotheses.

Table 4: Discussion of HIV Named Reporting During HIV Testing

How and When Last Tested	Venue						Total	
	Gay bar		STD clinic		SEP			
	# Tested	% Discussing HIVRPN*	# Tested	% Discussing HIVRPN*	# Tested	% Discussing HIVRPN*	# Tested	% Discussing HIVRPN*
Anonymous Before Law	10	10.0%	2	100%	14	42.9%	26	34.6%
Anonymous After Law	43	44.2%	16	56.3%	62	72.6%	121	60.3%
Confidential Before Law	30	33.0%	32	21.9%	13	23.1%	75	26.7%
Confidential After Law	125	69.6%	75	40.0%	58	60.3%	258	58.9%

* "% Discussing HIVPRN" refers to the percentage of respondents who indicated that someone had discussed whether or not their name would be reported to the State Health Department during their last HIV test. Excludes HIV-positive respondents. "Before -After" law differences statistically significant ($p<0.05$) for both anonymous and confidential testers overall. "Before-After" law differences statistically significant ($p<0.05$) for confidential testers in the gay bar and SEP samples.

Reasons for Delaying or Avoiding HIV Testing

Survey respondents who reported never testing for HIV were asked about their reasons for avoiding testing. Likewise, respondents with prior HIV testing histories were asked whether or not they had ever delayed HIV testing, and, if so, their reason(s) for delay. Figure 2 indicates that nearly a third of the sample (30.3%) reported HIV testing without delay, while about one-half of the sample (50.6%) reported delaying their decision to HIV test. As reported above, 19.1% of the sample had never tested for HIV.

With few exceptions, the reasons given for avoiding HIV testing were not significantly different from those given for delaying testing, thus responses were grouped together and reported in Table 5. Table 5 classifies the top reasons for avoiding or delaying HIV testing, overall, and by venue. The percentage of respondents who indicated each reason for not HIV testing is provided, as is the percentage that indicated each reason as being the most important reason for avoiding or delaying testing.

Figure 2: HIV Testing History (n=686)

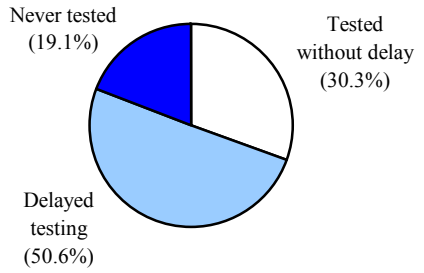


Table 5: Reasons Avoiding or Delaying HIV Testing by Venue*

Reason and Most Important Reason for Avoiding or Delaying HIV Testing		Total Sample (n≈476)	Venue**		
			Gay Bar (n≈229)	STD Clinic (n≈158)	SEP (n≈89)
It was unlikely you were HIV-positive	A Reason:	46.4%	43.7%	55.7%	37.1%
	Most Imp. Reason:	35.8%	34.2%	36.8%	38.2%
Fear of finding out you were HIV-positive	A Reason:	29.0%	26.5%	33.3%	27.3%
	Most Imp. Reason:	18.8%	16.0%	19.4%	25.0%
Did not want to think about your own serious illness or death	A Reason:	28.6%	30.7%	30.8%	19.3%
	Most Imp. Reason:	8.5%	12.3%	6.9%	1.5%
Waiting for the test results would be too stressful	A Reason:	21.8%	19.7%	25.8%	20.2%
	Most Imp. Reason:	6.8%	5.3%	7.6%	8.8%
Did not have time	A Reason:	20.8%	24.1%	20.8%	12.4%
	Most Imp. Reason:	10.3%	10.2%	11.8%	7.4%
Concern about name reported to the government if tested positive	A Reason:	5.1%	4.0%	5.0%	7.9%
	Most Imp. Reason:	0.3%	0.0%	0.0%	1.5%

* Includes HIV-negative participants who had delayed/avoided HIV testing. ** Differences by venue significant for "A Reason" at $p<0.05$ for "It was unlikely you were HIV-positive" only. Differences by venue not significant for "Most Important Reason" at $p<0.05$.

The most common reasons participants identified for delaying or avoiding testing in general were because: 1) It was unlikely they were HIV-positive (46.4%), 2) they were afraid of finding out they were HIV-positive (29.0%), and 3) they did not want to think about their own serious illness or death (28.6%). When asked to pinpoint their most important reason for testing delay or avoidance, these first two reasons accounted for 54.6% of all responses (Table 5). The advent of rapid HIV testing technologies directly addresses the fourth most common reason for avoiding or delaying testing: The stress of waiting to receive HIV test results. This was given as a reason for avoiding or delaying testing by 21.8% of the sample, with 6.8% identifying this as their most important reason for testing delay/avoidance. It is important to note that just 5.1% of all respondents cited concern about their name being reported to the government as a reason for avoiding or delaying HIV testing, with just one person (0.3%) citing this as the most important reason. Reasons for delaying or avoiding did not vary significantly by venue, however, the general patterns noted above held true within each testing venue (Table 5).

III. Knowledge of HIV Testing Policies

Tables 6 and 7 present the results from questions assessing awareness of name-based HIV reporting in NYS, including requirements concerning the need to name partners and the availability of anonymous testing options. Most respondents were not aware of NYS's HIV reporting and partner notification regulations. In fact, while 47.5% of participants were aware that HIV results are reportable in some manner (data not shown), less than one in five respondents (17.7%) knew that positive test results are reported by name. The STD clinic sample was the least knowledgeable about named reporting, while the gay bar sample was the most knowledgeable. Although a larger percentage of those last tested after the law knew about name-based reporting (20.3% versus 17.7%), these differences were not statistically significant. Interestingly, while nearly 60% of those HIV testing after the law reported that named reporting was discussed during their last HIV test (see Table 4), only 23.9% of these respondents were able to correctly identify NYS's name-based HIV reporting policy (data not shown).

The majority of survey participants (70.4%) were aware that anonymous HIV testing is available in NYS. Awareness varied by venue and testing status, with SEP respondents most aware (77.1%) and individuals who had never tested for HIV least aware (43.5%) (Table 6).

Table 6: Knowledge of Named HIV Reporting and the Availability of Anonymous HIV Tests in NYS

	Know that HIV is reportable by name in NYS*			Know that anonymous HIV testing is available in NYS		
	n	%	p-value	n	%	p-value
Total Sample	413	17.7%	NA	751	70.4%	NA
Venue						
Gay Bar	217	24.9%	<0.01	358	69.3%	<0.05
STD Clinic	98	9.2%		192	65.5%	
SEP	98	10.2%		201	77.1%	
HIV testing history**						
Tested after the law	257	20.2%	Not significant	431	75.4%	<0.01
Tested before the law	62	17.7%		155	80.0%	
Never tested for HIV	71	8.5%		131	43.5%	

*Buffalo excluded due to differential question wording in Buffalo. ** Excludes 25 individuals without an exact HIV test date. Numbers within subgroups may not add to total cases due to missing data.

Participants' knowledge about NYS's PN policy, including the voluntary nature of naming sexual and needle sharing partners, the availability of PN assistance programs and the confidentiality of PN, was greater than their knowledge of named HIV reporting. Table 7 reveals that 50.6% of the sample knew that individuals testing HIV-positive are not required by law to name their partners, 54.2% knew that PN assistance programs are available in NYS, and 65.6% knew that the names of HIV-positive persons are not disclosed during the notification process.

Differences existed by venue and testing history for one of the three knowledge areas. Where differences existed by venue, persons interviewed in gay bars were most knowledgeable, while STD clinic respondents were least knowledgeable. Although not reaching the level of statistical significance, those who tested after the law went into effect (47.6%) were less likely to know that naming partners is voluntary compared to those tested prior to the law (59.2%), perhaps indicating that discussion of named reporting and PN processes during pre- and post-test counseling is confusing to some clients. However, those who had ever been HIV tested (regardless of whether it was before or after the law) were more likely to be aware of PN assistance programs than those who had never tested, suggesting that this message is being conveyed in test counseling sessions (Table 7).

Table 7: Knowledge of Partner Notification Regulations and Assistance Programs in New York State

	Know that naming partners is not required for people who test HIV-positive			Know that partner notification assistance programs are available			Know that health workers who conduct PN never tell partners who exposed them to HIV		
	n	%	p-value	n	%	p-value	n	%	p-value
Total Sample	656	50.6%	NA	746	54.2%	NA	672	65.6%	NA
Venue									
Gay Bar	297	53.9%		355	63.4%	<0.01	302	64.2%	Not significant
STD Clinic	176	45.5%	Not	191	39.8%		184	72.3%	
SEP	183	50.3%	significant	200	51.5%		186	61.3%	
HIV testing history*									
Tested after the law	395	47.6%	Not	431	59.9%	<0.01	403	66.7%	Not significant
Tested before the law	125	59.2%	significant	153	58.2%		126	71.4%	
Never tested for HIV	108	52.8%		128	32.0%		112	58.0%	

* Excludes 28 individuals for whom an exact HIV test date was not available. Numbers within subgroups may not add to total cases due to missing data.

IV. Attitudes and Perceptions

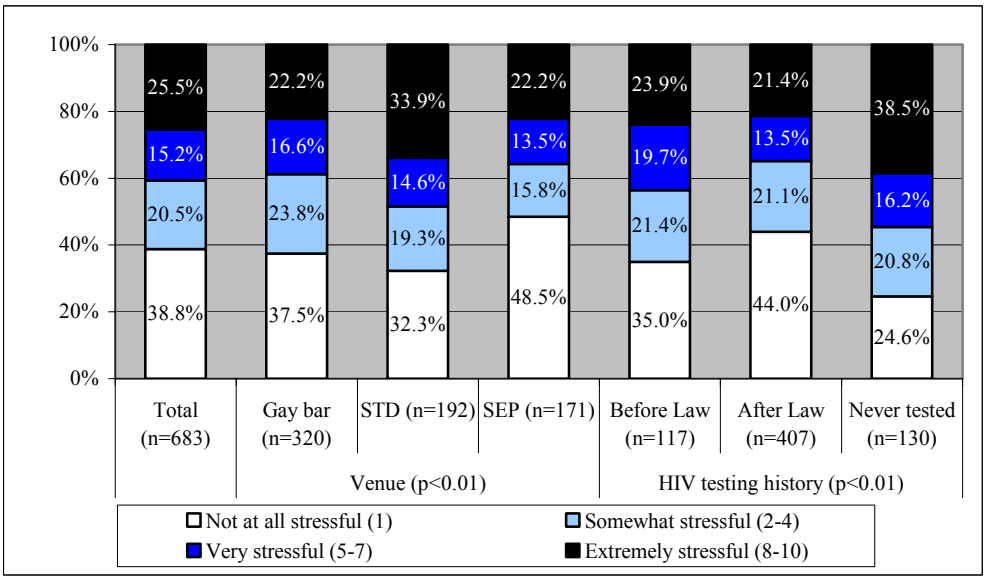
H-TAPS respondents were asked about the stressfulness of HIV testing, about their attitudes concerning HIV partner notification, and about the likely reactions of their partners should they test HIV-positive.

Stress of HIV Testing

Participants who were HIV-negative or of unknown HIV status were asked how stressful getting an HIV test would be for them (on a scale ranging from 1, not at all stressful, to 10, the most stressful thing imaginable). Results are summarized in Figure 3. Although more than one-

third of participants (38.8%) felt that HIV testing was not at all stressful, 40.7% felt that it was either very stressful (15.2%) or extremely stressful (25.5%). SEP participants were the least stressed by HIV testing while STD clinic participants indicated the greatest amount of stress. HIV testing history was also related to the perceived stress of testing, with those never testing expressing the greatest amount of perceived stress and those testing most recently (since the law) expressing the least amount of perceived stress (Figure 3).

Figure 3: Perceived Stress Associated with HIV Testing*



* Excludes HIV-positive individuals.

Attitudes Toward Partner Notification

Participants were asked nine questions to assess their attitudes toward PN and toward PN assistance programs. Original response categories ranged from strongly agree to strongly disagree on a four-point scale, but were collapsed into two categories (agree/strongly agree and disagree/strongly disagree) for presentation purposes. Results are portrayed in Table 8. In addition, respondents were asked a general statement about the benefit of PN assistance programs, the results of which are displayed by venue in Table 8A.

Although the majority of participants felt that PN helps reduce the spread of HIV (88.9%), that PN assistance programs make it easier to notify partners (89.6%), that assisted notification is safer than notifying partners directly (68.5%) and that assistance programs do more good than harm (73.2%), participants exhibited concerns about both PN and PN assistance programs. For example, over one-half the sample felt that PN puts the HIV-positive person at risk for physical harm from their partner (52.9%), that PN assistance programs are too impersonal (56.9%), and that partners notified by assistance programs can figure out who named them (54.6%). In addition, a sizeable minority of respondents felt that PN is an invasion of privacy to the HIV-positive person (44.7%) and that being notified by PN assistance programs violates the privacy of the person being notified (36.3%).

Responses to all nine statements concerning PN and PN assistance programs varied by venue. STD clinic and SEP participants were more likely to agree that PN is necessary and that it reduces the spread of HIV than were gay bar participants. STD clinic participants exhibited the most concern about IPV resulting from PN but were the least concerned that PN violates privacy. Although the majority of gay bar participants felt that assistance programs make PN easier, they were less supportive of assisted notification than STD clinic and SEP participants. Notably, only half of gay bar participants agreed that assistance programs do more good than harm, while about 90% of the other participants endorsed this statement (Table 8A).

Additional data analyses (not shown in Table 8 or 8A) revealed that some attitudes differed by previous experience with PN assistance programs. Respondents who had previously been contacted by a health worker and notified of their exposure to an STD or HIV (n=57) were *less* likely to believe that PN reduces the spread of HIV (71.9% compared to 90.6%, $p<0.01$), that assisted notification is safer (56.1% vs. 69.4%, $p<0.05$), that HIV-positive people need to notify partners of their exposure (82.5% vs. 95.2%, $p<0.01$) and that assistance programs do more good than harm (60.7% compared to 74.7%, $p<0.10$).

Table 8: Percentage of Participants Who Agree with Statements about PN and PNAP

	Total (n≈750)	Venue*		
		Gay bar (n≈355)	STD clinic (n≈193)	SEP (n≈201)
Attitudes towards PN				
HIV-positive people need to notify partners of their exposure	93.9%	89.4%	97.9%	98.0%
PN helps reduce the spread of HIV by encouraging safer sex	88.9%	81.6%	94.8%	96.5%
PN puts HIV-positive person at risk for physical harm from partner	52.9%	50.8%	66.8%	43.3%
Attitudes towards assisted notification				
PN assistance programs make it easier for HIV-positive person to notify partners	89.6%	81.3%	97.4%	97.0%
PN assistance programs are safer than direct notification	68.5%	63.5%	81.3%	65.2%
PN assistance programs are too impersonal	56.9%	51.1%	49.7%	74.1%
Partners notified by PN assistance programs can figure out who named them	54.6%	49.4%	69.1%	49.8%
Providing partner names invades privacy of HIVpositive person	44.7%	46.5%	35.9%	49.8%
Being notified by PN assistance programs is an invasion of privacy	36.3%	38.7%	21.6%	46.0%
* Differences by venue significant at $p<0.05$ for each statement				

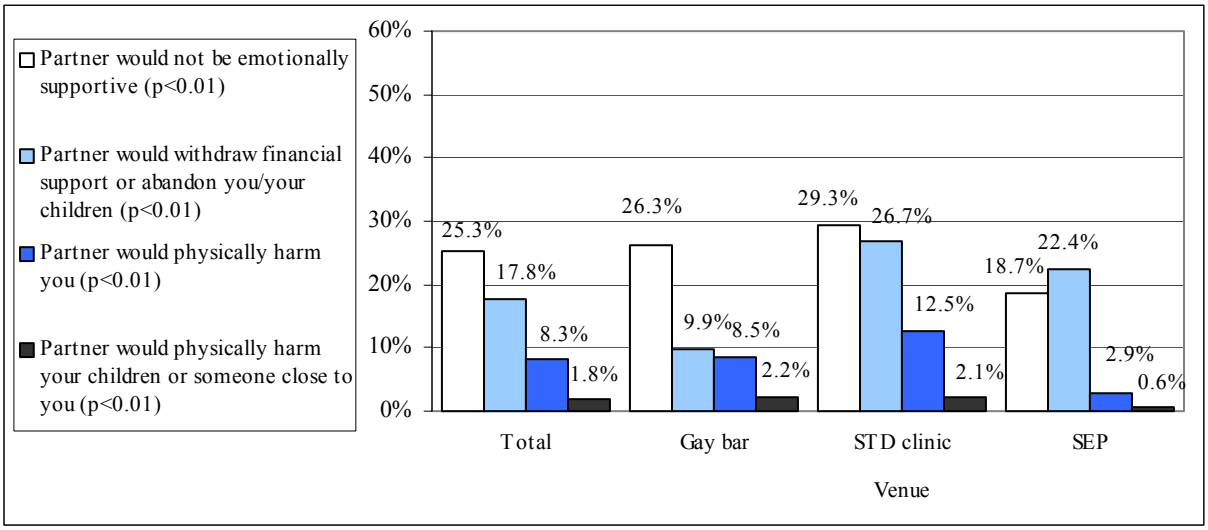
Table 8a: Overall Assessment of the Benefits of Assisted Notification Programs

		Venue*		
	Total (n=749)	**Gay bar (n=357)**	**STD clinic (n=192)**	**SEP (n=200)**
PN assistance programs:				
Do more good than harm	73.2%	53.8%	89.6%	92.0%
Do more harm than good	4.3%	5.9%	3.1%	2.5%
Have no impact/Don't Know	22.6%	40.3%	7.3%	5.5%
* Venue differences significant at p<0.05				

Perceptions of Partner Responses Resulting from HIV Disclosure

Participants who were HIV-negative or of unknown HIV status were asked about the likelihood of a variety of negative reactions from their partner if they were to test positive for HIV. Figure 4 presents a summary of the responses to these questions. Overall, lack of emotional support from partners was the most commonly anticipated reaction, selected by 25.3% of the sample. Eighteen percent of the sample believed that their partner would withdraw financial support and/or abandon them. Physical abuse to the respondent (8.3%) or someone close to the respondent (1.8%) was anticipated as a likely outcome of HIV disclosure by less than 10% of the total sample. Statistically significant differences in respondent perceptions existed by survey venue (see Figure 4). Interestingly, just 11.5% of those reporting physical violence in their current or most recent relationship (discussed in next section) anticipated physical abuse as a likely or somewhat likely result of an HIV-positive disclosure (data not shown).

