Values and preferences of HIV self-testing options in UK men who have sex with men (MSM): Barriers, facilitators and intervention preferences.

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HIV testing in MSM in the UK

- UK guidelines - annual testing, or more frequently if ongoing risk.
- <50% of MSM follow testing guidelines.*
- April 2014 - HIVST legalised

  April 2015 - CE marked test released.
- HIV self-sampling (HIVSS) provided through national service.
- Evidence suggests HIVST is highly acceptable to MSM.**
- Work undertaken to guide intervention development for RCT providing HIVST to 6000 MSM.

Figure 1: BioSure™ HIV self-test.

* Witzel et al. 2016.

**Flowers et al. 2016.

Aims & objectives

Aim: to understand values and preferences for HIVST interventions targeting MSM in the UK.

Objectives

- Understand acceptability of HIVST among MSM in the context of known barriers and facilitators to testing for HIV;
- Assess preferences for, and the concerns about, HIVST.

Methods

- Purposive quota sampling
- Topic guide developed through literature review with reference to COM-B and Theoretical Domains Framework (TDF) theories of behaviour change**
- 4 FGDs used general purposive sampling, 1 for higher risk MSM, 1 for those who had not tested.
- Thematic framework analysis.

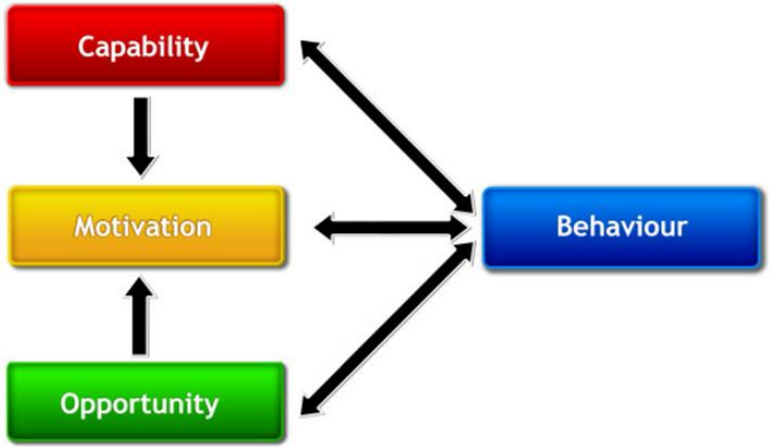


Figure 2: COM-B model of behaviour change

** Michie et al 2011; Cane et al 2012

Participant characteristics

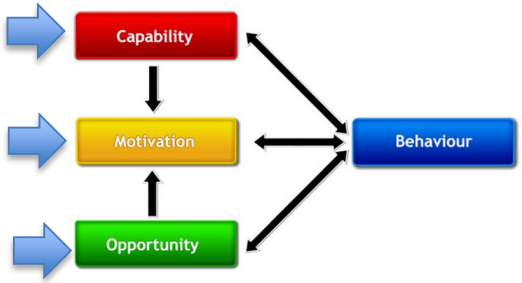
Table 1: Sample characteristics		
Demographic characteristic		MSM recruited
Age group	18 - 25 years	9
(Min 18 max 64)	26 - 39 years	21
	40+	17
Ethnicity	Black	4
	Asian	6
	White	37
	Other / Mixed	0
Sexual orientation	Gay	38
	Bisexual	5
	Other (not gay or bisexual)	4
Recency of HIV testing	Never tested	8
	Tested 12 months+ ago	9
	Tested in last 12 months	30
Use of HIV testing locations (multiple answers allowed)	GUM	30
	GP	6
	Community / PoCT	6
	Self-Sampling	11
	Self-testing	4

Facilitators

Facilitators

- Convenience, confidentiality, choice

"My ex-partner was a Muslim and within his family, and all that, being gay is not allowed. But I think having a self-testing kit when he can do it at home in our home, I know he would appreciate that. I know he couldn't take it back to where he's from, but in my home he can." (51-year-old gay man, Manchester)

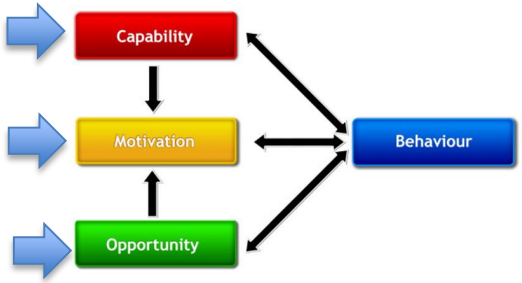


Barriers

Barriers

- Capabilities, confidentiality, dislocation from care pathways.

"What you were saying about it being human error... I think it's a whole host of other things as well. I am quite clumsy and I am not good with instructions and I do not like what to be told what to do. So, I think, how can you trust that it you have done it right? How can you trust that you can interpret the results correctly?" (25 year-old man, Manchester)



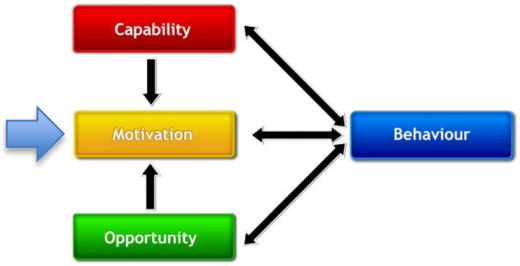
Intervention preferences

Table 2: Intervention preferences exercise results				
	Number of respondents ranking in position			
Test attribute	1	2	3	4
Window period	17	12	5	2
Sample type	12	13	9	3
Access options	7	5	13	12
Instructions	2	7	9	19

Intervention preferences: window period

- Most important element of test for majority of participants.
- 4th generation tests understood as gold standard.
- Available HIVST is 2nd generation, undermining immediacy of intervention.

