ANNEX TO GUIDELINES ON HIV SELF-TESTING AND PARTNER NOTIFICATION

SUPPLEMENT TO CONSOLIDATED GUIDELINES ON HIV TESTING SERVICES

Annex 30. Report on the values and preferences on HIV self-testing and partner notification in Jordan, Lebanon, Morocco and Tunisia

DECEMBER 2016
Contents
Acknowledgements .................................................................................................................. 1
Acronyms and abbreviations .................................................................................................... 2
30.1 Background ...................................................................................................................... 3
30.2 Introduction ....................................................................................................................... 3
30.3 Methodology ..................................................................................................................... 4
  30.3.1 Selection of participants ............................................................................................ 4
  30.3.2 Process ......................................................................................................................... 4
  30.3.3 Data collection and analysis ....................................................................................... 4
30.4 Results ................................................................................................................................ 5
  30.4.1 Characteristics of study population ........................................................................... 5
  30.4.2 HIV self-testing .......................................................................................................... 5
  30.4.2 Partner notification ...................................................................................................... 8
30.5 Discussion ........................................................................................................................... 9
  30.5.1 HIV self-testing .......................................................................................................... 9
  30.5.2 Partner notification ...................................................................................................... 10
30.6 Strengths and limitations ................................................................................................. 11
30.7 Recommendations and conclusions ............................................................................... 11
References .................................................................................................................................. 12
Acknowledgements

This study has been conducted by The Regional Arab Network against AIDS (RANAA) supported by the WHO Eastern Mediterranean Regional Office. RANAA wishes to acknowledge the work of Mrs. Rana Haddad, the lead consultant on this study. Heartfelt appreciation also goes to the focal points in Jordan, Lebanon, Morocco and Tunisia for conducting the focus group discussions. Finally, acknowledgment and respect go to the study participants from the key populations, the outreach workers and the service providers who agreed to be part of this study and to share their experiences and thoughts, which will benefit many people.
**Acronyms and abbreviations**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>acquired immune deficiency syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>antiretroviral therapy</td>
</tr>
<tr>
<td>FGD</td>
<td>focus group discussion</td>
</tr>
<tr>
<td>FSW</td>
<td>female sex workers</td>
</tr>
<tr>
<td>HIV</td>
<td>human immunodeficiency syndrome</td>
</tr>
<tr>
<td>HIVST</td>
<td>HIV self-testing</td>
</tr>
<tr>
<td>HTS</td>
<td>HIV testing services</td>
</tr>
<tr>
<td>MENA</td>
<td>Middle East and North Africa</td>
</tr>
<tr>
<td>NGO</td>
<td>non-governmental organization</td>
</tr>
<tr>
<td>PWID</td>
<td>people who inject drugs</td>
</tr>
<tr>
<td>RDT</td>
<td>rapid diagnostic test</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
30.1 Background
In July 2015, WHO published the first Consolidated Guidelines on HIV Testing Services (HTS), which included some discussion of HIV self-testing (HIVST) and partner notification(2). Countries then requested updated guidance on those two topics.

WHO defines HIVST as a process in which individuals who want to know their HIV status collect their own specimen, perform a test and interpret the result, often in private. HIVST could increase access to testing and play a particularly important role for people who are unable or unwilling to attend formal HTS, or who require repeat HIV testing(1-3).

Partner notification may also increase HIV testing among partners of people diagnosed with HIV, and facilitate HIV case-finding, early diagnosis and linkage to prevention, treatment and care. WHO defines HIV partner notification services, also known as disclosure or contact tracing, as a voluntary process whereby a trained provider asks people diagnosed with HIV about their sexual partners and/or drug injecting partners, and then, if the HIV-positive client agrees, offers these partner(s) HTS. Partner notification is provided using passive or assisted approaches(4).

The WHO Eastern Mediterranean Regional Office, in coordination with its key partners in the region, supported a study to assess whether the implementation of HIVST would be an acceptable approach to increasing uptake of HIV testing, and to understand the knowledge, experiences and views of the individuals who will be affected by the new guidance on HIVST and partner notification.

