OptTEST
OPTIMISING TESTING AND LINKAGE TO CARE FOR HIV ACROSS EUROPE

SCALING UP EARLY DIAGNOSIS FOR HIV THROUGH DIVERSIFYING HIV TESTING APPROACHES BEYOND CLINICAL SETTINGS

Policy briefing

Overview

Achieving the global and country commitments to end the AIDS epidemic by 2030 requires a significant expansion and diversification of HIV testing and linkage to care interventions that address the needs of key affected populations.

Across the European region, over 2 million people are living with HIV, and one-third of them do not know their status. Across Europe the HIV epidemic is still primarily concentrated to specific high risk "key population" groups: i.e. men who have sex with men (MSM), people who inject drugs (PWID), prisoners, sex workers and migrants from high HIV prevalence countries.

Barriers to early HIV diagnosis across Europe, include institutional and health care provider level barriers (accessibility of testing facilities, laws and regulations, stigma and discrimination, reluctance to offer the test) as well as patient level barriers (such as perceived low risk or fear of positive result).[1]

Leading international institutions and organisations now promote diversifying HIV testing strategies which are tailored to the epidemic profile of each country in order to reach key populations.

This policy brief calls for expanding access to HIV testing through diversifying HIV testing approaches beyond medical settings. Such expansion would include more testing in non-medical settings, HIV testing delivered by trained lay providers and HIV self-testing. A second policy brief examines the expansion of provider initiated HIV testing with focus on implementation of indicator condition-guided HIV testing.

[1] J Deblonde, et al. Barriers to HIV testing in Europe: a systematic review. Eur J Public Health 2010; 20 (4): 422-432

This policy brief was developed for the OptTEST by HiE project, coordinated by CHIP, RegionH by Bryan Teixeira, Ann Isabelle von Lingen (EATG).

Acknowledgments
Thanks to the OptTEST project partners and steering committee, and CHIP in particular Stine Finne Jakobsen (CHP), Maiken Mansfeld (CHIP) and Ida Sperle (CHIP) and Ann Sulllivan (SSAT) for their thorough review and input.

OptTEST is co-funded by the 2nd Health Programme of the European Union.

Suggested citation:
Bryan Teixeira, Ann Isabelle von Lingen for OptTEST by HIV in Europe, OptTEST: Scaling up early diagnosis for HIV through diversifying approaches beyond clinical settings, Belgium 2017.

Belgium, August 2017

1. The policy context

Key policy documents	Relevant action points and conclusions
ECDC HIV Testing: increasing uptake and effectiveness in the European Union (2010)	- Increase HIV testing conducted in non-medical settings, in collaboration with NGOs, and establish community-based testing services for marginalised and vulnerable groups like uninsured individuals, non-residents, undocumented migrants, PWID, MSM and prisoners. - Address the restriction of HIV testing provision to particular professional groups or settings. - Replace pre-test 'counselling' with pre-test discussion to normalize HIV testing. - No longer require detailed sexual and/or drug-taking history before offering an HIV test.
WHO Consolidated Guidelines on HIV testing services (2015)	- Introduce an additional new HIV testing approach: *test for triage*, where trained and supported lay providers conduct a single HIV rapid diagnostic test (RDT) and then refer individuals on to other health services depending on their test results. - Expand community-based testing to include home-based testing, mobile outreach campaigns, and testing in workplaces, parks, bars, places of worship and educational establishments, and any other settings convenient to key populations. - No longer recommend pre-test risk assessment & counselling.
WHO Global Health Sector Strategy on HIV, 2016-2021 (2016)	- Scale up testing efforts to reach key and other vulnerable populations, e.g., men who have sex with men, people who inject drugs, sex workers, transgender people, prisoners, and mobile and displaced populations. - Overturn laws and change practices that create barriers for these populations in accessing effective services, such as age of consent laws for adolescents, lack of social protection for migrants and displaced populations, and the criminalization of drug use, sex work and sex between men. - National HIV programmes to include decentralised self- and community-based testing and task-shifting to lay testers.
WHO Action plan for the health sector response to HIV in the WHO European Region (2016)	- Focus HIV testing services to reach key populations in settings where HIV prevalence is highest and ensure early linkage to treatment, care and prevention services. - Promote rapid HIV testing through an expanded range of approaches as appropriate to the national context – including testing initiated by health care providers, testing of key populations through community and outreach services and lay service providers, testing in closed settings and self-testing. - Simplify the strategy for HIV diagnosis to ensure timely enrolment in treatment and care.
UN Political Declaration on HIV and AIDS (2016)	- Member States committed to using a variety of HIV testing strategies, including community-based testing, and to addressing legal and regulatory barriers to such testing. - Governments also committed to reform any legislation that may create barriers to testing in general, and specifically mentioned age of consent laws, and policy provisions and guidelines that restrict access to services among adolescents.
WHO *Guidelines on HIV self-testing and partner notification (2016)*	- Strongly recommend an additional approach to HIV testing services, i.e., HIV self-testing (HIVST), a process where someone collects his/her own specimen, performs the test, and interprets the result, either with the assistance of someone else (assisted HIVST) or on their own (unassisted).

