TITLE

**Values and preferences of PLHIV and key populations in HIV self-testing (HIVST) and partner notification (PN) in the Middle East and North Africa (MENA)**

PRESENTER

**Joumana Hermez**

AUTHORS

**J. Hermez[1], G. Eid[2], R. Haddad[3], G. Azzi[4], C. Khoury[4], E. Ballan[4], C. Johnson[5], C. Figueroa[5], C. Payne[5], A. Verster[5], G. Riedner[1]**

INSTITUTIONS

**[1]World Health Organization - Regional Office for the Eastern Mediterranean, HIV-STI-Hepatitis, Cairo, Egypt, [2]Regional/Arab Network against AIDS (RANAA), Beirut, Lebanon, [3]Independent Public Health Consultant, Beit Chabab, Lebanon, [4]Arab Foundation for Freedom and Equity (AFE), Beirut, Lebanon, [5]WHO, HIV, Geneva, Switzerland**

**Background:** In 2016, WHO issued guidelines recommending HIVST and PN. In this context, the WHO Regional Office for the Eastern Mediterranean conducted an assessment of the values and preferences of key populations (KP) in collaboration with two regional networks, RANAA and AFEMENA. The results of the assessment will be used to address low access to HIV testing services (HTS) and antiretroviral therapy in the region.

**Methods:** Focus group discussions and in-depth interviews were conducted by trained service providers in Morocco, Tunisia, Lebanon and Jordan. Forty people who inject drugs, 34 female sex workers (FSW), 24 men who have sex with men, 24 transwomen (TG) and 72 people living with HIV (PLHIV) were recruited using a convenience sample. Consultation with service providers was conducted virtually. All answers were categorized and analyzed thematically.

**Results:** HIVST was known to a minority of participants, including service providers. A large proportion of the participants perceived HIVST as beneficial to increase access to HTS and overcome stigma and discrimination (S&D). TG were more skeptical due to lack of awareness in the community. PLHIV with prior bad experiences with HTS favoured HIVST while those with positive experiences tended to reject it. Unacceptance of HIVST was due to overprotection of PLHIV, distrust in rapid testing, fear of self-harm, and lack of counselling and linkage. Overall, assisted and unassisted HIVST were acceptable especially if supported by population-tailored information and delivered through NGOs, peers via outreach programs, pharmacies or health services.

PN was considered essential by all groups, but less so by FSW due to the difficulty of reaching clients, fear of violence and income loss. Barriers include S&D, limited awareness, loss of partner''s trust and fear of HIV status being known by others.

The preferred approaches to PN were dual and contract referral due to the protection and support by the service provider. Few empowered and independent participants preferred the passive referral.

**Conclusions:** Introduction of HIVST and PN in MENA is acceptable to KP, service providers and PLHIV. Implementation will require advocacy, raising awareness and building capacity among communities and service providers, along with tailoring service delivery to community needs and context.