30.2 Introduction
According to the Joint United Nations Programme on HIV and AIDS (UNAIDS), there are around 2 million new HIV infections every year worldwide, of which key populations account for 40%. Yet approximately 54% of people living with HIV (people living with HIV) are still not on treatment, and many of them do not know their HIV status.(5). In 2014, 41% of the new infections in the Eastern Mediterranean region were among clients of sex workers and sexual partners of other members of key populations, 28% among people who inject drugs (PWID), 18% among men who have sex with men, 9% among sex workers; the remaining 4% of new infections were in the general population.(5).

In an effort to accelerate the global response to HIV, UNAIDS has set new targets, the 90-90-90 strategy: 90% of people living with HIV know their status, 90% of diagnosed people living with HIV are on treatment and 90% of people living with HIV on treatment achieve an undetectable viral load, by 2020.(6). It is the first target that is both essential to the ultimate success of the response and the key challenge to the effectiveness of many prevention tools now available.

Despite global progress in scaling up HTS, there is a substantial testing gap, with an estimated 43% of all people living with HIV still undiagnosed.(7). There is an increasing number of HIV tests performed every year, yet HIV testing coverage for men continues to be lower than for women in most countries. Coverage among key populations also remains low; this is due to availability in some settings, but also depends on acceptability of services, and fear of stigma, discrimination and criminalization of behaviour. New approaches to HTS delivery are needed to reach people with HIV who remain undiagnosed, especially those in key populations, and to achieve national and global testing targets.

The following report presents the values and preferences of individuals in the Eastern Mediterranean region—focusing on people who inject drugs (PWID), female sex workers (FSW) and people living with HIV, with particular attention to women living with HIV—who would be affected by new guidance on HIV self-testing and partner notification. Providers of these services also participated in the study. This report summarizes the methodology used to develop the report, documents and analyzes the findings and proposes recommendations for consideration during the guidance development process.
30.3 Methodology

This study used qualitative research methods considered especially effective for obtaining culturally specific information about the values, opinions, behaviours, and social contexts of particular populations (8).

30.3.1 Selection of participants

NGOs serving key populations were contacted and those willing to participate identified a focal point. Recruitment was either done by the focal point who contacted clients of the NGO or by other partner NGOs serving the same populations. Based on selection criteria, participants were recruited either by the focal point or peers of the target groups such as outreach workers and peer educators.

Selection criteria included:

- people who inject drugs with and without previous experience in HIV testing from different age groups, married and unmarried, and of different educational level;
- female sex workers with and without previous experience in HIV testing, with varied number of sexual partners, age groups, testing experience, and educational level;
- people living with HIV, especially women living with HIV.

A total of 116 individuals (55 men, 61 women) representing key populations and people living with HIV agreed to participate in focus group discussions (FGD) in Jordan, Lebanon, Morocco and Tunisia. A group of ten service providers (four men and six women) was asked to participate in a virtual consultation. The group included programme managers, service providers and outreach workers.

30.3.2 Process

Specific qualitative techniques included FGDs1 with key population and people living with HIV community members and a virtual consultation (via WebEx, hosted by the WHO Regional Office for the Eastern Mediterranean with service providers from the region who have experience working with the study target groups. Planning and logistics were done by phone, email and skype.

The following questions were used to guide the FGDs.

- To what extent do the target groups have knowledge on HIVST and partner notification services?
- Based on the target groups’ experiences with self-testing and/or partner notification services, what were the gaps and good practices?
- To what extent do the target groups accept HIVST and partner notification services?
- To what extent do the values and preferences of target groups allow for successful HIVST implementation in the region, and what are their views on partner notification?

Service providers were asked about their perspectives on HIVST and partner notification, potential uptake by key populations, accessibility issues and views on the information needed to accompany self-test packages.

