



HIV-COBATEST
Qualitative Study Report

Implementation of Community-Based Voluntary Counseling and Testing (CBVCT) Programs and Services

**QUALITATIVE STUDY REPORT
WP5**

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Qualitative Study Report

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Introduction and Methodology

In Western and Central Europe, 820 000 adults and children were living with HIV in 2009 according to the UNAIDS Report on the Global Aids Epidemic¹. It is estimated that 30% of them are not aware of their serological status², which is particularly important, since early diagnosis is crucial in decreasing transmission rates, improving quality of life of people living with HIV/AIDS and decreasing mortality. In this region, 31.000 people were newly infected during 2009.

The prevalence of HIV infection among the different European countries is higher in some populations like men who have sex with men (MSM), migrants, and injecting drug users (IDU). This is due to several factors but, undoubtedly, one of the most significant is that of not having access to a quality HIV counseling and testing service. One of the main consequences of this low access to VCT is stronger transmission rates among these so-called vulnerable groups. Thus, in 2001³, MSM accounted for 29% of the infections in central Europe (vs. 22% of HIV infections acquired through heterosexual contact excluding cases originating in countries with a generalized HIV epidemic) and 39% of the HIV infections in Western Europe (vs. 24% of heterosexual transmissions excluding cases originating in countries with a generalized epidemic).

Scientific literature indicates that barriers to HIV testing are related to political, economical and social dimensions. Indeed, stigma, concerns about confidentiality, fear of institutions, fear of getting a positive result⁴, language barriers, financial resources, lack of legal documents, distance to testing sites for the poorest⁵ have been identified as barriers to HIV testing. Even more, some studies⁶ put forward that "counseling and testing strategies (dislike of counseling, anxiety waiting for results, and venipuncture)" can also restrain HIV testing. All these factors make access to HIV testing more difficult for the populations identified above. For these reasons, European members of public health systems and/or NGOs have tried to improve access to quality HIV testing for most-at-risk populations by implementing Community-Based Voluntary Counseling and Testing. These CBVCT programs are quite different depending on political, cultural, economical and social contexts, but all of them share one objective, that of improving access to vulnerable populations and promoting early diagnosis in hard-to-reach groups. By implementing CBVCT services it is

¹ UNAIDS, *AIDS scorecards: overview: UNAIDS report on the global AIDS epidemic 2010*, 2010.

² Hamers F., Devaux I., Alix J., Nardone A. *HIV/Aids in Europe: trends and EU-wide priorities. Eurosurveillance 2006*, 2006.

³ European Centre for Disease Prevention and Control, WHO Regional Office for Europe, *HIV/AIDS surveillance in Europe 2010*, 2011.

⁴ Worthington C., Myers T., *Factors Underlying Anxiety in HIV Testing: Risk Perceptions, Stigma, and the Patient-Provider Power Dynamic*, 2003.

⁵ Leibowitz A. A., Taylor S. L., *Distance to Public Test Sites and HIV Testing*, 2007.

⁶ Spielberg F. et al., "Overcoming Barriers to HIV Testing: Preferences for New Strategies Among Clients of a Needle Exchange, a Sexually Transmitted Disease Clinic, and Sex Venues for Men Who Have Sex with Men", *Journal of Acquired Immune Deficiency Syndromes*, 2003.



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expected to reduce fear by establishing good rapport between the client and the provider⁷, to offer non-judgmental settings, to provide pre and post-test counseling and often to offer the possibility of performing HIV rapid tests in order to avoid failure to return for HIV test results.

Indeed, failure to return for HIV test results (FTR) sometimes reaches dramatic rates: according to a study led in 2004 by P.S. Sullivan et al.⁸, FTR “was commonly reported among 2241 respondents: 10% of MSM, 20% of high risk heterosexuals (HRHs), and 27% of IDUs”. A rapid test could be a way of avoiding this FTR. Fear, lack of time and apathy are three barriers to receiving results. Other parameters influencing FTR are positive counselor/client interactions. That is why the dynamic in CBVCT services and programs could motivate people to get their results.

Thus, CBVCT could significantly reduce many obstacles linked to difficult access to HIV testing and reach the expectations of most-at-risk populations. “The convenience of [a community HIV testing service], in terms of its location, operating hours, was the most important facilitator to accessing testing”, according to the literature review established by A. Pedraba et al.⁹. This point is related to rapid testing too. Furthermore, the environment and the type of staff (close to the target population), followed by anonymity, are also aspects of CBVCT which facilitate HIV testing. Thanks to these assets, CBVCT manages to reach people from the targeted population who have not been tested for HIV recently¹⁰. Another advantage of the VCT approach is that it is a supplementary and complementary data source for HIV surveillance¹¹.

To promote these programs and contribute to their improved implementation, the HIV-COBATEST project aims to evaluate some already existent CBVCT programs in order to identify weakness and strengths in order to develop a code of good practices for the correct implementation of future CBVCT services and programs. The present report aims to highlight the different dimensions which are important both for the CBVCT’s coordinators and clients for a managed implementation of CBVCT, according to national contexts. Why do people decide to get tested in CBVCT services? How does CBVCT work in concrete terms? How do CBVCT programs and health institutions work in their own national contexts? Which improvements can be done?

⁷ Worthington C., Myers T., “Factors Underlying Anxiety in HIV Testing: Risk Perceptions, Stigma, and the Patient-Provider Power Dynamic”, *Qualitative Health Research*, 2003.

⁸ Sullivan P.S., Lansky A., Drake A., *Failure to Return for HIV Test Results Among Persons at High Risk for HIV Infection. Results From a Multistate Interview Project*, 2004.

⁹ Pedrana A., Guy R., Bowring A., Hellard M. & Stoove M., *Community models of HIV testing for men who have sex with men (MSM): Systematic Review 2011*. Report commissioned by ACON, 2011.

¹⁰ Champenois K., Le Gall J.-M., Jacquemin C., et al., ANRS-COMTEST: description of a community-based HIV testing intervention in non-medical settings for men who have sex with men, *BMJ Open*, 2012.

¹¹ Horyniak D., Guy R., Prybylski D., et al., *The utility of voluntary counseling and testing data as source of information on HIV prevalence: a systematic review*, 2010.



Objectives of the HIV-COBATEST Project

The main objectives of the HIV-COBATEST project (HIV Community-Based Testing Practices in Europe) is to promote early diagnosis of HIV infection in Europe by implementing, building, and evaluating community-based practices in order to increase access to HIV voluntary counseling and testing. Thus, five specific objectives were stated:

- 1) To identify the characteristics of the implementation of CBVCT programs in European countries.
- 2) To develop good practice guidelines by means of a qualitative study.
- 3) To propose a core group of indicators for monitoring and evaluating CBVCT.
- 4) To define a protocol to monitor HIV testing activities.
- 5) To assess the acceptability, feasibility and impact of the introduction of oral rapid test technology at CBVCT.

The present qualitative study is intimately related to the second specific objective: "To develop good practice guidelines by means of a qualitative study". In fact, the study's main goal is to gain a thorough understanding of CBVCT programs and services in order to identify different practices concerning the implementation of CBVCT. Nevertheless, the data obtained in this study are related to other specific objectives of the project.

Finally, it must be stated that the final objective of this study is to develop a code of good practices based on these qualitative results, for the implementation of community-based voluntary counseling and testing services in Europe.

Methods

Study design

For this study, a cross-national qualitative survey was conducted in the 8 EU participating countries, based on the principles of action research. This type of research emphasizes "learning by doing" and aims to contribute to practical concerns of people in a challenging situation and simultaneously to further the goals of social science. Thus, researchers and people concerned work together on the identification of a problem and do something to resolve it. In the words of Kurt Lewin (1946)¹², who first coined the term, we can define action research as a "comparative research on the conditions and effects of various forms of social

¹² Lewin K, *Action research and minority problems*, J Soc. Issues 2(4): 34-46, 1946



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action and research leading to social action that uses a spiral of steps, each of which is composed of a circle of planning, action, and fact-finding about the result of the action”.

For this project, researchers and community members worked together on the study design, conducted the interviews and focus groups, participated in and validated the present report and will be in charge of the restitution of the present results to the communities of those concerned by the HIV-COBATEST project.

Objectives of the qualitative study

1. General objective:
 - To identify and describe different practices in the implementation of CBVCT.
2. Specific objectives
 - To identify different types of CBVCT implementations (working together with WP4¹³) and partners in a subset of CBVCT services.
 - To spot variables related to the programs in order to build a typology of CBVCT programs.

Sample

This study was conducted in a convenience sample of CBVCT coordinators and clients, and used two qualitative methods (focus groups and semi-structured interviews). At least one CBVCT per participating country was selected. In fact, a core group of field-coordinators (one per country) was set up in order to guarantee linkage with all these centers, to moderate the focus groups and to perform the interviews.

For each European country participating on the project, we performed:

- One interview with each CBVCT service coordinator.
- One focus group with clients of CBVCT service.

This means that 8 interviews were performed and 7 focus groups were conducted. The reason for having conducted only 7 focus groups instead of 8 was that one of the participating countries, Poland, faced financial difficulties that prevented them from having access to a physical place for conducting the focus

¹³ “Cross-national survey on the Implementation of Community Based Voluntary Counselling and Testing Programmes” which main objective was to describe the already existing CBVCT services in Europe.



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group. What is more, Polish rules on anonymity and confidentiality did not allow for such a focus group.

The countries participating in data collection for the qualitative study were: Spain, Italy, France, Denmark, Germany, Slovenia, Poland and the Czech Republic (which corresponds to the 8 HIV-COBATEST participating countries).

According to the **definition of CBVCT** proposed by the HIV-COBATEST Project during the kick-off meeting, we included any program or service which offers HIV counseling and testing as one of its main activities (independently of clinical services), targeted to specific groups of the population and clearly adapted and accessible to the communities to whom it is addressed.

The CBVCT programs included in the study accomplished, as decided in the HIV-COBATEST Steering Committee, at least one of the following criteria:

- CBVCT took place in the same context and community where it was originally set up.
- CBVCT was perceived as a reference point by the target group (local community, vulnerable population) to receive information, support and HIV counseling and testing.
- CBVCT used participative research methods (qualitative techniques such as interviews, focus groups, etc.) in order to ensure the community's participation. Moreover, community representatives were involved in the planning and implementation of the organization of the VCT center.
- CBVCT was easily accessible and adapted to the specific needs of the target group.

The inclusion criteria did not take into account physical location, staff characteristics, sources of funding, or whether the services are provided free of charge or not. Therefore, prisons, primary health care and STI clinics were excluded from the project; while pharmacies, outreach programs and point of care services were potentially included.

It must be stated that after a first analysis of the data collected in the "Cross-national survey on the Implementation of Community Based Voluntary Counselling and Testing Programmes" (WP4), in order to ensure uniformity, the HIV COBATEST Group proposed a refined definition of CBVCT: "CBVCT is any program or service that offers HIV counselling and testing on a voluntary basis outside the formal health facilities and that has been designed to target specific groups of the population most at risk and is clearly adapted for and accessible to those communities. Moreover, these services should ensure the active participation of the community with the involvement of community



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representatives either in planning or implementing HIV testing interventions and strategies". Nevertheless, as we used the former definition in our qualitative study, we have decided, for methodological reasons to keep it.

Tool description

Mini focus groups (3-5 people).

For this study it was fundamental to talk with hard-to-reach populations and since the topics discussed required as many details and clarifications as possible, we choose this technique in order to obtain more in-depth conversations.

A detailed description of the conduction of these focus groups can be found in the WP5 Qualitative Study Protocol. Concerning some methodological aspects is must be stated that:

- All the focus groups were recorded (after written and recorded consent from all the participants), transcribed and translated into English.
- The mean duration of the focus groups was 75 minutes (range: 60-90 minutes).
- The mean number of participants in the focus groups was 3. One exception was the Denmark focus group, were 6 participants attended.
- All the focus groups were physically conducted at the CBVCT venues.
- The field-coordinator of each country was in charge of moderating the focus group, transcribing them and responsible for getting the transcriptions translated into English.
- All the field-coordinators used the same "discussion guide" (see WP5 Study Protocol), a document with the main topics to cover.

Table 1. Fields coordinators.

	CBVCT programs	Field Coordinator
Czech Republic	Ceska spolecnost AIDS pomoc	Ludek Danes ludan@sendme.cz
Denmark	Stop-AIDS	Francois Pichon pichon@stopaids.dk
France	AIDES	Daniela Rojas Castro drojas@aides.org
Germany	AIDS Hilfe	Frank Funk frank.funk@nrw.aidshilfe.de
Italy	Arcigay	Michele Breveglieri m.breveglieri@crrps.org
Poland	The National AIDS Centre	Marta Walichnowska m.walichnowska@centrum.aids.gov.pl
Slovenia	Institute of Public Health of the Republic of Slovenia	Ales Lamut Ales.lamut@ivz-rs.si
Spain	Projecte dels Noms-Hispanosida	Eduardo Ditzel editzel@hispanosida.com



Semi-structured interviews.

All the participating CBVCT service coordinators were interviewed by the field-coordinator. The main objective was to obtain a thorough knowledge of implementation and current functioning of CBVCT.

A detailed description of the conduction of these interviews can be found in the WP5 Qualitative Study Protocol. Concerning some methodological aspects it must be stated that:

- All the interviews were recorded (after written and recorded consent from all the participants), transcribed and translated into English.
- The mean duration of the interviews was 75 minutes (range: 60-90 minutes).
- The mean number of coordinators for each interview was 1. However, two countries, Italy and Germany, invited more than one person to their interviews. In fact, they interviewed not only the coordinator participating in the study but also other regional coordinators or experts.
- All the interviews were physically conducted at the CBVCT venues. One exception was the French interview, which was not physically conducted at the CBVCT venue.
- The field-coordinator of each country was in charge of conducting the interviews, transcribing them and responsible for getting them translated into English.
- All the field-coordinators used the same "discussion guide" (see WP5 Study Protocol), a document with the main topics to cover.

Finally, it must be noted that in order to have a better understanding of the perceptions of CBVCT clients, some questions were put to groups, coordinators and clients. This allowed us to understand to what extent some CBVCT practices are perceived and/or interpreted by CBVCT clients.

Material quality analysis and limitations of the study

The present report is based on data collected in 8 different countries with very different national contexts, HIV epidemics, and with diverse ways of developing CBVCT because of social, legal, economical and historical reasons. This is a first subject which must be stated when reading this report; we are analyzing one "voice" per country, which is already a potentially biased source of information since we are giving an important credence to one community-based testing experience to the detriment of other experiences. Nevertheless, for some countries there is only one experience of such a kind. In any case, we can accept



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this bias given that our main objective was to have a better and wider knowledge of CBVCT experiences and not to have an in-depth one, which would be impossible given that there is not a clear definition of what CBVCT is and there is not an already existing network of CBVCT services to be surveyed. In fact, these are the final objectives of the HIV-COBATEST project.

In the second place, and for all the reasons mentioned before, we had no choice but to use a convenience sample. The coordinators who were interviewed accepted to be interviewed because they were already participating in the project, which shows their interest and involvement in having a better knowledge of and improving CBVCT services. As for clients, they were chosen because field coordinators had already a good “rapport” with them; this means that we have access to the opinions of people who already attend CBVCT venues and who are minimally satisfied with this experience.

Another main issue is that of the use given to the “discussion guides”. All field coordinators had the same English version of the interview and focus group “discussion guide”. However, these guides were translated, and we could not guarantee the reliability of the translations. Besides, in the course of the interviews and focus groups, modifications occurred in the way of stating the different issues and even in the issues themselves. Actually, some field coordinators failed to ask questions regarding some of the main issues. Since there is only one interview and one focus group per country, this means that for some of the main issues we lack information for a few countries, which reduces our possibility of giving a more comprehensive panoramic view of our data. This lack of information becomes particularly problematic when it concerns a country whose situation is different to that of the majority of other countries.

In the fourth place, we noticed that the quality of translation is quite varied. Countries with a larger custom of using English provided more precise translations than the others. In several cases, the content is not really accurate but is understandable, particularly because the issues discussed are well known for people working in the HIV and testing field. But, in some cases, even the meaning of the answers remains unclear because of the translation. In these cases, we decided to be conservative and did not decide what was the most likely interpretation of the content. Once again, these situations engender lack of information on some important topics.

In the fifth place, it must also be stated that most of the participants in the focus groups were men who have sex with men. Nevertheless, even if they were not numerous, other populations like migrants, transsexuals, and women were represented.

Finally, there are particular situations in the way of conducting the focus groups and interviews which must be considered. From our point of view, the three most



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important are: 1) the Italian interview was done mostly with one CBVCT coordinator, but in the middle of the interview two other people got involved, which clearly changed the dynamics of the discussion; 2) the French CBVCT coordinator was not available for a physical interview, so it was decided to send him the "interview guide" and he gave a written answer, which did not allow for development and in depth discussions on some issues; finally, 3) the German focus group was not a real focus group but three interviews were conducted separately, this means that there was not a confrontation of the different points of view and practices as occurs in the other focus groups. These particularities introduce a difference in the quality of contents.

In this section we have presented the limits of the materials collected for the present qualitative analysis in order to keep in mind to what extent these results can be generalized and the potential biases. However, it should also be stated that the content of the interviews and focus groups is really rich and interesting and has allowed us to have access to the experiences of coordinators and clients of CBVCT services and programs. All of them they have shared their points of view on very various and, sometimes, difficult and sensitive issues.

Content analysis

A content analysis was carried out in order to identify the main patterns related to CBVCT suitable implementation experiences and to have a better knowledge of and understand the various experiences of the participating countries.

These patterns have been interpreted on the basis of the health quality approach (WHO, 2008)¹⁴, this means that results have been examined in order to identify the strengths and weaknesses of various CBVCT experiences.

The *corpus* of this qualitative study was shaped by the content of the focus groups and interviews. A coding table was created in order to list the different categories of answers. Two tables were used, one for the focus group content and another for the interview content. This codification was simultaneously done by two people from the work package team in order to guarantee the content validity. Moreover, once this codification was done it was debated with two other members of the French team in order to obtain a second validation on the content categorization.

It was decided that no modification of the corpus should be done. This means that unclear quotes were not "re-transcribed" or written in more comprehensible

¹⁴ Guidance on developing quality and safety strategies with a health system approach. WHO, 2008



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English. In our opinion, this would introduce a potential bias and would result in an analysis founded on modified information.

A number was assigned to each country in order to differentiate the quotes used for illustrating the various dimensions which emerged from the participating countries.

Table 2. Identification number of the participating countries

Slovenia	Poland	Italy	France	Denmark	Germany	Czech Republic	Spain
1	2	3	4	5	6	7	8



Results

The content of the eight interviews and seven focus groups, in spite of some methodological difficulties, provide us with a wide quantity of information regarding the implementation and functioning of diverse forms of CBVCT present in rather different national contexts.

The results of data collected by using interviews for coordinators and focus groups for clients will be presented as follows:

- 1) Main topics on CBVCT implementation and functioning were decided on once the tables of contents were created (corresponding to themes more frequently dealt with in scientific literature and to those issues already addressed by the participating countries on the project). In this way, results concerning several questions (e.g. "What does CBVCT mean to you?" and "In your experience, which would be the major differences between CBVCT and other HIV screening settings?") can be presented on the same main topic (e.g. Definition and characterization of CBVCT).
- 2) Each subject will be presented on the title, while the questions formulated during the interviews and focus groups will be stated in the subtitles.
- 3) For most of the topics we found answers from coordinators and clients. In this case, results concerning the former will be presented in the first place, then results from clients will be described, and finally, a discussion describing the convergences and differences of these two populations will be proposed.
- 4) If the topic was only answered by coordinators or by clients, a simple presentation of the results will be presented.
- 5) In some rare cases, where no major differences were found, results corresponding to the coordinators and clients will be presented together.
- 6) Sometimes respondents answered or gave examples which did not exactly correspond to the question stated; in these cases, and in order to have a better understanding of and show the representations of coordinators and clients, we have choose to present the results as stated by the interviewees instead of presenting them in a more "accurate" part of the report.
- 7) In order to illustrate the contents analyzed, we will present in some cases word clouds. They will offer a graphical representation of the most frequent words used by the study participants.
- 8) Fragments of the interviews and focus groups will guide the presentation of the results. It has been decided to use the following identification keys:



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Interview (coordinator): Int + Number of country (e.g. Int-7)

Focus group (clients): FG + Number of country (e.g. FG-3)

- 9) After each issue a "Key Points" window will be presented in order to summarize main results. In some cases this table will summarize the results of several points, depending on the length of the contents.
- 10) Results concerning the participants (e.g. sex, experience with CBVCT) based on the reporting sheets will be presented in a table (see Annexes).



Section 1

National HIV-Testing Context

One of the main objectives of the HIV-COBATEST project is to develop a code of good practices for implementing community-based voluntary counseling and testing (CBVCT) services and programs around Europe. However, the national contexts of the participant countries and of those potentially using this code of good practices are very different. For this reason while this qualitative study was being conducted, (whose main objective is to identify elements helping or hindering the implementation of CBVCT services), several questions regarding national HIV-testing frameworks of the participating countries were asked in order to obtain detailed information on them. Thus, CBVCT coordinators and clients were asked about institutions involved in HIV testing, if there was national and/or regional regulation, the kind of funding, procedures for HIV positive referral to formal health settings, etc.

Since political, bureaucratic and legal settings must be considered in order to implement HIV screening settings such as CBVCT, we consider that these experiences will provide the foundations for “building” appropriate CBVCT services.

STAKEHOLDERS, REGULATION, COMMUNITY INVOLVEMENT AND FUNDING

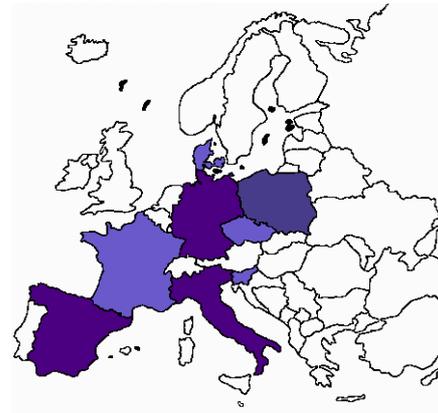
WHAT’S THE NATIONAL HIV SCREENING AND MONITORING CONTEXT? COULD YOU DESCRIBE THE COMMUNITIES’ INVOLVEMENT IN HIV DECISIONS? WHAT’S THE GOVERNMENTAL/REGIONAL REGULATION COVERING HIV TESTING? COULD YOU BRIEFLY DESCRIBE HOW DOES FUNDING FOR CBVCT WORK?

The first request to CBVCT coordinators was to offer a description of the national HIV-testing setting. In order to achieve this objective, several questions were stated regarding the different stakeholders involved in HIV testing, the various regulations covering HIV testing and the involvement of communities regarding national HIV policies. Finally, coordinators were asked to describe the type of CBVCT funding since it depends significantly on the former issues.



Who does what? Diverse national contexts

We obtained very diverse responses to this question. The majority of the eight coordinators interviewed mostly described access to HIV testing, while only a few coordinators described if National/Regional HIV Strategies or if HIV-Testing guidelines exist or if they are aware of them. We could say that instead of describing “*who does what*”, coordinators essentially gave us information about “*what is done*”.



Regarding the **availability of HIV testing**, we found that all the participating countries declared that HIV testing is available for the general population in hospitals; that in some countries there are also specialized clinics, and then, there is CBVCT.

“HIV screening is done by the hospitals that offer the HIV test, by general practitioners and by CBVCT. The monitoring is done by the national surveillance institute, and in this context, CBVCT is an extra testing facility for specific risk groups”. (Int-5)

Nevertheless, even if there is a theoretical global access to HIV testing, some coordinators clearly expressed that this availability becomes much less actual when we observe the real daily lives of people who would like or wish to take a HIV test.

“The tests are accessible - to as wide group of people as possible - at specialized institutions. Although in theory, one could have access to the test at every doctor's office”. (Int-1)

“Of course it can be done by all GPs but in practice it doesn't work”. (Int-7)

Concerning the **existence of CBVCT** in the different participating countries, we found that some countries like Spain referred to the existence of several community-based experiences while others, like Italy or the Czech Republic only have one center of this nature.

“Our organization is the only one carrying out testing and counseling services. They are provided once a month in collaboration with a hospital in Florence. We are the only ones who do a test within an association and we are the only ones who provide a service of pre and post-test counseling. Well, obviously, for the post counseling test, you need to look at how many people actually want to do it”. (Int-3)



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Furthermore, the **nature of CBVCT** changes a lot depending on the country where the interview was conducted. Some of these differences depend on the place where the CBVCT service is located (e.g. a hospital in the Italian case versus an NGO in the Spanish case), to the staff performing the test and/or the counseling (this point will be dealt with in more detail further on), to the funding, etc. To sum up, what we found is that there are substantial differences among the various CBVCT participating in the study. There is no reason to think that other CBVCT experiences in Europe are not concerned by these differences. Nevertheless, there is one common point for all CBVCT, they target **specific populations**: “risk groups”, “vulnerable populations”, “hard-to-reach populations”, “most-at-risk populations” or “most-exposed populations”. All these terms turn up during the interviews, and they reveal different ways of perceiving these populations and, even more, they also entail different ways of approaching community-based testing.

“The CBVCT is an extra testing facility for specific risk groups.

Which groups?

In Denmark it's specifically men who have sex with men (MSM), immigrants and sex workers.

What about drug addicts?

Hmm... There has been for quite a number of years a specific program on needles exchange, so that drug users do not share needles, so they can walk into any pharmacy and have injection needles free of charge.

Ok so you mean that there is not much HIV transmission through sharing needles in Denmark?

Yes, there is a very low transmission rate among intravenous drug users in that group”. (Int-5)

From this example we can observe to what extent the implementation and functioning of CBVCT is entirely interconnected to **other health policies** like those concerning harm-reduction strategies. The Danish example, regarding the free supply of injection needles, illustrates how this kind of policy decreases HIV transmission rates in those populations most exposed to HIV (e.g. injecting drug users).

Turning to another matter, we observe in Spain and Italy the **impact of the administrative organization in the HIV screening context**. We found a lack of framework regarding this issue. As the coordinators explained, there are no national guidelines or policies concerning HIV testing. Furthermore, in some cases regional policies regarding HIV testing do not exist. Nevertheless, this situation has not necessarily prevented notable community-based testing experiences from developing.



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“Well, I don’t know much about the Italian situation whereas I can tell you something about the situation in Florence and Tuscany, also in terms of what happens outside our organization”. (Int-3)

“First of all, I should say there’s no national HIV testing policy in Spain, nor in Catalonia”. (Int-8)

In fact, we can observe that sometimes, the lack of a framework allows the development of experiences that would otherwise not take place. Like this, the French experience is a good example of how more structured national states can prevent or demand steps to develop new HIV testing settings. AIDES, the French NGO currently performing community-based testing had to conduct a biomedical project (ANRS-Com-Test) in order to prove the efficacy and reliability of non-medical HIV testing. Once the results confirmed this efficacy, a change in the law¹⁵ was required in order to allow community-members without medical backgrounds to perform the tests outside biomedical frameworks.

“HIV screening using rapid tests was only allowed in France in 2010 at the same juncture as non-medical community-based testing. Community-based organizations are just beginning to assume ownership of this new tool and use it in the field”. (Int-4)

Another issue that emerged when coordinators were interviewed was that of **surveillance data control**. Some countries, like Poland or the Czech Republic, show us strong HIV data testing surveillance, including mandatory HIV testing for pregnant women and blood donors (without informed consent). This obligation to declare HIV positive results is not the same in the various countries questioned. In Spain, for example, an associative movement against the construction of a HIV-positive epidemiological register prevented, until 2007, the establishment of an accurate national reporting system.

“The HIV monitoring context is a very complicated issue, because the creation of an HIV national reporting system in 2000 was taken to court (because at that time, the NGOs considered the reporting a violation of the protection of personal data), and only in 2007 the Spanish court published the decision that this reporting system was legal. The application of the reporting system depends on the Health Department of each Autonomous Community, which communicates the data to a central reporting system”. (Int-8)

“It is obligatory to register obtained positive results confirmed by Western Blot to District Sanitary and Epidemiological Stations. Such Stations send their records to the National Institute of Public Health”. (Int-2)

¹⁵ *Arrêté du 9 novembre 2010 fixant les conditions de réalisation des tests rapides d'orientation diagnostique de l'infection à virus de l'immunodéficience humaine (VIH 1 et 2).*
<http://www.legifrance.gouv.fr/affichTexte.do?cidTexte=JORFTEXT000023093746&fastPos=5&fastReqId=796374388&categorieLien=id&oldAction=rechTexte>



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Finally, we found that only one coordinator mentioned the existence of a National HIV Strategy when asked about the national HIV testing setting; even if there are National HIV Strategies in most of the other participating countries. In our opinion, is very interesting and symptomatic that only one of the coordinators makes reference to their National HIV Strategy, which should be an important reference for the functioning of CBVCT. Maybe this **lack of significance of the National HIV Strategies** by the CBVCT coordinators is related to the fact that National HIV Strategies do not know about CBVCT experiences in their own countries.

“Yes there is a national plan, and at the end of 2009, a new guideline was adopted speaking more in detail about people from risk groups that nurses and doctors should encourage people to take an HIV test if they belong to the MSM group, the migrant group, the sex worker group or to the intravenous drug user group”. (Int-5)

National and/or regional regulation concerning HIV

In some countries, the regional regulation regarding issues like education or health is almost as important as the national regulation, and so it was decided to include a question regarding both types of HIV testing regulations. The first comment that we should refer to, and as stated before, is the fact that some **CBVCT coordinators are not aware of this HIV testing regulation**. Like this, we found that some CBVCT stakeholders do not perceive this political dimension of HIV testing as something they need to know.

“I know there are regulations, but I don’t know details. That’s up to our umbrella organization and up to my boss. It is stuff that doesn’t belong to my working area”. (Int-6)

Again, it is not surprising that, in some countries like Spain, who already describe a devolved administration, a vacuum regarding HIV testing regulation is found:

“There’s no governmental regulation concerning this issue”. (Int-8)

The Italian experience, which shares this strong regional functioning with Spain, describes a sort of unawareness of the HIV testing regulation due to the **diversity of possible “performances”** regarding the HIV test.

“Well, I’m not so... I’m not really aware of the details of the law, but I think that there are too many constrains. I know some of them, and I partially agree with them. [...] You can get tested only in the hospitals, except, well, I know only the exception of this association... Honestly I don’t know any other association who



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that about one hundred thousands of Euro for whole country. Speaking about HIV testing and counseling the situation is much worse outside Prague. There are some regions where is not available at all. We try to supplement it and we have opened our branch in Ostrava and recently in Brno. Also many centers use counseling in their name only and it is not provided. One reason is there is no program guaranteed by state of education for counselors. There was but with cuts it has disappeared”. (Int-7)

Finally, we found countries like Poland, France and Denmark, which describe very detailed standards concerning the running of HIV testing. In the case of Denmark we found again a **noteworthy public health policy** for testing all those people who are not unaware of their HIV status.

“We have the National AIDS Centre standards on how to run a VCT in a proper way and who may be employed there. There are also principles of Polish AIDS Research Society that provide information on who should be tested and how testing should look like. It is also obligatory to register confirmed positive results. We have clear procedures for laboratory diagnosticians on how to perform an HIV testing. For example: every result has to be written down on paper, stamped and signed by a diagnostician. There is no possibility of revealing the outcome of an HIV test only orally”. (Int-2)

“CBVCT is regulated by the law at the national level (with obligations on training and quality) and the regional health authorities check these criteria and allow some organizations to do community-based rapid testing interventions. They also evaluate the programs which are implemented”. (Int-4)

“Well, historically back from 1987 we've had four pillars in our national HIV plan: testing should be anonymous, voluntary, based on open, direct and honest information about access to testing and testing facilities and a wish to avoid any form of discrimination against people. And finally that any citizen should feel comfortable engaging with the health care system in Denmark. And that was made back in 1987, and reconfirmed by the national parliament in 1997, and then in 2009, these new guidelines are still based on anonymity and voluntary access, but there was then added that doctors and nurses should encourage people from risk groups to get tested in order to bring down what we call "the dark figures", the number of people who are HIV-positive but do not know their status”. (Int-5)

Community's involvement in HIV policies building up

Another important question was the communities' level of involvement in building up HIV testing policies. It must be noted that a genuine community-based approach implies having representatives of the community in order to identify needs, to establish goals, to implement actions and to evaluate these actions.



