



Protecting and improving the nation's health

Community-based HIV testing in Europe: a systematic review

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Background

- 2010: European Centre for Disease Prevention and Control (ECDC) published first HIV testing guidance¹
- Guidance used by countries² but HIV testing has remained low³
- 2016: Project to update testing guidance given novel testing strategies and technologies
- Systematic review to inform the new testing guidance
- Objective: to synthesise the body of recent evidence from the EU/EEA on:
 - Strategies aimed at increasing HIV testing
 - Barriers to HIV testing across all testing settings
- HepHIV 2019: community-based HIV testing (CBT)

¹ ECDC. HIV testing: increasing uptake and effectiveness in the European Union. Stockholm: ECDC; 2010.

² Sullivan AK, Sperle I, Raben D, Amato-Gauci AJ, Lundgren JD, Yazdanpanah Y, et al. HIV testing in Europe: Evaluating the impact, added value, relevance and usability of the European Centre for Disease Prevention and Control (ECDC)'s 2010 HIV testing guidance. Eurosurveillance. 2017;22(48):17-00323.

³ ECDC. HIV testing - Monitoring implementation of the Dublin Declaration on Partnership to fight HIV/AIDS in Europe and Central Asia: 2017 progress report. Stockholm: ECDC; 2017.

Community-based HIV testing

- Community-based HIV testing (CBT): programme or service offering HIV testing outside formal health facilities
 - Community-based testing sites (fixed sites): providing client-initiated (voluntary) testing services outside formal health facilities.
 - <u>Drug-services</u> (fixed sites): providing services targeting people who use drugs with a low threshold for attendance and easy access for users
 - Outreach activities (no fixed site): service delivery in the community (e.g. mobile units or vans, street outreach, satellite services based at other agencies)
- Targeted and accessible to groups disproportionately burdened by HIV – may not access traditional HIV testing and care

Methods

- Systematic searches (2010-2017): Embase, Medline, PsycINFO, Cochrane, Scopus
- Conferences abstracts (2014-2017): CROI, AIDS/IAS, EACS, Drug Therapy, HepHIV
- Reports (2014-2017): WHO, HIV in Europe
- Search term concepts: HIV, Europe, HIV testing
- Inclusion/exclusion criteria:

 - EU/EEA (30 countries)
 No language restrictions
 - Jan. 2010 Mar. 2017
- Excluded studies in occupational settings
- Adults (aged ≥15 years) being tested for or diagnosed with HIV
- PRISMA guidelines
- Critical appraisal: NICE/AXIS checklists^{1,2}

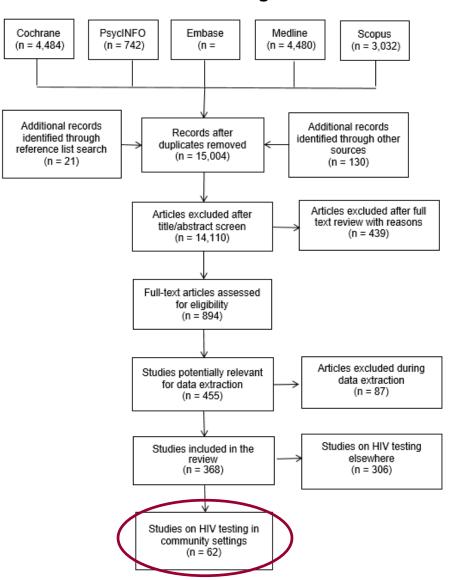
Downes MJ, Brennan ML, Williams HC, Dean RS. Development of a critical appraisal tool to assess the quality of cross-sectional studies (AXIS). BMJ Open. 2016;6(12).

² National Institute for Centre Excellence. Appendix F Quality appraisal checklist – quantitative intervention studies. London: NICE; 2016.

Results: overview

- 62 studies on testing in community-based settings included:
 - Peer-reviewed: 33 studies
 - Conferences: 29 studies

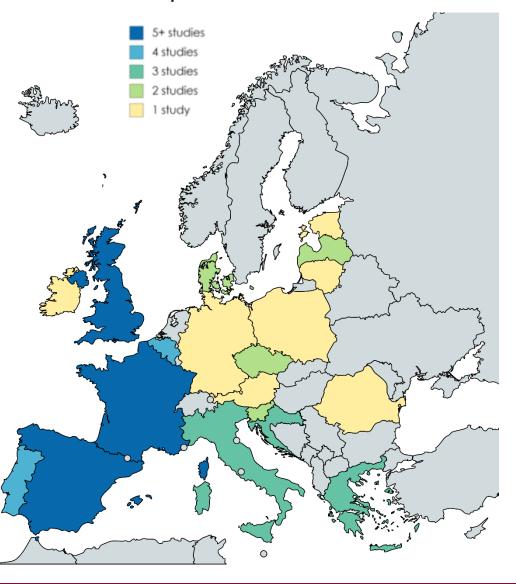
PRISMA flow diagram



Testing implementation

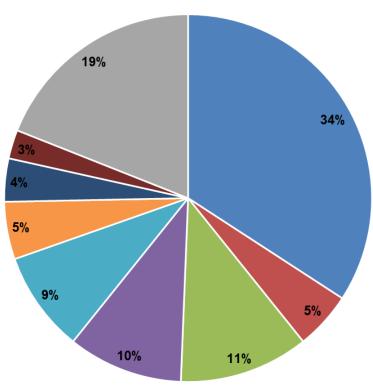
- 56 studies on communitybased HIV testing implementation
- Most studies were set in:
 - Spain: 19
 - United Kingdom: 17
 - > France: 5
- Three studies covered multiple European countries.