30.3.3 Data collection and analysis

Data were collected from FGDs that were conducted in a mix of health facilities and community sites, and from the virtual consultation with regional service providers. Given the sensitivity of the issue and the circumstances of the participants, it was decided not to record the discussion. A note taker was assigned to each of the FGDs, and the data were typed by the note taker and verified with the FGD facilitator. The data were further reviewed and validated by the consultant and the focal point as needed. Standard thematic analysis was applied to the notes to identify areas of

1 FGDs were held with target groups in Jordan (3), Lebanon (4), Morocco (4), and Tunisia (2).
Annex 30

consensus, diverging views, and personal and professional insights on the two study topics. While the primary focus of this report is the views of communities who will be affected by new guidance on HIVST and partner notification, the perspectives of providers who will support implementation of new recommendations were also included for their important perspectives on acceptability and feasibility.

30.4 Results

30.4.1 Characteristics of study population

Selection criteria focused on people who would be most likely to have experienced, know about, or have insights into the research topics (HIVST and partner notification). Quota sampling was used to select individuals within each sub-group with the characteristics presented in Table 1.

Table 30.1: Characteristics of the study populations (n=126)

<table>
<thead>
<tr>
<th>Type of population</th>
<th>Sex</th>
<th>Mean age (years)</th>
<th>Educational level</th>
<th>Marital status</th>
<th>Country or area of birth</th>
<th>Previous HIV testing</th>
<th>Mean number of sexual partners*</th>
</tr>
</thead>
<tbody>
<tr>
<td>People who inject drugs</td>
<td>M</td>
<td>33</td>
<td>University – 1, Diploma – 1</td>
<td>Married – 7</td>
<td>Jordan – 8</td>
<td>Yes</td>
<td>36</td>
</tr>
<tr>
<td></td>
<td></td>
<td>34.8 yrs</td>
<td>Primary – 11, Illiterate – 1</td>
<td>Unknown – 10</td>
<td>Morocco – 12</td>
<td></td>
<td>1.53</td>
</tr>
<tr>
<td>Female sex workers</td>
<td></td>
<td>n/a</td>
<td>University – 6, Secondary – 15</td>
<td>Married – 7</td>
<td>Jordan – 8</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>34</td>
<td>Intermediate – 5, Primary – 4</td>
<td>Single – 7</td>
<td>Lebanon – 5</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>33.1 yrs</td>
<td>Illiterate – 4</td>
<td>Divorced – 16</td>
<td>Morocco – 13</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Separated – 2</td>
<td>West Bank and Gaza Strip</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Widowed – 2</td>
<td>Syrian Arab Republic – 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Tunisia – 10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>People living with HIV</td>
<td></td>
<td>18</td>
<td>University – 1, Secondary – 21</td>
<td>Married – 12</td>
<td>Jordan – 9</td>
<td></td>
<td>42</td>
</tr>
<tr>
<td></td>
<td></td>
<td>24</td>
<td>Intermediate – 6, Primary – 7</td>
<td>Single – 10</td>
<td>Lebanon – 10</td>
<td></td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>37.5 yrs</td>
<td></td>
<td>Divorced – 5</td>
<td>Morocco – 9</td>
<td></td>
<td>0.91</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Widowed – 3</td>
<td>Syrian Arab Republic – 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Unknown – 12</td>
<td>Tunisia – 12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service providers**</td>
<td></td>
<td>4</td>
<td>n/a</td>
<td>--</td>
<td>--</td>
<td></td>
<td>--</td>
</tr>
</tbody>
</table>

Note: n/a: not available or not applicable
Note: 1 FSW reported injecting drug use
* In previous month
** NGO managers and programme officers, service providers, outreach workers contacted trough Webex, an online platform.

30.4.2 HIV self-testing

General views

Awareness of HIVST was low among most participants, but most felt it would be beneficial due to the confidentiality of the test; many people emphasized this as the key determinant in the decision to be tested. Other benefits mentioned were decreased embarrassment and shame, simplicity and less time required than at HTS sites. Some participants felt the convenience of this option would allow a person to test more frequently. Others felt that HIVST would reduce their worries, and some people mentioned using the test to confirm a negative test result. Some people living with HIV suggested that this approach would eliminate the stigma and discrimination they had experienced attending HTS. However, several participants noted concerns about receiving a positive result without the information and support available at a testing site. Some female sex workers in Jordan questioned the accuracy of the test.