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The answers provided by the CBVCT coordinators were, logically, closely related to the preceding ones. Indeed, we could believe that a more developed national regulation concerning HIV would correspond to a deeper reflection about the place of the community in HIV testing and to a greater involvement of the communities. However, we did not find such a parallel; on the contrary, the experiences related by coordinators show that the communities can be instigators of such programs and can have a decisive influence on HIV policies.

Thus, Spain, Italy and the Czech Republic, where national/regional regulation is not clear or inexistent, there is **little involvement of the communities** in the process of building up HIV policies. However, as for Spain and the Czech Republic, this trend seems to be changing.

“The policy makers in Spain never took seriously the role of the involvement of communities in HIV decisions. In fact, the health authorities were not at all in favor of doing HIV testing in non-clinical settings. Only in the latest edition of national plans, the CBVCT has been incorporated”. (Int-8)

“Well, we don’t have such kind of policies in Italy! (he laughs) We don’t have any specific policies, and it is even a miracle that we could create this service here in Firenze”. (Int-3)

“There is a national plan for HIV, middle-term plan, currently 2009-2012, so they should prepare soon a new one. This plan was accepted by the government, so it has relatively strong position as a document, but broader social support is not strong because HIV prevalence in the country is low. In this plan is mentioned a role of communities and HIV prevention and... testing and counseling. I think CBVCT is implemented in the national AIDS plan”. (Int-7)

On the other hand, we found countries where HIV activism has been strong for a good many years. France and Denmark describe how communities concerned by HIV/AIDS are involved in decision making processes. Now, this **taking part in HIV policies is the result of the HIV community’s determination to participate** and not necessarily an invitation from formal health institutions.

“Well historically the community activists have been very active in performing prevention and influencing national plans, but I would say that it was essentially a response to the political systems lack of response to the situation at that time. So the activist level simply had to do something, because politicians simply were not quick enough.

And today I would say that prevention strategies and plans on a national level are carried out by politicians, and we have meetings with health politicians. We have a close contact with them, and we seek influence in terms of lobbying and in terms of showing what we can do and presenting our prevention programs to them. So we don’t have direct power in decision making, but we have a close collaboration with politicians and with the national institute of surveillance and the national board of Health”. (Int-5)



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“We intervene on three levels: on the national level we negotiate and defend the needs of the communities with the Health Ministry (we managed to achieve a change in the law and a financing plan regarding CBVTC) we act in partnership with large community-based organizations and networks, in particular gay or sub-Saharan African communities. We also work locally with each French city organizing steering committees on CBVTC actions with local representatives of the communities in question”. (Int-4)

Other countries, like Slovenia, show a flow of **cooperation that is barely starting**, but exists.

“Yes. We have three NGO-s that have their representatives in National AIDS Commission. Therefore there is some communication on this formal level and basically all the relations between “stakeholders” in the area, that is between the representatives of the authorities from health institutions, state institutions and some non-governmental stakeholders, proceed through this body. In this way a certain communicational flow of cooperation is in action. Actually we, too, take part in it – I alone am a member of this AIDS commission as well and that's why I'm familiar with the national situation in the area and the authorities in the state that deal with these issues have an insight into our project”. (Int-1)

For the two remaining countries, Poland and Germany, we found similar answers. Both of them answer in terms of **communication rather than actual involvement**. In fact, they describe a community that participates in communicating on HIV testing services, but do not necessarily take part in building up HIV policies. Typically, there are examples, mainly from an institutional point of view, where “involving” the community means using the community to communicate about a decision regarding HIV prevention and/or testing (e.g. campaigns) without having invited the community to participate in the previous, and also future, steps of decision making.

“Yes we are very involved in the community. We use all ways to get in touch with the focused group of men. Social networks, real as well as virtual are very important. The community informs itself by everyone who uses our offer and talks about it. We are part of the community. In addition we use the press, especially community magazines of our region. We've got good cooperation with the local press with many synergies, so not much work for us”. (Int-6)

“In case of MSM we have a collaboration of governmental organizations (the National AIDS Centre), non-governmental organizations that work for the HIV positive and organizations that work in the field of LGBT. Thanks to that interchange we managed to launch a social campaign directed to MSM and to get media involvement, esp. the internet. Thanks to that collaboration it was possible to hang banners on HIV and AIDS on gay dating portals, portals targeting MSM and LGBT. It was possible to write to experts who passed information on HIV



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prevention. Specific activities were developed in clubs, saunas, which are places frequently visited by MSM”. (Int-2)

Therefore, the involvement of the community depends on its own mobilization and depends on the relations with the health institutions which they may be more or less open to the idea of letting the communities take a role.

CBVCT Funding

One last issue of this section is CBVCT funding. Indeed, and logically, the way CBVCT services and programs are funded is a direct consequence of both the kind of HIV testing regulation and the level of community involvement in decision-making.

Getting back to the Spanish situation where, according to the CBVCT coordinator, there is no national or regional HIV testing regulation. We observe **no “explicit” funding** for CBVCT but various subsidies that are insufficient and therefore NGOs must find other means to keep the CBVCT services running.

“As policy makers haven’t really taken seriously the role of CBVCT, budgets do not include funding for CBVCT. To be able to make a CBVCT work in Spain, one has to add low amounts of subsidies, private funding and lots of hours of volunteer work”. (Int-8)

As for the rest of the countries, we found that most of them are partly financed by their respective **national institutions** (e.g. Health Ministries), in some cases also by their **regional administrations**, and then, in some cases there is **private funding**.

“The biggest part is covered from the AIDS budget covered from the Ministry of Health. But we also need to have some other money because it's usually seventy percent of needs can be covered by one grant from ministry. We need to get some other thirty percent. We have some money from municipality of Prague (even from Prague is less than half of our clients). And honestly some clients support us, they have chance to give us some money when leaving Lighthouse (not in the VCT center). We had last years some money from the events of Art for life foundation and from Red ribbon. So financing of our CBVCT is one of our priorities and until now there is no serious problem. We do not pay for the tests and they are done in National AIDS lab free for us (they have another grant from AIDS budget for anonymous testing)”. (Int-7)

“The financing consists of different complementary pillars. Namely, in part the means were contributed by private, profit sector – these are the donations. Then there is the Ministry of Health where in 2010 we applied for and were granted the means since our pilot project was part of an action plan based on national



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strategy. And the third sources are other tenders or non-governmental organizations, like the student organization last year”. (Int-1)

“The CheckPoint Copenhagen project is partly sponsored by the Copenhagen city council. [...] So we're partly covered by that plan, and then we are covered by a national fund which gives money to projects aiming at people in social risk groups”. (Int-5)

It is only when the funding issue arises that the potential role of pharmaceutical companies gets mentioned for the first time. In this particular case is Poland who describes that even if there is financial help from the Health Ministry and also local aid, NGOs are calling on other potential sources of funding like **pharmaceutical companies**.

“The majority is financed from the Minister of Health budget, thanks to the subsidy from the National AIDS Centre, in some cities local governments help. [...] Non-governmental organizations that run VCTs try to get private resources, sometimes we have testing campaigns financed by pharmaceutical companies”. (Int-2)

Key points

- ⌘ Wide availability of HIV testing, which does not necessarily correspond to people’s daily-lives.
- ⌘ Even if CBVCT programs are diverse in “nature” and quantity they all target “most-at-risk” populations.
- ⌘ In countries with more developed CBVCT programs, a strong interconnection with other health policies is found (e.g. harm reduction strategies targeting IDU).
- ⌘ Lack of knowledge regarding National/Regional regulations.
- ⌘ National/Regional regulations are quite diverse, ranging from those currently being developed to very exhaustive standards.
- ⌘ Communities’ involvement in National Health Strategies depends on the balance of power.
- ⌘ Diverse sources of funding regarding CBVCT centers (national, regional and/or private funding).



IS THERE EASY ACCESS TO HIV SCREENING?

IN YOUR OPINION, IN YOUR COUNTRY, ARE THERE DIFFICULTIES THAT HINDER ACCESS TO HIV SCREENING?

Knowing if there is effective and easy access to HIV testing in the countries participating in the study, will undoubtedly help to explain the role of CBVCT, since it is implemented to avoid potential barriers to HIV testing. Since these barriers are mainly experienced by **clients**, they were asked to indicate if, in their opinion, there are difficulties that hinder access to HIV testing.

“Why do some people hesitate to get tested and then they find out too late, when they are seriously ill?”

I thought it was a breakthrough the first time; I sort of felt people staring at me when I entered from the street. I felt labeled.

Labeled?

Yes, labeled as gay.

[...]

So, if you're interested in HIV or get an HIV test, you can be labeled as gay, because only gay men get tested. Is that it?

- Yes, sort of.

- I agree, now I know a number of people – being a foreigner myself – still lots of prejudice, even though there are people from many professions – it's not just illiterates or what the expression is. Maybe it's ignorance. They never learned about it – That it's an illness and not just men who have sex with men, but also women that are infected and men can get infected by women. So you get labeled – only gay men get HIV or Syphilis or whatever you get - in their eyes or their minds”. (FG-5)

“Yes, I agree with you. Maybe in certain isolated areas it could be... but it might have more to do with the reluctance one may have on going to their family doctor ... than that they don't have a sufficiently broad range of options”. (FG-8)

Even if in all the participating countries, CBVCT coordinators described a wide access to HIV testing. It becomes evident that the **decision taking** is much more complex than the mere accessibility to HIV test.

“I think it's a good experience. From beginning to ... It took half an hour and – seriously – you feel welcome, they are serious. I think it's ... I don't see how you can do better. The decision is difficult, but first you made the decision, it's a perfect place to attend.

So, you mean the decision to get tested?

- Yes, it's the hurdle you have to overcome.

- You have to bring yourself to do it”. (FG-5)

This extract illustrates the point of view of CBVCT clients. According to them, there are no formal barriers limiting access to HIV testing. Nevertheless, **fear of**



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being “labeled” as gay when one goes to get tested is a powerful social barrier. This label can involve violent consequences; which are evoked, in this case, by one French client:

“Yeah, don’t even think about it...I used to live in a little town near Chartres. Once, some people found out about a guy being gay and they destroyed him! He was found dead in his own house – he had hung himself. Because they messed up his car, they messed up his letter box, they stole his mail. They found out that he was getting pornographic films in his letter box, so he went to make a complaint to the police who didn’t...dirty queer....he wasn’t supported at all. And when he was found dead, the people were wondering why...and that happened quite recently. My landlord, also in a little village, arrived once in the middle of the night, and broke down his own door-of the house I was living in- to destroy me and my boyfriend. And when we went to the police station the next morning, it was ok for me but my boyfriend couldn’t get over it, they told us that we could just as well have fallen down the stairs at home and they wouldn’t file the complaint, this was in 2000”. (FG-4)

Such experiences remain in clients’ minds and might encourage them to hide their homosexuality, which represents a major obstacle to HIV testing. However, this climate depends on the place, its culture and the influence of the gay community.

“And why do you think it’s easier in this sense in Barcelona?”

- Well, Barcelona is a very open city, culture wise; and what’s more, it has a very important gay community... so it’s nothing unusual or exotic, is it? It’s something you bump into in the street... people are used to seeing it.

- Yes. It’s a very big city. There are lots of people everywhere. It has a lot of tourism... people who have traveled around, who are here now and may be moving on somewhere else later... who have seen the world. And so I think that the more experiences you have of that kind, the more open you are... the fewer prejudices you have.

- It’s probably because people are open minded. On the other hand they just mind their own business and I think it’s both these things”. (FG-8)

Furthermore, answers to this question caused some clients to underline the “classical” association between HIV and homosexuality that heterosexuals often make. The latter do not feel concerned by HIV since HIV/AIDS is still perceived as a “gay disease”. According to some clients, **campaigns specifically targeting most-at-risk populations** (e.g. migrants and MSM) do not facilitate the deconstruction of these **stereotypes**.

“- I don’t think heterosexuals have any problems, because they’re in couples and they’re faithful...I have practically no heterosexual friends, very few of them get tested. Aids still seem to be a gay disease.

- And again it’s because of clichés, on nationwide HIV prevention campaigns; they still put a gay couple and a black person. As if both groups were being



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targeted. We still have these assumptions so white heterosexuals don't feel concerned". (FG-4)

Another aspect that was pointed out by the CBVCT clients was the issue of living in **big cities versus small towns**. The latter were mentioned as places where campaigns do not reach the different populations concerned by HIV and where there are *de facto* more barriers to HIV testing.

"- According to the place you are, the type of activities or hobbies you do, you're going to have more or less a chance to see the poster campaigns or you might not have access to them at all. For instance someone living in a tiny little town would never have access to awareness campaigns in their town or in bars and clubs. There could also be family pressure or it could be a taboo subject, in any case they wouldn't be aware of what's on offer. Or maybe they'd see them and reject them outright so as not to be seen. The smaller the town is the more you risk being seen by others.

- Yes, I went through something like that. Being in a little town or even being gay three years ago, it was like being a witch in the olden days, they were burned at the stake.

- Or if you're HIV positive it's even worse". (FG-4)

Finally, CBVCT clients also reported another potential barrier to HIV testing, the fear of being **diagnosed with HIV**.

"I don't think it's only the case in Denmark. People in general are just afraid of being taken ill. It's a universal thing, no matter if you live in Poland or ... I don't feel that anything specific in Denmark should make it difficult. It's difficult on a human level". (FG-5)

An interesting illustration of the barriers to HIV testing is that of these German clients, who insisted on the absence of legal barriers to HIV test but clearly stated that there exist barriers, and they are on **people's mind**.

"In your opinion, are there legal barriers which restrain HIV screening access?"

- No. I don't know about any and couldn't imagine there are any.

- Oh no. You could choose any doctor. It's possible to get information right at the CBVCT or later somewhere else.

- Not at all. Objective: not at all. The only obstacles exist in people's minds. And of course there is a difference between City and land. I just know about the situation in this metropol-region". (FG-6)



ARE HIV TESTS FREE?

DO THOSE ATTENDING CBVCT HAVE TO PAY FOR THE TEST? HAVE YOU EVER HAD TO PAY TO DO THE TEST?

A free test is one of the main steps to guarantee accessibility to HIV testing, particularly when vulnerable populations are concerned. For this reason, CBCT coordinators were asked to explain if their CBVCT provided HIV testing for free and CBVCT clients were asked to describe their experiences of “free” or “chargeable” HIV testing.

Coordinators. Tests in CBVCT are free

When the CBVCT coordinators were asked to indicate if their clients were supposed to pay for getting tested, we found that all of them answered that **HIV tests at CBVCT are provided for free**. Nevertheless, there are two situations, both of them reported by the Czech partner that ought to be mentioned. First, HIV tests are free of charge unless the client asks for a “certificate” indicating his/her HIV status:

“Only exemption is so called the certificate. That's, official test result given by our national AIDS laboratory. That is the only place when they can get it. It is a document for entry to some, maybe thirty, countries usually not very democratic ones who demand it”. (Int-7)

Secondly, it happens that some clients offer gifts or become donors of the organization in order to support the work of CBVCT. The possibility of financing CBVCT services was developed also for other countries and will be described further on.

“We are grateful for any financial present and some clients gave some gifts. But it is not checked by us and we do not ask for it. If somebody wants to support us and give us some money he has possibility. Some people even have started to be regular sponsor”. (Int-7)

Clients. Free tests in CBVCT services, but not in other settings

According to the participants of the focus groups, the information about payment given by the coordinators is confirmed. The participants from Slovenia, France, Denmark, Germany, Spain and the Czech Republic, have never paid for HIV testing at a CBVCT.



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When asked about HIV tests performed elsewhere, we found that **some clients had to pay for their test**. But there are differences according to the place where the test was performed and to the different reimbursements made by national health systems. In France, for example, everybody has access to national health insurance; however, this insurance does not cover all costs, and some people have private insurance to cover the rest. This means that if a person does not have this private insurance, they will have to pay some of the costs themselves:

*“Have you ever had to pay to do a test or get tested?
Yes, it was considered like a blood test in the laboratory
But don’t you get reimbursed afterwards?
No, at that time I didn’t have any private insurance”.* (FG-4)

For some of the participants, e.g. Danish focus group, the fact that testing is free of charge is something absolutely natural and expected.

*“No? You know nothing about payment?
- No.
- Why do you ask? Do they pay in other countries?”* (FG-5)

In other countries, like the Czech Republic, we found different results. In the first place, the clients are aware of the possibility of having to pay for the test, and the **reactions to the payment are diverse** and not necessarily opposed to it.

*“- That's not so important.
- It is important. Because I asked how much cost the testing somewhere else and it is pretty expensive.
How much did they say?
I was in the centre and they wanted something like thousand crowns (about 50 USD).
Yeah. So that thousand crowns would be an obstacle for you to go for the testing?
Not so clearly... I would pay for it but when is there an option to have it free of charge, so...
Right, number three?
I prefer free of charge”.* (FG-7)



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Table 3. Economical affordance for clients according to the HIV-Cobatest Cross-national survey on the Implementation of Community Based Voluntary Counselling and Testing Programmes.

	Czech Republic	Denmark	France	Germany	Italy	Poland	Slovenia	Spain
HIV test free of charge in the public health system	Always	Always	Always	Not everywhere	Not everywhere	Not everywhere	Not everywhere	Always
HIV test free of charge in CBVCTs	Yes	Yes	Yes	Yes, except in 2 CBVCT	Yes	Yes	Yes	Yes

Finally, some CBVCT clients are concerned about the financial independence of these services and **propose paying** for CBVCT in order to guarantee the continuity of a service that benefits the community. This is the case of the Spanish participants in the focus group:

“And do you think it is important that the service is provided free of charge?”

- Yes, very.

- Perhaps charging the clients could be a financing option, I think... It would be nice to see if there is a market for it... there should be a more comprehensive medical service targeted at the community which could be a service you pay for, or a co-payment option. For example... what he proposed concerning annual checkups. I know that there is a private centre in Madrid to the gay community that provides an annual screening for sexually transmitted diseases for the community, even for people with HIV. I don't know those clinics, but I know they exist. You can use them for annual STI testing or at specific times, but you always pay for it. If this approach can finance a centre like this, I think it might be a possible option for everyone's benefit.

- On this last aspect, I would like to say that it's fundamental that it is free of charge at least one part of it. Other services could be added on later and could be charged, but this minimum should be open and free to everyone... a public service that should cover HIV and syphilis and then you could have other things. This is absolutely essential because the people who come here are from all walks of life. It may be people who are studying, people who can't afford to pay ...This must be guaranteed. Otherwise, there are people who won't come, just for the money.

- Yes. You're right.

- And it's to the benefit of the whole community”. (FG-8)



REQUEST FOR ID?

DO YOU NEED/DO THEY NEED TO SHOW YOUR ID OR OTHER LEGAL DOCUMENTS BEFORE DOING THE TEST?
TELL US YOUR EXPERIENCE ABOUT THESE ASPECTS.

Since we are talking about HIV testing in most-at-risk populations, where discrimination and stigma are common, the issue of having to show ID becomes central. In fact, having to identify themselves can prevent people from getting tested for HIV.

Coordinators. Description of “anonymous” testing

Most of the coordinators, when asked about having to show ID, answered only for CBVCT venues. In fact, all of them insisted on the fact that no ID is requested when someone uses CBVCT services to get tested for HIV.

“Do they have to present their identification or any other document prior to the testing?”

No, nothing”. (Int-1)

“Due to the fact that they are anonymous you do not have to show your ID, they are available to foreigners”. (Int-2)

“No ID or personal documents are necessary. The test can be done anonymously”. (Int-4)

“And about your second question, in terms of personal ID or national security number, no, we don't require any form of ID, and as I said, they don't even have to give their proper name, so they can be called John, Tom or Harry”. (Int-5)

“Our clients do not need to show any personal ID for getting tested, but if the client leaves any personal data (as their telephone number, for example), this will be confidential as guaranteed by the law”. (Int-8)

The French coordinator provided a good description of the **law regarding confidentiality** and connected this information with the possibility of getting tested anonymously.

“Confidentiality in medical matters is an obligation under French law, for all people who have access to this kind of information, whether they are medically trained or not. It is even more important regarding testing seeing that in France there are now law suits brought against some people for having infected a person with HIV. Everyone must trust that confidentiality is guaranteed so that nobody is afraid of getting tested. HIV positive people are used to coming to AIDES and have been doing so for years so we are extremely careful about these issues. If



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the person wants, the test can be done completely anonymously; in any case we never ask people to show us their ID!” (Int-4)

However, concerning the non request of ID, there is only one exception, that of the Czech Republic. It happens that when the client asks for a **written result**, they must show their ID.

“No it's an anonymous. Only some people who ask for written result, it must be in advance and it is not advertised, have to show their ID or some identification. But it is few percent”. (Int-7)

Clients. Showing my ID “doesn’t bother me”

Regarding questions related to **anonymity and presenting ID**, the experiences and opinions described by the clients are quite different between, but also inside, the participating countries. In any case, since clients portrayed situations regarding several HIV testing sites, their information allows us to have better information concerning the requirement of showing ID when getting tested.

Thus, the Slovenian clients describe that ID is requested when attending an STI clinic while French clients reported the same when getting tested in private laboratories.

“Yes, I had to show my health card”. (FG-2)

“They ask you for your social security card. When you go to a laboratory, it’s the social security card they ask for, so it’s not anonymous”. (FG-4)

In other countries like Denmark, Germany and Spain, both kinds of experience co-exist. However, it is surprising that for one of the German participants, being asked for the postal code is experienced like “identity”-related information.

“- I think, I’ve been anonymous every time.
- I’ve showed my social security ID at XXX Hospital”. (FG-5)

“- No. I wasn’t asked for any fee or identification. That wouldn’t be anonym anymore and that’s what I go there for.
- I didn’t have to pay anything and personal data was never been use, instead of once: at public health service I was ask for my postal code”. (FG-6)

“- Yes, in my family doctor. Here (CBVCT) I never had to show any ID.
- Yes, in a lab and at XXX (the STI Public Health Clinic), not here.
- Yes, the same (laughs)”. (FG-8)



Showing ID, is it such an important issue?

Even if the “anonymity” issue is always raised as one of the main positive aspects of CBVCT, results indicate that this subject is much more complex than a simple request for ID, since anonymity, confidentiality, privacy and visibility of one’s sexual orientation and/or sexual behavior are involved. Further details on this issue will be highlighted in the third section of this report. In any case, regarding the request for ID, we found that the clients participating in the focus groups declared **not being bothered by showing an ID card**. In fact, showing a document is understood as a facilitating step for the organizations performing the test and/or for the tested people themselves to receive the results.

Now, even if clients participating in this study did not seem to be bothered by providing ID, they were concerned about the potential negative effects of this request for other people:

“Does that bother you?”

- No, it’s never bothered me. Even being gay, it doesn’t...if people ask me, yes but if they don’t, I’m not going to shout it from the roof tops. I’m not ashamed of who I am and...

Do you think that giving your ID could be a concern for some people?

- Yes.

- Of course, there are so many young people who are still on their parents’ social security cards”. (FG-4)

Key points

- ⌘ Barriers to HIV screening according to clients: small towns, fear of being “outed”.
- ⌘ CBVCT provide free tests while other HIV testing settings are not free.
- ⌘ As for clients, paying is not always a problem; they even suggest that paying could be a way of financing CBVCT services.
- ⌘ CBVCT services do not ask for ID while other HIV testing settings do.
- ⌘ As for clients, the request for ID does not seem to be an issue however anonymity is important.



HIV POSITIVE REFERRAL

ARE THERE LEGAL BARRIERS THAT RESTRAIN HIV+ REFERRAL? DESCRIBE PROCEDURES OF REFERRING AN HIV POSITIVE TESTED INDIVIDUAL TO A MEDICAL TREATMENT CENTER. WHAT ABOUT SEXUAL PARTNER NOTIFICATIONS WHEN A PERSON TESTED POSITIVE? IS THERE A STANDARDIZED PROCEDURE?

Linkage with formal health care setting of those who have been diagnosed HIV positive is an unavoidable issue when describing how CBVCT operates. Since one of the main objectives of CBVCT is reaching most-at-risk populations, it seems essential that after testing for HIV, those who get a positive result have access to treatment and medical follow-up. For all these reasons, coordinators and clients were asked to describe potential legal barriers to HIV positive clients referral and to describe the procedure. Besides, two other related issues emerged; psychological follow-up and notification of HIV status to sexual partners.

Coordinators. No legal/administrative barriers but obstacles

When asked about legal barriers, all the countries answering the question described a **legal and/or administrative situation where there are no barriers** concerning referral of HIV positive people when the result is given in a CBVCT.

Nevertheless, two coordinators emphasize that even if there are no legal barriers, there is fear among undocumented people. This fear could be preventing access to health care systems.

“However we have found that some people are afraid of going to hospital if they are undocumented migrants, because of the new tougher laws on migration”.
(Int- 4)

In some countries, like Poland, the fact of obtaining a positive Western-Blot does not oblige the client to be treated as a HIV positive patient, letting him/her the option of attending the formal health when he/she decides.

“It is written in health care legislation that an anonymous Western blot result does not give the right to treat a patient as HIV positive and subject him/her to care for HIV positive”. (Int-2)

Regarding the **access to health for undocumented migrants** we found only one coordinator who raised this issue (Czech Republic). This may be due to the fact that in the rest of participating countries there is health insurance for immigrants (whether they are legal or not). However, this situation is currently changing at different levels in some countries like Spain, where no health



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insurance will be provided to immigrants starting from September the 1st 2012¹⁶ or France, where the law has recently changed regarding residence permits for health reasons¹⁷.

“The only problem is if the client is foreigner because all Czech people have health insurance but foreigners, especially illegal immigrants, don't have. So we recommend if they are living in the country to get Czech health insurance”.

(Int-7)

Other kind of barriers was reported, nevertheless, by the Spanish coordinator; the one that some health professionals can put up when it is people working for an **NGO who perform the test**.

“But there are cultural barriers where health professionals do not believe in the work of NGOs”. (Int-8)

Confirmatory test and linkage with formal health setting

For most of the CBVCT programs included in this study the procedure for getting a Western-Blot confirmation is the same. That is, CBVCT services use ELISA tests, and if there is a positive result, the client is supposed to contact the formal health system in order to get a **diagnostic confirmation** and decide on his/her follow up.

“A positive result has to be confirmed by Western blot, legislation requires this and it has to be issued directly to the person who was tested. The result cannot be given out to any other person (unless the court sends a writ), or a patent agrees to give out the result to somebody else but we do not practice that in our VCTs”.

(Int- 2)

Moreover, for some of the coordinators interviewed, **very close cooperation with formal health systems** guaranteeing linkage and quality follow-up in the case of a positive result is the key to the success of CBVCT.

“We have had no problems with the users that we have in CheckPoint Copenhagen, the MSM group, with referring HIV-positive people into the hospital system. I think we have a very close cooperation, because we have a nurse from one of the hospitals as a counselor in the project, so we've set up I would say an almost water proof system into the hospital setting. [...] That it functions at a very high level so that we do not "lose" an HIV patient from when

¹⁶ Real Decreto 557/2011, de 20 de Abril, por el que se aprueba el Reglamento de la Ley Orgánica 4/2000, sobre derechos y libertades de los extranjeros en España y su integración social, tras su reforma por Ley Orgánica 2/2009

¹⁷ Loi N°2011-672 du 16 juin 2011 (JORF n°0139 du 17 juin 2011 page 10290 – NOR: IOCK1003689L)



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he's tested positive with the rapid test until the confirmatory test and the referral to a hospital". (Int- 5)

Coordinators were asked to describe in detail the procedure for referring a HIV-positive client to a medical center. A first element to be highlighted is that most CBVCT participating in the study, and as stated before, are **not allowed to provide a confirmatory positive result**. This means, that they have to accompany the client to the formal health setting in order to obtain a confirmatory result, or in the words of the Slovenian CBVCT coordinator, they have to go with the client to *"the last transition between the individual and the institution, that last piece of the bridge"*.

"Actually, we do check at the institution whether people show up, since it's us who refer those individuals to them. It's being done for statistic purposes. It helps us now what, how many, well, we can't really say it indicates our efficiency because should someone decide not to take additional tests it can't point towards our efficiency - it gives indication of different reasons why a person despite our firm instructions didn't take the test within the institution". (Int-1)

"If the person so desires, we can go with them to treatment centers. All CBVCT programs carried out by AIDES have agreements with laboratories and HIV care services to make sure that people don't drop off the radar and also to ensure that the treatment process is as straightforward as possible. We can call the centers to make an appointment for the person the day of the test or the following day". (Int-4)

"In our case, and once again we are an exception, we make an appointment in an HIV unit at the same time we have given the HIV reactive result. That's basically because we have some formal agreements with the HIV units in Barcelona, what facilitates this procedure. When our clients leave the centre, they already have the details of their doctor's appointment (name of the hospital, day and hour of the appointment, name of the doctor, clinical reference number, appointment with the lab for blood analysis and instructions of how to get to this unit) which always take place within one week after the visit in our centre". (Int-8)

As these three experiences show us, CBVCT becomes a bridge between the community and formal health settings. The need to confirm the positive result as soon as possible is a powerful means of establishing this linkage. But other experiences, like those of Denmark and Poland, where confirmatory results are performed in their own centers, show that they have a very good linkage with the medical centers even if they do not depend on the formal setting. For these countries, particularly for Denmark, one of the key points for implementing a successful CBVCT is to guarantee a very good liaison with formal health care settings.



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“So most people you find positive here will be referred successfully to the hospital system?”

Yes, all of them. Either they come back here for the confirmatory test result, and then we send them further on to the hospital setting, or they show up the following day for the confirmatory test at the hospital. And then we have an added collaboration with another HIV organization called HIV-Denmark, where they counsel HIV-positive people, so not only sending the HIV-positive people into the hospital system, but also offering an appointment with an HIV-counselor who is trained to deal with the needs of a newly diagnosed HIV positive person.

Ok

And we have - if we call and tell them that we have a positive person, then they will make room in their schedule and they will take him in as soon as possible, and that is usually within the next week.

Ok, so you have good connections with the other areas of the system, the hospitals and other organizations, so it works very smoothly.

Exactly”. (Int-5)

Concerning the German experience, and since they perform the test in mobile units, we found that they advise their clients to do a confirmatory test, but without making it an obligation.

“As mentioned before, we test at a parking area by a highway. Some participants came long distances, so we give advice to get a classical blood test to confirm the first result, but we don’t insist to do it immediately. Everyone has to take care for himself; this is one of our principles. The participant knows something is wrong, we advise him to go to public health service or a doctor or a clinic, we offer him support, we offer the possibility to get tested anonymous right away, but he is the person who has to decide. We hand out a card with partners, experts, contact data and the results of the rapid test”. (Int-6)

It seems extremely important to **guarantee this linkage with high-quality counseling**, in order to support those clients who have to wait for a confirmatory result in a different setting than that of the CBVCT and who are facing the possibility of living with HIV.

“This part is verbal in the form of counseling and the part that we're working on, upgrading it, the protocol we're developing, is offering support to these people up until they don't pass over into the hands of an institution [...] We'd like to make it possible for them to call the person that handed out the result, ask additional questions, get additional counseling, be given encouragement. It's aimed at those that perhaps different reasons would hinder them from carrying it through, because at that point they're worried whether their result is positive or not and they need that support to go through with it – if the result is positive they have to face the consequences at any rate and if not, they can be relieved of a fear. It's crucial that they're not alone during that time, because it increases a chance that they're stuck halfway with this ambivalence or discomfort and we're looking for ways that would prove efficient when offered to a person in such cases”. (Int-1)



Psychological follow-up for HIV positive people

An interesting answer of the Italian coordinator came to light when asked about HIV positive referral. He not only described the linkage with HIV specialized units for “medical” follow-up, but also linkage with formal health settings where HIV positive clients have the opportunity of receiving “psychological” follow up.

“In addition, the referral process is not easy. I know, for example, of people who were looking for this type of service but weren’t given the information about it. [...]

