HIV in Europe
Working Together for Optimal Testing and Earlier Care

Status Document on the Monitoring and Evaluation of HIV Testing Efforts in Europe

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Contents

1. Introduction

The rate of HIV transmission remains high despite new HIV testing policies, strategies and guidelines, and in 2015 153,407 people were newly diagnosed with HIV in the WHO European Region (1). Increasing HIV testing uptake is instrumental in controlling the epidemic, and while there have been improvements, testing among key populations at high risk of HIV remains low (2). Recent evidence demonstrates that the number of people with HIV presenting late for care has not decreased over the last 10 years (3). Availability of robust monitoring data on HIV testing services to inform the design and tailoring of HIV testing programmes as well as the allocation of resources is therefore key. However, limited availability of data and poor data quality make it difficult to assess and compare data across countries, and to identify and address current gaps in order to improve HIV testing uptake and reduce late diagnosis in Europe.

2. Aim and Objectives

The aim of this project was to develop a status document providing an overview of current initiatives and best practices on monitoring and evaluation (M&E) of HIV testing in the WHO European Region with focus on assessing the level of available HIV testing data from community and health care settings as well as from self-sampling or self-testing.

Objectives

- To describe current initiatives (including the main actors, and overlaps and gaps between initiatives) defining and using standardized indicators and data collection tools for the monitoring and evaluation of HIV testing in community and health care settings as well as from self-sampling/self-testing.[1]
- To provide an overview of existing data collection tools and M&E frameworks targeted at community and health care settings as well as HIV self-sampling or self-testing.
- To identify best practices and main gaps in the use of standardised indicators for M&E on HIV testing and linkage to care in community and health care settings as well as HIV self-sampling or self-testing.

3. Methodology

To address the aim and objectives of the project, a mixed methods approach was used including: I) Desk review to identify publications on monitoring and evaluation of HIV testing; II) Survey to national focal points on HIV testing sites and data collection practices; and III) Key informant interviews.

I. Desk review

An online search was conducted in Google in July - August 2016 to identify reports and articles in English on HIV testing. The following search terms were used: "HIV testing Europe" AND "monitoring, evaluation, case reporting, coverage, positivity rate, uptake, evaluation, survey, guidelines, tool, indicator, standards, prevalence, incidence, surveillance, health care settings, community-based, home-based, self-test, linkage to care, high risk populations, MSM, PWID, SW, migrants, young people".

The identified reports and articles (abstracts or full text) were screened based on the following criteria:

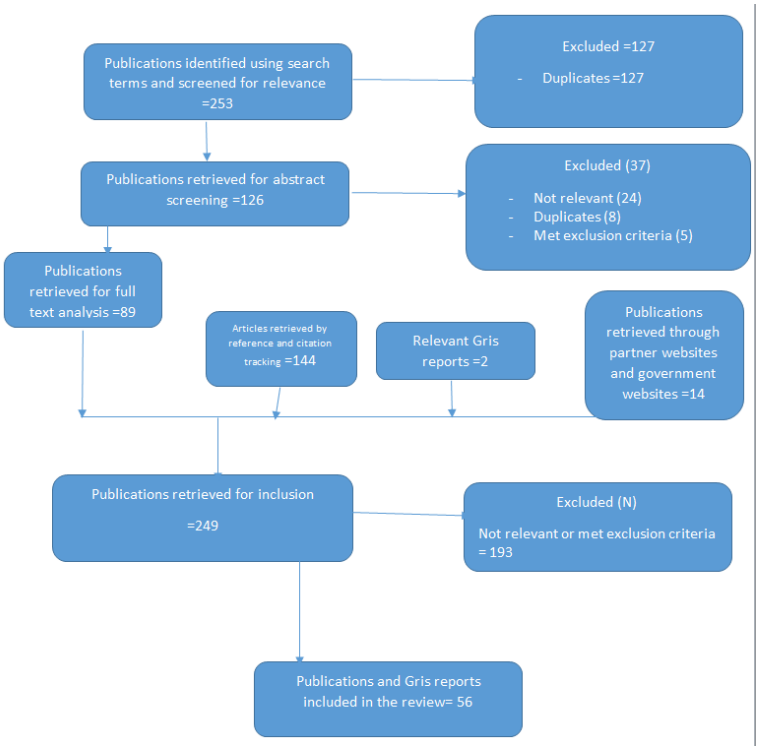
[1] This setting was not sufficiently covered in the overall report and not included in this short report

- Inclusion criteria: Publications focused on monitoring or evaluation of a project, programme or initiative on HIV testing and/or linkage to care in any of the 53 Member States of the WHO European Region.
- Exclusion criteria: Publications focused on assessing HIV policies or strategies, implementation of testing strategies, effectiveness, cost-effectiveness, impact and/or screening programmes (Antenatal Care (ANC) testing and blood screening).

Additional searches were performed: a) from the references of the included articles; b) websites of key international organizations (European Center for Disease Control, WHO, UNAIDS), c) grey literature identified through correspondence with the HiE Working Group (WG) on HIV testing.

The final list of relevant articles, reports and documents was compiled in an Excel database.

Figure 1: Diagram of the publication selection process



II. Quantitative survey on HIV testing settings

One question on where people can test for HIV in a given country and whether the data from these settings is captured as part of national level surveillance was included in the OptTEST survey on linkage to care distributed in September 2016 to ECDC's national surveillance contacts in EU/EEA countries in collaboration with ECDC (See Annex 1).

III. Key informants interview

In September-October 2016 interviews were held with key informants from identified relevant projects and initiatives working on defining and using standardized indicators and data collection tools for the monitoring and evaluation of HIV testing. An interview guide was circulated ahead of the interview and included questions on existing HIV testing monitoring initiatives and projects on standardising M&E of HIV

testing, practices and challenges of using indicators, and ideas for improvement (See Interview guide and list of experts in Annex 2).

4. Results from desk review

4.1 Identification of recommended variables and indicators

The review and searches conducted of key international organizations (European Center for Disease Control, WHO, UNAIDS) websites yielded a dozen guidelines and guidance documents, which recommend variables and indicators for HIV testing M&E.