“I prefer to have the test in the presence of a specialized person because of my limited knowledge regarding how to deal with the disease...many will collapse if the result is positive and wouldn’t know what to do.” Male, PWID, 25 years
Guidelines on HIV self-testing and partner notification: supplement to consolidated guidelines on HIV testing services

“. . . Since it is a self-administered test I will avoid fear and shame related to requesting the test as the person might look downward on me... so it prevents embarrassment.” FSW, 42 years

“Imagine a person . . . alone, and the result comes positive, don’t you think he/she will commit suicide? A supportive person should be present while doing the test.” FSW, 33 years

Service providers, while noting confidentiality and reduced exposure to stigma and shame as benefits of HIVST, stressed the importance of pre- and post-test counselling to ensure that individuals understand the process and implications of testing as well as supporting the individual with a positive test result. Providers also noted a number of challenges in establishing access to HIVST:

- Low levels of knowledge about HIV and its consequences;
- Partner notification;
- Access to treatment and follow-up;
- Psychological impact of a positive test result (which may be a false positive);
- The need for confirmation of a positive result, which the individual may not seek;
- Possibility of misunderstanding a negative test result;
- Exposure to exploitation or abuse by a partner;
- The possibility of losing the link between testing and follow-up services;
- Lack of confidence in key populations to practice prevention;
- Exposure to legal consequences or discrimination if accessing through pharmacies;
- Appropriate conservation and handling of testing supplies;
- Inappropriate use of the test.

“The test can be used in unhealthy ways: in some cases known to us, people talked about buying the test and administering it to the partner before the sexual relationship; if the result is negative then they will not use condom....” Service provider, age non available

“We will lose the opportunity to inform the partner and we might not be able to offer the needed follow up in case of a positive result. Furthermore, in case of a negative result we will lose the opportunity to inform about essential services... and discuss the use of a condom, etc. as well as to maintain the “healthy” status of the person in relation to any sexually transmitted diseases and to adopt safe behaviour.” Service provider, age non available

Uptake of HIVST

The majority participants from PWID and FSW communities stated that they would use the self-test if it were available, while people living with HIV were more divided, although few had used the self-test. Many of those in favour felt that detailed but clear information about how to use the test and interpret results is critical to uptake. Some female sex workers saw it as an opportunity to test clients or partners who refuse to use a condom.

“It is an outstanding test, however not effective without information.” Male, PWID, 30 years

“. . . I say we should ask the clients who refuse to use the condom to undertake the self-test first.” FSW, 33 years

“The test is safe and rapid; I believe people will use it because it will save time and effort. I will surely use it. It is good that a person checks on him/herself.” Female, people living with HIV, 25 years

Those not in favour of HIVST felt the need to take the test in the presence of a trained provider to assure adequate support, including risk assessment and counselling on how to cope with a positive test result, and referral to services as necessary.
“It is better if someone administers the test for me and ensures confidentiality and privacy, because if the result is positive they will tell me what to do and they might have a treatment or [something] that can help me.” Male, PWID, 49 years

Reasons for reluctance among people living with HIV included concern about misuse and inaccurate results; fear of a harmful reaction (such as suicide) to a reactive result; lack of support from service providers; unethical behaviour by a person who has received a positive test result with no counselling or other support; and difficulty in accessing comprehensive care following the test.

“I don’t recommend it (HIVST) because it is not very good that the person does the test alone because he/she might face a psychological collapse. What [would] stop me from doing the test is the fear of being alone. What is encouraging about it is that the person can reassure himself (about his serological status).” Female, people living with HIV, 49 years

Some providers believe that HIVST will be popular with key populations as a safer, more private testing option. Some reported having received requests from key population community members for a self-test, and some of these individuals had requested using rapid tests from NGOs in a similar way to the self-test. A provider noted that FSW could face the prospect of losing their income if they had a positive test result. Other concerns regarded the safety of injecting drug users if they are arrested and found to be in possession of a self-test.

