7 February 2020

Dear Ambassador Birx:

Thank you for your immediate response to the 13 January 2020 letter endorsed by 76 civil society organizations, including MPact, regarding index testing among key populations. While we are pleased that the 2020 Country Operating Plan Guidance initiated an immediate halt in all index testing among key populations, there remains significant confusion in the field about PEPFAR's intentions and guidance. With this letter, we wish to further explain our own concerns regarding the use of this practice with gay, bisexual and other men who have sex with men.

Index testing and assisted partner notification services are often neither effective nor appropriate to use with gay, bisexual and other men who have sex with men, particularly in contexts where this community is criminalized or at risk for high levels of violence, stigma, and discrimination.

Consultation with our partners in Botswana, Ghana, Kenya, Tanzania, Vietnam, and Zimbabwe has revealed the following factors that impact the efficacy of index testing for gay and bisexual men:

- **Inability to provide partner contact information.** Newly positive men who have sex with men may be unable to provide the names and contacts of sexual partners, as the contact information may not be known, or the relationship between the sexual partner is strained or damaged for other reasons. This points to the fact that index client identification will not even be a possibility in many circumstances.
- **Forced or inadvertent disclosure of sexual orientation.** The use of index testing can essentially force newly positive men who have sex with men to disclose their same-sex sexual partners to health care providers, when they are not willing to do so. Disclosure can pose serious risks to the mental, physical, and economic security of men who have sex with men.
- **Increased mental health distress with inadequately tailored support systems.** Partners cited inadequate counselling and mental health services provided to newly positive men who have sex with men, and the insistence on notifying/identifying partners only served to exacerbate negative thinking and, in some cases, suicidal ideation. Adding this extra component of notifying partners places newly positive gay men and other men who have sex with men in a further precarious place, when adjusting to the recent news of seroconversion should be the priority.
- **Negative impact on ART adherence.** Partners shared that some newly positive men who have sex with men were so dismayed at the process of partner notification by health care providers, they felt isolated and ashamed to maintain relationships and friendships with other men. These conditions affected the mental health of newly positive men, who were then lost to follow-up or did not continue with treatment.

An effective and appropriate case finding strategy for gay, bisexual and other men who have sex with men should rely first and foremost on consultation with local LGBT-led community-based organizations. In some instances, index testing may not be appropriate, especially in countries that criminalize same-sex sexual behavior and/or HIV transmission, exposure, and non-disclosure. Other considerations that we strongly urge PEPFAR consider for ensuring efficacy and appropriateness in case finding for gay and bisexual men include:

1) Immediately decouple index testing from case finding targets. Due to the well-documented human rights violations and issues described above, *case finding targets should NOT be tied to index testing.* The creation of index testing proportion targets creates undue pressure/burden on health care providers, facilities, and implementing partners to achieve the target above all else and at the cost of unintentionally violating consent and confidentiality procedures.
2) Ensure all testing and case identification processes are led by/driven by community, not donors, health facilities, or implementing partners. Community must participate in the *design, implementation*, and *evaluation* of all testing programs, including index testing. Zimbabwe and Ghana have experienced success when index testing is implemented by trained gay and other men who have sex with men peers. When a newly positive men who has sex with men is supported by community peers with extensive knowledge about the above-mentioned challenges, there is a higher possibility that the index client will be willing to share partner contact information or contact partners himself.
3) Utilize groups led by gay men and other men who have sex with men to pilot index testing prior to its implementation at facilities. Community groups must design, test, and evaluate any index testing methodologies *first*, before this method is promoted and implemented at facilities. Efforts can be made to concurrently strengthen the relationships between facilities and communities for eventual partnership, but the process must be started and led by community-based organizations.
4) Offer a variety of voluntary options for notification, including (but not limited to): *no notification of index partners*; PLHIV notifying partners on his/her own; PLHIV with support of a counselor or peer to notify partners; counselor or peer to notify partner; health care provider to notify partner. A key consideration while weighing these options is the element of time: a newly positive individual may request time to adjust to their new status before involving other people. Client consent and agreement on the index testing process must be mandatory; the entire approach must be *client centered and client led.*
5) Develop mandatory training for index testing counselors, in consultation/partnership with communities. Any counselor, peer, or health care provider that notifies a partner must undergo comprehensive training that has been vetted and approved by community-based organizations. Trainings should include modules on conflict resolution, negotiation, interpersonal skills, intimate same-sex partner violence, as well as review of policies enacted within the country about data privacy and HIV. These trainings should be regularly

administered and attended; one training at one point in time is insufficient.

6) Offer a variety of other voluntary testing options for index partners, including self-testing, community-led testing, mobile testing, on-site testing, flexible hours testing.
7) Offer a variety of supportive services and resources for the index client and their partners, including prevention services, including PrEP, mental health services, trauma-informed services to address violence, harm reduction resources, motivational counseling, among others. It is essential to make clear the variety of community-vetted services available in the area.
8) Ensure the index client and their partners understand their rights and can stop the process at any time, without shame, punishment, consequences, disruption or delay of services. Compliance/participation in any testing process should not be mandatory; individuals should be informed of their ability to opt-out at any time. Clients should never be denied services as a result of not being able or willing to notify partners. There should *never* be incentives given to clients for disclosing partners, as this compromises human rights.
9) Implement a clear course of discipline for health care providers and counselors who violate any of the above rules. Health facilities and implementing partners must be held accountable to discipline any counselor or provider who violates confidentiality, consent, or delays/disrupts services to clients as a result of index testing.
10) Employ *qualitative* measures, when evaluating index client testing. Quantitative measurement on numbers of trainings and other indicators is insufficient to assess success of index testing. USG agencies must consider in-depth individual and group interviews, other qualitative sources of data regarding the efficacy index testing and the experiences of men who have sex with men. In addition, facilities implementing HIV services should be systematically, objectively, and routinely monitoring *client satisfaction*.
11) Develop an independent monitoring team, led by community representatives chosen by their peers, to receive and handle any feedback or reports from clients regarding adverse events, human rights violations or other problems in the process of index testing. Monitoring and evaluation of index testing must be conducted and overseen by community members in collaboration with PEPFAR agencies.
12) Develop transparent and comprehensive guidance, in collaboration with communities, to indicate how index testing will be implemented. In consideration of WHO, UNAIDS, and other normative guidance, comprehensive guidelines for the implementation of index testing should be created and widely disseminated throughout health systems and facilities that deliver HIV testing and counseling services. The Guidance should address all the concerns and recommendations above.
13) Ensure health care workers are adequately resourced to provide quality services to clients and index partners. Health care workers are often responsible for transport and communication to reach clients and index partners; they must be adequately resourced to efficiently complete these tasks.

We welcome the opportunity to discuss the above with you in more detail, and to link you with gay and bisexual men's advocates around the world with their own unique perspectives on this issue. We stand with other key population-led networks and women-led advocacy groups in demanding that PEPFAR-supported case finding and index testing is community-led, conducted ethically, client-centered, and rights affirming.

Sincerely,

Achievers Improved Health Initiatives
Africa Queer Youth Initiative
APCOM
Center for Economic Public Health, Law and Social Economic Right Advocacy (CENTA)
GayLatino
Health Options for Young Men on HIV/AIDS/STIs (HOYMAS)
Ishtar MSM, Kenya
Lighthouse Social Enterprise
MPact Global Action for Gay Men's Health & Rights
PEMA Kenya
SOMOSGAY
Support Group & Resource Center on Sexuality Studies (SGRC)
Young Queer Alliance