Challenges of HIV self-tests distribution for index testing in a context where HIV status disclosure is low: preliminary experience of the ATLAS project in Bamako, Mali

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INTRODUCTION

In Côte d'Ivoire, Mali and Senegal, the ATLAS project has introduced HIV self-testing (HIVST) as an additional index testing strategy, by offering during HIV consultation HIVST kits to people living with HIV (PLHIV) so that they can offer them to their partners.

An ethnographic survey was conducted in an HIV clinic in Bamako (Mali), where most HIV patients, in particular women, have not disclosed their HIV status to their partners, for fear of jeopardizing their relationships. The main objective of this poster is to analyse the limits and the challenges surrounding HIVST distribution in such context of weak HIV status disclosure to partners.

METHOD

An ethnographic study was carried out between 25 September and 27 November 2019 in an HIV clinic in Bamako. Data were collected based on (i) 8 individual semi-directive interviews with health professionals (3 doctors, 1 nurse, 1 social worker, 1 pharmacist, 2 psychosocial counsellors) directly or indirectly involved in the distribution of HIVST; (ii) observations of 591 HIV consultations led by four health professionals including the social worker and (iii) 7 patient groups discussions led by peer educators.

RESULT

Difficulties in addressing the topic of HIVST during the observed consultations

During the 591 observed consultations, the majority of PLHIV were women (450/591, 76%). The reasons for the consultations were diverse (biological assessment, treatment follow-up, support/counselling) but were mostly related to prescription renewals (in such case, the patient could be represented by a third party). Most consultations were very short, 5 minutes on average, especially for prescription renewals.

HIVST was discussed only during a few consultations. Usually, health professionals did not present or discuss HIVST when they knew that their patient did not have a partner, was widowed, had not disclosed their HIV status to their partner, or that their partner was already being followed for HIV. When the patient's marital status was unknown to the health professional, the latter usually asked the patient about it. When a PLHIV reported no partner or that HIV status was not disclosed, health professionals rarely discussed HIVST with them.

In the end, HIVST has been presented/discussed during only 51 of the 591 (9%) consultations observed, 49 times at the health professional's initiative and twice at the patient's initiative who previously heard about it. In the 49 consultations where the discussion was initiated by the provider, 6 patients were found, after discussion, not to have a partner, 5 had a partner who had already been tested or followed up for HIV, 27 had disclosed their HIV status to their partner and 11 had a partner to whom they had not disclosed their status.

Three main barriers to HIVST emerged from our data

1) Almost all health professionals avoid offering HIVST to PLHIV when they think or know that they have not disclosed their HIV status to their partners

According to the ATLAS program, HIVST could be offered to any PLHIV with a partner regardless of HIV status disclosure (HIVST being seen as an opportunity to disclose HIV status). But for health professionals, as reported in their interviews, HIV status disclosure to the partner was considered as a prerequisite for offering an HIVST kit.

In practice, an HIVST could nevertheless be offered to some patients who did not disclose their status, but it remained less frequent. Thus, among the 27 patients with whom the HIVST was discussed and who had disclosed their HIV status to their partner, the HIVST was offered by the health professional to all of them. Among the 11 patients who did not disclose their status, 9 were offered an HIVST kit.

"Interviewer: *But what criteria do you use to dispense self-tests?*

Health professional: *Well. The criteria, for example, if we ask the person: has your partner been screened yes or no? If the person says no; we ask: do you possibly want him or her to do the test? Of course, we need to know if the person has shared his or her status. It all starts there. So if the person says: yes, I would like my partner, really, my partner, to have the test anyway. Right now, we explain the outline; and then we propose the test."* (In-depth interview with a health professional)

2) The reluctance of PLHIV to offer HIVST to their partners when HIV status was undisclosed

HIV status disclosure also played a key role in the adoption of HIVST by HIV patients. Of the 27 people who had already disclosed their status and were offered HIVST, 26 (96%) accepted, while of the 9 who had not disclosed their status, 7 (77%) refused, 6 of them explicitly mentioning non-disclosure as the main decline reason.

"Doctor: *Did you share your status with him?*
Woman: *No. I am very afraid* (...)
Doctor: *If you are given something, could you give it to him for testing?*
Woman: *No, I can't.*
Doctor: *So he's going to ask you if you did, too?*
Woman: *Yes."*

(discussion between a health professional and a patient during one of the observed consultations)

3) The limitations of support strategies for HIV status disclosure

In the peer-educator-led patient group discussions where HIVST was discussed, one of the first requests from patients was to get some tricks/strategies on how to propose an HIVST kit to a partner without having to disclose their HIV status.

In the 2 consultations where HIVST has been accepted by patients who had not disclosed their status to their partner, the health professional did not offer any specific additional support and patients to manage on their own how to propose it to their partner. One of the two patients asked for two HIVST kits so that she would be able to propose it as a couple testing strategy.

"Doctor: *So you'd have to convince him to do it.*
Woman: *It's not going to be easy. He's going to ask me to use it first. So I would need two kits for that."*

(discussion between a health professional and a patient during one of the observed consultations)

DISCUSSION/CONCLUSION

HIVST was little discussed during consultations, partly because few consultations were appropriate to it, and partly because health professionals are reluctant to discuss it with their patients when they know that they had not disclosed their status. PLHIV's fear of HIV status disclosure to their partner and the difficulties facing by health professionals to support them in this process were barriers to the secondary distribution of HIVST for index testing.

Self-testing could be seen as an opportunity for people living with HIV to disclose their status to their partners. However, HIV status disclosure was considered rather as a prerequisite by both health professionals and patients.

Index testing, in general, cannot be effective without improved support for HIV status disclosure. Self-testing alone is not sufficient to overcome this barrier. It is crucial to develop strategies to support HIV testing of PLHIV' partners, adapted to local contexts and allowing partners' testing without having to disclose HIV status.

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