Do you mean to say that they needed the service but they didn’t have access to it? The reality is that they didn’t have access. They don’t tell you about these services. What I mean to say is that if you make a specific request... I.e. the person who discovers that he is HIV positive has to take the initiative to say “I want a psychologist”. It doesn’t happen automatically [...]. We have 3 important centers that deal with sexually transmissible diseases. One is the hospital in Careggi, the other is Santa Chiara that is specific for STI, so there are no infectious diseases specialists, only dermatologists, and the other is Santa Maria Annunziata. They all work in different ways. The one in XXX, as far as I know, is the most disorganized, but it is the one that offers more easily the services of the psychologist whereas in other cases, the service is lacking or you just have to hope that you will be seen by an infectious diseases specialist who has the sensitivity to advise you about this or even who might know people within the different organizations and so will suggest they contact them. But these cases are rare”. (Int-3)

Notification to sexual partners

Another question involved notification to sexual partners in case of a positive result. Only three of the eight participating countries answered this question. Regarding the three answers obtained, we found, in the first place, that there are **no procedures regarding notification to sexual partners.**

“There is no legal or standard procedure. But it is talked about with the person getting tested when a positive result is given”. (Int-4)

“No, there is no standardized procedure for sexual partner notification, nor a framework which includes ethical and legal aspects. Nevertheless, in our centre, we have the position and the confidence of the client to recommend contacting all their sexual partners to get tested as soon as possible and we always give these sexual partners the preference in using our services”. (Int-8)

Moreover, for some of the CBVCT coordinators, the reason for this lack of recommendations can be found in the fact that they are not allowed to provide positive results.



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“That is beyond our reach – except for the recommendations – because we don't communicate positive results. The whole segment in case of a vague result basically consists of a warning that the partner should be informed and so on”.
(Int-1)

Clients. I don't know, but if I was positive I would prefer CBVCT

Clients were asked to indicate if they knew the procedure for accompanying someone with a HIV positive result. There are three countries, Slovenia, Spain and the Czech Republic, where participants declared **not knowing the procedure** nor the experience of other people who tested HIV positive in CBVCT venues.

“Can you describe the procedure of accompanying this person to the clinic; are you pleased with this procedure?”

- We don't know. I mean, at least I don't.

Have you heard in the course of this testing what is the procedure afterwards?

- No, also not.

- No.

- No”. (FG-1)

In the case of the Czech Republic, an interesting result came up since clients talked openly about their assumptions regarding getting a positive HIV result in a CBVCT site compared to other places: **getting a positive result in a CBVCT site is perceived as better** because of the “setting”.

“- I don't know anybody like that. I think if I found it here it would be probably better... The environment here is more suitable... But anyway... It would be a... shock!

- I also don't know such a person. But it would be better here... I trust the local personal staff, but I think I would be so shocked... I wouldn't feel it so much.

- I know one HIV positive person, but he found it somewhere else. I would prefer to find it here than anywhere else. Probably from the same reasons as the others”.

(FG-7)

Some clients, like German and French, were able to recall some steps of the HIV positive referral procedure and the role of CBVCT services. For them, it was particularly clear that the staff of the CBVCT service would provide them with **emotional and personalized support** and at the same time help them regarding **linkage with hospitals and treatment follow-up**.



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“- They talk to us about it and tell us that (if necessary) they’ll come to the hospital with us to get the test confirmed. There is a good follow up. They don’t just leave us to our own devices after the test. It’s our choice to accept or refuse the support. But they offer to bring us.

- And they listen to us so we’re not alone”. (FG-4)

“But I guess they’ll name you a specialist. Wait, they also told me, it’s possible to get a “buddy”, someone who cares for me after a positive result. I can remember being impressed of such a service”. (FG-6)

In addition to this individual support, one of the CBVCT clients stated that when it comes to HIV, there is a whole network that gets activated thanks to the **organization of the MSM community around HIV**.

“And I know there is a network or the like that would be mobilized right away. I don’t know if that is the case within the public health care. We know better than they do –we’re organized when it’s about HIV”. (FG-4)

A final comment, which illustrates assumptions surrounding the announcement of a HIV positive result is the following: this example shows us the “indicators” that clients use in order to guess if the result is positive or negative.

“My result was negative; neither did I witness a positive tested person. From my private environment I know, that the door to the counseling talk and to the doctor is closed longer than usual, if the result is positive. I know that there is a good support for positive tested persons, because the doctor is a specialist and therefore is sensitive in such situations. Many people told me so”. (FG-6)

Key points

- ⌘ No legal barriers for HIV positive referral are reported, but other obstacles (e.g. fear in the case of undocumented migrants).
- ⌘ Lack of knowledge and absence of standard procedures regarding HIV positive referral according to clients and coordinators.
- ⌘ Lack of standard procedures regarding notification to sexual partners.
- ⌘ Linkage to formal health system is indispensable.
- ⌘ As for clients, linkage to formal health system must include emotional and personalized support.
- ⌘ Gay community mobilization around HIV is a reassuring element if HIV test result is positive (the community will teach you how to deal with HIV).
- ⌘ CBVCT clients express a preference for receiving a positive result in a more “gentle” environment.



CONCLUSION

The present section of the qualitative study report aimed to present an overview of HIV testing in the eight participating countries.

First of all, we found that theoretically there is a wide availability of HIV testing in all the countries participating in the study. However, this availability does not necessarily mean easy access to HIV screening because (among other reasons), fear of being “outed” as gay, or because in small towns attending a HIV testing facility is much more difficult than in big cities.

In this context, the emergence of community-based voluntary counseling and testing (CBVCT) sites, which contrary to other HIV testing sites are free of charge and do not require ID (even if CBVCT clients declare not being especially bothered by this ID request), appears as an interesting option for getting tested for HIV.

The nature, procedures and funding of these CBVCT programs are quite different depending on the countries where the study was carried out. This fact prevents us from creating different categories of CBVCT but only describes experiences intimately related to existing health policies, to the HIV associative history, to the different kinds of national and/or regional administrations and to different legal settings. Nevertheless, all the CBVCT experiences share the fact of targeting most-at-risk populations.

If we are to design a code of good practices, it seems clear that the following points should be dealt with:

- The availability of HIV testing in the national setting.
- The different ways of designing CBVCT.
- The awareness and use of existing health policies (e.g. IDU harm reduction strategies).
- The need to know current National HIV Strategies.
- The potential effects of national and/or regional regulations regarding HIV testing in general.
- The need to link HIV testing to other policies e.g. the right to health care for undocumented migrants.
- The description, creation and development of an effective involvement of the communities in national HIV health policies.
- The way CBVCT is funded: who, why, what for and which effects.
- The effects of a community-based mobilization around HIV.
- Free of charge and ID requirement.
- The need for protocols: confirmatory test, HIV positive referral, access to treatment, counseling (pre and post as well as special emotional and personalized support for HIV positive people), and notification to sexual partners.



Section 2

CBVCT. What are we talking about? What's the point?

In the first section, several data regarding national HIV settings, including CBVCT, were provided. Nevertheless, there is the issue of meaning that deserves to be independently dealt with; the definition of CBVCT and its advantages in comparison to other HIV testing sites.

As stated in the introduction of this report, even during the development of this project, the definition of CBVCT services and programs changed. In fact, the question of how “community-based” could be characterized is quite difficult; being more appropriate to think of “community-based” as a horizontal line, and to situate the various experiences on different points of this line, ranging from very little involvement to a full involvement of the community.

In the text below, results concerning the meaning of community-based testing will be presented as well as the reasons and the advantages of choosing this setting rather than others.

WHAT IS A COMMUNITY-BASED VOLUNTARY COUNSELING AND TESTING SERVICE?

WHAT DOES CBVCT MEAN TO YOU? COULD YOU BRIEFLY DESCRIBE THE COMMUNITY-BASED APPROACH IN THIS COUNTRY?

There is no doubt that one of the main issues when working on community-based voluntary counseling and testing services is their own definition and characterization. When scientific literature, but also guidelines, are reviewed, it becomes clear that the term “community-based service” is used for a large range of services. It can refer to any kind of service addressed to a particular population, or to a service implemented with the participation and involvement of the community throughout the process.

For this reason, this study was particularly interested in investigating the definition used by the coordinators of the 8 CBVCT participating centers, but also about the definition of the users of these CBVCT services.

In this second section, results concerning the definition of a CBVCT service, the reasons for choosing this service rather than formal health settings and the



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advantages that CBVCT represents in comparison with other HIV testing settings will be presented. The more negative aspects and/or experiences of CBVCT centers will be presented in the third section.

Coordinators. Non-clinical HIV testing

As for the coordinators interviewed, one interesting result is that they had not necessarily thought about a definition. For instance, one coordinator declared having got to know the term through his participation in the project.

“Well, I got to know the term itself while working on this project”. (Int-1)

But, if we analyze the answers of all the CBVCT coordinators regarding the definition of CBVCT, we can structure their responses by using the following categories:

• Community-friendly staff

- “CBVCT is a non-clinical setting, designed, operated and addressed by and to the community”. (Int-8)
- “Counseling is done by the people from the community so is client oriented, friendly” (Int-7)
- “Not medically dressed people”. (Int-1)
- “CBVCT is a testing facility run by an organization or people strongly connected to a specific community: the MSM community, the ethnic community”. (Int-5)
- “We recruit counselors who have a specific background, either medical or counseling background”. (Int-5)
- “It's more about having a deeper understanding of the users within the community, and of the sexual behaviors that are common in our community. Also being able to meet people without prejudice, be open and listen to any risk behavior that users describe and engage with, and talk openly about it without discrimination”. (Int-5)
- “Those involved and trained in rapid testing [...] are community stakeholders, i.e. non-medically trained individuals from the communities”. (Int-4)

• Physical place

- “CBVCT is a non-clinical setting”. (Int-8)
- “Community-based activity is making the tests available in areas that are close to people forming this community”. (Int-1)
- “Outside the institutions”. (Int-1)
- “To go into the community and make our offer, without forcing it to anyone”. (Int-6)
- “For me it is very important “counseling and test” should take place, where those men are. Participants don't have to go to a project's place, the projects meets them in their places”. (Int-6)
- “Testing that low threshold center with easy access”. (Int-7)
- “Within the club where people are gathering”. (Int-1)



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• Targeted groups

- “From and for our people”. (Int-1)
- “Testing connected with counseling especially directed to vulnerable groups that are in special danger of risk of infection”. (Int-2)
- “Our idea is not to work for specific community like MSM only, but we understand there are other people who are asking us for HIV test and they should not be omitted. It should help to integrate community into whole society”. (Int-7)
- “CBVCT is an non-clinical setting, designed, operated and addressed by and to the community, where people can get tested and receive counseling for risk reduction”. (Int-8)
- “It’s an offer to high-vulnerable groups, not for the whole public”. (Int-6)
- “CBVCT is a testing facility [...] strongly connected to a specific community: the MSM community, the ethnic community”. (Int-5)

• Funding

- “And it is necessary to have some donation or sponsors, because even with some state support it is not enough”. (Int-7)

• Opening hours

- “Outside the institutions and their office hours”. (Int-1)

• Confidentiality/Anonymity

- “It should be also anonymous, even not necessary but it should be friendly to specific groups like gay men. If it is not anonymous a specific confidentiality of the client should be guaranteed”. (Int-7)

These results show us that the two most frequently mentioned dimensions are: 1) the staff performing the VCT and 2) the physical place where the VCT is performed.

Regarding the **staff and/or organization** offering the service, we found that for the respondents, the most important element is the necessity of recruiting people who understand the targeted community, but do not necessarily belong to this community. Even if in some cases, “community-based” means done by and for the community members (last citation).

“Community based means to me, that all is done by gay men or by men who have sex with men”. (Int-6)



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“It's not just about being part of the community. It's more about having a deeper understanding of the users within the community, and of the sexual behaviors that are common in our community. Also being able to meet people without prejudice, be open and listen to any risk behavior that users describe and engage with, and talk openly about it without discrimination”. (Int-5)

“Counseling is done by the people from the community so is client oriented, friendly”. (Int-7)

“CBVCT is a non-clinical setting, designed, operated and addressed by and to the community”. (Int-8)

With one exception, most of the coordinators did not insist on the professional background of those performing the tests. In fact we only found one example insisting on non-medical staff:

“Non-medically trained individuals from the communities”. (Int-4)

For the remainder of respondents, different professional backgrounds are perfectly compatible, while others decide to recruit community members with medical backgrounds.

“We recruit counselors who have a specific background, either medical or counseling background”. (Int-5)

As for the **place where CBVCT services should be located**, we found a strong unanimity for establishing outreach venues or implementing these services in **non-clinical settings** (i.e. associations).

“Community-based activity is making the tests available in areas that are close to people forming this community. [...] Outside the institutions”. (Int-1)

“Participants don't have to go to a project's place, the projects meets them in their places”. (Int-6)

“Testing that low threshold center with easy access”. (Int-7)

“CBVCT is a non-clinical setting”. (Int-8)

The Slovenian coordinator explained in detail this idea of CBVCT as a place, belonging to the community and not to the institutions. Specially, medical institutions that receive clients, in his opinion, “shielded” with their white coats.



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“This is how I see that this “community based” idea relates to a new spatial situation: something belonging to an institution emerges in a specific space and those that are bringing it about are a part of this space. The later is very important in order to introduce the novelty as something that has a symbolic notion of it being there for us and not as an external intervention - that is without medically dressed people, shielded as in cases of nuclear disaster, marching in”. (Int-1)

However, this non-clinical setting is not always possible for the organizations offering this service, and some of them must use formal health facilities like hospitals in order to conduct HIV testing.

“They have to fill in the form that goes to the hospital together with the blood sample”. (Int-3)

In second place, we found another major topic, the **targeted population**. Most of the coordinators agree that VCT services must be addressed to those groups who are the most exposed to HIV infection.

“Testing connected with counseling especially directed to vulnerable groups that are in special danger of risk of infection”. (Int-2)

“CBVCT is a non-clinical setting, designed, operated and addressed by and to the community”. (Int-8)

“It’s an offer to high-vulnerable groups, not for the whole public”. (Int-6)

“CBVCT is a testing facility [...] strongly connected to a specific community: the MSM community, the ethnic community”. (Int-5)

However, there is one exception to this “community” point of view, according to this coordinator, the general population should not be neglected from this opportunity.

“Our idea is not to work for specific community like MSM only, but we understand there are other people who are asking us for HIV test and they should not be omitted. It should help to integrate community into whole society”. (Int-7)

Finally, we found four other issues that were mentioned only once. They are: 1) the need to seek funding from sponsors since the governmental support is not enough; 2) the opening hours of CBVCT, which should be different to traditional health institutions and 3) the need to guarantee confidentiality.



The symbolic use of physical spaces

A very interesting element which emerged from the interviews was the symbolic value of performing a blood test in a space belonging to the community, the gay community in this case instead of in formal institutions. The fragment below shows quite clearly how communities who have been historically rejected and stigmatized, prefer to have HIV screening on their own “territory” and not in institutions which have participated in the aforementioned discrimination.

“20 years of history were striving towards liberating certain spaces and for instance making them belong to gays in a subcultural sense for instance, as well as to bring something that people consider as a part of an institution, a part of the state, a part of the exterior, a part of the system, a part of the unfamiliar, to bring this process of blood sampling, right, into the area where symbolic and practical interactions of this community otherwise take place. This is how I see that this “community based” idea relates to a new spatial situation: something belonging to an institution emerges in a specific space and those that are bringing it about are a part of this space”. (Int-1)

This symbolic value could be developed and promoted as a novelty in order to ensure better communication on CBVCT services.

Community versus universal approach

Finally, another interesting issue is that of cultural differences concerning the concept and the value attributed to the “community”. There are cultures that have historically refused the “community” approach, preferring to offer a universal service.

“The French approach to public health is to offer a universal service. Our culture doesn’t like targeted programs that focus on one community or another”. (Int-4)

Clients. Improving HIV prevention with non-stigmatizing staff

The response given by the CBVCT clients about “*what is CBVCT?*” strongly depends on the local context. As stated before, focus groups were conducted in very different settings; some of them quite close to formal health institutions while others prefer to emphasize their “community-based side”. Consequently, the definitions stated by CBVCT users changed according to their experience of these services.



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• **Community-friendly staff**

- “I suppose “testing” is the chance to get tested or make get tested about one’s own condition and serological status as regards sexually transmitted infections and similar”. (FG-3)
- “Place and staff are part of the community”. (FG-6)
- “The type of people who work there”. (FG-8)
- “People having the same view”. (FG-1)
- “Community based counseling is important, because in my cognition many gays are afraid of talking to non-community-people”. (FG-6)
- “I think the main role is detabooization or how to say, because as long as this is in the domain of clinical practice there are always some kind of prejudices connected with it and some kind of...” (FG-1)
- “I mean, this is, what I think, the most important that we understand what is there as traumatic, here it appears as the biggest advantage that you are actually doing this in the company of people having the same views”. (FG-1)
- “Particularly sensitive for than specific minority”. (FG-3)

• **Targeted groups**

- “Targeted to people who have similar characteristics” (FG-3)
- “A screening for the serological status, and the counseling after that, both of them are targeted to a specific homogeneous group, in order to go in detail with the communication and have positive feedback about the test, doing it in an environment”. (FG-3)
- “I think about who the service is targeted to, a community of people with homogeneous characteristics”. (FG-3)
- “As a centre that is especially targeted at the gay community”. (FG-8)

• **Meaning of HIV testing**

- “Like a routine”, “Everyday practice” (FG-1)
- “Totally preventive”. (FG-1)
- “And rising awareness, rising awareness on the one hand, if it is already something public, right, so this would mean that this is also present. So let’s start with prevention, well that kind of view”. (FG-1)
- “Something that must be conceived from inside the community as a service for the community”. (FG-8)

• **Confidentiality/Anonymity**

- “Certainly the first important thing is to have it anonymous. So people don't have a problem with going here in the Light House where is anonymous testing”. (FG-7)
- “Basically, anonymous testing really, maybe from the point of view, because you come to get tested for a purpose, but that there’s a waiting room filled with different people and each has its own purpose and also the treatment is totally different from that at the clinic”. (FG-1)



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- **Physical place**

- “Place and staff are part of the community. It may be a sauna, a parking ground, cruising areas, like public toilets, perhaps in bars too.” (FG-6)
- “For me, a CBVCT is an offer that takes place where I use to be and where I sometimes have sex”. (FG-6)

- **Environment**

- “More free”, “Easier”, “More relaxed”, “More friendly” (FG-1)
- “I mean it’s a lot easier to get tested like this, well voluntarily, than I don’t know, that you go now to your doctor to get a note or I don’t know on the infection clinic, well to get tested, but it’s almost like going on a cup of coffee. You meet with your friends, you go there, you’re done with it and you go on to do your errands”. (FG-1)

- **Voluntary**

- “Somebody who decides to get tested for their own benefit; that it is something totally optional”. (FG-1)

From what clients said, we could **define CBVCT services** as fixed or mobile places targeting specific groups (a community) who voluntarily decide to get tested for HIV and where the test and counseling is performed by a member of the community or by people close to the community.

The “**community**” is understood as a homogeneous group and both CBVCT coordinators and clients frequently assume that talking about community is talking about the “MSM community”.

Nevertheless, some participants insisted on the idea that there is not only the MSM community, but other populations which could be concerned by HIV prevention.

“I wouldn’t relate it so much to the MSM group and all that, but it would be a center that works with a specific community of one kind or another... [...] that works with a group from inside the group and in this case around HIV prevention”. (FG-3)

Just like CBVCT coordinators, CBVCT clients assert that the main defining characteristic of CBVCT centers is the presence of **staff that is close to the community**. For clients, the key issue is not being faced with prejudice, stigma and/or guilt because of sexuality and/or sexual behavior when getting tested for HIV.



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“I think the main role is detabooization or how to say, because as long as this is in the domain of clinical practice there are always some kind of prejudices connected with it and some kind of... stigmas”. (FG-1)

The necessity of this friendly staff is closely related to the populations targeted by this kind of service. For most of the participants it is clear that CBVCT centers are targeted to specific **populations that are more vulnerable than general population.**

“Yes, it could be. Because if you want to see the serological status or similar, or, better, if there are specific services for a community it is because you think that in that community there are more health problems compared to another, so, if you have such services in the Nigerian community living in Verona, where you can maybe also find prostitution problems and so on, if you have services oriented to the counseling to face this problems...” (FG-3)

A fairly interesting result is something that was not touched upon by CBVCT coordinators and that seems to be essential for understanding the reasons for implementing this kind of service: raising awareness about HIV prevention in the targeted community. In fact, for some clients **the “preventive” role is more important than the “detection” role.** Thus, participants in this study bring to mind a broader view of the role of CBVCT. It could also be said that clients have gone further than some coordinators when talking about the necessity of designing this kind of service involving the community from beginning to end.

“Totally preventive”. (FG-1)

“And rising awareness, rising awareness on the one hand, if it is already something public, right, so this would mean that this is also present. So let’s start with prevention, well that kind of view”. (FG-1)

“Something that must be conceived from inside the community as a service for the community”. (FG-8)

The environment, the staff and the simplified procedures allow the targeted population to feel **more comfortable and more confident** when getting tested for HIV via CBVCT.

“I mean it’s a lot easier to get tested like this, well voluntarily, than I don’t know, that you go now to your doctor to get a note or I don’t know on the infection clinic, well to get tested, but it’s almost like going on a cup of coffee. You meet with your friends, you go there, you’re done with it and you go on to do your errands”. (FG-1)

The fact that VCT includes the concept of **“voluntary”** was sometimes misunderstood or presented as a potential problem. More in detail, some clients



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were **no clear** about if “voluntary” makes reference to the people getting the test or to the people performing the test.

“And I don’t know what’s this voluntary means; does this also include those who conduct the test or just those who get tested? Like, is this whole project based on voluntariness or...” (FG-1)

Furthermore, one client declared that presenting HIV testing as voluntary can produce the effect of minimizing the importance of getting tested.

“Voluntary testing? So... Mainly this connection evoke something like... not so much important, what isn't needed. It's like... some extra testing. Maybe I would choose different words for it. To better impression... as it is important”. (FG-7)

One final issue that must be reported is the **potential difficulty of implementing CBVCT**. This question was put to some CBVCT clients, and even if there were not a lot of answers, some interesting views came up. The first result is **acceptance of homosexuality in society** and the impact of this acceptance on CBVCT projects. An odd comment appears in this quote regarding assumptions about CBVCT funding sources. In this case, the participant believes that funding would come from a bank loan, and that for a bank would be difficult to fund a project related to sexuality.

“I think it’s difficult to start a CBVCT project, because acceptance of bi- and homosexuality is not given all over the country and society. It seems impossible to get a loan from a bank for purposes like that”. (FG-6)

In the Spanish focus group we also found an observation regarding the difficulty of implementing a service targeting only a specific public instead of a more general service; **even if socially the need exists**.

“It starts off from an association or a specific body that seeks out funding and sets it up as it can.

And do you think it is easy...difficult to set up a centre?

- I don’t think it’s easy. Because the more specific your public is the more difficult it is to seek financing.

- Yes. What’s more, if we are talking about a community centre that deals with HIV, I don’t know whether this is of general interest... [...]

You mean it’s more related to a social and political context. Is that what you mean?

- Yes. I think you have to identify whether there is social demand and whether this demand is considerable.

- If you find out that it’s not considerable it will evidently be a lot harder for you even though there is demand”. (FG-8)



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Key points

- ⌘ For some of the respondents (clients and coordinators), this was the first time that they heard the term “community-based” testing.
- ⌘ Clients and coordinators do not necessarily share the same definition of CBVCT. While clients insist on a non-judgmental environment that facilitates prevention, coordinators put forward the issue of a non clinical setting.
- ⌘ Nevertheless, for both of them, non stigmatizing staff and a non-medical setting are major dimensions for defining CBVCT.
- ⌘ Community is largely understood as MSM community.
- ⌘ The implementation of CBVCT services and programs is intimately related to the societal situation regarding homosexuality and HIV.



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A second practical advantage was the *geographical proximity* of these centers to the most-at-risk populations targeted by community-based testing.

“Suddenly the testing takes place where there are 400, 500 MSM-s present at the same time, which is as close to the community as possible, in as far as it physically exists in Slovenia”. (Int-1)

“And I think also that we have an open facility that people can actually come in from the street, I think that's very important as well. And then we're centrally located, so it's very close to the gay community in terms of the bars, and the clubs”. (Int-5)

Finally, the *opening hours of CBVCT* centers were also mentioned by the coordinators as an advantage, since most formal health facilities are only accessible during work hours, preventing some clients from getting tested.

“The big advantages of our project are the offering times”. (Int-6)

“I think about one I haven't mentioned yet it. That is our office hours. We are open on Monday since 4 p.m. till 7 p.m. It is not easy to go away from work for HIV test”. (Int-7)

Beyond these practical advantages, there is a main result that concerns the capacity of CBVCT to **offer an adapted response** to the people who are most-at-risk of HIV infection. In fact, this adapted response (e.g. offering counseling) becomes even more important than the test itself.

“Maybe the biggest different of all, we respond as much as possible to participants needs”. (Int-6)

“Our offer is much more personal than the public health service. We are mostly in contact with the participants in front. At the public health office you are on your own and have to wait silently all by yourself. We use waiting time to talk to participants, if they want to. Counseling and talking are more important to us, than to test”. (Int-6)

This adapted response can take different forms; in the first place, we find that CBVCT has the advantage of *offering a non-judgmental setting*, a protected setting where sexual orientation and/or sexual practices do not need to be hidden to protect the client from a stigmatizing situation.

“The advantage is that VCTs offer anonymous and free-of-charge services. Counselors employed there never judge and offer the comfort of an individual talk. A client who had a sexual encounter outside the relationship and betrayed is not judged”. (Int-2)



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“But I must say that they (MSM) look for a more protected environment, about their sexual orientation. So, in short, the good news is that the service works from this point of view, in terms of privacy... The environment is protected from this point of view”. (Int-3)

“What is very positive is that it's a peer-to-peer counseling. The counselors are familiar with the users' sexual behavior. They can relate to the needs of the users, and the other thing is the product that we use, the fact that it's a rapid test, is also of great importance to the groups that we work with.” (Int-5)

“For some people is better to say "Yes I had sex in some cruising area and it was risky" because he knows that we will understand them. He knows we understand it. We are not shocked we do not moralize. We can hear about forty partners per three months. It is O.K. We are here for test and not for moral evaluation; even sometimes it may not be our behavior. The experiences from other centers are very different. Sometimes they do not expect even the MSM client at all”. (Int-7)

“As I said before, the positive things are the ability to overcome barriers that the clients find with health professionals whenever they need an HIV test (we can get to a lot of MSM, we offer a close and safe environment so that they can talk openly about their sexuality and doubts, an environment free of prejudice, and where they can get tested as many times they want)”. (Int-8)

In the second place, we found a setting where certain *fears and requests have the opportunity of being expressed*, while formal settings do not usually offer this option.

“In short, the test is a very delicate thing for the person who gets it, whatever the result, because it brings into play a thousand fears, brings into play things which are not easy to talk about and maybe there would be a need of prevention counseling, in order to explain many things. At the hospital you don't find such kind of things, and maybe the person who goes there does not feel in a suitable context for making certain requests. So this is mostly the positive side here, that you welcome the person!” (Int-3)

Then, we also find the opportunity of *providing practical information*. Information that means that clients do not suffer from unnecessary stress and get correct information about HIV transmission.

“But then you see them arriving in a state of difficulty and already after the first interview they are more relaxed. Very often they are more relaxed because we give practical information that they don't have, or have looked for in the Internet, founding conflicting answers, and then we try to... So even simple questions such as... The kid who comes and tells you “I had sperm up my stomach and I get to take the test” and we tell him “well, if you want to take the test, but that's not how...” and we explain in detail the modalities of transmission. Then you



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know that there are areas of doubt... but we try to be as detailed as possible”.
(Int-3)

In fourth place, in comparison with some traditional HIV settings, CBVCT has the advantage of *offering client centered prevention*, as counselors are usually closer to clients. However, in some CBVCT sites and as this coordinator stated, there is also the objective of “redirecting” clients’ sexual behavior.

“We focus on a client-centered HIV prevention counseling, we take care of emotions and we try to redirect the client’s sexual behavior for a safer one”.
(Int-2)

To our knowledge, this is not necessarily the preferred approach of the rest of CBVCT centers participating in the HIV-COBATEST project. For most of them it is more important to defend a less “directive” approach and to insist on risk reduction strategies. The main objective is not to persuade people that they need to reach some sexual preventive standards but rather to adapt their sexual behavior to reduce the risk of HIV transmission or acquisition.

Finally, regarding the adapted response offered by CBVCT centers, we found a comment regarding the *provision of a positive result*. For one of the coordinators, these centers would be more adequate if the client has to receive a positive result.

“The biggest differences are observed in the offer of counseling and the ability to give out a positive result”. (Int-2)

Other issues arose when coordinators described the advantages of CBVCT centers in comparison with other HIV testing settings. Thus, we found that these centers were, as stated before, much more gentle physically speaking than hospitals or GUM clinics. This **non-medical environment** would facilitate access to HIV testing.

“Strictly medically speaking the only difference is seen in the fact that instead of the blood sampling taking place within the institution or being done by its representative, a professional - again: not a member of the institution – carries out the testing on the spot, that is in a typical space for this community. That’s the only difference. Basically, we came as a social extension of the institution, so to speak. However, from social point of view this is a huge difference, so from medical point of view is, granted, the handing out of the results is specific as well – not within the framework of the institution but within the association”. (Int-1)

“First of all, the fact that the test takes place in a non-medical environment, (no white coats, a friendly atmosphere) for many people, contributes to reducing the stress associated with getting tested. Secondly the fact that the tests are carried out by peers means that nobody is being judged on their sexual practices and



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there is a greater understanding because everyone present shares similar life experiences. And finally, the fact that CBVCT is offered to people who wouldn't normally come forward for testing in traditional settings". (Int-4)

The issue of **efficiently detecting HIV cases** that otherwise would not be detected was cited by the Spanish coordinator.

"Efficacy in detection of HIV cases. This means that with a small number of tests, we are able to detect a high number of new cases. We are also able to link almost all the HIV cases, over 95% of them (they are all confirmed by Western Blotting Technique) to a specialized HIV unit within the National Health Service for care within one week". (Int-8)

There is a final element that was brought up by the French coordinator which seems to us essential when the future implementation of CBVCT is discussed. As he states, one of the advantages of implementing this kind of service is **mobilizing and involving the communities concerned**.

"Warm welcome shown by the community members and their desire to take part in initiatives happening in their own communities and neighborhoods". (Int-4)

Clients. A place for "us"

Clients frequently defined CBVCT services by comparing them with other HIV screening settings. But, since we wanted to have a more detailed knowledge of these differences, a specific question regarding the latter was put to coordinators and clients. Since previous results - reasons for choosing CBVCT instead of other HIV testing settings - are truly related to the present results, and in order to follow a more logical presentation, we will start by presenting clients' results and then the coordinators' results.

A gay space vs. a heterosexual world

As indicated in the material analysis, most of the study participants were gay men. This is mainly due to the fact that CBVCT programs participating in the HIV-COBATEST project are mostly targeted to the MSM community. This clearly represents a limit for this study. Nevertheless it also helps to have a better knowledge of the experience of this community regarding CBVCT.

Regarding MSM, we can recognize in the focus groups some elements indicating how significant **having a space that belongs only to them** is to this population. The following comments, which came up during the Danish focus group, show to what extent there is a need for building and sharing spaces



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where MSM can get away from a heterosexual world that usually is synonymous with prejudice for them.

“I think it’s fine that we have our own clinic. As soon as we leave here and walk into the street, it’s ‘hetero’ all over the place. It’s definitely a privilege that we’ve managed to build up a gay community without shutting out people in general. We should protect the gay community after all. It’s different, when you walk out the door downstairs. I find that important”. (FG-5)

“The public in general are still prejudice when it comes to homosexuals. While this is still a fact, we need a place like CheckPoint, no doubt. I wish that people wouldn’t stare: “Oh, that guy – he’s a homo; he’s on his way to that clinic, for sure”. (FG-5)

As the following quote shows, MSM participating in the study, are aware of being **more concerned by HIV than other people**. Even if they do not contest that other groups also need testing, they say that the majority of medical staff is heterosexual and therefore this population does not need special places. For some participants, this “tension” becomes stronger and they insist that given that heterosexuals can attend their own doctors they should not “invade” the scarce “MSM places”.

“So you think it’s fine, that the gay community take on that role?”

- Yes, we have the resources for doing this. The kind of understanding which I believe is present; we must protect that.

- STD’s are relatively wide spread among men who have sex with men. So, a clinic where you can turn up and say: “We know we’re at risk, so we go to the clinic.” It’s a good thing.

Yes, we are - in percentages - much more at risk.

- Yes, and we know that the risk is much higher in our community. (Laughter)

- It’s important too that heterosexuals get tested – and they can go somewhere else, then.