To extract the most widely recommended variables and indicators for the national M&E of HIV testing, five key documents issued by ECDC, WHO Europe and WHO HQ were selected and reviewed:

1. WHO/ECDC: "Dublin Declaration indicators and progress reports" (2): ECDC is in charge of the continuous Dublin Declaration monitoring process of Europe's response to HIV. Reports are prepared drawing on several data sources (country reporting to UNAIDS on core indicators used for Global AIDS Response Progress Reporting (GARPR); country data collected by EMCDDA on HIV and drug use; and the specific Dublin questionnaire developed by ECDC in consultation with country representatives that focuses on regional issues, including key populations most affected by HIV). The regular progress reports presents main findings, key issues and progress made for the various stages of the HIV continuum of care.
2. ECDC: "HIV testing: increasing uptake and effectiveness in the European Union, ECDC guidance" (4). This guidance was published in 2010,and the main objective was to present all of the available evidence on HIV testing in order for European countries to develop and implement effective HIV testing interventions and to ensure equal access to HIV-related services. The guide has been widely adopted and referenced nationally throughout Europe and continues to be relevant among international guidelines (8).
3. WHO: "Consolidated Guidelines on HIV Testing Services: 5Cs: Consent, Confidentiality, Counselling, Correct Results and Connection 2015 (Chapter 10 - Monitoring and Evaluation)" (5). From 2015, these WHO guidelines focus on methods of effective delivery of HTS in a variety of settings, recommendations to support HTS performed by trained lay providers and considerations on HIV self-testing. The key audiences for the guidance range from national programme managers and service providers to those providing HTS in community-based settings.
4. WHO: "Monitoring the building blocks of health systems: A handbook of indicators and their measurement strategies" (6). This publication from 2010, is a guide for decision makers to track progress and performance of health systems, evaluate impact and ensure accountability. This guide covers six health system core components: (i) service delivery, (ii) health workforce, (iii) health information systems, (iv) access to essential medicines, (v) financing, and (vi) leadership/governance; and outlines for each the related indicators, information sources and strategies.
5. WHO: "Guide for monitoring and evaluating national HIV testing and counselling (HTC) programmes" (7).Published in 2011, this guide aims to describe a set of indicators that can be used by national programme managers to monitor and evaluate HIV testing services. It draws on and integrate indicators from the UN system, WHO and UNAIDS – both indicators that rely on routine monitoring and on periodic population surveys – with a focus on national programme level.

A review of the five documents identified a series of "HIV testing"-related variables and indicators, which all were mentioned at least once (Table 1).

Table 1: Recommended HIV testing-related variables and indicators

Variables:	**Indicators:** *(see Annex 3 for a definition of the indicators)*
• N of people seen at service • N of tests • N of reactive tests (rapid test results) • N of new diagnoses (confirmed) • N of linked to care • N of new diagnoses with AIDS at presentation • N of new diagnoses recently infected	• Coverage • Uptake • Positivity rate • Offer rate • Linkage to care rate

An overview of the recommended variables and indicators for M&E of HIV testing identified in the different HIV testing guidelines is provided below (Table 2).

Table 2: Recommended indicators to measure HIV testing services in European and international guidelines

	Monitoring of the Dublin Declaration (ECDC)(2)	**2010 Guidelines on HIV testing (ECDC)(4)**	**2015 Consolidated Guidelines on HIV Testing Services (WHO) (5)**	**2010 Monitoring the building blocks of health systems (WHO) (6)**	**2011 Guide for monitoring and evaluating (WHO) (7)**
VARIABLES					
N of people seen at service					
N of tests		X			X
N of reactive tests (e.g. rapid test result)		X			
N of new diagnoses (confirmed)	X	X	X		
N of linked to care		X	X		X
N of new diagnoses with AIDS at presentation	X		X		
N of new diagnoses recently infected	X		X		
INDICATORS					
Coverage		X	X	X	X
Uptake			X		
Positivity rate					
Offer rate		X			X
Linkage to care rate		X	X		X

4.2 Google search for publications on HIV testing M&E

The conducted Google search to identify publication on monitoring or evaluation of a project, programme or initiative on HIV testing and/or linkage to care yielded 56 articles and grey literature reports including, the guidance documents and guidelines described in the previous section(diagram of selection process in Figure 1). The included publications have been organized according to the HIV testing setting: 1) health care, 2) community and 3) self-sampling/self-testing.

4.2.1. HIV TESTING DATA IN HEALTH CARE SETTINGS (NON-HIV SPECIALIST)

There are ten publications - primarily peer-reviewed journal articles - reporting on monitoring and evaluation of HIV testing in non-HIV specialist health care settings such as primary care services, emergency departments, low thresholds drugs services, general practitioners, emergency departments and dermatology departments. In terms of the data gathered in the studies, 10/10 studies monitored “positivity rate”, 9/10 monitored “coverage” and “uptake”, 7/10 monitored “offer rate” and only 1/10 monitored the “linkage to care rate” (Table 3).

Table 3: Monitoring of HIV testing in non-HIV specialist health care settings

Reference N	Author(s), year	Country/ agency	Setting	Brief description of the study	Collected data*	Sample size
9	Sullivan A, et al., 2013	Regional	Inpatient and outpatient health facilities	*Feasibility and Effectiveness of Indicator Condition-Guided Testing for HIV: Results from HIDES I (HIV Indicator Diseases across Europe Study)* HIDES I was a survey of indicator condition-guided HIV testing across 16 hospital settings in Europe from 2009-2011.The study proved that IC guided HIV testing is acceptable, feasible and an effective strategy to facilitate early HIV diagnosis. The highest positivity rate was found in clients with STIs at 4.06%. Median coverage of testing in hospital settings was 92% and 12% in primary care. The median uptake in both settings was 96% (range 62–100%).	• Coverage • Uptake • Positivity rate • Offer rate of HIV test	3588
10	Raben D, et al., 2015	Regional	Inpatient and outpatient health facilities	*Auditing HIV Testing Rates across Europe: Results from the HIDES 2 Study* The HIDES-2 study created an audit system of HIV IC guided HIV testing in HS. The overall test rate was 72%. The lowest- median was in Northern Europe at 44%, while the highest was in Eastern Europe at 99%. Tuberculosis and oesophageal candidiasis patients were found to be most likely to be HIV positive. Positivity rate was highest in Southern Europe (2,9%) and Eastern Europe (1,2%).	• Coverage • Uptake • Positivity rate	7037
11	Burns F, et al., 2013	UK	Acute admissions unit	*Acceptability and Feasibility of Universal Offer of Rapid Point of Care Testing for HIV in an Acute Admissions Unit: Results of the RAPID Project* In the RAPID project, rapid HIV point of care tests were offered to patients (19-65 years old) at an acute medical admission unit where an educational video was shown to clients while in the waiting room. HIV testing performed at acute admission unit was found as acceptable, feasible and cost-effective. Three tests were found positive out of the 135 people tested (2.2%). 23.0% of eligible admissions (606) had an HIV test. 93.6% (131/140) agreed to an HIV test and four patients had an HIV test but did not watch the video. Three tests (2.2%, 3/135) were reactive and all were confirmed HIV positive on laboratory testing.	• Coverage • Uptake • Positivity rate • Offer rate of HIV test	606
12	Rayment M, et al., 2012	UK	Emergency Dept, Acute Care Unit, Dermatology Outpatient, Primary Care	*HIV Testing in Non-Traditional Settings – The HINTS Study: A Multi-Centre Observational Study of Feasibility and Acceptability.* The HINTS study was a multi-centre observational study of HIV testing in four non-traditional settings which showed high HIV testing feasibility and acceptability of routine HIV testing offers. The study had a 92% acceptance rate. Eight individuals were diagnosed with HIV and all transferred to care. No significant associations were found between uptake and ethnicity, or clinical site. 96% of health care providers supported the expansion of HIV testing while 72% identified a need for training.	• Coverage • Uptake • Positivity rate • Offer rate of HIV test • Linkage to care rate	6194
13	Rayment	UK	Emergency	*Routine HIV testing in the emergency department: tough lessons in sustainability*	• Coverage	