Figure 4: Perceptions of the Likelihood of Various Partner Responses to HIV Disclosure*



* Excludes HIV-positive individuals.

It is important to note that, consistent with the low level of concern about physical abuse resulting from disclosure of HIV status, few (5.6%) of the HIV-positive participants indicated that they or someone close to them was actually physically hurt by a past or current partner who found out that the participant tested HIV-positive (data not shown).

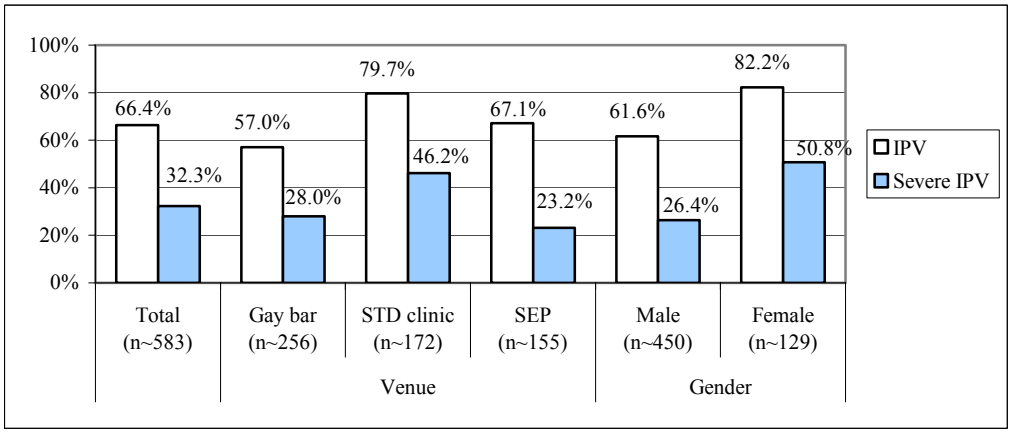
V. Intimate partner violence

Survey respondents were asked about their *lifetime* experience with physical intimate partner violence (IPV), including whether or not they had experienced each type in their current or most recent relationship. A modified version of the Conflict Tactics Scale (CTS) was utilized to assess experience with IPV. The CTS was modified by adding instructions to facilitate verbal administration of the scale, by consolidating the nine items from the physical abuse subscale into seven items, and by adding a sexual abuse item, resulting in an eight-item scale. The eight dimensions of physical IPV included: 1) having something thrown at them by partner; 2) being pushed, grabbed, or shoved; 3) being, kicked, bitten, slapped or hit with bare hands; 4) being threatened or hit with an object; 5) being beaten up; 6) being choked, burned or scalded; 7) being threatened or attacked with a knife or gun; and 8) being forced to have sex or do sexual things. Two levels of physical IPV were created, an overall measure including all eight items and a severe IPV index comprised of the last four items only. In order to help place reports of IPV in context, respondents reporting IPV were asked how many times each type of IPV had occurred, the timeframe of the last occurrence, and whether or not they were ever injured or had ever sought medical care for each type of IPV.

Lifetime Experience with Intimate Partner Violence

The majority of participants (66.4%) reported that they had, at some point in their lives, experienced physical IPV, with STD clinic (79.9%) and female (82.2%) participants being most likely to report having ever experienced IPV (Figure 5). Although statistically significant differences existed by both venue and gender (in fact, females were more likely than males to have ever experienced six of the eight violent acts assessed (data not shown)), general IPV levels were high among respondents from all sampling venues. Severe IPV levels were also high across both gender and sampling venue, with 32.3% of respondents reporting having ever experienced severe IPV. As with our general IPV measure, lifetime prevalence of severe IPV was highest among females (50.8%) (Figure 5).

Figure 5: Percentage of Participants Reporting Having Ever Experienced IPV*



* Number of respondents differed slightly for IPV and Severe IPV scales. Venue and gender differences are statistically significant at p<0.01 for both IPV and Severe IPV scales.

Injuries from IPV

Table 9 displays the percentage of respondents reporting injuries resulting from IPV. Overall, 33.6% of those reporting IPV further reported being physically injured at some point in their lives as a result of IPV. As with the prevalence of IPV, STD clinic respondents (42.6%) and females (55.2%) were most likely to report injuries associated with IPV (Table 9). It should be noted that HIV-positive individuals were specifically asked about IPV resulting from HIV disclosure. Results (not displayed) indicated that just 5.6% HIV-positive individuals (4 out of 72) reported being physically injured by a past or current partner as a result of testing positive for HIV.

Table 9: Injuries Among Those Experiencing IPV*

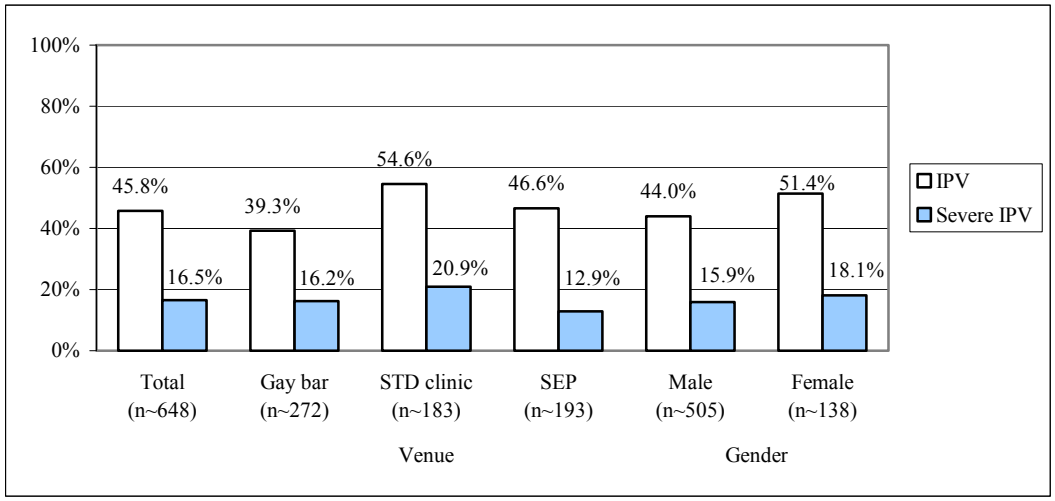
	% ever injured from IPV	p-value
Total (n=378)	33.6%	
Venue		<0.01
Gay Bar (n=141)	31.9%	
STD Clinic (n=136)	42.6%	
SEP (n=101)	23.8%	
Gender		<0.01
Male (n=269)	25.3%	
Female (n=105)	55.2%	

* Includes only those respondents reporting having ever experienced IPV

Experience with IPV in Current/Most Recent Relationship

Figure 6 presents IPV data pertaining to participants' current or most recent partner. Although, as expected, rates of IPV are lower than those reported in Figure 5, nearly half the participants reported experiencing IPV from their current of most recent partner. Interestingly, reports of IPV from one's current or most recent partner did not vary by gender (Figure 6) or HIV status (data not shown).

Figure 6: Percentage of Participants Reporting IPV in Current/Most Recent Relationship*



* # of respondents differed slightly for IPV and Severe IPV scales. IPV differed by venue (p<0.01).

Experience with Battering in Current/Most Recent Relationship

Psychological battering in participants' current or most recent relationship was also assessed, using a modified version of the Women's Experience with Battering (WEB) scale (Smith, Earp, and DeVellis, 1995). All 10 items in the WEB scale were retained, but the language was modified to include gender-neutral terms in order to administer the scale to both males and females. A six-category Likert response option was utilized, with a score of 1 indicating the strongest level of disagreement with a statement and a score of 6 indicating the strongest level of agreement with a statement. All statements were coded such that a higher score meant a higher level of psychological abuse. Consistent with the literature, scores greater than 19 were considered indicative of a high level of psychological battering.

Results from the modified WEB sale are presented in Figure 7. One-quarter of respondents reported a high level of emotional battering from their current or most recent partner. Interestingly, the prevalence of psychological battering varied only by venue, with STD clinic (36.4%) and gay bar (23.8%) respondents more likely to be classified as high on the scale, compared to SEP (17.3%) participants (Figure 7).

Figure 7: Percentage of Participants Who Experienced a High Level of Battering Symptoms From Their Current or Most Recent Partner

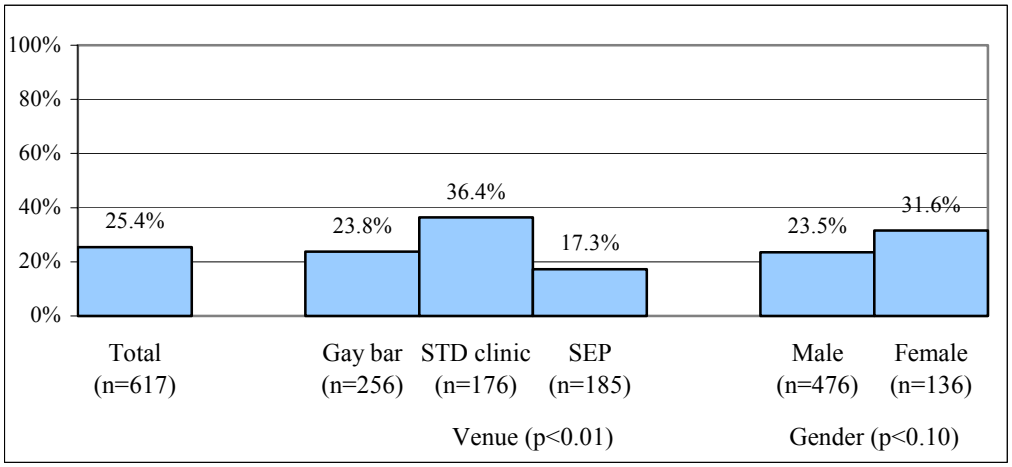
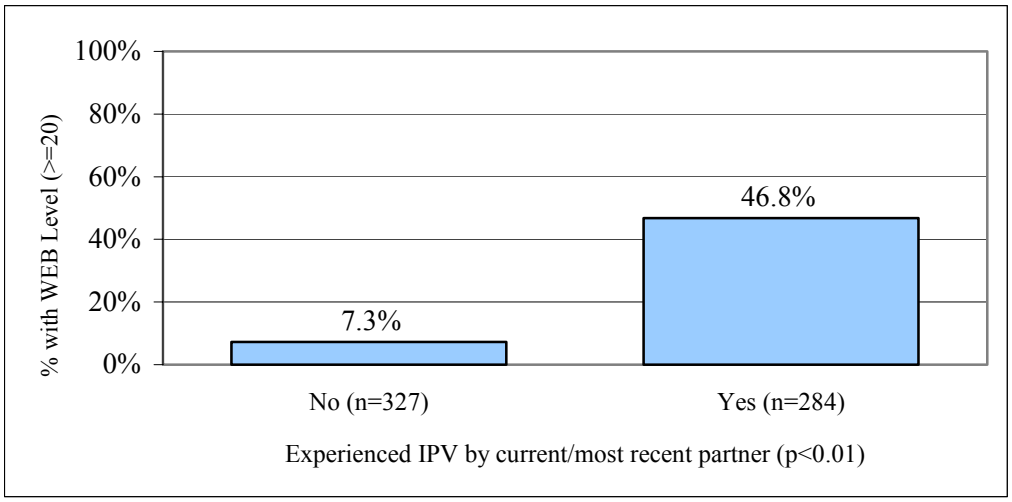


Figure 8 explores the relationship between physical and psychological IPV. The results from Figure 8 clearly indicate that participants who reported physical IPV from their current or most recent partner were much more likely to rate high on the psychological battering scale (46.8% compared to 7.3% among those not reporting physical IPV). It is interesting to note, however, that more than one-half (53.2%) of those reporting physical IPV did not rate high on the psychological battering scale.

Figure 8: The Relationship Between Having a High Level of Battering Symptoms and Physical IPV by the Current/Most Recent Partner



VI. HIV risk

Sexual Risk Behavior by Venue and Gender

Sexual and injection drug use behaviors in the past 12 months were examined to verify that the venue-based sampling methodology was successful in enrolling people at high risk of acquiring HIV. Table 10 indicates that just 12.2% of the sample reported no sexual partners within the past year, and most of these individuals were interviewed in the SEP, where injection drug use was almost always a risk factor. The gay bar sample had the most sexual partners, with one-fifth of the sample reporting more than 10 sexual partners in the past year. The SEP sample reported the fewest sexual partners, with over 70% reporting zero or one partner. Males reported more sexual partners in the past year than females.

Table 10 also reveals that less than one-fifth of the sample (17.6%) reported always using condoms during vaginal and anal sex. Condom use varied significantly by venue but not by gender. STD clinic participants were the least likely to report *always* using condoms (9.4%), but the SEP sample was the most likely to report *never* using them (50.8%). Additional analyses (data not shown in Table 10) found that participants with one sexual partner were more likely to report never using condoms than participants who had two or more sexual partners (53.7% versus 15.4%, respectively, $p<0.01$). The inconsistent use of condoms and/or multiple sexual partners indicate a sizable risk for acquiring HIV through sexual practices among people sampled across all three venues.

Table 10: Sexual Risk Behaviors in the Past Year by Venue and Gender

	Total	Venue				Gender		
		Gay bar	STD clinic	SEP	p-value	Male	Female*	p-value
# of sexual partners:					<0.01			<0.01
0	12.3%	12.1%	1.1%	25.1%		11.8%	13.3%	
1	30.6%	19.5%	31.7%	49.1%		27.3%	43.4%	
2-5	34.5%	33.9%	50.0%	18.7%		33.9%	35.7%	
6-10	11.9%	14.7%	12.4%	6.4%		14.0%	4.9%	
11+	10.7%	19.9%	4.8%	0.6%		13.0%	2.8%	
n	664	307	186	171		516	143	
# of sexual partners:**								
Mean	5.8	9.2	3.4	2.1	<0.01	6.7	2.5	<0.01
Median	3.0	4.0	2.0	1.0	<0.01	3.0	1.0	<0.01
N	579	268	183	128		453	123	
Condom use during vaginal and anal sex					<0.01			NS
Always	17.6%	23.1%	9.4%	17.7%		19.0%	12.5%	
Sometimes	53.8%	54.9%	67.4%	31.5%		53.3%	55.8%	
Never	28.5%	22.0%	23.2%	50.8%		27.7%	31.7%	
N	578	273	181	124		458	120	

* Female participants' female partners are not included in this analysis.
** Among those with at least one partner. Excludes one female STD clinic participant who had over 1,000 partners.

Sexual Risk Behavior by HIV Testing Status

Table 11 presents sexual risk behavior information by HIV testing status. Although a higher percentage of HIV-positive individuals reported having no sexual partners during the past 12 months (24.2%) compared to those testing HIV-negative at their last test (11.3%) and those never testing for HIV (10.3%), these differences did not reach the level of statistical significance. The mean and median number of sexual partners, among those with at least one partner, also did not differ by HIV testing status. Finally, self-reported condom use varied by testing status: Although HIV-positive individuals reported always using condoms at rates more than two times higher than those reported by individuals testing HIV-negative or never testing, more than half of all positive individuals admitted to inconsistent (46.8%) or no (10.6%) condom use (Table 11).