2. Summary of the evidence

2.1. Outreach testing, community-based HIV testing and testing by trained lay providers

Experience show that community-based centres and lay provider HIV testing interventions that are located within easy reach, are proactive in their approach and have low barriers to accessing testing play a crucial role in reaching people unknowingly living with HIV and linking them to care, in particular among key populations. It is estimated that certain community testing centres are capable of detecting 20% of the HIV cases.[2]

A systematic review from 2017 on HIV testing conducted by trained lay providers using HIV RDTs found high patient satisfaction and similar quality (sensitivity/specificity) when compared to HIV testing conducted by health care personnel.[3]

The OptTEST project examined legal and regulatory barriers which impede access to HIV testing and linkage to care the 53 WHO European region countries. The project also compiled a comprehensive overview of the extent of community-based HIV testing, usage of trained lay providers, self-testing across the European region, as self-reported by people on the ground in these 53 countries. The overview found that in 14 countries NGOs can perform rapid testing without clinical supervision (Belarus, Cyprus, Finland, France, Germany, Hungary, Kyrgystan, Malta, Moldova, Norway, Romania, Spain, Sweden, Switzerland). Nevertheless, the most current information indicates that testing in NGOs is still not legal in 7 countries (Albania, Armenia, Iceland, Kazakhstan, Montenegro, Turkey and Uzbekistan).[4]

A recent study from the Euro HIV EDAT project[5] demonstrates that the community based service model most frequently designed for MSM (The Checkpoint model) produce benefits in terms of numbers of HIV reactive tests at an acceptable cost, regardless of the epidemiological context and prices in the country. Common elements of the Checkpoint model include linkage/referral to care, staff consisting largely of peer volunteers, predominantly use of rapid tests, provision of pre- and post-test counselling, and that the service is offered by community-based organisations outside the formal national health system.

Detection and linkage to care in the Barcelona Checkpoint
Barcelona Checkpoint (BCN Checkpoint), a community led service to MSM, has noted that since 2009 more than one-third of all new HIV cases in Catalonia were detected from their Checkpoint. More than half of the cases detected were from infections within the last 12 months. Of those with reactive tests, 88.8% were linked to care by the Checkpoint and another 5.2% self-linked, for a total linkage to care of 94%[6]. A recent pilot from BCN came to the conclusion that same day confirmation of reactive rapid point-of-care HIV testing accelerates linkage to care and reduces anxiety[7].

[2] M. Meulbroek, *BCN Checkpoint: Same-day confirmation of reactive HIV rapid test with Point Of Care PCR test accelerates Linkage to Care and reduces anxiety*, HepHIV Conference 2017. See also *Checkpoints: Beyond VCT Centres. Next steps for Community Testing in Europe.* Barcelona - 20 October 2015 - Meeting Report.
[3] C. E. Kennedy, P. T. Yeh, C. Johnson & R. Baggaley (2017): Should trained *lay providers perform HIV testing? A systematic review to inform World Health Organization Guidelines, AIDS Care*
[4] http://legalbarriers.peoplewithhiveurope.org/en
[5] J Perelman et al. AIDS Care 29 (8), 985-989. 2016. Economic *evaluation of HIV testing for men who have sex with men in community-based organizations – results from six European cities*
[6] Presentation at a satellite session of the HepHIV 2014 Conference in Barcelona community testing centres
[7] M. Meulbroek, *BCN Checkpoint: Same-day confirmation of reactive HIV rapid test with Point Of Care PCR test accelerates Linkage to Care and reduces anxiety*, HepHIV Conference 2017.