Accessibility and delivery

Unassisted self-testing was considered safer by some participants, but most people felt that some level of assistance or engagement with a knowledgeable person was preferable to avoid facing the shock of a positive test result alone. Delivery through a specialized NGO or health centre would ensure confidentiality, information, support and referral to follow-up services as needed. Delivery through outreach workers was also considered acceptable, while participants were less certain about obtaining the test at pharmacies (unless pharmacy staff had training and appropriate, non-judgmental attitudes) due to concerns about stigma, exposure and personal safety.

People living with HIV felt that HIVST should be widely available, even though schools and universities, and that it should be free. A common view is that more awareness of the challenges that face key population communities is needed, and that stigma reduction in the general population would facilitate access to HIVST.

Some FGD participants felt that both directly-assisted and unassisted approaches should be available to ensure optimal coverage for PWID and the general population. Lebanese participants preferred facility-based HTS to HIVST. All providers in the virtual consultation agreed that HIVST should be one of the options for HIV testing. Promotion of this testing approach, however, should be preceded by general awareness-raising campaigns on HIV in order to correct misconceptions and to decrease stigma and discrimination. In their view, this would help key population community members to feel more confident about seeking testing.

Providers also recognize that negative provider attitudes and fees for testing services are significant barriers to access for key populations, especially for female sex workers. Based on these service quality issues, as well as concerns about breaches of confidentiality, risk of arrest and exposure to abuse that are viewed and experienced as barriers to services by some members of key populations, providers stressed the importance of specific training—with the participation of key populations—for providers and government actors on the importance of HIVST in curbing the HIV epidemic.

Providers felt that key populations are not ready for unassisted approaches, especially people who inject drugs, who may be more dependent and vulnerable to discrimination, and who may need assistance when self-testing and counselling, along with interventions and support to modify risky behaviours. Some also felt that unassisted HIVST is not culturally sensitive in the regional context where there may be more confidence in accessing HIV testing through trusted service providers rather than through the internet or other distributors. Most providers felt that the directly-assisted approach through outreach workers or NGOs would be preferable as most members of key populations (especially PWID) would be reluctant to purchase from pharmacies due to fears of being judged or apprehended by the police.
Some providers suggested using brothels as distribution points where a trained counsellor would also be available.

Some providers felt that the directly-assisted approach was so similar to traditional testing with an NGO provider that an individual might as well test and receive assistance in place. But when HIVST was preferred, hotlines and access to counselling and services should available. If possible, key populations should be trained in promoting and supporting HIVST in their communities.

**Information dissemination**
Promotion of HIVST should be done—with the participation of key population community members—through a robust information campaign in Arabic, using both mainstream and social media. The test package should contain comprehensive information about the test itself (sensitivity and specificity), the pros and cons of the approach, clear usage instructions, and explicit information on the actions to take in the case of a positive result. The importance of confirmatory testing must be stressed. Contact information including physical addresses for follow-up services and hotline numbers should be included. Formats should be context- and audience-specific, using appropriate language and videos and booklets with clear instructional graphics. Providers considered follow-up through outreach workers as potentially useful. However, participants emphasized the need to be cautious about channels of communication that could be used to identify arrest or abuse key population members, especially in the PWID community.

“Going on the streets where the girls are working is very important to enable them to know about the HIVST and where to get it.” FSW, 43 years

**30.4.2 Partner notification**
**Willingness to notify partner/s**
Around half of participants from the PWID community said they would notify their sexual or injecting partners or disclose to their family in order to get support; to encourage a partner to take an HIV test; and to seek advice. Most FSW participants were reluctant to notify their partners due to fear of retribution, while opinions among FSW in Lebanon were divided. Some would consider notification if they could avoid seeing the client again or if they could convince the client that he was the source of infection. Almost all people living with HIV agreed on the importance of notifying partner/s because of the links to preventing transmission, avoiding disruption of relationships and getting support; some people living with HIV felt that partner notification should be obligatory.

“It is not a problem for the sex worker to know about her HIV infection; of course she will be afraid to lose her job . . .” FSW, 24 years

“It is the right of the partner to know since maybe the virus will be transmitted to him if no protection is used, [and] he can get the treatment if he is infected. It is a crime if not told.” FSW, 29 years

Providers felt that most people will notify their partner/s of a positive test or diagnosis, but that it may take time to accept the result, have it confirmed and then come to terms with the new situation. Factors that may affect willingness to notify include type of relationship (it may be easier to notify a stable partner vs. an occasional partner); level of trust between partners; and quality of communication between partners.

