Results from ACTION TEST : first rapid HIV testing project for SAM in Brussels

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ABSTRACT We launched a community-based HIV rapid testing project in Brussels for SAM. We were able to conduct 250 HIV tests in 2017 using 4 different strategies (Fixed, Bus, Partners, Appointment). We showed that demedicalised and decentralised HIV testing is efficient for the SAM communities in Brussels. Moreover, each strategy seems to reach a different type of population.

1. BACKGROUND

Demedicalised and decentralised HIV testing

- Recommended in national HIV plan 2014-2019 [1], combined with classic testing
- Must be adressed towards key populations, namely MSM and SAM, which had the highest incidence in Belgium in 2015 [2].
- Royal autorisation has not been granted yet

ACTION TEST

Plate-Forme Prévention Sida
SidAids Migrants
Observatoire du sida et des sexualités

Free & anonymous rapid HIV testing for SAM in Brussels

In collaboration with ARCs and ARLs (training, referral, test validation) and municipalities and community or non-community organizations.

2. OBJECTIVES

- **Facilitate access to rapid HIV testing for SAM**
- Demonstrate the need and the relevance of community HIV testing for SAM
- Compare different strategies

3. METHODOLOGY

Strategies

1. Fixed : weekly event at Siréas (SidAids Migrants) office in Ixelles, Matongé.
2. Bus (outreach) : health bus parked in public places or events attended by SAM
3. Partners (outreach) : regular events or one-shots at our partners facilities.
4. On demand appointments at SidAids Migrants.

Tests

- TROD INSTI VIH1/2 (Nephrotek).
- Test and validation of every batch by an ARL (according to furnisher's protocol).

Data collection

- Anonymous electronic questionnaires (pre- and post-test counselling).
- Pre-test : socio-demographic situation, risk exposition, HIV and STIs testing habits, sexual preventive behaviour and relational and sexual life.
- 17 volunteers were trained (testing, questionnaire, ethics, etc) according to the recommendations of the Superior Health Council and most of them were SAM as well.

Communication

- Via web posters and flyers in community venues, webpages, health radio shows, etc.
- Mobilisation volunteers were trained to community mobilisation techniques.

Linkage to care

- Those who had a reactive test were offered to be accompanied by volunteers to an ARC for test confirmation and linkage to care.
- Psycho-social support is also offered according to the needs and regardless of the result.

Statistical analysis

- Appointments on demand (strategy 4) were excluded from the analysis as only 12 persons used this strategy.
- The option « Prefer not to answer » was systematically excluded from the analysis.
- One-way ANOVAs were runned with Stata 14 ($p<0,05$).

4. RESULTS

	Strategy	1. Fixed		2. Bus		3. Partners		**Total**	
Tests / event		**1,3**		13,1		5,1		4,8	
		n_{tot}	%	n_{tot}	%	n_{tot}	%	n_{tot}	%
Reactive TROD		46	2,2	105	1,0	87	1,2	238	1,3
From SSA origin (vs No)		33	65,1	105	61,9	85	63,5	233	63,1
Male gender (vs female)		46	65,2	105	76,2	87	78,2	238	74,8
Risk exposition	**Had no partners in the last year**	40	0,0[3]	86	7,0[3]	81	21,0	207	54,6
	MSM[a]	25	16,0[2]	77	1,3	66	12,1[2]	168	7,7
	Had unprotected sex in the last year[b]	38	76,3	90	70,0	81	59,3	209	77,0
	Ever had an STI	39	20,5	83	8,4	83	18,1	205	14,6
	Practiced anal sex	35	22,9	85	8,2	78	14,1	198	13,1
	Ever paid for sex[a]	24	20,8	66	9,1	65	16,9	155	14,2
Risk awareness	**Came for no particular reason**[c]	43	16,3	97	85,6[1]	84	82,1[1]	224	71
	Never tested for HIV before	44	29,6	96	41,7	85	40	225	38,7
	Don't know what PEP is	41	46,3	85	67,1	81	70,4[1]	207	64,3
	Don't know what PrEP is	46	58,7	85	82,4[1]	80	95,0[1]	206	84,0

[a]Among men. [b]Without a condom, PrEP or TasP. [c]Reason chosen was « none » (vs routine testing, exposed to risk, pregnancy planning or to start a relationship) and people specified opportunity, occasion, curiosity or because they saw the bus.
Bold : there is a significant difference.
Significant difference between groups: [1] different from 1; [2] different from 2; [3]different from 3.

250 persons were tested for HIV between February and October 2017. 238 of them were reached with 3 strategies. The global prevalence rate was high (1,3%), with no difference between strategies. 3 tests were reactive, among 2 men and 1 woman from SSA.

The outreach strategies (2 and 3) allowed to reach more people per event than the fixed one (13,1 and 5,1 tests/event vs 1,3).

63,1% were SAM, the median age was 34 years old (IQR=28-41) and 74,8% were men.

Those who used strategy 1 (Fixed) :
- Had a higher risk exposition than those in group 2 (Significantly more were MSM) and than those in group 3 (Significantly more had at least one partner in the last year).
- Had a higher awareness of HIV risk than those in strategy 2 and 3 : significantly more came for a particular reason and were aware of PEP or PrEP.

Those who used strategy 2 (Bus) :
- Seemed to have a lower risk exposition than those in groups 1 and 3 (significantly less were MSM and less than 10% ever had an STI, practiced anal sex or ever paid for sex against more than 20% in group 1) even though 70% reported unprotected sex in the last year.

Those who used strategy 3 (Partners) :
- Seemed to have a mixed risk exposition : significantly more were MSM, but significantly more had no partners in the last year. Moreover, they were less than in group 1 but more than in group 2 to have ever had an STI, practiced anal sex or paid for sex.

5. CONCLUSIONS

1. Targeted HIV testing projects among SAM allow to reach a higher prevalence than on the overall conventional system (1,3% vs 0,15%[1]).
2. Outreach strategies allow to reach people who aren't aware of their risk exposition and who won't go and get tested on their own.
3. The different strategies seem to reach different sub-populations :
   - **Fixed** : high risk exposition and high risk awareness.
   - **Outreach** (Bus & Partners) : mixed risk exposition and low risk awareness.

→ This approach must be combined with classic screening to reach the most vulnerable populations and facilitate their access to the health care system.

6. REFERENCES

1. HIV Plan 2014-2019
2. Sasse A et al (2016), *Epidémiologie du SIDA et de l'infection à VIH en Belgique : Situation au 31 décembre* 2015, Bruxelles, Institut de Santé Publique (WIV-ISP), 63 p.
3. Superior Health Counsil (2015) *Publication du conseil supérieur de la santé n°9224; Dépistage décentralisé et démédicalisé du VIH en Belgique : réponse à unedemande d'avis émanant des autorités de santé publique*