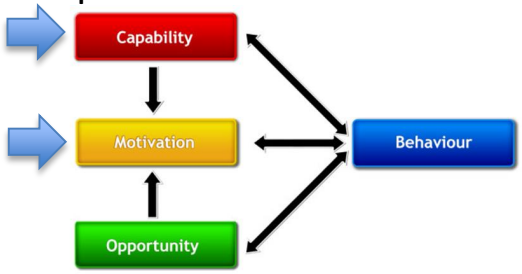
"I guess you don't want it to be "oh crap, things went a bit crazy last week and I'll get this now and do it and oh this is a negative" and find that actually it's much more like twelve weeks… I could imagine [using HIVST] *but only if I could get a test* [where the] *window period was as good as a clinic test."* (20-year-old queer man, London).



Intervention preferences: sample type

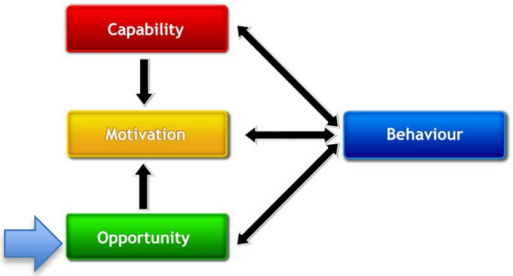
- Preference for blood over saliva due to perceived issues of sensitivity.
- Saliva sample availability crucial for small group of men.

Figure 3: OraQuick saliva sample HIVST



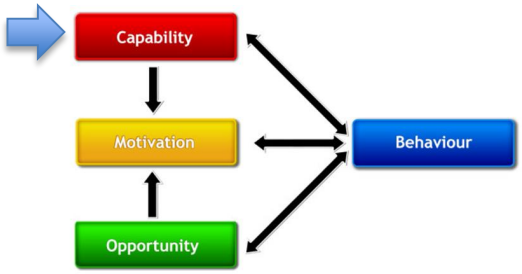
Intervention preferences: access options

- Range of access options seen to be crucial to maintain convenient and confidential nature of HIVST.
- Particularly acute for those with issues surrounding domestic privacy.
- Sense that existing infrastructure should be utilised whenever possible (i.e. clinic pick up, pharmacy but also click-and-collect systems).



Intervention preferences: instructions

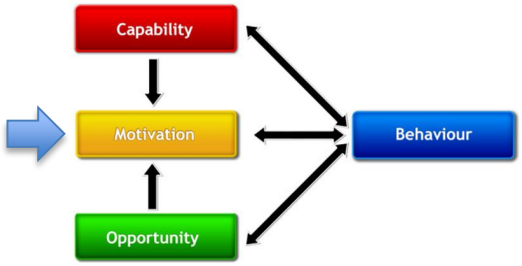
- Kits thought to be overproduced as a means to justify high prices.
- Existing kits do not cater to the diverse range of abilities represented amongst MSM.
- Videos very important for individuals with literacy issues, and to demonstrate the test.



Intervention preferences: support

- Most pronounced concern related to dislocation of HIV testing from care pathways.
- Assumed that HIVST would lead to 'de-skilling', self harm, increase in bacterial STIs, and potentially in HIV transmission.
- Telephone helpline most favoured approach to support, ideally run by NHS.
- Embedding HIVST interventions in clinical services also viewed favourably.

"I learn so much from when I go to get tested, there's always something new coming out or a trial or some sexual health information that I maybe didn't know and if someone's just carrying on their own doing it themselves..." (26-year-old gay man, higher risk group, London).



Summary

- Boosts choice significantly, even in a saturated marketplace of services and amongst marginalised communities.
- Issues to do with capability (can I do it?) central to uptake.
- Accuracy is key for widespread use.
- Both blood and saliva samples important for very wide appeal.
- Range of access options central to assuring accessibility.
- Adjustments in intervention features impact on different domains of behaviour, important to keep the needs of groups targeted by an intervention in mind when developing HIVST services.
- Dislocation from care pathways felt to be extremely problematic. Requires innovative approaches to embed HIVST in existing clinical structures.

References

- Cane J, O'Connor D, and Michie S. Validation of the theoretical domains framework for use in behaviour change and implementation research. Implementation Science. 2012; 7:37.
- Flowers P, Riddell J, Park C, Ahmed B, Young I, Frankis J, Davis M, Gilbert M, Estcourt C, Wallace L & McDaid LM. Preparedness for use of the rapid result HIV self-test by gay men and other men who have sex with men (MSM): a mixed methods exploratory study amongst MSM and those involved in prevention and care. HIV Medicine. 2016. (In press).
- Michie S, van Stralen M M & West R. The behaviour change wheel: A new method for characterising and designing behaviour change interventions. Implementation Science. 2011; 6:42.
- Witzel T C, Melendes-Torres GJ, Hickson F, Weatherburn P. HIV testing history and preferences for future tests among gay men, bisexual men and other MSM in England. BMJ Open (under review).