Geographical distribution of community-based HIV testing implementation studies



Testing implementation strategies

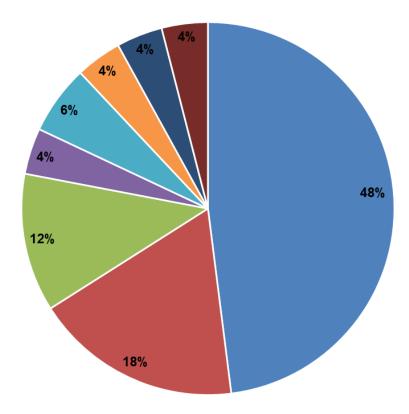
Community-based testing studies by target group



- Men who have sex with men
- Migrant
- Sex workers
- Homeless
- General population

- Black and minority ethnic groups
- People who use/inject drugs
- Young people
- · Key risk groups not specified

Community-based testing studies by setting



- Fixed community testing sites
- Event-based mobile units
- Gav venues
- Homeless services/hostels
- Street-based mobile units
- University-based mobile units
- Brothels
- Migrant venues

Testing indicators

- Positivity/reactivity varied by target group and setting
- Five studies with 0.0% positivity/reactivity
- Not all studies reported key testing indicators

Testing uptake: 42

Positivity/reactivity: 4

Setting and target population of community-based testing implementation studies (N=56)

Target population	Testing venue	Number of tests performed	% Testing coverage	Positivity rate
Men who have sex with men	Community testing sites	9-14,453	16%-74%	0.9%-4.3%
	Outreach	7-2,955	10%-78%	0.0%-11%
Black and minority ethnic groups /migrants	Community testing sites	302-4,219		2.1%-3.6%
	Outreach	26-5,676	18%	0.0%-6.2%
People who use/inject drugs	Community testing sites	323		1.9%
	Outreach	141-7,113	97%	2.5%-32%
Sex workers	Community testing sites	923-1,969		0.9%-2.1%
	Outreach	112		0.9%
Homeless	Outreach	58-110	45%	0.0%
Young people	Outreach	27-512	19-100%	0.0%
Multiple high risk groups	Community testing sites	341-12,261		0.6%-3.9%
	Outreach	186-8,923	42%-95%	0.0%-2.5%
General population	Community testing sites	1,849-71,465		1.3%-3.2%
	Outreach	188-95,575	5.8%-98%	0.0%-2.2%

Other interventions and cost effectiveness

- 10 studies used multi-faceted interventions to increase testing (HIV testing implementation +):
 - Education/training to those administering the tests: 4
 - Promotion/campaigns to raise awareness of availability of testing: 7
 - Text and online communication of test results: 2
 - Network of community organisations working with key risk groups and offering testing: 1
- Economic evaluation of MSM attending CBT services
 - 2014: Copenhagen, Paris, Lyon, Athens, Lisbon, Ljubljana
 - Total cost of CBTs: €54,390-245,803
 - Cost per HIV test: €41-113
 - Cost per reactive test: €1,966-9,065

Feasibility/acceptability

31 studies on the feasibility/acceptability of community-based testing

Testing venue		Selection of feasibility/acceptability indicators		
Community testing sites		Community testing acceptable: 65%-70% Community testing recommendation to a friend: 75% Rapid testing in the community acceptable: 90%-96% First time testers: 12%-43% First time accessing any health service: 55%		
Outreach services	Sauna	Sauna outreach clinics were well attended and feedback from users was positive, particularly valuing the convenience and confidentiality of the service First time testers: 13%-37%		
	IIVIONIIA LINIT	Outreach service acceptable: 90%-99% Self-testing in outreach acceptable: 82% Ability to interpret self-test results correctly: positive result: 96%; invalid result: 94%; negative result: 95% First time testers: 18%-95% First time testers who would have not otherwise tested: 40%		
	Hostels	Testing in hostels acceptable: 100%		
	Drug services	Testing in harm reduction services easy or very easy to do (staff): 100% Confidence in test results from tests performed in harm reduction services (staff): 60% First time testers: 18%		
	Other	Self-sampling cost effective in outreach settings (positivity rate >0.1%) First time testers in brothels: 25%		

Conclusions

- Community-based HIV testing: acceptable and effective strategy for reaching populations at higher risk of HIV that may not be accessing healthcare settings
- Wide variety of CBT programmes being implemented in the EU/EEA
- Geographical coverage limited most studies set in Northern and Western Europe
- Not as much evidence on CBT as testing in healthcare settings
- 47% (29/62) of included studies were not published or peer reviewed
- Few studies reported before/after data difficult to evaluate the improvement of the intervention
- Important to ensure successful linkage to care after a positive test
- No barriers identified with testing in community settings

More information

- PS4/04: Community-based HIV testing in Europe: a systematic review (oral/poster)
- PO4/01: HIV self-sampling and self-testing in Europe: a systematic review (poster)
- PS3/05: Evidence-based public health guidance for integrated HBV, HCV and HIV testing in Europe (oral/poster)

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