	M, et al., 2013		department	In this study, all attending emergency department patients fulfilling the inclusion criteria were offered an HIV test. The mean proportion offered an HIV test was 14%, while the mean proportion accepting a test was 63%. Patient uptake remained high, however, maintenance of test offering needed further examination.	• Uptake • Positivity rate • Offer rate of HIV test	
14	Moreno S, et al. 2012	Spain	Primary care	*Prevalence of undiagnosed HIV infection in the general population having blood tests within primary care in Madrid, Spain.* HIV tests were offered to all clients (16-80 years old) at blood extraction centres who were having blood tests for non-HIV related reasons. 12 patients tested HIV positive, however, many were already under follow-up care for medical conditions (including: abnormal liver function tests, anaemia, hyperthyroidismand hypercholesterolaemia). The positivity rate was 0.35 therefore the study concluded that routine offers of HIV testing was needed.	• Uptake • Positivity rate	3695
15	Joore IK, et al., 2016	Netherlands	GP: STI-related consultation	*Missed opportunities to offer HIV tests to high-risk groups during general practitioners' STI-related consultations: an observational study.* In this observational cohort study, medical data of HIV-positive patients in HIV care from 2008-2013 was examined to look at the HIV testing offer rate during STI-related consultations with Dutch general practitioners. HIV testing coverage was reported in 40% of STI related consultations with the key reason of non-testing being low risk perception by the doctor or the client. Patients in general practice with STI related consultations were more likely to be (1) female or heterosexual males than MSM; (2) sub-Saharan African than Dutch; and (3) 50 years or older. The study found that one-third of the STI-related consultations of persons from high-risk groups did not have an HIV test performed in primary care.	• C Coverage • Uptake • Positivity rate • Offer rate of HIV test	907
16	Desai M, et al., 2013	UK Public Health agency London, UK.	Sexual health clinics	*Audit of HIV testing frequency and behavioural interventions for men who have sex with men: Policy and practice in sexual health clinics in England.* 25 sexual health clinics were surveyed using a semistructured audit asking about risk ascertainment for MSM, HIV testing and behavioural intervention policies. The audit found that 42% (251/598)of the men surveyed was offered and accepted behavioural intervention and 92% (552/598) had one or more HIV test(s) over a 1-year period.	• Coverage • Uptake • Positivity rate • Offer rate of HIV test	598
17	Tweed E, et al. 2010	Leeds Teaching Hospital Trust laboratory PHE	Non-specialist healthcare settings	*Monitoring HIV testing in diverse healthcare settings: results from a sentinel surveillance pilot study.* This study assessed the feasibility and utility of sentinel laboratory surveillance of HIV testing as a tool for understanding patterns and trends in HIV testing in a range of healthcare services. Over a 12 month period, 77 % of positive cases were found to come from genitourinary clinics and antenatal settings. Additionally, 13% came from haemodialysis, fertility treatment and occupation health screenings and less than 4% came from general practice.	• Coverage • Positivity rate	41013

18	Elmahdi R, et al. 2014	Imperial College London, Univ. of Amsterdam and Amsterdam institute of Global Health.	Non-specialist healthcare settings	*Low levels of HIV test coverage in clinical settings in the UK: a systematic review of adherence to 2008 guidelines.* A systematic review of 30 studies in the UK measured adherence to the 2008 National Guidelines on routine HIV testing. The review looked at testing levels in non-specialist settings. The overall pooled estimate of test coverage was 27.2%. Testing coverage was higher in settings where routine testing is recommended (29.5%; genitourinary medicine, sexual health and antenatal clinics) than in those with clinical indicator diseases (22.4%). The audit demonstrated high test acceptance by patients (71.5%) and low test offer rates by providers (40.4%) in non-specialist health settings.	• Coverage • Uptake • Positivity rate • Offer rate of HIV test	30 audit studies

*Austria, Belarus, Belgium, Bosnia, Croatia, Denmark, Germany, Italy, Netherlands Poland, Spain, Sweden, UK, Ukraine

**Indicator Conditions: Sexually transmitted infections (STI); Malignant lymphoma, irrespective of type (LYM); Cervical or anal cancer/dysplasia (CAN)' Herpes zoster (HZV); Hepatitis B or C virus infection, acute or chronic, and irrespective of time of diagnosis relative to survey (HEP); Ongoing mononucleosis-like illness (MON); Unexplained leukocytopenia/thrombocytopenia lasting >4 weeks (CYT); Seborrheic dermatitis/exanthema (SEB).

4.2.2. HIV TESTING DATA IN COMMUNITY-BASED SETTINGS

Eleven of the included articles reporting on monitoring and evaluation of HIV testing in community based settings (Table 4). In the included studies: 11/11 monitored "positivity rate", 7/11 reported "linkage to care" rates, 4/11 "coverage rate", but only 1/11 monitored "offer" and "uptake" rates.