Table 11: Sexual Risk Behaviors in the Past Year by HIV Testing Status

	HIV Testing Status			p-value
	HIV-positive	Last tested HIV-negative	Never HIV tested	
# of sexual partners				NS
0	24.2%	11.3%	10.3%	
1	22.6%	31.5%	3.10%	
2-5	32.3%	35.9%	30.2%	
6-10	12.9%	10.9%	15.5%	
11+	8.1%	10.3%	12.9%	
n	62	485	116	
# of sexual partners*				
Mean	5.3	5.3	8.1	<0.10
Median	3.0	2.0	3.0	NS
N	46	429	103	
Condom use during vaginal and anal sex				<0.01
Always	42.6%	15.5%	17.9%	
Sometimes	46.8%	52.5%	57.5%	
Never	10.6%	32.0%	24.5%	
n	47	438	106	
* Among those with at least one partner. Excludes one female STD clinic participant who had over 1,000 partners.				

Injection Drug Use

All H-TAPS respondents were asked about their drug use behaviors in the year leading up to their interview. More than one-quarter of the sample reported injecting drugs within the past year (Table 12). As expected, injection drug use was much more prevalent among SEP participants, with 94.0% injecting within the past year. It is important to note that the SEPs in this study provide a variety of services in addition to syringe exchange. Some individuals may also exchange syringes for someone else. Thus, the fact that a small percentage of SEP respondents failed to report injection drug use does not, per se, indicate that these respondents were not being truthful. Table 12 also reveals that approximately 1 in 5 injection drug users admitted to using a needle previously used by someone else, and 70% of these individuals further admitted not always cleaning shared needles prior to use.

Table 12: Injection Drug Use Behaviors in the Past Year

		Venue			
	Total	Gay bar	STD clinic	SEP	p-value
Used injection drugs	27.5% n=(734)	3.5% (n=346)	0.5% (n=187)	94.0% (n=201)	<0.01
Used a needle previously used by someone else*	20.2% (n=198)	40.0% (n=10)	0.0% (n=1)	19.3% (n=187)	NS (Exact)
Did not always clean needles**	70.0% (n=40)	100.0% (n=4)	- - - - (n=0)	66.7% (n=36)	NS (Exact)
* Among those who used injection drugs ** Among those who shared needles					

VII. Comparison of HITS and H-TAPS Responses

As mentioned, H-TAPS is a modified version of the Centers for Disease Control and Prevention's HIV Testing Survey (HITS). HITS was first conducted in Buffalo and Rochester from September 2000 to February 2001, shortly after implementation of NYS's HIVRPN Law. H-TAPS, as discussed, was administered in Buffalo from November 2001 to June 2002 and in Rochester from July 2002 to March 2003. This section of the report compares results from the administration of HITS and H-TAPS in Buffalo and Rochester, the only two cities where both surveys were implemented. The actual survey sites were identical for the SEP and STD clinic venues of both studies, and overlapped greatly for the gay bar component as well. Many of the interviewers were also the same between both surveys. This fact may have helped reduce the number of individuals participating in both the HITS and H-TAPS surveys, but there was no way to systematically measure this. Thus, the degree of overlap in respondents between the two studies is not known. Finally, since neither survey represents a probability sample of targeted individuals, a formal comparison between the two surveys for purposes of establishing trends is inappropriate. The following section compares responses on selected questions from the two surveys for exploratory purposes only.

Distribution of Respondents

The distribution of cases by city and sampling venue were very similar between the HITS and H-TAPS studies (Table 13).

Table 13: Comparison of HITS and H-TAPS Samples

		Total (n=1,216)	HITS (n=587)	H-TAPS (n=629)
City*	Buffalo	51.6%	49.4%	53.6%
	Rochester	48.4%	50.6%	46.4%
Venue*	Gay bar	38.4%	40.4%	36.6%
	STD clinic	30.6%	29.6%	31.5%
	SEP	31.0%	30.0%	32.0%
* Differences in distribution of respondents by city or venue were not statistically significant. H-TAPS data from Buffalo and Rochester only.				

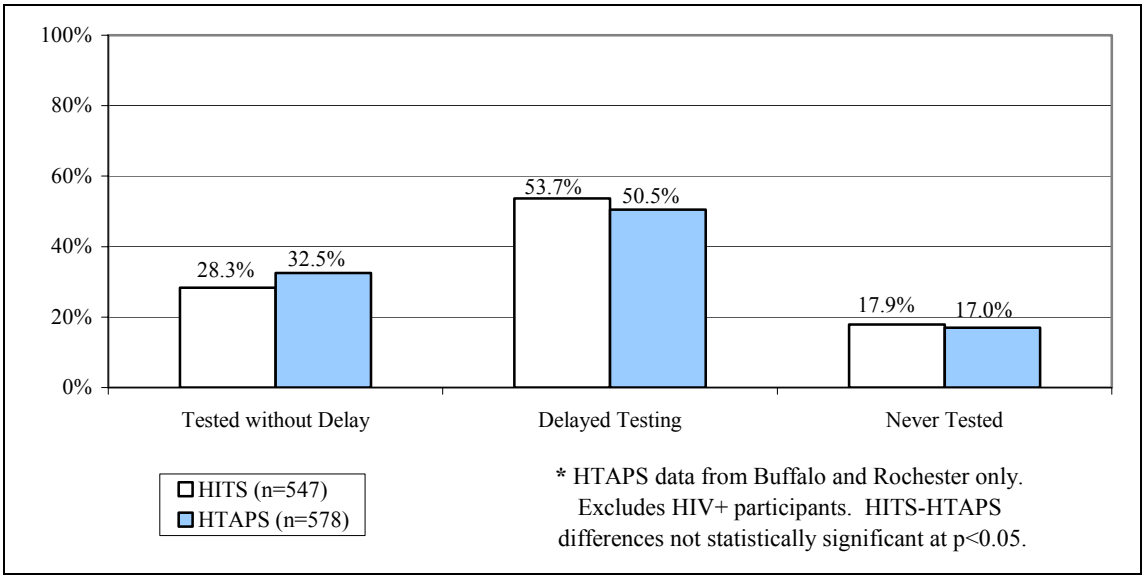
HIV Testing History

Participants' HIV testing history is described in Table 14 and in Figure 9. HIV testing history of the HITS sample was similar to that in the H-TAPS sample, with over 80% of both samples having been tested for HIV at some point, and about 50% within the past year. The percentage of individuals who last tested anonymously was also similar between both surveys. Finally, the rate at which respondents reported delaying HIV testing did not increase between administrations of the HITS and H-TAPS surveys (Figure 9).

Table 14: HIV Testing History

	Survey			
	Total	HITS	H-TAPS*	p-value
Date of last HIV test				NS
More than 1 year ago	32.4%	34.4%	30.5%	
Within the past year	50.3%	47.7%	52.7%	
Never	17.3%	17.9%	16.8%	
N	1124	547	577	
Last tested anonymously	30.9%	33.8%	28.3%	<0.10
N	997	477	520	
* H-TAPS data from Buffalo and Rochester only.				

Figure 9: HIV Testing History Among H-TAPS and HITS Respondents*



Knowledge of HIV Testing Policies

Although H-TAPS was conducted well after implementation of the HIVRPN law, there was very little difference in awareness of the law between the two studies: An almost identical (and very small) percentage of HITS (14.4%) and H-TAPS (16.7%) participants were aware of New York's name-based HIV reporting policy. This was the case despite the fact that a much higher percentage of H-TAPS respondents had tested after the law went into effect (Table 15).

Table 15: Knowledge of Name-Based HIV Reporting in NYS by HIV Testing Status and Survey

HIV testing history	Total		Survey				p-value
			HITS		H-TAPS*		
	# Tested	% know law**	# Tested	% know law**	# Tested	% know law**	
Tested since the law	345	16.2%	147	13.6%	198	18.2%	NS
Tested before the law	301	16.6%	265	17.0%	36	13.9%	NS
Never HIV tested	123	8.9%	84	8.3%	39	10.3%	NS
Total	801	15.2%	514	14.4%	287	16.7%	NS

* Only includes H-TAPS data collected in Rochester.
** Refers to knowledge of name-based reporting of HIV-positive results in NYS.

VIII. Summary and Conclusion

The three sampling venues utilized in this study proved useful at reaching three distinct groups of high-risk individuals. The individuals interviewed at gay bars, SEPs, and STD clinics differed greatly in their demographic and HIV risk composition. They also differed significantly in their responses to most sections of the H-TAPS survey. Reports of sexual and injection drug use behavior verified that the venue-based sampling methodology was successful in enrolling people at high risk of acquiring HIV. Just over 10% of the sample reported no sexual partners within the past year, and most of these individuals were interviewed in syringe exchange programs, where injection drug use was almost always a risk factor. The gay bar sample had the most sexual partners, with about 20% of the sample reporting more than 10 sexual partners in the past year.

Less than one-fifth of the sample reported always using condoms during vaginal and anal sex. The inconsistent use of condoms and/or multiple sexual partners indicate a sizable risk for acquiring HIV through sexual practices among people sampled across all three venues. Although a higher percentage of HIV-positive individuals reported having no sexual partners compared to other survey respondents, these differences did not reach the level of statistical significance. In addition, the mean and median number of partners among those having sex did not differ by HIV status. Despite the fact that HIV-positive individuals reported consistent condom use at much higher rates than other H-TAPS respondents, more than half of all HIV-positive individuals admitted to inconsistent or no condom use during vaginal and anal sex.

One-fourth of the sample reported injecting drugs within the past year. Somewhat alarming was the finding that 1 in 5 injection drug users admitted to using a needle previously used by someone else, and 70% of these individuals further admitted not always cleaning shared needles prior to use. This is surprising since the vast majority of these individuals were SEP participants, where access to sterile syringes is, at least in theory, not a problem. It is possible that some of these individuals were reporting risk behaviors that predated their enrollment in the SEP, or that they were sharing less often as a result of SEP utilization.

The H-TAPS sample was experienced with HIV testing. More than one-half of the sample had tested for HIV within the twelve months leading up to their interview, while 30% had last tested more than a year ago. Just one in five respondents reported never testing for HIV,

although HIV testing history differed by venue, with over one in four STD clinic respondents never testing for HIV. The most common reasons for HIV testing centered around concerns about health and medical treatment, or about possible HIV exposure through sexual or drug using behaviors. Reasons for HIV testing also differed by sampling venue, with many differences expected given the risk behaviors and characteristics of people interviewed at each venue.

Survey responses suggest that discussions of HIV name-based reporting during pre-test counseling sessions increased subsequent to the HIVRPN law. This was true for those tested in both anonymous and confidential settings, with the most dramatic increases observed in the gay bar and SEP venues. Our examination of H-TAPS data revealed no support for the argument that people were moving away from confidential HIV testing due to concerns about NYS's HIV reporting law. In fact, the percentage of respondents who reported that their last HIV test was anonymous prior to the HIVRPN law was similar to the percentage testing anonymously after the law. In addition, the perceived stress associated with HIV testing was inversely related to the temporal proximity of testing, with those testing most recently (since the law) expressing the least amount of perceived stress and those never testing expressing the greatest amount of perceived stress. More to the point, just 5% of respondents cited concern about their name being reported to the government as a reason for avoiding or delaying HIV testing, with just one person citing this as the most important reason.

Further evidence that HIV testing decisions were not being influenced by NYS's HIVRPN law was provided by the finding that most respondents were not even aware of the State's HIV reporting and partner notification regulations. In fact, less than one fifth (17.7%) of the sample knew that HIV-positive test results are reported by name in New York State. Interestingly, while nearly 60% of individuals HIV testing after the law reported that named reporting was discussed during their last HIV test, only about 24% of these respondents were able to correctly identify the NYS policy of name-based HIV reporting. Possible reasons for this discordance include a lack of concern about this issue on the part of clients and/or imperfect descriptions of the HIVRPN law during pre-test counseling sessions. It is also possible that individuals simply forgot the details about the new law between their last HIV test and their H-TAPS interview, although this could also be construed as evidence that individuals are not concerned about the change in policy.

Knowledge about NYS's PN policy, including the voluntary nature of naming sexual and needle sharing partners, the availability of PN assistance programs and the confidentiality of PN, was greater than knowledge of named HIV reporting. Where differences existed by venue, persons interviewed in gay bars were most knowledgeable, while STD clinic respondents were least knowledgeable. Although the differences did not reach the level of statistical significance, those who tested after the law went into effect were actually *less likely* to know that naming partners is voluntary, perhaps indicating that discussion of named reporting and PN during pre- and post-test counseling is confusing to clients. However, those who had ever been HIV tested (regardless of whether it was before or after the law) were more likely to be aware of PN assistance programs than those who had never tested, indicating that this basic message is being conveyed in test counseling sessions.

H-TAPS respondents expressed mixed feelings about the desirability and efficacy of PN in general, and about assisted notification programs in particular. Most agreed that PN helps reduce the spread of HIV, and that assistance programs make it easier to notify partners and are safer than direct notification. However, respondents exhibited concerns about the potential for physical harm resulting from notifying partners, and about assistance programs being too impersonal, violating privacy, and being unable to protect the anonymity of the index client. Attitudes toward PN varied greatly by venue, with STD clinic respondents being most concerned about the potential for violence resulting from PN, and gay bar respondents being the most skeptical of assisted notification programs. Surprisingly, respondents who reported personal experience with assisted notification programs for STD or HIV were actually *less* likely to believe that PN reduces the spread of HIV, that assisted notification is safer, that HIV-positive people need to notify partners of their exposure, and that assistance programs do more good than harm.

The vast majority of participants reported that they had, at some point in their lives, experienced physical violence. Although statistically significant differences existed by both venue and gender, *lifetime* IPV levels were high among respondents from all sampling venues. Females were also much more likely to report injuries resulting from IPV. Interestingly, the prevalence of IPV pertaining to subject's *current* or *most recent* partner did not vary by gender. One-quarter of respondents reported a high level of emotional battering from their current or most recent partner. The prevalence of psychological battering varied only by venue, with STD clinic participants most likely to be classified as high on this scale. More than one-half of those reporting physical violence did not rate high on the psychological battering scale. The scale used to assess physical violence did not differentiate between aggressive acts or self-defensive acts by the partner. It is therefore possible that some individuals reporting physical violence without psychological battering could be perpetrators of violence, rather than victims. Exploring this possibility is beyond the scope of this report and will be addressed in supplemental issue-specific papers stemming from this study.

Rates of IPV were comparable between HIV-positive and HIV-negative/unknown status respondents. This study found no evidence that disclosure of one's HIV status was a specific trigger for violence. Participants who were HIV-negative or of unknown HIV status were asked about the likelihood of physical abuse from their partner if they were to test positive for HIV. Physical abuse was anticipated as a likely outcome of HIV disclosure by less than 10% of the total sample. More germane to this point was the finding that just 4 out of 72 HIV-positive individuals reported being physically injured by a past or current partner as a result of testing positive for HIV.

The HIV testing histories among HITS respondents just following implementation of the HIVRPN law was similar to that in the H-TAPS sample, with over 80% of both samples having been tested for HIV at some point, and about 50% within the past year. The percentage of individuals who last tested anonymously was also similar between both surveys. The rate at which respondents reported delaying HIV testing did not increase between administrations of the HITS and H-TAPS surveys. Finally, although H-TAPS was conducted well after implementation of the HIVRPN, there was very little difference in awareness of the HIVRPN law between the two surveys. This was the case despite the fact that a much higher percentage

of H-TAPS respondents had tested after the law went into effect. These trend data provide further evidence that high-risk individuals are not avoiding or delaying HIV testing, or turning to anonymous testing options, due to concerns about name-based HIV reporting in NYS.

IX. Limitations

This study was successful at surveying individuals at elevated risk for acquiring STDs, including HIV. However, because we were not able to utilize probability sampling methods to conduct the surveys, the extent to which our findings can be generalized to high risk New Yorkers in general is unknown. In addition, we were not able to sample in all the venues called for by the HITS study methodology in Albany and Syracuse, due to an inability to reach sufficient numbers of the target populations in these smaller cities.

References

Smith PH, Earp JA, DeVellis R. Measuring battering: Development of the women's experience with battering (WEB) scale. *Women's Health*. 1995;1(4):273-288.

Component 5

HIV Counselors' Attitudes and Practices Survey (H-CAPS)

General Findings Report

Office of Program Evaluation and Research
NYS Department of Health AIDS Institute
CDC Grant: R06/CCR218723

Overview

The HIV Reporting and Partner Notification (HIVRPN) legislation changed the role of HIV counseling and testing (C&T) providers in New York State (NYS). The law requires that HIV testers report known contacts of newly infected individuals and attempt to elicit other sexual and needle sharing partners to increase the number of partners being notified of their exposure risk. Intimate partner violence (IPV) screening must be conducted for each partner reported. Given the expanded role of HIV C&T counselors in partner notification and IPV screening, it was deemed important to assess their knowledge, attitudes and practices surrounding the new law.

The HIV Counselors' Attitudes and Practices Study (H-CAPS) sought to identify NYS HIV C&T providers' current knowledge, practices and training needs regarding HIV pre- and post-test counseling, reporting of HIV-positive results, notification of partners and IPV screening. H-CAPS included two components: A survey of supervisors of agencies that conduct HIV C&T and a survey of individuals performing HIV C&T services. This report presents summary findings from H-CAPS. In-depth analyses are ongoing, and will be the subject of separate publications.

