

Partner Notification for HIV: Running Out of Excuses

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No excuses offered anyway.

The Rolling Stones

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RELUCTANCE TO CONDUCT partner notification (PN) for HIV infection may be ebbing after nearly 20 years at high tide. Two studies appearing in this issue of the journal ought to accelerate the ebb.^{1,2} They provide evidence that HIV PN neither promotes risky sexual configurations nor partnership violence or dissolution. These imagined fears ought to be the last in a long line of untested scenarios advanced by opponents of HIV PN since the beginning of the epidemic.

In the early 1980s, opponents argued that there was no need to notify partners of AIDS cases because there was no test for infection. By mid-1985, availability of reliable HIV antibody tests helped shift grounds for objection to fear that PN would contribute to compilation by government agencies of lists of stigmatized individuals, especially gay men.³ Moreover, they argued that, with treatment not available, PN would needlessly anguish notified partners and perhaps cause an increase in suicide. After approval of the first antiretroviral drug (AZT [zidovudine]) in 1987, detractors opined that PN would be inordinately expensive⁴ and that, moreover, it would not be welcomed by high-risk populations and would be ineffectual because of partner anonymity.^{5,6} HIV control monies would in any case be more effectively spent on other (read: less personally intrusive) interventions.

None of these objections was supported by experience and none of these fears materialized. By the mid-1990s, and with the advent of efficacious anti-HIV medications,⁷ this litany of concerns faded.⁸ Nevertheless, some detractors continued to imagine new scenarios to discourage PN. Notifying partners would “promote the breakup of old partnerships and increase the acquisition of new partners, thereby spreading HIV infections”¹ and could stimulate domestic violence.⁹ With publication of the present studies, these final (?) imagined concerns, like their predecessors, bite the dust.

Researchers in New Orleans and Denver coevally sought to determine the influence of PN on partnership stability and risky sexual pairing. In addition, the New Orleans study¹ attempted to gauge the potential contribution of PN to partnership abuse and violence. That these separate investigations should exhibit com-

monalities may in part be due to researcher concurrency: at least two (T. A. P. and J. E. M. from the Centers for Disease Control and Prevention) of the combined 13 authors contributed to both. Notably, neither site sought to examine the impact of PN on patterns of injecting drug use, which I surmise is related to a dearth of eligible subjects.

Similarity of results in both cities and heterogeneity of participants bode well for fans of generalizability. The stereotypic participant in New Orleans is black, heterosexual, and in a steady long-term relationship, while the stereotypic one in Denver varies ethnically, tends to be homosexual or bisexual, and reports more diverse relationships. Although index subjects and their comparisons differ in each study and although reported data are not strictly comparable, similarities emerge. In brief, both studies show that PN increases neither dissolution nor formation of partnerships, and both show its association with increases in reported condom use at follow-up. Although both sites report high partnership dissolution rates (about half to nearly two thirds), these likely represent background noise. Both report similar incident partnership formation rates (about 16%). Last, substantial decreases in reported emotional and physical abuse at 6-month follow-ups are associated with PN where measured (New Orleans).

Both studies reveal weaknesses commonly experienced with PN populations: low enrollment interest and high follow-up loss. Only about two fifths of eligible subjects participated, and follow-up yielded populations largely representing presently nonpromiscuous people in main relationships. Although not noted by the authors, such bias may be a strength, because the outcomes of interest—partnership dissolution and abuse/violence in particular—may be of greater relevance within main partnerships. After all, who expects less than high dissolution rates with occasional partners? Or high abuse/violence rates with casual partners, since the usual association is with domestic partners? This is precisely what was observed in New Orleans: the likelihood of partnership dissolution is strongly related to casual and short-lived relationships. In essence, not only are results of these two studies consonant with anecdotal experience but also substantial participant loss at follow-up seems unlikely to have seriously biased the results and hence the conclusions.

Reluctance to conduct PN has been part of the broader reluctance to implement standard public health interventions in response to the HIV/AIDS epidemic.^{8,10} Activism occurred early for public health—exempt status, an exemption “granted” by many public health authorities.¹¹ Until recently, name-reporting, contact-

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tracing, behavior restrictions,¹² high-risk-milieu proscriptions, targeted mandatory testing, and core-group monitoring—time-honored public health measures—were discouraged. In their stead came civil liberties-inspired, client-centered, community organization-mediated initiatives encouraging anonymity.¹¹ Oversight of HIV/AIDS control initiatives shifted, starting in the late 1980s, from public health workers to behavioral scientists, then clinicians, and then politically motivated activists. Accompanying this transfer of power was a subtle shift, pregnant with fate, in the underlying professional philosophy, from community orientation to focus on customer service¹³—in brief, public health by plebiscite.

This, in my opinion, is the principal reason for the pro forma support accorded to PN by those who control the local community response to HIV/AIDS, despite its endorsement by the public health establishment.^{14–15} Those in positions of authority are professionally disinclined to implement it because, likelier than not, they subscribe to the “patient-autonomy model”.¹³ To a disappointing extent, the history of the AIDS epidemic has been the history of clashing professional paradigms. As Richards and Rathburn observe,¹³ “The patient-autonomy model that underlies personal health care is incompatible with the subrogation of individual interests that is necessary for effective public health. . . Public health puts the community’s interests before those of the individual patient. . . [and] rejects the patient’s right to have sole control of his/her treatment.”

Here is not the place to advertise the benefits of PN to individuals, its cost-effectiveness, or, indeed, its lacunae and difficulties. Each set of authors adequately reviews and cites the modest literature. What needs emphasis is the critical *public health* function of PN. It is much more than a means of notifying *individuals*; it is the best means of delineating the risk *networks* hosting current transmission.^{16–19} This goal is unlikely to be attained when the operational philosophy is governed by the patient-autonomy customer service model.²⁰ Society needs accurate assessment of the magnitude and direction of the HIV epidemic locally, at a given moment. Comprehensive PN data, collated to elucidate risk networks and their configurations, demonstrably offer the best opportunity to achieve this aim.^{19,21,22} Such data are the magnifying lens for community transmission patterns. Moreover, for society to effectively and efficiently intervene, PN not only is appropriate as a network intervention but also may be the *only* practical one.

Empirical evidence is the strength of these two articles.^{1,2} Never mind that, had HIV/AIDS PN been routinely performed in the United States, these studies would have been unnecessary. Experienced contact tracers could have told us that PN rarely damages relationships or promotes violence and that, if anything, exposure to PN contributes to safer behaviors. In the final analysis, we should be grateful that these studies yield data supportive of anecdotal impressions. We should be especially grateful that the researchers succeeded in obtaining useful data from populations that are difficult to enroll and follow. Their findings’ true value, however, rests on how persuasive they will be to those in positions of public health authority. What is clear is that avoidance behavior toward HIV PN—or indeed toward promising, nontraditional, PN-like focused interventions²³—is no longer defensible.

Currently, only about one third of patients with newly diagnosed HIV infection in the United States receive PN.²⁴ Let’s improve on that. Let’s do it right^{25,26} and for the right reasons.¹⁷ No excuses offered, anyway.

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