Table 4: HIV testing Data collected at Community-based Settings

N Ref	Authors	Country/agency	Setting	Brief description of the study	Collected data	Sample size
19	Fernàndez-López L, et al., 2016	22 countries*	MSM, PWID, SW	*The COBATEST network: a platform to perform monitoring and evaluation of HIV community-based testing practices in Europe and conduct operational research* In 2014, the COBATEST network consisted of 40 CBVCTs in 18 European countries. Data regarding HTS services was collected from this network and provided a common database for global data analysis and comparison in order to evaluate HTS in the Europe.	• Coverage • Positivity rate • Linkage to care rate	9266
20	Vanden Berghe W, et al. , 2011	Belgium	MSM venues	*A venue-based HIV prevalence and behavioural study among men who have sex with men in Antwerp and Ghent, Flanders, Belgium, October 2009 to March 2010* This study found a prevalence of HIV among MSM to be 14%. This study was the first of its kind in Belgium and the results constitute the evidence base for local, targeted interventions.	• Positivity	649
21	Belza MJ, et al., 2015	Spain	Outreach street-based HIV testing	*Assessment of an outreach street-based HIV rapid HIV testing programme as a strategy to promote early diagnosis: A comparison with two surveillance systems in Spain* This study monitored mobile CBVCT services in different neighbourhoods in Madrid from 2008-2011. This study found a 4% HIV prevalence among Spanish-born MSM and 15% prevalence among MSM from Latin America.	• Coverage • Positivity rat • Linkage to care rate	8923
22	Gios L, et al., 2016	13 countries*:*	MSM	*Bio-behavioural HIV and STI surveillance among men who have sex with men in Europe: the Sialon II protocols* Sialon II was a multi-centre biological and behavioural cross-sectional survey carried out across 13 European countries in community settings. The purpose of the survey was to implement a large-scale bio-behavioural survey among MSM in order to contribute significantly to increasing the comparability of data in EU countries through the use of common indicators and in implementing effective public health strategies and policies in areas of high need.	• Positivity rate • M • Linkage to care rate	1305
23	Parisi M, et al., 2013	Italy	MSM	*Cross - sectional study of community serostatus to highlight undiagnosed HIV infections with oral fluid HIV - 1/2 rapid test in non - conventional settings* From 2008 – 2012, the "EASY test Project" provided HIV rapid tests through a mobile clinic in different settings to evaluate the acceptability of alternative, free and anonymous testing. Of the amount of people that were tested (7,865), 50 new infections were found (0.6% of the total) and 48% had never undergone an HIV screening before.	• Coverage • Positivity rate Linkage to care rate	7865
24	Qvist T, et al., 2014	Denmark	CBVCT - checkpoi	*High linkage to care in a community-based rapid HIV testing and counseling project among men who have sex with men in Copenhagen*	• Positivity rate • Linkage to care	3012

			nt	This study evaluated the reach of a community-based HTS program with MSM. All who tested HIV positive (38/3012) had confirmatory testing (with 1 to be found false positive). All but 1 were successfully linked to care and achieved full viral suppression after a median of 8 months.	rate	
25	Fernández-Balbuena S, et al., 2014	Spain, Madrid	Outreach street-based HIV testing	*Highly visible street - based HIV rapid testing: Is it an attractive option for a previously untested population? A cross - sectional study* A street-based mobile programme was implemented in various Spanish cities to conduct rapid tests and a risk behaviours survey to evaluate its effectiveness in attracting persons at risk for infection. This programme saw 3517 fito evaluate its effect22 who tested positive (prevalence of undiagnosed HIV infection: 0.6%). Of those who tested positive, 19 were MSM (3.1%), 1 was MSW (0.1%) and 2 were women (0.1%).	• Coverage • Positivity rate	7552
26	Bozicevic I, et al., 2012	Croatia	MSM venues	*Prevalence of HIV and sexually transmitted infections and patterns of recent HIV testing among men who have sex with men in Zagreb, Croatia* A bio-behavioural survey was conducted from 2010 – 2011 to determine the prevalence of HIV and other STIs among MSM. The study found a HIV prevalence of 2.8%.	• Coverage • Positivity rate	387
27	Marcus U.2015	Germany	CBVCT checkpoint	*Risk factors for HIV and STI diagnosis in a community-based HIV/STI testing and counselling site for men having sex with men (MSM) in a large German city in 2011–2012* To identify current risk factors for a diagnosis of HIV and/or STIs among MSM in Germany, HIV and STI testing were offered anonymously and free of charge at CBVCTs. During this study, 2.9% of the clients tested positive for HIV (41/1413) and syphilis or rectal STI diagnosis were associated with increased risk for HIV diagnosis.	• Coverage • Positivity rate • Linkage to care rate	1476
28	Wouters K, et al. 2014	Belgium	Low threshold HIV testing service	*Use of rapid HIV testing in a low threshold centre in Antwerp, Belgium, 2007 – 2012.* The aim of this study was to examine the effectiveness of using rapid HIV testing at the Antwerp Helpcenter. The overall prevalence of HIV infection was 1.5% and higher among the risk groups: 4.0% of men having sex with men and 2.2% of migrants from sub-Sahara Africa. The availability of a rapid test was an important reason to present at the Helpcenter and had a high client satisfaction rate.	• Coverage • Positivity rate • Linkage to care rate	5025

*22 countries: Austria, Greece, Czech Republic, Croatia, Denmark, Germany, Hungary, France, Italy, Latvia, Lithuania, Serbia, Slovenia, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, UK and Ukraine

**13 countries: Belgium, Bulgaria, Germany, Italy, Lithuania, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden, UK

4.2.3. HIV TESTING DATA IN HOME-BASED SETTINGS

At the time of producing this status document, HIV self-tests were only registered in UK and France, and the conducted literature yielded no documents or articles on HIVST data collection that fulfilled the inclusion criteria.

5. HIV Testing Data Collection on National Level

One question on where people can test for HIV in a given country and whether the data from these settings is captured as part of national level surveillance was included in the OptTEST survey on linkage to care distributed in September 2016 to ECDC's national surveillance contacts in EU/EEA countries in collaboration with ECDC (See Annex 1). After several reminders, a total of 17 EU/EEA Member States responded the survey: Croatia, Cyprus, Czech Republic, Denmark, Estonia, France, Germany, Greece, Ireland, Italy, Latvia, Lithuania, Luxembourg, Norway, Poland, Spain and the UK (*Table 5-7)*.