Methods

Sample and Procedure

C&T Agency Survey

The *HIV Counseling and Testing Resource Directory* database maintained by the NYSDOH AIDS Institute was used to define the universe of C&T agencies for H-CAPS. This database, updated on a continual basis, contains site records of agencies that provide HIV C&T services in NYS. Service information extracted from this database is published periodically in the *HIV Counseling and Testing Resource Directory*. Agencies that did not want their records published in the *Directory* were not eligible for the H-CAPS. In addition, sites operated by the AIDS Institute's Direct Programs Operation (DPO) unit, and those that limit HIV testing to inpatients and employees only, were excluded from the sampling frame. DPO sites were excluded because the supervisors and the counselors are employees of NYSDOH and were not eligible to receive the incentives offered through the study. The final sampling frame contained 478 HIV C&T sites.

The C&T Agency Survey was mailed (via United States Postal Service first class mail) to the supervisors of agencies selected for the study. Follow-up mailings were sent after four and nine weeks and telephone follow-up of non-responders was conducted approximately 13 and 17 weeks after the initial mailing. A $10 money order was sent (via certified mail with return receipt) to agency supervisors who completed the Agency Survey.

The Agency Survey was sent to 163 agencies in NYS that conducted HIV C&T. Thirty-nine agencies were deemed ineligible (20 due to incorrect contact information, 12 no longer conducted HIV testing, 2 facilities had closed, and 5 due to duplications in the database or other

reasons). Ineligible cases were replaced to maintain the initial sample size of 163. Completed Agency Surveys were returned from 110 of the 163 agencies, yielding a response rate of 67.5%

Counselor Survey

One hundred eleven of the 163 agencies sampled for the Agency Survey agreed to distribute the Counselor Survey to their HIV test counselors (95 out of the 110 agencies completing the Agency Survey and an additional 16 agencies not completing the Agency Survey but agreeing to participate in the Counselor Survey). This represents 68.1% of the 163 agencies selected to participate in the Agency Survey. Agency supervisors requested as many surveys as needed (between 1 and 63; median = 4, mean = 6.1, standard deviation = 7.3). Nearly one-fifth (19.6%) of the Counselor Surveys were distributed to four agencies.

Counselor Survey mailings were conducted (via FedEx next day delivery) between February and June 2004. Agency supervisors whose counselors had not completed the Counselor Survey received two telephone calls and a letter requesting that they follow-up with non-responding counselors. A $10 money order was sent (via certified mail with return receipt) to HIV test counselors who completed the Counselor Survey. Six hundred eighty counselor surveys were distributed. Sixteen of them were completed by individuals who were not eligible (i.e. not providing HIV C&T services directly to clients) and were therefore excluded from the analysis. Two hundred eighty-four Counselor Surveys were completed by eligible respondents, yielding a response rate of 42.8%.

Measures

Agency Survey

Agency supervisors were asked about the location of their agency, number of employees and clients, the perceived effect of the HIVRPN legislation on HIV C&T and use of the NYS Department of Health's (NYSDOH) guidelines for integrating IPV screening into HIV C&T services. In addition, agency supervisors were asked to assist in the distribution of Counselor Surveys to all staff engaged in HIV C&T activities.

Counselor Survey

HIV test counselors were asked for general demographic information, their current job position and the number of HIV C&T clients counseled in the past year. Counselors were asked about pre and post-test counseling and IPV screening practices, reasons why clients delayed or avoided HIV testing and their knowledge of New York's HIVRPN legislation. Counselors' opinions of PN, PN assistance programs, HIV reporting, IPV and IPV screening were also elicited. Counselors were also asked about their proficiency and interest in training in various aspects of partner elicitation, PN and IPV screening. The Counselor Survey instrument is included in Appendix B.

Data entry and analysis

Agency and Counselor Survey data were entered using SPSS Data Entry, version 3.03 (SPSS Inc., Chicago, Illinois) and analyzed using SPSS for Windows, version 11.01 (SPSS Inc., Chicago, Illinois). Pearson's χ^2 and Fisher's exact tests were used for comparison of categorical variables. Analyses of variance were conducted to compare the means of continuous variables between different strata. All tests of significance were two-sided and assessed against an alpha level of 0.05.

Results: Agency Survey

Description of the Agency Survey sample

A description of the agency sample is provided in Table 1. More than half (52.7%) of the 110 participating agencies were located in Upstate New York, while over one-third were located in the five counties comprising New York City (NYC). Community health centers, outpatient hospital clinics and family planning services comprised over 50% of the sample.

The provision of HIV C&T services was seen as a high priority (4 or 5 on a 5 point scale) by nearly two-thirds of agency directors and a moderate priority (3) by another 30%. The number of employees, HIV test counselors, HIV C&T clients, and clients testing HIV-positive varied widely among agencies. Regional differences were observed only for the percentage of clients testing HIV-positive. Agencies in and around NYC reported a higher percentage of clients who tested positive for HIV than those in the rest of the state (regional comparisons not displayed in Table 1).

Table 1: Description of the Agency Sample

	New York State (n=110)	
	n	%
Region		
New York City	38	34.6%
New York City Vicinity	14	12.7%
Rest of New York State	58	52.7%
Location		
Community health center	21	19.1%
Outpatient hospital clinic	20	18.2%
Family planning services	19	17.3%
Specialty clinic or private physician's office	11	10.0%
State/local health department	11	10.0%
Substance abuse treatment or STD clinic	10	9.1%
Other	7	6.4%
AIDS, human/social, mental health or HIV test agencies	6	5.5%
AIDS treatment center	5	4.5%
Priority of providing HIV C&T services		
High priority (4-5)	71	65.7%
Moderate priority (3)	32	29.6%
Low priority (1-2)	5	4.6%

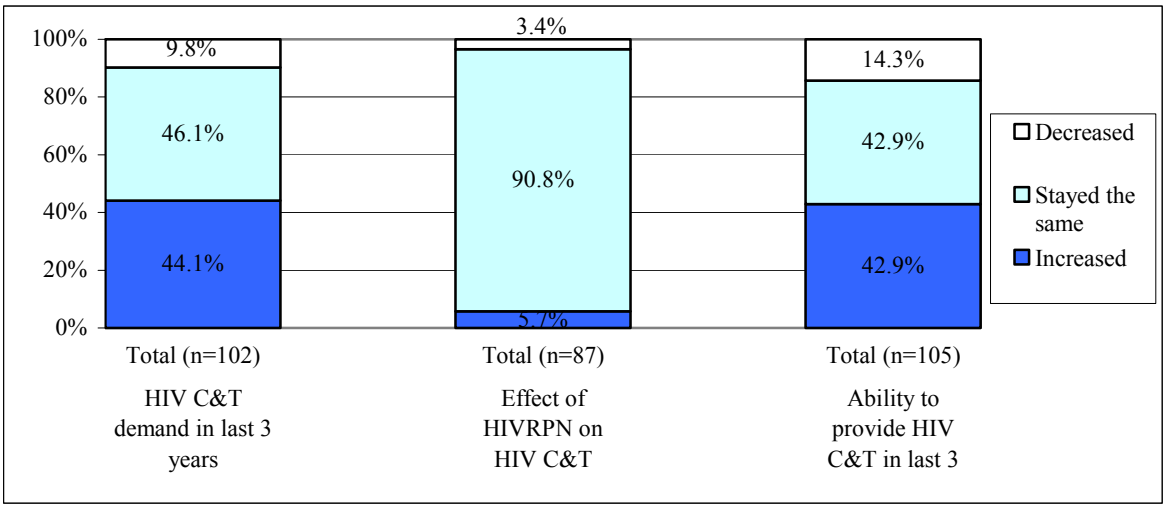
Table 1: Description of the Agency Sample Continued……

	New York State (n=110)
# of HIV test counselors** (n) Mean (std dev) Range	(104) 6.3 (9.1) 0-63
# of employees** (n) Mean (std dev) Range	(85) 86.9 (321.4) 1-2,700
# of HIV C&T clients (n) Mean (std dev) Range	(98) 808.4 (1,271.2) 4 – 7000
% of HIV C&T clients who tested HIV-positive (n) Mean (std dev) Range	(96) 4.2% (12.7) 0.0% - 94.4%

The effect of HIVRPN on HIV C&T agencies

Nearly half (44%) of agency directors reported that the demand for HIV C&T services increased over the preceding three years, however, most agency supervisors did not attribute the increase in demand to the HIVRPN legislation (Figure 1). In fact, 91% of agencies reported that New York's HIVRPN law had no impact on its demand for HIV C&T. Six percent reported that the law had increased the demand for C&T, while just 3% believed that the law had decreased HIV C&T demand. Finally, over 80% of agencies either experienced an increase or no change in their capability to provide HIV C&T services during the past three years. Perceived demand for HIV C&T services, capability to provide HIV C&T services and the effect of the HIVRPN legislation on the demand for HIV C&T services did not differ between agencies in the three regions (NYC, NYC vicinity, and rest of NYS - regional comparisons not displayed in Figure 1).

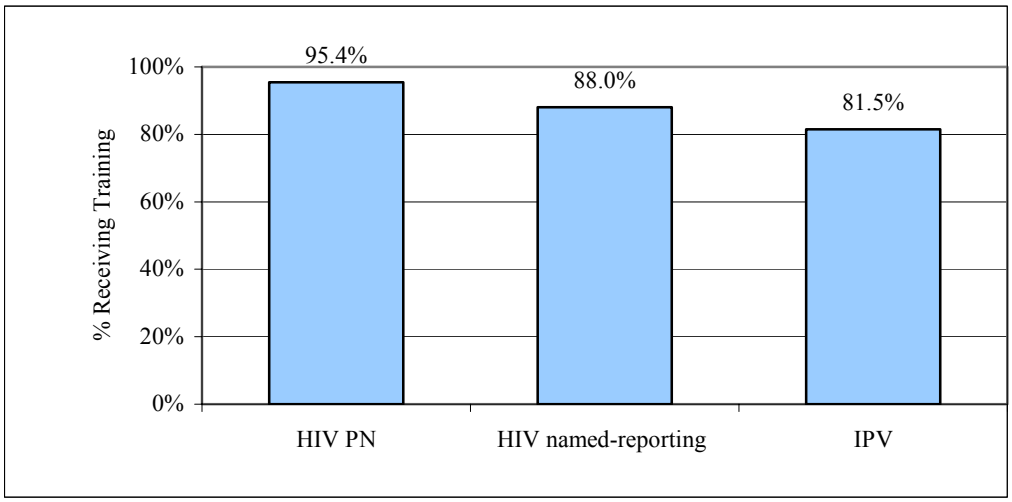
Figure 1: Effect of HIVRPN on the Demand for and Provision of HIV C&T Services



Training on New York's HIVRPN Law

Nearly all agency directors reported that their staff had received training on the major aspects of the HIVRPN legislation. PN aspects of the law were covered in 95% of agency trainings, followed by the named-based reporting aspects of the law (88%) and IPV screening requirements (82%) (Figure 2). Major sources of training on the law included agency staff and staff from state and local health departments. Content and sources of training were relatively uniform across the three regions (regional comparisons not displayed in Figure 2).

Figure 2: Topics of Training on HIVRPN (n=108)



NYSDOH Guidelines for Integrating IPV Screening into HIV C&T

The New York State Department of Health developed guidelines to assist providers in integrating IPV screening into their regular HIV C&T services. Agency directors were asked about their familiarity and use of these guidelines. Results are reported in Figures 3 through 5. About half (48%) of agency supervisors reported being "very familiar" with the NYSDOH guidelines, while an additional 38% reported being "somewhat familiar" with them (Figure 3). Over 80% of these supervisors (or their staff) had used the guidelines to develop or modify their agency's IPV screening protocol (Figure 4).

Just under half (48%) of the 21 agencies that had not used the guidelines to develop or modify their IPV screening protocol reported that they were currently reviewing their protocol and would consult the guidelines if necessary (Figure 5). Other reasons for not using or consulting the guidelines included the existence of agency-specific IPV screening protocols (19%), the belief that the state-developed guidelines were impractical in their service setting (10%), and the use of other screening protocols (5%).

Figure 3: Familiarity with the NYSDOH Guidelines for Integrating IPV Screening into HIV C&T

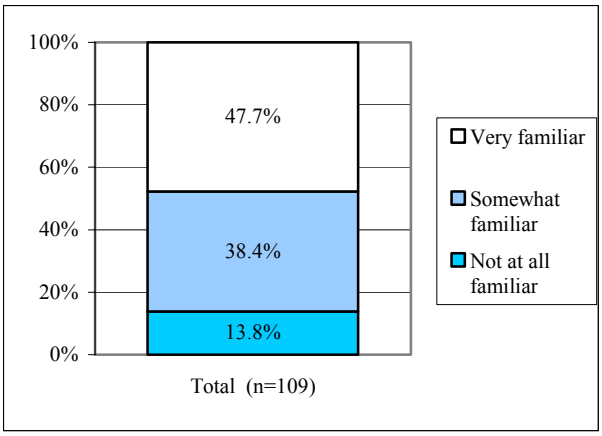


Figure 4: Were the Guidelines Used to Develop or Modify Screening Protocols? (Among Agencies Very or Somewhat Familiar with the Guidelines)

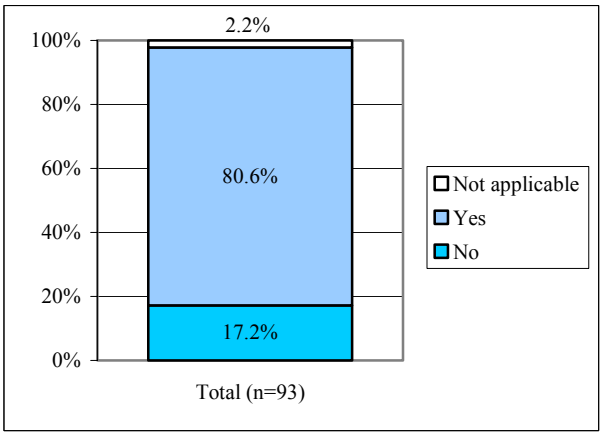
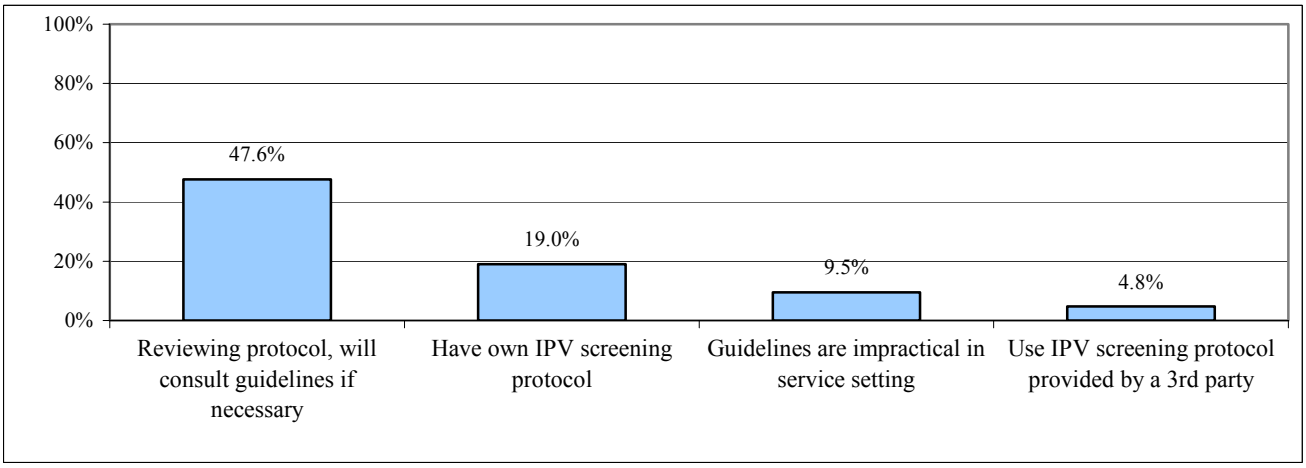


Figure 5: Reasons Why the Guidelines Were Not Used to Develop or Modify Agencies' IPV Screening Protocol (n=21)



HIV Counselor Survey

Description of the Counselor Sample

Table 2 contains a description of the 284 HIV C&T providers completing the HIV Counselor Survey. The majority of the participants were female and non-Hispanic white. Approximately one-fifth of the sample was Hispanic and one-fifth was non-Hispanic black. The vast majority of the sample (nearly 80%) identified their primary job as something other than an HIV test counselor. In fact, more than one-third of the sample was made up of nurses or nurse practitioners. The HIV C&T experience of the sample was diverse, ranging from zero to over 17 years of counseling and testing experience. However, most counselors reported at least five years of HIV C&T experience. The number of clients pre- and post-test counseled in the past year ranged from zero to over 1,500, with about one-half of providers (47%) post-test counseling at least one HIV-positive client (Table 2)

Table 2: Characteristics of HIV C&T Counselors

	Total (n=284)			
	n		%	
Gender				
Male	37		13.0%	
Female	247		87.0%	
Race/Ethnicity				
Hispanic	57		20.7%	
Non-Hispanic white	165		59.8%	
Non-Hispanic black	50		18.1%	
Non-Hispanic other	4		1.4%	
Current job title				
Nurse/NP	106		37.3%	
HIV C&T counselor	65		22.9%	
Case manager/Social Worker/Therapist/Counselor	48		16.9%	
Administrator/Program Manager/Supervisor	20		7.0%	
Educator/Outreach worker	19		6.7%	
Physician/Physician Assistant	4		1.5%	
Other	22		7.7%	
	n	**Mean**	**Median**	**Range**
Length of time working as an HIV C&T counselor	241	6.4	5.3	0-17
HIV C&T experience in past year				
Number of clients pre-test counseled	265	188.7	60.0	0-1,679
Number of clients post-test counseled	259	137.2	50.0	0-1,430
Post-test counsel any HIV-positive clients?	269	46.9%	---	---
Number of HIV-positive clients post-test counseled	127	15.6	5.0	1-190

HIV Counseling and Testing Practices

Providers were asked about the frequency with which they discussed topics related to HIVRPN during pre-test and post-test counseling sessions with HIV-positive clients. Most counselors reported always discussing HIV reporting, PN and IPV risk during the pre-test counseling session. However, counselors discussed HIV reporting and PN more often than they discussed IPV. The vast majority of HIV C&T counselors reported being compliant with the HIVRPN legislation by discussing PN and IPV risk with clients who tested positive for HIV (Table 3).