**Barriers to partner notification**
The nature of HIV infection and taboos related to sex and stigma underlie most of the barriers to partner notification discussed by participants. These include fear of rejection or betrayal by a partner or family, and fear of manipulation or aggression by a partner or others. Female sex workers, often viewed as guilty of spreading disease, believe that they are particularly vulnerable to the risks of partner notification. They fear verbal and physical abuse from clients and loss of work, as well as rejection by partners. Some also mentioned feeling that they did not have to skills to inform a partner about their HIV status. FSW also face challenges due to the number of partners they may have and an inability to
contact former clients. A few participants who are living with HIV felt that partner notification is “risky” due to the reasons listed above.
Participants proposed ways to address barriers, such as consultation with a trusted provider or friend; getting more informed about how to notify a partner in the most effective or supportive way; and attending HTS as a couple.
Facilitating factors included: type and quality of the relationship; knowledge about the disease and skills to notify the partner; and the presence of a service provider for guidance and support.

Delivery of partner notification services
Views on partner notification services and types of referrals varied widely across countries; there was no consensus. However, many participants, including providers, emphasized the need to improve counselling services and train both service providers and community members on partner notification.

“Dual referral is better so that he empathizes with me and the service provider would better explain to him.” FSW, 24 years
“Passive referral is better as it reinforces the trust between the married couple or lovers.” FSW, 25 years

Most participants expressed a preference for assisted over passive services, although Lebanese participants were more inclined toward passive services. In general, participants felt that partner notification could be enhanced through training; greater awareness about the benefits; more open communication between sexual partners; and better promotion of services through a variety of channels, including social media.

“Should inform him wisely in the presence of a neutral person to avoid misunderstanding and get support.” Male, PWID, 25 years

Providers recognize that individuals have different needs and preferences. Therefore, all the modes of delivery should be offered. In addition, more work is needed to educate the public on HIV, treatment options and human rights in order to reduce stigma and to reduce the fear and misconceptions around living with HIV, as this would support and facilitate the partner notification process. Some participants mentioned the importance of support for adherence to treatment in cases where a person refuses to notify their partner.

30.5 Discussion
30.5.1 HIV self-testing
HIVST is being considered by WHO as a way to boost HIV testing coverage, thus enabling countries to reach the UN 90-90-90 testing target. To date, several countries have introduced self-testing into their national HIV testing policies (7), and the Eastern Mediterranean region is now contemplating the integration of HIVST as an additional approach.

As shown in this study, HIVST is known to a limited number of study participants and has been used by very few. This is likely due to the limited availability of the test in the countries where the study was conducted. Even some service providers are not very aware of the test and will need capacity development in this area.

Once informed about HIVST, a large proportion of the participants, including service providers, perceived it as potentially beneficial and agreed to use or promote it if it became available. Recent data show that HIVST more than doubles uptake of HIV testing among men who have sex with men and male partners of pregnant or post-partum women and can result in identifying an equivalent or greater proportion of HIV-positive people (2, 3).

Those with unfavourable views on HIVST—members of key populations as well as service providers—were most concerned about the potentially negative effect of a positive result in the absence of support, assurance and advice on next steps. However, there is evidence that HIVST, when compared to standard HIV testing, does not increase HIV risk behaviours (such as condomless anal intercourse) or the number of bacterial sexually transmitted infections; does not increase reported social harm, adverse events or behaviours; can perform as well as an HIV RDT used and interpreted
by a trained health worker; and can achieve acceptable sensitivity (80–100%) and specificity (95.1–100%), especially using products that meet quality, safety and performance standards (7).

There are concerns given the novelty of the approach in the Eastern Mediterranean region, as confirmed by WHO. Early attempts to introduce self-testing were banned by several countries, often due to concerns about misuse, self-harm, and primarily the lack of, or limited, availability of treatment for people living with HIV (6). Diversification of testing approaches will increase the number of people tested; this should be emphasized to reassure those concerned about HIVST. Despite the value of taking an HIV test, there are many barriers for key populations, especially PWID and FSW communities. They face stigma and discrimination from society as well as from service providers when they receive a positive test result; they risk legal consequences as drug users or loss of clients and income in the case of female sex workers; and they often lack information about safe and confidential HTS.