Table 5: Detailed listing of sites where people can test for HIV per country (N=17)

Testing site	STI clinics	Emergency departments	Antenatal services	Labour wards	ID unit	Other inpatient admissions	TB services	Other outpatient services (oncology, gastroenterology, hepatology, etc.)	Drug services	Prisons	GP / primary care	Pharmacies	Community settings (sites, outreach)	Self-sampling	Home / self-testing	Labs	Can undocumented migrants test?
Croatia					X								X				X
Cyprus		x	X	x	X	X	X	X		X	X		X			X	X
Czech Rep.	x	x	X	x	X	X	X	X	X		X		X			X	X
DK	x	x	X	x	X	X	X	X	X	X	X		X				
Estonia	x	x	X	x	X	X	X	X	X	X	X		X			X	X
France	x	x	X	x	X	X	X	X	X	X	X		X			X	X
Germany	x	x	X	x		X	X	X	X		X		X			X	X
Greece	x	x	X		X	X	X	X	X	X	X		X			X	X
Ireland	x	x	X		X	X	X	X	X	X	X		X				
Italy	x	x	X	x	X	X	X	X	X	X			X			X	X
Latvia	x	x	X		X	X	X	X	X	X	X		X			X	X
Lithuania	x	x	X	x	X	X	X	X	X	X	X					X	X
Luxembourg	x	x	X	x	X	X	X		X	X	X		X			X	X
Norway	x	x	X	x	X	X	X	X	X	X	X					X	
Poland	x	x	X		X	X	X	X	X	X	X					X	X
Spain	x	x	X	x	X	X	X	X	X	X	X	x	X			X	X
UK	x	x	X	x	X	X	X	X	X		X		X	x	x		X

Table 6: Data on all HIV tests performed in this setting reported as part of national surveillance

Testing site	STI clinics	Emergency departments	Antenatal services	Labour wards	ID unit	Other inpatient admissions	TB services	Other outpatient services (oncology, gastroenterology, hepatology, etc.)	Drug services	Prisons	GP / primary care	Pharmacies	Community settings (sites, outreach)	Self-sampling	Home / self-testing	Labs
Croatia																
Cyprus																
Czech Republic	x	x	x	x	x	x	x	x	x	x	x		x			x
Denmark																
Estonia																
France	x												x			x
Germany																
Greece													x			x
Ireland			x													
Italy																
Latvia																
Lithuania	x	x	x	x	x	x	x	x	x	x	x					x
Luxemb.					x								x			x
Norway																
Poland	x	x	x		x	x	x	x	x	x	x					x
Spain																
UK	x	x	x		x		x				x					x

Table 7: Data on HIV positive test results in this setting reported as part of national surveillance*

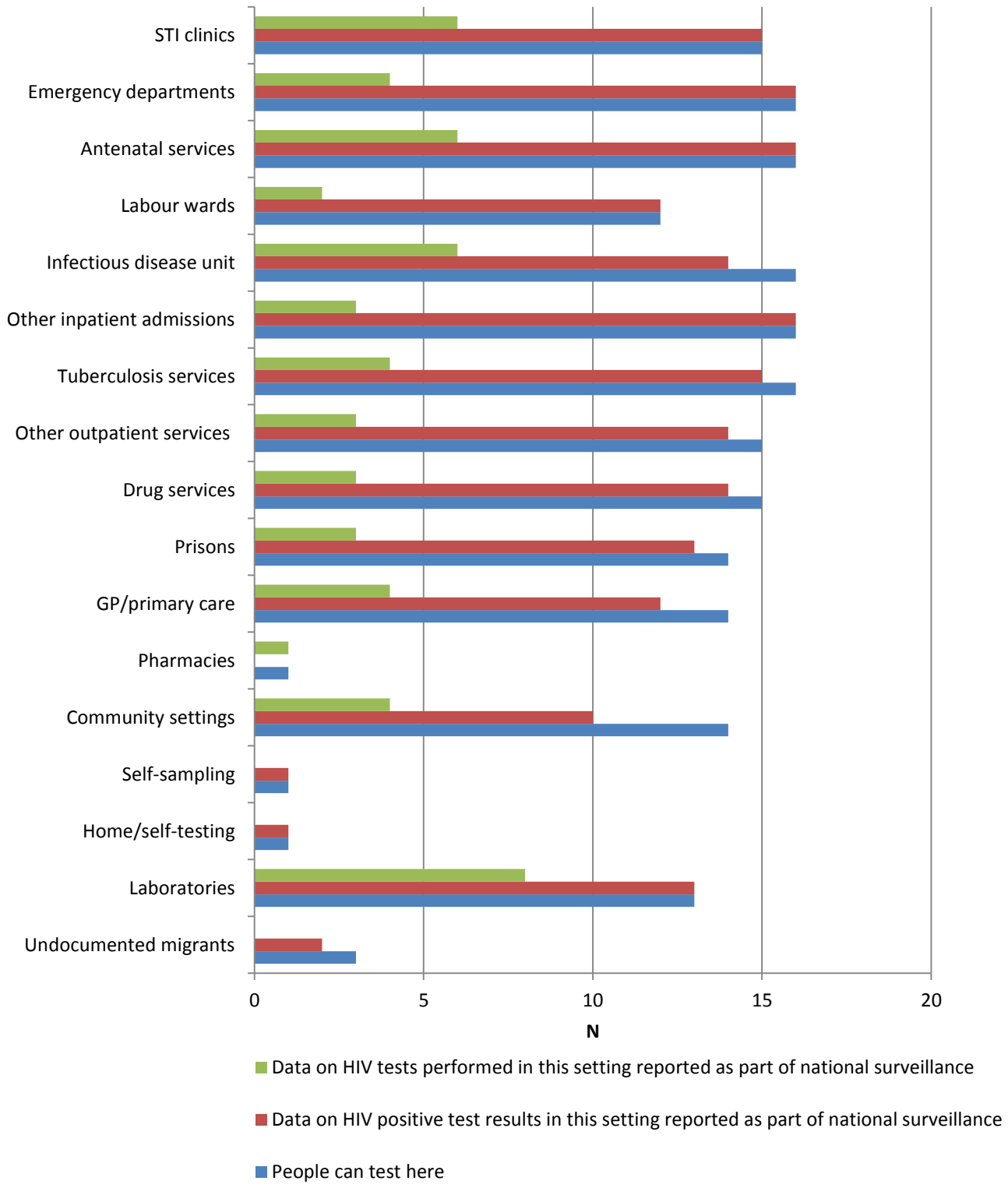
Testing site	STI clinics	Emergency departments	Antenatal services	Labour wards	ID unit	Other inpatient admissions	TB services	Other outpatient services (oncology, gastroenterology, hepatology, etc.)	Drug services	Prisons	GP / primary care	Pharmacies	Community settings (sites, outreach)	Self-sampling	Home / self-testing **	Labs
Croatia										X						
Cyprus		x	X	x	X	X	X	X		X	X		X			X
Czech Rep.	x	x	X	x	X	X	X	X	X		X		X			X
DK	x	x	X	x	X	X	X	X	X	X	X		X			
Estonia	x	x	X	x	X	X	X	X	X	X	X					X
France	x	x	X										X			X
Germany	x	x	X			X	X	X	X		X		X			X
Greece	x	x	X		X	X	X	X	X	X	X					X
Ireland	x	x	X		X	X	X	X	X	X	X		X			
Italy	x	x	X	x	X	X	X	X	X	X			X			X
Latvia	x	x	X		X	X	X	X	X	X	X					X
Lithuania	x	x	X	x	X	X	X	X	X	X	X					X
Luxemb	x	x	X		X		X		X	X			X			X
Norway	x	x	X	x	X	X	X	X	X	X	X					X
Poland	x	x	X		X	X	X	X	X	X	X					X
Spain	x	x	X	x	X	X	X	X	X	X	X	x	X			X
UK	x	x	X	x	X	X	X	X	X		X		X	x	x	