Table 3: Topics Discussed During Pre and Post Testing Counseling Sessions*

Topic Discussed	Pre-test (n≈258)			Positive Post-test (n≈113)		
	% never	% some-times	% always	% never	% some-times	% always
HIV reporting	8.0%	8.0%	84.1%	7.1%	6.3%	86.6%
Options for anonymous/ confidential testing	3.1%	10.5%	86.4%	33.0%	23.9%	43.1%
Privacy/confidentiality of the HIV test result	0.0%	1.2%	98.8%	2.7%	3.6%	93.6%
Provider's role in reporting known partners to the health department	8.6%	12.9%	78.5%	6.3%	6.3%	87.5%
Self-notification of partners	7.6%	17.1%	75.3%	2.7%	10.6%	86.7%
Assisted notification	13.0%	14.6%	72.3%	6.3%	10.8%	82.9%
Availability of PNAP/CNAP	9.8%	18.1%	72.0%	2.8%	6.4%	90.8%
IPV risk to client if HIV-positive and partners are notified	9.0%	25.1%	65.9%	3.6%	6.3%	90.1%
IPV risk by client against partner(s) if HIV-positive	14.5%	25.4%	60.1%	3.6%	11.6%	84.8%
Referral for IPV services	18.7%	31.3%	50.0%	9.0%	21.6%	69.4%

Beliefs about Reasons for Not Testing

HIV C&T providers were asked about the reasons that clients may delay or avoid HIV testing. The percentage of respondents indicating each reason for delaying or avoiding HIV testing is provided in Table 4, as is the percentage that indicated each reason as being the *most important* reason. The most commonly endorsed reasons for clients to delay or avoid HIV testing were their fear of finding out that they were HIV-positive or clients' belief that there was a low likelihood that they were infected with HIV. Just over half of the counselors believed that the *most important* reason that clients delayed or avoided HIV testing was their fear of finding out that they were HIV-positive. While fear of named-reporting of HIV-positive results was cited as a reason to delay or avoid testing by 67.5% of counselors, less than 2% of counselors believed it was the most important reason.

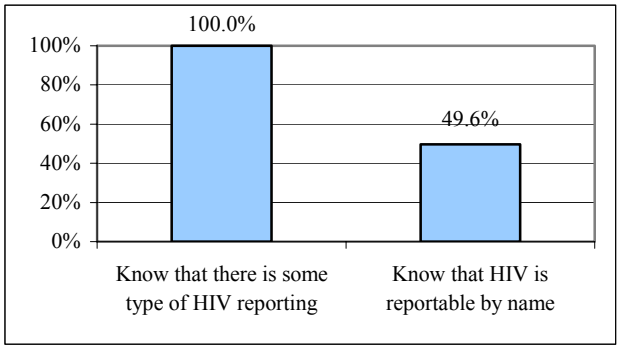
Table 4: Counselor Beliefs about Client Reasons for Delaying or Avoiding Testing

Reasons why clients delay or avoid HIV testing	A reason (n~280)	Most important reason (n=267)
Clients are afraid of finding out that they are HIV-positive	96.8%	51.3%
Clients perceive a low likelihood of being infected with HIV	93.3%	19.5%
Clients do not want to think about their own serious illness or death	93.2%	7.1%
Clients do not want others to think that they are HIV-positive	87.5%	4.1%
Clients are afraid of needles	63.7%	3.4%
Clients worried that name will be reported to government if HIV-positive	**67.5%**	**1.9%**

HIV Reporting: Knowledge, Practices and Attitudes

Although all HIV C&T providers were aware that there is HIV reporting in New York State, only half correctly identified New York as a name-based reporting state (Figure 6). Surprisingly, knowledge did not differ significantly by experience with post-test counseling of HIV-positive individuals: Fifty-three percent of those who had post-test counseled HIV-positive individuals in the past year correctly identified NYS's name-based reporting policy, compared to 46.7% of those who had not post-test counseled HIV-positive individuals (HIV post-test counseling experience comparison not displayed in Figure 6).

Figure 6: Percentage of HIVC&T Providers who Correctly Identify NYS HIV Reporting Law (n=274)



Partner Notification: Knowledge, Practices and Attitudes

We also assessed knowledge of the PN components of the HIVRPN legislation. Results of these questions are displayed in Table 5. Providers were very knowledgeable about the confidentiality of PN. However, counselors were less knowledgeable about other details of the PN component of the HIVRPN legislation. Nearly one-quarter were not aware that they were required to ask HIV-positive clients for identifying information about their partners and one-half did not know that partners known to the provider, but whose information was not disclosed by the client, had to be reported to the State Health Department. Approximately one-third of counselors did not know that individuals testing HIV-positive are not required to name partners. Finally, nearly half of the participants incorrectly believed that it was against NYS law for HIV-positive people to have unprotected sex.

Table 5: Knowledge of the PN Component of the HIVRPN Legislation

	N	% correct*
HIV C&T counselors who conduct PN never tell partners who exposed them to HIV	273	82.1%
HIV C&T counselors are required to ask HIV-positive clients for identifying information about sex and needle-sharing partners.	279	77.4%
HIV C&T counselors are required to report known contacts of HIV-positive clients to the state/local health department, even if the client does not disclose this information	274	48.9%
If a person tests HIV-positive, it is against New York State law to have unprotected sex with another person.	275	51.3%
* Answers to the first three statements are true, while the fourth statement is false.		

Partner Notification Assistance Programs

Providers were asked about their experiences working with the partner notification assistance programs operated by the State (PNAP) or NYC (CNAP) Health Departments. Just over one-fifth (22%) reported ever working directly with PNAP or CNAP to assist HIV-positive clients in notifying partners. Among those that had, 70% had done so five times or less (Figure 7). Similarly, just 21% reported ever being contacted by PNAP or CNAP to discuss PN for one of their HIV-positive clients (Figure 8).

Figure 7: Times Worked Directly with PNAP/CNAP to Assist HIV-Positive Clients in PN (n=278)

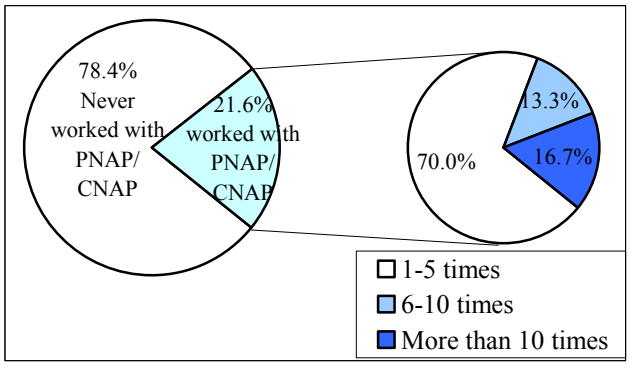


Figure 8: Contacted by PNAP/CNAP Staff to Discuss HIV-Related PN Involving One of Your Clients (n=283)

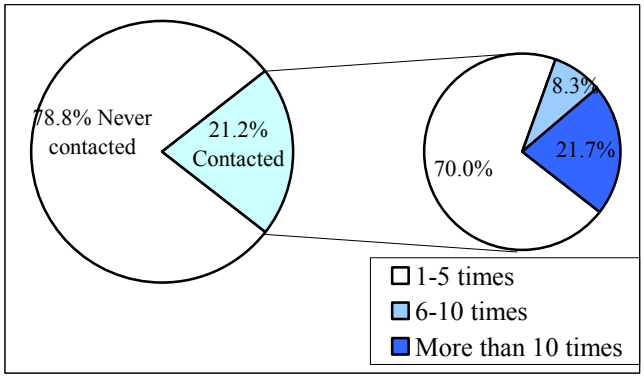


Table 6 reports the results of questions asking about attitudes towards various aspects of PN assistance programs. The majority of the sample believed that PN assistance programs facilitate PN, are safer than direct notification, do not invade the privacy of either HIV-positive clients or notified partners and are an effective way to get previously untested partners to be tested for HIV. However, many counselors believed that these programs may put HIV-positive people at risk for IPV and that partners may be able to figure out who named them.

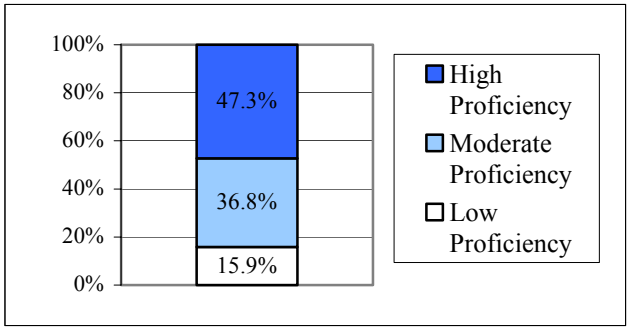
Table 6: Attitudes Towards PNAP (Note: "Don't know" Left in Denominator)

	n	% agree or strongly agree
PN assistance programs make it easier for HIV-positive person to notify partners	282	91.5%
PNAP/CNAP are effective means to get untested partner(s) to test for HIV.	278	86.7%
PN assistance programs are safer than direct notification	282	65.2%
PNAP/CNAP put HIV-positive person at risk for physical harm from partner	276	41.7%
Partners notified by PN assistance programs can figure out who named them	277	41.2%
PN assistance programs are too impersonal	277	16.6%
Providing partner names invades privacy of HIV-positive person	276	13.0%
Being notified by PN assistance programs is an invasion of privacy	277	11.2%

Partner Notification: Proficiency and Interest in Training

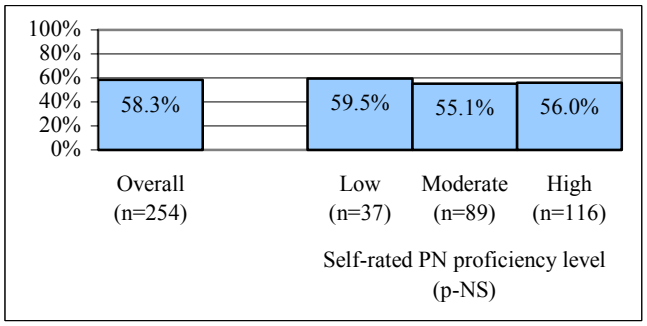
Providers were asked to rate their proficiency in 12 aspects of partner notification and indicate whether they were interested in receiving additional training on each aspect. Individual responses to these 12 items were used to create a summary proficiency score for each respondent. Figure 9 reveals that nearly half of the HIV C&T providers rated their proficiency in PN for HIV-positive patients as high, while 37% rated it as moderate. Just 16% self-rated their proficiency as low.

Figure 9: Overall Proficiency in Partner Elicitation and Notification for HIV Patients (n=258)



More than half of the counselors were interested in training on at least one aspect of PN (Figure 10). Interest in training did not differ significantly by self-rated proficiency level, however.

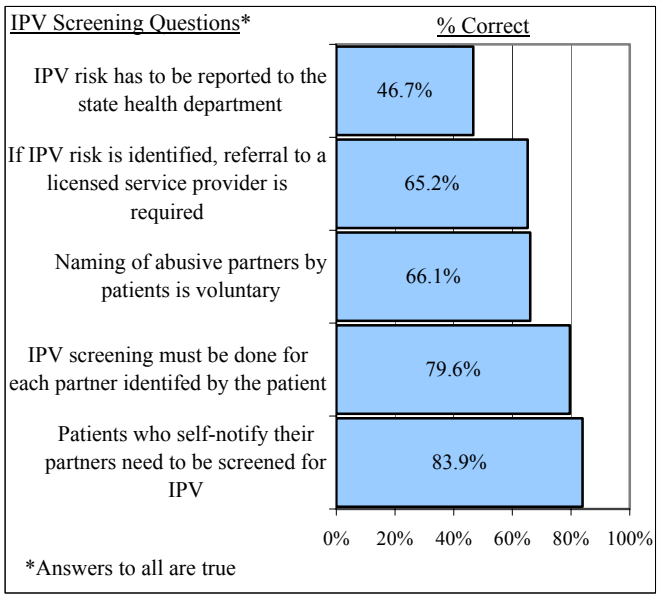
Figure 10: Interest in Training on at Least One of the 12 Aspects of PN



Intimate Partner Violence (IPV) Screening: Knowledge, Practices and Attitudes

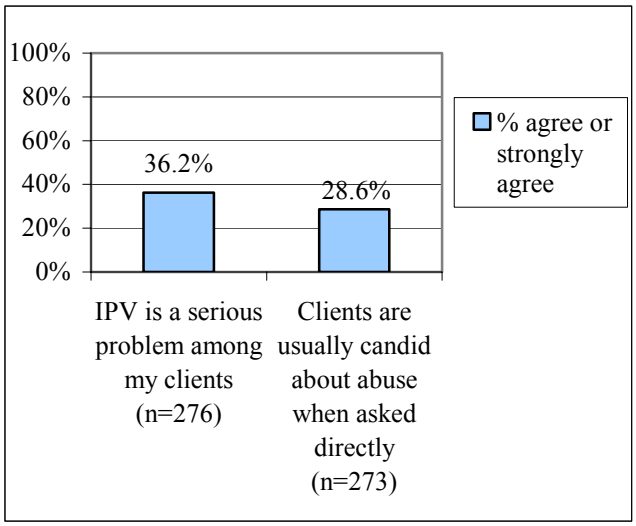
Providers' knowledge, attitudes and practices concerning the IPV screening requirements of the HIVRPN law were also assessed. Figure 11 reveals varying knowledge levels regarding the IPV screening requirements of the law. While the vast majority of providers knew that self-notifying patients must still be assessed for IPV (84%) and that the screening must be done separately for each partner named (80%), less than half knew that IPV screening results were reportable to the State Health Department. Additionally, just two-thirds knew that naming of abusive partners by the patient is voluntary, and that referral to a licensed IPV service provider is required when a risk for IPV is identified.

Figure 11. Knowledge of IPV screening Requirements When Diagnosing HIV (n≈280)



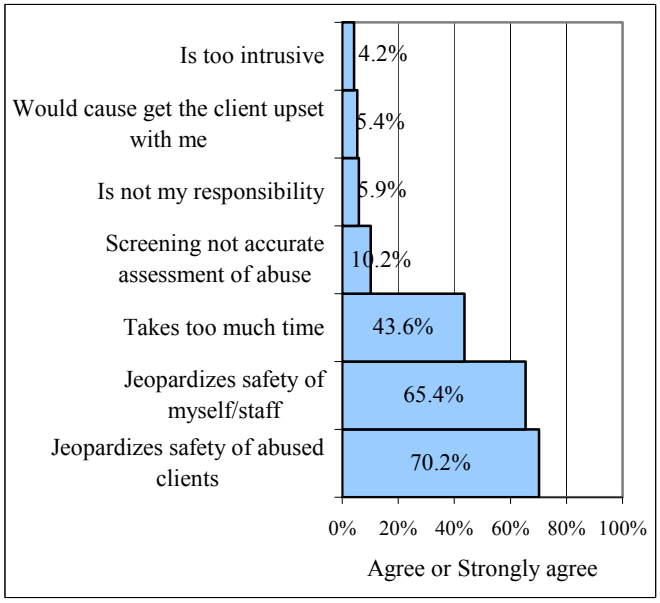
Providers were asked about the seriousness of IPV among their clients and about their ability to elicit candid responses when screening for IPV. Approximately one third of respondents believed IPV to be a serious problem among their clients, while just 29% felt that their clients were candid about abuse when questioned directly (Figure 12).

Figure 12: Beliefs about IPV



Providers were asked whether they agreed or disagreed with several statements concerning IPV screening. Results are displayed in Figure 13. Very few HIV C&T providers felt that IPV screening was too intrusive (4%), would upset clients (5%), was not their responsibility (6%) or that IPV screening would fail to accurately assess abuse (10%). However, providers did exhibit some concerns about IPV screening. They were more inclined to indicate that IPV screening was too time consuming (44%) and that it might jeopardize the safety of their clients (70%) and/or office staff (65%).