Cost-effectiveness of testing in Checkpoints
The Euro HIV EDAT study has looked at cost-effectiveness of testing in Checkpoints in Athens, Copenhagen, Lisbon, Ljubljana, Lyon, and Paris. Data on costs were collected on all resources used in the services: operating space, utilities, staff costs, test kits, capital costs, transportation, and communication. Data on effectiveness was based on the number of HIV tests, number of HIV reactive tests, and number of HIV reactive tests successfully linked to care. The cost per HIV reactive test varied from 1,966€ (Athens) to 9,065€ (Ljubljana). The scientific literature on this topic, mostly from the USA, points to values ranging from 1,391€ to 14,763€ per HIV reactive test in clinical and non-clinical settings. The article concludes that median costs for these rapid testing services are among the lowest found in the literature (always slightly above or below 100€ per test and below 10,000€ per detected case).[8]

2.2. Self-testing

A systematic review from 2016 conducted by WHO on HIV self-testing and partner notification found that HIV self-testing increased the uptake of HIV testing among male partners of pregnant or postpartum women and the frequency of HIV testing among MSM.[9] Self-testing was not shown to increase HIV risk behaviours, decrease the uptake or frequency of testing for STIs, increase social harm or other adverse events.

According to data from OptTEST self-testing is allowed in 11 countries: Belgium, Czech Republic, Estonia, France, Moldova, the Netherlands, Portugal, Romania, Russia, Ukraine, and the UK. However, in fact, HIV self-testing kits are currently only legally sold in Belgium, France, Italy and the UK.[10]

Transition to self-testing in Ukraine
In Ukraine, a government protocol required that HIV tests were administered by medical professionals. However, with the withdrawal of Global Fund support, there was a need to reduce the costs of the medical staffing for conducting community-based rapid testing. The continuance of community-based testing services for key populations like MSM, drug users and sex workers was put in jeopardy.
The International HIV/AIDS Alliance in Ukraine (now the Alliance for Public Health, www.aph.org.ua) had operated these community-based rapid HIV testing services since 2007. They therefore contracted a lawyer to review the legislation and discovered that the government protocol only covered testing when administered by a second party. Self-administered HIV testing had not been thought of when the law was drawn up. The Alliance therefore replaced the existing medical service with a new self-testing service using rapid testing kits supervised by peer support staff. In 2015, as a result of this change, the Alliance was able to support more than 200,000 tests and diagnose over 4,000 people with HIV.

RECOMMENDATIONS

1. Increase the reach of HIV testing to key populations through non- medical and community settings, e.g., mobile outreach campaigns, testing in parks, bars, saunas and places of worship where migrant gather, home-based testing, self-testing, and in any other locations or settings convenient to key populations.

2. Legalise and make HIV rapid testing available

[8] *Economic evaluation of HIV testing for men who have sex with men in community-based organizations – results from six European cities, December 2016*
[9] WHO *Guidelines on HIV self-testing and partner notification (2016)*
[10] http://legalbarriers.peoplewithhiveurope.org/en

3. Establish community-based HIV testing services for/with marginalised and vulnerable groups, in collaboration with NGOs and peers, e.g., uninsured individuals, non-residents, undocumented migrants, PWID, MSM, and prisoners.

4. Promote a community-based HIV testing approach that involves trained and supported lay providers conducting HIV rapid testing.

5. Establish effective pathways between all new testing strategies and relevant HIV services, specifically for confirmatory testing and care where there is a reactive HIV test, and linkage to prevention services (including reminders to regularly re-test) for those with negative HIV tests

6. Replace specialist pre-test 'counselling' with pre-test discussion.

7. Make new testing tools affordable to help ensure access and address the price barriers of self-testing.

8. Remove any requirements for written consent, or a detailed sexual or drug-taking history before offering an HIV test.

9. Overturn laws and regulatory practices that create barriers for vulnerable populations to access testing, e.g., age of consent laws for adolescents, lack of social protection for migrants and displaced populations, and the criminalization of drug use, sex work and sex between men

OptTEST PARTNERS

chip
Centre for Health & Infectious Disease Research

REGION H Rigshospitalet

Aids Fonds

EATG European AIDS Treatment Group

GNP+ Global Network of People Living with HIV

MEDFASH

Public Health England

Tervise Arengu Instituut
National Institute for Health Development

Inserm

SSAT
St Stephen's AIDS Trust

Ministerio de Economía y Competitividad

isc Instituto de Salud Carlos III

Co-funded by the 2nd Health Programme of the European Union