ACADEMIA | Letters

Managing HIV prevention in the Eastern Mediterranean Region during the COVID19 outbreak: challenges and opportunities

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Coronavirus disease (COVID-19) is a global pandemic and has had a significant impact on society, health and wellbeing in the Eastern Mediterranean Region (EMR). There is limited insight into the potential impact of the pandemic on HIV outcomes. This paper focuses on the challenges and opportunities for HIV management amid the COVID-19 outbreak and provides three key recommendations for the EMR: condom distribution and packaging in light of physical distancing measures through civil organizations; implementation of a special hotline for HIV/sexual health through community testing centers; and most importantly scale-up of the recently implemented HIV self-testing which plays a crucial role in the management of HIV during COVID-19.

Since its first clinical observations in China in December 2019, Coronavirus disease (COVID-19) has been designated a global pandemic. In February 2020, the first cases of COVID-19 were observed in the Eastern Mediterranean Region (EMR)[1] by the World Health Organization (WHO). As of 3 January 2021, a total of 4,977,852 cases (5.97% of the global confirmed cases) has been detected and 122,061 deaths (6.66% of the global deaths) recorded

[1] According to World Health Organization (WHO) includes Afghanistan, Bahrain, Djibouti, Egypt, Iran, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sudan, Syrian Arab Republic, Tunisia, United Arab Emirates and Yemen

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[1]. While there is emerging research into the challenges of COVID-19 for mental health [2], there is limited insight into the potential impact of the pandemic on sexual health outcomes. This commentary focuses on the challenges and opportunities for HIV management amid the COVID-19 outbreak and provides three recommendations which should be implemented in the region.

HIV remains a highly stigmatized condition in the EMR [3]. Although the EMR has one of the lowest prevalence rates of HIV in the general population, some key populations are disproportionately affected by the condition: people who inject drugs (PWIDs), men who have sex with men (MSM), commercial sex workers (CSWs), and the sexual partners of people from these key populations. There is particular concern about the migrants, displaced people and refugees such as the Palestinian and Syrian refugee communities in Lebanon who, for a variety of reasons, have inconsistent access to HIV services compared to the host population [4]. In the EMR, 95% of the new HIV infections are reportedly in these key populations [3,5]. The biggest obstacle to the delivery of lifesaving antiretroviral therapy (ART) is the limited access to HIV testing among people who live with HIV (PLHIV). It is estimated that only 37% of PLHIV are aware of their positive serostatus [6]. Moreover, ART coverage is as low as 24% in the EMR [6]. This is especially concerning in view of the high rates of condomless sex which have been observed in recent studies in Lebanon. In a study of 2700 heterosexual university students [7], unprotected sex was reported by 36.3% of respondents and, in a study of 1364 MSM [8], the rate was 35%. This indicates an elevated risk of infection and onward HIV transmission. Moreover, a systematic review of basic knowledge reports from the EMR showed an overall low level of HIV knowledge, a high prevalence of misinformation and misconceptions about the disease and low perceived HIV risk, with these effects being particularly pronounced in women, rural populations, refugees, and other marginalized populations [9]. Furthermore, attitudes towards PLHIV tended to be negative, which may preclude testing behaviors [9]. Finally, pre-exposure prophylaxis (PrEP) is only available in one of the EMR countries – Morocco.

Under the guidance of the WHO, many different measures have been taken to respond to the pandemic in the EMR countries. Containment measures included border closures, travel restrictions, lockdowns and curfews. In such contexts, sexual health is not a priority and it may even be (erroneously) assumed that people are not engaging in sexual contact with casual partners. Given that it has been observed that sexual risk-taking behavior can sometimes constitute a response to psychologically challenging situations and poor mental health [10], it is possible that some people are engaging in high-risk behavior amid the COVID-19 outbreak and associated lockdown measures. This may be facilitated by the availability and use of geospatial mobile social networking applications. It is also clear that access to HIV testing

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is restricted because of the low clinical priority of testing, the lockdown, the cancellation of appointments relating to 'non-essential' healthcare [11]. Yet, the lockdown period may constitute one of the most significant opportunities to close the gap in undiagnosed HIV because it has been assumed that, during the lockdown, most people are not engaging in sex with casual partners [12]. However, there is evidence that sexual risk-taking continued in Lebanese MSM during the lockdown [13]. While this can be the case in other countries of the EMR, no data are available about risk-taking in other countries and/or in other key populations.

Continuous ART supply for PLHIV has been adopted by the Region under the guidance and technical help of the WHO but remains a challenge. Condom distribution (an essential component of HIV prevention in the EMR) has been adversely impacted and people who do continue to meet casual sexual partners may be unable to access condoms. Counselling services – both to address psychological stressors which may lead to sexual risk behavior and to provide awareness and understanding of one's sexual risk – are available only on electronic platforms and may therefore not be appropriate for individuals whose living arrangements do not allow this (e.g. young MSM who live with their parents; married men who have extramarital sex). These limitations may adversely impact the general population with especially pronounced effects in vulnerable communities such as women, PWIDs, MSM, CSWs, and in refugee groups. MSM are a group of particular concern [8]. Homophobic stigma, which is prevalent in Lebanon, may lead MSM to experience psychological stress, to conceal their identities, and to engage in maladaptive behaviors to cope [14].

In view of the elevated risk of poor sexual health outcomes in the EMR amid the COVID-19 outbreak, it is essential that action is taken at an institutional level.

- Condom use must continue to be promoted and to be distributed in a way that is compatible with social distancing measures. For instance, civil organizations can distribute pre-packaged kits of condoms and information leaflets concerning sexual health including a list of reliable sources of information.

- The implementation of a special hotline for sexual health through community testing centers is recommended so that sexual health advice can be imparted and HIV testing and linkage to HIV care can be provided.

- Most importantly, the recently implemented HIV self-testing diagnostic technologies (HIVST) must play a crucial role in the management of HIV during the outbreak.

HIVST is a process whereby the individual collects his or her own specimen (oral fluid or blood), performs the test and interprets its results in a private setting [15]. This initiative was developed to reach first-time testers and to ensure that people who need to test frequently,

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such as those in high-risk populations and sero-discordant couples, are able to do so. HIVST represents another step forward in the EMR, in line with efforts to increase patient autonomy and self-care interventions, to decentralize services and to create demand for HIV testing among those not presently reached by existing services [16]. Some countries in the EMR, such as Morocco and Lebanon, have already implemented HIVST [16]. During the outbreak of COVID-19, HIVST can play a role in maintaining a continuity of HIV testing services. However, at least two limitations exist in regards to HIVST and should be taken into consideration by implementing programs [16]. First, this diagnostic tool cannot track testers who disengage after receiving a reactive test result and, thus, they may not seek or receive a confirmatory HIV test. Second, this method involves a certain level of independence and assumes a basic level of HIV knowledge to ensure proper interpretation of reactive tests and linkage to further testing and care. Thus, the interpretation of the HIVST results need to be validated by trained professionals. This can be challenging during the lockdown and, thus, it is recommended that HIV awareness-raising, counselling services and proactive engagement of at-risk communities, collectively, remain at the forefront of HIV prevention efforts in the EMR.

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