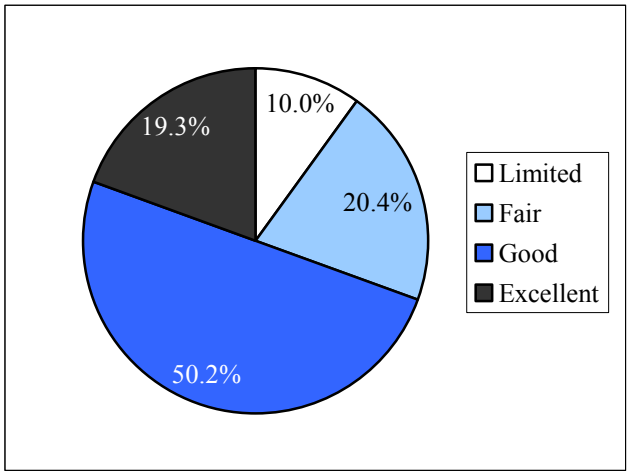
Figure 13: Perceived Barriers to IPV Screening (n≈276)



Proficiency and Interest in Training on IPV Screening

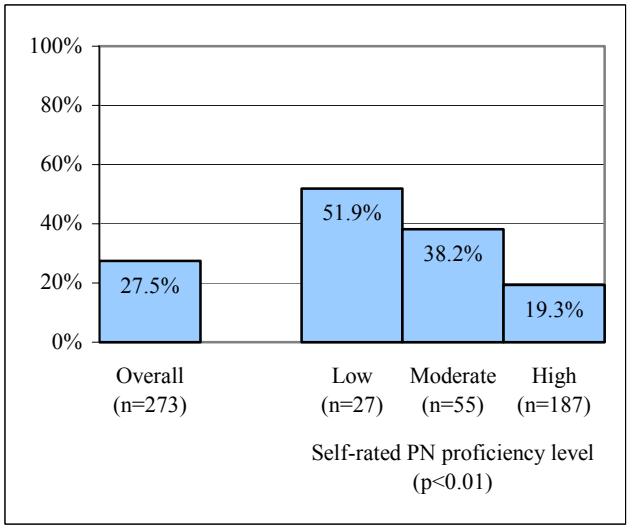
Nearly 70% of HIV C&T providers indicated that their proficiency in assessing patient concerns about risk of partner violence was good or excellent (Figure 14). Similarly, 70% felt that they had been well trained to conduct IPV screening (data not displayed in Figure 15).

Figure 14. Proficiency in Assessing Patient Concerns About Risk of Partner Violence (n=269)



Approximately one-quarter of respondents were interested in training on IPV screening (Figure 15). There was an inverse relationship between proficiency level and interest in training: HIV C&T providers who had a low proficiency in IPV screening were the most interested in training on IPV screening.

Figure 15: Interest in Training on IPV Screening by Self-Rated Proficiency in Assessing Patient IPV Concerns



Summary and Conclusion

The H-CAPS surveys provide data on the impact of New York's HIVRPN law from the perspective of the organizations and individuals who provide HIV counseling and testing services throughout New York State. HIV C&T services were of high priority in most of the agencies surveyed. C&T services were most commonly provided by nurses and nurse practitioners, followed by dedicated HIV test counselors and then mental health/case management workers. Staff in almost all agencies had received training on the HIVRPN

legislation. Common sources of training included the agency itself, followed by local or state health departments and regional training centers.

Agency supervisors perceived an increase in the demand for HIV C&T services over the past three years, but did not attribute this increase to the HIVRPN law. Very few agencies indicated that their capability to provide C&T services had decreased over the past three years.

Most agencies were familiar with NYS guidelines for integrating IPV screening into HIV counseling and testing activities and 80% reported using those guidelines to develop or modify its own IPV screening protocols.

HIV C&T providers rated themselves as proficient at various partner elicitation and notification tasks. Likewise, perceived proficiency in conducting IPV screening was also relatively high. Despite high rates of training and perceived proficiency, knowledge of many of the specifics of the HIVRPN law was still relatively low. Just one-half of counselors surveyed were able to correctly identify how HIV-positive test results are reported in New York State. Respondents were particularly confused with the PN and IPV aspects of the law. For example, approximately one-third of the sample was unaware that naming partners was not mandatory for those testing HIV-positive, while about one-half did not realize that they are required to report known contacts of HIV-positive clients, even if the clients do not disclose these contacts to the provider. Similarly, less than half the sample knew that IPV screening results must be reported to the State, while one-third did not realize that a referral to a licensed service provided is required for those with an identified risk of IPV.

HIV C& T providers in the sample had varied experience with HIV C&T: Some individuals reported counseling over 1,500 clients in the past year, while others had counseled none during the same time period. Although providers reported almost always discussing HIV reporting, PN and IPV risk during the pre- and post-test counseling sessions, their imperfect knowledge of important aspects of the law sheds uncertainty on what is actually being conveyed to clients during HIV C&T sessions. More than half of respondents were interested in training on at least one aspect of PN and just over one-quarter were interested in training on IPV screening. Given the confusion that apparently exists about some aspects of the law, additional training on these aspects should be encouraged.

C&T providers believed that clients delayed or avoided HIV testing primarily because they didn't want to know that they were HIV-positive. Fear of named reporting was commonly chosen as a possible reason for their clients to delay or avoid testing, however very few providers thought this to be the most important reason. Data from the H-TAPS component of this grant clearly indicate that the testing decisions of high-risk individuals are not influenced by concern about HIV reporting. In fact, just 5% of high-risk individuals indicated concern about their name being reported by the government as a reason for testing avoidance or delay, with just 0.3% choosing this as the most important reason (see Component 4 results). Since many C&T providers appear to believe otherwise, this finding from H-TAPS should be made widely available to HIV test counselors throughout New York State.

Finally, less than one-quarter of the sample had ever had contact with partner notification assistance programs operated by the NYC and NYS Health Departments. While contact with the programs was low, perceptions of the programs were positive. Given this, attempts at increasing communication between these programs and HIV testing providers would likely be well received.

Limitations

Completed surveys were returned by agencies and by HIV C&T providers directly to the Department of Health, which regulates HIV reporting and partner notification activities. In addition, the data were obtained through self-report. Both of these factors could have resulted in socially desirable responding, however, respondents were assured that all data would be maintained in a confidential manner and that their responses would be grouped with others and used for research purposes only.

Although a statewide listing of HIV C&T agencies existed, there was no listing of specific individuals engaged in HIV C&T activities. This fact necessitated that we rely on C&T agency supervisors to distribute the survey to, and consequently follow up with, C&T staff. The study team never had direct contact with the counselors. This method affords less control over the response rate and efforts to increase it. The resulting response rate was 43% and, therefore, the results may not be generalizable.

Component 6

STD-CONTACT:
A Survey of Physicians in New York State

General Findings Report

Office of Program Evaluation and Research
NYS Department of Health AIDS Institute
CDC Grant: R06/CCR218723

Overview

The United States has the highest rates of curable STDs in the developed world. That, coupled with the extended life that is possible with highly active antiretroviral treatment (HAART) for those with HIV, makes it important that partners of those testing positive for HIV and STDs be notified of their exposure risk as soon as possible. Recent evidence from the National Health and Social Life Survey (a population-based household survey of the sexual behavior of Americans) suggests that a significant portion of STD diagnoses take place in the private health care sector. In fact, 62% of respondents with an STD in the previous year indicated that they received their diagnosis from a private doctor or group practice.[1] However, most research on STD diagnosis and contact tracing trends takes place in publicly funded STD clinics. Little is known about private physicians' experience with STDs and their clinical practices regarding STD management.[2]

Under the HIV Reporting and Partner Notification (HIVRPN) law in New York State (NYS), physicians are required to report newly diagnosed cases of HIV to either the New York City or New York State Department of Health. In addition, the law requires that health care providers report known contacts of newly infected individuals and attempt to elicit other sex and needle sharing partners to increase the number of partners being notified of their exposure risk. Intimate partner violence (IPV) screening must be conducted for each partner identified. Given the expanded role of physicians in HIV reporting and partner notification, it was deemed important to assess their knowledge, attitudes and practices surrounding the new law. This study sought to identify NYS physicians' current attitudes, practice patterns and training needs regarding STD and HIV reporting, notification of partners, and screening for IPV.

The Centers for Disease Control and Prevention (CDC) conducted a national survey in 1999 to examine the STD clinical practices of private physicians. This survey took place before New York State's HIVRPN was enacted in June, 2000. The CDC agreed to provide NYS-specific data for 1999 to the New York State Department of Health (NYSDOH) to use for a baseline comparison. A second statewide survey conducted by the NYSDOH took place in early 2003, approximately 2.5 years after enactment of the HIVRPN. This survey was a collaboration with the NYS STD/HIV Prevention Training Center, which was able to support the direct costs of the survey (with its added training assessment dimensions) with funding it receives for partner services training from the Training and Health Communications Branch in the Division of STD Prevention at CDC. This report will provide descriptive results from both the pre-law (1999) and post-law (2003) surveys. More in-depth analyses examining relationships between knowledge, attitudes and practices will be the subject of separate publications.

Methods

Sample

Both the pre- and post-law surveys used the American Medical Association Masterfile[a] to randomly select a sample of physicians (MDs and DOs) in five medical specialties: Internal medicine; family/general practice; obstetrics/gynecology; pediatrics; and emergency medicine. These specialties were chosen based on evidence that they provided care for 85% of STDs diagnosed in the US and that the percentage of physicians from other specialties who treat STDs is small.[2,3,4] Additional inclusion criteria were that physicians have a primary practice address in New York State, spend at least 50% of their professional time in direct patient care and that they care for patients between the ages of 13 and 60.

The data provided to the NYSDOH by the CDC from the 1999 national survey included 295 physicians practicing in NYS. The CDC survey had a national response rate of 70%, however, information on state-specific response rates was not available.[2]

The 2003 sample was stratified by four regions of New York State: New York City, Greater Metropolitan Area, Western NY and Central/Northeastern NY. A total of 2,000 physicians were included in the original sample. However, 627 physicians were deemed ineligible to participate because: Current contact information was unavailable (222 physicians); they were no longer practicing in one of the eligible specialties in NYS (182); they felt that they were ineligible because they saw few or no patients with STDs or HIV in the specified age range (181); or they felt they were ineligible for other or unspecified reasons (42). A total of 835 out of the remaining 1,373 eligible physicians completed the NYSDOH post-law survey, resulting in a response rate of 61%. Region-specific response rates ranged from 55.9% in New York City to 66.1% in Western NY.

Survey

The Sexually Transmitted Disease Clinical Observation, Notification, Tracing and Control Techniques (STD-CONTACT) survey was developed by CDC for use in the national study conducted in 1999. This survey collected information on STD screening, testing, case reporting, partner notification and clinical behaviors. The 2003 version, created by staff from the New York State Department of Health, was a partial replication of STD-CONTACT: Original survey questions were maintained and additional questions were added to collect information on IPV screening practices, knowledge of New York State's HIV and STD reporting laws, and proficiency and interest in training in specific partner elicitation and partner notification tasks.

[a] The Master File contains information on all licensed physicians, not just American Medical Association members. Those physicians who indicate to the AMA that they do not want their contact information released (2%) were not included in the sample.

Procedure

Survey packets were sent via FedEx to the physician's preferred mailing address. For both the pre- and post-law surveys, packets included a cover letter, survey booklet, business reply envelope and an incentive check of $15. A $15 incentive was used by CDC in the national STD-CONTACT study, based on results of a preliminary study which found that an incentive of this level was needed to maximize returns from busy clinicians.[5] Initial survey packets were sent via FedEx so that they might bypass office staff and be delivered directly to the intended physician. Non-responders were sent a reminder postcard 10 days after the initial mailing, and repeat surveys at approximately 4, 7, 11 and 15 weeks. At the end of the follow-up period, the database connecting names with survey identification numbers was destroyed, rendering the survey responses anonymous.

For both surveys, each sampled physician was sent a cover letter including a statement of informed consent. This statement discussed the purpose of the CONTACT survey, its procedures, the potential risks and benefits of participation, confidentiality, incentives, and the right to refuse or withdraw. In this statement were instructions indicating that completion and return of the survey constituted passive consent to participate in the study.

Weighting of Data

The 2003 data were weighted to adjust for stratification of the sample and regional differences in response rates. Weighting allowed the study to be generalizable to physicians in New York State and did not alter the number of physicians included in the analysis (n=835). The weight for each region was the product of two sub-weights. The first sub-weight compared the percentage of physicians in the region in the AMA database to that in the survey sample. The second sub-weight compared the expected number of respondents in each region if there had been no differences in regional response rates to the actual number of respondents in the region.

Results

Description of the Samples

The samples of physicians surveyed before (1999) and after (2003) the enactment of the HIVRPN law were similar to each other in most areas, with most statistically significant differences being relatively small in absolute magnitude. The variables in which they were most discrepant were specialty (post-law participants were more likely to specialize in internal medicine) and current employment setting (post-law participants were more likely to be residents or interns and less likely to be self-employed). These differences are most likely due to the fact that residents were included in the post-law sample, but not in the pre-law sample. Descriptions of differences between the physicians surveyed before and after the law can be found in Table 1.

While it was not asked in the pre-law survey, it is interesting to note that nearly half of the post-law sample completed medical school outside of the United States and Canada.

Differences in physician practice characteristics between the two samples are, again, largely attributable to the inclusion of residents in the post-law sample. Post-law participants were more likely to practice in hospital settings and had fewer years of primary practice experience.

Physicians saw, on average, between 72 and 93 patients per week, with post-law participants seeing fewer patients and higher percentages of Hispanic and white patients.

Table 1: Physician and Patient Characteristics in Pre- and Post-Law Surveys

	Pre-law (1999) (n = 295)	Post-law (2003) (n = 835)	p-value
Mean age (years)	47.8	44.7	<0.01
Gender			
Male	66.9%	61.5%	NS
Female	33.1%	38.5%	
Race/Ethnicity			
Hispanic	5.2%	8.4%	NS
Non-Hispanic White	65.4%	60.7%	
Non-Hispanic Black	6.6%	7.7%	
Non-Hispanic Asian	21.3%	21.1%	
Non-Hispanic Other	1.4%	2.2%	
Primary Specialty			
Internal Medicine	**28.1%**	**40.8%**	<0.05
Pediatrics	28.8%	23.6%	
Family Practice	17.3%	14.2%	
Obstetrics/Gynecology	15.6%	13.6%	
Emergency Medicine	8.1%	6.1%	
General Practice	2.0%	1.7%	
Mean years practicing medicine	19.4	16.4	<0.01
International medical graduate	N/A	45.7%	N/A
Mean hours per week in direct patient care	40	44	<0.01
Current employment			
Self-employed or a partner in an office/clinic	49.5%	38.0%	<0.01
Office or clinic employee	47.4%	34.0%	
Hospital employee	0.0%	8.6%	
Resident fellow or intern	**0.3%**	**14.0%**	
Other	2.8%	5.5%	
Primary Practice Location			
Primary care office	65.3%	51.8%	<0.01
Hospital setting	24.5%	35.8%	
Community/public/urgent care/other	10.2%	12.5%	
Mean years at primary practice	10.7	8.3	<0.01
Mean # patients seen per week	93.4	72.2	<0.01
Gender of patients			
Female	61.6%	60.4%	NS
Male	38.4%	39.6%	
Hispanic/Latino ethnicity	17.7%	24.3%	<0.01
Race of Patients			
White	58.2%	64.5%	<0.01
Black	25.0%	19.3%	<0.01
Asian	6.5%	6.9%	NS
Other	10.1%	7.4%	<0.05

HIV Diagnosis and Screening

The majority of physicians in both samples had diagnosed HIV, however, physicians in the post-law survey were more likely to have diagnosed HIV (ever) than those in the pre-law survey (Figure 1). Approximately one-third of each sample had diagnosed HIV in the past year (Figure 2).

Overall, approximately one-third of physicians reported routinely screening their asymptomatic patients for HIV. There was no significant difference between the pre- and post-law surveys on this practice, overall, by gender, or by patient pregnancy status (Figure 3).