- At their own doctor’s. (Laughter)

- The ‘heteros’ drove us out of ‘Sebastian’ (former gay bar). I hope they don’t take over CheckPoint as well (Laughter)”. (FG-5)

However, this protected space which was set up in order to avoid facing prejudice becomes for some clients a **prejudicial space for others**, like for example, women. In any case, this quote shows that when they are questioned on the actual possibility of having women performing HIV tests, this rejection does not last long, and what appears as really important is having a true knowledge of HIV, STI symptoms and gay sexuality.

“What are the biggest differences between being tested at CheckPoint compared to other test clinics. We’ve talked about waiting time and we’ve talked about counseling. More inputs? What else is important?”

No women around. (Laughter)



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“- Eh... It's more intimate here in the Light House. And the personal staff is high level. And also... it's more quiet here.
- It's better here. More quiet... nice environment...” (FG-7)

“I also think, although it may not be the most important thing that the surroundings, the environment, the image also help. I remember the first time I went to XXX (the STI Public Health Clinic) that you go in with your doubts and your fears... you enter an extremely ugly place and there you find junkies, the posters with horrible images about diseases, then you enter the elevator. It's a bit like... the doors of hell (laughs)... and you're next in line, you know... and here in BCN Checkpoint you find guys who are close, kind and are also good-looking (laughs)... it's true... that also helps”. (FG-8)

Time to get tested, time for getting the results vs. “traumatic waiting”

The matter of time, as detailed when reasons for attending a CBVCT were presented, is a main issue. In many of the participating countries CBVCT services are only allowed to perform rapid HIV tests (finger prick), and this potential “limitation” regarding the kind of test that CBVCT can perform becomes actually one of the main sources of client satisfaction. Actually, they declare that **waiting for the HIV results is a very difficult and distressful moment**, and that with rapid tests this waiting time has been shortened and this in turn facilitates all the testing process. In the quote below it can be observed how waiting for the result can in some cases be traumatizing.

“When I got tested, I saw that these results were there on the nurse's desk and then when they told me to call in I don't know how many days. I remember exactly, it was May 25th, I called and this alone was like, I mean, there's always some uncertainty, because at that time I got tested not just like that but with a reason, this suspicion right, and then the nurse answered the phone and I was sure she'd tell me, this my condition right away, but she asked me to wait and that she'd have to call the doctor right, and of course this is the usual procedure for everything, but considering that I saw the results on her desk, when I was there, I assumed it was something exceptional, that it must be a bad thing if the doctor has to announce it and then I waited literally 20 minutes on the phone for the doctor to come and in those twenty minutes, it was like when they say that your whole life flashes before you again and I was sure that this now was the end. And then everything was okay and the doctor said what he had to say but for instance, for me, I was doing this for the first time and didn't know at all how things go, it was really, really, well agonizing”. (FG-1)

Furthermore, **the waiting time between the finger prick and the results seems to be much less stressful when you are in the company** of people who know the potential consequences of getting a positive result.



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“In other centers the results come back days later, as far as I know... from my experience it has been weeks later... and you go in and pick up an envelope and that’s it. That may be fine or it may not be fine. It doesn’t matter, if you want it that way. I don’t think it’s wrong. But here it’s different. First of all it’s instantaneous. You get the result back almost immediately and secondly ...the feedback, especially in the case of a bad result...that nobody expects to happen but it may happen...the way you are going to receive this news is different...it is clearly more supportive. And then also... the people are gay and they know what we are dealing with all along”. (FG-8)

The whole CBVCT procedure seems to be easier and quicker than in traditional health care centers. This **simplicity** is a very important point for those users who get tested regularly and who are quite confident of getting a negative result: they do not need to ask for a receipt/order to get tested, to make an appointment, the test is performed rapidly and the waiting time for results is short. CBVCT appears as an effective means for not introducing a delay from the moment the person decides to get tested and the moment they actually get tested. Besides, counselors are available to discuss sexuality and prevention strategies with them.

“Well, it’s a quick procedure, because I remember there at the clinic, I went to the doctor, and the referral, and then there to get an appointment and go and get tested, and the results and so on, I find it a lot more complicated, there are a lot of steps that you have to make and here, well, there are basically two steps and that’s it. You just go, get it done and you get the results in two days, that’s how fast a procedure it is”. (FG-1)

“For my part it was also the fact that I could just walk in; you don’t have to go to your family doctor by appointment, and then wait. And all that waiting! I’ve been tested once before at XXX Hospital – I got the result after 2 weeks or 10 days, it was almost... What is the test result? You get nervous and think of life and death. At CheckPoint you know you wait for – say 10-20 minutes, and you get the result right away, and then you move on from there”. (FG-5)

Closer and non-judgmental staff vs. limited listening and stigmatizing staff

The CBVCT staff is described by the clients as more attentive to their questions and feelings. In fact, they take **time to listen to** the client and to give detailed answers, a time that staff in traditional HIV testing centers usually do not have.

“The differences I’ve experienced after being tested twice, once at XXX Hospital, once at CheckPoint; some counseling before testing and then: “This is how it goes...” Nothing like that at XXX Hospital. “Okay, pants down and we’ll check you out” – Okay, fine. I would like to know how. No, there was just nobody...” (FG-5)



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Moreover, clients feel more confident in CBVCT because of **staff belonging to or being close to the community**. People getting tested for HIV and participating in this study are particularly worried about potential negative judgments on their sexuality and on their sexual behavior (e.g. risk behavior); not fearing these kinds of comments on their sexual life because people conducting the test have a fine knowledge of their sexuality, reassures them in comparison with public health services, where they have frequently experience stigma.

“In my opinion the biggest difference is based in well-being. I feel better talking to someone, who knows about my life and sexuality circumstances”. (FG-6)

“That’s easy: I can go there completely open, just being gay, don’t have to worry about it. In public health service I feel regarded suspicious and strange”. (FG-6)

“On the other hand, here it’s just – it’s safe here – I feel secure coming here, maybe not so much prejudice here as in hospitals. And more openness...” (FG-5)

In fact, respondents enumerated several steps in the HIV testing procedure where a stigma might arise. Thus, the simple fact of being in the *waiting room* and not being neglected or frowned upon by staff, but being talked to:

“People talk! You know. Your friends, your family, they talk! The staffs at the hospital look at you out of the corner of their eyes because.... They know! However, they are not supposed to tell. People get nervous about getting tested – suppose you met someone known to you. “What are you doing here?” (FG-5)

Regarding the pre-test and the performance of the HIV test, clients indicate that CBVCT staff is able to pay more attention to the client and be *more understanding* because of a better knowledge of the people attending.

“Well. I find it easier. I think it’s something that is important and specific enough to require paying more attention to the person you have in front of you, I mean, the person needs a closer attention... It’s more exhausting to go to those public health centers... and I think in this centre you know what you’re going to find...the same people, the same philosophy and even the same point of view on many things”. (FG-8)

“I prefer people who possess a certain ‘understanding’. [...] You can be outspoken. We have all been through the same; that is of great importance. They ask the right questions and you quickly get to the point”. (FG-5)

Besides, the *potential reception of “bad news”* is better anticipated if the person giving the result is really concerned about the result and the effects on the person receiving it.



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“Yes, the simplicity is the main motivation, there’s really a lot of red tape there, just to receive potentially bad news. And I don’t know, humans are like that that we don’t really feel like doing this a lot and here, yes”. (FG-1)

We can conclude that counting on staff that is close to the community has two major advantages: 1) people are not afraid of being stigmatized and 2) people experience the CBVCT environment as an open space, where they are free to talk. These two circumstances create a favorable climate for establishing a good relationship between the person who is performing the test and the person getting tested. This relationship facilitates the provision of appropriate counseling. In the quote below we find a good example of how health staff can sometimes give stigmatizing messages, even if it is not their intention.

“- I have been many times to XXX (the STI Public Health Clinic) and there are existing prejudices... I remember once that a doctor...a nurse asked me: “Have you had risky sex?” and I said, “No, I don’t think so”. To which she answered: “Then why are you getting tested? If you're getting tested it's because you're not completely sure”. Which got me thinking that they may be doing a lot of campaigns so that you get tested for HIV and when you get tested they make you think that you’ve done something wrong, they judge you... so that's precisely the wrong message, isn’t it? It’s the opposite message I think. Obviously it’s not something you can generalize about and apply to all the other centers but there are still messages of this kind coming out to a collective that in some cases is stigmatized; and these people keep stigmatizing sexual practices and this obviously isn’t right.

- I have also felt the same. More than anything else, what has made me feel comfortable here... the reason why I come back is the way you receive the messages here. In the family doctor or in XXX (the STI Public Health Clinic) they told me that I was looking for getting infected with HIV or other sexually transmitted infections, that it was surprising that more things haven’t happened to me, based in my sexual behaviors... That's not what I want at all when I get tested and counseled for HIV. I don't want anyone who's going to judge me... Here in Checkpoint I was never judged by anyone, ever. And I like that a lot. So, the message you give here is very clear: “If you’ve done this, the risk is...” “If you’ve done that...” or “you can avoid this...” etc. What I like is the clarity here and the open environment you offer.

- You don't get these moralistic messages here... That’s the defect of that particular clinic. For years I had been getting the HIV test through my private insurance health company and they didn’t judge me either, basically because they didn’t talk much to me, but in this specific public clinic they do, they judge. I think they’re still some years behind as far as this is concerned”. (FG-8)

Finally, it appeared one “typical situation” of the formal health system (that can easily become a barrier for speaking freely about sexuality) which does not occur in CBVCT sites: having in front of you **several different people when**



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attending consultations (doctors in training, nurses, other health staff present during the interview with the patient, etc).

“You come in a certain environment where the people there actually have some same opinion, the same opinion, but are actually the same or similar orientation, so that maybe everything is more relaxed on the one side, than on the other side. Because there, there are, I don’t know, six eyes on you at once, right, and you have a feeling that with all those questions, you actually have to watch what you’re saying, right, I mean, it depends on the person, how he’s got things figured out about himself, I’m quite open about these things, I can talk about it but sometimes it’s really uncomfortable. Yes, it’s really uncomfortable”. (FG-1)

Counseling vs. Moralizing

All the participants conveyed a **favorable opinion about receiving counseling** and highlighted its importance. First, because counseling allows people to speak freely about their practices (e.g. sex, drug use) without being judged. Secondly, because it is a means of obtaining information about risk behavior, HIV infection and about what living with HIV/AIDS means.

“What did you think of the counseling? Was it useful?”

It was personalized which is important I think, not getting general information you can get anywhere, but getting information which corresponds to you personally. So I was satisfied with that. It wasn’t generalized”. (FG-4)

“Did you receive counseling when you were screened?”

- Oh yes, I got counseled and it was very good. I was able to ask any question, and because it was a gay volunteer in front of me, I didn’t hesitate to describe my risk-behavior. Of course he got a picture of me and of my way of living, but that’s ok; better he, who knows about the community, than a public servant.

- Counseling was very helpful for me. It cost me quite an effort to do the test, but the counseling ensued a test as necessary and not painful for me. It fitted very good to me and my needs. It’s just usual that two persons rate each other in an interview, but it didn’t give me a bad impression or made me feel bad.

- We talked a lot about it, what occurs absolutely new to me. I discovered new ways of risk management during the talk. It was very good. He responded to my thoughts and questions”. (FG-6)

“Do you think this counseling is useful in some way?”

Yes I think so. It’s extremely useful, I believe. People need to be informed; otherwise one can always get infected if one doesn’t know how to protect oneself, no?

And has this counseling been adapted to your needs in any way?”

Yes, here we can talk openly about our doubts and we are never judged by anyone. I mean, no matter how my sexual practices are, the guys here are always



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open to listen and to inform you. It's the complete opposite from the family doctor, where they judge you even by taking the test". (FG-8)

It's interesting to note that, as recommended when providing counseling, at the end of the sessions counselors asked clients if there were other topics they wished to speak about; clients declared taking advantage of this possibility to discuss more **intimate issues** as they did not usually have the opportunity of doing it before. As we can conclude from this quote, this kind of discussion is particularly difficult in formal health settings.

"I was told "you must do this" or "you shouldn't do that"; and having lived that experience, I imagined that getting tested here at BCN Checkpoint, the experience would be different. So I tried it and liked it very much!" (FG-8)

Another positive aspect of counseling provided in CBVCT programs, as declared by the clients, is that of relieving users from the **stress and/or fear of getting a HIV-positive result**.

"So, how do you estimate the counseling in itself?"

I think it was perfect. At least the first time I was here; I felt a little... I didn't know what I was letting myself in for. But the counselor made me calm down. You worry, you're scared the first time. I was told, that you can get medication and then live an almost normal life. That was a great help, I think.

So, you are talking about the counseling about getting infected with HIV, and living with HIV?

Yes, and everything else I got to know. Information about HIV in general, that was perfect. I didn't know very much, when I came here – only those 'phrases'.

So, the general information about HIV, living with HIV. You value that?

Yes, I was really satisfied.

Anything else concerning the counseling?

The counseling was good because I was nervous. They talk about all the tests you get and - "if the result is positive, we might spend a little more time to calm you down and do what's necessary" - that had an effect; I calmed down before the test was performed - Fine, just fine". (FG-5)

Post-test counseling in the formal health setting, as described by clients, is much **quicker** than pre-test counseling and is sometimes even non-existent. In fact, many focus groups participants did not remember receiving post-test counseling at all in formal health settings, and if they did they had no recall of the issues discussed. This might be due to the fact, (as scientific literature has already demonstrated), that people do not consider the conversation after the test as "counseling" or because the announcement of the result prevents them from paying attention.



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“What about later, when you come for the results, is there also any counseling, does the doctor also offer any counseling?”

- Yes of course, the doctor does.

- Well, I was always very quickly in and out, I went in, took the envelope, opened it, saw that everything was o.k. said thank you and goodbye. I don't know now, I never had any questions, I don't know, and I don't really remember if she offered if I wanted to know anything that I would ask her, I don't remember that, I was very quickly in and out”. (FG-1)

If we look at the issue of counseling within different national contexts, we find that **pre and post-test** counseling **are not compulsory** in all the participating countries, nevertheless in most of the participating CBVCT sites, counseling is provided. However, counseling comprises a wide variety of actions, ranging from a short talk to conducting a questionnaire. Besides, counseling can be performed by different people depending on if we are talking about pre or post counseling, and on the results.

We found an interesting example of a participant who stated being “out” of the gay community and who explains how attending a CBVCT site might be a way of *getting informed* on the real risks of HIV acquisition/transmission. Thus, the ignorance that feeds prejudices against HIV positive people could be reduced.

“And last time it went real well, because you also asked about unsafe sex and so on. It was good, that you questioned closely – it was about time, I think. It's my impression; there has been a little too much ‘fear of contact’.

Fear of contact?

Well yes, concerning being HIV-positive - I don't move in the gay community, I like an anonymous life as such, but my impression is – from what I've heard – that there has been are some prejudice against HIV-positive persons, maybe it's still a fact; much ignorance too.

And you believe counseling can do something about that?

Definitely. Damn it! You should know the risks of unsafe sex”. (FG-5)

Anonymity and confidentiality vs. “traceability”

The issue of **anonymity and confidentiality** is one of the most mentioned among all the questions regarding CBVCT. Indeed, we found that the CBVCT sites participating in the HIV-COBATEST project offer anonymous testing (i.e. no ID is asked for). As stated above, this is an important point for some CBVCT clients, for whom it is a criterion for attending the testing site. For them, this anonymity is a way of **avoiding the stigma** related to disclose sexual orientation and/or sexual behavior.

“The biggest difference is the anonymity. It feels more anonym to get tested in a community location, than in a public office”. (FG-6)



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In the Slovenian focus group, participants clearly described the differences in anonymity between CBVCT and formal health care settings. For them, the main risk when getting tested in traditional health care settings is that **the person is easily traceable**, as all the personal information, including the result, appears in the medical insurance file. In CBVCT sites the person has the opportunity of getting tested without giving any ID.

- “- [...] If you come to the doctor’s, there you’re a person with a name and a surname, address, they know, for example, who you are, and in case you were, I don’t know, positive, they know exactly who you are.
- It’s even written on your medical insurance.
- Yes, maybe you wouldn’t like it so much that, let’s say, someone, that this would say in your chart, right, now I don’t know, so that, I think.
- It’s definitely written in your chart, right, and maybe that fear too that, oops, the information from the medical insurance company leaked out, who got tested for whatever, because all the things today are in fact in computers.
- As soon as something is officially noted in the chart, you can immediately be stigmatized, at once, practically anyone who looks at your chart knows this, right. With this anonymous testing, you none the less keep a sort of, I don’t know, partial anonymity.
- It’s not a disgrace, right.
- No, it’s not a disgrace just that maybe you wouldn’t be okay with it.
- But public opinion is another thing, right”. (FG-1)

It is not possible to know from the focus group if these declarations are opinions or if they are founded on fact. In any case, this example illustrates the fear of being “outed” in a context where HIV and homosexuality are still controversial subjects. Faced with this fear, CBVCT offers the possibility of preserving anonymity and consequently of protecting clients against potential HIV and gay stigma.

“I choose this offer because it felt more anonymous to me. Public health service is very public, too many people, therefore a sauna is more anonymous. There wouldn’t go everybody. I knew some of the guests and can expect to meet them there. In agency I don’t know who I’m going to meet there by accident”. (FG-6)

“For those in “rainbow” among others. Young people told me: going to hospital, if you happen to meet someone who’s not there for a test and they see you going for one, automatically you’re a queer and you’re going to get beaten up for it. In Lens, not so long ago, a young gay couple in their twenties were walking in the street and they were shot at in the head because they were walking hand in hand and they were gay. It’s around 5 or 7 years ago”. (FG-4)

Nevertheless, we have to temper this opposition between traditional HIV testing centers and CBVCT regarding anonymity since in some countries the former also offer anonymous testing. A complementary approach seems to be more



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interesting, letting clients choose their testing site on the basis of other criteria. Besides, and as described in section 3, there are CBVCT services that even if they guarantee anonymity, they are not in capacity of guaranteeing confidentiality (e.g. small cities or small MSM community).

“There’s nothing anonymous here, because this isn’t an anonymous testing, because that would definitively mean, that you weren’t notices, that no one has seen you then, right. Now, I don’t know if this word “anonymous testing” is on the right place in this context”. (FG-1)

“Do you think confidentiality is maintained and your private life is respected in community-based testing?”

- Some of my friends came to be tested and I never heard them say “oh look, it’s him...” I even came with a friend to get tested and they didn’t say anything even though the person who did the test was a friend of mine and he told me he’d be the one doing the counseling. And if he doesn’t want to, he doesn’t want to but I won’t say anything about his result and what he told me, it’s private and confidential.

- I was satisfied too. You can say what you want without feeling under pressure; it’s not an interrogation where you’re going to tell your life story. If you want to talk about it, you’ll be listened to but then...

And compared to other kinds of testing? Are you satisfied that your private life is respected?

- I prefer the laboratory to the free and anonymous testing centers. I prefer to pay, the people are friendly and pleasant, but at least there’s no judgment. I should go back as I’m with a new partner now but he wants to go to the centre. When you go there you know how they’re going to react, but I can go to the laboratory any time. They’ll be friendly, they won’t judge me, I prefer it like that. And even if I didn’t have private health insurance I’d go to a laboratory. Or to AIDES. But for other kinds of tests, seeing as AIDES only does Aids tests... they should also do hepatitis tests”. (FG-4)

One last issue that came up was the question of CBVCT fulfilling **clients’ expectations**. The examples of people answering this question show that these expectations were not only fulfilled but exceeded.

“And your expectations when you came to the centre... Did you receive what you had expected?”

- Yes, absolutely. In fact it was much better than what I expected. I imagined it a little different and the truth is I liked it a lot. The staff was very good, and the way you are treated is even better... and I had come in part to get away a bit from the family doctor. I found that the people here were really professional and nice and in the end I decided to keep getting tested here.

- Yes. Yes. The same goes for me. In fact, rather than fulfilled, my expectations were exceeded. My expectations were more standard and I think that they were fulfilled and more”. (FG-8)



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Finally, we found an example of one focus group participant who **summarizes** all the reasons stated by CBVCT clients for coming to a CBVCT site.

“First of all, because you are located next to home. (Laughs). Secondly, because it’s a very pleasant place to visit. It isn’t.... perhaps my previous experience with having been tested before... I used to get tested at the family doctor or through private insurance medical facility, and sometimes I took advantage of some regular blood tests I had to do and then I would ask the doctor to test me for HIV as well. However, the regularity with which this centre allows me to get tested, every three months or whenever I need to get tested is extremely important and helpful; and put my mind at ease is invaluable... and then it’s also for free. And getting tested at the STI Clinic (STI Public Health Clinic) is not exactly a friendly experience...it’s not that they’re better or worse but it’s a different thing altogether... So, at BCN Checkpoint it’s not only convenient but also you get tested with people more aligned with you, equals”. (FG-8)

Key points

- ⌘ There are advantages of CBVCT in comparison with other HIV testing settings.
- ⌘ For clients:
 - CBVCT venues are friendly and privileged places for the community.
 - CBVCT services are synonym of getting results quickly and being accompanied by another person.
 - Staff who feel to the clients run CBVCT services: they listen, they counsel and do not judge (sexual orientation, sexuality).
 - CBVCT venues guarantee not being “traceable”.
- ⌘ For coordinators:
 - Practical reasons for choosing CBVCT: rapidity, opening hours, geographical proximity.
 - Adapted approach: being unprejudiced regarding sexual orientation and sexuality and providing prevention information.
- ⌘ Besides, it is a non-medical environment, an efficient way of detecting new HIV cases and a means of mobilizing communities.
- ⌘ Clients declared that their expectations concerning CBVCT services are not only fulfilled by exceeded.



CONCLUSION

The present section of the qualitative study report aims to present the main results regarding the characterizing dimensions of CBVCT as well as the reasons for choosing CBVCT rather than other HIV settings and the main advantages of such services. It must be stated that most of the experiences described in this report come from the MSM community, and that implementation of CBVCT targeting this community must take into consideration the societal situation regarding acceptance of homosexuality but also of HIV.

First of all, we found that the very expression “community-based” is not manifest for all participants. Besides, even if coordinators and clients agree that non-stigmatizing staff is the major feature of CBVCT, they do not highlight the same CBVCT features. Thus, while clients insist on a non-judgmental environment that facilitates prevention, coordinators emphasize the fact that CBVCT sites are non-clinical venues targeting specific populations.

In the second place, clients stated that their reasons for getting tested for HIV in CBVCT instead of other HIV testing settings were: rapidity; being unprejudiced about sexual orientation and sexual behavior, the possibility of not being traceable (as gay or HIV positive), the opening hours and the possibility of having access to HIV preventive information. When clients were asked about their expectations regarding CBVCT, they declared that the former were not only fulfilled but exceeded.

Finally, and regarding the advantage of CBVCT in comparison with formal health settings we found that clients reported as an advantage the same dimensions that they stated as reasons for choosing CBVCT (rapidity, counseling instead of moralizing, anonymity). As for coordinators, two dimensions emerged: 1) a practical dimension, which included rapidity, opening hours and geographical proximity, and 2) an approach dimension, which referred to the possibility of providing client-adapted counseling, providing accurate preventive information and a non-stigmatizing attitude. Besides, they focused on other aspects that were not touched upon by the clients: CBVCT takes place in a non-medical setting, is an efficient way of detecting HIV cases and is an opportunity for mobilizing the community.

Regarding the creation of a code of good practices, points that should be dealt with are:

- The definition and characterization of CBVCT.
- The importance of non-stigmatizing staff capable of providing counseling and accurate preventive information.
- The necessary awareness of the societal situation regarding HIV, homosexuality, but also migration, drug use, etc.



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- The impact of "time" in the HIV testing process: from the moment the person takes the decision to get tested until the provision of HIV test results.
- The evaluation of expectations regarding CBVCT and the fulfillment or otherwise of these expectations.
- The "community" issue: a place "only for us" and the risk of encouraging other prejudices.
- The importance of the non-medical environment.
- The opportunity of mobilizing communities for other purposes.



Section 3

CBVCT features: through thick and thin

The third section of this qualitative study report aims to summarize the main characteristics of CBVCT services and programs. In the previous section the advantages of CBVCT settings were illustrated, therefore in this section we will focus on the aspects that might represent an obstacle for CBVCT clients and/or which could be improved. Finally, results regarding the evaluation of CBVCT satisfaction will be presented.

KNOWING THAT THERE EXISTS A CBVCT SERVICE

WHICH METHODS DOES THE CBVCT USE TO DISSEMINATE THEIR ACTIVITIES/SERVICES? DOES THE LOCAL CONTEXT ALLOW COMMUNICATING FREELY ABOUT THESE SERVICES? IS OUTREACH POSSIBLE IN YOUR LOCAL CONTEXT? HOW DID YOU LEARN THAT A CBVCT EXISTED?

One first issue to think about when implementing CBVCT services is the dissemination of the information. This kind of services targets populations not always easy to reach, for this reason communication about the service must be carefully considered.

CBVCT coordinators were asked about the different means used for “advertising” their testing services, and CBVCT clients were asked about how they learnt the existence of such services.

Coordinators. By all possible means...

Regarding CBVCT coordinators we can observe that most of them declare using **several means for promoting and advertising** their CBVCT center.

“By all possible means. We use Internet pages, leaflets promotion campaigns in media, press, public transportation; all depends on our financial means. Also during conferences, we give interviews”. (Int-2)

“I think CheckPoint is a firmly established name in the gay community, and the way we do PR (public relations) for the project is through web banners on gay chat sites, it's through flyers which are disseminated by our volunteers. It's by PR in the gay media, and sometimes also stories in the gay media about counselors or users who have used the testing facilities. Then we have information screens in some of the saunas and the clubs, where we have PR for CheckPoint and for



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getting tested. I also see our on-site syphilis testing as an ongoing PR to promote testing and CheckPoint”. (Int-5)

“At least four specific campaigns are launched; volunteers distribute condoms, lubes and information at gay venues, parties and beaches. We also launch our campaigns on our website and Facebook profile. Most importantly, new clients reach our centre by recommendations of other clients (mouth by mouth)”. (Int-8)

1) Some coordinators remarked the importance of using the **Internet** in order to disseminate information regarding the existence of CBVCT. The use of the Internet is closely related to the recreational but also informative use that MSM can do of this tool (parties, gay bars, sexual partners seeking but also information about prevention or HIV testing).

“Here internet is the key. [...] As for the association, the information is announced on some web pages that the population visits and we're also working on launching our own homepage. [...] We're trying to make use of electronic social Networks. [...] The population we're dealing with is dispersed and the internet is one of the only means to more directly reach. I mean, it is necessary for the information to occur at a place where they'd be looking for information on the club, on partying”. (Int-1)

2) There are other experiences, like that of Italy and Germany, where the use of the different sources of advertising does not seem to be so wide. Thus, the Italian coordinator, for example, reports that they do **only use leaflets** (short and large format).

“Leaflets, in a small format that can be left on the table, and a larger format that can be posted in strategic places, universities, local hospitals too”. (Int-3)

“We promote our offer with small cards, like business cards and of course by talking, mouth-to-mouth advertise. On the cards are all appointments and how to find us. We also use the Internet of course to promote and being at parties too. We approach through several sites in the Internet, for example herzenslust and our homepage. Oh, and local gay print media too. That's seems to me a good mix”. (Int-6)

3) Interestingly, there are other two examples where CBVCT coordinators state using **community mobilization** as a means to promote the CBVCT. In the French case, this community mobilization refers not only to communication but also to the implementation and evaluation of the CBVCT.

“We use community mobilization to extend the CBVCT offer. In every city in France, there is a steering committee organized by AIDES which gathers members of different communities, to evaluate the programs and suggest potential improvements”. (Int-4)



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“We don’t promote our offer, but we use networks, newspapers and the community to make it known in public, especially in the community. We don’t have flyers or something like this, because it would not bring that much response, but our strategy of telling some networked persons, who each tell some more persons and so on, is a proofed and very successful way. We reach the focus group very good”. (Int-6)

4) Another issue that appeared frequently during the coordinators interviews were the **outreach activities**. They are mainly done by volunteers who are trained to accurately communicate about sexual behavior and to not be judgmental. It must be noted that outreach does not always aim to conduct HIV testing but just informing people of the existence of the CBVCT center.

“We have a large group of volunteers engaged in various outreach programs: We have people offering massage in the saunas and they talk about risk behavior, about HIV, about HIV-testing.

Do you train these outreach people?

These people are trained to communicate about sexual risks and behavior, and also trained not to be judgmental in terms of other persons’ sexual behavior”. (Int-5)

“Eh... Outreach is possible. We have an outreach. But during outreach is not HIV testing possible. It would be possible if we had saliva tests”. (Int-7)

✓ An *ethical issue* emerged when describing outreach activities. In fact, it was explained that the philosophy of the CBVCT was that of using “seduction” in order to induce people to take the test. As explained by the coordinator, that HIV is the result of a (sexual) interaction, taking the test can also result from a similar dynamic. It would be interesting to consider more seriously the potential consequences of promoting HIV testing using this “seduction” strategy instead of choosing a more “cold” approach.

“And for a certain part of the population the direct approach, this « peer-to-peer » dimension, is crucial. Namely, just as HIV doesn't transmit, I'd say, immaculately – it's the result of a sexual interaction – there's no reason why a decision to take the test couldn't be a result of an interaction, right. Just as the dynamics of MSM relations is an interaction as well. We're talking about sexual interaction that comes in the form of non-verbal and sometimes verbal interaction. In this way « seducing » someone to take the test is a method that we – not broadly, but nevertheless – use as well. Why not individually address people to take the test?! After all, we decided we shouldn't be biased to this approach, since just as people address each other individually to have sex, they can address each other individually to take the test as well. This, basically, yes, this is the philosophy we opted for”. (Int-1)



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✓ As indicated by the Slovenian coordinator, one of the dimensions to keep in mind when doing outreach is that of “*rhythm*”. More concretely, and in his opinion, it is needed to establish a regular presence in gay venues in order to raise a certain awareness in the gay public of the possibility of getting tested.

“This is what we wanted to establish - the continuity of the rhythm: the testing is available every month during every party. In this way the presence of the test is incorporated into individuals' awareness. That it's there and that they can easily wait until they're ready to take the test. I find this crucial. That this rhythm, this continuity is secured. Although it started as a pilot activity one of key developments of this project is its continuity: once a month, at the same time. Every first Monday – even during summer - and at every party at the club”.

(Int-1)

✓ Regarding the **reception of outreach workers** by community members in gay venues, four different attitudes are described in the citation below.

“Our gay street-worker say: one quarter of people are very interested in HIV give me questions, want to discuss. Sometimes come back. Other quarter is not so enthusiastic, but they accept the information. The other quarter take condom, take materials, like card, but they do not want to speak about it and leave me soon. And the last quarter reject the information, do not take condom or put it openly away. Sometimes even f..d me off verbally”. (Int-7)

A final element of interest was that of **potential problems regarding the dissemination of information** (e.g. too explicit sexual contents). Unexpectedly, most of the participating countries did not report any problems when advertising the existence of their CBVCT services.

“*Can you promote VCTs in Poland freely?*”

Yes, there are no constraints concerning VCTs promotion. We have not met any resistance concerning information included in our leaflets, neither testing nor safer sexual techniques. We also do not have any problems with the Voivodship Sanitary and Epidemiological Station where our VCT has its premises. It is an institution involved in HIV subject and we have no trouble to promote leaflets directed to various groups, sexual minorities or sex workers included”. (Int-2)

“In Spain there is no problem for campaigns for MSM, as long as there is no Pope's visit in town (laughs)”. (Int-8)

Nevertheless, other countries, like Czech Republic described other problems related to the dissemination of CBVCT information. Thus, in some cases is difficult to count on the collaboration of **gay bars owners**.

“I think the main problem is with some bar owners because they are not very friendly”. (Int-7)



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Another difficulty cited by the Czech coordinator was that of reaching gay population. As he explained, the **fashion gay bars** change really quickly and there are mixed or heterosexual bars that are not identified as “gay bars” but that are largely frequented by MSM.

“Some bars are new and other disappears. It is not easy to keep with it. There are also some mixed bars. There are some discos for young people frequently visited by MSM who are not identified as gays. But if you are gay and little bit older you do not know it. We have young volunteers so that they knew where to go”.
(Int-7)

Finally, in those countries where **CBVCT funding** is not widely developed, it is difficult to inform the community about the existence of this HIV testing setting because there are no financial means for doing so.

“We have leaflets, cards and posters in gay bars. [...] We have send information about VCT to office of GPs and some of them put it to the message board. We could do more but the problem is money. Edition activity was not supported for three years and we almost done have any promotion materials”. (Int-7)

Clients. Social networks, then advertising and, finally, outreach activities

Six focus groups dealt with the question of learning the existence of CBVCT services. According to the different answers provided by clients, we can list three main ways of getting informed about these services.