* HIV positive by confirmatory test

** Answers reflecting situation by October 2016

Broken down per type of testing site rather than country the survey shows where there is no linkage between the sites where people can get tested for HIV and the surveillance system – resulting in a gap in the national surveillance data on HIV testing (Figure 2). It is clear from this survey that people can test in a variety of settings, and that positive tests are generally reported to the national surveillance systems; however data on number of HIV tests performed is only reported for approximately 1/3 of testing sites.

Figure 2: HIV testing settings in Europe (N=17)



6. Projects Promoting Standardized HIV Testing Data Collection

With starting point in the HiE Working Group (WG) on HIV testing and the HIV in Europe Steering Committee members' past and current engagement in standardization of HIV Testing data collection on regional or local level, five projects were identified. Information on the work was drawn from project documents consulted and from interviews with a total of 15 key actors (see list in Annex 2).

1. **Operational knowledge to improve HIV early diagnosis and treatment among vulnerable groups in Europe (Euro HIV EDAT[2])**
   Euro HIV EDAT worked to improve rates of early diagnosis through exploration of innovative strategies for testing and gain a better understanding of the role and impact of community-based voluntary counselling and testing services (CBVCTs). The project focused on consolidating monitoring and evaluation data from CBVCTs across Europe using a set of standard Indicators and Data collections instruments developed in the frame of the COBATEST project (see below). The M&E indicators consist of 11 mandatory and 7 optional ones. In 2015 and 2016 41 CBVCT services from 15 European countries contributed with M&E data.

2. **HIV community-based testing practices in Europe (COBATEST)[3]**
   The main aim of the European project COBATEST is to promote early diagnosis of HIV infection in Europe by improving the implementation and evaluation of community-based testing practices. This network aims to help community-based voluntary services to monitor and evaluate HIV testing activity, and conduct operational research. At present, 52 CBVCTs in 21 European countries participate in the network.

3. **HIV in Europe (HiE)[4]**
   The overall objective of HIV in Europe is to ensure that people living with HIV and viral hepatitis enter care earlier in the course of their infection than is currently the case, as well as to study the decrease in the proportion presenting late for care. The initiative has developed audit tools to monitor IC-guided HIV testing in health care settings and pilot teste these in the HIDES 1 and HIDES 2 studies.

   HIDES I was a survey of indicator condition-guided HIV testing across 16 hospital settings in Europe from 2009-2011.The study proved that IC guided HIV testing is acceptable, feasible and an effective strategy to facilitate early HIV diagnosis. The HIDES-2 study created an audit system of HIV IC guided HIV testing in HS. The overall test rate was 72%. The lowest- median was in Northern Europe at 44%, while the highest was in Eastern Europe at 99%. Tuberculosis and oesophageal candidiasis patients were found to be most likely to be HIV positive. Positivity rate was highest in Southern Europe (2,9%) and Eastern Europe (1,2%).

4. **Optimising Testing and Linkage to Care for HIV Across Europe (OptTEST)[5]**

[2] www.hiveuroedat.eu
[3] www.cobatest.eu
[4] http://hiveurope.eu
[5] http://www.opttest.eu

The main aims of OptTEST were to reduce the number of undiagnosed people with HIV infection in the European region and to promote timely treatment and care through providing tools and assessment methods to analyse and effectively respond to late presentation for HIV care and treatment. Within OptTEST tools were developed for use in health care settings to monitoring IC-guided HIV testing. A total of 5839 HIV tests were performed during the pilot testing of tools conducted in 23 clinical sites in Czech Republic, Estonia, France, Greece, Poland, Spain and UK (within the EU) – and in Belarus, Georgia and Ukraine.

5. **European HIV-Hepatitis Testing Week (ETW)**[6]
The objective of the European Testing Week is to ensure that more people become aware of their HIV and/or viral hepatitis status. Within the project a monitoring and evaluation tools has been developed for use by the participants to follow the conducted testing activities. In 2016 519 partners from 47 of the 53 countries in the WHO European Region participated in ETW, and 25.8% submitted the evaluation survey. Around 50 participants submitted data using the monitoring and evaluation tool.

Table 8: Indicators used in ongoing initiatives and projects in Europe to measure HIV testing

	Projects			
Data collected	**Euro HIV EDAT**	**COBATEST**	**OptTEST/HIV in Europe**	**Testing Week**
Setting	**Community**	**Community**	**Health care**	**All**
N clients/patients attending service		X	X	X
N HIV tests performed	X			
Reasons for HIV testing (e.g. risk behavior/factors)	X	X		
N clients/patients offered test			X	X
N clients/patients accepting a test	X		X	X
N clients/patients reporting previous HIV test	X	X		
N clients/patients with reactive/positive screening result			X	X
N clients/patients with reactive/positive screening result who had a confirmatory test	x	x		
N clients/patients with a positive confirmatory test result	x	x		
N clients/patients linked to care	x	x	X	X

[6] http://www.testingweek.eu

7. Discussion

To respond efficiently to HIV and meet the global goal of ending the AIDS epidemic by 2030 (29), ensuring access to HIV testing is crucial. To accurately plan and allocate resources to HIV testing services it is imperative to know where there are gaps and need for interventions to improve testing uptake. One important step to effectively reach the undiagnosed PLHIV is a diversification of testing services, i.e. broaden the options and settings where HIV tests are offered. To secure efficiency and assess the impact of such different testing approaches, access to testing services monitoring data is critical.

