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Assisted partner services for HIV case-finding

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Data from sub-Saharan Africa show that a substantial reservoir of undiagnosed HIV infection remains in the area, as well as a large proportion of diagnosed people who are not on treatment. According to UNAIDS, 36.7 million people are living with HIV globally, of whom 25.6 million (70%) are in sub-Saharan Africa where 12.0 million (47%) are on antiretroviral therapy.¹ As of 2015, the global gap for the UNAIDS 90-90-90 targets was 10.9 million people living with HIV who did not know their HIV status.² To achieve the first 90 (diagnosis of HIV), countries need to implement innovative and targeted HIV case-finding approaches.

Delivery of partner services is the process through which a public health system ensures that sex and needle-sharing partners of people infected with HIV are notified of their exposure and subsequently assessed and engaged in care.³ Partner services fit into a model of case-finding through screening because the approach is a type of targeted screening in networks of infected and exposed people.⁴ Partner services have not been included in HIV prevention programmes in sub-Saharan Africa. Although partner or family testing of individuals diagnosed with HIV and disclosure of infection are within the standard of care, health facilities often take a passive approach and focus on the immediate family or household, and do not routinely follow up patients to ensure that all of their contacts have been tested. Common concerns include loss of confidentiality, the threat of intimate partner violence, stigma, discrimination, and absence of community and political support.⁵ Despite these barriers, findings from one review⁶ of partner services in low-income countries showed that most people accepted the principles of partner notification.

New evidence further reinforces the acceptability and effectiveness of partner services. In *The Lancet HIV*, Peter Cherutich and colleagues⁷ test a partner services programme in what they describe as a pragmatic community trial. This unmasked cluster-randomised trial done in 18 districts in Kenya compared immediate with delayed (6 weeks after enrolment) assisted partner services. Compared with the delayed group, investigators found that immediate assisted partner services were associated with an increase in partner HIV testing (incidence rate ratio 4.8, 95% CI 3.7–6.4), the number of sex partners testing for the first time (14.8, 5.4–41.0), new HIV diagnoses (5.0, 3.2–7.9), and enrolment of HIV-positive partners into care (4.4, 2.6–7.4).

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This study shows the proper pragmatic use of randomisation in population-level studies because the study population was randomised to a new approach in the context of the existing programme. Most importantly, this approach to randomisation serves translational aspects of research through the fact that the study itself tests the principle of partner services in the relevant programmatic setting.⁸ Even the study participation (70%) would be considered meaningful in the context of most prevention programmes for HIV and sexually transmitted diseases. Of course, investigators of future studies might learn how to modify steps in the partner services algorithm tested in this study to improve efficiency. In the meantime, application of the partner services algorithm as tested in this study seems to pose little risk because the new approach resulted in an almost 15 times increase in new testing and five times increase in new diagnoses. With effect sizes this large, a very large unknown confounder would have to be present in the environment for the findings not to be valid. Despite achievements to date and known barriers that have prevented adoption of partner services, findings from this study support calls to say no to complacency made during the AIDS 2016 conference in Durban.⁹ Scaling up of immediate assisted partner services is clearly an innovative casefinding approach that might be instrumental in helping countries achieve UNAIDS Fast-Track targets by 2030.¹⁰

Some issues pertinent to sustainability exist. For example, the authors note counsellors' training requirements and suggest that some efforts might be needed to rely on "task shifting to a less highly educated cadre than those used in this study" in the future. Additionally, districts with administrative hurdles or low numbers of people with HIV infections were excluded from the trial. A national programme would of course have to overcome these hurdles and provide a minimum level of services for low-prevalence sites. That noted, the study incorporated 18 of 28 districts across Kenya with a-priori administrative acceptance, indicating first steps toward sustainability.

In the USA, HIV partner services appear to be a cost-effective prevention and control strategy.¹¹ In countries such as many of those in sub-Saharan Africa, even though the cost of treatment might be lower than in the USA, and therefore cost-effectiveness harder to achieve, the number of undiagnosed HIV cases in sub-Saharan Africa suggests that any method that yields as many cases as shown in this study is likely to be worth the investment. For that matter, a partner services programme also reveals networks of transmission and social contact and connects people infected with HIV to life-saving health services. A well known comment in partner services literature reads "contact tracing's price is not its value",¹² an axiom shown once again.

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