First, we found clients who learnt the existence of CBVCT thanks to their **social networks**: friends, boyfriends and associations. It is worth noting that participants declare to recommend the CBVCT services to other friends, so clients become a means for informing other community members about CBVCT.

“Now, let’s move on to how you learned about CheckPoint. How did you find out that CheckPoint exists?”

I learned about CheckPoint from Out & About.

You mean ads?

You can say that. Also a couple of friends told me: “If you have any doubts, just stop by on Mondays, you can make an appointment, or - in the afternoon - you can just walk in””. (FG-5)

“Through the association, Arcigay”. (FG-3)

“Of course I meet friends on campus and... I have standard references”. (FG-6)



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“Yes, from the friends, absolutely”. (FG-7)

In the second place, some clients declared learning about CBVCT service thanks to **posters, flyers, cards** placed in bars, discos, schools **and the Internet** (e.g. banners).

“...only through acquaintances and friends and Facebook”. (FG-1)

“How about the rest of you?”

- Boyfriend.dk I think.

- Same.

So, ‘boyfriend’ and different ads?

Yes.

Was CheckPoint recommended to you or did you recommend to others?

- Sure, I’ve recommended CheckPoint.

- Me too, but nobody recommended CheckPoint to me”. (FG-5)

“I saw a poster at the toilet in some club”. (FG-6)

“I’ve seen (posters) even at schools”. (FG-7)

“- Yes. It’s been a long time now and I don’t remember very well but I think the first contact I had with you was through advertising on cards that were handed out with condoms in a disco.

- I think it was through flyers in a disco or in some gay organization, an advert or something like that”. (FG-8)

Finally, some clients took directly contact with the CBVCT service because they met “physically” a mobile testing unit or someone performing the HIV test during outreach activities (e.g. saunas). This means that **outreach activities**, according to clients participating in this study, was not a main source of knowledge of CBVCT services.

“- I recognized the van one day, while I was cruising. At home I searched “Herzenslust” and next time I went there I participate. I told friends about it, because I know many of them had the same time and setting problem. We talk quit often about sex and about risks.

- I got in touch with it, because I visited the sauna. In my personal community context... well actually I had my coming out very late and just got a few gay friends. We talk about these topics in general, but I would never talk or ask specific. In my family or at work I would never broach the issue of sexuality in any case”. (FG-6)



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Key points

- ⌘ CBVCT try to use all the possible means in order to advertise their service.
- ⌘ Community mobilization is rarely named as a way of communication about the testing service.
- ⌘ Potential clients receive outreach workers and activities in diverse ways.
- ⌘ Gay bar owners are sometimes not helpful (preventing from disseminating leaflets or doing outreach).
- ⌘ CBVCT advertising depends on funding.
- ⌘ Identifying gay venues is not always easy (e.g. MSM attending “heterosexual places”, mixed bars).
- ⌘ Clients learnt about CBVCT services thanks to: 1) social networks, 2) paper and Internet advertising, and in the last place 3) outreach activities.



PLACE: WHERE IS THE HIV TEST PERFORMED?

WHERE IS THE TEST PERFORMED? (VAN, BAR, SAUNA, CBVCT VENUE)? IS THAT CONVENIENT FOR YOUR ATTENDING POPULATIONS NEEDS?

The tests are performed in different places according the choices and means of the CBVCT services. Regarding the eight participating countries we observe **three main strategies**:

- Performing HIV testing in the CBVCT center. This “fix venue strategy” concerns Poland, Italy, and the Czech Republic.
- Performing HIV testing in gay venues (clubs, saunas, van): Germany.
- Combining the both precedent strategies: Spain, Slovenia, Denmark, and France.

These strategies depend on the target population, on the staff and on the national context. For instance, in the Czech Republic, **national regulation** does not allow to perform blood tests outside the CBVCT venue (where the test is conducted by medical staff). Thus, if there is an outreach testing strategy, the only option is to use saliva test.

“Outside health facility is not tolerated to take blood by the law. The Lighthouse is also officially health facility. It is possible to do saliva tests outside but not blood one. We have a gay street-worker who promote our VCT in bars etc. but he is not able to make the test”. (Int-7)

An accessible, but not too visible, “charming” place

According to the CBVCT clients, several aspects are important to foster HIV testing. Many of them declare that an important issue for them is the convenience of the CBVCT venue. Like this, the physical location has to be **easily accessible**. For the participants, a fix venue should be located in a central place, well served by common transports or with parking nearby.

“You can also park at that hour there nearby”. (FG-1)

“It’s a place where NGO is located, in the Lighthouse. It is in the center very close to the main bus station and station of two metro lines”. (Int-7)

Thus, location is a very important strategic issue if the goal is to reach a particular population. In Slovenia, for instance, the CBVCT coordinator indicates their willing of developing their activity in a club because it is a place especially frequented by foreigners.



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“At the club “K4 roza” on Saturday and at the association Legebitra's office on Trubarjeva. For now, only in Ljubljana. We had a location in Velenje – a mobile location it was. However, it is a much more difficult situation, because the area has to be adapted afresh and also the response was relatively meager. This part in perspective is our goal to establish a mobile situation that could attract people. The advantage of the club K4 is the fact that people from all around Slovenia come to visit it. So, this is a certain advantage. Because people already come from different places”. (Int-1)

The **question of visibility** seems to be important too. The CBVCT center should be “neutral”, so that the CBVCT center would not be identified as the “gay” or “HIV” place.

“Do you find the location of the testing suitable?”

- I think it's very suitable, because there's no sign, where you're entering, so from the street it doesn't show that you're going now to Legebitra on some HIV testing, but you could be living there, you could go there, I don't know, what's there, some sort of shop or boutique, or something.

- Yes, about the location suitability”. (FG-1)

“So, a central location is important? How about ‘Ishøj Strand’ (a gay beach outside Copenhagen)?”

CheckPoint has a neutral location; you can just go there.

So, a neutral location is important?”

- Very much so.

- It's important to many people. You don't have to travel through the whole city just to get a test.

To reach CheckPoint you have to pass through a clothes shop. How do you feel about that?”

It's just funny; I find it funny (Laughter).

Is it one up for you, one down or... It's not important?”

- It's funny, one down. I simply find it funny.

- One down for me two. I happened to buy two pairs of jeans (Laughter)” (FG-5)

However, the German clients nuanced the question of a “confidential” place. They declared that, in their opinion, being seen in CBVCT services was not so problematic since **HIV is something that concerns the MSM community**.

“The atmosphere appeared very confidential to me. In other settings, like at local health authority, it doesn't, because it's possible I meet colleagues or relatives or neighbors. Meeting friends of the community in a test setting is no problem, because we are all affected”. (FG-6)

The **environment** is also a crucial issue. Fix CBVCT venues should be pleasant places. As stated in the first section of this report, decoration, tranquility and the presence of “warming” elements are important. Besides, this environment should also guarantee anonymity.



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“Is it comfortable for clients, what do you think?”

I do think that VCTs run by FES are comfortable places. We worked out standards to make it cosy. A client who visits a VCT at Nowogrodzka Street is only accompanied by other VCT clients, there are no other, strange people there. Before, FES ran a VCT in a clinic and it was a problem for our clients, they were scared and worried about their anonymity. At the moment VCTs are mainly directed towards testing so there are no other people there. Thanks to that we guarantee anonymity and confidentiality”. (Int-2)

“And what about the place where the test was done? Was the room nice and comfortable?”

- Yes, it was nice and clean. When we do it here, sometimes it’s upstairs
- Its not austere, it’s always in friendly surroundings
- There’s a warm welcome, there’s coffee or orange juice on offer, there’s something about the welcome that you.... there are some magazines upstairs”.
(FG-4)

It is interesting to note how fix CBVCT venues are, in some cases, organized in order to manage and preserve anonymity as well as to create a cordial environment.

“Our VCT is placed on the premises of the Voivodship Sanitary and Epidemiological Station. We have 3 rooms, two of them are used by counselors, the third one serves as a blood donation room. We also have a corridor, places to sit down where we display and offer our educational and prevention leaflets. In a VCT at Nowogrodzka Street there is nobody else during our opening hours. In a VCT at Żelazna Street during our opening hours an immunization unit is also opened. This unit is run by another organization”. (Int-2)

“Well, as I said, since we do the test once a month, that Wednesday we try to keep the place free from any other activity. However, the association is opened, and then it is also possible that someone comes to ask about our activities. Some people can come, yes. That’s why, since we have this flat here nearby where the psychologists do their counseling, we thought to move there the testing too, in order to maintain privacy and tranquility”. (Int-3)

The Danish coordinator detailed a new experience called “flex-test facility”, which main goal is to preserve anonymity of clients by booking a time for getting tested alone, without anyone else in the waiting room.

“I would say on the other hand, because we have an open facility, it also means that we have a waiting room, where people sit and wait, and that could be a negative side. Some people may not wish to sit in a waiting room with people they know, and as a consequence of that, we’re working on something that we call the flex-test facility, where people can actually book a time outside opening hours. So that they don’t need to sit in a waiting room with others, but they can



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come and have total anonymity, and in that respect don't have to be recognized or don't have to meet their ex-boyfriend or partner or whatever in the waiting room". (Int-5)

The good and the bad things of mobile and fix CBVCT venues

To increase the level of awareness of the most-at-risk populations is important to get to their frequented venues. Thus, the "mobile" CBVCT services reach people who have not contemplate, in most of the cases, the possibility of getting tested. The mobile service is a way to introduce or remind, and to offer them the possibility of getting tested. People getting tested in these mobile units can be described as "opportunity testers". In any case, mobile CBVCT services seem to be an efficient method to do HIV prevention.

"The disadvantage is that not in all places VCTs are open long enough. There are cases where they are opened once per week, there are many clients so the talk cannot be long enough". (Int-2)

"I think it's damn important that you reach out, you see – I've been to Amigo (Gay sauna) a couple of times – and my impression is that people just fucking don't care – many don't care.

Care about what?

- Well, some just – to speak frankly – turn their back to you and you can stick it in. So I think it's important that you are visible in those venues and that CheckPoint is not just a clinic.

- I agree; it's important that you reach out. Sometimes people just forget that they might be... or forget to be checked and say, it the doctor appears you think: "Okay, let me have a check-up" – people get inspired, I think. It's a good idea to have a check-up from time to time and in due time before it's too late because you believe nothing is wrong; and suddenly it's too late. So it's okay; it's a good idea to reach out and offer your services to those who dare not visit CheckPoint". (FG-5)

"But I think that a testing vehicle standing somewhere for a concrete hour or with a concrete time limit is even more effective. That is the most successful in the "voluntary testing" point of view". (FG-7)

However, we notice that even if the test can be performed in different places, there are some questions that must be respected in order to reach the target population and to offer adequate conditions for the HIV test: an easily accessible location, adapted opening hours and a cordial and confidential place. Besides, a more diverse offer increases the likelihood of proposing places where most-at-risk population will feel comfortable concerning the test taking. As stated by one participant of the Italian focus group:



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“If Mohammed doesn’t go to the mountain, the mountain goes to Mohammed, and the possibilities to get tested are increased! Because a lot of people who I know are worried about doing it”. (FG-3).

Now, regarding the **assets and drawbacks** of the different location strategies, the BCN Checkpoint coordinator puts forward clearly the advantage and the inconvenient of performing HIV testing in CBVCT venues, vans and saunas.

“In BCN Checkpoint, the test is performed within our venue. In the rest of the country, the test is performed most of the times at the CBVCT venues, which is the most convenient, we believe. The test sometimes is performed in a van, which has the inconvenient that there’s no confirmatory test in that case, nor are people linked to health care (which is extremely important). Finally, in Spain, the HIV test is also performed in some saunas, which we believe is not so convenient as the person does not receive the result at the same time, so there may be a loss of a number of cases. If you do not give the test result immediately, people not always come back to get this result”. (Int-8)

Indeed, in some cases the results are only available in the fix CBVCT venues (e.g. the Czech Republic and Spain). This means that if clients are tested in a mobile service, and are asked to get their results in the fix CBVCT venue, we will find that **failure to return for HIV test results** will be as problematic as in the formal health setting.

Another potential negative point rose when the German coordinator described how HIV test is performed in a van. In fact, for some clients the fact of **being in a public place** would restrain HIV testing.

“Disadvantage for example is if someone likes to stay apart or wants to take some time alone or don’t want to get into the van in public, then we only can advise him to use other offers”. (Int-6)

Furthermore, the fact of being in a **festive venue** is not considered by some clients as a propitious place for learning a HIV positive status.

“I remember that when I saw the chance of the test in the sauna in Amsterdam, at the end I didn’t get tested because I thought: “I’m here in the sauna and I would like to enjoy my time, if I go upstairs and they say that I’m HIV positive, what should I do? It’s better if I don’t know it now!” (He laughs)”. (FG-3)

When testing takes place in **festive venues, the time and the procedure have to be adapted to the context**. Some respondents are concerned about the possibility of learning a positive result when they are under the effects of alcohol and/or drugs.



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“And sometimes certain individuals have to be denied the testing due to their intoxication, there's always a lot of noise in the club and certain counseling related discussions take place in specific conditions, right, instead of where there's peace and quiet, right and so on, which is a weakness and a strength at the same time, because people are still more willing to talk in an informal »setting«, right”. (Int-1)

As proposed by CBVCT clients, there are two possible ways of minimizing this risk in festive venues:

- Not performing tests if the clients are not in conditions to do it: “We don't want to offer a quick test to people who are drunk and don't know what they are doing. The counselors at those venues try to avoid those who are not in possession of all their faculties”. (FG-5)
- Performing the test but provide the results later in the fix CBVCT venues.

Finally, we found that there exists a **symbolic question regarding the mobile CBVCT**. As explained by one Slovenian client, until now there was a separation between the recreational setting (where you can acquire HIV/Aids) and the clinical setting (where you learn your HIV positive status). The apparition of mobile CBVCT has broken this physical and temporal separation.

“Well, I don't know, because we've, exactly because we have always traditionally separated this world of fun and the potential situations of infection that come with it and this cold clinical world, where we come to repent for what we've done there, right, so that already physically it had to be separated and temporally if it was at least possible”. (FG-1)

In fact, through these testimonies we observe that the preferences are diverse and that in order to be effective the best option is to offer a **wide-ranging of testing possibilities**.

“Would you appreciate a terrain testing? Eh... like in the gay clubs, saunas, streets. Why it would be better or worse? Would you let them take your blood at such a place or it should be rather a salivary testing?”

- I would absolutely appreciate it. Of course it depends on the environment of the blood taking... But... when it would be hygienic, then why not..

- I would be worried exactly about that hygiene. But I really like that truck, where is the blood taking done.

- I also wouldn't be probably satisfied with that hygiene. Maybe I would prefer that salivary testing”. (FG-7)

“Maybe the choice is important, giving the chance to choose different ways to get tested. There are people who prefer to go to the hospital, some other to the private clinic like Gruppo C, someone else in an association or even in a sauna”. (FG-3)



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The testimony of the French coordinator sums up these different issues:

“The objective is to facilitate routine testing as much as possible, so easy access and getting close to the people are necessary. Tests can be done anywhere as long as there is sufficient lighting, that confidentiality is not compromised and that people can hear each other speaking (this can sometimes be difficult in party or leisure settings)”. (Int-4)

In any case, we observe that whatever the strategies are, **some populations remain unreached.**

“There are some groups who do not come for tests even we try to offer it them. For example homeless people, people from lower social groups, young sex workers. But they don't come; it's really rare that somebody of them would come for HIV test. Maybe because they have a lot of other problems. They will... would ask for it. If it could be done at this park, yes, they probably would say yes. But I am not sure if they would pick up the result”. (Int-7)

Key points

- ⌘ The implementation of fixed, mobile and mixed CBVCT services depends on national regulations and financial situation.
- ⌘ Fixed CBVCT venues should be “warming”, well communicated (e.g. common transports) but not too visible.
- ⌘ Assets for mobile testing services: reaching people who would not get tested otherwise
- ⌘ Drawbacks for mobile testing services: failure to return for HIV test results (if there is not rapid test), prevention of getting tested “in public”, the issue of alcohol and drugs use.
- ⌘ A most varied offer increases the likelihood of reaching more people.
- ⌘ Some populations remain unreached (e.g. homeless, sex workers).



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OPENING HOURS

WHAT'S THE TESTING SCHEDULE OF THE CBVCT? IS THAT ADAPTED TO THE POPULATIONS NEEDS?

As already stated, the issue of operating hours is really important when it comes to offer an alternative service to classical HIV testing. To have a detailed knowledge of the operating hours of the CBVCT services participating in the HIV-COBATEST project, clients and coordinators were asked about the days and hours where the CBVCT centers were open.

The table below summarizes the main answers given by clients and coordinators, and to whom this question was stated during the focus groups and interviews. This information might have changed since the data collection took place in 2011.

Table 4. Opening hours declared by CBVCT clients and coordinators

	CBVCT Clients	CBVCT Coordinators
Czech Republic	?	Monday 16-19 Wednesday 9-12 (Only counseling and testing, no results)
Denmark	Only on Mondays Book in advance or just show up.	Every Monday from 16h to 20h 2 Counsellors on duty and a receptionist 16 users/opening days on average
France	On Wednesdays from 17h to 20h	?
Germany	Once per month in the evening hours On Monday Early evening hours	On Sundays from 16h to 19h in the summer month. Café and office are opened every working day Every second week from 18h to 21h at a parking place on a highway nearby
Italy	Gruppo C: from 8:30 to 12:30 from Monday to Friday Borgo Roma : from 10:30 to 16:30	From 17:30h to 19h
Poland	?	VCTs run by FES (2 in Warsaw) open daily: 1) Nowogrodzka Street (from Monday to Friday from 16h to 20h) 2) Żelazna Street (from Monday to Friday, from 15.30h to 18.30h)
Slovenia	On the premises: afternoon, once a week Off the premises: on Saturdays from 22h and till	Off the premises: between 22 and 2 am On the premises: afternoon, once a month from 17h to 20h
Spain	?	?



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We observe that most of the CBVCT programs propose HIV test once a week on the premises, more in detail, testing occurs during a half-day (morning or afternoon) or during the evening. If the HIV test takes place off the premises, time-slots depend on the concrete places where the test is performed and on the targeted populations.

Unusual opening hours, out of working hours!

According to some clients, it would be much easier to get tested regularly if there were places to get tested out of the usual working hours. Evening and weekends would be excellent moments, according to clients, to get tested. Given that such opening hours are not frequent, it is reasonable to think that people who are not currently tested could be reached with an extension of the time-slots.

“I had to ask to my boyfriend to take me there, and we got tested together... But, actually, if there was an opened place in the evening time, for example, it would make the access easier. Personally, I didn't get tested so many times, but I would have done it more frequently if it was more accessible. I don't know, if you are dancing at Romeo's... then I don't know if I really would have done it, but if you have some doubts, in that moment you can remove all doubts. I mean, if you have the occasion, maybe you do it. While, on the contrary, you must go deliberately to Gruppo C, in those opening times, and so on...” (FG-3)

Thus, some CBVCT services do an effort for **proposing unusual opening hours, out of working hours**, in order to facilitate access to HIV test. However, these services are far from being the majority. For this reason, “mobile CBVCT” services are a good means to broaden the time-slots.

“Well, as the TROD¹⁸ are getting more and more common in bars and night clubs it means extra time slots”. (FG-4)

Clients declare being really satisfied when the **opening hours** are wide. This larger opening hours prevent them for losing a whole day or work in order to get tested. Both users and coordinators would prefer to have larger opening hours and a larger choice of **opening days (e.g. weekends)**. Indeed, some CBVCT services propose one unique day to make the test.

“What do you think?”

Yes, I mean, the timing is great, because that's when normal people with normal jobs have time, for those who aren't normal, it's not okay, right. But yeah, we would, I don't know, maybe even once a whole round in the morning and one in the afternoon, you know.

During the weekends or the week?

¹⁸ Test rapide d'orientation diagnostique – Rapid test for a diagnosis orientation.



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Better during the weekends”. (FG-1)

“The disadvantage is that not in all places VCTs are open long enough. There are cases where they are opened once per week, there are many clients so the talk cannot be long enough”. (Int-2)

“You must be free from job for a half day”. (FG-3)

“Do you think this schedule suits people’s needs?”

It’s not long enough or often enough I think. [...] It would be better to have more hours, at least a whole day”. (FG-4)

However, there are clients that expressed that CBVCT opening hours **fit their needs**.

“Opening hours only on Mondays isn’t satisfactory to me, because I work at irregular hours. So, yesterday I couldn’t have dropped by. Then you have to wait a little longer before you... Twice a week would be fine”. (FG-5)

“I use an offer, if it fits to my needs. This offer is community based and in the evening hours: perfect. I don’t need an appointment or had to wait long... even if, it wouldn’t matter because in the evening it’s leisure. Contrary to CBVCT I do have to take time at work or even vacation to be able to use an offer of the public health service”. (FG-6)

One of the reasons for not opening more hours is the **financial issue**. Even if the centers have room and staff for performing the test, more funding would be necessary in order to broad the opening hours.

“[CBVCT] could be open for longer, we have enough staff and room but unfortunately, we do not have enough money”. (Int-2)

Regarding the fact of opening only one day, some elements must be taken into consideration. Thus, the Danish coordinator explains that they choose Monday because if there is a client with a HIV positive result he/she will have the time to do the confirmatory test during the week:

“The CheckPoint Copenhagen is open every Monday from 4 to 8 in the afternoon and evening with 2 counselors on duty and a receptionist, and on average we have 16 users pr. opening day. We would like to experiment or do a pilot project on opening another weekday, but the reason we chose Monday is because that minimizes the waiting time for people who test positive.

Waiting time for what?

The waiting time for doing the confirmatory test at the hospital. So Monday has been chosen because they run these tests on Tuesdays, and we can have the result of the confirmatory tests at CheckPoint on Thursday, so the user can come her on Monday and test, and if they test positive, they wait until Thursday or at the latest



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Friday for the confirmatory test result. So the opening hours have been chosen to minimize the time where the user has to wait for the confirmatory result”. (Int-5)

Some clients propose to open CBCVT venues **in changing weekdays**. Nevertheless, any changes in the testing schedule requires from a good communication (e.g. Internet) about in order to keep all the potential clients informed.

“So afternoons are okay? Do you all agree?”

- Opening hours is okay, but different weekdays would be a good idea. Off course it’s an administrative mess, but different weekdays would mean ... Because many people ... me for instance, I’m busy every Monday.
- For my part; I think a fixed weekday is okay.
- There is another point of view
- I think hours are too short. But different weekdays – Oh no! Then you have to check the hours on the Internet, and then you don’t get it done”. (FG-5)

The **length of the HIV test depends on the CBVCT organization**. Thus, some CBVCT services require an appointment while other do not. Some of them perform rapid test whereas other prefer classical test and, besides, there is a different waiting time in function of the affluence. All theses aspects can encourage, or discourage, CBVCT clients from getting tested.

“Often you go there and wait one hour, one hour and a half, because the doctor arrives late, or he’s busy. [...] Because there is the counseling, and so on... While in Borgo Roma you go from 10:30AM to 4:30PM and you know that you go there and in 5 minutes you have finished! Usually in Borgo Roma there are few people... Maybe Gruppo C is used by more people, I don’t know, maybe it’s for that... But I know that, for example, in Villafranca there is another center like Gruppo C with more flexible opening times, like for example on Tuesdays till 6:30PM, and it can be comfortable, at least for those who live there”. (FG-3)

“You can do both: Book in advance or just show up. The whole thing takes an hour. I’ve never booked in advance, and then someone is taken care of before me and I think: “What the hell!” – But they obviously booked in advance (Laughter)”. (FG-5)

“The whole test procedure lasts 35 minutes”. (FG-6)

“I don’t took exact time, but it took about 30 minutes, the test itself 5-10, remaining time counseling. Very close to my needs”. (FG-6)

“It’s relatively quick coming here and taking the test”. (FG-8)

As stated in the methodology section, we only interviewed CBVCT clients that accepted to participate, that are relatively satisfied with this experience. As a consequence, we cannot count on the opinions of people who would use the



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CBVCT service but who actually do not because of the opening hours. It would be necessary to **interview people not attending CBVCT services**.

“You were saying that your service is opened one hour and a half in the evening?”

Yes, one hour and a half. Usually from 17:30 to 19, then we always open till 19:30 really. It is an unusual opening hours, so sometimes it really facilitates the access, because going in the morning, when you work, is often a little bit complicate. Maybe for someone else our opening hours is an obstacle, but I can't know it, because I only see those who come! Maybe there are pro and con about our opening hours”. (Int-3)

Finally, the question of **home test** emerged in the Italian focus group. Home test is perceived as a way to extend hours to do the test. Nevertheless, people are aware of the different problematic that this kind of test rises.

“If I had the chance to get tested with a rapid test in the pas, I would have done it more frequently! On the contrary, I did it in 2006, and... Well, I did it few times, if I think about it, but if I had it at home I would have done it more frequently! Maybe it's true that if the result is positive you don't know what your reaction can be, maybe you are desperate, I don't know, but... You keep your health more monitored”. (FG-3)

Key points

- ⌘ CBVCT places should have convenient opening hours, mainly out of working hours and weekends.
- ⌘ Some clients declare that current opening hours fit their needs.
- ⌘ Most of the clients demand more opening days and more opening hours, especially out of working hours.
- ⌘ The length of the HIV test depends on the CBVCT organization (staff, appointment or not, rapid or classical test, affluence...).
- ⌘ Since we have no data from people not attending CBVCT services, we do not have information regarding their problems with the opening hours.
- ⌘ Home-test is evoked as a means for “extending opening hours”.



KIND OF HIV TEST

WHAT KIND OF TEST DO YOU USE? HOW WOULD YOU DESCRIBE YOUR EXPERIENCE WITH THIS TESTING METHOD? WHY ARE YOU USING THIS KIND OF TESTS AND NO OTHERS?

As described previously, the question of where the test is performed is strongly related to the kind of test performed. We asked to coordinators, but also to clients, about the kind of HIV test performed. We expected a more specific knowledge for the former, while we were more interested in gaining knowledge about how clients experience the different kinds of HIV test.

Table 5. Test used for diagnostic purpose in the CBVCT according to HIV-Cobatest Cross-national survey on the Implementation of Community Based Voluntary Counselling and Testing Programmes and HIV-Cobatest qualitative study.

	Czech Republic	Denmark	France	Germany	Italy	Poland	Slovenia	Spain
Type of HIV test in the CBVCT	Classical test	Rapid test (prick test)	Rapid test (prick test)	Classical test and rapid test (saliva test)	Classical test and rapid test (prick test)			

Coordinators. A good knowledge of the HIV testing technology

Some of the coordinators were able to provide a very concrete and **detailed description of the HIV test** used in their CBVCT programs (e.g. Spain, Denmark, and Poland). In some cases, they did also explain the procedure.

“There are mainly fourth generation tests so they check antigen p24 and antibodies. In case of a positive result we use Western blot confirmation test. Selected VCTs use blood rapid tests, however it means the necessity to employ a laboratory diagnostician who would confirm the result. The procedure is the following: if a screening test shows positive we make the second screening test using the second sample of the serum that comes out of the same blood donation. If this tests shows positive we send the serum to be tested by means of Western blot.

What is your opinion on such a procedure?

I consider it appropriate due to the fact that it gives a chance to verify if a given person is infected or not. Of course, if we include additional counseling and take into account the problem of window period”. (Int-2)

“For the HIV test, it's Determine, and we also do syphilis testing, and that's the Core syphilis test. But at the moment we are also testing the Determine syphilis test to see if it has improved sensitivity or a better performance than the Core test”. (Int-5)



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“We use rapid and conventional test, but because of the high reliability, and because it’s so easy to perform, the clients prefer the rapid test in almost 100% of the cases. In Catalonia, the Determine® Test is used, and in a near future the INSTI® Test will be available. In the rest of Spain, non-clinical settings cannot work with blood, and therefore use the OraQuick® Test”. (Int-8)

In other cases, coordinators gave a very **succinct description** of the typology of HIV tests used in their services.

“ELISA, last version. Just to be clear, that which allows a result with a window period of one month and a half, or two”. (Int-3)

“We offer the rapid HIV-test, rapid Syphilis-Test and classical blood test for HIV”. (Int-6)

Finally, we found some examples where the coordinator reported **not having a very detailed knowledge of the technology used**. This lack of knowledge on the technology corresponds to examples where the CBVCT service has to provide to the laboratory a proper blood sampling according to national health standards, without any other “technological” involvement.

“I have no further knowledge of the technology, right. We know that our job is to provide a proper sampling, medically proper sampling and distribution of samples to the laboratory. That’s our duty. From there on the laboratory is working according to its standards that we have every faith in, because it’s a national institution”. (Int-1)

It must be noted that some countries are allowed to conduct the **Western-Blot** confirmatory test in the CBVCT venues, and that in some countries CBVCT services are obliged to **register positive results** confirmed by Western-Blot.

“Some VCTs have the possibility to make Western blot in labs where they make screening tests”. (Int-2)

Since it was interesting to know the **reasons for choosing a kind of HIV test instead of another**, a question regarding this issue was stated to the coordinators. Answers to this question were scarce, but all of them are summarized by the following Czech coordinator quote. He makes reference to pre-existing agreements with national health institutions in charge of the epidemiological surveillance and to the issue of lack of confidence on the test reliability.

“Because there was such agreement with national AIDS laboratory. It was very before introducing reliable rapid tests. And the cooperation is good, also it did



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not increase our costs. It is important also for them because of some epidemiological surveillance. [...]

The other reason is also a little bit more reliability of the test and shorter window period. We accept two months period if the client does not use any medicaments (or any conditions like syphilis) that could prolong immunological reaction. We are not sure if the same could be applied to rapid tests. Many people even gay men are tested at the beginning of their partnership and plan to have unprotected sex if they are negative. We are not in similar situation like in France where a lot of people are tested regularly. Rapid tests are used only by some low threshold centers for drug users but nobody knows exactly how it works because they don't send their data back for ministry and Public health workers. But we are open to idea to use rapid tests". (Int-7)

In fact, the question of **using or not rapid tests** was widely discussed by CBVCT coordinators. It is noteworthy the reasons why the French and the German CBVCT centers decided to conduct rapid tests: 1) they are validated by the national Health Safety Agencies, 2) they facilitate testing during outreach and 3) they are attractive to those who are reluctant to get tested.

"We chose the tests which were the most reliable both for sensitivity and accuracy after a comparison done by the French Food Safety Agency. They are not the cheapest tests but they are the most efficient! When choosing a test, an important criterion is also the length of time it takes for the result to appear. When you are doing outreach work and there are a lot of people wanting to get tested, a test giving a result in less than a minute can be much more attractive than one that takes 30 minutes". (Int-4)

"Most participants came for rapid HIV-test, everything else needs a second appointment because we have to wait for the laboratory results. Usually there are no questions about the accuracy of the test. If anything is unclear or the rapid test should result positive we would always take care for a classical test". (Int-6)



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and since the stress and fear experienced during that waiting time, besides of being a useless suffering, can prevent from getting tested, most of the coordinators look to facilitate the HIV test, to provide a non-judgmental place and to prevent from a traumatic waiting time. Nevertheless, there is one coordinator who presents this distressing waiting time as an opportunity for making people reflect about their risky behavior and, eventually, “being more careful” in the future. As presented before and further on, this opinion would not be in accordance with CBVCT clients’ wishes and experiences.

“On the other hand, we observe our clients and those who wait 24 hours for the test result do reconsider their life situation. That huge stress has positive effects so next time before taking up a risky behavior they are more careful. Of course, not all of them, but our clients tell us that these 24 hours are the worst in their lifetime and that they have time to consider the possibility of a positive result. People who make rapid tests and receive the result in on hour do not tend to think so deeply. Their motto is: “nothing happened, life goes on”. So I do think that one day of waiting is a better one. [...]

So, to be honest, rapid tests are no so rapid. In the end, clients start to hurry, they do not listen, they do not want to listen. Traditional testing provides 24 hours for reflection”. (Int-2)

Clients. A one week wait is acceptable, but rapid tests are welcome...

Clients remembered their **experiences** with different kinds of HIV test, and as described in the following citation, all of them are mostly positive.

“- I got rapid tested. The itch was made by a doctor, but I wouldn’t mind to do it myself, just like a blood glucose test. [...]