Figure 1: Percentage of Participants in Pre- and Post-Law Surveys Who Ever Diagnosed HIV (p=<0.01)

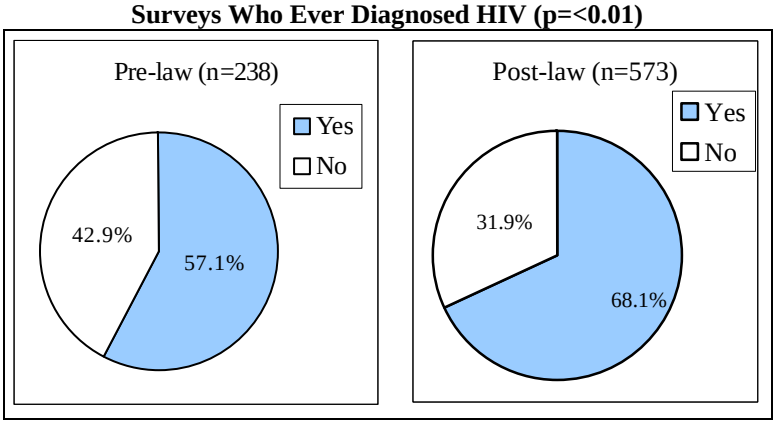


Figure 2: Percentage of Participants in Pre- and Post-Law Surveys Who Diagnosed HIV in the Past Year (p-NS)

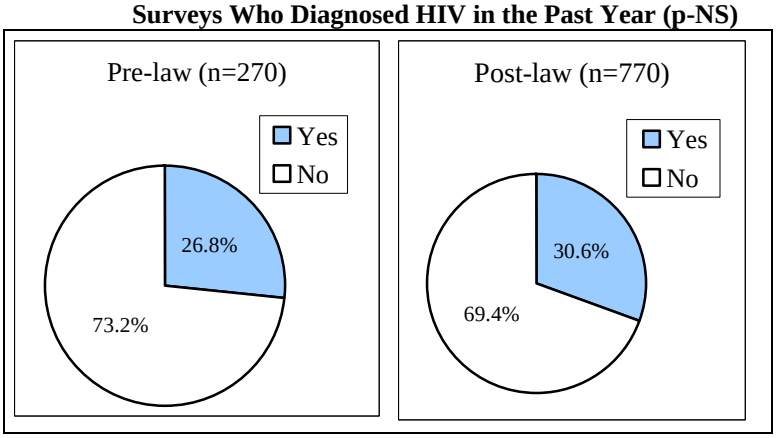
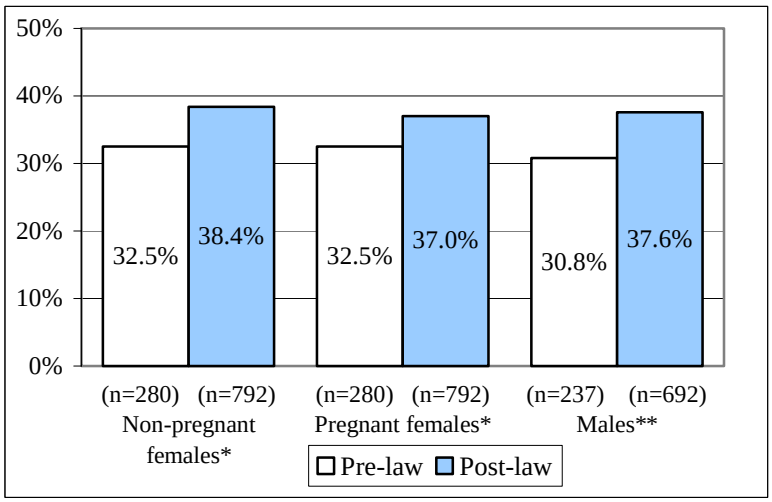


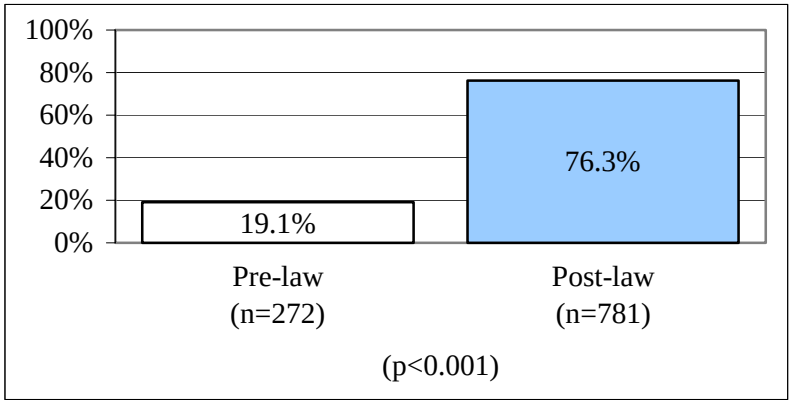
Figure 3: Screening Asymptomatic Patients for HIV in Pre- and Post-Law Surveys (All Pre/Post Law Comparisons NS)



*Physicians who treat any females in their primary practice
**Physicians who treat any males in their primary practice

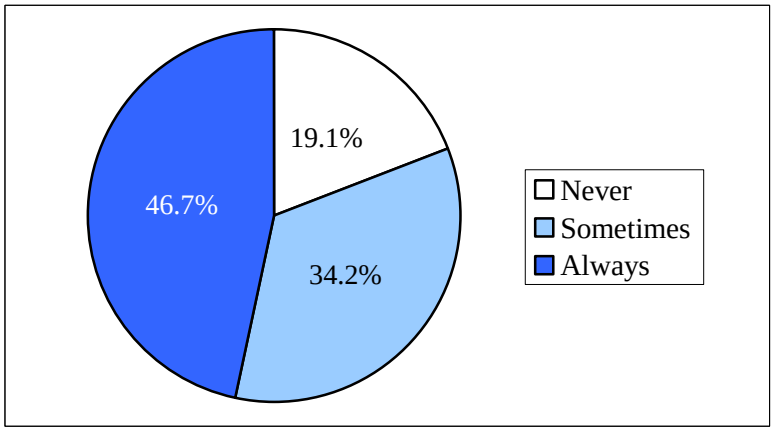
Prior to the HIVRPN law, physicians had very low levels of knowledge regarding whether physicians were required to report HIV to the Department of Health (they were not required to report prior to June 2000). Physicians who were surveyed after the HIVRPN law went into effect were fairly knowledgeable about their roles in HIV reporting, with 76% correctly responding that physicians are required to report (Figure 4).

Figure 4: Percentage of Physicians Correctly Identifying the HIVRPN Law in Pre- and Post-Law Surveys (p<0.01)



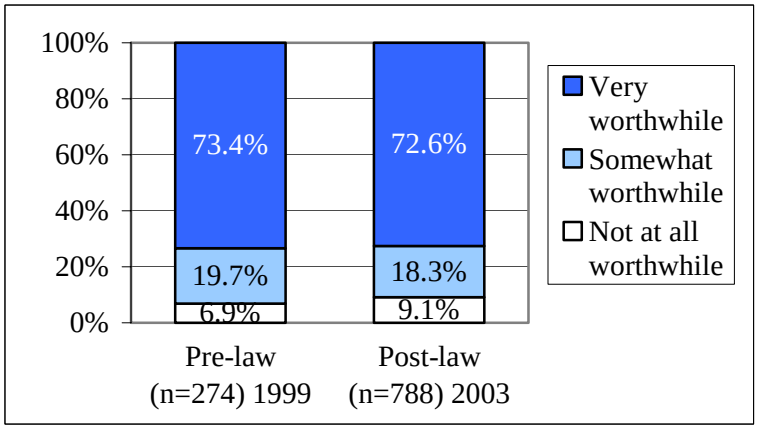
Physicians in the post-law survey were asked how frequently they reported newly diagnosed cases of HIV. Of those who had ever diagnosed HIV, nearly half of post-law participants indicated that they always reported HIV, while 34% indicated that they "sometimes" report (Figure 5). Nearly one-fifth responded that they never report new cases of HIV infection. Physicians who had diagnosed HIV within the past year (as opposed to ever; n = 264) had a similar frequency of HIV reporting (43.6% always, 28.4% sometimes, 28.0% never) (data not shown).

Figure 5: Frequency of HIV Reporting among Physicians Who Have Ever Diagnosed HIV (Post-Law Only, n = 321)



The majority of physicians taking part in both surveys considered named HIV reporting to be a worthwhile mechanism for controlling the spread of HIV, with no significant changes in the perceived worthiness of named HIV reporting between the pre- and post-law surveys (Figure 6).

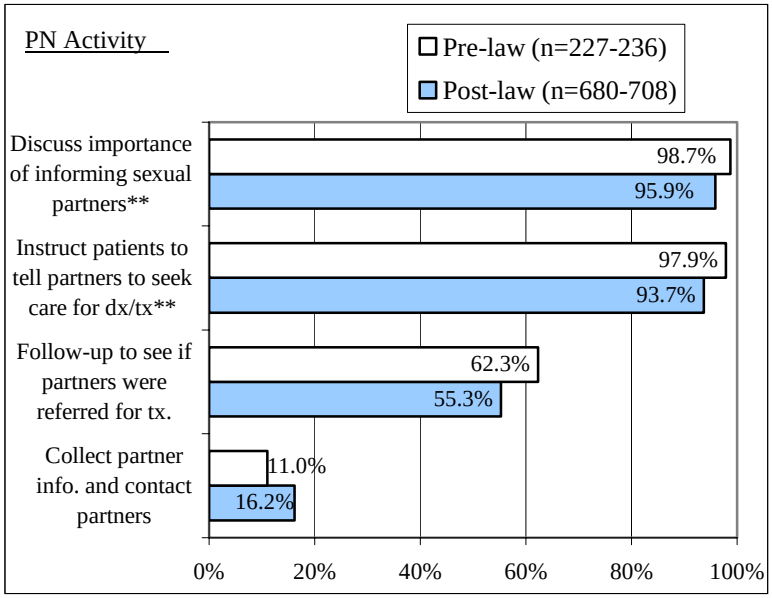
Figure 6: Worthiness of Named HIV Reporting for Controlling the Spread of HIV in Pre- and Post-Law Surveys (p-NS).



Partner Notification: Practices

Nearly all respondents reported speaking with their HIV-positive patients about the importance of notifying their partners. However, physicians were much less likely to report that their staff actually collects partner information and contacts partners themselves (Figure 7). There was little change in physicians' PN practices between the pre- and post-law surveys.

Figure 7: Physicians' PN Activities When Diagnosing HIV in Pre- and Post-Law Surveys*



*Percentages refer to those who reported "usually" or "always" engaging in each PN activity. Includes only those physicians who have ever diagnosed HIV.
**Significant difference between 1999 and 2003 ($p < 0.05$)

Partner Notification Assistance Programs

Physicians who participated in the post-law survey were asked specifically about their experiences with partner notification assistance programs. The majority of physicians reported no direct contact with their Health Department PN program. In fact, just 38% of physicians reported ever referring a patient to a partner notification assistance program (Figure 8). Those who did report referring a patient with an STD or HIV to the local Health Department's PN program had done so only once or twice (data not shown).

Just 24% reported ever being contacted by PN assistance program staff to discuss one of their patients, with 65% of these physicians reporting just 1 or 2 contact(s) (Figure 9).

Despite relatively low levels of contact between physicians and PN assistance programs, 84% of those physicians with at least some contact reported favorable impressions of these programs (Figure 10).

Figure 8: Referrals to Partner Notification Assistance Programs by Physicians Who Have Diagnosed HIV/STDs in the Past Year (n=628) (Post-Law Only)

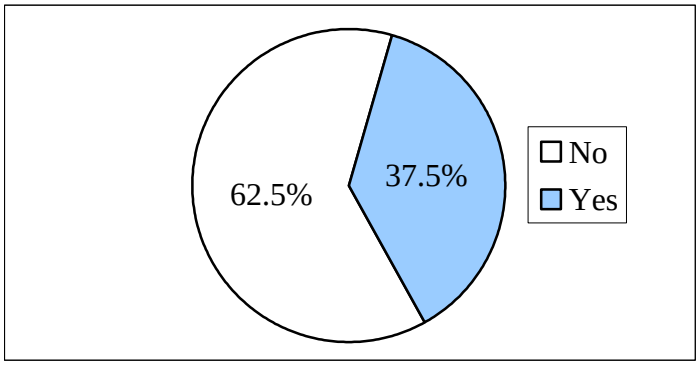


Figure 9: Prevalence and Frequency of Being Contacted by PN Assistance Program Staff Among Physicians Diagnosing HIV/STDs in the Past Year (n=669) (Post-Law Only)

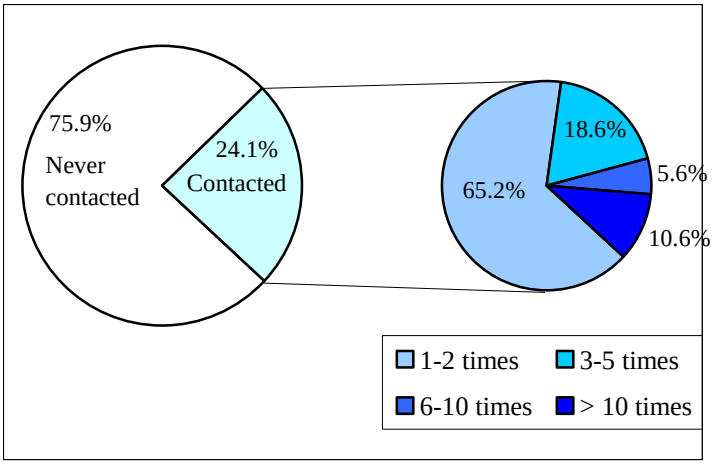
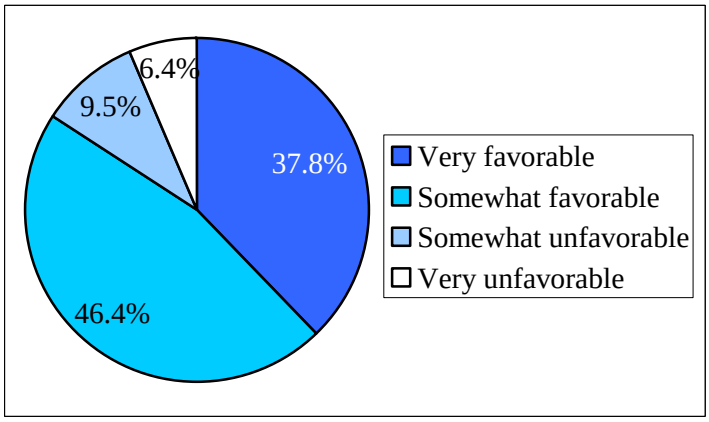


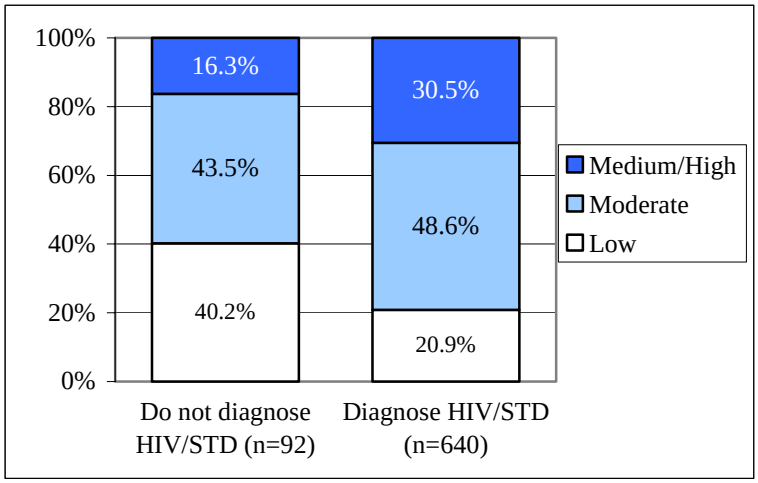
Figure 10: Impressions of the Local or State PN Assistance Programs (n=309) (Post-Law Only)



Partner Notification: Proficiency and Interest in Training

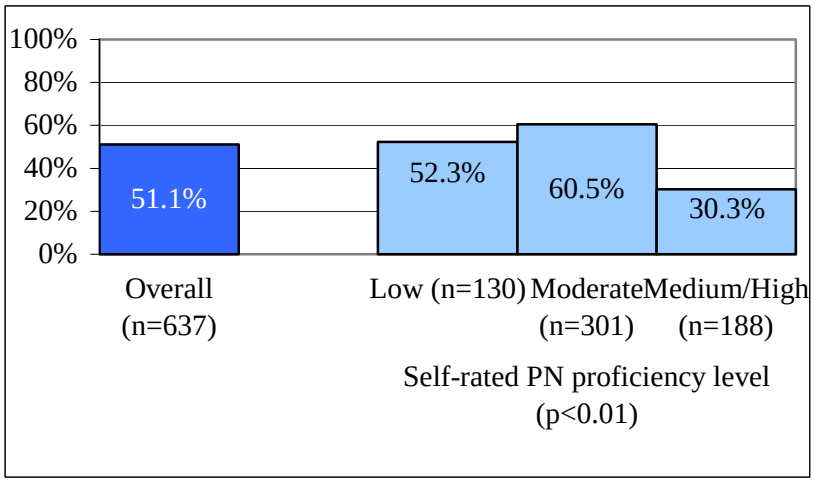
Physicians surveyed after the law were asked to rate their proficiency on 13 separate aspects of partner elicitation and notification. While proficiency varied by task, a composite proficiency summary score showed nearly half of physicians felt moderately proficient in conducting partner elicitation and notification (Figure 11). As expected, physicians who had experience diagnosing HIV or STDs felt more proficient than physicians who did not diagnose HIV or STDs.