The 53 countries in the WHO European Region supply case-based HIV data to the TeSSY data collection platform managed by ECDC and WHO Europe, but there are certain gaps. Data is for example not disaggregated by risk group, testing setting is not identified nor time and place of first HIV+ diagnosis or type of HIV test used (conventional ELISA/rapid test, or type of rapid test (blood, saliva).[7] In addition to the HIV case reporting, the countries submit annual reports on the public health response to HIV in accordance with the Dublin Declaration and UNAIDS GARP indicators. However, only six of the 53 countries report data on the full "cascade of care" (30).

Establishing mechanisms to document HIV testing in community and non-HIV specialist health care settings as well as from self-sampling/self-testing, and then secure a connection and data flow to national surveillance will enable a better monitoring of HIV testing outputs and outcomes at local and national levels, and also of reporting the data to the regional level. And such improved data collection on HIV testing activities at provider level and national level, would enable countries to report more detailed data to the regional systems, and this would enable monitoring and comparisons across countries.

There exist tools and guidelines on how to implement national M&E of HIV testing services developed by international organizations and others in an attempt to improve and regulate HIV testing monitoring across the region. However, data collection on HIV testing throughout the WHO Europe region remains a challenge. In particular middle-income countries may not have the capacity or resources to collect data from all HIV testing services – but many others simply lack a national standardized system for data collection providing information beyond "number of positives".

[7] ECDC: TESSY data collection http://ecdc.europa.eu/en/aboutus/what-we-do/surveillance/Pages/data-access.aspx

8. Conclusions and next steps

The information gathered and reviewed in this project show that the most widely utilized HIV testing indicators are: Coverage rate, Uptake rate, Positivity Rate, Offer rate and to a lesser degree Linkage to care rate. However, the international organizations' guidelines and guidance (WHO and ECDC) show certain disagreement on which indicators to consider for measuring outputs or outcomes for national HIV testing programmes. This may be related to the fact that each country has its own national HIV response programmes that include its own HIV testing component and possibly monitoring system. From the articles and documents reviewed it is clear that there is a difference between health care and community settings in terms of metrix and data collected. The description provided here of current projects evidence that much efforts has been put into developing and pilot testing monitoring and evaluation instruments.

Standardized metrix across testing settings would facilitate comparability and programme planning, but a breach remains, however, between the monitoring tools and the sets of indicators used at some testing sites and the national and European level HIV surveillance and monitoring systems.

It is clear that many efforts aimed to improve the HIV testing data collection have been launched and implemented during the last ten years in Europe. With both evidence based guidelines and data collection tools at hand, we have the foundation for a scaled up of standardised data collection across all countries.

Next steps

In order to reach the proportion of undiagnosed people living with HIV it is important to expand **Coverage of** HIV testing among eligible populations. This is achievable through expanding HIV testing in both health care and community settings. Assuming the eligible population has access to HIV testing services either at Health care or community based settings the two following components will influent the test coverage: the service **Uptake** by the client and the test **Offer** by service provider. Thus, measuring the Offer and Uptake rates at service delivery level facilitate revealing the bottlenecks at the service delivery level and plan further public health interventions to improve the coverage.

To ensure that national HIV programmes apply resources in a cost-effective way, priority should be given to the most affected populations. The higher the **Positivity** rate among the tested population the more cost-effective is HIV testing in this target group. Thus, measuring the positivity rate is important while planning public health interventions especially in middle income countries. Measuring the **Linkage** to care rate of those found positive at the testing service is an important HIV testing outcome and provides the feedback for the second of the 90-90-90 goals (proportion of HIV positive people on treatment).

If standardized numerator and denominator data is collected by HIV testing settings, feed into national level surveillance systems and to the regional level reporting, then improved planning and targeting of intervention, as well as comparison across countries and settings, would be possible.

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10. Annexes

Annex 1. Question in quantitative survey distributed to national surveillance contacts of the European Centre for Disease Prevention and Control in EU/EEA countries in September 2016

1. Where can people test for HIV in your country and are data on HIV testing activity from these setting captured as part of national surveillance? *(tick all that apply)*

	People can test here	Data on HIV tests performed in this setting reported as part of national surveillance	Data on HIV positive test results in this setting reported as part of national surveillance
Sexually transmitted infection clinics	☐	☐	☐
Emergency departments	☐	☐	☐
Antenatal services	☐	☐	☐
Labour wards	☐	☐	☐
Infectious disease unit	☐	☐	☐
Other inpatient admissions	☐	☐	☐
Tuberculosis services	☐	☐	☐
Other outpatient services (oncology, gastroenterology, hepatology, etc.)	☐	☐	☐
Drug services	☐	☐	☐
Prisons	☐	☐	☐
General practice / primary care	☐	☐	☐
Pharmacies	☐	☐	☐
Community settings (community sites, outreach)	☐	☐	☐
Self-sampling	☐	☐	☐
Home / self-testing	☐	☐	☐
Laboratories	☐	☐	☐
Other _____	☐	☐	☐

Annex 2. Key informants interview- Interview guide and list of experts interviewed

Key informant interviews included the following questions:

a) Which current project(s)/initiatives are you aware of that focus on defining and using standardized indicators and data collection tools for the monitoring and evaluation of HIV testing in healthcare settings; community-based settings and self-testing?

b) What do you consider to be the main gaps for collecting data on these three levels?