- I got tested by a classical blood test and a rapid test parallel. It was ok, but it was my first test, so I’m not able to compare. Both tests are reasonable, but I regard the vein blood test safer in result, because it takes longer. In both cases the blood was taken by a doctor, which was comfortable for me, because I’m not able, not calm enough to do it.

- In that case a rapid test was taken by a small itch in my finger. The doctor...well, I knew about this, because my grandma is diabetic, the Doctor didn’t use the best way to itch my finger, but it was ok. I think there is no safety difference between the rapid and the classical test. I prefer the rapid test because of the time efficiency”. (FG-6)

Regarding the potential dislike or fear of **venipuncture**, clients declared not having any problems with the fact of being itched.

“So was it out of the finger or the vein?”

The vein, yes.



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And, no problem?
No". (FG-1)

Nevertheless, some clients declared that classical test is sometimes **painful** and, therefore, they prefer rapid test.

“So there is a big difference between those two tests?

- Lately I had a test at my doctor's. He didn't do it properly at his first attempt.
- Another reason not to go see your doctor. (Laughter)
- Exactly. You're absolutely right.
- This is less; yes... It's less painful". (FG-5)

“And how would you describe your experience with this method?

- Yes. It's fine because it's quick.
- Yes. As far as I'm concerned it was good too. In fact I prefer this method to getting jabbed and having your blood drawn.
- Yes. It's much more practical". (FG-8)

The question of the reliability on the **oral fluid test** did also emerged among CBVCT clients.

“You put in your mouth, there's no needle

- If its effective, if its proven to be as effective as a blood test, yes you have to move with the times.
- Yes it's a good idea for people who are afraid of needles or of seeing blood. Nobody is afraid of saliva. And if there's no blood, there's less risk for the person doing the test.
- They were gloves though
- Yeah but there's less fear
- Yeah why not but we have to be sure it's the same result". (FG-4)

Now, most of the CBVCT clients' comments on the differences between both methods (classical versus rapid) concerned the **waiting time for the HIV test result**. Thus, one of the German clients described that waiting the results for a whole week is unpleasant.

“I don't see any difference in the quality of different tests, but in time and life quality. Waiting a whole week to get a result is very unpleasant". (FG-6)

“What do you think that are the main differences between the quick test that is used here and the classic HIV test?

- The time you wait. With the other test you have to wait days or weeks for the result. You should have another visit just to get the results.
- And here it seems more direct because it happens right before your eyes. There isn't that blood that disappears (laughs) that you don't know where it's going and suddenly you get a letter or a call. Here it's.... I don't know...a lot more direct.
- Yes, I agree with you". (FG-8)



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test is more easy and more... I got tested because of that; otherwise I didn't, because I'm so afraid... As most of the Africans who are afraid like me". (FG-3)

Finally, a close related issue emerged when speaking about the kinds of test: **auto-test**. The Italian participants declared having already used auto-test, even if not all of them have a good level of information regarding this issue.

"Did you do it by yourself?"

Yes, yes, I did it alone by myself at home.

And can I ask you the reason why you decided to do it alone by yourself at home?

- Well, because I wanted to avoid the bother of going to loose my time in the places where...

- How is it possible to do it alone at home?

- Well, you buy it in Internet and in 10 minutes you do it alone at home!

- Illicit traffic...

- Not really, not so illicit, I think that in other countries you can buy it in pharmacy too. I don't know in Italy, I never asked in pharmacy...

- I think it is forbidden!

What do you know about that?

- I don't know..." (FG-3)

In the French focus group, the question of auto-testing also emerged. Firstly, clients declared not showing any inconvenience about performing themselves the test. However, since lack of experience with this testing strategy could produce doubts about the reliability of the results, CBVCT clients expressed their interest in being "trained".

"Would it bother you to do it yourself?"

- No I wouldn't mind

- No, I wouldn't mind. But I'd be afraid of doing it wrong and having doubts about the reliability of the result if I did it myself. I'd trust someone who had already done it 500 times much more than myself.

- Someone who was trained to do it". (FG-4)



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Key points

- ⌘ Coordinators have, in general, a good knowledge of the HIV test technology used in their centers.
- ⌘ Some CBVCT services are allowed to perform Western-Blot confirmatory tests.
- ⌘ Different opinions among the CBVCT coordinators regarding the desirability of using rapid tests.
- ⌘ For some coordinators rapid tests are reliable, facilitate outreach and promote test among those people who otherwise would not get tested.
- ⌘ For some coordinators rapid test are not reliable.
- ⌘ Almost no failure to return for HIV test result is observed in CBVCT.
- ⌘ There are CBVCT services that consider that stress during the waiting time has a preventive effect.
- ⌘ A long waiting time (e.g. one week) appeared as a problematic issue for some clients, even if for others it is acceptable. Nevertheless, all the clients welcome rapid tests.
- ⌘ Auto-test emerged among the CBVCT clients as an alternative. Even if training would be appreciate.



OTHER STI TESTS?

ARE OTHER STI TESTING PROPOSED? WHAT'S THE PROCEDURE?
WHICH PREVENTIVE AND INFORMATIVE MATERIALS ARE PROVIDED?

When CBVCT is described, it is automatically assumed that they concern HIV testing. Nevertheless, once HIV test has been more or less established, the possibility of performing other STI tests emerges. Since a global health approach is quite interesting when implementing CBVCT, CBVCT coordinators and clients were asked about actual screening and about their requests regarding this issue.

Coordinators. Not always, and problems of anonymity

Regarding **Hepatitis B**, only Slovenia and Denmark are performing a HBV screening test. Besides, in the case of Denmark they do also provide vaccination.

“Currently the HIV testing comes in a package – one can choose the whole package with HIV and hepatitis B. It isn't possible to take one without the other, because the test is designated in such a way that all samples are being tested for both. [...] If a person is negative for hepatitis B, one is informed of vaccination possibilities. At the moment we're working on a direct contact with Institute of Public Health of Ljubljana where vaccination could be available, more available to the individual from the MSM population. Basically, the negative result is the best possible time to refer the person to further testing or in case of a positive result to refer them urgently to their doctors for further treatment of hepatitis B and monitoring of the infection.

So, to one's personal doctor?

Yes. To obtain further treatment one needs a personal doctor's referral. Right now we're still working on that protocol's details, because it turns out that certain individuals don't have personal doctors – what to do with them? We're still working on clarifying such cases, that is to say, we're monitoring them individually”. (Int-1)

“That's a separate program: you can come here without getting tested, but only for the hepatitis B vaccination”. (Int-5)

As for **sypphilis**, we found that among the participating countries, Germany, Spain and the Czech Republic are already proposing the screening test. However, there are some nuances that merit to be mentioned. When German coordinators were asked about the provision of other STI tests, we found one opinion against this possibility. In fact, this coordinator was not proposing other STIs because while HIV is a silent disease, other STI would combined with symptoms, and these symptoms would necessarily encourage clients attending to a health center.



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“- We –our project- don’t test for other STI, because during implementation of the project, there was no support for other testing. I honestly have to say, there is no need to test more. HIV is silent and it takes long time until something is recognizable on body. Other STI are usually combined with symptoms, pain or something like that. So it’s much more urgent to test as much as possible for HIV, then just test a few, but for any infection that’s possible.

- We also offer a syphilis rapid test – just parallel to the HIV-test. We ask participants if they want to, that’s it. I’d like to test for more infections... silent infections, someone is not able to recognize immediately. Hepatitis, for example. I don’t know if there is already a rapid test for Hepatitis, but if, I’d like to be able to offer it”. (Int-6)

As for the Spanish CBVCT center we found that while syphilis is offered to all the clients, it is necessary to **get enroll in clinical studies** if people wish to get tested for other STIs.

“As a standardized protocol, we offer syphilis test for all our clients, as some other NGOs do in Catalonia. For all other STIs, we offer the possibility of enrolling in a study, which obviously has its inclusion criteria. But this possibility of enrolling a study is only applicable for our centre”. (Int-8)

The Danish experience is quite interesting, since they are piloting a project where testing is conducted in outreach venues, but **results are provided** in the CheckPoint **facilities**. This pilot experience works for HIV and syphilis, since the latest is also proposed to all the clients. Furthermore, there is also the option of getting vaccinated against hepatitis B. In the case of this **vaccine**, an insurance number is asked, so this becomes **a non-anonymous service**.

“There has been a hesitation to test for HIV on-site, but we will certainly be moving forward and also take the HIV test. Experimenting and doing a pilot project. We won't give the results at the venues, but we may do a pilot project later this year on HIV rapid testing in the community, and then they need to come to CheckPoint for the answer. We don't give the syphilis test result face-to-face either. We send an email the day after specifying if your result was positive or negative, and describing in details what to do.

Ah ok. You almost answered this question already, but are there other STI's - beside HIV and syphilis - that you test for? Or do you have other "products" in CheckPoint?

Yes. Almost everyone who comes here asks for both HIV and syphilis test. And then we also offer a vaccination program for hepatitis B. That's a separate program: you can come here without getting tested, but only for the hepatitis B vaccination. For that we do need what we in Danish call the CPR-number, the national insurance number, because the vaccines are ordered through this number, so that's where the anonymity stops.

Ah ok, so you cannot be anonymous, when you're getting this free vaccination?

No, you have to have a national insurance number”. (Int-5)



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Regarding the lack of anonymity, there are other examples, like the Czech one. More in detail, the coordinator explained that syphilis testing is offered in their CBVCT service, but since this test is covered by **the health insurance** an ID document is requested. In his opinion, this loss of anonymity might be a barrier for getting tested.

“As I have mentioned we do, especially syphilis that is emerging problem among MSM. We discuss with MSM symptoms, the ways of transmission. Two years ago we have started to offer syphilis test if it is needed. But it is not anonymous. It's covered by the health insurance and some people because of it reject it”.
(Int-7)

There are three countries that reported **not conducting other STIs tests**: France, Poland and Italy. However, information about places where these tests are available is given to all the clients attending the CBVCT venues.

“Screening or diagnosis for other STIs is not possible with non-medical CBVCT. However the subject of STIs is talked about during the counseling session and the person is referred to other healthcare services where this type of testing is on offer”. (Int-4)

“We would like a lot, but nowadays the law does not allow that”. (Int-2)

“Then another thing that we do is giving everyone the addresses and telephone numbers of the places where it is possible to make tests and be visited for the other STDs, even if I must come back to what I said before: if you really want to get all those tests you need the prescription of the doctor, so...” (Int-3)

Besides, several countries, included Poland, pointed out **attempts of conducting other STIs tests without success**. Thus, the Slovenian coordinator explained that because of methodological reasons syphilis testing could not be implemented. Unfortunately, no details were given regarding which were these methodological reasons.

“We were, however, unsuccessful in broadening the test to syphilis that is relatively common in MSM population as well. For now we stick to HIV and hepatitis B, so basically.
Syphilis failed for financial reasons or?
For methodological reasons”. (Int-1)

As for the Czech Republic, even if their CBVCT center offers syphilis testing, and count with medical staff, there are not able of administrating vaccination against hepatitis B, for example.

“We discuss at the counseling some other diseases usually we speak again about symptoms and ways of transmission. If there is suspicion we offer gay colleague



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of gay friendly colleague from STI clinic. We asked also MSM if they have you been vaccinated against hepatitis B. Sometimes I check the health symptoms because I am the only physician in our team”. (Int-7)

Finally, Poland has tried to conduct HCV detection without success. Like in other countries, anonymity issues appeared when other STIs are proposed. But there is also another barrier; in order to perform this test, medical staff is required, and medical staff is not always present in CBVCT services.

“We made attempts to test HCV in VCTs and many clients were interested so maybe we come back to that idea. Other STI require registration in the monitoring system of infectious diseases and that is the main reason why we do not offer such tests. Additionally, some testing require special blood donation, urethral or genital swab performer by a professional. We could also offer other testing, for example syphilis but unfortunately is has to be registered with the name. Polish law only allows anonymity in case of HIV testing”. (Int-2)

Regarding the **provision of information regarding HIV and other STIs and preventive materials**, we found that most of the centers provide with information (leaflets) and condoms. As for the information, it concerns the places where clients can get tested:

“Well, at the testing location the individuals get pamphlets with condoms provided by associations for the MSM population. The pamphlets contain information regarding possibilities to take tests and then there is some information about associations, programs...” (Int-1)

In other cases, the quantity of information provided is larger. Thus, the Spanish CBVCT provides information regarding a wide variety of issues:

“In our centre, we offer condoms, lubricants, written information on STIs, Post-Exposition Prophylaxis and HIV, and also information about other venues where people can get tested, where they can get a doctor’s appointment, or where they can be treated for STIs”. (Int-8)

Even if most of the participating countries provide preventive materials and information, there are some examples showing that the CBVCT stakeholders have not yet done the drafting of the written materials.

“So, yes, we give some things and soon some materials will be written directly by us”. (Int-3)



Clients. Yes, no, but in any case, it should be done

First of all, we found that **globally, clients had a good recall and a good knowledge of other STI tests** proposed apart from HIV at CBVCT venues. Thus, we found that Danish clients, for example, are capable to name the Syphilis test and the HBV vaccination. Furthermore, they also stated their opinion regarding the need or not to perform other STIs test, like Chlamydia.

“Does CheckPoint offer other kinds of STD-tests than HIV? You know the answer; it’s just for the record ...

Syphilis.

Right, is that good?

- Yes, the more the better.

- If it’s possible add more tests.

More STD’s?

But not Chlamydia, you don’t have to add that one”. (FG-5)

“Do you know other ‘products’ offered by CheckPoint?

Vaccine.

What kind of vaccine?

Hepatitis B.

And how is that? How do you like that offer; a vaccination against Hepatitis B?

Is it for free?

Yes, it’s for free”. (FG-5)

In the German focus group, some participants declared having been proposed a syphilis test. The Spanish clients had also proved a good knowledge of the procedure regarding other STIs tests, even if in the Spanish CBVCT center only HIV and syphilis are offered.

“Is there screening for other sexually transmitted diseases in this centre?

Yes, there is.

And what is the procedure that is applied in this case?

It’s the same for Syphilis (the rapid test in blood), and for all the other girls (laughs) samples from mouth, urine analysis, blood analysis, and an analysis you do in the anus”. (FG-8)

Nevertheless, there is one experience indicating how **people might be accepting tests without having a fully understanding** of which tests have been proposed. This episode illustrates the importance of accurately informing clients about STIs (what are they, what are their symptoms, potential effects, kind of test, results and treatment in case of positive result).



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“Did they at this particular testing offer also testing for other sexually transmitted infections?”

- No.

- No.

- No, I mean hepatitis, that's probably not.

[...]

- I mean, we were tested for hepatitis A and B, or B and C.

- No, for all of them, weren't we not? Well, whatever we were tested for (laughs), we were for four things, definitely HIV and then A, B and C.

- And D.

- D doesn't exist". (FG-1)

As for the Slovenian CBVCT clients, we observed that when asked about their STIs tests in other health settings that CBVCT, **information was insufficient**. Finally, clients indicated that even if anonymity is not possible, they would like to get tested for other STIs.

“- Nobody has recommended this to me... And I don't know about it. I am vaccinated against Hepatitis B... I would admit a syphilis testing and I would even get over my anonymity.

- I don't know about it too. But I would certainly appreciate that option even when I would lose my anonymity.

- I have the same opinion. And I haven't undertaken the syphilis testing yet". (FG-7)

In the second place, we found some situations where **no other STIs tests have been proposed** when attending the CBVCT center. And, thirdly, some clients reported that other STIs tests facilitate **talking about STIs and sexual risk behavior with the counselors**. Participants were aware of the relationship between the risk of acquiring the HIV infection and the presence of other STIs. Besides, Slovenian and French participants declared not having difficulties regarding this issue in CBVCT venues.

“In the course of this testing, did you find it difficult to talk about STDs with the people who offered you the testing?”

- No.

- No.

- No". (FG-1)

“So to summarize, you talked about other STIs when you had your HIV test. Was it easy to talk about these other illnesses with the people who did your test?”

I didn't have much information before, and here I got information and advice.

Did you have any trouble speaking or asking questions?”

No it was fine. The people I saw didn't judge me or change their attitude. I'd even say they're more professional than the professionals in some ways". (FG-4)



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It must be noted, that depending on the place where the HIV test is performed, other STIs tests are proposed or not. Thus, when tests are conducted in saunas, for example, counselors recommend attending public health services in order to get tested.

- “- Yes, actually yes. I was ask to take a syphilis rapid test too. I think that’s good, because STI can be related to another. And it’s efficient; once talking about risk-behavior and sexuality it is a close topic. I’m glad an offer like this exists.
- Not in the sauna, but I was told there is a possibility to get tested for other STI for example at the public health service. I’m not sure if it is necessary, but I would take part - just for sure”. (FG-6)

Intimately related with this former aspect, appeared **satisfaction with other STIs tests at CBVCT venues and other testing settings**. As explained by CBVCT clients, they are not really satisfied with STI screening in formal health setting because of taboo related to “sexual diseases”.

“Are you pleased with the testing for sexually transmitted diseases in Slovenia in general?”

- No, I’m not pleased.
- Why not?
- Because it wouldn’t be a subject of some, it’s not a subject of some problem that would at all echo in public in general, because I think that, that it is, and it’s not a taboo subject but the testing for sexual diseases or STI’s is actually not that widespread, maybe just through the eyes of the society I’m not pleased with it, maybe it’s not emphasized enough, but it’s...
- Rising awareness, maybe?
- Yes, yes, exactly. I’m not pleased only with this method of rising awareness
- But you are with the accessibility, that’s okay, right?
- Accessibility yes, that yes. Maybe accessibility of some anonymous, but that’s.
- I must say that when I got tested at the clinic back then, I really had, I can’t say that I had a bad experience, I didn’t, really, all the workers were kind to me, I didn’t get the feeling of being judged or whatever, by anyone, so that I can’t say, couldn’t say something bad about any kind or way of testing.

And you?

I can say it could be better.

In the sense of what the forerunners mentioned, or?

- Yes, all, the accessibility, I mean, rising awareness, counseling.
- Rising awareness could be better.
- And the procedure itself could be a little less complicated friendlier, quicker I mean, yes”. (FG-1)

“Because when I was getting tested I got some advice, I read magazines. Actually, you go back to square one. Because you find yourself in the same situation or you’re going to be stigmatized in a centre which is not community-based. So you go round in circles. Because you need to go to hospital at some point or other”. (FG-4)



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On the other hand, clients seem to be much more satisfied with other STIs testing in CBVCT venues. This is not surprising given the former results regarding HIV test. In fact we found a similar pattern: STI screening is available, but because of prejudices is not an issue that comes easily in the discussion between a doctor and a patient. For this reason, clients propose to train doctors in order to better tackle sex-related issues.

“Generally speaking, in Spain is the access to other STI tests difficult or easy? I mean, is it easy to get tested for STIs in Spain?”

- No for other infections I don't think it's easy... I don't think it's easy at all.

- Well, I agree with you that it's something normal if you go to the doctor and ask specifically for them. I mean it has to come from you. It's not something they put forward to you... unlike here. Here you have this screening available, but not in your family doctor. In other words I think access is easy, but only when you have symptoms. You go to the clinic and ask for it and they do it for you. With exotic questions included but... (laughs)

I don't rule out either hypothesis.

- Yes. I'm a little bit between these two opinions. Access could be easier...that's true but it's not very complicated either. But I think the problem here is that people are not that used to asking for it as they are for HIV.

- I think that there's not that much awareness and general doctors don't have training for detecting certain things”. (FG-8)

Finally, CBVCT clients insisted in **the need and pertinence of conducting other STIs tests**.

“I think it's something that should be done in a much more matter of fact way. The same as when you go to the doctor to have your blood pressure taken. I think so”. (FG-8)

Two considerations should be kept in mind: 1) paying close attention to the person who performs the test (non-judgmental staff); 2) performing all the tests in one in order to avoid being “itched” more than once.

“No, I wasn't asked to participate in any other STI test or to get information, but I think that would be useful, but the counselor should be no one, I knew from a personal background. And it should be all in-one: I go there for a rapid HIV test, if it's possible to screen for other STI with the same blood – good! If it would be necessary to itch me for each test – no thanks”. (FG-6)

As the French clients indicated, since they already have to give a step forward in order to ask for a HIV test, it would be convenient to conduct other STIs tests. Thus, people would not have to repeat unnecessarily this effort.

“- Yes, you should be able to get tested for everything at AIDES.

- At least hepatitis and syphilis



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- I'd like to know how many people who got this advice would really get tested for other illnesses. I think they'd be apprehensive also. It'd be better to get tested for everything at the same time. The first time you go, you have to bite the bullet and so if you have to do it every time for each illness and each place.... doing it all in one go would be ideal. If you have to bite the bullet 6 times, you'll lose hope.
- It took a while to get it set up here and to be able to the tests. So if we add more things on, which would be great and the logical result of this work". (FG-4)

An interesting comment was done during the Spanish focus group, for them, **STI screening should take place in the same way that many other screening programs** (e.g. mammography for breast cancer screening).

“And do you think that this program for detecting other infections is important? Why?”

- Yes, I think it is very important. These are tests that they don't normally give you in the family doctor. Whereas the HIV test is given in other centers or even in routine blood tests... but this screening here is more specific and I think it's a good idea.
- I think you're right, in other centers under other circumstances these types of tests are given once you have symptoms not by way of prevention.
- And therefore, in my opinion, it should at least be available to everyone who wants it and not just on a pilot program or something like that.
- What's more, depending on the type of behavior or lifestyle shall we say, it would be a good idea that this became a routine almost. For example, older people get their blood sugar level tested once a year, women get mammographies once a year. So I think that this should be part of a yearly checkup for a certain type of people. I think that if you go to your family doctor and ask them to look in your mouth they're going to ask you “Why...not?” or “Have you got something?” The problem is that it doesn't hurt at all at that given moment.
- Yes. But I think that this is something that it's difficult to get access to and even more so now with the financial cuts in the public health system". (FG-8)



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Key points

- ⌘ Other STIs tests are not systematically proposed in the different participating countries.
- ⌘ Hepatitis B test is available in Slovenia and Denmark.
- ⌘ Syphilis test is available in Germany, the Czech Republic and Spain.
- ⌘ Some STIs tests do not allow anonymity (health number insurance is required).
- ⌘ France, Poland and Italy do not offer other STIs tests in CBVCT venues.
- ⌘ CBVCT services provide with information (leaflets, cards) regarding STIs, PEP, HIV and other STIs testing services. They do also distribute condoms and lubricants.
- ⌘ Clients are not always well informed about the STIs tests performed.
- ⌘ Clients declare that talking about STIs allows discussion about sexual risk behavior.
- ⌘ Clients declared not being satisfied with STIs screening in other health settings and consider necessary to perform other STIs testing in CBVCT services.



INFORMED CONSENT

COULD YOU DESCRIBE THE INFORMED CONSENT REQUEST AND PUT IT IN LINE WITH THE LEGAL SITUATION OF SEXUAL MINORITIES, SEX WORK, AND HIV TRANSMISSION?

DID YOU RECEIVE INFORMED CONSENT? WAS IT ORAL OR WRITTEN? WHAT KIND OF INFORMED CONSENT DO YOU PREFER? DO YOU THINK THAT IT IS NECESSARY? WHY, WHY NOT?

Table 6. Informed consent according to HIV-Cobatest Cross-national survey on the Implementation of Community Based Voluntary Counselling and Testing Programmes and HIV-Cobatest qualitative study.

	Czech Republic	Denmark	France	Germany	Italy	Poland	Slovenia	Spain
<i>Informed consent according to WP4</i>								
Is the informed consent required?	Oral required informed consent	Written required informed consent	Oral required informed consent	?	Oral or written required informed consent			
<i>Informed consent according to WP5: CBVCT users' particular experience</i>								
Did you receive informed consent?	Yes	Yes	Yes or don't remember	Yes	?	?	Yes	Yes
What kind of consent?	?	Oral	Oral	Written and oral	?	?	Oral	Written and oral

Coordinators. No legal framework and diverse practices

A first result that must be highlighted is that **legal frameworks** regarding informed consent in the participating countries are quite different. Like this, we range from Spain, without legal framework, to Poland, where there is a very well-defined legal framework.

“Spain does not have a framework which should cover these areas”. (Int-8)

“Every person who is tested for HIV in Poland should give a conscious consent. [...] People who are between 16 and 18 have to agree to get tested and have to have the agreement of their parent or guardian. In case of sexual minorities the rules are the same.

In case of IDU, the counselor talks to such a client to check if that person is fully aware of his/her actions, understands the possible test result, and if he/she is ready to accept it. The addicted who use therapies or stay in specialized centers are also made aware of the possibility of a positive result and they are asked if



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this is an appropriate moment for HIV testing. Sex workers are not discriminated in any way, they have the same possibility to get tested as any other person. Nobody has the right to test another person for HIV without that person's consent. Even if somebody comes and says: "that woman is a sex worker, please test her for HIV" the test would never be performed. The only exception is the situation when we have a rape victim and the aggressor is caught. In that case the court may issue the obligation to test the lawbreaker". (Int-2)

The Italian coordinator pointed out an interesting reflection on the meaning of the informed consent. For him, such a document would be an explicit indicator of a **lack of trust in the staff** performing the test (no matter in which setting, formal or community-based).

"The person must give the consent, this consent protects you from the violations of your privacy, but it is also something paradoxical, because who knows the fact that you get tested or even the result? The health professionals, so this means that we don't trust our health system, our doctors and nurses! In brief, this law protects us from them, or at least this is how I interpret the situation! So in my utopian vision I imagine a test that doesn't need informed consent, but I know it is utopian, because, considered the situation, it is needed!" (Int-3)

Word Cloud 8. Informed consent according to coordinators



As for the actual procedures regarding informed consent we observe that the different participating countries function in very diverse ways. Thus, the Slovenian CBVCT service **does not ask for any informed consent** on the grounds that if someone is coming to a VCT service, the client is necessarily informed of the implications of attending to such a service.

"Well, actually that's not our practice; that's not in our protocol, because we think that anyone voluntarily approaching really does it on voluntary basis. There are no stimulations being advertised, no compensations – it's a personal decision and



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I believe that with the mere fact of taking the test, the person is giving that consent”. (Int-1)

Other CBVCT services ask only for an **oral consent** while doing the counseling and because there is no legal need to do so. Even more, for some coordinators, like the French one, the main **goal of the pre-test interview is to obtain the informed consent**. Thus, informed consent would be the result of rising awareness in the client about the potential effects of the result in his/her life.

“The law does not specify the informed consent. We expect that during client oriented testing is not necessary specific any written procedure because client usually come because he/she wants to be tested”. (Int-7)

“One of the objectives of the pre test interview is to acquire informed consent before carrying out the test. It’s very important to have this when doing rapid tests as the result is immediate. The person must anticipate what the result of the test will mean for their life. In order for the consent to be informed, the person also needs to understand how HIV is spread and how they could have been exposed to it”. (Int-4)

Clients. Oral consent is better

When CBVCT clients were asked about their experience with informed consent, we found that even if in some cases they had a good recall of their oral or written informed consent, there were **several clients who did not remember** signing or being informed. Moreover, some of them confound the informed consent with behavioral questionnaires.

“We were asked that and we answered, we didn’t sign anything”. (FG-1)

“Were you provided with an informed consent?”

Probably

Don’t you remember?

What?

An informed consent, like the one you just signed.

They give us a questionnaire with lots of boxes to tick.

And what about the consent?

I don’t remember

Do you remember (to other participant)?

They explained to me clearly what was going to happen, that I’d get a result. He told me it’d take thirty minutes and he’d be there to talk about it if it was positive. So he told me what I’d have to do afterwards. He told me he had to explain all that first so I’d know, so I’d be informed.

But did you have to sign anything?



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I don't remember if I signed anything. I don't think so, I think he just explained it to me verbally so I'd know what I was doing. He asked me if I had thought about it". (FG-4)

Regarding the preference for oral or written consent, clients expressed distinct opinions. For some of them, **oral consent is a better option because**: 1) the testing situation is quite stressing, which prevents from getting concentrate and understanding a written document, 2) because it is easier, 3) because "the fewer papers, the best", 4) because when there is an oral exchange, there exist the possibility of asking questions and/or doubts; for others, the **written option is better because** the client can read it after the test, since there is people who do not recall verbal information. On the contrary, a main disadvantage for written consent was named: written consent is "traceable".

"I got information written and spoken. Problem for me: I was very agitated, so that reading was senseless for absence of concentration". (FG-6)

"Regarding HIV testing, there aren't a load of choices; it's either positive or negative so I know what I'm doing.

- Maybe it's better to tell people orally than to get them to read something, you can't always understand everything so when someone explains it to you, you can say if you don't understand. But if we leave a form there to be signed people won't ask us any questions. It'll take some people two minutes to read it, some ten minutes, some fifteen minutes. We can explain some things to people if they don't understand and I think they'll remember it better than if they read it on a bit of paper, some people sign without reading what they've signed". (FG-4)

"I was pleased with the written form of the information, because I forget spoken information quickly. Written information you put into your bag and even if you threw it away afterwards, it's another moment to recognize it. I regard this information very important". (FG-6)

"Probably because it's not written, if it was written, then maybe?"

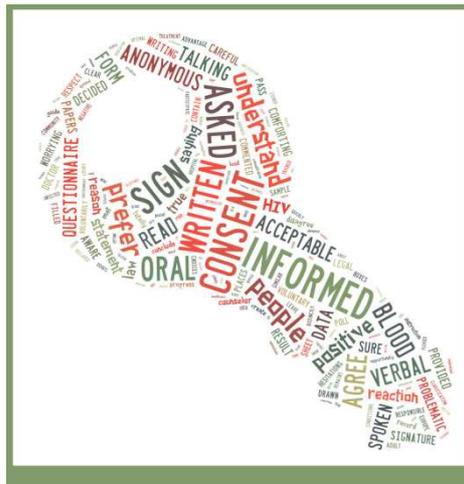
- That's maybe true.

- Maybe because there would be a record". (FG-1)



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Word Cloud 9. Informed consent according to clients



Once clients described their preferences regarding informed consent, they were asked to say if they considered **informed consent necessary**. As the citations below show, clients do not consider necessary the informed consent, but from the moment they start to discuss about this subject, the potential legal consequences of not being informed, particularly in the case of a positive result, aroused. When the legal issue comes into clients' mind, they re-evaluate the necessity of the informed consent and are more favorable to it. In any case, it seems that **informed consent is not a problematic issue for clients**.

“Do you think that the statement itself is necessary?”

I don't think it's necessary.

No?

Unless there's some other law behind this that without your consent, no one can take your sample of blood or do the test, but if that's not necessary then it's not necessary, because you come over there for a reason, right". (FG-1)

“To be informed. At least to be informed, but apart from that, do you think it's better to sign or to accept verbally?”

- Verbally is ok for me

- I don't see any advantage in signing, when you get all the information, you accept. A signature is no use afterwards but the questionnaire could be very useful to go forward and make progress. But for the signature, I don't see any reason for it.

- I don't know what I think about this informed consent; I don't understand what it's for. If you come here to get tested then you're a responsible adult, you know what you're doing". (FG-4)

“And in your opinion do you think that informed consent is necessary and why?”

- I think so. I think that in most cases it's not necessary but I suppose there must be a few cases where someone tests positive and has a bad reaction ... I don't know but something like that. I'm talking more on a legal level... that the



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Association has a proof that it has informed the person... more for those specific cases... in general, it may not be so necessary... I think it's more for that". (FG-8)

Key points

- ⌘ There is a lack of national/regional regulations and/or guidelines regarding informed consent for being tested for HIV in CBVCT services.
- ⌘ According to the CBVCT coordinators oral informed consent is more frequently asked than written consent.
- ⌘ Coordinators consider pre-test counseling as a means to obtain the informed consent.
- ⌘ Clients confound sometimes informed consent with behavioral questionnaires.
- ⌘ Clients seem to prefer oral informed consent to written consent.
- ⌘ Clients do not consider necessary the informed consent, but when legal issues arise they change their mind.
- ⌘ Generally, clients do not consider problematic the informed consent.



THE PROFESSIONALS OF SECRET – STAFF AND CONFIDENTIALITY

WHAT PROFESSIONALS ARE PERFORMING THE TESTS (CONVENTIONAL AND RAPID)? ARE THEY THE MOST INDICATED FOR THAT TASK? WHY? WHO DO YOU THINK WOULD BE THE MOST INDICATED?

The question of what kind of staff should perform HIV testing is, undoubtedly, one of the most important issues regarding CBVCT. Coordinators and clients were asked to indicate who was already performing the test in CBVCT venues, but also who where the persons the more suitable for this task.