Access to HIVST via appropriate and safer delivery channels—internet-based distributors, NGOs serving key populations, trusted, non-stigmatizing pharmacies, outreach workers or peer providers—may help to reduce many of these barriers for key populations. Data show that when services are made available within an environment free of stigma and discrimination, new HIV infections have declined significantly (5).

Although PWID and FSW participants did not agree on delivery of HIVST, both people living with HIV and service providers preferred the directly-assisted approach. Previous experience of people living with HIV with testing, coping with a diagnosis and disclosure may influence this view. Those PWID and FSW who preferred unassisted delivery of HIVST were more self-confident, had a stronger sense of independence and valued confidentiality, privacy and safety very highly.

Study participants all agreed that NGOs offer good quality counselling and testing services; thus they expect to access HIVST through NGOs with specialized programmes for key populations. This may reflect the strengthened capacities of NGOs to address the needs of key populations, Incorporating HIVST within peer-based and outreach programmes would ensure greater accessibility, especially in places where health services are less available for vulnerable communities practicing risky behaviours.

30.5.2 Partner notification
Partner notification was considered essential by people living with HIV, important when possible by PWID and less feasible by FSW. The views and reservations of FSW could be explained by the multiplicity of partners and difficulties in reaching them, as well as the fear of violence, loss of income, and rejection and abuse from a partner who might be unaware of the sex work of his partner. Gender norms may also cause additional concerns for some women. PWID and people living with HIV feared partner notification because of the stigma and discrimination related to the infection.

Most PWID indicated a preference for provider referral. Around half of FSW participants in Lebanon and Morocco preferred the passive mode, while FSW from Jordan preferred the provider referral mode. Based on their previous experiences, most people living with HIV supported both the passive and the dual referral mode; men tended to be more in favour of the passive mode.

Training for service providers and for members of key populations, promotion of partner notification, and stigma reduction were suggested as key strategies to improve partner notification services. Providers felt that a variety of strategies should be available to accommodate personal preferences, and treatment adherence was recommended for those who refuse to notify their partners. However, relatively weak inputs from service providers on the partner notification discussion might indicate a lack of experience in this area.
30.6 Strengths and limitations
A key strength of the study is that data were collected from four countries in the region (Jordan, Lebanon, Morocco and Tunisia) and involved outreach workers and service providers; this permitted confirmation of the opinions coming from different perspectives.

One of the limitations of this study was that a large proportion of the participants receive services from the NGOs involved in the data collection; this may have influenced some of their responses about service delivery. Another limitation was the short timeframe of the study. Consequently, one research team was not able to visit all the study sites, and different facilitators were involved in data collection from the FGDs within and across countries. Thus, data quality and comprehensiveness depended on the skills of the facilitators and rapporteurs, which may have varied.

30.7 Recommendations and conclusions
The following recommendations are based on the results of the study, reflecting participants’ perspectives on successful implementation of HIVST and partner notification programmes.

1. NGO community-based programmes, outreach programmes and peer education programmes should integrate HIVST into their services. Pharmacies may also be considered as delivery points for the general population and for key populations in some settings.
2. Provide appropriate and clear information on how to correctly perform the test and interpret the result. In addition, detailed information on how and where to get support and to access stigma-free HIV testing, prevention, treatment, care and support services should be included in the test packaging or via social and web-based media. Messages tailored to specific target groups and appropriate channels should be used to disseminate the information and to promote the HIVST, including through outreach peer educators.
3. Update communication campaigns for the general population to inform them about new developments in the response to HIV in terms of prevention, testing and treatment to demystify the disease and to reduce stigma and discrimination.
4. Train service providers and key populations on HIVST.
5. Offer different partner notification choices and train providers on all these methods to ensure that people living with HIV have an array of options that fit their needs and situations. Partner notification should be offered periodically at multiple service delivery points.
References