The following experts were interviewed:

1) Dorthe Raben, 2) Ida Sperle, HIV in Europe Initiative

3) Martin Donoghoe, WHO Europe

4) Jordi Casabona, 5) Laura Fernandes-Lopez, 6) Juliana Reina, 7) Cristina Augusti (CEEISCAT Centro Nacional de Epidemiología, Catalunia, Spain and Euro HIV EDAD)

8) Tom Platteau, Institute of Tropical Medicine, Antwerp, Belgium

9) Daniel Simões, GAT-Portugal, European AIDS Treatment Group

10) Stine Finne Jakobsen, 11) Marie Louise Jakobsen, 12) Sara Croxford, 13) Ann Sullivan, OptTEST project

14) Tim Greacen, INSERIME project

15) Gennady Roshupkin, key informant on community-based HIV projects in Russia, Ukraine and other countries in Eastern Europe and Central Asia Eurasian Coalition on Male Health [ECOM].

Annex 3: Definition of key Indicators for monitoring HIV testing outputs and outcomes in HC, CB and HB settings

Coverage=Test rate

Coverage Numerator: Number of clients eligible* for HIV Testing at service provider/year Denominator: Number of people tested

**The eligibility for HIV testing is normally defined by national guidelines (routine test offer or IC-guided testing) that vary from country to country.*

"Uptake"="Acceptance rate"

HIV test uptake: Numerator: Number of clients accepted offer of HIV of test by service provider/year Denominator: Number of clients offered HIV test in HIV testing setting/year

"Positivity rate"

In accordance with literature review all testing settings measure the number of positivity results.

Positivity Rate: Numerator: number of positive clients identified at the setting /year Denominator: number of tested population/year

"Offer rate"

HIV test offer rate: Numerator: Number of clients with IC offered HIV Test Denominator: Number of clients with IC attended the service (eligible for HIV test)

"Linkage to Care Rate"

Linkage to care Rate: Numerator: number of positive clients identified at the setting linked to care /year Denominator: number of positive clients identified at the setting

Annex 4: Key actors working on standardisation of M&E of HIV testing in community-based, health care and home-based settings in Europe

International organisations working on policy, guidelines and standards of HIV testing in Europe:
The following initiatives are working on developing standardised indicators andcollecting and analysing the HIV testing data based on standardised indicators in Europe:

1. ECDC - writing guidelines, tools, collecting and analysing data via its TESSY database from EU and EFA countries;
2. WHO EURO – using common database with ECDC and collecting and analysing data from EE and CA countries;
3. WHO HQ – writing guidelines and tools;
4. UNAIDS & WHO Monitoring and Evaluation Reference Group (MERG) - writing guidelines and tools and collecting data globally.

Regional initiatives working on standardisation of HIV testing monitoring & evaluation in Europe:

- HIV in Europe;
- OptTEST project;
- Euro HIV EDAD project and;
- COBATEST network coordinated by Euro HIV EDAD

International projects and civil society networks advocating HIV testing standards in Europe

- European AIDS Clinical Society (EACS)
- European AIDS treatment group (EATG)
- AIDS Action Europe network of HIV-service NGOs in most countries of WHO European Region
- AIDS Health Care Foundation (AHF): network of HIV check points in Estonia, Greece, Lithuania, Netherlands, Portugal, Russia and Ukraine
- Eurasian Coalition on Men's Health (ECOM)

National agencies active in developing and introducing standards of monitoring HIV testing

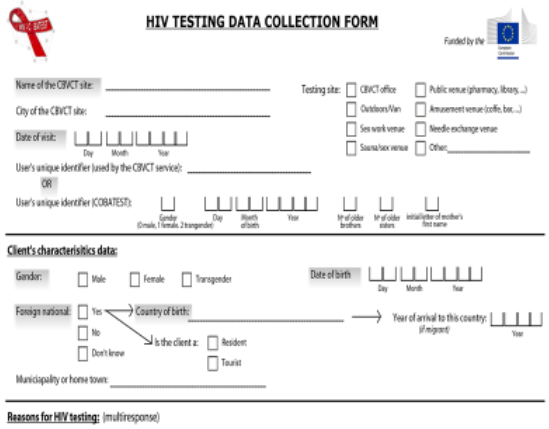
- Catalonia: CEEISCAAT (Centre d'Estudis Epidemiològics sobre les Infeccions de Transmissió Sexual i Sida de Catalunya)
- UK: Imperial College London, Public Health England, British HIV Association (BHIVA)
- Belgium: Institute of Tropical Medicine, HIV/AIDS Centre (IHAC), Department of Public Health, Antwerp
- Netherlands: collaborative effort of Academic Medical Center, Amsterdam, National Institute for Public Health and the Environment (RIVM), and, NIVEL Primary Care Database, Utrecht and 4Stichting HIV Monitoring, Amsterdam.

Annex 5: COBATEST Data Collection Form

COBATEST Innovations in the data collection

- **Standardised data collection forms**
- **Proposed Unique Identifier**
- **Web-based application for the data collection**

HIV testing Data Collection Form



HIV TESTING DATA COLLECTION FORM

Name of the CBVCT site: _____

City of the CBVCT site: _____

Date of visit: Day Month Year

User's unique identifier (used by the CBVCT service): _____

OR

User's unique identifier (COBATEST): Gender (1 male, 2 female, 3 transgender) Day Month of birth Year Nr of older brothers Nr of older sisters Initial letter of mother's first name

Testing site: ☐ CBVCT office ☐ Public venue (pharmacy, library, ...) ☐ Outdoors/Van ☐ Amusement venue (coffe, bar, ...) ☐ Sex work venue ☐ Needle exchange venue ☐ Sauna/sex venue ☐ Other: _____

Client's characteristics data:

Gender: ☐ Male ☐ Female ☐ Transgender

Date of birth: Day Month Year

Foreign national: ☐ Yes → Country of birth: _____ → Year of arrival to this country: (if migrant) Year

☐ No

☐ Don't know

Is the client a: ☐ Resident ☐ Tourist

Municipality or home town: _____

Reasons for HIV testing: (multiresponse)

Annex 6: HIDES Audit form

HIDES Audit
Page 1 of 1

HIDES Audit

Audit ID: _____
(XXXX-(A-F) (eg. 1234-A))

How many patients with:

- ◯ A) Tuberculosis
- ◯ B) Non-Hodgkin's lymphoma
- ◯ C) Anal cancer
- ◯ D) Cervical cancer
- ◯ E) Hepatitis B and C
- ◯ F) Candida esophagitis

who were not yet known to be HIV positive have you seen in your clinic within (specify dates beneath): _____

From: _____

To: _____

How many of these have been offered an HIV test: _____

How many of these have been HIV tested: _____

How many were HIV positive: _____

Completed by and date

Completed by: _____
((investigator's initials))

Date completed: _____