Coordinators. Medical staff vs. Community members

Regarding **who does the test**, we observe that most of the blood sampling, when classical test is performed, is done by medical staff (doctor, nurse). Only in the case of rapid tests, we found that trained staff, no matter what background, was able to perform the test.

“A registered nurse does the sampling – here we are completely in tune with institutions – and then there's a doctor, not otherwise specialized in HIV context, but with many years of experience in the field of prevention activities”. (Int-1)

“In a VCT counseling is done by a counselor, tests are made in a lab that cooperates with a given VCT. Both ordinary and rapid tests must be certified by a laboratory diagnostician. So there is a necessity to have a laboratory where professionals sign and stamp the results”. (Int-2)

“No, they all perform the rapid test, but the conventional test - the actual blood sample test (for the confirmatory test, red.) - can only be done by nurses or by doctors, so for each opening night, we always have a nurse or a doctor, so we can do the confirmatory test”. (Int-5)

The legal dimension of who is allowed to perform a HIV test was also named by CBVCT coordinators. In fact, we found that while in some countries there is **no clear information** regarding what professionals can perform blood samplings, in other countries it is clearly stated by the law that positive results can only be provided by a doctor. Thus, we can observe in some case that the **announcement of the positive result** has to be postpone.

“Ok, so you don't know if there is a kind of agreement, even a legal agreement, about who can take the blood test...”

No, I don't know, but... Well, the answer is that I don't know. But common sense tells me that finding anyone for taking the blood samples... First you don't find him, but which would be the sense?



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Yes, but I mean: you don't know if, in general, they required a medical doctor, a nurse, if any kind of insurance is needed...

I don't know. But I think it is an important issue, so later I will give you a better answer. It is something that precedes my arrival for several years". (Int-3)

"The other problem is waiting time. We would be able to give results little bit earlier. But if it is positive it must be given by the physician. It is the law. And there is no physician at the Lighthouse for full time job. So all results are given in one day in a week". (Int-7)

"What is the problem? The problem is that in case of a positive result, by law we cannot communicate this. This is a big problem because obviously the greatest fragility of a person who turns to us is when they need this service but we find ourselves in the paradoxical situation that when it comes to communicating the result, we can't do this, only the hospital can". (Int-3)

As for **who does the counseling**, we find that there are more options than medical staff, and that in most of the cases coordinators indicated the need to train people in order to provide accurate information and support to CBVCT clients in case of a positive result.

"This time we have a student of a later semester of medical school who passed the seminar of HIV prevention do the counseling". (Int-1)

"People who work as counselors in VCTs are specially trained to lead a pre-and – post-test test counseling and they know how to hand out a positive result in a proper way (the National AIDS Centre standards determine who and in what way may obtain a certificate)". (Int-2)



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“In AIDES we only do finger-prick blood sample rapid tests which are carried out by community members, we have absolutely no medical staff. They also do the counseling, there are no psychologists or professional specialized counselors. We feel that the main interest of community-based testing is that it is done by peers who experience the same risks or exposure to risk as those coming to get tested and so there is no judgment. If somebody wants to meet a medical professional or a psychologist we can refer them to places where these services are offered”. (Int-4)

One coordinator also evoked the fact that, sometimes **migrants are more confident** in tests performed by a doctor than by a community member.

“On the other hand especially participants with a migration history feel more value in a test taken by a doctor”. (Int-6)

The confidentiality issue was cited by the Czech coordinator, who detailed that CBVCT staff has to sign an **agreement of confidentiality**.

“Our workers and volunteers have to sign the Agreement of Confidentiality. It's a regular document and it's done for all our professionals and volunteers. Of course it's applied also for all counselors in community based VCT. I, as a medical doctor, have to fulfill medical confidentiality. I think the confidentiality is guaranteed. But you can imagine some people do not believe it because gay world is sometimes full of rumors. Even we don't have any notice about violation of this document”. (Int-7)

The training, but mostly the **evaluation** topic, was raised by the Polish and the Slovenian coordinators. In the opinion of the former, there should be a way of evaluating if people working in VCT services are suitable or not. For the Slovenian coordinator, evaluation is more related to the identification, among those with qualification, of the better “profiles” for conducting VCT.

“There should be an available system of trainings based on the obligatory skills improvement, not on proving that somebody is skillful enough or not. If somebody works in a VCT on daily basis there are methods to check if he or she is good enough or not”. (Int-2)

“Therefore we have an in-house evaluation arrangement which makes them, beside their formal education, otherwise very much qualified for the specifics of the matter and that, I think, is an “addition”, so regarding these profiles slight changes are possible, but in general, this is it”. (Int-1)

A last issue evoked by the French coordinator was that of **work conditions**. Community members involved in VCT are supposed to test people outside the ordinary “opening hours” and sometimes have to work in uncomfortable or



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outdoor environments. This is an important question if quality of services provided wants to be guaranteed.

“As for the negative aspects or at least difficult aspects, I think CBVCT programs can be exhausting for those involved. It’s not very easy to test people all day long or all night long in what can sometimes be uncomfortable or outdoor environments. We have to keep this in mind to make sure we safeguard the quality of the interventions. The other important thing to consider for us here in France is that these programs remain community-based, reaching the people who need testing and not those who are already familiar and comfortable with more traditional settings”. (Int-4)

Table 7. Staff according to HIV-Cobatest Cross-national survey on the implementation of Community Based Voluntary Counselling and Testing Programmes and HIV-Cobatest qualitative study.

	Czech Republic	Denmark	France	Germany	Italy	Poland	Slovenia	Spain
Type of staff	Doctors, nurses, community members	Doctors, nurses, community members, psychotherapist	Community members	Doctor, community members	Nurses	Doctors	Doctors, nurses, community members	Community members

Clients. Community member or professional, it must be trained

A first result that must be noted is that clients do not search to know what the professional background of people doing CBVCT is. In fact, some of them have never before **thought about it**.

“Did you notice if the performer of the test was a professional? A doctor or a nurse?”

Now that you ask, I remember it was a nurse, but I haven’t given it a thought until now that you ask.

Okay, so it really didn’t matter to you?

No”. (FG-5)

“So it’s the impression of the person that matters, not the diploma. Is that correct?”

A diploma doesn’t say much. Take family doctors for instance, it’s their own responsibility how up to date they are, and so they can be more ignorant than a person from the gay community, so it’s more important, what they’ve studied, than what the diploma says”. (FG-5)

However, clients manifest very different opinions about the kind of staff that should perform VCT. Thus, in some cases clients declare **preferring**



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professional staff in order to feel themselves in safe hands and in order to feel more reassured regarding the confidentiality.

“No, but I prefer that the person who take my blood is a medical doctor or a nurse, or at least someone who does it regularly, at least a trained person... Not a simple volunteer of the association who is doing it for the first time without training”. (FG-3)

“Well, we must say that a person... Maybe not very much in the gay community, because it is a very heterogeneous community and maybe people don't know each other... But the fact that a person of the same community takes the blood sample could be dangerous, because when you get tested through a doctor you could be reassured by the fact that he is a stranger, and this helps to keep the secret in your community...” (FG-3)

In other cases, we found exactly the opposite opinion. Clients claimed preferring having in front of them **another member of the community** without medical background.

“Persons who offer the test and who counsel should be member of the gay community. Background of persons who just execute tests are less important to me”. (FG-6)

“Who, in your opinion, is the most suitable for performing such a task? So, a community representative or a medical worker?”

1. Both at the same time.

3. Though for counseling, a community representative maybe also better, because he might know better, the troubles, the problems specifically from this environment, I don't know, he might have more to say than someone who is just well simply some medical worker, right”. (FG-1)

“I think it isn't necessary to be a doctor or a nurse to perform the test, to be honest. And I don't feel uncertain or badly attended because of this either”. (FG-8)

There are even examples of people who declared **getting tested by a friend** and who evaluate this experience as highly positive, since they felt safe because a friend would always announce them the result in a more tactful way.

“For me too it was done by a friend and I didn't mind, I'd prefer a friend to give me the results. I know all the people who do it here. I have closer to some more than others but the person who did it didn't bother me. On the contrary, I wanted it to be a friend. I felt safe, I knew he'd be tactful about giving me the result”. (FG-4)

Even more, there are original experiences like that of clients getting tested by a **nun**. This is not such a surprising result, since there are countries where Catholic



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Church has been very present in the medical setting, and keep being it. In any case, the client concerned was not bothered by this experience, even if a little bit amazed.

“Maybe I was surprised about who took the blood when in XXX the person who did it was a nun (he laughs). I mean, going there and tell a nun that I’m gay and I want to get tested because I had risky sexual behaviors was a little strange... Then, of course, I laughed about it, but I suppose that someone else could have been scared and could have decided to run away rather than getting tested with a nun!” (FG-3)

However, for several clients, getting tested by members of the community raises **important issues of confidentiality**. In fact, clients fear that disclosure of their HIV positive status might occur inside the community if VCT is performed by community members.

“I would feel uncomfortable. I mean, going to get tested with a person who I danced with me the day before or who I saw in the sauna... (he laughs). I mean, it can be a nun, a nurse or a medical doctor, but I prefer to see an institutional person, someone who was put there to make that job professionally and who doesn’t mix with my everyday life... And I also feel more sure about the privacy and professionalism...” (FG-3)

“- No, for me it’s a matter of privacy, I don’t want that in the gay community they know if I’m HIV positive or negative!
- Well, but my expectation is that who does it is also bound to a rule of secrecy and privacy, and keeps the information by himself!
- Oh god, yes, but the doctor can tell you what he wants, but you see him once and after that you don’t see him anymore. While in the community there is a risk of circulation of private information...” (FG-3)

“I think the most negative is that some people are afraid that somebody who is his friend know him that he is probably HIV positive. Some people may be afraid somebody from the Lighthouse can know him and he will see him. Somebody expect that a person who is tested has risky behavior. But we recommend to all MSM to be tested even their behavior was safer. We try to spread this information that every gay should be tested”. (Int-7)

“-And when you know half of the staff and meet people in the corridor; anonymous? I don’t think so. But it’s part of the group, I guess. What is that word again?
- The community.
- Right, the community.
- Difficult word (laughter)”. (FG-5)

We notice that this point of view depends on the local context. For instance, in Italy, where the tests are performed by medical staff, we found that participants



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“Persons who offer the test and who counsel should be member of the gay community. Background of persons who just execute tests is less important to me”. (FG-6)

“And who in your opinion are the most suited personnel for this type of service? Someone from the community or from a medical team? Or is it the same?”

- I think it doesn't matter.

- Neither one nor the other. If they receive some training I think practically anybody can do this.

- Well. I would like to add that it's always good to have a doctor...not necessarily for doing the test himself...but nearby just in case you have any queries which the person who is providing this service may not know how to answer”. (FG-8)

“I had the impression that it was important for some of you, that the counselor was gay like you. So, we're going in a different direction, or..?”

- It also depends, what kind of life you're living. I mean, I'm not in the closet, so it doesn't matter to me.

- I agree, and that's exactly what makes CheckPoint so special. You turn up and then we'll all in the same boat.

- I don't mind that either, it's the counselors, the receptionist. I wish they were just neutral”. (FG-5)

The case of the Czech Republic is a representative example of these different opinions:

“Do you think that the counselors should be professionals (doctors, psychologists, social workers) or trained amateurs are sufficient?”

1: I think that in this case the professionalism is better.

2: Hum, I think that some trained personal staff would be enough.

3: Due to my experience it's better fifty-fifty”. (FG-7)

For clients, the **“medical” aspects of HIV testing are very simple**, not requiring the presence of medical staff.

“Because there is basically nothing to it. The technical or “medical” part is very mechanical. It's very simple. They prick your finger... a drop of blood and there's practically no more to it. And as far as counseling is concerned I think if you are properly informed or educated... for example the first time I was with Ferran who isn't a doctor I didn't see any difference. There was no problem at all. One is not going to talk about an illness anyway... complaining that one doesn't feel well and so on, so I think medical expertise is not essential”. (FG-8)

In any case, no matter what kind of staff performs the HIV test, what clients clearly state is that **training** is necessary:



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“I think there’s a lot of hard work to fulfill all regulations. I don’t know, if there are any regulations for staff, but in my opinion they need to be trained in communication and of course in expertise of HIV and sexuality”. (FG-6)

“They could have some training like how to work with these people when something happens. And they should have some psychological knowledge”. (FG-7)

“- Yes but it’s important to have someone to provide medical information and nursing... isn’t it?

- I think it’s basic that the people who are going to perform the test, to offer the service to users be well trained and informed beforehand. And also people with patience (laughs)”. (FG-8)

To sum up, we can use the words of this German participant who states that **staff should be persons who:**

“a) Know about their work; b) have been educated and c) should have fun in what they’re doing. I met counselors, who were really good in what they did, that calmed me”. (FG-6)

Key points

- ⌘ According to coordinators, in 6 out of 8 CBVCT centers, medical staff performs the test while community-members do the counseling.
- ⌘ Coordinators have divergent opinions about who (medical staff, community-members without medical background, or both) should perform VCT.
- ⌘ Coordinators indicate that staff should be evaluated, trained in order to perform VCT, but also well cared since it is a hard work.
- ⌘ Clients have very different opinions about who should perform the test: a professional, a community-member and/or someone neutral independently of his/her background.
- ⌘ However, clients raised confidentiality issues regarding being tested by a community member. They express worries as for potential disclosure of their serology or sexuality.
- ⌘ Whatever the background of staff is, according to the clients, CBVCT staff must be trained in order to assure a quality VCT.



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COUNSELING: THE ART OF TALKING

DID YOU RECEIVE COUNSELING WHEN YOU WERE SCREENED? WHAT DO YOU THINK OF THIS COUNSELING? WAS IT ADAPTED TO YOUR SITUATION, TO YOUR NEEDS? DO CBVCT IN YOUR COUNTRY FOLLOWS STANDARDIZED PROCEDURES/GUIDELINES?

Strongly related to the staff was the issue of providing counseling and what kind of counseling during the HIV screening. The clients asked about their experience with counseling, started by providing a definition of what did they believe that counseling is.

“Counseling obviously means psychological support and support in a group, like self help groups”. (FG-3)

Word Cloud 12. Counseling according to clients



This conception of counseling is quite psychological. However, when CBVCT coordinators discussed about counseling, we found that they had a characterization closer to the description given by the related literature.

“Counseling is not just naming all information; it’s more about listening and responding to the participant and his needs”. (Int-6)

As stated during the previous sections of this report, the issue of **“counseling” and not “moralizing”** or giving instructions of what and how they must have sex is a very important question. Thus, we found some quotes regarding this “moralizing” and judging aspect of counseling provided by medical staff.

“But all the times I went and I found this doctor with a beard, and he said: “all, let’s have a look at what we have here... Are you gay, right?” (He laughs). I said “yes” (he laughs) but I have to say that could think something bad about this... Then he asked me: “did you do something risky?” And I said: “well, yes...”, and he answered: “ah, bad, bad, bad! Certainly something happened!” And, well, he



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had this kind of paternalistic attitude, as if he wanted to scare me, or something similar, but, a except from this, when I went to get my result there was another doctor who said... He also did a minimum counseling, even if the result was negative and they were... However, it was funny when my friend went in after me, and the doctor said: “do you have drug problems?” But he didn’t! (He laughs)”. (FG-3)

“When I had a test, I could have summed up everything you’re not supposed to do, so I don’t think I needed counseling, at least not about facts. What I needed was some advice about my behavior. And when you say counseling it sounds like: “You’re not supposed to fuck without a condom; you are not supposed toballs!” But it’s about my behavior – I know what I’m not supposed to do, I just do it anyway. Can you cope with that in 20 minutes – we all know what we shouldn’t. I just don’t know you can move people”. (FG-5)

“Of course I felt judged. First of all I got a form that I could fulfill, but it wasn’t compulsory. I did and all the questions aimed on risk I guess. Next was the talk to the counselor, who read through the form and looked for my highest risk. We talked a lot about it, what occurs absolutely new to me. I discovered new ways of risk management during the talk. It was very good. He responded to my thoughts and questions”. (FG-6)

Another issue regarding counseling is that of medical counselors who provide **“opinions” instead of accurate information**. This kind of performance generates a strong distrust among people getting tested for HIV. In other cases, clients declared **not having received any counseling** but just medical information.

“Do you remember if anything was said about your HIV status or your risky behavior?”

- No, not about my status. “From what you tell me, I don’t think you’re positive.”

- I think – if this counselor had been mistaken, it would totally have undermined this person’s credibility. Maybe you don’t think about it, but if somebody keeps saying: “I don’t believe you’re positive” – “I don’t believe you’re positive” - It’s the same at this clinic - Now, there’s professional secrecy, yes – but the impressions is, he’s guessing.

- I feel the same way. When I was in the clinic – it’s probably a couple of years ago – if I had experienced the same as you did; at that time I didn’t have any idea about being HIV positive or – so it was – I experienced somebody who said: “I don’t believe you’re HIV positive”. But then again, I don’t think – I think it’s good to be reassured – again, if you don’t know a shit about being HIV positive and so on, it can be comforting; one thing is being sweaty and nervous, I think it’s comforting – those 20 minutes is a long time”. (FG-5)



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“What do you two think; well, you haven’t said, what were your experiences with the doctor’s counseling?”

Oh, the doctor’s? Yes well, basically she interprets the data, what’s it all about, I know she checked the result, she asked, I mean, she said that everything was good, she also asked me, if I’d like to know anything else and it was like that, well, over quickly”. (FG-1)

When **coordinators** were asked about the existence of guidelines for conducting an adequate counseling, we found, once again, very different situations in function of the different countries. Thus:

1) In Poland HIV counselors must get **a certificate in order to perform HIV VCT.**

“Yes, they are more and more clear and they have changed in recent years. Some years ago we had a clear procedure that there was one exam, after the exam you got a certificate valid for several years. After some years you came to prolong it and to check your professional skill. After the second prolongation you received an indefinite certificate. But some years ago it changed and now there are no unequivocal principles on the validation of your certificate and who receives it, how the exam should look like, because this changed as well. Some people are given particular certificates. It is not OK, because there are people who study on their own, attend conferences, who are experts in different places or they specialize in infectious diseases and directly work with the infected but they do not receive indefinite or particular certificates but they have to prove the level of their knowledge over and over again”. (Int-2)

2) Germany and the Czech Republic reported the existence of **guidelines for counseling.**

“Yes, there are guidelines; the whole work is much defined structured, including methods to be used in counseling talks, up to regulations to organize. For example, given standards for the counseling and test caravan; standards given by the local organization; standards given by the regional organization, standards given by the public health authorities; many public organizations that build a gantry of standards and regulations”. (Int-6)

“I could say we do it. Officially there is a booklet of HIV counseling, it is a little bit older, but we can say it reflects the most important knowledge. I think we are some who provide any counseling at all”. (Int-7)

3) France, where there are no special standards or guidelines regarding counseling and testing, has decide to write its own guidelines and to create a **specific training** addressed to all those willing to perform HIV testing.

“Legally there are some standards to comply to regarding the procedure but for now there are no real guidelines. However, AIDES has written its own guidelines



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“There is no counseling so in many cases a patient is aware that it is today’s result and has no idea of the window period. Unfortunately, frequently the results are given out in an envelope so their interpretation may be erroneous. Many people think that negative result is a bad one, but we know that in case of HIV negative means no infection. When counseling does not take place patients are not able to understand the result, they have no idea about the window period, in the end the results are not credible.

We observe a shortage of professionals among health service staff. Professionals who would talk with the client about the risk of infection, about the window period, who would be acquainted with HIV testing rules and how to give out positive results in a proper way”. (Int-1)

Another important subject discussed by some coordinators was the **post-test counseling**. For them, post-test counseling is, when HIV result is negative, the most appropriate moment for discussing about sexuality and other sensitive issues, since clients are more relaxed and familiarity is easier to establish.

“I said precisely that the positive side is that the pre-test counseling, and even more the post-test counseling, where users are more relaxed after seeing the result, it is a moment when they open themselves a lot, they tell you about their concerns, I make a lot of questions ... That is, a lot of familiarity is created. Then they are more relaxed, so they might go into details about their doubts on the transmission of the virus, they ask about the penetrative intercourse, anal intercourse, in short, they make all these questions and talk about many things. Some of them make also questions about the HIV status, what are the medicines...” (Int-3)

Nevertheless, it must be noted that some participants, (mostly those coming frequently to CBVCT sites), declared already having information about most of the topics dealt with during the counseling sessions, and **not listening carefully** to the counselor anymore. These clients would like to benefit from more personalized counseling. In any case, they recognized the importance of counseling.

“What do you think about this counseling?”

- Well, maybe for someone who’s there the first time, it might be good to hear some things, otherwise I think, well, I don’t know, if you come there repeatedly and hear the same thing over and over again (laughs).

- Yes, I’ve heard it so many times that I forgot what we were talking about, but for someone it’s essential, right, ok if you repeat the procedure for the eight time, well in my opinion, it was my fifth time there now, at the testing and I actually don’t hear it, in fact I’m not even listening anymore. I have to pay attention for when I have to give my consent.

So, you’re saying that this is something that’s very much the same, something that the counselor just, let’s say, rattles off.



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- Maybe he must say it, yes. I don't know, maybe if I'd ask him something, if I needed any information about it, it's definitely welcome that a counselor is present, right". (FG-1)

Even more, in some cases clients declared not willing to have a risk evaluation of their sexual behavior.

"What you're saying is: Some would like to have a risk assessment and some don't.

- It's not a crucial point.
- It's good to be confirmed.
- It's the ethical – you should relate to that". (FG-5)

For some clients the question of receiving or not a post-test counseling is not even under consideration, since they believe that a good way of improving CBVCT services would be to provide results in the Internet in order to avoid a second visit to the CBVCT service.

"They probably don't inform you that the test is there, because they don't have your data, right, well you get a code anyhow but if there was a chance to look it up on the internet, that would be great, because these information are still stored somewhere under some number and no one knows it's you, while you have 24 hours a day, I mean, access to your result, right". (FG-1)

A final interesting aspect, even if quite singular, is the cultural dimension of counseling. Like stated in the citation below, being counseled by someone of another origin can be a facilitating factor for discussing about sexual behavior. At least, this is the experience of one migrant client reported during the present study.

"So you were able to talk about your sexual behaviors in Africa?

Yes, because he was a foreigner, he was not Senegalese. He was a foreigner who came to perform the HIV tests, with secret and targeted to homosexuals, that's why I risked telling the truth.

And what kind of test was is?

A rapid test, with finger prick". (FG-3)

Besides, in function of the different cultural context we might different approaches to counseling.

"I didn't have so many experiences in my life, because I did it only three times, one in Africa and two here in Italy. And I think that when I did it here I felt more comfortable than in Africa, because in Africa they scared me a little bit, they asked me so many questions, while here they didn't ask anything, they didn't ask anything bad...

What do you mean?



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Well, they didn't make me feel guilty, they were gentle with me. While in Africa they scared me a lot, because they asked many frightening things". (FG-3)

In any case, CBVCT clients consider in most of the cases that their counseling experience in CBVCT devices is satisfactory, mainly because there is not a judgment on the sexual behavior and because information is individualized.

“What did you think of the counseling? Was it useful?”

It was personalized which is important I think, not getting general information you can get anywhere, but getting information which corresponds to you personally. So I was satisfied with that. It wasn't generalized.

Were you able to ask questions and talk about any doubts you have?

Yes absolutely

And you didn't feel judged?

Not at all". (FG-4)

Key points

- ⌘ Counseling is understood in different ways: providing the result, giving medical information, and psychological support.
- ⌘ Counseling is not about explaining “how to do” but about “how to do it better”.
- ⌘ Regarding procedure/guidelines very different situations exist, ranging from nothing at all to the request of a certificate in order to provide counseling.
- ⌘ Some community-based organizations are capable of creating their own guidelines and training.
- ⌘ Post-counseling is an appropriate moment to talk about sexuality and sensitive issues, in case of a HIV- result.
- ⌘ Globally, clients are satisfied by the counseling provided by CBVCT services.
- ⌘ Some clients did not received counseling in the formal health settings.
- ⌘ Clients prefer an individualized counseling.
- ⌘ Clients who often have a test prefer, in some cases, receiving the results by the Internet: they are not really concerned about post-test counseling.
- ⌘ Clients and coordinators did not really spoke about post-test counseling for HIV positive people.



EVALUATION, SATISFACTION AND IMPROVEMENT OF CBVCT SERVICES

HAVE YOU ANY MEANS TO KNOW THE SATISFACTION WITH CBVCT IN YOUR COUNTRY? WHY? HOW IS SATISFACTION MEASURED? WHAT FOR? ARE THESE RESULTS USED TO IMPROVE THE SERVICES? ARE THERE ECONOMICAL MEANS, HUMAN RESOURCES TO IMPROVE THESE RESULTS?

One of the main sources of information for establishing good practices is using the experiences of CBVCT users and staff. They are the people actually in contact with these services and have a privileged perspective for identifying aspects which are already positive and efficient, and those which would need to be improved. But, in order to have access to this source of information CBVCT programs must use some tools (e.g. questionnaires, interviews) to assess the level of satisfaction with the services provided in these CBVCT sites.

For this reason, we decided to ask if there were any means among the participating countries for evaluating satisfaction, and if the answer was positive, we asked which form took this evaluation of the satisfaction.

Coordinators. Lack of systematic evaluation, lack of funding

The main results concerning the answers provided by 7 of the 8 CBVCT coordinators show us that even if all of them conduct some kind of evaluation, most of their services have not really implemented a systematic way for measuring clients' satisfaction. Nevertheless there are some countries describing a very systematic measurement of satisfaction. This means that we find **examples ranging from just informal conversations to Internet questionnaires.**

“We're holding informal conversations with participants, in particular with those that we know and that are willing to engage in such informal conversations. [...]. Based on the users' opinions we're changing the procedures”. (Int-1)

“We don't have any official evaluation [...]. We have some feedback from some clients in bars, sometimes from our friends. So that the people give us feedback and sometimes very critical to us”. (Int-7)

“We got a form to evaluate. Some questions on a sheet of paper the participants are asked to fill in. Evaluation in the past was good, we got high acceptance, we are well known. We reach a big part of gay men, for example young, unemployed, immigrant but also rich, well educated, old – a big gauge”. (Int-6)

“You may find a questionnaire on the National AIDS Centre Web page to be filled in by a VCT client. Every person leaving one of our VCTs gets this



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information on a separate piece of paper. We also browse Internet portals where people exchange opinions on HIV testing and we look up for information about our VCTs. We also get information directly from our clients, for example from those who come back to us and tell us that they would like to get tested in our VCT because they feel comfortable here. Since several years clients who have filled in the questionnaire for statistic purposes answer that they got to know our VCT from friends. That tells us an important thing: the service we offer fulfills its purpose. Sometimes we get mails that contain positive or negative opinions on our VCT". (Int-2)

As for those countries where no satisfaction assessment is done, **indirect measures are chosen** as a way of evaluating CBVCT satisfaction:

"Hopefully increasing rate of clients from MSM community can be our measurement". (Int-7)

"I have to say that in the majority of cases, they come back when we are here and that's good thing because it means that the service has worked. That is, after having talked to us before doing the test, they want to have another session with us and I believe that this is a sign that the service works". (Int-3)

Other countries have conducted satisfaction assessments but only for a limited period of time or conduct a **randomized evaluation**. In both cases, coordinators express their wish to systematize this satisfaction assessment. However, and as described by one of the coordinators, financial support is needed for implementing this evaluation.

"We know about user satisfaction from a self-reported questionnaire. Every time they come to CheckPoint, the users are asked to fill in a questionnaire about why they chose to get tested, why they chose CheckPoint, how or where they heard about CheckPoint and they can add any feedback about their general experience of CheckPoint. So we have a very good idea about what users think of the CheckPoint facility, but we would like to do a more in-depth questionnaire or survey on user satisfaction in the future. [...]. As a pilot project in the autumn of 2011, as a follow-up after they visited the CheckPoint, so maybe 2 or 3 days or a week later, we contact them with 10 questions. You know an online questionnaire or a phone call, so that they have reflected a little bit about "how was it". Because what we get out of the questionnaire they fill out today is something they write on the actual evening. Maybe sometimes people reflect and give it another thought, when they've slept overnight. But as I said before, we have a very good idea, and people are very satisfied with the CheckPoint facilities". (Int-5)

"Scaling up CBVCT is quite recent and we do not have the means of assessing it yet, except for the fact that we need more funding". (Int-4)



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“In our centre, an anonymous satisfaction survey is performed randomly to find out the satisfaction of our clients. On the other hand, CBVCT should take very seriously when a complaint arrives to the centre”. (Int-8)

One interesting aspect mentioned are the potential **negative effects of social networks**. Since these networks are an important source of information for some hard-to-reach populations targeted by CBVCT, one coordinator emphasizes the need of being particularly careful of complaints expressed by CBVCT users.

“Nowadays, with social networks if CBVCT is not working well, this information will be very fast disseminated”. (Int-8)

A very interesting result was that of one coordinator who questioned the kind of evaluation that should be conducted. For him, it is much **more interesting to ask about alternative ways of providing a service than asking about the quality of the service provided**. However, this comment is partly due to the negative effect of generating doubts on the work done by counselors. In any case, this quote shows the importance of the dimensions which are considered as the most relevant when satisfaction is evaluated.

“I personally don't think it's necessary, because people want to take part in our offer, so they are satisfied just because it exists. Perhaps we should not ask: “Did we a good job?” but ask: “Should we do it more often or somewhere else?” And maybe a question likes: “Did we a good job?” could cause doubts in our profession”. (Int-6)

Finally, it is also mentioned that no systematic evaluation is offered to **people working on CBVCT programs**, even if CBVCT staff could be considered as one of the best sources of information on what should be improved in such services. This lack of interest in the staff opinion is interpreted as an insufficient support for health authorities.

“I just wished for more support by authorities and more continuity. A special evaluation for us, team members does not exist, but we are always able to say what we think or would like to improve”. (Int-6)

The Slovenian coordinator detailed, how they perform staff evaluation in order to change operating systems, even if this depends only on the coordinator's personal decision.

“Somehow we're trying, I as a coordinator am trying, to make sure that key things are modified, although protocols aren't being written down. Or right now we're working on writing down as many protocols as possible. I gave that task to everyone, to really describe all the ambiguous, unclear situations in writing, because that's one of our methodological reactions in this phase of the project - to



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“If we had those resources (but we do not) we would invest in increasing qualifications of our counselors and in different trainings offered on regular basis. [...] If we had more money we would invest in better analysis of the questionnaires that are filled in VCTs, both statistical ones and epidemiological ones. They form a very interesting source of information. Thanks to them you may check the most common profile of a client and prepare the counseling specific for a given kind of group. [...] Counselors employment rules should be changed. At the moment, many people give up the moment they see how it looks like. For sure, it would be good if more people get tested, however, the present number of clients fits the number of VCTs and their opening hours. VCTs have great potential and it is not fully used. Our counselors are very well trained, they are fantastic professionals who could work more hours but we have money barrier. VCTs financed from the minister of health budget should be financed from prevention unit but should be treated as a system. For example, it should be a minister of health obligation to run such VCTs that offer defined services, opened 8 hours per day just like any other health units. In that way, access to VCTs would be easy and clients would have no problems to get tested”. (Int-2)

“But in terms of the users who request improvements, some of them would like to have the opportunity to test for other STI's, Gonorrhea, Chlamydia or Hepatitis, we can't at the moment implement that. But we've put it in the idea box, and if we get funding for it, that could be an option. Another thing we're looking into is having a counselor on hold or on call for those evenings where we have a lot of people sitting in the waiting room. So yes, we listen to what they say and we try to implement it, after we've talk with the counselors about it”. (Int-5)

“It's very difficult. Because the average salary in our NGO are deeply under average income in Prague. [...] They are very good but if we would be very critical we could lose them. There are no crowds of potential volunteers waiting for the work in our NGO. And you can't hire a new volunteer only you need to educate him. Many of them are students and when they finished study we lose them. I think we have for money we can offer people with very good quality”. (Int-7)

Clients. Evaluation allows insight for improving CBVCT

Overall, CBVCT clients' **expectations are fulfilled and sometimes exceeded**. They declared having finally found a place where they can talk freely with someone close to them, obtaining information thanks to the prevention materials distributed in the CBVCT venues, having the possibility of getting freely and easily tested (time, anonymity) and in a warm environment (nice decoration, empathetic staff, non-judgmental setting). All these points were emphasized when people were asked about the main positive aspects of CBVCT services.



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On the contrary, there are other clients who clearly remembered the way satisfaction was evaluated and who have expressed their opinion about the role of evaluation.

