

# Partner notification in the Eastern Mediterranean Region: is there a way?

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## Overview of the HIV epidemic in the Eastern Mediterranean Region

According to the World Health Organization (WHO), new HIV infections are on the rise in the Eastern Mediterranean Region (EMR)<sup>1</sup>. The estimated number of new infections increased by 28% over the past 7 years to reach 36 000 in 2017. This figure represents the highest regional increase rate (1). Mortality among people living with HIV (PLHIV) in EMR has also increased by 31% in 2017 compared to 2010 (1). Moreover, out of 350 000 estimated PLHIV in the Region, the majority live in 5 countries (Islamic Republic of Iran, Morocco, Pakistan, Somalia and Sudan) (2).

While the percentage of the general adult population living with HIV in the Region remains among the lowest globally (< 0.1%), key populations continue to be disproportionately affected. Ninety-five percent of new HIV infections in the Region are within key populations; i.e., people who inject drugs (PWID); men who have sex with men (MSM); sex workers (SW); and within clients of SW and sexual partners of key populations. Higher HIV prevalence rates are found among PWID in Afghanistan (4.4%), Egypt (2.4%), Islamic Republic of Iran (9.3%), Morocco (7.9%), Pakistan (21%) and Tunisia (3.9%), and large size estimates for PWIDs are found in Islamic Republic of Iran (200 000) and Pakistan (110 000). HIV prevalence among MSM was estimated at 12.6% in Lebanon, followed by Morocco (5.7%) and Sudan (1.4%) and Tunisia (1.4%). Large population size estimates are found in Pakistan (830 000) and Sudan (130 000). HIV prevalence among SW was found in Djibouti (12.9%), Egypt (2.8%), Pakistan (3.8%) and Somalia (5.2%), and high population size estimates are found in Pakistan (230 000) and Sudan (220 000). (3).

Limited access to HIV testing for PLHIV remains the biggest obstacle to the delivery of lifesaving antiretroviral therapy, where only 34% of PLHIV are aware of their infection (1). In addition to HIV testing among key populations, sexual and injecting partners of PLHIV are at a very high risk of HIV transmission. Extending HIV

testing to this population group can efficiently identify PLHIV who, otherwise, would not know their HIV status (4). In spite of this, EMR countries reported a negligible number of partners of PLHIV who received an HIV test in 2017 (5).

According to the WHO recommendations issued in December 2016, partner notification (PN) is a voluntary process whereby a trained provider asks people diagnosed with HIV about their sexual partners and/or drug injecting partners, who are then informed through a variety of methods (passive or assisted<sup>2</sup>) that they may have been exposed to HIV. Among other benefits, PN increases the uptake of HIV testing services by partners of PLHIV, and fosters both mutual support in accessing HIV prevention, treatment and care services, and improved adherence to and retention of treatment (6).

A report about the values and preferences of individuals in 4 EMR countries (Jordan, Lebanon, Morocco and Tunisia) showed that PN was considered essential by PLHIV and important by PWID despite the fear of stigma and discrimination. It was considered less feasible by female sex workers (FSW) (6). Lack of feasibility could be explained by the difficulties in identifying and reaching multiple partners, the fear of violence and rejection and abuse from a partner, and the loss of income. There was a significant heterogeneity based on geography and risk group type. Another report from Lebanon, Morocco and Tunisia showed that differences in the attitudes among MSM and transgenders (TG) towards PN may be related to different social and cultural contexts. For instance, the priority for Tunisian PLHIV was privacy and security, whereas in Lebanon it was the involvement of a professional. In Morocco where both MSM and TG were less supportive of PN, taking responsibility and facing one's partner were considered important.

In line with the values and preferences of key populations and PLHIV in the Region, three major issues

<sup>1</sup>EMR according to WHO includes Afghanistan, Bahrain, Djibouti, Egypt, Islamic Republic of Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen.

<sup>2</sup>Passive PN refers to when HIV-positive clients are encouraged by a trained provider to disclose their status to their partner(s) by themselves, and to also suggest HIV testing to the partner(s).

Whereas assisted PN refers to when consenting HIV-positive clients are assisted by a trained provider to disclose their status or to anonymously notify their partner(s) of their potential exposure to HIV infection. Assisted PN is done using contract referral, provider referral or dual referral approaches.

should be considered in regards to PN implementation in EMR (6). First, maintaining confidentiality because of the high social stigma and discrimination; PLHIV are also stigmatized based on moral judgement and association of the HIV infection with key populations (7), creating social fear, medical mistrust and a lack of attendance for treatment. Second, in EMR societies, an individual and his social status is highly bound to his family, which may originate from traditional and religious beliefs. In this context, behaviours that are considered “inappropriate” (from both moral and religious points of view) are not welcome and may profoundly stigmatize people taking sexual risks (7), which applies to key populations (FSW, MSM, TG) (5). Third, EMR countries are diverse and some are multiethnic, which makes one universal approach that applies for all EMR countries unrealistic (8).

### Recommendations for partner notification planning in the Eastern Mediterranean Region

Although existing evidence supports the conclusion that partner notification is safe, implementing those services in the EMR requires careful planning and should take into consideration the nature of the target populations, their environment and socio-cultural beliefs, improve acceptance, maximize uptake and safeguard for adverse consequences. Service providers should be carefully selected and adequately trained to efficiently and effectively provide PN services without causing any harm to its beneficiary.

Full involvement of key populations and PLHIV in planning, delivering the service, monitoring and evaluation is crucial in assessing the potential harms, as

well as assessing concerns and identifying safeguard measures. Furthermore, involvement of the beneficiary can build trust in the community and encourage uptake, and has been repeatedly reported by many authors including Dalal et al. who showed in their meta-analysis a 1.5-fold increase of testing uptake, especially with assisted PN (1.5 times higher with assisted PN than with passive referral) (9). In their systematic review of 10 studies across Africa, the United States of America and Spain, the authors found that on average passive referrals resulted in 31.1% of partners of HIV cases getting tested, while assisted partner notification resulted in 46.3% of partners getting tested. As mentioned previously, EMR countries reported a negligible number of partners of PLHIV who received an HIV test in 2017 (5). Here, a crucial role can be played by civil society organizations that have the potential to reach greater numbers of people, particularly those unlikely to go to a facility for testing (4). Partners can also be reached using new approaches such as HIV self-testing (HIVST), which allows a person to test for HIV in private, and could be one way of reaching partners of PLHIV (4).

The programme should identify a network for referrals and linkages in order to address any potential harm or violence, including intimate partner violence, following intentional or un-intentional HIV status or sexual behaviour disclosure. Further linkages and referral mechanisms to HIV prevention treatment and care services also need to be identified. Thus, HIV PN in the EMR is a highly needed intervention to identify and deliver services to underserved population groups, which would only be identified through their HIV positive partners. However, PN services need special attention along with a multidimensional support system from health, psychological, religious, social, and legal perspectives.

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