Figure 11: Physicians' Proficiency in Partner Elicitation and Notification for HIV/STD Patients (Post-Law Only) (p<0.01)



Physicians were also asked about their interest in training on 13 aspects of partner elicitation and notification. Just 51% of physicians expressed an interest in training on any of these 13 aspects (Figure 12). Physicians rating themselves as moderately proficient in conducting partner elicitation and notification were more interested in training than those with either low or high self-rated proficiency. Eighty- nine percent of physicians were interested in additional information on best practices related to partner elicitation/notification (data not shown).

Figure 12: Physicians' Interest in Training on at Least One Aspect of PN Among Physicians Diagnosing HIV/STDs in the Past Year (Post-Law)



Intimate Partner Violence (IPV) Screening:
Knowledge, Practices and Attitudes

Physicians' knowledge, attitudes and practices concerning NYS's policies on IPV screening during HIV counseling and testing were assessed in the post-law survey. Overall, physicians possessed very low knowledge levels regarding IPV screening protocols. For example, while 59% of physicians were aware that IPV screening must be done separately for each partner named, just 38% knew that IPV screening results were reportable to the NYSDOH (Figure 13). Additionally, approximately two-thirds wrongly believed that patients are mandated to name abusive partners.

Approximately two-thirds of physicians surveyed after the law reported having ever screened any of their patients for IPV (Figure 14). However, physicians reported that the majority of their patients who were seen within the last year were not screened, with only 4% indicating that they screened all of their patients (Figure 15).

Figure 13. Physician Knowledge of IPV Screening Requirements When Diagnosing HIV (n=774-783) (Post-Law Only)

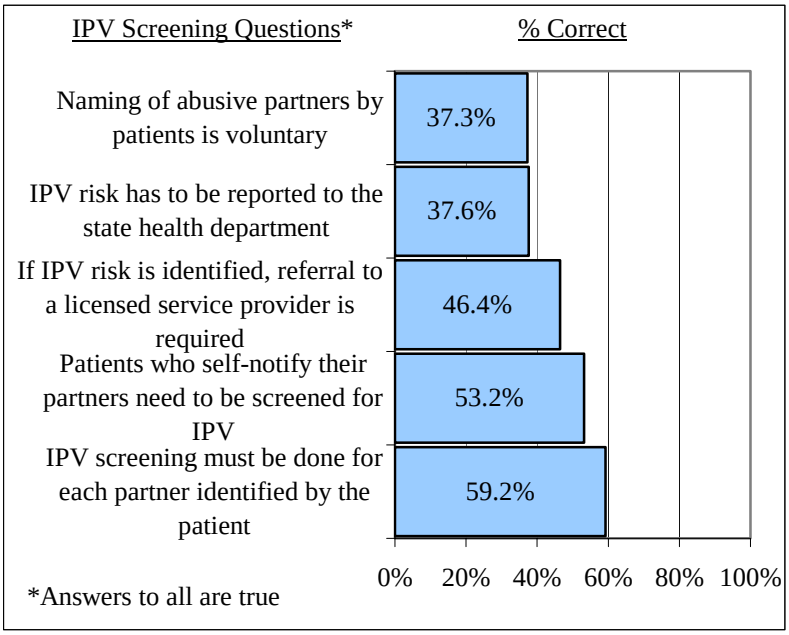
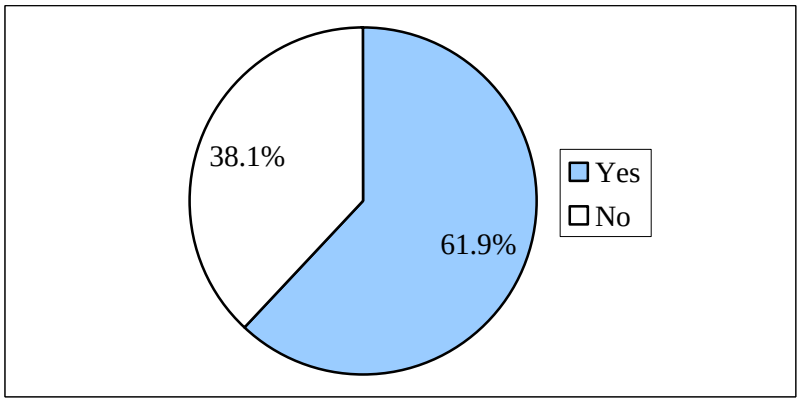


Figure 14: Percentage of Physicians Who Ever Screened atients for IPV (n=791) (Post-law)



Physicians who have ever screened patients for IPV were asked about the seriousness of IPV among their patients and about their ability to elicit candid responses when screening for IPV. Approximately two-thirds of respondents indicated that they believed IPV to be at least somewhat of a problem among their patients (Figure 16). Physicians also felt that their patients were usually at least "somewhat" candid about abuse when questioned directly, perhaps indicating that physicians do find IPV screening to be an effective means for detecting partner violence.

Figure 15: Percent of Patients Screened for IPV in the Past 12 Months by Physicians Who Ever Screened Patients for IPV (n=456) (Post-Law)

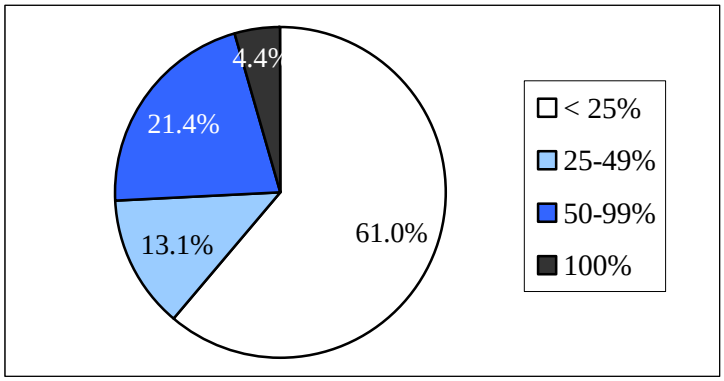
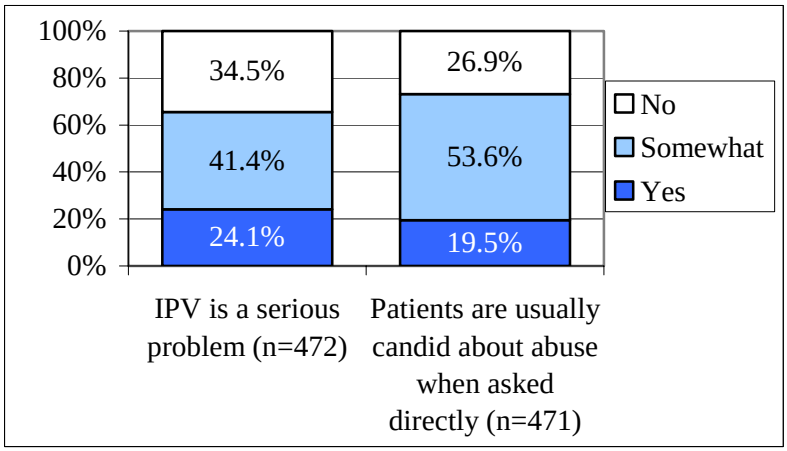


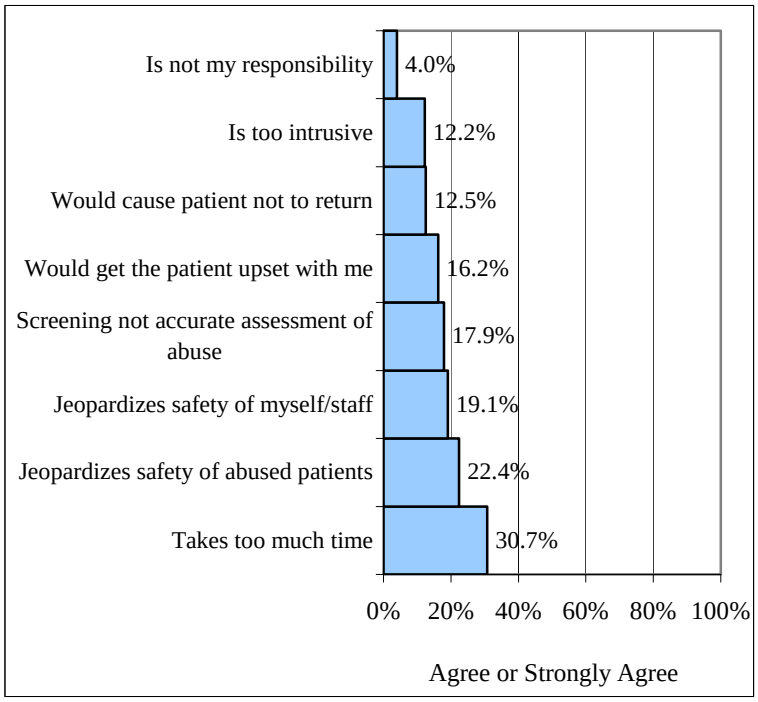
Figure 16. Physician Beliefs about IPV (Among Those Who have Ever Screened) (n=490) (Post-Law)



Intimate Partner Violence Screening:
Knowledge, Practices and Attitudes-Continued

Physicians were asked whether they agreed with several statements about IPV screening (Figure 17). Very few physicians felt that IPV screening was not their responsibility (4%), was too intrusive (12%), would upset (16%) or cause patients not to return (13%), or that IPV screening would fail to accurately assess abuse (18%). However, physicians did exhibit some concerns. They indicated that IPV screening was too time consuming (31%) and might jeopardize the safety of patients (22%) and/or office staff (19%).

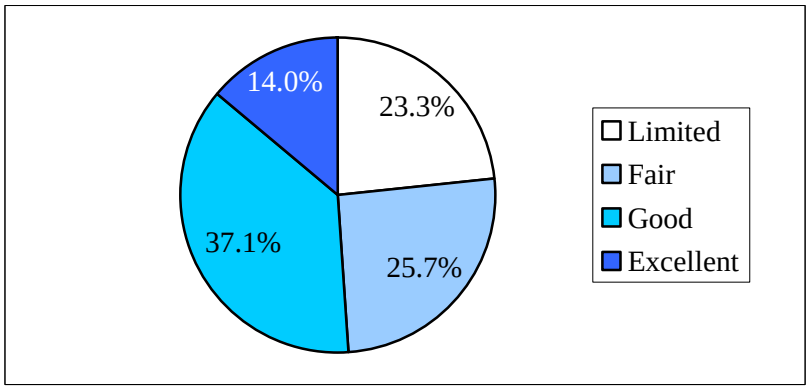
Figure 17: Physicians' Agreement with Statements Concerning Barriers to IPV Screening (n=753-759) (Post-Law)



Proficiency and Interest in Training on IPV Screening

Approximately half of physicians surveyed rated themselves as being proficient (good or excellent) in assessing patients' IPV concerns (Figure 18). However, 60% of physicians felt that they were not well trained to conduct IPV screening (Figure 19). In fact, only about one-third (33.1%) of physicians who had ever screened patients for IPV had actually received formal training on conducting IPV screening (data not shown).

Figure 18: Physicians' Perceived Proficiency in Assessing Patient Concerns about Risk of Partner Violence (n=773) (Post-Law)



Proficiency and Interest in Training on IPV Screening-Continued

Despite low levels of training, physician interest in receiving training on IPV screening was low, and varied only moderately with self-rated proficiency at assessing patient IPV concerns (Figure 20). For example, overall just 24% of physicians were interested in receiving training on IPV screening, including just 34% of those with "limited" proficiency in this area.

Figure 19: Staff/Self Not Well Trained to do IPV Screening (n=758) (Post-law)

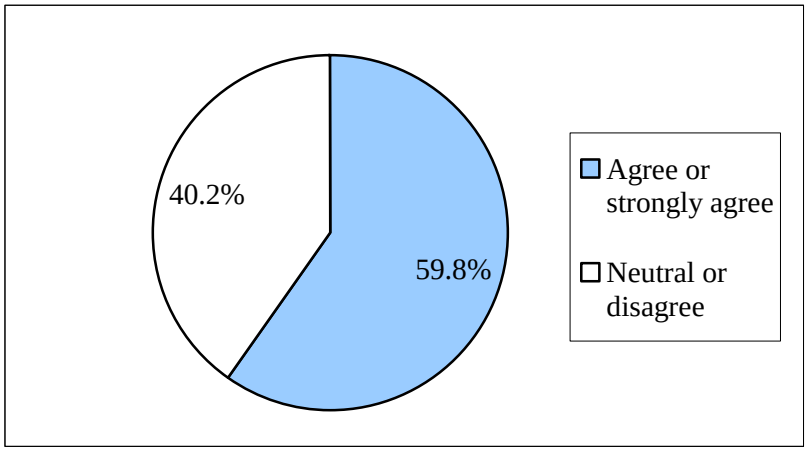
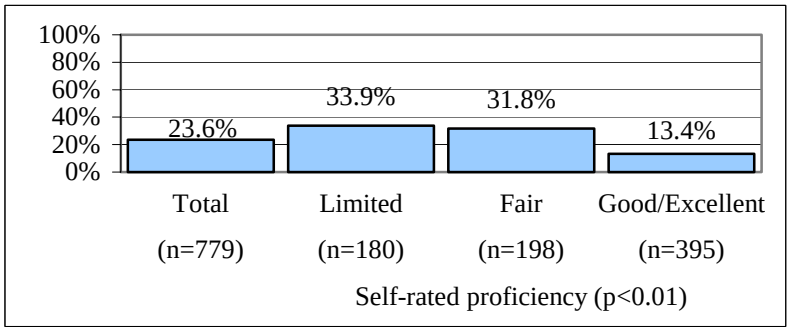


Figure 20: Physician Interest in Training on IPV Screening by Self-Rated Proficiency in Assessing Patient IPV Concerns (Post-Law)



Discussion

This study, which combined data from 1999 and 2003, provided a natural comparison to examine the impact of the HIVRPN legislation on physician knowledge, attitudes and practice. Knowledge of the way in which HIV-positive test results are reported increased significantly after the law took effect. However, physicians surveyed after the law went into effect were considerably less knowledgeable about the IPV screening components of the law than they were about the named reporting component.

The majority of physicians had diagnosed HIV during their careers and of those, the majority had reported it at some point. However, approximately two-thirds of both samples indicated that they do not routinely screen their asymptomatic patients for HIV. Additionally, less than one-half of physicians completing the post-law survey indicated that they always report HIV infections to the state. This is concerning given that reporting of newly diagnosed HIV cases is now required in NYS. This may indicate that physicians need additional follow-up in order to consistently report HIV to the NYSDOH. On a more promising note, almost three-quarters of both samples believed that named HIV reporting was a worthwhile activity for controlling the spread of HIV.

Physicians felt strongly that discussing partner notification with their patients diagnosed with HIV was a worthwhile activity. Upon further investigation, however, it became clear that physicians preferred patient-directed notification over physician-assisted notification. Physicians were supportive of local partner/contact notification assistance programs, despite having limited contact with them. The fact that physicians reported only moderate levels of proficiency in partner elicitation and notification activities may indicate a need for further training in this area if they are to play a primary role in partner elicitation and notification. It also raises the question of whether it is realistic to expect physicians to be proficient in this role, let alone to have sufficient time in the medical encounter to thoroughly address it. An alternate approach would be to encourage them to work more directly with and actively refer to Health Department partner notification programs which maintain staffs of disease intervention specialists who have received in-depth standardized training on partner elicitation and notification skills. It is particularly notable that "describing the services available through the Health Department's partner notification program" was one of the areas where physicians felt least proficient. That about half of physicians reported a desire for additional training, suggests that, if offered, efforts should be made to ensure that trainings are easily accessible, offer continuing education units (CEUs) and provide the relevant information in an interesting and timely manner in order to maximize physician attendance. Other forms of technical assistance could also be considered, given the very high level of interest in additional information on best practices related to partner elicitation/notification.

New York's HIVRPN law requires intimate partner violence screening for all partners being reported to the NYSDOH. Physicians' knowledge of the screening and partner reporting process was relatively low. Although most physicians acknowledged that IPV is a serious problem for their patient population, very few physicians reported regular IPV screening of their patients. Physicians identified safety and time-related barriers to conducting IPV screening with patients. Finally, while approximately half of physicians rated their proficiency in conducting

IPV screening as good/excellent, most indicated that they had never actually received training on how to do it, and few expressed an interest in receiving such training.

Limitations

Completed CONTACT surveys were returned by physicians directly to the NYSDOH, which regulates HIV reporting and partner notification activities. In addition, the data were all obtained through physician self-report. Both of these factors could have resulted in socially desirable responding, however, physicians were assured that all data would be maintained in a confidential manner and that their responses would be grouped with others and used for research purposes only.

The response rate for the post-law survey of 61%, while moderately acceptable, may preclude generalizing results to the targeted physician population in NYS. In addition, only the five specialties believed to provide 85% of STD care were sampled. This excluded input from physician populations that provide the remaining 15% of care to individuals with STDs.

Finally, the two samples, although similar, did differ slightly on physician, patient and primary practice characteristics (possibly due to the inclusion of residents in the post-law sample only). It is not known the extent to which these differences between the samples affected the study's results.

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