“Yes I think it was actually quite precise. Yes there were five or six criteria with an evaluation scale”. (FG-4)

For them, **it is a meaningful way of improving CBVCT services and of having an insight into the evolution of the program** (in terms of targeted populations for instance). They point out the mutual interest of such an approach; on the one hand, users have the opportunity of expressing the difficulties they encounter (if it is the case), and on the other hand, the staff has access to feedback about their work and about the provision of other possible services.

“Do you think it’s important for you to measure your level of satisfaction with such an experience?

1. Yes because then if there’s a problem, it can be sorted out, we can move forward, we can say so. It helps the staff to improve things”. (FG-4)

“Do you think that it is important to evaluate this kind of services?

Actually the volunteer asks me, if I felt all right or if I could make suggestions for an improved CBVCT. I think that is a great proof for the service and user orientation of this project”. (FG-6)

“I think it is good, because maybe in time, in several years, it will give some important results, it can show how this is developing forward, which area isn’t covered well, where would it be good to maybe do something more, so that I definitely think it is good, yes”. (FG-1)

One German client made an interesting comment on the meaning of evaluating satisfaction. For him, the mere existence of such a service is already fundamental for the community. This **gratefulness could result in a willingness to say anything negative about CBVCT**.

“I don’t have an answer really, because I can’t compare. I support everything, that’s an offer to the community. I’m just grateful to be able to consume something in my community, by my community. I can’t remember if I was asked about my satisfaction – I’ve been so nervous”. (FG-6)

To sum up, we observe a high level of satisfaction with CBVCT services and programs, but we must keep in mind that there is undoubtedly a **selection bias**, since people participating in the focus groups were often frequent CBVCT clients. It would be extremely interesting to get information from people who are not satisfied or who are reluctant to use these kinds of services. Once again we have



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to analyze these opinions in line with different national contexts; people could be expressing opinions according to what they believe they are supposed to say.

Key points

- ⌘ According to the coordinators, 7 out of the 8 participating centers do not perform a systematic evaluation of clients' satisfaction with the VCT. Indirect measures are used.
- ⌘ Some coordinators express inconveniences with evaluation (they feel evaluated themselves).
- ⌘ Coordinators state that their opinion would also be useful in order to "evaluate" the CBVCT service.
- ⌘ Coordinators report insufficient financial resources for improving CBVCT services.
- ⌘ Clients report that expectations are fulfilled and sometimes exceeded.
- ⌘ Some clients feel so grateful that they do not wish to "evaluate" CBVCT service, while others consider that evaluation is a meaningful way of improving CBVCT services.
- ⌘ It would be interesting to know the opinion of those who do not come, or who do not get back to CBVCT services.



CONCLUSION

This last section of the HIV-COBATEST qualitative study aimed to characterize the functioning of CBVCT services and programs in order to have a detailed knowledge of the different already existent European experiences. Thus, these results will be a rich source of information for the creation of a European code of good practices regarding the implementation of CBVCT.

As all the advantages of CBVCT, in comparison with other HIV testing settings, were detailed in the previous section, it was decided that for this part of the qualitative study those aspects which could be improved or which suppose a barrier to get tested (e.g. fear of being “outed” because attending a CBVCT venue) would be treated in detail. In our opinion, having a thorough knowledge of the weaknesses of the participating CBVCT services, is the best way to anticipate and to prevent them (when possible) when new CBVCT services will be implemented.

First of all, we asked about the CBVCT services promotion in the different participating countries. Most of them declared using several means for communicating: flyers, posters, banners, virtual social networks (e.g. facebook), but also conducting outreach activities. No problems regarding the contents of these materials were declared. As for outreach activities, coordinators declared that they were not always supported by gay bar owners and that the targeted population is not always receptive to this approach. In fact, it was the last source of information cited by the clients, who have learnt about the existence of the CBVCT mainly by other people and by the Internet. Community mobilization was rarely evoked as a means for promoting CBVCT.

In the second place, the location and “opening hours” topics were discussed, since both of them are extremely important if the goal is to reach “hard-to-reach” populations. As for CBVCT locations, it was found that choosing between a mobile, fix or mixed strategy depends on the national regulation (e.g. HIV test cannot be performed in outreach venues) and on the financial situation of the CBVCT services (e.g. employees or volunteers). Mobile and fix venues represent advantages and inconveniences depending on the needs and/or fears of clients. In any case, clients declared that the ideal fix venue is a location well communicated, friendly decorated but not too visible from the exterior. Regarding mobile VCT, it was clearly stated that it is a major way of reaching people that otherwise would not get tested (“opportunistic testers”), even if in some cases other clients will be troubled by getting tested “in public”. Finally, even if fix or mobile strategies for testing are developed, and even if it is clear that a wide offer increases the likelihood of reaching more people, there are still populations that remain unreached (e.g. homeless).



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As for the opening hours, clients agreed that there is a clear need of increasing the opening days and hours of CBVCT venues. For them, it is essential to have access to these services outside the working hours. In this context, the issue of auto-test emerged as a solution to this lack of access to CBVCT services.

A third aspect discussed was that of the kind of HIV test performed and the screening of other STIs. Results show that the technology used depends strongly on the kind of staff and on the national regulations concerning HIV testing. Thus, some CBVCT services do not provide rapid test because only doctors can announce a positive result, and prefer to do a classical test in a fix venue. Besides, and regarding rapid tests, we found that some coordinators are not confident in the reliability of the result, while others declare that this test is reliable and facilitate outreach testing. In any case, clients expressed an important level of satisfaction with the rapid test, since for them, the possibility of reducing the waiting time is a major issue. Here again, the issue of auto- test emerged as an alternative to HIV testing sites, nevertheless, clients declared that training in auto-test would be welcome.

Regarding other STIs, very different situations were found among the participating countries. Some countries are not allowed to perform other STIs (France, Poland, Italy) while others do syphilis screening (Spain, Germany and Czech Republic) and/or hepatitis B screening and/or vaccination (Slovenia and Denmark). A potential barrier to this STI screening is that in some countries anonymity is not possible for that kind of tests. In any case, for CBVCT clients it seems necessary to increase this offer in order to avoid multiplying their visits to different centers. A global sexual health approach would be much more convenient.

Fourthly, and as for the informed consent, a lack of legal framework is manifest. The different situations on the participating countries range from some rare cases with a very strict legal framework (e.g. Poland) to its complete absence (e.g. Spain). The CBVCT clients have, in some cases, difficulties to differentiate the informed consent of the behavioral questionnaires administrated during the pre-test. In any case, they seem to prefer an oral rather than a written informed consent and believe that providing information about the consequences of performing the test is not problematic, particularly in the case of a positive result.

In the fifth place, there is the question of the CBVCT service staff. Once again, there exist very diverse configurations among the participating countries. While some CBVCT services are highly medicalized (e.g. Poland or Slovenia), others have a good mix among medical-staff and community members (e.g. Denmark) and others do only work with community-members (e.g. France and Spain, even if these two experience do not share the same definition of community-members). When clients are asked to indicate who, in their opinion, are the best



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suitable persons for performing VCT, it is impossible to find a consensual answer. There are as many opinions as people answering the question. However, it must be stated that one important barrier for the clients was confidentiality issues as a consequence of getting tested by someone else of the community. In any case, it appeared clearly that staff (with professional background or not, community member or not) must receive a specific training in order to offer a quality service. Other issues that aroused concerning the staff, was the necessity of taking good care of them, since they are exposed to difficult situations and do often work in non optimal conditions (e.g. schedule, outdoor venues).

Intimately related to the subject of staff was that of counseling. A first result is that clients and coordinators did not discuss about counseling targeting people obtaining a HIV positive result. In part, this can be explained by the fact that when there are positive results, CBVCT staff is not allowed, because of legal reasons, to announce the result. In any case, it is an issue that should have been more discussed. Definitions of counseling were not the same for the people participating in this study. In some cases a psychological approach appeared, in other cases, people insisted more in providing information about risk reduction strategies, information, without forgetting to clearly explain the meaning of HIV the "positive" and "negative" result. As for clients, most of them reported lack of counseling in their previous experiences or compulsory messages regarding their sexuality ("you're not supposed to..."). Regarding the existence of guideline for conducting counseling, there is a wide range of situations: while in Poland you must get a certificate, in other countries like Italy there do not exist any protocols. Interesting experiences were reported by the Danish and the French coordinators, which detailed the creation of guidelines, training and internal evaluation in order to conduct an adequate counseling service. Finally, it must be stated that clients are not always interested in receiving counseling. In some cases they prefer to receive the results by the Internet, or not doing risk assessment of their sexual practices.

Finally, the topic of evaluating the level of satisfaction with CBVCT was discussed. There are no systematic evaluations of the level of satisfaction with the services provided. Some coordinators feel uncomfortable with the idea of evaluating the level of satisfaction because they would not like to be "evaluated". Others consider that it would be pertinent to conduct evaluation of the service also among the CBVCT service staff. As for the clients, they claim that their expectations as to regard to CBVCT services are fulfilled and sometimes exceeded; nevertheless, they believe that evaluation is a meaningful way of improving these services.



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Regarding the creation of a code of good practices, points that should be dealt with are:

- The means (posters, flyers, Internet, social networks, outreach) and funding for promoting CBVCT services.
- The need of involving community members in CBVCT services promotion (e.g. gay bar owners).
- The importance of getting an adequate location for the CBVCT venue (well communicated, not too visible, friendly decoration).
- The awareness that the better way of reaching people is offering VCT in all its possible forms (e.g. mobile VCT allows to reach "opportunistic testers").
- The awareness that even if VCT is largely proposed, there are always populations who remain untested (e.g. homeless).
- The need of proposing adequate opening hours and days.
- The fact that in some countries, Western-Blot can be performed in CBVCT settings.
- The intimate relation between national HIV testing regulation and 1) the provision of rapid or classical test, 2) the need of specific staff to provide positive results, 3) the place where HIV test can be performed or not.
- The need of being confident in the technology used (e.g. rapid test).
- The need of thinking about the strategic objective: reaching targeted populations (e.g. rapid test).
- The fact that even if a long waiting time can be acceptable, clients prefer getting their results rapidly.
- The fact that auto-test is an emerging issue, since it is an alternative to other HIV testing settings.
- The pertinence of proposing other STIs screening (even when there are anonymity issues).
- The need of informing accurately clients about the STI screened.
- The need of providing prevention information and materials (condoms, lubs).
- The knowledge of different legal frameworks regarding informed consent.
- The need of providing accurate information about what an informed consent is.
- The fact that oral consent seems more acceptable than written consent.
- The fact that there are very diverse opinion about who is the appropriate person to perform the tests (professional or not, community member or not).
- The need of training staff in order to offer a quality VCT service.
- The fact that being tested by a member of the community can raise important confidentiality issues.
- The need of counseling guidelines.
- The fact that some clients are not willing to receive post-test counseling.
- The fact that even if clients declare that their expectations are fulfilled, they consider than evaluating their level of satisfaction is a meaningful way of improving the CBVCT service.
- The fact that evaluating the level of satisfaction can invite not also clients but also staff.
- The fact that sometimes conducting an evaluation, if the financial resources are scarce, will not allow improving, *de facto*, the CBVCT services.
- The fact that obtaining information of those who do not attend these CBVCT settings would be really interesting.



Final comments

- ⌘ The “HIV-COBATEST Qualitative Study” (WP5), whose results have been presented in this report, aimed to identify different European experiences and practices in the implementation of community-based voluntary counseling and testing (CBVCT) services and programs. The very nature of this study and its goal explains the choice of presenting highly descriptive results. The materials and the diversity of situations do not allow a more analytic presentation of the results.
- ⌘ The information collected during the conduction of the present study has resulted extremely rich and varied, even if there are methodological limits. Thus, a Code of Good Practices for the implementation of CBVCT services and programs will be developed based on the results of this study.
- ⌘ As the results already presented show, it is not possible to present a “typology” of CBVCT services, but a description of what is being done in each particular country, under different legislations, with singular societal and historical backgrounds. However, even if the eight participating countries described diverse experiences, there are several main issues that emerged and that concerned all of them. This means that these are the variables to work with on the Code of Good Practices in order to successfully implement CBVCT in Europe.
- ⌘ The present report is divided in three sections which present the main results regarding: national context, the definition of CBVCT and its advantages (in comparison with formal health setting), and the description of CBVCT features (insisting in those aspects which might constitute a barrier or which need improvement). A conclusion at the end of these three sections presents the main results. Besides, there are “key points” windows after each main issue discussed by CBVCT clients and coordinators summarizing the most important results. Finally, in the Annexes a final table with the main results for clients and coordinators is available.
- ⌘ However, sometimes key results might be not only those that emerged but those that are absent; there is one major issue that deserves to be mentioned in these final comments. There is a significant lack of political discourse when coordinators and clients describe the drawn, the usefulness, the implementation and the actual and potential consequences of the existence of such a service. More in details, there did not appeared any in depth societal and political framings of the CBVCT, neither a larger reflection about the role that CBVCT has or can have in the global functioning of the different health systems and that the different communities can play with



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regards to HIV infection. As stated all along the report, there was systematic lack of information about the different aspects treated during this study, showing that a global perspective of this kind of services does not exist. One citation of one coordinator regarding how they did arrive to coordinate a CBVCT service is quite eloquent, working in VCT is about helping people, but in a very concrete and not in a broader way.

“I think it’s obvious why we do this work; we want to elucidate and to help.”

- ✘ In any case, we do believe that the present results will provide interesting and pertinent clues for the implementation of new CBVCT services as well as for improving those already functioning. The HIV-COBATEST project will provide with a Code of Good Practices as well as will create a European network of CBVCT services that by sharing their different experiences will reinforce the major role that these service can play in order to improve early diagnosis of HIV and to diminish the current unequal access to health and to improve, in somehow, the quality of life of those facing vulnerability and discrimination.



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Annex

Summarizing Table

Themes	CBVCT coordinators' point of view	CBVCT clients' point of view	Other key points
Stakeholders, Regulation, Community involvement and Funding	<p>Diverse national contexts. Wide theoretical HIV testing availability: hospitals, specialized clinics, and CBVCT. But, this wide availability does not necessarily correspond to people's daily-life.</p> <p>Even if CBVCT programs are diverse in "nature" and quantity they all target "most-at-risk" populations, mainly MSM.</p> <p>Lack of knowledge regarding National/Regional regulations. National/Regional regulations are quite diverse, ranging from those currently being developed to very exhaustive standards.</p> <p>Communities' involvement in National Health Strategies depends on balance of power.</p> <p>Diverse sources of funding (national, regional and/or private).</p>		<p>In those countries with more developed CBVCT programs, a strong interconnection with other health policies is found (e.g. harm reduction strategies targeting IDU).</p>
Is there easy access to HIV screening?		Barriers to HIV screening: small towns, fear of being "outed" but no formal barriers.	
Are HIV tests free?	Tests in CBVCT are free.	<p>Free tests in CBVCT, but not in other HIV testing sites.</p> <p>Paying is not always a problem; some people even suggest that paying could be a way of financing CBVCT services.</p>	
Request for ID?	"Anonymous" testing in CBVCT while other HIV testing settings ask for ID.	Showing ID does not bother the majority participant clients but it could be a barrier for other potential clients.	



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Themes	CBVCT coordinators' point of view	CBVCT clients' point of view	Other key points
HIV Positive Referral	<p>No legal barriers but obstacles: fear for undocumented migrants; cultural barriers.</p> <p>Confirmatory test are not made in the CBVCT: the CBVCT service is a bridge between the community and formal health settings and provides psychological follow-up for HIV positive people.</p> <p>Linkage with formal health system is perceived as indispensable.</p> <p>Lack of procedures regarding notification to sexual partners (in case of a positive result).</p>	<p>Lack of knowledge and absence of procedures regarding HIV positive referral. But clients prefer CBVCT in case of a HIV positive result: more "gentle" environment.</p> <p>Linkage to formal health system must include an emotional and personalized support.</p>	
What is a Community-Based Voluntary Counseling and Testing Service?	<p>Characteristics :</p> <ul style="list-style-type: none"> - Community-friendly staff - A non-clinical HIV testing - Targeted groups - Specific funding - Non traditional opening hours - Confidentiality <p>Community versus universal approach</p>	<p>Characteristics :</p> <ul style="list-style-type: none"> - Community/MSM-friendly staff : non-judgmental - Targeted groups - A routine HIV test, a preventive attitude - Confidentiality/anonymity - Physical places : sex place, community place, fixed or mobile places - Pleasant environment - Voluntary test 	<p>"Community-based testing" is a new expression for some respondents.</p> <p>The implementation of CBVCT services and programs is intimately related to the societal situation regarding homosexuality and HIV.</p>
Reasons for choosing a CBVCT : Advantages of a CBVCT	<ul style="list-style-type: none"> - More practical: rapidity, opening hours, physical proximity. - Adapted to clients: lack of prejudices regarding sexual orientation, sexuality, non-medical environment and providing preventive information. - A non-medical environment is an efficient way of detecting new HIV cases and a means for mobilizing communities. 	<ul style="list-style-type: none"> - A gay space vs. a heterosexual world: CBVCT venues are friendly and privileged places for the community. - A friendly vs. an inhospitable atmosphere - CBVCT services are synonym of getting the result rapidly and accompanied - Closer, listening and non-judgmental staff: no prejudices regarding sexual orientation and sexuality. - Counselling, access to HIV prevention. - Anonymity and confidentiality vs. "traceability" 	



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Themes	CBVCT coordinators' point of view	CBVCT clients' point of view	Other key points
Knowing that there exists a CBVCT service	<p>By all possible means: Internet, leaflets, mobilization of the community, outreach activities.</p> <p>Strategies to reach people: "seduction", regular presence in gay venues.</p> <p>Difficulties: disseminating information in gay venues and identifying gay venues (e.g. MSM attending "heterosexual places", mixed bars) is not easy. Besides, lack of financial support for advertising.</p>	<p>Clients knew the CBVCT by :</p> <ol style="list-style-type: none"> 1) Social networks 2) Paper and Internet advertising 3) Outreach activities. 	<p>Community mobilization is rarely named as a way of communicating about the testing service.</p>
Place: where is the HIV test performed?	<p>Fix, mobile and mixed CBVCT venues but always an accessible and "charming" place.</p> <p>Fix CBVCT venues should be "warming", well communicated (e.g. common transports) but not too visible.</p> <p>Assets for mobile testing services: reaching people who would not get tested otherwise, a way to extend the time-slots Drawbacks for mobile testing services: failure to return for HIV test results (if there is not rapid test), prevention of getting tested "in public", the issue of alcohol and drug use.</p> <p>A most varied offer increases the likelihood of reaching more people but some populations remain unreached (e.g. homeless, sex workers).</p>	<p>CBVCT places should have convenient opening hours (out of working hours, weekends...).</p>	<p>Type of implementation depends on national regulations and financial situation.</p>
Kind of HIV test	<p>In general, a good knowledge of the HIV technology.</p> <p>Different opinions regarding the use of rapid test:</p> <ul style="list-style-type: none"> - For some coordinators rapid tests are reliable, facilitate outreach and promote test among those people who otherwise would not get tested. - For some coordinators rapid tests are no reliable. <p>There are CBVCT services that consider that stress during the waiting time has a preventive effect.</p>	<p>Waiting a week is acceptable, but rapid tests are welcome.</p> <p>Auto-test emerged among CBVCT clients as an alternative. Even if training would be appreciated.</p>	<p>Come CBVCT services are allowed to perform Western-Blot confirmatory tests.</p> <p>Almost no failure to return for HIV test result is observed in CBVCT.</p>



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Themes	CBVCT coordinators' point of view	CBVCT clients' point of view	Other key points
Other STI Tests?	<p>Other STI tests are not always available in CBVCT.</p> <ul style="list-style-type: none"> - Hepatitis B: Slovenia and Denmark. - Syphilis: Germany, Czech Republic and Spain. - Some countries, like France, Poland and Italy do not offer other STIs tests in CBVCT venues. <p>Limits: some STI tests do not allow anonymity (health number insurance is required), medical staff is required.</p>	<ol style="list-style-type: none"> 1) Good knowledge of the other STI tests (in most of the cases). 2) Other STI test should be proposed. 3) As for HIV test, CBVCT is a place to do STI tests without judgment. 4) Talking about STIs allows talking about sexual risk behavior. 	<p>CBVCT services provide with information (leaflets, cards) about STIs, PEP, HIV and other HIV testing services.</p> <p>They do also distribute condoms and lubricants.</p>
Opening Hours	<p>Effort to propose unusual and wide opening hours.</p> <p>Lack of funding is a limit.</p>	<p>Some clients declare that current opening hours fit their needs.</p> <p>Most of the clients ask for more opening days and more opening hours, especially out working hours.</p> <p>Auto-test is evoked as a means for "extending opening hours".</p>	<p>The length of the HIV test depends on the CBVCT organization (staff, appointment or not, rapid or classical test, affluence...).</p> <p>Information regarding the problems with the opening hours of the people not attending CBVCT services is not available.</p>
Informed consent	<p>No legal framework and diverse practices.</p> <p>Oral informed consent is more frequently asked.</p> <p>Pre-test counseling is a means to obtain the informed consent.</p>	<p>Informed consent is sometimes confounded with behavioral questionnaire.</p> <p>Oral informed consent is preferred.</p> <p>Clients do not consider necessary the informed consent, but when legal issues arise they change their mind (mainly in the case of a HIV positive result).</p> <p>Clients do not consider problematic the informed consent.</p>	



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Themes	CBVCT coordinators' point of view	CBVCT clients' point of view	Other key points
The Professionals of Secret - Staff and Confidentiality	<p>Coordinators indicate that in CBVCT, generally, doctors perform the test and community-members do the counseling.</p> <p>Coordinators have divergent opinions about who should do VCT: professionals or community-members, or both?</p> <p>Coordinators indicate that staff should be evaluated, trained, but also well cared since is a hard work.</p>	<p>Clients have very different opinions about who should perform the test: a professional, a community-member and/or someone neutral independently of his/her background.</p> <p>Clients raised confidentiality issues regarding being tested by a community member.</p> <p>Clients consider that professional and not professional CBVCT staff must be trained.</p>	
Counseling: the art of talking	<p>Guidelines for counseling do not frequently exist but sometimes, the community-based association creates its own criteria (France, Denmark).</p> <p>Post-counseling is an appropriate moment to talk about sexuality and sensitive issues, in case of HIV-.</p>	<p>Counseling must not be understood as a moralizing moment.</p> <p>Clients who often have a test would prefer a personal counseling.</p> <p>Some clients would prefer receiving the results by the Internet: they don't care about counseling.</p> <p>Globally, clients are satisfied by the counseling in CBVCT.</p>	<p>Counseling is understood in different ways: a psychological support, a listening and responding to the participant moment.</p> <p>Some clients did not experience counseling in formal health settings.</p>



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Themes	CBVCT coordinators' point of view	CBVCT clients' point of view	Other key points
<p>Evaluation, Satisfaction and Improvement of CBVCT Services</p>	<p>There is no a systematic evaluation of the satisfaction with the VCT: some CBVCT use informal conversation, other questionnaire.</p> <p>Indirect measures are also used: growth of the number of clients, come back of the clients.</p> <p>Some coordinators express inconvenience with evaluation (they feel evaluated themselves).</p> <p>Coordinators argue that their opinion would also be useful.</p> <p>Coordinators report insufficient financial resources for make a systematic evaluation and to improve CBVCT services.</p>	<p>Clients report that expectations are fulfilled and sometimes exceeded.</p> <p>Some clients feel so gratefulness that they feel anxious about "evaluating" CBVCT, others consider that evaluation is a meaningful way of improving CBVCT services.</p> <p>Evaluation is a way of having an insight into the evolution of the program (in terms of targeted populations for instance).</p>	<p>It would be interesting knowing the opinion of those who do not come, or who do no get back to CBVCT services.</p>



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Summary of data presented in the Qualitative Study Report

	Czech Republic	Denmark	France	Germany	Italy	Poland	Slovenia	Spain
Type of staff	Doctors, nurses, community members	Doctors, nurses, community members, psychotherapist	Community members	Doctor, community members	Nurse	Doctors	Doctors, nurses, community members	Community members
Other STI tests	Yes : Syphilis	Yes : HBV	No	Yes : Syphilis	No	No	Yes : HBV	Yes : Syphilis
Kind of test	Classical test	Rapid test (prick test)	Rapid test (prick test)	Classical test and rapid test (prick test)	Classical test and rapid test	Classical test and rapid test (prick test)	Classical test and rapid test (saliva)	Classical test and rapid test (prick test)
<i>Informed consent according to WP4</i>								
Is the informed consent required?	Oral required informed consent	Oral required informed consent	Oral required informed consent	Oral required informed consent	Written required informed consent	Oral required informed consent	?	Oral or written required informed consent
<i>Informed consent according to WP5 : CBVCT users' particular experience</i>								
Did you receive informed consent?	Yes but explications are necessary	Yes	Yes or don't remember	Yes	?	?	Yes but explications are necessary	Yes
How was it?	?	Oral	Oral	Written and oral	?	?	Oral	Written and oral
HIV test free of charge in the public health system	Always	Always	Always	Not everywhere	Not everywhere	Not everywhere	Not everywhere	Always
HIV test free of charge in CBVCTs	Yes	Yes	Yes	Yes, except in 2 CBVCT	Yes	Yes	Yes	Yes



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Focus groups characteristics

	Czech Republic	Denmark	France	Germany	Italy	Poland	Slovenia	Spain
Name of the CBVCT	Czech Aids Help Society - Lighthouse	Checkpoint	AIDES Lille	Aids Hilfe Esseau Aids Hilfe Bochum Aids Hilfe Dusseldorf	Gruppo C, Borgo Roma		?	BCN Checkpoint (Projecte dels NOMS-Hispanosida)
Type of CBVCT	Community center	Community center	Community center	Community center	Hospital	VCT hospital	Community center	Community center

Characteristics of participants of WP5 : CBVCT users.
Age / Gender / Educational level / Number of times in a CBVCT

Participant 1	41 male university CBVCT 2-5 times	22 male secondary CBVCT 2-5 times	26 FTM univeristy CBVCT 2-5 times	28 male university CBVCT once	?		28 male secondary CBVCT once	33 male university
Participant 2	36 male university CBVCT once	43 male university CBVCT once	23 female university CBVCT once	32 male secondary CBVCT 6-10 times	?		38 male university CBVCT 2-5 times	31 male university
Participant 3	19 male university CBVCT once	55 male secondary CBVCT 2-5 times	48 male Secondary CBVCT 2-5 times	48 male secondary CBVCT 2-5 times	?		25 male university CBVCT 6-10 times	46 male university



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	Czech Republic	Denmark	France	Germany	Italy	Poland	Slovenia	Spain
Participant 4		41 male university CBVCT 2-5 times						
Participant 5		25 male university CBVCT 2-5 times						
Participant 6		38 male university once						



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Focus groups guide

Issue	Min	Done
PRESENTATION	3'	
What do you understand for a CBVCT? Is your opinion that in your country there exist a community-based approach? If yes, could you describe it (what do you think is the role of communities concerning HIV plans, CBVCT...)? If not, which reasons could explain this fact?	5'	
How do you think that implementing a CBVCT occurs? Do you think that is something easy/difficult? What kind of staff is needed? (the idea is to learn what are their representations concerning the implementation of a CBVCT9)	5'	
Why do you use CBVCT for getting screened for HIV? (in function of reasons for coming to the CBVCT, you can ask if their expectatives were fulfilled)	5'	
In your experience, which would be the major differences between CBVCT and other HIV screening settings? Talk about the time that counseling takes, the time to get your results, the way you were treated... etc.	4'	
How did you learn that a CBVCT existed? Do you think that your local context allow to communicate freely about this kind of services? Is outreach possible in your local context? Why?	5'	
In your opinion, in your country, are there difficulties that restrain HIV+ screening access? And HIV treatment?	3'	
Have you ever had to pay for making the test? Do you need you ID or other legal documents to be presented before doing the test? Tell us your experience concerning these aspects.	3'	
Regarding the last time you were tested in this CBVCT service...		
What kind of person did perform the test on the CBVCT, a professional or a community representative? What did you like and what you did not like of being screened by this person? Who do you think that are the most indicated for that task: community representatives or medical staff? Why? How were you treated?	5'	
Did you receive informed consent? How was it? Was it oral or written? What kind of informed consent do you prefer? Do you think that it is necessary? If yes, why? If not, why? Do you think that is a good thing or you have some doubts about how it can be used? If not, is that ok with you?	5'	
Are you satisfied with confidentiality/privacy in CBVCT? And in other screening settings? (keep in mind the previous question) If yes, why? If not, why?	5'	
Did you receive counseling when you were screened? What do you think of this counseling? Was this counseling helpful? Was it adapted to your situation, to your needs? Did you have the opportunity of asking your doubts or questions? Did you feel that you were being judged? If yes, Can you please give us un example? What kind of feelings did you feel because of being judged?	5'	
What kind of test was performed to you (oral, blood...)? How would you describe your experience with this testing method? Is there big difference between rapid and classical tests? Did you have to pierce yourself? Was this a problem for you?	3'	
Are other STI testing proposed? What's the procedure? Is that necessary in your opinion? Is it difficult to you to talk/to ask about other STI? Are you satisfied with STI testing if it exists in your country?	3'	
If you were positive, or if you know the experience of someone else knowing that he/she's HIV positive in the CBVCT, could you describe the procedure of accompanying a diagnosed patient in the clinical setting? Are you satisfied with that procedure?	3'	
What's the testing schedule of the CBVCT? In your opinion, is that adapted to your needs?	3'	
Where is the test performed? (van, bar, sauna, CBVCT venue)? Is that convenient for you?	3'	
Could you describe the positive and negative things of the CBVCT setting? Why are they positive and negative? What and how would you improve it? (do not forget to insist about satisfaction on psychosocial and health-related information, and on prevention materials offered)	4'	
Have you ever (before than today) been asked to evaluate your satisfaction with the CBVCT? If yes, how was satisfaction measured? If not, do your think that it is important to evaluate this kind of services?	5'	
ENDING OF THE FGD	3'	



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Interview guide

Issue	Min	Done
PRESENTATION	3'	
What's the national HIV screening and monitoring context? Who does what?	3'	
How did you arrive to coordinate a CBVCT?	3'	
What do you understand for a CBVCT? Could you briefly describe the community-based approach in this country?	3'	
Could you describe the communities involvement in HIV decisions (national plans, prevention, CBVCT, other activities/procedures)?	5'	
What's the governmental/regional regulation covering HIV testing? And covering testing on CBVCT?	3'	
Could you briefly describe how does it work funding for CBVCT?	5'	
Could you describe the informed consent request and put it in line with the legal situation of (sexual minorities, prostitution, HIV transmission)?	5'	
What are the norms concerning confidentiality/privacy in CBVCT? And in other screening settings? (keep in mind the previous question)	5'	
What professionals are performing the tests (conventional and rapid). Are they the most indicated for that task? Why? Who do you think would be the most indicated?	5'	
Do CBVCT in your country follow standardized procedures /guidelines for counseling and testing? Are there any regulations concerning training and procedures?	5'	
What kind of test do you use? How would you describe your experience with this testing method? Why are you using this kind of tests and no others?	5'	
Which would be the major differences between CBVCT and other HIV screening settings in your country?	4'	
Could you describe the positive and negative things of the CBVCT setting? Why are they positive and negative? How would you improve it?	4'	
Is people attending paying the test? Do they need their ID or other legal documents to be presented before doing the test?	3'	
What's the testing schedule of the CBVCT? Is that adapted to the populations needs?	3'	
Where is the test performed? (van, bar, sauna, CBVCT venue)? Is that convenient for your attending populations needs?	3'	
What prevention materials (e.g. condoms, lubs, flyers) and information on existing services either governmental or non governmental (for psychosocial and health related needs) is provided on venue?	3'	
What about sexual partner notifications when a person tested positive? Is there a standardized procedure?	2'	
Are other STI testing proposed? What's the procedure?	3'	
Are there legal barriers which restrain HIV+ referral?	3'	
Describe procedures of referring an HIV positive tested individual to medical treatment center		
Which methods does the CBVCT use to disseminate their activities/services? Why have been them chosen? Does the local context allow to communicate freely about these services? Is outreach possible in your local context? Why?	5'	
Have you any means to know the satisfaction with CBVCT in you country? Why? How is satisfaction measured? What for? Are these results used to improved the services? Are there economical means, human resources to improve these results?	5'	
ENDING OF THE INTERVIEW	2'	